The Dudley Group NHS Foundation Trust

TITLE:	Infection Prevention and Control Annual Report 2020/21		
AUTHOR:	Kim Jarrett – IPC Specialist Nurse Jo Wakeman – Deputy Chief Nurse	**PRESENTER**	Kim Jarrett Jo Wakeman

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

SO3: Drive service improvements, innovation and transformation

SO4: Be the place people choose to work

SO5: Make the best use of what we have

SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

The Dudley Group NHS Foundation Trust is committed to ensuring that a robust infection prevention and control function operates across all Trust Services/ departments of the organisation which supports the delivery of high quality healthcare and protects the health of its service users and staff.

The Annual report seeks to provide assurance to the organisation with regards to the progress of the prevention, control and management of infection from April 2020 to March 2021.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description: Vacant Lead Nurse post in IPC Team**
	Risk Register: Y	**Risk Score: 16 – Major.**
	Y	**Risk Description: Reduction in Hydrogen Peroxide Vapour service.**
	Risk Register: Y	**Risk score: 16 – Major.**
	Y	**Risk Description: Overcrowded IPC office**

	Risk Register: Y		**Risk score: 15 – Major.**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe and effective care
	NHSI	**Y**	**Details:** MRSA bacteraemia and C. difficile targets. E coli bacteraemia to achieve a 50% reduction.
	Other	**Y**	**Details:** Compliance with Health and Safety at Work Act 2008 updated 2015

ACTION REQUIRED OF COMMITTEE: To receive the report and note the contents.

Decision	Approval	Discussion	Other
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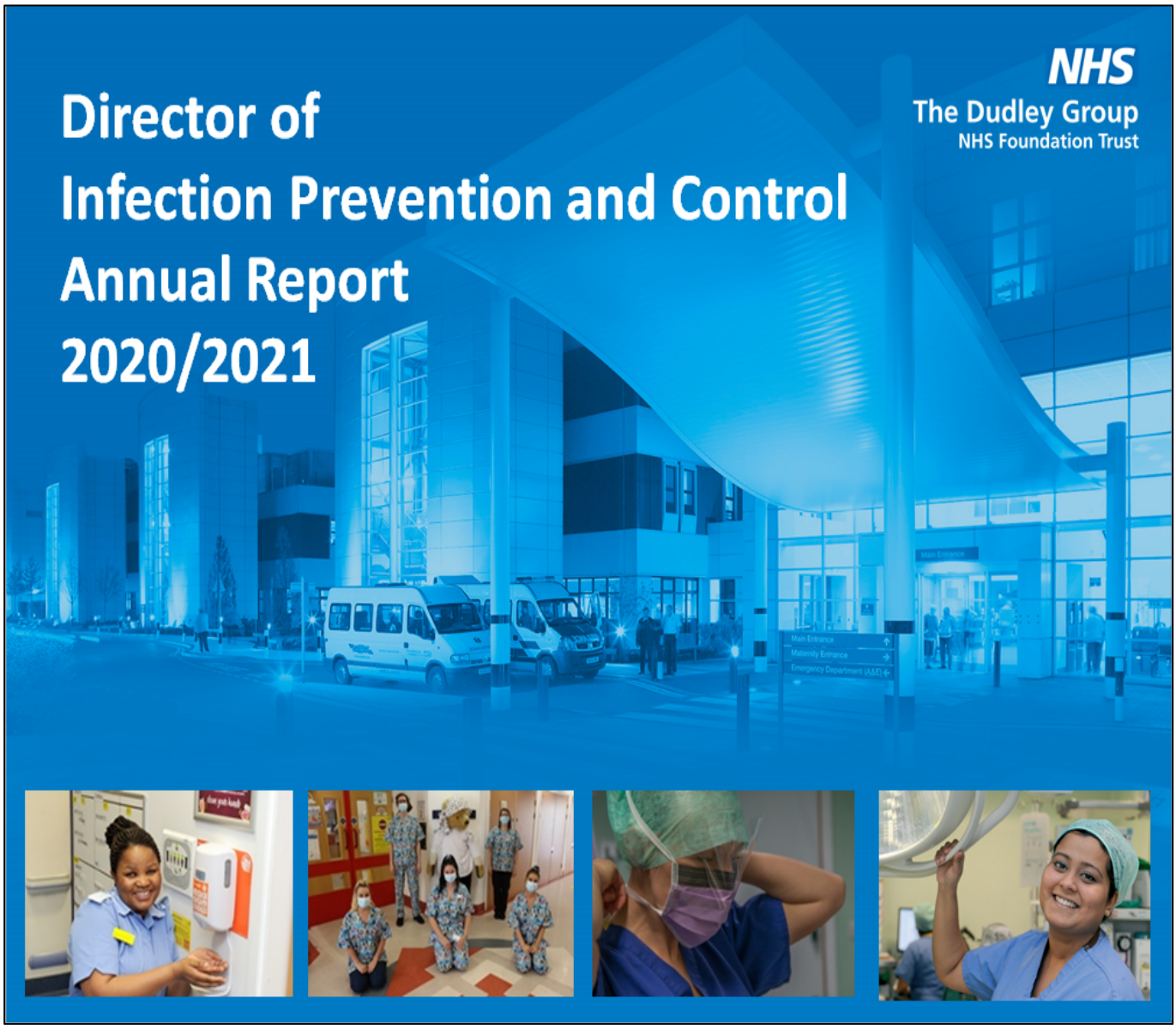
RECOMMENDATIONS FOR THE COMMITTEE: To receive the report and note the contents.

NHS
The Dudley Group
NHS Foundation Trust



Section	Title	Page Number
	Introduction to the report by the Director of Infection Prevention and Control	
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	
a	Director of Infection Prevention and Control	
b	The Infection Prevention and Control Team	
c	Committee Structures and assurance processes	
d	Trust Board	
e	Quality and Safety Committee	
f	Quality and Safety Group	
g	Infection Prevention and Control Group	
h	Surveillance of Healthcare Associated infection	
i	Methicillin resistant staphylococcus aureus blood stream infections (MRSA)	
j	Methicillin sensitive staphylococcus aureus blood stream infections (MSSA)	
k	Clostridioides difficile (Also referred to as Clostridium difficile) Infection (CDI)	
l	CDI root cause analysis and investigation	
m	Gram Negative Blood stream infections - Escherichia coli (E-coli)	
n	Vancomycin/glycopeptides resistant enterococci (vre/gre)	
o	Carbapenemase producing enterobateriaceae (cpe)	
p	Norovirus	
q	Covid-19 Pandemic	
r	Audit programme	
s	Hand hygiene audits	
t	Mandatory training	

u	Seasonal influenza staff vaccination programme	
v	IPC link workers	
w	Incidents and outbreaks	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection	
2.1	Providing a Clean safe environment	
2.2	Water safety management	
2.3	Management of Decontamination	
3	Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion	
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharge of and discharge their responsibilities in the process of preventing and controlling infection	
7	Provide or secure adequate isolation facilities	
8	Adequate access to laboratory support as appropriate	
9	Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections	
10	Providers have a system in place to manage the occupational health needs of staff in relation to infection	
	Appendix 1 – 2021/2022 Work plan	
	Appendix 2 – 2020/2021 Work plan	

Hygiene Code Criterion

Compliance Criterion	What the registered provider will need to demonstrate	Assurance	RAG rating
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 that their environment and other users may post to them.	A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly.	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained. A HPV service is in place, however this service has had reduced capacity during the latter half of the year due to a reduction in available personnel. Increased cleaning including touchpoints has been established during the COVID-19 outbreak. The Cleaning contracts with MITIE are currently under review. The Hydrogen peroxide vapour (HPV) service is limited and an external company is commissioned for periods when cleaning is required. The reduction in the HPV service is detailed on the risk register.	
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy. Work towards achieving the AWARE list compliance is ongoing. Monitored through the IPC Group. AWARE – Access – Narrow spectrum first line antibiotics. Watch – Broader spectrum but	

		should not be used first line. Reserve – Should only be used on Specialist advice or when no other option is available	
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.	Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support. Patients who have been identified as having an infection are reviewed by the IPC Team.	
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk. Compliance with COVID screening is variable and the data is not easily accessed to monitor compliance.	MRSA elective screening 97 % compliance and emergency screening 91% compliance as at 31.03.21.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection. During the latter part of the year specific PPE training (Donning and Doffing) was provided during the pandemic. Mandatory training was compromised by the onset of the surge in COVID cases during March 2020.	Based on an annual assessment of the position the Trust average is 89% for March 2021.
7	Provide or secure adequate isolation facilities.	There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms. A Zoning SOP was developed in March 2020 due to COVID -19 Pandemic	
8	Secure adequate access to laboratory support as appropriate.	The Trust has access to a CPA/UKAS accredited Microbiology and Virology	

		laboratory. The current version of the ICNet service is being updated in line with the Black country pathology service. There is advice available from a Microbiologist 24 hours per day, 7 days per week.	
9	Have adherence to policies, designed for the individuals' care and provider organisations that will help to prevent and control infections.	All policies, as recommended in the Hygiene Code, are in place. Audit data confirms compliance with policies and identifies areas for improvement.	
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	There is in house provision of Staff Health and Wellbeing. There are regular reports to the Infection Prevention and Control Forum detailing any issues raised within this system.	

LIST OF ABBREVIATIONS

C.diff	Clostridiodes difficile (Formerly Clostridium difficile)
COVID-19	An infectious disease caused by a newly discovered coronavirus.
CQC	The Care Quality Commission – the integrated regulator of health and adult social care
DH	Department of Health
D and/or **V**	Diarrhoea and/or Vomiting
DIPC	Director of Infection Prevention and Control. An individual with overall responsibility for infection control and accountable to the registered provider
E-Coli	Escherichia coli
ESBL	Extended-Spectrum Beta-Lactamases (ESBLs) are enzymes that can be produced by bacteria making them resistant to cephalosporin's e.g. cefuroxime, cefotaxime and ceftazidime - which are the most widely, used antibiotics in many hospitals
QSC	Quality and Safety Committee
GRE	Glycopeptide-Resistant Enterococci
HCAI	Health Care Associated Infections
IPC	Infection Prevention and Control
IPCG	Infection Prevention and Control Group
IPCT	Infection Prevention and Control Team
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
SHAW	Staff Health Wellbeing Department
PFI	Private Finance Initiative

PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment
SLA	Service Level Agreement
UTI	Urinary Tract Infection
WHO	World Health Organisation

Introduction to the Annual Infection Control Report

Infection Prevention and Control is a scientific approach and practical solution designed to prevent harm caused by infection to patients and health care workers (WHO) it is essential to ensure safety and quality of care for our patients can be provided. At The Dudley Group NHS Foundation Trust Infection Prevention and Control is a key priority.

As the Director of Infection Prevention and Control I am proud to be able to present the Annual Infection Prevention and Control Report for 2020/2021

The role of Director of Infection Prevention and control was initially held by the Consultant microbiologist and Infection Control Doctor until October 2020. The role then transitioned over to the Chief Nurse who currently holds the position of Director of Infection Prevention and Control.

The Dudley Group NHS Foundation Trust is committed to delivering the highest infection prevention and control standards to prevent avoidable harm to patients, visitors and staff from healthcare associated infection. It is a key priority to ensure that a robust infection prevention and control function operates and is embedded within all clinical areas of the organisation. Effective prevention and control of infection is embedded as part of everyday practice and applied consistently by everyone at all times.

The infection prevention agenda faces many challenges including the ever increasing threat from emerging diseases, antimicrobial resistant micro-organisms, growing service development in addition to national targets and outcomes. The Trust Infection Prevention and Control Team experienced a number of changes in personnel over the last year and recruitment into the team has been challenging. This has resulted in periods of reduced staffing levels and reduction in the service provided to clinical teams.

The Trust has a comprehensive programme of infection prevention and control activities in order to support compliance with the Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance and CQC regulation 15.

The report provides assurance that systems are in place and working effectively to minimise and avoid hospital acquired infection and that the Trust has oversight and compliance against the Hygiene Code.

The Coronavirus pandemic has significantly impacted on the trust further highlighting the role of Infection prevention and control has in keeping our patients and staff safe. I want to formally acknowledge and thank all trust teams for their commitment during that last year.

1. **Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.**

a. DIRECTOR OF INFECTION, PREVENTION AND CONTROL

Director of Infection Prevention and Control – Mary Sexton (Chief Nurse)

The Director of Infection Prevention and Control (D.I.P.C.) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act 2015). The DIPC will have the executive authority and responsibilities for ensuring strategies are implemented to prevent avoidable HCAIs at all levels within the organisation.

The DIPC will be the public face of IPC and will be responsible for the Trust's annual report, providing details on the organisations IPC programme and publication of HCAI data for the organisation.

The DIPC will lead the commitment to quality and patient safety, good communication and ensure robust reporting channels and access to a group of staff with expert prevention and control knowledge, able to offer advice and support. The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. Additional support is provided by the antimicrobial pharmacists and Lead Nurse for Infection Prevention and Control. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Code.

At The Dudley Group NHS Foundation Trust the Chief Nurse holds the role of DIPC.

b. THE INFECTION PREVENTION AND CONTROL TEAM

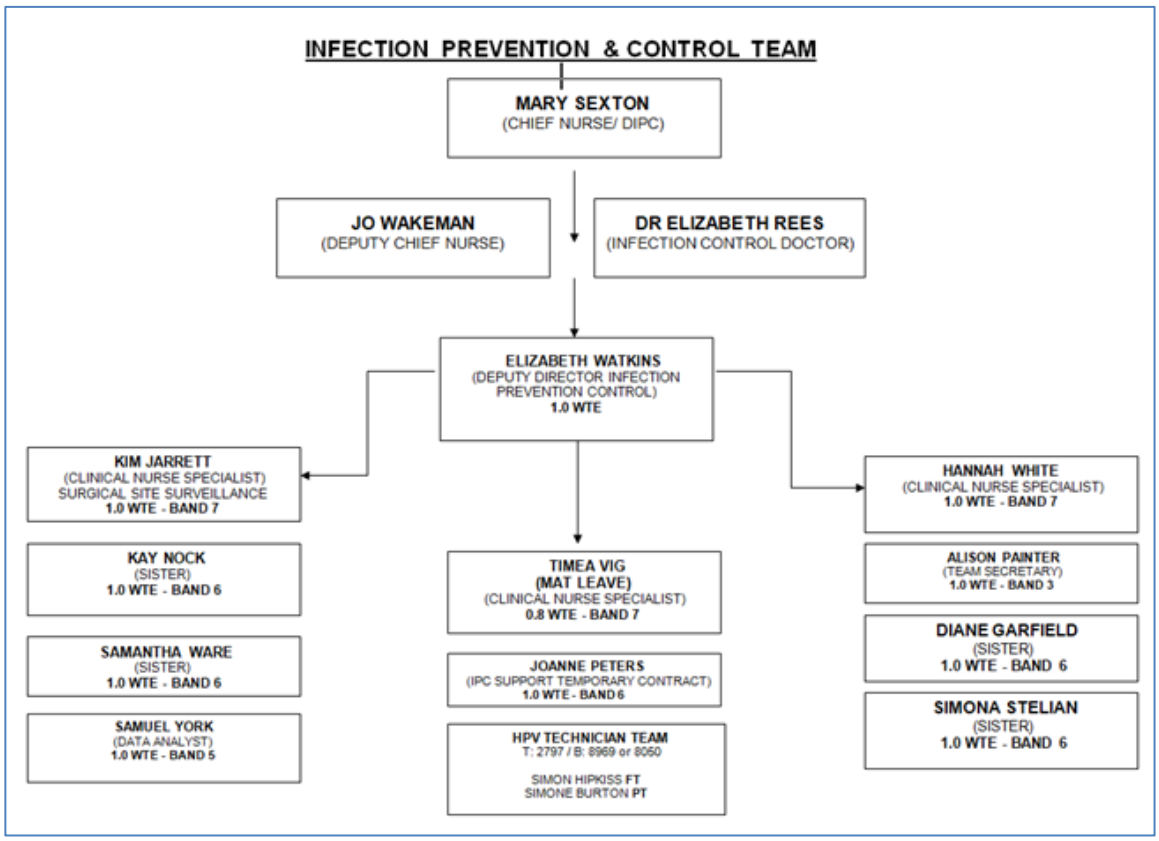
The IPC Team is led by the Lead Nurse (This post has been replaced by a Deputy DIPC in May 2021) for IPC and is supported by Infection Prevention Nurse Specialists, Infection Prevention Sisters, Data Analyst and Team Secretary.

The IPC service is provided through a structured annual programme of works which

includes expert advice, education, audit, policy development and review and service development. The Trust has 24 hour access to expert Consultant Microbiology advice accessible via switchboard.

The DIPC has overall responsibility for the IPC Team. The IPC Team works collaboratively alongside clinical leaders at the Trust.

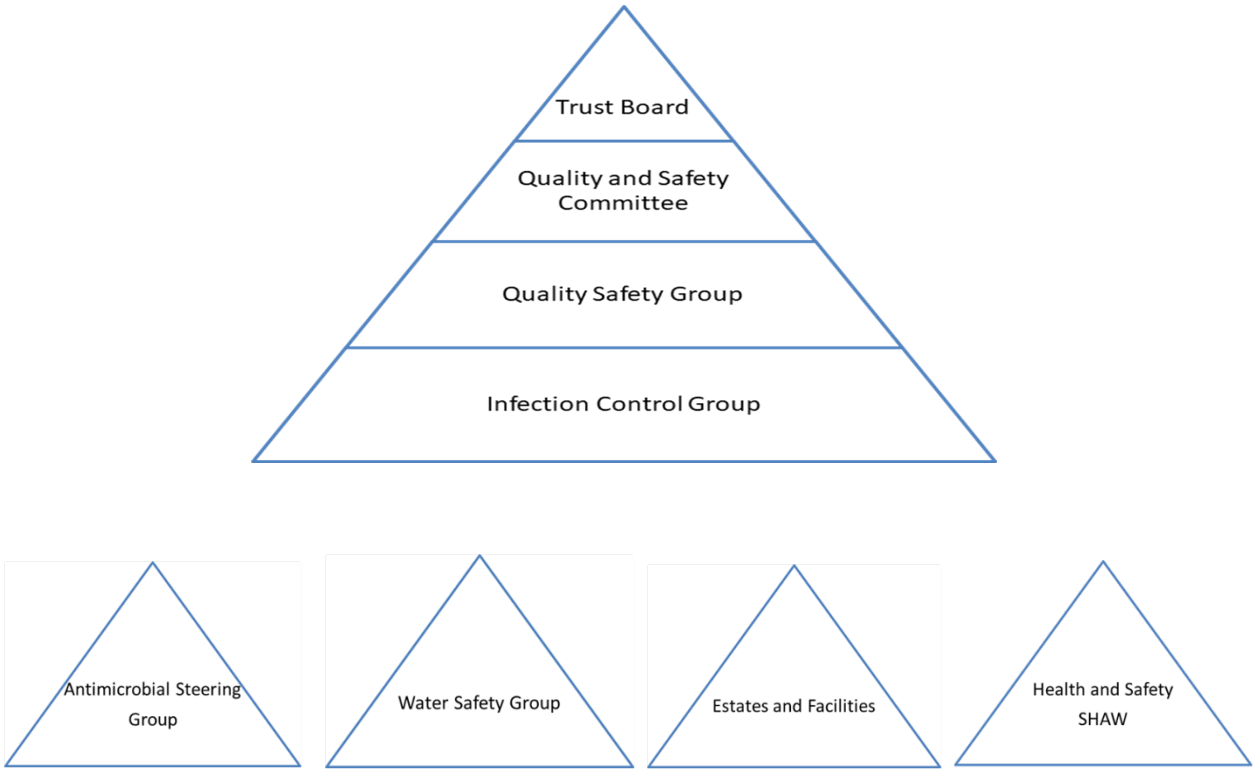
A workforce review of the IPC Team is being undertaken as one of the lessons learnt from the COVID-19 pandemic. This review will be presented to the trust executive team. The review will look at the service being provided over a 7 days period while putting in a sustainable model to future proof the team and the service.



Infection Prevention and Control Team - Healthcare Hero Winners June 2020

In addition to this award the Infection Prevention and Control Team were also recognised in the Annual Committed to Excellence awards hosted by DGH. The Team were awarded with the Outstanding Achievement – Team award which was presented to the team via a virtual awards ceremony in May 2021. Dame Yve Buckland – Chairperson presented the team with their award.

c. COMMITTEE STRUCTURES AND REPORTING PROCESS



d. TRUST BOARD

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for IPC. The Chief Executive (CE) has overall accountability for the control of infection at DGFT and any IPC matters across the trust.

e. QUALITY AND SAFETY COMITTEE

The Quality and Safety Committee is chaired by a Non - Executive Director (NED), it is a sub- committee of the Trust Board which meets monthly. The purpose of the Quality and Safety Committee is to provide oversight and scrutiny of infection control standards and practices and seeking assurance that IPC Standards are being met.

It will also provide assurance to the Trust Board around the DGFT's arrangements for protecting and improving the quality and safety of patient-centered healthcare, thus improving the experience for all people that come into contact with the services at DGFT.

f. QUALITY AND SAFETY GROUP

The Quality and Safety group (QSG), chaired by the Chief Nurse/ DIPC, meets monthly and is responsible for ensuring that there are processes in place for ensuring patient safety and continuous monitoring and improvement in relation to key areas including IPC, but also covers sub divisions of the trust as well as other specialties. The QSG receives assurance from the IPC that adequate and effective policies, processes and systems are in place. This assurance is provided through a regular process of reporting. The IPC Team provide a monthly report to the Group covering the full aspects of the hygiene code.

g. THE INFECTION PREVENTION AND CONTROL GROUP

The Infection Prevention and Control Group meet monthly, chaired by the DIPC.

The purpose of the Group is to oversee compliance of the Health Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections. The Group provides assurance that risks are appropriately managed and that appropriate arrangements are in place to achieve a safe clinical environment. The IPCG reports to the Quality and Safety Committee and is required to comply with any reporting requirements set by the Quality and Safety Committee as to format and frequency.

The membership of the Group is multidisciplinary and also includes representatives from The Office of Public Health at Dudley Metropolitan Borough Council, private finance initiative partners and Public Health England. This Group provides assurance to Quality and Safety Committee that the infrastructure for infection prevention and control is in place.

The Group is responsible for:

a) Monitoring compliance against the 10 criterion of the hygiene Code. Health and Social Care Act 2008.

b) Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.

c) Developing relevant policies, procedures, care pathways and clinical guidelines.

d) Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.

e) Ensuring, through the DIPC, that the Chief Executive and associated committees are advised of any significant issues relating to infection control.

f) To receive the Annual Infection Prevention and Control Report.

g) To ensure that the wider aspects of maintaining IPC are reported and reviewed within the IPC group these include : Health and Safety, Estates, Water Safety, Antimicrobial stewardship and SHAW.

h. SURVEILLANCE OF HEALTHCARE ASSCIATED INFECTION

Surveillance is undertaken within DGFT on a number of alert organisms and mandatory reporting to PHE is undertaken via the HealthCare Associated Infection Data Capture System. Performance is monitored by Dudley Clinical Commissioning Group (CCG).

i. METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS BLOOD STREAM INFECTIONS (MRSA)

Staphylococcus aureus is an organism harmlessly carried on the skin by around 1 in 30 of the healthy population and remains endemic in many UK hospitals. The transmission of MRSA and the risk of MRSA infection (including MRSA Bacteraemia) can only be addressed effectively if measures are taken to identify MRSA carriers as potential sources of infection, and treating them to reduce the risk of transmission, therefore guidance is in place regarding the screening of our patients for MRSA for both emergency and elective admissions at DGFT. In addition DGFT also have processes in place to ensure isolation of patients colonised with MRSA, following national guidance.

Infection associated with indwelling medical devices, particularly intravascular devices, is a major cause of morbidity and occasionally, mortality.

The DGFT also comply with national guidance to reduce the risk of blood stream infection and have systems in place for:

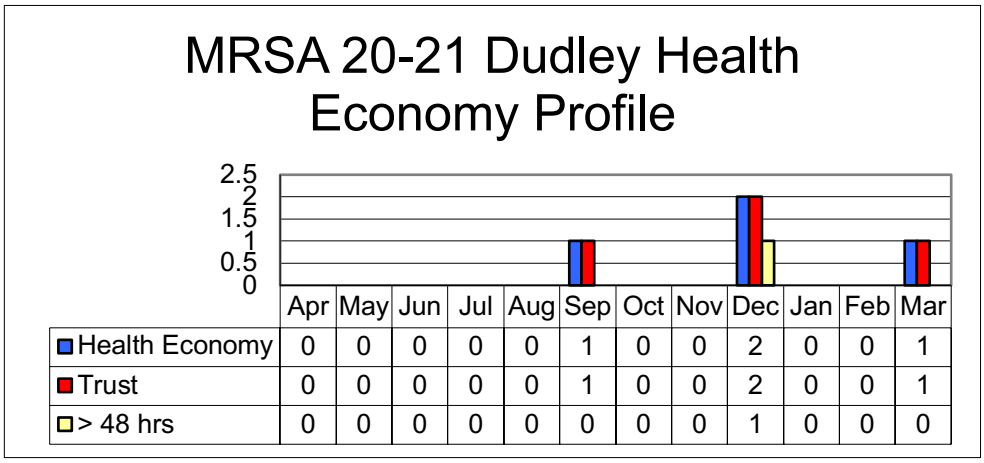
- The management and care of devices
- Antimicrobial prophylaxis
- Compliance with national guidance

There have been four cases of MRSA bacteraemia identified in total. For the cases that were identified as pre 48 hour cases (Admitted within 48 hours of the positive result being identified) investigations were carried out by the CCG and actions identified. For the period covered by this annual report there has been one case of post 48 hour MRSA bacteraemia, identified in December 2020. A Post infection review was carried out and the investigation concluded that the patient had multiple in-patient and outpatient attendances and contacts with a variety of specialists over the 10 year period following a hip replacement, patient was also known to be colonised with MRSA. Actions from the RCA identified and shared with staff.

The common themes identified through Post infection reviews of these cases were cannulation and MRSA policies not being followed, this includes screening on admission and screening of wound sites. Lessons learnt from these investigations have been identified and as a result of the investigations undertaken, MRSA compliance is monitored against the monthly ward compliance for MRSA in order to identify any missed screening opportunities and investigate reasons for this occurrence. The areas with the lowest screening compliance are mainly identified as areas where a small number of screens have been completed. This continues to be monitored; however an increase in compliance was noted in March 2021.

Cannulation training continues to be provided via the clinical skills nursing team with competency assessments carried out on ward areas. Saving lives scores are undertaken by link workers on the ward areas with some peer reviews in operation in order to cross reference locally reported scores to ensure assurance.

Actions from the RCA's are completed and monitored through the division and Goverance.

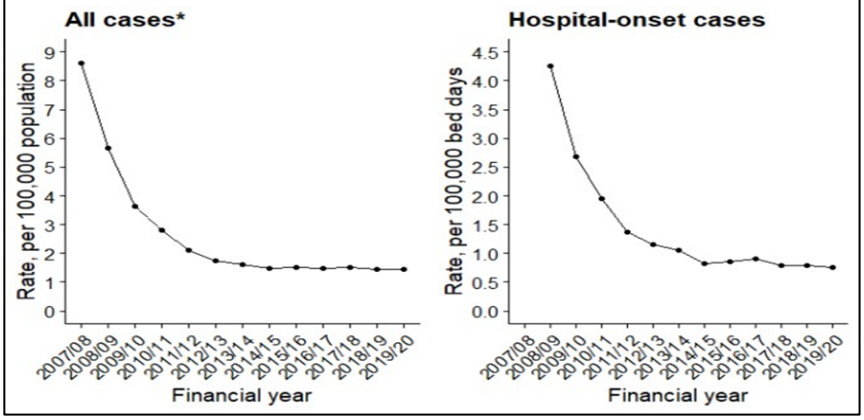


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	0	0	0	0	0	1	0	0	2	0	0	1
Trust	0	0	0	0	0	1	0	0	2	0	0	1
> 48 hrs	0	0	0	0	0	0	0	0	1	0	0	0

Month	**Trust Apportioned >48 hours**	**Health Economy Total**
April 2020	0	0
May 2020	0	0
June 2020	0	0
July 2020	0	0
August 2020	0	0
September 2020	0	1
October 2020	0	0
November 2020	0	0
December 2020	1	2
January 2021	0	0
February 2021	0	0
March 2021	0	1
Yearly Total to Date	**1**	**4**

Epidemiological analyses of Staphylococcus aureus bacteraemia data

Figure 16: Trends in the all case and hospital-onset rate of MRSA bacteraemia, England: 2007/08 to2019/20



DGH is in line with the national performance when compared to peers across England.

There has been a considerable decrease in the incidence rate of all reported MRSA bacteraemia since the enhanced mandatory surveillance of MRSA bacteraemia began in April 2007.

The rate has subsequently decreased to 1.4 cases per 100,000 population between January to March 2014 and January to March 2020.

A total of 13,007 Staphylococcus aureus bacteraemia cases were reported to PHE in 2019/20 through both the meticillin resistant S. aureus (MRSA) bacteraemia and meticillin-susceptible S. aureus (MSSA) bacteraemia surveillance schemes.

At its peak (2007/2008) MRSA bacteraemias accounted for approximately 40% of all S. aureus bacteraemia cases in England (Johnson AP 2005).

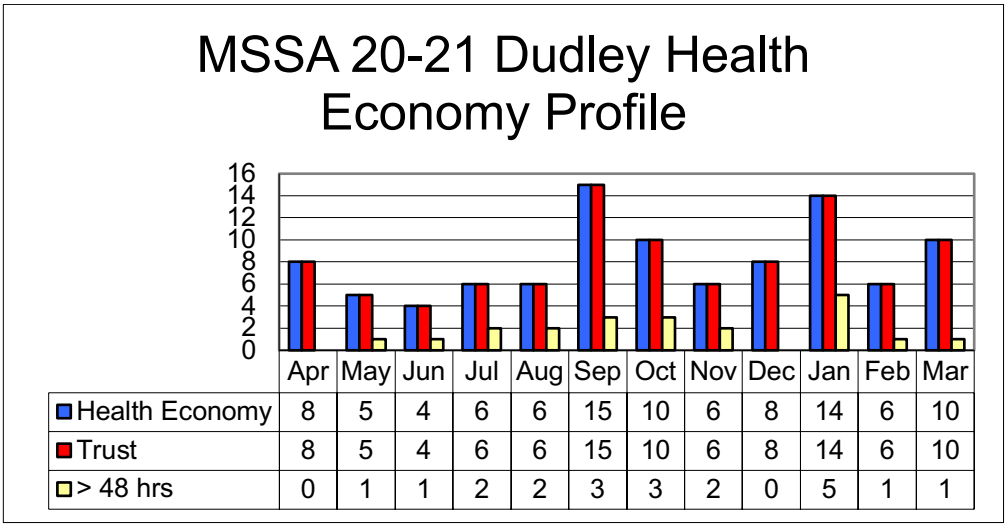
The objective to achieve at DGH is a target of zero cases of post 48 hour MRSA bacteraemia cases.

j. METICILLIN SENSITIVE STAPHYLOCOCCUS AUREUS BLOOD STREAM INFECTIONS (MSSA)

Meticillin-sensitive Staphylococcus aureus is a type of bacterium which lives harmlessly on the skin and in the noses, in one third of people. People who have MSSA on their bodies or in their noses are said to be colonised.

MSSA colonisation usually causes no problems, but can cause an infection when it enter s into the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. grazes, surgical wounds.
MSSA can cause serious infections called septicaemia (blood poisoning) where it gets into the bloodstream.

Following a Secretary of State announcement on 5 October 2010, there was a mandatory requirement for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.



Meticillin Resistant Staphylococcus Infections

Month	Trust Apportioned >48 hours	Health Economy Total
April 2020	0	8
May 2020	1	5
June 2020	1	4
July 2020	2	6
August 2020	2	6
September 2020	3	15
October 2020	4	10
November 2020	2	6
December 2020	0	8
January 2021	5	14
February 2021	1	6
March 2021	1	10
Yearly Total to Date	**16**	**74**

When this data is compared to the post 48 hour infection rates for the previous financial year there has been a reduction in cases from 21 post 48 hour cases to 16.
Common themes identified following patient review include chronic leg ulcers, infective endocarditis. Lower respiratory tract infections and infective dermatitis with many of the cases identified having underlying disease prior to admission. MRSA screening compliance, including wounds is discussed through the divisions monthly in order to review missed screening compliance and identify any gaps in compliance.

k. CLOSTRIDIOIDES DIFFICILE (PREVIOUSLY REFERRED TO AS CLOSTRIDIUM DIFFICILE INFECTION (CDI)

Changes to the CDI reporting for the 2019/20 year have been made to align the UK definitions with international descriptions of disease.

These changes mean that additional patients will be included in the group of patients that the trust is required to investigate. The patients who will be included are categorised in the following groups:

1. Hospital Onset Healthcare Associated (**HOHA**): cases that are detected in the hospital two or more days after admission

2. Community Onset Healthcare Associated (**COHA**): cases that occur in the community or within two days of hospital admission when the patient has been an inpatient in the Trust reporting the case, within the previous 4 weeks

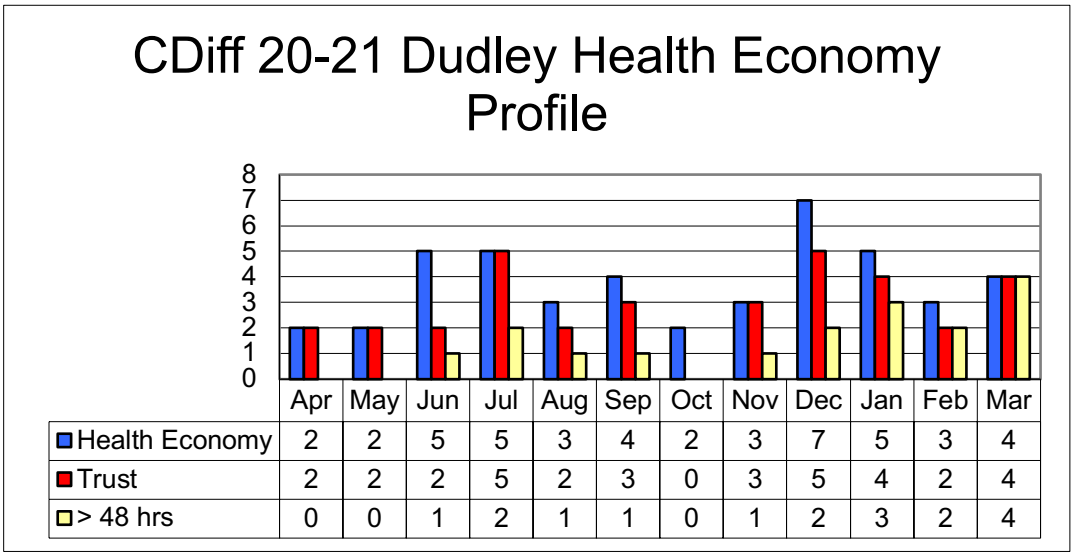
For patients in group 2 (COHA), diagnosed in the community or on admission to DGFT but with a previous admission the Infection Control Team will lead the RCA. Patients in group 1(HOHA) will be investigated by the local clinical team.

During 2020/2021, the number of cases that occurred were:

- 21 Hospital Onset Healthcare Associated (HOHA)
- 13 Community Onset Healthcare Associated (COHA)

Cases were discussed across the Health Economy using the national apportionment tool. Due to the COVID-19 pandemic several RCA meetings did not go ahead as planned as they were not quorate due to the increased work commitments across the trust by all parties. In order to address issues that were identified, the clinical teams were required to develop action plans which were then monitored locally and via reports submitted by the divisions to the Infection Prevention and Control Group. The RCA meetings have now recommenced with the introduction of a scrutiny panel held internally to review each case.

C.diff Apportionment Decisions to Date Hospital onset healthcare associated – April 2020 to March 2021



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	2	2	5	5	3	4	2	3	7	5	3	4
Trust	2	2	2	5	2	3	0	3	5	4	2	4
> 48 hrs	0	0	1	2	1	1	0	1	2	3	2	4

There have been 17 post 48 hour cases identified in 2020/2021; of these cases 11 have been associated with having a lapse in care. The common themes identified have been antimicrobial stewardship and issues relating to mandatory training compliance. To assist with the improvement of antimicrobial prescribing, several actions have been initiated to include:

- Executive level reporting to influence change.
- Antibiotic awareness week campaign.
- NICE guidance baseline assessment completed.
- Patient safety bulletin published online and sent to all staff.
- Hub communication/ screen saver produced to raise awareness.
- Junior Dr antimicrobial prescribing teaching sessions completed.
- Antimicrobial stewardship section in Trust wide Governance newsletter.
- Feedback to the divisions provided via ASG.
- Monthly Antimicrobial stewardship report provided monthly to Infection Prevention and Control Group, Drugs and Therapeutics Group &Medicines Management Group.

Further details related to antimicrobial stewardship can be located in the relevant section of this report.

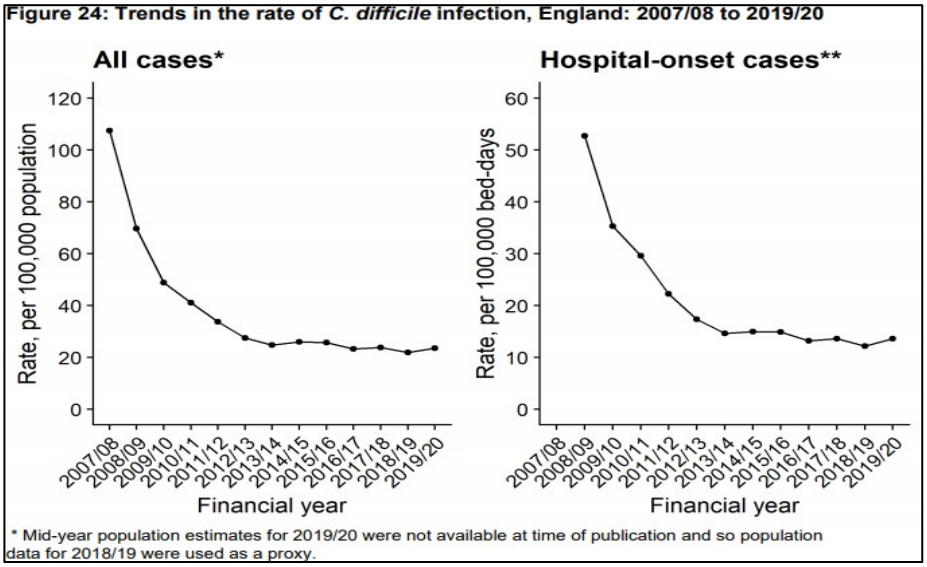
Reduced compliance of infection control mandatory training was noted during July 2020 onwards; the trust was under immense pressure due to COVID-19 and associated workforce challenges. Face to face teaching sessions were suspended due to social distancing measures this has impacted on training compliance across the Trust.
In order to ensure we have systems in place to increase the compliance across the trust there is a direct link to enable staff to complete the training via the DGH intranet page, making it easier for staff to access e learning.

The face to face training sessions for IPC Training have now been re- introduced with a reduction in the capacity to ensure social distancing requirements are maintained.

Epidemiological analyses of *Clostridiodes difficile* infection data (England)

A total of 13,177 cases of Clostridioides difficile infection were reported by NHS trusts in England between 1 April 2019 and 31 March 2020. This is a small increase of 7.4% from 2018/19, and a decrease of 76.3% from 2007/08. The below graph shows the trends in rates of CDI cases for all cases and hospital-onset cases from 2007/08 to 2019/20. The rate of all CDI cases per 100,000 population, per year has fallen from 107.6 in 2007/08 to 23.5 in 2019/20.

A reduction in C diff infection post 48 hours has been identified. At DGH 21 cases were identified in 2019/2020 with 14 lapses in care identified, in comparison to 2020/2021 with the figure reducing by 3 cases associated with a lapse in care, bringing the lapse in care total to 11. Work is required to reduce the figures further, actions following lapses identified antimicrobial stewardship work continues as well as a focus on mandatory training compliance and cleaning divisionally and trust wide.



The division of cases into hospital-onset and community-onset cases does not take into account any patient who may have been admitted into healthcare within the previous twenty eight days leading up to the positive CDI result. Patients who have received previous inpatient care may be at increased risk of developing CDI. For this reason reporting of information prior to trust exposure to Healthcare facilities was introduced in April 2017.

L. CDI ROOT CAUSE ANALYSIS AND INVESTIGATION

Preventing and controlling the spread of CDI is a vital part of the Trust's quality and safety agenda by a multifaceted approach and the proactive element of early recognition and isolation of CDI toxin positive cases and of those cases that are CDI carriers (GDH positive).

In all cases control measures are instigated immediately. Each HOHA and COHA CDI's have a Root cause analysis completed.

The HOHA cases undergo an RCA panel to establish root cause of the infection and any learning outcomes identified. Following this process and review by the CCG each case is apportioned to identify if any lapses or no lapses in care can be identified. The lapses in care are then plotted against the trust objective for CDI for that year. This is then feedback via reporting mechanisms to the IPCG. An improvement has been noted throughout this year in comparison to the previous year with a reduction of HOHA cases identified.

The COHA cases have a review by the IPCT and following a review of the recent admissions within 28 days an apportionment form is completed and returned to the CCG. Any cases where a lapse has been identified will be plotted against the objective for the trust. In comparison to the previous year's data a reduction in cases associated with a community onset case where an admission to the trust has been identified has reduced.

Lessons Learnt

Following review of all of the Root Cause analysis completed some common themes

have been identified. These include antimicrobial stewardship and appropriateness of antimicrobial prescribing in line with Trust guidelines, Environmental Cleaning scores below an overall compliance of 95% and IPC Mandatory training compliance falling below the Trust objective of 90% compliance. All RCA's have an action plan completed with objectives to achieve and a timeframe for completion with all having a matron sign off to ensure this has senior level review. Many of the actions are addressed through divisional governance meetings or teams meetings with minutes being taken as well as daily staff reminders on the ward in the form of huddle board meetings. Action plans and compliance are then monitored through the divisions.

An objective to reduce the amount of Cdiff cases reported by 10% is something the trust is thriving to achieve and the end of year totals for C diff identify a 19% reduction in HOHA's for this reporting period.

DGH closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic Clostridiodes Difficile in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic Clostridiodes Difficile within a period of 28 days and associated with stay in the same ward or area, each case is reviewed to establish if they can be linked by time and place and identify any common themes. Should this occur samples are obtained and submitted to Public Health England for ribotyping. This helps to identify wards or areas where patient to patient transmission is likely to have occurred, with enhanced focus on control measures and increased cleaning of the patient areas if necessary.

The terminology of Clostridiodes difficile is not commonly used, therefore further work in terms of communication of this is required to filter down to the wider organisation.

There was one incident identified with two cases of C diff which did meet the criteria for a period of increased incidence. Both cases were reviewed and they had both been admitted to the trust within 48 hours of the positive specimen being received. Neither case could be linked by time or location on the Ward. Both cases were sent to Public Health England for ribotyping which confirmed both samples were different and therefore not a nosocomial infection.

An additional scrutiny panel has been introduced to discuss all cases of C diff internally with ward representatives, microbiologist, antimicrobial pharmacist and IPC Team. This allows oversight and challenge against each case identified, to identify any learning and agree action plans prior to the RCA panel discussion with external colleagues.

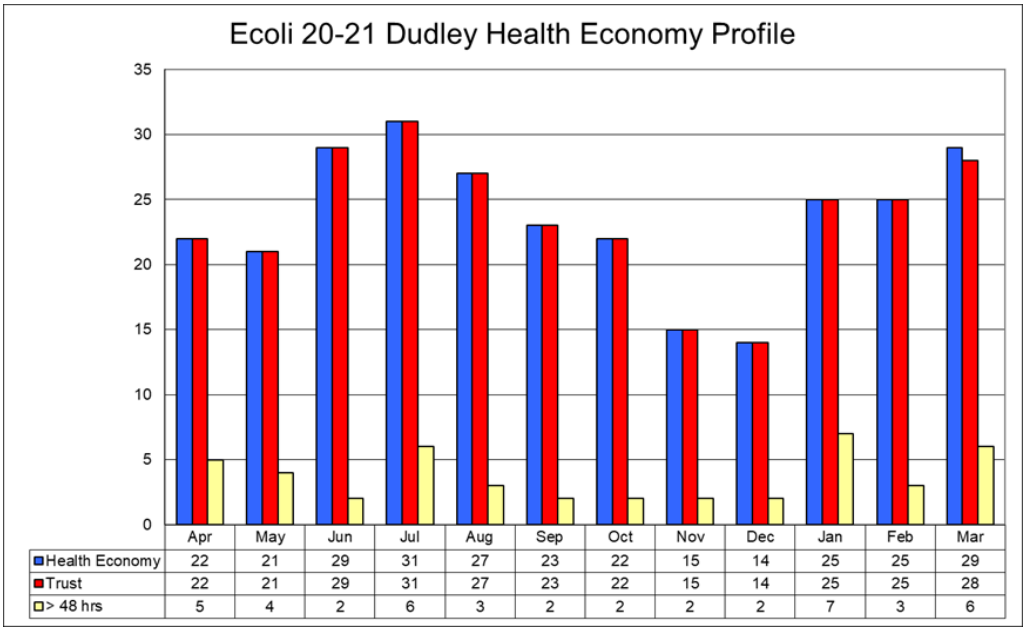
m. GRAM NEGATIVE BLOOD STREAM INFECTIONS – ESCHERICHIA COLI (E- COLI)

Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E. coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E. coli BSI may be caused by primary infections spreading to the blood.

The Secretary of State for Health, (2017) launched an ambition to reduce healthcare associated GN bloodstream infections (BSIs) by 50% by 2021.

Enhanced surveillance of E. coli BSI has been mandatory for NHS acute trusts since June 2011 and is reported monthly to PHE. This is to ascertain themes and trends associated with E.coli bacteraemia within the acute Trust to see where lessons may be learnt. There is work ongoing that is part of the national agenda for health and social care economies to reduce the number of Gram-negative bloodstream infections (BSIs) with an initial focus on Escherichia coli (E.coli). To date this has focused on the management of patients with long term urinary catheters and a catheter passport was introduced in conjunction with the CCG and used across Birmingham and the Black Country.

As detailed in the graphs below 251 E coli infections have been identified with 38 classified as post 48 hour cases. Each post 48 hour case will be reviewed by the IPCT to establish the potential source of the bacteraemia.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	22	21	29	31	27	23	22	15	14	25	25	29
Trust	22	21	29	31	27	23	22	15	14	25	25	28
> 48 hrs	5	4	2	6	3	2	2	2	2	7	3	6

Month	Trust Apportioned >48 hours	Health Economy Total
April 2020	5	22
May 2020	4	21
June 2020	2	29
July 2020	6	29
August 2020	3	27
September 2020	2	22
October 2020	2	22
November 2020	2	14
December 2020	2	14
January 2021	7	25
February 2021	3	25
March 2021	6	29
Yearly Total to Date	**44**	**279**

Epidemiological analyses of Gram- negative bacteraemia data (England)

***E. coli* bacteraemia**

The graph below identifies the trends in e coli infection up until 2020.

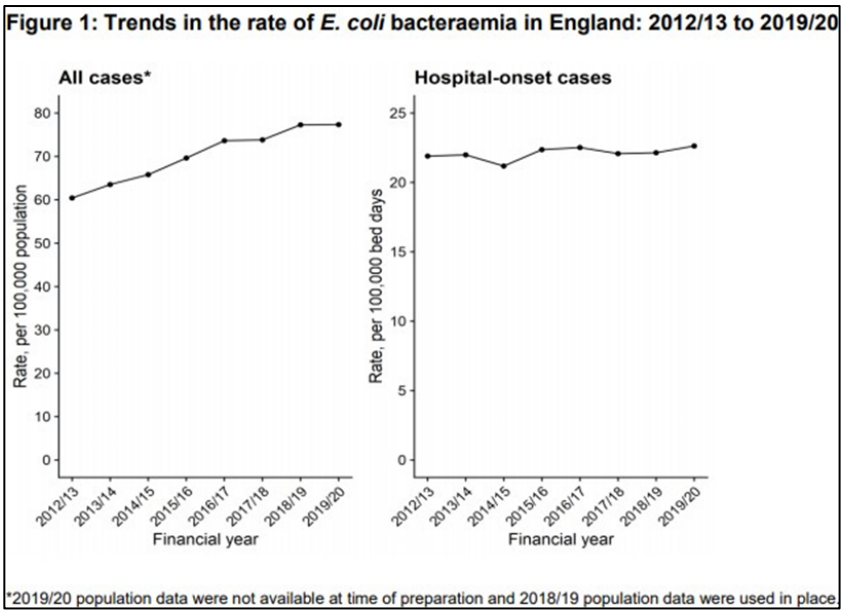


Figure 1: Trends in the rate of *E. coli* bacteraemia in England: 2012/13 to 2019/20

*2019/20 population data were not available at time of preparation and 2018/19 population data were used in place.

During the year 2020/2021 279 cases of e coli bacteraemia have been identified compared to 351 cases in the previous year. This is a total of 26% reduction in overall cases identified. Hospital acquired cases have increased to 44 which is an increase of 37%.

Further work is needed in order to reduce the number of cases reported within DGH and examples of these include a catheter passport which was introduced across Birmingham and the Black Country which due to issues associated with the COVID-19 pandemic the embedding of this has been fragmented.

A simplified algorithm was introduced associated with Urinary tract infections in over 65s within ED and in agreement with the ED lead. Teaching sessions completed for all Pharmacists on management of simple UTIs.

n. VANCOMYCIN/ GLYCOPEPTIDE RESISTANT ENTEROCOCCI (VRE/GRE)

Enterococci are part of the normal bowel flora and can cause urinary tract and blood stream infections.

VRE/GRE may be found in the healthy population thought to reflect inappropriate use of antibiotics in farming.

Mandatory surveillance was discontinued in 2013.

For the period covered in this report there have been 4 cases of blood stream associated infection.

o. CARPOPENAMESE PRODUCING ENTEROBACTERIACEAE (CPE)

The Enterobacteriaceae are a large family of Gram negative bacteria including species such as E. coli, Klebsiella sp., Proteus sp., and Enterobacter sp. They live usually harmlessly in the guts of both humans and animals. They are opportunistic pathogens, capable of causing urinary tract infections, abdominal infections and bloodstream infections (Public Health England (PHE), 2013).

Some of these bacteria develop resistance to antibiotics through various mechanisms, one of them being the ability to produce an enzyme called Carbapenemase which is capable of destroying the β-lactam ring, an essential component of β-lactam antibiotics. The Carbapenemase enzyme makes these organisms resistant to multiple antibiotics, hence the options of treating infections caused by CPE is limited. Antibiotic resistance is a major Public Health concern and stringent Infection Prevention and Control precautions need to be instigated and maintained to reduce the spread of these organisms.

PHE published a toolkit in 2013 to control the spread in healthcare and onwards in the community.

DGH did not identify any cases of CPE during the time period covered by the report

p. NOROVIRUS

Norovirus is abrupt explosive onset of profuse watery diarrhoea which may be accompanied by projectile or violent vomiting. Several cases may occur on the ward within hours. If this occurs the ward must gather information about the patient's affected, this infection is known to be highly infectious. The virus is easily transmitted through contact with infected individuals from one person to another or environmental contamination. In hospital this environmental risk is considerable and outbreaks are common.

Management therefore relies on prompt recognition of symptoms, robust isolation and IPC procedures as well as enhanced environmental cleaning within the area affected.

For the period covered in this report DGFT had no confirmed cases of Norovirus.

1q.COVID-19 PANDEMIC

The World Health Organisation (WHO) issued a press release (Thursday 9 January 2020) announcing the discovery of novel virus identified in China and called for more research. In January 2019 Public Health England declared a National Incident following a preliminary determination of a novel (or new) coronavirus by officials in Wuhan, China.

The Department of Health and Social Care also declared an incident and established an incident team. As human to human transmission escalated globally numerous countries declared outbreaks with increasing pressures on healthcare systems. On the 12th March 2020 WHO declared a global pandemic of COVID-19.

Background

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others more severe disease such as MERS and SARS. Some transmit easily from person to person, while others do not. A novel coronavirus is a new strain that has not been previously identified in humans. The virus was named as SARS-CoV-2 and the infection caused by the virus named as COVID-19.

The Trust has implemented the requirements as identified by NHS England in order to manage the additional pressures on healthcare systems. A COVID19 planning team was established and comprises of all key partners that are required within trust to ensure all aspects of COVID19 are considered and planned for. The Trust is well engaged with all local arrangements and national planning. This work is ongoing and subject to change as national guidance is updated.

Significant changes have been made to how the Trust operates during the COVID-19 pandemic to keep patients staff and visitors safe; face to face training, consultations and meetings were suspended or held virtually to ensure social distancing.

Hospital Acquired COVID-19 Definitions

- **Admission –** defined as day 0
- **Community-Onset (CO) -** Positive specimen date less than or equal to 2 days after hospital admission or hospital attendance.
- **Hospital-Onset Indeterminate Healthcare-Associated (HOHA)** – defined as positive result within 3-7 days after hospital admission.
- **Hospital-Onset Probable Healthcare-Associated (HOHA) –** defined as positive result within 8-14 days after the hospital admission.
- **Hospital-Onset Definite Healthcare-Associated (HOHA) –** defined as positive result within 15 days or more of the hospital admission

A **probable** or **definite** hospital-onset healthcare associated COVID-19 infection is a **patient safety incident** and should be reported and responded to according to the trust's existing policies.

A probable or definite hospital-onset healthcare associated COVID-19 infection **death** is defined as;

- The death of a patient who has a positive specimen result where the swab was taken within 28 days of death and/or COVID-19 is cited on either Part 1 or Part 2 of the death certificate (i.e. the death resulted from a COVID-19 clinically compatible illness with no period of complete recovery between the illness and death).
- The COVID-19 infection is linked to the death which meets the definition of 'probable' or 'definite' hospital-onset healthcare associated infection (see above).

In instances where a patient has had a positive test result and the swab date was more than 28 days prior to death, this death would not be considered a COVID-19 death unless COVID-19 is cited in part 1 or part 2 of the death certificate.

Similarly, the death is not considered a COVID-19 death if there is a clear alternative cause of death that cannot be related to COVID disease (e.g., trauma) and so COVID-19 is not cited in part 1 or 2 of the death certificate.

Public Health England / Reporting, reviewing and investigating hospital-onset COVID-19 cases and COVID-19 deaths (February 2021)

Hospital Acquired Covid-19 Data.

3103 individuals were tested positive for COVID-19 from 1st March 2020 to the 12 April 2021 at The Dudley Group.

In November 2020 PHE/NHSI/E requested that each acute Trust submit a daily return identifying confirming positive cases and at which point during the patients stay did they become positive. Below is the available data 1st December 2020 to 12th April 2021.

Critical Care Data - 1st March 2020 12th April 2021

370 patients were admitted to Critical Care of which 114 patients sadly died. 301 of the 370 patients (89.85%) were community onset against the criteria.

There was no evidence of 36 patients having had a COVID–19 positive screen. However, these patients may have been treated clinically for signs of COVID.

There are 69 patients within the Critical Care data set that will require a review as part of a harm review process. NHSIE/PHE recommend any patient that requires level 2 or level 3 care as part of a hospital acquired COVID positive pathway must be assessed for harm and long term health needs. A harm review will be completed during 2021 and will be reported in subsequent report.

Level 2 care is defined as patient who requires support for one organ failure. Level 3 care is patients who require support for two or more organs that are failing.

Contact Tracing Evidence

Whilst the IPC team and Ocupational Health undertook some limited staff contact tracing during the first wave, it was recognised during the second that a bespoke team was required to meet the national guidance the Chief Nurse supported resourcing a contact tracing service for staff which came into service in November 2020.

To date (16th April 2021) 512 COVID-19 positive staff members have been contact traced (this includes all members of the MDT and PFI staff). This information is fed into the outbreak meetings so that data can be triangulated establishing any potential breaches in the use of PPE or behaviour aspects that may have contributed to the outbreak.

Key themes identified from staff contract tracing have included:

- Changing Rooms
- Breaching PPE – face masks
- Car Sharing
- Smoking Areas
- Communial break areas – Doctors Mess, canteen

In line with trust policy all patients who test positive for COVID-19 are informed if appropriate. All cases are investigated and contact tracing undertaken this includes notifying any potential contacts of exposure to isolate as per national guidance.

All patient contact information is stored on a newly created patient database. Information regarding positive patient/s and contacts are detailed within the file and discussed as part of the outbreak meetings held internally. This system provides assurance and oversight for any patient and staff member that recieves a positive result for COVID 19, allowing triangulation of data and the monitoring of any potential outbreaks across the Trust. This early detection and any remedial action taken to prevent further transmission.

COVID-19 Outbreaks

Outbreaks as defined by PHE (08.2020) two or more cases linked by time and place. Outbreak meetings were established in line with best practice toolkit from NHSI/E.

Each outbreak has an indivudal timeline where all information regarding these patients are Collated and reviewed.

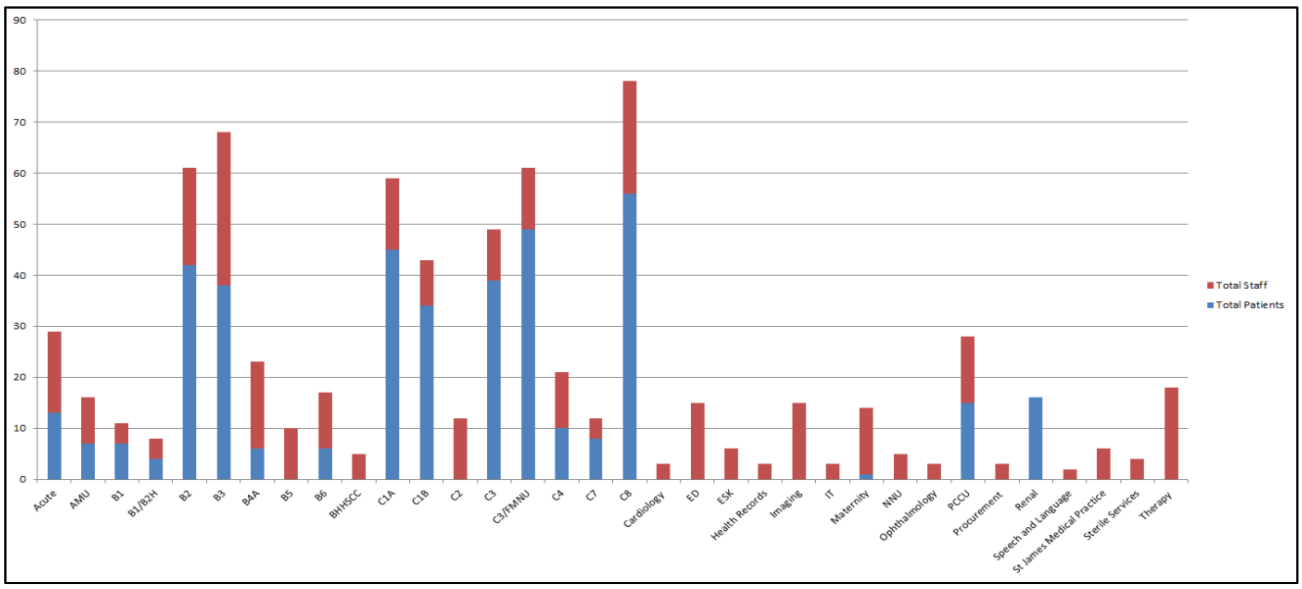
These meetings are recorded and minuted, detailing all attendee discusions and findings. Once this information has been signed off by Chief Nurse/DIPC or her deputy the information is shared with partners via the Outbreak System.

Since September 2020 there have been a total of 52 outbreak areas relating to Covid-19 within the Trust where 2 or more cases tested positive on the same ward that can be linked by time and place.

Once the outbreak areas have been identified within the trust, reviews are undertaken to find potential themes/issues behind the outbreak occurring. Outbreak meetings are arranged and actions identified where necessary.

The screening for COVID-19 came into effect from summer 2020 and this is when the outbreaks started to be recorded and therefore is the earliest available data.

The chart below identifies all outbreak areas since 01.09.2020 to date (11th March 2021). Some areas have more than one occurrence. The breakdown below details positive cases of patients and staff.



Review of Outbreak Areas – Action Plans

Once outbreak areas have been identified within the trust, reviews are undertaken to find potential themes/issues behind the outbreak occurring. Audits are undertaken by a member of the IPC team to identify compliance and where necessary action plans are devised to prevent any further occurrences. Our Estates departments have been responsive in enabling the zoning of departments within wards in response to demand to enable segregation of patients.

Clinical practice audits are completed and compliance scores for each ward are collated. Where improvements are required, advice is provided by the IPC team to the wards to facilitate an improvement in their overall compliance. By reviewing areas, risks and non-compliance can be identified to limit the potential of outbreaks occurring within the trust.

Specialist audits have been devised and implemented for specific visits to off-site areas such as the new vaccination centre at The Black Country Museum in Dudley.

Recommendations from the COVID – 19 Pandemic

- Ensure all patients identified as potential harm via a Structured Judgement Review are referred to the Weekly meeting of harm and a datix completed.
- To set up a harm review panel to discuss level 2 and level 3 patients to review potential harm as a direct consequence of contracting COVID 19 whilst in our care.
- Work with our PFI partners to review the cleaning specification in line with the new cleaning standards.

Dissemination of the learning is disseminated through the divisions and shared with all Trust teams.

r. AUDIT PROGRAMME

The DGH has a programme of audits in place undertaken on all clinical areas and outpatients departments. The IPC Team provide assurance against consistent compliance with evidence-based practice and policies. Each audit completed creates an action plan for review and completion by the ward teams.

These audits are undertaken quarterly to ensure all wards and departments receive monitoring to provide assurance that improvements are being made.
Where a period of increased incidence occurs, risks are identified and the IPC Team undertakes additional audits in accordance with risk requirement, this will be daily initially with an increase to weekly once an improvement and consistency in scores has been identified. Action plans are developed by the clinical areas and these are managed and monitored within the divisions and escalated to IPCG and upwardly reported through the DGH Governance structure.

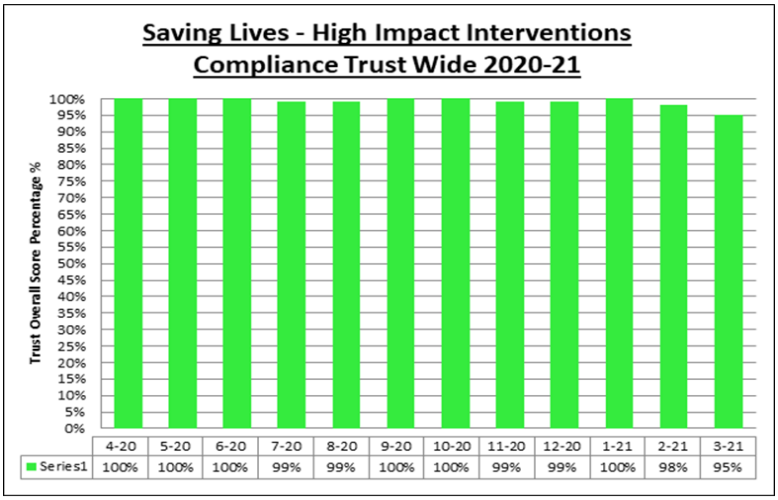
High Impact Interventions

High Impact Interventions relate to key clinical procedures or care processes based on evidence based approach.

The High Impact Interventions are:

- HII 1 – Ventilator Associated Pneumonia
- HII 2a – Peripheral Vascular Access Devices (Insertion)
- HII 2b – Peripheral Vascular Access Devices (Ongoing Care)
- HII 3a – Central Venous Access Devices (Insertion)
- HII 3b – Central Venous Access Devices (Ongoing Care)
- HII 4a – Surgical Site Infection Prevention (Preoperative)
- HII 4b – Surgical Site Infection Prevention (Intraoperative Actions)
- HII 5 – Infection Prevention in Chronic Wounds
- HII 6a – Urinary Catheter (Insertion)
- HII 6b – Urinary Catheter (Maintenance and Assessment)

The clinical nursing team's complete self-assessment practice audits across each ward area and look at the elements of the high impact interventions applicable to their area. Below is an outline of the performance broken down by month for each of the elements highlighted.

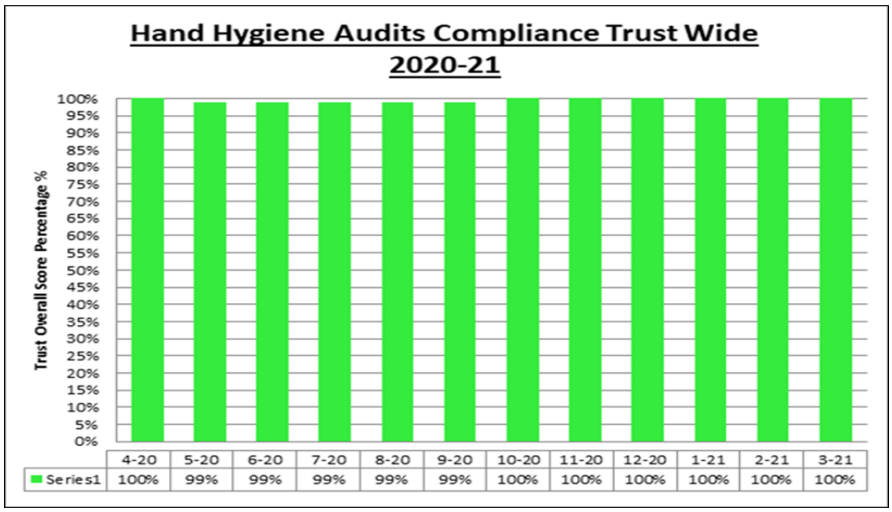


Clinical practice audits have been commenced by the IPC Team to monitor compliance of key infection control issues across the wards and departments such as environmental cleanliness, hand hygiene compliance, equipment monitoring and sharps compliance.

A peer review undertaken by NHSI which observed poor compliance in terms of Saving Lives, hand hygiene and commode audits, however it was noted this was not reflected in the monthly audit scores being submitted. As an immediate action, peer reviews were introduced across all wards and departments and IPC completed quarterly audits set against the IPS Standards in order to identify any gaps in compliance. A new hand hygiene audit tool was introduced in March 2021 which focuses on the 5 moments of hand hygiene compliance across all staff groups.

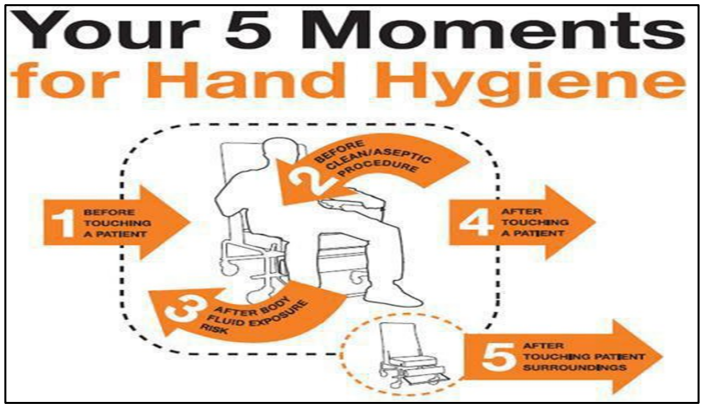
s. HAND HYGIENE AUDITS

Hand hygiene continues to be included in the audit programme. An environmental hand hygiene audit was in place throughout a large part of the year which includes environmental elements. Due to the COVID – 19 pandemic some of the Hand hygiene scores were not uploaded and there were some gaps in submission, therefore the figures in the chart below may indicate compliance based on the data submitted.



The DGH introduced the 5 moments of hand hygiene tool in March 2021 which focuses on opportunities and performance of hand hygiene across a variety of staff groups on each area. This is completed in conjunction with an environmental hand hygiene audit and the hand hygiene audits completed as part of the ward environmental audit programme.

Hand hygiene continues to be audited across all wards and departments, on a monthly basis, this now includes monthly compliance following the WHO 5Moments of Hand Hygiene tool and an example of the 5 moments of hand hygiene tool can be found below:



Patients, visitors and staff are encouraged to challenge staff if they have any concerns about hand hygiene and in cases of repeated non-compliance, concerns are raised divisionally. This is across all staff groups including nurses, medical staff, AHP's and our PFI partners.

Raising awareness of hand hygiene and the 'Bare below the elbow' are consistanly monitored throughout the year.

t. MANDATORY TRAINING

The revised mandatory requirement is to update Infection Control training annually for clinical staff. The previous requirement for this was every 3 years.

The following measures have been introduced to achieve compliance of 90% of clinical staff.

Reduced compliance of infection control training was noted during July 2020 onwards; the trust was under immense pressure due to COVID-19 and associated workforce challenges. Face to face teaching sessions were suspended due to social distancing measures this has impacted training compliance across the Trust. In order to ensure we have systems in place to increase the compliance across the trust:

- There is a direct link for the mandatory IC training on the HUB making it easier for staff to access e-learning.

- Face to face sessions have now been re-introduced with a reduced capacity to ensure compliance with social distancing requirements.

As of March 2021 the trust total is 84.3%. This data is based upon an annual cycle. The reduction in compliance is in part due to the cancellation of several face to face training sessions due to COVID-19. The IPC Training compliance is managed by the divisions and is discussed monthly at divisional meetings. This is then fed through the IPC Group with actions being taken to improve compliance and discuss current progress.

Month	Corporate / Management	Medicine/ Integrated Care	Surgery	Clinical Support
April 2020	84%	87%	88%	90%
May 2020	93%	86%	87%	90%
June 2020	89%	88%	86%	91%
July 2020	85%	87%	84%	88%
August 2020	88%	89%	85%	85%
September 2020	89%	90%	87%	86%
October 2020	89%	88%	86%	85%
November 2020	89%	88%	85%	82%
December 2020	88%	89%	85%	83%
January 2021	85%	87%	82%	77%
February 2021	81%	83%	78%	75%
March 2021	82%	87%	81%	80%

u. INFLUENZA VACCINATION PROGRAMME

There are 4 types of seasonal influenza viruses, types A, B, C and D. Influenza A and B viruses circulate and cause **seasonal epidemics** of disease.

Seasonal influenza is characterized by a sudden onset of fever, cough, headache, muscle and joint pain, severe malaise, sore throat and a runny nose. The cough can be severe and can last 2 or more weeks.

Illnesses range from mild to severe and even death. Hospitalization and death occur mainly among high risk groups. Worldwide, these annual epidemics are estimated to result in about 3 to 5 million cases of severe illness, and about 290 000 to 650 000 respiratory deaths.
(WHO, 2018)

The most effective way to prevent the disease is **vaccination**. Immunity from vaccination wanes over time so annual vaccination is recommended to protect against influenza.
(WHO, 2018)

The Dudley Group held an influenza flu campaign running from August 2020. The campaign included:

- Peer vaccinators across the trust assigned with an online flu competency to be completed.
- Flu posters created and distributed across the trust, via the trust website and on social media.
- New strapline for the year introduced which was added to t shirts and sashes for peer vaccinators to wear and it was used in all communications on the trust intranet and on social media
- A screensaver was developed prior to the launch to display across trust computers

- Ward based vaccinators were recruited as well as sessional vaccination sessions at the hospital health hub
- Staff health and wellbeing provided advice and guidance for staff that had underlying conditions or allergies.

This year the Trust made excellent progress with regard to the 2019/20 flu vaccine campaign having achieved 83% of front line staff vaccinated which was an increase from the previous year. Peer vaccinators were identified in all ward areas and departments to increase the number of opportunities for staff to receive the vaccination along with additional sessions held at the Health Hub.

v. LINK WORKER PROGRAMME

The IPCT continues to provide the Infection Prevention and Control Link Nurse programme.

Link Worker sessions are run every second month and provide an educational session and, usually include a guest speaker to support the nurses to maintain their enthusiasm and commitment.

Numerous topics are covered and have included for example, hand hygiene, MRSA screening and outbreak management. The sessions run for approximately two hours.
The aim of these sessions is to update on any new guidance / policies and to increase the flow of Infection Prevention and Control communications There is a link worker in every department both inpatient and community areas and they are key in undertaking monthly audits of practice.

Throughout this year several face to face link worker sessions were cancelled due to the COVID-19 pandemic. Audit work continued by the link workers and there are plans to reintroduce the link nurse programme.

w. INCIDENTS AND OUTBREAKS

Cystoscopy Pseudomonas Decontamination Investigation March 2020 – reported as an SI

Patients who had under gone cystoscopies at the Corbett Urology cystoscopy suite were identified as having pseudomonas infections ranging from urinary tract infections, testicular infections and discitis. The suite environment and scopes were sampled and pseudomonas was also identified. The pseudomonas samples were riybotyped and found to be indistinguishable.

The Clinics were suspended while the investigation was conducted, Environmental audits were completed and some recommendations made which were actioned by the departmental leads. A review of the decontamination sinks was undertaken, all items should be single use and this was implemented. The department underwent a full Hydrogen peroxide vapour clean prior to reopening. The management of the outbreak was monitored through Risk and Assurance Committee.

Klebsiella Outbreak January 2021

5 patients were identified via the trust infection control outbreak meeting as having Klebsiella pneumoniae in a variety of clinical sites which was subsequently treated as a Klebsiella Pneumonia outbreak in Critical Care.

An outbreak meeting was held on the 27.01.2021 concerns were raised by the Consultant Microbiologist regarding 2 patients that were suffering with klebsiella bacteraemia on the Critical Care Unit (CCU). Further investigation identified that there have been 5 patients in total in whom a Klebsiella pnuemoniae had been isolated from a clinical sample. All samples were sent for typing and returned as being indistinguishable indicating cross infection.

An environmental review of the Critical Care Unit was undertaken on 29.01.21. The review included observation of practice and swabs were undertaken of all lines and wounds and swabs were taken of the environment all environmental swabs were negative.

Daily Hand hygiene audits commenced in the department with initial low scores. These were undertaken by ward staff as well as independent audits by the IPC Team.

This incident was included in the Chief Nurse Report and the Quality and Safety Committee report. This incident goes through the IPC Group for monitoring.

The Outbreak policy is being reviewed for the next financial year and all policies that have been reviewed can be found in section 9.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection

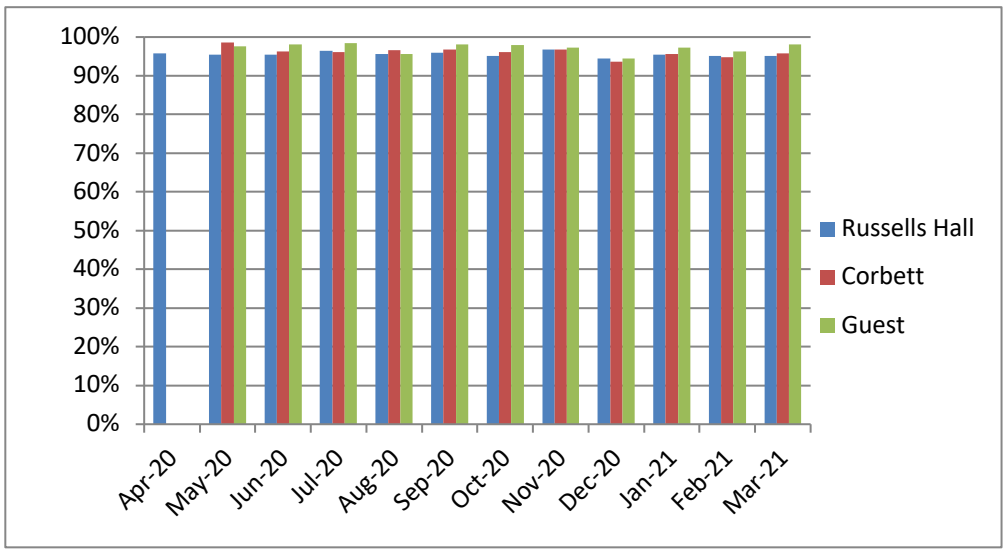
2.1 PROVIDING A CLEAN SAFE ENVIRONMENT

ESTATES AND FACILITIES

Environmental Audits

The Trust recognises its duty to provide safe and clean environments where patients, staff and other visitors can expect to be protected from the risk of Infection. The environmental cleaning service is provided by Mitie Facilities Management as part of the Trusts PFI contract with Summit Healthcare (Dudley) Ltd (Summit). The contract is managed by the Trust's Facilities and Property Development Department. Environmental audits are undertaken by the Trust Auditors in partnership with Mitie and clinical staff where possible.

The table below outlines the technical cleaning scores / audits against the national 49 cleaning elements as well as the PFI service level for The Trust for this reporting period (Apr 20 – Mar 21);



Cleaning scores across the Trust have continued to plateau over the past 12 months. In the main, Russells Hall, Corbett and Guest Hospital continue to achieve an overall monthly score above the 95% threshold on a monthly basis, although December 20 was a month where all sites fell below 95%. An average of 163 audits are carried out each month although this was reduced during the first phase of COVID-19 Apr/May 2020. Since this time, the Trust has continued to audit all areas of the hospital as outlined in the Trust's Cleaning and Disinfection policy and continued to apply the performance management mechanisms within the PFI contract throughout this period. The Trust's Facilities Team has worked closely with Summit and Mitie during this time.

Whilst technical audits are carried out by the Trust's audit team, with Mitie attendance, more frequent attendance by the clinical team is encouraged. Access to rooms/areas is not always available at the time of the audit but as many rooms as possible are audited at each session. It is good practice for a minimum of 50% of each area to be audited in one session, making the audit representative of the whole area.

Wards have received a detailed clean after concerns were raised with the level of cleaning in some areas. Often these areas of concern were 'attention to detail' to include the cleaning of floor corners/edges, storage areas etc, as well as other' environmental maintenance aspects such as high level dust.

A 'cleaning review' with the Trust, Summit and Mitie is being scheduled to take place during the 2021/22 financial year which will entail a review of the current service level agreement with consideration being given to the National standards of healthcare cleanliness 2021 which are expected to be issued during April 2021.

PLACE 2019

PLACE is the national system which focuses exclusively on the environment in which care is delivered; it does not cover the clinical care provision. PLACE was last carried out at Dudley Group Foundation Trust during November 2019. With regard to the PLACE 2020 programme and COVID-19 there were several factors to be taken into consideration including how sites were operating at the time, the requirements around social distancing and the safety of assessors and staff, and as a result a decision was

taken by NHS E&I for the annual PLACE collection for 2020 to not go ahead due to the operational difficulties and associated risks.

Following PLACE in November 2019, a Trust action plan was produced and whilst some of the actions have been followed through to close out, others such as the availability of a 'Changing Places' facility have been worked through and it is envisaged that works will commence on-site shortly. All cleaning concerns on the PLACE action plan were completed and in order to provide reassurance on cleaning through the pandemic, the Trust's audit team have continued to monitor all areas providing monitored scores and ensuring rectification. In addition, the Trust's Facilities team have worked with the PFI provider, Mitie, to ensure the identified maintenance tasks on PLACE have also been carried out/scheduled. The remaining actions will be worked through with Executive Lead involvement. Cleaning scores throughout this year have been variable and have contributed to some of the outbreaks identified during the pandemic.

The Trust are currently in the process of having a new Acute Medical Unit (modular building) on-site at Russells Hall Hospital and the PLACE requirements have also been taken into account in its design.

Currently the Trust are waiting to hear whether the 2021 programme will take place, but are looking to undertake some local assessments when it is safe to do so.

HEALTH AND SAFETY

The Dudley Group Foundation Trust has a legal obligation to protect employees at work, in accordance with the Health and Safety at Work Act 1974. Since the outbreak of SARS-COV-2, a respiratory disease, in December 2019 in China, and here in the UK in February 2020, social distancing measures have been implemented across the trust to limit the transmission of the virus within the workplace.

A number of measures have been implemented across the trust to aid social distancing in non- clinical areas such as breakrooms, changing facilities and offices.

An audit was carried out between the 2nd and 4th of December to determine the level of compliance across the trust. This was followed up with another mini audit on 09-10th December to look at the areas that were previously non-compliant with the risk assessments and Covid secure declaration, and again in March 2021.

The social distancing audit will be carried out by the health and safety team on a quarterly basis to ensure that there is ongoing compliance and that risk assessments remain suitable and sufficient in line with emerging government guidance.

The short audit was performed by the trust health and safety team, for areas that were previously non-conformant with the risk assessments and Covid declaration sheets as identified from the original audit. The results of the original audits were discussed at the trusts task force meeting on the 7th December and the heads of each directorate emailed those areas to ask for the risk assessments to be emailed to the health and safety team. A message was added in the daily communications email too. The risk assessments received have been added to the table below with the existing risk assessments. Areas that previously had no Covid declaration on display were revisited on the 18th December

and again on the 15th March 2021. All areas are due to be re-audited in April 2021 to ensure that areas remain compliant and that risk assessments have been reviewed to reflect current government guidance and health and safety control measures.

Results:

Table 1 shows the compliance across the trust for the areas audited as of 18:00pm on 16/04/2021.

	Risk assessments	**Covid declaration**
Compliance as a percentage (March 2021)	100 %	100 %
Increase in compliance from first audit (3/4th Dec 2020)	30.60%	50.99%

The table shows a marked increase in compliance in both areas with risk assessments available increasing to 100 % from 30.6%, and Covid secure declarations being displayed up from 50.99% to 100%.

Learning outcomes:

A folder for each department/ward has been added to the health and safety drive for holding the Risk assessments. This allows the Health and safety team to access the risk assessments, received by email, by department/ward.

Some risk assessments were sent incomplete where the department/ward name had been missed off the top of the form and no actions or signatures were included on the form. This is an area of bad practice, all risk assessments should be signed by the assessor and the departmental manager.

Face Fit Testing

The Trust has positive assurance in the form of 2 fit to fit accredited instructors enabling the trust to key train. The Dudley Group are able train the trainers without the need to rely on external providers therefore increasing uptake, amount of fit test trainers and driving down costs.

The trust has currently 90 trained fit test key trainers across the organisation.

The Trust procured 3 portacount machines during the pandemic due to the sheer volume of face fit testing required on FFP3 masks. The portacount machines in the Trust reduces the face fit testing time to 9 mins 20 secs per face fit test – compared to the average test time of a minimum 45 mins. This has had a massive impact on time taken from wards and departments for face fit testing, which means that we have more clinical time spent on the wards. The FFP3 used within the Trust was determined by regional supplies, which meant that as the FFP3 masks changed to a different type, more face fit testing was required.

Due to the uncertainty around the delivery of FFP3's throughout the pandemic, the Trust PPE cell made the decision to procure 2000 reusable half face masks. This strategy was

implemented so that areas where FFP3 usage was high would have the benefit of staff having their own respiratory protective device; the trust arranged a continued with HSG 53: Respiratory Protective Equipment at Work. Staff members were trained on how to maintain and document the maintenance as well as don and doff the masks as part of the staff face fit testing. This initiative allowed the trust resilience in respect that there was a less reliance on centrally delivered FFP3 masks, this also had a positive impact on FFP3 usage within the trust.

The Trust has carried out around 7000 face fit tests since March 2020. The Trust continue to carry out face fit tests on a regular basis, this is mainly for new staff, returning staff or due to new masks being delivered to the Dudley Group.

2.2 WATER SYSTEMS MANAGEMENT

The Water Safety Group (WSG) oversees all aspects of water safety for the PFI Estate. The Group is chaired by Summit Healthcare Limited who are the owners of the PFI Estate. The members of the group included:

- Assistant General Manager (Summit)(Chair)
- Responsible Person for Water Safety (Mitie)
- Authorising Engineer for Water Safety (Mitie)
- Estates Manager (Mitie)
- Technical Compliance Manager (Trust)
- Consultant Microbiologist (Trust)
- Infection Prevention and Control (Trust)
- Authorising Engineer for Safety

A regime of regular water quality testing is in place across the PFI estate which has been agreed by the Water Safety Group. The tests include legionella and Pseudomonas Aeruginosa. As previously reported, no issues of significance have been identified in the past 12 months.

The Authorising Engineer (AE) for Water Safety has completed the required Audit on the arrangements in place. The outcome of the audit was described by the AE as site inspections suggest that the system is mostly well managed and maintained with only minor issues identified which are being actioned.

Flushing of underused outlets has been on agenda of the Water safety Group on many occasions as there are over 400 outlets being flushed twice weekly. The group endorsed a survey of the outlets conducted my Mitie which via electronic monitoring connected to the pipework records the actual usage of the outlets. From the results of the survey, which is ongoing, this has removed significant numbers of outlets, mainly wash hand basins, from the flushing schedule.

Pseudomonas risk assessments have been carried out by the Authorising Engineer, which are awaiting ratification by end users and the WSG.

Ventilation

During early stages of Covid 19 wave 1, mechanical ventilation serving Main Theatres, ICU and other Covid cohort areas were converted to negative pressure. This was at the

request of Clinicians to contain, dilute and remove potential contaminants within the space, avoiding overspill into adjacent areas. This was also endorsed by the DIPC. Following guidance received from NHSi in June 2020, indicating that positive areas should not be converted to negative, the modified systems were converted back to their positive pressures as per design and HTM, providing greater dilution of any airborne virus particles with fresh air changes.

Where ventilation systems were modified, performance verification was carried out by skilled and experienced Technicians. When converted back to their design parameters, the systems were verified by third party specialists.

In Covid Blue areas (C5 and B3) To supplement ventilation in patient bedded areas, which only have natural ventilation in the form of opening windows, extractor fans were installed into fixed pane window frames. This also aided with reducing oxygen enrichment from patients receiving high flow oxygen treatment.

As per the latest HTM 03 requirement, critical ventilation systems including ICU, MHDU, Renal, Theatres, CCU, Lung Function, Endoscopy, Mortuary etc (as defined in HTM 03-01 Part B - 4.7) are annually verified for system performance is in accordance with HTM 03-01, design, and room data sheet (RDS) requirements. Although the ventilation systems serving non critical areas, which were designed and installed to HTM2025 are inspected in accordance with HTM 03, there is currently no requirement for systems to be checked for performance at the grilles. The Trust will instruct Mitie FM to routinely check and confirm system performance of all non-critical ventilation systems are in accordance with original design and RDS.

Following HSE inspections, it has been requested that donning and doffing areas have adequate ventilation air changes and these defined areas have been prioritised to confirm their performance.

2.3 MANAGEMENT OF DECONTAMINATION

The Dudley Group NHSFT do not currently have a Decontamination Lead at the trust. In order to ensure there are processes in place this has been added to the trust risk register:

- Any medical device non-compliance with the Decontamination Policy to be logged via datix
- A suitable person to be agreed to take on the role of decontamination lead
- An incident identified where patients developed pseudomonas infections in July 2020 linked to urology outpatient area. Investigations and actions undertaken in relation to the incident and scoping was suspended for a period of time while the source of the infection was identified. This is now complete and service is fully functional.
- An authorising engineer for decontamination had been identified

ANTIBIOTIC STEWARDSHIP

Antimicrobial Stewardship Report 2019-20

The following report provides an update and an assurance of compliance with standards set out by Health and Social care IPC code of practice for Antimicrobial stewardship,

Department of Health “Start Smart then Focus” and NICE NG15 (2015) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicines use.

All national CQUINs were suspended for 2020/2021 due to pandemic.

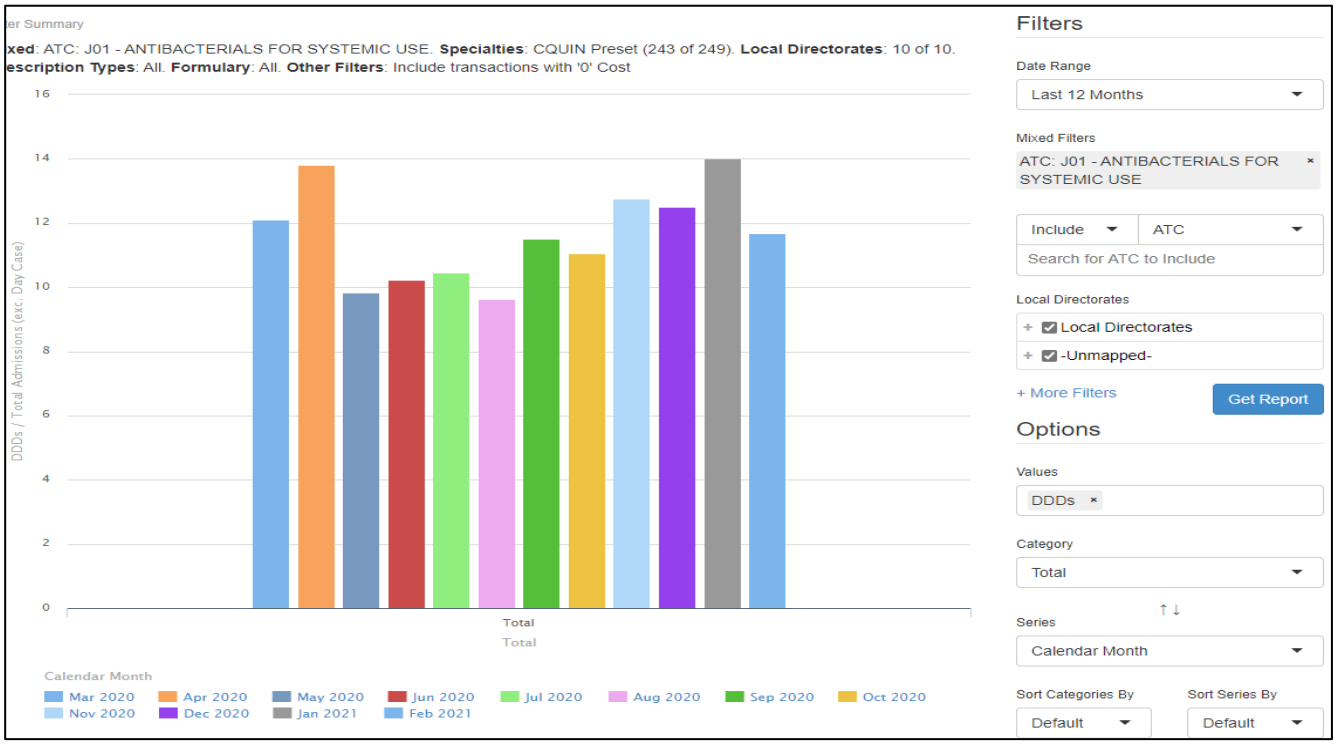
Antimicrobial Consumption

The unprecedented times have fluctuated antimicrobial use significantly. The detail analysis will be performed once the pandemic ends.

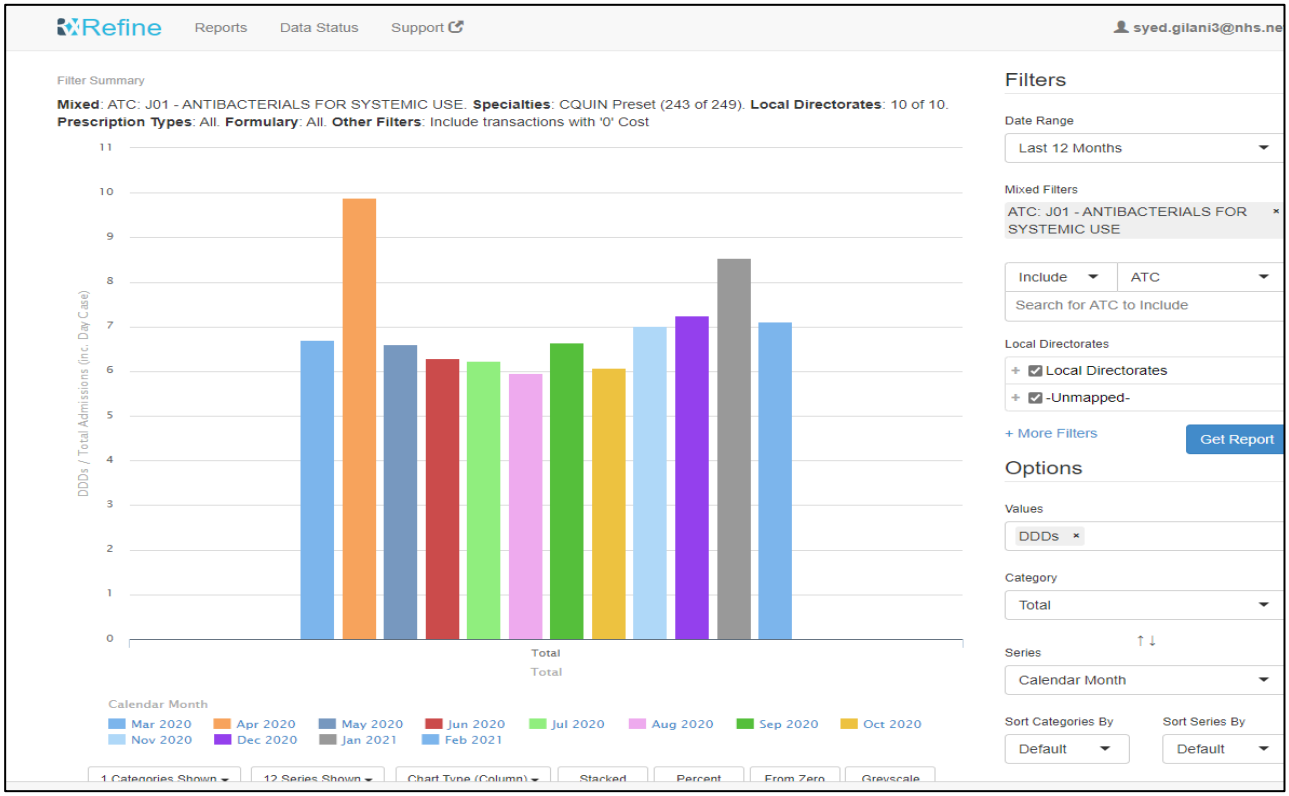
Total Consumption

Consumption during Covid-19 Pandemic

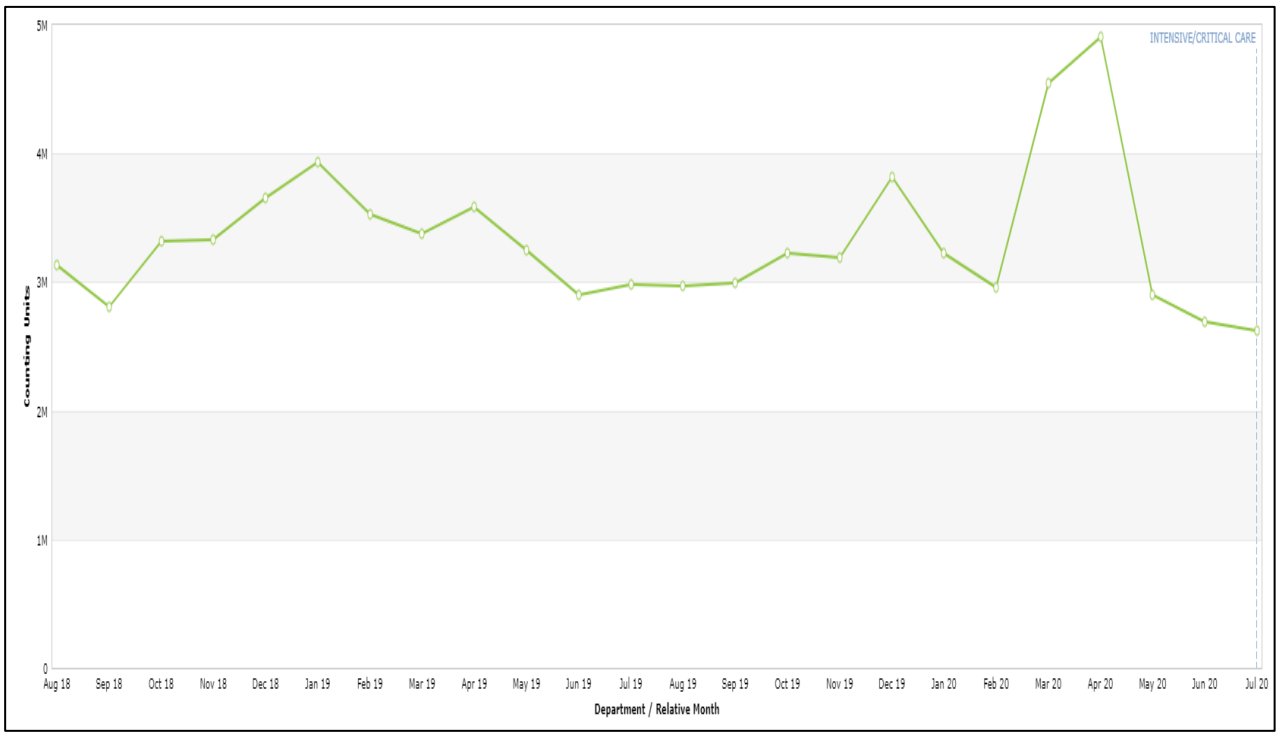
Consumption of antibiotics data excluding day case admission data



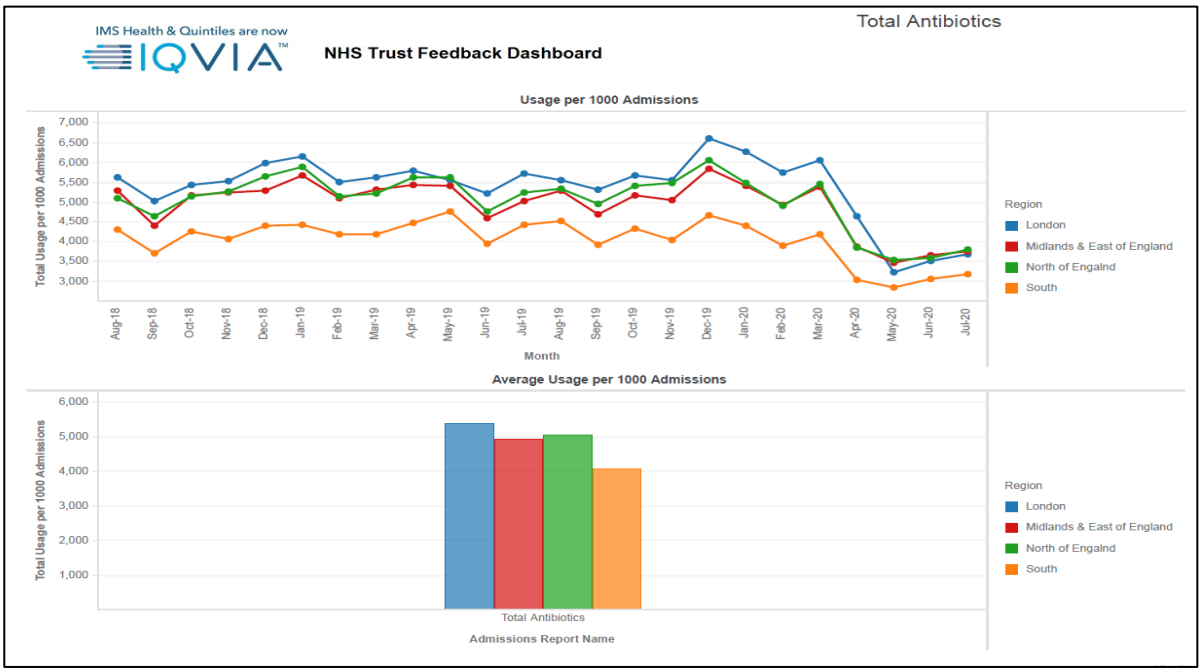
Consumption of antibiotics data including day case admission data



National antibiotic consumption on intensive care units

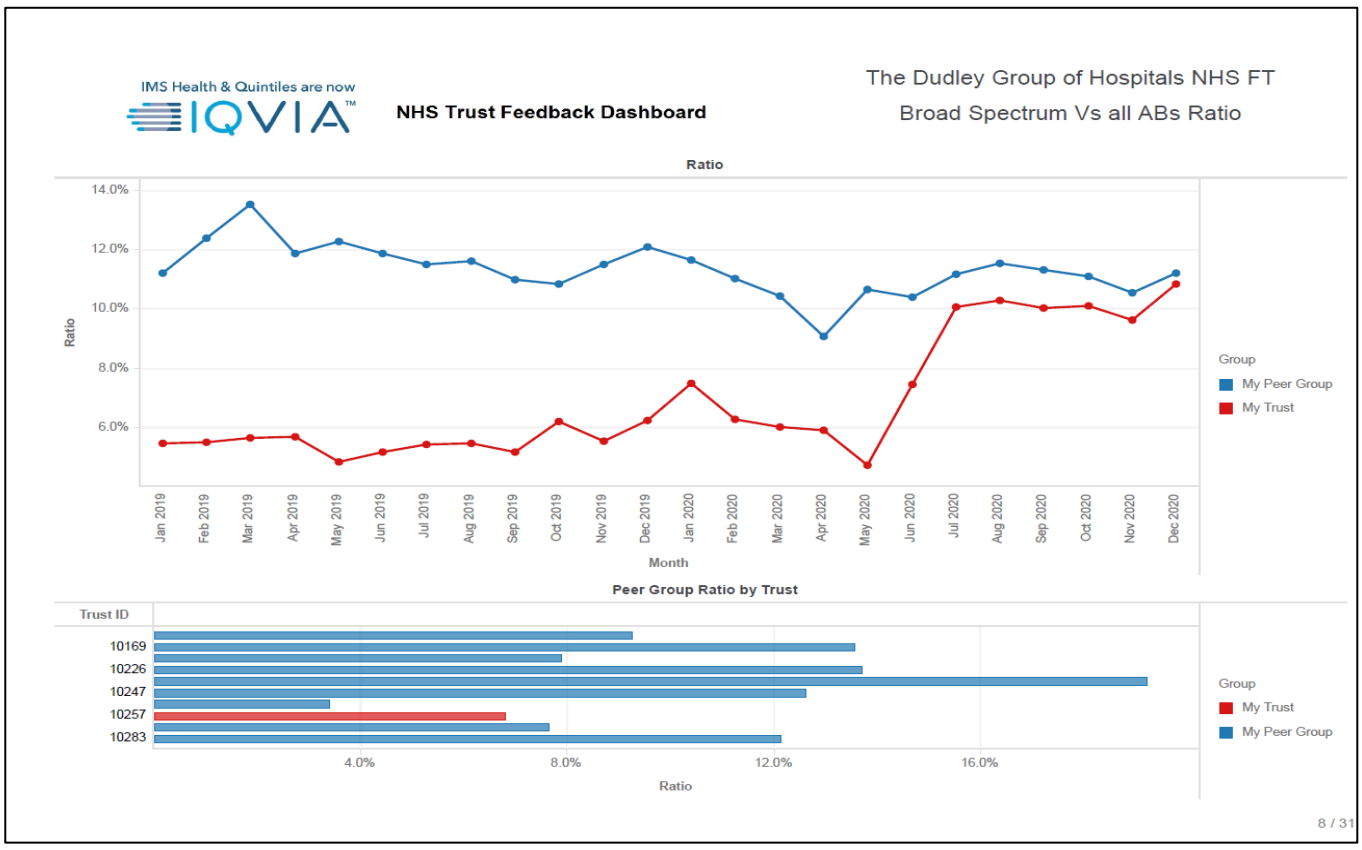


National antibiotic consumption per 1000 admission

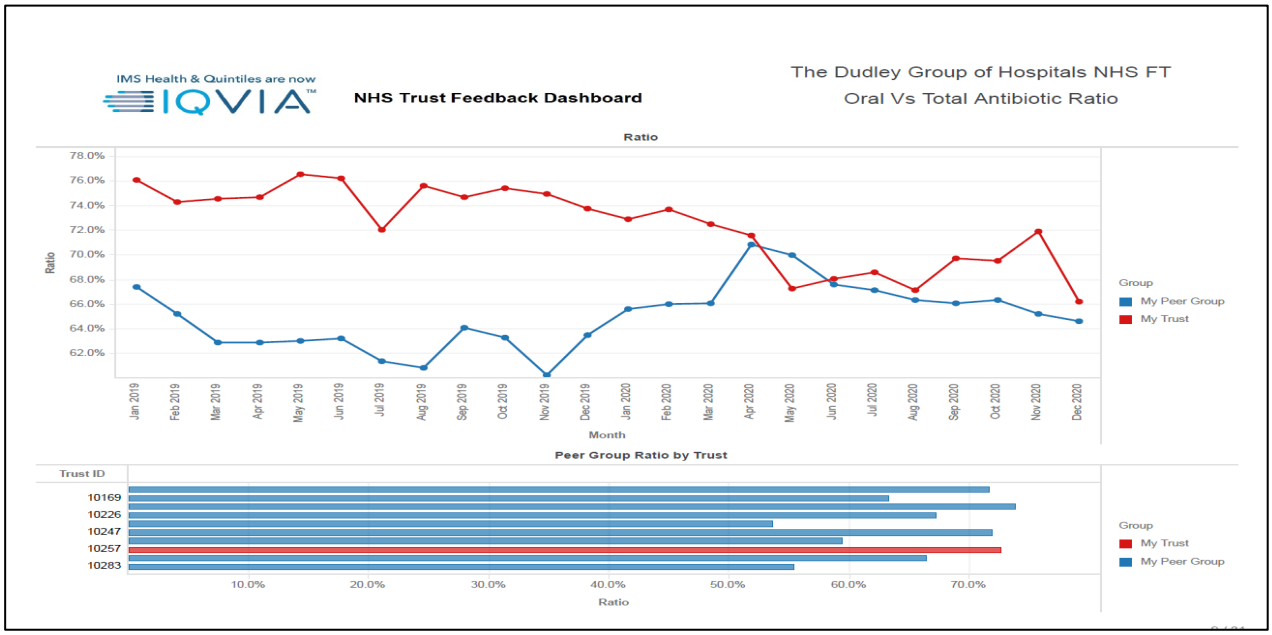


Ratio of Oral vs IV

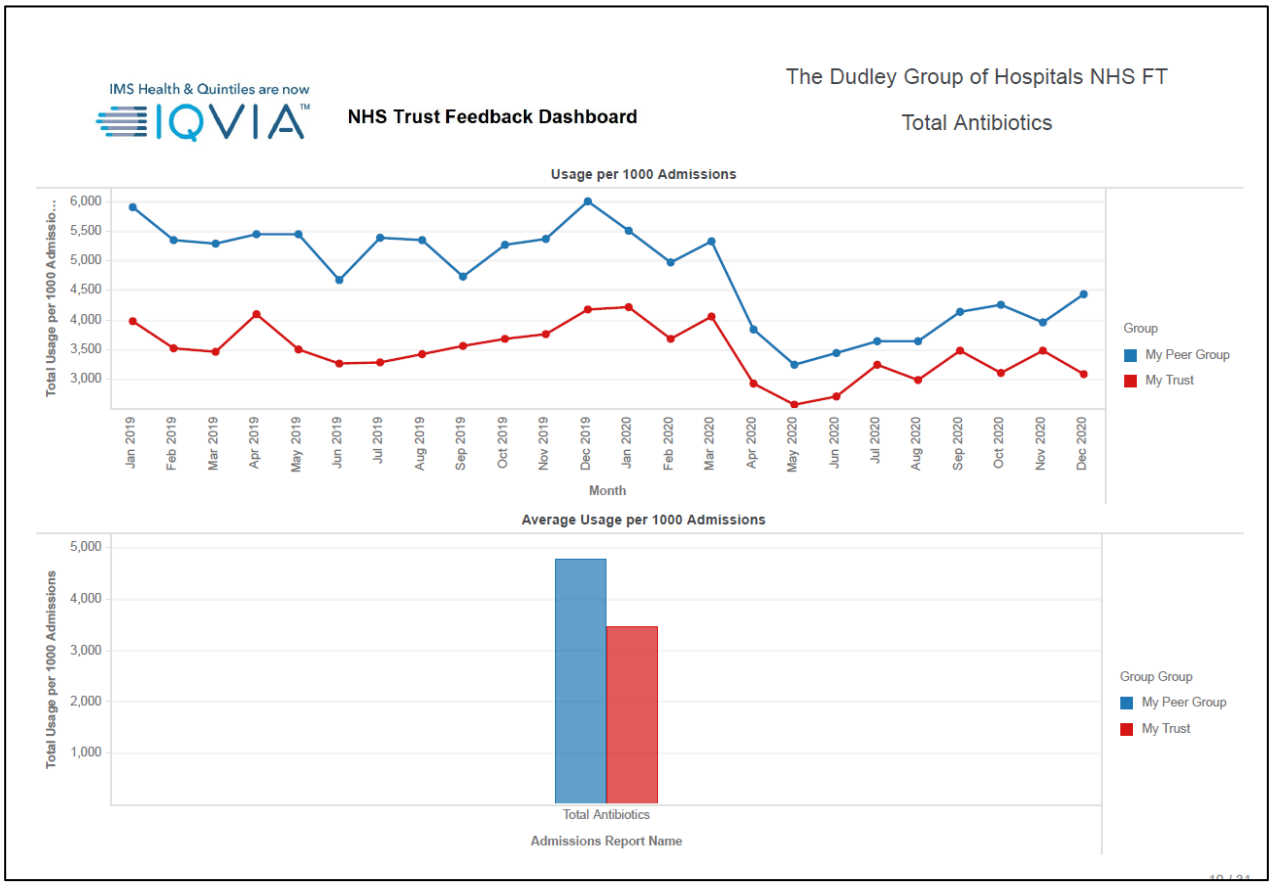
Antibiotics



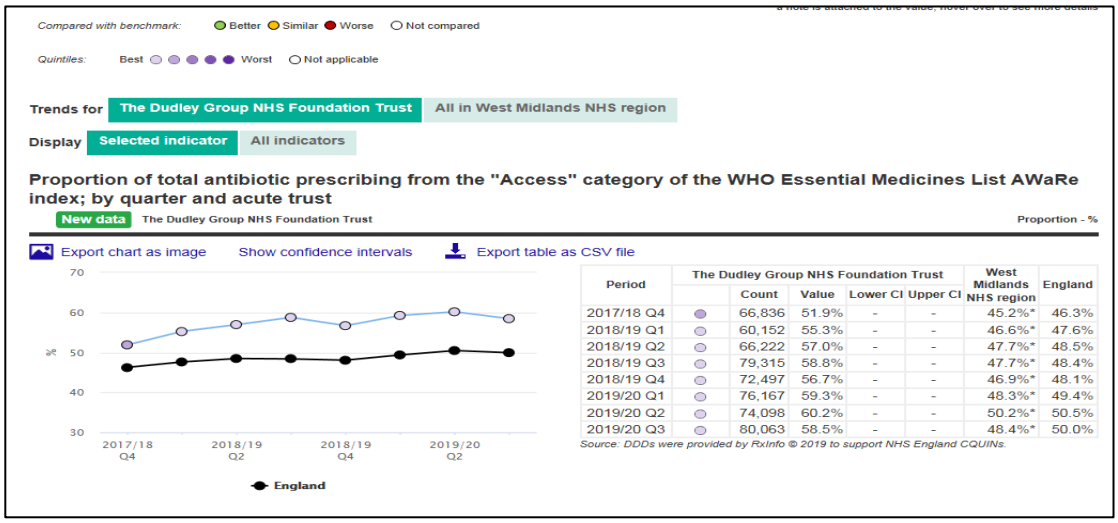
Oral vs Total antibiotics Ratio of The Dudley Group



Total antibiotics consumption The Dudley Group compared to peers



The Dudley Group NHS Foundation Trust is among the best quantile in England for using access list antibiotics.



Period	The Dudley Group NHS Foundation Trust				West Midlands NHS region	England
	Count	Value	Lower CI	Upper CI		
2017/18 Q4	66,836	51.9%	-	-	45.2%*	46.3%
2018/19 Q1	60,152	55.3%	-	-	46.6%*	47.6%
2018/19 Q2	66,222	57.0%	-	-	47.7%*	48.5%
2018/19 Q3	79,315	58.8%	-	-	47.7%*	48.4%
2018/19 Q4	72,497	56.7%	-	-	46.9%*	48.1%
2019/20 Q1	76,167	59.3%	-	-	48.3%*	49.4%
2019/20 Q2	74,098	60.2%	-	-	50.2%*	50.5%
2019/20 Q3	80,063	58.5%	-	-	48.4%*	50.0%

Source: DDDs were provided by RxInfo © 2019 to support NHS England CQUINs.

Antimicrobial Prescribing Snap Shot Audit

Dudley Group NHS Foundation Trust - Snap shot audit			
22 June 2020			
		Percentage	Regional target
Number of patients audited	458	-	
Allergy Status recorded on chart (NKDA, Yes, No)	453	98.9	> 98%
Number of patients with an allergy who have the nature of the allergy documented	66	49.3	> 98%
Number of patients on Antibiotics	165	36.0	
Number of Patients on intravenous antibiotics	72	15.7	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	19	26.4	
Number of patients where total course over 5 days (>7days Jan 2013)	6	3.6	
Number of patients where stop / review date documented on the prescription chart	48	29.1	> 70%
Has the indication been documented on the chart/notes?	126	76.4	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	2	2.8	< 10%

The Dudley Group NHS Foundation Trust

All the results from the snapshot audits carried out over the last year have shown significant improvement.

Current data shows:

- A reduction in the proportion of patients on antibiotics
- A reduction in the nature of allergy documentation
- An increase in the relative proportion of patients on a carbapenem
- Reviews not always documented
- Allergy nature documentation better than last Quarter. EPMA should improve as it is a mandatory field on electronic prescription
- Trust wide snapshot audit of antimicrobial prescribing was completed in February 2021
- Currently working on an IT solution for easy data collection.

The audit tool has been modified to collect more useful information i.e. indication and compliance with Trust guidelines. Nature of allergy is further clarified during the medicines reconciliation process by ward pharmacy teams when needed.

The documentation of stop/review date seems low however; data collected within the snapshot audit is limited to prescription charts and does not include documentation or stop/review in the medical notes.

Patients on restricted antibiotics e.g. meropenem & piperacillin/tazobactam (which are not recommended in the Trust guidelines or approved by microbiology) are referred to the antimicrobial pharmacists.

The pharmacy team monitor and raise awareness at ward level on how to correctly document allergy status on drug charts. Snap shot audit was carried out across Trust in February 2021 as well but the data has not been analysed yet as all audit work was stopped due to Pandemic.

Interventions over past 12 months to improve Antimicrobial Stewardship at DGH

The targets were achieved with the help of multiple initiatives i.e.

- Executive level reporting to influence change.
- Project group formed including medical director, chief pharmacist, AMS team, Sepsis leads and service improvement.
- Antibiotic awareness week campaign (completed).
- ASG (Feb 2021) obstetrics guidelines updated.
- ASG (Feb 2021) Gentamicin prescribing guidelines updated.
- Critical care Gentamicin Prescribing and monitoring guidelines updated.
- NICE guidance baseline assessment completed.
- Audit tool designing for antimicrobial prescribing on EPMA in progress.
- Antimicrobial usage during surge is being analysed locally and nationally. Report suggest surge in use (admission data might have affected)
- Remdesivir guidelines added to Microguide for easy access
- EPMA antimicrobial prescribing TDM modules are being tweaked to improve them further.

- EPMA antimicrobial prescribing module in place so far no major issues, work being carried out to increase clinicians awareness on ward level.
- Patient safety bulletin published online and sent to all staff.
- Hub communication/ screen saver produced to raise awareness.
- UTI in over 65s simplified algorithm for ED in agreement with ED lead.
- Discussed and shared plans at West midlands Antimicrobial Pharmacists Group.
- Junior Dr antimicrobial prescribing teaching sessions completed.
- Teaching session completed for all Pharmacists on management of simple UTIs.
- Antimicrobial stewardship section in Trust wide Governance newsletter.
- Acute medicine Junior Drs are involved for assisting in data collection.
- Antimicrobial stewardship session delivered to community team.
- Feedback to the divisions provided via ASG.
- OPAT virtual ward rounds started (Antimicrobial Pharmacist, Microbiologist and In-charge OPAT Nurse).
- Monthly Antimicrobial stewardship report provided monthly to Infection Prevention and Control Group, Drugs and Therapeutics Group &Medicines Management Group.

Education and Training

Mandatory training for clinicians in antimicrobial prescribing and stewardship continues to take place. All doctors new to the Trust are provided with antimicrobial training at induction. Better Training Better Care for FY1 and FY2 doctors in Antimicrobial Prescribing received excellent feedback from the participants. Additional training sessions have also been carried out through the year when guideline changes have occurred.

Teaching sessions for CMTs are delivered around antimicrobial stewardship and infection management.

Grand rounds around CQUINs and antimicrobial stewardship is delivered whenever required.

Pharmacists receive regular feedback on antimicrobial prescribing in their clinical areas after the snapshot audits, pharmacist prescribers' complete online modules on antimicrobial prescribing.

Feedback is provided to clinicians after every RCA for C. diff infections. The newly recruited band 7 Specialist Antimicrobial Pharmacist will be enrolled onto an independent pharmacist prescribing course which will further strengthen the antimicrobial stewardship activities across the Trust.

Research

AMS team is always looking for research opportunities and is involved in all the studies carried out in Trust around infection management.

AMS team completed a study in collaboration with acute medical team around prevalence of increasing beta lactam resistance in gram negative organisms at DGH which has been published.

AMS team also contributed to the development of national guidelines for treatment of CPE infections.

Plans for 2021/2022

- Assess the impact of Covid -19 on antimicrobial stewardship and consumption after the pandemic ends.
- Review guidelines in view of new NICE guidance issued in coming months.
- Continue working as a part of sepsis work streams: created "Sepsis team" (4x sepsis nurse practitioners band 7s + 2 x antimicrobial pharmacists+ Consultant Physician)
- Focus on drive for IV2PO switch – septic patients flagged to antimicrobial team. Reinforce the need for a high standard antimicrobial stewardship at pharmacist clinical huddles.
- Training sessions with all pharmacists to highlight the changes and rationale.
- Engage clinicians from medical and surgical divisions to attend ASG meetings and feedback to respective directorates.
- Regular snap shot audits to assess antimicrobial prescribing.
- Increase the frequency of AMS ward rounds currently 3 days a week on critical care, 1 day a week on Medical HDU and 3 days a week on acute medical wards.
- Regular communication in the form of patient safety alerts, screen savers, trust wide communication emails on changes in processes and guidance.
- Scope development of antifungal stewardship.
- Support postgraduate diploma pharmacists in conducting clinical audits as part of their infectious disease module.
- Support 2021/22 pre-registration pharmacists with antimicrobial audits if required.
- Patient safety bulletins around arising issues over the year.
- Organise and promote Antibiotic awareness week 2021.
- Identify opportunities for research and development around antimicrobial stewardship.

3. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion

- At The Dudley Group NHSFT there is a dedicated communication team. In cases of outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is sought.

- Communication boards are located across the Trust providing patients and visitors of key communication

- The IPC Team have a page on the Trust intranet page which provides information to staff. The external Trust website also has key messages relating to infection control.

- The Trust Intranet promotes infection prevention issues and guides users to information on specific alert organisms such as MRSA and Clostridium Difficile as well as key organisms that may be of particular concern seasonally.

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Surgical Site Infection (SSI)

Surgical Site Infections are a particularly important Healthcare-associated Infection (HCAI) because they can increase a patient's length of stay in hospital and are associated with considerable morbidity. It has been reported that over one-third of postoperative deaths are related, at least in part, to SSI.

However, it is important to recognise that SSIs can range from a relatively trivial wound discharge with no other complications to a life- threatening condition" National Institute for Health and Clinical excellence (NICE) (2008).

Guidelines for the prevention of SSI were issued by NICE in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health.

Mandatory surveillance of infections, in the following procedures, started in April 2004 specifying that each trust should conduct surveillance for at least 1 orthopaedic category for 1 period in the financial year. This surveillance helps hospitals, in England, to review or change practice as necessary.

- Hip replacement
- Knee replacement
- Repair of neck of femur
- Reduction of long bone fracture

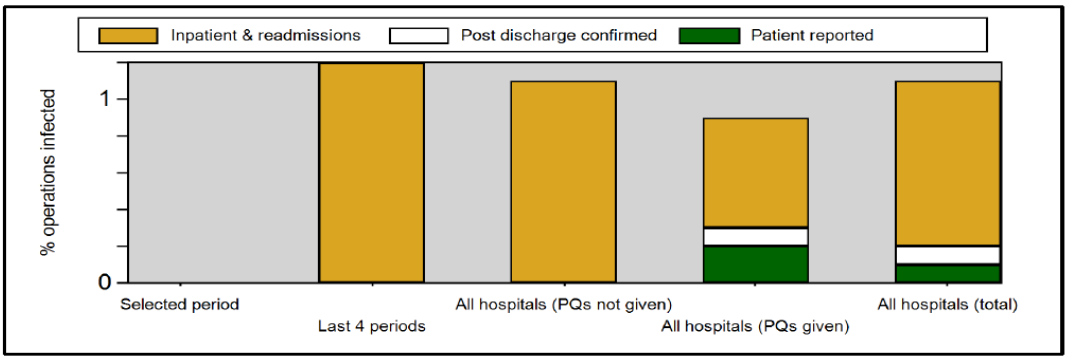
For the period relating to this report the IPCT undertook one quarter of surveillance focusing on fractured neck of femur repair. Zero cases of surgical site infection were identified during this period this is compared to 1.2% over the last 4 periods of surveillance completed. A smaller patient group was included in the surveillance due to pressure related to COVID; elective surgery was stopped due to capacity required for COVID. For the upcoming surveillance the patient group should be a larger sample size.

Repair of neck of femur — July - September 2020

Table 1: No. of operations and completed post-discharge questionnaires with rates of SSI by selected period (Jul-Sep 2020) and the last 4 periods for which data are available (Jul-Sep 2020, Apr-Jun 2017) at your hospital.

Operations & surgical site infections		Your hospital	
		Selected period	Last 4 periods
Operations	Total no.	16	83
	No. with PQ given	16	69
	% PQ completed	6.3%	68.1%
Surgical Site Infection	No. inpatient/readmission	0	1
	% infected	0.0%	1.2%
	No. post-discharge confirmed	0	0
	% infected	0.0%	0.0%
	No. patient reported	0	0
	% infected	0.0%	0.0%
	All SSI	0	1
	% infected	0.0%	1.2%

Figure 1: Rates of SSI by inpatient/readmission, post-discharge confirmed and patient reported SSIs for the selected period (Jul-Sep 2020) and last 4 periods compared to all hospitals* for the previous 5 years available (Oct-Dec 2015 to Jul-Sep 2020).



Note: a more precise estimate of the incidence of SSI can be made by cumulating data over several surveillance periods

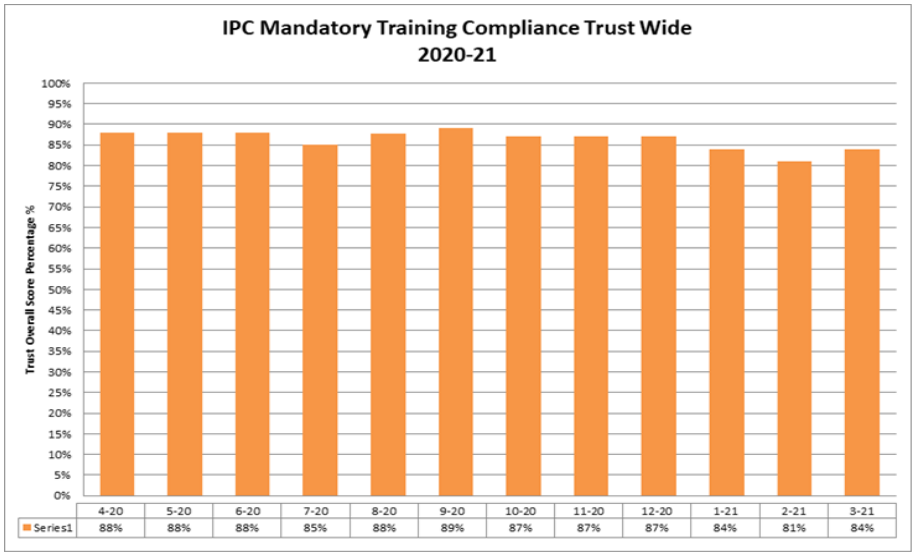
The mandatory surveillance for 2021 is to be commenced shortly and will be shared over the coming months once reconciliation is completed.

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

At The Dudley Group infection prevention is everyone's responsibility and is included in all job descriptions across the Trust.

All clinical staff receives training and education in infection prevention practices during induction and mandatory training sessions. Additional bespoke training is provided to wards and departments as necessary and in response to shared learning.

The graph below identifies the compliance of mandatory IPC Training throughout the year. For each month compliance has been above 80%, however due to the COVID-19 pandemic these scores were not achieving the required objective of 90% compliance. Scores started to improve at the end of the financial year and following divisional escalation IPC Training continues to be a key priority in order to ensure the Trust reaches this objective with improvements in compliance being observed.



7. Provide or secure adequate isolation facilities

Spread of infection in healthcare facilities may be prevented by isolation or other barrier procedures which may vary according to the nature of the infection. Isolation may involve either source containment, whereby infected patients are nursed with precautions necessary to prevent the spread of infection to others, or protective isolation, which is used for patients at special risk of acquiring infection such as haematology or oncology patients.

There is a policy in place to ensure that patients are isolated appropriately.
Decision to isolate a patient should be based on a risk assessment with regular assessment taking place to ensure the most appropriate use of the isolation facilities. 25% of the inpatient beds take the form of single ensuite rooms which is prioritised for patients either confirmed or developing signs of infection.

In addition to the Isolation policy a Zoning SOP was developed in March 2020 due to COVID -19 Pandemic which identified that for the duration of the COVID-19 pandemic clinical facilities at Dudley Group NHS Foundation Trust (DGNHSFT) will be segregated into differing zones into which patients will be admitted dependent on their COVID-19 status. All patients admitted to an inpatient bed will be swabbed for COVID-19 regardless of whether they display any signs or symptoms of the disease. The zoning introduced was:

- Green zone – proven COVID-19 negative
- Yellow zone – admissions where COVID-19 test results are still awaited
- Blue zone – confirmed COVID-19 positive or very high clinical suspicion of COVID-19 infection, who have had a negative test-these patients are to be placed into a side room within a blue area.

Once the number of cases started to decrease the SOP was updated and the decision made that patients who test positive for COVID-19 will be admitted into a side room on the specialty area. This side room will then be reallocated as blue.

8. Adequate access to laboratory support as appropriate

The Infection Prevention and Control Team work closely with the clinical microbiology department which provides comprehensive microbiology advice. The laboratory forms part of the Black Country Pathology services which covers 3 hospital sites to include The Royal Wolverhampton NHS Trust, Sandwell and West Birmingham NHS Trust and The Dudley Group NHS Foundation Trust.

The trust has access to a CPA/UKAS accredited laboratory. The clinical microbiology departments provide support to the Infection Prevention and Control Team through reporting of results, processing of clinical samples and provision of expert microbiological advice as required. Electronic systems are available for the reporting of alert organisms. Out of hours, the on call duty microbiologists will provide Infection Prevention and Control advice for the Trust. The current ICNet system is due to be upgraded which will be across Birmingham and the Black Country.

9. Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

All IPC policies, guidelines and standard Operating procedures are available for staff to view on the Trust Intranet site. This is clearly displayed under the documents section and this has also recently been included o the Infection Control page for ease of access for staff. There is a formal Governance structure in place for reviewing and ratifying such documents and is monitored via the IPC Group.

Below is a list of all of the policies which relate to IPC and the date of review:

1	Cleaning and Disinfection of the Environment and Non Invasive Equipment Policy	May-21
2	Infection Control Precautions Necessary in a Pandemic Flu Situation Policy	May-21
3	Prevention of Infection Associated with the Use of Peripheral Venous Cannulae Policy	Jul-21
4	Isolation of Patients with Suspected and Confimed Infections Policy	Jul-21
5	Standard (Universal) Infection Control Precautions Policy	Jul-21
6	Standard (Universal) Infection Control Precautions Policy	Jul-21
7	Outbreak of Infection in Hospital Control Policy	Oct-21
8	Control of Infections with Specific Alert Organisms Policy	Dec-21
9	Reporting Infections to Public Health England/Local Authority Policy	Dec-21
10	Iinfection Control Precautions for Extended Spectrum BETA (ß) LACTAMASE (ESBL) and AMPC Producing Organisms Policy	Aug-21
11	Healthcare Associated Infections Surveillance Policy	Mar-22
12	Transmissible Spongiform Encephalopathies (TSEs) (Proven or Suspected) Patients Management Policy	Mar-22
13	Infection Control in the Built environmental Policy	May-22
14	Hand Hygiene Policy	May-22
15	Diarrhoea Management for Patients and Staff Policy	May-22
16	Glove Policy	Aug-22
17	Decontamination and Decontamination of Medical Devices Policy	Oct-22
18	Meticillin-Resistant Staphylococcus Aureus Screening: Emergency and Elective Admissions Policy	Nov-22

10. Providers have a system in place to manage the occupational health needs of staff in relation to infection

SHAW offer a wide range of services aimed at reducing ill health at work and supporting those at work with health problems and disabilities. Below are a list of the services provides within Staff Health and Wellbeing at the Trust:

- New employee health assessments where necessarily with pre-existing conditions, all new employees have immunisation screening
- Crisis support post incident or ill health(duty line)
- Immunisations (Hepatitis, MMR, Flu, pertussis)
- Screening for immunity to blood borne viruses
- Manage needle stick/ splash/ contamination incidents for staff
- Management referrals in order to assist with sickness management.
- Health and lifestyle advice
- Work related health surveillance-Covid exposure health risk assessments
- NHS Health Checks
- Skin Assessments
- Long Covid clinic via self-referral and management referral

SHAW have been actively involved in achieving the 81% of front line staff uptake of the Influenza vaccination, as well as dealt with inoculation injuries and immunisation/ blood tests for staff.

Plan for the next 12 months

This last year has been unprecedented in many ways, mainly due to the experience of the COVID-19 pandemic which has affected the NHS on a global scale. Infection Prevention and Control remains a key priority for the upcoming year and a work plan and strategy for the upcoming year has been developed. The IPCT will reflect on individual and team performance to ensure that the quality of the service provided is of a high standard, supportive to ensure high quality safe care.

Infection Control Strategy objectives for the upcoming year are:

- Minimise the risk to patients from healthcare-associated infection and prevent all avoidable HCAI's
- Maintain compliance with all requirements of the Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance 2015
- Continued commitment to working in partnership with other healthcare providers and the multidisciplinary team
- Continued delivery of education and training on prevention and control of infection so that staff understands their responsibilities and action to take
- Review and improve internal processes and systems related to infection control and PFI partners
- Enhanced surveillance of infections and learning through actions
- Support proactive antimicrobial stewardship within the Trust
- Ensure appropriate information relating to infection risks is communicated to relevant parties.
- Ensure collaborative working within the Trust to ensure the maintenance of a clean and appropriate environment.
- Ensure policies are in place and reviewed to ensure they fully reflect and meet the regulatory standard.
- Continued commitment to an approach whereby prevention and control of infection is viewed as integral to service delivery and development.
- Enhance patient and public involvement in infection prevention in order to improve patient experience and reduce risk to the public.
- Develop a programme of quality improvement to underpin the delivery of high quality infection prevention practice with the potential to foster improvements in experience, safety and effectiveness of patient care
- Team members will be supported to develop their skills and knowledge within the field of infection prevention and control ensuring that the quality of service provided by all the members of the team is robust and of high standard

What are the key challenges?

- Level of hospital activity and service capacity
- Prioritising resources to deliver the Strategy within the current financial climate
- Emerging infections, resistance patterns and new strains of microorganisms
- Limited isolation facilities
- Ensuring a clean fit for purpose environment
- Meeting regulatory HCAI targets
- Educating workforce, patients and public

- Engaging with key stakeholders and external agencies
- Providing assurance that there is continued compliance with Infection Control policy and standards
- Releasing staff to undertake training

Progress against 2020/2021 Work Plan.

The end of year outcome of the Infection Prevention and Control work plan and strategy for 2020/2021 had 36 elements relating to the programme of work over the ten criterion of the hygiene code. Out of these actions 25 have been completed with several actions unable to be achieved due to pressures relating to COVID.

Criterion 1 – Out of 14 elements in this criterion 8 have been completed

- Mandatory training compliance required to achieve 90% compliance or above
- Link worker programme to be relaunched
- Saving Lives audits to be completed monthly by the IPC link worker for each area. All audits have now transferred over to AMAT.
- Programme of audits – this was as a result of pressures related to COVID and the audit programme was suspended. An audit programme has been developed for the upcoming year with audits to be completed each quarter to include inpatient and outpatient areas across all three sites within DGH.
- Electronic IPC risk assessment to be added onto the sunrise system. Pressures related to COVID means this was delayed

Criterion 2 – Out of 4 elements in this criterion 1 has been completed.

- Cleanliness standards remain reduced, audits continue via the trust audit team facilitated via the Facilities manager for the trust.
- PLACE assessment did not take place over this year due to COVID.
- Hydrogen peroxide vapour service has a reduced capacity, therefore proactive cleans suspended.

Criterion 3 – Out of 8 elements in this criterion 7 have been completed.

- Ward rounds were reduced during the peak of the pandemic, can now utilise electronic prescription system,
- Virtual ward rounds started on OPAT and all critical care areas.

Criterion 4 – Out of 3 elements in this criterion 1 has been completed.

- Catheter passport role out suspended.
- Patient information leaflets to be updated.

Criterion 5 – Out of 1 element all completed

Criterion 6 – Out of 3 elements 2 completed

- Link worker competency booklet to be relaunched.

Criterion 7 – Out of 2 elements all completed

Criterion 8 – Out of 2 elements 1 has been completed.

- ICNet system upgrade in progress. Version currently used is not supported.

Criterion 9 – Out of 1 element all completed

Criterion 10 – Out of 1 element all completed.

The outstanding actions from the work plan with be carried forward and ongoing monitoring will continue throughout the current year.

The work plans are attached as an appendix

Appendix 1

INFECTION PREVENTION AND CONTROL WORK PROGRAMME 2021/22

RAG Rating: **Overdue** **In progress** **Completed**

Compliance against Criteria	Programme of Work for 2020/21	Lead	Evidence	Completion Date	Review and additional information	RAG Rating
Criterion 1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users are and any risks that their environment and other users may pose to them.	**1.1** Schedule of reports to be circulated for submission to the forum to include: divisional reports, governance reports, estates and facilities reports, learning and development, water safety , surveillance, staff health and wellbeing, health and safety, outbreak and incident reports	Infection Prevention Group Secretary	Minutes and reports to the Infection Prevention Group	Ongoing		
	1.2 Review Group Terms of Reference annually	DIPC/Group members	IPC Group minutes	Completed April 2021		
	1.3 Undertake root cause analysis for serious incidents of HCAI, • **Surveillance database to be reviewed and updated**	Consultants, Matrons, Lead Nurses, IPC Team Governance IPC team	Completed reports (RCA) with feedback from divisions at IPC forum. Reports discussed at divisional quality meetings	Completed April 2021	New database in use from April 2021. IPC support by informatics	
	1.4 Plan and deliver a full programme of education for all staff to include • **Hand Hygiene – new 5 moments for hand hygiene implemented March 2021** • **Bed Cleaning – Joint with Mitie**	IPC Team	Training figures reported by the Divisions at the Infection Prevention Forum	Ongoing	Additional Hand hygiene tool introduced in March 2021 focussing on 5 moments of hand hygiene. Tool live on AMaT from April 202. Ongoing. Bed cleaning under review – new cleaning standards released May 2021	

1.5 Review quarterly ongoing infection control link worker programme for acute and community teams. • **Feedback of attendance to Lead Nurses Matrons** • **Topic of the quarter**	IPC/Lead Nurses	Attendance lists of link worker meetings/ education Session evaluation	End of 2021	Plan to re-start link worker meetings by end of the year.	
1.6 To establish regular meeting with estates to ensure all planned works is approved and signed off by IPC Monthly meeting with Mite/Estates	IPC/ Capital projects and facilities	Minutes of IPC Forum. Evidence key decision fully implemented. Contractual standards met.	September 2021	IPC to meet with Mitie and Facilities to discuss possibility of combining meetings , currently have 6 individual meetings – water, Waste, Cleaning, Catering, Sterile Service, Medical devices, Ventilation.	
1.7 Ensure that IPCT advice is sought on all stages of the contracting process for facilities and other services that have implications for infection control such as cleaning, laundry services, food handling and clinical waste disposal	Head of Estates and Facilities, Director of Operations, Divisional Managers	Minutes of meetings, emails Evidence Infection Control underpinned decision making.	September 2021	IPC to meet with Mitie and Facilities to discuss possibility of combining meetings , currently have 6 individual meetings – water, Waste, Cleaning, Catering, Sterile Service, Medical devices, Ventilation.	
1.8 All areas to be audited against national standards quarterly. Audit tool to be reviewed against national standard.	IPC team	Ward audit reports/results and action plans	Ongoing April – Jun Jul- Sep Oct – Dec Jan - Mar	Full audits to be completed every 3 months. First quarter currently on target to complete.	
1.9 Link Workers to undertake monthly High Impact Interventions Audits To include 5 moments of hand hygiene Audit Audit database to move from IPAS to AMaT	Matrons and Lead Nurses	Audit results available and reported to IPC Group Compliance %	July 2021	All IPC audits moved from IPAS/Electronic email submission to AMaT. Due to the change over 3 months been given to ensure full compliance and allow for any issues that may arise.	

	1.10 Undertake Mandatory Surgical Site Surveillance. National requirement is to undertake 1 module of orthopaedic surveillance annually. IPC to aim to complete 2 modules over the next 12 months	IPC Team/SSS Nurses	Surgical site surveillance reports presented at the IPC group Divisional level and action	Commence June 2021 – Ongoing throughout year	IPC to liaise with ICD regarding mandatory and voluntary SSS modules which are to be undertaken.	
	1.11 Undertake national mandatory surveillance Database to be reviewed	IPCT	Monthly lockdown of data by the CEO and data reported to Board on time.	April 2021	New database in use from April 2021. IPC support by informatics	
Criterion 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	**2.1** Review clinical environment against Health and social care act 'Code of Conduct' quarterly	Head of facilities management Matrons and Lead Nurses IPCT, IPC Group	Ward/ department cleaning scores. Minutes of IPC Group Results circulated	April 2021	Audit tool reviewed to ensure still in line with IPS guidance. See point 1.8 All completed audits to be shared with lead nurses and matrons and any common issues raised at IPC group	
	2.2 An Audit and Escalation policy to be devised to ensure assurance can be provided of routine audits	IPCT	Monitoring against audit plan Delivery of plan not just monthly			
	2.3 Option appraisal paper to be written for management of ongoing HPV service	IPCT	HPV service in situ with monitoring of numbers of cleans undertaken.	Ongoing	Deputy chief nurse liaising with current HPV company to discuss future service delivery.	
Criterion 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	**3.1** Bimonthly Antimicrobial Steering group meeting	DIPC/ Antimicrobial Pharmacists	Minutes of ASG meeting			
	3.2 Work towards full compliance with NICE guidelines (NG63 and NG15) and Quality Standard (QS121)	DIPC/ Antimicrobial Pharmacists	Position statement			
	3.3 Undertake review of local antibiotic susceptibility surveillance to ensure optimal guideline recommendations	DIPC/ Antimicrobial Pharmacist	Minutes of review meeting			

	3.4 Monitor and analyse DATIX reports for antimicrobial errors	Antimicrobial Pharmacists	Minutes of ASG meeting (findings reported at ASG)			
	3.5 Data collection for CCG 1a and 1b CQUIN	Antimicrobial Pharmacists	Minutes of ASG			
	3.6 Education and training	Antimicrobial Pharmacists	Better training better care (Drs Induction) CMT teaching session Senior Clinicians medicines management update Nurses medicines management session			
	3.7 Antimicrobial stewardship ward rounds	Microbiologist/ Antimicrobial Pharmacist	Ward rounds		Currently completed via teams due to remote working of microbiologist	
	3.8 Quarterly Antimicrobial prescribing snap shot audits	Antimicrobial Pharmacists	Minutes of ASG meeting			
Criterion 4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	**4.1** Review patient information leaflets	IPC team communications	Patient information leaflets available in the HUB	September 2021	All IPC patient leaflets to be reviewed	

Criterion 5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.						
Criterion 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	**6.1** Participate in World Health Organisation Global Hand Hygiene Day	IPC Team Communications Link Workers		May 2021	IPC team/DIPC/Chief Exec participated in world hand hygiene day, visiting areas throughout trust promoting the 5 moments.	
	6.2 Plan and identify resources required to deliver a programme for international infection control awareness week in October 2021	IPC Team Communications	Promotional material and staff awareness of IPC week	October 2021.	IPC team will plan and deliver activities and awareness of IPC topics throughout the week. Plan to have stand and front of trust if restrictions allow.	
Criterion 7. Provide or secure adequate isolation facilities	**7.1** Proposed redevelopment of ED to ensure adequate isolation facilities are incorporated within the design.	Head of facilities management Matrons and Lead Nurses IPCT, IPC Group	IPC sign off on all new building work.		IPC have been involved and worked alongside group for the new modular build	
Criterion 8. Secure adequate access to laboratory support as appropriate	**8.1** Ensure laboratories up to date Clinical Pathology accreditation – RWT	DIPC RWT	Confirmation from labs	June 2021	Labs currently in Voluntary suspension – due accreditation visit end of June 2021	
	8.2 Secure funds for updated ICNET system that will be connected to the Black Country Pathology Services ILMS system	DIPC/IPC Lead Nurse/IT		Ongoing	Meetings ongoing to secure new ICNET system with IT and other partners.	
Criterion 9.	**9.1** Review policies/guidelines:	IPC Team	Updated policies	June 2021	IPC team identified 8	

Have and adhere to policies, designed for the individual's care and provider organisations, which will help to prevent and control infections	Out of date CDIFF policy to be devised COVID policy		available on the Hub		policies that are due for review before July 2021. All policies shared with IPC group for comments and will be published on the HUB in June. CDiff policy in process of being written and will be shared in Junes IPC meeting. To be discussed in IPC meeting if COVID19 policy required alongside SOP.	
Criterion 10. Providers have a system in place to manage the occupational health needs of staff in relation to infection.	**10.1** IPCT to assist with the annual Influenza/COVID19 vaccination programme	Staff health and wellbeing HR project co-ordinator /Flu co-ordinator		October 2021	IPC team to participate as workload allows with the delivering of flu vaccine	

Appendix 2

INFECTION PREVENTION AND CONTROL WORK PROGRAMME 2020/21

RAG Rating: **Overdue** **In progress** **Completed**

Compliance against Criteria	Programme of Work for 2020/21	Lead	Evidence	Completion Date	Review and additional information	RAG Rating
Criterion 1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users are and any risks that their environment and other users may pose to them.	**1.1** Schedule of reports to be circulated for submission to the forum to include: divisional reports, governance reports, estates and facilities reports, learning and development, water safety , surveillance, staff health and wellbeing, health and safety, outbreak and incident reports	Infection Prevention Group Secretary	Minutes and reports to the Infection Prevention Group	March 2021	April 2020 –group suspended COVID May 2020-submitted June 2020-Submitted July 2020-submitted August 2020 No meeting September 2020- October 2020 November 2020 December 2020 No meeting January 2021-Group suspended February 2021 March 2021	
	1.2 Review Group Terms of Reference annually	DIPC/Group members	IPC Group minutes	June 2020	Presented for review November 2020	
	1.3 Undertake root cause analysis for serious incidents of HCAI, MRSA bacteraemia, and Clostridium difficile (Hospital onset health care associated cases and Community onset healthcare associated cases), **COVID-19 (hospital-onset probable healthcare-associated and hospital-onset definite healthcare-associated)** and outbreak • C diff RCA tool to be reviewed to ensure it captures accurate information • C diff surveillance excel sheet to be	Consultants, Matrons, Lead Nurses, IPC Team Governance IPC team	Completed reports (RCA) with feedback from divisions at IPC forum. Reports discussed at divisional quality meetings	March 2021	RCA panel meeting suspended due to COVID work place pressures RCA panels reintroduced with the addition of a scrutiny panel to allow for internal review of cases prior to panel meeting.	

	updated with national definition • Review feedback process to clinical teams					
	1.4 Plan and deliver a full programme of education for all staff • Review annual mandatory training – **to include Donning and Doffing** lecture and competency assessment • Review IV Training lecture	D Garfield K Nock S Stelian	Training figures reported by the Divisions at the Infection Prevention Forum		PHE Donning and Doffing video included in mandatory training Mandatory training compliance remains below the expected standards of 90%. Face to face sessions suspended due to pressures with COVID. E learning still available, however scores under the expected standards.	
	1.5 Review quarterly ongoing infection control link worker programme for acute and community teams. • Feedback of attendance to Lead Nurses Matrons	D Garfield	Attendance lists of link worker meetings/ education Session evaluation	March 2021	Due to COVID-19 Link worker meetings suspended. Plans to refresh Link worker role and IPC support for IPC Awareness week also suspended	
	1.6 Water Safety Group monthly meeting	Head of facilities management DIPC IFM	Report to IPC group, minutes	March 2021	June 2020 WSG cancelled July 2020 group met August September 2020 Group met October 2020 November 2020 December 2020 January 2021 February 2021 March 2021 Water safety group meet monthly	

	1.7 IPC team to be advised of all ward movements and when preparing service specifications for engineering and building services **1.8** Refurbishment programmes and to monitor progress. When preparing tender processes for building and commissioning	IPCT Capital projects and facilities	Minutes of IPC Forum	March 2021	Modular building ED re design Full involvement with IPC and meeting attendance as requested. IPC have visited the modular build and advice provided. ED redesign ongoing. IFM projects meeting continue monthly.	
	1.9 Ensure that IPCT advice is sought on all stages of the contracting process for facilities and other services that have implications for infection control such as cleaning, laundry services, food handling and clinical waste disposal	Head of Estates and Facilities, Director of Operations, Divisional Managers	Minutes of meetings, emails	March 2021	IPC advice provided when works are being carried out across the trust.	
	1.10 Undertake annual ward/departmental audits an audit tool based upon national infections prevention society standards.	IPC team	Ward audit reports/results and action plans	March 2021	Audit programme suspended due to COVID work load and lack of staff resources An audit programme has been developed for the upcoming year with audits to be completed each quarter. Action remains amber due to suspension of the audits.	
	1.11 Link Workers to undertake monthly High Impact Interventions Audits (Saving Lives)	Matrons and Lead Nurses	Audit results available and reported to IPC Group	March 2021	IPC team to support by completing sense check audits competed via new IPC Quality Rounds IPC link workers continue to submit Saving Lives scores, although some gaps have been identified throughout the year due to pressures related to COVID.	
	1.12 Undertake Mandatory Surgical Site Surveillance. National requirement is to undertake 1 module of orthopaedic surveillance annually. **Take part in 1 voluntary module**	S Stelian	Surgical site surveillance reports presented at the IPC group	March 2021	Voluntary Module abdominal wounds planned-unable to complete due to COVID pressures.	

	1.13 Undertake national mandatory surveillance of *Staphylococcus aureus*, MRSA, Escherichia *coli*, *Klebsiella* spp., *Pseudomonas aeruginosa* bacteraemia, *Clostridium difficile* and **COVID** infections.	IPCT	Monthly lockdown of data by the CEO and data reported to Board.	March 2021	Completed; April, May, June, July, August, September, October, November, December, January, February and March.	
	1.14 Ensure that IPC assessments are included in the new Electronic patient records-admission, transfer documents and IPC risk assessment	IPCT E Fulloway	Attendance at the EPR meetings	March 2021	Planning in progress Continued work around sunrise, all assessments not yet available.	
Criterion 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	**2.1** Monitor standards of cleanliness.	Head of facilities management Matrons and Lead Nurses IPCT, IPC Group	Ward/ department cleaning scores. Minutes of IPC Group Results circulated	March 2021	Interserve audits continue, IPC hold regular formal and informal meetings with facilities provider to monitor standards	
	2.2 Patient-led assessments of the care environment (PLACE) to be conducted and IPCT to be included in the assessment team	Head of Facilities Management	Minutes of IPC Forum	March 2021	Notification emails have been shared with Trust, inspections are not taking place this year	
	2.3 HPV Team to undertake pro-active disinfecting programme and respond to requests / requirements of departments. **In Q 4, commence work on tender as contract ceases in 18 months from start of 2020.**	S Stelian	HPV service in situ with monitoring of numbers of cleans undertaken.	March 2021	Staff resource issues during August and September have impacted service delivery. Reduced service resulted in the service being unavailable for large parts of the year.	
	2.4 The CAS alert : Decontamination of Fans	IPCT and Estates and Facilities	SOP in place	July 2021	Fan SOP devised and Facilities are currently devising how to implement	
Criterion 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of	**3.1** Bimonthly Antimicrobial Steering group meeting	DIPC	Minutes of ASG meeting	March 2021		
	3.2 Work towards full compliance with NICE guidelines (NG63 and NG15) and Quality Standard (QS121)	DIPC/ Antimicrobial Pharmacists	Position statement	March 2021		

adverse events and antimicrobial resistance	**3.3** Undertake review of local antibiotic susceptibility surveillance to ensure optimal guideline recommendations	DIPC/ Antimicrobial Pharmacist	Minutes of review meeting	March 2021	This happens on a rolling basis, most recently gram negative organisms' susceptibility data was analysed and a study was published as well.	
	3.4 Monitor and analyse DATIX reports for antimicrobial errors	Antimicrobial Pharmacists	Minutes of ASG meeting (findings reported at ASG)	March 2021	All datix with antibiotics mention goes to the Principal Antimicrobial Pharmacist and are dealt with promptly.	
	3.5 Data collection for CCG 1a and 1b CQUIN	Antimicrobial Pharmacists	Minutes of ASG	March 2021	Not required anymore suspended due to Pandemic	
	3.6 Education and training	Antimicrobial Pharmacists	Better training better care (Drs Induction) CMT teaching session Senior Clinicians medicines management update Nurses medicines management session	March 2021	All sessions delivered as planned	
	3.7 Antimicrobial stewardship ward rounds	Microbiologist/ Antimicrobial Pharmacist	Ward rounds	March 2021	Ward rounds were reduced during the peak of the pandemic, can now utilise electronic prescription system, Virtual ward rounds started on OPAT and all critical care areas.	
	3.8 Quarterly Antimicrobial prescribing snap shot audits	Antimicrobial Pharmacists	Minutes of ASG meeting	March 2021	The Trust now has electronic prescribing system which will enable live data	
Criterion 4. Provide suitable accurate information on infections to service users, their visitors and any person concerned	**4.1** Monitor and audit use of the catheter passport, to include information given to relevant patients, which has been implemented across the health economy.	K. Jarrett Dudley Health Economy Group	Catheter passport in use. Results of audit undertaken to be fed back and discussed at Dudley health economy group.	March 2021	Catheter passport promotions suspended due to COVID. Wards continue to utilize the passport. Not achieved the 50% reduction in E coli.	

with providing further support or nursing/ medical care in a timely fashion.	**4.2 Implement and assist with embedding Mouth Care Matters within the Trust**	IPC team Clinical Divisions communications	Policy	March 2021	E.Fulloway has commented on the new mouth care policy	
	4.3 Review patient information leaflet: MRSA CPE- I am colonised CPE- Carrier CPE- Maybe a carrier C.diff GDH positive **COVID-19** **FLU**	IPC team communications	Patient information leaflets available in the HUB	March 2021	Draft COVID-19 leaflet due to be shared for comments September 2020	
Criterion 5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	**5.1** Flag all patients with MRSA, Clostridium difficile and CPE on the Sunrise system and identify other resistant organisms which require an alert.	IPC Team	Presence of flags on Sunrise	March 2021	Patients flagged on sunrise system.	
Criterion 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	**6.1** Participate in World Health Organisation Global Hand Hygiene Day	IPC Team Communications Link Workers	Minutes of IPC Forum	May 2020	Due to the COVID-19 pandemic the team were unable to complete planned activity due to social distancing. Communication distributed via social networking **COMPLETED**	
	6.2 Plan and identify resources required to deliver a programme for international infection control awareness week in October 2019	IPC Team Communications	IPC Forum minutes Updates on HUB	Nov 2020	Refresh of IPC Link worker to Champion Role and update competency book. Due to pressures related to COVID this was suspended. Relaunch of the IPC link worker	

					programme is in progress including competency book.	
	6.3 Staff and contractors are aware of COVID 19 prevention measures: PPE Use, social distancing, cleaning and hand hygiene	IPCT Divisional Leads Communications		March 2021	IPC attend COVID Task force meetings and are to review clinical practice by competing assurance walk rounds initial walk round completed 21/09/2020 COVID taskforce meetings attended by IPC Lead nurse.	
Criterion 7. Provide or secure adequate isolation facilities	**7.1** Proposed redevelopment of ED to ensure adequate isolation facilities are incorporated within the design.	Head of facilities management Matrons and Lead Nurses IPCT, IPC Group	IPC team included in planning and project meetings	March 2021	IPC Team included in meetings related to the ED redesign.	
	7.2 Input into the modular ward design	Head of facilities management Matrons and Lead Nurses IPCT, IPC Group	IPC team included in planning and project meetings	March 2021	IPC Team invited to modular build meetings and provides advice. IPC Team has walked around the build.	
Criterion 8. Secure adequate access to laboratory support as appropriate	**8.1** Ensure laboratories up to date Clinical Pathology accreditation.	DIPC	IPC Forum Minutes	March 2021	Currently accredited 24/7 microbiology advice available. Black country pathology services in place with Wolverhampton are central lab.	
	8.2 Complete business case for updated ICNET system that will be connected to the Black Country Pathology Services ILMS system	DIPC/IPC Lead Nurse	Business case completion	March 2021	Draft business case in development ICNet business case has been developed. ICNet has agreed to provide support until the new system is in place. This system will link across the Black country pathology services.	
Criterion 9. Have and adhere to policies, designed for the individual's care	**9.1** Review policies/guidelines:	IPC Team	Policies on HUB	March 2021	Draft Zoning policy commenced frequent changes of national policy Zoning SOP updated as	

and provider organisations, which will help to prevent and control infections					required to reflect national changes.	
Criterion 10. Providers have a system in place to manage the occupational health needs of staff in relation to infection.	**10.1** IPCT to assist with the annual Influenza vaccination programme	Staff health and wellbeing HR project co-ordinator /Flu co-ordinator	Staff health and wellbeing report to the IPC Group	March 2021	IPC Team attended meetings and assisted with the roll out of the vaccination of influenza.	