Lincolnshire Partnership
NHS Foundation Trust

Infection Prevention and Control

Annual Report

2016/2017

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Glossary:

CAUTI	Catheter Associated Urinary Tract Infection
CCG	Clinical Commissioning Group.
CDI	*Clostridium Difficile* Infection
CQC	Care Quality Commission.
DIPC	Director for Infection Prevention and Control
E. Coli	*Escherichia coli*
ECT	Electro-Convulsive Therapy
HCAI.	Healthcare Associated Infection.
HCW	Health Care Worker
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCT	Infection Prevention and Control Team
ITT	Invitation to Tender
L & D	Learning and Development
MICE	Monitoring of Infection Prevention and Control, Cleanliness and Environment Audit
MRSA	Methicillin Resistant *Staphyloccocus Aureus*
MSSA	Methicillin Sensitive *Staphylococcus Aureus*
NHSE	NHS England
NICE	National Institute for Clinical Excellence
PEAG	Patient Environment Action Group.
PLACE	Patient Led Assessment of the Care Environment
WHE	Whole Health Economy
WHO	World Health Organisation

Contents:

1. Introduction

Lincolnshire Partnership Foundation Trust (LPFT) provides specialist health services for people with learning disabilities and mental health problems in a wide variety of Community and Inpatient settings across a large geographical area.

The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (Revised July 2015), describes the statutory responsibilities for all NHS organisations for the prevention and control of infections. It highlights the importance of good Infection Prevention and Control (IPC) practices across health and social care as a key part of the quality and safety agenda for patient care.

The code emphasises the importance of strong leadership, management and governance arrangements, the design and maintenance of the environment and devices, the application of evidence based clinical protocols, education and training, and communication. These play a crucial part in reducing the risk of acquiring HealthCare Associated Infections (HCAIs) during an episode of care. Effective IPC of HCAIs must be embedded into everyday clinical practice and applied consistently by everyone. (Department of Health, 2015).

As an NHS registered provider, LPFT is required to be compliant with the Code of Practice, the requirements of their commissioners and other monitoring/regulatory bodies including the CQC. IPC performance monitoring and quality assurance of standards and practice to ensure safe patient care and clinical effectiveness are reported regularly through the Trust governance processes. This includes surveillance of HCAI, management of unavoidable infections, standards of cleanliness, IPC audits and incidents/exceptions.

IPC remains everybody's business and all LPFT employed staff have an individual responsibility for practicing and maintaining high standards.

2. Aims and Objectives

2.1 Aims

This report provides the Board of Directors with detail of IPC activity and performance throughout 2016/17.

2.2 Objectives

- To provide assurance of compliance with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (July 2015)
- To report any exceptions and demonstrate actions to address these
- To demonstrate the achievements related to IPC throughout 2016/17 and set out the key priorities for 2017/18 through the annual work programme.

3. Infection Prevention and Control Governance Arrangements

3.1 The Chief Executive

The Chief Executive has ultimate responsibility for ensuring effective IPC arrangements are in place across the Trust.

3.2 The Board of Directors (via Quality Committee).

On behalf of the organisation, The Board of Directors (B.O.D) has strategic accountability for ensuring that legal and statutory IPC responsibilities in the prevention of HCAI are achieved. Through their leadership and an up-to-date and working knowledge and understanding of IPC, the B.O.D. discharges these responsibilities in the following ways:

- A nominated non-executive director member is an active champion of the IPC agenda within the Trust.
- Ensuring a culture of continuous quality improvement designed to increase safety for patients, in accordance with national IPC legislation/guidance (including NICE PH36 Healthcare Associated Infections, Prevention and Control Quality Improvement Statement 1).
- Monitoring performance against key IPC indicators
- Ensuring that a mechanism is in place to report regularly to board meetings on important infection risks and control measures that have been implemented.
- Agreeing an annual improvement programme for IPC which is linked to the business planning cycle and has identified actions and resources.

- Requiring assurance that monitoring mechanisms are in place in each clinical area, and that each area is accountable for compliance with relevant aspects of the code of practice.
- Demonstrating to patients, the public, staff and itself that it is making continuous progress towards meeting statutory requirements for IPC.

3.3 Director of Infection Prevention and Control (DIPC)

The Director of Nursing and Quality is the designated Director for Infection Prevention and Control (DIPC) and Trust Decontamination Lead. The DIPC has discharged responsibility for IPC from the Chief Executive and B.O.D and reports on IPC matters to them via the Executive Team (ET) and the Quality Committee (QC).

3.4 Patient Safety and Experience (PSE) Committee.

Chaired by the DIPC, the PSE Committee consists of key internal and external stakeholders for patient safety and experience which includes IPC matters. Bi Monthly PSE meetings are held, and a component of the meeting is set aside to:

- Review compliance with the Health and Social Care Act (2008) Code of Practice by receiving a progress/exceptions report against the annual IPC work programme from the Infection Prevention and Control Team (IPCT)
- Support the IPCT in the implementation of new local and national initiatives and EU directives.
- Provide challenge and scrutiny of how IPC practices/standards throughout the Trust impact/affect quality and patient safety and/or service delivery.
- Ensure timely delivery of the annual report to B.O.D (via the Quality Committee).
- Approve the completed IPC annual work programme from the previous year and the content of the forthcoming year.

3.5 The Infection Prevention and Control Team (IPCT)

The IPCT consists of:

- 1.0 WTE IPC Nurse Specialist (Band 7)
- 1.0 WTE Head of Physical Healthcare, IPC, Medical Devices and Smoking Cessation (Band 8B)

The IPCT are responsible for the strategic and operational delivery of IPC standards and practice for the prevention of avoidable infections and the control and management of unavoidable risks of infection to patients, carers, staff and visitors. This is carried out by the provision of specialist knowledge, advice,

support and guidance including surveillance, audit and development and implementation of necessary policies.

The team uses both a proactive and reactive approach, working collaboratively and positively, engaging internally with Trust staff, establishing and maintaining good working relationships with teams including Senior Nurse Managers, Allied Health Professionals and the Estates and Hotel Services; and externally e.g. with IPC colleagues across Lincolnshire and the wider whole health economy (WHE) both in Primary and Secondary care settings.

The IPCT provide leadership and support, but their visibility across the organisation and the relationships with staff is pivotal in staff engagement, service improvement and supporting them to embed high standards of IPC into their day to day practice. They act as a conduit for the dissemination of evidence-based knowledge and skills and a facilitator of excellent practice.

The IPC Nurse Specialist is an active member of the Infection Prevention Society (IPS), attending Trent branch meetings and is taking on increased responsibility within the IPS Special Interest Group for Mental Health by becoming the Deputy Communications Officer. They are also an active member of the Lincolnshire WHE Social Care IPC forum, working with IPC colleagues within the Lincolnshire geographical area on initiatives to drive forward service improvements that meet the needs of patients within all partner organisations.

During 2016/17, the IPC Nurse Specialist was nominated and shortlisted for the British Journal of Nursing Infection Prevention Nurse of the Year, coming third. They also secured national funding from the IPS to attend the IPS national annual conference in Harrogate.

3.6 IPC Link Practitioners Network

The IPC Link Practitioner Network consists of registered and non-registered nursing staff working in both inpatient and Community clinical teams. They are a key resource, acting as first contact for team colleagues when IPC issues arise, disseminating information, providing education, challenging practice and facilitating change. They met quarterly throughout 2016/17.

3.7 LPFT Employed Staff (including bank, agency and voluntary workers)

In accordance with the Code of Practice it is essential that there are “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.” This is achieved via induction (both at a Trust level and locally within teams), IPC as a standing agenda item at staff meetings, and reflected in job descriptions/roles and responsibilities

3.6 Estates and Facilities.

Partnership working between estates and facilities and IPC is crucial to ensuring high standards, particularly relating to cleanliness and the quality of the patient environment. The strong and extremely productive relationship between the IPCT and housekeeping services through the Estates and Facilities advisor in particular, has continued to be consolidated and enhanced through joint auditing, collaboration in development of policies and guidance, delivering shared training, and supporting and supervising both nursing and housekeeping team members.

3.7 Microbiology Services

Following the end of the existing pathology services contract on 31st March 2016, continued provision from Pathlinks has remained in place and works well to meet the needs of the service and demonstrate compliance with the Code of Practice.

These include; generation of daily isolates reports, monthly, quarterly and annual reports against performance targets agreed in the Service specification along with Consultant Microbiologist advice by telephone provided on an ad hoc basis.

4. Healthcare Associated Infections (HCAI)

As part of the national Public Health England national annual surveillance programme, mandatory notification of the following attributable HCAI is required:

- *Clostridium difficile* Infection (CDI)
- Meticillin Resistant *Staphylococcus Aureus* (MRSA) bacteraemia
- Meticillin Sensitive *Staphylococcus Aureus* (MSSA) bacteraemia
- *Escherichia coli* (E. coli) bacteraemia.

As a registered Mental Health Trust, LPFT are not currently assigned annual trajectories for the reduction of the incidence of these HCAIs. These are designated as attributable to either a clinical commissioning group (CCG) or Acute Provider (in accordance with given criteria). Surveillance of these organisms is reported monthly as part of the IPC Quality Indicators submitted by the IPCNS to the Lincolnshire Confederated CCGs.

In the event of a reported positive case where the patient has received care at LPFT as part of their care pathway; the IPCT would provide relevant information to the lead investigator from CCG or Acute Provider, completing a Post Infection Review (PIR) of MRSA bacteraemia or Root Cause Analysis (RCA) investigation of *Clostridium difficile* infection. In addition, the IPCT would undertake internal enhanced surveillance to investigate any aspects of care or contributable factors relating to care received with LPFT

LPFT Attributable HCAI	No of cases 2015/16	No. of cases 2016/17
***Clostridium difficile* Infection (CDI)**	0	0
MRSA bacteraemia	0	0
MSSA bacteraemia	0	0
***Escherichia coli* bacteraemia (E. Coli)**	0	0

5. Surveillance

Routine surveillance of identified isolates is carried out by the IPCNS as part of the mandatory notification process of MRSA, MSSA and E-Coli bacteraemia and Clostridium *difficile* infection (see section 4).

NICE Quality Statement QS 113 states that organisations should ensure that "Systems are in place to carry out mandatory monitoring, not only of HCAI, but also other infections of local relevance, including resistant organisms; and ensure that the results are shared across the organisation and used to drive continuous quality improvement." This is done through the Whole Health Economy forum and collaborative working with colleagues in the CCGs and Public Health England (PHE).

Surveillance of MRSA colonisation notifications is monitored and actioned by the IPCNS. This is in line with the "Modified admission MRSA screening guidance for NHS (2014) Department of Health expert advisory committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)"; and to support the Trust policy for Meticillin Resistant *Staphylococcus Aureus* (MRSA) Management and Control.

5.1 MRSA Colonisation

In accordance with the above guidance, the following patients are identified as requiring MRSA screening on admission to LPFT inpatient services:

- Patients admitted from a care home
- Patients who have been transferred to LPFT from an Acute Trust
- Patients who self-harm
- Patients with a history of IV drug use
- Patients with a diagnosis of delirium
- Patients with chronic wounds or indwelling devices
- Patients with a dermatological condition
- Patients who have remained within a medium or high secure hospital for more than 5 years
- Patients with a history of previous MRSA colonisation or infection.
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No. Patients in risk categories admitted (approx.)	No. Patients screened on admission	Percentage screened on admission	Positive screen on admission	Decolonisation treatment offered.
371	396	106.7%	6	6

MRSA screening levels are reported through to Commissioners on a monthly basis as part of the IPC Quality Indicators for Non-Acute Trusts.
There has been a slight increase in the number MRSA colonisation identified through screening on admission. This is very likely to be because of the increase in the awareness of the need for screening evidenced by the percentage of screening of "At Risk" groups exceeding 100%. Overall, numbers remain extremely small.

5.1 Catheter Associated Urinary Tract Infections (CAUTI).

NICE Quality Standard 61 Infection prevention and control, Statement 4 states that; "People who have a urinary catheter have their risk of infection minimised by the completion of specified procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed."

Within LPFT, the number of patients with catheters continues to be extremely low, as were the numbers of CAUTI. During 2016/17, numbers of CAUTI were as follows:

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/15	0	2	2	1	1	1	1	0	0	1	2	2
2015/16	1	1	0	0	0	0	0	0	0	0	0	1
2016/17	0	0	0	0	0	0	0	0	0	0	0	0

0 (zero) laboratory confirmed CAUTI were reported from April 2016 to March 2017. This continued the trend of significant reduction over a period of 3 years.

As part of the action plan for the Safety Thermometer for harm reduction, Trust teams continue to proactively manage catheters through the use of the High Impact Intervention Urinary Catheter Care bundle for insertion, on-going care and regular review of need, including trial without catheter for patients for whom this is indicated.

There is a national ambition to reduce healthcare associated Gram-negative blood stream infections (healthcare associated GNBSIs) by 50% by March 2021. For 2017/18 the focus will be on *E.coli* (*Escherichia coli*) as a one of the largest GNBSIs infection groups which often arises from Urinary Tract Infections. This will be supported by the Quality Premium for Clinical Commissioning Groups

(CCGs): As an integral member of the WHE, the Trust will be actively contributing to the development of a joint improvement plan by September 2017 that describes how the health economy will achieve a 50% reduction in healthcare associated GNBSIs by March 2021, with a focus on a 10% or greater reduction of *E.coli* in 2017/18.

6. Antimicrobial Stewardship.

This will be a key indicator for the 2017/18 Infection Prevention and Control Quality Indicators and a CQUIN for 2017/18 for Primary care and Acute providers to reduce the number of antibiotic prescriptions which will also have an effect on Trust provision and will form a part of the IPC strategy in development for 2017/19.

The Trust has been registered as an Antibiotic Guardian since 2015.

The IPCNS will be working with the Pharmacy team to support actions arising from the antibiotic audit including targeting prescribing without specimens being collected and sent for culture and sensitivity and review of antibiotic prescriptions after 48 hours following the receipt of results showing infectious microorganisms and sensitivities.

7. Patient Environment.

7.1 Cleanliness

To be able to demonstrate compliance with criterion 2 of the Code of Practice, it is essential that all patient environments meet cleanliness standards that facilitate the prevention and control of infections. This includes ensuring that all parts of the premises from which care is provided are suitable for the purpose, kept clean and maintained in good physical repair and condition.

Monitoring of these standards takes place through the following:

- Annual IPC audit,
- Annual Patient Led Audit of the Care Environment (PLACE),
- Bi-weekly Hotel Services supervisors audits for inpatient premises
- Cleanliness audits by contracted providers for community and outpatient premises

Any matters which require immediate or further action are escalated, in the first instance, to ward managers and team leaders, or alternatively to building

managers and Estates and Facilities services. Exceptions or delays to works are escalated to Divisional Operational Managers, Patient Environment Action Group (PEAG), the PSE Committee and, if necessary, the Executive Team.

The challenge that continues to be faced by LPFT is that patient services and care delivery takes place in multiple premises/sites across the county in differing states of age and repair. In addition, not all of the premises/sites are LPFT owned. The estate ranges from recently commissioned, purpose built Trust owned premises, through to shared ward environments in buildings owned and managed by other healthcare providers, and clinics and out-patient departments in converted buildings that may not have a long term future in the Trust. This makes consistent compliance with IPC standards and practices difficult for staff to maintain.

7.2 Capital Planning/Refurbishment Projects

The IPC team have had some continued involvement in the final stages of the project for the development of the Hartsholme Centre Psychiatric Intensive Care Unit (PICU) particularly liaising with the clinical team regarding the placement of hand hygiene dispensers.

8. Audit.

8.1 Annual IPC Audit Programme

Audit remains an effective strategy tool for assessing staff compliance with standards and clinical practice, identifying compromises in patient safety, compliance with national guidance and legislation, and driving service improvements.

The IPCT endeavour to make the audit cycle an inclusive, positive and supportive process for Ward managers and their teams, generating action plans which are realistic and achievable, designed to improve patient safety and enhance their experience. Scrutinising and challenging observed and reported practice and behaviours in order to drive forward improvements is a fundamental part of audit in the patient environments but is a more successful strategy when done well, with reference to the underlying guidance or evidence.

8.2 Summary of Audit Findings to Inpatient Areas: (Appendix 2)

The audit cycle for 2016/17 routinely included Community team premises for the first time. The graph has not been included for this report because there is no comparator from previous years to measure progress against.

Overall, the audit findings and progress against action plans highlight that staff continue to be committed to maintaining and improving patient environments to high standards but they still face some challenges.

All reports were disseminated directly to teams with action plans arising. Audit reports, action plans and updates on action plans have all been published on the IPC page on Sharon.

Following feedback from clinical teams, the Director of Nursing and in consultation with the Head of Physical Health and IPC, the reviewed audit tool was not felt to be fit for purpose and the difficult decision was made to revise it again half way through the audit cycle. This means that comparative analysis of this year's programme will be difficult, but the potential risks were felt to be small and outweighed by the risk of disengagement from the IPC strategy by clinical teams if it was continued. The revised tool in use gives a more accurate picture, is more accessible by teams and generates more realistic action plans with better outcomes for ward environments and patient experience.

Issues, themes and exceptions have been reported to Ward Managers and Team leaders in the first instance, then through Divisional Team meetings. Several common themes have been highlighted:

- Cleanliness in clinic rooms, often caused by clutter left on work surfaces by clinicians, meaning that housekeeping staff were unable to clean them adequately. This was addressed through the action plans.
- Cleaning of instruments and equipment for physiological observations was poorly evidenced and existing assurance systems (Green is Clean indicator tape) were not adequately used or were completely absent. There will be work though the IPC link practitioners, physical health leads and the IPC Nurse Specialist with the support of the Clinell area sales representative through 2017/18 to address this.
- General standards of cleanliness in some areas. This is being addressed through liaison with Estates and Facilities particularly concentrating on self-auditing by cleaning contractors in community premises.
- One consistent issue was the cases that CPNs used to transport medications and depots. Some were in a very poor state of repair, most were unable to be cleaned and some were extremely soiled. Equipment was not stored or carried in a way to maintain cleanliness and it was difficult to tell what was clean and what was used in some cases. A small work group consisting of the IPCNS, Team coordinators and CPNs will look at the use of cases, reconcile the actual needs of teams, and possibly trial new bags that will meet the needs of teams as well as addressing IPC concerns

In 2016/17, the average percentage scores for the annual IPC audit for all inpatient areas was 83%, for 2015/16, the average percentage score was 77.5%. This increase demonstrates the progress made in many areas. Significant work has been completed in many inpatient environments, both on the material building and cleanliness. This is reflected in clear improvements in individual wards and the overall percentage. (See Appendix 2)

The average score for community teams as a whole for 2016/17 was 72%. Some of the lower scores can be explained by this being the first year that teams have been systematically included in the audit cycle, so there is a lack of knowledge and awareness of expected standards. Work has been completed and is ongoing to address issues identified with individual teams and as a whole division with input from the Estates and Facilities team, particularly liaising with contracted cleaning companies.

The IPCT are confident that the levels of engagement with the IPC audit processes and findings, and a clear commitment to environments being seen as an important factor in recovery from ward and community staff, will result in an anticipated further improvement in the forthcoming year. This will be supported by the IPCSN engaging with and supporting teams in continuing to move forward to higher standards

8.3 Patient-Led Assessments of the Care Environment (PLACE) Audits

PLACE scores and action plans are uploaded onto the Estates and Facilities pages. There is some cross-over of highlights, concerns and actions. The IPCNS continues to work with Estates and Facilities and Ward Teams to address issues raised that affect IPC standards.

8.4 Waste Audits

The Trust's Estates and Facilities Waste Advisor, conducts the annual internal healthcare waste audit of all community and inpatient premises/sites across the organisation as part of a rolling programme.

Themes for 2016/17 have been a reduction in the amount of inappropriately segregated waste, in particular, unnecessary infectious waste, and improvements in the use of temporary closures of sharps bins and correct labelling of sharps waste bins.

8.5 Sharps Audit

As part of the continued service provision, Daniels Healthcare (sharps containers suppliers) carried out an external annual audit to inpatient and community

premises/sites during 2016/17, assessing staff practices and sharps management. The findings were very positive with good overall staff practices. Issues identified with one community team were addressed directly with the team leader.

9. Estates and Facilities

9.1 Capital Planning/Refurbishment Projects

NICE Quality Standard QS113 Healthcare Associated Infections (February 2016) states that Hospitals should: "involve infection prevention and control teams in the building, refurbishment and maintenance of hospital facilities." The IPC team routinely work with Estates and Facilities collaboratively in the planning, design and maintenance of capital, maintenance and refurbishment projects to ensure that needs are anticipated, planned for and met, legislative compliance is demonstrated, and that the risk of healthcare-associated infections is minimised.

9.2 Water Safety Group.

This group was established in 2016/17. The Water Safety Group, chaired by the Associate Director of Estates and Facilities is a multi-disciplinary group formed to oversee the commissioning, development, implementation and review of the Water Safety Plan. This has the aim of ensuring the safety of all water used by patients, staff and visitors to the Trust. The group meets quarterly or more frequently if there are water safety incidents. The IPC Nurse Specialist was instrumental in ensuring that the Trust had an up to date Water Safety Policy, co-authoring with the Authorising Engineer and Estates Officer. The Trust Water Safety Plan is currently being drafted.

10. Policies.

The following policies have been reviewed and updated during 2016/17 (in accordance with Code of Practice criterion 9 – Policies appropriate to regulated activities):

- Correct Use of Personal Protective Equipment

Outbreak packs for both Gastrointestinal Outbreak and Respiratory Tract Infection Outbreak have been updated

New policies and guidance have been issued:

- Guidance on Animals in Healthcare Premises
- Guidance for The Safe Collection and Disposal of Discarded Sharps and Drug Paraphernalia on LPFT premises.

- Guidance for Bare Below the Elbows for Clinical Staff
- Single Use Items Guidance posters
- Norovirus info graphs offering specific advice for Inpatient, Community, Corporate and Learning and Development teams as well as patients and visitors.
- Equipment Decontamination guidance for the Speech and Language Therapy Service for Community Learning Disabilities
- Mattress audit tool and guidance for the repair and disposal of mattresses.

The IPCT have continued to lead on ensuring that all necessary policies in relation to preventing, reducing and controlling the risks of infection are in place and up to date. A database of the policies has been set up to ensure that all are review dates are adhered to or reviewed as required e.g. in response to new relevant guidance/legislation.

11. Education and training.

11.1 IPC and Hand Hygiene Training

Hand Hygiene and IPC training continues to be delivered as e learning through the Virtual College. Compliance at end of year 2016/17 was 92.79% against a Trust target of 95%. This achievement was mainly due to the commitment and support of the Learning and Development team.

The IPC Nurse specialist liaises directly with Team Leaders and Ward Managers and through the Divisional meetings to identify hot spots and identify ways to increase compliance. This has included IPC link practitioners delivering sessions in their teams with use of Glow Boxes and a training pack received from Clinell.

A change in frequency of updating training to annual compliance meaning that large numbers of staff are non-compliant from 1st April 2017, has made this a challenging issue for 2017/18. Face to face delivery will become a crucial additional element of the overall training strategy and is included in the work plan for the year.

11.2 Bespoke Training

In 2016/17, the IPCSN delivered bespoke IPC training to a variety of teams and groups:

- Outbreak management of D&V to IPC link practitioners
- MRSA screening training to staff on Older adult wards
- Induction Training for new staff on Manthorpe Unit
- Commode cleaning training

- Management of body fluid spillage
- Hand hygiene sessions to Psychiatric Liaison team
- Hand hygiene and IPC to non-clinical apprentices
- Full day IPC training to IPC link practitioners and Hotel Services Supervisors delivered jointly with KS (title)
- Sepsis awareness teaching session for Physical Health Link Practitioners

11.3 Annual Nursing Conference 2017

The IPCT facilitated an "IPC stand" as one of the exhibitors at the 3rd annual LPFT nursing conference. The stand displayed information about Antimicrobial Resistance, hand hygiene and the benefits of good sanitation. Quizzes and crosswords were distributed and completed and engagement was very positive.

11.4 Hand Hygiene Day Event.

The IPC Nurse Specialist coordinated a Trust wide Hand Hygiene day on 22nd June 2016. This involved Link practitioners, Ward activities coordinators and Learning and Development staff. Events were held at the inpatient facilities, the Learning and Development Centre and Trust Headquarters. Staff were asked to "make a pledge" to promote good hand hygiene practices including being Bare Below Elbows during clinical practice by placing hand prints on a "pledge tree". Staff who took part received a certificate and reported as compliant for their hand hygiene. Service users and carers were encouraged to be involved and also participated in a poster competition. The Learning and Development team created a slogan "Stop Bugging Me!" and used quizzes and competitions to engage with staff attending block training. Following this, they were approached by a local school to deliver hand hygiene awareness supported by the IPCSN. It was a very enjoyable day with really enthusiastic participation from many teams around the Trust which engaged large numbers of staff, patients and visitors, including the Executive Team, in raising awareness of good hand hygiene practices. The Communications team supported the event by publishing an article on the Sharon homepage and the Weekly Word with lots of photographs.

11.5 Regional Hand Hygiene Event

A regional hand hygiene awareness day was held at Arnold Carnival in Nottingham on 18th June 2016. The IPCNS attended with other specialist nurses from the Trent branch of the Infection Prevention Society (IPS). This was another fantastic event with the opportunity to encourage good hand hygiene practices with the general public, network with other IPC practitioners and raise the profile of the Trust regionally.

11.6 Regional IPC Conference. Sepsis Awareness.

The IPCNS was an active member of the planning and facilitation group for the inaugural annual Regional IPC Conference commissioned by the Lincolnshire Confederated Clinical Commissioning Group. This day was aimed at IPC Link practitioners from organisations across the county including Social Care providers, primary and secondary care providers and other private and NHS providers. The theme was Sepsis and was used as a valuable opportunity to raise awareness of the early recognition and treatment of Sepsis to improve outcomes for those affected.

11.7 Hand Hygiene Torch Relay.

The IPCNS was a part of a national initiative raising hand hygiene awareness with the general public. This consisted of a Torch Relay in the style of the Olympic torch relay where a torch was passed on like a baton from region to region and IPC teams took the message of hand hygiene out into public spaces and events. This, again, raised the profile of the Trust as an active promoter of IPC and gained local and regional press attention, involving locally recognised icons such as the Battle of Britain Memorial Flight and the Red Arrows in spreading the message.

12. Outbreaks and Incidents.

Despite periods of increased incidence and activity in the wider health economy, LPFT continued to have very low numbers of outbreaks and incidents related to infection. (see Appendix 1)

13. Information Dissemination.

13.1 Carriage of Infectious Wastes and Specimens in Vehicles

All used sharps are considered to be infectious and sharps bins are now required to be stored in secure boxes for carriage in cars. If diagnostic specimens such as swabs and blood samples are to be carried in a community nursing container a supplementary carriage of dangerous goods diamond should be applied to the container to show compliance with UN 3371. The IPCNS liaised with Community Team Leaders via the Divisional meetings to ensure that this information was cascaded to teams and that the correct equipment could be ordered. Compliance will be audited through the IPC annual audit of community teams throughout 2017/18.

13.2 Solidifying Sachets

Following an outbreak where the management of infected body fluids was challenging because of the lack of a sluice facility, a trial of solidifying sachets was conducted on the Manthorpe Unit for minimising the risks of body fluid spillage. The sachets were well received and reviews suggested that they would be extremely useful to other teams, particularly in outbreak situations. They are low cost, have a long shelf life and are very effective. They are also used by partner organisations in Lincolnshire. The IPCT recommended that a box be held in reserve on each ward, particularly those without a sluice for use when an outbreak occurs where management of contaminated body fluids is necessary. Availability and use of these will be included in the annual IPC audit for 2017/18.

13.3 Sharps Collection Kits.

The Health and Safety Committee supported the implementation of the Guidance for The Safe Collection and Disposal of Discarded Sharps and Drug Paraphernalia on LPFT with monies that were used to purchase items for small kits to be distributed for the use of teams with no access to general sharps management equipment.

13.4 Spill kits.

Improved spill kits for the safe management of body fluid spillage have become available. Existing kits consisting of chlorine releasing granules were inconvenient to use and released unpleasant and hazardous gases. They had the potential to cause skin, eye and respiratory irritation and damage the surfaces they were used on. The chemicals used also necessitated the provision of 2 different kits depending on the body fluid they were being used on.

The new kits are far more pleasant to use, consisting of a large absorbent pad and cleaning wipes. They contain different agents to sanitise potentially infected fluids and can be stored where they can be easily accessed by all staff. They were piloted on Ward 12 and have been well received by teams. Their use was disseminated throughout all teams.

13.5 Hand Hygiene Consumables Provision.

Review of hand hygiene products in use across inpatient services in LPFT to ensure best efficacy, quality and value for staff and patients was carried out in 2016/17. A pilot of Deb products was carried out at Witham Court with very positive feedback. An event was conducted at Witham Court on 30.03.17 to review the outcome and the decision was made to use the products in all areas. Estimated cost savings to the Trust annually will be around £1,000 and the level of support in regard to materials and educational input has been vastly improved.

Roll out of products once the design for bespoke dispensers is approved will be in quarter 1 of 2017/18.

14. Service User and Carer Involvement.

14.1 Therapeutic Interventions

Pillows and Duvets: The IPCT were asked to consult with Ash Villa regarding the use of washable duvets and pillows. This was following complaints from service users and carers and comments from the CQC during the inspection in December 2015. An options appraisal was been formulated and the unit, along with the IPCSN worked in collaboration with hotel services to ensure that systems were put in place to manage the IPC risks while meeting the needs of service users.

Caged bird: The patients at Ashley House requested that they be enabled to purchase a budgie as a companion animal for all of the residents. There are serious IPC implications when keeping a caged bird in enclosed spaces, especially for people who may have pre-existing health conditions. The IPCNS worked with the ward manager and in consultation with a service user to formulate a risk assessment and management plan to ensure that the risks were mitigated and the therapeutic outcomes for patients of keeping a pet were facilitated.

14.2 Involvement

Service user involvement at LPFT mirrors that of many similar organisations and includes service user input into the Patient Environment Action Group (PEAG) and participation in Patient Led Audit of the Care Environment (PLACE).

During 2016/17, progress was made to advance service user involvement in the IPC agenda. This included:

- Expressions of interest were sought from the “Voice of 100” to be involved at all levels of IPC including consultation on policy and guidance issued to potential involvement in the IPC Committee. Uptake was disappointingly low for this but did result in consultation with a service user on the wording and content of several of the polices and guidance issued in 2016/17.
- A service user being very actively involved in completing the risk assessment and management plan for the budgie at Ashley House.
- Service Users and carers were involved in the hand hygiene day in June 2016 with pledges being made, participation in filling in hand hygiene trees and posters designed for the campaign.

- Service users on the Rochford unit joining in hand hygiene sessions delivered to staff by the Activities coordinator including use of the Glow Box.

Further levels of inclusion remain a priority for 2017/18 and are included in the work plan.

15. Commissioner Assurance.

Reporting against a compliance framework on a monthly, quarterly and annual basis throughout 2016/17 directly to the Head of Health Protection / Deputy DIPC, Federated Lincolnshire NHS CCGs and quarterly through the Quality Schedule was completed.

Work to demonstrate compliance with the Quality Indicator Toolkit for 2017/18 is already underway. The development of an overarching IPC strategy for 2017/18 is on target for reporting to Commissioners by the end of Q1. The IPC Team is confident that all other indicators are on target for compliance throughout 2017/18.

16. Seasonal Influenza Campaign.

All employers of individuals working as providers of NHS and social care services are responsible for:

- management and oversight of the flu vaccination campaign or alternative infection control measures for their frontline staff

- support to providers to ensure access to flu vaccination and to maximise uptake among those eligible to receive it

Vaccination for 2016/17 was provided primarily by Occupational Health services with support from the IPC Nurse Specialist and some embedded vaccinators in inpatient teams. Vaccine uptake from patients was also encouraged.

Additionally, a CQUIN was attached to the campaign with achievement thresholds of 65%, 70% and 75%. For 2017/18, partial achievement thresholds are 50%, 60%, 65% and 75%.

The flu plan for 2017/18 has been completed and approved and will be led by the IPCNS with support from the Staff Wellbeing Lead.

The ambition of the seasonal flu campaign is to improve the uptake rate across all staff groups beyond the 37.8% achieved in 2016/7. A target of a minimum of

50% to achieve the first payment threshold for the CQUIN has been agreed as realistic and achievable.

The IPCNS was successful in securing Innovations monies to support the flu programme for 2017/18 to finance the purchase of small publicity items for vaccinators to distribute while administering vaccinations. The B.O.D will also be asked to support the campaign to achieve the achievement threshold for the CQUIN.

17. Summary.

NICE Quality Standard 61, Infection prevention and control Statement 2.

“Organisations that provide healthcare have a strategy for continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems”

Encouraging progress continues within the Trust across all directorates in all aspects of IPC particularly in levels of engagement with clinical teams. The annual work plan for 2017/18 identifies areas of practice where improvement is necessary in order to demonstrate robust compliance with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (July 2015).

The IPCT must remain responsive, adaptable and proactive, working in collaboration with colleagues within the Trust and the wider Whole Health economy to reduce avoidable HCAI through the provision of clean, safe care by a competent, motivated workforce who have the knowledge and tools to deliver it in a clean, suitable environment and to ensure that staff, service users and carers understand their role and responsibility in reducing the risk of infection.

18. References

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National Institute for Health and Care Excellence (2012) NICE Clinical Guideline 139 Prevention and control of healthcare-associated infections in primary and community care.

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National institute for Health and Care Excellence (2016) NICE Quality Standard 113. Healthcare Associated Infections.

.Public Health England. (2014) Clostridium difficile: guidance, data and analysis. Public Health England. London.

APPENDICES

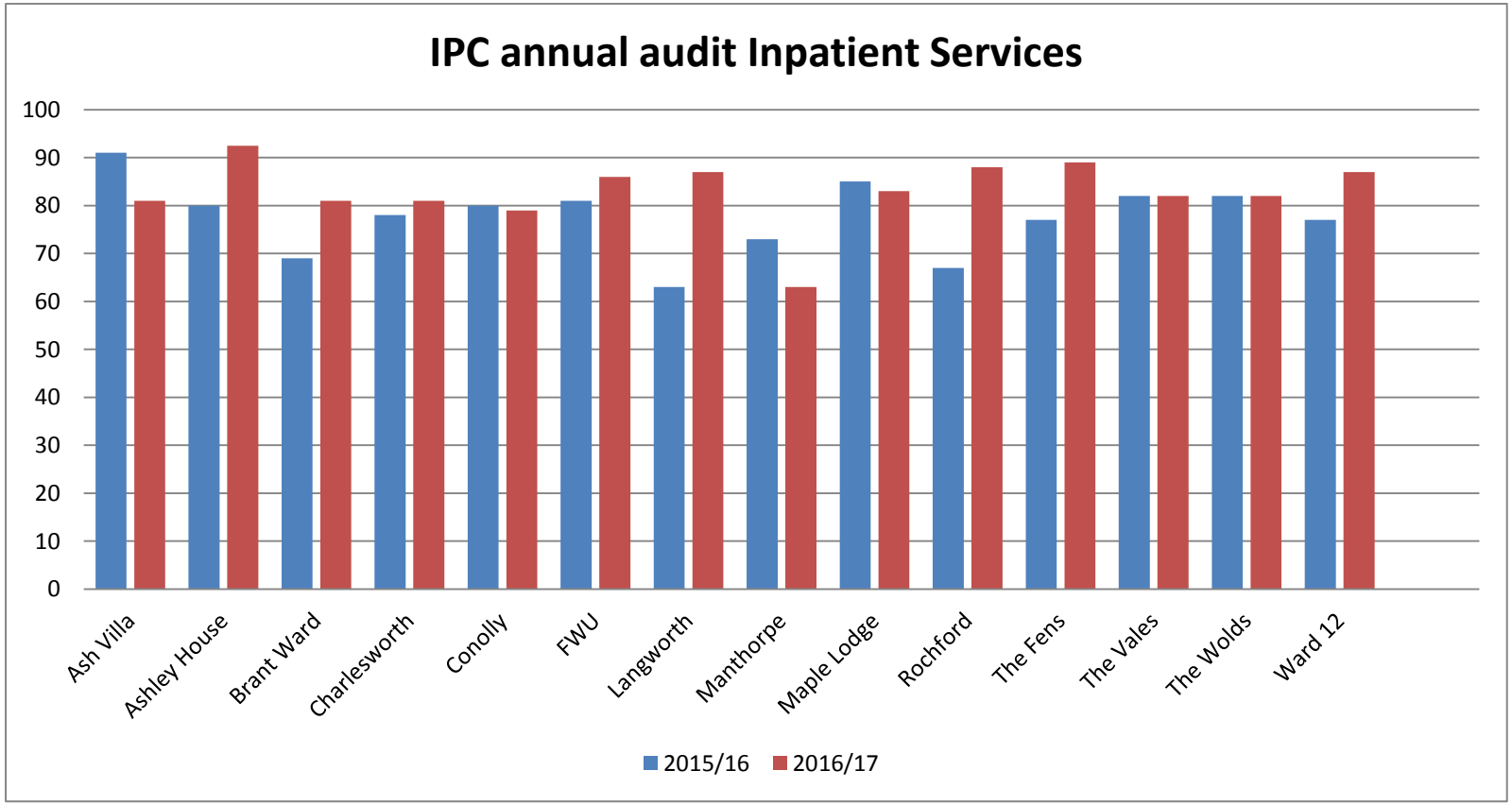
Appendix 1 - Outbreak Summary 2016/17

Location	Date started	Date ceased	Type of outbreak	Organisms isolated	No. Affected		Issues:
					Patients	Staff	
Manthorpe Unit, Grantham.	12.05.16	28.05.16	Diarrhoea and Vomiting	Norovirus	7	6	• Unit has all single rooms, but not en suite, therefore shared facilities. Nature of client group was a significant challenge to staff and made isolation difficult- cohort nursing implemented to reduce spread. • An early decision was taken to close the ward by nurse in charge supported by the On call manager • Some staff members continued to attend work while symptomatic or returned prior to being 48 hour symptom free. • Clarification was necessary regarding travelling to and from work in uniforms. • Early notification of the staff bank of the outbreak received positive feedback and outcomes.
Rochford Unit, Boston	07.04.16	11.04.16	Diarrhoea and Vomiting	None	4	1	• Some delays in reporting, isolating affected individuals and sending samples. Addressed with Ward Manager at time of incident.
Conolly Ward, Lincoln	06.04.16	11.04.16	Vomiting	None	7	3	• Issues arose with transfer of patients across LPFT sites and to Acute Hospital trust • Weekend leave of affected and unaffected patients • Difficulty isolating/cohorting patients due to their presentation and behaviours.

Appendix 2 - Inpatient IPC 2016/17 Audit Overall Scores and Comparison from previous year

Minimum acceptable score is 80%

The IPC Audit tool was reviewed part way through the cycle so comparative analysis of this year's programme is difficult. Overall, progress can be observed in most areas and this is significant in several inpatient environments.



Appendix 3

Lincolnshire Partnership NHS
NHS Foundation Trust

Infection Prevention and Control (IPC) Service April 2016 – March 2017 Annual Plan
Progress Report: Quarter 4 (Jan 2017-March 2017)

R	**= Work not completed**	**A**	**= Work behind schedule**	**G**	**= Work completed**	**NA**	**= Work on target to be completed**

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance 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.**					

Reporting
• Produce Infection Prevention and Control (IPC) reports (including cleanliness), which inform the organisation of progress and exceptions via appropriate governance structures/processes including:
  ○ Quarterly IPC Committee
  ○ Quarterly Quality schedule
  ○ Bi-annual Quality Committee, Board of Directors.
  ○ Annual IPC report
 	
• Produce assurance report (monthly, quarterly, and annual) for Commissioners (Lincolnshire NHS CCGs Federated Health Protection) against IPC quality indicators.
	Throughout 2016/17:
	
	IPC Committee report completed quarterly
	
	PSE Committee reports completed bi-monthly
	
	Reports for Quality Schedule completed quarterly
	
	Annual report completed
	
	Monthly assurance report sent monthly
	
	Quality Toolkit update reported quarterly
		G	31.03.17	• Reports
				• Action plans
				• Meeting minutes
					Criterion 1
					1.1, 1.5

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Staff Induction Training • Review current IPC training package for staff induction • Deliver IPC training to all new starters on monthly induction **Bespoke Staff Training** • According to individual/specific staff group/ discipline need e.g. shared learning from incident, link practitioner training.	• Head of IPC approached learning and development re. IPC Nurse Specialist (IPCNS) delivering face to face training at Trust induction as opposed to E-learning. • Head of IPC/IPCNS delivered outbreak management training to IPC link practitioners 27.4.16 • MRSA training to staff on older adults wards at Witham Court 29.4.16 • MRSA training offered to other OA IP teams ○ Delivered Manthorpe Unit 14.7.16	G G G G	31.03.17 27.4.16 29.4.16 14.7.16	IPC and Hand hygiene training to remain as e learning package Attendance records Training presentation Feedback	Criterion 1 1.1 Criterion 6 Criterion 10.1
Hand hygiene (HH) Compliance • Ensure that all front facing staff i.e. with patient contact, are observed to be compliant with HH techniques on an annual basis	• IPCNS and learning and development (L&D) clinical skills trainers to facilitate an organisation wide HH awareness day on 22.06.16 • IPCNS to work with IPC link practitioners in developing and implementing an observation audit tool for HH. ○ IPS Hand hygiene audit tool to be used ○ Distributed to link practitioners for monthly reporting from April 2017 • All training records to be sent to	G G G	22.6.16 31.03.17	Hand hygiene trees Weekly word article Training records Email reminders to W/Ms	QS61.3

<table>
<tr><th>Objective/Objective Actions</th><th>Actions required/Progress To Date</th><th>Status</th><th>Completion Date</th><th>Evidence of Completion</th><th>Reference</th></tr>
<tr><td></td><td>team/service leads and L&D on a monthly basis.</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Post Infection Review (PIR)/Root Cause Analysis (RCA) investigations (in accordance with national/mandatory reporting)

• IPC team to take lead on any LPFT PIR/RCA

• IPC team to work with CCG/Acute Provider colleagues leading on attributable PIR/RCA investigation where LPFT has been involved in the case:
○ Attend PIR/RCA meetings
○ Obtain case information for actions/ shared learning
○ Disseminate shared learning (as appropriate)
○ Devise LPFT specific action plan (if required) for shared learning and monitoring of completion</td><td>No of cases during 2017:
<table><tr><td>MRSA Bacteraemia</td><td>0</td></tr><tr><td>MSSA Bacteraemia</td><td>0</td></tr><tr><td>Clostridium difficile Infection (CDI)</td><td>0</td></tr><tr><td>E-Coli Bacteraemia</td><td>0</td></tr></table></td><td>G</td><td>Quarterly reporting</td><td>• Reports</td><td>Criterion 1 1.5</td></tr>
<tr><td>Monitoring and reporting of infections
• Maintain and further develop robust surveillance systems to ensure prompt reporting of infections and appropriate actions are taken by clinicians to prevent cross infection or avoidable harm to</td><td>• IPC Team assist and support with notifications of patients management plans/ care pathways
• IPC team check isolates reports routinely and cross reference any reported infections through WebV,</td><td>G
G</td><td>31.03.17</td><td>• Electronic Patient Record entry on Silverlink
• Email traffic
• Incident/ exception</td><td>Criterion 1.1, 1.5</td></tr>
</table>

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
service users, staff or the general public • Ensure that incidence of infection and/or outbreaks are reported through the appropriate governance streams • Ensure reporting of outbreaks to relevant bodies e.g. Public Health England.	taking account of reported sensitivities and resistance. • IPCT identify periods of increased activity and/or trends for enhanced surveillance, support or training needs for staff teams • IPCT supported GI outbreaks in 2x inpatient areas April 2016 • IPCT supported 1x GI outbreak in inpatient area May 2016	G G	31.03.17 April 2016 May 2016	reporting • Meeting minutes/ reports • Daily Situation report • Post outbreak report/review	
Clinical Incidents • Lead on any IPC clinical incidents: ○ Work with staff on shared learning/ improve practice/service delivery (as required) ○ Generate action plans as appropriate ○ Report/Escalate in a timely manner (as appropriate) through governance processes	• IPCT has led on various site specific and themed aspects of IPC affecting numerous sites • IPCT instigated management care plans/pathways to ensure patient quality and safety and minimise potential spread	G	31.03.17	• Email traffic/incident reporting • Meetings minutes/reports at: ○ IPCC ○ Quality Committee ○ Annual Report ○ Monthly reporting to CCCGs ○ Patient safety group	Criterion 1.1, 1.5, 1.7
Compliance Criterion 2. **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.**					
IPC Audit Programme • Devise a planned IPC audit programme across LPFT to assess IPC standards/ practices in accordance with national	During 2017, the IPC team: • Reviewing the IPC audit tool for inpatient areas • Devising and implementing an IPC	G	31.5.16	• Audit tools • Audit programme • Audit reports	Criterion 2.1

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
guidance/legislation	audit tool for non-inpatient areas/ services across LPFT • Devising a rolling IPC audit programme to all relevant areas where clinical practice takes place. • At year end, formulate an annual audit report for submission through the relevant governance structures/ processes.		31.5.16 16.5.16 31.03.17	• Action plans and updates • Patient and staff feedback • Annual audit report	
Specific/Targeted Audit • Carry out/facilitate (as appropriate) specific/ bespoke audits reactive to needs/ concerns/ issues on specific aspects of IPC	• Individual site reports/action plans to be generated and sent to clinical leads • Liaise with colleagues e.g. Estates/ Health and Safety, waste contractors, on any site specific issues raised during audit			• Audit tools • Audit reports • Action plans and updates • Patient and staff feedback	Criterion 2.1
• Implement a formalised mattress audit from procurement to end of life of the mattress to the mattresses used o For patient care o Hospital mattresses o Secure mattresses used in seclusion o Excluding air mattresses	During Q2 the IPC team will: • Review the results of the mattress audit carried out by current suppliers via procurement • liaise with physical health nurse to devise/adapt audit tool as necessary • Devise an audit programme to all areas using mattresses • Liaise with Trust Waste Specialist to ensure that clear guidance on the disposal of mattresses is distributed and implemented • Report findings through PEAG and IPCC	**G**	30.9.2016	• Audit tools and reports • Guidance	Criterion 2.2
• Produce a strategy and guidance for the use of duvets and pillows that will satisfy	During Q2, The IPCNS will: • Survey the use of pillows and duvets	**G**	Met with Ash Villa Deputy	• Options appraisal produced by Ash	

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
patient need and IPC requirements	throughout the inpatient services • Liaise with ward managers, clinicians and patients representatives to assess the needs and wants of the patient group on each ward • Collaborate with Hotel Services to produce an options appraisal with attendant guidance to enable and support managers to make informed decisions about service provision and ensure that systems are in place to manage the risks		manager/ hotel services supervisor July 2016	Villa	
Capital Planning/Refurbishment • Ensure that premises where care is delivered are fit for purpose from an IPC perspective through walkthrough visits/ audits/reports of: • New Builds - From early development stages to commissioning • At the time of relocation/refurbishment of premises • Liaise with colleagues e.g. Site managers and H&S (as appropriate) on identified actions	Throughout 2017, IPCT have been involved in: • PICU design team meetings where necessary	**G**	31.03.17	• Meeting minutes • Design blueprints	Criterion 2.1, 2.2
Patient Environment Action Group • Provide specialist IPC advice to the Patient Environment Action Group (PEAG) and undertake any associated project work arising • . Provide feedback to PEAG regarding environmental issues arising from infection control audits and cleanliness	IPCSN provides verbal report on IPC issues at quarterly PEAG meeting	**G**	06.66.16 08.08.16 13.02.17	• Meeting minutes • Action plans • Associated project plans	2.1, 2.2

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
monitoring, ensuring compliance issues are reported back or escalated as required in order that appropriate action is planned. • Escalate urgent issues via team leaders/ Ward managers, hotel services or estates and facilities as appropriate					
Hand Hygiene Consumable Provision • Lead on a review of existing hand hygiene products in use across LPFT to ensure best efficacy, quality and value for staff and patients.	The IPC team will: • Liaise with procurement to establish current provision review any contractual requirements. • Assess the provision which will best meet the needs of clinical teams • Standardise provision of Hand Hygiene products to include community/leased premises. o Completed by external contractors	**G**	July 2016 Dec 2016		
Compliance Criterion 3. **Ensure appropriate antimicrobial use to optimise inpatient outcomes and to reduce the risk of adverse events and antimicrobial resistance.**					
• IPC team to support Pharmacy as leads for to antimicrobial stewardship to ensure that appropriate antimicrobial use is continued according to national and local guidelines such as NICE, guidance on PGDs and Start Smart, Then Focus guidance.	• Attendance at Medicines management Committee where outcomes of the antibiotic audit and action plans generated from it are reviewed. • Report any exceptions through appropriate governance structures. • Contribute to devising of an antimicrobial stewardship programme •	**G**	31.03.17		Criterion 3.2 NICE QS. 61.1

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance Criterion 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.**					
• IPC team to work in partnership with service user representative groups(PALS/ Health watch/Involvement) to set up systems to ensure that information is available for service users and carers in a format which is understandable and accessible	IPC team will produce signposting to ensure that information related to: • General IPC principles • Role and responsibilities • Good use of antimicrobials • Hand hygiene compliance for visitors • Compliance with visiting policies particularly in outbreak situation • Reporting concerns Will be available to all via the Trust website	**R**	December 2016 Please see exception report point 1, and annual work plan 2017/18 for work planned to address this issue	• Meeting minutes • Materials produced	Criterion 4.1, 4.2. QS61.6
Inter/intra agency transfer form • Ensure that accurate information is shared with healthcare professionals involved in all stages and aspects of care	• Review and relaunch the Inter/intra agency transfer form • Design an audit tool to measure compliance for all relevant teams • Report compliance or exceptions through IPC Committee report This work has been superseded by the review of Clinical Systems and will be included in the consultation for the Clinical Reference Group	**G**	September 2016 Please see exception report point 2, and annual work plan 2017/18 for work planned to address this issue	On the back of our LPFT policies	Criterion 1.10, 4.4, 4.5
Notice Boards • Ensure that sufficient information and instruction is provided for service users	The IPC team will: • Provide and signpost to up to date, standard and rolling information for	**G**	31.03.17	• Notice boards • Screen savers • Articles and links	Criterion 4.3

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
and others in order to limit the spread of infection • Inform via Trust Communications systems e.g. Weekly Word, Sharon, Events management	staff, service users and visitors • Provide and signpost to local, national and international campaign materials through notice boards, the IPC page, communications processes • Update as and when required e.g. Pandemic flu, Ebola, Zika, vaccination schedules, Public health incidents			• Weekly word • Poster campaigns • Events	
Compliance 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.**					
MRSA screening • Provide evidence of clear and robust processes in place for screening on admission and proactive monitoring to identify likely sources of infection and the spread thereof	The IPC team will continue to: • Ensure that screening protocols are in place • Liaise with audit team to produce MRSA screening report • Cross reference screening report against monthly reports to ensure compliance with protocol • Work with inpatient teams to close gaps in compliance with protocol	**G**	31.03.17	• MRSA screening compliance report • Screening tool	Criterion 5.1, 5.2
Community team risk assessment • Ensure as far as possible that Community team workers are protected from IPC risks when conducting home visits	During Q2, the IPC team will work collaboratively with IPC specialists in partner organisations to: • Survey what, if any, IPC specific risk assessments for Community Team HCWs are being used across the Lincolnshire WHE.	**G**	• SIG email sent • Meeting invitations sent	• Screening tool is complete and in use • Email trails • Meeting minutes	Criterion 5.1, 5.2, 10.3

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
	• Play an active role in developing any assessment tool necessary A specific assessment tool was not deemed necessary	G	• 31.08.16		
	• Disseminate information to teams for use	G	•		
	From January 2017, • Attend Adult Community, Older Adult and Specialist Services divisional meetings to discuss issues arising and disseminate information directly to divisions specific to team needs. This work has been superseded by the review of Clinical Systems and will be included in the consultation for the Clinical Reference Group	G	• 31.03.17		
Patient risk assessment • Ensure process for assessing infection risk for patients is robust both on admission and following admission	In Q2, The IPC team will: • Review admission documentation • Liaise with clinical record keeping to ensure that IPC risk for patients are assessed on admission • Develop an assessment tool This work has been superseded by the review of Clinical Systems and will be included in the consultation for the Clinical Reference Group	R	March 2017 Please see exception report point 3, and annual work plan 2017/18 for work planned to address this issue		Criterion 5.1, 5.2

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Patient influenza vaccination campaign 2016/17 • Ensure that flu vaccination is accessed by inpatients that require it during the campaign period. This will include facilitation by the Trust for inpatients as well as encouraging patients to access the vaccine via their GP if they are considered to be in a risk category • Promote Flu vaccine through Health Promotion systems.	The IPCSN will: • Identify current trained vaccinators on inpatient areas(currently link practitioners) • Identify other potential vaccinators within teams • Liaise with Learning and Development to identify training needs for vaccinators • Work with vaccinators to coordinate raising of awareness in patient groups regarding their risks and eligibility for vaccination	**G**	20.5.16 20.5.16	• Vaccinator database • Training records • EPR	Criterion 5.1, 5.2
Patient alert system • Establish a system to alert clinicians and prescribers to significant patient IPC issues such as previous history of: o MRSA colonisation o MRSA infection o Clostridium Difficile Infection o Clostridium Difficile Toxin Negative colonisation	The IPC team will: • Liaise with clinical systems team to establish the capability of the system to support an alert process • Drive the initiative forward and implement /launch to staff • Be responsible for ensuring alert added to the Electronic Patient Record on receipt of diagnosis whilst maintaining confidentiality • Inform pharmacy to inform the antimicrobial audit so that review of prescribing decisions can be encouraged/ supported as per antimicrobial stewardship programmes	**G**	22.5.16	• Prescription charts • Antimicrobial audit • EPR • Meeting minutes	
Compliance 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.**					

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Link Practitioner Network • Ensure a network of link practitioners are embedded within teams	• The IPCSN will coordinate link practitioners within clinical teams. This will include: ○ Chairing quarterly link practitioner meetings and disseminating minutes in a timely manner ○ Coordinating an annual link practitioner training day in partnership with Head of Health Protection / Deputy DIPaC Lincolnshire NHS CCGs Federated Health Protection. ○ Disseminating up to date IPC information to the link practitioners for cascade to teams as and when they arise ○ Encourage attendance of practitioners at local, regional and national IPC study days and conference ○ Extend membership further to non-inpatient areas	**G**	27.4.16 27.7.16 11.5.16	• IPC page • Weekly word • National, local, etc. • Campaigns • Notice boards	Criterion 6.1
Transportation of sharps • Ensure that staff who transport used sharps and specimens are aware of their legal obligations and have the equipment necessary to discharge those responsibilities	The IPCSN will: • Liaise with the Trust Waste advisor to disseminate correct information to teams. • Include the management of sharps is included in IPC audits in Community Team areas to reflect the changes in the legislative framework • Report exceptions and escalate concerns through the appropriate	**G**		• Availability and use of transport boxes • Audit of availability and use	

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
	governance channels				
Induction • IPC to continue to be a part of local induction checklists	The IPC team to ensure that • local induction checklists continue to highlight IPC issues and direction to resources such as IPC page on Sharon	G	Complete April 2016 and maintain through 2016/17	Induction checklist	Criterion 6.2
• Policies and Procedures/ Guidance	• See criterion 9.	G			
Compliance Criterion 7. **Provide or secure adequate isolation facilities.**					
• Ensure that staff providing care are aware of isolation contingency plans in their own ward areas. • Ensure that staff providing support to those providing direct care are aware where the information is available on reasonably practicable isolation facilities to inpatient areas. • Ensure that staff teams working in outpatient facilities are aware of the need for an area to direct patients or carers to in order to limit their face to face contacts with staff or other patients if it becomes apparent that there may be evidence of an infectious disease	• Work through the link practitioner network to produce contingency plan for each individual inpatient area • Distribute isolation facility survey to on call managers • IPCNS to review facilities to non-inpatient areas as part of 2016/17 work-plan • Provide guidance and support to staff managing patients in isolation as and when the situation arise	G	December 2016		Criterion 7.1, 7.2, 7.3
Compliance Criterion 8. **Secure adequate access to laboratory support as appropriate**					
• Contribute strategic/operational plans for forthcoming contract bids/tender • Review of existing contract	• April - May 2016 – Head of IPC involved in working group for the ITT of pathology services contract	G	July 2016	ITT documentation Meetings Email trail	Criterion 8.1, 8.2

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Specimen collection • Ensure timely and good quality specimens are collected and sent to laboratory correctly and within acceptable timeframes	• Provide education on specimen collection for in-patient units as required through link practitioners network,	**G**	October 2016		
Compliance Criterion 9. **Have and adhere to policies designed for the individuals care and Provider organisations that will help to prevent and control infections.**					
IPC Policies • Ensure LPFT have all relevant, up to date, evidence based IPC policies (See Appendix A). • Ensure that they are easily accessible to all staff at all times	• IPC team to review IPC policies as per appendix A and identify any policies which are outstanding, out of date, require reviewing in line with new guidance/legislation • IPC team to review or formulate policies as necessary as part of the work plan for 2016/17 • Formulate a database of current and new IPC policies and review dates required	**G**	19.5.16	• Policy and procedures pages on SHARON • Links on IPC page on SHARON	Criterion 9.1, 9.2, 9.3
Outbreak Management • Review and update the existing management pack and arrangements in place for the management of outbreaks of infection (known/ suspected)	• IPCSN to review the outbreak pack in light of updated guidance and information.	**G**	31.7.16	• Updated outbreak management pack for both D&V and RTI is available to all staff	
Compliance Criterion 10. **Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.**					

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Post Exposure Incident Management • Contribute to the review of post exposure incident (e.g. needle-stick injury) management to ensure: o Quality and patient safety o Compliance with Health and Safety, Occupational Health and IPC legislation and guidance	The IPC team will: • Liaise with OH to ensure up to date policies and processes are in place and adhered to for staff • Review incident reports and follow up on practice issues with managers and team members to ensure best practice • Report any exclusions through appropriate governance channels	**G**	31.03.17	• Datix reviews • Investigation reports • Exception reports	Criterion 10.3
Safer Sharps • Review of sharps management and segregation across LPFT • Continue to report the impact of the introduction of safe sharp devices on the number of reported inoculation injuries.	The IPCSN will • Review sharps incidents as they arise, • Follow up on incidents if an IPC issue is generated from the incident • Report incidents quarterly through Infection Control Committee • Attended meeting with BD to discuss on-going quality issues	**G**	31.03.17	• Meeting minutes • Incident reports	Criterion 10.3
Spill Kits • Review the current provision of spillage kits across the Trust to ensure best efficacy, quality and value for staff and patients	The IPCSN will: • Liaise with procurement to establish current provision review any contractual requirements. • Liaise with Hotel Services and link practitioners to survey what provision is currently on the market • Assess the provision which will best meet the needs of clinical teams • Standardise provision of spillage kits products to include community/leased	**G**	31.03.17	•	

Objective/Objective Actions	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
	premises.				
Clinical Leadership Promote, lead and implement evidence based IPC practice/IPC service across LPFT through: • Visibility and availability of IPC Nurse Specialist (IPCNS) • Support and guidance of Head of Physical Health and Infection Control.	IPCNS will: • Follow up promptly on reports of IPC incidents/outbreaks either by telephone or by visiting affected areas to offer guidance and support • Disseminate information though appropriate governance pathways in a timely manner • Coordinate a rolling programme of team visits and clinical days in ward environments to gain a deeper understanding and knowledge of IPC issues that teams face	**G**	31.03.17	• Situation reports • IPC contact sheet • Email trails • Meeting minutes • Weekly word • IPC page on Sharon	

Appendix 4

HEALTH AND SOCIAL CARE ACT 2008 CODE OF PRACTICE (CRITERIA 1-10)/NICE: QUALITY STANDARDS QS61- INFECTION PREVENTION & CONTROL ACTION PLAN 2016/17

Exception reporting end of year 2016-17:

	Criterion:	Action Outstanding:	Exception:
1.	Criterion 4.1, 4.2. QS61.6	IPC team to work in partnership with service user representative groups(PALS/ Health watch/Involvement) to set up systems to ensure that information is available for service users and carers in a format which is understandable and accessible	• Up to date information available to service users and staff through the NHS Choices website. Signposting to the appropriate page already occurs. • This is a priority for the work plan for 2017/18 • Collaborative working with the Whole Health Economy to ensure a joined up approach and no duplication. • Work has commenced with the Learning Disabilities team for easy read guidance to be developed
2.	Criterion 5.1, 5.2	**Patient risk assessment** • Ensure process for assessing infection risk for patients is robust both on admission and following admission	• This work has been superseded by the Trust wide review of Clinical Systems and will be included in the consultation for the Clinical Reference Group • The IPC nurse Specialist is consulting with other IPC teams in Mental Health to investigate what they are currently doing to meet this requirement.

			• Checking of Web V for IPC alerts is being considered as an addition to the admission checklist
3.	Criterion 1.10, 4.4, 4.5	**Inter/intra agency transfer form** Ensure that accurate information is shared with healthcare professionals involved in all stages and aspects of care	• Alert system in place on Electronic Patient Record to ensure all professionals who use Silverlink are able to access relevant information • Web V also now has a system of alerts for IPC issues • Form currently included as part of outbreak management plans • The IPC nurse Specialist is consulting with other IPC teams in Mental Health to investigate what they are currently doing to meet this requirement

Lincolnshire Partnership NHS
NHS Foundation Trust

Infection Prevention and Control (IPC) Service April 2017 – March 2018 Annual Plan

R	**= Work not completed**	**A**	**= Work behind schedule**	**G**	**= Work completed**		**= Work on target to be completed**

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Compliance 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.**					
Reporting • Produce Infection Prevention and Control (IPC) reports (including cleanliness), which inform the organisation of progress and exceptions via appropriate governance structures/processes including: ○ Quarterly IPC Committee ○ Quarterly Quality schedule ○ Bi-annual Quality Committee, Board of Directors. ○ Annual IPC report ○ Divisional meetings quarterly • Produce assurance report (monthly, quarterly, and annual) for Commissioners (Lincolnshire NHS CCGs Federated Health Protection) against IPC quality	From January 2017, • Attend Adult Community, Older Adult and Specialist Services divisional meetings to discuss issues arising and disseminate information directly to divisions specific to team needs.		31.03.18	• Reports • Action plans • Meeting minutes	Criterion 1 1.1, 1.5

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
indicators.					
Bespoke Staff Training • According to individual/specific staff group/ discipline need e.g. shared learning from incident, link practitioner training.			31.03.18	IPC and Hand hygiene training to remain as e learning package Attendance records Training presentation Feedback	Criterion 1 1.1 Criterion 6 Criterion 10.1
Hand hygiene (HH) Compliance • Ensure that all front facing staff i.e. with patient contact, are observed to be compliant with HH techniques on an annual basis	IPCNS to support Learning and Development to supplement hand hygiene training with face to face delivery where necessary to address areas where training is struggling to become compliant or when specifically requested to do so in response to team needs by ward managers or team coordinators • All training records to be sent to team/service leads and L&D on a monthly basis. • IPC link practitioners to assess hand hygiene compliance monthly with the use of the IPS **Clinical Practice Process Improvement Tool** Hand Hygiene Technique		31.03.18	Training records Email reminders to W/Ms	QS61.3
Post Infection Review (PIR)/Root Cause Analysis (RCA) investigations (in accordance with national/mandatory reporting)	No of cases during 2017/18: MRSA Bacteraemia MSSA Bacteraemia		Quarterly reporting	• Reports	Criterion 1 1.5

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
• IPC team to take lead on any LPFT PIR/RCA • IPC team to work with CCG/Acute Provider colleagues leading on attributable PIR/RCA investigation where LPFT has been involved in the case: ○ Attend PIR/RCA meetings ○ Obtain case information for actions/ shared learning ○ Disseminate shared learning (as appropriate) ○ Devise LPFT specific action plan (if required) for shared learning and monitoring of completion	Clostridium *difficile* Infection (CDI) E-Coli Bacteraemia		31.03.18		
Monitoring and reporting of infections • Maintain and further develop robust surveillance systems to ensure prompt reporting of infections and appropriate actions are taken by clinicians to prevent cross infection or avoidable harm to	• IPC Team assist and support with notifications of patients management plans/ care pathways • IPC team check isolates reports routinely and cross reference any reported infections through WebV,		31.03.18	• Electronic Patient Record entry on Silverlink • Email traffic • Incident/ exception	Criterion 1.1, 1.5

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
service users, staff or the general public • Ensure that incidence of infection and/or outbreaks are reported through the appropriate governance streams • Ensure reporting of outbreaks to relevant bodies e.g. Public Health England.	taking account of reported sensitivities and resistance. • IPCT identify periods of increased activity and/or trends for enhanced surveillance, support or training needs for staff teams			reporting • Meeting minutes/ reports • Daily Situation report • Post outbreak report/review	
Clinical Incidents • Lead on any IPC clinical incidents: ○ Work with staff on shared learning/ improve practice/service delivery (as required) ○ Generate action plans as appropriate ○ Report/Escalate in a timely manner (as appropriate) through governance processes	• IPCT to lead led on specific and themed aspects of IPC affecting numerous sites • IPCT instigated management care plans/pathways to ensure patient quality and safety and minimise potential spread		31.03.18	• Email traffic/incident reporting • Meetings minutes/reports at: ○ IPCC ○ Quality Committee ○ Annual Report ○ Monthly reporting to CCCGs ○ Patient safety group ○	Criterion 1.1, 1.5, 1.7
Compliance Criterion 2. **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection.**					
IPC Audit Programme • To Carry out a planned IPC audit	The IPC team will • Conduct a rolling IPC audit programme		31.03.18	• Audit tools	Criterion 2.1

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
programme across LPFT to assess IPC standards/ practices in accordance with national guidance/legislation	to all relevant areas where clinical practice takes place. • At year end, formulate an annual audit report for submission through the relevant governance structures/ processes.			• Audit programme • Audit reports • Action plans and updates • Patient and staff feedback • Annual audit report	
Specific/Targeted Audit • Carry out/facilitate (as appropriate) specific/ bespoke audits reactive to needs/ concerns/ issues on specific aspects of IPC	• Individual site reports/action plans to be generated and sent to clinical leads • Liaise with colleagues e.g. Estates/ Health and Safety, waste contractors, on any site specific issues raised during audit		31.03.18	• Audit tools • Audit reports • Action plans and updates • Patient and staff feedback	Criterion 2.1

Capital Planning/Refurbishment
• Ensure that premises where care is delivered are fit for purpose from an IPC perspective through walkthrough visits/ audits/reports of:
  • New Builds - From early development stages to commissioning
  • At the time of relocation/refurbishment of premises
 	
• Liaise with colleagues e.g. Site managers and H&S (as appropriate) on identified actions
			31.03.18	• Meeting minutes
				• Design blueprints
					Criterion 2.1, 2.2

Patient Environment Action Group • Provide specialist IPC advice to the Patient Environment Action Group (PEAG) and undertake any associated	IPCSN provides verbal report on IPC issues at quarterly PEAG meeting		31.03.18	• Meeting minutes • Action plans • Associated project plans	2.1, 2.2

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
project work arising • . Provide feedback to PEAG regarding environmental issues arising from infection control audits and cleanliness monitoring, ensuring compliance issues are reported back or escalated as required in order that appropriate action is planned. • Escalate urgent issues via team leaders/ Ward managers, hotel services or estates and facilities as appropriate					
Hand Hygiene Consumable Provision • Hand hygiene products in use across LPFT to be replaced to ensure best efficacy, quality and value for staff and patients.	The IPC team will: • Support the roll out of new provision in consultation with suppliers and clinical areas		31.08.17		
Compliance Criterion 3. **Ensure appropriate antimicrobial use to optimise inpatient outcomes and to reduce the risk of adverse events and antimicrobial resistance.**					
• IPC team to support Pharmacy as leads for to antimicrobial stewardship to ensure that appropriate antimicrobial use is continued according to national and local guidelines such as NICE, guidance on PGDs and Start Smart, Then Focus	• Attendance at Medicines management Committee where outcomes of the antibiotic audit and action plans generated from it are reviewed. • Report any exceptions through		31.03.17		Criterion 3.2 NICE QS. 61.1

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
guidance.	appropriate governance structures. • Contribute to maintenance of an antimicrobial stewardship programme				
Compliance Criterion 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.**					
• IPC team to work in partnership with service user representative groups(PALS/ Healthwatch/Involvement) to set up systems to ensure that information is available for service users and carers in a format which is understandable and accessible	IPC team will produce signposting to ensure that information related to: • General IPC principles • Role and responsibilities • Good use of antimicrobials • Hand hygiene compliance for visitors • Compliance with visiting policies particularly in outbreak situation • Reporting concerns Will be available to all via the Trust website		31.12.17	• Meeting minutes • Materials produced	Criterion 4.1, 4.2. QS61.6
Notice Boards • Ensure that sufficient information and instruction is provided for service users and others in order to limit the spread of infection • Inform via Trust Communications systems e.g. Weekly Word, Sharon, Events management	The IPC team will: • Provide and signpost to up to date, standard and rolling information for staff, service users and visitors • Provide and signpost to local, national and international campaign materials through notice boards, the IPC page, communications processes • Update as and when required e.g. Pandemic flu, Ebola, Zika, vaccination schedules, Public health incidents	**G**	Complete April 2017 and continue through 2017/18	• Notice boards • Screen savers • Articles and links • Weekly word • Poster campaigns • Events	Criterion 4.3
Compliance Criterion 5. **Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate**					

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
treatment to reduce the risk of transmitting infection to other people.					
MRSA screening • Provide evidence of clear and robust processes in place for screening on admission and proactive monitoring to identify likely sources of infection and the spread thereof	The IPC team will continue to: • Ensure that screening protocols are in place • Liaise with audit team to produce MRSA screening report • Cross reference screening report against monthly reports to ensure compliance with protocol • Work with inpatient teams to close gaps in compliance with protocol	**G**	Complete April 2017 and continue through 2017/18	• MRSA screening compliance report • Screening tool	Criterion 5.1, 5.2
Patient risk assessment • Ensure process for assessing infection risk for patients is robust both on admission and following admission	The IPC team will: • Be an active and proactive member of the Clinical Reference Group for the review of clinical systems provision in order to ensure that IPC needs and assessments to minimise risk to patients and staff are met This work has been superceded by the review of Clinical Systems and will be included in the consultation for the Clinical Reference Group		31.03.18		Criterion 5.1, 5.2
Patient influenza vaccination campaign 2017/18 • That flu vaccination is accessed by inpatients that require it during the campaign period. This will include facilitation by the Trust for inpatients as well as encouraging patients to access the vaccine via their GP if they are considered to be in a risk category	The IPCSN will: • Identify current trained vaccinators on inpatient areas(currently link practitioners) • Identify other potential vaccinators within teams • Ensure that identified vaccinators have adequate training to fulfil their duties • Work with vaccinators to coordinate		31.03.18	• Vaccinator database • Training records • EPR	Criterion 5.1, 5.2

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
	raising of awareness in patient groups regarding their risks and eligibility for vaccination				
Patient alert system • A system is available to alert clinicians and prescribers to significant patient IPC issues such as previous history of: ○ MRSA colonisation ○ MRSA infection ○ Clostridium Difficile Infection ○ Clostridium Difficile Toxin Negative colonisation	The IPC team will: • Be responsible for ensuring alert added to the Electronic Patient Record on receipt of diagnosis whilst maintaining confidentiality • Inform pharmacy to inform the antimicrobial audit so that review of prescribing decisions can be encouraged/ supported as per antimicrobial stewardship programmes	**G**	Complete April 2017 and continue through 2017/18	• Prescription charts • Antimicrobial audit • EPR • Meeting minutes	
Compliance 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.**					
Link Practitioner Network • Ensure a network of link practitioners are embedded within teams	• The IPCSN will coordinate link practitioners within clinical teams. This will include: ○ Chairing quarterly link practitioner meetings and disseminating minutes in a timely manner ○ Coordinating an annual link practitioner training day in partnership with Head of Health Protection / Deputy DIPaC Lincolnshire NHS CCGs Federated Health Protection. ○ Disseminating up to date IPC information to the link	**G**	Complete April 2017 and continue through 2017/18	• IPC page • Weekly word • National, local, etc • Campaigns • Notice boards	Criterion 6.1

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
	practitioners for cascade to teams as and when they arise ○ Encourage attendance of practitioners at local, regional and national IPC study days and conference ○ Extend membership further to non-inpatient areas				
Transportation of sharps • That staff who transport used sharps and specimens are aware of their legal obligations and have the equipment necessary to discharge those responsibilities	The IPCSN will: • Include the management of sharps is included in IPC audits in Community Team areas to reflect the changes in the legislative framework • Report exceptions and escalate concerns through the appropriate governance channels	**G**	Complete April 2017 and continue through 2017/18	• Availability and use of transport boxes • Audit of availability and use	
Induction • For IPC to continue to be a part of local induction checklists	The IPC team to ensure that • local induction checklists continue to highlight IPC issues and direction to resources such as IPC page on Sharon	**G**	Complete April 2017 and continue through 2017/18	Induction checklist	Criterion 6.2
Compliance Criterion 7. **Provide or secure adequate isolation facilities.**					
• That staff providing care are aware of isolation contingency plans in their own ward areas. • That staff providing support to those providing direct care are aware where the information is available on reasonably practicable isolation facilities to inpatient areas. • That staff teams working in outpatient	• Work through the link practitioner network to maintain contingency plans for each individual inpatient area • Ensure that isolation facility survey is available to on call managers • Provide guidance and support to staff	**G**	Complete April 2017 and continue through 2017/18		Criterion 7.1, 7.2, 7.3

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
facilities are aware of the need for an area to direct patients or carers to in order to limit their face to face contacts with staff or other patients if it becomes apparent that there may be evidence of an infectious disease	managing patients in isolation as and when the situation arise				
Compliance Criterion 8. **Secure adequate access to laboratory support as appropriate**					
Specimen collection • That timely and good quality specimens are collected and sent to laboratory correctly and within acceptable timeframes	• Provide guidance and education on specimen collection for in-patient units as required through link practitioners network,	**G**	Complete April 2017 and continue through 2017/18		
Compliance Criterion 9. **Have and adhere to policies designed for the individuals care and Provider organisations that will help to prevent and control infections.**					
IPC Policies • That LPFT have all relevant, up to date, evidence based IPC policies (See Appendix A). • They are easily accessible to all staff at all times	• IPC team to maintain the review of IPC policies and identify any policies which are outstanding, out of date, require reviewing in line with new guidance/legislation • Maintain a database of current and new IPC policies and review dates required	**G**	Complete April 2017 and continue through 2017/18	• Policy and procedures pages on SHARON • Links on IPC page on SHARON	Criterion 9.1, 9.2, 9.3

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Outbreak Management • That arrangements are in place for the management of outbreaks of infection (known/ suspected)	• IPCSN to ensure the outbreak pack is up to date in light of any updated guidance and information. • IPCNS to ensure that outbreak pack is readily available to all staff at all times	**G**	Complete April 2017 and continue through 2017/18	• Updated outbreak management pack for both D&V and RTI is available to all staff	
Compliance Criterion 10. **Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.**					
Post Exposure Incident Management • That review of post exposure incident management is carried out (e.g. needle-stick injury) to ensure: ○ Quality and patient safety ○ Compliance with Health and Safety, Occupational Health and IPC legislation and guidance	The IPC team will: • Contribute to the review of incident reports and follow up on practice issues with managers and team members to ensure best practice • Report any exclusions through appropriate governance channels	**G**	Complete April 2017 and continue through 2017/18	• Datix reviews • Investigation reports • Exception reports	Criterion 10.3
Safer Sharps • That review of sharps management and segregation across LPFT is maintained • That the impact of the introduction of safe sharp devices on the number of reported inoculation injuries is reviewed	The IPCSN will • With matrons, review sharps incidents as they arise, • Follow up on incidents if an IPC issue is generated from the incident • Report incidents	**G**	Complete April 2017 and continue through 2017/18	• Meeting minutes • Incident reports	Criterion 10.3

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Annual Flu Campaign for Frontline Healthcare Workers • That LPFT have a robust approach and plan to ensure that frontline HCW have the opportunity to access flu vaccination to protect themselves and patients from the potential serious complications of influenza	The IPCNS will ensure that flu vaccination is readily available for LPFT HCWs by: • Leading on the 2017/18 annual flu programme with the support of the Staff Wellbeing Lead • • Developing the annual LPFT flu plan • Ensuring that sufficient trained peer vaccinators are embedded in teams • Seeking and engaging the support at board level for the campaign		31.03.18	•	

Objective	Actions required/Progress To Date	Status	Completion Date	Evidence of Completion	Reference
Clinical Leadership That evidence based IPC practice/IPC service is available across LPFT through: • Visibility and availability of IPC Nurse Specialist (IPCNS) • Support and guidance of Head of Physical Health and Infection Control.	IPCNS will: • Promote, lead and implement evidence based IPC practice/IPC service across LPFT • Follow up promptly on reports of IPC incidents/outbreaks either by telephone or by visiting affected areas to offer guidance and support • Disseminate information though appropriate governance pathways in a timely manner • Coordinate a rolling programme of team visits and clinical days in ward environments to gain a deeper understanding and knowledge of IPC issues that teams face • Ensure that LPFT are active members of the local whole health economy	G	Complete April 2017 and continue through 2017/18	• Situation reports • IPC contact sheet • Email trails • Meeting minutes • Weekly word • IPC page on Sharon	