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NHS
Gloucestershire Health and Care
NHS Foundation Trust

Infection Prevention and Control

Annual Report 2023/24

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Contents

Foreword by the Director of Infection Prevention and Control

Welcome to our Trust's Infection Prevention and Control Report for 2023/24.

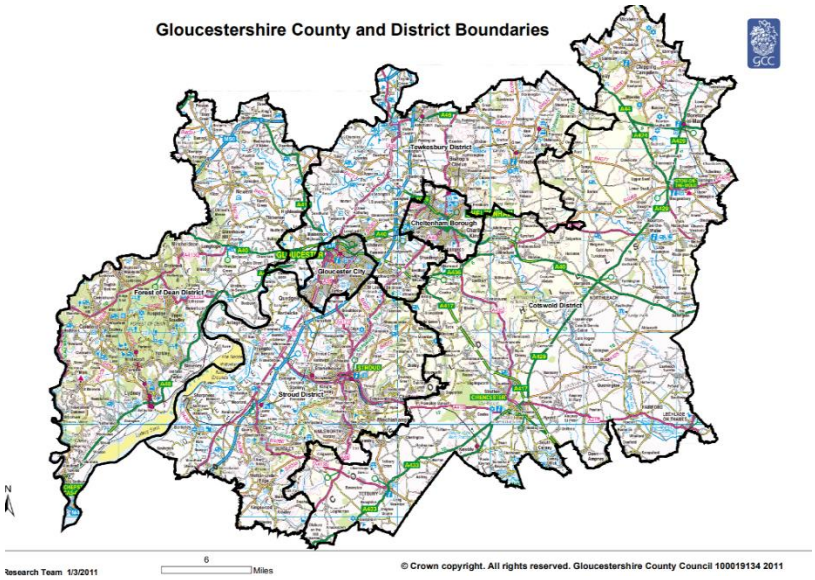
This report reflects the hard work, professionalism and dedication of, not just our dedicated Infection Control Team, but our colleagues in Facilities and Estates who work tirelessly to maintain high standards of cleanliness across our Trust.

This report shares with the reader the ever-increasing scope of infection control work in the Trust over the year and how well we perform across the many areas of required reporting. The report shows good levels of compliance, assurance and governance around our infection control standards. It also shows where we need to continually seek improvement. Our good standards of infection control are delivered by clinical and therapeutic staff alongside our fantastic facilities teams of caterers, cleaners, porters and volunteers, our estates teams who look after our buildings, water, ventilation and waste and also colleagues at the laboratories at Gloucestershire Hospitals NHS Foundation Trust. I do not underestimate how hard this year has been for all of our teams and so finally I would like to say a huge thank for your hard work, commitment and unwavering support throughout the year.

Hannah Williams
Director of Infection Prevention and Control
Deputy Director of Nursing, Therapies and Quality

August 2024

2.0 Introduction



Gloucestershire Health and Care NHS Foundation Trust provides a range of community physical health, mental health and learning disability services for adults and children in Gloucestershire, serving a population of around 646,000 people.

These services include:

- 7 community hospitals (The Dilke, Lydney Hospital, Tewkesbury Hospital, North Cotswold Hospital, Cirencester Hospital, Stroud Hospital and The Vale),
- 2 mental health hospitals and recovery in-patient units (Charlton Lane Hospital, Wotton Lawn Hospital, Laurel House and Honeybourne)
- A learning disability in-patient unit (Berkeley House),
- Adult community nursing and mental health teams,
- Children's community nursing and mental health teams,
- Therapy services,
- Specialist services (e.g. Heart Failure, Sexual Health)
- Dental services
- Urgent care services.

All NHS Trusts have a legal obligation under the Health and Social Care Act 2012 to produce an annual report and make this available to the public. This annual report covers the period April 1st 2023 to March 31st 2024 and outlines the infection prevention and control activities undertaken to fulfil the statutory requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

3.0 Key Achievements and Challenges in 2023/24

2.1 Key Achievements in 2023/24

The Trust had a very low incidence of UK Health Security Agency (UKHSA) reportable healthcare associated infections during 2023/24. The Trust reported 6 cases of toxin positive Hospital Onset Healthcare Acquired *Clostridioides difficile* against a tolerance figure of 15. There were no MRSA and MSSA Bacteraemia's.

The Infection Prevention Control (IPC) Team have responded to an ever-changing environment and provided clinical teams with timely advice, support and guidance. Following the Covid-19 pandemic, the IPC nurses produced action cards to be used alongside the updated Respiratory policy. This aided decision making and supported clinical teams to transition towards "living with Covid-19".

The IPC nurses are improving their working relationship with the Single Point of Clinical Access (SPCA) Bed Management team. A daily patient flow meeting is prioritised and attended by an IPC nurse to facilitate safe and effective patient transfers and respond to escalation concerns from Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT).

Throughout 2023/24, the team have also continued to work very closely with Mental Health and the Learning Disability Matrons and Leads to improve IPC awareness and practice. Ad hoc MRSA training/awareness sessions have been provided for Wotton Lawn Hospital staff. The team have established strong links with the Matron at Charlton Lane and supported ward staff during outbreaks of Norovirus.

The team are developing the IPC link worker programme in 2023/24. Virtual meetings are used as additional education sessions and to disseminate Government IPC guidance updates. Attendance has gradually improved, however, this remains a team priority for 2024/25.

Community podiatry outpatient clinics were a priority for the IPC audit programme for 2023/24. The team audited most (1 outstanding) of the clinics and gained a better understanding of podiatry processes.

IPC team localities/responsibilities were changed in 2023/24 to enable the IPC nurses to reach more services across the county, in particular community services. This has given the IPC team a better understanding of IPC in community settings and has been well received by staff throughout the Trust.

IPC Ward Dashboards, that pull together a range of IPC related information, are included in monthly Matrons Governance reports. Ward staff have fed back that they find them a useful resource. They also allow IPC nurses to monitor the effectiveness of IPC measures on the wards and address any themes or trends reflected in the data.

The Team have continued to promote hand hygiene and education during clinical visits which has resulted in an overall Trust score of 95.25%.

2.2 Key Challenges During 2023/24

There are continual challenges to maintaining good infection prevention and control standards in some of the Trust's older properties. There is a refurbishment programme in place, managed by Estates but with IPC nurse input, and the Forest of Dean hospital will be opening in 2024/25.

The IPC Team have had to adapt, evolve and adjust throughout 2023/24 in response to new processes (e.g. new Patient Safety Incident Response Framework), new guidance, new ways of locality working and the departure of, in February 2024, the Director of Nursing/Director of Infection Prevention and Control. All of this has been challenging but the team have been supportive of the changes and to each other.

The aim, in 2023/24, was for the Estates team to establish a Ventilation Safety Group to prioritise and monitor ventilation safety. After initial meetings they have not become as well established as they should and will be re-established as a priority in 2024/25.

4.0 Health and Social Care Act 2008 (Revised 2022)

The Health and Social Care Act 2008: code of practice on the prevention and control of infections sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a healthcare provider on how it complies with infection prevention requirements. The Code of Practice was updated in December 2022. The 10 compliance criteria are listed in the table below.

Table 1: Health and Social Care Act 2008: code of practice on the prevention and control of infections compliance criteria

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	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	The provision of 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	That there is a policy for ensuring that people who have or are 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.
6	Systems are in place 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	The provision or ability to secure adequate isolation facilities.
8	The ability to secure adequate access to laboratory support as appropriate.
9	That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.
10	That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

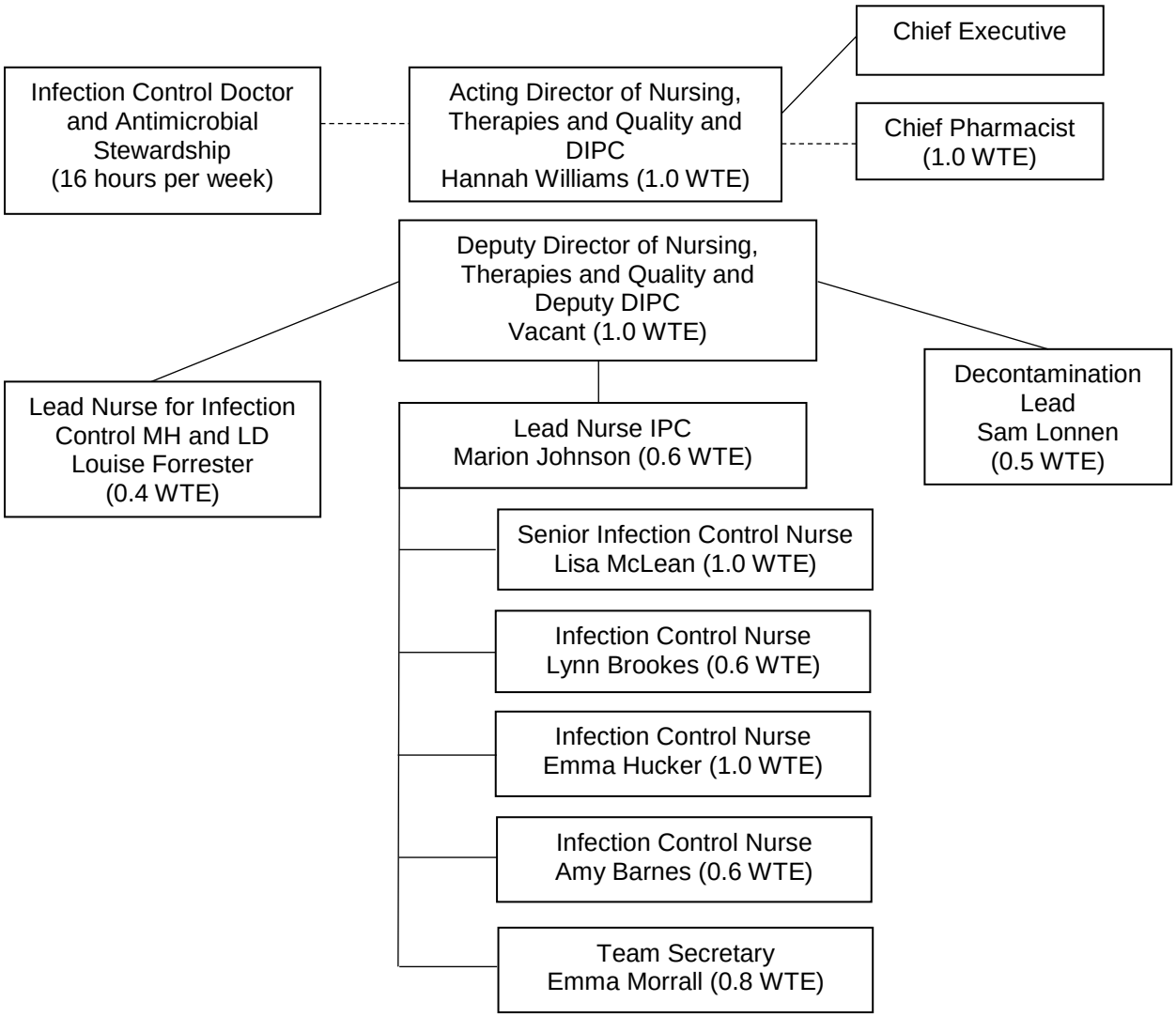
Good Infection Prevention and Control (IPC) is essential to ensure that people who use Trust services receive safe and effective care. This Annual Report shows how the Trust is performing against the Code of Practice criteria, what the Trust has achieved during 2023/24 and where the Trust would like to improve for 2024/25.

5.0 Infection Prevention and Control Team Structure 2023/24 (Criteria 1)

The Chief Executive holds overall responsibility for infection prevention and control within the Trust but the day to day management is delegated to the Director of Infection Prevention and Control (DIPC). The DIPC works closely in partnership with the Infection Control Doctor/Consultant Medical Microbiologist for the Trust.

The specialist IPC Team provides infection prevention and control knowledge and expertise to children's and adult community physical health, mental health and learning disability services across the Trust. The team structure is outlined in the chart below.

Chart 1: Infection Prevention and Control Team Structure as at March 31st 2024



The Trust DIPC, John Trevains, left the Trust in February 2024 to pursue a new opportunity at an Integrated Care Board. His leadership and contribution to the Trust,

along with the wider system in Gloucestershire, including through the COVID-19 pandemic, was significant and he will be sorely missed. Hannah Williams, Deputy Director of Nursing/Deputy DIPC, took over in February as Acting Director of Nursing/DIPC until the post is recruited to.

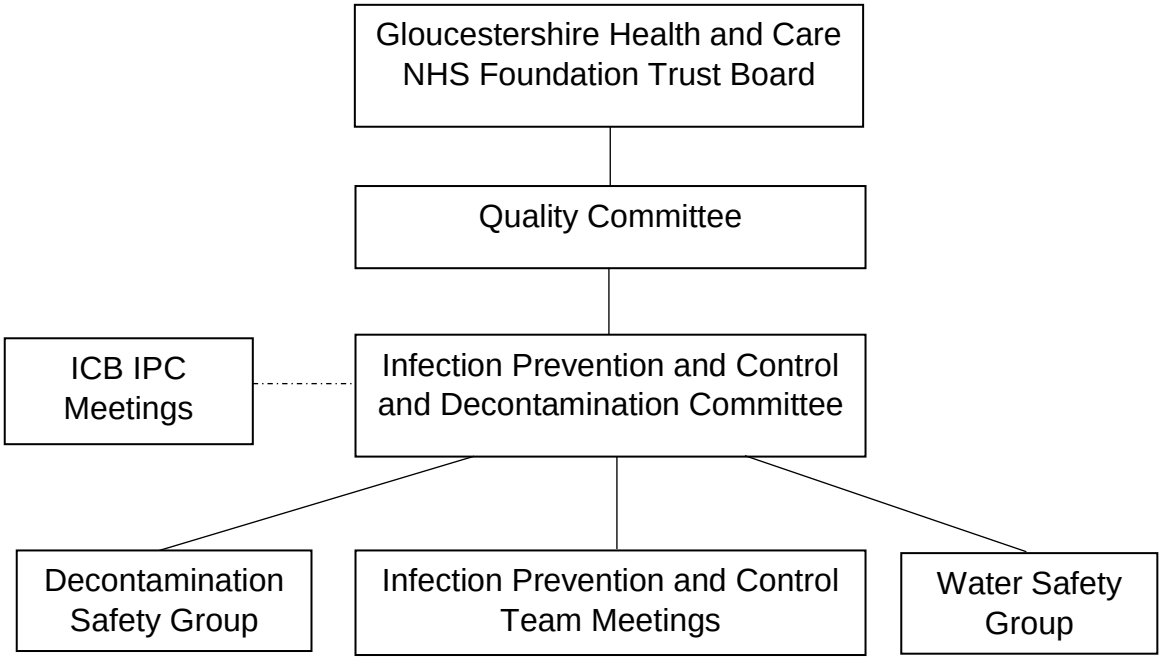
The band 6 experienced IPC nurse has agreed to extend her contract for another year.

The Trust has a Service Level Agreement (SLA) in place with Gloucestershire Hospitals NHS Foundation Trust for the provision of an Infection Control Doctor (ICD) of four programmed activities a week, equivalent to approximately 16 hours. The ICD provides support, expertise and guidance to the IPC Team on IPC and to the Trust on antimicrobial stewardship. The SLA time includes the provision of out-of-hours Consultant Medical Microbiologist cover.

5.0 Infection Prevention and Control Governance (Criteria 1)

The Chart below outlines the IPC Governance framework within the Trust.

Chart 2: Infection Prevention and Control Governance framework as at March 31st 2024



The DIPC reports directly to the Chief Executive, the Trust Board and Trust Quality Committee on all IPC related matters. The IPC Board Assurance Framework has been regularly reviewed by the DIPC throughout the year and assurance reported at Trust Board meetings.

The DIPC is Chair of a bi-monthly Infection Prevention and Control and Decontamination Committee (IPCDC). Membership of the IPCDC includes the Deputy DIPC, Infection Control Doctor, IPC nurses, Estates, Facilities and Working Well Occupational Health. Other representatives may attend as a one-off according to the agenda. The purpose of the IPCDC is to gain assurance that the Trust is fulfilling national and local infection prevention and control and decontamination requirements. Performance on the number and status of specific reportable and non-reportable Healthcare Associated Infections (HCAI) in the Trust is reported to the IPCDC monthly. The IPC Board Assurance Framework is also presented to IPCDC. IPCDC agreed the 2023/24 Annual IPC Work Plan and monitors progress against plan. This oversight ensures Trust IPC priorities are agreed, implemented with any IPC issues identified early and escalated as needed.

The Water Safety Group reports into the IPCDC via the Estates and Facilities report. A Decontamination Safety Group was established in 2023/24 and it operates in a similar way to the Water Safety Group, reporting into IPCDC.

Monthly Integrated Care Board IPC meetings continue to promote a countywide collaborative approach to managing IPC and various work streams are established:

- *C. Difficile* Improvement Group - to develop a countywide *C. difficile* pathway to improve patient experience
- Policy Group - to establish shared policies across the system
- IPC Education Group – to identify areas of IPC expertise across the system and identify any additional training needs

The team daily 'huddle' meetings ensure all staff are aware of IPC priorities and responsibilities for the day. They are especially useful for part-time staff in the team who can be updated on any IPC developments that may have arisen during their non-working days.

The team undertake risk assessments to support the identification and mitigation of the risks of infection using the NHS England template. Berkeley House is a learning disability inpatient unit for patients who can present with challenging behaviours. The residents have bespoke individual flats and needs which often require an individualised IPC approach and a risk assessment was undertaken for Berkeley House in December 2023. In January 2024 a risk assessment for measles in healthcare settings was completed. Both risk assessments are reviewed at regular intervals.

5.1 Contracts for Infection Prevention and Control

Service level agreements (SLAs) are in place to provide a specialist infection prevention and control service for:

- Longfields Hospice
- Great Oaks Hospice
- Sue Ryder Hospice
- Tetbury Hospital
- Kate's Home Nursing

The IPC team undertake annual IPC audits for these organisations and support them to produce an IPC Annual Action Plan. The IPC team also provide education, advice and support as required and attend governance meetings.

6.0 Facilities and Estates 2023/24 (Criteria 2)

The Trust has dedicated cleaning teams in each locality that are responsible for ensuring Trust sites are cleaned and decontaminated.

The Trust uses the National Standards of Healthcare Cleanliness 2021 (NSoHC2021) as its formal cleaning framework. Facilities performance data is reported to, and monitored by, IPCDC and the Buildings Environment and Medical Equipment Group.

6.1 Cleanliness Audits

Trust cleanliness audits are undertaken in line with NHS England cleanliness standards. Data is formally managed through a third-party system, FM First. The table below shows the frequency of audits and compliance by risk category.

Table 2: NHSE National Standards of Healthcare Cleanliness 2021: frequency of audits and compliance standards by risk category

Risk Category	NHSE Standard	Trust Compliance 2023/24
FR1	98%	99.37%
FR2	95%	98.42%
FR3	90%	96.63%
FR4	85%	96.87%
FR6	75%	96.81%

All clinical sites are now mapped on the auditing system and form part of a locality auditing plan, mental health sites were added in 2023/24.

The software auditing contract was renewed with the same supplier in April 2023 following a procurement tender exercise. The new contract will run until March 2026.

6.2 Swabbing: Adenosine Triphosphate

Adenosine Triphosphate (ATP) swab testing provides a quick method of on-the-spot assurance of the standard of cleanliness of a piece of equipment or surface. It is an additional level of assurance that is recommended to Trusts but it is not mandatory.

A schedule of swabbing is in place in the Trust and the table below summarises the ATP swabbing results for 2023/24. Any equipment or surface resulting in a swab test failure are cleaned and re-tested.

Table 3: Trust ATP Swabbing Results 2023/24

Swab Result	Number of Location Points Swabbed
Pass	5,041
Caution	321
Failure	675
Total	**6,037**

6.3 Kitchen Hygiene – Environmental Health Audits

In 2023/24, all registered sites maintained the highest Environmental Health Hygiene rating score of 5 (hygiene standards are very good) during Environmental Health Audits. The Facilities team undertook internal audits throughout the year to monitor standards to ensure these high standards were maintained.

6.4 Patient-Led Assessment of the Care Environment (PLACE)

The patient-led assessment of the care environment (PLACE) is a national annual assessment of non-clinical aspects of the patient environment. They are undertaken by local people, known as patient assessors, who go into hospitals in teams to assess:

- Privacy, dignity and wellbeing
- Food and hydration
- Cleanliness
- General building condition, appearance and building maintenance
- The extent to which the environment is able to support the care of those with dementia or with a disability

The PLACE Assessments for 2023 were completed between September 2023 and the beginning of November 2023. Planning for the assessment period starts in the summer and Facilities colleagues co-ordinate the assessments. Where points have been lost it is seen as an opportunity for the Trust to improve. Overall, Trust scores remain high across all domains, with 5 out of 8 achieving organisational averages of 90% or more. The two domains scoring lowest are disability and dementia. A breakdown of Trust scores per site and domain are in the table below:

Table 4: Trust PLACE Assessment Results 2023

Gloucestershire Health and Care NHS Foundation Trust - 2023 Results								
Site Name	**Cleanliness**	**Food Overall**	**Organisational Food**	**Ward Food**	**Privacy, Dignity and Wellbeing**	**Condition Appearance and Maintenance**	**Dementia**	**Disability**
Berkeley House	100%	94.54%	90.45%	100%	89.74%	98.33%	N/A	83.82%
Charlton Lane Hospital	100%	95.56%	91.67%	100%	96.51%	98.7%	89.31%	85.78%
Cirencester Hospital	100%	92.05%	87.59%	97.44%	93.33%	99.35%	70.22%	66.5%
Dilke Hospital	100%	93.03%	87.59%	98.04%	87.72%	97.88%	79.35%	80.13%
Honeybourne Hospital	100%	95.97%	92.19%	100%	90.7%	96.67%	N/A	85.42%
Laurel House	100%	94.84%	90.97%	100%	92.86%	96.67%	N/A	87.5%
Lydney Hospital	100%	82.65%	87.59%	78%	88.46%	99.17%	66.51%	70.35%
North Cots Hospital	99.35%	94.05%	87.59%	100%	91.8%	99.01%	84.53%	82.87%
Stroud Hospital	100%	89.71%	89.18%	90.2%	85.96%	98.77%	71.88%	72.89%
Tewkesbury Hospital	100%	92.97%	87.59%	100%	94.23%	99.18%	68.81%	67.65%
Vale Hospital	100%	85.66%	88.65%	82.05%	94.23%	99.18%	74.77%	73.56%
Wotton Lawn Hospital	99.7%	95.48%	92.19%	100%	96.83%	99.32%	N/A	86.41%
Organisational Average	**99.89%**	**92.79%**	**89.78%**	**96.39%**	**93.18%**	**98.85%**	**76.61%**	**78.97%**
National Average	**98.1%**	**90.90%**	**91.2%**	**91%**	**87.5%**	**95.9%**	**82.5%**	**84.3%**

Although Berkeley House received a 100% score for cleanliness in the PLACE assessment, a focused CQC inspection of Berkeley House in October 2023 noted some cleanliness and IPC issues. The residents at Berkeley House have bespoke individual flats and needs, requiring an individualised IPC approach, and the IPC nurses work closely with estates, facilities and clinical teams.

At the time of the inspection the IPC team were visiting Berkeley House weekly, following some concerns that had been raised about the cleanliness of the flats and the management of infection control. Any identified issues (e.g. cookers needed cleaning and the inability to clean grills in the windows) had plans in place with a person who was responsible for ensuring remedial actions were undertaken. Cleaning responsibilities and schedules were also developed for staff.

The CQC report noted that the delays in completing some repairs meant there were increased infection control risks and gave the example of non-wipeable materials being used to board up windows. Environmental damage occurs frequently at Berkeley House and emergency repairs may not comply with infection control requirements. To mitigate against these risks the Berkeley House matron and unit manager had been holding monthly meetings with Estates and Facilities to monitor cleanliness and repairs, monthly contracted deep-cleans were arranged and enhanced cleaning was being carried out by clinical and facilities staff.

The CQC report noted that improvements in cleanliness and infection control had been made since the inspection.

6.5 Decontamination

Decontamination is the combination of processes (including cleaning, disinfection and sterilisation) used to make re-usable equipment safe for further use on patients. Effective decontamination of re-usable equipment is essential in reducing the risk of transmission of infections. NHS England issues guidance, called Health Technical Memoranda (HTM's), on the design, installation and operation of building and engineering technology used in the delivery of healthcare. There are 4 HTM's that cover decontamination (HTM 01-01, HTM 01-04, HTM01-05 and HTM 01-06).

An Estates Decontamination Manager was appointed in 2023/24. They support the Decontamination Lead and the IPC team. During the year, the Decontamination Manager passed assessment by the Authorised Engineer Decontamination (AED) to be the Trusts Authorised Person (Decontamination) (AP(D)) and they are awaiting appointment.

In 2023/24, a Decontamination Safety Group was established and meetings held on a quarterly basis. The overall aim of the Group is to promote safe and best practice with regard to decontamination, in line with HTM 01, through:

- Leadership on decontamination policies and procedures
- Training
- Risk assessments and guidance
- Ensuring organisational and managerial structures, required in the management of decontamination services, are in place
- Inspiring and sustaining collaborative approaches for continual improvement of decontamination standards
- Ensuring the Trust maintains a co-ordinated approach to the management of decontamination of reusable invasive medical devices and services

HTM 01-01 covers the management and decontamination of surgical instruments (medical devices). A range of Trust policies are available on the intranet that set out the roles and responsibilities of staff, along with the method and levels of decontamination required for different types of medical devices. All staff receive decontamination training during induction and competency-based training is undertaken by staff who use medical devices. If specialist decontamination is required, staff receive annual certificated training provided by the decontamination equipment company.

Medical devices that require sterilisation (except dental units) are sterilised at Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT) in their Central Sterile Services Department (CSSD) on behalf of the Trust. CSSD is audited annually by the British Standards Institute against ISO standards for the reprocessing of reusable medical devices and relevant clauses of the Medical Devices Directive 93/42/EEC. CSSD maintained full accreditation in 2023/24. There have been occasions when instruments processed at CSSD have not met the stringent standards expected by the Trust or GHNHSFT. On these occasions the instruments have been returned to CSSD and the incident is reported through the Trust's incident reporting system (Datix) and investigated.

The Trust has a contract with Premier Healthcare for the decontamination of specialist/dynamic mattresses (e.g. pressure relieving mattresses).

HTM 01-04 covers the decontamination of linen for health and social care. Linen includes all reusable textile items requiring cleaning/disinfection via laundry processing (e.g. bed linen, curtains and towels). Trust linen is rented and the majority is laundered, in line with HTM 01-04, through a contract with a commercial laundry services company. The contract is managed and monitored by the Associate Director of

Estates, Facilities and Medical Equipment. As part of a patient's rehabilitation or recovery process, patients have the ability to launder on site at Wotton Lawn Hospital, Honeybourne and Laurel House recovery units and at Berkeley House. Guidance is given to patients to ensure the laundering is in line with HTM 01-04.

HTM 01-05 covers decontamination in primary care dental practices. The Dental clinics continue to aim for best practice and a range of new processes were implemented in 2023/24 to raise standards for patient care and safety.

In 2023/24, the Decontamination Manager and Dental Manager created an annual Dental e-Learning package for staff involved in the Dental decontamination process. This package covers testing methods, paperwork/record keeping for specialist equipment used, hand hygiene, personal protective equipment, how to inspect instruments and other criteria that need to be adhered to.

During the year a Planned Preventative Maintenance (PPM) schedule was developed to monitor and track planned quarterly and annual validation of decontamination equipment. An AED for Trust Dental Services was appointed in 2023/24 to oversee annual validation reports and provide advice and support. The AP(D) reviews the quarterly validation reports. During quarterly validation, some of the Ultrasonic Baths in the Dental units were found to be failing soil tests and were decommissioned. New Ultrasonic Baths were purchased and distributed to clinics. In order to continue raising decontamination standards in the Dental units Washer Disinfectors will be purchased in 2024/25 for the 2 units that do not currently have these.

A weekly process has been implemented in 2023/24 to decontaminate Dental cart bottles as there was no regime in place. These bottles hold Reverse Osmosis (RO) water. RO is a process the water goes through to purify it to ensure it doesn't cause limescale or leave any sediment.

HTM 01-06 guidance covers the decontamination of flexible endoscopes. Annual Decontamination audits against HTM 01-06 were undertaken by the Decontamination Lead in February and March 2024, Cirencester scored 98% and Stroud 97%.

The Final Rinse Water results for Endoscopy, during the early part of 2023, were not as consistent as they needed to be and, on a few incidences, exceeded the internationally accepted colony forming unit (cfu) tolerance levels for processing cystoscopes. Multiple possibilities for the higher cfu results were investigated by the Decontamination Manager and Decontamination Lead in order to identify and resolve issues. The investigations established that the final rinse water samples were not being obtained in accordance with the manufacturer's (Wassenburg) protocol. Working in partnership with Wassenburg and the organisation that obtains the samples on the

Trusts behalf, the protocol was implemented with an improvement in final rinse water cfu count results.

Other issues identified, addressed and resolved at regular assurance meetings, included:

- Incomplete final rinse water reports from the water testing lab
- Samples not being taken at the Final Rinse Stage Cycle
- Samples did not remain within the temperature tolerances required to meet HTM directives because they were placed in transport containers that were not cooled with ice packs
- Insufficient length on the sample extrusion tubing (tube sizing impacts the sample extraction method)

Further quality initiatives in 2023/24, led by the Decontamination Manager, have included discussions with the lab to place the sterilisation date and batch cycle number on the sample packaging. This gives extra assurance in the decontamination process.

Both Cirencester and Stroud Endoscopy Units had Annual Joint Advisory Group (JAG) Institute of Healthcare Engineering and Estates Management (IHEEM) audits undertaken in March 2024. Both Endoscopy Departments have submitted the required data for JAG accreditation and the Trust is awaiting the assessment process outcome at the time of writing this report.

A thorough permit to work system was implemented in 2023/24 for Trust Endoscopy units and Dental clinics. This system tracks and monitors routine maintenance, breakdowns and PPM schedules. It also ensures that only authorised personnel are allowed to carry out the work required on equipment, that they have the necessary training and that all safety procedures are followed.

The Decontamination Manager and the Decontamination Lead have been involved extensively in the planning of the new Forest of Dean Community Hospital ensuring that the new build meets decontamination requirements.

6.6 Water Safety

The Trust's Water Safety Scheme of Control (WSSC) is owned and managed by the Water Safety Group (WSG). The WSSC provides detail on how the risks from microbiological and scalding hazards, associated with the supply and use of water, are assessed, managed and controlled.

The WSG meets every three months and reports into the IPCDC and Buildings, Environment and Medical Equipment Management Group. The Trust's DIPC/Deputy DIPC and Consultant Microbiologist are members of the WSG.

The Trust has a rolling programme of Water Risk Assessments (WRA) across all Trust sites, with frequencies as follows:

- In-patient sites every two years
- Out-patient sites every four years
- Offices every five years

WRA are monitored by the WSG and, as at 31st March 2024, all WRA's were in date. On completion of WRA's, any actions are added to the Trust's Water Safety Action Plan. Remedial works are prioritised and monitored by the designated Responsible Person in the Estates Team and the WSG.

Water Safety audits are carried out by the Trust's Water Authorising Engineer. The latest audit was carried out in March 2024 (report awaited). The last two audit results are outlined in the table below.

Table 5: Summary of Authorising Engineer's Water Safety Audits June and September 2023

Areas Audited	Legislation Compliance 02/09/23	Legislation Compliance 28/06/23	Compliance Level 02/09/23	Movement
Responsible Person Delegation	HIGH	HIGH	100%	⇔
Water Safety Group and Meetings Structure	HIGH	HIGH	100%	⇔
Water Safety Policy	HIGH	HIGH	100%	⇔
Water Safety Procedures and Plan	HIGH	HIGH	100%	⇔
Training Requirements	HIGH	HIGH	100%	⇔
Legionella Risk Assessments	HIGH	HIGH	100%	⇔
Legionella Risk Assessments – Management	HIGH	HIGH	90%	⇔
Scheme of Control / Monitoring	HIGH	HIGH	95%	⇔
Log Book Operation / Management	HIGH	HIGH	80%	⇩
Flushing Regimes (Based on August and September Figures)	HIGH	HIGH	95%	⇔
Overall Compliance	**96%**	**98%**		

The latest audit found a high level of water hygiene management at the Trust, that Responsible and Deputy Responsible Persons nomination letters were up-to-date, the training programme was well managed and up-to-date and the Water Safety Policy and Water Safety Scheme of Control were both current and up to date. The slight drop in compliance was because some jobs booked in September 2023 were not completed. A review of all jobs booked showed there was an imbalance in bookings across the year, with some months having a lot more jobs booked than others. They have been distributed more evenly over the 12-month period to ensure jobs are completed on time.

6.6.1 Legionella

There is a rolling programme of Legionella sample testing at the Trust's in-patient sites. Water sampling is carried out at each site every 6 months by the Trusts maintenance team and samples are sent to Alfa Scientific for analysis. Results are held on the Zeta Safe Water Management Portal and are monitored at WSG. The majority of sites returned negative samples during testing but there were a few elevated results during 2023/24:

- Vale Hospital Peak View Ward (May 2023)
- Laurel House (November 2023)
- Stroud Maternity (December 2023)
- Stroud Hospital Cashes Green Ward (December 2023)

When there are elevated results appropriate remedial action is taken (e.g. cleaning, de-scaling, flushing, chlorination, filter changes) and the affected area is re-sampled. All re-samples for the above sites came back negative after the remedial action was undertaken.

6.7 Ventilation Safety

The Trust has a Ventilation Lead and during 2023/24 a new Authorising Engineer for Ventilation was appointed. Together they monitor and manage Trust compliance with HTM 03-01 specialised ventilation for healthcare buildings (NHSE).

Annual verifications of critical healthcare ventilation systems are undertaken by Approved Air. Critical ventilation systems are present in the following locations:

- Cirencester Hospital (Theatre and Endoscopy)
- Stroud General Hospital (Theatre and Endoscopy)
- Tewkesbury Community Hospital (Theatre)

In addition to the verifications, a Critical Ventilation audit was carried out by the Authorising Engineer in October 2023. Any issues and actions identified in the verifications and audit during 2023/24 have been resolved or are in the process of being resolved.

In early 2023 concerns were raised regarding air changes at the Endoscopy recovery area in Cirencester Hospital. An investigation was undertaken by the Estates team which concluded that, from installation, the Air Handling Unit (AHU) was being fed from the ward area AHU instead of the endoscopy's AHU supply. This was rectified and a re-balance of the system was completed in September 2023.

There is a rolling programme of maintenance, refurbishment and replacement works relating to ventilation.

The aim was for the Estates team to establish a Ventilation Safety Group to prioritise and monitor ventilation safety but after initial meetings they have not become as well established as they should. This will be a priority for 2024/25.

6.8 Waste Management

The Trust has several contracts for the management of waste, including:

- Tradebe for all clinical waste
- Veolia for general and recyclable waste
- Printwaste for confidential and food waste
- Rentokil-Initial for sanitary waste

These contracts are managed and monitored by the Recycling and Waste Manager in the Estates team. During 2023/24, several non-conformance charges were levied against the Trust, all were for Stroud General Hospital. The Recycling and Waste Manager plans to monitor waste at Stroud General Hospital in order to identify and rectify any issues. Issues with waste reported by staff during 2023/24 to the Recycling and Waste Manager included missed collections, broken or dirty waste bins, broken locks on bin holds and contractors leaving bin holds open. All issues were addressed with the relevant waste contractors.

Sites that produce 5 or more tonnes of waste are required to be audited annually. Sites producing less than 5 tonnes are to be audited every 5yrs. Pre-Acceptance Audits (PAA) on sites that produce 5 or more tonnes of waste commenced in 2023/24 and all required PAA audits will be completed by June 2024. In addition, audits on external bin holds commenced during 2023/24.

6.9 Building Environment Works

A rolling programme of building environment improvement works is undertaken each year, overseen by the Trust's Estates Team. Some of these will have IPC implications and the IPC team input into plans and are involved in meetings and discussions. During 2023/24, the following buildings' environment works were completed:

- Stroud Hospital – refurbishment of Physiotherapy area
- Wotton Lawn Hospital – upgrades to clinics, sluice, laundry, Dean and Kingsholm Ward clinics
- Stroud Hospital – relocation of Phototherapy room
- Acorn House sensory room

Environment improvement works that have commenced and are not yet completed, as at 31st March 2024, include:

- New Forest of Dean Hospital
- Cirencester theatre work
- Wotton Lawn AHU unit refurbishment
- Berkeley House – Harrier Flat upgrade
- Honeybourne Unit refurbishment
- Lydney Health Centre – temporary community Physiotherapy base

The estates team work collaboratively with IPC and Berkeley House during refurbishments, on-going repairs and bespoke alterations to buildings in order to accommodate the very specific requirements of patients residing at Berkeley House.

Throughout 2023/24, the building industry continued to face challenging times. Supply issues meant it was difficult to get certain materials and/or there were longer lead times. There was a skills shortage within specialist trades and rising inflation meant fluctuating costs and pricing. These have all had an effect on the progress and cost of several work schemes in 2023/24.

7.0 Antimicrobial Stewardship (Criteria 3)

The Trusts Chief Pharmacist is the designated lead for antimicrobial stewardship for the Trust. The Trust has an SLA with Gloucestershire Hospitals NHSFT for the provision of Consultant Medical Microbiologist support, expertise and guidance.

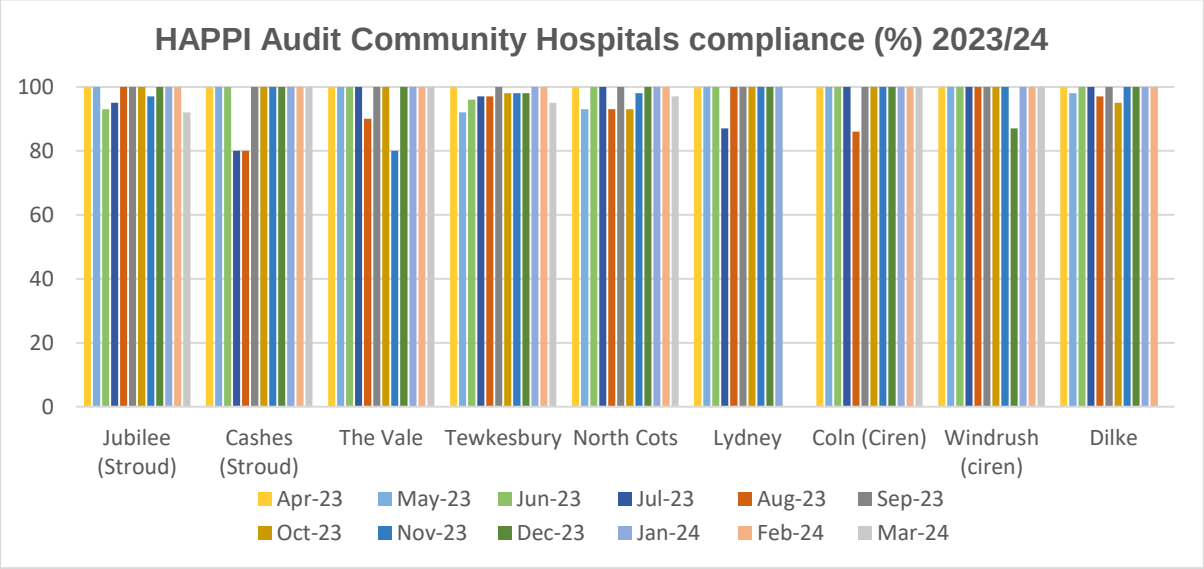
7.1 Audit

A monthly Hospital Antimicrobial Prudent Prescribing Indicator (HAPPI) audit, based on start SMART then Focus principles, is carried out by the pharmacy team in physical health in-patient wards. It covers five key areas of antimicrobial prescribing governance:

- The allergy box on the drug chart is completed correctly
- An indication for the antibiotic prescribed is documented on the drug chart
- A review/stop date is clearly documented on the drug chart
- The route of administration is appropriate. In particular, IV administration has been reviewed after 48 hours.
- The antibiotic, at the dose and duration prescribed, is included in the current Trust antimicrobial guidance or has been prescribed on the advice of a microbiologist

The results for 2023/24 are shown in the chart below:

Chart 3: HAPPI audit results for 2023/24 in community hospitals

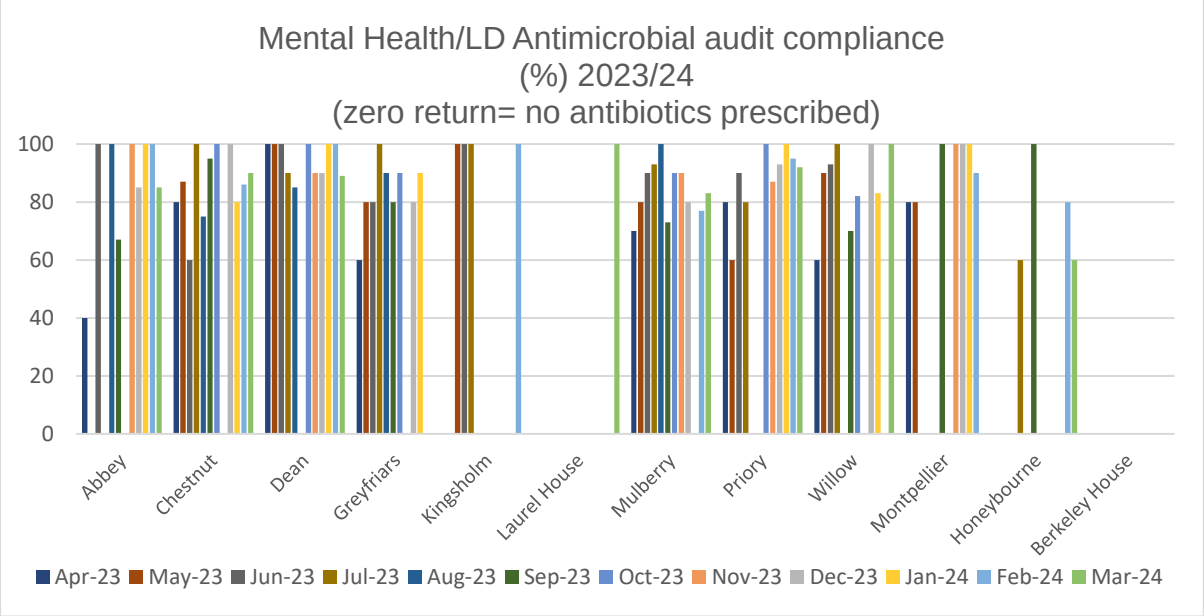


Mental health and LD inpatients are prescribed very few antimicrobials, therefore, every antimicrobial presciption written is audited. The criteria recorded are slightly different; the 'route is appropriate' criterion is not included as it unusual for MH/LD to prescribe an antimicrobial for adminstration other than oral and topical. The following criteria are reported on:

- Allergy status is completed
- Indication for prescribing is recorded on the drug chart
- Review date or stop date is recorded on the drug chart
- The antimicrobial prescribed is on the Trust approved guideline or on the advice of microbiology
- The duration of treatment is as per the guideline

The results for 2023/24 are shown in the chart below:

Chart 4: Antimicrobial Audit Mental Health/LD Inpatient compliance 2023/24



For both physical and mental health wards, results are shared with ward managers and ward prescribers, to inform of areas of improvement, and are included in the IPC monthly ward dashboards.

7.2 Patient Group Directions

Patient Group Directions (PGDs) are in place for a range of antimicrobials. PGD's support immediate access to antimicrobials, when clinically appropriate, in urgent care and in-patient settings, when medical or non-medical prescribers may not be available.

All PGDs for antimicrobials are reviewed and approved by the Trust's Consultant Medical Microbiologist in addition to the usual approved Trust signatories.

7.3 Antimicrobial Guidelines

Trust Antimicrobial Guidelines for specific body systems are in place. These are based on National Institute for Health and Care Excellence (NICE) guidance with local adaptation by the local microbiologist. Where clinically appropriate, guidelines in the Trust reflect those in the wider Gloucestershire health and care system. All Trust antimicrobial guidelines are available on the Gloucestershire Countywide Medicines Formulary.

In January 2024, the Medicines and Healthcare products Regulatory Agency (MHRA) advised of additional risks with prescribing fluoroquinolones. Due to the potential risk of disabling and potentially long-lasting or irreversible side effects, systemic fluoroquinolones can now only be prescribed when other commonly recommended antibiotics are inappropriate. This follows a review by the MHRA which looked at the effectiveness of current measures to reduce the identified risk of disabling and potentially long-lasting or irreversible side effects.

As a result of this alert:

- All Trust antimicrobial guidelines have been reviewed by the Chief Pharmacist and Consultant Microbiologist to ensure that any indications for use of fluoroquinolones are appropriate and necessary
- All prescribers have been made aware of the risks and actions required

7.4 Training

A range of tools are in place to provide support to staff on the prudent use of antimicrobials to reduce the risk of antimicrobial resistance:

- A powerpoint on antimicrobial resistance and stewardship is shown to new starters at clinical induction
- The Trust Consultant Medical Microbiologist delivers, as required, an update to non–medical prescribers on antimicrobials, stewardship and resistance
- All antimicrobial guidelines contain information in line with NICE guidance on appropriate prescribing, including when not to prescribe, the use of delayed prescriptions and safety netting. This is also reflected in PGDs for antimicrobials
- The Royal College of GP's TARGET antibiotic toolkit (designed to support primary care clinicians to champion and implement antimicrobial stewardship) is available to all staff through the staff intranet.

- The antimicrobial prescribing competency framework (developed by the Professional Education sub-group of the Expert Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) and UKHSA) are available on the staff intranet. The aim of the framework is to improve the quality of antimicrobial treatment and stewardship and, therefore, reduce the risks of inadequate, inappropriate, and adverse effects of antimicrobial treatment. This will improve the safety and quality of patient care and make a significant contribution to the reduction in the emergence and spread of antimicrobial resistance.

7.5 Committees

Antimicrobial stewardship is a standing agenda item on the Trust's bi-monthly Medicines Optimisation Group at which the Consultant Medical Microbiologist is a core member. The minutes of the group are shared with the Trust Quality Assurance Group (QAG) through the Medicines Optimisation Quarterly reports.

Antimicrobial stewardship is also a standing agenda item on the bi-monthly IPCDC chaired by the Director of Infection Prevention Control.

The Trust's Chief Pharmacist attends Gloucestershire Hospitals NHSFT monthly antimicrobial stewardship operational meeting, where antimicrobial guidelines are discussed, and chairs the Integrated Care System (ICS) Antimicrobial Stewardship Strategy group. This group aims to take an ICS strategic approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness within Gloucestershire.

8.0 Patient Information (Criteria 4)

Staff intranet pages were re-fashioned in 2023 and information uploaded has been regularly updated. External links for guidance and management of infections has been added, including chickenpox, measles and shingles. Patient information leaflets for Norovirus, influenza, *C.difficile* and MRSA are available for staff to download for patients.

The IPC page on the staff intranet has the following information available:

- IPC policies
- Posters and other information
- Hospital in-patient IPC dashboards
- IPC education and training that is available
- Templates for IPC ward audits
- Decontamination information
- A dedicated page for IPC Link Workers
- Contact details of the members of the IPC team

The IPC team have a dedicated telephone support and advice line (in-hours). Out of hours advice and support can be sought from the on-call Microbiologist.

The IPC team work closely with the communications department to disseminate information across the Trust, including visiting guidance which is available on the internet alongside general IPC information.

9.0 Healthcare Associated Infection (HCIA) and Surveillance (Criteria 1 and 5)

Avoidable infections are not only potentially devastating for patients and healthcare staff, they also consume valuable healthcare resources.

9.1 Surveillance and Reporting

A proportion of the IPC team's workload involves daily surveillance and identification of people who have, or are at risk of developing, an infection so that they can receive timely and appropriate treatment and to reduce the risk of transmitting the infection to others.

Some organisms are subject to mandatory reporting requirements to the UK Health Security Agency (UKHSA). These are:

- MRSA
- MSSA
- *C. difficile*
- Gram-negative bloodstream infections (*Escherichia coli, Klebsiella spp, Pseudomonas aeruginosa*)

Infections that are reportable to UKHSA are recorded on the national Healthcare Associated Infections (HCAI) data capture system on a monthly basis.

There is a robust reporting system in place. The Gloucestershire Hospitals NHSFT laboratory inform the IPC team of alert organisms that need to be mandatorily reported, as well as others of infectious significance, such as influenza, COVID-19, Norovirus or Tuberculosis (TB). Positive results are reported to clinical teams via email, so that clinical staff are notified at the earliest opportunity, and via ICNet (IPC specific surveillance software).

Data on all relevant organisms is generated via ICNet and reported monthly at IPCDC.

9.2 MRSA bacteraemia

There were no MRSA bacteraemia cases during 2023/24 and there have been no cases since the Trust merger in 2019.

	Tolerance	2023/24 number reported	Compliance
MRSA bacteraemia	Zero	Zero	Green

9.3 Other Bacteraemia Surveillance (*E. coli*, MSSA)

There were also no cases of *E. coli* and MSSA bacteraemia in the Trust during 2023/24 and there have been no cases since the Trust merger in 2019.

	Tolerance	2023/24 number reported	Compliance
MSSA bacteraemia	Zero	Zero	Green

	Tolerance	Pre-48 Hour	Post 48 hour	Compliance
E. coli bacteraemia	No set tolerance	Zero	Zero	Green

9.4 Health Care Associated Infections

9.4.1 MRSA Acquisition

Daily surveillance by the IPC nurses identified 5 patients that were an MRSA acquisition for the Trust. An acquisition is defined as a patient that was previously MRSA negative when screened on admission but has subsequently become colonised with MRSA 48hrs after admission. MRSA can be detected in either the wound or in their nose and groin. Although MRSA acquisitions are not a UKHSA mandatory reporting requirement, the IPC team will investigate them to identify any learning.

There was also a cluster of possible associated MRSA cases within the homeless community during 2023/24. Meetings were held with the Homeless Healthcare and Health Protection teams who concluded there was no evidence of transmission within this group. As a precaution, however, education posters were produced by Health Protection team and given to the Homeless Healthcare team to disseminate to patients.

9.4.2 *Clostridioides difficile (C.dificile)*

The Trust provides mandatory surveillance to UKHSA for *C.difficile* toxin positive results. National thresholds for HCAI's are set for acute Trusts and ICB's but not for community Trusts. Locally, therefore, the *C.difficile* threshold for the Trust is set by the

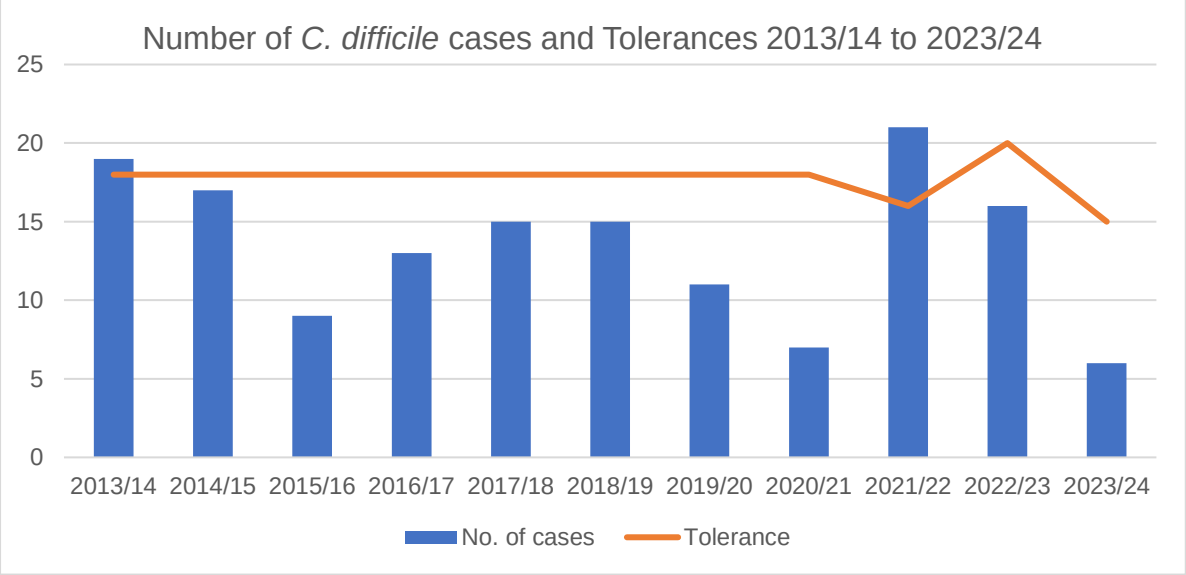
ICB. The locally set threshold for 2023/24 was for no more than 15 cases of *C.difficile* occurring 48 hours or more following admission into hospital.

In 2023/24, there were 6 Hospital Onset Healthcare Associated Infections reported; this is 10 less than in 2022/23 and within the set threshold level. All occurred in community hospitals.

	Tolerance	2023/24 number reported	Compliance
C. difficile	15	6	Green

The chart below shows the number of Trust *C. difficile* cases and threshold levels since 2013/14.

Chart 5: Number of *C.difficile* cases and thresholds in the Trust since 2013/14



All *C.difficile* toxin positive and gene detected results are recorded on the patient's clinical record to alert the clinical teams. An IPC nurse will visit the ward within 48 hours of diagnosis to give specialist advice for patient management. Regular support to clinical staff is given by IPC nurses thereafter.

A period of increased incidence (PII) is defined as two or more cases of *C.difficile* occurring on the same ward within a 28-day period, that are both more than 48 hours post-admission and not classified as relapses (a return of symptoms within the previous 28 days). During 2023/24 there were no PII's. The Trust has adopted the Patient Safety Incident Response Framework (PSIRF) and the IPC team now work closely with the Patient Safety team to follow the PSIRF process to identify learning.

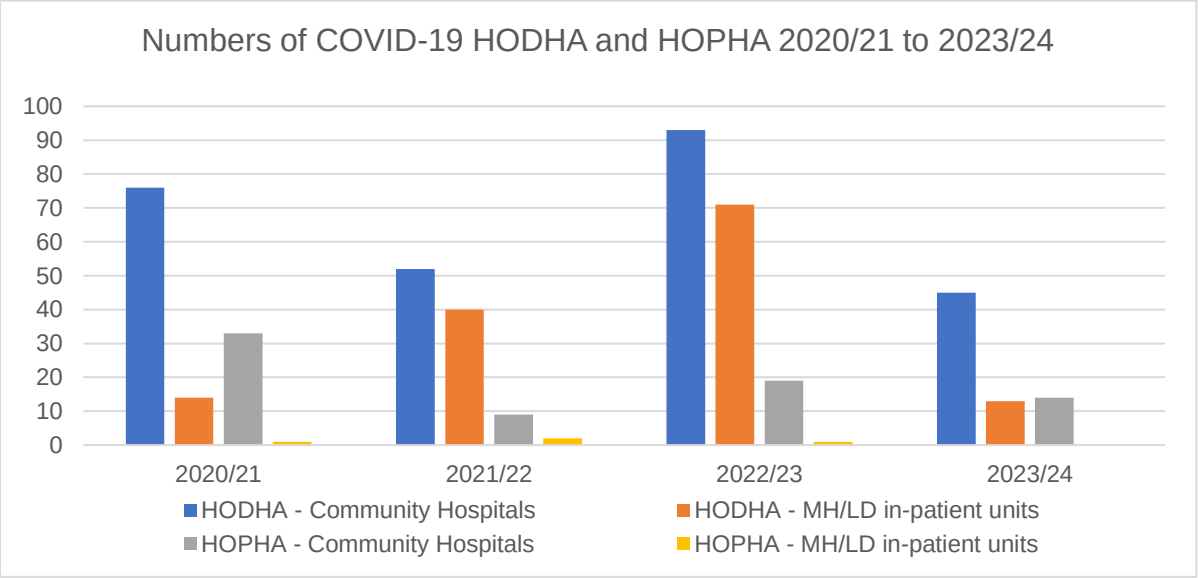
9.4.3 COVID-19

During 2023/24, there were 58 Hospital Onset Definite Hospital Acquired (HODHA) COVID-19 cases and 14 Hospital Onset Probable Hospital Acquired (HOPHA) COVID-19 in the Trust. The definitions for hospital acquired COVID-19 are:

- **HODHA -** Hospital Onset Definite Healthcare Acquired - first positive specimen taken 15 or more days after hospital admission
- **HOPHA -** Hospital Onset Probable Healthcare Acquired - first positive specimen taken 8-14 days after hospital admission.

The chart below shows the number of HODHA and HOPHA COVID-19 cases in the Trust over the last four years.

Chart 6: Number of COVID-19 HODHA and HOPHA Cases 2020/21 to 2023/24



The criteria for swabbing for COVID-19 changed in August 2023. Only patients with respiratory symptoms that met the criteria for antiviral, or nMabs, treatment were to be swabbed.

9.5 Outbreaks

NHSE define an outbreak of infection as:

- Two or more people with the same disease or symptoms or the same organism isolated from a diagnostic sample, who are linked through a common exposure, personal characteristics, time or location

- A greater than expected rate of infection compared with the usual background rate for the particular place and time

During outbreaks throughout the year ward staff were supported by the IPC team and the Microbiologist with clinical visits to the ward and telephone advice and support.

The table below shows the number of outbreaks by infection in the Trust during 2023/24.

Table 6: Number of outbreaks by infection in the Trust during 2023/24

Month	Number of Outbreaks			
	COVID-19	Flu A	Norovirus	RSV
April	2	0	0	0
May	0	0	0	0
June	1	0	0	0
July	0	0	0	0
August	2	0	0	0
September	2	0	0	0
October	2	0	0	0
November	2	0	0	0
December	1	0	0	0
January	0	0	0	0
February	0	0	0	0
March	0	0	2	0
Total	**12**	**0**	**2**	**0**

9.5.1 COVID-19

COVID-19 was the organism responsible for causing all of the respiratory outbreaks in 2023/24. The duration of the outbreaks, and the impact for patients, was significantly reduced compared to 2022/23. This was partly due to the COVID-19 vaccination programme, prompt recognition and management of symptoms by clinical teams and a change in swabbing guidance. The IPC team supported the clinical teams to manage these respiratory outbreaks effectively. In-patients eligible to receive a COVID-19 vaccine, were offered a vaccine if they had not already had one from their GP.

9.5.1.1 Patient Screening and Testing for COVID-19

The IPC team continue to work closely with the Trust's patient SPCA Bed Management teams to ensure the safe transfer of patients from GHNHSFT or other acute Trusts. A robust patient screening programme has remained in place throughout

2023/24 to identify patient COVID-19 status and ensure patients were placed in wards in a way that minimised any potential COVID-19 outbreaks.

National COVID-19 swabbing guidance changed in August 2023 and this was implemented across the trust. From August 2023, only patients with respiratory symptoms that met the criteria for antiviral, or nMabs, treatment were to be swabbed.

9.5.2 Influenza

There were no reported cases of influenza in the Trust during 2023/24, compared to 12 cases for 2022/23. In-patients eligible to receive an influenza vaccine, were offered a vaccine if they had not already had one from their GP. Additionally, clients known to the Trust who do not usually engage with primary care services (e.g. serious mental illness or learning difficulties, Homeless Health and Violent Patient Health services) were also offered an influenza vaccine.

9.5.3 Viral Gastroenteritis

During 2023/24, there were 2 outbreaks of viral gastroenteritis infection. The first outbreak lasted 10 days and a total of 12 patients were affected. The second outbreak lasted 7 days and 6 patients were affected. Both outbreaks were on Mental Health wards and Norovirus was confirmed as the causative organism for both. Both wards were closed to non-urgent transfer of patients and visiting was restricted. The IPC nurses supported the clinical team with daily phone contact and regular visits to the ward.

10.0 Training and Education (Criteria 6)

All clinical staff undertake mandatory e-learning IPC training annually through the Trusts learning and development system Care to Learn. Non-clinical staff undertake training every three years. All new staff (clinical and non-clinical) undertake IPC induction and are asked to complete the e-learning within three months of joining the Trust.

Training compliance is recorded on Care to Learn (staff education and training system) which is monitored by IPC, senior management and reported to IPCDC where any areas of lower compliance are highlighted. The table below shows Trust IPC training compliance as at 31st March 2024.

Table 7: Trust IPC training compliance as at 31st March 2024 with comparison to March 2023

Mandatory Training Name	Percentage of Staff Certified		Percentage of Staff not Certified		Number of Staff Certified	
	2024	2023	2024	2023	2024	2023
Infection Control – Clinical (1 Year)	92.4%	88.1%	7.6%	11.9%	3,905	3,521
Infection Control – non-Clinical (3 years)	98 %	95%	2%	5%	1,394	1,280

There is on-going education for other existing staff including support staff, volunteers, agency/locum staff and staff employed by contractors. This training incorporates the principles and practice of prevention and control of infection.

Infection prevention is included in all job descriptions for staff, clinical and non-clinical, including volunteers. Contractors working in servicer user areas must maintain good standards of IPC practice, including hand hygiene, and guidance is included in the Control of Contractors Policy. Clinical staff are responsible for ensuring contractors are aware of IPC expectations within the clinical environment.

IPC have been working with the Learning and Development Team and colleagues to improve access to aseptic non-touch technique (ANTT) training. In 2023/24 this became available as an e-Learning session on the Care to Learn system.

The IPC team successfully hosted an IPC Study Day in June 2023. It was attended by 43 staff from across the Trust as well as hospice staff (under the service level agreements).

The team held bi-monthly infection prevention and control link worker virtual education sessions in 2023/24, providing an opportunity for focused learning and discussions on hot topics.

A quarterly newsletter, called ‘The Gloucestershire Bug’, is produced for staff which provides information on topical infections in a more informal way.

The IPC team use clinical visits as an opportunity for educating and supporting staff, responding to queries or informing wards about new infection cases.

NHS England published an Infection Prevention and Control Education Framework in March 2023 NHS England » Infection prevention and control education framework which sets out the vision for the design and delivery of IPC education. The IPC team have reviewed this framework and is working with colleagues to ensure the Trust is compliant with it. This has been a work priority for the IPC team in 2023/24.

11.0 Isolation Facilities (Criteria 7)

The Trust has a commitment to providing safe and effective care and provides isolation facilities in all community hospitals. Some community hospitals consist entirely of single rooms that can be used for isolation, including:

- North Cotswold Hospital
- Tewkesbury
- The Vale
- Charlton Lane Hospital
- Wotton Lawn Hospital

Some of the Trust's older estates are in the process of being refurbished and a new purpose-built hospital will open in 2024/25 in the Forest of Dean. Increasing the number of isolation facilities is a priority consideration for refurbishment plans and the IPC team are involved in planning discussions.

The IPC team work closely with clinical and operational teams to ensure prompt isolation of potentially infectious patients in line with the Trust's Isolation Policy. Daily bed management meetings have taken place between IPC and Trust operational colleagues to ensure patients are placed in appropriate beds, according to their infection status, whilst balancing the need to maintain bed flow within a very pressured healthcare system.

Isolating patients and minimising the risk of transmission of infections, whilst maintaining patient flow and maximising capacity, has continued to be a challenge. On the few occasions where there were insufficient isolation facilities patients were cohort nursed together in bays in in-patient areas.

12.0 Laboratory Support (Criteria 8)

The Trust has a contract with Gloucestershire Hospitals NHS Foundation Trust for the provision of Microbiology laboratory support. The laboratory provides support for all Trust screening and testing requirements, e.g. MRSA screening, *C.difficile* and COVID-19 testing.

The department is accredited by UKAS to the standards of ISO 15189:2012 with the certificate being viewable at:

https://www.ukas.com/wp-content/uploads/schedule_uploads/00007/9576-Medical-Single.pdf

13.0 Infection Prevention and Control Policies (Criteria 1, 5, 6 and 9)

The Trust has a range of IPC policies in place to support the prevention, reduction and control of risks of infections in line with Health and Social Care Act 2008, national guidance and Infection Prevention Society best practice.

There is a robust process of reviewing IPC policies every one to three years to ensure they are up-to-date and relevant. They can also be updated in a timely manner as required, for example, if there are changes to national guidance. All IPC policies are agreed by the Trust's DIPC, medical microbiologist and deputy DIPC with final ratification by the Clinical Policy Group (CPG).

During 2023/24 four IPC Policies were reviewed, updated and finally ratified by the CPG:

- Animals and Pets (Companion Animals) within a Trust Hospital Building (CLP220, August 2023)
- Personal Protective Equipment Policy – excluding Viral Haemorrhagic Fever (CLP 083, October 2023)
- Tuberculosis (Community) (CLP074, November 2023)
- Management of Patients with a Viral Respiratory Illness (CLP 080, October 2023)

Staff are supported in understanding and adhering to IPC policies through telephone advice and support, IPC clinical visits and IPC training.

Assurance of compliance with Trust IPC Policies is monitored by the IPC team through:

- An audit programme
- Monitoring of IPC incidents (recorded on Datix)
- Post-infection reviews and outbreak reports
- Monthly surveillance
- Clinical IPC quality site visits, ward IPC dashboards and Matrons' clinical governance.

The IPC team meet hospital Matrons on a regular basis to conduct clinical quality site visits where IPC practice and cleanliness of premises is reviewed. These visits provide assurance on IPC measures in in-patient facilities and enable any IPC issues to be identified early.

13.1 Audits

There is an IPC audit programme in the Trust which covers:

- Anti-microbial management (monthly, in-patient units)
- Cleanliness (a programme of audits across all Trust sites)
- Hand Hygiene (monthly, community hospitals, mental health hospitals and LD in-patient unit)
- Mattress (monthly, community hospitals, and annually, mental health hospitals)
- Commode, Cushion, Curtain (monthly, community hospitals)
- IPC Environment (monthly, community hospitals, 6-monthly, dental sites, annually endoscopy units)
- Ad hoc IPC audits at selected sites (selected at the start of the year and Podiatry, Sexual Health, Complex Leg Wound services (CLEWS) and Minor Injuries and Illness Units (MIIU) were the areas of focus for 2023/24)

Action plans from these audits are developed by the IPC team with any learning and actions being included in Matrons' Clinical Governance reporting. The team undertook 25 IPC audits at sites and clinics across the county. All achieved IPC compliance and results are shown in the table below.

Table 8: IPC audits and results 2023/24

Function	Site	Date	Compliance %
Podiatry	Churchdown, Gloucester	08/10/23	96%
Podiatry	Coleford	21/11/23	92%
Podiatry	George Moore, Bourton-on-the-Water	22/01/24	96%
Podiatry	Independent Living Centre, Cheltenham	30/11/23	92%
Podiatry	Kings Street, Stroud	12/03/24	94%
Podiatry	Lydney Health Centre	25/01/24	95%
Podiatry	St Pauls, Cheltenham	15/02/24	90%
Podiatry	Tewkesbury Hospital	12/09/23	96%
Podiatry	Vale Hospital	05/01/24	97%
Sexual Health	Hope House, Gloucester	11/09/23	86%
Sexual Health	Milsom Street, Cheltenham	03/11/23	96%
Sexual Health	SARC, Swindon	19/09/23	88%
CLEWS	Cirencester Hospital	06/10/23	99%
CLEWS	George Moore, Bourton-on-the-Water	22/01/24	98%
CLEWS	Milsom Street, Cheltenham	03/11/23	95%
CLEWS	Stroud Hospital	01/09/23	98%

MIIU	Cirencester Hospital	12/01/24	93%
MIIU	North Cotswold Hospital	23/08/23	98%
MIIU	Stroud Hospital	31/08/23	96%
MIIU	Tewkesbury Hospital	12/09/23	96%
MIIU	The Vale Hospital	01/09/23	97%
Theatre	Cirencester Hospital	29/11/23	99%
Theatre	Stroud Hospital	12/10/23	97%
Ward	Cotswold View, North Cotswold Hospital	12/04/23	99%
Homeless Healthcare	Rikenal, Gloucester	22/02/24	95%

13.1.1 Endoscopy Audits

An IPC Environment audit was undertaken in Cirencester (05/03/24) and Stroud (26/02/24) Endoscopy sites as part of the JAG accreditation process. The results of these audits can be seen in the table below. Both Endoscopy Departments have submitted the required data for JAG accreditation and the Trust is awaiting the assessment process outcome at the time of writing this report.

Table 9: Endoscopy IPC environment audit results 2024

	Cirencester		Stroud	
Audit Sections Completed	**% Compliance**	**Status**	**% Compliance**	**Status**
Environment	96%	Pass	95%	Pass
Hand Hygiene	100%		100%	Pass
Patient Equipment	100%	Pass	100%	Pass
Sharps Handling and Disposal	100%	Pass	100%	Pass
Personal Protective Equipment	100%	Pass	100%	Pass
Waste management	100%	Pass	100%	Pass
Linen Management	100%	Pass	100%	Pass
Transport of Specimens	100%	Pass	100%	Pass
Decontamination	99%	Pass	98%	Pass
Endoscopy Staff	100%	Pass	100%	Pass
Overall	**98%**	**Pass**	**97%**	**Pass**

13.1.2 Dentistry Audits

IPC Dental audits are undertaken every six months by the Dental Nurse leads. They audit compliance against HTM01-05 guidance (Decontamination and Environment).

IPC support the dental service to develop and implement Action Plans. In 2023, the IPC team also undertook IPC audits at the Dentist sites, results are shown below.

Table 10: Dentistry IPC audit results 2023/24

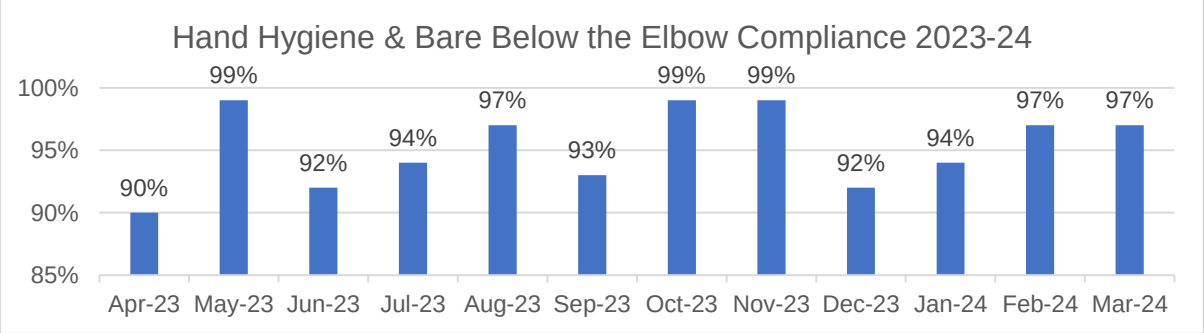
	Beeches Green	Cirencester	Lydney	Southgate	Springbank	St Pauls
Date of Audit	14/09/23	26/09/23	19/10/23	18/10/23	05/10/23	12/10/23
Prevention of blood-borne virus exposure	100%	100%	100%	100%	100%	100%
Decontamination	100%	100%	100%	100%	88%	90%
Environmental Design and Cleaning	92%	76%	76%	92%	84%	86%
Hand Hygiene	100%	100%	100%	100%	100%	100%
IPC Management	100%	100%	100%	100%	100%	100%
PPE	100%	100%	100%	100%	100%	100%
Waste Management	100%	100%	100%	100%	100%	80%

13.1.3 Hand Hygiene

Effective hand decontamination is an essential element in infection prevention and control. Monthly observational hand hygiene audits are undertaken in all Trust in-patient units (mental health, community hospitals and learning disability), Minor Injury and Illness Units (MIIUs), out-patient departments, endoscopy units, theatres and the Electroconvulsive Therapy suite (Wotton Lawn Hospital) by IPC link nurses.

Results are collated, monitored and reported to the Trust Board and IPCDC. If an individual area reports a score below the minimum standard of 85%, additional support and education is provided to improve compliance. The chart below shows the monthly average compliance scores for 2023/24.

Chart 7: Hand Hygiene Audit Results 2023/24



Overall Trust compliance, set by the Trust, is 90%. The Trust achieved overall compliance of 95.25% in 2023/24.

The World Health Organisation 'World Hand Hygiene' initiative on 5th May 2023 was supported by the IPC team and the Trust and promoted via social media.

The focus for International Infection Prevention week in October 2023 was 'small actions can make a big difference' such as being 'Bare below the elbows'.

Good hand hygiene was promoted during the week with the help of the Ultraviolet Glow Box (simulated germ particles on hands and wrists are revealed by the ultraviolet light).

There was a competition for all staff to showcase their small actions and the winners came from Charlton Lane, Tewkesbury, Stroud (Jubilee Ward) and Lydney Hospitals (pictured).

13.1.4 Sharps Audit

The Trust's sharps supplier, Daniels, conducted an annual sharps audit in October 2023 covering both community and in-patient physical and mental health sites. The aim of this audit was to provide assurance that staff are adhering to the management and disposal of sharps as per Trust policy, and in line with legislation and other national guidance.

A total of 273 sharps bins in 72 clinical areas were audited. More areas were able to be audited in 2023/24 due to the reduction in COVID-19 measures. There was good compliance across all areas audited, although there was a slight decrease in overall compliance compared to 2022. Trust-wide results are shown in the table below.

Table 11: Trust Overall Sharps Audit Results 2023

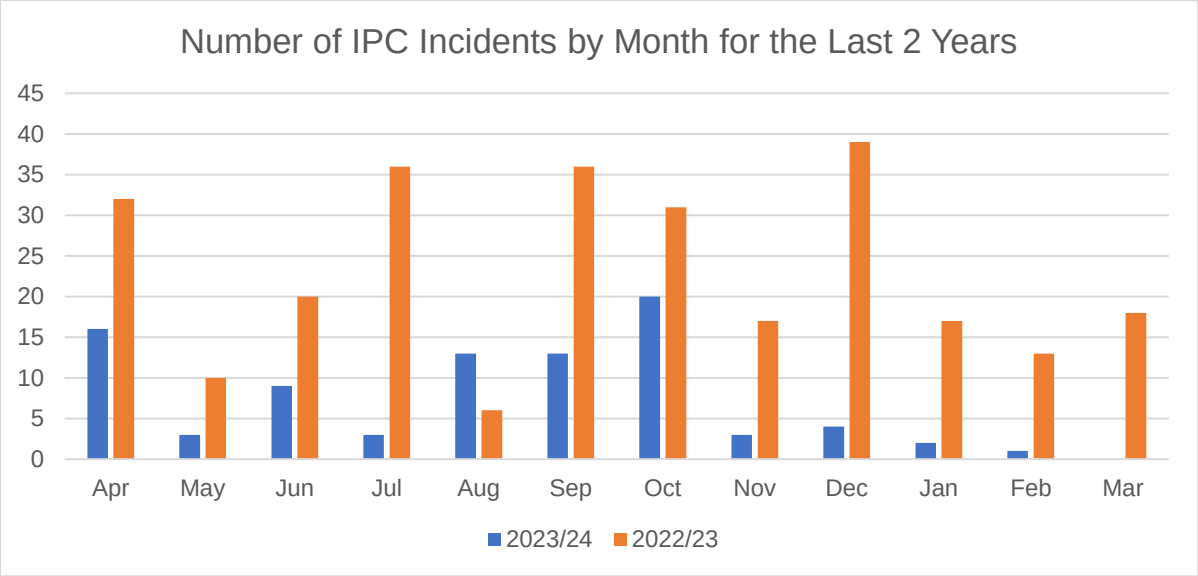
Standards		Compliance 2023	Compliance 2022
Number	Criterion		
1	Not containing protruding items	100% (273/273)	99% (177/179)
2	Correct assembly of containers	96% (262/273)	98% (175/179)
3	Matching lids and labels	99% (272/273)	100% (179/179)
4	No items above the fill line	100% (273/273)	99% (178/179)
5	Containers on the floor or at an unsuitable height	96% (263/273)	100% (179/179)
6	Containers not in brackets or mobile holders	Audited as part of number 5	85% (141/165)
7	Containers not labelled whilst in use	93% (256/273)	98% (175/179)
8	Not containing inappropriate contents	99% (272/273)	99% (178/179)
9	Temporary closure in use when left unattended or during movement	82% (226/273)	93% (166/179)
	Overall Compliance	**95% 2097/2184**	**97% 1548/1597**

Any areas of non-compliance were either immediately rectified or learning was shared with teams.

13.2 Incident Reporting (Datix)

Datix is the system used by the Trust for reporting incidents. Incidents are categorised as either No, Low, Moderate or Severe Harm incidents. In 2023/24, there were 87 IPC related reported incidents on Datix which is a decrease of 68% from 2022/23. This decrease is predominantly due to the reduction in hospital acquired COVID-19 cases and the changes in COVID-19 swabbing guidance that came into effect in August 2023. The table below shows the numbers of IPC incidents reported by month for the last 2 years.

Chart 8: IPC incidents reported by month for the last 2 years



The majority of Datix in 2023/24, 67 of the 87 (or 77%), were COVID-19 related. Datix were also raised for other healthcare associated infections, including *C.difficile* and MRSA, a missed CPE screen on admission and there were 4 instances where isolation was not possible (due to no side-room availability) when patients would have been co-hort nursed.

The IPC team continued to work with the Patient Safety team and ward staff in 2023/24 to embed the Patient Safety Incident Response Framework (PSIRF), in order to learn and improve patient safety from IPC related incidents. For 97% of incidents reported the level of harm was identified as either 'No' or 'Low' Harm. In 2023/24, there were 2 reported incidents identified as 'Moderate' Harm and 1 as 'Severe' Harm. The Patient Safety Team supported the ward and IPC team through the PSIRF process to identify any learning from these incidents.

14.0 Staff Health and Wellbeing (Criteria 10)

14.1 Working Well Occupational Health

Working Well is a Safe, Effective, Quality, Occupational Health Service (SEQOHS) accredited NHS Occupational Health Service. Working Well was awarded a 5-year re-accreditation in October 2022. As part of accreditation, there is a requirement for an annual review which was awarded in 2023. Working Well monitors activities and services to ensure services provision meets staff need and statutory requirements. Working Well offer a range of services, including:

- A screen of all new employees
- A programme for Immunisation of Healthcare and Laboratory staff, in line with Chapter 12 of the Green Book
- A service for staff who have a contamination injury, with access to rapid boosters if required
- 'Disease Outbreak' support by providing timely contact tracing. Working Well undertook 91 episodes of staff contact tracing in 2023/24
- Screening programmes for skin surveillance; 18 skin assessments were completed in 2023/24 following a referral to Working Well
- Advice and guidance to individuals and line managers

The following Working Well protocols and policies were in place for 2023/24:

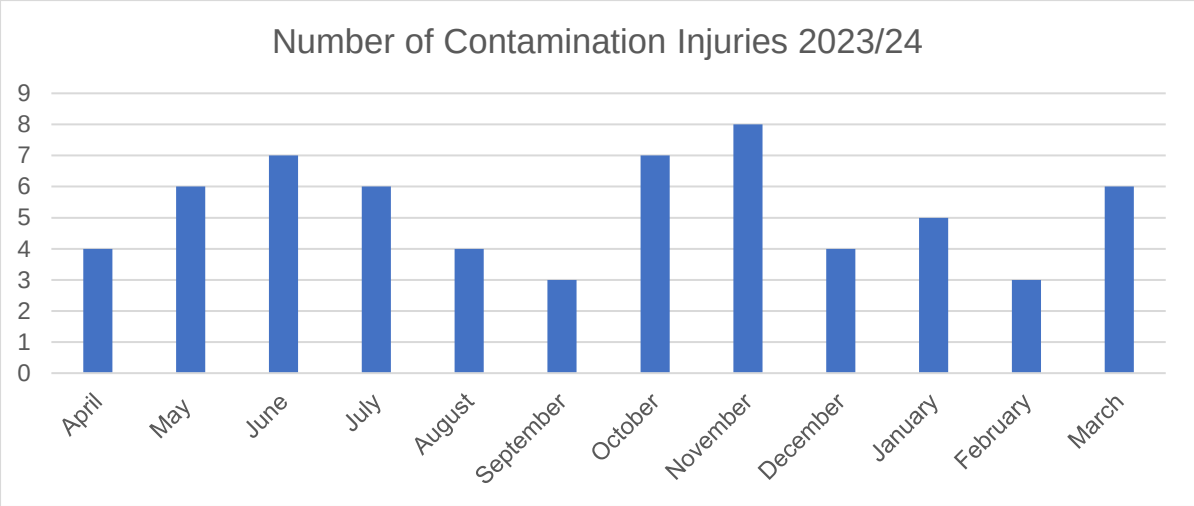
- Glove Use
- Blood Borne Virus contamination injuries
- Dermatitis
- Latex Allergy
- Staff Screening and Immunisation Policy

14.1.1 Sharps and Contamination Injuries

The Trust's 'Sharps and Splashes Injuries Prevention and Management of Occupational Exposure to Blood Borne Viruses' Policy outlines the steps the Trust and staff need to take in order to minimise the risks to staff of acquiring blood borne viruses through contamination injuries.

In 2023/24, Working Well supported staff with contamination injuries in 63 instances. The number of contamination injuries reported by month are shown in the chart below.

Chart 9: Number of Contamination Injuries by Month 2023/24



Datix are raised and all contamination injuries are investigated by Working Well; no trends were identified during 2023/24. The Trust had no Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable events during 2023/24. The number of contamination injuries remains very low for the Trust.

14.2 Staff Influenza and COVID-19 Vaccination

The Trust offered influenza and COVID-19 vaccinations for staff during 2023/24 at a variety of bookable and drop-in clinics across Gloucestershire. The uptake of staff vaccination is shown in the table below.

Table 12: Staff Uptake of Influenza and COVID-19 Vaccine 2023/24

	COVID Vaccines up to 31/03/24				Influenza Vaccines up to 31/03/24			
Staff Role	**No**	**Yes**	**Total Staff**	**% Uptake**	**No**	**Yes**	**Total Staff**	**% Uptake**
Doctor/Dentist	94	63	157	40%	87	70	157	56%
NHS Infrastructure	513	476	989	48%	440	549	989	58%
Nurse/Midwife	1,044	477	1,521	31%	913	608	1,521	53%
Other Professionally Qualified	432	378	810	47%	376	434	810	58%
Support to Clinical	957	428	1,385	31%	854	531	1385	56%
Grand Total	**3,040**	**1,822**	**4,862**	**38%**	**2,670**	**2,192**	**4,862**	**45%**

The uptake of the influenza vaccination was slightly lower than 2022/23, 45% uptake compared to 56% in 2022/23. However, the uptake of COVID-19 was higher than the previous year, at 38% compared to 23% in 2022/23. Staff also have the option of receiving both vaccines from their GP or local pharmacy. Vaccines received outside of the Trust would not be recorded on staff files.

14.3 Filtering Facepiece Fit-Testing Programme

Infection prevention and control measures, in line with national guidance, are in place to protect staff from acquiring suspected or known infections or diseases that are spread, wholly or partly, by the airborne route. These measures include the wearing of Respiratory Protective Equipment (RPE), i.e. filtering face pieces (FFP). In order to be fully effective, the FFP3 mask must fit correctly and not leak. Quantitative fit testing is recognised as the most effective method for checking that a specific model and size of FFP3 mask matches the wearers facial features and seals correctly to the wearers face. Fit testing also helps to identify unsuitable facepieces that should not be used.

All staff who may need to wear a FFP3 mask when carrying out their duties are required to be fit tested and the Trust has had a fit testing programme in place throughout 2023/24. The IPC Decontamination Lead is responsible for the fit testing programme and manages the fit testers providing fit test sessions at venues across the county.

Staff are divided into three groups:

- Group 1 – Theatre staff, clinical dental staff, respiratory physiotherapists and clinical ECT staff
- Group 2 – All level 3 resuscitation trained staff Trust wide
- Group 3 – All mental health, LD and physical health staff who deliver care, including AHP's Estates and Facilities staff, Outpatient staff

All three Groups require fit testing every 2 years to ensure that staff are able to wear the mask correctly and also to ensure that they are wearing the most up to date FFP3 mask available to the Trust.

In the event that no FFP3 mask fits a member of staff effectively then staff can access a respiratory protective hood (RPH). There are 58 RPH's available across the county with spare hoods available at Trust headquarters in the event any further hoods are required.

15.0 Infection Prevention and Control Team Plan/Aims for 2024/25

The IPC team have continued to provide a responsive service to physical health, mental health and LD in-patient units in 2023/24 and to support staff to transition to "living with COVID-19". The intention for 2024/25 is to continue to provide a proactive and equitable IPC service across all Trust services.

The main focus and IPC priorities for 2024/25 will be:

- Continue to review ANTT practice across the Trust
- Mouthcare Matters health education for staff
- Review Matrons Walkabouts for a more effective way of gaining assurance
- Prioritise Ventilation Safety and work with Estates to establish a Ventilation Safety Group
- Community services – continue with the focus and progress made in 2023/24
- Review Hand Hygiene assurance
- Continued focus on MH and LD with IPC audits planned in Quarter 1 for Wotton Lawn Hospital
- Improve glove usage awareness
- Review NHSE IPC Education Framework when it is published and implement any changes
- Monitor emerging threats and collaborate with UKHSA

15.1 Personal Development of the Team

Every member of the IPC team was supported with their personal development throughout 2023/24. Facilitated team away days were supported by the DIPC/Deputy DIPC and provided an opportunity to review and improve ways of working.

Marion Johnson, Lead Nurse IPC:

- Water safety responsible persons course
- Appraisal Conversation training
- Job Evaluation training
- Infection Prevention Society (IPS) South West (SW) forum
- IPS SW Conference at Exeter
- CPE Conference – Birmingham
- Reviewing HTM documents for Ventilation, Water Safety and Dentistry

Louise Forrester, Lead Nurse for IPC MH and LD:

- Measles and pertussis webinars
- IPS SW Conference – Exeter

Sam Lonnen, Decontamination Lead and FFP3 Fit-test Team Lead:

- Knowlex Infection Prevention and Control Conference 2023

Lisa McLean, Senior Infection Control Nurse:

- PSIRF - Applying PSIRF, PSIRF process mapping and IPC and PSIRF QA with Sally Matravers webinars
- Appraisal Conversation training
- IPC moments that matter and Clinell webinars
- Student Supervisor and Assessor update training
- One Gloucestershire system thinking Masterclass
- Learning from Patient Safety Events
- Measles, pertussis and Introduction to Model Health webinars

Emma Hucker, Infection Control Nurse:

- Hand Hygiene webinar
- IPC Study day
- IPC and PSIRF QA with Sally Matravers webinar
- Moments that matter webinar
- ICNET updates

Lynn Brookes, Infection Control Nurse:

- Measles and pertussis webinars

Amy Barnes, Infection Control Nurse:

- ANTT study day
- Better Care Sustainability day
- NHS England SW Greener Nursing and Midwifery Regional Conference
- Giving Constructive Feedback
- Authentic, Compassionate Leadership

In March 2024, Amy was a finalist for the Regional CNO Sustainability Nurse Award and was selected to present her QI Patchwork Project to the Queens Nursing Institute.

Emma Morrall (was Bray)

- Continuing with Silver QI
- Part of the QI project team for 'Increasing Service User and Carer Involvement in QI'
- Loggist Training for Incident Management
- 2 x Digital Support Training Sessions

16.0 Acknowledgements

Thank you for reading the IPC Annual Report for 2023/24.

This report was prepared with input from:

- Hannah Williams, Acting Director of Nursing, Therapies and Quality and Acting Director of Infection Prevention and Control
- Marion Johnson, Lead Nurse IPC
- Lou Forrester, Lead Nurse for IPC MH and LD
- Lisa McLean, Senior Infection Control Nurse
- Sam Lonnen, IPC Decontamination Lead
- Corinne Dyer, Estates Decontamination Manager
- Richard Ashton, Performance and Compliance Manager- Facilities
- Laura Buckley, Chief Pharmacist
- Philippa Moore, Infection Control Doctor
- Amanda Horne, Occupational Health Lead Nurse
- Mark Turk, Estates Compliance Manager