Infection Prevention & Control Annual Report 2022/2023

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Contents

1. Introduction

The purpose of this report is to inform patients, public, staff, the Trust Board of Directors, Council of Governors of the infection prevention and control work undertaken in 2022/23 and provide assurance that the Trust remains compliant with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (National infection prevention and control manual for England 2022). It covers the management arrangements, the state of infection prevention and control within Royal Papworth NHS Foundation Trust (hereafter referred to as 'RPH'), outcomes and progress against performance targets.

All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections in accordance with the Health and Social Care Act 2008 (Appendix 1)

RPH has a pro-active infection prevention and control team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients.

RPH complies with the "Saving Lives" programme. High impact interventions (HII) were originally published in 2005 as part of 'Saving Lives' initiatives. Since then, the tools have been updated in 2007, 2010 and 2017. The latest review was undertaken by a working party commissioned by the Infection Prevention Society (IPS) in 2017 in association with NHS Improvement. The infection prevention and control audit and surveillance programme incorporate this guidance and along with other audits such as the IPS audit tools, allows constant monitoring of all infection, prevention and control policies and procedures.

In February 2016 the National Institute for Health and Care Excellence (NICE) published Quality Standard 113 which covers organisational factors in preventing and controlling healthcare-associated infections in hospital settings.

The annual DIPC report is aligned to the ten compliance criteria as outlined in the Health and Social care act, Code of Practice on the prevention and control of infections and related guidance (Appendix 1).

The report aims to reassure the public that the minimisation and control of infection is given the highest priority at RPH.

2. Executive Summary – Overview of Infection Control Activities within the Trust

The Director of Infection Prevention and Control (DIPC) Annual Report reports on infection prevention and control activities within Royal Papworth Hospital NHS Foundation Trust (RPH) from April 2022 to March 2023.

RPH continues to take part in mandatory surveillance of Methicillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia, Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia, *Escherichia.coli* (E. coli) bacteraemia and *Clostridioides difficile (C.difficille)* infection via the national UK Health Safety Agency,(UKHSA) healthcare associated infections Data Capture System (HCAI DCS). In addition, mandatory reporting of Carbapenemase-Producing Enterobacteraies (CPE) was introduce in 2016/17 and *Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Kleb sp.*) was introduced in 2017 which is included in this report.

Royal Papworth Hospital has reported one MRSA bacteraemia for 2022/23 which is the first MRSA bacteraemia since 2020, There has been an increase in reported MSSA acquisitions (n=19) from previous year.

RPH monitors incidence of *C.difficile* and the ceiling threshold is reset annually by the Integrated care system (ICS). All *C.difficile* incidences that occur two or more days following a patient's admission are counted towards RPH annual threshold. *C.difficile* reporting was below the threshold for 2022/23 at 7 cases (against a threshold of 12). It was acknowledged that RPH were much lower than the threshold when compared to national and regional benchmarking. It is recognised however that RPH is 100% single rooms which reduces risk of transmission of infection.

Overall, the rate of *E. coli* bacteraemia RPH year on year has been very low compared to the national rates. The Trust reported a total of 9 cases for 2022/23, which was the same as last year.

Root cause analysis of all reportable infections were subject to scrutiny panel review with improvements and lessons learned monitored by the Infection Prevention and Control Committee.

The work of the IPC team was significantly impacted by the surgical site infection rates through-out 2022/23. SSI was declared as a serious incident for the trust in May 2022, as we continued to see a high rate of surgical wound infections at Royal Papworth Hospital. Our annual figures show that following CABG surgery the rate of surgical wound infection is 10.7% (83 infections out of 778 surgeries) and for valve surgery it is 3.6% (20 infections out of 552 operations). All deep and organ space infections had an in-depth RCA which are presented to an expert panel where learning and themes were identified, and any evidence of harm being referred to the Trusts incident review panel. Improvement work has continued to 23/24.

Review a of the Hygiene code (Health and Social Care Act 2008) highlighted areas of improvement to gain assurance particularly in the areas of decontamination and ventilation assurance subgroups have been established that report into ICPPC committee.

M abscessus continues to have a priority focus for the Trust and IPC team. An executive oversight group with representation from external stakeholders overseas M abscessus activity and actions been taken to minimise risk of M abscessus. In 2022/23 there were two cases of acquired M abscessus which were related to the RPH identified strain. This is a reduction from previous year, 2021/22.

3. Description of Infection Control Arrangements

3.1 Corporate Responsibility (Criterion 1)

The Chief Nurse has lead responsibility within the Trust for Infection Prevention and Control and reports to the Chief Executive and the Board of Directors. Following publication of the Chief Medical Officer's strategy for infection control (*Winning Ways: working together to reduce healthcare associated infection*), by the department of Health, 2003, the Chief Nurse post has been designated as Director for Infection Prevention and Control (DIPC) for RPH as outlined in *the Health and Social Care Act (2008) updated in this report in line with revised guidance issued July 2015.*

The Executive Directors engage with patient environment rounds which include Infection Prevention and Control compliance. The Medical Director and the Heads of Clinical Governance and Risk Management, through their respective roles, also exert their influence at a corporate level in areas that have direct impact on infection prevention and control. Infection prevention and control is part of the Matron role at RPH and Matrons play a key role in auditing, monitoring, reporting on compliance and following up actions with IPC standards and practises.

3.2 Infection Prevention & Control Team (Criterion 1)

Specialist advice is provided to clinicians throughout the hospital by the infection prevention and control team. A Consultant Microbiologist is the designated Infection Prevention and Control Doctor (IPCD), with the weekly allocation of 4.7 programmed activities (18 hours per week for 42 weeks of the year) of infection control doctor time. Cover for leave of absence is not included but out of hours cover is provided by the Consultant microbiology team. Support for virology is provided through Cambridge University Hospitals NHS Trust.

The specialist infection, prevention and control nursing team provide education, support, and advice to all Trust staff with regard to infection prevention and control matters and liaise regularly with patients and relatives to provide information on alert organisms, offering advice and reassurance when required.

The team liaise with clinicians and divisional managers together with managers who have responsibility for operational support, clinical governance, and risk management. The remit of the team includes:

- To have policies, procedures and guidelines for the prevention, management, and control of infection
- To communicate information relating to communicable disease to all relevant staff
- To ensure that training in the principles of infection control is accurate and appropriate to the relevant staff groups.
- To work with other clinicians to improve surveillance and to strengthen prevention and control of infection.
- To provide appropriate infection control advice to key RPH committees, taking national guidance and policy into account.
- To share information with relevant stakeholders within the NHS when transferring the care of patients to other healthcare settings.
- To ensure high standards of infection control are maintained through a programme of audits and surveillance.
- To be key experts and part of the relevant stakeholder group to maintain safety.

Full details of the infection prevention and control team are provided in the organisation chart provided in Appendix 2. A full working plan for IPC team is reviewed annually.

3.3 Infection Prevention & Control Committee Structure and Accountability (Criterion 1)

The Infection Control and Pre and Perioperative Care (ICPPC) Committee is the main forum for discussion concerning changes to policy or practice relating to infection prevention and control. The membership of the Committee is multi-disciplinary and includes representation from all clinical divisions, estates and facilities, clinical audit, antimicrobial pharmacist, clinical governance and occupation health service. The Committee is chaired by the Director of Infection Prevention and Control (DIPC) or Deputy Chief Nurse and meets every month. The Committee provides an assurance report and items for escalation to the Quality and Risk Management Group (QRMG) and Quality and Risk Committee, (subcommittee of the Board of Directors). In 2022/2023 an additional Surgical Site stakeholder group meetings were held fortnightly to support the SSI improvement work.

Terms of Reference for the ICPPC were established on recommendations for the composition and conduct of infection control committees contained in Department of Health in December 2003, of the Chief Medical Officer's strategy for infection control (*Winning Ways: working together to reduce healthcare associated infection*).

Additionally, clinical IPC link roles and IPC champions have been identified in clinical and non-clinical areas and form a "Infection Control Link Group". This group acts as a forum for education and discussion and helps with embedding best practise across RPH.
Monthly IPC masterclass and IPC study days have taken place throughout 2022/23 to support the IPC link team, ward sisters/charge nurses and Matrons.

3.4.1 Infection Control Team Representation on Committees at Royal Papworth Hospital (Criterion 1)

The IPC team provide subject matter expert advice and guidance at RPH internal and external meetings and committees as required.

3.4.2 Infection Control Team Representation on External Committees

- East of England Regional Microbiology Development Group
- East of England Infection Prevention Society Branch Meetings
- Network meetings with the Integrated Care board and services including regional hospital.
- DIPC attends the integrated care board (ICB) IPC Board

3.5 Assurance, internal and external inspections (Criterion 1 & 2)

The assurance process includes internal and external measures. Internally, the accountability exercised via the committee structure described above ensures that there is internal scrutiny of compliance with national standards and local policies and guidelines. Furthermore, external assessments are also used. These include the "Controls Assurance" measures for infection control and decontamination standards, International Standards for Organisation Care Quality Commission standards and the Patient-led assessments of the care environment (PLACE), plus a Health and Social Care act 2008, review.

All controlled assurance and progress in these areas during 2022/23 is summarised below:

Standards for Decontamination (Criterion 1,2,9)

Sterile Services is subcontracted and provided by Nuffield Health. Nuffield Health is independently audited and appropriately accredited and provides assurance reports to RPH to demonstrate that the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008 are met. For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only). The Trust has appointed a decontamination lead, to monitor and manage sterile service and manage endoscopy within RPH. A decontamination sub-committee working group was established in December 2022. A monthly d assurance report is presented to the ICPPC committee.

Care Quality Commission Standards (Outcome 8)

RPH is registered with the CQC and, in accordance with this regulation, monitors compliance against the ten criteria as outlined in the Hygiene Code (Health and Social Care Act 2008 doc) A full gap analysis (Appendix 3) against all ten criteria was completed and further reviewed quarterly through-out 2022/23. CQC fundamental regulation15 - Premises & Equipment (including cleanliness & infection Control) is reviewed annually under a mock review, which is presented to the fundamental of care group for assurance and shared learning.

UKHSA Data Capture Mandatory reporting (Criterion 1)

The Infection Control Doctor is responsible for mandatory reporting of alert organisms to the UKHSA Data Capture website. The monthly alert organism report is shared through the ICPPC committee and governance structures through to Board of Directors.

Patient Led Assessments of the Care Environment (PLACE) Programme:
PLACE Audit Results table inspection (Criterion 1 & 2):

All healthcare providers are required to take part in the national Patient-Led Assessment of the Care Environment (PLACE) annual inspections. PLACE is a national self-assessment tool designed to measure standards of:

- Cleanliness,
- Food comprising Organisation Food and Ward Food
- Privacy, Dignity & Wellbeing,
- Building Condition, appearance & maintenance,
- Dementia friendly environment
- Disability friendly environment

The Health & Social Care Information Centre (HSCIC) provide comprehensive guidance on the organisation and conduct of assessments and separate guidance documents for staff and patient assessors. PLACE assessments are carried out by internal and external assessors within inpatient facilities and the surrounding patient environment. Assessors include Governors, Volunteers, Trust members and representatives from the Trust's facilities contractors.

The outcome for 2022/23 shows that while we have a diverse spread of inpatient environments, the quality of the cleanliness and condition, appearance and maintenance remain at a high standard across the whole Trust. This is reflected in the Trust score being above the national average in these categories.

The latest published assessment was undertaken in November 2022 and is available at:
Patient-Led Assessments of the Care Environment (PLACE), 2022 - England - NDRS (digital.nhs.uk)

3.6 DIPC Reports to Board of Directors and QRMG (Criterion 1- 10)

A monthly IPC report forms part of the patient safety agenda at Quality and Risk Management Group (QRMG) and reports on mandatory monitored healthcare associated infections (HCAIs) such as *C. difficile* and MRSA, as well as other healthcare associated infections. The report also highlights adverse infection prevention and control issues and incidents or concerns in clinical practice. QRMG provides an assurance report and items for escalation to Quality and Risk and through to Board of Directors as required.

3.7 Infection Control Report & Programme for 2022/23 (Criterion 1 & 4)

Work undertaken by the Infection Prevention and Control Team during 2022/23 covers the following areas:

- Compliance with the Health and Social Care Act 2008 *updated in this report in line with revised guidance issued July 2015.*
- Infection Control, pre and perioperative care committee
- Link Practitioner Network and monthly IPC masterclasses
- Development and maintenance of policies and procedures
- Audit and Surveillance monitoring and reporting
- Education including newsletters, IPC study days and workshops for Matron.
- Compliance with Department of Health initiatives – High Impact Interventions / WHO 5 Moments for hand hygiene
- Outbreak and incident management
- HII monitoring is reported in the Royal Papworth integrated performance report.
- Infection Prevention and Control guiding and managing Living with COVID-19.
- Leading a refreshed fit testing service to ensure staff are protected from airborne infection and ongoing service as supported by Health & Safety Agency (HSA).
- Working in collaboration with the SSI stakeholder group.
- Providing IPC expertise in essential safety groups.
- Develop decontamination subgroup and support the decontamination lead.

3.8 High Impact Interventions

At RPH the designated Infection Prevention and Control link practitioners carry out monthly High Impact Intervention (HII) audits. The HIIs are an evidence-based approach to clinical procedures and care processes. The appropriate use of HII audits help to identify gaps in practise that pose a risk to hospital acquired infection and identify areas for improvement. These audits include HII1 Central Venous Catheter insertion and ongoing care, HII2 Peripheral Intravenous Cannula insertion and ongoing care, HII4 Surgical Site Infection pre-op, HII5 Ventilation-association Pneumonia, HII6 Urinary Catheter insertion and ongoing care and HII8 Cleaning and Decontamination. A monthly audit of aseptic non-touch technique (ANTT) has been introduced as part of RPH approach to reduce surgical site infections. In 2022/23 a review of the full audit cycle was completed and an action plan programme was developed which required clinical areas that fall below the standard for HII audit, which was <95%, to provide evidence of an improvement plan. This is overseen by the ICPPC. RPH achieved a cumulative total of 98% for HH audits and 95% for all HII audits. There is further work to look at how robust the audit is and if a peer review would change the results, as well as reviewing the number of audits completed within the IPC annual audit plan.

4 HCAI Statistics (Criterion 1, 4 & 9)

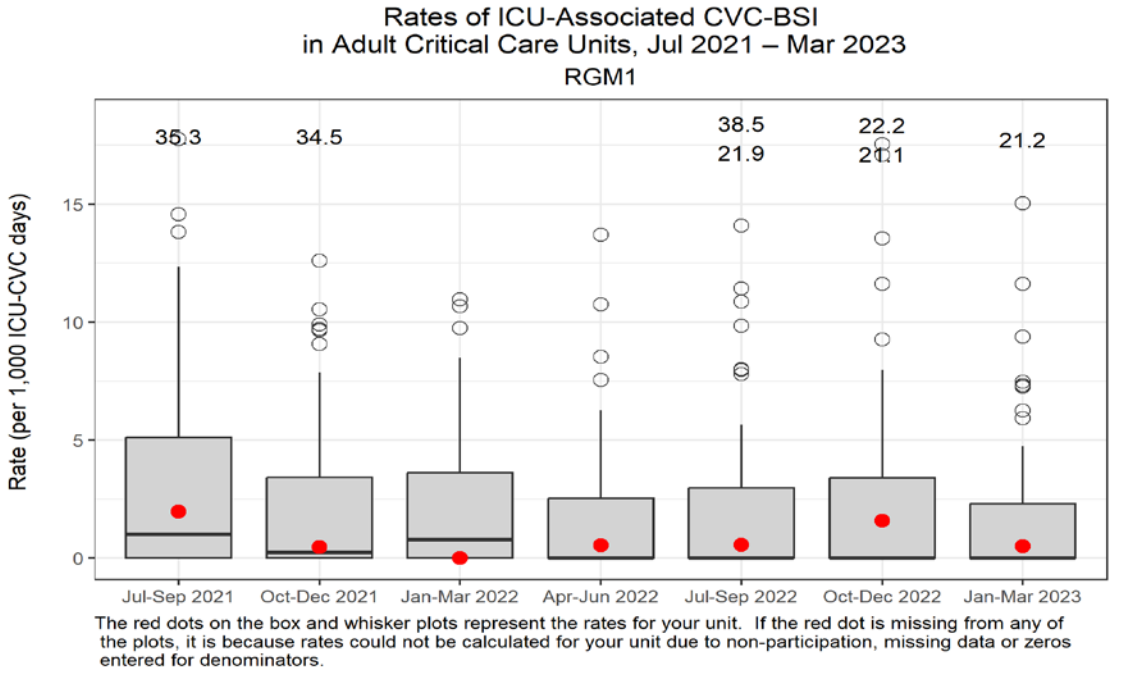
4.1 Infection in Critical Care Quality Improvement Programme (ICCQIP)

The ICCQIP board was set up in 2016 to address the concerns of hospital-associated Infections (HAI) in intensive care units (ICU) around central venous catheter care in England, following on from the publication of the successful 'Matching Michigan' study.

The ICU surveillance programme aims to characterise and monitor all ICU and central venous catheter (CVC) associated blood stream infections to identify concerns and support actions to reduce the infection rates. Data is collected and analysed on a quarterly basis and unit level reports are generated and sent to respective units.

The results for 2022/23 are presented in the form of a graph as below:

RPH is indicated by the red dot and indicates the rate of ICU-associated CVC-BSI is within the interquartile range in all periods which shows low rates of ICU/CVC/BSI. 2022/23 is much lower than last year 2021/22 which showed an increase in line-related infection during the COVID pandemic. The quarterly report is discussed with the critical care multidisciplinary team and an improvement plan monitored by the ICPPC committee.



4.2 Mandatory Reports (Criterion 1, 2, 4, 5, 7 & 9)

4.2.1 MRSA

MRSA bacteraemia figures for the past 10 complete years are represented in the table below.

Papworth Annual MRSA bacteraemia rates

01.04.13 To 31.03.14	01.04.14 To 31.03.15	01.04.15 To 31.03.16	01.04.16 to 31.03.17	01.04/17 to 31.03.18	01.04.18 to 31.03.19	01.04.19 to 31.03.20	01.04.20 to 31.03.21	01.04.2021 to 31.03.2022	01.04.2022 to 31.03.2023
0	1	0	0	5 (3 on trajectory)	2 (1 on trajectory)	0	2 (1 on trajectory)	0	1 (on trajectory)

The ceiling for MRSA bacteraemia's set for Royal Papworth for 2022/23 by UKHSA was zero. There was 1 MRSA bacteraemia in year. A full post infection review was completed, and actions/lessons learnt were shared.
Compliance with MRSA screening in 2022/23 was 97% The introduction of universal MRSA screening allows early identification and treatment of patients colonised with MRSA which considerably reduced infection rates.

4.2.2 *C. difficile*

C. difficile figures for the last seven years are represented in the table below. Following updated guidance from UKHSA all *C. difficile* cases that occur two or more days into the patients' admission are counted towards RPH annual threshold, regardless of whether the scrutiny panel has found any learning outcomes and it was unavoidable. Root cause analysis (RCA) and scrutiny panel meetings are held for each case to identify any lessons learning.

	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
C. difficile >65 yrs	2	4	6	6	5	8	2
C. difficile < 65 yrs	0	3	5	5	3	4	5
Total	2 (0 attributable)	7 (3 attributable)	11 (2 attributable)	11	8	12	7

The ceiling threshold set for Royal Papworth by the UKHSA for 2022/23 was 12 cases. RPH were below the threshold set by UKHSA and all cases reviewed were identified as complex with multiple predisposing factors meaning these patients were more suspectable to acquiring C difficile. All *C. difficile* cases had an RCA completed and learning shared where required.

4.2.3 MSSA bacteraemia

Reporting of Methicillin Sensitive Staphylococcus aureus (MSSA) bacteraemia to the UKHSA Health through the MESS system has been compulsory since January 2011. There is no threshold set by external regulators for MSSA. The numbers given below include cases where the blood cultures were taken within 48 hours of admission to the hospital which could indicate community acquired infection as well as hospital acquired.

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Methicillin sensitive *Staphylcoccus aureus* bacteraemias (MSSA)	18	9	16	21	17	14	22	9	16	17	12	19

MSSA was higher than previously in 2021/22. This was internally reviewed and found no themes, outbreak or cluster was identified, apart from in March 2022 4 were identified in the same month which is higher than normal so a full RCA/PIR were completed and investigation took place. No one cause or theme was identified.

4.2.4 E. coli bacteraemia

Reporting of E. coli bacteraemia to the Department of Health through the HCAI DCS system has been compulsory since June 2011. These infections are reported to the Infection Prevention and Control Committee. There is no threshold set by external regulators for these infections at present. Reporting of klebsiella and P. aeruginosa bacteraemia's have become mandatory since 2017, but also no threshold set.

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
***E. coli* Bacteremia's**	6	11	12	11	9	9	14	9	9
***Klebsiella* sp. Bacteremia**				7	12	13	28	13	15
***P. aeruginosa* Bacteremia**				3	6	4	9	5	4

All ALERT

4.3 Other Surveillance Reports

4.3.1 GRE/VRE and ESBL bacteraemia

	2013/14	2014/15	2015/6	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Glycopeptide (or Vancomycin)-Resistant *Enterococcus* (GRE/VRE) bacteremia's	2	4	3	8	11	8	3	14	12	2
Extended spectrum B-lactamase producers (ESBL) bacteremia's	0	0	3	5	3	1	2	6	1	3
Carbapenemase-producing *Enterobacteriaceae* (CPE)				1	5	5	6	7	1	2

VRE and ESBL bacteremia's and CPE are reported to the Infection Prevention and Control Committee and to UKHSA quarterly. There are no ceilings set by external regulators for these healthcare associated infections. There was a reduction in VRE bacteremia's compared to the previous year. ESBL and CPE whilst low rates there were 2 2 infections more than 2021/22. This will be closely monitored for 2023/24.

4.4 Mycobacterium abscessus (M abscessus)

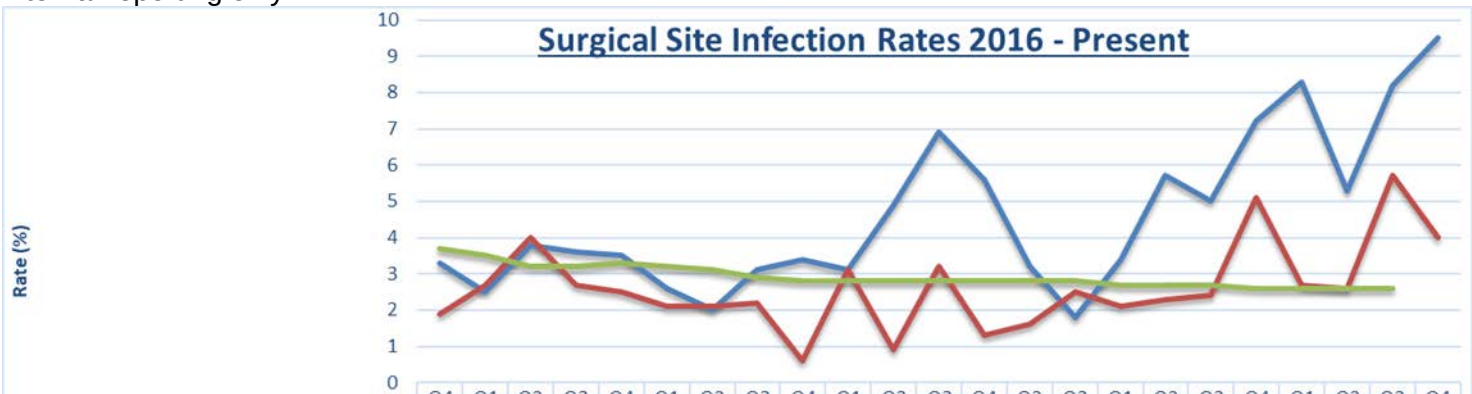
In 2019, following some routine testing, we launched an investigation into some cases of *M. abscessus* infection, a rare infection which can cause problems for people with specific underlying respiratory conditions or who are immunosuppressed as a result of their condition.
Immediate measures to act, including putting in enhanced 'point of use' filters, providing bottled water to our most susceptible patients, doing extra tests and taking more water samples, installing a dosing plant (called a hydrogen peroxide dosing plant) and an ultra-violet treatment unit on site, and putting in specialist shower heads and hoses in patient areas, among other interventions. Since implementing our stringent and additional water safety measures, we have significantly reduced the counts of mycobacteria at the Trust, although we cannot ever 100% confirm this will be completely gone.

The newly formed Oversight Committee established in January 2021, now with developed working groups namely: Estates and Facilities, Clinical and Research, and Governance and Communication that feed into the oversight committee. An executive led including external panel Stakeholder Group meets bimonthly and reports to RPH Quality and Risk Committee. RPH have seen a reduction on M.abscessus positive cases for 2022/23 with only 2 related to RPH and zero classed as moderate harm.

4.5 Surgical Site Surveillance (Criterion 1, 2, 3, 4, 5, 6, & 9)

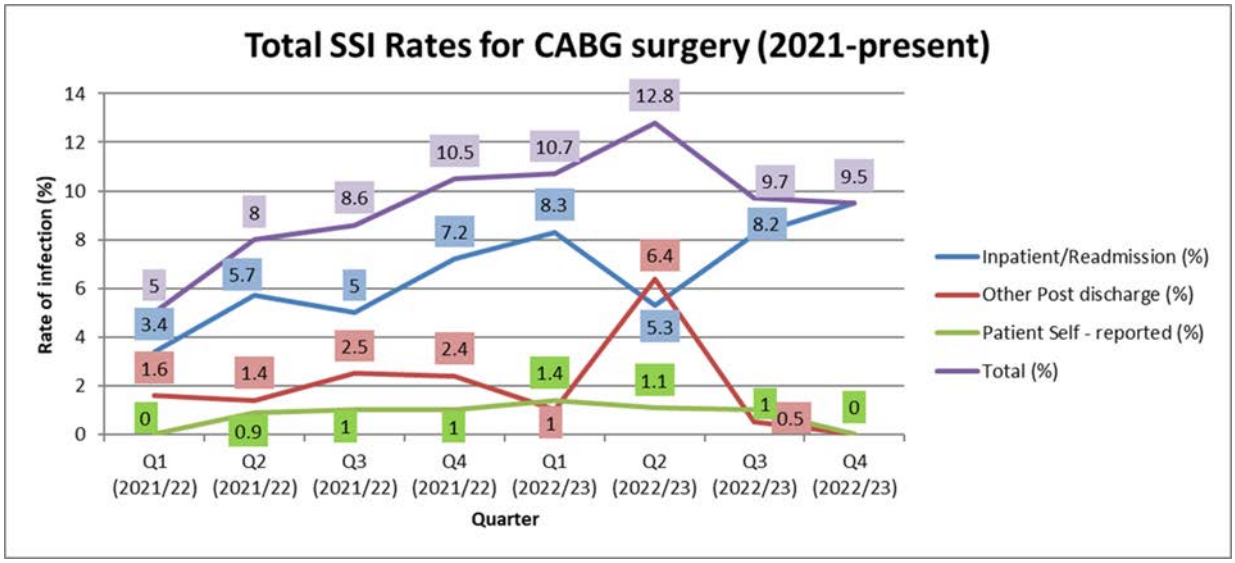
Surgical Sites Infection rates 2022-2023

Since moving to the Cambridge Biomedical Campus in May 2019, RPH has seen a significant rise in SSI rates. Surveillance was paused during Covid, however once recommenced in 2021, rates have continued to be on the incline. This is being reflected in the number of patients requiring specialist management of deep and organ space wounds by the Wound Care Tissue Viability and Surgical teams.
Annual SSI figures for CABG and valve surgeries for Q1-Q4 2022-2023 have shown consistently high rates above the national benchmark.
Our inpatient/readmission CABG infection rate has reached a rate of 10.7% this year, the highest rate we have seen since SSI surveillance began at Royal Papworth. The annual national benchmark has remained at 2.6%. The following run chart represents the inpatient/readmission CABG rates from 2016 to 2022/2023 with UKHSA benchmarks.
This run chart also shows valve infection rates for the same period. Valve infection rates have historically remained around 2 – 3%, with occasional spikes. The Valve infection rate for 2022/23 reached 3.6%. Again, these are the highest valve rates we have seen since SSI surveillance in 2016. There is no national wound surveillance of patients who underwent valve replacements, therefore, infections in this patient group are for internal reporting only.

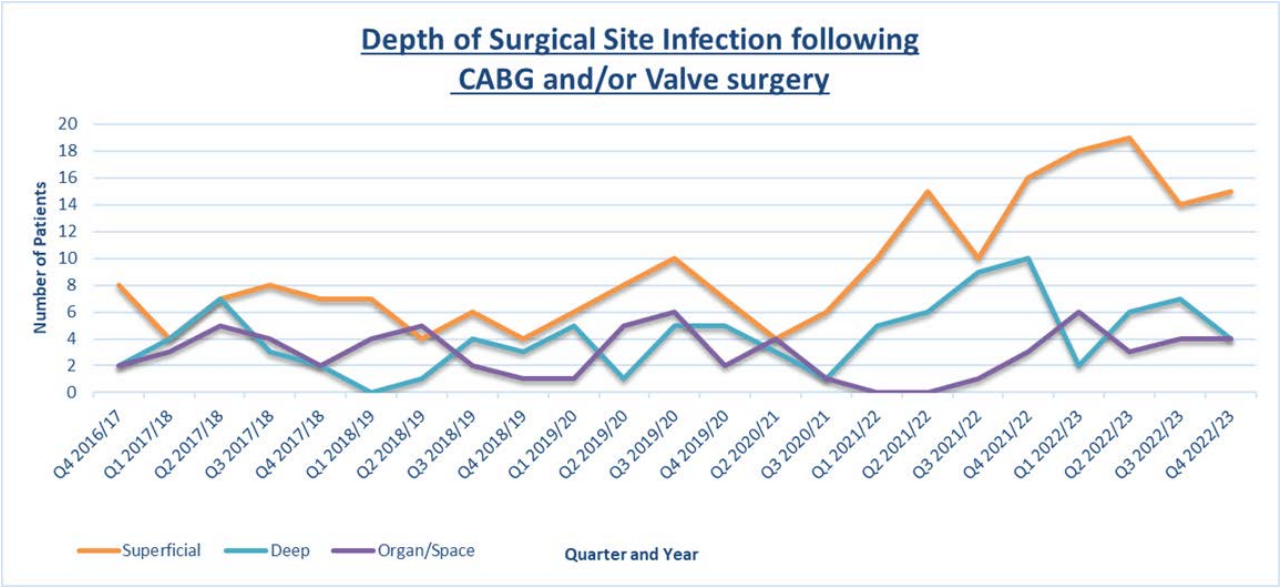


	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Q2 20/21	Q3 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23
CABG (inpatient/readmissions %)	3.3	2.5	3.8	3.6	3.5	2.6	2	3.1	3.4	3.1	4.9	6.9	5.6	3.2	1.8	3.4	5.7	5	7.2	8.3	5.3	8.2	9.5
Valve (%)	1.9	2.7	4	2.7	2.5	2.1	2.1	2.2	0.6	3.1	0.9	3.2	1.3	1.6	2.5	2.1	2.3	2.4	5.1	2.7	2.6	5.7	4
UKHSA CABG cumulative incidence for inpatient/readmission SSIs (%)	3.7	3.5	3.2	3.2	3.3	3.2	3.1	2.9	2.8	2.8	2.8	2.8	2.8	2.8	2.8	2.7	2.7	2.7	2.6	2.6	2.6	2.6	

The following graph shows the total infection rate for CABG surgery including all identification groups. 2022/2023 has seen the total rate of 10.7% CABG and 3.6% in Valves.



The depth of infection has remained predominantly superficial, however the number of patients with deep and organ space wounds is on an overall increase.



Surgical Site Infection Stakeholder Group

The SSI stakeholder group was established in 2019 following the increase in SSI's rates following the move to new Royal Papworth Hospital. The stakeholder group has representation from the multi-disciplinary team involved in the patient's surgical pathway.
Following year end 2021/2022 the Trust reported a serious incident in respect to surgical site infections due to the continued increased incidence especially in deep wound infections. This was to ensure transparency to internal and external stakeholders and allow further scrutiny and learning to improve performance.

Stakeholder meetings have continued to be frequent throughout the year to address actions and review learning. No one cause has been identified for the increase in infection rates however we continue to closely monitor and assess any potential contributing factors. We are engaging with our regulators e.g., CCG, UKHSA and the CQC keeping them informed of actions taken.

Reducing the incidence of SSI's is a priority for the clinical decision cell and the group are supporting implementation of appropriate recommendations including inviting external stakeholders to perform a peer review.

4.5 Antimicrobial Stewardship (Criterion 1, 3, 5 & 8)

Antimicrobial Stewardship (AMS) 2022-23

Antibiotic use (expressed as WHO Defined Daily doses/1000 Admissions FY 2021/22 through to FY 2022/23

Royal Papworth Hospital = **Orange Line** Liverpool Heart and Chest = **Light Blue Line**

Total DDD's 2021/22	Total DDD's 2022/23	% Difference
162,006	153,894	5.01

To help assist the HMG achieve the UK's five-year national plan in tackling antimicrobial resistance, an antibiotic consumption reduction target was reinstated within the NHS Standard Contract. Since 2019, the Contract has required acute providers to make year-on-year reductions in their per-patient usage of antibiotics from the "Watch and Reserve" categories, in line with the ambition for a 10% cumulative reduction set out in the UK 5-year action plan for antimicrobial resistance 2019 to 2024.
In 2022/23 the target for all Trusts in England was a 4.5% reduction for 2022/23 in Watch & Reserve antibiotics, which for RPH meant a reduction of DDDs/1000 admissions by 330 and a reduction of 7000 defined daily doses of antibiotics.

	Total Watch & Reserve DDD's	Total Admissions	Total Watch & Reserve DDDs/1000 admissions
2018/19	172979	23598	7330
2022/23	114276	20330	5621

For 2022/23, RPH saw a **23.32% reduction** in the use of Watch and Reserve category antibiotics. Access, Watch and Reserve (AWaRe) list of antibiotics is a novel metric to describe antimicrobial use published by the World Health Organization and adopted by NHS-England.
Access group of antibiotics consists of first and second choices for the empirical treatment of the most common infection syndromes and antibiotics that should consistently be widely available globally.
Watch group are antibiotic classes considered to have higher toxicity concerns and/or resistance potential.
Reserve group includes new antibiotics and treatment options reserved for complex infections or multi drug resistance (MDR).
The reduction in antibiotic use is a result of multidisciplinary team (MDT) working and the AMS Team were short listed for a Health Service Journal Patient (HSJ) Safety Award and the United Kingdom Clinical

Pharmacy Association (UKCPA) service improvement poster award for its work with the Surgical Division to introduce AMS MDT ward rounds to the Trust. The AMS Team is looking to resource other AMS MDT ward rounds in other clinical divisions e.g. cardiology and respiratory.

Other AMS activities in 2022/23 include:

Education and Training
The AMS Team has met weekly, in 2022/23 to discuss its objectives and plan its workload. It has expanded its ad-hoc membership to include meeting with Infection Control Lead Nurse monthly and the Education Departments Medical Trainers Lead every 3 months. This is in order that we can build our network and direct our resources to clinical areas of greatest need. As a result, the AMS Team has been invited to present and participate in various infection control and tissue viability training days and we regularly present to non-medical and medical prescribers on AMS topics. The AMS Team have worked collaboratively with the Communication and Education Teams to create 2 bite sized training videos on AMS and Management of post-operative pyrexia.

Audit
The AMS team have participated in surgical antibiotic prophylaxis audits throughout 2022/23 to support the Trust in identifying whether any causality could be found in inappropriate antibiotic administration pre and peri-operatively and the high surgical site infection rates seen throughout 2022/23. No causality could be found but the audits have afforded the AMS Team the opportunities to work closer with surgical and anaesthetist colleagues as well as reviewing and updating our surgical prophylaxis guidelines. Other (re)audits undertaken: Gentamicin and Blood Culture Pathway, both have led to a review of our guidelines.

Guidelines: 12 clinical guidelines were reviewed, updated/in progress including its Antimicrobial Strategy in 2022/23.

Patient Safety: 3 Patient Safety projects have been completed/in progress:
"azole checklist" - a collaborative piece of work with the respiratory team to ensure that patients requiring "azole" antifungals receive the correct monitoring are informed as to which adverse reactions to watch out for.
"Penicillin de-labelling project" - planned collaborative service with the anaesthetists and surgical division looking at a specific patient cohort that meet the criterium for a direct oral therapy challenge. If this project is successful then it may mean that previously penicillin allergy labelled patients could receive a more effective penicillin-based antibiotic instead of multiple non-penicillin antibiotics (which can be more renally toxic), leading to shorter course lengths, fewer bed days, reduction in associated costs and improved patient care and satisfaction.
"aminoglycoside and voriconazole patient counselling" – all patients initiated on these antimicrobials receive counselling from the AMS Pharmacy Technician on monitoring requirements/side-effects etc.

4.6 Incidents and Outbreaks (Criterion 1-10)

Incident and outbreak investigations occurring in 2022/23 were managed and reported to the ICPPC throughout the year.

Influenza
The total number of flu cases within Royal Papworth were nine cases with two that were hospital acquired. There were no influenza outbreaks for 2022/23.

Norovirus
Norovirus cases remained low for 2022/2023 with no outbreaks or ward closures reported.

***Clostridioidies difficile* (*C. difficile*)**
There were no outbreak or cluster incidents relating to *Clostridioidies difficile* infection in 2022/23 and all C difficile cases which were hospital acquired had an RCA and panel review for any lessoned learnt.

MRSA
There was one case of MRSA bacteraemia which was hospital acquired in 2022/23. A post infection review was completed, and a meeting was held. All learning outcomes were identified, and action plan completed.

MSSA
RPH saw an increase in MSSA and a cluster of 4 cases was identified in March 2022. A full Post Infection Review was completed, and lessons learnt were highlighted and shared. No one cause was identified therefore it was defined as a cluster rather than an outbreak.

***Mycobacterium abscessus* (*M. abscessus*)**
In 2022/23 two new cases were identified which were related to the RPH outbreak water with zero moderate harm. Both incidents were reviewed at Serious Incident Executive Review Panel.

Mycobacterium tuberculosis
There were no incident or outbreak related to Mycobacterium tuberculosis.

Vancomycin Resistant *Enterococcus* VRE and Extended Spectrum Beta-Lactamases (ESBL)
All positive clinical site samples are monitored to enable RPH to identify increases in these organisms and act accordingly. There were no incident or outbreak of VRE or ESBL.

Carbapenemase Producing *Enterobacteriacae* (CPE)
There has been no evidence of CPE transmission or outbreaks during 2022/23

COVID-19
RPH continued to be a registered ECMO (extra corporeal membrane oxygenation) centre. ECMO is a treatment used for patients who have severe acute respiratory distress as a result of e.g. H1N1, COVID-19, influenza or other respiratory infections.
RPH accepted COVID 19 as business as usual for 2022/23 and made sure guidance was embedded within our IPC and isolation policies. An increase in COVID19 hospital acquired infections cases was identified in January, February, and March 2023. Nosocomial cases in 2022/23 are:

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
New positive patient	37	5	7	12	9	6	13	3	6	9	6	6
Nosocomial 8+ days	0	0	0	0	1	0	2	0	0	1	0	1
Nosocomial 14+ days	0	0	0	2	0	0	0	0	0	1	2	0
Total new nosocomial	0	0	0	2	1	0	2	0	0	2	2	1

There were no staff outbreaks relating to COVID 19. All nosocomial were fully investigated, and information shared externally consistent with mandatory reporting compliance and ICPPC committee. IMARCH report had to be complete nationally for each incident or outbreak.

Legionella incident.

In August 2022, RPH declared a Legionella incident. During an investigation of a potential hospital acquired case, it was highlighted there was a sufficient increase in legionella positive from water outlet across the sight meaning an increase in safety measure was put in place. Regular meetings were held to discuss the incident and the water safety group stepped up to discuss water management. Estates and the water safety group worked together to maintain safety for both patients and staff. The patient at the time of the investigation whom developed Legionella was fully investigated to see if there was a link, which was not. Due to this investigation a program for increased regular testing for Legionella was implemented. Regular cleaning of thermostatic mixing valve (TMV) outlets has been completed, chlorine clean within the pipe work

in some area has taken place that continues to have repeated positives, an increase in silver/copper added. and to water system regular enhanced water outlet flushing continues. All these measures continued. throughout the rest of 2022/23. This is being monitored through the water safety group and report to the ICPPCC.

5. Environment

5.1 Cleaning Services (Criterion 1, 2, 6 & 9)

OCS provides cleaning services to Royal Papworth Hospital, through a PFI contract arrangement. This is monitored through ICPPC committee as well and QC audits which are monitored with the oversight from the Matrons.

- Within each department/ward of the hospital there are *"commitment to cleaning"* boards that display the roles, responsibilities, and cleaning routines of that department; these also incorporate the required SLA for that specific department/ward
- As an output spec contract there are no specific staffing number requirements aligned to the cleaning contract, the service level that OCS are monitored against is the frequency of work.
- The PFI contract is a self-monitoring contract which enables the contractor to take a lead in all cleaning audits. In addition to this we have organised joint audits that take place according to the 13-week schedule. In the event of an audit failing, OCS will rectify the failings immediately and the area will be audited again on completion.
- Any failures in cleaning audits are reported in the monthly performance report and managed through the PFI contractual management process.
- OCS & E&F are continuing to work to ensure sufficient staffing levels are maintained within the agreed contract.
- The Trust and OCS are jointly working to implement NHS cleaning standards 2021 by the end of August 2023. This has been delayed due to the contract renegotiation with provider services and the benchmarking process.

5.2 Deep Cleaning Programme

The Trust continues to work closely with OCS to implement a robust deep cleaning programme in line with the PFI contract that is carried out through-out the year. The progress against this is reported back to the infection control committee group. The new NHS National Cleaning standards 2021 was reviewed in 2022, and RPH and OCS are working closely together to implement these standards in 2023. The periodic (deep) cleaning schedule was requested during the SSI reviewed and is monitored through the ICPPC Committee.

5.3 Management Arrangements

OCS is overseen by the Senior General Manager from Project Co, and the Director of Estates and Facilities and Operations Manager from the Trust. The OCS Regional Contracts Manager visits the site regularly. Together they oversee management of the cleaning contract. This management structure also supports the cleaning supervisors on a day-to-day basis.

5.4 Monitoring Arrangements

The contract is set up to be self-monitoring. OCS have implemented an audit system called iAuditor which uses the NHS 49 elements template to track and score audit scores. Trust Estates have access to the system which allows transparency in the data. The employment of OCS supervisors alongside Trust Estates Monitoring Officers ensures consistent focus on both quality-of-service delivery and effective communication on monitoring results. The results of all cleans across the Trust are sent to the IPC team and Senior

Nurses/Department Heads, and any discrepancies are discussed at the ICPPC. OCS utilise the National Standards for Cleanliness audit tools and follow the recommendations as laid down by this national body. Out of hours cleaning provision is available.

Quality controls (QC)s are undertaken frequently as per schedule below, and QC teams consist of a matron or nursing representative, OCS and Estates and Facilities; all results are captured on the iAuditor system and are reported monthly.

Area	Frequency
FR1	Weekly
FR2	Two-weekly
FR3	Monthly
FR4	6-monthly

*FR = frequency risk

5.6 Linen Service

The linen service is provided by Ellis via a shared service with Cambridge University Hospitals; their contract is for clean linen to be delivered to site daily consisting of the following: sheets, draw sheets, pillowcases, towels, blankets, scrubs, and patient gowns. These are stored in the linen room and dispatched to the wards by the porter team. Dirty linen is collected from the wards by porters and then collected by Ellis for cleaning. The linen is cleaned in accordance with NHS standards Trusts are invited to visit if they wish and a team have previously been to review this service for assurance. The company are externally audited and have been accredited for there service. If there are any issue within this service RPH are alerted to this and action is taken immediately.

5.7 Water Safety

The Trust has a Water Safety Group, which reports to the Infection Prevention and Control Committee. The Water Safety Group meets regularly to review the water safety plan and report any issues relating to water systems relating to water health.

The Water Safety Group is the working group whose duties are to advise on and monitor the implementation and efficacy of all Legionellosis and Pseudomonas Management & Controls as well as temperature control and safe hot water management programmes across all sites constituting the Trust Estate. The group consists of the Trust Responsible Person and Deputies, Infection Control Doctor and/or deputy (IPC lead nurse), Matrons or Ward Based Representative, Risk Manager, Estates Operation Manager and the Trust Legionellosis Management & Control Consultants and Skanska team. Details of the Trust's water safety procedures are documented in DN654 Water Safety Plan available on the Intranet. Any concerns raised regarding water management are escalated through the ICPPC committee. RPH have appointed an Authorising Engineer for water from Hydrop company who completes a yearly audit and completes a risk assessment to improve the waters system health.

5.8 Ventilation Safety Group

The Estates and Facilities Team chair and facilitate a monthly Ventilation Safety Group which started in September 2022/2023 with dates planned throughout the year.

The Ventilation Safety Group is a newly formed group, and consists of the Trust Head of Estates, Operations Manager, Hard FM Manager, IPC Lead Nurse, Clinical Representation alongside representatives from OCS and Skanska, Future planning is underway for Authorising Engineers (AE) and Appointed Persons to attend from each organisation at future meetings.

Any concerns, air flow systems and management via HTM 03-01 are discussed, raised and monitored within this group**.** This feeds into the ICPPC committee for assurance. The annual maintenance in high critical areas has a 14-month contractual obligation to be completed. These reports for 2022/23 have been reviewed approved at the ICPPCC.

6 Training Activities (Criterion 1, 4, 6, 9 &10)

Infection Prevention and Control training mandatory sessions were delivered as outlined in the table below:

Teaching sessions	Frequency	Delivered by
Induction session for **all** new starters	Monthly	Presentation provided and reviewed by IPC team; supervised by education team. 100% attendance as it is mandatory to complete.
IPC Masterclass and IPC study day	Monthly	Presentation presented by the IPC lead surrounding current hot topics and findings.
Training for Foundation and Core Medical Trainees	Three times yearly	Education manage this with IPC supporting updates.
Update for qualified nurses in cardiac and thoracic directorate via e-learning	Annually	Standard e-learning package Mandatory requirement
Update for non-qualified nurses in cardiac and thoracic directorate via e-learning	Annually	Standard e-learning package Mandatory requirement
Hand hygiene update for all other clinical staff via Hand Hygiene week for practical plus e-learning	Annually	IPCT to complete- Hand hygiene awareness week and clinical education team complete session quarterly.
Training session for Housekeepers via e-learning	Annually	IPC team review and update training pack.
M. abcsessus essential training	Annually	Standard e-learning package. Updated by IPC team. Ad hoc teaching session via teams supported by IPC team.

Summary

The trust achieved 100% compliance for IPC training on induction for all new starters in 2022/23. Compliance with Infection Prevention and Control annual updates is a requirement for all staff for completion of their annual appraisals. All mandatory training data is shared to the management teams for them to manage and support is provided to increase training compliance. ESR training mandatory IPC training compliance is reviewed at the ICPPC Committee. Compliance for training for 2022/23 is:

CSTF REQUIREMENTS (EXC STARTERS IN LAST 3 MONTHS)	AS AT 31.03.2023		
UPDATED COMPETENCY	**No. Required**	**No. Compliant**	**% Compliant**
Infection Prevention and Control - Level 1	1931	1769	91.61%
Infection Prevention and Control - Level 2	1471	1236	84.02%

M. abscessus training was implemented in May 2021 for staff to complete via online training. This was to encourage all staff to have awareness and education in respect to *M. abscessus*. 2022/23 training continued to be monitored through ICPPCC:

EXCLUDING TEMPORARY STAFFING (CLINICAL)	**No. Required**	**No. Compliant**	**% Compliant**
M.Abscessus Training	1847	1457	78.88%

INCLUDING TEMPORARY STAFFING (CLINICAL)	**No. Required**	**No. Compliant**	**% Compliant**
M.Abscessus Training	2080	1539	73.99%

As part of our review of high surgical site infection rates an ANTT refresher training programme was developed and continued through to 2022/23. Results were monitored through the ICPPCC for 2022/23 which were:

ANTT	All staff groups	Compliance	Percentage
Total Staff (target group)	519		
Total Trained (target group)		496	
Total compliance (target group)			96%

7. Annual Programmes (Criterion 1-10)

IPC Annual Audit Programme and result 2022/2023 (Criterion 1-10)

Title	Frequency	Results 2022/23	
Hand Hygiene	Monthly	98%	
HII*	Monthly	94%	*High Impact Interventions HII1 – CVC insertion and ongoing care HII2 – PIV insertion and ongoing care HII4 – Prevention of surgical site infection HII5 – Ventilated patients HII6 – Urinary catheter insertion and ongoing care HII8 – Cleaning and decontamination of clinical equipment
ANTT	Monthly	94%	
MRSA Screening	Yearly	97%	
Isolation	Monthly	65%	
Covid Passport	Monthly	Individual results to wards	
Vulnerable group and POU filter (*M. abscessus*)	Monthly	77%	
Commodes	Quarterly	Individual results to wards	**Summary: All audits are taken to the ICPPC for review and robust action plans completed so everyone has an overall insight. IPC and audit team work closely and share monthly reports to the clinical team.**
Raised Toilet Seats	Quarterly	Individual results to wards	
Sharps	Annual	91%	
Linen	Annual	94%	
Environment	Annual	94.5%	
Alcohol Gel	Annual	77% (re-audited and shared)	
Hand Hygiene technique	Annual	98%	
The Spinal Hospital	Annual	IPC support	
Waste	Annual	96%	
CVC BSI	Quarterly	See comments above	
Scrubbing and Gowning	Rolling		
Skin Prep	Rolling	96%	
National Surgical Audit (NICE guidelines)	Rolling	See comment under SSI.	

8. Influenza and COVID-19 Vaccine uptake for 2022/23 Season (Criterion 1, 10)

Headlines as at 16-Dec-2022;	Flu	Covid Booster
Number of RPH staff vaccinated (includes those vaccinated elsewhere but does not include OCS/Skanska/Volunteers)	1329	1271
% of eligible* RPH staff vaccinated (includes those vaccinated elsewhere but does not include OCS/Skanska/Volunteers)	59.7%	57.1%

	Flu	Covid Booster
% of eligible* RPH staff vaccinated – Clinical Roles	56.8%	54.0%
% of eligible* RPH staff vaccinated – Non-Clinical Roles	70.0%	67.6%

* Number of 'eligible staff' can change due to starters and leavers.
Bank/Locum staff are included but only those that have worked a shift at RPH in the last three months

	Flu	Covid Booster
Number of vaccinations administered at RPH	1669	1574

NB. will include vaccinations given to OCS, Skanska, Volunteers etc

Immunisation of frontline staff against influenza and COVID-19 reduces the transmission of infection to vulnerable patients. This year's flu programme was run by the Royal Papworth team and delivered from October 2022 to January 2023 in combination with the COVID boaster vaccine programme. The data is uploaded to UKHSA via the ImmForm system. There has been a decline in staff uptake from previous years. It is not clear why this is.

9. Inoculation injuries 2022/23

9.1 Annual quarterly figures

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2020/21	5	5	9	8	27
2021/22	9	8	11	22	52
2022/23	10	5	10	12	37

This year has seen a slight reduction in sharps injuries reported from previous year (where there had been an increase) but it is still above the rates recorded in 2020/21. In 2022/23 OH have upgraded their OH system and it is anticipated will enable improved reporting for 2023/24.

9.2 Areas reporting Incidents

Needlesticks incidents by directorate 2022/23	22/23 Q1	22/23 Q2	22/23 Q3	22/23 Q4	Total
Cardiology	1	0	2	2	5
Cath Labs	0	0	3	1	4
Surgical	1	0	1	2	4
Theatres, Critical Care and Anaesthesia	6	4	1	4	15
Thoracic	1	1	1	1	4
Transplant	1	0	1	1	3
Other (nursing & R&D)	0	0	1	1	2
Total	10	5	10	12	37

This data shows areas where sharps injuries have occurred and the higher rates of injury are theatre, critical care.
Themes and incidents are reviewed in the health & safety committee. All departments have undertaken a risk assessment in respect to safer sharps and training in the use of safer sharps has been provided to areas as required.

Additional Occupational Health Covid-19 activities

In 2022/23 Occupational Health department continued to provide support on the Covid risk assessment Version 7 individual risk assessment process and guidance for staff with individual health vulnerabilities, advice for staff on reactions with personal protective equipment and skin assessments. Covid work is now being integrated into the core occupational health activities through management referral and pre-appointment screening processes.

10. Risk associated to IPC

There is always risk associated to IPC and these are monitored through the ICPPC committee and QRMG. Any emerging risk and escalation from ICPPC committee goes to the Quality Risk Management group. There are two main overarching risk which are reviewed and updated monthly as a board assurance risk. One is the risk to patient if RPH fail to protect patient from harm from hospital acquired infection and the other is regarding the outbreak of M.abscessus and the risk to patient whom are vulnerable to this infection.

11. Summary of key areas for this coming year

The IPC team are committed to work with all departments and services to maintain a safe environment for patients, staff and visitors. As 2022/23 ended we look forwards to 2023/24 and areas that the IPC team will continue to focus attention on are:

- Continue to complete a gap analysis of the Hygiene code and complete the new updated IPC national board of assurance (BAF) framework. To support this work and improve our compliance where it was identified as partial or non-compliant:
    - Work closely with the decontamination lead to improve the endoscope services and maintain safe sterile service by reviewing our Policy, completing a full audit of the endoscope and following up of actions and introducing appropriate training materials of the team.
    - Enhance assurance reports to the ICPPC committee from water safety, ventilation safety, by full engagement from the Estates team, completion of a yearly audit and follow up on actions. Appointing an AE for ventilation to support the safety group and develop a Ventilation safety plan.
    - Occupational Health team to provide assurance report to ICPPCC quarterly- by working closely with the team.

  - To fully implement the new 2021 national cleaning standards entirely at Royal Papworth Hospital NHS Foundation Trust by attending regular audit and developing a cleaning standard meeting.
  - Support and work alongside the health & safety committee to maintain staff safety and developing IPC within the patient safety framework.

- Continue working with the SSI stakeholder group to improve the surgical site infections rates. Ongoing work which will include:
  - Invite and visit external experts to support our ongoing work related to SSI.
  - Increase the IPC environment rounds.
  - Support the SSI surveillance team and increase surveillance to a wider group, including all cardiac patient and patients having sternotomy surgery.
- Management and maintain safety mitigation throughout RPH with M.abscessus by:
  - The executive corporate group will continue to monitor for a further 6 months and then review.
  - Use the risk assessment completed and work on the actions and risks identified to maintain safety.

12. References and resources

IPS & NHS Improvement (Nov 2017) 4th Ed of Saving Lives: High Impact Interventions,

Department of Health (2015), Health and Social Care Act 2008, Code of practice on the prevention and control of infections and related guidance

Department of Health (2003), of the Chief Medical Officer's strategy for infection control (*Winning Ways: working together to reduce healthcare associated infection*)

NHS Improvement & Infection Prevention Society (2017) High Impact Interventions: Care processes to prevent infection. 4th Ed

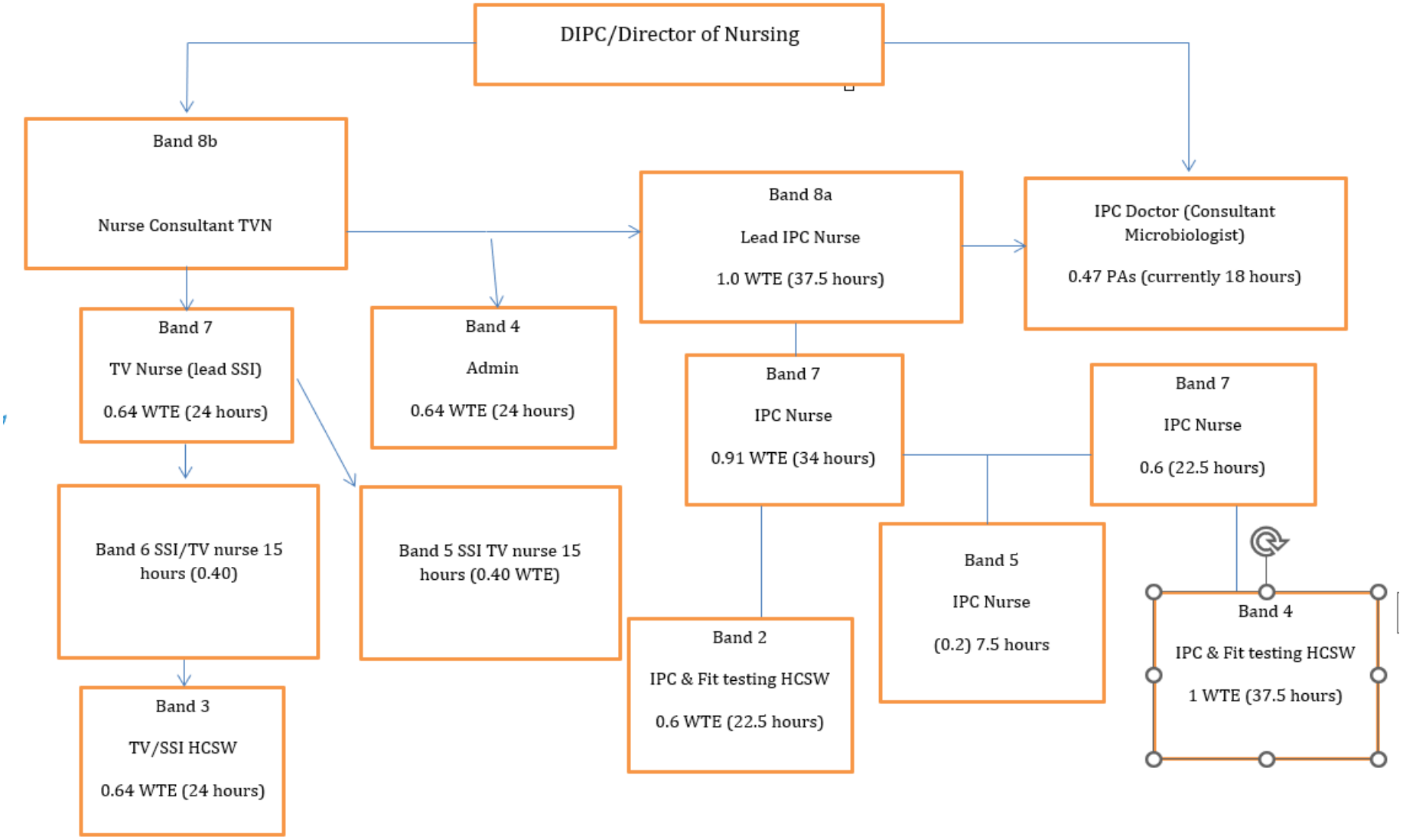
Public Health England 2017. Guidance, Health matters: preventing infection and reducing antimicrobial resistance. [ONLINE] Available at: https://www.gov.uk/government/publications/health-matters-preventing-infections-and-reducing-amr/health-matters-preventing-infections-and-reducing-antimicrobial-resistance [Accessed May 2018]

***Appendix 1**: The requirements of the Health and Social Care Act (2008) updated in this report in line with revised guidance issued July 2015.*

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure 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 facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

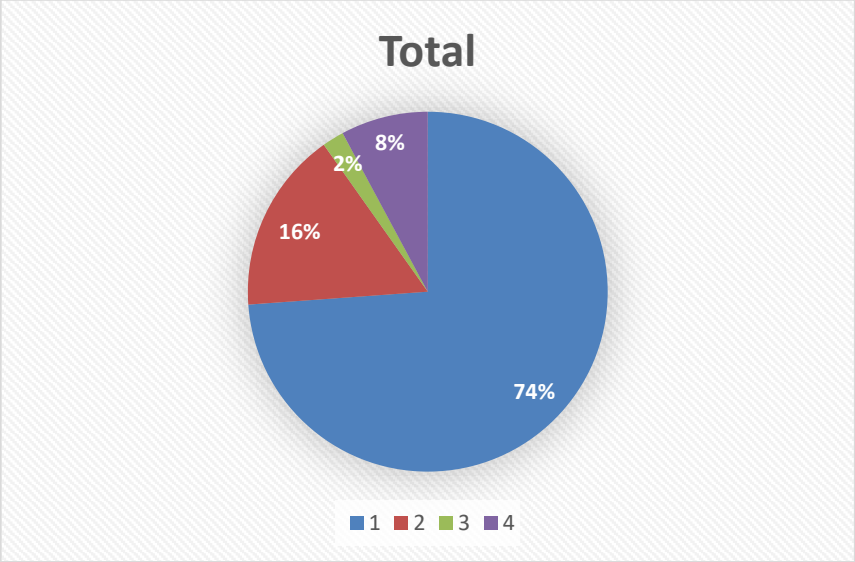
Appendix 2

Infection Prevention & Control Team (Criterion 1)



Appendix 3- Hygiene Code Gap Analysis

	Compliant	Partial compliance	Non-compliance	Not Completed
Criterion 1	26	3	1	**0**
Criterion 2	12	3	0	**1**
Criterion 3	3	2	1	**0**
Criterion 4	10	3	0	**0**
Criterion 5	2	0	0	**0**
Criterion 6	0	3	0	**0**
Criterion 7	2	0	0	**0**
Criterion 8	1	2	0	**0**
Criterion 9	54	8	1	**0**
Criterion 10	3	1	0	**10**
Total	**113**	**25**	**3**	**12**



- Blue- compliant
- Red- partial compliant
- Purple not completed
- Green – Non- compliant.

Appendix 4-

2022/23 write up:

Patient Led Assessments of the Care Environment (PLACE) Programme 2022
All healthcare providers are required to take part in the national Patient-Led Assessment of the Care Environment (PLACE) annual inspections. PLACE is a national self-assessment tool designed to measure standards of;

- Cleanliness,
- Food comprising Organisation Food and Ward Food
- Privacy, Dignity & Wellbeing,
- Building Condition, appearance & maintenance,
- Dementia friendly environment
- Disability friendly environment

The Health & Social Care Information Centre (HSCIC) provide comprehensive guidance on the organisation and conduct of assessments and separate guidance documents for staff assessors and patient assessors. PLACE assessments are carried out by internal and external assessors within inpatient facilities and the surrounding patients assessed environment. Assessors include Governors, Volunteers, Trust members and representatives from the Trust's facilities contractors. Staff areas and clinical treatments are excluded from this assessment.
The tables below demonstrate the Trust performance against the national average. The Trust has scored above the national average in the following areas: cleanliness; food including organisation food and ward food; condition, maintenance and appearance, dementia and disability, demonstrating that the new site is of an exceptional standard.

Area	2022/23 Site Scores	2022/23 National Average	Comments
Cleanliness	**99.1%**	98.0%	The Trust's cleaning service OCS are continuing to uphold high levels of site management. They have maintained staff numbers throughout the year. The audit results show cleaning has this year scored above the national average.
Food (comprising Organisation and Ward Food)	**94.8%**	90.2%	Food scores are high for this year following a high level of input between Trust and OCS teams to ensure patient food quality is of a high level. In efforts to improve the training/education/ management of the Housekeepers, the Trust has employed a Patient Catering Manager. The role of the Manager aims to assist with development of housekeeping staff skills such as presentation, allergen understanding and service times to maintain an effective housekeeping relationship, which in turn will allow us to deliver a more efficient food service to our patients.
Organisation Food	96.9%	91.0%	
Ward Food	93.38%	90.3%	
Privacy, Dignity & Wellbeing	**85.6%**	86.1%	The score for this year is slightly below national average – this is largely due to the site not scoring in some categories where services don't exist, such as Children's Services. The introduction of single en-suite rooms, enhanced patient entertainment systems and a more patient focused care environment has however improved on scoring from the previous Royal Papworth site. .
Condition, Appearance & Maintenance	98.3%	95.8%	The Trust continues to focus in this area with PFI partners to maintain the condition and maintenance of the site, particularly focusing on clinical areas. It is essential and remains a priority for the Estate and Facilities team that we continue to deliver a safe and well-maintained environment for our patients and visitors.
Dementia	79.8%	79.2%	The Trust has maintained similar scores to national average in the Dementia-friendly element, and works with advisors to review and improve where opportunity exists.
Disability	84.7%	82.5%	

Action Plan

A few minor issues relating to cleaning and maintenance were brought up in the feedback session. Due to the regular Patient Environmental rounds the issues identified during the PLACE audit were successfully captured and completed.