NHS
University Hospitals of North Midlands
NHS Trust

Infection Prevention, Flu and Sepsis Team

Annual Report 2019/20

Together Compassion Safe Improving

Infection Prevention SAVES LIVES
Does your patient need their Cannula?
CATHETER
DON'T HANG ABOUT TAKE IT OUT
CANNULA
Does your patient need their Catheter?

Infection Prevention, Flu & Sepsis Team

PROUD TO CARE

Foreword by Chief Nurse/Director of Infection Prevention and Control (DIPC)

Infection Prevention and Control Annual Report 2019-20

This Annual report covers the period 1st April 2019 to 31st March 2020 and has been written in line with the ten criteria as outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation.

The 2019/20 proved to be another busy and challenging year for the Infection Prevention, Flu & Sepsis Team. UHNM established a planning group in the response to the COVID-19 pandemic outbreak and contingency plans devised in line with national guidance. During March 2020 UHNM started to see their first cases of COVID -19.

MRSA bacteraemia, Clostridium *difficile* and antimicrobial audits remain a high priority for the Trust, alongside the gathering of information from: Root Cause Analysis, Post Infection Reviews and listening to front line staff which has helped in developing action plans and programmes of work to target areas in order to make a difference by improving patient safety/outcomes.

Healthcare associated infections remains high on the media and political agenda, being seen as a visible and unambiguous indicator of quality and safety of patient care. The infection prevention agenda faces many challenges including the ever increasing threat from Pandemic outbreaks, antimicrobial resistant micro-organisms, growing service development, national guidelines and targets/outcomes. The Secretary for Health launched an important ambition to reduce Gram negative blood stream infections by 25% by 2021 and 50% by 2024. UHNM is working closely with the Health Economy colleagues to achieve this and a Senior Sister within the IP Team is dedicated to drive the UHNM action plan to reduce E. coli blood stream infections. This is reviewed bi-monthly by myself at the Infection Prevention and Control Committee.

The Infection Prevention, Flu & Sepsis Team (IPT) structure is now embedded within our organisation, focusing on prevention and supporting our front-line colleagues to optimise the safety of our patients.

The IPT do not work in isolation; the successes over the last year are due to the commitment to infection prevention that is demonstrated at all levels within the organisation. It is crucial that this commitment continues to ensure that high standards are maintained. I would like to thank everyone for the part they have played and your response to the COVID -19 Pandemic pandemic. The emphasis continues to be on sustaining and improving outcomes for 2020-2021.

Michelle Rhode, Chief Nurse/Director of Infection Prevention

Key Achievements of 2019- 20

- Established Sepsis Team which underpins the vital work in improving patient outcomes through the prevention, early identification and treatment of sepsis.

- Participation in Getting It Right First Time (GIRFT) which is an NHS improvement programme delivered in partnership with the Royal National Orthopaedic Hospital NHS Trust.

- Continued sepsis awareness, education kiosks audits and spot checks. Awareness campaign for staff and public on World Sepsis day held September 2019.

- 8,375 influenza vaccines were given which is the highest ever number of staff vaccinated in previous years.

- Building upgrade projects to provide modern facilities to treat our patients which help infection prevention, improve patient experience and in some cases reduce unnecessary stay in hospital.

- Strengthening of the theory and practice of Aseptic Non Touch Technique (ANTT) took place; Standardising aseptic technique reduces variability in practice and better protects patients from preventable healthcare associated infection.

- Gram negative blood stream infection (BSI) reduction action plan in place. Action plan formally reviewed monthly and shared with National NHSi Lead.

- Health Economy Gram Negative Blood Steam Infection Working Group.

- Collaborative working with Tissue Viability Team to standardise Urinary catheter packs.

- There is a Health Economy approach to Infection Prevention which included sharing best practice and discussing trends in antimicrobial prescribing and any related actions.

- A collaborative work ethos with commissioners in relation to MRSA bacteraemia and Clostridium *difficile* infection root causes took place.

- Working Group formed for Acetic Acid trial proposal of weekly treatment of water outlets in an area with multiple CPE acquisitions.

- Infection Prevention Lead support to Shrewsbury and Telford Hospitals NHS Trust (SATH) Quarter one.

Abbreviations

AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
C *difficile*	Clostridium *difficile*
CCG	Clinical Commissioning Group
CDI	Clostridium *difficile* infection
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment Framework
DH	Department of Health
DIPC	Director of Infection Prevention & Control
E coli	Escherichia coli
ESR	Electronic Staff Record
ESBL	Extended Spectrum Beta Lactamase
GDH Ag	Glutamate dehydrogenase antigen of *C. difficile*
GRE	Glycopeptide Resistant Enterococcus
HCAI	Health Care Associated Infection
ICD	Infection Control Doctor
IM&T	Information & Technology
IP	Infection Prevention
IPCC	Infection Prevention and Control Committee
IPN	Infection Prevention Nurse
IPT	Infection Prevention Team
IV	Intravenous
MDT	Multi-Disciplinary Team
MGNB	Multi resistant Gram negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *staphylococcus aureus*
MSSA	Meticillin Susceptible *staphylococcus aureus*
OPAT	Outpatient Parenteral Antibiotic Therapy
PCR	Polymerase Chain Reaction
PFI	Private Fund Initiative
PHE	Public Health England
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, amber, green
RCA	Root Cause Analysis
RSUH	Royal Stoke University Hospital
SSI	Surgical Site Infection
TEC	Trust Executive Committee
UHNM	University Hospitals of North Midlands
VNTR	Variable-number tandem-repeat
VCTM	UHNM on line learning

Introduction

This report summarises the combined activities of the Infection Prevention, Flu & Sepsis Team (IPT) and other staff at University Hospitals of North Midlands (UHNM) in relation to the prevention and control of healthcare associated infections (HCAIs).

The Trust recognises that the effective prevention and control of HCAIs is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this law there are two principles:

- to deliver continuous improvements of care
- it meets the need of the patient

With this in mind, patient safety remains the number one priority for the Trust. Infection prevention is one of the key elements to ensure UHNM has a safe environment and practices which is reflected in the Trust '2025 Vision' and 3 years objectives and milestones – turning the vision into a reality.

Compliance Criteria 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

Infection Prevention Team

At UHNM the DIPC is the Chief Nurse and has overall responsibility for the IPT. The Associate Chief Nurse (Infection Prevention) at UHNM also has the role of Deputy DIPC.

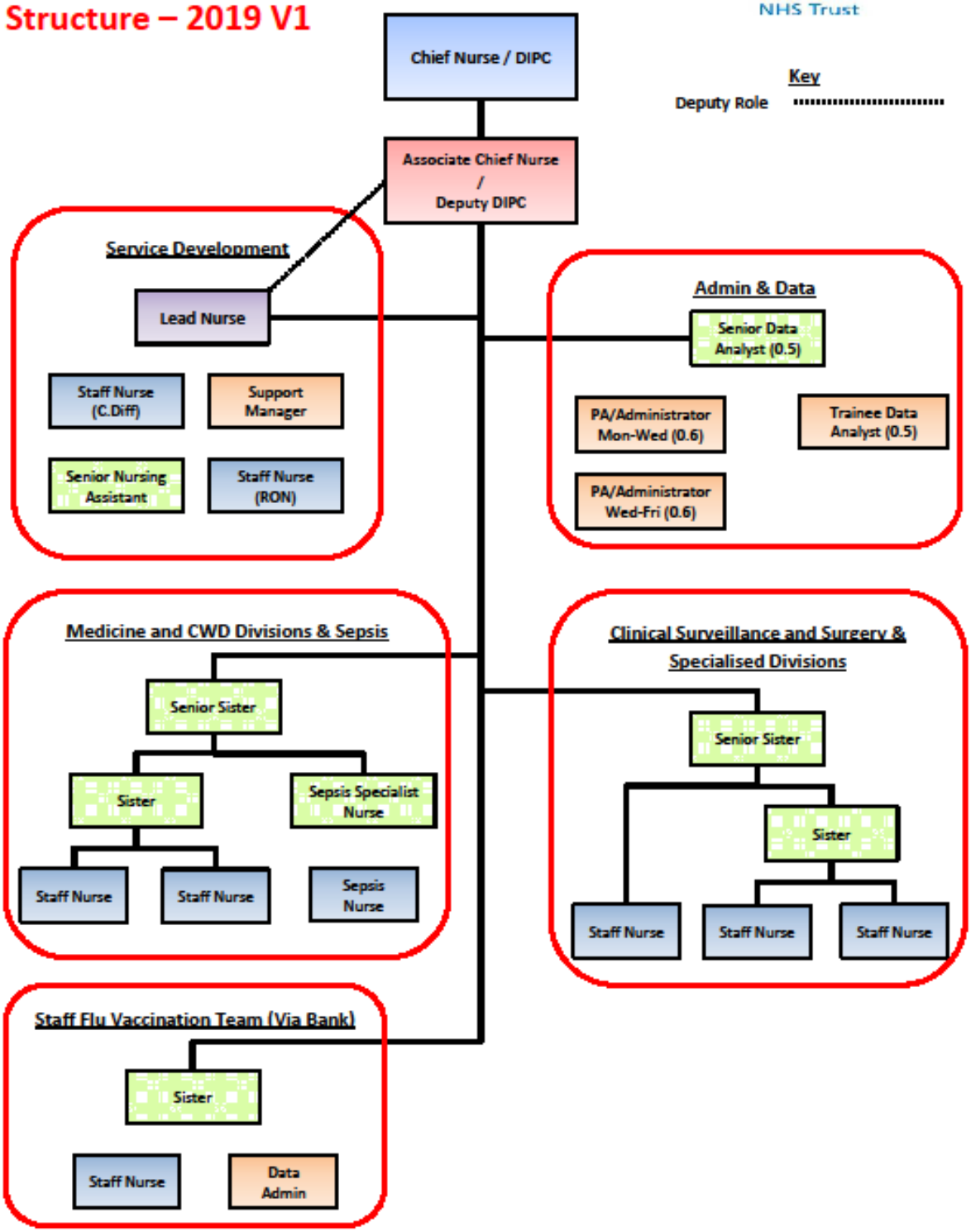
The IPT work collaboratively alongside front-line Clinical Leaders, supporting proactivity with improved clarity and defined alignment to clinical services. The introduction of new technologies allows the IPT to be present within the clinical settings for the majority of their time.

Quality Nurses remain an integral part of service delivery at UHNM. Nurses have a significant role in patient safety explicit within their responsibilities. This provides a key lynch-pin, and an ideal opportunity for the IPT to meet the challenges and significantly change the method of service delivery to front-line colleagues.

The infection prevention service is provided through a structured annual programme of works which includes expert advice, education, audit, policy development, and review and service development. The Trust has 24 hour access to expert advice and support.

Infection Prevention & Sepsis Structure – 2019 V1

University Hospitals of North Midlands NHS Trust



Committee Structures and Assurance Processes

Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for infection prevention and control. The Chief Executive has overall responsibility for the control of infection at UHNM. The Chief Nurse is the Trust designated Director of Infection Prevention and Control (DIPC). The DIPC attends Trust Board meetings with detailed updates on infection prevention and control matters. The DIPC also meets regularly with the Chief Executive.

Quality Assurance Committee

The Governance and Risk Committee is a sub-committee of the Trust Board and is the committee with overarching responsibility for managing organisational risks. The Governance and Risk Committee reviews high level performance data in relation to infection prevention and control, monitors compliance with statutory obligations and oversees management of the risks associated with infection prevention and control.

Quality and Safety Forum

The Quality and Safety (Q&S) forum meets monthly and is responsible for ensuring that there are processes for ensuring patient safety; and continuous monitoring and improvement in relation to infection prevention. The Q&S forum receives assurance from IPCC that adequate and effective policies and systems are in place. This assurance is provided through a regular process of reporting. The IPT provide a monthly report on surveillance and outbreaks.

Divisional Infection Prevention Groups

These groups are responsible for monitoring local performance in relation to infection prevention. Assurance is provided by Divisional IP groups, and Infection Prevention meetings. Groups provide assurance to the Trust IPCC that adequate systems and processes are in place within wards and departments and that performance and risks are being monitored.

Antimicrobial Stewardship Group

The Antimicrobial Stewardship Group (ASG) is a multidisciplinary group responsible for the monitoring and review of good antimicrobial stewardship within the Trust. The ASG reports directly to the IPCC and meets on a bi-monthly basis. The group drives forward local activities to support the implementation of international and national initiatives on antimicrobial stewardship including Start Smart then Focus and the European Antibiotic Awareness Campaign. The ASG produces and updates local antimicrobial guidelines which takes into account local antibiotic resistance patterns; regular auditing of the guidelines; antimicrobial stewardship practice and quality assurance measures; and identifying actions to address poor compliance with guidelines. Antimicrobial audit results are reported widely throughout the organisation, for example at Divisional Clinical Governance and Speciality Morbidity and Mortality meetings. There is an escalation process for clinical areas that do not follow clinical guidelines and there is active engagement at Executive level with Senior Clinicians in Specialities with repeated non-compliance.

There is a separate **Health Economy Antimicrobial Group** chaired by one of the Consultant Microbiologists. The group meets quarterly, and has representation from all key stakeholders, including general practitioners. A regular report is submitted to IPCC.

Decontamination Meetings

The Trust Decontamination Lead is the Chief Executive. The management of Decontamination and compliance falls into three distinct areas: Estates, IPT and the Equipment User, details are outlined later in the report.

Water Safety Group

The Water Safety group is a sub group of IPCC and meets quarterly. It is chaired by the Deputy DIPC with multi-disciplinary representation.

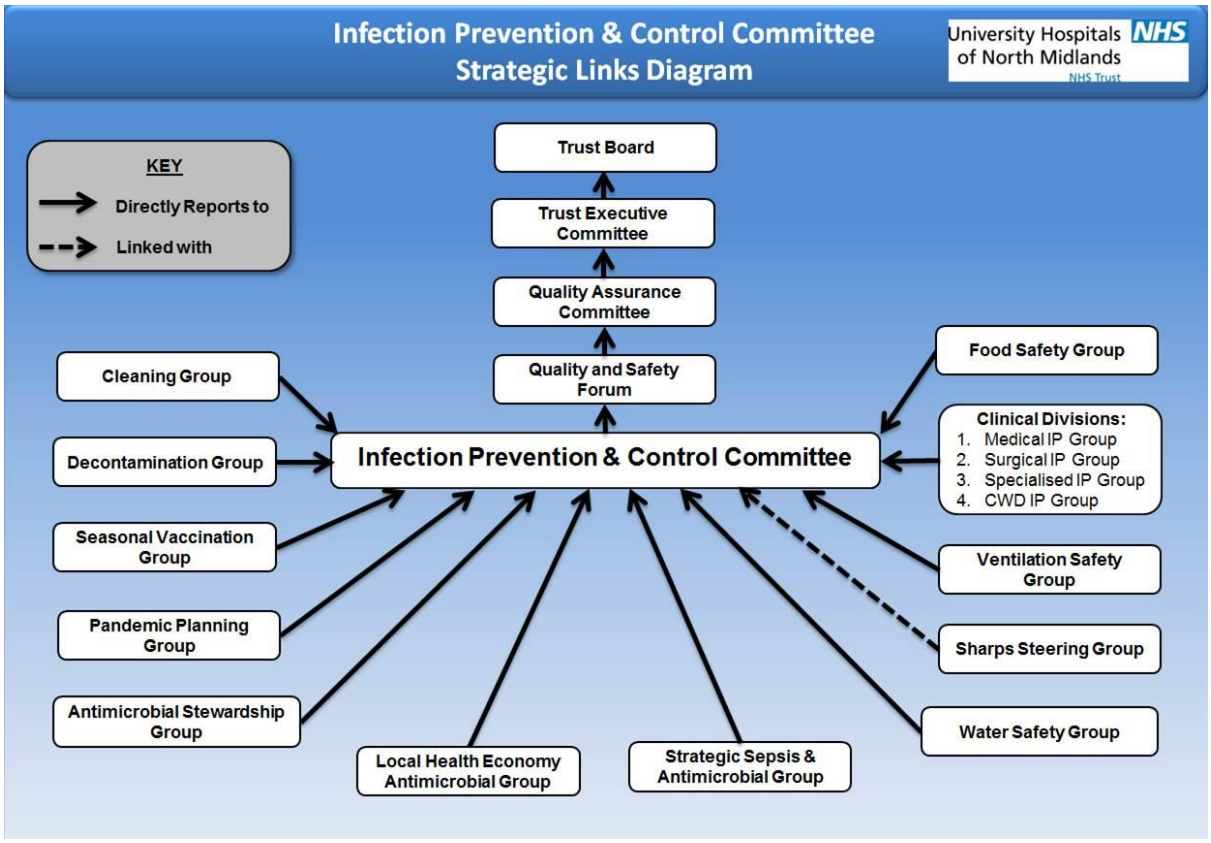
Mortality Review Group

The Trust Mortality Review Group meets monthly the Chair for the group is the Deputy Medical Director (Patient Safety). This group reports directly to the Quality and Safety Forum, providing an understanding of the interpretation and application from mortality data. The group has initiated a proactive approach to reviewing mortality alerts and providing prompt assurances to both the Trust and its external stakeholders in relation to any potential alerts relating to mortality. The mortality information and analysis is also reported to the Quality Assurance Committee to allow for non-executive review and challenge around the robustness of the data and the processes in place for reviewing mortality and providing assurances to the Trust Board.

The corporate structure for reporting and monitoring on mortality issues is outlined below:

Clostridium *difficile* 30 day all-cause mortality information is included in the Infection

Infection Prevention and Control Committee (IPCC) Strategic Links



Reports/Papers Received by IPCC

Policy/Procedure Updates and Standard Operating Procedures (SOP) updates	Rotational Report: Water Safety
UHNM HCAI Surveillance & Performance Reports	Rotational Report: Occupational Health
Outbreaks & Incidents	Rotational Report: Decontamination
Divisional Reports	Review & Update Committee Terms of Reference
Environment Report	Pandemic Flu Update
UHNM Antimicrobial Group Update	Annual Report
Antimicrobial CQUIN Update	Sepsis Report
Local Health Economy Antimicrobial Group Update	Annual Manual Decontamination Audit
Documents Received from other Committees, Regional & National	Annual Mattress Audit Report
HCAI Monthly Bulletin	Annual IP Link Practitioner Report
SSI Report	Food Safety Group Update
Blood Culture Contamination Rates Report	Antimicrobial Stewardship Group Minutes
BSI Report /Gram negative Report	Decontamination Group Minutes

Hand Hygiene Audits	IP Risk Register
ANTT Update	Water Safety Group Minutes
CDI Plan Update	Sharps Report
PHE Update	Health Economy Committee
Annual IP Code of Practice Self -Assessment Tool	3T Heater Cooler Update

Groups/Meetings Infection Prevention Team Attend

Antimicrobial Stewardship Group	Health Economy Antimicrobial Group
Clinical, Equipment, Standardisation and Produce Implementation Groups	Patient Safety Specialised Group
Compliance Steering Group	Infection Prevention Divisional Group
Clostridium *difficile* Multi- Disciplinary Meetings	Infection Prevention Group Meeting , Estates, Facilities and PFI Division
Clostridium period of increased incidence meetings (PII)	Pneumatic Tube Meetings
Bed and Mattress	Quality and Safety Forum
Decontamination Group	Seasonal vaccination Group
Estates refurbishments and new development projects	Strategic Sepsis and antimicrobial Group
Trust Health and Safety Committee	Tissue Viability
Health and Safety Imaging	Teaching and Educational Meetings
Fire Enforcement	Water Safety Group
Mortality Review	Group Strategic Sepsis and Antimicrobial Group

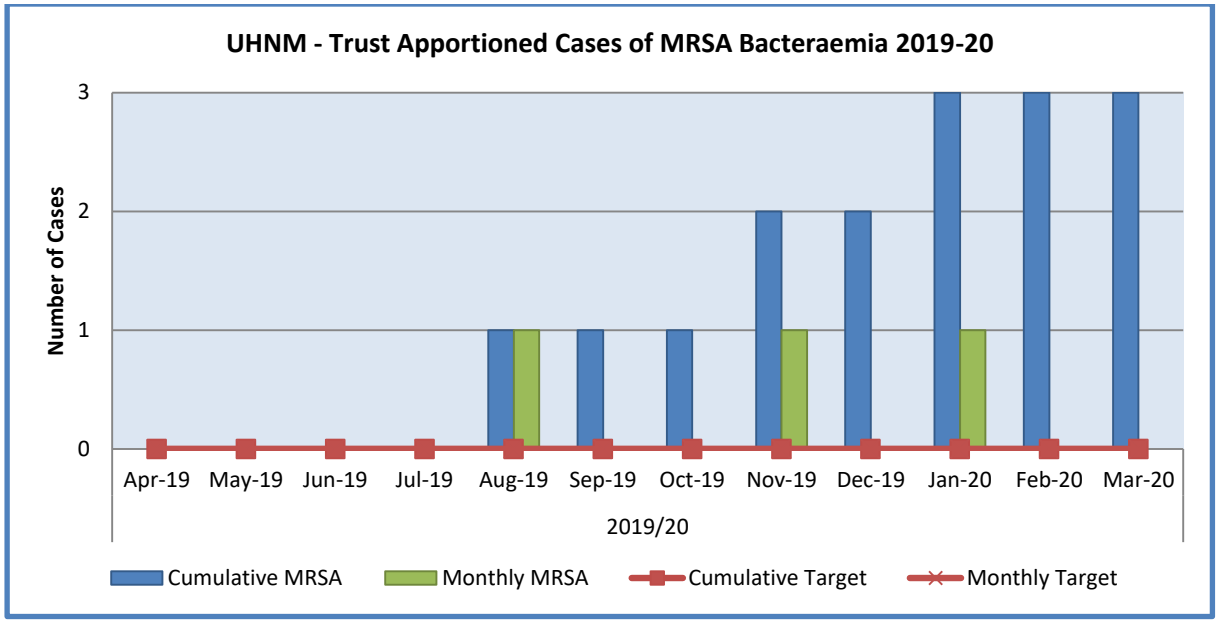
The IPT completed a gap analysis of evidence required to comply with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infection and related guidance (updated 2015). This was reported to IPCC.

COVID-19
COVID-19 Pandemic outbreak which originated from China, Public Health England and NHSe are leading a national plan for this.

UHNM Established a planning group and contingency plans are in place, with information on the intranet. Simulated exercised were held. As this is a dynamic situation planning assumptions and response are updated constantly with the support of the Chief Nurse/DIPC. During March 2020 UHNM started to see their first cases.

The Infection Prevention Team has been fundamental in this collaborative Trust wide work.

MRSA Bacteraemia (Blood stream infection)



Patient 1: Meeting held with internal and external stakeholders. MRSA typing a community strain, no history of previous Healthcare contact. Decision unavoidable, no lapse in care identified during patient journey.
Patient 2: Meeting held with internal and external stakeholders. Known MRSA positive since 2016, failed numerous MRSA decolonsation attempts. No lapses in care identified during patient journey.
Patient 3: Meeting held between internal and external stakeholders. Known MRSA since 2019, numerous failed MRSA decolonisation attempts. No lapses in care identified during patients journey.

***Clostridium difficile* Infection (CDI)**
Clostridium *difficile* is a bacterium that can cause colitis. Symptoms range from mild diarrhoea to a life threatening disease. Infections are often associated with healthcare, particularly the use of antibiotics which can upset the bacterial balance in the bowel that normally protect against CDI. Infection may be acquired in the community or hospital, but symptomatic patients in hospital may be a source of infection to others. A proportion of the healthy population have Clostridium *difficile* normally residing in their gut without causing any illness.

In March 2012 the Department of Health (DH) issued revised guidance on how to test, report and manage CDI. The new guidance aimed to provide more effective and consistent diagnosis, testing and treatment of CDI. It provided the ability to categorise patients into one of three groups:

- CDI likely
- Potential Clostridium *difficile* excretors (carriers)
- CDI unlikely

Identification of potential Clostridium *difficile* excretors may aid infection control measures.

UHNM is compliant with DH testing guidance for CDI.

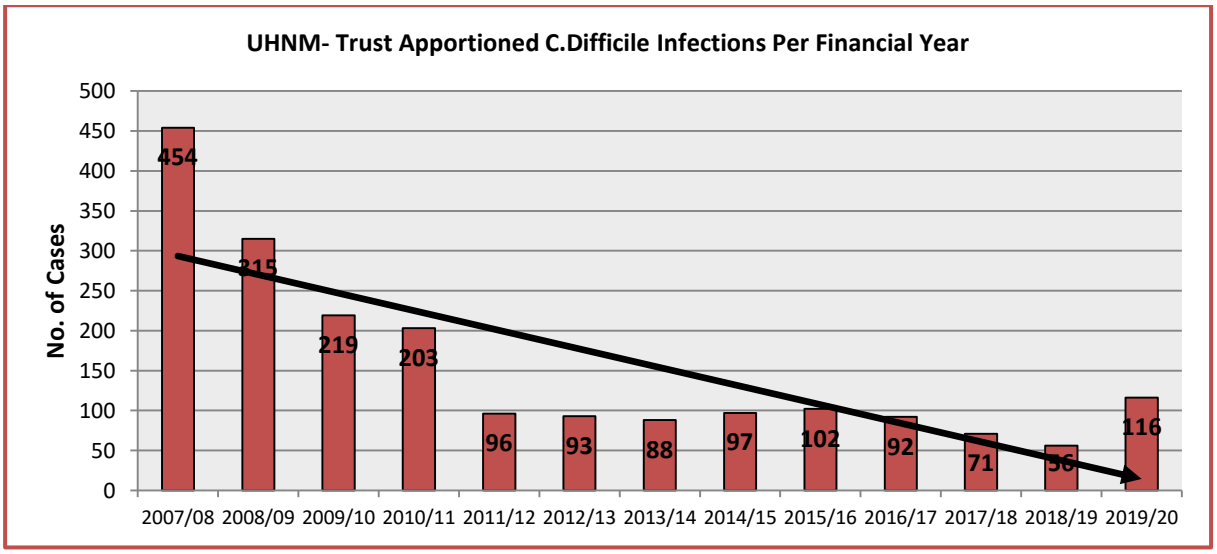
All patients with a toxin A/B positive or a toxin B gene PCR test positive report are isolated until at least 72hrs free of symptoms and a formed stool has been achieved.

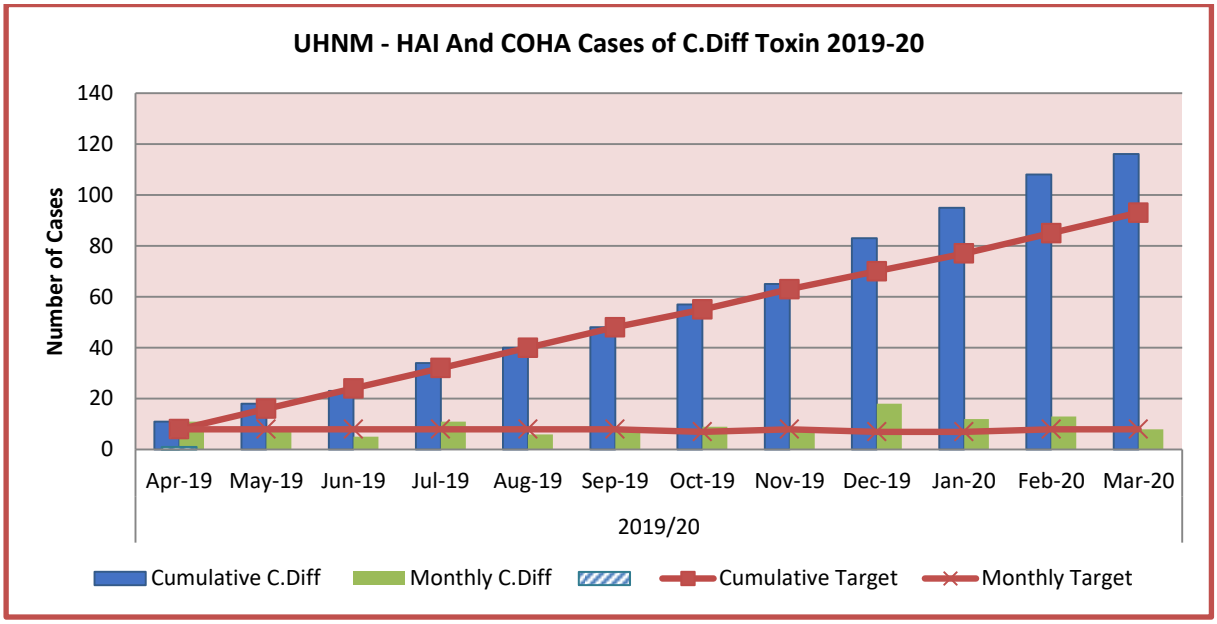
Healthcare associated cases (HAI) Cases are Clostridium *difficile* toxin positive specimens taken on or after day 3 of a hospital admitted spell where day 1 is the day of admission

Community onset hospital associated (COHA) Cases are Clostridium *difficile* toxin positive specimens taken on day 1 or day 2 of a hospital admitted spell where the patient has been discharged from an overnight stay within 28 days preceding the specimen date

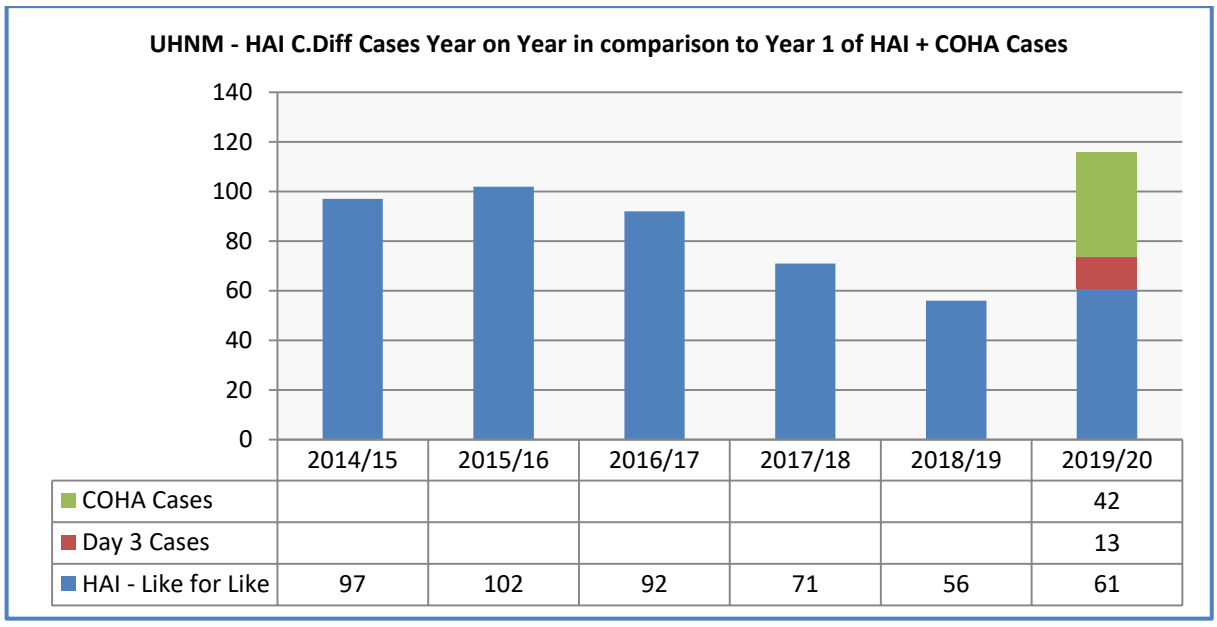
From April 2019 onwards the performance of each Trust in relation to their annual target (as set out by NHSi in their CDI Objectives for NHS organisations) regarding trust apportioned cases is the total of **HAI** cases plus **COHA** cases.

The target set by NHS England for Trust acquired cases at UHNM 2019-20 was 93. UHNM reported a total of 116 cases which is an 89% increase on the previous year 2018/19 (when 56 Trust apportioned cases were reported), and well above the target. Out of the 116 cases 16 were deemed as avoidable (lapse in care) (12 HAI cases and 4 COHA cases).

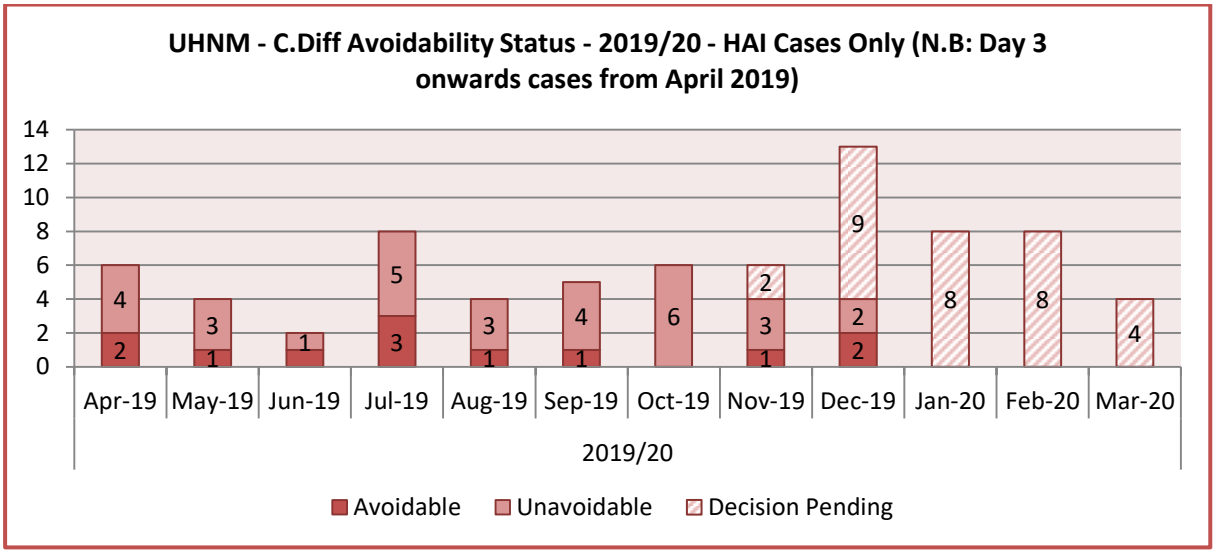


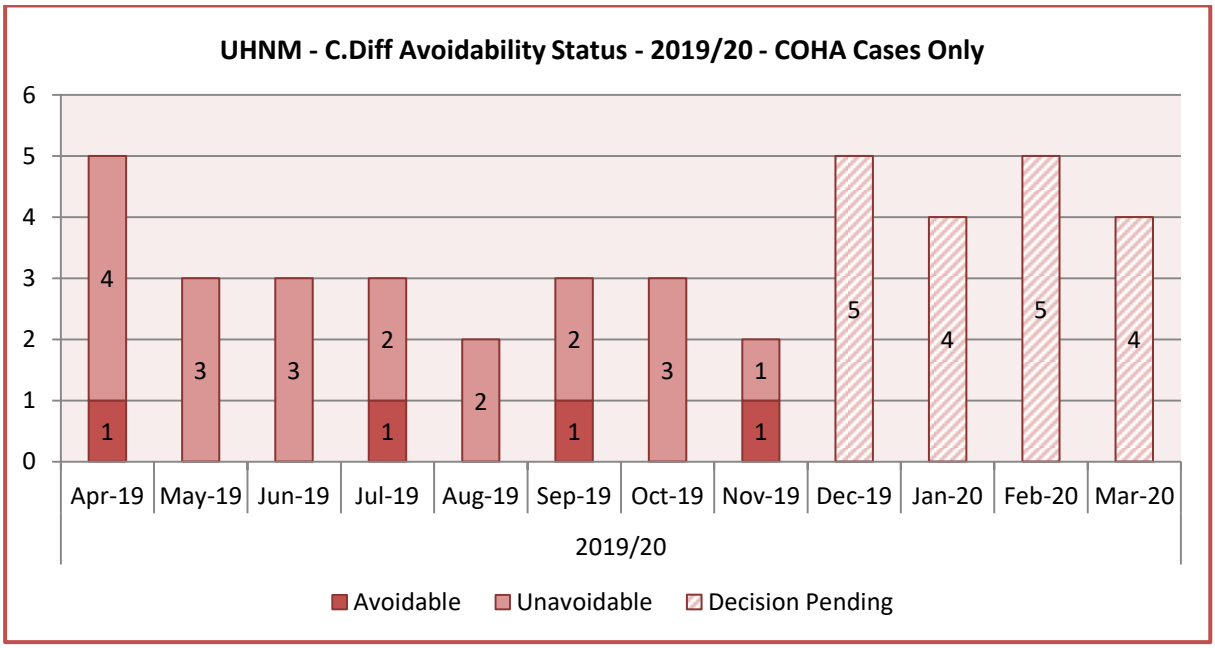


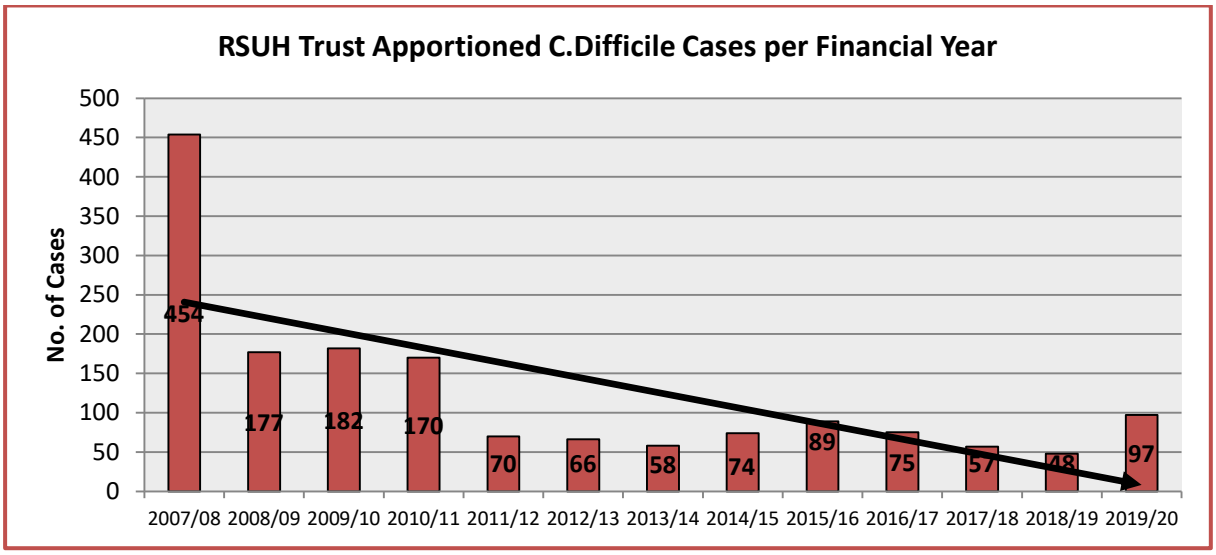
The following chart shows the impact that the change in Trust apportionment rules have had on the total number of cases attributed to UHNM in 2019/20. Using the previous apportionment rules of specimens taken on or after day 4 of an admission spell where day 1 is the day of admission UHNM would have reported 61 HAI cases. The effects of the new definition of using specimens taken on day 3 onwards plus specimens taken on day 1 or day 2 of a re-admission within 28 days are clearly shown in the following chart as accounting for an extra 13 cases where the specimen was taken on day 3 and 42 cases where the specimen was taken within 28 days of a previous discharge (COHA cases).

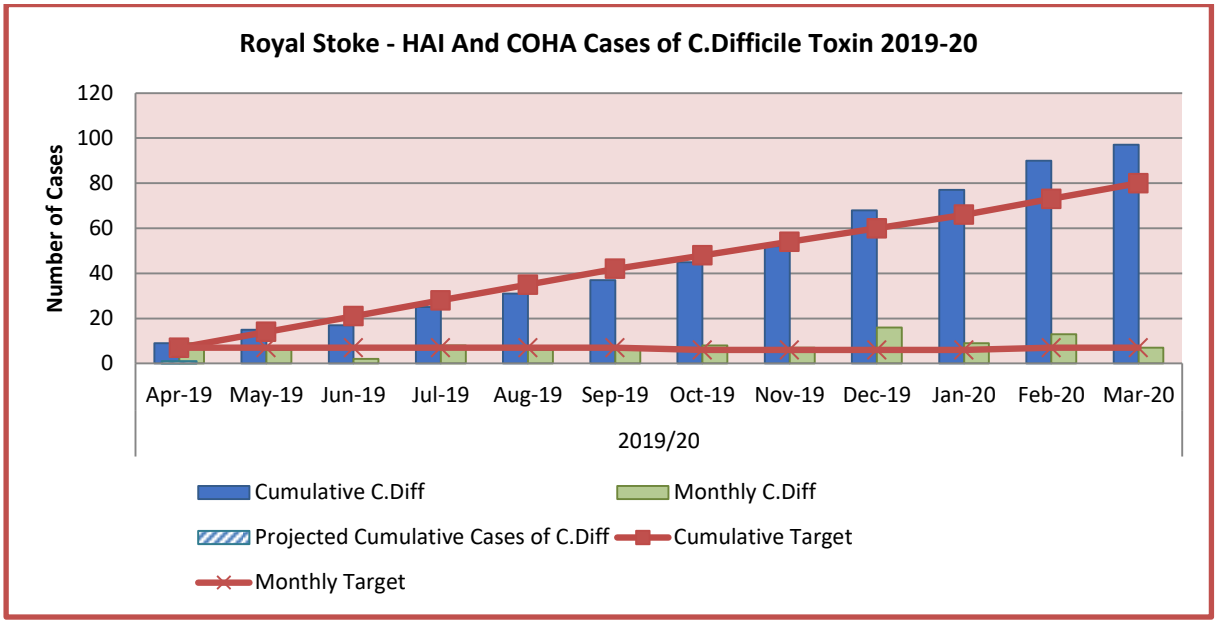


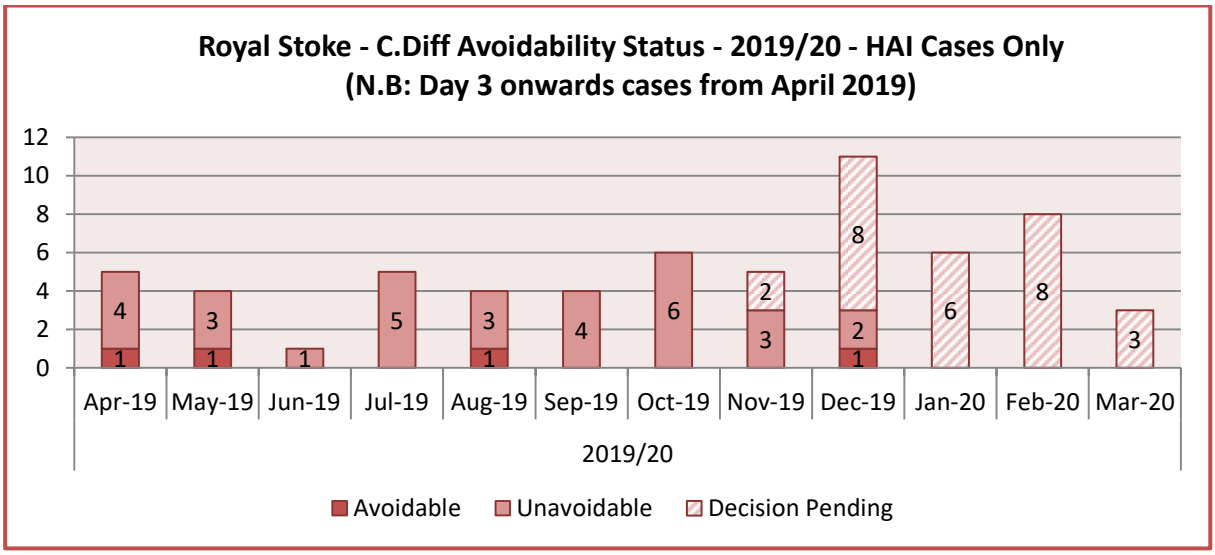
	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
COHA Cases						42
Day 3 Cases						13
HAI - Like for Like	97	102	92	71	56	61

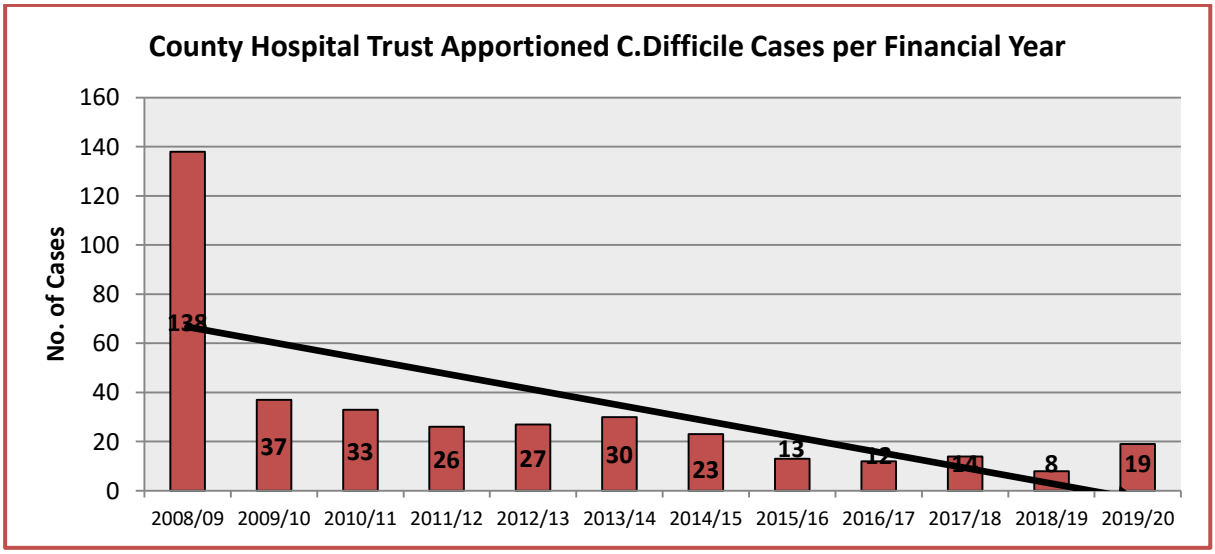

UHNM - C.Diff Avoidability Status - 2019/20 - HAI Cases Only (N.B: Day 3 onwards cases from April 2019)
14
12
10
8
6
4
2
0
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20
2019/20
Avoidable
Unavoidable
Decision Pending


UHNM - C.Diff Avoidability Status - 2019/20 - COHA Cases Only
6
5
4
3
2
1
0
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20
2019/20
Avoidable
Unavoidable
Decision Pending


RSUH Trust Apportioned C.Difficile Cases per Financial Year
No. of Cases
500
450
400
350
300
250
200
150
100
50
0
454
177
182
170
70
66
58
74
89
75
57
48
97
2007/08 2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20


Royal Stoke - HAI And COHA Cases of C.Difficile Toxin 2019-20
Number of Cases
120
100
80
60
40
20
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
2019/20
Cumulative C.Diff
Monthly C.Diff
Projected Cumulative Cases of C.Diff
Cumulative Target
Monthly Target


Royal Stoke - C.Diff Avoidability Status - 2019/20 - HAI Cases Only
(N.B: Day 3 onwards cases from April 2019)
12
10
8
6
4
2
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
2019/20
Avoidable
Unavoidable
Decision Pending


County Hospital Trust Apportioned C.Difficile Cases per Financial Year
No. of Cases
160
140
120
100
80
60
40
20
0
138
37
33
26
27
30
23
13
12
14
8
19
2008/09
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2011/12
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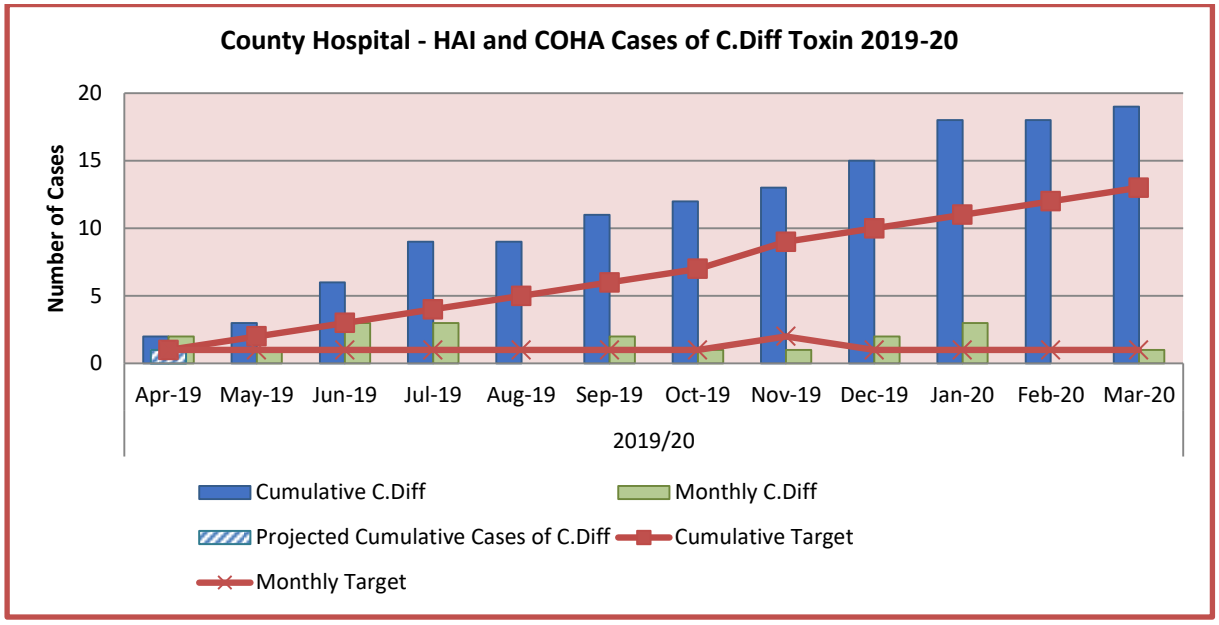
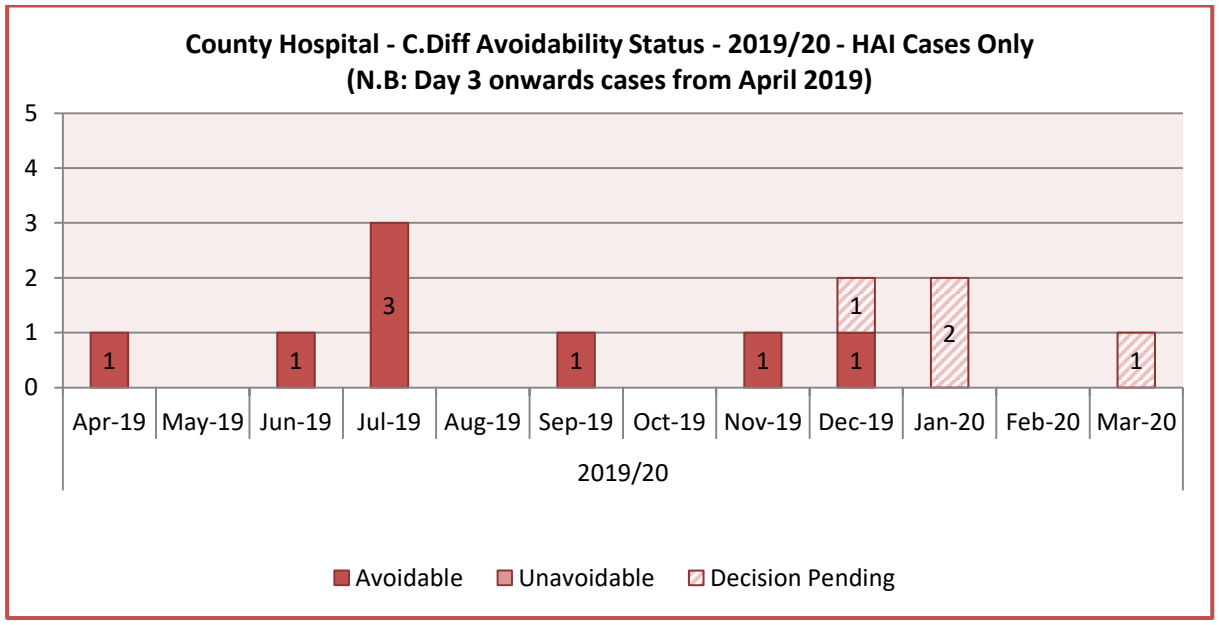
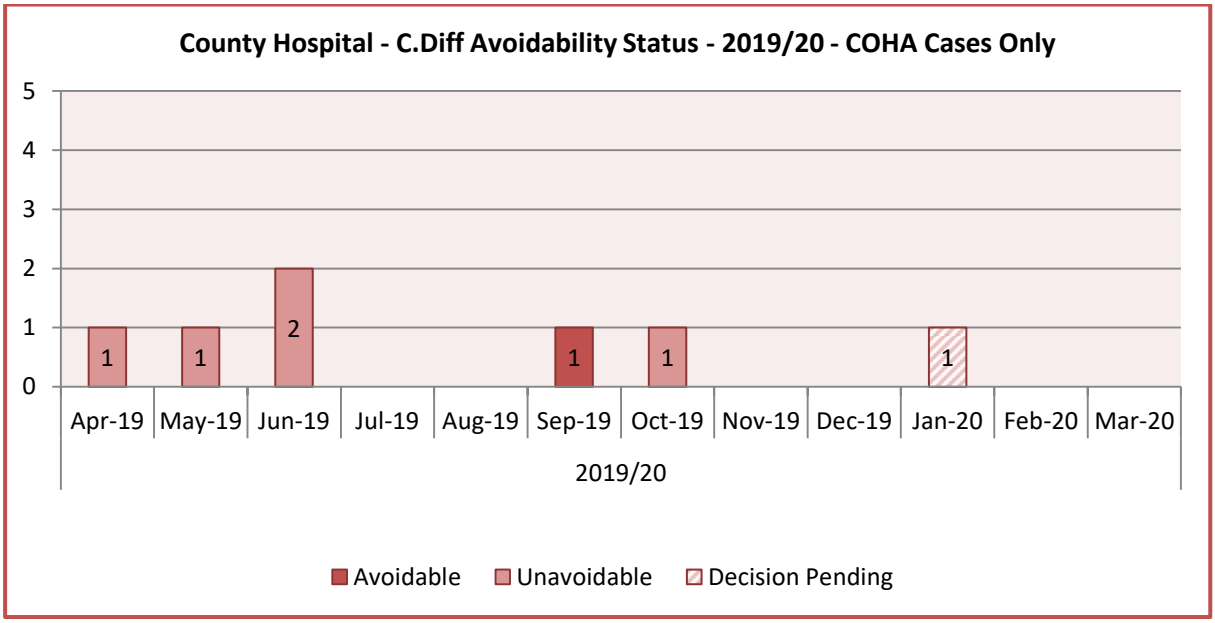
2014/15
2015/16
2016/17
2017/18
2018/19
2019/20


County Hospital - HAI and COHA Cases of C.Diff Toxin 2019-20
Number of Cases
20
15
10
5
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
2019/20
Cumulative C.Diff
Monthly C.Diff
Projected Cumulative Cases of C.Diff
Cumulative Target
Monthly Target


County Hospital - C.Diff Avoidability Status - 2019/20 - HAI Cases Only
(N.B: Day 3 onwards cases from April 2019)
5
4
3
2
1
0
1
1
3
1
1
1
1
2
1
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
2019/20
Avoidable
Unavoidable
Decision Pending



Clostridium *difficile* Action Plan

Preventing and controlling the spread of Clostridium *difficile* 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 Clostridium *difficile* toxin positive cases and of those cases that are Clostridium *difficile* carriers (PCR positive).

All hospital acquired Clostridium *difficile* positive samples or cases where the patient has had a recent hospital stay at UHNM are submitted to Public Health England for ribotyping. Samples with the same ribotype are then examined further by way of VNTR. This helps to identify wards or areas where patient to patient transmission has likely to have occurred, with enhanced focus on control measures, with decanting and deep-cleaning of the patient areas if necessary.

Ribotyping service has since been paused due to COVID-19 testing pressures.

In all cases control measures are instigated immediately, and RCA's are reviewed. Each inpatient is reviewed by the Clostridium *difficile* Nurse at least three times a week, and forms part of a weekly multi-disciplinary review where the patients' case is discussed including antibiotics and where necessary feedback to Ward Doctors is given.

All HCAI CDI toxin cases are subjected to a Root Cause Analysis and each case discussed with Head of IP and Clinical Commissioning Groups to decide their avoidability (lapses in care) with feedback to the IPCC and Divisions, with the Divisions to action Duty of Candour where necessary.

UHNM closely monitor Periods of Increased Incidence (PII) of patients with evidence of toxigenic Clostridium *difficile* in any ward or area. The definition of a PII is two or more patients identified with evidence of toxigenic Clostridium *difficile* within a period of 28 days and associated with a stay in the same ward or area.

Wards with HCAI CDI are placed on barrier cleans for a total of 28 days provided no further HCAI cases are reported from the area, in addition wards with a PII undergo a full terminal clean.

Sporicidal disinfectant is used routinely across UHNM for cleaning of the general environment and non-invasive equipment used in wards/departments e.g. commodes. Emergency portals are on a routine six monthly deep clean programme in addition to all other cleans.

The above approach has assisted greatly in the early identification and termination of any outbreaks of CDI.

Fidaxomicin is used as first line treatment for patients with a high risk of recurrence of C.*difficile*

Criteria for use

- Aged 65 years or over and /or
- Recurrent CDI cases
- Concomitant systemic antibiotics treatment for an indications other than CDI
- Patient severely immuno–compromised

In addition a switch to fidaxomycin is undertaken in any patient, if treatment with several days of oral vancomycin has failed clinically, and the likely continuing signs/symptoms are caused by CDI.

Faecal microbiota transplant (FMT) involves the infusion of healthy human donor flora bacteria into the bowel of the affected patient. The indications for the treatment were either recurrent diarrhoea or no response to aggressive CDI management.

Education is a key aspect of helping to promote the prevention of Clostridium *difficile* within the Trust. Assisting with staff knowledge of stool sampling practices and Clostridium *difficile* risks factors.

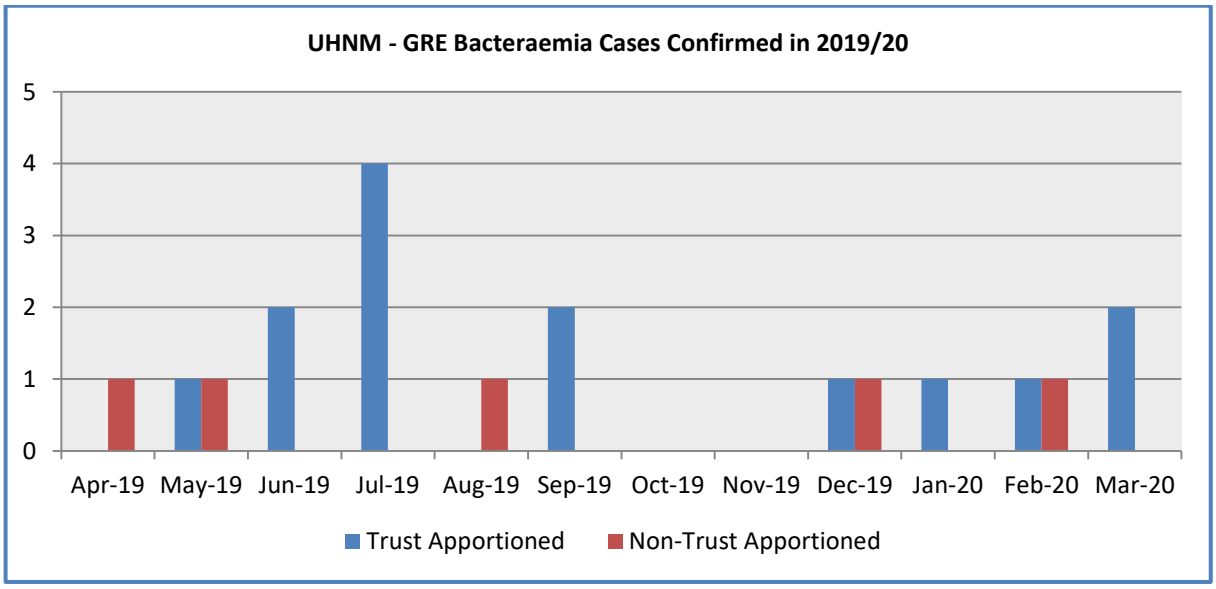
A programme of Clostridium *difficile* educational is in place, with sessions extended to include non-clinical staff such as Domestic Staff, plus the introduction of online Clostridium *difficile* education.

A top tips cards for staff are issued to staff during the education sessions, again promoting sampling practices and the ‘Pooh’ help line. A Pooh helpline awareness stands were held in December 2019 to promote the Pooh helpline.

All patients with CDI are provided with an information leaflet which contains the Clostridium *difficile* passport (green care), this card is for the patient to keep and then show to any doctor, pharmacist, dentist or healthcare provider.

Glycopeptide Resistant Enterococcus (GRE) Bacteraemia
Enterococci are bacteria commonly found in the bowel and GRE are enterococci that have become resistant to glycopeptides (for example vancomycin). Reporting of bacteraemia caused by GRE has been mandatory for NHS acute Trust in England since September 2003.

During 2019-20 the Trust reported 19 of this type of blood stream infection (see chart below), with 23 cases recorded at UHNM in 2018-19.



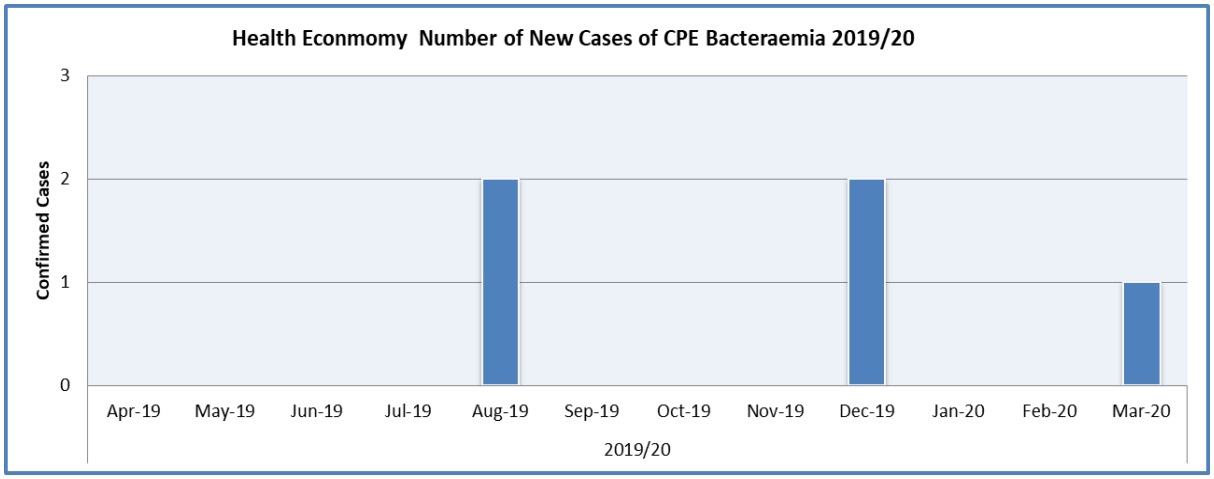
Carbapenemase – Producing Enterobacteriacea (CPE)
Public Health England published a toolkit for the early detection, management and control of CPE in December 2013. The toolkit provides expert advice on the management of CPE to prevent or reduce the spread of these bacteria into (and within) health care settings, and between health and residential care settings.

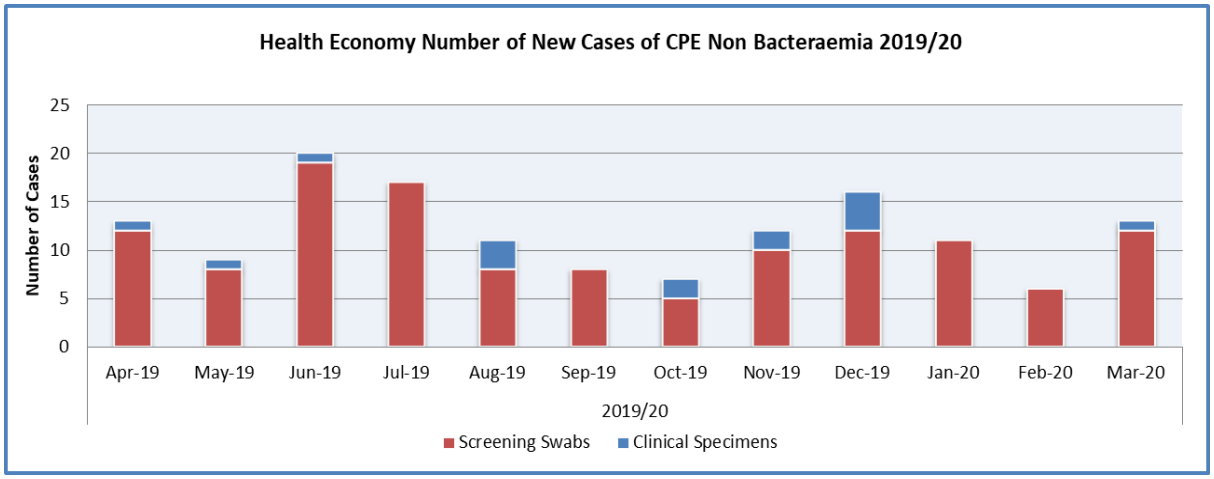
A Trust CPE policy has been in place for some time; this reflects screening guidance recommended by Public Health England.

In addition to national guidance UHNM perform routine admission and weekly screening on the following wards: Adult Intensive Care Unit, Renal Ward, Infectious Diseases Ward, and all Elderly Care Wards.

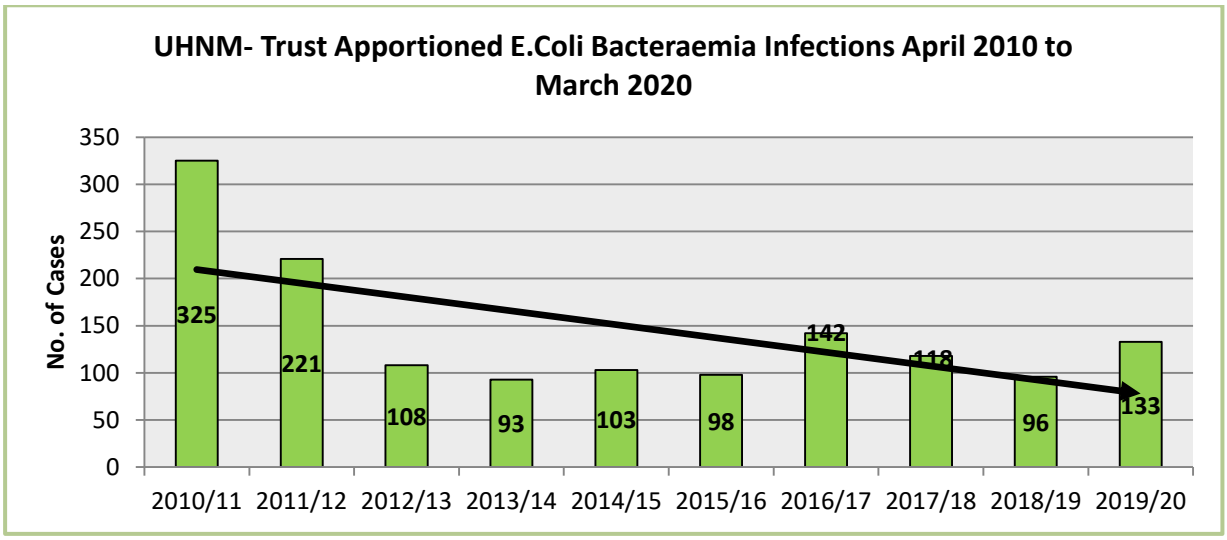
A screening close contact flow chart remains in place to assist staff in the clinical areas where contact screening of patients is required.

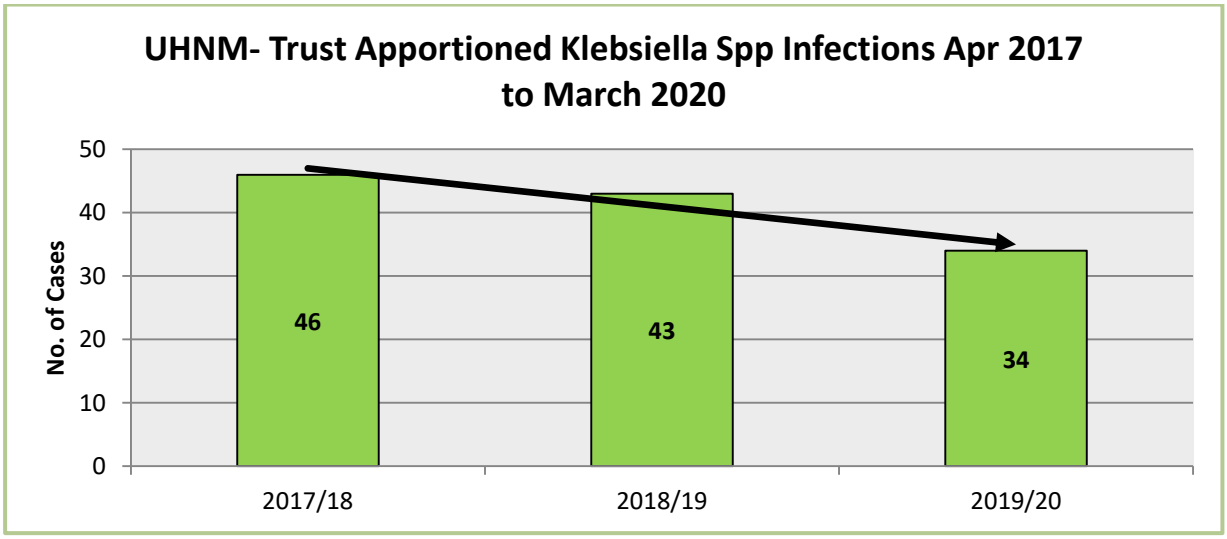
UHNM screening method (for rectal swab & catheter sample urines) uses culture plates that can detect both ESBL and CPE, for identified hospitalised close contacts of confirmed CPE UHNM PCR tests are performed on rectal swabs to enable rapid results and subsequent actions.

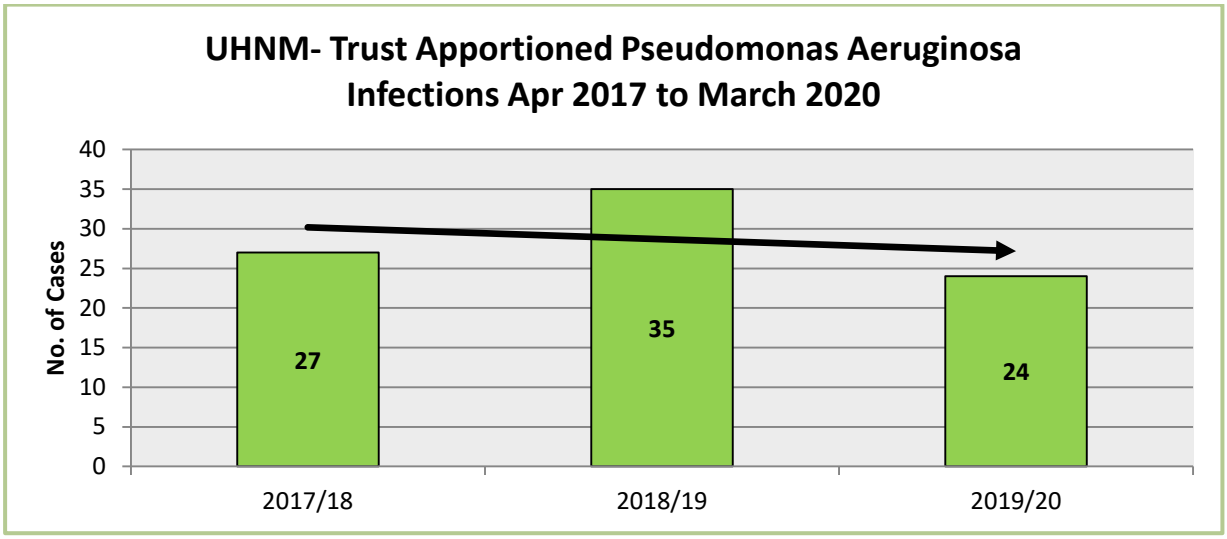




Gram- negative Bacteraemia Trust Apportioned







Pseudomonas aeruginosa is a Gram-negative bacterium often found in soil and ground water. It is an opportunistic pathogen and it rarely affects healthy individuals, however, it can cause a wide range of infections, particularly in those with a weakened immune system e.g. cancer patients, new-borns and people with severe burns, diabetes mellitus or cystic fibrosis.

A retrospective review of Trust Hospital Acquired *Pseudomonas aeruginosa* BSI's, identified between 1st April 2018 – 31st March 2019, was completed by the Clinical Surveillance Team (CST) to influence the Trust's action Plan, using information from electronic systems: ICNet, Masterlab and iPortal. A total of 34 cases of hospital acquired *P. aeru* BSI were identified. The review found that in over 55% of cases the primary focus for *P.aeru* BSI was not determined. The Infection Prevention Team will check Masterlab, ICNet and iPortal electronic systems, in addition to liaising with clinical staff, to obtain this information wherever possible.

Clinical areas have an ongoing responsibility to identify any unused or infrequently used water outlets and to implement flushing regimes as specified in the Water Safety SOP, available via the Trust Infection Prevention intranet page.

Gram Negative Blood Stream Infections

The national ambition to halve healthcare associated Gram-negative bloodstream infections and halve inappropriate antimicrobial prescribing by 2021 was announced in 2017. The date for attainment of a 50% reduction in healthcare associated Gram negative BSI's has since been revised to March 2024, with a 25% reduction by March 2021. This is due to the complexity of this challenge with more than 50% of infections occurring in people outside of healthcare settings. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015. We know GNBSI cases can occur in hospitals however, half of all community onset cases have had some healthcare interventions either from Acute, Primary or Community Care. Therefore, we can only achieve the reductions by working together across the whole Health and Social Care sectors. A Healthcare Economy approach to reducing E.coli BSI's continues to be the focus.

Collaborative work is on-going with Tissue Viability to standardise urinary catheterisation packs, following completion of a joint BARD Trust catheter associated urinary tract infections (CAUTI) steering group 'Zero-in' audit of Trust catheter usage. BARD catheter trays have been implemented at County Hospital site since October 2019, following training by BARD staff. Evaluation by BD is pending. An ANTT Clinical Guideline for catheter insertion utilising the BARD catheter trays is awaited from ANTT.org. The BARD catheter trays are now accredited by the ANTT organisation. A urinary catheter passport and urinary catheter patient information document is currently under review and it is anticipated that this will be a joint MPFT and UHNM document. Follow-up of these projects is currently paused due to COVID-19 pressures.

Delivery of the Trust gram-negative action plan is monitored weekly by the Infection Prevention Senior Sister for the Clinical Surveillance Team and reviewed formally with the Deputy DIPC monthly. Progress is shared with Trust IPCC and monitored in Divisional Infection Prevention meetings and presented at CQRM quarterly as per HCAI contractual requirements if required, and also shared with the CCGs Head of Infection Prevention & Control.

The action plan themes are currently identified as:

1. Surveillance
2. Antimicrobial prescribing
3. Urinary Tract Infection (UTI)
4. Catheter associated urinary tract infection (CAUTI)
5. Hydration
6. Skin and soft tissue / Oral hygiene/denture in the elderly / SSIS
7. Device related - vascular access device (VAD) care
8. Hand Hygiene
9. Learning – patient information and education

The Trust gram-negative layout / format requires amendment but due to COVID-19 pressures is currently outstanding.

Candida auris

Public Health England produced a document - Guidance for the laboratory investigation, management and infection prevention and control for cases of *Candida auris,* which is a yeast species *(C. auris).*

C. auris is a recently identified *Candida* species that has been associated with infection and outbreaks in healthcare settings on five continents including the UK. It has been isolated from a range of body sites, including skin (very common), urogenital tract (common), and respiratory tract (occasional), and resulted in invasive infections, such as Candidaemia, pericarditis, urinary tract infections and pneumonia.

C. auris affects both paediatric and adult populations, and has predominantly been identified in critically unwell patients in high dependency settings.

As with other organisms associated with nosocomial outbreaks, it appears to be highly transmissible between patients and from contaminated environments, highlighting the importance of instituting effective infection prevention practices.

A screening policy, guidance on treatment and infection prevention precautions is included in the Infection Prevention Questions and Answers Manual.

Audit Programme to Ensure Key Policies are Implemented

UHNM has a programme of audits in place, undertaken by both clinical areas and the IPT to provide assurance around practice and ensure that areas are consistently complying with evidence based practice and policies. Action plans are devised by areas where issues are highlighted and fed back to the IPCC via the Matron for the area.

The audit tools for general ward areas are designed to ensure relevant to that Clinical Area. In addition the IPT completed additional audits where infection numbers are highest or where there appears to be an identified risk concern so improvements in the care process can be identified quickly and put into action.

Check and Prompt Audits

The check and prompt audits continued as part of the Trust's Clostridium *difficile* plan. These audits are undertaken by the IPT to review patients with a hospital stay of 3 months, 6 months and 9 months. The objective is to provide assurance for common IP interventions and proactively seek improvements where necessary to reduce the risk of health care acquired infections.

Audits of Hand Hygiene Practice

Hand hygiene remains central to the audit programme. There is a Senior Nursing Assistant within the IP Team who undertakes unannounced random hand hygiene assessments in clinical areas, as well as providing weekly hand hygiene training sessions.

The Trust continues to focus on four main components:

- Alcohol hand rubs at the point of care, prominently positioned near each patient or staff carriage so that hands can be cleaned before and after care within the patient's view.

- Audit of hand washing practice at least monthly, Wards that do not achieve 95% repeat the audit after two weeks.
- Patients are encouraged to challenge staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.

Staff Information

- Alert organism surveillance is reported to the organisation by the Infection Prevention Nurses daily
- Monthly ward based/Divisional surveillance data is produced, including surveillance, information on MRSA, Clostridium *difficile*, ESBL , MGNB and antimicrobial. This information is used to update ward dashboards which are on display on the wards; this informs the public on ward performance.
- IP promotional activities have been held throughout the year promoting infection prevention with good practice being targeted at both staff and visitors to the Trust.
- Intranet: IP continues to make use of the intranet for providing staff with an easy access portal for information, policy guidance and IPT contact details. This information is regularly updated.
- IPT continue to lead the Infection Prevention Link Practitioner scheme
- Norovirus and other toolkits are available for all ward areas. The toolkits include everything that staff require to help manage infections, including posters and information for relatives/visitors.
- Posters and information leaflets are displayed throughout the Trust. These provide key infection prevention messages and actions for staff, public and visitors.

Staff Training

The IP Team continue to have a strong training role within the UHNM, educational sessions have been delivered throughout the year. These have included programme of mandatory sessions and induction days, in addition; Sepsis, MRSA, CPE, MRSA screening and decolonisation, influenza, flu vaccination, norovirus, Clostridium *difficile,* winter planning, water safety/flushing, Personal protective equipment (donning and doffing)

A number of Infection Prevention educational sessions are also available via the Trusts online system.

Mask Fit Training

The IP Senior Nursing Assistant provides regular sessions for mask fit training for clinical staff with masks fit cascade trainers are in place throughout the Trust to mask fit staff within their own clinical area.

Seasonal Staff Influenza Vaccination Campaign

Seasonal influenza staff vaccination campaign is well established at UHNM and is a year round process.

IP Link Practitioner Scheme

The IPT continued to support the IP Link Practitioner with most areas having a designated link member of staff. This Scheme is open to all staff as everyone has an important role in infection prevention and cascading best practice in their area of work.

Estates
Education sessions for retained estates was undertaken covering basic Infection prevention principles. This training was well received by the department.

Shadowing
During 2019-20 Student Nurses from Keele University continued to be allocated to the IPT. This is a valuable experience to provide an opportunity for students to gain an insight into IP within a hospital setting and to improve practice whilst working in the clinical areas.

Aseptic Non Touch Technique (ANTT)
Healthcare associated infections (HAI) can be significantly reduced when effective aseptic technique is practised. UHNM adopted ANTT in 2015 as the standard for all clinical procedures. Throughout 2019/20 work has continued to strengthen the theory and practice of ANTT throughout the Trust with the Infection Prevention Clinical Surveillance Team (CST) working with clinicians to ensure that ANTT is embedded into all policies, protocols, guidelines and training. Cascade trainers have been supported by CST with cascade trainer training sessions, meetings, educational newsletters and nationally updated ANTT resources made available on the Trust Intranet. The Trust "Roles and Responsibilities" for ANTT Cascade Trainers is available via the Trust intranet providing clarity of the role and the Trust expectations, also to assist managers when allocating the role to an appropriate member of the team.

The Trust's My ESR ANTT theory package was launched in August 2018 has been accessed and completed by many clinical staff across the Trust. Practical assessments are able to be recorded on erostering as a clinical skill by Department Managers to enable an overview of how many staff have completed practical assessments and are competent.

A UHNM corporate audit of ANTT is pending. Ad hoc audits of ANTT practice will be carried out by the IP CST Team, across all clinical divisions. This will be a collaborative audit with the UHNM Quality, Safety and compliance Department. ANTT update sessions continue for individual clinical areas, as required and to support with any PII.

Through attendance at the Trust Clinical Equipment Standardisation and Product implementation Group (CESPIG) standardisation and suitability of equipment and medical consumables continues to be promoted across the Trust.

Staff Supervision
Infection Prevention Team are allocated their own areas of responsibility for wards/departments/Matrons. This enables IPNs to link in with ward staff to provide relevant training and expert advice to staff as well as monitoring compliance in those areas. In this way, the work of staff in the Trust was subject to scrutiny and supervision but more importantly clinical staff felt supported and knew who their point of contact was.

Bed Management and Movement of Patients
The IPNs work closely with the Clinical Site Team especially during the winter period, providing timely and expert advice on the management and movement of potentially infected patients. There is an updated RAG rating system for the use of side room/isolation facilities available for staff to use to ensure that as far as possible informed decisions are made when considering patient placement.

Compliance Criteria 2:

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

Monitoring Processes

Royal Stoke
The cleaning provided at the Royal Stoke Hospital site for all clinical and non-clinical areas are split between an in-house cleaning team as well as an external cleaning contractor (Sodexo).

Monitoring Processes for In-house Retained Estate Cleaning/Domestic Services
The Retained Estate Team is responsible for cleaning approximately 21% of areas at The Royal Stoke, and provides a comprehensive 24/7 scheduled and ad-hoc cleaning service.

The Retained Team complete environmental audits which occur in all patient areas once every three months, this is carried out with representatives from the Retained Cleaning, Clinical and Estates Teams.

Self-monitoring is completed by the Retained Supervisory Team on a weekly basis, to ensure standards are maintained throughout all of the retained areas. If there are areas of concern, the monitoring is increased until the Team are satisfied that the standards are being met. Spot checks and unannounced ad-hoc audit inspections are also carried out by the Management Team, the frequency of these is determined on a week to week basis.

The Retained Team are committed to providing an outstanding service which is reflected in the Environmental Audit scores and our Patient-Led assessments of the care environment (PLACE) results.

Representatives from the Retained Management Team also participate in any outbreak or periods of increased incidents (PII) meetings, when issues are identified on site.

Scheduled and ad-hoc meetings with Infection Prevention, Matron's and Clinical colleagues to regularly monitor, review progress and address/resolve any issues are held to ensure that standards and performance target and compliance is met.

Monitoring Processes for Sodexo Cleaning Services
Sodexo is responsible for cleaning approx. 79% of areas at The Royal Stoke and provides a comprehensive 24/7 ad hoc and scheduled cleaning service via a helpdesk on site. The contract in place ensures that all areas are cleaned to the 2002 NHS Cleaning Standards and are self-monitored at least once every 10 weeks. The Trust has a Contract Performance Management (CPM) Team in place to ensure that standards on site are maintained for Sodexo areas. The CPM Team work closely with Sodexo to drive and sustain improvements, concerns regarding cleanliness can be raised by all staff via the helpdesk route, and an escalation process exists should users feel that their concerns have not been addressed satisfactorily.

The CPM Team completes environmental audits which occur in all patient areas once every three months with representatives from the Clinical, Estates and Cleaning Teams present. In addition to this the CPM Team also provides representation for the Water Safety Group, Clinical Excellence Framework Group, as well as participate in any outbreak or periods of increased incidents (PII) meetings when issues are identified on site.

The CPM continue to work closely with Sodexo on-site, their National Senior Management Team, Matron's and Clinical colleagues to regularly monitor, review progress and address/resolve any issues or concerns promptly:

- Regular meetings between Sodexo management representatives and Trust clinical teams to review cleaning performance and ensure that improved performance is sustained and confidence in the service is maintained.
- Frequency of joint spot-checks and unannounced cleanliness audit inspections continue at an increased level.
- FM Team continue to work closely with the IPT.

Infection Prevention Meetings

- Monthly meetings are held between the IPT and CPM/Sodexo to review cleaning scores and discuss any areas of concern.

County Hospital

Monitoring Processes for Cleaning/Housekeeping Services

The County Team is responsible for cleaning all areas (with exclusion to Theatres) on this site, and provides a comprehensive scheduled and ad-hoc cleaning service from 6am – 10pm, seven days a week. In March 2020, due to the COVID pandemic, the Housekeeping service on site has increased to a 24/7 service, mirroring the service provision at Royal in both retained and Sodexo serviced wards and departments.

The County Monitoring Officer completes environmental audits which occur in all patient areas once every three months; this is carried out with representatives from the Clinical locations. If areas raise concerns due to failures identified, they are re audited within that same quarter.

Self-monitoring is completed by the Housekeeping Supervisory Team on a weekly basis, dependant on risk rating of areas, to ensure standards are maintained throughout all of the retained areas. If there are areas of concern, the monitoring is increased until the Team are satisfied that the standards are being met. Spot checks and unannounced ad-hoc audit inspections are also carried out by the Management Team.

The County Team are committed to providing an outstanding service which is reflected in the Environmental Audit scores and our Patient-Led assessments of the care environment (PLACE) results (2018 & 2019 PLACE scores 100%).

Representatives from the County Management Team also participate in any outbreak or periods of increased incidents (PII) meetings, when issues are identified on site.

Scheduled and ad-hoc Meetings with Infection Prevention, Matron's and Clinical colleagues to regularly monitor, review progress and address/resolve any issues are held to ensure that standards and performance target and compliance is met.

PLACE Inspection

The annual PLACE inspection took place in October 2019 with results published in January 2020 for all Trusts.

Site Name	CLEANING Score %	FOOD Score %	PRIVACY, DIGNITY & WELLBEING Score %	CONDITION & MAINTENANCE Score %	DEMENTIA Score %	DISABILITY Score %
THE ROYAL STOKE UNIVERSITY HOSPITAL	99.94	94.75	90.17	99.51	90.34	92.45
THE COUNTY HOSPITAL	100	96.75	99.56	99.88	96.47	96.10
UHNM TRUST SCORE	99.95	95.03	91.49	99.56	91.21	92.97
NATIONAL AVERAGE	**98.6**	**92.2**	**86.1**	**96.4**	**80.7**	**82.5**

PLACE Scores 2019

Terminal Cleans

All emergency portals undergo a deep clean on a six monthly basis in addition to other cleans.

All terminal clean requests required within working hours are requested via the IPT. Requests for terminal cleans outside of these hours are requested via the Site Matron, and are completed by the respective teams to ensure that patient flow is not slowed down.

Radiator Cleaning

UHNM has a planned programme of radiator cover removal to allow for cleaning.

Food Safety

The Food Safety Task and Finish Group have developed and finalised documentation relating to food bought in for patients, these have been added to the FM services section of the intranet for use by the clinical teams. In the event that foods are brought into hospital the information will be documented on the supporting form and the form will be retained at ward level for the duration of the patients stay.

The documentation has been developed to help explain to the patient, relatives and friends the reasons why certain foods should not to be brought into hospital for consumption by the patient. These are known as HIGH RISK FOODS which can cause food poisoning if kept in the wrong conditions.

The training module has been designed for staff who handle food and drink on behalf of patients to be will be completed via E-Learning on a biennial basis. The module will be available through the Electronic Staff Record.

Food Hygiene Inspection Royal Stoke University Hospital
The food hygiene inspection at RSUH was carried out by Stoke on Trent City Council Environmental Health Officer, Public Protection Division in January 2020 which resulted in the Royal Stoke Hospital Site being awarded five stars under the national food hygiene rating scheme.

Food Hygiene Inspection County Hospital
The food hygiene inspection at County Hospital by Stafford Borough Council's Environmental Health Inspectors in early 2019 has resulted in the hospital being awarded five stars under the national food hygiene rating scheme.

For the fourth year running, the catering department at County hospital has maintained a five star food hygiene rating for compliance in all aspects of food safety.

Food businesses are required by law to comply with food hygiene regulations as lay down by the Food Standards Agency and the public can find how compliant a food business is with legislation by logging on to www.ratemyplace.org.uk On the website, food businesses are rated on a star award system with five stars being the maximum achievement. Upon inspection, the Food Safety Officer, checks how well the establishment are meeting the law on food hygiene in the three areas below:-

Criteria Assessed
Compliance with food hygiene & safety procedures
Compliance with structural requirements
Confidence in management/ control procedures

Water Safety Group
The Water Safety Group is a sub group of IPCC and meets quarterly, reporting directly to IPCC. The Water Safety Group is chaired by the Deputy DIPC.

Management of Decontamination
Management and compliance currently falls into three distinct areas i.e.

- Estates – for medical device reprocessing equipment. UHNM provides Estates Services and also those provided by Sodexo as part of their estates (hard FM) management responsibilities within the PFI contract.
- Infection Prevention – for monitoring/audit of compliance of medical devices with Trust Policies and advise with pre purchase questionnaire (PPQ)
- User – to comply with Trust Policies and to ensure all decontamination equipment within their area is fit for use and subject to periodic testing and maintenance.

The Decontamination Group is a sub group of IPCC and meets monthly, reporting directly to IPCC.

Waste Projects

The close involvement of Infection Prevention has been crucial to the continued success of waste management projects.

Staff continue to help to prevent fluid leaks by:

1. **Correct Fluid Disposal**: Preventing fluid disposal into the offensive waste stream through ensuring that all areas of the Trust dispose of fluids in a correctly defined, standardised and consistent way.
2. **Effective Bag Tying:** learning the correct waste bag tying technique and using the SOP in order to eliminate any problems of fluid leaks at the moving and handling stage.
3. **Bin Washing:** Hopefully by preventing fluid leaks with proper disposal and bag tying leaks and splashes won't occur, however, there is an offensive waste bin washing process so that only clean bins are put back into the system.

A waste management policy remains in place having been devised to detail the specifics around handling infectious wastes (use of PPE, securing bags, labelling, storage and the correct waste streams, colour codes and waste categories and points of contact).

Infection Prevention isolation signs depict the colour of waste bag for patients requiring isolation precautions. These continue to be used throughout the Trust.

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- User – to comply with Trust Policies and to ensure all decontamination equipment within their area is fit for use and subject to periodic testing and maintenance.

The Decontamination Group is a sub group of IPCC and meets monthly, reporting directly to IPCC.

Sinks
The Infection Prevention Team worked with closely with facilities to standardise the process in which hand wash sinks are cleaned to avoid contamination of the water outlet and address and any issues.

Ascetic Acid Trial
Earlier this year the Consultant Microbiologist presented a paper to IPCC titled Carbapenemase-producing Enterobacteriaceae (CPE), Epidemiology at Royal Stoke University Hospital in 2017 and 2018, and Interventions to Prevent Acquisition and Infection and a proposed trail of chlorine solution treatment of drains on a weekly basis for three month in an area of multiple CPE acquisitions as identified by weekly screening for Multi drug resistant Gram negative bacteria (MGNB).

Following the initial proposal publication May 2019 issue of the Journal of Hospital Infection published “Controlling Gram-negative bacteria in healthcare settings”.Smolders-D et al which used 25% acetic acid and reported satisfactory results.

A working group was formed and a number of meetings held, with the aim to work through Health and Safety hazards, availability of product, job safety analysis, COSSH/risk assessment, environmental impact, SOP formation, training, costing and then progress to business case, with the outcome for a proposed trial of using 25% Acetic acid solution for weekly treatment of water outlets in an area with multiple CPE acquisitions.

Acetic acid has a safe working level exposure; air monitoring was also completed in preparation for the trial

This trial business case was paused due COVID-19 pandemic work.

Research project
Infection Prevention Team supported a PHD research student from Southampton University who is studying relevance and prevalence of hospital biofilms with clinical visits and environmental sampling from a number of clinical areas. This work will continue over the next three years.

Cardiac Surgery Bypass Machine
In June 2015 MHRA issued a Medical Devices Alert concerning all heater-cooler machines used for cardiac surgery. This is part of a pan European issue following a case of post-operative wound infection from mycobacterium reported in Switzerland. A European wide surveillance programme has been established, led by PHE in England. A further MHRA MDA alert was issued in December 2016, together with a joint PHE/MHRA/NHS England Webinar on 27th March 2017 for all Acute Trusts in England that undertake cardiac surgery. Letters have been issued to all relevant patients as part of the UK wide initiative. UHNM, as are all cardiac surgery centres, continue to work closely with PHE and the MHRA on this initiative with regular updates provided to the IPCC. All required control measures were instigated following the initial MDA alert in 2015, and continue to be in place together with Surveillance for any potential infections. No Mycobacterium chimaera has been identified with the machines at UHNM, which are regularly cleaned and tested as per national requirements.

Refurbishment Projects
The IPT provided advice on a number of planned programme of maintenance and refurbishment projects throughout the Trust.

Compliance Criteria 3:

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

Sepsis Team
Sepsis is defined as a life threatening organ dysfunction caused by a dysregulated host response to infection. It is a syndrome of physiological, pathological and biological abnormalities induced by infection. It is now a major public health concern (NICE UK Sepsis guidelines 2017).

There are 250,000 cases of sepsis in the UK each year resulting in between 52,000 and 68,000 deaths. That's more than breast cancer, bowel and prostate cancer combined. With effective screening and early treatment we can save 14,000 lives across the UK. The UK mortality rate for patients admitted to hospital with red flag sepsis can be up to 30%.

The Sepsis Team was established and has been in place from October 2016, comprising of a Sepsis Clinical Lead, Sepsis Fellow, Senior Sister, Nurse Specialist and a Sepsis Nurse. The main aim of the team is to achieve the sepsis CQUIN compliance target, by ensuring that our patients are safe at all times, as well as reducing the mortality rate and morbidity. However, for 2019/2020 and up to present, the Sepsis CQUIN will be incorporated into the Trust contract, with stringent requirements and penalties remaining.

The Sepsis Team are working optimally and collaboratively with our AMR colleagues and front-line clinical colleagues to continue to raise awareness and propagate education and training in sepsis, which has clearly had a demonstrable effect. Sepsis training is now an integral part of the newly qualified nurses', Band 4 and Medical Staff. Working with our AMR colleagues ensures that there is an equal emphasis on sepsis screening, treatment and antibiotic stewardship

National Sepsis CQUIN: There are three elements needed to be achieved and will remain into the contract

- All patients with a National Early Warning Score (NEWS) of five or greater (or three in a single parameter) need to be screened for sepsis.
- All patients that have red flag sepsis need to receive IVAB within one hour.
- All IVAB for sepsis patients have to be reviewed within 24 to 72 hours.

Challenges
The change of Modified Early Warning Score (MEWS) moving to the use of NEWS resulted in a corresponding reduction in compliance. This was due to the increased sensitivity of triggering using the NEWS criteria and subsequently adopted the NEWS2 on the Quarter 3 of 2018. As a result, this is now embedded into good practice and the trust aim to maintain and sustain excellent compliance.

In line with all other Trusts in the country, UHNM has seen a significant demand on its emergency services and inpatient beds, including patients waiting in queues, and consequently from March 2019 the COVID-19 pandemic had imposed a challenge where in patients are more likely to develop sepsis or admitted with sepsis, in response to these challenges the Sepsis Team have;

- Increased focus of sepsis adhoc training and education around COVID-19- Sepsis in Emergency departments as well as on COVID -19 ward areas.
- Sepsis education and training continued and provided to all levels of clinical and medical staff to improve awareness and answer questions.
- Maintain sepsis actions in Emergency portals, in addition an A&E Sepsis bleep was put in place to support compliance as well as introduction of sepsis nurse during the shift to mainly deal with potential patients with COVID-19/ sepsis by ensuring IVAB within hour treatment will be achieved.
- Arranged one to one meetings with clinical teams addressing and highlighting their concerns.
- Robust actions put in place to ensure good compliance are maintained, sustained and embedded into good practice.

The Sepsis Team has put robust actions in place and are working closely with frontline staff, multi-disciplinary & senior teams, and medical staff to have a maximum effect on the achievement of the Trust's CQUIN/ contract. The aim is to protect patients from deadly conditions and ensuring that they are safe at all times.

Initiatives Undertaken

- The Sepsis Team launched a Sepsis Awareness & Campaign during the World Sepsis Day since 2017, 2018 and the most recent in September 2019 with a great success.
- Introduction of a Sepsis Trolley as part of every awareness and campaign in the Trust.
- UHNM own sepsis information flyers and compliance sepsis cards created and distributed Trust wide for continuous awareness. Additional cards also created specifically for community settings.
- Had a great success in identifying Sepsis Champions (staff nurses/nursing assistant/ in house doctors/ANP) in each clinical area/divisions as well as providing Sepsis Champion Day training that includes workshops & simulation learning.
- Sepsis kiosks & face to face training continued and provided to all staff





including doctors. The aim to train as many departments throughout the year.

- Departmental sepsis slides presentation organised to capture all level of clinicians within the Trust's four Divisions.
- The Sepsis Team continued to regularly attended/provided sepsis updates to all Trust Divisional IP meetings, supporting all areas and helping drive for compliance.
- Regular Strategic Sepsis & Antimicrobial Group meetings and Sepsis Team Senior Team meetings put in place, to work optimally and collaboratively.
- Online training resource developed via ESR for staff nurses/doctors and other clinical staff with demonstrable great outcome
- Sepsis reinforcement continued, holding a meet and greet in the clinical area, updating senior staff, clinical staff and consultants regarding sepsis compliance.
- The Sepsis Team provided Doctors, Band 4 or Trainee Associate Practitioners, new nurses and student nurses inductions as well as external training provided to GP's, Royal College of Nursing study day in Stoke on Trent, St. John's ambulance, Katherine House Hospice and other community hospitals.
- Introduction of electronic Vitalpac (NEWS2) served as great success and the electronic sepsis vitals module are up and running now.
- Reward progress on wards/ clinical areas and possibility of working closely with sepsis survivor to create further awareness.
- Involved in collaborative works around Matneo Sepsis NHSi improvement project which was presented at a conference in London March 2019.
- A collaborative work is under-going with the UHNM charity and sepsis survivor/s to create further awareness both internally and externally.

Sepsis Team Achievement

The Sepsis CQUIN compliance achievement throughout the year of 2019/20 contract with the aim to maintain, sustain and embed good practice. Our sepsis robust actions remain in place and the sepsis team work closely with frontline staff, multi-disciplinary, senior teams, and medical staff to have a maximum effect on the achievement of the Trust's CQUIN/ contract. The support and hard work of all staff/senior team/divisions in the Trust is vital to protect patients from deadly conditions and ensure that they are safe at all times.

Antimicrobial Stewardship (AMS)

The Trust has an Antimicrobial Team (AMT) that supports the work of the Trust Antimicrobial Stewardship Group (ASG). The AMT consists of a Consultant Microbiologist, one WTE Advanced Pharmacist Practitioner (APP), one WTE Antimicrobial Nurse (AMN), the Infectious Diseases Specialist Pharmacist based at the Royal Stoke and the Antimicrobial Pharmacist based at the County. The latter two pharmacists provide sessional support to the ASG and CQUIN work streams in addition to their substantive core clinical roles. The APP and AMN were appointed in 2016-2017 following a Business Case and have a key role in delivering the AMR CQUINs, carrying out targeted ward reviews of antibiotic prescribing (often supporting a Consultant Microbiologist) and providing strategic leadership to ensure the antimicrobial stewardship agenda remains a high priority across all clinical areas. The team is also supported on an ad hoc basis by a data analyst and clinical information technician as required to support the compiling of reports for submission to PHE and NHS E, and the compilation of pharmacy led antimicrobial audit data on a quarterly basis.

The expanded team brings clinical experience and expertise in all aspects of antimicrobial stewardship and, on behalf of the ASG, is supported in escalating prescribing or clinical issues relating to antimicrobials to the appropriate forum. The AMT has developed initiatives to drive forward good antimicrobial stewardship and promote awareness of the global rise in antibiotic resistance

The UHNM has continued to build on the foundations put in place over the last few years, core functions which are routinely undertaken include:

- A regular review of the ASG membership to include representatives from both hospital sites so that local champions will support engagement with good antimicrobial stewardship. The Terms of Reference have recently been reviewed and new members recruited to reflect diversity e.g. non-medical prescribers and junior medical representation.
- A regular update of the Trust Antimicrobial Stewardship Policy. Quarterly audits measure compliance with this policy, with an escalation process in place for clinical specialities that require support to achieve compliance.
- A rolling Antimicrobial Audit Programme in line with Start Smart then Focus has been in place across the Trust for a number of years. The results of the audits are available on the Trust Intranet so that trends can be reviewed by specialities and their peers. The ASG review and support the development of action plans in areas of poor compliance and, going forward, specialities will be required to report progress against to the ASG. This has been particularly important in supporting the achievement of the AMR CQUIN antibiotic consumption targets over the past few years.
- The Trust's Antimicrobial Treatment and Prophylaxis Guidelines were reviewed in response to global and national shortages of certain key antibiotics: alternative antibiotics were procured and temporary alternative guidance was issued.
- A full review of the UHNM Adult Antimicrobial Treatment and Prophylaxis Guidelines was took place during 2019/20. Successful collaboration with specialities resulted in the development of a number of new guidelines to rationalise antibiotic prescribing in line with good antimicrobial stewardship. This work is on-going to support appropriate prescribing during COVID19.
- The Antimicrobial Guideline App (Microguide) for mobile devices continues to support prescribers by facilitating easy access of antimicrobial guidelines at the point of prescribing. The web-based app allows more efficient updating of guidelines following review by ASG members. This year links to national guidelines have been embedded to facilitate timely access by prescribers
- There is an Antimicrobial Education and Training Strategy. All antimicrobial stewardship-related presentations are available on the Trust Intranet.
    - Antimicrobial stewardship educational sessions for Pharmacy staff across both sites continue to be undertaken to support a uniform approach to antimicrobial stewardship and the quarterly antibiotic audit process. Sessions continue to be delivered on the increase in Gram negative infections and carbapenemase resistance, as well as key messages and supporting materials to support the CQUIN. Workshops on the prescribing, dosing and monitoring of two high risk drugs, gentamicin and vancomycin, are delivered as part of the antimicrobial stewardship induction programme to familiarise newly appointed pharmacists with the vancomycin and gentamicin dosing calculators and associated

guidelines in place at UHNM, so that consistent advice and information is provided to prescribers and nursing staff.

- In addition to pharmacist awareness sessions, ad hoc sessions on AMS, gentamicin and vancomycin are provided for nursing staff, advertised via Trust Communications
- The AMT provides training to each intake of overseas nurses recruited to UHNM as well as the preceptorship nurse scheme. This is important to align practice amongst colleagues who may have worked in different Trusts (and countries) with different approaches to antimicrobial stewardship.

The following initiatives have continued throughout the year:

- A rolling programme of antimicrobial sessions for Nursing staff.
- Targeted ad hoc sessions for Specialities/Wards.
- The development of gentamicin/vancomycin workshops for nurses on doses, monitoring and side effects of these high risk antibiotics.
- Antimicrobial stewardship and antimicrobial resistance awareness sessions for Laboratory and Infection Prevention staff.
- Engagement sessions with prescribers, nurses and pharmacists in relation to the updated UHNM Adult Antimicrobial Treatment and Prophylaxis Guidelines.

There are 5 Consultant Microbiologists (one post is covered by a locum) and 2.6 WTE Consultant Physicians in Infectious Diseases, who provide antimicrobial stewardship by telephone and face-to-face on ward rounds and during teaching sessions. In February 2020 the Microbiology Department recruited 2 WTE staff grade doctors, and the team also includes one trainee from the West Midlands Deanery and one International trainee. Antimicrobial stewardship ward rounds continue to be undertaken on targeted wards on a daily basis which provide opportunities for the AMT to raise awareness and make timely AM interventions.

Antimicrobial consumption by Specialities and Wards was analysed on a monthly basis throughout the year to allow flexible targeted stewardship/antimicrobial review ward rounds for those areas requiring additional support in order to promote good antimicrobial stewardship and reduce antibiotic consumption. There remains regular microbiologist support for Paediatrics including Neonatal Intensive Care Unit and Children Intensive Care Unit. The Critical Care Unit Pods 1-6 are visited twice weekly, whilst other key areas such as Renal and Haematology/Oncology, are visited weekly (unless a Microbiologist was on leave). As part of the response to the COVID-19 pandemic, some ward rounds were suspended but novel ways of working were explored with the result that virtual ward rounds were implemented in March 2020.

The AMS team also provides input into the OPAT, Clostridium *difficile*, Endocarditis / Valve, and Bone & Joint and Spinal MDTs. In March 2020 due to the COVID 19 pandemic some MDTs had to be cancelled but others continued via virtual meetings.

In common with other Trusts in the UK, UHNM continued to face challenges as a result of on-going shortages of a number of key antimicrobials due to manufacturer's supply problems in 2019/20. Aztreonam injection was once again intermittently available throughout the year. Worldwide manufacturing and capacity issues resulted in shortages with piperacillin / tazobactam, levofloxacin, vancomycin, gentamicin, mupirocin, trimethoprim and co-trimoxazole throughout the year. The ASG, Microbiology and Pharmacy Departments worked

collectively to ensure that alternative agents were available for patients in a timely manner and to support the Trust's surgical programme:

- Antimicrobial guidelines were reviewed in their entirety during 2019/20 and alternative agents chosen taking into account antimicrobial stewardship and local resistance patterns, benefits and risks of proposed substitute agents, including cost pressure to the Trust as a result of using more expensive alternatives.
- These reviews required a significant amount of time and support from many members of staff across all divisions and was coordinated by the AMS nurse.
- Alternative medicines were sourced, purchased and made available in key areas via review of stock lists.
- Information on dosing, administration and side effects of the new alternative was communicated to prescribers, nursing staff and pharmacists.
- Targeted ward rounds undertaken by the AMS team enabled informed choices to be made by prescribers when considering switching to alternative therapies.
- Aztreonam was conserved for those patients with which an alternative was not an option, for example due to patterns of resistance, co-morbidities, or side effects.
- Acquisition costs of antimicrobials are monitored by the Antimicrobial Pharmacists and opportunities for cost saving initiatives are identified to support the Trust CIP programme. NHSe has taken a strategic role in managing antimicrobial drug capacity issues and their guidance requires on-going review and implementation at UHNM led by the AMS team.

In Year Initiatives:

World Antibiotic Awareness Week took place to coincide with European Antibiotic Awareness Day (EAAD), an annual event held across Europe on 18 November. UHNM regularly supports, EAAD with an extensive campaign targeting both clinical and non-clinical staff, patients, carers, and members of the public. Both of these events are designed to raise awareness of the growing threat to public health from rising antibiotic resistance around the world. New pocket guide resources were developed to promote 4 key messages for UHNM clinical staff:

- **Penicillin Sensitivities:** a quick guide to antibiotic prescribing in a penicillin sensitive patient. This included a description of an immediate penicillin reaction and a non-immediate penicillin reaction, plus a "traffic light" grouping of common antibiotics (Red = contra-indicated, Amber = use with caution, Green = considered safe.
- **Gentamicin dosing** and **monitoring** for **treatment** of infection
- **Gentamicin dosing** for **surgical prophylaxis**
- **Think Duration:** the evidence for extended duration of antibiotics is poor in many infections. Unnecessary antibiotic use increases the risks of adverse effects of antibiotics, AMR and HAI. Total antibiotic duration includes both IV and oral treatment. Durations of treatment for common infections were also included

NHS E Antimicrobial CQUINs 2019-2020

Public Health England (PHE) & NHS Improvement issued a CQUIN for 2019/20 with the following focus:

- Total antibiotic consumption (target 2% reduction on 2018/19 baseline)
- Lower UTI diagnosis and management in the over 65s

- Management of prophylactic antibiotics for elective colo-rectal surgery patients
- Anti-fungal stewardship – implementation of new best practice guidance

Financial incentives attached to the CQUIN scheme fell under the control of the new 'intelligent contract' with UHNM commissioners and did not attract specific remuneration from NHS E as in previous years. Due to the impact on clinical and surveillance activities due to the COVID-19 outbreak in the UK, NHSE I informed Trusts that a return for Q4 would not be required on all of the CQUINs. Nevertheless the AMS team summarised the appropriate returns for what would have been the CQUIN Q4 return:

Total Antimicrobial Consumption

By the end of February 2020 the total consumption was trending back toward achieving the year-end target due to the measures and interventions introduced in year to address excess antibiotic consumption. With the outbreak of COVID-19 the Trust saw an increase in the prescribing of antibiotics for community acquired pneumonia which, coupled with a huge decrease in admissions, resulted in the Trust managing to meet the target set by PHE and thus comply with the consumption element of the CQUIN. (Actual 3562 vs. target 4006 DDD/1000 admissions)

CCG1a: Lower UTI Diagnosis and Management in the over 65s

This CQUIN focused on improving the diagnosis and management of lower UTI's in older people (over 65's) based on best practice guidance (PHE and NICE NG109) and included the following 4 elements:

- Diagnosis of lower UTI in over 65's should ALWAYS be based on clinical signs and symptoms
- Urine sample should be sent to microbiology
- Do not use dipstick result to diagnose UTI
- Empirical antibiotic choice should follow UHNM antimicrobial guidelines

This CQUIN also supported the Local Health Economy wide work stream to reduce E.Coli blood stream infections as the most common source of this infection relates to UTI.

Along with other Trusts, data collection at UHNM for this CQUIN was challenging and labour intensive: in excess of 300 notes were required to be reviewed each quarter to attain the minimum sample size of 100 patients.

Previously developed good practice key messages "Wee Tips for over 65's" and "DUDE don't dip" posters were revisited and shared with ward managers, quality nurses and the local health economy group members. A 'Wee Wagon' trolley displaying resources was produced to tour wards and departments with members of the AM Team to promote engagement, plus photographs were shared on social media to raise awareness.

The UHNM antimicrobial guidelines (MicroGuide) were updated with links to the PHE flowcharts for diagnosing and managing lower UTI for men and women over (and under) 65 years for clinicians.

In 94% of patients, samples were sent to microbiology and in 89% antibiotic choice was correct but improvements are needed in the diagnosis of UTI (reducing the use of inappropriate urine dip stick tests) and documentation of clinical signs and symptoms.

Despite note achieving all targets of this CQUIN, the improvements made support the NHS Long Term Plan priority of antimicrobial resistance and stewardship, helped to reduce inappropriate antibiotic prescribing, improved diagnosis (reducing the use of inappropriate urine dip stick tests) and improved treatment and management of patients with UTI.

CCG1b: Antimicrobial Prophylaxis in Colorectal Surgery
Target: 100% patients receive a single dose of antibiotic as per Trust guideline.

There is no indication for repeat doses of prophylactic antibiotics in this type of surgery.

The Surgical prophylaxis AM guidelines were reviewed and published in August 2019. Despite this major change mid-year compliance demonstrated the excellent uptake within surgical and anaesthetic teams at UHNM.

Although the final quarter submission was deferred, UHNM would have met this target.

Medicines Optimisation Trigger 5: Antifungal Stewardship
There is evidence that antifungal resistance is increasing worldwide. PHE have tasked all Trusts with developing local antifungal guidelines and an antifungal stewardship team by the end of the year.

Although this was deferred due to the COVID pandemic, all elements of this CQUIN were subsequently achieved. The support for antifungal stewardship at UHNM will be further strengthened during 2020/21 with the appointment to a 1.0 WTE substantive post of Advanced Specialist Pharmacist – antifungal stewardship.

The above initiatives have been underpinned by on-going formal and informal antimicrobial stewardship education and training for new and existing Medical, Nursing and Pharmacy staff. The Trust also supports antimicrobial stewardship training for undergraduates and newly qualified staff.

Feed-back received from users on these initiatives has been positive. These initiatives will be further expanded and developed during 2020/21 as the AST look to further embed excellent AMS for the patients at UHNM.

The antimicrobial work is fully supported by the Chief Executive, Chief Nurse and Medical Director who receive regular updates on progress.

Compliance Criteria 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.

Communication Programme

The Trust has a dedicated Communication Team. 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 invaluable. The IP Team ensures that the Communications Team are involved in the following:

- Advertising infection prevention events.
- Communication campaign to inform GPs and the public around management of Influenza and Norovirus.
- Updating the Trust website.
- Press statements during outbreaks.
- Sepsis.
- Flu vaccination campaign.
- COVID-19 information and Posters

Trust Website and Information Leaflets

The Trust website promotes infection prevention issues and to guide people to performance information on MRSA, Clostridium *difficile* and other organisms.

The IPT have produced a range of information leaflets on various organisms.

UHNM subscribe to ICNet surveillance system which enables information to be shared with colleagues in the Health Economy.

The Trust has a policy on the transfer of patients between wards and departments.

Compliance Criteria 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.

Infection Prevention Nurses attend a daily review of laboratory alert organism surveillance attended by Consultant Microbiologists and members of the Laboratory Team.

The Trust has a policy for screening both elective and emergency patients for MRSA and a system is in place for monitoring compliance.

iPortal System

The Lead Consultant Microbiologist/Infection Control Doctor worked closely with IM&T Team regarding patient alerts. This system provides clinical staff with real time alerts and access to information from other hospital systems. Infection Control real-time alerts on the iPortal system includes Red and Amber alerts for patients with a very recent and relatively recent history, respectively, of MRSA, CDI, PVL-toxin producing *S. aureus*, and ESBL or Carbapenemase producing multi-resistant Gram Negative Bacilli. These alerts enable staff on wards and departments to promptly identify patients who have recently had an alert organism identified, allowing wards/departments to timely isolate and follow-up patients appropriately and to prescribe appropriate empiric antibiotics if antibiotic treatment is indicated.

Surgical Site Infection Surveillance (SSIS)

UHNM have continued to participate in the Public Health England (PHE) National Surveillance Program. The aim of SSIS is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of SSI over time and against a national benchmark rate, this information is used to review and guide clinical practice.

The implementation of the ICNET SSIS module has helped to automate the data collection process and improve accuracy and efficiency.

During 2019-20 UHNM participated in the following PHE Surgical Site Surveillance:

SSI SURVEILLANCE 2019-20		
QUARTER	PERIOD	SURVEILLANCE Royal/County
1	Apr – Jun	Both categories deferred in order to support GIRFT SSI Survey
2	Jul – Sep	Both categories deferred in order to support GIRFT SSI Survey
3	Oct – Dec	Both categories deferred in order to support GIRFT SSI Survey
4	Jan – Mar	Knee Replacement (Repeated Surveillance at the request of PHE) data consolidation and input in progress

Methodology for Surveillance
The surveillance was undertaken by the Clinical Surveillance Team (CST). All eligible patients were reviewed 2-3 times per week and monitored for signs of infection, whilst an inpatient. Electronic tags were added to eligible patient records in ICNet to provide alerts if a patient was readmitted or had a wound swab sent for the duration of the surveillance period, 30 days or 365 days if an implant is inserted at the time of surgery.

CST has worked with clinical teams to advise on the surveillance process and worked collaboratively to confirm any cases of SSI.

RSUH 2019-20				
Quarter	**Category**	**No. of ops**	**No. of SSI's**	**%**
1	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A
4	Knee Replacement Surgery	9	0	0%

County Hospital 2019-20				
Quarter	**Category**	**No. of ops**	**No. of SSI's**	**%**
1	N/A	N/A	N/A	N/A
2	N/A	N/A	N/A	N/A
3	N/A	N/A	N/A	N/A
4	Knee Replacement Surgery	129	0	0

Trust wide - Qt4 2019-20

Category of Surgery	No of operations performed	No of SSI's	No. of SSI's as a % of total operations performed
Knee Replacement - Qtr 4	138*	0	0**

*Figure represents the number of procedures and does not reflect the number of patients within this category.
**Cumulative inpatient and readmission SSI incidence (knee replacement), NHS Hospitals England - April 2014 to March 2019 = 0.5%

- The category for quarter **4** (Jan to Mar 2020) is Knee Replacement Surgery:

*Figure represents the number of procedures and does not reflect the number of patients within this category.
**Cumulative inpatient and readmission SSI incidence (knee replacement), NHS Hospitals England - April 2014 to March 2019 = 0.5%

The IPT work closely with specialities that report infections during the surveillance period. Investigations are carried out and reported through the Surgical Division and the Tissue Viability Group. Surgical Site Surveillance is a standing item on the IPCC agenda with a report presented by CST.

Surgical Site Infection Surveillance (SSIS)

Getting it Right First Time (GIRFT)
UHNM participated in the Getting It Right First Time (GIRFT) SSI Survey 2019. This was a national programme designed to improve surgical and medical care by reducing unwarranted variations in the way services are delivered and by sharing best practice between hospitals. GIRFT aims to identify changes that will improve patient care and outcomes, as well as delivering efficiencies such as the reduction of unnecessary procedures and cost-savings.

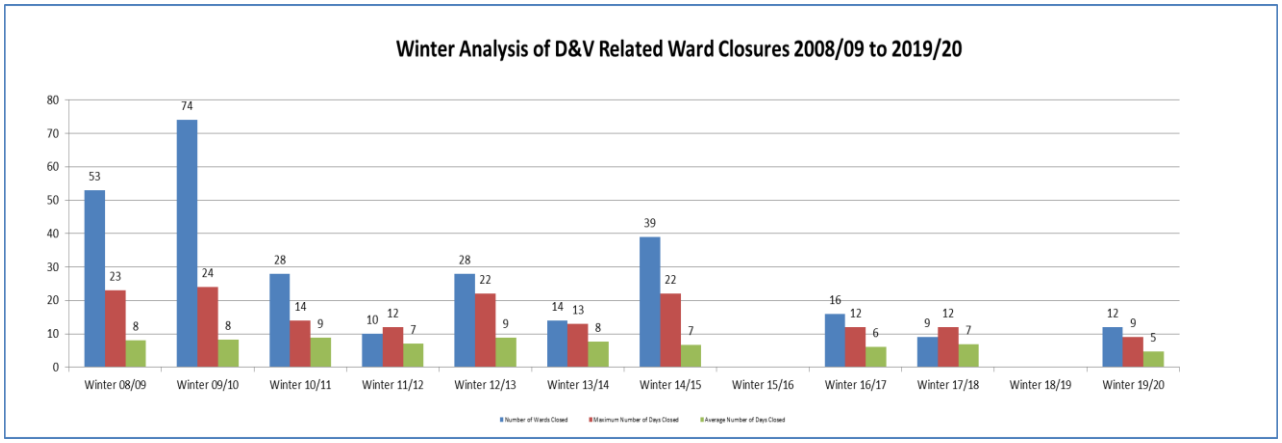
3 GIRFT specialities (similar to those surveyed for GIRFT SSI Survey 2017), were chosen to be surveyed.

- **Breast Surgery:**
  1. Breast Implant – subdividing into Pre-pectoral (mesh), Sub-pectoral (mesh) and Dermal sling (without mesh);
  2. Level 2 mammoplasty - therapeutic or symmetrising;
  3. Procedures requiring a flap – local/ free/ pedicled.
- **General Surgery:**
  1. Emergency laparotomy;
  2. Emergency Appendectomy;
  3. Elective Large Bowel resections.
- **Spinal Surgery:**
  1. Posterior cervical spine decompression and instrumented fusion
  2. Lumbar spine single level instrumented posterior fusion (including interbody fusion)
  3. Lumbar spine single level discectomy or decompression (unilateral or bilateral)
  4. Posterior correction of adolescent idiopathic scoliosis

The 2019 survey encompassed a six month period from 1st May - 31st October 2019 and an update was presented to IPCC 03/2020. The GIRFT datapack has been received by the Trust - review of this data is currently postponed due to COVID-19 pressures.

Managing Outbreaks of Infection - Responses to Incidents and Outbreaks
The IPT are involved in the management of outbreaks, periods of increased incidence and incidents.

The Senior member of the IPT attended the daily command and control meeting during period of outbreaks

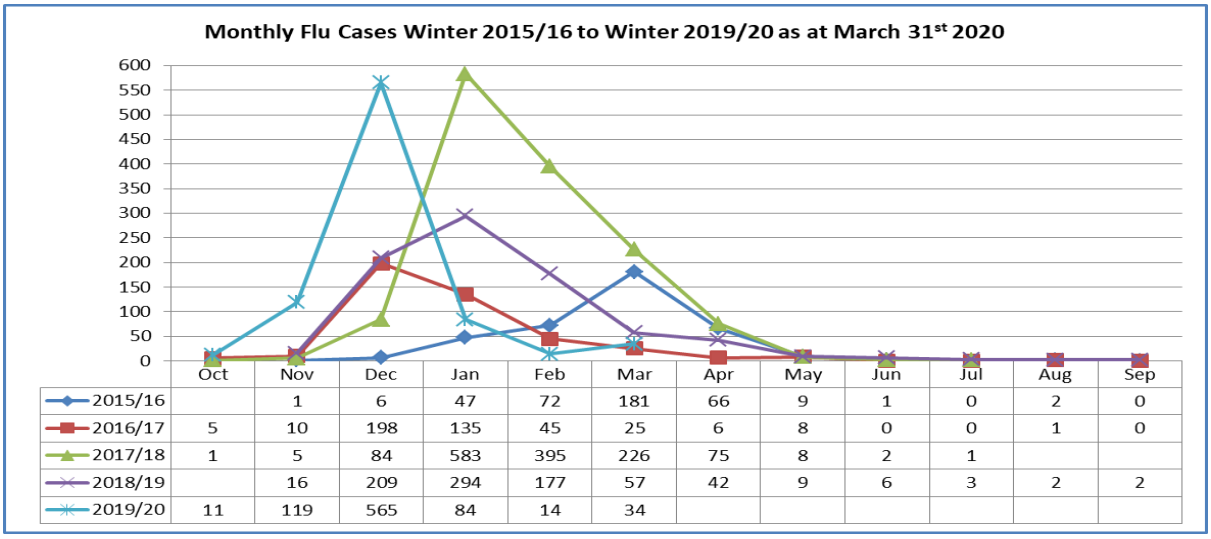


Seasonal Influenza

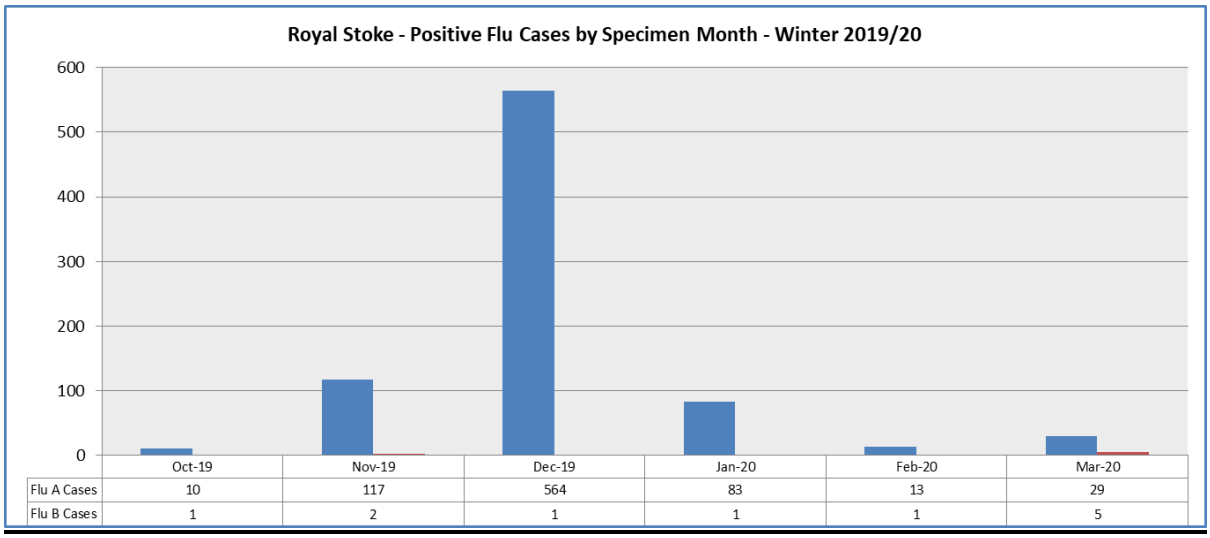
The UK saw a significant number of influenza cases again during this winter during the early part of the winter season, and UHNM was no exception with a significant number of cases presenting to the emergency portals, which was on top of other pressures the Trust saw from acutely unwell patients. This was predominantly during November and December 2019.

For each case immediate control measures were instituted, following the latest PHE guidance, including the use of antivirals. Affected areas were visited and assessed by an Infection Prevention Nurse at least twice daily, and at weekends additional IP staff were brought in to assist, due to the burden from other infections that continued.

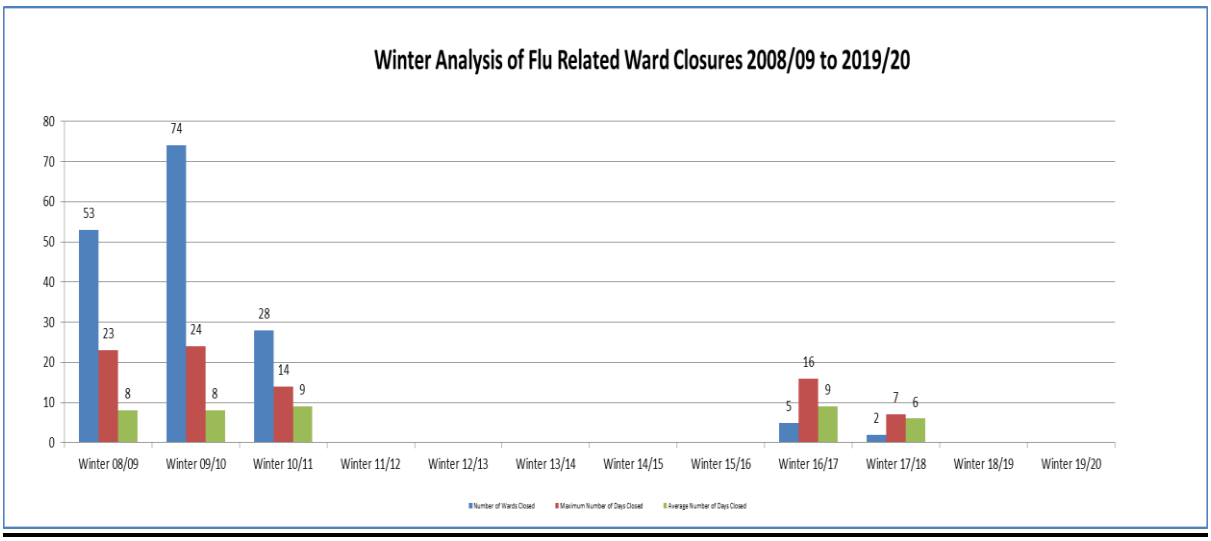
Pressures in the emergency unit prevented early isolation in a smaller number of cases compared to the previous year. Nevertheless, the staff did a magnificent job in preventing further spread as best as they could, given the pressures, implementing antiviral medication as per PHE guidance to those exposed patients where this was required, but again to a lesser degree than in the previous winter. Swabbing of patients for respiratory viruses was followed as per the guidance issued. Independent audits confirmed that indiscriminate swabbing was not a significant issue. The Department of Clinical Infections supported the clinical teams.

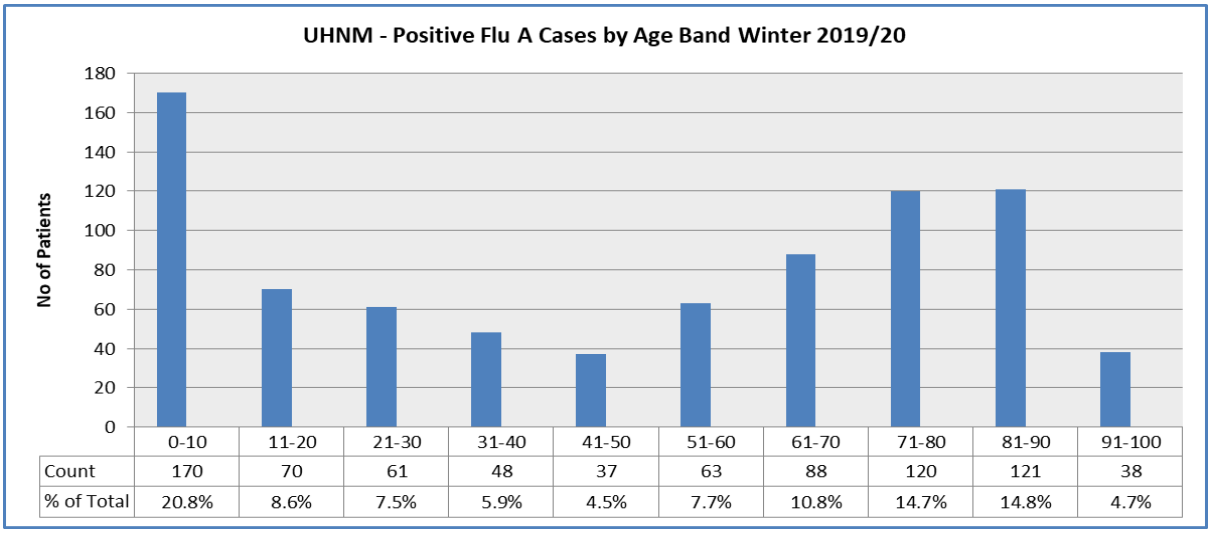


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2015/16		1	6	47	72	181	66	9	1	0	2	0
2016/17	5	10	198	135	45	25	6	8	0	0	1	0
2017/18	1	5	84	583	395	226	75	8	2	1		
2018/19		16	209	294	177	57	42	9	6	3	2	2
2019/20	11	119	565	84	14	34						



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Flu A Cases	10	117	564	83	13	29
Flu B Cases	1	2	1	1	1	5





	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
Count	170	70	61	48	37	63	88	120	121	38
% of Total	20.8%	8.6%	7.5%	5.9%	4.5%	7.7%	10.8%	14.7%	14.8%	4.7%

Carbapenemase Producing Enterobacteriaceae (CPE)
There was one Respiratory ward that identified a number of patients colonized with CPE in their gastrointestinal tract through routine screening. External cluster meetings were held.

Control measures have continued, including a terminal clean with Virusolve and enhanced CPE screening for admissions, weekly and discharge. The situation is being closely monitored for any new cases since the enhanced cleaning processes and refresher training, together with an action plan has been put in place.

Surveillance and control measures continue.

Compliance Criteria 6:

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

At the UHNM infection prevention is included in all job descriptions**.** All clinical staff receive training and education in optimum infection prevention practices.

Occupational Health services are provided by Team Prevent.

Seasonal Staff Influenza Vaccination Campaign
Planning for the 2019-20 seasonal flu vaccination campaign is well established, covering both sites, Training for the 80 vaccinators was held during September 2019. The campaign officially began on 1st October 2019 with a wealth of information/videos available to staff on the UHNM intranet as well as the locally based flu champions. A 24 hour flu jab-a-thon was held in early November 2019.

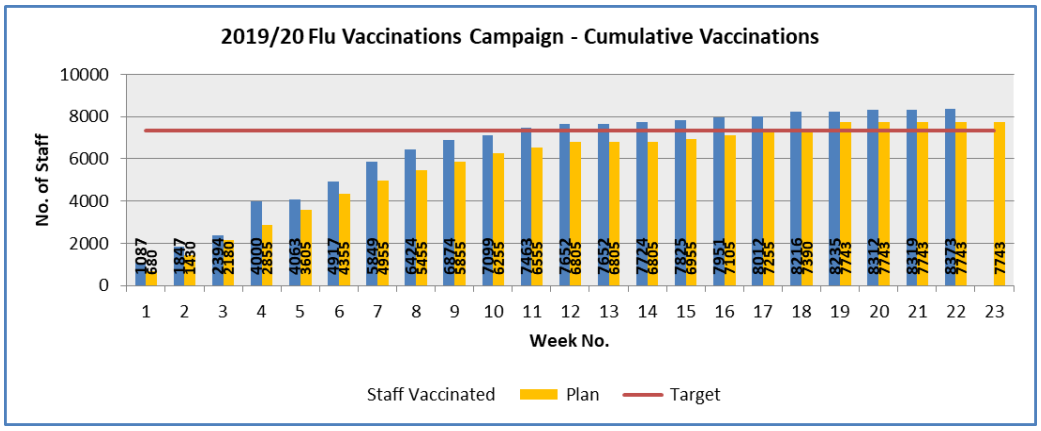
The campaign launched on 1st October 2019. There is a national CQUIN for staff seasonal flu vaccination during 2019-20. 8,375 vaccinations were administered which is the highest number of staff ever vaccinated at UHNM.

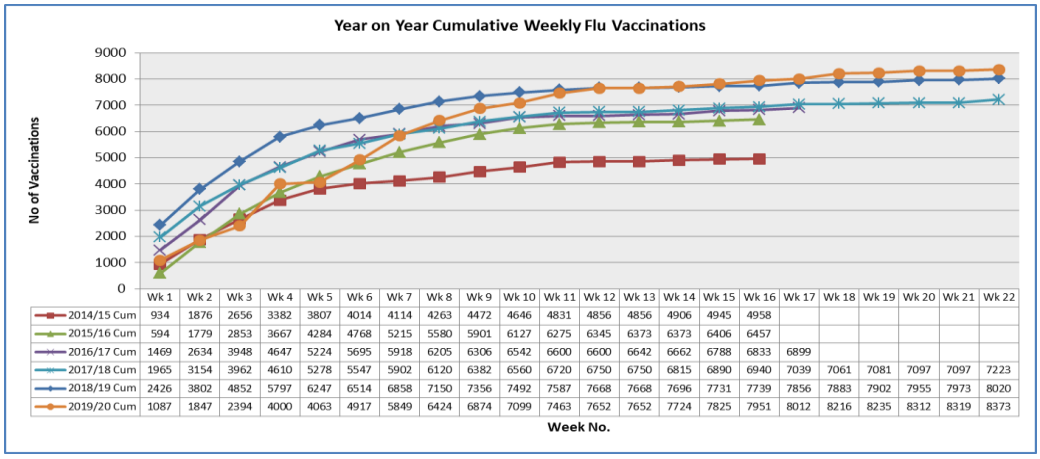
The Seasonal Influenza Vaccination Group continues to meet regularly throughout the year, with minutes presented at the IPCC. This Group reflects and debriefs on the previous campaign to ensure lessons are learnt as well as new initiatives introduced (from national forums and information sharing). The group includes representation from the IPT, Pharmacy, Nurse Education, Communications and Occupational Health as well as working collaboratively with colleagues from the Public Health Team in the local authorities to cover all UHNM locations.

The 100 vaccinators supported by champions in clinical areas. Vaccination training was organised for three separate dates in September 2019. This training is well supported by the Infectious Diseases, Resuscitation, Nursing Directorate and Pharmacy teams. This year on-line (via VCTMS) training has been introduced for established vaccinators to gain refresher training. Both vaccinators and champions are well supported by the Lead Vaccinator from the IPT. PGDs for the flu vaccine and adrenaline have been completed and circulated.

The Occupational Health Department (Team Prevent) work very closely with the vaccinators so that there is a seamless inter-woven campaign.

The Communications Team are integral to the whole planning process and have a well-rehearsed plan to communicate important messages to staff, including myth busting. This year, six short videos have been produced, which staff can access. The videos include myth busting messages as well as staff and patients who have experienced the effects of influenza. In addition to the vaccinators and champions within every clinical area, vaccination clinics and a roving service will operate. In addition, this year a new 'choose and book' service will augment the provision, allowing staff to book a timeslot. Discrete groups of staff have vaccination clinics organised within their area, for example Estates, HSDU and Pathology.
UHNM Pot Luck has this year donated several large tubs of sweets as an initiative to entice staff to be vaccinated, and Sodexo have kindly donated £5 vouchers for staff to have a weekly draw covering the first 10 weeks of the campaign. Additionally a £10 voucher will be drawn at the end of October, November and December.





	Wk 1	Wk 2	Wk 3	Wk 4	Wk 5	Wk 6	Wk 7	Wk 8	Wk 9	Wk 10	Wk 11	Wk 12	Wk 13	Wk 14	Wk 15	Wk 16	Wk 17	Wk 18	Wk 19	Wk 20	Wk 21	Wk 22
2014/15 Cum	934	1876	2656	3382	3807	4014	4114	4263	4472	4646	4831	4856	4856	4906	4945	4958						
2015/16 Cum	594	1779	2853	3667	4284	4768	5215	5580	5901	6127	6275	6345	6373	6373	6406	6457						
2016/17 Cum	1469	2634	3948	4647	5224	5695	5918	6205	6306	6542	6600	6600	6642	6662	6788	6833	6899					
2017/18 Cum	1965	3154	3962	4610	5278	5547	5902	6120	6382	6560	6720	6750	6750	6815	6890	6940	7039	7061	7081	7097	7097	7223
2018/19 Cum	2426	3802	4852	5797	6247	6514	6858	7150	7356	7492	7587	7668	7668	7696	7731	7739	7856	7883	7902	7955	7973	8020
2019/20 Cum	1087	1847	2394	4000	4063	4917	5849	6424	6874	7099	7463	7652	7652	7724	7825	7951	8012	8216	8235	8312	8319	8373

8,375 vaccines was given which is the highest ever number of staff vaccinated in previous years.

During the 2019/20 campaign the quadrivalent vaccine was used which contained two ‘A ’strains’ and two ‘B’ strains of Influenza.

Compliance Criteria 7:

Provide or secure adequate isolation facilities.

Royal Stoke Hospital

Single Bed Rooms & En Suites

Trent Building

	No. of Single Rooms	No. of En Suites
Ward 120/121	6	0
Ward 122/123	6	0
Ward 124	16	16
Ward 126	0	0
Ward 127	0	0

Lyme Building

	No. of Single Rooms	No. of En Suites
SSCU	2	0
Ward 100/101	4	3
Ward 102/103	7	4
Ward 104/105	7	3
Ward 106/107	3	2
Ward 108/109	8	4
Ward 110	12	12
Ward 111	12	12
Ward 112	12	12
Ward 113	12	12

Maternity Centre

	No. of Single Rooms	No. of En Suites
Delivery Suite	16	16
Neonatal Unit	6	6
Ward 205	10	10
Ward 206	12	12
Midwifery Birthing Centre	11	11

Cancer Centre

	No. of Single Rooms	No. of En Suites
Oncology Day Unit	5	5
Haematology & Oncology Inpatients	23	23

West Building

	No. of Single Rooms	No. of En Suites
FEAU	4	4
Ward 78/79	8	2
Ward 80/81	4	0
Ward 76a	3	1
Ward 76b	3	1

Ward 76b have 4 pods around bed spaces

Main Building

	No. of Single Rooms	No. of En Suites
CDU	4	3
215	4	0
216A	4	4
216	9	9
217	9	9
217B	5	5
218	15	14
CCU	3	0
220	13	13
221	11	10
222	9	9
223	17	16
225	17	16
226	11	10
227	10	9
228	17	16
230	17	16
231	11	10
232	11	10
233	17	16

Isolation Rooms	
PICU	2 single rooms (3&4)with positive pressure gowning lobby
Emergency Department	1 treatment room (2) with balanced pressure gowning lobby
Infectious diseases (Ward 117)	4 negative pressure isolation rooms with lobbies

Side rooms within Critical Care	
Standard Side Room (No gowning lobby, neutral air pressure)	
Pod 1	Side room1
Pod 2	Side room 9
Pod 3	Side room 24
Pod 5	Side room 33
Pod 6	Side room 4

Side rooms within Critical Care	
Isolation Side room (Gowning lobby, side room neutral pressure)	
Pod 1	Side room 8
Pod 2	Side room 16
Pod 3	Side room 17

Side rooms within Critical Care	
Isolation Side room (side room negative pressure)	
Pod 2	Side room15
Pod 4	Side room 32 (has lobby) and side room 25
Pod 6	Side room 3 (has lobby)

Side rooms within Critical Care	
Protective isolation room (with gowning lobby, side room positively pressured)	
Pod 5	Side room 34

County Hospital

Ward	No. of Single Rooms	Toilet	Shower/bath
Elective Trauma and Orthopaedic Ward	13	13	13
Ward 12	12	12	12
Ward 14	12	12	12
Ward 15	12	12	12
Ward 7	4	3	0
AAU	3	0	0
AMU	3	3	0
Critical Care Unit	0	0	0
A&E	6	0	0
A&E Ambulance corridor	3	0	0
A&E Ambulatory	4	0	0
Chemotherapy Unit	6	3	0
Ward 1	4	3	0
Medical Receiving Unit	3	0	0
Ward 8 Choices	3	3	1

ED side room (RAT 1) negative pressure

Compliance Criteria 8:

Secure adequate access to laboratory support as appropriate

Laboratory services for UHNM are located in the purpose built Pathology Laboratory on-site at RSUH. The Laboratory is United Kingdom Accreditation Service (UKAS) accredited.

The Infection Prevention Nurses work closely with the Biomedical Scientists.

Compliance Criteria 9:

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

An Infection Prevention Questions and Answers Manual, with an overarching policy is in place at UHNM this significantly enhances the quick location of key infection prevention guidance by our front line staff.

The overarching policy is written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Both policy and manual are available for staff to view on the Trust intranet.

Clinical Governance has produced a directory of policies alerting when policies are due for update, policies are also updated prior to review date if guidance is updated.

Compliance Criteria 10:

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

All job descriptions include infection prevention responsibility and this message is reiterated during mandatory training. The IPT participate in mandatory updates for all staff groups (clinical and non-clinical). The IPT regularly meet with representatives of the Occupational Health Service to ensure compliance with Criteria 10.

Staff Training
This has been documented earlier in this report.

IPN/Team Development
Infection Prevention Nurses attended the Infection Prevention Society (IPS) conference

IPT have also attended several study days on different aspects of Infection Prevention throughout the year, Surgical Site Surveillance, Infection Today, Wolverhampton, IV conference, Sheffield, CAUTI conference, Manchester, NHS AMR conference, Infection prevention Conference , Wolverhampton

Deputy DIPC and Lead IP Nurse attended DIPC development days held throughout the year.

Three Infection Prevention Nurses have attended the Infection Prevention Course at Birmingham City University.

Three Infection Nurses attended the Marion Reed Development Course

All new Nursing staff to the Infection Prevention Team undergoes a two week supernumerary induction programme on Infection Prevention, as well as being issued with a personal copy of a relevant textbook.

A number of educational sessions between IPT and Microbiologist were held.

Conclusion

Infection prevention is a key marker of patient safety within UHNM, as it encompasses a broad range of factors, from the state of the environment through to the effect of antibiotic use on the selection of organisms such as Clostridium *difficile,* MRSA and CPE. This requires the involvement of all grades of staff, on an on-going basis, and the IPT are central to this.

At UHNM we acknowledge that the Trust has a number of challenges:

- Reduction of Gram negative blood stream infections by 25% by 2021, 50% by 2024
- Continuing with threat of COVID-19
- Continuing threat from CPE.
- Reducing the incidence of CDI.
- Reducing the incidence of MRSA bacteraemia.
- Sustainability of Infection Prevention practices across the Trust.
- Monitoring of pharmacy/prescribing data.
- Monitoring of Surgical Site infections.
- National/international threats, e.g. multi-resistant Gram Negative Bacilli; emerging respiratory viruses and working closely with the Emergency Planning Team.

Appendix 1 Annual Programme of Works 2020-2021

Infection Prevention Programme of Works for the period April 2020- March 2021
The Trusts aim is to care for patients in a safe environment protecting them from harm with a zero tolerance to avoidable hospital attributable infections. The document sets out the Trust's objective and priorities risk of infection for the period 1 April 2020 – 31 March 2021. The intentions detailed below aim to sustain and strengthen the Trust's position in achieving compliance with The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and Related Guidance (updated 2015) and other key national documents. The programme details the essential components of the infection prevention service including- • Surveillance • Policy development and review • Outbreak prevention and management • Quality improvement and audit • Education and training • Specialist advice including promoting compliance with regulation, legislation, guidance and evidence based practice. The following abbreviations are used throughout the document: DIPC – Director of Infection Prevention and Control IPN – Infection Prevention Nurse IPT – Infection Prevention Team ICD – Infection Control Doctor CCG – Clinical Commissioning Group NHSI – National Health Service Improvement PLACE – Patient Led Assessment of the Care Environment RON – Resistant Micro-organism Nurse

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 1 Systems to manage and monitor the prevention and control of infection	**Assurance Framework**		
	Key committees including Quality and Safety Committee and the Trust Board will receive reports and presentations, monthly as a minimum for the former and quarterly for the latter from the DIPC.	DIPC	Quarters 1-4
	The DIPC will ensure the Trust Board agree and approve the:		
	• Annual Programme of Works	DIPC	Quarter 1
	• Annual report	DIPC	Quarter 1
	• Policy, procedure and guidance documents	DIPC	Quarters 1-4
	• Cleanliness and Patient Led Assessment of the Care Environment (PLACE) scores	Support Services	Annually
	The DIPC will ensure that the Trust Board is made aware of:		
	• Emerging issues with the potential to impact upon patient safety and the delivery of clinical services (COVID-19)	DIPC	Quarter 1-4
	• Unforeseen issues impacting upon progress of the annual programme	Deputy DIPC	Bi monthly
	• Ensure the progress of the annual programme is monitored by the IPT and any identified or emerging issues affecting the programme are reported to members of the group and where necessary escalated to the Trust Board.	DIPC	Quarter 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	• Ensure that the Infection Prevention Control Committee meet bi-monthly and is chaired by the DIPC.	Deputy DIPC	Bi -monthly
	IPT to attend Health Economy Antimicrobial Meetings	Deputy DIPC	Quarterly
	IP Deputy DIPC any Health Economy meeting organised by the CCG	Deputy DIPC	As required
	Infection Prevention Nurse to attend Trust Antimicrobial Stewardship Group	Lead Nurse Infection Prevention	Bi Monthly
	Performance Management Ensure that the Quality, Safety and Compliance Team receive appropriate information to support on-going registration with the Care Quality Commission	Governance	As required
	Report on progress against the HCAI assurance framework. strategy including emergency and elective screening compliance	Deputy DIPC	Monthly
	Quarterly report to Quality Assurance Committee	Deputy DIPC	Quarterly
	Ensure that monthly data summaries, incidents and outbreaks are included in the Quality and Safety reports.	Deputy DIPC	Monthly
	Deputy DIPC meeting with CCG to review Clostridium *difficile* root cause analysis and agree unavoidability/avoidability	Deputy DIPC	Quarterly
	Update any Infection Prevention risks on risk register	Deputy DIPC	Bi Monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Make a suitable and sufficient assessment of the risks of infection and take actions to minimise the risk	IPT / ICD/Consultant Microbiologist	Daily
	Using ICNet, review laboratory reports during periods of duty and provide specialist advice to clinical teams on the management of individual patients.	IPT	Daily
	Undertake alert organisms surveillance report to IPCC	ICD and Senior Data Analyst	As required but at least bi monthly
	Outbreaks		
	Respond to and advise on the management of outbreaks of infection	IPT	Within 24 hours
	Where required report outbreaks of infection as a SI through Trust reporting systems. Inform the DIPC, senior management, Heads of Services, Performance Management and key individuals of outbreaks	IPT	No later than 48 hours after incident or lapse in care is identified
	Initiate the Root Cause Analysis investigation process	IPT	Within 24 hours
	Prepare outbreak summary reports and submit to IPCC, Quality and Safety Forum and the Board.	IPT	At next IPCC
	Root cause analysis performed for hospital attributable clostridium *difficile* cases • Learning and actions owned and received at divisional IP meetings and summary to IPCC	Associate Chief Nurse/Matron/Ward Sister/Ward Charge Nurse for the Division/ IPT	As required

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Post infection review for all MRSA bacteraemia • Learning and actions owned and received at divisional meetings and summary to IPCC	Associate Chief Nurse/Matron/Ward Sister/Ward Charge Nurse for the Division/ IPT	As required
	Facilitate Screening of alert organisms e.g. MRSA, Multi drug resistant organisms admitted or transferred to UHNM in accordance with National guidance and evidence based practice	IPT/Senior Data Analysis	Quarter 1-4
	Participate in multi- disciplinary review of Clostridium difficile toxin positive patients	Infection Prevention Nurse/ Microbiologist/Dietician/ Pharmacist/Gastroenterologist/ Surgeon	Weekly Quarterly
	Maintain and review Clostridium difficile action plan and Submit to CQRM bi monthly	Deputy DIPC	Bi -Monthly
	Monthly Clostridium difficile 30 day all-cause mortality report	Deputy DIPC	Bi- Monthly to IPCC
	Surgical Site Surveillance Infection Surveillance programme in place. Feedback to Directorate Meetings	Clinical Surveillance Team IP	Quarters 1-4
	Review and update Gram negative action plan and submit CQRM bi monthly	Clinical Surveillance Team IP	Bi-Monthly
	IPT to attend and provide specialist advice: • Infection Prevention Divisional meetings	IPN	Bi -Monthly
	• Seasonal influenza vaccination planning group	Deputy DIPC	Three times per year

	• Sepsis planning meetings Strategic and antimicrobial group	Deputy DIPC	Bi monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	• Covid-19 Pandemic meeting/Groups	Deputy DIPC/Lead	Daily/Weekly
	• Trust Antimicrobial Group	Lead	Bi -Monthly
	• Quality and Safety Forum	Deputy DIPC/	Monthly
	• Health & Safety Committee	Lead	Bi- Monthly
	• CCG Infection Prevention Group	Deputy DIPC	As Required
	• Ventilation group	IP Decontamination Lead	Bi- annual
	• Water Safety Group	Deputy DIPC	Quarterly
	• Health Economy Antimicrobial Group	Deputy DIPC	Quarterly
	• IP Divisional Meetings	IPT	Monthly
	• Mortality review meetings	IP Lead Nurse	Monthly
	• Decontamination	IP Decontamination Lead	Monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 2 Provide and maintain a clean and appropriate environment in managed premises that facilities the prevention and control of infections	IPT to attend and provide specialist advice:		
	• Multi- Disciplinary Environmental Strategy Group	IPT	Monthly
	• Water Safety Group	Deputy DIPC	Quarterly
	• Environmental Health Food Hygiene Inspections	IPT	Annually
	• Refurbishment and Building Meetings	IPT/Service Development Team	As required
	• Infection Prevention Cleaning Services (Soft FM)	IPT/Service Development Team	Monthly
	• Decontamination Group	IPT/Service Development Team	Monthly
	• Clinical Procurement and Standardisation Group	IPT/Service Development Team	Monthly
	• CPE trial Task and Finish Group	IPT/Service Development Team	As required

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Whole room technology explore in house team arrangements	Service Development Team	Quarter 2 & 3
	Re refresh Pooh help line	IP C.difficile nurse	Quarter 2
	Support biofilm research project undertaken by PHD Student Southampton University	Service Development Team	Quarters1-4
	Fans	Service Development Team	Quarters1-4
	CPE three month trial treatment of drains on 2 wards	Service Development Team	Quarters 1-4
	Quality Improvement Audits		
	IPN to conduct period of increased incidence (PII) audits when PII is identified. Feedback to ward, Matron and Divisions.	IPN	As required
	IPN to conduct Clostridium *difficile* audit following each hospital acquired case	IPN	As required
	IPN's will undertake a programme of unannounced audits in clinical areas, including hand hygiene audits	IPN/Hand Hygiene Trainer	As required
	Audit tools and programme in place for Divisions/areas to monitor environment. IPN's to support service leads, Matron and Ward Sisters/Charge Nurse	Associate Chief Nurses/Matrons/ Ward Sister/Charge Nurse	Weekly/Monthly/ Quarterly
	Cleaning for Credits (C4C) audit programme in place - feedback bi -monthly at IPCC	Facilities Manager	Bi Monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Prompt to protect audits	IP Team	Weekly
	IPCC to receive summary progress and action plans for Divisions	Associate Chief Nurses/Matron	Bi Monthly
	Building works and refurbishments IPT to advise on building and refurbishments.	IPT/Service Development Team	As Required
	IP Team to advise on new cleaning products and deep clean programmes	Deputy DIPC/IPT	As Required
Criteria 3 Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance	Work with partner organisations to ensure that the Trust has systems and procedures which minimise the risk from emerging and resistant organisms	Advance Specialist Pharmacist Antimicrobials/Microbiologist/ ICD DIPC	Quarters 1-4
	Representation at Local Health Economy Antimicrobial Group Meeting	Deputy DIPC/Microbiologist	Quarterly
	Antimicrobial pharmacist to report antibiotic audits to IPCC	Advance Specialist Pharmacist Antimicrobials	Bi monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Trust signed up for National AMR CQUIN	Microbiologist	Quarters 1-4
	The IP and Antimicrobial Team work closely together. The CQUIN for 2020-21	Microbiologist/Advanced Specialist Pharmacist Antimicrobials Deputy DIPC/IP Team	Quarters 1-4
	Access to Microbiologist to advise on appropriate choice of antimicrobial therapy		Quarters 1-4
	Access to microbiology diagnosis, susceptibility testing and reporting of results	ICD/Microbiology Manager	Quarters 1-4
	Sepsis CQUIN part of Trust contract	Deputy DIPC/ Sepsis IP Team	Quarters 1-4
	Strengthening of Sepsis champions and sepsis screening	Deputy DIPC/ Sepsis IP Team	Quarters 1-4
	Sepsis educational material	Deputy DIPC/Sepsis IP Team	Quarters 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 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.	DIPC to liaise with Communications Team to deliver public messages in times of outbreaks Patient information leaflets available for the public. IPT to actively participate in promotional activities across the Trust, raising awareness of good practice e.g. visitor's stands / Infection Prevention Awareness Week/ Hand Hygiene World Health Organisation Day Review public internet page All Clostridium *difficile* given a "green alert card" to be presented when receiving future healthcare Hand hygiene education for patients Explore if hand hygiene key message can be added to standard outpatient letter	DIPC IPT/Service Development Team IPT Service Development Team/IPT Hand hygiene Technician Service Development Team	As required Quarters 1-4 Quarter 1 As required Quarters 1- 4 Quarter 3-4
Criteria 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	Alert tag system place at Royal Stoke to allow staff to check for current and previous alert organisms to enable proactive approach to IP. Norovirus/winter signage displayed throughout the Trust Introduction of COVID -19 role within the IP Team	IPT IPT Deputy DIPC/ Lead Nurse	As required Quarter 3-4 Quarter 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	**Education and Training** Liaise with the Education and Learning Team, Service Leads and Business Managers to ensure all staff are suitably educated in the prevention and control of infection.		Time scale in accordance with documented programmes
	IPT to attend • Teaching and Education	IPT	Quarters 1-4
	• Corporate induction	IPT	Quarters 1-4
	• Mandatory training days	IPT	Quarters 1-4
	• Scheduled programme of updates	IPT	Quarters 1-4
	• Infection Prevention Link Practitioners study days	IPT	Quarters 1-4
	Planned programme for Student Nurses to shadow the IPT	IPT	Quarters 1-4
	Contribution for the continuous personal development programme for medical and other staff.	IPT/ICD	Quarters 1-4
	Provide cascade training for volunteers/porters/catering assistants/domestics about the importance of complying with good practice.	IPT	Quarters 1-4
	Use variety of educational approaches to engage staff e.g. ATP monitoring, PowerPoint, shadowing, on line learning	IPT	Quarters 1-4
	Hand Hygiene and Mask Fit Training	IPT	Quarters 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 7 Provide and secure adequate isolation facilities	To advise/make recommendations on isolation facilities during refurbishment programmes Inform DIPC where there is lack of isolation rooms of when requirements change e.g. threat of alert organism	IPT Deputy DIPC	As required As required
Criteria 8 Secure adequate access to laboratory support as appropriate	Ensure CPA accreditation of laboratories is current Daily laboratory bench round with “on call” microbiologist	ICD/Lab Manager IPT	Annually Daily
Criteria 9 Have and adhere to policies, designed for the individuals care and provider organisation that will help to prevent and control infections	Amend polices or guidance and any related documents in response to legislation, regulations and evidence based practice. Ensure that existing policies with a review date falling within this period are revised and comply with legislation, regulations, current guidance and evidence based practice: Infection prevention Question and Answer manual in place	IPT Service Development Team	As required Quarter 3-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 10 Providers have a system in place to manage the occupational health needs of staff in relation to infection	Liaise with and support the Occupational Health Department in protecting healthcare workers from infections through: The review and follow up of inoculation and/or splash injury Work with partner organisation to ensure that the Trust has systems and procedure in place which reduces the risk from emerging and resistant organisms. Lead the planning and delivery of the staff seasonal influenza immunisation programme. Team Prevent to report to IPCC	Team Prevent ICD IPT Health and Safety Department ICD IPT Deputy DIPC Team Prevent	Quarters 1-4 Quarter 3 Quarters 1-4 Quarters 1-4 Quarters 1-4

References

Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Infection Prevention Society Audit tools. http://www.ips.uk.net/professional-practice/quality-improvement-tools/quality-improvement-tools/