2023/2024 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 (IPC) 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 Interim Chief Nursing Officer/Director of Infection Prevention and Control, Jo Howarth who has a wealth of experience and knowledge within the field of IPC.

The Infection Prevention and Control Committee has a function to fulfil the requirements of the statutory Infection Prevention and Control obligations. It formally reports to the sub-board Quality Committee, providing assurance and progress via 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 a last updated in December 2022.

The yearly IPC Optimisation plan, led and supported by the Infection Prevention and Control lead specialist nurse and Infection Prevention and Control Team (IPCT), sets clear IPC objectives for the organisation to achieve with strategies in place to meet the overall Trust strategic mission: “Outstanding care for people in ways which matter to them”. The IPC optimisation plan is developed closely with the completion of the new National Infection Prevention and Control Board Assurance Framework, which was launched in March 2023.

Overall, 2023- 2024 was another successful year, meeting key standards and regulatory requirements for infection prevention and control. Below documents a highlight for the IPC year: -

- The Trust met the trajectories set for MRSA bacteraemia, and following Root Cause Analysis reviews or the new IPC Patient Safety Incident Response Framework process for *Clostridium difficile* infections and Gram-Negative Pseudomonas blood stream infections Organisms, for 2023-2024.
- We have implemented the IPC Patient safety Incident Response Framework (PSIRF).
- The Trust continued to develop and adjust our response to the local and national requirements for COVID-19, as we continued to move away from pandemic to endemic guidance ‘living with COVID-19’ plan set out by the government.
- Trust Hand hygiene compliance has remained high and sustained at 97.8%.
- The trust continued to meet mandatory requirements for Surgical Site Surveillance (SSI) for Fractured hip, small and large bowel elective surgery and elective knee replacement.
- The Sterile Services 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).

- Face to face IPC education and training has continued, combined with an updated IPC e-learning programme. We have regularly increased our face-to-face training within specific departments, especially when a requirement has been deemed necessary. We have maintained very good compliance with IPC mandatory training.
- Enhanced water 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 2023– 31st March 2024. 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 Trust met the target for zero cases of preventable MRSA bacteraemia. The Trust identified 12 trajectory cases of *Clostridium difficile* against a target of 45 cases (53 total cases), a reduction from last year and was slightly over trajectory for the total gram-negative organisms. The Infection Prevention and Control Team have seen system and partnership working key to supporting the health and safety of the population. We have ensured continued collaborative working, sharing good practice, offering support where able and championing the benefits of digital support in the management of infection prevention and control.

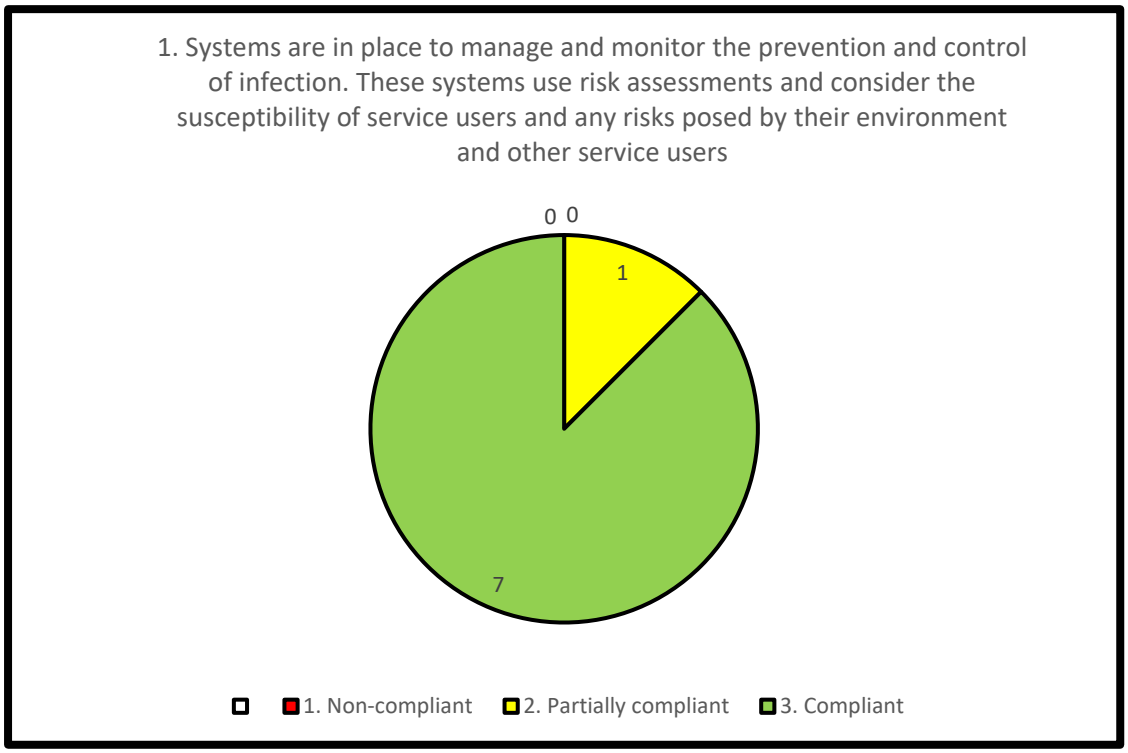
These lower rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases.

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 of 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 and related guidance sets out ten compliance criteria. This IPC Annual Report is divided into these ten-compliance criterion which follow below individually, demonstrating the trust compliance and evidenced assurance in meeting the ten criterions. The IPC lead has completed the new IPC Board Assurance Framework, which was issued in March 2023 by NHS England, which enables organisations to respond an evidenced-based approach to maintain the safety of patients, service users, staff, and others. It enables, supports, and provides an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National IPC Manual and the Health and Social Care act 2008. The IPC yearly IPC optimisation plan within Appendix A, links closely with the IPC Board Assurance Framework setting out a clear IPC workplan.

The framework enables clear compliance rating pie charts which are evident within this report below each criterion, reduced compliance links with the IPC Optimisation Plan – APPENDIX ONE.

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.



Partially compliant 1.7: All staff receive the required training commensurate with their duties to minimise the risks of infection transmission. Tier three of the IPC education framework not rolled out following national guidance but mitigated by all staff receiving yearly IPC mandatory training. The IPC team plan to implement separate face to face training to cover this tier.

INFECTION PREVENTION & CONTROL GROUP (IPCG)

The IPCG met 6 times during 2023- 2024. 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 IPC Committee (IPCC) meeting was chaired by the Interim Chief Nursing Officer, Jo Howarth, who is also the Director of Infection Prevention and Control (DIPC), with the responsibility for reporting to the sub-board Quality Committee for assurance.

DIPC REPORTS TO QUALITY COMMITTEE

The DIPC has presented the following items during 2023-2024:

- Monthly Gram-negative Bacteraemia surveillance.
- Monthly *Clostridium difficile* surveillance.
- Monthly hand hygiene rates.
- Monthly IPC audit results
- Outbreak and incident reports.
- IPC Escalation reports following bi-monthly IPC committee meetings.

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 Amy Bond, Infection Control Doctor Consultant Microbiologist
- Dr Cathy Jeppesen, Antimicrobial Stewardship (AMS) Doctor and Consultant Microbiologist
- Dr Lucy Cottle, Consultant Microbiologists lead
- Dr Mary Varghese, Consultant Microbiologist
- Emma Karamadoukis, IPC Lead Specialist Nurse
- Christopher Gover, IPC Specialist Nurse
- Abigail Warne, IPC Specialist Nurse
- Julie Park, IPC Specialist Nurse
- Helen Hindley, IPC Nurse
- Sophie Lloyd, IPC Nurse
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Rhian Pearce, Antimicrobial Pharmacist (left the trust January 2024)

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

IPC Implementation of Patient Safety Incident Response Framework (PSIRF)

We have changed the way we are reviewing our infections, in line with Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

PSRIF

• Advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents

• Embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The Infection Prevention and Control team launched the implementation of PSIRF on the 1st of January 2024, and we commenced reviewing our Healthcare Associated Infections (HCAI) differently, working within the framework to identify learning, recurrent themes and improve patient safety. The Root Cause Analysis (RCA) process ceased, and the below organisms are included in our internal PSIRF Programme; Clostridiodes Difficile - (HOHA Hospital Onset Healthcare Associated, COHA Community Onset Healthcare Associated), Gram-negative bloodstream infection – (klebsiella spp., pseudomonas aeruginosa, E. coli – HOHA cases), MSSA and MRSA

bloodstream infections (HOHA cases). We now hold monthly 'learning together' MDT (Multi-Disciplinary Team) meetings to discuss each case that has identified learning following the IPCT/Consultant microbiology after action review. As an IPC ICS (integrated Care system), we also commenced reviewing cases using the PSRIF ideology during our system wide post infection review meetings and cases that trigger an in-depth system wide case review, having triggered a PSII (Patient Safety Incident Investigation) will have an in-depth case review by all healthcare services involved. Quality Improvement projects are then driven following the identified learning and thematic reviews. Escalating concerns via IPCC, PLACE based partnership meetings and South West regional meetings.

HEALTHCARE ASSOCIATED INFECTIONS

This year NHS England updated the trajectories figures 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.).* The definition of a case are agreed 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.

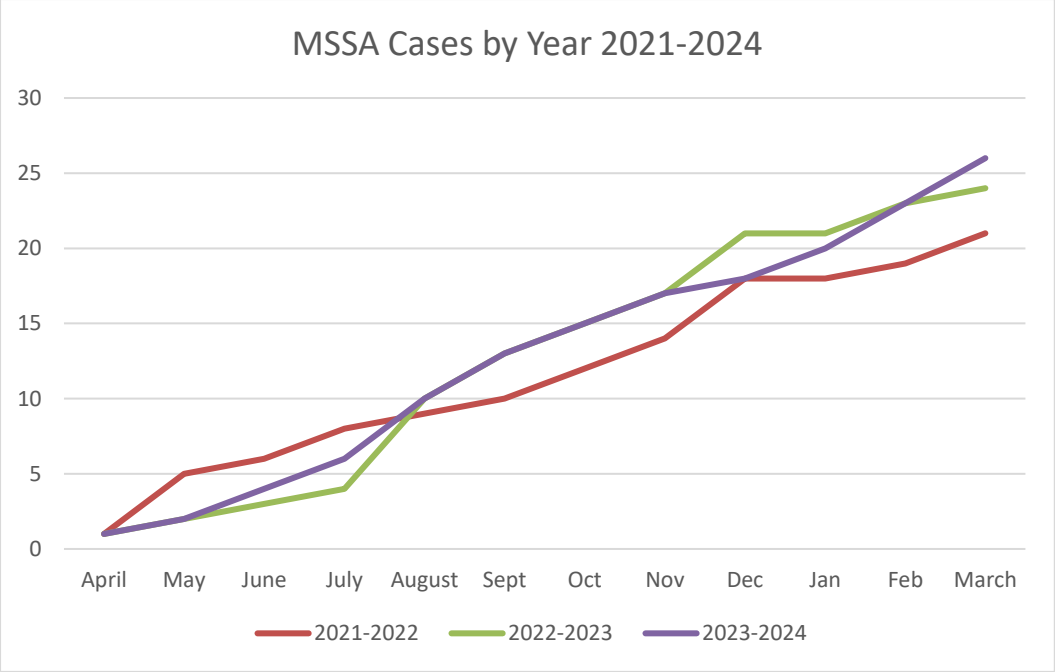
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA)BACTERAEMIA

There were no preventable cases of MRSA bacteraemia in 2023-2024 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. In 2023-2024 the trust had 3 MRSA Bacteraemia cases in total.

STAPHYLOCOCCUS AUREUS BACTERAEMIA (MSSA)

In 2023-2024 there were a total of 26 cases of MSSA bacteraemia (HOHA and COHA), 19 HOHA cases, a reduction from the previous year of 21 HOHA cases, 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 and a reduction in HOHA cases.



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 had a full Root Cause analysis review or the new PSIRF review, with the results and learning feedback to IPCC and senior leaders within the trust, quality improvement projects are then driven following these conclusions.
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. We have also reviewed and improved our elective orthopaedic screening and decolonisation treatment.

GRAM NEGATIVE BLOOD STREAM INFECTIONS

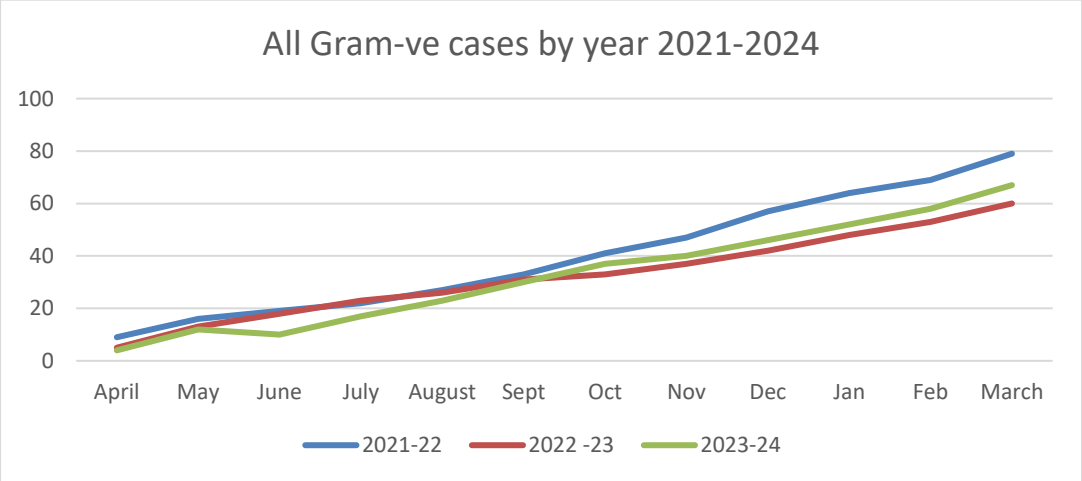
Gram-negative blood stream infections (BSIs) are a healthcare safety issue. From April 2017 there has been NHS ambition to halve the numbers of healthcare associated Gram–negative BSIs by 25% March 2021 (PHE 2017) and 50% March 2024 (PHE 2019). In February 2019 it was announced that the date for achieving 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 many 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. 2023-2024 formal trajectories for gram-negative blood stream infections were set by NHSE/I at 62 cases (39 Escherichia coli 9 Pseudomonas aeruginosa and 14 Klebsiella sps). Noting this trajectory is for HOHA and COHA combined. All cases of Gram-negative BSI HOHA cases are reviewed by the Infection Prevention & Control Team using the PSIRF process.

In 2023-2024 there were a total of 46 positive BSI samples for E. coli which were attributed to the Trust – HOHA & COHA. Noting a slight increase from 2022-2023 data but improvement from 2021-2022 data. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

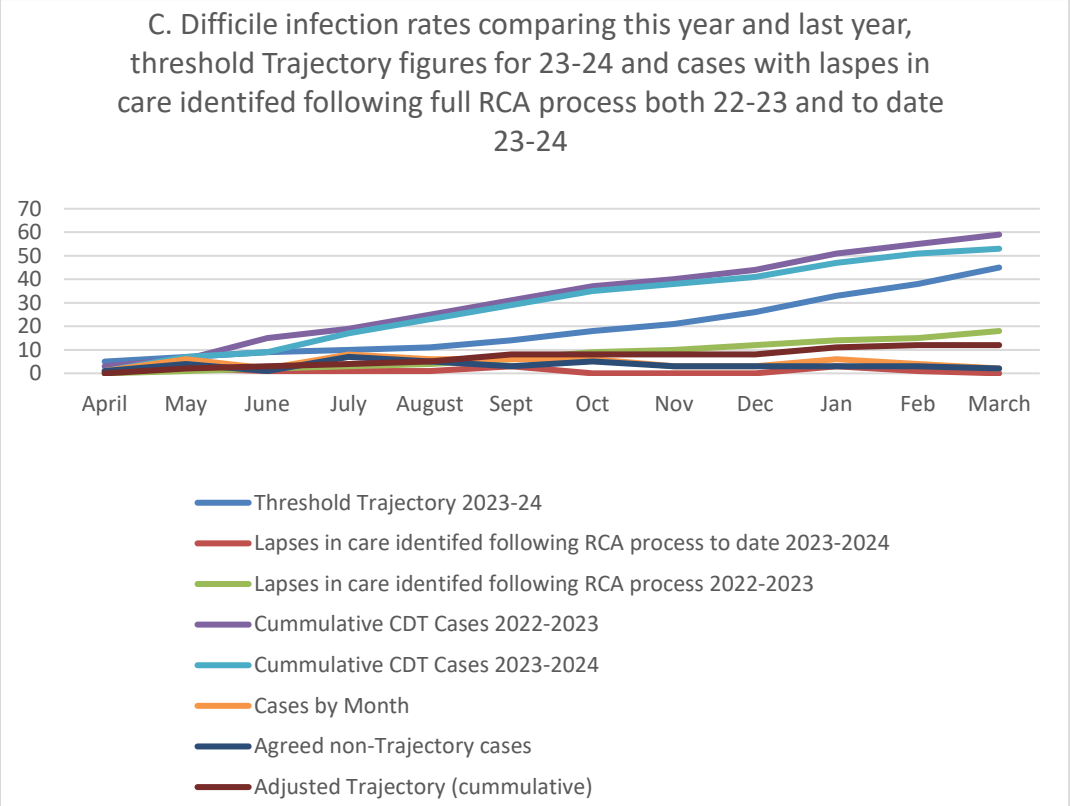
In 2023-2024 there were a total of 16 positive BSI samples for Klebsiella, which were attributed to the Trust – HOHA & COHA. Noting a slight increase from 2022-2023 data but improvement from 2021-2022 data. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

In 2022-2023 there were a total of 5 positive BSI samples for Pseudomonas aeruginosa, which were attributed to the Trust – HOHA & COHA. Noting an improved reduction in cases over the last three years. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.



CLOSTRIDIOIDES DIFFICILE INFECTION (CDI)

In 2023-2024 Clostridioides Difficile infection formal trajectories for were set by NHSE/I at 45. In total the Trust reported 53 cases detected HOHA/COHA; of these cases 12 were identified as preventable with lapses in care; and learning implemented trust wide. This data represents a reduction in cases from last year, with regards to both the number of cases and the cases which identified learning.



All cases CDI HOHA and COHA cases have a PSIRF investigation, pre-January 2024 a Root Cause Analysis investigation. The results following these investigations are escalated to IPCC and are presented Jo Howarth (Interim Chief Nursing Officer/Director of Infection Prevention and Control) and Emma Hoyle (Deputy Chief Nursing Officer/Associate Director of Infection Prevention and control) and any relevant learning from the cases is escalated via the correct governance processes and will also help trigger wider quality improvement projects. The learning actions when completed are then presented and signed off by the Divisional Matrons at the IPCC. 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 continuing to review this data, which also includes all Dorset anonymised case information. The IPCT have rolled out the use of Peracetic Wipes across the trust, which are to be only used for commode and equipment cleaning within side rooms for patients with known CDI, with the aim to support environmental cleaning for CDI.

OUTBREAKS OF INFECTION

NOROVIRUS

There have been four outbreaks of Norovirus in the reporting year 2023-2024. This is against the backdrop of a large incidence of norovirus within the community across the country. All declared outbreaks follow our trust procedural policy and the IPC lead always carries out a de-brief meeting afterwards, with the senior ward leadership team and escalates learning via IPCC.

INFLUENZA/RESPIRATORY SYNCYTIAL VIRUS (RSV)

During winter of 2023-2024 winter cases of Influenza A, B & RSV remained steady in comparison to the previous year. The identification of these cases at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, 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.

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 2023-2024 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.

The audits completed for 2023/2024; October 2022 - June 2023 Elective small and large bowel surgery, this was carried out pre implementation of a consultant surgeon Quality Improvement project for evidenced baseline data. Jan 2024 – March 2024 Fractured neck of femur and January 2024 – March 2024 Elective Orthopaedic Knee Surgery. All showing a low incidence of surgical site infection rates.

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 audit was 92% up from the last two years, 91% for 2023 and 79% for 2022 last year. The IPCT has also introduced monthly Central Venous Catheter audits showing 88.5% compliance for 2023-2024.

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. 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.

Compliance was measured against the requirement to accurately document indwelling urinary catheter insertion on Vital Pac, the audit results are excellent with an overall trust compliance of 94% of all catheters being recorded. When split between the Divisions, Family and Surgery returned 94% compliance and Urgent and Integrated Care 93% compliance. Noting a slight improvement from the data of 2022-2023. These percentages are an average.

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 during 2023 - 2024, 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, and we 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 2023 and March 2024, 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 89%. This has increased by 8% on the previous year's 81% result and also demonstrates a year-on-year improvement. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated quarterly for 2024-2025.

CANDIDA AURIS SCREENING

Following an outbreak of candida Auris within the region, and new guidance published from the UK Health Security Agency (currently remaining in draft form) the IPCT reviewed our own internal screening and policy guidance against national

recommendations mid-2023, and we have updated the local trust policy. To support the updated guidance, we have improved our own testing availability via our microbiology laboratory and developed a robust screening risk assessment, which now sits alongside our CPE screening triggers. Therefore, the CPE audit noted above also demonstrates our compliance with the trust Candida Auris screening policy for the last two quarters.

COVID-19

NHS England and UKHSA guidance has continued to be reviewed and updated over 2023-2024. Ensuring patient and staff safety remains at the forefront of providing healthcare services. The trust response continues to be led by the IPC lead and IPCT, and the trust follows the recommended national guidance.

Over the past 4 years the IPCT have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England/UKHSA. The IPCT have also continued to work closely with the Dorset wide ICS to share best practice and learn from other trusts in the Southwest region and beyond.

We have declared no Covid-19 outbreaks between April 2023 and March 2024. This is excellent comparing outbreak figures for other inpatient setting in the Southwest region, especially considering the extremely transmissible nature of Covid-19 and increased prevalence in the community. The identification of the symptomatic cases at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, 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.

Covid-19 testing and monitoring and reporting continues to be carried out daily by the IPCT and prompt de-escalation of cases with support from the medical teams, supports our trust isolation capacity.

INFECTION PREVENTION & CONTROL WEEK - OCTOBER 2023

To celebrate 'International Infection Prevention and Control week' on the 16th – 20th October 2023. The IPCT requested wards to produce a poster presentation with an IPC theme **'What are the 'little' things you do that make a 'big' difference'.**

The overall aim is to improve staff knowledge and increase awareness on any IPC practice, we also provided a busy week's agenda, which included daily IPC clinics, rep visits, staff training, IPC quiz and general fun IPC activities. Many wards within the trust produced beautiful poster displays encompassing many different topic areas and the judging was carried out by the IPCT and A Hutchison (Chief Medical Director). Prizes were awarded to the top three wards that entered.

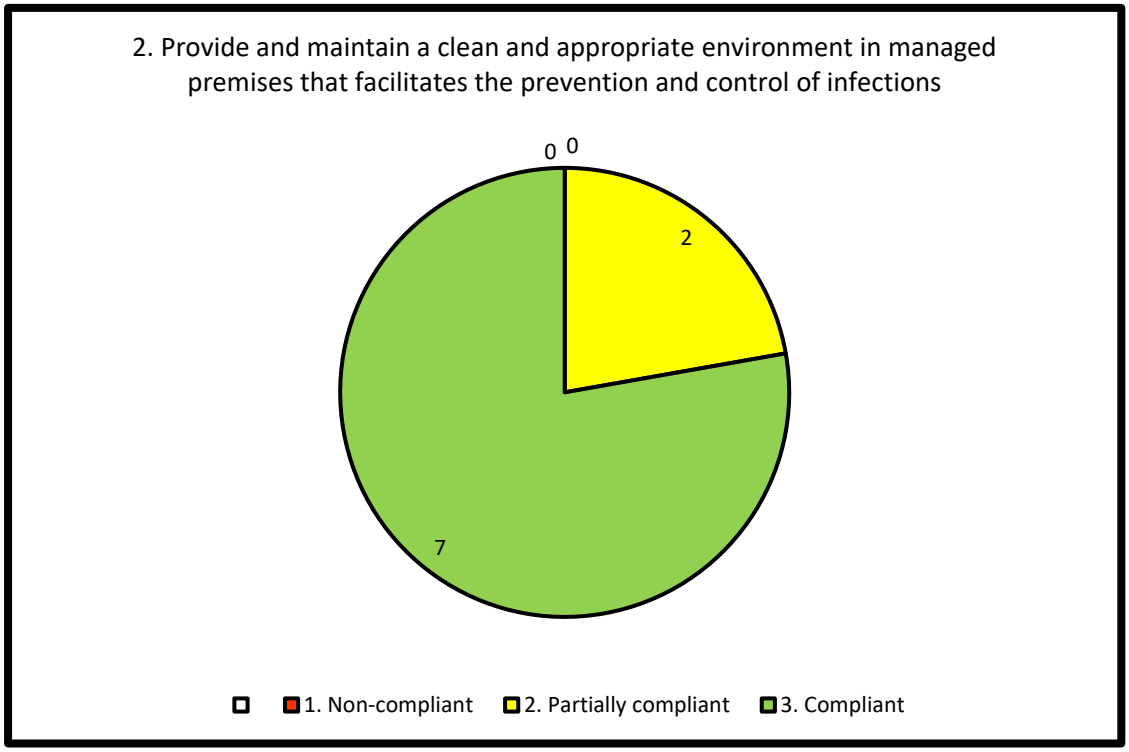
WORLD HAND HYGIENE DAY - May 2023

To celebrate world hand hygiene day the IPCT visited all the clinical areas, supporting best hand hygiene practice, including reducing the use of gloves, bear below elbow and the use of the correct hand washing technique. The IPCT carry out daily ward rounds during the week and hand hygiene audits form part of this ongoing review process and continued staff engagement with regards to supporting IPC best practice.

DCHFT RECYCLE, RESET AND REFRESH WEEK – JULY 2023

The trust organised a Recycle, Reset, and Refresh week with the aim to rest practice in many areas of the trust post Covid-19 pandemic. The IPCT played a big role during this week, aiming to reset IPC compliance following the Covid-19 pandemic, supporting leaders to find innovative ways to improve staff compliance with the National IPC Manual for England. The week also coincided with the 75th NHS Anniversary. This was part of a quality improvement plan for the IPCT and formed part of our IPC optimisation plan for 2023-2024. Appendix One. The week was very successful, especially in clearing away and recycling junk, review and resting the of the uniform policy and uniform standards, which included an IPC poster campaign, IPC education supported by reps and many more IPC activities across the whole week.

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



Partially compliant: 2.4 There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01. 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. The recommendations are 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. Update winter 2023 - ongoing progress now supported by DHC Trusts estates lead. Mitigations noted below in the water quality report. 2.9 Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer, or staff this must be stored in line with food hygiene regulations. Mitigation: This is policy and checked with auditing, although more robust procedures could be in place.

ESTATES REPORT

WATER QUALITY- T Markin – Mechanical Estates Officer

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 Committee. 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. Toby Markin is now water RP; David Oman will be undertaking the AP role once training has been completed.

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 ALL FOUR (North wing, South Wing, East Wing & South Walks House) 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 noted below: -
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, there is no scheduled date to move this information from spread sheet to MiCad but every effort is being made to keep the momentum of recent progress.

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, at the start of this year we recruited an Estates Mechanical Officer, who will be leading the Operational Water Group in developing the Water Plan, we are making very good progress showing a reduction in water borne infections.
2. CWS tank cleaning is now due again, Estates are liaising with specialist contractors to complete these works.

Regular sample testing has been maintained in high-risk areas as well as an expanded portfolio of general outlets throughout the Trust by Estates dedicated Operatives delivering an improved scope of sampling.

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 800 reactive calls to leaks in the period 01/04/23 – 31/03/2024 of various descriptions, with (approx.) (1% or 5 Emergencies): (27% being Urgent with the potential to cause significant damage), (45: were out of hours), a further (66% or 528) 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.

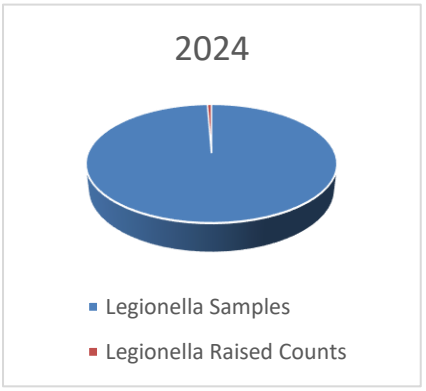
Sampling

The table below shows number of samples taken in the year; Pseudomonas (approx. 18% increase on the previous year) together with a raised count reduction & Legionella (approx. 33% increase on the previous year) together with a significant reduction on raised counts.

Legionella Samples	**2024**	538
Legionella Raised Counts	13	2.40%

Legionella Samples	**2023**	405
Legionella Raised Counts	69	17.00%

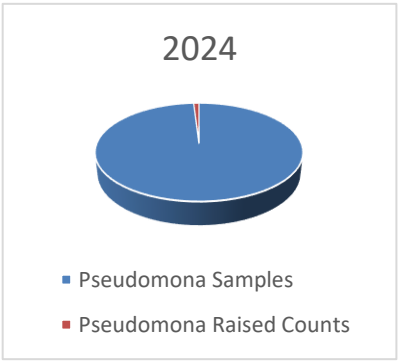
The source of these raised counts was hidden flexi tap connectors in diagnostic imaging these have since been removed. There was also a single count of 1 which would appear to be a dirty bottle.



Pseudomonas Samples	**2024**	511
Pseudomonas Raised Counts	20	3.91%

Pseudomonas Samples	**2023**	433
Pseudomonas Raised Counts	23	5.31%

9 x raised counts I SCCBU water cooler (now Removed).
5 x POW shower (now Isolated until temperatures can be raised to carry out thermal flush.
4 x POW Shower unit that has now been replaced.
2 x Maud Alex not repeated.



VENTILATION – C Carver – Senior Estates Officer

The Estates team continue to carry out routine inspections and maintenance on all ventilation systems and formal validations on all Theatre and Critical Areas in compliance with HTM 03-01 Part B and carrying out remedial work where required. In the past 12 months we have installed 2 of AHUs in South Walks House, and new AHUs in delivery rooms 27 and 25 in Maternity.

Estates are currently approving ventilation drawings for AHUs in Ridgeway Ward, Fortuneswell Ward, The New Hospital Build, The new Theatre in East Wing, and some additional ventilation in Mary Anning.

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.

REPLACEMENT FLOOR COVERINGS (Floor Works) DECORATION AND ENVIRONMENT (painting) – A Kersley - compliance and Assets Officer.

Estates Completed 247 calls to flooring works, 51 jobs were completed by contractors. This included full laying of South Wing Stairs, New flooring to all cubicles on Abbotsbury. Complete new flooring to Redwood House at Charlton Down.

We have worked closely with two local contractors, Future Flooring & Carpets 2000. Both contractors liaise with clients well & always give a very high standard of work.

We seem now to have eliminated most of the carpeted areas in & around the wards & are implementing cap & cove where required to clinical areas, this allows for much better cleaning & less areas to repair moving forward.

Estates have completed 168 painting jobs, the focus this year was on wards, however we have a long way to go & only one painter makes this very difficult.

Endoscopy: had a full redecoration with colour changes to aid the patient experience.

Abbotsbury: was fully completed as well.

Maternity: had a full redecoration, once again adding various colours to aid the patient experience.

Ilchester: had re-dec of corridors.

CAPITAL WORKS – R Swatton - Estates Capital projects Manager.

Projects 2023/24	Description of works
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 Decant Arrangement	Multi-phased works in preparation for Chemotherapy decant (Chemo refurb to start 2024/25)
Respiratory Medicine Labs	Full refurbishment of department
Radiology - Angiography Suite	Full refurbishment and equipment replacement.
Kingfisher De-escalation	Mental Health Welfare room. Creating Anti-ligature light suite and bathroom
Roof Works - Priority Areas	Roofing replacement works being undertaken across priority areas of the Trust. Highlighted as main risks to the areas of Clinical departments underneath.
Offsite Therapies Centre - Roof Replacement	Lifecycle replacement of Off-site therapies centre roof and guttering.
Aseptic Works	Remove sink, extend benching, and add IPS outside of suite.

Modular Discharge Lounge	New modular building funding from NHS England to be used for Discharge Lounge combined with Discharge Lounge +. Works completed but still in the defect period until July 2024.
Modular Discharge Lounge	Further carpentry works not included in scope of scheme
Fire Compartmentation	Survey of fire compartmentation; review of existing, changing if required and including if not existing already
Mortuary	Install new body store, replace all existing rollers and making good of area
Nurse Call Replacement	Stroke - full replacement completed 2023/24 POW - install 2024/25 Maternity (Including SCBU) - install 2024/25 Moreton - install 2024/25 Radiology - install 2024/25
Ridgeway Orthopaedic 24 ring fenced beds	Alteration to ward layout to support ringfencing if bed spaces for Orthopaedic recovery. Works on-going and will finish August 2024.
Asbestos Management Policy	In progress with Ion.
Kingfisher Balcony	Replacement floor, new storage areas and column padding - to become a usable patient area
PoW Side room Alterations	Further alterations to PoW Side rooms
Paediatric DSU bathtub	Removal of bathtub in E2-1035 to increase available space
Maternity Ventilation upgrade to 2x delivery Suites	Works to two delivery rooms to ensure Nitrous Oxide exposure is maintained at below 100 ppm and ensure compliance
Old Discharge Lounge	Enabling it to become a temporary Surgical Admissions Lounge.
Women's Health Recovery Room	Take down wall between existing recovery room and kitchenette and refurb. Displace kitchenette.
Damers Restaurant	Non-clinical but remained open to staff and patients throughout refurb
Abbotsbury Sister's Office Refurb	Redecoration and new flooring
Kingfisher Accessible Bathroom	Full refurb including layout change and removal of bath to allow for wet room area with adjustable shower table
MH Funding for improvements to Mary Anning	Installation of handrails and "stopping" point and wrapping of the doors

<u>DECONTAMINATION SERVICES REPORT</u> - **Joe Lythe – Service Manager: Theatres, Anaesthetics, CRCU and Decontamination, Fiona Sallows – Assistant Service Manager.**

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 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

authority.

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 November 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 two Outpatient Department at the moment due to South Walks House treatment suite coming online in May 2024.
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 November 2023

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and 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.

HOTEL SERVICES REPORT- CLEANING SERVICES - Sarah Jenkins - Hotel services manager.

Throughout the past year the Housekeeping Team have continued to work hard to maintain the cleanliness of the hospital, coping, as all services, with continued exceptional pressures we have experienced through the past months with the number of patients we have had within the hospital. There have also been new areas to clean, most particularly the opening and continuing expansion of the services at the Outpatient's Assessment Centre at South Walks House.

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 remains the responsibility of, and has been supported by, all teams help 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. The housekeeping schedules have been subject to extensive review in the last months and further changes to the service are being considered alongside the extension of the Ward Housekeeper pilot, to further enhance cleanliness and the patient experience.

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 national standards, in consultation with our IPC colleagues. The frequency can be changed, for example in a period of increased incidence of infection or when there are other concerns as to the standard in any area. 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 acceptable timescales.

Deep Cleaning

The continued pressures on the hospital have meant that the annual deep clean programme has once again been delayed. Whilst we would like to be able to carry out a full deep clean programme, the pressures on the hospital and the lack of space in which to decant patients from wards/ bays means that this is challenging. Along with our IPC colleagues we have identified a priority list which will indicate to us both when a deep clean of a ward / department may be needed and then a plan will be enacted with collaboration with the area concerned and other interested parties. The triggers are:

1. Concerns highlighted at an efficacy audit conducted by a team consisting of a minimum of a representative from estates, one from housekeeping and one from the IPC team.
2. Repeat low environmental audit scores.
3. Post infection outbreak.
4. Post Period of increase incidence.
5. Following refurbishment or extensive estates works, for example when the call bells are being replaced.
6. Concerns escalated by matron.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. As our three machines can be vital in maintaining flow on site, two machines were hired to carry out the necessary deep cleans to ensure the safety of patients in the opening of the Outpatients Assessment Centre, particularly important to ensure the cleanliness of the new procedure suite. Training has been rolled out to several staff across all shifts so that we are able to carry out deep cleans at all times, and further training is planned so there should always be someone on site to carry out these cleans. 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.

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, by the cleaning, estates, and nursing teams, of failures is also dictated by this categorisation and by the potential IPC risk.

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. It is hoped that in the coming weeks the audit software can be used to document action plans and so we will be able to report on the improvement plans as well as the progress of special projects such as the descaling of the toilets.

The housekeeping supervisors have, been using the new auditing software with increasing confidence. On the completion of the audit, the results are emailed to the department leads, the estates team and the Hotel Services management team, leading to greater awareness and more transparency than previously. Soon it is hoped that the rectifications needed by the cleaning team will be immediately sent to either the member of the cleaning team working on the ward or a rapid response team who will help remedy the failings in the department.

Efficacy Audits

At the end of 2023, the Infection Prevention and Control team have refreshed the process for trust wide efficacy audits to be in line with the National Standards for Healthcare Cleanliness. The efficacy audit is a management tool to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards. These audits inform the healthcare organisation that correct training, IPC, health and safety, and safe systems of work are being used. We also identify any estates jobs that are required during the audit and monitor standards such as the general appearance of staff and hand hygiene. These audits also focus on the process of cleaning rather than its outcome to ensure that standards are maintained in the process and not just the outcome.

Once a week the IPCT, plus a representative from housekeeping and estates, undertake the efficacy audit of all wards and departments across the Trust. All clinical areas have been risk stratified to provide assurance of our process for the schedule of our efficacy audits, but each clinical area is reviewed at least yearly or more frequently if concerns are raised through the processes mentioned within the deep clean plan above.

The results are fed back to the ward lead and matron to acknowledge good practice and address poor service and actions required to drive continuous improvement.

PLACE

We once again carried out a Patient Led Assessment of the Care Environment, (PLACE) in the autumn of 2023.

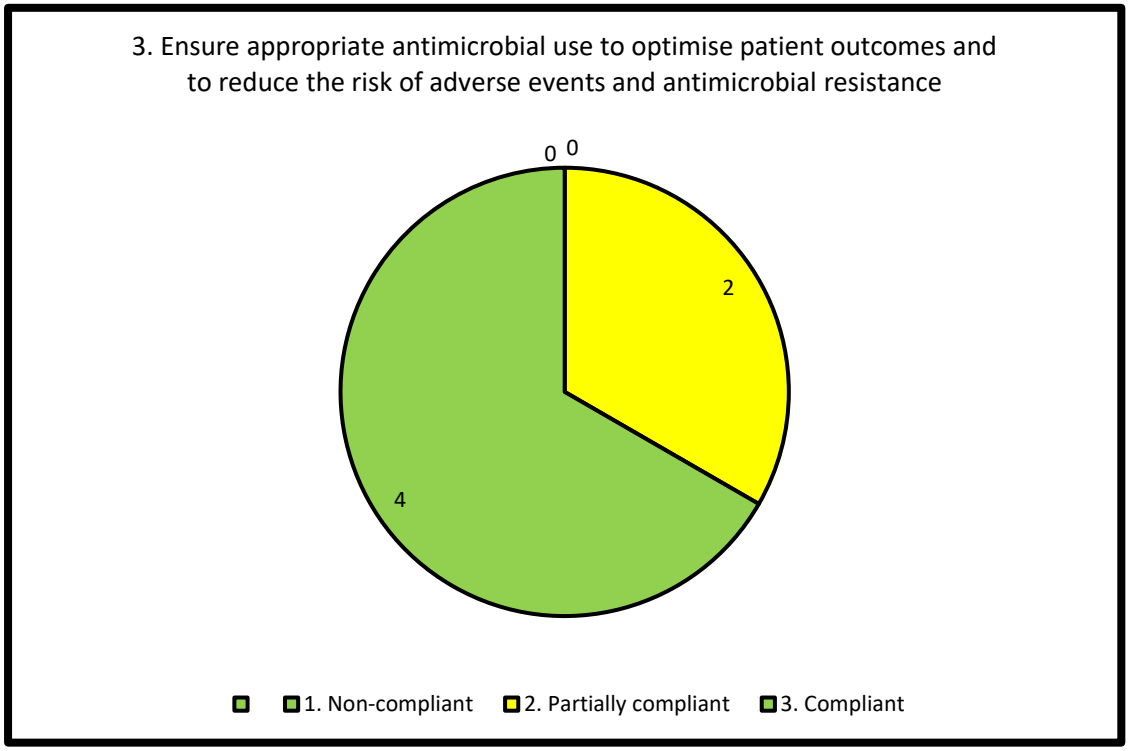
PLACE assessments are an annual appraisal of the non-clinical aspects of NHS and independent/private healthcare settings, undertaken by teams made up of staff and

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.

It should be noted 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. Both in the areas of condition and cleanliness we saw an improvement on already pleasing scores from the previous year.

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.



Partially compliant: 3.5 Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: total antimicrobial prescribing. broad-spectrum prescribing. intravenous route prescribing. treatment course length. Mitigation: IV route prescribing monitoring is part of the AMS work plan for FY 2023/24. •QI work relating to early IVOS is part of the AMS work plan for FY23/24. 3.6 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) Mitigation: Funding secured for a 0.5 WTE AMS technician role to support the AMS pharmacist, focusing on developing a digital work plan to bolster AMS efforts locally.

Antimicrobials: Summary report for financial year 2023/24.

Rhian Pearce (Antimicrobial pharmacist) – left the trust January 2024, Cathy Jeppesen (Consultant microbiologist) and Ben Squibb (Pharmacy Technician Higher Level).

Overview

Antimicrobial resistance (AMR) is an emergent crisis threatening health outcomes across all healthcare settings.
The hospital's Antimicrobial Stewardship (AMS) Programme 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. The UK has recently published the latest five-year AMR National Action plan (NAP) 2024 – 2029 “Confronting Antimicrobial Resistance”, which aims to take the UK closer to reaching its vision of containing and controlling AMR by 2040. This plan, like the previous plan, will focus on three key ways of tackling AMR: reducing the need for and

unintentional exposure to antimicrobials, optimising the use of antimicrobials, and investing in innovation, supply, and access.

This has been a challenging year for antimicrobial stewardship in DCH as our Antimicrobial Pharmacist Rhian Pearce left the trust in January 2024. Pharmacy has yet to recruit a replacement and is exploring a shared post with UHD. In the meantime, a 0.5 WTE pharmacy technician BS has been seconded to AMS since September 2023 and has been extremely valuable in maintaining many aspects of AMS work, including data collection and analysis, while microbiology consultant CJ has taken over the role of lead microbiologist for AMS and is also trying to mitigate the loss of AMS pharmacist. Lack of an AMS pharmacist has been placed on the trust risk register.

Nonetheless, there have been notable achievements by the AMS team in the year 2023/24:

- **Establishment of a new AMS Group to direct, support and re-invigorate local AMS activity.** This replaces the AMS committee, which was becoming difficult to convene, and is being chaired by Dr Cecilia Priestly. The first meeting took place in December 2023 and the group is meeting monthly to begin with, in order to maximise progress.

- **Participation in the National point Prevalence Survey of Antimicrobial Use and Healthcare associated infection.** This significant piece of work took place in October 2023 and involved surveying all patients on all wards during the data collection period and submitting the results on the UKHSA web portal. The full report and benchmarking data are due to be published in May. Overall, 31% of inpatients were on antimicrobials at the time of the survey and 88% of prescriptions were judged optimal or adequate.

- **Achievement of the IV to oral switch national CQUIN (see below)**

- **Migration of DCH antibiotic guidelines onto the Microguide app and review of guidelines – in progress.** The Microguide app is used by the majority of NHS trusts to host antibiotic guidelines. It enables ready access on laptops and mobile devices for clinicians and is easy to update with a full audit trail. It has been an aim of the DCH AMS team for a number of years to migrate our antibiotic guidelines from SharePoint onto the App, and we are eventually making good progress in this task. We are taking the opportunity to review existing guidelines, and address gaps for infections where we have no trust guidelines. Where possible we are adopting or adapting UHD guidelines to fill these gaps, with the UHD AMS team's agreement. In time we hope to harmonise guidelines across UHD and DCH, but this aim is limited by shortage of AMS pharmacists and microbiology resource on both sites at the present time.

- **Quinolone prescribing**. In response to the strengthened MHRA safety warning about the possibility of rare but disabling side effects from quinolones, we have updated the DCH patient information leaflet, produced a quinolone prescribing guideline, and reviewed current prescribing with a snapshot audit (trust audit 6064). This was relatively reassuring in that 88% of prescriptions were deemed appropriate, but did identify areas where prescribing could be improved, including accuracy of penicillin allergy status.

- **Staff Education.** The microbiology consultants have delivered AMS teaching sessions to new starting F1s in September 2023, and to junior doctors (medical directorate teaching) in March 2024. A further session for all F1s will happen in May 2024, and AMS will be included in the new TEIR 3 IPC/ AMS training for band 6 nurses, to commence in late 2024.

- **Ward audits.** Proactive ward audits have been paused since the departure of the AMS pharmacist, but the microbiologists continue to review prescribing for all HOHA and COHA cases of C difficile and perform individual ward audits during C difficile PIIs (periods of increased incidence). There have been no alarming themes about antibiotic prescribing from these audits.

- **Co-amoxiclav prescribing in ED**. Before her departure, RP was working with ED clinicians to look at apparent significant increases in co-amoxiclav consumption in the ED department. This work resulted in good engagement but has unfortunately not progressed since January.

DCH Performance against national AMS targets

1. **<u>AMS CQUIN schemes 2023/24</u>**

There are significant benefits to IVOS interventions demonstrated in research literature including: increasing hospital bed capacity; reducing exposure to broad spectrum antibiotics; increasing nursing workforce capacity; reducing drug expenditure; reducing carbon footprint of medicines; and reducing healthcare-associated bloodstream infections.

This CQUIN aligns with a commitment in NHS England's 2022-23 Priorities and Operational Planning Guidance to support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary.

Locally agreed performance metrics and data submission:
DCH adopted the IVOS CQUIN scheme for 2023/24, which mandated a data collection requirement of 100 cases per quarter, regardless of trust size. Given the AMS team's resource constraints, we were unable to collect data for Q1 and Q2. Data was collected and submitted for Q3 and Q4.

100 non-ICU adult patients who had been on IV antibiotics for >48h were reviewed by the AMS team to determine whether they were already eligible for oral switch, based on an IV to oral switch tool. If there was an active need for ongoing IV administration, they were defined as compliant.

Performance against the CQUIN target and QI interventions

We achieved 80.39% compliance (19.61% non-compliance) in Q3, well below the non-compliance threshold of 40%. This was maintained in Q4, achieving 80.2% compliance overall (19.2% non-compliance), which meant we met the full payment for our combined performance for the year. A breakdown of compliance against CQUIN indicators is provided below (Fig. 1)

Fig 1. DCH data vs national target

Quarter (23/24)	Percentage	Target
Q1	No Data	<40%
Q2	No Data	
Q3	19.61%	
Q4	19.8%	

During Q3 a poster campaign was started where two posters designed by the AMS Pharmacist and reviewed by the medicines committee titled “The oral solution” and “IV league” were provided to all wards in the trust. These posters aimed to provide the nurses with the information and confidence to highlight to prescribers when they felt the patient would be clinically appropriate to switch from IV to oral and to provide prescribers with some understanding of the burden of IV preparation and administration, how a switch even for the last dose would make things significantly easier, provide more time for the nurses and help prepare a patient to be discharged (as patients are rarely discharged whilst having IV medications).

We are awaiting the end-of-year report to benchmark our performance to the national mean, but benchmarking data produced by UKHSA (Fingertips website) indicates that for non-teaching hospitals, the average non-compliance rate is 21.1%, so we performed slightly better than average in this audit. However, the proportion of DCH total antibiotic consumption which is IV was 31% (in September 2023) compared to a national figure of 25% for all non-acute trusts in England, which suggests there are improvements to be made.

This CQUIN will not be mandatory in 2024/25.

2. NHS standard contract for the financial year 2022/23: Reduction in WARE antibiotic consumption

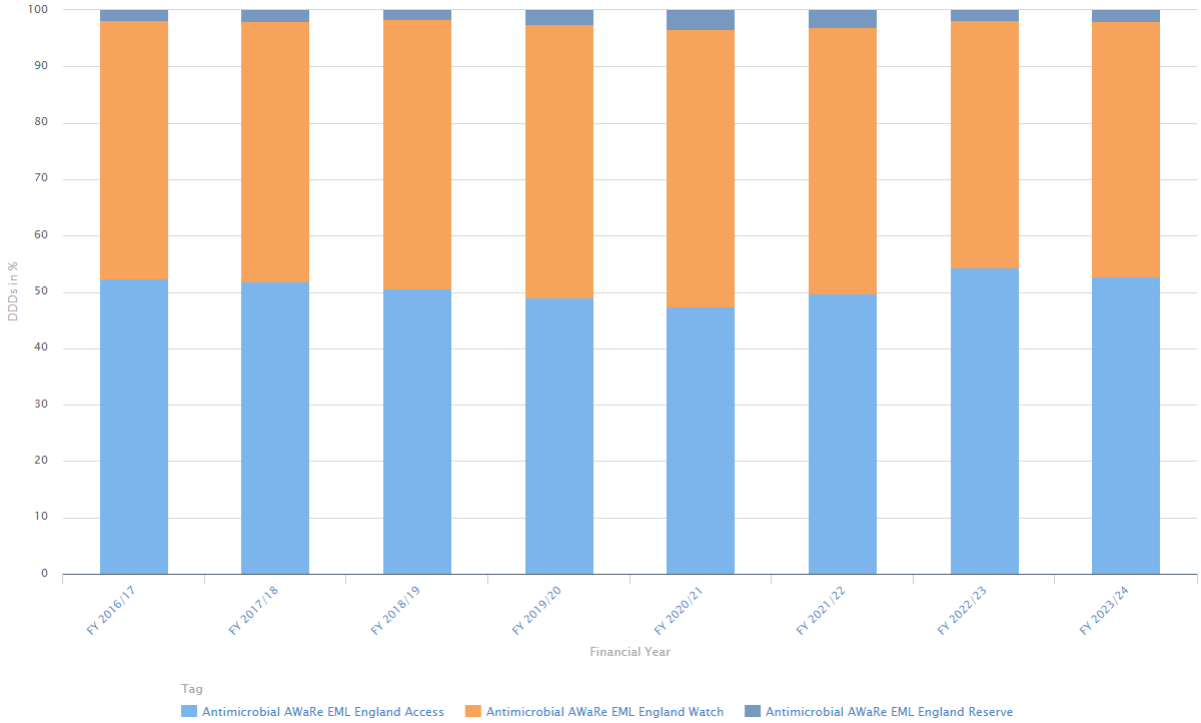
Since 2019, the NHS Standard Contract has required acute providers to make year on year reductions in their per-patient usage of antibiotics from the “Watch and Reserve” categories, in line with the ambition of the UK 5yr AMS action plan for 2019 – 2024. In the contract for the financial year (2023/24), NHS trusts were required to reduce 'watch-reserve* (WARE)' antibiotics by a cumulative 10% compared to their 2017 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 has not achieved this target, as our use of WARE antibiotics has grown during this period by 18.7%. As a proportion of our total antibiotic consumption (fig 2), use of WARE antibiotics has remained stable, suggesting that it is our overall antibiotic consumption that has increased. The proportion of our total antibiotic prescribing that

is from the ‘Access’ group is 52%, according to UKHSA Fingertips data, similar to the national average of 51% for non-teaching acute trusts.

Fig 2. Watch (orange), reserve (dark blue) and access (pale blue) antibiotics as a proportion of total antibiotics at DCH. Trend from 2016/17 to 23/24



Reassuringly, the graph in Fig 3 shows that the jump in WARE prescribing at DCH, has stabilised since 2021. Figure 4, taken from a National Analysis of Standard Contract performance data, provided by the SW regional lead for AMS, shows that many trusts in Southwest did not meet the contract target (red lines) and shows that our total antibiotic prescribing is relatively low for our area. Of note, SW is one of the areas with the lowest WARE prescribing in England.

This data offers some reassurance about antibiotic use at DCH, but there is certainly a suggestion that there is scope to reduce use of WARE antibiotics as some of our peers have done. Whether this is best achieved through amending our empiric policies, encouraging earlier switch to ‘Access’ category antibiotics, or encouraging use of shorter durations of antibiotic overall, is something for the AMS group to work on. Our approach will also depend on what resources we have available, and whether an awaited electronic prescribing (JAC) update - which includes tools to better support antimicrobial stewardship - is introduced. Of note, there are no corresponding outcome data comparisons - it would be reassuring to know that trusts with highest use of access antibiotics saw no detrimental effects on clinical outcomes.

A new National 5-year plan has just been published in May 2024 and the contents may affect which, if any, targets are chosen for the coming year.

Fig 3. DCH trend in watch and reserve antibiotic consumption by FY (2016/17 – 2023/24). Locally produced data.

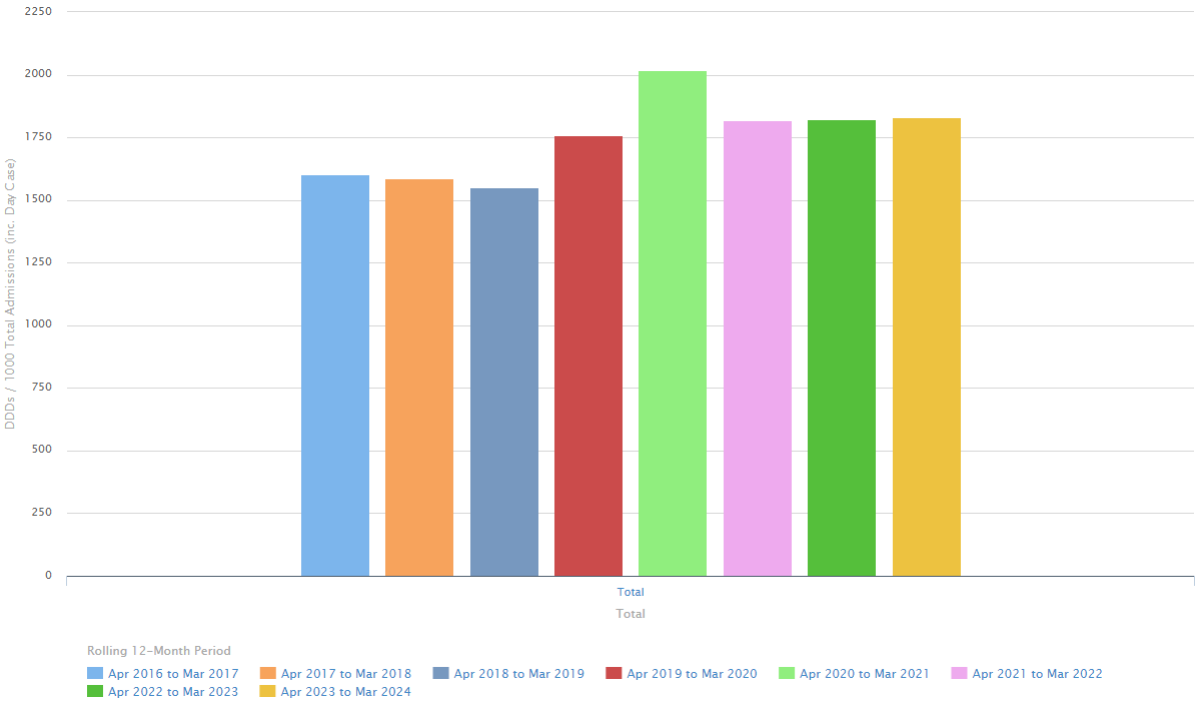
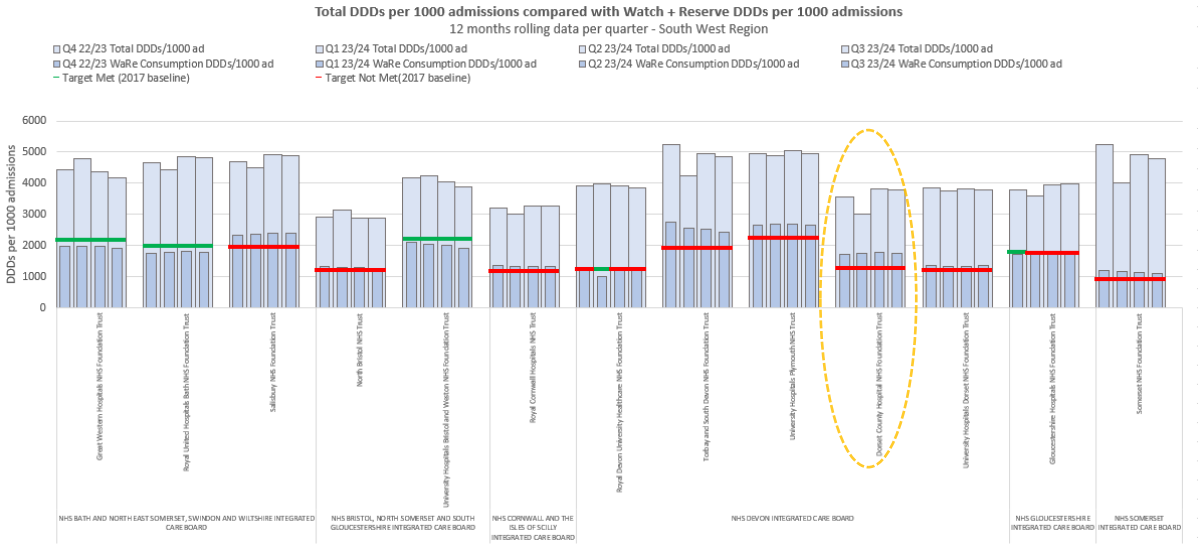


Fig 4. Total DDDs per 1000 admissions (pale blue) compared with watch + reserve DDDs (darker blue) per 1000 admissions. Bars show data from Q1-4 23/24. Lines show the 10% reduction target, if met it is in green. DCH data is circled.



Antimicrobial resistance surveillance and benchmarking

1. Resistant rates for Enterobacteriaceae in blood cultures

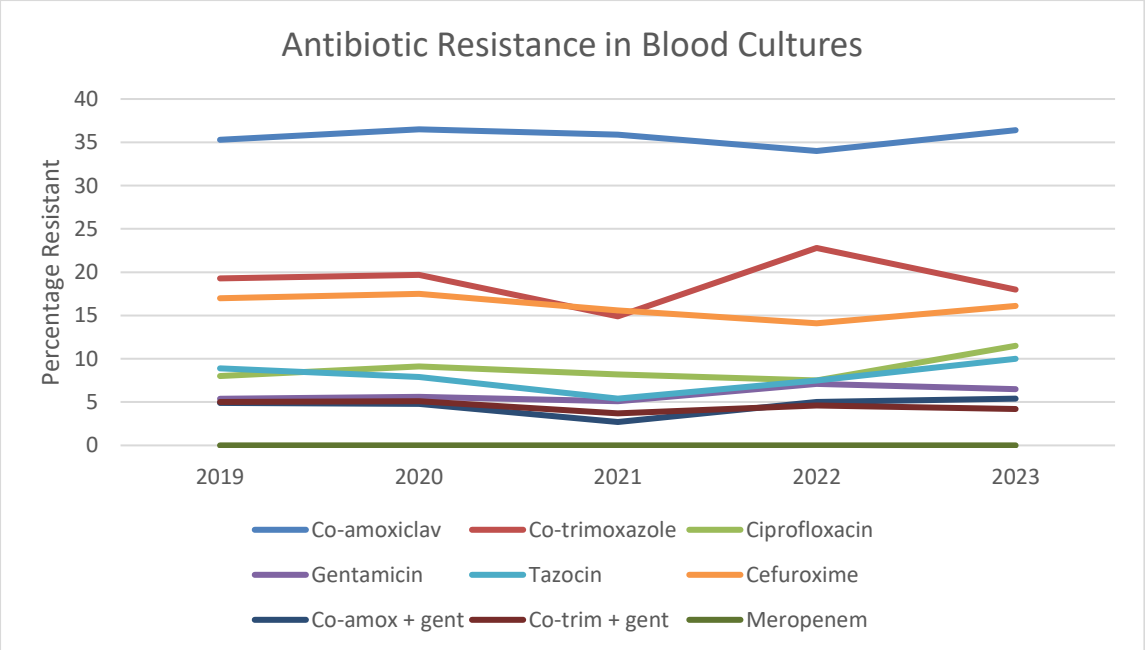
Source: local laboratory antimicrobial susceptibility results.

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. There are no definite trends observed in resistance to our workhorse antibiotics.

Table 1

	2019	2020	2021	2022	2023
Co-amoxiclav	35.3	36.5	35.9	34	36.4
Co-trimoxazole	19.3	19.7	14.9	22.8	18
Ciprofloxacin	8	9.1	8.2	7.5	11.5
Gentamicin	5.4	5.6	5.1	7.1	6.5
Tazocin	8.9	7.9	5.4	7.5	10
Cefuroxime	17	17.5	15.6	14.1	16.1
Co-amox + gent	4.9	4.8	2.7	5	5.4
Co-trim + gent	5	5.1	3.7	4.6	4.2
Meropenem	0	0	0	0	0

Figure 1



2. Benchmarking for antimicrobial resistance in E coli isolated from Blood Cultures

Source: UKHSA Fingertips.

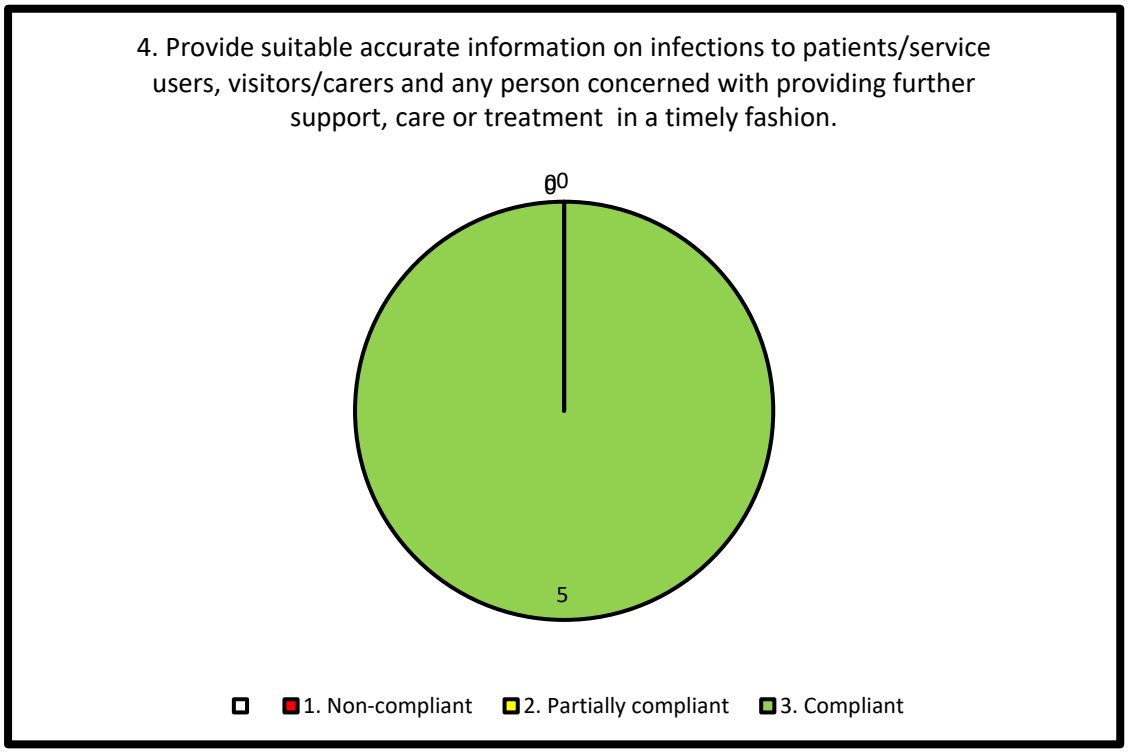
Table 3 shows quarterly average percentage of antibiotic-resistant E coli in Blood Cultures, for DCH compared with other local hospitals and England. This is data for 2023 Quarter 3.

Table 3

	England	DCH	UHD	UHS	Salisbury	RD&E
Tazocin	11.7	7.0	7.0	No data	16.0	6.0
Gentamicin	11.7	7.0	12.0	19.0	5.0	11.0
Ciprofloxacin	20.5	14.0	16.0	21.0	18.0	9.0
3rd-gen cephalosporins	16.6	13.0	13.0	21.0	11.0	7.0

Yeovil was included in this table last year but has not submitted data to Fingertips during 2023.

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 CDI 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 together we update staff via email and staff bulletins all when new guidance that is implemented. We also have a dedicated IPC section on the trust intranet site, which is updated regularly, especially when any guidance changes are implemented. We also review the IPC information leaflets regularly and update and update the hospital IPC internet pages.

The IPC team monitor all CDI and Potential CDI 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. This year we have also developed new trust isolation poster for placement outside cubicles containing updated clear information. We audit the correct

use of the posters across the trust and our audit results for 2023-2024 demonstrated 83% compliance with the use of correct cubicle signage.

The IPCT work closely with the IPC ICS to identify the needs of the local population and develop strategies, collaboratively to ensure joined up working. We also have monthly post infection review meeting to share learning, raise concerns and discuss our systemwide priorities.

INFECTION PREVENTION AND CONTROL SURVEILLANCE SYSTEM (ICNET)

Over the last few years, we have worked jointly as an ICS IPC team on the procurement and implementation of a county wide utilisation of ICNet, an infection prevention and control surveillance system supplied by Baxter Healthcare Ltd.

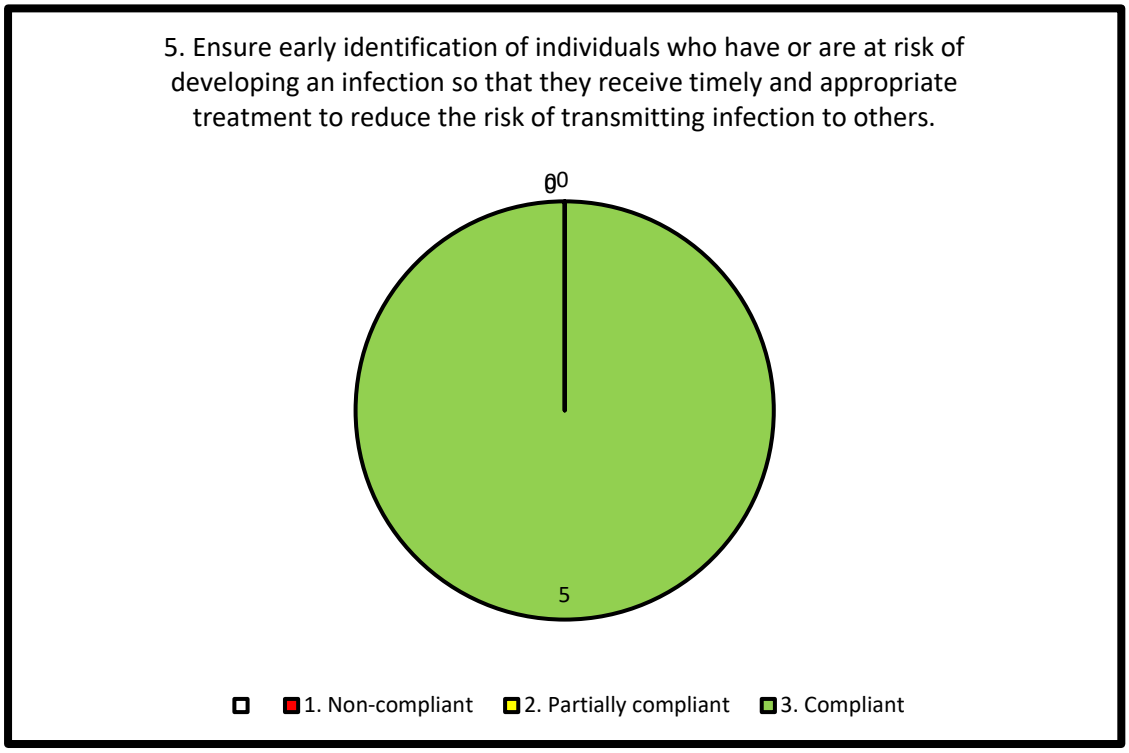
The IPC implementation Programme is divided into three phases:

- Phase 1 – DCHFT migration to hosting by DHC – completed July 2020.
- Phase 2 – UHD (both sites) implementation – completed 2021.
- Phase 3 – DHC implementation – Completed September 2022.

During 2023-2024 the system has been running smoothly across all the Dorset system trusts, and we continue to work collaboratively together to ensure as a Dorset system we are using the ICNET effectively and advantageously.

Within Dorset County hospital the Clinical Site Managers and the housekeeping team have access to ICNET, and they use it to support isolation of patients promptly and effectively and also ensure the correct cleaning is achieved. The IPCT continuously update the isolation list within the system to support prompt isolation and continuously risk assess as necessary, ensuring patient safety is paramount and effectively achieved with regards to cleaning and isolation.

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.

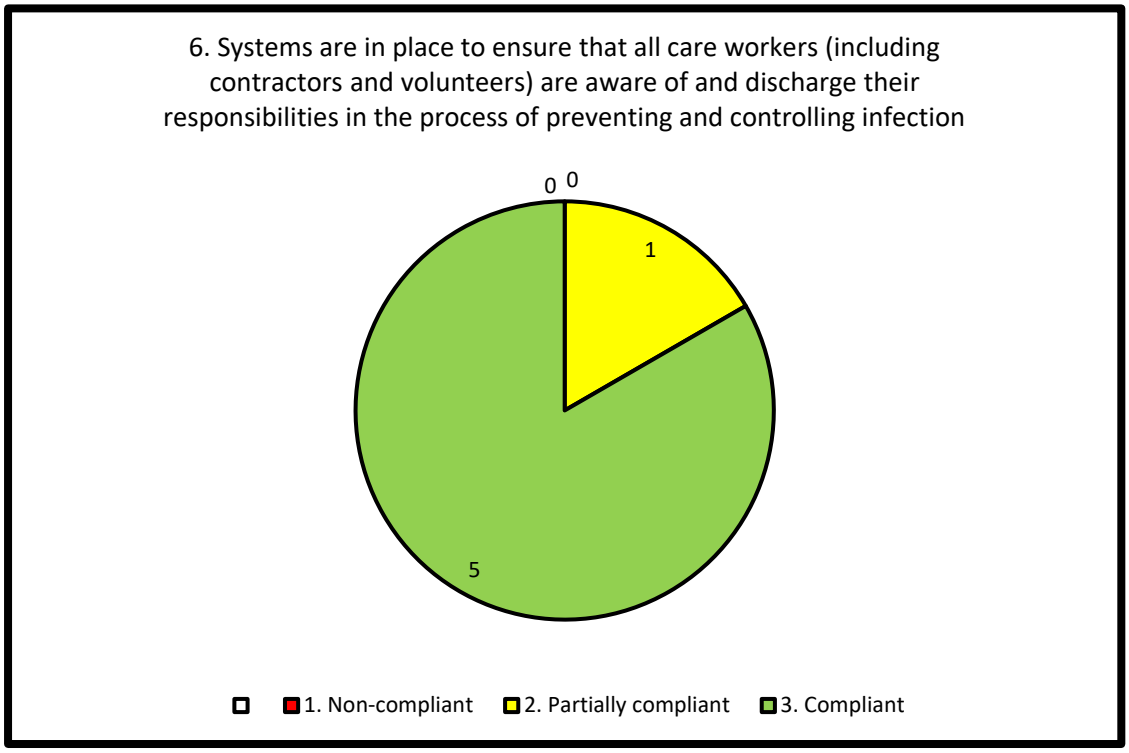
As a team we link closely with GP's, ensuring they are promptly informed via letter or verbal contact via the consultant microbiologists of any new organisms, such as C Diff, Potential C Diff infection, MSSA and MRSA BSI's and Gram-Negative organisms.

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 2023/2024 3 Periods of increase incidents of C Diff, 4 Norovirus outbreaks and 0 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. The IPC team always produce a report, which is noted and discussed at IPCC and the IPC lead specialist nurse always conducts a de-brief following a PII or outbreak. Recurring themes from these investigations are disseminated through the IPC Committee meetings. Action plans that are put in place by the ward manager and/or matron are supported and 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.



Partially compliant: 6.2 The workforce is competent in IPC commensurate with roles and responsibilities. Mitigation: Tier three of the IPC education framework, covered by mandatory training. The IPC team plan to implement separate face to face training to cover this tier.

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
- Clinical Practice Educators

Mandatory IPC Training for clinical and non-clinical staff has been also offered via an online e-learning workbook. Overall compliance with mandatory IPC training over the year has remained very high for clinical staff. Compliance is part of the yearly appraisal review process for all members of staff. The Divisions are responsible to release staff to access their training. The E-learning IPC Mandatory training programme was updated last year and includes all the relevant IPC Core Skills Training Framework.

The IPCT continue to provide extra training to specific groups of staff as and when necessary, this has included Allied Health Professionals, Porters, housekeeping staff etc. The team have also supported yearly training in areas that maybe required to

care for patients with a suspected or confirmed High Consequence Infectious Disease (HCID). Including the correct PPE donning and doffing procedures to further protect themselves in their working environment. This year the trust has rolled out employing Clinical Practice Educators in most clinical areas, this group of staff support and provide education within the ward area and have a close link with IPC and support ongoing IPC best practice.

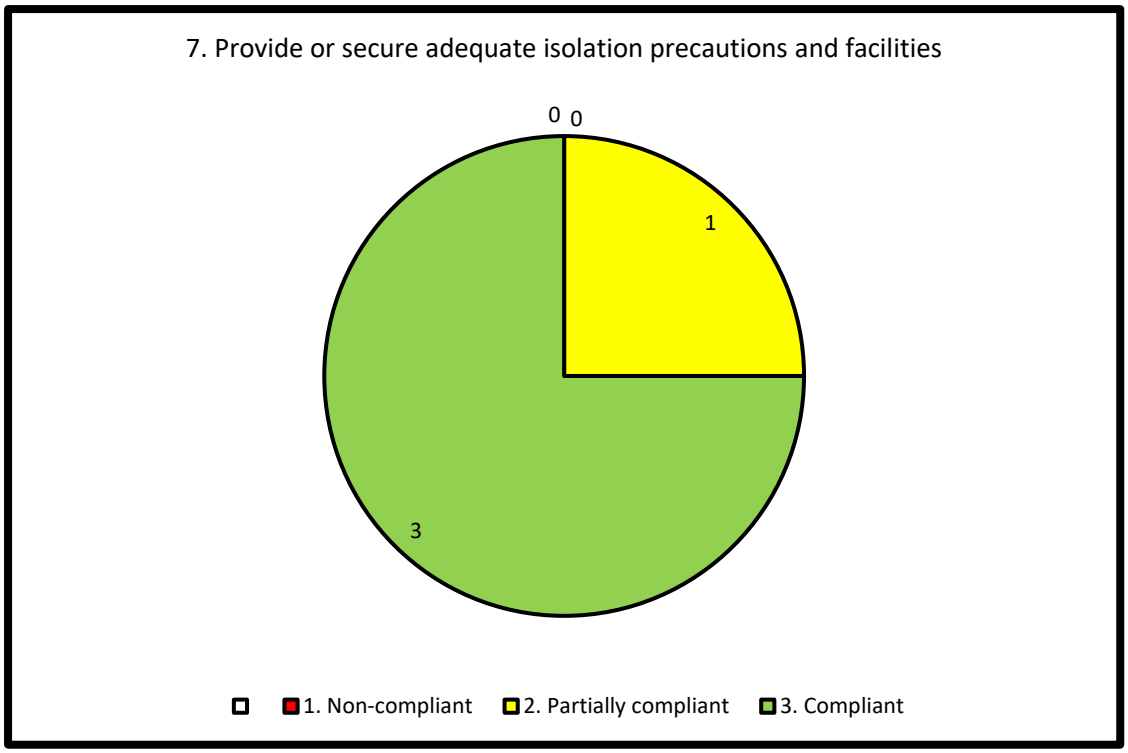
The IPCT are currently working towards ensuring we are achieving the educational recommendations within the National IPC Educational Framework. Which sets out a vision for the design and delivery of IPC education for staff that will support effective and safe care. The framework will support and enhance the skills and expertise in our existing workforce and deliver a positive impact for all learners, our people, educators, patients in our care and our populations. The learning outcomes are a minimum expectation and do not preclude additional outcomes being developed. There are three tiers, which are incremental, building from tier 1 to tier 3. We are currently fully achieving mandatory training for tier 1 and tier 2, and we are working on a new educational programme to achieve tier 3 suitable for staff who are responsible for an area of care. We plan this tier will involve yearly face to face training and include a large (Antimicrobial stewardship) AMS element.

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

FACE MASK FIT TESTING

Fit testing has declined in numbers over the past two years. After many clinics being added and offered to staff, the uptake has been minimal. 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. The fit mask testing co-ordinator has escalated this via the IPC committee meeting and has been supported by divisional leads. A new agreed plan with the trust fit mask testing co-ordinator has been agreed, an action card developed, with the plan that each area has fit mask testers to cascade training within departments. These fit mask testers are provided with face-to-face half day training sessions and can either use the porta count machine or manual assessment method. The fit mask testing co-ordinator continues to improve fit mask testing compliance across the trust, particularly focusing in areas with higher risk as we move into 2023-2024.

CRITERION SEVEN: Provide or secure isolation facilities.



Partially compliant: 7.2 Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: single rooms are in short supply and if there are two or more patients with the same confirmed infection, there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk. The IPCT carry out daily risk assessment for all the trust's isolation cubicles. Comments and mitigation for a request to increase the cubicle numbers on the renal ward, in May 2023 IPC lead has escalated the lack of cubicles on the renal unit, added to the trust risk register. Plan to link with estates to improve the cubicle use of the renal ward. Capital planning and space utilization meeting 30/06/2023 have a plan to improve cubicle use on the renal ward - Actions and works to be completed by January 2024.

ISOLATION

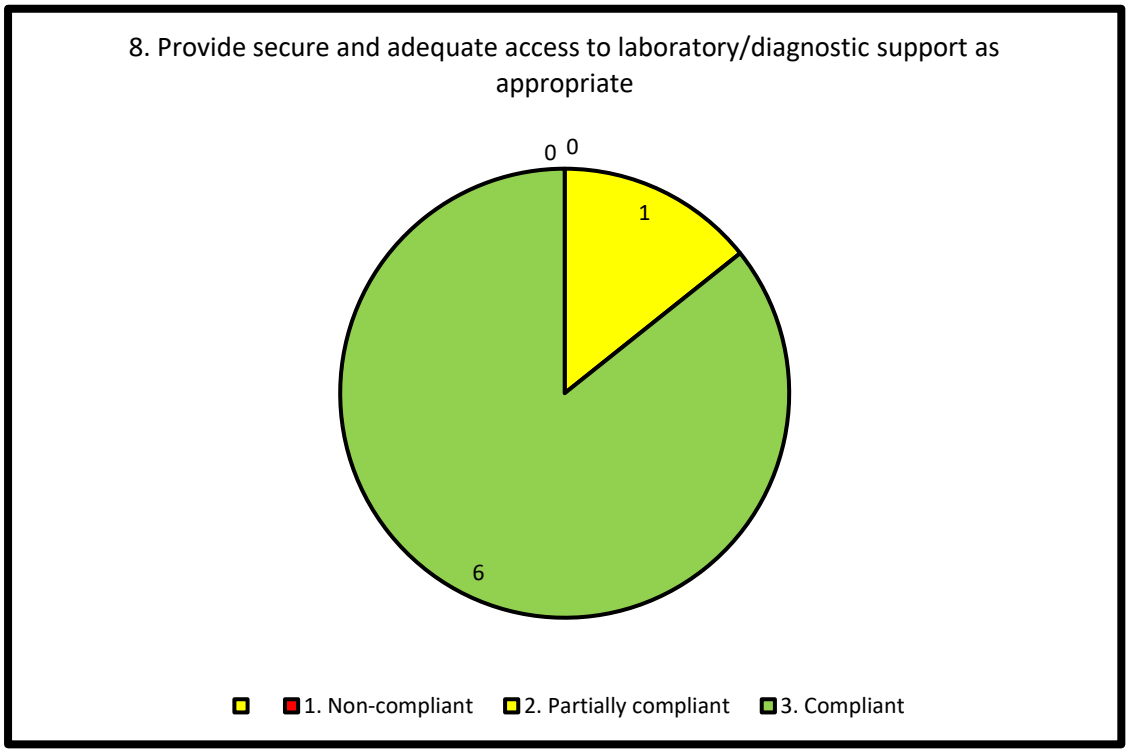
DCHFT has 18% (54) isolation cubicles against the standard bed base. There is no recent statistics to compare this figure to the national average within acute trusts. This percentage can impact the ability to isolate patients according to the national guidance, the National Infection Prevention and Control Manual for England 2024. Using the concept of cohort nursing patients during high prevalence of certain infections such as Flu A, Covid-19, or RSV, which the IPCT continue to suggest, support, and provide guidance on, when necessary. Isolation capacity is consistently well managed and the requirement to isolate patients as required is largely achieved and if not, in-depth risk assessments are carried out to support best practice depending on the organism.

The IPCT carryout daily ward rounds to review the use of side rooms, providing an ongoing updated isolation list on ICNET, which housekeeping and clinical site managers can access. The IPC Team risk assesses as necessary, supporting 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 January 2024 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 83% had correct signage, 17% incorrect signage and a total of 100% overall side rooms where in use across the trust. This data demonstrates a much-improved percentage compared to last year's audit. At the time of the audit being carried out, staff were educated on the importance of using correct signage to protect not only the patients but also themselves, visitors and thus reducing the transmission of infection. This year we have developed and implemented new trust isolation posters. The trust has been working on a strategic plan to improve our isolation capacity within the Renal unit, which is a Renal tertiary centre for renal services, with a plan to open two more cubicles in the near future.

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



Partially compliant: 8.1 Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system. Mitigation: The microbiology lab is currently suspended by UKAS from accreditation to the ISO15189:2012 standard, UKAS inspectors have cleared the Quality Management System findings and are looking to reinspect. An effective QMS is the key to drive the Quality mechanisms and will also be audited against by the DCH pathology quality team as part of their remit.

MICROBIOLOGY LABORATORY UPDATE – G Rees – Head BMS Microbiology

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.

This year DCHFT have employed another 0.85 WTE consultant microbiologist. The microbiology consultants are extremely busy but still find to assist the IPC team and we link closely together.

This year has seen the rise of two vaccine preventable diseases (Measles and Whooping Cough) and the first isolation of Candida auris in DCH.

A significant amount of additional work has been seen in the lab through the public health testing aspects of Measles and Whooping Cough from within the hospital and across the areas of Dorset we serve.

The laboratory was preparing to introduce Candida auris screening by setting up ICE test request codes, evaluating culture media and implementing the testing process when the first isolation occurred. A full screening and monitoring programme was rolled out supporting IPC two weeks sooner than had been originally anticipated. The Candida auris screen is complementary to the CPE screen patients and enhances our ability to detect infections.

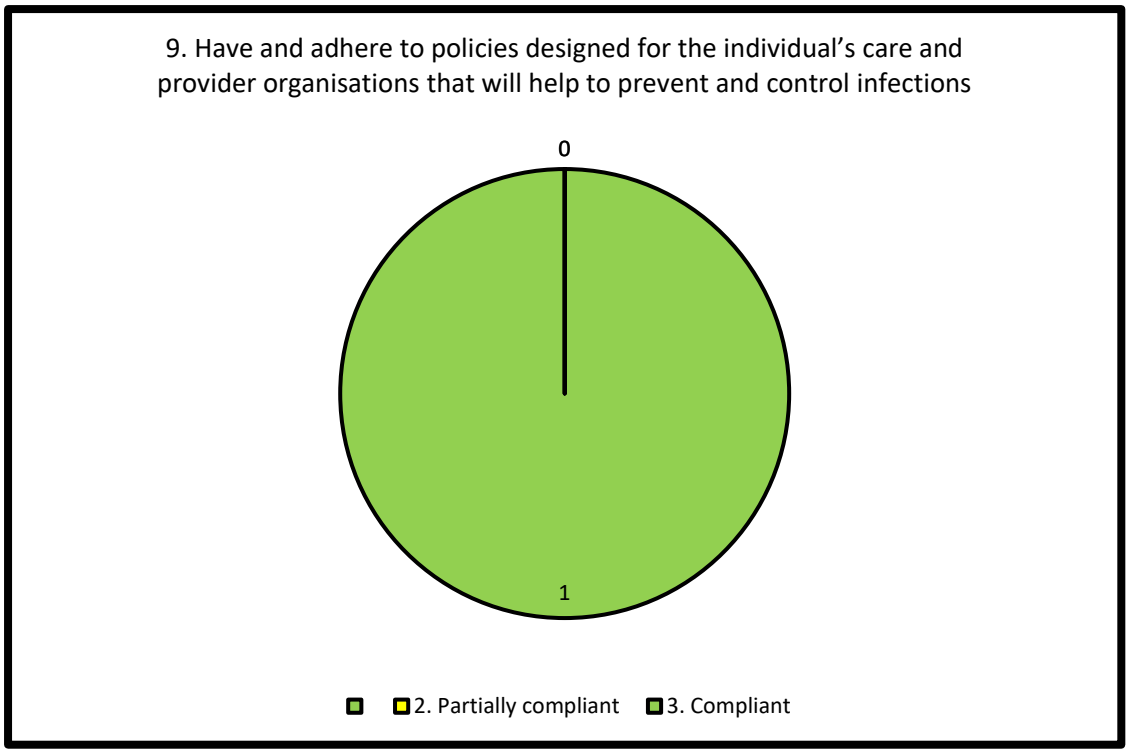
Laboratory Team members have been working for some time with our Blood Culture System vendors and Pathology IT to be able to generate blood bottle volume data to drive optimal bottle fill volumes through feedback and education. The first data set in which we can identify the originating wards against average fill volumes has been encouraging and the picture across the Trust will become clearer as more culture bottle sets are received.

Winter preparation for respiratory virus (COVID/Flu A/Flu B/RSV) testing was successful with GeneXpert PCR platforms available 24/7 in Emergency Department and Kingfisher Childrens Ward, a larger machine operated in the Microbiology Department for surge capacity and greater throughput. Testing peaked at over 500 samples per month aiding patient flow. Guidance on discharge to care homes changed earlier this year requiring fewer tests.

One Dorset Pathology Tier 1 for senior management combining both DCH and RBH Pathology was enacted in early 2024. Tiers 2 and 3 for the remaining laboratory team are anticipated in 2024. Laboratory staffing establishment vs. workload continues to be challenging with the potential to affect patient flow and IPC response at DCH if not addressed.

Following considerable reflection, DCHFT took the difficult decision to voluntarily withdraw the Microbiology Department from UKAS accreditation. We plan to become externally accredited to the latest 2022 standard once sufficient resources are available.

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

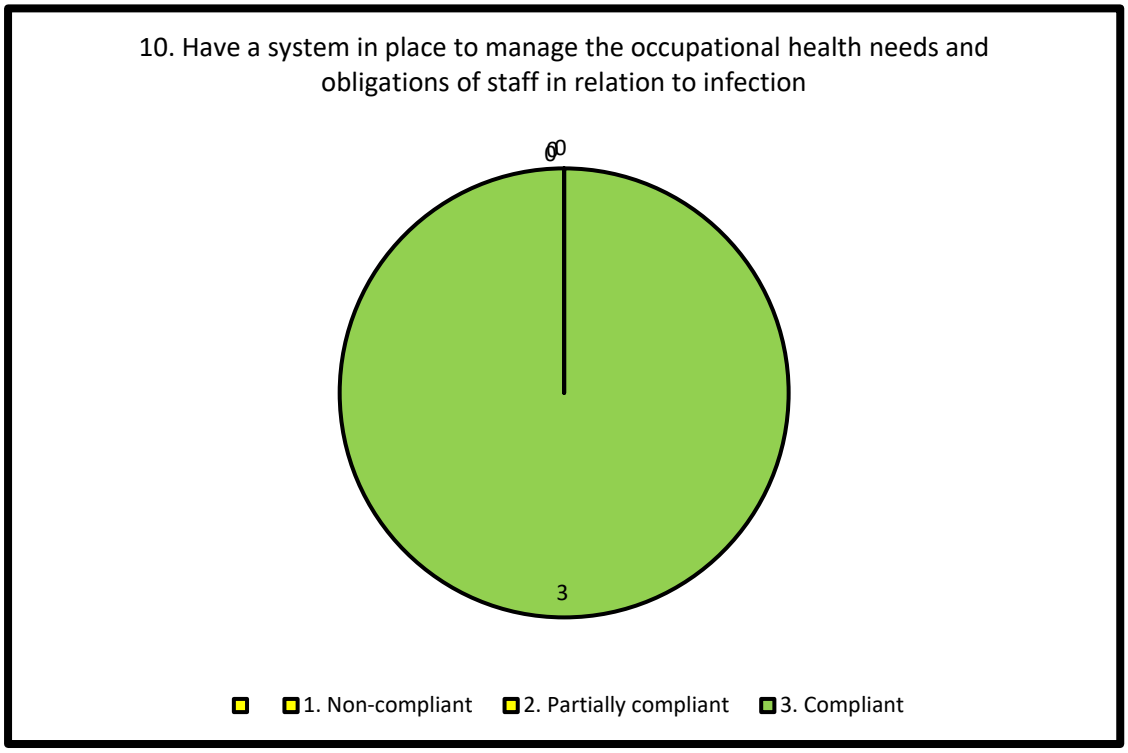
There is a comprehensive list of Infection Prevention and Control policies, procedures, and guidance on the trust intranet. These polices are reviewed by the IPCT and relevant specialities on a three or five yearly review date or when guidance changes, these documents are evidenced based and reflect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

The following policies have been developed / reviewed / removed during the year 2023-2024:

Ice Machines in the Trust - Guidance for the Use and Maintenance of
Transmissible Spongiform Encephalopathies (CJD/vCJD) - Infection Control of
Outbreak of COVID-19 - Policy for the Management of
Urinary Catheter Care Policy
Ebola Operational Guidance for Staff
Candida Auris - Screening Protocol for
Blood Cultures (Adults) - Policy for Taking
Infection Prevention & Control Policy
Avian Influenza - Infection Prevention and Control Advice for Management of Patients with Suspected
Multi-drug resistant gram-negative bacteria including extended spectrum beta-lactamases (ESBLs) - policy for the management of patients with
Clostridioides difficile Diarrhoea Policy
Carbapenemase Producing Enterobacteriaceae (CPE) - Policy for the Assessment and Management of Patients with
Isolation Policy
Norovirus and Infectious Diarrhoea Policy - Management of

Surveillance Guidelines
MRSA Policy
Viral Haemorrhagic Fever - Patients with Suspected - Policy for the Management of
Standard Precautions - Infection Control
Measles
Norovirus Ward Outbreak Pack
Admission for Patients Requiring a Planned/ Elective Procedure Accessing Ridgeway Ward – Low Risk Pathway - Standard Operating Procedure
Suspected Avian Influenza - Infection Prevention and Control Advice for Management of Patients with

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



OCCUPATIONAL HEALTH REPORT – H Hunt Head of Occupational health.

DCHFT Occupational health service was provided by Optima health, but since January 2024 Dorset Healthcare now provide DCHFT with an Occupational health provision.

General Summary of Work relevant to the Infection Prevention and Control during this Quarter:

Dorset HealthCare Occupational Health Services (DHC OHS) commenced providing OHS to Dorset County Hospital (DCH) on the 2nd of January 2024, this report reflects the work carried in the Q4.

Vaccination data

Dorset County Hospital	Jan-24	Feb-24	Mar-24	TOTAL Q4
	No	No	No	No
Hepatitis B Vaccination	8	26	28	62
MMR Vaccination	5	16	16	37
Pertussis Vaccination	2	2	5	9
Varicella Vaccination	0	2	7	9
BCG Vaccination	0	0	1	1

Mantoux Test	0	0	1	1
Hepatitis B Blood Test	50	67	36	153
Hepatitis C Blood Test	19	25	16	60
HIV Blood Test	20	25	14	59
IGRA Test	37	42	16	95
Measles Blood Test	37	44	24	105
Rubella Blood Test	37	44	23	104
Varicella Blood Test	37	43	19	99
DNA / Canx 24 hours: Immunisation Appts	8	27	33	68

Following the Measles outbreak in areas of England, 454 questionnaires were sent to high-risk staff in this quarter 97 have been returned, 1 declined, 25 provided evidence, 61 booked in for blood test and 10 booked for MMR vaccine.

Sharps Data

28 Blood Borne Virus (BBV) incidents were reported to DHC OHS, 14 x Needlestick injuries, 5 contact with sharps, 3 x splash, 1 x bite & 5 x other.

Highest departments
5 – Operating theatres
5 - ED

Monthly BBV figures and details are sent to H&S Manager to review compliance with Datix reporting.

Other

No Occupational Dermatitis to report.

CONCLUSION

Last year has continued to be a challenging year for IPCT, as we continually strive to reduce healthcare associated infections, which has remained a priority for the trust, ensuring our patients, staff and the public are kept safe. The work of the IPC team remains unpredictable and, I would like to thank all the team for their hard work, dedication, and positive attitude throughout the year.

2023-2024 has been a successful year. The total CDI cases have reduced notably this year, trajectories for Gram negative blood stream infections have remained stable and Pseudomonas aeruginosa BSI rates well under the trajectory figure and we have continued to see a very low incidence of MRSA blood stream infections. We have successfully implemented the IPC Patient Safety Incident Response framework, completed the IPC Board Assurance Framework, and linked our compliance with the

yearly IPC optimisation plan. We have reviewed and developed many IPC related polices and improved our Candida Auris screening processes. All our ongoing IPC audits have showed an improve percentage this year.

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 IPC optimisation plan for 2023-2024 reflects a continuation of support and promotion of IPC. Looking forward to 2024-2025 we will strive to maintain high standards within IPC and continue to develop strong Antimicrobial Stewardship, ensuring our staff maintain a high level of compliance with IPC. A robust governance structured approach across the whole organisation will remain crucial in the prevention of all healthcare associated infections.

Throughout 2024-2025 the IPC team will continue to strengthen and support close working relationships with the IPC Integrated Care System. Dorset-wide use of ICNET will continue 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, quality improvement projects 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 ONE

Dorset County Hospital
NHS Foundation Trust

Infection prevention and Control Optimisation Programme

April 2023 to March 2024

Emma Karamadoukis, IPC Lead Specialist Nurse

Written: May 2023, updated September 202

Introduction

The programme will be monitored through the Infection Prevention and Control Committee with an annual progress report presented to the Quality Committee and be incorporated within the annual report. Each work stream / action is RAG rated as follows:

G	Fully completed.
A	Partially completed with actions still to be completed, but due for completion with timescale.
R	Not completed, unlikely to be completed within timescale or significant risks to compliance.

The Key Objectives have been identified from the completion of the IPC Board assurance framework, which aims to demonstrate compliance with the Health and Social Act 2008 and the Ten Criteria outlined in the Act. The objectives have been identified as partially complaint and therefore an area for development or improvement.

Key Objectives

Objective 1: Education - This objective links to the new IPC education framework and compliance with Tier three of the IPC education framework, Tier 1 & 2 are to be reviewed but expected to be already covered by the IPC mandatory training. The IPC team plan to implement separate face to face training to cover tier three.

Linked to Criterion 1 IPC BAF – 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, specifically - 1.7 All staff receive the required training commensurate with their duties to minimise the risks of infection transmission and Criterion 6 IPC BAF Appendix 1- Systems are in place 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, Specifically , - 6.2 The workforce is competent in IPC commensurate with roles and responsibilities.

We will do this by:

- By the IPCT reviewing the recommended learning outcomes for Tier 1 & 2

- The IPCT to review the recommendations of Tier 3 and plan an implementation training programme to encompass all the learning outcomes. This will be largely but not inclusively, be relevant for all staff who are responsible for an area of care.

- The IPCT will liaise with all ward leads and Matrons to ensure compliance with the IPC education framework.

Objective 2: **Patient Safety - This objective links to the reset of IPC compliance following the Covid-19 pandemic, supporting leaders to find innovative ways to improve staff compliance with the National IPC Manual for England.**

Linked to Criterion 1 IPC BAF – 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, specifically – 1.4 - They implement, monitor, and report adherence to the NIPCM.

We will do this by:

- By developing a driver diagram QI project to reset IPC practice and compliance in four key areas: Improve hand hygiene, all staff to have the confidence and ability to challenge poor practice, improve peripheral Venous catheter. Appendix 3.

Objective 3: **Compliance - The IPCT will liaise with specific departments to ensure robust governance structures are in place to ensure close links, demonstrating IPC assurance and departmental collaboration. Which will feed into IPC Committee meetings, highlighting areas of concern and demonstrate clear escalation processes.**

Linked to Criterion 2 IPC BAF - Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections, specifically IPC BAF sections 2.3 - There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards, 2.7 - The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal., and 2.9 - Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer or staff this must be stored in line with food hygiene regulations., and Criterion 3 IPC BAF Appendix 1- Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance, specifically IPC BAF sections 3.5 - Contractual reporting requirements are adhered to, progress with

incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:

- **total antimicrobial prescribing.**
- **broad-spectrum prescribing.**
- **intravenous route prescribing.**
- **treatment course length, 3.6 - 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).**

We will do this by:

- By the IPCT attending all relevant committee meetings and provide IPC support and guidance when relevant.
- The IPCT will request and remind departments for their reports for discussion and review, with recommendations and presentation at the bi-monthly IPC committee meetings.
- The IPCT will liaise with AMS trust lead and AMS microbiologist to support the role and support the planned QI improvement programme within this speciality.

Objective 4 – Patient Safety - The Implementation of PSRIF (Patient safety Incident Response Framework) within IPC and within the wider Integrated Care system (ICS) for Dorset. Using this framework to review reportable infections whether they be COCA (Community Onset Community Associated), COIA (Community Onset Indeterminate Associated), COHA (Community Onset Healthcare Associated) or HOHA (Hospital Onset Healthcare Associated) cases.

Linked to Criterion 1 IPC BAF - 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, specifically IPC BAF sections 1.3 - That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.

We will do this by:

- The IPC lead attending the trust PSIRF workshops to identify the best way to implement the framework within IPC.

- The IPC ICS team to work closely together with the aim of moving away from Post Infection reviews of all COHA & HOHA CDI, MSSA and MRSA cases but to explore ways to provide an end-to-end review of the patients journey that led to an infection. The new process will involve each trust organisation bringing to the monthly meetings cases for discussion and identifying any lesson learnt. Each trust will carry out a comprehensive review of the patient experience to include all healthcare interventions. With this process in place, we will be inviting our colleagues from primary care, community care local authority to attend these meetings and review the patient's journey. The three trusts within Dorset will continue to carry out their own internal infection review processes.

Objective 1 – Education							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
1.1 Ensure DCH achieves Tier 1 & 2 of the IPC education framework.	All Staff complaint with their IPC education framework	• IPCT to check IPC framework against trust IPC e- learning module.	• Monitor trust compliance with IPC mandatory training.	Emma Karamadoukis/Chris Gover/Julie Park	November 2023	Julie/Emma have obtained the E learning modules, now need to compare against framework.	**G**
		• IPCT to check IPC framework against trust IPC face to face training.	• Gain feedback for staff following completion. • Re start face to face training for medical staff • IPCT to get link persons for all allied healthcare professional specialities and department and gain better engagement.	Emma Karamadoukis/Chris Gover/Julie Park	July 2023 November 2023 November 2023	Chris is linking with medical education teams to develop medical IPC training. Update IPC now carry out IPC training as required and deemed necessary. Housekeeping staff, Preceptees, junior doctors and ward staff training completed 2023.	**G**

Objective 1 – Education							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
1.2 Ensure DCH achieves Tier 3 of the IPC education framework	All Staff responsible for an area of care are complaint with their IPC education framework Tier 3	• IPCT to review the learning outcomes and devise a training plan appropriately.	• System in place.	Emma Karamadoukis/Chris Gover/Julie Park	January 2024	Programme to be in place by Summer 2024, carried into next optimisation plan.	**A**
		• IPCT to review a behaviour change approach, as suggested the COM-B model, and identify was to implement.	• Understand the model and implement with the training programme	Emma Karamadoukis	January 2024	Programme to be in place by Summer 2024, carried into next optimisation plan.	**A**
		• IPCT to link with other specialist teams to support the training programme.	• System in place and all leaders attend the training yearly.	Emma Karamadoukis/Chris Gover/Julie Park	January 20204	Programme to be in place by Summer 2024, carried into next optimisation plan.	**A**

Objective 2 – Patient Safety							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
2.1 Reset of IPC compliance following the Covid-19 pandemic, supporting leaders to find innovative ways to improve staff compliance with the National	IPC compliance improves across the trust.	• IPCT to develop ways to improve IPC compliance across the trust.	• IPCT to develop a driver diagram to demonstrate IPC quality improvement plans. Appendix 3. Action tracker to be developed alongside the Driver diagram. Appendix 3.	Emma Karamadoukis	April 2023	Completed and shared at IPCC May 2023.	**G**

Objective 2 – Patient Safety							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
Manual for England.							

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
3.1 The IPCT will liaise with specific departments to ensure robust governance structures are in place to ensure close links with other key departments related to IPC, supporting IPC assurance and agreement.	IPCT support housekeeping with their compliance, with regards to national cleaning standards.	• IPCT to liaise closely with Sarah Jenkins and support Audits and overall hospital presentation.	• Efficacy audits • PLACE and PLACE LIGHT reviews	Emma Karamadoukis/Chris Gover/Julie Park/Sarah Jenkins/Helen Hindley/Sophie Lloyd	Ongoing May 2023	PLACE and PLACE LIGHT dates set for the year. Ongoing and carried forward for 24-25 optimisation plan.	**G**
	IPCT support the water safety Group with IPC compliance.	• IPCT to liaise closely with Toby Markin the Trusts Authorising Officer and Terry May. • Emma Karamadoukis to arrange meeting with Microbiology Cathy Jeppesen and Toby Markin to discuss expectations between the two departments. • IPCT to attend the Water Safety Group meetings and link closely when concerns are raised.	• Clear escalation plans • Close monitoring of water safety reports and these should feed into the Water Safety Group and IPCC	Emma Karamadoukis/Chris Gover/Julie Park/Toby Markin/Terry May	June 2023	Emma Karamadoukis has arranged a meeting with Toby Markin and Microbiology for June 2023. Meeting completed Toby is working through water safety assurance and will link closely with all relevance teams and provide an update during IPC committee meetings.	**G**

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
						Ongoing and carried forward for 24-25 optimisation plan.	
	IPCT support the Ventilation safety Group with IPC compliance.	• IPCT to liaise closely with Colin Carver, the Trusts Ventilation Authorising Officer. • Emma Karamadoukis to request a ventilation update for all IPCC meetings. • IPCT to attend the Ventilation Safety Group meetings and link closely when concerns are raised.	• Clear escalation plans • Close monitoring of Ventilation reports and these should feed into the water safety groups and IPCC	Emma Karamadoukis/Chris Gover/Julie Park/Colin Carver/Terry May	Ongoing May 2023	Emma Karamadoukis has requested a Ventilation update for IPCC, using a suggested chart to provide cleaning assurance. Ongoing and carried forward for 24-25 optimisation plan.	G
	IPCT support an effective antimicrobial stewardship in accordance with local and national guidelines	• Antimicrobial Stewardship action plan to be written. • IPCT to support the National point Prevalence Survey of HCAI and Antimicrobial use in England. • If IPC funding/staff budget allows, to recruit into a newly developed AMS nurse specialist post.	• Action plan submitted to Antimicrobial Stewardship Committee (ASC) and reviewed at Medicines Committee and Infection Prevention and Control Committee. • National PPS to be completed with the support from the trust. • AMS nurse in post.	Rhian Pearce/Emma Karamadoukis/Cathy Jeppesen	July 2023 – still ongoing	Antimicrobial stewardship Plan being created – to be reviewed at Medicines Committee and Infection Prevention and Control Committee. Emma has discussed with UHD AMS nurse specialist, Emma to develop job	G

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
						description and advertise job ASAP. AMS working group started 11/12/2023, Cecilia Priestley leading the group. UKHSA national point prevalence survey of healthcare-associated infections and antimicrobial completed November 2023, AMS nurse post paused due to funding hold. CNO to liaise with UHS and head of pharmacy re AMS support. Ongoing and carried forward for 24-25 optimisation plan.	
	IPCT support the Decontamination Group with IPC compliance.	• IPCT to liaise closely with Joe Lythe, the Trusts Decontamination Lead. • Emma Karamadoukis to request a	• Chris Gover to become the Deputy Decontamination lead, attend relevant course and support	Chris Gover/Joe Lythe	September 2023	Chris Gover is booked on the relevant course for September 2023.	**G**

Objective 3 - Compliance							
Issue	**Desired Outcome**	**Action(s)**	**Evidence/Assurance**	**Lead(s)**	**Target Date**	**Update**	**RAG**
		decontamination update for all IPCC meetings. • IPCT to support the decontamination lead in his role.	Joe Lythe with his role as lead.				

Objective 4 – Patient Safety							
Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	**RAG**
4.1 The Implementation of PSIRF (Patient safety Incident Response Framework) within IPC and the wider Integrated Care system (ICS) for Dorset	• DCH IPCT to review and develop a new process for the implementation of PSIRF for Gram negative/MRSA/MSSA and CDI organisms.	• Emma Karamadoukis to attend all trust PSRIF workshops and devise a plan for PSIRF to be implemented within IPC.	• Attend workshops or send a representative for IPC.	Emma Karamadoukis	September 2023	Emma Karamadoukis has attended the first two workshops.	**G**
		• Develop a process for IPC to collaborate with the microbiology team and leads for the reviews of all HOHA and COHA using the PSRIF framework for Gram negative/MRSA/MSSA and CDI organisms.	• Emma Karamadoukis to collaborate with the microbiology team and present a plan for the implementation of PSRIF.	Emma Karamadoukis	September 2023	Emma Karamadoukis has developed an IPC PSIRF plan and shared across team, awaiting feedback July 2023.	**G**
		• Once PSIRF plan agreed – implement process and review progress.	• Emma Karamadoukis to collaborate with the microbiology team and present a plan for the	Emma Karamadoukis	September 2023	Once process agreed Emma Karamadoukis will implement, awaiting new	**G**

			implementation of PSRIF.			consultant microbiologist to start to free up time for consultants to support new process. Date for meeting planned October 2023 with microbiology team. IPC PSIRF plan to start 01/01/2024, communications sent.	
	System wide process for the implementation of PSIRF and develop a new Post Infection review Process.	• PSIRF to be implemented systemwide during all PIR meetings.	• Close working with the wider Dorset system and develop an implementation programme.	IPC ICS Dorset system	April 2023	New process in place and under review for improvement. Including the use of ICNET results page to enable better initial reviews.	**G**

Appendix 3 – Driver Diagram and Action tracker for QI plan for IPCT

IPC Action Tracker

Staff involved
Emma Karamadoukis (EK)
Chris Gover (CG)
Jules Park (JP)
Helen Hindley (HH)
Sophie Lloyd (SL)
Cheryl Heard (CH)

Action status key:	Status
Open	Open and needs action
In progress	In progress or completed but needs checking
Closed	Completed and signed off
No action	Not actioned (reason for no action to be added in Progress/outcome column)

Date Action Logged	Detail/ Action	Name/Org of person responsible for	Progress/outcome	Action status	Deadline
01/05/2023	Ad hoc ward visits and education on hand hygiene, continued hand hygiene audits.	IPC team	IPC Teams carry out more ward rounds, ad hoc teaching and close engagement with wards.	Closed	
01/05/2023	Re education on the correct way to complete ward hand hygiene audits	IPC team	Chris Gover has engaged with wards and emailed the correct processes to carry out Hand hygiene audits.	Closed	
01/05/2023	DCH IPC promotion week 'Brush up on your IPC week'	IPC team	Date set for 1st week in July. Trust has completed Recycle, refresh and reset week, IPC team ensured good IPC focus particularly on PPE, hand hygiene and uniform policy adherence.	Closed	
01/05/2023	Standing item on weekly comms on relevant IPC information	IPC team	IPC team has commenced weekly IPC comms.	Closed	
01/05/2023	Staff placement for learning with IPC	IPC team	IPC team encourage all interested staff to attend IPC ward rounds to improve knowledge, Student placements within IPC continue. We have had Clinical site managers and students and the wider ICS IPC visit IPC team for training	Closed	
01/05/2023	IPC champion on celebrating success	IPC team	IPC team have started championing good IPC practice within the celebrating success bulletin	Closed	
01/05/2023	Use Shock tactics of poor compliance with PVC compliance i.e. Cannula catastrophe	IPC team		Closed	
01/05/2023	Engage volunteers in IPC Knowledge	IPC team		Closed	
01/05/2023	Quarterly IPC Newsletter	IPC team	May 2023 newsletter launched. Next one due out August 2023.	Closed	
01/05/2023	Re-Enforce uniform policy through training Particularly HCA care certificate, IPC ward rounds and modelling by senior leaders. IPC to use new ideas to get the message across.	IPC team	New uniform policy produced and was a large focus during recycle, refresh and reset week 1st July 2023. Poor compliance is an ongoing issue and the IPC team will continue it challenge daily.	Closed	
01/05/2023	Production of communications led media to demonstrate acceptable standards	IPC team	New IPC twitter account set up and CNO and Deputy CNO has assisted with social media.	In progress	