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| **Committee / Group / Meeting, Date** | |
| Quality and Safety Committee 20th June 2024 | |
| **Author:** | **Contributors:** |
| Name: Samantha Young  Role/Title:Deputy Director for IPC | Anna Morris – IPC Clinical Lead  Hayley Gingell – IPC Assurance Lead  Sian Langford – Estates and Facilities |
| **Report sign-off:** | |
| Samantha Young | |
| **Is the report suitable for publication:** | |
| YES | |
| **Key issues and considerations:** | |
| The IPC Annual Report demonstrates the activities of RJAH relating to infection prevention and control from April 2023 to March 2024, including progress made against the work plan and targets identified in the Infection Prevention and Control Annual Programme. It also includes performance against key areas in Infection Prevention and Control. Ward specific audits are reported monthly through Trust wide Key Performance Indicators (KPIs). | |
| **Strategic objectives and associated risks:** | |
| The report fulfils its statutory requirements under the Health and Social Care Act 2008: Code of Practice on the prevention and control of infection and related guidance, which sets out ten criteria of which a registered provider must be compliant. The prevention and management of infection is the responsibility of all staff working withing RJAH and is integral to patient safety. The Infection Prevention and Control Team maintains organisational focus and works collaboratively to deliver the IPC strategy to ensure continued compliance with IPC practices.  The following strategic objectives are relevant to the content of this report:   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | The following strategic objectives are relevant to the content of this report:   |  |  |  | | --- | --- | --- | | **Trust Objectives** | |  | | 1 | Deliver high quality clinical services | 🗸 | | 2 | Develop our veterans service as a nationally recognised centre of excellence | 🗸 | | 3 | Integrate the MSK pathways across Shropshire, Telford and Wrekin | 🗸 | | 4 | Grow our services and workforce sustainably | 🗸 | | 5 | Innovation, education and research at the heart of what we do | 🗸 |   This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:   | **Board Assurance Framework Themes** | |  | | --- | --- | --- | | 1 | Continued focus on excellence in quality and safety | 🗸 | | 2 | Creating a sustainable workforce | 🗸 | | 3 | Delivering the financial plan | 🗸 | | 4 | Delivering the required levels of productivity, performance and activity | 🗸 | | 5 | Delivering innovation, growth and achieving systemic improvements | 🗸 | | 6 | Responding to opportunities and challenges in the wider health and care system | 🗸 | | 7 | Responding to a significant disruptive event | 🗸 |   System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:   |  |  |  | | --- | --- | --- | | **System Objectives** | |  | | 1 | Improve outcomes in population health and healthcare | 🗸 | | 2 | Tackle inequalities in outcomes, experience and access | 🗸 | | 3 | Support broader social and economic development | 🗸 | | 4 | Enhance productivity and value for money | 🗸 | |  |  |  | | --- | --- | |  | What providers will need to show evidence of | | Criterion 1 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them. | | Criterion 2 | Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections | | Criterion 3 | Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance | | Criterion 4 | Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion | | Criterion 5 | Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. | | Criterion 6 | Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. | | Criterion 7 | Provide or secure adequate isolation facilities. | | Criterion 8 | Secure adequate access to laboratory support as appropriate | | Criterion 9 | Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections. | | Criterion 10 | Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection | | |
| **Recommendations:** | |
| The Committee is asked to review the amended report and approve as an accurate record of IPC services for 2023-2024 ready for publication on RJAH external internet site. | |
| **Report development and engagement history:** | |
| This report is produced annually and offers an overview of compliance and quality specific to The Health and Social Care Act 2008: Code of Practice on the prevention and control of infection.  **Infection Prevention & Control and Cleanliness Report 2023/24** | |

**Forward by the Director of Infection Prevention and Control**

**A person with a grey shirt and blue lanyard

Description automatically generated**As the Director of Infection Prevention and Control (DIPC), I am proud to introduce the Trust’s Infection Prevention and Control annual report for the year 2023/24. It describes the achievements of the Trust under the specialist advice, guidance and support of our Infection Prevention and Control (IPC) Team led by the Deputy DIPC.

This year, we have focussed on a return to business as usual following the COVID-19 pandemic. The report includes highlights of how the IPC Team have delivered on the IPC Strategy and how all staff across the Trust are engaged in effective IPC practices, ensuring we continue to provide safe, effective, and caring services.

They have increased their visibility and engagement to advise, guide and educate staff, patients, and visitors in all IPC matters. In addition, they have developed new systems and revised policies to align with the NHS Patient Safety Strategy and National Infection Prevention and Control Manual. This includes how the Trust investigates infection events and monitors Surgical Site Infections, sharing improvements and learning with colleagues, not only locally but across the Country with the Royal Orthopaedic Hospital in Birmingham.

Auditing remains a mainstay of how we monitor compliance with standards and legislation, and I am delighted that our audit suite has been updated to make it easier for our teams to demonstrate the standards expected in IPC practice, as well as the cleanliness of our facilities and improvements to our estate.

This report demonstrates that we continue to sustain our improvements in IPC and that infection prevention and control is taken very seriously here at the Trust. We are committed to providing the highest standard of care in a safe and clean environment.

A close-up of a note

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Paul Kavanagh-Fields

**Chief Nurse, Director of Infection Prevention & Control, and Patient Safety Officer**

**Glossary of terms**

|  |  |
| --- | --- |
| Bacteraemia | The presence of bacteria in the blood without clinical signs or symptoms of infection |
| CDI | Clostridioides difficile infection. It is a bacterium found in the intestines of around 1 in 30 adults, and usually causes no harm. An overgrowth of this bacteria can produce toxins which cause inflammation and can be difficult to treat. |
| E. coli | Escherichia Coli is a bacterium found in the intestines. It can cause infections and can prove difficult to treat. |
| HAI | Healthcare Associated Infection. An infection either as a direct result of healthcare intervention such as medical or surgical treatment, or from being in contact with a healthcare setting. |
| MRSA | Methicillin Resistant Staphylococcus Aureus is a highly resistant strain of the common bacteria |
| MSSA | Methicillin Sensitive Staphylococcus Aureus is the more common sensitive strain of Staphylococcus Aureus. |

**Acronyms**

|  |  |
| --- | --- |
| AE (D) | Authorised Engineer (D) |
| AMS | Antimicrobial Stewardship |
| ANTT | Aseptic Non-Touch Technique |
| CAUTI | Catheter-Associated Urinary Tract Infection |
| CQC | Care Quality Commission |
| DIPC | Director of Infection Prevention & Control |
| E. coli | Escherichia coli |
| HAI | Healthcare Associated Infection |
| HPV | Hydrogen Peroxide Vapour |
| HTM | Health Technical Memorandum |
| IPC | Infection Prevention & Control |
| IPCM | Infection Prevention & Control Meeting |
| IPCT | Infection Prevention & Control Team |
| ICD | Infection Control Doctor |
| ICS | Integrated Care System |
| KPIs | Key Performance Indicators |
| MDT | Multi-Disciplinary Team |
| MHRA | Medicines and Healthcare products Regulatory Agency |
| PIR | Post Infection Review |
| PLACE | Patient Led Assessment of the Care Environment |
| SATH | Shrewsbury and Telford Hospitals |
| SSI | Surgical Site Surveillance |
| SNAHP | Senior Nurse and Allied Health Professionals |
| SOP | Standard Operating Procedure |
| STW | Shropshire, Telford and Wrekin |
| TSSU | Theatre Sterile Services Unit |
| UKHSA | UK Health Security Agency |
| WTE | Whole Time Equivalent |

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### **Introduction**

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a specialist orthopaedic centre. We provide specialist and routine orthopaedic care to our local catchment area, as well as specialist services both regionally and nationally.

Our organisation is a single site hospital based in Oswestry, Shropshire, close to the border with Wales. We serve the people of England and Wales, as well as acting as a national healthcare provider. We also host some local services which support the communities in and around Oswestry. The hospital is a specialist centre for the treatment of spinal injuries and disorders and provides specialist treatment for children with musculoskeletal disorders. Additionally, the Trust works with partner organisations to provide specialist treatment for bone tumours and community-based rheumatology services.

The Trust is part of the National Orthopaedic Alliance (NOA), an acute care collaboration vanguard designed to improve orthopaedic care quality across England.

We are proud to be a Veteran Aware hospital aiming to provide the best care for veterans in the NHS.

Veteran Aware hospitals are leading the way in improving veterans' care within the NHS.

We are part of the Veterans Covenant Hospital Alliance (VCHA) which means we're sharing and driving best practice in NHS care for people who serve or have served in the UK Armed Forces in line with the Armed Forces Covenant.

We support the health commitments of the Armed Forces Covenant and are committed to ensuring no disadvantage and giving special consideration where appropriate.

As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to deliver world class care by working in partnership to continuously improve and meet the needs of those we serve.

# **Health and Social Care Act 2008: code of practice on the prevention and control of infections**

The Health and Social Care Act (revised 2022), sets out the code of practice on the prevention and control of infections and applies to registered providers of all health and adult social care in England. This act sets out the overall framework for the regulation of health and adult social care activities by the Care Quality Commission (CQC).

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|  | What providers will need to show evidence of |
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# **Key Achievements 2023/24**

Infection Prevention and Control is a key priority for the Trust and every member of our staff is committed to ensuring safe and effective IPC practices and procedures. This year, IPC has been focussed on a return to basics following the impact that the COVID-19 pandemic had across our Trust.

Following the launch of the IPC strategy in January 2023, throughout 2023 and into 2024, the Trust has been working toward achieving excellence in IPC practice. Progress has been achieved through all 4 domains of integrated working; education; digital technology and enhanced engagement and is reported through our governance structures.

The IPC team underwent changes in structure this year with a new IPC Clinical Lead, Anna Morris, appointed in May 2023. There have also been several changes to the way the service is delivered which has supported the IPC team strategy, and we are proud of this year’s key achievements with highlights below:

* We hosted the annual IPC Fayre in May which was well attended by staff across the Trust. Our continued collaboration with the Estates & Facilities teams enabled us to have a combined approach to infection prevention and control, which included practical demonstrations on how to perform effective cleaning of patient equipment.

  A group of people in a room

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* We have redesigned the way we deliver IPC services across the Trust. We have introduced a new programme that includes an audit refresh, increased support and visibility to our clinical teams, involving our patients in audit, re-invigorated our education programme and following the NHS Patient Safety Strategy, changed how we manage and investigate infection events. With increased capacity within the IPC Team since October, we have been able to extend our quality assurance audit programme into non-clinical areas to ensure that high standards of infection prevention and control is adopted in all areas of the Trust.
* We have introduced a new way to monitor Surgical Site Infections through Statistical Process Control charts. These allow us to track trends and variations and triggering investigations when our control limits are reached. We conduct thorough investigations into all Healthcare Associated Infections liaising with our IPC partners across the Integrated Care Board, NHSE and the United Kingdon Health Security Agency. We have also been working closely with colleagues from the Royal Orthopaedic Hospital to share best practice on infection prevention.
* Patient hand hygiene surveys – the IPC team acknowledged difficulties in the monitoring of the WHO 5 moments of hand hygiene compliance that is performed at the patients’ bedside (often behind the privacy curtain), and this was demonstrated in ward and department weekly hand hygiene audits. The IPC Team devised a new patient hand hygiene survey that is carried out by the IPC support worker. The survey enables patients to give feedback around how hand hygiene is performed as an in-patient, prompting opportunities to for education and promotion of best practice. The results of are now included in monthly IPC quality reports where themes can be shared, and improvements agreed and implemented.
* We acknowledged the difficulties that staff face in leaving their work areas to attend training, so we devised several IPC related educational resources and delivered sessions to staff within their work environment to support their needs.
* We developed a new way of enabling staff to provide best practice for patients with alert organisms by creating care checklists. The checklists provide organism specific precautions for staff to ensure are in place to prevent cross-infection, in line with the National IPC Manual for England. Staff have fed back that they find the checklists helpful in the management of patients with infections.
* At this year’s Nursing/AHP celebration event, we were very proud of our IPC Support Worker Will Walter, who was the first healthcare assistant to receive the Dame Agnes Hunt Medal.

A group of men holding a certificate

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*IPC Support Worker Will Walter (centre)*

# **Criterion 1: Systems to manage and monitor the prevention and control of infection.**

**IPC Structure**

**A diagram of a company

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The **Chief Executive Officer** has overall responsibility to ensure that systems and resources are available to implement and monitor compliance with infection prevention and control at RJAH.

The **Director of Infection Prevention & Control** **(DIPC)** is the Executive Lead for IPC and oversees the implementation of the IPC programme of work through their role as Chair of the Trust Infection Prevention and Control and Cleanliness Meeting (IPC&CM). The DIPC delegates the responsibility and management of IPC for the Trust to the Deputy Director for Infection Prevention and Control (DDIPC). The DDIPC reports directly to the DIPC and on to the Chief Executive and the Board on all IPC matters.

The Trust employs an Infection Control Doctor who is employed by SaTH and has a contract to deliver services for RJAH in the in and out of hours period. This includes clinical microbiology advice and reporting, virtual, microbiology ward rounds, antimicrobial stewardship and infection prevention and control advice.

The ICD:

* Advises and supports the DIPC
* Oversees local IPC policies and their implementation by ensuring that adequate laboratory support is in place
* Attends the Water Safety Group and Decontamination Group
* Provides expert clinical advice on infection management
* Attends Infection MDT meetings and provides expert advice on complex/infected cases
* Has the authority to challenge clinical practice including inappropriate antibiotic prescribing

**The Infection Prevention and Control Team (IPCT)**

The Infection Prevention and Control Team (IPCT) are the medical and nursing infection prevention and control specialists responsible for providing a proactive IPC service to the Trust aligned to the National Infection Prevention and Control Manual, the IPC Strategy, and their programme of works.

RJAH Orthopaedic Hospital NHS Foundation Trust (RJAH) IPCT currently consists of:

* Deputy Director of IPC (1.0 WTE)
* Infection Prevention and Control Lead Nurse: Band 7 (1 WTE)
* Infection Prevention & Control Nurse Specialist: Band 6 (1.0 WTE)
* IPC Assurance Lead (1.0 WTE): Band 6
* Surgical Site Surveillance Nurse: Band 5 (0.4 WTE)
* Surgical Site Surveillance Practitioner Band 5 (1.0 WTE)
* IPC Support Worker Band 3 (1.0 WTE)
* IPC Administrator/Support Secretary Band 2 (1.0 WTE)

**The Antimicrobial Pharmacist**

The Trust has a designated Antimicrobial Pharmacist. They work with the ICD and other members of the IPC team. The role of the antimicrobial pharmacist includes:

* Supporting antimicrobial stewardship initiatives
* Lead for the Trust antimicrobial CQUINs
* Maintaining a programme of audits in line with national guidance

**Infection Prevention Control & Cleanliness Meeting**

The RJAH Infection Prevention & Control Meeting (IPCCM) is a multidisciplinary Trust Meeting with stakeholder representation from UKHSA and the ICB. The IPCCM oversees the activity of the IPCT and observes the implementation of the infection control programme of work.

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**The IPC Programme of Work/Workplan**

The IPC Programme of Work 2023-24 was designed to focus on achieving full compliance with the standards identified in the Health and Social Care Act, and to monitor compliance with national and local infection related thresholds. To ensure consistent momentum with improvements, the team adopted an annual workplan to meet deadlines assigned to works sited on the IPC Quality Improvement plan. The last action in progress is updating IPC Policies in line with the new national IPC manual.

**Quality Management System**

We continue to use a quality management system to capture all data in relation to IPC. The system holds a data warehouse that consolidates all IPC related data and provides a central space for correlation of themes and trends. The system incorporates a dashboard providing a live position for IPC governance position.

This year, the system has evolved to include:

* Live Unit level dashboards for real-time data
* Policy matrix and review tracker
* IPC unit reports linked to the system for auto-population of data. Unit reports are presented at Infection Control & Cleanliness Meeting.
* Reports to monitor and track actions relating to IPC generated from many sources.
* Rolling audit plan to include IPC Assurance audits
* Live reporting to surgical site infections and statistical process charts.

**Infection Prevention and Control Working Group**

The purpose of the Infection Prevention and Control, and Cleanliness Working Group (IPC&CWG) this group is to ensure that the Trust is fully engaged and proactive in delivering the IPC agenda aligned to the statutory requirements of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections (Revised December 2022) Care Quality Commission Standards and other national, regional or professional bodies. This involves oversight of leadership and ownership of IPC&C at a service and operational level.

The group provides a forum for discussion, review and approval of IPC&C and Estates related activity, policy, procedure and guidance, and monitors the progress of actions against the Infection Prevention and Control Quality Improvement Plan and IPC Quality Management System.

The Infection Prevention and Control Working Group met on a bi-weekly basis throughout 2023. The meetings were well attended with the IPC Quality Improvement plan as a standing item on the agenda to maintain oversight of actions. This group reports to the Infection Prevention & Control and Cleanliness Meeting. The Working Group provides effective communication between the IPC team, operational areas, and Estates & Facilities by identifying and resolving issues in line with Trust priorities.

**IPC Link Staff System**

The IPC Link Staff system enables the IPC Team to deliver key information, education, and advice that is shared to the wards and departments in a cascade system. IPC Link Staff form part of a group that meets bi-monthly. The IPC Team and the link staff ward/department managers agree to roles and responsibilities which clearly define the expectations of the link staff role. Attendance at meetings has continued to improve this year, with a variety of topics covered including ways to improve hydration to avoid urinary tract infections, teaching sessions around CDI, MRSA screening, and how to take urine samples from catheters safely. Continuing with our collaborative approach with Estates & Facilities we included an educational session around the roles and responsibilities for cleaning in line with the National Standards of Cleanliness.

**Board Assurance Framework**

The Health and Social Care Act was revised in December 2022 to reflect changes in the IPC role in improving antimicrobial use and combating resistance.

In February 2023, an updated version of the National IPC Board Assurance Framework (BAF) was released to align with the criteria of the Health & Social Care Act 2008. This framework serves to provide boards with a structure for self-assessing compliance with measures outlined in the National Infection Prevention and Control guidance by the UK Health Security Agency (UKHSA).

The IPC Team has developed a dashboard that combines elements of the HSCA and IPC BAF to oversee compliance. Trust position at close of 2023/24 reported compliance of 97% with no areas of non-compliance as demonstrated below:

A green circle with numbers and a number on it

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Compliance to both frameworks is monitored by the IPC Team and reported through the IPC&CC Meeting for oversight.

**Mandatory Surveillance**

All organisms of significance are monitored by the IPC team via a database supported by the SaTH laboratory so that timely action can be taken to support the clinical teams in the management of patients, including safe patient placement and advice on isolation requirements to prevent cross infection risks.

**Healthcare Associated Infections**

Reducing healthcare associated infections (HAIs) remains high priority. Challenges in the management of infections have been experienced nationally with not only an increase in resistant micro-organisms, but also the number of patients experiencing infections.  The Trust has seen a rise in Healthcare Associated Infections, and we have been working closely with NHSE to monitor data and share learning.

HAIs can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being on contact with a healthcare setting. There is overwhelming evidence that the implementation of IPC best practices leads to significant reductions in HAIs and patient harm. All healthcare workers are responsible for the prevention of HAIs by ensuring they practice standard infection control precautions at every patient interaction.

Reportable infections are categorised either as avoidable or unavoidable:

An **avoidable** HAI is an infection that could have been prevented by following correct IPC precautions. For example, a patient could develop a urinary tract infection from a catheterisation performed in a healthcare setting where the practitioner did not follow correct precautions.

An **unavoidable** HAI is an infection that could not have been prevented, despite following best practice. For example, a patient with a history of CDI who has had a prolonged stay in hospital, and receives antibiotics to treat an infection, which disrupts the microbiome of the intestines and allows CD to germinate and produce toxins that can cause watery diarrhoea.

The IPC Team follow a post-infection review process for every RJAH acquired reportable infection. This system allows the organisation to identify how the case occurred and identify how the Trust can learn and improve.

The chart below shows the total number of HAIs reported for this year and highlights that the Trust exceeded the set objectives for MSSA, CDI, E. coli and Klebsiella this year.:

A table with numbers and letters

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**Multi-drug resistant organisms (MSSA, E.Coli, Klebsiella)**

Although the cases were attributed to the Trust, they were classed as unavoidable. This means that there was nothing we could do to prevent our patients developing the infection at the time. Aligned to our policy, the IPCT investigated all cases. We discovered that those confirmed as catheter associated urinary tract infections (CAUTIs) were assocaited with a particular brand of urine collection bag that had been procured for the Trust. This was a significant contributory factor. The Trust immediatley removed these products from use and reported through the Yellow Card reporting mechanism to the Medicines and Healthcare products regulatory Agency (MHRA) who are responsible for regulating medicines, medical devices and blood componments for tranfusion in the UK, over concerns that this product was occluding, resulting in ineffective draining. RJAH IPCT also reported the issues to the system procurement team and advised our partner organisations. We are pleased to report a reduction in CAUTI associated bacteraemia cases since the products have been taken out of use and an alternative product supplied.

**Clostridioidies difficile infection (CDI)**

Clostridioidies difficileis a type of bacteria that can cause diarrhoea and other symptoms. It is found in peoples’ intestines and affects around 3% of the populaion where is causes no symptoms. If Clostridioidies difficile is present in the bowel, it can grow to unusually high levels (usually after taking antibiotics for another infection) and can produce toxins that attack the intestines and cause mild to severe infection.

The Trust reported 5 cases of RJAH acquired CDI this year. Whilst this has taken the Trust over the objective of 2, it is important to note that these cases were attributed to a total of two patients who had multiple relapses (or reoccurances) of CDI due to other risk factors.

A rise of hospital onset CDI has been observed nationally following the COVID-19 pandemic, whereas prior to this, rates were generally declining with some fluctuations. This change in trend to a steady increasing trajectory is of major concern and is the only data collection where there has been a major shift post pandemic. The reason or which are being investigated by NHSE. In response to the national rise in CDI, the Deputy Director for IPC submitted a CDI action plan for a collaborative approach to the prevention of CDI to the ICB. The IPC Team shared several helpful tools such as CDI prompt cards, care checklists and teaching sessions to provide staff with underpinning knowledge required to manage suspected or confirmed cases of CDI and to avoid the risk of cross-infection. In September, IPC link staff attended the bi-monthly IPC Link Staff meeting where they were educated on CDI and they created fact sheets related to their clinical areas for staff to raise awareness.

**Infection Prevention & Control Ward/Department Audits**

Wards and departments complete a package of infection prevention and control audits across the year to show continuous monitoring of standards. The suite comprises of environmental auditing, hand hygiene, and bare below the elbows (BBE).

The following graph shows the Trust’s over all compliance for each audit.

The results show that the Trust averaged above the 95% target for Hand Hygiene and BBE, and IPC General Inspections.

A graph of a number of blue and orange squares

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**IPC Quality Assurance Walks**

The IPC team undertake regular audits called Quality Assurance Walks. The walks enable us to monitor standards of IPC within the wards/departments, such as hand hygiene, patient placement, cleanliness of the patient environment, linen management, waste management, and other standard infection control precautions.

Since introduction of the IPC Quality Assurance Walk system in August 2021, the team continue to undertake a rolling programme of assurance audits driven by a Red Amber Green (RAG) rated escalation process, with frequencies set in line with functional risk categories from the National Standards of Cleanliness.

In 2023-2024 the IPC team prioritised alignment of all audit toolkits to the National Infection Prevention and Control Manual for England (NIPCM); to provide further assurance around standard infection control precautions.

This year a total of 85 walks were undertaken that identified common themes such as condition of walls and floors in clinical areas. Quality assurance walks are documented using an electronic programme that enables actions to be identified to the responsible ward/dept manager straight away. All actions are monitored through the Infection Prevention and Control & Cleanliness Working Group to ensure that actions are dealt with in a timely manner.

This year, the IPC team are pleased to report 100% compliance to the IPC QA walk plan.

# **Criterion 2: Provide and maintain a clean and appropriate environment**.

The Trust understands the importance of providing a well maintained and functional environment where patients, staff and visitors can be assured of high standards of cleanliness.

**Cleanliness**

Cleaning was provided by the Trust’s in-house team of cleaners and deep cleaners and our internal team was supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the Credits for Cleaning information system, with further input from local stakeholders, on a risk adjusted basis.

The ward housekeepers, introduced in Q4 of 2022/23, have become embedded throughout the year, with cleaning responsibilities updated to reflect this new hybrid role.

Outcomes for cleaning continued to be monitored internally throughout the year. To provide greater levels of assurance, external and patient led monitoring, including PLACE assessment were also completed in line with our workplan.

**Cleanliness – Enhanced Cleaning**

Whilst routine cleaning is completed in all areas daily, staff in high-risk areas are supported with extra staff to complete an enhanced clean on a weekly basis. In the very high-risk area of theatres there is a rolling deep clean programme that runs alongside the routine clean; cleaning in these areas is completed over night, when the theatres are not in use, to provide the most effective service.

The Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour for the fogging of facilities and equipment in certain circumstances, as specified by the Infection Control Policy, room cleaning is completed as below:

* Green – Standard daily clean using detergent.
* Amber – Terminal clean using 1000 ppm Chlorine Based Agent
* Red – Terminal clean using 1000 ppm Chlorine Based Agent followed by HPV fogging.

This protocol has ensured that there are no delays in the provision of enhanced cleaning whilst clinical sign off is sought.

The Trust employed an external contractor to complete HPV fogging; responses to date have been quick, effective, and professional.

2 individual rooms, 3 complete bays and 2 theatres have required a red terminal clean in 2023/24; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion. This is consistent with the number of red cleans reported in 2022/23.

This year, the infection control and cleanliness working group has reviewed it’s enhanced cleaning process, including demonstrations of alternative technologies. The group were assured the current process remains fit for purpose.

**Cleanliness – Internal Monitoring**

The Housekeeping Department has devised an effective sign-off sheet that allows staff to easily demonstrate the work they have completed and alert the next person on shift to any outstanding requirements. Evidence of cleaning is retained by the department and is validated by supervisor monitoring and managerial spot checks. This year, the team have worked closely with clinical colleagues to use this template to improve documentation of cleaning of bedspaces, providing consistency across documentation regardless of the cleaning responsibility.

Internal monitoring is carried out every day, visiting all areas on a rolling programme according to their risk. All cleanliness matters are issued within 24 hours to the relevant team, assurance is provided in relation to resolution through signed off completion. All required improvements identified by the audits are acted upon by the internal team and the results are reported to the Infection Prevention & Control Meeting on a quarterly basis, with specific action plans or failure themes managed through the Infection Prevention & Control Working Group.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2023/24 the Trust achieved an average score of 96.20%.

**National Standards of Cleanliness 2021**

The Trust fully complies with the requirements of The National Standards of Healthcare Cleanliness (2021). In 2023, as recommended by the standards, we invited colleagues from Shrewsbury and Telford Hospitals NHS Trust to complete an external assessment against the standards, which included a review of governance and reporting processes, staff interviews, and technical inspection. The assessment reported full compliance with the requirements of the standard, and particularly noted the evidence of collaborative working across clinical teams and support services to ensure assurance is provided of the cleanliness standards maintained throughout the Trust.

**Infection Prevention & Control and Cleanliness - Collaborative Working**

The Estates, Facilities and Infection Prevention and Control teams work collaboratively throughout the year, formally through the Infection Prevention & Control and Cleanliness Working group, documented sign off following refurbishment works and quarterly reports. This year, the team has joined to facilitate an IPC fayre, where awareness and education relating to waste segregation, cleaning standards and cleaning techniques were shared.

**Cleanliness and Environment - Kitchen**

The Trust kitchen retained its 5-star food hygiene rating at last inspection in November 2022, which in particular, highlighted the high standards of cleanliness within the Trust kitchens and maintenance of assurance records in line with Hazard Analysis Critical Control Point (HACCP) principles.

Recommendations highlighted as part of the 2022 inspection included structural improvements within the kitchen – this work was completed in 2023 and included replacement of flooring and plastic coating of wall to protect against damage and facilitate effective cleaning.

The onsite nursery is registered with Shropshire Council environmental health and retained its 5-star food hygiene rating in November 2023.

Compliance with the National Standards for Healthcare Food and Drink, published in 2022 and requiring specific standards for food safety within a healthcare setting, is monitored by the Nutrition & Hydration Steering Group, with Food Safety also specifically discussed through Health and Safety Working Group. Going forward, this will include ensuring the Trust has in place access to a food safety specialist and reports are received in line with the workplan.

**CQC Inpatient Survey**

The CQC Inpatient Survey 2022 results were published in September 2023, with the Trust scoring top in the country under the metric ‘how clean was the hospital room or ward that you were in’ with an average score of 9.87. The consistently excellent results achieved through this survey are a testament to the dedication and exacting standards maintained by the entire housekeeping team.

**PLACE – Patient Led Assessment of the Care Environment**

The National PLACE assessment was completed and submitted in October 2023.

PLACE captures responses to questions on cleanliness; food; privacy, dignity, and wellbeing; condition, appearance and maintenance; dementia and disability. Each year questions are updated/added to reflect what is deemed as best practice – therefore careful consideration must be given when making any comparison to previous years responses, however this patient led assessment provides vital insight into the patient’s perspective of the environment.

This year, we welcomed colleagues from Shropshire Community Health Trust to take part in the assessment, gaining valuable insight from their perspective alongside patient panel and volunteer representation.

|  |  |
| --- | --- |
| Domain | 2023 score |
| Cleanliness | 98.84% |
| Food | 88.60% |
| Privacy, Dignity & Wellbeing | 91.84% |
| Condition, Appearance & Maintenance | 95.75% |
| Dementia | 79.40% |
| Disability | 80.42% |

**Linen**

Quarterly review meetings were held to ensure standards relating to the provision of linen were monitored.

Linen services are provided by an alternative external supplier, who continues to provide assurance to the infection control working group through monthly compliance reporting against National Guidance standards (HTM 01 04)

**Clinical Waste**

Quarterly review meetings continued to ensure standards relating to the provision of clinical waste were monitored.

Clinical waste services are provided by an alternative external supplier. Assurance this waste is being managed, both at Trust level and by the external contractor, in line with National Guidance is provided to the infection control working group though annual pre acceptance audits.

This year, NHS England published its first Clinical Waste strategy, alongside a refresh of relevant guidance (HTM 07 01). The strategy sets out a clear direction of travel for the management of clinical waste, including a waste segregation target of 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste.

The Trust took action to ensure waste segregation was being applied in line with this latest legislation, specifically within the theatre department where offensive waste had not widely been utilised, resulting in significant improvements with the Trust now reporting segregation metrics above those specified by the strategy.

Compliance with this guidance is monitored through the Health and Safety working Group, in close the collaboration with Infection Prevention and Control team.

**Estates Department Contribution to the Clean and Appropriate Work Environment**

Estates department activity is essential in delivering the IPC agenda, it is delivered under the principles outlined in National Guidance, which covers the importance of a clean, safe environment for all aspects of healthcare.

Matters of Estate that impact the clean environment are escalated through the IPC working group for prioritisation and oversight. This year, projects have included:

* Refurbishment of therapies areas including floor replacement and wall cladding
* Refurbishment of Clwyd & Powys staff change & toilets.
* Refurbishment of metabolic room including storage
* Ongoing refurbishment of bathrooms
* Ongoing refurbishment of outpatient rooms
* Replacement floor in areas of theatres including entrance corridor and bone bank.
* Refurbishment of Kenyon sluice
* Replacement of flightwash within main kitchen
* Extension and refurbishment of main linen room
* Replacement of decontamination equipment in TSSU B

**Water**

The control of water is a legal requirement; the Estates Department work to National Guidance to mitigate risks from exposure to Waterborne Pathogens

The Estates department continues to employ a third-party contractor to provide technical advice for water services and undertake water risk assessments on Trust properties every two years, or where required following incidents or significant infrastructure changes.

There is a written site-specific scheme of control within the Water Safety Plan. Eurofins provide the Trust an internet-based water testing database storage and reporting for statutory test results. There is also a three-monthly review of test results, control measures and procedures at the Water Safety Group to ensure compliance with current legislation and these results are published at the Infection Prevention Control Working Group.

In line with National Guidance. The Trust has an Authorising Engineer for Water AE (W), appointed in writing. The AE(W) is a ‘independent advisor,’ who offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust’s resilience and bolsters the management of water hygiene.

The Estates Department continually undertake water tests throughout the Trust estate. This water testing is carried out in line with legislation and guidance. Testing is standard practice at RJAH to ensure robust control of waterborne infections such as legionellosis; it is a method of using qualitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. The Trust conducts Water sample tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

In response to out of parameter results, the mechanical team within the Estates department continue to employ an effective method of thermal disinfection. This process increases efficacy and reduces costs because of the in-house delivery of such works. Disinfection is often employed to manage domestic water hygiene.

The Trust is therefore assured that the Water Safety of the site is compliant in-line with current Legislations and guidance.

**Ventilation**

It is a legal requirement to provide adequate Ventilation in enclosed areas of a workplace.

Ventilation is led and monitored by the Estates Department, supported by an Authorising Engineer for Ventilation AE(V), appointed in writing. The AE(V) is a ‘independent advisor,’ a requirement of National Guidance and offers technical advice to the Trust, auditing the Specialised Ventilation and increasing the Trust’s resilience.

The Trust conducts monthly air velocity tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

The RJAH Estates team conduct Quarterly PPM’s on all Air Handling units (AHU’s) to ensure they are clean, fully functional, and proactively manage any issues that should arise.

Accredited third party contractors revalidates theatres on an annual basis, providing an inspection and reverification report. These reports are then reviewed by the Trusts Authorising Person (AP(V) and the AE(V)

The Trust is therefore assured that the sites Ventilation Systems are compliant in-line with current Legislations and guidance.

**Decontamination Group**

Decontamination, which covers the theatre and sterile services environment, is led and monitored by the Estates department supported by their third party accredited Authorising Engineer for Decontamination AE(D), who is appointed in writing. The AE(D) is a ‘independent advisor,’ a requirement of National Guidance who offers technical advice to the Trust, auditing the Decontamination equipment and increasing the Trust’s resilience.

The RJAH Estates team maintain a local testing regime of Decontamination equipment on a weekly basis and proactively manage any issues that should arise. Reports are produced for Quarterly and Annual Testing. These reports are then reviewed by the Trusts Authorising Person (AP(D) and the AE(D)

The Trust is therefore assured that the Decontamination of Theatre Surgical equipment is compliant in-line with current Legislations and guidance.

**Personal Protective Equipment (PPE)**

The department maintained responsibility for control of PPE, to ensure the Trust benefited from sufficient stock of appropriate PPE; responsibilities included:

* Management of Trust stock through the National PUSH model and consideration of mutual aid requests to support the wider region – noting that this model was scaled down throughout the year and will cease operations and return to normal operating procedures for procurement in April 2024.
* Installation of daily top up service of PPE stations, alongside ensuring adequate PPE is available at point of care for clinical teams.
* Provision of FFP3 fit testing & supporting clinical teams to ensure staff are protected with masks in line with the most up to date guidance.

Post COVID, there is an ongoing mandatory requirement for the Trust to ensure that relevant members of staff are supplied with, and fit-tested for, FFP3 close-fitting face masks to comply with legislation contained in The Control of Substances Hazardous to Health Regulations and guidelines in the National Infection Prevention and Control Manual for England, the FFP3 Resilience Principles in Acute Settings and Emergency Preparedness, Resilience and Response Core Standards.

Staff are required to be fit mask tested at two yearly intervals and to two different styles of FFP3 mask. The Health and Safety Team procured a flexible solution using an external contractor to undertake the Trust fit mask testing to provide a flexible solution to account for RJAH Operational pressures, which commenced in March 2024.

# **Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.**

The antibiotic usage data has been obtained from Refine which is based on supply records from the CMM dispensing system and is not at patient level.

This graph shows that the total antimicrobial consumption within the trust over the last 24 months (June 2022 – May 2024) has remained fairly static when looking at DDDs/1000 total admissions.

DDD (Defined Daily Dose) – ‘The assumed average maintenance dose per day for a drug used for its main indication in adults’. It is defined by the World Health Organisation (WHO).

This graph shows the percentage of access, watch and reserve antibiotics that have been used over the past 24 months (June 2022 – May 2024) in the trust. The usage has remained fairly static with watch antibiotics increasing by only 2% and reserve antibiotics decreasing by 2%.

EML – List of Essential Medicines

AWaRe – This is a WHO classification for antimicrobials which is split into Access, Watch and Reserve:

* Access antibiotics e.g. amoxicillin – first or second choice antibiotics which are used empirically for common infections while minimising the potential for resistance. They usually have a narrow spectrum of activity, fewer side effects and are lower cost.
* Watch antibiotics e.g. meropenem – first or second choice antibiotics which are used for more specific limited number of infections. They need to be closely monitored to avoid overuse as they are more prone to be a target of antibiotic resistance.
* Reserve antibiotics e.g. linezolid – these are ‘last resort’ antibiotics used for severe infections usually associated with multi-drug resistant bacteria. They need to be closely monitored to ensure their continued effectiveness.

According to the WHO AWaRe classification carbapenems and Tazocin are watch antibiotics. The graphs below indicate the usage of both as they are often prescribed within the trust.

This graph shows the overall usage of carbapenems (meropenem and ertapenem) within the trust over the last 24 months (June 2022 – May 2024). Since Q2 2023 the usage has gradually declined. When reviewing data from Q2 2024, 100% of patients prescribed ertapenem had microbiologist involvement, whereas 71.4% of patients prescribed meropenem were either as per culture sensitivities or prescribed after microbiologist advice was obtained.

This graph shows the overall usage of Tazocin over the last 24 months (June 2022 – May 2024). In Q3 2023/2024 a SLA (Service Level Agreement) was put in place with Sheffield hospital for antimicrobial support in Orthopaedics only. Since then, there has been a varying increase in its use as the Sheffield first line antibiotics for revision of infected arthroplasties includes Tazocin. However, the use has declined since March 2024 but this reflects the different patient groups that are admitted to the trust.

It is important that the trust continues to monitor the usage of antimicrobials through good antimicrobial stewardship to help combat antimicrobial resistance which will support further scrutiny of watch and reserve antimicrobials.

**Future actions**

* A weekly antimicrobial ward round with the antimicrobial pharmacist and IPC lead will provide greater insight into the use of antimicrobials within the trust.
* Quarterly antimicrobial reports will be presented to the Drug and Therapeutics Committee.
* Implementation of EPMA (Electronic Prescribing and Medicines Administration) will be able to provide the trust with patient level prescribing data which will be a more accurate reflection of the prescribing patterns.

**Point Prevalence Survey (PPS)**

Point Prevalence Surveys collect information on prescribing practices of antibiotics and other information relevant to treatment and management of infection in hospitalised patients, and complements surveillance of antibiotic usage. Last year, the Trust took part in a National PPS. Data for the PPS was collected over 2 days in December 2023, which included antibiotics, indication, co-morbidities, whether there had been a switch from IV to oral and vice versa. Completion of the PPS and upload of the data to the national database was completed within the timeframe.

The survey was aimed at providing a snapshot of the burden of HCAIs (healthcare associated infections) and describes antimicrobial use to allow meaningful comparisons between organisations and over time. Unfortunately, the value of the denominating data was insufficient for generating valuable insights through analysis and evaluation, however, it is important to note that the Trust continues to monitor antibiotic prescribing aligned to this criteria.

# **Criterion 4: Provide suitable accurate information on infections to service users.**

# 

Patients who are identified to be carrying or infected with alert organisms are visited by the IPC Team to ensure that patients are well informed about their condition and how they will be managed during their admission. During the visit, patients and families can discuss any queries or concerns.

**Patient Information**

All patient information leaflets are stored on the Trust website and in paper format.

A review of all patient information leaflets was conducted this year, with improvements made to align the content with current guidance, to enhance accessibility of information for patients, and to avoid information overload.

In addition to the Trust website, the IPC team have an intranet page which is managed locally by the IPC Administrator/Support Secretary. This page has proven to be an effective information hub for staff and serves as a central source for all IPC related information.

**IPC Bulletin**

The IPC bulletin continues to be produced monthly and distributed to ensure efficient communication among staff. Management of the bulletin has transitioned to the local IPC Team, with administrative oversight handled by the IPC Support Secretary. It remains pivotal in conveying updates in IPC procedures, sharing learning and improvements, and highlighting exemplary IPC practices within the Trust.

**Medical Illustration Team**

The IPC team maintains strong links to the Medical Illustration team who continue to provide much help and support this year to enable us to deliver key information to staff and patients. Examples include:

* Poster information for IPC Fayres and exhibitions
* Patient Information Leaflets

We continue to be supported by the team who provide us with a prompt service; enabling us to relay information in a professional, and timely manner.

# **Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection.**

The IPC team perform several activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at a local level; alert organism surveillance and managing outbreaks of infection.

**Oswestry Infection Control (OIC)**

The IPC Team receive a daily report (between Mon-Fri) which identifies all positive samples sent to the laboratory as part of the OIC reporting system. This system enables the IPC team to advise and support on the management of patients’ infections; including patient placement, to reduce risk of cross-infection.

**MRSA screening**

Meticillin-Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that has become resistant to many of the antibiotics used in hospitals. It usually lives harmlessly on the skin, but if it enters the body, it can cause serious infection.

All elective surgical patients undergo screening for MRSA, and positive results are alerted to the IPC Team daily as part of the OIC reporting system. This enables prompt recognition of MRSA so that decolonisation treatment can be offered to the patient, preventing potential delays or complications of surgery.

The graph and table below demonstrate the MRSA screening compliance, which is consistently above 99%.

A graph of a number of months

Description automatically generated with medium confidence

A table with numbers and percentages

Description automatically generated

**Surgical Site Infection Surveillance Service (SSISS)**

Surgical site infection (SSI) is a type of healthcare associated infection in which a surgical incision site becomes infected after a surgical procedure. SSI are associated with increased morbidity and mortality in surgical patients and risk can be minimised with appropriate care before, during and after surgery. The management of an SSI can involve prolonged hospitalisation, readmission, and reoperation, can be associated with increased diagnostic and treatment costs affecting patient safety and care.

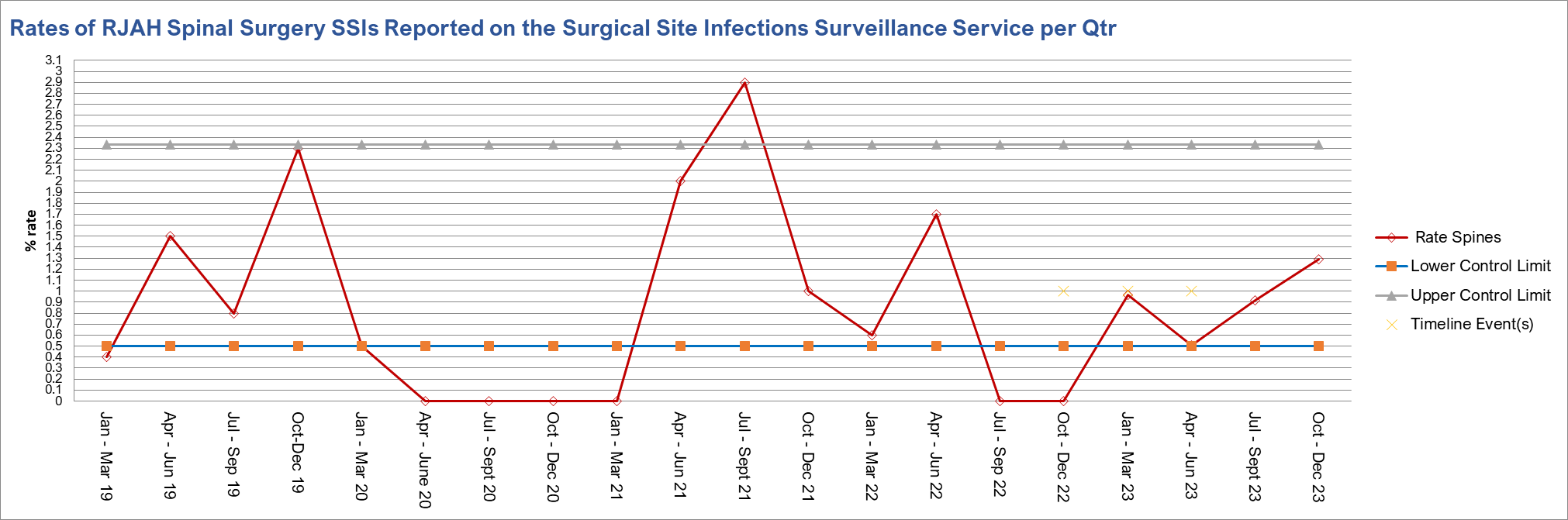
Surveillance of SSI with appropriate and timely feedback of data to clinicians is crucial in supporting strategies to reduce the burden of infection within the health system. The importance of monitoring and reducing rates of surgical site infection is widely acknowledged and the IPC Team at RJAH follow policy and process to support early SSI recognition and actions to minimise risk and preserve patient safety.

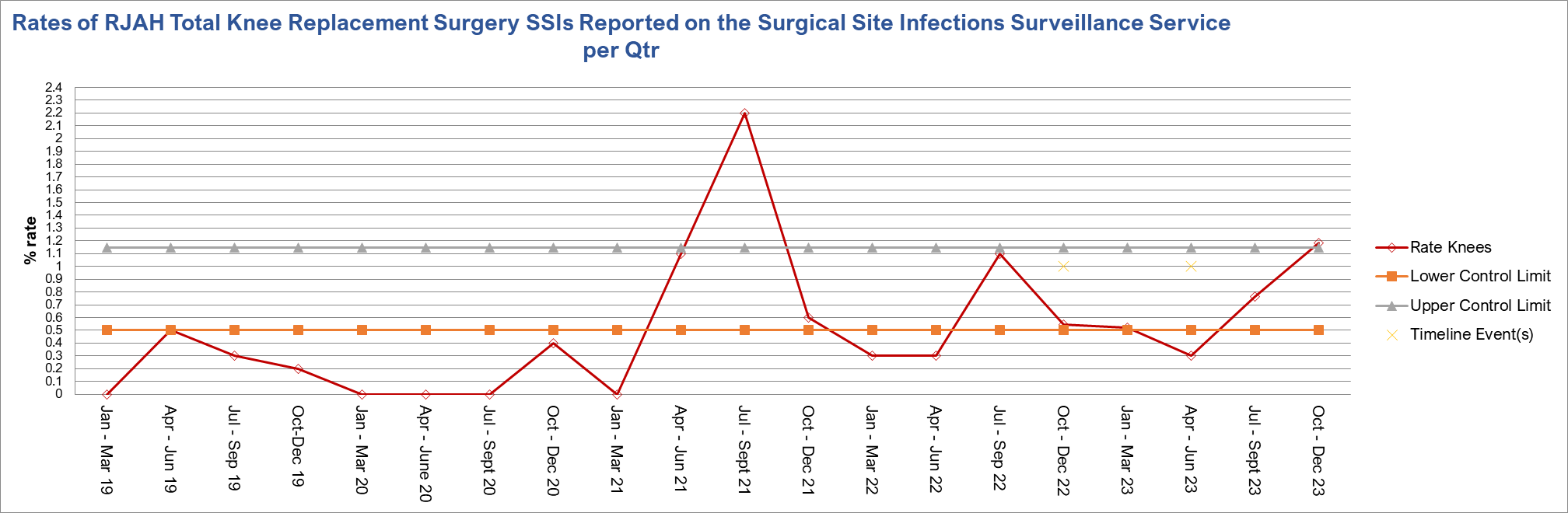
In April 2004, surveillance of surgical site infections (SSIs) in orthopaedic surgery became mandatory for all English NHS Trusts. RJAH submits surgical site infection data to the UK Health Security Agency (UKHSA) database on a quarterly basis.

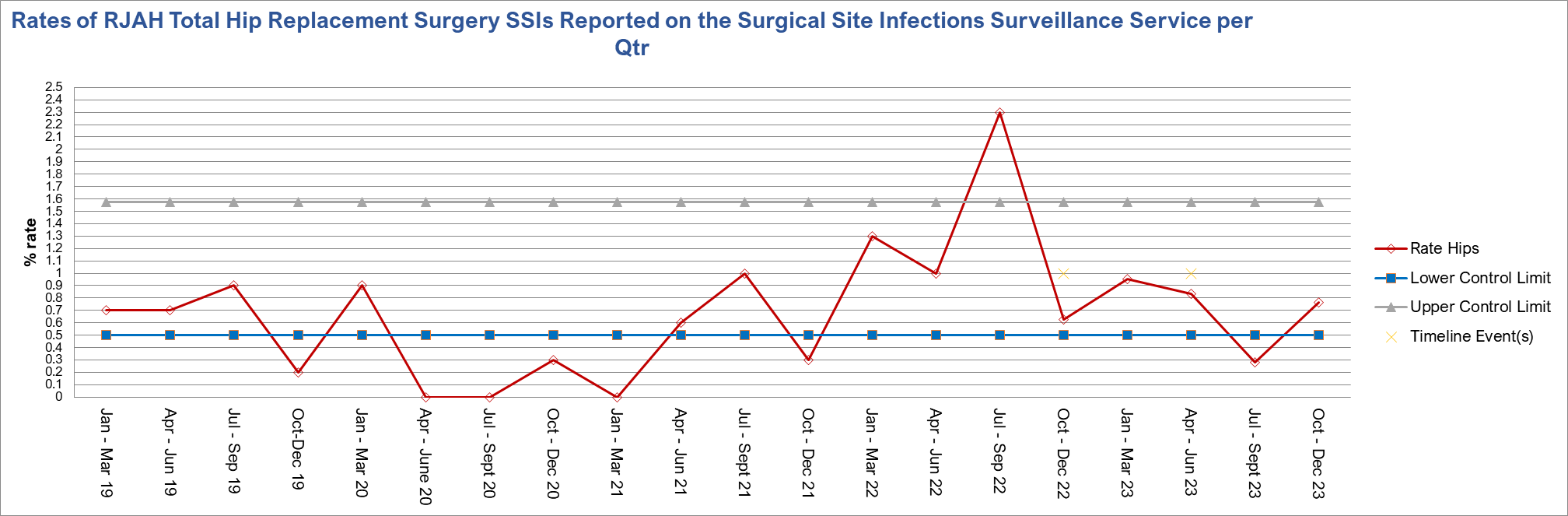
The UK Health Security Agency (UKHSA) analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence may be high or low, enabling the Trust to benchmark against the national rate of infection.

From April 2023 – October 2023, RJAH submitted data to SSISS on total of 2902 operations – 1107 Total Hip Replacements (THR), 1146 Total Knee Replacements (TKR) and 694 Spinal surgeries was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 22 reported, with 7 THR, 9 TKR, and 6 spinal surgeries.

The following graphs show the breakdown in RJAH rate of surgical site infections reported to UKHSA between January 2023 and December 2023. At the time of writing this report, UKHSA have not yet reconciled SSI data for Jan-March which is why it is not shown below.







**Periods of Increased Incidence**

There was one period of increased incidence of SSIs during Quarter 3 (Oct-Dec). The Trust reported 11 SSIs for this period (3 hip replacements, 5 knee replacements and 3 spinal surgery). Information gathered from case reviews showed that the most common microorganism identified was a type of bacteria commonly found on the skin. It is often very difficult to identify the root cause for an SSI with so many potential risk factors, including those originating from the patient.

Pathogens that cause SSI may originate from:

• the patient’s own microbial flora presents on skin and in the body

• the skin or mucous membranes of operating personnel

• the operating room environment

• instruments and equipment used during the procedure

There are several activities undertaken at the Trust to prevent SSIs from occurring:

* Minimising the number of microorganisms introduced into the incision site, for example removing microorganisms that normally colonise the skin of patient, maintaining asepsis and managing air quality.
* Enhancing the patients’ defences against infection, for example by minimising tissue damage and maintaining normal body temperature during the procedure.
* Preventing the multiplication of microorganisms at the incision site, for example using prophylactic antibiotics.
* Preventing access of microorganisms into the incision site, for example postoperatively by use of a wound dressing

The Trust continue assess the standards across the surgical pathway in the form of a bi-annual assessment using the OneTogether Assessment.

OneTogether is a partnership between leading professional organisations with an interest in the prevention of surgical site infection (SSI). The partnership has been initiated as a quality improvement collaborative with the aim of promoting and supporting the adoption of best practice to prevent SSI throughout the patient’s surgical pathway.

The OneTogether assessment tool has been designed to demonstrate compliance across the surgical pathway and is set out in 7 standards:

1. Skin preparation
2. Prophylactic antibiotics
3. Patient warming
4. Maintaining asepsis
5. Surgical environment
6. Wound management
7. Surveillance of surgical site infection

Assessments were undertaken in August and February, and we are pleased to report 94% compliance to standards. Improvements in how we record patient temperatures have been made, to ensure that patients are kept warm during their journey to promote wound healing.

Actions around SSI prevention continue to be monitored through IPC governance structures for oversight and challenge.

**Infection Multi-Disciplinary Team (MDT)**

The Infection MDT meet weekly to discuss infections and make recommendations for treatment. The Infection MDT is attended by Consultant Surgeons, a Consultant Microbiologist, an antimicrobial Pharmacist, the Infection Prevention & Control Team, and a Consultant Radiologist.

UKHSA Surgical Site Surveillance System requirements are to report hip, knee, and spinal surgery, however the Infection MDT reviews patients from all orthopaedic specialities, including upper limb, lower limb, sports & spinal injuries.

**Outbreaks**

An outbreak of infection is described as two or more people (this could be patients and staff) with the same disease or symptoms or the same organism and are linked through a common exposure, personal characteristics, time, or location. The Trust follows the recently updated Infection Event and Outbreak Management Policy to ensure a standardised response to outbreak management that includes external reporting.

There were 3 outbreaks reported this year:

|  |  |  |
| --- | --- | --- |
| **Date** | **Location** | **Outbreak** |
| April 23 | Sheldon Ward | COVID-19 |
| Dec 23 | Sheldon Ward | Norovirus |
| March 24 | Clwyd Ward | Diarrhoea and Vomiting |

After action reviews continue be undertaken to identify areas of good practice and opportunities for learning.

The reviews were led by the IPC Team in collaboration with the Matron and Ward/Departmental Manager. Feedback takes the form of a poster for areas to display and are included in all reports through the IPC&CWG.

### **Serious Incidents**

There were no serious incidents related to IPC to report in 2023/24.

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

Our IPC Arrangements and Responsibilities policy reflects the management and reporting structure of RJAH outlining its collective responsibility for IPC from Board to floor, demonstrating that responsibility is disseminated to all staff in the organisation.

The following IPC modules are monitored via ESR and mandatory for staff to completed:

* Infection Control Training Clinical & Non-Clinical
* Hand Hygiene
* Donning & Doffing
* Aseptic Non-Touch Technique
* Cleaning for Confidence Intensive Care Units
* Cleaning for Confidence: Introduction

The chart below shows that the Trust has maintained good compliance to infection prevention and control training and has met the required Trust target of 90%:

A graph of a graph showing a number of employees

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Additional to the mandatory suite of IPC modules managed via ESR, the following training is delivered by the IPC Team:

* Induction training for all clinical and non-clinical staff and rotational doctors
* Hand washing assessments to clinical staff to ensure staff obtain full hand hygiene competency.
* All volunteers receive a training presentation and hand hygiene education.

The IPC Team have provided a number additional of education sessions throughout the year as part of the IPC strategy, including:

* MRSA Decolonisation
* Handwashing
* Catheter specimen urine sampling
* Standard IPC precautions
* Transmission-based precautions
* CDI management
* Surgical site infection prevention
* Care Certificate: IPC
* HCSW Academy: IPC
* Ad-hoc sessions in ward/departmental areas

# **Criterion 7: Provide or secure adequate isolation facilities.**

The Trust has isolation policies in place and has single side room accommodation with en-suite facilities to isolate patients when required.

The Trust Isolation Policy includes a risk assessment tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case-by-case basis. In rare cases where there has been no side room available; the IPC team have assisted the ward area with mitigations dependent upon the organism – this is documented in a risk assessment template and kept in the patient’s notes.

Cleaning and management of our isolation facilities is conducted by our facilities team in accordance with our policy, the National Cleaning Standards, and the National IPC Manual.

# **Criterion 8: Secure adequate access to laboratory support as appropriate.**

The contract for laboratory services is with Shropshire and Telford Hospitals NHS Trust (SaTH) which is fully UKAS (United Kingdom Accreditation Service) compliant under ISO 15189. The ICD is a Consultant Microbiologist at SaTH who is contracted to work at RJAH as a specialist. Medical microbiology support is provided 24 hours a day, 365 days a year. In addition, we have a service level agreement with Sheffield laboratory who provide advice and guidance specific to samples from theatres and radiology.

# **Criterion 9: Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections.**

Following introduction of the National IPC Manual in early 2023, the IPC Team initiated a review of all policies and procedures to ensure complete alignment with its requirements. To show progress, a policy tracker was implemented and monitored through the IPC Workplan. Subsequently, the following policies underwent thorough review and were ratified:

|  |  |
| --- | --- |
| Policy/Procedure | Date ratified at monitoring committee |
| POL266: Infection Event and Outbreak Management Policy | Nov 23 |
| SOP426: Notifications of Infectious Diseases (NOIDS) | Nov 23 |
| SOP425: IPC Principles in the Management of Invasive Devices | Nov 23 |
| POL098: Infection Prevention and Control Arrangements and Responsibilities Policy | Nov 23 |
| POL266: Infection Event and Outbreak Management Policy | Nov 23 |
| POL269: High Consequence Infectious Diseases Policy | Jan 24 |
| Transmission Based Precautions Policy | Jan 24 |

Efforts will persist and continue to be monitored throughout 2024-2025 to achieve complete alignment.

# **Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.**

**Optima Health Occupational Health**

As a Trust, we are committed to supporting our colleagues recognising that their wellbeing is fundamental to the smooth running of the hospital, having a positive impact on patient care, and supporting morale. We have a service level agreement with Optima Health along with our partner providers in STW and a suite of wellbeing support services accessible to all staff. In line with the Health and Social Care Act and Department of Health guidelines, Optima Health have arrangements in place for assessing the immunisation status of all Trust employees as well as regularly reviewing the immunisation status of existing healthcare workers and providing vaccinations as necessary and in accordance with the Green Book and Joint Committee on Vaccination and Immunisation. All staff can access OH services here on site, or at the OH facility at SaTH for convenience.

**Blood Borne Virus Exposure**

Blood borne virus exposure incidents or injuries may represent a significant risk to staff working in healthcare environments. Under Health and Safety Legislation, Optima Health work collaboratively with the Trusts Health and Safety Leads in preventing, reducing, and controlling the risks of healthcare associated infection and management of occupational exposure to blood borne viruses and post exposure prophylaxis. Optima Health are responsible for the assessment and follow up of all blood borne virus exposure incidents occurring during departmental opening hours and for the follow up of those exposure incidents occurring out of hours in emergency departments.

**Safer sharps**

The Trust has maintained compliance with the Health and Safety (Sharp Instruments in Healthcare Regulations) 2013.

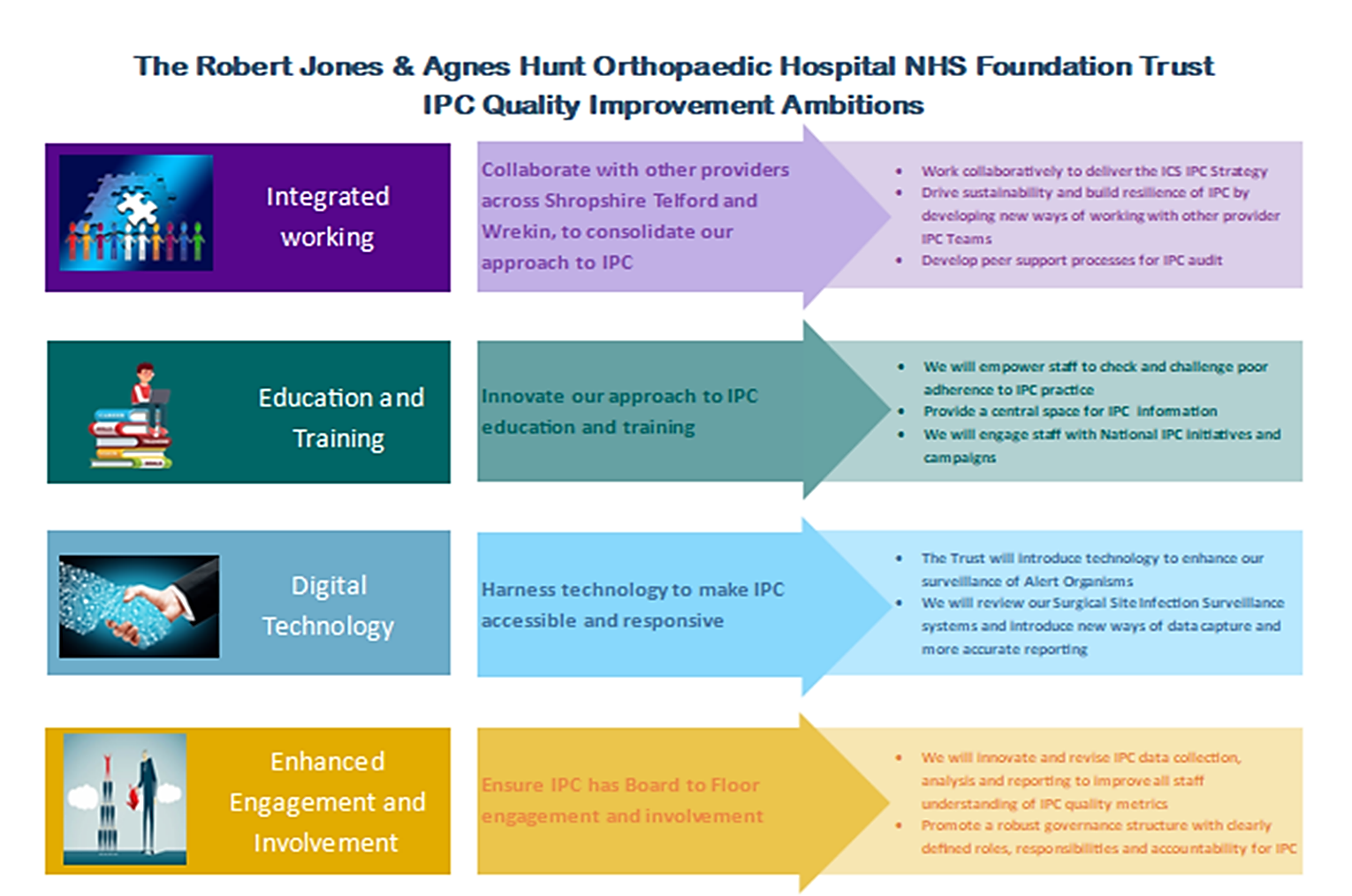
Sharps (including needlestick) injuries remained at a low level with 18 incidents reported this year. This is a downward trend since last year. Work is ongoing to ensure that safer sharps become the default devices of choice wherever reasonably practicable.

**Flu Campaign 2023/2024**

This year's flu and covid vaccination campaign, led by the Trust’s Assistant Chief Nurse and Medicines Management Lead Nurse, saw an uptake of 53% for staff. This is similar to last year’s figures.

# **Moving Forward**

We have made good progress with our 2-year IPC strategy and look forward to focussing the next year around education and training including a structured approach to IPC learning through the National IPC Education Framework.



Our success against our strategy is summarised below:

**Integrated Working**

* The RJAH IPC Team provide representation at the ICS IPC and AMS monthly meetings and deliver a provider report on local IPC metrics.
* The RJAH IPC Team work collaboratively with Estates and Facilities and are key members of the PLACE audits.
* The IPC Team participate as an objective auditor to support SCHT.
* The Deputy DIPC has worked collaboratively with colleagues from STW to deliver the Clostridioides Difficile Action Plan; this is regular reviewed through the ICS IPC monthly meetings to ensure oversight and delivery of actions.

**Education and Training**

* The IPC HCSW has created an IPC education package for paediatric patients on the importance of hand hygiene in the prevention of infection.
* IPC sessions within Care Certificate programme have been reviewed to ensure they align to the National Infection Prevent and Control Manual (NIPCM).
* IPC Fayre conducted in May had multidisciplinary attendance and received excellent feedback.
* We continue to schedule bi-annual IPC fayres and lead on improvement cycles. The next IPC Fayre will be held in May 2024 to coincide with World Hand Hygiene Day.
* We took part in a Patient Safety Fayre in October 2023 which focussed on SSI prevention, CDI, and the launch of a paediatric education package which was created by the IPCSW.
* MRSA teaching sessions have been provided with Sheldon Ward teams to ensure an understanding of transmission-based precautions and the importance of screening.
* Training relating to C diff has been delivered to ward teams including the provision of C diff aide memoire cards.
* Link practitioner meetings have been reviewed and are now project focussed with the practitioner’s delivering solutions.
* The HCSW Academy presentation has been updated to ensure that the IPC principles are broad and align to the NIPCM.
* IPC continue to provide face to face induction training and signposting to online training and information for new starters to the Trust.

**Digital Technology**

* An IPC Quality dashboard has been designed by the IPC Quality Assurance Lead for the Surgical Site Infection Prevention Working Group (SSIPWG).
* The SSI policy and process has been updated to align with SSISS protocol and PSIRF. This is steps ahead of IPC PSIRF implementation across the Midlands.
* Reporting SSI has been reviewed to ensure that continuity of data and key messages are consistent throughout different Groups and Committees. This is to minimise the risk of duplication, miscommunication and data inaccuracies therefore providing a cohesive and comprehensive SSI rate report to the Board.
* An IPC tagging system is under development within Apollo to ensure thatwe capture IPC data and display this to clinical teams at all aspects of the patient journey. This will ensure IPC management is a priority, reducing the risk of acquisition and HAI.
* The IPC team have met with the Apollo team to ensure that we capture IPC data and display this to clinical teams at all aspects of the patient journey.

**Enhanced Engagement and Involvement**

* Tendable audits have been reviewed to ensure they are aligned with the NIPCM.
* The IPC Quality Assurance Lead has been working with pharmacy to design an antimicrobial stewardship audit on Tendable.
* The Deputy DIPC and IPC Clinical Lead have met with Primary Care colleagues to educate, collaborate and network to improve their understanding of the SSISS and pathways for treatment and referral.
* The Units have been provided with a live self-service area on the QMS, so they are able to download data pertaining to their compliance with IPC for their reports.
* The Surgical Site Infection Prevention Working Group Terms of Reference have been reviewed and the meeting re-invigorated to increase attendance and drive action.
* Quality Assurance walks now include ward/dept representation so issues can be highlighted and dealt with in a timely way.
* The IPC Team continue to provide support and specialist advice to staff, visitor and patients.
* The IPC team continue to include ward/dept representation at all Quality Assurance walks so that immediate actions can be taken to remedy IPC related issues. The Facilities team are given feedback around issues related to their responsibilities within the Cleaning Charter.
* We continue to share IPC data through the IPCCM governance reporting structures and provide support the Matrons who are responsibility for providing monthly Unit reports.

# **Conclusion**

This year the IPC team have focussed on getting back to basics. Not only have we been looking at governance and policy updates, but we’ve been out and about working alongside staff on wards, clinics, in theatre and our Specialist Unit. We’ve supported our therapies team to update the gym and their facilities, giving the whole area a brighter and cleaner appearance. We have moved our team around to increase their visibility allowing us to have a more proactive approach to supporting and advising the Trust on all IPC matters.

Over this next year, the team are working on innovating IPC education, providing opportunities for staff to engage in face-to-face activities and training events. This is aligned to our IPC Strategy, now entering its second year. As part of this Strategy, moving towards digital transformation and going live with the Apollo System, we have also been working alongside our digital team to ensure IPC remains a high priority in our patient care journey. This will enhance patient safety by providing a digital platform to share key information, collect data to shape our practices and guide staff on patient management.

We are delighted to say that we have seen a sustained approach to IPC across the Trust and, despite the challenges faced nationally with increasing HAI, the staff here have shown continued commitment and dedication to their role, keen to learn and improve from every single event. We look forward to working alongside you all again this year.

Samantha Young Director of Infection Prevention and Control (DIPC)

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Hayley Gingell IPC Assurance Lead

May 2024