

2024/2025
Infection Prevention
Management Annual
Report



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1. **Criterion 1**

There are systems to monitor the prevention and control of infection. These systems use risk assessments & consider the susceptibility of service users and any risks that their environment and other users may pose to them.

2. **Criterion 2**

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

3. **Criterion 3**

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

4. **Criterion 4**

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

5. **Criterion 5**

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

6. **Criterion 6**

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

7. **Criterion 7**

Provide or secure adequate isolation facilities.

8. **Criterion 8**

Secure adequate access to laboratory support as appropriate.

9. **Criterion 9**

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

10. **Criterion 10**

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Appendix A – IPM Optimisation Plan (Workplan)

Abbreviations

Abbreviations	Full Description
AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
C difficile	Clostridioides difficile
CDI	Clostridioides difficile infection
COHA	Community onset Hospital Acquired
COVID-19	Coronavirus disease 2019
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment Framework
DCHFT	Dorset County Hospital Foundation Trust
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DON	Director of Nursing
E.coli	Escherichia coli
ESBL	Extended Spectrum Beta Lactamase
GDH	Glutamate dehydrogenase antigen of C. difficile
GRE	Glycopeptide Resistant Enterococcus
GP	General Practitioner
HCAI	Health Care Associated Infection
HOHA	Hospital Onset Hospital Acquired
IM&T	Information & Technology
ICS	Integrated Care System
IPC	Infection Prevention & Control
IPM	Infection Prevention Management
IPMC	Infection Prevention Management Committee
IPMN	Infection Prevention Management Nurse
IPMT	Infection Prevention Management Team
MGNB	Multi resistant gram-negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Methicillin Resistant staphylococcus aureus
MSSA	Methicillin Susceptible staphylococcus aureus
PCR	Polymerase Chain Reaction
PFI	Private Fund Initiative
PHE	Public Health England
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, amber, green
RCA	Root Cause Analysis
SSI	Surgical Site Infection
UKHSA	UK Health Security Agency

EXECUTIVE SUMMARY

The annual report provides a summary of the Infection Prevention Management (IPM) formally known and Infection Prevention & Control (IPC), activity over the last year and status of the healthcare associated infections (HCAIs) for Dorset County Hospital NHS Foundation Trust (DCHFT). Infection Prevention Management is the responsibility of everyone in healthcare, and this is successful with strong leadership and collaborative working.

The Director of Nursing – Acute services is the accountable board member responsible for Infection Prevention Management and undertakes the role of the Director of Infection Prevention Management. This year DCHFT Jo Howarth, Director of Nursing – Acute services/Director of Infection Prevention Management, has continued this role. Jo Howarth has a wealth of experience and knowledge within the field of IPM.

The Infection Prevention Management Committee has a function to fulfil the requirements of the statutory Infection Prevention Management obligations. It formally reports to the sub-board Quality Committee, providing assurance and progress via exception reports. All Trusts have a legal obligation to comply with the Health and Social Care Act (2008) – Code of Practice on the Prevention and Control of infections and related guidance, which was last updated in December 2022.

The yearly IPM Optimisation plan, led by the Infection Prevention Management lead specialist nurse and Infection Prevention Management Team (IPMT), sets clear IPM objectives for the organisation to achieve our new joint strategy. Our vision is for healthier lives, empowered citizens, thriving communities. Our mission is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best. IPM plays a key role in the four strategic objectives: care, communities, colleagues and sustainability. The IPM optimisation plan is developed closely with the completion of the new National Infection Prevention and Control Board Assurance Framework, which was launched in March 2023.

2024 - 2025 was another successful year, meeting key standards and regulatory requirements for IPM. Below documents a highlight for the IPM year: -

- The Trust cases for MRSA Blood Stream Infection (BSI) rates remain low, MSSA BSI rates have significantly dropped this year and are at their lowest rate for the past five years.
- Gram-negative Blood Stream Infection (GNBSI) rates for E Coli and Klebsiella are at the lowest rate for the last 3 years and within the agreed trajectory level set by NHS England.
- Gram-negative Blood Stream Infection (GNBSI) rates for Pseudomonas aeruginosa cases are slightly above the trajectory level set by NHS England. Although, it should be noted the trajectory case rate is set at a very low level of three cases.
- Clostridioides difficile infection rates are slightly over trajectory for 2024-2025. UK Health Security Agency has stood up a National Incident response due to the increase in Clostridioides Difficile infections in England. The response is likely to lead to additional epidemiological and microbiological investigations, this will provide better understanding of the recent increases and help target control measures and mitigations.

- The IPM Patient safety Incident Response Framework (PSIRF) has now been implemented for over a year. The framework allows all cases to be reviewed by experts, thematic learning identified, and actions formulated.
- The Trust continued to follow, review and develop the trust winter plan. The winter plan is supported by ED and Paediatric point of care testing helping to reduce the incidence of nosocomial infection and outbreaks.
- Trust Hand hygiene compliance has remained high and sustained at 99%.
- The trust continued to meet mandatory requirements for Surgical Site Surveillance (SSI) for elective hip replacement and breast surgery.
- The Sterile Services department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).
- The IPM team have launched the IPM Education Framework tier 3 training, which sets out a vision for the design and delivery of IPM education for our people that supports effective and safe care. We have now performed several training sessions to achieve the IPC education framework - tier 3. The training has a strong Antimicrobial Stewardship (AMS) focus and feedback has been very positive. We are the first Trust in the Integrated Care System and most of the southwest to implement this training using the tiered approach.
- Antimicrobial Stewardship (AMS) has been another key focus for the trust, despite not having had an antimicrobial pharmacist for most of the year. The development of an AMS group with a clear focus towards the newly released government's 2024-2029 UK antimicrobial resistance (AMR) national action plan 'Confronting antimicrobial resistance 2024-2029'. We have now successfully appointed a Consultant Pharmacist in a joint post working with University Hospitals Dorset.
- Face to face IPM education and training has continued, combined with an updated IPM e-learning programme. We have increased our face-to-face training within specific departments, especially when a requirement has been deemed necessary. We have maintained very good compliance with IPM mandatory training.
- Enhanced water monitoring continued to mitigate risk of pseudomonas and legionella in tap water in high-risk areas.

Trust remains key national benchmark for use of data management system in infection prevention & control (ICNET).

INTRODUCTION

The Director for Infection Prevention and Control (DIPC) annual report summarises the work undertaken in the Trust for the period 1st April 2024– 31st March 2025. The Annual Report provides information on the Trust's progress on the strategic arrangements in place to reduce the incidence of Healthcare Associated Infections (HCAI's). The purpose of the report is to provide assurance that the trust remains compliant 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). The code sets out 10 criterion which are listed in the contents, and the report uses these criteria as a guide to provide evidence and assurance.

The NHS Standard Contract 2024/25 includes quality requirements for NHS trusts and NHS foundation trusts to minimise *Clostridioides difficile* (*C. difficile*) and Gram-negative Bloodstream Infections (GNBSIs) rates to threshold levels set by NHS England. These requirements support the delivery of the Antimicrobial Resistance (AMR) National Action Plan (NAP) 2024-2029 which includes a target to prevent any increase in all GNBSIs from the 2019/20 baseline by 2029 and is not limited only to Healthcare-Associated infections. The aging profile of the population between now and 2029 means that this in reality represents a 17% reduction in underlying trends. This is a crude estimate based on modelling of estimated population data, against 2019/20 GNBSI rates. The NAP also includes a target to prevent any increase in a specified set of drug-resistant infections in humans from the 2019/20 baseline by 2029.

The 2024/25 NHS Priorities and Operational Planning Guidance states that: 'Systems are being asked to sustain efforts to combat antimicrobial resistance (AMR) in line with the UK 20-year vision for effective containment, control, and mitigation of AMR, particularly concerning reducing the proportion of antibiotics used from the World Health Organization watch and reserve categories. Effective approaches to healthcare-associated infections (HCAIs) will support both addressing AMR overall and the use of Watch and Reserve antibiotics.

While not part of the Standard Contract requirements, as in previous years, NHS England sets out the thresholds, reflecting that the prevention of infections requires preventative, pathway-based approaches. Having targets within the new NAP focussed upon all GNBSIs, not just healthcare-associated, supports this approach.

The Trust cases for MRSA Blood Stream Infection (BSI) rates remain low with two Hospital Onset Healthcare Associated (HOHA) cases and no Community Onset Healthcare Associated (COHA) cases. MSSA BSI rates have significantly dropped this year and are at their lowest rate for the past five years. Gram-negative Blood Stream Infection (GNBSI) rates for *E Coli* and *Klebsiella* are at their lowest rate for the last three years and within the agreed trajectory level set by NHS England. Gram-negative Blood Stream Infection (GNBSI) rates for *Pseudomonas aeruginosa* cases are slightly above the trajectory level set by NHS England. Although, it should be noted the trajectory case rate is set at a very low level of three cases. *Clostridioides difficile* infection rates are slightly over trajectory for 2024-2025. UK Health Security Agency has stood up a National Incident response due to the increase in *Clostridioides Difficile* infections in England. The response is likely to lead to additional epidemiological and microbiological investigations; these will provide better understanding of the recent increases and help target control measures and mitigations.

The Infection Prevention Management team have seen system and partnership working key to supporting the health and safety of the population. We have ensured

continued collaborative working, sharing good practice, offering support where able and championing the benefits of digital support in the management of IPM.

These lower rates of infection have been achieved by the continuous engagement of the Trust Board and most importantly the efforts of all levels of staff. The commitment to deliver safe, quality care for patients remains pivotal in the goal to reduce HCAI's to an absolute minimum of non-preventable cases.

Quality improvement requires constant effort to seek, innovate and lead practice. The Infection Prevention Management team epitomizes this quality improvement ethos, and they significantly contribute to achieving our strategic mission, which is to work in partnership to provide high quality, compassionate services and to nurture an environment where people can be their best. Their support for training and engaging with the clinical teams has been of the highest standard, reflective of the care provided and experience by our visiting public.

The Health and Social Care Act 2008: code of practice on the practice on the prevention and control of infections and related guidance sets out ten compliance criteria. This IPM Annual Report is divided into these ten-compliance criterion which follow below individually, demonstrating the trust compliance and evidenced assurance in meeting the ten criterions. The IPM lead has completed the new IPM Board Assurance Framework, which was issued in March 2023 by NHS England, which enables organisations to respond an evidenced-based approach to maintain the safety of patients, service users, staff, and others. It enables, supports, and provides an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National IPC Manual and the Health and Social Care act 2008: code of practice on the practice on the prevention and control of infections and related guidance. The yearly IPM optimisation plan within Appendix A, links closely with the IPM Board Assurance Framework setting out a clear IPM workplan. The framework enables clear compliance rating pie charts which are evident within this report below each criterion, reduced compliance links with the IPM Optimisation Plan – Appendix One.

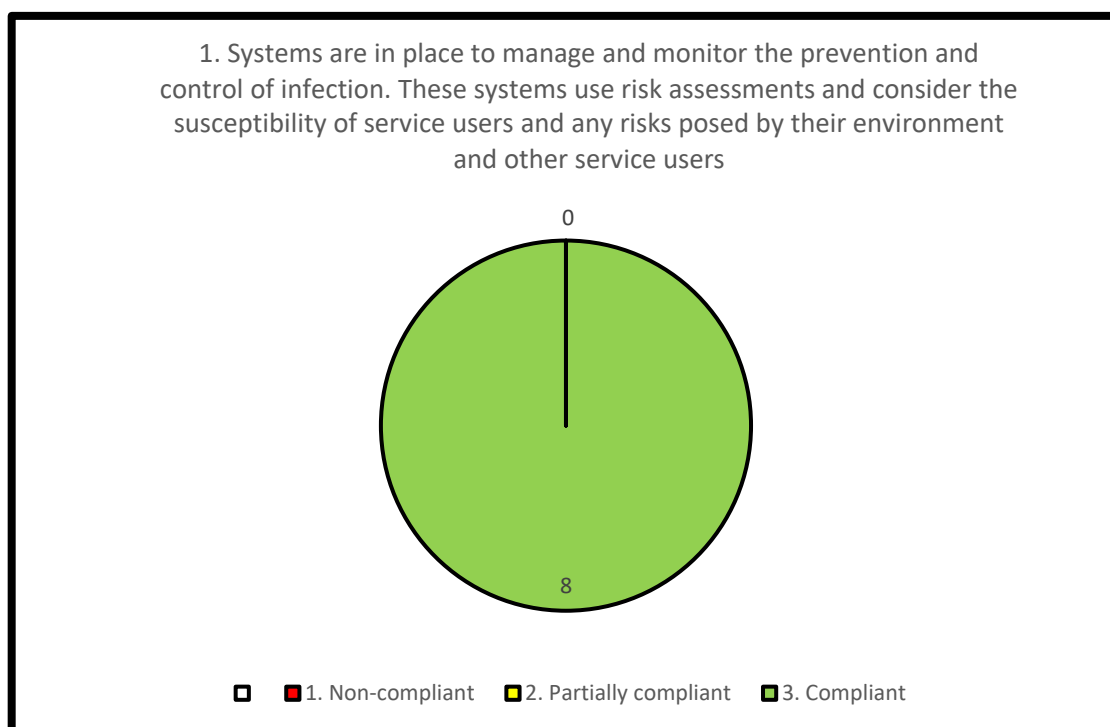
[Confronting antimicrobial resistance 2024 to 2029](#)

[NHS Standard Contract 2024/25: Minimising Clostridioides difficile and Gram-negative bloodstream infections](#)

[Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK](#)

CRITERION ONE:

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



INFECTION PREVENTION MANAGEMENT COMMITTEE (IPMC)

The IPM Committee met 6 times during 2024- 2025. It is a requirement of The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections, that all registered providers: *“have in place an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks”*.

The IPM Committee (IPMC) meetings have been chaired by Jo Howarth Director of Nursing – Acute services/Director of Infection Prevention and Control (DIPC), with the responsibility for reporting to the sub-board Quality Committee for assurance. (Meeting Chaired occasionally by Louisa Way, Deputy Director of Nursing - Acute services/Deputy Director of Infection Prevention and Control (DDIPC)

DIPC REPORTS TO QUALITY COMMITTEE

DIPC reports to Quality Committee via the Quality Assurance Group.

The DIPC has presented the following items during 2024-2025:

- Monthly Gram-negative Bacteraemia surveillance.
- Monthly *Clostridium difficile* surveillance.
- New emerging themes and IPM actions
- Outbreak and incident reports.
- IPM Escalation reports following bi-monthly IPM committee meetings.

INFECTION PREVENTION MANAGEMENT TEAM

The IPMT has welcomed new members in the year, and the team consists of:

- Jo Howarth, Chief Nursing Officer / Director of Infection Prevention and Control
- Emma Hoyle, Associate Director Infection Prevention and Control/Deputy Chief Nursing Officer. Post currently held by Louisa Way as interim.
- Dr Amy Bond, Infection Control Doctor Consultant Microbiologist
- Dr Cathy Jeppesen, Antimicrobial Stewardship (AMS) Doctor and Consultant Microbiologist
- Dr Lucy Cottle, Consultant Microbiologists lead
- Emma Karamadoukis, IPM Lead Specialist Nurse
- Christopher Gover, IPM Specialist Nurse
- Abigail Warne, IPM Specialist Nurse
- Angela Brown, IPM Specialist Nurse
- Helen Hindley, IPM Nurse
- Sophie Lloyd, IPM Nurse
- Sharon Thomas, IPM and Tissue Viability Audit nurse
- Cheryl Heard, Senior Administrator & Fit Mask Co-ordinator
- Darren Wilson, Lead Antimicrobial Pharmacist

The IPM teamwork within the structure of the newly developed IPM optimisation plan, which has been developed alongside the ten criterions. (Appendix A)

IPM Implementation of Patient Safety Incident Response Framework (PSIRF)

For over a year, we have changed the way we are reviewing our infections, in line with Patient Safety Incident Response Framework (PSIRF). The PSIRF sets out the NHS approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Patient safety incidents are unintended or unexpected events (including omissions) in healthcare that could have or did harm one or more patients. PSIRF promotes a proportionate approach to responding to patient safety incidents by ensuring resources allocated to learning are balanced with those needed to deliver improvement.

PSRIF

- Advocates a co-ordinated and data-driven approach to patient safety incident response that prioritises compassionate engagement with those affected by patient safety incidents
- Embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

The IPM team launched the implementation of PSIRF on the 1st of January 2024, and we commenced reviewing our Healthcare Associated Infections (HCAI) differently, working within the framework to identify learning, recurrent themes and improve patient safety. The Root Cause Analysis (RCA) process ceased, and the below organisms are included in our internal PSIRF Programme; Clostridioides Difficile - (HOHA Hospital Onset Healthcare Associated, COHA Community Onset Healthcare Associated), Gram-negative bloodstream infection – (klebsiella spp., pseudomonas aeruginosa, E. coli – HOHA cases), MSSA and MRSA bloodstream infections (HOHA cases). We hold monthly 'learning together' MDT (Multi-Disciplinary Team) meetings to discuss each case that has identified learning following the IPMT/Consultant microbiology after action review. As an IPC ICS (integrated Care system), we also commenced reviewing cases using the PSRIF ideology during our system wide post infection review meetings and cases that trigger an in-depth system wide case review, having triggered a PSII (Patient Safety Incident Investigation) will have an in-depth case review by all

healthcare services involved. Quality improvement projects are then driven following the identified learning and thematic reviews. Escalating concerns via IPMC, PLACE based partnership meetings and Southwest regional meetings.

HEALTHCARE ASSOCIATED INFECTIONS

This year NHS England updated the trajectories figures for *Clostridium Difficile* and Gram-negative blood stream infections. The Gram-negative organisms are *Escherichia coli* (*E. coli*), *Pseudomonas aeruginosa* (*P. aeruginosa*) and *Klebsiella* species (*Klebsiella spp.*). The definition of a case is agreed as follows:

- HOHA – Hospital onset healthcare associated – cases detected within 48 hours after admission.
- COHA – Community onset healthcare associated – cases that occur in the community or within 48 hours of admission when the patients have been an inpatient in the Trust reporting the case in the previous 4 weeks.
- COIA – Community onset indeterminate association - cases that occur in the community with admission to the reporting Trust in the previous 12 weeks but not in the previous 4 weeks.
- COCA – Community onset community associated – cases that occur in the community with no admission to the reporting Trust in the previous 12 weeks.

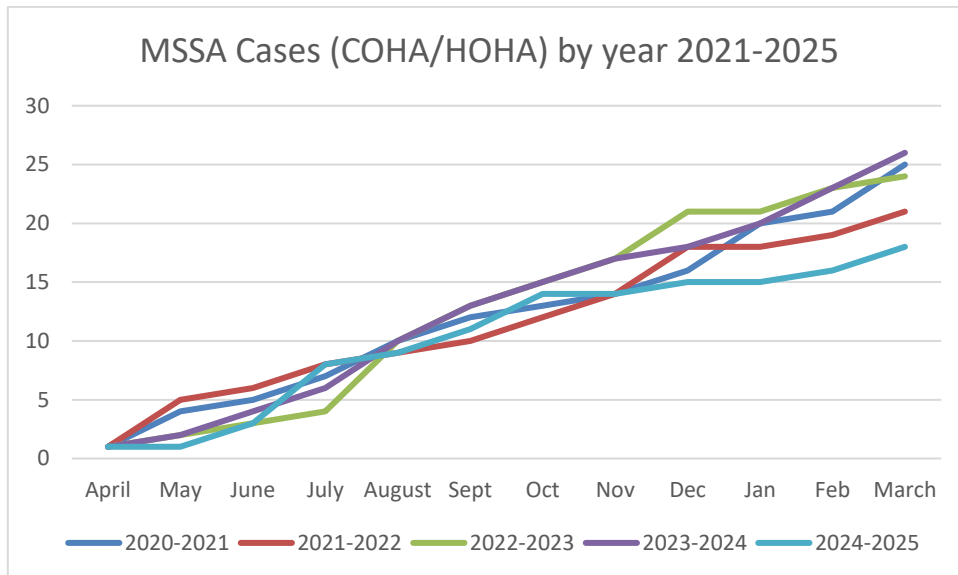
For the purposes of agreed trajectories HOHA and COHA are now combined in reporting.

METICILLIN RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) BACTERAEMIA

Following an in-depth case review using the IPM PSIRF process, there were two preventable cases of MRSA bacteraemia in 2024-2025 assigned to the Trust. This provides confidence that the IPM practices in place have been sustained. In 2024-2025 the trust had 2 MRSA Bacteraemia cases in total.

***STAPHYLOCOCCUS AUREUS* BACTERAEMIA (MSSA)**

In 2024-2025 there were a total of 18 cases of MSSA bacteraemia (HOHA and COHA), a reduction year on year for the last 4 years. The previous year we identified 19 HOHA cases, and 10 HOHA cases identified this year (cases detected >48 hours after admission). No national trajectories have been set for these organisms. At DCHFT this demonstrates stability in cases over the last three year and a reduction in HOHA cases.



To manage MSSA blood stream infections we have implemented control measures that include, screening for certain high-risk patient groups, decolonisation of high-risk patients prior to procedures and close monitoring of indwelling devices via audit. All Hospital Onset Healthcare Associated MSSA infections have an in-depth case review using the IPM PSIRF process, with the results and learning feedback to IPM Committee and senior leaders within the trust, quality improvement projects are then driven following these conclusions.

GRAM NEGATIVE BLOOD STREAM INFECTIONS (GNBSI)

In England, the incidence of GNBSIs is projected to increase. As part of the Governments 2024-2029 UK antimicrobial resistance (AMR) national action plan 'Confronting antimicrobial resistance 2024-2029'. One of the targets in this document is by 2029, we aim to prevent any increase in Gram-negative bloodstream infections in humans from 2019-2020 financial year baseline.

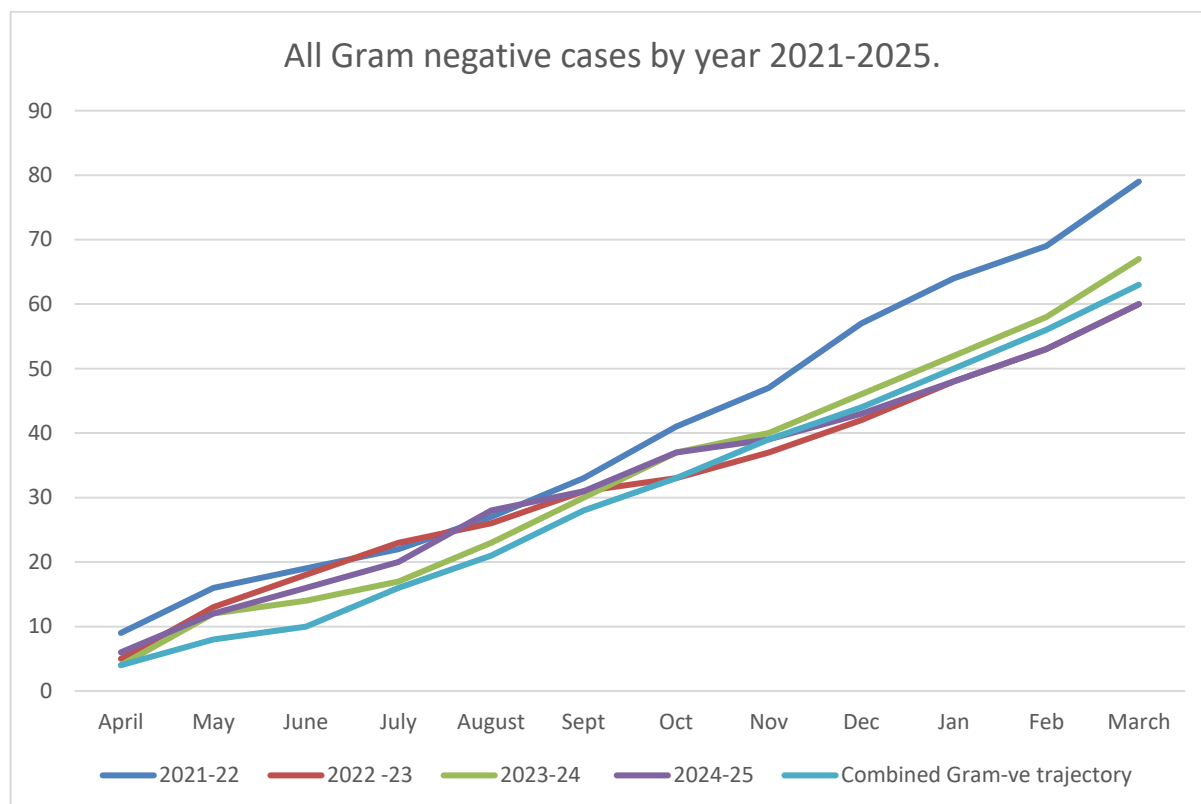
The Gram-negative reportable organisms are *Escherichia coli* (*E. coli*), *Pseudomonas aeruginosa* (*P. aeruginosa*) and *Klebsiella* species (*Klebsiella spp.*).

Mandatory data collection has been in place for many years for *E. coli*. In addition, from April 2017 additional mandatory data collection and surveillance has been in place for *Klebsiella* spp. and *Pseudomonas aeruginosa*. The 2024-2025 formal trajectories for gram-negative blood stream infections were set by NHS England at 63 cases (45 *Escherichia coli*, 3 *Pseudomonas aeruginosa* and 15 *Klebsiella* spp.). Noting this trajectory is for HOHA and COHA combined. All cases of Gram-negative BSI HOHA cases are reviewed by the IPM team using the IPM PSIRF process. In 2024-2025 a total of 60 HOHA and COHA cases for all Gram-negative reportable organisms - *Escherichia coli* (*E. coli*), *Pseudomonas aeruginosa* (*P. aeruginosa*) and *Klebsiella* species (*Klebsiella spp.*). This is the lowest level for four years.

In 2024-2025 there were a total of 42 positive BSI samples for *E. coli* which were attributed to the Trust – HOHA & COHA. Noting this is the lowest rate for the last three year. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

In 2024-2025 there were a total of 11 positive BSI samples for Klebsiella, which were attributed to the Trust – HOHA & COHA. Noting again this is the lowest level for the last three years and a significant drop from last year. A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.

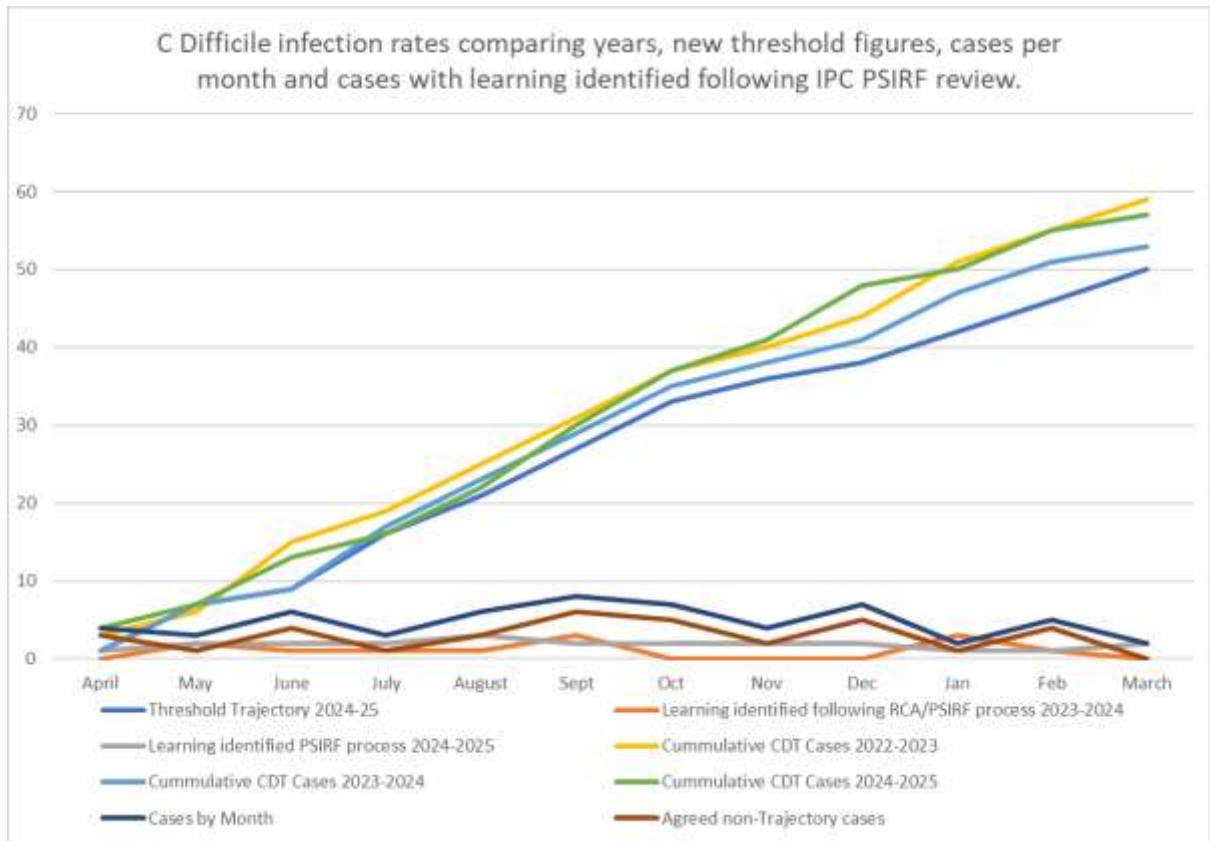
In 2024-2025 there were a total of 7 positive BSI samples for Pseudomonas aeruginosa, which were attributed to the Trust – HOHA & COHA. Noting a slight increase in cases from last year and that our trajectory level is set very low at only 3 cases total per year (HOHA/COHA). A full data collection process is carried out in accordance with UKHSA guidance; this includes all mandatory and optional data.



CLOSTRIDIODES DIFFICILE INFECTION (CDI)

In 2024-2025 Clostridioides Difficile infection formal trajectories for were set by NHS England at 50. In total, the trust reported 57 detected HOHA/COHA cases. Of these cases 22 were identified as preventable with lapses in care; and learning implemented trust wide. This data represents a slight increase in total number of cases from 53. UK Health Security Agency has stood up a National Incident response due to the increase in Clostridioides Difficile infections in England. The response is likely to lead to additional epidemiological and microbiological investigations; these will provide better understanding of the recent increases and help target control measures and mitigations.

Consideration is being given to metrics being planned for 2025-26 to include variation in diarrhoeal sampling and CDI testing rates. These will be monitored to understand their effect on surveillance data. To support preparations for this, it is recommended that organisations validate the accuracy of the CDI sample and testing data that they submit on a quarterly basis in 2024–2025.



All cases CDI HOHA and COHA cases have an IPM PSIRF investigation. The results following these investigations are escalated to IPM committee and all the IPM PSIRF learning and actions are presented quarterly to the IPM committee meeting. The thematic process of IPM PSIRF allows the development of wider quality improvement projects. The IPM team and consultant microbiologists have continued a CDI review of all the CDI cases, looking for trends, areas of improvement and emerging themes. In 2023, the IPM team have also completed an extensive collaborative data collection on all Potential CDI and CDI cases. NHS England have used this data to help identify causes for a national increase in CDI cases. The IPM team have continued to ensure the correct use of Peracetic Wipes across the trust, which are to be only used for commode and equipment cleaning within side rooms for patients with known CDI, with the aim to support environmental cleaning for CDI.

The trust declared one Period of Increased Incidence (PII) of CDI in September 2024. All PII CDIs follow national guidance, weekly meetings to review the situation and appropriate actions are taken as necessary. A formal report is produced at the end of the PII CDI, which is escalated to the IPM committee meeting.

OUTBREAKS OF INFECTION

NOROVIRUS

There have been three outbreaks of Norovirus in the reporting year 2024-2025. This is against the backdrop of a large incidence of norovirus within the community across the country. All declared outbreaks follow our trust procedural policy and the IPM lead always carries out a de-brief meeting afterwards, with the senior ward leadership team and escalates learning via IPM Committee meeting. A formal report is produced at the end of any outbreak, which is escalated to the IPM committee meeting. Prompt isolation of symptomatic patients at the front door is greatly assisted by close monitoring and continued risk assessments of the trust isolation cubicles throughout

the day by the IPM team and the use of ICNET (Clinical Surveillance System). This is used by Clinical Site Managers (CSM) team and housekeeping team.

INFLUENZA/RESPIRATORY VIRUSES

During winter of 2024-2025 cases of Influenza A, B & RSV increased over the Christmas and new year period, linking to the national epidemiological data. The identification of these viruses at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks. This winter we implemented measures to help reduce the spread of infection, such as increasing the use of fluid resistant surgical masks in some areas and extending the staff vaccine campaign. Cohort nursing the same respiratory viruses together improved our isolation capacity and prompt daily reviews and medical de-escalation of cases supported flow within the hospital. We experienced a potential shortage of point of care COVID/Flu/RSV inactivation media due to overwhelming demand and delayed supplier restock due to the Christmas break. Therefore, we moved to a different, more responsive supplier that manufacture locally. In the interim we stood up an enhanced lab-based testing solution to maintain stocks of media in ED and the paediatric ward for overnight testing when the lab was not available. The inactivation media supports effective rapid 24/7 POCT testing in ED and the paediatric ward as part of the DCH Winter Plan. In preparation for 'seasonal flu' all Trust staff were offered the annual flu vaccine.

The 2025 Winter Plan will be updated to include: when the IPM team should cover at weekends taking into account the epidemiological data, continue to recommend suitable cohort areas for respiratory cases across the trust, PPE stocks will continue to be closely monitored linking to the national availability, a detailed plan when to recommend escalation into fluid resistant surgical masks in some areas, and a plan to use a targeted approach for staff vaccinations, including the use of peer vaccinators particularly in areas expected to have high prevalence of Flu and/or covid-19.

Critical Care Carbapenemase Producing Enterobacteriaceae (CPE) Outbreak

We declared a CPE outbreak in our critical care unit in 2024 (lasting four weeks). The outbreak was fully investigated using national guidance, support from other trusts who have experienced a similar outbreak, NHS England and UKHSA. A formal report was produced at the end of the outbreak, which was escalated to the IPM committee meeting and escalated as necessary. Any learning identified has been actioned.

CLINICAL AUDIT

SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are defined to a standard set of clinical criteria for infections that affect the superficial tissues (skin and subcutaneous layer) of the incision and those that affected the deeper tissues (deep incisional or organ space).

Preventing surgical site infections is an important component of Infection Prevention Management programmes. There is a Mandatory requirement by the Department of Health for all Trusts' undertaking orthopaedic surgical procedures to undertake a minimum of three months' surveillance in each financial year.

SSI for all surgery involves 3 stages of surveillance:

Stage 1- collection of data relating to the surgical procedure and inpatient stay.

Stage 2 (not mandatory) collection of post discharge surveillance at 30 days post procedure.

Stage 3- review of patients readmitted within 365 with SSI.

During 2024-2025 the IPM team have supported 2 modules for surveillance between April 2024 – March 2025. The IPM team facilitate a less time-consuming model of data collection utilising the IPM data tool ICNet. The system facilitates readmission alerts, and data upload from PAS, theatre and microbiology systems and the ability to directly upload the data to PHE SSI site.

January 2024 – March 2025 surveillance.

- Repair of neck of femur data collected between January – March 2024. No SSI's identified during this period. Data not collected since 2020 Q1 and 2020 Q3.
- Knee Replacement data collected between January – March 2024. No SSI's identified during this period. Last 4 periods 2 x all SSI identified = 1.1% SSI rate.
- Elective Hip replacement data collected between October – December 2024. One SSI identified during this period. Last 4 periods 3 x all SSI identified = 1.9% SSI rate.
- All breast surgery data collected between April – June 2024. 1 x SSI identified during this period = 0.8% SSI rate. Over the last 4 periods 4 x all SSI identified = 1.2% SSI rate, demonstrating an improved percentage. This would coincide with improvements made regarding MRSA/MSSA screening and decolonisation PGD implementation.

PERIPHERAL VENOUS CANNULA (PVC) and CENTRAL VENOUS CATHETER (CV) AUDITS

PVC/CVCs are devices commonly used in acute hospitals for the administration of intravenous fluids and medication. Failure to monitor these devices correctly can result in early signs of infection being missed with the potential for serious infections to develop. The evidence presented in the national guidance suggests a move away from routine PVC replacement to regular review and early removal if signs of infection are evident or when the PVC is no longer required. The IPM team have redesigned the audits this year. The audits are performed monthly, with the aim to provide assurances that the care of these devices correlates to policy. These audits now feed into the ward dashboards and the IPM dashboard, allowing wards to take ownership of their own results. Any learning identified and any escalations feed into divisional meetings and then to IPM committee meeting.

COMPLIANCE WITH URINARY CATHETER POLICY

Insertion of a urinary catheter is known to be a significant risk factor in the development of urinary tract infections and the risk increases with the duration of catheter insertion. It is therefore important to ensure there is a comprehensive process in place to ensure that the risk of urinary tract infection is considered prior to insertion of the urinary catheter and there is a continuous process for review.

The IPM team have redesigned the audits this year. The audits are carried out monthly, with the aim to provide assurances that the care of these devices correlates to policy. These audits now feed into the ward dashboards and the IPM dashboard, allowing wards to take ownership of their own results. Any learning identified and any escalations feed into divisional meetings and then to IPM committee meeting.

CARBAPENEMASE PRODUCING ENTEROBACTERIACEAE AUDIT (CPE)

Carbapenem antibiotics are a powerful group of β -lactam (penicillin-like) antibiotics used in hospitals. Until now, they have been the antibiotics that doctors could always rely upon (when other antibiotics failed) to treat infections caused by Gram-negative bacteria.

In the UK we have seen a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. A number of clusters and outbreaks have been reported in England during 2024 - 2025, some of which have been contained, providing evidence that, when the appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

UK Health Security Agency (UKHSA) recommends that as part of the routine admission procedure, all patients should be assessed on admission for Carbapenemase-producing Enterobacteriaceae status. UKHSA advice was updated in September 2022, and we have a dedicated policy for CPE, and it remains that all patients admitted to the trust must have a screening risk assessment carried out on admission.

DCHFT carried out a CPE quarterly audit, between April 2023 and March 2024, which aims to determine the level of compliance across the trust with the screening assessment being conducted on admission and the correct actions taken if screening is required.

Results show that the overall compliance with undertaking the admission screening risk assessment was 89%. This was the same as last year and the previous year's 81% result, which demonstrates sustained compliance. To demonstrate continued adherence to CPE guidance and Trust policy this audit will be repeated quarterly for 2025-2026.

CANDIDA AURIS SCREENING

Following an outbreak of candida Auris within the region, and new guidance published from the UK Health Security Agency the IPM team reviewed our own internal screening and policy guidance against national recommendations mid-2023, and we have updated the local trust policy. To support the updated guidance, we have improved our own testing availability via our microbiology laboratory and developed a robust screening risk assessment, which now sits alongside our CPE screening triggers. Therefore, the CPE audit noted above also demonstrates our compliance with the trust Candida Auris screening policy for this year.

COVID-19

Over the past 4 years the IPM team have continued to support the trust throughout the pandemic with updates to guidance in line with Public Health England/UKHSA. The IPM team have also continued to work closely with the Dorset wide ICS to share best practice and learn from other trusts in the Southwest region and beyond.

We have declared no Covid-19 outbreaks between April 2024 and March 2025. This is excellent comparing outbreak figures for other inpatient setting in the Southwest region, especially considering the extremely transmissible nature of Covid-19 and increased prevalence in the community. The identification of the symptomatic cases at point of admission into DCHFT has been greatly assisted by point of care testing available in our emergency department and paediatric unit, which has enabled prompt isolation of patients attending for emergency care and subsequent admission and therefore reducing transmission in hospital and the occurrence of outbreaks.

Covid-19 testing, monitoring and reporting continues to be carried out daily by the IPM team and prompt de-escalation of cases with support from the medical teams, supports our trust isolation capacity.

STANDARD INFECTION CONTROL PRECAUTIONS MONITORING TOOL

We have rolled out the use of the above-mentioned Standard Infection Control Precautions monitoring tool. Department matrons are requested to complete this tool quarterly.

This Standard Infection Control Precautions (SICPs) monitoring tool has been developed to support implementation of the National Infection Prevention and Control Manual (NIPCM) for England. The monitoring tool is for use by all those involved in care provision in England to provide assurance in NHS settings or settings where NHS services are delivered. This monitoring tool is not compulsory, but as a trust we felt it would be a useful tool to demonstrate and provide assurances of IPM practices. It can be used in place of, or in addition to local tools used by organisations to ensure application of guidelines as set out in the NIPCM for England.

The purpose of this monitoring tool is to support self-assessment of SICPs* and to identify areas:

- of good practice
- for improvement (including providing education and training)
- which require immediate action to improve IPC practice and mitigate risk.

The terms used in this tool has been aligned with the NHSE Board Assurance Framework (BAF) and therefore can also be used to provide evidence to support completion of the BAF.

INFECTION PREVENTION & CONTROL WEEK - OCTOBER 2024

To celebrate 'International Infection Prevention and Control week' on the 14th - 18th October 2024. The IPM team organised a 'Bug Hunt'! Our not-so friendly cartoon bacteria were hiding in plain sight around the hospital. We hope to bring a bit of light-hearted fun whilst also raising awareness of the typical infections we are trying to prevent and treat. The aim of the game is to find as many of these bugs as possible, with the winner (having shown evidence of their 'catches') finding the highest number by the end of the week.

The overall aim is to improve staff knowledge and increase awareness on any IPM practice, we also provided a busy week's agenda, which included daily IPM clinics, rep visits, staff training, and IPM quiz.

WORLD HAND HYGIENE DAY - May 2024

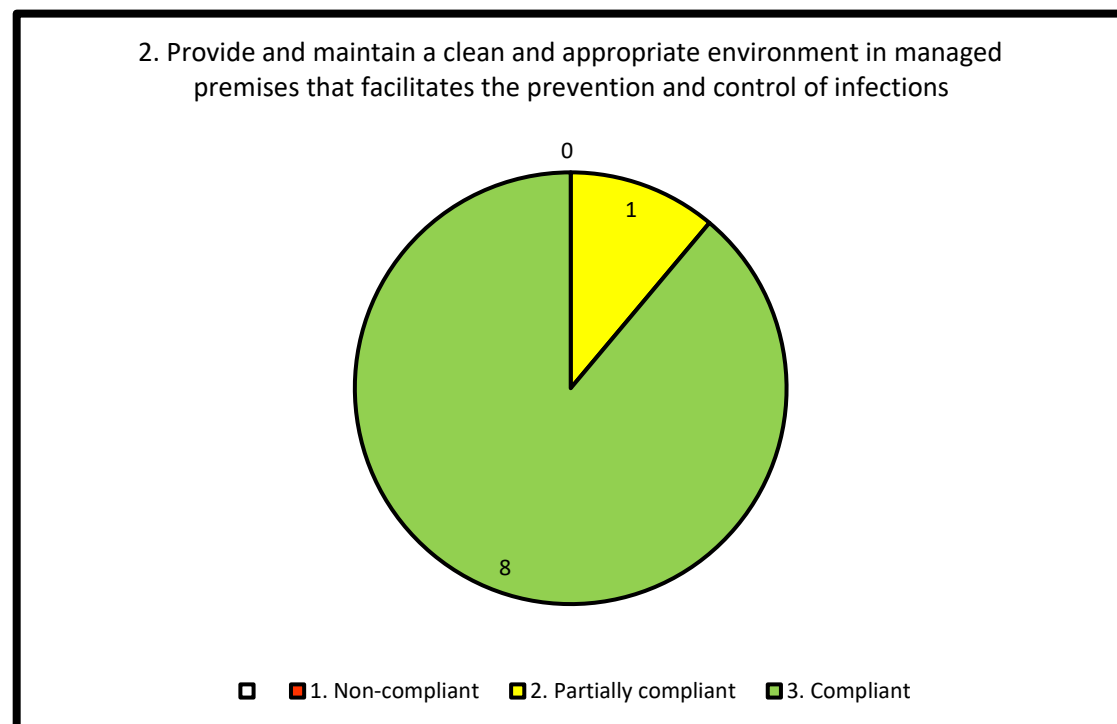
To celebrate world hand hygiene day the IPM team asked staff trust wide to design a new poster for the Hospital, to promote good hand hygiene. There was an overwhelming response to the competition with so many to judge, it was tough to

decide on a winner as they were all worthy. During the day the IPM team decorated a “test your hand washing skills” trolley, with bacteria bunting and rewards for the “best washed hands”. Travelling through to the wards, we were greeted with an air of trepidation; all professions love the idea of getting a free pen and a sticker to say “well done” but not wanting to show their skills of hand washing! We explained that this is not a finger pointing exercise but a bit of fun just to promote good hand washing. For each contender we explained that the fluorescent powder used will need to be rubbed all over their hands, then they put their skills to the test by washing the powder off, “With soap and water?” one staff member asked! Yes please, washing their hands by giving them a good scrub and drying, hoping for a good result by seeing their efforts pay off. All the wards that took part were fantastic and full of enthusiasm!

The importance of hand hygiene day is to promote reducing the risk of spreading bacteria and viruses that are a cause of some infections that can be serious to health.

CRITERION TWO:

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.



Partially compliant: 2.9 Food hygiene training is commensurate with the duties of staff as per food hygiene regulations. If food is brought into the care setting by a patient/service user, family/carer, or staff this must be stored in line with food hygiene regulations. Mitigation: Hotel Service Manager will look to increase the monitoring of this, and the possible introduction of a ward hostess service will support this. Update 2024 , several wards now have hostess roles within the wards. Updated 2025 this role is being reviewed.

ESTATES REPORT

VENTILATION – T Markin Electrical & Mechanical Manager

The Estates team continue to carry out routine inspections and maintenance on all ventilation systems and formal validations on all Theatre and Critical Areas in compliance with HTM 03-01 Part B and carrying out remedial work where required.

In the past year 3 new AHU's have been installed, Theatre 8, Ridgeway Ward and the yet to be commissioned Chemotherapy Ward.

Estates have instigated a new AHU service sheet that incorporates a permit to work specifically for critical areas that require an audit trail, this has been approved by the VSG and will be in place until such time as we upgrade our reporting system and start using tablet type devices to enable electronic records

With the exception of the isolation rooms all AHU's that require verification are up to date, the isolation rooms we are hopeful will be verified between 16th & 19th June 2025.

The AP(V) works under the auspices of an AE(V) maintaining the Permit to work system and ensure all statutory and regulatory records are validated. Following changes to the HTM 03-01 all ventilation issues are discussed at the Ventilation Safety Group.

WATER QUALITY- T Markin Electrical & Mechanical Manager

The Estates Team are responsible for maintaining the Trust's water systems, across the main hospital site and satellite properties, and reporting status to the Water Quality Management Group (WQMG) and Infection Prevention Management Committee. Provisions for water safety are independently audited by experts from the Water Hygiene Centre, who provide the Trusts third party Authorised Expert for water safety. Toby Markin is now water RP; Unfortunately, due to a series of events the AP roll remains open however we are hopeful to fill this post within the next 2 months. There are multiple CP's and further training is expected for new starters.

Work is well under way to install a new water main through North Wing and up to the water storage tanks including local connections to various supplies, this was (still is) the most troublesome source of significant leaks with the potential to cause substantial damage, the new pipe line is of stainless steel construction which is considerably more durable than the previous/existing copper pipe, we also took the opportunity to install better quality, thicker insulation making the water system more resilient to temperature fluctuations due to heat gains.

2.Regular sample testing has been maintained in high-risk areas as well as an expanded portfolio of general outlets throughout the Trust along with out by Estates dedicated Operatives delivering an improved scope of sampling.

There have been 175 reactive calls to leaks in the period 01/05/24 – 20/05/2025 of various descriptions, with (approx.) (7.5% or 13 Emergencies/Urgent): (9.5% being out of hours, the remainder were of various descriptions with a lesser significance. This is a significant improvement on the previous year with over 75% reduction in reactive calls for water leaks.

Legionella Samples	2025	611	<p>2025</p> <ul style="list-style-type: none"> Legionella Samples Legionella Raised...
Legionella Raised Counts	50	8.18%	
Legionella Samples	2024	538	
Legionella Raised Counts	13	2.40%	
<p>At first glance this looks like a significant increase in legionella raised counts, which it is, however 39 of these raised counts are from 8 outlets all of which have been resolved.</p> <p>The 3 raised Pseudomonas raised counts are from the same single outlet and is the only raised count in over 2 years</p>			<p>2025</p> <ul style="list-style-type: none"> Pseudomonas Samples Pseudomonas Raised Counts
Pseudomonas Samples	2025	582	
Pseudomonas Raised Counts	3	0.5%	
Pseudomonas Samples	2024	511	
Pseudomonas Raised Counts	0	0%	
<p>3 x POW shower (now Isolated) until infection cleared</p>			

REPLACEMENT FLOOR COVERINGS (Floor Works) DECORATION AND ENVIRONMENT (painting) – A Kersley - compliance and Assets Officer.

The re-flooring and redecoration work that has been done in the last 12 months is below.

Estates Completed 41 calls to flooring works; 29 jobs were completed by contractors.

We have worked closely with two local contractors, Future Flooring & Carpets 2000. Both contractors liaise with clients well & always give a very high standard of work. We seem now to have eliminated most of the carpeted areas in & around the wards & are implementing cap & cove where required to clinical areas, this allows for much better cleaning & less areas to repair moving forward.

Estates have completed 152 painting jobs; however, we have a long way to go & only one painter makes this very difficult.

In the last 12 months the following areas were given full redecorations:

- Children's Centre
- Endoscopy
- ENT
- Dermatology
- Maternity
- Trust H/Q
- Old SECURITY Office
- NW Level 3
- Cardiac Care Ward

CAPITAL WORKS – R Swatton - Estates Capital projects Manager.

Projects 2024/25	Description of works
Fortuneswell Chemotherapy Outpatients	Full strip out and refurbishment. Service decanted for the duration of the works
Surgical Admissions Lounge (SAL)	Conversion of decanted Outpatient Consultation spaces into open plan SAL
Mary Anning - MH Funding	Redecoration and replacement flooring throughout
Sensory Garden	Creation of quiet garden space with seating. Non-clinical but adjacent to Special Care Dentistry and access/egress through Hospital Streets
Colposcopy	Creation of additional Colposcopy Suite, storage room and adaptation of reception
Portesham Unit	Ongoing defect rectification

HIVE Volunteer Hub	Refurbishment of space including; redecoration, partition installation and replacement flooring. Non-clinical but adjacent to main hospital street
Frailty SDEC	Adaptations including additional storage, track adaptation, addition of access control and push button access/egress
Renal	Adaptation of the old Discharge Lounge to allow utilisation as a Renal training room following Renal Pod closure
POW	Adaptations following closure of Renal Pod
Theatre 8	Full strip out and refurbishment to create Theatre, Recovery Room and all further support spaces
Ridgeway	Alteration to ward layout to support ringfencing of bed spaces for Orthopaedic recovery
Roofs	Priority Roof works - full strip and replacement
Chemotherapy Decant Space	Minor refurbishment of 3x rooms to allow for use as Chemotherapy decant space
MDT	Conversion and refurbishment of DTI footprint to form new dedicated MDT space
DTI Offices	Refurbishment and creation of DTI Offices to support decant from MDT space - non-clinical but access/egress via streets
Hospedia Arm Removal	Full removal of TV screens and arms throughout Trust
Junior Doctor's Office	Full refurbishment including redecoration, cooling and flooring replacement
Nurse Call Replacement	Radiology Ilchester Maternity SCBU POW Moreton
6 Facet Survey	Survey throughout Trust - non-intrusive but attending clinical areas

**DECONTAMINATION SERVICES REPORT – Gaurika Kapoor – Service Manager:
Theatres, Anaesthetics, CRCU and Decontamination, Fiona Sallows – Assistant
Service Manager.**

STERILE SERVICES DEPARTMENT

Quality Management System - Accreditation

The department continues to maintain a full Quality Management System and maintain certification to BS EN ISO 13485:2016. The department is also registered with the Medicines and Healthcare products Regulatory Agency (MHRA).

As a result of Brexit there are some ongoing changes in regulatory requirements. The Medical Device Directive has transferred to the Medical Device Regulation UK MDR 2002 (as amended). Our Notified Body that was based in Sweden as an EU Representative has been transferred successfully after a transitional audit to a UK based competent authority. The Accreditation held by the service continues to give quality assurance on the products and allows the department to provide services for external customers.

External Customers

The department provides a service to various external customers, including Dorset Community Dental Service, DHC Podiatry across Dorset, a local GP practice and the Dorset & Somerset Air Ambulance. Undertaking work for external customers is only possible due to the accreditation achieved by the service. We are looking to potentially increase our external customers for the service to other local GP Practices & Dentists.

Environmental Monitoring

The Clean Room Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates
- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on three washed but unsterile items per machine – Quarterly
- Water Endotoxin - Annually

The latest testing of all areas occurred in February 2025 and the pack room was given a Class 8 clean room status, which is appropriate for the service.

All results are analysed for trends, and corrective actions are undertaken for any areas or items found to be outside of acceptable limits. There are no areas of particular concern currently.

For compliance with HTM 01-01, ProReveal testing is undertaken on a quarterly basis; this involves 50 instruments per washer (200 in total) being tested to detect any residual protein on the instrument surface, after being released from the washer-

disinfectant but prior to sterilisation. Results have been in excess of 99% for each test; this gives assurance that the detergent used in each validated washer-disinfectant is effective.

Tracking and Traceability

Patient registration by clinical users against sterile items at the point of operation is undertaken in one Theatre and two Outpatient Departments.

Best practice would see this system being used in all patient treatment areas and this has been recommended through the Decontamination Group Meeting; currently there is insufficient funding for the purchase of the necessary scanners and software licences. Patient tracking at the time of use significantly reduces the risk of expired items or used instruments being inadvertently used on a patient.

Shelf-Life Testing

Products that had been packed and sterilised for greater than 365 days (our maximum shelf life) are sent for sterility testing or when a new wrap is introduced. Historical testing has showed 100% sterility which gives assurance that the decontamination process is effective.

Staff Training

All Managers and 80% of our supervisors have achieved qualifications relevant to their role. We had one new Supervisor start in post December 2024 and they are due to complete their qualifications before our full accreditation audit which is due in early 2026. This gives assurance that they have a full understanding of the Decontamination process and can effectively manage SSD on a day-to-day basis.

All members of staff receive training appropriate to the area of production they are working in and are observation-assessed following initial training. Refresher training is repeated for all staff after 3 years of service followed by further observation assessment by a supervisor. No member of staff will work independently without having been assessed as being competent to undertake the role.

Joe Lythe, Deputy Divisional Director of Operations is the Trust's Decontamination Lead.

ENDOSCOPY DECONTAMINATION UNIT

Quality Management System

The department is not accredited for external customers but continues to maintain a full Quality Management System. This service is not registered with the MHRA, as the unit does not have a controlled environment product release area, therefore full registration cannot be achieved; this means that an endoscope reprocessing service cannot be offered to external customers.

Environmental Monitoring

Validation is completed by an accredited external laboratory on a quarterly basis. This consists of:

- Settle Plates
- Contact Plates

- Active Air Samples
- Particle Count
- Water – Total Viable counts (TVC)
- Detergent testing

The laboratory also tests:

- Product bio burden on cleaned endoscopes at point of release from the washer and at 3 hours following release which is the maximum usage period following release – Annually
- Product bio burden on surrogate scopes stored in a drying cabinet for 7 days and at 3 hours following release - Annually.

The latest testing of all areas occurred in February 2025 and the Endoscopy Decontamination clean room was given a Class 8 clean room status, which is appropriate for the service

Tracking and Traceability

Patient registration by clinical users at point of use is undertaken in all 3 treatment rooms in Endoscopy and the Outpatient Urology Suite. This provides accurate traceability of all endoscopes used and significantly reduces the risk of endoscopes that have expired the 3-hour window for being used on a patient.

HOTEL SERVICES REPORT- CLEANING SERVICES - Sarah Jenkins - Hotel services manager.

During the past year the Housekeeping Team have continued to work hard to maintain the cleanliness on both the main Trust site and across the wider estate, coping with the changes and additional clinical areas, both temporary and permanent. Staff shortages at times have led to challenges which the team have overcome, and the recruitment of some new staff will help with the ever-increasing workload.

This would not have been possible without the support we have received from our colleagues across the Trust. The new National Standards of Healthcare Cleanliness 2025, which have been published in the past weeks, reemphasise the importance of cleanliness and this being everyone's responsibility and not just that of the housekeeping team. This supports the multi-disciplinary approach which has been taken for many years, and it is this that helps us maintain our standards across all departments.

Cleanliness

Cleaning services throughout the buildings occupied by the Trust, both on and off the main hospital site, in both clinical and non-clinical areas, are provided by an in-house team of staff supervised through a 24/7 rota by a team of supervisors. This team is augmented by external contractors, managed by the Hotel management team, who undertake the window cleaning and pest control aspects of cleanliness. Both these contracts have been retendered in the last year, and the frequency of external window cleaning has increased to give better assurance.

As far as is practicable staff are allocated to a particular area, giving them a sense of ownership, and belonging to the area as well as continuity in the cleaning regime. The

amount of time allocated daily is determined by the frequency of cleans as outlined in the Standards of Healthcare Cleanliness 2025 and by input from the clinical and housekeeping teams. We continue to review these considering changes to IPM guidance, presence of infection outbreaks and the differing pressures caused by reduced numbers of staff at times of increased sickness. The housekeeping schedules are being reviewed with a view to potential change in light of the new 2025 National Standards.

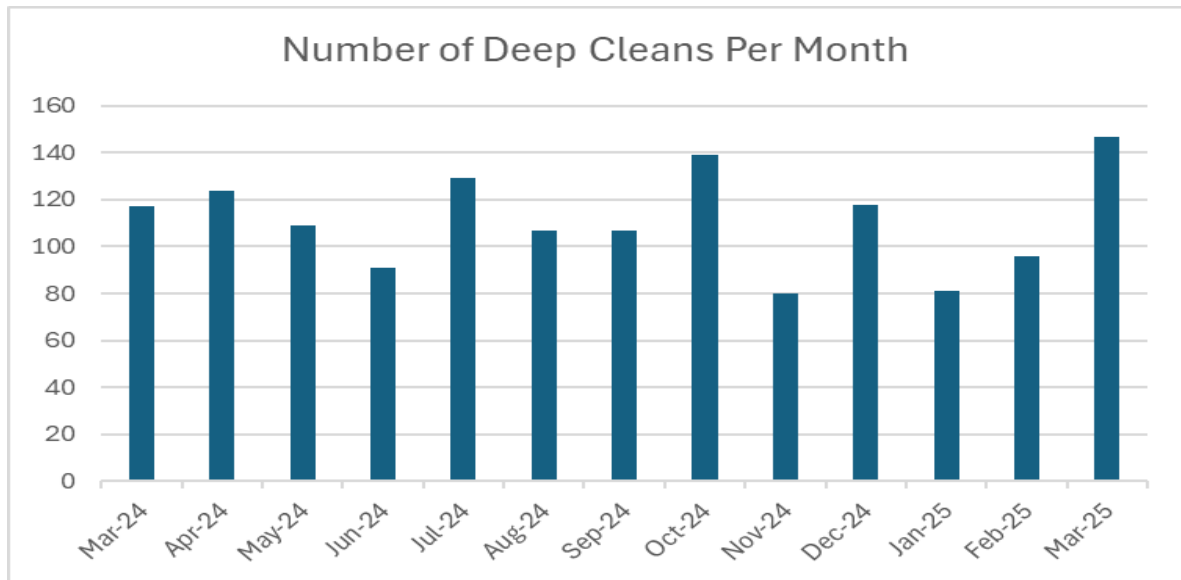
Standards of cleaning are monitored through the audit process, the frequency of which is determined by the functional risk category assigned in accordance with the national standards, in consultation with our IPM colleagues. The frequency can be changed, for example in a period of increased incidence of infection or when there are other concerns as to the standard in any area. These standards also set a timetable for the rectification of failures based on the risk category. Standards are further monitored through reports received from PALS, the environmental audit process and through PLACE. Feedback is given to staff on the areas from these audits.

Deep Cleaning

The continued pressures on the hospital have meant that the annual deep clean programme has once again been delayed. Whilst we would like to be able to carry out a full deep clean programme, the pressures on the hospital and the lack of space in which to decant patients from wards/ bays means that this is challenging. Along with our IPM colleagues we have identified a priority list which will indicate to us both when a deep clean of a ward / department may be needed and then a plan will be enacted with collaboration with the area concerned and other interested parties. The triggers are:

1. Concerns highlighted at an efficacy audit conducted by a team consisting of a minimum of a representative from estates, one from housekeeping and one from the IPM team.
2. Repeat low environmental audit scores.
3. Post infection outbreak.
4. Post Period of increase incidence.
5. Following refurbishment or extensive estates works, for example on duct cleans
6. Concerns escalated by matron.

The deep clean process is supported by fogging with a hydrogen peroxide vapour. We have 3 machines which enable us to carry out cleans in a timely manner which will help flow. Training continues to be rolled out to staff across all shifts so that we can carry out deep cleans throughout each 24-hour period, and further training is planned so there should always be someone on site to carry out these cleans. The new machines provide far greater assurance in terms of reporting of itself and in ease of checking that an area has been cleaned and are safer for the operatives, in that the machines are turned on remotely once the operator has sealed the room, the vents and fire alarm sensors are covered without the operator having to use a ladder and reports are generated to confirm successful operation.



Internal Monitoring

The housekeeping team monitor the cleaning standards through audits. The frequency of these audits is dependent on the functional risk categories to which the area is assigned, and these vary from weekly to annually. The timescale for rectification, by the cleaning, estates, and nursing teams, of failures is also dictated by this categorisation and further by the severity of the risk.

Star ratings are being assigned for display instead of the percentage of cleanliness achieved, rated from 5 to 1 star. The percentage needed to achieve the five-star status is also linked to the functional risk category. Should an area receive 3 stars or less than a list of remedial actions is followed to ensure that the area is brought back up to and remains at standard. Our audit software can be used to document action plans and so we will be able to report on the improvement plans as well as the progress of special projects.

The housekeeping supervisors complete the audits on our audit software and on the completion of the audit, the results are emailed to the department leads, the estates team and the Hotel Services management team, leading to greater awareness and more transparency than previously. It is hoped that the rectifications needed by the cleaning team will be immediately sent to either the member of the cleaning team working on the ward or a rapid response team who will help remedy the failings in the department, but staffing shortages have meant there has been a delay in the roll out of new software.

Average Audit Results April 2024- March 2025

FR Rating	Examples of Area	Audit Frequency	Average Score	Target Score
FR1	Theatres, Fortuneswell Ward	Weekly	98%	98%
FR2	General Ward Areas	Monthly	97%	95%
FR3	Radiology	Bimonthly	97%	90%
FR4	General OPDs and Streets	Quarterly	94%	85%

FR5	Medical Physics	Twice Yearly	96%	80%
FR6	ICT	Annually	96%	75%

Efficacy Audits

Efficacy audits are a management tool to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPM and safety standards. These audits inform the healthcare organisation that correct training, IPM, health and safety, and safe systems of work are being used. We also identify any estates jobs that are required during the audit and monitor standards such as the general appearance of staff and hand hygiene. These audits also focus on the process of cleaning rather than its outcome to ensure that standards are maintained in the process and not just the outcome.

Once a week a team including a member of the IPM team, a representative from estates and one from housekeeping undertake the efficacy audit of all wards and departments across the Trust. All clinical areas have been risk stratified to provide assurance of our process for the schedule of our efficacy audits, but each clinical area is reviewed at least yearly or more frequently if concerns are raised through the processes mentioned within the deep clean plan above.

The results are fed back to the ward lead and matron to acknowledge good practice and address poor service and actions required to drive continuous improvement.

PLACE

We once again carried out a Patient Led Assessment of the Care Environment, (PLACE) in the autumn of 2024.

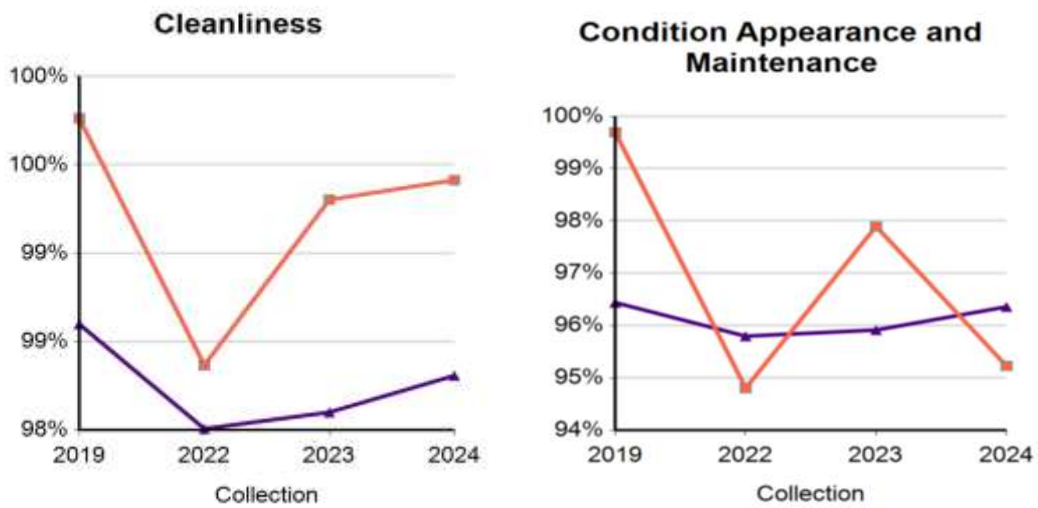
PLACE assessments are an annual appraisal of the non-clinical aspects of healthcare settings, undertaken by teams made up of staff and members of the public, known as patient assessors. The questions are focussed around 6 domains, the relevant ones for this report being the cleanliness and condition of the buildings.

It should be noted that the PLACE findings represent a snapshot of the areas as they were found on the day, and the good scores in these domain areas are a testament to the hard work of the housekeeping and wider estates teams as they strive to maintain the environment with stretched resources. We saw an increase in the cleaning score from the already good result from the previous year but saw a fall in the scores for the condition of the estate, which reflects the increasing maintenance backlog despite the best efforts of the estates team.

The failings identified in the exceptions report form part of a action plan, which is used to inform the estates and facilities departments of areas which require attention and improvement, and some projects are already underway and completed, such as the provision of a new changing places toilet.

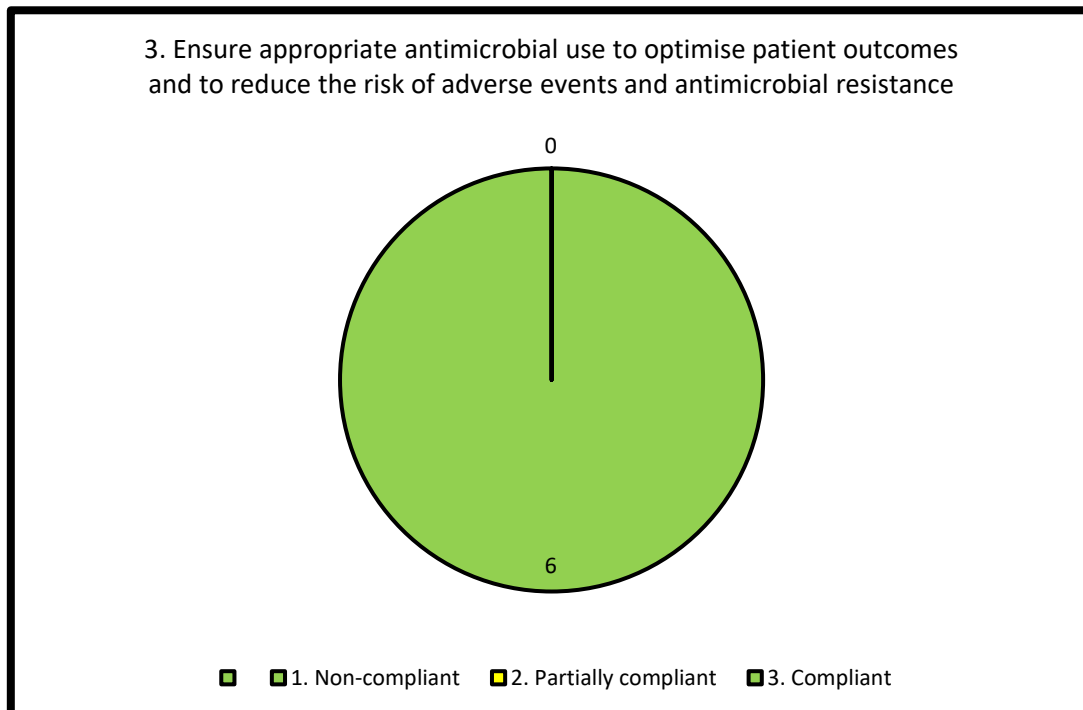
We unfortunately have not had the resource this year to carry out any PLACElite audits but hope to hold some in the coming months. These act as a mini-PLACE audit and allow us to see areas in which we have improved and those areas where there is still room for action. We are joined on these by our patient assessors, to give the patient's perspective on the environment, and whilst we do not report on these nationally, they give us an indication of areas for improvement

Graphs showing the scores in recent years as compared to the national average



Organisation Average National Average

CRITERION THREE: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.



Antimicrobials: Summary report for financial year 2024/25.

Catherine Jeppesen, Ben Squibb and Darren Wilson

Introduction

Antimicrobial resistance (AMR) is a pervasive threat which is already causing people to suffer longer from infections which are more difficult to treat. If AMR continues to spread, some infectious diseases which, in the UK, would normally be simple to treat with an antibiotic, may become significant new causes of illness and death. In 2024 the UK published the latest five-year AMR National Action plan (NAP) 2024 – 2029 “Confronting Antimicrobial Resistance”, which aims to take the UK closer to reaching its vision of containing and controlling AMR by 2040. The next 5 years are described as a pivotal period in addressing the global threat of AMR.

The 4 key themes of the plan are:

Theme 1 – reducing the need for, and unintentional exposure to, antimicrobials

Theme 2 – Optimising the use of antimicrobials.

Theme 3 – Investing in innovation, supply and access

Theme 4 – being a good global partner

The plan also emphasises the importance of taking a One Health approach, with collaborative working across agriculture, animal and human health sectors necessary to achieve success. Theme 2 is the most relevant theme for secondary care AMS teams, and will be discussed in more detail below, but we also work collaboratively

Box 1: National Action Plan Theme 2 – Optimising the use of antimicrobials.

Outcome 1 - Antibiotic stewardship (and disposal). Includes the aims of:

- Supporting frontline clinicians to target antimicrobials to those most likely to benefit
- Supporting front line clinicians to optimise the agent, dose, route and duration of treatment for individual patient
- Reducing total antibiotic prescribing by 5% by 2029, compared to 2019 baseline
- Aiming for ≥ 70% of prescriptions to be from the Access* group (UK version of the WHO classification). This may refer to the whole health system, not necessarily for individual secondary care providers. Trust level targets in this area have not yet been set.

Outcome 2 – AMR workforce. Includes the aims of:

- Embedding completion of IPM and AMS training for all health and social care workers and students, and to provide career pathways and promote skills retention for specialist posts.

*Based on the AWARE antibiotic classification system, antibiotics are classified into three groups; Access, Watch and Reserve. Access antibiotics tend to be narrower spectrum and should be used first line, whereas watch and reserve antibiotics are generally broader spectrum with activity against more resistant organisms, and their use should be limited

with the Infection Prevention Management (IPM) team around theme 1. The Dorset AMR board is being re-vitalised to provide strategic support and guidance across IPM and AMS.

For much of 2024/25, the AMS team at DCH has been without an antimicrobial pharmacist, but fortunately this situation ended in January 2025 with the appointment of Darren Wilson to a joint senior/consultant AMS pharmacist position split 50:50 across DCH and UHD. Prior to his appointment, Dr Cecilia Priestly did a fantastic job of chairing monthly meetings of the AMS group to maintain momentum and motivation. She has now handed over the chair to DW. It is intended that this post will lead to more joint working across the Dorset acute trusts, harmonisation of guidelines over time, and facilitate benchmarking and the sharing of best practice and learning.

The AMS team now consists of Darren Wilson, lead AMS pharmacist (0.5 WTE), Ben Squibb AMS pharmacy technician (0.5 WTE) and Dr Cathy Jeppesen, microbiology lead for AMS.

Optimising the use of antimicrobials

A summary of desired outcomes relating to theme 2 of the NAP is shown in box 1. Notable achievements by the AMS team during the year 2024/25 which contribute to these outcomes include:

- **Migration of DCH antibiotic guidelines from SharePoint to the Eolas platform.** This is an online platform and App which took over the Microguide App during 2024, and as such is used by the majority of trusts in UK to house their antibiotic guidelines. It will support clinicians in using the most appropriate agent, dose and duration of antimicrobial in an easy-to-access, easy-to-update format. This was a substantial piece of work involving clinical review and formatting of over 100 guidelines. Many were updated and/or aligned with UHD, with some new guidelines adopted from UHD or written de novo to address gaps. The DCH Eolas

antibiotic guidelines were launched on Nov 16th, 2024, during antibiotic awareness week, with communications and a poster campaign.

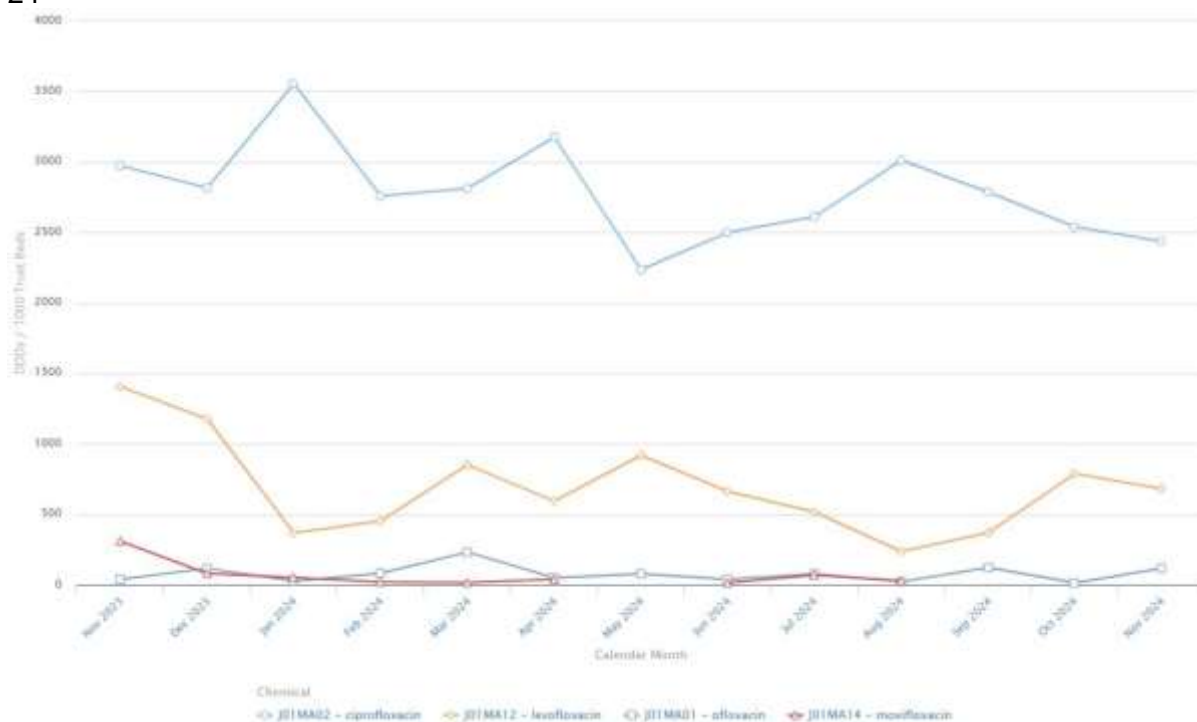
- **Quinolone prescribing.**

The AMS team has undertaken a number of measures to reduce inappropriate quinolone prescribing in response to updated MHRA warnings about their risks. A quinolone alert was produced, circulated by email and added to Eolas. Indications for quinolones have been removed from a number of guidelines including non-severe HAP, and the MHRA message has been included in educational sessions for F1s, medical directorate, pharmacists, senior nurses and the surgical governance meeting.

This appears to have been effective based on a repeat snapshot audit of quinolone use, which demonstrated that half as many inpatients were taking quinolones during audit days in April 2025 compared to March 2024, and 100% were deemed appropriate (according to guidelines or as directed by microbiology) compared to 88% last year. There is still some overuse in patients documented as penicillin 'allergic', however, where their reaction is either non-severe allergy or minor intolerance, so this is an area for further work.

Figure 1 below also suggests the activity has been successful with a downward trend in total monthly quinolone usage (includes both in and outpatient).

Fig 1 – DCH Fluoroquinolone usage (DDDs per 1000 beds by month) Nov 23 – Nov 24



- **Penicillin allergy de-labelling.**

Penicillin allergy is reported in up to 10% of the general population, however, over 90% of patients reporting such an allergy tolerate penicillin without incident. True penicillin induced anaphylaxis is exceedingly rare (0.015%-0.04% of patients). Inappropriate penicillin allergy labelling has negative impacts on health care. Patients labelled as penicillin allergic have longer hospital stays and increased exposure to suboptimal antibiotics (for example, quinolones).

BS performed an audit of 188 inpatients labelled on JAC as penicillin allergic during May – July 2024 (trust audit 6076). 79 (42%) patients were able to give at least partial answers to the questionnaire; the remainder were unable due to mental or physical barriers to participation. The questionnaire covered questions used in the PEN-FAST tool (Trubiano et al 2020), namely details of the allergy symptoms and how long ago it occurred.

7 (9%) of the 79 patients stated that they were not allergic to penicillin-group antibiotics, and they were unsure why this label had been added to their primary care records. The audit identified 40 patients that were categorized as very low or low risk by the PEN-FAST tool (17 and 23 respectively) who could be suitable for oral challenge, potentially allowing them to be given penicillin's in the future. Penicillin de-labelling will be explored further in the coming year, although there are challenges around who would perform de-labelling, and whether successfully de-labelled patients would inadvertently regain their allergy label from other care records.

- **Staff education.**

The microbiology consultants have delivered medical teaching sessions on AMS to new starter F1s in September 2024, a second session for F1s in March 2025, and a joint AMS session with a gerontologist for the medical directorate teaching programme in March 2025. CJ has also presented a section on AMS as part of the new IPM training for TEIR 3 senior nurses, which is a new staff group for AMS training and feedback was very positive.

This is a start towards embedding AMS awareness and education for all staff groups, in line with the NAP recommendations, however AMS is currently not part of the national mandatory training agenda, and as such there are hard to reach groups such as existing medical staff, and all training material has to be developed locally. There are opportunities to share training strategies and materials with UHD and the SW region which will be explored in the coming year.

- **PSIRF learning**

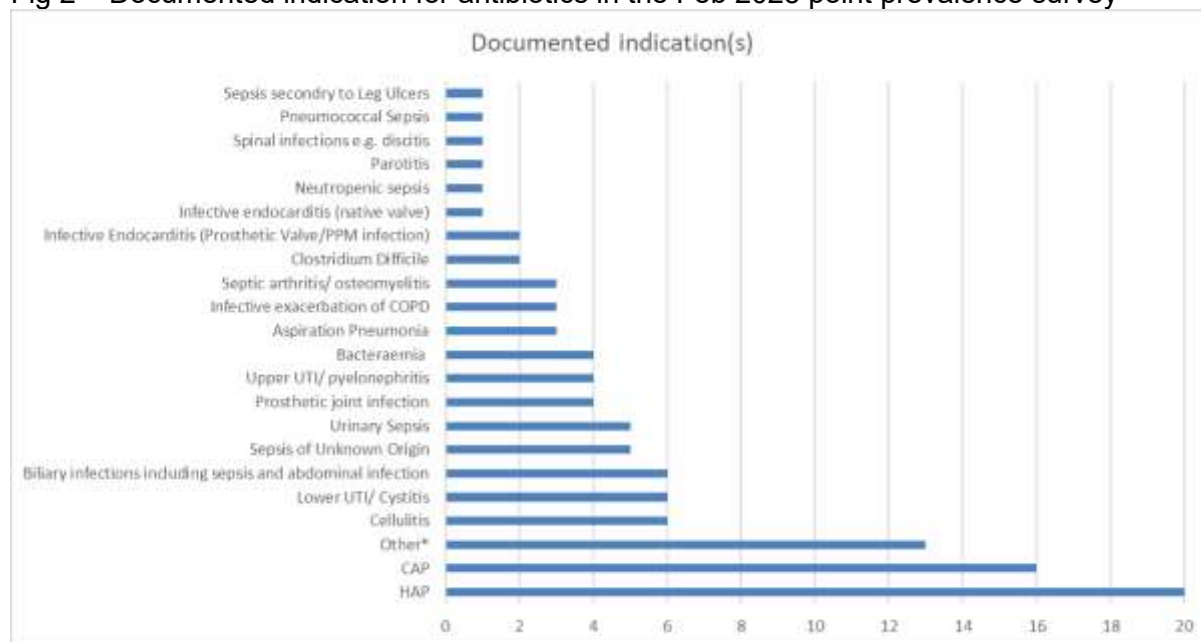
Microbiologist LC has produced 2 succinct and well-received educational emails for all clinical staff, to feedback the findings and themes from C difficile PSIRF reviews.

- **Local Point prevalence surveys and Data Dashboard.**

Since starting in post, DW has begun a programme of quarterly point prevalence surveys. The first PPS, in February 2025, found that 110 of 337 inpatients (32.6%) were prescribed antibiotics on the day of survey. The indications are shown in figure 2.

This is the start of a data dashboard which is being developed by the AMS team and will include several key AMS metrics. The aim is to provide information for action: to inform strategy and priorities, for reports and assurance, and will to trend analysis over time and assessment of the effectiveness of interventions.

Fig 2 – Documented indication for antibiotics in the Feb 2025 point prevalence survey



Antibiotic Consumption Data 2024-25

There were no mandatory CQUINS or AMS targets in the standard contract for 2024/25. The locally produced consumption graphs below demonstrate a mixed picture. In recent years our total antimicrobial consumption is trending down, which is good, however it is higher than it was in 2019, the comparator year used by in the national action plan. The proportion of antimicrobials from the Access category is stable at around 52%, and there is likely to be room for improvement if we compare ourselves with UHD. But for context, the southwest is the region with the lowest use of Watch and reserve antibiotics in the UK, and UHD is one of the lowest users in the SW. So, while there is certainly scope to learn from practice at UHD, we should also allow for the differences in our patient populations – DCH has an older patient demographic, and for example the commonest indication for inpatient antibiotics from our first quarterly point prevalence data was hospital acquired pneumonia, which necessitates broad spectrum coverage.

Figure 3. Annual Total Antimicrobial consumption data (DDDs per 1000 admissions including day case) from 2016/17 to 2024/25. This demonstrates a downward trend over the past 3 years which is encouraging, although when compared to the 2019, the year used as a comparator year in the NAP, our total consumption has gone up. (DCH data extracted from RxInfo)

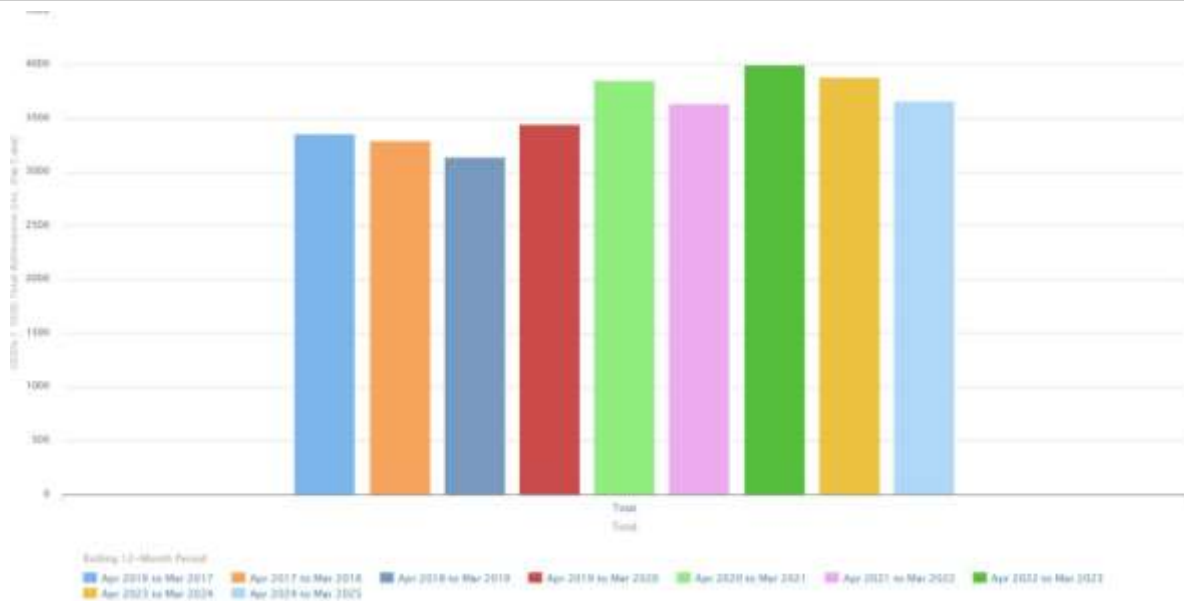


Figure 4. Proportion of DCH Antimicrobial Consumption data from the Access, Watch and Reserve categories (DDDs per 1000 admissions including day case), annual data from 2016/17 to 2024/25. This shows a fairly static picture around with around 53% of consumption from the desired Access category. (RxInfo)

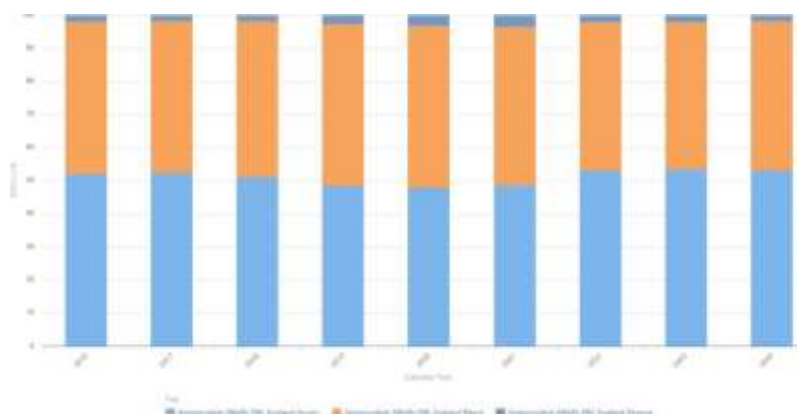


Figure 5. Proportion of Antimicrobial Consumption data from the Access, Watch and Reserve categories (DDDs per 1000 admissions including day case), 2024/25 data across SW trusts. This suggests our proportions are close to average for similar sized trusts in the SW region, but higher than our neighbouring Dorset trust, UHD, where over 60% are from the Access group. (data from RxInfo)

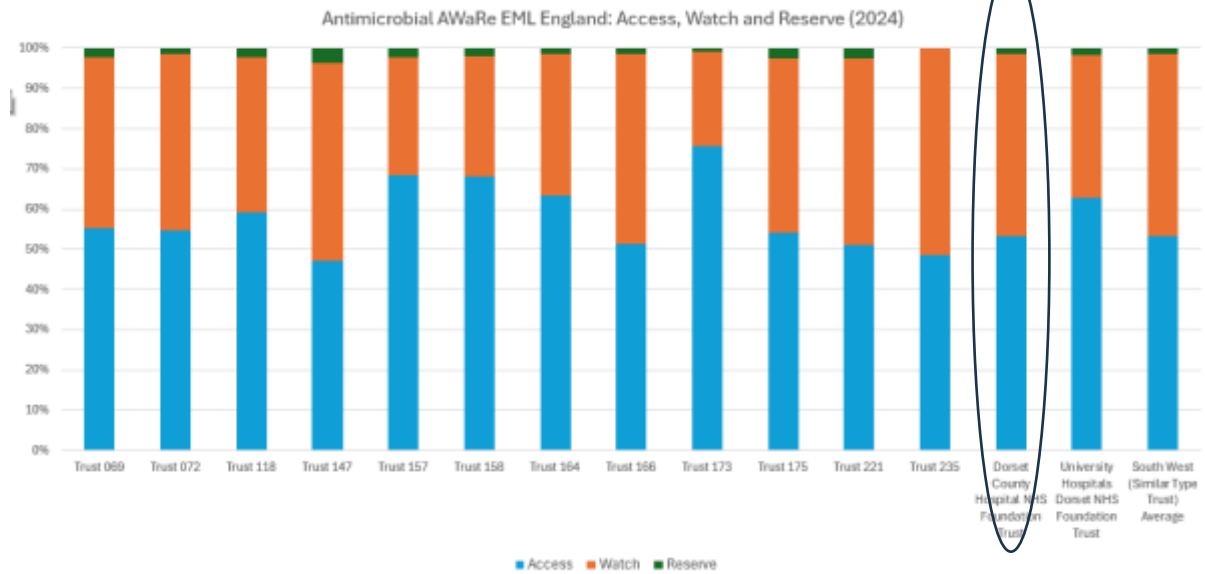
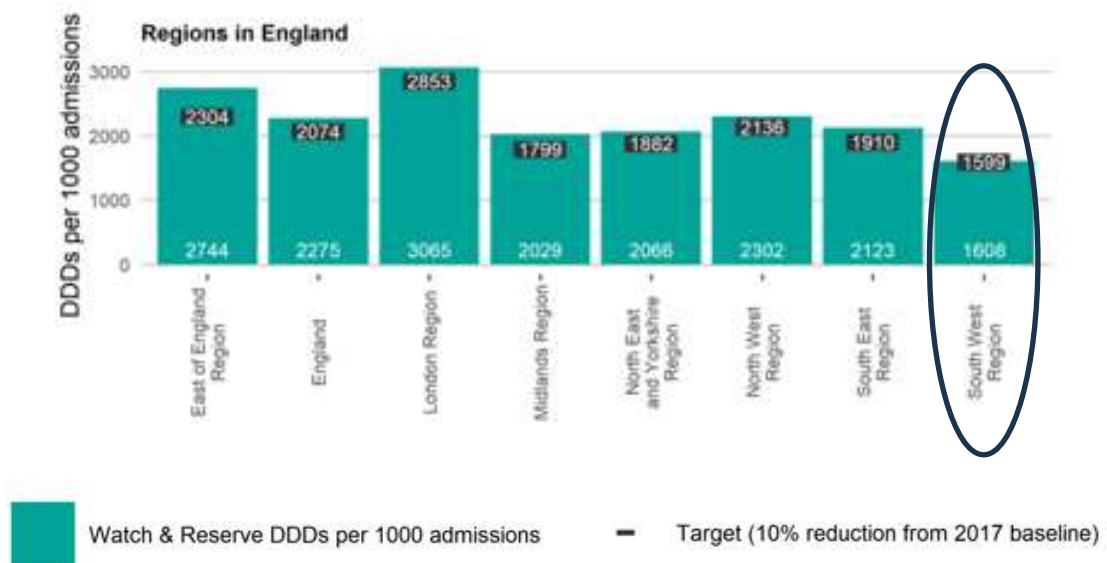


Figure 6. Watch and reserve antibiotics (DDDs per 1000 bed days) for the 4 quarters to Q2 2024/25, data by regions across England. For context this data from the NHS England demonstrates that the SW is the region with the lowest usage of Watch and Reserve antimicrobials in England.

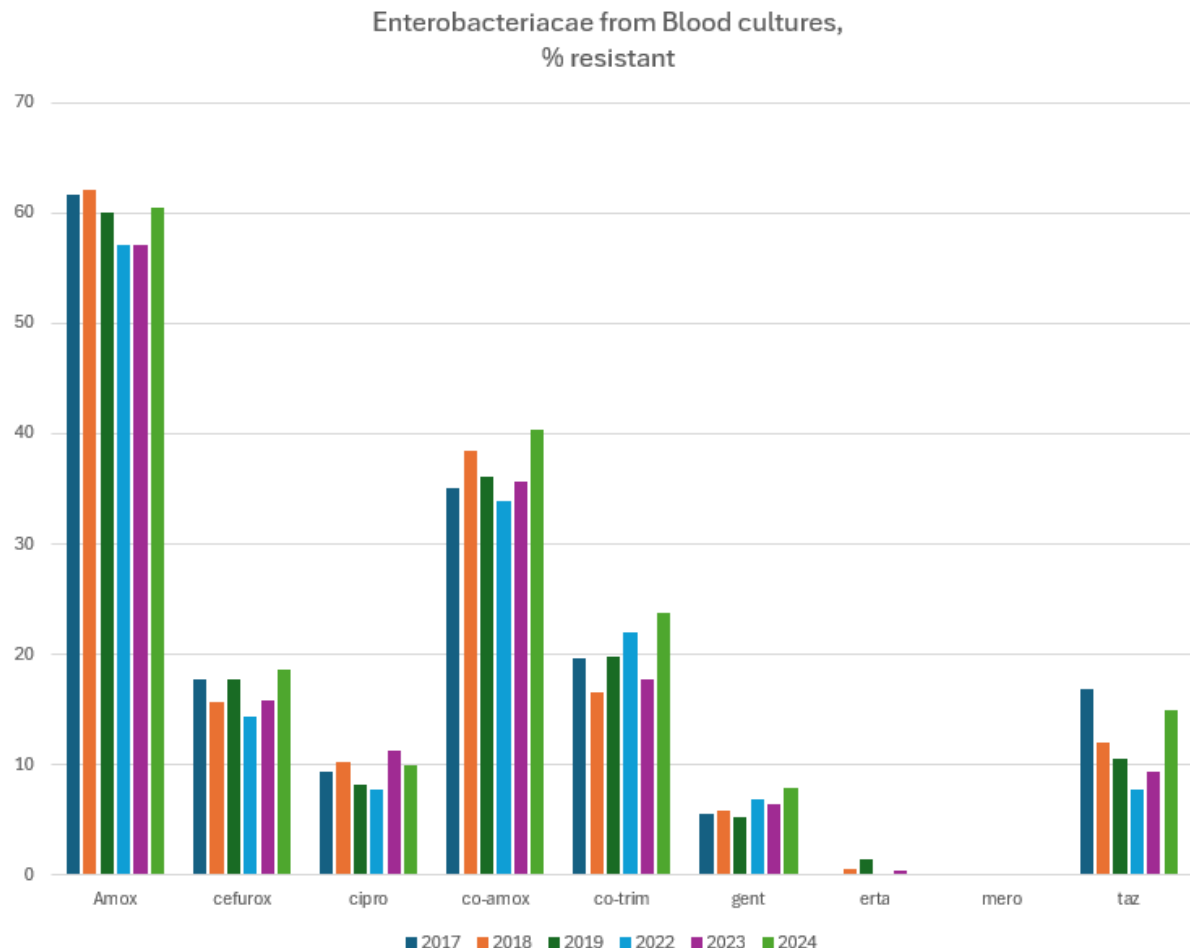


Antibiotic resistance surveillance data

Local antibiotic resistance data is important for informing empiric treatment guidelines and detecting changes in resistance patterns. Gram negative organisms such as E coli and Klebsiella spp have the greatest variability in susceptibility patterns, with many possible chromosomal and plasmid mediated resistance mechanisms, including the extremely difficult-to-treat Carbapenemase-producing organisms (CPEs). The chart below shows resistance rates in gram negative (Enterobacteriaceae) blood culture isolates from DCH patients over the last 6 calendar years.

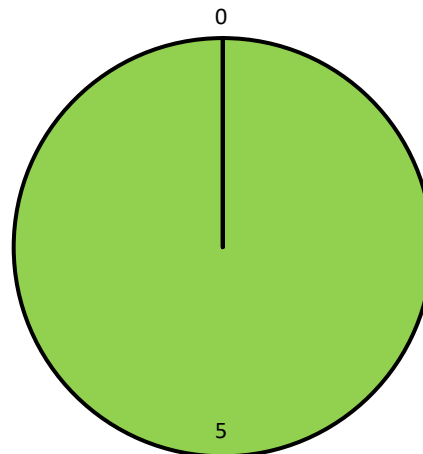
Fortunately, Carbapenemase resistance is still extremely uncommon in blood stream infections at DCH, although we are seeing increasing numbers of isolates from other sites. There appear to be upward trends of resistance to gentamicin, tazocin and co-trimoxazole which need to be monitored – especially as we are increasingly using co-trimoxazole as an ‘Access group’ oral alternative to co-amoxiclav and quinolones. However, it is possible that some of this can be explained by changes to laboratory reporting of the ‘ATU’ (area of technical uncertainty) category of susceptibility testing in recent iterations of the EUCAST testing rules.

Source: DCH laboratory reporting of blood culture isolates, extracted using ICNet.



CRITERION FOUR: Provide suitable accurate information to patients/service users, visitors/carers and any person concerned with providing further support or nursing/medical care in a timely fashion.

4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.



■ 1. Non-compliant ■ 2. Partially compliant ■ 3. Compliant

The IPM Team works closely with the clinical site managers, ward leads, ward staff and facilities service and attends all bed meetings throughout the day to support patient placement and cleaning requirements. Infection control Patient Activity summary (PAS) flags are added as applicable to all newly identified infections.

The IPM team visit in person all newly diagnosed patients with MRSA and CDI infections, providing the patient with an information leaflet, discuss the diagnosis and answer any questions.

The IPM Team work closely with the communications team and together we update staff via email and staff bulletins all when new guidance that is implemented. We also have a dedicated IPM section on the trust intranet site, which is updated regularly, especially when any guidance changes are implemented. We also review the IPM information leaflets regularly and update the hospital IPM internet pages.

The IPM team monitor all CDI and Potential CDI infections daily and include an in-depth weekly review of patients. Escalating concerns to medical teams, wards, and consultant microbiologists. Our consultant microbiologists contact GP's directly when patients are diagnosed with CDI. We also send out GP letters, in a timely manner alerting them of any new CDI, Potential CDI, MSSA, MRSA and Gram-negative Blood stream infections. We also use isolation posters. Which are used for placement outside cubicles containing updated clear information about the recommended cleaning, Personal Protective Equipment and visiting guidance. We audit the correct

use of the posters across the trust twice yearly and our last audit results for 2024-2025 demonstrated 94% compliance with the use of correct cubicle signage. This demonstrated a compliance improvement over the previous 4 years.

The IPM team work closely with the IPM ICS to identify the needs of the local population and develop strategies, collaboratively to ensure joined up working. We also have monthly post infection review meeting to share learning, raise concerns and discuss our systemwide priorities.

INFECTION PREVENTION MANAGEMENT SURVEILLANCE SYSTEM (ICNET)

Over the last few years, we have worked jointly as an ICS IPM team on the procurement and implementation of a county wide utilisation of ICNet, an infection prevention management surveillance system supplied by Baxter Healthcare Ltd.

The IPM implementation Programme is divided into three phases:

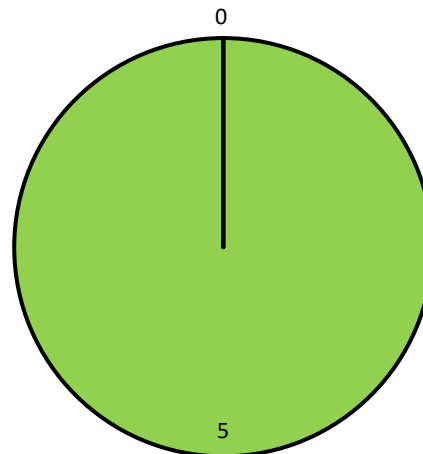
- Phase 1 – DCHFT migration to hosting by DHC – completed July 2020.
- Phase 2 – UHD (both sites) implementation – completed 2021.
- Phase 3 – DHC implementation – Completed September 2022.

During 2024-2025 the system has been running smoothly across all the Dorset system trusts, and we continue to work collaboratively together to ensure as a Dorset system we are using the ICNET effectively and advantageously. We are working collaboratively to ensure that our Clinical safety case report, Hazard log and clinical risk management plan are all up to date.

Within Dorset County hospital the Clinical Site Managers and the housekeeping team have access to ICNET, and they use it to support isolation of patients promptly and effectively and also ensure the correct cleaning is achieved. The IPM team continuously update the isolation list within the system to support prompt isolation and continuously risk assess as necessary, ensuring patient safety is paramount and effectively achieved with regards to cleaning and isolation.

CRITERION FIVE: Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infections to others.

5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.



■ 1. Non-compliant ■ 2. Partially compliant ■ 3. Compliant

The use of ICNET allows the IPM team and clinical site managers out of hours to be alerted to any new alert organisms or existing alert organisms. The IPM team are constantly reviewing these patients. The microbiology consultants also use the ICNET system for note documentation to enable seamless sharing of information between teams. This information is also shared across NHS Dorset following the rollout of ICNET across Dorset Trusts.

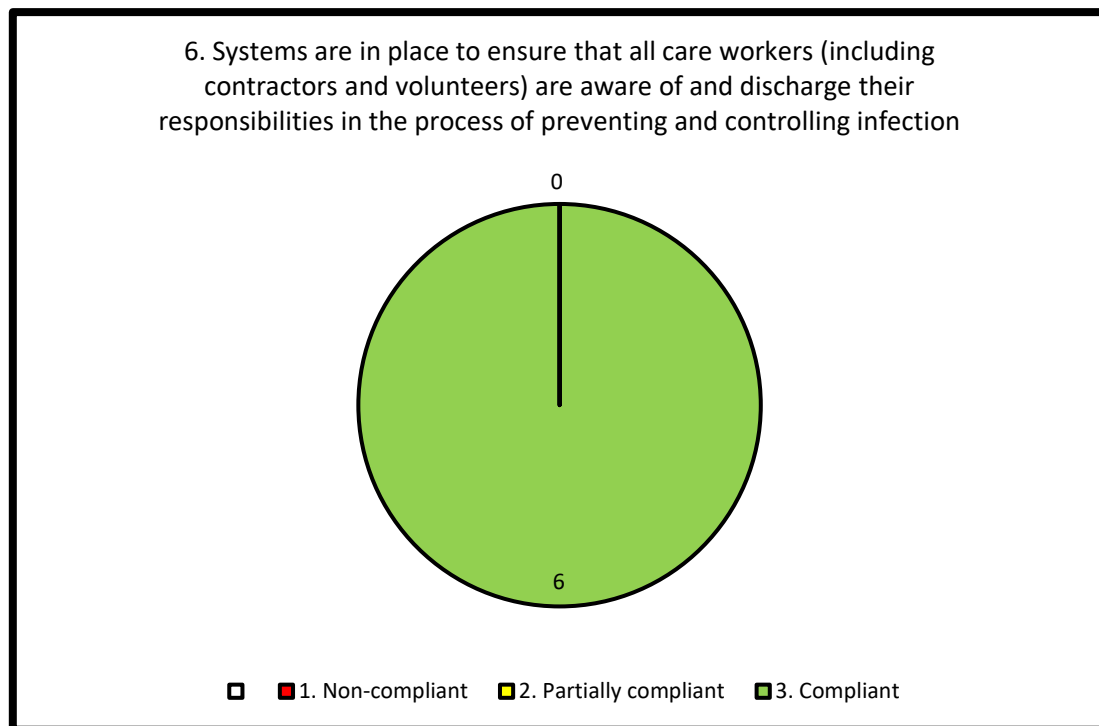
As a team we link closely with GP's, ensuring they are promptly informed via letter or verbal contact via the consultant microbiologists of any new organisms, such as C Diff, Potential C Diff infection, MSSA and MRSA BSI's and Gram-Negative organisms.

The Trust is able to demonstrate that responsibility for infection prevention management is effectively devolved to all professional groups by means of inclusion in all job descriptions and mandatory inclusion in appraisal documentation including for medical staff.

The IPM Team are involved in the management of outbreaks and periods of increased incidence. The IPM team monitors all alert organisms to identify trends and potential links between cases based on their location. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a weekly meeting to discuss potential cases is held as soon as possible. This task is greatly aided using ICNET.

In 2024/2025 1 Periods of increase incidents of C Diff, 3 Norovirus outbreaks and 1 CPE outbreaks which were declared during this time frame. These figures are much improved from last year. All outbreaks are discussed for the purpose of shared learning and service development through divisional governance meetings and IPM committee meetings. The IPM team always produce a report, which is noted and discussed at IPM Committee meeting and the IPM lead specialist nurse always conducts a de-brief following a PII or outbreak. Recurring themes from these investigations are disseminated through the IPM Committee meetings. Action plans that are put in place by the ward manager and/or matron are supported and monitored by the IPM team for compliance.

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



EDUCATION

The Infection Prevention Management Team continued to provide formal and informal face to face education training sessions for both clinical and non-clinical staff. IPM team have also been incorporated into the following teaching programmes and all the nursing team were involved in delivering the sessions:

- Care Certificate for Health Care Support Workers
- Medical Tutorial Teaching programme
- Overseas Recruitment Training
- Clinical Practice Educators

Mandatory IPM Training for clinical and non-clinical staff has been offered via an online e-learning workbook. Overall compliance with mandatory IPM training over the year has remained very high for clinical staff. Compliance is part of the yearly appraisal review process for all members of staff. The Divisions are responsible to release staff to access their training. The E-learning IPM Mandatory training programme uses a national programme.

The IPM team continue to provide extra training to specific groups of staff as and when necessary, this has included Allied Health Professionals, Porters, housekeeping staff etc. The team have also supported yearly training in areas that maybe required to care for patients with a suspected or confirmed High Consequence Infectious Disease (HCID). Including the correct PPE donning and doffing procedures to further protect themselves in their working environment. The trust has rolled out employing Clinical Practice Educators in most clinical areas, this group of staff support and provide

education within the ward area and have a close link with IPM and support ongoing IPM best practice.

This year the IPM team rolled out the IPM educational recommendations within the National IPC Educational Framework. Which sets out a vision for the design and delivery of IPM education for staff that will support effective and safe care. The framework supports and enhances the skills and expertise in our existing workforce and deliver a positive impact for all learners, our people, educators, patients in our care and our populations. The learning outcomes are a minimum expectation and do not preclude additional outcomes being developed. There are three tiers, which are incremental, building from tier 1 to tier 3. We are currently fully achieving mandatory training for tier 1, tier 2, and tier 3. Tier 3 training is suitable for staff who are responsible for an area of care and involves a yearly face to face training session and includes a large (Antimicrobial stewardship) AMS element.

The IPM team continue to carryout daily ward rounds, during these ward rounds we support staff, monitor practice, provide advice, and provide continued IPM education.

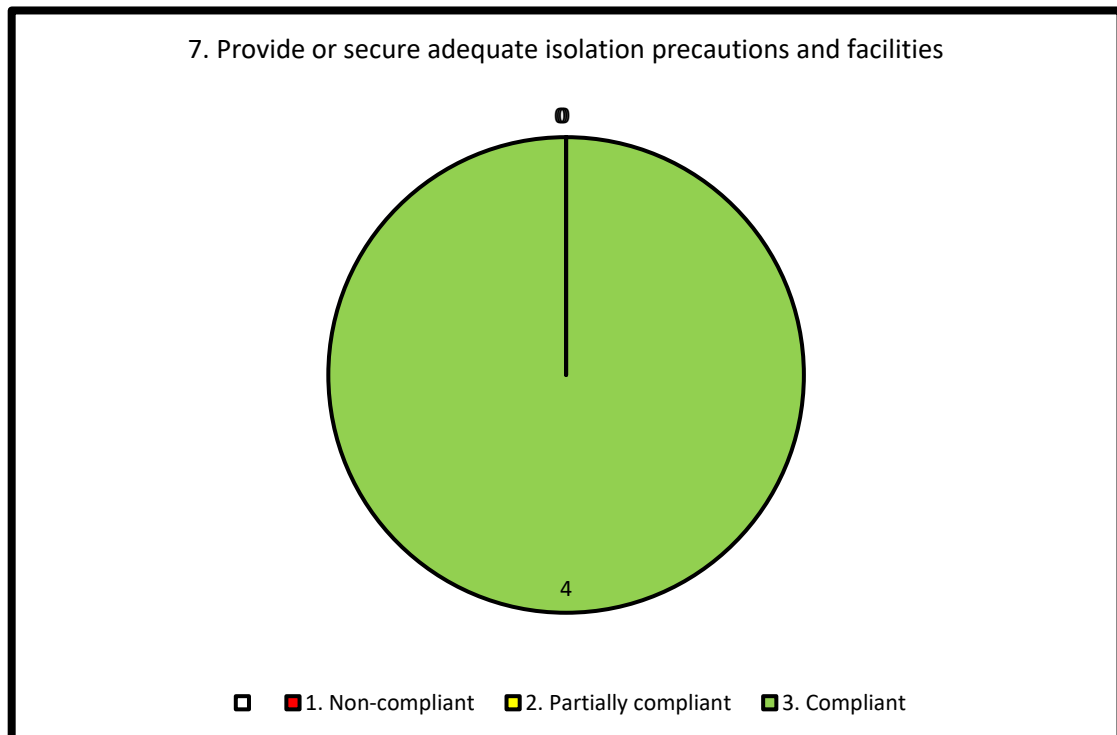
FACE MASK FIT TESTING

As per plans from last year, several more staff have been trained to be face mask fit testers on both the hood and machine, making it more accessible to ward staff. However, some areas have managed to test staff, but other areas still lack the time and capacity to fulfil the testing requirements.

Update training has been offered to those previously trained, but little has been completed. This has been raised many times at IPM and remains a concern.

As we move into 2025-2026, The Fit test co-ordinator plans to gain a permanent place where staff can drop in on various allocated days to make it even more accessible to staff on wards. Compliance with fit mask testing will not improve unless staff are given time and space to carry out this legal requirement.

CRITERION SEVEN: Provide or secure isolation facilities.



ISOLATION

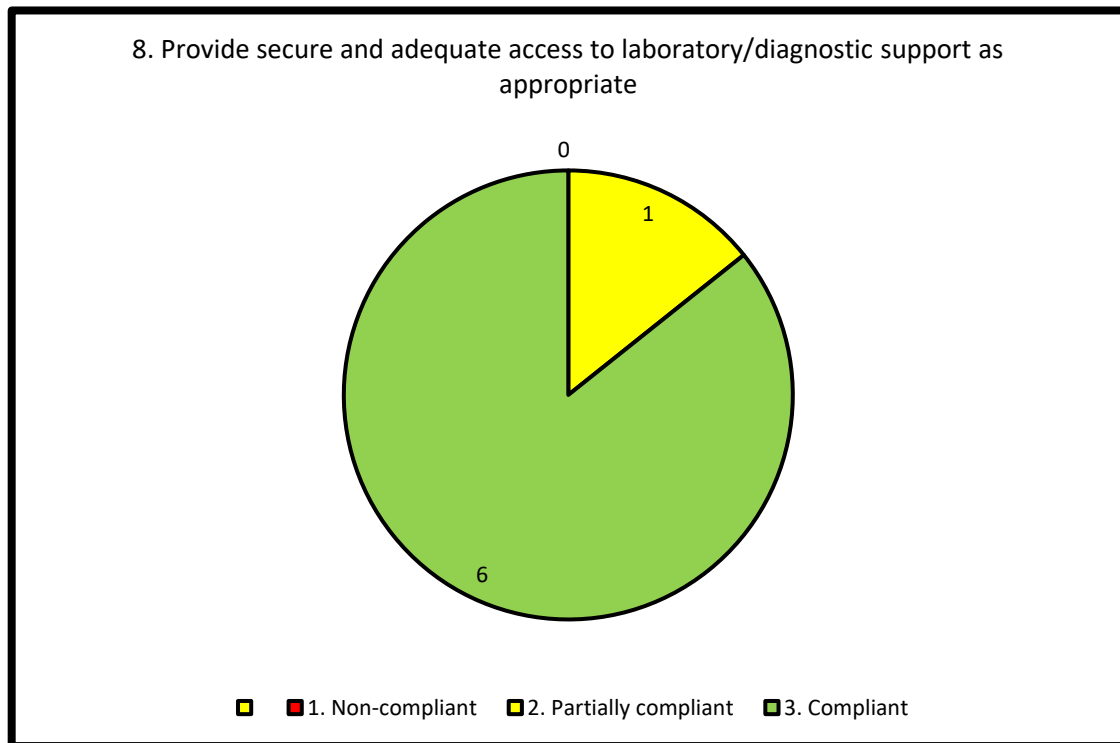
DCHFT has 65 isolation cubicles against the standard bed base (figure taken at the time of audit). There is no recent statistics to compare this figure to the national average within acute trusts. This percentage can impact the ability to isolate patients according to the national guidance, the National Infection Prevention and Control Manual for England 2024. Using the concept of cohort nursing patients during high prevalence of certain infections such as Flu A, Flu B, Covid-19, or RSV, which the IPM team continue to suggest, support, and provide guidance on, when necessary. Isolation capacity is consistently well managed and the requirement to isolate patients as required is largely achieved and if not, in-depth risk assessments are carried out to support best practice depending on the organism.

The IPM team carry out daily ward rounds to review the use of side rooms, providing an ongoing updated isolation list on ICNET, which housekeeping and clinical site managers can access. The IPM Team risk assess as necessary, supporting ward staff and clinical site managers to ensure the most effective use of side rooms according to risk, and this is carried out throughout the day.

ISOLATION AUDIT

This year the side room isolation audit took place twice in August 2024 and January 2025 and looked at all inpatient areas with results as follows; Out of 65 rooms in use an average of 89% of side rooms had the correct signage, 11% incorrect signage and a total of 100% overall side rooms where in use across the trust. This data demonstrates a much-improved percentage compared to last year's audit. At the time of the audit being carried out, staff were educated on the importance of using correct signage to protect not only the patients but also themselves, visitors and thus reducing the transmission of infection. Last year we have developed and implemented new trust isolation posters.

CRITERION EIGHT: Secure adequate access to laboratory support as appropriate.



Partially compliant: 8.1 Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system. Mitigation: The microbiology lab voluntarily withdrew accreditation to the ISO15189:2012 standard and will continue until resource is available for accreditation to the current ISO15189:2022 standard.

MICROBIOLOGY LABORATORY UPDATE – G Rees – Head BMS Microbiology

The laboratory services are located on the DCH site, there is seven-day laboratory working and 24 hour access to microbiology advice, this includes a 24 hour Point-Of-Care Testing in ED and Kingfisher paediatric ward supporting respiratory testing PCR (COVID, Flu, RSV). The IPM team are physically located next to the Laboratory department and have a close working relationship with the Microbiology Consultants, we also have a weekly meeting between the IPMT, microbiology consultants and head biomedical scientist.

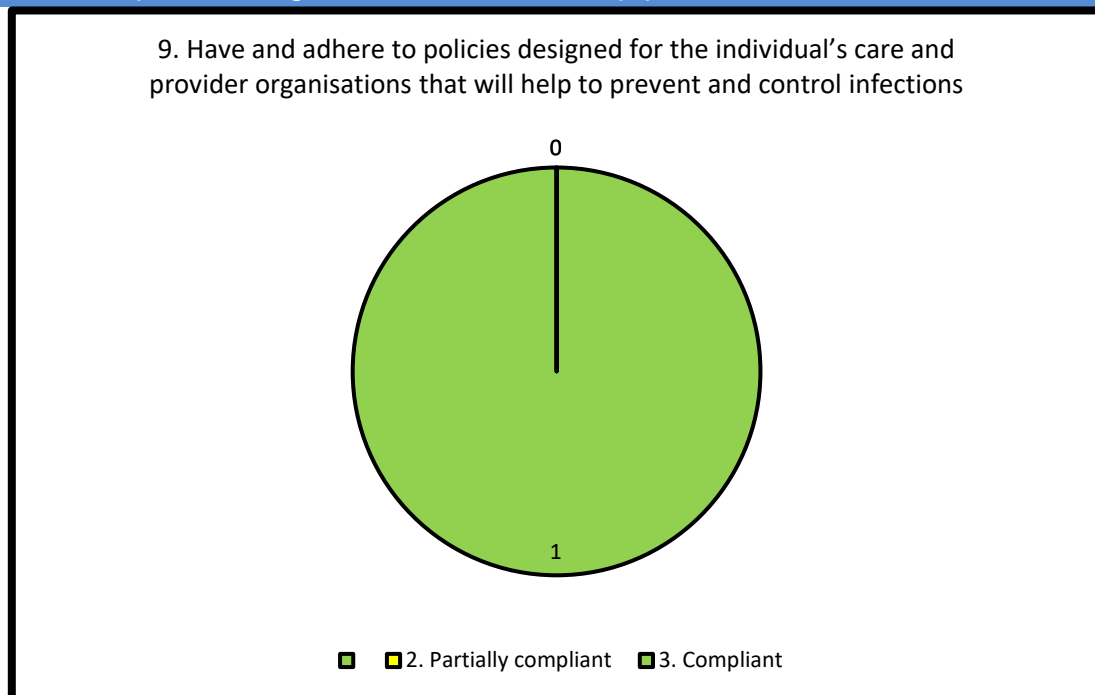
Screening activity and outbreak working remains all year round although a large peak in winter saw the respiratory testing double, this year peaking at around 1100 tests (~£50k on kits) per month. A cross DCH team effort succeeded in maintaining patient flow when a supplier was late delivering inactivation buffer needed for efficient workflow. A new supplier had already been identified, and we were planning to change later in the year, this process was accelerated.

Laboratory tests continue to increase in number, some have doubled since pre COVID, with the same staffing and equipment resource. This has impacted our UKAS accreditation recovery, and we are planning to become accredited once sufficient

resources are available. Increasing demand for testing without increasing capacity continues to be a service risk.

One Dorset Pathology Network (DCH and UHD) continues to develop. The Tier 1 (band 8b) management structure has been completed, the Tier 2 (band 8a) individual laboratory managers is in progress and Tier 3 (band 7 to 2) is due to start, staff at DCH will still be employed by DCHFT. Processes are becoming aligned between pathology at Dorchester, Poole and Bournemouth sites, specialisms are developing i.e., high volume Chlamydia and Gonorrhoea molecular testing for Dorset is now located at Dorchester. South Six Pathology Network are concluding the Lot 5 Molecular Tender after 6 years, this will bring an equipment refresh for the molecular platforms (refresh in bacteriology is long overdue as equipment is 17 years old) to DCH and bring a new syndromic molecular capacity including rapid meningitis/encephalitis agent detection.

CRITERION NINE: Have and adhere to policies designed for the individuals care and provider organisations that will help prevent and control infections.



POLICY DEVELOPMENT/REVIEW

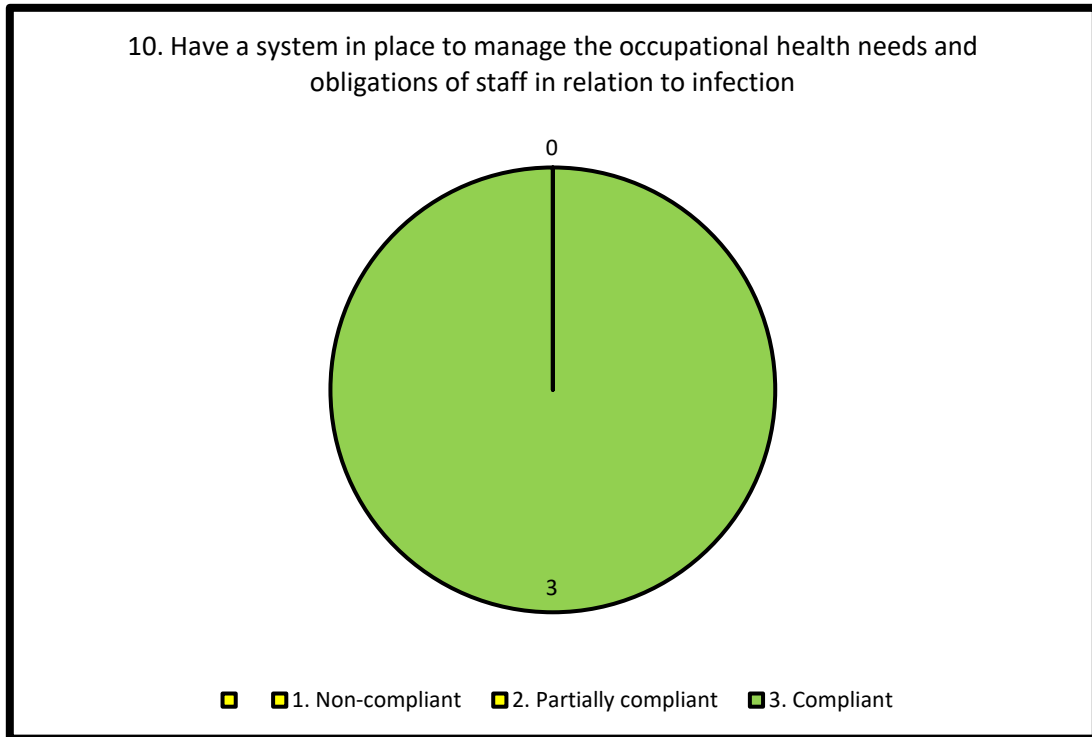
There is a comprehensive list of Infection Prevention Management policies, procedures, and guidance on the trust intranet. These policies are reviewed by the IPM team and relevant specialities on a three or five yearly review date or when guidance changes, these documents are evidenced based and reflect national guidance. Compliance is audited with key policies as detailed in Criterion one.

The following policies have been developed / reviewed / removed during the year 2024-2025:

0793-infection-control-standard	0853-Major-OB.
0856-VHF	0684-aseptic-tech.
0779-Ward-Outbreak-pack-2009	2248-Measles
0802-pandemic-flu	0296-scabies
2058-IPC-ultrasound-gel	0289-MRSA/MSSA
0386-hand-hygiene-policy	2266-SOP-Pertussis.
1446-Discharge-with-Urinary-Catheter	1865-PGD-Naspetin-for-MRSA-MSSA-decolonisation.
1440-PGD-Octenisan-for-MRSA-MSSA-decolonisation.	2063-PGD-Suspected-neutropenic-sepsis-meropenem.
1174-Policy for Infection Prevention and Control Operational Haematology/ Cancer Ward	

The IPM team have worked collaboratively to develop one High Consequence Infectious disease (HCID) policy, archiving four other policies, this policy has now been ratified and is available on SharePoint.

CRITERION TEN: Have a system in place to manage the Occupational health needs and obligations of staff in relation to infection.



OCCUPATIONAL HEALTH REPORT – H Hunt Head of Occupational health.

**Occupational Health Report
Dorset County Hospital
Infection Prevention Management Committee
Q4 2024/25 Report**

**From: Helen Hunt Head of Occupational Health Services
Department: Occupational Health Services, Dorset HealthCare NHS Trust**

General Summary of Work relevant to the Infection Prevention Management Committee

Introduction

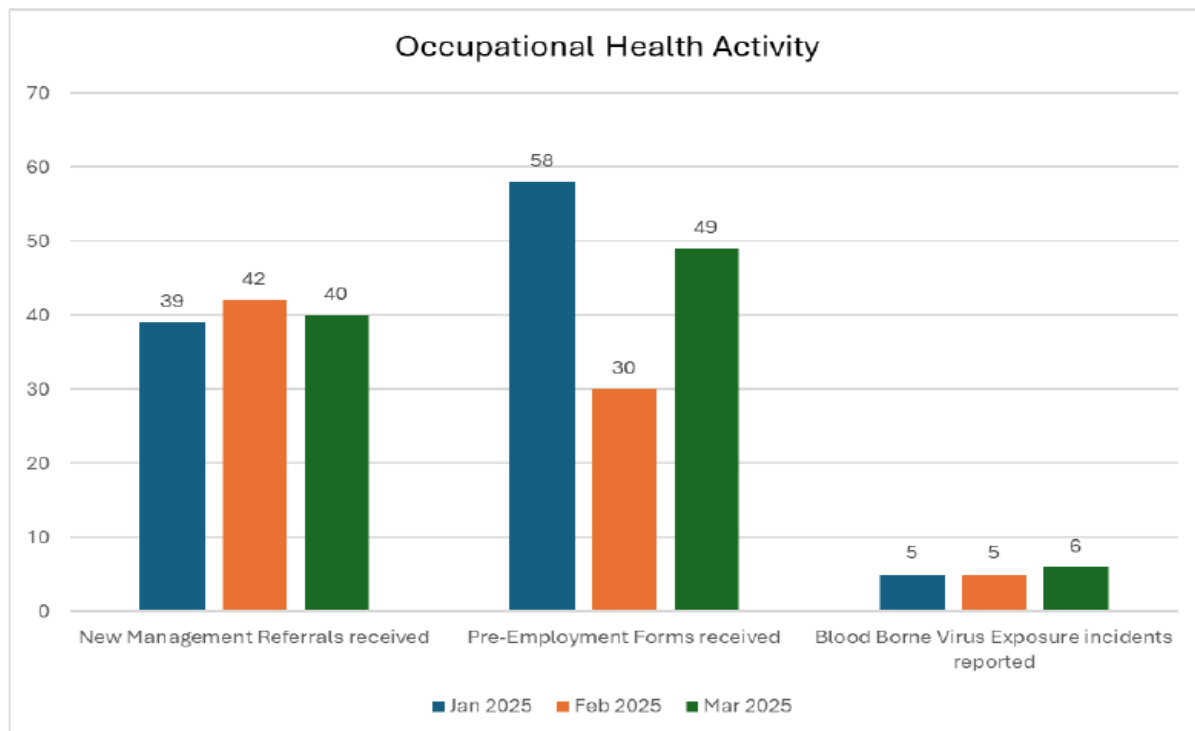
The contract for Dorset Healthcare University NHS Foundation Trust to provide Occupational Health services to Dorset County Hospital commenced on 01 January 2024. This report reflects the work carried out in Q4 2024/25.

Activity

The graph below also provides annual figures for 2024/25:

Activity
Monthly activity summary:

	Apr 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	% change on previous month	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
New Management Referrals received	31	47	37	44	36	40	46	42	32	39	42	40	-5%	115	120	120	121
Pre-Employment Forms received	66	124	103	83	47	64	41	36	38	58	30	49	63%	293	194	115	137
Blood Borne Virus Exposure incidents reported	6	6	3	6	9	6	4	5	6	5	5	6	20%	15	21	15	16



Reasons for Management Referral

There were 37 attended Management Referral appointments in March 2025.

The highest reasons for these Management Referrals were:

- Musculoskeletal
- Advice on Workplace Adaptations
- High Sickness Absence

Further information was added for the below reasons:

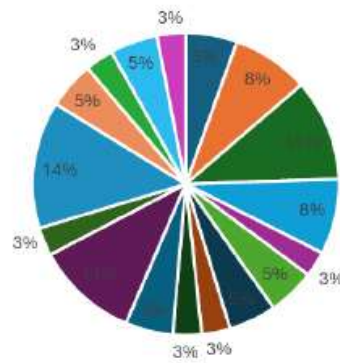
Advice on Workplace Adaptations:

- Musculoskeletal
- Back Pain
- Hip Pain following a fall

Advice on Workplace Adaptations

- Physical Health
- Review of workplace adjustments
- Advice sought on working environment together with high sickness absence

Reason for Referrals March 2025



- Advice on Working Hours (5%)
- Advice on Workplace Adaptations - Musculoskeletal (11%)
- Anxiety - Work Related (3%)
- Chronic Health Condition (5%)
- Gynae Problems (3%)
- High Sickness Absence (11%)
- Musculoskeletal (14%)
- Skin Problems/Dermatitis (3%)
- Surgery/Post Surgery Advice (3%)
- Advice on Workplace Adaptations - Mental Health (8%)
- Advice on Workplace Adaptations - Physical Health (8%)
- Back Problems (5%)
- Depression - Work Related (3%)
- Headache/Migraine (5%)
- Long Term Sickness (3%)
- Pregnancy Complications (5%)
- Stress - Work Related (5%)

Blood Tests

Activity	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Hepatitis B Accelerated Serology	11	5	10	3	13	13	8	1	6	11	4	6	91
Hepatitis B Core Antibodies	0	0	0	0	1	0	1	0	1	0	0	0	3
Hepatitis B Surface Antibodies	11	17	21	15	26	11	19	13	19	29	21	32	234
Hepatitis B Surface Antigen	7	5	4	1	2	3	2	1	8	5	6	2	46
Hepatitis C Antibodies	7	7	6	1	4	4	5	4	7	9	7	5	66
Hepatitis C RNA	1	4	2	0	3	6	2	1	4	0	2	1	26
Hepatitis B Core Antibodies (EPP)	0	0	0	0	0	0	0	0	1	0	0	0	1
Hepatitis B Surface Antibodies (EPP)	6	5	3	17	17	3	8	6	4	4	1	2	76
Hepatitis B Surface Antigen (EPP)	6	13	4	24	28	4	9	4	3	6	2	8	111
Hepatitis C Antibodies (EPP)	6	12	4	25	28	5	9	4	3	6	2	8	112
Hepatitis C RNA (EPP)	1	0	0	0	0	0	0	0	0	0	0	0	1
HIV Test (EPP)	7	12	4	26	29	5	8	3	3	5	2	9	113
HIV Test	9	9	8	1	5	12	5	4	7	11	8	5	84
IGRA Test	14	23	23	26	27	12	17	4	9	6	5	9	175
Measles Antibodies (IgG)	57	27	30	24	49	14	35	9	18	28	17	19	327
Rubella Antibodies (IgG)	43	26	29	24	49	13	35	9	17	28	18	19	310
Varicella Antibodies (IgG)	18	21	19	21	27	8	24	10	14	13	10	12	197
Total	204	186	167	205	308	113	187	73	124	161	105	137	1973

Vaccinations

Activity	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
Hepatitis A & B Twinrix 1st Vaccination	1	0	0	0	0	0	0	3	0	0	0	0	4
Hepatitis A & B Twinrix 2nd Vaccination	0	1	1	0	0	0	0	0	2	0	1	0	5
Hepatitis A & B Twinrix 3rd Vaccination	0	0	0	0	0	0	0	0	0	1	0	0	1
Hepatitis B 1st Accelerated Vaccination	8	11	15	9	18	2	1	0	0	0	1	0	65
Hepatitis B 2nd Accelerated Vaccination	9	11	9	10	15	16	6	2	0	0	0	0	78
Hepatitis B 3rd Accelerated Vaccination	6	7	8	7	8	20	3	0	0	0	1	0	60
Hepatitis B 1st Accelerated Secondary Vaccination	6	4	3	4	7	4	0	0	0	0	0	0	28
Hepatitis B 2nd Accelerated Secondary Vaccination	0	4	0	3	3	7	1	0	0	0	1	0	19
Hepatitis B 3rd Accelerated Secondary Vaccination	0	0	0	2	6	3	1	0	0	0	0	0	12
Hepatitis B 4th Accelerated (12 Month)	1	1	0	0	1	1	3	1	1	3	3	5	20
Hepatitis B 1st Standard Vaccination	0	0	0	0	0	5	17	11	8	9	14	7	71
Hepatitis B 2nd Standard Vaccination	0	0	0	0	0	1	7	7	13	13	9	15	65
Hepatitis B 3rd Standard Vaccination	0	0	0	0	1	0	5	0	6	7	9	10	38
Hepatitis B 1st Standard Secondary Vaccination	0	0	0	0	0	0	6	2	7	2	7	2	26
Hepatitis B 2nd Standard Secondary Vaccination	0	0	0	0	0	2	5	4	5	3	6	6	31
Hepatitis B 3rd Standard Secondary Vaccination	0	0	0	0	0	0	1	2	2	1	6	3	15
Hepatitis B Challenge Vaccination	0	0	0	0	0	0	1	0	1	3	8	1	14
Hepatitis B Immediate Booster	5	7	4	2	12	6	7	3	4	7	7	4	68
BCG Vaccination	7	2	4	1	0	3	3	6	3	4	3	8	44
Mantoux Test	7	2	4	1	0	3	3	6	3	4	4	9	46
MMR 1st Vaccination	11	3	5	6	13	10	7	6	6	9	5	7	88
MMR 2nd Vaccination	10	7	3	7	6	8	12	6	5	11	9	7	91
Pertussis Vaccine	5	4	1	5	9	1	1	0	4	3	3	1	37
Varicella 1st Vaccination	8	0	3	2	5	3	5	0	5	3	0	3	37
Varicella 2nd Vaccination	0	1	3	1	2	4	2	5	1	3	3	1	26
Total	84	65	63	60	106	99	97	64	76	86	100	89	989

DNA (appointment that did not attend)

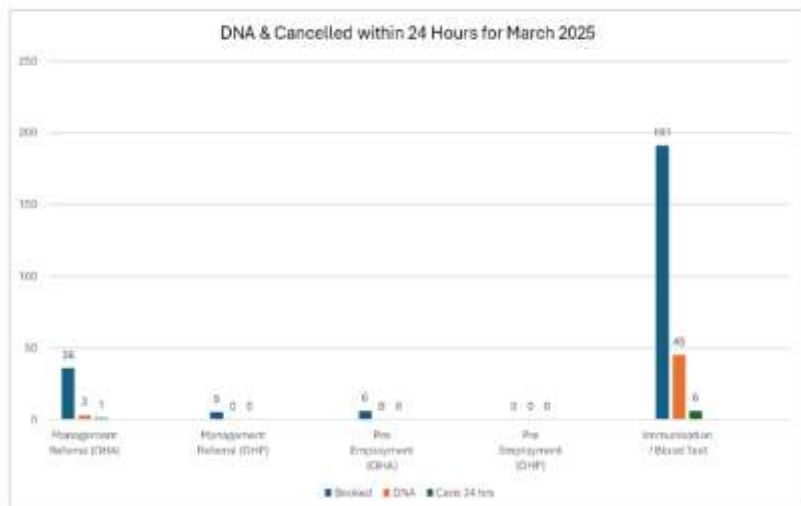
Data for DNAs and cancelled within 24 hours for March 2025

March 2025	Booked	DNA	Canx 24 hrs	% Not Attended
Management Referral (OHA)	36	3	1	11%
Management Referral (OHP)	5	0	0	0%
Pre Employment (OHA)	6	0	0	0%
Pre Employment (OHP)	0	0	0	N/A
Immunisation / Blood Test	191	45	6	27%

DNAs (appointment that did not attend) accounted for 20% of appointment slots.

Appointments that were cancelled within 24 hours by the staff member accounted for 3% of appointment slots.

In March a total of 21 hours of clinical time was lost due to non-attended appointments.



Cost of DNAs in March: £1,596. (Immunisations = £1,1260).
This is a reduction of £1,175 as Feb which was £2,771 in total.

Blood Borne Virus (BBV) Data

January 2025:

5 BBV incidents were reported to OH - 2 x Theatres, 2 x Endoscopy & 1 x Home Treatment service.

February 2025:

5 BBV incidents were reported to OH – 2 x Theatres, 1 x Portesham Ward, 1 x Cardiac care, & 1 x Ilchester Ward.

March 2025:

7 BBV incidents were reported to OH – 3 x no specific area identified, 1 x Endoscopy, 1 x Ridgeway, 1 x medical & surgical ward and 1 x Prince of Wales.

Occupational Health will continue to send monthly BBV figures and details to DCH H&S Manager to review compliance with Datix reporting.

Other

Following a review of OH referrals, from Jan 2025 to date 6 x Management Referrals have been received where concerns have been raised from employees since the introduction of the new soap commenced. This has been raised with DCH H&S Manager and requires further discussion.

CONCLUSION

2024-2025 has been a successful year. The Trust cases for MRSA Blood Stream Infection (BSI) rates remain low, MSSA BSI rates have significantly dropped this year and are at their lowest rate for the past five years. Gram-negative Blood Stream Infection (GNBSI) rates for E Coli and Klebsiella are at the lowest rate for the last 3 years and within the agreed trajectory level set by NHS England. Gram-negative Blood Stream Infection (GNBSI) rates for Pseudomonas aeruginosa cases are slightly above the trajectory level set by NHS England. Clostridioides difficile infection rates are slightly over trajectory for 2024-2025.

This year we successfully implemented the IPM Patient Safety Incident Response framework, completed the IPM Board Assurance Framework, and linked our compliance with the yearly IPM optimisation plan. We have reviewed and developed many IPM related policies and continued our improved Candida Auris screening processes. Our ongoing IPM audits are showing improved percentages, with some of the audits having been fully reviewed and improved to provide extra assurances of practice and care.

This report demonstrates the continued commitment of the trust and demonstrates the success and service improvement through the leadership of a dedicated and committed IPM team. Infection Prevention Management is the responsibility of all the Trust employees and the IPM team do not work in isolation. The successes over the last year have also only been possible due to the commitment for infection prevention management of all DCHFT staff ensuring IPM is high on everyone's agenda.

The annual IPM optimisation plan for 2024-2025 reflects a continuation of support and promotion of IPM. Looking forward to 2025-2026 we will strive to maintain high standards within IPM and continue to develop strong Antimicrobial Stewardship, ensuring our staff maintain a high level of compliance with IPM. A robust governance

structured approach across the whole organisation will remain crucial in the prevention of all healthcare associated infections.

Throughout 2025-2026 the IPM team will continue to strengthen and support close working relationships with the IPM Integrated Care System. Dorset-wide use of ICNET will continue support this work.

The trust 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 colleagues, patients, service users and careers to develop and implement a wide range of IPM strategies, quality improvement projects and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Emma Karamadoukis
IPM lead Specialist Nurse

REFERENCE

Department of Health (2015) Health and Social care Act 2008, Code of practice on the prevention and control of infections and related guidance, Available at: [Health and Social Care Act 2008: code of practice on the prevention and control of infections](#) , Accessed 15.04.2023

National Infection Prevention and Control manual for England (2022), [NHS England » National infection prevention and control](#)

Infection Prevention Management Optimisation Programme

April 2024 to March 2025



Emma Karamadoukis, IPM Lead Specialist Nurse

Written: April 2024 and continually updated

Introduction

The programme will be monitored through the Infection Prevention Management Committee with a quarterly progress report presented to the meeting and any escalations included in the escalation reports presented at the Quality Committee meeting. Information is also incorporated within the annual report. Each work stream / action is RAG rated as follows:



Fully completed.



Partially completed with actions still to be completed, but due for completion with timescale.



Not completed, unlikely to be completed within timescale or significant risks to compliance.

The Key Objectives have been identified from the completion of the IPM Board assurance framework, which aims to demonstrate compliance with the Health and Social Act 2008 and the Ten Criteria outlined in the Act. The objectives have been identified as partially complaint and therefore an area for development or improvement.

Key Objectives

Objective 1: Education - This objective links to the National IPC education framework and compliance with Tier three of the IPM education framework, Tier 1 & 2 have been reviewed, and the trust meets the expected level which is already covered by the IPM mandatory training. The IPM team plan to implement separate face to face training to cover tier three and this work will continue from 2023-2024.

Linked to Criterion 1 IPM BAF – 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 their environment and other users may pose to them, specifically - 1.7 All staff receive the required training commensurate with their duties to minimise the risks of infection transmission and Criterion 6 IPM BAF Appendix 1- 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, Specifically , - 6.2 The workforce is competent in IPM commensurate with roles and responsibilities.

We will do this by:

- The IPMT to continue to review the recommendations of the IPM education framework - specifically Tier 3 of the framework and plan an implementation training programme to encompass all the learning outcomes. This will be largely but not inclusively, be relevant for all staff who are responsible for an area of care.
- The IPMT will liaise with all ward leads and Matrons to ensure compliance with the IPM education framework.

Objective 2: Patient Safety - This objective links to IPM monthly audits. Ensuring our audits provides assurance to the trust, that best IPM practice is evidenced with particular reference to Peripheral venous catheter and urinary catheter care.

Linked to Criterion 1 IPM BAF – 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 their environment and other users may pose to them, specifically – 1.4 - They implement, monitor, and report adherence to the NIPCM.

We will do this by:

- Review each policy related to the audits and identify areas of practice to audit.
- By reviewing our IPM audits and linking with the clinical audit team to ensure our audits link with other trust systems. These audits will support the implementation of the IPM Patient Safety Incident Response Framework (PSIRF).

Objective 3: Compliance - The IPMT will liaise with specific departments to ensure robust governance structures are in place to ensure close links, demonstrating IPM assurance and departmental collaboration. Which will feed into IPM Committee meetings, highlighting areas of concern and demonstrate clear escalation processes.

Linked to Criterion 2 IPM BAF - Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections, specifically IPM BAF sections 2.3 - There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards, 2.4, There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. 2.4.1 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01.

2.4.2 Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01, 2.8 There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06, and Criterion 3 IPM BAF Appendix 1- Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance, specifically IPM BAF sections 3.5 - Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including:

- total antimicrobial prescribing.
- broad-spectrum prescribing.
- intravenous route prescribing.
- treatment course length, 3.6 - Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must

include all care areas and staff (permanent, flexible, agency, and external contractors).

We will do this by:

- By the IPMT attending all relevant committee meetings and provide IPM support and guidance when relevant.
- The IPMT will request and remind departments for their reports for discussion and review, with recommendations and presentation at the bi-monthly IPM committee meetings.
- The IPMT will liaise with AMS microbiologist and attend the AMS Group meetings to support the role and support the planned QI improvement programme within this speciality.

Objective 4 – Patient Safety - The Implementation of PSRIF (Patient safety Incident Response Framework) within IPM and within the wider Integrated Care system (ICS) for Dorset. Using this framework to review reportable infections whether they be COCA (Community Onset Community Associated), COIA (Community Onset Indeterminate Associated), COHA (Community Onset Healthcare Associated) or HOHA (Hospital Onset Healthcare Associated) cases.

Linked to Criterion 1 IPM BAF - 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 their environment and other users may pose to them, specifically IPM BAF sections 1.3 - That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.

We will do this by:

- The IPM lead, after attending the trust PSIRF workshops and PSIRF training to continue to develop and improve the IPM PSIRF plan.
- The IPM ICS team to work closely together with the aim of developing and improving the PSIRF Post Infection reviews of all COHA & HOHA CDI, MSSA and MRSA cases, exploring and improving out systemwide end-to-end reviews of the patient's journey that led to an infection.

Objective 1 – Education							
Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	RAG
1.1 Ensure DCH achieves Tier 3 of the IPM education framework	All Staff responsible for an area of care are compliant with the IPM education framework Tier 3	• IPMT to review the learning outcomes and devise a training plan appropriately.	• System in place.	Emma Karamadoukis/Chris Gover	End 2024	Programme in place by Winter 2024. First session 18 th November.	G
		• IPMT to review a behaviour change approach, as suggested the COM-B model, and identify how it can be implemented.	• Understand the model and implement with the training programme	Emma Karamadoukis	End 2024	Programme in place by Winter 2024. First session 18 th November.	G
		• IPMT to link with other specialist teams to support the training programme. IPM to attend and present to the mandatory training request meeting to gain agreement for Tier 3 to be placed on the mandatory training list for specific clinical staff.	• System in place and all clinical leaders attend the training yearly.	Emma Karamadoukis/Chris Gover	End 20204	Programme in place by Winter 2024. First session 18 th November.	G

Objective 2 – Patient Safety

Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	RAG
2.1 This objective links to IPM monthly audits. Ensuring our audits provide assurance to the trust, that best IPC practice is evidenced with particular reference to Peripheral venous catheter and urinary catheter care.	IPM audits are robust, ensuring and providing supporting evidence that trust clinical practice, for peripheral venous catheters and urinary catheter care follows policy and supports improvements in compliance across the trust using the audit cycle and audit reports.	<ul style="list-style-type: none"> • IPMT to review peripheral venous catheters and urinary catheter care polices and ensure they are evidenced and up to date. 	<ul style="list-style-type: none"> • Polices reviewed and up to date. 	Emma Karamadoukis/Abigail Warne	May 2024	Roll out completed and continues to be reviewed under PDSA cycle.	G
		<ul style="list-style-type: none"> • IPMT to link with the clinical audit team to develop ways to improve the specific IPC audits, linking with trust systems and ensuring the audit questions provide the assurance required. 	<ul style="list-style-type: none"> • IPMT to improve the specific audit processes, linking with polices and aim to roll out a new audit plan for peripheral venous catheters and urinary catheter care. 	Emma Karamadoukis/Abigail Warne	May 2024	Roll out completed and continues to be reviewed under PDSA cycle.	G
		<ul style="list-style-type: none"> • Update the specific IPM audits and update the audit registrations and audit reports as necessary. 	<ul style="list-style-type: none"> • New audits in process that provides the trust with assurance regarding the clinical practice for peripheral venous catheters and urinary catheter care. 	Emma Karamadoukis/Abigail Warne	May 20204	Roll out completed and continues to be reviewed under PDSA cycle.	G

Objective 3 - Compliance							
Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	RAG
3.1 The IPT will liaise with specific departments to ensure robust governance structures are in place to ensure close links with other key departments related to IPC, supporting IPC assurance and agreement.	IPMT support housekeeping with their compliance, with regards to national cleaning standards.	<ul style="list-style-type: none"> • IPMT to liaise closely with Sarah Jenkins and support Audits and overall hospital presentation. 	<ul style="list-style-type: none"> • Efficacy audits • PLACE and PLACE LIGHT reviews 	Emma Karamadoukis/Chris Gover/Sarah Jenkins/Helen Hindley/Sophie Lloyd	Ongoing but end of 2024.	PLACE and PLACE LIGHT dates to be set for the year 2024. Update date set winter 2024	G
	IPMT support the water safety Group with IPM compliance.	<ul style="list-style-type: none"> • IPMT to liaise closely with Toby Markin the Trusts Authorising Officer and Terry May. • IPMT to attend the Water Quality Management Group (WQMG) meetings and link closely when concerns are raised. Ensuring assurance is provided and any escalations actioned appropriately and escalated to IPM committee meeting. 	<ul style="list-style-type: none"> • Clear escalation plans • Close monitoring of water safety reports and these should feed into the Water Safety Group and IPMC 	Emma Karamadoukis/Chris Gover/ Toby Markin/Andrew Kersley	Ongoing but end of 2024.	Summer 2024, water assurances much improved and they are fed into IPCC bimonthly.	G
	IPMT support the Ventilation safety Group with IPM compliance	<ul style="list-style-type: none"> • IPMT to liaise closely with Colin Carver, the Trusts Ventilation Authorising Officer. • Emma Karamadoukis and Cheryl Heard to request a ventilation update for all IPMC meetings. • IPMT to attend the Ventilation Safety Group meetings and link closely when concerns are raised. 	<ul style="list-style-type: none"> • Clear escalation plans • Close monitoring of Ventilation reports and these should feed into the water safety groups and IPMC 	Emma Karamadoukis/Chris Gover/Colin Carver/Terry May	Ongoing but end of 2024.	Emma Karamadoukis has requested a Ventilation update for IPCC, using a suggested chart to provide cleaning assurance 2023 - 2024. Ongoing assurance requests. Assurance improving with new joint federation lead within estates.	G

Objective 3 - Compliance

Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	RAG
	IPMT support an effective antimicrobial stewardship in accordance with local and national guidelines.	<ul style="list-style-type: none"> • Antimicrobial Stewardship action plan to be supported by the IPMT. • AMS working group started 11/12/2023, Dr Cecilia Priestley leading the group. • If IPM funding/staff budget allows, to recruit into a newly developed AMS nurse specialist post. 	<ul style="list-style-type: none"> • Action plan and reports submitted to ICS Antimicrobial Stewardship Committee (ASC) and reviewed at Medicines Committee and Infection Prevention Management Committee. 	Cecila Priestley	Ongoing but end of 2024.	Trust appointing consultant AMS pharmacist by end 2024. AMS group has a 24-25 optimisation plan and escalation process, feeding into medicines committee.	G
	IPMT support the Decontamination Group with IPM compliance.	<ul style="list-style-type: none"> • IPMT to liaise closely with Joe Lythe, the Trusts Decontamination Lead. • Emma Karamadoukis and Cheryl Heard to request a decontamination update for all IPMC meetings. • IPMT to support the decontamination lead and deputy in their role. 	<ul style="list-style-type: none"> • Escalation reports and decontamination assurance trust wide, with a robust decontamination trust plan. 	Chris Gover/Joe Lythe	Ongoing but end of 2024.		G

Objective 4 – Patient Safety							
Issue	Desired Outcome	Action(s)	Evidence/Assurance	Lead(s)	Target Date	Update	RAG
4.1 Continued Implementation of IPM PSIRF (Patient safety Incident Response Framework) plan within IPC and the wider Integrated Care system (ICS) for Dorset, aiming to review process and make improvements as deemed necessary.	<ul style="list-style-type: none"> DCH IPMT to review and continually develop the implementation of PSIRF for Gram negative/MRSA/MSSA and CDI organisms. 	<ul style="list-style-type: none"> Emma Karamadoukis to continue to review, develop and escalate the IPC PSIRF plan. 	<ul style="list-style-type: none"> The IPM PSIRF is robust and follows the PSIRF ideology. 	Emma Karamadoukis	Ongoing but end of 2024.	Roll out complete and working well.	G
		<ul style="list-style-type: none"> IPM lead to link with ward leads, matrons, and divisional heads to ensure an excellent IPC PSIRF plan that identifies learning and quality improvement plans. 	<ul style="list-style-type: none"> Learning is identified, patient safety improved and ultimately a reduction in healthcare associated infections. 	Emma Karamadoukis	Ongoing but end of 2024.	Roll out complete and working well, feeds into IPCC bimonthly.	G
	<ul style="list-style-type: none"> Following IPM PSIRF thematic review. The IPM lead has suggested a Quality Improvement (QI) plan: To gain assurance that Central venous catheter (CVC) line care practice is consistent across the trust and within policy, aiming to reduce the risk of healthcare associated infections related to CVC care. 	<ul style="list-style-type: none"> IPM lead and Nutritional nurse lead to develop a QI project in relation to CVC line care practice and driver diagram to focus our plan. 	<ul style="list-style-type: none"> Completion of the QI project over the following year and CVC line audits to demonstrate improvements and infections rates to show a reduction in HCAI related to CVC line care. 	Emma Karamadoukis and Jen Ashmore	March 2025	Update September 2024 - QI project on going and under regular review. Update February 2025 – this project is not via the patient safety governance route and the training will continue via the pathway.	G

	<ul style="list-style-type: none"> • Following urology Audit and escalation of concerns. To ensure better trust documentation for urinary catheter insertions and therefore aim to improve urinary catheter care. Poor documentation noted following a urology audit. 	<ul style="list-style-type: none"> • The trust to agree an improved method for documenting the insertion of urinary catheters and roll out this agreed plan trust wide. 	<ul style="list-style-type: none"> • Urology documentation re audit to demonstrate improved compliance and IPC Urinary catheter Audits to demonstrate improved compliance against agreed standards. 	Abigail Warne, Helen Hindley and urology team	March 2025	Nov update, new insertion documentation developed and currently with the documentation group for approval. Still awaiting support from documentation group. However, all IPC action have been completed and awaiting agreement from documentation group lead.	G
	<ul style="list-style-type: none"> • The System wide process for PSIRF is reviewed regularly and a continual process of development and improvement for the Post Infection review Process is evidenced. 	<ul style="list-style-type: none"> • IPC Integrated Care System (ICS) PSIRF PIR plan to be reviewed regularly and developed with system wide collaboration. Meetings planned 6 monthly to review processes. 	<ul style="list-style-type: none"> • Close working with the wider Dorset system and develop an implementation programme. 	IPC ICS Dorset system	Ongoing but end of 2024.	Roll out under constant review but currently fully actioned and working well, with collaboration from the IPC ICS team. SW IPM strategy under review and actioned appropriately.	G

Appendix 1 – IPC Board assurance Framework

Linked separately due to large file content.

Appendix 2 – IPC Education Framework

[NHS England » Infection prevention and control education framework](#)