Warrington and Halton Teaching Hospitals NHS Foundation Trust

QUALITY ASSURANCE COMMITTEE

AGENDA REFERENCE:	**QAC/25/07/****			
SUBJECT:	**Director of Infection Prevention and Control Annual Report**			
DATE OF MEETING:	8 July 2025			
ACTION REQUIRED:	To note and approve			
Author	Lesley McKay, Associate Chief Nurse for Infection Prevention + Control			
EXECUTIVE DIRECTOR SPONSOR:	Alison Kennah Chief Nurse/Director of Infection Prevention + Control			
LINK TO STRATEGIC OBJECTIVE:	SO1: We will... Always put our patients first delivering safe and effective care and an excellent patient experience. SO2: We will ... Be the best place to work with a diverse and engaged workforce that is fit for now and the future. SO3: We will ... Work in partnership with others to achieve social and economic wellbeing in our communities.			
EQUALITY CONSIDERATIONS: (Please select as appropriate)	Please indicate who is impacted by the equality considerations:	**Patients**	**Workforce**	**Public**
	Are there any equality considerations linked to the general duties of the Public Sector Equality Duty and Armed Forces Act 2021:	**Yes**	**No**	**N/A**
				✓
	Further Information / Comments:			
EXECUTIVE SUMMARY:	This report outlines the arrangements, activities and achievements of the Trust relating to infection prevention and control for the April 2024 to March 2025 financial year (FY). Covid-19 cases were significantly reduced compared to the previous year with: - • 51 Hospital onset/probable healthcare associated cases • 60 Hospital onset/definite healthcare associated cases • 4 Outbreaks Totals for Healthcare Associated Infections (HCAI) were: - • 90 *Clostridium difficile* (*C. difficile*) cases – 30 cases over threshold • 4* *MRSA* bacteraemia cases (1 case reapportioned to another healthcare provider) • 34 *MSSA* bacteraemia cases – no threshold • 89 *E. coli* bacteraemia cases – 10 cases over threshold • 30 *Klebsiella Spp.* bacteraemia cases – 2 cases over threshold			

<table>
<tr><td></td><td colspan="3">

- 10 *Pseudomonas aeruginosa* bacteraemia cases – on threshold

Despite an increase in *C. difficile* cases, the Trust remained a low outlier for cases compared to other NW Trusts.

Prevention actions plans are in place to prevent HCAI.

Gratitude is extended to the Infection Prevention and Control Team for maintaining their proactive leadership of a challenging and extremely busy agenda. Collaboration and successful engagement with colleagues across the Trust have contributed to the successes detailed within this report.

This report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.
</td></tr>
<tr><td>PURPOSE: (please select √ as appropriate)</td><td>Approval</td><td>To note
✓</td><td>Decision</td></tr>
<tr><td>RECOMMENDATION:</td><td colspan="3">The Quality Assurance Committee is asked to receive and note the report.</td></tr>
<tr><td rowspan="4">PREVIOUSLY CONSIDERED BY:</td><td>Committee</td><td colspan="2">Infection Control Sub-Committee</td></tr>
<tr><td>Agenda Ref.</td><td colspan="2">ICSC/25/06/67</td></tr>
<tr><td>Date of meeting</td><td colspan="2">19 June 2025</td></tr>
<tr><td>Summary of Outcome</td><td colspan="2">Submit to Quality Assurance Committee</td></tr>
<tr><td>NEXT STEPS: State whether this report needs to be referred to at another meeting or requires additional monitoring</td><td colspan="3">Submit to Trust Board</td></tr>
<tr><td>FREEDOM OF INFORMATION STATUS (FOIA):</td><td colspan="3">Release Document in Full</td></tr>
<tr><td>FOIA EXEMPTIONS APPLIED: (if relevant)</td><td colspan="3">None</td></tr>
</table>

QUALITY ASSURANCE COMMITTEE

SUBJECT	Infection Prevention and Control DIPC Annual Report	AGENDA REF:	QAC/25/07/XXX

Table of Contents

1. BACKGROUND/CONTEXT

Executive Summary

Organisation

Warrington and Halton Teaching Hospitals NHS Foundation Trust, sits within the Cheshire and Merseyside Integrated Care System in the northwest of England, providing healthcare services to Warrington, Runcorn, Widnes, and surrounding areas. The Trust has 3 hospitals across two sites and circa 520 beds, with over 4,400 substantive staff.

The Trust's mission is to be 'outstanding for our patients, our communities and each other,' with a vision that 'we will be a great place to receive healthcare, work and learn.' Good infection prevention and control practices are a fundamental part of this mission and vision.

Infection Prevention and Control Strategy and Annual Work Plan

The Infection Prevention and Control Strategy, launched in 2022, included four objectives: -

- prevention of healthcare associated infections
- strengthening antimicrobial stewardship
- commitment to cleanliness
- sustainability

The Infection Prevention and Control Team (IPC Team) worked towards delivery of the annual work plan. Mandatory surveillance was complied with, policies, guidelines and standard operating procedures were updated as per schedule, and audits of IPC practices and standards of cleanliness were carried out. Clinical teams were supported with the provision of advice on managing patients with suspected or known infections and education and training was provided to meet mandatory requirements and in response to emergent issues.

An additional workstream called Brilliant Basics in Infection Prevention and Control was implemented in response to the increase in *C. difficile* cases in Quarter 1.

The annual work plan (appendix 1) has been revised for the 2025/26 financial year. The work plan includes attendance at other committee meetings to ensure integration of infection prevention and control across the organisation; compliance with all mandatory surveillance requirements; monitoring of environmental cleanliness standards; audits of practice, policy/guideline reviews and a programme of education and awareness raising events.

Code of Practice on Prevention of Healthcare Associated Infections

The Trust is working towards full compliance with the 10 criterions in the Code of Practice on Prevention of Healthcare Associated Infections (2022) (Code of Practice), which is linked to Regulation 12 of the Health and Social Care Act (2008). Assessment shows: -

- 7 are fully compliant
- 3 have minor non-compliances

These minor non-compliances relate to old estate i.e., lower number of side room facilities, and in a small number of areas, lower ratio of hand washing sinks to patient number than current guidance, temporary reduction in Consultant Microbiology staffing and limited access to side room facilities.

The annual Patient Led Assessment of the Care Environment (PLACE) occurred in October 2024 (Warrington) and November 2024 (Halton sites) and achieved cleanliness scores above 99%.

Healthcare Associated Infections

NHS standard contracts include a quality requirement to minimise rates of *C. difficile* and Gram-negative bloodstream infections (GNBSI) to thresholds set by NHS England (NHSE). The approach to learning from HCAI events has been revised to align with the Patient Safety Incident Response Framework (PSIRF). Trust apportioned HCAI figures include hospital onset/healthcare associated (HOHA) and community onset/healthcare associated (COHA) cases. The Trust apportioned cases are detailed below.

Table 1 HCAI Data and Trust Thresholds

Organism	Trust Apportioned (HOHA/COHA)	Total	Trust threshold
C. difficile	66 HOHA: 24 COHA	90	60
E. Coli bacteraemia	60 HOHA: 29 COHA	89	79
Klebsiella Spp. bacteraemia	21 HOHA: 9 COHA	30	28
MRSA bacteraemia	3 HOHA: 1 COHA	4*	Zero avoidable
MSSA bacteraemia	24 HOHA: 10 COHA	34	No threshold
P. aeruginosa bacteraemia	8 HOHA: 2 COHA	10	10

- 1 MRSA bacteraemia case reapportioned to a neighbouring healthcare provider

Actions in place to prevent *C. difficile* include hand hygiene (staff and patients), environmental cleanliness and antimicrobial stewardship. An in-depth action plan called Brilliant Basics in IPC was launched in 2024 to drive improvements in infection control.

Covid-19

The Covid-19 pandemic continued to present challenges. Timely and integrated working took place between the infection prevention and control and operational teams to ensure safe patient placement. Cases were significantly reduced compared to the previous year: -

- 51 Hospital onset/probable healthcare associated cases
- 60 Hospital onset/definite healthcare associated cases
- 4 Outbreaks

This report outlines the arrangements, activities, and achievements during the 2024/25 FY. The report builds on previous annual reports submitted to the Board of Directors to give a full year account of infection prevention and control activity.

Alison Kennah
Chief Nurse/Director of Infection Prevention and Control (DIPC)
June 2025

Acknowledgements

Lesley McKay	Associate Chief Nurse Infection Prevention and Control/Associate DIPC
Dr Zaman Qazzafi	Consultant Medical Microbiologist/ Infection Control Doctor/Deputy DIPC
Kate Rainbird	Lead Pharmacist in Antimicrobial Stewardship
Julie McGreal	Head of Facilities
Claudine Reynolds	Lead Nurse Medical Care CBU

2. KEY ELEMENTS

Description of Infection Control Arrangements

Infection Prevention and Control Team

The Infection Prevention and Control Team (IPC Team) is scheduled to meet fortnightly. Membership includes: -

- Consultant Medical Microbiologists: -
  - Dr Zaman Qazzafi (Deputy DIPC and Infection Control Doctor)
  - Dr Toong Chin
  - Dr Janet Purcell (0.6 WTE)

- Associate Chief Nurse for Infection Prevention and Control: -
  - Lesley McKay (Associate DIPC)

- Infection Prevention and Control Nurses: -
  - Aalifha Mariadhas Margret (extended leave)
  - Jessica Ford
  - Louise Bale (0.6 WTE)
  - Shaiby Coot

- Infection Prevention and Control Nurse secondees
  - Kavya Kalloor
  - Sari Sashidaran Nair
  - Soumya Zacharias

- Lead Pharmacist in Antimicrobial Stewardship
  - Faye Smale (interim until September 2024)
  - Clavel Chan (interim from October 2024)

- Infection Control Administrator: -
  - Kiera Hatton (from September 2024)

- Head of Estates Maintenance, Compliance and Risk
  - Kieran Beech

Infection Control Sub-Committee

The Consultant Medical Microbiologist/Infection Control Doctor/Deputy DIPC chairs the Infection Control Sub-Committee. Meetings were held monthly.

Membership comprises of the Chief Nurse/Director of Infection Prevention and Control (DIPC), Associate Chief Nurse for Infection Prevention and Control, Lead Nurses or Matron from each Clinical Business Unit (CBU), Estates and Facilities Managers, an Allied Health Professional, an Occupational Health and Wellbeing Nurse and a representative from the Health and Safety Team.

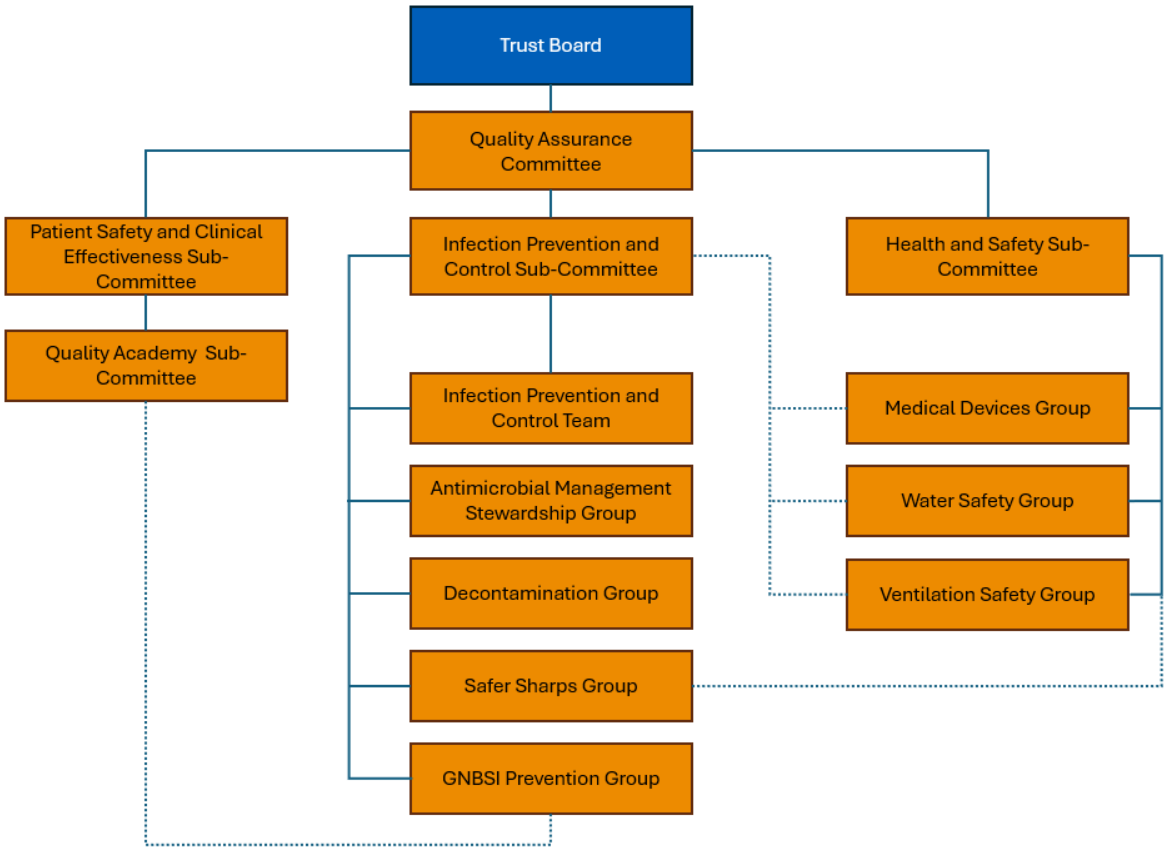
The Lead Nurses for each CBU, the Allied Health Professionals and Estates and Facilities representatives, submit reports at each meeting as a standing agenda item. This allows the

Infection Control Sub-Committee to give assurance to the Quality Assurance Committee and Trust Board of Directors on infection prevention and control activity within the Trust.

Assurance is provided from the IPC Team on compliance with the Code of Practice, the IPC Board Assurance Framework (2023) (IPC BAF) and that there is a programme of continuous improvement.

High level briefing papers are submitted by the Infection Control Sub-Committee Chair to the Health and Safety and Patient Safety and Clinical Effectiveness Sub-Committees. The reporting line to the Trust Board is detailed in figure 1.

Figure 1 Reporting Line to Trust Board



There are links to the Medicines Governance Group via: -

- Consultant Medical Microbiologists
- Lead Pharmacist in Antimicrobial Stewardship
- Antimicrobial Management Stewardship Group

DIPC Reports to Trust Board

Reports and high-level briefing papers, which included compliance assessments against the Code of Practice, IPC BAF, key performance indicators, HCAI surveillance data and outbreak/incident details were submitted to the Quality Assurance Committee with onward reporting to Trust Board: -

- IPC Board Assurance Framework Compliance Report/Action Plan – July 2024
- IPC Board Assurance Framework Compliance Report/Action Plan – January 2025

- IPC Healthcare Associated Infection Report Q1 – August 2024
- IPC Healthcare Associated Infection Report Q2 – November 2024
- IPC Healthcare Associated Infection Report Q3 – February 2024
- IPC Healthcare Associated Infection Report Q4 – May 2024

- DIPC Annual Report – July 2024

Annual Work Plan

The IPC Team work plan was developed to give assurance that each element of the Code of Practice and the IPC BAF, which underpin the Health and Social Care Act (2008) linked to Regulation 12, are adhered to and that appropriate evidence of compliance is available.

This work plan is underpinned by action plans for key performance indicators/prevention of mandatory reportable healthcare associated infections and a programme of audit that provides evidence of policy/guideline compliance. The annual work plan has been revised for 2025/26 and is included at appendix 1.

IPC Strategy

The IPC Strategy was launched in 2022 with a: -

- Mission to work together to deliver outstanding healthcare by engaging, educating, and empowering healthcare staff, patients, and their carers to prevent healthcare associated infections

- Vision for a world in which healthcare associated infections have been reduced to the lowest possible level

The strategy included 4 objectives:

1. Prevention of Healthcare Associated Infections
2. Strengthening Antimicrobial Stewardship
3. Improving Environmental Cleanliness
4. Greening the NHS

A vast amount of activity has been undertaken to support delivery of the strategy objectives with performance monitored at the Infection Control Sub-Committee.

All elements of the IPC Team activities focus on reducing risks of infection and details of cases from the 2024/25 FY are included in the HCAI surveillance section of this report. Antimicrobial Stewardship concerns were recognised from a robust monitoring process, and action implemented to engage prescribers to direct improvements.

A trust-wide deep cleaning programme was implemented following an increase in *C. difficile* cases in Q1 and multi-disciplinary efficacy audits refreshed. IPC Team membership of the Product Evaluation Group helps direct attention to consideration of sustainability.

Health and Social Care Act (2008) Compliance Assessment

Compliance with the Health and Social Care Act (2008) is assessed biannually by conducting a gap analysis against the 10 criterions in the Code of Practice. The Care Quality Commission (CQC) uses the Code of Practice to assess registered provider compliance with the cleanliness and infection control requirement set out in the regulations.

The latest compliance assessment (March 2025) is detailed in table 2 and shows: -

- 7 fully compliant
- 3 minor non-compliances

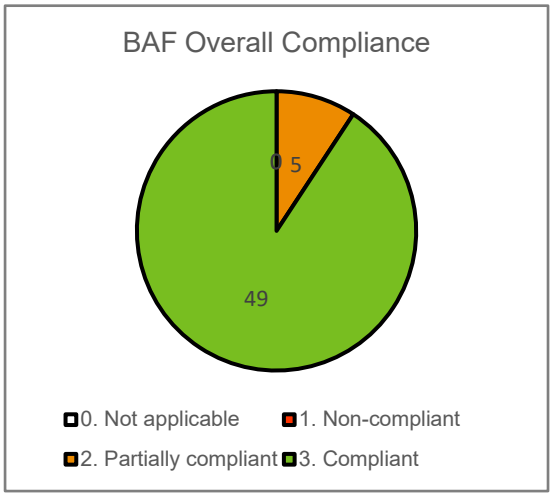
Table 2 Compliance with the Code of Practice

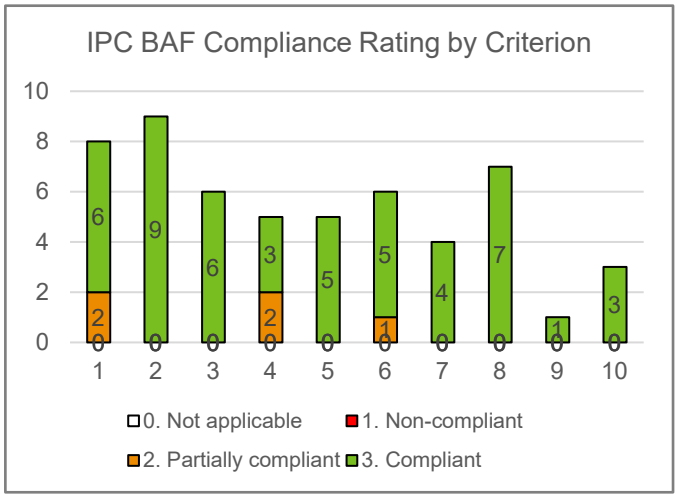
Criterion	Assessment	Action required/Progress
1. Systems to manage and monitor the prevention and control of infection.	Compliant	
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Partially compliant	Upgrades to some hand washing sinks required (design and location). Audit of handwashing facilities scheduled with Estates Team. Ventilation systems review to ensure all comply with HTM 03 01
3. Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Partially compliant	Temporary reduction in Consultant Microbiologist staffing. Recruitment to locum post in progress.
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.	Compliant	
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.	Compliant	
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.	Compliant	
7. Provide or secure adequate isolation facilities.	Partially compliant	Continuous liaison with the Patient Flow Team to optimise use of side rooms for appropriate patient isolation
8. Secure adequate access to laboratory support as appropriate.	Compliant	
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant	
10. Providers have a system in place to manage the occupational health needs of staff in relation to infection.	Compliant	

IPC Board Assurance Framework

The IPC BAF, published by NHS England, is designed to support assessment of compliance with IPC standards set out in the National IPC Manual. Compliance assessments are carried out biannually, with overall findings and compliance by criterion shown in figure 2.

Figure 2 Compliance with IPC BAF





An action plan is in place to: -

- Align IPC event reviews with the Patient Safety Incident Response Framework and strengthen thematic analysis
- Ensure completion of action plans in relation to IPC audits
- Implement the NHS Waste Strategy
- Ensure robust recording of clinical skills competency assessments
- Plan to complete IPC policies/guideline reviews

Healthcare Associated Infection Surveillance

The Trust participates in mandatory reporting of HCAI. There are 3 HCAI prevention action plans, linked to mandatory reporting requirements which were reviewed 3 times per annum. Review of HCAI events was undertaken in line with PSIRF and action plans developed to promote learning from cases.

C. difficile

The Trust reported 130 *C. difficile* toxin positive cases with 90 cases apportioned to the Trust: -

- hospital onset/healthcare associated (HOHA)= 66
- community onset/healthcare associated (COHA) = 24

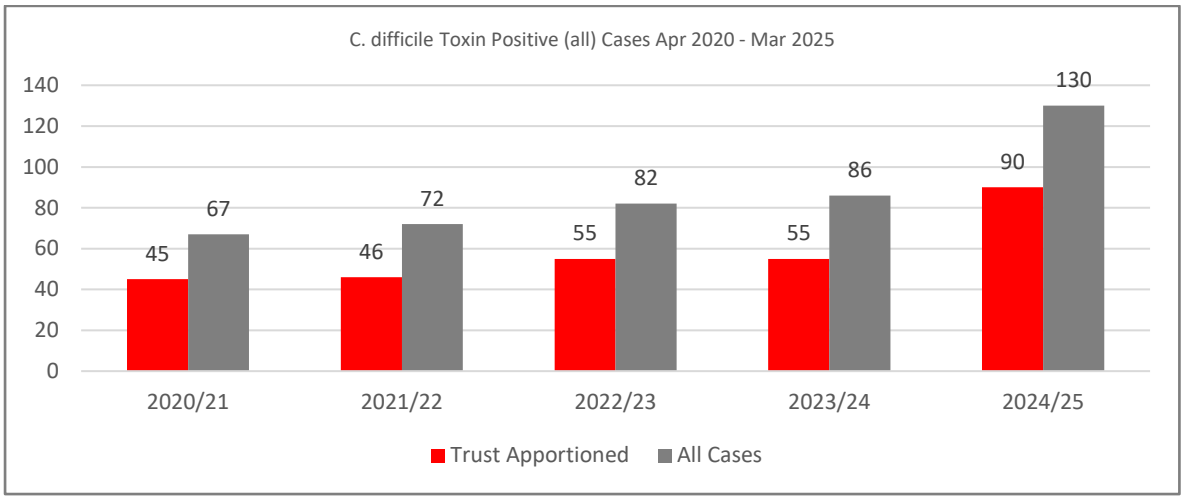
} 90 Trust apportioned cases

- community onset/indeterminate association (COIA) = 13
- community onset/community associated (COCA) = 27

The NHSE threshold for *C. difficile* was set at 60 cases or less (which includes HOHA and COHA cases). The Trust was 30 cases over threshold with a total of 90 cases. Whilst there were 90 cases, 14 patients had a second positive test result in year and three of these patients had a third positive test result. A change to use of 'decision to admit' in place of admission date, from 1 April 2024, led to an additional 6 cases apportioned to the Trust, which would in previous years been considered community apportioned cases.

There was a sharp increase in Trust apportioned cases compared to previous financial years as shown in figure 3.

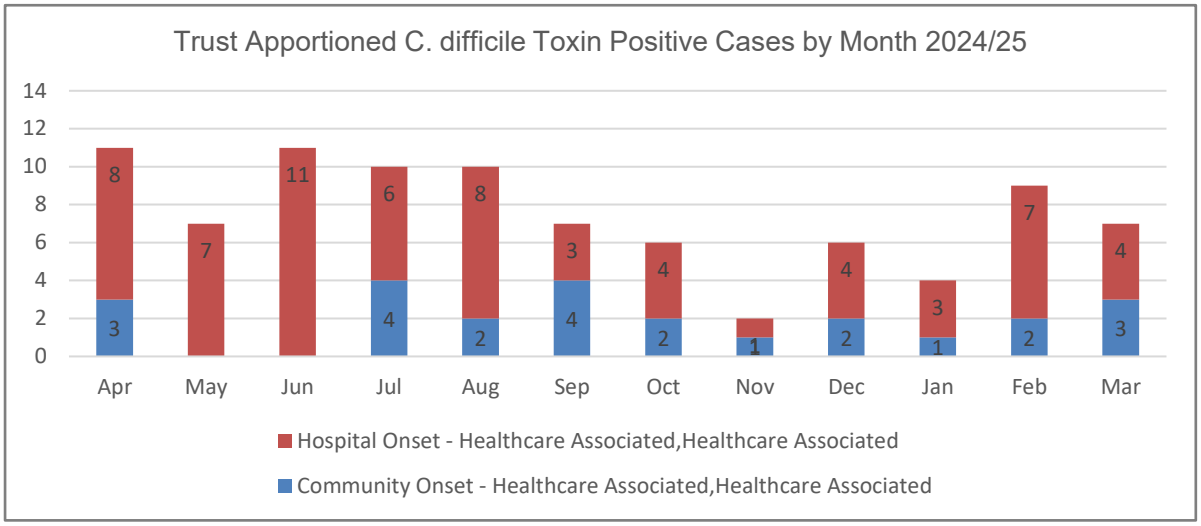
Figure 3 *C. difficile* Toxin Positive Cases (all) April 2020 – March 2025



The rise in *C. difficile* cases was noted nationally and in response the UK Health Security Agency (UKHSA) set up a national standard incident. A review is in progress to gain an understanding of the situation. This review includes examining how trusts test for *C. difficile,* i.e., what samples they test, what tests they use and in what order. The IPC Team have participated in this review by submitting the Trust's laboratory standard operating procedure for testing and completing a survey.

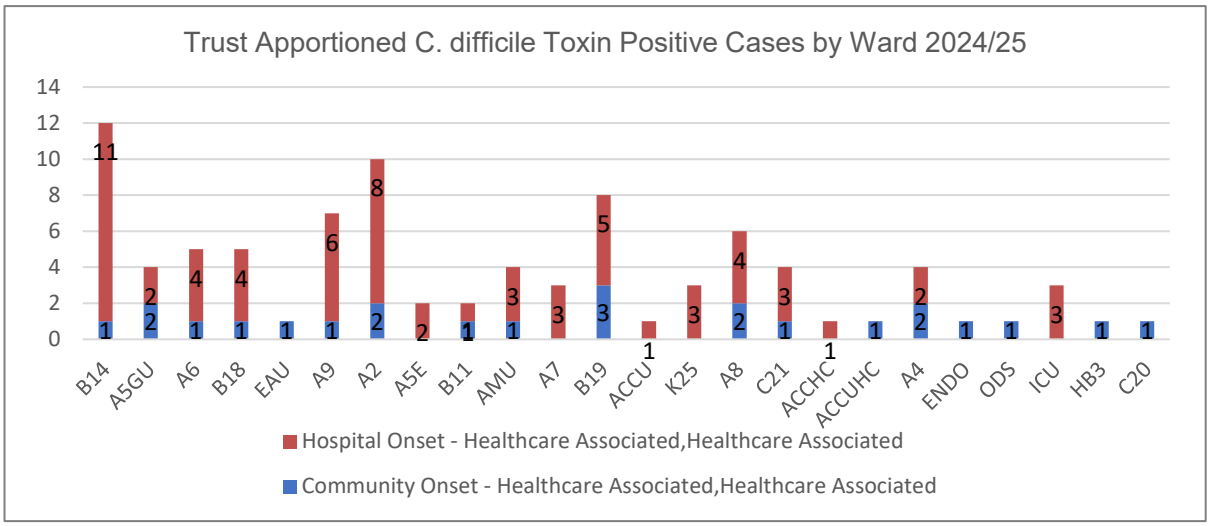
Despite the increase in cases, the Trust has remained a low outlier compared to other NW Trusts. Trust apportioned (HOHA/COHA) *C. difficile* toxin positive cases by month are shown in figure 4.

Figure 4 Trust Apportioned *C. difficile* Toxin Positive Cases by Month



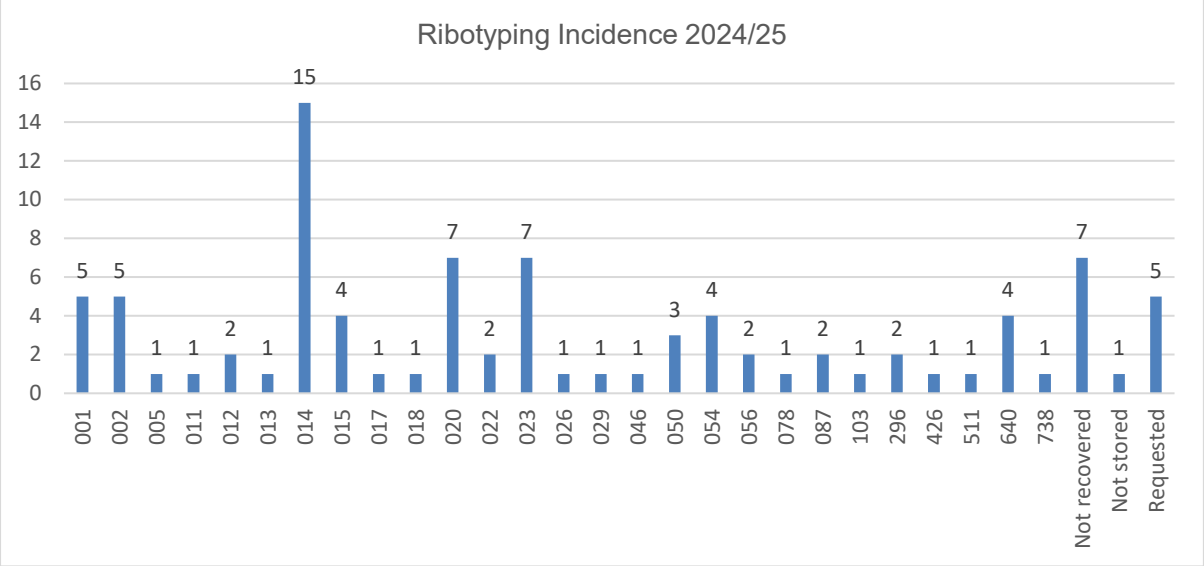
HOHA cases by location when the sample was taken and COHA cases by the discharging ward are displayed in figure 5. The location the specimens were obtained from is not necessarily where the infection was acquired as patients may have been on the ward/department for less than 48 hours when tested.

Figure 5 Trust Apportioned HOHA *C. difficile* Toxin Positive Cases by Location Tested and COHA Cases by Ward/Department Discharged From



All Trust apportioned *C. difficile* toxin positive isolates are submitted for ribotyping. From the 90 isolates, 27 different ribotypes were identified. *C. difficile* was not recovered from 7 of the samples, one sample was not stored, and 5 results were awaited at the time of writing this report. Ribotyping results are shown in figure 6 and demonstrate 014 ribotype is seen more frequently.

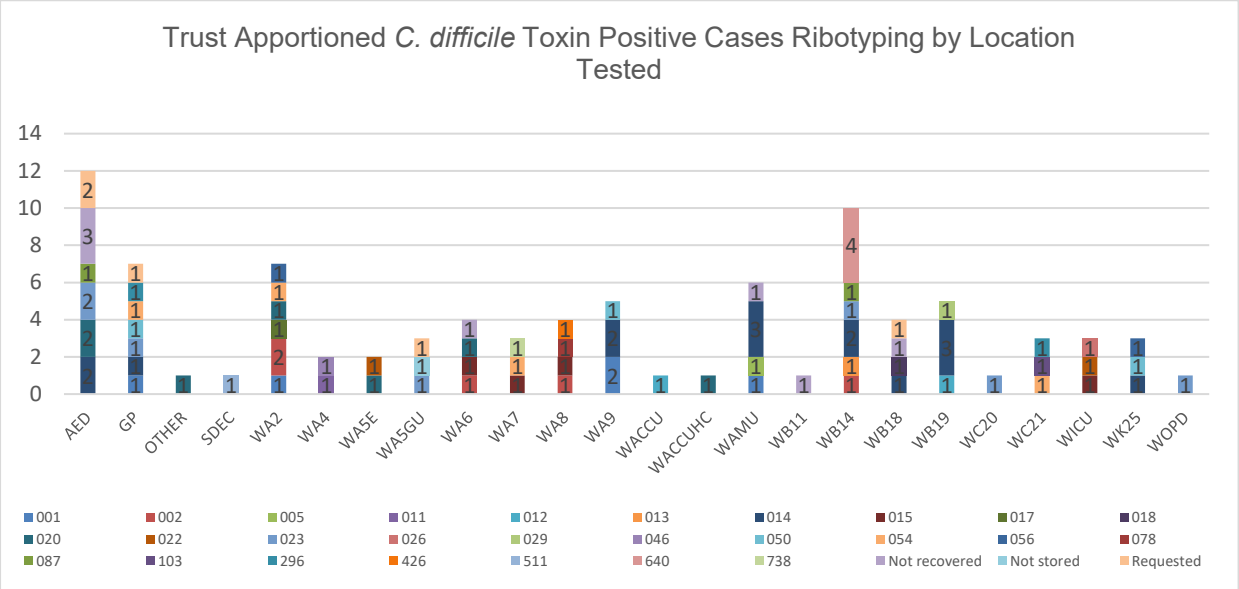
Figure 6 HOHA/COHA C. difficile Toxin Positive Ribotyping Results



C. difficile ribotyping results by ward/department are shown in figure 7. The cases tested in ED are COHA cases. Prompt testing in ED supported timely isolation and contributes to reducing the risk of exposing other patients.

Ward B14 has had a higher number of cases, 4 of which were part of an outbreak.

Figure 7 *C. difficile* Toxin Positive Ribotyping Results by Location



*1 additional case of ribotypes 640 occurred on B14 in a *C. difficile* PCR positive/toxin negative isolate.

C. difficile Outbreak

Local surveillance of *C. difficile* cases is carried out to identify periods of increased incidence (PII) of *C. difficile* cases. A PII is defined as two or more new cases (occurring >48 hours post admission, not relapses) in a 28-day period. Using this approach a PII was detected on ward B14 in June 2024. Ribotyping was requested and the results for 4 patients were the same (640). An additional ribotyping test was carried out on a PCR positive/toxin negative isolate and this ribotype was also 640. This ribotype had not previously been seen in the Trust. As this was a rare ribotype, and all 5 cases had an epidemiological link, the situation was declared an outbreak and reported to UKHSA.

Learning was identified in relation to stool chart completion and timely sampling. An infection control standards audit identified gaps with cleanliness of bed rails and ventilation grilles and handwashing sinks not being dedicated for that purpose. The SIGHT mnemonic was not followed with 3 of the patients not isolated at the time of sampling. Actions undertaken included: -

- decant and deep clean using hydrogen peroxide vapour
- increase infection prevention and control auditing
- increase in environmental cleanliness monitoring
- directing use of soap and water for hand hygiene and training using UV light box
- peer hand hygiene audits
- training for Care Support Workers on sampling and stool chart use
- liaison with Patient Flow to support timely isolation
- including the ward in antimicrobial stewardship ward rounds
- training for ward staff on use of SIGHT mnemonic

The outbreak contributed to the increase in case numbers seen in Q1 and the Infection Prevention and Control Nurses launched an IPC Brilliant Basics Campaign. The initial approach included: -

- dump the junk campaign and introduction to well organised wards
- decant and deep cleaning programme using hydrogen peroxide vapour
- commode spot checks and feedback on trust-wide findings

- mattress audit and refresher on cleaning guidance

The campaign moved on to include other infection prevention standards including: -

- urinary catheter care
- safe care of linen
- efficacy auditing with facilities and clinical teams
- handwashing sinks dedicated purpose
- roles and responsibilities for cleaning
- replacing chairs with damaged covers
- well organised wards and the 5S model
- masterclass on the Matrons role in environmental standards
- amending electronic forms to support documentation of stool output
- temporary role for an Assistant Infection Prevention and Control Educator
- an A-Z infection prevention and control themed weekly focus

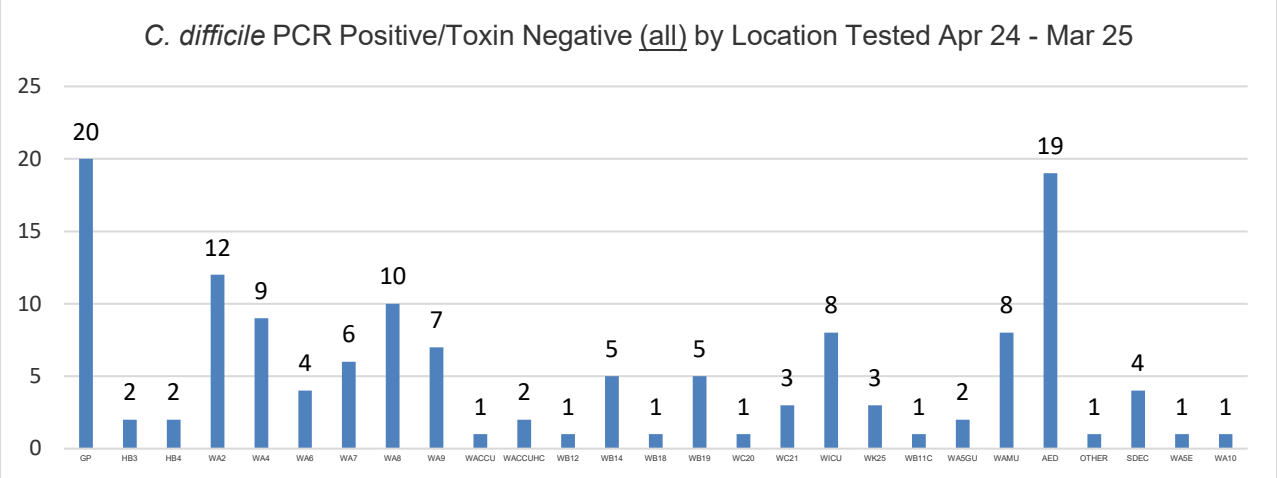
The campaign included feedback from audits, details on accepted standards and inspirational quotes to support engagement. The campaign received positive feedback from staff.

C. difficile (Toxin Negative/PCR Positive)

Diagnostic testing methods for *C. difficile* infection distinguishes between patients who are colonised with *C. difficile* (toxin negative/PCR positive), and those with *C. difficile* toxins present. Presence of toxins indicates infection is more likely.

Patients who are *C. difficile* toxin negative/PCR positive are at a higher risk of developing *C. difficile* infection than non-colonised patients. These patients are reviewed and if exhibiting symptoms are nursed in isolation and treatment advice provided. The locations for patients who were *C. difficile* toxin negative/PCR positive at the time of testing are shown in figure 8.

Figure 8 *C. difficile* PCR Positive/Toxin Negative Cases (all) by Location Tested



Meticillin resistant *Staphylococcus aureus* (*M*RSA) bacteraemia

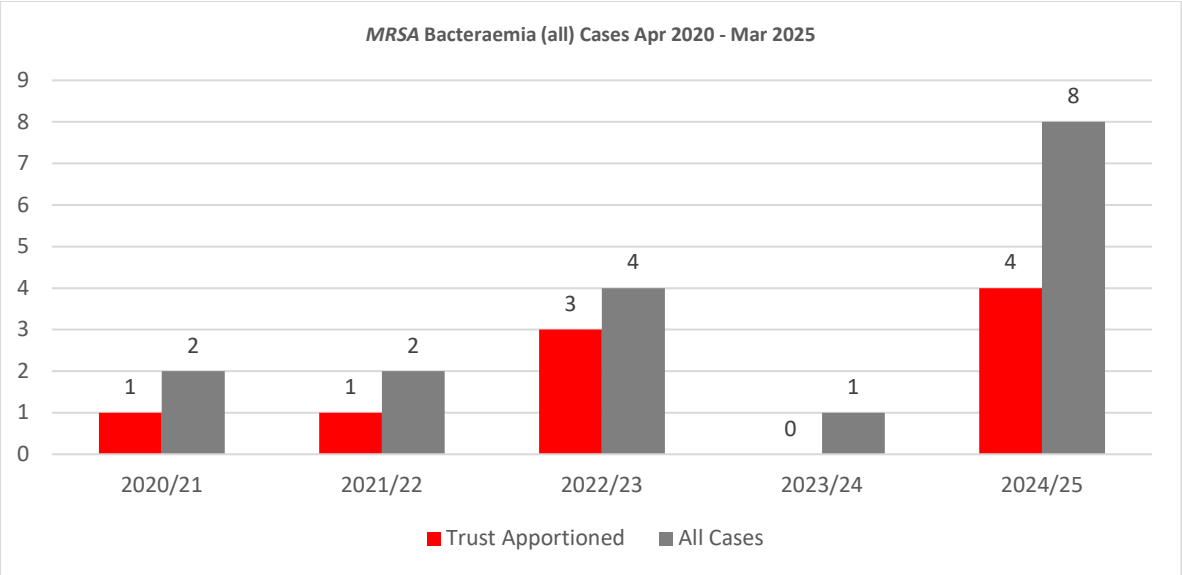
The Trust reported 8 *MRSA* bacteraemia cases, 4 of which were apportioned to the Trust.

- 3 hospital onset/healthcare associated (HOHA)

- 1 community onset/healthcare associated (COHA)

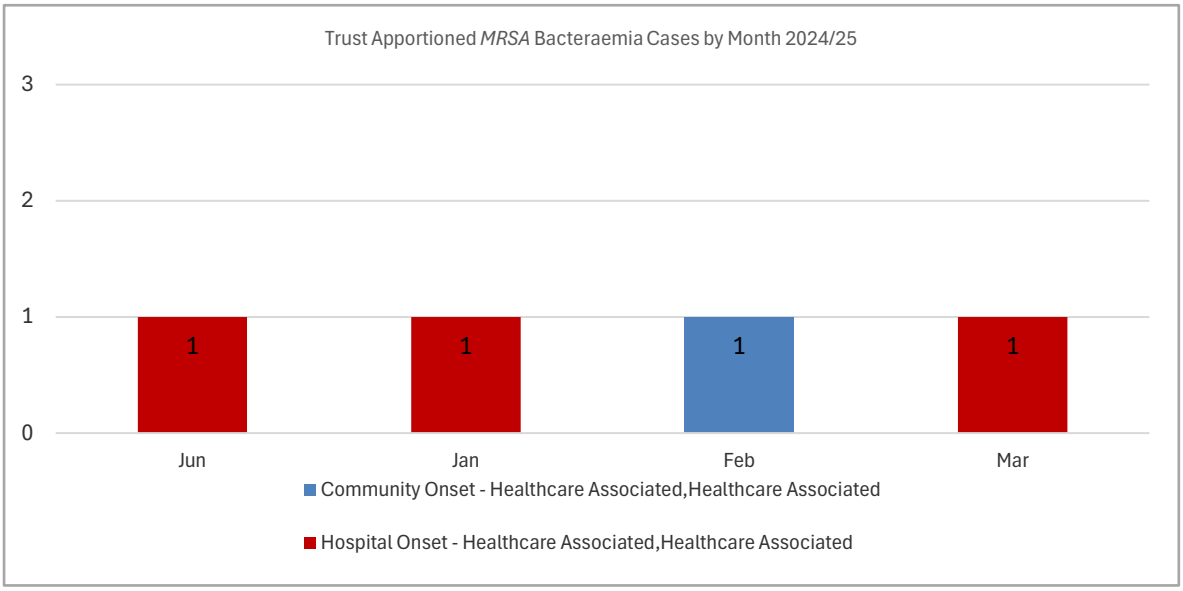
This is an increase in 4 cases compared to the previous financial year. Data for comparison with earlier financial years is shown in figure 9.

Figure 9 *MRSA* Bacteraemia Cases (all) April 2020 – March 2025



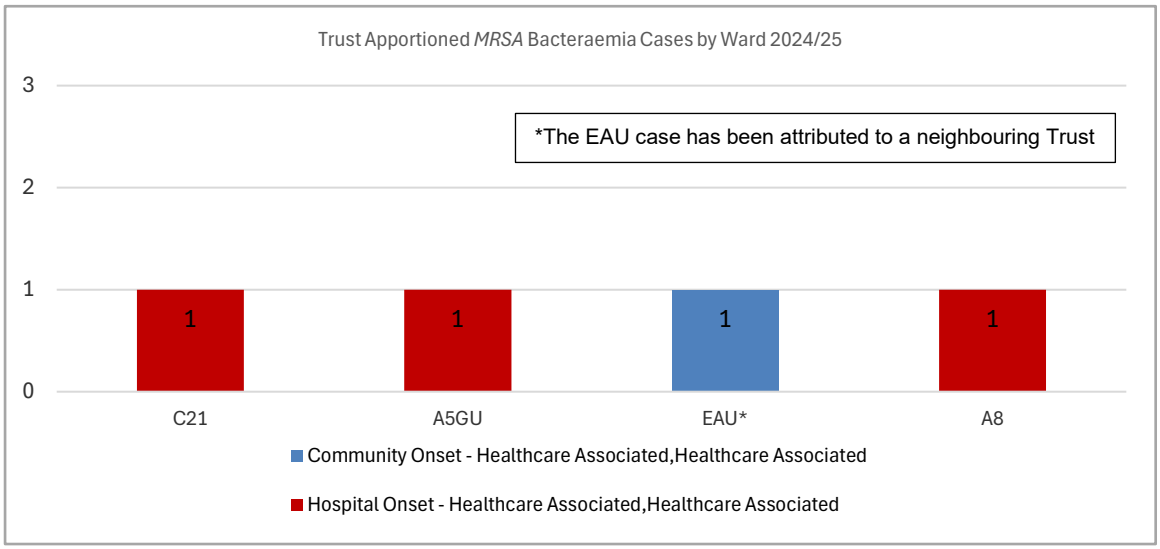
MRSA bacteraemia cases by month are shown in figure 10.

Figure 10 *MRSA* Bacteraemia Cases by Month



MRSA bacteraemia cases by location when tested are shown in figure 11.

Figure 11 *MRSA* Bacteraemia Cases by Location when Tested



Likely primary sources and learning points for these cases are shown in table 3.

Table 3 Likely Primary Sources of *MRSA* Bacteraemia Cases

Ward	Learning Points
C21	**Possibly wound associated** Negative admission and second screen (taken after blood culture result) Leg/groin wound present on admission (superficial ulcer) - swab not taken as part of admission screen (later *MRSA* positive) Protection of peripheral cannula key sites/difficult to cannulate (4 cannula/ consideration of use of longer dwell time device) Possible cannula site association/source – elevated VIP score Earlier wound swab may have influenced antibiotic choice (to cover *MRSA*) Possible contact with other *MRSA* colonised patients
A5GU	**Peritonitis** Documentation to provide assurance on aseptic technique for LocSSIPS (ascitic drain) Ensuring empirical antibiotics include cover for *MRSA* where patients are known to be colonised with *MRSA* Highlight concerns with skin fragility to direct choice of *MRSA* suppression therapy and isolation in a single room Supporting self-caring patients with applying *MRSA* suppression therapy (antiseptic skin wash and nasal ointment)
EAU*	**Urinary Tract Infection** Transferred between WHH and another local healthcare provider Communication between WHH and other provider to advise concerns and support for result communication *MRSA* wound swab result not actioned timely by another Trust Patient factors including agitation and self-removal of catheter Linked to another case at the other provider (against a cluster of 4 other cases) Delay in commencing antibiotics for urinary tract infection

Ward	Learning Points
A8	**Unknown source** February COCA case with repeat blood culture sample taken > 14 days after initial test leading to HOHA category Antibiotic treatment if renal function is reduced – accurate calculation of creatinine clearance. Consultant Microbiology contact should be timely

Areas identified for care improvement included: -

- *MRSA* admission screening (CSU if catheterised) and Wound Swabs (if wounds present)
- Empirical antibiotic cover if known *MRSA* colonisation and dosing in renal impairment
- Invasive device selection and management

Learning from these cases was shared by the Infection Control Sub-Committee.

Meticillin sensitive *Staphylococcus aureus* (*MSSA*) bacteraemia

The Trust reported 74 cases of *MSSA* bacteraemia with 34 cases apportioned to the Trust.

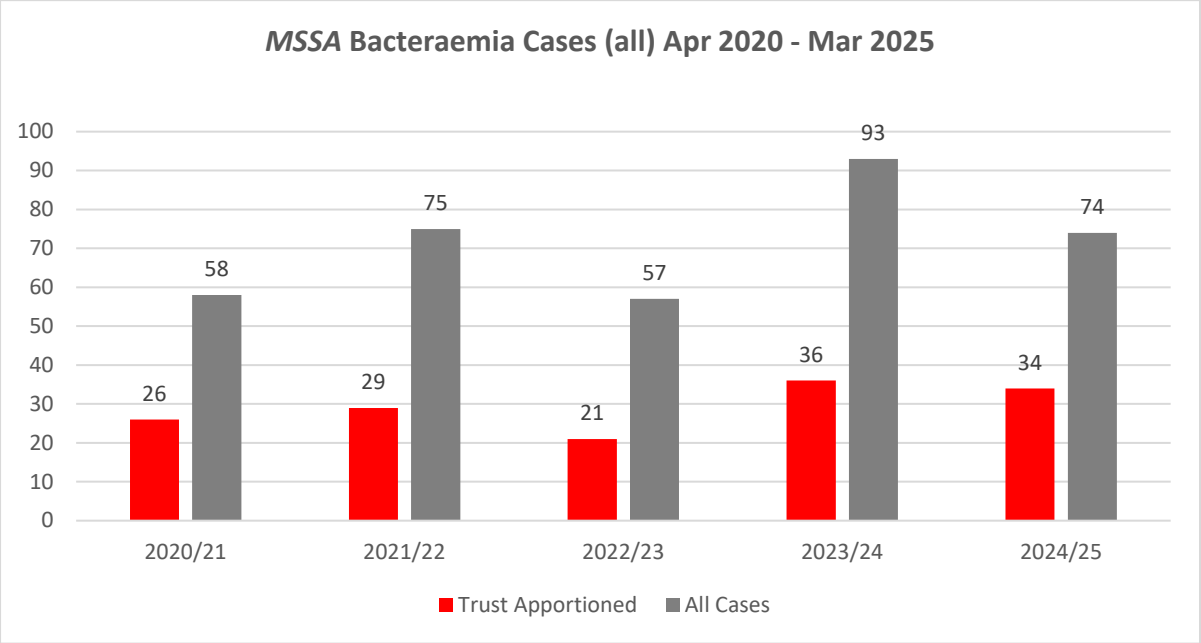
- hospital onset/healthcare associated = 24
- community onset/healthcare associated = 10

} 34 Trust apportioned

- community onset/community associated = 40

This was a decrease by 2 Trust apportioned cases from the previous financial year. Thresholds for the reduction of *MSSA* bacteraemia have not been set. Data for comparison with previous financial years is shown in figure 12.

Figure 12 *MSSA* bacteraemia cases (all) April 2020 – March 2025



Trust apportioned *MSSA* bacteraemia cases by month are shown in figure 13.

Figure 13 Trust Apportioned *MSSA* bacteraemia cases by month

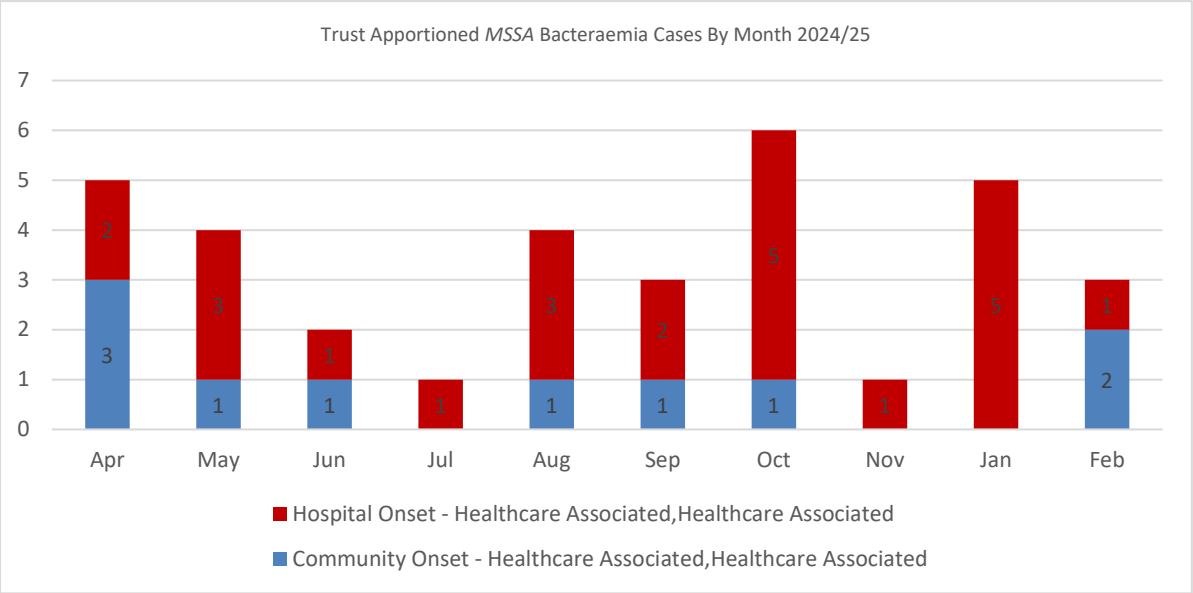


Figure 14 shows the patients' locations at the time the specimen was obtained for HOHA cases and discharging ward for COHA cases.

Figure 14 Trust Apportioned *MSSA* Bacteraemia Cases by Location

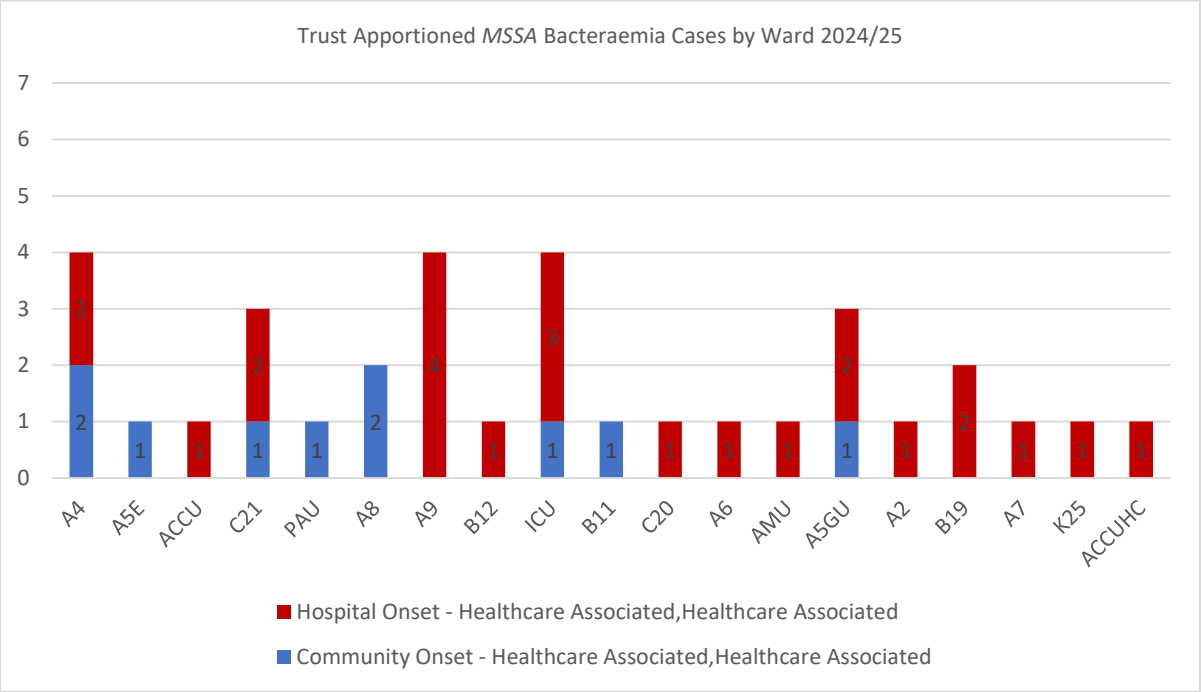
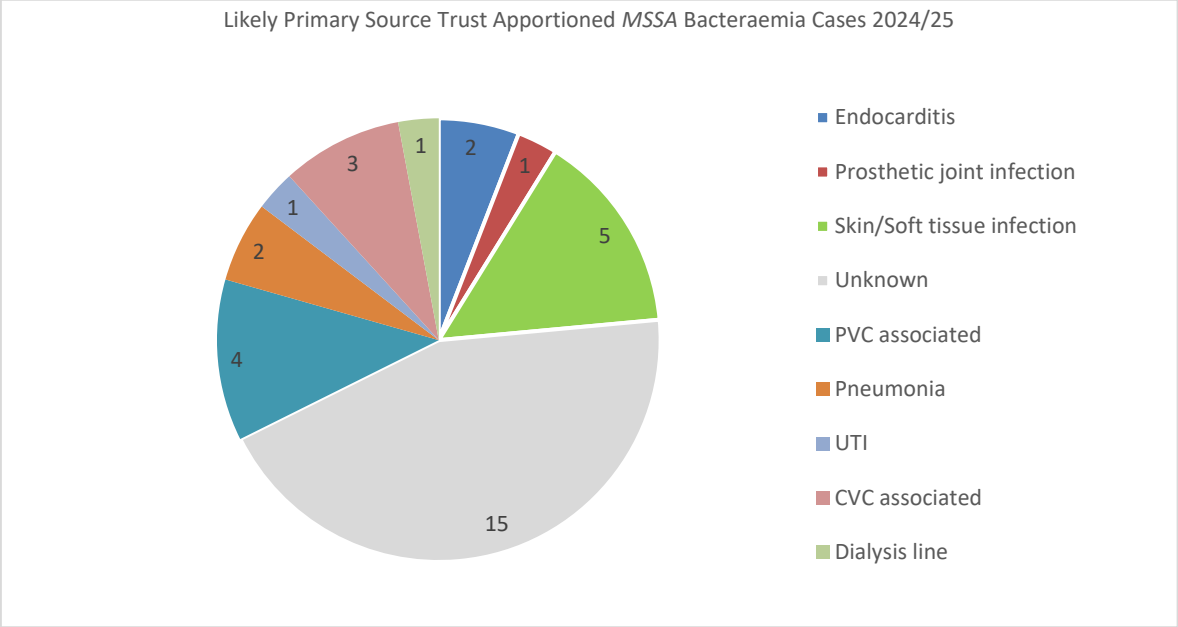


Figure 15 shows the likely primary sources of the Trust apportioned cases

Figure 15 Likely Primary Source of Trust Apportioned *MSSA* Bacteraemia Cases



An action plan is in place that sets out the work required to prevent the risks of *MRSA/MSSA* bacteraemia cases. Training in aseptic non-touch technique and care of invasive devices continues to be the focus on preventing these cases.

Gram Negative Bloodstream Infection (GNBSI)

E. coli Bacteraemia Cases

The national target to prevent GNBSI (*E. coli; Klebsiella spp.* and *Pseudomonas aeruginosa*) remains in place. The IPC Team continued to promote hydration, continence management, reducing usage of urinary catheters and improving catheter care, hand hygiene (including patients) and urinary tract infection detection and management. An increase of 8 Trust apportioned cases was reported compared to the previous FY.

The Trust reported a total of 270 *E. coli* bacteraemia cases, 89 of these were Trust apportioned cases. The threshold of 79 cases set by NHSE was exceeded by 10 cases.

- hospital onset/healthcare associated = 60
- community onset/healthcare associated = 29

} 89 Trust apportioned

- community onset/community associated = 181

This was an increase by 8 Trust apportioned cases compared to the previous financial year. Data for comparison with previous financial years is shown in figure 16.

Figure 16 *E. coli* bacteraemia cases (all) April 2020 – March 2025

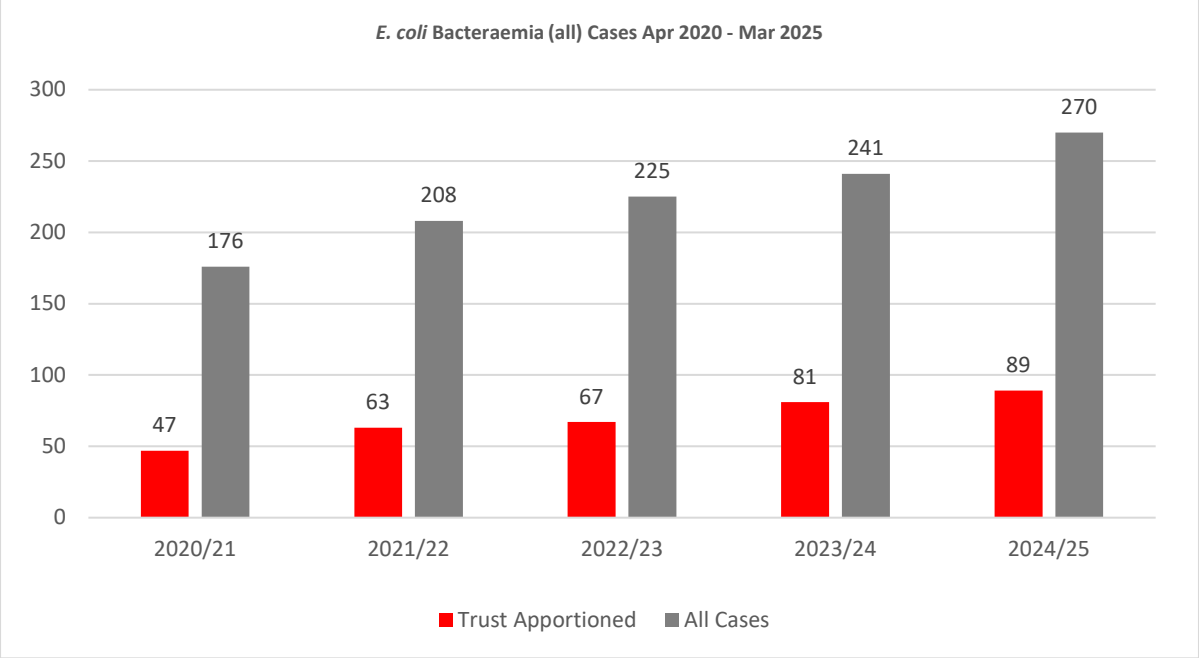
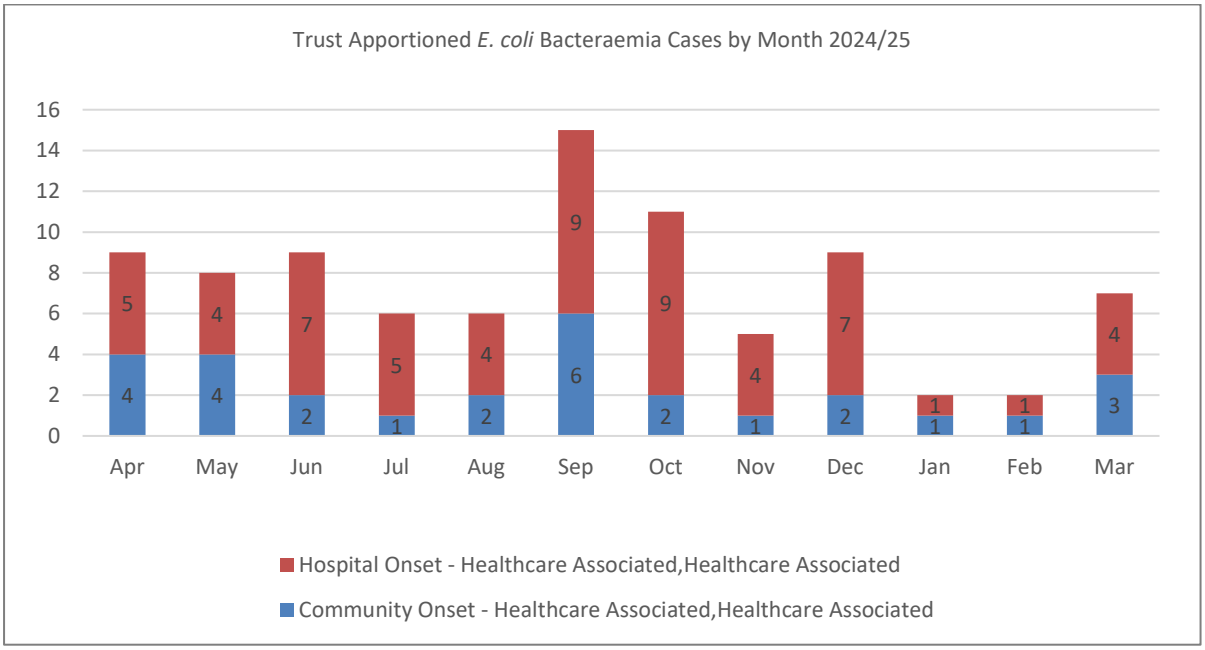


Figure 17 shows Trust apportioned cases by month.

Figure 17 Trust Apportioned *E. coli* Bacteraemia Cases by Month



The Trust apportioned E. coli bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases are shown in figure 18.

Figure 18 Trust apportioned *E. coli* Bacteraemia Cases by Location

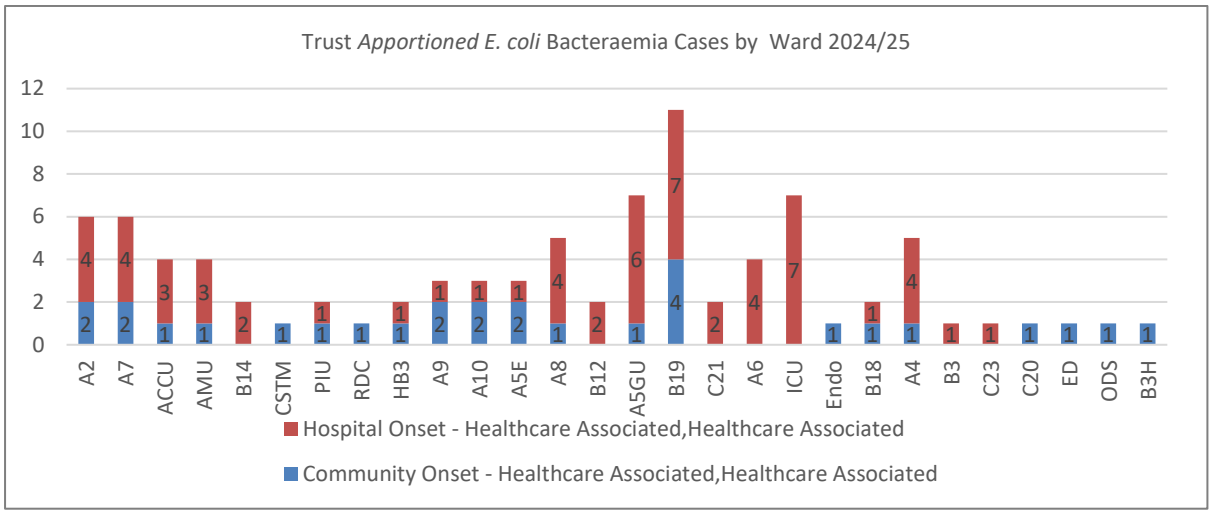
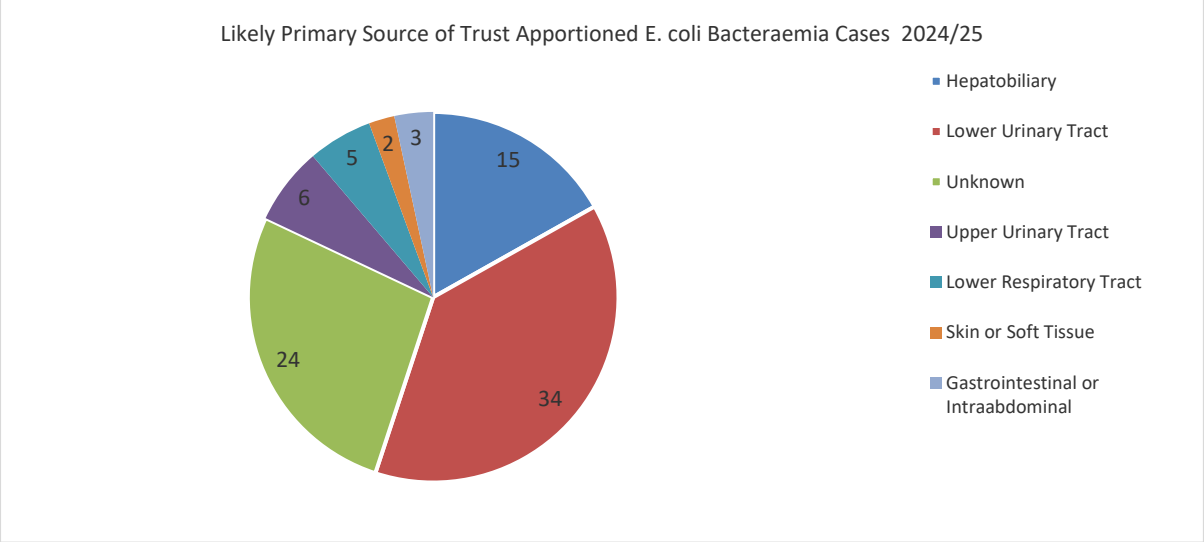


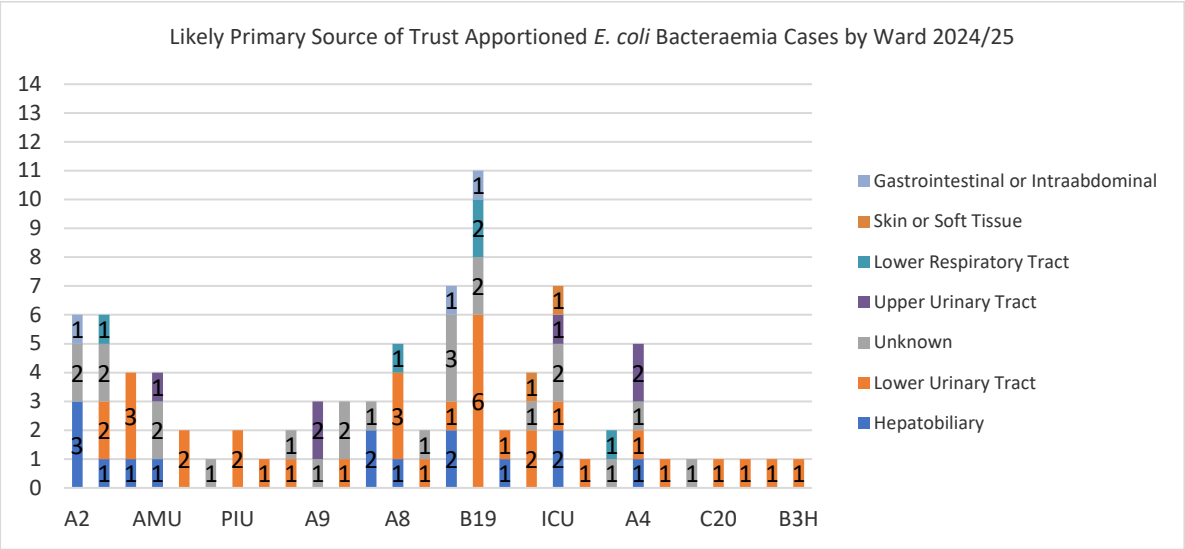
Figure 19 shows the likely primary sources of the Trust apportioned *E. coli* cases.

Figure 19 Likely Primary Sources Trust apportioned *E. coli* Cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 20.

Figure 20 Trust Apportioned Cases - Likely Primary Source by Location



Klebsiella spp. Bacteraemia

The Trust reported a total of 69 *Klebsiella spp*. bacteraemia cases, 30 of these were Trust apportioned cases. The threshold of 28 cases set by NHSE was exceeded by 2 cases.

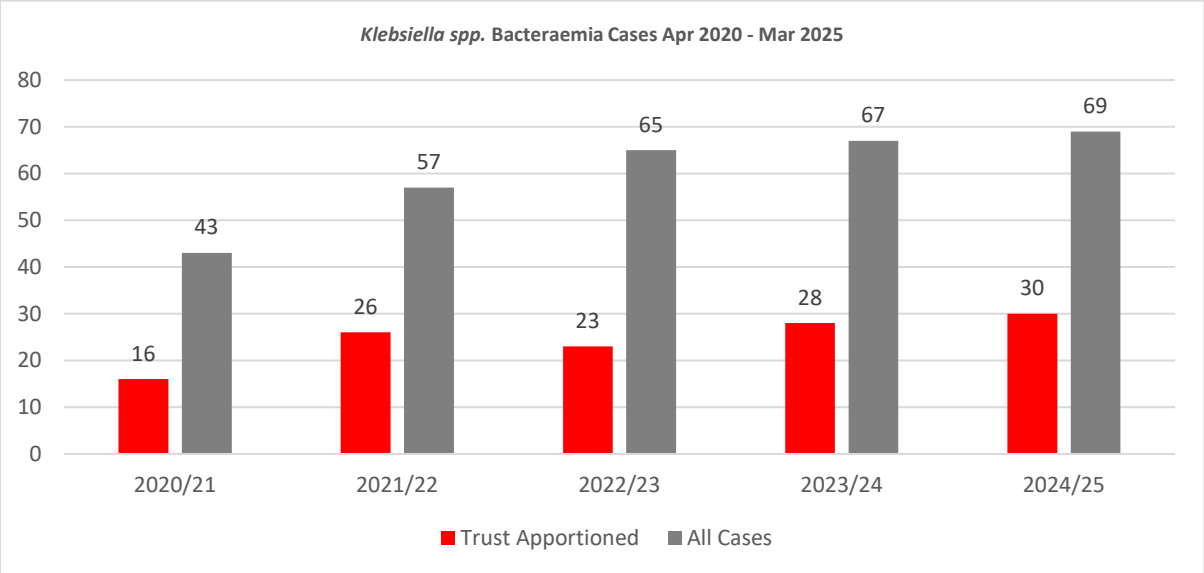
- hospital onset/healthcare associated = 21
- community onset/healthcare associated = 9

} 30 Trust apportioned

- community onset/community associated = 39

A comparison with previous year's data is shown in figure 21.

Figure 21 *Klebsiella spp*. Bacteraemia (all) April 2020 – March 2025



Following a routine data check by UKHSA, the Trust was alerted to the name change of *Enterobacter aerogenes* to *Klebsiella aerogenes.* A review was undertaken and an additional 9 *Klebsiella* bacteraemia cases were identified, that required addition to the UKHSA Data Capture System. A system unlock was requested and the 9 cases (between Nov 22 and Dec 24) were added.

Figure 22 shows Trust apportioned cases reported each month.

Figure 22 Trust Apportioned *Klebsiella spp.* Bacteraemia Cases by Month

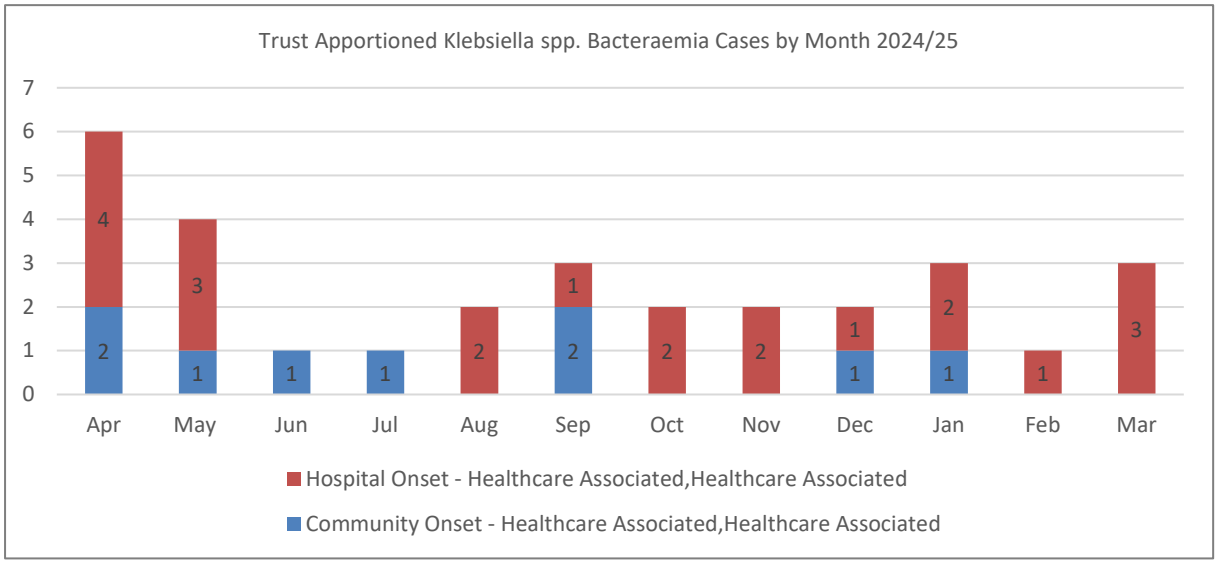


Figure 23 shows Trust apportioned *Klebsiella* spp. bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 23 Trust Apportioned *Klebsiella Spp.* Bacteraemia Cases by Ward Location

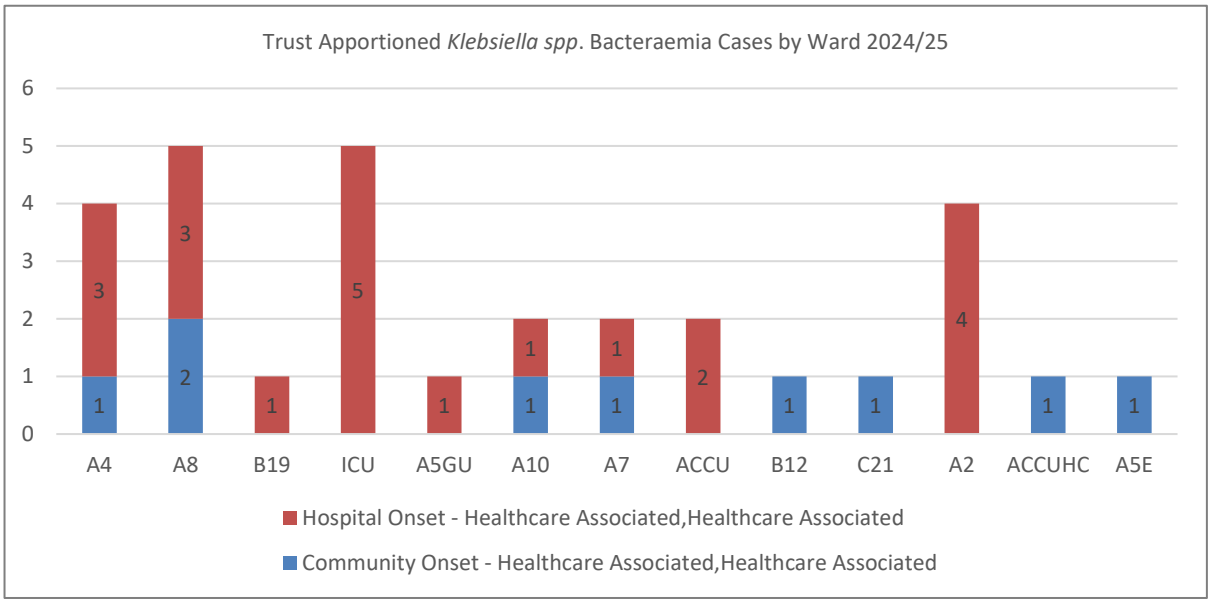
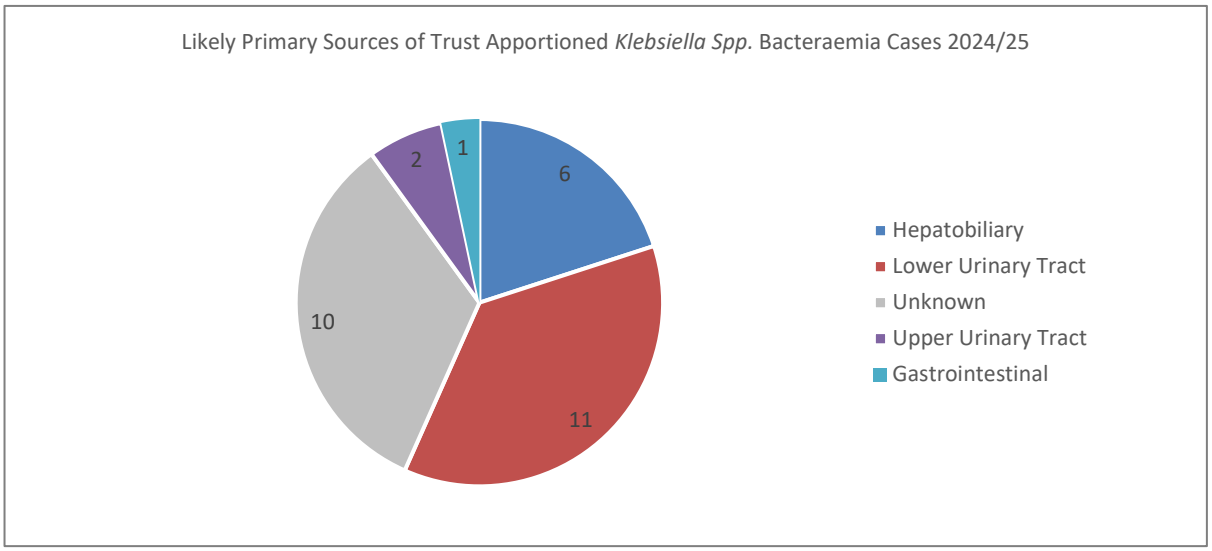


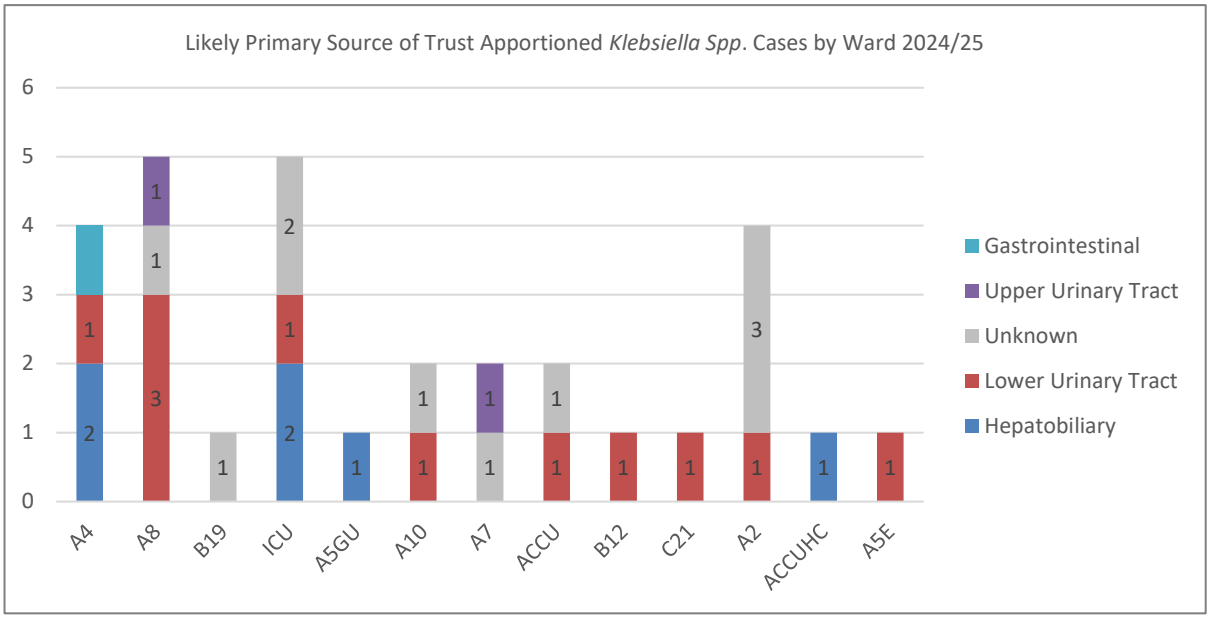
Figure 24 shows the likely primary sources of the Trust apportioned cases.

Figure 24 Likely primary sources of Trust apportioned cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 25.

Figure 25 Trust Apportioned Cases - Likely Primary Source by Location



Pseudomonas aeruginosa bacteraemia

The Trust reported a total of 18 *Pseudomonas aeruginosa* bacteraemia cases, 10 of these were Trust apportioned cases. The threshold of 10 cases set by NHSE was met and a decrease by 1 case compared to the last financial year observed.

- hospital onset/healthcare associated = 8
- community onset/healthcare associated = 2
- community onset/community associated = 8

} 10 Trust apportioned

A comparison with previous year's data is shown in figure 26.

Figure 26 *Pseudomonas aeruginosa* bacteraemia cases April 2020 – March 2025

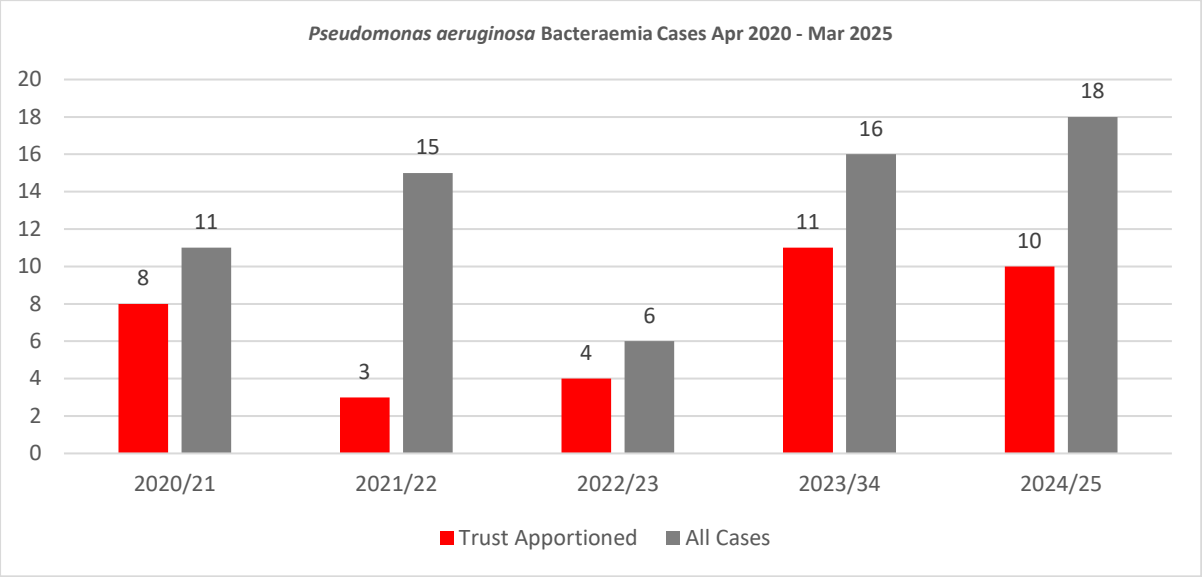


Figure 27 displays the Trust apportioned cases reported by month.

Figure 27 Trust Apportioned *Pseudomonas aeruginosa* Bacteraemia Cases by Month

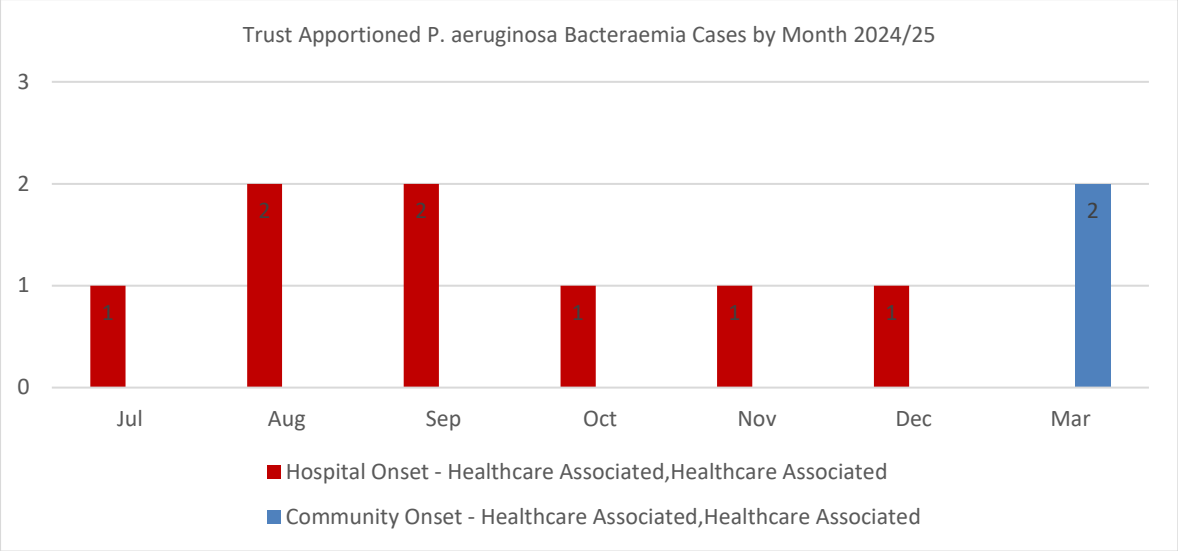
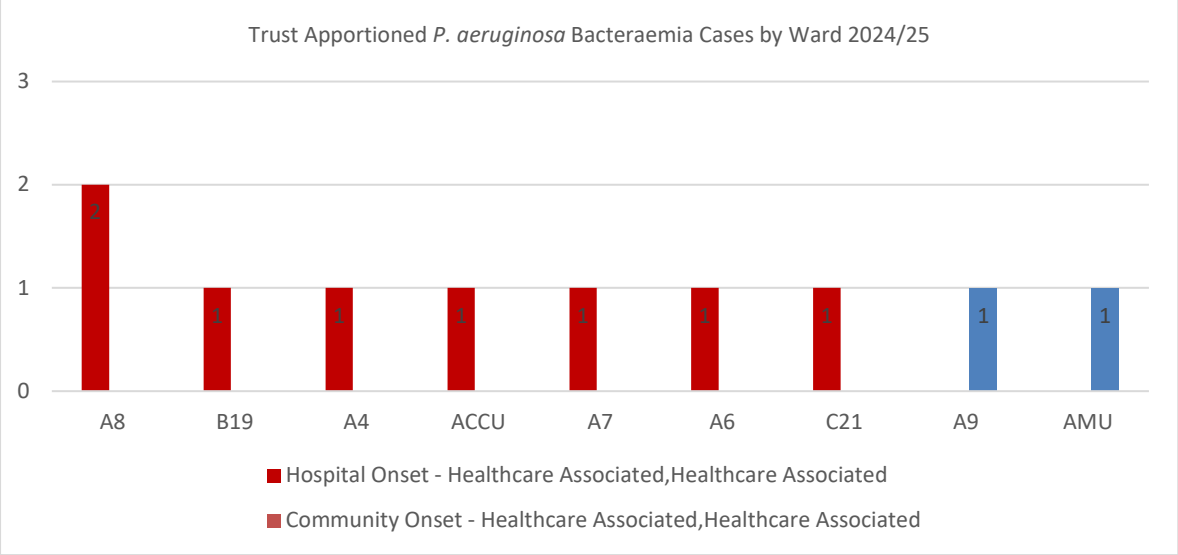


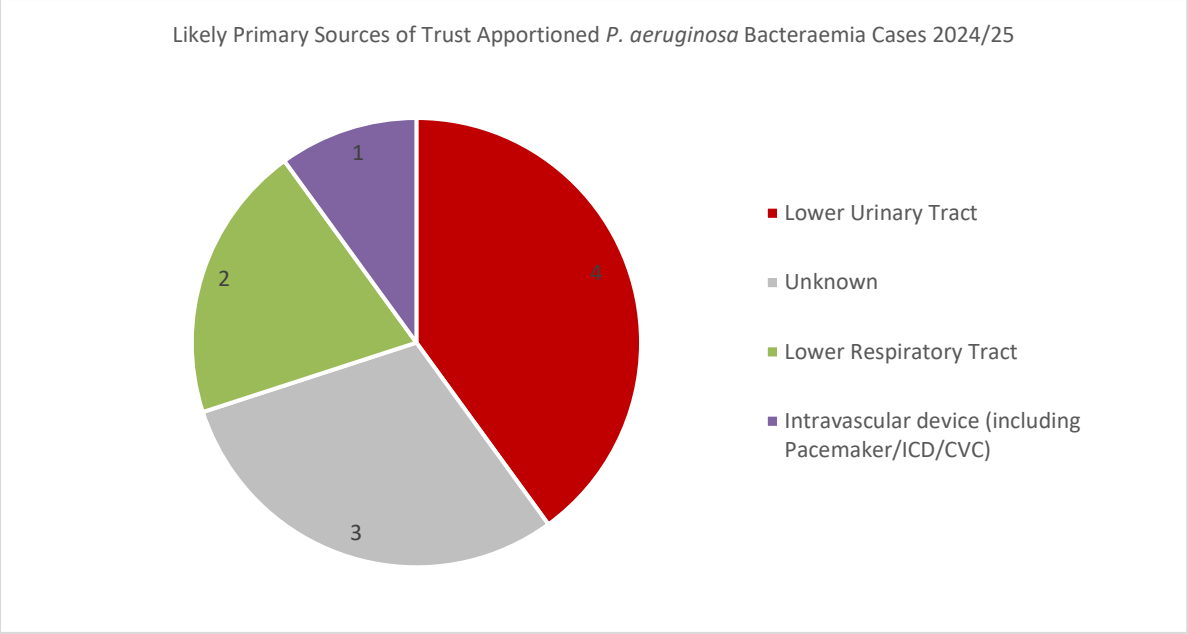
Figure 28 show Trust apportioned *Pseudomonas aeruginosa* bacteraemia cases by location where specimen was taken for HOHA cases and location discharged from for COHA cases.

Figure 28 *Pseudomonas aeruginosa* Bacteraemia Cases by Location



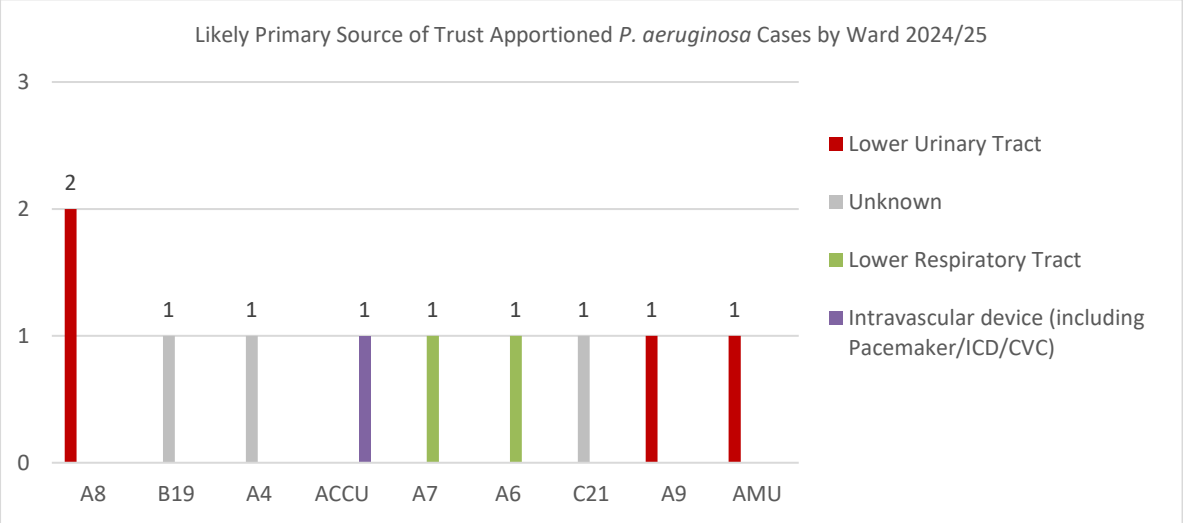
A breakdown of Trust apportioned cases to show likely primary source is shown in figure 29.

Figure 29 Likely Primary Sources of Trust Apportioned Cases



A breakdown of Trust apportioned cases to show likely primary source by location is shown in figure 30.

Figure 30 Trust Apportioned *P. aeruginosa* Bacteraemia Cases Likely Primary Source by Location



There is recognition in the National Action Plan on Confronting Antimicrobial Resistance 2024 – 2029, that the incidence of GNBSIs is projected to increase and there is limited evidence in the literature for interventions which work to prevent GNBSI.

The most frequent likely primary source for GNBSI is the urinary tract. Learning from review of GNBSI cases and audit findings will be applied and the focus for the next financial year will continue and includes: -

- patient hydration
- reduction in use of urinary catheters
- improvements to care of urinary catheters
- competency assessments incorporating Aseptic Non-Touch Technique
- patient hand hygiene strategy
- system learning across acute Trust and community settings

Information on all mandatory reported HCAI is circulated weekly with up-to-date information on cases and learning from reviews. HCAI dashboards are circulated monthly after data validation. Work is in progress with CBUs to ensure completion of action plans from HCAI events.

Covid-19

Activity to respond to Covid-19 cases continued. Community case admissions peaked in June, July, and September. The introduction of point of care testing for seasonal respiratory viruses, including Covid-19, significantly contributed to safe patient placement. The Non-Elective Patient Testing for Respiratory Viruses, Patient Placement and Infection Control Precautions SOP was updated to reflect changes to testing and patients were managed in single rooms until the end of their infectious period.

Standard operating procedure documents for fit testing respiratory protective equipment, using qualitative and quantitative methods, were updated and communicated to clinical

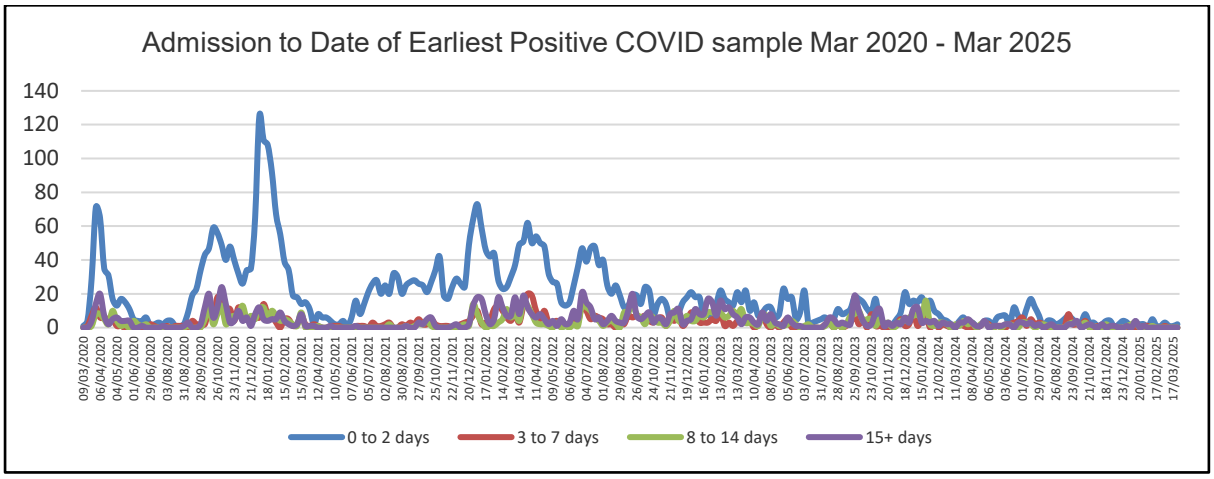
teams to ensure the programme of Fit Testing staff for Face Filtering Piece (FFP) respirators continues.

Nosocomial Covid-19 cases, as per NHS England definitions, decreased significantly compared to the previous financial year: -

- Hospital onset/probable healthcare associated cases (days 8-14) = 51 cases
- Hospital onset/definite healthcare associated cases (>15 days) = 60 cases

Figure 31 shows inpatient cases according to NHSE definitions since the start of the pandemic in March 2020.

Figure 31 Covid-19 Cases by NHSE definitions

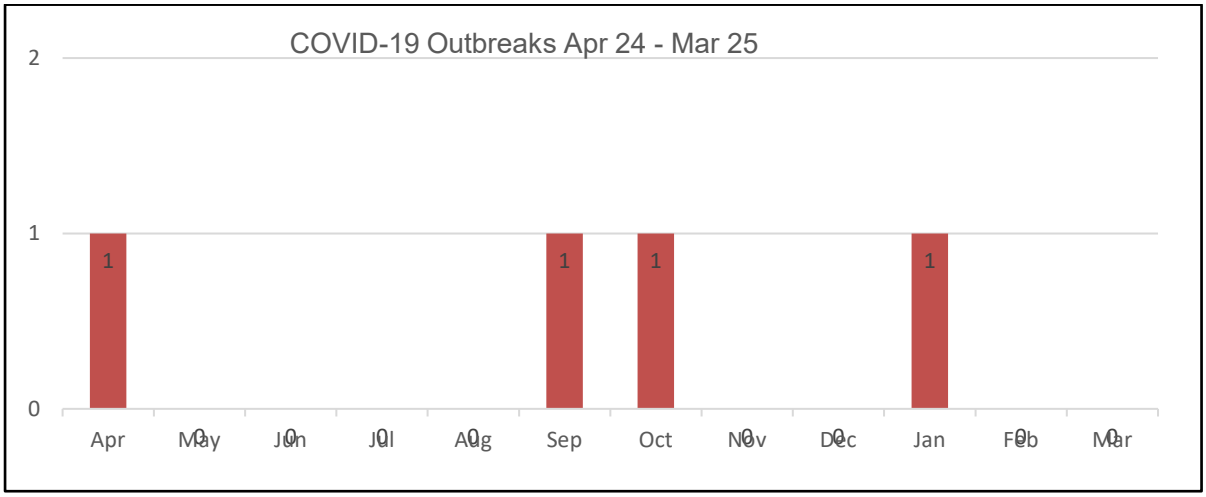


Covid-19 Outbreaks

The IPCNs conducted surveillance to detect Covid-19 clusters. Where outbreaks were declared, Outbreak Control Groups were established to limit further cases.

A total of 4 Covid-19 outbreaks were detected as shown in figure 32.

Figure 32 Covid-19 Outbreaks reported by month



Challenges to managing Covid-19 cases includes: -

- Old estate – limited side rooms

- Patient movements
- Poorly ventilated bays/wards
- Bed spacing <2 metres
- Open visiting

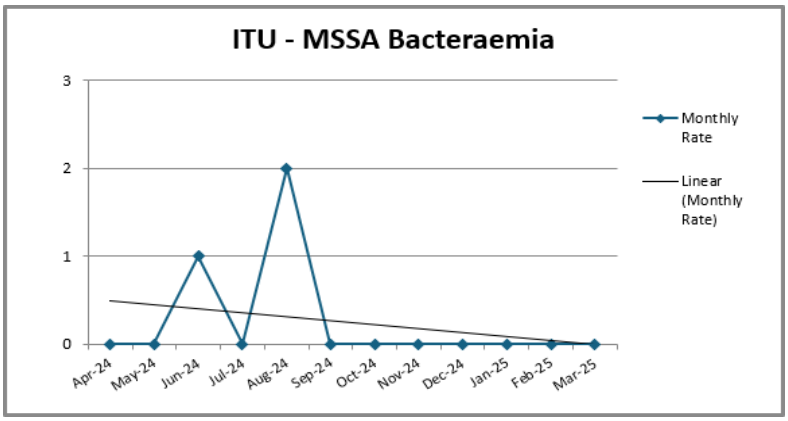
Action taken included: -

- Testing in line with national guidance
- Communication on updated Covid-19 guidance
- Monitoring of compliance with infection prevention and control precautions and directing improvements

Critical Care Surveillance

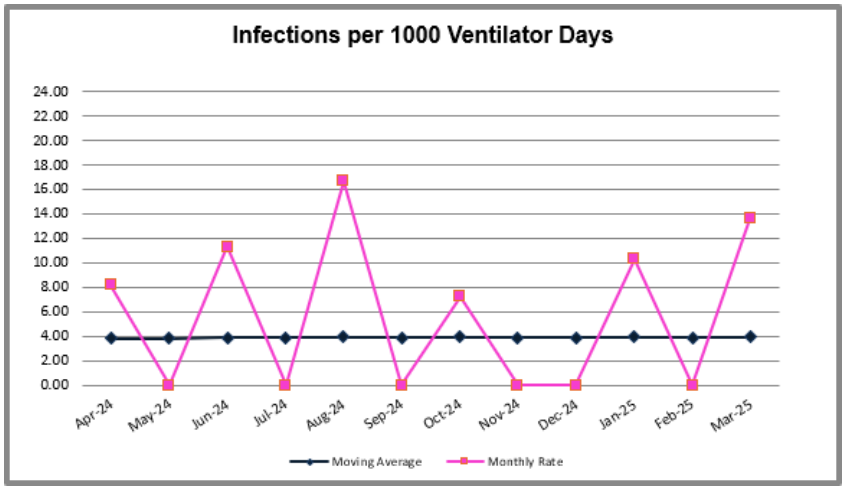
The Critical Care Unit conducts surveillance of bloodstream infections. *MSSA* bacteraemia cases were monitored, and 3 intravascular line associated case was observed as shown in figure 33.

Figure 33 Critical Care *MSSA* Bacteraemia Surveillance



The Critical Care Unit also collates data on ventilator associated pneumonia (VAP) cases. This facilitates identification of trends of bacterial pneumonia in ICU patients who are mechanically ventilated with data on infections per 1000 bed days shown in figure 34.

Figure 34 Ventilator Associated Pneumonia Surveillance



Incidents/Outbreaks

Carbapenemase Producing Enterobacteriaceae (CPE) transmission A5GU

CPE are bacteria that are resistant to Carbapenem (considered last resort) antibiotics. In Feb 2025, a patient was transferred to ICU from ward A5GU and identified to have CPE on ICU admission screening. Contact screening on A5GU identified an additional 2 patients colonised with the same organism, confirmed by whole genome sequencing.

The IPC Team implemented an intense programme of support and monitoring. Deep cleaning of the ward environment, with use of HPV was undertaken and improvement trajectories were set for training and infection prevention and control practice standards. Local training was provided to support improvements in hand hygiene and care of invasive devices and nil further cases were seen.

Influenza

Following review of a cluster of 3 cases of influenza A, on ward A9, an outbreak was declared. The patients were given antiviral treatment and contacts were given antiviral prophylaxis following a risk assessment. Advice and guidance on use of personal protective (including respiratory) equipment was given and an increased frequency of infection prevention and control audits was implemented to support compliance.

Pertussis Exposure Maternity

In September 24, the Executive Medical Director was alerted to a clinically diagnosed case of Pertussis (whooping cough) at a training event, that had been attended by four WHH Trust Midwives.

The Infection Control Doctor and Associate Chief Nurse for IPC attended an Incident Management Team meeting chaired by a Consultant for Communicable Disease Control (CCDC) from the local UKHSA Health Protection Team. It was determined that the index case was in the infectious period and that significant contact had occurred. Advice from the CCDC was implemented which included: -

- Prescribing antibiotic prophylaxis for the Midwives uncertain of vaccination history (in the last 5 years) and to attend Occupational Health and Wellbeing for booster vaccination
- Providing ‘warn and Inform’ advice on vigilance for symptoms of whooping cough Whooping cough - NHS (www.nhs.uk) for staff exposed and what to do if symptoms arise to prevent exposure to vulnerable individuals
- Access to Occupational Health and Wellbeing services for further advice and support within their hours of operation

Additional Information/Actions

- Promote pertussis vaccination to all WHH staff who work with pregnant women and unvaccinated infants
- Promote pertussis vaccination to pregnant women attending WHH for antenatal care in the vaccination window 16 – 32 weeks gestation
- Provide an update on the current situation of high pertussis activity and symptoms to all staff who work with pregnant women and unvaccinated infants so that they can be vigilant for symptoms
- Inform UKHSA Incident Management Team of WHH Trust actions

- Participation in an after-action review which will be hosted by the Trust hosting the training event and share learning as appropriate

Norovirus

The Trust was significantly impacted by norovirus during Q4. Twenty-nine wards reported symptoms of viral gastroenteritis affecting patients, to the Infection Prevention and Control Team, with twenty-five wards having confirmed cases of norovirus.

UKHSA reported a concurrent increase in laboratory reports of norovirus, noting a change in the dominant circulating strain. UKHSA advised contributory factors to the situation included: -

- Post-pandemic changes in population immunity
- Changes in diagnostic testing capability
- Changes to national surveillance
- True increase in incidence due to changes in the dominant strain

Precautions were implemented to limit transmission of norovirus within the Trust, and the Infection Prevention and control Team worked closely with operational teams to safely manage/maximise operational flow and ensure areas were re-opened when safe to do so.

Clean Environments

Domestic Services Management Arrangements

The Domestic Team is an in-house service with Trust staff employed by the Estates and Facilities Management Team. The team is led by the Head of Facilities and on a day-to-day basis managed by a Support Services Manager on each site.

The Domestic Task Team provides a 24/7 cleaning service which includes routine cleans in accordance with the NHS national standards of cleanliness, dealing with emergencies, routine and emergency curtain changes, terminal cleans, and any cleaning required following infection outbreaks. They also form the core team progressing deep cleans in clinical areas using hydrogen peroxide fogging to assist with decontamination of the environment.

The budget allocation for domestic services was £5.6 million with 144 whole time equivalent (WTE) staff.

Cleaning Arrangements

In line with the NHS standards of cleanliness, the functional groups are divided into levels of cleaning intensity, based on the risks associated with inadequate cleaning in that specific area with recommended rectification timescales: -

FR1 98%: Assessment within 20 minutes and task completed at the next scheduled clean or within 2 hours (if the area is accessible) whichever is the soonest. Areas include ED, ICU, all Theatres, Birthing Suite, Neonatal Unit, A5 elective, Cantreat, Urgent Care, PACU

FR2 95%: Assessment within 20 minutes and task completed at the next scheduled clean or within 4 hours whichever is the soonest.

Areas include All wards not listed in FR 1, Angio, Endoscopy, Day case, TSSU, Ophthalmic Day case, Nest, UCC, Xray, Renal Dialysis, GUM, Blood rooms

FR3 90%: Assessment within 1 hour and task completed at the next scheduled clean or within 12 hours whichever is the soonest.
Areas include Orthodontics, Mortuary

FR4 85%: Assessment within 1 hour and task completed at the next scheduled clean or within 72 hours whichever is the soonest.
Areas include CT, Pharmacy, MRI, Ultrasound, Radiology Day Case, Breast screening, Blood rooms, Surgery Pre-op, Occupational Health, Main linen store, entrances and exits, OPD, Daresbury, Halton Eye clinic, SAU, X Ray, Anti-Coagulation clinic, ANDU, Physio, Surgical Appliances, Gynaecology Clinic, Pathology Laboratory, Children's OPD, Vascular lab, Clinical skills, Delamere Centre, ECG, Audiology, Cardiology, Diabetic drop in, Occupational Therapy, Cardiac rehab

FR5 80%: Assessment within 24 hours and task completed at the next scheduled clean or within 96 hours whichever is the soonest.
Areas include Medical Engineering, Chapel, Main Receptions, linen and waste cupboards, equipment store

FR6 75%: Assessment within 24 hours and task completed at the next scheduled clean or within 120 hours whichever is the soonest.
Areas include Offices, Medical Records, Stores, Drs Mess

Monitoring Arrangements

There is a dedicated Monitoring Team within Facilities, who monitor standards of cleanliness and waste compliance within clinical and non-clinical areas at both sites. A separate Facilities Manager leads this team to ensure there is no conflict of interest. The team are all trained to British Institute of Cleaning Science (BICS) standard.

The monitoring of ward kitchens is undertaken by the Catering Department, who monitor cleanliness and food hygiene standards. A schedule is in place to routinely monitor ward kitchens. Any serious breaches of food hygiene are dealt with immediately. An annual inspection of ward kitchens is also carried out by the Local Authority's Environmental Health Team.

The monitoring frequency is dictated by the risk grading of areas, which are as follows: -

FR1 Areas Weekly
FR2 Areas Monthly
FR3 Areas Every 2 Months
FR4 Areas Every 3 Months
FR5 Areas Every 6 Months
FR6 Areas Every 12 Months

Copies of the monitoring reports are circulated to the Lead Nurses, Matrons, Ward Managers, Support Service Managers and Estates, to address any remedial action required. Actions are then reported through to Infection Control Sub-Committee.

Ward Housekeepers are responsible for ensuring any actions on monitoring forms are dealt with promptly. If there are any specific areas of concern, this is reviewed, and focus is given to address the issue. When necessary, frequency of monitoring is increased to address concerns.

Terminal Cleaning

Terminal cleaning is carried out by the Task team on request by a Ward when there is an infection or when a patient has been discharged outside normal working domestic hours.

Table 4 Terminal Cleans

Terminal cleans	A	M	J	J	A	S	O	N	D	J	F	M	Total
2023/24	369	479	385	348	360	428	448	435	552	660	578	561	**5,603**
2024/25	349	394	404	589	385	389	431	400	692	651	527	511	**5,722**

Table 5 HPV Cleans

HPV use	A	M	J	J	A	S	O	N	D	J	F	M	Total
2023/24	27	25	13	31	34	34	20	21	22	64	24	27	**308**
2024/25	25	21	24	32	37	21	47	28	36	25	50	35	**344**

Cleanliness Scores

The 2024/25 cleanliness monitoring scores (Domestic only) for FR1 and FR2 clinical areas were as follows:

FR1 Target score 98%
Warrington: 99%
Halton: 99%

FR2 Target score 95%
Warrington: 97%
Halton: 97.5%

PLACE (Patient Led Assessments of the Care Environment)

PLACE assessments were carried out at Warrington and Halton in November 2024. An action plan was produced and shared with the clinical teams.

Corporate Reporting

A monthly report is submitted by Facilities to the Infection Control Sub-Committee regarding cleanliness standards scores, number of terminal cleans/curtain changes, efficacy audits, process audits for cleaning hand wash sinks and PPE, ward kitchen monitoring, linen, pest control and waste.

Training

The Domestic Staff receive specific theoretical and practical cleaning training as part of their induction, on infection control elements, including the use of FFP3 masks and this is supported by subsequent refresher training.

Random process audits are carried out to ensure that staff follow the correct procedure and wear the correct personal protective equipment (PPE) when cleaning hand washing sinks. Staff competency audits are also carried out to ensure that domestics are working in accordance with their training and the Trust Cleaning Standards Policy.

Routine efficacy audits take place on a weekly basis. These include the IPC Team, senior nursing staff, Estates and Housekeeping staff.

Clinical Access/Responsibility

The Facilities Team centrally manages the domestic staff; however, the Ward Managers and the Housekeepers can direct the domestic staff based on each ward regarding day-to-day priorities. There is also close liaison with the Matrons, who have a specific responsibility for cleanliness standards for their CBU.

Facilities also have a close working relationship with the Ward Housekeepers and attend their monthly meetings to share concerns or offer support as and when required.

Efficacy Audit Results

The programme of efficacy audits was refreshed in October 2024 to review cleaning processes related to infection prevention and control. The efficacy audits are carried out by the Domestic/Facilities Manager, IPC Team, and senior nursing staff. Representation from Estates is included to support review and prioritisation of backlog maintenance.

The audits are scored and any remedial action carried out to promote meeting agreed standards. Efficacy audit findings are shown in figure 35 (Unplanned Care) and figure 36 (Planned Care).

Figure 35 Efficacy Audit Results Unplanned Care

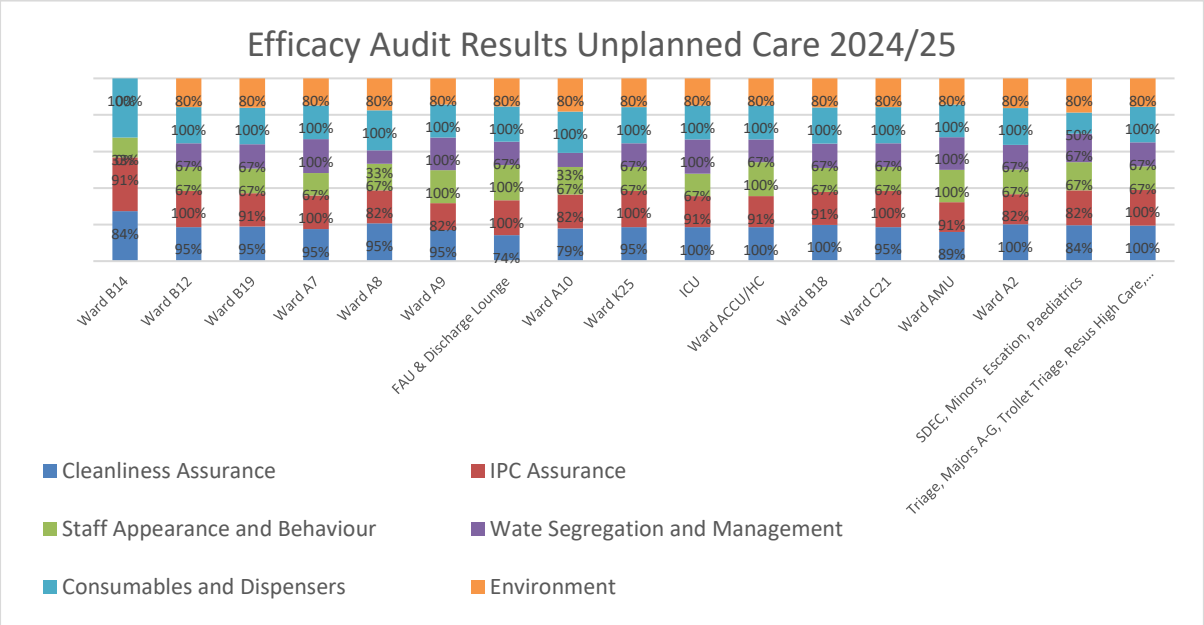
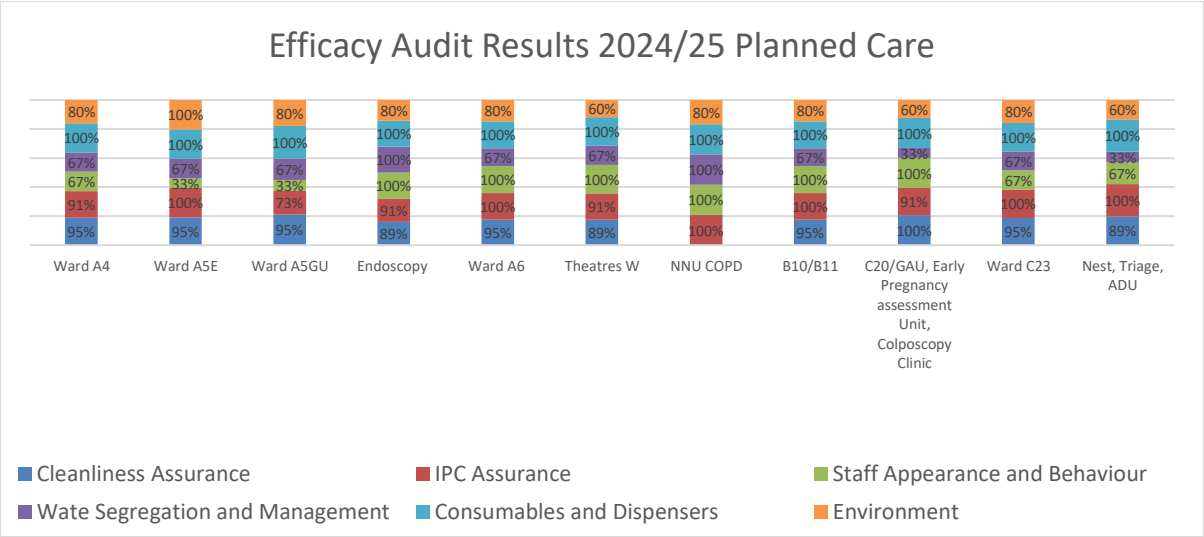


Figure 36 Efficacy Audit Results Planned Care



Infection Prevention and Control Audit Programme

Hand Hygiene

Audits of compliance with the hand hygiene policy are undertaken weekly at ward and department level. Average monthly compliance rates were 98 – 99%. Audits are completed by each ward with peer audits promoted. Results by month are shown in table 6.

Table 6 Trust Wide Hand Hygiene Audit Results by Month

Month	A	M	J	J	A	S	O	N	D	J	F	M
Compliance	98%	99%	98%	98%	99%	99%	99%	99%	99%	98%	98%	99%

Infection Prevention and Control Audits

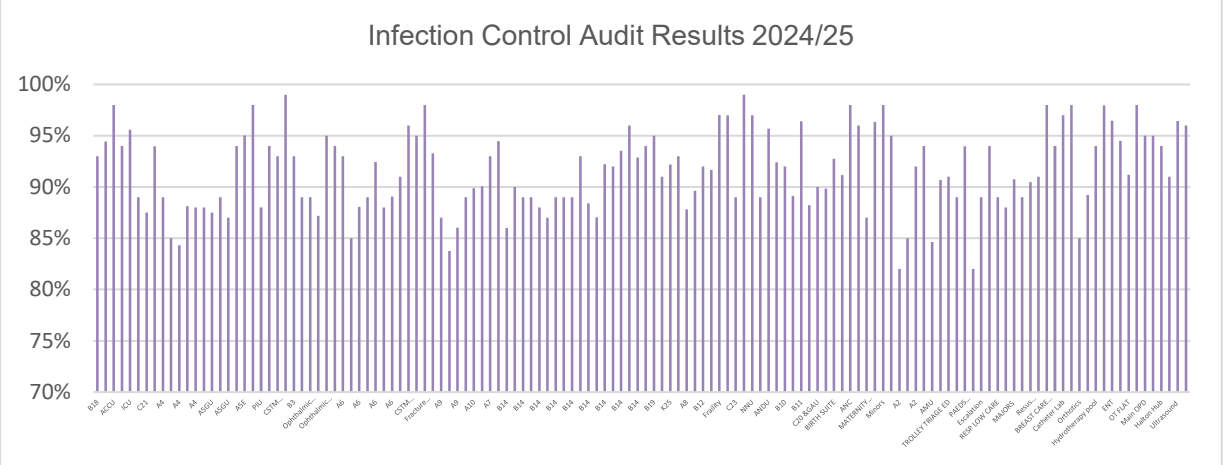
The aim of the IPC audit programme is to measure compliance with Infection Prevention and Control policies/guidelines and assess cleanliness in the patient care environment. This audit programme contributes to providing assurance that infection control policies are followed, and risks are effectively managed within the Trust.

The audits are carried out by the IPCNs using an approved Infection Prevention and Control audit tool. The audit tool has 11 components. A rolling programme of audit is in place to cover all patient areas. Additional audits are completed outside of the rolling programme when infection events occur.

Reports on findings are fed back to the nurse in charge of the clinical area at the time of the audit. This is followed up by a written report within one week of the audit. The manager of the clinical area is responsible for producing an action plan to address areas for improvement.

A summary of overall scores is shown in figure 37.

Figure 37 Infection Control Audit Results



High Impact Intervention Audits

The CBUs have continued a rolling programme of audit to assess compliance with the Department of Health's High Impact Interventions Toolkit. Audit scores are mostly in the region of 90-100%. The results are discussed at the Infection Control Sub-Committee and fed back to the ward teams. Action plans are produced by wards and departments for areas where care improvements are required.

An increase in auditing frequency is requested when scores are below accepted standards. Matrons are directed to provide assurance that the audits drive improvements rather than being a monitoring process.

Training Activities

The IPC Team continue to provide a structured annual programme of education. This includes an infection control eLearning package (aligned to the Core Skills Framework) or face-to face training for all staff. Training attendance figures, for substantive staff, were monitored monthly with details shown in table 7.

Table 7 Infection Control Training Compliance

IPC Mandatory Training	A	M	J	J	A	S	O	N	D	J	F	M
Level 1 – Non-Clinical	95%	94%	94%	94%	95%	94%	95%	95%	95%	94%	94%	94%
Level 2 – Clinical	87%	86%	85%	85%	85%	85%	87%	87%	86%	85%	86%	86%

CBUs with compliance below 85% have been directed to set improvement trajectories. Additional training sessions have been offered by the IPCNs to support the CBUs.

The following sessions are included in the infection control training plan: -

- Trust corporate induction - all new starters
- Mandatory training - all staff
  - Patient facing staff – annual
  - Non-patient facing staff – 3 yearly

Other training includes: -

- F1/F2 Doctors

- Blood culture sampling (indications; aseptic technique; performance management)
- Antimicrobial Stewardship
- Aseptic Non-Touch Technique

Medical Students

- Infection Prevention and Control
- Various infection/microbiology topics

Ad hoc teaching was provided infection events and included: -

- C. difficile management
- CPE and screening
- Isolation priorities
- Linen management
- MRSA screening and suppression therapy
- Personal protective equipment

Antimicrobial Stewardship

From 1 April 2024 - 31 March 2025, 73 joint Consultant Microbiologist and Antimicrobial Pharmacist ward rounds were conducted at Warrington Hospital.

To cover maternity leave, a senior Clinical Pharmacist was seconded into the Antimicrobial Pharmacist post for first part of 2024/25, and they successfully maintained and developed the stewardship agenda. From October 2024, in the absence of a Lead Pharmacist for Antimicrobial Stewardship, a clinical pharmacist covered the ward rounds to ensure continuity of service. Additional Pharmacists are also trained to cover the antibiotic ward round to build resilience within the service. This has now been extended in the form of six-monthly rotations for junior pharmacists.

The weekly Outpatient Parenteral Antimicrobial Therapy (OPAT) Multi-Disciplinary Team (MDT) meeting has continued.

In addition to the joint ward rounds the Consultant Microbiologists have continued to undertake additional ward rounds and attend multi-disciplinary team (MDT) meetings in select areas: -

- Daily ICU antimicrobial ward rounds (Mon-Fri) with a Consultant Intensivist
- A Consultant Microbiologist attends board round every Friday (when staffing allows) on the Acute Medical Unit (AMU) to review patients prescribed antimicrobials and establish individualised treatment plans for the weekend and help with early supported discharge
- A Consultant Microbiologist attends a weekly MDT on ward B19 (*C. difficile* cohort facility) to review antimicrobial prescribing in patients who have a diagnosis or history of *C. difficile* infection. This MDT is not exclusive to patients with a current diagnosis/history of *C. difficile* infection and other patients on the ward are frequently discussed

Consultant Medical Microbiologist/Antimicrobial Pharmacist Ward Rounds

The UK Health Security Agency, Antimicrobial Stewardship (AMS) Toolkit, states that improving antimicrobial prescribing and stewardship is dependent on strong clinical

leadership. They recommend that antimicrobial quality improvement should be done in collaboration with a Consultant Microbiologist/infectious diseases specialist and the Antimicrobial Pharmacist.

Within the Trust, we aim to undertake three joint Consultant Microbiologist and Pharmacist ward rounds each week at Warrington Hospital. These ward rounds target patients who are prescribed specific "target antimicrobials," wards with higher rates of antimicrobial prescribing or wards where there are concerns about compliance with the Trust antimicrobial formulary (picked up through the quarterly antimicrobial point prevalence audit) or higher incidence of HCAI.

"Target antimicrobials" are antimicrobials that we have determined locally require closer monitoring than other antimicrobials because they are either: -

- Broad-spectrum antimicrobials that should be reserved for the treatment of more complicated infections that are not responding to the Trusts first line antimicrobials
- Form part of the "reserve" category within the UK-AWaRe antibiotic classification or
- Antimicrobials that are more commonly associated with the development of *C. difficile* infection

The "target antimicrobials" within the Trust are: -

- Piperacillin/Tazobactam (Tazocin®)
- Meropenem
- Cephalosporins
- Aztreonam
- Linezolid
- Clindamycin
- Quinolones

Patients prescribed "target antimicrobials" are identified from a prescribing report generated from the Electronic Prescribing Medicine Administration (EPMA). The ward rounds are a way of gaining assurance that these "target antimicrobials" are being prescribed appropriately across the Trust.

Ward Pharmacists are also able to refer patients for review on the antimicrobial ward round. Common reasons for referral are: -

- Concerns that patient is deteriorating from an infection point of view and the clinical team have requested a review
- Patient is prescribed antimicrobials that are non-compliant with the antimicrobial formulary
- Duration of antimicrobials has been extended beyond the recommendation within the formulary
- Culture and sensitivity results are available to allow rationalisation of antimicrobials but not actioned by clinical team
- Patient clinically well and suitable for oral step down or cessation of antimicrobial therapy but the team with clinical responsibility for the patient are not undertaking this or are requesting Consultant Microbiologists advice

Aim of the Ward Rounds

Ward rounds are undertaken to promote AMS and improve antimicrobial prescribing standards across the Trust. The ward rounds are undertaken in partnership with the clinical teams. We promote that every time a patient is reviewed the **5 antimicrobial prescribing decision options** are considered and the outcome is clearly documented within the electronic patient record (EPR).

1. Stop antibiotics
2. Switch IV to oral antibiotics (IVOS)
3. Change antibiotics as per culture and sensitivity results (escalation or de-escalation as appropriate)
4. Continue antibiotics
5. Refer to Outpatient Parenteral Antibiotic Therapy (OPAT) Team.

Since 2023-24, the Trust has subscribed to the IVOS CQUIN (Commissioning for Quality and Innovation) which promotes prompt IVOS within 48 hours of commencement, unless a patient meets clearly documented exemptions. Research has shown that prompt IVOS can reduce risk of the patient going on to develop a bloodstream or catheter related infection, reduce hospital length-of-stay, increase patient mobility and comfort and release nursing time to care for patients. Given these multiple benefits, the importance of IVOS has also been conveyed through these ward rounds.

Benefits of the Ward Rounds

Patient Safety & comfort

During or prior to each ward round the Consultant Microbiologist accesses MOLIS (laboratory information system) and a review is undertaken of each patient's recent microbiological samples to see if any organisms have been isolated, during this admission, that will influence antibiotic prescribing decisions. Additional factors that are also considered include history of multi-drug-resistant organisms or *C. difficile* infection.

The ward rounds are not just about reviewing the antibiotics prescribed but also ensuring the patient has had the appropriate microbiological samples sent or undergone appropriate clinical investigations to ensure antimicrobials can be stopped, escalated, or de-escalated as appropriate. These interventions ensure that patients are exposed to fewer days of broad-spectrum antimicrobial treatment or antibiotics are changed to more appropriate antimicrobial treatment in a timely manner. Consequently, this improves patient safety because if patients are exposed to fewer days of unnecessary broad spectrum antimicrobial therapy, then the risk of the patient going on to develop a HCAI such as *C. difficile* infection is reduced. Likewise, if it is identified that the patient has grown a multi-drug-resistant organism (MDRO) in the past then this may be relevant, and antimicrobial therapy will be tailored to cover this organism and ensure safe and appropriate antimicrobial treatment.

The ward rounds allow the Consultant Microbiologist and Antimicrobial Pharmacist to review patients with complex histories/infections who benefit from more specialist input.

Junior Doctors & Antimicrobial Stewardship (AMS)

The Consultant Microbiologists and Pharmacist use the ward rounds as an opportunity to build relationships with ward teams and provide education to junior doctors. Appropriate prescribing is just one part of good antimicrobial stewardship. Timely and appropriate microbiological sampling, and regular clinical review of both the patient and the diagnosis are also vital parts of the Start Smart, Then Focus (SSTF) antimicrobial prescribing algorithm. The ward rounds seek to engage all doctors (mostly junior doctors) and promote these vital steps and help them develop a wider understanding of AMS.

The antimicrobial formulary is actively promoted on each ward round and the junior doctors are reminded of the importance of AMS and their vital role in slowing down antimicrobial resistance (AMR). Junior doctors are encouraged to participate in the ward rounds, and they are informed of the reasons for any suggested changes to antimicrobial therapy which develops their knowledge of microbiology. It is hoped that the education provided during the ward rounds will influence their prescribing practice as they progress in their career and develop their confidence around diagnosis and management of different infections.

Financial

Cost savings are made through the ward rounds by reducing unnecessary consumption of antimicrobials by timely cessation of antimicrobial treatment or de-escalation in treatment where appropriate. Nursing time is saved by the appropriate cessation of antimicrobials, particularly intravenous antimicrobials, releasing the nurse to provide additional time to care for the patient. There is also a cost saving associated with reduced equipment, reduced length-of-stay and medication costs by prompt IVOS or discontinuation of antimicrobials.

Identification of patients who may be suitable for early supported discharge for completion of long-term IV antibiotic therapy in the community setting via the OPAT Team has financial savings for the Trust by reducing hospital length-of-stay.

Compliance with NICE Guidance

NICE guideline NG15 recommends that all care settings should establish an antimicrobial stewardship programme. This ward round is part of the Trusts AMS programme and ensures compliance with NICE guidance. It provides an opportunity to feedback to individual prescribers, monitor prescribing habits and provides education and training.

Other Benefits

The ward rounds help the Trust to manage antimicrobial shortages.

Participation in the antimicrobial ward rounds is a good development opportunity for Junior Pharmacists and improves their knowledge and confidence in AMR and AMS. Trainee Advanced Care Practitioners, medical students and various practitioners undertaking non-medical prescribing qualifications have also joined the ward rounds this year as an educational experience.

Summary of Antimicrobials Reviewed

A total of 549 patients were reviewed on the ward rounds between 1st April 2024 and 31st March 2025.

The two antibiotics most frequently reviewed were Piperacillin/Tazobactam (Tazocin®) and Meropenem. These antibiotics are targeted on the ward round because they are broad-spectrum antibiotics that should be prescribed only as per the formulary or for patients who are known to have previously grown susceptible organisms.

Summary of Ward Round Interventions

Of the 549 patients reviewed, we were able to stop antimicrobials in 84 (15.3%) patients. A further 171 prescriptions (31.1%) were de-escalated and 7 were referred to the OPAT service. 167 patients were continued on their current therapy and 41 required escalations of their therapy.

De-escalation is defined as: -

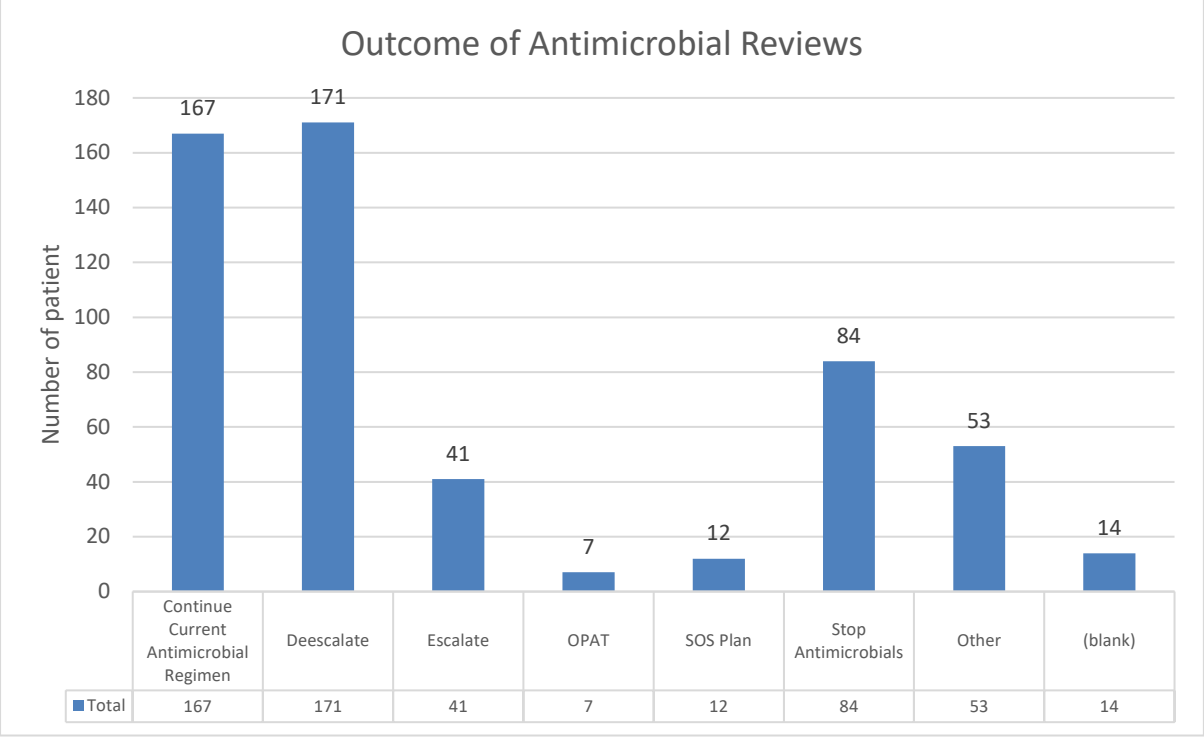
- a change in IV antimicrobial regimen to a narrower spectrum agent
- IV to oral step down

Escalation is defined as: -

- additional antimicrobial cover added
- oral to IV switch

Changes to antimicrobial therapy were only made if the team with clinical responsibility for the patient could be contacted and the proposed changes were discussed and agreed.

Figure 38 Outcome of Antimicrobial Reviews



Future Developments

- The antimicrobial ward rounds could be expanded or further ward-based MDTs added so that more patients on antimicrobials are reviewed. However, this is limited by Consultant Microbiologist and Antimicrobial Pharmacist availability. This is mitigated currently by targeting wards found to have lower compliance with the antimicrobial formulary on the point prevalence audit on the existing weekly antibiotic ward rounds
- Continue training of junior pharmacists to strengthen the Antimicrobial Stewardship agenda within the Trust
- Develop the Antimicrobial Ward Form to make it easier to extrapolate data from EPMA
- Re-launch the IVOS initiative across the Trust through education sessions and promotion of the IVOS Decision Aid Tool in the EPR

Updated Policies, Guidelines, Standard Operating Procedures

The following documents were revised and approved by the Infection Control Sub-Committee: -

- Infection Prevention and Control Team Assurance Framework
- Needlestick and Body Fluid Exposure Policy
- Non-Elective Patient Testing for (Winter) Respiratory Viruses, Patient Placement & Infection Control Precautions (Adults/Children) SOP
- Mattress Inspection and Cleaning SOP
- Trolley Mattress Inspection and Cleaning SOP
- Theatre Personal Protective Equipment SOP
- Theatre Terminal Cleaning SOP
- Surveillance of Surgical Site Infection SOP
- Management of Mpox SOP
- IPC Infection Control Sub-Committee HLBP template
- Infection Prevention and Control Audit Schedule
- Meningitis/Invasive Meningococcal Disease – Infection Control Guidelines
- Infection Prevention and Control Policy
- Nursing Management of Transmissible Spongiform Encephalopathies Guidelines
- Isolation of Immunosuppressed Patients.
- Operational Policy *C. difficile* Cohort Isolation Facility (B19)
- Viral Haemorrhagic Fevers Policy
- Urinary Catheter Passport
- Surveillance of Surgical Site Infection Group Terms of Reference
- ANTT Guidelines
- Major Outbreak Guidelines
- Group A Streptococcus Guidelines
- Winter Virus Testing SOP
- Nebuliser Decontamination SOP
- Hand Hygiene Policy
- Standard and Transmission Based Precautions Guidelines
- Waste Segregation, Handling & Disposal at Ward/Department Level
- Notification Policy
- Hand Hygiene Training Strategy
- Hand Hygiene Training Booklet

- Chickenpox and Shingles Guidelines
- Personal Protective Equipment Guidelines
- Winter Virus Testing SOP
- Tuberculosis Guidelines
- CJD Instrument Handling Guidelines
- Mandatory Reporting of Healthcare Associated Infections
- Qualitative Fit Testing SOP
- Quantitative Fit Testing SOP
- Terminal Cleaning Guidelines
- Proton Pump Inhibitor Policy
- Isolation Guidelines
- Viral Gastroenteritis Patient Information Leaflet
- Infection Control Sub-Committee Terms of Reference
- Safer Sharps Group Terms of Reference
- IV Task and Finish Group Terms of Reference

Revised and updated infection control policies, procedures and information leaflets are available on the Trust's SharePoint for staff to access.

Additional Activities

The Infection Prevention and Control Team has been involved in several initiatives within the Trust to promote the importance of infection prevention and control. These included: -

- Unannounced spot checks
- *C. difficile* care support worker training
- Response to complaints
- Response to FOI requests
- Participation in global/national awareness raising campaigns

Awareness Raising Events

The team had a proactive approach to awareness raising events using Trust wide safety brief, good morning WHH global email, desktop messages and promotional campaigns.

World Hand Hygiene Day May 2024

International Infection Prevention Week October 2024

World Antimicrobial Awareness Week November 2024

World Tuberculosis Day March 2025

Contribution to other initiatives

Capital Projects

All areas that have undergone upgrade work have been reviewed and signed off by the IPC Team prior to re-occupation by patients.

External groups

The IPC Team participated in the following external groups: -

- Mersey Care NHS Foundation Trust Infection Control Committee
- Place-based System Collaborative for Infection Prevention
- NW Nutrition and Hydration Group
- NHSE Regional NW IPC Network Meeting

Annual Plan and Forward Strategy

An annual workplan (appendix 1) has been established for the next financial year. This workplan is subject to change following the summit meeting, June 2025, to plan integration with Bridgewater Community Trust.

Conclusion

The IPC Team have worked hard throughout the year to deliver the annual work plan. Through a matrix approach of surveillance, updates to policy documents, audits and spot checks, support to the antimicrobial stewardship agenda, clinical guidance and education, team members have provided a good output of activity to address the challenges with associated with preventing HCAI.

High level briefing papers and reports, submitted as per cycles of business, to the Patient Safety and Clinical Effectiveness and Health and Safety Sub-committee and quarterly reports submitted to the Quality Assurance Committee and Board of Director, provide assurance on infection control activities and outcomes.

Gratitude is extended to the IPC Team for maintaining their proactive leadership of a challenging and extremely busy agenda.

3. ACTIONS REQUIRED/RESPONSIBLE OFFICER

The Quality Committee is asked to receive the Infection Prevention and Control DIPC Annual Report and note the progress made.

4. IMPACT ON QPS?

Q = Improvements to quality by preventing cases of healthcare associated infection

P = Training of staff to care for patients with suspected/diagnosed infections

S = Work with procurement to support the carbon net zero 2040 ambition

5. MEASUREMENTS/EVALUATIONS

Monitor progress against the Infection Control Sub-Committee work plan

- Healthcare associated infection surveillance data
- Progress against HCAI prevention plans
    - Gram-negative bloodstream infection
    - *Staphylococcus aureus* bacteraemia (*MRSA/MSSA*)
    - *C. difficile* infection
    - Well Organised Ward project
- Delivery of the Infection Prevention and Control Annual Plan

- Education and training compliance figures
- Audit of policy/guideline compliance and action plan for non-compliance
- Progress with policy revision schedule

Progress against the IPC Strategy and Annual Action Plan was monitored at the Infection Control Sub-Committee.

Compliance assessment against Code of Practice and IPC BAF will be conducted biannually.

6. TRAJECTORIES/ OBJECTIVES AGREED

2024/2025 Trajectories

- C. difficile ≤ 60 cases
- *MRSA* bacteraemia cases - Zero tolerance to avoidable cases
- *MSSA* bacteraemia cases – no threshold
- Gram negative bloodstream infections
    - *E. coli* bacteraemia ≤ 79 cases
    - *P. aeruginosa* bacteraemia ≤ 10 cases
    - *Klebsiella spp*. bacteraemia ≤ 28 cases
- IPC Strategy Delivery

HCAI Objectives for 2025/2026 are awaited.

Objectives for 2025/26 will be jointly agreed with Bridgewater Community Healthcare Trust as part of the integration plans.

7. MONITORING/REPORTING ROUTES

High level briefing papers from the Infection Control Sub-Committee are submitted to: -

- Health and Safety Sub-Committee
- Patient Safety and Clinical Effectiveness Committee

DIPC reports are submitted to the Quality Assurance Committee and Trust Board quarterly.

IPC BAF compliance assessments are submitted to the Quality Assurance Committee bi-annually.

Verbal updates are provided to Trust Board monthly as part of the IPR (in full) report.

A Director of Infection Prevention and Control Report is submitted to Trust Board annually.

8. TIMELINES

Financial year 2024/25

9. ASSURANCE COMMITTEE

Infection Control Sub-Committee

10. RECOMMENDATIONS

The Quality Assurance Committee is asked to receive and note the report and progress made.

Alison Kennah
Chief Nurse/Director of Infection Prevention and Control (DIPC)
June 2025

Appendix 1 Annual Work Programme 2025/26

Progress against this action plan will be monitored at the ICSC monthly. Updates will be made where additional activities are identified.

Governance														
	Target date	**Leads**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**
Review of ICSC Terms of Reference	Annual	Deputy DIPC												✓
Review of ICSC Cycle of Business	Annual	ADIPC												✓
Review of Annual Work Plan	Annual	ADIPC												✓
Review of IPC Team infrastructure and reporting lines	Annual	ADIPC												✓
DIPC annual report	Annual	ADIPC			✓									
Quarterly DIPC reports to ICSC	Quarterly	ADIPC	✓			✓			✓			✓		
Quarterly DIPC reports to Quality Assurance Committee (QAC)	Quarterly	ADIPC		✓			✓			✓			✓	
Quarterly DIPC reports to Trust Board	Quarterly	ADIPC			✓			✓			✓			✓
Risk register review	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ICSC HLBP submission to PSCE; and H & S sub-committees and CSS Care Group Governance Meeting	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review of revised HCAI (GNBSI/C. difficile Objective for 2025/26)	Annual	ADIPC	✓											
Review of progress against this work plan	Quarterly	ADIPC	✓			✓			✓			✓		
Revision to IC strategy/Bridgewater Integration	Biannual			✓						✓				
Provision of commentary for Trust Quality Account	Annual	ADIPC	✓											
Code of Practice for prevention of HCAIs – compliance assessment	Biannual	ADIPC					✓						✓	
Review of HCAI prevention action plans C. difficile;	3 / annum	ADIPC		✓				✓				✓		
Review of HCAI prevention action plans GNBSI;	3 / annum	ADIPC	✓				✓				✓			
Review of HCAI prevention action plans Staphylococcus aureus	3 / annum	ADIPC			✓				✓				✓	
Submission of commentary to CQPG	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Committee/Group Meeting Attendance														
Antimicrobial Stewardship Group Meetings	Quarterly	AMSG Lead CMM	✓			✓			✓			✓		
Bed meetings	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CDT MDT	Weekly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Decontamination Group	Quarterly	ICD / ADIPC	✓			✓			✓			✓		
EPRR Group	Monthly		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GNBSI Prevention Group	Monthly	ICD / ADIPC				✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI Network – UKHSA	TBC													
Health and Safety Sub-Committee	Monthly		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Protection Warrington BC	Quarterly		✓			✓			✓			✓		
Health Protection Halton BC	Quarterly		✓			✓			✓			✓		
Housekeeper Forum	Monthly	IPCN	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ICSC	Monthly	All	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ICU/IPC	Biannually					✓						✓		

	Target date	Leads	A	M	J	J	A	S	O	N	D	J	F	M
Infective Endocarditis MDT	Weekly	CMM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPC Team Meetings	Fortnightly	IPC Team	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IPS	TBC	ADIPC												
Medical Devices Group	Quarterly	IPCNs	✓			✓			✓			✓		
NNU/IPC Meetings	Biannual	IPCNs												
Nursing, Midwifery and Allied Health Professionals Forum (Including Ward Managers)	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nutritional & Hydration Group	Monthly	TBC				✓	✓	✓	✓	✓	✓	✓	✓	✓
NWB ICC	TBC	Deputy DIPC												
Occupational Health and Wellbeing/IPC	Biannual	IPCNs					✓						✓	
Operational Patient Safety Group	Monthly		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Experience and Inclusion Sub-Committee	Monthly	IPC Matron	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Safety and Clinical Effectiveness Committee	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
PSIRF HCAI event meetings	As required													
Quality Assurance Committee – Reporting only	Monthly	CNO/DIPC		✓			✓			✓			✓	
Safer sharps group meeting	Bimonthly	IPCN	✓		✓		✓		✓		✓		✓	
Sepsis Improvement Group	Monthly		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
System Collaborative for Infection Prevention	TBC					✓						✓		
Trust Wide Safety Brief (via email)	Daily		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ventilation Assurance Group	Quarterly	ICD / ADIPC			✓			✓			✓			✓
Water Safety Group	Quarterly	ICD / ADIPC			✓			✓			✓			✓
Surveillance														
Compliance with mandatory reporting of MRSA; MSSA; C. difficile; GNBSI (E. coli, Klebsiella and Pseudomonas)	Monthly	IPCNs/ ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory reporting data validation and timely sign off	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MSK compliance with Mandatory orthopaedic surveillance	Quarterly	LN MSK	✓			✓			✓			✓		
Zero tolerance to avoidable MRSA bacteraemia cases	Monthly	ALL	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI surveillance reports – weekly to Chief Nurse, Associate Chief Nurses, Lead Nurses, and Matrons	Weekly	IPC Admin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Surveillance of HAI alert organisms (MRSA, VRE, CDT etc.)	Daily	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting for Trust dashboards with commentary	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HCAI reporting to ICSC dashboards	Monthly	ADIPC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pseudomonas surveillance in Augmented care area (ICU: NNU: B18)	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
VRE surveillance	Fortnightly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete Quarterly Mandatory Laboratory Returns and submit to UKHSA	Quarterly	Deputy DIPC	✓			✓			✓			✓		
Antibiotic ward rounds daily on ICU	Daily	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Antibiotic ward rounds	Weekly	CMMs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Environmental Cleanliness Monitoring														
Environmental cleanliness monitoring	Monthly	Facilities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matron and IPC Walkabouts	Monthly	Matrons /IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mock CQC inspections	TBC	Matrons	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	Target date	Leads	A	M	J	J	A	S	O	N	D	J	F	M
Estates PAM assessment	Annual	ADE												✓
Legionella Assessments and Compass Flushing Reports	TBC	ADE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NHS Cleaning standards and Cleanliness Charter Efficacy Audits	Monthly	HoF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audit														
Audit Programme (IPC led) against standard precautions with reporting to ICSC	Annual	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hand hygiene audits	Weekly	LNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
MRSA pre-operative screening audit	Quarterly	LN DD	✓			✓			✓			✓		
MRSA screening compliance audits	Monthly	IPCNS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Support areas requiring improvements identified on the Quality Metrics programme/Outbreak or cluster areas	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Policy /Guideline/SOP/Leaflet Reviews														
Non-elective patient testing for respiratory viruses, patient placement and Infection Control Precautions	Apr 25	CMM	✓											
Notification Policy	Apr 25	ADIPC	✓											
Chickenpox and Shingles Guidelines	Apr 25	ADIPC	✓											
Meningitis/Invasive Meningococcal Disease Guidelines	Apr 25	ADIPC	✓											
Laundry Policy	May 25	ADIPC		✓										
Viral Gastroenteritis Guidelines	May 25	ADIPC		✓										
Candida auris screening SOP	Jun 25	ADIPC			✓									
Decontamination of Reusable PPE SOP	Jun 25	ADIPC			✓									
MRSA	Jun 25	IPCNs			✓									
C. difficile	Jun 25	IPCNs			✓									
Measles	Jun 25	IPCNs			✓									
MSSA SOP	Jul 25	ADIPC				✓								
Decontamination Policy	Sep 25	IPCNs						✓						
Spillage Guidelines	Sep 25	IPCNs						✓						
Deceased patient	Oct 25	IPCNs							✓					
Local Surveillance	Oct 25	IPCNs							✓					
Ward/Department Closure	Oct 25	IPCNs							✓					
Specimen collection	Nov 25	IPCNs								✓				
Admission, transfer, discharge Guidelines	Nov 25	IPCNs								✓				
Multi-Drug-Resistant Organism Guidelines	Dec 25	IPCNs									✓			
Blood Culture Policy	Dec 25	CMM									✓			
Awareness Raising Events														
Global Hand washing Day	May	IPCNS		✓										
Uniform and workwear promotion	TBC	All												
October IC week – Topic Boards	Oct	IPCNs							✓					
November World Antibiotic Awareness Week	Nov	CMM								✓				
Seasonal flu campaign with OHWB	Dec	OHWB							✓	✓	✓	✓		
World TB Day	Mar	IPCNs												✓

	Target date	Leads	A	M	J	J	A	S	O	N	D	J	F	M
Education														
ANTT Peer Assessor Training	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Induction training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mandatory training sessions as per timetable	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Single Point Lessons as requirement identifies	Monthly	IPCNs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Foundation Doctor induction	Oct	CMM							✓					

D = deferred
✓= Planned
✓= Completed
X= Cancelled