INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

NHS
Dorset County Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report 2019-20

Infection Control Week 2019- Heroes and Villains Theme winners

Ilchester Ward

Nicola Lucey - Director of Nursing and Quality/ Director of Infection Prevention and Control

Emma Hoyle - Associate Director Infection Prevention and Control

Dr Paul Flanagan – Infection Control Doctor

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EXECUTIVE SUMMARY

The annual report provides a summary of the Infection prevention and control activity over the last year and status of the healthcare associated infections (HCAIs) for Dorset County Hospital NHS Foundation Trust.

The Director of Nursing and Quality is the accountable board member responsible for infection prevention and control and undertakes the role of the Director of Infection Prevention and Control.

The Infection Prevention and Control Group function in order to fulfil the requirements of the statutory Infection Prevention and Control committee. It formally reports to the sub-board Quality Committee, providing assurance and progress exception reports. All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) – part 3 Code of Practice for the Prevention and Control of HCAIs), which was reviewed and updated in 2015.

The workplan, led and supported by the Infection Prevention and Control team (IPCT), sets clear objectives for the organisation to achieve with clear strategies in place to meet the overall Trust strategy of Outstanding.

Overall 2019-2020 was a successful year, meeting key standards and regulatory requirements for infection prevention and control. Below is the highlight of those:-

- The Trust met the trajectories set for MRSA bacteraemia and *Clostridium difficile* infections for 2019-2020
- The Trust has successfully reduced healthcare acquired infections year on year
- The Trust developed and adjusted in the global pandemic of COVID-19
- Hand hygiene compliance has remained high and sustained at 97%
- Only two outbreaks of Norovirus which were well contained and occurred for a short period only
- The Trust achieved above the national average for several elements of the PLACE assessments for the year.
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Mitigation and enhanced monitoring continued to control pseudomonas and legionella in tap water in high risk areas
- Trust remains key national benchmark for use of data management system in infection prevention & control (ICNet).

1. INTRODUCTION

This is my fourth year as Director of Nursing and Quality, with the responsibility of Director for Infection Prevention and Control (DIPC) and this report summarises the work undertaken in the Trust for the period 1st April 2019– 31st March 2020. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's).

I am pleased to report good progress against the trajectory for HCAIs. The Trust met the target for zero cases of MRSA bacteraemia and reported 6 trajectory cases of *Clostridium difficile* against a target of 16 cases. In addition, the Trust has been very proactive in reviewing trends and improvements in Gram-negative blood stream infections (BSIs) with sharing across system partners as part of the Dorset Integrated Care System (ICS). The Infection Prevention and Control Team has seen their system and partnership working as key to supporting the health and safety of the population, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection prevention and control.

These low rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases. I am incredibly proud of the teamwork that has enabled this positive track record of patient safety.

It has been a particularly challenging year for the Trust and Infection Prevention and Control in the last quarter as the world-wide pandemic of COVID-19 evolved. The Infection prevention and Control team have been vital in developing and supporting the Trust during this period of time. They have provided expert counsel to others across the system and region, sharing best practice and challenge to ensure COVID-19 secure environments fort patients and staff.

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention and Control team support epitomize this quality improvement ethos and they significantly contribute to achieving our strategic mission: "Outstanding care for people in ways which matter to them". Their support for training and engaging with the clinical teams has been at the highest standard, reflective of the care provided and experience by our visiting public.

Of course I am never complacent, with ongoing high ambitions for patient safety, as I look forward to another year ahead of delivering outstanding services every day through effective, efficient and joined up infection prevention and control.

Nicola Lucey
Director of Nursing and Quality
Director of Infection Prevention and Control

2. INFECTION PREVENTION & CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 5 times during 2019- 2020. It is a requirement of *The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections,* that all registered providers: "*have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks".*

The IPCG is chaired by the Chief Executive Officer, Patricia Miller. Director of Nursing & Quality, Nicola Lucey, who also is the Director of Infection Prevention and Control (DIPC), is in attendance and acts as deputy Chair, with the responsibility for reporting to the sub-board Quality Committee for assurance.

2.2 DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2019-2020:

- Monthly MRSA Bacteraemia surveillance;
- Monthly *Clostridium difficile* surveillance;
- Monthly hand hygiene rates;
- Outbreak and incident reports;
- Antibiotic Stewardship Report;
- Progress with national ambition to reduce Gram Negative Blood Stream Infections by 50% by 2023

2.3 INFECTION PREVENTION and CONTROL TEAM

The IPCT has welcomed new members in the year and consists of:

- Patricia Miller, Chief Executive
- Nicola Lucey, Director of Nursing and Quality/ Director of Infection Prevention and Control
- Dr Paul Flanagan, Consultant Microbiologist and Infection Control Doctor
- Emma Hoyle, Associate Director Infection Prevention and Control
- Abigail Warne, Specialist Nurse-returned from maternity leave June 2019
- Julie Park, IPC Nurse – returned from maternity Leave January 2020
- Christopher Gover, Specialist Nurse – Seconded to team to cover Maternity Leave
- Debs Scott-Denness - Seconded to team to cover Maternity Leave until May 2019
- Helen Belmont – Bank Specialist Nurse
- Cheryl Heard, Administrator
- Rhian Pearce, Antimicrobial Pharmacist
- Emma Diaz, Lymphedema Specialist Nurse (supported the team and worked with us during COVID-19 peak period)
- Divisional Heads of Nursing/Quality

3. HEALTHCARE ASSOCIATED INFECTIONS

3.1 METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

There were no cases of MRSA bacteraemia in 2019-2020. The last case of MRSA bacteraemia assigned to the Trust was July 2013. This provides confidence that the IPC practices in place have been sustained. Our performance is in keeping with national data whereby Trust apportioned cases of MRSA (blood samples taken ≥48hours post admission) have significantly reduced.

3.2 *STAPHYLOCOCCUS AUREUS* BACTERAEMIA (MSSA)

In 2019-2020 there were a total of 52 cases of MSSA bacteraemia, of these 44 cases were identified <48 hours of admission and 8 identified >48 hours after admission (Chart 1).

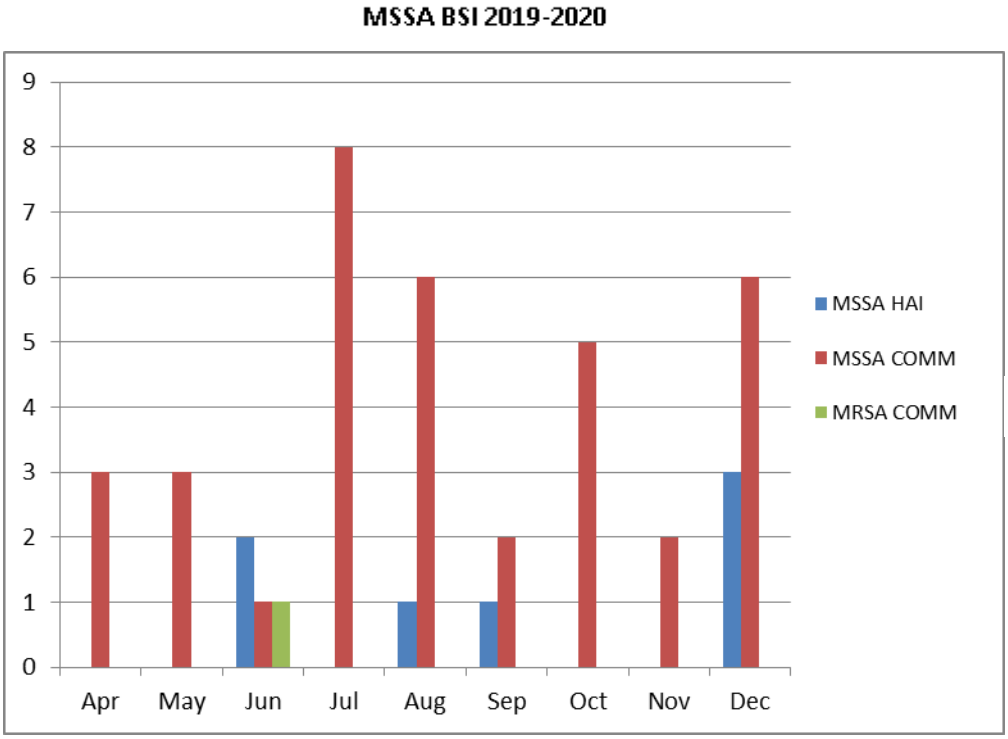


Chart 1

To achieve this reduction we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices. Analysis of cases in the >48 hour group has shown that there were no focus of infection related to hospital treatment. However, in two of the cases it was noted that there was poor documentation of indwelling devices. Despite this the rates of MSSA infections remains lower in comparison to the national picture.

3.3 GRAM NEGATIVE BLOOD STREAM INFECTIONS

3.3.1 Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 25% March 2021 (PHE 2017)

and 50% March 2024 (PHE 2019). February 2019 it was announced that the date for achieving this reduction has been changed to 2023. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.)*

3.3.2 Mandatory data collection has been in place for several years for E.coli. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for Klebsiella spp.and Pseudomonas *aeruginosa.*

3.3.3 In 2019-2020 there were a total of 162 positive BSI samples for E.coli. 11 of these cases were attributed to the Trust (Chart 2). This was a decrease by 9 cases from 2018-2019. All cases of E.coli that occur >48hrs after admission are reviewed by the Consultant Microbiologist and Infection Prevention & Control Team. A full data collection process is carried out in accordance with Public Health England guidance; this includes all mandatory and optional data. Full antibiotic review is carried out taking into account the preceding 28 days. In 2019-2020 DCHFT achieved a 45% reduction in cases from the previous year and a 35% reduction since 2016/2017 which brings the Trust back into trajectory for the 50% reduction by 2023.

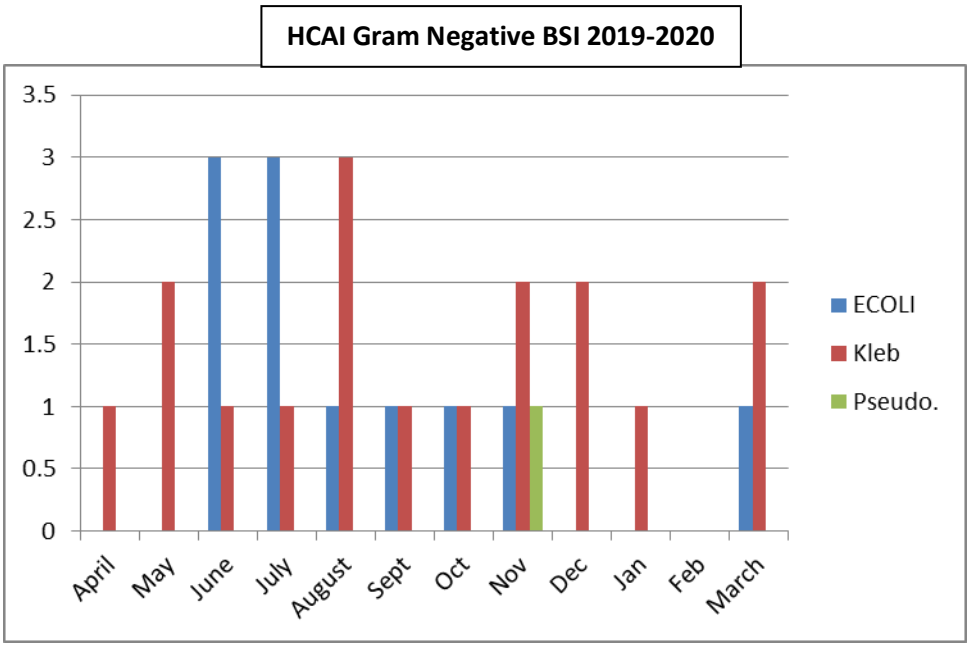


Chart 2

3.3.4 In 2019-2020 there were a total of 56 positive BSI samples for Klebsiella sps, 17 of these cases were attributed to the Trust (Chart 2). This was an increase by 7 cases from 2018-2019.

3.3.5 In 2019-2020 there were a total of 6 positive BSI samples for Pseudomonas *aeruginosa*, 1 of these cases were attributed to the Trust (Chart 2). This was a decrease by 1 case from 2018-2019.

It has been noted that there has been a rise in taking blood cultures for investigation over the past 3 years (Chart 3). This is in response to the action by the Trust to diagnosis and management of sepsis.

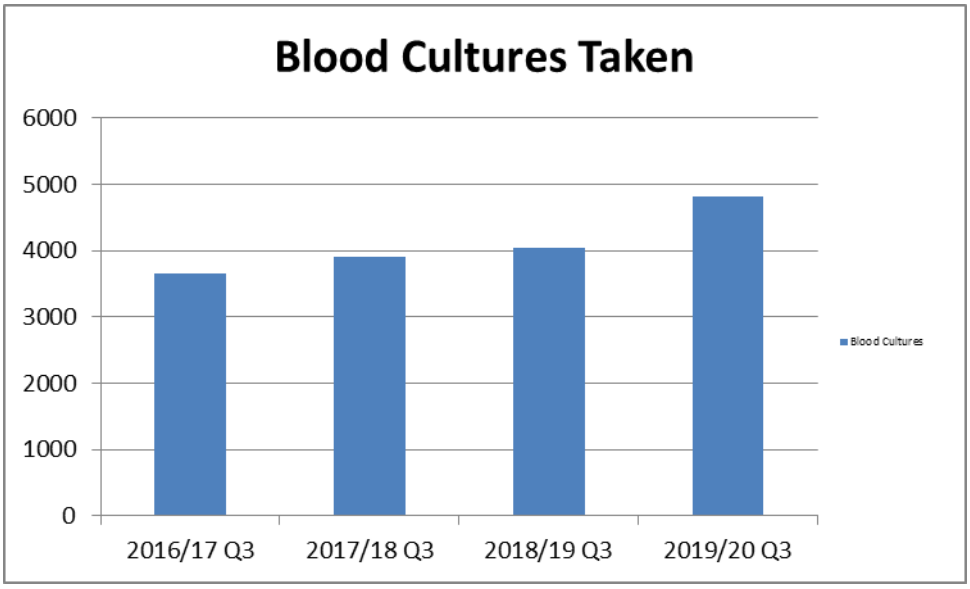


Chart 3

3.3.6 The IPCT continues to be involved in the nationally organised events and training via NHS Improvement (NHSI). Through these events it has been recognised and agreed that the reduction of gram negative BSIs is proving difficult to achieve and the target date for completion has been extended to 2023. At DCHFT the IPCT have been addressing the following to check current processes:

- Monthly audit of urinary catheter care including documentation and discharge
- Audit and subsequent actions into monitoring of indwelling devices e.g. Peripheral vascular cannula
- Participation in Hydration Projects Trust wide
- Supported the reduction in the use of urinary dipsticks

Within Dorset the four healthcare Trusts are working together on joint projects to seek solutions to this target as the majority of cases are community acquired and support is required to achieve resilience county wide. Nationally, the decrease in gram negative BSI has not been recognised and NHSE/i have agreed to stretch the target to 2023. This will enable further engagement with primary care – this remains the same since the last report.

3.4 *CLOSTRIDIUM DIFFICILE* INFECTION (CDI)

This year NHS England changed the reporting of C Difficile. This was from one definition of a case – sample taken over 72 hours after admission was deemed a HCAI requiring review. This year the definition is as follows:

- HOHA – Hospital onset healthcare associated – cases detected within 48 hours after admission
- COHA – Community onset healthcare associated – cases that occur in the community or within 48 hours of admission when the patients has been an inpatient in the Trust reporting the case in the previous 4 weeks

- COIA – Community onset indeterminate association - cases that occur in the community with admission to the reporting Trust in the previous 12 weeks but not in the previous 4 weeks
- COCA – Community onset community associated – cases that occur in the community with no admission to the reporting Trust ion the previous 12 weeks

Bearing this in mind and the change in definition it has remained a successful year for reducing cases of CDI. The Trust trajectory for the year was 16 cases. In total the Trust reported 25 cases detected HOHA and COHA; of these cases 19 were appealed as non-preventable with no lapses in care; this resulted in 6 cases reported as hospital acquired (Chart 4).

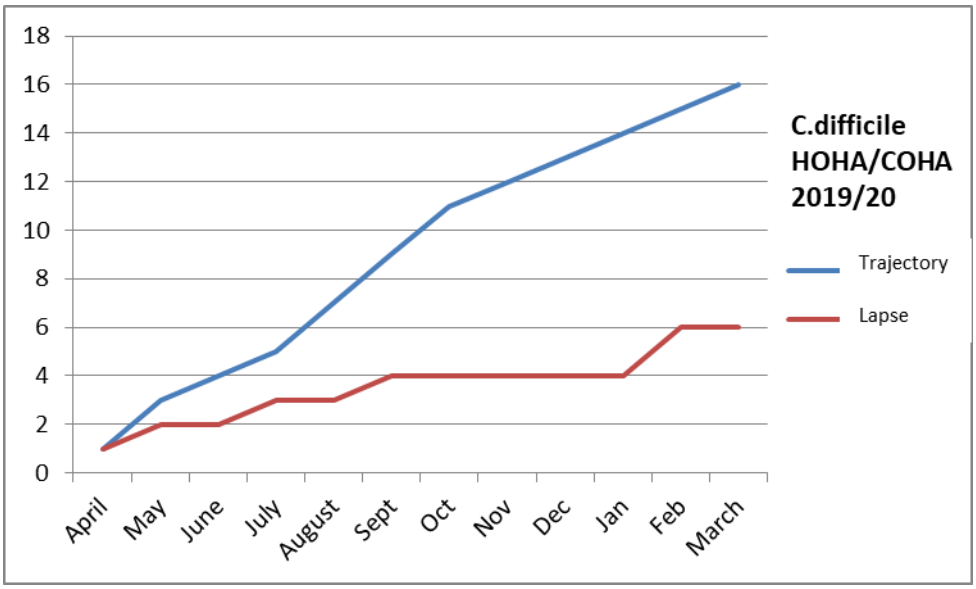


Chart 4

Over the course of the year we identified 6 different phage types. We can confidently say that we have not had any outbreaks or linked cases of CDI in the Trust 2019-2020.

All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Patricia Miller, Chief Executive Officer and scrutinised to identify any relevant learning from the cases. The learning actions when completed are then presented and signed off by the Divisional Matron at the IPCG.

4. OUTBREAKS OF INFECTION

4.1 NOROVIRUS

Outbreaks of this viral illness have been identified at the Trust during this year in line with seasonal reporting. Individual cases have also been reported in very small numbers. There has been 2 outbreaks of Norovirus 2019-2020. This was identified quickly, patients sampled and isolated in line with Trust policy. In comparison with the national average the number of bed days lost due to outbreaks remains low.

4.2 INFLUENZA

A review of the Influenza Season (Summer 2019) in the Southern Hemisphere identified an early peak to the season which the Trust was prepared for.
There has been a national reduction in cases of Influenza A & B during the Winter 2019-2020 in comparison to the previous year. The Trust was able to demonstrate learning from the previous year and the impact at operational level for the Trust was minimal.
In preparation for 'Flu Season' all Trust staff were offered the annual flu vaccine. 89% of front line staff were immunised and 84% of all staff, an increase from 79% the previous year. The Trust were the top of the Southwest region for compliance with staff vaccination
The Trust did not have any outbreaks of influenza and all cases identified in the Trust were isolated and treated in a timely manner.

5 CLINICAL AUDIT

5.1 SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are defined to a standard set of clinical criteria for infections that affect the superficial tissues (skin and subcutaneous layer) of the incision and those that affected the deeper tissues (deep incisional or organ space).

Preventing surgical site infections is an important component of Infection Prevention and Control programmes. There is a Mandatory requirement by the Department of Health for all Trusts' undertaking orthopaedic surgical procedures to undertake a minimum of three months' surveillance in each financial year.

SSI for all surgery involves 3 stages of surveillance:
Stage 1- collection of data relating to the surgical procedure and inpatient stay
Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure
Stage 3- review of patients readmitted within 365 with SSI

During 2019-2020 the IPC team have supported 5 modules for surveillance. Surveillance. The IPCT are able to facilitate a less time consuming model of data collection utilising the IPC data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

5.2 SURGICAL SITE SURVEILLANCE OF HIP REPLACEMENT

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for April- June 2019 (Table 1) and last 4 periods for which data was available.

The percentage of post discharge questionnaires returned by patients is significantly higher than the national data for all hospitals.

During this quarter the increased incidence of post-operative infections in orthopaedic cases were monitored and actions taken to investigate and seek the root cause.

Further to intensive investigation no source was found and no further infections identified.

Table 1 April – June 2019 Hip Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		Apr-Jun 2019	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	59 59 81.4%	302 302 79.5%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0% (3.1 % Apr-June 2018)	3 1%
	No of post discharge confirmed % infected	0 0% (2.1% Apr-June 2018)	3 1.0%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	0 0% (5.1% Apr-June 2018)	6 2%

Result s of this quarter were significantly improved from the previous years audit.

5.3 SURGICAL SITE SURVEILLANCE OF KNEE REPLACEMENT

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for July - September 2019 (Table 2) and last 4 periods for which data was available.

The percentage of post discharge questionnaires returned by patients is significantly higher than the national data for all hospitals.

During this quarter the increased incidence of post-operative infections in orthopaedic cases were monitored and actions taken to investigate and seek the root cause.

Further to intensive investigation no source was found and no further infections identified.

Table 2 July – September 2019 Knee Replacement Surveillance

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		July - Sept 2019	Last 4 periods
Operations	Total number No. with PQ given % with PQ completed	75 75 76.7%	294 292 79.1%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0%	0 0%
	No of post discharge confirmed % infected	1 1.3%	3 1.0%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	1 1.3%	3 1.0%

Results of this audit were the same as other hospitals in England.

Surgical Site Surveillance of Breast Surgery, Hips and Fractured Neck of Femur repair (Jan – March 2019 - data not available for 2019-2020 Annual report)

Data collection for this audit will be completed at the end of June 2019 the final report is not yet available from Public Health England.

5.4 GETTING IT RIGHT FIRST TIME (GIRFT)

Between May and October 2019 the Trust participated in the GIRFT surgical audit. Data was gathered for Orthopaedic and General Surgery. The COVID-19 pandemic has delayed formalisation of this audit and final results will be shared once available.

5.5 PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVC's are commonly used devices in acute hospitals, used for the administration of intravenous fluids and drugs. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. Regular auditing to check that all PVCs are having visual infusion phlebitis (VIP) score checks completed has continued this year and remains ongoing. The annual average compliance for this year's audits has been 92% up from 90% last year.

Should compliance fall below 90% additional weekly/monthly audits are carried out. Divisional leads are invited to IPCG on a bi-monthly basis to discuss their areas results.

5.6 SHARPS AUDIT

The annual sharps bin audit by IPCT was completed in September 2019 with our main sharps box provider Daniels Healthcare Ltd completing their annual audit in November.

The audits seeks to gain insight into current practices with regard to the management of sharps in the clinical area with an aim to raise sharps awareness, assess current practice, discuss problems and advice on compliance to ensure that sharps are disposed of in a safe way to minimise the risk of injury.

Overall compliance was 95%.

These results were fed back to divisional nursing leads through the IPCG and sharps awareness continues to be a part of mandatory infection control training.

5.7 SLUICE AUDIT

Sluice areas across the trust must comply with a set range of standards and policies to ensure that infection control is optimised and ensure that sluices and commodes are fit for purpose.

This audit was conducted by external company Vernacare who supply the trust with pulp products and commodes. They looked at all sluice areas to assess the commodes and macerators in each sluice as well as looking at the overall cleanliness and storage of pulp products.

The IPCT fed back to all sisters and matrons any areas of concern to ensure that any non-compliance found was addressed; this was to be incorporated into divisional IPC plans. The biggest non-compliance was regarding the correct storage of pulp products and ongoing sluice and commode audits will continue as part of the trust environmental audit schedules.

5.8 ISOLATION AUDIT

This year's side room isolation audit took place in March and looked at all inpatient areas (excluding Kingfisher ward and ITU) with results as follows; Out of 35 side rooms in use for infection control purposes 71% had correct signage, 29% incorrect and a total of 92% overall side rooms in use across the trust. At the time of audit being carried out staff were educated on the importance of using correct signage to protect not only the patient but also themselves and visitors and thus reducing the transmission of infection.

5.9 COMPLIANCE WITH URINARY CATHETER POLICY

Over the past year the following audit has been carried out monthly in relation to Urinary Catheter Care;

- Indwelling Urinary Catheter Recording on Vital Pac

Compliance with the requirement to accurately document indwelling urinary catheter insertion on VitalPac has been good with an overall Trust compliance of 91% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 89% compliance and Urgent and Integrated Care 91% compliance.

Due to complications with methodology a decision was made to drop the previously audited Discharge from DCHFT with Urinary Catheter Pathway. This was agreed through IPCT.

6. EDUCATION

The Infection Prevention & Control Team provided formal education sessions training for both clinical and non-clinical staff. IPCT also was incorporated into the following programmes and the team were involved in delivering formal sessions:

- Care Certificate for Health Care Support Workers
- Preceptorship Training
- Overseas Recruitment Training
- Intravenous Training
- Tissue Viability
- Volunteers Training

Mandatory Training for clinical and non-clinical staff has been offered via an online workbook. Overall compliance with mandatory IPC training over the year was 82% for clinical staff and 83% for non-clinical staff. IPCT recognised that additional support and training was required and so now provides monthly face to face formal mandatory training sessions for staff in addition to the online package. The drop in compliance may be attributed to the access opportunities in the last quarter due to the COVID-19 pandemic.

7 POLICY DEVELOPMENT/REVIEW

The following policies have been developed / reviewed during the year:

- Ward Closure Policy due to an outbreak of healthcare associated infections
- Policy for taking Blood Cultures
- Infection control of transmissible spongiform encephalopathies (cjd/vcjd)
- Guidelines for use of portable fans in the healthcare environment
- Isolation Policy including Isolation requirement for listed and infecting agents
- Isolation of Neutropenic patient son Fortuneswell Ward
- Pets for Therapy Policy
- ESBL/Gram Negative Policy
- Decontamination Procedures for Invasive Devices

- Policy for Venepuncture
- Clostridium difficile Policy
- Seasonal Influenza Policy
- Ice making Machine Standard Operating Procedure
- Wuhan Novel Coronavirus (WN0COV) Infection Prevention and Control Guidance

8. INFECTION CONTROL WEEK

The theme for this year's Infection Control Week was Superheroes Vs Supervillains and wards were asked to present a display showcasing their infection control superhero and supervillains focusing on an aspect of IPC relevant to their clinical area and how the hero can do 'battle' against the villain. Some of the displays included: Influenza Vs The Flu vaccine, Measles Vs Vaccination and MRSA Vs Decolonisation. The wards did not disappoint and there were some fantastic displays.

The annual judging of the displays was led by Patricia Miller and Nicky Lucey. Winners included:

- 1st place- Ilchester Ward
- 2nd place- Barnes Ward
- 3rd place- Medical Day Unit
- Highly Commended- Ridgeway Ward

1st place- Ilchester Ward

We were also supported by Reps from Schülke, Ecolab, Clinell, Vernacare, Daniels and GoJo who kindly donated prizes for the winners and some came in to promote IPC with stands in Damers restaurant.

9. COVID-19

In December 2019 an emerging virus was identified in Wuhan, China resulting in a global pandemic which remains ongoing.

This is the first pandemic that DCHFT has had to manage and preparedness for the evolving virus commenced in January 2020. Initially, this was lead via Infection Control and Emergency Planning but by February 2020 the international situation dictated a Trust wide response.

The Trust response was led by the Incident Management Team. Patient and staff safety was at the forefront of the pandemic.

The hospital environment has been adapted to suit the needs for this new virus and the complexities that it creates. Personal Protective Equipment (PPE) supplies remained good over the past six months and there has been no shortages. Staff support remains ongoing and at the time of writing the annual report routine patient services are re-starting.

A formal report will be provided to Quality Committee and Trust Board to provide further detail.

10. FACILITIES REPORT - CLEANING SERVICES (PAUL ANDREWS)

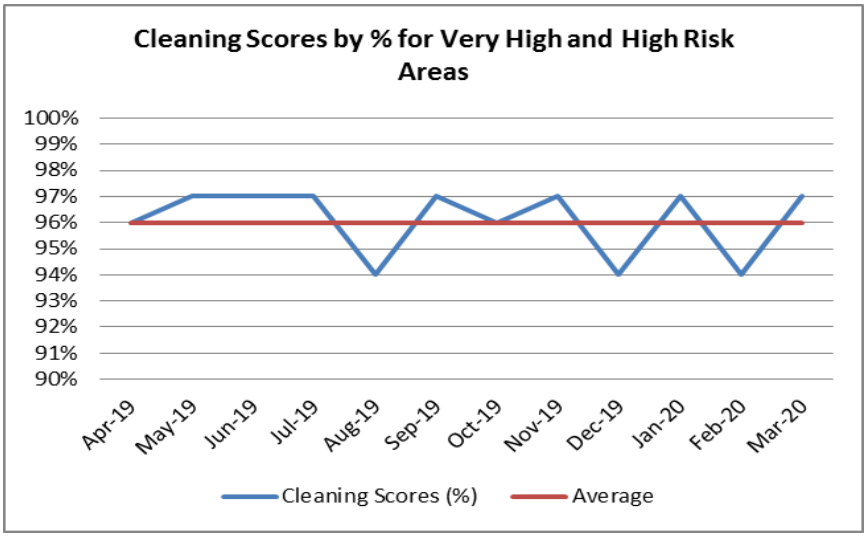
10.1 INFECTION PREVENTION & CONTROL & CLEANLINESS ANNUAL REPORT 2019/20

Provide and maintain a clean and appropriate environment

The Trust understands the importance of a clean, appropriate environment and focuses on providing excellent outcomes.

10.2 CLEANLINESS

Cleaning is provided by the Trust's in-house team of cleaners and deep cleaners; the internal team is supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the DomTime information system, with further input from local stakeholders, on a risk adjusted basis.
Outcomes for cleaning are monitored through several sources including internal monitoring, internal patient satisfaction surveys, the PLACE assessment and the CQC inpatient survey. We have continued to sustain a high standard of cleaning across all areas and continued to see low infection with improved patient feedback, which improves the overall patient experience and maintains patient safety.



10.3 CLEANLINESS – DEEP CLEANING

Whilst routine cleaning is completed in all areas on a daily basis, staff in very high and high risk areas are supported with extra staff to complete a full clean on a weekly basis. In the very high risk area of theatres there is a rolling deep clean programme that runs alongside the routine clean; cleaning in these areas is completed over night, when the theatres are not in use, to provide the most effective service, this is achieved with the assistance of the Estates team who undertake the high dusting of these areas.

In case of an outbreak or a high risk infection, the Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour (HPV) for the fogging of facilities and equipment.
The Trust has a working relationship with Glosair, whose services can be called upon as need requires it. We are currently looking to replace our 3 current HPV machines, as technology has vastly improved in this area, especially around the amount of time it takes to fog an area and the use of air scrubbers to remove any remaining hypochlorite solution from the environment. This will then enable a quicker turnaround of beds and cubicles, which is critical for any NHS Trust, without compromising patient safety.

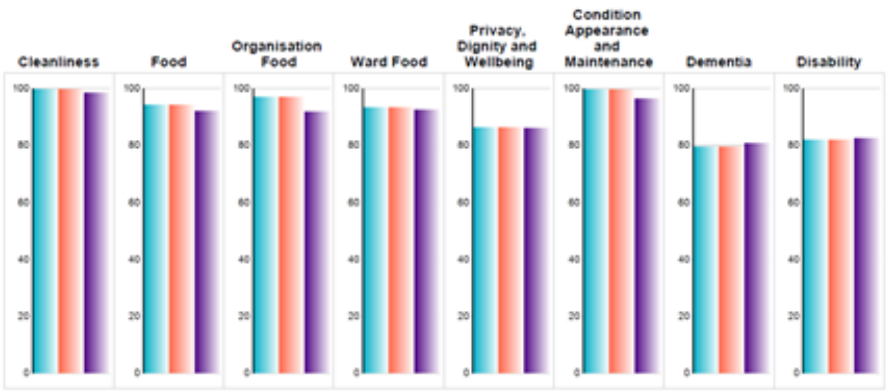
10.4 CLEANLINESS – INTERNAL MONITORING

The Housekeeping Department has devised an effective sign-off sheet that allows staff to easily demonstrate the work they have completed and alert the next person on shift to any outstanding requirements. Evidence of cleaning is retained by the department and is validated by supervisor monitoring.
Internal monitoring is carried out every day, visiting all areas on a weekly basis. Very high risk and high risk areas are monitored by an independent team made up from clinical, estates and facilities and supported by patient assessors who validate the ward audit scores, and check the patient experience to ensure the broadest picture is seen. All required improvements identified by the audits are acted upon by the internal team and the results, along with the patient survey, go to the Infection Prevention & Control Committee on a quarterly basis.

10.5 PLACE – PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT

The 2019 PLACE assessment identified many positives for the Trust and also areas to work upon. In relation to cleanliness and the environment; Cleanliness maintained its historical high score, in line with other internal and external audits; minor issues were identified and subsequently rectified immediately.
Condition, Appearance and Maintenance improved its score from the previous year, and was above the national average.
The areas that the Trust needs to focus upon are Dementia and Disability, as there was greater focus on these this year. The Trust did improve in these two areas, with Dementia and Disability scoring 79.56% and 81.91% respectively; these were still slightly below the national averages as shown in the graph below. The Trust has undertaken an audit across all of its premises, looking at compliance with new disability legislation, and planned works have already commenced in many areas to improve access and egress from these buildings and external areas.

DORSET COUNTY HOSPITAL- Collection: 2019



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	2516.0000	341.3333	87.3333	254.0000	461.3333	967.0000	611.0000	462.0000
Available Score (Actual)	2522.0000	362.0000	90.0000	272.0000	534.0000	970.0000	768.0000	564.0000
Site Score	99.76%	94.29%	97.04%	93.38%	86.39%	99.69%	79.56%	81.91%
Organisation Average	99.76%	94.29%	97.04%	93.38%	86.39%	99.69%	79.56%	81.91%
National Average	98.60%	92.19%	91.92%	92.62%	86.09%	96.44%	80.70%	82.52%

11 ESTATES REPORT (ANDREW MORRIS – Head of Facilities and Estates)

11.1 WATER QUALITY

Throughout 2019, the Estates Team have maintained responsibility for the Trust's water services, reporting to the Water Quality Management Group (WQMG). Activities to maintain water quality continue to be supported and audited by independent experts in water hygiene management from Water Hygiene Centre with the WQMG sitting FOUR times per annum.

The Responsible Person, Andy Morris, and Authorising Engineer (Water), Paul Limbrick, were formally appointed in late 2019 and early 2020 respectively. Nicola Lucey, Director of Nursing/ Quality and DIPC is the Executive Director on Trust Board for Water Safety.

In March 2020 the 'Water Safety Policy' and accompanying 'Operational and Maintenance Procedures' were temporarily amended, in agreement with the WSMG, to take account of anticipated difficulties in routine surveillance monitoring due to COVID-19. This will be subject to continuous review and amended after consultation according to circumstances.

There has been continued progress in the remediation and closure of items identified in the 2016 L8 Risk Assessment throughout the period including;

- Installation of subordinate loop temperature monitoring system (ongoing)
- Purchase and ongoing installation of TWENTY RADA Sense 'auto-flushing' showers for Augmented Care areas prioritising those prone to raised Pseudomonas,
- Purchase of an HD Borescope to aid inspection of risk systems,
- Removal of dead legs and Little Used Outlets in Renal, Fortuneswell and Respiratory.
- Twenty one L8 Risk Assessments were carried out in the period along with Scald Risk Assessments. These will form the basis of ongoing works to maintain and improve system integrity alongside the continuing review and update of system schematics, asset registers and information on system use.

Pipework corrosion issues continue to occur resulting in leaks. These primarily present risks to continuity of supply rather than direct infection issues. Leaks are handled on an ad hoc basis with additional isolation valves put in place where possible to aid future maintenance and reduce the scope of necessary supply shut downs.

Bacteriological surveillance, principally for Legionella and Pseudomonas, has continued according to previous schedules across the Trust. This work has been brought in-house to improve costs and control and a review of sampled outlets and scheduling undertaken.

Over the period covered by this report, MAR19 – MAR20, there were SIXTEEN instances of raised Pseudo. A. discovered during regular surveillance testing;

- POW – ONE instance
- Fortuneswell Ward - THIRTEEN instances
- SCBU – TWO instances

WSP procedures were followed in all cases and significant system or outlet changes made in order to mitigate further issues including the removal or little used outlets and the installation of self-flushing outlets. Further investigation of hot and cold water systems continues throughout the Trust property portfolio.

There have been THREE instances of raised Legionella counts in Renal Dialysis, Robert White Centre and Diagnostic Imaging. The Renal Dialysis issue is limited to a single outlet and under investigation. The Robert White Centre is more widespread and due to poor design, which remains unresolved and whose remediation is being planned. Despite a full system disinfection the issue remains and is expected to do so until the system is re-engineered to maintain control temperatures and fix inherent faults. Diagnostic Imaging remains under investigation, with remediation actions underway.

11.2 SUPPORT FOR THE DEEP CLEAN PROGRAMME

A Deep Cleaning programme continues to be supported by the Estates Team when requested.

11.3 REPLACEMENT FLOOR COVERINGS

During 2018/19 the Estates delivery team and contractors have completed more than 140 various flooring repairs and a number of necessary replacements in corridors, shower rooms, ward and non-clinical areas.

11.4 DECORATION AND ENVIRONMENT

The Estates team continue to respond to reactive requests for decoration identified by staff and through the environmental auditing process. We are also carrying out proactive, scheduled inspections of high use and public facing areas to maintain an acceptable standard.

11.5 VENTILATION

During 2019/20 Estates and Housekeeping have continued to carry out high level deep cleaning in critical areas. Any deficiencies are reported through the Decontamination Group.

The Estates team continue to carry out routine inspection and maintenance on all ventilation systems and formal validations on all Theatres and Critical Areas in compliance with HTM 03-01 Part B carrying out remedial works as required. TWO AP(V) under the auspices of an AE(V) maintain Permit to Work system and ensure all statutory and regulatory records are validated.

11.6 WARD AUDITS

The Estates Dept. continue to support weekly environmental audits in association with Infection Control, Pharmacy Housekeeping and Patient Representatives.

11.7 CAPITAL WORKS

11.7.1 CONTAINMENT LEVEL 3 FACILITY REFURBISHMENT - The existing lab facility was installed during phase 1 of the hospital build in excess of 30 years ago; as a result it was in urgent need of replacement. The facility has been identified on the capital programme over the last four years for upgrade & replacement, but has been unable to be prioritised due to other pressures within the Trust's capital programme.

The aged facility was removed and replaced in early 2020, providing the lab with an upgraded and safer facility in accordance with the HSE guidance, Health Building Notes and Health Technical Memoranda.

BEFORE

AFTER

11.7.2 ULTRASOUND ROOMS (WOMEN'S HEALTH) - Ultrasound Rooms A and B were updated for the first time since the original East Wing build in 1997. Hand washing facilities were replaced with new IPS units, compliant wash hand basins and WRAS approved taps. The air conditioning outlet was also redirected, flooring and worktops were replaced and power and data points were adjusted to enable staff to work efficiently within the space available.

11.7.3 NURSE BASE ON PURBECK WARD - The nurse base was removed, redesigned and replaced to improve both the use of the space and visibility for staff. Due to the works being in the middle of a live ward, careful measures were used to

minimise the risk of infection from construction dust. This worked successfully with no issues reported.

11.7.4 FACET PROPERTY APPRAISAL - A survey was undertaken to formally identify the condition of the site, its buildings and infrastructure, as well as highlight and record Backlog Maintenance. As part of the survey Statutory Compliance and the breakdown of Clinical/Non Clinical area usage was also assessed.

The appraisal was carried out addressing each of the 21 physical elements pertaining to NHS building stock, including items such as;

- Drainage, sewerage and water supply
- Ventilation systems
- Hot and cold water systems

As a result, the Trust now have a more detailed and formal way of identifying High and Significant Risks, and this information will be fed in to the development of the updated Estates Strategy and work package/budget planning going forward.

11.7.5 THEATRE OPERATING LIGHTS – The main operating theatre lights were replaced in Theatres 2 and 5 where the surface of the original lights had been flaking away in parts, which was a major concern. The successful replacements have now removed this significant risk.

The scheduled replacement of the lights in Theatres 3 and 4 has been delayed by COVID-19; however the lights have been purchased and are being stored on site, with the intention to fit them as soon as access can be gained.

11.7.6 ROBERT WHITE CENTRE SLUICE – The addition of a sluice to the first floor area of the recently constructed building was requested in April 2019 by the users of the first floor, to allow them to do some minor procedures. Work could not be carried out until June 2019 as the Trust were required to wait until defects period on the construction had expired.

A collaborative project with the IPC Team, the works involved converting one of the two staff only toilets. Air flow rates were increased and a new full stainless sluice hopper sink, cistern and taps were installed with IPC sign off before use.

11.7.7 OTHER CAPITAL WORKS

Carpet flooring was replaced with vinyl in Respiratory Medicine and Neurophysiology and other notable flooring works were completed in Diagnostic Imaging, Damers Restaurant and Kingfisher Ward, making cleaning easier and more effective.

Estates assisted Procurement with the installation of improved and fit for purpose storage in a number of wards.

Two additional birthing pools were installed in the Maternity Department as part of the formation of a new Midwife Led Unit. Technical challenges had to be overcome around the waste water in order to comply with water safety regulations.

12 DECONTAMINATION SERVICES REPORT (Kate Still, Decontamination Services Manager)

12.1 STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016. The department is also registered with the MHRA.

The Notified Body Intertek undertook an annual audit in May 2019 and no non-conformances were found. This Accreditation continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

The 3 day Re-certification Audit by the Notified Body Intertek scheduled for May 2020 cannot be undertaken on site due to travel restrictions. This will now be undertaken remotely via video link which is a new experience for the department and the auditor based in Poland.

External Customers

The department provides a service to various external customers including dental practices in East and West Dorset as well as a local GP practice. More recently the team have worked with the Dorset & Somerset Air Ambulance to help create bespoke surgical sets for their service which are now reprocessed in the unit. The accreditation maintained by the department gave the DSAA Consultants assurance of the consistent quality of the service. The team were presented with an Award Certificate from DSAA acknowledging the ‘can do’ attitude of the team.

Environmental Monitoring

The Clean Room Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on five washed but unsterile items – Quarterly
- Water Endotoxin - Annual

Latest testing of all areas occurred in February 2020 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are trended and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern at this time.

For compliance with HTM 01-01 ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested to detect any residual protein on the instrument surface, after being released from the washer-disinfector but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance that the detergent used in each validated washer-disinfector is effective.

Tracking and Traceability
Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and one Outpatient Department at the moment.

Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently used on a patient.

Shelf Life Testing
Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing on an annual basis and when a new wrap is introduced. All expired samples that were sent for testing still showed 100% sterility in the last round of testing which gives assurance that the decontamination process is effective.

Staff Training
All Managers and Supervisors have now attended the SSD Managers/Supervisors course at Eastwood Park. This City & Guild qualification gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day to day basis.

The service administrator and one Supervisor have achieved NVQ qualifications appropriate to their area of work. The service manager has taken on the role of Trust Decontamination Lead following completion of the C&G Decontamination Lead course at Eastwood Park and is now a Chartered Member of the IDSc (Institute of Decontamination Science).

All members of staff receive training appropriate to the area of production they are working in and are observation assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a Supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

12.2 ENDOSCOPY DECONTAMINATION UNIT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN 13485:2016 as an extension to scope of the existing certification in the Sterile Services Department.

This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customer.

Environmental Monitoring
Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Quarterly
- Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually

Latest testing of all areas occurred in February 2020.

All results are trended and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern at this time.

Weekly rinse water samples are taken from each washer chamber on a weekly basis to be tested for TVC and pseudomonas aeruginosa. There have been occasional raised results but no confirmed root cause has been established. Protocol has been followed on each occasion with the relevant chamber being placed on restricted use for low-risk scopes only with an internal Field Safety Notice being issued for any high-risk scopes processed in the affected chamber. Various corrective actions have been undertaken previously, on the advice of the Authorised Engineer (Decontamination), and further advice has been sought from Public Health England. As the results have returned to within specified limits on the week following the raised result and pseudomonas results have been negative on each occasion it is deemed that there is no immediate concern. Evidence from the Decontamination network indicates this is similar to other units.

Tracking and Traceability
Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and provides accurate traceability of all endoscopes used and significantly reduces the risk of an endoscope that has expired the 3 hour window being used on a patient.

TRUST WIDE AUDITS

Audit #4723 Compliance with Decontamination Procedure for Invasive Devices (Guideline 1341)

It is a required standard of HTM (Hospital Technical Memorandum) 01-01:2016 that full traceability of reusable items can be evidenced. In relation to invasive probes, used in the Outpatient or Theatre setting, this requires the completion of the Tristel Wipe audit book and the insertion of the Tristel Wipe decontamination sticker being placed in the patient's health care record.

The only exception was in Ultrasound; the Radiology Patient System is audited for the same information as patient's health care records are not accessed during this diagnostic process.

This annual audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The 2019 audit showed that compliance with the use of the appropriate system is overall very good and has been sustained in those areas familiar with its use.

The only non-conformance related to appropriate record keeping in the patient's health care records in one area. That particular area was already under increased surveillance from the 2018 audit but despite being provided with additional training mid-year results still showed some non-compliance with appropriate record keeping although there were no concerns relating to the decontamination of the item. An action plan was approved at the Decontamination Group meeting and these actions proved to be effective as all records from that point were audited and found to be fully compliant.

Audit #4734 Decontamination and Single Use Instruments

This annual audit is used to measure compliance with requirements for the management of sterile instruments and single use instruments as per HTM 01-01:2016 and the sample involves each department that is supplied by Decontamination Services and/or uses single use surgical instruments.

This observation audit is carried out by the audit team member for each area with results then reviewed by the Audit Lead and any non-conformances discussed at the Decontamination Group meeting.

The outcome of the 2019/20 audit showed excellent and sustained compliance with the appropriate storage of sterile items and the transportation of contaminated items.

The only non-conformances related to the failure to display a ‘single use’ poster in some storage areas. This was rectified on the day the results were reviewed and new posters provided to those departments.

13 ANTIMICROBIAL REPORT - RHIAN PEARCE (Antimicrobial pharmacist) Antimicrobials: Summary report for financial year 2019/20

13.1 OVERVIEW

Antibiotic misuse is widespread and has profound adverse consequences, most notably the development of antimicrobial resistance. Judicious antimicrobial prescribing is recognised as a critical component in slowing the development of resistance.

Antimicrobial Stewardship (AMS) can both optimise the treatment of infections and reduce adverse events. AMS is now a prominent feature on the government's healthcare agenda, with numerous publications and directives issued to promote stewardship across all healthcare settings.

13.2 SUMMARY 2019/20

- The Antimicrobial Stewardship Committee (ASC) is now meeting regularly. In recent years the ASC has suffered from dwindling clinician engagement. Since clinical leadership is critical to the success of any antibiotic stewardship programme, we are pleased to welcome Alastair Hutchison (Medical director) as the new chair.

- EPMA reporting capacity has continued to improve. Several reports have been developed to allow targeted intervention and improve data capture to support a wide range of stewardship activities. We have also introduced a powerful reporting database (REFINE), which allows active surveillance of antibiotic prescribing across the Trust. It also allows comparison of prescribing trends against other hospitals.

  Effective antimicrobial oversight is the foundation of any stewardship program, but sustained progress in this area can only be delivered through continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship Team.

- Continued work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. We have also reconfigured our antibiotic guideline webpage, making our guidelines easier to navigate.

- Non-CQUIN related audits have been performed on an ad-hoc basis. Limited resource, coupled with competing demands from mandatory targets, has hampered a formal programme of sustained audit activity. Timely reporting with feedback to clinicians is recognised as a significant driver for changing behaviour and improving prescribing and this is something we are keen to renew.

- Participation in *Clostridium difficile* RCA meetings and identifying themes related to antimicrobial prescribing and pharmaceutical review of patients.
- Published a range Safe Medication Practice Bulletins; penicillin allergy, antibiotic oral switch review, fluoro adverse reaction awareness.
- Procalcitonin has been introduced to steward early discontinuation of antimicrobials in COVID patients. We also performed a gap-analysis of available fungal diagnostics locally. Improving the range of laboratory based diagnostic testing for infection is recognised an essential tool for tackling resistance and optimising patient outcomes.
- FY1 teaching sessions; principles of antimicrobial prescribing, diagnosis and treatment of urinary tract infections, Gentamycin/Teicoplanin/Vancomycin prescribing.

13.2.1 NATIONAL TARGETS

CQUIN CCG1a: Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.

Data collection was not possible due to difficulties identifying patients. Data submission is no longer mandatory due to the COVID pandemic. Other trusts have reported similar difficulties, prompting a review of the CQUIN data collection methodology for next year.

CQUIN CCG1b: **Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines.**

DCHFT met the target, achieving 98% compliance. This exceeds the national mean of 87% for Q3.

CQUIN PSS1: Trigger 5, Antifungal Stewardship:

Attainment criteria were met for Q1, Q2 and Q3. This included the development of a comprehensive set of local antifungal prescribing guidelines. Q4 data submission has been suspended by NHSE due to the COVID outbreak.

13.2 ANTIBIOTIC CONSUMPTION TRENDS

Total antibiotic consumption targets now form part of the standard NHS contract. Carbapenem and access target indicators have been removed, but are included below for local use.

13.2.1 TOTAL ANTIBIOTICS

Target: Reduce total antibiotic consumption by 1% from the calendar year 2018 baseline.

Total antibiotic consumption is down 0.46% on last year, but falls short of the 1% reduction required (Fig 1). However, it still represents a total reduction of 22% compared with the 2016 baseline year, with DCHFT achieving the greatest reduction regionally during this period (Fig 2).

*Date range excludes COVID period

Fig. 1

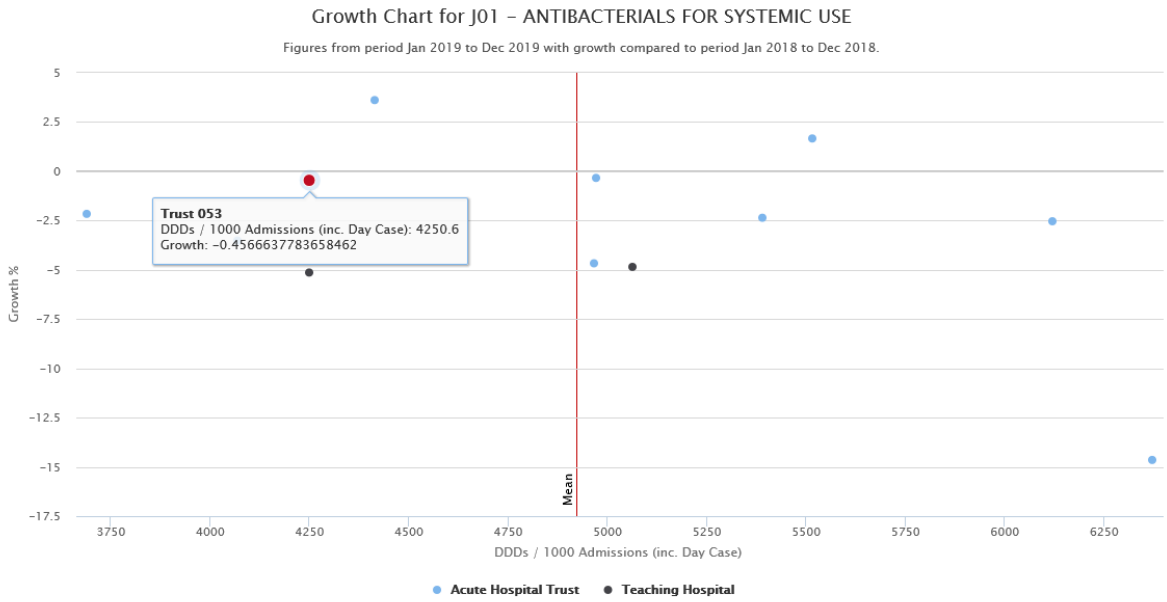
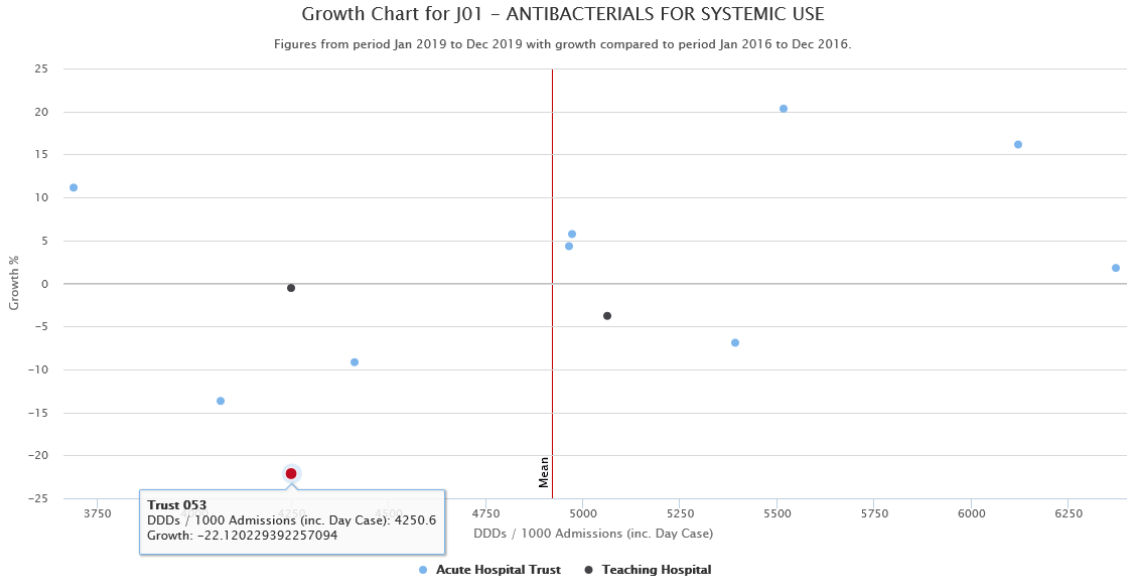


Fig 2.

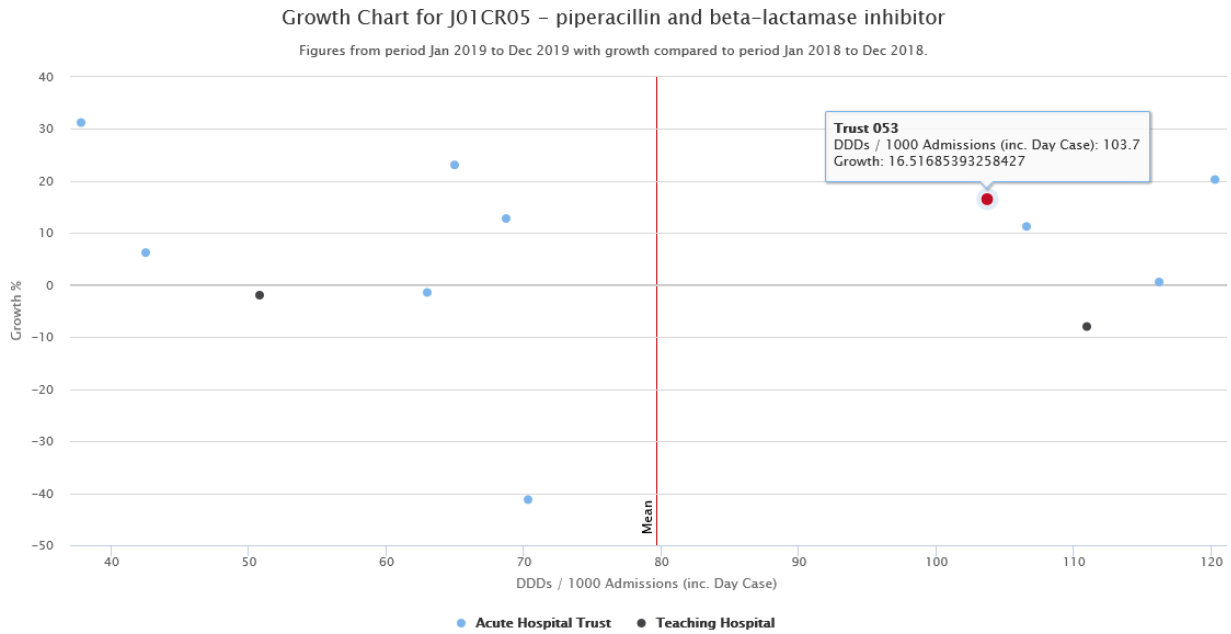


13.2.2. CARBAPENEMS AND PIPERACILLIN/TAZOBACTAM

Our standard reporting tool for monitoring carbapenem consumation indicates that usage for 2019/20 has approximately doubled compared to the previous financial year. Data validation is in progress to verify the figure. A separate report will be submitted to the next ASC and IPC.

Piperacillin/tazobactam consumption is up 16% on last year (Fig 3). The rise in consumption is currently being investigated. A separate report will be submitted to the next ASC and IPC.

Fig .3



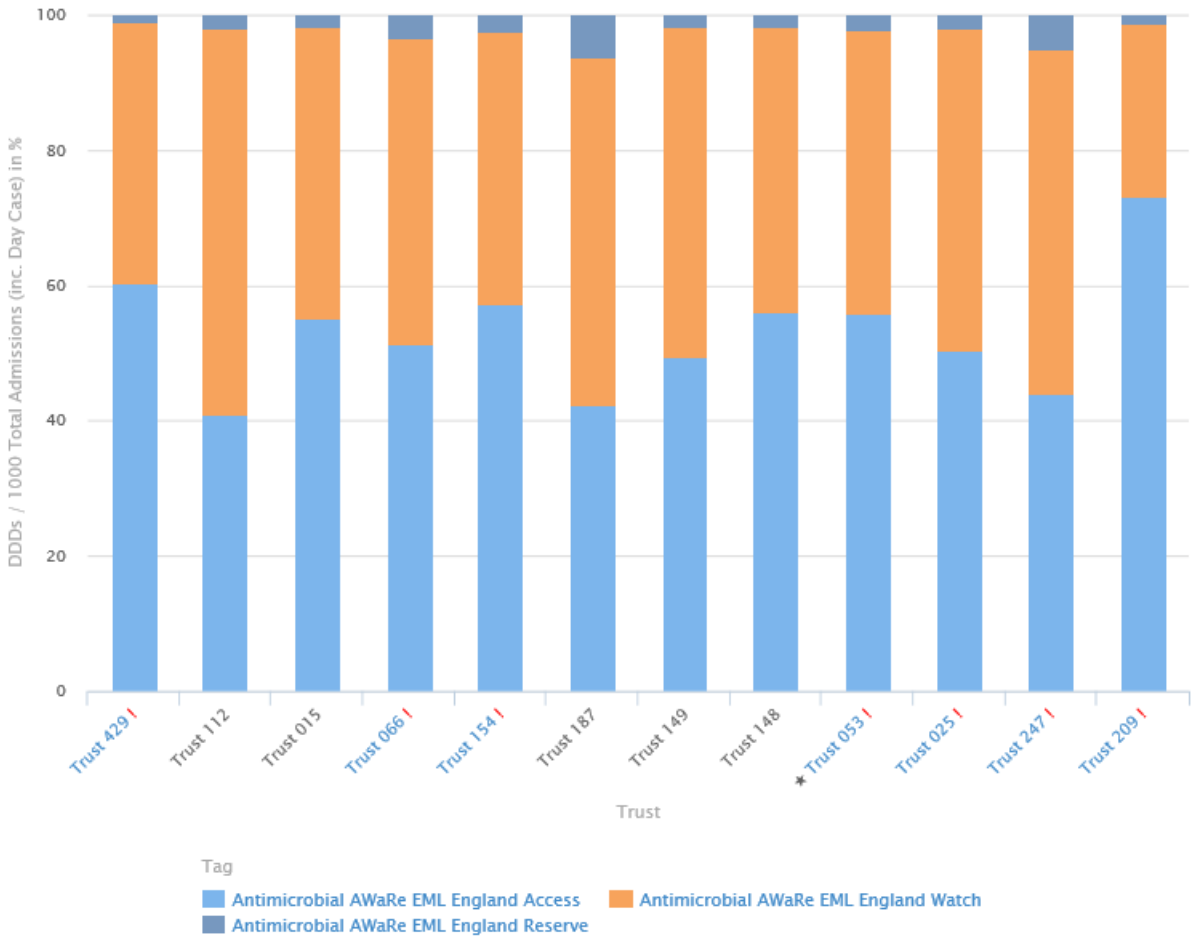
13.2.3. PROPORTION OF TOTAL ANTIBIOTICS BY AWARE CATEGORY

56% of DCHFT's total antibiotic consumption for 2019/20 were narrow spectrum agents (AWaRe access category), comparable to the previous year (57%). See Fig. 4.

Using consumption data alone, measured by DDDs, is a poor surrogate for overall antibiotic stewardship performance. In reality, a trust would meet the consumption targets by using a larger proportion of broad-spectrum antibiotics instead of narrow-spectrum agents. This is a known limitation of how antibiotic consumption figures are currently calculated, and using AWaRe categorisation alongside consumption helps mitigate this limitation.

Fig 4 AWaRe - Proportion of DDD per 1000 admissions by EML (England) category over last 12 months

(DCHFT =trust 053)



13.3 LIMITATIONS

Data are unadjusted for the confounding effects of case mix, age and sex. As such, direct comparison between DCHFT and the national or regional average is limited. In addition, CQUIN audit indicators are prone to inter-rater variability, which may in part explain the variability in performance across England.

Patient outcome data is not routinely collected or published alongside CQUIN and consumption data, raising concerns over the potential unintended consequences following their implementation.

13.4 SUMMARY OF FUTURE WORK

- To establish local AMR CQUIN groups to monitor progress against the 2020/21 AMR CQUINs and steer intervention. This group will report to the AMS committee.

- To ensure that AMR CQUINs are allocated to a suitable clinical lead, to encourage clinical engagement.

- Updating and streamlining the existing audit programme to incorporate CQUIN specific indicators for 2020/21. The CQUINs for 2020/21 focus on diagnosis and treatment of UTI and community acquired pneumonia.

  Next year's CQUIN has a demanding data collection element. NHS England has stipulated that stewardship teams should not collect data; instead, their time is better spent steering intervention and focussing on quality improvement. We would echo this recommendation and urge the Trust to recognise that the current data collection demands cannot be absorbed by the stewardship team, without displacing other core stewardship activities.

- To develop a systematic approach for reviewing local susceptibility patterns as part of the antibiotic guideline development process.

- To delineate channels within the organisation to disseminate audit results and garner support for AMS.

- Continued work on integrating the laboratory and stewardship programme to ensure rapid provision of test results and that clinicians understand their implications.

- We plan to introduce a comprehensive package of antimicrobial prescribing and stewardship training for doctors, nurse prescribers and pharmacists. This will be delivered via e-learning.

- Continued work on developing a set of metrics for monitoring stewardship activity; focusing on process and outcome measures to better illustrate the value and sustainability of our programme. This should also provide us with evidence for future investment and better resource allocation.

- As pharmacist recruitment and retention improves, we are keen to implement a framework for pharmacy-led interventions to optimise antimicrobial therapy, including dose optimisation and systematic conversion of intravenous to oral antimicrobial therapy.

It is essential that we continue to make progress, and as a team, we are pushing ourselves with a new set of challenging ambitions for next year. However, we are unlikely to meet these goals without increased engagement from the organisation, recognising that AMR is a threat to patient outcomes across all clinical divisions and is a shared responsibility. There is also a potential financial loss for the Trust if insufficient resources are allocated to meet the CQUIN targets for next year.

CONCLUSION

2019-2020 has been a very successful year with significant reductions in healthcare acquired infections reported i.e. Clostridium difficile, ECOLI and MSSA blood stream infections. Trajectories for both MRSA and Clostridium difficile were achieved demonstrating excellent practice and engagement with infection prevention and control by Trust staff.

This report demonstrates the continued commitment of the Trust and evidences successes and service improvement through the leadership of a dedicated and proactive IPC team. It is also testimony to the commitment of all DCHFT staff dedicated in keeping IPC high on everyone's agenda.

The last quarter of the year was dominated by COVID-19 and the IPCT workload increased dramatically as a result. Keeping the Trust staff and patients safe was priority during this time and the working day of the IPCN was unpredictable and often very stressful. Throughout this time the team dedicated their time to the management of the pandemic and should be recognised for this hard work. I personally would like to thank my team for their dedication and maintenance of their positive spirit.

The annual work plan for 2020-2021 reflects a continuation of support and promotion of infection prevention & control. Looking forward to the year ahead the staff at DCHFT will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

2020-2021 will be a progressive year as DCHFT leads on the clinical element for the ICNet rollout Dorset-wide.

The Trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working with colleagues across the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Hoyle

Associate Director Infection Prevention & Control

Appendix 1

Infection Prevention & Control Work Plan 2020-2021 V1

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
1	Systems to manage and monitor the prevention and control of infection	Assurance to Trust Board that Infection Prevention & Control standards are maintained throughout the Trust	Bi- monthly Infection Prevention Group to meet and ensure provision of exception and assurance report to the Quality Committee	Further reduction in Healthcare Acquired Infections (HCAIs)	Associate Director Infection Prevention & Control	Bi-Monthly	
		Business continuity and provision of 'live' data for quality of IPC care to remain at a high standard	IPCT to maintain current contract with ICNet. Support of the Dorset wide project to be clinically lead by DCHFT	Contract renewal	Associate Director Infection Prevention & Control	September 2020	
		The Trust will maintain a high standard of Infection Prevention & Control	Heads of Nursing to report on a monthly basis to Divisional Quality & Governance meetings IPC performance standard dashboard to be met Learning from performance data to be disseminated	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Heads of Nursing / Quality	March 2021	
2	Provide and maintain a clean	DCHFT will maintain a clean and safe	Dorset County Hospital to support PLACE	The environment is safe and clean	Infection Prevention & Control Team	Sept 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	and appropriate environment in managed premises that facilitates the prevention and control of infections	environment for patient care	assessment				
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	Facilities Manager	
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	IPC Team Facilities Manager Estates Manager Patient representatives Pharmacy	March 2021	
		All clinical equipment is clean and ready for use at point of care	Use of Clean/Dirty indication stickers implemented Trust wide 2018/19	All clinical equipment will be identified as clean or requiring cleaning	IPCT to implement review process via ward rounds Divisional Heads of Nursing / Matrons to monitor	August 2020	
		DCHFT will maintain a clean and safe water system	Policy to be updated and communicated and implemented Trust wide. Regular audits will be carried out to confirm the effectiveness of the policy.	DCHFT will deliver the Water Safety Policy. Water Safety is a standing item at IPCG.	Head of Estates	March 2021	
3	Provide suitable accurate information on infections to service users and	Patients will be fully informed about their presenting infections. All new cases of *CDifficile,* MRSA and	IPCT to visit newly identified infectious patients and their carers. Provide verbal and written information and	Positive patient feedback	IPCT	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	their visitors	ESBL will be counselled by an IPCN	contact details				
		The Trust will have up to date patient information relating to infection control	Review of all IPC patient information. Check meets standards and revise accordingly	Positive patient feedback	IPCT	March 2021	
4	Provide suitable accurate information on infections to any person concerned with providing further information support nursing/ medical care in a timely information	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all patients and staff	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher, Maternity & Emergency Department, providing clinical support to staff and patients	Minimum cross infection, reduced prolonged outbreaks of infection, reduced HCAIs	IPCT	March 2021	
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other	Achieve trajectory for *Clostridium difficile* infection (CDI) TBC cases (does not include cases whereby no lapses of care were identified	Undertake Root Cause analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset- Healthcare Acquired and Community Onset Healthcare Acquired	All cases of CDI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Divisional Head of Nursing / Matrons	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	people	Reduce rates of Gram-negative blood stream infections (BSI) by 50 % by 2023	Undertake IPC led Root Cause analysis of all hospital acquired cases of gram negative BSI – escalate to full RCA if lapses in care	All cases of Gram negative BSI will have RCA investigation and relevant action plan if deficits identified. RCA's will be discussed by IPCT and any trends reported to Infection Prevention Group (IPG)	Associate Director Infection Prevention & Control	March 2021	
		Ensure the Trust is robustly prepared for Winter	Support staff vaccination programme for seasonal influenza Reinforce Seasonal Influenza Policy and Pandemic Influenza Policy Ensure staff are familiarised with the Outbreak/Noro policy	The Trust will be able to function effectively during the Winter months and Infection Control standards are maintained	Associate Director Infection Prevention & Control	October 2020	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		Ensure Trust remains aligned to Public Health England COVID-19 Infection Control Guidance.	Maintain COVID-19 Board Assurance Framework and report bi-monthly to IPCG , Quality Committee and Trust Board	The Trust will be able to support the demands of the COVID-19 pandemic	Associate Director of Infection Prevention and Control Director Of Quality and Nursing	Ongoing	
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection	High standards of hand hygiene practice throughout the Trust.	Hand hygiene audits to be undertaken by all clinical wards/departments. Wards/departments that achieve<90% to present action plan to IPG.	Hand hygiene results >95% and sustained at this level for all wards/departments Departmental Managers to report to IPG with action plan when hand hygiene results <90%.	Divisional Head of Nursing / Matrons	Monthly	
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT	Bi-Monthly	
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2020	
		Education	Support DCHFT mandatory training programme	Education reflects national and local requirements for	IPCT	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Via e-learning and face to face training	mandatory IPC training.			
7	Provide or secure adequate isolation facilities	Ensure the risk of cross infection is reduced Trust wide	Undertake annual audit of isolation precautions to ensure appropriate signage, PPE precautions are in place. Ensure that audit incorporates patients who should be in isolation.	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2021	
8	Secure adequate access to laboratory support as appropriate	IPCT to support and be involved in the county wide pathology project ensuring delivery of safe patient care is not affected	IPCT to be involved in county wide meetings where appropriate and provide expert support for the project	Safe transition of service	Associate Director Infection Prevention & Control	March 2021	
			IPCT at DCHFT to take nursing lead on development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project to be implemented once funding released	One ICNet system across Dorset	Associate Director Infection Prevention & Control	March 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	Audit programme- to audit compliance with Key IPC policies	PVC audits undertaken to ensure compliance with observation standard	PVC observations will be observed every shift and recorded on Vital Pac	IPCT	Quarterly	
			Urinary catheter documentation audits undertaken to ensure compliance with observation standard	Urinary catheters will be reviewed on a daily basis and care documented on Vitalpac	IPCT	Monthly	
			Audit compliance with CPE screening recommendations. Divisional Matrons to review results with wards and develop action plans dependant on results of audits	Audit identifies that documentation supports appropriate risk assessment is undertaken for patients admitted to Trust	IPCT Divisional Matrons	Biannually	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Participation in mandatory Surveillance of Surgical Site Infections for Orthopaedics and Breast. Review results with clinicians. *Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.* If required, action plan to be developed and implemented Results to be presented at Divisional Governance Meetings and IPCG	Surgical site surveillance meets national mandatory requirement Rates of SSI are within acceptable parameters	IPCT Divisional Consultant Leads Divisional Matrons	March 2021	
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the	Reduce the number of sharps injuries caused by sharps disposal	Undertake annual Sharps Audit to ensure Trust wide adherence to recommended practice. Action plan with Divisions to reduce risks identified on audit.	Audit identifies compliance with safe management of storage and disposal of sharps	IPCT	Sept 2020 (IPCT) Oct 2020 (Provider)	
		Prepare all clinical staff to provide direct patient care for those requiring airborne precautions	Divisional fit mask testers in place to support evolving needs created continuous change of suppliers of masks influenced by COVID-19 pandemic	All clinical staff will have access to FFP3 training and able to care for patients using airborne precautions	Health & Safety Lead	Ongoing	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	provision of health and social care	Staff at DCHFT are equipped with the knowledge, skills and equipment to care for 'high risk' infectious patients	Ensure all 'IPC Emergency Boxes' are maintained and in date Ensure all relevant policies are up to date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	All clinical staff are aware and able to support the emergency preparedness of the trust for IPC issues	Associate Director Infection Prevention & Control / Lead Emergency Planner	October 2020	

There are 10 criteria set out by the *Health and Social Care Act 2012* which are used to judge how we comply with its requirements for cleanliness and infection control. This is reflected in the *Care Quality Commission Fundamental Standards Outcome 8* and detailed above in the annual work plan which is monitored by the Trust's Infection Prevention and Control Group.

Emma Hoyle – Associate Director Infection Prevention & Control June 2020

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