Cover Sheet

Trust Board Meeting in Public: Wednesday 13 September 2023

TB2023.90

Title:	**Infection Prevention and Control Annual Report 2022-2023**

Status:	**For Information**
History:	**Hospital Infection Prevention and Control Committee**

Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance, Policy, Performance**

Executive Summary

1. The Infection Prevention and Control (IPC) Annual Report reports on infection prevention and control activities within the Oxford University Hospitals (OUH) NHS Foundation Trust between April 2022 and March 2023. The report covers Infection Prevention and Control (IPC) for the four main sites: John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre and Horton General Hospital, and sites across the region including satellite dialysis units, midwife led units and Katherine House Hospice.
2. The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability, in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.
3. The following organisms are subject to NHSE mandatory reporting: Methicillin-resistant *Staphylococcus aureus* bacteraemia (MRSA), Methicillin-sensitive *Staphylococcus aureus* bacteraemia (MSSA), *Clostridioides difficile*, and Gram-negative bloodstream infections (*Escherichia coli,* Klebsiella species*, Pseudomonas aeruginosa*). In 2022/23 OUH complied with all external reporting requirements. The Trust Board received bi-monthly updates via the Integrated Assurance Committee. A monthly report is submitted to the Patient Safety and Effectiveness Committee (PSEC) which reports to Trust Clinical Governance Committee.

   Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteraemia:

   The Trust reported 3 HOHA and 1 COHA cases of MRSA bacteraemia. NHSE has a zero-tolerance policy for MRSA bacteraemia.

   Methicillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia:

   The Trust reported 42 HOHA cases and 24 COHA cases for 2022/23. There is no trajectory set by NHSE for MSSA.

   Clostridioides difficile:

   The OUH reported a total of 141 cases in 2022/23. This will be revised to 124 cases (data re-submitted July 2023). This was above the NHSE trajectory set at 104 cases. A new assay was introduced in the laboratory at the end of January 2023 which has subsequently been shown to generate some false positive results. This included 3 false positive results for January 3 for February and 11 for March. UKHSA have given permission to correct the results which will mean that we will report a total of 124 cases. The MHRA have been informed via the yellow card system, and Duty of Candour completed July 2023.

   Several interventions designed to reduce C. difficile infection were introduced in December 2022 with an encouraging fall in case numbers in Q4. However more time will be required to ensure this is sustained rather than a chance reduction in case numbers. Nationally case numbers are increasing.

   Gram negative blood stream Infections (GNBSI):

The NHSE national target is to halve healthcare associated Gram-negative blood stream infections by 2024/25. In 2021/22, thresholds related to GNBSIs were introduced to the NHS Standard Contract for the first time. The thresholds were set at a 5% reduction on calendar year 2019. For thresholds set for 2022/23, the OUH did not exceed the required trajectory for Klebsiella sp. BSI and Pseudomonas BSI but were above trajectory for E. coli.

4. **Audits**: Audits took place on invasive vascular devices and urinary catheters.
5. **Surgical Site Infection**: The OUH undertakes both mandatory and voluntary Surgical Site Infection surveillance. Information is submitted to the UK Health Security Agency (UKHSA). Mandatory surveillance of repair of fractured neck of femur procedures is undertaken within Trauma and Orthopaedics. Voluntary surveillance relating to Coronary Artery Bypass Graft procedures and cardiac valve and transcatheter aortic valve implantation is undertaken within Cardiac surgery and reported to HIPCC (Hospital Infection Prevention and Control Committee) and Cardiac governance meetings.
6. **COVID-19:** The operational impact of COVID-19 on the Trust in 2022/23 remained considerable. COVID-19 related work was a constant focus for the IPC team and therefore the ability to undertake proactive projects was limited. The COVID-19 clinical forum continued to run throughout the year to provide information to staff on IPC guidance, and staff and patient testing. The IPC team followed up all cases of COVID-19 admitted to the hospital to assist with the prevention of nosocomial acquisition.
7. **Environmental IPC:** The IPC team has provided support to both ongoing and new environmental concerns throughout 2022/23.

   Water Safety at the Churchill Cancer and Haematology Hospital: Ongoing work to deliver an engineering solution to address the failings of the water system continued in 2022/23. Point of use filters remain on all outlets within the building to maintain safe water at the point of use. The Extraordinary Water Safety Group continues to meet to ensure progress is being made.
8. **Investigation of Infection Prevention and Control Incidents and Outbreaks:**

   - Chicken pox
   - Mpox
   - COVID-19
   - Group A Strep
   - Neonatal Unit Outbreaks: MRSA, ESBL Klebsiella sp. and E. coli, *Staphylococcus capitis*
   - Norovirus
9. **Antimicrobial Stewardship (AMS):**

   - Antibiotic consumption
   - *C. difficile*
   - CQUINs
   - AMS ward rounds

Contents

1. Purpose

1.1. This report provides the Trust Board with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention and Control Team between April 2022 and March 2023. The publication of the Infection Prevention and Control (IPC) Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2028: Code of Practice on the Prevention and Control of Infection and related guidance. This report follows the format of the Health and Social Act, reporting on each of the 10 criteria outlined in the Act.

Infection Prevention and Control Board Assurance Framework (BAF)

1.2. The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the 10 criteria outlined in the Act.

1.3. The Board Assurance Framework worksheet is ordered by the ten criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

1.4. The compliance rating column allows for the selection of a RAG rating for each criteria using a drop-down list. Specifically: not applicable, non-compliant, partially compliant, compliant.

1.5. Once options have been selected a summary plot for each criterion is generated automatically, which are displayed in the corresponding worksheet. The overall RAG status for an organisation/provider across all ten criteria is shown in plots under the summary worksheet.

1.6. At the end of each section is the RAG rating of the OUH's compliance to NHSE IPC BAF (Appendix 3).

1.7. Where there are areas of partial compliance to the BAF (there are no non-compliant areas) then these elements have been added to the IPC Strategic Plan for action during 2023-2025. The annual plan for 2022-2023 (Appendix 1) and the IPC Strategic Plan 2023-2025 (Appendix 2) are included for information.

2. Background

2.1. The Director of Infection Prevention and Control's (DIPC) Annual Report reports on infection prevention and control activities within the Oxford

University Hospitals (OUH) NHS Foundation Trust for April 2022 to March 2023. The report covers IPC for the four main sites: John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre and Horton General Hospital, and several sites across the region, for example satellite dialysis units, midwife led units and Katherine House Hospice.

2.2. A zero-tolerance approach continues to be taken by the Trust towards all avoidable Healthcare associated infections (HCAIs). We ensure that good IPC practices are applied consistently and are part of our everyday practice meaning that people who use OUH services receive safe and effective care.

2.3. This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical, who play a vital role in improving the quality of patient and stakeholders experience as well as helping to reduce the risk of infections. Additionally, the Trust continues to work collaboratively with several outside agencies as part of its IPC and governance arrangements including:

- Oxfordshire Clinical Commissioning Group (CCG), now the Integrated Care System
- Oxford Health NHS Foundation Trust
- Thames Valley Health Protection Team/UKHSA
- NHSE

2.4. The Hospital Infection Prevention and Control Committee (HIPCC) meets monthly. HIPCC now reports to the Patient Safety and Effectiveness Committee (PSEC) and the Lead Nurse is member of the Clinical Governance Committee.

2.5. Committees reporting to HIPCC are:

Decontamination Committee
IV Steering Group
Regular reports to HIPCC are detailed in the Business Cycle (Appendix 1) and include:

- Divisional IPC reports
- UKHSA/local Health Protection Team
- Oxfordshire Clinical Commissioning Group (CCG) (ICS)
- Antimicrobial Stewardship Team (AMST)
- OUH Estates and Facilities
- Soft Facilities Management
- Centre for Occupational Health & Wellbeing (COHWB)
- Cardio-thoracic surgical site infection report

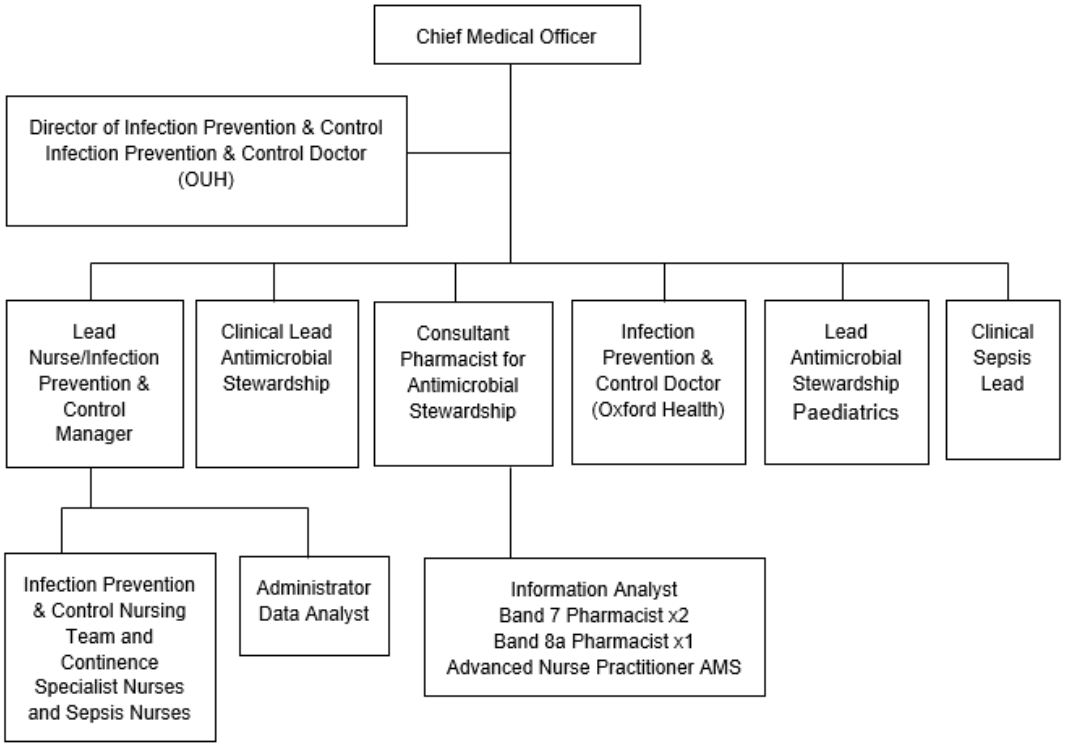
Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

3. Infection Prevention and Control Staffing

3.1. Table 1 shows the organisational chart for the IPC team at the end of March 2023.

Table 1
Organisational Structure of Infection Prevention Services



3.2. To deliver a safe service, there is a close working relationship with all teams across the Trust, including the Microbiology Laboratory, Clinical Infection team, Estates and Facilities, Health and Safety team, procurement, COHWB, Communications team, clinical and managerial staff, and across the PFI structure.

3.3. The IPC Manager chairs the Water Safety Group, is the Trust Decontamination Lead and is a member of the Ventilation Safety Group. There have been several projects throughout the year that have required the expertise of the IPC team on planning and opening of new wards and clinical areas.

3.4. As necessary, members of the wider microbiology/infectious diseases team are co-opted on to the team.

4. Organisms subject to mandatory reporting

4.1. The OUH is required to report to UKHSA on the following organisms:

- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Methicillin-sensitive *Staphylococcus aureus* (MSSA)
- Gram negative Bloodstream Infections
- *Clostridioides difficile* (C. difficile)

Bacteraemia prior trust exposure categories

4.2. The two categories of reporting cover:

Hospital-Onset, Healthcare Associated (HOHA)

Any NHS patient specimens taken on the third day of admission onwards (i.e., ≥ day 3 when day of admission is day 1) at an acute trust.

Community-Onset Healthcare-Associated (COHA)

Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated and where the patient was discharged within 28 days prior to the current specimen date (where date of discharge is day 1).

Reporting and Investigation

4.3. HOHA and COHA cases of MRSA and MSSA bacteraemia are reported through the Trust incident reporting system Ulysses. The root cause analysis (RCA) tool is now completed as a questionnaire on Ulysses and the incident report is completed by the IPC team on identification of cases.

4.4. Divisions are asked to report by exception to HIPCC on action plans regarding MRSA and MSSA.

Methicillin-resistant *Staphylococcus aureus* (MRSA)

4.5. There were 3 HOHA and 1 COHA cases of MRSA bacteraemia. All cases have undergone a root cause analysis (RCA) and been reviewed at the Health Economy meeting with the CCG/ICS.

Table 2

MRSA Bacteraemia's 2022-2023

Location	Category	Source and Learning
Paediatrics	COHA	This was in a baby whose mother developed a surgical site infection in which MRSA was isolated
Vascular Surgery	HOHA	Diabetic Foot Ulcer: This bacteraemia was deemed not preventable.
Stroke Unit	HOHA	Likely peripheral cannula
Trauma	HOHA	Pressure Ulcer- subject to a SIRI

Methicillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

4.6. The Trust reported 42 (41in 2021/22) HOHA cases and 24 (18 in 2021/22) COHA cases for 2022/23. The main recorded infection sources are documented below:

Table 3
Breakdown of Top 3 Sources of Infection

Recorded Source	Number of HOHA	Number of COHA
Lines/devices	15	4
Unknown	13	6
Skin or soft tissue (includes surgical site infection)	8	5

Table 4

SPC Healthcare associated MSSA bacteraemia data:
Nine of 12 monthly totals below the centre line demonstrating a high degree of statistical control.

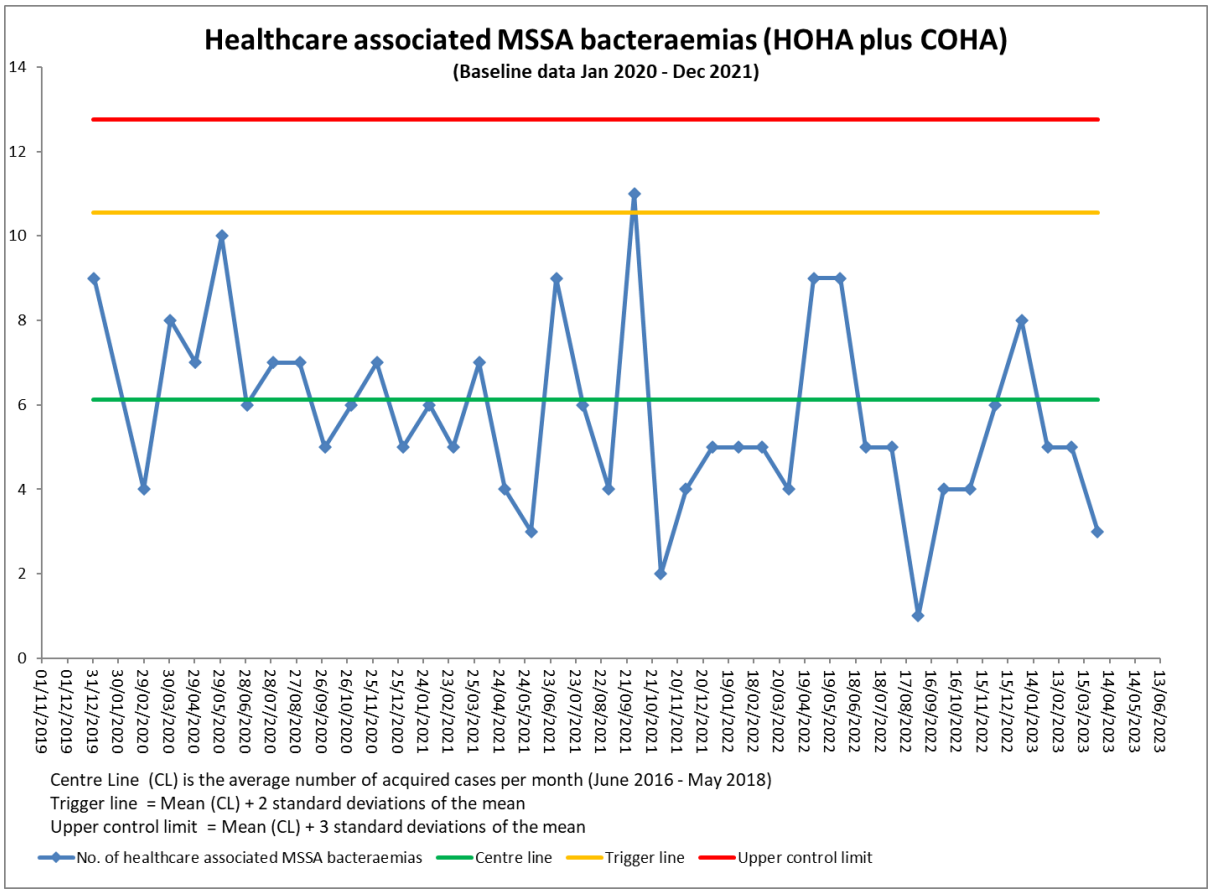
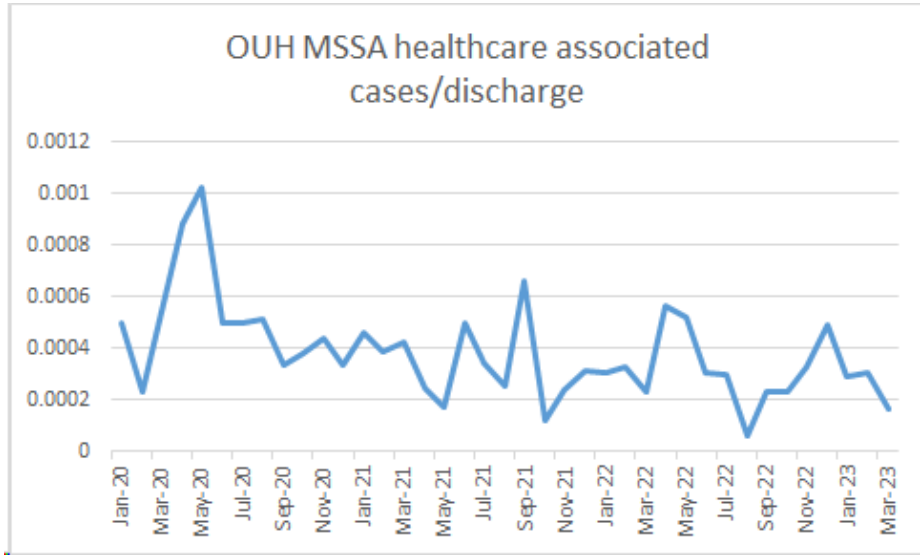


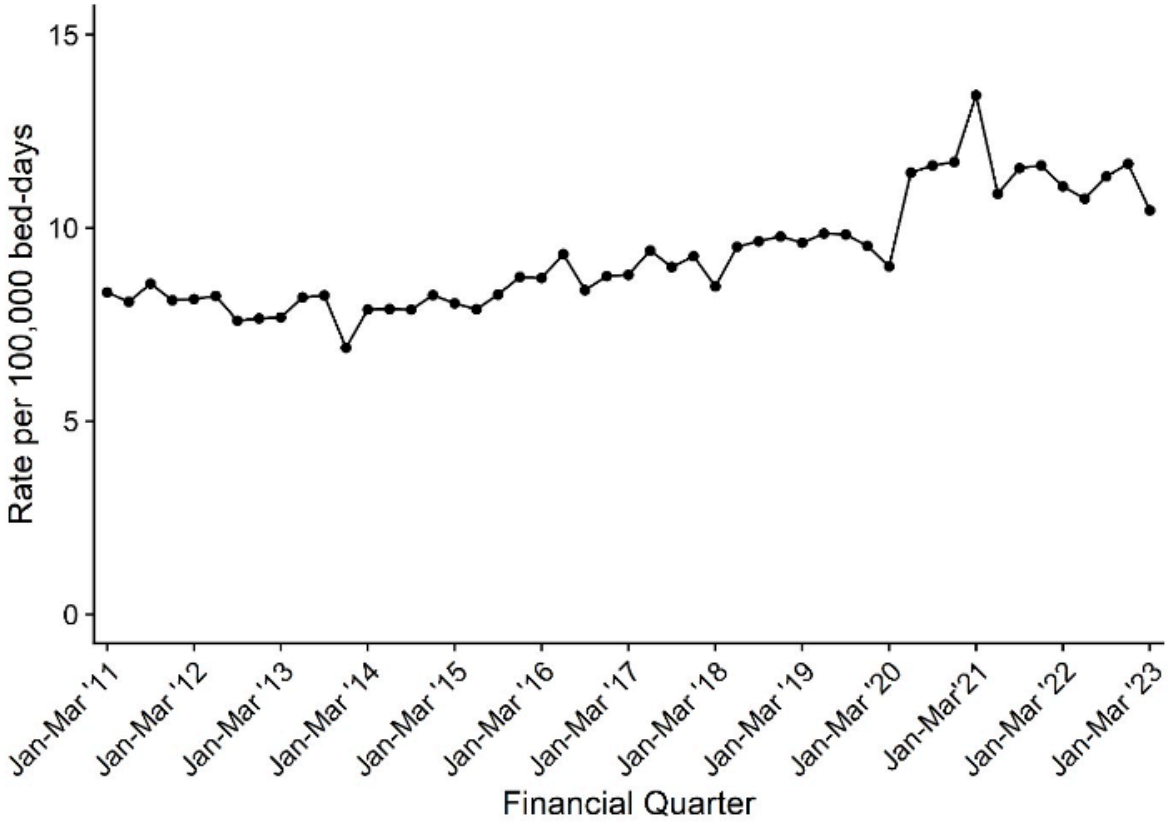
Table 5
OUH Healthcare associated MSSA bacteraemia cases controlled for activity (discharges)



National MSSA picture

4.7. In contrast to the picture at the OUH, nationally since the April to June 2020 quarter, there has been an increase in the incidence rate of hospital-onset MSSA bacteraemia cases. When comparing the current quarter to the pre-pandemic period of January to March 2019, hospital-onset MSSA bacteraemia cases have increased by 10.9% from 844 to 936, which corresponds to an 8.7% increase in the incidence rate from 9.6 to 10.5 per 100,000 bed-days.

Table 6
National Quarterly rates of hospital onset MSSA bacteraemia: January 2011 to March 2023



Gram Negative Bloodstream Infections

4.8. NHS England has set a national target of halving of healthcare associated Gram-negative blood stream infections (GNBSI) by 2024/25. In 2021/22 thresholds related to GNBSIs were introduced to the NHS Standard Contract for the first time - set at a 5% reduction on calendar year 2019 figures.

4.9. There are no clear themes or interventions to reduce the rate of rise of E. coli infections. The changes in patient demographics with an ageing population (18.6% of the total population were aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011) and more people at risk because of comorbidity or treatment such as immunosuppression are likely to contribute to an increase in cases.

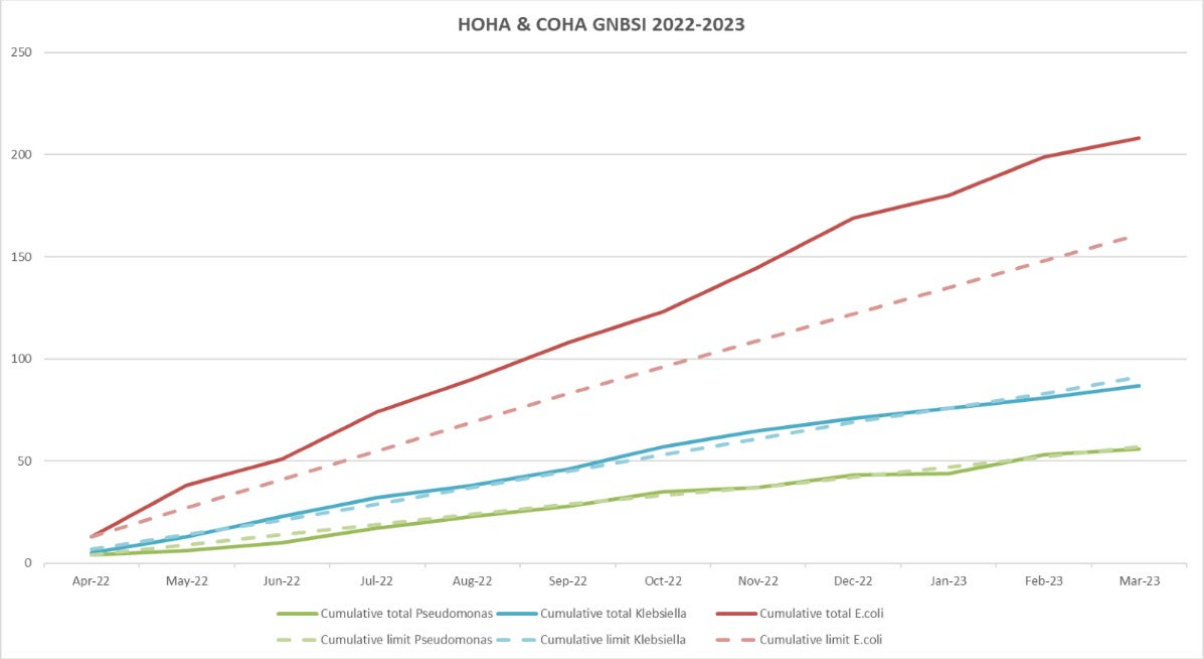
4.10. Around a quarter of all our GNBSI occur in patients that are receiving chemotherapy or haematological transplantation and are usually secondary to unavoidable gut translocation of bacteria due to mucosal barrier injury. All GNBSI have a short RCA completed by the IPC team to review source, any potential risk factors and whether the infection was a healthcare associated infection (HCAI).

4.11. At the end of this financial year, the OUH has come in successfully slightly below the 5% reduction trajectory for Klebsiella and Pseudomonas but has exceeded the trajectory for E. coli by 47 cases. The trajectory for 2023-24 will be challenging for reasons articulated above.

Table 7
Thresholds for 2022/23 and 2023-2024

	Threshold 2023 -24	Threshold 2022-23	Final numbers 2022-23
E. coli	153	161	208
Pseudomonas	47	57	56
Klebsiella	86	91	87

Table 8
Post – 48-hour Gram Negative Bloodstream Infections (April 2022- March 2023)



Clostridioides difficile (C. difficile)

4.12. C. difficile root cause analysis is linked with Ulysses incident reporting. Community Onset–Indeterminate Association (COIA) and Community Onset–Community Associated (COCA) cases are reported on Ulysses in addition to HOHA and COHA cases. COIA and COCA cases are investigated by the IPC team with contribution from clinical areas and the CCG (now ICS) as required.

4.13. The threshold for OUH apportioned cases of C. difficile for 2022/23 was set at 104 cases. A new assay was introduced in the laboratory at the end of January 2023 which has subsequently been shown to generate some false positive results. This included 3 false positive results for January 3 for February and 11 for March. UKHSA have given permission to correct our results which will mean that we will report a total of 124 cases. The incident was assessed by the patient safety team as minor harm, but nevertheless duty of candour has been undertaken (completed July 2023). The Medicine and Healthcare products Regulatory Agency (MHRA) have been informed via the yellow card system.

4.14. It is clear however that cases were increasing in the OUH from September onwards prior to the assay switch and in line with national data (see below). The reduction in cases from January 2023 is extremely encouraging (see SPC chart) and occurred at the same time as the introduction of a number of interventions (see below).

Table 9
Cumulative cases of OUH apportioned *C. difficile* (COHA and HOHA) per month (April 2022 – March 2023)

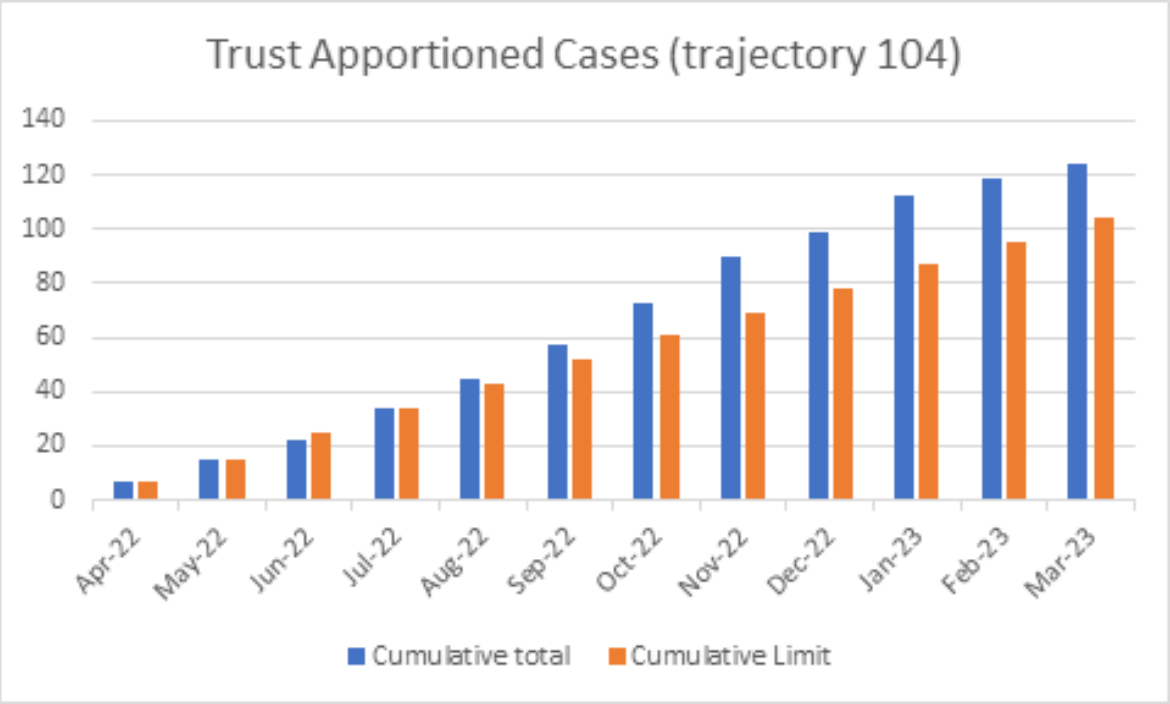


Table 10
Breakdown of C. difficile HOHA v COHA (April 2022- March 2023)

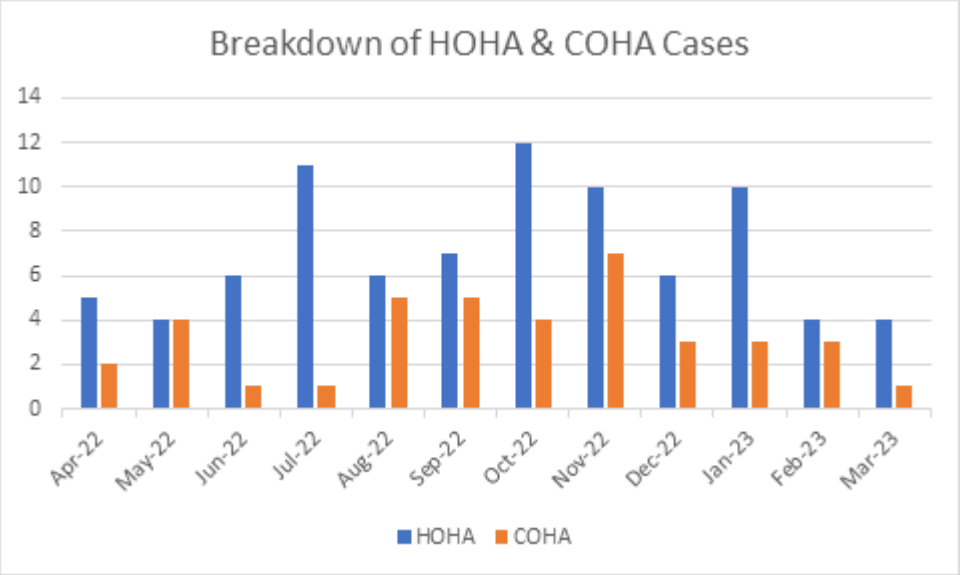


Table 11
Statistical Process Control (SPC) chart of OUH apportioned C. *difficile* infection counts
NB Baseline data is April 2017-March 2019 with no correction for activity.

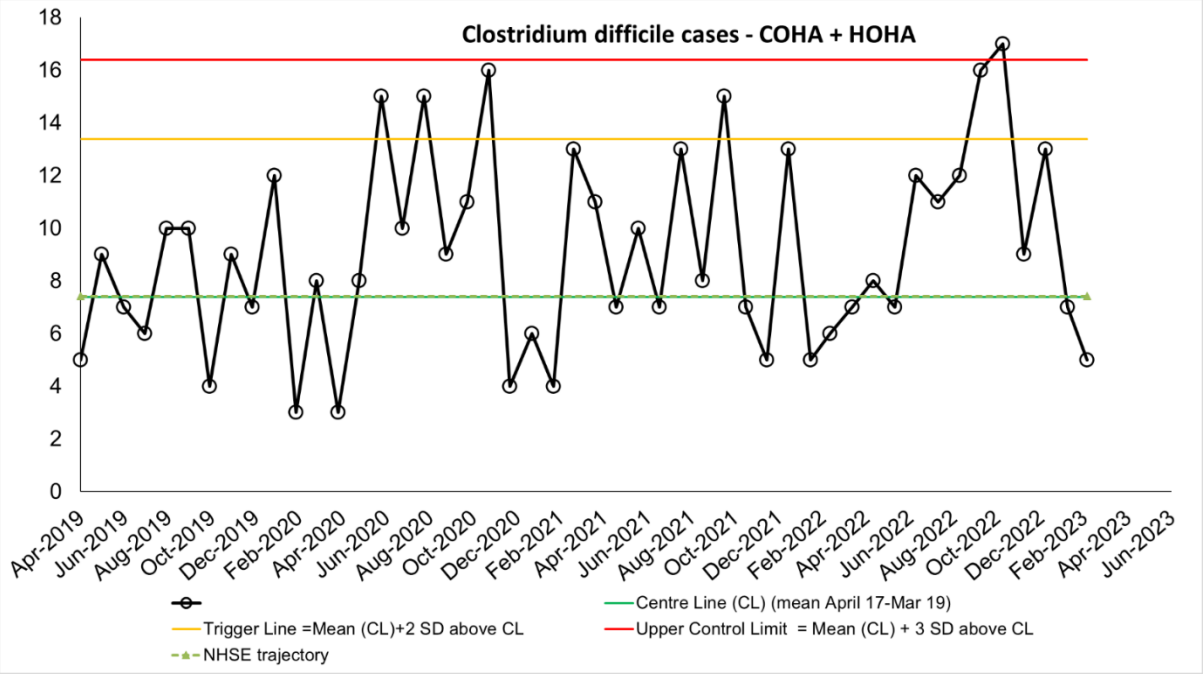


Table 12
Health care associated C. difficile cases corrected for activity (discharges)

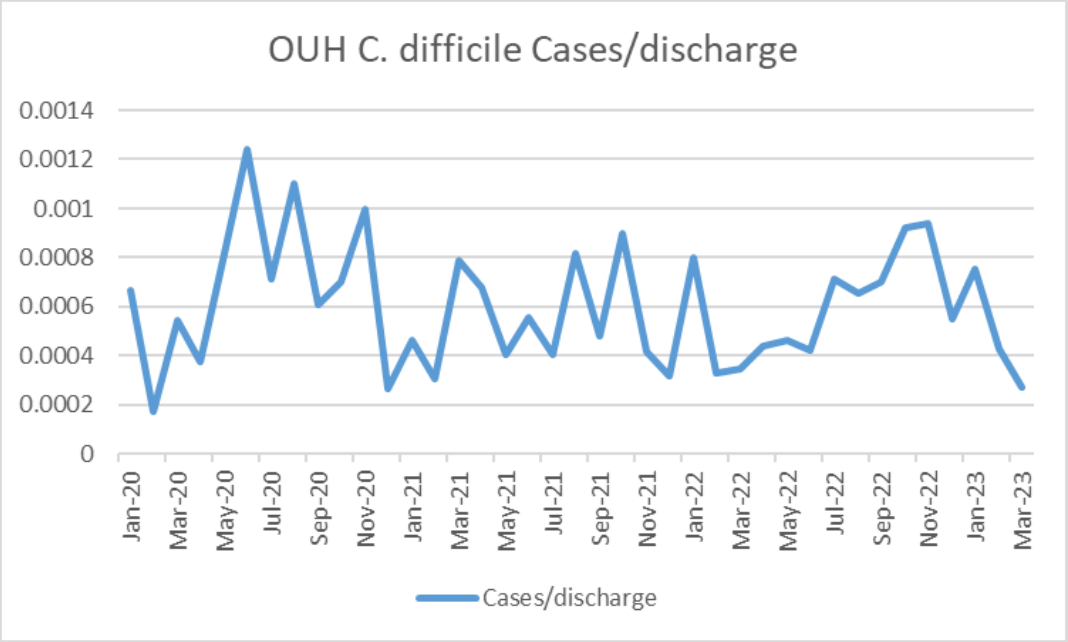
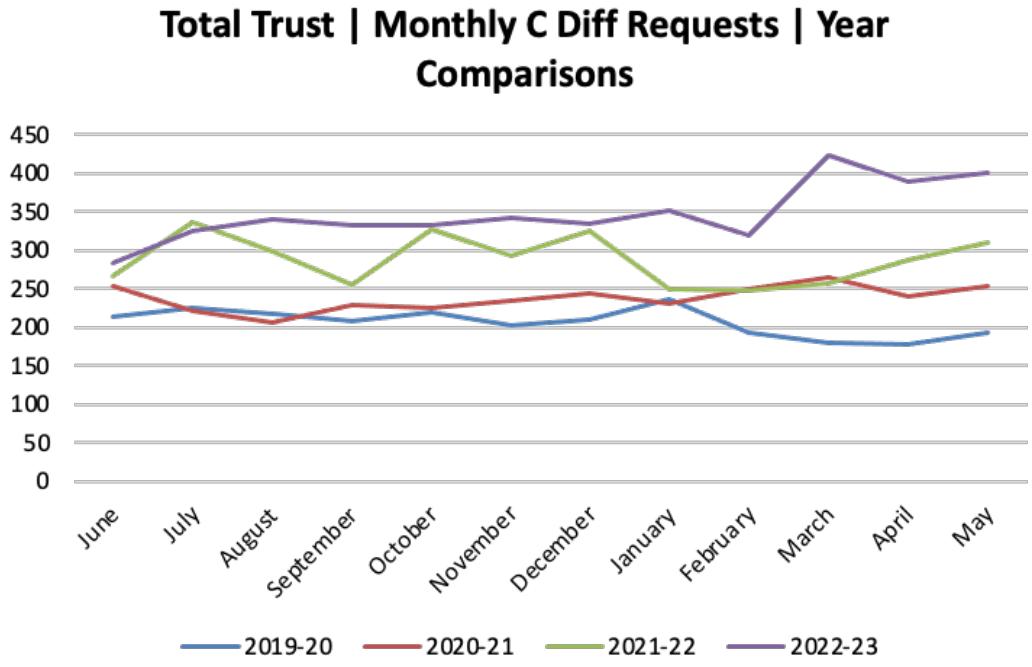


Table 13
Number of stool samples processed for C. difficile by OUH Microbiology laboratory
The number of stool specimens processed for C. difficile has increased year on year with a doubling of testing rates over the last few years. This includes a small proportion of samples from the community.



4.15. A number of interventions have been implemented over the year to try to reduce the number of C. difficile cases as detailed below.

Management of C. difficile GDH Positive Toxin Negative Patients

4.16. It was not previously Trust policy to isolate patients who are carriers of C. difficile (GDH positive but toxin (FT) negative). Other local trusts including the BOB (Buckinghamshire, Oxfordshire, and Berkshire) hospitals perform additional testing on these patients to see if they carry strains with potential to produce toxin (toxin positive (TS) on molecular testing) and do isolate this cohort of patients. A decision was made to move in line with other organisations and isolate and treat GDH+/FT- patients if they are symptomatic (but with no additional molecular testing). There is evidence (Mawer et al 2017*) to suggest that symptomatic TS+ /FT– patients are a source of C. difficile transmission, albeit they account for less onward transmission than FT+ cases.

4.17. Since December 2022, these patients have been isolated and treated if they have symptoms consistent with C. difficile infection (CDI), as they can potentially transmit C. difficile in the ward environment.

C. difficile Pop Up

4.18. A C. difficile pop-up was created on EPR to remind people requesting stool sample testing for gastro-intestinal pathogens to request C. difficile testing if suspecting CDI. This went live at the end of January 2023, and is likely to have contributed to the increased number of samples sent to the laboratory since that time. The idea behind this prompt is to encourage early sampling in patients admitted with diarrhoea as root cause analysis has shown that delayed sampling leads to incorrect attribution of cases to the Trust, when in fact they were acquired in the community.

Safety Message December 2022

4.19. The interventions introduced and included in the Safety Message are:

- The introduction of the use of sporicidal wipes for cleaning of all commodes and bedpans as standard practice
- A focus on patient hand hygiene
- Clinical areas to ensure patient equipment is clean
- Patients without detected faecal toxin should remain isolated if they have diarrhoea; these patients will be followed up by the IPC team
- Message to be included in the clinical report from microbiology to advise ‘Isolation and treatment should be continued if features are consistent with CDI’
- Themes from Health Economy have identified lapses in care around correct prescribing of treatment and therefore there will be an emphasis on correct management

Review of Repeat/Relapse/Continuing Infection

4.20. An audit of relapsed/recurrent cases from April 1st, 2022, to Jan 31st, 2023, showed good adherence to CDI treatment guidance on MicroGuide, with no missed opportunities to treat. Cases received fidaxomicin. Further enquiries will take place with Trusts using fidaxomicin first line to compare relapse/recurrence rates.

Training and Education

4.21. Additional training to raise staff awareness of the requirement to use sporicidal wipes for cleaning of all commodes and bedpans as standard practice was provided. This training was supported by the Clinical trainer GAMA Healthcare. 22 clinical areas were visited across the Horton and John Radcliffe Hospitals and a total of 95 staff trained.

4.22. Enhanced cleans were not being completed in line with policy after a review of the enhanced cleans requested at the John Radcliffe Hospital. A significant number of cleans have been missed on multiple ward locations indicating a Trust-wide need for reminder.

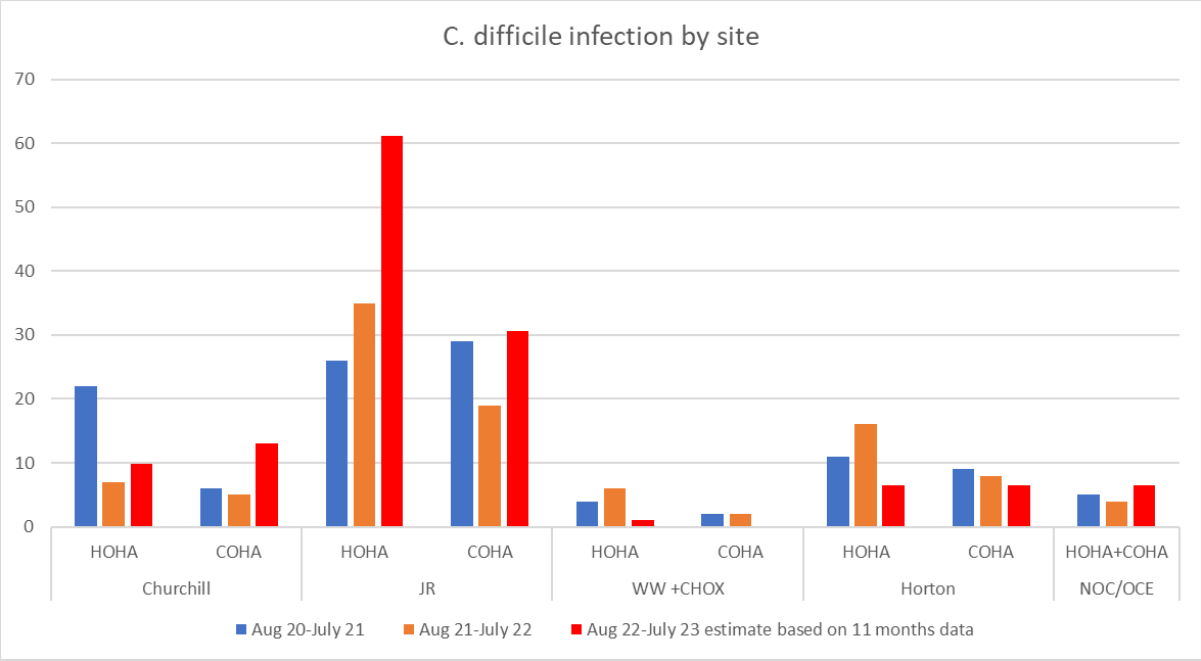
Antimicrobial Stewardship Rounds

4.23. On review of the antimicrobial prescribing during December, there was a clear increase in consumption of antibiotics most likely due to the increase in the number of patients admitted to the Trust with influenza/respiratory illness requiring treatment, and concern around an increase in cases of invasive Group A streptococcal infection. There was an increase in sepsis alerts leading to antibiotic prescription. It is hypothesised that this may have led to an increase in C. difficile cases in January on the JR site (7/13 cases on CMU (Complex medical unit C). Antimicrobial stewardship rounds in the Emergency Assessment areas were implemented.

4.24. Table 14 shows the distribution by site of HOHA and COHA cases. Regular weekly antimicrobial stewardship rounds commenced at the Churchill hospital in August 2021 and continue. The data highlights that most cases in 2022/23 have been on the John Radcliffe site and a doubling of the HOHA rate for the JR site has occurred in the last year to date (July 2023). We know that the Influenza epidemic from December 2022 was associated with a rise in the number of sepsis alerts, and an increase in antibiotic usage mainly on the JR site. January saw a high number of HOHA cases attributable to the JR site. The impact of the changes made to the management of C. difficile in December has yet to be realised.

4.25. In January 2023, the AMS team started a 6-day working week, increasing the amount of support for stewardship interventions over the weekend.

Table 14
Distribution by site of HOHA and COHA cases.
The reduction hospital onset in cases on the Churchill site following the introduction of a comprehensive weekly AMS round in August 2021 has been maintained.

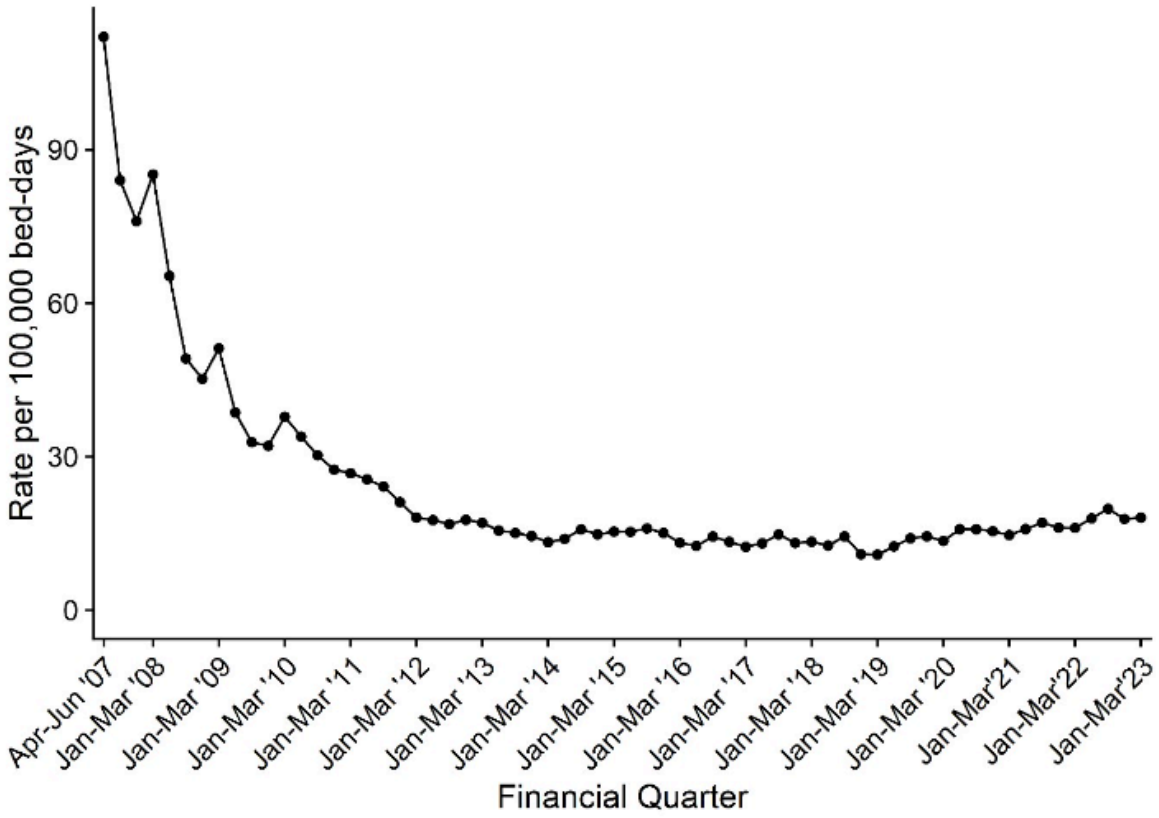


National increase in C. difficile

4.26. The increase in the number of cases overall is of concern and is reflected nationally. When comparing the most recent quarter with January to March 2019, which was a more typical period prior to the COVID-19 pandemic, the hospital-onset CDI cases have increased by 70.3% from 950 to 1,618 which corresponds to an incidence rate increase of 67.0% from 10.8 to 18.1 cases per 100,000 bed-days. The reasons for these observed increases are still being investigated nationally.

NHSE held a national meeting in early December to review the national increase in C. difficile numbers. The outcome was reported as not being able to explain the increase in rates to a newly emergent strain and or antibiotic prescribing. An ICS wide C. difficile collaborative meeting was then held in January 2023 with the ask from the Integrated Care System IPC Lead to identify and commit to 3 key action areas that will support the behaviour changes needed to drive improvements and reduction in C. difficile numbers. The members of the meeting were unable to identify 3 new key action areas. The OUH presented the interventions that have been introduced locally and reported that a year was probably required to monitor the impact of these.

Table 14a
Quarterly rates of hospital-onset C. difficile: April 2007 to March 2023

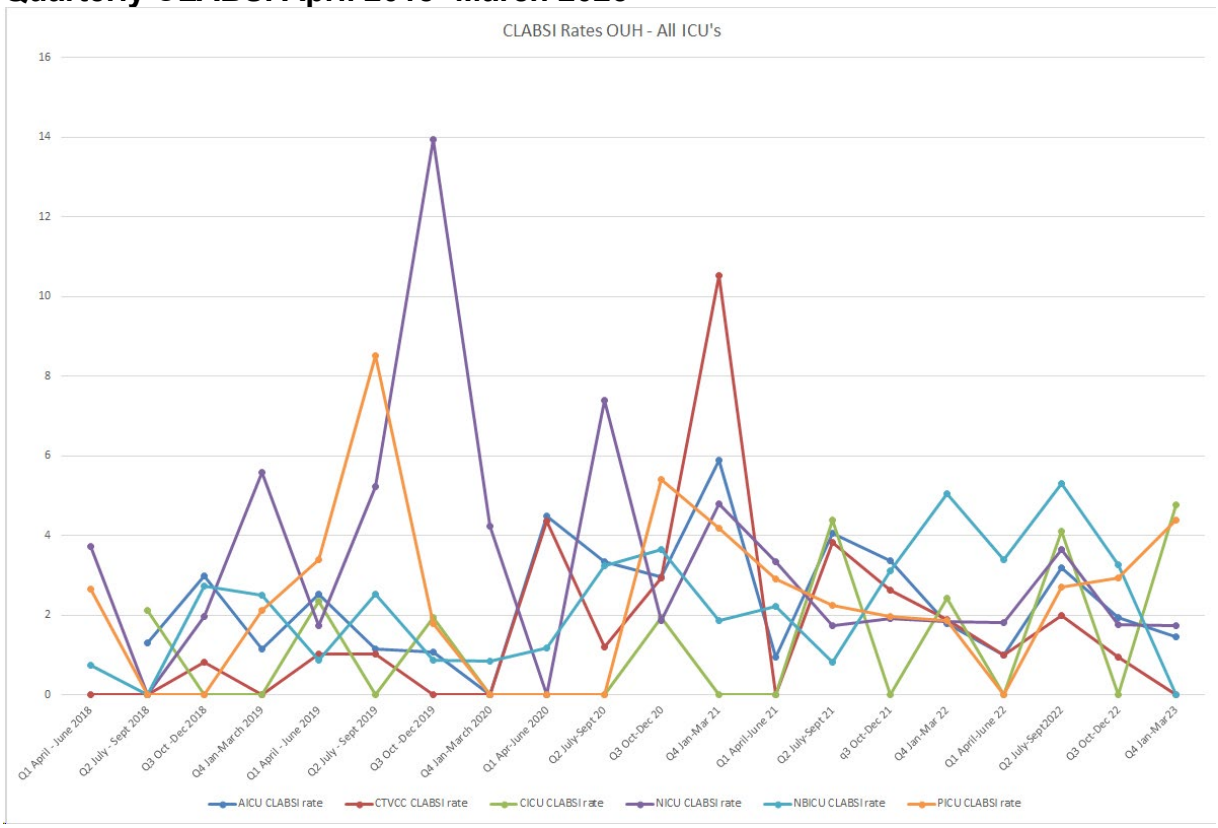


5. Central Line Associated Bloodstream Infection (CLABSI) surveillance
CLABSI surveillance in the Intensive Care Units

5.1. Central Line Associated Bloodstream Infections (CLABSIs) are serious infections typically causing a prolongation of hospital stay, increased cost and risk of mortality. CLABSIs can be prevented through proper insertion techniques and management of the central line, using evidence based central venous line care bundles. CLABSI surveillance is undertaken for all the intensive care areas by the IPC team.

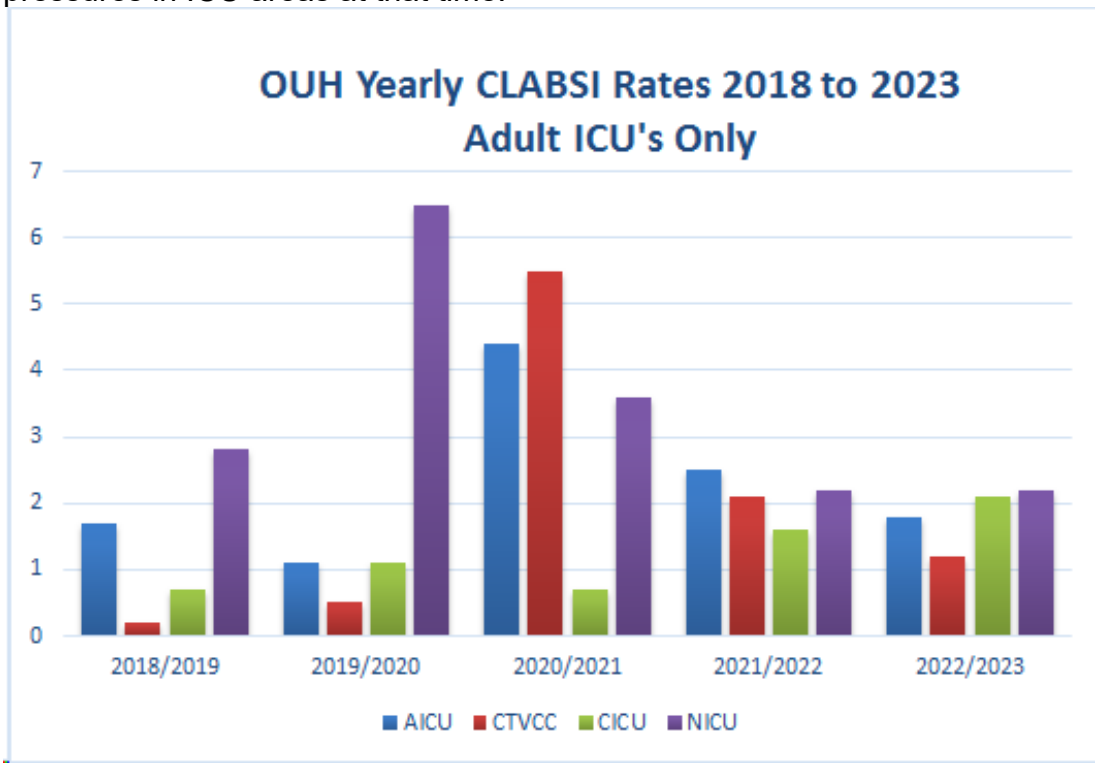
Table 15

Quarterly CLABSI April 2018- March 2023



5.2. There is now 6 years of data showing that all the adult ICUs perform very similarly. The aim will be to bring this down further to below 1.5 in the next financial year**.**

Table 16
Annual CLABSI Rates for Adult Intensive Care Areas
Rates in 2020/21 were adversely affected by the COVID-19 pandemic and increased pressures in ICU areas at that time.



Trust wide non-ICU CLABSI surveillance

5.3. The IPC team continues to maintain Trust wide non-ICU Central line associated bloodstream infections (CLABSI) surveillance. These are not reported in rates per 1000-line days as above due to difficulty obtaining denominator data from the Electronic Patient Record (EPR).

5.4. The definitions of HOHA and COHA as used for other healthcare-acquired infections reported in the Trust was not adopted for this surveillance as would exclude ambulatory encounters.

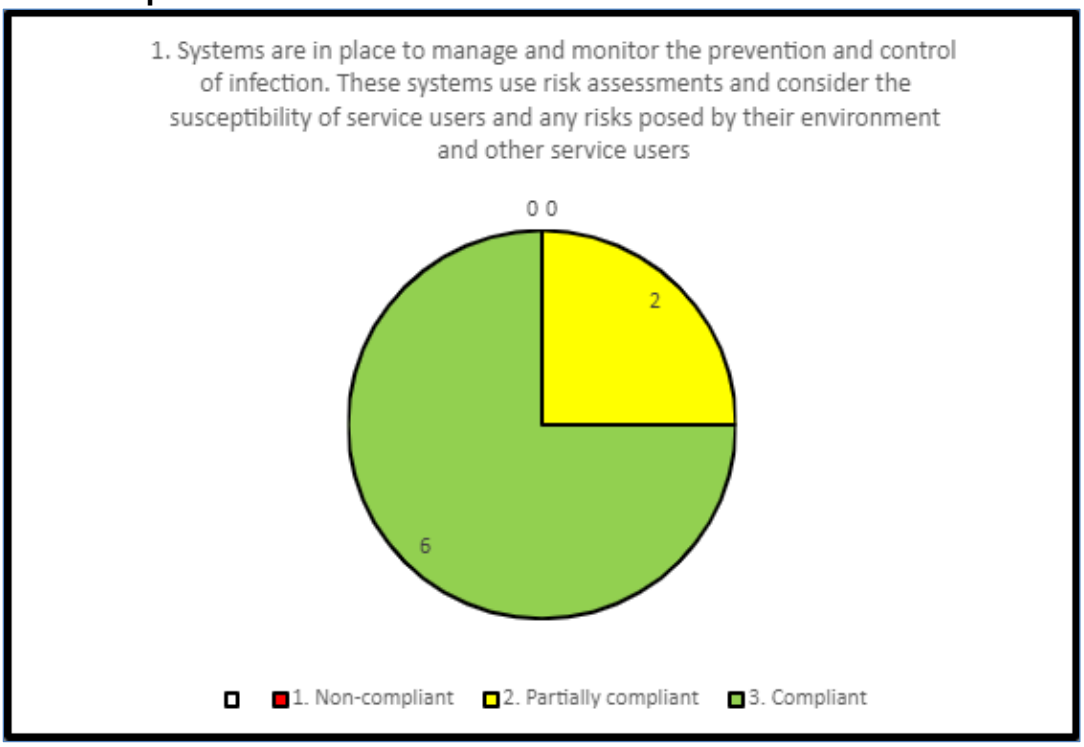
5.5. Every suspected CLABSI case is reviewed and classified against the Centers for Disease Control and Prevention (CDC) CLABSI definition. The data was validated with oversight by a Consultant in Infection.

5.6. There was an increase in MSSA cases on the Haematology ward in Q4 22/23. In February, they were all vascular device associated. Haematology ward represents a high percentage/number of the non-ICU line associated cases for OUH in the last financial year. There was also an increase in non-ICU CLABSI cases in Q4 22/23, in February and March.

5.7. The review has highlighted issues around dressing and positive pressure needle free connector change frequencies and the associated documentation. The ward is concentrating on this. Biopatch is being introduced for PICC and midlines with the support of the vascular access team. The surveillance for

non-ICU CLABSI is being re-energised with collaboration between IPC and the ward teams. Data will be shared at monthly governance meetings for the department.

Figure 1
BAF Compliance to Criterion 1



Partial Compliant Elements to the BAF:

8 elements, 2 partial compliances for:

- The Trust implement, monitor, and report adherence to the National Infection Prevention and Control Manual (NIPCM).
- Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.

Criterion 2

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

6. Environmental IPC and decontamination

6.0 Water Safety Group (WSG) and Ventilation Safety Group (VSG)

6.1. The Trust's WSG and VSG meet quarterly. The IPC team are active members of both groups. Both safety groups are attended by the multidisciplinary team and our PFI colleagues. Compliance reports are produced by the Operational

Estates team, and all the PFI partners. HIPCC receives reports from the Operational Estates team on water, ventilation, and environmental concerns. The Trust PFI office report on behalf of the PFI providers.

Water Safety at the Churchill Cancer and Haematology Hospital

6.2. An ongoing issue with Legionella positive water samples at the PFI Cancer and Haematology Hospital on the Churchill site has been reported annually since 2018/9. This was first identified in 2015 when the Legionella risk assessment indicated hot water system circulation issues that are likely to date from construction (2009) and recognised to be a systemic problem in 2019 via the Serious Incident Requiring Investigation (SIRI) process.

6.3. In September 2019 increased surveillance showed continued presence of legionella widely within the water system. As a result, all water outlets in the Churchill PFI Cancer and Haematology hospital have had point of use filters (POUF) in place since 10 October 2019. POUFs ensure that water is safe at the point of use for both patients and staff.

6.4. Water sampling continues to yield positive Legionella samples in the Churchill PFI building. The root cause is thought to be a failure to maintain the flow of hot water, with cooler temperatures supporting growth of Legionella. The engineering solution has been progressing throughout the year with progress being monitored by the Extra-ordinary Water Safety Group. Once finished, there will be a period of surveillance of hot water temperatures prior to Legionella sampling occurring. The POUFs remain in place.

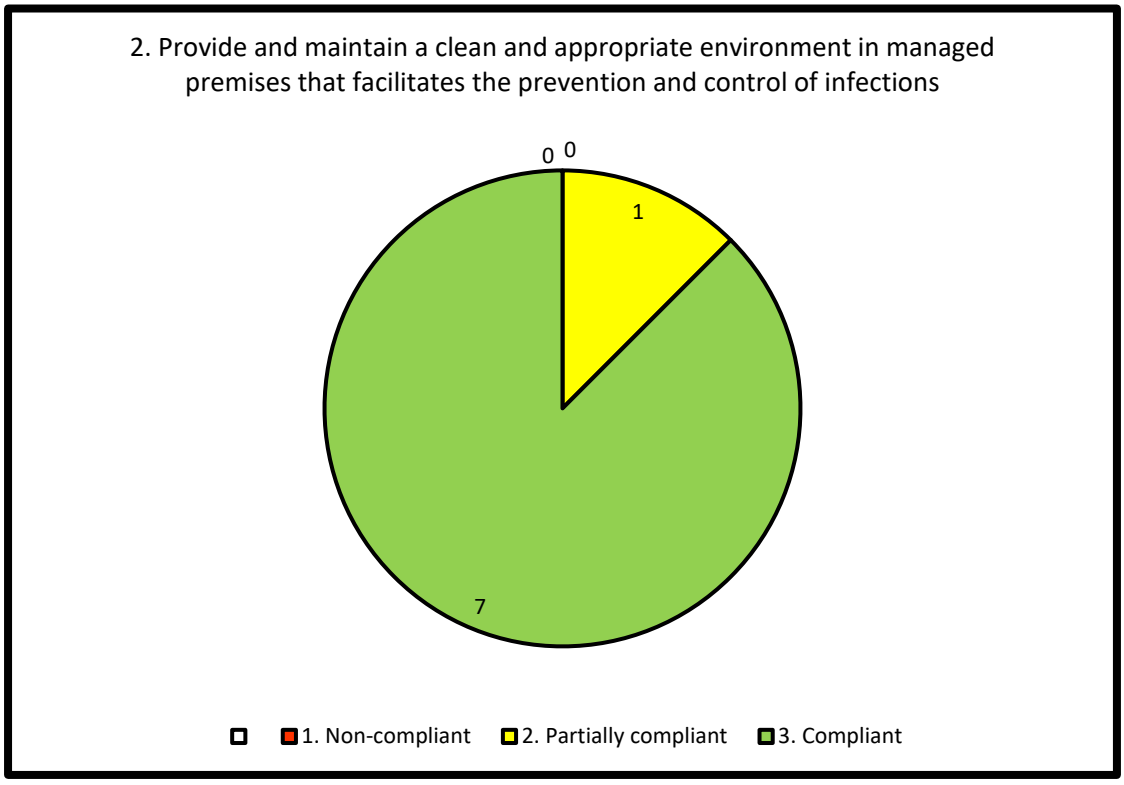
Decontamination

6.5. The Decontamination Committee meets quarterly and covers decontamination in Sterile Services, endoscopy, decontamination of medical devices and patient equipment cleaning. This committee reports to the Hospital Infection Prevention and Control Committee. The IPC service now has a Clinical Decontamination Practitioner in post to support decontamination practice.

Cleaning

6.6. The National Standard of Cleaning has been implemented across the organisation. HIPCC receives a report from the Trust PFI office, reporting by exception those areas that have a low star rating and action plans to resolve concerns. IPC also receive an alert if an inpatient area has a 3-star rating or less. The IPC team, including the new Clinical Decontamination Practitioner participate in cleaning audits as required. Of particular concern to HIPCC this year has been the standard of cleaning in the neonatal unit which has now improved and has consistently either been a 4 or 5 star as of the last few months.

Figure 2
BAF Compliance to Criterion 2



Partial -Compliance Elements
8 elements, 1 partial compliance to**:**

- The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.

Criterion 3

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

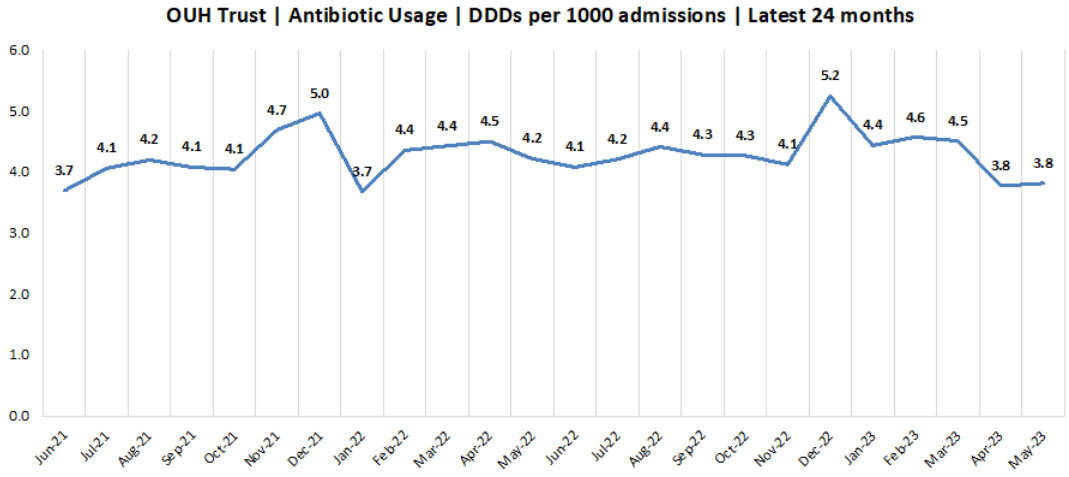
7. **Antimicrobial Stewardship (AMS)**

7.1. Antimicrobial resistance is a global public health threat, and the UK has responded to this global campaign with a series of National Action Plans and national surveillance of antimicrobial resistance patterns with key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics.

7.2. The AMS team continuously monitor total antibiotic consumption within the Trust. Antibiotic consumption is presented as Defined Daily Doses (DDD) which is an internationally recognised measure of antimicrobial consumption. DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults. Table 17 shows the consumption of antibiotics over the last 24 months expressed per 1000 admissions. The increase in consumption in December 2022 is discussed below.

Table 17
Antibiotic consumption expressed per 1000 admissions.

Consumption with Admissions Denominator



Source: Define Reports to June 2023. N.B. data source admissions denominator for March 2023 to May 2023 is based on a 28 day February.

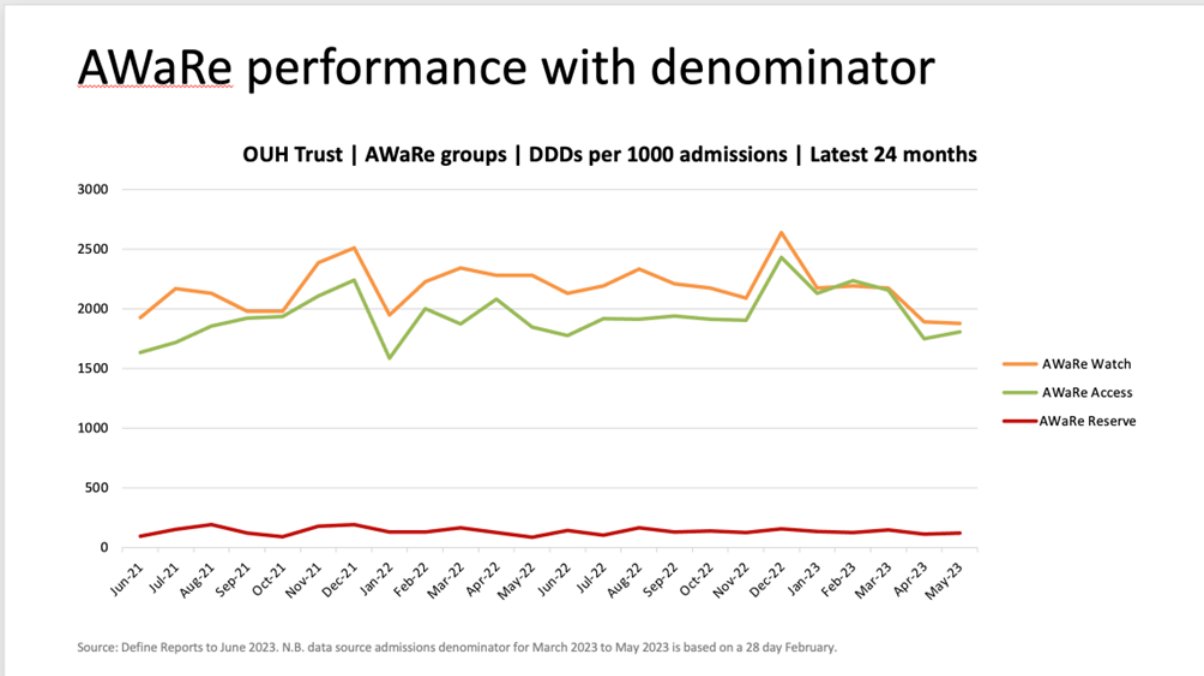
AMS targets included in the national standard contract:

7.3. The World Health Organisation (WHO) categorised antibiotics into three broad groups [AWaRe: Access Watch and Reserve] based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare associated infection such as *Clostridioides difficile* Infection (CDI).

7.4. The NHS National Contract in England for 2022-2023 which started on 1st April 2022 utilises a modified version of the WHO list Access, Watch and Reserve antibiotic classification (microguide.global). The Trust had a target of a 4.5% reduction in consumption of antibiotics in the WHO 'Reserve' and 'Watch' categories from the AWaRE classification (adapted) against a 2018 (calendar year) baseline value. Preliminary data from NHS England shows that OUH achieved this reduction, but the finalised data will be available in September 2023. OUH is one of only three Trusts in the region that met the target.

7.5. The consumption of antibiotic in the 'Reserve,' 'Watch' and 'Access' categories is shown below in Figure a. The plot shows variation in consumption of 'Watch' and 'Access' but similar usage of 'Reserve' antibiotics over time.

Table 18
Consumption in DDD of 'Watch', 'Access' and 'Reserve' antibiotics over time.

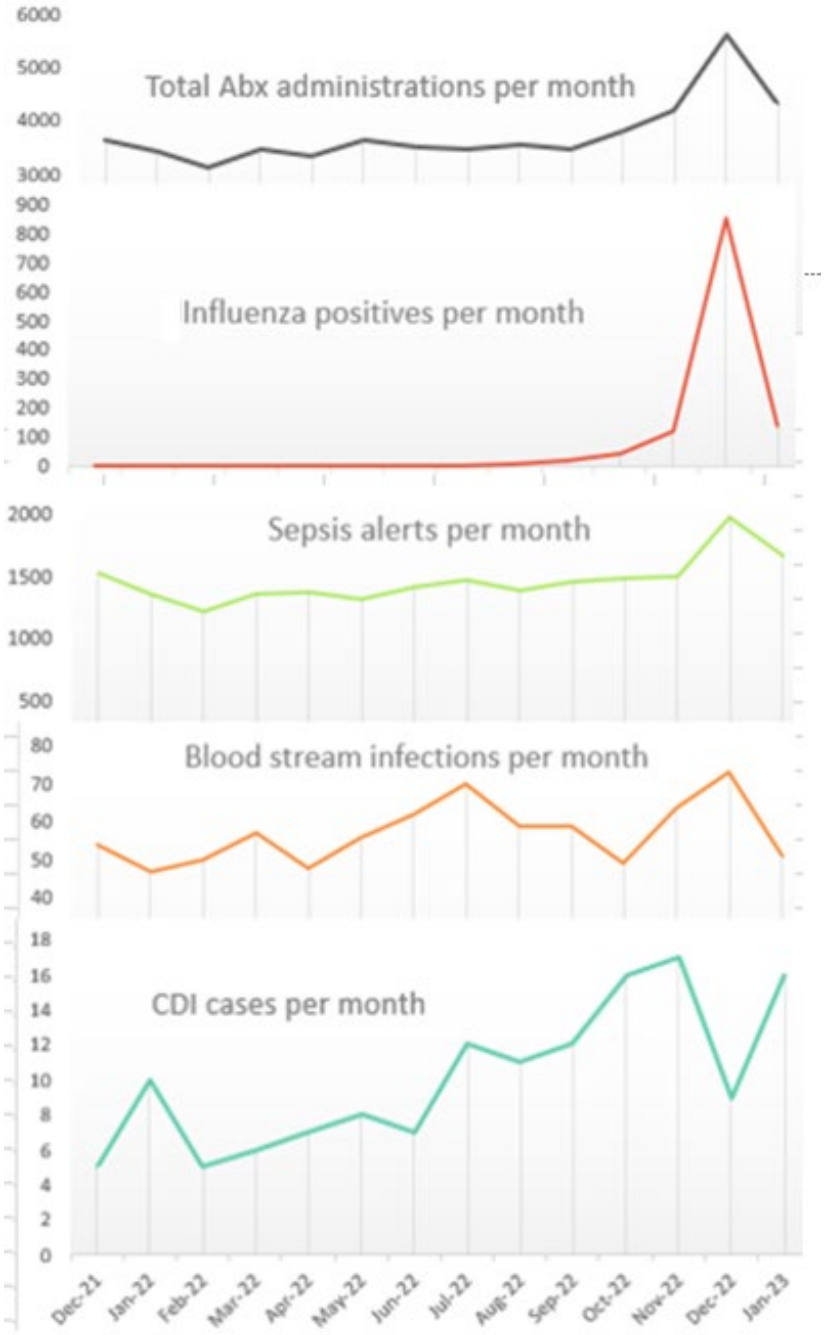


7.6. AMS activities which contributed this reduction in consumption were:

- Use of data to monitor consumption at divisional, directorate and speciality level and identify areas for improvement.
- Education for clinical teams and divisions about their prescribing practice and consumption, including audit and individual feedback.
- Updating prescribing tools – Guidelines were reviewed and updated to reduce the use of 'Watch' and 'Reserve' antibiotics especially in high-risk patients e.g., review of frailty guidelines.
- AMS ward rounds (discussed below)

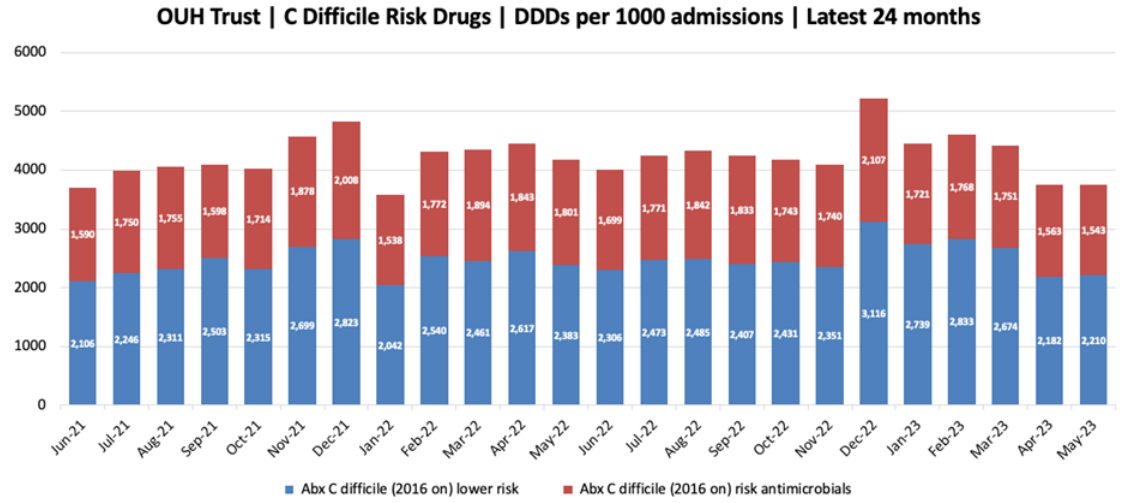
7.7. All Trusts in the UK saw a spike in consumption in December 2022 due to an increased number of Group A Streptococcus infections, influenza patients as well as usual winter infections. The AMS team explored this further evaluating the effects of increasing seasonal respiratory virus activity (RSV and influenza) on sepsis alerts, blood culture (BC) positivity, antibiotic prescribing and *Clostridioides difficile* (CDI) rates in Acute General Medicine (AGM). This data was accepted as a poster at the British Infection Association Spring Meeting and the poster was awarded 'Best Poster' at the conference. The data is shown in Table 19 where the correlation can be seen.

Table 19
Monthly figures for antibiotic administrations, Influenza positive respiratory tests, sepsis alerts, blood stream infections and CDI rates (note CDI for January 2023 is incorrect – should be 13).



7.8. The AMS team have also been monitoring use of 'C. diffogenic' antibiotics to support learning from C. *difficile* cases, an example is shown in Table 20. This work included review of use of specific antibiotics, for example ceftriaxone and carbapenem antibiotics. The AMS team are working with the Infection Prevention and Control teams to identify and share learning about C. *difficile* infections within OUH.

Table 20
Consumption of *C. difficile* Risk antibiotics over time adjusted with admissions



Source: Define Reports to June 2023. N.B. data source admissions denominator for March 2023 to May 2023 is based on a 28 day February.

Antimicrobial Resistance CQUIN for 2022-2023:

7.9. The Trust adopted the Antimicrobial Resistance CQUIN for 2022-2023. This was CCG2: Appropriate antibiotic prescribing for Urinary Tract Infection (UTI) in adults aged 16+. The target was achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that met NICE (National Institute of Clinical Excellence) guidance for diagnosis and treatment.

7.10. Patients to be considered for the CQUIN had the following:

- Documented diagnosis of specific UTI based on clinical signs and symptoms
- Diagnosis excluded use of urine dipstick in people aged 65+years and in all catheter associated UTI (CAUTI)
- Empirical antibiotic regimen prescribed following NICE/local guidelines
- Urine sample sent to microbiology as per NICE requirement
- For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.

7.11. OUH successfully met the target for the CQUIN. The compliance for 22/23 is shown in Table 21 below:

Table 21
Compliance with appropriate antibiotic prescribing for UTI reported each quarter

Indicator name	Description	Compliance Q1	Compliance Q2	Compliance Q3	Compliance Q4
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	69%	70%	74%	69%

AMS ward rounds:

7.12. Antimicrobial Stewardship (AMS) Multidisciplinary Team (MDT) ward rounds are conducted on a weekly basis. The rounds consist of pharmacists, nurses and infectious diseases clinicians who review patients on broad spectrum antibiotics. During the AMS MDT ward round interventions are made and the nature of the intervention is recorded. In addition, ward rounds in all ICU areas are performed by members of the Clinical Infection team several times a week.

7.13. Current AMS ward rounds are

- Haematology-Oncology
- Churchill (excluding ITU and renal transplant)
- JR West Wing (excluding neuro-ITU)
- Horton (adults)
- Paediatrics at JR
- Neonatal unit
- Paediatric Intensive care
- Horton paediatrics

Table 22 shows the number of ward rounds between April 2022 and March 2023 in each area.

Ward Round	Number of ward rounds
Churchill AMS	57
Horton AMS (Adults)	15
JR AMS (Adults)*	9
JR AMS (Paediatrics)	66
Total	**147**

*JR ward round at West Wing started Feb 23

Table 23 shows the number of patients reviewed and the number of interventions between April 2022 and March 2023 in each area.

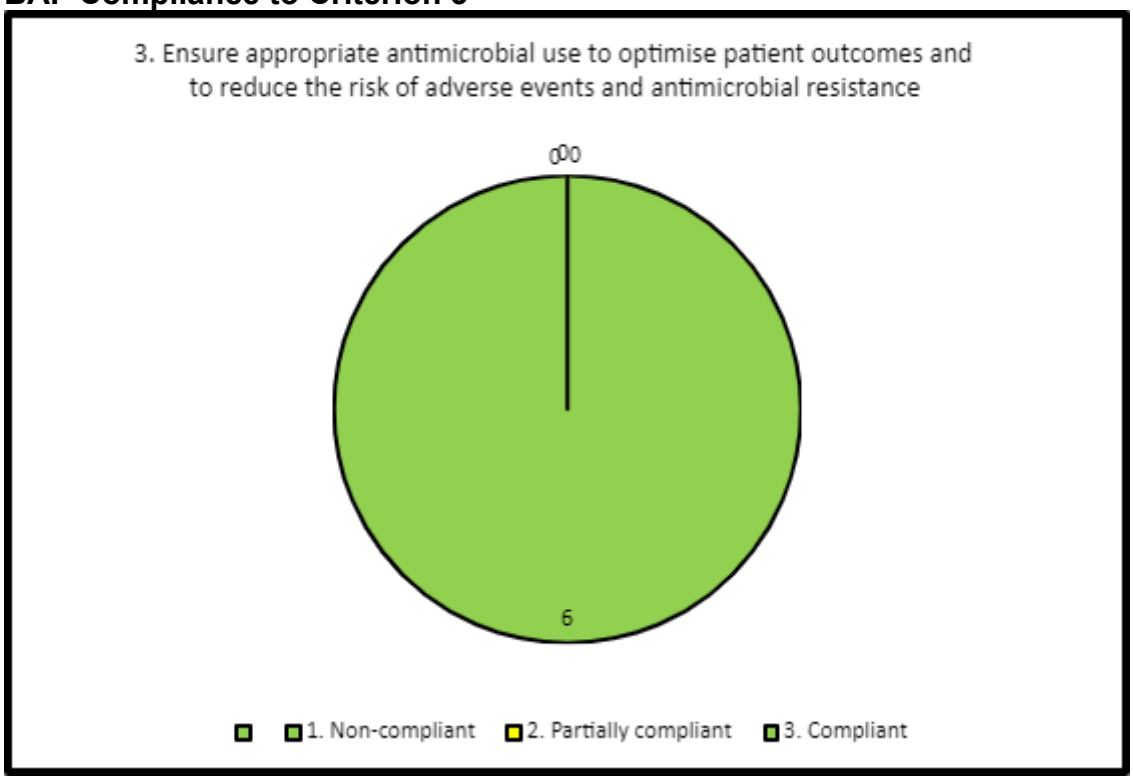
Sites	Number of patients reviewed	Number of interventions
JR adults*	135	71
Horton	175	93
Churchill	978	474
JR paediatrics	909	691

*JR ward round at West Wing started Feb 23

7.14. The AMS team were invited to deliver an oral presentation about the success of the rounds at the international conference European Congress of Clinical Microbiology and Infectious Diseases.

7.15. During 23/24 the AMS team will start to look at whether the recommendations have been implemented within 24 hours by the clinical team.

Figure 3
BAF Compliance to Criterion 3



Criterion 4

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

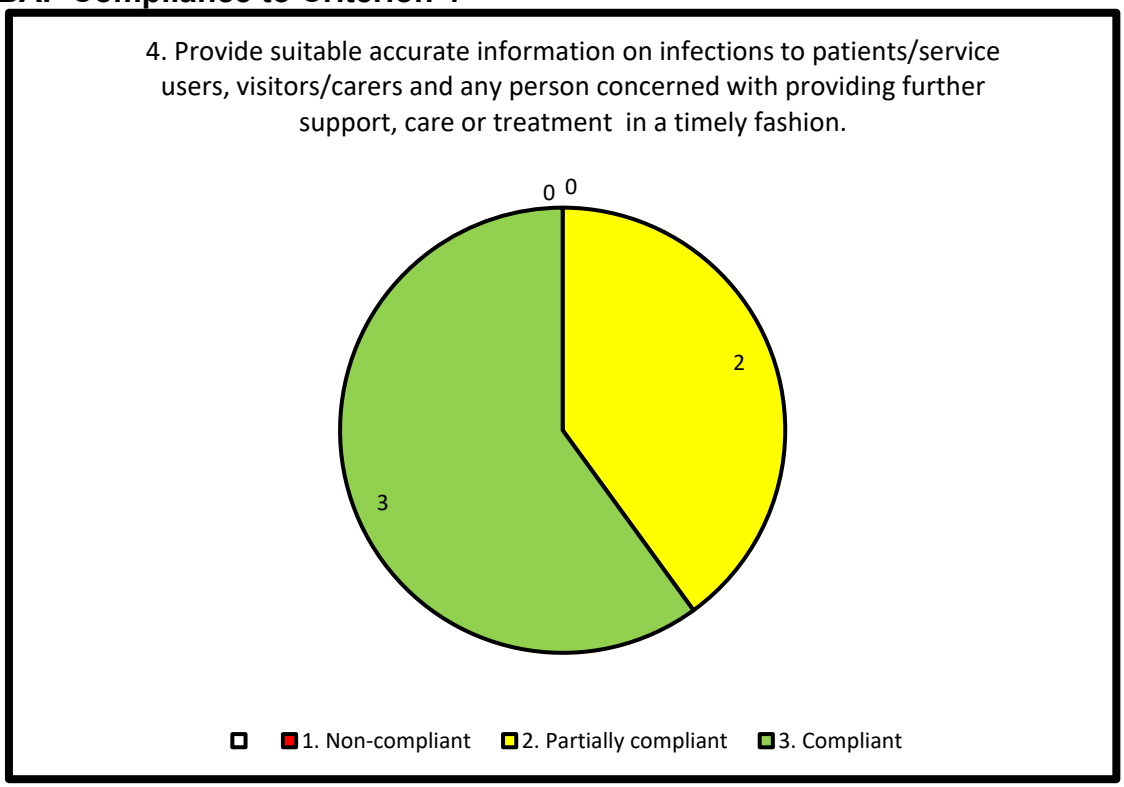
8. Provision of Information

8.1. The IPC team have taken active roles in promoting patients, staff, and visitors' safety during the pandemic, for example, working with the communication and media team on visual material, and the procurement team and supplies of PPE (Personal Protective Equipment) at the front doors. The Lead Nurse has been interviewed twice by Radio BBC Oxford on COVID-19 in the hospital.

8.2. The IPC team have also worked closely with the Chief Nursing Officers team on the visitor policy, assessing the risk of potential nosocomial transmission with compassion.

8.3. The Trust implemented the National Standards of Cleaning and all the star ratings on Cleanliness are therefore displayed for the public.

Figure 4
BAF Compliance to Criterion 4



Partial Compliance Elements to BAF
5 elements 2 partial compliances for:

- Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include:
- Hand hygiene, respiratory hygiene, PPE (mask use if applicable)
- Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g., cleanliness)
- Explanations of infections such as incident/outbreak management and action taken to prevent recurrence.
- Provide published materials from national/local public health campaigns (e.g., AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors, and advocates to minimise the risk of transmission of infection.
- Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.

Criterion 5

That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

9. Infection Prevention and Control Surveillance Software

9.1. The company that supplies the surveillance system (ACMEipc) to the infection prevention and control team (IPCT) has ceased trading. The system can still be used but is unsupported and cannot be fixed should any problem arise.

- ACMEipc has been used by the IPC team (IPCT) since before 2009. It interfaces with Sunquest (the laboratory management system) and Cerner PAS. It provides a daily list of alert organisms to the IPCT. The South 4 pathology network laboratory information management system, due for implementation across all OUH and networked laboratories in early 2024, will be unable to interface with ACMEipc to provide the necessary surveillance data.
- ACMEipc sends email alerts to the IPCT when a patient with an alert organism is admitted to the Trust
- ACMEipc sends an email to the IPCT when a C. difficile sample is received in the lab or for a positive result.
- COVID -19 results are reported to the IPCT through the system

9.2. The IPCT review the daily list and any alerts. This allows the appropriate management of infectious or potentially infectious patients in real time to reduce the risk to others. The risk has been added to the risk register and escalated to relevant parties. Ongoing discussions are in progress to find a solution. There is discussion as to whether this should be a joint BOB platform, or individual organisations and/or whether it should include the South4 pathology network.

9.3. The ICS are in support of the purchase and is an objective on the ICS Joint Forward Plan.

10. Investigation of Infection Prevention and Control Incidents

IPC and the Neonatal unit

10.1. The neonatal unit has been of concern to the IPC team this year, and concerns have been raised with the Chief Medical Officer and Chief Nursing Officer. The three units that make up the neonatal department are cramped, with limited storage, and lack a sluice and a suitable area for decontamination of the incubators. They are heavily reliant on paper for all clinical and nursing notes and have no electronic prescribing facility.

10.2. An outbreak of MRSA was declared in April 2022, following an increase in the numbers of babies becoming colonised with MRSA and 2 MRSA bacteraemia's.

10.3. Throughout the year there have been regular outbreak meetings attended by IPC, the neonatal unit, senior divisional members, and ICB and UKHSA representatives. The detail has been reported throughout the year in the IPC Patient Safety and Effectiveness Committee monthly report.

10.4. The outbreak of MRSA in the neonatal unit was declared over 23rd November 2022 as there were no new cases of horizontally acquired MRSA since 4/10/22 (only 1 case of vertical transmission, mother to baby, with baby being recognised as colonised within a few days of birth). Around 50% of the staff working on or visiting the neonatal unit participated in MRSA screening. Several MRSA positive staff were found (as expected in any population). All were successfully decolonised. Whole genome sequencing (WGS) was undertaken with the assistance of the Oxford Health Protection Research Unit (HPRU) and none of the staff were colonised with the major outbreak strains found to be colonising babies on the unit. WGS is underway by the Oxford HPRU to confirm transmission rather than multiple introductions.

10.5. An ESBL outbreak was declared 23rd November 2022 due to the increasing number of babies colonised with ESBL-positive Klebsiella and E. coli found on routine screening. An external peer review visit by IPC NHSE and UKHSA took place in December; the findings were formally reported in January 2023. There were no significant action points not already in place. However, there were a few actions that had not been progressed for some months and was therefore escalated to PSEC and CMO. The outbreak was closed in July 2023 as there has now been progress with the small works business case to improve storage and decontamination facilities, a plan for incubator replacement and traction on

moving from paper-based notes to electronic systems. There will continue to be a monthly IPC/unit meeting to ensure that actions continue to progress, and on-going surveillance of ESBL positive isolates.

10.6. In addition to the MRSA and ESBL outbreaks, high rates of CLABSI have been observed on the unit which has improved in the most recent quarter (zero cases). The unit is known also to be part of the national increase in cases of *Staphylococcus capitis*. WGS is in progress with publication expected later this year.

10.7. The actions for the outbreaks have focused on the standard infection prevention and control precautions and good antimicrobial stewardship.

Safe Management of the Care Equipment

- Incubator decontamination
- Ultrasound probes
- Equipment cleaning
- Employment of housekeepers

Safe Management of Care Environment

- Cleaning of the unit
- Sink etiquette/safety use
- Storage
- Moving to paperless environment

Patient placement/assessment of infection risk

- Overcrowding in the department

Hand Hygiene/Appropriate glove use

- Weekly hand hygiene audits/ development of education tools

Table 24
Neonatal *Staph. capitis* cases

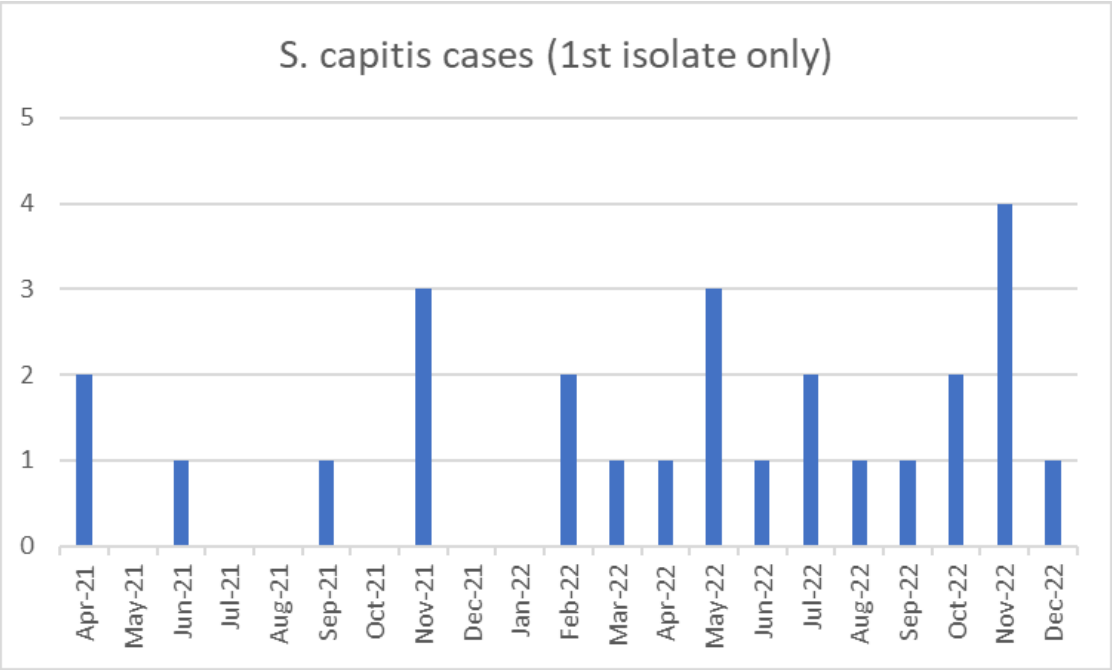


Table 25
MRSA New Cases by First Isolate 2017-2022

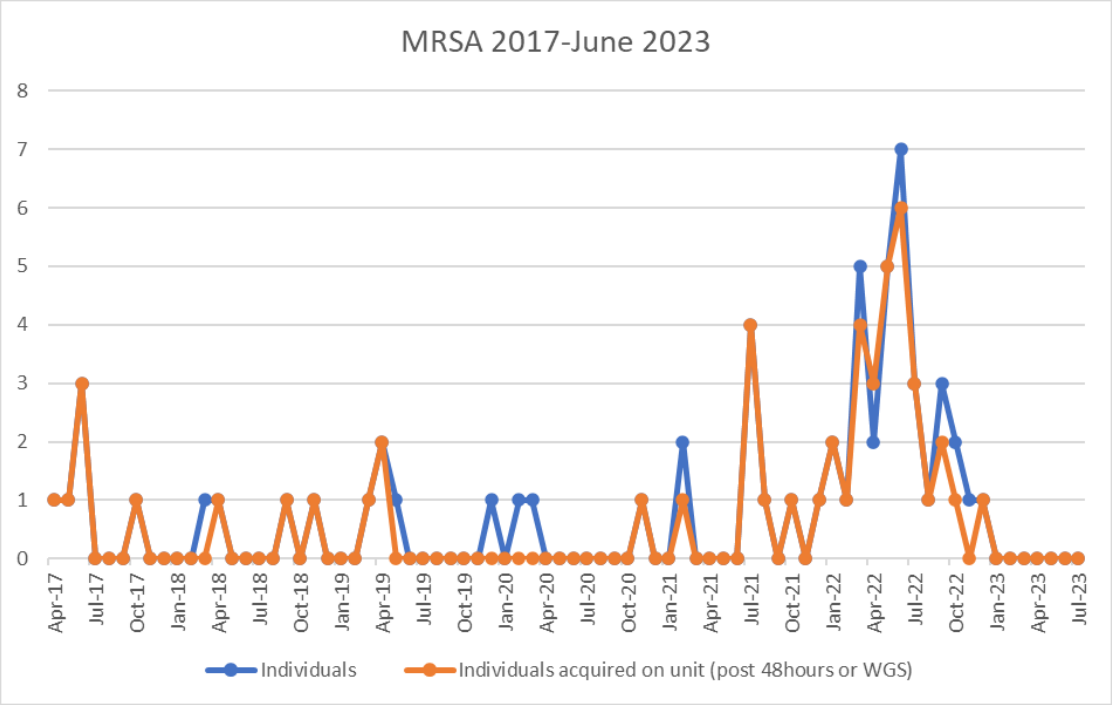
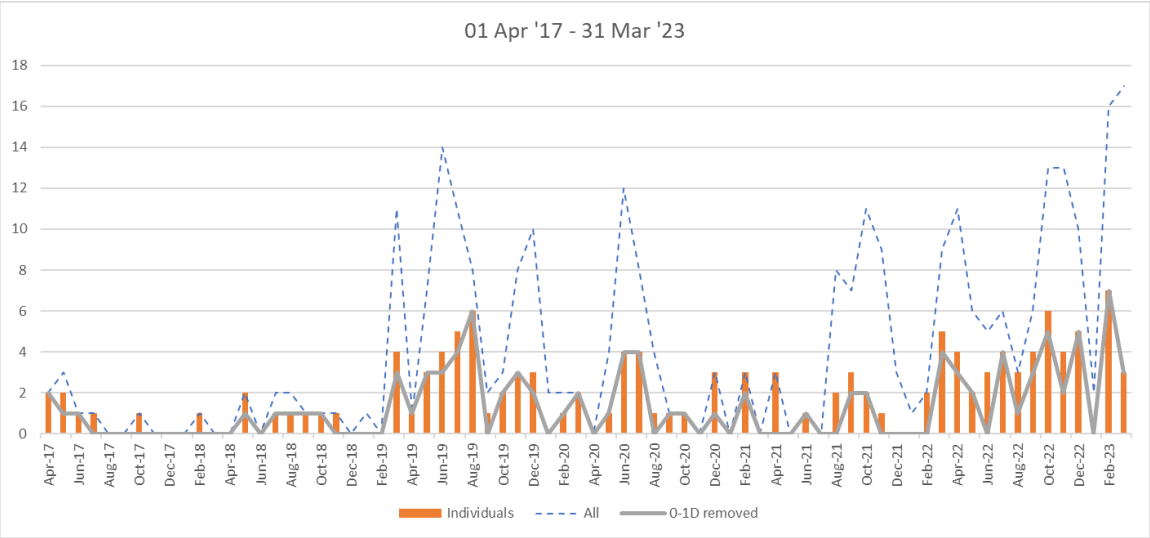


Table 26
Neonatal ESBL by sample type



Norovirus Outbreak

10.8. An outbreak of Norovirus in December was reported on CMU-D Ward at the John Radcliffe Hospital. A total of 12 patients were symptomatic with vomiting and diarrhoea with 3 patients confirmed positive for norovirus. 5 staff were reported with symptoms associated with the outbreak. The Ward was initially closed to admissions in response to the number of bays affected and the lack of side-room facilities to isolate patients. An outbreak meeting was convened, and the Ward was re-opened to admissions and discharges.

MPox

10.9. Several individuals have been assessed and diagnosed with MPox by the sexual health and infectious disease services. Some individuals have required admission to John Warin Ward, mainly for pain management. Post-exposure prophylaxis with smallpox vaccine has been available for exposed staff at national centres. The OUH has run several pre-exposure vaccine clinics for individuals identified as being at high-risk with very positive feedback, winning the award for Delivery at the OUH Staff Recognition Awards 2023. Weekly operational meetings were held. National guidance on management has undergone frequent changes, regarding isolation and contact tracing.

Chicken Pox

10.10. There were 3 unrelated chicken pox incidents on Kamran's ward between 03/08/2022 and 08/08/2022 which included 2 patients and 1 staff member who was at work when symptomatic. Contact tracing was undertaken where required.

10.11. In July and August contact tracing of staff and patients was required for an antenatal woman and her partner across 2 departments in Women's hospital.

10.12. All contacts were confirmed to be immune or vaccinated and anti-virals were administered for one exposed patient contact based on their individual risk factors**.**

Aspergillus

10.13. A briefing on an apparent increase in invasive Aspergillus infection in Paediatric Haematology was prepared for the executive team detailing the confirmed and suspected cases, the management of the cladding project and recommendations going forward.

Listeria

10.14. A general medical patient was identified as having Listeria monocytogenes in a blood culture. Investigations have been undertaken to understand the potential source of the infection as they had been an inpatient for the three weeks prior to the collection of the positive blood cultures, and therefore they most likely acquired the infection during their hospital stay.

10.15. The UKHSA Enhanced Surveillance questionnaire which includes food eaten by the patient has been completed and returned to UKHSA. The Trust PFI Office have been working with Mitie to complete the food history element. The patient was also brought in food by her family. The incident has been reported through Ulysses and reported as moderate harm. There have not been any further cases of Listeria bacteraemia in the OUH since this case was reported, and there are no national alerts regarding Listeria in hospital food currently. There have been 14 linked cases of listeriosis since 2020 in England and Scotland in association with the consumption of smoked fish, with eight of these since January 2022.

11. Surgical Site Infection Surveillance (SSI)

Cardiac Surgery

11.1. Cardiac surgery continues to participate in voluntary surveillance and Surgical Site Infections (SSIs) information is reported to the UKHSA SSI surveillance service every quarter. The national benchmark for Coronary Artery Bypass Surgery (CABG) is currently 3.8% and for non-CABG surgery is 1.8%.

TAVI surgical site surveillance:

11.2. There have been no reported SSI cases for TAVI patients since April 2022. The total cases during this period are 424 patients.

Table 27
Non –CABG SSI RATES April 2022 to March 2023

Non-CABG Sternal wound infections					

Period	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Final
Quarter 1 Apr-Jun 2022	(0/81) = 0%	(0/81) = 0%	(0/81) = 0%	(0/81) = 0%	Yes
Quarter 2 Jul-Sep 2022	(1/64) = 1.6%	(0/64) = 0%	(0/64) = 0%	(1/64) = 1.6%	Yes
Quarter 3 Oct-Dec 2022	(0/84) =0%	(0/84) =0%	(0/84) =0%	(0/84) =0%	Yes
Quarter 4 Jan-Mar 2023	(0/79) = 0%	(0/79) = 0%	(0/79) = 0%	(0/79) = 0%	No

Table 28
CABG SSI RATES April 2022 to March 2023

CABG Sternal wound infections					
Period	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Final
Quarter 1 Apr-Jun 2022	(3/96) = 3.1%	(0/96) = 0%	(0/96) = 0%	(3/96) = 3.1%	Yes
Quarter 2 Jul-Sep 2022	(2/96) = 2.1%	(2/96) = 2.1%	(1/96) = 1%	(5/96) = 5.2%	Yes
Quarter 3 Oct-Dec 2022	(4/116) = 3.4%	(1/116) = 0.9%	(0/116) = 0%	(5/116) = 4.3%	Yes
Quarter 4 Jan-Mar 2023	(1/105) = 0.9%	(1/105) = 0.9%	(2/105) = 3.8	(4/105) = 3.8% TBC	Yes

Trauma and Orthopaedic SSI Surveillance

11.3. Mandatory surveillance of infections in trauma and orthopaedics started in April 2004, specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. The categories are:

- hip replacements
- knee replacements
- repair of neck of femur
- reduction of long bone fracture

11.4. The OUH collects continuous data on repair of neck of femur.

Table 29
Fractured Neck of Femur SSI Rates

Fractured Neck of Femur SSI Rates

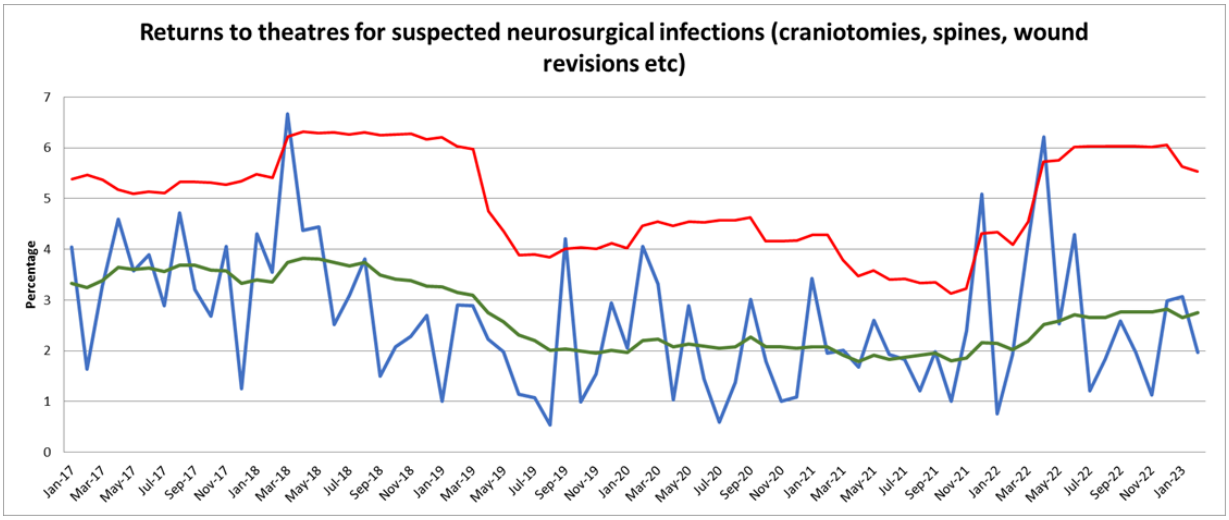
		JRH			HGH		
		All #NOF Operations	No. SSI cases	JR SSI rate (%)	All #NOF Operations	No. SSI cases	HGH SSI rate (%)
2022	Q1 Jan-Mar	103	1	1.0%	51	0	0.0%
	Q2 Apr-Jun	102	0	0.0%	51	0	0.0%
	Q3 Jul-Sep	105	0	0.0%	79	0	0.0%
	Q4 Oct-Dec	111	1	0.9%	71	1	1.4%

Neurosurgery SSI Rates

11.5. The green line is the moving average over the last 12 months.
The red line is the 95% confidence limit for the moving average so peaks outside this are/were a concern. The red line hasn't dropped yet because we haven't had enough months to allow it to drop yet even though from July 22 it looks like it has fallen.

11.6. Neurosurgery use returns for suspected to theatre as an indication of their SSI rates. This does not follow the traditional UKHSA methodology on SSI surveillance but is less resource intensive for the neurosurgery team. They have been undertaken surveillance in this manner for several years now and has allowed them to identify periods of increase infection and act when spikes are noted. Each return to theatre is reviewed by the neurosurgical clinical governance lead to identify if the return to theatre was for confirmed infection.

Table 30

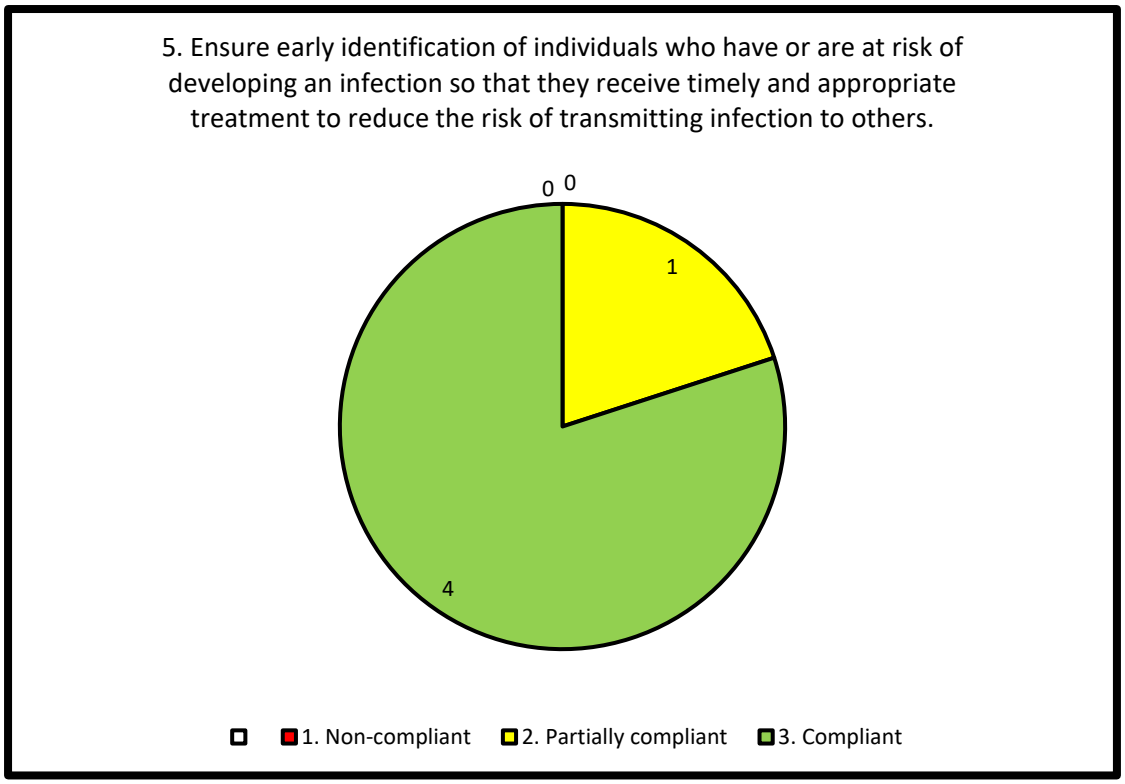


Spinal Service and Surgical Site Infection (SSI)

11.7. Following a Paediatric Spinal Surgery Service Review visit, where the service team raised a concern regarding the high surgical site infection (SSI) rates, a letter was sent to the Trust regarding additional information that NHSE required. The IPC team have been meeting monthly with the Spinal Surgery Governance Lead prior to this visit, as previously reported, to try an understand what the rates of infection were in both adults and children and what actions were being taken to reduce the risk of SSI.

11.8. The IPC team are continuing to work with the spinal service to refresh the SSI reduction bundle and to ensure responsibility of each element is clear. A retrospective audit is being undertaken by the service to identify compliance to the existing bundle and the NOTSSCaN theatre matron is supervising a prospective audit.

Figure 5
BAF Compliance to Criterion 5



Partial Compliance Elements to BAF

5 elements, 4 compliant 1 partial compliance for:

- All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have or are at risk of developing an infection receive timely and appropriate treatment to reduce the risk of infection transmission.

Criterion 6

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

12. IPC Training

12.1. There is an IPC eLearning package that meets the national requirements and is a Trust-wide requirement. Rates of compliance are reported by the divisions.

12.2. The IPC team offers bespoke training in a variety of ways and participates in training for medical students and doctors.

12.3. The IPC team are currently engaged with a Virtual Reality company to look at how to make IPC learning more interactive and engaging.

12.4. The Lead IPC Nurse has monthly walkarounds of clinical areas with the Chief Medical Officer to speak with staff, and to understand barriers to good IPC practice and environmental challenges.

12.5. Hand Hygiene awareness and Continence awareness weeks have been organised and successfully delivered to promote visibility and reach.

12.6. There is now a strong IPC Link Practitioner cohort of staff, who are attending IPC run workshops and completing competencies. Clinical areas have been supportive of the Links having time to attend sessions. These Link Practitioners could be an extremely useful resource should the pandemic resurface, or in the event of a new outbreak of infection.

13. OUH IPC Team national positions of responsibility

13.1. The Lead Nurse is President for the Infection Prevention Society (IPS) (2022-2024)

13.2 The DIPC is President of the British Infection Association (BIA) (2021-23) and is a member of the Infectious Diseases National Clinical Reference Group, and the UKHSA Steering Group for Standards in Microbiological Investigation.

13.3. Members of the IPC nursing team hold positions of responsibility within the IPS.

13.4. The Consultant Pharmacist for Antimicrobial Stewardship is Chair of the South Central regional antimicrobial pharmacist network (SCAN) and Associate Member Secretary for the BIA.

14. Harm Free Care Meetings

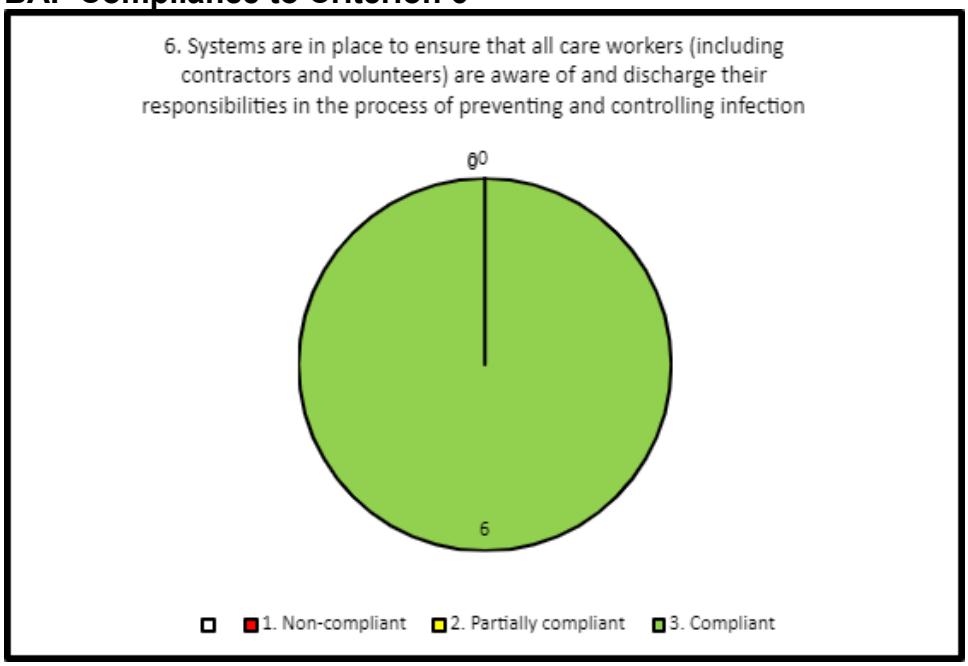
14.1. These meetings have provided a forum to reflect on patient safety incidents involving Health Care Associated Infections with a focus on C. difficile, MRSA and MSSA. At these meetings, the IPC team work together with clinical teams and with Infectious Diseases to agree on source (for MRSA and MSSA), agree on level of impact to patient, level of investigation and identify missed opportunities for learning.

14.2. Some of the key actions that have been generated from C. difficile harm free care meetings are promoting early identification of infectious diarrhoea using Bristol stool chart to document within the Interactive view section of patient's EPR notes; clear communication and documentation of medical review to reduce delay in C. difficile sampling, requesting enhanced cleans via help-desk and consulting the ID team via EPR consult to promote safe antibiotic choices which are in line with OUH MicroGuide.

14.3. The Antimicrobial Stewardship team have also contributed significantly by reviewing antibiotics within 3-month periods and provided feedback of compliance or non-compliance identified. The participation of the AMS team at harm free care meetings have been useful for clinical teams.

14.4. For MSSA/MRSA, some of the key actions for noting include providing staff with refresher learning on accurate VIP scoring, documentation within I-View and escalating when required. The at-a-glance document on the Guideline for taking blood cultures was also used to provide learning from one of the Harm free care meetings.

Figure 6
BAF Compliance to Criterion 6



Criterion 7

The provision or ability to secure adequate isolation facilities.

15. Isolation facilities

15.1. The John Warin Ward continues to provide isolation facilities with 4 isolation suites with positive pressure ventilated lobbies (PPVL). There is an additional isolation facility in the JR Emergency Department with direct access from the external environment. The new critical care facility on the John Radcliffe site offers additional isolation facilities with 10 PPVL rooms. The Trust has made a successful application to become a centre for Airborne high consequence infectious disease (HCID) – likely to be implemented in 2023/24. The Trust has an HCID group that meets monthly and maintains the HCID protocol.

16. Impact of COVID-19 in 2022-23

16.1. Throughout 2021/22, much of the IPC day to day work continued to be COVID-19 focussed. The OUH continued to follow national guidance. The COVID Clinical Forum continued to meet at least fortnightly throughout the year. The greatest challenge around the management of COVID –19 was the operational

issue in terms of being able to promptly isolate positive patients or protect vulnerable ones. This was largely due to the capacity demands in the Trust. In addition, most of the wards rely on natural ventilation except for the respiratory ward and one medical ward. The IPC team attend the operational meetings to support correct placement of patients. The IPC team have also supported the Trust by providing a spreadsheet 7 days a week during the peak months of patients with COVID/influenza which has been particularly resource intensive for the IPC team. Going into winter 2023/24 support from the informatics team will be required.

Table 31
COVID-19 Patients, Nosocomial Cases and Outbreaks

Month	Number of COVID-19 patients	Definite Nosocomial	Probable	Number of open outbreaks
April 2022	460	21	34	2
May	169	10	6	0
June	318	29	28	2
July	660	50	69	12
August	190	13	6	8
September	190	30	22	1
October	432	54	41	13
November	211	25	20	6
December	410	45	48	6
January 2023	236	37	40	4
February	228	20	29	7
March	297	24	17	4
Total	3801	358	360	65

Summary of Timeline of events:

April

- The symptomatic PCR testing service continued to support staff, family, and household testing in March.
- Number of staff being tested by PCR decreasing due to the new government guidance that a positive LFD is sufficient.
- Staff were expected to upload 2 LFD results per week

May:

- Increase in cases reflected community prevalence, nosocomial acquisition and staff

June:

- Reintroduction of some interventions to reduce the number of outbreaks and nosocomial acquisitions- restarting asymptomatic screening, isolation of exposed patients, asking visitors to wear masks and strongly recommending to our staff that they wear masks in non-clinical areas.
- Significant operational pressures and at times there have been insufficient COVID beds/side rooms to expediate the movement of positive patients from a bay of non-positive patients.

July:

- Still seeing increase in cases and nosocomial acquisition, and operational pressures remained.
- Number of outbreaks has decreased this month.
- Staff symptomatic screening continues and staff lateral flow tests twice weekly.

August:

- UKHSA recommended a pause in asymptomatic staff and patients testing with exceptions for patients being transferred to hospices/care homes and immunosuppressed patients. This was implemented in the Trust.
- The trust staff reporting website was closed following the change to recommended testing by UKHSA.
- Symptomatic staff were still able to access lateral flow testing through the government website.

September:

- In the middle of September there were around 40 COVID-19 positive inpatients however, two weeks later, the number had doubled and continued to rise.
- Increase in number of outbreaks and nosocomial cases.
- Asymptomatic screening reintroduced for unplanned admissions as an intervention to facilitate patient placement and reduce risk of outbreaks.
- Moving of COVID-19 positive patients out of bays has remained a challenge whilst trying to balance risk against the Emergency Department targets.

October/November:

- The asymptomatic screening of unplanned emergency admissions continued through October to aid correct placement of patients and to reduce the risk of nosocomial acquisitions and outbreaks.
-

December:

- Asymptomatic PCR screening of unplanned emergency admissions continued up to December 22nd to aid correct placement of patients and to reduce the risk of nosocomial acquisitions and outbreaks.
- From 22nd December the Trust issued updated guidance with immediate effect that asymptomatic unplanned admissions should be screened with a lateral flow test only to aid patient placement.

January:

- Due to operational pressures, it was not always possible for the operational team to move exposed or positive patients to single rooms or cohort areas. Operational team asked to try and place COVID-19 patients on ward 5E/F which has mechanical ventilation in place.
- OPEL (Operational Pressure Escalation Level) level 4 for the first eight days of January.

February:

- Very small decrease in COVID-19 patient numbers compared to January levels but a decrease in the nosocomial rate.
- There was a large outbreak on CMU-A involving 30 patients.

March:

- New testing guidance was issued by UKHSA at the end of March to reflect changes in the funding of PCR-based diagnostic assays from April 1st to business as usual.
- Implemented on 17th April along with changes in guidance on the wearing of masks, and staff and patient isolation.

Table 32
Staff Lateral Flow Positive Results

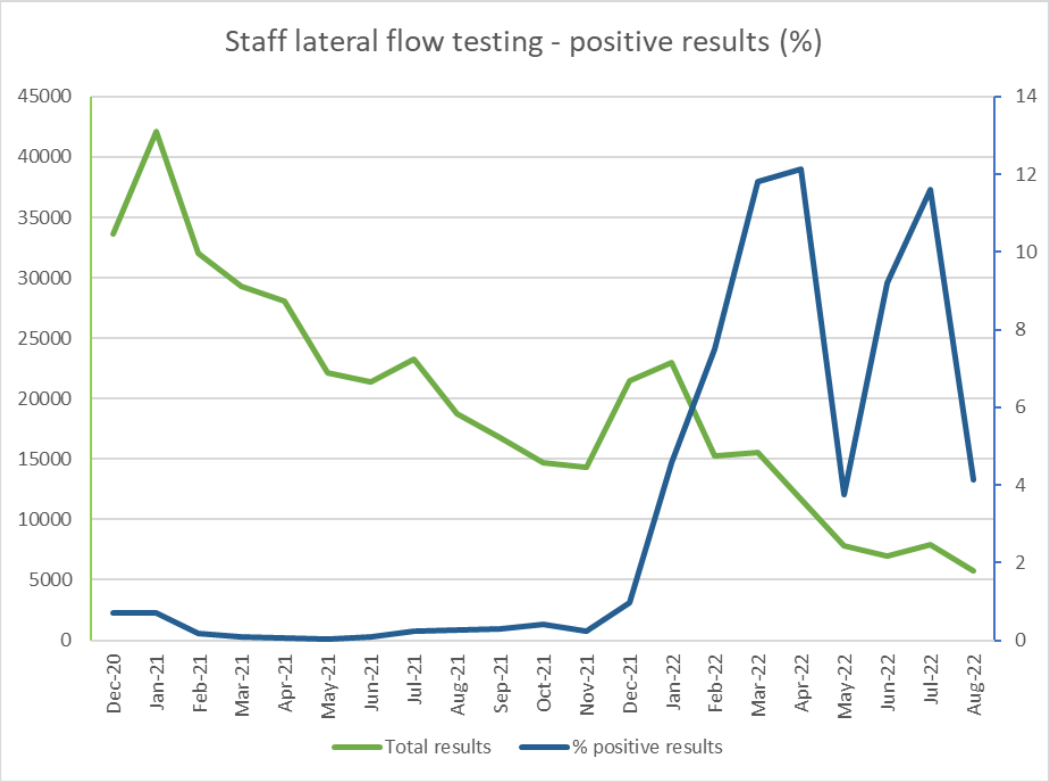
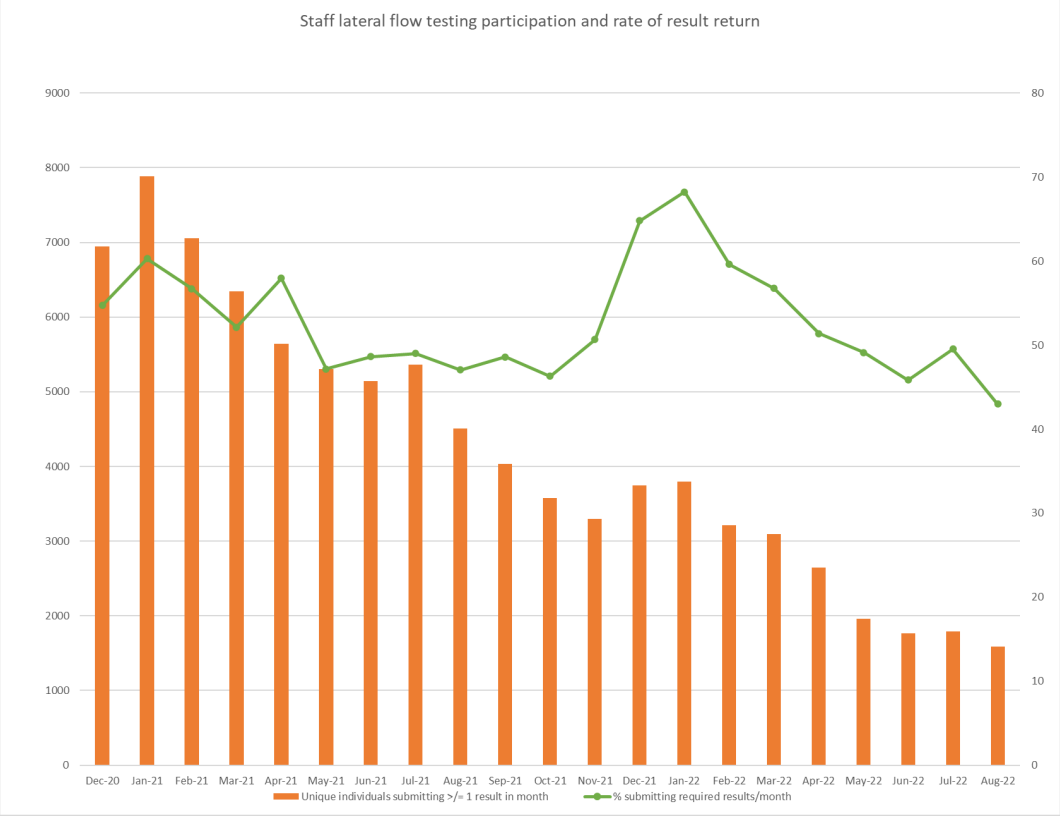


Table 33
Staff Lateral Flow Testing Participation and Rate of Result Return



17. Influenza and RSV

17.1. From November 1st to December 31st, 2022, 715 point of care tests (POCT) for RSV were done in emergency settings of which 179 (25%) were positive. For influenza 1550 POCTs were performed, of which 408 (26.3%) were positive. This rapid testing facilitated patient triage at the time of admission and will have also supported direct home discharge. Comparable figures for laboratory-based PCR testing are 156/825 (19%) positive for RSV and 190/825 (23%) for influenza. The POCT and laboratory datasets will have some overlap, but clinicians were encouraged not to send confirmatory tests to the laboratory for patients testing positive for RSV or influenza.

17.2. The number of influenza cases dropped dramatically in January compared to December. In January there were 170 patients testing positive, not all will have been admitted.

17.3. Pre-Christmas there was a rapid increase in influenza admissions, causing considerable difficulty with appropriate cohorting of patients with different respiratory viruses. In general length of stay was short. Point of care testing worked well in emergency settings and most patients tested were sent home. A small number of influenza cases have required ICU admission. Several cases have been in children. RSV numbers have also increased and have been operationally challenging in children's services.

Table 34
Weekly OUH Influenza Numbers to end of February 2023

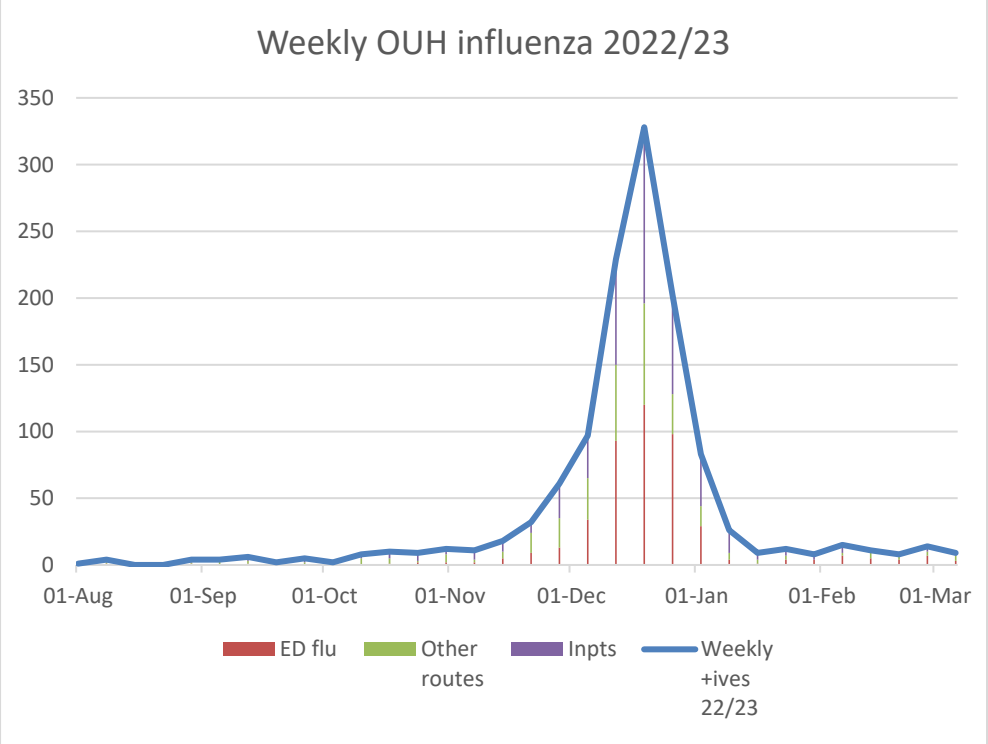
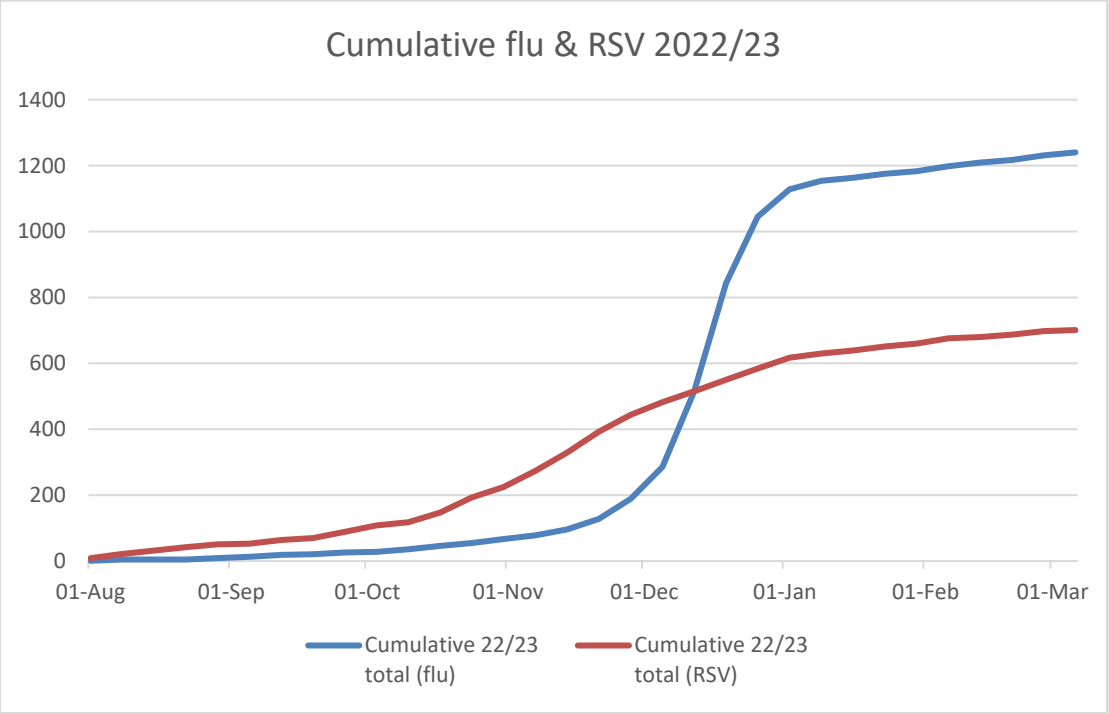


Table 35
Cumulative Influenza and RSV Numbers (Aug 22- February 23)



18. Group A Streptococcus

18.1. Notifications of Group A streptococcal infections, including scarlet fever, invasive infections (iGAS) and severe pulmonary infections were higher than normal in England and causing significant public concern. This was reflected in a high number of attendances in the emergency department, especially in Paediatrics, and a higher number of patients than usual were admitted with a positive Group A streptococcus culture and diagnosis of iGAS. All cases of iGAS are notified to the local health protection team.

Table 36
Weekly numbers of iGAS laboratory reports up to week 02 in the Southeast

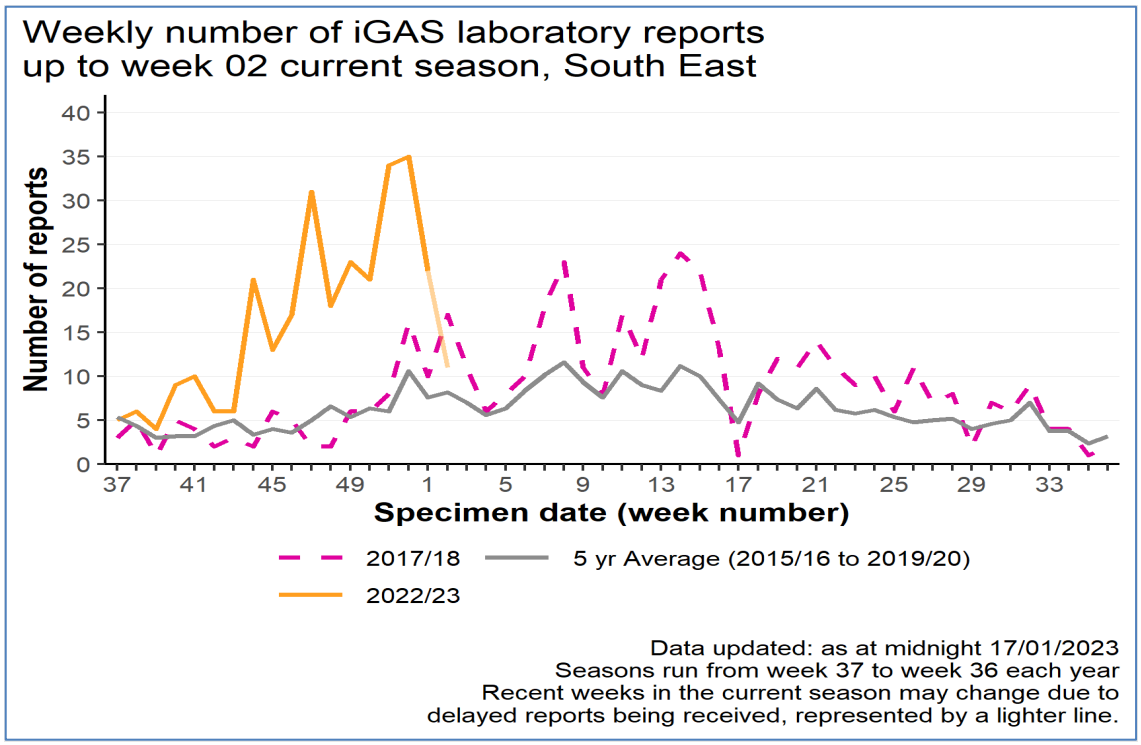
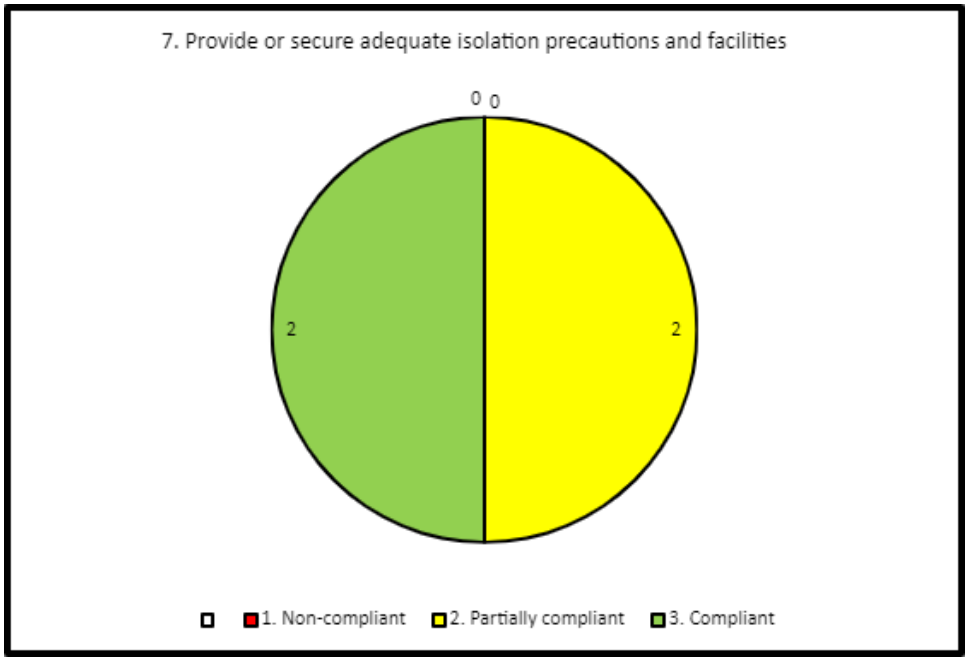


Figure 7
BAF Compliance to Criterion 7



Partial Compliance Elements to BAF
4 elements, 2 partial compliances for:

- Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.
- Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: single rooms are in short supply and if there are two or more patients with the same confirmed infection or are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.

Criterion 8

The ability to secure adequate access to laboratory support as appropriate.

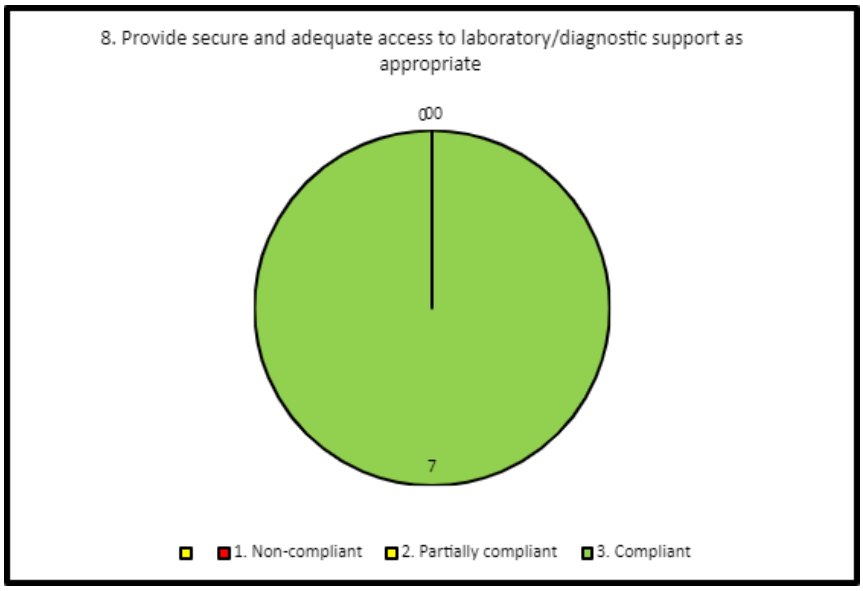
19. Role of the Microbiology Laboratory

19.1. OUH has a dedicated in-house Microbiology Laboratory which provides a 24/7 service with UKAS (United Kingdom Accreditation Service) accreditation (ISO-15189). A Microbiology Consultant and SpR are available 7 days a week to provide IPC advice and support. The IPC team attend the Microbiology 'plate' round daily, and present cases and issues for discussion, including C. difficile RCAs for feed-back to clinical teams in real-time. The Microbiology Laboratory Information Management system automatically flags alert organisms to the IPC system, although the future of this is in doubt if unable to replace the ACMEipc IPC surveillance system. The laboratory supports IPC investigations such as environmental swabbing as part of outbreak investigation.

19.2. During 2022/2023 the microbiology laboratory continued to support the Trust with a 24/7 SARS-CoV-2 testing service, for both emergency and elective patients to try and minimise operational pressures and help facilitate the Trust recovery process. In 2022 that laboratory was the first NHS lab in the country to be contracted to provide a SARS-CoV-2 sequencing service for South 4 and South 5 pathology networks to support national surveillance activities.

19.3. Working with the Oxford HPRU, university staff have supported the OUH and IPC team by providing sequencing for outbreak organisms of interest, most notably this year *Staphylococcus capitis* and MRSA to support the management of the neonatal unit outbreak.

Figure 8
BAF Compliance to Criterion 8



Criterion 9

That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

20. Device Related Infection Prevention

Urinary Catheter Audit

20.1. A point prevalence audit of urinary catheters was undertaken in November 2022. A total of 562 patients were observed during the audit with 103 found to have a urinary catheter. The documentation was reviewed to understand whether the presence of the catheter was recorded in the electronic patient record, reason for insertion, and whether a fixation device was in use.

Table 37
Results of Audit

	Audit Findings
Record of insertion on EPR	69 (67%)
Fixation device present	41 (40%) (unable to assess 10 patients)
Reason for insertion documented	48 (47%)

20.2. The IPC/Continence team are currently working with procurement to consider the implementation of a 'catheter pack'. The catheter pack contains all items required to undertake catheterisation and has been demonstrated in some organisations to reduce the rates of CAUTI, be cost effective and sustainable. The main reason for the reduction of CAUTI when using this package is thought to be because the drainage bag comes attached to the urinary catheter. This means that there is a closed system in place reducing the risk of the introduction of infection by 41% (Madeo et al 2005*). Further work is being undertaken and through Procurement the company will assist the IPCT with clinical audit of understanding of adherence to catheterisation guidelines in the clinical area**.**

20.3. The CAUTI workstream is being reintroduced for 2023/24.

Vascular Device Audit

20.4. For 1 week in November 2022 the IPC team conducted a Trust wide audit of invasive devices. A total of 33 clinical areas were visited and 562 patients were reviewed. The results were fed back to the clinical areas at the time of the audit. The aim of the audit was to review:

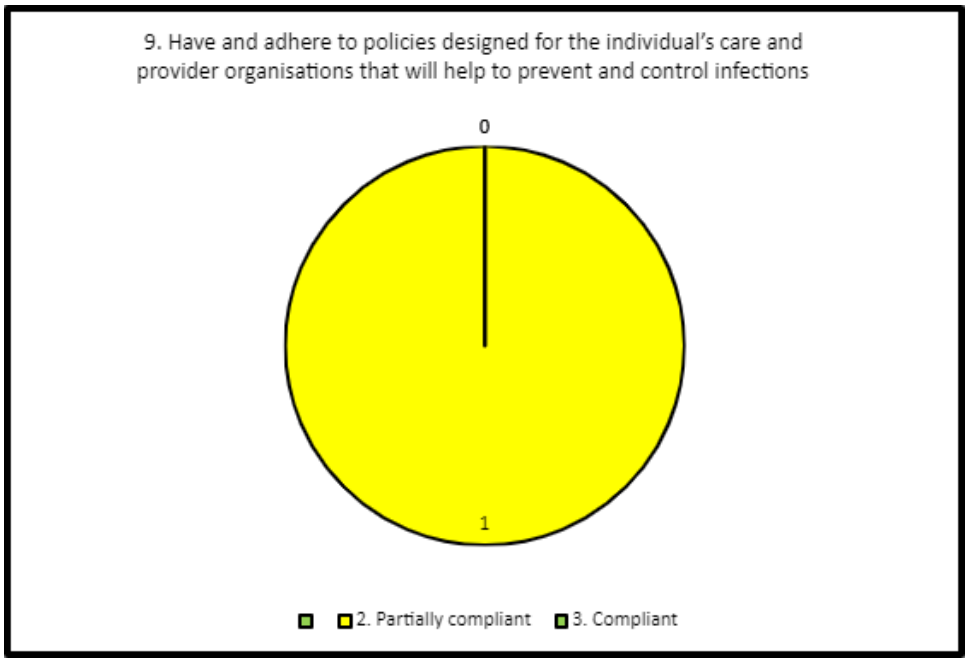
- whether the invasive devices were recorded within the Interactive View section on EPR (CareVue in ITU's) at least once a shift in line with current policy
- if Visual Infusion Phlebitis (VIP) scores were documented at least once a shift as per current Trust policy for peripheral cannulas and central lines.

Table 38
Results from Vascular Device Audit

Peripheral Lines	Central Lines
309 peripheral cannulas were observed of which 261 (84%) were documented on EPR (improvement on previous audit score of 76%) 212 (69%) had a VIP score recorded at least once per shift as per current policy (improvement from the 54% from the previous audit) 252 (82%) of the peripheral cannulas were still indicated for use 282 (91%) had a dressing which was clean, dry, and intact	A total of 43 central lines were reviewed. 91% were documented on EPR 74% had VIP scores recorded at least once per shift 91% were still required 91% had a clean, dry, and intact dressing

Figure 9

BAF Compliance to Criterion 9



Elements of Partial Compliance to the BAF

1 element, 1 partial compliance for:

Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM).

Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

21. Staff health

21.1. The Centre for Occupational Health and Wellbeing (COHWB) are members of HIPCC and present a twice-yearly report. Unfortunately, the OUH was unable to offer the COVID-19 fourth booster alongside the seasonal influenza vaccine, which is likely to have reduced staff uptake as staff had to make their own arrangements to receive the vaccine from other NHS providers.

See section 21 for staff SARS-CoV-2 lateral flow testing programme.

21.2. Flu vaccine rates

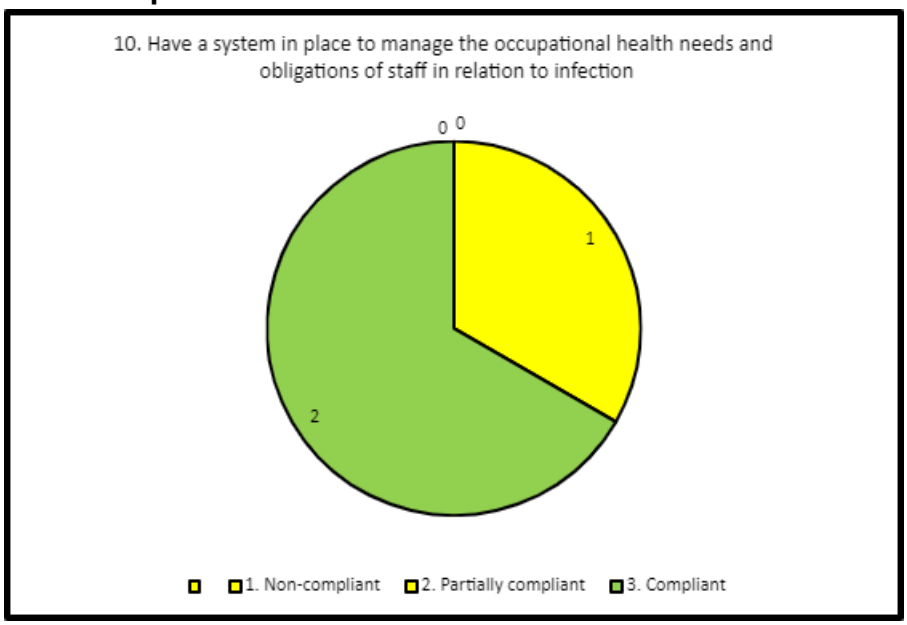
- The final percentage for flu vaccination in front line HCW: 55.3%.
- Total No. of HCW's involved with direct patient care: 12,879

- Total No. of HCW vaccinated with Influenza vaccine since 1st Sept 2022: 7,124

22. Infection Prevention and Control Board Assurance Framework

22.1. NHSE developed a Board Assurance Framework for COVID which was completed and reviewed, as necessary. The new BAF is no longer focussed on COVID-19 and is based on the H&S Care Act domains.

Figure 10
BAF Compliance to Criterion 10



Elements of Partial Compliance to BAF

3 elements, 1 partial compliance for:

- Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting. The non-compliance is that a system of health risk management is currently not in place for skin health (COSHH Regulations). A system of organisational (regular) skin checks is required to ensure cases of occupational dermatitis are identified. This has been raised at Health and Safety Committee.

23. Conclusion

23.1. This report details the work of the IPC teams over 2022-2023 and is set against the Health and Social Care Act (2015) criterion.

24. Recommendations

24.1. The Trust Board is asked to note the contents of this report for information

Appendix 1: IPC Annual Plan 2022-2023

Topic	Metric of Assurance	Q1 Review	Q2 Review	Q3 Review	Q4 Review
Infection Prevention and Control Team					
Lines, Tubes & Device Related Infection (1) Continue to monitor CLABSI rates across intensive care areas and present through the IPC metrics dashboard (2) Continue with monitoring of CLABSI outside of ICU (3) Work towards establishing central line days with EPR team (4) Addition of CLABSI RCA to Ulysses	(1) Benchmark against ICCQIP and prior unit performance (2) Provide CLABSI rates as a proportion of all blood stream infections for paediatric and adult haematology and gastroenterology to establish a benchmark. (3) System in place for monitoring and reporting of CLABSI across the Trust (4) RCAs completed on Ulysses allowing themes to be identified for quality improvement strategies to be developed	(1) All ICU areas are within benchmarking of <2 CLABSIs/1000 catheter days apart from NBICU (2,3,4)	(1) Analysis in progress (2,3,4)	(1) ICU CLABSI rates monitored and presented quarterly at HIPCC by Divisional Governance leads. NBICU is an outlier for Q3. (2) No progress, (3) CLABSI monitoring continues monthly for non-ICU CLABSI, no progress for reporting (4) RCA available on Ulysses, limited uptake and use so far.	(1) Continue to monitor the ICUs and present at HIPCC and PSEC (2) CLABSI reviewed outside of ICUs (3) No progress, working to procure ICNET which will help with this

Gram Negative Bloodstream Infections (GNBSIs) mandate to reduce the number of healthcare associated GNBSI by 50%, by financial year 2024 to 2025. (1) to review current toolbox kit (2) Successful appointment of new band 7 continence nurse/CAUTI prevention and increase hours of existing band 6 nurse (3) Once team fully established develop CAUTI surveillance, prevention and interventions to reduce rates (4) Develop ICS-wide approach with regional colleagues	(1) Audit outcome data (2) Appointment of new nurse (3) System in place for monitoring and reporting of CAUTI across the Trust (4) Feedback from OJICC meeting/ ICS	1,2,3,(4) OJICC discussion July 2022 - Listed as actions to reduce GNBSI in Primary care are TARGET, SCAN guidance, Wound management, Catheter Management, and the UTI prescribing audit.	(1) more detailed review of cases reported to PSEC, further analysis required (2) B7 post offered- to start Jan 2023 (3) Process yet to be established. Audit of urinary catheters planned for Nov 22 (4) Q2 OJICC in Oct	(1) Continued rise in cases. No clear themes. (2) Continence team fully staffed from 3rd January 2023 (3) Analysis of urinary catheter audit results (Nov 2022) underway (4) OJICC Q2&Q3 focus was on national rise in CDI. No ICS-wide approach in place	(1)End of year, finish on trajectory for Klebs & Pseudo, above for E.coli (2)Successful appointment of B7 (started in Jan but PT) (3) Team now established and will look to how CAUTI surveillance may begin. Catheter audit reported in PSEC, improvement in documentation. Bard coming in Q1 to support audit of practice in catheterisation in Trust to inform on whether a 'ready pack for catheterisation may improve practice (4) ICS forming, intention to have a T&F group on GNBSI and interventions.

Information & Education (1) Improve internet information for visitors (2) Review how we present our IPC data in PSEC paper and consider new way of format for annual report (3)Review content on IPC intranet	**(1)** Create a more user friendly internet for external use (2) Evidence of new data presentation (3)Intranet up to date	(1) Discussion with comms re possibilities of change (2) Not yet considered (3) Some updates made	(1) Research of other organisations commenced (2) Consideration of aligned paper to H&S Care Act domains (3) overhaul made, outdate info removed, will need further modernisation	(1)Trustwide changes planned for the internet site, to work with Trust lead on this in next months (2) Annual report writing will commence next quarter, scoping exercise of how this may look to be undertaken (3) work commenced on moving IPC intranet site to SharePoint, stats if use of site reviewed	(1) Not yet progressed (2) Annual report for 2022/23 to be written under headings of H&S Care Act as will Annual Plan 2023/24 (3)Complete, awaiting final meeting before going live
Screening- to ensure all areas that are required to undertake screening are compliant (1) Annual audit of MRSA and CPE screening	**(**1)Paper presented to HIPCC on results of screening audit	(1) Audit not carried out	(1) Audit not carried out. Confirmation from the EPR team received that the changes requested i.e. additional question to Adult KIPI & Children KIPI and rule to drop CPE screen MCS task/order to include the patient transfers to the Critical Care Units was updated at the beginning of September 2022. To allow 6 months after this change to embed, so the earliest date for CPE audit is beginning of February 2023	(1) Audit tool to be updated to reflect changes in CPE screening criteria. Audit planned for end February 2023.	(1) Point prevalence CPE audit undertaken in late March 2023,data analysis to be undertaken with feedback of results/action plan reported in Q1. MRSA audit not progressed in Q4.

Sustainability - (1) work with the sustainability team to help reduce carbon foot print of the Trust, e.g. through appropriate PPE, IV to oral antibiotic switch	(1) Evidence of sustainability project, AMS reports	(1) Scoping work of potential projects	(1) Task and finish group set up to review use of disposable curtains and poor quality pillows. Reviewing potential use of reusable sharps containers	(1) Curtain project currently on hold due to lack of time. Discussions with JnJ around recycling in theatre, continue to attend Green theatre workstream	(1) Number of projects team keen to get off the ground- glove reduction, reusable sharps bins, recycling in theatres, washable curtains, new HH products. Discussions held with Director of Improvement in how we take forward.
Establishment of 7 day working for IPC and AMS teams (1) recruitment into vacancies (2) Completion of consultation period for 7 day working	(1) Posts recruited to (2)Team working 7 days a week	(1) Interview underway	(1) IPC - unable to find suitable B7 for IPC nursing posts. 6 xB6 posts offered. AMS- B7 posts recruited, AMD Nurse JD written, 8A pharmacist post offered. Bowel & Bladder- B6 hours increased, B7 post offered (2) Consultation process underway, not on position to start weekend working	(1) 6 new starters now in post for IPC team , continence and sepsis recruited. 2 sepsis nurses on maternity leave, AMS team working 6 days/week. AMD nurse appointed but not yet started (2) Consultation process not yet concluded as unable to give a start date of weekend working as insufficient skilled staff to cover weekend and week days at present	(1)Progress on business case now reported monthly in PSEC paper and to Productivity Committee. 2 x B7 vacancies in the IPC team, sepsis, AMS, continence now fully recruited. (2)AMS working 6 days a week, poor skill mix at present for IPC team to cover 7 days

Ventilator Associated Pneumonia (1) For rates of Ventilator Acquired Pneumonia (VAP) within intensive care settings and adherence to prevention bundle to be reported via the IPC Metric dashboard to HIPCC (2) Once team fully established review hospital acquired pneumonia surveillance and interventions to reduce rates	(1) VAP rates to be reported by intensive care areas to HIPCC. VAP rates and interventions monitored to demonstrate improvement (2) Process developed to review HAP surveillance	(1) VAP audit on MyAssure - divisions beginning to report on HIPCC dashboard (2) NO progress to date	(1) VAP audit on MyAssure - divisions beginning to report on HIPCC dashboard- more now reporting (2) no progress to date	(1) OCC have demonstrated a significant reduction in VAP in Q1&2 - presented HIPCC Q3 (2) Plan to work with respiratory research nurse to establish rates of HAP on CMU ?? KJ TBC	(1) Adult VAP audit compliance reliably reported to HIPCC, need to start seeing children's. Work this new year will be to set up a VAP group, and to have VAP rates reported to HIPCC (2) Unable to progress at present

Surgical Site Infection (1) To work with surgical specialities to support them to undertake surgical site surveillance. Rates of SSI to be reported to HIPCC through the IPC Dashboard **(2)** To work with specialities that have higher rates than national benchmarks to reduce their rates **(3)** Continue to work with Johnson & Johnson in development of SSI app (4) Re-establish the SSI Group	(1 & 2) Rates presented to HIPCC and benchmark OUH SSI rates against national rates (3) Pilot of app and outcome results (4) SSI Group activity reported to HIPCC	(1 & 2) Rates not being presented to HIPCC yet-phase 2 of the dashboard (3) App now ready for trial (4) SSI leads working with Procurement on antimicrobial sutures	(1 & 2) Rates not being presented to HIPCC yet-phase 2 of the dashboard (3) App now ready for trial (4) Plan for Trust wide bundles being developed, resources being developed. Maternity go live on 1st Nov	(1) Work with maternity and SEU on using the SSI app to record SSI rates continues, only cardiac reporting rates to HIPCC at present. All theatres have now identified SSI champion and received training for SSI reduction. Standard Trust SSI reduction bundle in place and bespoke bundles being developed for plastic, maternity, and updating spinal one. Antimicrobial sutures now being rolled out (2) Monthly meeting continue with spinal service around SSI rates (3) Trial of the app due to commence on 1st March provided contracts are signed (4) SSI group to be reinvigorated with SSI champions, provisional date of 6th March	(1) Conversations with DD of SUWON & NOTSSCaN to consider practical ways of undertaking SSI (2) Ongoing work with spinal but not yet undertaking surveillance (3) App trial to commence May in maternity (4) SSI Group to meet in June

Sepsis					
Improving identification and management of sepsis (1) To continue to ensure that 90% patients with a diagnosis of suspected sepsis receive antibiotics within one hour **(2)** To provide a 5 day week cross site sepsis cover **(3)** To work with specialities where the standards are <90% to improve their sepsis care **(4)** to continue to report sepsis performance on a monthly basis to the board and AMR governance **(5)** Introduce sepsis PGDs to ED/EAU for prompt antimicrobial administration **(6)** Developing the Sepsis Link Nurse role with a register of nurses, training updates and newsletter **(7)** Feedback to clinical areas where cases of septic shock and delayed antimicrobials identified	(1) Monthly audit of ORBIT sepsis data (2)Recruitment to the 2 vacant Sepsis posts. Team working at JR, CH and HGH sites (3) identification of areas for improvement using new Sepsis Agent dashboard and providing teaching and training. Focussing on specific clinical areas during quarterly Sepsis Working Group (4) Monthly audit of ORBIT sepsis data (5) PGD approval, development of e-learning, audit of PGD use (6) Register of cross site link nurses and introduction of newsletter (7) Monthly audit of ORBIT sepsis data and trust board reporting	(1) ongoing, (2) no progress (3) using sepsis dashboard to identify areas of poorer performance, (4) ongoing, (5) PGDs eLearning created, (6) pending, (7) started feedback process including M&M presentations.	(1) ongoing, (2) planned to review end of year - with increased staff cross-site working will be more feasible, increased presence at HGH, (3) using sepsis dashboard to identify areas of poorer performance, (4) ongoing, (5) PGDs approved for ED - running some interviews as a QI project before full adoption, (6) newsletter started, (7) started feedback process including M&M presentations.	(1) ongoing, (2) x2 new sepsis nurses recruited in December 2022. Plan to review September when maternity leave ends and full complement of sepsis nurses, (3) identification of poorer performing areas identified through monthly audit, ongoing engagement with PDN's to provide bespoke teaching, (4) ongoing, (5) progress currently paused due to winter pressure and ED departmental pressure- to review spring time, (6) register for link nurses doubled in 6 months, quarterly newsletter established, (7) feedback process in M&M meetings ongoing, plan to incorporate case studies into upcoming workshops	(1) Ongoing. Achieved in MRC / ED for quarter 1 2023, (2) 4 nurses appointed but 2 on maternity leave, further leaving on maternity in August. Secondment sought, identification of poorer performing areas identified through monthly audit, ongoing engagement with PDN's to provide bespoke teaching, (4) ongoing, (5) pilot introduction in ED, used 3 times to date, (6) link nurse mailing list and well-attended training days, (7) feedback process in M&M meetings ongoing, plan to incorporate case studies into upcoming workshops

Developing the Infection Specialist Nurse role (1) To rebrand as "Sepsis and Infection Specialist Nurses", working alongside Infection Consult and AMS teams to provide advice on investigations and antibiotic choice beyond the first hour of sepsis management	(1) Timetabled participation on consult rounds and educational activities. Joining AMS rounds at the Churchill and introducing AMS rounds to JR site	(1) discussed with Infection Team more broadly. Piloted attendance on JR Consults	(1) ongoing. Now timetabled on a weekly basis with feedback that this has been educational and practically useful	(1) ongoing- regular JR consults attendance established. Plan to re-join AMS rounds at Churchill Hospital starting Jan 2023.	(1) Ongoing. Discussions on how best to introduce IVOS / stewardship aspects into the role, including IVOS rounds of EAU and prompting of penicillin allergy de-labelling

Screening (1) Continue to use the EPR sepsis agent to capture cases of suspected sepsis. Review with clinical informatics if 'reason for triggering' can be presented by the sepsis agent **(2)** Increased bedside review of patients with suspected sepsis and documentation of sepsis / not-sepsis	(1) Review Sepsis Agent with Clinical Informatics (2) Introduction of a Sepsis Review power note and weekly discussion of cases with Sepsis Lead	(1 + 2) new sepsis proforma and proactive reviews	(1 + 2) sepsis proforma and proactive reviews. Discussion of complex / challenging cases ad hoc and at weekly meeting	(1+2) ongoing- discussions of complex/challenging cases with sepsis lead weekly is ongoing	(1+2) ongoing- discussions of complex/challenging cases with sepsis lead weekly is ongoing. Sepsis guidelines likely to be reviewed shortly - no changes to Sepsis Agent in interim.
Antimicrobial Stewardship					
PPS (KPI): annual point prevalence survey in Q1 (JR) and Q2 (Horton) and PPS for Q3 and Q4 as per clinical need: Data recorded includes indication, duration and review, allergy, appropriateness and adherence to guideline. Outputs are examined to see themes for further audit and feedback to teams	(1) Indication and duration recording both >95% 2). Appropriateness >90%	1) achieved 2)72.4% appropriateness	1) achieved 2) 72.5% appropriateness	1) achieved 2) not achieved, this was the first time that surgical prophylaxis specifically was reviewed using the surgical prophylaxis point prevalence survey tool. Areas for review have been identified and will be actioned with local clinical team.	

AMS ward rounds on all sites	(1) Continue to deliver Churchill AMS rounds and JR paediatric AMS rounds (2) establish (and gather data from) Horton AMS rounds by end Q2 (3) establish (and gather data) JR adult AMS rounds by end of Q4 (4) Recruitment to the approved business case posts	(1) weekly AMS ward round delivered at Churchill and Paediatrics 2) Work is ongoing 3)this work has not started yet 4) Band 7 pharmacists are in post, the 8a pharmacist post has been recruited to the 8a AMS nurse post is in development.	(1) Data shows >50% intervention rate in AMS rounds at Churchill and Paeds. Fewer C diff cases at Churchill noted (2) AMS rounds are being undertaken at the Horton, data is being collected and work is on-going to expand the rounds 3)this work has not started yet 4) Band 7 pharmacists are in post, the 8a pharmacist post has been recruited to the 8a AMS nurse post is in recruitment process.	(1) Wards round on-going and interventions are being collated. (2) AMS rounds are being undertaken at the Horton, data is being collected and work is on-going to expand the rounds. Positive feedback from the local clinical teams and ID teams at the Horton. 3)this work has not started yet 4) Band 8a AMS nurse post has been filled and is in final stages of recruitment process.	
Reduction of watch and reserve antibiotics (National Standard Contract)	(1) Monitor on a quarterly basis and use feedback to inform prescribing practice (2) By end of Q4 achieve a 4.5% reduction in use of Watch and Reserve antibiotics	1) this work in on-going 2) the trajectory to date suggest we should be on target to achieve this	1) this work in on-going 2) the trajectory to date suggest we should be on target to achieve this	1) this work in on-going and we are still exploring how to automate this work 2) the trajectory to date suggest we should be on target to achieve this (last national data was end of Q2 22/23)	
Guideline development and maintenance	(1) 100% review of all guidelines in MicroGuide within 3 years rolling basis	Work is on-going for adult and paediatric guidelines	Work is on-going for adult and paediatric guidelines	Work is on-going for adult and paediatric guidelines	

Appendix 2: IPC Strategic Plan 2023-2025

Strategic Plan 2023-2025

Key line of Enquiry	Deliverable	Lead	Deputy Lead	Progress			
Aim	**Action required for aim to be deliverable**			**Q1**	**Q2**	**Q3**	**Q4**
Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them							
To deliver a 6 day service from a appropriately skilled IPC team	(1) Re-commence the consultation process (2) Recruit 2 further experienced IPCP (3) Recruit 8A (4) Consultation process to be successful (5) Develop SOP for agreement of remit of working on a Saturday (6) Rota to be developed with support from Healthroster (7) Aim for all IPC practitioners to have a basic IPC qualification (8) All IPCP to complete IPS competencies	LB	Band 8A	(1)The consultation process to move to 7 day working commenced July 2022 but not closed due to not having a start date for weekend working. Process has been restarted in July (2)band 7 post offered to external candidate, awaiting start date (3) Band 8A post not signed off in Q1 (4) Team to be written to again re start date (5)Not yet commenced (6) KPMG revisited to consider staffing level numbers/skill mix (7) CPD requests submitted (8) IPS competencies part of team and individuals objectives			

For Ventilator Associated Pneumonia (VAP) rates and compliance to reduction bundles for all intensive care areas to be reported in Divisions HIPCC dashboard (baseline data for VAP from coding available for 2022/23).	(1) VAP group to be established (2)Agreement of a definition of VAP in (a) adults (b) children (3)Review of literature to understand acceptable rates of VAP (4)Agreement on a standard bundle for adult areas (5)Agreement on a standard bundle for children and neonates (6)Develop audit tool based on agreed bundle (7) Standardisation of products e.g. mouthcare products (8) Agree methodology for surveillance (9) Undertake surveillance (10)Develop HIPCC dashboard to include VAP rates and bundle compliance (11)Consider reporting method for VAP e.g. Ulysses	LB/LRK	MT	(1) VAP group established (2-8) work commenced on agreement of these topics (9-11) will commence after agreement on other topics			
For Catheter Associated Urinary Tract Infections (CAUTI) rates and compliance to reduction bundles to be reported in Divisions HIPCC dashboard (baseline data for VAP from coding available for 2022/23).	(1) CAUTI group to be established (2)Agreement of a definition of CAUTI (2)Review of literature to understand acceptable rates of CAUTI (3)Agreement on a standard bundle (4) Develop audit tool based on agreed bundle (5) Standardisation of products (6) Agree methodology for surveillance (8) Undertake surveillance (9)Develop HIPCC dashboard to include CAUTI rates and bundle compliance	SM/SH/OO	LB	(1) Preliminary work commenced			
Review and refresh current process for undertaking RCA/questionnaires for MRSA/MSSA/C.diff/GNBSI in consideration of the PSIRF and BOB	(1) Work with patient safety team, BOB and clinical reps to review current process (2) Streamline questionnaires (3) Agree process for management of IPC incidents	SW		(1) Preliminary work commenced (2) COVID-19 RCA reviewed (3) Not yet confirmed			

IPC e- learning to be reviewed to ensure that reflects the new NHSE Infection prevention and control education framework and national changes to policy	(1) Gap analysis of updates to current policy (2) Update current package to be in line with guidance	CS		(1) Up to date list of policies being pulled together (2) hand hygiene policy, birthing pool guidance, animals in hospital, chicken pox, pertussis, SSI, outbreak updated			
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections							
Review and update the decontamination intranet site	(1) Assess current content (2)Update to ensure in line with national guidance/legislation/trust practice	MHF	LB	No progress this quarter			
Review of current disposable curtains and pillows to improve sustainability and reduce cost	(1) Workstream with stakeholders to be recommenced- actions to be agreed with group	LB		(1) Meeting arranged but was cancelled due in unavailability of key members			
Review of current cleaning products	(1) Review of alternative products to bleach ensuring sporicidal cover	LB	MHF	(1) Peracide considered but discounted as doesn't meet correct EN standard. Looking at alternative sporicidal products			
Review current hand hygiene care products and consider options	(1) Stakeholder group to be set up	LB		(1) Procurement undertaking preliminary back ground work			
Trustwide audit of current decontamination practice to be undertaken for assurance of good practice and review of where procedures are occurring in (1) Semi- invasive probes (2) surface probes used for undertaking invasive procedures	(1) Develop audit tool (2) Develop priority list (3) undertake surveillance (4) Report to Trust decontamination committee	MHF	LB	(1) Not yet progressed			
Criterion 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance							
PPS : Annual point prevalence survey with each quarter focusing on one clinical area that has been shown to have a high level of antibiotic use and/or a low level of adherence to guidelines or appropriateness.	(1) Indication and duration recording both >95% 2). Appropriateness >90%	AMS team					

We would aim to evaluate the whole trust once each year. Data recorded includes indication, duration and review, allergy, appropriateness and adherence to guideline. Outputs are examined to see themes for further audit and feedback to teams.							
AMS ward rounds on all sites : A multidisciplinary ward round involving AMS pharmacists, AMS nurse, ID/Micro Consultant or registrar and local clinical team where antibiotic prescriptions are evaluated for adherence to guideline and appropriateness and recommendations are then discussed with the team looking after the case. They happen across all sites on a weekly basis in adults and paediatrics.	(1) Continue to deliver AMS rounds across all sites (2) identify areas of need for focused audit including further scrutiny related to AMS and implement AMS activities.	AMS team					
Reduction of watch and reserve antibiotics as per National Standard Contract	(1) Monitor on a quarterly basis and use feedback to inform prescribing practice (2) By end of Q4 achieve a 10% reduction in use of Watch and Reserve antibiotics compared to baseline period (2017)						
Guideline development and maintenance	(1) 100% review of all guidelines in MicroGuide (adult and paediatrics) within 3 years rolling basis						
Criterion 4: Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion							

To review, update and move IPC intranet to SharePoint	(1)Undertake SharePoint training (2) Review current content on intranet site (3) Transfer to SharePoint site (4) Set go live date (5) Ask for feedback, monitor reviews an incident reports	GP		(1) Training by undertaken by those who will be updating the site (2)Content reviewed (3) Transfer to SharePoint complete (4) Site launched (5) Forum for users now available to feedback to team			
Procurement of IPC surveillance system to replace current unsupported system	(1) Key stake holder groups- BOB/South 4pathology network - decision to be made whether to alone as trust or jointly (2) Project group to be organised-needs to be run by IT (3) Business case to be written	LB/KJ		(1) Key stake holder conversations held, seems unlikely that a joint procurement can occur (2) Quote for IT requirements received and is significant (3) CMO suggest submitting a business case			
Training programme to support the Link Practitioners	(1) Two study days to be held for the link practitioners (2)Update of competency framework	OO		(1)Workshop held in June, second planned for July(2) Competencies updated			
Criterion 5: That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.							
Screening compliance audits of CPE/MRSA	(1) Conduct annual audit of MRSA and CPE screening compliance			(1)March CPE audit results presented to HIPCC in June, increase in compliance noted. MRSA audit commenced			
Develop EPR Care plans	(1) Review current IPC care plans (2) Develop list of care plans required (3) Produce care plans	RM		No progress this quarter			
Criterion 6: Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.							
Criterion 7: The provision or ability to secure adequate isolation facilities							
Criterion 8: The ability to secure adequate access to laboratory support as appropriate							
Criterion 9: That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.							

Ensure that all policies/protocols are up to date and include alignment where appropriate to the National Infection Prevention and Control Manual implementation	(1) Policy tracker to be developed and presented at monthly team IPC meeting (2) NIPCM compliance to be assessed against current policies (3) Gap analysis of existing policies against Code of Practice (4) Update policies as expire to conform where appropriate with NIPCM	JB/LB	LB	(1) Policy tracker under development (2) As policy review dates come up, NIPCM included in reference (3) Yet to be undertaken (4) In progress			
Gloves Off Campaign - to reduce inappropriate glove use	(1) Quality Improvement project - stakeholder group to be established (2) Work plan to be developed (3) Pilot site to be agreed (4) Campaign material to be developed	AS/B6 team	LB	(1) Group established (2)Workplan developed (3)NOC agreed to be the pilot site (4) to be progressed			
Use of audits to improve practice	(1) Current IPC audits to be reviewed and updated (2) Consider if further audits need adding (3) Work with divisions to review action plans (4) Present results/action plans at HIPCC	SW		(1) Number of audits updated including sharps, ANTT, Hand Hygiene, CAUTI			
Criterion 10: That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.							
Review of sharps disposal for improving safety and sustainability	(1) Stakeholder group to be set up (2) Actions to be agreed	LB		(1) Initial meeting held for high level discussion, further discussion required between waste contractor, procurement and sharps company			
Review of current IPC Team objectives and structure of team meetings	(1) Agree team objectives and share (2) Monitor progress at monthly team meeting (3) Review current team meeting function and structure (4) Agree new standing agenda (5) Incorporate into team meeting	LB	LRK	(1) New team objectives agreed (2) Yet to have a meeting since new objectives agreed (3) Current team meeting structure reviewed and updated (4) New agenda decided and agreed (5) Will be incorporated from July			

Appendix 3: IPC Board Assurance Framework

Infection Prevention and Control Board Assurance Framework v0.1						
	Key Lines of Enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**	**Comments**	**Compliance rating**
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	The Hospital Infection Prevention and Control Committee (HIPCC) is chaired by the DIPC and meets monthly. A monthly IPC report is provided to Patient Safety & Effectiveness Committee (PSEC) which reports to Clinical Governance Committee (CGC), IPC attend this committee. Any concerns raised by IPC at PSEC are escalated to CGC. There are regular DIPC meetings between the DIPC, IPC lead and the Chief Medical Officer who reports IPC matters to the board. The IPC team work collaboratively with the ICS, BOB partners, NHSE, and Thames Valley Health protection Team. There is a Lead for IPC and a team of IPC practitioners, Continence nurses, Sepsis nurses and an antimicrobial stewardship team.	None identified	N/A		3. Compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	HIPCC receives monthly IPC reports from the Divisional teams and regular reports from: • UKHSA/local Health Protection Team • Oxfordshire Clinical Commissioning Group (CCG)	None identified	N/A	IPC dashboards have improved over the year, next step will be to have the action plans pulled through from Ulysses and shared at HIPCC. Phase 2 of the IPC dashboard planned for	3. Compliant

		• Antimicrobial Stewardship Team (AMST) • OUH Estates and Facilities • Soft Facilities Management • Centre for Occupational Health & Wellbeing (COHWB) • Cardio-thoracic surgical site infection report • Decontamination Committee • IV Steering Group Reports are reviewed and discussed at HIPCC; action log maintained.			2023/24 to start to include other HCAI information e.g. Catheter associated infection (CAUTI), hospital acquired pneumonia (HAP), ventilator associated pneumonia (VAP), Surgical site infection (SSI)	
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	The OUH has a culture that promotes the reporting of incidents. The IPC team have twice weekly incident huddles to review any IPC related huddles. They work closely with the Patient Safety Team and are reviewing current investigation process in line with PSIRF.	None identified	N/A	Work 2023/24 will be to review current processes.	3. Compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	The IPC team are including reference to the manual when updating policies. It is available on the IPC intranet.	Policies will be updated as expire to include reference to the manual.	Existing policies do not contradict manual	Policies to be updated in 2023/24	2. Partially compliant
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	Surveillance of mandatory organisms is reported, COVID-19 outbreaks reported to the National Outbreak portal, other outbreaks managed as per outbreak policy. End of year figures for mandatory organism (trajectory number in brackets) C.diff 141 (104),MRSA 3 HOHA 1 COHA, E.coli 208 (161) Pseudomonas 56 (57), Klebsiella 87 (91)	None identified	N/A	Plan to include non-mandatory surveillance in 2023/24 of HAP, VAP, CAUTI, SSI	3. Compliant

1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	The trust reports mandatory organism surveillance data to UKHSA. The Trust is moving to audits being recorded on Ulysses & the IPC team are refreshing content of their audits. Divisions report HCAI numbers to HIPCC, audit results, incidents, IPC related risks, action plans. Key points for escalation are taken to CGC. IPC prepare monthly report to PSEC, bi-monthly report for CMO. Mandatory IPC training available on line. Systems in place to recognise outbreaks.	The current IPC surveillance system has been withdrawn, leaving us with a unsupported system. The implication of this is that IPC team will not be alerted to patients being admitted with infectious organisms or new results in real time. HCAI rates for VAP, HAP, CAUTI, SSI surveillance not routinely collected.	The IPC team have taken steps to reduce risk through manual checks but ultimately a new IPC surveillance system is the only solution. Baseline audits of VAP, HAP, CAUTI now undertaken to form next steps. Securing ICNet would improve efficiency of surveillance	VAP, HAP, CAUTI baseline rates for 2022/23 known, interventions for improvement to be planned for 2023/24	2. Partially compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	Online IPC mandatory available to all staff, covers the Skills for Health Framework. Divisions responsible for ensuring staff undertake training and reporting compliance rates.	None identified	N/A	IPC e- learning will be reviewed 2023/24 to ensure that reflects the New Infection prevention and control education framework (NHSE)	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	IPC/Occupational Health/Health and Safety worked collaboratively to develop risk assessment tools around hierarchy of controls, updated regularly and available on the OUH intranet. IPC/Estates/H&S available to support clinical areas	None identified	N/A		3. Compliant
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						

2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	A task and finish group is set up to implement the NSoC. This addresses as part of the working group which is now a quarterly meeting with service providers and Trust. Strategic Cleaning Policy has been updated in line with the new standards. Cleaning audits are carried out on set frequencies by multi-disciplinary teams. Failures are addressed post audit by the responsible parties. Audit frequencies are increased where cleaning standards on areas have declined. Monitored by the PFI Contract Management team. Trust assurance audits completed on Synbiotics and departmental audits of equipment are completed on MyAssure. Audits presented at HIPCC.	Where an area/dept falls below the agree standard of clean during an audit for that area dependant on risk.	Rectify failures, work with IPC, department and service provider to understand failures. Review training, equipment, performance. Re audit and increase monitoring until we have the assurance the area is to a safe clean level.		3. Compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	Led and managed by the Patient Experience Team. Actions are shared with responsible parties to rectify or mitigate reason to why actions cannot be completed.	Awaiting outcome for the actions required from 2022 assessment		Doesn't sit with IPC team	0. Not applicable

2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Strategic Cleaning Policy has been updated in line with the new standards which identifies roles and responsibilities for maintain a clean environment, along with IPC and Department policies for clinical equipment and decontamination. Cleaning Charters displayed on all wards and departments identifying roles and responsibilities. Service providers contract have been reviewed and updated to adhere to the NSC21.	Trust staff and service providers not always aware of their roles and responsibilities.	From the audits carried out, we are able to address any anomalies in responsibilities and advise/train. The IPC team recruited a Clinical Decontamination Practitioner to support clinical areas and decon/cleaning practice		3. Compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	There is an established WSG and VSG with appropriate policies and guidelines, following relevant HTMs. The meetings are held quarterly and IPC attend. The VSG receive updates on ventilation assessments from the operational estates and all 3 PFI partners. The VSG reports into the Health and Safety Committee and operational estates report ventilation concerns to HIPCC. The WSG is chaired by the Lead IPC Nurse and is attended by operational estates, the 3 PFIs and all produce a compliance report. HIPCC receives a report from operational estates and from the PFI office. It has been agree now that WSG will also provide exception reporting to health and Safety Committee. IPC also reports ventilation and water concerns through the monthly Patient Safety and Effectiveness Committee.	None identified	N/A		3. Compliant

2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	With Estates to answer re PPM section. IPC are involved in all new projects. They attend the Project Compliance and Co-ordination Group, Estates Compliance Group and Project meetings.	None identified for new projects	N/A for new projects		3. Compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Linen stored in dedicated facilities, policy in line with the HTM.	Issues with linen inappropriate storage of linen in the Churchill	Plan in place to resolve linen being stored in the corridor		3. Compliant

2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Classification & Segregation: • Acceptable waste receptables & bags used for Sharps, Non-Sharp Clinical & Non-Clinical waste. • BioTrack labels. Storage: • Bins used are metal, fully enclosed (lidded) and foot operated. • Recycle - Corridor boxes. • Confidential – locked Cabinets, 240Ltr or 120Ltr bins. • Green/Grey 1100Ltr waste wheelers- used for domestic waste bags, recycling bags & cardboard. Transport: • Clinical Waste collected by Tradebe to Swindon: • CH & NOC six days a week. • JR seven days a week. • HGH three days a week. • KHH Clinical Waste collected by Grundon 2 days a week. • Recycling Waste collected by Grundon using Front End Loaders (FEL) lorry and tipped on site, 5 days a week. Recycling Compactor also used and emptied on request. • Domestic Waste collected by Grundon via exchange or empty of compactors on weekly, bi-weekly schedules or as and when requested. • Cardboard collected by Trigg via Grundon monthly. • Confidential Waste collected by Restore scheduled collections from wards & dept's and shredded off site. • Metal Waste collected by Grundon & Metal Salvage and collected on	• Waste Policy is currently being updated. • Implementation of Offensive Waste to achieve 20:20:60 set out by NHSE. KHH and NOC site have been audited and changed over completed. • HGH Site Audit completed but no recorded received. However, there has been a changeover of bags in bins situated in corridors & OPD. • CH Site audit has been completed. • JRH site to be audited.	Not fully implemented due to Tradebe Account Manager leaving. No changeover implemented due to Tradebe Account Manager leaving.		2. Partially compliant

		request. • WEEE Waste collected by Grundon via a skip exchange & TOC Recycling collect on request using 7.5T lorries. Disposal: • Clinical Waste is segregated @ Swindon. Incineration – Fawley. Alternative Treatment – Swindon. Offensive waste – Swindon. • Domestic Waste – Energy from Waste (EfW) – Colnbrook. • Recycling Waste – sorted and separated at MRF's – Colnbrook. • Metal Waste – recycled – Colnbrook. • WEEE Waste – Skip exchange to Ewelme. • Loose WEEE Waste – collected & segregated at contractors' site in Leighton Buzzard. • Yellow locked 770Ltr waste wheelers used for orange bags, yellow bags, and waste receptacles. • These are stored in designated waste holds internal & external & moved, by use of tugs, to waste compounds. Packaging: • Cardboard & acceptable plastic packaging along with metal is recycled. • Polystyrene disposed by general waste skip.				

2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Bi-monthly Decontamination Committee, reports received from Sterile Services, Endoscopy. New post commenced March 2023 of Clinical Decontamination Practitioner to support decon across the trust. AE[D] undertakes JAG audits of endoscopy. Automated HLD for semi-invasive probes	Potential of semi-invasive ultrasound been undertaken in areas unknown to us	Trustwide audit to be undertaken	Trust wide audit of current decon practice to be undertaken for assurance of good practice and review of where procedures are occurring	3. Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Trust policies and processes in place regarding food hygiene regulations and what food can and can't be bought in for patients and how it is to be stored. Food bought in for patients cannot be reheated on site. Clinical staff must document on patient notes if a patient who consume food not provided by the catering team. All clinical staff complete a basic level of food safety training for ward level food service. The catering department and ward hosts complete higher levels of food safety and manage, clean and monitor the ward kitchen equipment and temperatures. Food bought in by staff for consumption must be kept separate to patient food and stored in a designated staff refrigerator in a staff area.	If regulations are not adhered to.	Internal catering audits and reviews carried out regularly to make sure all are adhering to policy.		3. Compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	There is a lead physician for AMS within the organisation and there is board-level leadership for AMS from the Chief Medical Officer. There is an AMS policy, and an AMS team (covering adult, paediatrics and	None identified	N/A		3. Compliant

		neonates) allowing arrangements for AMS to be maintained.				
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	The AMS team provide a quarterly report to the Hospital Infection Prevention and Control Committee about AMS activities and progress in stewardship work (adults, paediatrics and neonates) and contribute to the annual report for the board from Infection prevention and control	None identified	N/A		3. Compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	The CMO provides board-level leadership with a combined IPC (including decontamination) and antimicrobial stewardship role.	None identified	N/A		3. Compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.	A baseline assessment was conducted against NG15 in 2016 and the Trust was compliant with the guidance. Since then many more stewardship interventions have been implemented to optimise patient outcomes, minimise inappropriate prescribing. The principles of Start Smart Then Focus underpin all of the AMS work and are also referred to in the trust antimicrobial guidelines as well as in education provided re AMS. There is a quarterly point prevalence survey to assess appropriateness of antimicrobial prescribing and the results are fed back to clinicians to help inform practice and develop solutions to any points raised. There is an antimicrobial consumption dashboard on Orbit+ which allows comparison of prescribing to peers	None identified	N/A		3. Compliant

		as well as comparison between specialities.				
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	Reporting: the AMS team submit quarterly the outcomes of the AMS CQUIN to UKHSA and the progress with the AMS related Key Performance Indicators are submitted to ICB. The results of the national standard contract related to AMS is extracted directly by UKHSA. The results of each of these are included in the quarterly report to the Hospital Infection Prevention and Control and overall themes are included in annual board report. These CQUINs and KPIs look at different elements each year but they cover the points raised in column B.	None identified	N/A		3. Compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	A quarterly point prevalence survey looks at appropriateness of prescribing and this has covered all sites across the trust. Paediatrics and neonates also review appropriateness of antimicrobial prescribing. There are multiple AMS ward rounds each week which allow review of infection management in patients and provide feedback about treatment plans to clinical teams. There are multiple audits and service improvement projects undertaken each year by the AMS team looking at range of topics in range of areas all of which allow measure of adherence to practice and identify areas for improvement.	None identified	N/A		3. Compliant

4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	IPC will use national resources for patient leaflets to ensure meets needs of the population. HIPCC has patient rep.	None identified	N/A		3. Compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	IPC information on trust web site. IPC intranet site currently being moved to SharePoint and content reviewed	Information in need of a refresh for external audience	N/A	Internet update required	3. Compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	Information leaflet is available for patients given an antibiotic during their admission or at discharge which provides advice about use of antibiotics and supports AMS agenda to reduce AMR. An antifungal patient information leaflet has been developed and awaiting launch. There have been updated information lists for MRSA decolonisation and one for skin decolonisation prior to procedure.	None identified	N/A		3. Compliant

4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Signage around hospital around mask wearing	Outdated signage- needs refreshing			2. Partially compliant

4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Patients with infectious conditions are 'flagged' on their electronic record. The flagging system is covered in the IPC eLearning programme. There is an interhospital transfer form for staff to complete and identify infection risks.	The current IPC surveillance system has been withdrawn, leaving us with a unsupported system. The implication of this is that IPC team will not be alerted to patients being admitted with infectious organisms or new results in real time.	The IPC team have taken steps to reduce risk through manual checks but ultimately a new IPC surveillance system is the only solution.	Progress with procurement of ICNet	2. Partially compliant
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.						
Systems and processes are in place to ensure that patient placement decisions are in line with the NIPCM:						
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Patients with known infectious conditions eg MRSA colonised are flagged on the EPR system, staff are training on understanding the system and expected to check patients on admission. Automated EPR triggers for patients that require screening for MRSA and CPE prompts through the KPI. Audits undertaken to review CPE screening compliance. IPC work closely with Ops team to prioritise single rooms	The current IPC surveillance system has been withdrawn, leaving us with a unsupported system. The implication of this is that IPC team will not be alerted to patients being admitted with infectious organisms or new results in real time.	The IPC team have taken steps to reduce risk through manual checks but ultimately a new IPC surveillance system is the only solution.	Progress with procurement of ICNet	2. Partially compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and	As above, IPC team will follow up where possible to ensure safe management. At a Glance's available on IPC intranet for quick guidance	None identified	N/A		3. Compliant

	documented in the patient's notes.					
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Interhospital transfer form, plus flag on EPR to ensure communication around status. Incident reports monitored to assess if any gaps.				3. Compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	The IPC team have developed a suite of isolation posters which are accessed through the IPC intranet, based on NIPCM. Correct use of isolation posters part of IPC eLearning	None identified	N/A		3. Compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	There is a policy on outbreak management which defines management and governance process.	None identified	N/A		3. Compliant
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	Online IPC mandatory available to all staff, covers the Skills for Health Framework. Divisions responsible for ensuring staff undertake training and reporting compliance rates.	None identified	N/A	IPC e- learning will be reviewed 2023/24 to ensure that reflects the New Infection prevention and control education framework (NHSE)	3. Compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	As above, divisions responsible for ensuring staff undertake training and for monitoring compliance.	None identified	N/A		3. Compliant

6.3	Monitoring compliance and update IPC training programs as required.	As per comments in 6.1 and 6.2	None identified	N/A		3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	Part of eLearning and divisions have nominated Practice Education leads responsible for donning/doffing, PPE selection. Records held centrally. Resources including videos, posters are available on the IPC intranet and OxSTaR website. The Fit Testing team continue to fit test to a minimum of 2 FFP3 models	None identified	N/A		3. Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	As per 6.4	None identified	N/A		3. Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	ANTT training part of student nurses/medical students training. IPC run injectables courses, ANTT audits undertaken by clinical areas and reported to HIPCC. Competency will be recorded in MLH	None identified	N/A		3. Compliant
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						

7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Protocols in place for undertaking screening of potentially infectious patients. Recent CPE audit of compliance of screening undertaken results improved since last audit. Patient records- flag for biohazard if required, recognition of biohazard flag in IPC e-learning but not always observed by staff. Limited number of single rooms in some parts f the Trust.	Non recognition of biohazard flag, inappropriate placement of patients. IPC not always aware of patients in wards with biohazard flag due to antiquated IT surveillance systems	IPC support operational team in prioritising single room use. Ulysses monitored for incorrect patient placement, or non-recognition of biohazard flag- followed up by IPC/reviewed in twice weekly IPC incident review meeting	ICNet business case to be written	2. Partially compliant

7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	IPC team work with clinical areas and operational team to support prioritising of side rooms and advise on patient management if unable to place in single rooms. Cohorting occurs when appropriate. Ward refurbishments during pandemic with increased numbers of single rooms and improved mechanical ventilation	Due to operational pressures, infectious patients may not always be moved out of bays immediately. Not always sufficient single rooms to isolate in single rooms	IPC support operational team in prioritising single room use. Ulysses monitored for incorrect patient placement, or non-recognition of biohazard flag- followed up by IPC/reviewed in twice weekly IPC incident review meeting.	ICNet business case to be written	2. Partially compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	TBP -IPC working to update terminology from barrier nurse to TBP, NIPCM being implemented through polices, IPC link practitioner workshops rolling out TBP. Isolation posters available on IPC intranet	Signage not always appropriate if patient in a bay with TBP in operation	Ulysses monitored		3. Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	Clinical areas aware of this, interhospital transfer form available for patients being transferred to other health and social care facilities	Not formally audited so unclear on compliance	Ulysses monitored, does not suggest there is an issue with compliance		3. Compliant

8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	Competency Records as per requirement for ISO15189 controlled by the lab manager. Laboratory test repertoire is accredited by UKAS .	None identified	N/A		3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Electronic requesting and reporting systems in place to facilitate early and accurate dissemination of information. Automated reporting via SGSS to UKHSA in place. Laboratory staff comply with Health Protection notification requirements for urgent notifiable organisms. Clinical oversight is provided at all times with 24/7 availability of Microbiology/Infectious Disease SpRs and Consultants.	None identified	N/A		3. Compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	The laboratory is fully accredited via UKAS to ISO15189 standards. SOPs are in place for all aspects of the testing process. Contracts are in place where required for external service users. Turnaround times are monitored, including for external users such as NHSBT to support the transplant donor characterisation programme.	None identified	N/A		3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	As per section 5	None identified	N/A		3. Compliant

8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Local guidelines, which reflect national guidelines in place for testing/retesting	None identified	N/A		3. Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	Laboratory is able to respond to requests to increase workload or introduce new tests to support outbreak investigation e.g. Candida auris outbreak. Protocols in place to support IPC, plan to undertake inhouse sequencing to support and understand outbreaks	None identified	N/A		3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Competency Records as per requirement for ISO15189 controlled by the lab manager.	None identified	N/A		3. Compliant
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an	A-Z resource recently provided, will be a resource for the IPC team. Policies and procedures in place, including outbreak policy	Policies will be updated as expire to include reference to the manual.	N/A		2. Partially compliant

	outbreak/incident by the registered provider.					
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	• Occupational health provides risk assessment and advice to the Trust for those HCW vulnerable to Covid19 infection. • Occupational health advises on pregnancy risk assessment via management referral where specialist work related advice is requested e.g. where a pregnancy is complex and requires more specialist advice on reasonable adjustments.	Nome identified	N/A		3. Compliant

10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	• Occupational health are notified of infection risk outbreaks in line with Trust and occupational health policy. Groups of staff are assessed for evidence of immunity to those occupationally relevant biological health risks and followed up where relevant. • Occupational health specialist assessment and advice is in place for cases of occupational dermatitis. With onward referral to further specialists where appropriate. • Occupational health provides HCW with advice and follow up, following contamination incidents /exposure to blood borne viruses.	• A system of health risk management is currently not in place for skin health (COSHH Regulations). A system of organisational (regular) skin checks is required to ensure cases of occupational dermatitis are identified.	• Occupational health are currently developing a guidance document outlining the system required for organisational legal compliance.		2. Partially compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Occupational health provides new starter immunisation assessments and occupational immunisations for HCW in non- EPP and EPP roles. In line with DH and UKHSA and NICE guidelines.	None identified	N/A		3. Compliant

Appendix 4: Hospital Infection Prevention & Control Committee Business Cycle 2022/23

			Q1			Q2			Q3			Q4	
	Apr 2022	**May 2022**	**Jun 2022**	**Jul 2022**	**Aug 2022**	**Sept 2022**	**Oct 2022**	**Nov 2022**	**Dec 2022**	**Jan 2023**	**Feb 2023**	**Mar 2023**	**Lead**
CSS Divisional Report	X	**May meeting rescheduled to 1st June**	X	X	X	X	X	X	**December meeting cancelled**	**January meeting rescheduled to 8th February**	X	X	**CSS**
MRC Divisional Report	X		X	X	X	X	X	X			X	X	**MRC**
NOTSSCaN Divisional Report	X		X	X	X	X	X	X			X	X	**NOTSSCaN**
SUWON Divisional Report	X		X	X	X	X	X	X			X	X	**SuWOn**
Antimicrobial Stewardship			X			X		X				X	**LD/NJ**
Contracts Team PFI Cleaning Report PFI Water management Report	 X X		 X X	 X X	 X X	 X X	 X X	 X X			 X X	 X X	 **DA** **CHa**
Estates & Facilities	X			X	X		X				X		**AM**
IPC Clinical Governance Report/ IPC Patient Safety & Clinical Effectiveness Report	X		X	X	X	X	X	X			X	X	**IPC**
IPC Risk Register	X			X	X							X	**IPC**
OCCG/BOC ICB Briefing Paper	X			X			X				X		**HM**
Occupational Health & Wellbeing	X							X			X		**CE**
UKHSA Briefing Paper			X	X		X		X				X	**CH/DR**
SSI Cardiac			X	X		X		X					**SH**
Committee Reports													
Decontamination Committee	X				X						X		**IPC**
IV Steering Group				X		X						X	**IPC**
Reports / Policies													
IPC Annual Plan			X	X			X				X		**IPC**
IPC Annual Report				X draft			X						**IPC**
CLABSI Surveillance Report 2021-2022			X										**IPC**
SSI Update			X										**ZS**
Water Cooler/Ice machine Procedure			X										**IPC**

Guidelines for Animals in the Hospital Setting					X								**IPC**
TB Guideline					X								**IPC**
High Consequence Infectious Disease Plan							X						**DS**
Ventilator associated pneumonia update								X					**CS**
TB Guideline								X					**IPC**
Policy for Prescribing, Preparing & Administering Injectable Medicine in Clinical Areas								X					**PW**
Guidance for the Management of Patients & Staff with Varicella/Herpes Zoster												X	**IPC**
Guidance for the Management of Patients & Staff with Pertussis, or Exposed to Pertussis												X	**IPC**
Hospital Outbreak, Closure of Wards, Department & Premises to New Admissions												X	**IPC**
Reducing Surgical Site Infection, Surgical Pathway for Adults & Children												X	**IPC**