Director of Infection and Prevention Control Annual Report

2022/2023

NHS
The Dudley Group
NHS Foundation Trust

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i EXECUTIVE INTRODUCTION FROM THE CHIEF NURSE AND DIRECTOR OF INFECTION PREVENTION AND CONTROL

"Dear Staff, Patients, Carers, Service Users and Partners,

Firstly, a huge thank you to you all for all your positive endeavours and in particular in dealing with an unprecedented pandemic.

Special thanks go to our staff, both those in clinical practice facing roles and to those support staff behind the scenes, for their commitment to provide the best possible response to the new challenges and ways of working resulting from these demanding times.

Welcome to The Dudley Group NHS foundation Trust (DGFT) Infection Prevention and Control Annual Report which has been developed in collaboration with the Deputy Director for Infection Prevention and Control and the Infection Prevention and Control Team.

As the Trust's Director of Infection Prevention and Control I am proud to be able to present the Annual Infection Prevention and Control Report for 2022/23. The purpose of this report is to outline the activities relating to infection prevention and control for the year from April 2022 to March 2023 and to discuss the arrangements DGFT have in place to reduce the spread of infections. It reviews our accountability arrangements, policies and procedures relating to infection prevention and control, audit, and the education necessary in order to support the prevention and control of infection.

Our key achievements were:

- 39 *Clostridiodes difficile infections attributable to DGFT against a threshold of no more than 48*
- *Zero Hospital Onset Healthcare Associated (HOHA) MRSA Bacteraemia infections.*
- *Mandatory Infection Prevention and Control training completed by 87.96% of clinical staff.*
- *94.1% of non-clinical staff up to date with Infection Prevention and Control (IPC) e-learning*
- *Response to the challenges arising from SARS CoV-2 (COVID-19)*
- *Upgrading of the laboratory system to the latest version of IC NET*
- *Recruitment to the IPC team under very challenging circumstances*
- *IPC promotional activities included IPC week and World Health Organisation Clean Your Hands Day*
- *An IPC Link worker study day was held in March 2023*
- *Increased surgical site surveillance activity*

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 the last year.

Looking forward to 2023/24, the IPC team and all DGFT staff will continue to work towards the prevention of all healthcare acquired infections."

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

TABLE 1: The requirements of the Health and Social Care Act (2008: updated 2022)

Compliance Criterion	What the registered provider will need to demonstrate
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.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and 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 so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people.
6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

ii LIST OF ABBREVIATIONS

ACP	Advanced Care Practitioner
AER	Automated Endoscope Reprocessor. A specialised machine for washing and disinfecting endoscopes
AHP	Allied Health Professional
AmpC beta lactamases producing Enterobacteriaceae	Produce enzymes which mediate resistance to a wide variety of B-lactam antibiotics e.g., amoxicillin
AMS	Antimicrobial Stewardship
ASG	Antimicrobial Stewardship Group
Bacteraemia	A bloodstream infection
BBFE	Blood and Bodily Fluids Exposure
BCPS	Black Country Pathology Services
BCWB	Black Country and West Birmingham
BSI	Bloodstream Infection
CCGs	Clinical Commissioning Groups subsumed in to Integrated Care Boards in July 2022

CD	Contact Dermatitis
CDI	*Clostridioides difficile infection.* *Clostridioides difficile* is a bacterium which lives harmlessly in the intestines of many people. *Clostridioides difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
CE	Chief Executive
CMT	Certified Medication Technician
COHA	Community Onset Healthcare Acquired
COIA	Community Onset Indeterminate Association
COVID-19	Coronavirus disease
CPA/ UKAS	Clinical Pathology Accreditation (CPA UK) is a subsidiary of United Kingdom Accreditation Service (UKAS)
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (CQUIN) payment framework
CSSD	Central Sterile Services Division
CSU	Catheter Specimen of Urine
D&V	Diarrhoea and vomiting
Datix	Patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organisations.
DDIPC	Deputy Director of Infection Prevention & Control
DGFT	The Dudley Group NHS Foundation Trust
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DMC	Dudley Metropolitan Council
E.coli	*Escherichia coli.* *E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals.
ED	Emergency Department
ENT	Ear, Nose and Throat
EPMA	Electronic Prescribing and Medicines Administration
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics.
ESR	Electronic Staff Record
GNBSI	Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas.

GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HCAI	Healthcare Associated Infection
HII	High Impact Interventions
HOHA	Hospital Onset Healthcare Associated
HR	Human Resources Department
HSDU	Healthcare Sterilisation Decontamination Unit
HSE	Health and Safety Executive
ICB	Integrated Care Board replaced Clinical commissioning Boards July 2022
IC NET	IPC Surveillance software and database
ICS	Integrated Care System
IPC	Infection Prevention and Control
IPC BAF	Infection Prevention and Control Board Assurance Framework
IPCG	Infection Prevention and Control Group Meeting
IPCT	IPC Team
IPMO PLG	Integrating Pharmacy and Medicines Optimisation Pharmacy Leadership Group
IPS	Infection Prevention Society
IV	Intravenous
KPI	Key Performance Indicator
LFD	Lateral Flow Device
LHE	Local Health Economy
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g., inside the nose) without causing any problems. It most commonly causes skin and wound infections.
NED	Non-Executive Director
NEWS 2	The latest version of the National Early Warning Score (NEWS), which advocates a system to standardise the assessment and response to acute illness.
NHS	National Health Service
NHSE/I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
NITCAR	National infections team's collaborative for audit and research
NNU	Neonatal Unit

Norovirus	Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults.
OH	Occupational Health
Outbreak	One or more persons with the same signs, symptoms in time place and space.
OPAT	Out-patient parenteral antimicrobial therapy
OPD	Outpatients Department
PEG	Patient Experience Group
PFI	Private Finance Initiative
PGD	Patient Group Direction
PHE	Public Health England now UK HSA
PII	Period of Increased Incidence
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment e.g., gloves, aprons, and goggles
QSC	Quality and Safety Committee
QSG	Quality and Safety Group
RCA	Root Cause Analysis
RCN	Royal College of Nurses
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SARS-CoV-2	COVID-19
SENDS	Safety engineered needleless device systems
SEPSIS	A potentially life-threatening condition caused by the body's response to an infection.
SEQOHS	Safe, Effective, and Quality Occupational Health Service
SHAW	Staff Health and Wellbeing Service
SIGHTED	Suspect, Isolate, Gloves and Aprons, Hand washing, Test for Toxins, Educate, Document
SIP	Service Improvement Plan
SLA	Service Level Agreement
SOP	Standard Operating Procedure
SSI	Surgical Site Surveillance
TDM	Therapeutic Drug Monitoring
The HUB	Staff Intranet Site
TOR	Terms of Reference
UK HSA	UK Health Security Agency formally Public Health England (UK HSA)
UTI	Urinary Tract Infection
WHO	World Health Organisation
WSG	Water Safety Group

SECTION ONE:
INTRODUCTION

The purpose of this report is to provide assurance to The Dudley Group NHS Foundation Trust (DGFT) Board of Directors, Governors and the public for the reporting period 1 April 2022-31 March 2023 regarding the Infection Prevention and Control (IPC) activity including compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (update December 2022) (commonly known as The Hygiene Code) and with regard to appropriate National Institute for Health and Clinical Excellence (NICE) guidance.

This annual report fulfils the Trusts' statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Updated December 2022), which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. This sets the basis of our annual programme which is monitored at the Trust's bimonthly Infection Prevention and Control (IPC) Group meeting. Infection prevention and control is the responsibility of everyone in our healthcare community and is only truly successful when everyone works together. The aim of the IPC team is to increase organisational focus and collaborative working to ensure continued compliance and continuous improvement.

The Trust's is registered with the Care Quality Commission (CQC) and has declared full compliance with the ten compliance criteria as detailed in Table 1.

Compliance criterion	What the registered provider will need to demonstrate
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.
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6	Systems to ensure that all care workers (including contractors, volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

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 that the safety and quality of care for our patients can be provided. At The Dudley Group NHS Foundation Trust Infection Prevention and Control (DGFT) is a key priority.

Our 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 and control agenda face 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 Board of Directors and ultimately the Chief Executive, as the accountable officer, carries responsibility for IPC throughout the Trust and it is a vital component of Quality and Safety. The day-to-day management is delegated to the Director of Infection Prevention and Control (DIPC). All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike and is committed to the promotion of excellence within everyday practice of IPC.

As with the previous year, the 2022/23 NHS Outcomes Framework included reducing the incidence of HCAIs, in particular Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemia and *Clostridium difficile* infection (CDI) as areas for improvement. Within Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm of the Outcomes Framework reducing all HCAIs remained a priority.

As previously reported, the extension to the mandatory surveillance to include Meticillin Sensitive *Staphylococcus aureus* (MSSA) and *Escherichia coli* (*E.coli*) Bacteraemia infections since 2011 together with the MRSA Bacteraemia and CDI national reduction thresholds set for Acute and Clinical Commissioning Groups (CCGs) reflects the zero-tolerance approach for all avoidable HCAIs.

This report will provide information of the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2022-31 March 2023 by DGFT. The report is aligned to the 2022/23 IPC Programme, informing progress against the objectives set and outlines performance of DGFT against the MRSA Bacteraemia and CDI reduction thresholds.

In addition, the report aims to reassure the public that reducing the risk of infection through robust infection prevention and control practice is a key priority for DGFT and supports the provision of high-quality services for patients and a safe working environment for staff.

SECTION TWO:
WHO ARE WE, OUR DUTIES, ARRANGEMENTS AND ASSURANCE

2.1 Who are we?

As a Trust, the Dudley Group provides health services to around 450,000 people in Dudley. These include for example three hospital sites, Russell's Hall, Corbet and Guest Hospitals and community nursing services.

In a year we…

- deliver 4,100 babies.
- see around 600,000 outpatients.
- treat almost 173,000 patients in our emergency department.
- We have 450,000 people in our catchment area.

Our PFI partners

- Dispose of 468 tonnes of infectious waste
- sterilise 636,350 clinical instruments.
- undertake 100,000 portering moves.
- recycle approximately 146.78 tonnes of mixed recyclables.

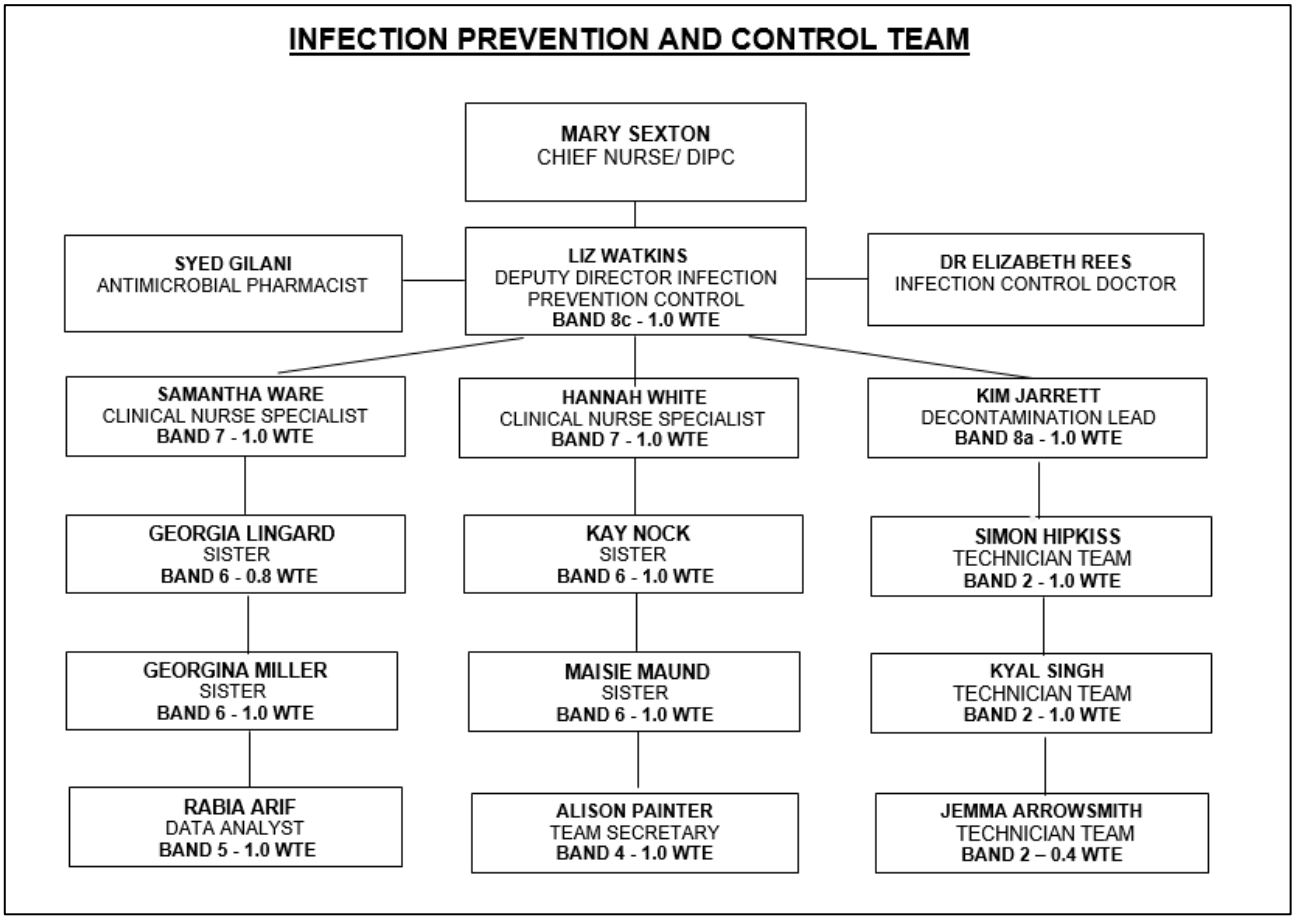
DGFT has a committed IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. The IPC team utilises a both a reactive and proactive approach with the emphasis on being visible so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e., being a regular familiar friendly face rather than only visiting to audit or when there are outbreaks of infections or problems.

Looking forward, it is critical that DGFT maintain this level of commitment. As in previous years, we will continue to work closely with our partner organisations Integrated Care Board (ICB), and the Local Health Economy (LHE) as well as experts in other organisations, UK Health Security Agency (UK HSA) and NHS England.

Our Duties and Arrangements

Infection Prevention and Control Service:

- Director for Infection Prevention and Control (Chief Nurse)
- Deputy Director for Infection Prevention and Control
- Infectious diseases Doctor
- Antimicrobial Pharmacist
- Decontamination Lead
- Infection Prevention and Control Nurse Specialists
- Infection Prevention and Control Nurses
- Data Analyst
- HPV Technicians
- Infection Prevention and Control Team Secretary



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

The Director of Infection Prevention and Control (DIPC) is a role (whether by that name or another) required by all registered NHS care providers under current legislation (The Health and Social Care Act2008, updated 2022). 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 Hygiene Code.

At the Dudley Group, the Chief Nurse holds the role of DIPC.

2.3 The Infection Prevention and Control Team

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

The IPC Team is led day to day by the DDIPC for IPC and is supported by Infection Prevention Nurse Specialists, Infection Prevention Sisters, Data Analyst and Team Secretary.

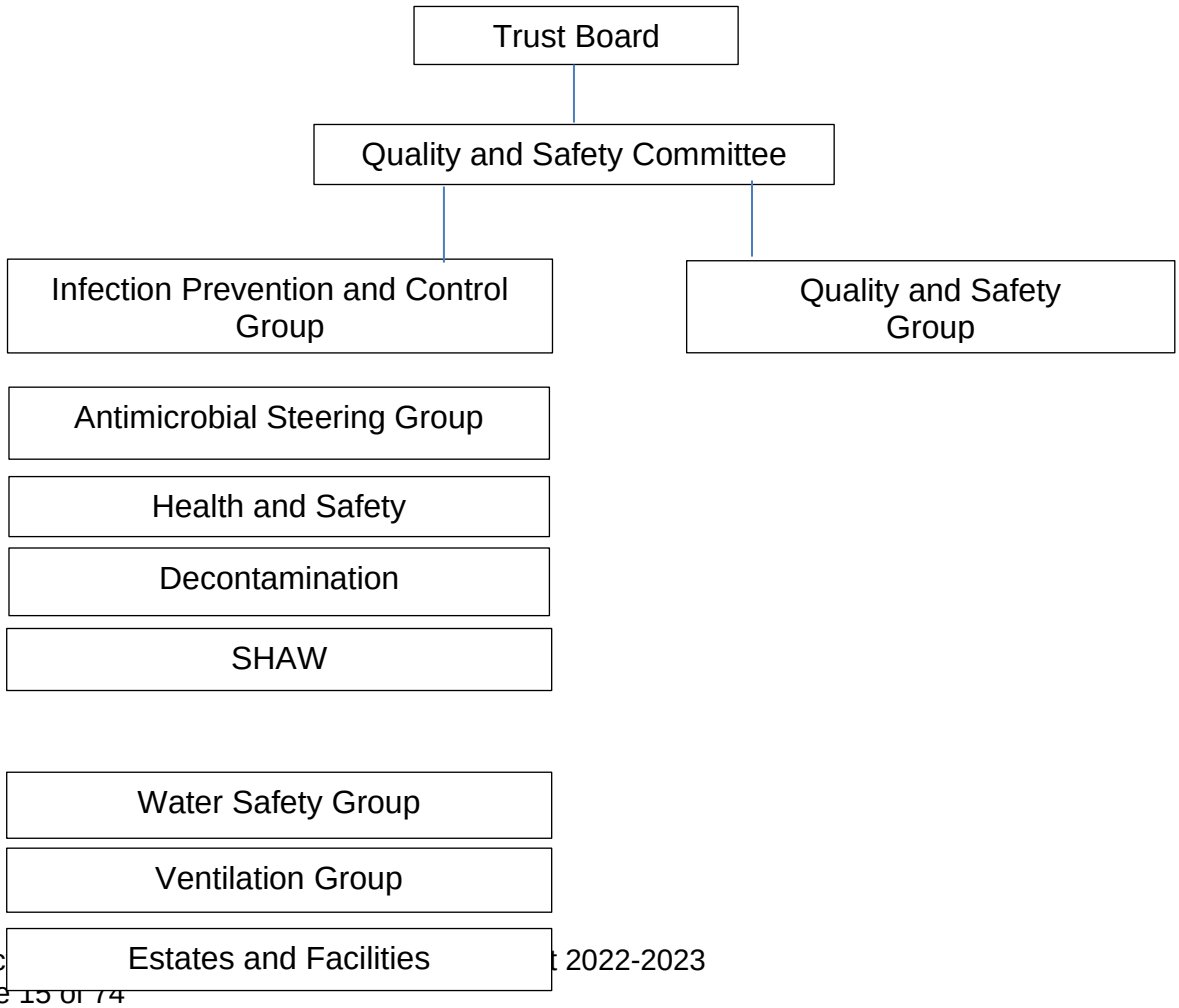
The IPC service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development and review and service development. DGFT has a Service Level Agreement with Royal Wolverhampton Trust for specialist support from a Consultant Microbiologist. Medical microbiology support is provided 24 hours a day, 365 days a year via Black Country Pathology Services.

A workforce review of the IPC Team has been undertaken and an IPC business case has been developed 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-day period while putting in a sustainable model to future proof the team and the service.

The IPC team devises and implements a robust Annual Programme of Work to reduce HCAIs. This is achieved by working in collaboration with all DGFT services and staff. The IPC team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level; alert organisms' surveillance and managing outbreaks of infection.

The IPC Team has re-introduced IPC Link staff which was suspended due to COVID-19. This group now meets on a monthly basis via TEAMS. A Link worker study day was held on in March 2023 for the Trust, 16 staff attended. The overall theme was 'Strengthening the Core' and topics included respiratory infections, sharps safety, hand hygiene, antimicrobial stewardship, and decontamination. The day evaluated very well with lots of positive feedback and comments. There are plans to repeat this annually.

2.4 Committee Structures and Reporting Processes



2.5 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.

DCFT's performance against National and local thresholds are included in Performance Report and Quality and Safety Reports which are presented at DGFT Board meetings.

2.6 Quality and Safety Committee

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

The QSC will 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.

2.7 Quality and Safety Group

Bimonthly IPC reports are presented to the Quality and Safety Delivery Group meetings. The Quality and Safety Group (QSG), chaired by the Chief Nurse/ DIPC, (until December 2022 now chaired by the Director of Governance), 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 subdivisions 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.

2.8 Infection Prevention and Control Group (IPCG) Meeting

The membership is multi-disciplinary and includes representation from the divisions, operations and quality directorates, estates department, antimicrobial pharmacists, and Consultant Microbiologist. Additional members are representatives from UK HSA, Dudley Metropolitan Borough Council, ICB and Private finance Initiative (PFI) partners. The meeting is chaired by the DIPC and meets bimonthly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programme, approves IPC policies and monitors compliance with them.

The purpose of this meeting is to oversee compliance against the Health and Social Care Act (2008, updated 2022) and to provide assurance that risks are appropriately managed and that appropriate arrangements are in place to provide safe, clinical environments for patients, visitors, and staff.

The IPC Governance Meeting is responsible for:

- Reviewing and monitoring the progress of the annual programme and assisting and affecting implementation.
- Reviewing, developing, and adopting relevant policies, procedures, care pathways and guidelines and standard operating procedures.
- Assessing the impact of all existing and new relevant plans and policies on infection prevention and control and make recommendations for change.
- Ensuring, through the DIPC, the Chief Executive, associated Committees and the Trust Board are informed of any significant infection prevention and control concerns.
- To receive, review and endorse the publication of the Infection Prevention and Control Annual Report.
- 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 Staff Health and Wellbeing Service (SHAW).
- Effective management of IPC related outbreaks and concerns

2.8.1 DGFT Water Safety Group

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor water risk assessments especially around Legionella, flushing regimens, annual disinfection, Automated Endoscope Reprocessor (AER) and capital developments.

2.8.2 Decontamination Group

This was established in January 2022 by the Trusts new Decontamination lead, the group monitors, challenges, reviews, and where appropriate takes action in response to presented assurances to ensure that the trust is demonstrating compliance against regulatory standards. The aim of the group is to identify any risk factors in relation to decontamination, to identify any trust strategies for the safe decontamination of medical devices in accordance with national and local guidelines with particular reference to HTM 01-01 and 01-06, Decontamination policies, Health, and Social Care Act 2008 (updated 2015), MHRA guidelines, NICE IPG 196 Guidance – replaced with IPG 666 2020 and Care quality commission. The group receives reports from Endoscopy services, Outpatients and Specialist Surgery, Sterile Services (CSSD), theatres and Imaging with the group meeting bimonthly. A Terms of Reference and Governance structure was developed and is reviewed by the Decontamination Group annually. The Group reports to the IPCG Meeting.

2.8.3 Ventilation Group Meeting

The membership is multi-disciplinary and has representatives from PFI Partners and an Authorising Engineer. The Group continues to monitor ventilation risk assessments especially around air handling units, air extraction and capital developments.

2.8.4 DIPC, DDIPC, Consultant Microbiologist and Deputy Chief Nurse

The DIPC, DDIPC, Consultant Microbiologist and deputy Chief Nurse meet weekly to offer a supportive environment within which clinical issues are discussed and a consensus obtained.

2.8.5 Infection Prevention and Control Link Staff –

The aim of our IPC link staff is to enhance the IPC knowledge of healthcare professionals working within DGFT, ensuring the delivery of high standards of quality and patient safety in relation to IPC. Our IPC link staff are responsible for arranging for IPC audits and self-audits to be undertaken where required and for disseminating IPC information to colleagues.

2.8.6 Divisional Leads, Matrons and Ward Managers, Sisters, Charge Nurses, and Team Leaders

Divisional leads, Ward Managers, Sisters, Charge Nurses, and Team Leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Monthly cleanliness audits are undertaken with staff. These audits are reported in the Divisional Leads and Estates reports to the IPCG meeting. The Sisters, Charge Nurses, Ward Managers and Team Leaders are responsible for ensuring the link staff are supported in performing their role and have appropriate time and resources to do this effectively. Self-audit scores and on-going work undertaken by the link staff is also included in Managers reports submitted to the IPCG meeting.

2.8.7 Learning and Development Team

Arrangements are in place for staff to attend corporate induction and complete mandatory training programmes which includes IPC. Due to COVID-19 this has been now delivered virtually. Arrangements are in place for staff training to be effectively recorded and maintained in staff records. Alerts inform managers of their staff's non-compliance with mandatory training. Training compliance is reported monthly to the Quality and Safety Committee.

2.8.8 Roles and Responsibilities of all Staff

All staff in both clinical and non-clinical roles within the Trust are responsible for ensuring that they follow the standard IPC precautions at all times and are familiar with IPC policies, procedures, and guidance relevant to their area of work. All staff have a duty of care to report any non-compliance and act as appropriate. All IPC policies and procedures are available on the staff intranet site, The Hub.

SECTION THREE:
POSITION IN RELATION TO HEALTH CARE ASSOCIATED INFECTIONS

3.1 Surveillance of Healthcare Associated Infection

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

3.2 Surgical Site Surveillance

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).

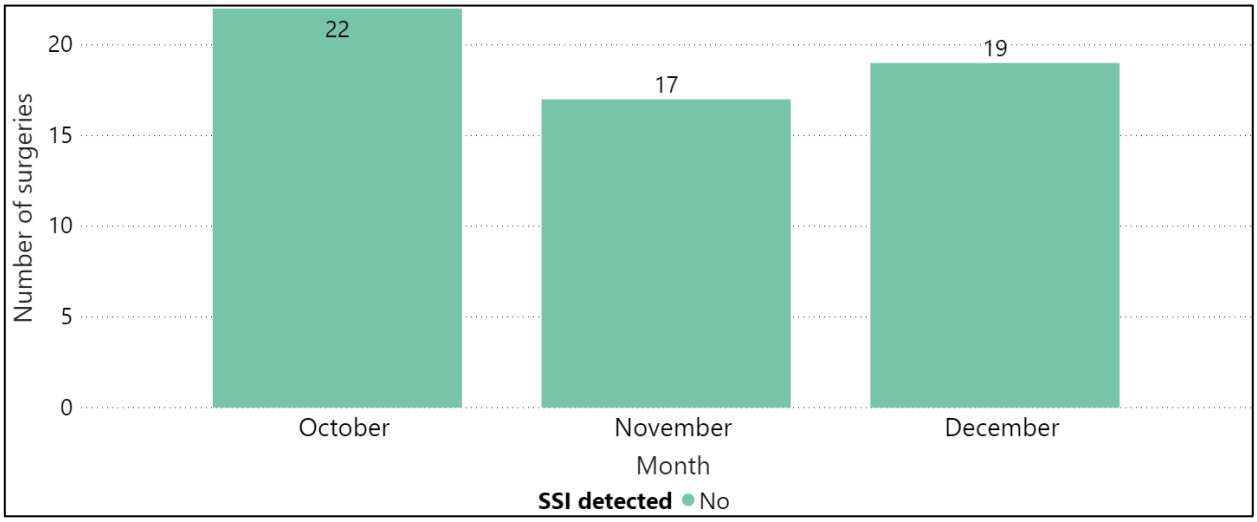
Guidelines for the prevention of SSI were issued by NICE in the UK, updated in 2013, and accompanied by a High Impact Intervention (HII) from the Department of Health.

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 IPC Team undertook two quarters of mandatory orthopaedic surveillance focusing on hip replacement surgery. In this period there were zero cases of patient reported surgical site infection. Previous surveillance completed did capture a smaller patient group due to pressure related to COVID-19. The surveillance period for this quarter was a larger sample size. 92.7% of all SSIS patients that were seen responded to the phone call and had a completed PDQ. Previously, letters were sent to these patients and in the last four periods 66.3% of patients had a completed PDQ. Moving to phone calls consequently led to a 23.5% increase in PDQ completion.

Figure showing the number of hip replacement patients in quarter three by SSI detection.



2023/2024
The results in the above table show the SSI patients who responded to the questionnaires and whether SSI.

Quarter one 2023/24 Mandatory Surgical Site Infections Surveillance module will change to Knee replacement following a request by the orthopaedic team. The aim is to complete a full 12-month period from the orthopaedic category. Four further members of the IPC team have completed the

Surgical Site Surveillance course (2 clinical, 2 nonclinical), with this in mind the IPC team are hoping to undertake a Voluntary Surgical Site Infection Surveillance module that will focus up on Caesarean Section.

3.3 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. Guidance is in place regarding the screening of our patients for MRSA for both emergency and elective admissions at DGFT. In addition, DGFT have processes in place to ensure isolation of patients colonised with MRSA, following the national guidance.

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

The Trust 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 2 cases of MRSA bacteraemia identified in total in the local Health Economy. 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 ICB and DMC and actions identified. For the period covered by this annual report there has been two cases of post 48-hour MRSA bacteraemia. Post infection reviews (PIR) were carried out and the investigations concluded that one case was a COHA and the other a Community Onset Indeterminate Association (COIA) with no HOHA being reported. Actions from the PIR were identified and disseminated to staff.

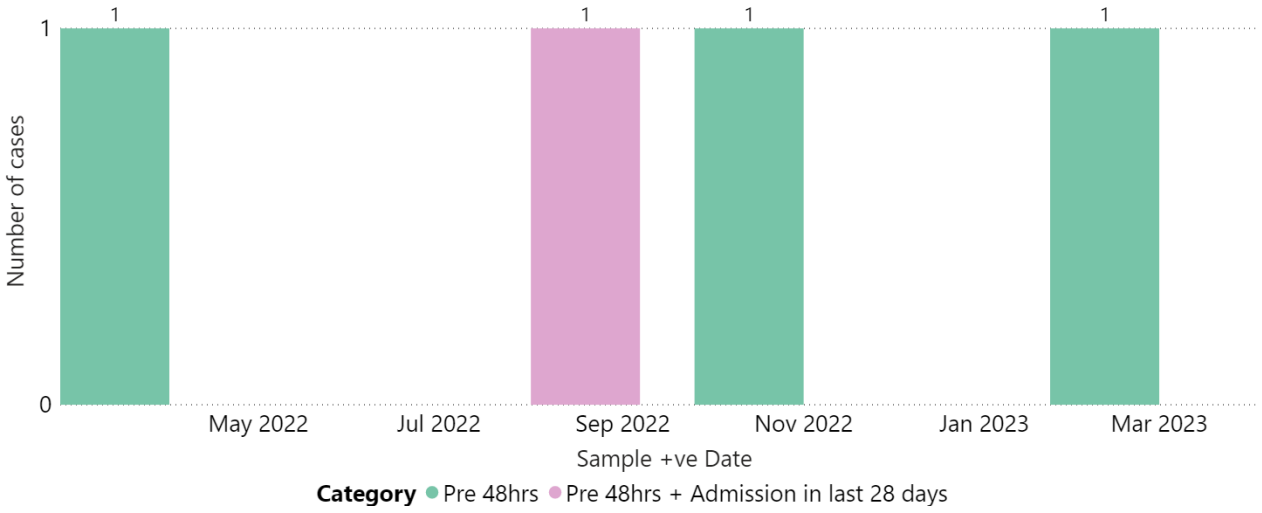
MRSA compliance is monitored against the monthly ward compliance for MRSA in order to identify any missed screening opportunities and investigate reasons for this occurrence. The areas with the lowest screening compliance are identified as areas where a small number of screens have been completed.

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 Governance forums.

Epidemiological analyses of *Staphylococcus aureus* bacteraemia data

Figure showing all MRSA cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	0	1
May 2022	0	0
June 2022	0	0
July 2022	0	0
August 2022	0	1
September 2022	0	0
October 2022	0	0
November 2022	0	1
December 2022	0	0
January 2023	0	0
February 2023	0	0
March 2023	0	1
Yearly Total to Date	**0**	**4**

The Trust undertook two Post infection reviews for post 48-hour MRSA bacteraemias. One was reported as a COHA and the other a CIOA.

Figure showing Health Economy Total MRSA cases in 2022-2023 compared to 2021-2022

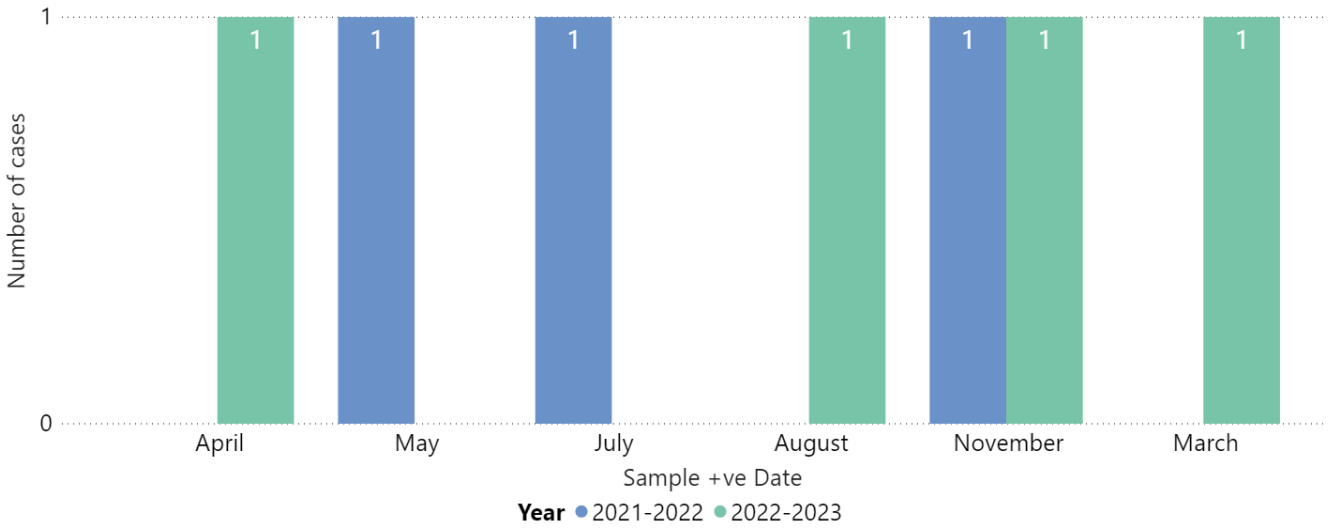


Figure showing quarterly counts of all reported MRSA: April 2007- March 2023

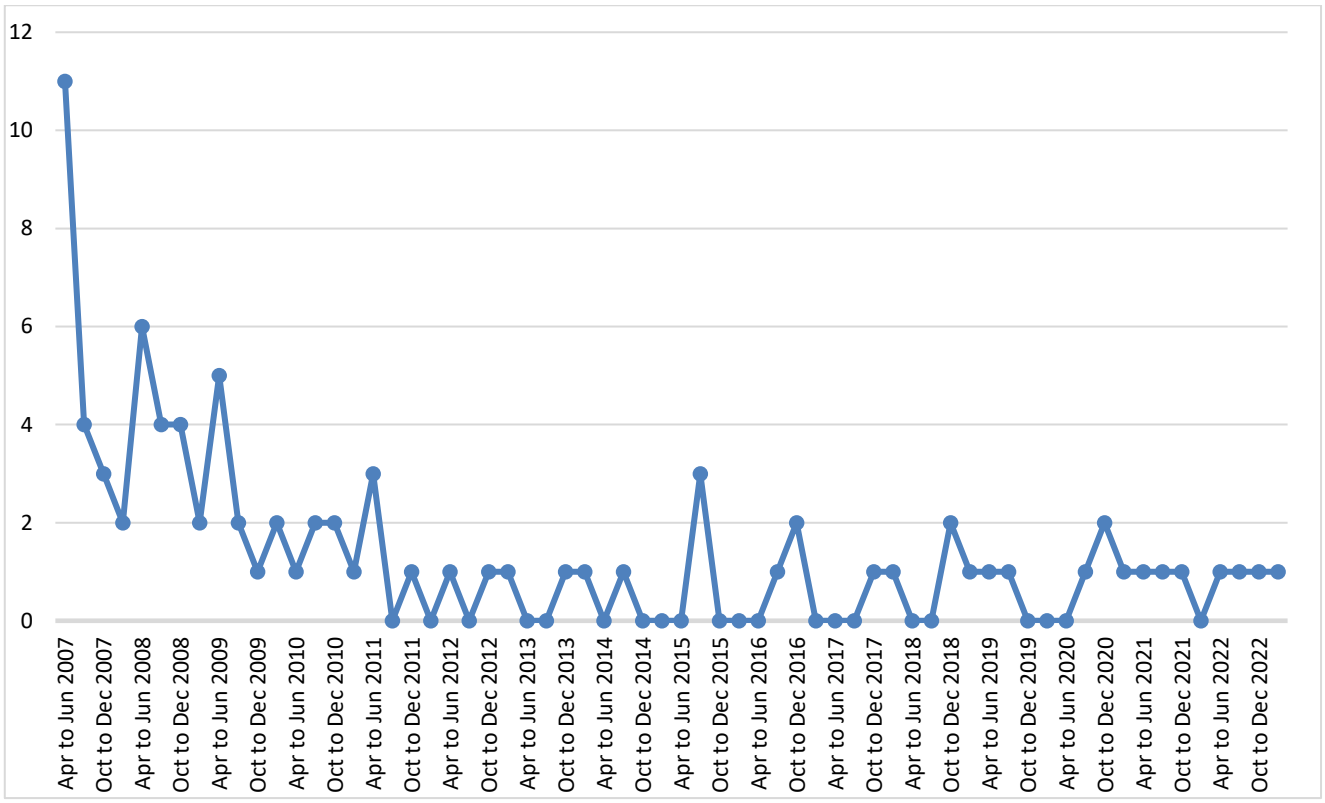
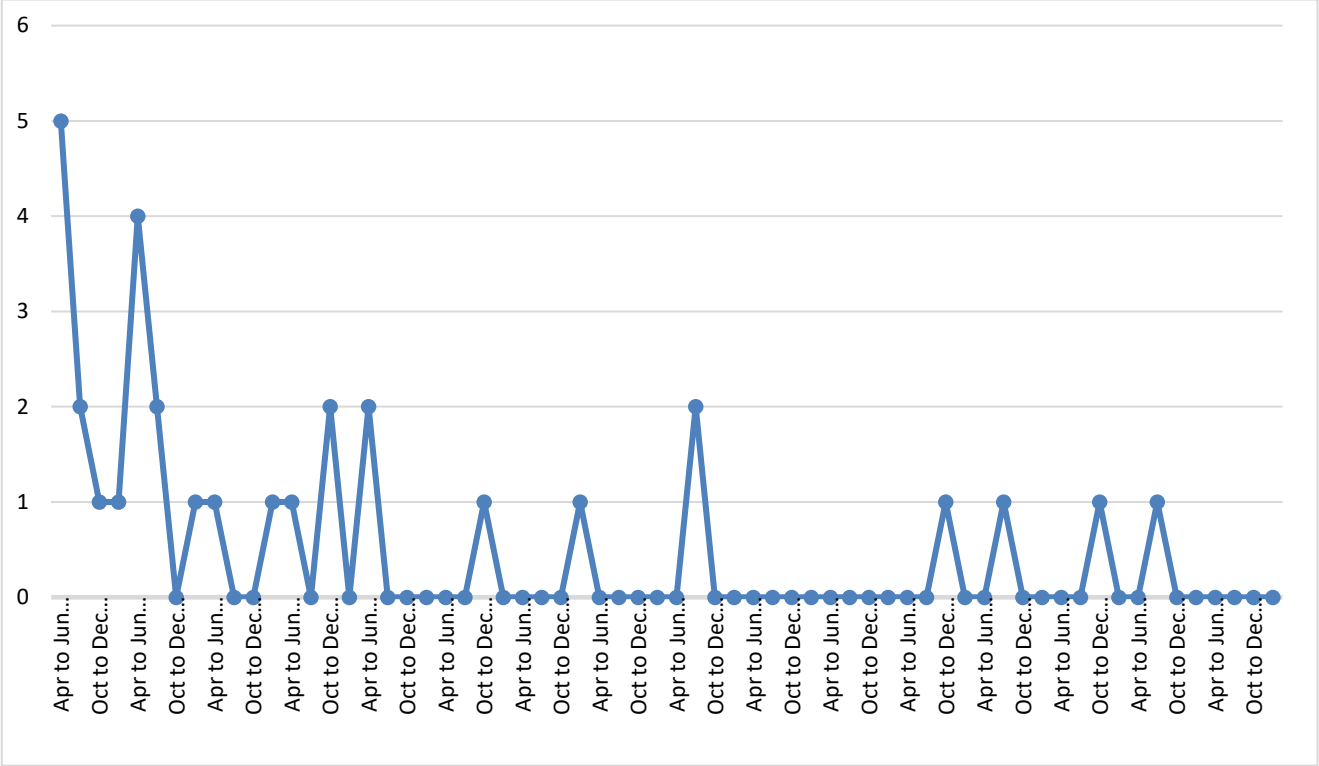


Figure showing quarterly counts of all hospital-onset MRSA: April 2007- March 2023



DGFT 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.

Rates of MSSA bacteraemia continued to increase moderately from April 2011 to March 2012 when the surveillance was introduced. From April to June 2011 to January to March 2023 there has been a 44% increase from 18 cases to 26 cases.

At its peak (2007/2008) MRSA bacteraemia's accounted for approximately 40% of all *Staphylococcus aureus* bacteraemia cases in England.

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

3.4 Methicillin Sensitive *Staphylococcus aureus* Blood Stream Infections (MSSA)

Meticillin-sensitive *Staphylococcus aureus* (MSSA) 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.

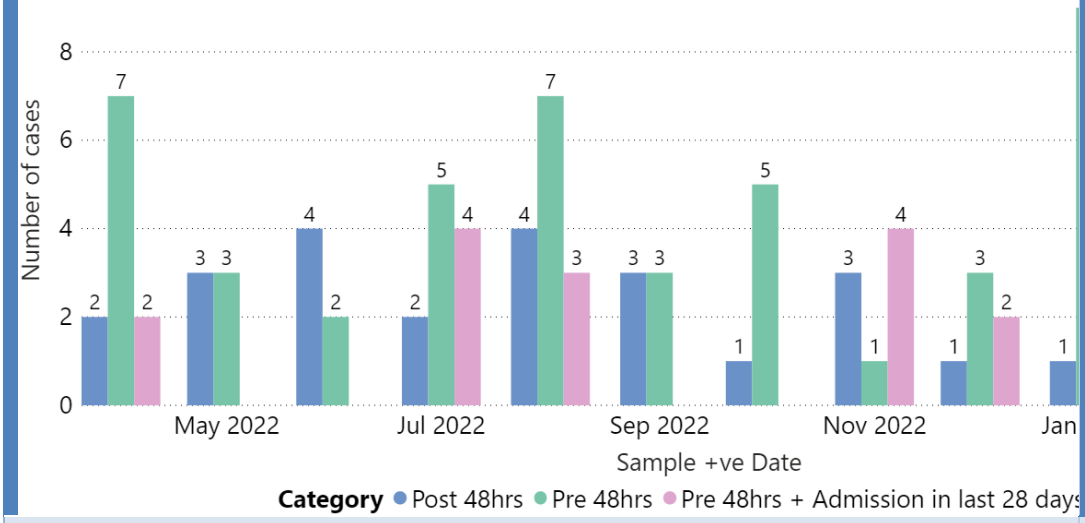
MSSA colonisation usually causes no problems but can cause an infection when it enters into the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g., Grazes, surgical wounds.

MSSA can cause serious infections called septicaemia (blood poisoning) or a blood stream infection where it gets into the bloodstream.

Following a Secretary of State announcement on 5 October 2010, there was a mandatory

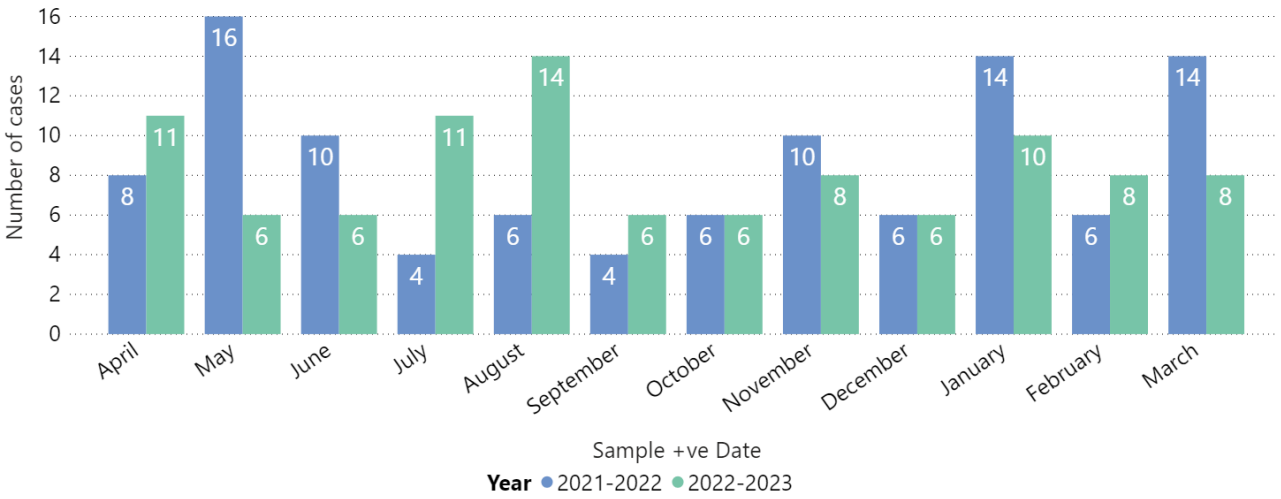
requirement for all NHS acute trusts to report MSSA bacteraemia. This applied to all cases diagnosed after 1 January 2011.

Figure showing all MSSA cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	2	11
May 2022	3	6
June 2022	4	6
July 2022	2	11
August 2022	4	14
September 2022	3	6
October 2022	1	6
November 2022	3	8
December 2022	1	6
January 2023	1	10
February 2023	1	8
March 2023	2	8
Yearly Total to Date	**26**	**100**

Figure showing Health Economy Total MSSA cases in 2022-2023 compared to 2021-2022.



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.

3.5 *Clostridiodes difficile* (Previously Referred to as Clostridium difficile) Infection (CDI)

*Clostridioides difficile (*CDI) reporting for 2019/20 year has aligned the UK definitions with international descriptions of disease.

These changes meant that additional patients would 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 Prevention and Control Team will lead the RCA.

Patients in group 1 (HOHA) will be investigated by the local clinical team.

During 2022/2023, the number of cases that occurred were:

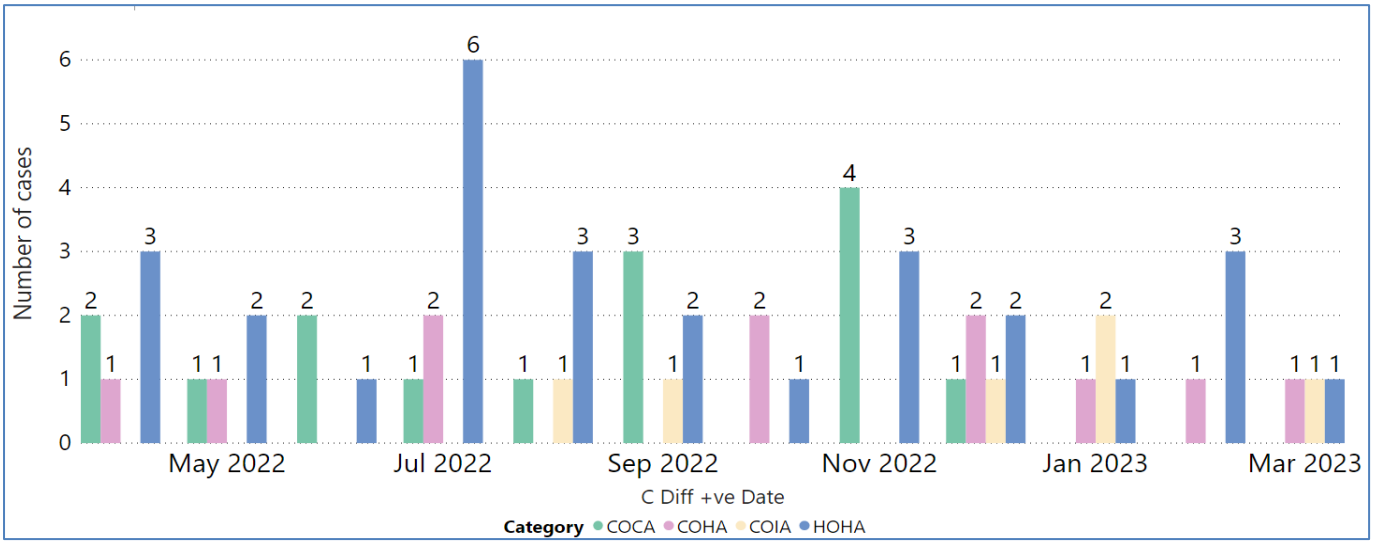
- 28 Hospital Onset Healthcare Associated (HOHA)
- 11 Community Onset Healthcare Associated (COHA)

All cases of CDI 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 involving external partners have now recommenced with the

introduction of a scrutiny panel held internally to review each case prior to the external partner review.

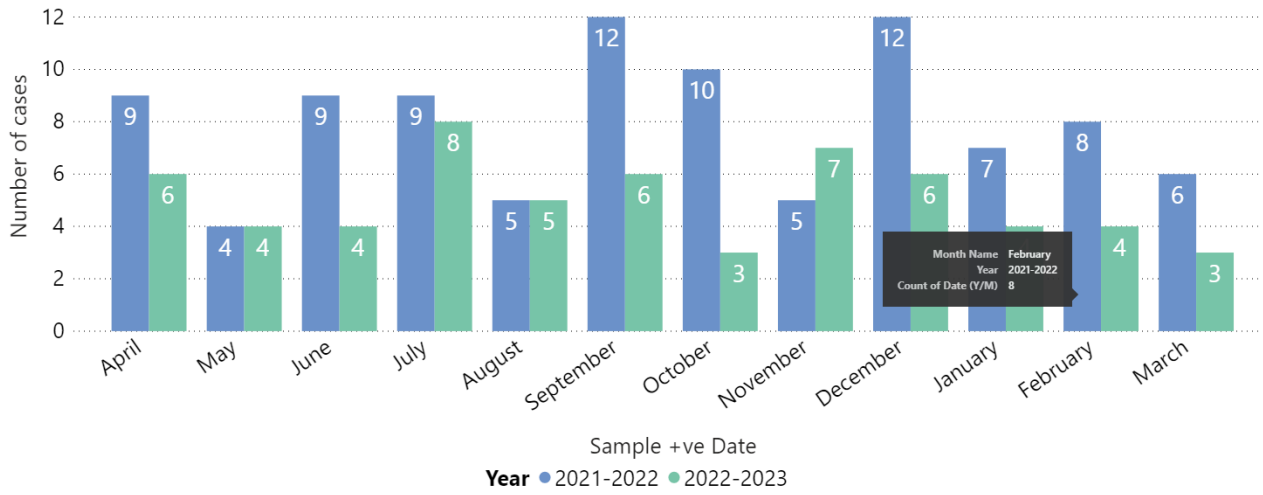
CDI Apportionment Decisions to Date Hospital onset healthcare associated. – April 2022 to March 2023

Figure showing all CDI cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	3	6
May 2022	2	4
June 2022	1	4
July 2022	6	8
August 2022	3	5
September 2022	2	6
October 2022	1	3
November 2022	3	7
December 2022	2	6
January 2023	1	4
February 2023	3	4
March 2023	1	3
Yearly Total to Date	**28**	**60**

Figure showing Health Economy Total CDI cases in 2022-2023 compared to 2021-2022



There have been 28 post 48-hour HOHA cases identified in 2022/2023; of these cases 3 have been associated with having a lapse in care. The common themes identified have been antimicrobial stewardship and issues relating to mandatory training compliance and samples not being obtained in a timely manner. 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 supported by IPC and Pharmacy teams.
- Patient safety bulletin published online and sent to all staff.
- Weekly CDI virtual ward round has been introduced with the Trusts Antimicrobial pharmacists to review the medication prescribed and drug interactions.
- Antimicrobial stewardship section in Trust wide Governance newsletter.
- Feedback to the divisions provided via Antimicrobial Stewardship group.
- Quarterly 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 2022/2023; 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 impacted on training compliance across the Trust however, IPC induction training for new starters were delivered face to face.

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 DGFT 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 following the removal of COVID-19 social distancing requirements.

The IPC Team have been involved in a project with NHSE to review and develop new RCA tools to review CDI cases, creation of new literature and resources including CDI pocket cards for nurses and medics detailing the SIGHTED pneumonic and Bristol Stool form chart and CDI severity.

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

Since the initiation of *C. difficile* (CDI) surveillance in April 2007, there has been an overall decrease in the count and incidence rate of both all-reported and hospital-onset cases of CDI.

Since April 2007 there has been a general decrease in the count of all C*. difficile* cases. This trend is also mirrored for all hospital onset *C.difficile* cases. A large part of the decrease in *C.difficile* count occurred between April to June 2007 and January to March 2012, with a 79% decrease in all reported cases of CDI from 149 cases to 32.

Subsequently, between January to March 2012 and January to March 2023, the count of all-reported cases decreased by 66%% from 32 to 11 cases.

For hospital onset CDI cases only there has been a 93% decrease in the number of reported cases between April to June 2007 and January to March 2023, from 71 cases to 5 cases.

Figure showing quarterly counts of all reported CDI: April 2007- March 2023

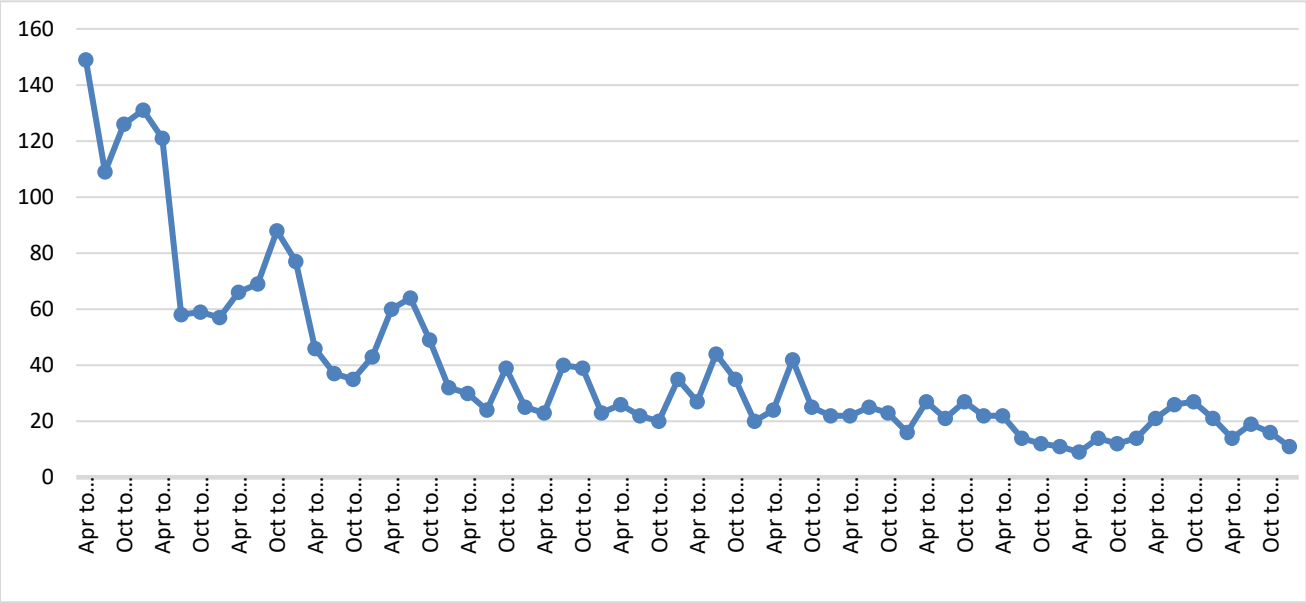
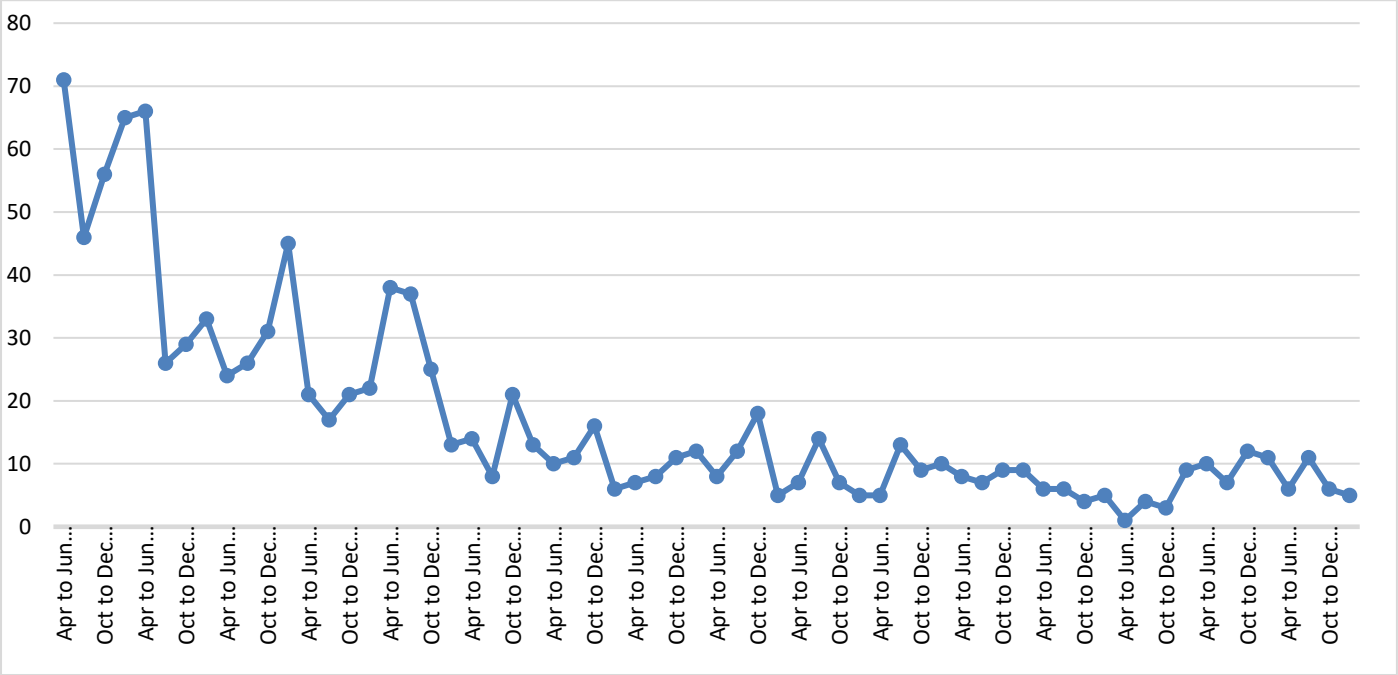


Figure showing quarterly counts of all hospital-onset CDI: April 2007- March 2023



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.

3.6 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 scrutiny panel to establish root cause of the infection and any learning outcomes identified. Following this process and review by the ICB/ Dudley Health Board 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.

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.

DGFT closely monitors periods of increased incidents (PII) of patients with evidence of toxigenic *Clostridioides difficile* in any ward or area. The definition of a PII is 2 or more patients identified with evidence of toxigenic *Clostridioides 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 UK HSA 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 *Clostridioides difficile* is not commonly used, therefore further work in terms of communication of this is required to filter down to the wider organisation.

An additional scrutiny panel has been introduced to discuss all cases of CDI 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 partners.

3.7 Gram Negative Blood Stream Infections – Escherichia coli (E.coli)

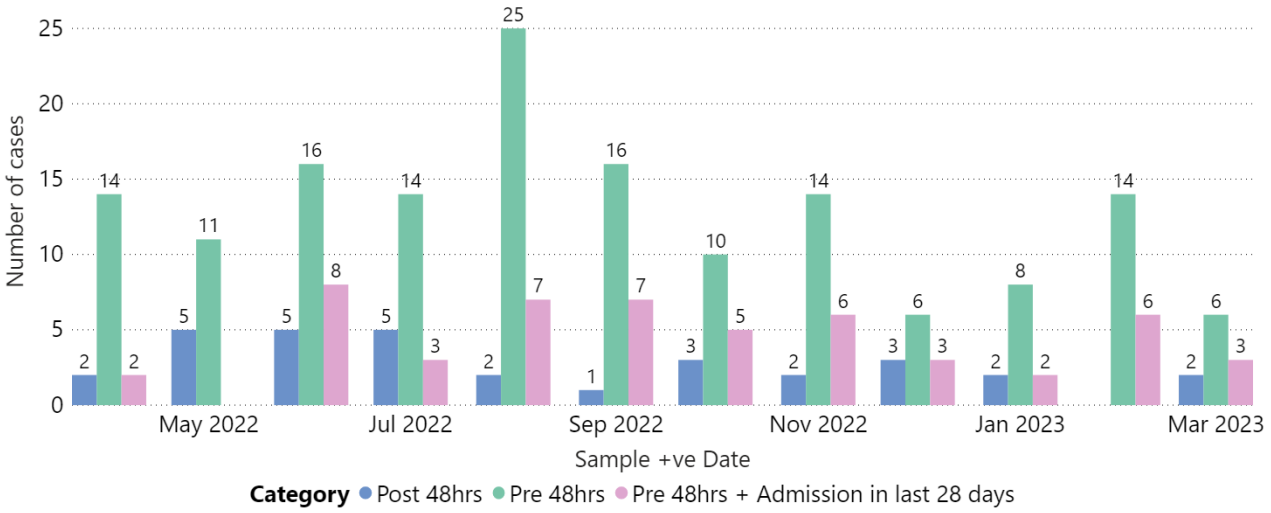
Escherichia coli (E. coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E. coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. 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 in 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 UK HSA. 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 ICB and used across Birmingham and the Black Country.

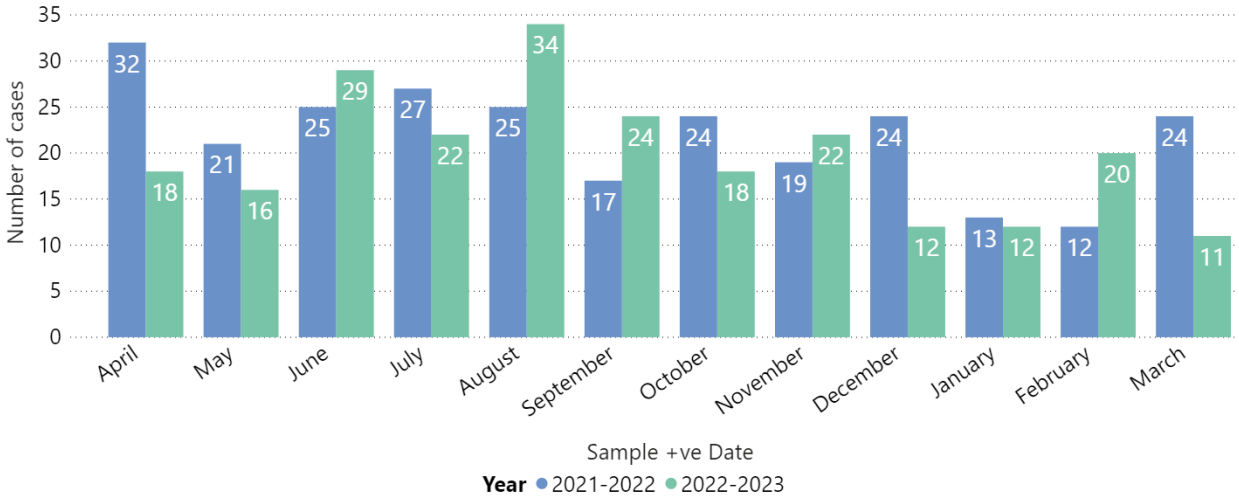
As detailed in the graphs below 238 E. coli infections have been identified with 30 classified as post 48-hour cases. Each post 48-hour case will be reviewed by the IPCT to establish the potential source of the bacteraemia.

Figure showing all E.coli cases since April 2022 by category.



	Trust Apportioned > 48 hours	Health Economy Total
April 2022	2	18
May 2022	5	16
June 2022	5	29
July 2022	5	22
August 2022	2	34
September 2022	1	24
October 2022	3	18
November 2022	2	22
December 2022	3	12
January 2023	2	12
February 2023	0	20
March 2023	2	11
Yearly Total to Date	**32**	**238**

Figure showing Health Economy Total E.coli cases in 2022-2023 compared to 2021-2022.



Epidemiological analyses of Gram- negative bacteraemia data (England)

E. coli bacteraemia

The incidence rate of all reported E. coli bacteraemia increased each year between the initiation of

the mandatory surveillance of E. coli bacteraemia in July 2011 and the start of the COVID-19 pandemic (January to March 2020). This increase was primarily driven by community-onset cases. The number and incidence rates of all reported and community-onset cases declined after the start of the pandemic but remain higher than observed at the start of E. coli surveillance.

In contrast, the count of hospital-onset cases fluctuates during the same period. Between April to June 2011 and January to March 2023, the count all reported cases of E. coli bacteraemia increased by 59% from 27 cases to 43.

Similarly, over the same period, the count of community-onset cases increased by 27% from 22 to 28 cases. Concurrently, the count of hospital-onset cases decreased by 20% from 5 to 4 cases.

Figure showing quarterly counts of all reported E.coli: April 2011- March 2023

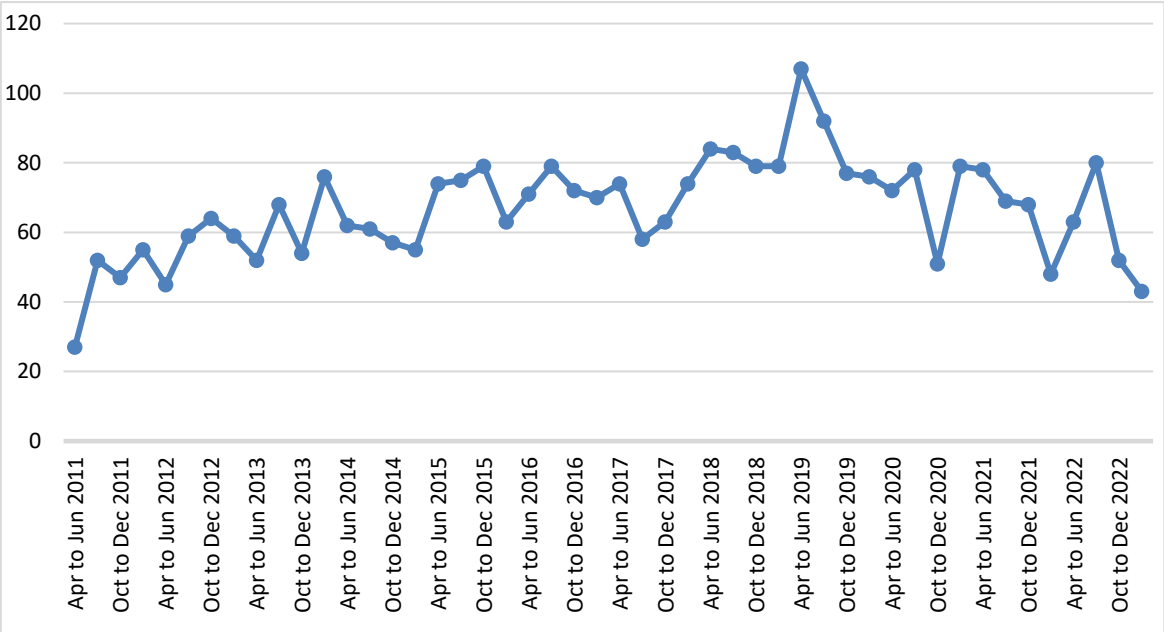
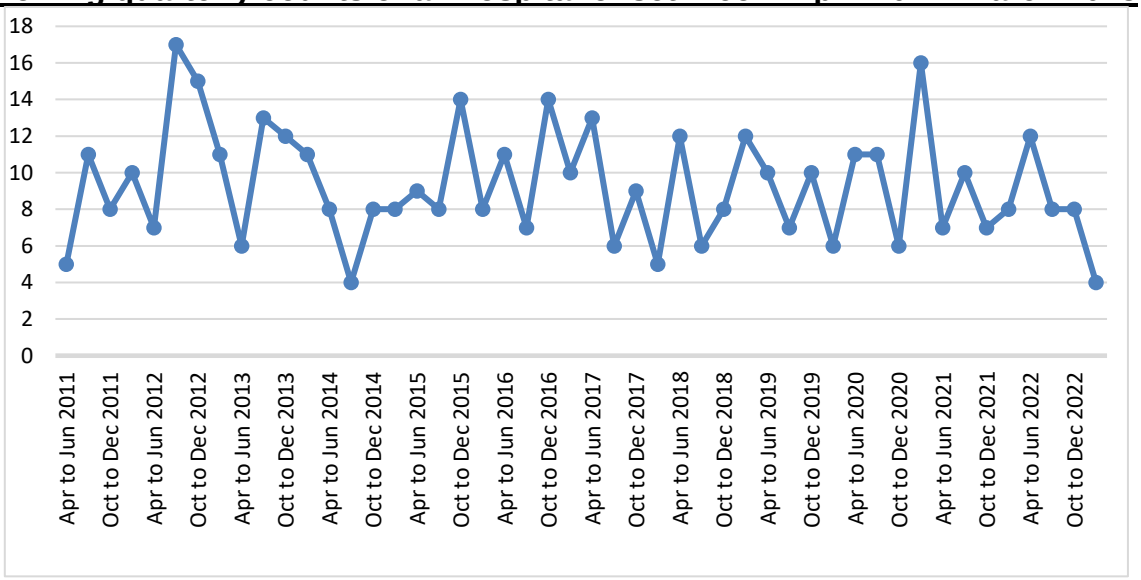


Figure showing quarterly counts of all hospital-onset E.coli: April 2011- March 2023



Further work is needed in order to reduce the number of cases reported within DGFT 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 Urinary Tract Infections (UTI)s.

3.8 Vancomycin / Glycopeptide Resistant Enterococci (VRE/GRE)

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

Vancomycin resistant enterococci (VRE) and Glycopeptide resistant enterococci (GRE) may be found in the healthy population thought to reflect inappropriate use of antibiotics in farming.

Mandatory surveillance was discontinued in 2013.

3.9 Carbapenemase Producing Enterobacteriaceae

The Enterobacteriaceae are a large family of Gram-negative bacteria including species such as E. coli, Klebsiella species, Proteus species, and Enterobacter species. 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 (UK HSA 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.

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

DGFT identified two cases of CPE during the time period covered by the report.

3.10 Norovirus

Norovirus is defined as an 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 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 50 confirmed cases of Norovirus and 7 outbreaks. Norovirus was prevalent throughout the local community through December to March. All outbreaks are reported to the UK HSA and an internal meeting was held to review. Lessons learned are disseminated throughout the Trust.

Figure showing all Norovirus cases since April 2022 by month.

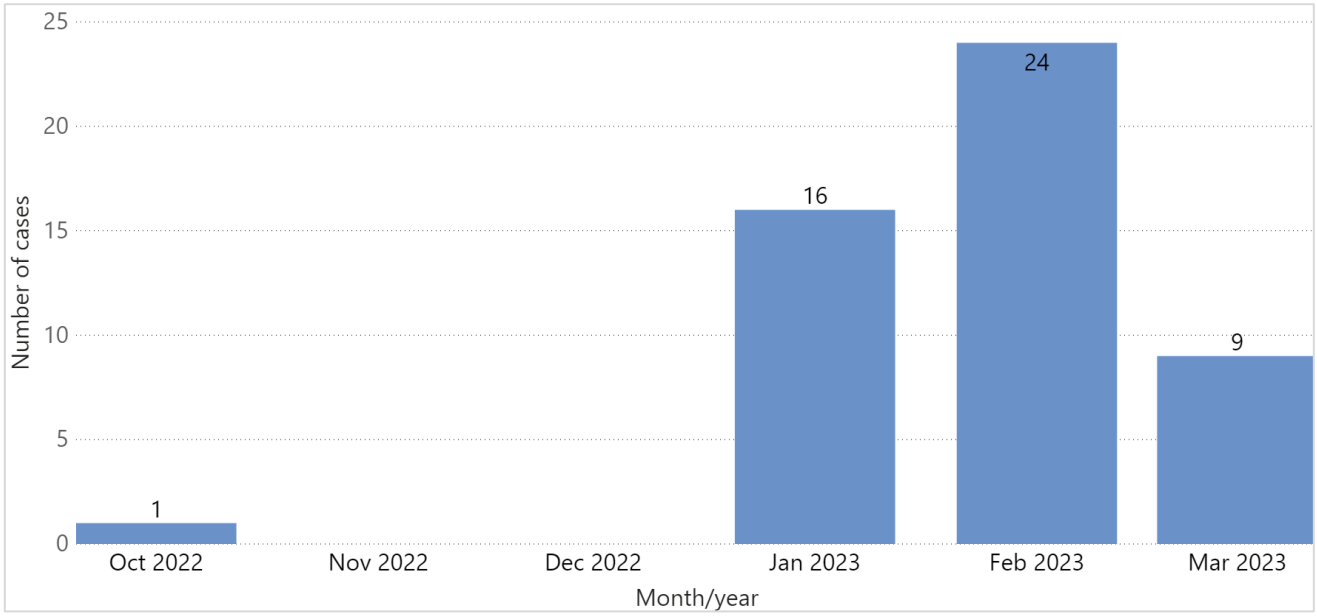
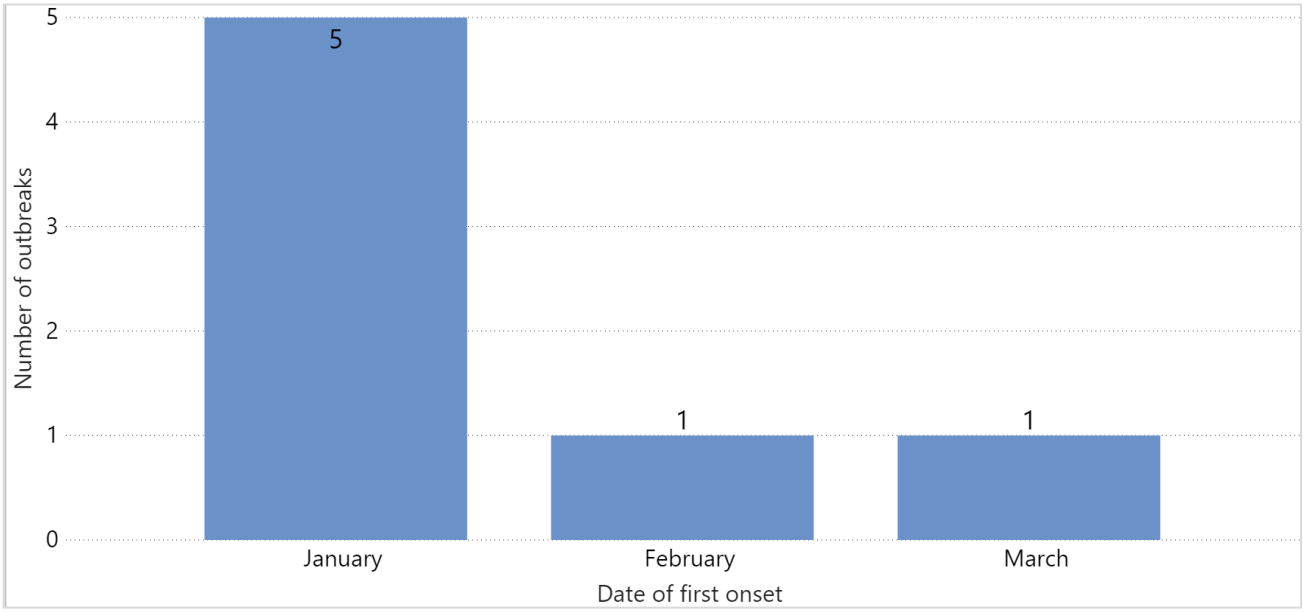


Figure showing all Norovirus outbreaks since April 2022 by month.



3.11 COVID-19

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 12 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 COVID-19 planning team was established and comprises of all key partners that are required within trust to ensure all aspects of COVID-19 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-19 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.

6777 individuals were tested positive for COVID-19 from 1st March 2020 to the 31st of March 2023 at The Dudley Group.

In November 2020 UK HSA / NHSE 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:

Critical Care Data - 1st March 2022 12th April 2023

260 patients were admitted to Critical Care.

There are 37 patients within the Critical Care data set that will require a review as part of a harm review process. NHSE and UK HSA recommend any patient that requires level 2 or level 3 care as part of a hospital acquired COVID-19 positive pathway must be assessed for harm and long-term health needs. A harm review will be completed 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 Staff Health and Wellbeing (SHAW) undertook some limited staff contact tracing during the first wave, it was recognised during the second wave 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.

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 Personal Protective Equipment (PPE) or behaviour aspects that may have contributed to the outbreak.

Key themes identified from staff contract tracing have included:

- Breaching PPE – face mask compliance
- Sociaising outside of work 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 patient database. Information regarding positive patient/s and contacts are detailed within the file and discussed as part of the outbreak meetings held internally andw with external partners. 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 UK HSA (08.2020) two or more cases linked by time and place where at least one case (if a patient) has been identified as having illness onset after 8 days of admission to hospital. Outbreak meetings were established in line with best practice toolkit from NHSE.

Each outbreak has an individual timeline where all information regarding these patients are collated and reviewed.

These meetings were 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 OTKA NHSE Outbreak System.

Since April 2022 there have been a total of 46 outbreak areas relating to COVID-19 within the Trust where 2 or more cases tested positive on the same ward or area 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 with external partners where necessary, and actions identified. Closure reports are issued after 28 days, and the outbreaks are recorded on the OTKA NHSE database.

The Dudley Group NHS Foundation Trust COVID-19 Outbreak Overview:

DGFT Outbreak Data- 31/03/2023	
Total outbreaks	128
Total COVID-19 Positives	1407
Total Patients	853
Total Staff	554

Figure showing all COVID-19 cases in 2022-2023 compared to 2021-2022.

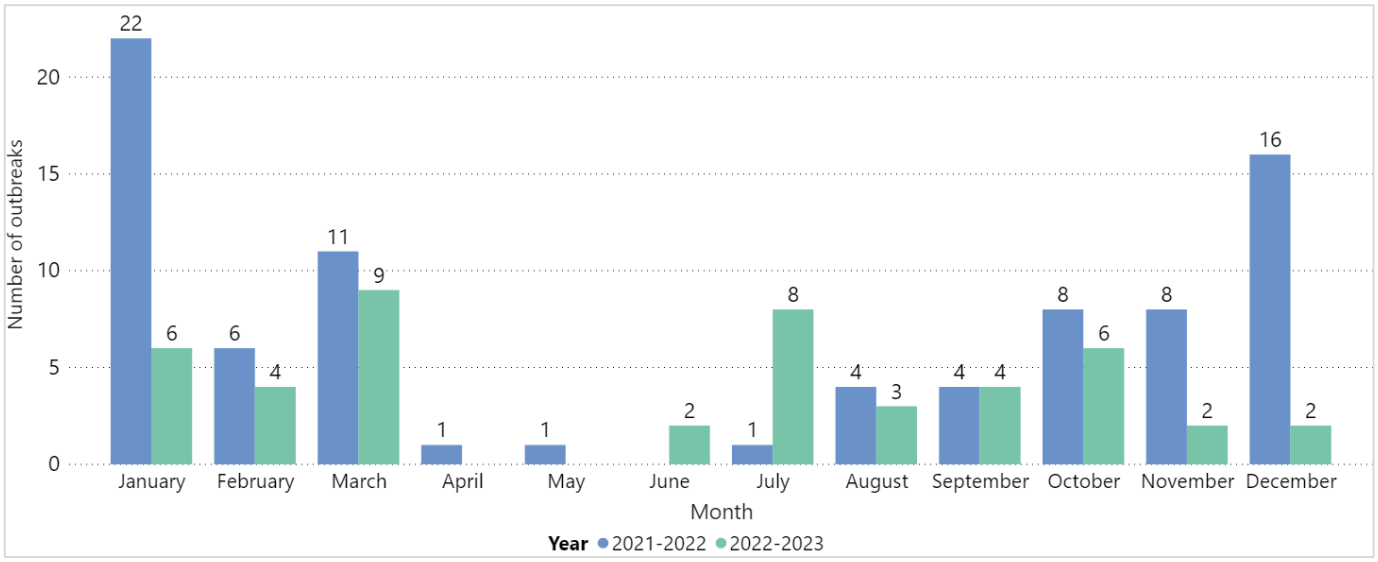
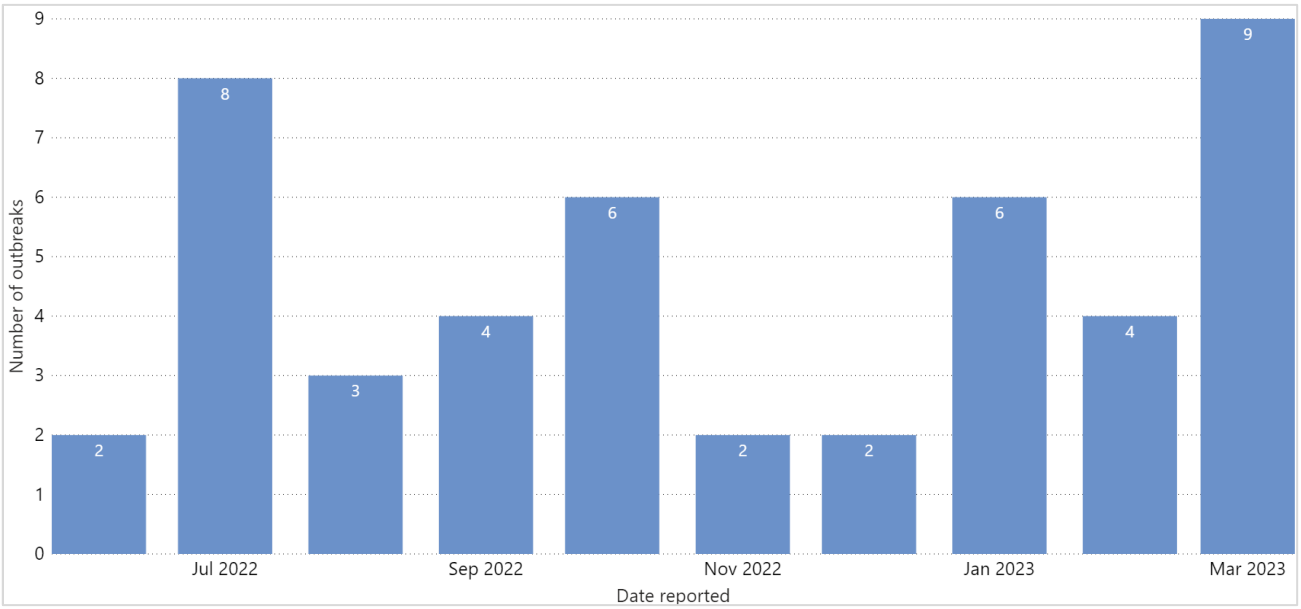


Figure showing all COVID-19 outbreaks since April 2022.



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 including hand hygiene, Matron peer review and Environmental 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 vaccination centre at Saltwells Centre, 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 cleaning standards.

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

3.12 Audit Programme

The DGFT 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. All Environmental audits are recorded on AMaT, and an electronic action plan is generated.

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 (PII) 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 DGFT 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.

DGFT OVERALL SCORES 2022-2023

Interventions		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		4-22	5-22	6-22	7-22	8-22	9-22	10-22	11-22	12-22	1-23	2-23	3-23
HII 1:	Ventilator Associated Pneumonia	100.0%	90.0%	90.0%	75.0%	90.0%	90.0%	70.0%	90.0%	100.0%	66.7%	77.8%	80.0%
HII 2a:	Peripheral Vascular Access Devices - Insertion	94.6%	97.0%	96.4%	95.0%	98.7%	97.9%	96.2%	96.6%	99.1%	95.9%	94.9%	95.5%
HII 2b:	Peripheral Vascular Access Devices - Ongoing care	90.2%	98.6%	97.4%	96.6%	95.8%	95.4%	97.0%	97.8%	96.2%	97.2%	92.6%	92.2%
HII 3a:	Central Venous Access Devices - Insertion	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HII 3b:	Central Venous Access Devices - Ongoing Care	100.0%	100.0%	100.0%	100.0%	100.0%	97.4%	100.0%	97.6%	96.8%	96.0%	94.4%	96.0%
HII 4a:	Surgical Site Infection Prevention - Preoperative	100.0%	92.6%	100.0%	100.0%	100.0%	100.0%	100.0%	89.3%	100.0%	100.0%	86.4%	100.0%
HII 5:	Infection Prevention in Chronic Wounds	94.9%	98.9%	98.7%	98.9%	98.5%	98.6%	100.0%	95.3%	100.0%	100.0%	100.0%	98.4%
HII 6a:	Urinary Catheter - Insertion	97.8%	98.6%	97.9%	97.9%	96.4%	99.2%	99.2%	98.4%	100.0%	99.2%	100.0%	99.0%
HII 6b:	Urinary Catheter - Maintenance & Assessment	94.0%	100.0%	97.0%	98.8%	96.8%	97.6%	98.1%	99.4%	98.6%	95.5%	94.9%	96.0%
High Impact Interventions Monthly Overall		96.8%	97.3%	97.5%	95.8%	97.4%	97.3%	95.6%	96.0%	99.0%	94.5%	93.4%	95.2%
Hand Hygiene		99.4%	99.3%	98.9%	99.3%	98.9%	98.8%	99.7%	99.9%	87.5%	90.0%	99.4%	98.6%
Commode Audits		98.0%	99.1%	98.5%	99.1%	99.1%	99.1%	99.0%	99.4%	98.3%	99.0%	98.8%	99.2%
Cleaning Scores													

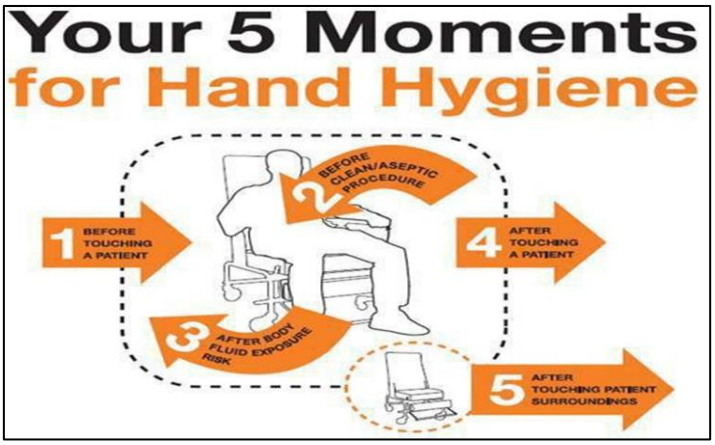
Clinical practice audits have been commenced by the IPC Team to monitor compliance of key infection control issues across the wards and departments such as environmental cleanliness, hand hygiene compliance, equipment monitoring and sharps compliance.

3.13 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 indicate compliance based on the data submitted.

The DGFT 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 5 Moments 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 consistently monitored throughout the year.

Individual hand hygiene assessment competencies were introduced on clean your Hands Day in May 2022. These are a peer review set of competencies to be completed by each clinical member of staff as part of their annual appraisal process. Compliance is monitored at the IPCG meeting.

3.14 Mandatory Training

The revised mandatory requirement is to update Infection Control training annually for clinical staff.

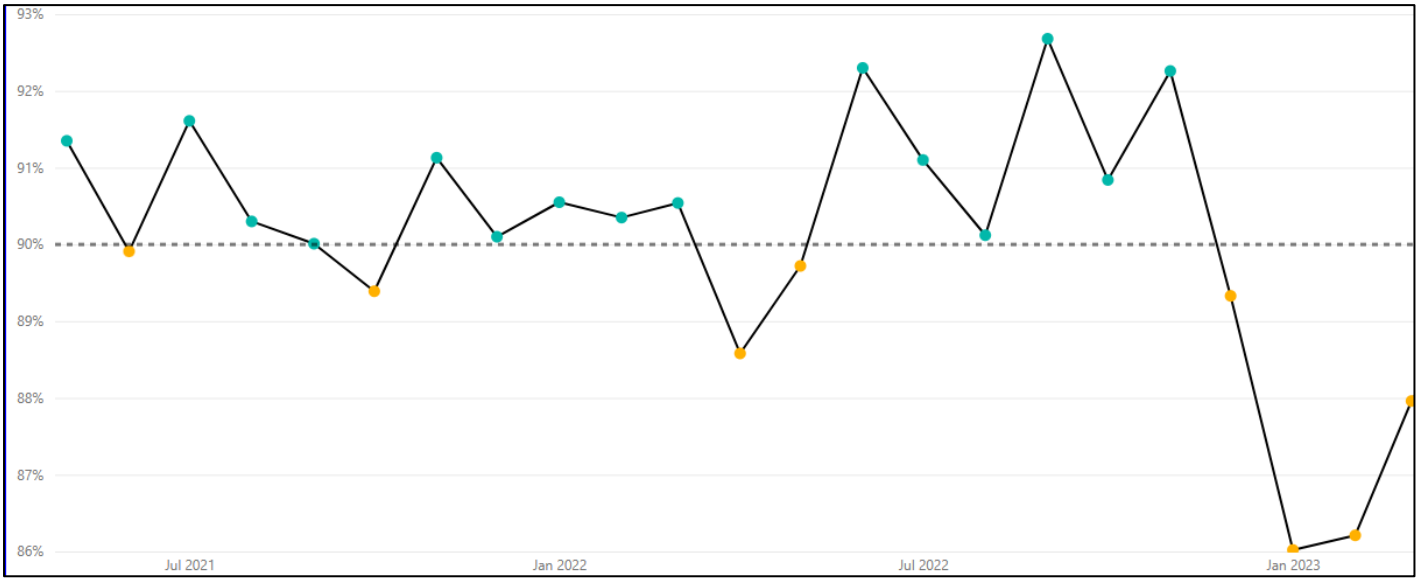
The following measures have been introduced to achieve compliance of 90% of clinical staff.

Reduced compliance of infection control training was noted during COVID-19; 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 IPC training on the staff intranet (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.

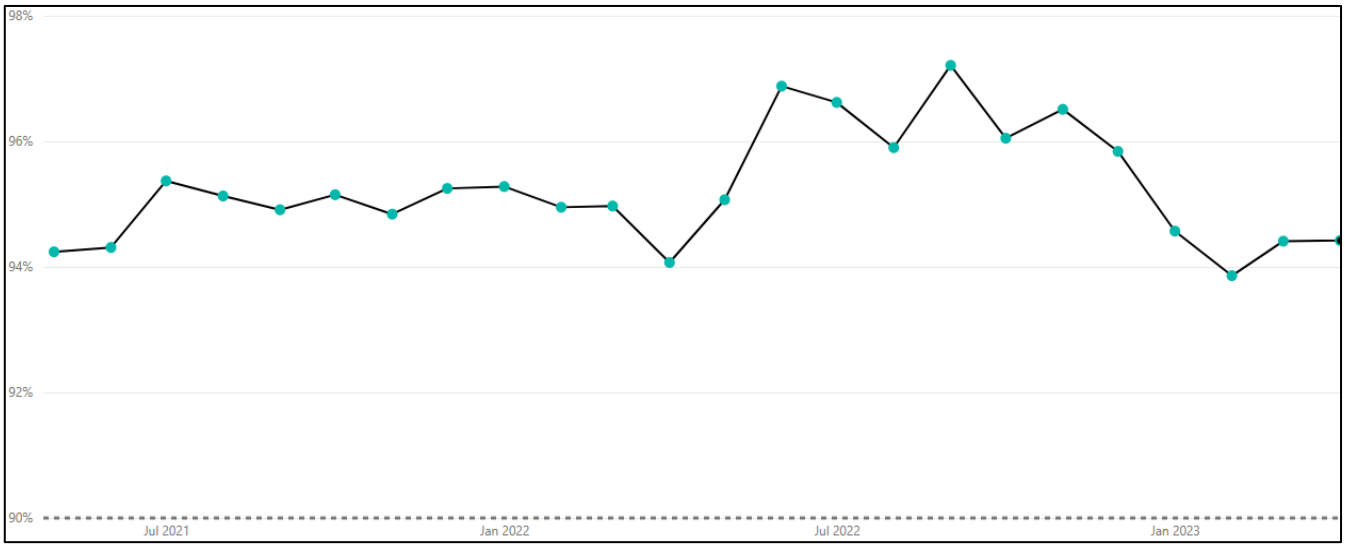
As of March 2023, the trust total is 87.96% (Clinical) & 94.41% (non-Clinical). This data is based upon an annual cycle. The IPC Training compliance is managed by the divisions and is discussed monthly at divisional meetings. This is then fed through the IPC Group with actions being taken to improve compliance and discuss current progress.

Figure showing Infection Control Clinical percentages since May 2021



Infection Control – Clinical %				
Month	**Corporate / Management**	**Medicine/ Integrated Care**	**Surgery**	**Clinical Support**
April 2022	84.66	88.89	88.37	89.33
May 2022	86.66	89.80	89.57	90.98
June 2022	89.17	92.35	91.80	94.91
July 2022	87.70	90.96	91.21	92.54
August 2022	88.82	89.09	90.88	92.35
September 2022	93.83	91.57	93.50	92.83
October 2022	92.50	89.27	90.42	93.67
November 2022	87.19	91.25	92.74	93.84
December 2022	89.08	86.29	90.23	92.69
January 2023	88.82	82.56	87.34	89.00
February 2023	90.90	83.66	85.44	90.78
March 2023	90.85	86.89	86.08	92.17

Figure showing Infection Control Non-Clinical percentages since May 2021



Infection Control – Non-Clinical %				
Month	**Corporate / Management**	**Medicine/ Integrated Care**	**Surgery**	**Clinical Support**
April 2021	91.81	95.09	96.44	94.11
May 2021	92.42	97.04	97.38	94.11
June 2021	94.44	98.28	98.64	98.80
July 2021	95.19	96.98	97.72	98.87
August 2021	94.39	95.73	97.74	97.82

September 2021	95.01	98.27	98.73	98.76
October 2021	93.89	97.85	97.25	97.09
November 2021	94.51	97.83	97.49	98.25
December 2021	94.96	97.42	95.45	96.70
January 2022	93.30	95.76	95.46	94.62
February 2022	92.34	95.31	96.34	91.53
March 2022	92.69	95.78	96.64	93.19

3.15 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 2022. 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 vaccination hub.
- Staff health and wellbeing provided advice and guidance for staff that had underlying conditions or allergies.

At the end of March 2022 64.1% of the DGFT staff had received their influenzas vaccine. This percentage is a reflection of substantive staff that have been corroborated against Electronic Staff Record (ESR). It was noted that PFI colleagues and volunteers were not included in this percentage in line with the national reporting requirements.

3.16 Link Worker Programme

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

Link Worker meetings recommenced in March 2022, and they run every month via TEAMS to provide education support and act as an IPC resource for the link staff to maintain their enthusiasm and commitment to IPC.

The aim of these meetings is to provide updates on any new guidance / policies, an opportunity to share learning outcomes and case studies, and to enhance effective communication across DGFT. There is at least one link worker in every department including inpatient and community areas, they are key in undertaking monthly audits of practice.

A Link worker study day was held on in March 2023 for DGFT, 16 staff attended, topics included respiratory infections, sharps safety, hand hygiene, antimicrobial stewardship, and decontamination. The day evaluated very well with lots of positive feedback and comments. There are plans to repeat this annually.

SECTION FOUR:

PROGRESS AGAINST 2022/2023 INFECTION PREVENTION AND CONTROL PROGRAMME

4.1 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 and any risk that their environment and other users may pose to them

- Infection Prevention and Control Arrangements and Responsibilities policy reviewed to reflect management and reporting structure of DGFT, outlining its collective responsibility for IPC and demonstrating responsibilities are devolved to all staff/groups in the organisation.
- IPCG meeting Terms of Reference (TOR) and membership reviewed annually.
- Head of IPC has provided quarterly reports to Quality and Safety Committee including thresholds, risks, and progress against objectives.
- Head of IPC has provided bi-monthly reports to Quality and Safety Delivery Group.
- The Annual IPC Report is produced and presented to the public board.
- The Annual IPC Report is made available for public viewing via the DGFT website.
- *Clostridiodes difficile* Improvement plan was developed and is reviewed and monitored at the IPCG meeting.
- IPC Board Assurance Frameworks were developed, updated as required and presented to the Quality and Safety Delivery Groups, quality, and Safety Committees and the DGFT Public Board
- Risks associated with infection have been entered on the DGFT risk register and are reviewed monthly.

- The IPC team continued to identify IPC risks and areas of weakness in policy and practice though audit and surveillance.
- CQC Provider Compliance Assessments completed.
- Information shared with external agencies and partners when requested.
- IPC Team has worked alongside clinical staff in the hospitals as a mechanism to deliver teaching and education to staff.
- New Source and Protective Isolation door signs were introduced.
- All infection outbreaks reviewed, and service improvement plans developed so that relevant learning was appropriately communicated and acted upon.
- RCA/CCRs were completed for all patients who developed a CDI tabled at the IPCG meeting.
- PIRs were completed when required.
- Alerts are added to patients' sunrise records to highlight risk of infection.
- New electronic patient record alerts have been developed to reflect COVID-19, supported by informatics reports to support national reporting requirements.
- The IPC Annual Audit Programme was reduced following an increase in COVID-19, winter pressures and staff sickness and vacancies within the IPC Team
- IPC audit tools adapted in 2011/12 from the Department of Health (DH) /Infection Prevention Society Quality Improvement Tools and DH Saving Lives care bundles have been revised and updated to incorporate new guidance. These are reviewed and updated annually.
- IPC training is delivered via a mixture of face to face, bespoke and via a Heath Education E-learning package.
- IPC Induction training is delivered face to face.

4.2 CRITERION 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates and prevention and control of infections

4.2.1 Estates and Facilities Outbreaks

The section below in italics has been completed by Jannine Dyke, Soft Services contract Manager.

The section below in italics has been completed by Jannine Dyke, Soft Services contract Manager.

Cleaning Audits

The Trust recognises its duty to provide safe and clean environments where patients, staff and visitors can expect to be protected from the risk of infection, cleaning services are in the main 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 Estates and Facilities Team. Cleaning audits are undertaken by the Trust Auditors in partnership with Mitie and clinical staff where possible across its sites.

During May 2022 the Trust revised its Cleaning and Disinfection of the Environment Policy to reflect the requirements for implementing The National Standards of Healthcare Cleanliness 2021, with the introduction of a Commitment to Cleanliness Charter, signed by the Chief Nurse & Director for Infection Prevention and Control. Signing up to this charter publicises the Trust's commitment to

achieving a consistently safe and high standard of cleanliness. The Trust continues to work with Mitie on the implementation of the Standards through training and introduction of new technology to drive improvement and efficiencies.

Each Department underwent a review to be given a functional risk (FR) rating (1-6) in line with the guidance provided by NHSE based on clinical activity and risk. Each FR rating has a description to assist the public in understanding why an area is categorised as such. These descriptions are displayed with the cleanliness charter and cleanliness star ratings.

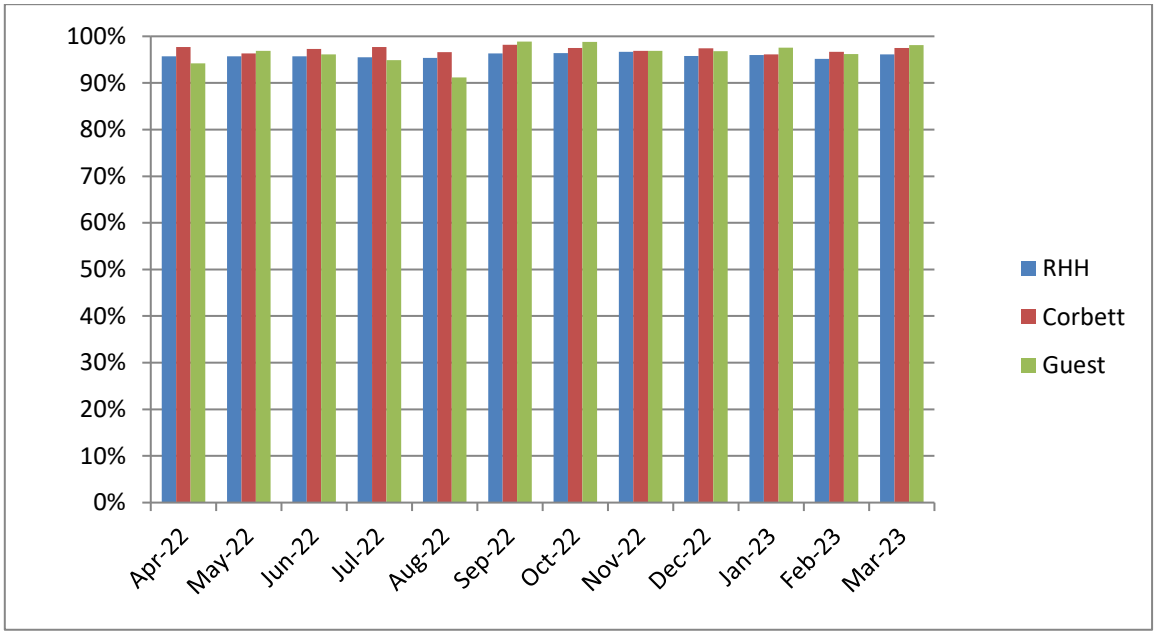
Technical cleanliness audit results are now shown as a star rating (1-5), rather than an audit percentage score. Star ratings are displayed in areas accessed by patients and where they are visible, for example in or near ward and departmental entrances, in circulation areas and/or waiting rooms. The purpose of the star rating is to give patients, staff, and the public an easily understood visual score of the standard of cleanliness being achieved in the area. Star ratings are provided dependent upon the FR rating and the overall cleaning score reviewed against the target score; this includes all cleaning, carried out by the Trust and Mitie. Functional areas rated at 3 stars or fewer are subject to an improvement plan, which is also displayed following the audit. 3 stars is when the overall scores are 4%-6% below the target score, 2 stars is when the overall score is 7%-9% below the target score and 1 star is 10% or more below the target score. Areas that achieve 3 stars or below are reported to the Board via the Infection Prevention and Control Committee (IPCC).

Technical audits are carried out by the Trust's audit team, with Mitie attendance, more frequent attendance by the clinical team continues to be encouraged. Access to rooms can sometimes be denied at the time of the audit but as many rooms as possible are audited at each session. Although the team try to achieve 100%, a minimum of 75% of each area is audited in one session making the audit representative of the whole area. At the end of the audit the auditor liaises with a senior member of the clinical team to advise of the audit outcome and point out any significant areas of concern.

During the technical cleaning audit, items of environmental maintenance are recorded by Mitie and followed through to close out.

Audit results are monitored by the Cleaning Monitoring and Operations Group, which meets monthly to review the scores, as well as other items agreed in the Terms of Reference.

Cleaning scores across the Trust have continued to plateau over the past 12 months. In the main, Russell's Hall Hospital, Guest and Corbett Out-Patient Centres continue to achieve an overall monthly score above the 95% threshold, apart from the Guest OPD where the score was less than this on three occasions. Please see chart below.



An average of 156 audits per month were carried out during the Apr 22-Mar 23 period. Areas were audited in line with the Trust's Cleaning and Disinfection of the Environment Policy and the Trust continued to apply the performance management mechanisms within the PFI contract throughout this period as relevant.

Additional Touchpoint cleaning has continued to take place where the Trust's Infection Prevention and Control (IPC) team have identified a need for this, usually where an infection has been identified. The Trust's Facilities team and IPC team worked closely with Mitie and Summit for this to take place.

Further developments in association with Mitie and Summit are to re-define the contract mechanism so that it aligns to the requirements of the National Standards for Cleanliness and the Trust Policy. The revised specification and contract mechanism will form part of the contract benchmarking in 2025.

Patient Led Assessment of the Care Environment (PLACE)

PLACE is the national system which focuses exclusively on the environment in which care is delivered; it does not cover the clinical care provision.

During 2022 a programme of PLACE-Lite sessions was carried out and an action plan produced to work through the points raised. This is monitored via the Patient Experience Group (PEG), chaired by the Chief Nurse. This programme put the Trust in a good position for the national PLACE assessment. The PLACE-Lite results are recorded on the NHS Digital platform, similar to national PLACE, but this information is not shared with other Trust's and no benchmarking takes place as with national PLACE.

PLACE was carried out in Dudley over two days, this was based on previous feedback by the patient assessors. Assessments took place on Tuesday 25th and Monday 31st October 2022. All PLACE domains were assessed, including Cleanliness, Food, Condition Appearance & Maintenance, Disability, Privacy, Dignity & Wellbeing, as well as Dementia, the results of which were published at the end of March 2023 and are identified below:

Name	Cleaning Score %	Food Domain Score %	Organisation Food Score %	Ward Food Score %	Privacy, Dignity & Wellbeing Score %	Condition, Appearance & Maintenance Score %	Dementia Score %	Disability Score %

Russells Hall Hospital	99.22%	92.91%	92.53%	93.02%	94.31%	97.83%	86.50%	91.52%
National Average	98.01%	90.23%			86.08%	95.79%	80.60%	82.49%

The Trust has achieved above the national average in all domains and is the first time this has been achieved over recent years.

Patient assessors were recruited from both Healthwatch and the Trust's Board of Governors, truly reflecting the patient population. Many of the assessors had taken part in the PLACE-lite programme so required minimal training for national PLACE. A variety of staff assessors also attended the assessments and provided specialist feedback during the assessments this included Matrons, other senior nurses, Deputy DIPC, Head of Dietetics, as well as representatives from the Trust's PFI partner, Mitie, Estates, Catering and Domestic teams.

Over the two days 10 wards were assessed: C3 including FGMN, B3, C7, B4, B6, B5, AMU Ground and First Floors, C1 and Neonatal Unit. The Emergency Department, Communal Areas and External Areas were also assessed. For non-ward areas a minimum of 25% needed to be included and areas visited included GI Unit, Day-Case, Renal Unit, Emergency Surgical Hub, North Block OPD, Main OPD, SDEC, Anti-Coagulant Clinic and Therapies. Assessors were encouraged to speak with patients during the assessments, in addition to making a judgement on what they saw.

In addition, 4 mealtime assessments were also completed on C3, B3, B4 and C1.

Of the clinical areas visited, all areas achieved 'confident' or above when asked 'Having carried out the PLACE assessment on this department, how happy/confident are you that a good level of patient care and experience will be delivered within the environment? This was apart from one clinic area that achieved 'not very confident', and this has been shared with the Matron and Directorate Manager responsible for the area.

An action plan has been generated for the areas not achieving the PLACE requirements and/or where recommendations have been made. The action plan is currently being worked through with the relevant teams to further improve on the environment for our patients.

4.2.2 Water Systems Management

The section below in italics has been completed by Darren Lowe, Estates Compliance Manager.

The Water Safety Group (WSG) oversees all aspects of water safety for the PFI Estate. The Group is normally chaired by Summit Healthcare Limited who are the owners of the PFI Estate, but due to a change in their management, Trust Estates Compliance Manager has been chairing the meetings until the new Managers become established. The members of the group included:

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

The Trust has recently appointed a new Director of Estates and Facilities who will be the supporting the group and management of water safety in association with Trust IPC and third-party stakeholders.

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. There were two occasions where concerns were raised from samples results with significant Legionella counts. During December 2022, a large quantity of sample results returned with high Legionella counts, which the water safety group convened and determined as spurious. Precautions were taken (PAL filters installed) and outlets immediately resampled. The results received back were all clear. A Legionella sample result of 14750cfu from North Wing Ophthalmology was received March 2023 and immediately investigated. Issues with flow straighteners on two outlets and a section of pipework were rectified and the system was disinfected. Outlets have been resampled and we await the results.

The Authorising Engineer (AE) for Water Safety did not complete an audit for 2022. An audit has been arranged for May 2023. The outcome of the 2021 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. One of the actions still outstanding are calorifier internal inspection, which Mitie has advised will be completed during May 2023. Mitie have commissioned a number of Compliance Engineering Technical Audits in 2022/23 and outputs will be shared with the Trust Water Safety Group in July 23.

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. During 2022 Mitie carried out temperature monitoring of outlets which were deemed underused. The analysis determined that a significant quantity of outlets serving wash hand basins were in fact being regularly used and following agreement with ward and department leads were removed from the flushing schedule. Following agreement from Mitie, all the wash hand basins currently on the schedule are now being flushed by Domestics Services during their daily cleaning activity, which is also documented.

Pseudomonas risk assessments have been carried out by the Authorising Engineer, which have been ratified the WSG.

Ventilation

The Ventilation Safety Group (VSG) oversees all aspects of Ventilation for the PFI Estate. The Group is normally chaired by Summit Healthcare Limited who are the owners of the PFI Estate, but due to a change in their management, Trust Estates Compliance Manager has been chairing the meetings until the new Managers become established. The members of the group included:

- *General Manager/Assistant General Manager (Summit)*
- *Authorised Person for Ventilation (Mitie)*
- *Authorising Engineer for Ventilation (Mitie)*
- *Estates Compliance Manager (Trust) (Interim Chair)*
- *Consultant Microbiologist (Trust)*
- *Infection Prevention and Control (Trust)*

The new Trust Director of Estates and Facilities has been working with the internal Estates Team to track compliance on outstanding actions following previous AE audit. These are tracked through monthly meetings and use the contract performance mechanism to drive improvement.

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 noncritical 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.

In January 2023, the Trust became aware that a number of remedial actions from the previous reverifications going back to February 2022 had not been actioned by Mitie. This was escalated to Summit/Mitie via the formal PFI contractual route ad regular weekly meetings are taking place to review progress. Mitie's Authorising Engineer for Ventilation has confirmed that there are no risks to the staff or patients from the remaining remedials.

4.2.3 Management of Decontamination

The section below in italics has been completed by Kim Jarrett the Trusts Decontamination Lead.

DGFT appointed to a 12-month seconded Decontamination Lead post which commenced in September 2021. This role was made permanent in September 2022.

This post is still developing with several key progressions made within the last 12 months.

- *A bespoke decontamination audit tool has been developed. Audits have been undertaken using the newly developed tool tr~~ialled~~ with the plan to roll out as an annual audit programme.*
- *All decontamination policies have been reviewed and incorporated into a new Trust wide Decontamination Policy including neonatal and children's services Standard operating procedures.*
- *This is available for staff to access on the trust's intranet.*
- *The National Standards of Cleanliness 2021 were implemented on 4 May 2022 throughout the trust. The detail was incorporated into the Trusts revised Cleaning and Disinfection of the Environment policy.*

  A commitment to Cleanliness Charter sets out the Trusts commitment to achieve a consistently high standard of cleanliness using the functional Risk (FR) categories, cleaning frequencies and cleaning responsibilities for each functional area. The charters are displayed outside wards and departments, lifts and areas used by the public. All wards and departments have been identified with a functional risk rating between 1 and 6 in line with the new standards. All areas are now audited in line with these categories.

- *Invasive ultrasound probes have been reviewed across the Trust and all areas are now using Tristel three stage wipes for high level disinfection of invasive probes. An initial baseline audit was completed in August 2022 by the Tristel rep and a further follow up audit is scheduled for April 2023.*
- *For short periods over the last 12 months there has been gaps in the Decontamination Group due to no decontamination Lead, this was placed on the risk register for this period. This Group was re launched with the first meeting held in January 2023.*
- *Due to the increased pressure on beds, the Trust sourced a more rapid decontamination approach to assist with capacity. A new Ultraviolet machine has been purchased by the trust which will provide rapid, efficient UV decontamination with a faster turnaround than Hydrogen Peroxide Vapor (HPV). The new UV service was launched in October 2023.*

- *The management and maintenance of the HSDU service is via the Trust PFI Contract with Mitie and is managed against the performance specification in schedule 14 of the contract and payment mechanism as per schedule 16. In 2022, Mitie have appointed a new HSDU manager to lead on their services.*
- *The Trust Endoscopy Washer and Dryer units are maintained through an external contract linked to consumable items from Steris. Performance issues have arisen in year over engineer availability and the Trust EBME team have taken the lead to assign asset information to a central database and manage all validation and call out activities. The service lead for EBME has many years' experience in the sector and funding has been requested to fund his accreditation to Authorised Person Decontamination (appointed by AE) .*

Decontamination Plan for the next 12 months

Over the next 12 months several key things are planned to further strengthen decontamination processes across DGFT:-

- *A further audit led by the decontamination lead and Tristel rep to the use of Tristel wipes and high-level disinfection throughout the Trust is planned to follow up the baseline audit. Particular focus is on invasive probes and devices. A business case continues to be strengthened within Imaging with the focus being on the implementation of an automated decontamination process.*
- *An audit plan has been developed which will cover all areas across all sites of the Trust. This will also include additional ad hoc audits as required.*
- *A proactive decontamination programme using the UV machine is being developed which will include all wards and departments, ensuring all areas receive decontamination on a regular rolling programme. Recruitment to expand the decontamination team has been successful with the addition of two decontamination technicians starting in April. This will provide both proactive and reactive disinfection over a seven-day period throughout the Russell Hall site.*
- *A combined trial between the trust and it's ~~the~~ PFI partners is in progress which will review the use of microfibre products. If the trial is successful consideration will be made to roll out microfibre products out across the wider trust.*
- *Training for EBME lead to be Trust Authorised Person for Decontamination*
- *EBME team to asset manage all HSDU and Endoscopy Equipment so that we have a central register for validation.*
- *Trust Estates and Facilities to engage an external stakeholder for the completion of a condition survey for all assets that are Trust Property to ensure that they are on the forward plan for lifecycle investment/replacement.*

4.3 CRITERION 3

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

The section below in italics has been completed by Syed Gilani, Principal Pharmacist Antimicrobial Therapy for the Trust.

Antimicrobial steering Group at The Dudley Group NHS Foundation Trust is the subgroup of Drugs and therapeutics which reports to quality and safety committee via medicines management group.

Antimicrobial Stewardship Annual Report 2022-23

This paper 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.

In 2022/2023 The Dudley Group NHS Foundation Trust signed up and achieved the National CQUIN targets on "Management of UTIs in adult patients".

CQUIN: Management of UTIs in patients over 16 years of age.

Achieving 60% of all antibiotic prescriptions for patients aged 16+ years that meet NICE guidance for diagnosis and treatment.

The cases where all the following actions were applied:

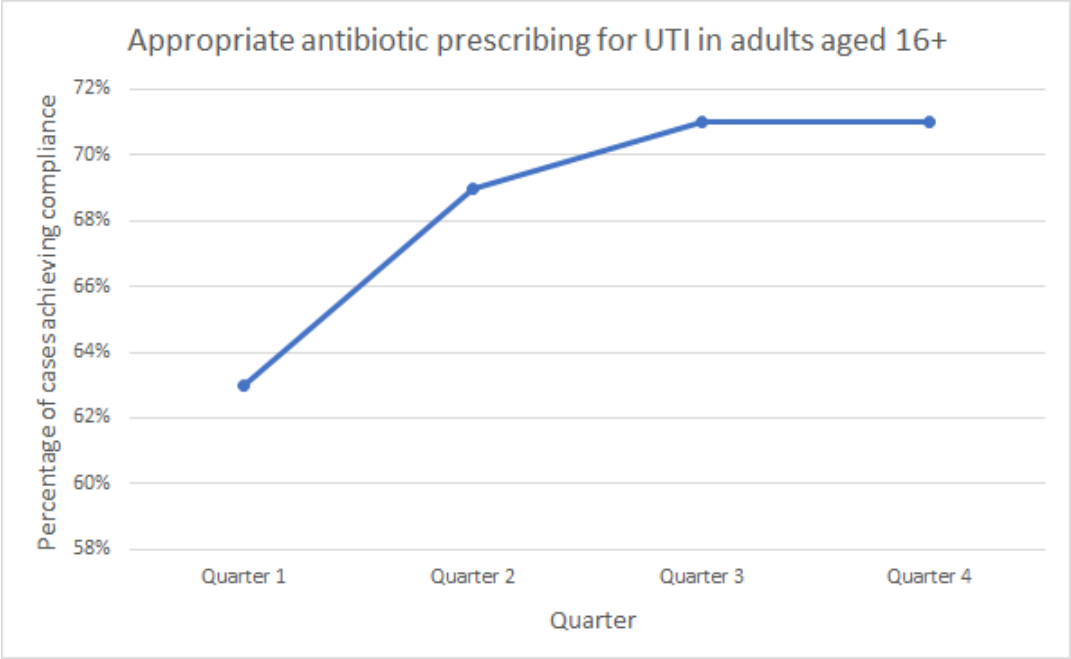
1. *Documented diagnosis of specific UTI based on clinical signs and symptoms.*
2. *Diagnosis excludes use of urine dipstick in people aged 65+ years and in all catheters associated UTI (CAUTI).*
3. *Empirical antibiotic regimen prescribed following NICE/local guidelines.*
4. *Urine sample sent to microbiology as per NICE requirement.*
5. *For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record.*

Data is submitted quarterly to UKHSA via the online submission portal.

- *The data collection has been completed for quarter 1 (total of one hundred patients' data) and has been submitted. The payment is based on minimum (40% compliance) and maximum (60% compliance).*

The delivery is currently on schedule.

- *Q1 compliance is 63%.*
- *Q2 compliance is 69%.*
- *Q3 compliance is 71%*
- *Q4 compliance 71%.*



National webinar (NHSE/I & AHSN)

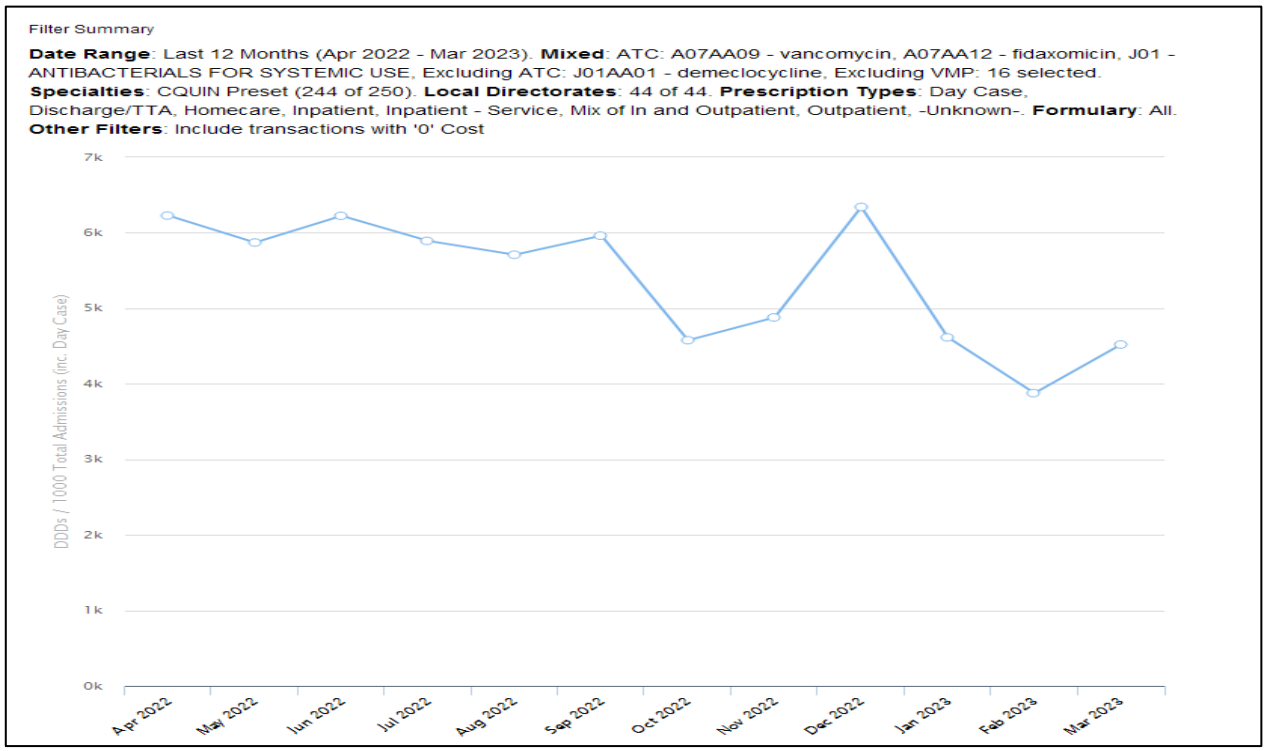
Delivered a national webinar on "Utilising Digital Solutions to Optimise Antimicrobial Stewardship "on 8th June 2022. Shared our good practices and challenges at The Dudley Group , the feedback was positive.

Antimicrobial Consumption

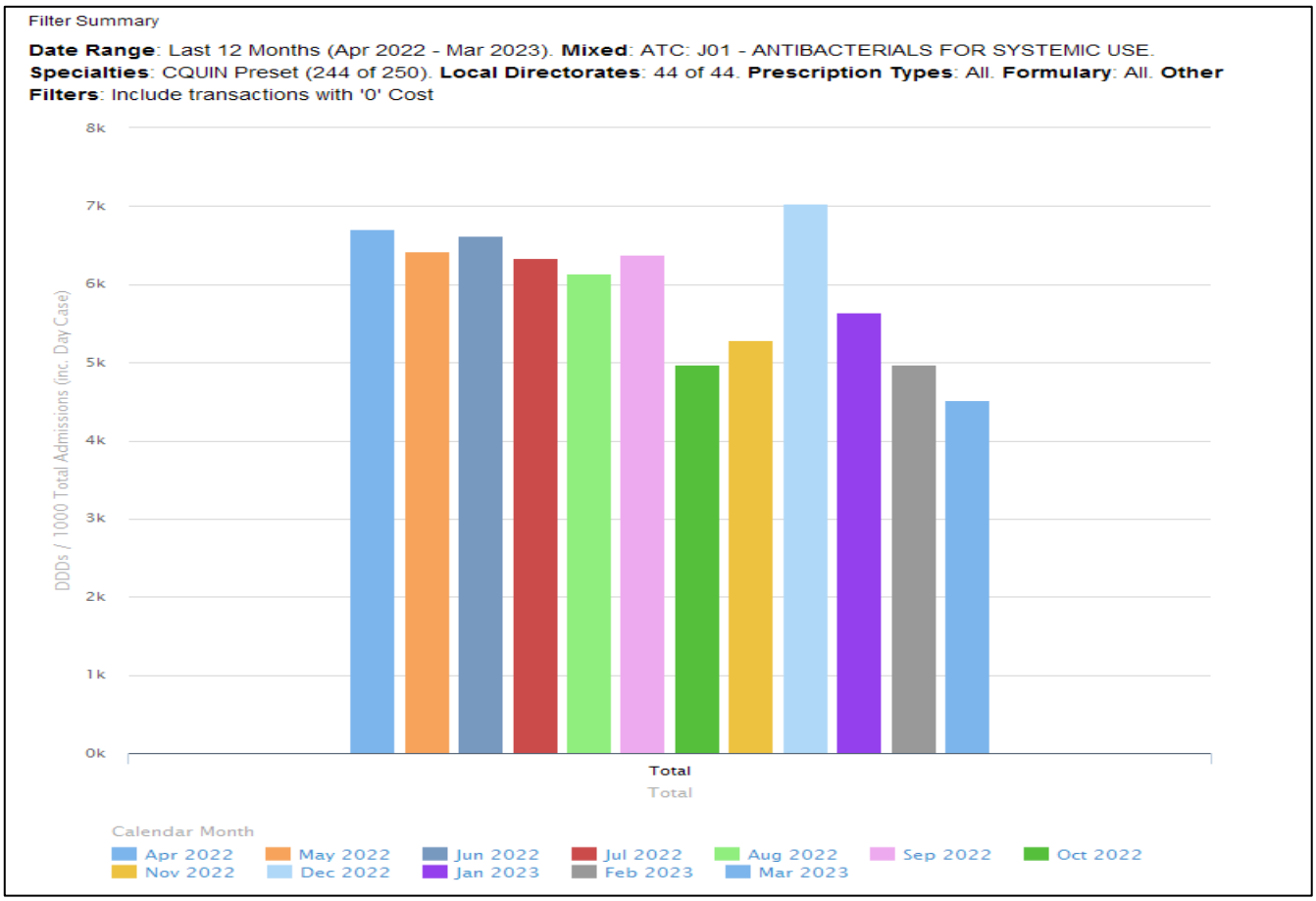
The unprecedented times have fluctuated antimicrobial use significantly.

Total Consumption

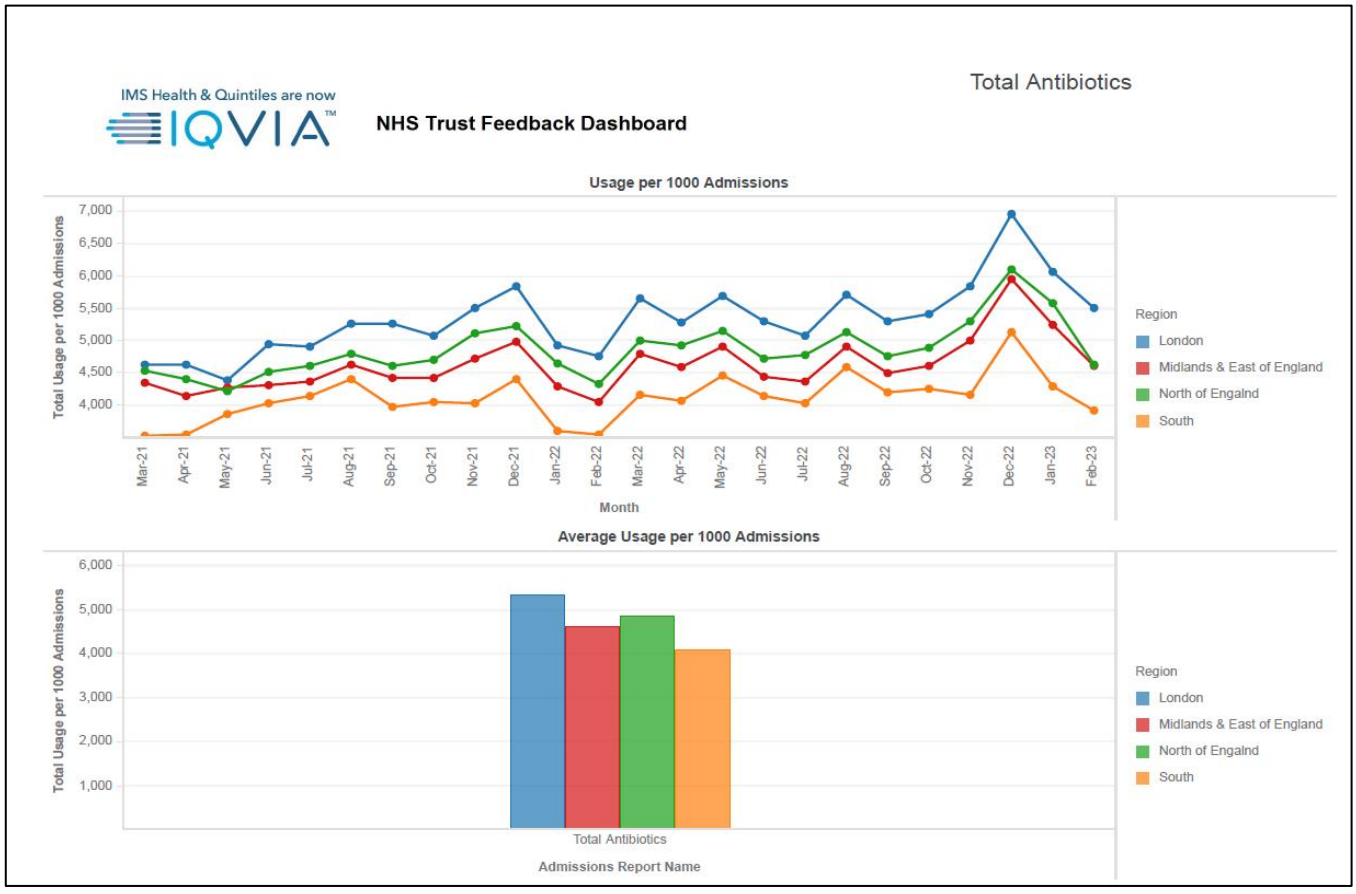
Consumption (2022-2023)



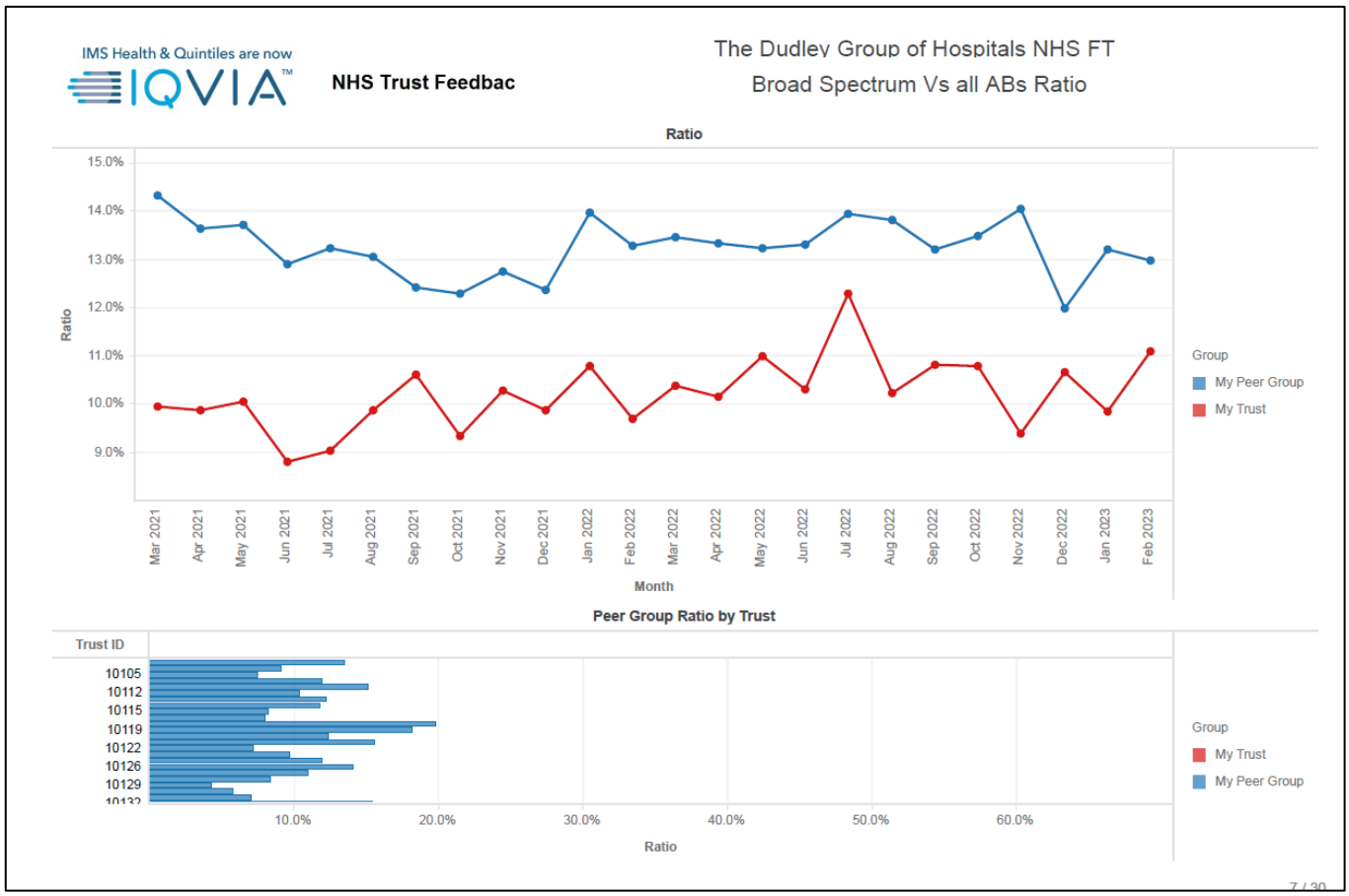
Consumption of antibiotics data excluding day case admission data



National antibiotic consumption per 1000 admissions (March 2021- Feb 2023)

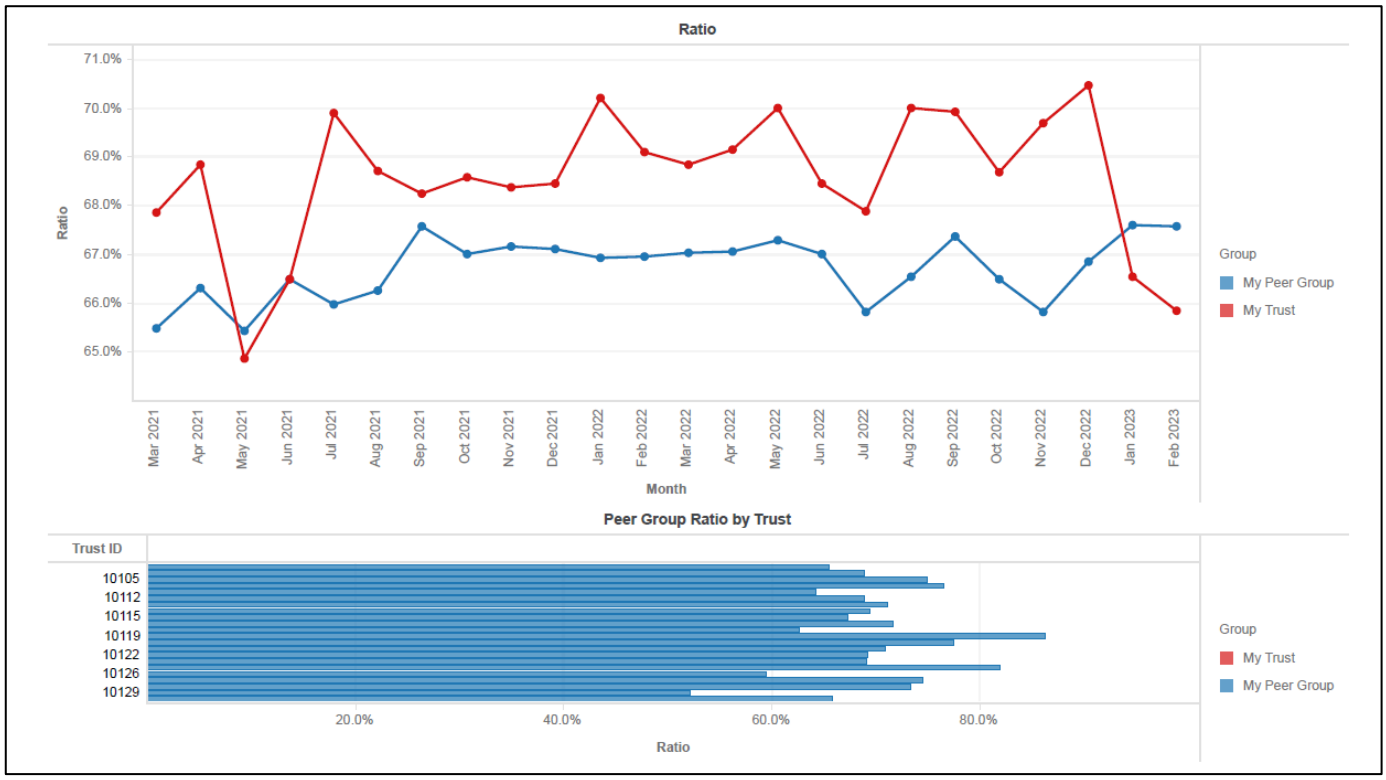


Ratio of Broad-spectrum vs all antibiotics

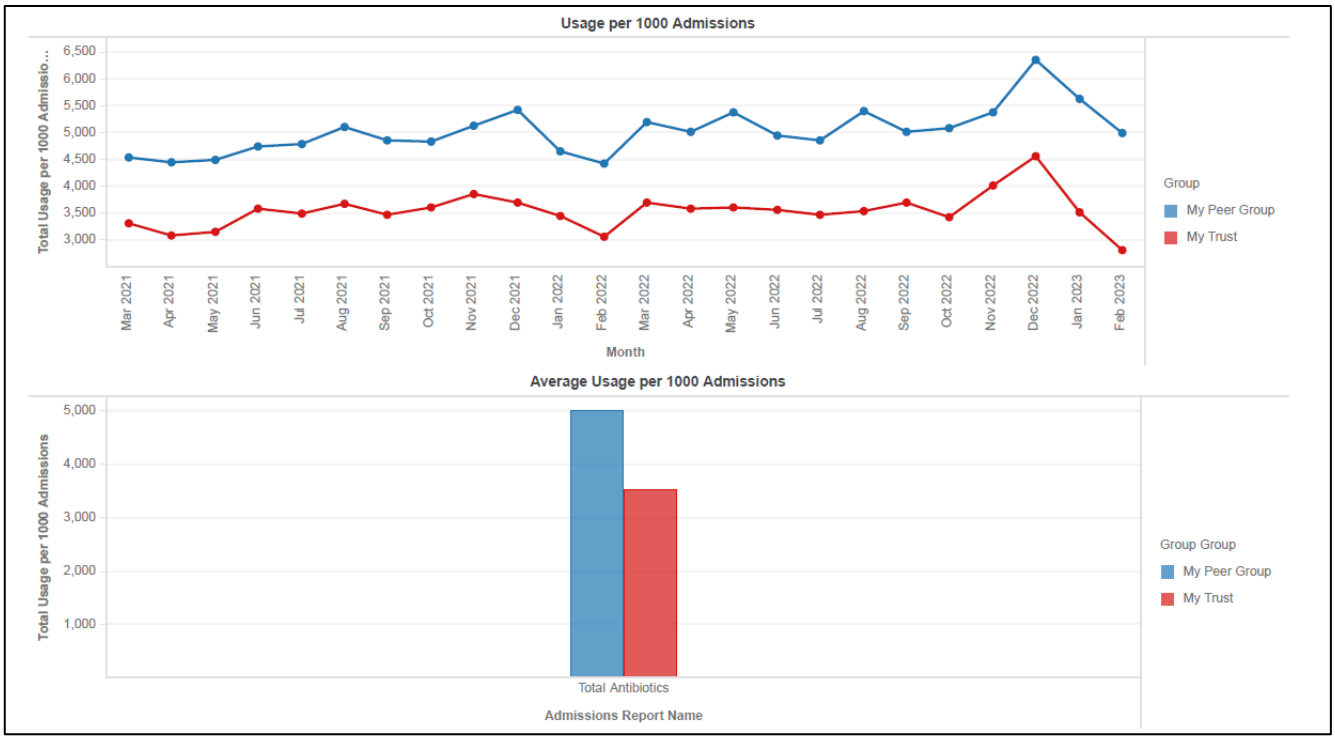


Data suggest Dudley group is performing better compared to its peers.

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.

Proportion of Access, Watch and Reserve list of antibiotics (2022/2023)
Access = Narrow spectrum (list provided by NHSE/I and UK HSA)
Watch = Broader spectrum (list provided by NHSE/I and UK HSA)
Reserve = Broader spectrum last line antibiotics (list provided by NHSE/I and UK HSA)

For financial year 2022/2023 the proportion of access list antibiotics used at DGFT was 57% similar to last year.

Antimicrobial Prescribing snapshot audit

Dudley Group NHS Foundation Trust - Snap shot audit			
		Percentage	Regional target
Number of patients audited	534	100.0%	
Allergy Status recorded on chart (NKDA, Yes, No)	530	99.3%	> 98%
Number of patients with an allergy who have the nature of the allergy documented	71	49.7%	> 98%
Number of patients on Antibiotics	208	39.0	
Number of Patients on intravenous antibiotics	110	20.6	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	47	42.7	
Number of patients where total course over 5 days (>7days Jan 2013)	40	19.2	
Number of patients where stop / review date documented on the prescription chart	208	100.0%	> 70%
Has the indication been documented on the chart/notes?	208	100.0%	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	5	4.5%	< 10%

All the results from the snapshot audits carried out over the last year shows significant improvements, the recurrent issue identified is type of allergic reaction documentation, and discussions have been started with EPMA team to explore a potential solution for it.

Medicines Division Data

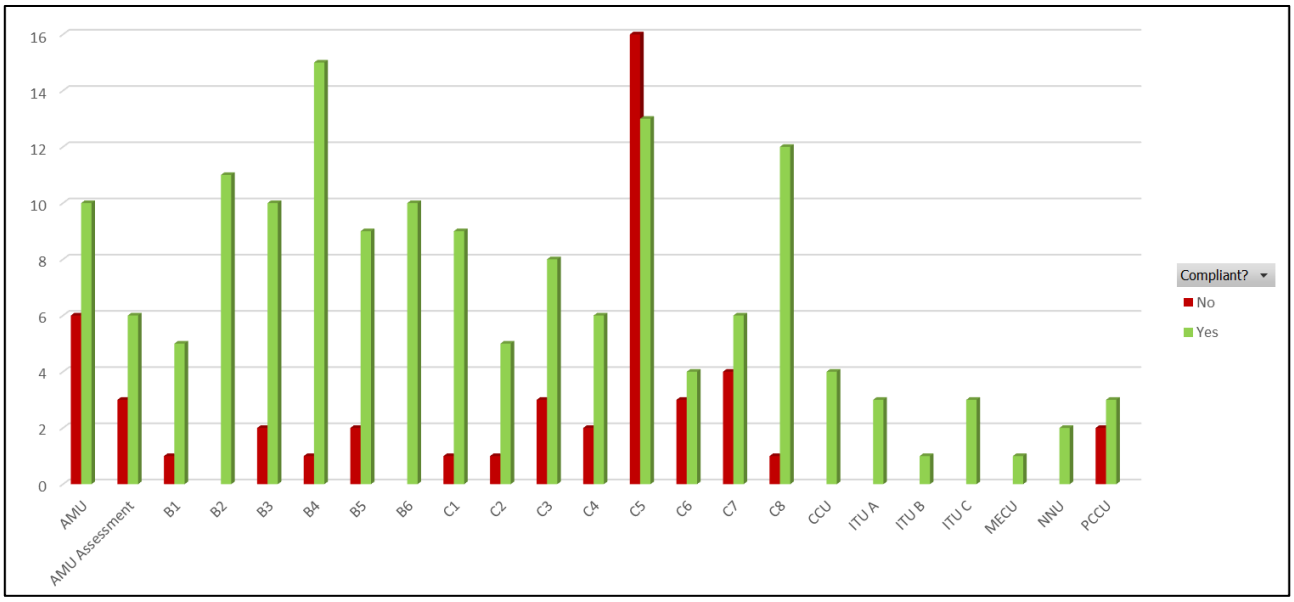
Medicine Divison - Snap shot audit			
		Percentage	Trust target
Number of occupied beds	327	100.0	
Allergy Status recorded on chart (NKDA, Yes, No)	327	100.0%	> 98%
Number of patients with an allergy who have the nature of the allergy documented	45	42%	> 98%
Number of patients on Antibiotics	134	41.0	
Number of Patients on intravenous antibiotics	61	18.7	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	20	32.8	
Number of patients where total course over 5 days (>7days Jan 2013)	25	18.7	
Number of patients where stop / review date documented on the prescription chart	134	100.0%	> 70%
Has the indication been documented on the chart?	134	100.0%	> 70%
Is patient on Meropenem/Ertapenem? (Out of those on an IV abx)	3	4.9%	< 10%

Surgical Division Data

Surgical Divison - Snap shot audit			
		Percentage	Trust target
Number of occupied beds	207	100.0	
Allergy Status recorded on chart (NKDA, Yes, No)	206	99.5%	> 98%
Number of patients with an allergy who have the nature of the allergy documented	26	61.9%	> 98%
Number of patients on Antibiotics	74	35.7	
Number of Patients on intravenous antibiotics	49	23.7	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	27	55.1	
Number of patients where total course over 5 days (>7days Jan 2013)	8	10.8	
Number of patients where stop / review date documented on the prescription chart	74	100.0%	> 70%
Has the indication been documented on the chart?	74	100.0%	> 70%
Is patient on Meropenem/Ertapenem? (Out of those on an IV abx)	2	2.7%	< 10%

Compliance by ward

Compliance by ward was fed back to respective directorate Pharmacists who then took the data to respective directorates for reporting and improvement plans.



Current data shows:

- *An increase in the proportion of patients on antibiotics*
- *An improvement in the nature of allergy documentation*
- *An increase in the relative proportion of patients on a carbapenem*
- *Allergy nature documentation is limited, and potential solutions are being looked at with EPMA team.*
- *Currently working on an IT solution for easy data collection moving forward.*

<u>The documentation of stop/review date seems low however, data collected within the</u> snapshot audit is limited to active prescriptions and does not include documentation of stop/review in the medical notes.

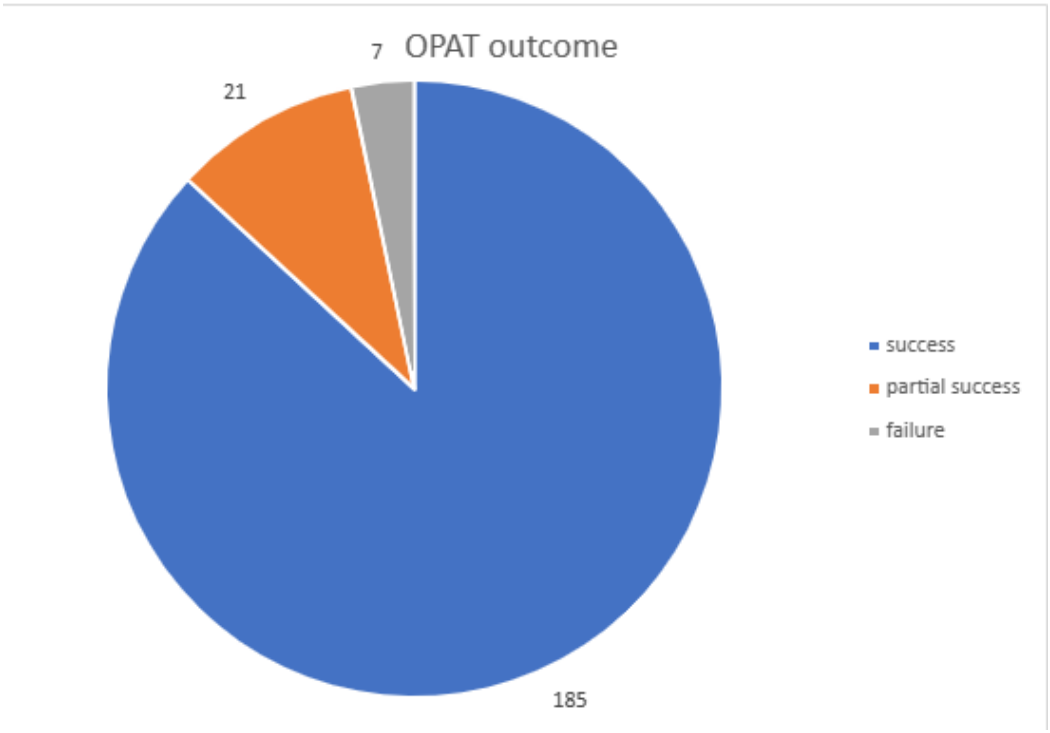
Patients on restricted antibiotics e.g., meropenem & piperacillin/tazobactam (which are not recommended in the Trust guidelines or approved by microbiology) are referred to the antimicrobial pharmacists.

The pharmacy team monitor and raise awareness at ward level on how to correctly document allergy status on prescribing system.

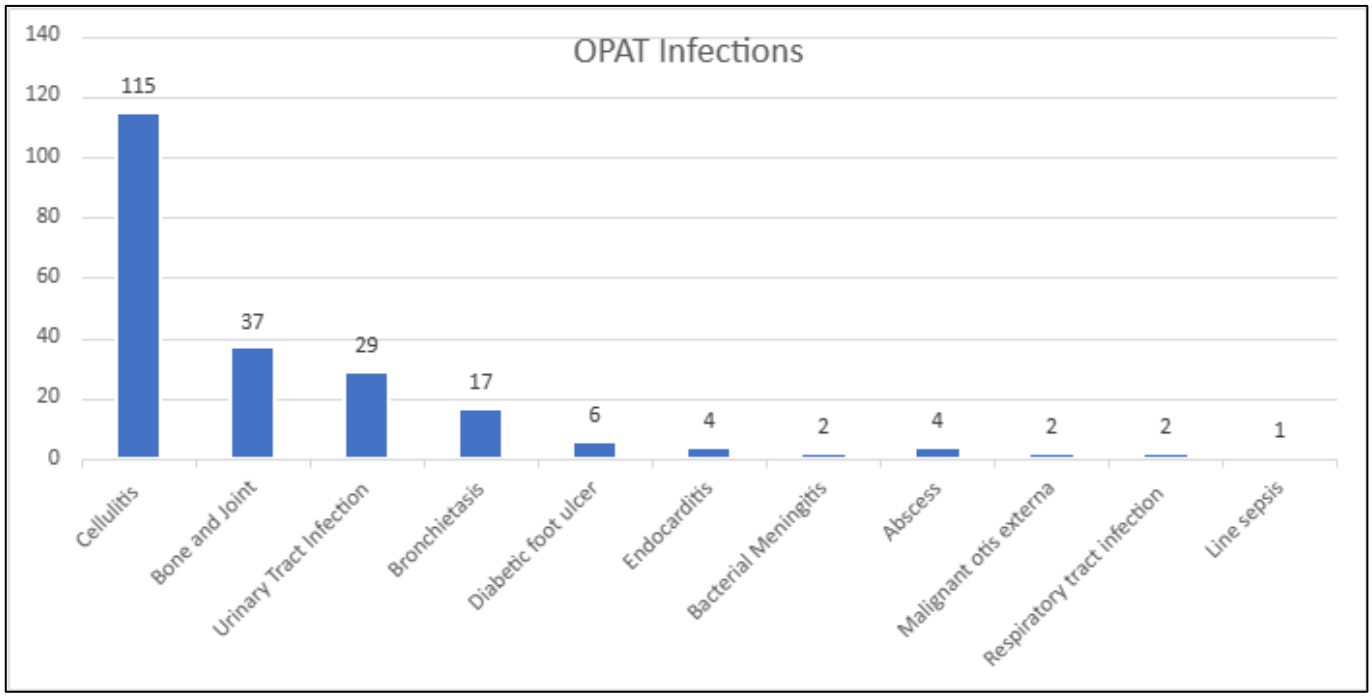
<u>OPAT data for 2022/2023</u>

The Dudley Group NHS Foundation Trust run a successful OPAT (OUTPATIENT ANTIBIOTIC THERAPY) service. An MDT review is carried out for each patient every Tuesday, MDT consists of OPAT nursing team, Antimicrobial stewardship Pharmacist and a Consultant Microbiologist.

A total of 221 patients have been treated as part of the OPAT service which has increased the Trust capacity by 3,199 bed days in the last financial year.



Breakdown of the clinical conditions treated via OPAT service is illustrated in the following figure.



Interventions over past 12 months to improve Antimicrobial Stewardship at DGFT

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.*
- *Established a C diff review ward round (once every week with one AMS pharmacist and one Clinical nurse specialist IPC).*
- *Antibiotic awareness week campaign (completed).*
- *Multiple guidelines updated and published on microguide through the year.*

- *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)*
- *COVID-19 therapeutics guidelines added to Microguide for easy access.*
- *EPMA antimicrobial prescribing module in place so far, no major issues, work being carried out to increase clinicians' awareness on ward level.*
- *CQUIN 2022/23 targets achieved for all 4 quarters.*
- *Patient safety bulletin published online and sent to all staff.*
- *Hub communication/ screen saver produced to raise awareness.*
- *Discussed and shared plans at West midlands Antimicrobial Pharmacists Group.*
- *Junior Dr antimicrobial prescribing teaching sessions completed.*
- *Teaching session completed for all Pharmacists on AMS principles.*
- *Antimicrobial stewardship section in Trust wide Governance newsletter.*
- *Antimicrobial stewardship session delivered to community team.*
- *Feedback to the divisions provided via Antimicrobial Stewardship Group (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.*
- *C diff ward rounds started once a week the team include an antimicrobial Pharmacist and an IPC Nurse.*
- *DGFT (antimicrobial stewardship (AMS)) team has led on the development of COVID-19 therapeutic pathways which were accepted and adapted by the Black Country and West Birmingham (BCWB) system.*
- *DGFT AMS team also heavily contributed to the national COVID-19 vaccination program and provided senior leadership and clinical expertise.*
- *Pelvic inflammatory disease antibiotic guidelines are updated, (awaiting publishing).*
- *Surgical prophylaxis guidelines agreed and updated.*
- *Orbital cellulitis guidelines are agreed.*
- *Bronchiectasis guidelines are agreed after looking at the local antimicrobial resistance trend.*

COVID-19 therapeutics

COVID-19 treatment algorithms are developed by The Dudley Group which were approved and shared across Black Country and West Birmingham (BCWB) Integrated Care system (ICS). AMS team oversees the clinical aspects of Covid-19 therapeutics at the Dudley Group and Dudley DIHC.

ICS AMS Group

The Dudley Group AMS team took the initiative to establish an ICS wide AMS group. The ICS AMS group reports to Clinical leadership group via the IPMO PLG group. The group is looking into all the sectors across the system. The Group has harmonised the Antibiotics formulary across the ICS and is now working on other work streams.

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.
Teaching/training sessions are delivered to primary care teams of Dudley to improve health economy wide antimicrobial stewardship that include primary care and CCG pharmacists and community/district Nurses and ACPs.

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 took part in a regional research piece around IV to Oral switch of antibiotics where survey was conducted. The results are being analysed with the intention of presenting a poster at FIS conference.

An undergraduate final year Pharmacy research project was completed on "Impact of pandemic on antibiotic consumption and C diff rates at Russell's Hall hospital," in collaboration with Birmingham University.

An undergraduate final year Pharmacy research project was completed on "resistance patterns of E coli blood culture isolates at Russell's Hall hospital" in collaboration with Aston University.

The AMS team enrolled and took part in the national quality improvement project around Gentamicin prescribing and monitoring "Co-Gent" which is run by the NITCAR (National infections teams collaborative for audit and research) and are awaiting the publication of results by the study team.

Current Challenges

- *COVID-19 has presented unprecedented challenges currently the national target of reduction in total consumption of antibiotics (Watch and Reserve list) seems unrealistic to achieve within the timeframe specified.*
- *Encouraging already stretched clinicians to represent their areas at ASG meetings.*
- *Capacity of AMS team is limited therefore ward presence is low. Currently 1 x Consultant Microbiologist vacancy with one substantive and one Locum in post. This limits pro-active monitoring through limited ward visits.*
- *Antibiotic shortages are unpredictable and require frequent guidance changes leading to prescriber confusion.*
- *Lack of e-PMA solution for capturing prescribing data at present is making the snapshot audits laborious (IT is developing a solution for it).*

Plans for 2023/2024

- *Deliver National CQUIN for 2023/2024 "Achieving 40% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria".*

- *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. IV2PO switch has been set as a high priority item on national agenda for AMR.*
- *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 snapshot audits to assess antimicrobial prescribing.*
- *Increase the frequency of AMS ward rounds currently 3 days a week on critical care, 2 day a week on Medical enhanced care unit and 1 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 further expansion of antifungal stewardship.*
- *Support postgraduate diploma pharmacists in conducting clinical audits as part of their infectious disease module.*
- *Support 2023/24 trainee pharmacists with antimicrobial audits and teaching if required.*
- *Patient safety bulletins around arising issues over the year.*
- *Organise and promote Antibiotic awareness week 2023.*
- *Identify opportunities for research and development around antimicrobial stewardship.*

4.4 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

- DGFT has 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 *Clostridioides difficile* as well as key organisms that may be of particular concern seasonally.

In January 2022, the IPC Team produced a newsletter for staff called "We've gone Viral" which provides updates to staff on current IPC matters. This newsletter will be published on a bi-monthly basis.

- IPC produced an annual report covering the organisation's approach to prevention and control of infections for publication on the DGFT website.
- Hand hygiene included in patient/visitor/volunteer/staff/agency staff and visiting health professionals' information leaflets.
- Strategically placed hand hygiene products available with information on how to use.
- Continued to encourage patient and public involvement in hand hygiene and cleanliness campaigns and services' Quality Review process, satisfaction surveys and PLACE inspections.

- Polices related to specific organisms and care pathways remind staff of the need to give affected patients and relatives leaflets about the infection.
- Information leaflets revised and placed on the DGFT public facing website informing patient/public on specific infections and hygiene measures they can adopt to reduce the risk of infection.
- The IPC team and other members of staff continue to respond to ad hoc requests for information related to IPC under the Freedom of Information Act.
- IPC requirements are included in the health economy transfer/discharge form.
- IPC team share infection rates and outbreak information with appropriate services based upon local, regional, and national surveillance.
- Surgical Site surveillance data is submitted externally.
- Alert organism surveillance by the IPC team.
- IPC polices and procedures are available on the IPC page on the HUB.
- MRSA screening compliance shared.
- IPC team used the Health Hub I main reception to promote Clean your Hands Day and Infection Prevention and Control Week
- A Hand Hygiene game was promoted for wards to compete in a World Cup style game to co-inside with the Football world cup.
- The IPC team promoted AMR in conjunction with the Trusts Pharmacy team.

4.5 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

- The IPC Arrangements and Responsibilities policy reflects the management and reporting structure of SCHT outlining its collective responsibility for IPC and demonstrating responsibilities are disseminated to all staff/groups in the organisation.
- Responsibilities of groups and staff included in IPC policies.
- Support provided by IPC team included visits and telephone contact.
- Continued to develop link staff and support their role.
- Continued to audit compliance with IPC polices and care pathways.
- IPC team access to IC NET Laboratory IT systems allowed enhanced alert organism surveillance. IC NET was updated in September 2022 when the microbiology laboratory transferred from Russells hall to Royal Wolverhampton Trust.
- IPC team reported outbreaks and incidents of infection to the ICB, UK HSA and NHSE Outbreak of infection meeting are held with external partners and agencies to ensure transparency and that any lessons learnt are disseminated throughout the organisation.
- IPC received notification of outbreaks of infection within the local health economy.
- IPC specific organism policies available e.g., MRSA, CDI, VRE/GRE.
- Patients are screened for MRSA on admission.
- Patients are screened for COVID-19 on admission.
- Blue, Amber, Green clinical pathways available to aid correct patient placement.

- Twice weekly COVID-19 Lateral Flow Testing (LFT) was introduced to all patient facing staff in November 2020 this was offered to all staff in February 2021. Routine testing for all staff was discontinued in October 2022.
- Antibiotic policy available to all clinicians.
- PIRs will be undertaken on all MRSA Bacteraemias.
- Use of SIGHTED mnemonic (see images 3 and 4 referred to earlier).
- Ward staff advised to use isolation checklist to ensure compliance with isolation policy.

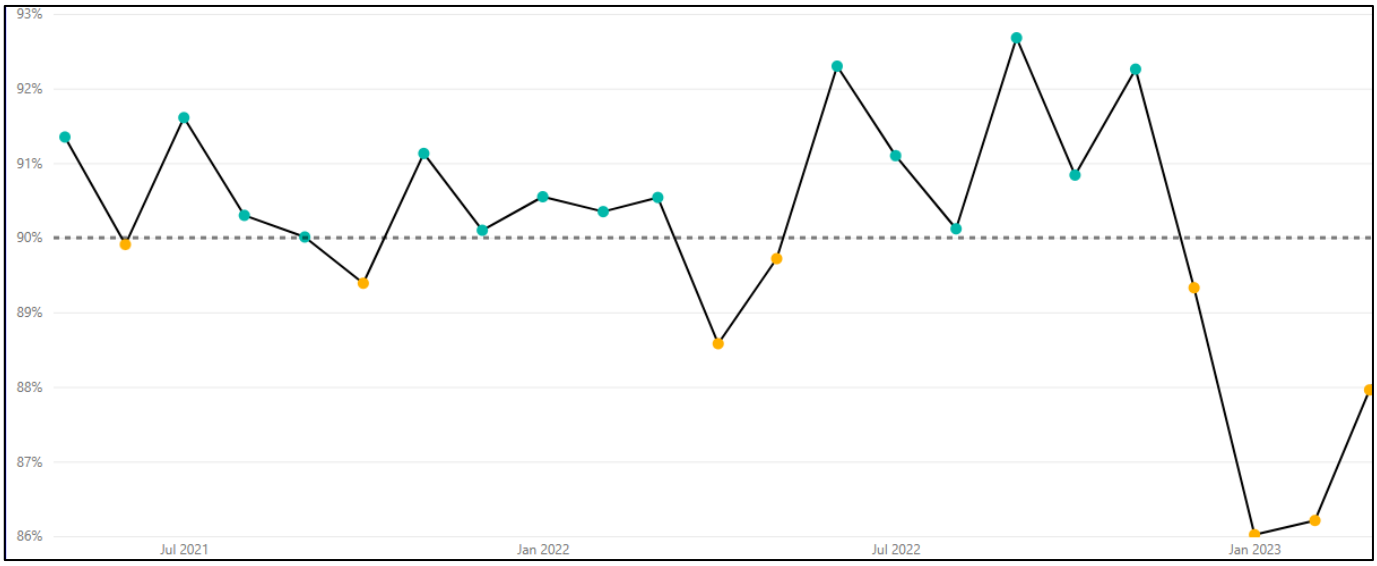
4.6 CRITERION 6

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 DGFT infection prevention is of paramount importance and everyone's responsibility, it is included in all job descriptions across the Trust.

All clinical staff receive training and education in infection prevention and control practices during their 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.



- Continued to work with NHS providers and facilitated by the LHE group, to aim to reduce all avoidable infections including MRSA Bacteraemia and CDI.
- Alerts are added to sunrise to highlight risk of infection.
- Compliance with MRSA screening policy audited monthly, and findings shared.
- As appropriate, joint investigations and reviews held between local partners and the acute trust on cases of MRSA Bacteraemia and CDI.
- To assist staff with managing outbreaks,
- Bespoke IPC Training is delivered if need identified.

- IPC team supported the development of DGFT clinical policies/procedures and Standard Operating Procedures (SOPs).
- Infection Prevention and Control Standard Operating Procedure for Building, Construction, Renovation and Refurbishment Projects in available for all contractors working in DGFT.
- IPC in the Built Environment Policy available via the HUB
- A Band 7 IPC nurse has completed the Infection Prevention and Control Course with Highlands and Islands University
- A Band 6 IPC Nurse completed her Professional Practice in IPC Course with Birmingham City University
- A Band 6 IPC Nurse completed the Marion Reed IPC course.
- The IPC team has attended conferences and study days throughout the year.

4.7 CRITERION 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 isolation, 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 which has been updated in 2022 to ensure that patients are isolated appropriately.

The decision to isolate a patient should be based on a risk assessment with regular assessments taking place to ensure the most appropriate use of the isolation facilities. 25% of the inpatient beds at Russell's Hall Hospital take the form of single ensuite rooms which are prioritised for patients with either confirmed or developing signs of infection.

In addition to the Isolation policy a Zoning Standard Operating Procedure (SOP) was developed in March 2020 due to COVID-19 which identified that for the duration of the COVID-19 clinical facilities at DGFT will be segregated into differing zones. Patients will be admitted in to or moved between the different zones dependent on their COVID-19 status. All patients admitted to an inpatient bed will be swabbed for COVID-19 on admissions, day 3, day 5, day 7, day 13 and weekly 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 has had a negative test, -these patients are to be placed into a side room within a blue area.

This SOP has been updated regularly due to changes in National Guidance.

- IPC Isolation Policy in place to support staff.
- Isolation Policy updated in 2020/21 to include COVID-19.
- Isolation Risk matrix developed to aid patient placement.
- Risk assessments performed by ward staff with support from the IPC team when insufficient isolation facilities were available to meet demand.

- Cohort approach taken as necessary within DGFT during outbreaks of diarrhoea and vomiting.
- All episodes where staff are unable to isolate patients are reported to Risk Management via Datix.
- COVID-19 swabbing has been updated throughout the year in line with National Guidance

4.8 CRITERION 8
Adequate access to laboratory support as appropriate

The IPC Team work closely with the clinical microbiology department which provides comprehensive microbiology advice. The laboratory forms part of the Black Country Pathology Services (BCPS) which covers 4 hospital sites to include The Royal Wolverhampton NHS Trust, The Dudley Group NHS Foundation Trust, Sandwell and West Birmingham NHS Trust and Walsall Healthcare NHS Trust.

The trust has access to a CPA/UKAS accredited laboratory. The clinical microbiology departments provide support to the IPC 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. Funding was secured and the Trust migrated on to the new version of IC NET in September 2022. The microbiology laboratory at Russells Hall Hospital was relocated to Royal Wolverhampton Trust during 2022, this has not led to any changes in service provision.

- Continuation of rapid testing for *Clostridiodes difficile* and use of typing to search for clusters and linked cases.
- Continuation of local test for Norovirus to speed up diagnosis and outbreak management of patients with infection.
- Continuation of local test for influenza to speed up diagnosis and outbreak management of patients with infection.
- Local testing for COVID-19.
- Point of Care testing available in Emergency Department for COVID-19 and Influenza
- Adequate resources available in laboratory for MRSA screening in line with national guidance.
- Mandatory surveillance also included MSSA, *E.coli* , pseudomonas Bacteraemia infections.
- Consultant Microbiologist at DGFT's is DGFT's IPC Doctor.
- Medical microbiology support provided by DGFT 24 hours a day 365 days a year.

4.9 CRITERION 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 SOPs are available for staff to view on the Trust Intranet site, the HUB. Access to these are clearly displayed under the documents section and there is a link on the IPC page for ease of use. A formal Governance structure is in place for the development, reviewing and ratifying such documents and is monitored via the IPC Group meeting.

- Rolling programme of policy / SOP review continued.

- Published evidence reviewed whenever policies were developed or reviewed on publication of new national guidance to ensure they reflect up to date, evidence based, best practice national guidance.
- New policies developed as need identified.
- In collaboration with Medicines Management team, commenced work to implement the relevant recommendations of the Tackling Antimicrobial Resistance 2019-2024, the UK's five-year national action plan.

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

Carbapenemase producing enterobacteriacea (CPE) screening, management and prevention of the spread policy	July 2024
Cleaning and disinfection of the environment policy	May 2025
Clostridiodes difficile (CDI) – control and management policy	Mar 2025
Control of an outbreak of infection in hospital policy	July 2024
Diarrhoea	
Group a streptococcus management policy	Nov 2024
Healthcare associated infections surveillance policy	May 2025
Gram negative bacteria outbreak in neonatal unit management guideline	March 2024
Decontamination policy	Oct 2025
Infection prevention and control in the built environment policy	May 2025
Infection control precautions for extended spectrum beta lactamase (ESBL) and Amp C producing organisms policy	Nov 2024
Linen procedures for patients personal clothing guideline	Mar 2024
Meticillin-resistant *staphylococcus aureus* (MRSA) screening emergency and elective admissions policy	Dec 2025
Reporting infections to UK Health Security Agency and local authority policy	Nov 2024
Management of scabies policy	Jan 2025
Management of patients with proven or suspected transmissible spongiform encephalopathies (TSE) policy	Apr 2025
Management of influenza in the hospital setting policy	Feb 2026

Compliance with policies was audited locally through the hand hygiene, cleanliness and IPC audit tools/checklists, specific competency tools and peer assessments. Specific audits undertaken by the IPC team as part of their annual programme, clinical incident reporting and root cause analysis of infections including debrief meetings were also used to monitor compliance.

4.10 CRITERION 10

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

4.10.1 Staff Health and Wellbeing (SHAW)

The section below in italics has been completed Priyanka Nar, Occupation Health Lead for Occupational Health and Wellbeing Department.

Staff Health and Wellbeing (SHAW) offer a wide range of services and continue to support DGFT by reducing ill health at work and supporting those at work with health problems and disabilities. There is joint work between SHAW and the Health and safety team whereby sharps/splash incidents are discussed to improve the safety of staff when handling sharp devices.

Sharps / Splash incidents

127 incidents in 2022/23

	2022/23
Suture needle	*16*
Vacuette	*14*
Butterfly Needle	*12*

The computer system, Cohort, used within SHAW is being updated internally. Moving forward, SHAW will be able to report data on the below areas:

- *Exact location of incident, breaking it down via department and division*
- *What was the sharps device?*
- *If the injury was sustained from a high-risk patient*
- *When the injury occurred (during or post procedure)*

Health Surveillance

A new health surveillance programme has been devised for SHAW. Moving forward SHAW will work towards the new health surveillance programme and outcomes will be reported to the Health & Safety Steering Group. We will be working with Health & Safety to identify if there are any other areas that require health surveillance, and they will be included into the programme.

Surveillance	**Department involved**	**Screening Required**	**Due Date**	**Comments**
Skin Surveillance	All HCWs who use skin sensitisers	Questionnaire	Jun- 23	N/A
Decontamination sensitiser	GI Unit	Questionnaire and Spirometry	May 2023	In Progress
TB	Respiratory wards, AMU, ED, ICCU, GUM and Respiratory Physiotherapists	Symptom reminder letter	November 2023	N/A

4.10.2 Health and Safety

The section below in italics has been completed by Jodi Griffin, the Trusts Health, and Safety Advisor.

The Health & Safety team have supported the IPC team with a number of projects this year including advising on changes to decontamination substances, provided assistances with risk assessments and took part in the IPC leads training day.

The IPC team have also supported the Health & Safety team with several projects particularly on Sharps incidents.

The health & safety team have carried out a number of audits this year, one of which being IPC related, this being the work around Sharps injuries and splashes.

There was no requirement in this financial year 2022/23 to carry out social distancing audits as all legislation has been removed. However, the Health & Safety team have a Trust overarching "Living with Covid" risk assessment that is updated as and when new IPC guidance is issued, particularly around mask wearing.

Sharps and Cuts injuries

Sharps and Cuts injuries are the most reported incident type under the Health and Safety Category year on year.

Last year (April 1st 2021-March 31st 2022), a total of 125 sharps and cuts injuries were reported on the datix system. Of these, 88% were Needlestick injuries.

An audit was carried out to look at the correlation between the number of needlestick injuries and use of non-safe sharps. The audit found that the departments that were using non-safe needles were reporting more sharps injuries than those areas using safer alternatives.

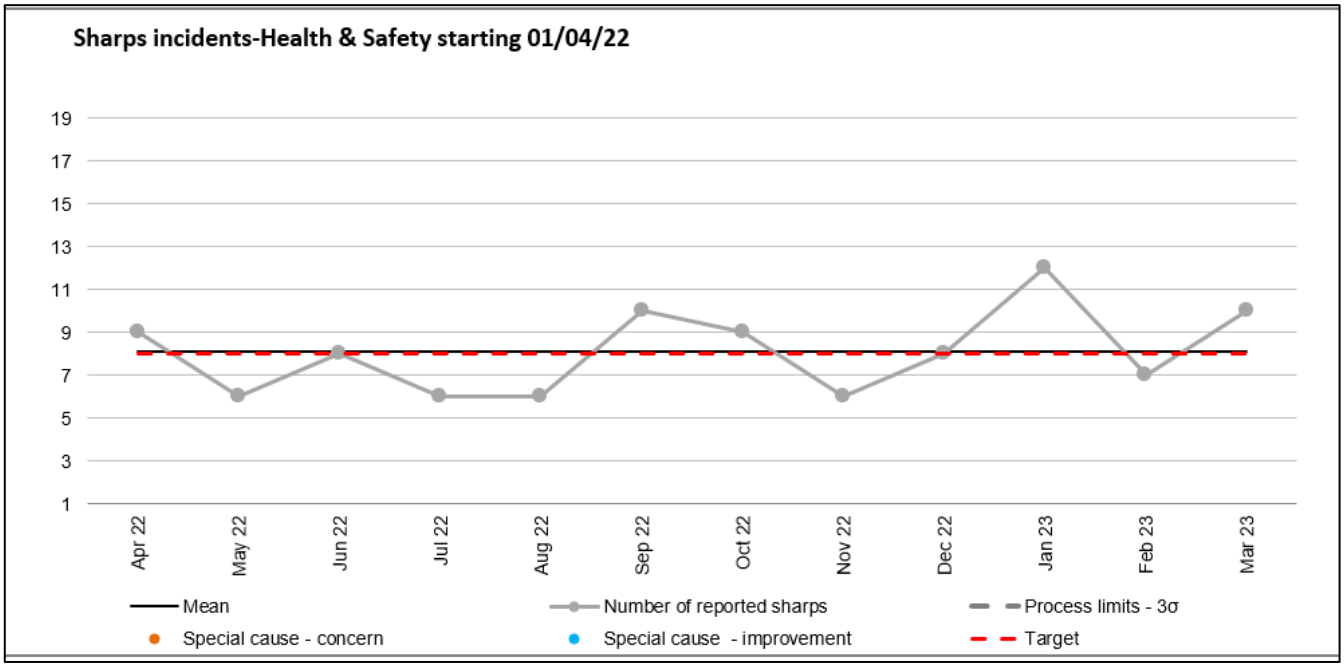
The audit also found that datix reports contained very little information about the type of device involved in the sharps and cuts incident. A new drop-down box where the device involved has to be entered has been made mandatory when completing a sharps and cuts datix report.

A task and finish group has been formed with representation from Health & Safety, deputy Director of Infection Prevention and Control , Deputy Chief Nurse, Clinical Skills , Blood Borne Virus team and Clinical Procurement team. The aim of the group was to look into ways to reduce the number of needlestick injuries and to investigate why some non-safe devices were still being used rather than the safer alternatives and to look at improving the pathways for post Sharps injury/splashes.

IPC related RIDDOR

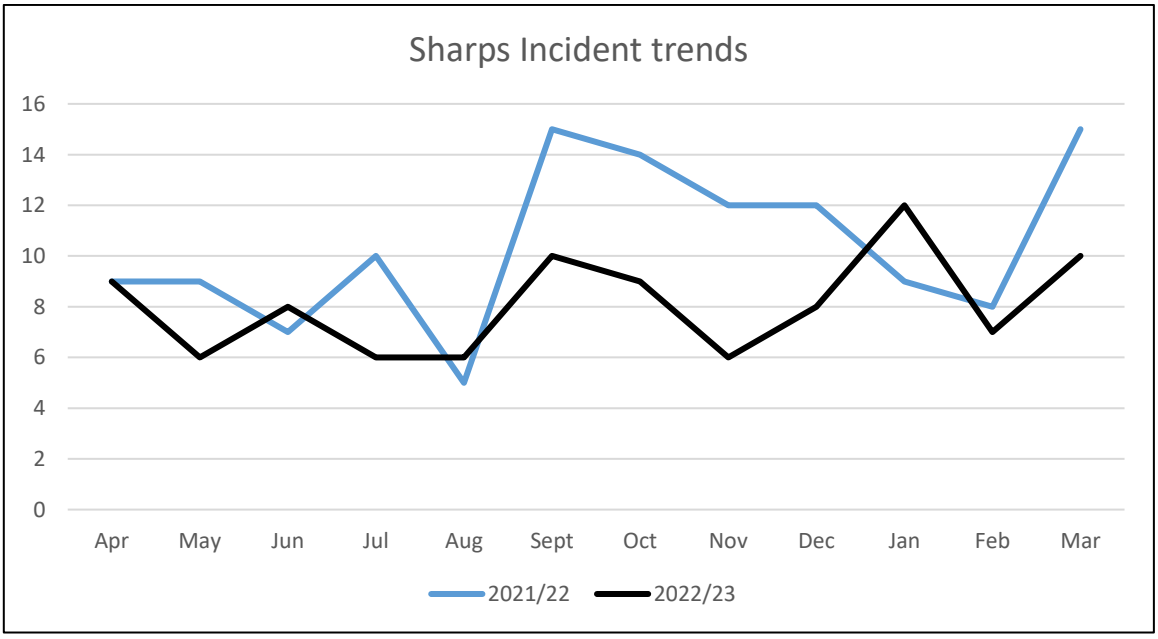
There were 4 IPC related incidents reports to the HSE under RIDDOR (Reporting of Injuries, Disease and Dangerous Occurrences regulations) in the financial year1st April 2022-31st March 2023). These incidents were needlestick injuries involving patients with known Blood Borne Viruses and were reported as Dangerous Occurrences and account for 25% of the reports submitted to RIDDOR in this financial year.

Graph 1: *Graph showing the number of Sharps and cuts incidents per month for year 2022/23*



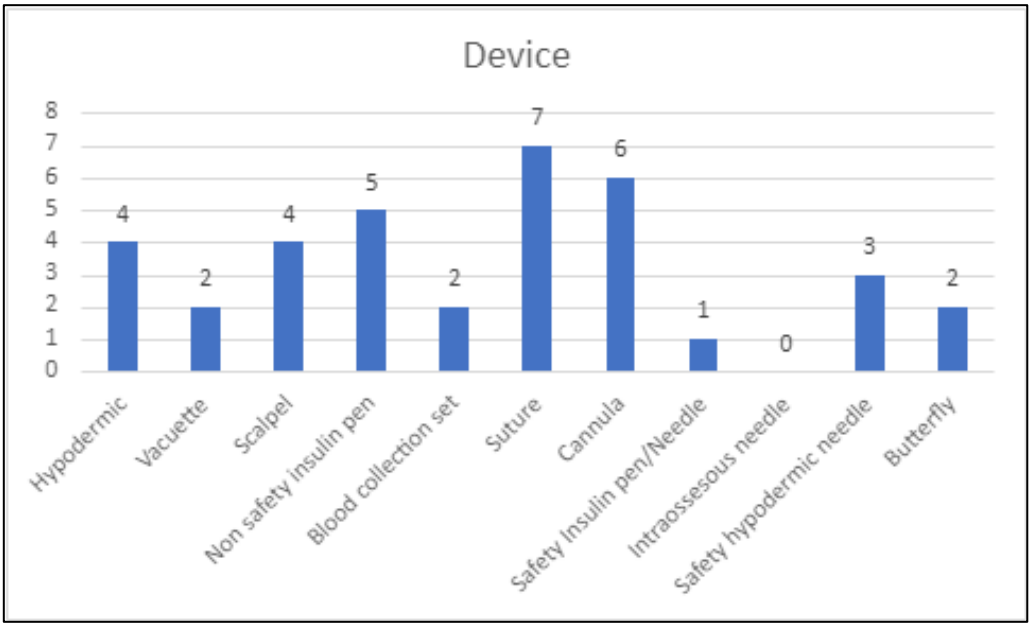
The graph shows spikes in the number of Sharps and Cuts incidents reported in September 2022 and January 2023. There does not appear to be a single caution for these increases.

Graph 2: *Showing the comparison between the number of Sharps and Cuts incidents reported each month for 2021/22 (Blue) and 2022/23 (Orange)*



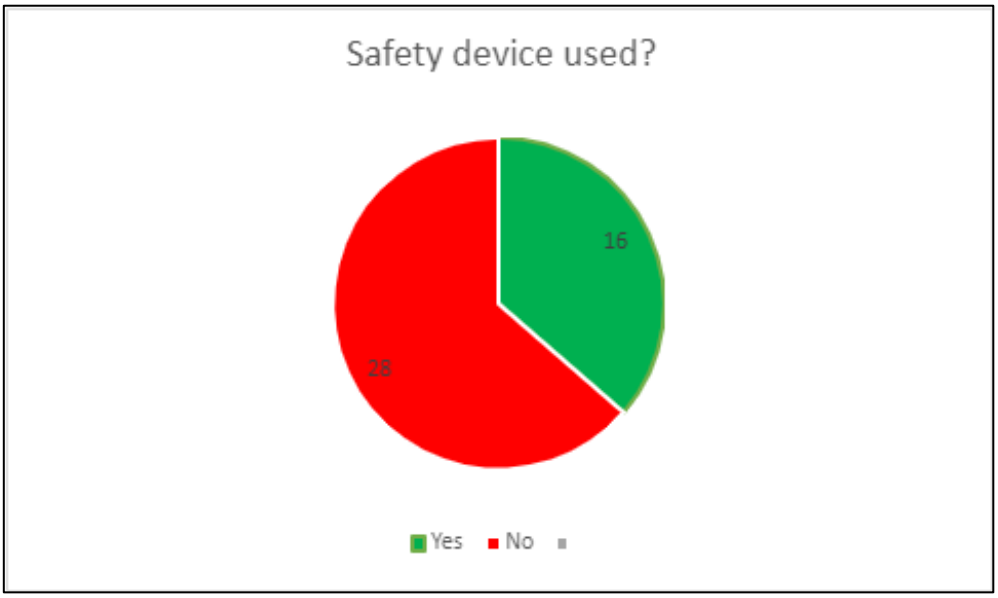
The graph shows that overall, few sharps related incidents were reported in 2022/23 compared to 2021/22. Interesting, in both years a spike in incidents is seen in September in both years and again in March. There does not seem to be a single causation for these spikes in incidents.

Graph 3: *Graph showing the devices/sharps involved in Sharps and Cuts incidents between 1st October 2022 and 31st March 2023 **



*The graph shows the data collated for devices involved in Sharps and Cuts incidents across the Trust between 1st October 2022 and 31st March 2023. Sutures are the most involved sharp device followed by cannulas. *The data collection started in October when the new drop down was added to the datix reports.*

***Graph 4:** Graph showing the number of incidents involving safer sharps versus non-safe sharps for date range 1st October 2022 and 31st March 2023.*



The graph shows that incidents where non-safety devices are involved are more prevalent that those that involve Safety devices.

**The data collection started in October when the new drop down was added to the datix reports. All departments using non-safe sharps have risk assessments in place for their use and rationales for their use are being considered by the Sharps group.*

The group are meeting with Maternity to look at training for use of sutures, as sutures are involved in more incidents than other types of sharps. The learning will then be shared with other departments that use sutures to try to increase awareness and reduce the number of sharps incidents across the Trust.

SECTION FIVE:
LOOKING FORWARD TO 2023 / 2024

5.1 An Overview of Infection Prevention and Control Programme 2023/24

This section gives an oversight of the work planned to prevent and control infections in 2023/24 and to achieve external thresholds and comply with the Code of Practice on the prevention and control of infections. It is designed to reflect DGFT's Quality Strategy to deliver care that is clinically effective; care that is safe; and care that provides as positive an experience for patients as possible.

The key aims in 2023/24 will be to build on the work that has been done in previous years to prevent HCAIs and improve the lives of the people who come into contact with DGFT services. Patient safety is at the heart of IPC, and to ensure our work is sustainable, DGFT promotes that every member of staff takes responsibility for IPC in order that that **no person is harmed by a preventable infection.**

Infection Prevention and Control Strategy focus 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 and control 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.
- Supporting National Campaigns including Gloves Off
- Introducing Mouth Matters throughout the Trust
- 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 Prevention and Control policy and standards.
- Releasing staff to undertake training.
- Post COVID-19

5.2 2023/24 Local Infection Prevention and Control Objectives as agreed with Commissioners

5.2.1 2023/24 Infection Thresholds

- Zero tolerance MRSA bacteraemia will continue in 2023/24 and reduction targets will be set for *Clostridiodes difficile* infection and Gram-negative bacteraemia (GNBSI), including *Escherichia coli*, Klebsiella and Pseudomonas. 2023/24 NHS Standard Contract
- Financial sanctions relating to MRSA bacteraemia and *Clostridiodes difficile* infection have been removed from the 2022/23 NHS Standard Contract and sanctions will not apply in relation to the new GNBSI targets.

5.2.2 2023/24 IPC Key Performance Indicator (KPI)

DGFT will continue to undertake MRSA screening for all relevant elective and emergency admissions.

5.3 Conclusion

The elimination of avoidable healthcare associated infections continues to be a priority for the Trust, patients and the wider public. In response, a robust annual programme of work has been implemented by the Trust over the last year which has been led by an experienced and highly motivated Infection Prevention and Control Team and supported by colleagues at all levels of the organisation. The successes over the last year have only been possible due to the commitment for infection prevention and control that is demonstrated at all levels within the Trust. High standards of infection prevention and control and antimicrobial stewardship will remain crucial to minimise the risk of infection and limit the emergence and spread of multi-drug resistant organisms.

SECTION SIX:
ACKNOWLEDGEMENTS AND FURTHER INFORMATION

Thank you for reading the IPC Annual Report for 2022/23.

If you require any further information about IPC in DGFT please email the team at dgft.infection.control@nhs.net or visit our webpage at Infection control - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

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