



INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE



Dorset County Hospital
NHS Foundation Trust

Infection Prevention and Control Annual Report 2020-21



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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 Chief Nursing Officer 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 work plan, 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 2020- 2021 was a challenging but 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 2020-2021
- 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%
- No outbreaks of Norovirus
- 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 fifth year as Chief Nursing Officer, 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 2020– 31st March 2021. 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).

It has been a particularly challenging year for the Trust and Infection Prevention and Control over the reporting year as the world-wide pandemic of COVID-19 continued. 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 for patients and staff.

The Trust met the target for zero cases of preventable MRSA bacteraemia and reported 12 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.

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention and Control team support epitomizes 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
Chief Nursing Officer
Director of Infection Prevention and Control

2 INFECTION PREVENTION & CONTROL ARRANGEMENTS

2.1 INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 5 times during 2020- 2021. 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. Chief Nursing Officer, 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 2020-2021:

- 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:

- Nicola Lucey, Chief Nursing Officer / Director of Infection Prevention and Control
- Dr Paul Flanagan, Consultant Microbiologist and Infection Control Doctor – left July 2020 – temporary replacement role by Dr Lucy Cottle and Dr Amy Bond
- Emma Hoyle, Associate Director Infection Prevention and Control – left for secondment March 2021
- Abigail Warne, Specialist Nurse- secondment to Matron IPC role from March 2021
- Julie Park, IPC Nurse
- Christopher Gover, IPC Nurse
- Helen Belmont, IPC 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 until June 2020)

3. HEALTHCARE ASSOCIATED INFECTIONS

3.1 METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2020-2021 assigned to the Trust. The last case of preventable 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 ≥ 48 hours post admission) have significantly reduced.

3.2 *STAPHYLOCOCCUS AUREUS* BACTERAEMIA (MSSA)

In 2020-2021 there were a total of 57 cases of MSSA bacteraemia, of these 40 cases were identified <48 hours of admission and 17 identified >48 hours after admission (Chart 1).

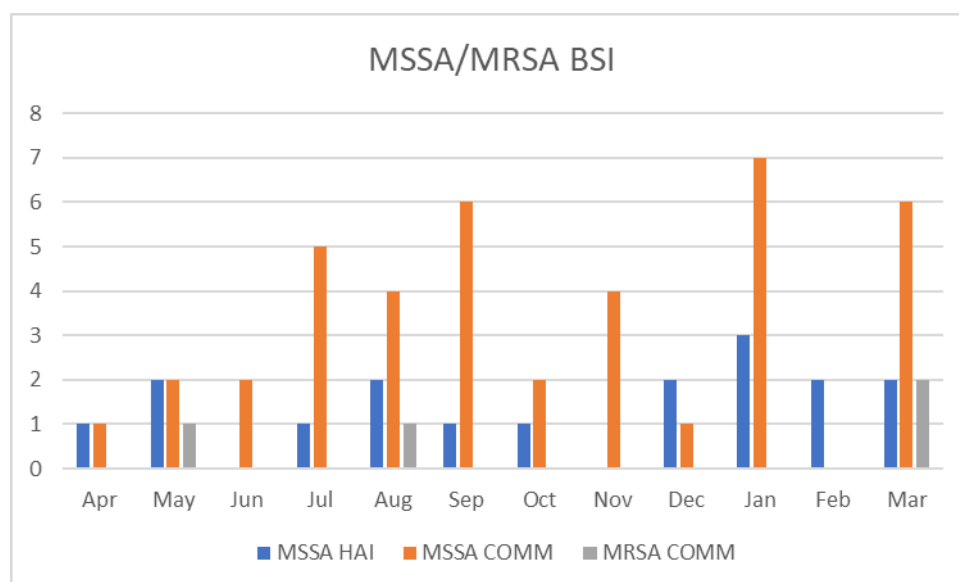


Chart 1

To manage MSSA blood stream infections 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.

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 2020-2021 there were a total of 172 positive BSI samples for E.coli. 17 of these cases were attributed to the Trust (Chart 2). All cases of E.coli that occur >48hrs after admission are reviewed by the 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.
- 3.3.4 In 2020-2021 there were a total of 40 positive BSI samples for Klebsiella spp, 10 of these cases were attributed to the Trust (Chart 2). This was a decrease by 8 cases from 2019-2020.
- 3.3.5 In 2020-2021 there were a total of 17 positive BSI samples for Pseudomonas aeruginosa, 6 of these cases were attributed to the Trust (Chart 2).

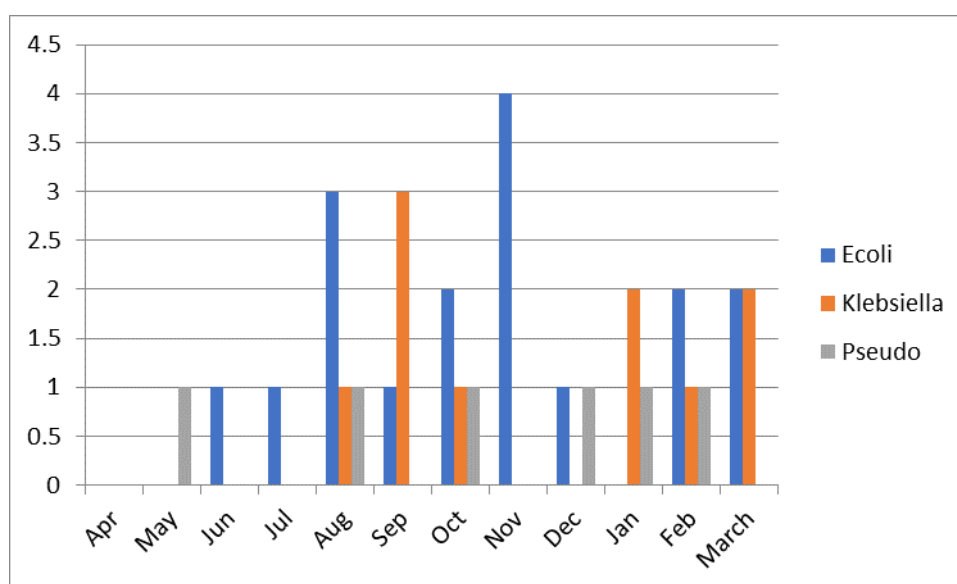


Chart 2

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 in the previous 12 weeks

Due to the COVID-19 pandemic trajectories were not nationally set. The Trust agreed to work towards the previous years trajectory which was 16 cases. In total the Trust reported 22 cases detected HOHA; of these cases 10 were appealed as non-preventable with no lapses in care; this resulted in 12 cases reported as hospital acquired. The Trust identified 57 cases in total.

All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Patricia Miller, Chief Executive Officer, or Nicola Lucey (Chief Nursing Officer/Director of Infection and control), 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

There have been no outbreaks or cases of Norovirus in the reporting year 2020-2021. This could be attributed to the national and local lockdowns implemented as a result of the COVID pandemic and measures put in place to manage social contact.

4.2 INFLUENZA

There has been a dramatic national reduction in cases of Influenza A & B during the Winter 2020-2021 in comparison to the previous year. The impact of social distancing, mask wearing in the community and local lockdowns reduced the infectivity to zero at DCHFT and we had no inpatients with influenza.

In preparation for 'Flu Season' all Trust staff were offered the annual flu vaccine. 91% of front line staff were immunised and 91% of all staff, an increase from 84% the previous year.

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. 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 FRACTURE NECK OF FEMUR

The following tables demonstrate the number of operations completed, and number of completed post discharge questionnaires for July – September 2020 (Table 1) and last 4 periods for which data was available. Data for Quarter 4 has not yet been received from PHE and is therefore not included in this report.

The percentage of post discharge questionnaires returned by patients is lower than the national data for all hospitals. The reported infection rate of 1.4% for the previous 4 periods is slightly higher than national picture of 1.1% over the past 5 years.

Table 1 July – September 2020 Repair of Fractured neck of femur

Operations & Surgical Site Infections		Dorset County Hospital NHS Foundation Trust	
		Jul-Sept 2020	Last 4 periods
Operations	Total number	53	138
	No. with PQ given	47	115
	% with PQ completed	66%	58.3%
Surgical Site Infection	No. of inpatient/readmission % infected	0 0%	1 0.7%
	No of post discharge confirmed % infected	1 1.9%	1 1.0%
	No of patient reported % infected	0 0.0%	0 0.0%
	All SSI % infected	1 1.9%	2 1.4%

Results for the second quarter 2020-21 show a slight improvement on those for the fourth quarter 2019-20 with an infection rate of 1.9% against 2.4 Continued surveillance during the next audit cycle (2021-22) will assist in maintaining improvements as will the continued feedback to surgical teams on performance

5.3 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. This has remained the case since the last IPC annual report.

5.4 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 79% down from 92% last year. Information from the audits is shared with Matrons and Divisions to discuss with ward leaders. Audits will then be retaken to see if there is increased compliance. 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. Results from any re-audits are fed back to Matrons and ongoing audits are completed to ensure any actions identified are effective.

5.5 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 34 rooms in use for infection control purposes 74% had correct signage, 26% incorrect signage and a total of 85% 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.

5.6 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 97 % of all catheters being recorded. When split between the Divisions, Family and Surgery returned 96% compliance and Urgent and Integrated Care 98% compliance. These percentages are an average. Urinary tract infections are the second largest single group of healthcare associated infections in the UK. Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is taken into account and considered prior to insertion of urinary catheter and there is a continuous process for review. Please note due to increased pressures trust wide a catheter recording audit was not carried out for the month of April 2020.

5.7 Carbapenemase producing enterobacteriaceae audit (CPE)

Carbapenem antibiotics are a powerful group of β -lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

Public Health England recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. Although PHE advice on this changed in December 2019 we have now produced a dedicated policy for CPE and it remains that all patients admitted to the Trust must have a screening risk assessment carried out on admission.

This audit, which was carried out in May and December 2020, aims to determine the level of compliance across the trust with the screening assessment being conducted on admission and the correct actions taken if screening is required.

Results show that for May the compliance with undertaking the admission screening risk assessment was 73% and in December 77.1%. This gives an overall compliance of 75% which is down 1% on the previous year's result. This audit will be repeated next year and, following launch of the new CPE policy, it is anticipated that compliance will improve. In order to demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated for 2021-22. In conjunction with the role out of a new CPE policy ward and unit leads have also had the opportunity to discuss changes in guidance with the IPC Team and it is hope that this will have a positive impact upon future audit results

6 EDUCATION

Despite the COVID pandemic the Infection Prevention & Control Team continued to provide formal face to face education sessions training for both clinical and non-clinical staff. IPCT also was incorporated into the following programmes and all of the nursing team were involved in delivering the sessions:

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

Mandatory Training for clinical and non-clinical staff has been also offered via an online workbook.

Overall compliance with mandatory IPC training over the year was 82% for clinical staff and 82% for non-clinical staff. The Divisions are responsible to release staff to access their training. During the pandemic some release of staff for mandatory training was reduced due to the safety pressures, as pressure reduced staff were able to move forward with the mandatory training.

IPCT recognised that additional support and training was required and now provides face to face mandatory training in addition to the online package.

Throughout the pandemic the infection control team also promoted the use of PPE, revisited hand hygiene and supported good IPC clinical practice trust wide, this included educating and demonstrating to staff how to effectively apply the fundamentals of donning and doffing to further protect themselves in their working environment.

During the second wave of the Covid-19 pandemic Dorset County Hospital were fortunate to have members of the military work alongside our workforce offering additional support with increased pressures across the trust and as such the military staff were also offered Infection Control Training.

7 POLICY DEVELOPMENT/REVIEW

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

- Standard Precautions
- Covid-19 outbreak
- Ebola guidance
- Surveillance guidelines
- SOP for COVID testing unit
- IPC Advice for suspected Avian Flu
- Management of patients with multidrug resist inc ESBL
- Urinary Catheter
- Major Outbreak
- SOP TVC endoscopy water tests
- Pandemic flu
- Ice making machine
- CJD
- CPE
- Major Outbreak

8. COVID-19

The global pandemic of Covid-19 remains ongoing and at the forefront of providing healthcare services that are safe for both patients and staff. The trust response continues to be led by the Incident Management Team.

The hospital environment has been adapted to suit the needs for this new virus and the complexities that it creates. Over the past 18 months the IPCT have continued to

support the trust throughout the pandemic with updates to guidance in line with Public Health England and expert response to emerging situations. The IPCT have also worked closely with the Dorset wide ICS to share best practice and learn from other trusts.

At DCHFT the IPCT have managed the routine swabbing of inpatients to ensure patients are swabbed for Covid-19 on admission, day 3 and day 5-7 as per national guidance. This has helped to ensure any potential cases or outbreaks are identified in a timely manner and have ultimately helped to achieve a low rate of nosocomial transmission.

However, due to the extremely transmissible nature of Covid-19 and increased prevalence in the community we did have 4 wards with identified outbreaks between December 2020 and January 2021. Comparatively this was a low number of outbreaks for an inpatient setting in the South West region.

There was also an outbreak in the Poole Dialysis unit (external provider) January 2021.

One staff outbreak within a non-clinical team based at Vespasian House. The total number of patients affected from outbreaks was 63 compared with 33 positive staff members.

The outbreaks were complex in nature to manage as prevalence of Covid-19 was high and the pandemic in the UK was reaching its second wave peak. The decision was made during the outbreaks to cohort positive patients due to the volumes being admitted.

These were our first outbreaks of covid-19 and increased cases of nosocomial transmission since the start of the pandemic was declared and the UK experienced its first wave of the virus in March 2020. The trust followed national IPC guidance throughout the pandemic and this is supported by the board assurance framework. On investigation due to the nature of the virus and its transmissibility it was hard to identify the root cause of outbreaks. However, the first outbreak was during a period of time when visiting was not restricted and Dorset was in tier 2 national restrictions and the outbreaks following this could have been attributed to the relaxation of lockdown rules over the Christmas period.

The response from the ward teams, matrons, CSM, microbiologists and IPCT was prompt enabling actions required following positive results to be taken quickly. Personal Protective Equipment (PPE) supplies have remained good and there have been no shortages. Staff support remains ongoing remobilisation of patient services was in place from September 2020.

9 Infection Prevention and Control Surveillance System (ICNet)

Last year we highlighted the joint procurement and implementation of a County Wide instance of ICNet, an infection prevention and control surveillance solution supplied by Baxter Healthcare Ltd.

a. The status of the Dorset partners varied at the inception of this Programme:

- Dorset County Hospital (DCH)
- Poole Hospital (UHD)
- Dorset Health Care (DHC)
- Royal Bournemouth and Christchurch Foundation Trusts (UHD)

b. The IPC Programme is divided into three phases:

Phase 1 – DCH migration to hosting by DHC – completed July 2020

Phase 2 – UHD implementation – completed 2021

Phase 3 – DHC implementation – scheduled September 2021

There have been several delays due to the pandemic which consisted of staff availability in testing, pathology lab issues and new pathology systems due to be installed. It is hoped that by the end of this current year the system will be running smoothly across the trusts.

**INFECTION PREVENTION CONTROL & CLEANLINESS ANNUAL REPORT
2020/21**

Throughout the past year, the Housekeeping team have worked hard to maintain the cleanliness of the hospital, coping with the fast changing nature of the service due to the unprecedented challenges of the covid 19 pandemic, and thus contributing to the safety of patients and staff.

We have worked in collaboration with the wider teams throughout the hospital, particularly with our colleagues in Infection Prevention Control, to ensure our continued focus on providing and maintaining a hygienically clean and appropriate environment for our patients, visitors and colleagues.

Cleanliness

Cleaning services throughout the hospital site and now, following office moves required by the new social distancing rules brought about because of the covid-19 pandemic, several office buildings outside are provided by our in house team of 140 housekeeping staff. The numbers of staff were increased by a number of volunteers who came to work in the Spring/ Summer of 2020 and by a number of military personnel in the early months of 2021. This team is augmented by external contractors who undertake the external window cleaning and pest control across the site, both contracts being managed by the housekeeping team.

As far as is practicable staff are allocated to a particular ward or area, giving them a sense of ownership and continuity in the cleaning regime. The amount of time allocated to the cleaning on a daily basis is determined initially by use of a software system, DomTime, and further by input from the cleaning and clinical teams. Throughout the past year the time allocated to areas have been reviewed and amended on a more frequent basis due to the changes in use of many areas and the changes in IPC and other guidance. Our team have adapted well to this constantly changing environment.

We are currently reviewing the needs of the whole hospital with the changes brought about by the return to business as usual, the increase in the amount of weekend working and the expansion of areas such as the Emergency Department (ED). This is also further necessitated by the introduction of the new national cleaning standards which we will incorporate into our working patterns to ensure our compliance with these and the maintenance of the high standards we strive to achieve. The review of all the cleaning schedules will form part of this to ensure they remain fit for purpose and further to ensure they can be converted to electronic form with the introduction of a new cleaning software solution.

Standards of cleaning are monitored through the audit process, which is carried out weekly or monthly depending of the category of risk, information submitted in several ways to the PALs team, the PLACE assessment and CQC surveys.

We receive the majority our patient feedback on a report from the PALS team on a monthly basis. Most of the comments we receive are favourable and we endeavour to share these with the staff who are responsible for the areas concerned. If there are a number of negative comments the area is audited to check standards are being maintained.

In spite of the additional pressures placed on the hospital and the housekeeping team due to the covid-19 pandemic, the high standard of cleaning across the site has been maintained. This contributes to the positive patient experience, patient safety and low infection rates.

Cleanliness- Deep Cleaning

In what has been a busy year it is pleasing to report that we have taken every opportunity to complete our deep cleaning schedule. Our deep cleans are supported with the use of fogging using our HPV machines, which use hydrogen peroxide vapour to ensure the area is sterile.

To enhance the efficacy of the cleaning of the ward areas of the hospital, a deep clean programme is planned for all areas throughout the year. The cubicles are deep cleaned frequently following the discharge of patients with infections.

The air conditioning work which took place on level 3 south wing facilitated the clean of all of the wards in that area, along with two of the level 2 wards. Other wards have been deep cleaned following covid outbreaks. We have worked hard with the clinical teams to schedule and complete these cleans whilst continuing to allow flow through the hospital and will continue to do so throughout the coming year.

We have started to work on the program to replace our current HPV machines and will be working with the IPC team and procurement to identify the best machines for our use. The new generation machines use much shorter cycles as the scrub the air after the HPV has had time to work and so will help with patient flow. They further use modern technology so that the user does not have to be present in the room to start the cycle thus contributing the health and safety of staff and visitors.

Cleanliness- internal Monitoring

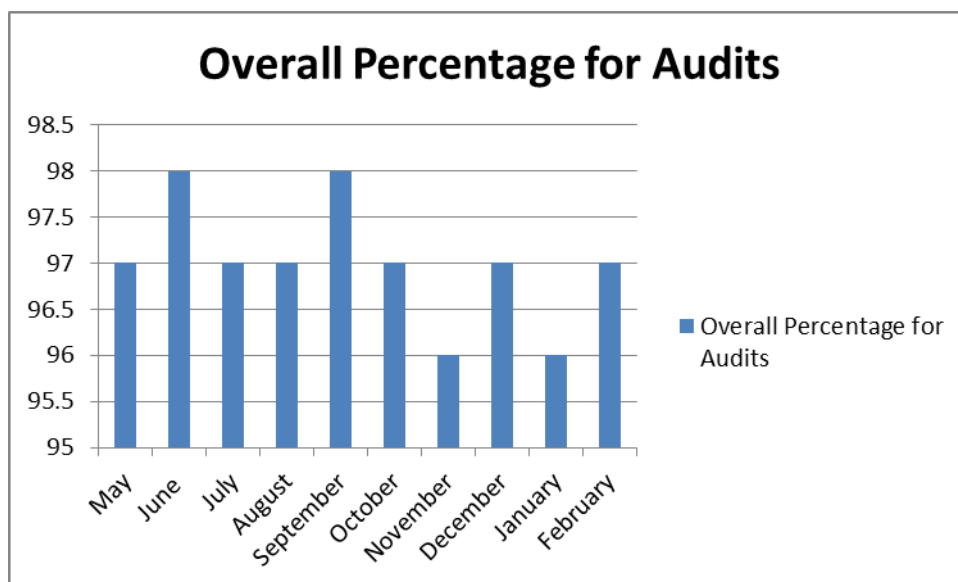
The restrictions put in place due to the covid 19 pandemic have affected the ways in which the standard of cleanliness is measured.

Audits, measuring our standard against the national standards of cleanliness, have continued to be carried out throughout the past year, although the areas that could be visited at times meant that some rooms could not be assessed due to infection control measures. The supervisors carry out these audits on a weekly or monthly basis, the timescale depending on the deemed level of risk in an area, and issues

are highlighted and addressed by the housekeeping team. Should the score be concerning a schedule of remedial work is put into place.

We are hoping to have a new IT system in place in the coming months which will make the amount of rectification needed and the timescale of completion more transparent to the clinical teams. This system will also support the audit of the new items required for audit under the new cleaning standards, such a mid-height surfaces which were not previously included.

A casualty of the covid 19 pandemic has been the weekly environmental audit where the housekeeping management team along with an IPC and estates representative are joined by two patient assessors to assess the cleanliness and condition of a ward or outpatient area. This has been used as a validation of the supervisor's audit. These were recommenced for a short period in the latter part of the year without the presence of the patient assessors and it is hoped that in the coming year the full program can be reinstated.



PLACE- Patient Led Assessment of the Care Environment

Due to the workload placed on the NHS and the infection control measures that remained in place throughout the year, the PLACE assessment for 2020 was cancelled. We are still waiting to be advised of the dates during which we will have to hold our assessment this year but this is likely to be in the autumn of 2021.

11 ESTATES REPORT (DON TAYLOR – Head of Estates and Facilities)

11.1 WATER QUALITY

Throughout 2020, the Estates Team have maintained the Trust's water services and reported to the Water Quality Management Group (WQMG). Both have been made more difficult to achieve due to the restrictions of COVID with the WQMG sitting only three times.

Activities to maintain water quality continue to be supported and audited by independent experts in water hygiene management from the Water Hygiene Centre.

The Responsible Person role has been transferred to the Deputy Head of Estates and Facilities, Terry May, whilst the role of Authorising Engineer (Water) continues to be fulfilled by Paul Limbrick. Nicola Lucey, Chief Nursing Officer/ 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 amended, in agreement with the WQMG, to take account of anticipated difficulties in routine surveillance monitoring due to COVID-19. These remain in force and under review.

Although COVID has presented the Estates team with unique and complex challenges there has been continued progress in the remediation and closure of items identified in the L8 Risk Assessment throughout the period including;

- Installation of subordinate loop temperature monitoring system (ongoing)
- Servicing and testing of Thermostatic Mixing Valves
- Replacement of booster sets and systemic balancing of systems temperatures,
- Removal of dead legs and Little Used Outlets across the system.

Additional resource should continue to 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 although these are fewer than in previous years. These primarily present risks to continuity of supply rather than direct infection issues and are handled promptly, making improvement as opportunities present themselves.

Bacteriological surveillance, principally for Legionella and Pseudomonas, has been improved in its scope and management, however, COVID has presented some difficulties with whole departments becoming less used and risking stagnation.

Over the period covered by this report, MAR20 – MAR21, there were a little over one hundred missed routine samples, the vast majority being sampled the next week but with the longest delay being six weeks in ICU due to it being a Red Zone for Covid and inaccessible. ICU carried out enhanced flushing as a prophylactic and the outlets showed clear when eventually tested.

There were eighty five instances of raised Pseudo. A. counts during regular surveillance testing involving eight outlets. The vast majority of the raised counts are from a single issue on Prince of Wales ward (POW) that was extremely difficult to fault find due to the multiple causative factors and considerable delay in correcting it as the system had to remain available for patients. Of the others, all of which short lived, there were two more in POW, one on SCBU and the remainder on Fortuneswell.

There were seventeen instances of raised Legionella counts during regular surveillance testing involving five outlets. Most of these are due to the design issues previously reported in the Robert White Centre which are yet to be satisfactorily addressed. There were wone other issue in each of ICU and Renal Dialysis.

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

Ordinarily we would have a list of areas re-floored with new vinyl, often replacing carpet. However this was not carried out in this period due to the pandemic.

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, although clearly the pandemic has affected access and productivity in many areas.

11.5 VENTILATION

During 2020/21 Estates and Housekeeping have continued to carry out high level deep cleaning in critical areas, particularly areas that have been affected by Covid. 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, although these have been limited due to the pandemic.

11.7 CAPITAL WORKS

11.7.1 BED Triage unit – modular unit quickly procured and installed to a high standard outside ED. This was in response to the pandemic and allowed ED to triage patients with or without Covid-19 symptoms outside of the

department. The unit is largely HBN and HTM compliant with appropriate water services and wash hand basin provision.

- 11.7.2 Assisted in-house estates team with the acquisition and installation of additional hand washing facilities and separation lines as the hospital configuration changed in response to the pandemic
- 11.7.3 **Supply and install of new signs** to compliment changes brought on by the pandemic, For instance, wash hand reminders, directional signage to relocated departments, social distancing signs, directional signs to Covid-19 testing unit and vaccination centre
- 11.7.4 **Dermatology** – improved spacing in PUVA treatment area to better separate patients and staff. Creation of additional clinic rooms in lieu of offices to improve clinical facilities in the department
- 11.7.5 **Female Changing Rooms (South 0)** – refurbishment removed some IPC risks including split flooring, porous surface finishes and overall fabric condition
- 11.7.6 **New CT Scanner** – environment designed and built to HTM and HBN. Improved ventilation, lobby protection, water services and wash hand basin provision
- 11.7.7 **Ridgeway Bay and Anaesthetist Office** – More suitable non-clinical location for anaesthetists combined with release of space to create 5 additional beds to HBN standard. New bay included suitable distancing between beds, wash hand basin provision and surface finishes to compliment cleaning
- 11.7.8 **Pharmacy Robot** – Replacement and upgrade of Pharmacy Robot including new flooring and associated mechanical and electrical works.
- 11.7.9 **Medical Day Unit (MDU) into Audiology** – Reconfiguration of Audiology area in South 0 into a suitable space for MDU to enable works to ED to commence.
- 11.7.10 **Flat Roof above Rehab** – Flat roof improvement / replacement
- 11.7.11 **Physio West Annex** - Alterations to Hall area to create suitable space for Physio / Pulmonary rehab - restart works to include 2no. Side rooms.
- 11.7.12 **Therapy Changing Room Facility** - Changing room facilities for therapy staff. Staff needed facility following departmental move from rehab corridor to Damers House.
- 11.7.13 **Children's centre audiology booth** - Construct an Audiology Booth within the Children's Centre
- 11.7.14 **LED Lighting** - Replacement of traditional lighting with energy efficient LED lighting
- 11.7.15 **Maternity Entonox** - Upgrade of ventilation system across delivery suites

- 11.7.16 **Ridgeway Ward Storeroom** - Create a storeroom in new clinical bay.
Demand caused by patient type changing and need for more patient aids
- 11.7.17 **ICU curtain rails** - Reposition curtain rails to offer privacy to patients where layouts in bays have changed
- 11.7.18 **New Modular Unit for Renal** - Provision of modular unit to increase renal dialysis space. Location outside South 0
- 11.7.19 **UPS Upgrades** - Replacement / upgrade of UPS in North Wing Main Server Room & Main Theatres 1 & 2
- 11.7.20 **Same day Emergency Care (SDEC)** - Multiple small jobs to enable currently SDEC area (formerly SAL) to work as SDEC in the longer-term
- 11.7.21 **3 Nr Distribution Board Replacement** – As part of the Pathology upgrade replacement of 3Nr distribution boards on North wing Level 3
- 11.7.22 **South Wing Cooling** – Installation of comfort cooling within the South Wing 3rd floor
- 11.7.23 **Therapies equipment Storage** – Provision of containers to provide storage for therapies equipment

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

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 Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive is transferring to the Medical Device Regulation and as our Notified Body is based in Sweden an EU Representative has been appointed to ensure compliance with transitioning UK standards.

The Notified Body will be undertaking a two day surveillance audit in April 2021 and this will be undertaken remotely via video link due to ongoing travel restrictions.

The Accreditation held by the service continues to give quality assurance on the products produced and also allows the department to provide services for external customers.

External Customers

The department provides a service to various external customers including dental practices in East and West Dorset, a local GP practice and the Dorset & Somerset Air Ambulance. Undertaking work for external customers is only possible due to the accreditation achieved by the service.

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 2021 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 or when a new wrap is introduced. Previous testing still showed 100% sterility which gives assurance that the decontamination process is effective.

A new double-bonded wrap was introduced in 2020 and sets wrapped in this will be sent for testing once they have expired their 365 day shelf life.

Staff Training

All Managers and Supervisors have achieved qualifications relevant to their role. This gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day to day basis.

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.

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 customers.

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 2021.

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.

Rinse water samples are taken from each washer chamber on a weekly basis to be tested for TVC and pseudomonas aeruginosa. There have been very occasional raised results but these have returned to an acceptable limit on the next round of testing. Pseudomonas aeruginosa has not been found in any sample taken.

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.

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and more recently in the outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3 hour window being used on a patient.

TRUST WIDE AUDITS

Audit #4936 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 2020 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 since the 2018 audit and whilst a significant improvement has been seen they are still unable to evidence full compliance with appropriate record keeping. There are no concerns relating to the decontamination of the item. Increased surveillance in this area will continue.

Audit #5010 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 also 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 2020/21 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 and having evidence of local protocols relating to the use of single use instruments and hood masks. These were rectified promptly and noted as complete on the non-conformance log. The log is reviewed during the Decontamination Group meetings.

13 ANTIMICROBIAL REPORT - RHIAN PEARCE (Antimicrobial pharmacist)

Antimicrobials: Summary report for financial year 2020/21

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.

2. Summary 2020/21

- The Antimicrobial Stewardship Committee (ASC) is now meeting regularly. In recent years the ASC has suffered from dwindling clinician engagement. Since medical clinical leadership is critical to the success of any antibiotic stewardship programme, we are pleased to welcome Alastair Hutchison (Chief Medical Officer) as the new chair.
- Effective antimicrobial surveillance 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;
 - ❖ 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 has greatly improved our ability to monitor antibiotic prescribing trends across the Trust. It also allows us to compare our prescribing trends against other hospitals.
- We have continued work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. Our antibiotic guideline webpage has been reconfigured, making our guidelines easier to navigate.
- We performed several audits, including;
 - ❖ An audit of the adherence to Teicoplanin prescribing guidelines
 - ❖ Audit of antibiotic course length in Community Acquired Pneumonia

- Participated in *Clostridium difficile* RCA meetings, providing a formal review of antibiotic prescribing and feeding back to clinical teams directly, allowing us to capture any emergent themes related to antimicrobial prescribing.
- We lead and investigate RCAs involving antimicrobials; as an example, we have implemented a range of improvements relating to gentamicin prescribing and monitoring as a result.
- We published the following Safe Medication Practice Bulletins;
 - Gentamicin and Ototoxicity
 - Gentamicin 5mg/kg extended interval dosing regimen
- Developed a series of posters to promote the early discharge of patients receiving antibiotics.
- Procalcitonin has been introduced to steward early discontinuation of antimicrobials in COVID patients. We also participated in a national research project investigating the utility of procalcitonin during the COVID pandemic. Improving the range of laboratory-based diagnostic testing for infection is recognised as an essential tool for tackling resistance and optimising patient outcomes.
- Teaching sessions to ANPs and FY1s;
 - Principles of antimicrobial prescribing
 - Gentamicin/Teicoplanin/Vancomycin prescribing
 - Introduction to the Antibiotic review toolkit with case studies.
- Dalbavancin and Ceftazidime/avibactam were welcome additions to the local formulary, improving the range of antibiotics available locally to treat increasingly complex cases involving resistant bacteria.

2.1. National targets/regional benchmarking.

CQUINs: Suspended due to COVID

NHS Benchmarking Network, Pharmacy & Medicines Optimisation – Antimicrobial Stewardship 2019-20;

DCHFT were noted to be outliers in terms of joint microbiologist/pharmacist AMS rounds, performing significantly fewer than the national mean (national mean = 1.3 AMS rounds per 100 beds per week, DCHFT = 0.4 AMS rounds per 100 beds per week).

Limited resource, coupled with competing demands from mandatory targets, has hampered a formal programme of sustained 'stewardship ward rounds' over the last 2-3 years. Timely reporting with feedback to clinicians is recognised as a significant

driver for changing behaviour and improving prescribing. This is something we are prioritising over the coming years, with an initial target of 1 extra extended ward-round per month visiting inpatient wards that are not currently covered. This will increase in frequency as microbiologist cover improves. We have also developed a range of EPMA reports to target specific areas for antimicrobial improvement, allowing us to perform AMS rounds remotely in a more resource-efficient way.

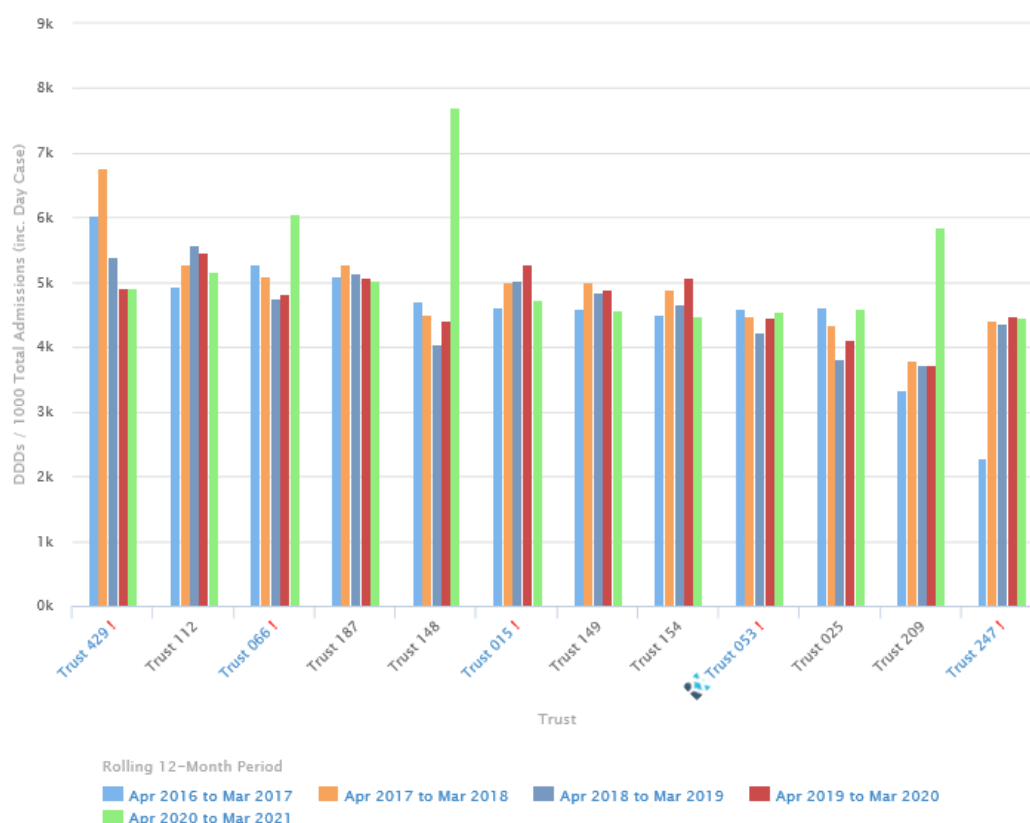
2.2. Antibiotic consumption trends

Typically, total antibiotic consumption targets form part of the standard NHS contract. However, the COVID pandemic has had a significant impact on antimicrobial consumption both regionally and nationally; for this reason, no specific targets have been agreed.

2.2.1 Total antibiotics.

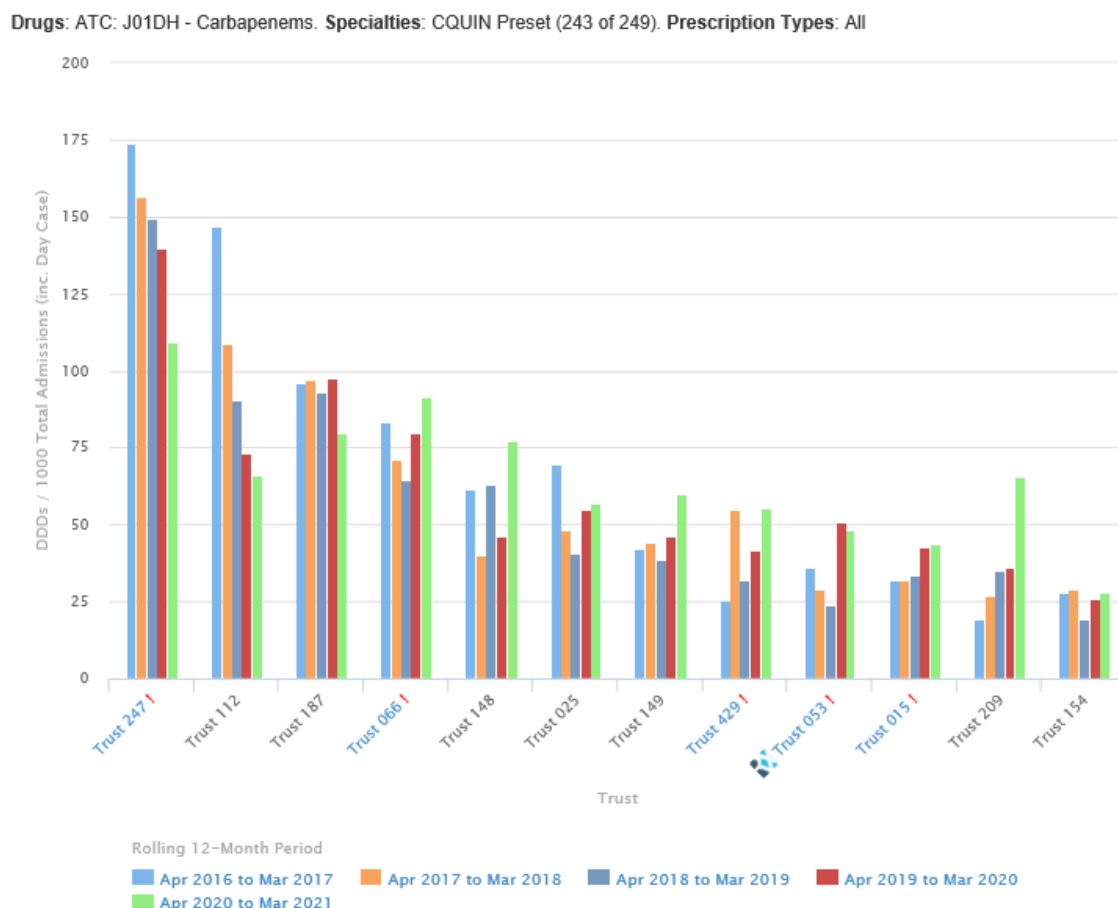
Total antibiotic consumption is up 1.9% on the previous financial year (see fig 1. DCHFT = Trust 0.53). Like other trusts, we observed an upswing in antimicrobial use during the first and second wave of the pandemic. As the pandemic eases and hospital activity returns to normal, a more accurate picture of any lasting change in consumption trends should emerge.

Fig. 1



2.2.2. Carbapenems

Carbapenem prescribing is down 4% on the previous financial year (Fig. 2). However, this still represents a significant increase compared with the 2018 financial year, equating to a doubling in consumption (Fig. 2). We perform regular audits of inpatient carbapenem use, which indicate that carbapenem use is generally appropriate, with the vast majority being recommended by the microbiology team. We are also implementing a regular review of local resistance data, specifically looking at ESBLs, which may be driving carbapenem use locally; CPEs will also be monitored more formally.



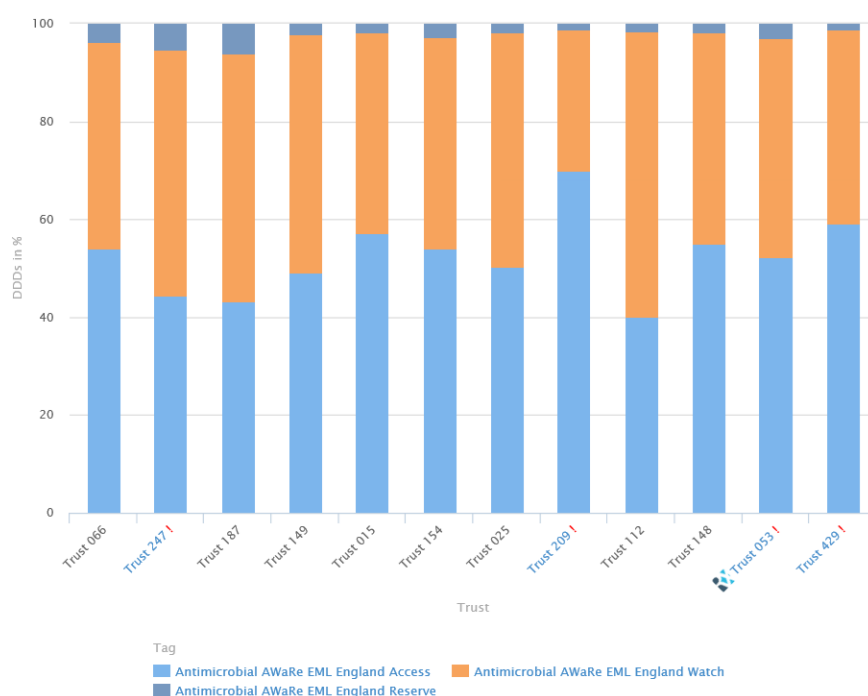
2.2.3. Proportion of total antibiotics by AWARe category

53% of DCHFT's total antibiotic consumption for 2020/21 were narrow-spectrum agents (AWaRe access category), comparable to the previous year (56%). See Fig. 3.

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

(DCHFT =trust 053)



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

3. Summary of future work

- To ensure that AMS 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 2021/22, if they are re-introduced.

Historically, AMS CQUINs have had a demanding data collection element. NHS England discourages stewardship teams from collecting 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 stewardship team cannot absorb CQUIN data collection demands without displacing 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.
- Continued work on developing Microguide (platform for hosting antimicrobial guidelines) to ensure guidelines are readily accessible at the point of care, thus promoting antibiotic guideline adherence.
- We plan to introduce a comprehensive antimicrobial prescribing and stewardship training package 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, systematic conversion from intravenous to oral antimicrobial therapy, and challenging excessive antibiotic course lengths.

We must 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 CQUIN targets when they are re-introduced.

CONCLUSION

The last 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.

2020-2021 has been a very successful year with significant reductions in healthcare acquired infections reported i.e. gram negative 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 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 HCAs 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

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)	Acting matron Infection Prevention & Control	Bi-Monthly	Bi-monthly IPCG meetings in place.
		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	Acting Matron Infection Prevention & Control	September 2021	Dorset wide ICNet roll-out in progress- May 2021.
		The Trust will maintain a high standard of Infection Prevention &	Heads of Nursing to report on a monthly basis to Divisional Quality & Governance	Evidence that IPC performance dashboard is discussed	Heads of Nursing / Quality	March 2022	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		Control	meetings IPC performance standard dashboard to be met Learning from performance data to be disseminated	and actioned at Divisional Governance meetings			
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	DCHFT will maintain a clean and safe environment for patient care	Dorset County Hospital to support PLACE assessment and PLACE-lite	The environment is safe and clean	Infection Prevention & Control Team	Sept 2021	First PLACE lite scheduled May 2021
			Maintain current annual deep clean programme with Facilities/Heads of Nursing/ Estates. Execute agreed deep cleaning programme	Deep clean programme is undertaken.	Facilities Manager	March 2022	March 2021 – Deep clean plan halted by COVID 19 pandemic – however, deep cleans carried out when opportunities arose – Facilities to summarise via Annual Report.
			Participation in	Review of	IPC Team	March	Environmental audits

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			weekly environmental technical audits	weekly audits identifies deficits and monitors remedial actions have been taken	Facilities Manager Estates Manager Patient representatives Pharmacy	2022	restarted in April 2021 and on-going weekly. Currently no patient representative but this will be reviewed.
		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 2021	Process reinforced agreed as ongoing requirement to monitor
		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 2022	March 2021 – Water Safety remains a standing item on IPCG meeting. Weekly updates provided by Estates team on water quality
3	Provide suitable	Patients will be fully informed	IPCT to visit newly identified infectious	Positive patient	IPCT	March	May 2021 – IPCT continue to visit patients with newly

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	accurate information on infections to service users and their visitors	about their presenting infections. All new cases of <i>CDifficile</i> , MRSA and ESBL will be counselled by an IPCN	patients and their carers. Provide verbal and written information and contact details	feedback		2022	acquired infections and established infections to provide information and reassurance.
		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 2022	May 2021 – All information leaflets in date, new leaflets developed in response to COVID-19
4	Provide suitable accurate information on infections to any person concerned with providing further	The Trust will have a reliable and available Infection Prevention & Control Team. Providing support to all patients and	IPCT to continue to carry out a daily ward round to all acute areas including Kingfisher, Maternity & Emergency Department,	Minimum cross infection, reduced prolonged outbreaks of infection, reduced	IPCT	March 2022	Daily IPCT ward rounds in place.

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	information support nursing/ medical care in a timely information	staff	providing clinical support to staff and patients	HCAIs			
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 people	Achieve trajectory for <i>Clostridium difficile</i> 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 2022	May 2021 – All cases of CDI that are hospital acquired are subjected to RCA. Yearend for 2020/21 not yet complete so final figure not yet available – to be reported via Annual Report. 1 case to go through PIR.
		Reduce rates of Gram-negative blood stream infections (BSI)	Undertake IPC led Root Cause analysis of all hospital acquired	All cases of Gram negative BSI will have	Acting Matron Infection Prevention &	March 2022	March 2021 - Yearend not yet complete so final figure not yet available – to be

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		by 50 % by 2023	cases of gram negative BSI – escalate to full RCA if lapses in care	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)	Control		report via Annual Report May 2021 awaiting final figures to report.
		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	The Trust will be able to function effectively during the Winter months and Infection Control standards are maintained	Acting Matron Infection Prevention & Control	October 2021	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			policy				
		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	Acting Matron of Infection Prevention and Control Associate Director of Infection Prevention and Control Director of infection Prevention and Control	Ongoing	May 2021- All current guidance and action cards in place align with PHE guidance. IPCT continue to keep up to date with any guidance changes. May 2021- Board assurance framework updated.

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
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	March 2021 – As per dashboard May 2021- as per dashboard
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT	Bi-Monthly	March 2021 – As per dashboard May 2021 – As per dashboard
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2021	May 2021- International hand hygiene day promoted by IPCT October 2021- IPC week,

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
							IPCT to organise events.
		Education	Support DCHFT mandatory training programme Via e-learning and face to face training	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2022	Ongoing – Mandatory training provided face to face and via remote learning throughout the year
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 2022	March 2021 – Audit completed.
8	Secure adequate access to	IPCT to support and be involved in the county	IPCT to be involved in county wide meetings	Safe transition of service	Acting Matron & Associate Director	September 2021	March 2021 – Ongoing support offered by IPCT to project – anticipated

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	laboratory support as appropriate	wide pathology project ensuring delivery of safe patient care is not affected	where appropriate and provide expert support for the project		Infection Prevention & Control		completion of project Summer 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	Acting Matron & Associate Director Infection Prevention & Control	September 2021	March 2021 – Project in final stages DCH, UHD complete and DHC last Trust to have single instance added
9	Have and adhere to policies, designed for the individual's care and provider	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	March 2021 – As per dashboard May 2021 – as per dashboard
			Urinary catheter	Urinary	IPCT	Monthly	March 2021 – As per

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	organisations that will help to prevent and control infections		documentation audits undertaken to ensure compliance with observation standard	catheters will be reviewed on a daily basis and care documented on Vitalpac			dashboard May 2021 – As per dashboard
			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	March 2021 – As per dashboard May 2021 – As per dashboard, roll out of new policy with changes to CPE screening in place.

	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. <i>Orthopaedic surveillance SSI cases to be discussed at Orthopaedic Governance meetings.</i> 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 2022	March 2021 – SSI Surgical Surveillance of Repair of Neck of Femur Surgery – Completed Surgical Surveillance of Breast Surgery – In progress Plan in place for 2021-2022 SSI surveillance.
1	Ensure, so far as is	Reduce the number of sharps	Undertake annual Sharps Audit to	Audit identifies	IPCT	Sept 2021	March 2021 – as per dashboard and

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
0	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 provision of health and social care	injuries caused by sharps disposal	ensure Trust wide adherence to recommended practice. Action plan with Divisions to reduce risks identified on audit.	compliance with safe management of storage and disposal of sharps		(IPCT) Oct 2021 (Provider)	Occupational health report presented at IPCG. May 2021 - As per dashboard
		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	Sept 2020 – Divisional fit mask testers in place and supporting requirement – portacount machine also available for use via IPCT
		Staff at DCHFT are equipped with the knowledge, skills and equipment to care for 'high risk' infectious	Ensure all 'IPC Emergency Boxes' are maintained and in date Ensure all relevant policies are up to	All clinical staff are aware and able to support the emergency preparedness	IPCT Acting Matron Infection Prevention & Control / Lead Emergency	October 2021	May 2021 – Policies updated as required. Action cards updated to reflect IPC guidance as current

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		patients	date and staff are aware of roles and responsibilities in relation to 'high risk' patients.	of the trust for IPC issues	Planner		

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.

Abigail Warne, Acting Matron, Infection Prevention and Control. Version 1 May 2021.