University Hospitals of North Midlands NHS Trust

Infection Prevention, Vaccination and Sepsis Team

Annual Report 2023/24

Together Compassion Safe Improving

PROUD TO CARE

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

Infection Prevention and Control Annual Report 2023-4

As Chief Nurse I am pleased to introduce our Annual Infection Prevention and Control Report for 2023-24.

This Annual report covers the period 1st April 2023 to 31st March 2024 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 2022). 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 last year has been another busy one for our teams. COVID, Flu RSV and measles are just a few of the challenges our teams have had to navigate and as always and I am both proud and in awe of our colleagues dedication to provide the best possible care to those requiring our services.

We have both refreshed and maintained reporting of our Infection Prevention Board Assurance Framework through Quality Governance Committee and Trust Board and welcomed the focus on this. We are clear where we need to drive continual improvement and will continue to promote good infection prevention practices as part of everything we do across the organisation.

We also have some exciting initiatives planned for 2024-2025 to support our continual improvement work and support deliver against our Strategic Objectives for 2024-2025

Ann Marie Riley

Abbreviations

AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
C *difficile*	Clostridium *difficile*
CDI	Clostridium *difficile* infection
CQC	Care Quality Commission
COHA	Community onset Hospital Associated
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
FFP3	Filter Face Piece (with an assigned protection of 20)
GDH Ag	Glutamate dehydrogenase antigen of *C. difficile*
GRE	Glycopeptide Resistant Enterococcus
HCAI	Health Care Associated Infection
HOHA	Hospital onset Hospital Associated
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
IVAB	Intravenous antibiotics
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
SOP	Standard Operating Procedure
SSI	Surgical Site Infection
TEC	Trust Executive Committee
UHNM	University Hospitals of North Midlands
UKHSA	UK Health Security Agency
VNTR	Variable-number tandem-repeat
VCTM	UHNM on line learning

Introduction

This report summarises the combined activities of the Infection Prevention, Vaccination & 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 key principles:

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

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

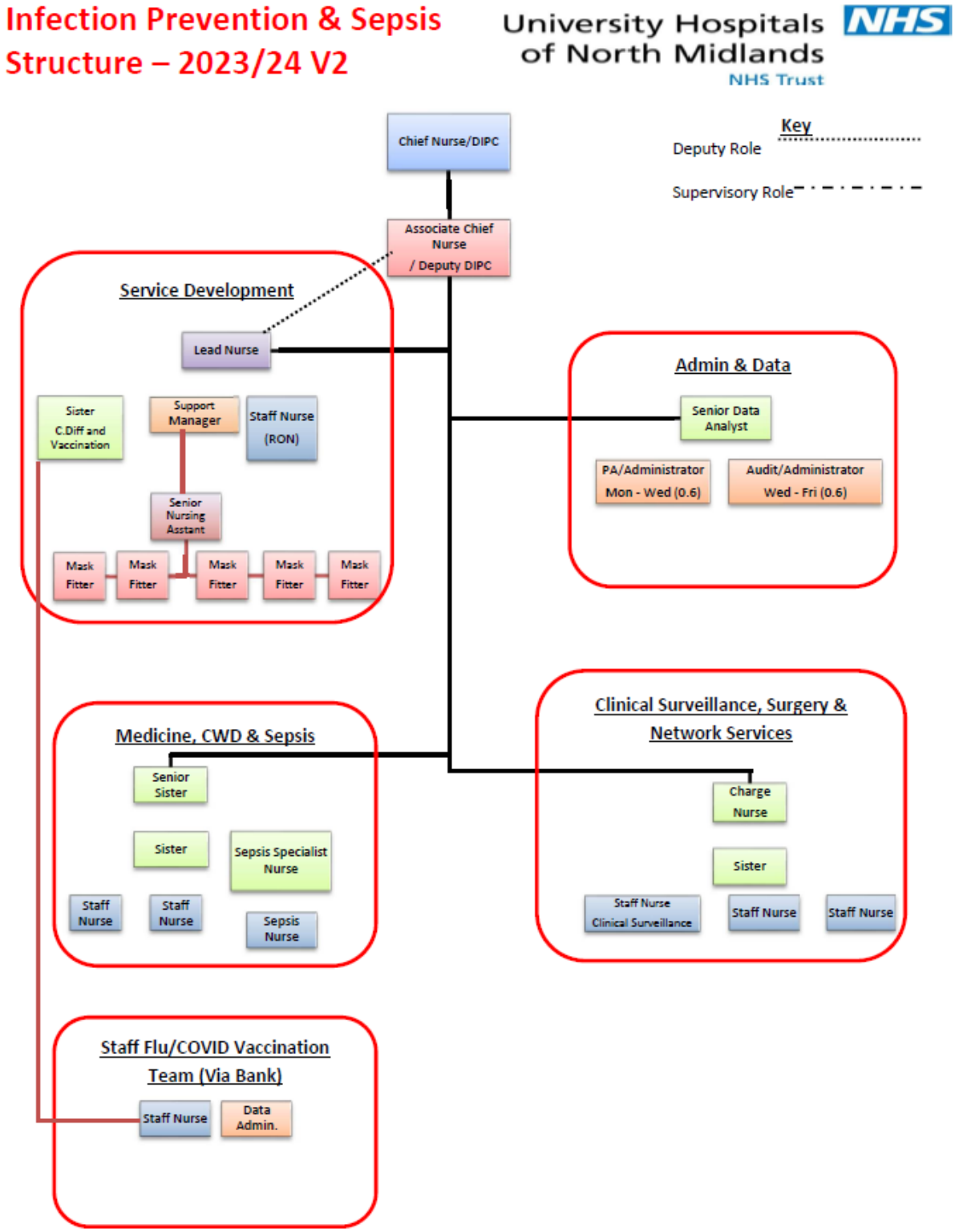
At UHNM the Director of Infection Prevention and Control (DIPC) is the Chief Nurse who has overall responsibility for the IPT. The Associate Chief Nurse (Infection Prevention) at UHNM also has the role of Deputy DIPC.

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.

The Infection Prevention Team experienced staff vacancies with the capacity for IP proactive work reduced. Whilst the majority of vacancies have been filled the new team are learning about IP roles and responsibilities to support clinical areas. The focus for next year will on back to basics.

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.



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 Governance Committee

The Quality Governance Committee is a non-executive committee of the Trust Board.
The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.
The Infection Prevention Team provides a quarterly report on surveillance and outbreaks. The Infection Prevention Board Assurance framework is also submitted to the committee quarterly.

Executive Quality and Safety Oversight Group

The Executive Quality and Safety Oversight Group has been formed as an Executive Group to support assurance through the Quality Governance Committee to the Trust Board on quality and safety.

The Executive Quality and Safety Oversight Group serves a dual purpose within the Trust's governance, assurance and performance arrangements:

- Accountable to the Quality Governance Committee, through its executive membership it will provide assurance across the key areas set out within the Board Assurance Framework
- It will receive and consider any concerns or issues escalated from Divisions and sub-groups and provide advice, guidance and support.

The Quality and Safety Oversight Group is the forum at which the Trust focuses on its delivery of patient centred care and services in accordance with the Trust's Strategic Objectives. The Group is responsible for developing, implementing, monitoring and evidencing actions which improve the quality and safety of care and services provided to patients and service users.

The Infection Prevention Team provides 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 are robust processes in place to support clinical areas that require additional support or oversight to achieve continual improvement.

There is a separate Health Economy Antimicrobial Group, chaired by a Consultant Microbiologist, which 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 a joint lead between the Director of Estates Facilities and PFI and the Chief Nurse/DIPC. 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 subgroup of IPCC and meets quarterly. It is chaired by the Deputy DIPC with multi-disciplinary representation.

Ventilation Safety Group
The Trust Ventilation Safety group is in place and meets quarterly.

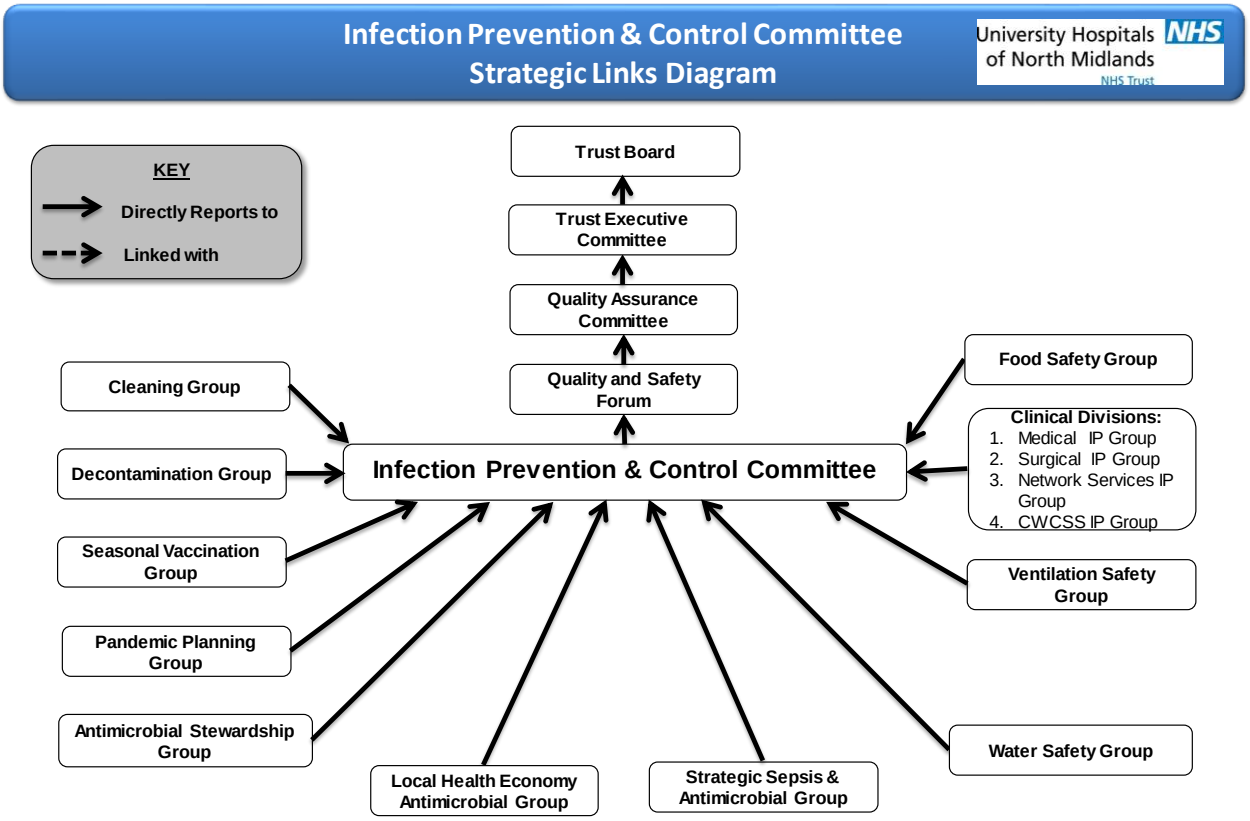
Mortality Review Group
The Trust Mortality Review Group meets monthly and the Chair for the group is the Deputy Medical Director (Patient Safety). This group reports directly to the Executive Quality and Safety Oversight Group providing an understanding of the interpretation and application from mortality 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 Governance 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 prevention reports to IPCC.

The IPT complete a Board Assurance Framework self-assessment which is reported into IPCC.

Infection Prevention and Control Committee (IPCC) Strategic Links



Reports/Papers Received by IPCC

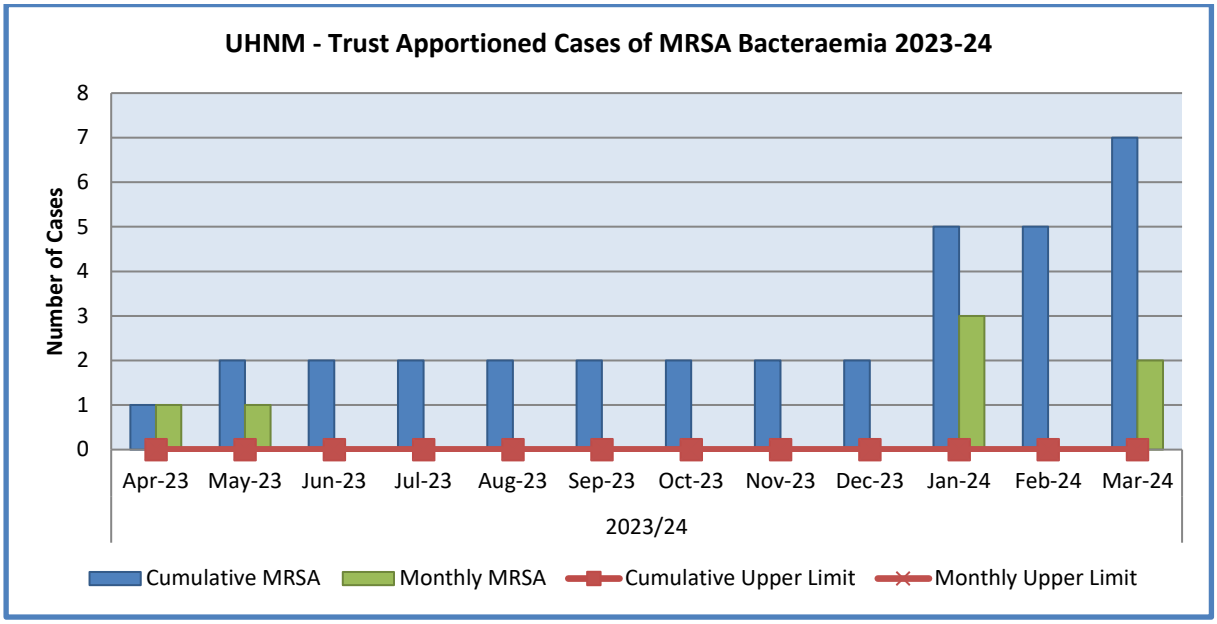
Policy/Procedure Updates and Standard Operating Procedures (SOP) updates	Rotational Report: Water Safety
UHNM HCAI Surveillance & Performance Reports	Rotational Report: Occupational Health
Outbreaks & Incidents	Rotational Report: Decontamination
Divisional Reports	Rotational ventilation
Environment Report	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
Compliance report for IPCC (Governance)	IP Risk Register
Review & Update Committee Terms of Reference	IP Stat & Mandatory figures (Quarterly)

IP Board Assurance Framework (BAF)	Food Safety Group Update
SSI Report	Antimicrobial Stewardship Group Minutes
Blood Culture Contamination Rates Report	Decontamination Group Minutes
BSI Report /Gram negative Report	IP Risk Register
Hand Hygiene Audits	Water Safety Group Minutes
ANTT Update	Sharps Report
CDI Plan Update	Health Economy Committee
UKHSA Update	3T Heater Cooler Update
Annual IP Code of Practice Self -Assessment Tool	

Groups/Meetings Infection Prevention Team Attend

Weekly Clinical Advisory Group	Health Economy Antimicrobial Group
Weekly IP Systems Meeting	Midlands Infection Prevention Meetings
Antimicrobial Stewardship Group	Theatre Product Evaluation Group (TPEG) Group
Clinical Equipment Product Evaluation Group (CEPEG)	Executive Quality and Safety Oversight Group
Quality Governance Committee	Health Economy IP Group
Seasonal vaccination Group and COVID 19 vaccination Group	Infection Prevention Divisional Groups
Clostridium *difficile* Multi- Disciplinary Meetings	Infection Prevention Group Meeting, Estates, Facilities and PFI Division
Winter Planning Group	Mortality Review Group
Clostridium period of increased incidence meetings (PII)	Pneumatic Tube Meetings
Bed and Mattress Meetings	Decontamination Group
Estates refurbishments and new development projects	Ventilation Group
Vitals Reporting Focus Group	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
Nursing and Midwifery and APH Advisory Forum	Weekend Planning Meeting
Bed A3 Meeting	County Working Group Meeting
National Standards for Cleanliness	

MRSA Bacteraemia (Blood stream infection)



7 patients developed a MRSA bacteraemia, out of the 7 cases 3 were deemed avoidable, action plans instigated, learning alerts were circulated Trust wide with the lessons learnt.

***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.

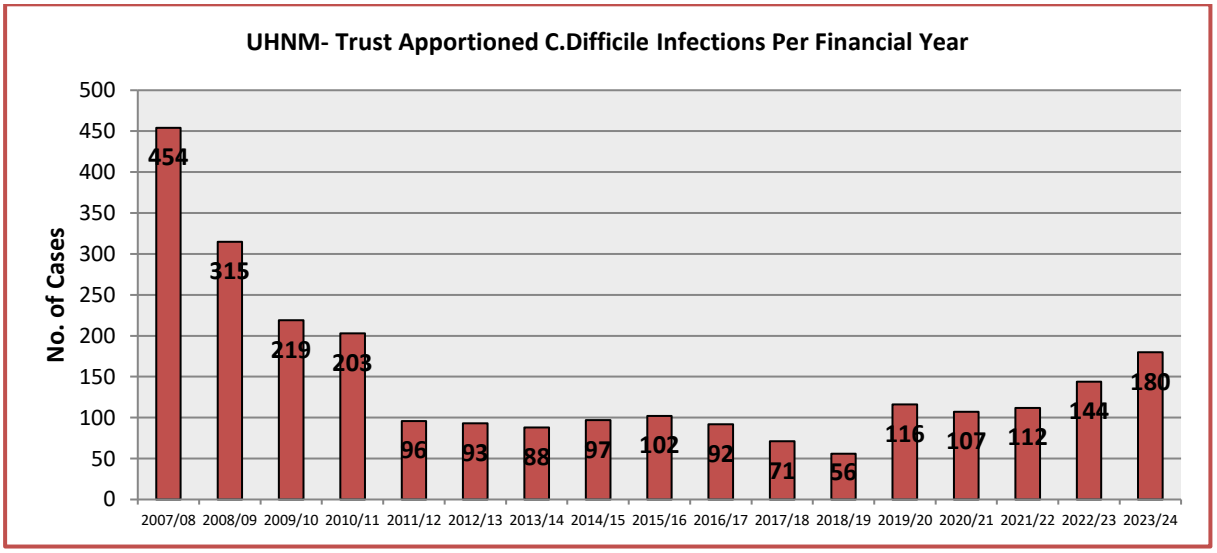
Reporting of Clostridium *difficile* toxin cases Public Health England (PHE)

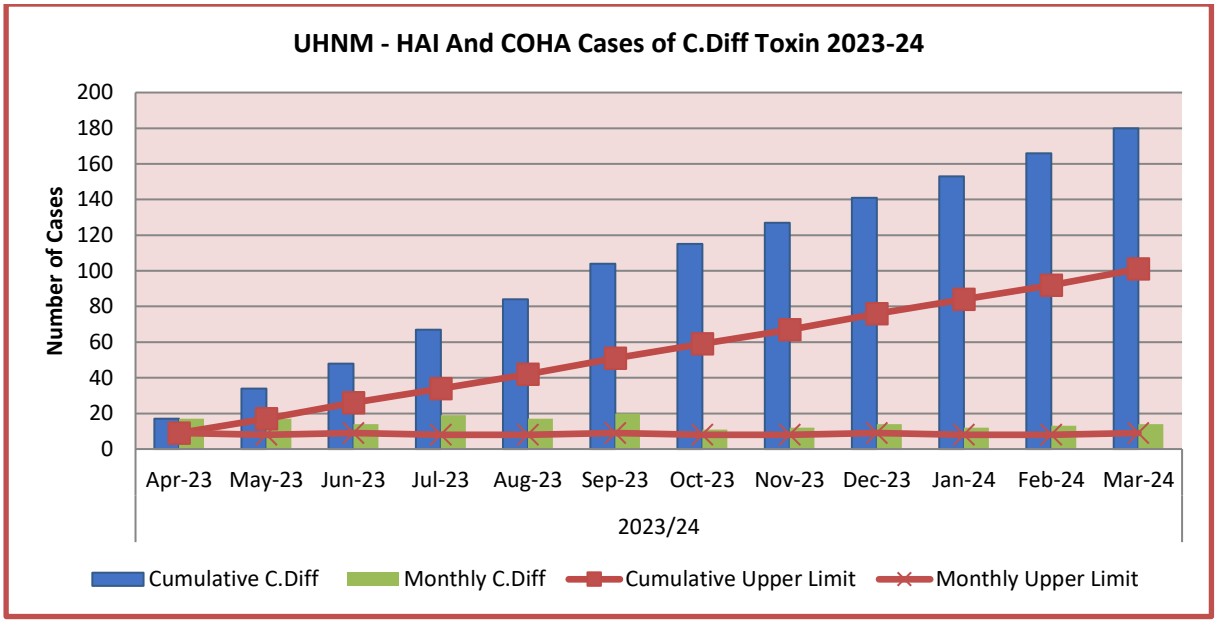
Healthcare associated cases (HAI) Cases are Clostridium *difficile* toxin positive specimens taken on or after day 3 of a hospital admitted spell where day 1 is the day of admission.

Community onset hospital associated (COHA**)** cases that occur in the community (or within two days of admission) when the patient had been an in-patient in the trust reporting the case in the previous four weeks.

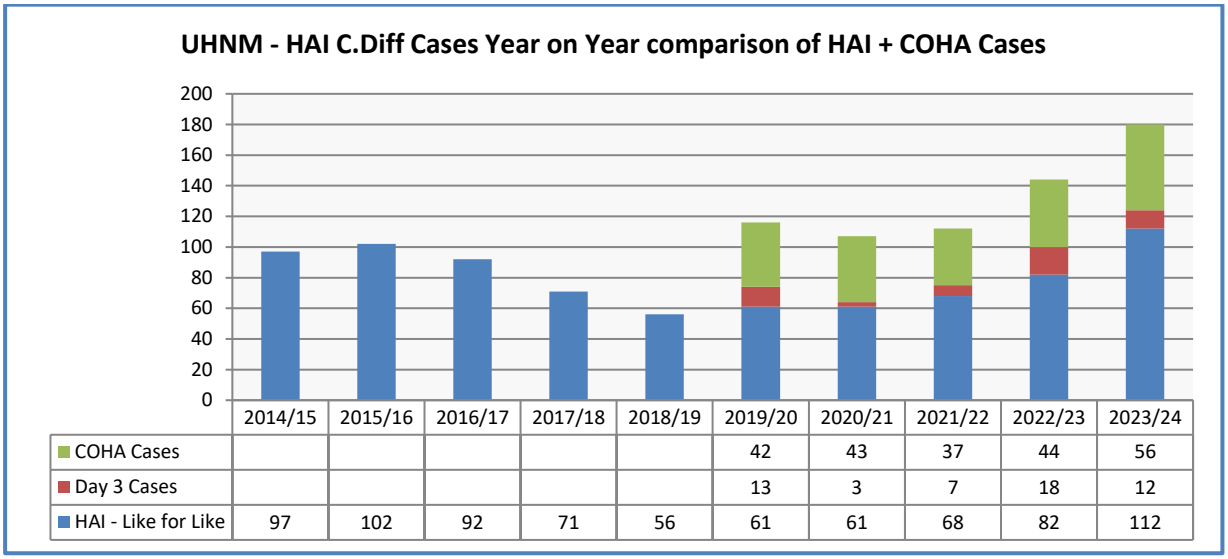
From April 2019 onwards the performance of each Trust in relation to their annual target (as set out by NHSei in their CDI Objectives for NHS organisations) regarding trust apportioned cases is the total of HAI cases plus COHA cases.

The upper limits set by NHSIE for Trust acquired cases at UHNM 2023-24 was 101. UHNM reported a total of 180 cases which is a 25% increase on the previous year (2022/23) when 144 Trust apportioned cases were reported, and well above the upper limit.

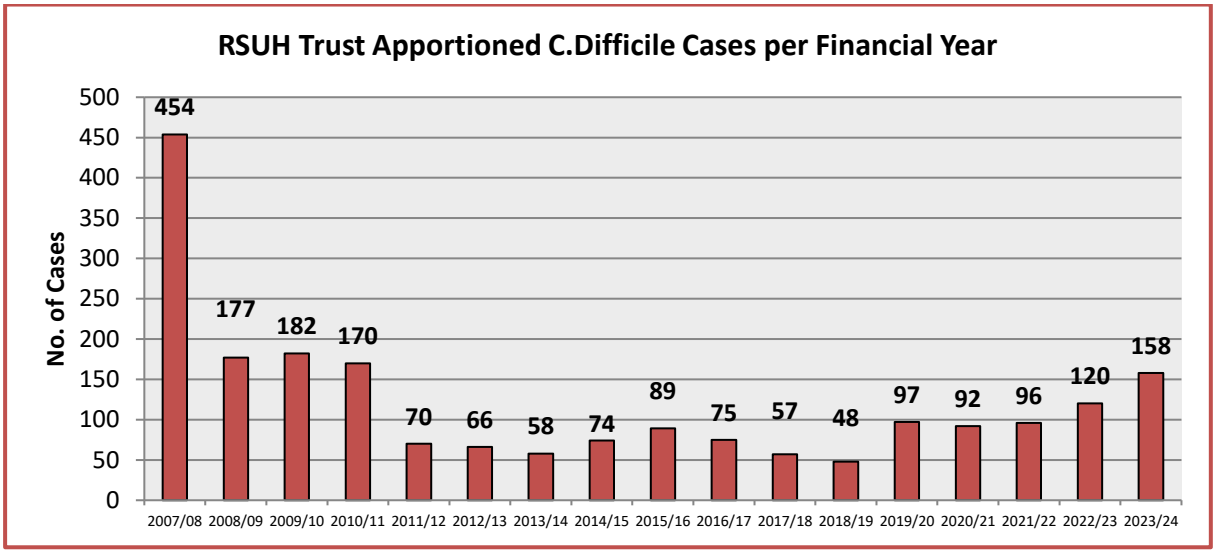


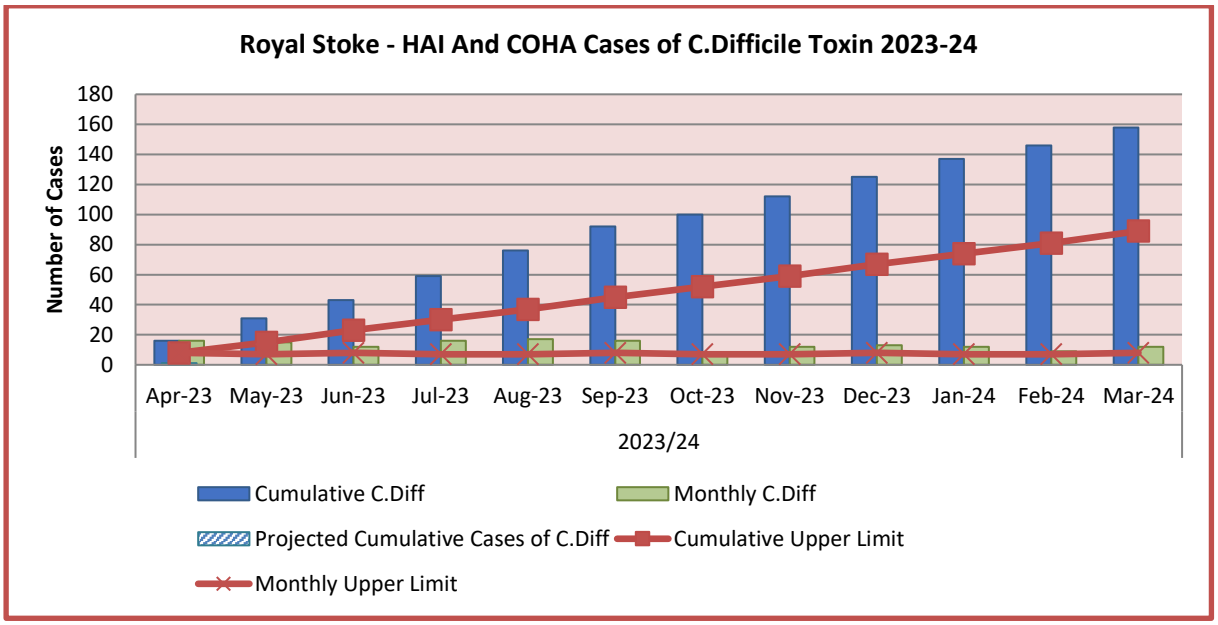


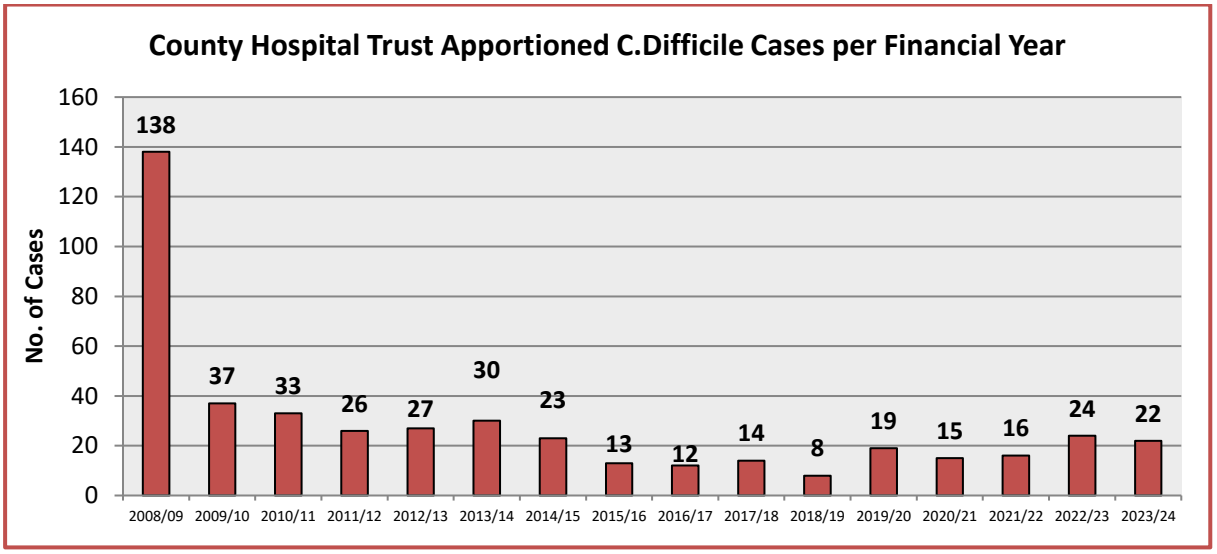
The following chart shows the impact that the change in Trust apportionment rules have had on the total number of cases attributed to UHNM. Using the previous apportionment rules of specimens taken on or after day 4 of an admission spell, where day 1 is the day of admission, UHNM would have reported 61 HAI cases in both year 1 (2019/20) and year 2 (2020/21) under the new apportionment rules. 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.

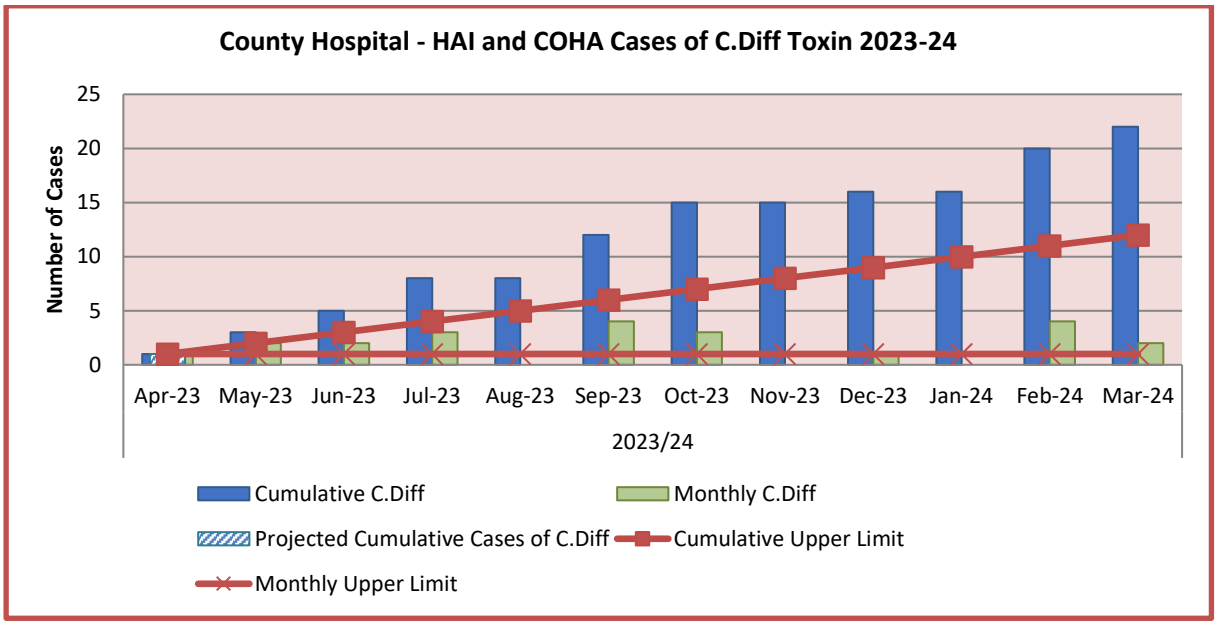


	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
COHA Cases						42	43	37	44	56
Day 3 Cases						13	3	7	18	12
HAI - Like for Like	97	102	92	71	56	61	61	68	82	112


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
92
96
120
158
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 2020/21 2021/22 2022/23 2023/24


Royal Stoke - HAI And COHA Cases of C.Difficile Toxin 2023-24
Number of Cases
180
160
140
120
100
80
60
40
20
0
Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24
2023/24
Cumulative C.Diff
Monthly C.Diff
Projected Cumulative Cases of C.Diff
Cumulative Upper Limit
Monthly Upper Limit





Clostridium *difficile* Action Plan

Preventing and controlling the spread of Clostridium *difficile* is a vital part of the Trust's quality and safety agenda utilising 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 were previously submitted for ribotyping.

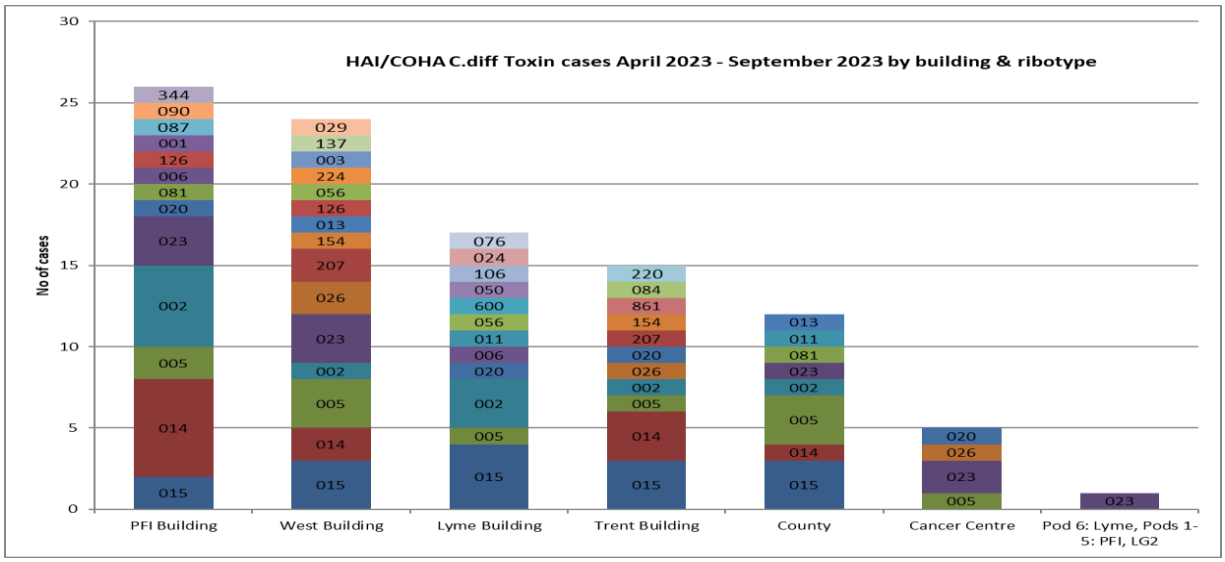
On 7th July 2023 all NHS Trusts were notified by UKHSA about the introduction of a charge per test for the typing of C diff toxin positive stool samples. This testing was previously done by UKHSA for free, the new charge will be **£60.08** per test requested.

UKHSA will no longer test PCR-positive samples with Clostridium *difficile* toxin below detection level, since they consider the probability of being able to culture and type the organism from such samples too low. This change will approximately half the number of positive samples that may be submitted for ribotyping.

The Executive Team have agreed funding to continue to send C *difficile* toxin samples for ribotyping for periods of increased incidents (n=~8 per month).

Ribotypes provide an indication if person to person transmission or environment to person transmission has occurred e.g. if the ribotype is the same. 027 ribotype is associated with more severe disease. We have not seen any 027 at UHNM.

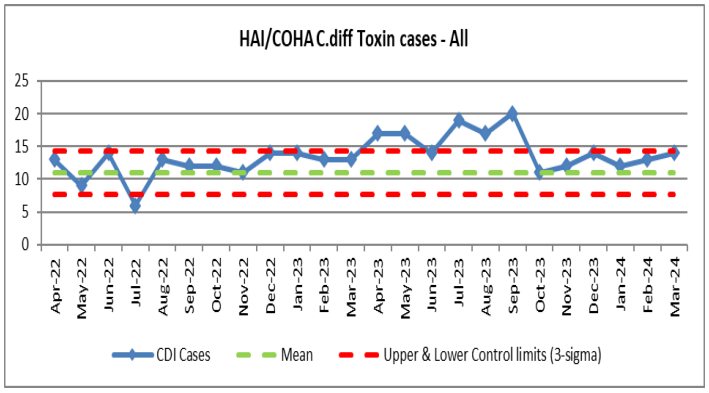
Ribotypes breakdown Clostridium *difficile* toxin

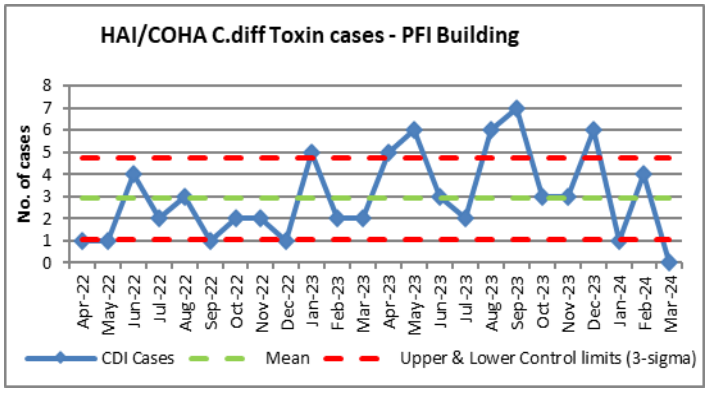


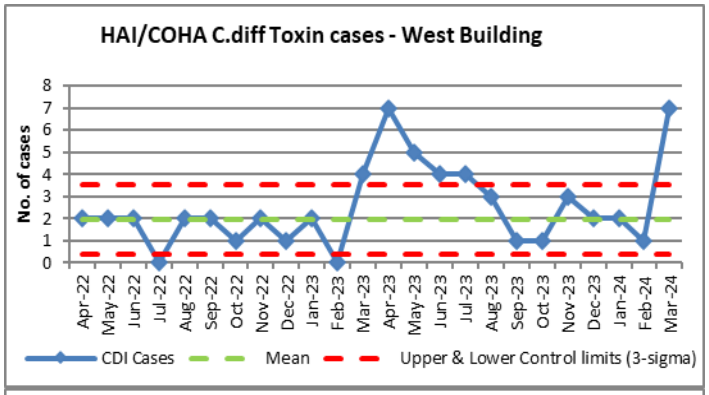
The chart above shows that a wide range of ribotypes have been seen across all buildings – 31 different numbered types across 100 ribotyped cases reported during the last 6 months.

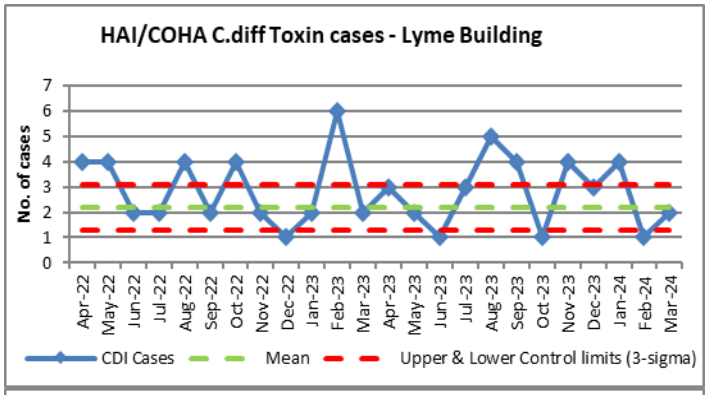
The 3 most common ribotypes were identified across a range of wards: Ribotypes 002, 005 014 and 015.

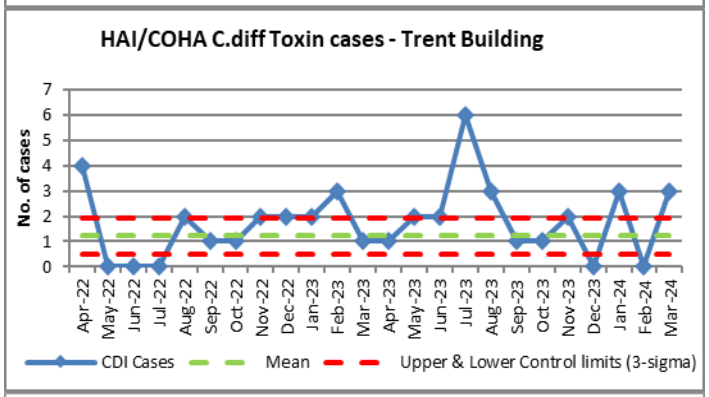
Statistical Process Control charts – Trends since April 2022

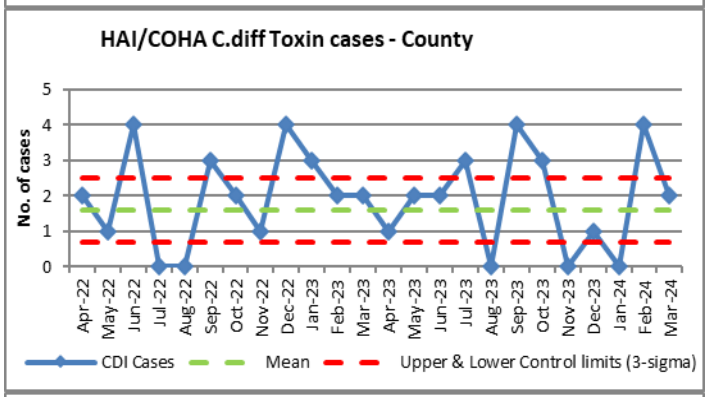


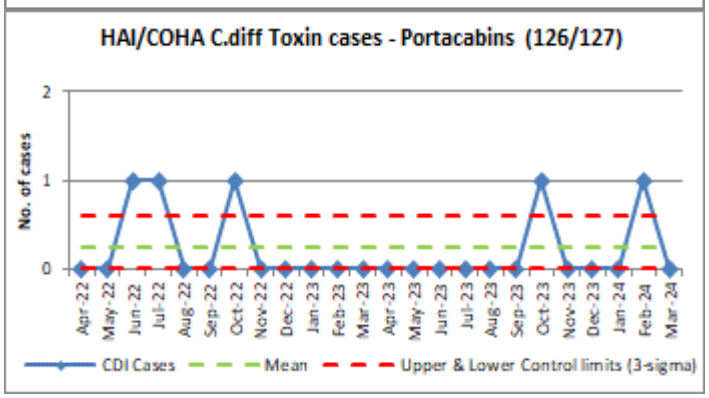


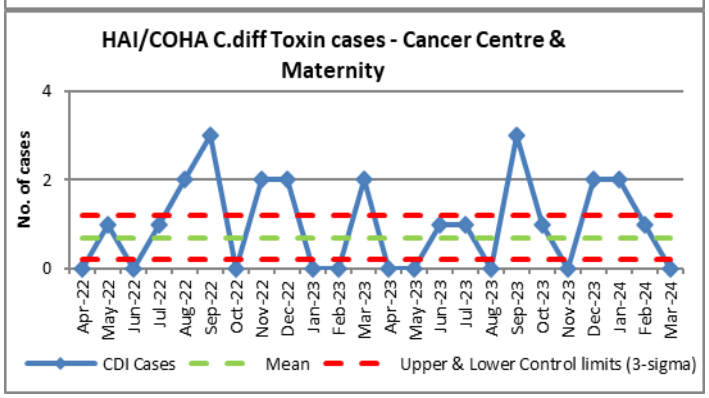












In all cases control measures are instigated immediately, and RCA's are requested. Each inpatient is reviewed by the Clostridium *difficile* Nurse, and forms part of a bi weekly multi-disciplinary review where the patients' case is discussed, including antibiotics and where necessary feedback to Ward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

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 or outbreak if proven to be the same strain of Clostridium *difficile* by variable number tandem repeat analysis VNTR (DNA sequence).

In the past, samples with the same ribotype were then examined further by way of variable-number tandem repeat (VNTR). This provides further analysis to establish if the same ribotypes match, indicating transmission between patients.

Leeds perform VNTR since the COVID 19 pandemic pressures VNTR has not been possible; however, all Infection Prevention measures were instigated. We have now revisited the process required for future VNTR requests with Leeds Hospital for areas with PII.

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.

In addition the Trust held a Big Bed Clean day.

The above approach has assisted greatly in the early identification and termination of any outbreaks of 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 Clostridium *difficile* management. Two FMT infusions were undertaken this year.

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* education is in place. The Clostridium *difficile* Nurse role is 50% patient reviews and 50% education.

Sessions are extended to include non-clinical staff such as Domestic Staff, plus Clostridium *difficile presentation* is available online.

As part of the Clostridium *difficile* work a Task and Finish Group was set up for the West Buildings

The biweekly clostridium *difficile* MDT meeting continue.

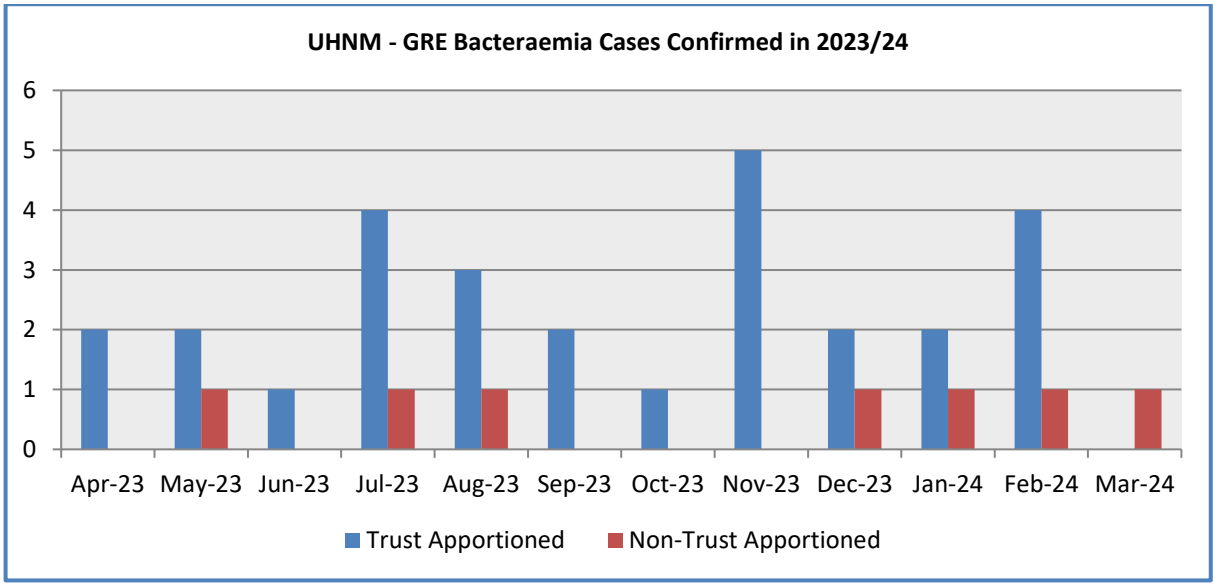
A top tips cards for staff are issued to staff during the education sessions, again promoting sampling practices and the ‘Pooh’ help line.

The ‘Pooh’ help line has been relaunched during the year. A Trust wide learning alert was also issued around timely sending of stool samples.

All patients with Clostridium *difficile* infection are provided with an information leaflet which contains the Clostridium *difficile* passport (green card), 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 2023-24 the Trust reported 35 of this type of blood stream infection (see chart below), with 26 cases recorded at UHNM in 2022-23.



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.

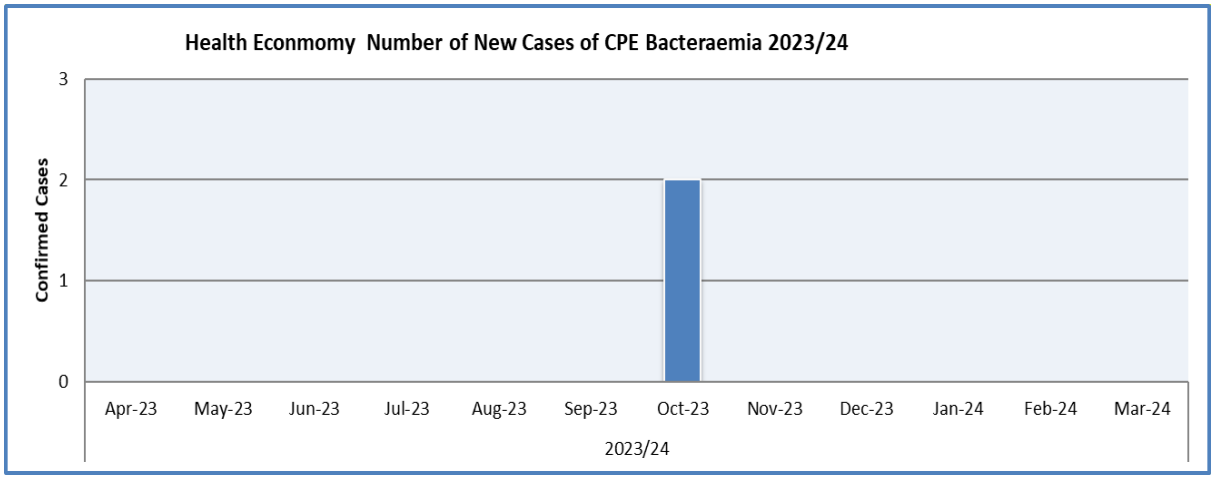
A Trust CPE policy has been in place for some time; this reflects screening guidance recommended by Public Health England.

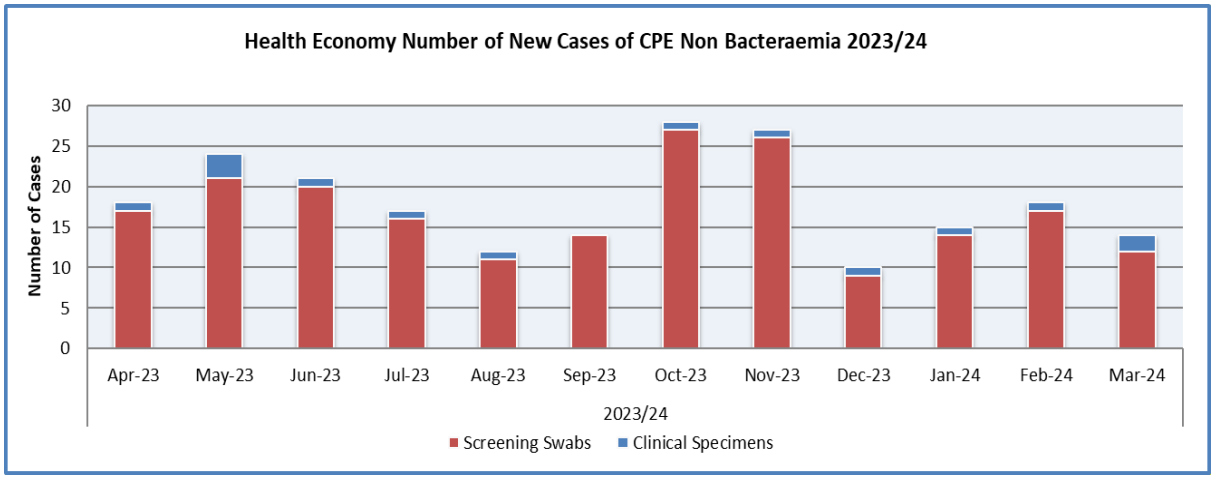
In addition to national guidance UHNM perform routine admission and weekly screening on the following wards: Adult Intensive Care Unit, Renal Ward, Infectious Diseases Ward, and all Elderly Care Wards.

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 extended spectrum beta-lactamase (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.

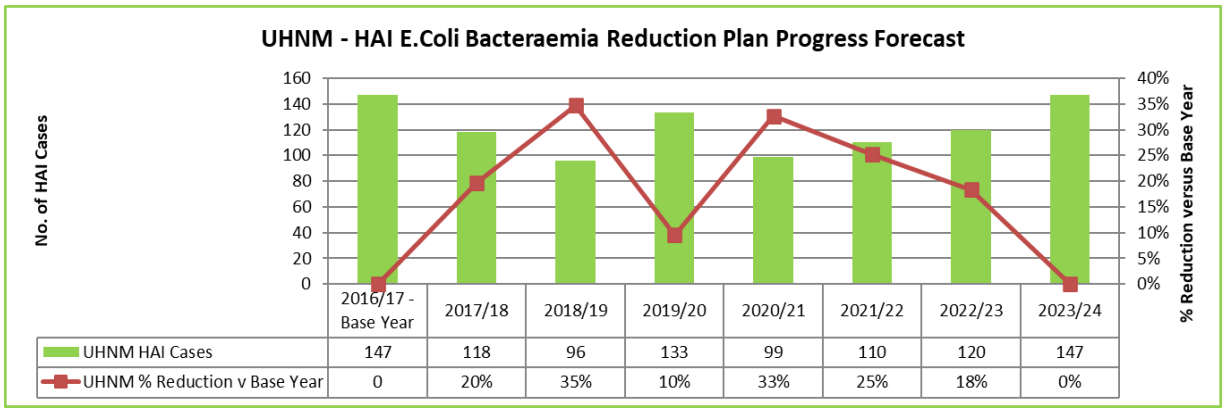




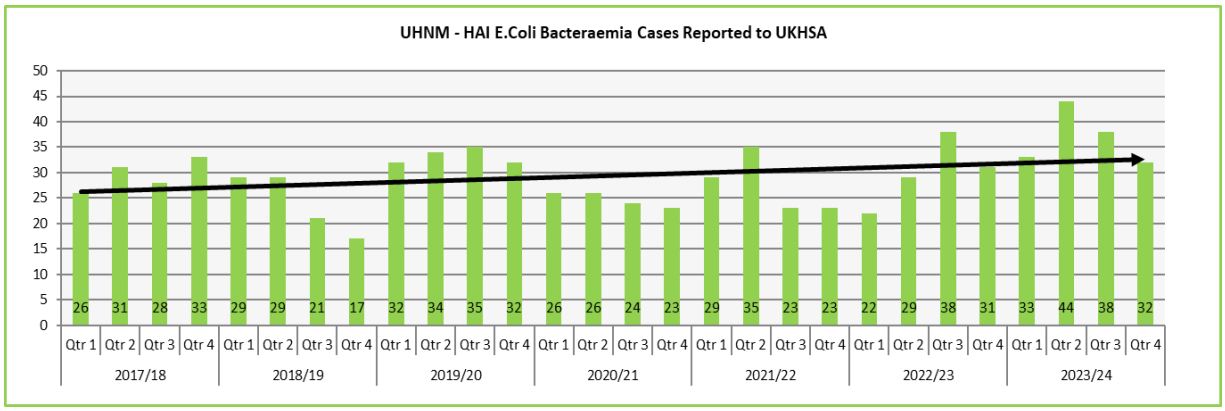
Gram –Negative Bacteraemia (Blood stream infections)

During 2017 NHSe contacted all Trusts regarding the number of Gram-negative blood stream infections (BSI's) being reported annually to UKHSA. Commencing April 2017 all Trusts were tasked to reduce the number of E Coli bacteraemia cases by 25% over a five-year period ending March 2021. UHNM issued an action plan to reduce their number of HAI cases by 50% using the fiscal year 2016/17 cases as a baseline.

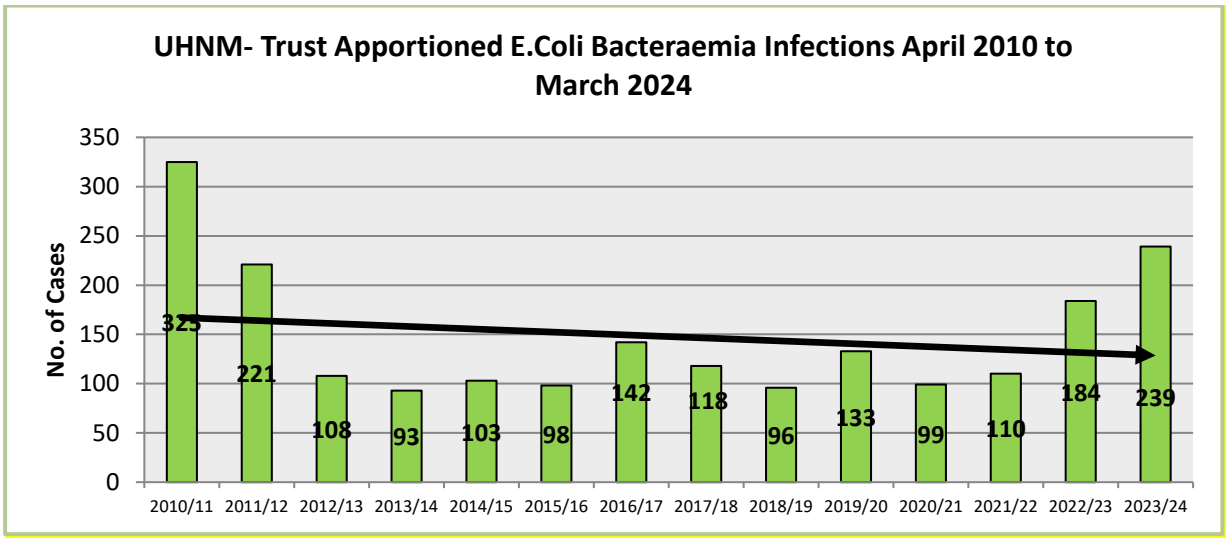
We know GNBSI cases can occur in hospitals, however half of all community onset cases have had some healthcare interventions either from Acute, Primary or Community Care. Therefore we can only achieve the reductions by working together across the Health and Social Care sectors, and a healthcare economy approach to reducing E. coli BSI's continues to be the focus.

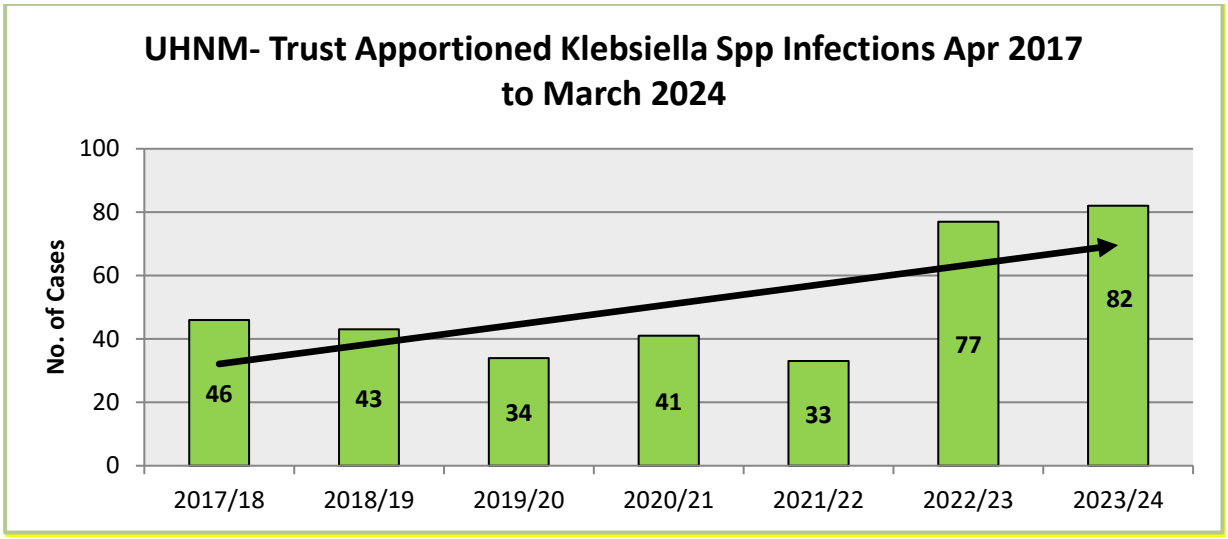


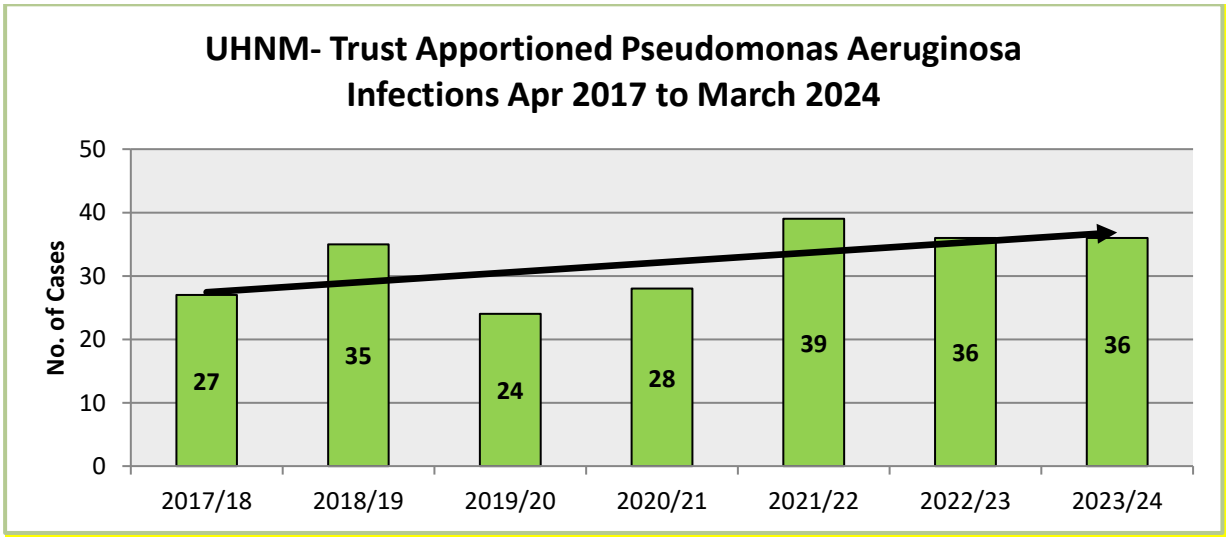
The following charts show the quarterly numbers and trend of HAI E. Coli cases reported to UKHSA since the implementation of the reduction plan. The Trust is working with the ICB to ensure a Health Economy approach to achieving this aspirational target.



Gram- negative Bacteraemia Trust Apportioned







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

To reduce the risk of water borne infections, clinical areas have an on-going 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.

Candida auris

In 2017, UKHSA produced a document - Guidance for the laboratory investigation, management and infection prevention and control for cases of *Candida auris (C. auris),* which is a yeast species.

C. auris is a *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 the adult population and has predominantly been identified in critically unwell patients in high dependency settings.

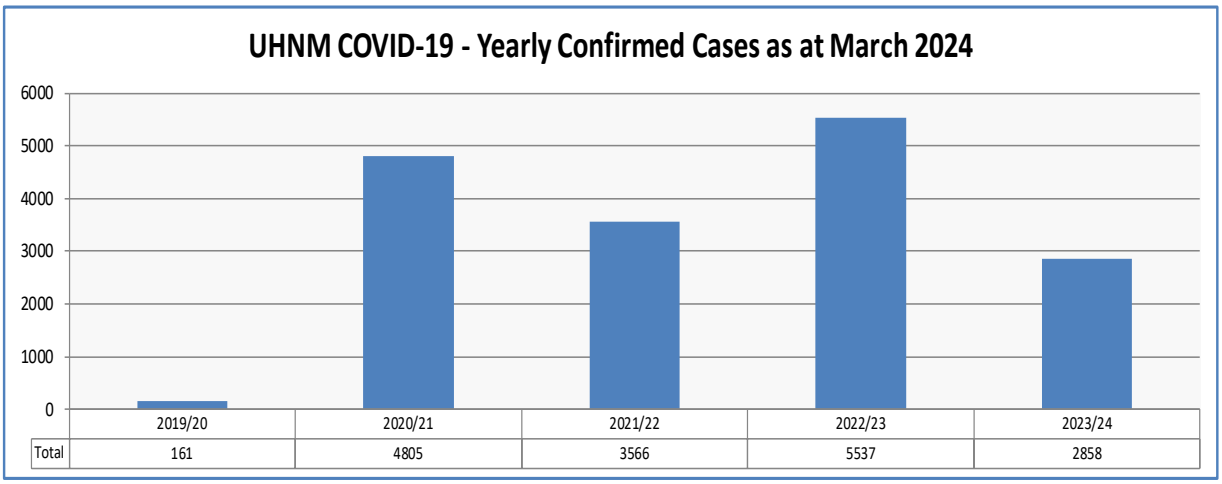
As with other organisms associated with nosocomial outbreaks, it appears to be highly transmissible between patients and from contaminated environments, highlighting the importance of instituting effective infection prevention practices.

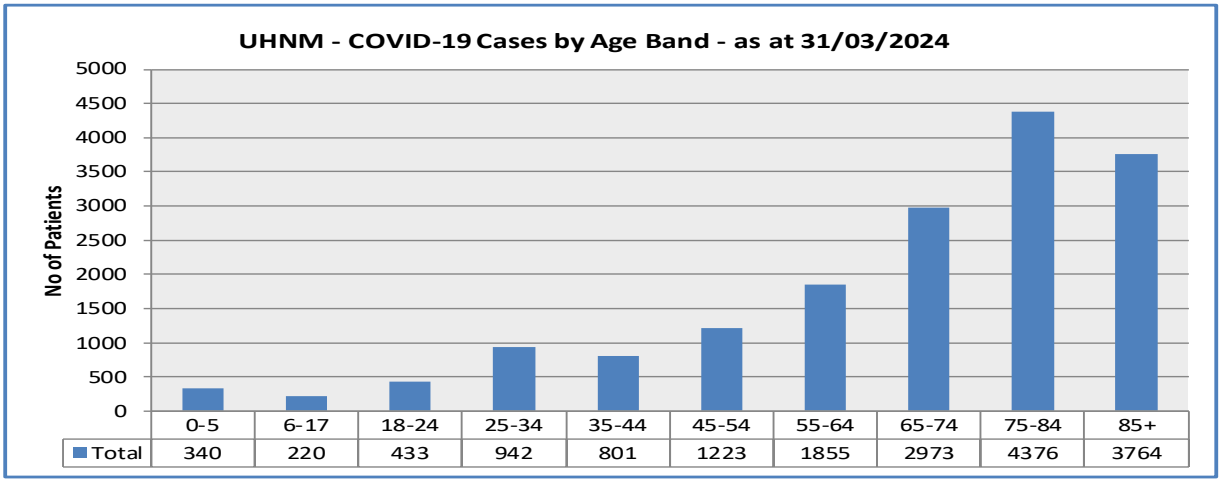
A screening policy, guidance on treatment and infection prevention precautions, is included in the Infection Prevention Questions and Answers Manual.

COVID 19

The Infection Prevention Team has been, and continues to be, fundamental to this collaborative Trust wide work.

During March 2020 UHNM started to see their first COVID-19 cases. As at March 31st 2024, laboratory confirmed cases since the start of the pandemic totalled 16,927. The following charts show the yearly numbers of new cases confirmed and the age groups of the patients who tested positive this includes both primary cause for admission and incidental finding.



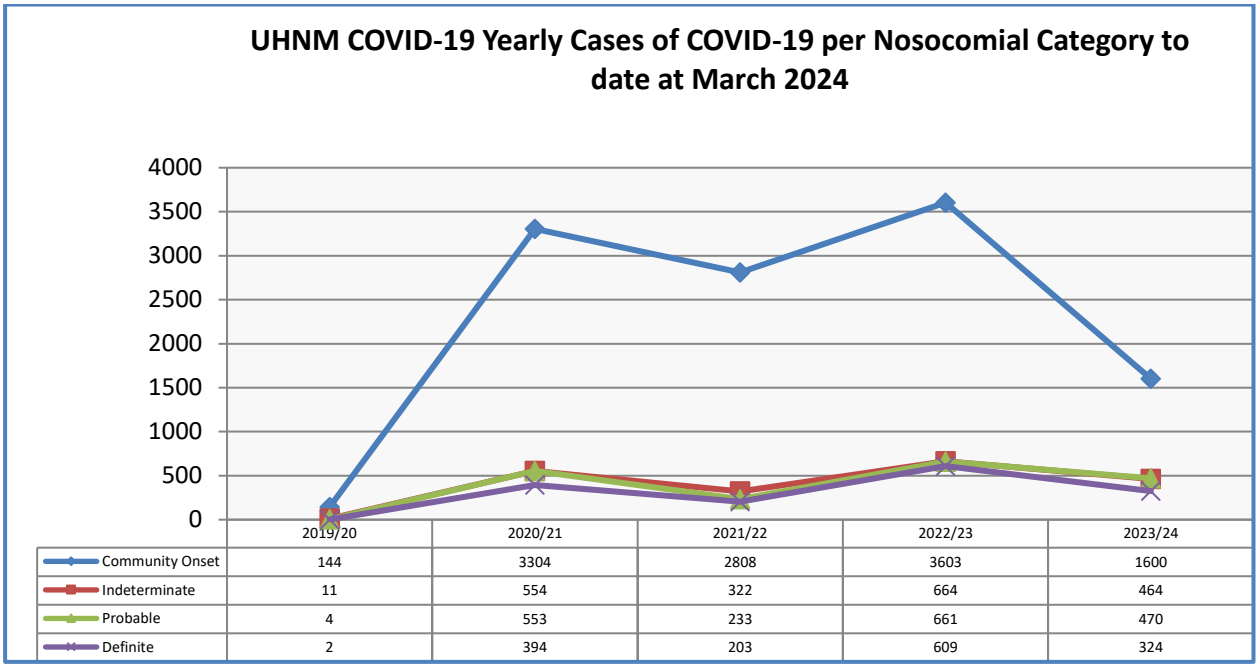


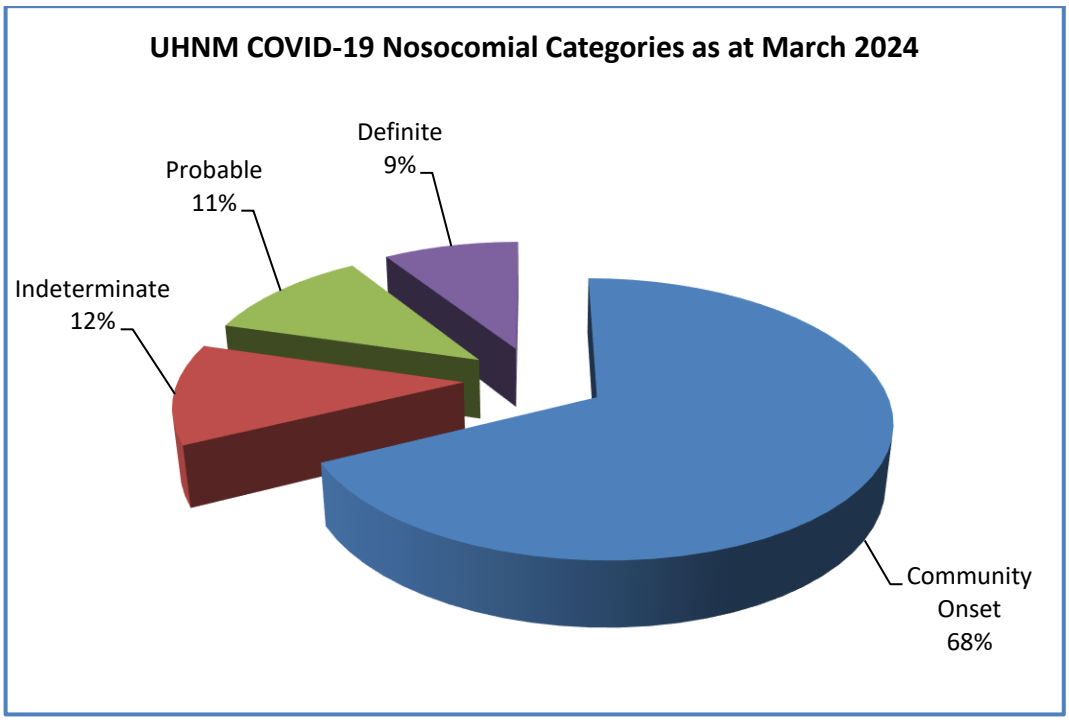
In June 2020 NHS England issued instructions to all NHS Trusts to submit data relating to their nosocomial infection levels of COVID-19.

The 4 categories of apportionment of cases for determining the probability of a case being hospital acquired or not are as follows (N.B: the first day of admission counts as day 1of the admission spell):

- **Community-Onset** – First positive specimen date <=2 days after admission to trust
- Hospital-Onset **Indeterminate** Healthcare-Associated – First positive specimen date 3-7 days after admission to trust
- Hospital-Onset **Probable** Healthcare-Associated – First positive specimen date 8-14 days after admission to trust
- Hospital-Onset **Definite** Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.

The following chart shows the monthly trend within each category of apportionment since March 2020, whereas the second chart shows the overall percentage split of cases within each category for all patients who became hospitalized at the point of confirming being COVID-19 positive.





UHNM has guidance on screening, testing and repeat testing for Covid-19 and interpretation of test results in relation to lifting Infection Prevention (IP) in place. A COVID 19 resource page on the Trust intranet was developed which is updated on a regular basis in line with new or changing guidance from NHSEI and UKHSA.

COVID 19 Outbreaks

At UHNM as soon as a suspected outbreak is triggered an immediate virtual meeting is held with the Chief Nurse/DIPC, Infection Prevention Doctor, Deputy Chief Nurse, Deputy Medical Director and Deputy DIPC who decide the immediate actions required, including whether to close the affected area to new admissions.

These control measures include:

- Isolation of positive patient(s)
- Symptomatic staff cases would be self-isolating, as per policy.
- Terminal clean and barrier cleans.
- Screening of contacts using ILOG number; any discharged patient deemed as a contact is contacted.
- Unannounced IP team visits and refresher training
- Staff screening may be instigated using a separate ILOG and swabbing team with strict staff lists, including medical, nursing, AHP, pharmacy, cleaning and dietetic teams.
- At least twice daily support visits to the outbreak area to provide support.
- Regular updates to the Chief Nurse/DIPC
- Reactive media statement prepared.
- Surveillance continues for 28 days after the last case before the outbreak is closed.

Outbreak meetings are convened with invitations to external colleagues in UKHSA, NHSEI, local authority public health and ICB. These meetings are minuted with actions undertaken reviewed and any additional measures agreed.

UHNM has a weekly clinical advisory group where any new COVID19 guidance is discussed.

A COVID19 swabbing training video is in place to help ensure false negative results are minimised as far as possible due to technique.

Infection Prevention Board Assurance (BAF)

The new IP BAF published 13th September 2023 replaced the original respiratory BAF. This has been aligned with the refreshed Health and Social Care Act 2008: code of practice on the prevention and control of infections and the National Infection Prevention and Contol Manual NIPCM.

This continuous self-assessment process ensures organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

The BAF is a standing agenda item at IPCC and presented to Quality Governance Committee and Trust Board.

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 to ensure that areas are consistently complying with evidence-based practice and policies. Action plans are devised where issues are highlighted and fed back to the IPCC via the Matron for the area.

Routine audits undertaken by the IPT were initially reduced due to and team vacancies, however now we have recruited to the vacancies the audits are now in progress.

The audit tools for general ward areas are designed to ensure relevance 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.
The hand hygiene audit is now available on the Tendable audit system.

Hand hygiene dispenser

SCJohnson

To assist with hand hygiene compliance a Trust wide survey of all the hand hygiene dispensers (gel, soap and moisturiser) was undertaken by the company SCJohnson, looking at both location and state of repair, following on from this a refurbishment of all the dispensers was undertaken across the Trust.

Audits of Hand Hygiene Practice

Hand hygiene remains central to the audit programme.

The Trust continues to focus on:

- 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 prompt staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.

Gloves off Campaign

The COVID 19 pandemic resulted in numerous guidance changes around the use of personal protective equipment over the last few years.

At times gloves were being used for most interactions with patients or the patient's surrounding area.

It is acknowledged that now we have moved to COVID 19 endemic and being part of business as usual, it is time to refresh the correct messaging about when gloves should be worn.

UHNM have implemented the *Take Your Glove Off* campaign developed by NHS England

The aim of the campaign is to remind all healthcare staff when it is appropriate to wear gloves and to inform when gloves are not required.

The campaign has a selection of themes which we used throughout the year.

UHNM communications assisted with the development of short animations for each theme/message chosen.

These were communicated via the intranet and are also available on the Infection Prevention page.

Objectives

- Remind when it is appropriate to wear gloves.
- Explain when and why gloves are not needed.
- To consider sustainability and the impact this has on the environment.

Example of themes

- Gloves are not required when completing patient documentation.
- Removing gloves when making a clean bed/trolley
- If not risk of bodily fluids/patient does not have an infection, then gloves are not required for taking patient observations.

Various education sessions have been held throughout the year where the gloves off campaign was promoted.

- Infection prevention presented at the first conference for clinical staff band 2-4.
- NA induction sessions
- Back to basics – West Buildings
- Hand Hygiene stands.

Staff Information

- COVID 19 intranet page which includes PPE information, posters, guidelines and questions and answers.
- 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.
- 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 role within the UHNM, educational sessions have been delivered throughout the year. These have included: Sepsis, MRSA, CPE, MRSA screening and MRSA decolonisation, influenza, flu and COVID 19 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

Health & Safety Executive (HSE) requirements and NHS England guidance state that it is a requirement that all staff that require to wear an FFP3 to protect them from transmission of infection must be fit tested by a competent Fit Tester on at least two different masks. To meet this requirement the Trust now has an established Team of five dedicated Fit2Fit trained fit testers.

In addition to fit testing, the Team of five undertake training on hand hygiene, PPE and support the gloves off campaign.

Seasonal Staff Influenza Vaccination Campaign and COVID 19 vaccination

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

The campaign launched on 18th September 2023, 6,414 flu vaccinations and 4966 COVID vaccinations were administered during the campaign. Nationally numbers were lower than in previous seasons, it is thought vaccine fatigue has been a factor.

Planning for the 2024-25 seasonal flu vaccination campaign has commenced. The last seasonal flu season (2023/2024) saw both the Influenza vaccine and the COVID-19 booster vaccine given simultaneously, to those who wished to receive both. Like the previous year, due to both vaccines being administered together peer vaccinators were not required in any areas.

All vaccinators were required to complete both Flu and COVID-19 vaccine training/assessments online. We began the campaign on 18th September 2023 with a wealth of information available to staff on the UHNM intranet.

The plans for 2023/2024 season included an on-line booking system which was commenced during the pandemic to aid social distancing. This system worked well so it was continued. This enabled staff to book their vaccine appointment at their convenience.

The Vaccine Steering Group utilising email communications and Microsoft Teams met weekly during the season to discuss planning and implementing the campaign. These meetings were well supported by the Infection Prevention Team, Transformation and PMO teams, Communications, IT, Nursing Directorate and Pharmacy teams. Meetings continued until the close of the campaign in March 2024. The Lead Vaccinator from the IP team would relay all decisions made to the vaccinators. PGDs/ written Instructions for both vaccines and adrenaline were updated, completed, and circulated prior to the commencement of the campaign and as required whenever national changes were made during the season.

The Communications Team is integral to the whole planning process and have a well-rehearsed plan to communicate important messages to staff regarding the influenza vaccine, including myth busting. Facebook was also used to transmit information throughout the campaign.

Like previous years, it was a requirement that we enter all flu and COVID 19 vaccine data to a National Online Database (NIVS) and we continued to go fully digital for both vaccines and remove the need for paper consent forms. This proved to be a remarkable success saving staff time to complete the consent forms.

The COVID19 vaccine campaign concluded on January 31st January 2024 following national guidance. The vaccination team at UHNM started roving service in November 2023 to offer the flu and COVID vaccine. We also found during these times that a number of staff had the flu vaccine outside the trust. The elsewhere forms were used to capture this information. These forms were made known via the communications team and during the roving service and identified staff were asked to complete these forms.
UHNM Potluck donated sweets that could be given to staff after their vaccination.

IP Link Practitioner Scheme

The IPT continued to support the IP Link Practitioner Scheme. 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.

Porters

Porter had also been included in education.

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.

The Infection Prevention Clinical Surveillance Team (CST) are able to support clinicians to ensure that ANTT is embedded into all policies, protocols, guidelines and training upon request. Documents available via the Trust intranet outline the 'ANTT cascade trainer training processes and the ANTT Cascade Trainer 'Role and Responsibilities' document, providing clarity of the role and Trust expectations and assisting managers to allocate the role to an appropriate team member. ANTT Theory sessions are on-going every month via MS teams for staff (both sites). ANTT resources are made available via the IP page of the Trust Intranet.

The Trust's My ESR ANTT theory package was launched in August 2018. Completion of this ANTT Theory ESR update is recommended on an annual basis for all clinical staff but is currently not mandatory. An application for this annual ANTT theory update to be added to the ESR statutory and mandatory training matrix for all staff undertaking clinical procedures has been made, this work is in progress. Annual ANTT practical assessments can be recorded on erostering as a clinical skill by Department Managers.

ANTT update sessions continue for individual clinical areas, as required and to support with any PII, staffing levels permitting.

Through attendance at the Trust Clinical Product Evaluation Group (CEPEG) 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 IP nurses 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 a 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 site and provides a comprehensive 24/7 scheduled and ad-hoc cleaning service.

The Contract Performance Management (CPM) team complete environmental audits for all wards and departments within the retained estate cleaned areas at a frequency dictated by the National Cleaning Standards 2021 which is determined by the functional risk rating of each area. All audits are completely unannounced to ensure that cleanliness standards found are reflective of those found by our patients and visitors and 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 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 approximately 79% of areas at the Royal Stoke site 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 all rooms 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 Contract Performance Management (CPM) team complete environmental audits for all wards and departments within the Sodexo cleaned areas at a frequency dictated by the National Cleaning Standards 2021 which is determined by the functional risk rating of each area. All audits are completely unannounced to ensure that cleanliness standards found are reflective of those found by our patients and visitors and is carried out with representatives from the Retained Cleaning, Clinical and Estates Teams.

In addition to this the CPM Team also provides representation for the Water Safety Group, divisional Infection Prevention meetings, 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 team continue to work closely with Sodexo on-site representatives, 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.
- CPM and FM Team's continue to work closely with the IP team to trial new cleaning and IP innovation on site to help further improvements of cleanliness standards on site.

Divisional Infection Prevention Meetings

Divisional monthly meetings are held between the IPT, PCo, Hard FM and CPM/Sodexo to review infection surveillance data, environmental cleaning scores, provide updates from the statutory and mandatory maintenance programme and discuss any areas of concern. This meeting has representatives from IP, PCo, retained estate, EFP Matron, Sodexo and CPM with representation from both Hard and Soft FM, allowing for a multidisciplinary group to work through IP concerns raised.

County Hospital

Monitoring Processes for Cleaning/Housekeeping Services

The County cleaning service is delivered via an in house retained team and is responsible for cleaning all areas (with exclusion of the original Theatres 1-7) on 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 increased to a 24/7 service. However, following an arranged review by the Executive Team the 24/7 cleaning service at County Site was removed and the housekeeping service reverted to a 6.00am-22.00pm service only as from August 2023.

The County Monitoring Team completes environmental audits in line with The National Standards of Cleaning 2021, all audits are carried out dependent on the dictated frequency ratings for each area. All audits are unannounced with only 20 minutes notice being given to other trust representatives from the Retained Cleaning, Clinical and Estates Teams to attend with the Monitoring Offices, this approach ensures a true reflection of the cleaning standards being provided.

Self-monitoring is completed by the Housekeeping Supervisory Team on a weekly basis to ensure standards are maintained throughout all the retained areas (with the exception of Theatres 1-7). 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.

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 are met.

National Standards of Healthcare Cleanliness 2021 Implementation

The National Standards of Cleanliness 2021 was successfully implemented on 1st June 2023 for all clinical and non-clinical areas at RSUH site. This has been well received by all teams and has helped to highlight where additional support and focus is required to ensure that the cleanliness standards found by both our patients, staff and visitors are as they should be. Display boards are in all public locations displaying star ratings and commitment to cleanliness charters along with any improvement plans required.

PLACE Inspection

The annual PLACE inspection took place in Oct/Nov 2023 with results published in February 2024 for all Trusts. Our patient assessors were welcomed back to our County and Royal Stoke sites over a series of inspection dates during October and November 2023 to visually inspect our hospital environment. The inspection team assessed how the environment supports the provision of clinical care, inspecting things such as cleanliness, food, general building maintenance, privacy and dignity and the specific needs of our patients with dementia, or with a disability.

UHNM have achieved excellent scores that are above the national average across all domains. These scores recognise that good environments and services that respond to the needs of our patients really do matter.

The table below outlines the site scores for Royal Stoke University Hospital and County Hospital plus the overall UHNM Trust organisation score alongside the national average for 2023.

UHNM achieved above the national average for all domains.

PLACE Scores 2023: -

Site Name	CLEANING Score %	FOOD Score %	Organisation Food %	Ward Food %	PRIVACY, DIGNITY & WELLBEING Score %	CONDITION & MAINTENANCE Score %	DEMENTIA Score %	DISABILITY Score %
THE ROYAL STOKE UNIVERSITY HOSPITAL	99.98%	95.34%	93.40%	95.86%	91.47%	99.89%	89.52%	92.72%
THE COUNTY HOSPITAL	100%	95.97%	94.10%	97.22%	93.24%	99.56%	92.15%	92.35%
UHNM TRUST SCORE	99.98%	95.43%	93.50%	96.04%	91.71%	99.85%	89.88%	92.67%
NATIONAL AVERAGE	98.10%	90.86%	N/A	N/A	87.49%	95.91%	82.54%	84.25%

An action plan has been compiled and will be worked through by a multidisciplinary group linking into the Trusts Values, Safe, Improving and Together.

Terminal Cleans

All emergency portals undergo a deep clean on a six-monthly basis in addition to their scheduled cleans, with terminal cleans being requested as required within the scheduled periods.

All terminal clean requests required within working hours are requested via the Trust Infection Prevention team. Requests for terminal cleans outside of these hours are requested via the Site Matron and are compare able to request and authorise their own terminal cleans to help with the flow through these 2 key areas. During busy times, priority for cleans are decided by

the site teams, to ensure that resources are directed to the area needed most urgently again to ensure patient flow through both RSUH and County Sites are not affected.

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

Food Safety

The CPM, Sodexo and Retained Estates teams continue to complete regular kitchen inspections on the Royal Stoke site and ensure that any issues highlighted are addressed quickly. Environmental/IP ward audits are also reviewed by the CPM team and the appropriate actions taken to rectify and monitor any food safety issues raised. Regular meal monitoring sessions are completed by Sodexo/CPM and Retained Estates teams were all aspects of the patient meal service are observed to ensure that all food service standards/guidelines are being adhered too.

Any emerging issues are discussed at the fortnightly Sodexo Operational Meetings the monthly Performance Meetings, the monthly Dieticians Meeting and with the Food Standards Group.

The Food Standards group are currently working on the implementation of the National Healthcare Standards for Food and Drink and have completed a GAP analysis exercise, along with a Food and Drink Matrix Score Sheet. The new standards relate to all aspects of healthcare food and drink including the provision of patient food and drink as well as retail and staff and visitor requirements. Sustainability, procurement and food waste is also featured in the new standards.

Food Hygiene Inspection Royal Stoke University Hospital Food hygiene inspections at RSUH were carried out by Stoke on Trent City Council Environmental Health Officer, Public Protection Division in January and March 2024 in the Sodexo main kitchen the ED Costa and all Retained Estates areas which resulted in the Royal Stoke Hospital Site being awarded five stars for all areas reviewed under the national food hygiene rating scheme.

Food Safety Training
All Retained Estates staff that handle food receive level 2 Food Safety training every 3 years, which is arranged by the Facilities Management team. Level 3 Food Safety is also obtained and renewed every 3 years for all staff from Supervisory level to and including the Facilities Manager.

Food Hygiene Inspection County Hospital
The food hygiene inspection at County Hospital undertaken by Stafford Borough Council's Environmental Health Inspectors in September 2023 has seen the sites Restaurant and Kitchen retain its five-star award under the national food hygiene rating scheme.

For the sixth 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 outlined by the Food Standards Agency. Members of the public can find how compliant a food business is with legislation through the following link University Hospitals of North Midlands NHS Trust | Rating Business Details | Food Standards Agency . On the website, food businesses are rated through a star award system with five stars being the maximum achievement. On the link provided above, the following three core subjects have been assessed through the inspection process. The outline below includes the narrative and overall standards found within each field:

Area inspected by food safety officer	Standards Found
Hygienic food handling - Hygienic handling of food including preparation, cooking, re-heating, cooling and storage	Good
Cleanliness and condition of facilities and building - Cleanliness and condition of facilities and building (including having appropriate layout, ventilation, hand washing facilities and pest control) to enable good food hygiene	Good
Management of food safety - System or checks in place to ensure that food sold or served is safe to eat, evidence that staff know about food safety, and the food safety officer has confidence that standards will be maintained in future	Very Good

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.

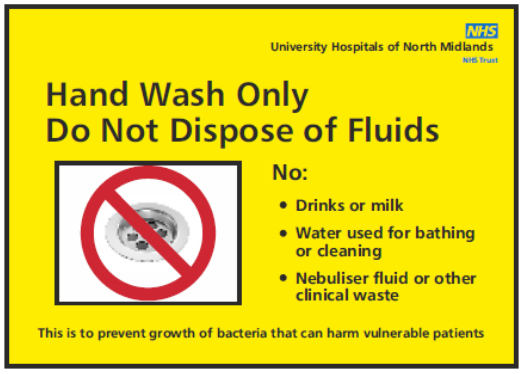
Waste Projects
The close involvement of Infection Prevention has been crucial to the continued success of waste management projects.

A waste management policy remains in place having been devised to detail the specifics around handling infectious waste, 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.

Sinks

The IPT continued to work closely with Estates and Facilities to ensure hand wash sinks are cleaned appropriately and also ensuring no other fluids were disposed down them by the continued roll out of the hand wash only signs in all areas.



In addition, a learning alert was created and communicated across the Trust, emphasizing the correct use of hand wash sinks and the importance of not disposing of any inappropriate items down the drains.

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 UKHSA in England.

UHNM, as are all cardiac surgery centres, continue to work closely with the UKHSA and the MHRA on the initiative with regular updates provided at the IPCC. All required control measures were instigated following the initial MDA alert in 2015 and continue in place together with surveillance for any potential infections. Regular updates are presented at the IPCC and Water Safety Group around the regular decontamination and sampling processes for the machines, as per manufacturer's instruction. No Mycobacterium chimaera has been identified with the machines at UHNM.

Refurbishment and new Build Projects

The IPT worked closely with the Capital Team and Estates providing advice on a number of planned programme of maintenance, refurbishment and new build projects throughout the Trust, including – at the Royal: Multistorey carpark, Acute Medicine Rapid Assessment Unit, Holistic Care Unit – at the County: New Modular Theatre, Breast Care Unit, and Day Ward. Some of which continue into 24/25 financial year. Advice was also given on the reconfiguration of a number of clinical and non-clinical areas.

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 is 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, Sepsis Specialist Nurse, and a Senior Nursing Assistant. The main aim of the team is to achieve the sepsis CQUIN compliance target, by ensuring that our patients are always safe, 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: However, some elements will change significantly once our trust is ready to implement the new NICE sepsis guidelines.

- All patients with a National Early Warning Score (NEWS2) of five or greater (or three in a single parameter) and when patient looks unwell or when there's a clinical concern, 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 must be reviewed within 24 to 72 hours.

Challenges

The new sepsis module in VitalPacs upgrade June 2022 was a great success and currently we are aiming for the Emergency Department for this year to be included and updated. Although more work required to be done in regards of sepsis vitals enhancement, IVAB treatment and management for adults with sepsis triggers.

Our trust sepsis clinical lead and team is aiming and working towards adopting the new NICE sepsis guidelines released in January 2024. However, as the new NICE guidelines is markedly different to the previous NICE sepsis guidelines, we needed our vitals system to be upgraded. Unfortunately, this is not an easy fix as the system C provider will be unable to update the sepsis module of January 2024 sepsis guidelines until 2025.However, in the next few months, the sepsis team will gradually commence strategic plan on implementing and rolling out education/training trust wide prior to the availability of the new sepsis guidelines module next year.

The antibiotic administration and compliance will be based on risk categories for high risk (to achieve within one hour of recognition), moderate risk (sepsis antimicrobials should be administered within 3 hours until bloods and investigation are available to make an informed decision and low risk-very low risk (continue with standard observation).

Furthermore, the advantage of the new Sepsis guidelines is the focus on risk ratification, clinical review, and rational judgement by the clinicians. It is anticipated to improve and promote best clinical practice such as antibiotic stewardship, decrease antibiotic resistance and associated costs as well as quality patient care through early clinical review and stratification.

As the pandemic has eased our training program has adapted to being able to train without the restriction and most of the time, we are able to provide training through face to face. Although there remain many challenges such as flow capacity, the use of corridors, staffing levels, and holding of ambulances. The sepsis team have continued the following.

- A training program comprising of ad hoc, planned training sessions, sepsis kiosks, sepsis champion day, out of hours training and bank staff training is ongoing and will continue as required.
- Areas of lower compliance identified through the audit process are prioritised to receive immediate training and support.
- Working closely with quality nurses, senior team, and sepsis champions to ensure staff requiring additional support are identified and ultimately ensuring screening and IVAB within hour treatment will be achieved.

Initiative and Awareness

- The Sepsis Team continued the Sepsis Awareness Campaign taking place during on World Sepsis Day each year on September 13th, since 2017 up to present.
- Trust wide awareness to include sepsis awareness notice boards, sepsis symptom cards, flyers, sepsis red flags cards, patient leaflets, and sepsis screening/IVAB compliance reminder cards.
- Our own sepsis pen as an additional visual awareness aid.
- Community awareness and on-going collaborative work with UHNM charity by organising a sepsis fundraising event each year.

Training

- On-going training plan to Identify Sepsis Champions (staff nurses/nursing assistant/ in house doctors/ANP) in each clinical area/divisions and planning Sepsis Champion Day (5 hours CPD) training that includes workshops & simulation learning for 2023-2024.
- Supporting and delivering sepsis sessions as part of Induction programme for Nursing assistants, new nursing staff and doctors in the trust.
- Sepsis kiosks, sepsis reinforcement and face to face and adhoc training provided to all clinical areas when required.
- Online training resource via ESR for staff nurses/doctors and other clinical staff is available, this will be updated once the new NICE sepsis guidelines is adopted.
- Supporting the upcoming introduction of electronic VitalPacs (NEWS2) to A&E at both sites with additional training and awareness once updated version become available.
- Recognition of significant contributions and improvements in sepsis management by rewarding specific clinical areas and individual staff with certificates.

collaborative Working

- Regular Strategic Sepsis & Antimicrobial Group meetings, Deteriorating Patient Steering Group and Sepsis Team meetings put in place, to work optimally and collaboratively.
- Contributing to Trust Divisional IP meetings, supporting, and providing regular sepsis compliance update to be able to help drive for compliance.
- The Sepsis Team has put robust actions in place and is working closely with frontline staff, multi-disciplinary & senior teams, and medical staff to have a maximum effect on the achievement of the Trust's sepsis contract.

Sepsis Team Achievement

The Sepsis CQUIN/ Contract compliance achievement throughout the year of 2023 to 2024 in our emergency department has proved to be a challenged. However, the Sepsis Team remain optimistic that our objective to maintain, sustain and embed best practice will continue. Our priority will remain to focus on providing education, promote sepsis awareness and campaign across the trust. The sepsis team will continue to work closely with frontline staff, multi-disciplinary, senior teams, and medical staff to have a maximum effect on the achievement of the Trust's sepsis CQUIN/ contract. The support and hard work of all the front-line staff/senior team/divisions in the Trust is vital to protect patients from deadly conditions and ensure that they are safe at all times.

world Sepsis Day 2023
(Board competition, excellence awards and sepsis walk awareness)

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 the Lead Consultant Microbiologist, 1 FTE Advanced Pharmacist Practitioner (APP), 0.6 FTE Antimicrobial Nurse (AMN), 1 FTE Advanced Specialist Pharmacist (ASP), 0.5 FTE Rotational Pharmacist (RP) and 1 FTE Lead Pharmacy Technician for AMS and Outpatient Parenteral Antibiotic Service (OPAT). The team hope to have input into future business case development for OPAT expansion to support pharmacy input into this key MDT. In the last 12 months the team has expanded with an additional ASP – AMS and Crit care joining.

The pharmacists and technician provide clinical support to the infectious diseases ward as well as supporting the Trust AMS agenda through CQUIN and Core Contract AMR work streams and attendance at the ASG. The team is also supported on an ad hoc basis by a Pharmacy data analyst and clinical information technician as required to support the compiling of reports for submission to UKHSA and NHSEI, and the compilation of other antimicrobial data on a regular 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 and relationships with key stakeholders to drive forward good antimicrobial stewardship and promote awareness of the global rise in antibiotic resistance. The team work closely with regional colleagues and regularly participate in national AMR initiatives.

The AMS team at UHNM has continued to build on the foundations put in place over the last few years. The 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. Regular audits measure compliance with this policy, with an escalation process in place for clinical specialities that require support to achieve compliance.
- Regular ward rounds and audits in line with ‘Start Smart then Focus’ have been in place across the Trust for a number of years. The results are shared via the bi-monthly ‘AMS Newsletter’ which is available on the Trust Intranet. Antimicrobial consumption and prescribing 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 action plans 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 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 COVID-19 and has incorporated support to clinicians with the ratification of rapid response in-house guidelines driven by new and emerging evidence for therapies. The team are currently reviewing all antimicrobial guidelines and will present changes to the next ASG meeting for ratification.

- 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. An increasing number of links to national guidelines are embedded to facilitate timely access by prescribers to evidence-based resources.
- 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.
    - A session covering therapeutic drug monitoring for high-risk antimicrobials is provided by the APP to year 5 Keele medical students.
        - In addition to pharmacist awareness sessions, ad hoc sessions on AMS, gentamicin and vancomycin are provided for nursing staff, advertised via Trust Comms
        - In the last 12 months the team have introduced AMS cards as an aide-memoire to support nursing staff in practice and which are available to order by wards
    - 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 despite significant operational and capacity challenges at times due to the pandemic:
    - A rolling programme of antimicrobial sessions for newly qualified nursing staff.
    - Targeted ad hoc sessions for Specialities/Wards. These are routinely based on analysis of local monthly antimicrobial consumption data to support antimicrobial review and optimising prescribing.
    - 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.
- Support for all Infection Prevention, Periods if increased incidence or outbreak review meetings and attendance at (and provision of data & advice to) any other ad hoc meetings requiring ASG input.

There are 5 Consultant Microbiologists (one post is covered by a locum) and 3.0 WTE Consultant Physicians in Infectious Diseases, who provide antimicrobial stewardship support by telephone and face-to-face on ward rounds and during teaching sessions in addition to their substantive posts. 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 is 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. As part of the response to the COVID-19 pandemic, Micro ward rounds were suspended but these are now re-starting in a phased manner to replace virtual rounds held during the pandemic.

The AMS team also provides input into the OPAT, *Clostridioides difficile*, Infective Endocarditis, Sacral ulcer MDT, Bone infection and Spinal MDTs. Recently attendance by the antifungal stewardship pharmacist has been introduced for the haematology / oncology MDT to support stewardship here.
The ASG, Microbiology and Pharmacy Departments work collaboratively to ensure that alternative agents are available for patients if first line antimicrobials become unobtainable.

Collaboration with colleagues across the health system locally (Stoke and Staffordshire ICS) continued and the APP worked as a key member of the CMDU planning and delivery of the COVID-19 therapeutics for patients in the community.

Work with AMS colleagues across the Midlands continued despite the pandemic and the APP is Chair of the West Midlands Chief Pharmacist AMS group and also a member of the Midlands regional Antimicrobial Optimisation Committee chaired by the NHSEI Regional lead.

In Year Initiatives:
The team have been concentrating on initiatives that had to be postponed during the pandemic. Rejuvenated AMS ward rounds at County and Stoke with AMN/specialist pharmacist ward rounds in high consumption areas have been re-introduced where capacity allowed. Links with specialist ward teams have increased pro-stewardship activity.

Support for European Antimicrobial Awareness Day was provided virtually and with the support of the Trust social media team. The UHNM AMS mascot, Bugsy McBugface, visited ward areas as part of a Twitter campaign and distributed lanyard AMS reminder cards to ward teams.

In line with National aspirations to increase the number of Consultant Pharmacist posts in acute Trusts, the UHNM AST are currently reviewing the credentialing process for post approval with the Royal Pharmaceutical Society and the APP is similarly undertaking credentialing as a prospective Consultant Pharmacist in Antimicrobial Stewardship.

The Advanced Pharmacist Practitioner – ID & Antimicrobials prepares updates for the bi-monthly IPCC meetings, and these form the basis for a similar submission as part of the IPC annual report to the Trust board.
This report outlines progress against NHSE and UKHSA targets such as CQUINs and Core Contract elements relating to AMS activities. The report also details supporting activities around AMS such as monitoring antimicrobial consumption, changes to AM guidelines, support for external events such as WAAW and EAAD and any other themes relating to the UK AMR National Action Plan.

NHS E Antimicrobial CQUINs 2023/24

A new IV to Oral switch CQUIN was introduced for 23/24. This required the AMS team to undertake a widespread programme of engagement activities and educational sessions. These included a 'Grand Round' lecture, targeted training in specific clinical areas, drop-in sessions for various professional groups and support material in the intranet and the Microguide.

CQUIN04: Prompt switching of intravenous to oral antibiotic

Description	Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.	
Numerator	Of the denominator, those who, at the point of audit, have already met the criteria for switching from IV to oral administration of antibiotics	
Denominator	Total number of adult inpatients (16+) with active prescriptions for IV antibiotics at the point of audit (sample size 100 patients per quarter)	
Exclusions	• Patients in ICU and HDU • Patients treated with intravenous antifungals or antivirals	
Data reporting and performance	Quarterly submission via e-mail to UKHSA. Refer to the AMR Programme Workspace in FutureNHS (link below) for details about auditing, data collection and reporting. Performance basis: Quarterly.	
Scope	Services: Acute, specialised acute	Period: All quarters
Payment basis	Minimum: 60% Maximum: 40% **Please note that for this indicator, a LOWER % = better performance**	Calculation: Quarterly average %
Lead contact	Kieran Hand england.amrprescribingworkstream@nhs.net	

Both the CQUIN and core contract targets were met for 2023/2024.

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 education
- Flu vaccination campaign.
- COVID-19 information and Posters.
- COVID 19 intranet and internet information.
- FFP3 mask and PPE information.
- Infection Prevention campaigns
- Gloves off Campaign

Trust Website and Information Leaflets

The Trust website promotes infection prevention issues and to guide people to performance information on COVID 19, MRSA, Clostridium *difficile* and other organisms.

These leaflets have been refreshed during 23/24.

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 works 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.

COVID 19 alert

The IP team continue to apply COVID19 contact tags in Careflow/iPortal as required and in ICNet. There is also an iPortal clinical note that can be added by Preams for patients assessed to have been COVID19 positive in the community in the 90 days prior to planned admission. This facilitates early identification and placement of contacts who are re admitted to the Trust.

Surgical Site Infection Surveillance (SSIS)

- UHNM participates in the UKHSA national surgical site surveillance programme.
- Hospitals can choose to undertake surveillance for one or more of 17 defined categories of surgical procedures. Orthopaedic SSIS for one quarter has been mandatory since April 2004.

The period of surveillance depends on whether the operation involves the insertion of a prosthetic implant. If the surgery does **not** include insertion of a prosthetic implant, surveillance for SSI is discontinued on the 30th day after the operation. For surgery where a prosthetic implant is inserted into the surgical site, then surveillance for SSI continues for 1 year after the operation.

- ICNet alerts are applied by the Infection Prevention Clinical Surveillance team (CST) and used to alert the IP team of readmission data and of any relevant specimens sent, for the duration of the surveillance period.
- UHNM is compliant with national and local commissioning requirements across both sites.

- 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.

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 to notify when 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).

The SSIS schedule for the year 2023-2024 was as below:

SSI SURVEILLANCE 2023-24		
QUARTER	**PERIOD**	**SURVEILLANCE**
		Royal/County
1	Qtr 1 - Apr – Jun	Paused IP staff vacancies
2	Qtr 2 - Jul – Sep	Paused IP staff vacancies
3	Qtr 3 - Oct – Dec	Paused IP staff vacancies
4	Qtr 4 - Jan – Mar	Knee Replacement Surgeries

SSI Surveillance for Qtr 4 on knee replacement surgeries has ended. 126 cases were included in the surveillance. Data reconciliation is under process for submission; however, no infections have been reported to date.

The proposed SSIS schedule for the year 2024-2025 is as below:

SSI SURVEILLANCE 2023-24		
QUARTER	**PERIOD**	**SURVEILLANCE**
		Royal/County
1	Qtr 1 - Apr – Jun	Coronary Artery Bypass Graft
2	Qtr 2 - Jul – Sep	Hip replacement
3	Qtr 3 - Oct – Dec	Abdominal Hysterectomy
4	Qtr 4 - Jan – Mar	Cranial Surgery

Managing Outbreaks of Infection - Responses to Incidents and Outbreaks

The IPT are involved in the management of outbreaks, periods of increased incidence and incidents.

CPE Outbreak

The Nephrology ward at RSUH undertake routine admission and weekly MRSA & CPE screening of all inpatients.

On 1st October 2023 a patient was identified with Klebsiella Oxytoca Oxa 48, over the course of the next few weeks 17 other patients were identified with the same organism. All the typing results were identified as PFGE-STOKPL-10. All cases were colonisations, with no clinical cases and no patient harm. The last case was identified on 30th November 2023.

A number of control measures were instigated immediately, and independent unannounced audits undertaken. There outbreak meetings were held with representatives from the ICB, NHSe and UKHSA present. All measures will remain in place.

The ward undertook Hydrogen peroxide vaporiser (HPV) cleaning, no further cases have been identified and the outbreak was reviewed 3 months after the last case.

Surveillance remains in place.

Norovirus

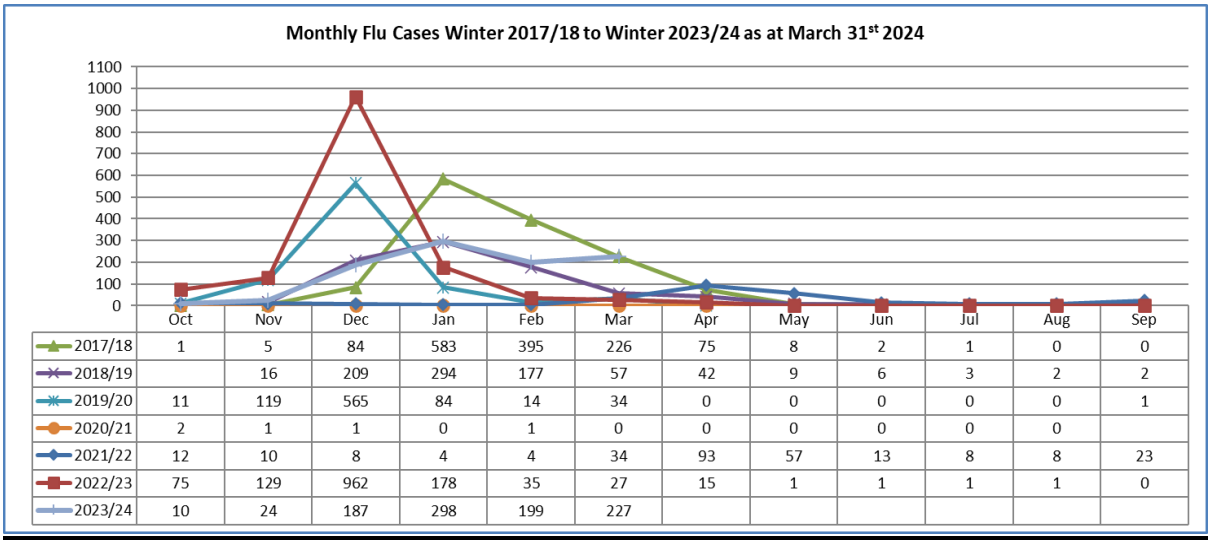
It was reported that there were very low levels of norovirus circulating in the community. There were 2 whole wards areas closed due to confirmed Norovirus in 2023/2024

Seasonal Influenza

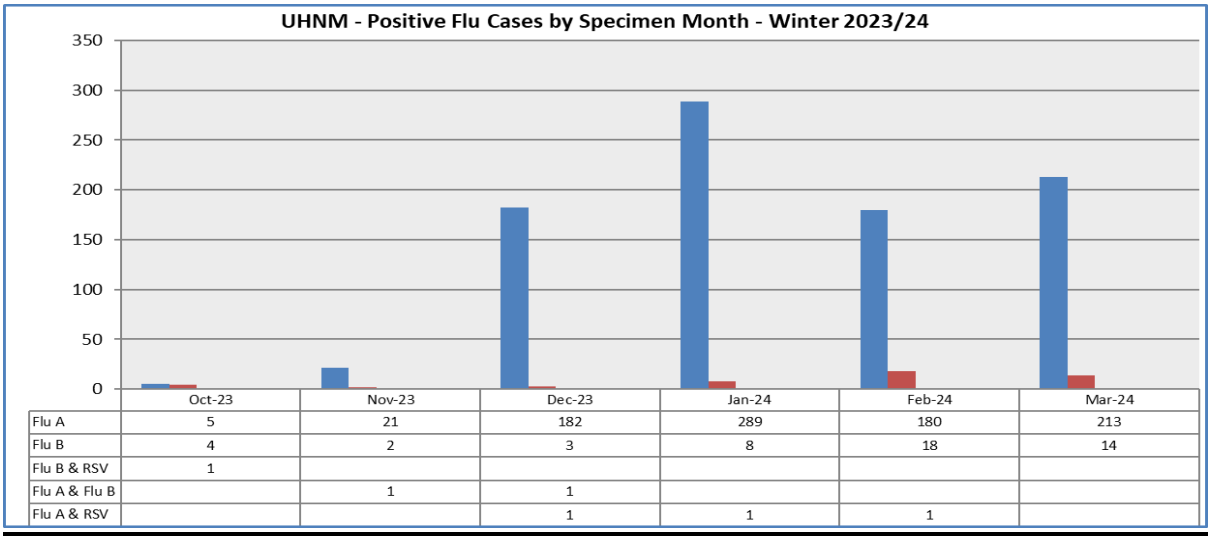
As will be seen from the graphs below UHNM have seen a major increase in patients compared to previous years with confirmed influenza, mainly Influenza A. with 966 cases reported in December alone.

For each case immediate control measures were instituted, following the latest UKHSA guidance, including the use of antivirals.

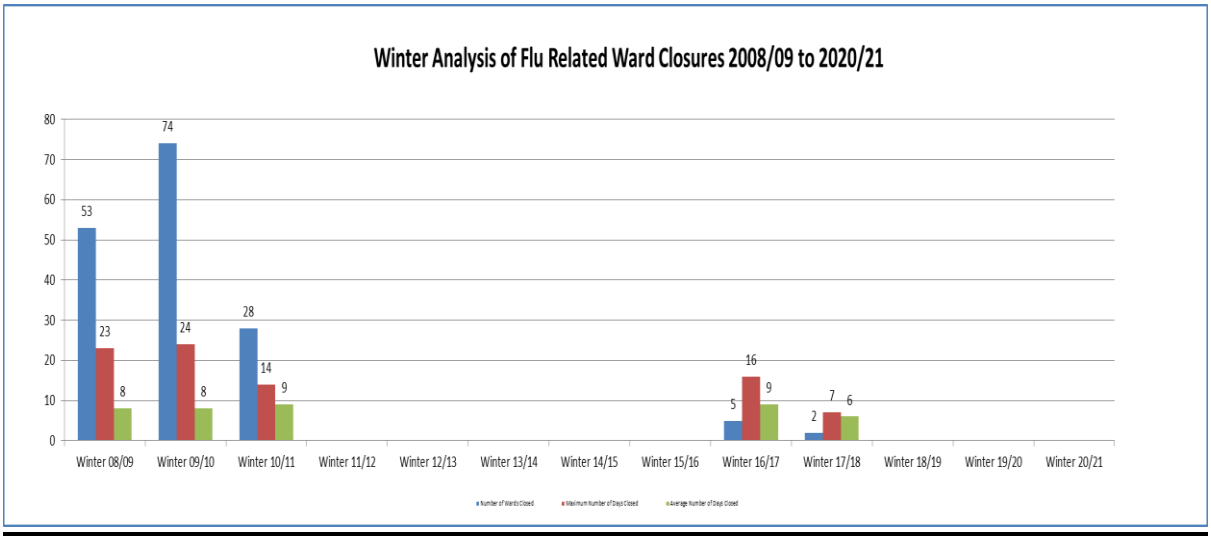
There were no whole ward closures due to influenza.

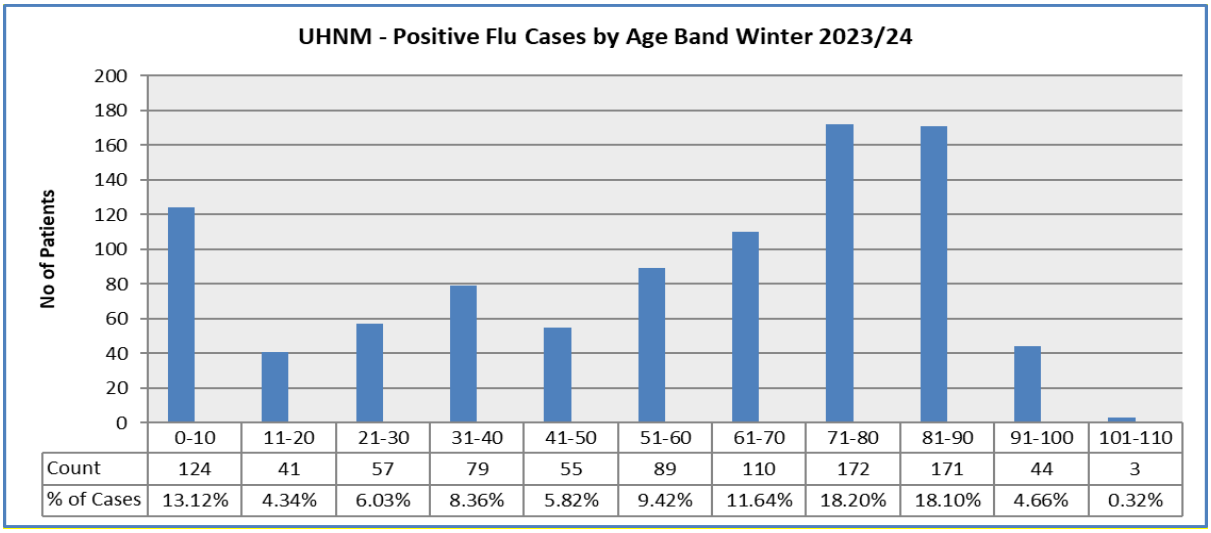


	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2017/18	1	5	84	583	395	226	75	8	2	1	0	0
2018/19		16	209	294	177	57	42	9	6	3	2	2
2019/20	11	119	565	84	14	34	0	0	0	0	0	1
2020/21	2	1	1	0	1	0	0	0	0	0	0	
2021/22	12	10	8	4	4	34	93	57	13	8	8	23
2022/23	75	129	962	178	35	27	15	1	1	1	1	0
2023/24	10	24	187	298	199	227						



	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Flu A	5	21	182	289	180	213
Flu B	4	2	3	8	18	14
Flu B & RSV	1					
Flu A & Flu B		1	1			
Flu A & RSV			1	1	1	





	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	101-110
Count	124	41	57	79	55	89	110	172	171	44	3
% of Cases	13.12%	4.34%	6.03%	8.36%	5.82%	9.42%	11.64%	18.20%	18.10%	4.66%	0.32%

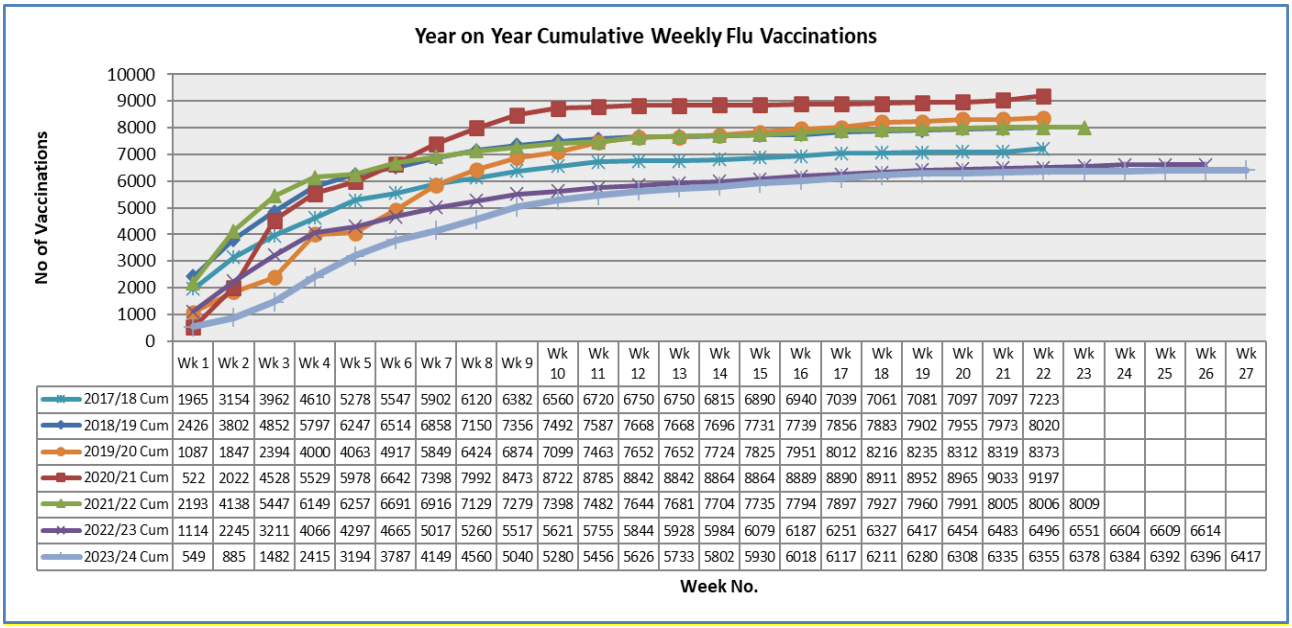
Compliance Criteria 6:

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 Optima Health

Seasonal Staff Influenza Vaccination Campaign
Refer to page 30 of this report.



	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	Wk 23	Wk 24	Wk 25	Wk 26	Wk 27
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					
2020/21 Cum	522	2022	4528	5529	5978	6642	7398	7992	8473	8722	8785	8842	8842	8864	8864	8889	8890	8911	8952	8965	9033	9197					
2021/22 Cum	2193	4138	5447	6149	6257	6691	6916	7129	7279	7398	7482	7644	7681	7704	7735	7794	7897	7927	7960	7991	8005	8006	8009				
2022/23 Cum	1114	2245	3211	4066	4297	4665	5017	5260	5517	5621	5755	5844	5928	5984	6079	6187	6251	6327	6417	6454	6483	6496	6551	6604	6609	6614	
2023/24 Cum	549	885	1482	2415	3194	3787	4149	4560	5040	5280	5456	5626	5733	5802	5930	6018	6117	6211	6280	6308	6335	6355	6378	6384	6392	6396	6417

Compliance Criteria 7:

Provide or secure adequate isolation facilities.

Royal Stoke Hospital

Single Bedrooms & En Suites

Trent Building

	No. of Single Rooms	No. of En Suites
Ward 120 Neurology	3	0
Ward 121 Diabetes & Endocrinology	3	0
Ward 122 General Medicine	3	0
Ward 123 Escalation Ward	3	0
Ward 124 Renal unit	16	16
Ward 126 Respiratory	4 Pods / 1 Side Room	0
Ward 127 Acute Stroke Unit	8 Pods	0

Lyme Building

	No. of Single Rooms	No. of En Suites
SSCU	2	0
Ward 100/101 DATAU	7	4
Ward 102/103 Emergency Surgery	Ward 102: 4 Ward 103: 4	Ward 102: 2 Ward 103: 2
Ward 104 SAU	5	2
Ward 105 SACU	4	1
Ward 106/107 Urology & Gynaecology	3	2
Ward 108/109 Surgical Elective Unit.	Ward 108: 4 Ward 109: 4	Ward 108: 2 Ward 109: 2
Ward 110 Vascular	12	12

Ward 111 Specialised Surgery	12	12
Ward 112 Elective Orthopaedics	10	10
Ward 113 Respiratory	12	12

Maternity Centre

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

Cancer Centre

	No. of Single Rooms	No. of En Suites
Oncology Day Unit	5	5
Ward 201 Haematology & Oncology Inpatients	20 3 Assessment Bed	20 3

West Building

	No. of Single Rooms	No. of En Suites
Ward 75 Winter Pressures/ Vaccination	Ward closed	
Ward 78/79 Older Adults Unit	Ward 78: 4 Ward 79: 4	Ward 78: 1 Ward 79: 1
Ward 80/81 Elderly Care	Ward 80: 2 Ward 81: 2	Ward 80: 0 Ward 81: 0
Ward 76a Elderly Care	3	1
Ward 76b Elderly Care	3 4 Pods	1 0

Main Building

	No. of Single Rooms	No. of En Suites
CDU	NA	NA
215 A High Independency Unit	6	6
216 Children Assessment Unit	8	8
217 Children's Surgery	13	13
217B Oncology Day Care	4	4
218 Children Medicine	12	11
CCU Cardiology	3	0
220 Cardiology	14	13
221 Cardiology	10	10
222 Respiratory NIV	10	10
223 Cardio Thoracic Surgery	17	17
225 Specialised #NOF	17	16
226 Trauma Orthopaedics	11	10
227 ARTU	11	10
228 Neurosurgery	15	15
230 Gastroenterology	17	16
231 AMU	11	10
232 AMU	11	10
233 SSU	7	6

233 AMRAU	10	10

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 room 8
Pod 2	Side room 16
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 1
Pod 2	Side room 15
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)
Pod 1	Side room 1

Side rooms within Critical Care	
Protective isolation room (with gowning lobby, side room. Positive pressure turned off)	
Pod 5	Side room 34

County Hospital

Ward	No. of Single Rooms	Toilet	Shower
Elective Trauma and Orthopaedic Ward	13	13	13
Ward 12 Respiratory	12	12	12
Ward 14 Diabetes & Endocrinology	12	12	12
Ward 15 Elderly Care	12	12	12
Ward 7 CLOSED FOR REFURBISHMENT	4	3	0
AAU	4	1	1
AMU	3	3	0
Critical Care Unit	0	0	0
ED Major	6	0	0
ED Resus	3	0	0
ED Ambulance Triage Corridor	3	0	0
ED Ambulatory	8	0	0
Chemotherapy Unit	6	3	0
Ward 1 (ward 7) General Medicine	4	3	0
Medical Receiving Unit	4	0	0
Ward 8 Choices	3	3	1

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.

The COVID 19 Trust guidance was regularly updated in line with UKHSA COVID 19 guidance.

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

Numerous Webinars and external conferences were held throughout the year which IP Team attended.
IP Senior Teams attended IPC Acute trusts Leads Forum held by NSHEi.
Various water safety, ventilation and mask fit, and decontamination webinars were attended throughout the year.

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.

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 Gram-negative Bacteria. 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:

- Continuing threat respiratory viruses such as Avian influenza
- National rise in measles cases
- Pertussis cases
- Continuing and developing FFP3 mask resiliency.
- Reduction of Gram-negative blood stream infections
- 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, childhood diseases such as measles and working closely with the Emergency Planning Team.

Appendix 1 Annual Programme of Works 2024-2025

Infection Prevention Programme of Works for the period April 2024 March 2025
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 2024 – 31 March 2025. 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 2022) 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 ICB – Integrated Care Board 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.	DIPC	Quarter 1-4
	• Unforeseen issues impacting upon progress of the annual programme.	Deputy DIPC	Bimonthly
	• 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 ICB	Deputy DIPC	As required
	Infection Prevention Nurse to attend Trust Antimicrobial Stewardship Group	Lead Nurse Infection Prevention	Bimonthly
	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 and IP BAF to QGC and Trust Board	Deputy DIPC	Quarterly/Monthly
	Ensure that monthly data summaries, incidents and outbreaks are included in the Quality and Safety reports.	Deputy DIPC	Monthly
	Deputy DIPC meeting with ICB 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 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 investigation process.	IPT	Within 24 hours
	Prepare outbreak summary reports and submit to IPCC, Quality Governance Committee 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 Quality and Safety Oversight Group	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 Quality and Safety Oversight Group bi monthly.	Clinical Surveillance Team IP	Bi-Monthly
	IPT to attend and provide specialist advice: • Infection Prevention Divisional meetings • Vaccination planning group • Sepsis planning meetings Strategic and antimicrobial group	IPN Deputy DIPC Deputy DIPC	Bi -Monthly Three times per year Bi monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	• Trust Antimicrobial Group	IP Lead	Bi -Monthly
	• Quality and Safety Oversight Group	Deputy DIPC/ Lead	Monthly
	• Quality Governance Committee	Deputy DIPC/ Lead	Quarterly
	• CQRM	Deputy DIPC	Monthly report
	• Health & Safety Committee	Lead	Bi- Monthly
	• ICB Infection Prevention Group	Deputy DIPC /Lead	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
	• Clostridium *difficile* Task and Finish Group	IP Lead	Bi Monthly
	• Stoke on Trent Health Protection Board	Deputy DIPC	

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 • Water Safety Group • Environmental Health Food Hygiene Inspections • Refurbishment and Building Meetings • Infection Prevention Cleaning Services (Soft FM) • Decontamination Group • Clinical Equipment Product Evaluation Group (CEPEG) and TPEG	 IPT Deputy DIPC/IP Decontamination IPT IPT/Service Development Team IPT/Service Development Team IPT/Service Development Team IPT/Service Development Team	 Monthly Quarterly Annually As required Monthly Monthly Monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Re refresh Pooh help line sampling CDI training video	IP C.*difficile* Nurse IP C.*difficile* Nurse	Quarter 1 Quarter 2
	Quality Improvement Audits IPN to conduct period of increased incidence (PII) audits when PII is identified. Feedback to ward, Matron and Divisions. IPN to conduct Clostridium *difficile* audit following each hospital acquired case IPN's will undertake a programme of unannounced audits in clinical areas, including hand hygiene audits/ATP/ spot checks Audit tools and programme in place for Divisions/areas to monitor environment. IPN's to support service leads, Matron and Ward Sisters/Charge Nurse National Cleaning Standards audit programme in place - feedback bi -monthly at IPCC	 IPN IPN IPN/Hand Hygiene Trainer Associate Chief Nurses/Matrons/ Ward Sister/Charge Nurse Facilities Manager	 As required As required As required Weekly/Monthly/ Quarterly 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
		Microbiologist	Quarters 1-4
	The IP and Antimicrobial Team work closely together re CQUIN	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	DIPC IPT/Service Development Team IPT Service Development Team/IPT Hand hygiene Technician	As required Quarters 2-4 Quarter 1-4 As required. Quarters 1- 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. Outbreak daily allocated Nurse within the IP Team as necessary.	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 2-4
	Planned programme for Student Nurses to shadow the IPT.	IPT	Quarters 34
	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, online learning.	IPT	Quarters 1-4
	Hand Hygiene and Mask Fit Testing. Trust Mask fit team in place. PPE donning and doffing, gloves off campaign	Deputy DIPC /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 influenza 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/