



North Tees and Hartlepool
NHS Foundation Trust

Director of Infection Prevention and Control Report 2019-2020



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Part 1: Executive Summary

- 1.1** 2019/20 saw a number of achievements in the reduction of healthcare associated infection within the Trust, however the year ending with the early stages of a global pandemic brought significant challenges to the NHS and the organisation which cannot be underestimated.
- 1.2** Our successes were in MRSA, Klebsiella and Pseudomonas bacteraemia cases and C difficile infections. We also saw a reduction in the number of outbreaks due to diarrhoea and vomiting which can have a detrimental impact both on patients and the business of the Trust
- 1.3** This report describes the activities we have undertaken to improve and sustain patient, visitor and staff safety across all of our healthcare settings, much of which has been achieved in conjunction with partner organisations.



Julie Lane

Chief Nurse/Director of Infection Prevention and Control

Date: May 2020

Part 2: Infection prevention and control arrangements

2.1 The prevention and control of infection is a top priority for the public and our patients. Avoidable infections can be devastating for patients and their families and therefore North Tees and Hartlepool NHS Foundation Trust continues to place this patient safety issue as a priority for action and improvement.

2.2 The Infection Prevention and Control Team (IPCT) provide a service to trust staff across all settings and also support care homes, local hospices, GP practices and an independent hospital through service level agreements and local agreements. We have an experienced team of Infection Prevention and Control (IPC) nurses supported by clerical and surveillance team members, working in close collaboration with Consultant Microbiologists, biomedical scientists the antimicrobial pharmacist and clinical teams across the Trust.

2.3 The Assistant Director of Nursing and Infection Prevention & Control is responsible for leading the IPCT and for providing support to the Director of Infection Prevention and Control (DIPC) who is the Chief Nurse and Director of Quality & Patient Safety.

2.4 In addition to the Assistant Director the following nurses are employed within the IPCT to cover the service needs of the settings described above.

Infection Prevention Matrons	1.8 WTE
Infection Prevention and Control Nurses	3.4 WTE

2.5 The service is supported by 1.5 WTE clerical and surveillance staff who also provide support to the tissue viability and chaplaincy team.

2.6 The Consultant Medical Microbiologists play an active role in infection prevention and control with one of them taking on the role of Infection Control Doctor and another being the Trust Antibiotic Lead. Out of hours IPC advice is provided by the on call microbiologist, which is a shared arrangement between two local NHS trusts.

2.7 The DIPC provides a report to each Board of Directors via an Integrated Quality report. A performance report is provided to the monthly Patient Safety and Quality Standards Committee, which is a sub Committee of the Board and is chaired by a Non-Executive director.

2.8 The reporting and governance structure for infection prevention and control is shown in Fig 1.

Fig 1. Reporting and accountability for Infection Prevention and Control



2.9 The *Health and Social Care Act 2008, Code of Practice on prevention and control of infection and related guidance (2015)* guides the activities carried out by the Infection Prevention and Control Team (IPCT) and is the basis of our annual programme. A self-assessment to measure adherence to the requirements of the Code of Practice is carried out annually and reported to the Infection Control Committee.

Part 3: Healthcare Associated Infection Surveillance and

3.1 Mandatory Surveillance

3.1.1 The Trust continues to report on the infections required by the mandatory surveillance programme facilitated by Public Health England:

- Clostridioides difficile infection (CDI)
- Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infections (bacteraemia)
- Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia
- Escherichia coli (E.coli)
- Klebsiella species (Kleb sp) bacteraemia
- Pseudomonas aeruginosa (Ps a) bacteraemia

3.1.2 National criteria are applied to establish whether cases of these infections are attributable to the Trust (hospital onset or healthcare associated).

3.1.3 For bacteraemia cases when the sample is taken on the day of admission or the following day it is considered to be community onset but samples taken after that time are considered to be hospital onset.

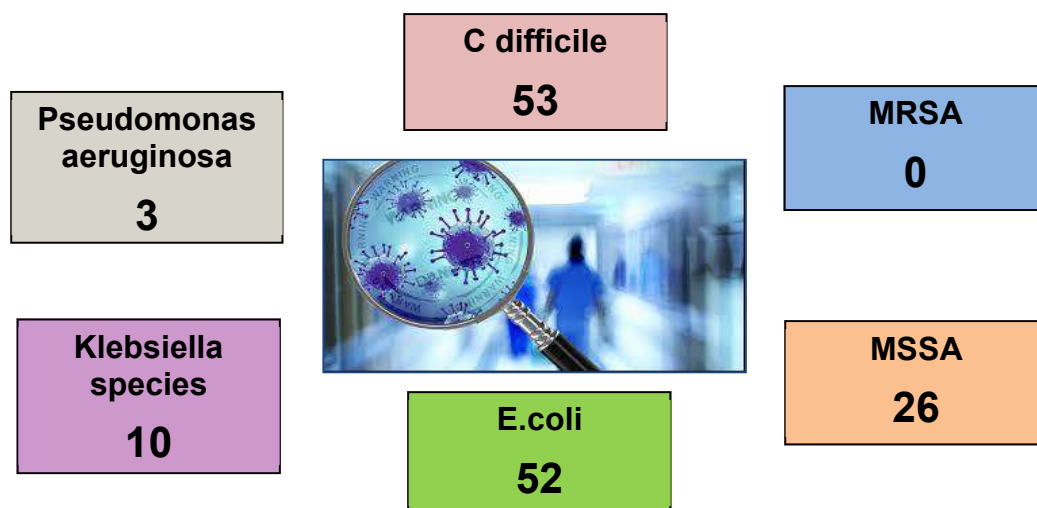
3.1.4 For CDI the thresholds for attribution changed from 1 April 2019 meaning there are now four categories of infection:-

- Hospital onset healthcare associated: cases that are detected in hospital three or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the trust reporting the case in the previous 4 weeks.
- Community onset indeterminate association: cases that occur in the community (or within 2 days of admission) when the individual has been an in-patient in the trust reporting the case in the previous 12 weeks but not in the most recent 4 weeks.
- Community onset community associated: cases that occur in the community (or within 2 days of admission) when the individual has not been an in-patient in the trust reporting the case in the previous 12 weeks.

The first two categories count as attributed to the trust reporting the case (healthcare associated).

3.1.5 National reduction objectives are set for all trusts. In 2019-20 the Trust had a CDI reduction objective of no more than 56 healthcare associated cases, and a zero tolerance of avoidable infections approach is adopted for MRSA bacteraemia. The Trust sets internal targets based on the performance of the previous year for the other organisms which in 2019-20 was a 10% reduction for each infection.

Fig 2 Total number of hospital onset infections during 2019-2020.



3.2 Clostridioides difficile infection (CDI)

3.2.1 Clostridioides difficile is a bacterium that is found in the gut of around 3% of healthy adults. It seldom causes a problem as it is kept under control by the normal bacteria of the intestine. However certain antibiotics can disturb the bacteria of the gut and Clostridium difficile can then multiply and produce toxins which cause symptoms such as diarrhoea.

3.2.2 During 2019-20 the Trust achieved the CDI target having reported **53** Trust healthcare associated cases against a trajectory of 56 cases. In addition to achieving the required objective we also achieved a 13% reduction when comparing the new criteria to the previous year when 61 cases would have been reported

3.2.3 We continue to focus our efforts on actions to control and reduce opportunity for infections to spread, whether we treat people in our hospitals, community premises or in their own homes. We have maintained a consistent approach to cleanliness across all areas of our environment. The commitment to environmental cleanliness is achieved in partnership with North Tees and Hartlepool Solutions LLP who provide our decontamination services. The focus on antimicrobial stewardship has continued and the importance of carrying out the fundamental aspects of good infection prevention practice is the basis of all of our work.

3.2.4 Actions to reduce the risk of CDI form part of the overall healthcare associated infection (HCAI) improvement plan which has been developed in conjunction with clinical staff and reviewed monthly. Progress against the plan is reported to the HCAI Operational Group and Infection Control Committee and the document has been regularly shared with commissioners.

Fig 3 Clostridium difficile cases 2018-20

Trust Clostridium difficile cases 2018-20

	Hospital onset	Community onset
2018-19	61	54
2019-20	53	39

Data obtained from Healthcare Associated Infections (HCAI) data capture system

3.3 Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia

3.3.1 Staphylococcus aureus is a bacterium commonly found on human skin which can cause infection if there is an opportunity for the bacteria to enter the body. In serious cases it can cause blood stream infection. MRSA is a strain of these bacteria that is resistant to many antibiotics, making it more difficult to treat

3.3.2 Many patients carry MRSA on their skin and this is called colonisation. It is important that we screen some groups of high risk patients when they come into hospital so that we know if they are carrying MRSA. Screening involves a simple skin swab. If positive, we can provide special skin wash and nasal cream that helps to get rid of MRSA. This measure reduces the risk of an infection developing.

3.3.3 In 2019-20 our organisation reported **zero** hospital onset MRSA bloodstream infection, which means we have not had a hospital onset for 25 months at the end of March 2020. This is a significant achievement. Three community onset cases were reported in 2019-20 which is an

increase on the previous year.

Fig 4 MRSA bacteraemia cases 2013-20

	Hospital onset	Community onset
2013-14	0	4
2014-15	1	2
2015-16	2	3
2016-17	1	2
2017-18	4	2
2018-19	0	0
2019-20	0	3

Data from Healthcare Associated Infections (HCAI) data capture system

3.4 Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia

3.4.1 MSSA is a strain of Staphylococcus Aureus that can be effectively treated with many antibiotics. It can cause infection if there is an opportunity for the bacteria to enter the body and in serious cases it can cause blood stream infection.

3.4.2 In 2019-20 we reported **26** cases of Trust attributed MSSA bacteraemia. Unfortunately this is an increase of 5 cases on the previous year. Each case is subject to a root cause analysis and the analysis of these investigations has shown that there are no apparent trends in terms of linked cases or frequently seen sources of infection. In many cases the source has been a chest or skin infection which would have been difficult to prevent and a number of these cases classed as hospital onset are as a result of infection already present when the patient was admitted.

3.4.3 However, the Trust recognises that further improvement can be achieved in this infection and increased emphasis on clinical practices continues to be a focus of our work to reduce the number of MSSA bacteraemia. A reduction in community onset cases was seen this year

Fig 5 MSSA bacteraemia cases 2013-20

	Hospital onset	Community onset
2013-14	13	30
2014-15	18	41
2015-16	24	64
2016-17	21	57
2017-18	25	71
2018-19	21	93
2019-20	26	75

Data obtained from Healthcare Associated Infections (HCAI) data capture system

3.5 E coli bacteraemia

3.5.1 Escherichia coli is a very common bacterium found in the human gut which can cause serious infections such as blood poisoning.

3.5.2 The numbers of E coli bacteraemia reported by the Trust for the year are shown in the table below. As the majority of these cases are those that are identified within the first 48 hours of hospital admission work is required across all healthcare settings to achieve improvements. In 2019-20 we saw an increase of 13 instances of hospital onset cases which is disappointing given previous improvements made.

3.5.3 Root cause analysis is completed for all cases deemed to have been hospital onset and action plans are developed where issues are identified. In many cases these bloodstream infections are related to urine infections and are thought to be not preventable, with only a small number of cases being in patients with a urinary catheter where there may be potential for improved practices. However we continue to work with staff to reduce the unnecessary use of catheters and encourage prompt removal to reduce risk of catheter associated infections. Some of these bacteraemia relate to infections present on admission to hospital.

Fig 6 E coli bacteraemia cases 2013-20

	Hospital onset	Community onset
2013-14	22	169
2014-15	28	176
2015-16	44	224
2016-17	50	267
2017-18	43	304
2018-19	39	317
2019-20	52	279

Data obtained from Healthcare Associated Infections (HCAI) data capture system

3.6 Klebsiella species bacteraemia

3.6.1 Klebsiella species are a type of bacteria that are found everywhere in the environment and also in the human gut, where they do not usually cause disease. These bacteria can cause pneumonia, bloodstream infections, wound and surgical site infections and can be associated with invasive procedures such as venous cannulation or urinary catheterisation

3.6.2 In 2019-20 the Trust reported **10** Klebsiella species bloodstream infections. This is a 50% improvement on the cases reported in the previous year. There is no reduction target associated with this infection currently but the Trust aims for a 10% reduction each year. Enhanced data collection is being carried out on each case to understand if there are any common themes to the

infections. This will allow us to target our efforts effectively to reduce the number of cases further in future.

Fig 7 *Klebsiella* bacteraemia cases 2016-20

	Hospital onset	Community onset
2016-17	22	49
2017-18	29	42
2018-19	20	40
2019-20	10	49

3.7 Pseudomonas bacteraemia

3.7.1 *Pseudomonas aeruginosa* is a bacterium often found in soil and ground water. It rarely affects healthy individuals but can cause a wide range of infections particularly in those with a weakened immune system. *Pseudomonas aeruginosa* is resistant to many commonly used antibiotics

3.7.2 In 2019-20 the Trust reported **3** trust attributed cases of *Pseudomonas aeruginosa* bloodstream infections. This represents a 66% improvement in this infection. As with *Klebsiella* there is no national reduction target assigned and enhanced data collection is underway to better understand the sources of these infections but it is difficult to identify any trends with such small numbers.

Fig 8 *Pseudomonas* bacteraemia cases 2016-20

	Hospital onset	Community onset
2016-17	9	9
2017-18	5	19
2018-19	9	20
2019-20	3	17

3.8 Glycopeptide resistant Enterococcus (GRE)

3.8.1 Enterococci are normally found in the gut and are part of the normal human gut flora. Although a common cause of urinary tract infections they can also cause serious infections such as endocarditis and can be a particular risk to immunocompromised patients.

3.8.2 The number of bacteraemia caused by GRE is low and cases are sporadic however the Trust has seen an increase in the number of other, non-blood culture specimens, being positive for this organism due to an increase in screening for other infections and the introduction of a sensitive test medium. In 2019-20 we reported **1** GRE bacteraemia cases which is an improvement on 2 cases reported in the previous year. This one case was not hospital onset.

3.9 Surgical Site Infection (SSI)

3.9.1 It is a mandatory requirement to conduct surveillance of orthopaedic surgical site infections for a minimum of one quarter in each reporting year, using the Public Health England Surgical Site Surveillance Service. The data collected is forwarded to the service for analysis and reporting.

3.9.2 We participate in continuous surveillance and collect data on several procedure groups. In 2019-20 **two** surgical site infections were identified as part of this surveillance. Both cases have been followed up and reviewed within the orthopaedic team so that any learning can be identified

3.9.3 In 2019 we also participated in a surgical site data collection for the Getting It Right First Time (GIRFT) programme. Data was collected over 6 months across a number of specialities. Over 8,000 applicable procedures were checked and 753 potential cases for review identified. Each of these cases was reviewed and the numbers of surgical site infections were identified as below

Fig 9 Surgical Site Infections (GIRFT) 2019

Type of surgery	No of cases included	No of SSI identified	Trust SSI rate	National SSI rate
Breast	85	1	1.6%	4.8%
General Surgery/Urology	226	8	3.7%	4%
Urology		0	0.0%	1.8%
Orthopaedics		2	0.5%	0.7%
Spinal	442	0	0.0%	1.1%

3.9.4 Further information on specific procedures was also provided in the report from GIRFT and the Trust achieved lower than the national SSI rate for 12 procedures out of 15 for which data was submitted. This information will be presented to the Infection Control Committee and will be used as the basis for discussion to identify pathways to further reduce SSIs

3.10 Influenza

3.10.1 In 2019-20 the Trust experienced a lower number of seasonal influenza cases than were expected. A small number of patients were treated in the critical care unit. On site and point of care testing was carried out to identify positive patients in order to facilitate prompt isolation and control measures.

3.10.2 All staff are encouraged to receive the seasonal influenza vaccination as a means of protecting themselves, their families and our patients. In 2019-20 we saw the percentage of front line staff who received the vaccine increase to **80%** thanks to a campaign led by the occupational health department and the use of peer immunisers to support the programme.



3.11 Voluntary Surveillance

3.11.1 In addition to the mandatory surveillance, the infection prevention and control team conducts voluntary surveillance to monitor infections in the Trust. This includes:

- Newly identified MRSA colonisation or infection (samples other than blood cultures)
- ‘Alert’ organism surveillance – results with a potential infection control significance
- Targeted surveillance – infections seen in specific specialities
- Voluntary reporting of norovirus outbreaks
- Central line related bloodstream infections (Matching Michigan)

3.12 Hand Hygiene

3.12.1 Monthly hand hygiene audits are carried out across the Trust. These are a combination of independent unannounced observations, self-assessment and patient/carer feedback. The results are provided to clinical areas in a monthly RAG report and form part of a safety and quality dashboard where compliance by staff group and ward can be displayed. The overall trust results for the year are displayed below. The Trust target for achievement is 95% and this has been achieved or exceeded every month with particularly good results in the last 4 months of the year. There may have been an impact on hand hygiene compliance from the COVID-19 pandemic.

Fig 8 Trust wide hand hygiene compliance 2019-20

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
%	96	97	98	98	98	98	97	98	99	99	99	100

3.12.2 The audit results are discussed bimonthly at the HCAI Operational Group Meeting where areas with the lowest scores are invited to present their improvement plans, and quarterly at the Infection Control Committee, where they form part of directorate reports.

3.12.3 We have a network of hand hygiene champions across the Trust with volunteers from all types of staff. These champions play a role in promoting good hand hygiene practice and challenging poor practice if they observe it. Each month they are given a challenge, which could be as simple as talking about hand hygiene at ward meetings or as practical as offering gel to those who are not carrying it.

3.12.4 Each year the Trust participates in events to raise awareness of the importance of hand hygiene for staff and patients, including World Hand Hygiene day which is on 5th May. In 2019 the campaign was 'Clean Care for all – it's in your hands' and focused on correct glove use and hand hygiene before and after glove use.

3.13 Outbreaks

3.13.1 Each year there are a number of outbreaks which affect patients and staff both in hospital and the community. In 2019-20 we had **zero** confirmed outbreaks of diarrhoea/vomiting and **8** alert situations where a full outbreak is not declared but a number of patients may be monitored for symptoms. This reduction was reflected in a lower number of outbreaks reported in local care homes.

3.13.2 An outbreak can have a wider effect than the ward where the affected patients are situated. When a ward is closed it reduces the number of beds available to admit new patients into and can also delay discharges of patients waiting to go into care homes

3.13.3 Increased cleaning is implemented during an outbreak or an alert situation and the ward is 'deep' cleaned before re-opening once the outbreak has been declared closed. This is a very important part of outbreak management and is instrumental in ensuring that there is no recurrence of the outbreak in the same setting.



Part 4: Policies and Audit

4.1 Policies

4.1.1 The Trust has a programme for review and revision of core infection prevention and control policies as required by the Health and Social Care Act 2008 Code of Practice (2015). All policies are available to staff on the Trust intranet site and many are also available to the public on the main internet web page.

4.1.2 A schedule for review and revision of policies forms part of the annual IPC programme. The status of policies can be seen below:

Policy Code	Policy Title	Status
IC1	Outbreak Policy	For review January 2023
IC2	Hand Hygiene Policy	For review June 2022
IC3	Infection Control Policy	For review May 2022
IC5	CJD Policy	For review October 2022
IC6	MRSA Policy	For review May 2022
IC7	Management of Viral Haemorrhagic Fevers incl Ebola Policy	For review Sept 2021
IC11	Tuberculosis Policy	For review May 2021
IC12	Local Decontamination of Medical Equipment Policy	For review June 2022
IC14	Clinical Specimen Policy	For review October 2020
IC15	Patient Isolation Policy	For review June 2022
IC17	Standard Precautions Policy	For review February 2021
IC18	Peripheral Cannulation Policy	For review June 2020
IC19	Clostridium difficile Policy	For review April 2021
IC 20	MRSA screening Policy	For review March 2021
IC21	Theatre Policy	For review September 2019
IC22	Management of Patients with Ectoparasitic Infestation Policy	For review July 2022
IC23	Infection Prevention and Control Surveillance Policy	Under review
IC24	Management and Control of CPE Policy	For review August 2020
IC25	Animals in Clinical Areas	New policy
C56	Antibiotic Strategy	For review April 2021

4.2 Audit programme

4.2.1 An annual programme of audit is agreed as part of the annual IPC programme. The audit programme is a combination of policy audits and general IPC audits carried out as part of an unannounced visit schedule. Audit results are collated and fed back to the clinical area and action plans are requested as appropriate. The audits are presented to the Infection Control Committee and an annual report is produced, summarising all of the audit activity and high level findings.

4.2.2 In summary the audit findings for 2019-20 are as below

Audit	Overall Trust compliance 2019-20	Overall Trust compliance 2018-19
Hand Hygiene	95%	91%
Standard Precautions	78%	88%
Environmental	91%	84%
Uniform	98%	97%
Overall Compliance	90%	90%

Isolation policy		Peripheral Cannulation Policy	
Overall Trust compliance 2019 20	Overall Trust compliance 2018 19	Overall Trust compliance 2019 20	Overall Trust compliance 2018 19
76%	80%	81%	91%
MRSA Policy		Clostridium difficile policy	
Overall Trust compliance 2019 20	Overall Trust compliance 2018 19	Overall Trust compliance 2019 20	Overall Trust compliance 2018 19
60%	60%	87%	91%

4.2.3 The actions identified from audits are added to an action tracker document with deadlines which are followed up and escalated if not met.

Part 5: Training

5.1 A blended approach to training has been applied in the Trust with a mixture of face to face and electronic learning or workbooks being available to staff. The IPC team attend a number of directorate training days to provide training and an opportunity for staff to ask questions.

5.2 We continue to utilize training within a streamlining programme, which means that training is portable between a number of organisations with a standard programme being agreed and delivered, has continued for all Trust staff. Level 1 training for non-clinical staff is required 3 yearly and is available in a number of formats. Level 2 training for clinical staff is required annually, and the existing workbook has been updated to reflect the national programme. This is also able to be used in facilitated sessions.

5.3 In addition to the mandatory training programme the IPC team also facilitate a number of different training sessions including:

- Decontamination of patient equipment
- Clostridium difficile infection
- Error room session where staff have to spot mistakes in a clinical room
- Infection specific sessions delivered in response to an incident or increase in infection such as CPE or COVID-19 for example

Part 6: Antimicrobial Stewardship

6.1 The antimicrobial audit programme continues with audit data uploaded to an online spreadsheet to aid with data collection and feedback reports to clinical areas.

6.2 We have a multidisciplinary approach to improving and expanding our outpatient antibiotic therapy (OPAT) services which allows us to treat more patients at home thus reducing bed pressures and facilitating patient flow, reducing the use of broad spectrum antibiotics, increasing cost efficiency and improving patient satisfaction and experience.

6.3 Our empirical antibiotic guidelines have been reviewed, with a view to reducing use of carbapenems and will be published once approved.

6.4 There is ongoing work with the Electronic patient record (EPR) team for Trakcare in order to improve stewardship by using software design of decision aids, incorporation of empirical guidelines and review reminders.

6.5 The Trust is represented at a regional Antimicrobial Stewardship work stream committee which aims to employ a regional approach to stewardship.

6.6 Antibiotic ward rounds take place daily in critical care and it is hoped that additional wards can be added with the recruitment of new consultant microbiologists. Weekly ward rounds also take place in Haematology and Orthopaedics as well as weekly Multidisciplinary Team review of CDI patients

6.7 The Trust again participated in European Antibiotic Awareness day in November 2019 where staff were encouraged to sign up as antibiotic guardians

Part 7: Decontamination of the environment and equipment

7.1 Decontamination is a process which removes or destroys infectious agents from furniture or medical equipment. Cleaning is always the first step in this process, which can then be followed by disinfection or sterilisation depending on the circumstances in which the equipment is used.

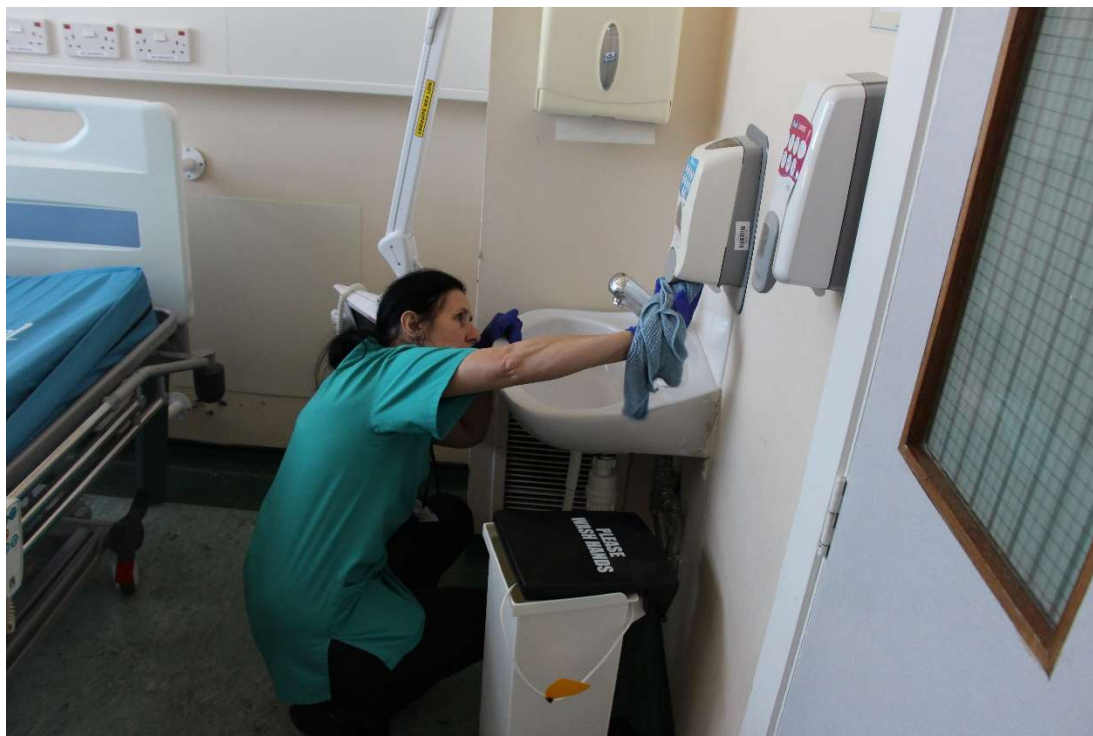
7.2 The sterile services department is responsible for reprocessing reusable medical devices. All processes are fully validated and compliant to national standards HTM 01-01 and ISO 13485:2016 an internally and externally audited process. Disposable items are used wherever this is possible and efficient.

7.3 Decontamination audits are carried out annually in departments where local decontamination takes place and the IPC team are part of the audit team. The results are presented to the Decontamination Group which reports into the Infection Control Committee.

7.4 The endoscope decontamination facilities on both sites are validated and compliant with national requirements HTM 01-06 and compliant to ISO 13485:2016. An Authorising Engineer (Decontamination) has validated the annual reports. All endoscopy reprocessing is provided by Decontamination services staff, trained and compliant in line with ISO 13485:2016.

7.5 The provision of cleaning services in hospital and external premises was provided in 2019-20 by a combination of LLP staff and external contractors who cover some community premises. Performance management systems are in place with monitoring staff carrying out checks of the environment and equipment in line with national standards of cleanliness and reporting via the HCAI Operational Group.

7.6 In addition to routine cleaning the Trust provides an enhanced cleaning service via the LLP with a response team and hygienist team responsible for additional cleaning of frequently touched items, deep cleaning, fogging with hydrogen peroxide and use of ultra violet light plus a mattress decontamination service



Part 8: Other significant issues

8.1 In January 2020 it was announced that a novel coronavirus was the cause of an outbreak in China which has since been designated a global pandemic. Coronaviruses are a large family of viruses with some causing less severe disease such as the common cold and others causing more severe disease such as Middle Eastern respiratory syndrome (MERS) and Severe Acute respiratory syndrome (SARS). This current virus is referred to as SARS CoV-2 and the associated disease is COVID-19.

8.2 The development of the pandemic led to a rapidly changing and evolving group of guidelines which were challenging to implement, and has impacted on the delivery of normal healthcare. Along with other organisations the trust has had pressures on obtaining supplies but has worked with local and national organisations and benefitted from the generosity of donors to ensure our staff are protected and can deliver safe care to our patients.

8.3 The infection prevention and control team have worked with community nursing teams, local authorities and care home providers to support care workers in difficult circumstances and the relationships built during this pandemic will continue in the future in the spirit of collaborative working.

Part 9: Conclusion

9.1 Eliminating avoidable healthcare associated infection has remained a top priority for our staff and patients. In response a robust annual programme has again been implemented.

However, a number of risks and challenges exist. In particular, these relate antimicrobial stewardship, the availability of sufficient single rooms to allow Trust policy to be fully implemented and the emergence of new infections such as COVID-19 which have placed such pressure on all NHS and care organisations. Our staff have risen to the challenge in a way that they should be proud of and have maintained high standards of care despite the difficult circumstances.

9.2 Where risks are identified these have been added to the Trust risk register and are monitored and managed accordingly and reported into the Infection Control Committee.

9.3 We continuously strive to improve practice and keep our patients as safe as possible and protected from avoidable infections. We will continue to work with partner organisations to take a whole systems approach to infection prevention across all patient pathways. We take great pride in having made reduction in four out of the six infections in the mandatory reporting programme and will continue to work towards further improvements in the coming year.

