

## Board of Directors (in public)

### Item 2.3a

**Subject:** DIPC (Director of Infection Prevention and control) /HCAI framework  
Report Q1 (April- June 25)  
**Date of meeting:** 23<sup>rd</sup> September 2025  
**Prepared by:** Nicola Best (Lead Infection Prevention and control nurse)  
**Presented by:** Mr Manoj Kuduvalli (Director of IP&C)

BAF Ref	Impact on BAF
BAF 1	Assurance on the infection prevention and control measures in place

## 1.0 Executive Summary

This paper provides information and an update on infection prevention and control issues for the 1<sup>st</sup> quarter of this financial year, 1<sup>st</sup> April until 30<sup>th</sup> of June 25. Previous reports have covered the period up to the end of March 2025.

This paper provides assurances that surveillance systems, audit and governance programmes are in place to monitor and prevent healthcare associated infections. The rates of reportable infections remain relatively low. A number of audits have been performed across the Trust which have identified some issues and actions have been taken to address these.

Working groups are in place to monitor and improve specific issues related to the prevention or management of infection including cleanliness, sepsis management, antimicrobial stewardship and surgical site infections.

## 2.0 Background

High standards of infection prevention and control are essential to ensure that people who use health care services receive safe and effective care. The *Health and Social care Act 2008: Code of Practice on the prevention and control of infections* identifies that good organisational processes and a robust assurance framework are essential to ensure effective infection prevention and patient safety.

In order to demonstrate that infection prevention is integrated into the assurance framework one recommendation is that the Board of Directors receives regular updates from the infection prevention and control team, including information on alert organisms, outbreaks, cleanliness standards and audit information. This report provides such an update.

### 3.0 Surveillance

There is a requirement that bacteraemias (blood stream infections) caused by certain bacteria and also Clostridiodes difficile infections are monitored and reported to UKHSA (UK Health and Security Agency) on a monthly basis.

NHS England have set thresholds for each Trust for the reduction of C. difficile infections and E coli, Klebsiella and Pseudomonas bacteraemias. Thresholds set for LHCH are some of the most ambitious in England, even when taking into consideration the number of admissions/bed days. Details are in the table below.

In addition to the mandatory reporting the Infection Prevention team continuously monitor and carry out surveillance on antibiotic resistant organisms or particular organisms of concern.

#### 3.1 Mandatory Reporting – Bacteraemias (Blood cultures)

	Attributable cases April to June 25 (Year to Date-Trust attributable)	Threshold
Methicillin Resistant Staphylococcus aureus (MRSA) bacteraemias	0 (0)	0
Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemias	4 (4)	7 (internal set threshold)
E coli bacteraemias	2 (2)	5
Klebsiella sp. bactereamias	1 (1)	4
Pseudomonas aeruginosa bacteraemias	1 (1)	1

Post infection reviews have been undertaken for all these patients, in conjunction with the relevant staff from each division. Probable causes of the bacteraemias were found to be intravascular line related infections, urinary tract infections, cholecystitis and pneumonia.

Reviews and learning points have been discussed at the relevant divisional meetings. A working group has been set up to review guidelines and practice related to ventilator associated pneumonia on the Critical Care.

### 3.2 Mandatory Reporting - Clostridioides difficile Infection

	Attributable cases April-June 25 (Year to Date)	Threshold
Clostridioides difficile infection (C. difficile toxin positive)	0 (0)	2

### 3.3 Carbapenemase Producing Enterobacterales (CPE) cases.

There were 8 patients with CPE in this time period, however all were known to be positive on transfer from other Trusts or were identified on admission, therefore not Trust attributable. They were all isolated in accordance with Trust policy.

### 3.4 MRSA cases (all isolates)

12 patients were identified as MRSA positive in this time period, all were identified pre or on admission, therefore not Trust attributable. The patients were isolated in accordance with Trust policy.

### 3.5 Respiratory Viruses

A number of patients tested positive for respiratory viruses in this time period.

1 patient tested positive for Influenza A on admission.

3 patients tested positive for SARS-CoV2. All were isolated in accordance with Trust policy

### 3.6 Norovirus

There were no patients identified with Norovirus in this time period.

## 4.0 Audit programme

An annual audit programme has been developed and a number of audits completed to provide assurance of compliance with national infection prevention and control standards. The following audits have been carried out by Infection prevention nurses.

Audit	Score	Actions
Infection Prevention and control standards (including kitchen linen, waste, decontamination of equipment, sharps disposal)	86-100%	All clinical areas were audited. Results, feedback and individual action plans were provided for each area.
Compliance with Critical Care screening policy	98%	Results feedback to Critical Care
MRSA screening audit	93%	Results and policy reminders were given to relevant areas

The matrons and ward staff have carried out audits of practice related to peripheral lines, urinary catheters and hand hygiene. Results have been feedback to individual staff and relevant areas.

## 5.0 Cleanliness audits

An audit tool and programme to monitor cleanliness across the Trust has been developed in line with the National Standards for Cleanliness. A multi-disciplinary group including Infection prevention nurses, Matrons and Hygiene service supervisors have performed the audits in the clinical areas, ensuring a collaborative and standardised approach to monitoring cleanliness. The average scores across the Trust, for each month are given below.

	April	May	June
Clinical areas/wards audited by multidisciplinary team.	12	12	12
Average score	97.4% (Range 93.2-99.5%)	98.4% (Range 96.6-100%)	98.6% (Range 94.1-100%)

Areas are given a star rating depending on the score and the risk category for that area. All clinical areas were awarded 4 or 5 star ratings.

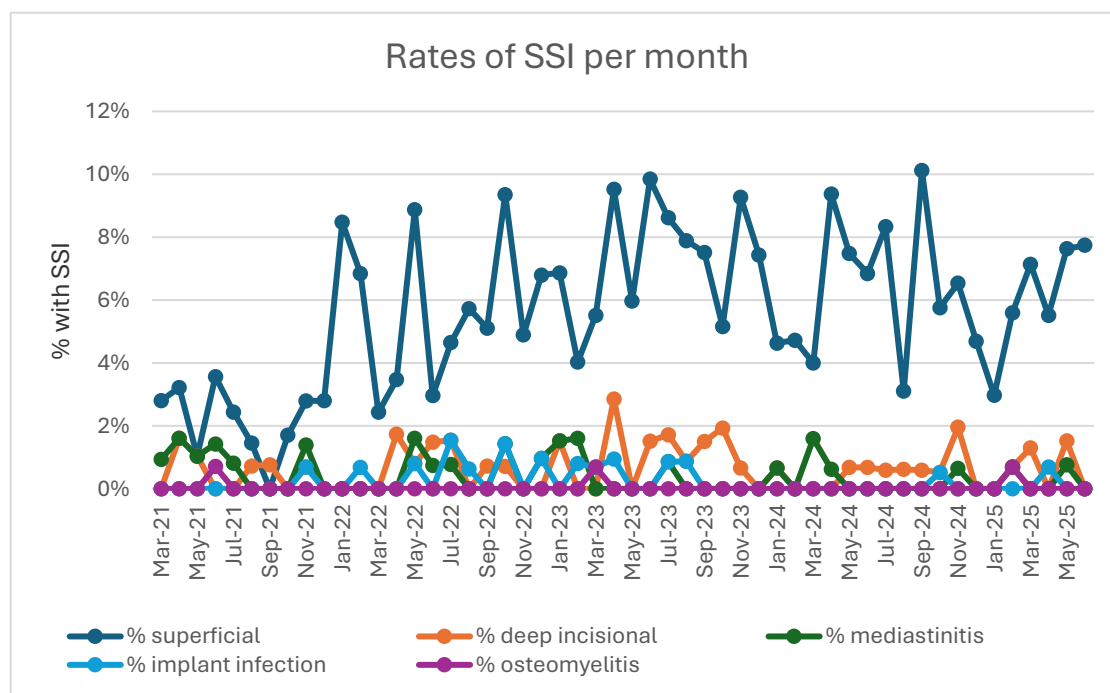
Some departments provide LHCH services but their cleaning services are provided by LUHFT e.g. Outpatients, Radiology, Pulmonary Function. There have been some issues noted in the past but there is now a joint monitoring programme with LHCH hygiene department.

## 6.0 Surgical Site Infection (SSI)

The Infection prevention team have a robust surveillance system for the continuous monitoring of SSI following cardiac surgery. Data on all patients undergoing cardiac surgery is collated every month and categorised into different classifications of infections i.e. superficial, deep incisional, mediastinitis, implant infections, osteomyelitis.

The SSI prevention group meets regularly and has an ongoing action plan to improve SSI. Data is presented to the Infection Prevention Committee and the Surgical Governance Committee.

Reviews of the severe infections (deep, mediastinitis, implant, osteomyelitis) are undertaken to identify if there are any trends or learning points. The rates of severe infections have reduced over the last 2 years.



Data on infections related to thoracic surgery has been collated and will be presented and discussed at the thoracic surgical meeting in September.

## 7.0 Antimicrobial Stewardship

Microbiology ward rounds continue each week with a multidisciplinary team. Antibiotic compliance audits have been performed and results fed back to relevant committees and to prescribers via the educational lead.

## 8.0 Sepsis

A sepsis group meets quarterly to monitor compliance, identify areas of challenge, and aims to continually improve all aspects of sepsis management and care. There is ongoing monitoring of compliance with key performance indicators on a weekly basis. The overall average scores for the quarter are given below.

Standard	Compliance April – June 25
Blood cultures taken prior to antibiotics.	94 %
Antibiotics within 1hr of a screen that identifies a possible high risk of sepsis.	93 %
Antibiotics within 3hrs of a possible high risk of sepsis	95 %

Individual cases where targets aren't met are reviewed by the sepsis team with learning fed back to departments / individuals involved.

## 9.0 Summary

The surveillance of infections continues to be monitored, and all reportable infections are reviewed to identify any trends or learning points, which are shared with relevant committees and groups. Work is ongoing to ensure the infection prevention quality and safety plan is fulfilled and that a robust audit programme is in place.

A number of working groups have been established to oversee issues related to the prevention or management of infection including the Cleaning Group, Sepsis Group, Antimicrobial stewardship

Group and Surgical Site infection Group. Each of these have their own audit schedule and action plans.

## **10.0 Recommendations**

The Board of Directors is asked to note the contents of this report, the ongoing work and the continued relatively low incidence of reportable infections.