2022/2023 Infection Prevention & Control Annual Report

Contents

Abbreviations

Abbreviations	Full Description
AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
C difficile	Clostridioides difficile
CDI	Clostridioides difficile infection
COHA	Community onset Hospital Acquired
COVID-19	Coronavirus disease 2019
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment Framework
DCHFT	Dorset County Hospital Foundation Trust
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DON	Director of Nursing
E.coli	Escherichia coli
ESBL	Extended Spectrum Beta Lactamase
GDH	Glutamate dehydrogenase antigen of C. difficile
GRE	Glycopeptide Resistant Enterococcus
GP	General Practitioner
HCAI	Health Care Associated Infection
HOHA	Hospital Onset Hospital Acquired
IM&T	Information & Technology
ICS	Integrated Care System
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCN	Infection Prevention & Control Nurse
IPCT	Infection Prevention & Control Team
MGNB	Multi resistant gram-negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Methicillin Resistant staphylococcus aureus
MSSA	Methicillin Susceptible staphylococcus aureus
PCR	Polymerase Chain Reaction
PFI	Private Fund Initiative
PHE	Public Health England
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, amber, green
RCA	Root Cause Analysis
SSI	Surgical Site Infection
UKHSA	UK Health Security Agency

EXECTIVE 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 (DCHFT). Infection Prevention and control is the responsibility of everyone in healthcare and this is successful with strong leadership and collaborative working.

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. This year DCHFT has welcomed a new Chief Nursing Officer/Director of Infection Prevention and Control, Jo Howarth, who has a wealth in experience and knowledge within the field of IPC.

The Infection Prevention and Control Group has a function 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) – Code of Practice on the Prevention and Control of infections and related guidance, which was last updated in December 2022.

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 strategic mission: “Outstanding care for people in ways which matter to them”.

Overall, 2022- 2023 was another 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, Gram Negative Organisms, and following Root Cause Analysis reviews of *Clostridium difficile* infections for 2022-2023.
- The Trust continued to develop and adjust in the global pandemic of COVID-19 in response to the local and national requirements as we moved from pandemic to endemic guidance ‘living with COVID-19’ plan set out by the government.
- Hand hygiene compliance has remained high and sustained at 98.7%.
- The trust continued to meet mandatory requirements for Surgical site surveillance for hip and breast categories.
- The Sterile Supplies department continues to maintain a full Quality Management System in line with BSO standards.
- Face to face education and training continued following the postponed teaching due to COVID-19, combined with an updated e-learning programme, we have maintained good compliance with IPC training.
- Enhanced monitoring continued to mitigate risk of 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).

INTRODUCTION

The Director for Infection Prevention and Control (DIPC) annual report summarises the work undertaken in the Trust for the period 1st April 2022– 31st March 2023. 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). The purpose of the report is to provide assurance that the trust remains compliant with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance Department of Health, 2015). The code sets out 10 criterion which are listed in the contents and the report uses these criterions as a guide to provide evidence and assurance.

The pandemic has continued to remain challenging for the Trust and Infection Prevention and Control over the reporting year as the governments COVID-19 response guidance shifted focus from pandemic to endemic and 'Living with COVID-19'. The Infection Prevention and Control team have been vital in developing and supporting the Trust with this response. They have continued to provide expert counsel to others across the system and southwest region, sharing best practice and challenge to ensure a COVID-19 secure environment for patients and staff.

The Trust met the target for zero cases of preventable MRSA bacteraemia. The Trust reported 17 trajectory cases of *Clostridium difficile* against a target of 46 cases (59 total cases) and was under trajectory for gram negative organisms. The Infection Prevention and Control Team have 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 lower 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.

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention and Control team 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.

The Health and social care Act 2008: code of practice on the practice on the prevention and control of infections compliance ten criterion follow below individually demonstrating the trust compliance and evidenced assurance in meeting the ten criterions.

CRITERION ONE:
Systems to manage and monitor the prevention and control of infections. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them.

INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 6 times during 2022- 2023. 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 was chaired by the Interim Chief Executive Officer, Nick Johnson, Chief Nursing Officer, Nicola Lucey, who also is the Director of Infection Prevention and Control (DIPC), and following change in appointment Chief Nursing Officer Jo Howarth, is in attendance and acts as Chair, with the responsibility for reporting to the sub-board Quality Committee for assurance.

DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented to the following items during 2022-2023:

- Monthly MRSA Bacteraemia surveillance.
- Monthly *Clostridium difficile* surveillance.
- Monthly hand hygiene rates.
- Outbreak and incident reports.
- IPC risk assessments relating to COVID-19

INFECTION PREVENTION & CONTROL TEAM

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

- Jo Howarth, Chief Nursing Officer / Director of Infection Prevention and Control
- Emma Hoyle, Associate Director Infection Prevention and Control/Deputy Chief Nursing Officer
- Dr Cathy Jeppesen, Infection Control Doctor and Consultant Microbiologist
- Dr Lucy Cottle and Dr Amy Bond, Consultant Microbiologists
- Emma Karamadoukis, IPC Lead Specialist Nurse
- Julie Park, IPC Specialist Nurse
- Christopher Gover, IPC Specialist Nurse
- Abigail Warne, IPC Specialist Nurse, currently on career break
- Helen Hindley, IPC Nurse
- Sophie Lloyd, IPC Nurse (Secondment - Joined October 2021)
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Rhian Pearce, Antimicrobial Pharmacist 2 days a week

The IPCT work within the structure of the newly developed IPC work plan, which has been developed alongside the ten criterions. Appendix A

HEALTHCARE ASSOCIATED INFECTIONS

This year NHS England updated the trajectories for C*lostridium Difficile* and Gram-negative blood stream infections. The Gram-negative organisms are *Escherichia coli*

(E. coli), Pseudomonas aeruginosa (P. aeruginosa) and *Klebsiella* species (*Klebsiella spp.).* This was from one definition of a case – sample taken over 72 hours after admission was deemed a HCAI requiring review. 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 have 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.

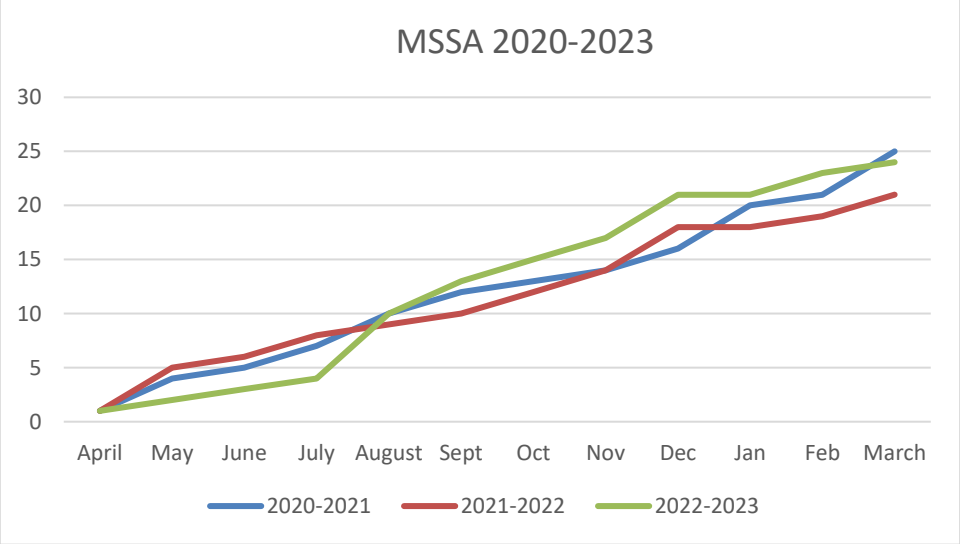
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA)BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2022-2023 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 ≥48hours post admission) have significantly reduced. In 2022-2023 the trust had 2 MRSA Bacteraemia cases in total.

STAPHYLOCOCCUS AUREUS BACTERAEMIA (MSSA)

In 2022-2023 there were a total of 24 cases of MSSA bacteraemia, identified >48 hours after admission. No national trajectories have been set for these organisms. At DCHFT this demonstrates stability in cases over the last three year.



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 via audit. All Hospital onset Healthcare associated MSSA infections have a full Root Cause

analysis review, with the results and learning feedback to IPCG and senior leaders within the trust.
The IPCT have led on a deep dive review within the renal service of MSSA bacteraemia's with the aim to align policy with practices and ensure high standards of evidenced based practice.

GRAM NEGATIVE BLOOD STREAM INFECTIONS

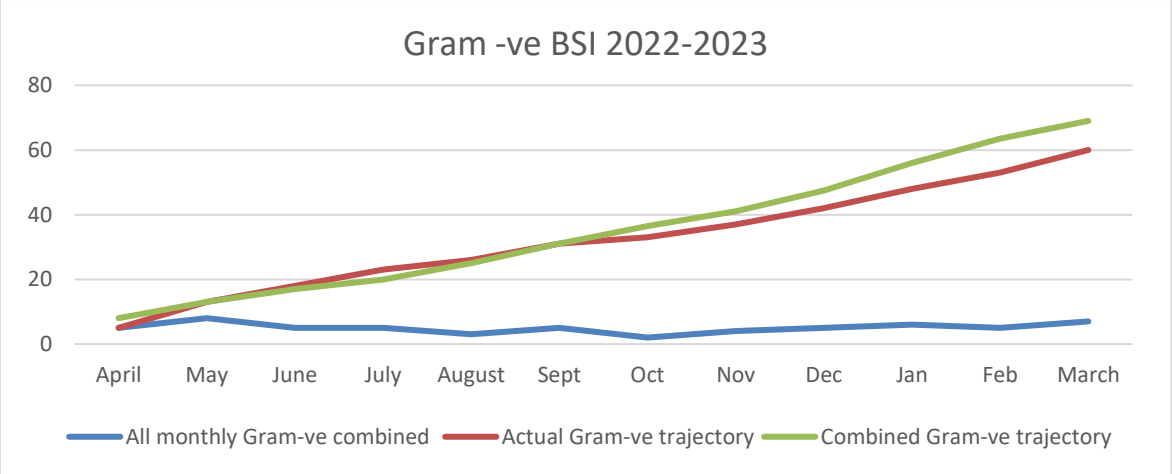
Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram –negative BSIs by 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). February 2019 it was announced that the date for achieving this reduction has been changed to 2024/2025. The Gram-negative organisms are *Escherichia coli (E. coli), Pseudomonas aeruginosa (P. aeruginosa)* and *Klebsiella* species (*Klebsiella spp.).*

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 app. and Pseudomonas *aeruginosa.* 2022-2023 formal trajectories for gram-negative blood stream infections were set by NHSE/I at 69 cases (43 *Escherichia coli* 9 Pseudomonas *aeruginosa* and 17 Klebsiella sps). Noted this trajectory was HOHA and COHA combined.

In 2022-2023 there were a total of 42 positive BSI samples for E. coli which were attributed to the Trust – HOHA & COHA. 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 UKHSA guidance; this includes all mandatory and optional data.

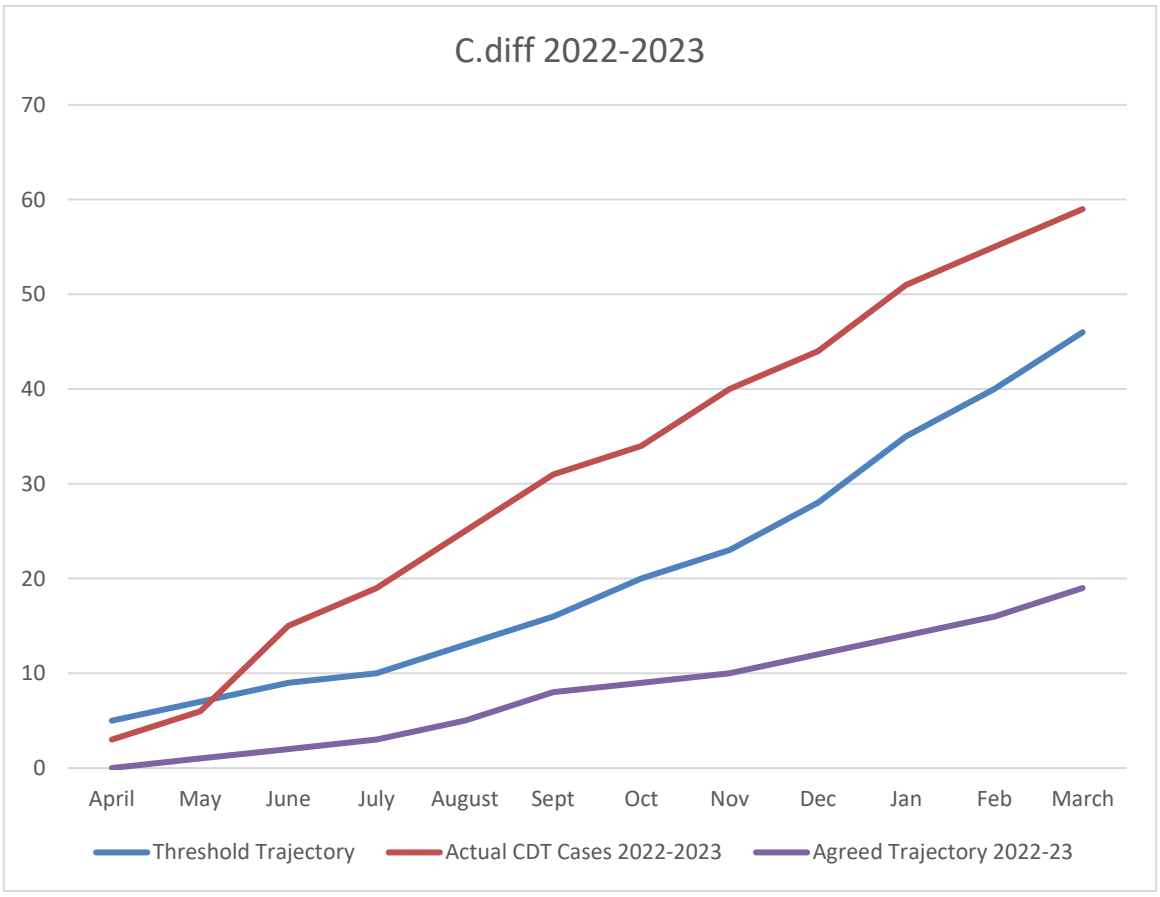
In 2022-2023 there were a total of 11 positive BSI samples for Klebsiella, which were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

In 2022-2023 there were a total of 7 positive BSI samples for Pseudomonas *aeruginosa*, which were attributed to the Trust – HOHA & COHA. All cases of Klebsiella sps. that occur >48hrs after admission are reviewed by the Infection Prevention & Control Team. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.



CLOSTRIDIUM DIFFICILE INFECTION (CDI)

In 2022-2023 Clostridium Difficile formal trajectories for were set by NHSE/I at 46. In total the Trust reported 59 cases detected HOHA/COHA; of these cases 18 were identified as preventable with lapses in care; and learning implemented trust wide.



All cases of hospital acquired CDI require a Root Cause Analysis investigation. The results are presented to Nicola Lucey and now Jo Howarth (Chief Nursing Officer/Director of Infection Prevention and Control) and Emma Hoyle (Deputy Chief Nursing Officer/Associate Director of Infection Prevention 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. The IPCT and consultant microbiologists have continued a CDI Deep dive review of all the CDI

cases, looking for trends, areas of improvement and emerging themes. The IPCT have also completed an extensive collaborative data collection on all Potential CDI and CDI cases. NHS England are reviewing this data, which also includes all Dorset anonymised case information.

OUTBREAKS OF INFECTION

NOROVIRUS

There have been two outbreaks of Norovirus in the reporting year 2022-2023. This is against the backdrop of high winter incidence of norovirus within the community.

INFLUENZA/RESPIRATORY SYNCYTIAL VIRUS (RSV)

There has been a national increase in cases of Influenza A, B & RSV during the Winter of 2022-2023 in comparison to the previous years. The identification of these cases at point of admission into DCHFT has been greatly assisted by point of care testing which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks.
In preparation for 'seasonal flu' all Trust staff were offered the annual flu vaccine and 42% of all staff have been vaccinated within the trust but the percentage of staff vaccinated will be higher due to staff receiving the vaccine buy another means.

CLINICAL AUDIT

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 2022-2023 the IPC team have supported 3 modules for surveillance. The IPCT can 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.

Three audits were completed for 2022/2023. Oct-Dec 2022 Hips found only one infection where the orthopaedic and microbiology teams reviewed and managed the case. Elective Colorectal surgery and Breast surgery for Jan- March 2022 are yet to be submitted.

PERIPHERAL VENOUS CANNULA (PVC) AUDIT

PVCs are devices commonly used in acute hospitals, for the administration of intravenous fluids and medication. 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 monthly auditing to check that all PVC's 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 91% up from 79% last year.

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

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 Vital Pac has been good with an overall trust compliance of 93% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 91% compliance and Urgent and Integrated Care 95% compliance. These percentages are an average. Urinary tract infections are one of the 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 considered prior to insertion of the urinary catheter and there is a continuous process for review.

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.

UK Health Security Agency (UKHSA) recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. UKHSA advice was updated in December 2019 we now have 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.

DCHFT carried out a CPE quarterly audit, between April 2022 and March 2023, which 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 the overall compliance with undertaking the admission screening risk assessment was 81%. This has increased by 5% on the previous year's 76.3% result. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated quarterly or 2023-24. In conjunction with the role out of a new CPE policy back in 2021 and ward/unit leads have had the opportunity to discuss changes in guidance with the IPC Team, it has demonstrated a positive impact on these audit results.

COVID-19

The global pandemic of Covid-19 and changes in NHS England and UKHSA guidance 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, see table 5 total number of covid cases for DCHFT per month.

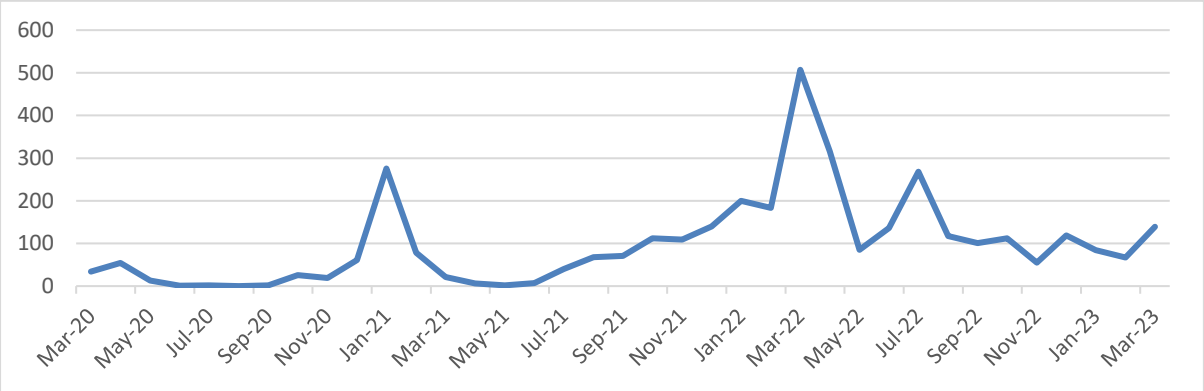
The hospital environment has been adapted to suit the needs for this new ongoing virus and the complexities that it creates. Over the past 3 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England/UKHSA and expert response to emerging situations. The IPCT have also worked closely with the Dorset wide ICS to share best practice and learn from other trusts in the Southwest region and beyond.

However, due to the extremely transmissible nature of Covid-19 and increased prevalence in the community we did have 3 wards with identified outbreaks between April 2022 and March 2023. This was a low number of outbreaks for an inpatient setting in the Southwest region.

The Trust followed national IPC guidance throughout the pandemic, and this is supported by the Infection Prevention and Control Board Assurance Framework Winter 2022 (Appendix B). On investigation due to the nature of the virus and its transmissibility it was hard to identify the root cause of outbreaks. However, the outbreaks were during a period when visiting was not completely restricted and community rates were rising.

The response from the ward teams, matrons, Clinical Site Managers, 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.

Table 5: Total number of covid cases over each month for DCHFT



INFECTION PREVENTION & CONTROL WEEK - OCTOBER 2022

To celebrate 'International Infection Prevention week' on the 16th – 21st October 2021. The IPCT requested wards to produce a poster presentation with an IPC theme (in View of the current workloads, Covid-19 pandemic, and ongoing staffing issues) on Clostridium Difficile and / or Antimicrobial Stewardship.

The poster presentation could encompass any area of Clostridium Difficile and / or Antimicrobial Stewardship. The overall aim is to improve staff knowledge on CDI. Many wards within the trust produced beautiful poster displays encompassing many different topic areas and the judging was carried out by the IPCT and N Johnson (Interim Chief Executive). Prizes were awarded to all the wards that entered, as the posters were all too good to pick a clear winner. During the week the IPCT also carried out a quiz in Damers restaurant and a lucky dip quiz on all our ward rounds.

CRITERION TWO:
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

ESTATES REPORT (Terry May – Deputy Head of Estates & Facilities)

WATER QUALITY

The Estates Team are responsible for maintaining the Trust's water systems, across the main hospital site and satellite properties, and reporting status to the Water Quality Management Group (WQMG) and Infection Prevention and Control Group. Provisions for water safety are independently audited by experts from the Water Hygiene Centre, who provide the Trusts third party Authorised Expert for water safety.

Policy & Governance

New appointments required by the Water Safety Policy have been made following changes in key personnel.

Estates on behalf of the Trust has undertaken via a specialised consultant, Water Safety Risk Assessments (RA's) of the Hospitals water systems. We have received two of three reports and expecting the third by the end of August. The recommendations are as we expected and not as favourable as we would have liked, however, this informs us of important actions we need to take to ensure we are managing Water Safety effectively and efficiently within the Trust.

Those most of concern are within the table below: -

Imminent Danger Table			
Building	**Unit**	**Survey Element**	**Imminent Danger and Recommendation**
		Inspection of the Written Scheme	There is no log book system in place.
			Create a log book system to hold all monitoring and maintenance records. No records produced during the risk assessment being carried out.
		Inspection of the Written Scheme	There is no suitable written scheme in place.
			Create a written scheme based on the requirements of ACoP L8, paragraphs 60-64. No Written Scheme was produced during the risk assessment being carried out.
		Cold Water (South Wing BTCW)	There is biofilm evident in the cold water tank(s).
			Short term - Clean and disinfect the tank. Investigate and eliminate the cause of the biofilm. Long term - remove units which accommodate highly susceptible ie immunocompromised patients, from this system. Supply them with direct mains fed water. It was seen evidence of some biofilm contamination was identified in form of black spotting inside cold water storage tank 72TA01.

We are aware that there is not an all-encompassing logbook for Water Safety within Estates, rather a collection of Excel Spreadsheets, which is not ideal and was meant to be an interim measure whilst MiCad was further developed, this is now being moved forward with improvements to MiCad being made.

1. It was always the intention to develop a full 'Written Scheme' being a revised and updated Water Safety Plan, following the adoption of the Water Safety Policy and the results of the Water Safety RA's, which also provide updated schematic drawings of the water systems. Staffing with Estates has been stretched and, in some areas, covered by agency staff, however, we have recently recruited an Estates Mechanical Officer, who will be leading the Operational Water Group in developing the Water Plan.
2. This work has been actioned, completed and the said CWS tank is being monitored.

The recommendations from the RA's and the Draft Water Safety Policy were both to be discussed at the Water Quality Management Group on the 10th August, however, this was postponed due to an unexpected major Generator and Power issue. A revised meeting is being set for September 2023, whereby, the Water Safety Policy can be ratified and the WQMG updated on progress of the analysis of the Water Safety RA's and development of the Water safety Plan.

Regular sample testing has been maintained in high-risk areas throughout the Trust, by Estates Operatives and supported Contractors. This is being reviewed as it is clear we require dedicated Operatives to undertake this work, which is being investigated as part of a wider Estates structure review with our partner DHC.

In summary, the Trust is working towards best practice for managing Water Safety across the Hospital, and in undertaking Water Safety RA's it is in a better place to be able to prioritise, develop and implement a well-informed Water Safety Plan to achieve this aim.

Risks

HCWS (Hot and Cold-Water Systems) are managed within capability and availability and, in general, the main site systems need investment to mitigate age related and maintenance issues.

There have been 696 reactive calls to leaks in the period 01/04/22 – 31/03/2023 of various descriptions, with (approx. 46% or 323) High Priority: 143: being emergency or urgent with the potential to cause significant damage,42: were out of hours, 30 were due to roof leaks, 78 leaks through ceilings, 16 leaks affecting theatres, 14 were air conditioning condensation water leaks, a further (54% or 373) were of various descriptions with a lesser significance.

New Properties

The acquisition of additional properties and capital projects have presented some challenges. Measures to mitigate the various problems have been identified and are being implemented.

Sampling

The table below shows the number routine samples and raised counts.

OUTLETS	SAMPLES TAKEN	RAISED COUNTS

Legionella	405	69
Pseudomonas A	433	23

REPLACEMENT FLOOR COVERINGS (Floor Works)

223 flooring jobs in the past 12 months have completed. Included in this, was the re-laying of the main staircase to South Wing, which has significantly improved the area and provides a very good impression for those entering the Trust by the South Wing entrance.

Where possible Estates have standardised floor covering by using Tarket IQ Granit, with nonslip areas, Tarket Altro Walkway 20 or Altro Aquarius is used. To improve aesthetics and cleaning the wooden skirting where possible has been removed and a cap and cove finish has installed. This is a more expensive exercise, however, improves the hygiene element and looks so much better in clinical areas, makes mopping and cleaning so much easier.

Estates use contractors, Future Flooring and Carpets 2000, for this specialised work, with both companies working very well with Estates and the departments, supported by very positive feedback on their cooperation and work ethics. Both are local smaller companies that works well, Estates have tried to use some of the bigger contractors, and they are not really interested, and the standards are poor, (Charlton Down being a fine example). Estates have considered bringing flooring works within the in-house Estates Maintenance Team; however, it appears to not be viable at this time.

DECORATION AND ENVIRONMENT (Painting)

371 painting jobs have been completed in within this financial year.
One completed 98% of these being the only painter. We have employed an additional Painter this financial year to improve output and catch-up on backlog.
Dulux Sterishield is used in all clinical areas, with BIosan used in Theatres.
Dulux Scuffshield has proven very efficient in the corridors.
Standard matt is used in ward corridors and some streets.
Gardenia is the standard colour, although moving forward we are introducing a palate of muted colours, to aid patients and visitors with the general feel of the building.

VENTILATION

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. In the past 12 months we have replaced the AHUs feeding UCV Theatre no1 and UCV Theatre no 2 and X-Ray CT1.

Estates are currently approving ventilation drawings for AHUs for South Walks House, Ridgeway ward and the new Hospital Build ED and CCU.

The AP(V) works under the auspices of an AE(V) maintaining the Permit to Work system and ensure all statutory and regulatory records are validated. Following changes to the HTM 03-01 all ventilation issues are discussed at the Ventilation Safety Group.

WARD ADUITS

In association with IPC and Hotel Services, Estates continue to support weekly environmental audits, with any identified Estates related works being duly raised within the Repairs System and undertaken on merit of priority.

Capital Works

Projects 2022/23	**Description of works**
POW Refurb	Alterations to the Prince of Wales Annex to form a number of single rooms and makes changes to the surrounding areas to enable this end of the ward to run more efficiently and make better use of the space
Fire Alarm Replacement	Replace fire alarm system site-wide to address corporate risk due to age of current system and non-compliance
Access Control	Replace existing 20 year old cotag system with new due to current system going in to obsolescence and reliability becoming an increasing issue
Chemo Unit Refurbishment	Improvement for patient enhancements to be carried out. Scopes of works has increased from original concept. Works to commence late 2023/24
Chemo Unit Decant Arrangement	Decant of Chemo therapy unit during works. Works to commence late 2023/24
Renal Pod	To make the building safe for clinical use and building compliance as risks identified. Works to be agreed 2023/24
Respiratory Medicine Labs	Full refurbishment of department
Xray Angiogram	Reviewing proposed works for 2023/24 as contract already been procured without Estates input
Xray Room 5	Proceeded without Estates input - works now complete - managed by Radiology
Kingfisher De-escalation	Mental Health Welfare room. Creating ligature light suite and bathroom
Pathway Home Hub	To reduce pressures on ED but creation of space for discharge lounge, frailty SDEC, pharmacy etc. Works likely to take place 2023/24
Helipad Works	Closure of helipad and relocation of service
Offsite Therapies Centre - Roof Replacement	Lifecycle replacement of roof and guttering. Works to take place 2023/24
South Wing Repointing	Water penetrating roof and department through brick work
Aseptic Works	Remove sink, extend benching and add IPS outside of suite. Works taking place 2023/24
Modular Discharge Lounge	New modular building funding from NHS England to be used for Discharge Lounge combined with Discharge Lounge +
Fire Compartmentation	Survey of fire compartmentation; review of existing, changing if required and including if not existing already - Operations Project
Mortuary	Install new body store, replace Paed store, replace all existing rollers

Nurse Call	Stroke POW Maternity - Not suitable for stand-a-lone unit, so will need a full upgrade Further scoping in progress to identify other priority wards Works to take place 2023/24
Roof Replacement	Site wide roof replacement programme
Site Wayfinding	Comms team have progressed some updated wayfinding
Ridgeway Orthopaedic 24 ring fenced beds	Alteration to ward layout to support ringfencing if bed spaces for Orthopaedic recovery
Asbestos Management Policy	In progress with Ion
Water Safety Management Remedials and Monitoring	This is to combat legionella and reduce backlog maintenance on water safety.
Gutter Cleaning	Clearance carried out to prevent the build-up of flora and fauna to maintain roof weather protection and integrity also to reduce infestation risk.
Kingfisher Balcony	Replacement floor, new storage areas and column padding - works to commence in 2023/24
PoW Side room Alterations	Further alterations to PoW Side rooms previously refurbed as part of project 4.13 Renal PoW alterations. Aiming to address stakeholder concerns with room size. Options appraisal to be sent across for further works to take place 2023/24
Maternity Day Assessment Unit	Creation of new larger DAU to help with increased demand on service
Orthodontics and Women's Health	Utilising an unused corridor to provide an additional Ultrasound room for WH and a staff rest area for Orthodontics
Vespasian - Decant for SWH Outpatient services	Replace floor so suitable for clinical services, secure blind ligature risks and film treatment room windows and doors
Medical Gas upgrade	Upgrade Medical Gas throughout North Wing
Hospedia Removals	Remove Hospedia units in North Wing, tied in with Med Gas upgrade works
ENT & Orthodontics	Installation of ventilation to each treatment room

DECONTAMINATION SERVICES REPORT (Joe Lythe – Service Manager: Theatres, Anaesthetics, CRCU and Decontamination)

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 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 has transferred to the Medical Device Regulation UK MDR 2002 (as amended) our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent authority.

The Accreditation held by the service continues to give quality assurance on the products produced and 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. We are looking to increase our external customers for the service to other local GP Practice & Dentists.

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 May 2023 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 currently.

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.

Joe Lythe Service Manager is the Trust's Decontamination Lead.

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 – Yearly.
- 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 May 2023

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 audit results for 2022/23 are not yet finalised.

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 2022/23 audit has not yet been finalised. This will be followed up and submitted once return is received.

HOTEL SERVICES REPORT- CLEANING SERVICES- Sarah Jenkins

Throughout the past year the Housekeeping Team have continued to work hard to maintain the cleanliness of the hospital, coping, as all services, with the fast-changing nature of the service due to the exceptional pressures we have experienced through the past months in terms of the number of patients we have had within the Trust. There have also been new areas to clean, many of these outside the main area of the hospital and there continue to be more to come.

This work has not been done in isolation but with the support of our colleagues across many disciplines. The importance of a clean environment, which has been supported by all teams helps 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 buildings occupied by the Trust, both on and off the main hospital site, in both clinical and non-clinical areas, are provided by an in-house team of staff supervised through a 24/7 rota by a team of supervisors. This team is augmented by external contractors, managed by the Hotel management team, who undertake the window cleaning and pest control aspects of cleanliness.

As far as is practicable staff are allocated to a particular area, giving them a sense of ownership, and belonging to the area as well as continuity in the cleaning regime. The amount of time allocated daily is determined by the frequency of cleans as outlined in the Standards of Healthcare Cleanliness and by input from the clinical and housekeeping teams. We continue to review these considering changes to IPC guidance, presence of infection outbreaks and the differing pressures caused by reduced numbers of staff at times of increased sickness.

Standards of cleaning are monitored through the audit process, the frequency of which is determined through the functional risk category assigned in accordance with the new national standards. These standards also set a timetable for the rectification of failures based on the risk category. Standards are further monitored through reports received from PALS, the environmental audit process and through PLACE and PLACE lite. Feedback is given to staff on the areas from these audits.

Despite the difficulties of the past 12 months, cleaning standards have been maintained with highlighted issues being remedied in reasonable timescales.

DEEP CLEANING

The continued pressures on the hospital have meant that the annual deep clean programme has once again been delayed. As per usual we have taken every opportunity to carry out these cleans as and when spaces have been available and when such a clean is indicated due to the type of infection the patient has presented with.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. Following the acquisition of two new machines last year, we have purchased a third machine which enable us to support more cleans and a times effective flow from the emergency department. Training has been rolled out to several staff across all shifts

so that we are able to carry out deep cleans at all times. The new machines provide far greater assurance in terms of reporting of itself and in ease of checking that an area has been cleaned and are safer for the operatives in that the machines are turned on remotely once the operator has sealed the room, the vents and fire alarm sensors are covered without the operator having to use a ladder and reports are generated to confirm successful operation.

With the introduction of the space which has become available following the purchase of the new modular discharge lounge it is hoped that there will be a more robust plan of deep cleaning the wards and bays in particular, with the space being available to decant patients whilst the deep clean and some remediable estates works are being carried out.

INTERNAL MONITORING

The housekeeping team monitor the cleaning standards through audits. The frequency of these audits is dependent on the new functional risk categories to which the area is assigned, and these vary between weekly and annually. The timescale for rectification of failures is also dictated by this categorisation.

Star ratings are being assigned for display instead of the percentage of cleanliness achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard. In the past 12 months.

The housekeeping supervisors have, despite a few technical issues, been using the new auditing software with increasing confidence. We have recently been able to add the email address of those who wish to receive the reports and so going forward the outcome of the audit and the areas of failure will be available on the wards immediately following completion of the audit.

We have also started to undertake efficacy audits on many areas as advised in the National Standards of Healthcare Cleanliness. These audits focus on the process of cleaning rather than its outcome to ensure that standards are maintained in the process and not just the outcome.

PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT (PLACE)

Following a pause since 2019, we were able to carry out the first Patient Led Assessment of the Care Environment in the autumn of 2022.

PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and members of the public (known as patient assessors). The questions are focussed around 6 domains, the relevant ones for this report being the cleanliness and condition of the buildings. The percentage scored for cleanliness was 98.37% with 2408 marks out of a possible 2448 being achieved. That for condition was 94.8% with 1058 out of a possible 1116 being scored.

Whilst we should not be complacent and always strive for perfection, it should be observed that the PLACE findings represent a snapshot of the areas as they were found on the day, and the good scores in these domain areas are a testament to the

hard work of the housekeeping and wider estates teams as they strive to maintain the environment with stretched resources.

We have also introduced PLACE lite audits at other times during the year. These act as a mini-PLACE audit and allow us to see areas in which we have improved and those areas where there is still room for action. We are joined on these by our patient assessors, to give the patient's perspective on the environment, and whilst we do not report on these nationally, they give us an indication of how we are doing.

CRITERION THREE: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobials: Summary report for financial year 2022/23.

Rhian Pearce (Antimicrobial pharmacist), Amy Bond (Consultant microbiologist)

Overview

Antimicrobial resistance (AMR) is an emergent crisis threatening health outcomes across all healthcare settings.

The hospital's Antimicrobial Stewardship Programme (ASP) aims to optimise the use of antimicrobial agents to improve clinical outcomes whilst limiting the emergence of AMR and *C. difficile (C-diff)*. It is our primary defence against the threat of AMR. ASPs require investment and adequate resources to operate effectively.

Antimicrobial Stewardship (AMS) is a prominent feature on the government's healthcare agenda, with numerous publications and directives issued to promote stewardship across all healthcare settings.

This report highlights the programme's performance over the last year, including progress against targets, improvement work, and challenges.

2.1 Achievements 2022/23	
Antimicrobial Stewardship Committee	• The Antimicrobial Stewardship Committee (ASC) has struggled to convene over the last year. Re-invigorating the ASC will be a priority for the coming year.
Surveillance • Effective surveillance of antibiotic prescribing, resistance patterns, HCAIs and infection-related outcomes is the foundation of any stewardship program but requires continued investment in informatics and IT solutions. This continues to be an area of focus for the Antimicrobial Stewardship Team.	**Antibiotics Consumption:** • EPMA reporting capacity has continued to improve. Several reports have been developed to support various stewardship activities, improve data capture and allow more targeted intervention. • We also utilised our REFINE/DEFINE database, dramatically improving our ability to monitor antibiotic prescribing trends across the Trust. **Resistance monitoring:** • We looked at Enterobacteriaceae resistance trends locally and compared them with other hospitals. **Patient outcomes for infection syndromes:** • We interrogated a recently launched AMR database to gather data on mortality, length of stay and readmission rates for various infections.

	These metrics provide critical intelligence, supporting monitoring, decision-making, evaluation, and local interventions. Harnessing digital technologies is a priority for AMS. We have secured additional resource to continue progress in this area.
Trust Policies (includes guidelines, PGDs, PSDs, clinical pathways)	**Antimicrobial prescribing guidelines:** Poor guideline accessibility, leading to poor guideline compliance and serious error, has emerged as a recurring theme from RCAs, AMS ward rounds and clinician feedback. We continue to work on updating guidelines to include robust diagnostic criteria as well as streamlining information into an easy-to-use format. Administrative support has been secured to develop our microguide platform to improve guideline accessibility.
RCAs/C-diff	• Continued participation in *C-diff* RCA and PII meetings where we provide a formal review of antibiotic prescribing, feeding back to clinical teams directly. This also allows us to capture themes related to antimicrobial prescribing and *C-diff* trends. • We formally reviewed themes relating to antibiotic prescribing as part of a 'c-diff deep dive'. Some poorly performing clinical specialities were highlighted as part of this review. We continue to collaborate with these areas to improve antibiotic prescribing. • We updated our hospital-acquired pneumonia guideline, replacing co-amoxiclav with doxycycline or co-trimoxazole, in an effort to reduce exposure to 'c-*diff* provoking' antibiotics.
Education	**Mandatory training** • Implemented a three-yearly mandatory training programme, delivered via e-learning, for all prescribers on AMS, using the ARK toolkit. Anticipated roll-out in the coming months to coincide with our EPMA upgrade, which has new functionality to support the ARK tool.
	Face-face teaching sessions: • Gentamicin/Teicoplanin/Vancomycin prescribing (F1s) • AMS and Introduction to the Antibiotic review toolkit with case studies. (F1s) • UTI CQUIN and stewardship principles – elderly care junior Drs

Audits/QI projects	We performed a number of audits and QI work this year, highlights include: establishing baseline data on antibiotic durations and penicillin allergy; a review of vancomycin prescribing on the renal unit and subsequent development of a vancomycin protocol in haemodialysis; audit and QI work to raise awareness of doxycycline- polyvalent cation interactions.
AMS ward rounds	We instated regular AMS rounds looking at 10-20 patients per round covering 3 months (Sept–Dec 2022), performed by the antimicrobial pharmacist and microbiology registrar. We used this time to gather intelligence on antimicrobial prescribing, target patients for intervention, and educate prescribers. Specific clinical areas and AMS metrics were reviewed, including IV/PO switch, broad-spectrum agents, and antibiotics exceeding 5 days. The intelligence gathered during this period suggests prescribing is generally satisfactory, and no concerning themes were identified. We have temporarily paused this activity due to resource constraints but plan to re-introduce regular ward rounds following the appointment of an additional microbiologist (planned start date; August 2023)

NATIONAL TARGETS

AMS CQUIN schemes 2022/23

Locally agreed performance metrics and data submission:

DCH adopted the UTI CQUIN scheme for 2022/23, which mandated a data collection requirement of 100 cases per quarter, regardless of trust size. Given the AMS team's resource constraints, we agreed to a reduced sample size with our CCG partners. This involved collecting baseline data in Q1 (20 patients), quality improvement interventions in Q2 and Q3, and a repeat measurement in Q4 to demonstrate improvement. This approach allowed us to prioritise quality improvement interventions over data collection.

Performance against the CQUIN target and QI interventions

We achieved 50% compliance in Q1, exceeding the minimum payment threshold of 40% but falling short of the maximum payment threshold of 60%. This improved significantly in Q4, achieving 95% compliance overall, which meant we met the full payment for our combined performance for the year. Our performance compares favourably to the national mean (Fig. 1). A breakdown of compliance against individual CQUIN indicators is provided below (Fig. 2)

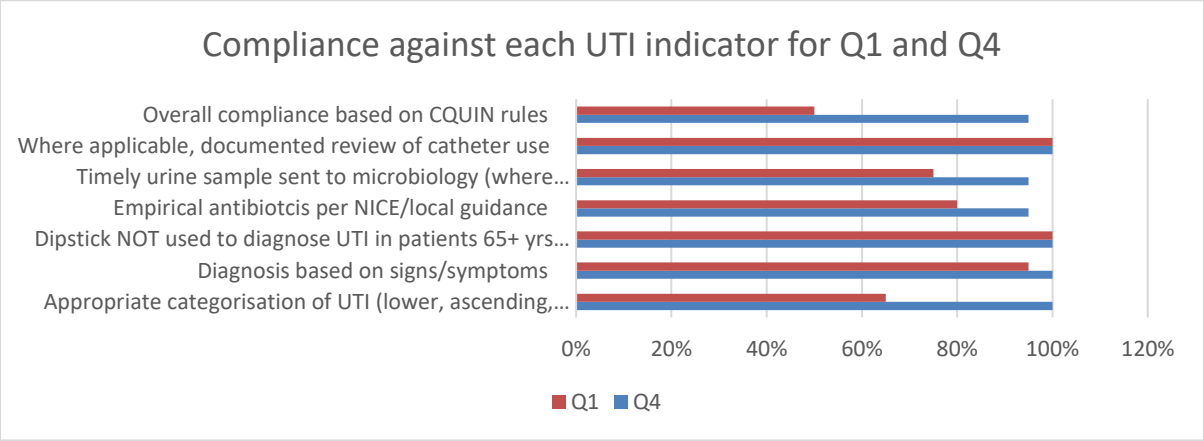
Our quality improvement interventions included: promoting nitrofurantoin over trimethoprim for the empirical management of lower UTI, which we achieved by creating an EPMA alert; incorporating specific learning points into the Junior doctor

induction; collaborating with a clinical lead in specialities of interest to champion improvement; using our AMS rounds to target UTI specifically allowing us to engage with prescribers in real-time and gather intelligence on drivers of non-compliance; delivering an education session to the elderly care junior doctors. Importantly, our QI interventions were highly targeted to the areas of non-compliance identified in the first quarter and tailored to the feedback received from clinicians.

Fig. 1.

CCG2: Appropriate antibiotic prescribing for UTI - DCH performance vs England average		
	England	**DCH**
2022/23 Q1	51%	50%
2022/23 Q2	55%	-
2022/23 Q3	56%	-
2022/23 Q4	58%	95%

Fig. 2.



NHS standard contract for the financial year 2022/23

As part of the NHS standard contract for the financial year (2022/23), NHS trusts were required to reduce 'watch-reserve*' antibiotics by 4.5% compared to their 2018 calendar year baseline.

**Based on the AWARE antibiotic classification system, antibiotics are classified into three groups; Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms, and their use should be limited.*

DCH performance against the standard contract target

Fig. 3: In-region comparison of growth for watch-reserve antibiotics; figures from the financial year 2022/23 compared with the 2018 calendar year

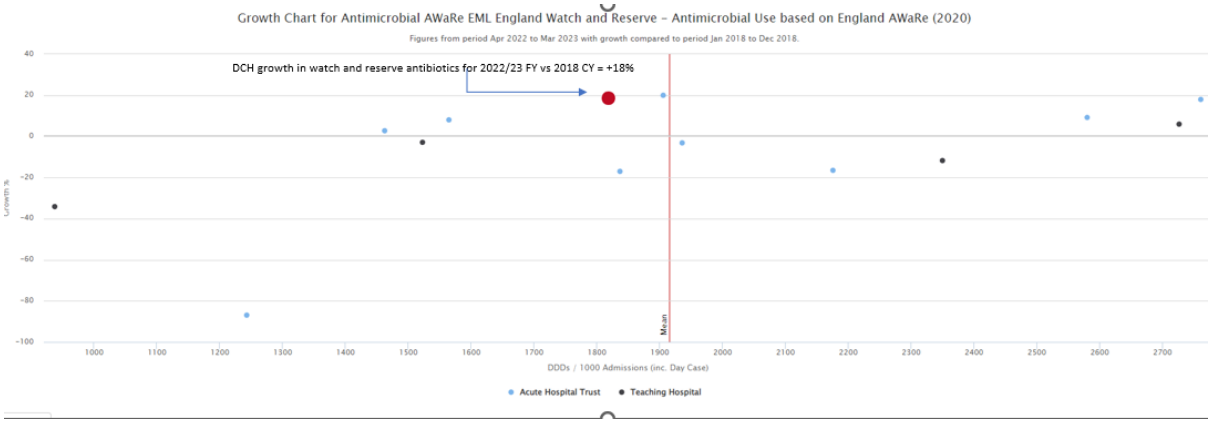
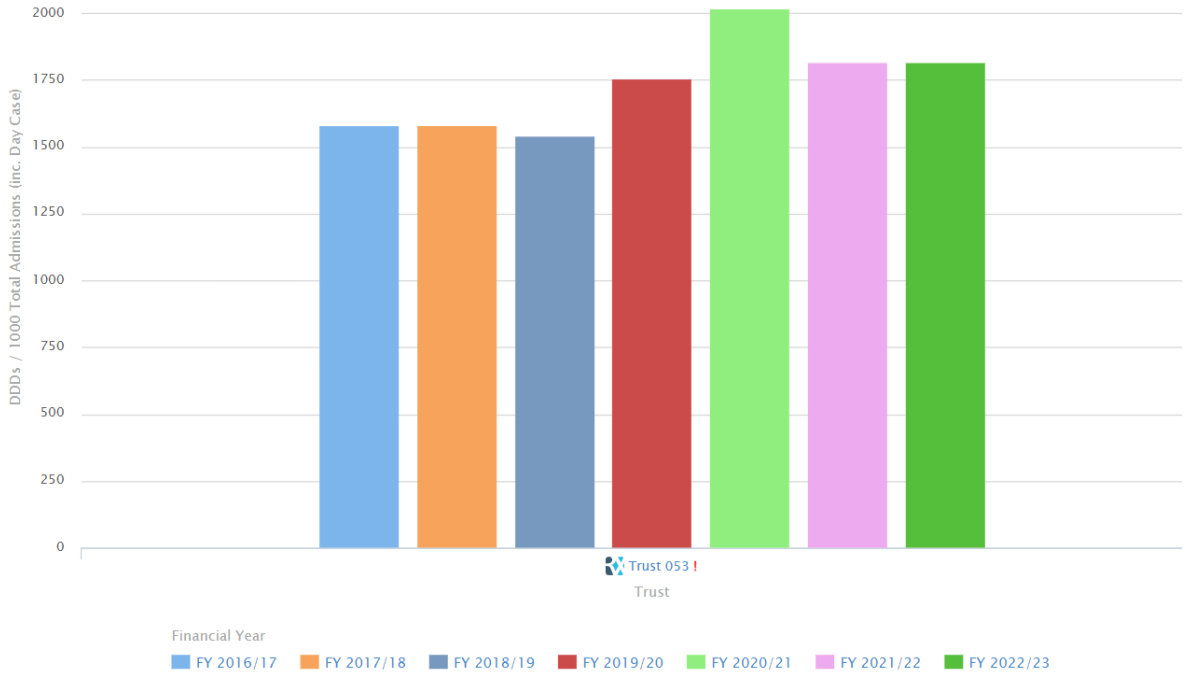


Fig. 4: DCH trend in watch and reserve antibiotic consumption by FY (2016/17 – 2022/23)



DCH did not meet the standard contract target for 2022/23. Watch and reserve (WaRe) antibiotic consumption for the financial year 2022/23, measured as total DDDs adjusted for admissions, is up 18% on our 2018 calendar year (Fig. 3). Compared with other trusts in the South-West, DCH has seen a comparatively larger increase in growth over this period. Despite this growth, DCH prescribing rates of WaRe antibiotics remain below the regional mean, and overall consumption in WaRe antibiotics is comparable to the previous FY (Fig. 4)

There are some important limitations to acknowledge:-

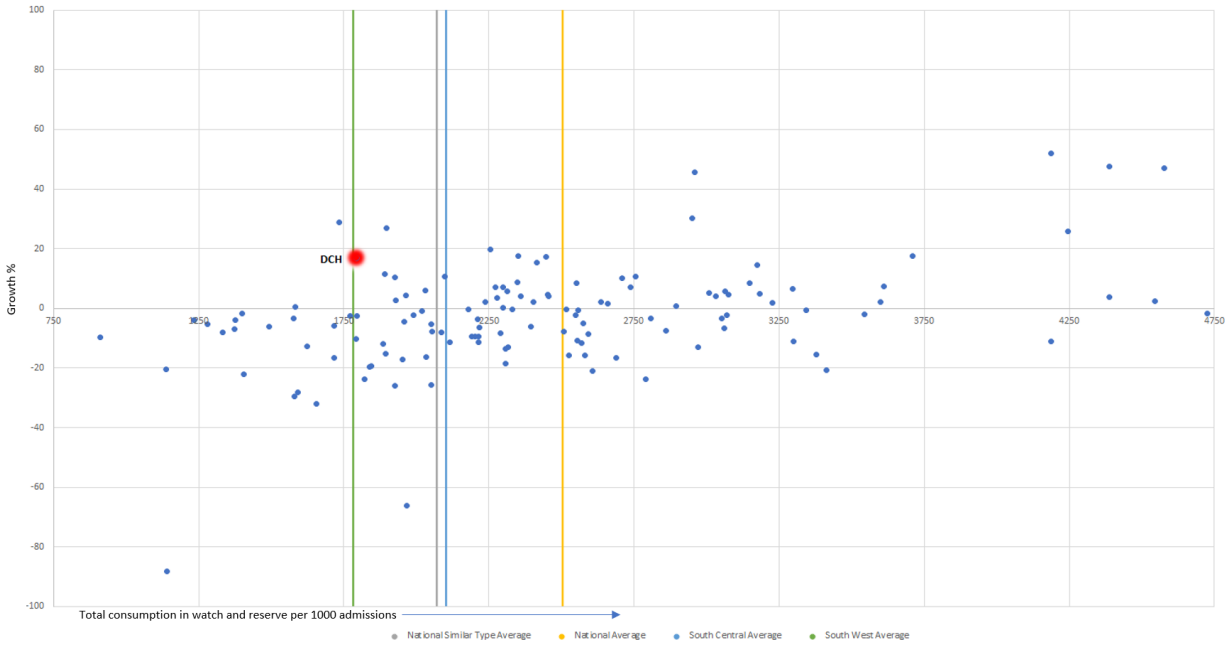
Data are unadjusted for case mix, age and sex. As such, direct comparison between DCHFT and the regional picture is limited. In addition, there is significant variation in hospital and regional antibiotic prescribing across England, so it is unclear who we should benchmark our consumption data against.

We, therefore, performed further analysis to better understand this variance and produce more meaningful benchmarking standards for DCH. We compared our WaRe prescribing rates against the South West, South Central, national aggregate,

similar type/size hospitals and looked at the national spread of data. Results are shown below (Fig 5).

Fig 5.

Scatter plot of acute trusts in England, illustrating DCH growth (compared to 2018 baseline) and total consumption in watch and reserve abx per 1000adm vs national, regional and peer hospital average.



This work provides assurance that DCH has low rates of WaRe antibiotic prescribing overall, appearing in the lower quartile nationally and comparing favourably against a range of benchmarks.

The standard contract target for DCH remains an important driver for stewardship efforts locally, but we need to be cautious of driving WaRe antibiotic use too low because it may negatively affect patient outcomes.

Patient outcome data and resistance trends are not routinely monitored alongside consumption data, which raises serious concerns over the potential unintended consequences of targeting antibiotic consumption in isolation; top-line consumption figures are only part of the picture. This has been a significant area of development for us, and we are therefore pleased to be able to present resistance and outcome data for the very first time (see section 4)

Reasons for observed growth:

The exact drivers for this observed increase in watch and reserve antibiotic use are undetermined. It is likely multifactorial. To date, we have not identified a convincing correlation with inappropriate antibiotic prescribing (based on ward-rounds, *C. diff* RCA findings and audit activity)

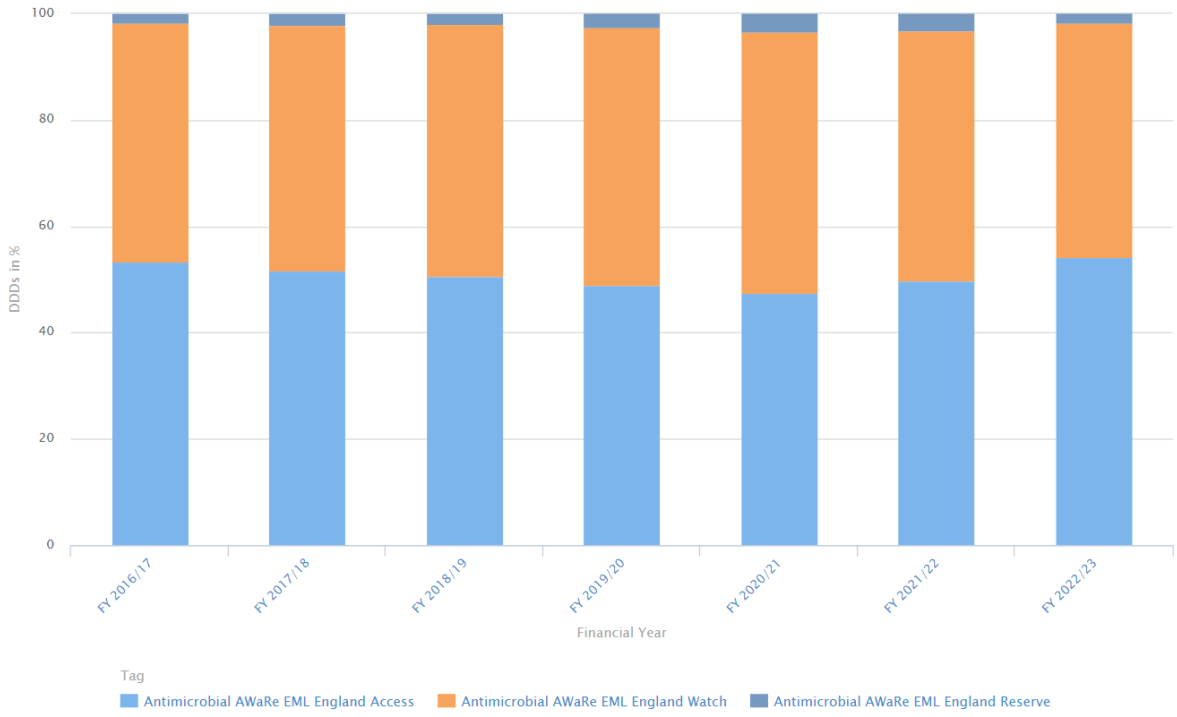
Potential explanations include;

- change in case mix/patient complexity
- lower threshold for initiating antibiotics due to sepsis campaign
- trend towards more aggressive antibiotic dosing regimens
- changes to local empirical antibiotic regimens (e.g. NICE guidance recommending broader spectrum antibiotics than we used historically)

- Increasing resistance rates
- a significant increase in ED activity

The relative proportions of Access, Watch and Reserve antibiotics for this financial year are comparable to our historical baseline, indicating that we are prescribing more antibiotics in general across all categories (Fig .6).

Fig. 6: Watch, reserve and access antibiotics as a proportion of total antibiotics



Consumption trends within DCH and clinical specialities of interest.

Co-amoxiclav accounts for the greatest proportion of WaRe antibiotics at DCH, representing 36% of total WaRe consumption for FY 2022/23 and 16% of total antibiotics prescribed (see Fig. 7).

We analysed antibiotic consumption trends across DCH which showed that ED disproportionately contributes to watch and reserve consumption, primarily due to their high use of oral co-amoxiclav (Fig. 8). ED prescribing of WaRe antibiotics has almost doubled since 2017 (Fig. 9). We are currently collaborating with our ED colleagues to better understand this growth. Of note, consumption data is currently adjusted for admissions and does not include ED attendances, which may explain the increase in ED's antibiotic use. We plan to work with business intelligence to improve our denominator figures to more accurately reflect changes in activity that influence antibiotic consumption.

Fig. 7

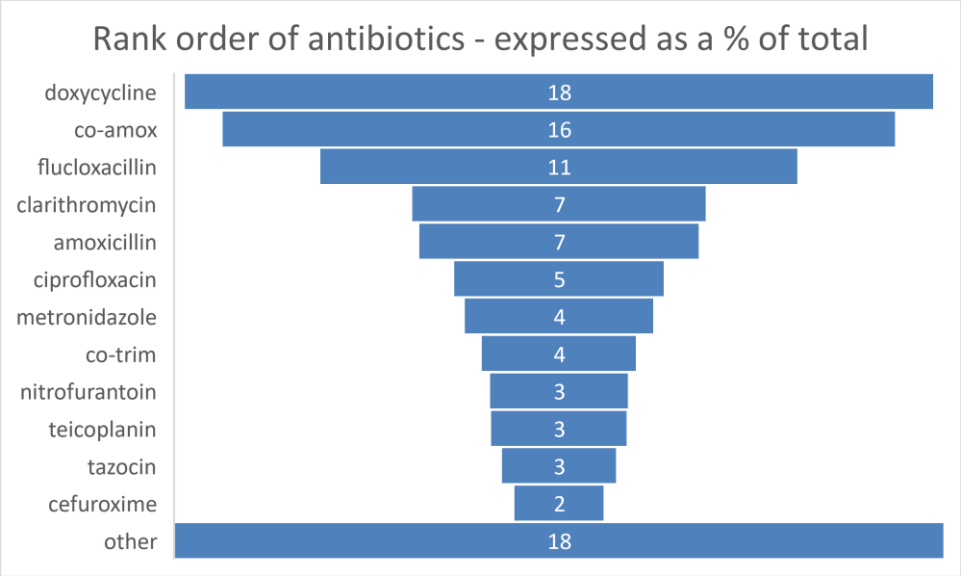


Fig. 8

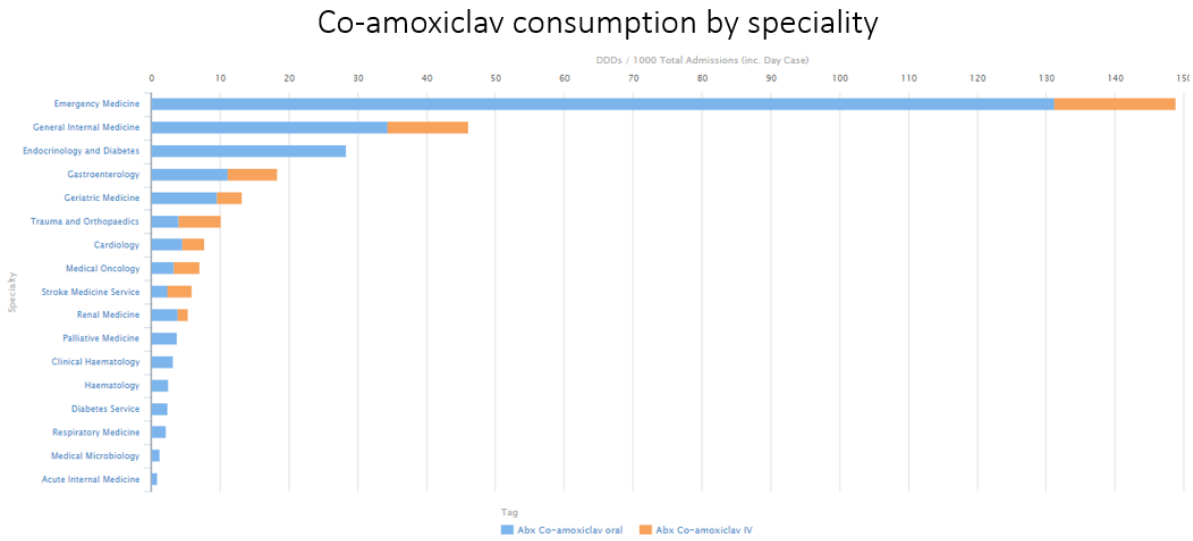
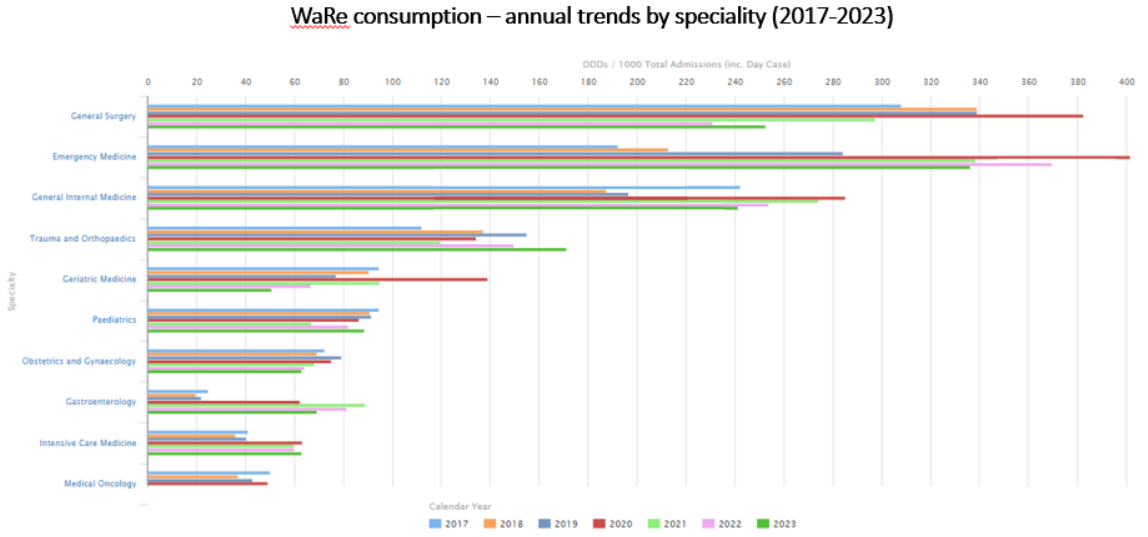


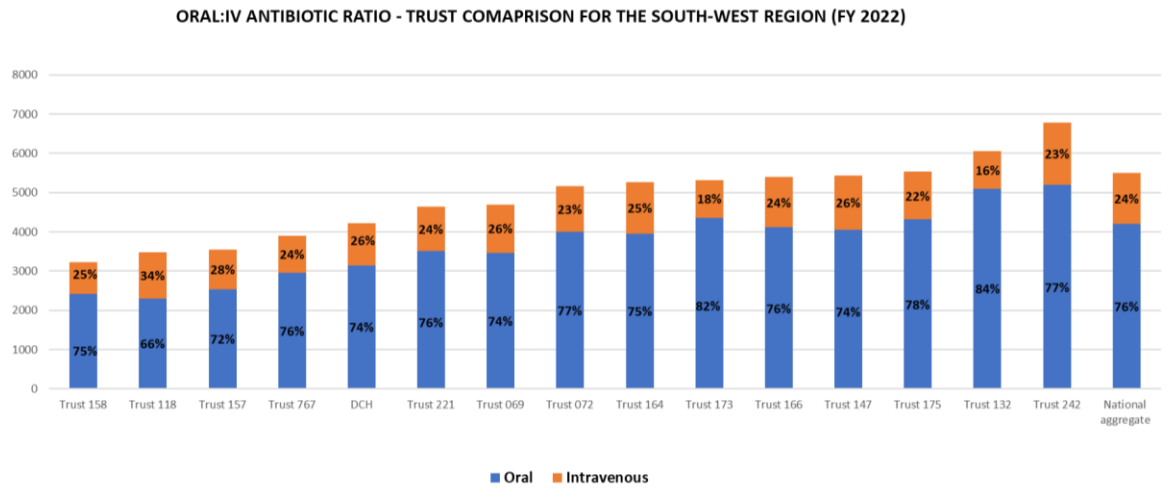
Fig 9.



3. Intravenous antibiotic prescribing.

DCH are required to report on intravenous antibiotic prescribing as part of our contractual obligations. There is also a CQUIN for the coming financial year (2023/24) to drive improvements in IV/PO antibiotic switch. DCH's PO:IV ratio is consistent with other trusts in the region and comparable to the national aggregate (Fig. 10). We will continue to monitor progress in this area.

Fig 10.



Antimicrobial resistance surveillance

Resistant rates for Enterobacteriaceae in blood cultures

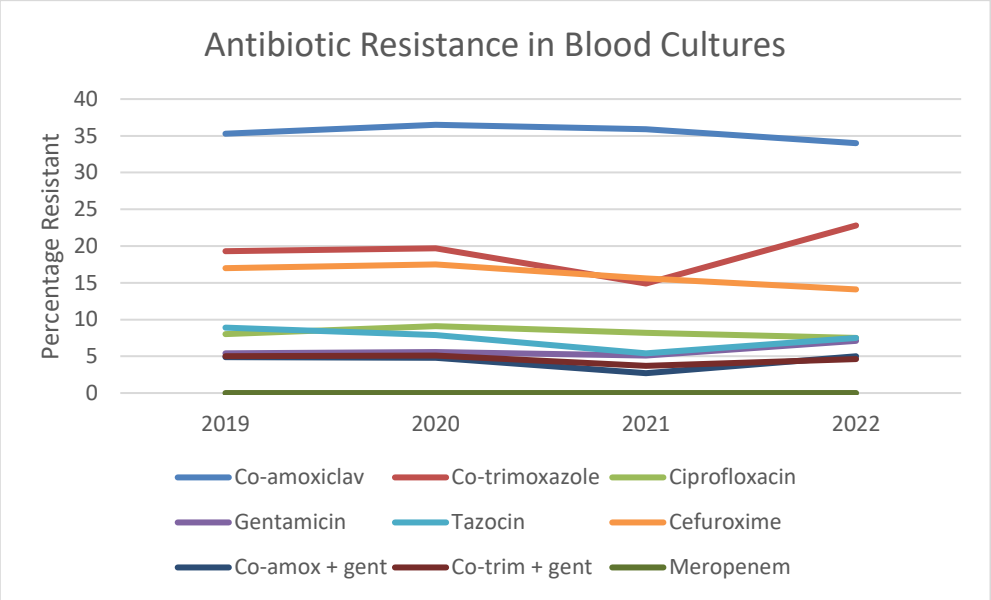
Source: local laboratory antimicrobial susceptibility results.

Table 1 shows percentage antimicrobial resistance rates and trend over time for all Enterobacteriaceae in blood cultures; Figure 1 is a graphical representation of the same data. This is annual data from 1 January to 31 December.

Table 1

	2019	2020	2021	2022
Co-amoxiclav	35.3	36.5	35.9	34
Co-trimoxazole	19.3	19.7	14.9	22.8
Ciprofloxacin	8	9.1	8.2	7.5
Gentamicin	5.4	5.6	5.1	7.1
Tazocin	8.9	7.9	5.4	7.5
Cefuroxime	17	17.5	15.6	14.1
Co-amox + gent	4.9	4.8	2.7	5
Co-trim + gent	5	5.1	3.7	4.6
Trimethoprim	27.7	28	23.6	
Meropenem	0	0	0	0

Figure 1



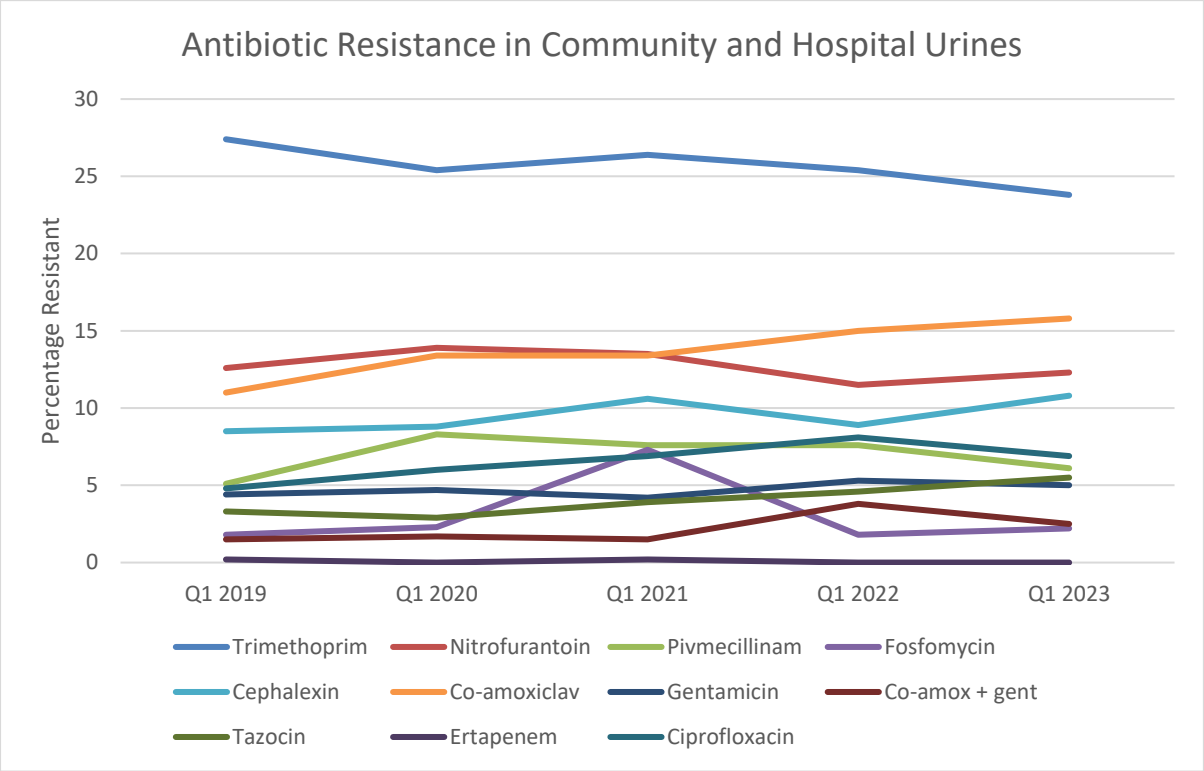
Resistance rates for Enterobacteriaceae in urine samples

Source: local laboratory antimicrobial susceptibility results.

Table 2 shows percentage antimicrobial resistance rates and trend over time for all Enterobacteriaceae in community and hospital (combined) urines; Figure 2 is a graphical representation of the same data. This is Quarter 1 data for each year.

Table 2	**Q1 2019**	**Q1 2020**	**Q1 2021**	**Q1 2022**	**Q1 2023**
Trimethoprim	27.4	25.4	26.4	25.4	23.8
Nitrofurantoin	12.6	13.9	13.5	11.5	12.3
Pivmecillinam	5.1	8.3	7.6	7.6	6.1
Fosfomycin	1.8	2.3	7.3	1.8	2.2
Cephalexin	8.5	8.8	10.6	8.9	10.8
Co-amoxiclav	11	13.4	13.4	15	15.8
Gentamicin	4.4	4.7	4.2	5.3	5
Co-amox + gent	1.5	1.7	1.5	3.8	2.5
Tazocin	3.3	2.9	3.9	4.6	5.5
Ertapenem	0.2	0	0.2	0	0
Ciprofloxacin	4.8	6	6.9	8.1	6.9

Figure 2



Benchmarking for antimicrobial resistance in E coli isolated from Blood Cultures

Source: UKHSA Fingertips.

Table 3 shows quarterly average percentage of antibiotic-resistant E coli in Blood Cultures, for DCH compared with other local hospitals and England. This is data for 2022 Quarter 3.

Table 3

	England	DCH	UHD	UHS	Salisbury	Yeovil	RD&E
Tazocin	10.5	8.0	3.0	No data	7.0	4.0	7.0
Gentamicin	9.6	10.0	10.0	6.0	13.0	12.0	9.0
Ciprofloxacin	18.6	8.0	15.0	19.0	18.0	16.0	13.0
3rd-gen cephalosporins	14.3	10.0	10.0	13.0	19.0	10.0	10.0

Summary

There are no immediate areas of concern with our resistance rates in blood cultures. There have been small increases in resistance to Tazocin and gentamicin – no immediate action is required but we will continue to monitor. Co-trimoxazole resistance in blood cultures is at 22.8%, however we do not often use this agent empirically in systemically septic patients. We have considered using co-trimoxazole in the Acute Abdomen guidelines, but at present it is probably not suitable for use as a sole Gram negative agent; we will continue to monitor.

Resistance rates in urine samples have remained fairly stable, with the exception of a 5% rise in co-amoxiclav resistance over the last 4 years. However, the combination of

co-amoxiclav and gentamicin has only 2.5% resistance and therefore remains suitable for empirical treatment of ascending UTI and pyelonephritis.

Overall, DCH resistance rates for E coli in blood cultures compare favourably to the England averages and are similar or better than our neighbouring Trusts. The exception is Tazocin, for which we are seeing higher rates of resistance than the other local Trusts – this requires close monitoring. As a first step, we should consider looking at how much of our current usage is outside the existing Antimicrobial Prescribing Guidelines.

Monitoring and benchmarking of outcomes

Source: NHSE Foundry

The following tables show outcome data for infection, as percentages, for DCH compared with England and UHD and UHS. This is financial year data (the data for Readmission rates is not yet available beyond January 2022).

Mortality

	All-cause sepsis	**Bacterial infection or bacterial sepsis**	**Pneumonia**	**Cellulitis**	**UTI**
2021-2022					
England	15.2	13.7	13.7	1.6	2.8
DCH	21.0	4.9	14.0	1.1	2.9
UHD	17.3	6.2	15.3	1.7	4.2
UHS	10.6	4.0	12.5	1.2	2.6
2022-2023					
England	16.8	13.9	13.9	1.7	3.1
DCH	21.5	5.4	14.9	0.5	2.7
UHD	17.1	5.9	15.1	1.9	3.8
UHS	10.6	3.5	10.5	0.6	1.4

Average length of stay

	All-cause sepsis	**Bacterial infection or bacterial sepsis**	**Pneumonia**	**Cellulitis**	**UTI**
2021-2022					
England	9.8	6.1	9.2	5.7	7.3
DCH	9.9	6.3	9.2	6.3	7.8
UHD	12.4	6.9	10.3	7.1	9.0
UHS	10.7	6.1	9.5	4.6	6.6
2022-2023					
England	10.2	6.3	9.5	6.0	8.0
DCH	8.7	7.2	9.4	7.2	11.1
UHD	12.6	7.3	10.8	8.2	10.4
UHS	10.6	5.9	8.7	5.0	6.2

Readmission rate

	All-cause sepsis	Bacterial infection or bacterial sepsis	Pneumonia	Cellulitis	UTI
Jan 2022					
England					
DCH	6.3	8.3	3.7	0	5.4
UHD	1.3	10.5	6.5	8.3	8.5
UHS	1.5	8.0	3.5	3.8	5.7

Summary

NSHE Foundry is new and we have only recently accessed this data, therefore there is still work to be done in understanding how it is derived and how we can use it.

There are no immediate areas of concern except for the all-cause sepsis mortality and readmission rates (highlighted). However, the outcomes for specific infections, i.e. cellulitis, pneumonia and UTI do not show the same level of discrepancy, therefore it is possible that this is a data anomaly resulting from differences in coding. Further investigation into this is ongoing.

It is noted that UHS have lower mortality than DCH for pneumonia and UTI. This may be influenced by the different populations, but it is an opportunity for us to compare our prescribing guidelines and clinical practice with UHS.

Summary of future work

We plan to continue work on developing a set of metrics for monitoring stewardship activity, focusing on process and outcome measures. We are also in the process of agreeing a work-plan for AMS, to better illustrate the need for future investment, improve resource allocation, and prioritise the limited resource we already have. One of the overarching aims will be to co-ordinate efforts regionally by strengthening collaborative relationships with the ICB, peer hospitals and our ICPT partners.

Closing statement

Despite the significant challenges ahead, we are committed to our vision for AMS at DCH – an ambitious and forward-thinking approach which is closely aligned with the Trust's priorities and goals. Importantly, there is a central focus on delivering meaningful change rather than 'ticking boxes' to give the illusion of assurance.

The AMS team will continue to develop and refine the programme workplan to deliver this vision. This will, of course, take time and need continual revision. We ask for patience and understanding from the trust board whilst this activity is undertaken.

A final word, the key to successfully implementing our vision is strong leadership and an unwavering commitment from senior management. This will be necessary to ensure adequate resource allocation, provide influence over workflows, and help us integrate the programme's objectives into the organisational framework and culture.

CRITERION FOUR: Provide suitable accurate information to patients/service users, visitors/carers and any person concerned with providing further support or nursing/medical care in a timely fashion.

The IPC Team works closely with the clinical site managers, ward leads, ward staff and facilities services and attends all bed meetings throughout the day to support patient placement and cleaning requirements. Infection control Patient Activity summary (PAS) flags are added as applicable to all newly identified infections.

The IPC team visit in person all newly diagnosed patients with MRSA and C Diff infections, providing the patient with an information leaflet, discuss the diagnosis and answer any questions.

The IPC Team work closely with the communications team and updates the trust staff via email when new guidance is implemented. We also have a dedicated IPC section on the trust intranet site, which is updated regularly and when any guidance changes are implemented. We also review the IPC information leaflets regularly. We have a dedicated covid-19 section on the trust intranet with many Covid Action cards, which are kept up to date as and when guidance is updated. These Action cards provided up to date information on staff, patient testing, PPE and visiting guidance.

The IPC team monitor all C Diff and Potential C Diff infections daily and include an in-depth weekly review of patients. Escalating concerns to medical teams, wards, and consultant microbiologists. Our consultant microbiologists contact GP's directly when patients are diagnosed with CDI. We also send out GP letters, in a timely manner alerting them of any new CDI, Potential CDI, MSSA, MRSA and Gram-negative Blood stream infections.

INFECTION PREVENTION AND CONTROL SURVEILLANCE SYSTEM (ICNET)

Last year we updated on the joint procurement and implementation of a county wide instance of ICNet, an infection prevention and control surveillance system supplied by Baxter Healthcare Ltd.

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

- Dorset County Hospital (DCHFT)
- 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 (both sites) implementation – completed 2021.
- Phase 3 – DHC implementation – Completed September 2022.

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. By the end of this current year the system has be running smoothly across all the Dorset system trusts.

CRITERION FIVE: Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infections to others.

The use of ICNET allows the IPC team and clinical site managers out of hours to be alerted to any new alert organisms or existing alert organisms. The IPC team are constantly reviewing these patients. The microbiology consultants also use the ICNET system for note documentation to enable seamless sharing of information between teams. This information is also shared across NHS Dorset following the rollout of ICNET across Dorset Trusts.

As a team we link closely with GP's, ensuring they are promptly informed via letter or verbal contact via the consultant microbiologists of any new organisms, such as C Diff, Potential C Diff infection, MSSA and MRSA BSI's and Gram-Negative organisms.

The Trust is able to demonstrate that responsibility for infection prevention and control is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

The IPC Team are involved in the management of outbreaks and periods of increased incidence. The IPC team monitors all alert organisms to identify trends and potential links between cases based on their location. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a weekly meeting to discuss potential cases is held as soon as possible. This task is greatly aided using ICNET.

In 2022/23 4 Periods of increase incidents of C Diff, 2 Norovirus outbreaks and 3 COVID-19 outbreaks were declared during this time frame. All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings. Recurring themes from these investigations are disseminated through the IPC governance meetings. Action plans that are put in place by the ward manager and/or matron are monitored by the IPC team for compliance.

CRITERION SIX: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

EDUCATION

The Infection Prevention & Control Team continued to provide formal and informal face to face education training sessions for both clinical and non-clinical staff. IPCT

have also been incorporated into the following teaching programmes and all the nursing team were involved in delivering the sessions:

- Care Certificate for Health Care Support Workers
- Preceptorship Training
- Medical Tutorial Teaching programme
- Overseas Recruitment 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 90% for clinical staff and 84% for non-clinical staff. The Divisions are responsible to release staff to access their training.

IPCT recognised that additional support and training was required and also provides face to face mandatory training in addition to the online package. The E-learning IPC Mandatory training programme has recently been updated and includes all the relevant IPC Core Skills Training Framework.

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.

The IPC team carryout daily ward rounds, during these ward rounds we support staff, monitor practice, and provide continued IPC education.

FACE MASK FIT TESTING

Fit testing has declined in numbers this past year. After many clinics being added and offered to staff, the uptake has been minimal. During 2022/2023 only 380 staff were fit tested using the porta count machine. These staff are mainly new starters. Sessions are advertised on the intranet along with separate sessions for the Education Department. It is a growing concern now that the pandemic has eased that staff are not making the effort to be fit tested even though it is a legal requirement. This has been escalated via the IPC governance meeting and has been supported by divisional leads and will be a focus as we move into 2023-2024.

CRITERION SEVEN: Provide or secure isolation facilities.

ISOLATION

DCHFT has 11% isolation cubicle against the standard bed base. There is no recent statistics to compare this figure to the national average within acute trusts. This percentage can impact the ability to isolate patients according to national guidance, DCHFT follow the National Infection Prevention and Control Manual for England 2023. Using the concept of cohort nursing patients during high prevalence of certain infections such as Flu A, Covid-19 or RSV.

The IPCT carryout daily ward rounds to review the use of side rooms, providing a daily spreadsheet to housekeeping and clinical site managers. The IPC Team risk

assesses as necessary and the IPC Team support ward staff and clinical site managers to ensure the most effective use of side rooms according to risk, throughout the day.

ISOLATION AUDIT

This year's side room isolation audit took place in February and looked at all inpatient areas (excluding Kingfisher Ward and ITU) with results as follows; Out of 39 rooms in use for infection control purposes 77% had correct signage, 33% incorrect signage and a total of 100% 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. We have developed new trust isolation posters with the aim to implement these posters early May 2023.

CRITERION EIGHT: Secure adequate access to laboratory support as appropriate.

The laboratory services are located on site, there is a provision of seven-day laboratory working and 24 hour access to microbiology and virology advice, including a 24 hour Point-Of-Care Testing in ED and the Paediatric ward for PCR testing when required (e.g. COVID-19, Influenza, RSV) The IPC team are based within the Laboratory department and have a close working relationship with the Microbiology Consultants, we also have a weekly meeting between the IPCT, microbiology consultants and lead biomedical scientist.

Microbiology – underwent an audit by UKAS in April which resulted in the suspension of the labs accreditation status. It is anticipated that the suspension will be for between 3 – 6 months. Service users have been notified and a recovery plan is in development. A new Head of Microbiology has been successfully recruited and commenced in post early in April.

DCHFT are still one WTE consultant microbiologist short. Attempts to appoint to this post have so far been unsuccessful. This reflects a shortage of consultant microbiologists UK wide. We are hopeful to appoint into this post in the near future. The microbiology consultants are extremely busy but still find to assist the IPC team and we link closely together. (Since this report has been written the trust has appointed one 0.85 WTE consultant microbiologist).

CRITERION NINE: Have and adhere to policies designed for the individuals care and provider organisations that will help prevent and control infections.

POLICY DEVELOPMENT/REVIEW

There is a comprehensive list of infection Prevention and control policies, prod cures and guidance on the trust intranet. These polices are reviewed by the IPCT and relevant specialities on a three or five yearly review date, these documents are evidenced based and reflect national guidance. Compliance is audited with key polices as detailed in Criterion one.

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

Aseptic and Aseptic Non-touch Technique (Clean) Protocol
Portable Fans in the Healthcare Environment - Guidelines for the Use of
Decontamination Policy
Ward Closure Policy Due to an Outbreak of Healthcare Associated Infections
MRSA Policy
Isolation Policy
Isolation Requirements for Listed and Infecting Agents
Seasonal Influenza Policy
Pets for Therapy Policy
Ward Outbreak Pack
Standard Operating plan (SOP) for the cleaning of toys, games and play equipment
Guidance for staff on the management of Accidental injury and exposure (including needlestick injuries)

CRITERION TEN: Have a system in place to manage the Occupational health needs and obligations of staff in relation to infection.

DCHFT Occupational health service is provided by Optima health, and they proved bimonthly sharps injury report for IPC governance meeting, and this is cross referenced to the sharps injury DATIX's. Optima health supported the update of the policy for the 'Guidance for staff on the management of accidental injury and exposure (including needlestick injuries) in February 2022.

CONCLUSION

Last year has continued to be a challenging year for IPC, Covid-19 as well as other respiratory viruses have dominated our IPC workload, particularly over the winter. Eliminating avoidable healthcare associated infection has remained a priority for the trust to ensure our patients, staff and the public are kept safe. The work of the IPC team remains unpredictable and although I am new in post, I would like to thank all the team for their hard work, dedication, and positive attitude throughout the year.

2022-2023 has been a successful year, trajectories for Gram negative blood stream infections were achieved and very low incidence of MRSA blood stream infections, we have worked hard to keep our Clostridium difficile rates as low as possible and our continued deep dive review, ensuring our CDI management meets national guidance, close working with the IPC integrated care system and NHS England data collection will continue to reduce CDI.

This report demonstrates the continued commitment of the trust and demonstrates the success and service improvement through the leadership of a dedicated and committed IPC team. Infection Prevention and Control is the responsibility of all the Trust employees and the IPC team do not work in isolation. The successes over the last year have also only been possible due to the commitment for infection prevention and control of all DCHFT staff ensuring IPC is high on everyone's agenda.

The annual work plan for 2022-2023 reflects a continuation of support and promotion of IPC. Looking forward to 2023-2024 high standards of IPC and developing strong

Antimicrobial Stewardship, ensuring our staff maintain a high level of compliance with IPC and a robust governance approach across the whole organisation will remain crucial in the prevention of all healthcare associated infections.

Throughout 2022-2023 the IPC team will continue to strength and support close working relationships with the IPC Integrated care system. Dorset-wide use of ICNET will support this work.

The trust remains committed to preventing and reducing the incidence and risks associated with HCAI's and recognises that we can do even more by continually working collaboratively together with colleagues, patients, service users and careers to develops and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Karamadoukis
IPC lead Specialist Nurse

REFERENCE

Department of Health (2015) Health and Social care Act 2008, Code of practice on the prevention and control of infections and related guidance, Available at: Health and Social Care Act 2008: code of practice on the prevention and control of infections , Accessed 15.04.2023

National Infection Prevention and Control manual for England (2022), NHS England » National infection prevention and control

APPENDIX A

INFECTION PREVENTION & CONTROL WORK PLAN 2022-2023 V4

	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)	Director of Infection Prevention & Control (DIPC)	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	Associate Director Infection Prevention & Control (ADIPC)	October 2022	May 2022 Dorset wide ICNet roll-out in progress. Sept 2022 – System now live across the ICS
		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 achieved. Learning from performance data to be disseminated and evidenced via Divisional performance reports	Evidence that IPC performance dashboard is discussed and actioned at Divisional Governance meetings	Divisional Heads of Nursing / Quality	March 2023	Via dashboards

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
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	The environment is safe and clean. Cross infection rates low	Facilities Manager	Sept 2023	Sept 2022 – Planned 30/09/2022
			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 2023	Sept 2022 – Update expected at IPCT meeting. Dec 2022 – Confirmed to formally commence April 2023 – areas deep cleaned in accordance with IPC recommendations
			Participation in weekly environmental technical audits	Review of weekly audits identifies deficits and monitors remedial actions have been taken	Facilities Manager (Lead) Estates Manager Patient representatives Pharmacy IPC Team	March 2023	
		All clinical equipment is clean and ready for use at point of care	Daily/Weekly Nursing Cleaning regimes in place in all clinical areas	Evidence via weekly audits – report compliance to IPCG	Divisional Heads of Nursing / Quality	Bi-Monthly	Sept 2022 – Divisions to feedback at Sept 2022 IPCG
		DCHFT will maintain a clean and safe water system	Policy in place 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. Additional meetings to be	Head of Estates	March 2023	May 2023 – Post COVID recovery meetings in place

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
				arranged and reported on for individual locations.			
		DCHFT will maintain a clean, safe and effective ventilation system	Establish ventilation safety group the reports to IPCG on a bi-monthly basis. Develop Ventilation Policy to measure compliance with HTM-03 and reduce risk of airborne infections in the healthcare settings	Compliance with refurbishment with HTM – 03 a/b	Head of Estates	March 2023	
		DCHFT will adhere to NHS Cleaning Standards 2021	Facilities and Housekeeping to ensure standards are maintained and audited vi monthly audit process	DCHFT will maintain high standards for cleaning within new framework – Bimonthly feedback to IPCG	Head of Facilities	March 2023	
3	Provide suitable accurate information on infections to service users and their visitors	Patients will be fully informed about their presenting infections. All new cases of *Cdifficile,* MRSA and ESBL will be counselled by an IPCN	IPCT to visit newly identified infectious patients and their carers. Provide verbal and written information and contact details	Positive patient feedback	IPCT	March 2023	May 2022 – IPCT continue to visit patients with newly acquired infections and established infections to provide information and reassurance.
		The Trust will have up to date patient	Review of all IPC patient information. Check meets	Positive patient feedback	IPCT	March 2023	Sept 2022 – Full review completed

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
		information relating to infection control	standards and revise accordingly. Apply Equality and Diversity policy to all IPC information leaflets				
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. Offsite support available e.g., South Walks House, Redwood House, Weymouth OPD	Minimum cross infection, reduced prolonged outbreaks of infection, reduced HCAIs	IPCT	March 2023	May 2022 - Daily IPCT ward rounds in place.
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	Achieve trajectory for *Clostridium difficile* infection (CDI) TBC cases 2022-2023 (does not include cases whereby no lapses of care were identified)	Divisions to undertake Root Cause Analysis of all hospital acquired cases of CDI under the revised definitions – Hospital Onset-Healthcare Acquired and Community Onset Healthcare Acquired. IPCT to support. Antimicrobial Pharmacist and IPC	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	Divisional Heads of Nursing / Quality / Matrons	March 2023	See dashboards

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	the infection to other people		Doctor to support pharmacy and medical element. This must be completed within 14 days of infection.	Prevention Group (IPG). Delays in RCA progress will be reported at IPCG on the Divisional Dashboards. Face to Face RCA meetings to be re-established with Executive Lead.			
		Achieve trajectory for Gram-negative blood stream infections (BSI) TBC cases 2022-2023	Undertake IPC led data analysis of all hospital acquired cases of gram-negative BSI – escalate to full RCA if lapses in care identified	All cases of Gram-negative BSI will have investigation and relevant action plan if deficits identified.	ADIPC	March 2023	See dashboards
		Ensure the Trust is robustly prepared for Seasonal variations in IPC.	Support staff vaccination programme for seasonal influenza/COVID-19 Reinforce Respiratory Guidance/Seasonal Influenza Policy and Pandemic Influenza Policy	The Trust will be able to function effectively during the variance in season IPC activity and Infection Control standards are maintained	ADIPC	October 2022	Dec 2022- Vaccination programme in place Dec 2022- IPCT reinforcing policies via IMT/Ward rounds/training.

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Ensure staff are familiarised with the Outbreak/Noro/COVID -19 policy				
		Ensure Trust remains aligned to United Kingdom HS Agency (UKSHA) 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	ADIPC	Ongoing	Sept 2022 – Await V1.11 to be formalise via NHSE. Dec 2022 – IPCG to approve current version – await final approval Jan 2023
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 Heads of Nursing / Quality / Matrons	Monthly	See dashboards
			Validation of hand hygiene audits	High level compliance with WHO 5 moments of care hand hygiene standards.	IPCT/ External auditors	Bi-Monthly	See dashboards

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			Participate in national infection control promotion events	Staff engage with IPCT promote best practice.	IPCT	October 2022	Oct 2022 - Completed
		Education	Support DCHFT mandatory training programme and other IPC training within educational packages Via e-learning and face to face training	Education reflects national and local requirements for mandatory IPC training.	IPCT	March 2023	See dashboard
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. Undertake quarterly PPE audit to confirm compliance with policy.	Audit identifies appropriate precautions to effectively manage patients with infections.	IPCT	March 2023	
		Ensure adequate isolation facilities in new build and any new build has the pandemic planning as part of process	IPCT to be involved in: • ED15 • New build Critical Care	New build is fit for purpose for isolation requirements and pandemic preparedness	ADIPC	March 2023	

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			• New build ED • South walks				
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 at DCHFT to continue to support development of ICNet 'single instance' across Dorset - Dorset-Wide ICNet project. IPCT to continue to monitor efficacy of data since transfer to single instance laboratory system. Dorset Healthcare to go live Summer 2022	One ICNet system across Dorset	ADIPC	October 2022	Sept 2022- ICNET now integrated across ICS
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	See dashboard
			Urinary catheter documentation audits undertaken to ensure compliance with observation standard.	Urinary catheters will be reviewed on a daily basis and care documented on Vital Pac	IPCT	Monthly	See dashboard

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
			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	See dashboard
			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 2023	
10	Ensure, so far as is reasonably practicable, that care workers are free of and are	Reduce the number of sharps injuries caused by sharps disposal	Undertake annual Sharps Audit to ensure Trust wide adherence to recommended practice. Action plan	Audit identifies compliance with safe management of storage and	IPCT	Sept 2022 (IPCT) Oct 2022 (Provider)	Sept 2022 – Quarterly feedback via July IPCG Sharps audit complete July 2022

	Health & Safety Act Criterion	Objective	Action	Measure of Success	Responsibility/ Operational Lead	Date of Completion	Evidence
	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		with Divisions to reduce risks identified on audit.	disposal of sharps			
		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	Lead Fit Mask Tester	Bi-monthly feedback via IPCG/H&SG	Sept 2022- Feedback via FFP3 lead Dec 2022- Feedback via FFP3 lead – training programme in place
		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	IPCT/ Lead Emergency Planner	October 2022	Dec 2022 – IPCT to provide update via IPCG
		Environmental controls are in place to ensure ventilation meets standard for respiratory pandemic precautions	Estates to ensure clinical and non-clinical areas have documented assessment and controls in place to support pandemic guidance	DCHFT can demonstrate compliance	Estates Lead	September 2022	Sept 2022- Feedback from Estates required

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 Deputy Chief Nursing Officer /Associate Director Infection Prevention & Control Jan 2023 V4

APPENDIX B

Infection Prevention and Control Board Assurance Framework Winter 2022

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • A respiratory plan incorporating respiratory seasonal viruses that includes: o point of care testing (POCT) methods for infectious patients known or suspected to have a respiratory infection to support patient triage/placement according to local needs, prevalence, and care services. o segregation of patients depending on the infectious agent taking into account those most vulnerable to infection e.g. clinically immunocompromised. o A surge/escalation plan to manage increasing patient/staff infections. o a multidisciplinary team approach is adopted with hospital leadership, operational teams, estates &	POCT in place in Emergency Department for COVID-19, influenza, Respiratory Syncytial Virus (RSV) – symptomatic adult children and young people (CYP) tested. Isolation triage in place via ICNET and infection prevention and control team (IPCT) Clinical Site Managers access database to assist placement of patients requiring contact, airborne and protective isolation. This is a risk RAG rated database updated by IPCT. Thrice daily bed meetings attended by IPCT assess current situation in the Trust and		

facilities, IPC teams and clinical and non- clinical staff to assess and plan for creation of adequate isolation rooms/cohort units as part of the plan.
 	
• Organisational /employers risk assessments in the context of managing infectious agents are:
  ○ based on the measures as prioritised in the hierarchy of controls.
  ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE.
  ○ communicated to staff.
  ○ further reassessed where there is a change or new risk identified eg. changes to local prevalence.
 	
• the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.
 	
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with the infectious agents.
	cohort/isolation plans agreed. In the event of outbreak and ward closure IPCT lead and manage response in accordance with policy - http://sharepointapps/clinguide/CG%20docs1/1038-ward-closure.pdf.
	
	Estates completed full site review 2020/2021 of ventilation and risk assessment of patient locations for aerosol generating procedures (AGPs) and high-risk infections.
	
	Operational capacity risk managed via bed meetings and documented via situations reports (sitrep) reported via ICS and as required via region.
	
	Standard weekly Communication email in place with additional comms where required.
	
	Prevalence of infection/variants of concern – risk assessments in place for personal protective equipment use (PPE) and action cards to support Action cards - All Documents
	
	Risk assessments requiring prompt action are agreed via specialist teams and escalated to the weekly Incident Management Team (IMT) Trust decision escalated to ICS IPC group for system agreement. IMT review any escalations or emerging risks. Risks agreed via Incident Management Team and entered onto the Trust Risk Register (COVID-19 is on the Corporate Risk		

• ensure that transfers of infectious patients between care areas are minimised and made only when necessary for clinical reasons. • resources are in place to monitor and measure adherence to the NIPCM. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • the application of IPC practices within the NIPCM is monitored e.g. 10 elements of SICPs • the IPC Board Assurance Framework (BAF) is reviewed, and evidence of assessments are made available and discussed at Trust board level. • the Trust Board has oversight of incidents/outbreaks and associated action plans. • the Trust is not reliant on a single respirator mask type and ensures that a range of predominantly UK made FFP3 masks are available to users as required.	register). Governance in place for sub-board committees to oversee risk assessments and escalate to the Trust Board. IMT consisted of leads of departments and services. Annual risk assessments for all areas (clinical and non-clinical) managed via Health and Safety. Minimised where possible and plans to cohort agreed by IPCT to support reduction of moves out of hours. Daily IPCT ward rounds in place to monitor compliance and address on-compliance issues. Monthly departmental and ward hand hygiene audits in place. Peer audits also actioned. Indwelling device audits in place and results reported via Divisions to Infection Prevention and Control Group (IPCG). All 10 Standard Infection Control Precautions (SICPs) C1636-national-ipc-manual-for-england-v2.pdf are audited and results and subsequent actions/learning reported via IPCG to Quality Committee. Escalation to Trust Board if performance is not maintained. All IPC incidents are escalated via the governance route. DCHFT utilises and tests staff on various respirator brands and have access to 5 options.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that:
 	
• the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.
 	
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/room
 	
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.
 	
• enhanced/increased frequency of cleaning should be incorporated into environmental decontamination protocols for patients with suspected/known infections as per the NIPCM (Section 2.3) or local policy and staff are appropriately trained.
 	
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
 	
• For patients with a suspected/known infectious agent the frequency of cleaning should be increased particularly in:
  ○ patient isolation rooms
  ○ cohort areas
  ○ donning & doffing areas – if applicable
	Cleaning Policy and audit process updated and agreed via September 2022 IPCG
	
	PAS team is able to share this and do so as required. IPCT update Housekeeping accordingly. Ad hoc increase in cleaning requirements achieved via IMT/IPCT comms
	
	Monthly cleaning audits reported via Divisional Dashboards at IPCG.
	
	Daily update and as required via IPCT directly to Housekeeping supervisors
	
	Regular training supported by manufacturers in place e.g. Clinell
	
	Full cleaning RAG rating process in place and communicated via training and posters on wards/clinical areas.
	Commode cleaning audits in place		

○ ‘Frequently touched’ surfaces e.g., door/toilet handles, chair handles, patient call bells, over bed tables and bed/trolley rails. ○ where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea and/or vomiting. • The responsibility of staff groups for cleaning/decontamination are clearly defined and all staff are aware of these as outlined in the National Standards of Healthcare Cleanliness •	Reinforced via Cleaning Policy		
• A terminal clean of inpatient rooms is carried out: ○ when the patient is no longer considered infectious ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens). ○ following an AGP if clinical area/room is vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	Action cards and reinforced via cleaning policy	Monitoring and assurance required from housekeeping leads via database	
• reusable non-invasive care equipment is decontaminated: ○ between each use ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment.	Decontamination Policy in place and actioned. Additional support offered via IPC/Equipment Library in relation to new equipment e.g. respiratory hoods		
• compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.			

• ventilation systems, should comply with HBN 03:01 and meet national recommendations for minimum air changes https://www.england.nhs.uk/publication/specialised-ventilation-for-healthcare-buildings/ • ventilation assessment is carried out in conjunction with organisational estates teams and or specialist advice from the ventilation group and/ or the organisations, authorised engineer and plans are in place to improve/mitigate inadequate ventilation systems wherever possible. • where possible air is diluted by natural ventilation by opening windows and doors where appropriate	Cleaning products supplied in all areas. Staff aware to clean between patients. Red and green 'I am clean' labels in use. Cleaning schedules in use in all areas. Ventilation Safety Group in place. Needs to report up to IPCG as escalation report Use of 'air scrubbers' in poorly ventilated areas e.g., Southwalks House OPD Areas that have windows advised to ensure opened to maintain ventilation. Posters circulated reminding staff of this.	Need Divisional Assurance via IPCG Assurance required for Estates and/or derogation of risk	
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship (AMS) are maintained and a formal lead for AMS is nominated • NICE Guideline NG15 https://www.nice.org.uk/guidance/ng15 is implemented – Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use • the use of antimicrobials is managed and monitored: o to optimise patient outcomes o to minimise inappropriate prescribing o to ensure the principles of Start Smart, Then Focus https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus are followed • contractual reporting requirements are adhered to, and boards continue to maintain oversight of key performance indicators for prescribing including: o total antimicrobial prescribing; o broad-spectrum prescribing; o intravenous route prescribing; adherence to AMS clinical and organisational audit standards set by NICE: https://www.nice.org.uk/guidance/ng15/resources • resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care areas and staff (permanent, flexible, agency and external contractors)	AMS lead in place with AMS lead consultant via microbiology AMS meeting in place and reports to IPCG, format of process built around NICE recommendations. Audits in place for AMS, lead AMS and lead consultant meet to review AMS Resources for auditing noted as difficult to achieve	AMS lead leaving Trust early 2023 Minimal resource to support audit and extended practice	Pharmacy lead seeking alternative resource

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
• **Key lines of enquiry**	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • IPC advice/resources/information is available to support visitors, carers, escorts, and patients with good practices e.g. hand hygiene, respiratory etiquette, appropriate PPE use • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national principles on inpatient hospital visiting and maternity/neonatal services will remain in place as an absolute minimum standard. national guidance on visiting patients in a care setting is implemented. • patients being accompanied in urgent and emergency care (UEC), outpatients or primary care services, should not be alone during their episode of care or treatment unless this is their choice. • restrictive visiting may be considered by the incident management team during outbreaks within inpatient areas This is an organisational decision following a risk assessment and should be communicated to patients and relatives. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, respiratory hygiene and cough etiquette. The	Resources in place and updated in accordance with requirement or change in guidance. Visits from patient relatives carers in place. Restricted visiting in place in cases of high incidence of infection e.g. outbreak area however visitors managed in this situation on a case by case process e.g. end of life care. Carers and relatives of attendees to the Trust encouraged and supported.		

use of facemasks/face coverings should be determined following a local risk assessment. • if visitors are attending a care area to visit an infectious patient, they should be made aware of any infection risks and offered appropriate PPE. • Visitors, carers, escorts who are feeling unwell and/or who have symptoms of an infectious illness should not visit. Where the visit is considered essential for compassionate (end of life) or other care reasons (e.g., parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting. • Visitors, carers, escorts should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment e.g., carer/parent/guardian. • implementation of the supporting excellence in infection prevention and control behaviours Implementation Toolkit has been adopted where required C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Local/system risk assessment in place PPE available for visitors/carers Communication in place and reinforced via external communication e.g. website Visiting Hours (dchft.nhs.uk) If attendance required e.g. child with parent PPE will be provided Toolkit supported via IPCT training, visits, communications	Posters across the Trust in place but noted a refresh and improve on current messaging	IPCT, Comms and Estates have completed a site visit and refresh plan in place
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			

• all patients are risk assessed, if possible, for signs and symptoms of infection prior to treatment or as soon as possible after admission, to ensure appropriate placement and actions are taken to mitigate identified infection risks (to staff and other patients). • signage is displayed prior to and on entry to all health and care settings instructing patients with symptoms of infection to inform receiving reception staff, immediately on their arrival (see NIPCM). • the infection status of the patient is communicated prior to transfer to the receiving organisation, department or transferring services ensuring correct management /placement • triaging of patients for infectious illnesses is undertaken by clinical staff based on the patients' symptoms/clinical assessment and previous contact with infectious individuals, the patient is placed /isolated or cohorted accordingly whilst awaiting test results. This should be carried out as soon as possible following admission and a facemask worn by the patient where appropriate and tolerated. • patients in multiple occupancy rooms with suspected or confirmed respiratory infections are provided with a surgical facemask (Type II or Type IIR) if this can be tolerated. • patients with a suspected respiratory infection are assessed in a separate area, ideally a single room, and away from other patients pending their test result and a	All non-elective patients triage via ED and POCT performed if symptomatic. Any patient with respiratory symptoms are reviewed, swabbed and isolated/cohorted (even if previously swabbed and negative result) Patients attending the Trust for routine appointments are requested not to do so if they have symptoms – telephone and video clinics in place to reduce the requirement for patients to visit the hospital. Noted Dorset wide ICNET in place to manage system patients. Out of area transfers managed generally as non-elective so triaged and swabbed accordingly e.g. renal, haematology Triage is carried out by trained staff and patients triaged according to pathway. Face masks offered to patients to wear but noted staff cannot enforce wearing of face masks for patients. Face masks available for patients and as above advised to wear. Confirmed with ED Matron triage in place in accordance with UKSHA guidance, updated as necessary with new guidance eg. Foreign travel history taking. Isolation facilitated and transfer	Poster review as above	

facemask worn by the patient where appropriate and tolerated (unless in a single room/isolation suite). • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting test results and a facemask worn by the patient where appropriate and tolerated only required if single room accommodation is not available. • patients at risk of severe outcomes of infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g., priority for single room protective isolation. • if a patient presents with signs of infection where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • The use of facemasks/face coverings should be determined following a local risk assessment. • patients that attend for routine appointments who display symptoms of infection are managed appropriately, sensitively and according to local policy. • Staff and patients are encouraged to take up appropriate vaccinations to prevent developing infection • Two or more infection cases linked in time, place and person trigger an incident/outbreak investigation and are reported via reporting structures.	to isolation on wards managed via CSMs supported by IPCT. IPCT RAG rate isolation requirements and this is shared with CSMs to support out of hours placements. ICS approach to face mask wearing via a RAG rating taking into account current regional pressures of infections. Staff and patient vaccination programmes supported for flu and COVID-19. ICNET provides a linked alert system to ensure any linked infections trigger a review with the prospect of an outbreak being declared.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that: • IPC education is provided in line with national guidance/recommendations for all staff commensurate with their duties. • training in IPC measures is provided to all staff, including: the correct use of PPE. • all staff providing patient care and working within the clinical environment are trained in hand hygiene technique as per the NIPCM and the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it (NIPCM); • adherence to NIPCM, on the use of PPE is regularly monitored with actions in place to mitigate any identified risk • gloves and aprons are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • hand hygiene is performed: o before touching a patient. o before clean or aseptic procedures. o after body fluid exposure risk. o after touching a patient; and o after touching a patient's immediate surroundings. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination (NIPCM)	IPC Training remains fluid and adapting to the national guidance changes as and when they occur. Ad hoc training supported by IPCT as required. All staff are supported with training and guidance on PPE and IPC practices. Including non-clinical staff with mask wearing PPE and Hand hygiene audits in place and monitored via Divisional Dashboard No hand dryers actively in use at DCHFT		

• staff understand the requirements for uniform laundering where this is not provided for onsite.	Detailed via action cards Staff laundry bags for home laundering available for staff. Extra scrubs ordered for medical and non-uniform clinical staff		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • that clear advice is provided; and the compliance of facemask wearing for patients with respiratory viruses is monitored (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • patients who are known or suspected to be positive with an infectious agent where their treatment cannot be deferred, care is provided following the NIPCM. • patients are appropriately placed i.e.; infectious patients are ideally placed in a single isolation room. If a single/isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. • standard infection control precautions (SIPC's) are applied for all, patients, at all times in all care settings • Transmission Based Precautions (TBP) may be required when caring for patients with known / suspected infection or colonization	National guidance advises symptomatic patients to wear facemasks if tolerated in an area with other patients e.g. cohort. PPE pathways via action cards in place Action cards - All Documents Daily reviews in place via IPC ward rounds and supporting Clinical Site Team if pressures evolve with patient placement. IPCT and the Clinical Site Team work closely to ensure isolation facility availability in place to support requirement. Surge plan in place if isolation capacity is reduced. Negative pressure suite on Lulworth Ward is dedicated to patients who are undergoing AGPs. Areas with confirmed respiratory cases cohorted are based on Moreton Ward and national IPC guidance.	Compliance with facemask wearing by patients is low.	IPCT reinforce on ward rounds when required

	IPCT available to support ward and clinical area queries with any PPE or infection related issue. New Isolation Posters in place to remind staff on precautions required		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • Laboratory testing for infectious illnesses is undertaken by competent and trained individuals. • patient testing for infectious agents is undertaken promptly and in line with national guidance. • staff testing protocols are in place for the required health checks, immunisations and clearance • there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available. • inpatients who go on to develop symptoms of infection after admission are tested/retested at the point symptoms arise. **COVID-19 Specific** • patients discharged to a care home are tested for SARS-CoV-2, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to	Accredited microbiology/virology lab utilised on site. Guidance in place to support staff – process already established as throat and nose swabs taken frequently by Trust staff for other organisms. Refresher training in place via IPCT. Symptomatic patients tested on admission via POCT units in ED. Other testing managed via the main lab. Monitored via lab team and reported to IPC if any delayed results. Action cards in place to direct staff on testing regime if patients are symptomatic and require swabbing, All patients discharged to a care home are swabbed as per national guidance – compliance monitored via DATIX		

discharge. Coronavirus (COVID-19) testing for adult social care services - GOV.UK (www.gov.uk) • for testing protocols please refer to: COVID-19: testing during periods of low prevalence - GOV.UK (www.gov.uk) C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk)			
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that • resources are in place to implement, measure and monitor adherence to good IPC and AMS practice. This must include all care areas and all staff (permanent, flexible, agency and external contractors). • staff are supported in adhering to all IPC and AMS policies. • policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and infectious linen/laundry used in the care of known or suspected infectious patients is handled, stored and managed in accordance with current national guidance as per NIPCM	Audit dashboard presented bi-monthly to IPCG, adherence monitored by IPCT, IPC Doctor, Matrons, Heads of Nursing. Additional training provided as required to embrace policy and action plans in place following formal audit with measured learning outcomes reported to IPCG. Policy in place. http://sharepointapps/clinguide/CG%20docs1/1038-ward-closure.pdf ICNET supports outbreak module to ensure documentation accessible. Waste streams in place. PPE supply and availability confirmed on w weekly basis via IMT		

• PPE stock is appropriately stored and accessible to staff when required as per NIPCM			
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**

Systems and processes are in place to ensure that:
 	
• staff seek advice when required from their occupational health department/IPCT/GP or employer as per their local policy.
• bank, flexible, agency, and locum staff follow the same deployment advice as permanent staff.
• staff understand and are adequately trained in safe systems of working commensurate with their duties.
 	
• a fit testing programme is in place for those who may need to wear respiratory protection.
 	
• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:
  ○ lead on the implementation of systems to monitor for illness and absence.
  ○ facilitate access of staff to treatment where necessary and implement a vaccination programme for the healthcare workforce as per public health advice.
	Optima Health provide Occupational Health Services for DCHFT. Local action cards/policies in place to support staff. Reinforced and additional support via Human Resources team.
	
	IPCT involved in Trust Induction and mandatory training reinforces safe systems of working.
	
	Fit Mask Testing lead in post and actioning programme to maintain fit testing at DCHFT. Bi-monthly update on progress to IPCG.
	
	Any breach in IPC procedures and requirement to access support, seek public health advice, human resources input and maintain sitrep. Human resources lead on sickness and absence monitoring as OH an external company. IPCT, Human resources, divisions and pharmacy work on vaccine programme to support access for staff to flu and COVID-19 vaccinations.
		Agency staff induction needs to be robust. Pack previously in place requires updating.	Local induction

○ lead on the implementation of systems to monitor staff illness, absence and vaccination. ○ encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in NIPCM. • a risk assessment is carried out for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza or severe illness from COVID-19. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups. ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • testing policies are in place locally as advised by occupational health/public health. • NHS staff should follow current guidance for testing protocols: C1662_covid-testing-in-periods-of-low-prevalence.pdf (england.nhs.uk) • staff required to wear fit tested FFP3 respirators undergo training that is compliant with HSE guidance	Action cards in place to support safe return to work post respiratory infection. COVID-19 risk assessments in place and it is the Divisional Lead responsibility to complete and update the assessment on a regular basis. Guidance for All Staff (dchft.nhs.uk) Action cards in place and reflect current national guidance re COVID-19 testing Full rolling training programme in place – bi monthly feedback by FFP3 testing lead to IPCG. This feedback includes: • Number of staff FFP3 fit mask tested • Number of available trainer • Models currently in use and relevant training provided		

and a record of this training is maintained by the staff member and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • fit testing is repeated each time a different FFP3 model is used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators or an alternative is offered such as a powered hood. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions • members of staff who fail to be adequately fit tested: a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held	Powered hoods available from the Equipment Library Health and Safety led risk assessment of reusable respirators and deemed high risk due to complexities of cleaning – not in use at DCHFT Alternative PPE can be provided via respirator hoods. Divisional leads will be responsible in this instance to keep a record of staff redeployed for this reason – currently no staff redeployed (Dec 2022) Bi-monthly report via FFP3 Lead Action cards in place		

record of results which is regularly reviewed by the board. • staff who have symptoms of infection or test positive for an infectious agent should have adequate information and support to aid their recovery and return to work.			

C1501 DCHFT response to national requirement for BAF

Emma Hoyle December 2022