**Annual report of Infection Prevention and Control, Vaccination and Medical Devices**

**APRIL 2021 - MARCH 2022**

**Contents**

| **Section** | **Page** |
| --- | --- |
| **1** | **Executive Summary** | 3 |
| **2** | **Registration with the Care Quality Commission**  | 3 |
| **3** | **Organisational structure** | 4 |
| **4** | **The infection prevention, control and medical devices work programme 2021-2022** | 5 |
| **5** | **Staff Flu campaign** | 5 |
| **6** | **Surveillance** | 7 |
| **7** | **COVID-19 testing: asymptomatic screening and symptomatic testing** | 8 |
| **8** | **Staff test and trace** | 10 |
| **9** | **Fit testing** | 10 |
| **10** | **Outbreaks**  | 11 |
| **11** | **Audit** | 13 |
| **12** | **Compulsory training** | 15 |
| **13** | **IPC Link Champion programme** | 16 |
| **14** | **Policy Development** | 17 |
| **15** | **COVID-19 vaccination programme** | 17 |
| **16** | **Cleaning and Waste Management** | 19 |
| **17** | **Antibiotic prescribing** | 20 |
| **18** | **Medical Devices** | 22 |
| **19** | **The Infection Prevention and Control, Antimicrobial Prescribing and Medical Devices Committee** | 22 |
| **20** | **Reporting Arrangements** | 23 |
| **21** | **Summary** | 24 |
| **Appendices** |  |
| **1** | **Annual Infection prevention, Control and medical Devices Work Programme 2021/22****Annual Infection prevention, Control and medical Devices Work Programme 2022/23** | 25 |
| **2** | 32 |

1. **Executive Summary**

**1.1** This annual report details infection prevention and control, vaccination and medical devices activity between 1st April 2021 and 31st March 2022 relating to LYPFT. The reporting period includes the Delta and Omicron waves of the COVID-19 pandemic.

**1.2** It provides an overview for the Board of Directors on the activity, progress and achievements in infection prevention and control. This is in relation to:

* the annual Infection Control Programme (ICP)
* compliance with the Care Quality Commission (CQC) Essential Standards (Regulation 12, Outcome 8)
* compliance with the Health and Social Care Act (2008); code of practice on the prevention and control of infections and related guidance
* Guidance issued by NHS England and NHS Improvement, and the Department of Health in relation to the COVID-19 pandemic. In this respect detail of the COVID-19 vaccination programme has also been included in the report.

**1.3** The Trust’s ICP is based on the updated CQC criteria for regulation and cross references all relevant Department of Health (DH) publications. It also includes the ongoing infection prevention and control requirements published during the pandemic. Business continuity arrangements have been in place intermittently during the reporting period, resulting in hibernation of some elements of the ICP. Currently the team is executing all elements of the plan; therefore, the report reflects the work of the team within this context.

**2. Registration with the Care Quality Commission**

**2.1** The law states that the Health and Social Care Act (2008): code of practice on the prevention and control of infections, must be considered by the CQC when it makes decisions about registration and that providers must have regard to the code when deciding how they will meet the regulations. From April 2009, providers of health and social care had to be registered with the CQC and thus provide evidence of compliance with the Health and Social Care Act in order to register with the CQC. In 2019, Leeds and York Partnership NHS Foundation Trust (LYPFT) received a rating of ‘good’ following inspection.

**3. Organisational Structure**

**3.1** The Executive Director of Nursing, Professions and Quality is the designated Director of Infection Prevention and Control (DIPC) for the Trust and reports directly to the Chief Executive and the Trust Board. The DIPC is supported by a Consultant Medical Microbiologist via a service level agreement with the Microbiology Department from Leeds Teaching Hospitals Trust (LTHT).

**3.2** The Head of Infection Prevention and Physical Health is the nominated Trust Infection Control Lead and is responsible for the development and implementation of the annual programme in compliance with the Health and Social Care Act 2008 (amended 2015). This includes the development and review of infection prevention and control policies.

**3.3** The Infection Prevention, Control and Medical Devices Committee meets four times a year and is chaired by the DIPC. The overall purpose of this group is to provide both strategic and operational leadership in relation to IPC standards and performance. The Committee of representatives from clinical teams, support services and expert advisors, reports to the Board of Directors through the Chair’s report of the Quality Committee; a designated subcommittee of the Board. Areas of concern are also escalated through the quarterly Executive Director of Nursing, Quality and Professions/DIPC report.

Membership of the committee aims to include representation from all services, improving the reach of IPC and enabling timely sharing of vital information essential to the containment of the spread of COVID-19, and other infections. Where applicable (i.e., during pandemic Incident Response Team (IRT) arrangements) the meeting reports to Silver Command through an information dashboard. From here, items requiring escalation are reported to Gold Command by the DIPC.

**4. The infection prevention, control and medical devices work programme 2021-2022**

**4.1** During the reporting period the Infection Prevention and Control work programme (appendix 1) has largely been reinstated following a period where intermittently, workstreams were hibernated due to business continuity arrangements being triggered. There have been a number of key achievements during the reporting period:

* There were no reportable cases of alert organisms (*c. difficile*, gram negative blood stream infections).
* Combined attendance at Infection Prevention and Control training was 85% for all staff groups. This breaks down as 82% compliance for clinical staff and 92% for those in non-clinical roles, and is an improvement on the previous year
* The environmental audit programme has been successfully reinstated following the first and second waves of the pandemic

**5. Staff Flu Campaign**

**5.1**     Planning for the seasonal flu programme begins early in the calendar year to enable the first vaccinations to begin in October and 2021 was no exception.
Unusually, the 2021/22 Flu campaign was not subject to CQUIN payment; however, in the second pandemic year (2021/22) providers were urged by NHSE to focus on achieving maximum uptake of the flu vaccine in existing eligible groups, as co-infection with COVID-19 and flu could be catastrophic for people categorised as vulnerable to either virus.

**5.2**     2021/22 presented ongoing operational challenges which were present in the previous year’s campaign; the usual opportunistic approaches to vaccination using Trust induction and drop-in clinics were, in the main, not practicable due to the need for social distancing. An appointment-based system was used to prevent queue build up and reduce the risk of outbreak. This meant that more staff and more venues were needed to deliver the sessions.

**5.3** The 2021/22 campaign was the first time that the Trust has used Vaccination Track; a cloud-based software system used to manage many aspects of the flu campaign such as communicating with staff, showing live clinic availability, and allowing staff to directly book into appointments. The system also shows real time data on vaccinations completed at team level which helps the IPC team to direct communications appropriately and engage with staff to increase uptake.

**5.4**     A concerted effort by the IPC team resulted in 62.8% of staff in a patient facing role receiving their flu vaccine. This is significantly lower than the uptake of 77% in 2020/21; however reduced uptake was a consistent picture across NHS Trusts, and the Trust exceeded both the national uptake (60.5%) and regional uptake (61.3%)[[1]](#endnote-1). Uptake across professional groups was as follows:

* Doctors 72.7%
* Registered Nurses 62.4%
* Other professionally qualified clinical staff 66.7%
* All support staff 59.1%

 Figure 1 shows vaccination trajectory by week of the campaign with each year represented as a coloured line. In previous years the most rapid uptake has been at the beginning of the campaign; a fridge failure resulting in a loss of vaccine by the Trust’s occupational health provider contributed to a less rapid start to the campaign than 2020/21.

**Figure 1**. Health care worker flu vaccination trajectory by year 2017-2022

**5.5** Protection from co-infection with COVID-19 and flu continued to be a key focus of the campaign that carried over from the previous year. Posters were used to highlight the contribution that flu vaccination could make to keeping staff and service users well and protecting others. The Flu Bee game application was used for the second year running to educate staff about the virus and encourage them to receive the flu vaccine via their mobile phones and PCs.

**6. Surveillance**

**6.1** Trusts are required to minimise rates of both *clostridioides difficile* (*c. difficile*) and of Gram-negative bloodstream Infections. These are organisms of clinical interest that can pass easily between people within a health care setting and result in infection for the patient. The pathology service at Leeds Teaching Hospital provides the IPC team with reports on any alert organisms in samples received from patients in our Trust, enabling investigation and appropriate action to be taken.

**6.2** New admissions are screened to assess if they meet the criteria for MRSA screening. For relevant individuals, the IPC team support ward teams to ensure screening is carried out where required and that treatment is completed as indicated. In the 2020/21 report, the IPC team described how work was due to begin to develop a reporting system linked to the electronic patient record which would enable improved recording and audit capability. This work has been further delayed due to the ongoing challenges of the pandemic; however, it has been carried over onto the work plan for 2022/23.

**7. COVID-19 testing: asymptomatic screening and symptomatic testing**

**7.1** Implementation and oversight of asymptomatic screening and symptomatic testing for COVID-19 has continued throughout the reporting period in line with national guidance which been frequently updated in an effort to develop the most robust pathway to prevent transmission of the virus in ward environments. More recently this has involved changing the majority of patient testing to lateral flow device testing (LFD), with only a minority of samples being sent for laboratory PCR testing in specific circumstances.

Prior to a guidance change in April 2022, all inpatients were screened weekly for COVID-19 (subject to consent). The aim was to enable rapid identification of asymptomatic carriage and protection of the ward household from outbreak. All testing was carried out and overseen by the IPC team. Figure 1 below shows testing activity during the reporting period.

Figure 2. Weekly asymptomatic screening April 2021 - March 2022

During periods of high community prevalence, the testing enabled early identification of asymptomatic cases of COVID-19 and helped to limit outbreaks on wards. Weekly screening ceased in line with the updated guidance at the end of the reporting period. All current testing protocols in the Trust are in line with in NHS England’s Testing for Inpatients guidance[[2]](#endnote-2)

Administration of the testing programme continues to be maintained by the IPC team to ensure there is clear oversight of the quality assurance and governance needed to maintain patient safety. All testing data is now being entered onto the patient record which will enable a more streamlined audit trail and easier identification of individual testing history.

 **7.2** In addition to the asymptomatic screening detailed above, testing occurs as follows:

* on admission, on the 3rd day of admission, and between days 5 and 7 after admission (known as the admission protocol)
* when a service user becomes symptomatic
* when a service user returns from leave, on the 3rd day after return, and between days 5 and 7 after return

 On average 18 service users per day were tested by the IPC team for the above reasons during the reporting period. This is in addition to the weekly asymptomatic screening described in section 7.1.

**8. Staff test and trace**

**8.1** In response to escalating numbers of staff experiencing symptoms, receiving NHS Test and Trace alerts, or testing positive; the IPC team developed a process for risk assessing staff to understand risk of transmission in the work place, and provide advice on isolation and testing. This process has been integral to the identification of staff and mixed staff/patient outbreaks, and also offers opportunity to continually reinforce good IPC practice through individual conversations with staff.

 The IPC team has responded to over 1,750 COVID positive cases in the reporting period and provided advice and guidance to many more in line with national procedures. For each case this involved speaking with the staff member to identify their contacts and assessing the level of risk posed by their contacts in the workplace based on a risk assessment tool developed by the team; this often required many follow up conversations with contacts. This process is under constant review in response to developing national guidelines.

**9. Fit testing**

**9.1** Fit testing is the process of carrying out various tests to ensure that any respiratory protective equipment (known as FFP3 masks) issued, is of a good fit in order to protect the wearer from being exposed to airborne viral particles – usually through an aerosol generating procedure such as performing chest compressions during resuscitation.

 **9.2** An external provider, funded by NHS England, has been supporting the team to reach as many clinical staff as possible. Achieving high numbers of staff who have been fit tested has proved challenging and we have constantly revised our processes to make the sessions as accessible as possible for staff, who often find it hard to attend due to ward pressures. A change in mask availability from NHS stock compounded the issue as it meant that staff had to be re-tested for new types of masks that could be available in the long term.

**10.**  **Outbreaks**

**10.1** Non-COVID-19 Outbreaks in inpatient environments are most likely to be related to viral gastroenteritis or influenza. All hospital settings are susceptible to outbreak due to the communal nature of the environment and multiple staff - patient physical contacts. Table 1 details non COVID-19 related outbreak occurrences over the last 5-year period. Only one gastroenteritis outbreak occurred over the reporting period; this was in a Specialist Supported Living facility.

 **Table 1.** Non COVID-19 outbreaks year by year count

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **YEAR** | **QTR 1** | **QTR 2** | **QTR 3** | **QTR 4** |
| 2021/22 | 0 | 0 | 0 | 1 |
| 2020/21 | 0 | 0 | 1 | 0 |
| 2019/20 | 0 | 3 | 0 | 0 |
| 2018/19 | 0 | 0 | 1 | 0 |
| 2017/18 | 0 | 2 | 1 | 3 |
| 2016/17 | 1 | 0 | 3 | 1 |

It is likely that this reduction is due to following patterns of practice directly related to the pandemic which resulted in:

* Very limited patient movement
* Very limited visiting
* Implementation of social distancing
* High frequency of hand hygiene
* High frequency of touch point cleaning and increased surface cleaning
* Mask wearing by staff and visitors
* Lower than average community transmission of viruses usually implicated in non-COVID-19 outbreaks

**10.2 COVID-19 outbreaks**

The NHSE definition of COVID-19 outbreak is more than one incidence of infection occurring in the same ward or environment; and may be a combination of patients, staff or other regular ward visitors. Probable Healthcare Associated Infection (HCAI) is defined as having illness onset (or first positive specimen date) between 8 and 14 days after admission; and definite HCAI case has illness onset (or first positive specimen date) 15 or more days after admission.

Figure 3 shows the pattern of outbreaks by month during the reporting period.

 From 1st April 2021 to 31st March 2022 the Trust reported 17 outbreaks affecting inpatient and non-patient settings. 4 of these outbreaks related to staff only.

In December and January, the Trust experienced its highest number of outbreaks due to the COVID-19 Omicron variant. In March there was a further peak due to the BA.2 sub-lineage. In some of these outbreaks, service users were infected for a second time, this despite having received vaccination.

All outbreaks were subject to Outbreak Control Meetings; chaired by the IPC Lead or a deputy and drew on the experience of staff from the affected areas, the IPC team, and a Consultant Microbiologist. Meetings for each outbreak were repeated until there was no longer evidence of transmission (supported by frequent asymptomatic testing). All incidences of outbreak were reported on the national outbreak platform and via the agreed process to Public Health England. Information about positive cases and areas affected continues to be provided to NHS England via daily SitRep submission.

**11. Audit**

**11.1** **Environmental audit**

Annual audits of a range of community and inpatient environments within LYPFT were undertaken by the IPC team to monitor compliance with infection prevention and control policies and procedures. This routine element of the IPC programme was hibernated during the previous reporting period but reinstated late 2021. The IPC team were able to audit 26 areas out of 31 which equates to an 86% compliance. Each of these audits has an action plan to address areas of IPC concern. Results and outcomes continue to be reported via the IPCC and Medical Devices Committee. The environmental and Patient led assessments of the care environments (PLACE) inspections continued to be hibernated throughout the reporting period due to the implications of the pandemic.

**11.2 Mattress audits**

Mattress audits are completed to ensure that damage to the integrity of the mattress cover e.g., through tears or soiling, does not pose an infection risk to the service user or environment. Audits at the Mount hospital site were completed by the Medical Device Support Officer. Across other clinical areas, wards were supported to complete their own audit and return them to the IPC team. This resulted in 85% of audits being received. The usual mattress audit process will recommence in 2022 as a return to usual IPC auditing routine occurs.

**11.3 Hand hygiene observational audit**

 These audits are routinely carried out by Infection Control Link Champions and are a means of monitoring compliance with hand hygiene policy across a wide range of staff. The Trust Hand Hygiene Audit Tool is based on the ‘Five Moments of Hand Hygiene’. This audit aims to find out if surveillance of the opportunity for Hand Hygiene demonstrates that staff comply with mandatory training, and policies and procedures (e.g., use of the 7-step hand hygiene tool) to reduce the instances of HCAI. The results are continually evaluated and fed back to staff and incorporated into the mandatory training programme. Table 2 shows an overview of the results from audits returned to the team during the reporting period.

 Table 2. Hand hygiene audit results

|  |  |  |  |
| --- | --- | --- | --- |
| Hand HygieneWas the correct 7 step hand hygiene technique used? | N/A | No | Yes |
| Q1 | 5% | 5% | 90% |
| Q2 | 6% | 6% | 88% |
| Q3 | 6% | 6% | 88% |
| Q4 | 8% | 4% | 88% |

Many inpatient areas have found submitting the required number of audits challenging throughout the reporting period. From 2022, the audit tool has been adjusted to incorporate compliance by service line. This will make it easier to address persistent non-compliance via existing clinical governance routes.

**11.4 PPE audit**

Auditing of PPE compliance continued throughout the reporting period to assess staff knowledge and awareness and consistency in application. The IPC team took over responsibility for receiving these audits mid- year, so that any difficulties in achieving compliance could be triangulated with other IPC intelligence e.g., outbreaks and environmental audits. Audits continue to be carried out by ward/team managers and are performed weekly in the inpatient environment and monthly by community teams. PPE compliance is reviewed at every outbreak meeting. Colleagues are encouraged to address any lapses in compliance on the spot and escalate repeated occurrences. Ad-hoc audits are completed by the IPC testing team as an additional assurance measure, and the process is under review to streamline how these are performed and align with the hand hygiene audit process.

 **11.5** **Inoculation audit**

The IPC audits all sharps injuries and related incidents annually following the introduction of the EU Directive on safety sharps. In 2021-22 there were 9 inoculation incident reports compared to 8 the previous year; these could be broken down into the following categories:

* Insulin administration 3
* Depot administration – 3
* Blood collection – 1
* Depot administration under restraint – 1
* Blunt (drawing up) needle - 1

Themes identified from Datix reporting included failure to activate the safety mechanism on the needle and not having a sharps bin appropriately placed at hand. These findings are fed back to staff and also used in training. Recommendations are made and where indicated; procedure changed as a result of investigations to prevent further incidents.

**12.** **Compulsory training**

**12.1** The IPC education programme helps to improve knowledge and raise the profile of infection control across the Trust. Clinical staff are required to attend IPC training annually, whilst non-clinical staff receive training every 3 years. The awareness of the potential risks of infection has increased significantly during the pandemic; during the reporting period the team made a concerted effort to increase the number of training places available as part of pandemic recovery. This included increasing virtual class sizes, increasing the frequency of sessions, and putting on training at different times of the day to make the training accessible to night staff.

Table 3 indicates the number of staff that have attended infection control training in the period April 2021 to March 2022 in comparison to recent years.

**Table 3. Training compliance**

|  |  |  |  |
| --- | --- | --- | --- |
|  | 2019-20 | 2020-21 | 2021-22 |
| Total staff in Trust | 2009 | 2588 | 2673 |
| Total Staff Trained (Clinical & Non-clinical) | 1703 | 1943 | 2264 |
| % Average of Staff Trained | 83% | 79% average 73% clinical 94% non-clinical  | 85% average 82% Clinical 92% non-clinical |
| Total Active Link Champions | 95 | 79 | 52 |
| Total Link Champion Training sessions offered | 74 | 41 | 86 |

The last 12 months has seen an improvement in percentage of clinical staff trained and the average now sits at 85%; clinical staff compliance is 82%, whilst non-clinical staff compliance is 92%. Training provision will continue to be reviewed to ensure the team is providing this in an accessible way.

**13. IPC Link Champion programme**

**13.1** Infection control Link Champions deliver training in support of the IPC agenda and in some cases also contribute to the local management of medical devices. The team is working with services to re-establish and increase the number of link champions after a period of instability during the last 2 years – where due to vacancy, shielding and redeployment of staff, the number and distribution across services of link champions reduced.

**13.2** In order to take on this role the Link Champions receive additional training; after a period of hibernation during 2020, this was re-established in 2021 and remains in the 2021/22 work programme. Records are kept and are available for inspection by the Care Quality Commission.

**14. Policy Development**

**14.1 Policy/Procedures under Development/Review**

Frequent changes to guidance and policy as a result of the COVID-19 have continued during 2021/22. The team has responded by regularly updating local operating procedures to reflect the changing course of the pandemic. A number of IPC policies had review dates extended to July 2021 following rapid review to ensure no fundamental changes had occurred to recommended practice. Full review of these policies is now underway and will follow the established governance process for implementation.

**14.2** The IPC team worked with communications colleagues to create posters and other resources to ensure our staff were equipped to deliver care in a way that felt safe to them and to our patients. Guidance continues to be developed and amended as we move through the different levels of restrictions; link champions were key in helping with the dissemination. All guidance is available on staffnet for staff to readily access.

**15.** **COVID-19 vaccination programme**

**15.1** The vaccination of staff and inpatients throughout the primary COVID-19 vaccination campaign and subsequent booster programmes has been led by the team at the vaccination hub, based on the Mount Hospital site. This team continues to be recognised as a key partner in the Leeds programme, especially in the context of ‘leaving no-one behind’. During the reporting period, the COVID-19 vaccination function was incorporated into the governance structure of the IPC and Physical Health team.

**15.2** Progresshas been made by the vaccination hub in the following key areas:

* All clozapine clinic and Assertive Outreach Team service users, who are some of the most physically vulnerable people we care for, were offered the 1st, 2nd, and booster dose of the COVID-19 vaccination. Figure 4 details uptake by provider of service users receiving clozapine.
* Inpatient, respite, and Specialist Supported Living environments continue to be visited on a weekly basis by the vaccination team to complete administration of the COVID-19 vaccinations. The team uses a flexible model to ensure we can offer the vaccine to as many individuals as possible.
* Community service users have had the opportunity to attend the hub for the completion of their vaccines. Those who were unable to attend the vaccination hub had home visits completed by the team to ensure they received their vaccinations. This was a combination of our MH and LD service users where best interest decisions and capacity assessments were also completed to ensure we were working within the Mental Capacity framework.
* 94% of LYPFT staff have received both 1st and 2nd vaccination and a further 74.4% received their booster vaccination. The vaccinations have also been offered to third sector organisations and contractors that work with LYPFT and the offer of vaccination to any staff member remains open.
* The LYPFT vaccination team worked collaboratively with LCH and Leeds City Council to clinically manage and deliver COVID-19 vaccinations via a mobile bus, pop-up clinics and women only clinics, for a period of 30 weeks during the reporting period. These were delivered to some of the most deprived areas of Leeds and those with lower uptake, to offer the vaccinations, as well as the university to capture the transient student population. During this time over 4146 vaccines were delivered to individuals, some of whom would not have received a vaccine elsewhere. This work was part of a wider health inequalities project and has been highlighted in the Director of Public Health’s annual report.
* Vaccinations are now delivered to staff as a mobile unit. The vaccination team attend the different sites within the trust and offer vaccination appointments in a more flexible way to capture people who may be unable to attend the Mount annexe where this was previously based.
* At time of reporting, the spring booster campaign is underway; this cohort of eligible patients is limited due to the JCVI eligibility criteria, however communication with all inpatient sites has been completed to ascertain the number of eligible patients.

**16.**  **Cleaning Services and waste management**

**16.1** The Infection Prevention and Control Committee continues to monitor cleaning standards via the environmental audit programme and the IPCT provides training for all cleaning service staff. The IPC team is represented on the Cleaning and Catering Standards Group and the NHS Standards for Cleanliness task and finish group. Good lines of communication exist between the team and Facilities Management for any rapid escalation of cleanliness problems.

**16.2** LYPFT has policies and procedures in place for management of the environment which include waste management, cleaning services and food hygiene. Waste Management and cleaning policies were updated in line with national guidance early in the pandemic; Standard operating procedures are available for staff through a number of avenues acknowledging that many do not have access to the internet during their working day. Enhanced cleaning remains in place, and this is escalated during times of increased incidence of infection.

**16.3** The Trust waste policy is compliant with national guidance and compliance monitored and reinforced through staff briefings, audit and compulsory training. A complete audit of LYPFT compliance with the policy is carried out annually by an external auditor.

**16.4** PLACE audits review the inpatient areas of the Trust and inform improvement work to the fabric of the environment and identify any areas for improvement in cleanliness standards. The Trust Patient Led Assessment of the Care Environment (PLACE) audit programme remained hibernated during the reporting period. The IPC team will be involved in the planning and activity of the 2022 audit programme once this is reinstated by the Estates and Facilities Management Team.

**17.**  **Antibiotic prescribing**

 **17.1** ThePharmacy and IPC teams work together to positively inform the Antimicrobial Stewardship agenda; the prevention of infection is a key component of the government’s action plan *Tackling antimicrobial resistance 2019–2024*.  The Trust’s Antimicrobial Pharmacist is a member of the Infection Prevention, Control and Medical Devices Committeeand antimicrobial stewardship is a standing agenda item.  Antimicrobial guidelines are available on the intranet to promote best practice and a biannual audit is carried out to assess compliance with this. Overall antibiotic use remains low in comparison to acute trusts. Future audits are planned to assess Trust compliance with the recommendations in the Start Smart – then Focus toolkit which aims to prevent antibiotic use unless there is clear evidence of infection and encourages prompt review and assessment of clinical need.

In the past 12 months:

- we have added a 72-hour clinical review to all antimicrobials prescribed on the Trust electronic system

- we have uploaded a document on to staffnet of how to take blood for culture and sensitivities

- the antimicrobial pharmacist had discussions with the Lead Consultant Psychiatrist for medicines management and the Trust lead for non-medical prescribers to disseminate any antimicrobial information to prescribers in the Trust

- the lead pharmacist for antimicrobials reviewed the antimicrobial prescribing protocols on the trust electronic prescribing system to make sure they are up to date with the current guidelines.

- an antimicrobial audit has taken place over the autumn 2021 and will be due to report summer 2022.

Figure 5 shows LYPFT as a low user of antimicrobial medication over reporting period (\*=LYPFT - 096)



**18. Medical Devices**

**18.1** During the reporting period, work has continued to ensure that the medical devices register is up to date. The Medical Devices Support Officer and Physical Health Lead have created a pool of physical health monitoring equipment on each of the Trust’s main sites, to ensure that staff can access the equipment needed over the 24-hour period. This was in response to an increase in demand when caring for service users who were unwell with COVID-19 infection.

**18.2** A robust procedure has been implemented for reviewing and responding to Field Safety Notices for medical equipment and this has been incorporated into Trust governance processes.

**18.3**   Providers offer servicing and calibration for Trust equipment through service level agreements. Procedures for this are reviewed on a case-by-case basis dependent on the level of infection control risk on the ward or hospital site.

**18.4** During the pandemic the team worked hard to ensure clinical equipment was redistributed to areas of clinical priority. Learning from this process about how equipment is distributed in the Trust has led to ordering of additional physical health equipment and identification of accessible storage areas on each inpatient site to ensure items are available for care delivery when needed. Ward staff have responded well to this change.

 **19.** **The Infection Prevention and Control, Antimicrobial Prescribing and Medical Devices Committee**

**19.1** The Committee, chaired by the DIPC, consists of representatives from clinical services and support services within the organisation, and expert advisors such as the Consultant Microbiologist. The meetings are held on a quarterly basis and the overall purpose of this group is to provide both strategic and operational leadership in relation to IPC standards. The group members are responsible for cascading information to their relevant teams and for bringing to the group, information aimed at improving standards.

 **20. Reporting Arrangements**

**20.1** Oversight of the IPC team is led by the Head of IPC and Physical Health who reports directly to the Deputy Director of Nursing. The Deputy Director of Nursing is line managed by the Executive Director of Nursing, Quality and Professions (also the DIPC). The team meet on a regular basis to provide updates and discuss future plans and progress against targets.

 **20.2** The DIPC is directly accountable and reports to the Chief Executive and the Board of Directors (BoD).

 **20.3** The DIPC is the Executive lead on the Quality Committee, ensuring quality and standards of care are not compromised, and that there is robust communication across the organisation.

 **20.4** The IPC team works with UK Health Security Agency and, formerly Public Health England, Leeds City Council Health Protection Board, and other partner organisations to ensure communication and a whole system approach is maintained.

 **20.5** During the reporting period and due to the pandemic, daily meetings chaired by the Deputy Director of Nursing or Head of IPC and Physical Health have taken place to ensure oversight of the immediate IPC agenda relating to COVID-19. These meetings have also served as supervision to support the team through the challenges of the pandemic.

 **20.6** Reporting of data as required through national systems (e.g., daily NHSE SitRep) has taken place via the EPRR team.

**20.7** Fortnightly meetings attended by all Directors of IPC, NHS England and Public Health colleagues have continued to take place during the reporting period to monitor outbreaks and share learning opportunities.

 **20.8** The IPC Board Assurance Framework for COVID-19 is updated on a quarterly basis and received by the Quality Committee

**21. Summary**

**21.1** The period 2021/2022 has continued to present extreme challenge for the IPC team; despite this many areas of the work programme progressed whilst others have been again, temporarily hibernated. Plans are in place for all elements of the programme to resume normal activity subject to further pandemic pressures; these are detailed in the appendix to this document.

 **21.2** The team is larger than pre-pandemic, with a new and varied skill mix which will support the recovery. However, specialist training and education is now needed to ensure that the team is equipped to move beyond COVID-19 focused IPC work into more general IPC issues.

**Appendix 1 ANNUAL INFECTION PREVENTION AND CONTROL WORK PROGRAMME 2021/22**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Objective** | **Action** | **Lead** | **Outcome** | **Evidence** | **Status** |
| 1. To meet mandatory surveillance requirements, monitor trends in infection and identify potential outbreaks promptly  | * Continue common alert organism and condition surveillance
* Ensure access to laboratory results from York
* To be alerted of all D&V viral samples taken
* To contact the ward immediately on notification of more than one case
* Continue mandatory surveillance
* Provide advice and support in the event of outbreaks or infection control incidents
* Provide performance reports for the Board of Directors
* A member of the IPCT will visit the ward receiving a new admission within 24 hrs to ensure they are screened for COVID as per agreed pathway
* Improve assurance in relation to the MRSA screening process
 | Michelle Higgins MHAmanda Bailey ABGugu Ncube (GN)Sara Chedzey (SC)GN, SCSC, GN, Adrian Walker (AW) SC, GN, AWSC, GN,MH/ABSC/GN AB  | Meet mandatory requirements.Report trends and outbreaks to Infection Prevention and Control Committee.Meet Public Health England reporting requirements for infectionsProcess in place for early identification to prevent outbreak or prevent outbreak spreading Increased awareness of MRSA screening requirements  | Surveillance reports to IPCC.Root Cause Analysis (RCA) reportsSummary of outbreak reportsCOVID results recorded on care director/ reports can be runOutbreak minutes Inform NHS platform Minutes from the BoD meetingsMRSA screening recorded on care director | ContinuousData reported monthly to BoD.Data reported quarterly to IPCMDC. |
| Work to Care Director commenced – hibernated during pandemic |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 2. To provide specialist infection control input into the PLACE assessment process and national standards of cleanliness audits. | * To ensure inclusion of IPC & agree requirements and date of inspections with Hotel Services lead.
* Follow up any infection control risks identified during these inspections
* Agree any actions required with Hotel Services Lead and discuss at the Cleaning Standards Group.
* Work with facilities to improve cohort/isolation facilities.
 | AB/GNSC, GN,GN/SCMH/AB/SC/ GN | That the PLACE teams are formally constituted, and that expert advice is available from MDT Issues regarding poor standards of environmental cleanliness are highlighted &actioned.Refurbishment of cohort facilities. | PLACE ReportsNational PLACE returnsNational Standards AuditsCSG Minutes | PLACE audits have not resumed at time of reporting. IPC specialist input is in place at NHS National Standards of Cleanliness T&F group |
| 3. To ensure that infection control knowledge is appropriate to job role and purpose. To aid staff in compliance with up-to-date infection control policies and procedures. | * Ad hoc sessions to meet training needs will be planned in response to requests, identified training need or audit findings.
* Mandatory training will continue. Staff will be trained to monitor hand hygiene compliance.
* Mandatory training will include outbreaks, standard precautions, sharps and waste management
* Training reviewed for accuracy
* The Infection Control Champion programme will continue. The IPCT will provide ongoing support and guidance and as well as initial training and plan to restart monthly meetings.
* Recovery plan: increased training sessions to add capacity for training. Prioritise patient facing staff
* Review forecast for training needs to meet compliance and resource accordingly capacity further
* Train the trainer sessions
 | SC, GN,SC, GN,SC, GN,GN,Lead for training GN/SCRG / AB/GN | To provide bespoke training to individual groupsTo provide enough training sessions to cover 100% of staffTo provide bespoke training for Infection Control Champions Increased numbers trained regain compliance Support for champions increase confidence/ network Recovery plan on schedule; potential increase to 82% compliance for patient facing staff by July end 2021 | Record of training sessionsLesson plansRecord of training session dates providedIlearn data As above As above  | ContinuousContinuousContinuousAchieved |
| 4. To improve hand hygiene awareness and compliance | * Implement the hand hygiene part of ‘preventing the spread of infection’ care bundle with CTMs/Infection Control Leads
* Compliance will be monitored using link champions and infection control leads.
* Provide suitable information and training for service users
* Provide service user feedback forms
* Ensure champions in all areas
 | GN, Debbie Leeming – Ferguson (DLF), Link Champion | Compliance with LPFT Hand hygiene procedureTo identify and prioritise areas of poor practice, provide support and training to rectify any issues.Improved compliance   | Training records85% complianceachievedMonitoring dataFeedback at meetings | ContinuousChallenging to receive high numbers of audits back from clinical teams as per procedure |
| 5. To undertake infection control audits of named inpatient, day case and addiction services using the adapted IPS/DH MH/LD audit tool. This will include hand hygiene, decontamination, use of PPE, safe sharps practice, environmental and other practice areas if relevant | * Undertake audits and complete reports. Follow up outstanding actions.
* Support units to develop action plans for remedial action.
* Advise Risk Manager and DIPC of any specific hazards/risks.
* Report analysis of audit in Annual Report.
* Recovery plan in place: audit programme reinstated to result in completion of all inpatient areas before September end 2021
* Undertake a monthly audit of the inter health transfer form.
* Support and monitor monthly infection control audits /walk rounds carried out by matrons/Lead nurses/DIPC
 | SC, GN,SC, GN,SC, GN,SCGN | There is heightened awareness of infection control issues and practice standards are improved.Provide action plans for units audited by IPCT Provide current information to the IPCT  | Audit ReportsAction PlansAnnual reportLOG/ Audit Reports | Ongoing cycle: completed |
| Audits and participation in Matron walk rounds hibernated during reporting period |
| 6. To ensure that all staff receive infection control training at induction and as part of essential training. | * Infection Control input will be provided on the corporate induction programme, co-ordinated by the Staff Development Team.
* Induction and essential training of medical staff will be reviewed and evaluated and further developed as required.

This will be monitored by the medical appraisal process. | SC/GN/ Ruth Grant (RG)SC/GN | Awareness of service, contact details and policies fundamental to safe practiceMandatory HHTTarget 90% of staff | Training recordsInduction PacksTraining recordsAppraisal records | Continuous action completed for the year |
| 7. To ensure the provision of relevant, evidence based, up to date infection control policies that have been approved and ratified by appropriate bodies. | * Review and revise existing policies according to review date. Ensure consultation with IPC partners as critical friends
* Recovery plan currently underway to review policies with an extended review date
* Ensure core policies /procedures are those required by the Hygiene Code.
* Ensure policies, procedures and guidelines are available via Staffnet to ensure that all staff are working to the same standards.
* Maintain links to other Trust wide policies, such as Occupational Health and HR policies on Blood borne viruses.
* To keep policies /procedures under review to ensure compatibility compliance with Both Leeds and York
 |  AB/ GN/ AWABB/GN/AWAB/GN/AWAB/ GN/ AW | Trust wide policies, procedures and guidelines are available to all staff.Infection Control policies, procedures and guidelines reflect current infection control guidance. | Audit reportsInfection Prevention and Control Manual. .IPCMDC Minutes.Quality Committee Minutes.Infection control staffnet page | ContinuousContinuousContinuousContinuous or 2 yearly review (or extended as agreed). All procedures within review period |
| 8. To ensure that service users and their carers are updated on risks of HCAI and given specific information on infections | * Review currently available information and ensure it reflects current guidance and needs.

Ensure information available on: * general risk of infection
* diarrhoea and vomiting
* MRSA
* C. *difficile*
 | GN /SC/ AW/  | Infection Control Risks to patients, staff and visitors will be minimised.Increased confidence in safe environment for visitors and service users due to transparency and sharing of good practice and areas being developed  | Information leaflets on wardsUpdated boards with latest statistic |   |
| 9. To ensure that specialist infection control advice is provided; to work with partners where infection control input will minimise risks to patients, staff and visitors. | An infection prevention and control member will attend meetings of relevant committees/groups i.e.* H&S
* Waste/environmental management
* Medical Devices
* Clinical Procurement
* New build/refurbishment steering groups
* Quality
* PHE
* Develop partnership working LCH/ LTHT
 | AB/ GN/SC | Infection Control Risks to patients, staff and visitors will be considered therefore minimising the risk Strong partnerships / links Share ideas, concerns, new ways of working – build network  | Meeting minutesAction log Good working partnerships/ links  | Continuous |
| 10. To ensure that new national guidance is reviewed and acted upon | * Ongoing review of national directives from the DH, NPSA, HCC/CQC
* Change/ amend guidance as required to reflect changes in a timely manner & communicate
 | MH/AB/GN/ Cathy Woffendin (CW) | Trust policies and infection control practice will comply with national guidance | Infection Prevention and Control Committee MinutesStaff netUpdated policies/ SOP  | Continuous |
| 11. To ensure that the Trust meets requirements for registration with the CQC, reflecting core standards of the Hygiene Code (2006) as amended (2008) | * Review 9 criterions for registration with the CQC and assess level of compliance.
* Produce action plans to address any areas where deficits identified
* Provide evidence of frequent review.
* Submit registration within agreed application period
 | MH/AB/CWMH/ABMH/AB/GN MH/GN/AB/CW | Registration with CQCTransparency No breaches of the Code | Evidence form compliance criteria.Environmental auditIPCC minutesCQC inspection reports | OngoingOngoingQuarterly  |
| 12. To deliver written reports to the Board of Directors and make them available to the Public. | * Ensure IPCC meetings are held at appropriate times in the calendar to ensure availability of papers to the BoD.
* Ensure papers are submitted to the BoD at agreed times.
* Ensure Infection Control Annual Report appears on the public website for information.
* IPC Board Assurance Framework
 | MH/AB/GNMH/ABMH/AB | All deadlines are metSubmission deadlines of two weeks prior to meetings are met.Annual Report appears on LYPFT web site Transparency of current status and actions  | Meeting timetableMinutesMinutesAvailable on public web site | quarterlyQuarterlycomplete |
| 13. To ensure that the Infection Control Team attends courses to obtain specialist information/qualifications. All staff to have the opportunity for development that will contribute to overall skill level and performance | * Identify training and development needs through personal development review process & support staff to achieve goals- offer guidance /steering
* Infection Control course
* Identify, attend relevant course/ training webinar/conferences
 | AB/GN SC | Appropriately trained infection control teamIncreased confidence and varied knowledge skill mix within the team | Copy of qualification retained for recordsCPD hoursDiversity of team skillsTeam prepared for revalidation  | ContinuousCompleted planned training for the year |
| 14. To monitor the use of anti-microbials and promote prudent use. | * Audit supply of antimicrobial medicines to all units.
* Include compliance with national guidance in audit programme e.g., *Start Smart and Focus*
* Appropriate antimicrobial prescribing to be part of Medicines management training for medical staff.
 | Lead Pharmacist for Antimicrobial Prescribing (Michael Dixon)Medical Director | Demonstrate the appropriate use of antibiotics through audit.Greater understanding of and adherence to prescribing guidelines with regard to antimicrobial medication used for treating and preventing infections. | 6/12 Audit report | Bi annual |
| 15. To increase the uptake of influenza vaccine by staff. | * Provide vaccination sessions in support of Occupational health
* training for peer-to-peer vaccinators
* devoted clinics
* collaboration with COVID-19 vaccination programme
* Ensure information uploaded to national reporting system
* Incentives/ communications
* Poster campaign
* Provide vaccination sessions at trust Induction days
 | Helen Whitelam (HW)SC/ GN/MH / RG | Achieve/exceed nationally set target. Protection of staff/ service usersReduced sickness/absence | Report of uptake as provided to national data collection system |  |
| Trust induction not held face to face during reporting period |
| 16. Medical devices | * Recovery plan to review existing leads and recruit where gaps
* Ensure medical device leads receive appropriate training
* Escalate where wards have not identified staff
* Monitor Datix for assurance
* Liaise with risk management for removal of equipment
* ensure maintenance of medical device programmes in place
* Protocols in place to repair /replace faulty equipment in a timely manner
* Spare Equipment stored on sites
* Guidance on care of device/ use
* Work with supplies, moving and handling to ensure contracts are in place.
* Gain intelligence as to what is required for clinical teams and provide/ review efficacy of equipment in circulation
 | AB/ GN/DLF | To review records and recruit leads maintain up to date medical devices recordsEquipment all serviced in working orderNo disruption to patient careTransparency and datix reporting where interruption in patient care occurs Improved service user care | Datix completed Service historyRepair log/ reportsFeedback  | 6 monthcontinues |

Appendix 2. Infection Prevention and Control Annual Workplan 2022-2023

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **OBJECTIVE** | **ACTION** | **LEAD** | **OUTCOME** | **EVIDENCE** |
| **1. To meet mandatory surveillance requirements, monitor trends in infection and identify potential outbreaks promptly** | Local monitoring of common infections e.g., Norovirus, scabies, influenza | MH, AB | Report of trends and outbreaks to Infection Prevention and Control Committee. | Surveillance reports to IPCC (minutes) |
| Ensure access to laboratory results for Leeds and York sites | GN, SC | Laboratory results from Leeds and York patients accessible on Leeds Care Record | Leeds Care Record results server |
| Meet public health reporting requirements e.g. for gastroenteritis and notifiable disease | GN, SC | Adherence to UKHSA reporting requirements for infections | Outbreak reporting platform, Sit-rep reporting data |
| To provide immediate support to clinical teams on notification of:- any infection with potential to cause outbreak- more than one case of any infection | SC, GN, AW | Process in place for supporting teams with infection management and identifying risk of outbreak.  | Summary of outbreak reports. Minutes of outbreak meetings Procedures for management of specific infection |
| Continue mandatory surveillance of MRSA, MSSA, Gram negative BSI and c. difficile cases  | SC, GN, AW | Exception reports provided to DIPC |  IPCC minutes and Root Cause Analysis (RCA) reports where relevant |
| Improve assurance in relation to the MRSA screening process | SC, GN | Increased awareness of MRSA screening requirements and areas of variation in the Trust | MRSA screening recorded on care director and subsequent reports |
| Meet IPC reporting requirements as outlined in Health & Social Care Act (2008) and CQC regulation 12 | SC, GN | Reports to IPCC (4 in 1) meeting | IPCC (4 in 1) meeting minutes and IPC Board Assurance Framework |
| Process in place to ensure testing for COVID-19 is carried out as per NHSE guidance | AB | Robust data collection process of COVID-19  | Covid results recorded on care director/ reports can be run |
| **2. To provide specialist infection control input into the PLACE assessment process and national standards of cleanliness audits.** | To ensure inclusion of IPC & agree requirements and date of inspections with Hotel Services lead. | SC/GN | That the PLACE teams are formally constituted and that expert advice is available From MDT  | PLACE Reports |
| Follow up any infection control risks identified during these inspections | SC, GN | Issues regarding poor standards of environmental cleanliness are highlighted &actioned. | National PLACE returns |
| Agree any actions required with Hotel Services Lead and discuss at the Cleaning Standards Group. | GN, SC | Refurbishment of cohort facilities. | National Standards Audits |
| Work with facilities to improve cohort/isolation facilities. | MH, AB, SC, GN |   | CSG Minutes |
| **3. To ensure that infection control knowledge is appropriate to job role and purpose. To aid staff in compliance with up-to-date infection control policies and procedures.** | Ad hoc sessions to meet training needs will be planned in response to requests, identified training need or audit findings. | SC | To provide bespoke training to individual groups | Record of training sessions |
| Mandatory training will continue. Staff will be trained to monitor hand hygiene compliance. | all who deliver training  | To provide enough training sessions to cover 100% of staff | Lesson plans |
| Mandatory training will include outbreaks, standard precautions, sharps and waste management |   | To provide bespoke training for Infection Control Champions  | Record of training session dates provided |
| Training reviewed for accuracy | SC, GN | Increased numbers trained regain compliance  | Ilearn data  |
| The Infection Control Champion programme will continue. The IPCT will provide ongoing support and guidance and as well as initial training and plan to restart monthly meetings. | GN Lead for training GN/SC | Support for champions increase confidence/ network  | As above  |
| Recovery plan: increased training sessions to add capacity for training. Prioritise patient facing staff  |   | Recovery plan on schedule | As above  |
| Review forecast for training needs to meet compliance and resource accordingly capacity further  |   |   |   |
| Train the trainer sessions Implementation of National IPC manual | RG (Ruth Grant)/AB/GNMH/AB/GN |  Supportive IPC policy documentation available for staff |  Staffnet platform  |
| **4. To improve hand hygiene awareness and compliance** | Continue the hand hygiene part of ‘preventing the spread of infection’ care bundle with CTMs/Infection Control Leads | GN / Debbie Leeming-Ferguson (DLF) | Compliance with LPFT Hand hygiene procedure | Training records |
| Compliance will be monitored using link champions and infection control leads. | To identify and prioritise areas of poor practice, provide support and training to rectify any issues. | 85% compliance achieved |
| Provide suitable information and training for service users | Improved compliance in audits  | Monitoring data e.g., hand hygiene audit reports |
| Provide service user feedback forms |   | Feedback at meetings |
| Ensure champions in all areasIntroduce improved audit tool |   |   |
| **5. To undertake infection control audits of named inpatient, day case and addiction services using the adapted IPS/DH MH/LD audit tool. This will include hand hygiene, decontamination, use of PPE, safe**  | Undertake audits and complete reports. Follow up outstanding actions. | SC, GN | Good awareness of infection control issues; practice standards improved | Audit Reports |
| Support units to develop action plans for remedial action. | SC, GN |   | Action Plans |
| Advise Risk Manager and DIPC of any specific hazards/risks. |   | Provide action plans for units audited by IPCT  |   |
| Report analysis of audit in Annual Report. | SC, GN |   |   |
| Undertake a monthly audit of the inter health transfer form. | SC |   | Annual report |
| Support and monitor monthly infection control audits /walk rounds carried out by matrons/Lead nurses/DIPC |   | Provide current information to the IPCT  | LOG/ Audit Reports |
| Consider introduction of audit software | GN, AB | potential for improved programme efficiency  | Evaluation/business case (if proceeding) |
| **6. To ensure that all staff receive infection control training at induction and as part of essential training.** | Infection Control session will be provided on the corporate induction programme, co-ordinated by the Staff Development Team. | SC/GN/ Ruth Grant (RG) | Awareness of service, contact details and policies fundamental to safe practice | Training records Induction Packs |
| Induction and essential training of medical staff will be reviewed and evaluated and further developed as required. | SC/GN | Mandatory HHT | Training records  |
| This will be monitored by the medical appraisal process. |   | Target 90% of staff | Appraisal records |
| **7. To ensure the provision of relevant, evidence based, up to date infection control policies that have been approved and ratified by appropriate bodies.** | Review and revise existing policies according to review date. Ensure consultation with IPC partners as critical friends |  AB/ GN/ AW | Trust wide policies, procedures and guidelines are available to all staff. | Audit reports |
| Recovery plan currently underway to review policies with an extended review date | AB/GN/AW | Infection Control policies, procedures and guidelines reflect current infection control guidance. | Infection Prevention and Control Manual. . |
| Ensure core policies /procedures are those required by the Hygiene Code. | AB/GN/AW |   | IPCMDC Minutes, Quality Committee Minutes |
| Ensure policies, procedures and guidelines are available via Staffnet to ensure that all staff are working to the same standards. |   |   | Infection control staffnet page |
| Maintain links to other Trust wide policies, such as Occupational Health and HR policies on Blood borne viruses. |   |   |  |
| To keep policies /procedures under review to ensure compatibility compliance with Both Leeds and YorkReview policies in line with IPC manual | AB/ GN/ AW |   |   |
| **8. To ensure that service users and their carers are updated on risks of HCAI and given specific information on infections** | Review currently available information and ensure it reflects current guidance and needs. | GN /SC/ AW | Infection Control Risks to patients, staff and visitors will be minimised. | Information leaflets on wards |
| Ensure information available on: general risk of infection diarrhoea and vomiting MRSAC. *difficile* |   | Increased confidence in safe environment for visitors and service users due to transparency and sharing of good practice and areas being developed  | Updated boards with latest statistic |
| **9. To ensure that specialist infection control advice is provided; to work with partners where infection control input will minimise risks to patients, staff and visitors.** | An infection prevention and control member will attend meetings of relevant committees/groups i.e., | AB/ GN/SC | Associated risks to good IPC will be identified therefore minimising the risk  | Meeting minutes Action Log |
| ·         H&S |   |  Good working partnerships |   |
| ·         Waste management |   | Share ideas, concerns, new ways of working  |   |
| ·         Medical Devices |   |  |
| ·         Clinical Procurement |   |   |
| ·         New build/refurbishment  |   |   |
| Develop partnership working LCH/ LTHT |   | Peer support / supervision pathways established with LCH. Increased IPC resilience  |   |
| **10. To ensure that new national guidance is reviewed and acted upon** | Ongoing review of national directives from the DH, NHSE/I, CQC, UKHSA | MH/AB/GN/ Cathy Woffendin (CW) | Trust policies and infection control practice will comply with national guidance | Infection Prevention and Control Committee Minutes |
| Change/ amend guidance as required to reflect changes in a timely manner & communicate IPC representation on CQC peer visits |   |   | Staff net: Updated policies/SOPGood IPC evidenced in peer review  |
| **11. To ensure that the Trust meets requirements for registration with the CQC, reflecting core standards of the Hygiene Code (2006) as amended (2008)** | Review criterions for registration with the CQC and assess level of compliance | MH/AB/CW | Registration with CQC | Evidence form compliance criteria. |
| Produce action plans to address any areas where deficits identified | MH/AB | Transparency evident where improvement is needed | Environmental audit |
| Provide evidence of frequent review. | MH/AB/GN |   | IPCC minutes |
| Submit registration within agreed application period |   |   | CQC inspection reports |
| Continually monitor quality of evidence for annual health check. |  MH/GN/AB/CW | No breaches of the Code |   |
| **12. To deliver written reports to the Board of Directors and make them available to the Public.** | Ensure IPCC meetings are held at appropriate times in the calendar to ensure availability of papers to the BoD. | MH/AB/GN | All deadlines are met | Meeting timetable Minutes |
| Ensure papers are submitted to the BoD at agreed times. | MH/AB | Submission deadlines of two weeks prior to meetings are met. | Minutes |
| Ensure Infection Control Annual Report appears on the public website for information. | MH/AB | Annual Report appears on LYPFT web site Transparency of current status and actions | Available on public website |
| **13. To ensure that the Infection Control Team attends courses to obtain specialist information/qualifications. All staff to have the opportunity for development that will contribute to overall skill level and performance** | Identify training and development needs through personal development review process & support staff to achieve goals- offer guidance /steering  | AB/GN | Appropriately trained infection control team. Increased confidence and varied knowledge skill mix within the team.Improved IPC support to the organisationImproved role satisfaction and retention of IPC skills | Copy of qualification retained for records. CPD Hours Diversity of team skillsStaff survey results |
| Infection Control course | SC |   |   |
| Identify, attend relevant course/ training webinar/conferences  |   |   |   |
|   |   |   |   |
| **14. To monitor the use of anti-microbials and promote prudent use.** | Audit supply of antimicrobial medicines to all units | Head of Pharmacy | Demonstrate the appropriate use of antibiotics through audit. | 6/12 Audit report and minuted updates to IPCC meetings |
| Include compliance with national guidance in audit programme e.g., *Start Smart and Focus* | Medical Director | Greater understanding of and adherence to prescribing guidelines with regard to antimicrobial medication used for treating and preventing infections. |   |
| Membership of local and regional AMR strategy groups |   |   | Minutes of WYAT and Leeds AMR strategy meetings |
| Appropriate antimicrobial prescribing to be part of Medicines management training for medical staff. |   |   |   |
| **15. To increase the uptake of influenza vaccine by staff.** | Provide vaccination sessions in support of Occupational health | Helen Whitelam (HW), SC/GN/MH/RG | Achieve/exceed nationally set target. | Report of uptake as provided to national data collection systemStaff feedback via surveys |
| Provide vaccination sessions at trust Induction days on recommencement |   | Protection of staff/service users |   |
| training for peer-to-peer vaccinators  |   | Reduced sickness/absence and workplace outbreaks |   |
| devoted clinics |   |   |   |
| collaboration with COVID-19 vaccination programme |   |   |   |
| Ensure information uploaded to national reporting system  |   |   |   |
| Incentives/ communications |   |   |   |
| Poster campaign |   |   |   |
| **16. Medical devices** | Recovery plan to review existing leads and recruit where gaps  | AB/GN/DLF | To review records, recruit leads, maintain up to date medical devices records | Datix completedService historyRepair log/reports |
| Ensure medical device leads receive appropriate training |   |   | Feedback  |
| Escalate where wards have not identified staff  |   |   |   |
| Monitor Datix for assurance |   |   |   |
| Liaise with risk management for removal of equipment |   | Equipment all serviced, in working order  | Record of medical deivces  |
| ensure maintenance of medical device programmes in place |   | No disruption to patient care |   |
| Protocols in place to repair /replace faulty equipment in a timely manner  |   | Transparency and datix reporting where interruption in patient care occurs |   |
| Ensure spare Equipment stored on sites  |   |   |   |
| Provide guidance on care of device/ use  |   |   |   |
| Work with supplies, moving and handling to ensure contracts are in place. |   | Improved service user care |   |
| Gain intelligence as to what is required for clinical teams and provide/ review efficacy of equipment in circulationPhysical health store cupboards at Becklin & Newsam – provision made locally with other sitesEquipment stored in Roseville Equipment brought to trust for personal (not owned by LYPFT to be added to datix.  |   | Improved information to enable response to alerts e.g., field notices can review what is on site easilyEasy access to physical health equipmentIncreased space on wards/ offices |   |

1. <https://www.gov.uk/government/statistics>

/seasonal-flu-and-covid-19-vaccine-uptake-in-frontline-healthcare-workers-monthly-data-2021-to-2022 [↑](#endnote-ref-1)
2. [https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/04/C1624-Novel-coronavirus-COVID-19-standard-operating-procedure-testing-for-in patients-April-2022.pdf](https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2022/04/C1624-Novel-coronavirus-COVID-19-standard-operating-procedure-testing-for-inpatients-April-2022.pdf) [↑](#endnote-ref-2)