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

**APRIL 2022 - MARCH 2023**

**Contents**

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

1. **Executive Summary**

**1.1** This annual report details infection prevention and control, vaccination and medical devices activity between 1st April 2022 and 31st March 2023 relating to LYPFT. It provides an overview for the Board of Directors on the activity, progress and achievements in infection prevention and control 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 (updated 2015)
* Guidance issued by NHS England and NHS Improvement, and the Department of Health in relation to the COVID-19 pandemic; detail of the COVID-19 vaccination programme has also been included in the report.

**1.2** The Trust’s ICP is based on the updated CQC criteria for regulation and cross references all relevant Department of Health (DH) publications. It includes any infection prevention and control requirements that remain as a response to the pandemic.

**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. Leeds and York Partnership NHS Foundation Trust (LYPFT) was last inspected in 2019 and received a rating of ‘good’.

**3. Organisational Structure**

**3.1** The Executive Director of Nursing and Professions is the designated Director of Infection Prevention and Control (DIPC) for the Trust and reports directly to the Chief Executive and the Trust Board. They are 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 Committee of representatives from clinical teams, support services and expert advisors, reports to the Board of Directors. The overall purpose of this group is to provide both strategic and operational leadership in relation to IPC standards and performance. 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 infections. Where applicable 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 2022-2023**

**4.1** During the reporting period the there have been a number of key achievements:

* There were no reportable cases of alert organisms (c. difficile, gram negative blood stream infections).
* The number of active IPC link champions has increased across clinical services.
* The team has adopted a new software package to assist with environmental audits; this will result in improved ownership of improvement actions at ward level and improve the process by removing the admin burden present under the old paper based system.

**5. Flu Campaign**

**5.1**     Planning for the seasonal flu programme begins early in the calendar year to enable the first clinics to begin as soon as vaccine is available. The 2022/23 flu campaign was subject to CQUIN payment and to receive full payment required 85% of patient facing staff to receive the vaccine. Only 2 Trusts achieved vaccine uptake rates of 85% or more. Depending on the Trusts reported performance against the relevant nationally set CQUIN indicators, no financial penalties were levied against Trusts that did not reach target.

**5.2** The programme resulted in 56.2% of staff in a patient facing role receiving the flu vaccine. This is significantly lower than the uptake of 62.8% in 2021/22; however reduced uptake was a consistent picture across NHS Trusts in 2022/23. LYPFT exceeded the average regional uptake (53.8%), and the average England uptake (49.9%). Average uptake for mental health Trusts (43.5%) was also exceeded. Table 1 shows the position of LYPFT compared with local organisations and regional and national averages.

**Table 1.**

In LYPFT, uptake across professional groups was as follows:

* Doctors 73.8%
* Registered Nurses 59.8%
* Other professionally qualified clinical staff 67.9%
* All support staff 45.9%

**5.3** The 2022/23 campaign was the second year that the Trust has used the Vaccination Track software system which allows staff to book their appointment directly by showing live clinic availability. The system also shows real time data on vaccinations completed at team level which helps with targeting communications appropriately. Vaccinators and staff Trust wide found the system user friendly in managing vaccine bookings.

**5.4** Protection from co-infection with COVID-19 and flu continued to be a focus of the campaign. The vaccine was promoted to staff in a variety of ways to highlight the contribution that flu vaccination could make to keeping staff and service users well and protecting others. The IPC teams from LYPFT, Leeds Community Healthcare and Leeds Teaching Hospitals collaborated on developing communications and strategies for improving uptake; this approach has been beneficial and will continue for the 2023-24 programme.

**6. Surveillance**

**6.1** All Trusts are required to minimise rates of both *clostridioides difficile* (c. difficile) and Gram-negative bloodstream Infections. Although there is no specific threshold for infection numbers set for mental health Trusts it is important that we recognise that care delivered by the Trust can impact on infections in people who move through the wider Leeds healthcare system. The organisms that cause these infections pass easily between people within a health care setting.

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. No infections caused by these organisms occurred in the Trust during the reporting period.

**6.2** New admissions are reviewed 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. Work was planned to develop a reporting system linked to Care Director; however, this has been delayed due to a reduced capacity in the team whilst colleagues support CMHT but will be picked up under the 2023/24 work plan.

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

**7.1** Asymptomatic screening and symptomatic testing for COVID-19 continued during the reporting period. National guidance removed the mandatory requirement for this in August 2022, however the Trust took the decision to continue screening due to the high number of positive COVID-19 cases and to reduce vulnerability to outbreaks across inpatient areas. Testing continued as follows:

* on admission, on the 3rd day of admission, and between days 5 and 7 after admission
* when a service user became symptomatic
* when a service user returned from leave, on the 3rd day after return, and between days 5 and 7 after return.

Oversight of the testing programme continued to be maintained by the IPC team providing the quality assurance and governance needed to maintain patient safety. Testing is recorded on Care Director to ensure that COVID-19 history is directly linked to the service user record and provide a more streamlined audit trail.

**8. Staff test and trace**

**8.1** During the reporting period, the IPC team continued to support staff who had tested positive for COVID-19. This provided information on how covid infection was transmitting in the work place, and also ensured staff had the correct information about isolation and testing. The IPC team has responded to 758 COVID-19 positive cases throughout 2022/23 compared to 1,750 in the previous year 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.

**9. Fit testing**

**9.1** Fit testing is the process of carrying out tests to ensure that any respiratory protective equipment (also known as FFP3) issued, will protect the wearer from being exposed to airborne viral particles. Having staff tested is required as one of the national Emergency Planning, Resilience and Response standards. Achieving fit testing in the required staff groups continues to be challenging across the whole Trust despite the team providing regular sessions. We remain committed to making the sessions as accessible as possible for staff and aim ultimately to link the correctly fitted mask type to the staff ESR records.

**10.**  **Outbreaks**

**10.1** Non-COVID-19 Outbreaks in inpatient environments are most likely to be related to viral gastroenteritis or influenza due to their nature of transmission. 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. Four outbreaks occurred during the reporting period. Three of these were gastrointestinal infections and one was due to parainfluenza, a common virus that can cause lower respiratory tract infections and symptoms of the common cold. All outbreaks occurred in older people’s inpatient services. All were of short duration with very low patient numbers involved.

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **YEAR** | **QTR 1** | **QTR 2** | **QTR 3** | **QTR 4** |
| **2022/23** |  |  | **3** | **1** |
| 2021/22 | 0 | 0 | 0 | 1 |
| 2020/21 | 0 | 0 | 1 | 0 |
| 2019/20 | 0 | 3 | 0 | 0 |
| 2018/19 | 0 | 0 | 1 | 0 |

Non-COVID-19 outbreak numbers have been very low in recent years and the small increase during 2022/23 likely relates to the reintroduction of patient movement, visiting, and higher numbers of circulating infections in the community setting due to relaxation of COVID-19 prevention measures.

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

From 1st April 2022 to 31st March 2023 the Trust reported 39 outbreaks affecting inpatient settings. The average duration of outbreak was 13 days. The minimum outbreak duration is 10 days as national guidance for inpatient areas requires a full 10 days to pass before reopening due to the long incubation period of COVID-19. All outbreaks were subject to Outbreak Control Meetings; chaired by the IPC Lead or a deputy from the IPC team. Meetings for each outbreak continue until there is no longer evidence of transmission. All incidences of outbreak continue to be 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.

**11. Audit**

**11.1** **Environmental audit**

The annual audit programme monitors IPC standards across service user environments within LYPFT. The IPC team audited 26 areas out of 33 which equates to 79% compliance. Each audit has an action plan to address areas of IPC concern such as those relating to observed practice, cleaning or wear and tear of furnishings. Results and outcomes continue to be reported via the IPCC and Medical Devices Committee and escalated as necessary via the Cleanliness and Estates group.

**11.2 Mattress audits**

Mattress audits are required in all inpatient areas by the IPC team to ensure that damage to the integrity of the mattress cover does not pose an infection risk to the service user or environment. Audits were completed by the IPC Nursing Associates and Senior Clinical Support Workers across the majority of the Trust resulting in 86% of all mattresses in use audited.

**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. Teams are required to complete 12 audits in each quarter.

The Trust Hand Hygiene Audit Tool is based on the ‘Five Moments of Hand Hygiene’. And looks at whether technique complies with mandatory training, and policies and procedures (e.g., use of the 7-step hand hygiene tool).

Wards 1 and 3 at Becklin Centre, Riverfields, 2 Woodlands Square and ward 5 at Newsam Centre had high completion rates for hand hygiene audits.

**11.4** **Inoculation audit**

The IPC team audits all sharps injuries and related incidents annually following the introduction of the EU Directive on safety sharps. In 2022-23 there were 19 inoculation incident reports compared to 9 in the previous year; these could be broken down into the following categories:

|  |  |
| --- | --- |
| **Type** | **Number** |
| Insulin administration | 3 |
| Depot administration | 6 |
| Blood collection | 1 |
| Lancet finger prick | 3 |
| Glass ampoule | 3 |
| Service user razor | 2 |
| Drawing up medication using administration needle | 1 |

The IPC team follow up on all inoculation incidents with those involved. This has revealed several areas where refresher training is needed regarding the preparation of medication, and this has been fed back to the Health and Safety team and pharmacy. Since the time of this reporting period, a proposal for training to support medicines safety has been developed and the findings from incidents will be incorporated.

Insulin administration injuries occurred from staff using a service user’s own insulin pen which does not have a safety device. When staff takeover the administration of insulin they are not using the recommended BD Auto-Shield safety needle for the Insulin Pens.  This would combat any inoculation incidents related to Insulin Pen devices.

All areas that reported inoculation injuries were advised of the recommended safety devices that should be in use/procured. When completing environmental audits, the use of safety devices is checked as part of the audit of medical devices.

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

**12.1** 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 increased significantly during the pandemic and the IPC team wish to sustain this awareness.; the number of training places made available increased as part of pandemic recovery. In December 2022 mandatory infection control training transferred to the online Learn portal and virtual sessions ceased. Adopting training to this mode of delivery will remove limitations to sessions, dates, and times enabling learners to join at a time convenient to them. The assessment completed at the end of the training will ensure comprehension of the learning session and better understanding of the subject matter. It is anticipated that the change in delivery model will improve compliance, particularly across the clinical workforce during the period of post pandemic reset.

Table 3 indicates the number and percentage of staff that have attended infection control training in the period April 2021 to March 2023 in comparison to recent years.

**Table 3. Training compliance**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
| Total staff in Trust | 2009 | 2588 | 2673 | 2865 |
| Total Staff Trained (Clinical & Non-clinical) | 1703 | 1943 | 2264 | 2362 |
| % Average of Staff Trained | 83% | 79% average 73% clinical 94% non-clinical | 85% average 82% Clinical 92% non-clinical | 82% average  81% Clinical  87% non-clinical |
| Total Active Link Champions | 95 | 79 | 52 | 57 |
| Total Link Champion Training sessions offered | 74 | 41 | 86 | 42 |

**13. IPC Link Champion programme**

**13.1** Infection control Link Champions delivered training in support of the IPC agenda until December 2022 (due to the training changes detailed in section 12) and in some cases also contribute to the local management of medical devices. The team continues to work with services to increase the number of link champions as part of IPC pandemic recovery. A regional task and finish group was formulated by NHSEI to develop a regional workbook for Link Champions and the team has contributed to this to ensure it is compatible with use in mental health and learning disability Trusts by supplying scenarios relevant to our settings. Ongoing work continues to develop the workbook which will form the competency framework for Link Champions. This will be rolled out to link champions in the next months. Records are kept and are available for inspection by the Care Quality Commission.

**14. Policy Development**

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

The team continue to ensure that policies and procedures in relation to IPC are updated to support staff. All procedures follow the established governance process for development and implementation. Over the reporting period, the majority of national guidance which was specific to preventing the spread of COVID-19 was withdrawn in line with the UK government’s living with covid principles. The team responded to this using local risk assessment, and this meant that as a Trust we maintained some measures beyond what was recommended in national guidance, to ensure the safety of service users, staff and visitors. The rationale for deviating from national guidance was discussed at the monthly IPC and Physical Health meetings and also benchmarked with local Trusts. The National Infection Prevention and Control Manual was introduced in 2023 and from 2024 it will be mandatory for Trusts to implement this, reducing the need for a large suite of policies at Trust level.

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

**15.1** The vaccination of staff and inpatient service users against COVID-19 continues to be led by the IPC and Physical Health team during the ongoing booster programmes. The 2022/23 Autumn booster campaign ended in March 2023. 47.6% of patient facing staff in the Trust received the vaccine which exceeded the national average of 42.1% for all NHS Trusts. In total 42.9% of all trust staff received the vaccine.

The team continues to support other services beyond the inpatient setting where specialist support is required e.g., with desensitisation and ensuring that people have best interest decisions and capacity assessments in line with the Mental Capacity framework. The LYPFT vaccination team, LCH and Leeds City Council were runners up for a Health Service Journal award during the reporting period for the collaborative vaccination approach used to address vaccine inequality.

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

**16.1** The Infection Prevention and Control Committee continues to monitor cleaning standards via the environmental audit programme. The team is represented on the Cleaning and Catering Standards Group and good lines of communication exist between the team and Facilities Management for any rapid escalation of cleanliness problems.

**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.

**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 and going forward:

- the antimicrobial pharmacist has 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 will next be due in the 2nd half of 2023

- Pharmacy have worked with the infection control team to obtain supplies of covid antiviral medications and covid vaccines when patients have required them on the wards

**18. Medical Devices**

**18.1** A dashboard for the register and maintenance of medical devices is maintained on the Datix system and overseen by the Medical Devices Support Officer. This role also involves liaising with manufacturers and outlets to ensure servicing occurs according to manufacturer’s instruction. Audits of equipment in patient areas have been completed throughout the reporting period.

Field safety notices (FSN) are a way of communicating important information regarding medical equipment which may impact on patient safety; all Trusts have an obligation to respond to these. The team processes FSNs issued by manufacturers and ensures that actions relevant to our services are undertaken. These alerts are registered on the Datix system.

**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.

**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 Leeds City Council Health Protection, to ensure communication and a whole system approach is maintained. The team represents LYPFT at a number of groups focussed on reducing HCAI and the challenge posed by antimicrobial resistance at both Leeds place and an Integrated Care System level.

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

**20.6** 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.

**20.7** The IPC Board Assurance Framework for COVID-19 is received by the Quality Committee.

**21. Summary**

**21.1** The IPC team has taken the opportunity to reset its core workstreams during the period 2022/2023, whilst maintaining some of the measures to address the spread of COVID-19 such as the ongoing testing requirements and frequent outbreak management. Reflecting on the year the team is considering the challenges for 2023-2024, such as how it can better support teams by achieving higher visibility, re-establishing a robust link champion programme, and engaging with colleagues to promote flu and COVID-19 vaccine uptake. Since the time elapsed from this reporting period the team has:

* progressed the environmental audit programme by implementing a software package to reduce the administrative burden and engage ward managers in local improvement measures.
* Delivered a COVID-19 spring booster programme to eligible inpatients.
* Begun to use the MyKitCheck software system to monitor compliance with maintenance and calibration requirements.
* Has stood down patient, staff testing and masking wearing in the absence of aerosol transmitted infections in line with guidance from UKHSA.
* Has experienced structural changes with the Head of Department leaving post.

**Appendix**

**ANNUAL INFECTION PREVENTION AND CONTROL WORK PROGRAMME 2022/23**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Not achieved |  | Partial achievement |  | Achieved |  | Objective changed during reporting period |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 | RG (Ruth Grant)/AB/GN |  | Staffnet platform |
| Implementation of National IPC manual | MH/AB/GN | Supportive IPC policy documentation available for staff | Work to implement this has begun through review of current procedures; link will be placed on policies and procedures staffnet page. |
| **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 areas Introduce 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 |  | Form was superseded during pandemic. Plan to reinstate with staff awareness campaign. |
| Support and monitor monthly infection control audits /walk rounds carried out by matrons/Lead nurses/DIPC |  | Provide current information to the IPCT | Process change during pandemic. Planning to reinstate matron walkround audit and incorporate IPC into cleaning audit by Matrons. |
| 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 | Trust induction is now delivered remotely. New staff are required to complete IPC training as part of compulsory training programme. |
| 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. | Suite of procedures available on staffnet |
| 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. (see section 3) |
| 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 York Review 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 and staffnet |
| Ensure information available on:  general risk of infection  diarrhoea and vomiting  MRSA  C. *difficile* |  | Increased confidence in safe environment for visitors and service users due to transparency and sharing of good practice and areas being developed | Updated information on staffnet. Webpage has been developed and is in process of having information added. |
| **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/SOP Good 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 organisation  Improved role satisfaction and retention of IPC skills | Copy of qualification retained for records. CPD Hours Diversity of team skills  Staff 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 system.  Staff feedback via surveys |
| Provide vaccination sessions at trust Induction days on recommencement |  | Protection of staff/service users | No longer part of vaccination strategy; drop in clinics across all sites used instead. |
| 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 completed Service history Repair 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 devices |
| 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 circulation Physical health store cupboards at Becklin & Newsam – provision made locally with other sites Equipment 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 easily Easy access to physical health equipment Increased space on wards/ offices |  |