Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 11 September 2024

TB2024.74

Title:	**Infection Prevention & Control Annual Report 2023-24**

Status:	**For Information**
History:	**Annual report**

Board Lead:	**Chief Medical Officer**
Author:	**Lisa Butcher, Lead Nurse & Manager, Infection Prevention & Control / Deputy Director of Infection Prevention & Control** **Professor Katie Jeffery, Director of Infection Prevention & Control**
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 2023 and March 2024. 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, midwifery led units, radiotherapy 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 2023-24 OUH complied with all external reporting requirements.
4. 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

5. The Trust reported 4 HOHA and 2 COHA cases of MRSA bacteraemia. NHSE has a zero-tolerance policy for MRSA bacteraemia but there is no threshold set.

Methicillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

6. The Trust reported 43 HOHA cases and 27 COHA cases for 2023-24. There is no threshold set by NHSE for MSSA.

Clostridioides difficile (*C. difficile*)

7. The OUH reported a total of 130 cases in 2023-24 (124 in 2022-23). This was above the NHSE trajectory set at 103 cases.

Gram negative blood stream Infections (GNBSI)

8. 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 2023-24, the OUH exceeded the required trajectory for Klebsiella sp. BSI, Pseudomonas BSI and for E. coli.

Central Line Associated Bloodstream Infections (CLABSI) surveillance in the Intensive Care Units

9. CLABSI surveillance is undertaken for all the intensive care areas by the IPC team.

Audits

10. Point prevalence audit undertaken in March 2023 to measure compliance with screening for Carbapenemase-Producing enterobacteracieae (CPE) in line with Trust CPE Guidelines.

Surgical Site Infection (SSI)

11. Information is submitted to the UK Health Security Agency (UKHSA) for: 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.
12. A pilot of undertaking SSI surveillance digitally was successfully undertaken in caesarean sections and for emergency surgery patients.
13. A review by NHSE Specialist Commissioning of paediatric spinal surgery identified two serious concerns (a) the high rates of SSI and (b) extended waiting times for paediatric surgery. An action plan has been developed and is being implemented to address both issues.

COVID-19 & Respiratory Viruses

14. The IPC team continued to follow up COVID-19 and influenza positive patients. Operational pressures regularly impacted the Trust's ability to isolate patients promptly.

The Built Environment and IPC

15. The IPC team has provided support to both ongoing and new environmental concerns throughout 2023-24.
16. Water Safety at the Churchill Cancer and Haematology Hospital: Ongoing work to deliver an engineering solution to control the failings of the water system with respect to Legionella was completed in 2023-24 and is currently in a period of surveillance. 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. The SIRI called in 2019 has yet to have the actions closed.
17. There have been a number of incidents reported related to sewage leaks caused by blocked sewage pipes across the John Radcliffe site across the year. IPC have

worked with the clinical teams and estates to maintain patient and staff safety but minimise operational pressure where possible.

Infection Prevention and Control Surveillance Software

18. 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. An alternative solution is not yet available.

Patient Safety Incident Response Framework

19. The IPC team have worked with the Patient Safety team to agree the process for managing IPC incidents.

Investigation of Infection Prevention and Control Incidents and Outbreaks

20. The following outbreaks/incidents have been subject to investigation by the IPC team.

- ESBL in the neonatal unit
- Toxigenic *Diphtheria ulcerans*
- Measles
- Bedbugs
- Norovirus
- *C.difficile* on CMU-B
- Increased Incidence of Diarrhoea and Vomiting in Sexual Health Clinic
- Tuberculosis on Renal ward
- Influenza outbreaks

Antimicrobial Stewardship (AMS)

21. AMS activity has included work in the following areas:

- Antibiotic consumption
- 6 day AMS service
- *C*. *difficile* prevention
- CQUINs
- AMS ward rounds

Recommendations

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

Contents

Infection Prevention & Control Annual Report 2023-24

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 2023 and March 2024. 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 (Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk). This report follows the format of the Health and Social Act, reporting on each of the 10 criteria outlined in the Act.

2. Infection Prevention and Control Board Assurance Framework (BAF)

2.1. 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.

2.2. This report is structured to report IPC activity and compliance against each of the 10 criteria.

2.3. The Board Assurance Framework worksheet is ordered by the 10 criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format.

2.4. 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.

2.5. 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.

2.6. At the end of each section is the RAG rating of the OUH's compliance to NHSE IPC BAF (Appendix 2).

2.7. 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 IPC team have been

working through 2023-24 to deliver the IPC Strategic Plan 2023-2025 (Appendix 1) and is included for information.

3. Background

3.1. 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 2023 to March 2024. 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.

3.2. 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.

3.3. 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 staff, patient and stakeholder 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:

- Integrated Care Board/System
- Oxford Health NHS Foundation Trust
- South Central Ambulance Service (SCAS)
- Thames Valley Health Protection Team/UKHSA
- NHSE

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

3.5. Committees reporting to HIPCC are:

- Decontamination Committee

3.6. Regular reports to HIPCC are detailed in the Business Cycle (Appendix 3) and include:

- Divisional IPC reports
- UKHSA/local Health Protection Team

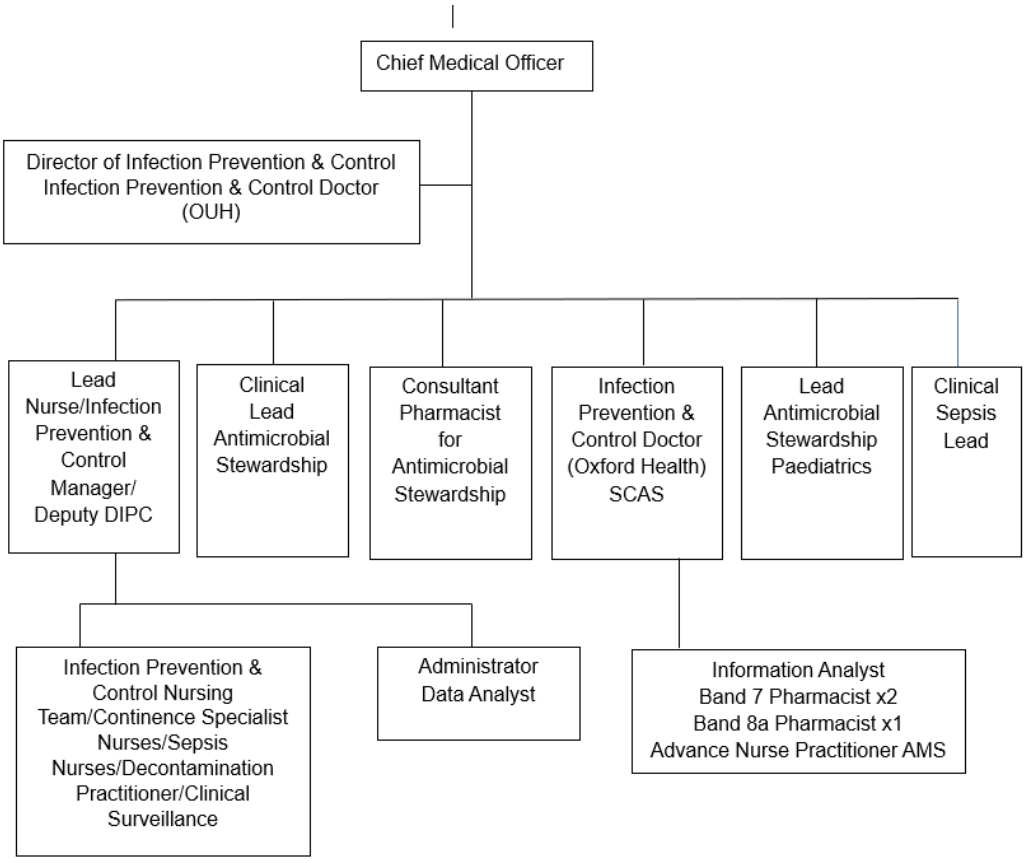
- Oxfordshire Clinical Commissioning Group (CCG) (ICS)
- Antimicrobial Stewardship Team (AMST)
- OUH Estates and Facilities
- Soft Facilities Management
- Centre for Occupational Health & Wellbeing (COHWB)
- Cardio-thoracic surgical site infection report

4. Criterion 1

4.1. 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.

5. Infection Prevention and Control Staffing

Table 1: Organisational chart for the IPC team at the end of March 2024



5.1. 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.

5.2. The Deputy DIPC/Lead Nurse 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.

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

6. Organisms subject to mandatory reporting

6.1. 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

6.2. 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

6.3. 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 completed as a questionnaire on Ulysses and the incident report is completed by the IPC team on identification of cases.

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

Methicillin-resistant *Staphylococcus aureus* (MRSA)

6.5. There were 4 HOHA and 2 COHA cases of MRSA bacteraemia in 2023-24. All cases have undergone a root cause analysis (RCA). Table 3 provides detail on the cases.

Table 2: SPC HOHA and COHA associated MRSA bacteraemia (April 2021-March 2024)

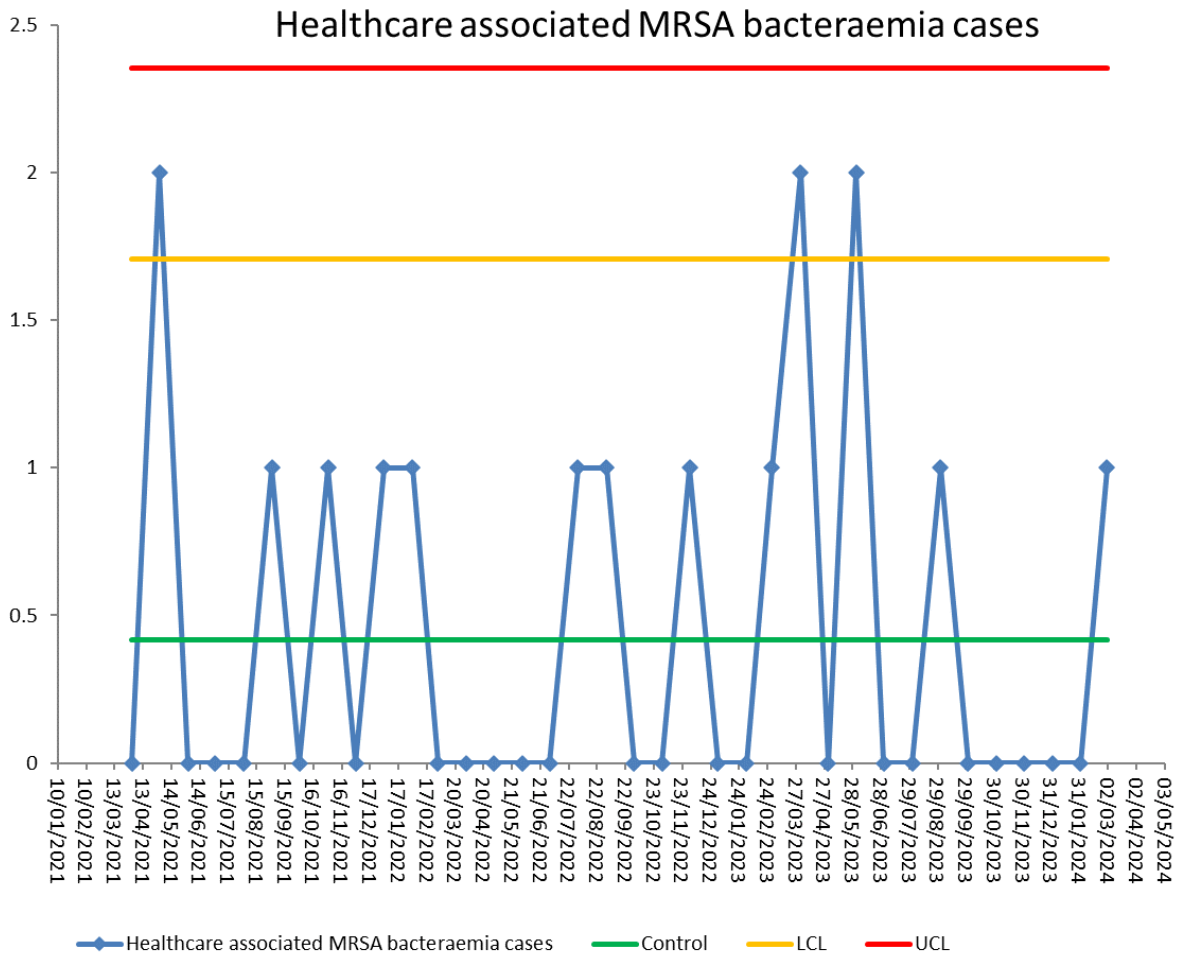
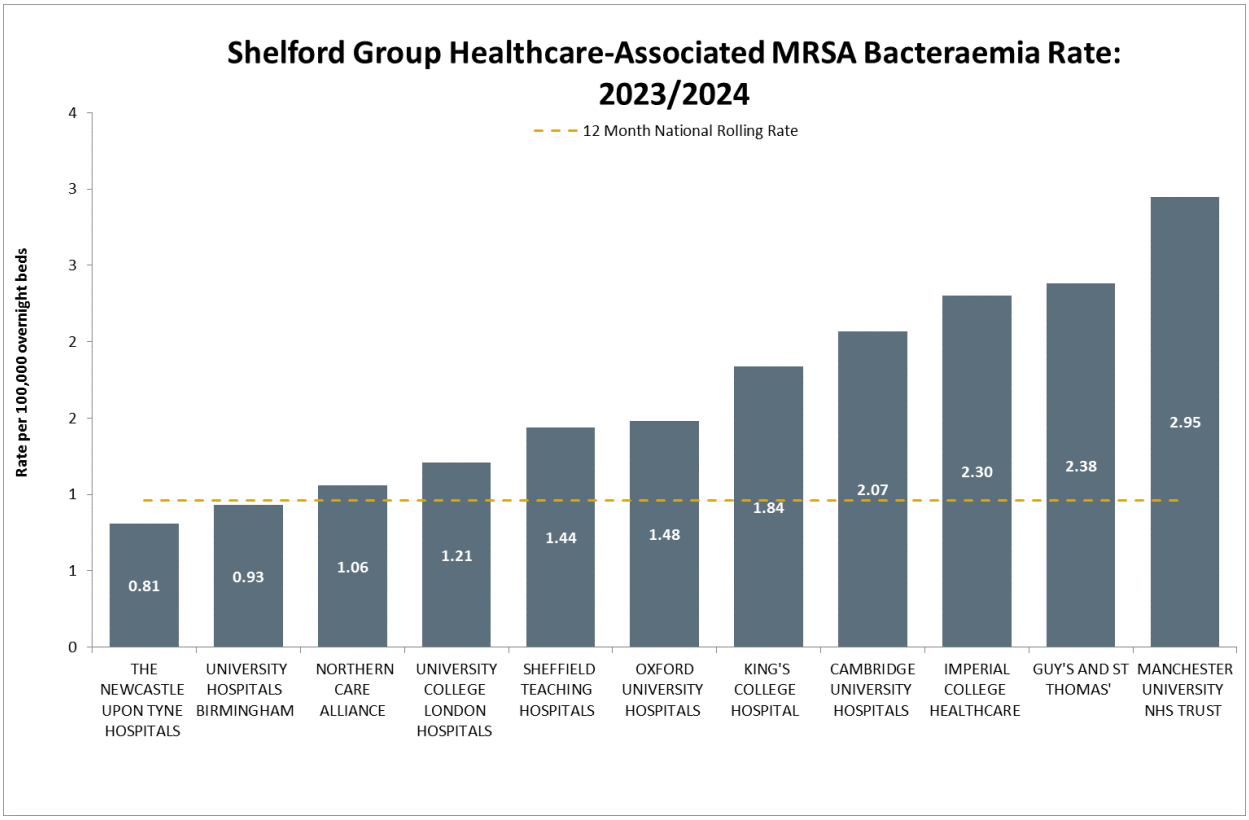


Table 3: MRSA Bacteraemia's 2023-24

Location	Category	Source and Learning
Haematology ward (April)	HOHA	RCA identified lack of documentation around care of the dressing and changing of the needleless connector. **Actions taken:** The IPC team are working with haematology to reduce the incidence of central line associated bloodstream infections (CLABSI). CLABSI incidence was reported at the haematology governance meetings. Biopatch, a foam dressing applied to the insertion site of central lines impregnated with an antiseptic (chlorhexidine gluconate) that is continuously released for 7 days, is now in use. Within 'interactive view' in EPR there is an existing section for recording of needleless connector changes.
Upper GI (April)	COHA	PICC line source. No learning identified.
JR EAU (Emergency Assessment Unit) (June)	COHA	Soft tissue source. No learning identified.
Neonatal unit (June)	HOHA	Child known to be colonised with MRSA and with significant co-morbidities. No learning identified.
CMU B	HOHA	Frail medical patient with severe skin issues which was thought to be the source of the bacteraemia. The patient did not meet the criteria for MRSA screening on admission so previous colonisation status is unknown. **Action taken:** Roll out an improvement plan across the CMU (Complex Medicine Unit) wards for hand hygiene
CTCCU	HOHA	PICC line source. No learning identified.

Table 4: Shelford Group Healthcare – Associated MRSA Rate 2023-24

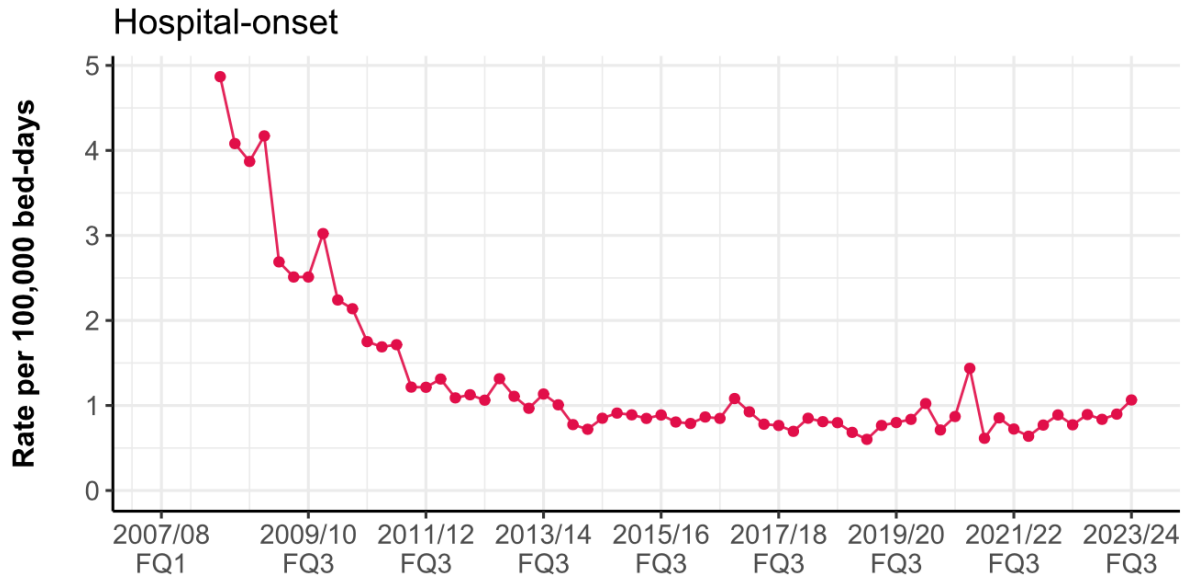
6.6. Bar chart shows OUH MRSA bacteraemia rate in comparison with the Shelford group of Trusts.



National MRSA Picture

6.7. When comparing October to December 2023 to last year's corresponding quarter, counts and incidence rates of total reported cases have increased by 27.9%. Although rates remain relatively low, this is the highest incidence rate seen since January to March 2018. The rise was evenly distributed between the community-onset and hospital-onset cases. Hospital-onset cases increased by 38.6% from 70 to 97 when compared with October to December 2022. As the overall numbers are small, this needs to be interpreted with caution.

Table 5: Quarterly rates of MRSA bacteraemia (April 2008 to December 2023) (National data)



Methicillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

6.8. The Trust reported 43 (42 in 2022-23) HOHA cases and 27 (24 in 2022-23) COHA cases for 2022-23. The main recorded infection sources are documented below and remain the same as last year.

Table 6: Breakdown of Top 3 Sources of Infection

Recorded Source	**No of HOHA**	**No of COHA**
Lines (includes peripheral, Hickman, PICC, central and midlines)	21	5
Unknown / unclear	4	6
Skin or soft tissue (includes surgical site infection)	7	4

6.9. In December 2023, we reported 6 cases of HOHA MSSA and 3 COHA cases and highlighted that the SPC demonstrated an upward trend. Cases included 4 invasive device infections; this was discussed at HIPCC with the Divisional teams with the request for areas to undertake aseptic non-touch technique (ANTT) audits to identify any areas for learning. The SPC continued to demonstrate an upward trend irepresenting special cause variation. It was discussed at Safety and Learning in Conversation (SLIC) meeting in January with particular reference to line related MSSA infections and the ongoing care/management of lines. The IPC team are planning an audit of devices in 2024-25 quarter 1, alongside review of the current educational programme for cannulation. A staff knowledge survey is also planned.

Table 7: SPC HOHA and COHA associated MSSA bacteraemia (April 2021-March 2024)

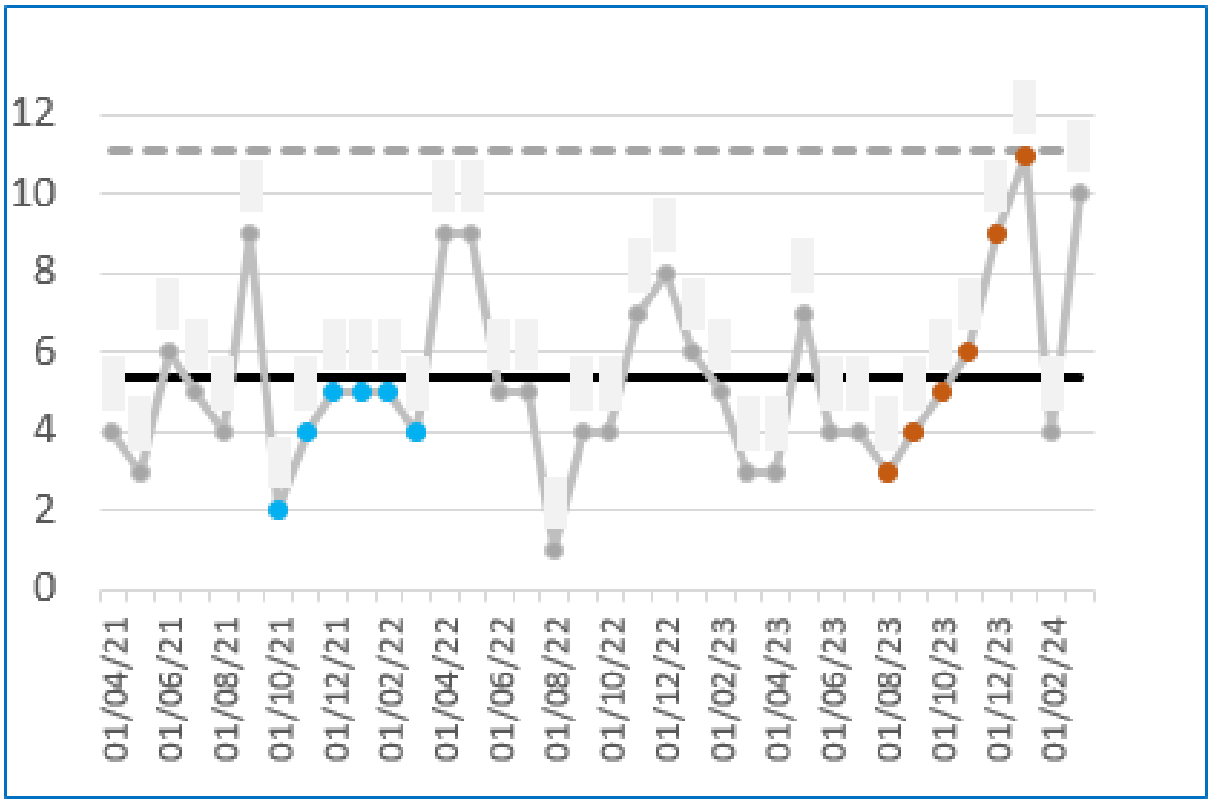


Table 8: OUH Healthcare associated MSSA bacteraemia cases controlled for activity (discharges)

6.10. Controlling the MSSA bacteraemia cases with discharges as a measure of activity shows a small increase in cases in 2023-24.

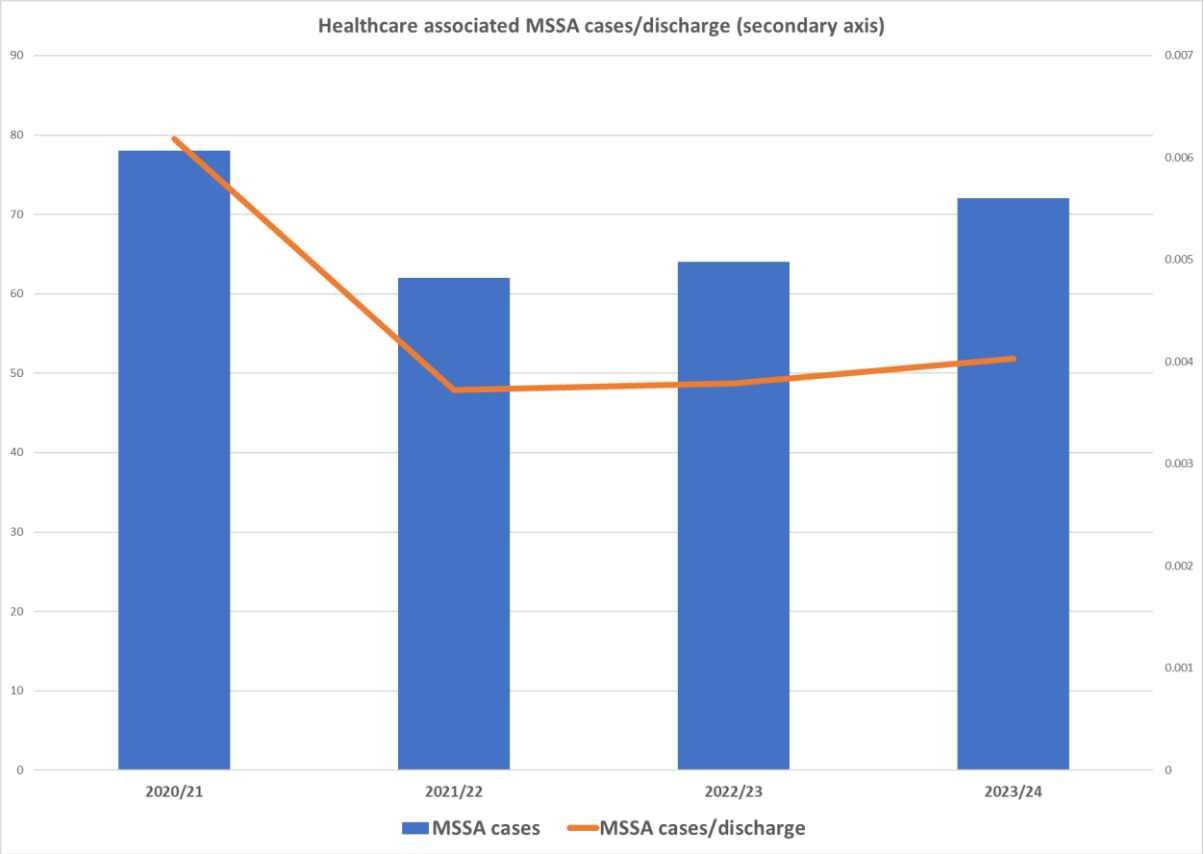
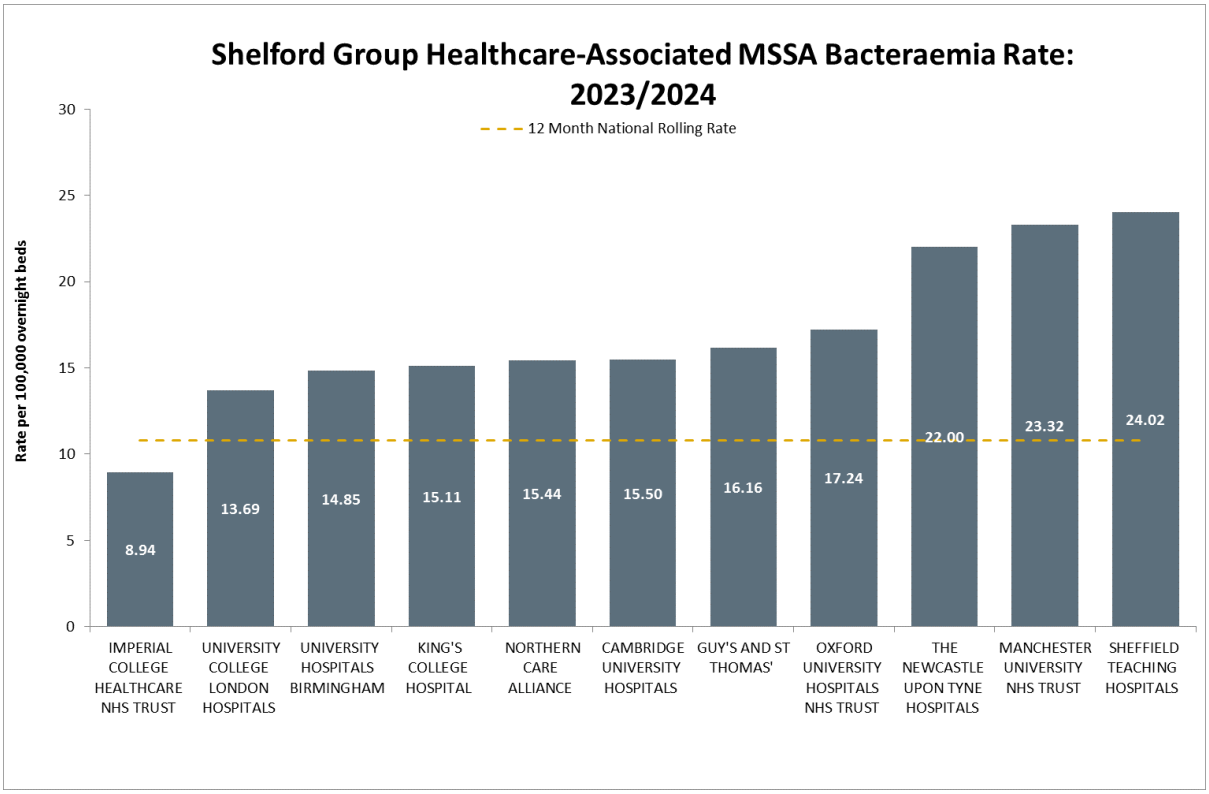


Table 9: Shelford Group Healthcare – Associated MSSA Rate 2023-24

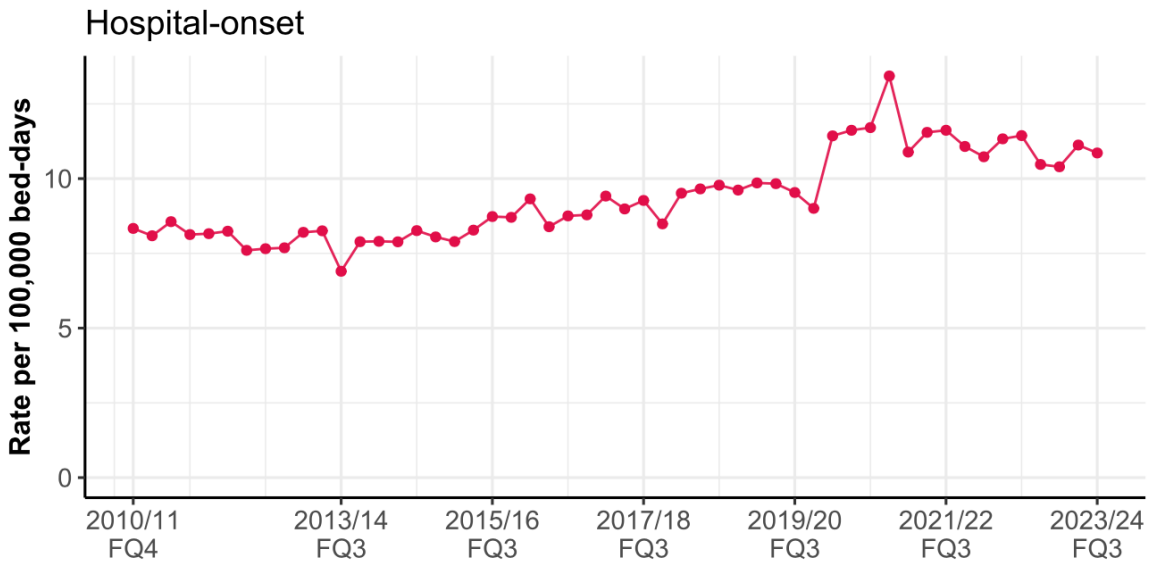
6.11. Bar chart shows OUH MSSA bacteraemia rate in comparison with the Shelford group of Trusts.



National MSSA picture

6.12. Counts and rates of MSSA bacteraemia remain higher than those seen at the beginning of the surveillance programme in 2011, corresponding to an increase of 47.5% in incidence rate, from 16.2 to 23.9 per 100,000 population. Over the same period the incidence rate of hospital-onset cases increased by 33.6% from 8.1 to 10.9 cases per 100,000 bed-days.

Table 10: National MSSA picture Quarterly rates of hospital-onset MSSA bacteraemia cases, January 2011 to December 2023



Gram Negative Bloodstream Infections

6.13. NHS England set a national target of halving 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.

6.14. 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. This has now been acknowledged in the National Antibiotic plan for 2024-29.

Table 11: Thresholds for 2022-23 and 2023-24

	Threshold 2023-24	Final Total Cases 2023-24	Final Total Cases 2022-23
E. coli	153	173	208
Klebsiella	86	94	87
Pseudomonas	47	63	56

Table 12: SPC HOHA and COHA associated E. coli bacteraemia (April 2021-March 2024)

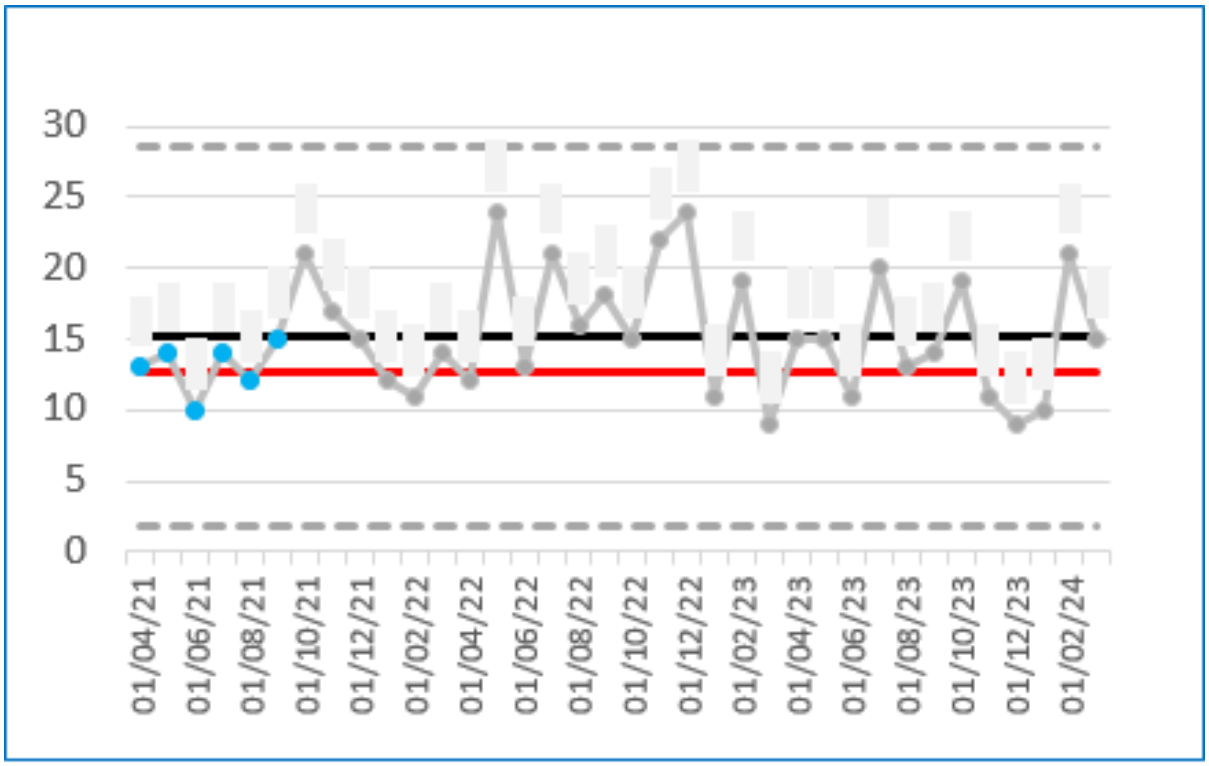


Table 13: SPC HOHA and COHA associated Klebsiella bacteraemia (April 2021-March 2024)

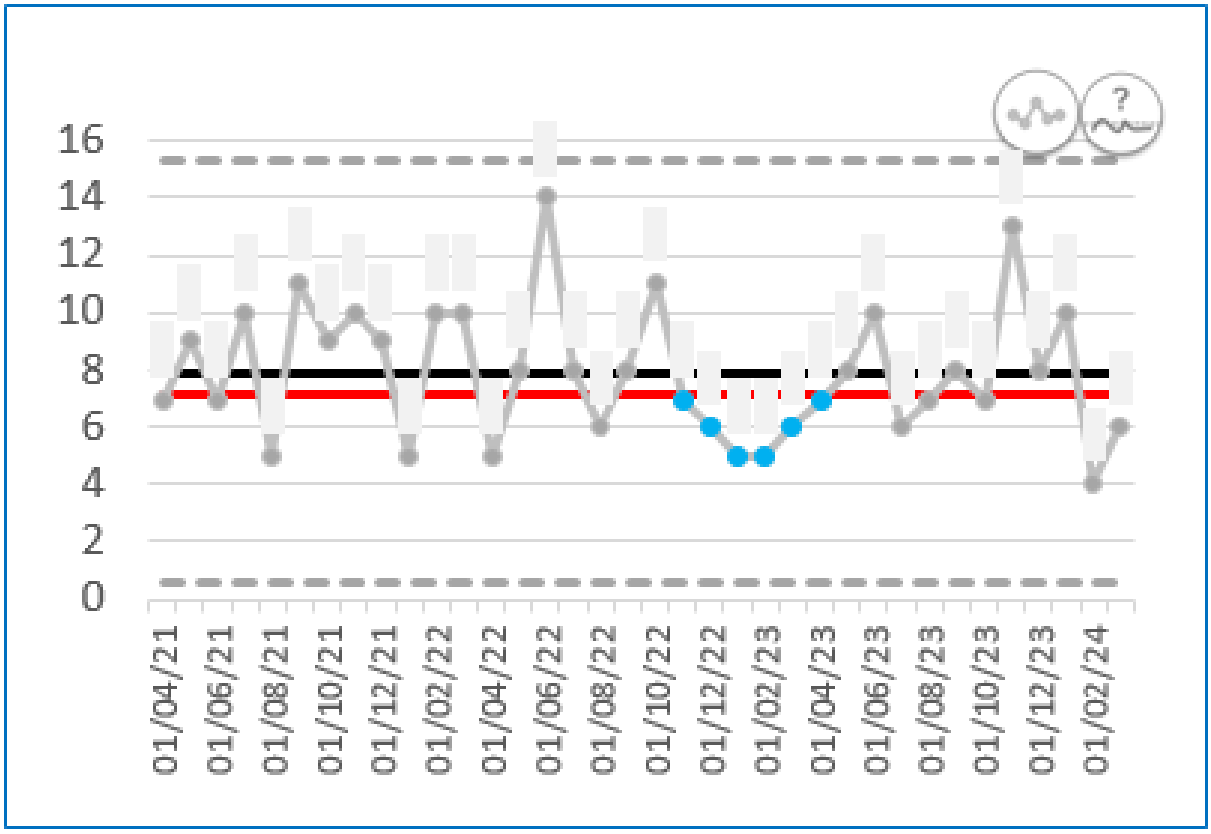


Table 14: SPC HOHA and COHA associated Pseudomonas bacteraemia (April 2021-March 2024)

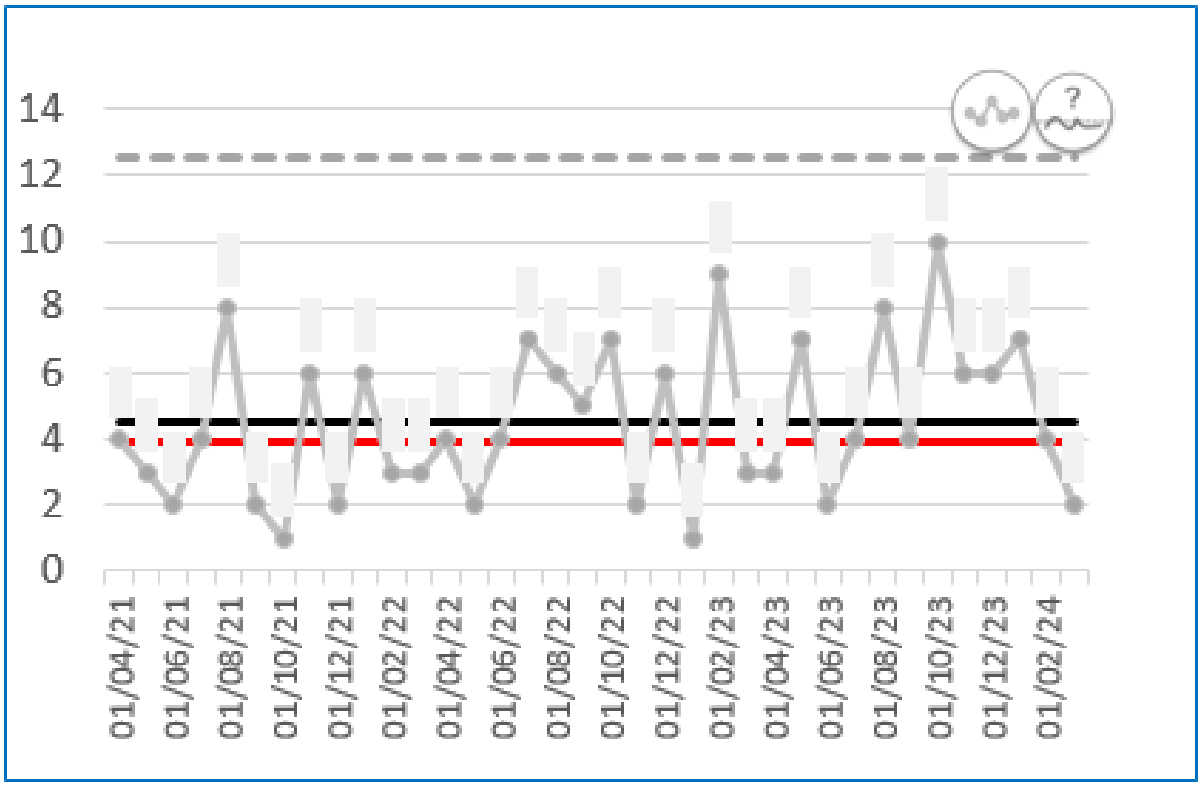


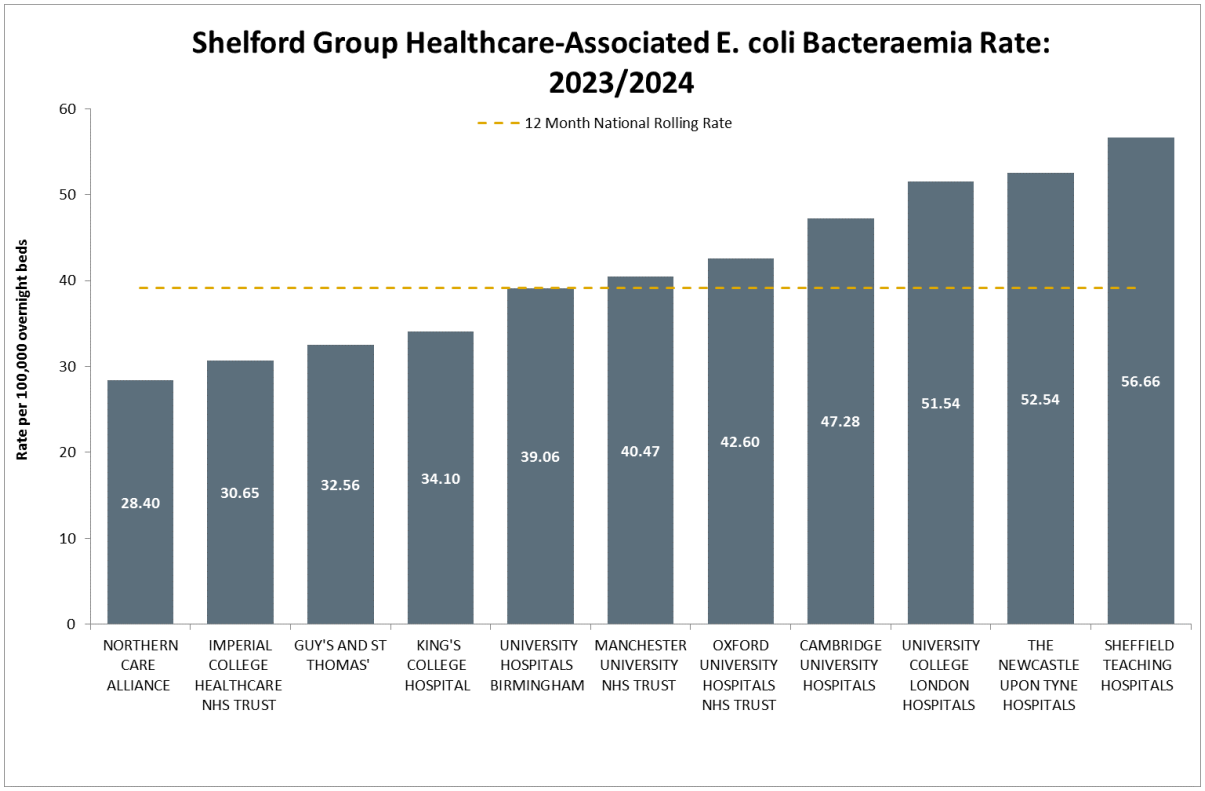
Table 15: Main Sources of Infection for Gram-negative Bloodstream Infections (HOHA)

	Unknown	Line / device	Gastro / Gut related	Chest	HPB	Urinary
Klebsiella	15	11	14	8	8	7
Pseudomonas	6	9	6	5	1	15
E.coli	22	5	23	2	11	21

Table 16: Main Sources of Infection for Gram-negative Bloodstream Infections (COHA)

	Unknown	Line / device	Gastro / Gut related	Chest	HPB	Urinary
Klebsiella	6	1	3	0	5	8
Pseudomonas	3	3	0	1	3	3
E.coli	14	2	5	2	13	43

Table 17: Shelford Group Healthcare – Associated E.coli Rate 2023-24



Clostridioides difficile (C. difficile)

6.15. 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 ICS as required.

6.16. The threshold for OUH apportioned cases of C. difficile for 2023-24 was set at 103 cases. OUH reported 130 cases. As reported in last year's annual report, a new assay was introduced in the laboratory at the end of January 2023 and was subsequently shown to generate a significant number of false positive results. Following a period of re-testing with alternative assays, a total of 60 patient samples were incorrectly reported from January to May 2023, these are not counted towards reported number of cases. This has been reviewed by the patient safety team and minor harm agreed. Duty of Candour was undertaken. The Medicines and Healthcare products Regulations Agency (MHRA) were informed via the yellow card system, and data shared with the company. Alternative assays and a process of confirmation for assay results in an equivocal range were introduced into the Microbiology Laboratory with no further major issues. On review of cases during May 2024, it was identified that one case in January had been incorrectly deemed positive by the lab. This has been

corrected with UKHSA but figures in this table have not been adjusted as the Quality Account has already been submitted.

Table 18: Cumulative cases of OUH apportioned *C. difficile* (COHA and HOHA) per month (April 2023-March 2024)

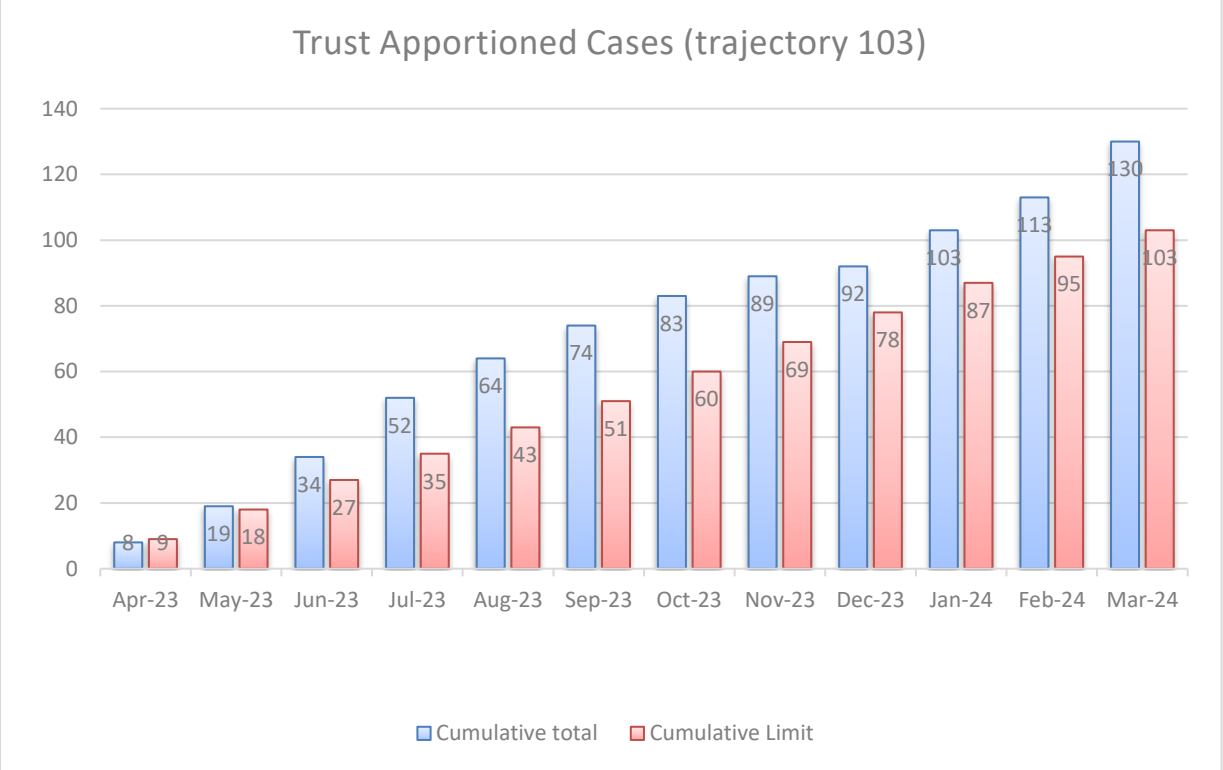


Table 19: Breakdown of C. difficile HOHA v COHA (April 2023-March 2024)

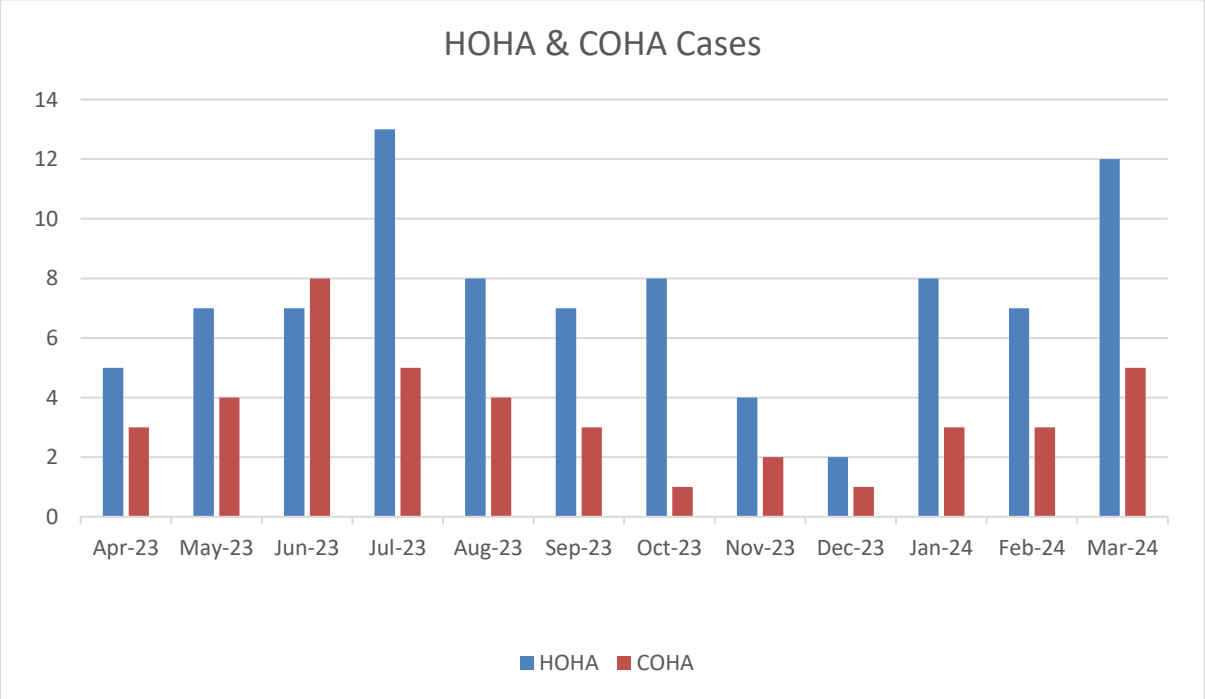
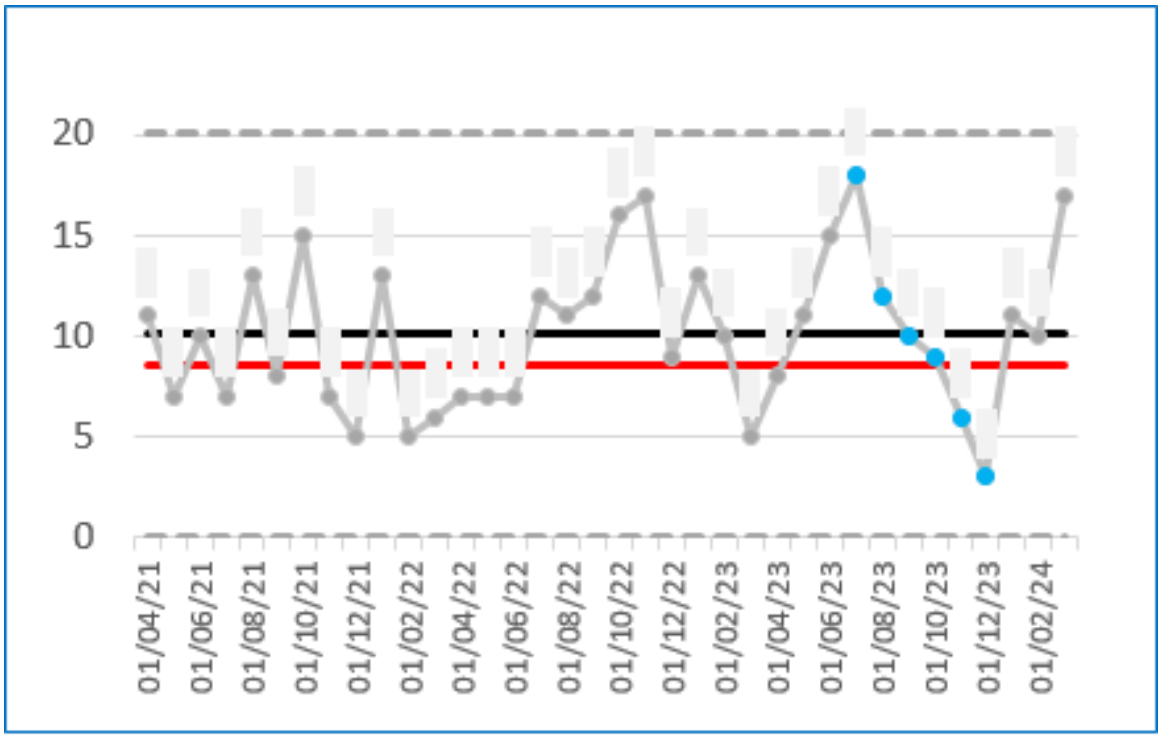


Table 20: Statistical Process Control (SPC) chart of HOHA and COHA C. *difficile* infection counts (April 2021-March 2024)



OUH compared to Shelford Hospitals

6.17. When comparing OUH to the Shelford groups, we are in the higher range of cases. In 2022-23, five out of 10 of the Shelford hospitals have seen an increase in the number of cases this year (Table 21).

Table 21: Shelford Group Healthcare – Associated C.difficile Rate 2023-24

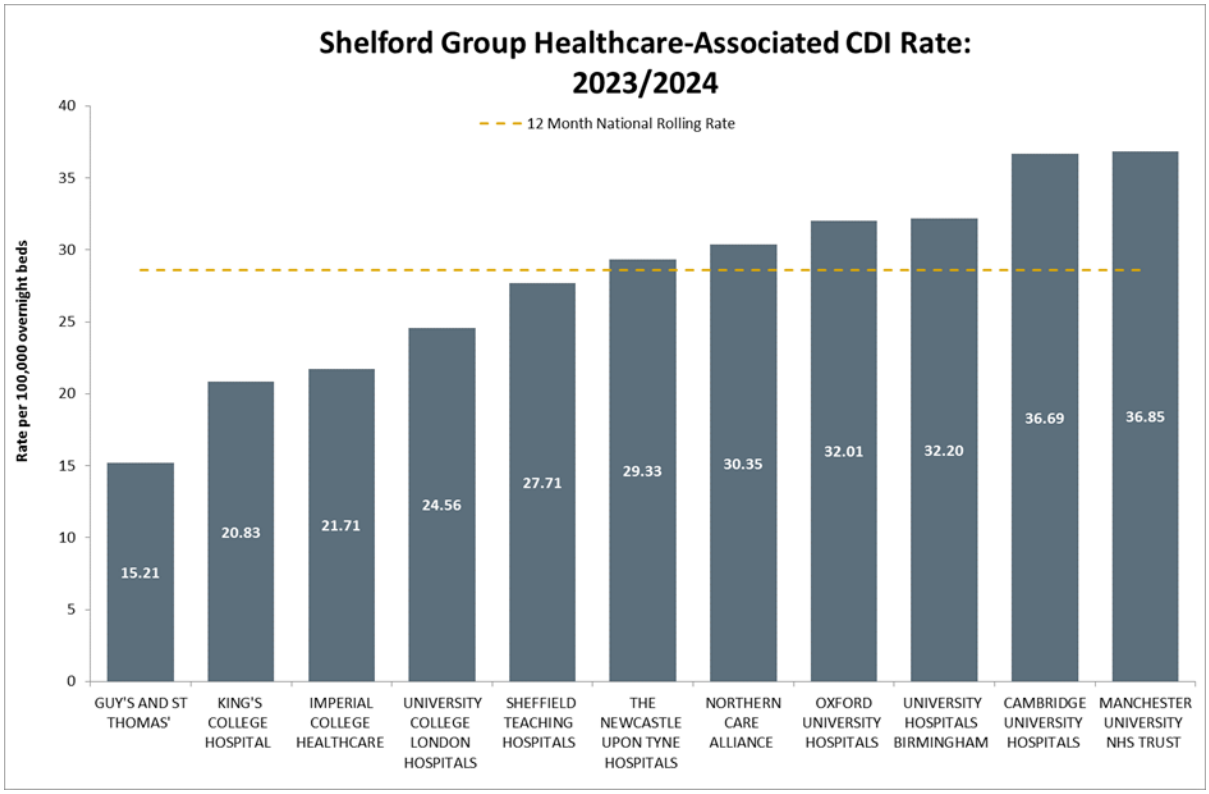


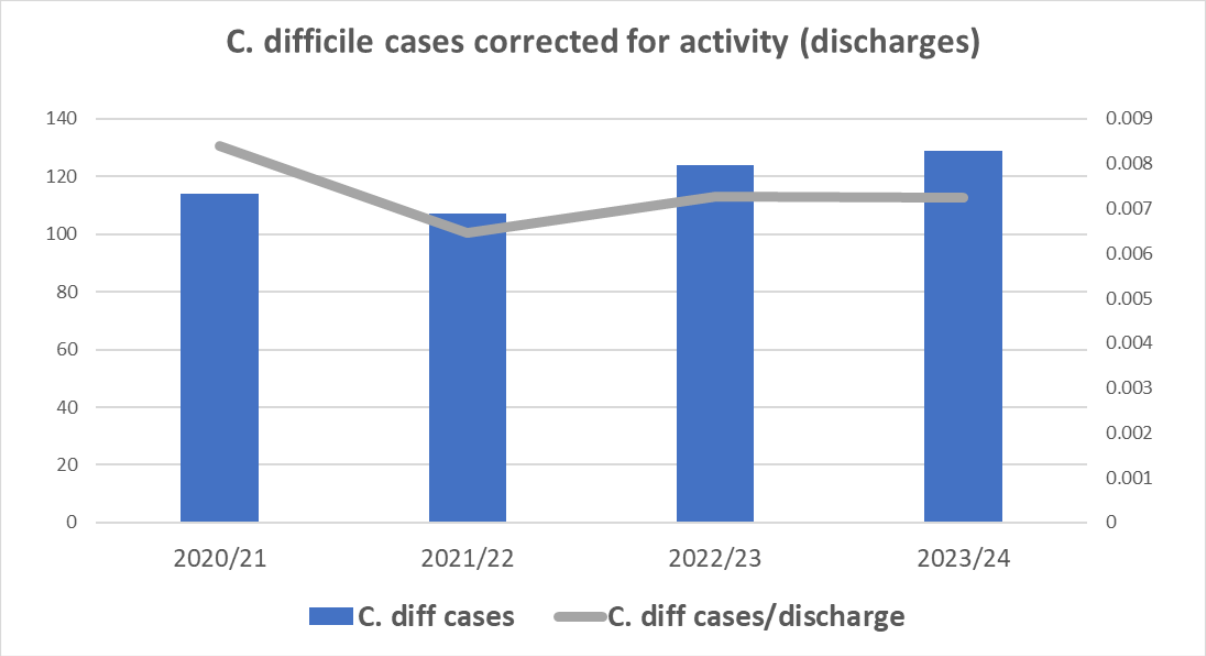
Table 22: Shelford Group Rates per 100,000 overnight beds 2021-24*

Organisation Name	2020/21	2021/22	2022/23	2023/24
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	12.36	13.82	14.30	15.21
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	20.08	19.04	24.03	20.83
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	17.82	18.44	23.05	21.71
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	35.71	34.32	41.59	24.56
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	35.36	31.91	34.79	27.71
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	27.63	34.51	35.13	29.33
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	35.01	26.42	30.62	32.01
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	27.15	25.52	29.58	32.20
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	21.99	31.61	33.42	36.69
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	30.31	27.55	27.14	36.85

***Green indicates improved performance and red worsening compared to previous year.**

Table 23: Health care associated C. difficile cases corrected for activity (discharges)

6.18. Correcting the C. difficile data using discharges as a measure of OUH activity shows no change from 2022-23.



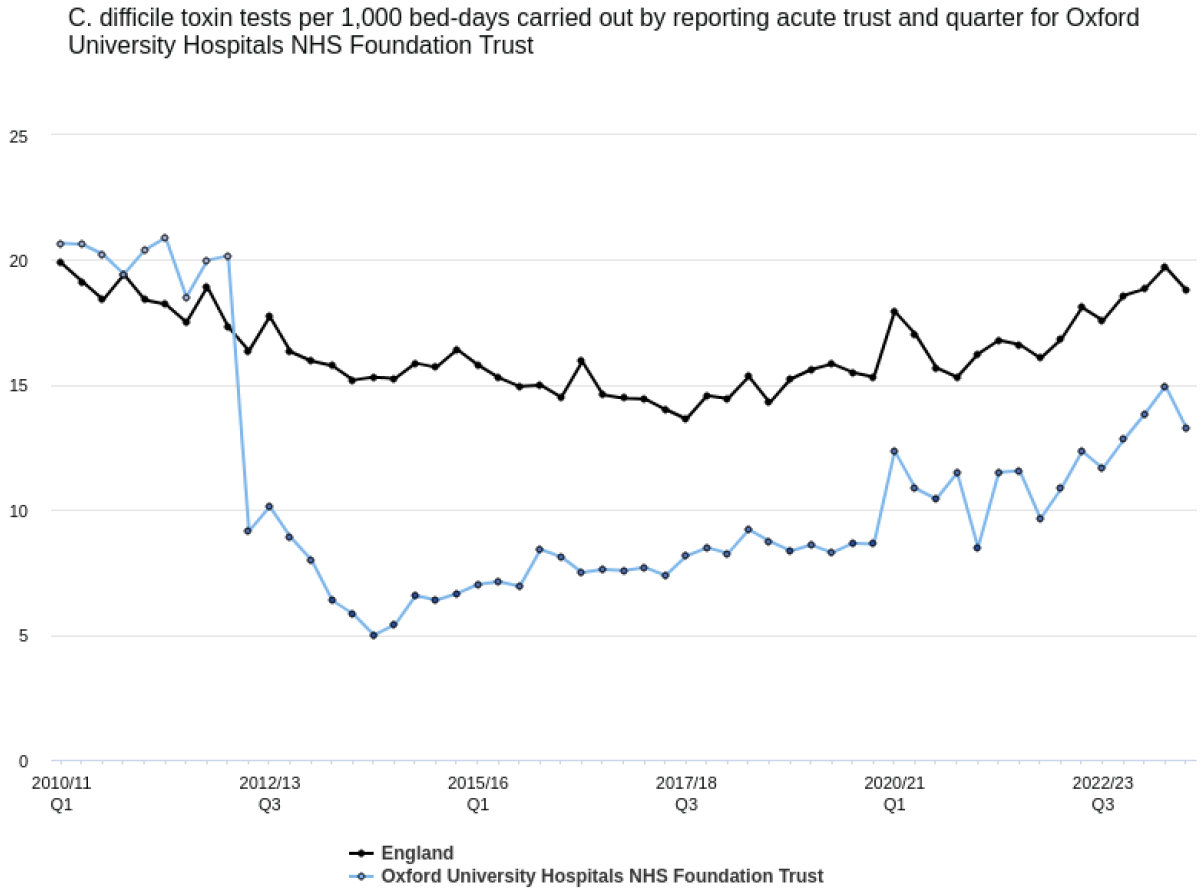
6.19. C. difficile rates are rising nationally and the rate reported in England in March 2024 is the highest for 7 years (21 cases/100,000 bed days, AMR local indicators - produced by the UKHSA - Data - OHID (phe.org.uk)). A C. difficile questionnaire is linked with Ulysses incident reporting. No major themes have been identified. Potential outbreaks (2 or more cases connected by location within a short time frame) are investigated by Ribotyping. Some evidence of nosocomial transmission was demonstrated on a medical ward, but other outbreaks have shown only unlinked cases.

6.20. Proactive work is in place in the OUH to minimise the occurrence of C. difficile infection. In the last 18 months we have introduced:

- Additional testing to identify those patients who are carriers of toxigenic strains but do not have C. difficile infection.
- Isolation of patients who are carriers of toxigenic strains as these patients can still transmit C. difficile.
- Pre-emptive treatment of patients who are carriers of toxigenic strains to reduce development of C. difficile infection and environmental contamination.
- Modification of MicroGuide to further reduce the empirical use of antibiotics such as Ciprofloxacin and Co-amoxiclav which have a stronger association with *C.difficile* infection.

- 6 day on-site infection prevention and control service, together with the 6 day antimicrobial stewardship (AMS) service which supports the microbiology team on a Saturday.
- AMS ward rounds (see AMS section for further detail) – 340 ward rounds took place in 2023-24, compared with 147 in 2022-23, including both adult and paediatric patients. 4,244 patients received a formal AMS team review, and 2,468 interventions were made (58%). This is in addition to the regular antibiotic reviews performed by the Infection Team across all 6 intensive units in the OUH, and the infection team consult work.
- Monitoring the use of antibiotics most likely to be associated with the development of *C. difficile* infection to support learning from C. *difficile* cases, and to guide which antibiotics to target on AMS rounds.
- A trial of regular cleaning with a different disinfectant across level 7 of the JR hospital.
- Block booking of enhanced cleans to avoid missing enhanced cleans due to requesting.
- A cleaning improvement project between infection prevention and control team and medical wards at JR resulting in sustained improvement in cleaning scores.
- Questionnaire for C. difficile cases reviewed and updated to reduce time spent investigating and more on proactive work. A quarterly report from Ulysses is being developed to be able to identify themes more easily from completed questionnaires.

Table 24: Number of stool samples processed for C. difficile by OUH Microbiology laboratory



6.21. The number of stool samples processed in the OUH for C. difficile has increased in line with the national data over the last 3 years since the pandemic. This includes samples from the community. This may be at least partly responsible for the local and national increase in cases (improved ascertainment).

6.22. Nationally, comparing the most recent quarter (October to December 2023) to the same period in the previous year (October to December 2022), hospital-onset CDI cases increased by 3.4% from 1,584 to 1,638; this corresponded to an increase of 2.8% in the incidence rate, from 17.5 to 18.0.

7. Central Line Associated Bloodstream Infection (CLABSI) surveillance

CLABSI surveillance in the Intensive Care Units

7.1. 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.

7.2. In 2023-24:

- OCC (Oxford Critical Care) (AICU) had zero CLABSI in the last two quarters.
- The neonatal unit (NBICU) have shown sustained improvement in 2024 compared to 2023.
- Neuro-ICU (NICU) reported a higher than usual rate, with three episodes of CLABSI in Q4 but all in the same patient, and therefore likely to be due to patient specific factors.
- Paediatric intensive care (PICU) had one quarter (Q1) which was high, but now back to baseline.
- Churchill ICU (CICU) data continues to show the most variation due to lower patient numbers and line days than the other units.
- Cardiothoracic critical care (CTVCC) CLABSI rates continue to remain below the benchmark (i.e. low).

Table 25: Quarterly CLABSI rates by ICU April 2018-March 2024

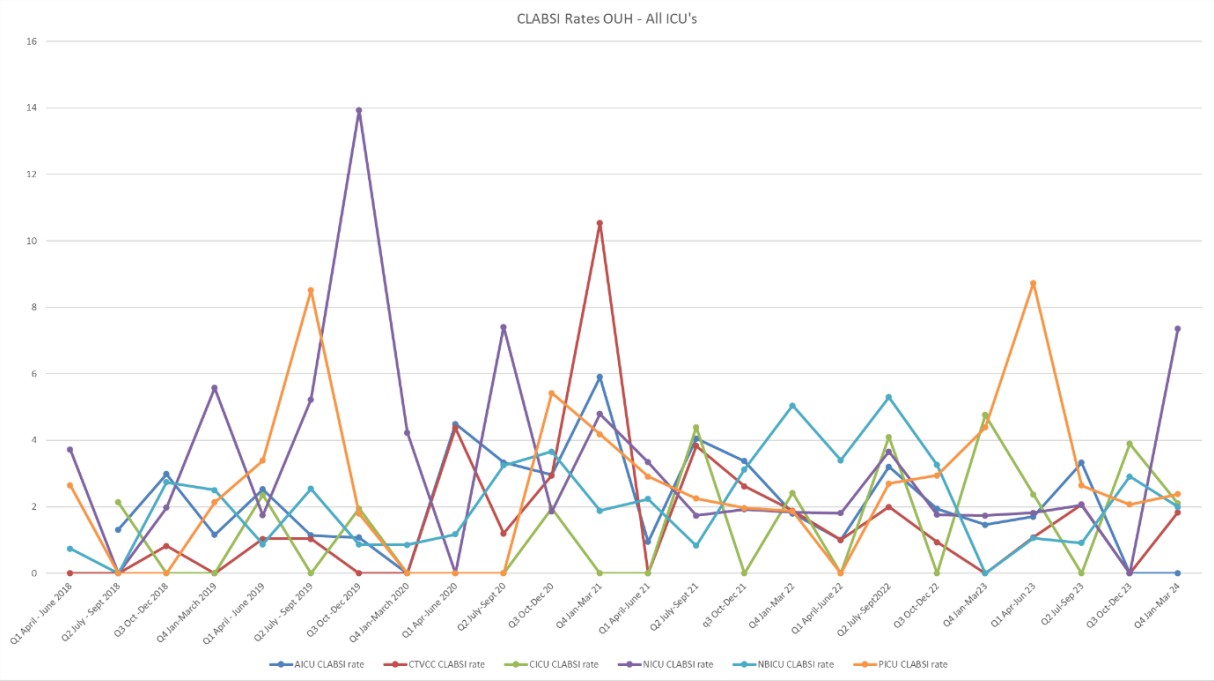


Table 26: Infection in Critical Care Quality Improvement Programme (ICCQIP) Benchmark for Intensive Care Areas

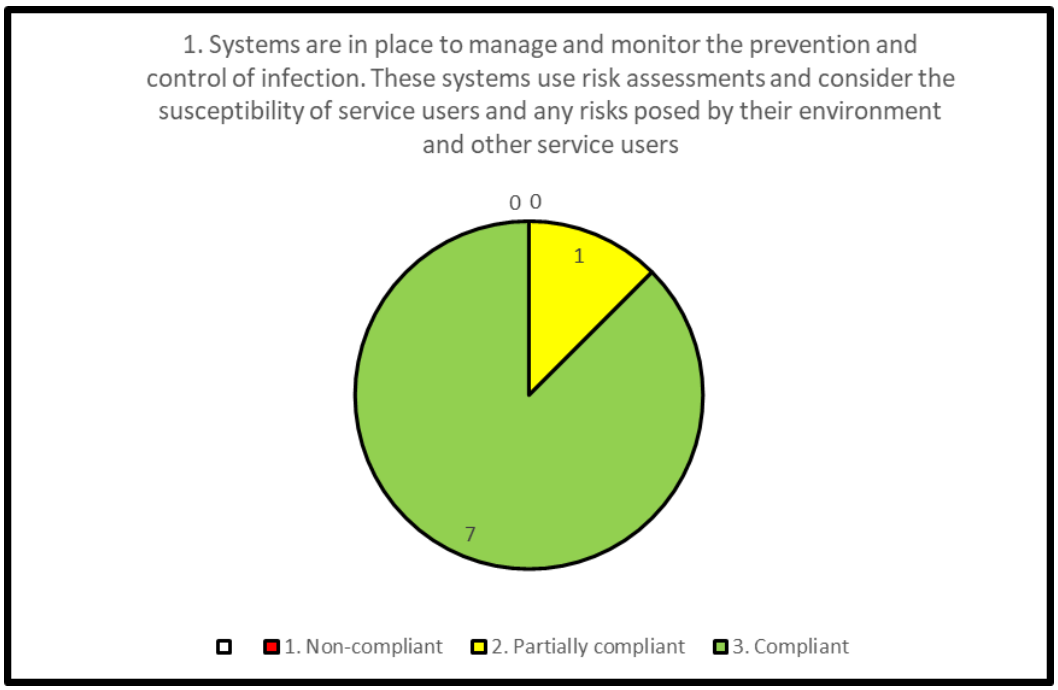
	AICU	CTVCCU	CICU	NICU	NBICU	PITU/HDU
No of quarters in 2023-24 with data	4	4	4	4	4	4
No of CLABSIs	6	5	4	5	7	7
Central line days	4,999	3,912	1,395	1,886	4,074	1,740
CLABSI/1000 central line days	1.2	1.3	2.9	2.7	1.7	4
Benchmark (ICCQIP) July 2021-June 2022	1.6	1.6	1.6	1.6	1	0
Trend from 2022-23	↓	same	↑	↑	↓	↑

Trust wide non-ICU CLABSI surveillance

7.3. The IPC team continues to maintain Trust wide non-ICU Central line associated bloodstream infections (CLABSI) surveillance. It has been challenging to maintain and therefore the data set is not complete so will be hard to draw comparisons on previous years. These have to date not been reported in rates per 1,000-line days as above due to difficulty obtaining denominator data from the Electronic Patient Record (EPR) and the large number of clinical departments that CLABSI may occur in. This data is now available to request from the information team for individual departments using Cerner to record their central line in interactive view. This will be utilised initially for Haematology and NICU and then expanded to include other departments. NICU had been using manual data entry for their line denominator data collection. The aim for 2024-25 is to be able to present Haematology CLABSI surveillance as a rate per quarter similarly to our ICU's.

7.4. For Ulysses incidents submitted for CLABSI there is a questionnaire in Ulysses to support investigations and identify any learning.

Figure 1: BAF Compliance to Criterion 1



Partial Compliant Elements to the BAF	Reason for Partial Compliance
Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the National Infection Prevention and Control Manual.	The current IPC surveillance system has been withdrawn, leaving us with an unsupported system. The IPC team will therefore not be alerted to patients being admitted with infectious organisms or new results in real time. Paper provided to BPG for support of purchase of ICNeT, next steps to be agreed. See Criterion 4.

8. Criterion 2

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

9. Environmental IPC and decontamination

Water Safety

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

9.1. 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.

Churchill Cancer and Haematology Hospital

9.2. 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 September 2019 when 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. At the beginning of October 2019 prior to completion of POUF installation there was a single confirmed case of legionella infection in a patient who died (sampled 24.09.2019). The timeline of events was consistent with a hospital acquired infection. Engineering works to manage this situation and provide a safe water supply have been ongoing since 2019 and have been managed via the Serious Incident Requiring Investigation (SIRI) process.

9.3. Water sampling continues to yield positive Legionella samples in the Churchill PFI building but counts are now falling. The root cause was thought to be a failure to maintain the flow of hot water, with cooler temperatures supporting growth of Legionella. The engineering solution has been completed this year with progress being monitored by the Extra-ordinary Water Safety Group. There is now a period of surveillance of hot water temperatures and continuing routine Legionella sampling. The POUFs remain in place.

Whitehouse Renal Dialysis Unit

9.4. The commissioning water testing results for the new Whitehouse renal dialysis unit in Milton Keynes had elevated levels of total viable counts (TVC) of organisms (not Legionella, Pseudomonas, E. coli or coliforms). The results were returned 3 days before the service were due to move in. Total viable count (TVC) is a laboratory test that is undertaken on commissioning of a new water services that indicates the level of heterotrophic organisms within a sample. Heterotrophs are a large group of organisms that can be further divided into fungi, yeasts, moulds, and bacteria. Therefore, the results of a TVC test may offer an indication of the ‘general level’ of contamination within a system.

9.5. The Trust are renting this building from Milton Keynes Council which adds a layer of complexity as there are also other tenants in the building.

9.6. Following discussion at the Trust WSG, advice was given that the service should not move in as the water could not be used except for the reverse osmosis (RO) system. However, as patients had already been booked to attend and there was no capacity to dialyse elsewhere, this was not possible.

9.7. A number of incident meetings with key stakeholders have been held and remedial actions completed which included increased flushing, re-chlorination, resampling, and the installation of temporary mobile handwash basins to be filled from the uncontaminated RO system.

9.8. Three months after opening the system is still not clear and POUF have now been fitted until the system is clear of high levels of TVCs.

Decontamination

9.9. The Decontamination Committee meets quarterly and covers decontamination in Sterile Services, endoscopy, decontamination of medical devices and patient equipment cleaning. This committee reports to HIPCC. The IPC service now has a Clinical Decontamination Practitioner in post to support decontamination practice. The decontamination policies have been updated this year. There have been no major decontamination incidents to report this year.

Cleaning

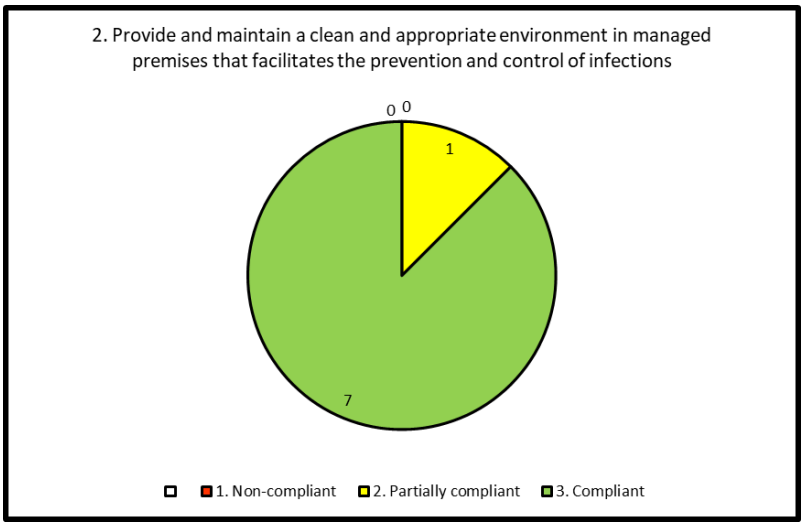
9.10. The National Standard of Cleaning has been implemented across the organisation. HIPCC receives a report from the Trust PFI office, reporting by exception those areas that have a low star rating and action plans to resolve concerns. IPC also receive an alert if an inpatient area has a 3-star rating 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 emergency department, Paediatric Critical Care and the neonatal unit.

Neonatal Unit Estate

9.11. The neonatal unit has experienced a number of outbreaks over the last two to three years, including colonisation of neonates with MRSA and with extended-spectrum beta-lactamase (ESBL) producing Gram negative bacteria. This was discussed at TME following presentation of the 2022-23 DIPC Annual Report last year and issues with the estate were of particular concern. Outbreak meetings have been held regularly with an action plan monitored. A number of actions have been completed, including the purchase of new incubators. The more complex actions such as moving from paper to electronic notes so that the paper notes can be removed from the unit; building a decontamination space; and storage solutions,

have yet to be undertaken. The outbreak is discussed in more detail under Criterion 5.

Figure 2: BAF Compliance to Criterion 2



Partial Compliant Elements to the BAF	Reason for Partial Compliance
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.	Waste Policy is currently being updated. Implementation of Offensive Waste to achieve 20:20:60 set out by NHSE. As of 2nd April 2024, all OUH sites are now compliant with the implementation of this waste stream.

10. Criterion 3

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

11. Antimicrobial Stewardship

11.1. Antimicrobial resistance is a global public health threat, and the UK has responded to this global campaign with a series of National Action Plans (NAP) and national surveillance of antimicrobial resistance patterns with key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. A new NAP was published in May 2024 therefore the AMS team are working on identifying the priorities from this plan.

11.2. The WHO categorises antibiotics into three broad groups [AWaRe: Access Watch and Reserve] based on their spectrum, anticipated risk of

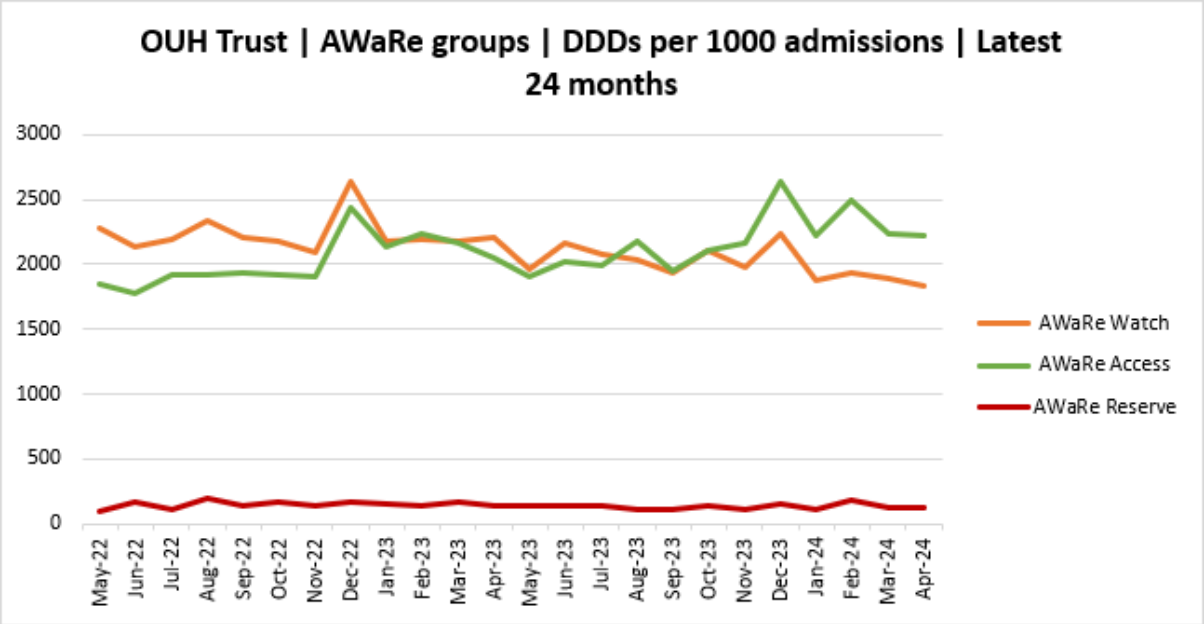
resistance development, risk of toxicity, and risk of causing healthcare associated infection such as Clostridioides difficile Infection (CDI).

11.3. The NHS National Contract in England for 2023-24 which started on 1 April 2023 utilises a modified version of the WHO list Access, Watch and Reserve antibiotic classification (microguide.global). The Trust had a target of a 10% reduction in consumption of antibiotics in the “Reserve” and “Watch” categories from World Health Organisation (WHO) AWaRE classification (adapted) against a 2017 (calendar year) baseline value.

11.4. At the time of preparing this report, formal data from NHS England is only available up to the end of quarter 3 2023-24. The data showed that OUH has a 6.6% reduction against the baseline value. This compares to Q1 where OUH was +1% and then Q2 where there was a 4% reduction. The data shows that the Trust has made significant reductions in consumption over the last financial year. Interim data for Q4 was made available in June 2024 and this shows a reduction of 8.7%. The finalised data will be available later this year. The data suggests that OUH may not meet the target reduction of 10% but the trajectory quarter on quarter shows the positive effect of the work undertaken by the AMS team.

11.5. The consumption of antibiotic in the “Reserve, “Watch” and “Access” categories are monitored by the Antimicrobial Stewardship (AMS) Team and reported in their quarterly report to Hospital Infection Prevention and Control Committee (HIPCC). This is shown below in Table 27. The plot shows an increase in the use of “Access” antibiotics with a reduction in “Watch” but similar usage of “Reserve” antibiotics over time, reflecting the successful work that the AMS team are doing to change the distribution of categories.

Table 27: Consumption of “Watch”, “Access” and “Reserve” antibiotics over time



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

- Introduction of a 6 day AMS service which supports microbiology team on a Saturday. This was funded by the IPC business case.
- AMS ward rounds (discussed below).
- Use of data to monitor consumption at divisional, directorate and speciality level and identify areas for improvement.
- Introduction of metrics for the monthly divisional reports to HIPCC which show the divisions consumption of antibiotic in the “Reserve, “Watch” and “Access”.
- 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 e.g. review of urology guidelines, urinary tract infection guidelines and skin and soft tissue infection guidelines.

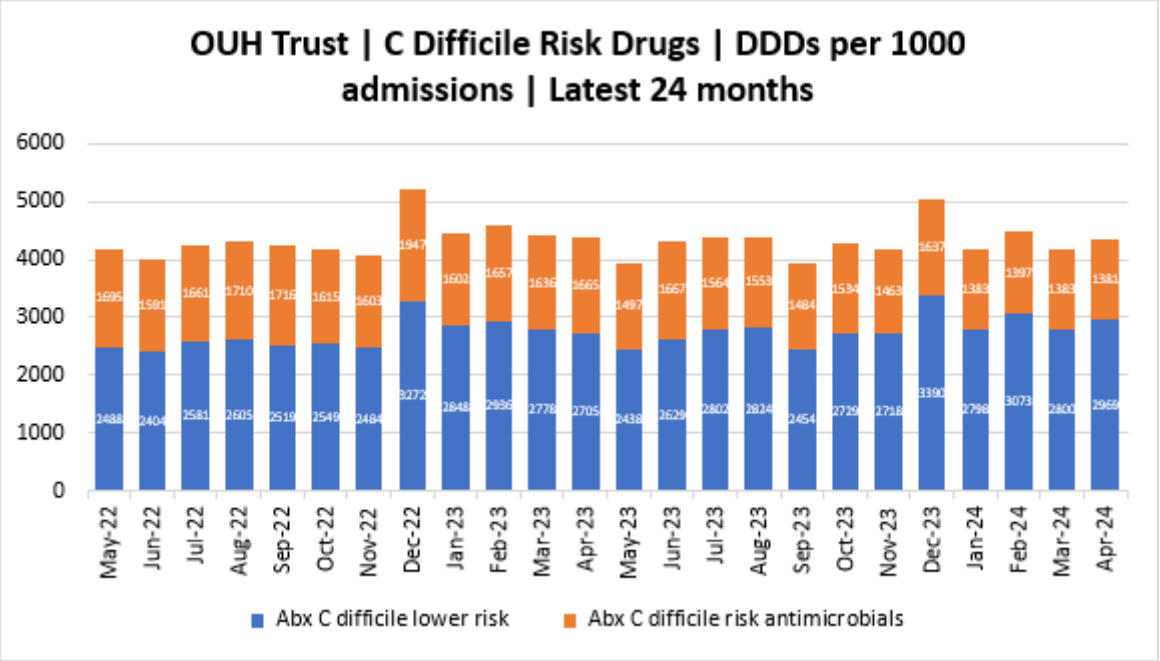
11.7. The 6 day AMS service (including adults, paediatrics and neonates) was introduced in January 2023 and the addition of the Saturday role has received positive feedback from clinical teams and Micro/ID. This benefit has been sustained across the year and the AMS team are recognised as part of the core weekend Micro service. At the weekend the pharmacist supports developing treatment plans for infection management, reviews antimicrobial TDM results and dosing, reviews broad spectrum antibiotic use, conducts a treatment review of patients with *Clostridioides difficile*

and attends the ICU ward round as part of Micro MDT to support discussion about infection treatment plans in addition to answering antimicrobial medication specific questions.

11.8. A treatment plan review of patients with *C.difficile* is conducted by AMS team 6 days a week. This includes an initial review (within the first 24 hours) to provide assurance that the patient's infection is being managed appropriately followed by a review of their antibiotic therapy within the last 28 days to contribute to the RCA process for *C.difficile*. Over the last year the AMS team have worked alongside the IPC team to review the *C.difficile* process, balancing the resource available with the need for a timely review of the patient's management.

11.9. The AMS team have also been monitoring use of antibiotics most likely to be associated with the development of *C. difficile* infection to support learning from C. *difficile* cases. An example is shown in Table 28. This work included review of use of specific antibiotics, for example ceftriaxone and carbapenem antibiotics.

Table 28: Consumption of *C. difficile* Risk antibiotics over time adjusted with admissions



Antimicrobial CQUINS

11.10. The Trust adopted the Antimicrobial Resistance CQUIN for 2023-24. This was CQUIN03: Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria. The target is that less than 60% of prescriptions reviewed should continue to be IV past the point at which they meet switching criteria. In this CQUIN the lower the percentage is the desired outcome.

11.11. Patients to be considered were adult patients (16 years and over) with active prescriptions for IV antibiotics at the point of audit. Exclusions were patients in ICU and HDU (High Dependency Unit).

11.12. OUH successfully met the target for the CQUIN. The compliance for 2023-24 is shown in the table below:

Table 29: Compliance each quarter with Prompt switching of intravenous (IV) antimicrobial treatment to the oral route of administration CQUIN

	Q1 23/24	**Q2 23/24**	**Q3 23/24**	**Q4 23/24**	**Average for the FY 23/34**
% of patients were still receiving IV antibiotics past the point at which they meet switching criteria	33%	12.75%	13.1%	26.27%	21.28%
Met the CQUIN target	Yes	Yes	Yes	Yes	**Yes**

Antimicrobial Stewardship (AMS) Multidisciplinary Team (MDT) ward rounds

11.13. 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 which are recorded.

11.14. Current ward rounds are:

- Haematology-Oncology
- Churchill (excluding ITU and renal transplant, conducted separately)
- JR West Wing (excluding neuro-ITU, conducted separately)
- Horton (adults)
- Paediatrics at JR
- Neonatal unit
- Paediatric Intensive care
- Horton paediatrics
- Oxford Critical Care Unit conducted separately
- Pilot: Surgical admission unit at JR.

11.15. Table 30 shows the number of ward rounds between April 2023 and March 2024 in each area. There has been an increase in the number of ward rounds compared to the same period in the financial year 2022-23 which was 147 rounds.

Table 30: Number of ward rounds in 2023-24

Ward Round	Number of ward rounds
Churchill AMS	79
Horton AMS Adults	31
Horton AMS Paediatrics	31
JR AMS Adults	92
JR AMS Paediatrics	107
Total	**340**

11.16. Table 31 shows the number of patients reviewed and the number of interventions April 2023 to March 2024 in each area.

Table 31: Number of patients reviewed and the number of interventions

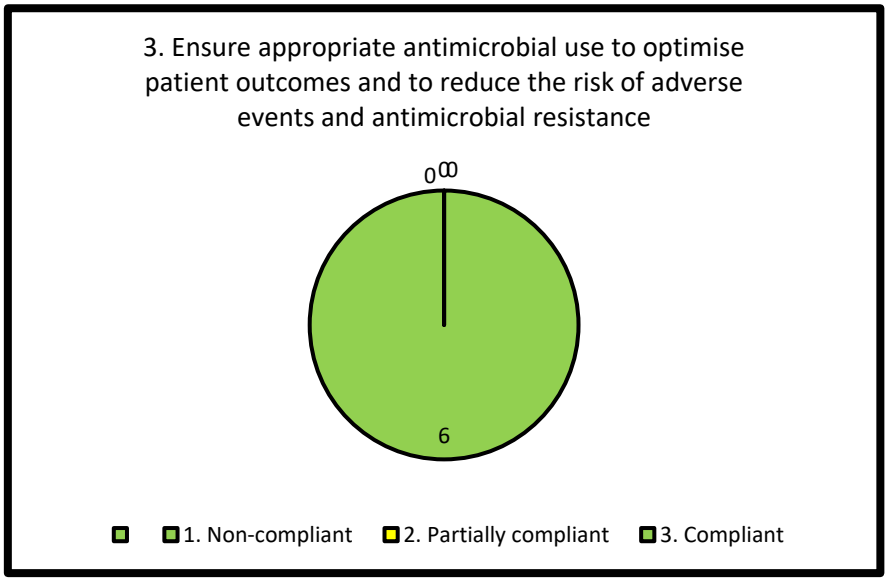
Sites	Number of patients reviewed	Number of interventions
Churchill	1521	1018
Horton Adults	424	171
Horton Paediatrics	87	60
JR Adults	967	554
JR Paediatrics	1245	665

11.17. The AMS team were invited to deliver a poster about the success of the rounds at the national conference British Infection Association Spring Meeting.

11.18. During 2023-24 the AMS team have been reviewing whether the recommendations have been implemented within 24 hours by the clinical team and this information has been shared with the local clinical teams to encourage engagement with AMS.

11.19. The AMS team respond to MHRA Drug Safety Alerts. There was an alert regarding ‘Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate’ in January 2024. The team have reviewed antimicrobial guidelines (adults and paediatrics), reviewed stock lists and ensured that there is access to Patient Information Leaflets when patients are prescribed fluoroquinolones.

Figure 3: BAF Compliance to Criterion 3



Partial Compliant Elements to the BAF	Reason for Partial Compliance
N/A	

12. Criterion 4

12.1. 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.

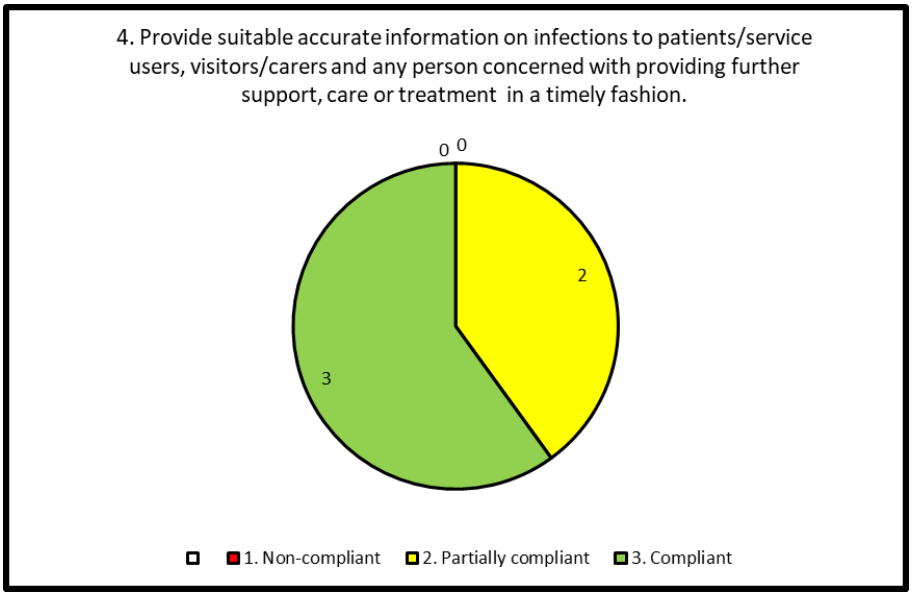
13. Provision of Information

13.1. The IPC team take an active role in promoting patients, staff, and visitors' safety, for example, working with the communication and media team on visual material, and the procurement team on supplies of Personal Protective Equipment (PPE) where required. We continue to work closely with the Chief Nursing Officer's team on the visitor policy questions and assessing the risk of potential nosocomial transmission for all infections, keeping in mind national guidance, and being compassionate.

13.2. The Trust implemented the National Standards of Cleaning and all the star ratings on Cleanliness are displayed for the public on entrances to clinical areas.

13.3. NHSE patient information leaflets are used for providing information to patients. The Buckinghamshire Oxfordshire and Berkshire (BOB) ICS IPC group are also looking at the availability of patient information.

Figure 4: BAF Compliance to Criterion 4



Partial Compliant Elements to the BAF	Reason for Partial Compliance
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 infections.	Working with BOB ICS IPC group to standardise patient information. We use National patient information leaflets. Signage around hospital on PPE use, visiting not always current.
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.	Current IPC surveillance system (ACMEipc) unsupported. System is shared with Oxford Health and will therefore not be able to share relevant information across organisational boundaries.

14. Criterion 5

14.1. 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.

15. Infection Prevention and Control Surveillance Software

1.1. The company that supplies the IPC 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. This system is also used by Oxford Health.

Background to the current system

- ACMEipc has been used by the IPC team (IPCT) since before 2009. It interfaces with Sunquest (the laboratory information management system - LIMS) and Cerner PAS (patient administration system). 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 Q3 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 (via Cerner PAS).
- ACMEipc sends an email to the IPCT when a C. difficile sample is received in the lab or for a positive result (via the LIMS).

- COVID-19 and influenza results are reported to the IPCT through the system.
- The IPCT can create ‘portals’ for any organism of interest, to provide real-time information to support surveillance and outbreak management.
- 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, supporting patient placement and optimal side-room usage, and correct use of equipment such as endoscopes and surgical instruments.

15.1. The risk of a lack of real-time IPC surveillance to support the minimisation of avoidable healthcare associated infection has been added to the risk register and escalated to relevant parties. Ongoing discussions are in progress to find a solution. At present there is no funding to purchase an alternative product and the ongoing revenue costs need to be resolved.

16. Audits

16.1. A point prevalence audit was undertaken in late March 2023 to measure compliance with screening for Carbapenemase-Producing Enterobacteriaceae (CPE) in line with Trust CPE Guidelines. An initial baseline audit undertaken in August 2018, indicated there was an overall compliance of 29.0%, with repeat audits showing compliance of 50.6% in March 2019, 61.3% in November 2019, 64.8% in June 2020 and 59% in June 2021. The results of the March 2023 audit have demonstrated further improvement with a compliance of 70.7 %.

Table 32: Summary of CPE screening compliance March 2023

March 2023	**Total**	**Percent screened**	**Screened?**		**Percent**
			Yes	No	
Screen not required	529	61.6%			
Location/speciality	222	25.8%	147	74	66.2%
Overseas hospital transfer	1	0.1%	1	0	100.0%
UK admission 12 months	4	0.5%	0	4	0.0%
UK hospital transfer	99	11.5%	85	15	85.9%
Inpatient abroad (12 months)	4	0.5%	1	3	25.0%
Previous positive	0	0.0%			
Overall	859		**234**	**96**	**70.7%**

17. Investigation of Infection Prevention and Control Incidents

IPC and the Neonatal unit

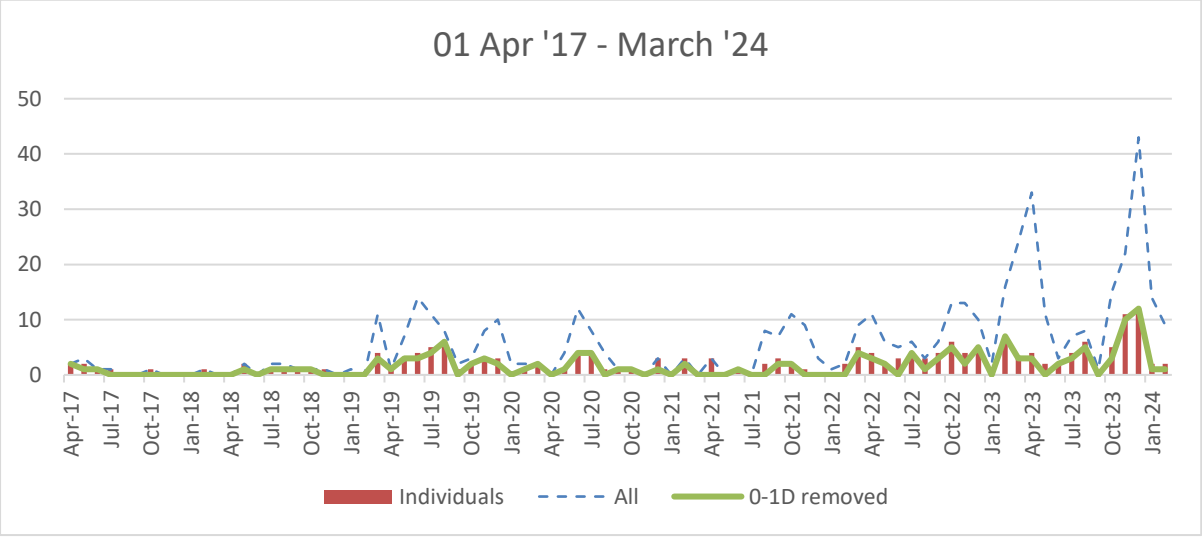
17.1. The neonatal unit has continued to be a cause for concern, this has been shared with the Chief Medical Officer and Chief Nursing Officer. The three units that make up the neonatal department are cramped, with limited storage, and lack a sluice and a suitable area for decontamination of the incubators.

17.2. They do not have an electronic patient record system and are heavily reliant on paper for all clinical, prescribing and nursing notes. This creates clutter in the unit, risk of transmission from multi-use paperwork, and hamper's ability to perform antimicrobial audit.

17.3. An ESBL outbreak was declared on 23 November 2022 and closed in July 2023. The ESBL outbreak was then reopened in November 2023 due to a significant increase in cases. The outbreak was closed again in February 2024 as there have been no new cases of ESBL colonisation with the outbreak strain since January 2024 (Table 33). Monthly meetings will continue to be held in addition to the regular IPC visits with a focus on IPC practice in the unit.

17.4. Outbreak meetings have been held regularly and an action plan monitored. A number of actions have been completed, including the purchase of new incubators. The more complex actions such as removing paper from the unit, building a decontamination space and storage solutions have yet to be undertaken.

Table 33: Neonatal ESBL by sample type



Toxigenic Diphtheria ulcerans

17.5. A patient was confirmed to have toxigenic *Corynebacterium ulcerans* (expressing diphtheria toxin) in a leg ulcer in July 2023. The source was

thought most likely to be a companion animal. An Incident Management meeting was held between the Trust and the local health protection team of the UKHSA to understand the treatment the patient was receiving and any risk of exposure to healthcare workers.

17.6. UKHSA guidance requires that cases of toxigenic *C. ulcerans* are managed in the same way as exposure to *C. diphtheriae*, with mass chemoprophylaxis and exclusion from the workplace for staff. A small number of cases of zoonotic transmission of toxigenic *C. ulcerans* is seen each year in association with companion animals. To date, person-to-person spread of *C. ulcerans* has not been definitively documented, and the majority of swabs taken from close human contacts of cases of *C. ulcerans* have been culture-negative. However, in three incidents, reported in 1996, 1998 and 2014, toxigenic *C. ulcerans* was isolated from asymptomatic contacts of cases, raising the possibility of person-to-person transmission. The DIPC therefore asked for a proportionate response, noting the pressures on NHS staffing and disbenefits associated with chemoprophylaxis. IPC, clinical teams, and Occupational Health undertook risk assessments of staff that were not wearing the correct PPE to decide on appropriate management, and exposed staff members were swabbed with no positive results. The John Warin team arranged for the vaccination of the patient, husband and SCAS team.

Measles

17.7. Outbreaks of measles have been ongoing in the West Midlands and London since 1 October 2023 which has led to a requirement for healthcare facilities to be aware of cases presenting within their organisation.

17.8. A number of suspected/confirmed cases have presented to OUH which has required contact tracing and ‘warn and inform’ correspondence.

17.9. The AMS/Pharmacy team have been working to ensure that the Trust has access to supplies of immunoglobulin and MMR vaccine, as UKHSA have now delegated that responsibility to local organisations rather than central provision. A new testing process to support rapid diagnosis has been set up by the laboratory as the surveillance system operated by UKHSA does not support acute trusts with urgent testing.

17.10. Regular communications have been sent out via corporate comms with more focused comms to key individual areas including all same day emergency care centre (SDECs). IPC team have completed walk arounds in SDECs to understand the level of awareness of measles. The Occupational Health team are reviewing staff immunity.

Bedbugs

17.11. Following a report from a maternity patient about itching, five out of eight mattresses across two bays in the Women's Centre were confirmed by Estates Pest Control to contain bedbugs, with an additional report of bedbugs in a parent room. All affected mattresses were removed and a chemical clean was completed.

Norovirus Outbreaks

17.12. Renal ward at the Churchill had a norovirus outbreak in July 2023, predominantly affecting the staff, 11 members reported symptoms and only two patients.

17.13. During December 2023 there were three confirmed Norovirus outbreaks on CMU C, 7F and Juniper ward. Other general medical wards reported an increased incidence of diarrhoea but with no laboratory confirmation of norovirus. 6-day working by the IPC team helped to contain the outbreak.

Increased incidence of C. difficile in CMU B

17.14. During June and July 2023 it was noted that CMU B were experiencing a higher number of C. difficile cases than usual. A look back to April and May was also undertaken.

Table 34: C. difficile cases on CMU B

Total C. difficile Positive Sample from April 2023 to July 2023	Samples
April 2023	1 COCA
May 2023	1 False Positive
June 2023	1 COHA, 2 HOHA
July 2023	4 HOHA

(Expected 0-1 HOHA cases/month)

17.15. An outbreak meeting was held with the key stakeholders. Nine samples were sent to the reference laboratory for typing. Four samples indicated new introductions but there was a cluster of three patients with ribotype 106 and two patients with ribotype 014 which indicated possible transmission. An action plan was developed and presented to demonstrate improvement in hand hygiene, and cleaning. Since the outbreak, IPC have been working closely with the clinical team to ensure that the standard of cleaning and hand hygiene is maintained. There have been two HOHA cases since July 2023. The ward replaced all the commodes, made sure there was sufficient stock of sporicidal wipes, expresso teachings were held to raise awareness, frequent walk rounds were undertaken to support the knowledge of the ward staff, for example reducing the delay in sampling.

Increased Incidence of Diarrhoea and Vomiting in Sexual Health Clinic

17.16. IPC were alerted to a number of staff working in the Sexual Health Clinic at the Churchill who had reported diarrhoea and vomiting, thought to have impacted around 12 people. IPC visited the unit with the matron and identified several concerning elements around sanitary conditions and IPC practice. Recommendations which included cleaning, hand hygiene were made which the staff acted upon.

Tuberculosis Incident in Transplant Ward

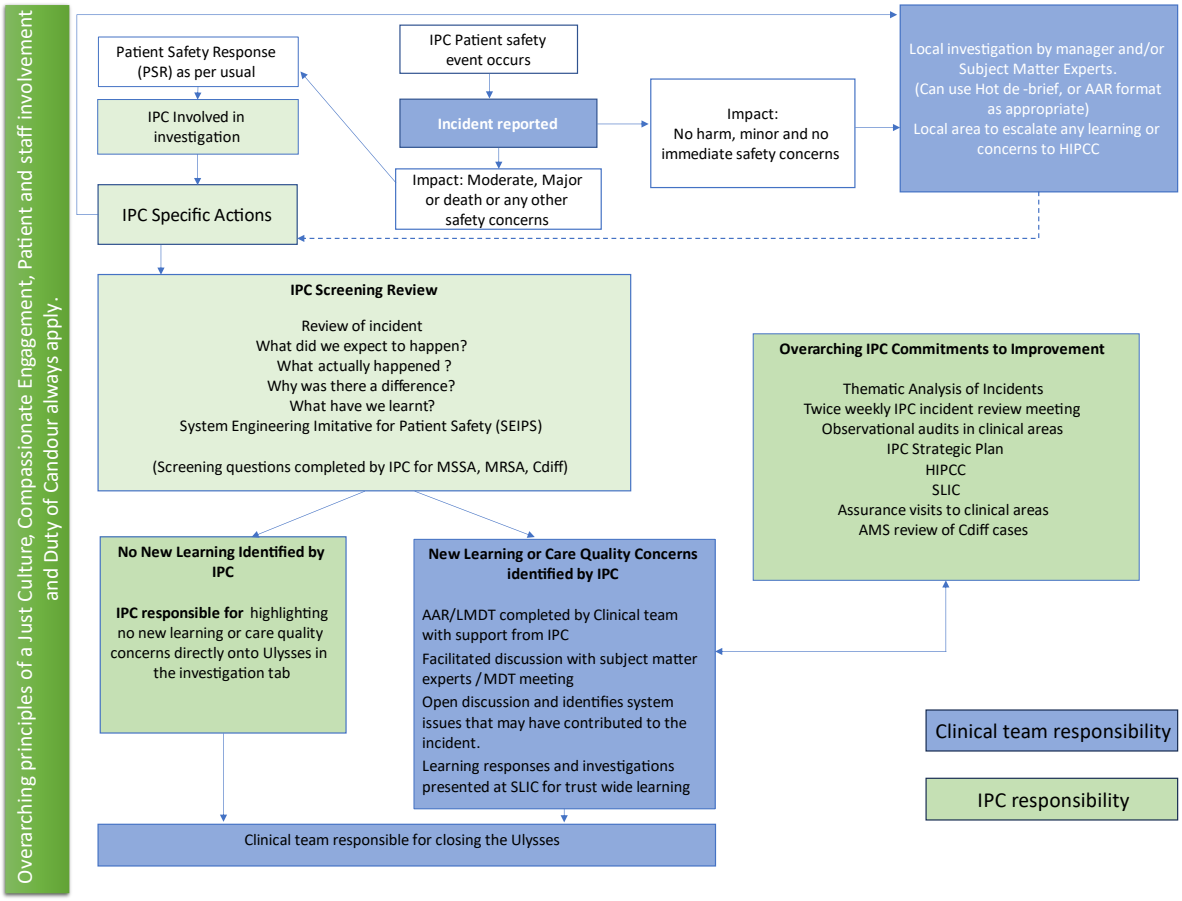
17.17. A patient in the Churchill site tested positive for Tuberculosis (April 2023). They were not smear positive and not coughing. The TB policy states if patients are exposed to a patient with sputum smear positive TB for long enough to be equivalent to household contacts or an exposed patient is known to be particularly susceptible to infection (e.g., immuno-compromised), they should be managed as equivalent to household contacts. As the patient was being cared for on a ward that predominantly looks after immunocompromised individuals, 6 patients were notified of their exposure. There is no evidence of transmission from this episode.

17.18. Occupational Health have informed staff of their potential exposure.

18. Patient Safety Incident Response Framework (PSIRF)

18.1. The IPC team have worked with the patient safety team and the divisions to agree on IPC incident management form 1 April 2024. A flowchart to support the IPC PSIRF process is shown in Table 35. This has been shared with the BOB ISC IPC group with positive feedback.

Table 35: IPC PSIRF Process



19. Surgical Site Infection Surveillance (SSI)

Cardiac Surgery

19.1. Cardiac surgery continues to participate in voluntary surveillance and Surgical Site Infections (SSIs) information is reported to the UKHSA SSI surveillance service every quarter.

TAVI surgical site surveillance

19.2. There have been no reported SSI cases for TAVI patients since April 2022 to March 2024. The total cases during this period are 875 patients.

Table 36: Non–CABG SSI RATES April 2023 to March 2024

Non-CABG Cardiac surgery Surgical site infections	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Final
Quarter 4 Jan-Mar 2023	(0/79) = 0%	(0/79) = 0%	(0/79) = 0%	(0/79) = 0%	Yes
Quarter 1 Apr-Jun 2023	(0/99) = 0%	(0/99) = 0%	(0/99) = 0%	(0/99) = 0%	Yes
Quarter 2 Jul-Sep 2023	(0/95) =0%	(1/95) =1%	(0/95) =0%	(1/95) =1%	Yes
Quarter 3 Oct-Dec 2023	(0/76) = 0%	(0/76) = 0%	(0/76) = 0%	(0/76) = 0%	Yes
Quarter 4 Jan-Mar 2024 (Due to finalised June 2024)	(0/88) = 0%	(0/88) = 0%	(0/88) = 0%	(0/88) = 0%	No

Table 37: CABG SSI RATES April 2023 to March 2024

CABG Surgical site infections	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Final
Quarter 4 Jan-Mar 2023	(1/105) = 0.9%	(1/105) =0.9%	(2/105) = 1.9%	(4/105) = 3.8%	Yes
Quarter 1 Apr-Jun 2023	(1/97) = 1%	(3/97) = 3.1%	(0/97) = 0%	(4/97) = 4.1%	Yes
Quarter 2 Jul-Sep 2023	(2/97) 2.1%	(0/97) = 0%	(0/97) = 0%	(2/97) 2.1%	Yes
Quarter 3 Oct-Dec 2023	(3/91) =3.3% TBC (one donor site)	(0/91) =0%	(0/91) =0%	(3/91) =3.3% TBC (one donor site)	Yes
Quarter 4 Jan-Mar 2024 (Due to finalised June 2024)	(1/100) = 1% (one donor site)	(0/100) = 0%	(0/100) = 0%	(1/100) = 1% (one donor site)	No

Trauma and Orthopaedic SSI Surveillance

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

- hip replacements
- knee replacements

- repair of neck of femur
- reduction of long bone fracture

19.4. OUH collects continuous data on repair of neck of femur at both the Horton and JR sites.

Table 38: Fractured Neck of Femur SSI Rates

	JRH				HGH			
	All #NOF Operations	No. SSI cases	JR SSI rate (%)	Outlier status	All #NOF Operations	No. SSI cases	HGH SSI rate (%)	Outlier status
Q4 Jan-Mar 2023	110	3	2.7%	High outlier	58	0	0.0%	
Q1 Apr-Jun	114	1	0.9%		72	0	0.0%	
Q2 Jul-Sep	95	0	0.0%		66	0	0.0%	
Q3 Oct-Dec	120	1	0.8%		59	0	0.0%	
Q4 Jan-Mar 2024								

Table 39: Fractured Neck of Femur SSI Rates Horton and JR (2020-23)

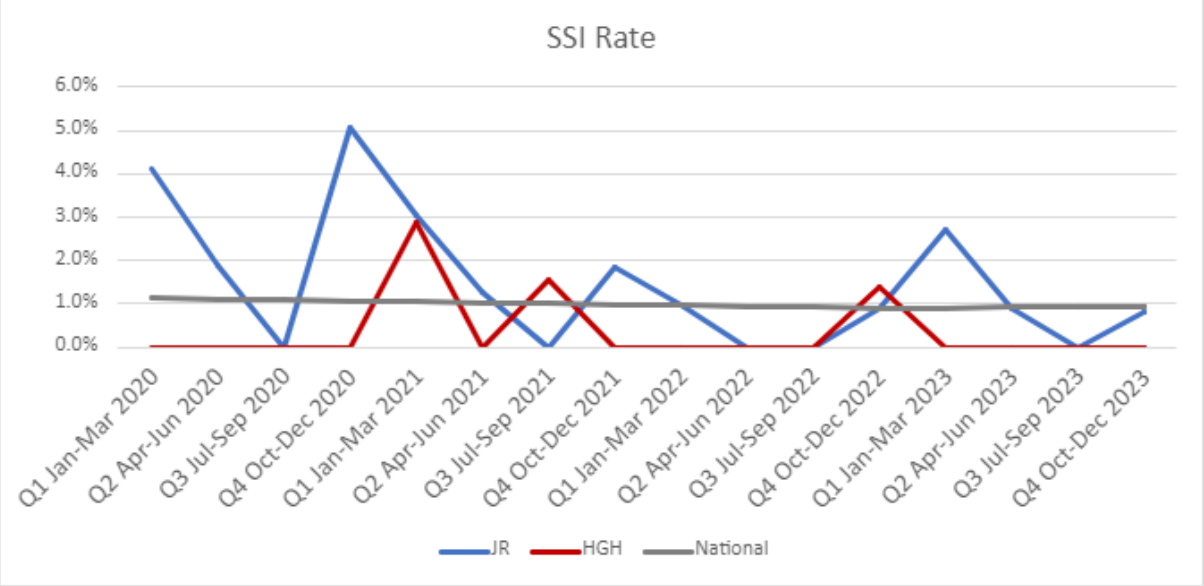


Table 40: National Average 5 years to date

All #NOF Operations	No. SSI cases	National SSI rate (%)
93810	852	0.9%
94075	839	0.9%
94925	851	0.9%
96216	867	0.9%

Spinal Service and Surgical Site Infection (SSI)

19.5. In January 2023, there was a review by NHSE Specialised Commissioning of paediatric spinal surgery service which identified two serious concerns (a) the high rates of SSI associated with idiopathic scoliosis surgery and (b) extended waiting times for paediatric surgery (the response to this aspect is not included in this report). NHSE Identified that the ongoing arrangement for monitoring progress in addressing the serious concerns would be to follow up through the contracting route as part of a Service Development Improvement Plan (SDIP).

19.6. The figure reported to the review team was an SSI rate of 9% (updated to 7.8%) against standard of 1.2%, and the review team reported that they were unclear what the learning had been following investigations.

19.7. The SSI reduction bundle was relaunched across the service in April 2024 and a number of actions agreed which included auditing compliance to the SSI reduction bundle. The IPC team have been involved in agreeing what is included in the audit tool and an IPC nurse with theatre skills will undertake theatre visits.

19.8. The paediatric neurosurgical governance lead has provided assurance that there is on-going SSI surveillance using a locally maintained database. This data will be reviewed when the NHSE Specialised Commissioning team return later in the year to review the audit compliance to SSI bundle data.

Table 41: Paediatric Spinal Infections 2023

EOS Early Onset Scoliosis (Scoliosis in children under the age of 10 years)

AIS Adolescent idiopathic scoliosis

NM Neuromuscular

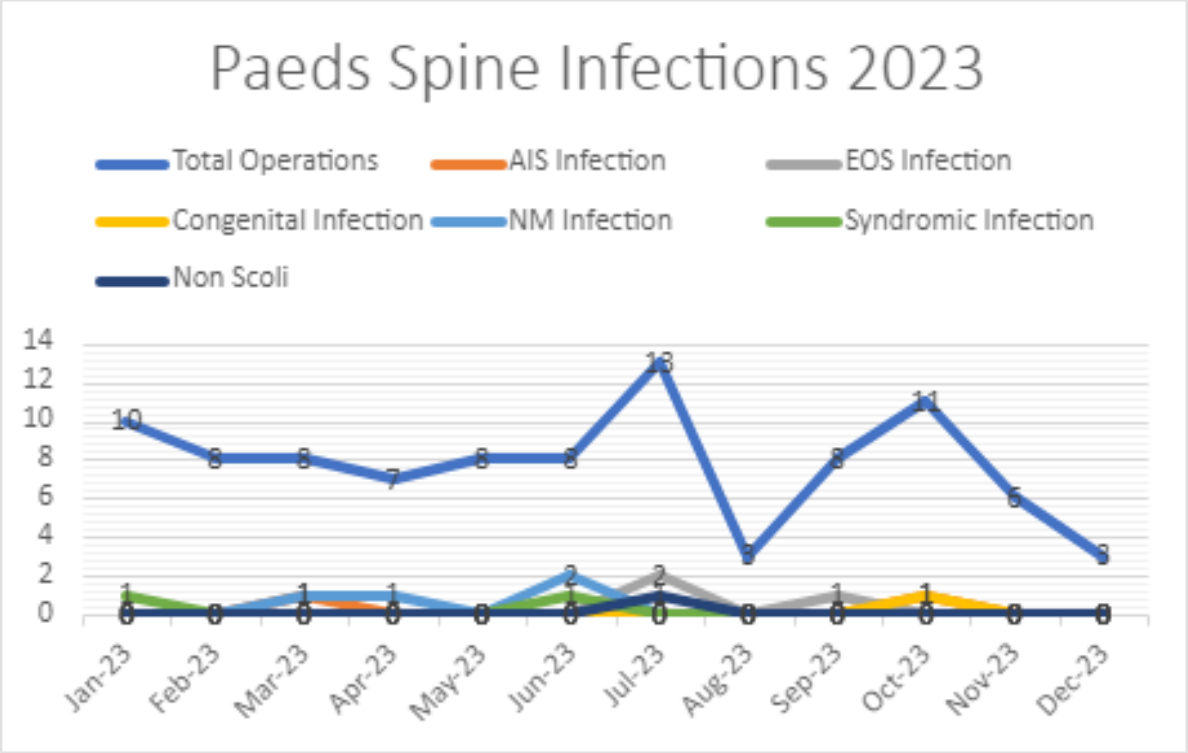
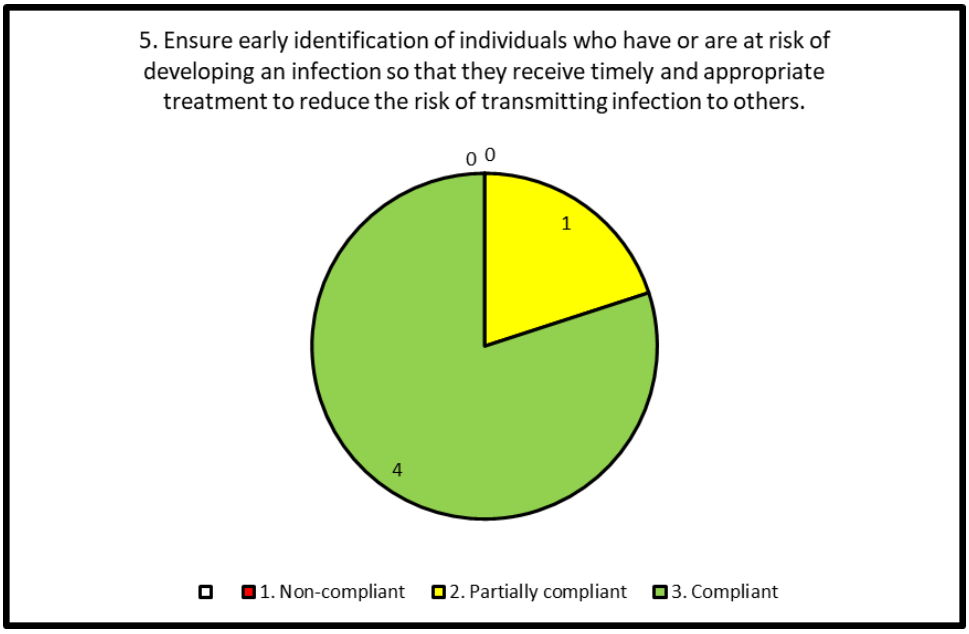


Figure 5: BAF Compliance to Criterion 5



Partial Compliant Elements to the BAF	Reason for Partial Compliance
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 receives timely and appropriate treatment to reduce the risk of infection transmission.	Loss of functionality from current IPC surveillance system and no replacement system planned

20. Criterion 6

20.1. 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.

21. IPC Training

21.1. 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.

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

21.3. 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.

Infection Prevention and Control Link Practitioner Workshop

21.4. The second link practitioner workshop was held in July 2023 and received excellent feedback with 100% of attendees reporting to be either extremely or very satisfied. The sessions were reported to be very informative and interactive and instilled confidence.

22. Sustainability Projects

22.1. The IPC team have been working with other teams to introduce some sustainability projects that are also cost neutral or cost saving, for example, removal of blue couch roll, standardisation of incontinence pads, trialling of washable curtains.

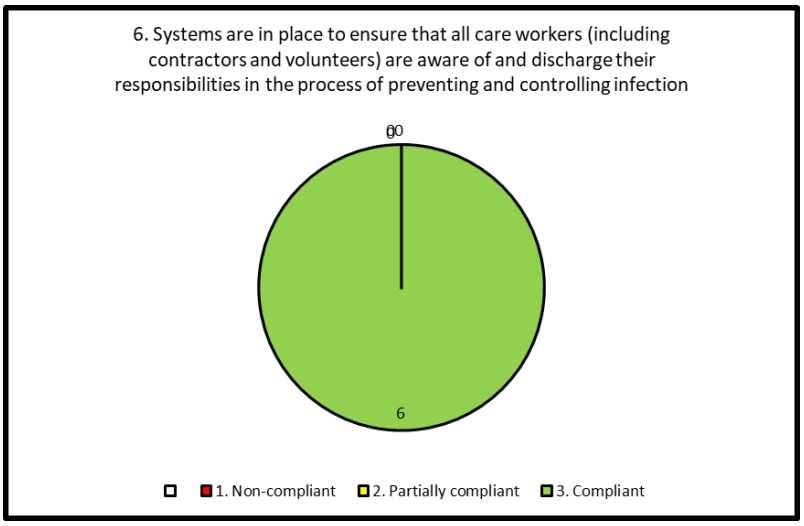
23. OUH IPC Team national positions of responsibility

23.1. The Deputy DIPC/Lead Nurse is President for the Infection Prevention Society (IPS) (September 2022-September 2024).

23.2. The DIPC was President of the British Infection Association until May 2023. She is a member of the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) which advises the government on the threat posed by new and emerging respiratory viruses, Expert Advisor to the Infected Blood Inquiry, and a member of the Infectious Diseases Clinical Reference (commissioning) group.

23.3. The Consultant Pharmacist for Antimicrobial Stewardship is the Associate Membership Secretary for the British Infection Association (de-mitted May 2024).

Figure 6: BAF Compliance to Criterion 6



24. Criterion 7

24.1. The provision or ability to secure adequate isolation facilities.

25. Isolation facilities

25.1. 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 critical care facility on the John Radcliffe site offers additional isolation facilities with 10 PPVL rooms.

26. High Consequence Infectious disease

26.1. The Trust made a successful application to become a centre for Airborne high consequence infectious disease (HCID) in 2023-24 and work has been undertaken this year to prepare the trust to receive patients. The Trust has an HCID group that meets monthly and maintains the HCID protocol. OUH has National HCID Airborne status which means that the unit (John Warin Ward and/or Oxford Critical Care) must be able to admit a patient (adult or child) and start treatment within six hours of a confirmed diagnosis; and to operate continuously for three weeks following unit activation with the admission of an HCID patient. The unit may be asked to take a family or up to three patients when fully operational.

26.2. The ‘go live’ date has not yet been agreed with between the OUH and NHSE as preparations are not yet complete for us to receive a confirmed case referral. We remain ready however, to receive suspected cases of airborne or contact HCID.

26.3. Actions for preparedness are being worked through and progress to date includes:

- Appointments of clinical leads in paediatrics, paediatric critical care, infectious diseases, and adult critical care.
- An HCID Lead Nurse is now in post.
- Enabling work on JWW to maximise storage and doors/security to separate the HCID facility from the main ward area has been completed with NHSE funding.
- Enrolment for the train the trainer day for 8 staff in HCID PPE to take place in June 2024 (Sheffield).
- Attendance at HCID Network Day in May 2024.
- Revision of HCID plan to separate into suspected and confirmed cases.
- Review of ventilation by the Authorising Engineer for Ventilation that now needs to be considered by the Head of Estates/DIPC.
- Visit from NHSE, the health and safety executive and EPRR (emergency preparedness, resilience and response) teams planned for June 2024.

27. Impact of COVID-19 in 2023-24

27.1. The new testing guidance issued in April 2023 by UKHSA/NHSE was implemented on 17 April along with a change in the wearing of masks, and staff and patient isolation.

27.2. Testing for SARS-CoV-2 was reduced to symptomatic patients, care home discharges or patients being admitted to wards where immunocompromised patients are cared for. In August reporting outbreaks to the national reporting database ceased. Most patients no longer require COVID-19 specific treatment and the requirement to isolate or cohort COVID-19 exposed/contact patients or undertake asymptomatic screening of them ceased, except for in immunosuppressed patient areas. If exposed patients become symptomatic, locally we require a lateral flow test for immediate IPC information and Polymerase Chain Reaction (PCR) taken as per the patient testing guidance. The IPC team continued to record details of exposed patients.

27.3. The IPC continued to follow up all COVID-19 cases throughout the year; this was approximately 1,650 cases. Throughout the year, operational pressures have regularly caused challenges to isolation of patients with infectious respiratory conditions.

28. Influenza and RSV (Respiratory Syncytial Virus)

Influenza and COVID -19 Outbreaks

28.1. CMU-C had 8 nosocomial cases of influenza between 30 December and 6 January. Four patients with a diagnosis of influenza died. The ward was temporarily closed to new admissions for 48 hours due to the concern over the number of positive cases and exposed patients.

28.2. The patients that died had a case review by the Infection Control Doctor in conjunction with clinical teams. The patients were all considered to be end of life prior to the positive influenza result and influenza was not thought to be the cause of death.

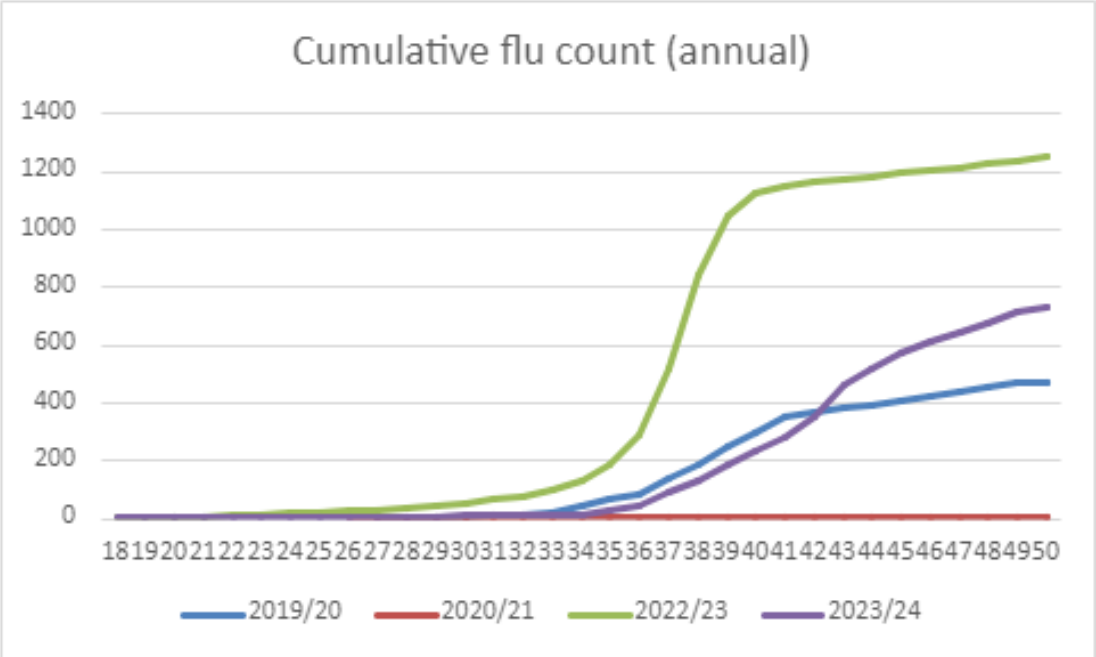
28.3. F ward at the Horton saw two patients who had coinfection with influenza and COVID-19.

28.4. Staff have been reminded to consider wearing masks in areas where there are influenza outbreaks/respiratory viruses circulating.

28.5. The Bone Infection Unit had an influenza outbreak during January, which involved five patients and two members of staff.

Table 42: Weekly OUH Cumulative Influenza Numbers to end March 2024

28.6. The graph of cumulative cases by week number shows that influenza case numbers overall were less than in 2022-23.



28.7. The cumulative and weekly RSV data shows a smaller number of cases in 2023-24 than in 2022-23, with a later onset of cases.

Table 43: Weekly Cumulative RSV Numbers

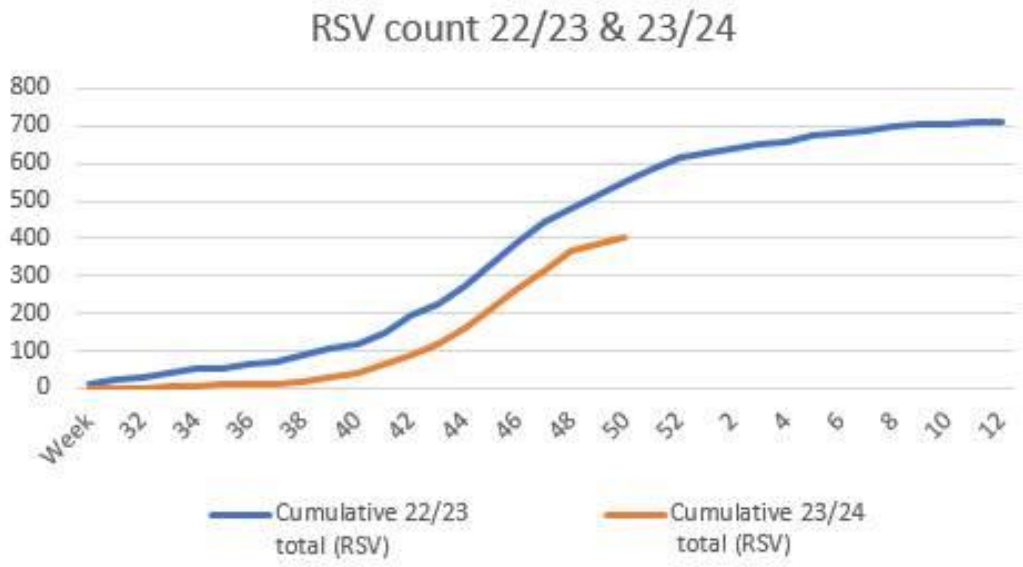


Table 44: Weekly RSV Counts

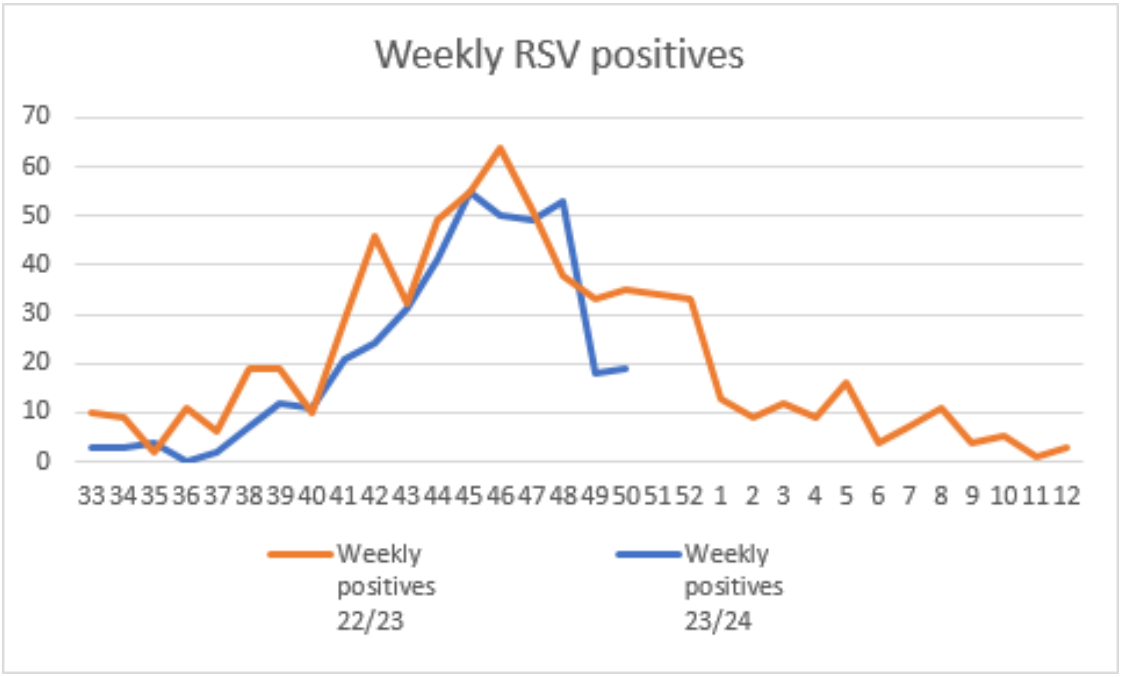
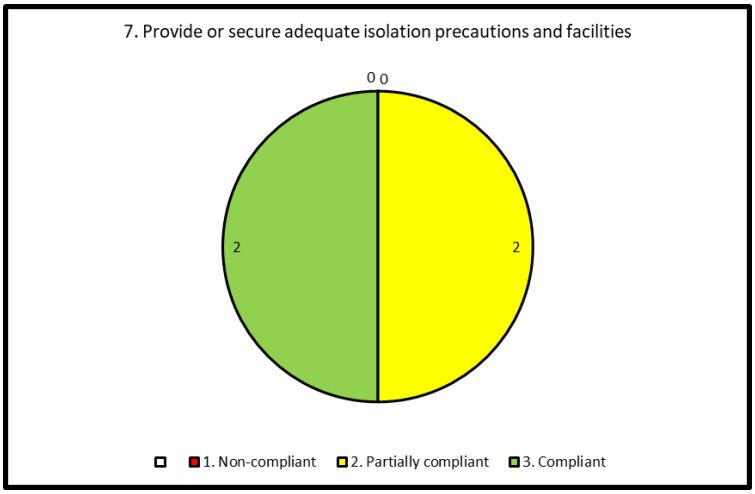


Figure 7: BAF Compliance to Criterion 7



Partial Compliant Elements to the BAF	Reason for Partial Compliance
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.	Loss of functionality from current IPC surveillance system and no replacement system planned.
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.	Loss of functionality from current IPC surveillance system and no replacement system planned.

29. Criterion 8

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

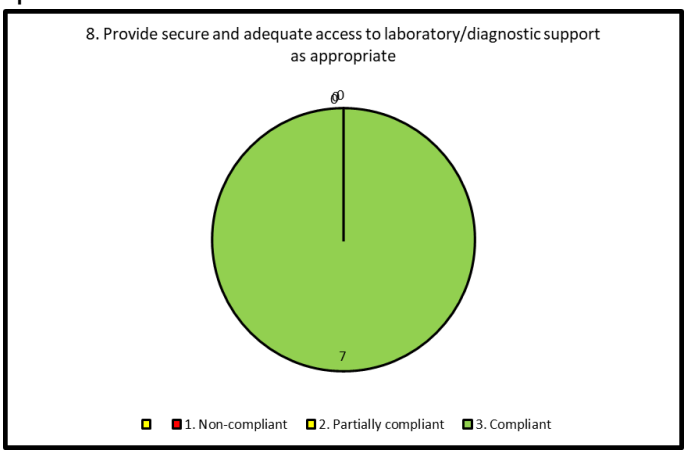
30. Role of the Microbiology Laboratory

30.1. OUH has a dedicated in-house Microbiology Laboratory which provides a 24/7 service with United Kingdom Accreditation Service (UKAS) accreditation (ISO-15189). A Microbiology Consultant and SpR are available 7 days a week to provide IPC advice and support. The Microbiology clinical team also provide out of hours IPC support to Oxford Health if required. The IPC team attend the Microbiology 'plate' round daily, and present cases and issues for discussion, including C. difficile RCAs for feedback to clinical teams in real-time. The Microbiology LIMS currently 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.

30.2. During 2023-24 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.

30.3. The Oxford University NIHR HPRU in Healthcare Associate Infections and Antimicrobial Resistance supports IPC Investigation with pathogen sequencing e.g. ESBL producing organisms on the neonatal unit, and 'big-data'.

Figure 8: BAF Compliance to Criterion 8



31. Criterion 9

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

32. Sepsis

32.1. The Sepsis Team expanded to four nurses from 2023, facilitating cross site cover of OUH including the Churchill and Horton General hospitals.

This has improved equity of service across the OUH and enabled us to provide cross site training, raising awareness and contributing to better patient care, management and outcomes as seen in the Trust's performance on sepsis care below.

Paediatric Sepsis Education Strategy Development

32.2. The Sepsis Team has been developing our paediatric sepsis education strategy. This initiative was prompted by a recent Serious Incident Requiring Investigation (SIRI) which identified no routine paediatric sepsis training within the Oxford University Hospitals (OUH).

32.3. We have collaborated closely with the paediatric education team to facilitate this training and are awaiting approval to advertise for a paediatric sepsis nurse secondment. This role will be instrumental in the development of a comprehensive paediatric sepsis education strategy, to include:

- A paediatric sepsis workshop.
- A paediatric sepsis e-learning package.
- An audit of OUH's current sepsis performance in paediatrics, specifically focusing on the time to antibiotics from a sepsis alert.

Adult Sepsis Training

32.4. In addition to our paediatric focus, we continue to deliver in-house adult sepsis training for the multidisciplinary team, which has received consistently positive feedback. Our quarterly bespoke workshops for Healthcare Assistants are particularly well-received and well-attended.

32.5. Moreover, we provide monthly update training for our link practitioners, with the next session in August already fully booked

Quality Improvement (QI) Project – blood cultures

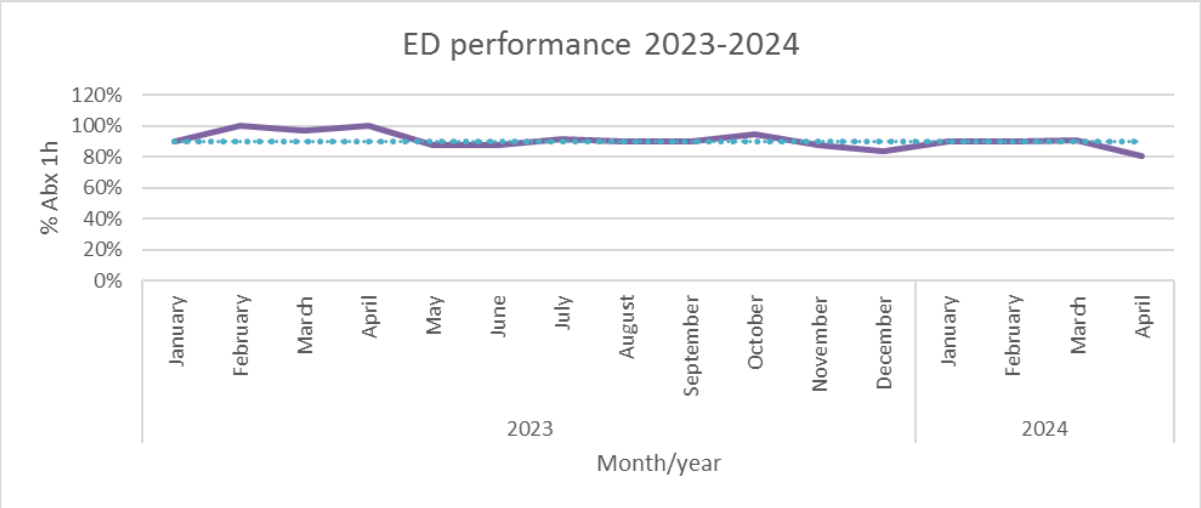
32.6. We are actively working on a Quality Improvement (QI) project aimed at enhancing the blood culture pathway. This project focuses specifically on improving blood volume and reducing contamination rates. Currently, we are in the data collection phase and plan to roll out education and training in collaboration with Becton Dickinson (BD). Following this, we aim to present our findings at the QI hub and explore publication opportunities.

Antibiotics within 1 hour of a sepsis diagnosis

32.7. Beyond education, the team continues to screen and review patients to ensure rapid clinical assessment and timely administration of antibiotics for those meeting the NICE high-risk criteria. As a trust, we have consistently

achieved over 90% compliance in administering antibiotics within one hour in patients presenting with sepsis over the past year.

Table 45: ED Sepsis performance – Antibiotics within 1 hour of a sepsis diagnosis



33. Ventilator Associated Pneumonia (VAP) Working Group

33.1. The coding team provided the IPC team with numbers of patients coded for a VAP in 2022-23, which was 136 spells. On review of the data there was some concern by the clinical teams that the data was not entirely accurate, however, it acted as a baseline measure.

33.2. A VAP working group has been formed with representatives from all adult and children's intensive care areas, IPC, Infectious Diseases and clinical risk practitioners. The aims of this group are for:

- VAP rates to be reported to HIPCC.
- Bundle compliance rates to be reported to HIPCC.
- VAP rates to be within agreed target rates.

33.3. In order to achieve these aims there a number of actions to:

- Agree a definition/diagnosis of VAP.
- Agree a VAP bundle.
- Agree methodology for surveillance.
- Undertake surveillance.

33.4. Progress has been made, a definition has been agreed, work on surveillance is underway, and the VAP bundle is on the Ulysses audit module.

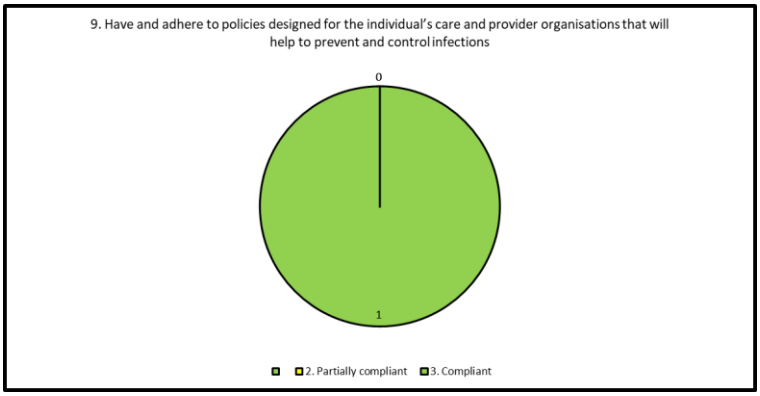
33.5. At the end of 2023-24 the number of spells for VAP had reduced by 22% (down to 106). This clearly means better outcomes for patients, a

reduction on the use of antimicrobials but also has a financial saving as NHSE quote that the cost of treating a VAP ranges from £10-£20,000.

34. Gloves Off Campaign

34.1. The Gloves Off project was launched in August 2023. During this year an IPCN has been undertaking a quality improvement project at the Nuffield Orthopaedic Centre (NOC). At the end of this financial year the action plan has been completed. There is now a period of review which includes looking at the number of gloves used, and this will be compared with the numbers from the previous year. In addition a 'glove use' audit will be conducted to verify if there has been an improvement in practice. The IPC team are keen to widen this out across the organisation.

Figure 9: BAF Compliance to Criterion 9



35. Criterion 10

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

36. Staff Health

36.1. The Centre for Occupational Health and Wellbeing (COHWB) are members of HIPCC and present a twice-yearly report, including data on needlestick injuries. Support for staff sustaining a needlestick or sharps injury is available 24/7, supported out of hours by the Microbiology on-call team. No reported blood borne virus transmission to staff has been reported in 2023-24.

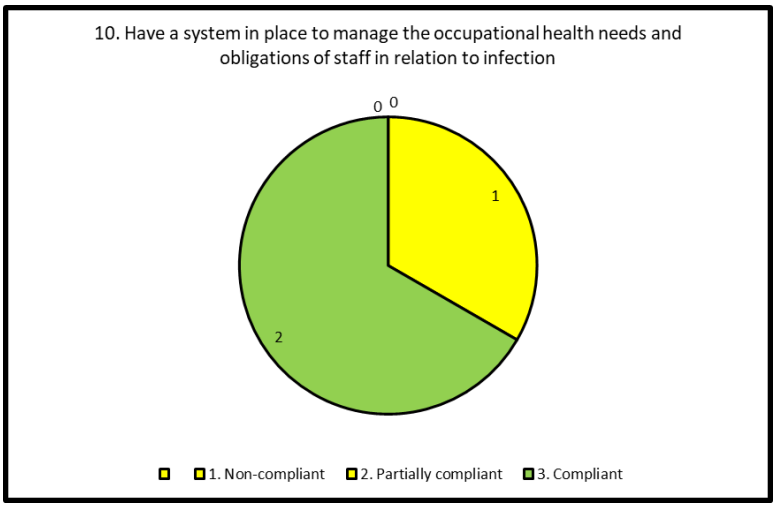
36.2. In 2023-24 Winter Staff Vaccination team was co-ordinated by the COHWB and together with 149 peer vaccinators delivered both Influenza and COVID-19 vaccination for OUH staff.

36.3. OUH Staff Influenza and COVID-19 vaccine rates 2023-24 season:

- The final percentage for influenza vaccination in front line HCW: 54%.
- The final percentage for COVID-19 vaccination in front line HCW: 41%
- Total No. of HCW's involved with direct patient care: 12,879.

36.4. In addition to routine staff immunisation activities, in response to the 2022 outbreak of MPox COHWB have supported staff immunisation for staff at risk of MPox exposure and have reviewed staff measles vaccination data as part of the response to the current national measles outbreak. Communication about the importance of staff immunity to measles and access to immunisation has been sent to all staff via the corporate communications system.

Figure 10: BAF Compliance to Criterion 10



Partial Compliant Elements to the BAF	Reason for Partial Compliance
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.	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.

37. Conclusion

37.1. This report details the work of the IPC teams over 2023-24 and is set against the Health and Social Care Act (2015) criterion.

38. Recommendations

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

Appendix 1: IPC Strategic Plan 2023-25

Strategic Plan 2023-24

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 an 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	SW	(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	(1) Consultation process now closed. Formal notification made to those impacted, HR and TUs. (2) Successful internal promotion of B6 to B7, otherwise unsuccessful with securing new B7 (3) New B8A in post (4) Completed (5) SOP developed and agreed (6) Rota planned for next 3 months for start of working Saturday's and BHs from beginning of Nov (7) Two B6's to begin Masters study this academic year (8) Work in progress	(2) ongoing (6) Healthroster now fully supporting Saturday and BH working rota. (7) 1B7 starting Masters study in January and the other deferred to start next academic year (8) ongoing	(2) two experienced B6's due to start in May (7) 3 B7 to commence formal qualification (8) Ongoing - will need a focus in appraisals

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 eg 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 eg Ulysses	LB	MT	(1) VAP group established (2-8) work commenced on agreement of these topics (9-11) will commence after agreement on other topics	(1) VAP grp established (2) Adult areas agreed to use CDC definition in adults (3-11) remain work in progress, agreement reached on audit criteria and to be amended on Ulysses.	(3-11) OCCU and PICU exploring ways with Phillips to extract VAP rates from CareVue, once this is solved we can then work on reporting rates.	(1) VAP group not met this quarter as working with CareVue (6) Audit tool agreed and on Ulysses audit module (9) Progress made with data extraction from CareVue, meeting to be held with ICU & PICU
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	SM/SH/OO	LB	(1) Preliminary work commenced		(1) SM/SH/OO (5) Work ongoing in the trust re-standardisation of products, working with BD (trays). Working across BOB ICB standardisation of passport and catheter care. Meeting arranged with Deputy Head of informatics to improve documentation of catheters following work with Mihir.	(5) initial trial of Catheterisation trays on CMU promising, further roll out planned at HH. PP now complete awaiting final feedback then printing. Work on going with informatics.

	(9)Develop HIPCC dashboard to include CAUTI rates and bundle compliance						
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	AS	(1) Preliminary work commenced (2) COVID-19 RCA reviewed (3) Not yet confirmed	(1) Consideration of process at team away day. Decision to move away from RCA/questionnaire on incidents where no new learning going to be found. (2) Discussed with BOB leads and ICS leads (3) Flow sheet of process being worked up.	(1) ongoing (2) ongoing, time scheduled with Ulysses team in February (3) ongoing, aim to have a documented plan by end of Jan for sharing with BOB	(1) Ongoing work (2) C.diff questionnaire shortened and will be on Ulysses in Q1 (3) Process now agreed and implementation started in Q1 2024
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	(1) Gap analysis undertaken (2) eLearning been updated, needs peer review and then will be launched	(2) Non-clinical E-learning updated and live Nov 23 and clinical E-learning updated and live Dec 23.	Now completed
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		(1) Clinical Decon Practitioner undertaken SharePoint training, now planning on populating site further	(1) As last quarter will now close as will become BAU

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	(1) Scoping meeting held; actions identified	(1) Plan to review the implementation of fabric curtains in WW and CHOX and use this as learning across rest of organisation.	(1) Awaiting update still from CHOX and WW
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	(1) Tristel Fuse (sporicidal product) being reviewed and considered for trial in CMU wards	(1) Tristel fuse in use on level 7. Evaluation to be undertaken	(1) As last quarter
Review current hand hygiene care products and consider options	(1) Stakeholder group to be set up	LB		(1) Procurement undertaking preliminary back ground work	(1) No update from last quarter	(1) no update	(1) Procurement do not have resources to look at this yet, delayed to next year
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	(1) Audit tool developed (2) Focus on critical scopes (3) Surveillance commenced (4) Will be presented at Decon Comm	(1) Audit tool available (2) Critical scopes this quarter with view to look at non-invasive in Q4 (3)Now have an asset list, working with Clinical Engineering (4) Agree that Clinical Decon Practitioner (CDP) will provide update paper on activities to Dec Committee and will be included in PSEC paper going from Q4	(2) Audit commenced
Criterion 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to recue 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. 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.	(1) Indication and duration recording both >95% 2). Appropriateness >90%	AMS team	1) 19/01/24 - Completed for Q1&2 - submitted to ICB	Data has been collected	13/10/23 Data in process of being analysed	1) 19/01/24 - Completed for Q1&2 - submitted to ICB	15/5/24 - Q3 and Q4 data was collected and analysed. Results have been submitted to ICB. Indication and duration target has been meet each quarter but the appropriateness has not been met each quarter. Work has been undertaken with clinical teams to address the issues raised in the PPS.
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	1)Ongoing work - now being extended to pilot on SEU Currently undertaken on: Horton West Wing Paeds (incl Horton) Churchill Horton Haematology Vascular	1 and 2 on-going and data being fed back to local teams for intervention and summary of data is being reported in AMS HIPCC report	1 and 2 on-going and data being fed back to local teams for intervention and summary of data is being reported in AMS HIPCC report	1)Ongoing work - now being extended to SEU Currently undertaken on: Horton West Wing Paeds (incl Horton) Churchill Horton Haematology Vascular	1)Ongoing work - as per Q3. 2)New areas being scoped for AMS rounds are EAU and AGM wards at JR

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)		1) No updated report from UKHSA at this time. Work is still ongoing to reduce Watch & Reserve	1) on-going 2) no interim data available from UKHSA	1) on-going 2) Initial data from UKHSA suggests further work is required to allow OUH to achieve this target	1) No updated report from UKHSA at this time. Work is still ongoing to reduce Watch & Reserve	1)Ongoing work - as per Q3. 2)New areas being scoped for AMS rounds are EAU and AGM wards at JR
Guideline development and maintenance	(1) 100% review of all guidelines in MicroGuide (adult and paediatrics) within 3 years rolling basis		1) Ongoing rolling process for both adults and paeds 2) Monthly ASG meetings continue	1) on-going	1) on-going, introduced additional Antimicrobial Steering Group meetings to enable final review and ratification of the guideline updates.	1) Ongoing rolling process for both adults and paeds 2) Monthly ASG meetings continue	1) Ongoing rolling process for both adults and paeds. 2) Monthly ASG meetings continue
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	Action now closed- will be kept updated and feedback sought.		
Procurement of IPC surveillance system to replace current unsupported system	(1) Key stakeholder 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 stakeholder 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	(1) Decision to go as Trust purchase only (2) No project group yet (3) Paper being written for Business planning group.	(3) Progressing, paper being written to go to TME	(3) No funding for ICNET this year, tactical approach been proposed by IM&T but needs further consideration and agreement of next steps

Training programme to support the Link Practitioners	(1) Two study days to be held for the link practitioners (2)Update of competency framework	OO	RV/KB	(1)Workshop held in June, second planned for July(2) Competencies updated	Current action completed, more dates to be organised for next year	(1) plan for Trust IPC Conference in July 2024	1. Plan to migrate IPC LP Content to MLH. 2 Plan to conduct short 2-hr workshop sessions for IPCLPs across all 4 sites Oct/Nov.
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	SJ	KB	(1)March CPE audit results presented to HIPCC in June, increase in compliance noted. MRSA audit commenced	(1) MRSA audit results	Plan to audit in Q4	Will not happen in Q4, delayed as waiting for Clinical Surveillance officer, now in post, Plan for late Q1/early Q2
Develop EPR Care plans	(1) Review current IPC care plans (2) Develop list of care plans required (3) Produce care plans	RM	OO	No progress this quarter	No progress this quarter	No progress this quarter	1. Plan for Q1 for EPR team to build IPC care plans for some common infectious organisms.
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	(1 &2) Policy tracker will be presented at Team meetings (3) Pets in hospital, HH, policies updated (4) In process	(3) IPC policy updated Dec 23, Insertion and management of a urethral intermittent, indwelling or supra-pubic catheter in adult guidelines update Jan 24 (4) ongoing	(4) Decon policies updated; pertussis updated. At a glances being reviewed. Objective to be closed as now business as usual- tracker reviewed monthly at Team meeting
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	LB	(1) Group established (2)Workplan developed (3)NOC agreed to be the pilot site (4) to be progressed	(1) Group established (2)Workplan developed (3)NOC agreed to be the pilot site (4) Pre intervention audit carried out. (5) Results shared with MDT team. (6) Project officially started. (7) Teaching session in progress 1-to-1. (8) Teaching days planned for Theatres. (9) Knowledge questionnaire in progress. (10) Challenges towards the end of Q3 due to sickness and rise in respiratory infection disease.	(3) Ongoing ward/unit teaching regarding appropriate use of gloves. Provide opportunity and scenario for learning and challenge current practice. (4) Collection and analysis of data regarding practice based on the form used at the beginning to compare results and confirm improvement in practice. Review of number of gloves used to be compared with previous years to verify if (?) practice improvement bring to a reduction of gloves use.	Collect data related to number of gloves used and re audit clinical area looking for improvement in practice.

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	**CS**	(1) Number of audits updated including sharps, ANTT, Hand Hygiene, CAUTI	(1) Plan to add ANTT specific audits, (2) Agreement of changes to VAP audit, specific children's VAP audit to be devised	(1) ANTT audit updated to include catheterisation, blood culture collection and cannulation procedures, to launch Jan 24. (2) changes to VAP audit live, children's VAP audit ongoing (3) no progress (4) Divisions starting to present through HIPCC dashboards. Some difficulties in pulling reports and detail from Ulysses	(1) Plan for Q1 for IPC to undertake vascular device audit during hand hygiene week
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	-2	LB	OO	(1) Initial meeting held for high level discussion, further discussion required between waste contractor, procurement and sharps company	(1) Stakeholder meeting on site at the Horton (2) Agreement to introduce at the Horton first, paper being written	(2) Meeting held in December; plans reinvigorated to introduce Sharpsmart	(2) Estates delaying rollout as they need to focus on rollout of offensive waste first.
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		(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	(1) Complete (2) New style team meetings in place (3 & 4) Agreed standing agenda (5) Incorporated into meetings and will be reviewed regularly. Action now closed.		

Appendix 2: 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	No change to report	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) • 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.	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 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) CLABSI in ICUs now on dashboards, VAP Ulysses audit updated and audit compliance rates being reported. VAP group meeting and definition of VAP agreed	3. Compliant
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. PSIRF process agreed for IPC incidents and implemented 1st April 2024	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 being updated, review dates being monitored at monthly team meetings, all will be updated with reference to the NIPCM	3. 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. More realistic to aim for 2024/25. Incidents/outbreaks reported in PSEC/IAC reports as required.	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 As above. Paper provided to BPG for support of purchase of ICNet, next steps to be agreed.	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) Corrections made to eLearning package and now available. Divisions responsible for monitoring compliance rates.	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	No update to report	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.	Cleaning scores continue to be presented to HIPCC with a focus on areas that are only achieving 3 stars.	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	Clinical Decontamination Practitioner commenced auditing of semi-invasive probes Decontamination policies updated in Q4 2023/34	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	No update to report	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	Planned preventative maintenance is scheduled and completed electronically using Computer aided facility management (CAFM) system (MRI Planet) and driven by industry standard maintenance specification known as SFG20. 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	New policy written on reducing risk of aspergillus during building works, plan to go to Clinical policy group in Q1 2024/25	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.			No update to report	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	• 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.	Updates provided at monthly HIPCC meetings by the Estates team. Offensive waste policy currently being implemented across OUH by Estates team	2. Partially compliant

		Restore scheduled collections from wards & dept's and shredded off site. • Metal Waste collected by Grundon & Metal Salvage and collected on 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. Audit is objective for the Clinical Decon Practitioner - commenced Q1	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.	No update to report	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 neonates) allowing arrangements for AMS to be maintained.	None identified	N/A	no change - compliance continues	3. Compliant
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	no change - compliance continues	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	no change - compliance continues	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 as well as comparison between specialities.	None identified	N/A	Compliance continues. To note: Start smart then focus has been updated nationally and OUH AMS have responded to this change and updated guidance as appropriate. Consultant level feedback using a dashboard in Orbit+ has been launched and is well received.	3. Compliant

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	no change - compliance continues	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	no change - compliance continues. To note: expansion of ward rounds to include a pilot of surgical admission units. The AMS ACP reviews if interventions are actioned post ward round and this is leading to new education for clinical teams.	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	No update to report	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 (eg 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. IPC intranet site now moved onto SharePoint	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 are information leaflets for MRSA decolonisation and one for skin decolonisation prior to procedure.	None identified	N/A	Update: The antifungal patient information leaflet has been developed and awaiting launch.	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 (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 infections.	Signage around hospital around mask wearing	Outdated signage- needs refreshing		No update to report	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, see previous entry for progress update	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 e.g. 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. As above	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 documented in the patient's notes.	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	No update to report	3. Compliant
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.			Number of issues around communication and management of CPE identified in Nov/Dec. Raised at Safety Learning and Improvement Conversation (SLIC) in December 2023.	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	No update to report	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	No update to report	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) Completed	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	No update to report	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	No update to report	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	HCID Lead Nurse now in post	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	No update to report	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	No update to report	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 Update as above	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 Update as above	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	No change to report	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	No change to report	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	No change to report	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	No change to report	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	No change to report	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	No change to report	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	No change to report	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	No change to report	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 outbreak/incident by the registered provider.	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	Policies being updated with reference to this	3. Compliant
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	No change to report	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.	No change to report	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	Some infrequent instances of staff who have not had EPP clearance when working in EPP roles. Raised this as a risk with HR/recruitment	3. Compliant

Appendix 3: Hospital Infection Prevention & Control Committee Business Cycle 2023-24

			Q1			Q2			Q3			Q4	
	Apr 2023	**May 2023**	**Jun 2023**	**Jul 2023**	**Aug 2023**	**Sept 2023**	**Oct 2023**	**Nov 2023**	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 202**	**LEAD**
NOTSSCaN Divisional Report	X	X	X	X	X	X	X	X	X	X	X	X	**NOTSSCaN**
SuWOn Divisional Report	X	X	X	X	X	X	X	X	X	X	X	X	**SuWOn**
CSS Divisional Report	X	X	X	X	X	X	X	X	X	X	X	X	**CSS**
MRC Divisional Report	X	X	X	X	X	X	X	X	X	X	X	X	**MRC**
PFI Cleaning Report	X	X	X	X	X	X	X	X	X	X	X	X	**DA**
PFI Water Management Report	X	X	X	X			X	X	X	X	X	X	**CHa/CW**
IPC Patient Safety & Clinical Effectiveness Report	X	X	X	X	X	X	X	X	X	X	X	X	**IPC**
Cardiac SSI Report	X			X		X			X		X		**KB**
Estates & Facilities Report	X		X		X		X		X		X		**AM**
Antimicrobial Stewardship Report			X			X			X			X	**LD/NJ**
IPC Risk Register						X						X	**IPC**
UKHSA Update		X		X		X		X		X		X	**CH/DR**
Occupational Health & Wellbeing Report		X					X						**CE**
BOB ICB Report	X			X			X			X			**HM**
Committee Reports													
Decontamination Committee	X		X		X				X		X		**IPC**
IV Steering Group			X										
Reports / Policies													
IPC Strategic Plan	X			X						X			**IPC**
IPC Annual Report				X									**IPC**
Hand Hygiene Policy	X												**IPC**
IPC Board Assurance Framework				X						X			**IPC**
Guideline for Animals in the Hospital Setting		X											**IPC**
Policy for Antimicrobial Stewardship		X											**IPC**
NOF SSI		X											**IPC**
CPE Audit Report			X										**IPC**

Guideline for the Decontamination of Birthing Pools				**X**									**IPC**
Caesarean Section SSI Report				**X**									**IPC**
Adult Guidelines for the Insertion & Management of a Urethral Intermittent, Indwelling or Supra-Pubic Catheter					**X**								**IPC**
SSI Update					**X**								**IPC**
Gloves Off Campaign Update													**IPC**
Infection Prevention & Control Policy								**X**					**IPC**
Hospital Infection Prevention & Control Committee Terms of reference								**X**					**IPC**
Aspergillus Checklist								**X**					**IPC**
Aspergillus & Other Fungal Infections during Building Work Procedure									**X**				**IPC**
Prevention & Management of Sharps & Splash Injuries									**X**				**OH/DIPC**
Procedures for Decontamination of Healthcare Equipment											**X**		**IPC**
Procedures for Decontamination of Reusable Medical Devices											**X**		**IPC**
Water Safety Plan Part 1.1 Governance Policy												**X**	**Operational Estates/ AP for Water**
IPC PSIFRF Process												**X**	**IPC**
Guidance on the Management of Patients & Staff with Pertussis or Exposed to Pertussis												**X**	**IPC**