Infection Prevention and Control

Annual report 2022/23

Lead Author, Angela Powell, Head of Infection Prevention and Control

On behalf of Julie Pearce, outgoing Chief Nurse, Executive Director of Quality and Caring Services (Jane Eades Deputy Director of Nursing and Quality)

Marie Curie

Contents

Executive summary

1. The Infection Prevention and Control Report, reports on infection prevention and control (IPC) activities within Marie Curie between 1 April 2022 to 31 March 2023. Publication of the IPC Annual Report demonstrates good governance, adherence to the standards we set in the organisation and our accountability to our stakeholders.
2. Marie Curie reports on the following organisms however there is no mandatory requirement to do so: Methicillin Resistant Staphylococcus aureus, Methicillin Sensitive Staphylococcus aureus, Clostridioides difficile and gram-negative blood stream infections (e.g., Escherichia coli).
3. During 2022/23 there were zero MRSA and E. Coli bacteraemia. There was one Methicillin Sensitive Staphylococcus aureus bacteraemia reported from Marie Curie Hospice, Newcastle in December 2022.
4. There was one case of Clostridioides difficile infection reported this year. The case was subject to a post infection review which revealed it was unavoidable and no lapse in care identified. This was a reduction in numbers reported in 2021/22 when three were recorded.
5. 70 in-patients tested positive for COVID-19 in 2022/23 (35 of these were not acquired in our care – community acquired). 16 cases were acquired in our care (healthcare acquired) compared to 38 cases acquired in our care in 2021/22.
6. 20 outbreaks of COVID-19 were reported in our services this year (14 in 2021/22). Post infection reviews were conducted after the outbreak was closed and key learnings shared across the organisation. There were also eight clusters of infection with COVID-19 during the same period. A total of two patients and 42 staff were affected as a result of COVID-19 clusters across both hospice and community settings.
7. A sepsis working group worked collaboratively with the UK Sepsis Trust throughout the year to develop a community Sepsis tool and training package for staff. The tool and training are being piloted in two place-based regions within Marie Curie before evaluation and roll out to all community staff in 2023.
8. IPC link nurses audited standard infection control precautions and transmission-based precautions over the year to assess clinical practice. Audit submissions for the community teams made a slight improvement this year due in part to improvements in the audit tool. To assist the process and make further improvements, a new guidance document has been produced for place-based teams.
9. Antimicrobial Stewardship (the steps we take to measure and improve how antibiotics are prescribed by clinicians and used by patients) is undertaken locally to ensure compliance with prescribing policies. Audits are also locally driven utilising the local acute tool. Results, actions, and recommendations are discussed at local governance groups. Work is underway nationally to develop one audit tool for use across our hospices. This will be launched in 2023/24. Results from the audits will allow for a national overview of prescribing practices/trends within all Marie Curie Hospices with opportunities for shared learning and improvement in practice.
10. Compliance with online IPC training is set at 95% by Marie Curie. Some hospices are showing figures below this target (64-96%). Challenges in hospice data have been identified relating to accreditation of prior learning for contingent workers. Low compliance scores are followed up by our Learning and Development team.
11. Influenza vaccinations for staff recorded as 26.73% on our reporting system (Oracle) this year. This system does not align to the NHS system and staff have to input vaccine history directly into their profile on Oracle. We know that not all staff remember to record this information and therefore this figure will not be an accurate representation. Last year locally held records gave a more accurate total. 2021/22 showed an uptake of 65%. A targeted strategy to improve input by staff is planned for the coming year.
12. National Standards of Cleanliness Group have been working on producing updated documents in line with national standards and will be launching in 2023/24.

Forward by Jane Eades Acting Director of Infection Prevention and Control (DIPC) and Angela Powell, Head of Infection Prevention and Control

It has been a privilege to take over as DIPC from Julie Pearce, Director of Infection Prevention and Control who was responsible for the work detailed in this annual report.

2022/23 has been a year of transition as we have moved through the pandemic back to a more normal business as usual approach. Changes have occurred at different rates both nationally and locally across the four nations and staff have continued to be adaptable and patient during this time, to ongoing restrictions.

Outbreaks of infection have continued to occur within our services, but they have been managed well and staff have remained resilient and worked tirelessly to ensure our patients are kept safe and cared for.

Both I (as Director of Infection Prevention and Control) and the Head of IPC once again give you our heartfelt thanks for your dedication and commitment to infection prevention and control in helping to reduce the number of healthcare associated infections overall this year; and a special thank you goes to the IPC link nurses who play a key role in delivering the service. This year we have seen further reductions in the number of COVID-19 cases acquired within our in-patient services from 38 in 2021/22 to 16 in 2022/23, despite outbreaks of infection occurring. We have also seen a downward trend in the number of Clostridioides difficile infection cases from three to one.

On a cautious note, however, we must remember that the threat of the pandemic has diminished but it has not been removed. It is vital over the coming year that we all remain vigilant and continue to maintain and improve our IPC practices by adhering to national guidance and standards, by measuring our compliance through audit and focusing our efforts on preventing infection as part of our role in antimicrobial stewardship. Vaccination has played an important part of being able to transit back to pre-pandemic arrangements and we encourage everyone to take up the offer of any COVID-19 booster that is offered and to receive the annual flu vaccination to keep you and others safe.

We will continue to provide strategic support on all aspects of IPC to enable teams to operate at a local level and work in collaboration to deliver the ambitions of the 2023/24 IPC work programme.

We look forward to what we can achieve together.

1. Purpose

The purpose of this report is to provide assurance to the Board of Trustees that systems and processes are in place within Marie Curie services to prevent and control infections.

The *Infection Prevention and Control Annual Report* outlines the activities undertaken during the period April 2022 to March 2023 as part of the work programme to prevent, control and manage infection within Marie Curie.

1.1 Recommendation

For the Quality Trustee Committee (QTC) to receive this report prior to approval by the Board of Trustees.

2. Compliance with regulators

Marie Curie has ten place-based regions with nine hospices and 11 community nursing services across the four nations and is regulated by six different regulatory bodies.

2.1 England

The Care Quality Commission (CQC) inspects hospices and community services in England.

The CQC assess IPC standards against the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health and Social Care, December 2022) which contains the ten criteria that healthcare providers are assessed against. No services were inspected during 2022/23.

2.2 Wales

The Healthcare Inspectorate Wales (HIW) inspects hospices in Wales and the Care Inspectorate Wales (CIW) inspects the community services. Both regulators assess IPC standards against the Care Standards Act 2000 and national minimum standards. There were no inspections in 2022/23.

2.3 Scotland

Healthcare Improvement Scotland (HIS) inspects hospices in Scotland and Care Inspectorate Scotland (CIS) inspects community services. HIS and CIS assess IPC standards against the National Health Services (Scotland) Act 1978, Healthcare Improvement Scotland (Inspections) Regulations 2011, Health and Social Care Standards 2018.

The Marie Curie Nursing Service in Scotland is registered with the Care Inspectorate Scotland as both a care-at-home service and a nurse agency. The Marie Curie Hospices in Scotland are registered with Healthcare Improvement Scotland (HIS). The Care Inspectorate undertook an announced (short notice) inspection for Scotland South on 6th May 2022. The report did not identify any areas for improvement from an IPC perspective.

2.4 Northern Ireland

The Marie Curie Nursing Service in Northern Ireland and Marie Curie Hospice, Belfast are registered with the Regulation and Quality Improvement Authority (RQIA). The RQIA assess IPC standards against the Independent Healthcare Regulations (NI) 2005, the Regulation and Improvement Authority Regulations (NI) 2011 and the Department of Health, Social Services and Public Safety Minimum Care Standards for Independent Healthcare Establishments 2014 (Standard 20 IPC) which contains the criteria that healthcare providers are assessed against.

An inspection of Marie Curie Hospice, Belfast took place in February 2023. Infection prevention and control was an area of focus for the inspection. All standards were met, and no areas of improvement were identified.

2.5 Monitoring arrangements

Infection Prevention and Control is monitored via:

- Quarterly Infection Prevention and Control Committee meetings.
- Executive Leadership Team Quarterly Board review.
- Quarterly Quality Trustees Committee.
- IPC Annual Report to the Board of Trustees.

3. Infection Prevention and Control (IPC) governance arrangements

Accountability for IPC sits with the Chief Executive who delegates responsibility to the Director of Infection Prevention and Control (DIPC). The DIPC in 2022/23 is the Chief Nurse, Executive Director of Quality and Caring Services who reports to the Board of Trustees.

The Head of IPC provides specialist advice to all clinical and non-clinical staff throughout the organisation and works closely with the DIPC, Senior leaders, clinicians and managers who have responsibility for operational support, clinical governance, and risk management.

A link nurse network is also in place (facilitated by the Head of IPC) consisting of clinical champions from both the hospices and community across the place-based services. The network is a forum that meets monthly and provides peer support and an opportunity to share information and good practice, exchange ideas and discuss issues or concerns.

Advice, guidance, and education is provided to the group by the Head of IPC which is then disseminated within the place-based teams by the link nurse who acts as a local resource.

Figure 1 Marie Curie Caring Services IPC accountability

Chief Nurse, Executive Director of Quality and Caring Services (Director of Infection Prevention and Control)
Head of Infection Prevention and Control
Registered managers for Clinical Services
IPC link nurses
Registered healthcare professionals

3.1 The Infection Prevention and Control Committee (IPCC)

The Infection Prevention and Control Committee (IPCC) is the main forum for discussion concerning changes to and approval of policy and practice relating to IPC. The membership of the committee is multi-disciplinary and includes representation from across the organisation. The committee is chaired by the Director of Infection Prevention and Control and meets every 12 weeks.

The Head of IPC presents the IPC Quarterly Report outlining surveillance data on monitored healthcare associated infections (HCAIs) such as Clostridioides difficile infection, MRSA, MSSA and E coli bloodstream infections along with outbreaks of infection. The report also highlights any topical IPC issues and incidents occurring in clinical practice.

The IPC Annual Report is submitted to the Board of Trustees.

The reporting structure is outlined in figure 2.

Figure 2 IPC Governance arrangements

Board of Trustees (BT)
Quality Trustees Committee (QTC)
Executive Leadership Team Quarterly Board Review (ELTQBR)
Caring Services Integrated Performance
Infection Prevention and Control Committee (IPCC)

4 Serious incidents

There have been two IPC incidents classed as serious incidents within our care. One was for a patient where COVID-19 was recorded on their death certificate and one for a patient who developed an MSSA blood stream infection. Both incidents were investigated thoroughly, and findings presented to the Marie Curie serious incidents learning panel. Learning from both cases have been shared locally and more widely to other clinical teams.

5. IPC work programme/Assurance Framework

The IPC Committee monitors progress quarterly against the IPC work programme to ensure assurance is provided to the Board of Trustees. During 2022/23 all 32 elements of the programme were met except for three areas which relate to audit compliance and staff vaccination where work is still in progress and has been incorporated into the work programme for 2023/24.

The IPC work programme (separate document and available on request) outlines the key objectives to deliver robust infection prevention and control standards across all areas within Marie Curie for the period April 2023 to March 2024. It will function as Marie Curie's HCAI (Healthcare Associated Infection) improvement plan with progress being monitored by the Infection Prevention and Control Committee and the Quality Trustee Committee.

6. IPC link nurse network

During 2022/23 the IPC network continued to develop across the Caring Services Directorate. There are now 33 IPC link practitioners in the ten place-based regions who cascade information received at the monthly IPC link meetings facilitated by the Head of Infection Prevention and Control. New guidance, updated policies, audit, national publications and a monthly update by the Head of IPC are some of the areas covered.

This forum is held virtually allowing both hospice and community staff to attend. It has continued to provide a vital means of communication between the link practitioners to provide peer support, encourage the sharing of good practice or lessons learnt from incidents, discuss challenges or concerns and to ask questions about any IPC issue.

Development of the link practitioner role will continue with the provision of an educational session to update knowledge on IPC topics.

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7. Response to the COVID-19 pandemic

During 2022/23 Marie Curie has continued to respond to the changing requirements as the nation has moved forward through the pandemic.

The Head of Infection Prevention and Control has supported the organisation with expert advice and interpretation of guidance from national bodies (e.g., UKHSA). The Next Steps guidance outlined plans for the move back to pre-pandemic arrangements and local place-based teams responded accordingly, taking into consideration pace of change within their local services. Further publications supporting the transition back included the National Infection Prevention and Control Manual (NHS England, July 2022). Marie Curie IPC policies were updated to reflect the updated guidance and made available to all staff via the intranet.

Due to the success of the COVID-19 vaccination programme across the UK and the continual drop in cases nationally, a pause to asymptomatic testing in England from 31 August 2022 was announced and in Wales from 8 September 2022. MC responded by ensuring staff received the information to implement within their services. Scotland and Northern Ireland have also now suspended asymptomatic testing.

As a result of moving forward the pandemic group (established at the beginning of the pandemic in March 2020) took the decision to step back weekly meetings, initially to every 2 weeks and then to monthly as the need decreased. The Caring Services designated pandemic inbox, also established at the beginning of the pandemic, stopped being used by staff who instead gained advice and support from the local place-based management team or the Head of IPC directly. The COVID-19 intranet page was kept up to date so that staff could access up to date information from this source as well.

To support the local teams leading into the winter period, a scoping exercise was conducted to identify current practice regarding COVID-19 measures in place. Results showed variation in practices across all four nations. To ensure consistency across the charity, local teams were requested to undertake a local risk assessment for the management of seasonal respiratory infections based on the practical

steps document from NHSE, which enabled them to identify where action was needed (including stepping down of universal masking).

Outbreaks and clusters of COVID-19 infection that occurred were managed collaboratively with the local management team, Marie Curie's Head of IPC, and local public health bodies where needed, to ensure that appropriate and timely actions were taken to contain and mitigate against further transmission of infection. To identify and share any lessons to be learnt from the outbreaks, post infection reviews were undertaken following closure of the outbreak.

8. COVID-19 Board Assurance Framework

NHS England developed an Infection Prevention and Control Board Assurance Framework in May 2020, to support providers to effectively self-assess compliance with Public Health England (PHE now UKHSA) and other COVID-19 related IPC guidance and to identify risks. The framework was originally structured around the ten criteria of the code of practice on the prevention and control of infection and related guidance, and local teams were asked to complete for their services to identify areas for improvement.

During 2022/23 the framework was updated in line with changing guidance and evidence. The most recent version was published in March 2023 and is now entitled the National Infection Prevention and Control Board Assurance Framework which is to be used by providers to 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 IPC guidance issued by the UK Health Security Agency (UKHSA).

The framework is not compulsory, and it relates to England only – however Marie Curie made the decision to use the framework across all place-based areas to provide assurance that good practice is in place and standards are being met. This has been disseminated to place-based teams to complete with the support from the Head of Infection

Prevention and Control and all will be reviewed at the IPCC.

9. Policies and procedures

There are a suite of IPC policies /procedures available to staff on the intranet that cover numerous IPC topics in line with national requirements. During 2022/23 work on updating the policies was a priority to complete, as the previous year the review date on the policies was extended due to the demands of the COVID-19 pandemic. Extra resources for undertaking this work were secured in Q2 and at the end of Q4 fourteen policies had undergone a complete re-write. They have now been published on the intranet for staff.

10. Healthcare Associated Infection (HCAI) surveillance (hospice only)

Surveillance helps to understand the prevalence, cost, and effects of Healthcare Associated Infection (HCAI). It is the foundation of good infection prevention and control practice and can help direct the focus to areas of concern. It can also aid the prevention and management of outbreaks through prompt recognition of one or more infections of "alert" organisms.

There are no national requirements for the surveillance of infection within Marie Curie. However, in line with best practice and the Marie Curie Surveillance and Reporting of Infectious Disease policy, we continue to monitor the acquisition of methicillin sensitive Staphylococcus aureus (MSSA), methicillin resistant Staphylococcus aureus (MRSA), Escherichia coli (E.coli) bloodstream infection (BSI), and Clostridioides difficile infection (CDI) as well as all other notifiable diseases (Table 2).

Table 2 indicates the number of key alert organisms.

Table 2. Number of key alert organisms

Key alert organism causing infections acquired following admission	Number of cases reported 2022/23	Attributable to Marie Curie 2022/23 (avoidable/ unavoidable)
Bloodstream infection		
MRSA bacteraemia (acquired within 48 hours of admission)	0	0
MSSA bacteraemia (acquired within 48 hours of admission)	1	1
E. coli bacteraemia (Acquired within 48 hours of admission)	0	0
Clostridioides difficile infection		
Clostridioides difficile Infection (CDI) toxin producing diarrhoea (Acquired within 48 hours of admission)	1	1 (Unavoidable)

The place based clinical teams are responsible for collecting and reporting the data via Sentinel, the complaints and incident logging and reporting tool used within Marie Curie. All reported acquisitions of HCAI are reviewed by the Head of IPC and where appropriate, a post infection review (PIR) is undertaken.

Investigations and post infection reviews are undertaken by the place based local team with the DIPC and Head of IPC on all cases of MRSA, MSSA, E.coli blood stream infections and CDI. PIRs are also undertaken on other HCAIs and notifiable diseases to identify causes where possible and to establish actions to prevent it recurring.

10.1 Clostridioides difficile toxin infection

Marie Curie Hospices only recorded one case of toxin producing Clostridioides difficile infection (acquired 48 hours after admission) at the Marie Curie Hospice, Newcastle. The case was reviewed by the Head of IPC to ensure that it was managed in line with the Clostridioides difficile policy. All cases of Clostridioides difficile infection are subject to investigation and a post infection review to determine if any learning or a change to practice is identified. The acquisition of Clostridioides difficile infection in this case was "unavoidable" and no lapse in care was identified. Learning was identified and an action plan was developed and monitored locally.

This is a reduction in the number of Clostridioides difficile infections occurring within our hospices. Last year (2021/22), three cases were reported. This supports compliance with antimicrobial prescribing guidance and clinical practice standards.

These numbers remain very low compared to the UK wide figures.

10.2 COVID-19

From April 2022 to March 2023, there were a total of 70 in patients who tested positive for COVID-19. In line with the NHSEI CNO letter May 19,2020 NHS England/Improvement, chief Nursing Officers Letter (Ref no: 001559), each case is subsequently categorized into one of four groups to identify where transmission may have occurred. Table 3 shows the number of cases per the categories of transmission. 16 cases were definite healthcare acquired (38 cases in 2021/22).

Table 3: Categories of transmission

Number of Cases	HCAI Category	Criteria
35 cases	Community-Onset	Positive specimen date <=2 days after admission to the hospice
11 cases	Hospice-Onset Indeterminate Healthcare-Associated	Positive specimen date 3-7 days after admission to the hospice
8 cases	Hospice-Onset Probable Healthcare-Associated	Positive specimen date 8-14 days after admission to the hospice
16 cases	Hospice-Onset Definite Healthcare-Associated	Positive specimen date 15 or more days after admission to the hospice

Figure 1 indicates by month when the patients tested positive.

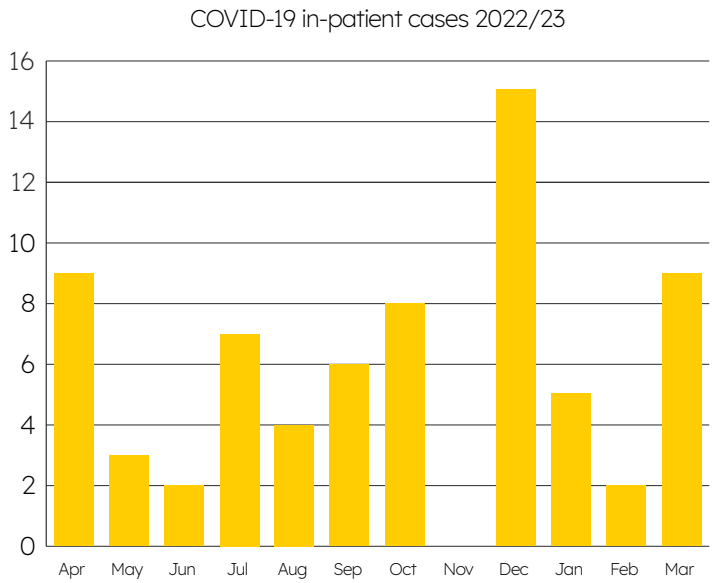
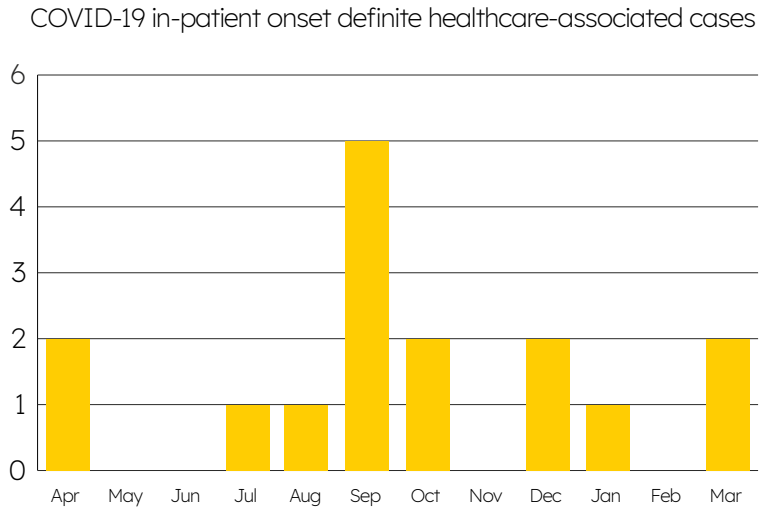


Figure 2 indicates the month the patient with a definite HCAI of COVID-19.



11. Incidents and outbreaks

COVID-19 outbreaks

Marie Curie had 20 outbreaks of infection with COVID-19 during the period April 2022 to March 2023. A summary table of the outbreaks, including the number of patients and staff involved and the status of the outbreaks as of 31 March 2023, are shown in Table 4.

There were also eight clusters of infection with COVID-19 during the same period. (A cluster is defined as two or more test confirmed cases of COVID-19 among individuals associated with a specific non-residential setting with illness onset dates within a 14 day period. (In the absence of detailed information about the type of contact between the cases).

A total of two patients and 42 staff were affected by the clusters of COVID-19 across both hospice and community settings.

Table 4: COVID-19 outbreak summary April 2022 - March 2023

Location	Date outbreak declared	Date closed	Number of patients affected	Number of staff affected
Cardiff and The Vale	04.04.2022	25.04.2022	0	4
Liverpool	07.04.2022	29.04.2022	7	11
Hampstead	06.04.2022	29.04.2022	1	6
Newcastle	29.04.2022	20.05.2022	3	6
West Midlands	21.06.2022	11.07.2022	0	23
Lincolnshire Rapid Response	01.08.2022	13.08.2022	0	11
Newcastle Hospice	09.08.2022	22.08.2022	3	9
Belfast	07.09.2022	30.09.2022	5	9
Bradford	27.09.2022	14.10.2022	1	10
Cardiff and The Vale	01.09.2022	15.09.2022	0	4
Bradford	21.10.2022	07.11.2022	0	5
Newcastle	20.10.2022	11.11.2022	2	3
Hampstead	25.10.22	03.11.2022	1	4
Caterham (MCNS)	28.10.2022	05.11.2022	1	2
Edinburgh	19.12.2022	06.01.2023	6	9
Hampstead	28.12.2022	07.01.2023	4	1
West Cornwall (MVS)	26.01.2023	10.02.2023	0	3
Hampstead	09.03.2023	25.03.2023	2	5
Hampshire MVS	22.03.2023	04.04.2023	0	4
Bradford	24.03.2023	06.04.2023	2	14

11.1 Learning from COVID-19 outbreaks

The critical learning themes arising from these outbreaks are shared for more expansive learning across the organisation.

Maintaining rigorous IPC oversight continues to be essential. Key learning from outbreaks include:

- regularly reminding staff not to attend work if symptomatic.
- staff to undertake Lateral Flow Device testing before attending work
- staff to only use facemasks supplied by Marie Curie
- early identification and recognition of symptoms to prompt testing
- paying attention to the maximum number of people allowed in rooms
- importance of adhering strictly to IPC measures
- adhering to PPE guidance prevented spread
- staff with outbreak fatigue – not accurately identifying / differentiating between disease related/COVID-19 symptoms
- differing rules between nations
- taking a phased approach to reducing restrictions.

11.2 Impact of outbreaks on the organisation

The impact of COVID-19 outbreaks on services has been variable. Both hospice and community teams have continued to work towards minimising the effects of an outbreak on their service delivery, taking immediate actions in response. Whilst managed carefully, there has inevitably been some disruption to admissions/referrals/service provision due to staff availability.

As we have moved through the pandemic this year and towards a business as usual approach, reducing universal masking restrictions within our hospices and social distancing has had an impact on some of the outbreaks and clusters seen amongst staff.

12. Patient safety alerts

There were no patient safety alerts for infection prevention and control published during this period.

13. Hospice Healthcare Associated Infection (HCAI) prevention plans

Marie Curie recognises that the effective prevention and control of HCAIs is essential to ensure that patients using our services receive safe and effective care. Effective infection prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. Good management and organisational processes are crucial to ensure that high standards of infection prevention and control are maintained.

During 2022/23, hospices were expected to develop and complete their prevention plans which reflected local and national priorities such as prevention of gram-negative bloodstream infections, antimicrobial stewardship, and compliance with IPC policy.

14. Sepsis

Sepsis, also referred to as blood poisoning or septicaemia, is a potential life-threatening complication of an infection or injury if it is not recognised and treated promptly.

A sepsis working group has worked collaboratively with the UK Sepsis Trust throughout the year to develop a community Sepsis tool and training package for staff. The tool and training are being piloted in two places within Marie Curie prior to evaluation and roll out to all community staff in 2023.

15. IPC quality improvement audit programme to ensure key policies are implemented

The infection prevention and control quality improvement audit programme is fundamental to providing assurance of compliance with IPC policies including Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) and practice within Marie Curie.

This ensures that:

- IPC is embedded into everyday practice.
- We reduce variation in IPC practice and standardise care processes.
- We can identify improvements required to achieve compliance with SICPs and the patient placement risk assessment elements of TBPs to reduce the risk of cross infection.
- We can improve the application of knowledge and skills in infection prevention and control.
- We can align practice, monitoring, quality improvement and scrutiny.

If non-compliance is identified, the place-based teams are responsible for devising an action plan to address this. The plan is then monitored at a local level via the governance arrangements in place. If there are challenges encountered in the delivery of the action plan at local level that hinders completion, then this is escalated to the national Infection Prevention and Control Committee for guidance.

Areas where actions are not progressed are invited to attend the Committee for additional support and advice.

15.1 Standard infection prevention and control precautions audits/TBPs audit

To provide an organisation wide approach to prevention of infection auditing, Marie Curie has adopted the use of the Scottish National Infection Prevention and Control Manual audit tools. These are used by the IPC link nurse working in the hospices to:

- Assess current compliance with each of the ten elements of Standard infection control precautions.
- Assess current compliance with the Patient Placement Risk Assessment element of Transmission Based Precautions.
- Identify any areas of non-compliance and devise improvement plans to address.

Hospices are required to provide SICP and TBP audit data to the local governance meetings and to the national Infection Prevention and Control Committee quarterly.

Audit submissions and results are monitored nationally by the Head of IPC and support offered where needed to make improvements.

During 2022/23, non-submission of data by hospices and Nursing Services was followed up and reasons established for this. For the hospices it was identified that:

- not all were using electronic tablets to input audit data and were instead using paper-based tools. This information was not being uploaded and therefore not included in the data pull at the end of the quarter.
- not all hospices were using standard audit tools but locally devised ones.

Audit submission from the community nursing teams has improved slightly this year resulting from changes made to the Hand Hygiene audit tool for community staff which is now in two parts (part 1 for self-assessment and part 2 as observation of practice).

Further work undertaken by the Head of IPC this year to improve the IPC audit process has included publication of a guidance document that advises staff:

- who should complete the audit
- how to access audit tools (with links to IQVIA)
- how to complete the audit and when (timetable)

- how many audits to return
- how to submit and
- how to write an action plan /escalate.

This guidance document has been distributed widely to support place-based teams to deliver the audit programme in the coming year.

15.2 Ongoing care of indwelling urinary catheter and vascular access devices audit

As part of the IPC quality improvement audit programme, link practitioners also undertook audits in in-patient areas to review the ongoing care of indwelling urinary catheters and vascular access devices as part of Marie Curie's commitment to supporting the reduction in the development of Gram-negative blood stream infections (GNBSI Reduction Plan – NHS Improvement 2017). Any areas identified for improvement were supported with a local action plan. Both audit tools were revised and updated this year to reflect standards required to be achieved.

16. Antimicrobial stewardship

Antimicrobial stewardship refers to a set of coordinated strategies to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes and reducing resistance to antibiotics.

Antimicrobial stewardship is a core responsibility for all Marie Curie hospices, particularly the Medical Director, Head of Quality and Clinical Practice/Head of Nursing and Pharmacy Leads. Their role is to take the lead on this to ensure antibiotic compliance and work together to ensure prescribing and use of antimicrobials is reviewed constantly. Feedback is provided to prescribers on inappropriate choices to improve appropriate usage and have better antimicrobial stewardship.

Currently, Marie Curie does not directly compare the results of every antibiotic audit as each hospice uses the local acute NHS Trust audit tool. Therefore, audit reports, actions and recommendations are discussed locally through appropriate governance groups.

During 2022/23 collaborative working between the Head of IPC, a Medical Director, and a Pharmacy Lead (Antimicrobial Stewardship team) commenced to review all the current audit tools in use across Caring Services. Following this benchmarking exercise along with a review of the NICE NG15 guidance on Antimicrobial Stewardship the team are now devising a bespoke antibiotic prescribing audit tool. This will be launched in 2023/24 across all hospices. The results from the audits undertaken will then allow for a national overview of prescribing practices/trends within all Marie Curie Hospices with opportunities for shared learning and improvement in practice.

Further work on antimicrobial stewardship education is planned for 2023/24.

17. Training and continuing professional development

Marie Curie education and training needs matrix contains the infection prevention and control requirements for all staff groups/disciplines. The Learning and Development team provide managers with information on compliance levels with the minimal of hand hygiene and infection prevention education every quarter.

17.1 Statutory and mandatory training

The tables below provide a summary of compliance with IPC mandatory training online for Caring Services. The target set by Marie Curie is to have 95% of staff trained. Where this is not met it is followed up with the Heads of Quality and Clinical Practice to action locally. In the case of Marie Curie Hospices Liverpool and Hampstead having low scores, action was taken locally with dedicated time being allocated for staff to complete their mandatory training. Learning and Development also promote IPC training on the intranet site when compliance figures fall below the expected compliance rates.

Table 5 Hospice compliance with mandatory IPC training

Hospice	Belfast	Bradford	Cardiff and The Vale	Edinburgh	Glasgow	Hampstead	Liverpool	Newcastle	West Midlands
Infection control – clinical	82%	98%	94%	91%	90%	72%	72%	98%	95%

Table 6 MCNS compliance with mandatory IPC training

MCNS	NEY NE	NEY Yorks	WLS	SOW	Mid	Scot SE	NTW	SOE	EST	Scot NW	LDN	Northern Ireland
Infection control – clinical	99%	99%	98%	95%	95%	95%	97%	97%	99%	98%	92%	95%

Table 7 Non-clinical staff training compliance with IPC training

	Compliance
Non-Clinical	96%

Line managers and senior managers are responsible for ensuring that staff have completed all mandatory training requirements. There is a clear escalation process which identified the timescale and responsibilities in relation to assuring compliance.

Apart from mandatory training, bespoke presentations and ad-hoc training sessions focussing on providing staff with specific training were delivered locally.

18. Occupational health

Occupational health services are provided by HML (Health Management Limited) an external company. All staff undergo an occupational health screen prior to commencing employment in Marie Curie. Referrals for occupational health support can be accessed by managers as required.

18.1 Staff influenza vaccination

During 2022/23 Marie Curie staff were offered free seasonal influenza vaccinations by national and local pharmacies and some NHS services (NHS Inform in Scotland). In Northern Ireland a list of participating pharmacies was shared from NI Direct, along with peer vaccination clinics in some Marie Curie Hospices. Staff are encouraged to receive the vaccine to reduce the risk of them contracting the virus and

impacting on their health as well as reducing the risk of transmitting the flu virus to patients in our care, colleagues, visitors, and their own family as well as staff absence impacting on service activity.

Promotion of the national flu campaign within Marie Curie was conducted by a national flu champions group that met regularly during the flu season supported by a comprehensive communications plan to encourage uptake. This plan was reviewed and enhanced regularly throughout the campaign.

Accurate data on this year's update figures has been challenging because of changes to the reporting agreed nationally. Previously uptake data was recorded by local teams using a MS Teams spreadsheet which changed to using the HR database Oracle reports only.

Oracle relies on staff recording their flu vaccine on their profile and despite supporting staff with this process by Flu Champions, managers, how to videos and regular communications, data recorded reveals low number of records. Monthly Oracle reports were shared with Flu Champions and a Q3 update was presented to the IPC Committee.

The overall Caring Services vaccination rate as of 31 December 2022 is 26.73%, compared to 65% in 2021/22. This is below national data on front line healthcare workers where uptake was 60.5%.

Of two hospices that maintained local records, vaccination rates were high.

At Marie Curie Hospice, Liverpool, local record data showed 92% vaccination rate whereas Oracle recorded 31% and at Marie Curie Hospice, Newcastle 90% was recorded versus Oracle record of 39%. This suggests that relying on staff recording their vaccination status on Oracle has not proved effective to monitor the impact of Marie Curie's annual flu vaccination programme. A targeted strategy to improve input by staff is planned for the coming year.

This year flu rates as anticipated post pandemic UK wide were high. A review of cold or flu sickness records showed a total of 1785 days lost compared to 1079 in 2021/22 for all Caring Services staff. This provides evidence as to why Marie Curie's flu vaccination programme remains essential to promoting the health of its staff and minimising impact on service provision of staff sickness from flu. This data will be flagged again at the beginning of the campaign next season to identify what improvements could be possible.

18.2 Staff COVID-19 vaccination

As part of ongoing national requirements, those individuals who are eligible for COVID-19 booster vaccinations are encouraged to receive this to protect themselves from acquiring the disease. This is then recorded on their Oracle record.

18.3 Staff immunisation

Immunising healthcare staff is necessary to:

- Protect the individual and their family.
- Protect patients and services users, vulnerable and immunosuppressed individuals.
- Protect other healthcare staff.
- Allow for the efficient running of services without disruption.

Interim arrangements remained in place in 2022/23 whilst the People team progressed the project to improve the recording of immunisation amongst Marie Curie's healthcare staff, this has included reviewing recommendations following an investigation into gaps identified.

18.4 Incident reporting: sharps practice

This year there was an increase in the number of reported sharps injuries from one in 2021/22 to four in 2022/23.

All four occurred in Q4 of this year. investigation of each incident highlighted that the injuries occurred:

a. during preparation of medication

b. following inappropriate disposal of sharps e.g., carrying in hand to sharps bin

c. following post administration of anticoagulation medication: patient known to be HIV positive. Policy was followed and staff member received appropriate post exposure prophylaxis. This was reported to the Health and Safety Executive under RIDDOR regulations.

d. picking up a used needle off the floor during cleaning process.

The incidents were discussed in local governance meetings and any learnings from them was shared.

19. Water safety

The Water Safety Group continues to meet quarterly to discuss water safety related issues and to ensure continual improvement in the management of Legionella and Pseudomonas aeruginosa. The Water Safety Group is supported by an independent Authorising Engineer (water) as per national guidance. Remedial work has been conducted at some hospices over the year to address positive counts for Legionella or Pseudomonas aeruginosa in line with the Water Safety Plan. Compliance with the Water Safety Policy is monitored through an annual water audit programme.

20. Estates and facilities

20.1 Cleaning (including National Standards of Cleanliness Group)

Operational cleaning services continue to be led by the Head of Operations and Facilities Managers in all in-patient units and are responsible for the implementation of Marie Curie's Cleaning policy. Facilities teams in each place-based location report through a structure of supervisory staff members who are responsible for the co-ordination of services and for monitoring cleanliness standards in all in-patient areas in line with national guidance.

During 2021/22 a National Standards of Cleanliness Group was set up and chaired by the Director of Estates and Facilities and Sustainability and Safety with representation from IPC, Nursing, Operations and Facilities to review the requirements of the National Standards of Healthcare Cleanliness 2021.

The group met regularly during 2022/23 to progress the implementation of the standards: work has included reviewing and updating the Cleaning and Decontamination policy, revising all cleaning specifications and method statements, devising a Decontamination of Equipment Certificate, developing a commitment to cleanliness charter, and drafting new audit tools. The implementation of the work will continue into 2023/24.

Cleaning services are predominantly provided in-house within Marie Curie Hospices which helps ensure they are linked to the needs of the clinical services. Only Marie Curie Hospice, West Midlands has an outsourced cleaning service.

To monitor compliance with the cleaning standards, Marie Curie undertakes monthly Hospice technical audits (covering 49 elements set out in the National Standards of Cleanliness 2007 Approved Code of Practice). If there are two consecutive months where audits were not undertaken or the areas did not meet the standards of cleanliness expected, this is escalated to the local place-based governance meetings via local environment and safety meetings.

The IPCC also receive an exception report as to why this has occurred with the appropriate assurance that the issues have been resolved.

20.2 Continued response to COVID-19

As the nation has continued to move forward through the pandemic, Marie Curie's Cleaning services have continued to provide a high level of cleanliness within the hospice settings, achieving their technical audit cleaning target scores throughout the year.

The local teams have continued to respond to requests for enhanced cleaning requirements during outbreaks of infection and undertaken thorough terminal cleans upon closure. The local IPC link nurse has worked in conjunction with the facilities team to ensure that the correct type of cleaning is undertaken.

20.3 Ventilation Safety Group

The Ventilation Safety Group set up in January 2022 continued to meet on a quarterly basis throughout 2022/23. This multidisciplinary group comprising of representatives from Estates, Facilities, IPC, Health and Safety, Operations and has a remit to assess all aspects of ventilation safety and resilience required for the safe operation and development of healthcare premises in line with the HTM 03-01 Specialist Ventilation for Healthcare Buildings.

Work undertaken this year has included:

- Asset and Verification Audits conducted in all hospices.
- Risk Assessments for room air changes based on clinical activity and review of air technologies.
- Planned work going forward will be to develop a Ventilation Strategy following consultation from the Authorised Engineer (Ventilation).

Appendix 1 IPC quality improvement audit programme 2023/24

Timetable of audits (Hospice)

Monthly	Auditor/ Person responsible	Bi-monthly (every other month)	Auditor/ Person responsible	Quarterly	Auditor/ Person responsible	6 monthly	Auditor/ Person responsible	Annually	Auditor/ Person responsible
Hand hygiene	IPC link / Clinical Nurse Manager	**Personal Protective Equipment (PPE)**	IPC link / Clinical Nurse Manager	**Isolation (TBP)**	IPC link / Clinical Nurse Manager	**Safe management of Linen**	IPC link / Clinical Nurse Manager	**Sharps (external)**	Facilities Manager/ Clinical nurse manager
Safe management of care environment	IPC link / Clinical Nurse Manager	**Patient placement**	IPC link / Clinical Nurse Manager	**Respiratory and cough hygiene**	IPC link / Clinical Nurse Manager	**Safe disposal of waste**	IPC link / Clinical Nurse Manager	**Ward kitchen**	IPC link / Clinical nurse manager
Cleaning: Technical	IPC link / Clinical Nurse Manager	**Safe management of care equipment**	IPC link / Clinical Nurse Manager	**Ongoing care of indwelling urinary devices**	IPC link / Clinical Nurse Manager	**Safe handling and disposal of sharps**	IPC link / Clinical Nurse Manager	**Specimen handling**	IPC link / Clinical nurse manager
				Vascular Device Audit	IPC link / Clinical Nurse Manager	**Occupational exposure management**	IPC link / Clinical Nurse Manager	**Antimicrobial prescribing**	Pharmacist /Medical Directors
						Safe Management of Blood and Body Fluid	IPC link / Clinical Nurse Manager	**Waste Management**	Facilities Manager
								Cleaning: Efficacy (new)	Director of Facilities/ Facilities Manager/Hof QCP/Head of IPC/link
								Laundry facilities (on site)	Facilities Manager / Domestic Supervisor

Timetable of audits (Nursing Services)

Monthly	Auditor/ Person responsible	Quarterly	Auditor/ Person responsible	Annually	Auditor/ Person responsible
Hand hygiene **Part 2 staff observation**	CNM – observing during visit	**Personal Protective Equipment (including resources)** **Self-assessment (observation tool)**	IHCW – self assessing CNM – observing during visit/IPC link	**Safe management of care equipment (NEW)**	HCW self-assessing CNM – observing during visit/IPC link

Abbreviations

AMR	Antimicrobial resistance
AGP	Aerosol generating procedures
BSI	Blood stream infections
CDI	Clostridioides difficile infection
CDT	Clostridioides difficile toxins
CGTC	Clinical Governance Trustees' Committee
CIS	Care Inspectorate Scotland
CIW	Care Inspectorate Wales
CoSHH	Control of Substances Hazardous to Health Regulations
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
E coli	Escherichia coli
ELT	Executive Leadership Team
HCAIs	Healthcare associated infections
HIS	Healthcare Improvement Scotland
HIW	Healthcare Inspectorate Wales
HCWs	Healthcare workers
IPC	Infection prevention and control
IPCC	Infection Prevention and Control Committee
IPCLN	Infection Prevention and Control Link Nurse
IPS	Infection Prevention Society
MCNS	Marie Curie Nursing Service
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
NHS	National Health Service
OHS	Occupational Health Service
PHW	Public Health Wales
PIR	Post-infection review
PPE	Personal protective equipment
RCA	Root cause analysis
RQIA	Regulation and Quality Improvement Authority
SICPs	Standard infection control precautions
SLA	Service Level Agreements
SOPs	Standard operating procedures
TBPs	Transmission-based precautions

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For further information, please contact

Director of Infection Prevention and Control

Marie Curie
One Embassy Gardens
8 Viaduct Gardens
London
SW11 7BW

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