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NHS
Gloucestershire Health and Care
NHS Foundation Trust

Infection Prevention and Control

Annual Report 2021/22

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Contents

Introduction and Foreword

Once again it is a privilege to present the Gloucestershire Health and Care NHS Trust Annual Infection Prevention and Control Report.

It has been another challenging yet rewarding year for the organisation with regard to the subject of Infection Prevention and Control. It is positive to see the continued development and expertise of colleagues throughout our services in the management of the continued COVID-19 pandemic. The benefit of vaccines, good access to testing and robust supplies of Personal Protective Equipment is recognised and with hope we look forward to further progress in seeing a reduced impact of the pandemic on day to day clinical work in the Trust in 2022/23.

Of course, Infection and Prevention and Control is not solely focused on COVID-19, this report includes the details of how we as a Trust strive for excellence in reducing harms caused by infectious diseases and conditions. I am most privileged to work alongside a motivated and diligent infection control team with the full support of colleagues across the organisation in complying with national guidance, following best practice directives and working hard to maintain high standards of infection control. A special thanks is also due to the Trusts wonderful facilities and estates colleagues alongside procurement and finance teams who contribute to all the work that goes into keeping our patients, families and colleagues safe from infectious diseases.

John Trevains
Director of Infection Prevention and Control

September 2022

1.0 National Guidance and Key Legislation

All 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 report covers the period April 1st 2021 to March 31st 2022 and relates to the services that Gloucestershire Health and Care NHS Foundation Trust (GHC) is registered to provide with the Care Quality Commission (CQC).

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

Good Infection Prevention and Control 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 2021/22, and where the Trust would like to improve for 2022/23.

1.1 Key Achievements During 2021/22

The Trust had a low incidence in the majority of mandatory reportable healthcare associated infection during 2021/22, with the exception of Hospital Onset Healthcare Acquired cases of toxin positive *Clostridioides difficile* and COVID-19.

The Infection Prevention Control (IPC) Team continued to be impacted by the demands of the COVID-19 pandemic but were able to respond efficiently and effectively to the rapidly changing environment and provide clinical teams with COVID-19 advice, support and guidance.

The IPC team liaised closely with the Single Point of Clinical Access (SPCA)/Bed Management teams to create a COVID-19 patient pathway, reduce the risk of COVID–19 transmission and ensure a safe transfer and admission of patients into Trust hospitals.

Throughout 2021/22, Louise Forrester, Lead Nurse for Infection Control Mental Health and Learning Disabilities, worked closely with Mental Health and Learning Disability in-patient settings to raise infection prevention and control awareness and improve practice. Louise used her Mental Health knowledge and experience to develop and improve relationships between clinical colleagues and the IPC team.

The Link Worker programme was refreshed, Emma Bray re-established membership of the group and requested topics for discussion. The IPC team provided informative IPC sessions via teams to the revised list of Link Workers.

Overall, the Trust achieved its target compliance for Hand Hygiene of 90% for 2021/22.

In response to updated HTM 03-01 Specialised ventilation for healthcare buildings (NHSE/I), a Ventilation Lead and Authorising Engineer (Ventilation) have been appointed and a Ventilation Group established to prioritise and monitor ventilation safety.

1.2 Key Potential Risks During 2021/22

Outbreaks of serious infection, including COVID–19, remain a potential risk.

There are continual challenges of maintaining good infection prevention and control standards in some of the Trust's older properties.

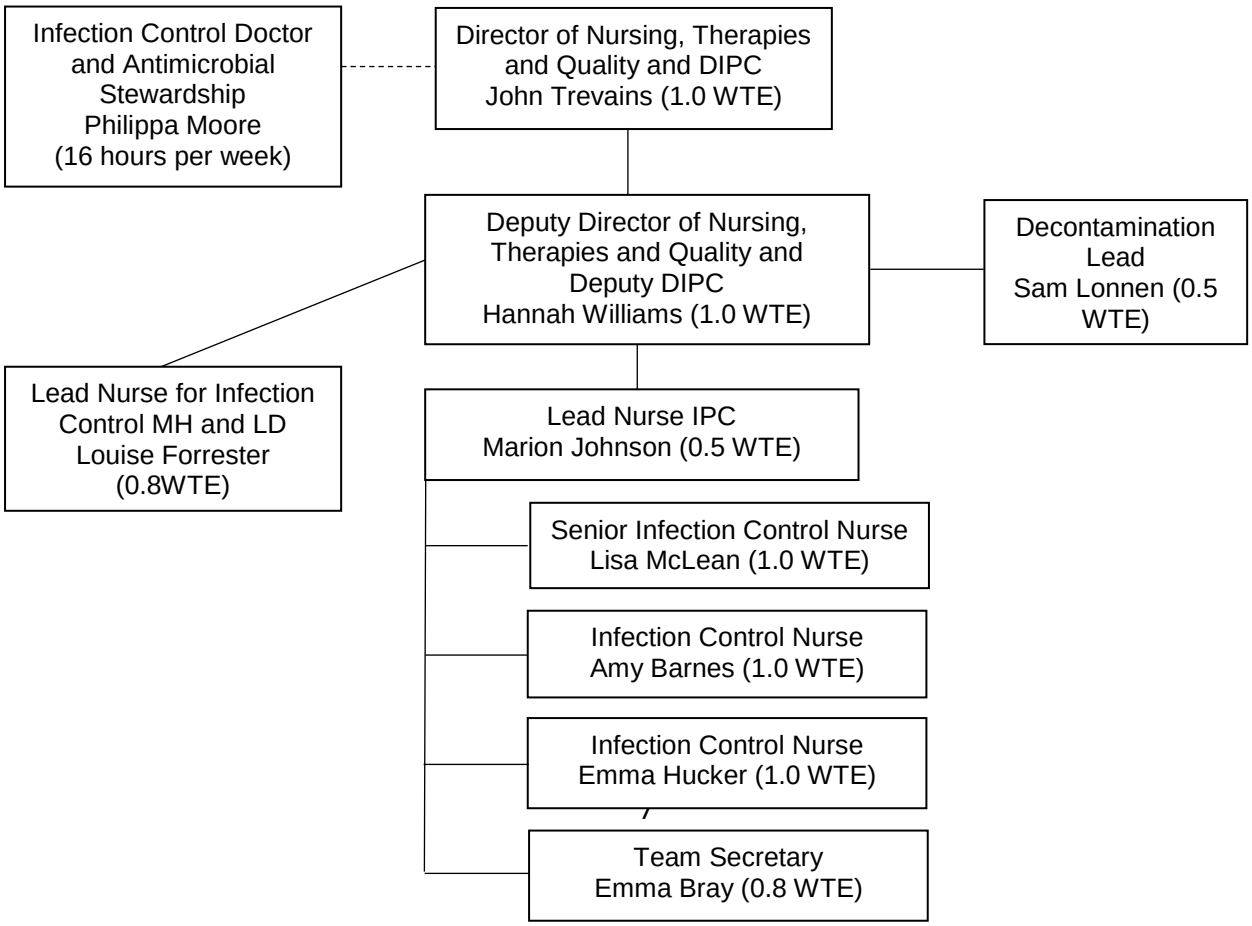
2.0 Infection Prevention and Control Team Structure 2021/22 (Criteria 1)

The Chief Executive holds overall responsibility for Infection Prevention and Control within Gloucestershire Health and Care NHS Foundation Trust. The Director of Nursing is the designated Executive Lead and Director of Infection Prevention and Control (DIPC). They report directly to the CEO and the Board. 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 community physical health, mental health and learning disability services across the Trust. The team structure is outlined in the chart below. Staff changes in the team during 2021/22 include the departure of Natalie Matthews (Senior Band 7 ICN) to pursue a career in training and development, Amy Barnes took maternity leave in March 2022, and there was the arrival of Emma Hucker (Band 5 ICN) in January 2022. Sam Lonnen took on the newly defined role of Decontamination Lead for the Trust in 2021.

The Team recruited a qualified and experienced band 6 ICN to cover the maternity leave (0.5 WTE); they are due to commence their role on May 30th 2022.

Chart 1: Infection Prevention and Control Team Structure as at March 31st 2022



GHC 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 antimicrobial stewardship. The SLA includes the provision of out-of-hours Consultant Medical Microbiologist cover.

It has been another extremely challenging year but the Team have maintained an excellent and dedicated IPC service to the Trust.

3.0 Infection Prevention and Control Governance (Criteria 1)

The DIPC reports regularly to the Trust Quality Committee on all IPC related matters. In April 2020, NHSE/I introduced a COVID-19 IPC Board Assurance Framework (IPCBAF) to support healthcare providers in self-assessing compliance against UK Health Security Agency (formerly Public Health England) and other COVID-19 guidance and identifying any COVID-19 related risks. This framework has been regularly reviewed by the DIPC and assurance is reported at Trust Board meetings.

The DIPC is the chair of the bi-monthly Infection Prevention and Control and Decontamination Committee (IPCDC). Membership of the IPCDC includes the Deputy DIPC, Infection Control Doctor, IPC Team, and representation from Hotel Services and Estates and Facilities. Working Well Occupational Health and 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. Monthly performance on the number and status of specific reportable and non-reportable infections in the Trust is reported to the IPCDC.

The IPCDC agreed the 2021/22 Annual IPC Work Plan and reviewed progress against the plan. This oversight ensures Trust IPC priorities are agreed and implemented and any IPC issues are identified early. The 2021/22 Annual IPC Work Plan covered the following areas:

1. Surveillance
2. Audit
3. Education and training
4. Policy development and review
5. Specialist advice, expertise and support for IPC and decontamination to staff
6. Information for patients and visitors
6. Commitment from all members of the healthcare community

The demands on the IPC Team, as with all other Trusts across the country, continued throughout 2021/22 due to COVID-19. The need to prioritise and focus resource on COVID-19 related work, whilst ensuring the Trust continued to fulfil its statutory reporting responsibilities, remained challenging and did have an impact on delivery of the IPC 2021/22 Annual Work Plan.

The team daily ‘huddle’ ensures all staff are aware of IPC priorities and responsibilities for the day. These daily huddles were essential during the pandemic, when there was

a rapidly changing IPC environment, and for the part-time staff in the team. These continue to prove useful in ensuring IPC work is prioritised effectively.

The Team meetings were also reviewed. There is now a monthly meeting to accommodate wider attendance from key stakeholders and a monthly focused operational team meeting. The Infection Control Doctor attends both meetings and is available to address any clinical questions.

The Infection Prevention and Control Bronze Cell continued for the majority of the year, and was attended by representatives from key stakeholders within the county. This ensured there was a co-ordinated countywide response to the management of COVID-19. As the threat and risk from COVID-19 has decreased, the decision was taken to continue with this forum and change the remit to cover all IPC alert organisms and further develop a countywide approach to managing IPC.

3.1 Contracts for Infection Prevention and Control

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

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

The IPC Team undertake annual Infection Prevention Society (IPS) Environmental 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.

Throughout the COVID-19 pandemic, the team have ensured that these organisations were informed of updated PHE guidance and had access to up-to-date copies of Trust IPC Action Cards.

4.0 Facilities and Estates 2021/2022 (Criteria 2)

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

Locality Facilities Teams have been working to their enhanced COVID-19 Cleaning Plan throughout 2021/22, with increased levels and frequency of cleaning, in order to mitigate against the risk of transmission of infection.

The National Standards of Healthcare Cleanliness 2021 (NSoHC2021) were updated in April 2021. A project team has been working towards migrating these standards into the Trust by November 2022.

Facilities performance data is reported to, and monitored by, the Infection Prevention and Control and Decontamination Committee and also the Buildings Environment and Medical Equipment Group.

4.1 Cleanliness Audits

Trust cleanliness audits are undertaken in line with NHSE cleanliness standards, Table 1 shows the frequency and compliance standard required.

Table 2: NHSE National Specifications for Cleanliness in the NHS (2007) frequency of audits and compliance standards by risk category

Risk Category	Frequency	Standard
Very High	Weekly	98%
High	Monthly	95%
Significant	13 Weeks	85%
Low	6 Monthly	75%

During 2021/22, the Facilities Team made huge progress in mapping all clinical sites and areas onto their auditing system (FM First), with the exception of Wotton Lawn Hospital. Wotton Lawn Hospital will be mapped onto FM First by July 2022.

Due to the ongoing impact of the pandemic, the cleanliness audit schedule has, at times, been interrupted, and audits were sometimes not undertaken at the frequency the Trust expects. Also, it was not always appropriate to audit the wards if there was a high risk of transmission of COVID-19.

Facilities Managers continually prioritised the team workloads to ensure higher risk areas were audited as a priority and the schedule was adhered to as much as possible. They also kept in close contact with their teams on each site and encouraged staff to escalate any concerns they may have had with cleanliness in their buildings. The Facilities Management Team worked closely with the COVID-Secure Environment Team, which provided further opportunity to identify any areas of concern around cleanliness. Despite the challenges that COVID-19 presented, good compliance against NHSE standards has been achieved for 2021/22. Table 2 shows Trust cleanliness compliance levels per risk category.

There is an expectation that the regular auditing regime will return to previous levels from April 2022 onwards.

Table 3: GHC 2020/21 Trust compliance by risk category

Risk Category	NHSE Standard	GHC Compliance 2021/22
Very High	98%	99.35%
High	95%	97.81%
Significant	85%	96.12%
Low	75%	89.15%

4.2 Swabbing: Adenosine Triphosphate

Adenosine Triphosphate (ATP) swab testing provides a quick method of on-the-spot assurance of the standard of cleanliness achieved on a particular 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 and results are submitted bi-monthly to the Infection Prevention and Control and Decontamination Committee. The table below shows a summary of the ATP swabbing results for 2021/22. A three-year ATP contract with Hygiena will formally start in April 2022.

Table 4: Trust ATP Swabbing Results 2021/22

Swab Result	Number of Location Points Swabbed
Pass	2,769 (85%)
Caution	159 (5%)

Failure	337 (10%)
Total	**3,265**

4.3 Patient Led Assessment of the Care Environment

The Patient Led Assessment of the Care Environment (PLACE) programme was paused in 2020 due to the pandemic. The assessments involve patient assessors visiting hospital sites to assess the quality of the patient environment, including cleanliness and general building maintenance.

NHS Digital developed PLACE-Lite during 2020/21 to support Trusts in conducting assessments in the absence of PLACE. Facilities teams conducted PLACE-Lite sample audits in 2021/22 and a report was submitted to the Trust's Quality Assurance Group. The results of the PLACE-Lite audits are shown in the table below. Cirencester and Wotton Lawn Hospitals did not have PLACE-Lite assessments due to resource issues as a result of COVID-19.

The Trust is expecting the annual PLACE assessments to resume in Autumn 2022.

Table 5: Trust PLACE-Lite Assessment Results 2021/22

Site	Privacy, Dignity & wellbeing	Cleanliness	Condition and Appearance	Dementia	Disability
Stroud	90.00%	100.00%	100.00%	94.27%	91.88%
Vale	84.00%	100.00%	99.05%	68.29%	70.42%
Dilke	87.50%	100.00%	98.70%	80.00%	76.56%
Lydney	85.19%	99.37%	95.67%	64.58%	71.05%
Tewkesbury	78.95%	100.00%	97.14%	73.68%	70.89%
North Cots	90.00%	100.00%	98.72%	79.17%	73.77%
Berkeley House	81.58%	99.34%	87.84%	66.67%	73.33%
Laurel House	87.50%	100.00%	96.23%	78.13%	78.05%
Honeybourne	84.21%	100.00%	94.59%	68.29%	76.47%
Charlton lane	92.11%	100.00%	93.98%	75.00%	70.88%

4.4 Kitchen Hygiene – Environmental Health Audits

In 2021/22, 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.

4.5 Decontamination

The Trust has an identified Decontamination Lead who is supported by the IPC team. Decontamination issues and performance are reported to the bi-monthly Infection Prevention and Control and Decontamination Committee.

Decontamination is the combination of processes (including cleaning, disinfection and sterilisation) used to make a re-usable medical device safe for further use on patients. The effective decontamination of re-usable medical devices is essential in reducing the risk of transmission of infections.

Health Technical Memorandum 01-01 - Management and decontamination of surgical instruments (medical devices) (HTM 01-01) sets out the statutory requirements on health care organisations to manage decontamination of medical devices and the Trust remains compliant with this.

Effective and safe decontamination is a priority for the Trust and a range of policies are available on the intranet that set out the roles and responsibilities of staff and the method and levels of decontamination required for different types of medical devices.

During 2021/2022, air decontamination (Clinell Rediair) units were introduced to patient care areas in older buildings with poorer ventilation. They are designed to improve air flow by providing ‘high efficiency particulate air’ (HEPA) filtered air to care areas and increasing the number of air changes per hour. The unit manufacturer stipulates that in order to achieve optimum performance the pre-filters fitted to the unit are cleaned every 14 days. A standard operating procedure was put together and the pre-filter change process is audited when the Decontamination Lead undertakes a clinical visit.

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 2021/22.

HTM 01-05 Decontamination in primary care dental practices guidance has been adopted for the Trust’s dental service and practices across the Trust are audited every six months using the Infection Prevention Society (IPS) dental audit tool and then reported to the Infection Prevention and Control and Decontamination Committee.

HTM 01-06 guidance covers the decontamination of flexible endoscopes. Annual Decontamination audits against HTM 01-06 are undertaken by the Trust's Authorising Engineer. These were completed at both endoscopy departments in March 2022; Cirencester scored 100% and Stroud 98% in their decontamination audits. Each endoscopy unit is also audited on an annual basis by the IPC team and have also achieved Joint Advisory Group (JAG) accreditation. JAG accreditation means that patients can have increased confidence in their endoscopy service and be assured of the same quality of care no matter where their endoscopy takes place. Additional assurance, for evidencing a high standard of scope decontamination, is provided by weekly final rinse water testing undertaken by Getinge.

Other medical devices, including items such as drip stands, commodes, dressing trolleys, blood pressure cuffs, hoists and hoist slings etc., are decontaminated in line with Trust policy. 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, e.g. Tristel.

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

Monitoring of decontamination is routinely undertaken in both in-patient and outpatient and specialist areas during IPC clinical/locality visits.

The Trust is fully committed to implementing the National Standards of Healthcare Cleanliness (April 2021) by the implementation date of November 2022. The Decontamination Lead has been involved in the implementation process over the past 12 months, representing the IPC team.

4.6 Water Safety

The Trust's Water Safety Scheme of Control (WSSC), which provides detail on how the risks from Microbiological and scalding hazards associated with the supply and use of water are assessed, managed and controlled, is owned and managed by the Water Safety Group. It is reviewed annually and is currently under review.

The Water Safety Group (WSG) meets every three months and reports into the Infection Prevention and Control and Decontamination Committee 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 across all Trust sites, with frequencies as follows:

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

Water Risk Assessments are monitored by the WSG and, as at 31st March 2022, all Water Risk Assessments were in date, with the exception of two out-patient sites (Lexham Pavilion and Cirencester Memorial, due February 2022).

On completion of Water Risk Assessments, 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. During 2021/22, capital funding was secured for a contractor to work though all properties' current Legionella Risk Assessment recommendations.

Water Safety Audits are carried out twice a year by the Trust's Water Hygiene Authorising Engineer. The latest audit was carried out on 7th December 2021 and audit results are outlined in the chart below.

Chart 2: Summary of Authorising Engineer's Water Safety Audits May and December 2021

Areas Audited	Legislation Compliance 07/12/21	Legislation Compliance 28/05/21	Compliance Level 07/12/21	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	MEDIUM	LOW	60%	⇧
Scheme of Control / Monitoring	MEDIUM	MEDIUM	70%	⇔
Log Book Operation / Management	MEDIUM	MEDIUM	60%	⇩

Flushing Regimes (Based on August and September Figures)	MEDIUM	MEDIUM	63%	⇔

This 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 Trust's Water Safety Policy had been reviewed and ratified at the Clinical Policy Group. The improvement that had been made to the process for monitoring the flushing regime was recognised in the audit.

A review of the site log books during the audit showed that compliance in some areas had dropped, hence the downward movement arrow under Log Book Operation/ Management.

These bi-annual audits have highlighted the need for improved service regarding the performance of the Trust's Water Hygiene contract, The Trust is bringing and bring this role back into the Trust from 1st June 2022. The Trust has plans in place to continue to maintain high standards for water related safety and improve audit outcomes in areas requiring attention.

4.6.1 Legionella

There is a rolling programme of Legionella sample testing at the Trust's in-patient sites; samples are taken every six months for testing and results are monitored by the WSG.

The majority of sites returned negative samples during testing but there were instances of slightly elevated results (with no risk to patients or colleagues) at Laurel House (June 2021), Montpellier Ward, Wotton Lawn Hospital (September 2021) and Stroud Maternity Hospital (October 2021). Required remedial actions were immediately undertaken for flushing, chlorination and re-sampling. Re-sampling returned negative results.

4.7 Ventilation

The Government published a research paper on the 27th May 2021 titled "EMG-SPI-B: Application of CO2 monitoring as an approach to managing ventilation to mitigate SARS-CoV-2 transmission". This paper outlined the importance of ventilation to mitigate against COVID-19 transmission.

In June and August 2021, HTM 03-01 specialised ventilation for healthcare buildings (NHSE/I), was updated to include improved risk mitigations for COVID-19 and a requirement for ventilation audits to be undertaken.

As a result, the Trust appointed a Ventilation Lead and an Authorising Engineer for Ventilation. The Trust Ventilation Lead completed Authorised Person training for Ventilation and Air Conditioning in August 2021. A Trust Ventilation Group has been established and the first meeting was in January 2022.

A smaller working group, to monitor air flow levels and undertake further risk assessments, was also created. An airflow audit was conducted in Community Hospitals and Mental Health Hospitals (December 2021 and January 2022). This audit covered all in-patient areas, including staff and office spaces on wards, and identified areas where there were raised levels of carbon dioxide. Air scrubbers were deployed to those areas to improve air flow alongside advice to open windows to promote improved ventilation.

Ventilation audits of air change rates were completed by the Authorising Engineer for Ventilation in January and February 2022. The recommendations made in the audit to improve air flow have been developed into an Action Plan, costings for remedial works are being collated and a capital bid will be developed to secure funding. The Action Plan will be monitored through the Ventilation Group. The Authorising Engineer will undertake bi-annual ventilation audits.

4.8 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 will have input into plans and are involved in meetings/discussions. During 2021/22, the following buildings' environment works were completed:

- Cirencester Hospital - Sluice revamp on Coln ward, repairs to damaged flooring, basin replacement throughout the Out-Patient Department, X-ray and theatres
- Weavers Croft - acoustics work
- Acorn House Annexe - accommodation reconfiguration
- Leckhampton Lodge – acoustic upgrades
- Rikenel- reconfiguration for Homeless Healthcare team
- Rikenel - Clinics refurbished for Children's Speech and Language Therapy teams
- Independent Living Centre - refurbishment
- Bowbridge Out-Patient Department - acoustic upgrades
- Section 136 Maxwell Suite, Wotton Lawn Hospital – upgrades

Environment improvement works that have commenced and are not yet completed:

- Southgate Moorings – ground floor refurbishment
- Montpellier Unit, Wotton Lawn Hospital – refurbishment of en-suites
- Jubilee Ward/MIIU, Stroud Hospital – upgrade and refurbishment
- Charlton Lane Hospital – replacement of showers
- Berkeley House – Kestrel Flat upgrade

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.

The British building industry experienced a supply crisis during 2021/22 and this has resulted both in delays to work completion and increased costs. In addition, there has been a shortage of contractors with capacity to undertake building work. This has resulted in delays to the completion of the environment improvement works programme.

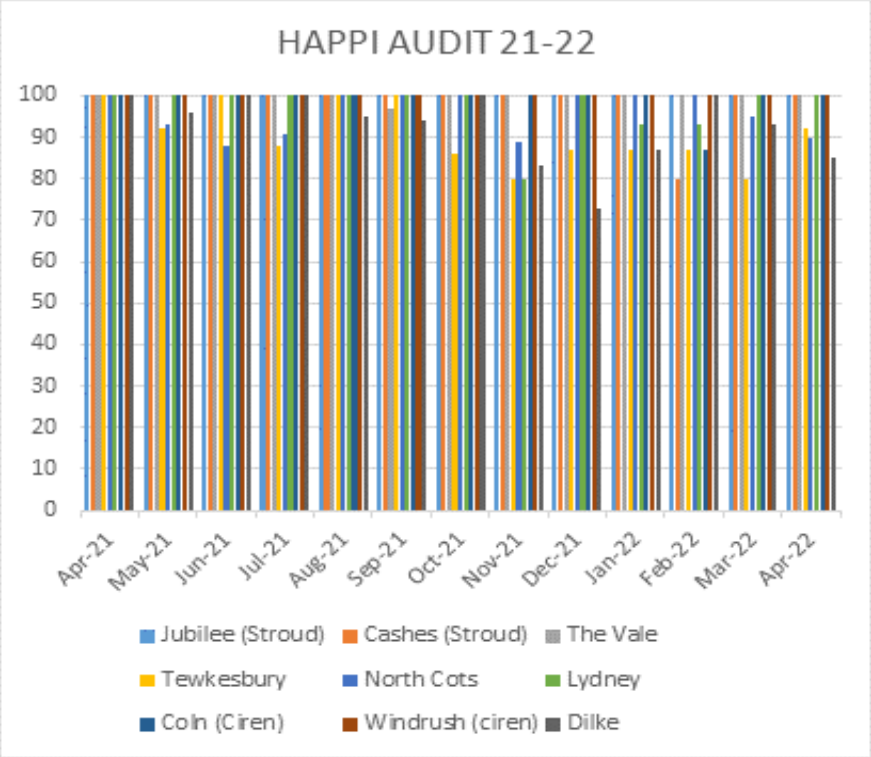
5.0 Antimicrobial Stewardship (Criteria 3)

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 inpatient wards. This audit looks at 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 are shared with ward managers and ward prescribers to inform of areas of improvement and will be included in the IPC monthly dashboard that is being developed. The results for 2021/22 are shown in the chart below:

Chart 3: HAPPI audit results for 2021/22 in community hospitals



It is proposed to introduce a HAPPI-style audit into Mental Health and Learning Disability in-patient areas to provide assurance of appropriate prescribing.

With the introduction of electronic prescribing across all areas that regularly prescribe antimicrobials, e.g. in-patient units, MIIUs, Rapid Response and Podiatry, work is underway with Clinical Systems to understand what antimicrobial prescribing data can be extracted to support robust governance.

5.1 Patient Group Directions

Patient Group Directions (PGDs) are in place for a range of antimicrobials to support immediate access when clinically appropriate in urgent care and in-patients 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.

5.2 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. Guidelines are available on the Gloucestershire Countywide Medicines Formulary and the introduction of an electronic platform and app, to host the guidelines, is planned in 2022/23.

5.3 Training

A range of tools are in place to support prudent use of antimicrobials by colleagues:

- A Powerpoint on antimicrobial resistance and stewardship is shown to new starters at clinical induction
- The Trust Consultant Microbiologist delivers an annual 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

5.4 Committees

Antimicrobial stewardship is a standing agenda item on the Trust's bi-monthly Medicines Optimisation Committee (MOC) and the Consultant Medical Microbiologist

is a core member. The minutes of the MOC 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 recently established Integrated Care System (ICS) Antimicrobial Stewardship Strategy group. This group aims to have an ICS strategic approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness within Gloucestershire.

6.0 Patient information (Criteria 4)

The IPC team reviewed and updated *Clostridioides difficile*, MRSA and Norovirus information leaflets during 2021/22 for patients and their visitors.

Through the pandemic, patients and visitors have been encouraged to access COVID-19 information electronically. Throughout 2021/22, the Trust's public-facing website displayed up-to-date information and guidance on COVID-19, including visiting arrangements during the pandemic.

The IPC team have a dedicated IPC section on the staff intranet with links to:

- IPC policies
- Posters and other information
- IPC education and training
- Templates for the IPC ward audits
- Decontamination
- A dedicated page for IPC Link Workers
- The members of the IPC team and team contact details

The IPC team provide staff with timely specialist IPC advice and support to enable effective management of infection. They have a dedicated telephone support and advice line (in-hours). Out of hours advice and support can be sought from the on-call Microbiologist.

7.0 Surveillance (Criteria 1 and 5)

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

7.1 Reporting

A large proportion of the IPC Team's workload involves 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) (this agency replaced Public Health England on 1st April 2021). These are:

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

Infections that are reportable to UKSHA are recorded on the national Healthcare Associated Infections (HCAI) data capture system on a monthly basis. Outbreaks of COVID-19 are reported to england.sw-incident@nhs.net.

There is a robust reporting system in place. The GHT 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 via email, so that clinical staff are notified at the earliest opportunity, and via ICNet (IPC specific surveillance software).

It is the responsibility of the clinician requesting the specimen to review the results, however, results are followed up with clinical teams by the IPC Team. This provides assurance that specimens are being followed up appropriately and gives the IPC Team an opportunity to support clinicians to manage the infection. Results are recorded by the IPC Team onto patients' clinical records to ensure clinical teams are aware and can take the appropriate IPC precautions.

Reports on all relevant organisms can be generated via ICNet for the Infection Prevention and Control and Decontamination Committee. During 2021/22, the IPC team increased utilisation of the software in order to be more aligned with

Gloucestershire Hospitals NHSFT's process. This has enabled results and actions to be consistently documented in both Trusts and provides better co-ordination across the patient journey.

7.2 MRSA bacteraemia

There were no bacteraemia cases during 2021/22, the same as reported in 2020/21.

	Tolerance	2021-2022 number reported	Compliance
MRSA bacteraemia	Zero	Zero	Green

7.3 Other Bacteraemia Surveillance (GRE, *E. coli*, MSSA)

There were also no cases of *E. coli* and MSSA in GHC during 2021/22, the same as reported in 2020/21.

	Tolerance	2021-2022 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

7.4 Health Care Associated Infections

7.4.1 MRSA acquisition

There were no cases of post 48-hour MRSA acquisition (colonisation or infection) in 2021/22 or 2020/21, compared to two cases in 2019/20.

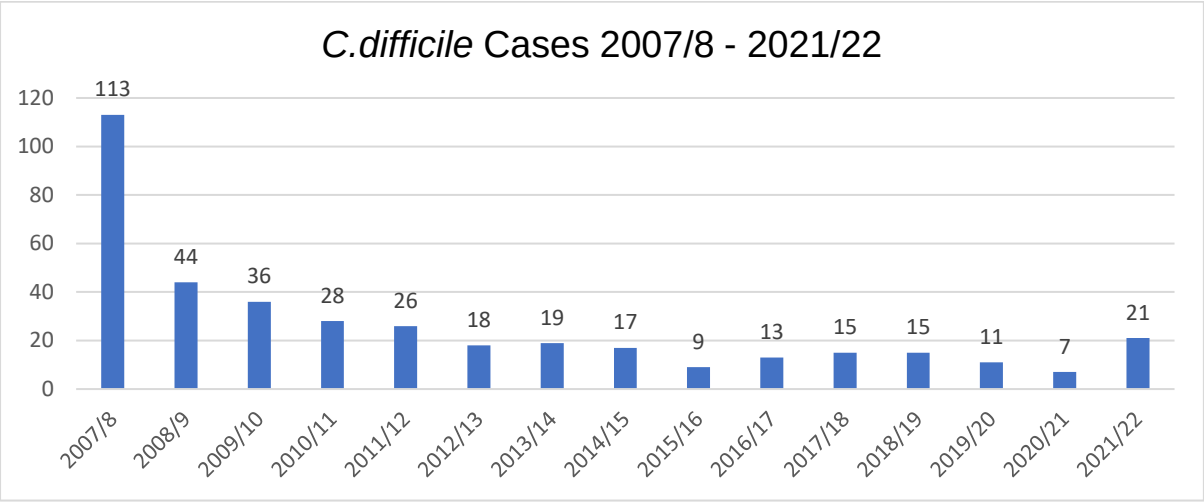
7.4.2 *Clostridioides difficile*

GHC provides mandatory surveillance to PHE for *C. difficile* toxin positive results. In 2021/22, there were 21 Hospital Onset Definite Hospital Acquired infections reported; this is 14 more than in 2020/21. All occurred in community hospitals.

	Tolerance	2020/21 number reported	Compliance
C. difficile	16	21	Red

The chart below shows the number of Trust *C. difficile* cases since 2007/08

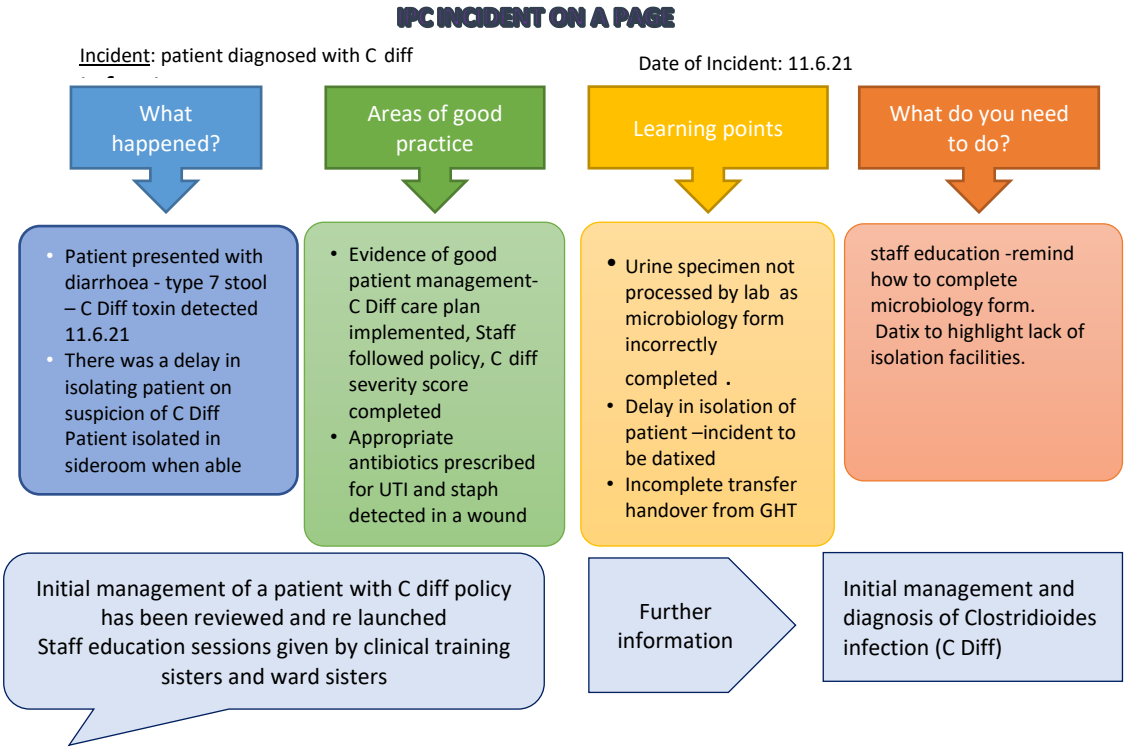
Chart 4: Number of *C. difficile* cases in the Trust since 2007/08



Each confirmed *C. difficile* diagnosis is investigated and a Root Cause Analysis completed, with input from the clinical teams, to ensure lessons are learned and actions taken, for example, non-compliance with policy, procedure or prescribing guidelines.

Interestingly our raised rates were not seen as out of step in context with a national increase. There was a noticeable increase of *C. difficile* cases throughout the UK during 2021/22, potentially linked to increased antibiotic prescribing during COVID-19. A review was undertaken of all *C. difficile* cases between 1st April and 30th September 2021 to see if there were any causes or links relating to the increase in cases. The review did not identify any causes or links. Learning was disseminated to the teams via IPC Learning on a Page, see chart below.

Chart 5: C. *difficile* Review – Learning on a Page



All *C. difficile* toxin positive and gene detected results are recorded on the patient's clinical record to alert the clinical teams. The IPC Team visit the ward within 48 hours, of diagnosis to give specialist advice for patient management, and regularly thereafter to support clinical staff.

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). There have been two PII during 2021/22, both at North Cotswold Hospital. The first one was in May/June 2021 and involved two patients; no common link was identified. The second was in January 2022 and also involved two patients. Again, no link was identified between the two cases.

7.5 Outbreaks

NHS England/Improvement (NHSE/I) 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

7.5.1 Influenza

There were no reported cases of influenza in the Trust during 2021/22 or 2020/21, compared to five confirmed influenza outbreaks in 2019/20.

In-patients who were 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 with serious mental illness or learning difficulties, who do not usually engage with primary care services, were also offered an influenza vaccine by Trust vaccinators, along with service users from the Homeless and Violent Patient Health Services.

During 2021/22, the Trust offered a free influenza vaccine to all staff; the table below shows the level of uptake of vaccination among staff.

Table 6: Staff Uptake of Influenza Vaccine 2021/22

Influenza Vaccines up to 31/03/22				
Role	**No**	**Yes**	**Grand Total**	**%**
Doctor/Dentist	58	73	131	56%
NHS Infrastructure	144	211	355	59%
Nurse/Midwife	619	823	1,442	57%
Other Professionally Qualified	313	479	792	60%
Support to Clinical	739	1,150	1,889	61%
Grand Total	**1,873**	**2,736**	**4,609**	**59%**

This uptake of the vaccination is a reduction on previous years; in 2020/21 90% of patient-facing staff accepted the vaccination. Staff may have received the vaccine from their GP or local pharmacy; this would not be recorded on staff files.

7.5.2 Viral Gastroenteritis

During 2021/22, there were no outbreaks of viral gastroenteritis infection.

7.5.3 COVID-19

During 2021/22, there were 92 Hospital Onset Definite Hospital Acquired (HODHA) COVID-19 cases in the Trust, an increase of 15% on 2020/21. The table below compares the number of HODHA COVID-19 cases for the past two years.

Table 7: Number of COVID-19 HODHA Cases 2021/22 Compared to 2020/21

Sites	Number of HODHA Cases 2021/22	Number of HODHA Cases 2020/21
Community Hospitals	52	76
Mental Health/Learning Difficulty In-Patient Sites	40	14

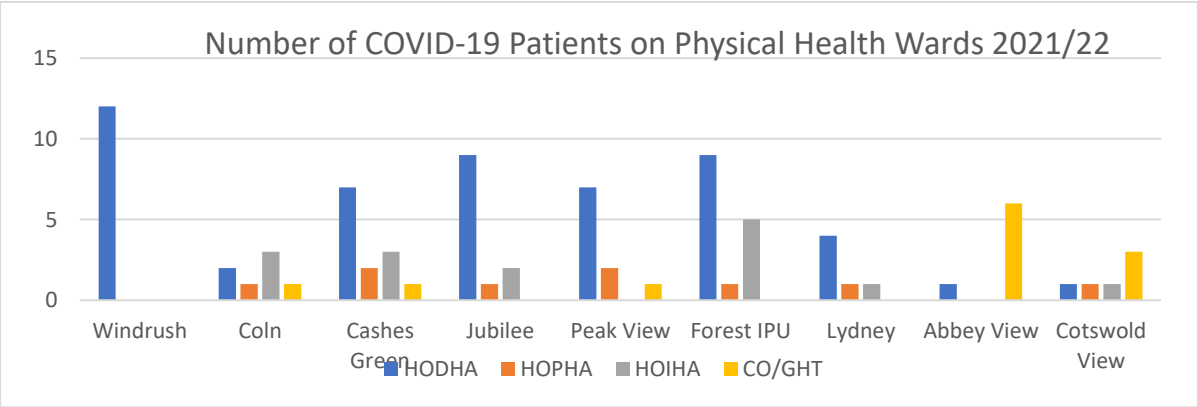
Many mental health patients tested positive for COVID-19 after returning from home leave, which is an element of their recovery plan. It is likely that they acquired COVID-19 when they were not on the hospital ward but the Trust is still required to report these cases as hospital acquired COVID-19, as they were under the care of the Trust at the time.

These resulted in ward outbreaks and closures across the Trust. Ward staff were supported by the IPC team and the Microbiologist through clinical visits to the ward and telephone advice and support.

Definitions and Key to Charts below:

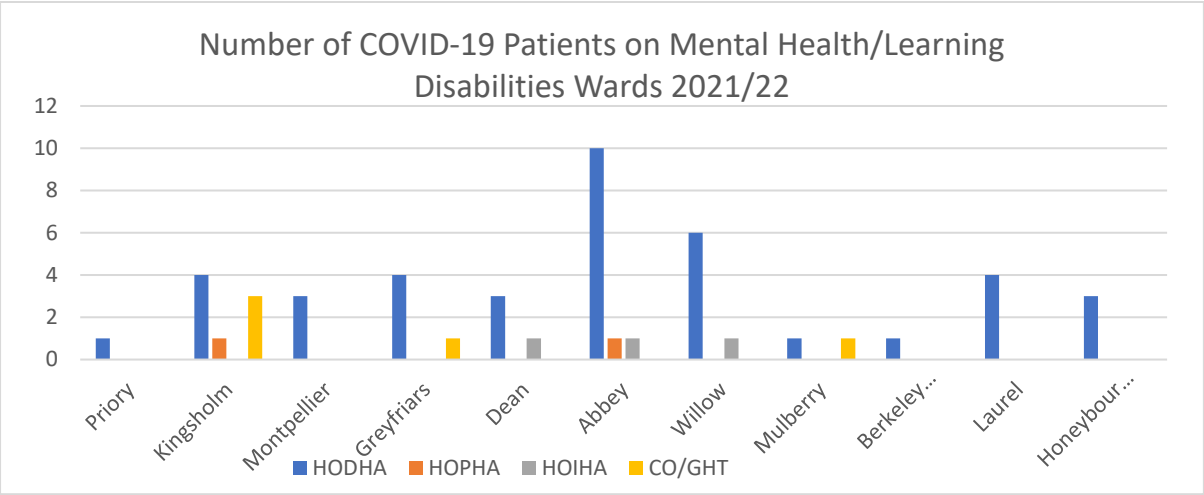
HODHA: Hospital Onset Definite Healthcare Acquired - an infection where the first positive specimen was taken 15 or more days after hospital admission
HOPHA: Hospital Onset Probable Healthcare Acquired - an infection where the first positive specimen was taken 8-14 days after hospital admission.
HOIHA: Hospital Onset Indeterminate Healthcare Acquired - an infection where the first positive specimen was taken 3-7 days after hospital admission
CO/GHT: Community Onset/Gloucestershire Hospitals Trust - an infection where the first positive specimen was less than or equal to two days after hospital admission

Chart 6: Number of COVID-19 Patients on Physical Health Wards 2021/22



Cirencester Hospital – Windrush and Coln wards
North Cotswold Hospital – Cotswold View ward
Tewkesbury Hospital – Abbey View ward
Stroud Hospital – Cashes Green and Jubilee wards
Dilke Hospital – Forest IPU ward
Lydney Hospital – Lydney ward
Vale Hospital – Peak View ward

Chart 7: Number of COVID-19 Patients on Mental Health/Learning Disability Wards 2021/22



Charlton Lane Hospital – Chestnut, Mulberry and Willow wards
Wotton Lawn Hospital – Abbey, Dean, Greyfriars, Kingsholm, Montpellier and Priory wards

7.5.3.1 Patient Screening for COVID-19

The IPC Team worked closely with the Trust's patient SPCA/Bed Management teams to ensure the safe transfer of patients from GHNHSFT.

A robust patient screening programme was in place throughout 2021/22 to identify patient COVID-19 status and ensure patients were placed in wards in a way that minimised any potential COVID-19 outbreaks.

Point of Care Testing (POCT) machines for COVID-19 were rolled out into community hospitals in January 2022 to help manage COVID-19. These machines give staff immediate results for any COVID-19 swabs taken. POCT is now used for patient admission screening and, where necessary, to help manage suspected outbreaks of COVID-19.

This has been instrumental in minimising hospital transmission of COVID-19 in the Trust. The Trust's Infection Prevention and Control Policy (CLP243) outlines how the Trust meets the requirements to minimise the risk of infection to patients, staff and visitors.

7.5.3.2 Staff Screening for COVID-19 during outbreaks

As part of the Trust's response to the pandemic, a staff screening programme was established. Staff had quick and easy access to COVID-19 PCR tests if, for example, there was an outbreak in their workplace or they developed COVID-19 symptoms. The IPC Team liaised closely with the COVID-19 testing team to arrange staff testing during ward outbreaks. POCT machines could also be used on the wards to screen ward staff. The table below shows the number of staff who received a COVID-19 PCR test during 2021/22.

Table 8: Staff PCR testing by month for 2021/22

Month	Number of GHC staff PCR tests
Apr-21	58
May-21	41
Jun-21	101
Jul-21	127
Aug-21	209
Sep-21	194
Oct-21	357
Nov-21	417
Dec-21	650
Jan-22	674
Feb-22	419
Mar-22	440
Total	3,681

The Trust also provided staff and patients with the opportunity of receiving a COVID-19 vaccination. See the table below for staff vaccination numbers.

Table 9: COVID-19 Staff Vaccinations as at 31st March 2022

Vaccines up to 31/03/2022							
Role	**Number of Employees by Role**	**First Dose**	**%**	**Second Dose**	**%**	**Booster**	**%**
Doctor/Dentist	155	148	95%	139	90%	76	49%
NHS Infrastructure Staff	365	329	90%	298	82%	234	64%

Nurse/Midwife	1,663	1,580	95%	1,466	88%	690	41%
Other Professionally Qualified	801	769	96%	735	92%	393	49%
Support to Clinical	2,748	2,523	92%	2,351	86%	1,264	46%
Grand Total	**5,732**	**5,349**	**93%**	**4,992**	**87%**	**2,661**	***46%**

*More staff decided to have their booster vaccination via their GP practice as it was more convenient, rather than book into a Trust arranged vaccination clinic. This explains the lower take-up of Trust offered vaccination by staff.

8.0 Training and Education (Criteria 6)

All clinical staff undertake mandatory IPC training annually via e-learning. 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.

IPC e-learning is an assessment-based training programme and staff are expected to achieve a 90% pass mark. The module includes a certificate as well as the opportunity for staff to feed back any comments, queries or questions to the training team and IPC team. The table below shows Trust IPC training compliance as at 31st March 2022.

Training compliance is recorded on Care to Learn (staff education and training system) which is monitored by IPC, senior management and reported to the Quality Assurance Group.

Table 10: Trust IPC training compliance as at 31st March 2022

Mandatory Training Name	Percentage of Staff Certified	Percentage of Staff not Certified	Number of Staff Certified
Infection Control – Clinical (1 Year)	88.1%	11.9%	3,521
Infection Control – non-Clinical (3 years)	95.0%	5.0%	1,280

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

The Trust has continued with a preference for e-learning through 2021/22. Additional training for clinical staff has been available to staff throughout the COVID-19 pandemic. This included donning and doffing of personal protective equipment (PPE) and the procedure for obtaining a COVID-19 nose and throat swab. Videos and supportive training are available for staff on the COVID-19 section of the intranet.

The IPC team have been unable to facilitate their annual IPC study day for the past two years; however, additional ad hoc IPC clinical updates were provided to staff on IPC clinical visits during 2021/22.

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.

Training of Aseptic Non-Touch Technique (ANTT) procedures, e.g. catheter insertion and cannulation, and other clinical procedures, is provided by the clinical skills team, training sisters and specialist teams. The IPC team work closely with the clinical skills and training teams and provide IPC advice and input into training. Monitoring of standards is gained during IPC clinical visits and incident monitoring. IPC are working with the Learning and Development Team to ensure there is standardisation of competencies across the Trust.

Bi-monthly IPC link worker sessions were reinstated in 2021/22 via teams, with very positive feedback. They provide an opportunity for focused training sessions for the IPC link workers and some discussion around current ‘hot’ IPC topics.

Ad hoc teaching is also given by the IPC team when visiting clinical areas, responding to queries or when informing wards about new infection cases.

9.0 Isolation Facilities (Criteria 7)

The Trust has a commitment to providing safe, 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 increasing the number of isolation facilities is considered a priority. The IPC team provides IPC advice to the planning teams involved in the refurbishments and are committed to ensuring the increased provision of isolation facilities in Trust properties.

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.

During the peaks of the pandemic, isolating patients and minimising the risk of transmission of COVID-19 has been a challenge. Patients were cohort nursed together in bays in in-patient areas where there were insufficient isolation facilities.

10.0 Laboratory Support (Criteria 8)

GHC has a contract with Gloucestershire Hospitals NHS Foundation Trust for the provision of Microbiology laboratory support. The laboratory provides support for all GHC 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

During the pandemic, the laboratory supported testing of up to 1,000 COVID-19 PCR samples per day. In addition, COVID-19 antibody testing was also available, via the Clinical Chemistry laboratory, as required. This is also an ISO 15189 accredited laboratory:

https://www.ukas.com/wp-content/uploads/schedule_uploads/00007/9574-Medical-Multiple.pdf

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

Gloucestershire Health and Care NHS Foundation 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, which meets every month.

During 2021/22, seven extensions to IPC policies were granted by the Clinical Policy Group due to the increased demand on IPC team time. Nine IPC Policies were reviewed, updated and ratified by the Clinical Policy Group during 2021/22, including:

- Infection Prevention and Control (CLP243)
- Laundry and Linen (CLP075)
- Management and Decontamination of Body Fluids/Waste Spillage (CLP081)
- Standard Precautions Safe Working Practice (CLP084)
- Diagnosis and Management of Patient with COVID-19 (CLP150)
- MRSA (CLP094)
- Viral Haemorrhagic Fever (CLP085)
- Management of *C. difficile* (CLP078)
- Management of Gastroenteritis (CLP076)

The Diagnosis and IPC Management of Patients with COVID-19 Policy (CLP 150) was reviewed more regularly, in May 2021 and September 2021, to reflect changes in national guidance and remains under constant review.

Throughout the COVID-19 pandemic, all COVID-19 related national guidance has been reviewed by the DIPC, IPC team and One Gloucestershire ICS to ensure there is a consistent county-wide approach to the management of COVID-19. Policies and Action Cards were developed/updated as needed and changes communicated to staff at IPC briefings, team meetings and via the staff intranet, where there is a dedicated page for COVID-19.

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

11.1 Assurance

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

- An extensive audit programme
- Monitoring of incidents
- Post-infection reviews and outbreak reports
- Monthly surveillance
- Clinical IPC quality site visits and Matrons' clinical governance.

The IPC team meet Hospital Matrons on a regular basis to conduct clinical quality site visits to review infection prevention and control practice and cleanliness of premises. These visits provide more robust assurance on IPC measures in in-patient facilities and enable any IPC issues to be identified early.

IPC compliance and assurance are reported bi-monthly to the Infection Prevention and Control and Decontamination Committee.

Hand Hygiene compliance and results of environmental audits, mattress, commode and cushion audits are also reported to Hospital Clinical Governance meetings.

11.2 Audits

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

- Anti-microbial management (monthly)
- 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)

Action plans from these audits are developed by the IPC team and learning and actions are incorporated in Matrons' Clinical Governance reporting.

The annual IPC Environment Audit programme undertaken by the IPC team was reviewed in April 2021. Priority was given to areas where robust assurance could not be gained from elsewhere. The team undertook 28 IPC annual audits at sites and clinics across the county; 26 achieved IPC compliance, however, there were two

failures at the Section 136 Maxwell Suite and Cheltenham General Hospital Podiatry clinic. All audits are followed up with action plans and failures are re-audited as a priority.

11.2.1 Endoscopy Audits

An Infection Prevention Society (IPS) IPC Environment Audit was undertaken in Stroud (1st March 2022 and 29th March 2022) and Cirencester (29th March 2022) Endoscopy sites as part of the Joint Advisory Group accreditation process. The results of these audits can be seen in the table below.

Table 11: Endoscopy IPC environment audit results 2021/22

	Cirencester		Stroud	
Audit Sections Completed	**%**	**Status**	**%**	**Status**
Standard Precautions	100%	Pass	100%	Pass
Environment	97%	Pass	91%	Pass
Hand Hygiene Technique	100%	Pass	100%	Pass
Patient Equipment	100%	Pass	96%	Pass
Sharps Handling and Disposal	100%	Pass	100%	Pass
Personal Protective Equipment	100%	Pass	100%	Pass
Waste management	100%	Pass	100%	Pass
Overall	97%	Pass	92%	Pass

11.2.2 Dentist Audits

Extensive IPS 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. The results of audits undertaken in open dental sites in 2021/22 are shown in the table below.

Table 12: Dentist Audit Results 2021/22

Jun-21	Prevention of blood-borne virus exposure	Decontamination	Environmental Design and Cleaning	Hand Hygiene	Management of dental medical devices - equipment and dental instruments	PPE	Waste Management	**Overall**
Beeches Green	14/14 100%	59/59 100%	25/25 100%	21/21 100%	28/28 100%	17/17 100%	17/17 100%	181/181 100%
Lydney	14/14 100%	59/59 100%	25/25 100%	21/21 100%	28/28 100%	17/17 100%	17/17 100%	181/181 100%
Southgate Mooring	14/14 100%	59/59 100%	23/25 92%	21/21 100%	28/28 100%	17/17 100%	17/17 100%	181/181 100%
Springbank	14/14 100%	59/59 100%	22/25 90%	21/21 100%	28/28 100%	17/17 100%	17/17 100%	181/181 100%
St Pauls	14/14 100%	59/59 100%	25/25 100%	21/21 100%	28/28 100%	17/17 100%	17/17 100%	181/181 100%
Dec-21								
Beeches Green	14/14 100%	59/59 100%	24/25 96%	18/21 86%	28/28 100%	17/17 100%	17/17 100%	177/181 98%
Cirencester	14/14 100%	59/59 100%	25/25 100%	19/21 90%	28/28 100%	17/17 100%	17/17 100%	179/181 99%
Lydney	14/14 100%	59/59 100%	23/25 92%	19/21 90%	28/28 100%	17/17 100%	17/17 100%	177/181 98%
Springbank	14/14 100%	59/59 100%	25/25 100%	18/21 86%	28/28 100%	17/17 100%	17/17 100%	178/181 98%
St Pauls	14/14 100%	59/59 100%	25/25 100%	18/21 86%	28/28 100%	17/17 100%	17/17 100%	178/181 98%

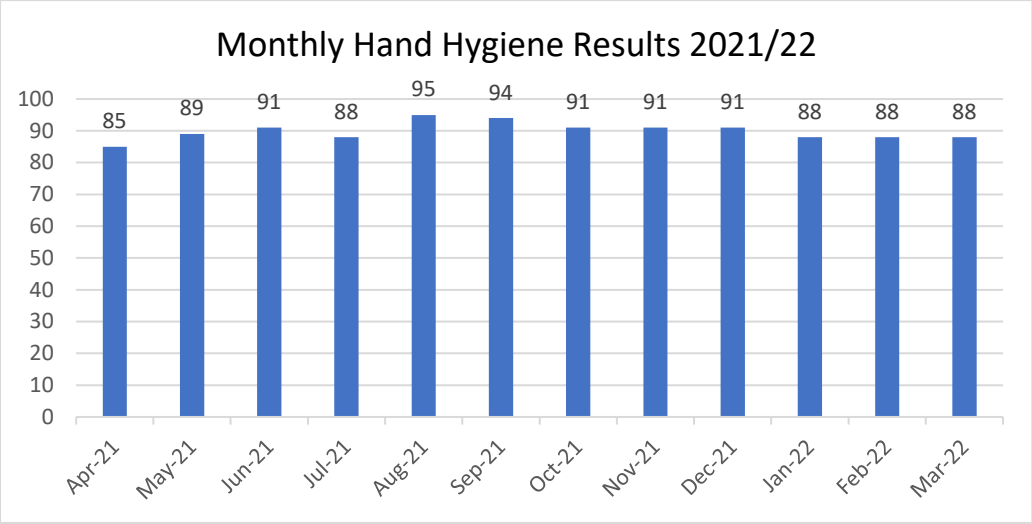
11.2.3 Hand Hygiene

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).

Results are collated, monitored by the IPC team, and reported to the Trust Board and Infection Prevention and Control and Decontamination Committee. If an individual area reports a score below the minimum expected standard of 85%, additional support and education is provided to the area to improve compliance. The chart below shows the monthly average compliance scores for 2021/22.

The overall Trust compliance (across the Trust), set by the Trust, is 90%. The Trust achieved overall compliance of 90% in 2021/22.

Chart 8: Hand Hygiene Audit Results 2021/22



The practice of effective and timely hand hygiene is a high priority for the Trust. The IPC link nurses support staff with hand hygiene guidance and conduct audits to provide assurance to the Trust.

The World Health Organisation 'World Hand Hygiene' initiative on 5th May 2021 was supported by the IPC team and promoted by the Trust. During the day, the IPC team gave a COVID-19 secure presentation at the two mental health in-patient units.

11.2.4 Reliability Audits

Observational audits, such as the PPE and Hand Hygiene audits, can suffer from the 'Hawthorne' effect where individuals modify their behaviour in response to being observed. In order to validate the monthly audits conducted by operational staff, the IPC team conduct bi-annually reliability audits for both PPE and Hand Hygiene practice.

Generally, the results from the PPE and Hand Hygiene reliability audits in March 2022 showed good compliance. A key theme arising was poor compliance with hand hygiene practice when donning and doffing PPE. This was raised with matrons, repeat audits will be undertaken and the IPC team will continue to monitor practice during IPC clinical visits.

11.2.5 Sharps Audit

The Trust's sharps supplier, Daniels, conducted an annual sharps audit in May 2021 across community hospitals and in four other clinical areas of the Trust. The aim of this audit was to provide assurance that staff were adhering to the management and

disposal of sharps as per Trust policy and in line with legislation and other national guidance.

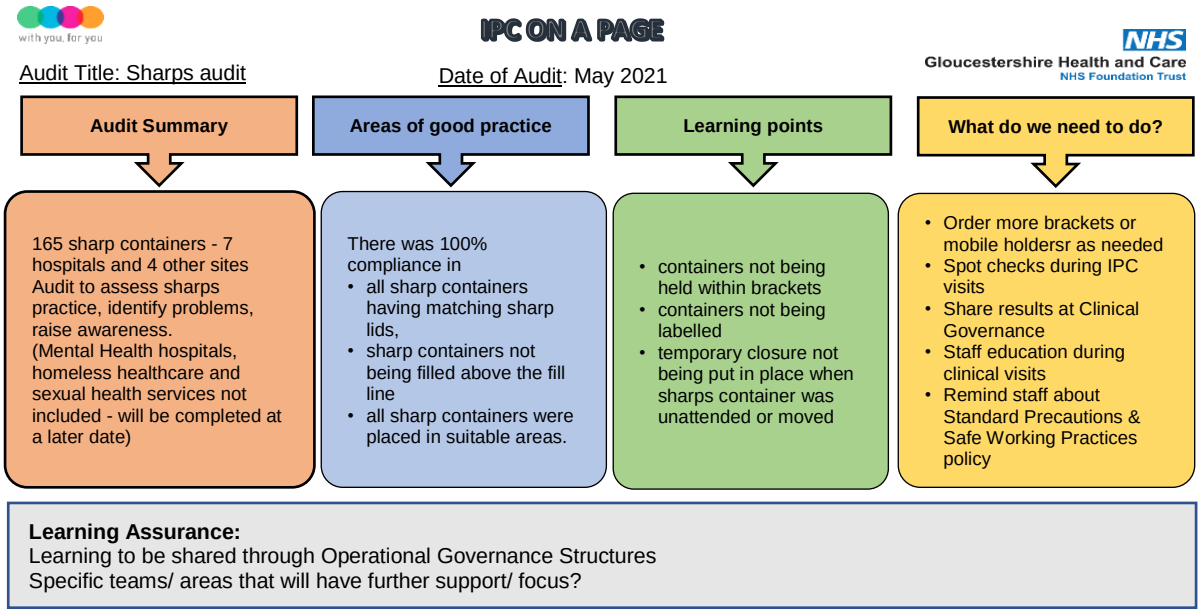
A total of 165 sharps bins across 54 areas were audited and there was good compliance across all areas audited, with improvements having been made on the previous audit in 2019. Trust-wide results are shown in the table below.

Table 13: Trust Overall Sharps Audit Results May 2021

Standards		**Compliance 2021**	**Compliance 2019**
Number	Criterion		
1	Not containing protruding items	99% (164/165)	100% (232/232)
2	Correct assembly of containers	97% (160/165)	98% (228/232)
3	Matching lids and labels	100% (165/165)	100% (232/232)
4	No items above the fill line	100% (165/165)	100% (232/232)
5	Containers on the floor or at an unsuitable height	100% (165/165)	100% (232/232)
6	Containers not in brackets or mobile holders	85% (141/165)	75% (173/232)
7	Containers not labelled whilst in use	98% (161/165)	96% (223/232)
8	Not containing inappropriate contents	99% (164/165)	99% (231/232)
9	Temporary closure in use when left unattended or during movement	94% (155/165)	86% (200/232)

An action plan was developed and learning was shared with teams via IPC Learning on a Page, see chart below.

Chart 9: Sharps Audit IPC Learning on a Page



11.3 Incident Reporting (Datix)

In 2021/22, there were 235 IPC related recorded incidents on Datix. This is an increase of 26% from 2020/21. This is believed to be driven by increased awareness regarding IPC matter across the organisations opposed to problems with delivery.

The highest number of Datix were for hospital acquired COVID-19; there were 92 Datix raised, which equates to 39% of the total. Datix were also raised for the *C. difficile*, MRSA, and other healthcare associated infections mentioned in the Surveillance section 7.

Other key IPC themes arising from 2021/22 IPC-related Datix included:

- Breaches (from patients, visitors and staff) of COVID-19 secure environments (25% of Datix)
- Staff having been exposed to infectious disease (7.5% of Datix)
- Beds, wards or units being closed due to infectious disease (2.5% of Datix)
- Isolation of patients were not possible (4.5% of Datix)

The IPC team worked with Patient Safety and ward staff to determine the level of harm to patients as a result of acquiring an infection whilst under the care of the Trust. For 94% of the Datix raised in 2021/22, harm to patients was identified as No or Low Harm. The Patient Safety Team managed the remaining 6% of Datix that were identified as Moderate Harm to the patient or higher through the usual patient safety incident management process.

12.0 Working Well: Occupational Health (Criteria 10)

Working Well is a Safe, Effective, Quality, Occupational Health Service (SEQOHS) accredited NHS Occupational Health Service, an accreditation scheme run by the Faculty of Occupational Medicine. Activities and services are audited regularly to ensure services are providing appropriate levels of service to clients.

Working Well operate a self-referral system, as well as a management referral system, and provide a range of services to Trust staff, including:

- A screen of all new employees
- A booster programme for Immunisation of Healthcare and Laboratory staff, in line with Chapter 12 of the Green Book
- A service for staff subject to a contamination injury, with access to rapid boosters if required
- 'Disease Outbreak' support by providing timely contact tracing, including COVID-19 episodes of staff contact tracing. The number of episodes of contact tracing are outlined in the table below:

Table 14: Working Well Number of Episodes of Staff Contact Tracing January 2021 to April 2022

Date	Number of Episodes of Staff Contact Tracing
Jan – Dec 2021	1,443
Jan – April 2022	944

- Screening programmes for skin surveillance; 24 skin assessments were completed in 2021/22 following a referral to Working Well
- Advice and guidance required due to a workplace infection.

The following Working Well protocols and policies were in place for 2021/22:

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

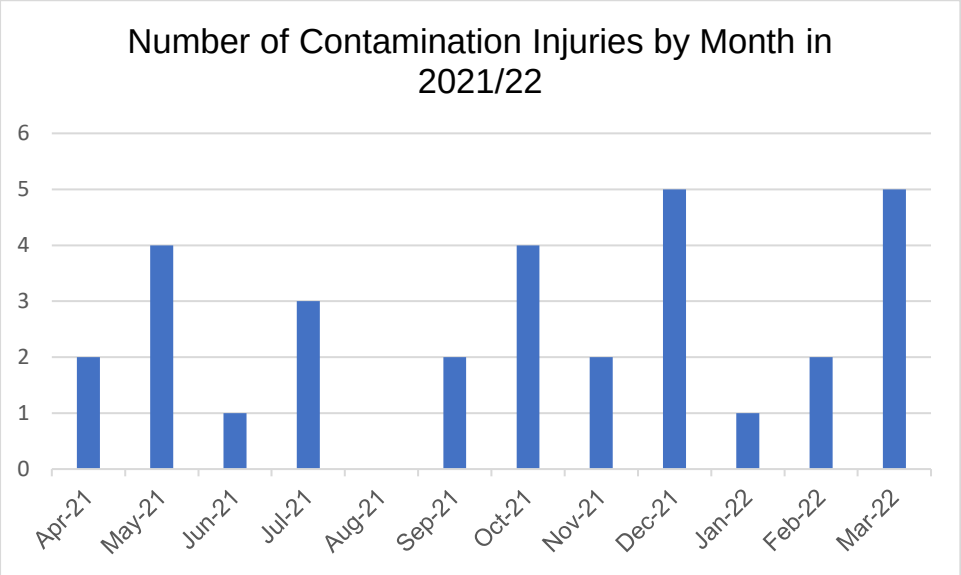
During 2021/22, IPC worked very closely with Working Well to produce Action Cards linked with the COVID-19 Policy, to ensure the safety of staff during the pandemic. Working Well are supported by well-established peer vaccinators throughout the Trust.

12.1 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 take in order to minimise the risks to staff of acquiring blood borne viruses through contamination injuries.

In 2021/22, Working Well supported staff for contamination injuries in 31 instances. The number of contamination injuries reported by month are shown in the chart below.

Chart 10: Number of Contamination Injuries by Month 2021/22



Datix are raised and all contamination injuries are investigated by Working Well. No trends were identified in relation to contamination injuries during 2021/22. The Trust had one high risk Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable event during 2021/22. The Health and Safety Executive investigated and was satisfied with the Trust's process for the management of contamination injuries. There were no recommendations for Working Well and the number of contamination injuries remains very low for the Trust.

12.2 COVID-19

During 2021/22, Working Well developed a risk assessment process/matrix for all managers to use to enable them to identify members of staff who were clinically vulnerable to COVID-19. More than 100 staff members were identified as clinically vulnerable and referred to Working Well for advice and support.

13.0 Infection Prevention and Control Team Plan/Aims for 2022/23

The IPC Team have historically provided more IPC support and focus to community hospitals. The intention for 2022/23 is to continue to provide a more proactive and equitable IPC service across physical and mental health/learning disability services.

The main focus and IPC priorities for 2022/23 will be to:

- Support Mental Health and Learning Disability colleagues to embed IPC practices
- Arrange for a Trust hand hygiene supplier to undertake a reliability hand hygiene audit across the Trust
- Review the annual IPC Environment audit programme to identify more effective ways to gain IPC environment assurance from existing audits, allowing the IPC team to focus on quality improvement projects
- Improve links with community teams
- Review team priorities and areas of work and empower IPC nurses to take on responsibility for overseeing those areas of work e.g. refurbishment of in-patient areas, ventilation, water safety, Endoscopy and Theatres
- Continue to participate in Water Safety Group to monitor water safety
- Continue to participate in Ventilation Safety Group to ensure the requirements of HTM 03 -01 are met.
- Work with Estates and Facilities to review ventilation within Trust premises and risk assess as per Hierarchy of Controls guidance from PHE
- Continue to support the Community Dental Service, providing an IPC nurse as a link to ensure IPC risks within dental services are identified and managed
- Work with Facilities to embed the National Standards of Healthcare Cleanliness 2021
- Review the *Clostridioides difficile* pathway and improve patients' experience, review and refine documentation, re-launch the *C. difficile* policy
- Support the IPC Link Nurse programme

13.1 Personal Development of the Team

The pandemic continued to have an impact on face-to-face personal development through 2021/22. However, the IPC team were able to undertake a range of personal development opportunities:

- Marion Johnson attended a Water Safety Awareness course, Serious Incident training, development coaching, and participated in virtual Regional COVID-19 seminars

- Lisa Mclean and Louise Forrester attended the annual Infection Prevention Society Conference in Liverpool and displayed and presented a poster on Personal Protective Equipment for Prevention Management of Violence and Aggression/Positive Behaviour Management as part of a research paper they were involved with.
- Emma Bray completed her Bronze Quality Improvement (QI) training, commenced a QI administrative project and completed Datix report training, loggist training, roster pro training. Emma was also responsible for recruiting, mentoring and supporting the Band 2 admin assistant
- Emma Hucker started her IPC certificate and the team have supported her to have regular study time.
- John Trevains was awarded a distinction on completion of a Post Graduate Certificate in IPC via the University of Essex Distance Learning Centre.
- Sam Lonnen has now taken on the role of Trust Decontamination Lead. This role will utilise Sam's IPC experience and provide the Trust with assurance that the decontamination processes employed by staff are effective, consistent and follow best practice. Since taking on the role of Decontamination Lead in July/August 2021, Sam has participated in the IPS Environment, Cleaning and Decontamination Event in November 2021.