

## Director of Infection Prevention and Control Annual Report 2023/2024



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## EXECUTIVE SUMMARY

The purpose of this report is to inform patients, public, staff, the Board of Directors and Governors of the infection prevention and control (IPC) work undertaken in 2023/24 and provide assurance on Trust compliance with the [Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance \(National infection prevention and control manual for England 2022\)](#). This report covers the management arrangements, the position of infection prevention and control within the Royal Devon University Healthcare NHS Foundation Trust (hereafter referred to as 'RDUH'), outcomes and progress against performance targets.

The publication of the Director of IPC (DIPC) annual report is a requirement to demonstrate good governance, adherence to Trust values and public accountability (Dept. of Health, 2004) and reports on IPC activities within the RDUH for the period covering April 2023 to March 2024.

All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections in accordance with the Health and Social Care Act 2008. The RDUH has a pro-active IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that IPC is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients.

The annual DIPC report is mapped to the ten compliance criteria outlined in the Code and takes the opportunity to celebrate successes and highlight the increasing challenges going forward in 2024/25. The following are highlights from 2023/24:

1. COVID-19 has remained a significant issue within healthcare. COVID-19 control measures remained in place for the NHS for much of the year although the success of the COVID-19 vaccination programme, availability of effective treatments and the current prevalence of less virulent strains of COVID-19, allowed small but incremental reductions to control measures.

The national direction has been to change the emphasis from 'COVID-19 control' back to a much broader approach of infection prevention and control (IPC) in welcomed recognition that all healthcare associated infection must be minimised. As national guidance has been amended and in response to local prevalence, changes have also been implemented within the Trust.

2. Work commenced during 2022/23 and continued into 2023/24 to align arrangements for managing and monitoring the prevention and control of infection within the newly integrated Trust. This included a focus on aligning Trust policies and procedures along with sub-groups reporting into the Infection Prevention and Decontamination Assurance Group.
3. From a clinical perspective, across the Trust there are both areas of good practice and for improvement:
  - There have been three healthcare associated MRSA bacteraemias in 2023-24, two hospital onset and the other community onset. All were determined to be unavoidable via a multi-disciplinary infection control led review. Incidental learning has yielded a useful review of Trust MRSA screening criteria and reinforced the importance of excellent communication within the patient care record.
  - The Trust reported sixty five cases of healthcare associated *Clostridioides difficile* infection giving a rate of infection of 19.84 per 100,000 occupied bed days which is lower than both the regional and national rates and a further improvement on last year.
  - Orthopaedic surgical site infection surveillance continues at all three Trust sites: The Princess Elizabeth Orthopaedic Centre, South West Ambulatory Orthopaedic Centre and North Devon District Hospital. The commitment to the UK HSA Surgical Site Infection

- Surveillance Service programme and subsequent review of trends and themes in real time facilitates collaborative improvements in patient experience and infection prevention.
- The Trust participated in the UK Health Security Agency National Point Prevalence Survey of Healthcare Associated Infection and Antimicrobial use in England in the Autumn of 2023. The preliminary Trust result is 5.6%. National results are to be published later this year but we remain confident, as with prior point prevalence surveys, that the Trust has maintained lower rates of infection as compared with national rates.
  - The rate of E. coli and MSSA blood stream infection within the Trust are higher than both the South West and national rates and remain the focus for multi modal improvement work included within the 2024/25 IPC annual programme as there has been no individual theme to focus improvement methodologies on to date. Guidance has been sought from the Integrated Care Board Infection Prevention and Control Lead and NHSE South West IPC Lead. This valuable collaboration has meant that local blood stream infection improvement groups have developed to produce a regional Mandatory Enhanced Surveillance Organism Reduction Group led by the Royal Devon Infection Prevention & Control team supported by both NHS Devon and NHS England South West. Whilst the yearly rate remains high, reductions in healthcare associated infection in the latter part of 2023/24 are encouraging.
4. In correlation with COVID-19 lockdowns and other restrictions in the community in 2020 and 2021, there was the reduction in both other respiratory viral infections, in particular influenza, and gastrointestinal viruses such as norovirus. With a return to normality in work and social activities in the community, these viruses have continued to be presenting the population and consequently in our hospitals. This has resulted in outbreaks and added to operational pressures the Trust has experienced particularly over the winter months.
  5. Trust Estates and Facilities services and IPC teams continue to work hard to maximise Trust compliance with Criterion 2 of the Code of Practice. The Trust allocated resources (£500,000) in its 2023/24 operating plan to ensure compliance with the National Cleaning Standards (2021).
  6. Processes for the decontamination of medical devices, reusable invasive instruments and hospital linen are all undertaken to national standards.
  7. The Trust has safe water systems at the main sites and in premises administered by the Trust, including the Nightingale. The planned programme of work to ensure that any concerns are identified promptly has been effective and where issues have been identified, they have been resolved efficiently and safely.
  8. A review of the delivery of infection prevention and control training to all staff was completed in 2022. This concluded that the National Health Education e-learning programmes at level 1 for non-patient facing staff and level 2 for patient facing staff would be adopted. These have been designed to meet the relevant learning outcomes in the UK Core Skills Training Framework. Some key groups require face to face training in addition to e-learning and this is being addressed by the IPC and learning and development teams, following the publication of a new national framework for IPC education.
  9. Lack of single room facilities is a recognised risk on both sites. This is partly mitigated from an IPC perspective through the use of cohort bays, wards and some portable isolation units for critical care areas This is a recognised risk and will be addressed in any new building developments including the Government New Hospital Programme planned in NDDH.

10. The Trust Occupational Health service remains critical in the delivery of both routine staff health surveillance and vaccination services and has met the additional requirements placed on it in relation to national and local increases in infections such as Measles and Whooping Cough.
11. In keeping with other NHS Trusts, flu vaccination uptake is lower than in previous years at 52% against a target of 75% with 5,547 vaccinations administered to our staff.
12. The Trust has a number of IPC risks associated with backlog maintenance. These are well-understood and documented by the IPC team and Estates. However, a lack of capital investment means there is a risk of these not all being mitigated in their entirety. This specifically relates to ongoing water safety and drainage concerns and the general condition of parts of the Eastern estate.

## **INTRODUCTION**

The publication of the DIPC annual report is a requirement to demonstrate good governance, adherence to Trust values and public accountability (Dept of Health, 2004). The purpose is to provide assurance that the Trust maintains high levels of compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015). Therefore, the annual DIPC report is aligned to the ten compliance criteria as outlined in the Health and Social Care Act, Code of Practice on the prevention and control of infections and related guidance (refer to Table 1).

Healthcare Associated Infections (HCAIs) can cause harm to patients, compromising their safety and leading to a suboptimal patient experience and increased length of stay in hospital. Maintaining low rates of HCAIs remains a cornerstone of the Trust's approach to providing safe, high-quality care across all the services. This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical who play a vital role in improving quality of patient experience as well as helping to reduce the risk of acquiring an infection. Additionally, the Trust continues to work collaboratively with a number of external partners as part of its IPC and governance arrangements.

The authors would like to express their appreciation and thanks to all those that helped the Trust meet the demands of the last year as well as acknowledging the contribution of other colleagues to this report.

**Table 1. The Hygiene Code Compliance Criteria and Trust compliance summary**

Fully compliant	Partial compliance	Non-compliant (NC)
No	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	
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections (known risk) <i>Non-compliant with 1 of 11 elements related to 'all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition'.</i>	
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance	
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion	
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people	
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	
7	The provision or ability to secure adequate isolation facilities due to limited side room capacity (known risk) <i>which will only be mitigated by future estates work across Trust sites and the New Hospital Programme (North)</i>	
8	The ability to secure adequate access to laboratory support as appropriate.	
9	Registered provider has and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infection.	
10	Service providers will have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.	

## **1. Systems to manage and monitor the prevention and control of infection.**

### **1.1 Governance arrangements**

- 1.1.1 The Trust wide Infection Prevention and Decontamination Assurance Group (IPDAG) is chaired by the Executive Lead for Healthcare Associated Infection/DIPC for Northern services the Trusts CNO. The group meets quarterly and reports to the Board of Directors through the Governance Committee via the Safety and Risk Committee sub-group report, highlighting concerns, risks and gaps in assurance.

The Trust continues to have different arrangements for the DIPC role across Northern and Eastern services, this will move to one unified arrangement in 2024.

- 1.1.2 The Trust uses NHSE's IPC Board Assurance Framework & CQC regulatory standards as a self-assessment framework to assess Trust's performance as a source of internal assurance that quality standards are being met.

## **2. Risk management**

- 2.1.1 The Trust has in place suitable and sufficient assessment of risks to patients receiving healthcare with respect of HCAI. These are benchmarked against national best practice, clinical judgment and local risk assessment. The Trust monitors risks of infection through data collection, audit and review of clinical incident reporting. These findings and a review of current risk assessments are reported to the IPDAG and the findings are used to inform future actions and strategy.

- 2.1.2 Corporate and local HCAI risk assessments are available on the Trust's Corporate Risk Register (CRR) and the risk rating report for high risks is reviewed on a quarterly basis by the Safety and Risk Committee. Existing control measures and further preventative measures are identified for action and monitored through divisional governance meetings. There is one risk on the CRR relating to the size and layout of existing inpatient bed spaces and the potential risk of increased nosocomial infection. There are 3 risks on care group risk registers related to water safety and condition of the estate within renal services (Eastern).

- 2.1.3 The Trust has a robust incident reporting system through which staff can report adverse events such as deviation from a clinical guideline or poor practice that may be detrimental to patient care. The IPC team has oversight of IPC incidents reported and provide expert advice and guidance as required to mitigate any further risk or patient harm. Ownership of clinical incidents reported usually remain with the divisions in which they have occurred and the divisions provide assurance to IPDAG about significant investigations and share key learning.

- 2.1.4 Outbreaks are reported on the incident reporting system. This does not necessarily mean that the outbreak could have been prevented but they are reported in this way because of the impact that outbreak control measures have on bed availability and patient flow. Outbreaks recorded in 2023-24 are summarised in section 1.8.

### **2.2 Infection Prevention and Control Teams (IPCT)**

- 2.2.1 The specialist IPC nursing teams provide education, support, and advice to all Trust staff with regard to infection prevention and control matters and liaise regularly with patients and relatives to provide information on alert organisms, offering advice and reassurance



when required. Since Trust integration, teams have worked collaboratively but progress to move to a single IPC nursing team structure has been delayed due to the complexities of the Operational Services Integration (OSIG) process. This remains a priority for 2024/25.

- 2.2.2 Through commissioned arrangements and service level agreements, the IPCTs also deliver services to Devon Partnership Trust, CHIME and through the Community Infection Management Service to care homes and primary care services. The IPCTs also provide advice and guidance to the Exeter Nightingale Hospital, Sexual Assault Services Vaccination Centres and the DCC Public Health Nursing Team.
- 2.2.3 Two of the medical microbiologists work collaboratively to fulfil the role of Infection Control Doctors (ICD) with one based at the Northern site and one at the Eastern site who also provides an ICD role under the service level agreement with DPT.
- 2.2.4 The antimicrobial stewardship team is led by a Consultant Medical Microbiologist with PAs identified for antimicrobial stewardship activities. Working collaboratively, the Consultant Medical Microbiologist and Antimicrobial Pharmacists provide leadership to influence and promote the safe and effective use of antimicrobials across the Trust, in accordance with local and national guidelines.
- 2.2.5 The Antimicrobial Stewardship Group (ASG) is tasked with ensuring that antimicrobial drugs are utilised throughout the Trust in a way which results in optimal treatment of infections while minimising the risk of adverse effects, including healthcare associated infections. The group is chaired by a Consultant Medical Microbiologist and reports to IPDAG.
- 2.2.6 An annual programme of work for 2023/24 was prepared and ratified by IPDAG. The programme of work is mapped to the duties of the Code of Practice thus demonstrating the Trust's continued work to maintain compliance with the Code.

#### **1.4 Surveillance of Healthcare Associated Infections**

- 1.4.1 Surveillance, together with clinical audit, provides invaluable data which highlights good practice and areas for improvement vital to the IPC programme.
- 1.4.2 Some surveillance data is only reported internally whilst other data is also reported externally as part of mandatory or voluntary surveillance schemes which provide opportunities for benchmarking. Mandatory surveillance data is reported through IPDAG to the Safety and Risk Committee and also directly to the Board of Directors, through the monthly Integrated Performance Report. The most important element of surveillance, however, is feedback to and the engagement of those teams directly involved in all elements of a patient's care. A powerful driver for change, surveillance is a tool through which to share learning, prompt review, and where necessary, initiate improvement.

#### **1.5. Mandatory Surveillance of Bloodstream infections and *Clostridioides difficile***

- 1.5.1 Mandatory reports are made to the UK Health Security Agency (UKHSA) utilising web-based surveillance data capture systems:
  - *Staphylococcus aureus* bloodstream infections
    - Methicillin Resistant *Staphylococcus aureus* (MRSA)
    - Methicillin Sensitive *Staphylococcus aureus* (MSSA)
  - *Escherichia coli*, *Klebsiella* and *Pseudomonas* bloodstream infections, collectively known as Gram negative bloodstream infections (GNBSI)

- *Clostridioides difficile* infection

1.5.2 For each type of bloodstream infection and *Clostridium difficile* infection, cases are defined as to whether they are healthcare associated or not. For those that are health care associated they may be further defined as being:

**Hospital onset healthcare associated (HOHA)** - if identified on or after 3 days of admission where day 1 is the day of admission.

**Community onset healthcare associated (COHA)** – if identified prior to or within 2 days of admission and the patient has also been discharged from hospital in the previous 28 days.

Bloodstream infections that are not healthcare associated are defined as community associated.

1.5.3 Under the NHS Standard Contract, requirements are set to minimise *Clostridioides difficile* infection and gram-negative bloodstream infections via threshold levels calculated by NHS England. Thresholds are based on the raw number of infections reported not rates of infection. For 2023/24, Trust-level thresholds were set to be lower than the lowest reported healthcare associated infections for a Trust in either of the two preceding years.

Table 2 shows the NHS England Trust level threshold count and the number of healthcare associated infections reported. This is displayed alongside organism specific infection rates per 100,000 occupied bed days. Comparison to regional and national rates are also displayed for benchmarking purposes.

**Table 2: Summary of Trust, South West & National cumulative GNBSI and *C.difficile* data**

	Threshold count	No. of reported HOHA + COHA	Royal Devon rate	South West rate	National rate
<i>Clostridioides difficile</i>	65	76	19.84	31.16	24.50
<i>Escherichia coli</i>	163	216	56.38	37.18	33.37
<i>Klebsiella spp.</i>	45	61	15.92	13.61	13.92
<i>Pseudomonas aeruginosa</i>	17	19	4.96	5.61	5.97

Source: UK Health Security Agency Field Epidemiology Service Data Tool South West (May 2024)

1.5.4 Although above the threshold count, it should be noted that the rates of *C. difficile* and *Pseudomonas aeruginosa* bloodstream infection are below the regional and national figures with *Klebsiella spp.* rates comparatively similar. Of concern is the rate of *E. coli* bloodstream infection which remains significantly higher than both the South West and national rates. Trust wide mandatory enhanced surveillance (MES) organism reduction initiatives are ongoing with measurable actions monitored through IPDAG.

1.5.5 Whilst MSSA surveillance is mandatory, threshold levels are not pre-set by NHS England. Performance and comparison with regional and national rates are shown in Table 3. A zero-tolerance approach to MRSA bloodstream infection is sustained in the NHS Standard

Contract quality requirement. There were three healthcare associated MRSA bloodstream infections in 2023/24.

Thorough investigation elicited no learning to have prevented infection in all three incidences with the infections deemed as unavoidable. Incidental learning and actions arising from infection deep dives have directly informed this year’s MES reduction plan. This has prompted review of Trust MRSA screening inclusion criteria and reinforced the need for clear and comprehensive communication of care via documentation within the patient record. Reassuringly Trust rates for MRSA are below the regional and national average. See Table 3.

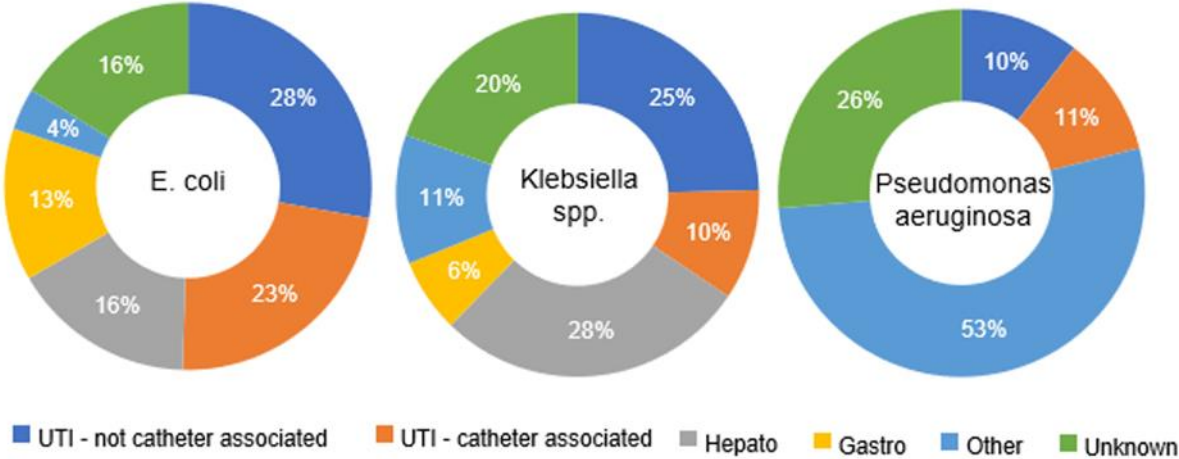
**Table 3: Summary of Trust and South West Staphylococcus aureus data**

	2023/24 Threshold count	No. of cases HOHA + COHA	Royal Devon rate	South West rate	National rate
MRSA	Zero	3	0.78	1.16	1.12
MSSA	Nil set	106	27.67	16.25	13.24

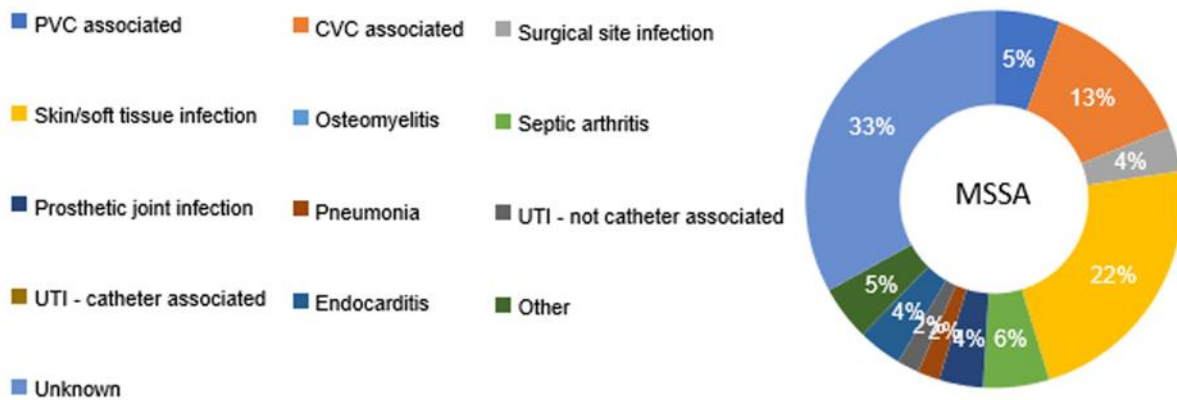
Source: UK Health Security Agency Field Epidemiology Service South West (May 2024)

1.5.6 The graphs in Figures 1 and 2 show the source split for gram negative and MSSA blood stream infection.

**Figure 1: Source data spilt for GNBSI HOHA + COHA 2023/24**



**Figure 2: Source data spilt for MSSA HOHA + COHA bloodstream infections 2023/24**



1.5.7 IPC resource is focused on the MES organism reduction plan, incorporated within the IPC annual programme of work, and monitored via IPDAG. The focus has been on indwelling devices and a back to basics drive across the whole healthcare economy. This allows increased communication, patient education, staff training and multidisciplinary engagement with infection reduction initiatives.

1.5.8 However these additional improvement drives, which commenced in the second half of 2023/24 have not yet had longevity enough within the Trust to have made an impact on the annual rates for this year. This is not unexpected and the Trust is encouraged by lower reported infections for the latter part of 2023/24.

Reassuringly, the Trust source split broadly mirrors the national picture allowing for meaningful collaboration within the region. The IPCT continues to work with and seek guidance from both the Integrated Care Board (ICB) and NHSE South West with attendance and contributory representation at ICB led and NHSE regional MES improvement groups.

## 1.6 Orthopaedic Surgical Site Infection (SSI)

1.6.1 It is a mandatory requirement to conduct surveillance of orthopaedic SSI, utilising the UKHSA Surgical Site Infection Surveillance Service (SSISS). Surveillance data submitted to SSISS for analysis and reporting is validated against a strict protocol to facilitate meaningful comparison between centres within England. Surveillance of implant surgeries requires follow-up of patients for 12 months post-procedure.

1.6.2 The mandatory minimum requirement is to report one quarter of orthopaedic surveillance from one of the following categories:

- Reduction of long bone fracture
- Repair of neck of femur
- Hip replacement
- Knee replacement

1.6.3 The minimum requirement is exceeded with continuous voluntary surveillance in both the hip and knee categories at the Princess Elizabeth Orthopaedic Centre, Royal Devon & Exeter Hospital (PEOC) and the South West Ambulatory Orthopaedic Centre (SWAOC). A single quarter of surveillance in the knee category is submitted for North Devon District Hospital (NDDH) at the start of the year.

1.6.4 Alongside dilution in volume of surgery across the three orthopaedic sites, case mix for both PEOC and NDDH has changed to involve more complex cases. This results in a

higher anticipated risk of infection in the acute hospital setting. One knee infection, noted in Q1 2023/24, was investigated with the full engagement of clinical teams. Whilst most SSI are deemed unavoidable, useful actions arising from that exercise, including those incidental to the incidence, were implemented in order to reduce future infection. Just one hip SSI was identified in Q1 2023/24. Valuable shared learning elicited as a result of the surveillance programme has this year prompted review of and facilitated ease of use of orthopaedic guidance and patient pathways. No SSI's were reported in the latter quarter of 2023/24.

1.6.5 The SWAOC site is utilised by orthopaedic surgeons from other hospitals across the Integrated Care System as well as from the Royal Devon. The IPCT work collaboratively with hospital teams throughout the South West region to share improvement and ensure strict readmission surveillance protocol is maintained for the full 12 months post procedure in keeping with the UK HSA SSI Surveillance Service requirement.

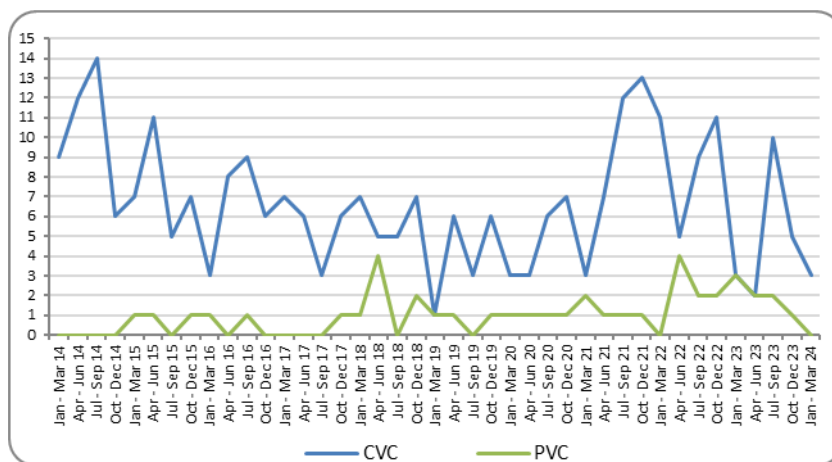
### 1.7 Voluntary Surveillance

1.7.1 In addition to mandatory enhanced surveillance, the IPCT conducts voluntary surveillance to monitor hospital infection in several areas, which includes:

### 1.8 Intravascular device associated blood stream infection surveillance

1.8.1 All central venous catheter (CVC) and peripheral venous catheter (PVC) associated bacteraemia, deemed attributable to the Trust per Nosocomial Infection National Surveillance Scheme (NINSS) definitions in Eastern services, are reported via Datix with shared learning fed back to clinical teams. From this, local and whole Trust action and improvement planning can occur in order to prevent further infection incidence, with wider communication of successes in infection prevention and lessons learnt shared throughout the whole Trust.

**Figure 3: Intravascular device associated blood stream infection (Eastern)**



1.8.2 The graph in Figure 3 demonstrates how the additional IPC focus this year, specifically targeted at indwelling device associated infection, has made tangible impact in intravascular device associated infection in the latter quarters of 2023/24. The drive to reduce indwelling device associated infection, 'review and remove' motto and a collaborative and well received back to basics approach will be sustained through next year's IPC programme of work.

### 1.9 Point Prevalence Survey

- 1.9.1 The Trust took part in the UK Health Security Agency national point prevalence survey of HCAI and antimicrobial use in England, in the Autumn of 2023.
- 1.9.2 Point prevalence surveys are useful in providing data on the proportions of HCAs and proportions of antimicrobial use at any one point (or period) in time. It gives an understanding of burden of both HCAI and community-acquired infection treated with antimicrobials.
- 1.9.3 The official national results will be published later this year but we have been given permission by the UK Health Security Agency to share our preliminary Trust HCAI result of 5.6%. We are confident, as with prior point prevalence surveys, that this will be below the national HCAI figure. For comparison, the recent European Centre for Disease Control point prevalence survey of healthcare associated infections and antimicrobial use in European acute care hospitals 2022–2023 has just published a rate of 7.1%.

## **1.10 Outbreaks and Incidents**

- 1.10.1 Early recognition of potential or actual outbreaks is important to reduce unnecessary exposure to patients, staff and visitors. An outbreak can be defined as two or more cases of the same infection related in time and place. However, when a particular infection is very common in the community two cases in the same time period and place in hospital does not necessarily mean that they are related and investigation does not always provide conclusive evidence either way.
- 1.10.2 Outbreaks of infection in the last 12 months are detailed below. Outbreaks increased when the hospitals were under pressure with the volume of patients requiring admission and challenges with delayed discharges.
- 1.10.3 Outbreak control measures were implemented in accordance with outbreak control policies and that included closing wards or bays to new admissions until the outbreak is at an end. Whilst this is the most appropriate action to take to minimise the number of patients exposed and the duration of an outbreak, this exacerbates the challenges of managing emergency admissions to hospital and the need to maintain elective services.
- 1.10.4 Therefore, wherever possible, steps were taken to avoid lost bed days by transferring into empty beds patients identified with the same infections or those that had recently recovered from the same infection. This does, however, extend the closure of the ward and delays discharges from the ward to other institutions such as care homes.

## **1.11 COVID-19 outbreaks**

- 1.11.1 The NHS COVID-19 response was formally stood down in May 2023. Much of the data reporting associated with this has either been discontinued or incorporated into business-as-usual reporting. All COVID-19 outbreaks were reported internally and externally via the national outbreak reporting portal, which closed at the end of March.
- 1.11.2 Most patients were identified on admission and isolated in single rooms or in COVID-19 cohort bays depending on prevalence. Some patients admitted to hospital for other reasons developed symptoms of COVID-19 whilst in hospital, however, for the majority of patients, infections remained mild.

1.11.3 In Eastern services, there were 8 outbreaks resulting in whole ward closures and 32 bay closures (not all were associated with an outbreak i.e. bay closed to admissions as unable to isolate an infectious patient). In Northern services, there were 10 outbreaks.

## **1.12 Influenza outbreaks**

1.12.1 In Eastern services, there were 2 outbreaks resulting in whole ward closures and bay closures on 17 occasions. In Northern services, there was 1 influenza outbreak.

## **1.13 Norovirus outbreaks**

1.13.1 Norovirus is predominantly a winter pathogen but can also cause outbreaks in summer months. Norovirus is easily transmitted between people even with excellent infection prevention and control practice. Outbreaks are often seen in semi-closed settings such as hospitals, schools, cruise ships, care homes and hotels.

1.13.2 In Eastern services, there were 17 outbreaks resulting in whole ward closures and bay closures on 36 occasions. In Northern services, there were 3 outbreaks.

## **1.14 Other Outbreaks and Incidents**

1.14.1 An outbreak of rhino/enterovirus (a common viral infection) occurred on the neonatal unit in July 2023 involving three premature babies, all of whom recovered completely.

1.14.2 The neonatal unit also sees sporadic colonisation of babies with MRSA or pseudomonas, picked up on routine screening. Outbreaks can occur with cross-transmission between babies on the unit and an outbreak involving three babies who acquired the same strain of MRSA occurred in September 2023. This did not result in any clinical infections with MRSA and the babies underwent de-colonisation treatment.

1.14.3 The Trust saw three cases of Listeria infection, one of which resulted in the death of the patient. Two of the cases occurred in oncology patients which prompted an investigation in collaboration with UKHSA, including sampling of hospital sandwiches, looking for a point source. Typing of the oncology Listeria samples showed they were not linked, and there was no link to hospital food identified.

1.14.4 The Trust and the South West in general, sees comparatively few multi-drug resistant gram negatives in contrast to major urban centres such as London, Manchester or Birmingham, however sporadic cases do occur and are expected to become more frequent. Two bloodstream infections with multi-resistant gram negatives occurred – one community onset which resulted in the death of the patient and one in a hospitalised patient who recovered. These involved different organisms and were not linked and no avoidable harm was identified in the hospital onset case.

1.14.5 There were 2 incidents relating to sub-optimal decontamination of theatre probes. In March 2023 Northern services identified that an ultrasound probe used within a sterile sheath was not decontaminated in accordance with national guidance. As a result of this a second type of ultrasound probe, also used within a sterile sheath, used by Northern and Eastern services was found not to be appropriately decontaminated. Full decontamination was introduced immediately on recognition of the lapse. The UKHSA assisted with the investigation and risk to patients was assessed as very low. No infections as a result of this incident were identified

## **1.15 Hospital Hand Hygiene Audits**

1.15.1 Hand hygiene (HH) is an important intervention for preventing the transmission of infection. All wards and clinical departments carry out a monthly audit of HH compliance in their area against the World Health Organisation's 5 moments for hand hygiene. Generally, high compliance rates are reported by these auditors however, informal observations and validation audits by the IPCTs have identified that hand hygiene compliance has been negatively impacted. There are many causes for this, including increased workload and reduced staffing, but the over use of gloves is perhaps the most significant. This is not limited to just a local issue. Training will focus on improving hand hygiene compliance through emphasising a 'gloves off' approach in 2024/25.

## **1.16 Community Hand Hygiene Audits**

1.16.1 Engagement of community teams continues to improve with an improved number of community teams submitting data each month including a proportion of teams based in the Northern locality. Compliance data is distributed monthly to designated managers with additional narrative content added to the spreadsheet to support interpretation and response. Compliance with the '5 Moments of Hand Hygiene' remains high, averaging 96.3% across the year from observations collected in the community as does compliance with being 'bare below the elbows'.

1.16.2 Compliance data is presented at IPDAG as part of the Community Division Report and is also discussed through Cluster Governance Meetings.

## **1.17 Spot Check Audits**

1.17.1 A selection of inpatient and outpatient areas across the hospital and in other off-site locations are "spot check audited" each month by the IPCNs. The audit tool draws on nationally available resources and is designed to check key infection prevention practices, cleanliness standards and identify any common themes.

1.17.2 Any specific areas of non-compliance or good practice are challenged or discussed with staff on wards / in departments at the time. The results are sent to ward / department managers, senior and divisional nurses, Sodexo, Estates and Facilities with a covering email highlighting any issues or good practice.

1.17.3 Many areas of IPC practice are checked within these audits and some examples are detailed below:

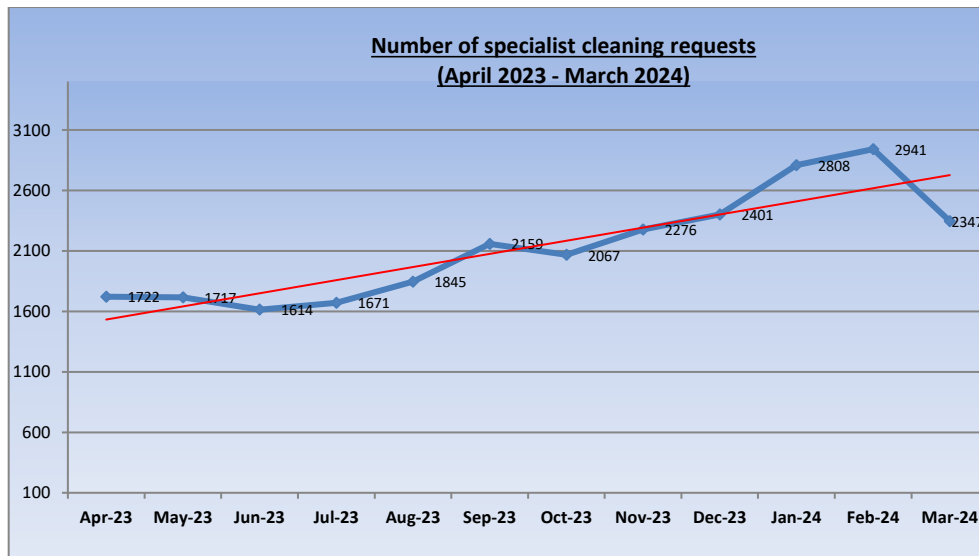
- Hand hygiene and Bare Below Elbows (BBE) compliance and availability of alcohol hand gel and accessibility of hand washing sinks
- On-going care of peripheral IV cannula and urinary catheters,
- Communication about patients on the ward with resistant organisms and MRSA suppression treatment.
- Isolation of patients for infection control reasons
- Storage and management of sharps bins
- Cleanliness of patient equipment some examples include hoists, tourniquets, trolleys, pillows, children's toys, bedpan shells, and commodes
- Linen and waste management
- Food hygiene and management of water coolers for patient use.



### **3. Provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infection**

#### **2.1 Domestic Services (Eastern)**

- 2.1.1 The Domestic Services Department continues to work closely with Ward Housekeepers. The management team are in regular daily contact and attend a Ward Housekeeper Forum on a monthly basis. A structured plan of visits has been implemented with each Supervisor having their own zones within the hospital to check upon, visit the wards and ensure the public areas are kept clean, tidy, free from clutter and any damaged items reported.
- 2.1.2 The most significant challenge for the domestic services team in 2023/24 has been vacancies within the department and difficulties in recruiting to them. It has been necessary at times of particularly high demand to redeploy domestic staff from all non-clinical areas to clinical areas in a bid to keep patient care areas up to standard. Vacancies are, however, now improving and we are hopeful to be at full capacity within the next six months.
- 2.1.3 In order to meet the environmental cleaning demands of an increasingly busy hospital during Norovirus and Influenza seasons, additional resources were added to the Specialist Cleaning Team in a bid to meet the increase in activity. This proved beneficial and helped improve patient flow in key areas such as the Acute Medical Unit and Emergency Department.
- 2.1.4 As COVID-19 and other viral outbreaks have reduced, all domestic assistants have returned to their normal duties and, when there are no deep/outbreak cleans, the Specialist Cleaning Team are assigned to non-clinical areas.
- 2.1.5 The Audit Team continue to undertake and record technical monitoring on a weekly basis along with the Quarterly Management Audits.
- 2.1.6 The Specialist Cleaning Team has been temporarily increased to twenty-four hours, seven days per week, due to the number of deep/specialist cleans being received to be completed overnight. This will revert back to two dedicated Specialist Cleaning Team members during the night throughout the week once the cleans start to reduce. The Site Management Team liaise with the overnight Supervisor and this continues to be a positive example of collaborative working.



2.1.7 The annual deep clean programme (a DoH initiative) commenced at the Royal Devon and Exeter and North Devon District Hospitals and has continued on the Eastern site, with the last deep clean completed within the spring-autumn of 2018/19. Since then, an opportunistic/ad hoc process is deployed across the Eastern site, utilising periods of reduced clinical activity or lower bed occupancy to deep clean areas. This is not often achievable, is challenging to ensure the appropriate teams and external contractors are available at short notice and is not a sustainable way forward. The Northern site continues with weekly ‘bay pulling’ alongside daily standard cleaning but this is not the desired approach to an annual deep clean. Recommendations have been presented to the IPDAG and Safety and Risk committee to explore opportunities to use and protect vacant space on the acute sites or community hospitals to facilitate an annual deep clean.

## 2.2 Domestic Services (Northern)

2.2.1 Sodexo maintain and deliver a quality service to the Trust, and continually strive to provide innovation and improvement to the contract. They have recently trialled ‘Robbie the Robot’, an automated floor cleaner.

2.2.2 Sodexo manage the in-house community Domestic Services which provide a high standard of cleaning to patients and visitors and have performed well with regards to recruitment of staff.

2.2.3 A weekly ‘bay pulling’ and maintenance function is embedded into Sodexo’s routine cleaning schedules. In addition, Sodexo provide a dedicated ‘bed washing team’ to clean beds when they become vacant, whether this is a routine clean (including use of steam cleaners) or a ‘terminal clean’ using a disinfectant. The team also check mattress integrity when they undertake this clean and replace damaged or contaminated mattresses as soon as they are identified.

2.2.4 Monitoring of cleaning is carried out by monitoring officers as well as auditing of this monitoring by the facilities department.

2.2.5 Sodexo employ an independent company (Safeguard) to monitor health and safety, training compliance annually

2.2.6 A programme of “aesthetics” monitoring is completed quarterly to identify environmental issues such as damaged flooring, flaking or damaged paint and plaster, damaged furniture

etc. that require repair. This enhances the condition and appearance of the environment for visitors, patients and staff, facilitates good cleaning and is a theme that runs throughout the documentation required for the National Patient Led Assessment of the Care Environment (PLACE) inspections.

- 2.2.7 The Northern site annual deep clean was last undertaken pre-2013 where areas/rooms were decanted. Since then, 'bay pulling' has been built into cleaning rotas but this is not always viable due to the nature of the activity on the ward.

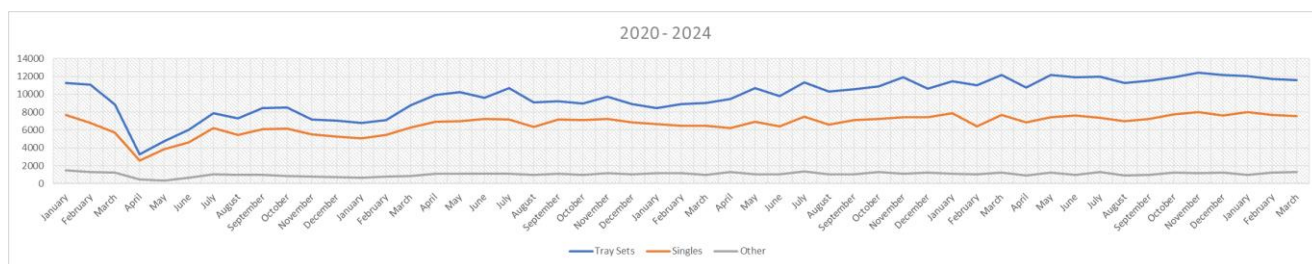
## 2.3 Patient Led Assessment of the Care Environment (PLACE)

- 2.3.1 PLACE assessments provide a view of how the Trust is performing against a range of non-clinical activities which impact on the patient experience of care. The criteria included in PLACE are not standards, but they do represent aspects of care which patients and the public have identified as important. The results for cleanliness in 2023/24 for the Trust was 97.90% a slight increase on last year. The results by site are as follows:

Victoria Hospital (Sidmouth)	100.00%
Tiverton & District Hospital	99.38%
North Devon District Hospital	98.70%
Royal Devon & Exeter Hospital (Wonford)	97.51%
South Molton Hospital	94.82%

## 2.4 Hospital Sterilisation and Decontamination Unit (HSDU) (Eastern)

- 2.4.1 The Trust has effective arrangements for the appropriate decontamination of instruments and other reusable medical devices. The Trust is fully compliant with *Health Building Note, HBN/13 – Sterile Services Department*; operates a quality management system in accordance with *ISO 13485:2016* and has registration under the *UK Medical Devices Regulation 2002 (as amended)*. Decontamination processes are undertaken in line with *Health Technical Memorandum HTM 01-01 – Decontamination of Surgical Instruments* guidance, incorporating *ISO 15883*, *ISO 17665* & *ISO 22441* standards as appropriate. The *Advisory Committee on Dangerous Pathogens (ACDP)* guidance on Transmissible Spongiform Encephalopathy (TSE) is followed in accordance with *National Institute for Health & Care Excellence (NICE) Interventional procedures guidance, IPG666*.
- 2.4.2 Unfortunately, due to staff absence and the wider Operational Services Integration (OSIG) work, the Trust has not appointed a designated Decontamination Lead with responsibility for ensuring that the decontamination policy is implemented in relation to the organisation and takes account of national guidance. This role has been covered by experienced Infection Control Doctors and will be formally established in 2024/25. There is also plan in place to implement a Trust wide Decontamination Safety Group in 2024/25.
- 2.4.3 The HSDU continues to see unprecedented levels of demand for its services, following the COVID-19 recovery phase. Theatre activity has risen to the highest rates since the peak of 2019 and continues to increase in a bid to tackle the growing patient waiting list. Just under 3.8 million surgical instruments were decontaminated, inspected, packaged and sterilised in 2023. Retention of experienced, skilled technicians has been instrumental in maintaining the service during this period. This year, staffing levels have been very consistent following a steady reduction both during and immediately after the pandemic.



2.4.4 Appropriate procedures are followed for acquisition and maintenance of decontamination equipment. This includes seeking expert advice from the Trust's appointed Authorised Engineer (Decontamination), AE(D), as well as appropriately skilled Authorised Persons (Decontamination), AP(D), appointed by the Trust.

2.4.5 The Trust has expanded its capabilities and continues to invest in cutting edge technologies, such as the provision of a second Xi 'Da Vinci' robot for Urology, Colorectal, Prostate, ENT Head & Neck and Gynae surgeries. Minimally invasive surgeries continue to increase at the Trust, delivering efficiency savings in terms of reduced bed stay, quicker recovery periods and more successful outcomes compared to traditional 'open' surgery. The reprocessing of these specialist instruments however, is more time intensive and complicated. There are additional steps required compared to general instrument reprocessing and a high level of Technician skill and knowledge is required to provide the necessary assurances in regard to decontamination and sterilisation.

2.4.6 Recently published guidance from the *NHS Estates Technical Bulletin (NETB/2024/1): Competency framework for staff working in sterile services and decontamination departments* has been received and fed through the Trust's governance control. It is considered an addendum to the Health Technical Memorandum (HTM01-01) and its objectives are to outline the knowledge, skills, abilities and behaviours required by staff working in decontamination units to ensure the highest standards of decontamination are achieved; as well as to give general recommendations for improving board-level commitment and oversight of decontamination quality.

2.4.7 A monitoring system is in place to ensure decontamination processes remain fit for purpose and meet all required standards:

- Comprehensive Divisional and Departmental Risk assessment to include COSHH review
- Full instrument 'Track & Trace' system in place for surgical instrument trays and supplementary instruments in circulation throughout the Trust and community sites.
- Regular review of NICE compliance (IPG666) in relation to reducing the risk of transmission of Creutzfeldt–Jakob disease (CJD) from surgical instruments used for interventional procedures on high-risk tissues.
- Environmental monitoring of Clean Room and associated processes to include quarterly bioburden testing and staff 'finger dabs' in line with ISO 14644 & BS EN 17141.
- Weekly water testing and feedback of results
- Machine checks, daily, weekly, quarterly & annual control tests and revalidation etc.
- Maintenance programme with available records
- Residual Protein Detection monitoring utilising ProReveal technology to accurately measure protein levels post decontamination to micro levels.
- Independent monitoring systems in place to assure parametric release of decontaminated and sterilised loads.
- External auditing of processes by an independent, approved body to include checks of all equipment and testing validation, staff training competencies etc.

## **2.5 Central Sterile Services Department (CSSD) (Northern)**

- 2.5.1 Decontamination of re-usable medical equipment in the Trust is carried out by the CSSD which is open 7 days a week with cover for Saturday and Sunday night via an on-call system.
- 2.5.2 Over the last 12 months, the CSSD has begun the process of replacing its decontamination equipment. Prior to this, the department had 3 washer disinfectors, each capable of cleaning a maximum of 15 standard size theatre trays and 3 steam sterilisers, with the capacity to sterilise 9 standard trays. The washers have been replaced over a phased programme, with 3 machines now installed and fully commissioned, with additional quarterlies taking place.
- 2.5.3 On completion of full commissioning of the washer disinfectors the programme for the steam sterilisers has taken place. The first steriliser was removed and the replacement machine has been installed with commissioning to take place early May 2024.
- 2.5.4 External quality certification for the CSSD is held and is audited by British Standards Institute acting as a notified body for certification to the Medical Device Regulations. The CSSD holds production quality assurance certificate CE02164 and quality system registration certificate MD 78459 from British Standards Institute. The scope of registration covers the sterilisation of theatre trays, procedure packs and single instruments, supply of pre-sterilised devices to end users and high-level disinfection of flexible endoscopes.

## **2.6 Linen Decontamination Unit (LDU)**

- 2.6.1 The Linen Decontamination Unit (LDU) is one of the largest NHS Healthcare laundries in the country and currently boasts some of the most up to date, technological and efficient laundering equipment and monitoring systems used within the UK today. It is based on the Eastern services site.
- 2.6.2 The LDU consistently meets and exceeds the expectations of all its customers in the quality assurance, as evidenced by regular positive feedback received during the quarterly contract review meetings and information contained in reports provided by its customers.
- 2.6.3 The overriding regulatory documentation for the LDU continues to be HTM 01-04 'Decontamination of Linen for Health and Social Care'.
- 2.6.4 The Health and Social Care Act recommends that healthcare organisations comply with the guidance and also outlines the linen handling requirements for laundering establishments who provide linen to the Health and Social Care sectors. These include working to one of two standard requirements, the Essential Quality Requirement (EQR) or Best Practice (BP). EQR is the minimum working standard required but all establishments must have plans in place to attain BP, if they don't already work to that standard. BP is now the desired requirement for Acute Trusts and other healthcare providers when purchasing new laundering services.
- 2.6.5 The LDU first achieved the Best Practice standard in October 2017, after successfully being assessed by an external auditor against the requirements of the British Standard BS: EN: 14065:2016 'Laundry Processed Textiles – Biocontamination Control System'. This assures the provision of the required standard of cleaned, decontaminated linen into the NHS, other public sector customers and the private sector. Registration lasts for 3 years and is maintained by two external annual surveillance visits. However, we have

gone even further, taking a progressive approach toward the safety of textiles, with particular regard to healthcare-associated infections and the safety of patients and staff.

- 2.6.6 In order to achieve and maintain registration, the LDU has implemented a RABC Management System to risk assess any hazard within the laundering process which could affect the biocontamination quality of textiles. Control measures and process controls have been implemented with the main aim of decontaminating used textiles and controlling the risk of re-contamination, throughout the process until dispatch back to the customer. All control measures and processes are continually monitored and internally audited by in-house staff.
- 2.6.7 The Risk Analysis Biocontamination Control (RABC) management system and registration to the provisions of BS: EN: 14065:2016, is currently certified by Atlas Certification Limited, who are accredited by a range of international bodies including United Kingdom Accreditation Service (UKAS) and are a full member of the International Accreditation Forum (IAF).
- 2.6.8 During the LDU's recertification audit for BS: EN: 14065:2016 in October 2023, we were advised by our external auditor that the LDU's RABC Management System is used by them as "a benchmark" when auditing other facilities, including some food processing premises.
- 2.6.9 The highest standard of safety and quality is at the forefront of the LDU's service provision and is rigidly controlled, employing some of the most efficient and up to date technological decontamination and biocontamination control processes used in the United Kingdom. We provide evidence to assure customers that we supply the safest products possible for both patients and staff. At the same time, we can make assurances that we will provide, maintain and continually improve the highest quality of service to them.
- 2.6.10 Decontamination of linen is achieved via Critical Control Points (CCPs) during the wash stage adopting the time and temperature standards of HTM 01-04, in order to neutralise the vast majority (99.99% kill) of bio-contaminants, dangerous substances or germs.
- 2.6.11 HTM01-04 defines that thermal disinfection occurs with a time/temperature relationship of 65°C held for a minimum of 10 minutes. This is our chosen criteria, however a time/temperature of 71°C held for a minimum of 3 minutes can also suffice.
- 2.6.12 The CCPs are verified by a real time monitoring system, which will hold the wash process and prevent release of the textiles if the critical temperature is not achieved.
- 2.6.13 The monitoring system itself is validated using Data Loggers, which are added directly into the wash machines, recording the actual temperature at each stage of the wash process. The process is additionally verified via monthly service visits from the detergent supplier, who audit and correct all aspects of the washing process, including temperatures, water testing and chemical dosing.
- 2.6.14 The LDU has taken the initiative to go one step further, above and beyond the requirements of BS: EN:14065:2016 and validate what scientists say in terms of killing germs within the wash process and to what degree. We have achieved this by arranging two independent analysis tests, which are undertaken biannually.
- 2.6.15 The first is a destructive test called Precision Analysis. This requires a sample of linen, that has been through the LDU's decontamination process, to be sent to an independent

laboratory for testing, where they identify the level of contamination, (including but not limited to S.aureus, Pseudomonas spp, B.cereus, Listeria spp and Salmonella spp). The LDU's test results have so far shown that we are below the recommended bacterial coliform forming units (cfu) 'Theoretical Limits of Detection' for all sample references.

## Precision Analysis Results



Christeyns UK Ltd  
Rutland Street  
Bradford  
West Yorkshire  
BD4 7EA

### CERTIFICATE OF ANALYSIS Microbiological Examination of Garments

Our Ref: PAF 24287-4

Your Ref: Royal Devon Uni Trust Powertrans 14  
washed with Pillowcases x 2 PO No: P76906

Date Received: 27.06.23

Date Started: 27.06.23

Date Completed: 02.07.23

Sample Reference	Lab Ref	TACC@30°C cfu/25cm <sup>2</sup>	Presumptive				Yeast &			
			Coliforms cfu/25cm <sup>2</sup>	<u>S.aureus</u> cfu/25cm <sup>2</sup>	<u>Pseudomonas</u> spp cfu/25cm <sup>2</sup>	<u>B.cereus</u> cfu/25cm <sup>2</sup>	Moulds cfu/25cm <sup>2</sup>	<u>Listeria</u> spp /25cm <sup>2</sup>	<u>Salmonella</u> spp /25cm <sup>2</sup>	
Corner	F48846	<20	Absent	<10	<10	<10	<10	Absent	Absent	
Corner	F48847	<20	Absent	<10	<10	<10	<10	Absent	Absent	
Corner	F48848	<20	Absent	<10	<10	<10	<10	Absent	Absent	
Corner	F48849	<20	Absent	<10	<10	<10	<10	Absent	Absent	
Centre	F48850	<20	Absent	<10	<10	<10	<10	Absent	Absent	
Centre	F48851	<20	Absent	<10	<10	<10	<10	Absent	Absent	
<b>Method based on</b>		A2/15	A2/06	A2/07	A2/11	A2/01	A2/13	A2/09	A2/10	
<b>Theoretical Limits of Detection</b>		20cfu/25cm <sup>2</sup>	10cfu/25cm <sup>2</sup>	10cfu/25cm <sup>2</sup>	10cfu/25cm <sup>2</sup>	10cfu/25cm <sup>2</sup>	10cfu/25cm <sup>2</sup>	1cfu/25cm <sup>2</sup>	1cfu/25cm <sup>2</sup>	

ND = not detected  
cfu = colony forming unit

For and on behalf of  
**PRECISION ANALYSIS (NW) LTD**

**Fiona Croft BSc (Hons) MSc**  
Head of Microbiology

Results relate only to the items tested.  
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Company No. 3097439

2.6.16 The second is a DES-infection Controller, and is intended for testing the degree of microbiological reduction of a process. This test involves passing swatches of fabric, containing a test-organism, (in our case *Enterococcus faecium*), through the LDU's decontamination process. Each of the swatches have been pre-packed in a semi-permeable membrane which allows the test-organism to be reached by water and chemicals, but not to be rinsed off. The start values for the level of microbial content on each swatch are increasing at 10<sup>5</sup>, 10<sup>6</sup> and 10<sup>7</sup> cfu/cm<sup>2</sup>. After the process, the swatches are sent back to the independent laboratory to determine which level of bacteria have been killed. The objective for germ reduction in industrial laundry processes for hospitals,



or the food-industry is  $10^6$ . The LDU's test results have so far shown that we have a minimum kill log of  $10^7$  or over.

## DES-infection Controller Results

		Cleaning Consultancy Delft bv. Haagweg 125-B NL-2612 CR Delft The Netherlands Phone : +31 15 2158676 IBAN : NL07ABNA0550105379 BIC : ABNANL2A VAT : NL0093.29.328.B01 www.ccd.eu / info@ccd.eu	
Our ref. :	250311.DES	Christeyns UK Mrs. A. Hunter Barnard Road, Gate 3 Off Rutland Street GB-BD4 7EA BRADFORD, WEST YORKSHIRE UNITED KINGDOM	
Date :	22-06-2023		
<b>RESULTS DES-infection CONTROLLER</b>		<b>KT3-7</b>	
Testorganism :	<i>Enterococcus faecium</i>	Serialnumber :	<b>250311</b>
<b>Process information</b>			
Testdate :	01-06-2023		
Machine :	Powertrans		
Formula :	09		
RESULTS FOR EACH STARTVALUE [cfu/cm <sup>2</sup> ]			
<b>10<sup>5</sup></b>	<b>10<sup>6</sup></b>	<b>10<sup>7</sup></b>	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
DEGREE OF REDUCTION:		<b>10<sup>7</sup></b>	
Remarks:			
DES-controller: this product is intended for testing the degree of microbiological reduction of a process. The results are only reliable if the user has acted according to the instructions, especially in regard to the limited usability. The DES-controller consists of test organisms which have been placed on standardised swatches. These swatches have been packed in a semi-permeable membrane, as a result of which the micro-organisms can be reached by water and chemicals, but cannot be rinsed off. The analysis determines which level of bacteria have been killed. Objective: for a process where germ reduction is needed, like e.g. industrial laundry processes for hospitals or the food-industry a required degree of reduction of $10^6$ is necessary.			
		Registered at Chamber of Commerce, no. 272.31.287 Terms of delivery deposited at Chamber of Commerce Haaglanden, no. 804	

2.6.17 The RABC system is additionally verified throughout the LDU by a series of Control Points (CPs), where control processes are in place to minimise re-contamination. These are audited and verified by evidence-based systems and document control. These include physical measures such as hygiene controls, protective footwear, KanBan style linen handling systems at the Washer Extractors, dip slide testing and documented evidence such as cleaning schedules, cage sanitisation records and dip slide test results.

2.6.18 The RABC system has an overall main emphasis on the pre-requisites in place, to enable the LDU to implement these controls and systems. A pre-requisite programme identifies the physical attributes and measures what we already have in place and include such elements as having the correct type of building, having physical barriers between the used and clean linen areas, adequate ventilation systems, hand washing facilities and cleaning

regimes. This, along with the biocontamination Risk Plan, helps us implement the control measures required to maintain the system.

2.6.19 The RABC system operates in tandem with the LDU's quality system currently in place, building upon overall standards and includes quality checks at all stages of the finishing section. The LDU has a detailed set of Standard Operating Procedures (SOP) and all staff are trained as per the SOP for the process they are carrying out. This includes carrying out inspection on finished linen, packing and loading in safe quantities and the covering of all cages prior to transit.

2.6.20 In summary, the LDU receives, decontaminates, cleans, folds and packs over 16.5 million articles per year, for the Trust, including the Nightingale Hospital Exeter, plus other Acute NHS Trusts, Community Trusts and other Healthcare and Non-healthcare establishments throughout the Southwest Peninsula area.

## 2.7 Water Safety

2.7.1 *Legionella* spp. and *Pseudomonas aeruginosa* (Pa) are the two primary bacteria that are capable of living in hospital water systems, and indeed can be found in almost any water course or feature as they can be found commonly in the environment around us. They have the potential to cause clinically significant infections in patients, especially those with underlying health conditions or immune suppression.

2.7.2 The Water and Ventilation Safety Group (WVSG) meets monthly on a departmental (Estates) level, twice per year on Trust level and as further required if an issue or risk with water or ventilation is identified. Among the attendees is an appointed external specialist, known as an Authorising Engineer (AE) who helps to ensure that the Trust is able to follow best practice and ensure continued control of *Legionella* spp. and *Pseudomonas aeruginosa*.

2.7.3 The primary Microbiological control of *Legionella* and *Pseudomonas aeruginosa* is achieved by:

- Temperature; the Trust employs temperature control as the primary method of *Legionella* and *Pa* control within the domestic water systems
- This is achieved by maintaining temperatures of:
  - Cold water at temperatures of < 20°C
  - Stored hot water at >60°C
  - Distributed water at >55°C
- The avoidance of stagnation by:
  - Removing any blind or dead ends on distribution pipework as far back to the origin of supply as possible
  - Ensure all Dead-Legs e.g. low use taps, are either flushed twice weekly or removed including any associated pipework
  - Minimising stored water volumes where possible
  - Ensuring that both existing and new systems ensure a good turnover of any water stored within them, e.g. appropriate tank sizing
  - Maintain cleanliness at outlets and follow prescribed cleaning routines to minimise cross contamination from plug holes etc.
  - Cold water storage tanks are inspected annually and cleaned as required by specialist contractors

- 2.7.4 A secondary form of bacterial control is provided by the use of a Copper/Silver (Cu/Ag) Ionisation unit. There are currently four units fitted as below, and each is carefully monitored and regular samples taken to prove its efficacy:
1. Centre for Women's Health
  2. Modular Wards Ashburn and Yealm
  3. Heavitree Hospital
  4. North Devon District Hospital
- 2.7.5 Historically *Legionella* bacterium have been found in very low numbers in water samples taken from outlets within the Trust. This is not entirely unexpected as the organisms can be found readily in most water supplies, and does clearly illustrate the need to effectively control the environment.
- 2.7.6 More recently due to the age of the Wonford Hospital's main building pipework system, scale and corrosion has impacted the available water flow resulting in the loss of thermal control in some secondary and tertiary loops (loops that feed floors and/or one or two outlets). This has led to bacterial colonisation within the water supply system and an increased risk of legionella related infection. This has been appropriately managed through extraordinary water safety groups and there is a risk on the Estates risk register to reflect ongoing concerns, controls and mitigations.
- 2.7.7 Engineering works to replace major pipework and pumps on the system have commenced with a supplementary and enhanced temperature monitoring system.
- 2.7.8 Along with engineering works to replace ageing infrastructure and rebalance the water system to regain thermal control a secondary biocide system (Cu/Ag) ionisation unit has been approved to be installed on the water systems to the main building. This will commence in May/June 2024.
- 2.7.9 *Pseudomonas aeruginosa* sampling takes place as per the HTM recommendations; in Augmented Care areas (ICU, HDU, NNU etc.), on a 6 monthly rolling program. Historically positive results have been recorded from both Yarty and Yeo Wards.
- 2.7.10 Remedial action for any outlet testing positive includes immediate isolation of the outlet and removal from use, an urgent review of cleaning processes, the implementation of a regular flushing and sampling regime; engineering works and chemical cleans as required and regular discussion with the WVSG and DIPC, followed by a prescribed sampling regime, which only allows the outlet to be put back into use when 3 consecutive sample results indicate the outlet is clear.
- 2.7.11 Further works to remove plastic flow straighteners, flexible hoses and corroded pipework or valves also reduces risk, and is undertaken as soon as is practicable.
- 2.7.12 Some parts of the sewerage system on the Eastern site appears to be unable to manage with the volume of effluent that it is expected to drain away or inappropriate matter is entering the system and the system is becoming repeatedly blocked. This can cause overflow and affect back pressure within the system and is being managed by the estates team and affected Care Groups, with a risk on the Medicine Care Group risk register.
- 2.7.13 The Trust has a number of IPC risks associated with backlog maintenance. These are well-understood and documented by the IPC team and Estates. However, a lack of capital investment means there is a risk of these not all being mitigated in their entirety. This specifically relates to ongoing water safety and drainage concerns and the general

condition of parts of the Eastern estate and therefore, the Trust is partially compliant with this criterion.

## **2.8 Ventilation**

- 2.8.1 Possible risks from ventilation are minimised by the use of contractors to clean the inside of each Air Handling Unit (AHU) on a 3 or 4-month rolling program. This includes disinfection of areas subject to moisture, such as cooling coils and fins, as well as regular filter changes.
- 2.8.2 Wall or ceiling mounted cooling units are also subject to regular maintenance and cleans by a specialist contractor, as are portable equipment, where the risk reduced as they are specifically excluded from use in clinical areas.
- 2.8.3 Other safety precautions include cleaning of ducting and ventilation grills as required and for key areas on a regular PPM program generated by MICAD, the computer aided facility management system.

## **2.9 Food Hygiene Eastern**

- 2.9.1 The Environmental Health Officers employed by Exeter City Council visit all Catering outlets run by the Trust, as well as visiting Patient Meal Service, and the 3 Community hospitals which serve food. They inspect at least every 18 months to ensure that we are adhering to the required hygiene standards in accordance with Food Safety regulations – this includes cleanliness, completing temperature records for fridges and freezers, stock rotation of all stores, compliance with Hazard analysis and critical control plan. The Trust has been awarded full 5-star ratings for all of our catering areas in the East.
- 2.9.2 All Catering staff in the East complete food safety training via an online Level 2 basic food hygiene course. This supports staff to adhere to food hygiene standards. We are looking to ensure all ward housekeepers also receive this training.
- 2.9.3 Our Team leaders complete weekly and monthly food safety and cleaning audits within catering. This ensures compliance with industry regulations and helps identify areas for improvement whilst ensuring that cleaning tasks are performed effectively and consistently.

## **2.10 Food Hygiene Northern**

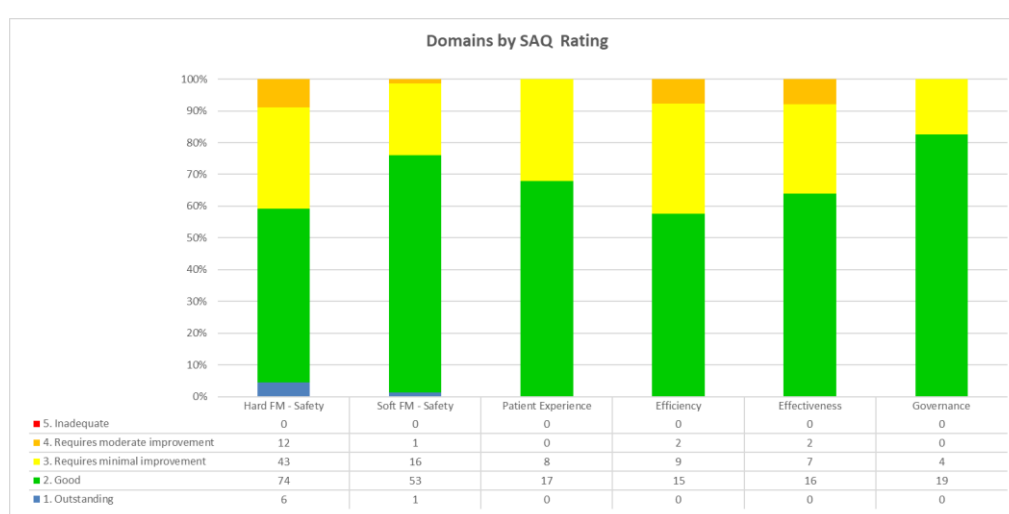
- 2.10.1 Environmental Health Officers employed by North Devon Council for Northern Services visit all catering areas every 18 months to ensure that we are adhering to the required hygiene standards in accordance with Food Safety regulations – this includes cleanliness, completing temperature records for fridges and freezers, stock rotation of all stores, compliance with Hazard analysis and critical control plan. The last visit was the 5<sup>th</sup> February 2024 where a 5-star rating for the main kitchen, restaurant & café at NDDH was awarded.
- 2.10.2 Food services in the Northern site are subject to an annual assurance review (Previously known as Safeguard) by the Sodexo HSEQ Team that looks at all Health & Safety on site which also includes food safety of all the catering operations on site. The review is conducted over 2 days which was completed in July 2023. The site was awarded a 90% pass rate. As well as the annual review, the site team also carry out monthly audits that cover food safety, allergens & calorie display checklist.
- 2.10.3 The Northern site was also audited by ISOQAR in April 2023 and no non-conformance was found. Certification was received to confirm that we adhere to the following standards: ISO 9001, ISO 14001, ISO 4500.

2.10.4 All Sodexo and Trust food handler's complete food safety training annually, compliance for this training is currently 98.5%.

## 2.11 NHS Premises Assurance Model (NHS PAM)

2.11.1 The NHS PAM is a management tool that provides NHS organisations with a way of assessing how safely and efficiently they run their estates and facilities services. The assessment covers the period 1st September 2022 to 31st August 2023. Completion of the PAM assessment, reporting to the Trust Board and online submission is a requirement of the NHS Standard contract.

2.11.2 The assessments are rated on a 5-point scale from Inadequate through Moderate or Minimal improvement to Good or Outstanding. From the applicable assessment criteria, the Trust rated;



2.11.3 The PAM assessment has not identified any high-level concerns or risks.

2.11.4 This is the first year of a merged Trust submission so there is no direct comparison. However, both Northern and Eastern services assessments demonstrate very little change from the previous year. None of the criteria were deemed is inadequate.

2.11.5 Areas of improvement identified through the PAM Assessment are recorded and reviewed through the Estates and Facilities Governance Groups in order to demonstrate continuing and targeted improvement.

## 3. Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance

3.1 Antimicrobial stewardship (AMS) optimises the treatment of infection and minimises the collateral damage associated with antimicrobial use such as the emergence of resistant organisms and *Clostridioides difficile* infection. It is recognised as one of the key components of IPC. AMS is a national priority and national targets set within the NHS standard contract continue to aim to drive down antimicrobial usage.

3.2 Stewardship activities have undergone significant upscaling during 2023/4 including:

- At Eastern sites;
  - stewardship ward rounds scheduled three times a week with a multi-disciplinary team (MDT) including microbiologists, clinicians, infection

- prevention and control (IPC) nurses, antimicrobial pharmacists and clinical pharmacists.
  - Weekly virtual antimicrobial review round of all vascular speciality patients with MDT including microbiologists, clinician and antimicrobial pharmacists.
  - weekly CDI review MDT meeting for current inpatients and community associated cases including microbiologists, clinicians, IPC nurses and antimicrobial pharmacists.
- At Northern sites;
  - Optimised MyCare reporting allows remote stewardship rounds of all urinary tract infection (UTI) patients and those on IV antimicrobials
  - weekly CDI review MDT meeting for current inpatients and community associated cases including microbiologists, clinicians, IPC nurses and antimicrobial pharmacists.
- Trust wide:
  - weekly antimicrobial review round of all paediatric and NNU patients. MDT includes microbiologists, clinicians, antimicrobial pharmacists, clinical pharmacists and Paediatric liaison and transition nurse.
  - Provision of educational sessions to junior medical staff, non-medical prescribers (NMPs), Physicians Associates (PA), IP&C link nurses and pharmacists
  - Intravenous to oral antibiotic switch (IVOS) CQUIN has been achieved with data collected between July 2023 to March 2024. Results for Q2 = 26%, Q3 = 40.4%, Q4 = 38.7%, with a CQUIN target of 40-60% (lower the percentage = better results).
  - Antimicrobial usage between April 2023 – March 2024 compared to 2018 baseline. Data from Rx info<sup>®</sup> which has now merged Northern and Eastern usage data.

Antimicrobial Agent	Joint Trust usage
Carbapenem	-34.6%
Tazocin	-17.1% (only Trust to reduce usage)
Carbapenem sparing antibiotics	-11.5%
Overall reduction	-11.9%

- Merging of Trust Antimicrobial Treatment Guidelines are underway. The following have been completed; Paediatrics guidelines, Antimicrobial Stewardship Policy and Diabetic foot. Many others are in the review process.
- Trusts' across Devon are working together to have a joint approach to MRSA decolonisation, pre-operatively in orthopaedics. The AMS team members have regularly attended these policy review meetings.
- In November 2023, Eastern and Northern AMS teams took part in the national point prevalence survey looking at rates of infections and antimicrobial prescribing. Results are due to be published in April 2024.
- The Outpatient Parenteral Antimicrobial Therapy (OPAT) Service continues to develop and expand. The OPAT service now includes patients in the Northern sites. There is now a daily review round lead by our OPAT specialist pharmacist and Microbiologist FY2 pro-actively looking for suitable candidates and reviewing all patients in our OPAT virtual ward (AHAH)
- In January 2024 the Medicines and Healthcare products Regulatory Agency (MHRA) updated the indications for all systemic fluoroquinolones stating they should only be used as alternative treatment, not first line agents. As a result, the AMS team have undertaken a review of all Trust guidelines associated with fluoroquinolones and introduced a patient information leaflet.

- Members of the AMS team have a monthly meeting with members of MyCare to ensure we are utilising all AMS features in the system. Currently the group is working on flagging empiric antimicrobial review to support the use of a hard stop at 72 hours duration.
- The Antimicrobial Stewardship Group (ASG), which oversees the development and implementation of the Trust annual AMS programme of work met four times over the year, and was quorate on each occasion. ASG now has representation from both Northern and Eastern services.
- The Trust signed up to the 5-year UK Antimicrobial Registry (UKAR) study at the end of last year, this collects live data on usage of specified antimicrobials which are used to treat MDR pathogens. This data is being collected nationally to answer a broad set of research questions around novel anti-microbial agents.

3.3 There remain a number of challenges which will be addressed through the IPC and ASG annual workplan for 2024/25:

- Availability of reports from Epic to provide data measuring adherence to key performance indicators for antimicrobial stewardship in the Trust. AMS team are working with business intelligence to develop.
- Provision of detailed data analysis of infection management, antimicrobial prescribing and breakdown of consumption figures. Challenges remain with regard to extracting antimicrobial susceptibility data, to guide empirical antimicrobial prescribing which will be mitigated by implementation of the IPC module within EPIC (Bugsy)
- Antimicrobial stewardship activities to provide more frequent stewardship rounds with clinicians and clinical pharmacists.

#### **4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further health and social care support or nursing/medical care in a timely fashion**

4.1 Information is provided in a variety of ways for patients, visitors and carers:

- Infection and infection control information is available on the Trust website.
- During times of outbreak, a pre-recorded message about visiting restrictions is in place on the hospital's telephony systems.
- Outpatient letters advise patients about any requirements with regard to infection control prior to their visit
- With regard to specific infectious conditions a range of patient information leaflets are available for patients and their carers.
- Annual reports are published on the external website and reports to the Public Board of Directors.

4.2 Information is also available for those providing further support or care through many of the same methods but also from the Community Infection Management Service (CIMS). The IPCTs are now in the fourth year of providing the CIMS, an ICB funded variation to contract, enabling the Trust IPCTs to provide a service to care homes and primary care, further enhancing relationship and communication between providers.

4.3 Visits were undertaken to GP practices on 12 occasions during the year either to introduce the service or to support improvement work, such as that focusing on cleaning standards. There were 21 site visits undertaken to care homes, these being more focused on the delivery of education and the follow-up of cases of urosepsis (see below).

4.4 A number of educational sessions were provided during the year including the following:



- There were 2 infection control training sessions addressing issues associated with antibiotic resistant organisms, antimicrobial stewardship and specimen collection. This was offered through the Eastern Care Services Team, the Trust's providers of existing training for the social care sector.
  - Eastern CIMS attended an 'Enhancing Health in Care Homes' day event coordinated by the Eastern Care Services Team as a way of networking with providers and promoting the service.
  - Primary Care Infection Control Link Network meetings were held each quarter through MS Teams with sessions including those on Measles, urinary tract infections, '*Staphs and Streps*', antimicrobial stewardship in tissue viability and the National Standards for Healthcare Cleanliness, 2021.
  - Sessions were offered to care providers both over MSTeams and through site visits to care homes titled 'Winter Preparedness'. These reviewed outbreak arrangements for respiratory viruses and norovirus-type infections and were well received.
  - The Devon Learning Hub was supported with CIMS attendance at a study day in Buckfast as well as through a training session on infection control audit at the Racecourse.
- 4.5 Regional and local meetings were attended regarding resources for GP practices, urinary Catheter management, antimicrobial stewardship, public health incidents and outbreaks, Local Authority quality reviews
- 4.6 The team has continued to review toxigenic cases of *C. difficile* arising in the community with feedback, where necessary, being provided to prescribers by Microbiology colleagues. During the year, 55 patients with toxin positive *C. difficile* infection who had either had an inpatient stay in the Trust longer than 4 weeks prior but within the 12-week period (Community Onset, Indeterminate Associated - COIA) or no inpatient stays within the prior 12 weeks (Community Onset, Community Associated- COCA) were reviewed. Requests for information regarding clinical history and antimicrobial treatments were sent out to GP practices and replies were obtained for 40 demonstrating a good level of engagement. Learning arising from prescribing was fed back to prescribers through the Microbiology team.
- 4.7 A new workstream during the year has been the follow up of patients being admitted with urosepsis who live in a care home. Reviews and, where possible, visits have been carried out to explore potential learning.
- 4.8 Outbreaks due to influenza, COVID-19, Infectious diarrhoea/vomiting and scabies were supported in care homes with support to a GP Practice given in response to an outbreak of MRSA and Group A *Streptococcus*.
- 4.9 The Community Infection Management Service continues to make in-roads into the social and primary care sectors and receives regular positive feedback from its involvement. Activity within the service is reported to IPDAG and to the Community Divisional Governance Group each quarter.
- 5. Ensure that people who have or are at risk of developing an infection are identified properly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.**
- 5.1 Patients are assessed on admission for signs, symptoms and risk factors for infection. The electronic patient record prompts this assessment with inclusion of relevant questions including travel history.

- 5.2 The Trust wide Source Isolation policy is in place. This provides guidance on prioritisation for patient placement in single rooms either for their own or others protection. The Trust wide Patient Placement and Movement Policy further guides the appropriate placement of patients to reduce risk of infection.
- 5.3 The movement of patients within the Trust is also included in key policy documents such as the admission and discharge policies. The IPCTs works jointly with the site management teams and with estates and facilities services in planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities.
- 5.4 Trust infection control policies identify the need for information on potential infection hazards to be forwarded to other institutions before patients are transferred out of the Trust. The IPCTs liaise with the discharge planning team and infection control information is included in all documentation.
- 6. Systems are in place to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection**
- 6.1 Responsibilities for IPC is included in job descriptions for all staff within the Trust.
- 6.2 The National Health Education e-learning programmes at level 1 for non-patient facing staff and level 2 for patient facing staff have been adopted. These have been designed to meet the relevant learning outcomes in the UK Core Skills Training Framework.
- 6.3 The Trust's decision for patient facing staff with certain key roles to also attend face to face training, or a virtual training session via MS Teams, provided by IPC specialists has been approved by the Operational Training and People Development Groups. Face to face IPC training at Trust induction and for annual updates will commence from May/June 2024.
- 6.4 In addition to induction and annual update training, IPC is also included in relation to clinical skills in face-to-face sessions on venepuncture, cannulation and parenteral drug/nutrition administration and IPC link practitioner courses.
- 6.5 Fit testing and training for use of FFP3 respiratory protective equipment is undertaken for all staff required to use it and this is provided by the fit testing team.
- 7. The provision or ability to secure adequate isolation facilities**
- 7.1 The Trust recognises the need to maintain and expand facilities for patient isolation for infectious purposes, while recognising the need to provide single room facilities for patients requiring privacy for other reasons. It has been noted in previous reports that the number of single rooms available and the quality of those single rooms needs to be improved. Most single rooms do not have *en-suite* toilet and shower facilities. Lobbies to negative pressure isolation rooms on Torridge Ward are too small to provide an adequate area for donning and doffing PPE. For this reason, the Trust is partially compliant with this criterion.
- 7.2 To assist staff, the Trust has policies associated with isolation and patient placement and the IPCTs advise on prioritisation of patients requiring single rooms.

7.3 To mitigate the challenge of the low proportion of single rooms to total beds, when the number of infectious patients exceeds the number of single rooms available, cohort bays for patients with the same infection are established.

7.4 A small number of portable isolation rooms, known as Redirooms, are also used in clinical settings for patients with infectious conditions where the patient cannot be moved into a cohort e.g. ITU and Respiratory HDU.

## **8. Secure adequate access to laboratory support as appropriate**

8.1 Laboratory services are located on both main acute sites and have full UKAS accreditation, which requires the provision of appropriate protocols and standard operating procedures.

8.2 There is provision of seven-day laboratory working and 24 hour access to medical microbiology advice.

8.3 There is a close working relationship with the IPCTs; Microbiology Consultants attend weekly meetings between the IPCT, virology and microbiology teams to address on-going and new issues.

## **9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections**

9.1 A comprehensive range of documents are available, via the Trust's intranet. The IPCT is responsible for the maintenance and updating of the infection control policies, procedures and guidance documents. There are currently a number of infection control documents that are evidence based and reflect national guidance. Approval for such documents arises via IPDAG and ratification of new policies is via the Safety and Risk Committee.

9.2 There are some instances where two sets of policies remain in use i.e. North and East but a considerable amount of work has occurred over the last 12 months to align policies with the aim of having Trust wide policies only by December 2024. Although two policies exist in some cases, both have been reviewed and remain fit for purpose while a Trust wide policy is progressed.

9.5 The antimicrobial prescribing policy is the joint responsibility of the Consultant Microbiologist and antibiotic pharmacist and is approved by the Antimicrobial Stewardship Group, which reports to IPDAG.

9.6 The decontamination policies and procedures are the responsibility of the decontamination lead.

9.7 All infection control policies carry a three to five yearly review date, or sooner in the light of new evidence. The review schedule is monitored within the annual infection control programme and by the Trust documents administrator. Compliance with key policies is audited according to a schedule included in the annual programme.

9.8 The IPCT also collaborates with others such as the Vascular Access Team in developing guidelines.

## **10. Have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control**

- 10.1 The Occupational Health Service is SEQOHS (Safe Effective Quality Occupational Health Service) accredited. It has been accredited since 2012 and was last reaccredited in December 2023.
- 10.2 The SEQOHS standards are the benchmarks that occupational health services are required to demonstrate they meet to be awarded accreditation and to retain accreditation. Accreditation is a robust process involving self-assessment and external peer assessment against accreditation standards, to establish and promote a culture of continual improvement
- 10.3 Particularly in a healthcare setting, the occupational health services play a significant role in infection prevention and control. Some of the work they have undertaken in 2023/24 to support the protection of staff is identified below:
- 10.3.1 Occupational Health continue to undertake vaccination and blood screening where indicated to reduce the risk of infection in staff at high volumes to tackle the backlog caused by the pandemic and higher levels of recruitment. Table 4 summarises the work carried out in 2023/2024 in comparison to 2022/23.

**Table 4: Vaccinations/Bloods**

			Jan - Mar 24	Total Apr - Mar 24	Total Apr - Mar 23	Comparison
Type of Service	East	North				
<b>Immunisations</b>						
TB Screening	28	4	32	425	355	20%
Hep B	246	201	447	1834	1195	53%
MMR	178	249	427	1315	950	38%
Varicella	32	21	53	242	108	124%
Other vaccinations	51	38	89	339	286	19%
<b>Sub Totals</b>	<b>535</b>	<b>513</b>	<b>1048</b>	<b>4155</b>	<b>2894</b>	<b>44%</b>
<b>Blood Test Screening</b>						
Quantiferon	53	43	96	421	311	35%
Varicella	54	64	118	503	416	21%
Hep B	279	170	449	1670	1355	23%
MMR	29	21	50	442	357	24%
Hep C	53	48	101	427	250	71%
Other screening	137	128	265	1187	618	92%
<b>Sub Totals</b>	<b>605</b>	<b>474</b>	<b>1079</b>	<b>4650</b>	<b>3307</b>	<b>41%</b>
<b>Vaccination Assessment</b>	184	298	<b>482</b>	1953	1775	10%
<b>EPPs</b>	57	45	<b>102</b>	565	424	33%

- 10.3.2 Overall immunisation and blood tests activity is 33% higher than the previous year. Every activity is higher than the last year with the largest % increases seen in varicella vaccinations and Other Screening. The Other Screening includes Pertussis screening. Backlog work and follow up work on DNAs continues and remains on the corporate risk register. The service is currently recruiting against vacancies within the OH practice nurse staff group.

**Table 5: COVID-19 Activity**

			Jan - Mar 24	Total Apr - Mar 24	Total Apr - Mar 23	Comparison
Type of Service	East	North				
Coronavirus advice	164	9	173	1073	6531	-84%
Coronavirus risk assessment	1	0	1	154	385	-60%
Coronavirus medical assessment	0	0	0	7	28	-75%
Coronavirus contact tracing	0	0	0	0	72	-100%
<b>Total</b>	<b>165</b>	<b>9</b>	<b>174</b>	<b>1234</b>	<b>7016</b>	<b>-82%</b>

10.3.3 Table 5 captures the additional COVID-19 activity logged onto the OH database. The overall total is 82% lower than the previous year with falls in all categories. The number of positives reported to Occupational Health during the year was 849 compared to 4,209 in the previous year; an 80% decrease.

10.3.4 Occupational Health continued to chair the COVID-19 alert status group. This group comprises Northern and Eastern services, DPT and University of Exeter. This group examines the local COVID-19 situation in the various organisations and the Devon COVID-19 prevalence to recommend the relevant COVID-19 alert level. Due to low levels of COVID-19, this group has been stood down but can be stood up if there are high numbers of COVID-19 or increased serious illness from COVID-19.

10.3.5 In keeping with other NHS Trusts, flu vaccination uptake is lower than in previous years at 52% against a target of 75%. This is 5,547 vaccinations administered to our staff.

ROYAL DEVON						
Employment code	A. Medical and Dental	B. Nursing and Midwifery Registered	C. All other professional clinical staff	D. Support to Clinical Staff	E. No direct patient care	TOTAL
Royal Devon	1649	3145	1702	4175	2504	<b>13175</b>
<b>TOTAL</b>	<b>1649</b>	<b>3145</b>	<b>1702</b>	<b>4175</b>	<b>2504</b>	<b>13175</b>
FLU - GIVEN	911	1718	895	2023	1346	<b>6893</b>
						<b>0</b>
COVID - GIVEN	853	1266	810	1504	1225	<b>5658</b>
						<b>0</b>
FLU % of staff group	55%	55%	53%	48%	54%	52%
COVID % of staff group	52%	40%	48%	36%	49%	43%

## 11. Conclusion

11.1 Eliminating avoidable healthcare associated infection has remained a priority for the RDUH to ensure our patients, staff and the public are kept safe. The work of the IPC team remains unpredictable but we would like to thank all the team for their hard work, dedication, and positive attitude throughout the year.

11.2 The Trust is fully compliant with 8 out of 10 criterion of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infection and partial compliance in 2 out of 10 criterion which are known to the Trust and mitigations have been identified.

- 11.3 The IPC annual programme of work for the RDUH 2024/25 was agreed by IPDAG in May 2024. Progress against the plan will continue to be monitored by IPDAG and the Safety and Risk Committee.
- 11.4 The RDUH remains committed to preventing and reducing the incidence and risks associated with HCAI's and recognises that we can do even more by continually working collaboratively together with staff, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

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