NHS
Medway
NHS Foundation Trust

Infection Prevention and Control Annual Report 2022-2023

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18 MAY 2023

Best of care
Best of people

Contents

Tables and figures

Glossary

Term	Meaning
IPC	Infection Prevention and Control
DIPC	Director of IPC
ADIPC	Associate Director of IPC
IPCT	Infection Prevention and Control Team
BAF	Board Assurance Framework
DDoN	Divisional Director of Nursing
HoN	Head of Nursing
Gthr	Trust audit tool
PII	Period of increased incidence
UIC	Unplanned and Integrated Care
PC	Planned Care
TOP	Therapies and Older Persons
POCC	Peri-op and Critical care
PIR	Post Infection Review
ICB	Integrated Care Board
AMS/AMR	Antimicrobial Stewardship/Resistance
AMSG	Antimicrobial Stewardship Group
GNBSI's	Gram negative bacteraemia Infections
PPE	Personal protective equipment
FFT	Friends and Family Test
RSV	Respiratory Syncytial Virus
SSIS	Surgical Site Infection Surveillance
SMART	Surgical, Medical and Acute Response Team
VHR	Very High Risk
HR	High Risk

1 DIRECTOR OF IPC INTRODUCTION

1.1 This annual report covers a summary record of all activities relating to practises in Infection Prevention and Control (IPC) at Medway NHS Foundation Trust during the period April 2022 – March 2023.

1.2 As Chief Nursing Officer and the Director of Infection Prevention and Control, it is always a privilege and a proud moment to present Medway NHS Foundation Trust's Annual Infection Prevention and Control Report. In the last year, even with the COVID-19 pandemic, I have watched:

- Staff across the Trust work closely with the IPC Team to ensure that during the busy winter period IPC standards are consistently maintained to ensure patient safety and experience.
- IPC practices and standards improve month-on-month, and our IPC Team connect with frontline teams to ensure IPC is always at the forefront of colleagues' minds when delivering patient services and care.
- The Care Quality Commission (CQC), through the Maternity Department's inspection, recognise the good work around IPC.
- NHS Kent and Medway Integrated Care System remove the Trust from IPC enhanced surveillance.
- The Trust Board feeling more and more confident in the IPC assurance they are receiving.
- Our Procurement, Operational Site, Estates and Facilities colleagues working closely with the IPC Team and working together to make improvements on issues and concerns as they arise.
- Exploratory work commence around what joint working with Medway Community Healthcare on IPC could look like and also what IPC from a health and care partnership perspective could look like.
- The energy, confidence, motivation and dedication of the IPC Team continue to increase.

1.3 With all of the above highlights I have felt honoured to have experienced, the report will cover in more detail, for example, the IPC Team and the governance structure, the Trust's position against the IPC board assurance framework, our position on the management of all of the different infections, our approach to managing the outbreaks we have had - including the learning identified and implemented, monitoring and surveillance, cleanliness, and many more aspects of IPC.

1.4 The report shows how the Trust continues to make improvements around IPC, and that it is still high on our agenda. Our challenges this year have been around hospital cleanliness and not meeting our targets around Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C. diff). This was disappointing for us but we are comforted by the fact that a number of the infections, following thorough investigation, where identified as unavoidable. We continue to work hard to make sure we reduce infections which is a key part of keeping our patients safe and ensuring they have a positive experience while in our care.

1.5 We remain committed to reducing infections and improving and ensuring high standards of practice are maintained at all times.

Kind regards

Evonne

Evonne Hunt
Chief Nursing Officer and Director of Infection Prevention and Control

2 BACKGROUND

2.1 In November 2021 with the appointment of a new Chief Nurse in the role of Director of Infection Prevention and Control (DIPC) changes were made to the

structure and leadership of the Infection Prevention and Control Team (IPCT) and the reporting structure for governance and assurance.

2.2 In April 2022 a new substantive Associate Director of IPC (ADIPC) was appointed.

2.3 The IPCT was expanded and began to work across divisions

2.4 The IPCT team added FIT testing, surgical site surveillance and estates reviews to their responsibilities.

2.5 There was continued work on the IPC Board Assurance Framework (BAF) from last year which was then updated in December 2022 following an updated version being published.

2.6 The IPCT's programme of work for the year was based on Health and Social Care Act 2008: *Code of Practice on the prevention and control of infections and related guidance.*

2.7 The Code of Practice sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirement for cleanliness and infection control.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

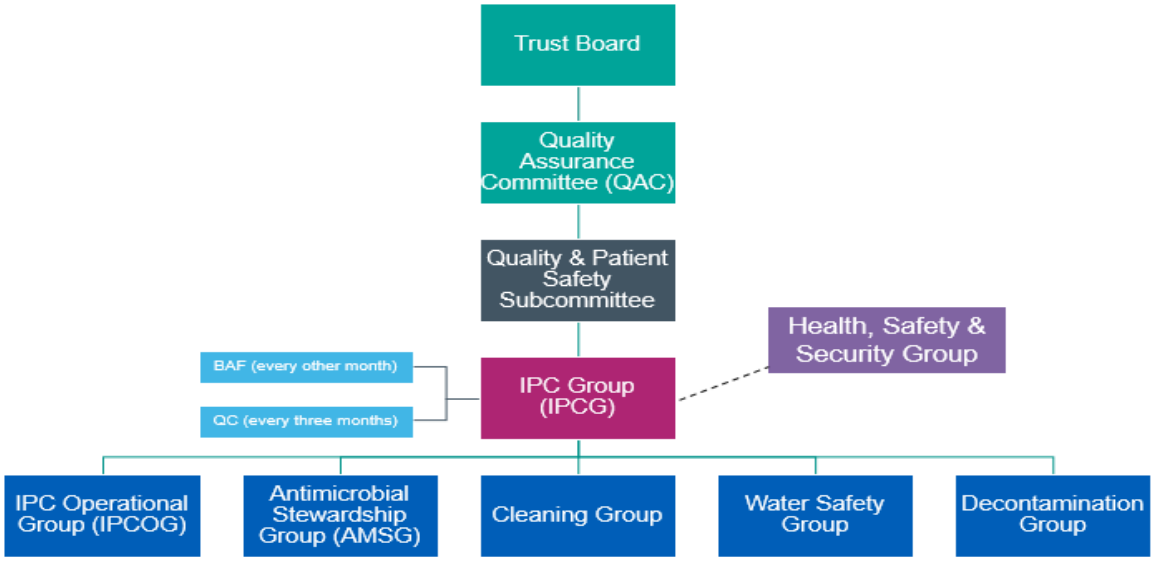
Figure 1: Compliance Criterion of The Code of Practice on the prevention and control of infections and related guidance

3 THE IPC TEAM AND STRUCTURE

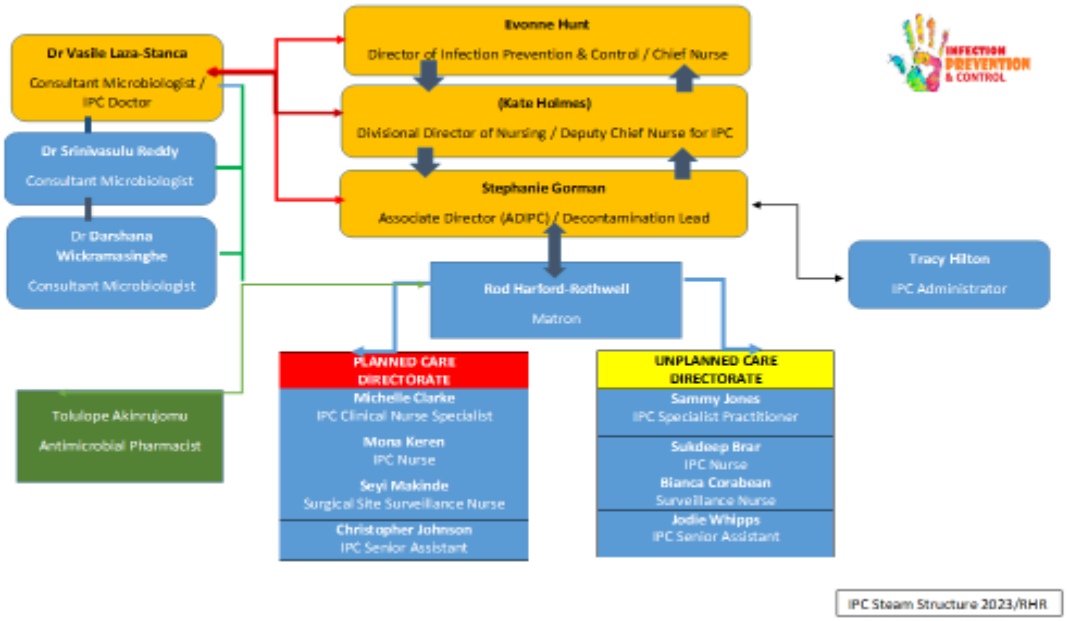
3.1 Delivery of Infection Prevention and Control sits within all departments and clinical services since it is fundamental to patient care. To enable this delivery, the Trust

has an organisational structure which oversees required actions. These are outlined below in the trust governance structure and the IPC team reporting structure.

3.2 Figure 2 - Trust governance Structure



3.3 Figure 3 - The IPC team Structure



3.4 The IPC team is fully recruited to and all staff were in post by July 2022.

3.5 There was the creation of an IPC Clinical Specialist Practitioner at band 7 which enabled a physiotherapist to join the team demonstrating that IPC is everyone's business and to provide a different way of thinking to the IPC team.

3.6 The team underwent multiple courses during 2022/23 underpinning their knowledge and skills as well as developing their leadership – Figure 4

Role	Course	Completion date
Associate DIPC	MA Leadership	Completed in 2022
Associate DIPC	Florence Nightingale Foundation Aspiring Directors of Nursing	May 2023
IPC Matron	Florence Nightingale Foundation IPC leadership	November 2023
IPC Clinical Specialist Nurse	MsC IPC	Completed in 2022
IPC Clinical Specialist Practitioner	NHSE Fundamentals in IPC	Completed 2023
IPC Nurses	IPS Conference	October 2022
IPC Nurse	NHSE Fundamentals in IPC	Completed 2023
IPC Surveillance Nurse	MsC Leadership	July 2025
IPC Planned Care Team	Surgical Site Surveillance Course	Completed in 2022

3.7 A further 2 microbiologists have joined the team.

3.8 In addition the Divisional Director of Nursing (DDoN) for Unplanned and Integrated Care (UIC) became the Deputy Chief Nurse for IPC.

3.9 The IPC Group (IPCG) continues to meet monthly and then reports to the Quality and Patient Safety Sub-Committee (QPSS) chaired by the Chief Nurse and the Chief Medical Officer. This then is reported to the Trust's Quality Assurance Committee (QAC).

3.10 The IPC team has been split into Divisional teams and the lead for each team is the Clinical Nurse Specialist and the Clinical Specialist Practitioner. They support the divisional teams with the IPCG report, they attend the Divisional Governance meetings to update on the data, share learning and highlight any IPC policies for approval.

3.11 All of the IPC audits are uploaded to the live audit tool Gthr used by the Trust. All wards can access these and they are reported at divisional level and Trust level.

3.12 The IPC operational group has been established for 1 year. There was good engagement and there is now a new Head of Nursing (HoN) chairing the meetings. There is a new focus on assessing audit data using Gthr and a template for wards and departments to report with their mitigating actions. This group reports monthly to IPCG.

3.13 The Antimicrobial Stewardship Group (AMSG) continues but attendance has not been consistent. The chair remains a medical consultant supported by the microbiologist consultant. There is a bi-monthly antimicrobial report presented at IPCG.

3.14 Also reporting into the IPCG are the decontamination group and water safety group which have been relaunched. A cleaning group has been developed to support the implementation of the National Standards for Healthcare Cleanliness and to provide assurance on the cleanliness of the hospital. This also reports to IPCG.

4 BOARD ASSURANCE FRAMEWORK

4.1 In June 2020 NHSE/I issued a Board Assurance Framework template to all NHS providers for compliance with the Health and Social Care Act 2008, *Code of Practice* and compliance with national COVID-19 strategies, policies and guidelines.

4.2 Following IPC visits in 2020/21 the Trust had 4 IPC action/improvement plans as well as a BAF. In January 2022 and following feedback from the November 2021 CCG visit the DIPC initiated and led on a collaborative discussion to combine all previous plans and actions into one plan. This was aligned against the 1.8 template version of the BAF published 24th December 2021.

4.3 Subsequently NHSE released a revised guidance following the "Living with COVID" measures to continue and support service recovery and the management of respiratory viruses for winter 22/23: Issued 28th September 2022 published 15th October 2022.

4.4 There were 216 actions identified within the Trust's 2021 IPC BAF improvement plan. By the update 159 actions had been fully implemented, 57 remained overdue awaiting full implementation.

4.5 Following the consolidation of the 2021 improvement plan with the September 2022 publication, the Trust now has a total of 145 actions, 39 remain overdue awaiting full implementation. These have been broken down against the Trust's Patient First True North Domain:

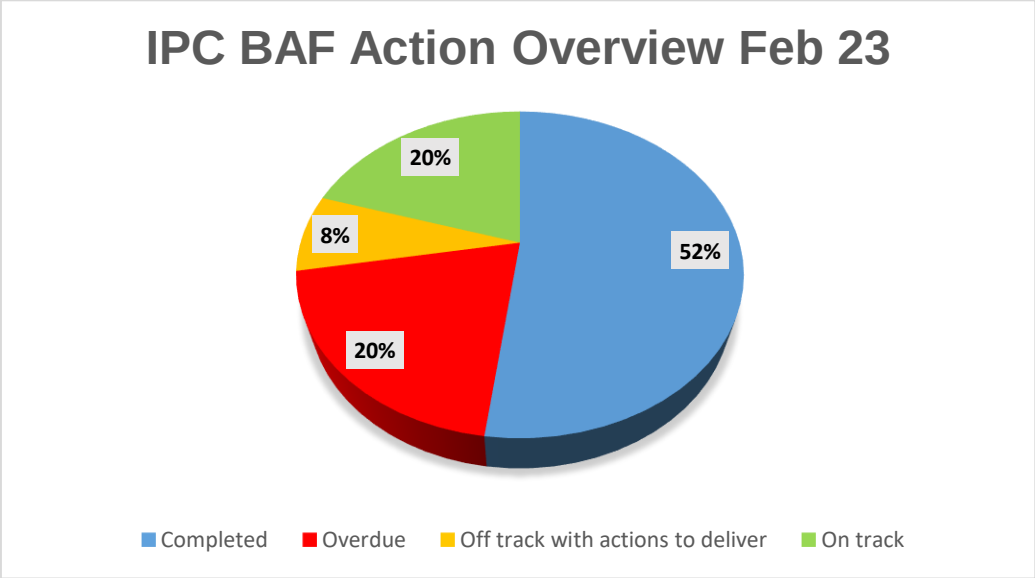
- 10 actions against **People**
- 4 actions against **Patients**
- 15 actions against **Quality**
- 9 actions against for **Sustainability.**

4.6 The new improvement plan was agreed at IPCG and QPSS in December/January and an update report is presented bi-monthly at both of those groups as well as QAC and the board.

4.7 The update includes

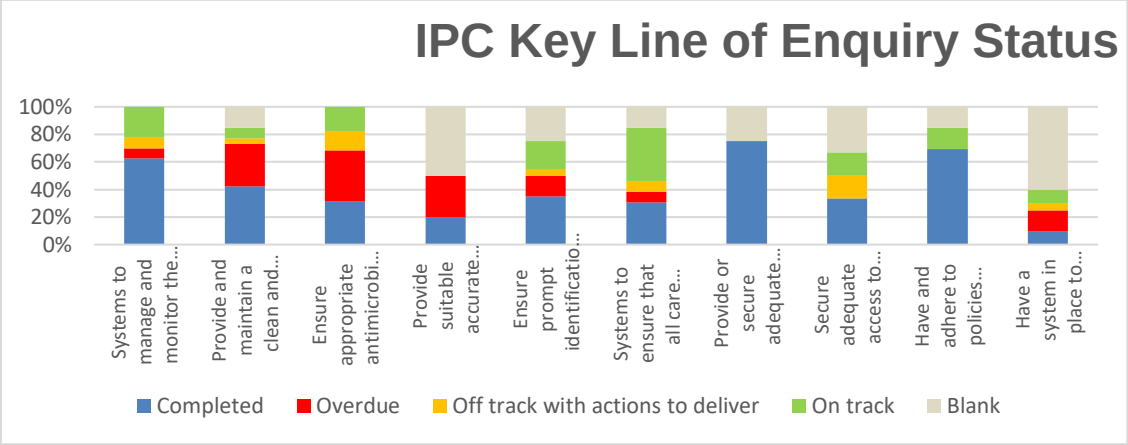
- Total number of actions
- Actions closed so far
- Actions on track for completion
- Actions off track and overdue with plans for completion and risk scores if no clear plan

4.8 The last report for the year 2022/23 was presented in March with an update for February. Figure 5



The table shows that 72% of the action plan is either completed or on track with over half being completed. Since the implementation of the new improvement plan no further actions have become overdue and 10 of the outstanding actions from the previous plan have also been completed.

4.9 The IPC Board Assurance Framework set the key lines of enquiry to measure compliance with the Health and Social Care Act 2008: the code of practice for prevention and control of infections.



The report measures compliance against each of the 10 criterion which enables the action holders to see easily areas that need more focus to ensure completion. Figure 6

4.10 There will be a new framework published in April 2023 which will cover Infection Prevention and Control for all organisms and practices.

5 METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

5.1 Since April 2018, cases of MRSA bacteraemia have been reported by the time of infection onset versus the time of patient admission and apportioned by the UK Health and Safety Agency (UKHSA) HCAI Data Capture System (DCS)

- hospital-apportioned where the infection onset is >2 days after admission
- Community-apportioned where the infection onset / blood culture collection is < 2 days after admission

5.2 In 2022/2023 the Trust reported 1 case of MRSA bacteraemia with a zero tolerance for any cases – figure 7. This was following 0 cases the previous year.

5.3 There is a Post Infection Review (PIR) system in place for any MRSA bacteraemia to identify any gaps and lapses in care, any learning, any good practice, understand the root cause and to develop actions to mitigate repeat occurrence.

5.4 Contributory factors following the PIR for the case were patient was admitted with a history of MRSA, there was a delay in decolonisation treatment, and admission screening result not checked by ward staff.

5.5 MRSA acquisitions, where MRSA is detected in patients on admission or through weekly screening, is logged and overseen by the IPC team. This is usually swabbing of the nose and groin and should also include any wounds, cannula sites that look infected and pressure sores. A sample should also be sent from a catheter if the patient has one

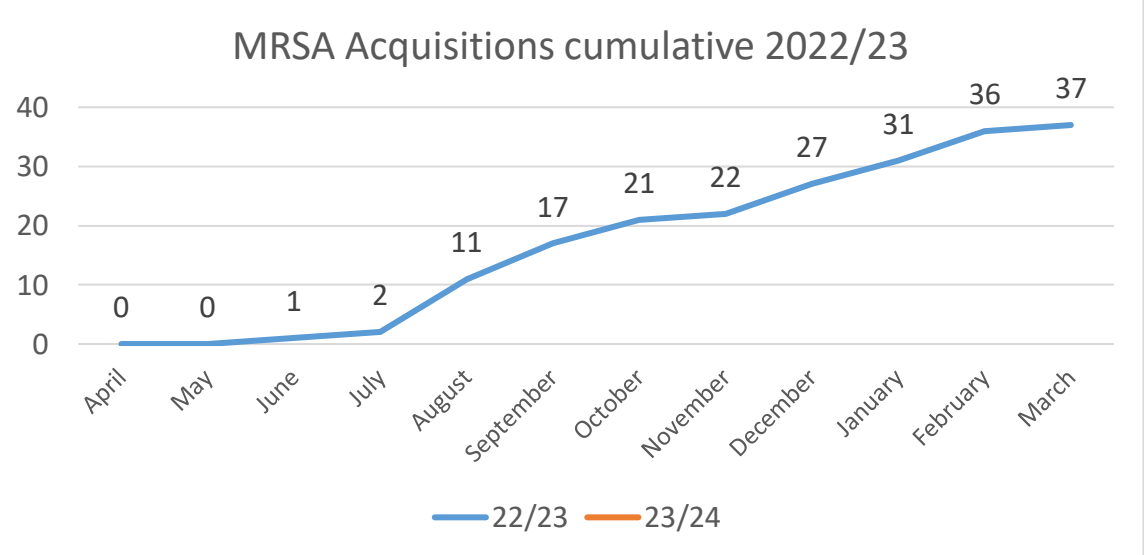
5.6 There is no national reporting process regarding acquisitions so therefore there is no national threshold.

5.7 MRSA acquisition is a near miss scenario for MRSA bacteraemias as the acquisition increases the risk of developing a bacteraemia through poor hand hygiene compliance at the point of care (especially when managing invasive

devices), incorrect use of Personal Protective Equipment (PPE) and cleanliness of equipment and the environment.

5.8 The Trust did not set any objectives for reduction for 2022/23 but has monitored numbers and locations of acquisitions throughout the year to determine an internal threshold for 2023/24.

5.9 The number of Hospital MRSA acquisitions has been collated across the year as cumulative – Figure 8



This will be compared in the coming year to understand if there is a significant improvement. Any wards that have 2 or more acquisitions within a 28 rolling period will also be measured under a Period of Increased Incidence (PII). This is a period of increased monitoring with focused auditing and support from the IPC team with weekly visits as a minimum and a resulting action plan.

5.10 The above table shows an increase in acquisitions through the year and this correlates to when the hospital was under pressure for capacity with the larger increases in August/September time and then again over December and January when the hospital was in Opel 4 or business continuity. This demonstrates the impact that this pressure can have on IPC practices as staff are stretched to manage the increase in patients.

5.11 The data has also enabled as to review the location of the acquisition as well as breaking it down for percentages by Division and then by care group. Figures 9, 10 and 11

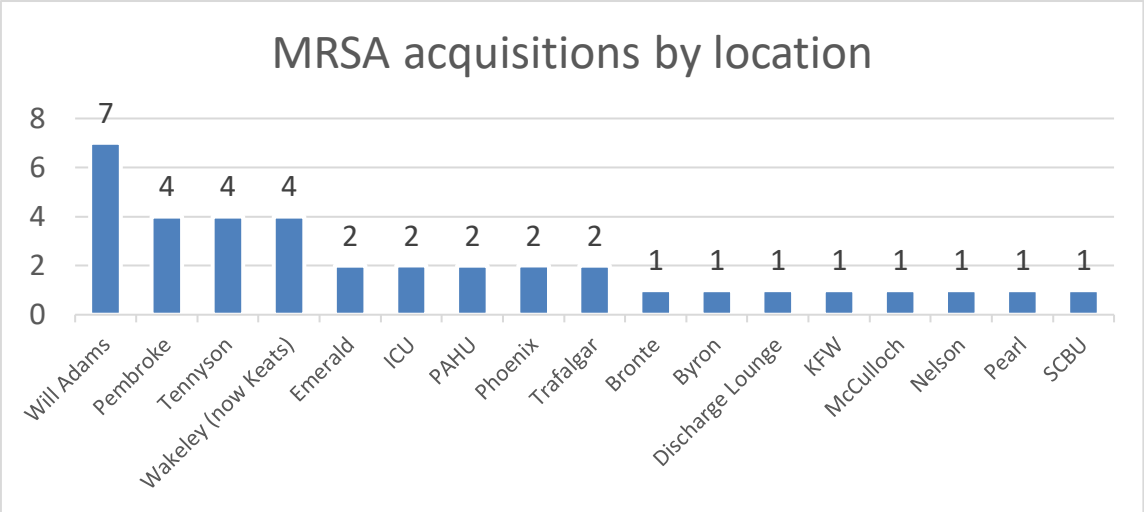
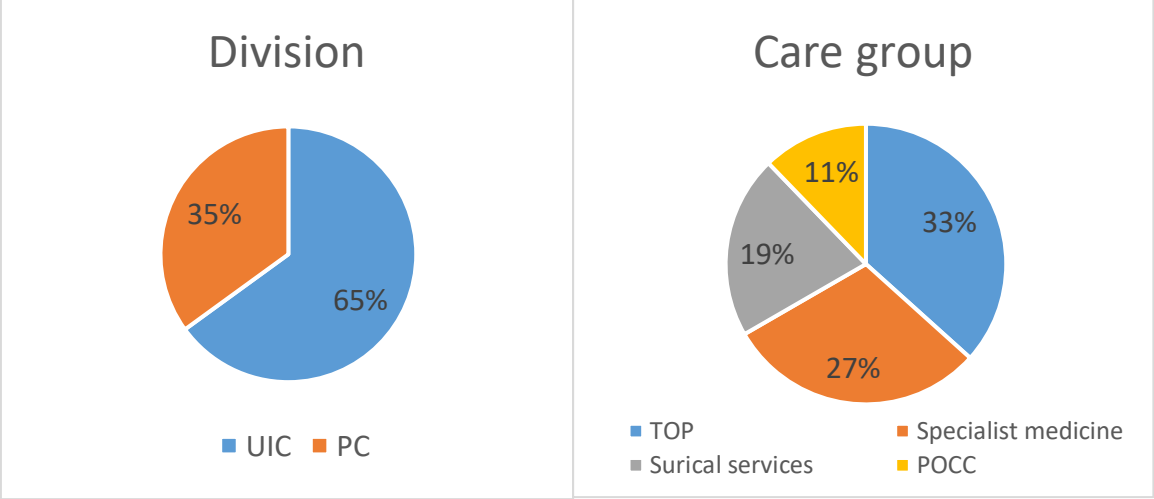


Figure 9 shows the locations of the acquisitions by ward across the year 2022/23. The ward with the most acquisitions is one of the escalation wards.

5.12 By looking at the percentage of acquisitions both by Division and then care group Figure 10 and 11 it is apparent that Unplanned and Integrated Care (UIC) have the larger proportion of the acquisitions.



Within that the care groups under most pressure are Therapies and older persons (TOP) and Specialist medicine. This is due to the number of patients within the frailty bed base with no criteria to reside who are being screened weekly throughout their stay and the escalation wards within specialist medicine which have a reliance on temporary staffing so there has been non-compliance with MRSA screening. This would be something to look at further within 2023/24.

5.13 MRSA screening has been audited for the last year – Figure 12. This is uploaded onto Gthr and discussed monthly at both IPC Operational group and IPCG

IPC - MRSA Screening Audit	83 (37)	78 (30)	86 (37)	89 (102)	87 (80)	88 (105)	84 (153)	86 (157)	83 (135)	82 (106)	87 (84)	88 (157)

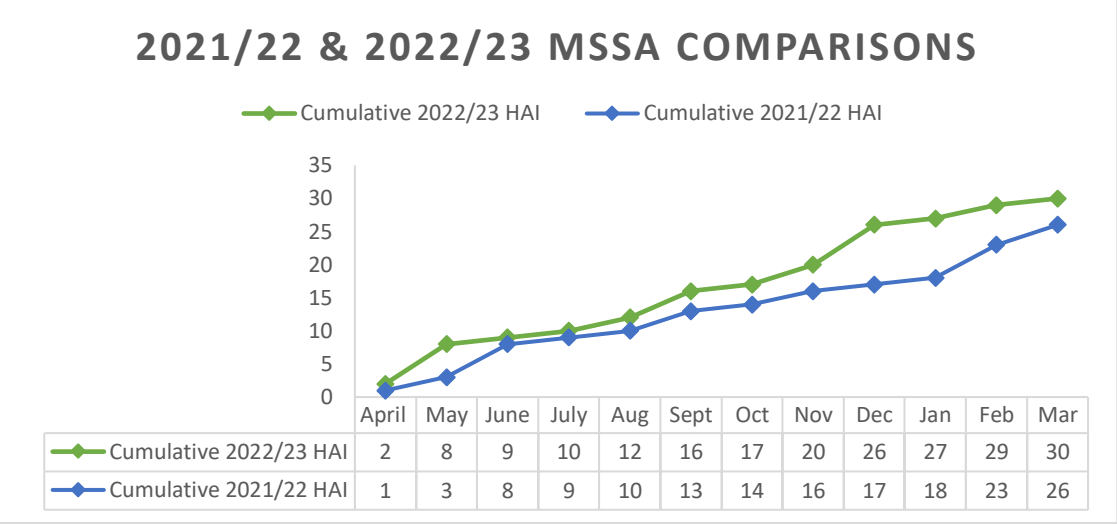
Throughout the year this metric has never achieved over 90% compliance. Through review at IPC operational group the main issues are around swabbing of wounds and IV devices. Further education for this is planned with both ward staff and the link practitioners.

6 METHICILLIN SENSITIVE STAPHYLOCOCCUS AUREUS (MSSA)

6.1 There is no national threshold for MSSA bacteraemias.

6.2 In 2022/23 the Trust reported 30 cases. This was a 13% increase on the previous year's total of 26 and the 2nd year of increase.

6.3 Figure 13 shows a comparison of MSSA infections for 2021/22 and 2022/23



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cumulative 2022/23 HAI	2	8	9	10	12	16	17	20	26	27	29	30
Cumulative 2021/22 HAI	1	3	8	9	10	13	14	16	17	18	23	26

6.4 There is no formal investigation of the root causes from the IPC team.

6.5 The IPC team have worked with the practice development team have developed competencies for aseptic non-touch technique which are part of training for new starters to the organisation.

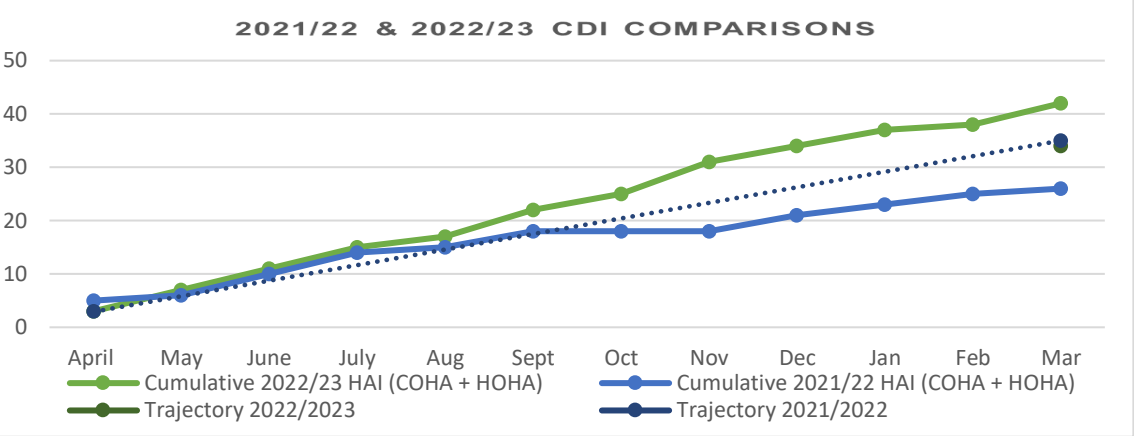
7 *CLOSTRIDIOIDES (CLOSTRIDIUM) DIFFICILE*

7.1 *C.difficile* is classified under 3 headings.

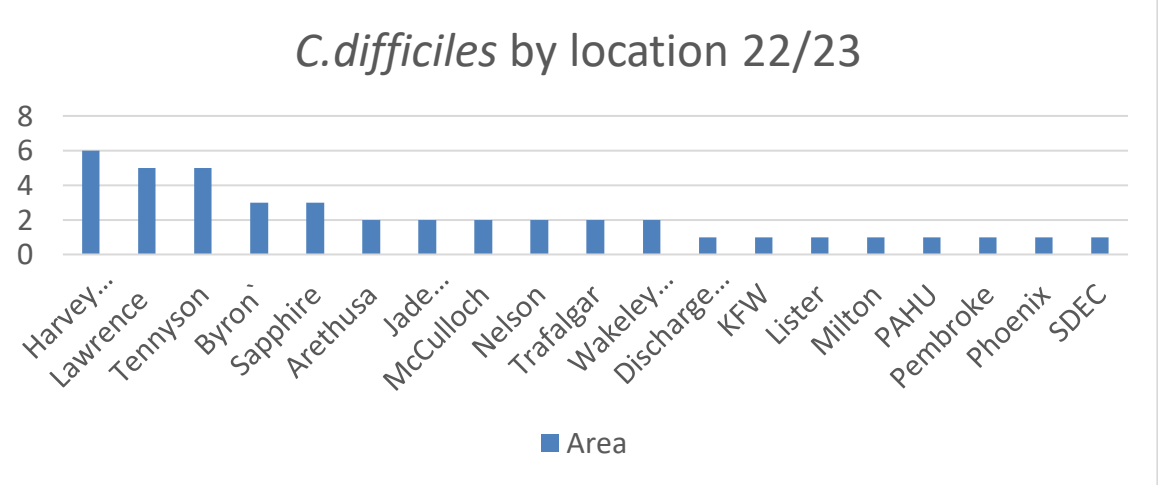
- **Hospital onset / healthcare associated (HOHA):** onset > 48 hours of admission. These cases are Trust-apportioned
- **Community onset / healthcare associated (COHA)**: cases that occur in the community (or within 2 days of admission) when the patient has been an in-patient in the previous 4 weeks. These cases are Trust-apportioned
- **Community onset, community associated (COCA)**: cases that occur in the community (or within 2 days of admission) when the patient has not been an inpatient in hospital in the previous 12 weeks. These cases are apportioned to the Integrated Care Board (ICB) formally the CCG.

7.2 From 2021/22 trust level thresholds include all healthcare associated cases (ie HOHA and COHA).

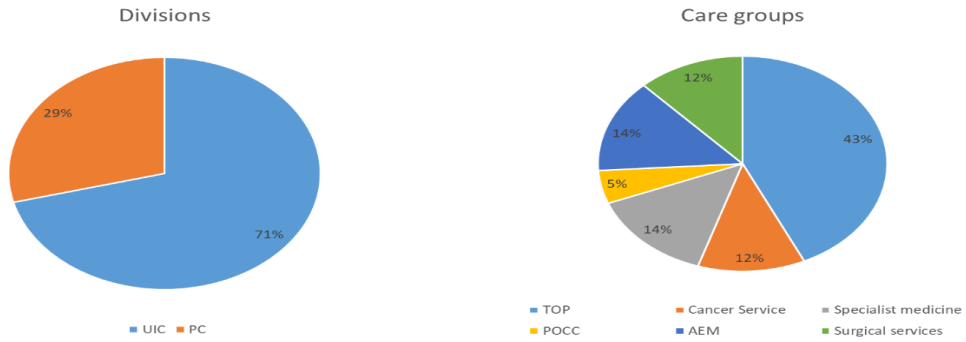
7.3 The Trusts tolerance for 2022/23 was 34 cases which was a reduction by 1 on the previous year. There has been a surge in hospital acquired infections in 2022/23 with many acute Trusts nationally breaching their thresholds. As you can see from the following graph the Trust breached the threshold in January 2023– figure 14



7.4 Figure 15 shows the number of *C.difficile* by location.



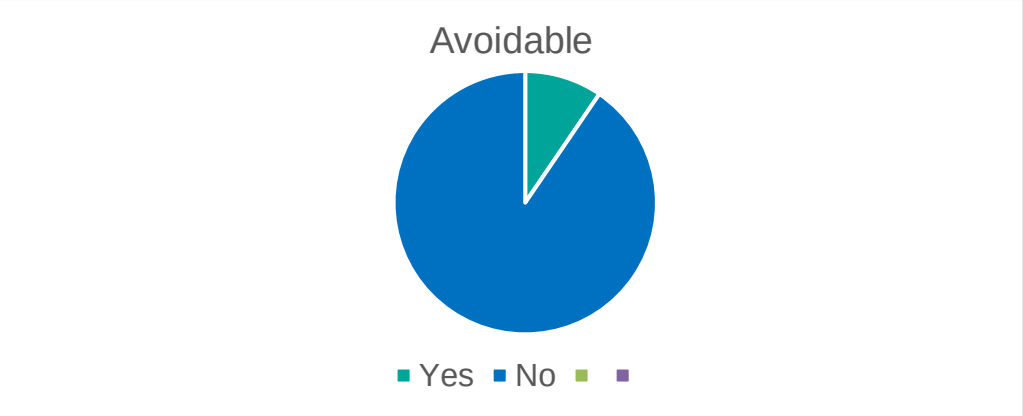
Predominantly in a similar picture to other Hospital Acquired infections this affected the UIC Division more than Planned Care (PC) – Figures 16



7.5 A Post Infection Review (PIR) is undertaken for all Trust apportioned *C.difficile* infections through a formal process. An invitation to attend the meeting goes to

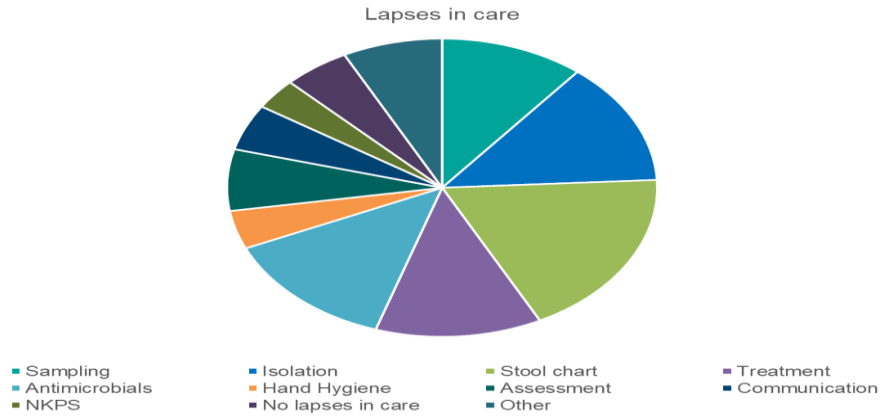
the ward manager, consultant overseeing the care, microbiology, matron, HoN, IPC team and ICB colleagues

7.6 Following the completion of the PIR's for 22/23 only 4 of these cases were avoidable- Figure 17. This was due to inappropriate or incorrect antimicrobial use.



The remainder were unavoidable as these patients were complex with a need for antimicrobials.

7.7 Although the cases were largely unavoidable there were lapses in care for many of the patients which did not impact their positive result but will have led to discomfort, isolation and potentially extended lengths of stay. Some cases had multiple lapses and some had zero – Figure 18



The most frequent lapses in care were to do with sampling, isolation, stool chart, treatment and antimicrobials. With the exception of the 4 avoidable cases for inappropriate antimicrobials the other issues were omissions in doses, not correct route or dose, no written indication on chart or not immediately available.

7.8 Actions taken in the year to improve on the previous year's results are

- Working with AMSG to ensure antimicrobial stewardship remains a top priority
- Continue to hold *C.difficile* PIR's as a panel to insure learning is understood for any lapses of care and omissions led by ADIPC
- Monthly IPCOG Gthr & PIR learning discussion: led by HON & IPC
- Commode competencies for cleaning for all staff

- Trust wide commode audit completed in May 2022 and repeated March 2023 to support plan for a single style commode easier to clean.
- Review of cleaning products and trial undertaken including potential for sporicidal wipes to improve commode cleanliness in September 2022. Business case being written.
- Diarrhoea assessment tool developed and being launched 3rd April 2023
- Weekly *C.difficile* numbers & PIR outcomes to DIPC and DDoN's
- Link practitioner session on stool chart, stool assessment and documentation

7.9 As part of the agreement at cleaning group UVC decontamination to be used for infectious cleans. This list of what clean is required has been reworked with facilities team and approved through cleaning group and IPCG

7.10 The team have also had a demonstration on Hydrogen Peroxide Vapour cleaning and with facilities and procurement are developing a strategy for use in 2023/24

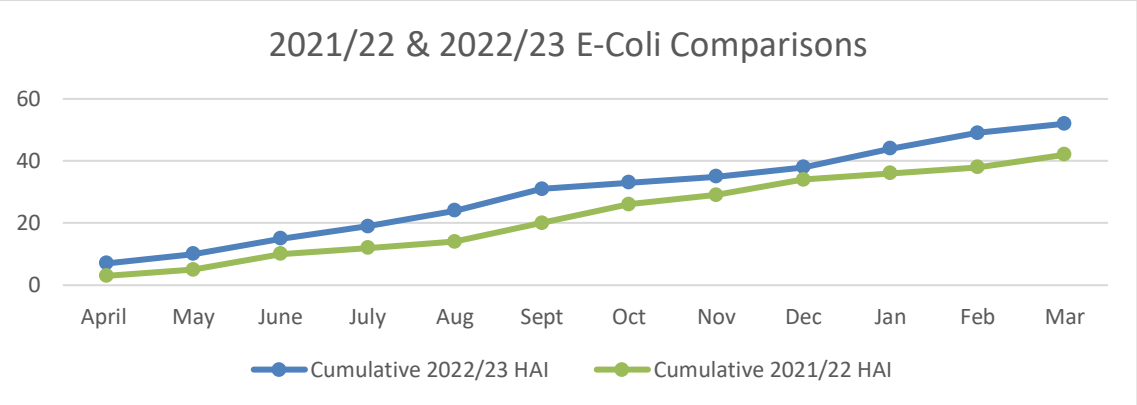
8 GRAM NEGATIVE BACTERAEMIA INFECTIONS (GNBI'S)

8.1 *Escherichia coli (E.coli),* Klebsiella and Pseudomonas are all gram negative bacteraemia and are reported nationally through the data capture system. All of these organisms have a significant impact of Kent and Medway Healthcare systems.

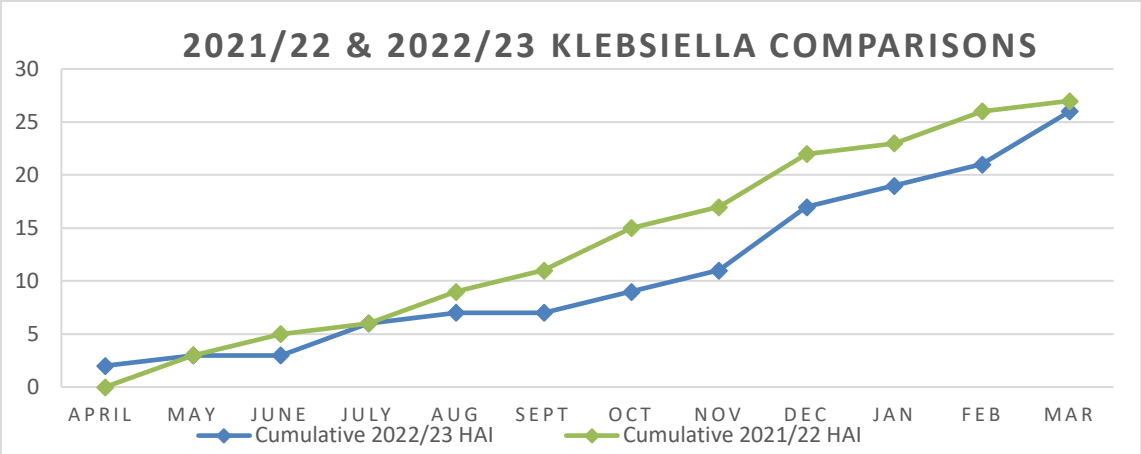
8.2 During 2022/23 the Divisions completed the root cause analysis tools for all GNBI's which were shared with IPC team and added to datix. During the COVID pandemic this has not been overseen consistently.

8.3 Of the 3 main organisms they all were below threshold however E.coli did not achieve a reduction on the previous year's total but both Klebsiella and Pseudomonas did.

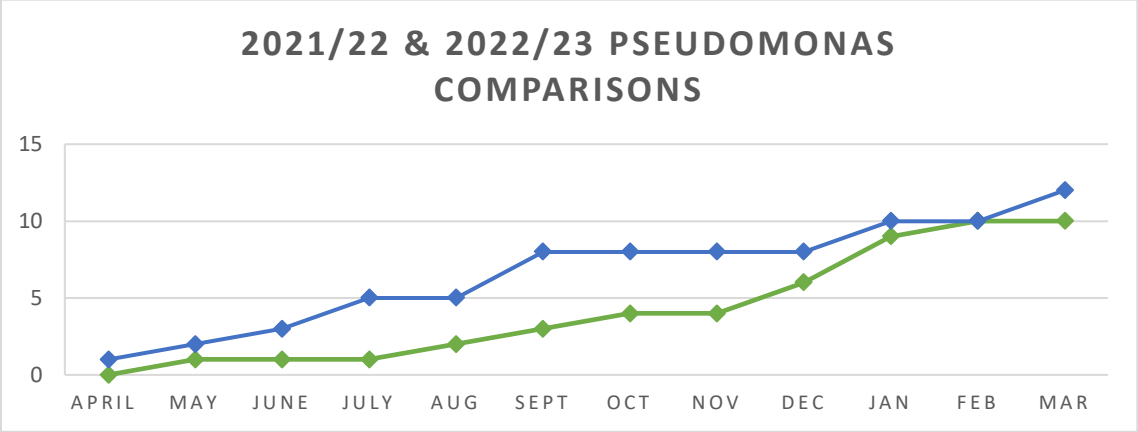
E.coli – figure 19 ended 2022/23 with 52 cases against a threshold of 77 cases and showed a 19% increase on last year's data after a reduction last year



Klebsiella – figure 20 achieved a total of 26 cases in 2022/23 against a threshold of 37 which is a 3% reduction in 2022/23 following an increase in 2021/22



Pseudomonas – figure 21 finished 2022/23 with 10 cases against a threshold of 17 cases. This is a reduction of 17% following an increase in 2021/22.



8.4 The Trust ambition for 2023/24 is to reduce by 5% on last year's achievement.

8.5 There is a new process for monitoring GNBSI's for 2023/24. 2 or more cases within a 28 day period will require an immediate review by the IPC nurses to review and confirm source, any delays and to ensure appropriate management. There will also be PII for 4 weeks, a root cause analysis style meeting to identify learning to support the development of an action plan to drive the target reduction.

9 SARS-COV-2 (COVID 19)

9.1 The novel coronavirus, SARS-CoV-2, has presented, and will continue to present for several years to come, a set of unique challenges for public health and changes to the way in which the NHS and a myriad of other public services function

9.2 Most people infected with the COVID-19 virus will experience mild to moderate respiratory illness and recover without requiring special treatment. Older people and those with underlying medical problems such as cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness.

9.3 On 23rd February 2022 the government published its road map to reducing all of the COVID-19 restrictions as “Living with COVID – a white paper.

9.4 Current epidemiology suggests the virus is now likely to be associated with less mortality and morbidity because of an increase immunity in the population following the vaccination programme and the development of therapeutic treatments for high risk patients.

9.5 Changes to the management of COVID came into force from April 2022 following the publication of the “Living with COVID” white paper by the government in February 2022.

This provided guidance on

- screening and testing of patients.
- isolation time reduced to 7 days using lateral flows to support early termination
- stopping social distancing
- stopping the identification and management of contacts.

Further changes to guidance were released throughout the year which included

- reducing mask wearing,
- increasing visiting
- pausing testing for asymptomatic patients and staff.
- Continuing to test patients being discharged to an ongoing care facility even if asymptomatic

9.6 The ability to use lateral flow tests in hospital was introduced to support an early end to isolation as well as an early return to work for staff.

9.7 Staff moved to using clinical judgement for identifying if a patient had developed COVID supported by using symptom checker. Patients who were suspicious of having COVID were isolated whilst waiting for a result and remained isolated for 10 days if positive.

9.8 The system of command used throughout the pandemic was stepped down in May 2022. This meant that tactical and strategic command meetings stopped. The decision was made to continue with the operational IPC cell to support the changes required for the easing of restrictions and as a way of continually monitoring the numbers of COVID and to re instigate the command meetings depending on escalation trigger level.

9.9 Following these changes the Trust was able to stop the need for COVID wards and has managed using side rooms and bays at times of surges. The last ward being used for COVID stopped in November 2022.

9.10 Determination of hospital acquired transmission was as below

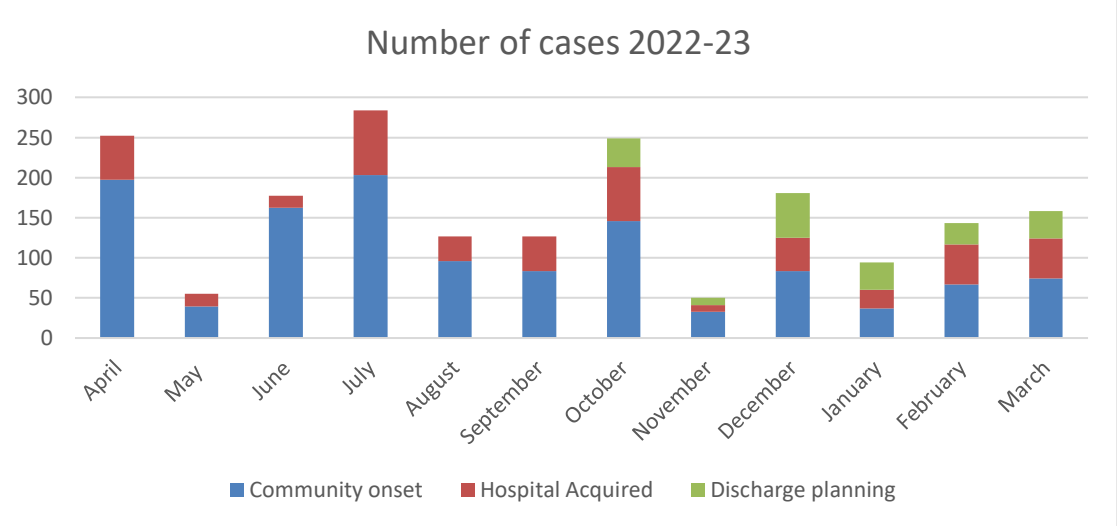
- **Hospital-onset probable healthcare-associated (HOPH)**– first positive specimen date 8-14 days after admission to the Trust

- **Hospital-onset definite healthcare-associated (HODH)**– first positive specimen date 15 or more days after admission to the Trust
- **Community acquired -** first positive specimen less than 8 days after admission

9.11 COVID-19 comparison figures – figure 22

Infection Control – COVID 19	2020-21	2021-22	2022/23
Total number patients admitted with COVID	1963	710	1220
Total COVID cases	NA	1186	1853
Total number of deaths with COVID in part 1	571	96	170
Total number of HAIs	NA	224	650
Total number of outbreaks	17	22	22

9.12 The table below – Figure 23 shows the number of cases per month and demonstrates peaks in April, July and October for positive results. Following on from the pause in asymptomatic testing an additional parameter for discharge planning was added. This is because many patients who tested positive for discharge to a care facility had been in the Trust longer than 8 days which is when a COVID infection can probably be hospital acquired however they were asymptomatic and had not been tested on admission.



9.13 During this time the Trust had a couple of periods of extreme pressure with an increase in hospital admissions and limited capacity and declared business continuity to support flow through the hospital. It is important to note that due to the lack of capacity at times positive patients were unable to move out of a bay into a side room or positive bay within an hour and could remain there for longer. This has been linked to the cause for 14 of the outbreaks declared. Other causes have been linked to an increase in community cases, opening up visiting with

visitors attending whilst positive. There has been no identified link of transmission between staff and patients.

9.14 From August 2022 with the changes to testing and isolation the trust added symptom checker to Electronic Patients Records (EPR). Understanding when to test someone for COVID became an essential part of managing the virus and ensuring the correct patients were isolated and quickly. The compliance with this was audited from August – Figure 24

IPC - Symptom Checker	47 (211)	74 (209)	83 (261)	72 (214)	81 (237)	79 (210)	74 (217)	77 (274)

Compliance with the use of symptom checker remains inconsistent. This is evidence that in 56% of records audited there were no gaps in the last 7 days with only 79% of patients having symptom checker completed within the previous 24 hours.

9.15 Following multiple RCA's for COVID-19 for all Hospital acquired COVID cases with the ward teams many cases were determined to be in asymptomatic patients as an incidental finding as part of routine screening with minimal harm. The IPC team took over doing these mini RCA's and now instigate a more formal review with the ward team if there are significant lapses in care.

10 INFLUENZA/ RESPIRATORY SYNCYTIAL VIRUS (RSV)

10.1 For Winter 2022/23 the Trust established respiratory pathways for both paediatric and adult patients to ensure patient safety by correctly cohorting patients with respiratory symptoms and therefore reducing the risk of a nosocomial transmission and outbreaks.

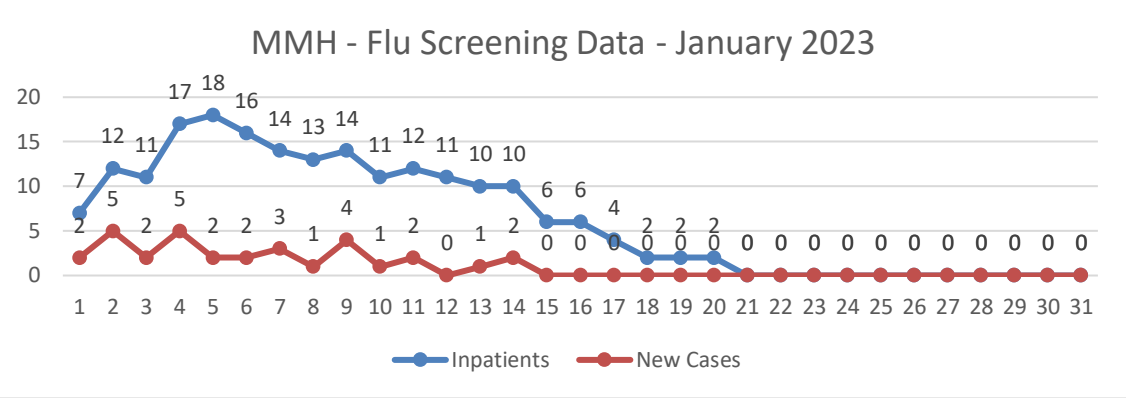
10.2 The pathways are supported by the Rapid Testing Service who provide the molecular assays to identify four main respiratory infections, COVID-19, RSV (paediatrics), influenza A and influenza B

10.3 There were initially technical issues regarding recording of results as the possibility to use system of reporting on iLAB was not possible. This was resolved through work with the EPR team. This was in place for testing for Influenza and RSV to start on 31/12/2022.

10.4 Due to the delayed start for testing the RSV season had ended so the focus for January 2023 would be Influenza. This was reported via the daily sitrep and into the site meeting

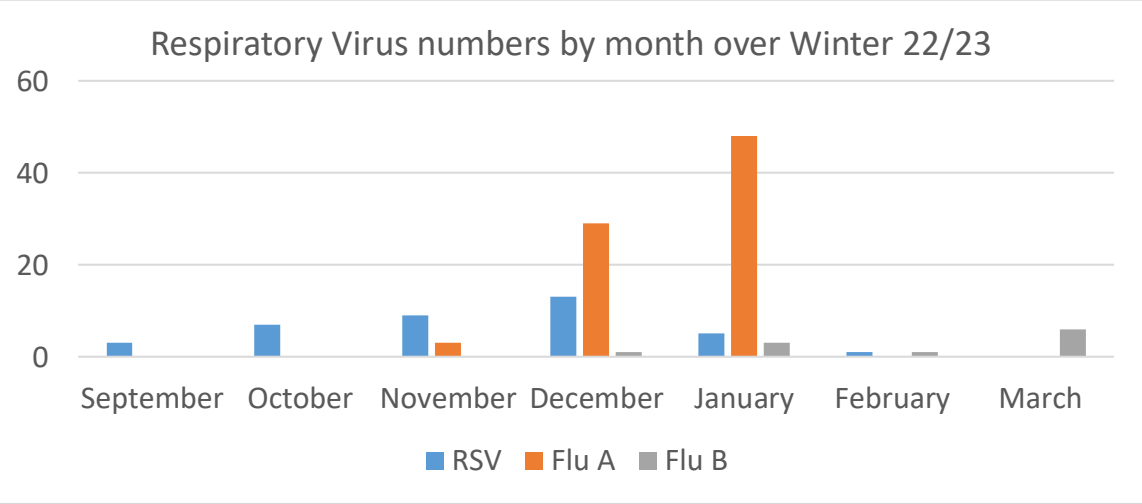
10.5 The trend data was reviewed at IPC cell meetings. Despite the late start in testing the peak of Influenza admissions was towards the end of the first week of January- Figure 25 dropping to zero by the end of that month with no further

increases. During this period there was only 1 patient admitted to critical care because of Influenza



10.6 The usual process for RSV and Influenza using PCR screening also continued alongside the Rapid Samba testing.

10.7 IPCT monitoring of respiratory viruses started from September and numbers of each month are shown in figure 26



Although this data suggests that the peak of RSV was in December and Flu in January this data is not comparative. This is because the rapid testing wasn't available until January.

11 OUTBREAKS

11.1 During 2022/23 there were outbreaks for COVID-19, 1 outbreak of Serratia marcescens and 1 outbreak of Norovirus

11.2 Throughout Winter 2022/23 MFT were under extreme pressure which saw most of the month escalating at Opel level 4 or business continuity to support flow through the hospital.

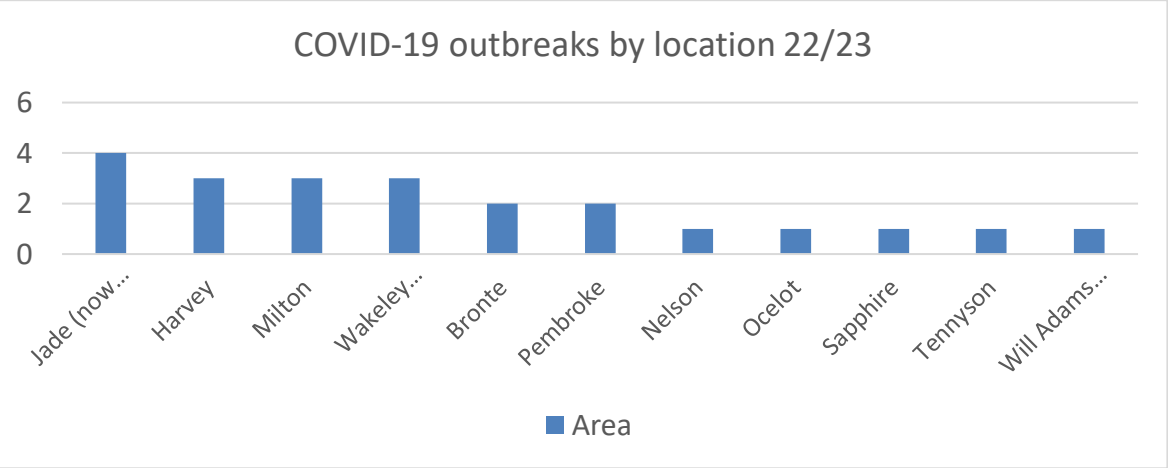
11.3 It is also important to note that due to the lack of capacity at times positive patients were unable to move out of a bay into a COVID bed within an hour and

could remain there for longer. This then led to subsequent exposures in that bay becoming positive and then becoming an outbreak.

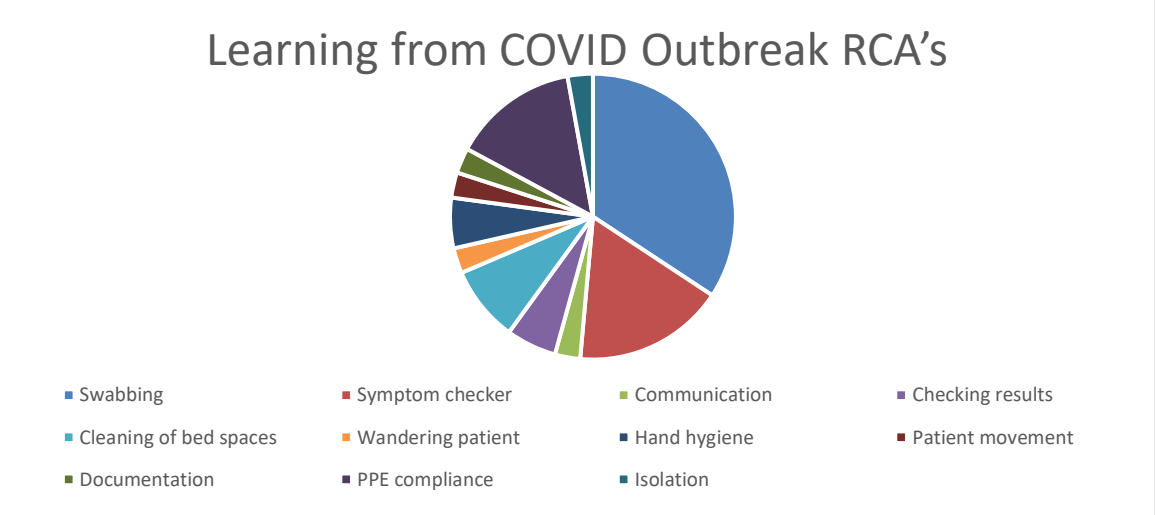
11.4 There were 22 COVID-19 outbreaks on the wards affecting 193 patients. Many of the outbreaks involved several index cases which were either clearly community acquired or there was no known source. Once a patient tested positive in a bay, due to the transmission of COVID-19 the remaining patients invariably tested positive.

11.5 Any ward where an outbreak was declared had increased cleaning, a PII and an RCA meeting to identify learning.

11.6 COVID outbreaks by location – figure 27 shows the areas where the outbreaks occurred



11.7 The key learning from the RCA meetings are in Figure 28



Many of the issues were regarding swabbing compliance especially when the trust was still screening on day 1, 3, 6 and weekly as this was often non-compliant. This resolved following the pause in asymptomatic testing in September 2022.

11.8 The next biggest learning was regarding symptom checker as this was not being completed with the 3rd issue being PPE compliance. This was predominantly not

wearing visors for suspected or confirmed cases of COVID and for non-adherence to mask wearing in some clinical areas.

11.9 The Serratia marcesens outbreak on NICU started in December and involved 9 neonates in total. The positive results were from infection swabs and seemed to be a new unique variant for this outbreak.

11.10 Serratia marcescens is gut commensal gram-negative bacteria. It can cause opportunistic infections in high risk patient (critical care patients, immunocompromised and patients with invasive devices). It is also found in the environment particularly on wet surfaces.

11.11 Serratia marcescens is rarely isolated from patients in Neonatal Unit at MFT with no bacteraemia or outbreak in the last 10 years. However it does affect around 11% of neonates during their stay nationally.

11.12 Serratia marcescens can be spread in hospital environment and to patients by contaminated hands and contact with contaminated surfaces as a result of inappropriate cleaning.

11.13 The first 8 cases were from December and were located in ICU, HDU and SCBU areas of Neonatal Unit.

11.14 Outbreak meetings were held with clinical team, IPC team, Microbiologist, Director of Midwifery, ICB, UKHSA and NHSE/I. These meetings reviewed the cases and considered causes and recommended actions.

11.15 An action plan was devised and monitored through the outbreak meetings with the likely cause being poor hand hygiene. Further training was provided to ward staff and parents.

11.16 The last case was identified in February 2023 as the ribotype was the same as the outbreak.

11.17 In February 2023 there was a Norovirus outbreak on Tennyson. It involved 24 patients with confirmed result of norovirus.

11.18 Outbreak meeting was held with clinical teams, IPC team, microbiology, ICB, UKHSA and NHSE/I.

11.19 The outbreak was contained to the one ward with no staff involvement. Good practice was identified with quick escalation to IPCT, good stool chart documentation and appropriate sampling.

12 SURGICAL SITE INFECTION SURVEILLANCE (SSIS)

12.1 SSI management was initially through the Surgical, Medical and Acute Response Team (SMART) up until July 2022

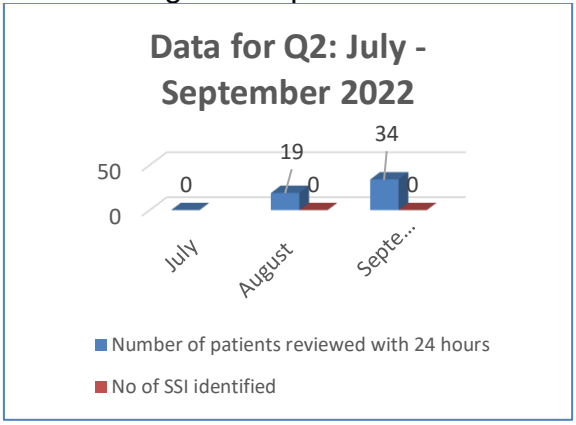
12.2 Due to capacity within the team SMART had not been able to gather consistent data for any submission and to ensure follow up reviews. From July 2022 the surveillance was completed by the IPCT.

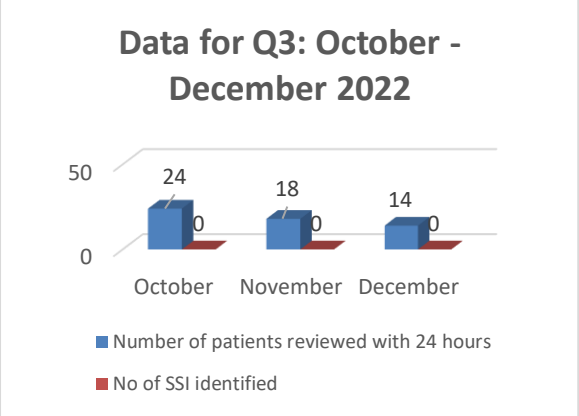
12.3 SSI data is submitted once a quarter and the minimum requirement is one submission per year. The IPC team and the SSI consultant lead are aiming to submit the maximum with 4 submissions a year.

12.4 Although there should be surveillance for all surgical sites the initial focus was for elective hips and knee surgery.

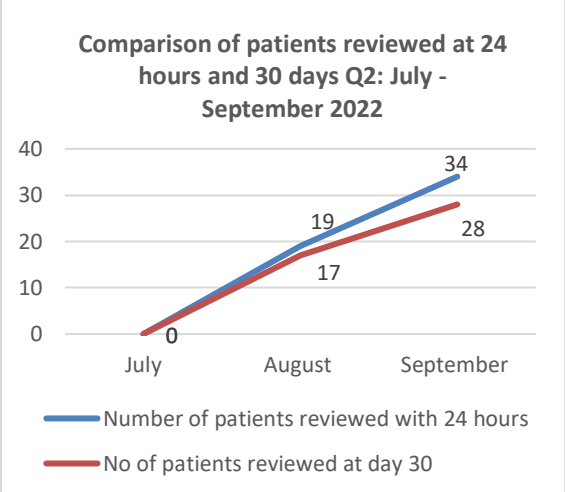
12.5 The team utilised Q2 to ensure their process was correct and collected data however their first submission on the national data capture system was Q3.

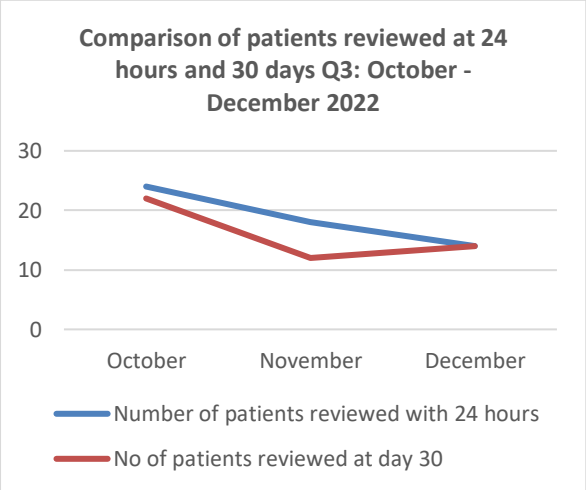
12.6 Figure 29 shows the data for the number of patients reviewed at 24 hours and also the number of SSI's noted for both Q2 and Q3. There was not a site infection noted during either quarter.





12.7 Part of the surveillance is to contact patients at 30 days via telephone to determine if after discharge there was any infection at the surgical site. Figure 30 shows the comparison between 24 hour review and 30 day follow up.





There is often a small drop in 30 day reviews. This is due to no answer when called at 30 days. There is no consistancy currently with the receiving of the lists and the patient details may be incorrect. It would be better for the team to contact patients on the wards whilst still inpatients to confirm contact details and explain process for 30 day review to reduce the missed patient reviews.

13 IPC Gthr AUDITS

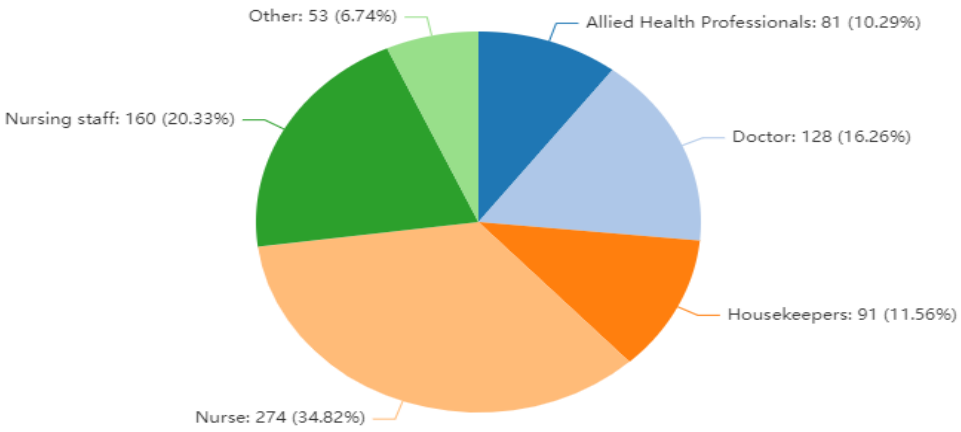
13.1 The Trust moved to Gthr in February 2022. This has allowed ward tams to access their audit data in real time. The dash board has allowed specific questions to be asked like bare below the elbows and Friends and Family Test (FFT) data on cleanliness. It also means that data can be reviewed at ward level, care group level, divisional and trust level.

13.2 Hand hygiene scores have remained consistent over the year 2022/23 – Figure 31

IPC Hand Hygiene	95 (408)	93 (794)	93 (801)	92 (768)	93 (815)	93 (725)	94 (745)	92 (731)	93 (706)	95 (789)	95 (742)	95 (855)

Reviewing the audit data PPE compliance is highlighted as an issue as part of the hand hygiene audits, either removal or not wearing appropriate PPE for the task.

13.3 The breakdown of staff observed for hand hygiene is in Figure 32



13.4 Another score that has remained consistent throughout 2022/23 is the bare below the elbows – Figure 33

Are staff bare below the elbows	98.8 (407)	99 (781)	98.2 (790)	98.5 (751)	98.3 (651)	99.6 (570)	98.3 (589)	98.3 (536)	98.2 (511)	99.1 (657)	99.1 (644)	98.8 (731)

13.5 The IPC team continues to challenge below standard practice where seen and supports all staff in understanding the importance of hand hygiene, when, where and how.

13.6 The IPC team promoted world hand hygiene day with a stall in the canteen and had information, games and challenges to educate staff about the importance of hand hygiene. This meant that foot fall was reduced due to the canteen being open for staff members only.

13.7 Unfortunately compliance with Commode cleanliness remained poor throughout 2022/23 – Figure 34

IPC - Commode Observation	50 (54)	68 (183)	55 (29)	79 (133)	73 (94)	74 (155)	85 (130)	84 (130)	85 (117)	78 (111)	78 (138)	84 (128)

During this time the IPC team completed 2 Trust wide audits in May 2022 and March 2023. On the last audit 25 commodes were either condemned or broken so replacements were ordered. This commode was chosen by vote during IPC week October 2022. Other actions included a commode cleanliness task and finish group which reviewed cleaning competencies, changed the assessment tool and introduced nurse in charge checks.

13.8 The audits into peripheral cannulas has not been consistent – Figure 35. EPR has allowed for devices to be monitored electronically. Initially there were teething issues as staff were unaware of this function.

IPC - Saving Lives: Peripheral Cannula	84 (216)	91 (219)	93 (254)	91 (306)	91 (253)	90 (300)	89 (308)	85 (251)	86 (359)	89 (347)	90 (248)	92 (249)

The gaps in the audits are a planned date for removal and documentation on continued need for the cannula. The IPC team continues to work with EPR team to resolve these issues.

13.9 Gthr has also become an integral part of the reporting by wards and departments to the IPC operational group. Wards have to present their areas of challenge to allow for discussion from other areas who have good practice. This is a forum for sharing ideas and solutions.

14 HOSPITAL CLEANLINESS

14.1 In April 2021 the NHS published the *National Standards of Healthcare Cleanliness* which would apply to all healthcare environments and replaced the *National specifications for cleanliness in the NHS* 2007

14.2 By July 2022 these standards had not been implemented in the Trust and there was no clear accountability or responsibility to make the change.

14.3 Part of the agenda at IPCG was a cleaning/housekeeping report. The DIPC was not assured that the hospital was at standard for cleanliness and was concerned that the *National Standards of Healthcare Cleanliness* had not been implemented.

14.4 A new cleaning group was established on the authority of the Infection Prevention and Control Group (IPCG). The purpose of this group is to:

- Ensure the National Standards of cleaning are reviewed and updated as required.
- Monitor compliance and efficacy of cleaning in all areas.

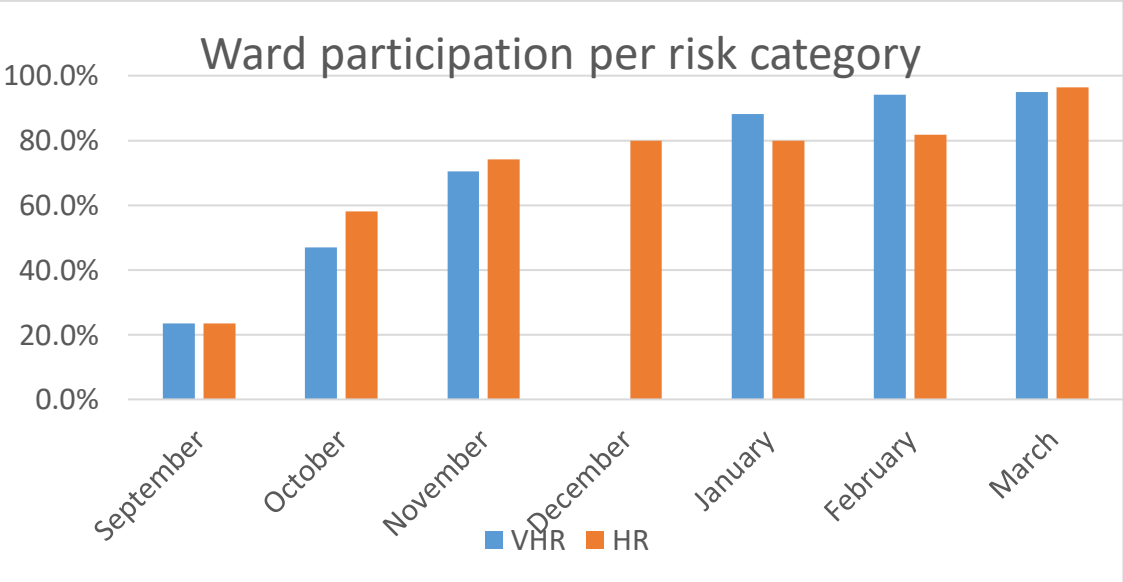
- Provide a means to review that policies and SOPS are in place and are an accurate reflection of current practice.
- Provide a forum for housekeeping and departments to discuss practice and changes.
- Review audit data and actions.
- Ensure clear roles and responsibilities in place regarding cleaning environment, equipment etc.

14.5 The core membership of the group includes housekeeping team, facilities team, IPCT, ward managers, department managers as well as matrons of HoN's.

14.6 Once the group was established and running well then a sub-group was created to ensure the implementation of the *National Standards of Healthcare Cleanliness* which was launched on 1/3/2023.

14.7 The cleaning group meets monthly and discusses the audit results for each clinical area, the participation scores for each area with ward staff supporting the audit alongside the housekeeping team and then any areas of concern.

14.8 When the group started there was disagreement with the audit scores and a clear lack of change each month. Discussion highlighted that often the auditors were completing the audits themselves with no participation from the wards. This meant that any issues or concerns raised were not challenged at the time. From September participation scores were also discussed at the meeting – Figure 36

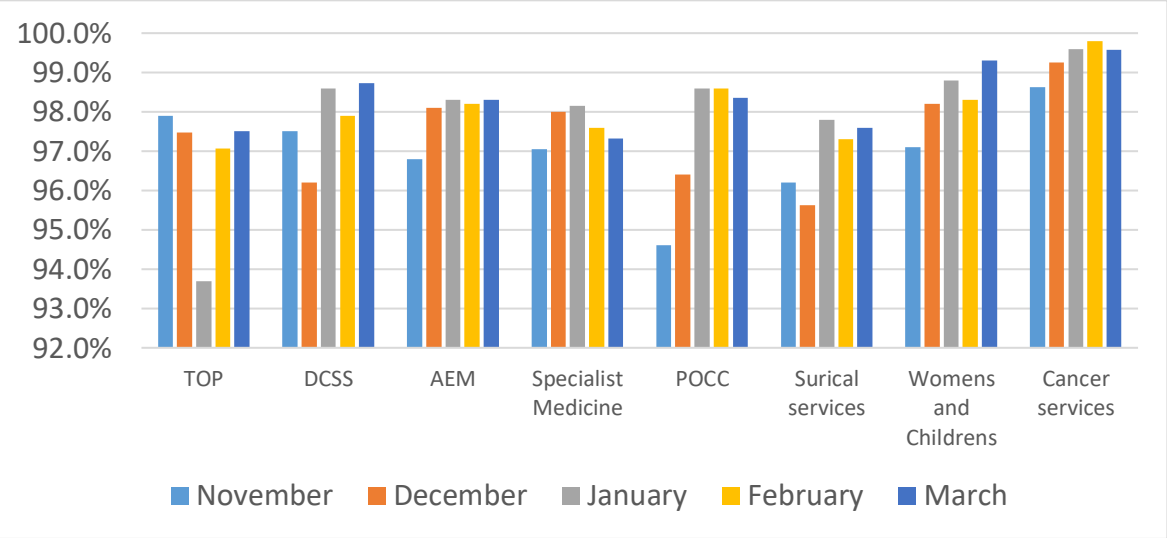


This graph shows a clear improvement in ward staff participation with the audit allowing for any issues to be rectified quickly and allowing ward staff to challenge in real time any concerns they have with the cleanliness of their area. The participation scores looks at the inpatient areas which are either Very High Risk (VHR) or High Risk (HR).

14.9 Some of these areas are audited after hours when units are closed so this affects some of the scores. There is also 1 month were no participation results were

available for the VHR category so it is unclear on whether someone supported from the ward area.

14.10 At each meeting the monthly scores for each risk category are looked at and the weekly scores for each area in the VHR category. This was started from November 2022 following feedback from the group that previous scoring chart was difficult to understand and compare – Figure 37.



This is difficult to directly compare this year due to changing of risk categories and the frequency different areas were audited during this period as the Trust changed to the new categories as part of the implementation of the National Standards of Healthcare Cleanliness. As an additional complexity many wards changed function and moved between care groups. For that reason this graph looks at month scores by care group. Higher scores are seen in cancer services. This reflects the consistency in audited areas with only Lawrence and Galton Unit where the other care groups have wards, clinical areas and outpatient's areas.

14.11 There have been changes to the Friends and Family Test process this year moving the system on to Gthr. One of the questions asked is about how clean the patient found the location where they were being cared for. From April 2023 the results of this question is being pulled through to the IPC dashboard. This will allow triangulation of data and to compare the audit scores with participation percentages against the patient's scores.

15 DECONTAMINATION

15.1 In September 2022 the ADIPC also became the decontamination lead. Prior to this the post had been supported remotely under temporary staffing.

15.2 First objective was to update the decontamination policy which was the most overdue IPC policy.

15.3 There was then a relaunch of the decontamination group with drafted Terms of Reference with a review of the core membership. The purpose of the group is

- To implement and monitor compliance with the decontamination policy as defined in Health Technical Memorandum (HTM) 0101 Management and decontamination of surgical instruments (medical devices) used in acute care (Part A: Management and Provision), and the Health and Social Care Act 2008.
- To ensure there are appropriate systems and processes in place for effective decontamination of patient environment and all patient equipment.
- To monitor compliance with assessing risks against the Health and Safety at Work regulations for Trust employees and service users.
- To ensure compliance with the Control of Substances Hazardous to Health (COSHH) regulations
- To action EU directives regarding medical devices
- Review audit data and actions

15.4 Decontamination group meets monthly and is chaired by the ADIPC. It reports into the IPCG bi-monthly. The aim of the group is to move to bi-monthly meetings but after a prolonged period with no onsite oversight o decontamination the agenda is extended.

15.5 After the policy was agreed the group then completed a gap analysis to develop an action plan which is overseen by the group.

15.6 Yearly audits by external regulators have continued through the pandemic however due to the lead being off site no internal audits led by the lead and IPC team have happened. There is a programme of audit planned from June 2023 with an audit tool to be agreed in May 2023. This will provide data to be reviewed at the group for the coming year.

16 COMMODE AUDITS

16.1 Reviewing Gthr data and particularly commode cleanliness led to a need to understand any issues with the Trusts commodes. This meant that an initial Trust wide Commode audit was completed in May 2022. Previous audits had been before the pandemic.

16.2 The Trust had been purchasing James Spencer commodes (blue lid) but when the company went out business needed to look for an alternative. This was at a time that the IPC team was reduced and before the changes so there was no guidance on best commode. This meant that Vernacare commodes (green) were supplied.

16.3 During this audit 6 commodes were in use in the Trust, each requiring different processes to clean effectively.

16.4 The table below shows the total number of commodes in the Trust and the number audited – Figure 38

	Commode Audit Results	2022	%
1	No of Commodes areas audited	96	NA
2	No of Commodes audited	90	ALL
3	No of soiled Commodes	48	50%
4	No of Commodes labelled as clean	51	61%
5	No of damaged commodes or parts missing	28	32%

Out of the commodes in the Trust 94% were audited by the IPCT. This was completed on a single day to ensure an accurate review of all the commodes.

16.5 The following actions were recommended

- All Ward/Department Managers must review commode cleanliness within their clinical areas to ensure that it *is* being undertaken thoroughly, and that staff are aware of the potential IP&C risks associated with soiled commodes.
- Changing how we clean the devices from using harsh Chlorine based products for a universal Ecolab Oxy S, Sporicidal wipe which will make commode cleaning easier for staff and as the wipe uses a Biocide to kill the active spores to remove all surface contaminants.
- The development of at least two 'Commode Champions' who will receive practical commode training on the date(s) provided, with the expectation that they will then cascade the commode cleanliness training to all the staff on their wards.
- The replacement of all broken and damaged commodes to replace aged and damaged stock, or the complete commode replacement of all commodes to ensure that the Trust has a standard commode that is easy to clean removing the potential for mis-management and the potential for faecal pathogen growth.
- An unannounced re-audit of commode cleanliness and condition will be undertaken by the IP&C Specialist Nurses in.
- Ward / Department Managers must also:
  - ensure that the "Commode Cleaning: 10 Point Plan" poster is clearly displayed in the ward / department sluice(s)

16.6 During IPC week the IPCT with the help and support of the procurement team were loaned 3 commodes from Roma, Vernacare and Gama. The team demonstrated these and generated a public vote for the favourite which would become the commode of choice. This was voted for by staff, patients and visitors. The winner was the Gama commode (white).

16.7 After a challenging winter and escalation areas opening and wards moving and before the business case was written to replace all existing commodes with a single product the IPCT team repeated the audit in March 2023

16.8 This table shows the number of commodes reviewed – Figure 39

	Commode Audit Results	**2023**	**%**

1	No of Commodes areas audited overall	89	100%
2	No of Commodes audited (Planned Care)	30	NA
3	No of Commodes audited (Unplanned Care)	59	NA
4	No of soiled Commodes overall	0	0
5	No of Commodes labelled as clean overall	89	100%
6	No of damaged commodes or parts missing needing replacement (Planned Care)	8	26.6%
7	No of damaged commodes or parts missing needing replacement (Unplanned Care)	19	32.2%

The number of commodes had reduced in 2023 but positively on this audit 100% of the commodes were clean. This is an improvement from the previous audit by 50%.

16.9 5 commodes on the day were condemned and immediately replaced with the new choice of the Gama commode (white). A further 25 were ordered and replaced the damaged commodes. The remaining commodes will be replaced throughout the year.

17 CLEANING TRIAL

17.1 During the task and finish group looking at commode cleanliness one of the blockages identified was the use of chlorine solution. This coincided with the mattress audit results from 2021/22 being reported at IPCG which showed significant damage to the mattresses likely consistent with the increased of achtichlor use for deep cleans during the pandemic.

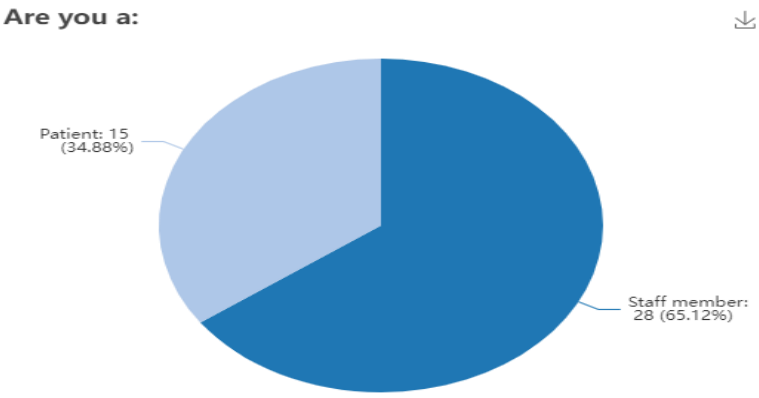
17.2 The decision was made for a trial of cleaning products as an alternative led by the IPC team and procurement, using Peracide – a solution from Sky Chemicals and OxyS - wipes from EcoLab. Both products were sporicidal and killed infected spores effectively but were not chlorine based.

17.3 The trial ran throughout September with the launch meeting taking place on 31st August 2022, involving the ward managers on Tennyson ward, Milton ward and Emerald Short Stay Ward; the IPC team; Patient quality; Procurement; Housekeeping manager; Porter manager and the Reps from the two companies.

17.4 Each area trialled a different product as follows: Tennyson ward used OxyS wipes on all surfaces and ActiChlor on the floors, Milton ward was the control ward where they maintained the products that were currently used on the ward (ActiChlor and Clinell green wipes), and Emerald Short Stay Ward used Peracide all surfaces and floor.

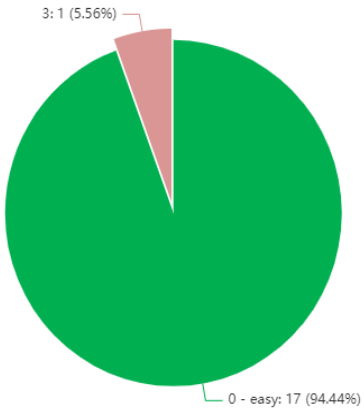
17.5 NICU was introduced into the trial, and were supplied with both products, as the products they were currently utilising were found to not be appropriate for cleaning the cots for infectious neonates.

17.6 Throughout, and at the end of the trial a staff and patient survey was requested to be completed by the participating wards. Unfortunately, completion from all areas was not optimal. The response from each survey is figure 40

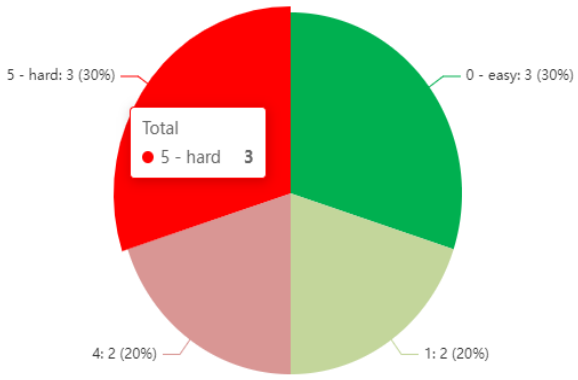


17.7 The questions were for either the OxyS wipes or the Peracide solution
The first question was how easy to use was the product – Figure 41

Oxy S Wipes



Peracide Solution



The feel from staff was that the wipes were easier to use than the solution.

17.8 The ease of use was measured looking at time it took to clean both a commode and a mattress using the different solutions. This was compared to the control ward who continued to use current product.
Commode cleaning time with Oxy wipes:

- White commode – 4 minutes
- Blue – 4 minutes 14 seconds

Commode cleaning times with peracide solution:

- White commode – 4 minutes 20 seconds
- Blue commode – 2 minutes 30 seconds
  (IPCT calculated it took 25 minutes for tablets to dissolve and be ready for use)

17.9 Next steps is developing a case for change in 2023 with procurement as both products have a cost implication but the result from feedback was to move to a

sporicidal wipe to clean commodes, continue with current clinell wipes for general mattress cleaning but to use peracide for deep cleaning mattresses and for deep cleans.

18 EDUCATION AND TRAINING

18.1 The *Code of Practice* requires that all staff undertake mandatory infection prevention and control training on a regular basis. The specific requirement is:

'that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patients' care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection'.

18.2 During the pandemic IPC training moved online fully through the Trust ESR system. Online training is undertaken by staff in core aspects of Infection Prevention & Control and this includes antibiotic stewardship

18.3 Level 1 training is e-learning is undertaken by non-clinical staff; Level 2 is undertaken by all clinical / patient-facing staff.

18.4 Training compliance for both levels was set at 90% by previous teams for IPC training although generally Trust compliance is at 85% for mandatory training.

18.5 Training compliance by division has been discussed at both IPCG and in the Divisional Governance meetings and has been part of the divisional reports. Figure 42 show Planned Care and Unplanned Care compliance throughout the year with level 1 and level 2 training

Planned Care

IPC	Apr 22	May22	Jun -22	Jul-22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
Level 1	98 %	97 %	96 %	96 %	98 %	96%	96 %	75%	97%	100 %	97%	98%
Level 2	90 %	90 %	91 %	90 %	90 %	89%	83 %	85%	89%	82%	89%	90%

Unplanned care

IPC	Apr -22	May-22	Jun-22	Jul-22	Aug-22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	March 23
Level 1	94%	94%	94%	95%	97%	97%	97%	97%	96%	96%	95%	96%
Level 2	91%	91%	91%	91%	89%	90%	89%	89%	87%	78%	86%	86%

18.6 It demonstrates consistent compliance in both divisions with level 2 training with over 95% except for a single month in Planned Care in November 2022.

18.7 Level 2 training compliance has continued to drop over the course of the year to below 90% compliance. Further work will be required to understand where the lapse is. For 2023/24 the divisional data for level 2 training will also be broken down into staff group.

18.8 During summer 2023 the IPCT will be reintroducing face to face training either for competencies or as scenario/simulation based to support learning from HAI's. This will then be updated as level 2 training completion.

18.9 Also in 2022 the IPC team was approved as a student placement for 2nd and 3rd year students. The placements range from 4-8 weeks and so far there have been 4 students.

18.10 The team have worked hard to improve the experience of the students based on their feedback. There is an induction booklet sent out prior to arrival detailing work times, contact details. There are a list of people for the students to spend time with to understand how IPC works within the hospital and to be introduced for 2023/24 the student nurse will present to the team on the organism of the month at the IPC team meeting or as part of the link practitioner sessions.

19 LINK PRACTITIONERS

19.1 Link practitioner training was reintroduced in July 2022. There were 3 meetings in, July, October and January.

19.2 Each ward and department has signed up at minimum of one practitioner who attends the sessions. These meetings are now a half day quarterly.

19.3 Engagement has been good since restarting with no less than 13 attendees at a session. Non-attenders will be flagged to their line manager and attendance is monitored for a 75% requirement. This is 3 meetings out of the 4 in a year.

19.4 Subjects covered include

- Housekeeping and enhanced cleaning
- Nursing TB patients
- Hand hygiene scenarios and competency assessments
- PPE use scenarios
- Commode cleaning and competency assessments
- Sharps safety
- Swabbing for MRSA, CPE and GRE/VRE
- Infection control admission assessment
- C.Difficiles update with learning from PIR's
- Stool assessment and stool chart on EPR

19.5 Feedback is that departments would like separate sessions as some information not always relevant.

19.6 All practitioners are invited to the Kent and Medway ICB IPC conference and many attended in 2022 and some have started on NHSE/I IPC sessions

19.7 Next year's sessions are planned with waste, laundry and MRSA screening as high priorities. The practitioners have asked that housekeeping continue to attend.

20 FIT TESTING

20.1 At the start of the Coronavirus pandemic in 2020 very few NHS staff had been fit-mask tested, this required an investment of resources (Training) as Trusts did not have sufficient staff trained or tested.

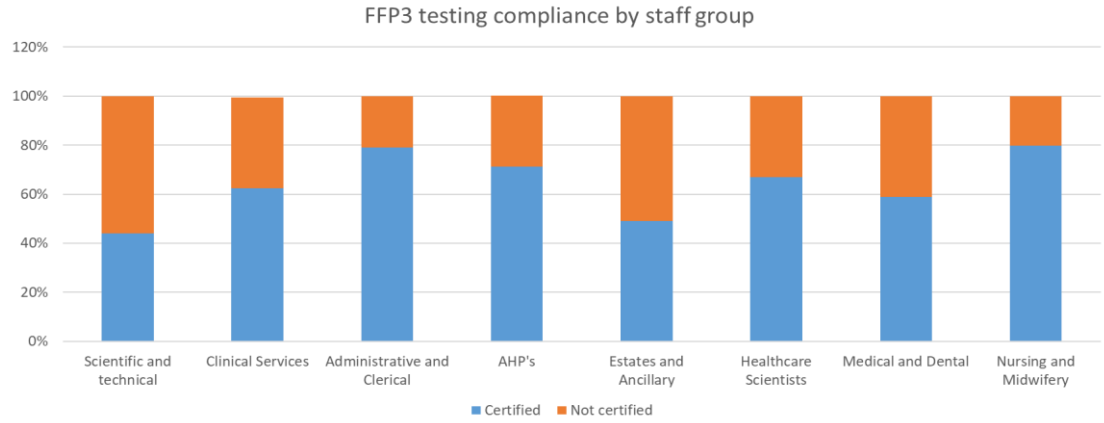
20.2 FFP 3 Fit-testing principles for Acute Hospital Trusts introduced in June 2021 became mandatory and forms part of EPRR Core standard 12 and became a legal requirement in August 2022. The Trust must have arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including high consequence infectious diseases (HCIDs).

20.3 The current fit-testing programme is provided on behalf of the Trust by Ashfield Healthcare through a central funding programme and the current arrangements in place are due to end in March 2023.

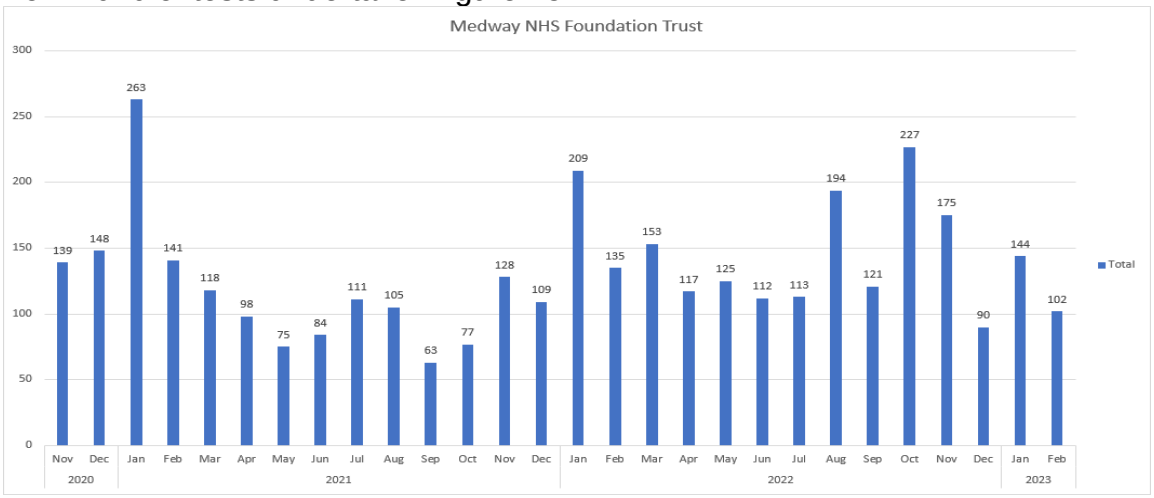
20.4 There are 3209 hospital workers who have FIT testing against their training profile. The breakdown per staff group is in Figure 43

Staff Group	Certified	Not Certified	Total required
Add Prof Scientific and Technical	44	56	100
Additional Clinical Services	460	276	736
Administrative and Clerical	15	4	19
Allied Health Professionals	129	52	181
Estates and Ancillary	149	150	299
Healthcare Scientists	2	1	3
Medical and Dental	316	221	537
Nursing and Midwifery	1067	267	1334
Grand Total	2182	1927	3209

20.5 Figure 44 shows this within a graph to view each staff group compliance as a percentage. Some groups with smaller numbers such as healthcare scientists may only have 1 or 2 staff not certified which reduces their percentage. Nursing and midwifery group and administrative and clerical group have the highest percentage of staff compliant.



20.5 Since Ashfield started providing the testing there is a monthly training comparison from 2020 of tests undertaken figure 45



The peak for testing was January 2021 at the height of wave 2 of the pandemic and with little surges in testing this has continued to reduce over subsequent years.

20.6 Ashfield completed their contractual arrangements on 30th March 2023 during their tenure testing 4,023 staff.

20.7 Trusts should be moving to testing on 3 masks every 2 years. Currently ESR still has 2 masks every 3 years. This, along with requirement of skill will be reviewed early 2023/24.

21 ESTATES WALK AROUNDS

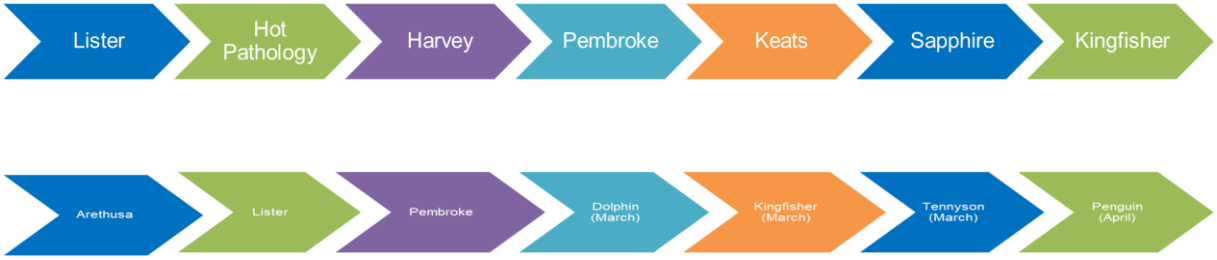
21.1 In June 2022 IPC and estates started a programme of weekly walk abouts. Team consisted of Director of Estates, ADIPC or IPC Matron, Estates – Building, Estates – Electrical, Estates – Ventilation/water, Housekeeping/Hotel services, and then as needed Fire and Health and safety, Ward Manager/Matron

21.2 The visits were a success and generated a lot of actions. From this came the need to refurbish 2 wards completely due to the repairs required. This meant the wards had to be closed to facilitate this.

21.3 The first ward refurbished completely was Keats ward which reopened on 29th December 2022. The ward has been completed to an exceptionally high standard. Following the Harvey ward closed in January and moved to Sheppey Hospital and opened as Sheppey Frailty Unit. This ward is undergoing refurbishment and will be completed to the same standard as Keats ward.

21.4 Following this and the extensive action list generated from the initial visits over the summer 2022 the visits were paused and then restarted in February 2023. In that time IPC developed an annual audit programme and this visit now allows all areas to have this completed. This will be uploaded to Gthr.

21.5 Where we went during June, July and August and then February and March – Figure 45



21.6 Part of the reviews are revisiting previously audited areas to update on actions and to confirm if actions are now closed or if further work is needed or if an action has not been able to progress to work to unblock.

21.7 The DDoNs also now join on these walk abouts or the HoN's in their absence. This helps the estates and IPC team to understand clinical priorities for actions and for the divisional teams to support with operational plans if needed.

21.8 Further study is required on outstanding actions and delays. Tis will now be reported quarterly to IPCG to oversee the action plan as well as HSSG.

21.9 The annual audit data will also start to be presented to IPCG through that report.

22 CONCLUDING REMARKS

22.1 Following on from some challenging times for IPC both nationally but also locally 2022/23 has been an opportunity for the IPCT to develop robust process and systems for monitoring management of infections, training, changes and improvements as well as start to make changes to ways of working, style and culture within the team.

22.2 The IPCT have achieved a great deal in 2022/23 with taking over both the FIT testing oversight, SSIS and decontamination.

22.3 The team have forged great links with new teams within the hospital and have worked well with estates and facilities to make changes to both cleanliness and the fabric of the building. IPC is now involved from the start of any building works. There is still work to do both with cleanliness and the estate but this has been a year to understand the problems that need to be resolved.

22.4 The IPCT have integrated into divisional working and support especially led by the 2 band 7's attending divisional and care group meetings

22.5 There has been collaborative working with facilities and procurement as well as clinical teams in trialling new products, reviewing practices and implementing new processes.

22.6 SSIS has ensured good working with the surgical team particularly the orthopaedic teams.

22.7 Areas of focus IPCT did achieve were

- To relaunch the link practitioner programme
- To undertake surgical site surveillance as part of IPC work
- To monitor location and dates of MRSA acquisitions to identify any trends
- To start to include PIR outcomes against the relevant organisms
- To continue to implement the COVID guidance in line with NHSE/I guidance
- To develop a decontamination lead post in the hospital to support decontamination work
- To develop the new staff as IPC practitioners and support their education
- To support the 2 teams in integrating into the divisions to provide the divisions with education, audit data and support

22.8 There were steps the team were hoping to implement this year but have now been planned for 2023/24 and are part of the annual programme. These are

- To develop a process similar to *C,Difficile* for MSSA and Gram negative bacteraemias to ensure learning and to support the 5% reduction required
- To return to face to face training as an addition to e-learning
- To ensure water safety, estates, occupational health and antimicrobial stewardship have an annual summary as part of this report

22.9 Other areas for the IPCT to focus on in 2023/24 are

- To develop a plan for continued FIT testing within the Trust along with EPRR
- To complete a business case for replacement of Commodes, introduction of sporicidal wipes and peracide
- To develop the service to be 7 days for IPC support
- Simulation IPC training to support wards that are challenged with HAI's and as part of level 2 training
- Continue to improve with hospital cleanliness and estates work looking at use of UVC and potentially HPV tools to support cleaning.
- Provide decontamination audit data which includes laundry, waste, endoscopy, theatres, mortuary and procurement.
- Improving the work of antimicrobial stewardship and supporting the antimicrobial pharmacist
- Developing an IPC web page with links to all of the surveillance data, organism of the month and key messages with learning from PIR's