University Hospitals of Leicester NHS
NHS Trust

Meeting title:	Trust Board **Public Trust Board paper L**					
Date of the meeting:	10th August 2023					
Title:	Infection Prevention Board Assurance Framework					
Report presented by:	Julie Hogg, Chief Nurse					
Report written by:	Elizabeth Collins, Lead Nurse Infection Prevention					
Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Patient safety committee Quality Committee					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which

Impact assessment
None to date

Acronyms used:
BAF Board Assurance Framework
UKHSA United Kingdom Health Security Agency
IP Infection Prevention
CQC Care Quality Commission
NHSE National Health Service England
NCS National Cleaning Standards

Purpose of the Report

To ensure the Committee is sighted to the revised Board Assurance Framework excel workbook / document

Recommendation

The committee is asked to:

- Receive and note this latest report detailing our compliance with the Infection Prevention Board Assurance Framework excel workbook
- Be assured that this is being implemented and monitoring has commenced within the Trust
- To note the BAF will be incorporated into the overarching Quarterly UHL Infection Prevention (IP) Framework for future reporting and this will be submitted quarterly to the Quality Committee
- To note the areas where we are non-compliant and our plans to address these
- To be assured that an external audit has been commissioned to validate our self-assessment
- To be advised that we have an NHSE peer review of infection prevention scheduled in August 2023

Summary

The Board Assurance Framework (BAF) was developed by the office of the National Chief Nurse to support all healthcare providers to effectively self-assess their compliance with the United Kingdom Health Security Agency (UKHSA) Infection Prevention and Control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) document.

This report provides assurance that a process for its use has been developed within UHL and regular reports will be presented to the Committee. Our overall compliance with the 10 criteria is as follows:

Compliance	Number	%
Not applicable	41	26.8
Non-compliant	7	4.6
Partially compliant	69	45.1
Compliant	36	23.5
Total	153	100

Main report detail

The BAF has been designed as a framework for providing evidence and as an improvement tool to optimise actions and interventions to prevent the spread of infection in the acute hospital setting. This revised version was issued in April 2023

The framework is not mandatory but was developed to help providers assess themselves, as a source of internal assurance, as to whether quality standards were being maintained. It was designed to also help organisations identify any areas of risk and show the corrective actions taken in response. The tool, therefore, can also provide assurance to organisational boards that organisational compliance has been systematically reviewed

It is also to enable organisations to provide Trust Board assurance that there are robust risk assessment processes in place and these are central to protecting the health, safety and welfare of patients and staff. This is legislated within The Health and Safety at Work Act 1974 and the Code of Practice on the Prevention and Control of Infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The National Infection Prevention and Control Board Assurance Framework (IPC BAF) has been published on the NHS England web site and can be accessed via this link: https://www.england.nhs.uk/wp-content/uploads/2022/04/nipc-board-assurance-framework.xlsx

For many years a comprehensive assurance Infection Prevention 'Toolkit' including the Annual Infection Prevention Programme for Wards/Dept, Health and Social Care Act (HASCAT) self-assessment Tool and CQC check list has been produced to provide oversight to the CMGs and Trust Board as to the comprehensive remit of IP within the organisation. Indeed we were commended on this 'toolkit' by NHSE and asked to share this with other organisations which of course we were delighted to do.

The recently produced NHSE BAF was developed using a framework very similar to that already used within our Trust for all English Organisations who may not have already had this in place, hence the direction that this was not compulsory. The CQC however have indicated that they will expect to see this tool in use and as there are revised sections included which have new lines of enquiry and we have decided to include the BAF within the UHL 'Toolkit' and produce a document with applicable tabs where everything in one framework in order to prevent colleagues having multiple documents to complete.

The document is organised into 10 sections which mirror the section headings within the Health and Social Care Act Code of Practise for Infection Prevention. Pie Charts and Bar Graph tabs provide a visual tool to aid the

review process and provide either assurance for colleagues or provide focus for direct actions and work streams where exceptions may exist.

The red rated exceptions are currently identified within:

Section 2 relates to the National Cleaning Standards (NCS) and work streams are on-going via an NCS Task and Finish Group.

Section 4 relates to An IP Communication Strategy and this is due for completion during Quarter 2.

Clear plans are in place for both areas.

Next Steps

We will re-name this the UHL Infection Prevention Framework incorporating the 'Toolkit'. We propose to do this for a year to enable colleagues to get used to the new format and thereafter this will become the UHL IP Framework.

A full review of the Framework will be undertaken once populated with Quarter 1 data and actions will be supported by the Trust Infection Prevention Operational Group and presented quarterly to the Trust Infection Prevention Assurance Committee.

Actions for the non-compliant criterions are as follows. Timelines for partially compliant action are in development and will be overseen by TIPAC.

Criterion	Action required	By Whom	By When	RAG
2.1	NCS task and finish meeting is progressing actions required within the designated timelines	NCS working group	06.10.2023	
4.1	IP communication strategy is agreed via TIPAC annually	Head of Communications	6.10.2023	

Supporting documentation

Board Assurance Framework links to the full UHL excel spread sheet/document

UHL-board-assuranc
e-framework UHL Jul

(copy attached)

National Infection Prevention and Control Board Assurance Framework

Version 1.0 March 2023

Publication approval reference:

Introduction

The National Infection Prevention and Control board assurance framework ('the framework') is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place).

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

The aim of this document is to identify risks associated with infectious agents and outline a corresponding systematic framework of mitigation measures.

The framework should be used to assure the executive board or equivalent, directors of infection prevention and control, medical directors, and directors of nursing of the assessment of the measures taken in line with the evidence based recommendations of the NIPCM (or whilst the NIPCM is being implemented) including the relevant criterion outlined in the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The outcomes can be used to provide evidence to support improvement and patient safety. The adoption and implementation of this framework remains the responsibility of the **organisation and all registered care providers** must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined.

If the criterion is not applicable within an organisation or setting for example, ambulance services then select not applicable option.

Links

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

Legislative framework

The legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting is detailed in the Health and Social Care Act 2008: code of practice on the prevention and control of infections, the duty of care and responsibilities are set out in the Health and Safety at Work Act 1974, and associated regulations for employers and employees.

Local risk assessment processes are central to protecting the health, safety and welfare of patients, service users, staff and others under relevant legislation. This risk assessment process (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings) has been designed to support services in identifying hazards and risks, and includes guidance on measures that should be maintained to improve and provide safer ways of working by balancing risks appropriately. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work using the risk assessment process and the organisation's governance processes.

Links

Health and Social Care Act 2008: code of practice on the prevention

Health and Safety at Work etc. Act 1974

Primary care, community care and outpatient settings

Acute Inpatient areas

Primary and community care dental settings

Instructions for use

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

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

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

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

N.B. Use of the framework **is not compulsory** but should be used by organisations to ensure compliance with infection prevention and control (IPC) standards (unless alternative internal assurance mechanisms are in place). In addition, not all of the criteria outlined in the framework will be relevant or applicable to all organisations or settings.

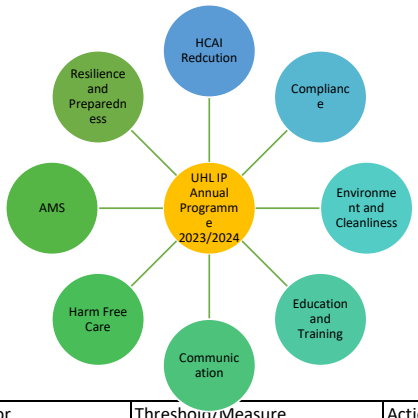
Please note: Specific URL's referred to in the document can be accessed via the ' Hyperlinks included in the BAF' tab. Or alternatively, can be accessed by clicking

Links

Section 1	
1.2	NICE QS 61
1.4	NIPCM
1.5	NICE Guidance QS 49
1.6	NICPM
	Primary care, community care and outpatient settings,
1.8	Acute inpatient areas
	Primary and community care dental settings
Section 2	
2.1	National cleanliness standards
2.2	Patient-Led Assessments of the Care Environment (PLACE)
2.4.1	HTM:03-01.
2.4.2	HTM:04-01
2.5	HBN:00-09
2.6	HTM:01-04
	NIPCM
2.7	HTM:07:01
	HTM:01-01
2.8	HTM:01-05
	HTM:01-06
Section 3	
3.2	UK AMR National Action Plan
3.3	UK AMR National Action Plan.
	NICE Guideline NG15
3.4	TARGET
	Start Smart, Then Focus
Section 5	
5	NIPCM
Section 6	
6.2	Roles and responsibilities
Section 7	
7	NIPCM
Section 9	
	UKHSA
9	A to Z Pathogen
	NIPCM

Definitions

NIPCM	National Infection Prevention & Control Manual
HTM	Health Technical Memorandum
HBN	Health Building



UHL BAF Ref	Programme indicator	Threshold/Measure	Action	Lead Responsbility	Assurance
1.1	CMG IPN/Ward Managers can provide evidence of collaborative working with IP link staff	Every ward/dept has an identifed IP link staff worker.	The IP register for the Ward/Dept link worker staff has been checked and updated accordingly	Ward/Dept Manager	Central IP register
1.2	MRSA Annual UHL objective 2023/24 : 0 cases Monitoring of CMG cases against UHL trajectory	0 cases, Monthly reporting via Quality & Performance report to EQB, QOC and Trust Board if required	Report submitted to EQB/QOC	IPT Lead	Reports available
1.3	IP DATIX reports of non-compliance with IP policy to be reviewed on a by on a quarterly basis.	Report/findings to be presented to CMG IPOG meetings by CMG IPN. Datix reports as a standard agenda item at IPOG/CC/Ward/Dept meetings to discuss and review	CMG Datix discussed and reviewed at IPOG	CMG Infection Prevention Leads	action points/discussion notes
1.4	Audit compliance with Urinary Catheterisation care bundle/vascular access care bundle/HH/MRSA screening/IP standard precautions and feedback results to staff responsible for care delivery and management audit 2023/2024	Implement actions for improvement in areas of <90% compliance and feedback to IP lead. Standard Item agenda at CMG IPOG/CC/Ward/Dept meetings	CMG Audit Summaries are discussed in IPOG meetings	CMG Infection Prevention Leads	action points/discussion notes
1.4	Feedback to staff on IP:Staff are provided with feedback on their performance in relation to infection prevention		Ward/dept Audit Summaries are raised at Ward/Dept meeting	Ward/Dept Manager	Ward/Dept Meeting discussion points
1.5	CDT Annual UHL trajectory 2022/23 91 : cases. Monitoring of CMG cases against UHL trajectory.		Every CDI case reviewed using standard UHL CDI template	IPT Lead	Number of cases reported/case reviews
1.5	CDiff Specialist Nurse to circulate C Diff Infection care pathway summary thematic review quarterly. Discuss review at CMG IP meeting and provide action plan with a named lead if required action	CDT thematic review quarterly. Areas of non-compliance require action plan and sign off at CMGQSB once completed.	CMG Thematic review completed	IPT Lead	CMG Thematic reviews
1.5	MRSA/MSSA bacteraemia (post-2 days) Post infection review (PIR) to be undertaken for each case (follow MRSA/MSSA PIR process flow chart, mandated by the ICBs) action plan completed by the CMG with IP input	Every case reviewed at monthly CMG IPOG meeting, reviewed by CMG, QSB, TIPAC and EQB Quarterly. Standard Item agenda at IPOG/CC/Ward/Dept meetings	CMG MRSA/MSSA BSI Cases are discussed in IPOG meetings	CMG Infection Prevention Leads	action points/discussion notes
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations across all wards/depts	All wards/depts are to ensure compliance with the NSC. Standing agenda item at CC and Ward/Dept meetings.	Ward/dept environmental checklist completed once a quarter.	Ward/Dept Manager	New Environmental Checklist

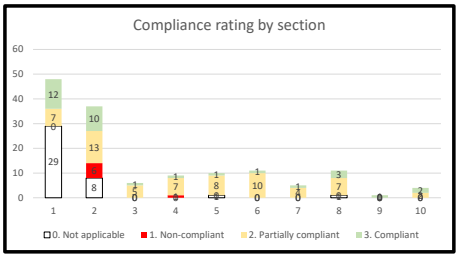
2.1	CMG to continue to support, in conjunction with facilities colleagues, the Deep Cleaning rolling programme with the use of Hydrogen Peroxide or UV, for wards within UHL. Where areas of non-compliance identified, these should be identified to the CMGQSB	Deep Cleaning programme undertaken where possible, using every opportunity to support this process.	Programme distributed to all CMGs in advance to support completion	Head of Facilities/Domestic Services	Facilities report to TIPAC
2.1	Consistant use of Bedspace cleaning checklists. Checklist to be fully completed and put into the patients notes	Quarterly audit of 10 sets of patient notes. 100% compliance expected. Where non-compliance identified the Ward Manager to ensure action is taken to rectify. Standing agenda item on Ward/Dept meetings	Review 10 sets of notes: check bed space cleaning checklists have been completed. and actions taken accordingly.	Ward/Dept Manager	Audits are available to view
2.1	Domestic Managers to present monthly cleanliness audit scores, to Matrons, Ward Managers, cc to Heads/Deputy Heads of Nursing. Where scores are below 90% provide evidence of remedial action	Audits carried out by Facilities. Action required if <90%. Re-audit weekly until rectified. Report to Domestic Leadership Forum monthly, CMGB/CMGQSBStanding Agenda item at IPOG for 3 star or below rated Wards/Areas	3 star rating areas and Wards/Depts have been discussed and reviewed at IPOG .	CMG Infection Prevention Leads	action points/discussion notes at domestic forum
2.4	Ensure Aspergillus Risk assessments are completed on all building projects including refurbishments prior to work commencing		Evidance of sign off where required	IP Senior Nurse (E&F)	Evidence of sign off
2.4	Ward and Dept Managers to ensure that actions to prevent transmission of Pseudomonas and Legionella to patients are in place. Records of flushing must be kept. The preferred method for doing this is the Compass System available through Facilities. Managers must ensure that they have an adequate number of delegates for this.	All low use water outlets flushed (daily for pseudomonas in augmented care areas/ 3x3 minutes per week for legionella all areas) the definition of low use in non augmented care is any outlet not used 3x3 minutes per week and for augmented care this is daily.	Compass flushing has been undertaken 3 x weekly for 3 minutes and recorded	Ward/Dept Manager	Compass or local retained records available
2.4	Ward and Dept Managers to ensure that actions to prevent transmission of Pseudomonas and Legionella to patients are in place.	Are there separate sinks for hand washing and dirty water. These must be clearly labelled	Include in Enviro check	Ward/Dept Manager	Visual observation
2.4	Domestic colleagues can provide evidence that limescale build up on taps in high risk areas has been reported for action. This action relates to the prevention of Psuedomonas and Legionella infection	Domestic services. Audit quarterly to TIPAC	Taps reported with limescale have been addressed or an remedial plan in place	Head of Facilities/Domestic Services	Process to capture this data to be agreed with Head of Facilities
2.5	Ensure IP sign off for all capital developments for change of use of clinical areas or new works	Evidance of sign off can be provided	Evidance of sign off where required	IP Senior Nurse (E&F)	Evidence of sign off
2.8	Decontamination of Flexible Endoscopes: Flexible endoscopes are decontaminated in accordance with CFPP 01-06	Complete IPS society audit tool bi annually.	Trust wide ward/dept decontamination audit completed in accordance with schedule	Matron	Audit results/report

5.1	iFive and A-F risk assessment (available on NerveCentre) is embedded across all areas.	Staff can articulate what the i five acronym means and how this is applied	Ask 5 members of staff: Describe the ifive risk assessment tool and when is it undertaken	Ward/Dept Manager	
5.1	If TB identified in a bay, a review meeting identifies any delays in diagnosis or isolation which may have caused risk to other patients, action plan developed and reviewed		All TB inpatient cases have been managed accordingly	IPT Lead	
5.5	If a suspected or confirmed outbreak has been identified- meeting to be arranged as per outbreak policy process	Alerted via IPT, every confirmed PII episode. IP Team to arrange meeting	Attendance at Outbreak/incident meeting	Ward/Dept Manager	Reports available
5.5	If Period of Increased Incidence (PII) of CDI identified- PII meeting to be arranged as per PIR process		IPT to arrange meeting within 7 days	IPT Lead	
5.5	PIR meetings must be carried out for all confirmed CDI cases. If medical representation is not possible the PIR review must be completed electronically by the lead clinician and returned within 5 working days. Where CDT recorded on Part 1 of a Death Certificate this is to be immediately reported and investigated by IP Team.	Completed reviews available and escalate as SI if required. IP Team to arrange meeting	Attendance at CDI Post infection Review meeting	Ward/Dept Manager	Completed reports available
6.1	IP mandatory training: Evidence of ward based team compliance (team builder reports) reviewed at CMG IP meeting	Team builder reports for review. Action within 30 days non-compliant staff	All nursing staff have completed IP mandatory training	Ward/Dept Manager	
6.2	There is evidence that IP link staff provide feedback to colleagues from training session and/or local issues	IP is a standing ward/dept meeting agenda item. Which will include feedback from IP link staff.	Summary from IP Link Staff at Ward/Dept meetings	Ward/Dept Manager	Evidence of shared learning at team meetings
6.2	Link staff are trained and current with IP practice and policies.	Ward Manager to support attendance at a minimum of 2 days training sessions a year.	IP link staff have attended a training session this quarter.	Ward/Dept Manager	Training records
6.5	All clinical staff Adult and Paeds across UHL must be FFP3 mask fit tested or provided with a suitable alternative.	Records to be kept locally and must be available for inspection of requested. Quarterly report on progress against Risk assessment for FFP3 Mask or alternatives to TIPAC	Quarterly report to be provided to TIPAC.	IPT Lead	Training records
6.6	All staff who insert invasive devices including blood cultures must have completed the ANTT online theory learning package prior to attending the clinical skills dept for practical training and assessment	Clinical Skills Passport monthly review of CMG data by CMG IP group. Exception report if compliance<90% to CMGQSB	All staff inserted invasive devices have completed an LCAT assessment on ANTT	Ward/Dept Manager	Training records
7.1	All in patient areas to implement the use of the Isolation (SI) risk assessment (RA) sticker for the placement of patients who require SI. The sticker that is to be completed and placed in the medical notes	Quarterly audit of 10 sets of patient notes. 100% compliance expected. Where non-compliance identified the Ward Manager to ensure action is taken to rectify.	Review 5 sets of notes: If the patient requires source isolation has the yellow risk assessment been completed and placed in the medical or nursing notes?	Ward/Dept Manager	Nursing metrics

8.4	CRO Screening for patients readmitted/admitted to hospital.	Ward Managers to ensure all staff are aware of the requirements to screen readmissions/admissions for CRO	Review 5 sets of notes: Has CRO screening been completed on admission accordingly	Ward/Dept Manager	
8.4	Respiratory screening compliance to be monitored and remain above 95%	Ward managers to ensure all staff are aware of the requirements to screen readmissions/admissions for respiratory viruses	Review 5 sets of notes: Has respiratory screening been undertaken accordingly.	Ward/Dept Manager	

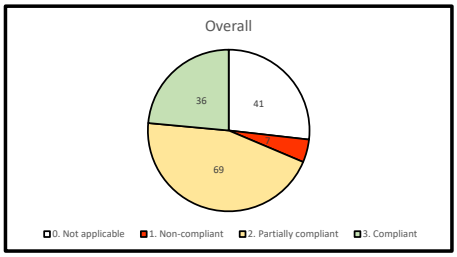
Compliance rating by section

	1	2	3	4	5	6	7	8	9	10
0. Not applicable	29	8	0	0	1	0	0	1	0	0
1. Non-compliant	0	6	0	1	0	0	0	0	0	0
2. Partially compliant	7	13	5	7	8	10	4	7	0	2
3. Compliant	12	10	1	1	1	1	1	3	1	2



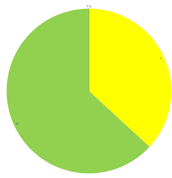
Overall

Status	No
0. Not applicable	41
1. Non-compliant	7
2. Partially compliant	69
3. Compliant	36



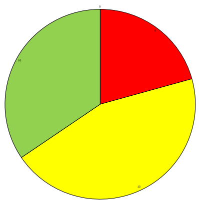
Infection Prevention and Control board assurance framework v0.1

	Key Lines of Enquiry	Evidence	Previous IP document taken from	Which Criterion it aligns to within the UHL BAF	Further detailed Evidence	Threshold/Measure	UHL Action	Who to Complete	Not compliant/ partially/ Complete	Assurance process	Womens-Childrens CMG Lead	CHUGGS	EM	ITAPs	MSS/MSK	RRCV	SM	Alliance	CSI	Estate & Facilities	OH	IP Team	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating per recommendation	Overarching Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them																											
Organisational or board systems and process should be in place to ensure that:																											
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	Overall accountability is with a dedicated Director of IP, with further dissolved responsibility through a dedicated structured IP team. Defined governance and performance outcomes and reporting frameworks are identified from ward to board level through Trust infection prevention committe (TIPAC), a Trust Infection Prevention Operational Group (TIPOG), CMG Infection Prevention Operational Groups (IPOG) and Ward Level Confirm and Challenge (CC) with ward to board input and a firm governance framework with reporting mechanisms to the Trust Board Level. Within the CMGs there is evidence that IP SIPN/Leads and link workers are taking responsibility and accountability for best practice in relation to infection prevention, and that the IP Responsibility for clinical areas is allocated e.g. to the manager of that area. The Trust has a 2023/2024 programme of work. End of report produced, signed off through TIPAC. A well organised governance IP structure within UHL, with task and finish groups reporting into TIPAC or the Harm Free Care agenda. CMG IPN/Ward Managers can provide evidence of collaborative working with IP link staff	HASCAT	1.1	Overall accountability is with a dedicated Director of IP, with further dissolved responsibility through a dedicated structured IP team. Defined governance and performance outcomes and reporting frameworks are identified from ward to board level	Every ward/area has an identified medical and nursing lead	The IP contact list on the IP CMG shared drive is up to date with the current details of the CMG Nursing and Medical Leads	CMG Infection Prevention Leads		ToRs TIPAC/TIPOG/IPOG/CC/Ward/Dept	2	2	2	2	2	2	2	3	2				Not all CMGs have an identified Medical Lead	All CMGs have a dedicated Nursing Lead	New register for Q2 2023/2024	2. Partially compliant	2. Partially compliant
			IP pro	1.1	CMG IPN/Ward Managers can provide evidence of collaborative working with IP link staff	Every ward/dept has an identifed IP link staff worker.	The IP contact list on the IP shared drive is up to date with the current details of Ward/Dept link worker	Ward/Dept Manager		Central IP register													Not all details of the ward/dept link workers are up to date or the ward/dept has no identified Link worker	All CMGs have a dedicated SIPN, IPN and Nursing Lead	New register for Q2 2023/2024	2. Partially compliant	2. Partially compliant
			HASCAT	1.1			IP link staff worker within the ward or dept and the IP Team IPN contact details are clearly	Ward/Dept Manager		IP Board													Not all contact details are displayed	SIPN and IPN make themselves known to all wards and depts. Contact details of IP team are on Insight	No further comments	2. Partially compliant	2. Partially compliant
				1.1	CMG IPN/Ward Managers can provide evidence of collaborative working with IP link staff	Opportunities to discuss local issues with CMG IP Lead.	Time has been allocated to the Link Staff to discuss local issues this quarter	Ward/Dept Manager		action points/discussion notes													Identified that Link staff are not given sufficient time to discuss and explore IP issues	CMG Leads attend TIPOG	New line of question for Q12 2023/2024	0. Not applicable	2. Partially compliant
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	MRSA Annual UHL objective 2023/24 : 0 cases Monitoring of CMG cases against UHL trajectory. Patient Transfer Risks: There is local infection prevention guidance on assessment of clinical need for and risk of patient transfer across all relevant wards/departments/clinical areas and compliance is monitored. Segregation of Elective and Emergency Patients. Local guidance on segregation of elective and emergency patients exists and compliance across all relevant wards/departments/clinical areas is monitored. There is evidence that IP leads are taking responsibility and accountability for best practice in relation to infection prevention.Yearly IP programme . IP leads are taking responsibility and accountability for best practice in relation to infection prevention. Defined governance and performance outcomes and reporting frameworks are identified at CMG level. Patient Transfer Risks: There is local infection prevention guidance on assessment of clinical need for and risk of patient transfer across all relevant wards/departments/clinical areas and compliance is monitored. Segregation of Elective and Emergency Patients. Local guidance on segregation of elective and emergency patients exists and compliance across all relevant wards/departments/clinical areas is monitored. UHL have considered the recommendations from NICE QS 61. Infeciton Prevention and Control	IP pro	1.2	MRSA Annual UHL objective 2023/24 : 0 cases Monitoring of CMG cases against UHL trajectory	0 cases, Monthly reporting via Quality Committee report and exceptional report to the Trust Leadership Team (TLT) and Trust Board if required	IP Report submitted to QC this quarter	IPT Lead		Reports available	2	2	2	2	2	3	2	3	2			Yes	not required	not required	not required	3. Compliant	2. Partially compliant
				1.2	Yearly IP programme		2023/2024 IP programme produced	IPT Lead		IP Programme 2023/2024												Yes	not required	not required	not required	3. Compliant	2. Partially compliant
				1.2	End of year IP report		2022/2023 end of year report completed and	IPT Lead														No	No gaps identified	not required	Report currently underway and will be submitted to the July TIPAC	2. Partially compliant	2. Partially compliant
			HASCAT	1.2	There is evidence that CMG IP leads are taking responsibility and accountabili	Ensure Head of or Deputy Nurse representation from all CMGs at TIPOG and TIPAC. Is the	CMG IP Lead or nominated Deputy attendance at all TIPOG meetings this quarter	CMG Infection Prevention Leads		TIPAC attendance will be monitored through meeting attendance record sheet													Not all CMGs present	TIPOG minutes are distributed to all CMGs	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
			HASCAT	1.2		Ensure minimum quartely IPOG	CMG IPOG meeting undertaken a minimum	CMG Infection Prevention Leads		action points/discussion notes													Not all IPOG meetings are undertaken per quarter	SIPN /IPN available for support	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
				1.2		CC meetings are being held	CC meetings undertaken as a minimum once this quarter	CMG Infection Prevention Leads		action points/discussion notes													Not all CC meetings are undertaken per quarter	SIPN /IPN available for support	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
			HASCAT	1.2	There is evidence that IP leads are taking responsibility and accountabili	Establish IP as a standard item agenda at all ward/dept ward level staff	IP is discussed at Ward/Dept staff meeting	Ward/Dept Manager															Not all wards/depts have IP as a standing agenda item at Staff meetings	SIPN /IPN available for support	IP team discussing a Ward/Dept standing agenda for Staff meetings	0. Not applicable	2. Partially compliant
			HASCAT	1.2	Patient Transfer Risks: There is local infection prevention guidance on assessment of clinical		Review 5 sets of notes in from physiotherapy and radiology departments to check	AHP Lead															No current assurance process in place to understand level of compliance	Staff should be informing the receiving team of any infection status that may require management. IP alerts are on Nerve centre.	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
			HASCAT	1.2	Segregation of Elective and Emergency Patients. Local guidance on segregation of elective and emergency patients exists and compliance across all relevant wards/departments/clinical areas is		There are no mixed surgical elective and emergency patients within 1 bay.	Ward/Dept Manager															During winter pressures mixing has occurred	Bed co ordinators are aware not to mix surgical emergency and elective patients.	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
			HASCAT	1.2	There is evidence that IP leads are taking responsibility and accountability for best practice in relation to infection		All mask wearing areas have the correct signage at entrances	Ward/Dept Manager															Changes to mask wearing	Mask wearing signage is available to use	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	IP DATIX reports of non-compliance with IP policy to be reviewed on a by on a quarterly basis. Reporting of Severe infections as Serious Untoward Incidents. All severe infections such as MRSA bacteraemias, Clostridium difficile associated deaths or colectomies are reported as Serious untoward incidents and investigated through risk management and governance frameworks. Where risks are identified a risk assessment is undertaken, along with appropriate mitigating actions. UHL IP risk register and CMG risk registers	IP pro	1.3	IP DATIX reports of non-compliance with IP policy to be reviewed on a by on a quarterly basis.	Report/findings to be presented to CMG IPOG meetings by CMG IPN. Datix reports as a standard agenda item at IPOG/CC/Ward/Dept meetings to discuss and review	New CMG datix exceptions from CC discussed at CMG IPOG meeting	CMG Infection Prevention Leads		action points/discussion notes	2	3	2	2	2	3	2	3	3				Datix not discussed at all IPOG meetings	CMGs are aware of any Datix incidents relating to there areas	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	0. Not applicable	2. Partially compliant
				1.3			CMG Ward/Dept Datix is discussed and reviewed at CC	CMG Infection Prevention Leads		action points/discussion notes													Datix not discussed at all CC meetings	CMGs are aware of any Datix incidents relating to there areas	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
				1.3			Datix IP incidents discussed at ward/dept level in staff meetings	Ward/Dept Manager		action points/discussion notes													Datix not discussed at all Ward/Dept meetings	CMGs are aware of any Datix incidents relating to there areas	New line of question for Q2 2023/2024. IP Team discussing Ward/Dept standing agenda items for Staff meeting	0. Not applicable	2. Partially compliant
				1.3			Datix has been discussed at TIPOG on a quarterly	IPT Lead		TIPOG papers												No	Datix not discussed collectively across the CMGs	CMGs are aware of any Datix incidents relating to there areas	TIPOG agenda is under review. Datix will be reviewed as a quarterly item	0. Not applicable	2. Partially compliant
				1.3	Defined governance and performance outcomes		CMG IP report to CMG QSB where actions are	CMG Infection Prevention Leads		CMG IP report													Need to quantify this statement			2. Partially compliant	2. Partially compliant
			HASCAT	1.3	Where risks are identified a risk assessment is undertaken,	Discuss risks at IPOG meetings and escalate to the CMG Q&S board.	CMG risks on the CMG risk register are discussed and reviewed at	CMG Infection Prevention Leads		action points/discussion notes													Not all IPOG meetings are undertaken per quarter. Not an standard agenda item	CMG HON are aware of the clinical risks on risk register	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	0. Not applicable	2. Partially compliant
			HASCAT	1.3	Reporting of Severe infections as Serious Untoward Incidents. All severe infections such as MRSA bacteraemias, Clostridium difficile associated deaths or	All severe infections such as MRSA bacteraemias, *Clostridium difficile* associated deaths or colectomies are reported as Serious untoward incidents and	All reported serious incidents are progressing within designated timelines	IPT Lead		Written reports following completed investigation												Yes	Not required	Not required	Not required	3. Compliant	2. Partially compliant
				1.3		Any ward level IP risks on the risk register are discussed at CC meetings.	CMG Ward/dept level IP risks are reviewed in CC meetings	CMG Infection Prevention Leads															Risk Register not discussed at all CC meetings	CMGs are aware of any Risk Register relating to there areas	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
				1.3			Ward/dept level IP risks on risk registers are raised in Ward/Dept staff	Ward/Dept Manager		Ward/Dept Meeting discussion points													Risks not discussed at all Ward/Dept meetings	CMGs are aware of any Risk Register relating to there areas	New line of question for Q2 2023/2024. IP Team discussing Ward/Dept standing agenda items for Staff	0. Not applicable	2. Partially compliant
1.4	They implement, monitor, and report adherence to the NIPCM.	CMG Monitoring of Audit Results: Clinical business units monitor and review the results of compliance audits and incorporate these into their plans for continuing improvement. Feedback to staff on IP:Staff are provided with feedback on their performance in relation to infection prevention. Audit compliance with Urinary Catheterisation care bundle/vascular access care bundle/HH/MRSA screening and feedback results to staff responsible for care delivery and management audit 2023/2024. CMG Monitoring of Audit Results: Clinical business units monitor and review the results of compliance audits and incorporate these into their plans for continuing improvement. UHL have a scheduled list of audits for 2023/2024. UHL has adopted the OneTogether is a partnership between leading professional organisations with an interest in the prevention of SSIs. The mission is to promote and support the spread and adoption of best practice to prevent SSIs across the surgical patient pathway. Audits incided as a standard agenda item at TIPOG, Feedback to staff on IP:Staff are provided with feedback on their performance in relation to infection prevention. UHL have a dedicated Surveillance Team and an internal surveillance programme, which feeds into an IP Surveillance committee and a highlight report for TIPAC. UHL engage in Regional NHSE/I collaborative task and finish groups for Surgical Site Infections Post Discharge Surveillance and Education and Resources. UHL undertake surveillance of Infection in Critical Care Quality Improvement Programme (ICCQIP). The IP team provide expertise to the CMG to support carrying out the ICCQIP assessment		1.4	UHL have a scheduled list of audits for 2023/2024.	This is an audit schedule of all IP Audits across UHL. Not all will be relevant for every CMG	Published list of audits for 2023/2024	IPT Lead		Audit Schedule	2	2	2	2	2	2	2	3	2			Yes	Not required	Not required	Not required	3. Compliant	2. Partially compliant
			HASCAT	1.4	CMG Monitoring of Audit Results: Clinical	All audits underatake n require analysis/summary and	CMG Audit summary and thematic review and	IPT Lead		Audit results are available/Summary												Yes	Not required	Not required	Not required	3. Compliant	2. Partially compliant
			IP pro	1.4	Audit compliance with Urinary Catheterisation care bundle/vascular access care bundle/HH/MRSA screening/IP standard precautions and feedback results to staff responsible for care delivery and managemen	Implement actions for improvement in areas of <90% compliance and feedback to IP lead. Standard Item agenda at CMG IPOG/CC/Ward/Dept meetings	CMG Audit Summaries are discussed in IPOG meetings	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for IPOG/Not all IPOG meetings are occuring on a qaurterly basis	All CMGs are provided with summaries of Audits and recommendations	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	0. Not applicable	2. Partially compliant
				1.4			Ward/dept audits are completed as per the 2023/2024 schedule	CMG Infection Prevention Leads		Audit Schedule													Clear gaps where wards/audits are not completed	Majority of the audits have been completed as required	New line of question for Q2 2023/2024		2. Partially compliant
				1.4		Audit results agenda item IPOG to discuss overarching summary and improvemen	Ward/dept completed audit summaries are discussed at CC	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for CC/Not all CC meetings are occuring on a qaurterly basis	All CMGs are provided with summaries of Audits and recommendations	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
			HASCAT	1.4	Feedback to staff on IP:Staff are provided with feedback on their performance in relation to infection		Outcome of Ward/dept audit summaries are raised at Ward/Dept staff meeting	Ward/Dept Manager		Ward/Dept Meeting discussion points													No current standard agenda for wards/depts. Not all wards/depts have IP on a Staff meeting	All CMGs are provided with summaries of Audits and recommendations	New line of question for Q2 2023/2024. IP Team discussing Ward/Dept standing agenda items for Staff meeting	0. Not applicable	2. Partially compliant
				1.4	UHL have a dedicated Surveillance Team and an internal surveillance programme, which feeds into an IP		Attendance at the surveillance committee if required to attend	CMG Infection Prevention Leads		Surveillance committee notes													No formal single place to discuss HCAI and outcomes from surveillance	IP team are aware of all HCAI.	Surveillance committee is in the planning stages. New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
				1.4	UHL undertake surveillance of Infection in Critical Care Quality	Findings of the surveillance to be provided for ITAPS	ITAPS ICCQIP summary and thematic review completed	CMG Infection Prevention Leads		Summary of Surveillance													Not required	Not required	Not required	3. Compliant	2. Partially compliant
				1.4			ITAPS ICCQIP summary and thematic review	CMG Infection Prevention Leads		action points/discussion notes													Not required	Not required	Not required	3. Compliant	2. Partially compliant
				1.4			ITAPS ICCQIP summary discussed at	CMG Infection Prevention Leads		action points/discussion notes													Not required	Not required	Not required	3. Compliant	2. Partially compliant
				1.4	UHL has adopted the OneTogether Toolkit which is a partnership between leading professiona		Base line assessment to be undertaken against OneTogether in each surgical speciality	IPT Lead		One together toolkit checklist												No	No gaps indentified	Other theatre checklists are in in place	Not a consistent approach to theatre checklist. One together toolkit was used previsouly.	2. Partially compliant	2. Partially compliant

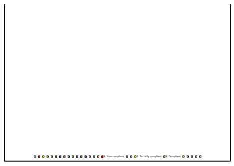


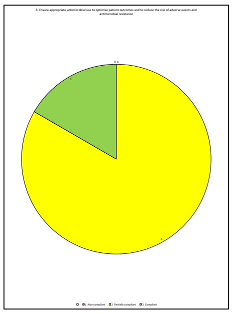
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	CDT Annual UHL trajectory 2022/23 91 : cases. Monitoring of CMG cases against UHL trajectory. CDiff Specialist Nurse to circulate C Diff Infection care pathway summary thematic review quarterly. Discuss review at CMG IP meeting and provide action plan with a named lead if required action. MRSAMSSA bacteraemia (post-2 days) Post infection review (PIR) to be undertaken for each case (follow MRSA/MSSA PIR process flow chart, mandated by the ICBs) action plan completed by the CMG with IP input. CDiff Specialist Nurse to circulate C Diff Infection care pathway summary thematic review quarterly. Discuss review at CMG IP meeting and provide action plan with a named lead if required action. Feedback of healthcare assocaited infections surveillance reports. UHL have a dedicated Surveillance Team and an internal surveillance programme, which in due course will feed into an IP Surveillance committee and a highlight report for TIPAC. UHL engage in Regional NHSE/I collaborative task and finish groups for Surgical Site Infections Post Discharge Surveillance and Education and Resources. UHL undertake surveillance of Infection in Critical Care Quality Improvement Programme (ICCQIP). Outcomes from the Surgical site surveillance programme will support the recommendations advised in the NICE quality standard 49 . The IP team provide expertise to the CMG to support carrying out the ICCQIP assessment	IP pro	1.5	CDT Annual UHL trajectory 2022/23 91 : cases. Monitoring of CMG cases against UHL trajectory.		Every CDI case reviewed using standard UHL CDI template	IPT Lead		Number of cases reported/case reviews	2	3	3	2	2	3	3	NA	NA			Yes	Not required	Not required	Not required	3. Compliant	2. Partially compliant
			IP pro	1.5	CDiff Specialist Nurse to circulate C Diff Infection	CDT thematic review quarterly. Areas of non compliance	CMG Thematic review completed	IPT Lead		CMG Thematic reviews												Yes	Not required	Not required	Not required	3. Compliant	2. Partially compliant
				1.5			CMG CDI summary/ thematic review and ward/dept actions are discussed and monitored in IPOG	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for IPOG/Not all meetings are occuring on a qaurterly basis	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	0. Not applicable	2. Partially compliant
				1.5			CMG Ward/Dept CDI cases are discussed at CC	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for CC/Not all CC meetings are occuring on a	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
				1.5			Ward/dept CDI cases are raised at Ward/Dept staff meeting	Ward/Dept Manager		Ward/Dept Meeting discussion points													No current standard agenda for ward/dept Not all meetings are occuring on a	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing Ward/Dept standing agenda items for Staff	0. Not applicable	2. Partially compliant
			IP pro	1.5	MRSA/MSSA bacteraemia (post-2 days) Post infection review (PIR) to be undertaken for each case (follow MRSA/MSSA PIR process flow chart, mandated by the ICBs) action plan completed by the CMG	Every case reviewed at monthly CMG IPOG meeting, reviewed by CMG, QSB, TIPAC and EQB Quarterly. Standard Item agenda at IPOG/CC/Ward/Dept meetings	CMG MRSA/MSSA BSI Cases or thematic review and ward/dept actions are discussed and monitored in IPOG meetings	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for IPOG/Not all meetings are occuring on a qaurterly basis	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	0. Not applicable	2. Partially compliant
				1.5			CMG Ward/Dept MRSA/MSSA BSI cases are discussed at CC	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for CC/Not all CC meetings are occuring on a	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
				1.5			Ward/dept MRSA/MSSA BSI cases are raised at Ward/Dept staff	Ward/Dept Manager		Ward/Dept Meeting discussion points													No current standard agenda for ward/dept. Not all meetings are occuring on a	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing Ward/Dept standing agenda items for Staff	0. Not applicable	2. Partially compliant
				1.5	Feedback of healthcare associated infections surveillance reports and surgical site surveillance	Surveillance findings from other HCAI are regularly fed back to clinical teams (e.g.	CMG other HCAI cases Thematic review completed if data available	IPT Lead		CMG Thematic reviews												N/A	Not required	Not required	Not required	3. Compliant	2. Partially compliant
				1.5			CMG other HCAI Cases or thematic review and ward/dept actions are discussed and monitored in IPOG	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for CC/Not all CC meetings are occuring on a qaurterly basis	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	0. Not applicable	2. Partially compliant
				1.5			CMG Ward/Dept Other HCAI cases are discussed at CC	CMG Infection Prevention Leads		action points/discussion notes													No current standard agenda for CC/Not all CC meetings are occuring on a	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
				1.5			Ward/dept other HCAI cases are raised at Ward/Dept staff meeting	Ward/Dept Manager		Ward/Dept Meeting discussion points													No current standard agenda for Ward/Dept/Not all meetings are occuring on a	All CMGs are provided with summaries of HCAI information and recommendations	New line of question for Q2 2023/2024. IP Team discussing Ward/Dept standing agenda items for Staff	0. Not applicable	2. Partially compliant
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	UHL has a comprehensive IP toolkit to demonstrate governance, monitor compliance and provide assurance to the board. Where additional resources are identified and required it will be raised in TIPAC or TIPOG depending on the requirement at the time.		1.6			Tag 1.1	not applicable															Not required	Not required	See 1.1	0. Not applicable	2. Partially compliant
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff within UHL including contractors, agency staff and volunteers whose duties directly or indirectly provide patient care receive suitable and sufficient information and were required training on measures required to prevent the risks of cross infection, also all available through internal INsight page. UHL has an extensive internal induction and training programme for all staff depending on requirements, role and clinical area. The insight page has a mechanism to post questions, queries and concerns.		1.7	All staff within UHL including contractors, agency staff and volunteers whose duties directly or indirectly provide patient care receive suitable	Training programme reflects roles and responsibilities and UHL requirements.	IP training programme has been reviewed and reflects current UHL needs	IPT Lead		HELM/IPT training programme.	2	3	3	2	2	2	2	3	3			Yes	Not required	Not required	Not required	3. Compliant	3. Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient areas, and primary and community care dental settings)	All CMGS are responsible for managing own risk registers, conducting risk assessments, and dynamic risk assessments where required. Support and information is provided by the IP team on the mitigating actions they can take based on the hierarchy of controls.		1.8	Where required across UHL local risk assessments are current and up to date and if required entry onto the risk register is considered.		CMG local risk assessments will be discussed on a quarterely basis in TIPOG.	not required															Not required	Not required	Tag 1.3	2. Partially compliant	2. Partially compliant
System and process are in place to ensure that:																											
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	The Trust has a task and finish group to review the National Standards of Healthcare Cleanliness. There is evidence of compliance with National cleanliness standards including monitoring and mitigations across all wards/depts. Matrons or persons of similar standing have personal responsibility and accountability for delivering a safe and clean care environment. The nurse or other person in charge of any patient area has direct responsibility for ensuring that cleanliness standards are maintained throughout the shift. CMG to continue to support, in conjunction with facilities colleagues, the Deep Cleaning rolling programme with the use of Hydrogen Peroxide or UV, for wards within UHL. Where areas of non-compliance identified, these should be identified to the CMG QSB. Consistant use of Bedspace cleaning checklists. Checklist to be fully completed and put into the patients notes. UHL have a dedicated working group focussed on cleanliness and the environment.All staff at UHL should have completed the mandatory infection prevention online HELM training.		2.1			NCS task and finish meeting is progressing actions required within the designated timelines	Head of Facilities/Domestic Services			1	2	2	2	2	2	2	2	2				gaps in compliance around cleaning, auditing and feedback identified. Senior group established address actions required to improve overall cleaning compliance	Cleaning is undertaken across UHL standard not consistent	Working group to address problems	1. Non-compliant	2. Partially compliant
			HASCAT	2.1	Responsibility of Person in Charge. The nurse or other person in charge of any patient area has direct responsibility for ensuring that cleanliness standards are		NIC/other person is allocated per shift to take responsibility for IP	Ward/Dept Manager		Ward Allocation sheets													Not consistently applied across all wards/depts, lacking IP leadership at ward/dept level	Staff are provided with information around IP to be able to carry out roles absent of Leadership.	No further commen	1. Non-compliant	2. Partially compliant
			IP pro	2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations across all wards/depts	All wards/depts are to monitoring the environment to ensure compliance with the NSC. Standing agenda item at CC and Ward/Dept meetings.	Ward/dept environmental checklist completed once a quarter.	Ward/Dept Manager		New Environmental Checklist													Currently IP team undertaking these audits on an adhoc basis with some ward/dept engagement. Needs to be owned at ward/dept level to ensure compliance at	Adhoc environmental checks completed by IP team	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
			HASCAT	2.1	Matrons or persons of similar standing have personal responsibility and accountability for delivering a safe and clean care	Establish Cleaning and Decontamination is discussed at ward level confirm and challenge meetings	Summary of actions required from Ward/dept environmental checklist are discussed CC meeting	CMG Infection Prevention Leads		Ward/Dept Meeting discussion points													Outcomes of environmental checks need discussing in CC	Adhoc environmental checks completed by IP team and shared with the ward/dept and at CC meetings where they occur.	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
				2.1			Summary of actions required from Ward/dept environmental checklist discussed at Ward/Dept staff	Ward/Dept Manager		action points/discussion notes													Outcomes of environmental checks need discussing in ward/dept Staff meetings	Adhoc environmental checks completed by IP team and shared with the ward/dept	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
				2.1			Attendance at Domestic forum a minimum once per	Ward/Dept Manager		action points/discussion notes at domestic forum													Lack of ward/dept representation at Domestic forums	Some wards/depts have closer working relationships with Domestic Leads	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
			IP pro	2.1	CMG to continue to support, in conjunction with facilities colleagues, the Deep	Deep Cleaning programme undertaken where possible, using every opportunity	Deep cleaning programme distributed to all CMGs in advance to support completion	Head of Facilities/Domestic Services		Facilities report to TIPAC													Not required	Not required	Not required	3. Compliant	2. Partially compliant
			IP pro	2.1	Consistant use of Bedspace cleaning checklists. Checklist to be fully completed	Quarterly monitoring of 5 sets of patient notes. 100% compliance expected. Where non-	Nursing Metrics: Review 5 sets of notes: check bed space cleaning checklists	Ward/Dept Manager		checklists are available to view. Nursing metrics													Bed space checklists are not consistently used	Checklists are available. Pilot project for bed spacing cleaning team	No further comments	2. Partially compliant	2. Partially compliant
				2.1			Summary of actions required bed space	Ward/Dept Manager		Ward/Dept Meeting discussion points													No clear process for feeding back outcomes	Checklists are available to review	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
			IP pro	2.1	UHL are required to meet National Standards of Healthcare Cleanliness within the Trust.	Technical and efficacy audits are carried out according to Functional risk assessment requirement	Techincal audits have been undertaken in accordance with UHL NSC schedule	Head of Facilities/Domestic Services		Schedule of Techincal Audits													There is an inconsistent approach to the audits undertaken. There are some audits not undertaken	Aware of this in the NCS group	No further commen	2. Partially compliant	2. Partially compliant
				2.1	Domestic Managers to present monthly cleanliness audit	Outcome of Audits shared with the CMGs/Ward/Depts	Star rating or NCS issues to be raised at TIPOG	Head of Facilities/Domestic Services															Not required	Not required	New line of question for Q2 2023/2024	1. Non-compliant	2. Partially compliant
			IP pro	2.1		Audits carried out by Facilities. Action required if <90%. Re-audit weekly until rectified. Report to Domestic Leadership Forum monthly. Standing Agenda item at IPOG for 3 star or below rated	3 star rating Wards/Depts exceptions and rectification plans from CC discussed at CMG IPOG meeting.	CMG Infection Prevention Leads		action points/discussion notes at domestic forum													No current standard agenda for IPOG/Not all meetings are occuring on a qaurterly basis	Star ratings are displayed. Some areas are made aware of the ratings.	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	2. Partially compliant	2. Partially compliant
				2.1			3 star below rated Wards/Depts have an rectification plan in place and working towards completion	Ward/Dept Manager		Improvement plan													Rectification plans are drawn up nut not fully deseminated to wards/depts. Ward/dept engagement in these plans are not	NCS wokring group are aware of this issue.	no further commen	1. Non-compliant	2. Partially compliant
				2.1			Efficacy Audits have been undertaken in accordance with UHL NSC schedule	Head of Facilities/Domestic Services		Schedule of Efficacy Audits													There is an inconsistent approach to the audits undertaken. There are some audits not undertaken	NCS wokring group are aware of this issue.	No further commen	1. Non-compliant	2. Partially compliant
				2.1			Overarching cleanliness report report	Head of Facilities/Domestic Services		TIPAC report													Not required	Not required	Not required	3. Compliant	2. Partially compliant
				2.1	Up to date knowledge of infection prevention		All E&F staff have completed IP mandatory training	Head of Facilities/Domestic Services															Not all staff have completed mandatory training	Available through HELM. Reports are readily available to see level of complaince	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE assessments are undertaken and exception reports presented to TIPAC or an exceptional meeting will be held if there are significant concerns. UHL undertake self assessment PAM assessments and present significant findings in a report and requires board approval. Senior IPN E&F and Decontamination Lead is involved. Report is shared at TIPAC.		2.2	PLACE assessments are undertaken and a full report report presented to TIPAC or an		PLACE assessments have been undertaken in accordance with schedule	Head of Facilities/Domestic Services		Report													Not required	Not required	Not required	3. Compliant	3. Compliant
				2.2			PLACE report submitted	Head of Facilities/Domestic Services															Not required	Not required	Not required	3. Compliant	3. Compliant
				2.2	UHL undertake self assessment PAM assessments and		PAM report shared at TIPAC followed assessment	Head of Facilities/Domestic Services		Report													Not required	Not required	Not required	3. Compliant	3. Compliant
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	Ward/Area cleaning charters displaying cleaning schedules and responsibilities. Ward/dept have a ward book to record cleaning of patient care equipment.		2.3	Ward/Area cleaning charters displaying cleaning schedules		Ward/dept has an up to date cleaning charter displayed	Ward/Dept Manager		Charters in Display Cabinets													No consistent monitoring of the boards to ensure they are current and up to	NCS working group are aware of this issue.	New line of question for Q2 2023/2024. annectodotally all charters are displayed across	2. Partially compliant	2. Partially compliant
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation	Ensure Aspergillus Risk assessments are completed on all building projects including refurbishments prior to work commencing. Ward and Dept Managers to ensure that actions to prevent transmission of Pseudomonas and Legionella to patients are in place. Records of flushing must be kept. The preferred method for	IP pro	2.4	Ensure Aspergillus Risk assessments are	Evidence of sign off of aspergillus risk assessment	Evidance of sign off where required for	IP Senior Nurse (E&F)		Evidence of sign off	1	2	3	2	2	3	3	3	2				Not required	Not required	Not required	3. Compliant	2. Partially compliant

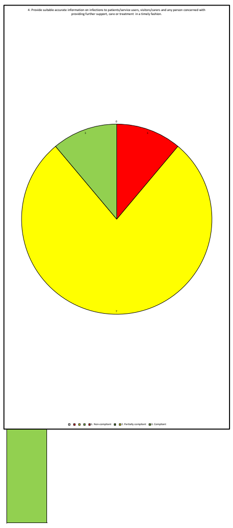
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



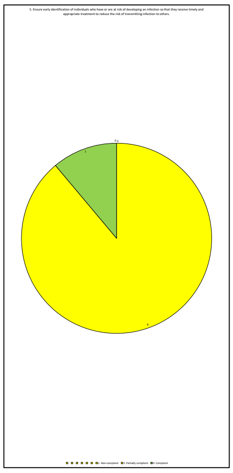
			IP pro	2.4	Ward and Dept Managers to ensure that actions to prevent transmission of Pseudomonas and Legionella	All low use water outlets flushed (daily for pseudomonas in augmented care areas/ 3x3 minutes per week for	Compass flushing has been undertaken 3 x weekly for 3 minutes and recorded	Ward/Dept Manager		Compass or local retained records available													Data states that not all areas are flushing accordingly. Not all CMGs are aware	CMGs are aware of the areas that are not fully compliant. IP team will also raise this with the ward/depts	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	2. Partially compliant	2. Partially compliant
			IP pro	2.4	Domestic colleagues can provide evidence that limescale build up on	Domestic services. Audit quarterly to TIPAC	Taps reported with limescale have been addressed or an	Head of Facilities/Domestic Services		Process to capture this data to be agreed with Head of Facilities													Not required	Not required	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
				2.4	UHL Have a dedicated Ventilation Safety group with	There will be meetings of the UHL ventilation safety group	Ventilation Highlight report submitted to TIPAC	Estates specialist services engineer		Highlight report	Highlight report submitted to TIPAC												Not required	Not required	Not required	3. Compliant	2. Partially compliant
				2.4	UHL have a dedicated Water safety groupwith a multidiscipl	There will be meetings of the UHL water safety group with	Water safety Highlight reports submitted to TIPAC	Head of Compliance Estates and Facilities		Highlight report													Not required	Not required	Not required	3. Compliant	2. Partially compliant
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	Ensure IP sign off for all capital developments for change of use of clinical areas or new works. UHL has a specialist senior IPN integral with E&F to support this. UHL aim to ensure that all bed spaces confirm to the correct bed space measurement.The estates strategy includes an agreed and resourced programme for planned and preventative maintenance. This should be approved by Infection Prevention. Infection Prevention Team are also involved at all stages of the design, building and refurbishment of healthcare facilities	IP pro	2.5	Ensure IP sign off for all capital developments for change of use of clinical areas or new works	Evidance of sign off can be provided	Evidance of IP sign off where required for capital developments	IPT Lead		Evidence of sign off	NA	3	3	3	2	3	3	3	3				Not required	Not required	Not required	3. Compliant	2. Partially compliant
				2.5	UHL aim to ensure that all bed spaces confirm to the correct bed space measurement	minimum 2.5m between centre of bed to centre of bed. Standing agenda item at IPOG/CC	Ward/dept has measured all bed spaces as a minimum 2.5m between centre of bed to centre of bed	Ward/Dept Manager		Evidence of completion													Not all bed spaces conform. Additional bed spaces due to winter pressures decreased bed spacing	Reviewing IPOGs standing item agenda to include issues with bed spacing. Some wards/depts will have risk assessments in place	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
				2.5			Summary of actions required from Ward/dept bed distance checks are discussed at CC if any undertaken	CMG Infection Prevention Leads		action points/discussion notes at domestic forum													Currently not consistently discussed at ward/cc level	Same as above	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	2. Partially compliant	2. Partially compliant
				2.5			Escalations bed distance breaches exceptions from CC discussed at CMG IPOG meeting.	CMG Infection Prevention Leads		action points/discussion notes at domestic forum													Breaches in bed spaces not consistently discussed at IPOG. Risk assessments not in place for all breaches	UHL did an overarching bed space report during the pandemic	New line of question for Q2 2023/2024. IP Team discussing IPOG standing agenda items	2. Partially compliant	2. Partially compliant
							If there are any significant breaches in bed spacing have these been raised	CMG Infection Prevention Leads																	New line of question for Q2 2023/2024. IP Team discussing TIPOG/TIPAC standing agenda items	0. Not applicable	2. Partially compliant
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	UHL has dedicated laundry facilities, dedicated central storage points and dedicated linen trolleys for clean and used linen and ward/areas.		2.6	UHL has dedicated laundry facilities, dedicated central storage points and	All Linen is managed affectively and appropriately across UHL. Standing	Ward/dept has a dedicated linen storage/process for clean linen, used and	Ward/Dept Manager															Observations from ward visits show not a consistent process across all areas	Not required	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
				2.6			Ward/Dept Laundry facilities deficits have been discussed at CC.	CMG Infection Prevention Leads															Not required	Not required	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Healthcare waste is monitored within the Trust to ensure waste is applied into the correct waste streams. Audits are undertaken to review this and actions are fed back through the CMGs. The Trust has a sustainability Lead who also focuses on waste management.		2.7	Healthcare waste is monitored within the Trust to ensure waste is applied into the correct waste streams. Audits are undertaken to review this and actions are fed back through the CMGs. The Trust has a sustainability Lead who also focuses		Waste management audit results are presented at TIPAC	Head of Sustainbility															This report has been been submitted to TIPAC	This report been sighted across other areas within the organisation	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	Decontamination of Reusable Equipment. Decontamination of Flexible Endoscopes: Flexible endoscopes are decontaminated in accordance with HTM 01-06. UHL has a dedicated Decontimation Lead with ongoing triumverate meetings with DIPAC/IP Lead/IP Consultant. Decontamination of Reusable Equipment. Decontamination of reusable equipment takes place in appropriate facilities		2.8	UHL has a dedicated Decontimation Lead with ongoing triumverate meetings		Highlight report including summary of Audits presented at TIPAC	Decontamination Lead		TIPAC report	2	3	2	2	2	3	NA	2	3				Results of Audit from Jan 2023 have not yet been presented to TIPAC	Audit has been undertaken	No further commen	1. Non-compliant	2. Partially compliant
			HASCAT	2.8	Decontamination of Flexible Endoscopes:	Complete IPS society audit tool bi annually.	Trust wide ward/dept decontamination audit	CMG Infection Prevention Leads		Audit results/report													Not required	Not required	No further commen	3. Compliant	2. Partially compliant
			HASCAT	2.8	Decontamination of Reusable Equipment.	i.e. not in dedicated hand wash basins	Decontamination of reusable equipment	Ward/Dept Manager															Not consistently across UHL	Some wards/depts have a process for monitoring but	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.	Policy on handling food from patients/relatives. Food hygiene training is available for staff to attend		2.9	Housekeepers and staff that are handling food within the ward/dept environments are trained and educated to allow them to fulfil their roles		A gap analysis of the training and education commensurate with duties across UHL is undertaken	Education Lead															It is unclear what level of education and training is currently delivered across UHL	Handling of patient food policy in place	New line of question for Q2 2023/2024.	2. Partially compliant	2. Partially compliant
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance **Systems and process are in place to ensure that:**																											
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	Antimicrobial working party meets alternate months and provides oversight of antimicrobial stewardship for UHL. Antimicrobial prescribing policy, guideline policy and guidelines are managed through this group.		3.1	Antimicrobial working party minutes reported to TIPAC.																		UHL does not have a formally identified nominated lead for antimicrobial stewardship. CMGs don't have a nominated/identified lead for antimicrobial stewardship that provides oversight of antimicrobial stewardship for the CMG and provides CMG representation on the	Trust level - Various individuals (Lead antimicrobial pharmacist, Antimicrobial working party chair, Lead infection prevention doctor) have some role but there is no formally arranged lead for the organisation.	For UHL as a whole - should the trust nominate and individual as lead, formalise the roles and responsibilities of those currently involved and is there sufficient resource within the current individuals to provide formal leadership and where appropriate have this detailed in job plans? 2) For each CMG: who is the nominated lead for antimicrobial stewardship in your CMG?	2. Partially compliant	2. Partially compliant
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	Antimicrobial working party report included in the Infection Prevention Annual Report		3.2	Infection Prevention annual report																		Annual report only details Trust level activites in relation to Antimicrobial Working Party, statutory targets and any additional significant Antimicrobial Pharmacy Team contribution - Microbiology, Infectious Diseases, CMG and ward level activites		Formal lead for AMS who has oversight of all activities, and to who the CMGs would be accoutable to would need to be appointed for a detailed report to be written	2. Partially compliant	2. Partially compliant
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National	Chief Nurse acts as Director for Infection Prevention and Control		3.3																						3. Compliant	2. Partially compliant
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: •to optimise patient outcomes. •to minimise inappropriate prescribing. •to ensure the principles of Start Smart, Then Focus are followed.	NICE guideline baseline assessment tool completed in 2015		3.4																			Most recommendations in NICE Guideline NG15 not 'fully met' due to available resource. CMGs do not have formalised internal stewardship activities and	Most recommendations are 'consider' recommendations and therefore do not have to be implemented.	Repeat the baseline assessment tool reflecting current position needs to be completed to identify resources required to deliver this criterion.	2. Partially compliant	2. Partially compliant
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: •total antimicrobial prescribing. •Broad-spectrum prescribing. •Intravenous route prescribing. •Treatment course length.	NHS Standard Contract reporting requirements for broad spectrum antibiotic prescribing reported from pharmacy through Define to UKHSA and NHS England. CQUIN audit reports for 2023 (IV to oral switch of antibiotics) reported quarterly to UKHSA. Progress reported to CMG Clinical Directors on progress towards standard contract target provided monthly by antimicrobial pharmacy team. Progress at organisational level reported to TIPAC quarterly.		3.5																			Trust Board does not have regular oversight of key performance indicators. CMG boards (with the exception of ESM in 2023) do not maintain oversight. Treatment course length is not routinely measured due to challenges with data availability for inpatients and	For inpatients course length is controlled via the antimicrobial prescribing policy.	There is no control on outpatient course length as UHL doesn't have an outpatient antimicrobial stewardship programme. New line of question of q2 23/24 - Which CMG board are antimicrobial consumption reports reviewed at and at what frequency?	2. Partially compliant	2. Partially compliant
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency, and external contractors)	Antimicrobial pharmacy team and microbiology team in place to support good practice.		3.6	4.2 wte establishment antimicrobial pharmacist resource however current available dedicated antimicrobial stewardship resource 1.9 wte due to vacancies and other core duties. Consultant microbiology resource 7 WTE Consultant medical microbiologist , 2 WTE Consultant virologist, 1 WTE																		There is limited identified resource to measure adherence to good pratice and quality improvement. There is no resource provided to support and measure good practice and QI in outpatient settings. Skill mix for antimicrobial stewardship is missing data analyst support, nursing involvement and pharmacy technician support	Antimicrobial prescribing policy supports good practice in inpatient areas.	National antimicrobia	2. Partially compliant	2. Partially compliant
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion **Systems and processes are in place to ensure that:**																											
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	UHL have a Patient information team to discuss patient leaflets and information to ensure that it meets the required standards. Ihealth training is also available through HELM to ensure staff are working within the parameters when providing patient leaflets and information. Patients are encouraged and supported to offer comments, compliments and feedback through a variety of mechanisms ie PALS. The Trust have a communication strategy incorporates information to the public on infection prevention. Our corporate publications and reports enable the public to make choices through appropriate presentation of healthcare associated infection information. Communication and feedback to patients and the public is incorporated into the whole patient journey across the health economy		4.1			CMG ward/area level complaints are discussed at CC.	CMG Infection Prevention Leads															No current question in place to provide assurance that IP complaints are dealth with and actioned as required	All complaints will be reviewed.	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
				4.1			Any ward/area level complaints are reviewed/ac	Ward/Dept Manager															Not required	Not required	New line of question for Q2 2023/2024. IP Team discussing CC standing agenda items	0. Not applicable	2. Partially compliant
				4.1			Insight pages patient facing information to be up to	IPT Lead		Insight pages												Yes	Not required	Not required	Not required	3. Compliant	2. Partially compliant
				4.1			UHL communication strategy is submitted to TIPAC on a yearly	UHL Comms Lead		report													This has not been sighted during 2022/2023.	Strategy available	needs reviewing to ensure it supports our patients/public with infection prevention	1. Non-compliant	2. Partially compliant
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (eg digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	HCAI Information on Patient records and discharge information. Staff are able to respond to information requests. UHL have an online store of patient information YOUR HEALTH. The IP team actively review materials for consideration. Where required will campaign, display or promote. These are either included in UHL led campaigns, guidance or as resources. These campaigns will be promoted through Insight pages. Patients across UHL should receive information regarding their IP treatment plans accordingly. This either via the ward/area teams if an inpatient or through discharge letters if the patient is discharged.. Staff are able to respond to information requests	HASCAT	4.2	Patients across UHL should receive information regarding their IP treatment plans accordingly. This either via the ward/area teams if an inpatient or through discharge	Patient records/discharge information incorporates HCAI information together with any action required	Review 5 sets of notes: Does the discharge plan incorporate HCAI information where there is an IP alert, and any deficits to be raised in Ward/Dept meetings for	Ward/Dept Manager		Discharge Summary/letters	1	2	3	2	2	2	3	3	3				HCAI information not fully included into discharge plans	Requested as part of NC phase 2 to pull over information into the discharge letter is possible to do so	No further comments	2. Partially compliant	2. Partially compliant
			HASCAT	4.2	Staff are able to respond to information requests	Staff have the training, knowledge and awareness to appropriately identify, inform and respond to patient	Ward/Dept patient facing information is current and up to date and patient leaflets are available upon	Ward/Dept Manager		Patient leaflets and information													Observations from ward visits show not a consistent across all areas	Not required	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	HOT boards and patient facing boards with current IP information in display boards. Patients across UHL should receive information regarding their IP treatment plans accordingly. This either via the ward/area teams if an inpatient or through discharge letters if the patient is discharged.				Hot board with current and up to date information across UHL.	All wards/depts to ensure all IP information on hot boards is current and up to date and supports seasonal	Ward/Dept Manager															Not all information is current and up to date	Most wards/depts have IP boards.	No further comments	2. Partially compliant	2. Partially compliant
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards of IPC and AMR and include: •Hand hygiene, respiratory hygiene, PPE (mask use if applicable) •Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (eg cleanliness) •Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. •Provide published materials from national/local public health campaigns (eg AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	Patient Transfer Information: Patient transfer information is shared with the individual, particularly in respect of appropriate risk reduction measures. Monitoring discharge and transfer of care (going home policy). HH posters/literature are available, along with PPE stations and HH signage. Visiting policy available on Insight. Wards will provide any specific visiting guidance depending on situation and clinical environment. Patients and visitors at UHL are made aware if any outbreak situation occuring on the ward/area and advised of any actions they are required to take.	HASCAT	4.4	Patient Transfer Information: Patient transfer information is shared with the individual, particularly in respect of appropriate risk reduction measures. Monitoring discharge and transfer of care (going home policy)	evidence of transfer form completed with accurate information	Review 5 sets of notes: Does the transfer form incorporate HCAI information where there is an IP alert and any deficits to be raised with the relevant Ward/Dept for discussion and actions if required	IPT Lead			2	3	3	2	2	3	3	NA	NA			No	Overarching monitoring of HCAI information within patient notes	Ward staff monitor elements through Nursing Metrics	New line of question for Q2 2023/2024	0. Not applicable	2. Partially compliant
				4.4	HH posters/literature are		PPE station is available for visitors	Head of Facilities/Domestic Services															Not required	Not required	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
				4.4			PPE station is available for visitors and patients on entrances to	Ward/Dept Manager															Not required	Not required	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant

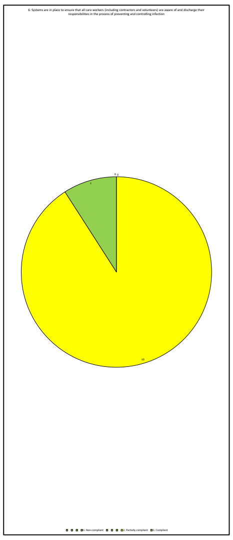


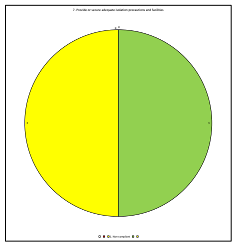


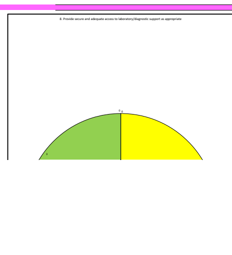


4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	UHL adopted LPT cathetar passport sporadically across UHL. Patients receive a patient information leaflet for some of the devices inserted. Sharing of the patient information is fragmented across LLR due to the inability to access one patient electronic record.		4.5			Review the reporting arrangements for the Catheter and continence group.	IPT Lead															Latest review of the cathetar bundle highlighted that this document is not used consistently used. No other passport for invasive devices	Cathetar, Continence working group has been formalised and lead by the patient experience team to review everything urine related inlcuding indwelling devices. Electronic Devices T&F group looking at how information can be shared electronically and how this information provided to	No further comments	2. Partially compliant	2. Partially compliant
5 Focus Systems																											
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receive timely and appropriate treatment to reduce the risk of infection transmission.	Risk Assessments and Individual Treatment Plans: Individual patient treatment plans reflect the outcome of risk assessment for healthcare associated infections. UHL are able to review patients vaccine status through the community primary care system. If TB identified in a bay, a review meeting identifies any delays in diagnosis or isolation which may have caused risk to other patients, action plan developed and reviewed. iFive and A-F risk assessment (available on NerveCentre) is embedded across all areas. UHL are able to review patients vaccine status through the community primary care system.	IP pro	5.1	If TB identified in a bay, a review meeting identifies any delays in diagnosis or isolation which may		All known TB inpatient cases have been managed according to the UHL inpatient exposure flowchart	IPT Lead		New Inpatient Exposure flowchart	2	2	2	2	2	2	2	2	3			No	No clear process within the IP team for TB inpatient cases	UHL have a dedicated TB service to work with	New document in final draft for comments	0. Not applicable	2. Partially compliant
			HASCAT	5.1	iFive and A-F risk assessment (available on NerveCentre	Staff can articulate what the i-five acronym means and how this is	Nursing Metric: Ask 5 members of staff: Describe the ifive risk	Ward/Dept Manager															Not all staff can describe the I five risk assessment	Information is available on insight on the I five risk assessment	No further comments	2. Partially compliant	2. Partially compliant
			HASCAT	5.1	Risk Assessments and Individual Treatment Plans: Individual patient treatment plans reflect the outcome of risk assessment for healthcare associated	Report admission time to IP risk assessment completion from Nerve Centre	Nursing Metric: Review 5 sets of notes: Has the IP ifive risk assessment been completed appropriately	Ward/Dept Manager		Nursing metrics													I five risk assessment tool not consistently used across all areas	This is an electronic assessment.	The IP team will be looking at how the data can be extracted from Staff Objects to see where the areas of concern for completion is.	2. Partially compliant	2. Partially compliant
				5.1			Nursing Metric: At handover or daily huddle do staff use iFive to assess their	Ward/Dept Manager		Nursing metrics													I five risk assessment tool not consistently used across all areas	No further comments	No further comments	2. Partially compliant	2. Partially compliant
			HASCAT	5.1		Report IP Risk assessment % completion from Nerve Centre	Review 5 sets of notes: Do individual treatment plans reflect IP I ifve risk	Ward/Dept Manager															Not all actions from the ifive risk assessments are followed through into treatment	All available electronically	SIPN can support the Ward/Dept to improve	2. Partially compliant	2. Partially compliant
			HASCAT	5.1		Report on assessment and accreditation care	SIPN are aware of the AA ratings of their allocated	IPT Lead														No	Not all SIPNs are accessing or retreiving ward level accreditation	Wards can work with SIPN in absence of data if required	SIPN can support the Ward/Dept if they are aware of the individual issues in relation	2. Partially compliant	2. Partially compliant
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care.** This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	UHL IP Team Monitor and promptly investigate positive laboratory reports providing specialist review and advice through an electronic record system.		5.2	UHL IP Team Monitor and promptly investigate positive laboratory reports providing specialist review and advice and recommendations		All IP imports are reviewed and actioned accordingly on work day basis.	IPT Lead														Yes	Not required	Not required	Not required	3. Compliant	3. Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	UHL have a dedicated discharge team with co ordinators that use transfer forms to support the safe movement of patients betweens organisations. UHL IP team have close working relationships with system wide health and social care IP teams to ensure where it is necessary to share information and risk that is shared safely.		5.3	See 4.4		Not required	not required															Not required	Not required	Tag this recommendation with 4.4	2. Partially compliant	2. Partially compliant
5.4	Signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	Signage is available on entry to some areas across UHL. Opportunities available to provide patient facing information on intranet pages and telephone comms		5.4	Instructions to patients are available in different forms such as signage, intranet and		Review patient facing information on the intranet, telephony messages	IPT Lead															Not required	Not required	New line of question for Q2 2023/2024. Patient facing instructions have been reviewed as we return Staff to usual.	2. Partially compliant	2. Partially compliant
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	UHL IP review all positive cases with infection in a timely manner. If a suspected or confirmed outbreak has been identified- meeting to be arranged as per outbreak policy process management is actioned. The IP team work closely with the ward/area staff in relation to these cases.UHL have a robust outbreak management process in place with supportive documentation, reflecting actions taken. If Period of Increased Incidence (PII) of CDI identified- PII meeting to be arranged as per PIR process. If a suspected or confirmed outbreak has been identified- meeting to be arranged as per outbreak policy process. PIR meetings must be carried out for all confirmed CDI	IP pro	5.5	If a suspected or confirmed outbreak has been identified- meeting to be arranged	Alerted via IPT, every confirmed PII episode. IP Team to arrange meeting	Attendance at Outbreak/Incident meeting	Ward/Dept Manager		Reports available	3	3	3	3	2	3	3	NA	NA				Attendance at meetings can be sporadic, not always a representative available	Not required	Attedance is noted on minutes of outbreak meetings	2. Partially compliant	2. Partially compliant
			IP pro	5.5	If Period of Increased Incidence (PII) of CDI		IPT to arrange meeting within 7	IPT Lead														Yes	Not required	Not required	Not required	3. Compliant	2. Partially compliant
			IP pro	5.5	PIR meetings must be carried out for all confirmed CDI cases. If medical representati	Completed reviews available and escalate as SI if required. IP Team to arrange	Attendance at CDI Post infection Review meeting	Ward/Dept Manager		Completed reports available													Not required	Not required	Not required	3. Compliant	2. Partially compliant
6.Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection Systems and processes are in place to ensure:																											
6.1	Induction and mandatory training on IPC includes the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	IP mandatory training: Evidence of ward based team compliance (team builder reports) reviewed at CMG IP meeting. All staff including contractors, agency staff and volunteers whose duties directly or indirectly provide patient care receive suitable and sufficient information and training on measures required to prevent the risks of cross infection	IP pro	6.1	IP mandatory training: Evidence of ward based team compliance (team builder reports)	Team builder reports for review. Action within 30 days non-compliant staff	All ward/dept staff have completed IP mandatory training	Ward/Dept Manager			2	2	2	2	2	2	2	NA	3				Not all staff have completed the mandatory IP training	Available on HELM. Ward/Dept managers are able to see which staff have not completed	IP team are able to deliver presentations to individuals to support this training if requested.	2. Partially compliant	2. Partially compliant
				6.1			All medical staff have completed IP mandatory online training	CMG Infection Prevention Leads		Training records													Not all medical staff have completed the mandatory IP training	Available on HELM. Ward/Dept managers are able to see which staff have not completed	IP team are able to deliver presentations to individuals to support this training if requested.	2. Partially compliant	2. Partially compliant
							All AHP aligned with the CMG have completed IP mandatory online	CMG Infection Prevention Leads		Training records													Not all AHP staff have completed the mandatory IP training	Available on HELM. Ward/Dept managers are able to see which staff have not completed	IP team are able to deliver presentations to individuals to support this training if requested.	2. Partially compliant	2. Partially compliant
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	IP link staff provide feedback to colleagues from training session and/or local issues. Link staff are trained and current with IP practice and policies. All staff across UHL are supported with training and development around IP. UHL staff are provided IP Training on Induction. Infection prevention is included in all job descriptions. There is evidence that IP link staff provide feedback to colleagues from training session and/or local issues. IP is discussed and Annual Appraisals	IP pro	6.2	There is evidence that IP link staff provide feedback to colleagues from training session and/or local issues	IP is a standing ward/dept meeting agenda item. Which will include feedback from IP link staff.	Summary from IP Link Staff at Ward/Dept staff meetings	Ward/Dept Manager		Evidence of shared learning at team meetings	2	2	2	2	2	2	2	2	2				Not all wards/depts have IP as a standing agenda item at Staff meetings	Link staff are embedded on the ward	No further comment	2. Partially compliant	2. Partially compliant
			IP pro	6.2	Link staff are trained and current with IP practice and policies.	Ward Manager to support attendance training sessions a	IP link staff have attended a training session this quarter.	Ward/Dept Manager		Training records													Not all link staff have attended IP link staff training sessions.	Training sessions are made available. IP team support the CMG	No further comment	2. Partially compliant	2. Partially compliant
			HASCAT	6.2		Infection prevention principles and practice is included in the induction of all new staff (including volunteers). This should occur within 1 week of commencem	All new ward/dept staff have been provided with IP information relevant to the ward/dept	Ward/Dept Manager		Record of induction programme content													New line of question for Q2 2023/2024	New line of question for Q2 2023/2024	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
			HASCAT	6.2	Infection prevention is included in all job		All recruitment posts have IP included	CMG Infection Prevention Leads		Include standard statement in all job													Not required	Not required	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
6.3	Monitoring compliance and update IPC training programs as required.	All staff across UHL are supported with training and development around IP	HASCAT	6.3	All staff across UHL are supported with training and developmen	A programme of ongoing training in Infection prevention is made	Training dates are live and published to allow bookings per quarter.	IPT Lead		Record of IP training content												Yes	Not required	Not required	Not required	3. Compliant	3. Compliant
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	UHL have a robust ordering system of PPE and IP equipment through supplies. Availability is monitored routinely. Procurement teams support procurement and review of equipment, supplies, clinical devices, and products. Products are stored in accordance with COSSH. Training around PPE donning and doffing is available through IP mandatory training.		6.4			Nursing Metrics: Review 5 staff are they wearing their PPE appropriatel	Ward/Dept Manager		Nursing metrics													Not all staff are compliant with when and where to wear PPE.	Gloves off campaign is also lookng at PPE use across UHL	PPE audit to be undertaken in July 2023	2. Partially compliant	2. Partially compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	All clinical staff Adult and Paeds across UHL must be FFP3 mask fit tested or provided with a suitable alternative. Some CMGs have mask fit testing staff in house and are able to provide adhoc mask fit testing.	IP pro	6.5	All clinical staff Adult and Paeds across UHL must be FFP3 mask fit tested or provided with a suitable alternative.	Records to be kept locally and must be available for inspection of requested. Quarterly report on progress against Risk	mask fit testing report is provided quarterly to TIPAC.	IPT Lead		Training records	2	2	2	2	2	3	2	NA	3			No	Urgent referals for staff that have not had any form of a mask fit test can be tested. Due to no mask fit testing service in place.	Interim urgent service is provided 2 days a week until service set up is completed.	Waiting for clarification on Mask Fit Testing Service business case to finalise recruitment strategy.	2. Partially compliant	2. Partially compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained to an agreed standard and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	There is evidence that IP leads are taking responsibility and accountability for best practice in relation to infection prevention. Training of Staff Prior to Procedures: Before undertaking procedures that require skills such as ANTT staff are trained and can demonstrate proficiency before being allowed to undertake these procedures independentlyAll staff who insert invasive devices must have completed the ANTT online theory learning package prior to attending the clinical skills dept for practical training and assessment. Aseptic Non-Touch Technique (ANTT): Competency assessments are required for all clinical staff who have not been assessed within the last three years. Quarterly update of % of staff completed assessments action plan if below 90% compliance. All staff who collect blood cultures must complete the online training package prior to performing the task. The IP team have a number of digital and devices to support IP training	IP pro	6.6	All staff who insert invasive devices including blood cultures must have completed the ANTT online theory learning package prior to	Clinical skills training on aseptic clinical procedures e.g. insertion and care of vascular devices and urinary catheters, is provided for all	All staff who are inserting invasive devices or undertaking a procedure requiring ANTT have completed the online Helm training on ANTT.	Ward/Dept Manager		Training records	2	1	2	2	2	2	2	3	2				ANTT competencies are not as standard covered in all clinical skills. Therefore no consistent approach to clinical competency. Not all staff have completed the online	Available on insight	Needs further discussion as part of the Vascular Access work	2. Partially compliant	2. Partially compliant
			HASCAT	6.6		Staff who carry out local hand hygiene audits have completed a hand hygiene audit session and attendance	All staff allocated to complete the HH audits have completed the HH competency training.	Ward/Dept Manager		HELM training report													Not all staff have completed the training	Available to book	No further commen	2. Partially compliant	2. Partially compliant
				6.6			Nursing Metrics: Review 5 sets of notes: Do patients with an IV	Ward/Dept Manager		Nursing metrics													Not consistently completed.	Agenda item at TIPOG	No further comments	2. Partially compliant	2. Partially compliant
				6.6			Nursing Metrics: Review 5 sets of notes: Is CVC	Ward/Dept Manager		Nursing metrics													Not consistently completed.	Agenda item at TIPOG	No further comments	2. Partially compliant	2. Partially compliant
				6.6			Nursing Metrics: Review 5 sets of notes: Do	Ward/Dept Manager		Nursing metrics													Not consistently completed.	Agenda item at TIPOG	No further comments	2. Partially compliant	2. Partially compliant
				6.6			Nursing Metrics: Complete 10 observations of Hand	Ward/Dept Manager		Nursing metrics													Not fully compliant with HH	Included in the Gloves off campaign. IP team have a number of resources to use	HH to be completed July 2023	2. Partially compliant	2. Partially compliant
				6.6			Nursing Metrics: Staff are washing or sanitising their hands appropriatel	Ward/Dept Manager		Nursing metrics													Not fully compliant with HH	Included in the Gloves off campaign. IP team have a number of resources to use	HH to be completed July 2023	2. Partially compliant	2. Partially compliant
7. Provide or secure adequate isolation precautions and facilities																											
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	All in patient areas to implement the use of the Isolation (SI) risk assessment (RA) sticker for the placement of patients who require SI. The sticker that is to be completed and placed in the medical notes. UHL have a dedicated teams to support flow of the patient through the hospital. All teams work together to ensure that where there is known or suspected infection that patients are managed accordingly with direct support from the IP team.	IP pro	7.1	All in patient areas to implement the use of the Isolation (SI) risk assessment (RA) sticker for the placement of patients who require	Quarterly monitoring of 10 sets of patient notes. 100% compliance expected. Where non-compliance identified the Ward Manager to ensure action is	Nursing Metrics: Review 5 sets of notes: If the patient requires source isolation has the yellow risk assessment been completed	Ward/Dept Manager		Nursing metrics	2	2	3	3	2	2	2	NA	NA				Not all patients have the correct IP pathway in place.	Signage is available. Information and support available through IP team. Insight pages have information on about the IP pathways	No further comments	2. Partially compliant	2. Partially compliant
				7.1			Nursing Metrics: Review 5 sets of notes: If the patient is in source	Ward/Dept Manager		Nursing metrics													Not all patients have the correct signage for isolation	Signage is available. Information and support available through IP team. Insight pages have information on	No further comments	2. Partially compliant	2. Partially compliant
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: •Single rooms are in short supply and if there are two or more patients with the same confirmed infection. •there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	UHL respond to positive infectious patients and consider at all touch points how to isolate the patients accordingly. This will be considered based on a hierarchy of needs at the point of infection. If Wards/depts are unable to isolate due to lack of SR facilities they should complete a datix. These datix are monitored by the IP team. During periods of Trust escalation or winter pressures, SR capacity should be reviewed. The IP teamwill support all CMGs, and advise is based on a heirarchy of respiratory/viral/bacterial infections as to where to place a patient and who may take priority. This information is available through the UHL IP policy and INsight page.		7.2			Insight pages are up to date with IP information around isolation and heirarchy of controls to support CMGs making decisions around isolating patients	IPT Lead		Insight pages													Not required	Not required	No further comments	3. Compliant	3. Compliant
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the	All staff are trained, supported and advised as to what level of PPE is required. IP team are able to provide electronic IP guidance that is directly aimed at ward/dept staff level. The IP team complete an SCIPs audit twice a year and support an improvement plan.		7.3			See 1.4	Not required															Tag with 1.4	Not required	Not required	2. Partially compliant	2. Partially compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	UHL have a dedicated teams to support flow of the patient through the hospital. All teams work together to ensure that where there is known or suspected infection that patients are managed accordingly with direct support from the IP team. UHL hold 3 x daily tactical meetings. IP produce a daily sitrep with suspected or known outbreaks or increased incidents that is shared across UHL. UHL have a dedicated discharge team with co ordinators that use transfer forms to support the safe movement of patients betweens organisations.		7.4			see 4.4	Not required															Tag with 4.4	Not required	Not required	2. Partially compliant	2. Partially compliant
8.Provide secure and adequate access to laboratory/diagnostic support as appropriate																											
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	UKAS accredication see https://www.ukas.com/find-an-organisation/		8.1			Exception reports of UKAS accreditation only to be submitted to TIPAC for information	Head of Service Clinical Microbiology		TIPAC paper													Not required	Not required	Not required	3. Compliant	3. Compliant
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	Risk Assessments and Individual Treatment Plans: Individual patient treatment plans reflect the outcome of risk assessment for healthcare associated infections. CRO Screening for patients readmitted/admitted to hospital.	HASCAT	8.2	Risk Assessments and Individual Treatment Plans: Individual patient	staff can describe when to screen patients for MRSA/CRO/Resp Virus and this is	Ask 5 member of staff: Can they describe when to screen for MRSA/CRO/R	Ward/Dept Manager															Indentified that there is a lack of knowledge as to who to screen and when	UHL MRSA screening policy on insight	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
				8.2			Nursing metrics: Review 5 sets of notes: Has MRSA	Ward/Dept Manager															Not all patients are screened on admission as directed in the policy	UHL MRSA screening policy on insight	No further comment	2. Partially compliant	2. Partially compliant
				8.2			Review 5 sets of notes: Has MRSA risk	Ward/Dept Manager															Risk site factors are often missed	UHL MRSA screening policy on insight	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant

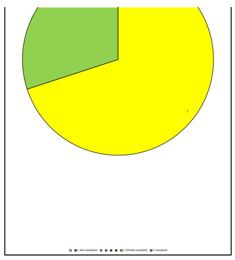


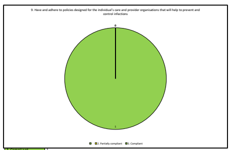




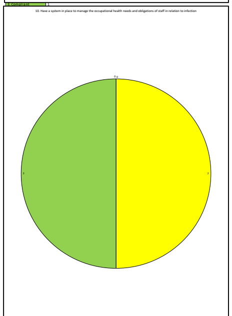


				8.2			Review 5 sets of notes: Has decolonisation/treatment been prescribed	Ward/Dept Manager															Not all patients are prescribed the correct decolonisation	UHL MRSA screening policy on insight	New line of question for Q2 2023/2024. Opportunity to raise at TIPOG for discussion	2. Partially compliant	2. Partially compliant
				8.2			Nursing Metrics: Review 5 sets fof notes: Has antibacterial wash (& nasal ointment where indicated) – signed & dated 100%	Ward/Dept Manager		Nursing metrics													Not all patients are adminstered the correct decolonisation	UHL MRSA screening policy on insight	New line of question for Q2 2023/2024. Opportunity to raise at TIPOG for discussion	2. Partially compliant	2. Partially compliant
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	UKAS accredication see https://www.ukas.com/find-an-organisation/	IP pro	8.3			Exception reports of UKAS accreditation only to be submitted to TIPAC for information only	Head of Service Clinical Microbiology		TIPAC paper													Not required	Not required	Not required	3. Compliant	3. Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	All patients admitted to UHL are screended in accordance with UHL MRSA policy/ CRO/ Respiratory guidelines which are in line or supersede National Guidance due to local prevalence.UHL screen patients prior to discharge to any care facility in accordance with National recommendations. CRO Screening for patients readmitted/admitted to hospital. Respiratory screening compliance to be monitored and remain above 95%	IP pro	8.4	Respiratory screening compliance to be monitored and remain above 95%	Ward managers to ensure all staff are aware of the requirements to screen readmissions/admissions for respiratory	Review 5 sets of notes: Has respiratory/ CRO screening been undertaken accordingly.	IPT Lead			2	3	3	3	2	2	3	NA	NA				identified that some patients are receieving routine screening as required upon assessment	I five risk assessment and ongoing daily monitoring in place for patients	No further comment	2. Partially compliant	2. Partially compliant
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	Symptomatic testing across UHL is in line with National guidance, including where routine asymptomatic has continued. Any changes to testing guidance across UHL is discussed at TIPOG.		8.5			Review 5 sets of notes to check testing has been undertaken in	IPT Lead		Nerve centre													identified that some patients are receieving investigation testing as required upon assessment	I five risk assessment and ongoing daily monitoring in place for patients	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of known/ emerging/novel and high-risk pathogens.	UHL have a dedicated Lab, IP Consultant and nominated Microbiologists and Virologists, with clinical expertise in health protection and communicable diseases. UHL also works closely with UKHSA regional Health Protection Team, all of which are invited accordingly to Outbreak Meetings/Increased Incident meetings.		8.6	See 5.5		Representation at TIPAC and TIPOG accordingly	Head of Service Clinical Microbiology															Not required	Not required	Not required	3. Compliant	3. Compliant
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Clinical microbiology user handbook on insite section 10.3, 11.1, 11.2 and 12. Also UHL VHF plan section 4.11		8.7				Head of pathology															waiting for a comment from Simon Hewson			0. Not applicable	0. Not applicable
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections																											
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA, A to Z pathogen resource, and the NIPCM). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	UHL have a dedicated team to ensure there are robust mechanisms around policies/procedures and or guidance. UHL have a team dedicated to monitor the current policies. There is a dedicated internal platform available for staff to readily access policies.		9.1	UHL have a dedicated team to ensure there are robust mechanisms around policies/procedures and or guidance. UHL have a team dedicated to monitor the current policies. There is a dedicated internal platform available for staff to	Policies are reviewed and submitted for consultation /review where required. All final draft documents are submitted to TIPAC before PAGs	All IP policies and procedures on the Trust policy list are up to date or have extensions requested.	IPT Lead		UHL policy list												Yes	Not required	Not required	Not required	3. Compliant	3. Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection																											
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:																											
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	All staff and managers have access to the OH duty nurse who will be able to provide advice on RA when an individual is pregnant/ immunosuppressed. Completion of the OH module on HELM is now mandatory for new starters and will be updated to include reference to this specific point. We will add a reminder statement to the appraisal paperwork to ensure this is reinforced yearly. The HSQ to be completed as part of the employment process is currently under review and will become electronic- this will also be updated to include reference to this statement		10.1	All staff and managers have access to the OH duty nurse who will be able to provide advice on RA when an individual is pregnant/ immunosuppressed. Completion of the OH module on	OH module on HELM is now mandatory for new starters	All new ward/dept staff have undertaken the OH mandatory module on HELM	Ward/Dept Manager		HELM record/TIPAC report													No current process to review HELM compliance	All CMGs are aware of the mandatory HELM module	New line of question for Q2 2023/2024	2. Partially compliant	2. Partially compliant
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	All staff and managers have access to the OH duty nurse who will be able to provide advice on the appropriate next steps. Staff are able to make self referals which is monitored through a platform called Cohort. Information is provided on the OH web pages and as part of the 'staff health' policy. OH have a comprehensive suite of policies to ensure staff exposures are managed correctly. The trust has a specific policy for the management of staff exposed to BBV's which involves OH, ED and infectious disease teams		10.2		All staff have support and access to OH services	All referals through Cohort have been reviewed accordingly	OH Lead		TIPAC report													Not required	Not required	No further comment	3. Compliant	3. Compliant
				10.3			All occupational staff exposure policies are current up to	OH Lead															Not required	Not required	No further comment	3. Compliant	3. Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	The OH service is SEQOHS accredited, and all OH staff will follow appropriate policies, processes and guidelines when providing immunisations, 'new starter' health checks, required health surveillance activities, advice and assessment of fitness to perform EPP. OH physicians (accredited specialists) with expertise in BBV and ability to provide clearance for EPP, including registering staff on the UKAP register) are employed within the OH service. A supplementary annual surveillance process is in place for work related hand dermatitis		10.3	The OH service is SEQOHS accredited, and all OH staff will follow appropriate policies, processes and guidelines when providing immunisati	Surveillance process for monitoring staff hand health at Ward/Dept level	Hand health checks has been completed at all appraisals undertaken this quarter	Ward/Dept Manager		Appraisal													No current process to review Hand health appraisal compliance	All CMGs are aware of the mandatory appraisal undertaken	New line of question for Q2. Work with Peoples Partners to change the links embedded in the appraisal documentation.	2. Partially compliant	3. Compliant
10.3				10.3			All EPP staff are	OH Lead		TIPAC report													Not required	Not required	Not required	3. Compliant	3. Compliant

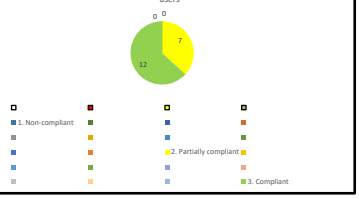




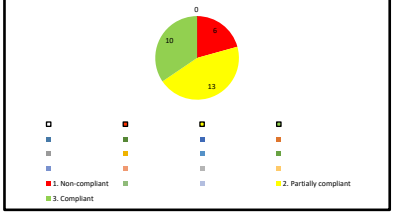
3. Compliant 1



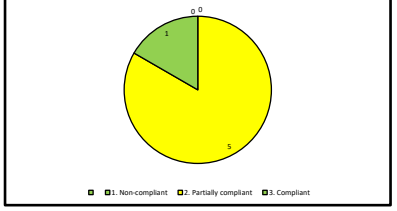
1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users



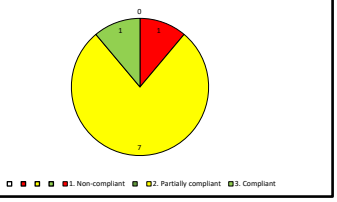
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections



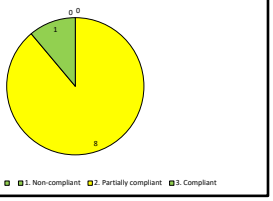
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance



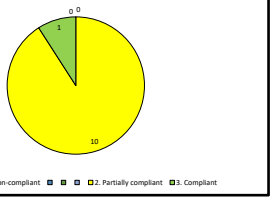
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



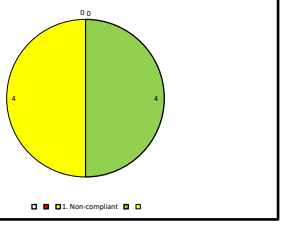
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



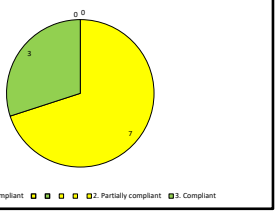
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection



7. Provide or secure adequate isolation precautions and facilities

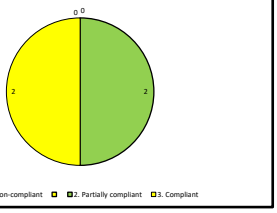


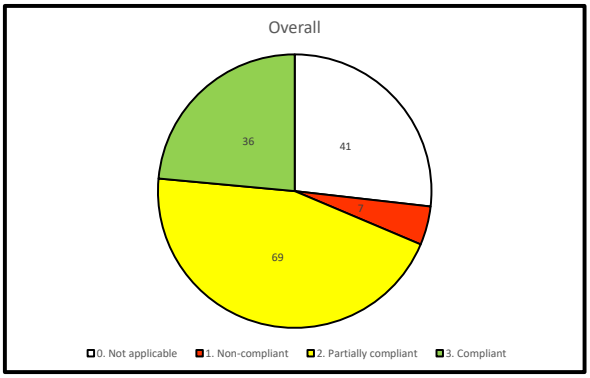
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate

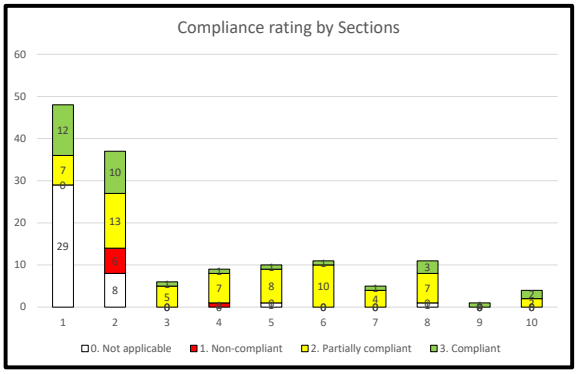


9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

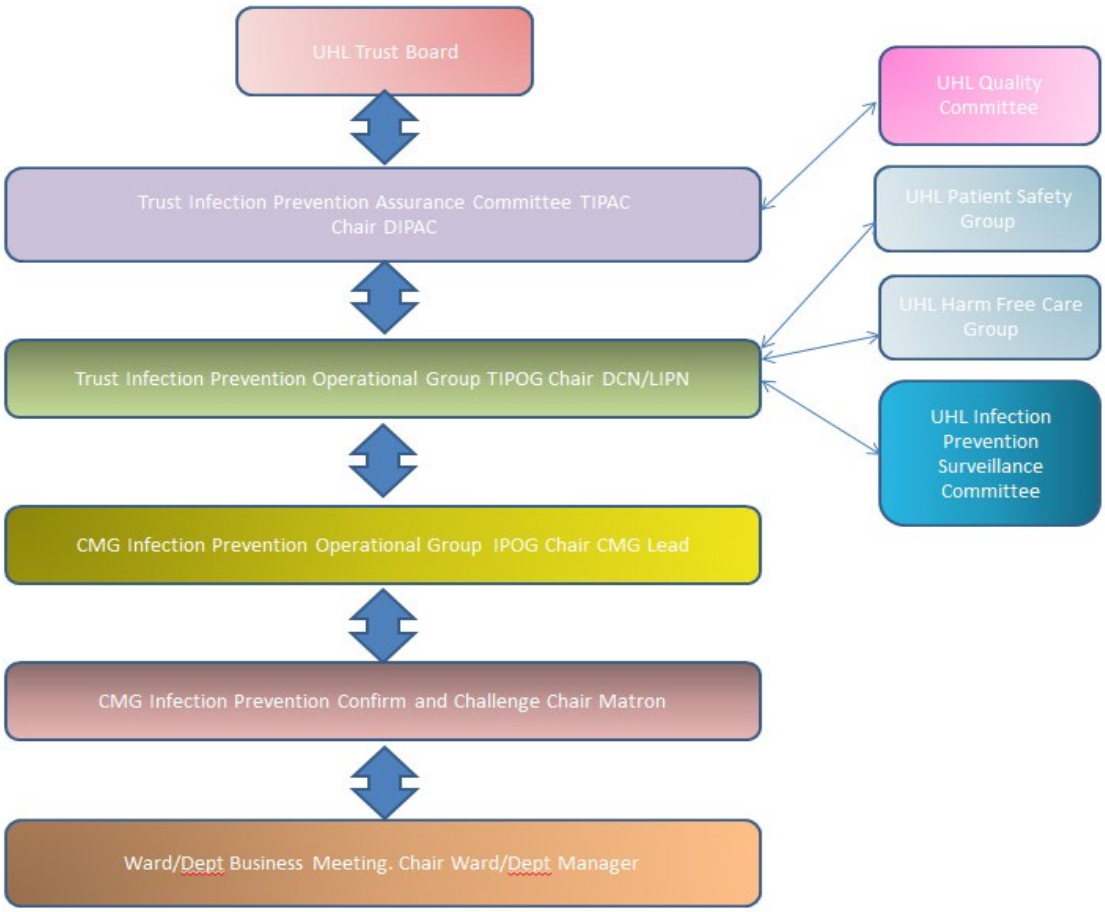



Overall
41
7
69
36
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant


Compliance rating by Sections
60
50
40
30
20
10
0
1
2
3
4
5
6
7
8
9
10
0. Not applicable
1. Non-compliant
2. Partially compliant
3. Compliant

Criterion	Action required	By Whom	By When	RAG	Comments
2.1	NCS task and finish meeting is progressing actions required within the designated timelines	NCS working group	06.10.2023		
4.1	IP communication strategy is agreed via TIPAC annually	Head of Communications	6.10.2023		


DIPAC
Specialist Infection Prevention Team
CMG Head of Nursing/Dept Infection Prevention- Lead
CMG Medical Infection Prevention Lead
Matron
Ward/Dept Manager
Ward/Dept Person In Charge per shift responsible for infection Prevention
Ward/Dept Infection Prevention Link Staff
All staff across UHL


UHL Trust Board
Trust Infection Prevention Assurance Committee TIPAC
Chair DIPAC
Trust Infection Prevention Operational Group TIPOG Chair DCN/LIPN
CMG Infection Prevention Operational Group IPOG Chair CMG Lead
CMG Infection Prevention Confirm and Challenge Chair Matron
Ward/Dept Business Meeting. Chair Ward/Dept Manager
UHL Quality Committee
UHL Patient Safety Group
UHL Harm Free Care Group
UHL Infection Prevention Surveillance Committee

QC	Quality Committee
CC	Confirm and challenge
TIPAC	Trust infection Prevention Assurance Committee
TIPOG	Trust infection Prevention Operational Group
CMG	Clinical Management Group
IP	Infection Prevention
DIPC	Director of Infection Prevention
IPOG	Infection Prevention Operational Group
SIPN	Senior Infection Prevention Nurse
IPN	Infection Prevention Nurse
ToR	Terms of References
HASCAT	Health and Social Care Act
HTM	Health Technical Memorandum
IPT	Infection PreventionTeam
ANTT	Aseptic Non Touch Technique
LCAT	Leicester Compentency Assessment Tool
AHP	Allied Health Professional
QSB	Quality Safety Board
HoN	Head of Nursing
EPP	Exposure Prone Procedure
HH	Hand hygiene
OH	Occupational Health
BBV	Blood borne virus
HCAI	Health care associated infection
ICCQIP	Infection in critical care quality improvement programme
SSI	Surgical site infection
CDT	Clostriodes Difficile Test
CDI	Clostriodes Difficile Infection
VHF	Viral haemorrhagic fever
ICB	Intergrated care board
BSI	Blood stream infection
MRSA	Methicilian resistant staphylococcus aureus
MSSA	Methicilian sensitive staphylococcus aureus
NCS	National cleaning standard
UKHSA	UK Health security agency
NIC	Nurse In Charge
CRO	Carbapenem resistant organism
FR	Functional Risk
UKAS	United Kingdom accredited labs
E&F	Estates and facilities
PPE	Personal protective equipment
FFP3	Face filtering piece
JD	Job description
SCIPs	Standard control infection prevention
TBPs	Transmission based precautions
PII	Period of increased incidence
AA	Assessment and accreditation
TB	Tuberculosis
NC	Nerve centre
LLR	Leicester, Leicestershire and Rutland