University Hospitals Bristol & Weston NHS Foundation Trust

Infection Prevention and Control

Annual Report 2023/2024

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) Infection Prevention and Control (IPC) annual report 2023/2024

i. Foreword

Infection Prevention and Control (IPC) remains a high priority for UHBW, with the emphasis and focus on prevention being the key, with often the simplest of actions such as hand hygiene having the greatest effect.

As an organisation, the operational demand means we are busier than ever, and therefore refreshing our organisational approach to maximising patient flow and capacity alongside assurance that IPC is effective and aligns with national guidelines and policies.

The focus on prevention means that we are continuing to use quality improvement opportunities, in a rigorous and structured way to engage the wider clinical teams in areas such as reducing the risk of Met(h)icillin resistant Staphylococcus aureus (MRSA) bacteraemia and Clostridioides difficile (C. difficile), where UHBW has not achieved the NHSE bench mark (limit), reflecting the national picture of an increasing incidence and risk of infection.

Equally refreshing the IPC clinical audits, which are undertaken monthly by clinical teams e.g. hand hygiene, cannula care and urinary catheter care, etc. all give opportunities for monitoring, and target the data in a meaningful way for continuous improvement.

Surgical site infection is closely scrutinised and seen increasingly as an aid to improving patient experience and the outcomes for our patients with attention on a number of Divisions in collaboration with the surgeons, theatre and ward clinical teams.

When infections do occur it is essential that there is a rapid review process to minimise any further risk and maximise learning for the benefit of others, therefore the implementation of Patient Safety Incident Response Framework (PSIRF) principles have been applied to streamline the approach.

Organisational assurance and compliance to the standards expected within the Infection Prevention and Control Code of Practice is monitored formally using the IPC board assurance framework against 54 standards, 6 being identified as not fully compliant but with actions for improvement in place. Part of this is based on the Trust's physical environment and both the importance and the technical requirements of mechanical ventilation systems in the buildings, and additionally, water safety. Aging infrastructure means that ongoing investment to assure environments are 'fit for purpose' is firmly on the Trust Board's radar.

The IPC team collaborate closely with partner organisations including North Bristol Trust working together on the implementation of a number of projects such as aligning IPC policies, using technology in the surveillance of infection and developing shared educational resources.

Professor Deirdre Fowler, Chief Nurse and Midwife
Executive Sponsor for Infection Prevention and Control
at University Hospitals Bristol and Weston NHS Foundation Trust

ii. Executive summary

The Annual Report for 2023/2024 informs patients, public, staff, Trust Board members and the Integrated Care Board (ICB) of the IPC activities undertaken within the Trust and demonstrates progress against the required performance targets.

- The Trust has exceeded its *Clostridioides* (previously *Clostridium) difficile* 'limit' of no more than 88 Trust apportioned cases in 2023/2024, finishing the year with 111 cases. In total, 80 were deemed hospital onset–healthcare associated (HOHA) and 31 community onset–healthcare associated (COHA).

- There were nine Trust apportioned MRSA bloodstream infections in 2023/2024 against a zero 'limit', which is an increase on the previous year. All cases are investigated to identify if learning can be found to decrease the likelihood of recurrence.

- 67 Trust apportioned *E.coli* bloodstream infections were reported during 2023/2024. Each case has been reviewed.

- The IPC team has continued to respond to emerging infection threats from the community, such as a resurgence in measles and whooping cough (pertussis), as required, however they also remain vigilant with infections such as SARS-CoV-2 (COVID-19) and influenza.

- The measles preparedness exercise was completed as an assessment of how robust UHBW could respond if the incidence of measles increased, including bolstering general awareness as well as ongoing work. This includes the Trust vaccination hub and Occupational Health working towards providing a robust vaccine response.

- Hand hygiene compliance remained good during 2023/24, with an average compliance score of 97.1%. The audit is performed by each department. The system for data management of these results changed in August 2023 to 'AMaT' this should provide greater assurance that hand hygiene standards are being met. The presentation of the data in clinical areas is being refined and will help support robust and effective compliance.

- The IPC team completed their annual work plan in 2023/ 24. This included an extensive IPC policy restructuring and review and an improved post-infection review process which aligned to the Patient Safety Incident Response Framework (PSIRF) streamlined to support rapid learning when hospital acquired infections have occurred.

- A Trust wide enhanced approach to Surgical Site Infection (SSI) surveillance has continued with a senior IPC nurse leading this work stream. Mandatory reporting is now across all UHBW sites in both Bristol and Weston supported by the SSI members of the IPC team. Cross Divisional collaboration is bringing together positive opportunities for quality improvement.

- Antimicrobial stewardship auditing continues with the planned introduction of an electronic prescribing system for the year ahead which will significantly enhance the ability for more robust antibiotic stewardship and oversight on all sites.

- The monthly cleanliness auditing has continued. The implementation of Cleanliness Standards for Healthcare (2021) has been delivered with additional scrutiny through the monthly Operational Infection Control Group. The introduction of annual multi-disciplinary 'Efficacy Cleaning Audits' further enhancing this challenge. In addition, an external audit of cleaning standards in the highest risk categories has been undertaken.

- The Patient Led Assessment of the Care Environment (PLACE) has been completed in the autumn of 2023/24. The action plan is in progress, and the final prioritisation of capital resources for improvements is underway in collaboration with divisions and the Estates department. Some actions remain outstanding from the 2022/23 plan.

iii. Introduction

The purpose of the report is to inform patients, public, staff, Trust board members and the Bristol, North Somerset and South Gloucestershire (BNSSG) ICB, of the IPC related activities undertaken in 2023/24 within UHBW NHS Foundation Trust. All NHS organisations must have effective systems in place to control healthcare associated infections as set out in the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance updated in December 2022. The document underpins regulated activities across the organisation with the Care Quality Commission (CQC). Infection Prevention and Control is part of UHBW NHS Foundation Trust's overall risk management strategy. This report provides assurance to the Board that the Trust has discharged its responsibilities as per the Act. Patient safety remains the focus in the delivery of IPC practice within UHBW.

The authors would like to acknowledge the contribution of other colleagues to this report, in particular, the sections on the IPC team, Occupational Health, Decontamination, Facilities and Estates, and Pharmacy.

iv. Director for Infection Prevention & Control Report to the Board

Corporate Responsibility

The Chief Nurse is the Executive Director sponsor for IPC and reports to the Chief Executive and the Board of Directors. The Director for Infection Prevention and Control (DIPC) is a consultant microbiologist in the Trust with a deputy DIPC.

Infection Prevention and Control and Trust Governance

The Infection Control Group (ICG) is responsible for ensuring that there is internal oversight and assurance of compliance with national IPC standards, local policies, guidelines, and external assessments, e.g., decontamination standards, Care Quality Commission standards and the Patient Led Assessments of the Care Environment (PLACE). The ICG is quarterly and chaired by the Deputy Chief Nurse. Reports are received at each meeting from the subgroups which are Decontamination Board, Antimicrobial Stewardship Group, Facilities and Estates (including Water and Ventilation Safety Groups), Occupational Health, the monthly Trust-wide Infection Control Operational Group and from each clinical division. ICG formally reports to the Clinical Quality Group, and Quality and Outcomes Committee (Trust Board sub-committee).

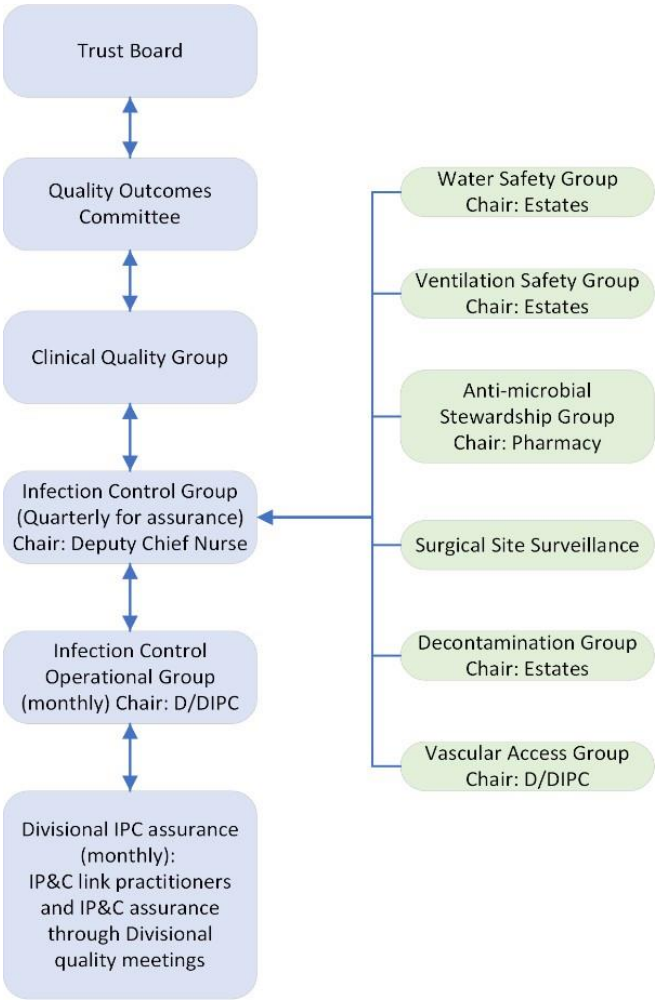
DIPC Reporting to UHBW Board of Directors

The DIPC reports quarterly to the Quality and Outcomes Committee. Key IPC performance metrics are reported monthly as part of the Board Integrated Quality Performance (IQPR) report with matters of concern escalated accordingly. The IPC annual report is submitted to the Trust Board of Directors and then publicly available thereafter. .


v. The governance structure for IPC in UHBW

The Trust IPC governance structure for UHBW is summarised in the diagram below:

A series of groups formally provide written reports into the Trust ICG for assurance purposes, with Divisions providing summary reports. The ICG then, in turn, report into the Clinical Quality Group & Quality and Outcomes Committee.



Trust collaboration

The approach to IPC across the organisation is based on a collaborative model across all Divisions, professions and with partner organisations with a clear focus on safety thus protecting patients, visitors and staff.

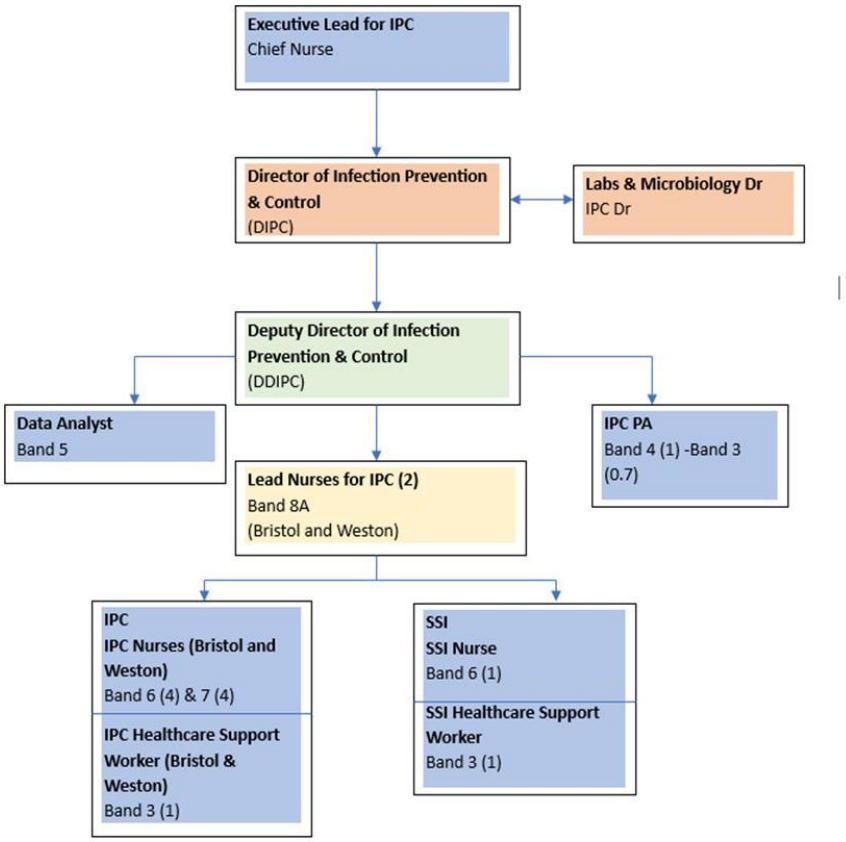
IPC governance including risk management.

The governance structure is summarised above and in more detail in section 5 and 6 of this report, defining the IPC risks that are being managed in UHBW. Governance and risk are supported by the Datix system to allow incidents such as infections to be tracked as well as the learning response, with post-infection reviews being undertaken as required.

vi. Infection Prevention and Control Team Structure (2023/24)

It is mandated that an acute trust should have a multi-disciplinary infection prevention and control service, with oversight from a Director of Infection Prevention and Control who links to the Trust Board. The IPC team is a central team, with links into each Division.

The IPC team is structured is described below:



The core IPC team are based in Bristol and Weston, with team members providing a 7-day service across all sites, working closely with the Clinical Operations Team and the Divisions.
There is a formal annual work plan for the IPC team agreed at the Infection Control Group (ICG).

For UHBW, the Infection Control Doctor role is provided by the medical microbiology team who are contracted from the UK Health Security Agency (UKHSA) with 24 hours on-call microbiology provision. The provision of the Infection Control Doctor role at Weston Hospital is by the on-site microbiologists and including out-of-hours support from the North Bristol NHS Trust. The DIPC in UHBW, maintains accountability across all sites.

The laboratory service is based in Bristol and Weston and works closely with the UKHSA laboratory at NBT for the main infection science service.

Antimicrobial stewardship is delivered in a number of ways and is coordinated Trust wide by a consultant Pharmacist.

The Facilities and Estates teams provide core elements of effective IPC practice within UHBW.

vii. Compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (updated 13/12/22).

The updated guidance has an emphasis on the importance of delivering cleaning standards and antimicrobial stewardship. A risk management strategy that delivers effective IPC is required, with appropriate mitigations. The responsibilities for individual roles in the wider IPC have added clarity, as well as robust and visible leadership in the wider context of the organisation.

The table below details the 10 domains of the Code of Practice for Infection Prevention and Control and summarises the expectations of the overall compliance criteria.

Compliance criteria title *(From the Code of Practice on the prevention and control of infections and related guidance – updated December 2022)*	
1	**Governance and oversight** 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	**Clean environment** The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	**Antimicrobial stewardship** Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	**Information on infections** The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5	**Those at risk of infections** 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	**Effective care** 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	**Sufficient Isolation facilities** The provision or ability to secure adequate isolation facilities
8	**Laboratory support** The ability to secure adequate access to laboratory support as appropriate.
9	**IPC Policies** 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	**Occupational Health and staff health** That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Each of the 10 criterions will be considered in this the report with narrative that provides assurance for UHBW. Some elements may cross over between criterion, but to prevent duplication of subject matter this will be picked up in one section only.

Additional scrutiny has been provided through the Trust's assessment of compliance using NHSE Infection Prevention and Control Board Assurance Framework (version 1.1). In UHBW this was completed in quarter three in 2023 /24 in collaboration with a multi-professional team. The UHBW assessment has then been further scrutinised through the Trust's governance structure with summary documents and presented to the ICG for assurance. A summary of this assessment is included section one of this report.

Compliance Criterion 1. Systems to manage infection including:

- **1.1 IPC Board assurance framework**
- **1.2 Health Care Associated Infection (HCAI) summary.**
- **1.3 Post infection reviews (PIR)**
- **1.4 Surgical Site Infections (SSI)**
- **1.5 The Physical Environment including Water/Ventilation safety and waste management**
- **1.6 Decontamination**

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.

There are a number of interventions within UHBW that aim to provide organisational assurance to the Executive team and indeed the patients who use our services for IPC related activities.

1.1 IPC Board Assurance Framework (IBAF)

An MDT process to assess compliance with the IBAF (version 1.1 13/09/2023) was undertaken. This was submitted in January 2023 to the Trust Infection Control Group.

Compliance The assessment of compliance is based on the evidence available and observed operational practice. These details are held on file. If specific evidence was not available direct observed practice would corroborate the criteria had been met. **46 out of 54 criteria were achieved.**

Non-compliance. There were 6 areas of non-compliance identified, detail below, with actions for improvement with key individuals with responsibility.

Element (non or partial compliance)	Summary of the element	Responsible person
2.9 – Non-Compliance	Food hygiene training is commensurate with the duties of staff as per food hygiene regulations.	Assistant Director for Facilities
2.4 – Partial compliance	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan.	Assistant Director for Estates
2.5 - Partial compliance	There is evidence of a programme of planned preventative maintenance for buildings and care environments.	Director of Facilities and Estates
2.6 - Partial compliance	The storage, supply and provision of linen and laundry.	Assistant Director for Facilities
2.7 - Partial compliance	Healthcare waste is consistent with regulatory waste management guidance.	Assistant Director for Estates
3.5 - Partial compliance	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR.	Chief Pharmacist
6.2 - Partial compliance	The workforce is competent in IPC commensurate with roles and responsibilities.	Director of IPC
6.6 - Partial compliance	If clinical staff undertake procedures that require additional clinical skills, for example, medical device insertion, there is evidence staff are trained.	Chief Medical Officer

The actions for improvement were logged with relevant individuals. Noting action 2.9 this has specifically been raised through Clinical quality group and is formally being addressed by the facilities team in collaboration with the Nutrition and Hydration steering group
A further assessment of compliance will be undertaken in the autumn of 2024.

1.2 Health Care Associated Infection (HCAI) summary.

Overview

UHBW NHS Foundation Trust continues to take part in mandatory surveillance of Methicillin-resistant *Staphylococcus aureus* (MRSA), Mehicillin-sensitive *Staphylococcus. Aureus* (MSSA), *Escherichia coli* (*E.coli*), *Klebsiella* species and *Pseudomonas aeruginosa* bloodstream infections and *Clostridioides difficile* infections.
The gram-negative reportable organisms (*E.coli, Klebsiella and P.aeruginosa*) account for more than 70% of all healthcare associated gram-negative bloodstream infections (GNBSI). GNBSIs continue to increase in England and cause significant morbidity and mortality in our patients.

For the Trust, those infections that are considered hospital onset–healthcare associated (HOHA) and community onset–healthcare Associated (COHA) are the cases that Trust performance is measured against with national limits set by NHSE. These thresholds are referred to as “limits”.

Healthcare Associated Infections (HCAIs)

These infections are formally reported quarterly within the organisation at the infection control group. MRSA and *C.difficile* cases are reported monthly as an integral part of the Trust Integrated Quality Performance Report (IQPR)

The tables below offer a summary comparison between 2022/23 and 2023/24 for HCAI for those organisms we currently report. Each infection has a cost to the individual patient and to the organisation by increasing length of stay.

In terms of the incidence of infection these results are formally reported quarterly to the Trust Infection Control group, and externally into the ICS, however daily scrutiny of infections, both those that are formally reported, and others takes place led by the Infection Control Doctors and nurses, supported by the use of technology such as ICNet.

Chart C.1.1 shows reportable HCAI numbers for 2022/2023 Chart C1.2 shows reportable HCAI numbers for 2023/2024

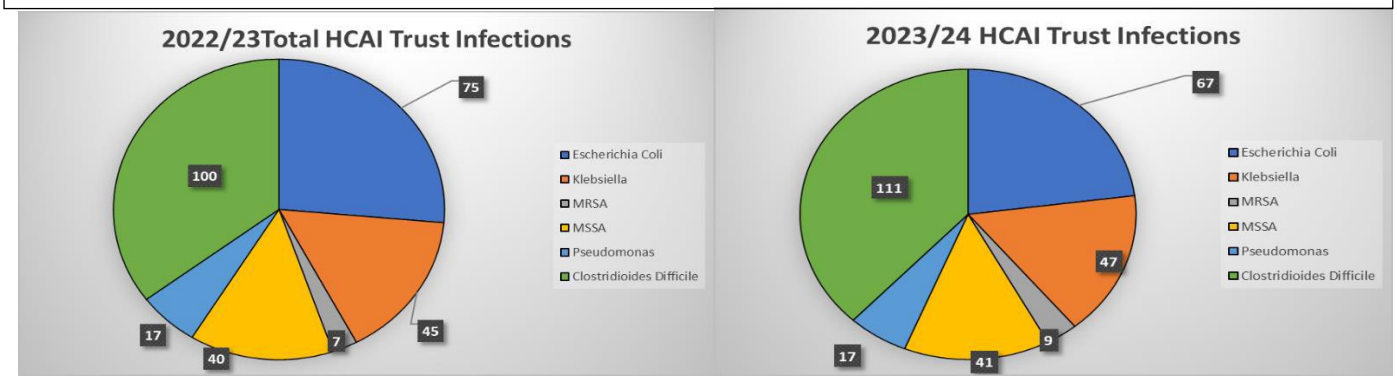
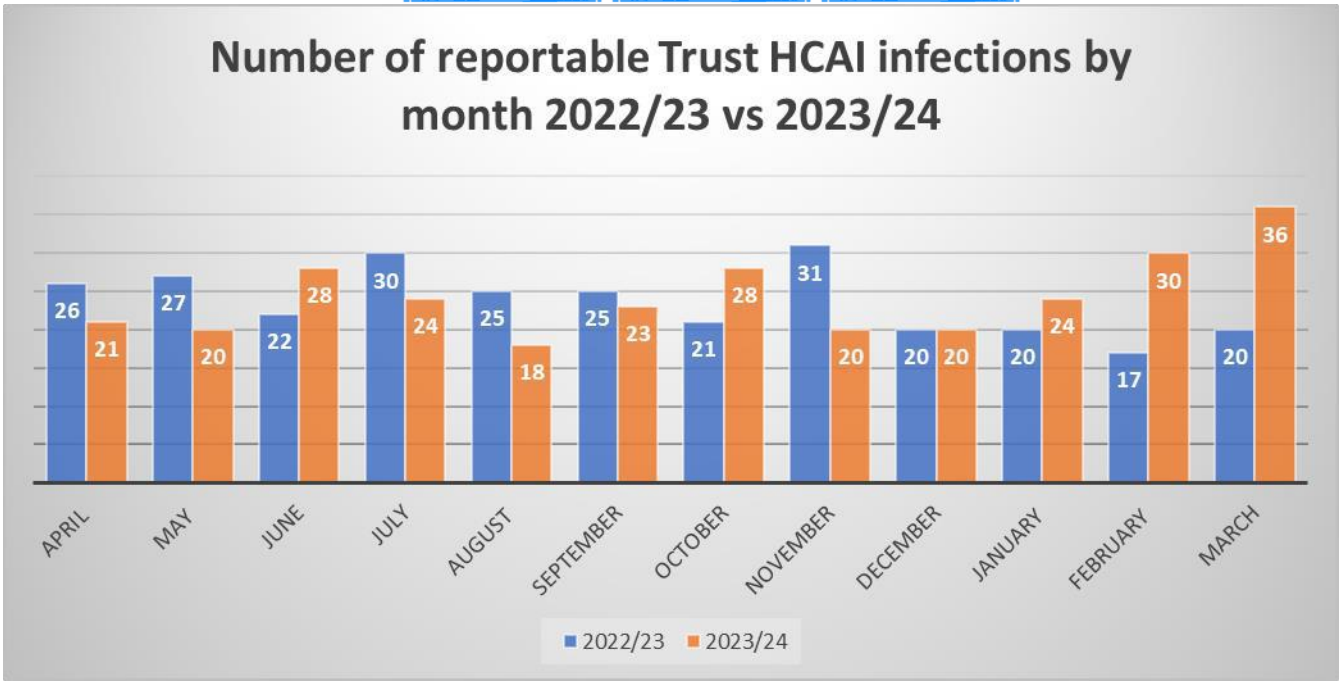


Chart C1.1 and C1.2 show the reportable HCAI numbers indicating an increase in C.difficile, MRSA, *Pseudomonas and Klebsiella but with a decrease in E.coli, but in the context of increased organisational activity year on year.*

C1.13 Total reported incidence of month on month comparing 2022/23 and 2023/24 of all Healthcare

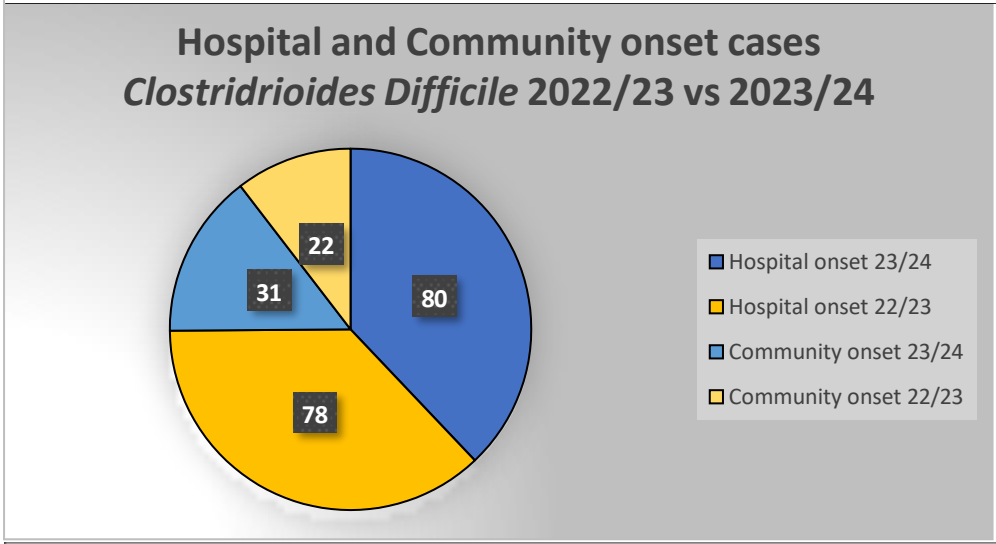
C1.13 Total reported incidence of month by month comparing 2022/23 and 2023/24 of all Healthcare Acquired Infections



There is monthly variation in the reported HCAIs

Clostridioides difficile

C1.4 *Clostridioides difficile* incidence comparing 2022/2023 vs 2023/24



C1.5 UKHSA Definitions of Healthcare acquired infections for reporting purposes

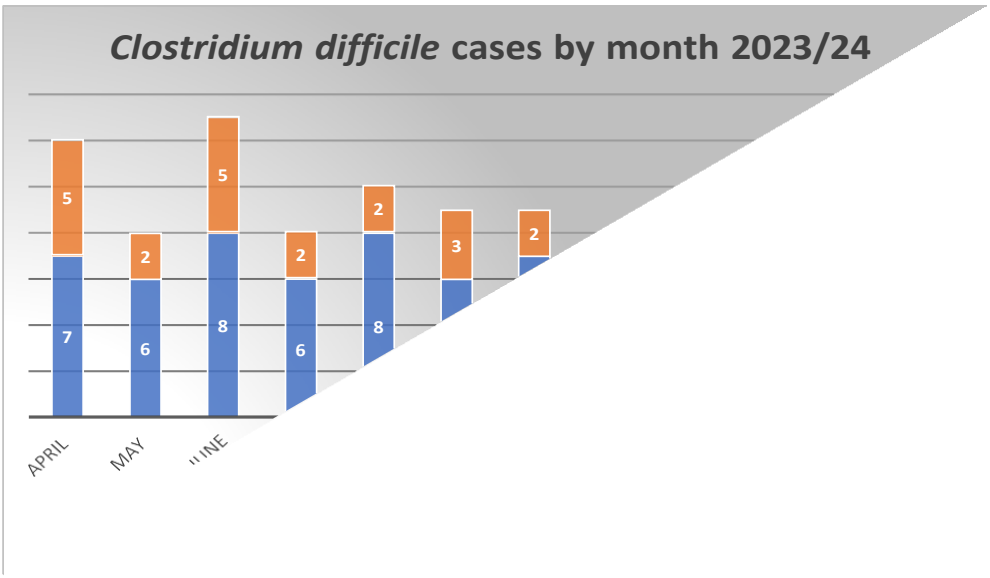
Hospital Onset – Healthcare Associated:
- Patient is an inpatient in an acute trust and has 3 or more days between admission and positive specimen

Community Onset – Healthcare Associated:
- Patient returns a positive specimen within 28 days of discharge from an elective or emergency hospital admission within the reporting trust

Community Onset – Indeterminate Association (*C.Diff* only):
- Patient returns a positive specimen between 28 and 84 days of discharge from an elective or emergency hospital admission within the reporting trust

Community Onset – Community Associated:
- Patient has not been discharged from an elective or emergency hospital admission in the reporting trust in the last 84 days for *C.Diff* and 28 days for all other organisms

C1.6 The incidence of C.difficile compared in 2022/23 and 2023/24 and monthly cases



There is a variance seasonally and from month to month with C.difficile, as detailed above for 2022/2023 and 2023/24.

Clostridioides (Clostridium) difficile infections (CDI)

The limit set for CDI for 2023/24 was 88; the Trust reported 111 cases.
It is of note that the incidence across the South West region for *C. difficile* is higher than the national position. The regional *C. difficile* collaborative is actively working to engage commissioners and providers in quality improvement approaches. UHBW has been working with system partners in BNSSG to support this initiative including redefining the *C. difficile* review process going forward to offer shared learning across the local healthcare system.

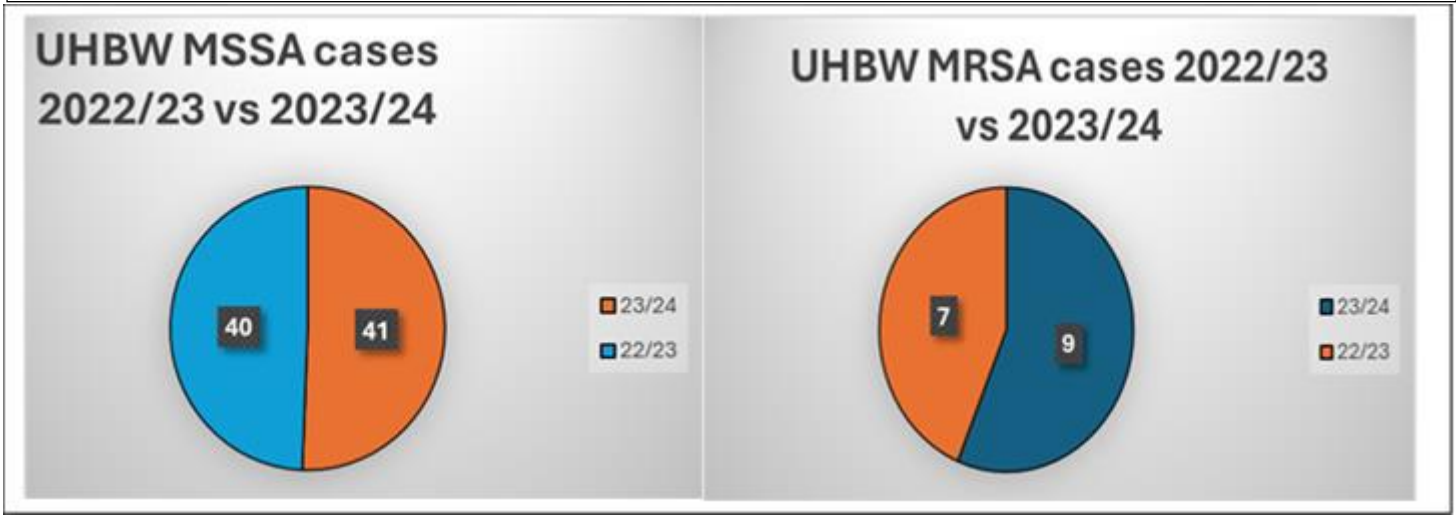
The Trust approach has been through the Leadership of the Divisional Directors of Nursing with a cross Divisional multi-professional *C. difficile* quality improvement group. This work is ongoing and includes clinical and non-clinical colleagues. Recognising the importance of AMS, cleaning standards and the physical care environment colleagues from Pharmacy, Facilities (for cleaning) and Estates are all actively involved.

In the absence of the formal validation process from the ICS for *C. difficile*, the IPC, clinical and medical Microbiology teams have continued to undertake the l review of cases.

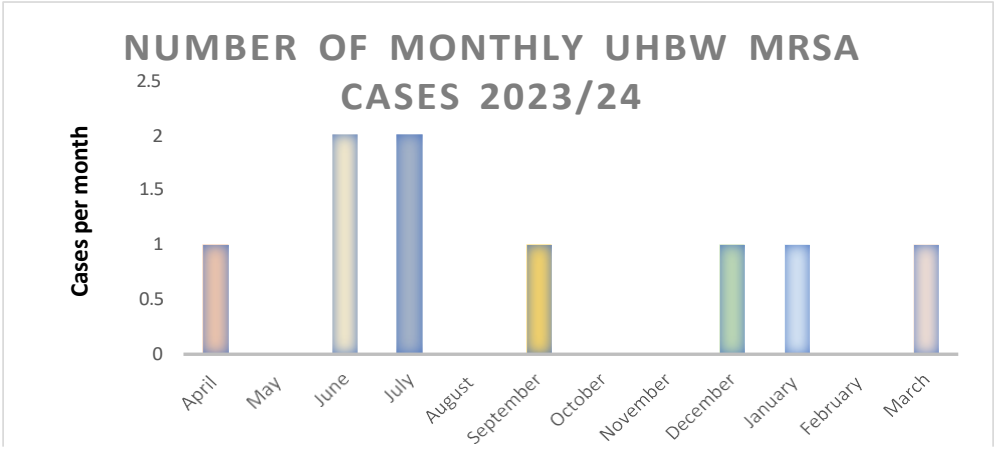
MRSA and MSSA bacteraemia cases

C1.7 the reported MSSA bacteraemia cases in 2022/23 and 2023/24 bacteraemia cases in 2022/23 and 2023/24

C1.8 The reported MRSA



UHBW MRSA Monthly Rate 2023/2024



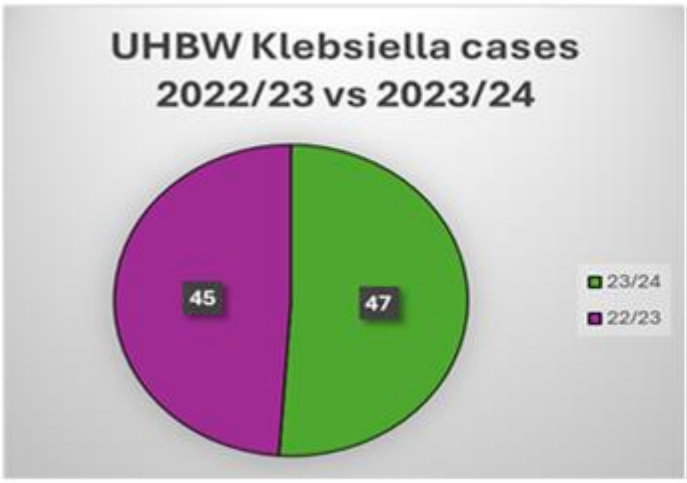
For the incidence of MRSA in 2023/24, UHBW it is noted as an outlier for NHSE

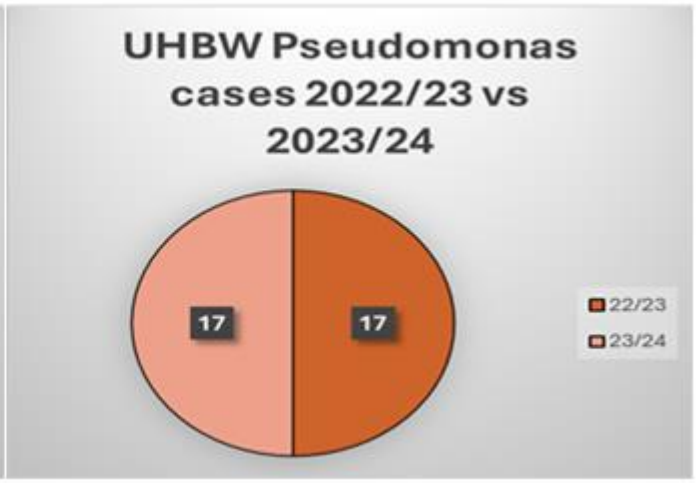
That has precipitated a call to action within the organisation through the Leadership of the Divisional Directors of Nursing with a cross Divisional multi-professional MRSA quality improvement group. This work is ongoing and does include clinical and non-clinical colleagues with a review of learning from previous cases and clear actions for improvement being developed

Reportable Gram negative HCAIs

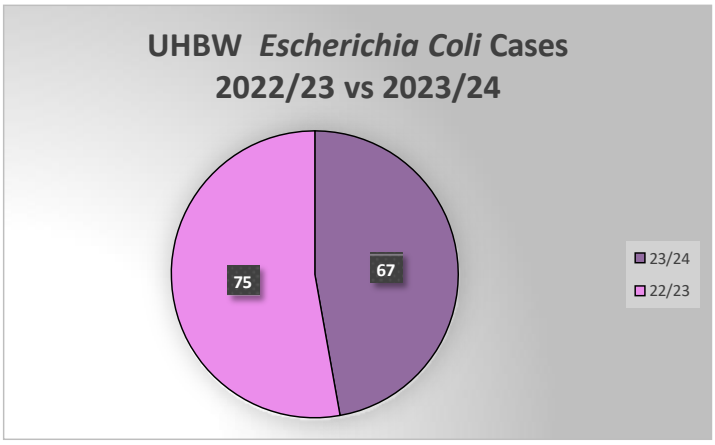
There are 3 additional organisms that are reported when blood stream infections (BSIs) occur as listed below. NHSE limits are set for these organisms

C1.10 The reported *Klebsiella* bacteraemia cases in 2022/23 and 2023/24. C1.1*Pseudomonas* cases in





C1.12 The reported *E.coli* bacteraemia cases in 2022/23 and 2023/2024



1.3 Post infection reviews (PIR)

Post infection reviews (PIRs) are co-ordinated by the IPC nurses with input from ward clinical teams, medical microbiology and pharmacy. The team have actively engaged in 'Patient First' with continuous improvement being the theme. In view of this, the IPC team have rationalised the PIR approach with advice and support of the patient safety team to adopt the Patient Safety Incident Response Framework (PSIRF) principles in the post infection reviews, which are now completed, focused on key learning points and direct the clinical team towards actions for improvement, with the review document being embedded in the patient record.

Surgical Site Infection Surveillance

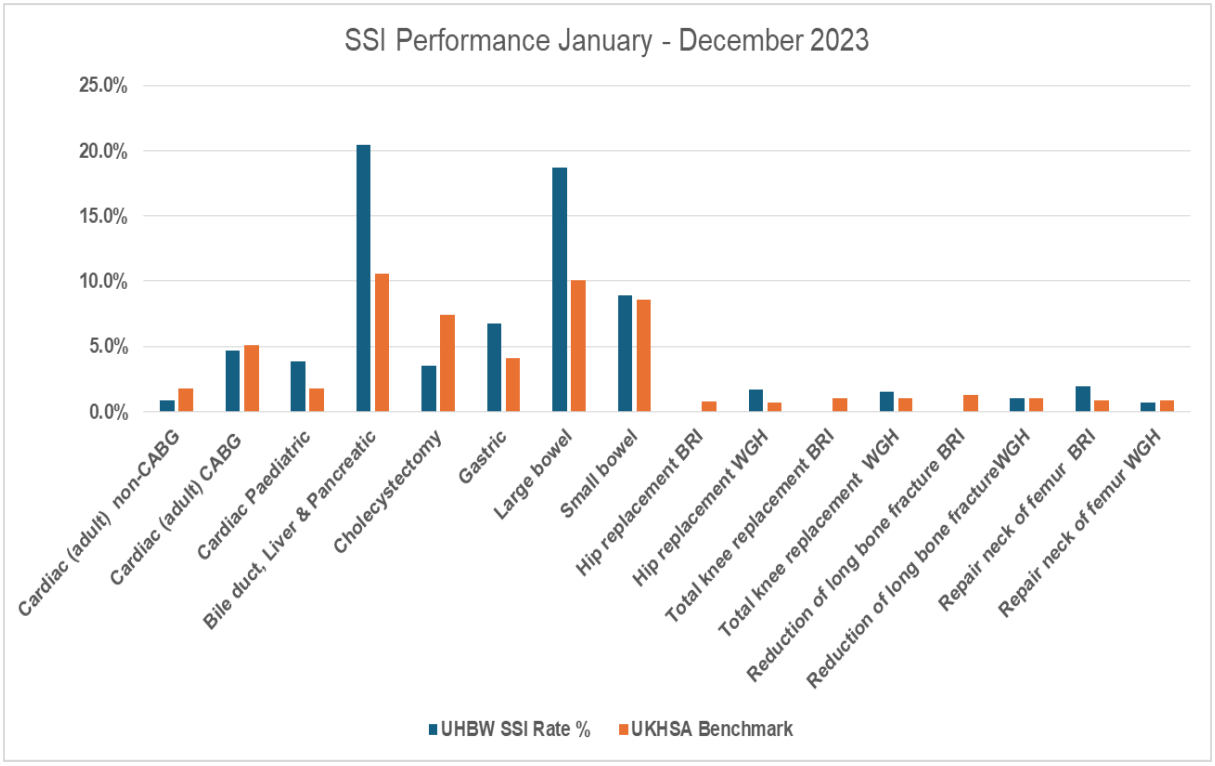
Surgical Categories SSI rate against National Data (January –December 2023)			
Surgical Category	**Reporting Hospital Site**	**UHBW SSI rate**	**National benchmark rate**
Cardiac (adult) non-CABG	BRI	0.9%	1.8%
Cardiac (adult) CABG	BRI	4.7%	5.1%
Cardiac Paediatric	BRHC	3.8%	1.8%
Bile duct, Liver & Pancreatic	BRI	20.5%	10.6%
Cholecystectomy	BRI	3.5%	7.4%
Gastric	BRI	6.7%	4.1%
Large bowel	BRI	18.7%	10.1%
Small bowel	BRI	8.9%	8.6%
Hip replacement BRI	BRI	0%	0.8%
Hip replacement WGH	WGH	1.7%	0.7%
Total knee replacement BRI	BRI	0%	1%
Total knee replacement WGH	WGH	1.5%	1%
Reduction of long bone fracture BRI	BRI	0%	1.3%
Reduction of long bone fracture WGH	WGH	1%	1%
Repair of neck of femur BRI	BRI	1.9%	0.9%
Repair neck of femur WGH	WGH	0.7%	0.9%

The approach to surgical site surveillance taken by different NHS organisation varies considerably. The only mandated requirement is the submission of specific orthopaedic data for one quarter of the year. UHBW have adopted a far broader position over a number of years.

The Surgical Site Infection Surveillance (SSIS) team collect data and carry out surveillance on the following UKHSA categories: mandatory surveillance for knee and hip replacements, repair of neck of femur, reduction of long bone fracture and voluntary surveillance of large bowel surgery, small bowel surgery, gastric surgery, cholecystectomy (non-laparoscopic), adult and paediatric cardiac surgery, and coronary artery bypass grafts.

UHBW continuously collects and submits data for each of the above surgical categories to the United Kingdom Health Security Agency (UKHSA) database. This generates a quarterly report comparing UHBW NHS Trust's Surgical Site Infection (SSI) rate against the National benchmark rate for each surgical category.

The table above and following graph summarise SSI data submitted to the UKHSA for UHBW in 2023, benchmarked against the national percentile rates.



Note the reporting period for the SSI data base is different to the standard NHS reporting hence only reporting for 2023, which does not include quarter 4 of 2023/24.

On occasion UHBW has been identified as an outlier in the reported data set to the UKHSA, with a higher incidence of infection in some SSIS reporting categories. This is formally acknowledged through the Trust's governance structure with an organisational risk on the risk register. It should be noted that the bench marking against other organisations can be troublesome because there isn't a nationally consistent SSI system of reporting in place.

The role of the SSIS Team is to enhance the quality of patient care, by providing data and feedback to assist the surgical and nursing teams with effective treatment/care pathways, aimed at reducing the rate of surgical site infection (SSI). This data capture involves working collaboratively with the departmental and surgical teams, providing reports and feedback to the surgeons. Patients are followed up at 30 days and at 12 months for any implant surgery, with a post discharge telephone call to capture post-discharge infections. The infection trends are reviewed over time noting any interventions prescribed/initiated by MDT and if they impact on patient outcomes.

As part of quality improvement, the ICNet SSI module is now available to assist with SSI monitoring. Implementation of the system has yet to be completed with some technical issues to resolve.

There are ongoing plans for service development including working with the adult cardiac wound care nurses, the SSI team plan to trial a post discharge surveillance questionnaire to be electronically sent to patients, this will include collecting photographs at discharge.

1.5 The Physical Environment including Water/Ventilation safety and waste management.

Estates reporting (including water and ventilation safety)

- The Trust Water Safety Group oversees the work to deliver the requirements set out in the Health Technical Memorandum (HTM) 04-01 revision. This multidisciplinary group ensures that there are systems and processes in place to manage the complex water systems and a water safety plan is in place.
- The Trust Ventilation Safety Group provides a means for the joint review of issues relating to the effective management and review and co-ordination of aspects of the performance of the site's ventilation systems in accordance with HTM 03-01 ventilation systems.
- The Trust waste management process is effective linked to (HTM) 07-01 standard.

Estates - Water Safety and Ventilation (Matt James, Assistant Director of Estates)

Water Safety

The Trust Water Safety Group meets quarterly and oversees the requirements set out in the HTM 04-01, Approved Code of Practice (ACoP L8) and associated guidance notes (HSG274 Part 2) in accordance with the requirements of the CQC and HSE). This multi-disciplinary group ensures that there is governance, systems, and processes in place to manage the complex water systems. This is detailed within the Trust water safety policy and water safety plan/ written scheme of control and reviewed at each quarterly meeting. Estates share information and provide assurance around maintenance activities undertaken, share water sample results taken and identify risks in line with guidance documentation. The group shares knowledge, learning from past experiences and ensures that the governance structures are in place. Background levels of *P. aeruginosa* within the augmented care areas are monitored and microbiology highlight areas of concern. Investigations take place as required and exception reports are progressed and escalated through Infection Control Group and the Trust Health and Safety Committee as required. The group is functioning well and has cross divisional representation as well as key stakeholders from the IPC team and Health and Safety.

Risks and incidents are managed through the Trust risk management system (Datix) and monitored at the Water Safety Group.

The Trust has an appointed Authorising Engineer for water safety as recommended in HTM 04-01 and they have undertaken an annual audit. The findings of the annual report have been shared with the Water Safety Group and actions are being monitored through that group as well as water risk assessment recommendations accepted by the Trust into the water action plan.

The Weston Estate has been integrated into the current Trust governance process and management systems.

Ventilation Safety

The Trust Ventilation Safety Group provides a means for the joint review of issues relating to the effective management and review / co-ordination of aspects of the performance of the Trust's specialist ventilation systems including the development of strategies and approaches to manage risks associated with those ventilation systems and accepts ownership of, and to be accountable for Ventilation Risk Management in accordance with all current legislation and guidance documentation.

The group has developed and approved a Trust ventilation safety policy and provides a risk-management approach to the safe operation of ventilation systems.

The Trust has an appointed Authorising Engineer for ventilation as recommended in HTM 03-01 and they have undertaken an annual audit. The findings of the annual report have been shared with the Ventilation Safety Group and actions are being monitored through that group.

Specialised ventilation systems are assessed and verified annually by a specialist sub-contractor and actions arising from these verifications are recorded and monitored 'by exception' through the Ventilation Safety Group. Operational ventilation group meetings have since been scheduled monthly, to support with progressing reactive maintenance works identified within the annual verifications, whilst ensuring that planned maintenance is undertaken prior to annual verifications to further drive improvement throughout the Trust.

In the past 12 months the Trust has also further improved its permit to work systems supporting the shut-down and hand-back procedures ensuring the clinical teams are more aware and sighted on the functionality of the ventilation systems that serve critical areas.

Sustainable and compliant waste management

The Trust has a collaborative group focused on sustainable waste management with involvement from key stakeholders. The group have oversight of incidents and risks related to waste management across UHBW and reviews waste management audits, both internally and externally and identifies gaps in compliance and supporting staff education where required.

The Health Technical Memorandum (HTM) 07-01 outlines the Trust responsibilities for Safe and Sustainable management of healthcare waste but also in context of the NHSE approach through the National Clinical Waste Strategy, and the Integrated Care System Green Plan to a greener NHS. Work is ongoing across UHBW to assure compliance with all waste management streams, and where non-compliance is identified this is addressed proactively with departmental teams. An integral part of this is the introduction of waste management education both face to face and via the Trust eLearning portal.

The waste management team have worked with the Trust Chief Nursing team to introduce waste into the ward accreditation criteria, the team is currently working with Clinical, Estates and Facilities teams to further strengthen the waste auditing process and ensure a robust approach to reporting and a clear escalation process in place for all Trust divisions. The introduction of monthly walkarounds with IPC and Facilities have facilitated regular reviews of waste management processes on the ground.

The Trust is reviewing its waste approach which have clear sustainable environmental objectives and targets. Progress against these targets is monitored and reported through the Trust Sustainable Waste Management Group, the Estates and Facilities Divisional Management Board as well as the ICS Green Plan Implementation Group."

1.6 Decontamination

Decontamination: (Annette Giles, Trust Decontamination Manager)
The Trust Decontamination Board formally meet quarterly and report into the Trust Infection Control Group.

Decontamination Risks

At the end of March 2024 there were 74 decontamination related risks on the Trust wide register of which 6 required further action and these are summarised below:

Risk Numbers	Risk theme requiring action
6884	Risk that staff are exposed to chemicals due to poor ventilation in two decontamination rooms
6331	Risk that CSSD RO plant that feeds washers is unable to make RO water in a timely manner
5113	Endoscope decontamination related risks including electronic tractability and the ageing profile of decontamination equipment
3627 2739	Decontamination of equipment related risks including ultrasonic machine failure, inability to decontaminate heat labile instruments due to machine failure and not being able to perform automated decontamination processes in OPD's
1344	Damage to external packaging of sterilised instruments, which render them unsterile and unable to be used.

Successes for the year 2023-24 in Decontamination services

The Central Sterilising Services Department (CSSD) retained accreditation to ISO 13485:2016 through external audit of its quality system and department practices.

The appointed Authorised Engineer for Decontamination (AED) undertook annual decontamination audits of all the decontamination units that perform local decontamination of medical devices across the Trust.

Decontamination practice remains good across the Trust. Few issues relating to ventilation of decontamination facilities identified during audit and estates are working to address these issues.

Installation and commissioning of 2nd Reverse Osmosis (RO) plant in CSSD to feed the sterilisers and provide the department with business continuity.

Installation and commissioning of 2nd Hydrogen Peroxide machine in CSSD (Sterrad machine) to support the sterilising of robotic instruments and also provide the department with business continuity.

Installation and commissioning of a replacement ultrasonic machine in CSSD, which is used as a pre-wash of heavily soiled instruments and robotic instruments, prior to processing via an automated washer.

Installation and commissioning of 2 new AERs at Day Surgery Endoscopy Unit at South Bristol Community Hospital, as replacements for an obsolete machine as replacements for an obsolete machine

Challenges for 23 – 24 in Decontamination Services

Bristol Royal Children's Hospital level 4 Decontamination area has been closed on a long-term basis, due to not being able to achieve ventilation compliance in this area. BRCH are using Level 5 decontamination area in TSB as their sole decontamination facility.

Roll out of endoscopy electronic track and trace system failed to progress.

CSSD at BRI finally ceased using steam to power decontamination equipment and is now powered entirely by electricity.

Compliance Criterion 2. Clean environments.

2.1 Facilities cleaning report

2.2 PLACE Report

The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

- There is a programme of cleanliness auditing conducted throughout UHBW which is focused upon high and very high-risk areas as directed by the National Standards of Healthcare Cleanliness (2021). The reports from these audits are presented through the monthly operational ICG by Divisions for local action and re-audit accordingly.
- If non-compliance is noted in cleaning standards, local departmental efficacy audits are led by the Facilities team, with Divisional, clinical and IPC input to review the area of non-compliance.

2.1 Facilities cleaning report

The National Standards for Cleanliness 2021 informs our cleaning policy, cleaning risk categories, approach to auditing frequency, cleanliness responsibility framework, cleaning practices and schedules.

UHBW is compliant with these cleaning standards, cleaning resources deployed effectively across the organisation. An internal audit process in 2023 by external auditors provided an additional level of scrutiny that the expected cleaning standards are being delivered. There were minor learning points that have been managed through the UHBW governance process for assurance.

Auditing Cleanliness

Areas deemed to be higher risk 'FR1 areas' for cleaning such as ICUs are audited weekly, general wards 'FR2' areas are audited monthly and lower risk areas less frequently. Linked to this are Cleanliness Star ratings that are displayed in patient areas (wards, clinics etc) and most UHBW areas have achieved either 4 or 5 stars. The Star ratings combine the scores for clinical, facilities and estates cleaning standard that has been noted when audited.

Additional Efficacy Management Audits for Cleanliness (clinical, facilities and estates cleaning) were completed by clinical and non-clinical staff. Sixty five percent of the patient areas across the Trust were assessed. Reports were distributed to clinical and non-clinical teams for action. Where areas scored 80% or less, a second audit was completed. The reports also contributed to the Clinical Award Accreditation process.

Over 200 areas across the Trust received a technical audit each month for clinical, facilities and estates cleanliness. The risk categories are: Functional Risk (FR) audited up to 4 times per month, FR2 monthly, FR3 bi-monthly, FR4 quarterly and FR5 six monthly.

The table below shows the UHBW cumulative average scores for cleanliness in 2023/24 by hospital location. This includes facilities (general cleaning), clinical cleaning (clinical equipment used for patients) and estates cleaning (windows, ceiling tiles, ventilation grilles and lights):

	Facilities FR3		Clinical FR3		Estates FR3
	April 23-Mar 24		April 23-Mar 24		April 23-Mar 24
	Year Avg		Year Avg		Year Avg
BRI	96.56	BRI	100.00	BRI	93.28
StM	94.07	StM	98.21	StM	94.68
WGH	95.64	WGH	99.00	WGH	98.59
	Facilities FR4		Clinical FR4		Estates FR4
	April 23-Mar 24		April 23-Mar 24		April 23-Mar 24
	Year Avg		Year Avg		Year Avg
BRI	94.12	BRI	96.36	BRI	98.27
BHI	92.47	BHI	91.80	BHI	97.68
BRCH	92.00	BRCH	93.86	BRCH	93.22
StM	93.30	StM	96.35	StM	99.24
BHOC	90.99	BHOC		BHOC	99.17
WGH	95.34	WGH	98.93	WGH	96.43
BEH	94.67	BEH	97.70	BEH	98.63
SBCH	97.97	SBCH	99.54	SBCH	99.31
CHC	86.68	CHC	100.00	CHC	97.82
BDH	85.88	BDH		BDH	99.01
	Facilities FR5				Estates FR5
	April 23-Mar 24				April 23-Mar 24
	Year Avg				Year Avg
BRI	95.95			BRI	94.45
CHC	94.82			CHC	100.00
	Facilities FR1		Clinical FR1		Estates FR1
	April 23-Mar 24		April 23-Mar 24		April 23-Mar 24
	Year Avg		Year Avg		Year Avg
BRI	97.39	BRI	93.49	BRI	95.99
BHI	98.11	BHI	98.21	BHI	97.97
BRCH	97.26	BRCH	95.60	BRCH	96.54
StM	97.04	StM	96.69	StM	96.97
BHOC	97.20	BHOC	96.75	BHOC	97.92
WGH	98.78	WGH	98.07	WGH	98.28
BEH	98.37	BEH	96.79	BEH	97.58
SBCH	98.82	SBCH	99.27	SBCH	98.11
	Facilities FR2		Clinical FR2		Estates FR2
	April 23-Mar 24		April 23-Mar 24		April 23-Mar 24
	Year Avg		Year Avg		Year Avg
BRI	94.86	BRI	94.45	BRI	96.74
BHI	96.66	BHI	95.56	BHI	97.94
BRCH	96.18	BRCH	93.40	BRCH	97.86
StM	95.40	StM	93.63	StM	98.34
BHOC	97.06	BHOC	98.56	BHOC	99.41
WGH	97.46	WGH	96.21	WGH	96.98
BEH	96.83	BEH	98.22	BEH	97.62
SBCH	97.49	SBCH	95.56	SBCH	97.07
CHC	96.56	CHC	99.48	CHC	98.23
BDH	93.72	BDH	98.11	BDH	97.91

There continues to be an ongoing focus in FR1 (>97%) and FR2 (>95%) areas to achieve the require standard.

The Trust facilities team are active participants in the Infection Control Group, both monthly and quarterly and in the IPC quality improvement initiatives for patient care, where cleaning standards are an integral part.

Rapid Response Team Cleans

The organisation requires an effective response to the hospital operational demands for additional cleaning, such if a patient is discharged who has an infection or if an infection outbreak scenario has occurred.

The enhanced cleaning process was reviewed against the National Standards for Cleanliness 2021. The review included key stakeholders from the infection control group, clinical and non-clinical teams. The updated SOP includes:

Rapid response team cleans (previously referred to as deep cleans) reflect the urgency and infection control type, with three types of rapid response cleans are: 1. Routine clean, 2. Enhanced clean and 3. Terminal clean. The types of cleans are determined by certain criteria set by the urgency of the clean from the Clinical Site Management Team or by infection prevention and control.

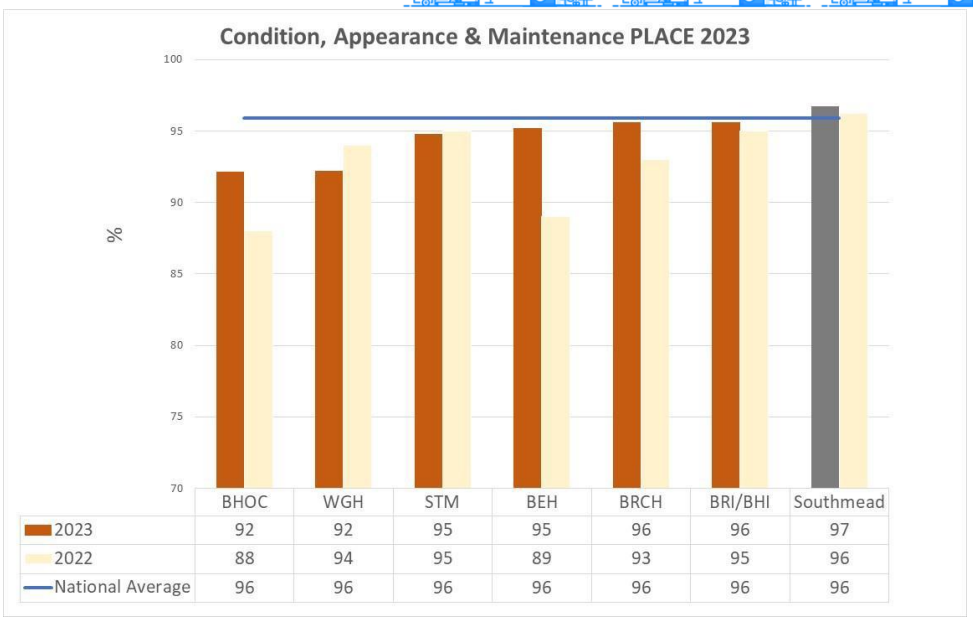
A development is that now these additional cleans are requested through the electronic task management system (Synbiotix), where the clinical staff request directly into the task management system.
The task management system (Synbiotix) allows data to be gathered to analyse contributing to the KPIs and exception reports, reported on a monthly basis to the Operational Infection Control Group and Facilities Cleaning meeting.

2.2 PLACE (Patient Led Assessment of the Care Environment)

PLACE assessments were completed in 2023 at Bristol Royal infirmary, Bristol Heart Institute, Bristol Royal Children's Hospital, Bristol Eye Hospital, St Micheals Hospital, Bristol Haematology Oncology Centre and Weston General Hospital. The results were issued by NHS England in February 2024.

Cleanliness: The graph for cleanliness shows the score was above the national average at 98%. Southmead scores were included to offer comparison as the nearest large Trust for benchmarking.

Condition, Appearance and Maintenance: The graph below shows the scores were below the national average but mostly better than the previous year scores. Over 100 maintenance jobs were entered on the internal Agility system. A further list of actions was prioritised by the Directors of Nursing, Estates and Facilities. £65,000 has been allocated to complete a number of the actions.



	BHOC	WGH	STM	BEH	BRCH	BRI/BHI	Southmead
2023	92	92	95	95	96	96	97
2022	88	94	95	89	93	95	96
National Average	96	96	96	96	96	96	96

The next assessment will be September to November 2024

Internal Audit of Cleaning Standards.

The Chief Nurse commissioned the Trust external auditors to undertake an exercise to determine if the internal UHBW process for weekly auditing of clinical areas considered to be high risk with a functional risk one rating (FR1) were completed to the required standard. The facilities management team and IPC agreed the approach. Overall, the finding reiterated that the standard of cleaning in FR1 areas, such as ICU's was to the required standard. There were some minor areas for improvement which have been part of an action plan. These actions were to strengthen lines of reporting if an area does not achieve the required standard, as well some procedural issues.

Catering services.

The external auditing of the Trust's ward kitchens and pantries in place is required with food safety regulations. The only IPC risks that have been identified linked to the provision of catering services within the organisation is for food hygiene, not for the facilities team but for the wider nursing team in wards and departments to ensure they have received the level of training expected.

Linen services

The contracted laundry suppliers continue to meet service needs appropriately in all areas at all sites. The Trust reports compliance to HTM standards referenced in this report, including for the provision of linen services.

Compliance Criterion 3. Antimicrobial use.

Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The importance of AMS is reiterated through the approach to infection prevention and control and the risks to patients in the future of increasing numbers of infections that will not have antibiotics that can fight them. The World Health Organisation describe this as a global health emergency.

Antimicrobial Stewardship

The term "antimicrobial stewardship" is defined as "an organisational or healthcare system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness" (NICE, NG15, August

2015). Antimicrobial Stewardship operates across all clinical areas of UHBW as part of the Trust's antimicrobial stewardship programme. The activity of the antimicrobial stewardship team is monitored through the Trust wide Anti-infective Steering Group (ASG).

The ASG regularly review prescribing compliance, expenditure, antimicrobial CQUIN delivery, meeting the requirements of the NHS Standard Contract, incident trends, update and produce new guidelines, feedback audits and deliver education and training, in line with the recommendations from the Department of Health (DoH) on the delivery of a robust Antimicrobial Stewardship Programme. The outcomes are reported to the Trust quarterly IPC meetings.

Prescribing Compliance

Multi-disciplinary ward rounds continue to be undertaken on the Bristol sites on a weekly basis in both the Adult and Children's hospitals; not every ward is covered but the team aim to review most of the specialities where antimicrobial use is high. Due to staff shortages, MDT ward rounds at Weston General Hospital (WGH) have been challenged and only undertaken once a month. Compliance data is emailed monthly to all consultants to share with their teams. Microbiologists continue to provide advice daily to the Intensive Care Units and Trust wide via telephone enquiries.

One of the aims of the ward rounds is to measure prescribing compliance and data is collected on stop or review dates, documentation of an indication and ensuring prescribing follows Trust guidelines. However, other activity includes a review of complex patients with deep seated infections or resistant organisms and many interventions are made which have a significant impact on patient outcomes and care.

Compliance data is added to a live reporting system (CMM), providing a record of any interventions or recommendations for each patient seen. The details are visible as a clinical note attached to each patient. This allows clinicians to see the results of prescription reviews, any recommendations made, including detail on which member of the team carried out the review. The Paediatric Infectious Diseases team and the specialist Paediatric Antimicrobial Pharmacist continue to provide antimicrobial ward rounds and data collection across the Bristol Children's Hospital (BCH) and St Michael's hospital throughout 2023/2024. Compliance data is input into the same system as above.

Electronic Prescribing and Medicines Administration (EPMA)

The lack of electronic prescribing in the Trust remains a rate-limiting step in the collection of compliance data, data to inform national CQUIN targets and NHS Standard Contract requirements. MDT Ward rounds are time consuming as individual patient prescribing data can only be found by interrogating drug charts. Staff shortages have impacted this work considerably, in particular at WGH.

The CMM electronic prescribing system (EPMA) system is being developed within the Trust and the AM Pharmacists have worked with the Informatics service to ensure stop or review dates and indications are mandatory. Other collaboration has included safety considerations ensuring therapeutic drug levels are linked to the relevant prescriptions and that where possible, antimicrobials can be prescribed as per indication.

The introduction of EPMA will inevitably change the way the MDT ward rounds work but it will enable a more focussed approach to stewardship, however the team aim to maintain a visible presence on wards, providing patient-specific advice and teaching at the point of prescribing.

Antimicrobial CQUIN 2023/2024

The NHSE Antimicrobial CQUIN for the year 2023/24 focussed on intravenous to oral switch (IVOS) of antibiotics; prompt IVOS switching reduces HCAI, reduces expenditure in terms of drugs and consumables, releases considerable amounts of nursing time and allows for earlier discharge from hospital.

The AMPs collected the data with 100 cases audited across the trust each quarter. The team provided education and training via a communications campaign to remind nursing staff and prescribers of the benefits of prompt IVOS where appropriate. A decision support tool was developed on the Microguide platform to further support prescribers.

The target was for 40% or fewer antibiotic prescriptions remaining as IV where the indication was appropriate, and data collected demonstrated that good practice. The CQUIN criteria were met in all quarters (Q1 = 6.4%, Q2 = 9%, Q3 = 7%, Q4 = 4.9%)

Antifungal stewardship MDT

A dedicated antifungal stewardship team continue to meet virtually once a week; complex patients are reviewed with mycology, microbiology, the specialist pharmacist and the relevant clinical teams; antifungal prescribing practice is also carefully monitored. In 2023 the MDT was expanded to include patients from North Bristol Trust (NBT) and thus has a system wide focus.

UHBW Endocarditis MDT

The specialist weekly MDT was established in 2023 and meets to discuss patients with infective endocarditis with expert input from Cardiology, Cardiac Surgery, Microbiology, and the AMS Pharmacy team in light of consensus recommendations from the Joint British Societies. The team discuss patients from across the wider BNSSG STP; the aim is to ensure all aspects of Infectious Endocarditis are considered and to improve patient outcomes.

Total Antibiotic Consumption 2023/2024

A reduction in total antibiotic consumption has been part of the NHS Standard Contract since 2018. This target was removed in 2022 and has been superseded by the requirement to achieve a reduction in Watch & Reserve antibiotics (see below).

NHS Standard Contract

The World Health Organisation (WHO) Antibiotics list was adapted by NHSE in 2019 and Define Daily Dose (DDD) for each antibiotic are subsequently grouped into the three UK Access, Reserve and Watch (AWaRe) categories. The Access category includes the narrowest-spectrum antibiotics, Watch includes broader-spectrum drugs, often used in hospitals and the Reserve category includes those drugs that should only be used on the advice of microbiology or for specific indications.

The target for 2023/24 was to achieve a 10% reduction in Watch and Reserve antibiotics against the 2017 calendar year baseline. UHBW met this target with an overall reduction of 10.06%.

A new 5-year Antimicrobial National Action Plan (NAP) has recently been published with broad targets to again reduce human consumption of antibiotics and where possible to increase use of those in the Access category. Further detail on targets for Acute care is anticipated in the coming months.

N.B. The NHSE Standard Contract states ‘the contractual requirement remains for “reasonable endeavours” to be used to achieve the reduction and there is, of course, no expectation that efforts to deliver the overall reduction should prevent individual patients from receiving necessary medication where clinically appropriate.’

Guidelines

UHBW Antimicrobial Guidelines are available Trust wide on Microguide, with access via the Microguide app and available on desktops. The vancomycin calculator is also now hosted on this platform along with an IV to PO switch decision support tool.

A lot of work has been undertaken with the NBT AM team to align antimicrobial guidelines across BNSSG to ensure, wherever possible, system-wide harmony. This work continues.

MHRA Quinolone warnings: wherever possible, the recommendation to prescribe quinolone antibiotics have been removed and alternative therapies suggested following the MHRA alerts issued earlier in 2024. The recommendations have been made in conjunction with colleagues at NBT where appropriate.

Audit

An audit of antibiotic prescribing for community-acquired pneumonia has been undertaken and results will be reported to the respiratory clinicians and microbiologists in the next month**.**

Expenditure

Anti-infective expenditure remains steady across Bristol and Weston sites. The availability of a number of generic antifungals and the success of the antifungal stewardship group continues to reduce antifungal expenditure.

Compliance Criterion 5. Those at risk of infection.

5.1 Including UHBW IPC risk summary

5.2 Summary of IPC related incidents

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.

Penicillin-allergy de-labelling

Work on penicillin-allergy de-labelling has been limited in recent months due to staffing shortages but work is underway to amend the current guidance for use in the ICUs. Other projects, such as rolling this out to BHOC patients is currently on hold.

Anti-Microbial Pharmacist (AMP) Team

The AMP team staffing remains challenged: our band 8a specialist pharmacist and our band 7 pharmacist have both moved into other roles in the Trust. We have recruited into the 8a post, and the new starter will begin in August 2024 and a 0.5 wte band 7 starts with the team in August. All Adult ward rounds and other work is currently being undertaken by the Consultant pharmacist and capacity is extremely limited. The NHS@Home/OPAT continue to increase their workload of Out-patient parenteral antibiotics (OPAT), maintaining oversight of any patients discharged on IV antimicrobials, working closely with microbiology to ensure appropriate prescribing, and limiting IV therapy wherever appropriate.

System & Regional Working

The team continue to work with colleagues across the BNSSG system and are active members of the local and regional (SW) AMR groups. As the remit broadens to include antimicrobial stewardship with Infection Prevention & Management in response to the 5-year National Action Plan to reduce antimicrobial resistance.

Compliance Criterion 4. Information on infections.

The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The NHSE Infection Prevention & Control manual (2022) is available within the Trust, with associated Trust guidelines and Standard Operating Procedures via the Trust 'MyStaff' app

National information leaflets are utilised for patient and public information on IPC where appropriate and are available with links through the Trust intranet.

- Trust patient information leaflets for IPC related matters are submitted to the patient experience group for review and approval and the Trust communications team. Generally, the national templated leaflets are used whenever possible.

- Posters, leaflets, and signage are used to promote good hand hygiene practices, inform patients and visitors of any requirements for IPC, and provide public health information and advice. The central Communications Team continues to support corporate messaging.

- Information is also available on the Trust website and relevant information is sent out using social media.

- The Trust IPC sign used for each single room has been standardised and updated in 2023 and is used across all inpatient wards in UHBW.

Patient confidentiality is always maintained, and information is only shared with other organisations in accordance with Data Protection principles.

- Risk management is an integral part of infection prevention and control, however, that is done in an operationally sensitive and pragmatic way that allows for a balanced risk approach e.g. patients with excessive delays in emergency departments are an equally important risk.

- All patients admitted to hospital undergo a risk assessment for infection risk to determine if the patient should be reviewed for isolation in a single room. The level of risk would change for a patient who develops signs of infection, and this should be re-evaluated at that time.

- There are various risks formally identified relating to a number of organisational factors including staff using robust IPC practice. There are a small number of organisational risks that are formally noted in this report as they have scored more highly. All risks are actively managed in accordance with UHBW policy and go through a process of assessment and acknowledgement with mitigation being enacted wherever possible.

- ICNet is the I.T system that allows IPC practitioners to review relevant results that are streamed from the information received from the pathology systems. The IPC team then work with clinical teams so that there is optimal management of infection control risks bysharing information with clinical teams as required. There are some modules within ICNet (SSI module and outbreak manager) that haven't been deployed because of limitations within the system itself.

IPC risks

UHBW manages its risks using the Datix system as the Trust Risk Register. The table below is a summary of the eight risks of note, which are managed through the IPC team. There are other risks identified which are held by Divisions. These are reviewed through the Infection Control Group. Each risk has action for improvement identified or mitigations where possible, but this is likely 'work in progress' to completely resolve the risk.

Risk & Datix number 2023/24	Status
6677 – Risk rating – 16 *Risk that there are non-compliant behaviours for effective IPC practice amongst staff in UHBW*	**Action required risk**
3216 – Risk Rating 12 *Risk that the trust will breach the NHSE limits for cases of Clostridiodes difficile*	**Action required risk**
6013 – Risk rating -12 *Risk that the trust exceeds its NHSE/I limit for Methicillin Resistant Staphylococcus aureus bacteraemia's*	**Action required risk**
7363 – Risk rating – 9 *Risk that UHBW is non-compliant with the mandatory requirement infection prevention & Control Code of practice with policies*	**Action required risk**
***3687* - Risk rating – 9** *Risk that ICNET is delayed in implementation at Weston, with the impact that patient infections might not be tracked*	**Action required risk**
5624 - Risk rating – 6 *Risk that mandatory surgical site infection surveillance does not have sufficient oversight and governance*	**Action required risk**
6582 – Risk rating – 6 *Risk that patients presenting with suspected or confirmed HCID could cause an emergency department to close*	**Action required risk**
7224 – Risk rating – 6 *Risk that UHBW is non-compliant with the NHSE requirements for IP&C education (tier 3)*	**Action required risk**

5.2 Summary of IPC related incidents

CPE

Carbapenemase-producing Enterobacterales (CPE) can be associated with persistent outbreaks in healthcare settings, and cause infections which are difficult to treat even with last-line antibiotics. UHBW investigated a cluster of *Klebsiella pneumoniae* cases harbouring NDM-1 resistance in Bristol Royal Children's Hospital, Bone Marrow Transplant Unit (BMT).

The CPE results match the 10 previously reported isolates from Starlight ward between October 2020 and August 2022.

The UKHSA undertook environmental sampling and completed an epidemiological investigation that identified multiple possible transmission pathways between cases and within the environment. Multidisciplinary collaboration has been key in the management of the situation. Actions around IPC practices, environmental cleaning and the replacement of damaged furnishings, fittings and equipment was required. The unit screen all patients on admission and weekly during their admission. The last case identified was on the 30th March 2024.

Respiratory viruses including SARS- CoV-2 (COVID-19), Influenza – testing platform incidence and impact on clinical services with restrictions.

SARS-CoV-2 (COVID-19)

The national recommendations for screening of all patients with respiratory symptoms including for SARS-CoV-2 (COVID-19) has continued, primarily in emergency departments and acute care settings. Appropriate isolation is used when required. Arrangements are in place to review to de-escalate patients after day 5 from their positive diagnosis when appropriate. The operational approach continues to be pragmatic with robust strategies in maintaining patient safety and organisational flow

There remains a risk, which is formally logged by the organisation, of nosocomial transmission of SARS-CoV-2-, especially in the Queen's building, BRI and at Weston. At Weston, HEPA-filtration units have been installed in some multiple occupancy inpatient bays as a mitigating measure, where there is no mechanical ventilation to facilitate reduction of respiratory virus transmission.

Influenza

The national influenza guidance is updated seasonally and requires the Trust to implement seasonal symptomatic patient testing to include influenza. This is integrated into the bundle of testing patients with respiratory symptoms. This was enacted in December 2023 until April 2024. Symptomatic patient testing allows for isolation when required and therefore minimising nosocomial influenza transmission. In Children's services a robust plan for cohorting patients, when seasonal surges were seen was put in place.

Norovirus

The incidence of Norovirus cases has been low. The IPC team support the clinical areas when restrictions are put in place and reopen promptly when it is safe to do so. Restrictions had been put in place as an IPC containment strategy in wards in BRCH / BRI / BHI and Weston, but these scenarios were complicated on occasion by concurrent infections such as influenza or SARS-CoV-2. During these restrictions, operational disruption is minimised as far as possible.

Measles

During quarter 3, the incidence of measles reported nationally was noted to have increased significantly in both London and most notably, the West Midlands. Therefore, the potential impact on health services regionally was thought to be a concern. As a consequence, the ICS, UKHSA and the Trust engaged in a 'Measles Preparedness' exercise. This included collaboration with IPC, Occupational Health, Emergency Planning, Laboratory medicine, Vaccination Hub, Trust Safety Department (for PPE), Pharmacy and the Clinical Divisions to align organisational strategies. Hence, if the incidence of measles did increase in Bristol or the surrounding area operational services were managed. The biggest element of this work was prevention and to ensure key staff had been vaccinated. The vaccination hub for measles (MMR) vaccinations was set up to enhance the Occupational Health offer, as there were gaps in staff vaccination records. The number of cases of measles seen by UHBW has been low with a small number of individuals admitted in both paediatric and adult services.

Whooping cough (*Bordetella pertussis*)

In quarter 4 the UKHSA reported an increased incidence of *Bordetella pertussis* infections. This had been unexpected with a rise in case numbers nationally in December 2023, increasing through the early part of 2024. Healthcare workers should be vaccinated to safeguard their patients with the highest risk staff being those working with pregnant women and acutely ill children. The Occupational Health team have created additional outreach vaccination clinic capacity targeting women's and children's services as a direct response with an ongoing internal communication for staff.

Compliance Criterion 6. Registered providers' responsibility to health and social care workers and those in care settings (including contractors and volunteers)

- **6.1 IPC Education and Training**
- **6.2 IPC assurance auditing**
- **6.3 Other IPC related auditing**

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.

- All IPC training is mapped against the UK Core Skills Training Framework Statutory/ Mandatory Subject Guide, Version 1.4 (2017). This includes measures to prevent risks of infection.
- All staff including both clinical and non-clinical should have IPC education for tier 1 and 2 training outlined in the 2023 NHS IPC education framework using the existing on-line resources provided by former Health Education England. These are being used and compliance is monitored quarterly, for new starter staff and every 2 years thereafter.

6.1 IPC Education and Training

- Infection Prevention and Control (IPC) is one of the eleven core skills recognised nationally per the UK Core Skills Training Framework. The Trust compliance target for this core skill is 90%. Compliance with mandatory IPC training amongst some staff groups was lower than the standard is 85% throughout 2023/24.

	387 Diagnostics And Therapies	387 Facilities And Estates	387 Medicine	387 Specialised Services	387 Surgery	387 Trust Services	387 Weston General Hospital	387 Womens And Childrens	Rate
Infection Prevention and Control	92.4%	97.0%	89.6%	87.5%	86.6%	94.5%	90.1%	86.8%	90.5%
Infection Prevention and Control Level 1	96.8%	97.0%	96.1%	96.8%	94.6%	95.6%	96.6%	95.7%	96.1%
Infection Prevention and Control Level 2	89.0%		88.1%	85.4%	84.5%	89.1%	88.8%	85.4%	87.1%

- IPC remains a mandatory component of staff induction and update training across the Trust. All induction and annual updates are provided by recognised NHS Skills for Healthcare e-learning using the national infection prevention and control resources, and placed on the Kallidus learning management system. Training compliance for each Division is reported at the quarterly ICG as part of the DIPC report, whilst breakdown compliance of the two different levels of IPC training are also shown in monthly compliance reporting.
- The IPC provide 'upskilling' training for Healthcare Support Workers quarterly coordinated through the central training team.
- The IPC team continue to provide local training in clinical departments as requested by Divisions including hand hygieine and areas of focused improvement such as the understanding of some organisms and management of *C. difficile.*
- Tier 3 training, which is identified in the NHSE IPC training framework remains a gap. This training is focused on team supervisors understanding their responsibilities. This training is being developed in collaboration with education and IPC specialist colleagues in NBT and Sirona.

6.2 IPC assurance auditing

Monthly auditing of IPC in clinical areas – Hand hygiene and change to AMaT

Hand hygiene auditing has continued throughout 2023/2024, but the platform has changed to 'AMaT' (Audit Management and Tracking)

The change of recording system has had some challenges to provide reliable data back to the clinical teams. Overall the visibility has significantly improved for Divisional teams of the results and therefore potential scrutiny. A Trust wide unified hand hygiene auditing approach is now possible including outpatient departments, as the approach is embedded into all clinical areas.

There is ongoing work between the IPC team, AMaT team and the clinical area to make best use of the IPC audit data to enable the focus for quality improvement. The monthly audits are an enabler to delivering the basics of IPC practice such as hand hygiene, peripheral cannula care, urinary catheter care, commode cleaning, PPE use and environment issues, if used with actions to address short comings in practice.

Hand hygiene audit results for Q4 across UHBW divisions, Tendable and AMaT Update

Hand Hygiene	* AMat system replaced Tendable 1st August 2023										
Month/year	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Trust score	97.1%	97.3%	92.8%	95.0%	97.8%	96.8%	96.7%	97.4%	96.9%	96.3%	96.3%

In addition to hand hygiene auditing there are also monthly audits undertaken for peripheral vascular cannula care, urinary catheters, commode cleanliness and the ward environment.

These audits results are monitored directly by the wards and Divisions and by the Operational infection control group.

6.3 Other IPC related auditing

There are a number of audits formally undertaken by the IPC team linked to organisational assurance and contractual obligations within the ICS. These include MRSA screening compliance, management of urethral urinary catheters and compliance with IPC policies.

MRSA screening compliance.

An annual audit was carried out to ascertain whether patients were screened for MRSA appropriately, in accordance with the UHBW screening policy. An initial audit was carried out in January 2023, which demonstrated that 4 out of the 6 divisions did not meet the audit criterion. Following realignment of each divisions' MRSA screening protocols and relaunching the updated policy a re-audit was carried out in October 2023. Results demonstrated that 4 of the 6 divisions met the criterion of the audit. However, 100% compliance to the MRSA screening policy was desired, but only 86 % compliance was achieved.

Additional changes to admission and ongoing infection/colonisation (including CPE) screening are to be launched in July/August 2024. Subsequently, this audit will be repeated in 2024/25.

Compliance Criterion 7. Isolation Facilities
The provision or ability to secure adequate isolation facilities.

- The Trust has approximately 1,135 beds which does not include additional capacity bed spaces used for winter pressures. Of these beds. 345 are single patient rooms (as listed in table 7.1). Each single patient room has dedicated equipment when possible. All sites are challenged at times to provide isolation facilities in a timely way.
- The IPC team are involved in the risk management of patients with infections if isolation is required, based on the principle of minimising transmission.
- The Weston site has the smallest proportion of its bed base as single patient rooms; this poses particular challenges for prompt isolation of patients with an infection. This is an identified risk with potential impact on emergency patient flow.
- The Trust does not have a formal organisational approach to increase the provision of single patient rooms for IPC requirements.
- The Trust has a small numbers of specialist ventilation single patient rooms for isolation. Specialist ventilation rooms are required for patients with specific infections or for patients who are severely immunocompromised. These rooms are mainly within the BHOC and BRI.
- The Trust has guidance in place when appropriate patient isolation is required including when specialist ventilation rooms are required such as transmission-based precautions with resistant organisms.
- There is a ward on the Bristol site (ward A900) that can be converted into a 6-bedded cohort ward should this be required in the situation of an outbreak.
- For safe management of patient's, side room facilities were prioritised to protect patients and staff with access restrictions in place. If cohorting of patients with the same infections, arrangements are required they are agreed with the IPC team, who are available 7 days per week.
- UHBW is not a designated centre for the management of High Consequence Infectious Disease (HCID) for either adult or paediatric services, however, there is an organisational procedure which describes a short-term containment approach prior to a confirmed HCID diagnosis and the expected transfer to a designated HCID centre.
- On occasions, patients with specific infections such as SARS-CoV-2 or influenza, particularly during winter pressures, may be grouped together in multiple occupancy bays in certain circumstances, most commonly in paediatrics.

- The isolation sign for UHBW has been standardised across the organisation, which is expected to be used as an immediate IPC visual guidance outside of all single rooms, updated at least daily but without breaching the principles expected of the Caldicott Guardian.

The chart below shows the breakdown of the isolation/ side room facilities across the Trust by Division /location:

Division / Location	Specialist ventilation isolation rooms	Side rooms with *en suite*	Side rooms only (no *en suite*)	Total side rooms
Medicine (excl. ED)	2 (1 in ED)	53	6	59
Weston	1	30	19	49
Surgery	8 (6 in ICU)	49	30	75
Women's Services	0	4	16	20
Children's (Bristol)	4	65	18	87
Specialised Services	9	47	7	54
			Total	344

Compliance Criterion 8. Laboratory support.

The ability to secure adequate access to laboratory support as appropriate**.**

There are two laboratory facilities in UHBW – at the Bristol Royal Infirmary (BRI) and at Weston General Hospital (WGH). Additional facilities are contracted to 'Severn Pathology Service' based at Southmead Hospital at the North Bristol NHS Trust who have their own accrediting process for these laboratories.

The Weston General Hospital is an "Essential Services Laboratory", is accredited to UKAS ISO 15189:2012 standards. The Bristol Royal Infirmary Essential Services Laboratory is currently working towards extension to scope and accreditation to new UKAS ISO 15189:2022. Appropriate policies and procedures and governance are in place at both sites and managed through the services.

Point of Care Testing (POCT) / near patient testing is used in numerous locations at UHBW for different requirements including blood gas analysis, blood glucose and ketone measurement, SARS-CoV-2, full blood count and coagulation. This is governed by the POCT Committee, chaired by the POCT Clinical Lead, who is the Principle Clinical Scientist for Biochemistry with contribution from Haematology, Microbiology, Divisional and IPC input. The committee reports to an overarching Medical Devices Management Group (MDMG) chaired by the Director of Medical Physics & Bioengineering. The laboratory provides support of external quality assurance, method technical validation and clinical advice and supports the MEMO team with provisioning of user access for devices where formal training is in place.

Compliance Criterion 9. Policies.

That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

- The IPC are responsible for the development and updating of Trust-wide infection prevention and control policies which are ratified through the ICG.
- These policies and guidance should be accessible to all staff as guidance of clinical care.

The NHSE National IPC manual is now adopted as the underpinning IPC document/ policy for the organisation. Part of this process has been an assurance exercise so that IPC policies fulfil the mandatory requirements within IPC Code of Practice. This means they are in date, available, current, and accessible for UHBW staff.

The IPC policies and guidance have all been reviewed and updated in collaboration with North Bristol NHS Trust and Sirona Healthcare. The intention was to align practice and minimise duplication within the Integrated

Care System (ICS). The IPC policy governance framework has been consolidated into a single document with an overarching statement that underpins the governance arrangements of all other IPC documents in the approach. The project is ongoing. There are now a series of aligned clinical guidelines for different infections/ conditions that are available in the same format providing concise advice for staff.

The platform used for managing policy documents in UHBW was changed in 2023 to 'MyStaff app' as the repository for all polices and other clinical guidance documents that should be available to staff. MyStaff is not exclusive to IPC related documents. Documents, following internal authorisation are published in the app and can then be accessed via internal intranet website by all staff. 'MyStaff' is an ongoing development as the platform is continuing to be refined.

All new or amended Trust wide IPC policies are approved through ICG before they are published on the 'MyStaff' app.

IPC Standard Operating Procedures or guidelines may be developed by the IPC team or by clinical Divisions with input from the team. These are held within Divisions but will have been through the Trust's document approval route as described.

Compliance Criterion 10. Occupational health
10.1 Occupational Health Report
10.2 Staff vaccinations
10.3 Fit testing compliance report for PPE (FFP3 respirator masks)

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention, and control.

- Occupational Health Services in UHBW are formally contracted to Avon Occupational Health partnership who also provide services to other NHS providers such as NBT and Sirona. This includes providing the mandated vaccinations for all staff and aspects of health screening in the event of staff exposure to higher risk infections such as pulmonary tuberculosis or measles, to reduce onward transmission as far as possible.
- Contact tracing for staff following exposure to a known infection is provided in collaboration with the UHBW clinical team. Contact tracing for patients is managed by the IPC team.
- Training for 'face FIT' testing, to ensure the safe use of different makes of FFP3 masks, continues to be available with a dedicated Trust wide team. The performance is formally reported into the Trust Health and Safety Committee.

Staff Health - Occupational Health

Avon Occupational Health Partnership (APOHS) provides occupational health (OH) services across UHBW for our employees. Services and clinics are provided at Whitefriars and also at Weston General Hospital. Staff can also access services on site at North Bristol Trust if this is geographically of more benefit to them.

The Trust recognises the critical importance of maintaining staff health and protecting them from the risks associated with infection exposure.

Immunisations and vaccinations:

Vaccination programmes and screening for infectious diseases for staff with patient or specimen contact continues. There has been a project to restart the Bacillus Calmette–Guérin (BCG) vaccinations for healthcare workers. Staff should now be offered on risk assessment of their possible exposure to patients that may have active pulmonary tuberculosis (TB) e.g. staff working in respiratory and bronchoscopy. Staff with contact of high-risk patients such as maternity, oncology etc will also be targeted for the protection of the patients. A look back exercise highlight staff not already protected with a BCG as well as new staff being included in the programme going forwards. The planned date

for restarting this programme is May 2024. This is in line with the NICE guidance Overview | Tuberculosis | Guidance | NICE

The active recruitment of overseas staff from high-risk TB countries has meant a marked increase in the number of staff requiring screening for latent TB using an interferon-gamma release assay (IGRA) test. Referrals to the local NHS TB teams for treatment for latent TB has also had a marked increase in numbers.

Due to the low incidence of Varicella Zoster (chicken pox) in the same localities, there has also been an increase in the blood testing and vaccination for unprotected staff.

There has also been additional input from OH with the Measles Preparedness programme. Work was in conjunction with the Trust to support the vaccination programme to offer MMR vaccines to unprotected staff. Processes were also put in place to ensure prompt follow up if and when staff contact tracing is required.

The new Occupational Health I.T programme has allowed staff candidates to be contacted advising them of the recommendations for immunisation for their role. It also requests they send in their immunisation history. This assists with ensuring they are offered protected against infections such as measles and hepatitis B.

Recommended vaccinations for healthcare workers are reviewed regularly by NHS England. Pertussis boosters have been recommended for staff working with pregnant women in the last trimester. Those working with neonates or infants before they have received their 3 childhood pertussis vaccines are also encouraged to have a one-off booster dose if not had one within the last 5 years. Additional on-site vaccination visits to relevant work areas have been provided by OH.

Contact tracing:

There has been a substantial increase in the cases where contact tracing of staff has been required in the last year. There have been cases of Pertussis, pulmonary TB, mumps, varicella zoster, measles and cutaneous diphtheria.

Appropriate follow up has taken place of exposed staff. Actions including the offering of prophylaxis treatment and/or vaccination, swabbing and blood testing, guidance to managers if staff exclusion is required. Staff with lower levels of casual contact with cases have been contacted and sent warn and inform notifications i.e. what symptoms to watch out for and what to do if any develop.

Skin issues in healthcare workers

Staff experiencing any skin or mask related health problems, such a dermatitis have access to the Occupational Health Advice Line Monday – Friday office hours. These issues are prioritised to be dealt with as soon as possible. OH has the facility to refer staff assessment at the Dermatology department if normal interventions are not effective.

10.2 Staff Vaccination summary

Vaccination info for staff 2023/2024:

- In 2023/2024 the organisation delivered 7,460 influenza vaccinations to staff. An additional 105 staff declared they had received their influenza vaccination elsewhere. The SARS-CoV-2 vaccination hubs set up during the pandemic, in both Bristol and Weston, have continued delivering booster vaccinations as per the Joint Committee on Vaccination and Immunisation's (JCVI) guidelines. During the autumn booster phase, they vaccinated 6,596 healthcare workers. An additional 77 staff declared they had received their COVID vaccination elsewhere.

The 2023/2024 COVID-19 Booster and Seasonal Influenza Vaccination Programme commenced at UHBW in September 2023.

Vaccines administered in house & elsewhere Autumn 2023	Total in cohort	Flu uptake	Flu %	COVID uptake	COVID %
All Staff groups	15,722	7,567	48.13%	6,673	42.44%

The Vaccination Hub team continued to develop their portfolio, working in partnership with the BNSSG Vaccination Programme and supporting Occupational Health. In addition to the core service of staff seasonal influenza and

COVID-19 vaccinations, the team has provided support to other staff vaccination campaigns including MMR and has continued to work closely with the antenatal team to deliver perinatal vaccinations. The programme team's focus is now on planning for the 24/25 seasonal vaccinations beginning in the autumn.

SARS-CoV-2 (COVID-19) vaccinations

Vaccination hubs were set up in both Bristol and Weston, vaccinating seven days per week providing seasonal influenza and COVID boosters as required to both staff, and defined patient cohorts including maternity.

10.2 Fit testing summary 2023-2024

When managing specific infections additional transmission-based precautions may be required, such as filtering face mask protection (FFP3) masks or respirators. For FFP3 masks it is required that each individual staff must have a tight-fitting mask which is tested to ensure there is an adequate seal to protect them. This is 'fit testing'.

Between April 2023 and the end of March 2024 the total number of staff with a valid Fit test increased from 1483 to 2124. This was in part due to the focus on Fit testing as part of Measles preparedness which resulted in large numbers of staff coming forward for testing.

Over the last year we have had to provide a 'rapid response' to approximately 4 clinical areas where a patient required staff to wear respiratory protection, but the department had low numbers of staff tested, to keep staff safe. The Fit testing team generally provide scheduled appointment attendance but have responded to different peaks and troughs in demand that we have been experiencing, such during measles preparedness in 2023/24.

Local testing for both GICU / CICU (General and Cardiac intensive care units) every couple of months to ensure that this high-risk group of staff are fit tested and to retest in the workplace when necessary. We also have attended both Adult ED and Heygroves Theatres but overall compliance in these areas remains low. With active engagement between the Trust Safety team and the clinical divisions to focus attention on delivering compliance by staff group the numbers with a valid Fit test are:

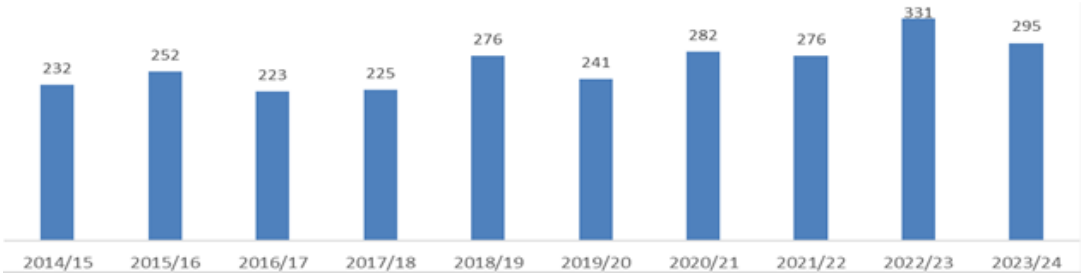
Professional group	Numbers updated / trained
Add Prof Scientific and Technical	65
Additional Clinical Services	419
Admin and Clerical	21
Allied Health Professionals	253
Estates and Ancillary	176
Healthcare Scientists	14
Medical and Dental	98
Nursing and Midwifery	1078

Each FIT test is only valid for 2 years and staff continue to be sent a recall notice weeks prior to their expiry. Work is ongoing to get results onto Kallidus as the results they are currently added to ESR as per Dept. of Health Guidance. Staff recalls can then be made via Kallidus which may increase the numbers reattending when required.

As the FIT testing team are currently distributing the two most commonly used Respirators and data is also sent to wards/departments requesting stock of Respirators. Staff fit testing compliance data is provided for clinical department with the reminder that staff must be Fit tested and can only wear a Respirator that they have been assessed to use.

10.3 – Sharps Safety and Sharps injuries

Annual comparison of clinical sharps incidents



With the implementation of the 'Sharps in Healthcare' Regulations in 2013 safer sharps devices are the norm in practice in most clinical areas. Where this is not the case and non-safer devices are used, the reason and controls in place are documented on risk assessments undertaken at department level.

The total number of incidents in this subcategory decreased overall by 11% within this annual period.

45% of this category of incidents were recorded as 'near miss' or 'no-harm' incidents.

Three incidents involving clinical sharps injuries were reported under RIDDOR legislation to the HSE and were fully investigated to identify learning opportunities.

A 'safer hypodermic' was introduced across all trust sites within this annual period with training initially provided by the supplier and ongoing coverage within Clinical Skills training. A robust procurement procedure is in place to prevent non-safety clinical sharps devices being ordered without a risk assessment in place to justify why 'safer' options cannot be used and identify control measures in place.

Training for clinical sharps was introduced within junior doctors training with a view that it would remain a permanent feature.

A Clinical Sharps group meet quarterly to track progress overall with management of clinical sharps.

Infection Prevention and Control Plans and Ambitions

- Surgical Site Infection and the collaboration between the IPC team and clinical divisions continue to gain momentum. However, there is a need for a culture change within the surgeon group to enhance engagement and therefore improve patient outcomes.

- A review of the SSIS service is planned in July and August to streamline the approach across the organisation to focus maximum benefit around qualitty improvement in surgical site infection

- Further embed the streamlined post infection review process using the Patient Safety Incident Response Framework (PSIRF) methodology to understand and share new learning across UHBW.

- Progress work to further align UHBW IPC policies across the system and ensure MyStaff App reflects all current policies and guidelines to facilitate staff access to up-to-date information.

- Continue with regional and national engagement with the IPC agenda for UHBW in order to be a flagship organisation for IPC practice; encourage the team to be a voice in national, regional and local forums and conferences.

- Use the outcome data from the Audit Management and Tracking (AMaT) platform to further drill down on where IPC improvement is required and can be made. Use the skills of the IPC team data analyst to provide meaningful data to support IPC improvement in all clinical areas.

- Realise tangible improvements in rates of hospital onset healthcare associated (HOHA) MRSA bacteraemia and *Clostridioides difficile* infections following the work being delivered by the quality improvement groups relating to these infections.

References:

Department of Health and Social Care - Health and Social Care Act (2008) – Code of practice on the prevention and control of infections (Updated December 2022).
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

NHSE Infection Prevention and Control Manual for England(Version 2.9 updated February 2024)

NHS England » National infection prevention and control manual (NIPCM) for England

NHSE - Board Assurance Framework (Version 1.1 May 2023)
National-infection-prevention-and-control-board-assurance-framework.xlsx (live.com)
NHSE Infection Prevention and Control education framework (March 2023)

NHS England » Infection prevention and control education framework

NHSE Patient Safety Incident Response Framework (PSIRF)

NHS England » Patient Safety Incident Response Framework

NHSE Premises Assurance Model (2024)
NHS England » NHS Premises Assurance Model

Department of Health (2013) Health Building Note 00-09: Infection control in the built environment.
NHS England » (HBN 00-09) Infection control in the built environment

NHS England (2021) Decontamination of linen for health and social care
NHS England » (HTM 01-04) Decontamination of linen for health and social care

NHS England (2021) Specialised ventilation for healthcare buildings (HTM 03-01)
NHS England » (HTM 03-01) Specialised ventilation for healthcare buildings

NHS England (2021) Safe water in healthcare premises (HTM 04-01)
NHS England » (HTM 04-01) Safe water in healthcare premises

NHS England (2021) Management and disposal of healthcare waste (HTM 07-01)
https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01

Department of Health and Social Care - UK 5-year action plan for antimicrobial resistance 2019 to 2024
UK 5-year action plan for antimicrobial resistance 2019 to 2024 - GOV.UK (www.gov.uk)

National Institute for Health and Care Excellence (NICE) Quality Standard 113 (2016) Healthcare-associated infections, NICE
https://www.nice.org.uk/guidance/qs113

National Institute for Health and Care Excellence (NICE) Guidance NG15 (2015) Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, NICE
https://www.nice.org.uk/guidance/ng15

National Institute for Health and Care Excellence (NICE) Guidance NG125 (2019)
Surgical Site Infection; prevention and treatment.
Overview | Surgical site infections: prevention and treatment | Guidance | NICE

National Standards of Healthcare Cleanliness (2021)
https://www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness-2021/

NHSE Guidance COVID-19: information and advice for healthcare professionals (updated March 2023)
Coronavirus » Revised UK infection prevention and control guidance (england.nhs.uk)

World Health Organisation. AWaRe Classification Antibiotics (2019)
https://www.who.int/news/item/01-10-2019-who-releases-the-2019-aware-classification-antibiotics

World Health Organisation. AWaRe classification (2021)
https://www.who.int/publications/i/item/2021-aware-classification

NHS Measles guidance for all healthcare settings (including hospitals) (updated March 2024)
NHS England » Measles guidance for primary, community care, emergency departments and hospital

UKHSA Guidance; Occupational Pertussis vaccination for Healthcare workers. (update June 2024)
Occupational pertussis vaccination of healthcare workers - GOV.UK (www.gov.uk)

Many thanks to all contributing authors from various departments who have helped to create the 2023/24 Annual report

Abbreviation table

AER - Automated Endoscope Reprocessor
AMaT - Audit Management and Tracking system
AMR – Antimicrobial Resistance
AMS – Antimicrobial Stewardship
ANTT – Aseptic non- touch Technique
AOHPS – Avon Occupational Health Partnership
ARK – Antibiotic Review Kit
ASG – Antimicrobial Steering Group
BBV – Blood Borne Viruses
BSI – Blood Stream Infection
BDH – Bristol Dental Hospital
BHI – Bristol Heart Institute
BNSSG – Bristol, North Somerset and South Gloucestershire
BRCH – Bristol Royal Children's Hospital
BRI – Bristol Royal Infirmary
C.diff - *Clostridioides difficile*
CPE – Carbapenemase producing enterobacterales
CVC – Central Venous Catheter (vascular device)
COHA – Community Onset Healthcare Associated
CQC – Care Quality Commission
CQG – Clinical Quality Group
CQUIN – Commission for Quality and Innovation
DIPC – Director Infection Prevention and Control
EPMA – Electronic prescribing and Medication Administration
EPP – Exposure Prone Procedures
FR(1-6) – Functional Risk category
GNBSI – Gram-Negative Bloodstream Infection
HCAI – Healthcare Associated Infections
HOHA – Hospital Onset-Healthcare Associated
HR – Human Resources
HSE - Health and Safety Executive
HTM – Health Technical Memorandum
ICB – Integrated Care Board
ICU – intensive Care Unit
ICS – Integrated Care System
ICG – Infection Control Group
IE – Infective Endocarditis
IPC – Information Prevention and Control
IVOS – Intravenous – to – Oral – Switch
JCVi – Joint Committee on Vaccination and immunisation
KPI – Key Performance Indicator
MDT – Multi Disciplinary Team
MEMO – Medical Equipment Management Organisation
MMR – Measles, Mumps, Rubella, (vaccination)
MRSA – Meticillin – Resistant *Staphylococcus aureus*
MSSA – Meticillin Sensitive *Staphylococcus aureus*
NBT – North Bristol Trust
NHS - National Health Service
NHSE – NHS England
t
PLACE – Patient Led Assessment
PPE – Personal Protective Equipment
PVC – Peripheral Venous Cannula
QOC-Quality Outcomes Committee
SBCH – South Bristol Community Hospital
SOP – Standard Operating Procedure
SSI – Surgical Site Infection
SSIS – Surgical Site Infection Surveillance
UHBW – University Hospitals Bristol and Weston
UKAS – United Kingdom Accreditation Service (for laboratory medicine)
UTI – Urinary Tract Infection
VIP - Visual Infusion Phlebitis
WGH – Weston General Hospital
WHO – World Health Organisation