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Norfolk and Suffolk NHS
NHS Foundation Trust

Report To:	Board of Directors – Public
Meeting Date:	April 2016
Title of Report:	Infection Prevention and Control Annual Report 2015 - 2016
Action Sought:	For Approval
Estimated time:	5 minutes
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Director:	Bohdan Solomka: Medical Director, Director Infection Prevention & Control

Executive Summary:

This report summarises activity and progress during the financial year April 2015-16 against each of the ten compliance criteria of the Code of Practice and sets out the plans for the forthcoming year. This report will be presented to the Board of Directors, it will also be made available to staff, patients and the public via the NSFT intranet and internet sites.

During the period 2015-2016, there have been no cases of methicillin resistant *Staphylococcus* aureus (MRSA) blood stream infection. One case of *Clostridium difficile* infection was attributed to the Trust. There have been no outbreaks of confirmed viral gastrointestinal infection during the period, although several potential clusters of cases were investigated. A key focus of the forthcoming year is to continue to work closely with staff in all settings regarding management of alert organisms with particular reference to MRSA, *C. difficile,* Norovirus and emerging antibiotic resistant organisms.

The Trust has continued its record for cleanliness of the environment with excellent Patient-Led Assessments of the Care Environment (PLACE) assessment scores for 2015.

The Infection Prevention & Control (IPAC) team has continued to build on improvements in mandatory training compliance. A new bespoke e-learning package developed collaboratively with the University of East Anglia has been made available.

The IPAC committee continues to monitor compliance with the annual work plan and reports to the Quality Governance committee for scrutiny with additional reporting to the Trust Board of Directors as required.

1. Introduction

Norfolk and Suffolk NHS Foundation Trust (NSFT) is committed to ensuring that a robust infection prevention and control function operates within the Trust which supports the delivery of high quality healthcare and protects the health of its service users and staff. Prevention of Healthcare Associated Infection (HCAI) remains a priority for patients, staff and the organisation.

The Trust has a statutory responsibility to comply with the requirements of The Health and Social Care Act 2008. The criteria against which the Care Quality Commission will assess compliance are contained within the Code of Practice of the prevention and control of infections and related guidance (revised 24/07/2015). The Director of Infection Prevention and Control report is a requirement stipulated in the Code of Practice.

The purpose of this report is to provide assurance to the Board of Directors that the Trust has robust and effective infection prevention and control services in place and is compliant with The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance (revised 24/07/2015). The Code of Practice (Part 2) sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements, which is set out in regulations.

The Infection Prevention & Control (IPAC) service endeavours to provide a comprehensive and proactive service to Norfolk and Suffolk NHS Foundation Trust (NSFT). The report continues to give assurance of the commitment to the prevention and control of infection within all services to achieve positive outcomes.

2. Key Achievements

NSFT staff succeeded in maintaining a low rate of HCAI; there were no cases of MRSA bacteraemia

The IPAC team have successfully introduced a new system of clinical practice auditing providing more meaningful data for hand hygiene practice and theory. This has included the IPAC team visiting areas in person to audit and deliver on the spot education to frontline staff.

A new suite of audit tools to focus on aspects of Standard Precautions practice was introduced. The findings have initiated close working with Procurement to standardise clinical products and equipment for best value and efficacy, for example; personal protective equipment items, decontamination products and medical devices. There are lists published on the intranet of standardised products to facilitate ordering.

The IPAC team have successfully produced with collaboration from the UEA an E learning package for clinical staff to be used by inductees and existing staff throughout the Trust

The IPAC team continue to work with colleagues in NSFT Strategic Estates & Maintenance Services to embed the importance of water quality throughout the organisation.

Following environmental audits undertaken by the IPAC team, improvements are in progress, the largest being the planned refurbishment of the bathrooms for the acute cluster on the Hellesdon hospital site.

3. Summary of activity and progress on the IPAC annual programme

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.

Description of Service Delivery Arrangements

The Chief Executive has overall responsibility for the prevention & control of infection within NSFT. On retirement of the post holder the Director of Infection Prevention and Control (DIPC) post was moved to the Medical Director.

The position of Infection Control Nurse Specialist/Deputy DIPC became vacant in January 2015, and a new Infection Control Nurse Specialist/Deputy DIPC commenced duties in June 2015. In addition a new post also commenced in June introduced a dual role of Physical Health Nurse and IPAC trainee. The IPAC nursing team until October 2015 were under the direct line management of the DIPC/Head of Physical Health. Direct line management of the infection control team is presently under the Deputy Director of Nursing. The diagram below summarises the current arrangements.

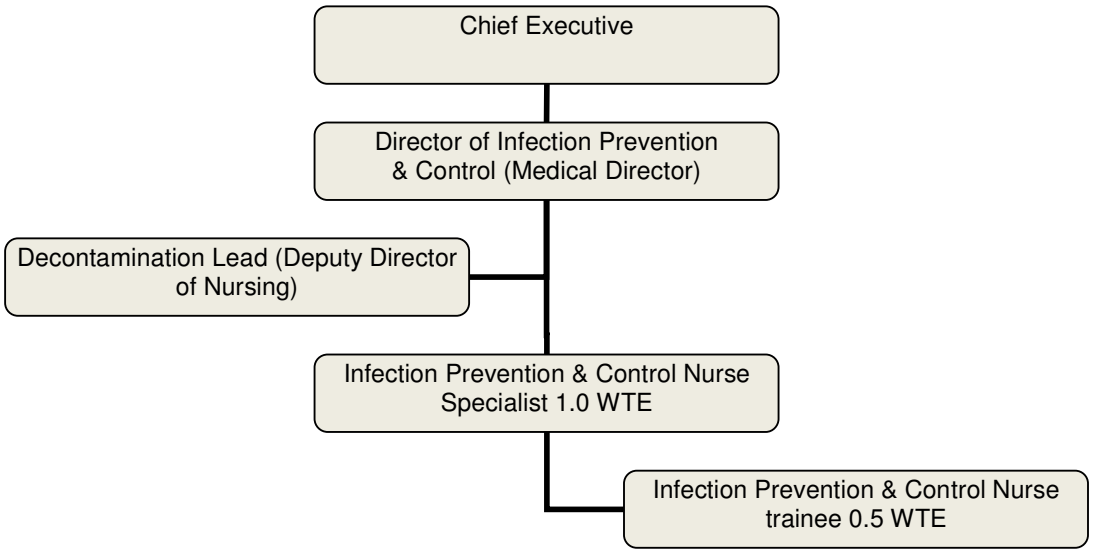

Diagram 1 IPAC Service Arrangements

The IPAC trainee nurse is currently completing a first degree via a distance learning programme to achieve a qualification in Infection Prevention & Control.

Administrative support for the IPAC team is shared with the Physical Health team.

To support the IPAC team the Trust operates a system of link infection control practitioners known as Local Infection Prevention and Control Supporters (LIPACS). Eighty LIPACS received training this year. The annual education and training programme is based on the application of standard IPAC policies and procedures; the content of this is further informed by learning from audits and incidents of the previous year. The training enables LIPACS to conduct clinical audits, and provide a level of knowledge and expertise in their service. Recruitment is ongoing and new LIPACS are added regularly. In 2016/17 the aim is to achieve 100% of service teams having a LIPAC supporter in place. Modern Matrons and locality managers continue to be influential in the support of the LIPACS and the IPAC

agenda and with monitoring staff application of standard precautions practice to prevent and control infections.

Out of hours Arrangements
IPAC advice continues to be provided by the general Trust on-call system with written guidance to support this.

Infection Prevention & Control Committee
The Infection Prevention and Control Committee (IPACC) acts as a consultative body and policy approval committee for all matters related to hygiene, healthcare associated infection (HCAI) and infection safety. The primary functions of the IPACC is to monitor progress with the IPAC annual programme, provide leadership and strategic direction based on national guidance and the local needs of the services provided by NSFT. The committee is also instrumental in the development of an organisational culture ensuring staff at all levels prioritise and engage in infection prevention and control.

The IPACC is accountable to the Board and reports through the Quality Governance Committee; the Trust Board of Directors receive updates through the Director of Nursing's Patient Safety and Quality report with additional progress reporting to the Trust Board of Directors twice per year (April & September).

The committee is chaired by the DIPC and three meetings per year are held. Minutes are published on the Trust intranet. The IPACC has broad representation from both internal and external clinical and corporate departments, including the contracted occupational health service and representatives from Public Health England and local commissioning organizations. It provides a forum for discussion, decision making and governance oversight on measures for the control and prevention of infection within the Trust. It has an annual programme of work to oversee which it determines against national and local priorities, with an overarching goal of prevention and safety.

IPAC Service links to Clinical Governance
An Infection Control Specialist Nurse is represented on:

- Water Hygiene Group
- Locality based governance meetings
- Health & Safety Committee
- Medical Devices Standards Group
- Resuscitation Standards Group
- Modern Matrons
- Physical Health Strategy Group
- Quality Governance Committee (attends quarterly)
- Domestic Services Contract Performance Monitoring
- Workplace Health & Wellbeing Operational Management Group
- External CCG Infection Prevention & Control Groups/Networks

Infection Prevention & Control Service Objectives
The overall strategic aim of Infection Control within NSFT is to increase the organisational focus and collaborative working on infection prevention and control.

The Norfolk and Suffolk NHS Foundation Trust is committed to:

- Identifying, developing and implementing best practice in all of its activities in order to reduce the risks of health care associated infections for all the patients, staff, contractors and visitors.

The IPAC committee supports the above aims and will work towards ensuring that:

- Best practice is identified and applied across the Trust
- National policy and guidance is appropriately and promptly implemented
- Reporting mechanisms ensure the Chief Executive, Executive Board and Board of Directors are kept fully informed.
- The IPAC committee serves as the main forum for consultation and policy approval on HCAI and decontamination issues within the Trust.
- NSFT participates in a health-economy wide approach to the prevention of HCAI and the control of infections occurring in the community.

The (IPAC) service arrangements for NSFT are defined in the following documents, reviewed and approved by the IPAC Committee March 2016:-

- Terms of reference and membership of the Infection Prevention and Control Committee
- IPAC reporting structure
- Assurance framework
- The annual programme and audit schedule
- The policy timetable

Infection Prevention and Control Programme 2016-2017

The Infection Control Team is responsible for ensuring that a coordinated programme of work is agreed and implemented annually. The IPAC nurses provide education and training throughout the organisation, undertake a programme of audits, policy formulation, alert organism surveillance, and provide infection prevention and control support and advice to staff and service users as required. Details of the Infection Prevention and Control Programme for the forthcoming year can be found in Appendix one.

Water Safety

A robust Water Hygiene Group as a sub group to the IPAC Committee has been established meeting on a quarterly basis with an operational sub-group. The chair of the Water Hygiene group moved to the Head of Strategic Estates & Maintenance during 2015.

Water safety and quality has become a focus for the IPAC team and the DIPC, following attendance at a Role of the Responsible Persons Course. The arrangements for the role of Responsible Person for Legionella sit with the DIPC. Deputy Responsible Person roles have been allocated to Heads of Maintenance in Norfolk and Suffolk.

The Water Hygiene Group ensures safe water maintenance systems are in place in line with current legislation and guidance. The group is responsible for the monitoring and regular review of the Trusts' operational policy and procedure for the control and prevention of

Legionella, Pseudomonas and other water borne bacteria to ensure adequate measures are in place to control the risks and ensure contingency plans are in place in the event of an incident.

Specialist water consultancy advice has been sought and retained. A comprehensive suite of risk assessments has been commissioned for the Trust which will support the drafting of a new Water Hygiene policy and Written Scheme Framework; final delivery is expected in the new financial year.

Criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

The Decontamination Lead post has been designated to the Deputy Director of Nursing. Oversight of decontamination is undertaken by the IPACC.

Domestic cleaning services are currently contracted to ISS. The quality of the service is monitored by a programme of joint audits conducted by the NSFT contract compliance officers and the ISS supervisors. The IPAC team participate in quarterly contract performance monitoring and continue to work closely with the contract compliance team and the contracted domestic services provider. In addition issues are picked up locally by the clinical teams and the IPAC team through adhoc spot checks and more formally through an IPAC quality improvement visit. Close working with the Modern Matrons and the LIPACS has supported the early identification and rectification of problems.

Training sessions delivered by the IPAC team for the contracted domestic service staff and IPAC team involvement adhoc at joint audits is illustrative of the collaborative working between ISS and NSFT.

The Trust Cleaning and Disinfection policy has been revised to reflect new responsibilities in line with the change in contractual arrangements for domestic services introduced in July 2015. The IPAC team have reviewed cleaning methods used by clinical staff across the Trust; it was noted that staff were engaging in a two tier system involving:

- Detergent
- Disinfection

The introduction of a combined detergent and disinfectant product was introduced. In addition a new spill mat kit for use in community clinic and outpatient areas for body fluid spill incidents has been made available.

As the Trust review of premises and services continues, the close working relationship with the Strategic Estates and Maintenance Services departments is important to ensure that the IPAC team have an opportunity to review the suitability of premises and influence any updates and refurbishments required.

A Trust-wide switch to the use of a non-alcohol based hand sanitiser was successfully initiated. Two brands of non-alcohol hand sanitizer have been made available either as hand-held/portable or wall mounted dispensers at the point of care.

The IPAC team continue to promote the drafting of cleaning schedules for decontamination of patient equipment by clinical staff. A local IPAC supporter audit of cleaning and disinfection practice was initiated in quarter four of the 2015/16 audit programme with results to be published early into the new financial year.

The Trust undertook Patient-Led Assessments of the Care Environment (PLACE) across 9 sites in Norfolk and Suffolk in 2015. The assessing teams comprised a mixture of staff (including the IPAC team, current service users and ex-service users, members from local HealthWatch and Governors). The results of the assessments were excellent; 99.38% for cleanliness and 97.34% for condition and maintenance of premises.

The IPAC team continue to work with the Medical Devices Lead and the Procurement Team regarding the suitability of medical devices and patient equipment specifically seeking assurance with respect to effective decontamination of reusable equipment.

A Trust wide audit of mattress was undertaken by an external agency in October. Of the 454 mattresses, 376 were tested which represents 80.58%. 303 passed the audit, 73 failed and of these 57 (15.5%) were cited as condemned; where both the cover and foam core gave cause for concern over the functionality of the mattress and 16 (4.25%) were advised as requiring replacement covers.

Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

A programme of audit of antibiotic usage and prescribing continues. Antimicrobial stewardship including audit activity is supported and monitored by the Drug and Therapeutics Committee.

The Trust-wide audit conducted during November 2015 illustrated a 25% decrease in the total number of antimicrobial prescriptions recorded when compared to the previous data from March 2015. Table two presents the results

	Total antimicrobial Prescriptions over the audit period				
Route	2011	2013	2014	Mar 2015	**Nov 2015**
Systemic	15	14	35	31	**26**
Topical	4	16	17	16	**9**
Total	19	31	52	47	**35**

Table 2: Trend of antimicrobials prescribing from 2011 - 2015

Three key standards are used to audit against

- **Standard One:**
  Does the prescribed antimicrobial have a documented indication?

- **Standard Two:**
  Does the prescribed antimicrobial have a documented stop/review date?

- **Standard Three:**
  Does the prescribed antimicrobial comply with the antimicrobial policy? If not, is the prescribed antimicrobial a reasonable and rational choice?

Significant improvements in compliance to the three audit standards were observed in both the Norfolk and Suffolk sites; the results are presented in figure one.

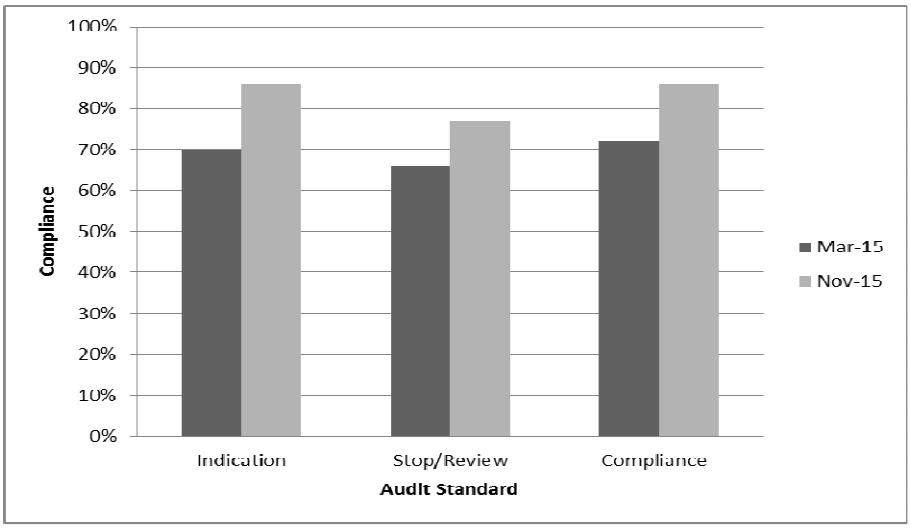

Figure one
A graphical representation of compliance to audit Standards comparing March 2015 and November 2015

Whilst the use of antimicrobials is relatively infrequent, the audit has demonstarted that improvements can be made in the prescribing of antibiotics; achieving high standards in prescribing practices for effective antimicrobial stewardship is considered as a priortity within the Trust.

The NSFT Antimicrobial Prescribing policy is under review, the revised policy will better support the principles contained within national antibiotic stewardship guidance and will signpost clinicians to the local CCG led formularies which take account of local antimicrobial resistance patterns. These formularies have been made are available on the Trust intranet and are overseen by the Drugs and Therapeutic Committee.

An analysis of National Institute for Health & Care Excellence (NICE) guidance (NG15) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use issued August 2015 was undertaken. This guideline covers the effective use of antimicrobials (including antibiotics) in children, young people and adults. It aims to change prescribing practice to help slow the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection. Of the 26 recommendations identified with specific relevance to NSFT, the Trust was found to be compliant with 25 (96%) of recommendations; a plan is in place to develop full compliance.

Criterion 4 – Provide suitable accurate information on infections to service user, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

A review of the current Inter-healthcare transfer form which is based on a national document is in progress. The review is required to ensure documentation on admission, transfer and discharge reflects the principles contained within antimicrobial stewardship initiatives, relevant screening results for resistant pathogenic organisms and other important HCAIs. It is anticipated that the finalised process will be made available in the new financial year and will be concordant with the relevant Trust policy on transferring patients, newly revised discharge checklists and also implementation into the Lorenzo electronic patient care record.

The policy for the application of clinical alerts has been revised during 2015 to reflect recording of alerts in the Lorenzo electronic patient care record. Significant HCAIs have been included in the suite of available alerts available to be applied as appropriate.

Criterion 5 – Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Mandatory Surveillance
All cases of *Clostridium difficile* infection (toxin positive) and blood stream infections due to methicillin resistant *Staphylococcus aureus* (MRSA) are required to be reported to Public Health England. Since 2011 blood stream infections due to methicillin sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (E coli) have been added to the national mandatory surveillance requirement.

Clostridium difficile
A local ceiling of zero cases of *C. difficile* applied contractually by the commissioner's was breached by one case. A post infection review including a full root cause analysis was undertaken, learning was identified during the multi-disciplinary review and an action plan completed. There was good liaison with the medical Microbiologist on a treatment plan in this case and compliance with anti-microbial prescribing formulary was found to be good.

Two cases of *C. difficile* colonisation were identified through specimen testing, both patients were symptomatic and enteric isolation measures were appropriately instituted. In both cases medical management was guided by the medical microbiologist.

MRSA
There have no cases blood stream infection with MRSA attributed to NSFT. A new MRSA management and admission screening policy was approved. The policy directs MRSA admission screening for inpatients in accordance with the Department of Health's modified approach to admission screening, which aims to focus screening and maximise the clinical impact for patients most likely to benefit. Within this approach the current practice of mandatory MRSA screening of admissions has been streamlined to include only those patients previously identified as colonised with or infected by MRSA. An action plan to achieve contractual compliance to screen 90% of eligible patients is in progress. The IPAC team continue to support clinical teams and work collaboratively with the Physical Health team in the identification of patients at risk of serious infection with MRSA, directing specimen collection and advising on the infection prevention and control management.

Gastrointestinal infection
There have been no confirmed outbreaks of viral gastrointestinal infection in NSFT inpatient wards since April 2015. The IPAC team continue to support areas where concerns on individual cases are identified, treating incidents as a potential outbreak until alternative explanations are available.

Other infections
One case of invasive Group A Streptococcus (iGAS) in the respiratory system was reported in an inpatient. iGAS is a notifiable infection under Health Protection Regulations 2010. This incident was managed in collaboration with the local Health Protection team. Following the required period of observation the incident was closed and this remained an isolated case with no other patients affected.

One case of Varicella Zoster virus (Chicken pox) occurred in an inpatient. No further cases were identified in this incident.

One patient was treated for scabies prophylactically following transfer from a care home with an outbreak of scabies.

Other antibiotic resistant organisms
The management of patients with an antibiotic resistant organism is an increasing priority nationally and will be a key focus for the IPAC team in the forthcoming year. Antibiotic resistant bacteria include extended spectrum beta lactamase producing organisms, and glycopeptide resistant enterococci. In addition the emergence of Carbapenemase-producing Enterobacteriaceae (CPEs) is predicted to pose significant challenges globally in the near future. Carbapenem antibiotics are a powerful group of B-lactam antibiotic used in hospitals. Until recently they have been able to be used to treat infections when other antibiotics have failed. Emerging resistance patterns have rendered in some cases Carbapenems ineffective. Public Health England have issued toolkits for use in either acute or community settings to enable the early detection, management and control of CPE. Work is currently in progress with respect to development of a policy to enable NSFT staff to provide safe and effective management of patients colonised or infected with resistant bacteria and minimise the risks of transmission in patients accessing mental health services.

Surveillance and case reporting
Whilst close working relationships with the acute Trusts' IPAC teams helps ensure the early communication of any organisms of concern identified through laboratory reporting, increasing usage of the WebICE system by clinicians across the Trust is a key focus for the forthcoming year; both for the requesting of and reporting on, clinical specimens and also the identification of patients with an alert signifying colonisation or infection previously with significant bacteria.

The Trust participates in the East of England outbreak monitoring system hosted by Public Health England (IOLog 2). This is a voluntary regional incident and outbreak logging system which allows organisations to access information on current outbreaks across the region and alert staff to problems in other areas which may affect admission and discharge processes. This system also enables the East of England team to gain an understanding of infection prevalence in the region.

All incidents of serious infection are reported through the Trust Datix system. Case and outbreak reports are produced with any findings used to inform guidance and policy and also added to the LIPACS training programme.

Criterion 6 Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

The Assurance Framework identifies the roles and responsibilities for staff at all levels of the organisation. These responsibilities are reinforced through the education and training programmes.

Staff compliance with the mandatory training is monitored through the Trustwide staff pathways system; (LARA) and is monitored for individuals through line management supervision.

The percentage for non-clinical staff compliant with infection control training is 81%. The frequency of training required for non-clinical staff is currently three-yearly and compliance is achieved via completion of an e-learning package.

There is a balance between the time required for training and the service needs. To address this, the IPAC team and E learning managers produced a series of 'e' questions to evaluate current understanding in infection prevention and control. The questions can be completed at a convenient time for the staff member, and are based on two premises – the basic understanding that is required in mandatory training and the fact that all staff will have received an initial lecture based session previously or at induction.

Compliance with annual update training for clinical staff is approximately 65%. The IPAC team have plans to increase learning opportunities through a range of initiatives concentrating on those issues essential to reducing healthcare associated infections.

The Trust commissioned the University of East Anglia to develop collaboratively with the IPAC team a bespoke and comprehensive e-learning package for completion by clinical staff annually and on induction. This package was made available on the intranet in December 2015 and is expected to be the main method of achieving infection control education in the forthcoming year.

Medical training continues to be lecture based. Medical staff joining NSFT on rotation receive an education session from the IPAC/Physical Health team as part of the induction process. The prescribing of antimicrobial agents is included within this session.

All clinical staff are expected to receive local induction pertaining to the specific arrangements for infection prevention and control in NSFT. This is undertaken by the LIPAC supporter through completion of a checklist in the workplace.

Criterion 7 – Provide or ensure adequate isolation facilities

The majority of the Trust in-patient environments consist of single patient rooms with ensuite facilities with plans for improvement of those areas identified as below standard.
Staff are supported in a risk assessment process for appropriate placement where individual patient factors require this.

Criterion 8 – Secure adequate access to laboratory support

Following the national reorganisation of laboratory services, the work of the contracts team to revise contracts with microbiology services has been supported by the IPAC team to ensure robust service specification and access to advice for clinicians.

The contracts team are continuing to work with other providers to ensure that the Trust has appropriate service level agreements for Infection Control Doctor support. Current provisions agreed in Suffolk included a retainer within the microbiology services contract for support for infection control doctor services for adverse incidents, for example cases of serious infection or outbreak.

Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Policies
A comprehensive range of policies, guidance and information leaflets are available on the intranet for use by staff. All policies required for the NHS Litigation Authority (NHSLA) compliance are available.
These policies are reviewed and updated according to a programme of dates but also in response to change in national policy. Progress against the policy review tracker is monitored by the IPACC.

Audit
Compliance with a number of key practice policies is been monitored through the annual audit programme.

Hand Hygiene
Hand decontamination audits are completed quarterly; in line with agreed changes to the hand hygiene audit schedule the IPAC team instituted a rolling programme. The inpatient areas identified to audit during the quarter received an initial unannounced visit from a member of the IPAC Team. Spot check auditing was undertaken at each visit. The introduction of the IPAC team participating in the quarterly audit rolling programme was chiefly to ensure a more targeted approach, to introduce validation into the audit process, facilitate learning in the clinical environment and to support the LIPACS.

The hand hygiene audit scores for the year are represented in the table two below. Audits completed by LIPACS are collated by the IPAC team; quarterly reports are disseminated across the Organisation. The audit assesses the availability of resources for hand hygiene, it also audits against policy standards for hand decontamination technique and staff knowledge in relation to hand hygiene and dress code. LIPACS are also required to observe colleagues to ascertain if hand hygiene is undertaken in accordance with the World Health Organisation standards identifying the opportunities for hand hygiene.

June 2015	September 2015	December 2015	March 2016
97%	97%	97.5%	99%

Table three Hand hygiene scores for quarterly auditing 2015

Compliance with clinical practice and knowledge relating to Standard Precaution principles is audited using a suite of bespoke audit tools. These audits are Trust wide and carried out quarterly. The audit tools used has been drawn from NSFT policies on infection prevention and control, NICE guidance, and the Infection Prevention Society's Quality Improvement tools. Action plans are provided and the IPAC team provide help and support as required to the areas to complete the action plan.

Quarter One Waste management 99% & Laundry management 96%
Actions arising from this audit included the need for clarification on the responsibility for cleaning/maintaining in-house washing machines and the use of white bags for laundry segregation at the Norvic clinic; these issues have been addressed with the matrons. There is an ongoing review involving IPAC and Maintenance services to resolve the laundry storage arrangements in Whitlingham ward. No significant issue were identified for waste management. A revised waste policy is anticipated in the new financial year.

Quarter Two Safe handling and disposal of sharps 96%
Whilst compliance was commensurate with the 2014 audit there was an improvement on the numbers of teams returning with forty nine teams submitting data. The lowest scoring elements in this audit were the non-completion of sharp box labels, the lack of use of the temporary closure mechanism and the location of the sharps container to ensure it is off the floor. The report drafted by the IPAC team identifies actions for individual areas to address. Sharps handling including the learning from this audit will be included in the LIPACS annual update training. In addition the new e-learning package includes the principles of safe handling and disposal of sharps to ensure Trust-wide education is made available.

Quarter Three Personal Protective Equipment (PPE) 97.5%
A new tool was drafted to audit the use and availability of PPE. 55 clinical areas were required to participate in this audit and 47 returned a response within the audit timeframe indicating a. participation rate of 85.5%. Non submitting areas are followed up by the IPAC team. Actions arising from this audit included the production of a standardised PPE list for assurance of suitability and cost effectiveness. For areas that did not have eye and face protection available this has been highlighted and addressed. Correct use of PPE was emphasised during LIPACS training and will continue to be a focus in the 2016 E learning and face to face training.

Quarter Four Cleaning & Disinfection 99.4%
A new tool for use by the LIPACS to audit standards of cleaning and disinfection was drafted. The aim was to audit against the standards contained within Trust policy for cleaning and decontamination of medical devices, equipment and the clinical environment. The audit assessed staff knowledge and awareness of responsibilities in relation to cleaning and disinfection, the availability of products and equipment and the use of cleaning schedules and documentation records.

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Criterion 10 – Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

This is achieved by staff education and training and the monitoring of compliance with key policies, for example the use of personal protective equipment and safe sharp handling as in the audits undertaken as detailed within this report.

NSFT has a contract with the Norfolk & Norwich University Hospital Workplace Health and Wellbeing Service to deliver employment screening, immunisation against communicable diseases and post inoculation exposure management.

The contracted occupational health service has not had to participate in any serious outbreak management programmes in this financial year. Advice has been offered to staff as required where they have had queries concerning communicable disease and their fitness to work, staff immunity status as required for minor events, such as, Shingles, Chicken pox, and queries relating to impetigo and Diarrhoea and Vomiting.

Needlestick and body fluid inoculation incident reduction is a key issue for the IPAC and Health and Safety team and for the Trust as a whole. To protect staff from needlestick injuries, safety engineered devices are available in all clinical areas in line with Regulatory requirements. The Procurement team are instrumental in ensuring restricted ordering of sharps devices to a published list of products. Additionally, the availability of these safer devices continues to be monitored by spot checks of clinic rooms and by root cause analysis of all needlestick injuries. The findings from the root causes of the incidents indicate that the

main cause of injuries include user error and non-compliance with policy, particularly where this relates to the use of diabetic needles. The IPAC team have followed up with additional training as necessary. In addition the IPAC team contributed to a Health and Safety Trust wide communication regarding the use of safer sharps.

There were ten reported incidents related to the use of contaminated sharps. This is a slight improvement on last year. The inpatient area is where the majority of injuries occurred. Figure 3 shows the locations where injuries occurred

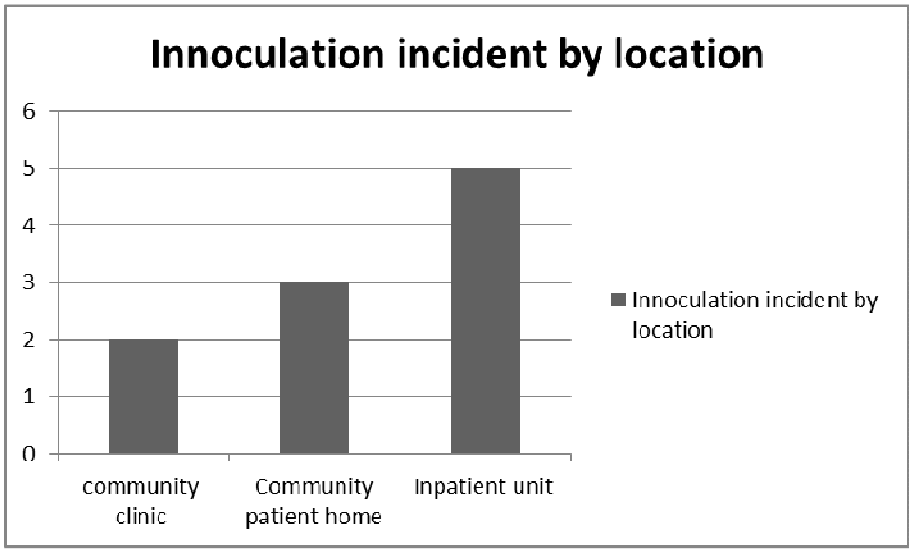

Figure 3

The administration of antipsychotic medication by injection knowns as 'depot injection' and diabetic care and venepuncture are the main tasks where injury occurs. These figures are presented in figure four.

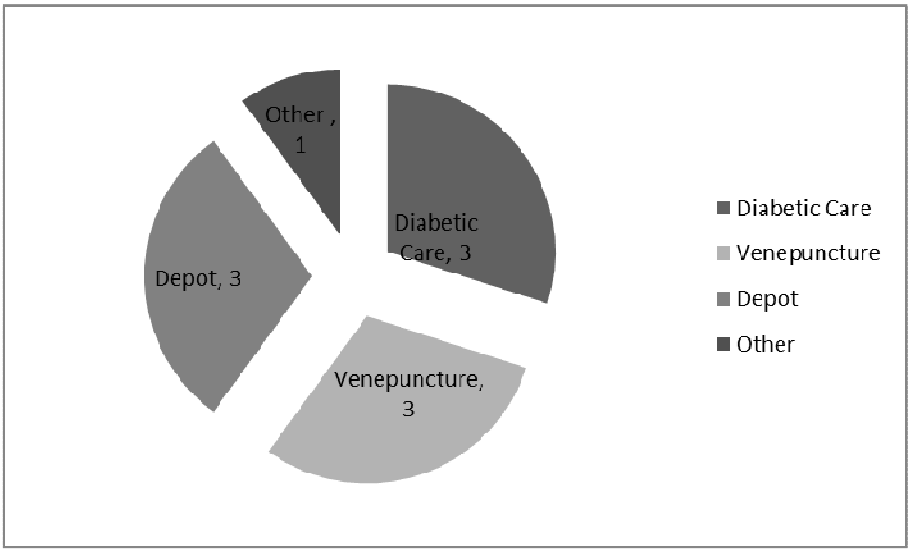

Figure 4

Of these incidents none of the staff affected required treatment with post-exposure prophylaxis drugs. One staff member identified as a non-responder to hepatitis B vaccine was given immunoglobulin as part of follow up care.

Seasonal Flu Vaccination Campaign for staff

There was an intensive flu vaccination campaign this year which resulted in 31.7% of frontline staff were vaccinated. The decrease in uptake compared with the previous year (34.9%) has been reflected nationally. The Trust campaign enabled a number of options for staff to get vaccinated including 21 Occupational Health led drop in clinics, and access to a further 10 clinics run by the Norfolk Recovery Partnership. A further 15 staff volunteered as peer vaccinators known locally as flu crew to facilitate vaccination to colleagues across the shift pattern. Whilst the campaign was well supported by the Trust Executive team and also by the Communications team; achieving Department of Health targets continues to challenge.

Future plans

The priority for the team is the effective delivery of a comprehensive annual programme.

Key areas of focus in the annual programme include:-

- To continue to work closely with staff in all settings regarding management of alert organisms with particular reference to MRSA, C. difficile, Norovirus and emerging antibiotic resistant organisms
- Improving compliance with mandatory education in IPAC procedures through a range of learning and assessment opportunities
- An evaluation of the effectiveness of the LIPACS programme and to continue embedding good infection control practices into every aspect of NSFT and therefore contribute to the continuing safety of our service users.
- Improved focus to ensure actions identified by audit are implemented and completed.
- The team will continue to monitor the clinical environment to ensure this is safe to protect service users, staff and visitors from healthcare associated infections.

Financial implications (including workforce effects)

Non-compliance with IPAC policies and guidance can contribute to longer in-patient stays for patients, influence the future health outcomes for patients with associated costs, and incur financial penalties as outlined in contracts for services. There is a risk to staff of acquiring an infection if they do not comply with policies and guidance or if their environment does not support good practice. There is also a potential for litigation.

Quality implications

Compliance with IPAC policy and guidance supports the Trust objective to retain and develop its focus on service quality by providing services in safe environments by informed and proactive staff.

Equality implications

The consistent application of IP&C measures ensure all service users, their carers, visitors, staff, employed and contracted are protected from infection acquisition.

All IP&C related policies take into consideration any variation that is necessary to accommodate an individual's personal preference in regards to their cultural or spiritual beliefs.

Risks/mitigation in relation to the Trust objectives

The activity related to IPAC is required for patient, staff and visitor safety, for registration with the Care Quality Commission and to achieve Trust NHS Litigation Authority (NHSLA) compliance. The role of the IPAC Committee is to ensure the annual activity plan is appropriate for both service users and commissioners and aids compliance with the Health and Social Care Act 2008 and for registration with the Care Quality Commission (CQC).

3.1 Recommendations

The Board of Directors approve the content of the DIPC Annual Report for 2015 – 2016 and confirm suitability for publication.

Background Papers / Information

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, DH (revised 2015)

Care Quality Commission (CQC) Provider Compliance Assessment, Regulation 12, Outcome 8, Cleanliness and Infection Control

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INFECTION PREVENTION AND CONTROL
Annual HCAI Reduction Plan and Programme for Activities
April 2016 – March 2017

Introduction

The work to establish single systems, procedures and supporting policies across NSFT continues with priorities established and staff objectives allocated to support delivery within the timescales identified within this plan.

The infection prevention and control staff and the physical health staff are developing joint knowledge and understanding of each other's agenda to improve the delivery of objectives across the Trust. This collaborative approach ensures that IPAC is included in all physical health teaching programmes operated within the Trust and all physical health policies and procedures aim to secure infection prevention where possible. Joint working also helps to prevent infection through reducing risk factors associated with physical health problems.

This will include providing advice and support to other staff, service users and carers on infections, both prevention and treatment. The team will also work to ensure and monitor the continued efficacy of systems to provide and receive this relevant information via other colleagues through the wider healthcare system. This is to improve patient safety.

About this annual programme

This programme has been developed to ensure all care environments and physical care interventions operated within the Trust are suitably managed to prevent infection or negate the risk of infection spread to patients, visitors and staff.

The prioritised actions for the forthcoming year are designed to ensure the Trust complies with all criteria stated in the Health and Social Care Act 2008 and national best practice standards.

The plan overleaf includes reference to the 10 specific criteria states with the Code of Practice on the prevention and control of infections and related guidance (rev.2015) against which a provider will be judged on how it complies with the registration requirements.

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	The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention and control of infections under The Health and Social Care Act 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirement for cleanliness and infection control
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing /medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure all care workers (including contractors and volunteers) area aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organizations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

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Topic and References	Description	Assurance information	Actions Target date for and monitoring system	RAG rating
Criterion 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them	Maintain and/or improve organisational arrangements for Infection prevention and control within the Trust Clearly defined responsibility for Infection Control within NSFT Have in place and operate effective management systems for the prevention and control of HCAI which are informed by risk assessment and analysis of infection incidents.	***Specifically: -*** **IPAC Team** • The designation of an individual as Director of Infection Prevention and Control (DIPC), to be accountable directly to the Chief Executive and the board • Appropriately constituted IPAC team **IPAC Committee** • 3 meetings per year of the Infection Prevention & Control Committee (IPACC). • The DIPC will attend the Committee to report on Trust compliance with the Health & Social Care Act, 2008 Outcome 8 • Minutes reported to the Trust Quality Governance Committee (QGC) and Board of Directors (BOD). • Annual review of membership and terms of reference. • Internal circulation of minutes & publication additionally on Trust Intranet. **Assurance framework** • DIPC led Annual review of Trust Assurance Framework for IPAC. The Assurance Framework will identify the key collective and individual responsibilities of staff and committees with • Statement of compliance outlining the collective responsibility of the Trust to protect staff, service users and visitors from infection is available on Trust Internet in the Trust	Maintain current systems	GREEN

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		Annual DIPC report and Annual plan • Annual DIPC report to IPACC and the Trust Board • Annual report published on the intranet and circulated to key stakeholders. • Mechanisms by which the board intends to ensure that sufficient resources are available to secure the effective prevention and control of HCAI. Will be achieved by noting annual DIPC report for 2015/16 and sign off of annual plan for IPAC for 2016/17. **IPAC attendance at internal and external meetings** • IPAC nurse attendance at modern matron meetings, nurse leadership forums, locality governance/ physical health meetings and external agencies including local HCAI network meetings led by the CCGs. **Out of hours arrangements for IPAC** • Out of hour's management of infection prevention and control incidents is provided through the Trust on-call system with additional information given to managers. • IPAC incidents – reported through the Datix incident and recorded on an on-call log. **External support for IPAC incidents** • Access to PHE on-call applies for relevant concerns		GREEN

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		Mandatory reporting / surveillance • Surveillance of alert organisms reported monthly to Performance and Commissioners • Mandatory reporting of all MRSA bacteraemia incidents - Microbiology laboratory in acute providers Trust carries out all mandatory reporting to Mandatory Enhanced Surveillance Scheme (MESS) at Collingdale and Co-Serv the East of England Enhanced Surveillance • Mandatory reporting of all Clostridium difficile infection incidents via Microbiology laboratory and confirmed attribution via the appeals process with the local CCG. **SLAs for Microbiology/Virology Services** SLAs in place for microbiology/Virology services in line with national revised provision of microbiology services **Infection Control Doctor Services** *SLAs for Infection Control Doctor services	*Confirmation from contracts leads outstanding. Continuing to work with contracts team to ensure appropriate SLAs with microbiology laboratories in line with national revised provision of microbiology services with additional retainer support for ICD services	Confirmation contracts in place from contracts leads except for NNUH – general contract finalisation outstanding with this Trust AMBER
Criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Designated lead for environmental cleaning and decontamination of equipment. All parts of the premises from which care is provided are clean and in good physical repair	**Decontamination Lead** • Designation of a Decontamination Lead – Deputy Director of Nursing Dawn Collins **Environmental cleanliness standards assurance** • Comprehensive contract for domestic services in place. • The IPAC team is involved in contractual negotiations for relevant services e.g. hotel services - evidence of IPAC team involvement in contracting relevant services; evidence of IPAC team involvement in building environment projects - relevant minutes/ documentation. • Review of environmental cleanliness standards and domestic services contract performance	Maintain current systems	GREEN

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	Continue IPCT involvement for all stages of the contracting process, refurbishment or new buildings e.g. for domestic, facilities, specimen transport, laundry, sharps and waste disposal services. Service specifications for engineering and building services Design stage for all new buildings/ refurbishment projects. Have in place policies on the environment to address environmental and equipment decontamination, waste handling, laundry, pest control, management of water supplies and food services & hygiene.	monitoring undertaken by Contract Compliance Officers within the Facilities Department monthly auditing and score system relevant to area of risk. Remedial interventions where required overseen by Compliance Officers with escalation to Deputy Director of Resource and Strategy, the IPAC team, and the Decontamination Lead where relevant. • IPAC team work in close collaboration with domestic services provider the with regards to reducing the risk of infection including the provision of IPAC training to support their in house competency based training (iLearn) • IPAC team participation in quarterly contract performance review meetings **Decontamination Policy** • All staff have access to a Trust wide Cleaning and Disinfection policy. The policy has clear definition of roles and responsibilities for cleaning, frequency specifications the process for urgent, terminal and clinical cleaning. Management of body fluid spills is also incorporated within this document. **Effective arrangements for cleaning of equipment and hand decontamination at the point of care**. • All staff have access to the standardised list of products for cleaning and disinfection including safety data sheets and COSHH information on the IPAC intranet site • Hand decontamination is available at the point of care - hand washing facilities or non-alcohol hand sanitizer. **Waste, Laundry and Pest Control Services** • Contract performance overseen by Facilities with reporting to IPAC committee. • Guidance for laundry handling contained with		GREEN

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		Standards Precautions Policy. Management of waste policy in draft & under direction of the Facilities department. **Water Safety and Quality** • The DIPC and IPAC specialist nurses are members of the Water Hygiene Group which meets quarterly and reports to the IPACC • Water Safety Policy available to all staff • Written Scheme available to all staff inclusive of method statements • Trust wide risk assessments for Legionella control undertaken by suitably qualified externally contracted services (Clearwater /Hydrop). • Responsible Person designated to Medical Director with Deputy Responsible Persons designated to Maintenance Services Leads. • Key principles for Legionella control included within annual LIPACS update package. **Refurbishment / New Build projects** • The IPAC team continue to work in collaboration with the Strategic Estates Department with regards to reducing the risk of infections including at the design stage for all new buildings/ refurbishment projects. **PLACE** • The IPAC team is involved with PLACE inspections which are led by the Facilities team. PLACE results reported to the IPAC Committee **Decontamination of medical devices/ patient equipment** • IPAC team to continue to advise on suitability for purchase, lease or loan of all medical devices and equipment used within the Trust.		GREEN

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		• Secure suitable decontamination systems for equipment both routinely and prior to service and repair. • The Trust employs a medical device lead, who is a member of the Physical Health care team • In liaison with the medical devices lead, up to date written policies are available for staff on items requiring decontamination prior to service or repair, single use equipment and safe equipment disposal systems. • Medical device manual available on the intranet • Standardised medical devices list is available on the Intranet • Mattress Policy available Trust-wide on intranet with audit undertaken annually by external agency. • Close collaboration with the Procurement team to make sure restricted (appropriate) ordering of medical devices that can be effectively decontaminated. • IPACT involvement with Medical Equipment Group • Clinical areas in the Trust have access to single use disposable equipment for invasive procedures • Information relating to the use of equipment and the MHRA single use symbol is contained with the Medical Devices and the Cleaning and Disinfection Policies. **Audit/ review** • LIPACS are trained to undertake environmental and equipment cleanliness audits relevant to their area of responsibility - LIPAC audit results reported to IPAC committee • Modern Matrons continue to monitor the environment and report deficiencies for action • IPAC team led spot check review of cleanliness		GREEN GREEN

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		standards across the Trust, areas of non-compliance reported with action plan to address non-compliance		
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Maintain and/or improve organisational arrangements for the management and monitoring of the use of antimicrobials to ensure inappropriate and harmful use is minimised. Improve and sustain antibiotic prescribing rates Active monitoring of prescribers that demonstrate either high antibiotic prescribing or prescribing that is not commensurate with the local formulary.	**System to monitor the use of antimicrobials** • *Antibiotic prescribing audits undertaken annually to monitor compliance with antimicrobial stewardship policy. Reporting to the Drugs and Therapeutics committee and additionally to the IPACC. • Local prescribing advisors (Pharmacists) review of all antibiotic prescriptions within inpatient settings – correspondence relating to feedback to individual prescribers and meeting minutes. • Root cause analysis of all case of Clostridium difficile to identify inappropriate prescribing of PPI's, anti-motility agents & antimicrobials not within formulary recommendations. • Lorenzo included medicine reconciliation and Summary Care Record access. • Standardised prescribing charts with dedicated antibiotic section. Electronic prescribing within Secure Services **Policy** • Clearly defined and clinically appropriate antibiotic formularies in place that take into account local antibiotic resistance patterns - Use of local CCG led prescribing formularies. • Incorporation of Start Smart then Focus principles for inpatient care prescribing within policy. **Antibiotic Stewardship Committee** • Leadership for antibiotic stewardship is within the of Drugs and Therapeutics committee – assurance information - meeting minutes	Audit schedule to be approved by D&T Committee - May 2016 **Trust wide guidance to be made available on principles of effective antimicrobial stewardship following approval at D&T Committee - May 2016	AMBER

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		Education • Inclusion of principles of effective prescribing in accordance with policy requirements within induction programme for medical staff in place • **Principles of antimicrobial stewardship to be made available Trust wide on the intranet. **Prescribing advice** • Contractual arrangements in place for microbiological services including prescribing advice.		AMBER
Criterion 4 Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.	Information should be developed with local service user representatives and PALS on the prevention of infection and key aspects e.g. importance of hand hygiene, reporting concerns relating to cleanliness & hand hygiene. Infection status of service user is available to all relevant personnel on transfer of service users between organisations to minimise the risk of inappropriate management and further	**Information for Service Users and Visitors** • Leaflets available from PALS. • Outbreak reports and key actions available within IPAC Committee meeting minutes • *Revision of information on new contact details for IPAC team & Local IPAC Supporter for Service Users, Visitors and Staff **Information to provider's delivering further support or nursing/medical care** • Interhealthcare transfer form previously used is under review • **Revision of information relating to infection status collected at admission incorporated into MDT Physical Health assessment completed on Lorenzo electronic patient care record. • Organizational review of discharge checklists to direct clinicians to provide relevant and accurate information to other healthcare provider. • Organisational policy addressing the admission, transfer, discharge and movement of patients within and between healthcare facilities - monitoring within documentation audits (discharge checklist and Fundamentals of Care audit).	*Review of patient and visitor information materials by June 2016 **Review of admission and transfer/ discharge documentation to include infection risks/incidents September 2016	AMBER AMBER

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	transmission of infection.	• Clinical alerts policy addressing application of alerts onto Lorenzo including alert organisms - in place • Feedback from other depts / Trusts		
Criterion 5 Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Continue current alert organism/ alert condition surveillance systems Reporting surveillance results to IPACC and BOD. Ensure suitable monitoring systems for infection risk (complaints, incidents and accidents) are in place and all such incidents are suitably analysed/ followed up with preventative actions and written action plans.	**Accessing electronic data relating to infections/ microorganisms** • *Following national review of all microbiology laboratory systems, development of electronic surveillance systems will be monitored. • Monthly activity reports to be received from microbiology labs via the Eastern Pathology Alliance and The Pathology Partnership -current system relies on contact between infection control personnel from acute Trust to NSFT. • IOLog 2 system in place to monitor outbreaks across East of England. • Internal record systems have been established within the Trust using Datix – Datix records available. • Internal spreadsheet database maintained by IPAC with DIPC report on significant infection incidents to IPACC, QGC and BOD. Meeting minutes and annual report published. **Management of Alert Organisms** • **In line with DH recommendations implementation of the revised MRSA policy to focus on high risk and those patients previously positive with MRSA. Provide the CCG and Board with quarterly reports of screening activity to demonstrate 90% compliance with screening of eligible patients by April 2017. • ***Implementation of the national guidance for the management of Carbapenemase producing Enterobacteriaceae (CPE). Initial work to develop Trust guidance and to continue with	*Requests made to TPP & NNUH for monthly activity reports from microbiology services providers. **MRSA policy in place. Action plan to support implementation in place. New supporting guidance to assist staff in draft. . Timescale - MRSA admission screening compliance at 90%	AMBER

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		further work required to embed the risk assessment system and ensure an auditable process. • Evidence of involvement of HPU (Consultant in Communicable Diseases) for the management of notifiable infections occurring in NSFT inpatients. • Root cause analysis (RCA) to be carried out (& in conjunction with colleagues in the acute sector if required) for all: Post 48 hour MRSA bacteraemia's. Post 72 hour Clostridium difficile infections and submitted for appeal where appropriate – in place	by April 2017 *** CPE guidance in draft. .	AMBER
		Documentation/ Policies • Major Outbreak plan available Trust wide on the intranet • Pandemic Flu policy and Pandemic Flu Plan available on the intranet. • Notifiable Disease policy available Trust wide • Policies relating to alert organisms and significant infections e.g. Clostridium difficile**,** MRSA and organism specific fact sheets available Trust wide • *Standardized electronic documentation for the recording of bowel output for inpatients in place on Lorenzo to facilitate early identification of altered bowel output which may be indicative of onset of gastrointestinal infection. • **New guidance issued for staff on the actions on suspicion of a case of Clostridium difficile **Arrangements to demonstrate that infection prevention is devolved to all groups in the organization delivering care**. • IPAC attendance at Physical Health Strategy Group -meeting minutes	Continued review of polices and guidance in accordance with policy review tracker. *Monitoring of stool chart at each RCA ** Review of practice during RCA of cases of Clostridium difficile infection.	GREEN

		• IPAC as a core agenda item within Physical Health Locality meetings • Close collaborative working with physical health locality nurses • The IPAC team are part of the corporate Physical Health team which ensures that IPAC is included in all physical health teaching programmes operated within the Trust and all physical health policies and procedures aim to secure infection prevention where possible. • System of Local IPAC supporters to embed IPAC within teams.		
Criterion 6 Systems to ensure all care workers (including contractors and volunteers) area aware of and discharge their responsibilities in the process of preventing and controlling infection	Ensure those providing care cooperates to meet the Code requirements. Maintain and Develop Identified Infection Control Communication Infrastructure Annual programme of Audit of assuring that key policies and practices are being implemented appropriately– audit schedule for 2016-17 Hand hygiene is the single most important measure for reducing transmission of	**Meeting the Code** • IPAC responsibilities stated on job descriptions • Evidence of ongoing development for IPAC team. **IPAC infrastructure** • The creation of Local Infection Prevention and Control Supporters has been extended to community staff, CAMHS, NRP and tasked with local induction, audit and liaison with IPAC team. IPAC team attend key Modern Matrons and clinical lead meetings. • Monitor database of LIPACS, Modern Matron meeting, nurse leadership forum attendance. Locality governance and Physical Health meetings. **Audit Programme** • Audit results submitted to IPAC department for evaluation. Teams that achieve <90% to present action plan to IPACC to meet required standards. Audit results to be evaluated within 4/52 of initial result and areas achieving less than 90% targeted for further training by IP&CT. • Audit results to be submitted to Norfolk &	Maintain current systems and develop systems of LIPACS within the areas as identified. Evaluate new programme for effectiveness	GREEN . GREEN

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	HCAIs in hospitals. To ensure that the profile of this vital precaution remains high compliance with the hand hygiene policy will be audited quarterly across all inpatient teams with a rolling programme for community team. Ensure all teams audited receive a full written report with recommendations	Waveney CCG & Suffolk CCG IPACN via IPAC committee. • Audits of mattresses on an annual basis to be included within the clinical audit schedule. • Assurance information relating to audit submitted as an audit report which is logged with the Audit team, internally circulated and NSFT locality managers, service managers & modern matrons and team leads, additionally published on the intranet and summarised within the BOD assurance reports and Quality Governance Committee report.		GREEN
Criterion 7 Provide or secure adequate isolation facilities	Ensure that service users in a shared environment are protected from the spread of infection	• The majority of service users are accommodated within single ensuite rooms, otherwise risk assessment process used to manage the patient and the environment, protecting other service users, visitors and staff. • Requirements for isolation continue to be reviewed on a daily basis by the infection control team and if required prioritised by greatest need e.g. those patients with diarrhoea of unknown cause.	Maintain current systems and monitor/influence building redesigns Monitor through control of individual infections and outbreaks	GREEN GREEN
Criterion 8 Secure adequate access to laboratory support as appropriate	Ensure that key staff are able to access advice on laboratory reports,	• Access to advice for specific patients from relevant acute Trusts available via standard access and advice arrangements as for GPs		GREEN

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	infection status and treatment	• Microbiology SLAs currently being strengthened in relation to a retainer for additional support if required for specific situations, e.g. outbreaks	SLA reviewed and agreed on an annual basis	With contracts team AMBER
Criterion 9 Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections" ..	Continual process of policy review: of all IPAC policies. To ensure that all policies are updated as soon as new guidance is issued and reviewed at a minimum frequency of every 2 years Audit programme to ensure that compliance with all key policies is monitored	• IPCT to draft / revise / review all policies, place those with major changes before the Infection Prevention and Control Committee for formal approval. • To ensure all policies are available through intranet access with additional supporting guidance made available as required to deliver best practice. • Policy development and review will be a standing agenda item on the IPACC – policy review tracker document • Monitor compliance with policies through a programme of audit – evidence of audit results	Key policies for NHSLA assessment completed and available on the Intranet. Policies continue to be reviewed on a rolling programme	GREEN

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Criterion 10 Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	To ensure that ALL staff receive suitable and sufficient training on the prevention and control of infection. All staff can access Occupational Health Services Occupational health policies are in place for the management and prevention of communicable diseases.	**Education & training** • Annual update training, induction training and periodic training for special courses/ groups - Annual training needs analysis, Training attendance data, Local Induction checklist audit results. • Creation of new educational e-learning tool tailored to meet the needs of all staff. • To supplement with additional bespoke face to face learning opportunities that concentrate on the essential components for the prevention and control of HCAIs. **Occupational Health services** • The Trust contracts the NNUH to provide Occupational Health services on behalf of NSFT • IPCT involved with monitoring compliance with service specification for Occupational Health Service • Information on how staff can access Occupational Health services available within post BBV inoculation policy on the intranet and also First Aid posters located in the Trust - included within sharps handling audit. • Accessing Occupational health services included within e-learning package and principles of Standard Precautions. • Access for out of hours occupational exposure via accident & emergency department –	Rolling figure for compliance with eLearning training to be >90% - WFD responsible for improving compliance with mandatory training. Training will continue to be reviewed WFD and PRG working on systems to improve compliance with all e-learning Continue to monitor use of safer needles as part of RCAs Continue to review policy implementation within the programme of audit.	AMBER GREEN

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		assurance of correct actions taken via RCA with action plan development for each needlestick injury. • Joint working with the contracted Occupational Health provider to monitor NSFT staff appointment attendance at follow up blood testing post inoculation injury assurance - meeting minutes and correspondence. • IPACT work collaboratively with the local TB nurse specialists –evidence of correspondence and attendance at CCG HCAI network meetings/ JICC. **Protection from exposure to BBV** • Standardisation of items of personal protective equipment to ensure suitability, efficacy and route to supply – list available on intranet. • Standard Precautions policy in place with programme of audit • A safer needle system is in place in all clinical areas and teams. Use of safer needles and glove wearing is monitored at each RCA which are required following a needlestick injury. **Influenza vaccination** IPACT lead on the seasonal flu vaccination campaign which is made available by a combination of Occupational Health led clinics and peer vaccination. IPAC report uptake to the DH via Immform and lead flu planning and review group (meeting minutes). **Record of training/PDP** Review of progress against LARA is within mandatory supervision template and included within appraisal process**.**	Suboptimal uptake by NSFT staff 2015 to be addressed through increased peer vaccinators to supplement Occupational Health service clinics	GREEN