East Suffolk and North Essex NHS Foundation Trust

INFECTION PREVENTION AND CONTROL ANNUAL REPORT APRIL 2023 - MARCH 2024

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Contents

Executive summary - overview of infection prevention and control (IP&C) activities in the trust 3

Criterion 1: Systems to manage and monitor the prevention and control of infection. 4

Organisational structure and reporting line to the Trust Board 4

Infection Prevention and Control Team 4

Infection Prevention and Control Team Activities 5

Infection Control Committee (ICC) 5

Infection prevention and control board assurance framework (NHSE 2023) 6

Threshold 7

The DH began mandatory surveillance of MRSAb in April 2004. No formal threshold was set for the current year although a full Post Infection Review (PIR) is carried out and cases are still required to be reported. The purpose of the PIR is to investigate how a case occurs and to identify future learning 7

3.2 Estates and Planning 18

3.4 Water Safety Management 20

4.0 Criterion 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance. 21

5.0 Criterion 4: 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. .. 21

6.0 Criterion 5: That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people. 22

7.0 Criterion 6: Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection. 23

7.3 IPC Audits 24

Criterion 7: The provision or ability to secure adequate isolation facilities. 25

Criterion 8: The ability to secure adequate access to laboratory support as appropriate. 25

Criterion 9: That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections. 26

Criterion 10: That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control. 26

IP&C programme for 2024/2025 27

Executive summary - overview of infection prevention and control (IP&C) activities in the trust

The annual report is a summary of the Trust's performance in relation to Infection Prevention and Control (IP&C) for April 2023 to March 2024. The information provided is evidence and assurance on the Trust's compliance with the Hygiene Code. It also includes information on incidents and actions undertaken to address these. This demonstrates that the Trust is providing a clean and safe environment ensuring infection prevention and control is everybody's business.

The following summary outlines the achievements and continued work against Trust set Thresholds from NHS England for 2023/24:

	ESNEFT threshold 2023/24	**ESNEFT performance 2023/24**
C.difficile	101	120
E.coli	113	162
Klebsiella spp.	36	54
Pseudomonas aeruginosa	19	33
MRSAb	N/A	7
MSSAb	N/A	61

Trust apportioned cases are allocated under the following criteria:

HOHA - Healthcare Onset Healthcare Associated - Sample taken 48 hours post admission
COHA – Community Onset Healthcare Associated – Patient has been an inpatient in the reporting within the last 28 days prior to sample being taken

In addition to surveillance organism the Trust has been challenged with outbreaks and increases in numbers throughout the year of Covid 19 and during winter months Influenza.

Key incidents have also required IPC input through this year including Decontamination incident, Group A streptococcus outbreak within community services and smaller outbreaks of organisms including C difficile, MRSA and Aspergillus.

Continued work to improve IPC standards and practice has been undertaken throughout the year, and includes the introduction of "snap shot" audits, target education and the implementation of an IPC dashboard.

Compliance with the Hygiene Code is underpinned by ten compliance criteria, this is monitored by the IPC committee (ICC), alongside the IPC Board Assurance Framework (BAF) (NHSE 2023). This ensures that the Trust continues to maintain and strengthen its compliance and has mitigation in place to manage the risks to compliance.

1. Introduction

Preventing infections is a key priority for the Trust. The objective and strategy for IP&C are based on the criteria within the Health & Social Care Act 2008 (H&SC Act) code of practice on the prevention and control of infections and related guidance (DoH 2015/22) ensuring compliance with the Hygiene Code (appendix 1). In addition, the Board Assurance Framework (BAF) (NHSE 2023) for IPC has been developed. Ten criteria and the Hierarchy of controls are reported against, with a cross reference of evidence and risks included

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

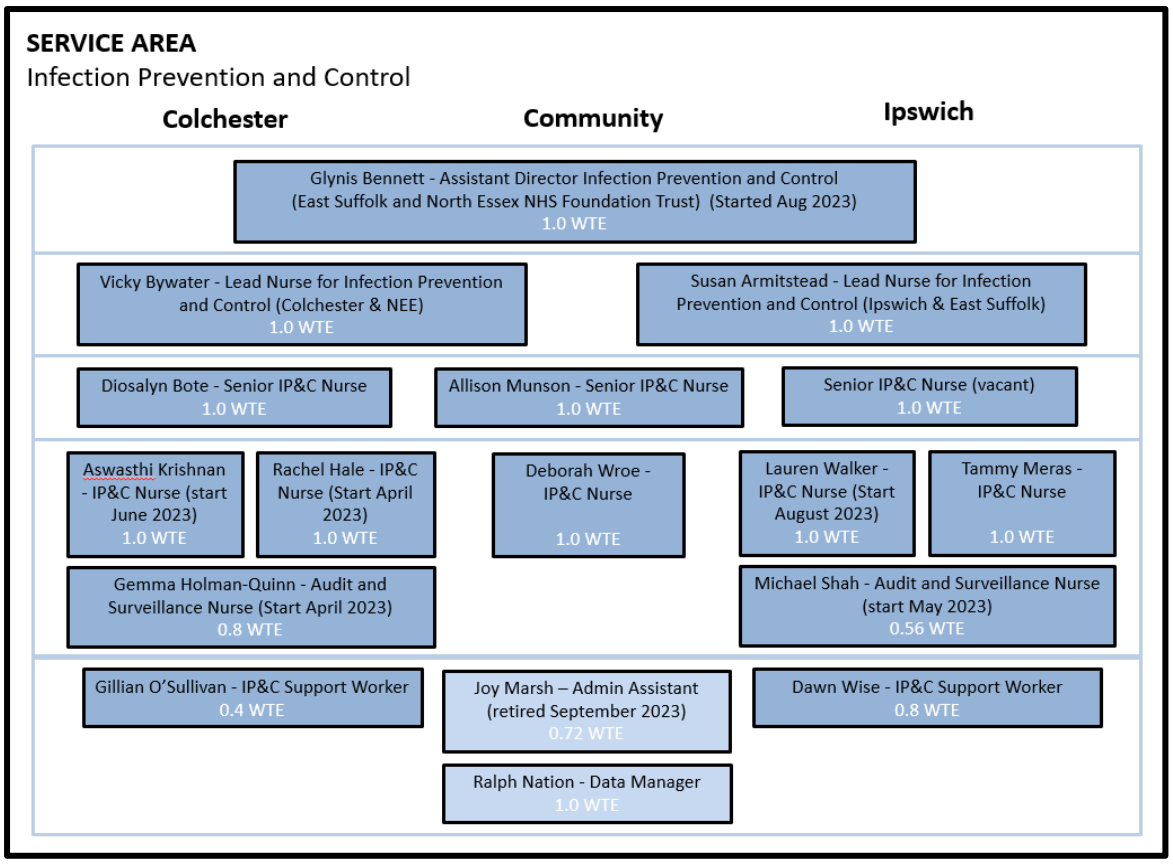
The Chief Executive has overall responsibility for IP&C. The post of Director of Infection Prevention and Control (DIPC) is held by the Chief Nurse who is also the executive lead for IP&C.

The Infection Prevention and Control committee was chaired by the DIPC or deputy and met monthly during 2023/24. The IPC committee includes divisions, estates, facilities, medical, nursing, occupational health, pharmacy, and patient lead representation along with ICS and UKHSA regional representatives.

Organisational structure and reporting line to the Trust Board

The chart below demonstrates the lines of reporting within the Infection Prevention and Control service.

Infection Prevention and Control Team



During the 2023/24 year the Trust Infection Control Doctor left the organisation. Since Oct 2024 Dr. Prema Singh Consultant Microbiologist has been undertaking the IPC Doctor Role (Part Time 2 days week – Locum)

In addition other Microbiologists have supported the IPC agenda and continue to undertake on call support out of hours. The Trust Consultant Virologist has also supported IPC with clinical, virology testing and operational pathways for viral conditions including alerts for measles, pertussis and other alerts.

Infection Prevention and Control Team Activities

Regular meeting with the DIPC and IPC team were undertaken during the year and included key individuals in discussions depending current incidents and surveillance data.

Meetings were attended as outlined in the list below:

- Infection Prevention & Control Team Meetings
- Infection Control Committee
- Incident Management Team Meetings (IMT)
- Matron and Ward Managers Meetings
- Facilities Contract Review Meetings Monthly (Ipswich Hospital site)
- Antimicrobial Stewardship Group
- Tactical Meetings
- Clinical Reference Group meetings
- Decontamination Committee
- Water Safety Group meeting
- Ventilation Group meeting
- Estates Strategy Programme Group
- Relevant project meetings
- Estates Operations and Development Group (EODG)
- Infection Prevention System Collaborative
- Joint IPC Laboratory meeting

The Director of Infection Prevention and Control or their deputy attends and reports to the following;

Infection Control Committee, Quality and Patient Safety Assurance Committee (QPSC), Patient Safety Group, Trust Board, Performance Committee, Executive Leadership Team, Executive Management Committee and Clinical Reference Group.

Infection Control Committee (ICC)

The ICC met monthly (except for December) throughout 2023/24.

Chairs key issues from the ICC are escalated to QPSC for approval / escalation / alert/ assurance / information.

DIPC reports to the trust board – summary

The DIPC or their nominated deputy reports monthly to the Quality and Patient Safety Assurance Committee (QPSC), which in turn reports monthly to the Trust board via the Trust's Integrated Performance Report.

Infection prevention and control board assurance framework (NHSE 2023)

This document is completed and updated quarterly, the document is shared via IPC Committee and QPS, with reporting of exceptions and key issues to board level.

2. MANDATORY SURVEILLANCE REPORTING OF Health Care Associated Infection (HCAI)

The Department of Health (DH) requires mandatory surveillance of specific categories of HCAI's. This allows national trends to be identified and can be used as a measure of progress within a Trust and as an indicator of standards.

The Trust is required to report on the alert organisms indicated below:

- *Methicillin resistant staphylococcus aureus (MRSA) bacteremia (MRSAb)*
- *Clostridioides difficile infection (CDI).*
- *Escherichia coli (E. coli) bacteraemia (E. colib)*
- *Methicillin sensitive staphylococcus aureus bacteraemia (MSSAb)*
- *Klebsiella spp bacteremia (klebb)*
- *Pseudomonas aeruginosa bacteremia (pseudob)*

National mandatory reporting for these organisms is coordinated by UKHSA using a national Data Capture System (DCS).

Fig 1 below illustrates trust performance against trajectory and the performance /benchmarking within the ICS and regionally.

Fig 1 – ESNEFT performance 2023/24

	ESNEFT threshold 2023/24	ESNEFT performance 2023/24	No HOHA	No COHA	Regional benchmark
C.difficile	101	120 (Inc. 0 avoidable)	95	25	Average
E.coli	113	162	72	90	Average
Klebsiella spp.	36	54	36	18	Average
Pseudomonas aeruginosa	19	33	23	11	Average
MRSAb	Zero tolerance approach	7	5	2	Higher numbers
MSSAb	Zero tolerance approach	61	39	22	Higher numbers

2.1 Trust Assigned *Methicillin Resistant Staphylococcus Aureus* Bacteraemia

HCAI Threshold

The DH began mandatory surveillance of MRSAb in April 2004. No formal threshold was set for the current year although a full Post Infection Review (PIR) is carried out and cases are still required to be reported. The purpose of the PIR is to investigate how a case occurs and to identify future learning Learning from all cases has been identified and shared with divisions and clinical areas. (Fig 2). Fig 3 highlights the number of Healthcare associated cases from 2019 – 2024.

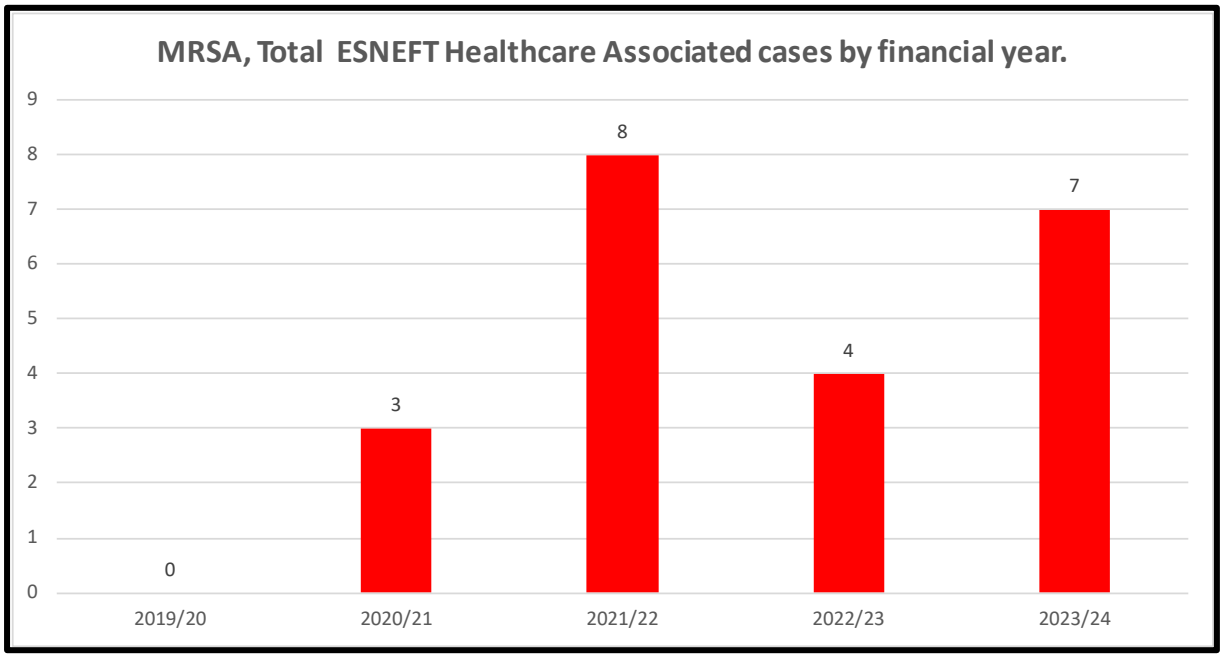
Between April 2023 and March 2024, the Trust has reported 7 cases (Fig 2):

- HOHA – Healthcare onset healthcare associated
- COHA -Community onset healthcare associated

Case date	Category	Location	Learning/good practice
Case 1 August 2023	HOHA *	Aldham/Peldon Ward – Colchester	• Documentation of clinical plans and management of PVD – reminder sent to all staff • Delay in blood cultures being taken (sepsis pathway commenced but no cultures taken) – flagged with clinical team. Patient colonised on admission screens MRSA + • Missed screening sites – education with ward staff • RIP from MRSAb
Case 2 January 2024	HOHA *	W Bergholt – Colchester	• Documentation of PICC line inadequate – reminder to staff • Line site red but line not removed – shared with clinical team • IPC audit data below standards and issues with cleanliness of clinical trays – follow up audits and improvements undertaken • **Good practice around documentation of PVD**
Case 3 January 2024	HOHA *	AMSDEC – Colchester	• Previously MRSA positive and poor skin integrity • Missed screening sites – education with staff • Poor documentation of PVD – reminder sent to staff • Decolonisation treatment not consistently given/documented – reminder of importance to staff • IPC audit data below standards – follow up undertaken
Case 4 March 2024	COHA **	Previously Easthorpe – Colchester	• Multiple previous admissions from Nursing Home with complex needs including SPC • SPC likely source of infection as site infected and urine dark colour • RIP gram positive sepsis
Case 5	HOHA*	EAU – Colchester	• MRSA screening incomplete on admission

October 2023			• Documentation for PVC not complete - both discussed at morning ward huddle
Case 6 December 2023	HOHA *	Cardiac Monitoring Unit Ipswich	• IV line in situ and practice not documented • MRSA screening not completed • Lapses with hand hygiene practice • Environmental audit failures/challenges
Case 7 July 2023	COHA **	Previously Shotley Ward Ipswich	• Previous admissions ++ • Likely chest infection source with pleural effusion

Fig 3 -GRAPH for TRUST MRSAB BY YEAR 2019-2024



2.2 MRSA Colonisation

During 2023/24 there were 4 wards where a period of increased MRSA (colonisation) was identified. Including Nayland Ward Colchester and Trinity Ward Harwich that was closed to admissions to prevent further transmission and facilitate deep cleaning.

Immediate actions undertaken included cleaning of areas, contact tracing and screening as per Trust policy.

Other actions undertaken included:

Review of admission criteria
Supportive visits from ICB
IPC audits
Enhanced screening regimes
Genetic typing of all isolates

2.3 M*ethicillin Sensitive Staphylococcus Aureus Bacteremia* (MSSAb)

Reporting of MSSAb has been mandatory since January 2011. As with MRSAb, no threshold is set for MSSAb. For the year 2023/24 there were a total of 61 cases attributed to the Trust (Fig1). Figure 4a illustrates cases overall since 2021. (HAI and community cases for comparison) Each case of MSSA is reviewed and findings from thematic analysis such as the presence of an invasive device were addressed.

There has been an increase in the number of ESNEFT apportioned cases 2023/24 (Fig 4a), no identified links in cases have been identified and work related to aseptic practice aims to reduce the number of cases. Source data highlights a variety of sources with no one area of concern (Fig 4b). However this data helps to provide focus for areas to focus on to reduce the numbers of cases

Fig 4a MSSAb April 2021 – March 2024

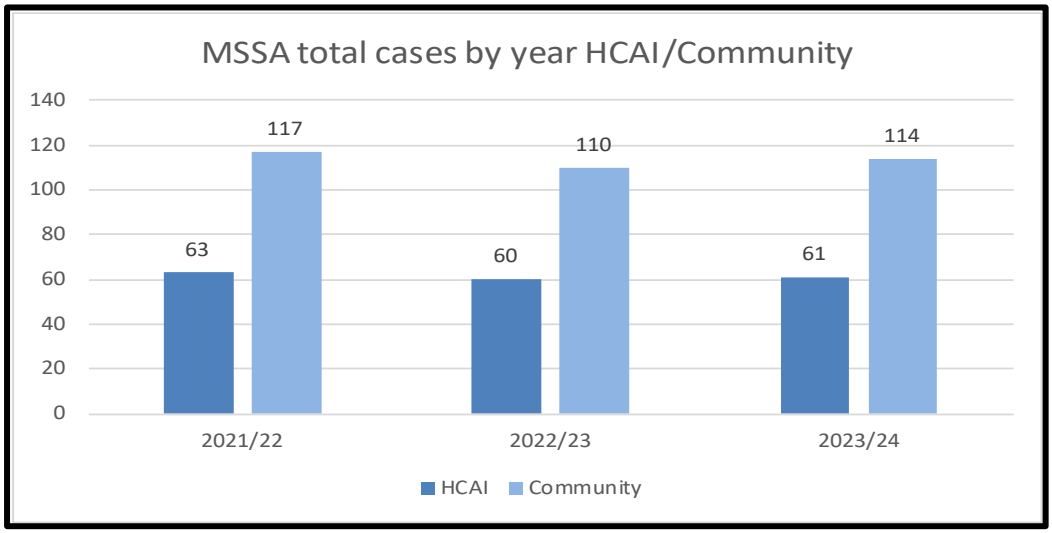
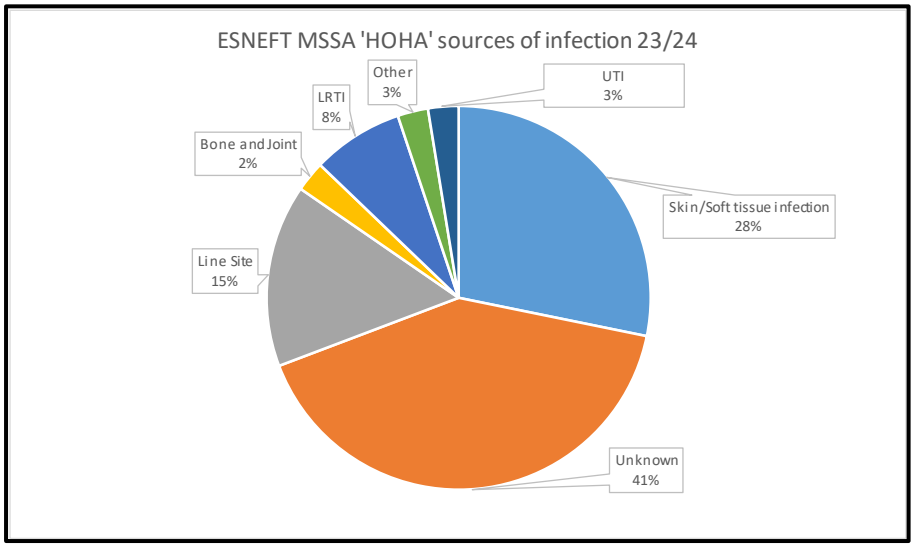


Figure 4b MSSAb source data (HOHA only) 2023/24



2.4 Gram Negative Blood Stream Infections (GNBSI)

For the year 2023/24 trajectories for GNBSI were set. ESNEFT thresholds and cases numbers:

Organism	Threshold	Cases attributed to ESNEFT 2023/24
E Coli	113	162
Klebsiella	36	54
Pseudomonas Aeruginosa	19	33

Cases were attributed to the Trust within the 2 categories:

1) Blood culture taken post 48 hours of admission. (HOHA Healthcare Onset Healthcare Associated – day on admission day 1)
2) Blood culture taken and patient been an inpatient within the previous 28 days. (COHA Community Onset Healthcare Associated)

Fig 5a - c, illustrates each organism pre/post 48 hours 2023/24 (HOHA and COHA)
Fig 6a-c, illustrates source data for all HOHA cases 2023/24.

A collaborative approach across the system to reduce GNBSI is required with the majority of cases being community or shared sources of infection. The focus on the main sources of infection both within Acute organisations is shared with ICS colleagues to provide a focus for planned works. Planning for a focus on urine source and catheter care is being led by ICS teams. Work on going and further plans with Community teams for aseptic techniques will also target GNBSIs. Investigations have not highlighted any themes or correlations within ESNEFT.

Fig 5a Pseudomonas aeruginosa 2023/24

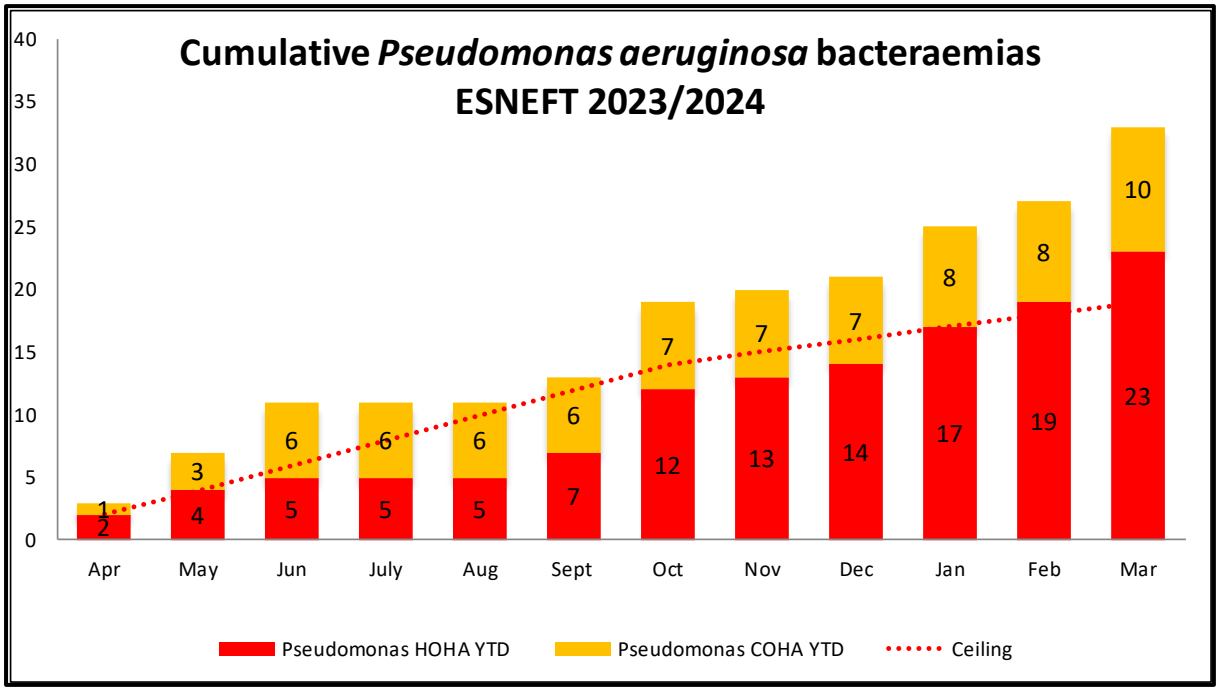


Fig 5b Klebsiella spp. 2023/24

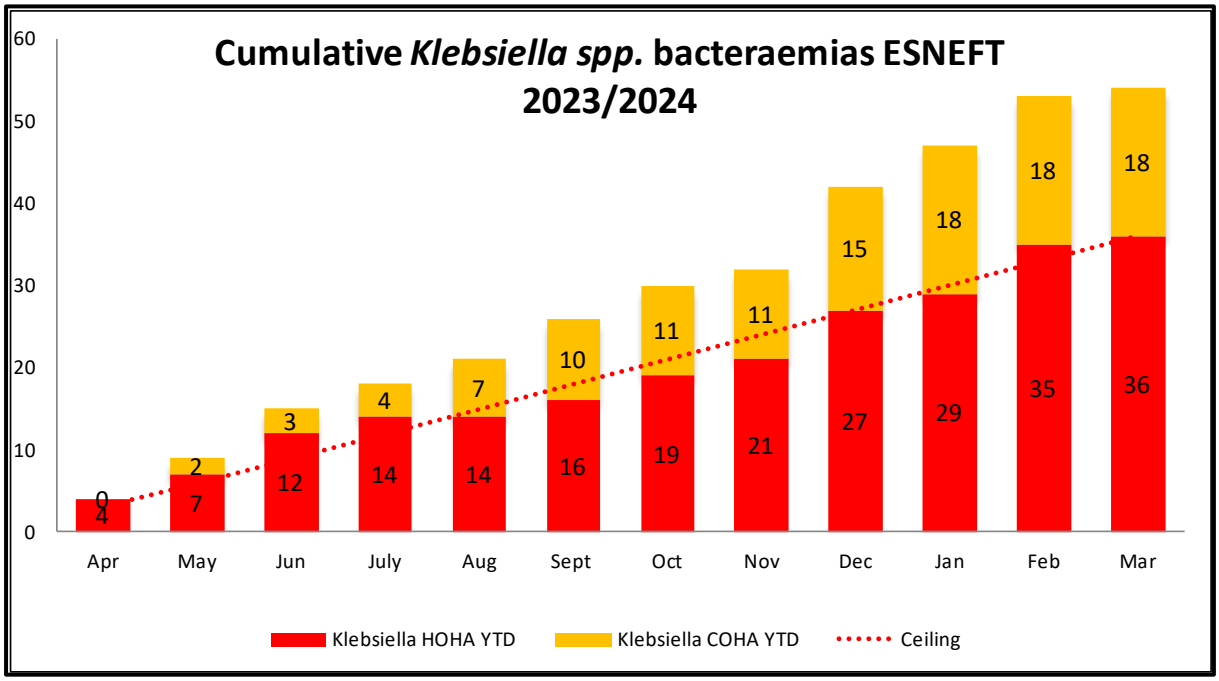


Fig 5c E Coli 2023/24

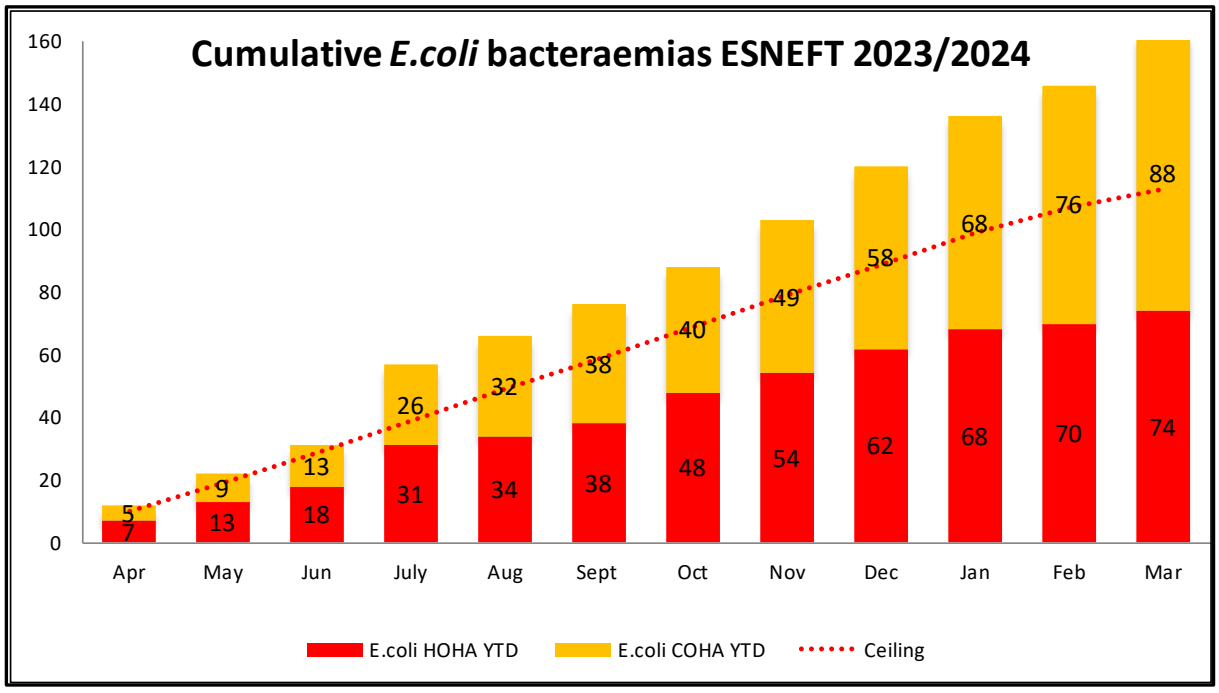


Fig 6a Source data Pseudomonas *aeruginosa* 2023/24 HOHA only

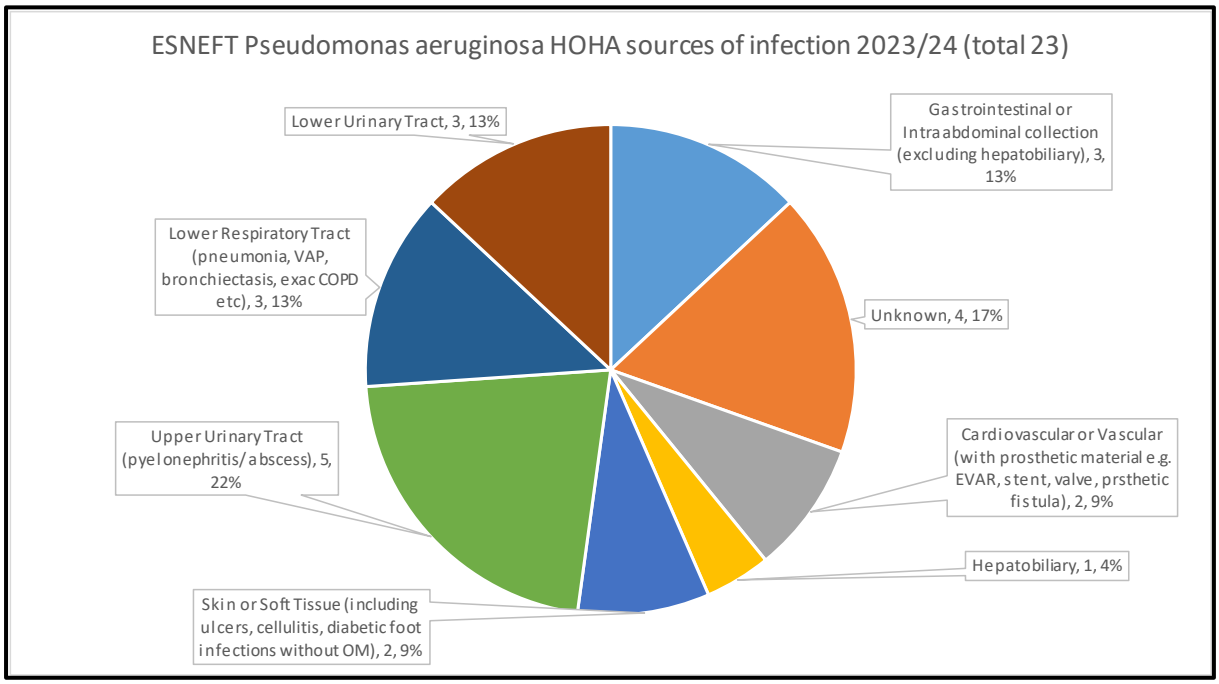


Fig 6b: Source data for Klebseilla *Spp* 2023/24 HOHA only

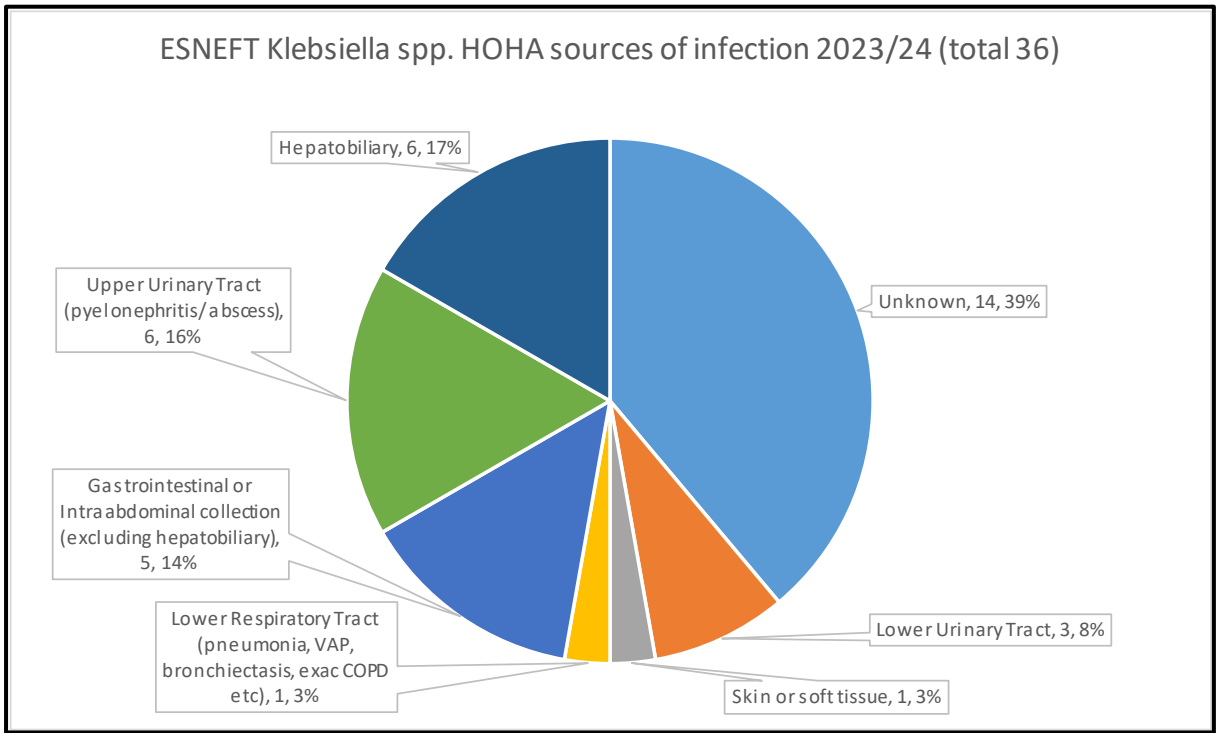
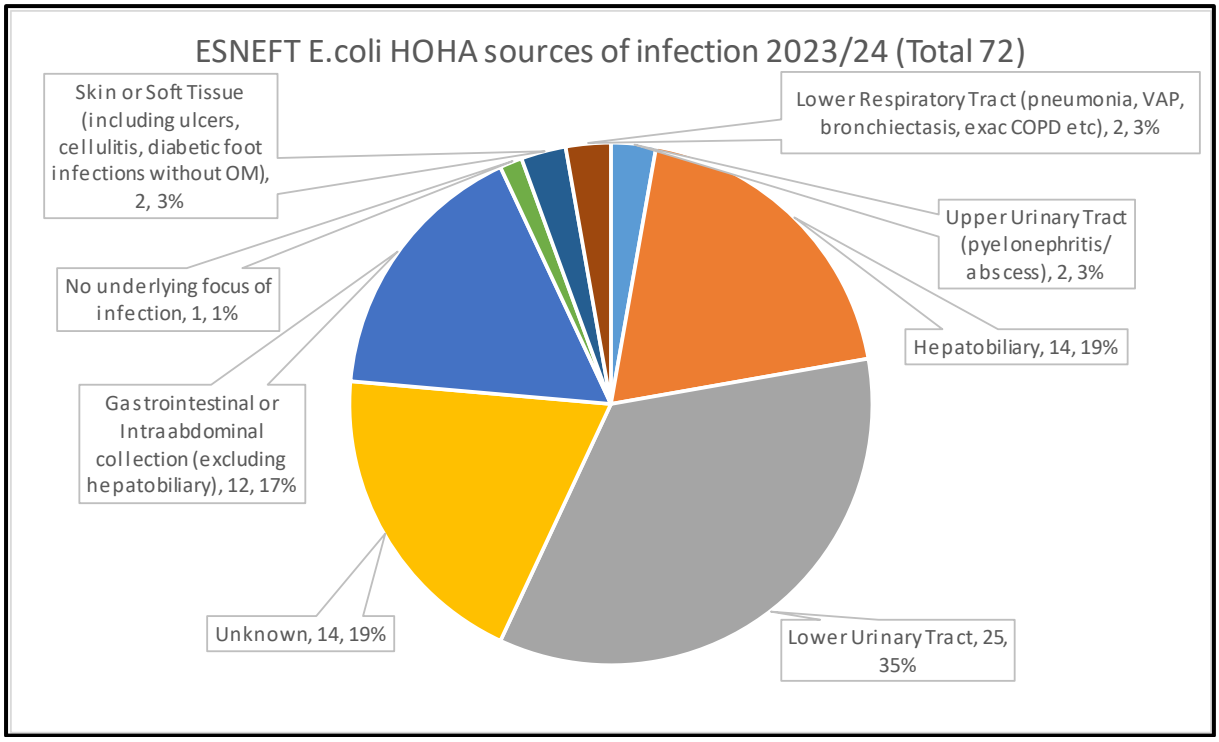


Fig 6c: Source data for E Coli 2023/24 HOHA only

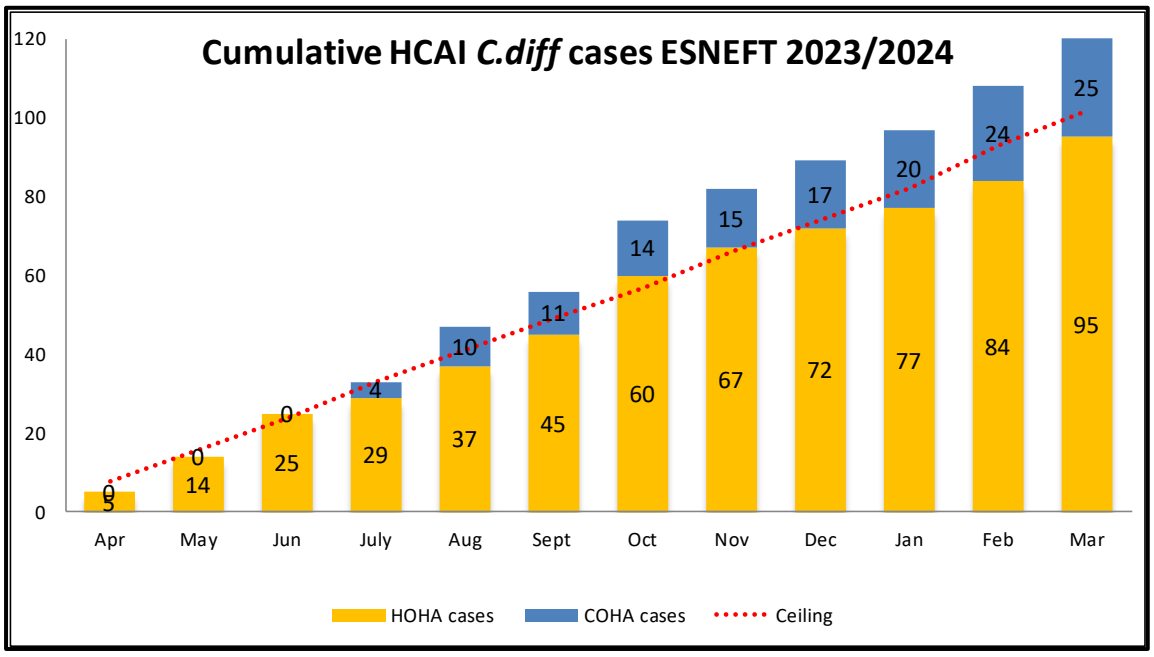


2.5 ESNEFT apportioned CDI cases (*C.difficile)* 2023/24

The Clostrioides difficile Infection (CDI) thresholds for 2023/24 are based on the criteria of 4 categories for apportioning of cases; this system commenced on 1 April 2019.
The trust trajectory for this financial year was 4, and Root Cause Analysis (RCA) are required to be completed for all cases.
All cases of CDI that fall in to the first two categories:

- Hospital onset healthcare associated (HOHA) – cases detected 2 days or more after admission
- Community onset healthcare associated (COHA) – cases that occur in the community that have had a hospital admission/inpatient in the reporting Trust in the previous 4 weeks prior to the specimen date

Fig 7 C diff figures by month 2023/24 for ESNEFT



Reviews of all cases are undertaken and during the early part of the year this was in the form of an RCA, later cases have been used by the trial of a Patient Safety Incident Review (PSIRF) process. Themes from cases are now being gathered and shared as part of thematic reviews and providing a focus for future work plans.

Key findings from this year's reviews have included:

- Delay in sending of stool samples
- In complete documentation of bowel habits/movements (stool charts)
- Delay in isolations – mainly due to occupancy and need for isolation/single rooms
- ABX prescribing and review
- Failure of IPC audit standards – cleaning of clinical equipment including commodes

In response to these findings work is underway and future work plans will continue to include:

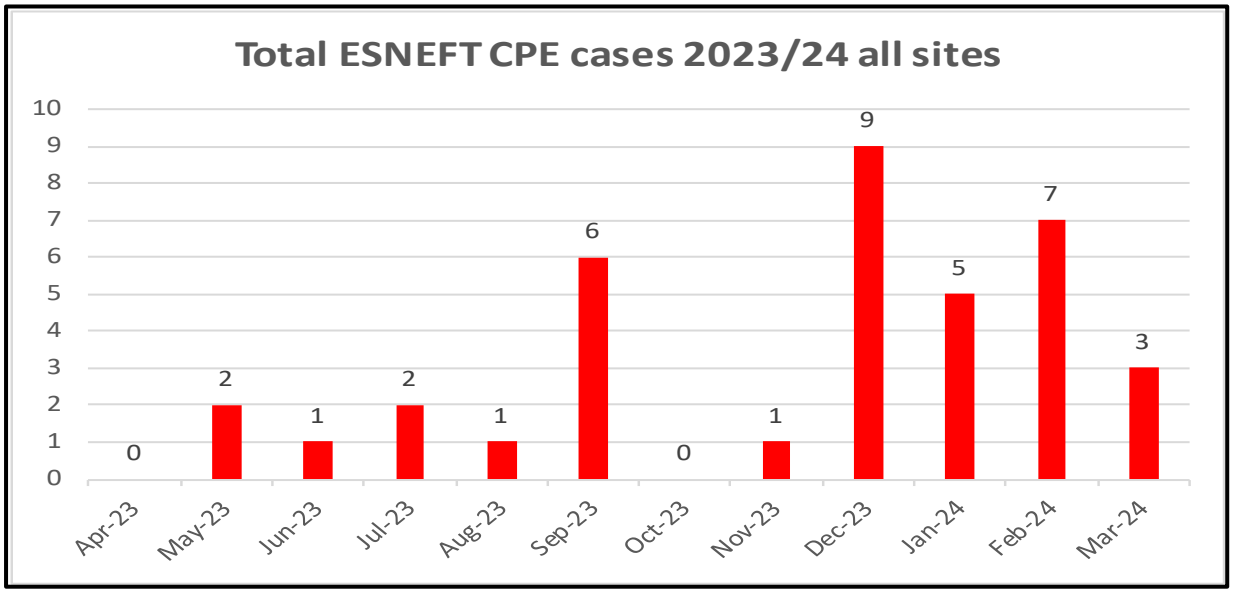
- Priority of isolation rooms - share with operational teams
- Documentation included on IPC audits
- Implementation of new audits for enteric isolation (and other isolation types)
- Focus on key equipment cleanliness including Commodes
- Trial of cleaning products (Sporicidal wipes and patient hand wipes) to assist in cleaning of items
- Deep cleans and enhanced cleaning implemented where Periods of Increase Incidence (PII) identified

2.6 Carbapenemase-Producing Enterobacteriaceae (CPE)

An increase in the number of cases of CPE detected have been identified throughout this year. The majority of cases have been identified as community associated with no Hospital contact. A strict policy based on national guidance is now in place having been reviewed this year. This includes the screening

of contacts and advice on cleaning, isolation and risk management. In addition work to review antibiotic prescribing in these cases has resulted in a review and decrease in the use of meropenum, which now requires microbiology approval before prescribing. Fig 8 highlights the number of cases this year and those hospital/community associated.

Fig 8 CPE 2023/24 ESNEFT community and hospital associated by month 2023/24



2.7 Influenza

During winter months cases of influenza were identified at both Ipswich and Colchester Hospitals. A respiratory management pathway to aid operational teams in the management of case was introduced and approved by the Trust Clinical Reference Group. A number of outbreaks were identified during winter months. A formal risk assessment has been undertaken for the management of IPC within Emergency and Admission areas. This includes the use of Air purification units (to improve ventilation), the isolation and cohorting of patients with suspected viral respiratory illness. The use of rapid testing with LFTs for Covid – 19 has been implemented and supports the management and placement of patients.

2.8 COVID-19

Peaks in numbers of COVID-19 cases have been prevalent throughout the last year. New setting strategies and operational pathways have been implemented to support with the management and clinical care of patients with the virus.

During 2023/24 the total number of COVID-19 outbreaks declared are shown in the table below:

	Total number of outbreaks in wards
Colchester	77
Ipswich	62
Community (East Suffolk)	7
Community (North East Essex)	14
Total	160

IPC Board Assurance Framework IPC BAF:

In June 2020 the IPC BAF was issued by NHSE to provide criteria for board oversight and assurance for standards relating to IPC and the management of COVID-19. Several updates have now been issued and the framework now provides a governance structure for IPC as a whole. The current version updated 2023 is reported on quarterly as part of IPC committee reporting.

Evidence and associated risks are reported on, and this is shared in key committees and forums. Evidence is collated from clinical areas, estates, facilities, human resources, and the Emergency planning teams.
Included as part of the BAF, the Hierarchy of Controls (Figure 9) forms assurance and a governance framework to formulate actions required. Reporting on the BAF is linked to this framework and the 10 key lines of enquiry outlined in the document

Fig 9: Hierarchy of controls

2.9 Norovirus

There have been only 5 wards affected with Norovirus in this year (2023/24). All in April 2023 when prevalence in the community was also noted as higher. 2 Wards and Ipswich and 3 at Colchester declared outbreaks. The standard IPC management was implemented and included cleaning of areas, and transmission based precautions (enteric precautions).

2.10 Group A *streptococcus* outbreak (Suffolk Community)

In October 2023 an outbreak of an identified strain (Emm11) of Group A *streptococcus.* (GAS). The outbreak still continues and a level 2 incident led by Integrated Care Board (ICB) is in place. Initial cases were identified via typing from invasive GAS cases, further testing and typing highlighted links with community nursing teams in Suffolk.

A full action plan has been implemented and includes all of the following:

- Auditing and practice reviews/support
- Cleaning and increase in standards of cleaning at Community Bases
- Staff and patients screening regimes
- Review of antibiotic treatments
- In depth review of individual cases

- Epidemiological investigations led by UKHSA
- Review of equipment and process for cleaning

At time of writing July 2024 - current situation re numbers of cases:

Total cases - 82 cases
67 identified as part of outbreak with typing as emm11 (57 GAS and 10 Invasive - iGAS)
A further 15 cases awaiting typing but could be associated 1(4 GAS and 1 iGAS)
.

2.11 Surgical Site Infection Surveillance (SSIS)

UKHSA state it is a mandatory requirement for each Trust to complete surveillance in a minimum of one module of orthopedic surgery for one quarter per financial year. This provides national data that can be used as a benchmark allowing individual hospitals to compare their rates of SSI with collective data from all hospitals participating in the surveillance programme in England. The national programme for surgical site surveillance suggests that at least 50 cases need to be surveyed in a three-month period in order to obtain statistically significant data.

The tables (Fig10) below summarises the data collected for SSIS by the Trust for the year 2023-24.

Fig 10 SSI rates mandatory reporting

Colchester Hospital

Surgery	National Benchmark	April-Jun 2023	July-Sept 2023	October-December 2023	January-March 2024
Hip Replacement (mandatory)	0.8%	1/102 1%	2/87 2.3%	0/84 0%	1/104 1%
Knee Replacement (mandatory)	0.7%	0/88 0%	0/89 0%	0/101 0%	0/137 0%
Repair of neck of femur (mandatory)	1%	0/131 0%	0/141 0%	1/148 0.7%	0/141 0%

Ipswich Hospital

Surgery	National Benchmark	April-Jun 2023	July-Sept 2023	October-December 2023	January-March 2024
Hip Replacement (mandatory)	0.8%	0/52 0%	1/76 1.3%	1/59 1.7%	0/104 0%
Knee Replacement (mandatory)	0.7%	1/79 1.3%	1/73 1.4%	1/70 1.4%	0/96 0%
Repair of neck of femur (mandatory)	1%	2/130 1.5%	2/115 1.7%	3/133 2.3%	3/118 2.5%

In addition to mandatory surveillance the IPC team have undertaken breast surgery surveillance for x2 quarters. Data is currently being collated.

3.0 Criterion 2 ENVIRONMENTAL CLEANING AND DECONTAMINATION

3.1 Environmental Cleanliness and Monitoring

The 2021 National Standards of Healthcare cleanliness were implemented in the previous year. This included the review of all areas for level of risk associated with cleaning, resulting in bespoke schedules and audit programmers for each area/dept. This has been re reviewed this year to ensure that all standards meet the required need of the clinical teams.

Services in Ipswich Hospital are by an external contractor OCS, and Colchester still has in house services. Community settings are covered by various contactors depending on the ownership of buildings.

Input from clinical staff including Ward Managers, Matrons and Housekeeping staff is encouraged throughout the audit process. Scores are divided into responsibilities including estates, domestic and clinical issues to identify the areas where improvement is required.
The cleaning audit scores are reported on the IPC dashboard and shared with ward managers on a monthly basis and are further discussed at the IPC Meetings and divisional reporting.
Joint working to ensure standards and consistency of standards are met has been on-going with the facilities teams. Regular meetings and reporting from facilities leads are in place.

3.2 Estates and Planning

The IP&C team have continued to support and provide advice relating to building projects, and schemes to develop or create facilities and services including:

- Colchester site – Elective orthopaedic Centre
- Clacton Endoscopy
- Ipswich – new theatres
- Ipswich –Child Health areas
- Colchester – endoscopy
- Minor works across wards at Colchester (ward improvements)
- Colchester ITU – roof works
- Ipswich – maternity
- Ipswich UTC

For any planned or emergency work a risk assessment process in the form of a SOP has been drawn up and agreed via IPC committee. The SOP is based on the HBN IPC guidance. All works are signed off by IPC and shared with clinical teams for awareness and management during the duration of works.

3.3 IPC Incidents and environment:

3.3.1 ITU Colchester

In Sept 2024 a number of cases of Aspergillus (6) were identified from various clinical specimens between August 2023 and March 2024 in patients within the ITU complex. These were linked with some environmental issues identified at the same time.

Roof leaks in the building resulted in water escaping via the ceiling into the unit and mould spores growing within the ceiling space.

Extensive roof works were required to repair a number of areas of the roof, and temporary work has been completed.

Further aspergillus cases have been identified (2) this year May/June 2024, surveillance and investigations continue. Roof works has been completed and plate testing in a number of areas within Colchester Hospital have been undertaken, no adverse results have been detected but surveillance continues. Further reviews of the ceiling/roof space is planned with onwards cleaning and works as required.

Measures implemented and continue in ITU have included:

- Decant and deep clean of ITU
- Ongoing enhanced cleaning in area
- Extra auditing cleaning and IPC
- Enhanced surveillance and investigations
- Updates on roof works and any new leaks
- Regular estates updates
- Inspections of roof space
- Planned review of ventilation

3.3.2 Ipswich Tower Block

Due to emergency lift works and repairs within the tower block at Ipswich, there is a need for lifts to be taken out of service for works to be completed.

There is a risk that lifts could be unavailable/out of service, causing issues with the transfer of emergency cases. The maternity services and delivery suite is located within the block on higher levels. Plans have been drawn up to manage the risks as below:

A room within Deben Ward has been adapted so this could be used as a procedural room if required. A full risk assessment for use of the room is in place with monitoring processes via weekly meetings during the period of lift works. The risk assessment includes:

- Ventilation
- Surveillance of patients
- IPC auditing and checks
- Cleaning

3.3.3 Theatre Ventilation Colchester

Annual Validation reports of Colchester Theatres in August 2023, highlighted some areas of noncompliance with the HTM guidelines. Further works have been undertaken to improve air changes and access to systems. A full validation post works is planned. A risk

assessment for management and use of the theatres has been agreed and discussed with the Trust Authorising Engineer.

3.4 Water Safety Management

The water management group meets monthly and comprises of a multi-disciplinary group of staff including the Trust Authorising Engineer (AE) for Water. The group advises on actions required to maintain the quality of water system in the organisation. An external water safety engineer also provides advice and oversight of water management. A full review of the Trust's Water safety plan has been undertaken and a plan agreed.
In accordance with HTM 04-01, the Trust is required to check for the presence of pseudomonas aeruginosa in augmented clinical care areas, including Women's and Children's services.
The Trust has a statutory responsibility to take appropriate measures for the control of all water-borne microorganisms including Legionella and pseudomonas. Regular temperature checks and surveillance is in place to monitor the water systems. This is reported via the Water Safety Group and IPC Committee.

3.5 Ventilation.

The ventilation is managed by the estates team with oversight from an authorising engineer (AE) for ventilation and the Trust Ventilation group. A programme of maintenance and checking is undertaken in all high-risk areas.

Ventilation has been central in the estates work since the COVID-19 pandemic and risk assessments including the use of air purification units have been in place. A review of all ventilation in both Ipswich and Colchester Hospitals is planned in the coming year.

3.6 Decontamination

Following an incident in July 2023 of a visibly contaminated instrument used in surgery, further investigations highlighted non conformities in the decontamination process, with more incidents identified including further onward incidents/occurrences of visible contamination.
A look back of 2 years to April 2021 identified reports of visible contamination in mainly orthopedic kits (bone fragments) and found only a small percentage of these had been reported formally.

An incident management process was initiated and subsequent reviews/reports have been completed. Risk assessments including 2nd checks and review of processes were in place to ensure the safe on going management.
The management of the incident was divided into 3 work streams:

1) Review and look back of incident and how we got here.
2) Current assurance and plans for future decontamination management
3) Clinical review and any follow up required.

Incidents and subsequent inspection of Ipswich SSD highlighted a number of non-conformities.
The Trusts Authorising Engineer (AE) for decontamination undertook an audit at both sites (Ipswich and Colchester Hospitals). The Ipswich site was found with a number of concerns re the wash process and subsequent actions were taken to ensure the safe process. A review at Colchester Hospital gave assurance of standards and processes in place.

A further peer review arranged by NHS England was also undertaken at the Ipswich site with the review undertaken by an SSD Manager from another Acute Trust along with an IPC lead, NHSE IPC Lead and members of the IPC ICB team. Key feedback included the training and staffing numbers, a process of monitoring staff and experience/training was implemented. These recommendations were added to the overarching action plan in place for the management of the incident.
This incident was also formally reported to the British Standards Institute (BSI) the regulatory body for decontamination process and associated standards.

An incident has been stood up using a silver/gold system of reporting.
The Trust developed a formal risk assessment, this includes evidence of checks and other mitigations. Key data is shared with “Gold” – board level for assurance.
A formal analysis and action plan has been collated. This included analysis against national standards and guidance including HTM 01-01, Hygiene Code and the IPC Board Assurance framework (BAF).
The document and action plans have been risked assessed using the Trust numerical framework and includes operational, clinical and corporate risks. This document has been shared as part of the external wider IMT.

4.0 Criterion 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Establishing antimicrobial stewardship programme is crucial to reduce healthcare associated infections (HCAI) and contributes to slowing the development of antimicrobial resistance. Antimicrobial stewardship team focused on the delivery of the AMR (antibiotic review and reduction in consumption of antibiotics from the Watch and Reserve category). The new NHS contract that came into force in April 2022 require providers to reduce the consumption of Watch and Reserve antibiotics.

Antibiotic audits are completed as part of the national “saving lives audits” the data is share at IPC committee. The use of Meropenem has been restricted in line with national guidance. This has reduced the overall usage.

A higher vacancy rate in the pharmacy team for the last few months has required a target approach on areas where support has been required. The team have worked with IPC to ensure all higher risk areas have had support and auditing.

5.0 Criterion 4: 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 team work with clinical teams to alert individual patients of their infectious status and support with advice regarding the treatment and management of these infections. A range of patient information leaflets on different infections are available for patients and visitors in a variety of formats. Many of these have or are in the process of being updated.

Visiting guidance is regularly reviewed and updated on the Trusts website. The information on the website can be translated into different languages. A recite feature is available on the Trusts website.

Signage to alert visitors to wards where a transmissible infections are being managed are available and utilised as necessary.

The procedure for internal and external transfer of patients with known transmissible infections is included in key IP&C documents. The IP&C team provide advice on transfers, discharges and movements between departments and other healthcare facilities as required.

Details of any infection identified during the patient’s hospital admission should be included within the patients discharge summary.

Communications are shared for specific incidents for IPC including outbreaks, advice on keeping yourself safe and general updates

6.0 Criterion 5: That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

Policies are available for staff on the Trusts intranet that define patients at greater risk of asymptomatic transmissible infections. Guidance is in line with national policy and the NHSE A-Z of infections

Guidance on the management of patients with known transmissible infections is contained with key IP&C documents.

Antimicrobial treatment guidelines are available on the intranet and via the microguide App.

6.1 Identification of patients with infections

The Infection Prevention and Control Team utilise ICNET (a bespoke surveillance system for IPC) for managing alert organisms results, ensuring effective communication with the Laboratory to act on results promptly. The Team ensures that those patients identified with alert organism are flagged eg MRSA, CPE, and C. *diff* to identify isolation precautions and give advice on the management of these patients. ICNET reporting functions enables reports for specific organism and areas to highlight any possible transmission and identify PII or outbreaks.

6.2 Assessment of patients with risk factors for infections

6.2.1 Diarrhoea & Vomiting (D&V) risk assessment

An assessment of patients presenting with D&V is used to assist in the management of patients that develop or are admitted with diarrhoea and/or vomiting. The IPC assessment process is used to identify risk factors for infections such as *C. difficile* and viral gastroenteritis (including Norovirus).
The team work closely with operational colleagues to advice of the efficient use of isolation rooms.

6.2.2 Admission IPC assessment

IPC assessment for patients on admission is used on admission to identify higher risk patients. This includes checking previous infection alerts, considering the risks of overseas travel, screening regimes and the clinical presentation of patients. This includes risks from all infections and previous risk factors including CPE and previous infection flags for infections including C *difficle* and MRSA.

A screening regime for patients with symptoms of respiratory viruses including covid 19 facilitates correct placement of patients within the organisation. LFT testing for covid 19 is in place and fast track testing (Cepheid) is used for influenza and RSV during winter months.

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

7.1 IP&C training activities

Induction and Mandatory update for all staff

Face-to-face IP&C training at Nurse Induction includes a practical handwashing exercise, this is undertaken for all staff on both Ipswich and Colchester sites. .

Bespoke ward based training in ward days, and away days has been completed as well as update sessions at board rounds and handovers. Specific ANTT training has been undertaken with community teams in response to outbreaks and learning from these.

The Trust uses the IP&C e-learning package produced by eLfH (a health education England programme in partnership with the NHS and professional bodies). A local supplement to mitigate an inaccuracy in the eLfH package is in place.
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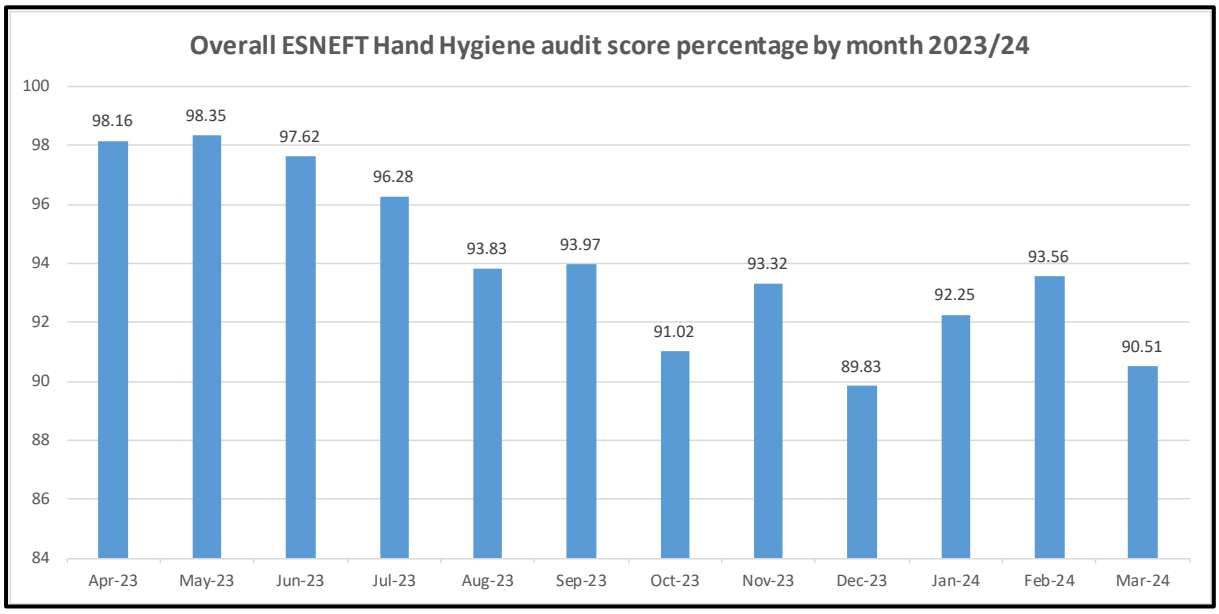
Other training activities

Changes in IP&C policies are communicated Trust wide in the staff ESNEFT newsletter. Within the ESNEFT intranet there is a dedicated section for IPC and relevant topics within this.

7.2 Hand Hygiene Audits Compliance

Effective hand hygiene remains a key intervention in the reduction of HCAIs. All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates continue to be calculated and individual tables for each area within the divisions are produced by the IPCT. The trust Hand hygiene compliance target is 95%. Compliance with hand hygiene is monitored in the bi-monthly through the IPC dashboard and forms part of the trust accountability framework. Where scores are indicated below the Trust benchmark the divisional IPC action plan is updated and subsequently re-audited (Figure 11). Focused work with identified staff groups and areas has been undertaken this has include support from supplies with education using their technology to measure the effectiveness of handwashing techniques.

Fig 11 Hand hygiene compliance graph

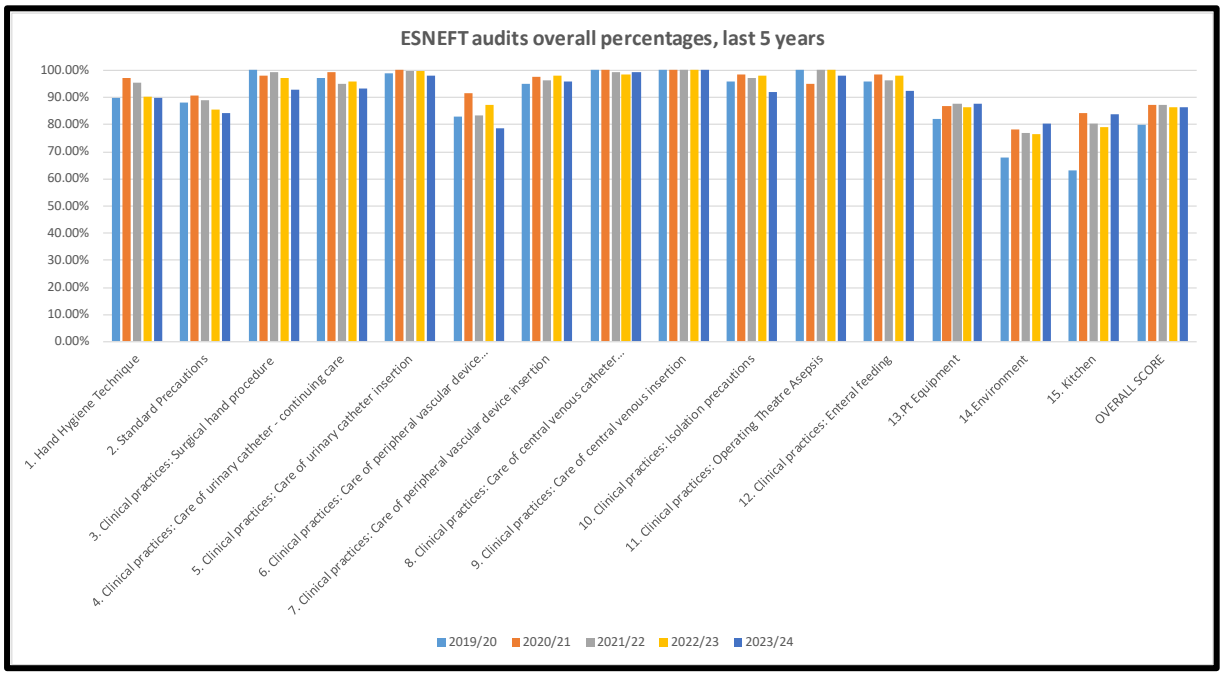


7.3 IPC Audits

IPC Audit are undertaken by both the IPC team and ward teams using a peer review "buddy system". Data is collated and shared with divisional leads, matrons and dept. heads, Feedback is given at the time of audit also. Actions to address area of unsatisfactory compliance are taken by the division and added to an IPC Action plans. These are also discussed at divisional level meetings.

In depth audits are undertaken by the IPC team and shared verbally at the time with formal written feedback, A "snap shot audits" has been developed and implemented this year and a wider audit plan to provide responses to incidents/outbreak, and includes check on isolation precautions, IPC practice and the environment.

Fig 12 Audit data ESNEFT 2019 – 2024



Criterion 7: The provision or ability to secure adequate isolation facilities.

The ESNEFT Isolation policy and procedure assists clinical staff to prioritise patients with transmissible infections for single room isolation. Staff are encouraged to escalate any issues regarding isolation capacity to the clinical flow mangers and the IP&C team on the respective site.

Cohort isolation of patients identified to have the same transmissible organism is used when single rooms are not available.

The Trust isolation policy is in the process of being updated to provide robust guidance out of hours to support operational teams.

Risk assessments for the IPC management of patients in admission areas and when boarding are in place to manage the risk of transmission of infections. This includes a review of ventilation in areas with the use of air purification units to support the existing systems, IPC practice, enhanced cleaning and targeted IPC support/education.

Criterion 8: The ability to secure adequate access to laboratory support as appropriate.

ESNEFT infection service maintains clinical microbiology laboratories on both sites, this is UKHAS accredited with the inspection and accreditation being archived this year The laboratories maintain links with national services for specialised services such as bacterial and viral typing, when required. Rapid testing for respiratory viruses is available and plays an important part in operational functions during times of high prevalence of infections.

The lab has supported throughout the year with extra testing during outbreaks, this has included screening of patients, staff and assisting with sending samples to reference labs for further typing.

The IPCT and Microbiology team work closely together to provide a comprehensive and cohesive IPC service to the Trust and meet regularly to discuss issues and future plans and initiatives

Criterion 9: That they have and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.

A range of IP&C policies are available for staff to access on the Trusts intranet. IP&C policies are approved by the ICC. All policies are reviewed every three years or sooner if there are changes in national guidance/evidence. The use of national guidance and links to these including the National IPC Manual (NIPCM) for England (NHSE 2023) and the A-Z of Organisms (NHSE 2023) is also in place. Evidence of compliance against policy is audited using IPC audit and via the review of outbreaks and HCAIs. Evidence is outlined via the IPC BAF.

Adult and paediatric antimicrobial treatment guidelines approved by the Antimicrobial Stewardship Group and Medicines Governance Group is also available on the trust intranet.

Criterion 10: That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

Workplace staff health is managed by the trust own in house Occupational Health Team than includes and Consultant and Specialist Nurses. The team provide vaccinations, health checks and support IPC with screening and staff contact tracing.

The IPC and Occupational teams work closely together with H&S to support staff in the prevention of transmission of infections.

Throughout this year the team have support with a number of outbreaks and staff screening with the largest being the Community teams associated GAS outbreak, where community Nurses have been screened.

The team provide updates to IPC committee.

IP&C programme for 2024/2025

Plan for 2024/25	Key points
Compliance with Hygiene Code (2008 updated 2015) and IPC BAF (NHSE 2023)	To update the National IPC board assurance framework 3-6 monthly and update IPC committee and QPSC committee
Adopt the process and principles of PSIRF and imbed in to the IPC review and investigation process	Replace the current PIR and RCA process in line with PSIRF share processes and learning across organization and wider healthcare system
Support with implementation of new cleaning contract and standards	Provide IPC advice to the tender and selection process for new cleaning contracts across the organisation to ensure required standards and monitoring processes are in place.
Surveillance	To continue surveillance to identify outbreaks. Plan and report on the stratergies to meet NHSE/UKHSA national thresholds for C *difficile* and GNBSI Share learning and data associated with outbreaks and overarching survillance/investigations
IPC Audit	Review audit process and imbed as part of the PSIRF process. Develop a SOP for completion and sharing of audit data.
Development and review of IPC team and working practices	Develop skills and knowledge of IPC team as new members have joined throughout previous year. Ensure the team work across the organization collaboratively and are visible across all areas to support clinical, operational and senior leadership teams
Facilities /Estates Project review	Collaborate with Estates to assist with the new development and improvements to the existing ESNEFT estate, providing IPC support and advice. Ensure processes are in place for the monitoring of key areas including water, ventilation and decontamination service.
Support the implementation of a new EPR system – EPIC with the IPC elements and new surveillance system	Provide support and proactively engage with the implementation of EPIC across the organization ensuring IPC elements and systems are implemented
Update IP&C policies	Ongoing programme to review and update ESNEFT IP&C policies and procedures, and as required by national guidance.
Continue with Surgical site surveillance	Continue to complete the orthopedic surveillance modules. Conduct voluntary SSIS modules across both acute sites once the audit and surveillance posts are filled. Develop services further to ensure that learning is shared and key actions implemented from findings.
Review and undertake risk assessments in the management of IPC with the challenges of operational pressures and elective pathways. Facilitate the achievement of operational and elective targets while maintaining IPC safety.	Proactively work with clinical and operational teams to provide advice, guidance and risk mitigations to teams in relation to IPC and the safe management of patients, taking into account infection prevalence data and clinical challenges.
Review and consider new technologies, products and strategies within IPC to improve IPC standards and infection data	Consider and review new systems, technology and products to improve IPC practices and impact on patient safety. Work with the relevant teams to ensure these are reviewed and considered.
Review IPC education	Work with education teams, clinical teams and supplies to ensure that IPC education and practice is in line with national guidance and supports teams. Including clinical process, to support staff and improve IPC across the organization with IPC practice and compliance to polices/procedures