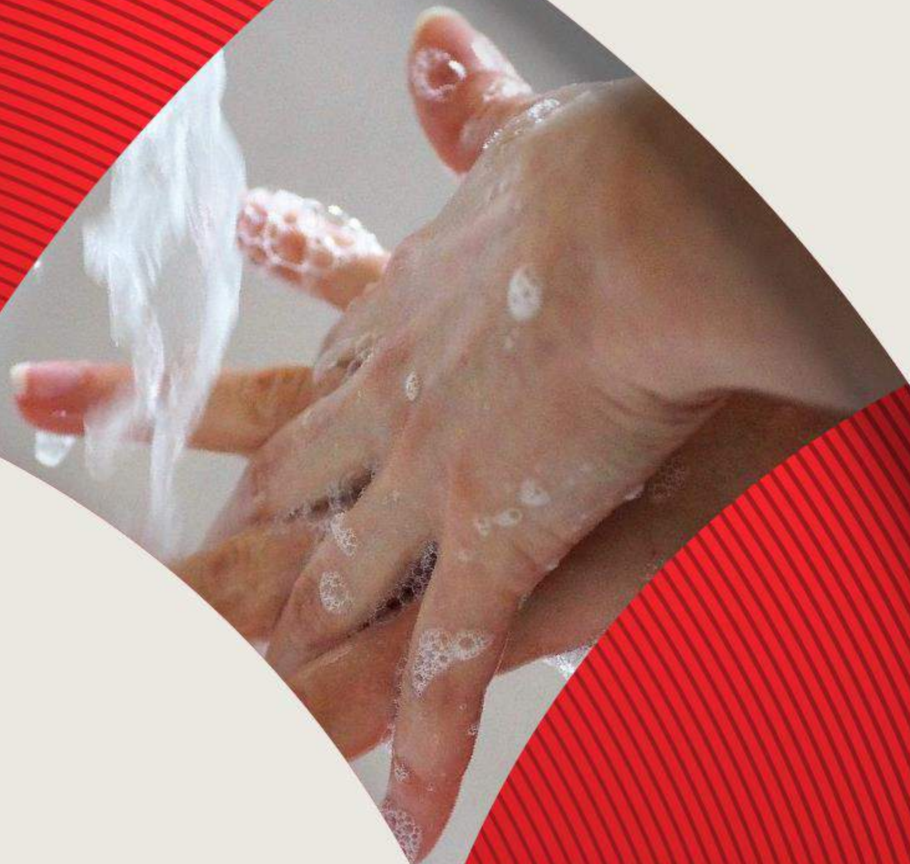
NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Infection Prevention and Control
Annual Report 2022/23



Contents

Introduction 5
1. Compliance with The Health Act 2008 Code of Practice on the prevention and control of infections and related guidance 5
2. Compliance with Key Performance Indicators 8
3.1 Training delivered 9
3.2 Training attended 9
4. Annual Audit and Inspection Programme 10
4.1 PLACE Scores 12
4.2 Hand Hygiene 12
4.2.1 Inpatient 12
4.2.2 Reasons for non-compliance 14
4.3 IPC auditing program 14
5. External Inspections and Audit 22
6. Surveillance of Alert Organisms and Outbreaks 27
6.1 Total number of organisms reported 27
6.2 Outbreaks (non-COVID) 30
6.3 MRSA Admission Screening 30
7.1 Seasonal Influenza vaccination .... **Error! Bookmark not defined.**
7.1.1 Actions taken to reach 100% uptake ambition .... **Error! Bookmark not defined.**
7.2 COVID vaccination .... **Error! Bookmark not defined.**
8. COVID-19 30
8.1 Reported outbreaks 30
8.1.1 COVID outbreaks per site and areas of concern 34
8.1.1.1 Dementia and Frailty - Juniper Centre .... **Error! Bookmark not defined.**
8.1.2 External visits .... **Error! Bookmark not defined.**
8.1.3 Outbreak surveillance 35
8.2 COVID guidance 36
8.2.1 FFP3 respirators face fitting 37
10. IPC Team Response to Alerts and Directives 39
11. Food Safety 39
12. Water Management 39
12.1 Water Safety – Positive Legionella bacteria samples 40
13. Cleaning Standards 40
14. Capital Developments 41

Appendices

Appendix 1 – Infection Control Doctor – Annual Statement for 2022-2023......................42
Appendix 2 – Estates & Facilities IPC Annual Report 2022-2023................................43
Appendix 3 – Water Safety Annual Report 2022-2023...51
Appendix 2 – Food Safety Audit Report 2022-2023..62

Tables

Table 1 - Hand Hygiene Scores for 2021/22 12
Table 2 - Hand Hygiene trainings delivered by the IPC team 13
Table 3 - Areas with no hand hygiene trainer 13
Table 3 - Audits undertaken by IPC team 17
Table 4 - IPC Spot Checks by IPC team 20
Table 5 - Average audit score per quarter 21
Table 6 - Conditions reported during the financial year 28
Table 7- Cases of D&V per quarter in each clinical area and site 29
Table 8 - Microorganisms reported to IPC during the finantial year 30
Table 9 - Outbreaks per quarter 31
Table 10 - SU and Staff affected during COVID outbreaks 31
Table 11 - Ratio Positive cases/number of outbreaks 34
Table 12 - FFP3 face fitted staff 37
Table 13 - Eclipse incidents reported by quarter 38
Table 14 - Eclipsed food related incidents 39

Executive Summary

The 2022/23 annual report outlines the Trust's continued commitment to minimising the risks of Healthcare Associated Infection (HCAI) on our services and to promote best practice in infection prevention and control, as well as the response to the COVID pandemic.

It details the activities undertaken by the Infection Prevention Partnership Committee (IPPC) and the Infection Prevention and Control team (IPCt) to lessen the risk of avoidable harm to service users and promote safe working practices for Trust staff and the measures put in place to minimise the disruption of services due to COVID as well as keeping staff, service users, contractors, and visitors safe.

It demonstrates collaborative working to ensure that national initiatives are incorporated into trust policies, procedures, and guidance to inform best practice and to improve health outcomes for our service users and the wider community.

The Trust has continued to monitor compliance with regulatory requirements and is assured through the IPPC that services are safely and effectively managed through receipt of quarterly reports on audit, training, and surveillance of incidents and outbreaks of infection.

The report follows the format of the Health and Social Care Act (2008) Code of Practice of the prevention and control of infections and related Guidance (Department of Health 2015) to demonstrate our compliance with the criteria and recommendations for 2022-2023 work plan to strengthen assurance.

Introduction

The IPC team workload has had a substantial challenge during this reporting period, in particular, due to the ongoing COVID pandemic and the path to a new type of normality.

The Trust has a contract with Public Health England Laboratory, Birmingham, to provide expert infection prevention and control advice by a Consultant Medical Microbiologist, referred to as the Trust Infection Control Doctor.

This report sets out the activity undertaken by the IPC team and the Infection Prevention Partnership Committee under the Executive Director of Quality and Safety (Chief Nurse) (DIPC).The report is not exhaustive of all work undertaken, focusing on the main areas of progress against the annual plan of work and items of note by exception.

1. Compliance with The Health Act 2008 Code of Practice on the prevention and control of infections and related guidance

The table below sets out the actions taken by the Trust to evidence compliance with the code of practice and actions for 2022/23 work plans to be monitored by IPPC.

Compliance Criterion	What the Registered provider will need to demonstrate	Evidence of Trust compliance	Recommendation/action for 2023-24 work plan
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	• Director for Infection Prevention and Control • Infection Prevention Partnership Committee (IPPC). • Annual Programme of Work. • Annual Audit Programme • Annual Report to Trust Board. • Quarterly report to Clinical Governance Committee. • Risk Register review ongoing and presented monthly at IPPC. • IPC champions programme • Policy, procedures, SOP's development and review programme • Water Safety Group (WSG) (quarterly and when needed and Water strategic meeting monthly). • Trust Infection Prevention and Control Team. • Access to expert advice by Consultant Microbiologist.	1. Development of IPC Dashboard to aggregate IPC monthly audits performed by the clinical areas as well as hand hygiene and ensure compliance is met. 2. Revision of IPC community monthly audit to ensure it is still relevant and cascade the new tool to the relevant teams. 3. Acquire electronic system for management and records purpose for IPC (e.g., ICnet®), including recording and management of outbreaks – Single point of access for IPC information.

		• Access to microbiological testing	
2	Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections.	• Quarterly reports on cleanliness standards to IPPC • Annual PLACE inspections • Rapid Response team • Monitoring of contractors cleaning performance. • Cleaning Policy • Decontamination Policy. • Quarterly Dental Suite audits • Waste Management Policy • Access to Food Safety Advisor • Food Safety Policy • Water Safety Group • Control of Legionella Policy • IPC input to the built environment new build and refurbishment projects.	4. Auditing control of legionella policy requirements undertaken by the WSG. 5. Ensure learning points from water safety review are implemented. 6. Recruit food safety advisor or procure external service. 7. Recruit decontamination officer for the Trust
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	• Electronic prescribing. • Quarterly Antibiotic Audit Report to be presented at IPPC. • Trust antimicrobial guidance document. Access to microbiological advice.	8. Further promotion of antibiotic awareness through training sessions with clinical staff, audit of cases where antibiotics are indicated, scrutiny of prescribing practice (Chief Pharmacist); 9. Include SEPSIS awareness training for IPC champions; 10. Ensure Trust Pharmacist antimicrobial use report is presented quarterly to IPC committee.
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.	• IPC notice boards • Hand washing notices. • BBV (Blood borne Virus) Screening secure care • Close work with communications department to ensure adequate messages and information is available on internal and external sites – Currently reviewing internal and external pages.	11. Provide information to be cascaded to clinical areas with relevant information displayed on the IPC boards in the clinical areas – Discuss processes to ensure information continuous to be successfully cascaded. 12. Regular meetings with matrons/managers for IPC update (through weekly matrons meeting) 13. Review internal and external web page and discuss with Comms process to ensure

			the pages are curated and timely updated;
5	Ensure prompt identification of people who have or are at risk of developing infection so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people	• Electronic notification forms to the IPC team from RiO patient record. • Electronic pathology reports • Expert infection Control advice from the Trust IPCN's and contracted service of a Consultant Microbiologist. • Access to specialist TB service at Birmingham Chest Clinic. • BBV screening • Sepsis awareness of risk associated conditions such as pneumonia, urinary tract, and wound infections.	14. Ensure information given on training IPC champions is cascaded to the team – Discuss processes to make this feasible. 15. Keep support from band 6 nurse to monitor RIO notifications and lab results in a timely manner and ensure the adequate advice is given and information cascaded within the team. 16. Discuss team structure and staffing.
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 infections.	• IPC fundamental care e-learning for all staff on induction and updates. • Link worker training x3 per annum • Infection Control responsibilities included in job descriptions. • Infection control training of contractors included in estates and facilities report to IPPC (report in appendix).	• Discuss update of local risk assessments to ensure staff are aware of national guidance and enable to make informed risk assessments in the workplace. • Ensure FFP3 mask fitting program is continued and compliance is improved to ensure adequate coverage is achieved.
7	Provide or secure adequate isolation facilities.	• Ensuite bedrooms to most inpatient services. Dedicated toilet facilities made available in non-ensuite areas. • Management of Isolation Procedure in place and reviewed. • COVID testing on admission and day 3, 5-7 and according to National guidance.	17. IT development of a solution to capture and monitor isolation information/checklists (within the integrated solution proposed in point 1).
8	Secure adequate access to laboratory support as appropriate.	• Pathology services provided by Sandwell & West Birmingham Hospitals NHS Trust.	18. Consider reviewing contract. Currently our microbiologist works for PHE labs at Heartlands and the results go through City Hospital which can create challenges on communication since the microbiologist will not have access to the result.

9	Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.	• Suite of procedures and policies aligned to the Trust Overarching Infection Prevention and Control Policy. • Annual plan of policy/procedure review in line with national standards and guidance and monitored through IPPC.	19. Policies/Procedures are reviewed according to annual plan of work.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	• Occupational Health provides vaccination at employment screening. • Flu Vaccination plan for employees. • Liaison with Birmingham Chest Clinic in response to staff exposure to TB. • Occupational Health activity reported to IPPC quarterly. • Monitor COVID cases in staff – Manage advice/ support; Prevalence (HR).	20. Occupational Health to provide input to Seasonal Flu Planning. 21. Occupational Health to support staff in vaccination as well as sharp injuries and any further needed support regarding infectious diseases.

2. Compliance with Key Performance Indicators

Standard	Progress
Compliance with national mandatory surveillance for bloodstream infection MSSA and E.coli.	*E. Coli Bacteraemia (1)* – Not multiresistant *Clostrifium diffcille (1)* - Non Toxicogenic
Zero tolerance of MRSA bloodstream infection, minimise rates of *Clostridium difficile* (C. diff)	*Nil to report*
Completion of Root Cause Analysis (RCA)/Post Infection Review (PIR) and other significant HCAI's within set time scales.	*Clinical reviews were undertaken in line with trust risk management policy in response to outbreaks of infection.*
Compliance with Hand Hygiene Audit. 95% threshold	*The Trust has met its overall compliance of 95%.*
Compliance with Antibiotic Audit. 80% Threshold	*Quarterly reports on usage and recommendations/actions presented to IPPC by Chief Pharmacist – No reports have been presented during the first 3 quarters. Report due for Q4 for the Q4 IPPC*
Compliance with national cleaning standards/British Standards 90% threshold.	*The Trust has consistently met its overall compliance of 90% or above.*

3. Training activity

3.1 Training delivered:

Q1	Q2	Q3	Q4
The IPC Champions webinar was delivered on 09/06/22. Topics covered were the new National standards of cleanliness, Tissue viability and infection control, Infection control news and updates (including regional surveillance and policy update); Monkey pox and COVID19 update and program of audits.	None	The IPC Champions webinar was delivered on 10/11/21. Topics covered: Update on COVID & Flu, Back to basics, National Cleaning standards & Decontamination. 02/10/2023 – Trust microbiologist provided a webinar open to all the Trust around Legionella awareness.	The IPC Champions webinar was delivered on 09/02/23, topics covered: Water safety, policy updates, regional surveillance, inoculation injuries, IPC board requirements, discussion on current IPC issues across the Trust.

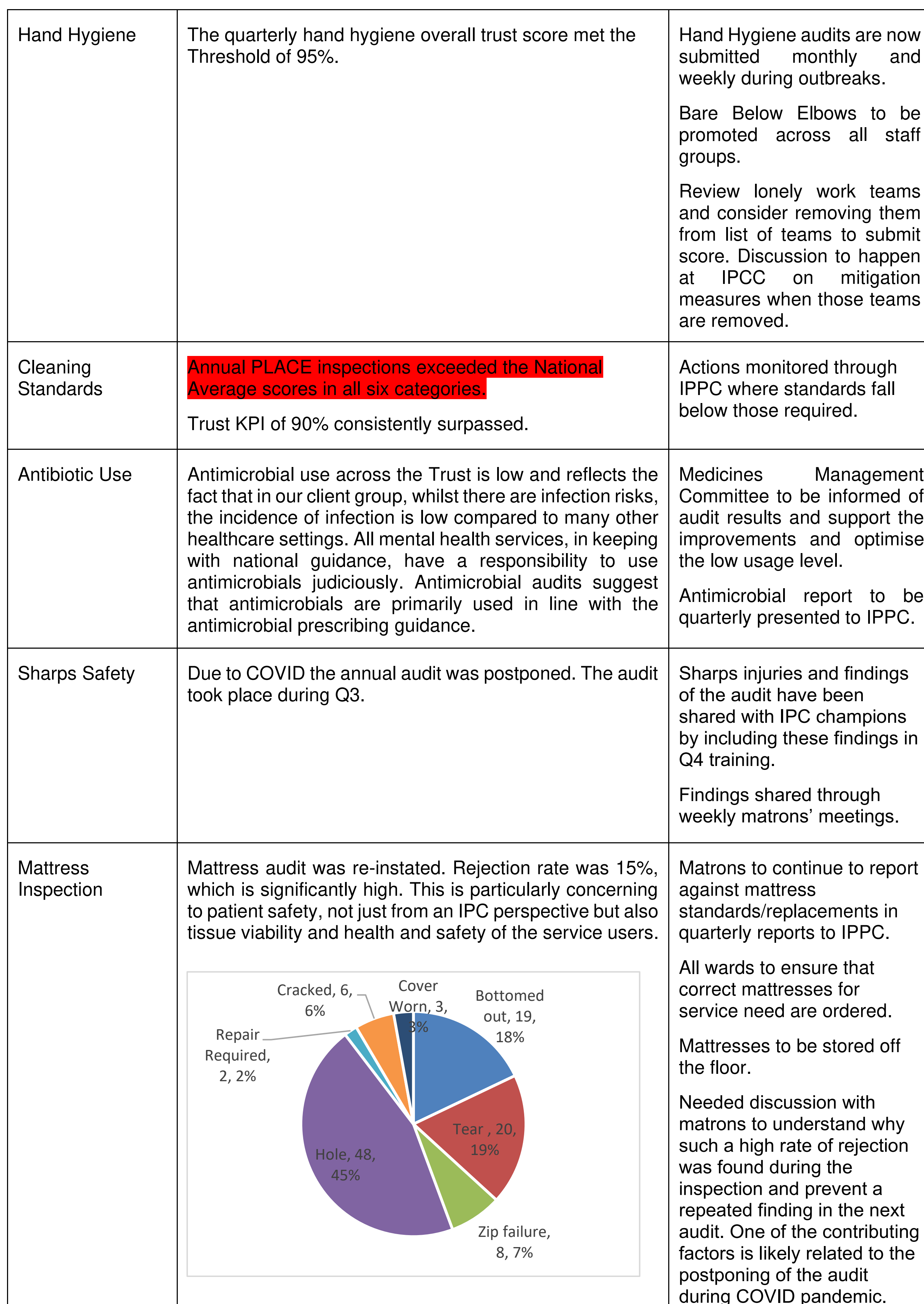
3.2 Training attended:

The IPC team continue to be an expert service to the Trust and have kept updated in their professional development as follows:

Q1	Q2	Q3	Q4
2/12/20 Transforming conversations – Building a Coaching Culture Mental Health and Covid-19 - Telling the Story in Mental Health Settings led by NHS England and NHS Improvement		27/10/2022 – Water safety Training LCA9010 (1 staff member) 02/11/2023 – Webinar – Legionella provided by Trust microbiologist (team) 13-14 December 2022 – Water Safety Training LCA9010 (1 staff member) 17-18 January 2023 – Water Safety Training LCA9010 (1 staff member)	10/01/2023 – Strength based Supervision (1 staff member) 07/03/2023 – NHSE session about Sepsis – 2 staff 08/02/2023 - Lunch and Learn – Mouth care matters – 1 staff

4. Annual Audit and Inspection Programme

Audit/Inspection	Findings	Recommendations/Actions
IPC Standards	The IPC team continued the IPC audit program above the established KPI of 5 audits per quarter, aiming at visiting all areas at least once during the financial year. A total of 119 audits were performed and 132 Covid target spot checks during the financial year. An agency IPC nurse has been recruited to ensure that IPC audits would still be performed as well as auditing outbreak sites as fast as possible and monitor action plans in place. This nurse has ceased working with the team during March 2023.	Cascading findings to Matrons and link workers and request action plan – Discuss communication routes to ensure flow of information is optimum. Involve estates and facilities on the audits and action plans – A recurrent meeting has been established between estates and facilities and IPC to discuss the challenges both teams face and find solutions to work together more closely. Cleaning roadshows have been put in place aimed at raising awareness about the new cleaning standards. Future aims will be having joint visits from estates and facilities and IPC to areas identified of higher concern. The framework for this is still being worked on. Monitoring improvements through inspections and actions in service area surveillance reports to IPPC Implement dashboard of IPC monthly audits and hand hygiene to ensure compliance is monitored and IPC is able to plan target auditing, including with the presence of representatives from estates and facilities. Continue to utilize the iAuditor platform for IPC audits. Consider looking at electronic auditing platforms for the wards with IT support.
Dental Suite Checks	Dental suits are open, however, AGP (aerosol generating procedures) only take place on Tamarind, since Reaside clinic does not have ventilation systems which guarantee the recommended air exchanges.	HTM 01-05 requirements to be designed into any new build/ upgrade.



Hand Hygiene	The quarterly hand hygiene overall trust score met the Threshold of 95%.	Hand Hygiene audits are now submitted monthly and weekly during outbreaks. Bare Below Elbows to be promoted across all staff groups. Review lonely work teams and consider removing them from list of teams to submit score. Discussion to happen at IPCC on mitigation measures when those teams are removed.
Cleaning Standards	Annual PLACE inspections exceeded the National Average scores in all six categories. Trust KPI of 90% consistently surpassed.	Actions monitored through IPPC where standards fall below those required.
Antibiotic Use	Antimicrobial use across the Trust is low and reflects the fact that in our client group, whilst there are infection risks, the incidence of infection is low compared to many other healthcare settings. All mental health services, in keeping with national guidance, have a responsibility to use antimicrobials judiciously. Antimicrobial audits suggest that antimicrobials are primarily used in line with the antimicrobial prescribing guidance.	Medicines Management Committee to be informed of audit results and support the improvements and optimise the low usage level. Antimicrobial report to be quarterly presented to IPPC.
Sharps Safety	Due to COVID the annual audit was postponed. The audit took place during Q3.	Sharps injuries and findings of the audit have been shared with IPC champions by including these findings in Q4 training. Findings shared through weekly matrons' meetings.
Mattress Inspection	Mattress audit was re-instated. Rejection rate was 15%, which is significantly high. This is particularly concerning to patient safety, not just from an IPC perspective but also tissue viability and health and safety of the service users.	Matrons to continue to report against mattress standards/replacements in quarterly reports to IPPC. All wards to ensure that correct mattresses for service need are ordered. Mattresses to be stored off the floor. Needed discussion with matrons to understand why such a high rate of rejection was found during the inspection and prevent a repeated finding in the next audit. One of the contributing factors is likely related to the postponing of the audit during COVID pandemic.

Food Safety	Completion of annual food safety audits by an independent food safety advisor. The audit did identify issues that had been picked up in the previous year's audits (please see report attached). This may suggest monthly kitchen inspections are not being undertaken/not undertaken correctly.	Food safety expert conducted audits across the Trust. Matrons to keep updates on actions from inspections. Trust does not have a food safety adviser. IPC advises the Trust to recruit one, since currently the Trust has no staff with this expertise and relies on ad-hoc support from Amey.
Legionella Policy compliance	Water Safety Group (strategic and operational) in place There was an external review of IPC and Estates that now needs to be analised and an action plan put in place to ensure the lessons learned are incorporated in the daily practice. A new WSP is due for approval. At the present moment the elements of sampling and actioning results have been approved due to the urgency to have those in place.	Develop a regular weekly meeting with estates and IPC to ensure IPC is kept informed of all the new results and current situation. Currently there is a flood of emails that make it very difficult to follow up on results and have a clear picture of the situation. The WSP must ensure that it covers all necessary actions to be triggered automatically and extraordinary actions by IPC or meetings only occur if anything out of the expected/planned has occurred – this also needs to be clearly delimited in the WSP.

4.1 PLACE Scores

BSMHFT 2022 PLACE scores are included within Estates & Facilities IPC 2022-23 Annual Report – attached to this report.

4.2 Hand Hygiene

4.2.1 Inpatient

The Trust has consistently kept the Hand Hygiene score above the 95% threshold.

The table below provides average Hand Hygiene scores for 2022/23 for the hand hygiene audits performed monthly.

	2021/22	2022/23	Variance
Trust-overall score:	97.2	97.5	+0.3
Trust inpatients:	97.4	97.6	0.2
Community:	97	97.4	+0.4

Table 1 - Hand Hygiene Scores for 2021/22

To enable the hand hygiene to be adequately monitored in the areas and local training delivery, the IPC team provides regular training to staff. Hand hygiene training is always part of the training package offered to the IPC champions during the IPC champions days. The following table shows the hand hygiene specific trainings promoted by the IPC team:

Date of HH training	No attendees
09/06/2022	24
28/09/2022	2
29/09/2022	9
12/10/2022	7
10/11/2022	19
14/12/2022	1
20/01/2023	7
09/02/2023	12
22/02/2023	6
16/03/2023	1
22/03/2023	8

Table 2 - Hand Hygiene trainings delivered by the IPC team

By the end of the year there are 15 teams that reported not having the hand hygiene trainer, but this is a dynamic situation, and the IPC team has delivered training along the year to ensure new hand hygiene trainers were prepared to cover the gaps identified. Table 3 lists the teams that by the completion of this report were still outstanding an HH trainer:

ServiceArea	Site	Department
Integrated Community Care	Warstock Lane Health Centre	25Plus Adult ADHD Service
Primary Care & SPS	Ashcroft	BHM West
Secure Care	Reaside Clinic	Blythe
Secure Care	Ardenleigh	Coral
Urgent Care	Liaison Psychiatry	Liaison Psychiatry - City Hospital
Urgent Care	Liaison Psychiatry	Liaison Psychiatry - QE Hospital
Recovery	Northcroft	North AOT
Urgent Care	Oleaster	Place Of Safety
Integrated Community Care	Small Heath Health Centre	Primary Care Liaison Hub - East
Integrated Community Care	Northcroft	Primary Care Liaison Hub - North
Integrated Community Care	Longbridge	Primary Care Liaison Hub - South
Integrated Community Care	Orsborn House	Primary Care Liaison Hub - West
Urgent Care	Oleaster	Psychiatric Decision Unit
Secure Care	Reaside Clinic	Severn
Dementia & Frailty	John Black	Solihull HuB

Table 3 - Areas with no hand hygiene trainer

There are several teams with lone workers where undertaking hand hygiene audits is not possible. The IPC team has been working towards ensuring those teams have up to date training on hand hygiene, but the auditing will not be possible do to the fact they are lone working teams and, therefore, they would be auditing themselves, which fails to give us any assurances. A discussion needs to be held to find an alternative way to gain the required assurance from those teams since auditing monthly is not feasible. This will be taken to the next IPCC to discuss options.

4.2.2 Reasons for non-compliance

The main reasons for non-compliance with hand hygiene were:

- Staff member not bare below the elbows.
- Issues with hand hygiene technique.
- Use of false nails or nails varnish.
- Use of watches/bracelets/jewellery

All issues were addressed with reinforcement of training and surveillance. The most common issues are related to false nails/varnish and staff not being bare below the elbows.

The hand hygiene audits' frequency kept increased to monthly to ensure a higher level of assurance.

There have been challenges with the submission of hand hygiene audit results with some teams. This has been escalated.

The auditing results report is generated in a format that makes the monitoring difficult. The IPC team Will be implementing a dashboard to aggregate all scores monthly for hand hygiene allowing an easier and more accurate follow up of the audit results and as a consequence enabling a more curate approach on the support given to the areas.

4.3 IPC auditing program

During this year the IPC team had the support of an agency IPC nurse, allowing us to increase the auditing program and the number of support visits performed. The IPC team undertook a total of 119 (from 59 last year) audits and 132 COVID Spot checks as can be seen on the table below:

Area	Quarter	Score	Type
Northcroft - North HTT	Q2	85.64%	Community
Endeavour Court	Q2	94.03%	Inpatient
Reservoir Court	Q2	88.65%	Inpatient
Endeavour House	Q2	86.50%	Inpatient
Northcroft	Q2	84.47%	Community
Ashcroft - west Hub CMHT	Q2	77.54%	Community
Ashcroft - Birmingham Healthy Minds - Perinatal	Q2	86.40%	Community
Ashcroft - Birmingham Healthy Minds	Q2	82.40%	Community
Juniper Centre - Bergamot	Q2	95.28%	Inpatient
Juniper Centre – Sage	Q2	87.34%	Inpatient
Juniper Centre - Rosemary	Q2	89.79%	Inpatient
Adams Hill	Q2	85.97%	Community
Reservoir Court - CMHT	Q2	76.89%	Community

Juniper Centre - Rosemary	Q2	85.81%	Inpatient
Grove Avenue	Q4	80.21%	Inpatient
Oleaster – Caffra	Q4	85.21%	Inpatient
Oleaster - Magnolia	Q4	98.94%	Inpatient
Oleaster - Tazetta	Q4	91.99%	Inpatient
Oleaster - Melissa	Q4	91.13%	Inpatient
Oleaster - Japonica	Q4	88.63%	Inpatient
Dan Mooney House	Q4	87.35%	Inpatient
Ardenleigh - Adriatic	Q4	94.21%	Inpatient
Ardenleigh - Pacific	Q4	94.06%	Inpatient
Ardenleigh - Atlantic	Q4	94.21%	Inpatient
Ardenleigh - Citrine	Q4	89.78%	Inpatient
Ardenleigh - Coral	Q4	93.00%	Inpatient
Rookery Gardens	Q4	98.71%	Inpatient
David Bromley house	Q4	85.01%	Inpatient
Mary Seacole - Ward 1	Q4	81.47%	Inpatient
Oleaster South East HTT	Q4	81.72%	Community
Oleaster South West HTT	Q4	83.06%	Community
Reaside First	Q4	78.23%	Community
Ardenleigh - Adriatic	Q4	86.15%	Community
Hertford House	Q4	96.27%	Community
Zinnia CMHT	Q4	90.96%	Community
Callum Lodge	Q4	86.39%	Community
Ashcroft	Q4	91.41%	Community
Ashcroft Perinatal	Q4	87.30%	Community
Longbridge CMHT	Q4	91.15%	Community
Warstock Lane CMHT	Q4	85.25%	Community
Lyndon CMHT	Q4	85.67%	Community
Reservoir Court - North Hub	Q4	91.80%	Community
Oleaster – Caffra	Q3	87.52%	Inpatient
Oleaster - Tazetta	Q3	85.06%	Inpatient
George Ward	Q3	86.23%	Inpatient
Oleaster - Tazetta	Q3	85.16%	Inpatient
Oleaster - Melissa	Q3	88.53%	Inpatient
Oleaster - Japonica	Q3	88.10%	Inpatient
Oleaster - Magnolia	Q3	92.06%	Inpatient
Eden Acute	Q3	88.85%	Inpatient
Eden PICU	Q3	84.89%	Inpatient
Endeavour House	Q3	90.36%	Inpatient
Endeavour Court	Q3	90.54%	Inpatient
Reservoir Court	Q3	82.78%	Inpatient
Zinnia - Lavender	Q3	73.20%	Inpatient

Zinnia - Saffron	Q3	89.78%	Inpatient
Grove Avenue	Q3	83.42%	Inpatient
Newbridge House	Q3	83%	Inpatient
Little Bromwich	Q3	92%	Inpatient
Newbridge house – Perinatal	Q3	90.24%	Community
Dan Mooney House	Q3	79.14%	Inpatient
Freshfields	Q3	95.16%	Community
Hertford House	Q3	86.94%	Community
Sycamore	Q3	80.52%	Inpatient
Hibiscus	Q3	73.18%	Inpatient
Acacia	Q3	82.87%	Inpatient
Laurel	Q3	82.42%	Inpatient
Lobelia	Q3	85.56%	Inpatient
Cedar	Q3	89.71%	Inpatient
Larimar	Q3	74.93%	Inpatient
Rookery Gardens	Q3	65.77%	Inpatient
Myrtle	Q3	86.97%	Inpatient
Forward House	Q3	81.11%	Inpatient
Tourmaline	Q3	88.28%	Inpatient
Coral	Q3	84.99%	Inpatient
Citrine	Q3	88.77%	Inpatient
Rosemary	Q3	84.13%	Inpatient
Bergamot	Q3	89.39%	Inpatient
Atlantic	Q3	84.05%	Inpatient
Pacific	Q3	84.66%	Inpatient
Osborne House	Q3	87.15%	Community
Orchard House	Q3	90.37%	Community
Handsworth & Ladywood HTT	Q3	80.44%	Community
Aston CMHT	Q3	78.10%	Community
Adriatic	Q3	73.19%	Inpatient
Berberry - Vetiver	Q1	90.06%	Community
Oleaster Caffra	Q1	86.26%	Inpatient
Oleaster Tazetta	Q1	92.98%	Inpatient
Oleaster Japonica	Q1	90.98%	Inpatient
Oleaster Melissa	Q1	92.35%	Inpatient
Oleaster Magnolia	Q1	90.92%	Inpatient
George Ward	Q1	88.36%	Inpatient
Tamarind Sycamore	Q1	94.49%	Inpatient
Tamarind Myrtle	Q1	94.21%	Inpatient
Small Heath Day Service	Q1	75.53%	Community
Small Heath CMHT	Q1	76.60%	Community
Tamarind Hibiscus	Q1	95.13%	Inpatient

Tamarind Lobelia	Q1	96.32%	Inpatient
Tamarind Laurel	Q1	93.40%	Inpatient
Tamarind Acacia	Q1	93.51%	Inpatient
Tamarind Cedar	Q1	97.11%	Inpatient
Eden Acute	Q1	79.54%	Inpatient
Eden PICU	Q1	78.17%	Inpatient
Small Heath AOT	Q1	76.26%	Community
Juniper Centre South CMHT	Q1	84.77%	Community
Zinnia Central HTT	Q1	83.27%	Community
Zinnia CMHT	Q1	55.22%	Community
Zinnia Day Services	Q1	76.82%	Community
Zinnia Lavender	Q1	88.53%	Inpatient
Zinnia safron	Q1	85.51%	Inpatient
Osbourne House Outpatients	Q1	81.15%	Community
Osbourbe House Handsworth &Ladywood HTT	Q1	77.01%	Community
Oleaster HTT East & West	Q1	82.39%	Community
Mary Seacole House – Ward 1	Q1	81.46%	Inpatient
Mary Seacole House – Ward 2	Q1	89.04%	Inpatient
Meadowcroft	Q1	80.91%	Inpatient
Newbridge House	Q1	90.06%	Inpatient
Recovery Near You - Wolverhampton addictions	Q1	75.52%	Community
Hillis Lodge	Q1	91.04%	Inpatient
Average		**86.05%**	

Table 4 - Audits undertaken by IPC team

And the IPC Spot Checks:

Area	Quarter	Score
Reaside Trent	Q1	72.00%
Reaside Swift	Q1	88.00%
Northcroft Reservoir Court	Q1	88.00%
Ardenleigh Tourmaline	Q1	80.00%
Juniper Bergamot	Q1	100.00%
Northcroft Eden Acute	Q1	73.08%
Reaside Swift	Q1	88.46%
Reaside Severn	Q1	80.77%
Reaside Trent	Q1	100.00%
Ardenleigh Tourmaline	Q1	92.31%
Juniper Bergamot	Q1	92.31%
Reaside Swift	Q1	84.62%
Reaside Trent	Q1	76.92%
Reaside Severn	Q1	84.62%

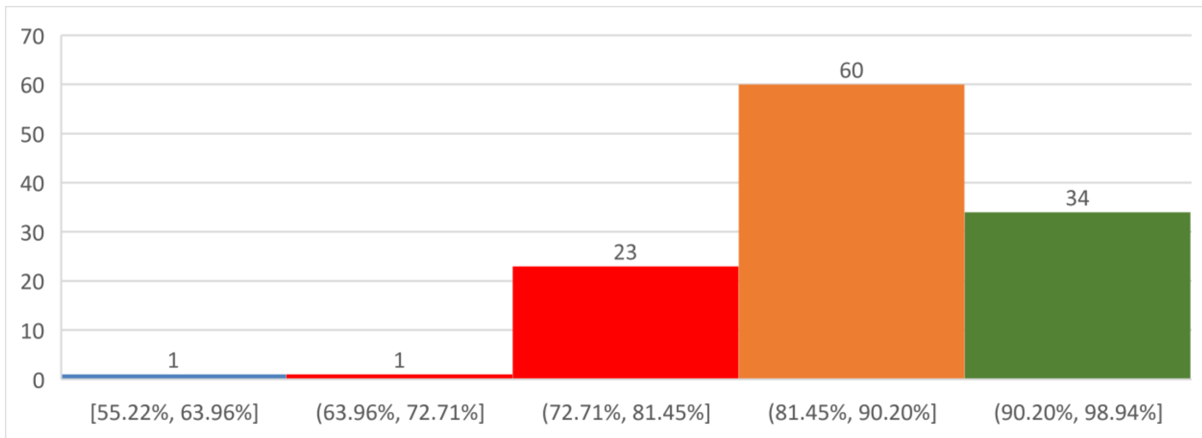
Northcroft Eden acute	Q1	88.46%
Northcroft Reservoir Court	Q1	100.00%
Ardenleigh Tourmaline	Q1	96.15%
Northcroft Eden Acute	Q1	76.92%
Northcroft Reservoir Court	Q1	100.00%
Ardenleigh Tourmaline	Q1	96.15%
Reaside Dove	Q1	96.15%
Reaside Severn	Q1	100.00%
Reaside Swift	Q1	92.31%
Juniper BErgamot	Q1	96.15%
Mary Seacole Ward 1	Q1	65.39%
Mary Seacole Ward 1	Q1	51.85%
Mary Seacole Ward 1	Q1	88.46%
Mary Seacole Ward 1	Q1	100.00%
Ardenleigh Coral	Q1	88.46%
Oleaster Japonica	Q1	92.31%
Ardenleigh Coral	Q1	100.00%
Oleaster Japonica	Q1	100.00%
Barberry Chamomile	Q1	92.31%
Barberry Cilantro	Q1	88.46%
Meadowcroft ICU	Q1	92.31%
Reaside Swift	Q4	96.15%
Juniper Bergamot	Q4	96.15%
Tamarind - Hibiscus	Q4	92.31%
Tamarind Lobelia	Q4	96.15%
Tamarind Hibiscus	Q4	100.00%
Tamarind Lobelia	Q4	89.19%
Reaside Trent	Q4	97.30%
Juniper Bergamot	Q4	81.08%
Oleaster Melissa	Q4	89.19%
Reaside Trent	Q4	100.00%
David Bromley House	Q4	97.30%
Oleaster Melissa	Q4	89.19%
Oleaster Tazetta	Q4	91.89%
Juniper Bergamot	Q4	78.38%
Juniper Bergamot	Q4	94.60%
Oleaster Tazetta	Q4	97.30%
Oleaster Melissa	Q4	94.60%
David Bromley House	Q4	94.60%
Larimar	Q4	86.49%
Larimar	Q4	89.19%
Tamarind Laurel	Q3	61.54%
George Ward	Q3	80.77%
Dan Mooney House	Q3	84.62%

Tamarind Myrtle	Q3	96.15%
Tamarind Myrtle	Q3	100.00%
Hillis Lodge	Q3	76.92%
Dan Mooney House	Q3	100.00%
George Ward	Q3	76.92%
Hillis Lodge	Q3	88.46%
George Ward	Q3	96.15%
Reservoir Court	Q3	92.31%
Urgent Care Oleaster	Q3	88.46%
Reservoir Court	Q3	84.62%
Maple Leaf Centre	Q3	92.31%
Ardenleigh Tourmaline	Q3	76.92%
Endeavour Court	Q3	88.46%
Endeavour COurt	Q3	100.00%
Oleastra Caffra Unit	Q3	62.96%
Oleaster Melissa	Q3	84.62%
Oleaster Caffra	Q3	76.92%
Endeavour Court	Q3	100.00%
Caffra Unit	Q3	84.62%
Oleaster Melissa	Q3	65.39%
Barberry Chamomile	Q3	88.46%
Barberry Chamomile	Q3	93.10%
Endeavour House	Q3	100.00%
Endeavour House	Q3	80.77%
Reaside Swift	Q3	100.00%
Juniper Bergamot	Q3	96.15%
Tamarind - Myrtle	Q2	84.62%
Tamarind - Cedar	Q2	80.77%
Northcroft George Ward	Q2	96.15%
Northcroft - Eden PICU	Q2	77.78%
Barberry - Cilantro	Q2	96.15%
Small Heath AOT	Q2	79.31%
Small Heath Day Service	Q2	93.10%
Mary Seacole House - Meadowcroft ICU	Q2	84.62%
Mary Seacole House - MSH Ward 2	Q2	79.31%
Mary Seacole House - MSH Ward 1	Q2	92.31%
Osborne House - Handsworth &Ladywood CMHT	Q2	78.57%
Northcroft - Eden PICU	Q2	100%
Tamarind Centre - Cedar	Q2	100%
Tamarind Centre - Myrtle	Q2	100%
Small Heath CMHT	Q2	96.55%
Osborne House - Handsworth &Ladywood CMHT	Q2	82.76%
Mary Seacole House - MSH Ward 2	Q2	81.48%
Reaside Avon	Q2	92.59%

Reaside Avon	Q2	92.31%
Tamarind Centre - Acacia	Q2	88.46%
Mary Seacole House - MSH Ward 2	Q2	84.62%
Reaside - Kennet Ward	Q2	77.78%
Juniper Centre - Rosemary	Q2	62.96%
Juniper Centre - Bergamot	Q2	96.15%
Reaside - Kennett	Q2	96.15%
Reaside - Avon	Q2	96.00%
Tamarind Centre - Acacia	Q2	59.26%
Juniper Centre - Rosemary	Q2	88.46%
Juniper centre - Bergamot	Q2	80.77%
Newbridge House	Q2	48.15%
Oleaster - Tazetta	Q2	80.77%
Dan Mooney House - Dan Mooney	Q2	74.07%
Newbridge House	Q2	96.15%
Northcroft - George Ward	Q2	65.29%
Oleaster - Tazetta	Q2	96.15%
Dan Mooney House - Dan Mooney	Q2	85.19%
Northcroft - Endeavour House	Q2	73.08%
Oleaster - Tazetta	Q2	92.31%
Northcroft - Endeavour House	Q2	96.15%
Oleaster - Melissa Unit	Q2	88.46%
Japonica - Oleaster	Q2	85.19%
Japonica - Oleaster	Q2	92.31%
Oleaster - Melissa Unit	Q2	88.46%
Juniper Centre - Rosemary	Q2	96.15%
Tamarind Centre - Laurel	Q2	100%
Little Bromwich Centre	Q2	82.86%
Little Bromwich Centre - CMHT	Q2	79.31%
Juniper Centre - Rosemary	Q2	88.46%
Average		**87.87%**

Table 5 – IPC Spot Checks by IPC team

The result distributions is as follows:



Graphic 1 - Histogram audit score distribution along the finatial year

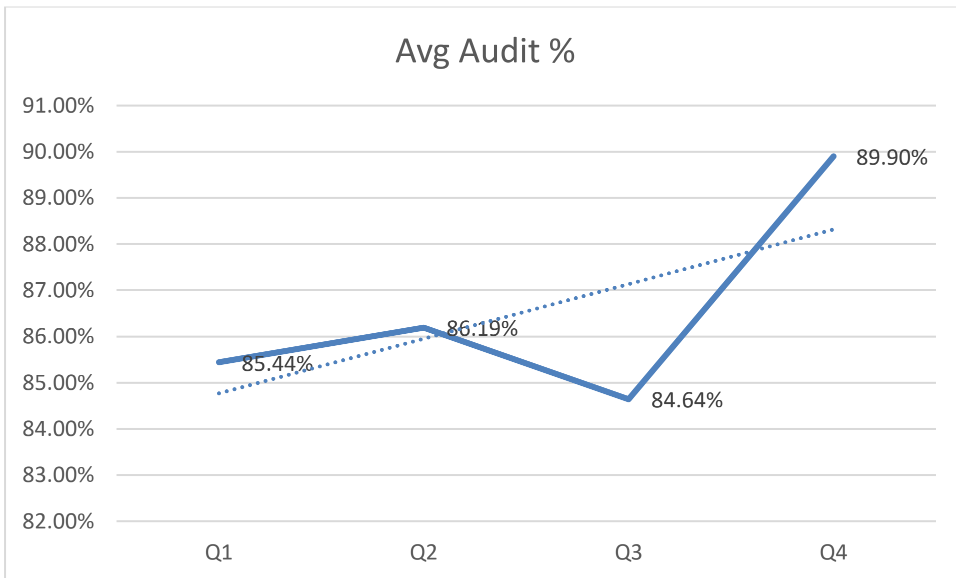
As can be seen in the above histogram, most of the results are above 81% and under 90% positioning them in amber. The second highest category is above 90.2% followed by under 80% (red).

When looking at the audit results we had an overall average score of 86.05%, therefore under the aim of 90%, nonetheless the distribution per quarter is as follows:

Quarter	Avg Audit %
Q1	85.44%
Q2	86.19%
Q3	84.64%
Q4	89.90%

Table 6 - Average audit score per quarter

And the following graphic:



Graphic 2 - Average audit score per quarter

According to this information there is a growing trendline and by the end of Q4 the auditing score average was 89.9%, therefore 0.10% under the 90% goal. This represents a shift from quarter 1 of 4.46%, which is small but significant. More targeted work will need to be developed across the new financial year, in particular finding more accurate and reliable ways to identify areas of concern so that

IPC support can be targeted, maximizing the use of resources were they are more needed. The actual model aimed at visiting all the clinical areas during the year and plan revisits according to the scores and level of concern resulted from the audit. A shift on the current paradigm is needed where clinical areas are responsible to undertake the audits and needed assurances and IPC team is able to analyse and determine were to direct its resources to achieve better outcomes.

For this to become possible, it is essential the implementation of an assurance dashboard were monthly all IPC local audits are collected as well as the results of the hand hygiene scores. Allowing to monitor the areas compliance with auditing the scores and more easily identify areas that will need further support.

5. External Inspections and Audit

5.1 Water Safety Review

Issues were identified within the water management in the Trust, following this a review was carried out by the ICB/ Hydrop on request of the Trust. Findings of the review have been received by the ICB.

The water safety group will produce an action plan to address issues identified from the review once both reports are received.

The findings of the review undertaken by the ICB were:

- Gap in systems and or process for accessing and viewing sampling dates.
- The IPC team and E&F working relationships and communication processes in relation to water safety including actions taken by whom and when require strengthening.
- There is little or no evidence to support that the IPC advice and recommendations are actioned by clinical staff.
- The process for completing legionella patient risk assessment requires clarity, including who completes these, when are these done, when are they reviewed and how are they accessible to all relevant parties.
- The process for completing legionella patient risk assessment requires clarity, including who completes these, when are these done, when are they reviewed and how are they accessible to all relevant parties.
- Governance processes and strategic oversight relating to water safety are unclear.
- written evidence to support running and flushing activity is inconsistent and is not always available for the IPC team to view.
- Clarity is required on management of positive clinical results and processes that support escalation of IPC concerns i.e. what triggers escalation, who is informed and by what route etc.

The recommendations from the report were:

1. A live, up to date, single, centralised, accessible system that is regularly monitored. This system is to be accurate, auditable, and organised. Clear communication and process to ‘close the loop’, with evidence to support timely reporting and actions taken.

2. Clarity in water safety plan and water safety group terms of reference (TOR) for IPC and E&F roles and responsibilities. Again, this record of communication needs to be accessible and auditable.

3. A written, clear operating procedure/process to support action in response to a service user/individual who develops respiratory symptoms, testing requirements and if they test positive for legionella, who is this reported to and what are the next steps. This should be reflected in relevant IPC policies i.e. outbreak, overarching, flu etc. and the water safety plan.
4. Sampling requirements, results, actions, flushing and running evidence to be presented at water safety group for monitoring.

Training activity to be evidenced, monitored and presented at IPC committee and water safety group.

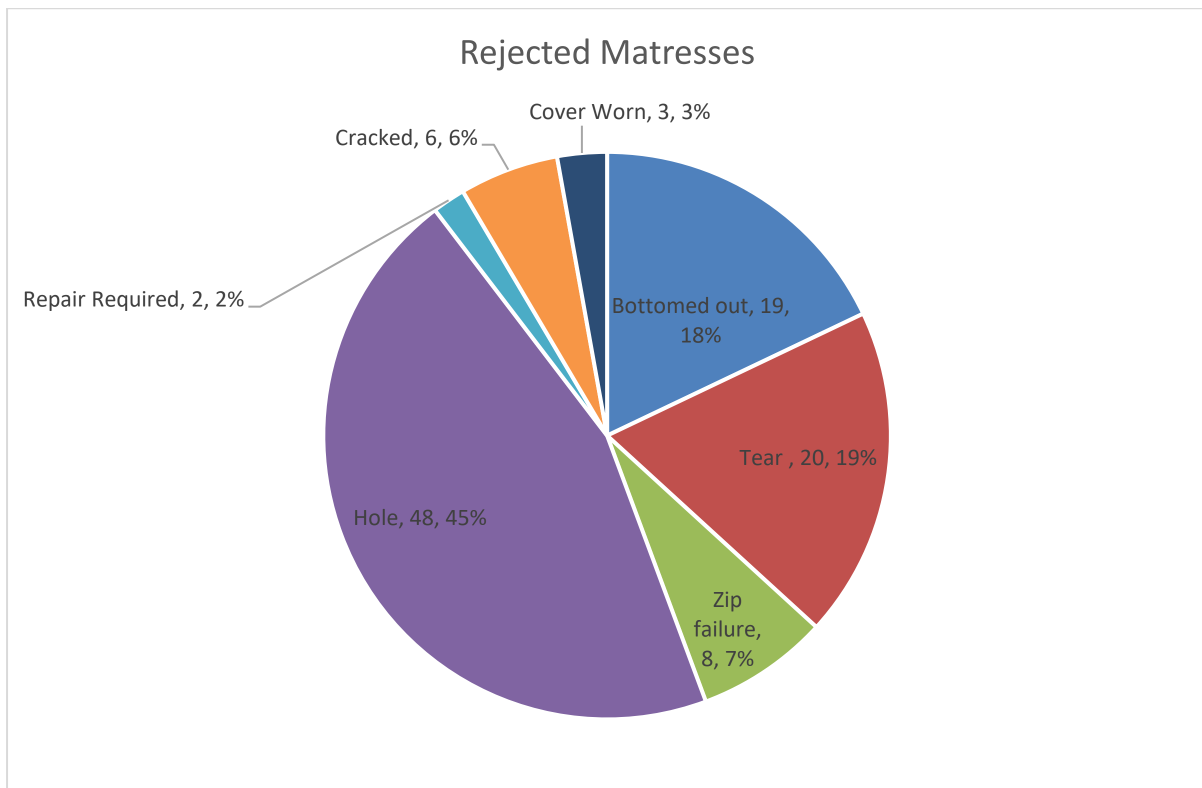
Following this report the IPC team produced comments to each recommendation and started to develop actions for some of those points, but this will need a wider working group to be implemented.

The following summarize the preliminary IPC comments:

1. The IPC team agrees, and we has suggested to Estates in several meetings that information regarding water management should be held in a centralised record, easily accessible by anyone that needs access to it. This should also apply to flushing records, as this is only shared with IPC by request. It would be ideal if this system allowed the IPC team to add notes in a similar fashion to other clinical systems in the Trust. The IPC team are sent numerous emails from the Estates team and it is very challenging to ensure continuity of case management/high counts of Legionella.
2. Clear actions need to be established – WSP in development. Actions must be guided by the water safety plan – any additional meetings must only be held in exceptional circumstances. Clear lines of action are needed to prevent any delays and ensure patient safety.
3. IPC Lead is ensuring that IPC activity in relation to water safety is part of the IPC team quarterly reports to IPC committee, as well as including this as an agenda item at water safety group. IPC Lead has written a clear operating procedure to support action in response to a service user/individual who develops respiratory symptoms, testing requirements and if they test positive for legionella, who is this reported to and what are the next steps, to be presented to the next IPCC for discussion and eventual approval.
4. Estates colleagues must come to IPC committee and present sampling results, actions, flushing and running evidence. A more robust system needs to be developed regarding water running logs, as these are kept locally at present.
5. It is not the IPC team's responsibility to monitor the training of Estates colleagues. According to the proposed WSP there is training for Trust Microbiologist and IPC team lead (management) that needs to be clarified.

5.2 Mattress Audit

Mattress audit conducted during March, in the week commencing 13/03/2023. 709 mattresses have been audited with 106 rejected (15%), which is a very significant number of mattresses. This brings concerns on how the quality of the SU mattresses is being monitored at ward level. The reasons for rejected mattress were:



The mattress audit result will be discussed during the next IPPC on 26th of April with the aim of understanding why such a significative number of mattresses were rejected, and why these findings had not taken place in local audits. We also need to have robust assurance in place regarding mattress audits, to ensure that faulty mattresses are identified and replaced mattresses when they are not of the required standard.

Some mattresses were found to have been condemned in the past, but not replaced. This is concerning and something that we also need to see addressed going forward.

The COVID pandemic may go some way to explain these findings, as some aspects of clinical work haven't been given the due priority needed due to the focus on the pandemic and outbreak management.

5.3 Sharps Audit

The Infection, Prevention & Control Team at Birmingham & Solihull Mental Health Trust requested that Daniels Healthcare undertake a sharps safety audit of their sites. The Daniels Healthcare auditor(s) undertook the survey in June 2022.

The following areas were audited:

1	OSBOURNE HOUSE	46	OUTPATIENTS
2	ASHCROFT COMMUNITY	47	LONGBRIDGE COMMUNITY
3	MARY SEACOLE	48	REASIDE CLINIC
4	WARD 1/2	49	SWIFT
5	MEADOWCROFT	50	KENNETT
6	NORTHCROFT	51	TRENT
7	EDEN - MALE	52	BLYTHE

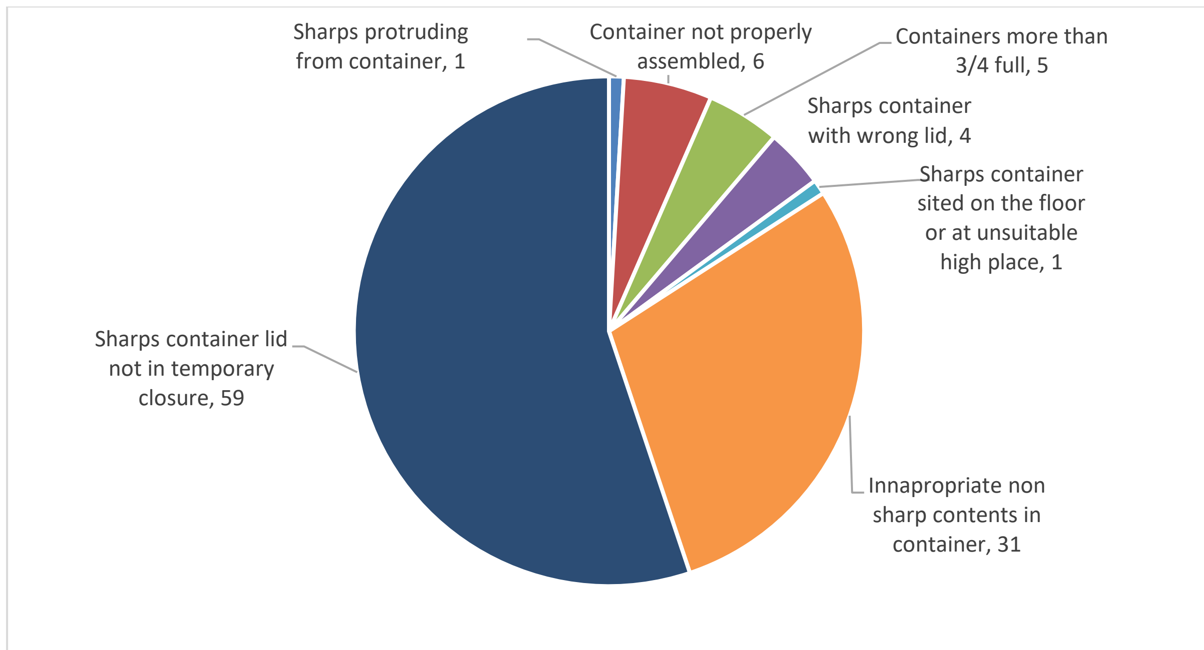
8	EDEN - PICU	53	AVON
9	GEORGE WARD	54	SEVERN
10	HOME TREATMENT/ASSERTIVE OUTREACH	55	DOVE
11	COMMUNITY	56	GP ROOM DENTIST
12	RESERVIOR COURT COMMUNITY	57	HILIS LODGE
13	RESERVIOR COURT IMPATIENTS	58	WARSTOCK LANE
14	ENDEAVOUR COURT	59	SMALL HEATH CENTRE
15	ENDEAVOUR HOUSE	60	DAN MOONEY
16	FORWARD HOUSE	61	DAVID BROMLEY
17	ARDENLEIGH	62	LYNDON CENTRE ASSERTIVE/COMMUNITY
18	ROOKERY GARDENS	63	HERTFORD HOUSE
19	LARIMAR	64	MAPLE LEAF
20	TAMARIND CENTRE	65	CLINIC A
21	NEWBRIDGE	66	CLINIC B
22	LITTLE BROMWICH	67	CLINIC C
23	OLEASTER	68	NEWINGTON CENTRE
24	COMMUNITY	69	
25	MAGNOLIA	70	
26	TAZETTA	71	
27	CAFFRA	72	
28	JAPONA	73	
29	MELISSA	74	
30	BARBERRY CENTRE	75	
31	JASMIN	76	
32	CILANTRO	77	
33	CHAMOMILE	78	
34	OUTPATIENTS	79	
35	VETIVER	80	
36	MOSELEY HALL	81	
37	OUTPATIENTS	82	
38	BERGAMOT	83	
39	ROSEMARY	84	
40	SAGE	85	
41	GROVE AVENUE	86	
42	ZINNIA CENTRE	87	
43	HOME TREATMENT	88	
44	SAFFRON	89	
45	LAVENDER	90	

The object of the site survey was to establish whether or not sharps are disposed of in a safe manner, containers are correctly used from the point of storage, assembly, security during use and dispose as well as if they are being used for the correct purposes.

The method used was to visit wards and departments and observe existing practices.

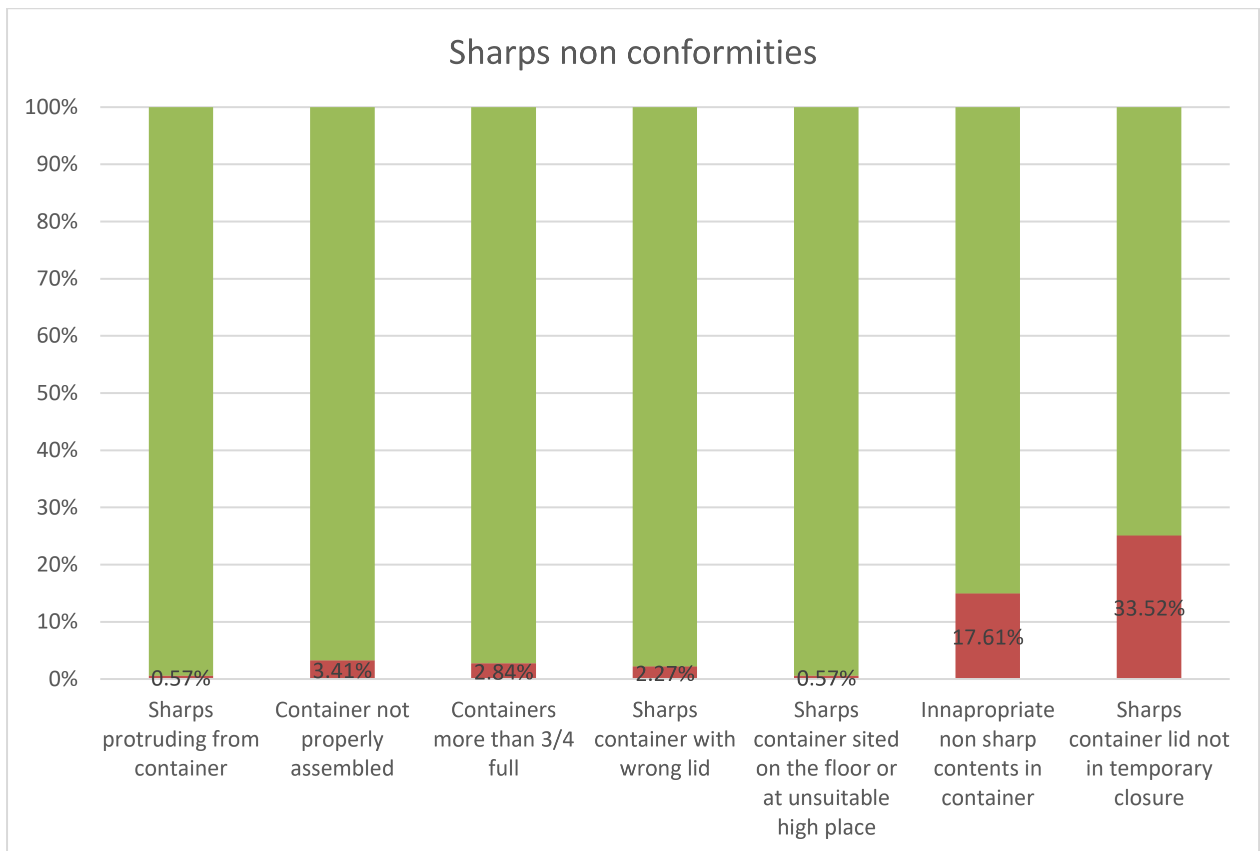
64 Wards/Departments were visited during the audit and 176 sharps containers were sighted.

The findings of the audit were:



Graphic 3 - Findings Sharps Audit

Looking at this information from a percentage perspective we can see in the following graphic:



Graphic 4 - Relative % findings sharps audits

The most significative finding was sharps bins not in temporary closure with 33.52% of the audited containers non compliant – This finding is in line with findings during IPC visits.Followed by finding of inappropriate non sharp contents in the bins. These findings will be addressed in future trainings for IPC champions and have been shared during the matrons meetings.

During IPC visits the sharps compliance is always monitored and on spot education is given as well as escalated as part of the wider audit to the ward manager and matron/manager.

6. Surveillance of Alert Organisms and Outbreaks

The IPC team have responded to numerous inquiries on the management of potential and actual infectious organisms; the following is a summary of the activity of individual cases and outbreaks.

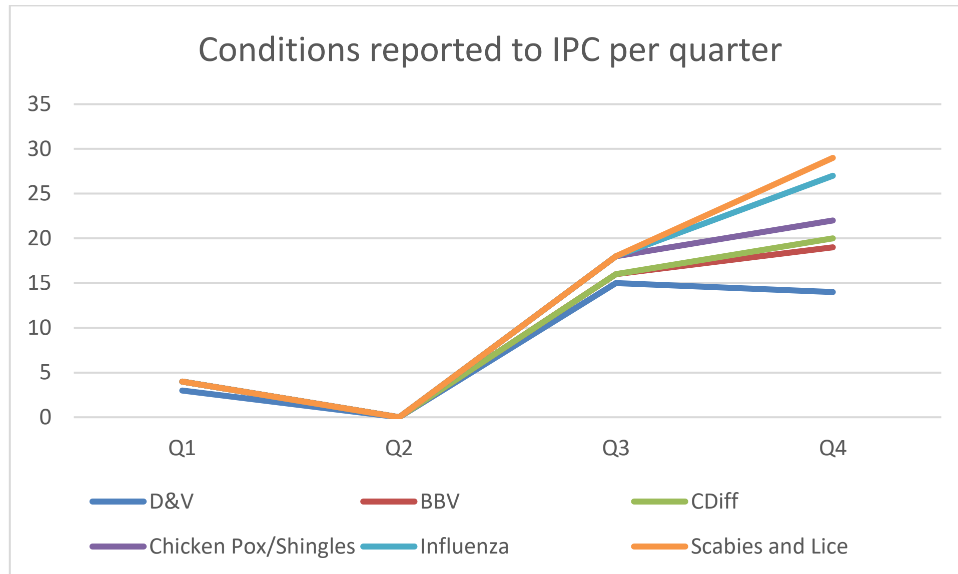
6.1 Total number of organisms reported

We had a total of 98 reports of infection (excluding MRSA and COVID related).

The following table and graphic shows the conditions reported to IPC during the financial year as well as the following graphic.

Organism/Condition	Q1	Q2	Q3	Q4	Grand total
D&V	3		15	14	32
BBV	1	0	1	5	7
CDiff				1	1
Chicken Pox/Shingles			2	2	4
Influenza				5	5
Scabies and Lice				2	2

Table 7- Conditions reported during the financial year



Graphic 5 - Conditions reported during the finantial year

D&V had the highest prevalence, flollowed by blood borne virus infections (BBV) and influenza.

On what concerns to D&V there does not seem to be a patter in the cases with exception than that most of the cases were reported during the last 2 quarters of the year, likely as a reflection of the ease of the Covid pandemic and the progressive returned to as close as possible to normality.

In the next table is the distributions of cases of D&V along the quarters:

Service area	Sites with D&V	Q1	Q2	Q3	Q4
Secure Services & Offender Health	Blythe			1	
Acute & Urgent Care Services	Tazetta			1	
Secure Services & Offender Health	Pacific			1	
Secure Services & Offender Health	Lobelia			1	
Secure Services & Offender Health	Tourmaline			1	

Acute & Urgent Care Services	Endeavour House			1	
Primary Care & Dementia Services	Reservoir Court			2	2
Acute & Urgent Care Services	Chamomile	3		2	2
Primary Care & Dementia Services	Rosemary			1	
Primary Care & Dementia Services	Sage			1	
Secure Services & Offender Health	Coral			2	
Acute & Urgent Care Services	Jasmine			1	
Secure Services & Offender Health	Laurel				1
Acute & Urgent Care Services	Dan Mooney				1
Acute & Urgent Care Services	Grove Avenue				1
Primary Care & Dementia Services	Bergamot				2
Integrated Community Care & Recovery	Rookery Gradens				3
Secure Services & Offender Health	Hillis Lodge				2

Table 8- Cases of D&V per quarter in each clinical area and site

The following table summarizes all the microorganisms detected and reported to IPC for advice during the year:

Microorganism	Q1	Q2	Q3	Q4	Totals
E.Coli (urine)	8	2	8	11	29
E. Coli (Feaces)				1	1
Citrobacter koseri - UTI	1				1
Enterococcus faecalis	1	1	1		3
Acinetobacter nosocomialis in urine				1	1
Beta Haemolytic Streptococcus Group C		1			1
Candida Albicans		1			1
Carbapenemase producing Enterobacteriaceae			1		1
Citrobacter koseri	1		2	1	4
Enterobacter Cloacae		1	3		4
Enterococcus faecalis		1	1		2
Haemophilus Influenzae			1		1
Hepatitis E			1		1
Hepatitus B				1	1
HIV1&2Antibody positive				1	1
Klebsiella oxytoca in urine		1		2	3

Klebsiella pneumoniae			2		2
Morganella Morganii			1		1
Proteus Mirabilis - UTI	1	1	1	1	4
Respiratory syncytial (sin-SISH-uhl) virus, or RS			1		1
Serratia marcescens			1		1
Sputum Stenotrophomonas maltophilia			1		1
Staphylococcus aureus		1	2	3	6
Streptococcus agalactiae		3	1	1	5
Syphillis			1	1	2
Threadworms			1		1
	12	**13**	**30**	**24**	**79**

Table 9 - Microorganisms reported to IPC during the finantial year

All reported cases had IPC advice and follow-up as needed.

6.2 Outbreaks (non-COVID)

No non-COVID related outbreaks declared.

6.3 MRSA Admission Screening

According to the Health and Social Care Act, the Trust continues to have management systems to ensure that MRSA colonisation is promptly identified. This includes screening patients admitted from other healthcare settings or have existing wounds or indwelling devices that could increase the risk to both the individual and other vulnerable patients of developing an MRSA infection. We had no patients MRSA colonised on admission.

7. COVID-19

The first confirmed cases of COVID-19 in the UK were on 29th January 2020, followed by more cases on the 6th of February. The first suspected patient case recorded in BSMHT was on 2nd March 2020, before the scope of the current report.

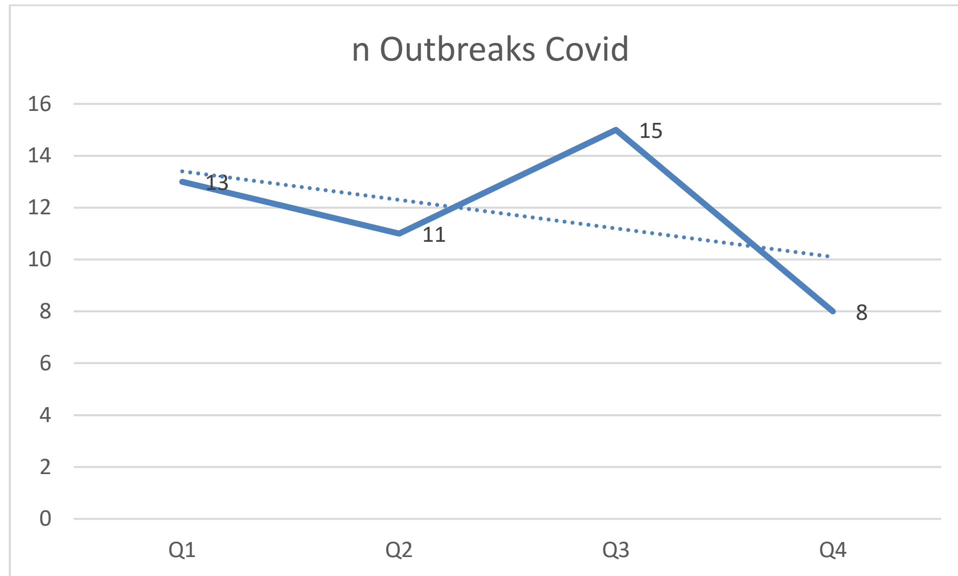
The IPC team was given continuous support of an extra staff members to cooperate with surveillance and local advice, freeing the team to provide specialised support to all Trust departments. The agency nurse that was supporting the team has ceased cooperation from the end of March 2023

8.1 Reported outbreaks

We reported a total of 47 outbreaks (+12 than last year). The following table and graphic illustrates the number of outbreaks per quarter:

Quarter	n Outbreaks Covid
Q1	13
Q2	11
Q3	15
Q4	8

Table 10 - Outbreaks per quarter



Graphic 6 - Covid outbreaks per quarter and trend

These findings come in line with what was the reality in the health economy during the year, with a sharp increase in the number of outbreaks during Q3 and a decrease from January. The sharp increase during the last months of the civilian year justified the re-instate of masks.

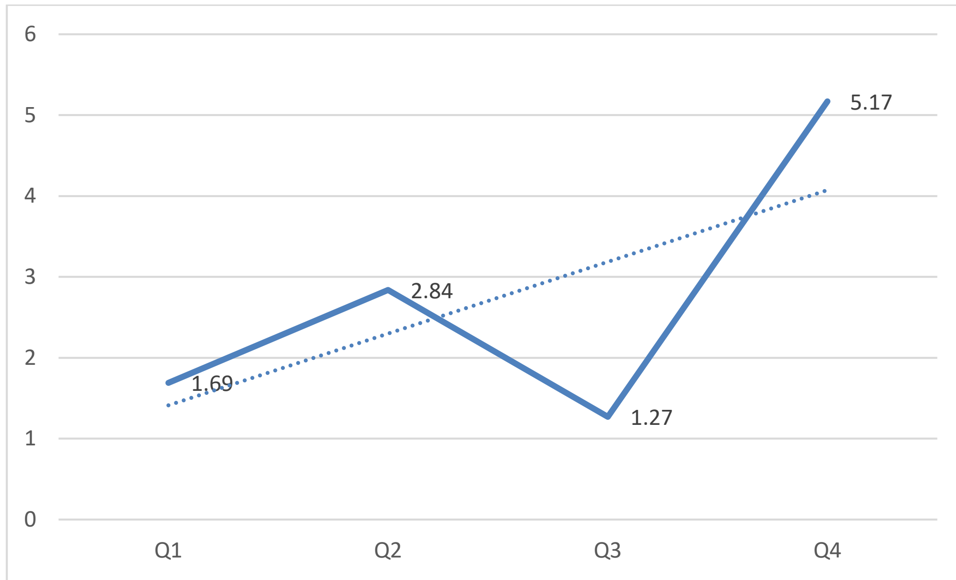
The use of masks topic will be discussed along this report.

A total of 239 SU (service users) have been affected during the outbreaks and 116 staff members:

Row Labels	Sum of SU affected	Sum of Staff affected
Q1	61	36
Q2	54	19
Q3	62	49
Q4	62	12
Grand Total	**239**	**116**

Table 11 - SU and Staff affected during COVID outbreaks

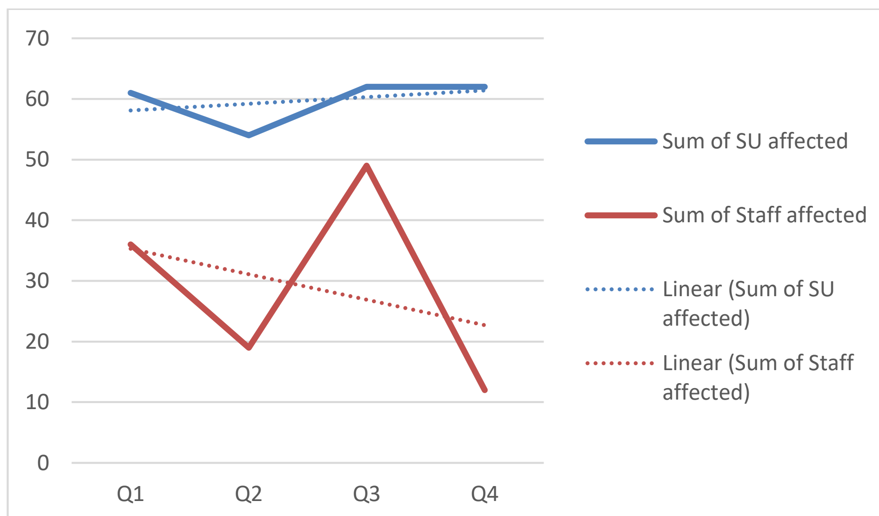
The overall SU/Staff affected ratio was 2.06 along the year. The following graphic shows how the ratio changed along the quarters:



Graphic 7- Ration SU/Staff affected during COVID19 outbreaks per quarter

The overall ratio SU/Staff affected is 5.17(62 SU and 12 Staff), Q3 the ratio was 1.7 with 62 SU involved and 49 Staff. Q3 had a ratio near 1, which shows that the number of SU affected, and staff were very similar, this is not what so far is being seen in the outbreaks in the last quarter where the proportion of SU affected is significantly higher than staff. This is likely related to the mandatory use of masks started at the end of December and it is now being reflected on the number of staff cases.

This can also be seen on the following graphic where we compare the evolution of positive cases in staff and in SU. We can see that the trendline for SU stabilized with a dip during Q2, which reflects the nature of COVID within the community, but there was a sharp increase on cases for staff during Q3 followed of a rapid decrease. This was likely related to the re-instatement of masks near Christmas and New Year's festivities that seems to successfully halted the progress of outbreaks to staff members:



Graphic 8 - Sum staff and SU affected during outbreaks per quarter

IPC has developed a risk assessment and options appraisal to inform around Trust wide mandated mask use to be approved at the IPPC committee.

The following table summarizes all outbreaks along the financial year:

Site	Date Reported	SU affected	Total SU area	Staff affected	Total Staff area	Ratio SU/Staff
Juniper Centre: Bergamot Ward	04/04/2022	7	18	6	36	1.17
Tamarind Centre: Lobelia Ward	04/04/2022	6	15	0	22	N/A
Reaside Unit: Swift Ward	04/04/2022	4	15	3	31	1.33
Eden - Acute	11/04/2022	4	16	0	22	N/A
Reaside Severn	13/04/2022	6	8	8	25	0.75
David Bromley House	19/04/2022	5	14	4	25	1.25
Reaside Dove ward	25/04/2022	6	14	0	25	N/A
Tamarind: Sycamore Ward	29/04/2022	3	8	0	35	N/A
Mary Seacole House: Ward 1	03/05/2022	5	16	2	27	2.50
Ardenleigh: Coral Ward	14/06/2022	4	6	1	40	4.00
Oleaster: Japonica Ward	20/06/2022	2	15	4	30	0.50
Orsborn House	21/06/2022	0	0	6	130	0.00
Tamarind: Cedar Ward	30/06/2022	9	15	2	27	4.50
Newbridge House	25/07/2022	6	16	0	50	N/A
Oleaster Centre: Tazetta Ward	25/07/2022	6	15	0	27	N/A
Mary Seacole House: Meadowcroft PICU	28/06/2022	6	10	6	23	1.00
George Ward	02/08/2022	3	16	0	22	N/A
Dan Mooney House	04/08/2022	3	14	1	26	3.00
Endeavour House	04/08/2022	7	11	0	20	N/A
Oleaster Melissa	28/08/2022	7	14	4	25	1.75
Oleaster - Japonica	30/08/2022	3	0	1	0	3.00
Juniper Centre: Rosemary Ward	09/09/2022	8	17	1	35	8.00
Little Bromwich CMHT	20/09/2022	0	0	6	23	0.00
Tamarind: Laurel Ward	26/09/2022	5	12	0	33	N/A
Dan Mooney	04/10/2022	5	13	3	26	1.67
Tamarind: Myrtle Ward	07/10/2022	2	11	0	23	N/A
George Ward	06/10/2022	3	16	0	22	N/A
Hillis Lodge	08/10/2022	11	15	0	25	N/A
Reservoir Court	17/10/2022	5	17	4	35	1.25
Admiral Team - Little Bromwich	17/10/2022	0	0	4	8	0.00
Urgent care CEntre	16/10/2022	1	0	10	0	0.10
Endeavour Court	04/11/2022	10	14	5	35	2.00
Caffra PICU Oleaster	11/11/2022	7	10	5	27	1.40
Melissa Ward - Oleaster	22/11/2022	4	16	2	21	2.00
Chamomile inpatient ward Barberry	07/12/2022	1	6	3	28	0.33
George Ward	16/12/2022	3	14	0	20	N/A
Endeavour House	20/12/2022	6	12	3	22	2.00
Juniper - Bergamot Ward	28/12/2022	2	17	6	37	0.33

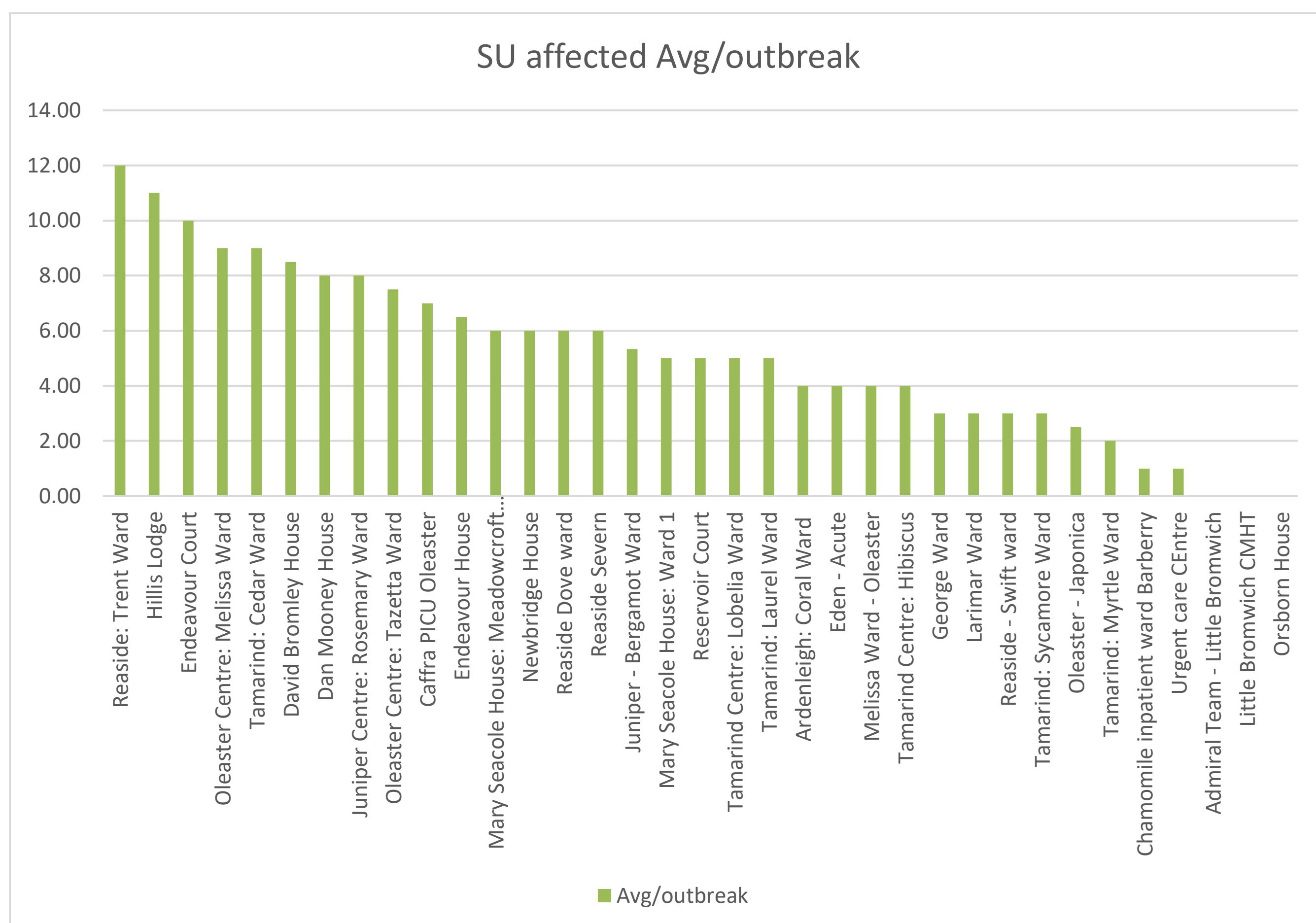
Reaside - Swift ward	28/12/2022	2	10	4	24	0.50
Tamarind Centre: Lobelia Ward	04/01/2023	4	15	1	22	4.00
Tamarind Centre: Hibiscus	04/01/2023	4	10	0	27	N/A
Reaside: Trent Ward	03/02/2023	12	14	1	23	12.00
Juniper Centre: Bergamot Ward	20/02/2023	7	16	0	25	N/A
Oleaster Centre: Melissa Ward	20/02/2023	11	16	4	40	2.75
David Bromley House	22/02/2023	12	16	3	22	4.00
Oleaster Centre: Tazetta Ward	27/02/2023	9	16	2	25	4.50
Larimar Ward	28/03/2023	3	15	1	23	3.00
Totals		239	574	116	1319	2.06

Table 12 - Ratio Positive cases/number of outbreaks

8.1.1 COVID outbreaks per site and areas of concern

The COVID outbreaks were widespread on the Trust, including some outbreaks in community settings (none of those had SU affected). There have been no areas with significant higher number of episodes than other areas.

When looking at areas with more SU affected on average per outbreak we can see the following:



Graphic 9 - SU affected in Average per outbreak

According to the graphic, the most affected area was Reaside – Trent ward, followed by Hillis Lodge, Endeavour court, Oleaster – Melissa ward and Tamarind Cedar ward.

The areas with the highest rates are areas with particular challenging cases of SU, as well as challenging environments, which can justify these finding. Regardless, by the graphic we can see that there is no particular trend on the type of service user most affected by the outbreaks, since the 5 highest rates fall within secure, acute, rehab, and dementia and frailty.

In conclusion, the number of SU affected seems to be stable across the quarters in line with the situation of COVID in the community. In future reports, the support of a data analyst would be beneficial to further deepen our knowledge of factors that might have contributed to these findings, including aspects related to the implementation of Trust policies in these areas.

8.1.2 Outbreak surveillance

All outbreaks were followed up with the local management area, Director of Infection Prevention and Control (DIPC), IPC team, Trust Microbiologist and external stakeholders invited to outbreak meetings (UK HSA, NHSE/I, ICB, Health protection team).

The Trust has continued with a weekly review meeting where all the outbreaks were discussed and assurances were given.

During the year, the Themes identified relating to the COVID Outbreaks were:

1. SU sharing in communal areas
2. Personal protective equipment (PPE) breaches by staff
3. Staff not bare below the elbows
4. High dust
5. IPC boards not up to date
6. Physical damage

Point 1 – In many of our areas, SUs have long lengths of stay, or may be too acutely unwell to to avoid congregations, as we work in the context of a mental health organization, which strongly relies on the interaction between human beings. IPC has advised all inpatient areas to ensure high levels of cleanliness are kept, staff keeps using PPE at all times and an individual and global risk assessment is made for each SU to be able to offer them a mask (if not jeopardizing other SUs safety). The result of the risk assessment and the SU adherence should be recorded on the care plan by the clinical team.

Point 2 and 3 – PPE breaches and staff not bare below the elbows has been frequently identified. HR team was involved in discussions around how to tackle this issue and a letter was produced to be delivered to staff who repeatedly demonstrated this behaviour (only substantial staff), reminding them of the possible disciplinary proceedings going forward. The delivery of the letter is preceded by a conversation to ensure the staff member is fully aware of the Trust guidance and our expectations. Besides these, PPE compliance continues to be a frequent noted point during IPC visits, in particular mask wearing. On this topic we believe that the resistance sometimes seen regarding correct mask use may be the result of some degree of mask use “fatigue”, due to the long period of time its use has been mandatory, including outside COVID outbreaks. Besides this, staff using cardigans, or not bare below the elbows are still a frequent find. The IPC team always brings this to the attention of the areas where the non-compliance was identified, as well as in external outbreak meetings, and the information/concern is shared with the Trust matrons while attending the Friday Matron meetings. IPC

has included a dedicated hand hygiene session to provide training to new Core Hand Hygiene all its training to the Trust IPC Champions.

During outbreaks, the compliance with use of PPE is recorded in the daily spot checks performed by ward managers. Any findings are discussed during the weekly outbreak meetings with the IPC team.

Point 4 – High dust has been a frequent finding. Whenever these were detected, an immediate escalation to the estates and facility team took place, to ensure cleaning is at the expected level. The Estates and facilities teams have frequently been involved during IPC visits, in areas that have been felt as more problematic. Regardless of this, the general cleanliness level of the Trust is very high as can be seen on the KPI consistently above the 90% mark. During outbreaks, Estates and facilities were always proactive in enabling adequate and fast response, even during the peak of the pandemic, when their teams were also struggling with high levels of absenteeism due to COVID.

IPC has organized a regular joint meeting (monthly) with estates and facilities to discuss ways to work together in a more efficient manner. From these meetings the Cleaning Roadshow initiative was born, where a member from Estates/facilities and an IPC staff member visit areas across the Trust to discuss the new cleaning standards, and aspects related to bare below the elbows. This initiative seemed to be very well received by staff in general with good informal feedback. At the present moment IPC and Estates/facilities are looking at possible new ways to cooperate, including performing some joint visits/audits.

Point 5 – The IPC team has found that IPC boards regularly have information that is out of date. This is part of the IPC audits. The findings are escalated to the area Matron and local managers. Teams are frequently reminded of the importance of updating the information in the IPC boards.

During IPC champions training sessions, the IPC team reiterates this message. On Q4 IPC training, the boards standard was discussed with the IPC champions to then be cascaded to the clinical areas.

Point 6 – The physical damage encountered mostly relates to wear and tear and planned upgrades/maintenance. Regardless of the challenges encountered during the COVID-19 pandemic, all measures have been taken to reduce risk of cross contamination between contractors, staff and SU's. During outbreaks only essential work has been carried out. Estates and Facilities keep a log of all works undertaken and outstanding. IPC supported on the planning of these activities, when contractors had to go to areas with known COVID-19 cases.

.

8.2 COVID-19 guidance

The COVID-19 National Guidance had constant revisions and changes, which made it very challenging to keep the team and Trust staff updated. . This issue was even more significant because there is limited mental health specific guidance. Some of the advice provided was not applicable to Mental Health organisations.

To ensure the guidance changes were quickly cascaded, regular meetings between IPC and the deputy director of nursing were arranged (variable frequency depending on need) and weekly matrons meeting with IPC presence. This allowed us to cascade any changes, share learning and discuss challenges.

Arrangements have been made with external face fitters to provide face fitting across the Trust. This arrangement has finished on the 31st of March 2023 and an options appraisal was submitted to the Director of Infection Prevention and Control (DIPC) to decide on the way forward, to ensure face fitting continues in a sustainable way. There needs to be a wider discussion around these arrangements since at the present moment, the coverage of staff face fitted is still poor, mostly under 50% (please see table fourteen on next page for details).

The Trust has 5 powered hoods (one of the hoods in Juniper Centre has a damaged screen and not available to use). Two are currently located at Juniper Centre , and the remaining at the ECT suite. The powered hoods have been previously prioritised to the ECT suite, since most AGP procedures on the Trust are undertaken there. Regardless of this, any other department can request these hoods if necessary (except in secure care where these are not to be used due to concerns the hood might be weaponised). It is important to understand that powered hoods are not be a replacement for face fitting, since they are not suitable for all clinical areas, and its use is dependent on a risk assessment, as well as not having enough stock to cover all clinical areas (5 available).

Continuous updated guidance has been issued to all professionals. To ensure this could be done optimally, communication channels were kept via the Deputy Director of Nursing and the COVID-19 department to ensure IPC messages could be cascaded effectively.

There is a COVID-19 SOP in the Trust, that is reviewed each quarter to reflect the most up to date guidance and whenever new guidance is released. When new guidance is released, the IPC team reviews this and communicates with the DIPC for approval. When guidance review is approved, this is cascaded to all clinical teams through comms and weekly matrons' meetings.

The Trust has always aligned with National guidance with the following 3 exceptions:

- Resuscitation procedures – FFP3 masks to be used during all stages – as per National Resus Team advice.
- Speech and Language Therapy (SALT) Assessment – FFP3 or powered hood used.
- Restrains – As per risk assessment, use of FFP3 with facemask or IIR with face mask.

8.2.1 FFP3 respirators face fitting

During the year a face fitting program has been in place with currently 3 different ,masks being used.

The Trust had the support of 2 external face fitters, but the support has now ceased, and there is no face fitting capacity in the Trust.

Currently there is one PortaCount® Respirator Fit Tester in the Trust that is held by the IPC team, but no face fitters (The PortaCount Respirator Fit Tester is a quantitative respirator fit tester). An options appraisal was prepared and sent to the DIPC to inform decision on next steps to ensure face fitting in the Trust is re-instated.

Face fitting in the Trust is a point of concern, not just for COVID exposure but other respiratory diseases like Flu, Tuberculosis, or any respiratory infection from unknown agent.

It is essential to work towards increasing not just the overall percentage of staff face fitted, but as much as possible to aim that most face fitted staff is able to use 2 different types of masks with the aim of increasing resilience in case of future struggles of supply.

The following table shows the percentage of staff face fitted:

Division	Requiring Mask Fit Test	Fit Tested	Passed	Failed	Not Fit Tested	% Fit Tested	% Passed	% Failed
⊞Acute And Urgent Care Services	657	343	282	61	314	52.2%	82.2%	17.8%
⊞Chief Executive Office	1	0	0	0	1	0.0%	0.0%	0.0%
⊞Exec Dir - Medical	100	16	15	1	84	16.0%	93.8%	6.3%
⊞Exec Dir - Nursing	55	23	16	7	32	41.8%	69.6%	30.4%
⊞ICCR	678	267	206	61	411	39.4%	77.2%	22.8%
⊞New Care Models	8	2	2	0	6	25.0%	100.0%	0.0%
⊞Secure Serv & Offender Health	794	443	367	76	351	55.8%	82.8%	17.2%
⊞Specialties	675	310	264	46	365	45.9%	85.2%	14.8%
⊞SSL Management Team	1	0	0	0	1	0.0%	0.0%	0.0%
⊞Strategy,people & Partnerships	10	2	2	0	8	20.0%	100.0%	0.0%
⊞Trustwide	1017	146	117	29	871	14.4%	80.1%	19.9%
⊞Not Mapped	26	0	0	0	26	0.0%	0.0%	0.0%

Table 13 - FFP3 face fitted staff

As can be seen in the table the percentage of staff fitted tested across the Trust is significantly low, which bring concerns from a resilience point of view, not just from IPC perspective but also from an emergency preparedness perspective.

IPC advice

- It is important that the Trust includes in its regular training a program of face fitting with a refresher at least every three years or before if needed. Organize oversight of face fitting program, including record and monitoring of compliance. Discuss ways to minimize impact in areas with lower compliance that do not have enough staff face fitted in the area in case of need. Include face fitting during induction

8. Incident Reporting

The IPC team also keeps a database of infectious incidents to ensure that those affected are reported to Occupational Health and are adequately followed up. Occupational Health reports numbers of staff injuries to IPPC.

The following table shows the reported incidents by quarter and correspondent trends.

The most significant values are related to "possible transmission risk", this particular item incorporates a very wide range of issues like spit with risk of contact with the eyes, to physical wounds with skin breach and would require a broader analysis to understand that if it is related to increase in violence in our wards and the factors contributing for it.

The second most prevalent is wards closure due to outbreaks. This is a reflex of the ongoing COVID-19 pandemic.

Type	Q1	Q2	Q3	Q4	Trend
Blood stream infections (E-Coli, MMSA, MRSA...)	0	0	0	0	
Clinical Waste Management	0	3	4	4	
Incorrect results (Specimens)	0	0	3		
MRSA Management	0	0	0	1	
Possible Transmission Risk	36	31	46	11	
Tests-Failure/Delay to undertake	6	1	7	1	
Ward Closure due to outbreak	10	2	11	6	
Wound Management	1	0	0	0	
Total	53	37	71	23	

Table 14 - Eclipse incidents reported by quarter

During Q3 there were concerns that the number of inoculation injuries reported by Oc. Health were lower than the ones detected through the eclipse incidents reports. There has been a meeting between the IPC team and Oc Health to clarify if the same definition of inoculation injury was being used by both the Trust and the Oc Health provider. The conclusion was that both were align and the difference of values on the report were due to Oc Health only reporting the inoculation injuries that after triage and advice required further follow up.
The IPC team takes part of the contract meetings between PAM and the Trust (every 2 months) to ensure any issues are resolved and/or escalated appropriately.

9. IPC Team Response to Alerts and Directives

The IPC team monitors all new alerts and directives released and ensures new guidance is adapted for the Trust. This has been particularly evident during COVID-19, since guidance for community and mental health settings has not always been available. IPC led on discussions internally and externally to ensure best practice was always adopted.

The IPC team cascaded the information to the clinical areas and other areas of the Trust through the Deputy Director of Nursing, through regular matrons' meetings and IPC champions during the training sessions.
During IPC audits adherence to IPC guidance was observed and, when appropriate, aspects of the guidance were incorporated in the auditing tools to ensure consistency.

10. Food Safety

Ward managers undertake quarterly food service audits and monthly activity kitchen audits. Findings are included in matrons service area reports to the IPPC, and checks are also included in IPCN inspections. Food safety advice and audit is provided externally.
At present, the Trust has no food expert, so the annual audit had to be externally sourced. It is recommended that the Trust contracts a permanent food safety expert to allow continuous monitoring and training of staff.
The Food Safety Report is attached to this document.
On the next table we can see the summary of food related incidents eclipsed across the year. The number of reports is low and we have not seen an increase across the year.

Type	Q1	Q2	Q3	Q4	Trend
Food From unnaproved supplier	0	0	1	0	
Foreign Body identified in food	0	0	0	1	
inappropriate storage of food	1	1	1	0	
No appropriate Ethnic/dietary option	3	2	0	7	
Other catering issues	1	0	4	1	
Other food safety issues	1	0	1	0	
Out of date food	0	0	0	0	
Total	6	3	7	9	

Table 14 - Eclipsed food related incidents

11. Water Management

The water surveillance is made through the Water safety group (WSG).

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan. The WSG aims to ensure the safety of all water used by patients/residents, staff, and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a wide range of competencies can be brought together, to share responsibility and take collective ownership for ensuring it identifies water-

related hazards, assesses risks, identifies, and monitors control measures and develops incident protocols.

12.1 Water Safety – Positive Legionella bacteria samples

Elevated cold-water temperatures can result in Legionella bacterium present in water systems becoming active. Legionella pneumophila is a waterborne bacterium and is spread via exposure to aerosols of water containing the bacteria.

Legionnaire's diseases present as a severe pneumonia, which is caused by exposure to Legionella pneumophila. Symptoms of Legionnaire's disease include muscle aches, tiredness, headaches, dry cough, and fever.

The water management during the year was challenging, with an incident of external report by the Deputy DIPC of a positive legionnaire's disease case during November 2022. IPC confirmed with the laboratory, that the result was negative and the service user was treated accordingly.

Water concerns resulted on the closure of Forward House. By the end of the financial year, Forward house was only partially open with some areas still presenting with high counts of legionella.
Due to the water related issues, an external review was commissioned from an IPC perspective (done by the ICB) and a second review of Estates services provided, undertaken by Hydrop (Independent Consultancy Practice Specialists in the Management of Legionella and Water Quality). The findings and actions taken so far from the IPC related audit have been discussed in 5.1.

Once both reports are available, joint work should take place to elaborate an action plan, and ensure the findings are acted upon, and measures are put in place to prevent repeat of these issues. Meanwhile, and in response to the findings of the first report, the IPC team is proposing an SOP to risk assess the SUs in areas with high counts of legionella, including chain of information, to ensure that the wrong reporting incident is not repeated. This document will be presented to the IPCC for consideration.

12. Cleaning Standards

IPC team along with Facilities carried out a trust clinical cleaning roadshow for all clinical staff in inpatient areas. Providing information on the following:

- NHS Cleanliness Standards.
- Trust Cleaning Policy 2022.
- FR3 Charter & Ratings
- Efficacy Audits.
- Trust Chemicals.
- IPC standard precautions.
- Cleaning Methods.
- Water Safety.

The Estates and Facilities report details activities undertaken to promote and maintain standards required to meet the Code of Practice and other regulatory standards.

Of note were the consistently high cleaning scores reported to IPPC. Cleaning scores can be seen on estates report attached.

13. Capital Developments

The IPC team has worked with Estates and clinical staff to ensure that standards to meet the requirements of the document Health Building Note 00-09: Infection control in the built environment have been incorporated into refurbishments and works undertaken.

15 Annual Programme of Work

The Annual Programme of Work document will be attached to this report. After analysing the past year's activity, the IPC team advises on the following:

- Revise team scope, capacity and structure.
- Audit ownership monthly into clinical areas and aggregated in IPC dashboard.
- Monthly IPPC meetings.
- All policies to be reviewed and have included auditing criteria/KPI.
- IPC audits planning to include monitor implementation/adherence to IPC policies (according to policies KPI).
- IPC team to target areas of concern instead of blanket auditing all Trust areas and sites.
- Full review of compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (commonly known as the "Hygiene code") to be continued and discuss plan of action to overcome the gaps with the deputy DIPC/DIPC.

Infection Control Doctor – Annual Statement for April 2022 - March 2023

Dr Gemma Winzor. Consultant Microbiologist, UKHSA Laboratory, Birmingham

SSL+

ESTATES & FACILITIES INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2022-23

1. CORONAVIRUS (COVID) PANDEMIC

➢ **Estates & Facilities COVID Programme of Works 2022/2023**
With collaborative support from Matrons, Ward Managers, and Estates Teams, Estates & Facilities continued to run a programme to assist in maintaining a safe environment for all staff, Service Users, and 3rd party visitors for example contractors across all sites by:

- Enhanced Touchpoint Cleaning in accordance with the guidance provided by Infection Prevention & Control Team
- Weekly Isolation Returns (to capture any COVID related issues and communicate to all parties involved). This has now stopped but will be re-started should covid number/outbreaks start to increase again.
- Provided Post Infection cleans and deep clean of sites when requested by Infection Prevention & Control Team and Clinical Staff.

2. DOMESTIC & HOUSEKEEPING MANAGEMENT

➢ **Estates & Facilities**
All domestic services continue to be provided by SSL with the North PFI sites; B1 Trust HQ services being provided by a third party outsourced provision. This means that all Estates and Facilities domestic service provision across the Trust is outsourced for 2022/2023 reporting period.

➢ **NHS England –National Standards for Healthcare Cleanliness**
NHS England National Standards for Healthcare Cleanliness were implemented in April 2022. The Trusts Cleaning Policy was updated and ratified to align with the National Standards. The cleaning policy is currently being revised to take into account the change in Functional Risk category for Dementia wards. This will be completed in Q1 of 2023/2024.

➢ **SSL Domestic and Housekeeping Operational Manual**
SSL Domestic and Housekeeping Operational Manual operations manual contains Domestic and Housekeeping COSSH safety data documentation (in line with the Trust COSHH Policy), task-based risk assessments and method statements, task-based standard operating

SSL+

procedures, cleaning method statements, Trust Infection Prevention & Control policies and procedures, and operating instructions for departmental electrical equipment.

- **SSL Facilities Rapid Response Team**
  During 2022/2023 SSL Facilities Rapid Response Team continued to undertake a programme of deep cleaning across the Trust.

3. CLEANLINESS

- **Cleanliness Audit & Inspection Programme**
  During 2022/23 the programme of cleanliness inspections and audits was undertaken. Cleanliness scores and reports were provided to the Trust Infection Prevention & Control Team each month and the Trust Infection Prevention Partnership Committee each quarter.

The programme comprises 2 levels with additional spot checks.

- Level 1 Monitoring by Domestic Supervisors
- Level 2 Trust-wide Management Audits

Cleanliness scores were reported against the thresholds in the National Standards for Healthcare Cleanliness, Inpatient building's - 90%, Outpatient and Offices 85%.

During 2022/23 the cleanliness scores throughout the Trust (BSMHFT, SSL and Amey Community Limited) averaged above 94% and were consistently above the thresholds set in the National Standards for Healthcare Cleanliness.

All special cleaning activity (including Isolation Cleaning, Post-Infection Cleaning and scheduled Deep Cleaning) was undertaken in compliance with the Trust Infection Prevention & Control Policy and was reported monthly to the Infection Prevention & Control Team and to the Infection Prevention Partnership Committee each quarter. The Trust's Deep Cleaning

SSL+

Programme is an integral element of the Trust Cleaning Policy and responds to the National Standards for Healthcare Cleanliness.

Key Cleaning Performance Data for 2022/23

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	1 April – 30 June 2022	1 July – 30 Sept 2022	1 Oct – 31 Dec 2022	1 Jan – 31 Mar 2023
	Trust Cleanliness Targets & Scores			
	Trust Overall Cleanliness Target = 90% inpatient Units, 85% Outpatient Units			
Trust Average	97.77%	96.24%	94.68%	95.39%
North PFI	97.06%	92.93%	92.33%	92.57%
BNHP	97.27%	96.14%	93.70%	95.46%
Community	97.90%	97.17%	96.40%	97.62%
Secure	97.52%	97.15%	95.35%	95.92%

- **PLACE (Patient Led Assessments of the Care Environment)**
  The 2022 PLACE assessment programme took place during September – November 2022. The results have been published and we are currently in the process disseminating these.

- **Cleaning Quality Operational Group**
  The Cleaning Quality Operational Group was re-established. It is led by Infection Prevention & Control and comprises of SSL Estates and Facilities Department representatives, Matrons, and PFI Partner Amey Community Limited and reviews all issues (and implements actions) regarding cleanliness within the Trust. The group reports into the Infection Prevention Partnership Committee.

- **Cleaning Policy**
  The aim of the Trust Cleaning Policy is to demonstrate compliance with the assessment criteria detailed in "The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (DOH, July 2015) on the standards of cleanliness that facilitate the prevention and control of infections and improve the quality of health service provision by ensuring that all cleaning related risks are identified and managed.

The policy requires delivery of consistent and compliant cleaning practices and cleanliness standards Trust-wide (whether delivered through SSL or PFI providers).

Compliance with the policy is monitored through the following.

- Estates & Facilities Cleanliness Audit & Inspection Programme
- Cleaning Quality Operational Group
- Estates & Facilities monthly reports to the Infection Prevention & Control Team and quarterly reports to the Infection Prevention Partnership Committee.

➢ **Cleanliness Training**

SSL Facilities Department manage an established Facilities Training Hub at The Barberry which continues to provide accredited education and training for SSL and Trust staff, as well as external companies. The Facilities Training Hub provides dedicated education and builds awareness of the cleaning profession through accredited training. Courses are delivered by Sue Ladkin (SSL) ranging from local induction training to higher level accredited training, whilst working alongside BSMHFT's Infection Prevention & Control Team and nursing colleagues. The Hub's syllabus also includes Level 2 in the Principles and Control of Infection in Healthcare Settings, Food Safety, Legionella and Water Safety and Biohazard Decontamination Training. During 2022/23, the Facilities Training Hub delivered FM training to Trust staff, SSL (Summerhill Services Limited) and PFI Partner Amey Community Limited.

The Trust's PFI Partner (Amey Community Limited) has contracted with the Trust's Accredited Training Hub to provide training to all of their Domestic Staff and Supervisors. The Trust's PFI Partner is also using the Training Hub to provide Level 2 Food Hygiene for their Domestic Assistants and Domestic Supervisors.

➢ **Computerised Cleanliness Monitoring System**

SSL Estates & Facilities Department and PFI teams operate a computerised cleanliness monitoring system "FM First" (based on the National Standards for Healthcare Cleanliness). The system generates cleaning scores and real time reports. This system was updated in April 2022 in line with the new Cleaning Standards.

4. CATERING MANAGEMENT

➢ **Environmental Health Inspections**

During 2022/23 Inspections by Birmingham City Council Environmental Health Officers carried out a visit to Juniper Centre on 10 October 2022. Scores on doors awarded 4 - Meals for Juniper are provided by Moseley Hall Hospital. SSL also carried out internal audits.

➢ **SSL Kitchen Inspections and SSL Food Safety and Quality Audits on behalf of BSMHFT**

During 2022/23 a programme of kitchen inspections and food safety and quality audits were undertaken once a quarter across the production kitchens with scores and reports provided to the Trust Infection Prevention Partnership Committee and the SSL/Trust Food Safety and Quality Group each quarter.

- **Allergy Awareness**
  Since changes in Food Safety Legislation in the UK, food businesses must inform you under food law if they use any of the 14 allergens as ingredients in the food and drink they provide. This list has been identified by food law as the most potent and prevalent allergens. SSL staff that handle food are required to complete the FSA online training. As this training has recently been updated in line with changes to the most recent legislation. If staff have completed the training before 16 September 2020, we would advise that you re-take this version as it contains new information. It has been recommended that all staff that handle or serve food complete this training and the link has been added to the Trust eLearning food safety level 1 package.

- **Food Safety Training**
  The Trust Food Safety Policy stated that all Housekeepers and Amey food service staff should be trained to Level 2 food Hygiene and food handlers to Level 1.
  However, is a requirement for all staff who handle food to have Food Safety level 2 training. Clinical staff on the North PFI sites, serve the food to the Service Users.

- **National Standards for Healthcare Food and Drink**
  The National Standards were implemented in November 2022, there are 8 standards that all NHS organisations are required to meet:
    - Organisations must have a designated board director responsible for food (nutrition and safety) and report on compliance with the healthcare food and drink standards at board level as a standing agenda item.
    - Organisations must have a food and drink strategy.
    - Organisations must consider the level of input from a named food service dietitian to ensure choices are appropriate.
    - Organisations must nominate a food safety specialist.
    - Organisations must invest in a high calibre workforce, improved staffing and recognise the complex knowledge and skills required by chefs and food service teams in the provision of safe food and drink services.
    - Organisations must be able to demonstrate that they have an established training matrix and a learning and development programme for all staff involved in healthcare food and drink services.
    - Organisations must monitor, manage and actively reduce their food waste from production waste, plate waste and unserved meals.
    - NHS organisations must be able to demonstrate that they have suitable 24/7 food service provision, which is appropriate for their demographic.

  The Food Group was set up in 2022.

5. WASTE MANAGEMENT

- Waste Contracts

The contract with the Violia for Domestic waste commenced 1st April 2020 and the Clinical Waste contract with Tradebe commenced 01 July 2020. These contracts were established for a period of 3 years with the option to extend on a +1 year and +1 year basis.

These contracts for Domestic and Clinical Waste have continued to deliver an effective and compliant service during 2022/23 whilst at the same time keeping costs to a minimum. The 24/7 helpline and call logging process enabling queries to be logged, responded to and tracked more effectively and in doing so improving service standards has continued to be effective. Contract Review Meetings are held regularly with a focus at each meeting of dealing with any isolated problems and seeking further service efficiencies.

- Duty of Care Audits
  Duty of Care Audits by external experts of the Trust's various waste contractors continue to be carried out on an annual basis to ensure that the Trust's waste is managed effectively and compliantly from point of consignment to final disposal. In addition, SSL has worked very closely with the clinical waste contractor Tradebe to complete many pre-acceptance audits, ensuring that waste is effectively managed, segregated and consigned by BSMHFT. Where issues have been identified the findings have been shared accordingly.

- Waste Management Policy
  The Trust's Waste Management Policy which was ratified in September 2021. This Policy places a clear responsibility on the producer of the waste (the ward / the team / the individual) to manage that waste compliantly and furthermore places a control responsibility on team / ward managers and equivalent who are custodians of healthcare within their sphere of influence to ensure that their staff manage waste safely and compliantly.

- Waste Management Training
  SSL's Estates and Facilities Department has supported clinical / healthcare colleagues by offering refresher training at their own sites this being to reduce the burden on clinical staff having to travel to 'training venues' to receive such on the job training.
  In addition, sharps management training was provided both by the Trust and its sharps supplier to the Trust's Infection Control Link Workers to allow them to disseminate best practice at their respective sites. This training will continue in 2022/23.

6. LAUNDRY & LINEN MANAGEMENT

- BSOL Laundry & Linen Consortium
  SSL Facilities Managers and SSL Procurement have and continue to work with the BSOL Laundry and Linen Consortium. The workshop is led by University Hospitals Birmingham and is attended by Midlands Trust's and Elis. The aim to retender the laundry and linen services across the BSOL consortium and have one contract specification and standards.

- Laundry & Linen Contract
  During 2021/22, Central Laundry was acquired by Elis. The service has seen a decline in standards. Weekly contract meetings held with Elis, SSL and PFI Partners. Termination warnings have been issued to Elis and there has been some improvement. The contract is in

the process of being extended as no alternative suppliers have been found. SSL and PFI Partners are currently exploring alternatives.

- Duty of Care Audits
  A Duty of Care Audit was undertaken of the Trust-wide Laundry and Linen supplier Ellis in 2022. These were to the Coventry plant and the team observed the supplier's compliance with the service contract, the Trust's Laundry & Linen Policy, and Health Technical Memorandum (HTM) 01-04 "Decontamination of Linen for Health and Social Care". The Duty of Care visit also observed standards, quality systems, risk assessments and standard operating procedures as well as Laundry Staff Training Records to ensure compliance.

7. PEST CONTROL

- Trust Pest Control Policy, drafted by SSL Facilities Management, ratified in April 2022.

Capital/Revenue Schemes/Projects 2022/23

A full schedule of schemes and projects is available on request. The following schemes are highlighted as being particularly pertinent to Infection Prevention & Control;

Location	Description of Scheme	Location	Description of Scheme	Location	Description of Scheme
Newbridge House	· Air Conditioning to Inpatient Lounge · Remedial works – Water Management Risk Assessment · Duct Work Cleaning	Eden PICU	· 8 no. anti-ligature WC's and Trovex IPS panels · 8 no. anti-ligature washbasins and Trovex panels · Remedial works – Water Management Risk Assessment	Trustwide - North PFI In-Patient Areas	· Remedial Works - Trust IPCT Audit - Risk Assessment · Replacement Flooring non-compliant with IPCT Policy and HTM 64:01 · Refurbishment of sanitaryware (across all WC's/bathrooms)
Ardenleigh	· Coral Ward Seclusion Suite · Heating & Ventilation System Works · Flooring and redecorations. Improvements to internal fabric, fixtures and fittings · Recommission the mechanical ventillation system · Recommission the mechanical ventillation system	Reaside	· Works to heating, ventilation & water distribution systems · Extract canopy to Main Kitchen Pot Wash · Various flooring works · Main Kitchen - Air-conditioning internal wall mount replacement · Various Wards - Shower Room upgrades · Flooring and redecorations. Improvements to internal fabric, fixtures and fittings	Tamarind	· Various flooring works · Various air-conditioning system replacements · Flooring and redecorations. Improvements to internal fabric, fixtures and fittings
Endeavour Court	· Creation of Clinic Room & External Fencing · Anti-ligature WC's & En-Suites to Ward	Warstock Lane	· Flooring and redecorations. Improvements to internal fabric, fixtures and fittings	Dan Mooney House	· Upgrades to internal fabric etc
David Bromley House	· Upgrades to internal fabric etc	Uffculme Centre	· Flooring and redecorations. Improvements to internal fabric, fixtures and fittings	Lyndon Centre	· Various Environmental Improvements · Upgrades to internal fabric etc
Mary Seacole 2	· Convert 1 no. Assisted bathroom to multi-functional Activity Room…	Larimar Ward - Ardenleigh	· Upgrade 1 no, Assisted Bathroom to full anti – ligature specification · En-Suite upgrades	Maple Leaf Centre	· Lagging uninsulated sections of pipework and replacement of damaged lagging · Upgrades to internal fabric etc
Forward House	· Creation of Clinic Room	Hillis Lodge	· Upgrades to internal fabric etc	Northcroft	· Flooring Works
Longbridge Centre	· Upgrades to internal fabric etc and Risk Assessment works	Rookery Gardens	· Redecoration Works	Juniper Centre	· Flooring and redecorations, improvements to internal fabric, fixtures and fittings
LBC	· Flooring Works · Remedial works – Water Management Risk Assessment, · Hot and Cold Water System Distribution Works	William Booth Centre	· Upgrade Unisex WC to anti-vandal/anti-ligature standard · Hot Water Cylinder to provide HTM compliant water temperature	Small Heath Health Centre	· Remedial works – Water Management Risk Assessment · Hot & Cold Water Systems Distribution 24 hr - 1 x Andrew 63/321
George Ward	· Remedial works – Water Management Risk Assessment,	Eden ACUTE	· Remedial works – Water Management Risk Assessment,	Northcroft	· Remedial works – Water Management Risk Assessment,

SSL+

Summerhill Services

Annual Water Safety Report 2022/23

April 2023

- **Operational Water Management Group: - NOTE! The newly re written WSP enhances the below but it not yet fully ratified.**

  - This is a multidisciplinary group formed to oversee the commissioning, development, implementation and review of the WSP. The aim of this group is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens and other risks such as scalding, chemical contamination and the risk of disruption to the water supply. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring it identifies water related hazards, assesses risks, identifies and monitors control measures and develops incident protocols.

The following is a typical list of tasks assigned to the OWMG

1. To work with and support the Infection Prevention and Control (IPC) team
2. To ensure effective ownership of water quality management for all uses
3. To determine the particular vulnerabilities of the at-risk population
4. To review the risk assessments
5. To ensure the WSP is kept under review including risk assessments and other associated documentation
6. To ensure all tasks indicated by the risk assessments have been allocated and accepted
7. To ensure new builds, refurbishments, modifications and equipment are designed, installed, commissioned and maintained to the required water standards
8. To ensure maintenance and monitoring procedures are in place
9. To review clinical and environmental monitoring data
10. To agree and review remedial measures and actions, and ensure an action plan is in place, with agreed deadlines, to ensure any health risks pertaining to water quality and safety are addressed which may include balancing the risks related to water safety and other safety risks such as ligature risks
11. To determine best use of available resources
12. To be responsible for training and communication on water related issues
13. To oversee water treatment with operational control monitoring and to provide an appropriate response to out-of-target parameters (that is, failure to dose or overdosing of the system)

14. To oversee adequate supervision, training and competency of all staff
15. To ensure surveillance of both clinical and environmental monitoring
16. To review areas/rooms taken out of commission, to ensure adequate provisions are made for flushing/draining the water systems as appropriate

Membership will include:

1. Head of Facilities Management (SSL) – Chair
2. Head of PFI
3. Senior Estates Manager – North PFI
4. Senior Estates Manager – South PFI
5. Senior Facilities Manager - Community
6. Senior Facilities Manager – Secure
7. Senior Facilities Manager South PFI
8. Senior Infection Prevention and Control Nurse or nominated Person
9. Authorising Engineer
10. Capital projects representative
11. Sector Specific Nominated Contractors
12. Deputy Director of Nursing or nominated representative

Regular meeting will be held quarterly. Agenda items will include the following:

1. Review of previous minutes. - Chair
2. Review of Action Plan - Chair
3. Community update (by exception) - Senior Facilities Manager (community)
4. Secure update (by exception) - Senior Facilities Manager
5. North PFI update (by exception) - Senior Estates Manager (North PFI)
6. South PFI update (by exception) - Senior Estates Manager (South PFI)
7. Capital works update - Capital Team
8. Service Provider Update
9. AE update / comments / policy / audits - AE
10. AOB

Quorum - attendance to be no less than 40% of membership (Senior Infection Prevention and Control Nurse or Microbiologist/Infection Control Doctor must be present at all meetings). If the chair of the OWSG is unable to attend, the chair will nominate a deputy dependant on current ongoing issues.

- **Strategic Water Safety Group: - NOTE! The newly re written WSP enhances the below but it not yet fully ratified.**

The Committee comprises of but not limited to the below and is held on a quarterly basis:

1. Responsible Person (or Deputy Responsible Person)
2. Sector Specific Nominated Persons
3. BSMHFT's Infection Prevention and Control representative (where applicable)
4. BSMHFT's Nursing department representative
5. BSMHFT's Health and Safety Manager
6. External Independent AE
7. Consultant microbiologist
8. Trust / SSL Authorised Persons

Committee's responsibilities include:

1. Provide a forum of discussion and sharing of information pertaining to Legionella Management & Control and Safe Hot Water Management across the Trust.
2. The ratification of appointment of Responsible and Nominated persons.
3. The preparation of all relevant Documentation, Works Specifications, PPM Programmes, Policies etc. (may be prepared by the team or by others for the team).
4. The ratification of all relevant Documentation, Works Specifications, PPM Programmes, Policies etc.
5. The monitoring and reporting upon the efficacy of all implemented PPM Programmes and all other relevant procedures.
6. The monitoring and reporting upon the efficacy of all contractors commissioned on Legionella related projects.
7. The monitoring and reporting upon the efficacy of all training Programmes implemented for associated staff.
8. The implementation of arrangements for managing an outbreak or suspected outbreak of Legionella.
9. The liaison between all other official bodies particularly in an outbreak situation.

Authorising Engineer:

SSL has appointed the Water Hygiene Centre to provide professional advice on water management issues.

The AE is an independent professional advisor whose primary role is to assist the Trust in managing the risks from exposure to legionella bacteria in water systems and also from other waterborne organisms associated with such systems such as pseudomonas and stenotrophomonas.

As a specialist, the AE will act as an independent professional advisor on water safety matters, and will work closely with both the Operational Water Management Group (OWMG) and Strategic Water Safety Group (SWSG).

The role of the AE is to provide:

1. Advice to the appointed duty holders, responsible persons and their deputies on regulatory compliance, communication, management procedures, procurement etc
2. Make recommendations for the appointment of the RP[W], DRP[W]/AP[W]. Certificates of appointment will be issued detailing areas of responsibility and limitations.
3. Monitor the performance of employees and contractors with regards to their tasks in legionella management
4. Conduct regular compliance audits of single or multi-site facilities.
5. The AE will also become involved in developing staff training plans, reviewing commissioning works, construction design appraisals, mothballing of unused premises, and the development of specialist water safety policies and procedures etc.

The AE will also provide the following services:

1. Attend quarterly Operational Water Management Group (OWMG) and Strategic Water Safety Group (SWSG) meetings.
2. Carry out annual audit of the Trust's control of legionella policy to ensure operational and management systems are in compliance with ACoP L8 and HTM 04-01; produce an audit report indicating areas of non-compliance; recommend actions and suggested improvements or amendments to policy and procedure documentation
3. Provide two half-day training sessions which include an update on the key principals of legionella risk management and associated legislation/codes of practice; two sessions to be targeted at trade maintenance staff, two at estates management staff; provide training workbooks and certificates of attendance for all delegates (BSMHFT Trust will provide the training venue and refreshments within the Birmingham locality)
4. Provide additional one day's refresher training for the Trust's infection control team
5. Provide on request ad hoc and technical expertise for all legionella risk management and other related matters via telephone, fax, letter or email; provide regular updates on any changes to legislation/codes of practice which may impact on the Trust legionella risk management system
6. Annual review of water safety plan.

- **Water Safety Plan**

The WSP has been developed in order to comply with the requirements of HTM 04-01: Safe Water in Healthcare Premises.

The purpose of the WSP is to assist with understanding and mitigating risks associated with waterborne hazards in distribution and supply systems, together with associated equipment. The WSP also provides a risk management approach to the safety of domestic hot and cold water and establishes good practice in local water usage, distribution and supply systems. The

WSP will also identify potential water related hazards, consider practical aspects and detail appropriate control measures.

The content of the WSP includes management and governance arrangements, together with details of training, professional support, maintenance regimes and supporting documentation.

The water safety plan was updated in August 2021 with Appendix 10 (Legionella Sample Result Action Levels Flow Chart) reviewed and updated March 2022 so we have consistency in approach (see below).

Water safety plan 09.08.21.docx

Appendix 10 Rev A.docx

A full re write of the WSP is underway taking lessons learned and actions from the independent review on the closure of Forward House, the updated WSP is currently out for consultation.

- **Legionellosis Management and control Policy**

Legionellosis Management and control Policy was reviewed, updated and ratified in September 2021 with the next anticipated review in 2024.

Legionellosis management and con

- **Training (Estates):**

Water Safety RP and AP Courses attended and completed across the SSL FM and PFI departments as per the below:

Water RP's

- Lee Gough – Head Of Facilities Management.
- Dean Redmond – Senior Facilities Manager (Secure Care).
- Roy Bradley – Senior Facilities Manager (Community).
- Tarnjit Singh – Estates Manager (Ardenleigh).
- Paul Tranter – Estates Manager (Tamarind).
- Martin Spiers – Estates Manager (Reaside).
- John Mead - Senior Estates Manager – PFI South.
- Martin Germaney - Senior Estates Manager – PFI North.
- Gary Stanton – Estates Contracts Officer – PFI North.
- Nicky Bowen – Senior Contracts & Commercial Services Manager – PFI North.
- Clive Round – Contracts Officer – PFI North.
- Yvonne Kelly - Contracts Officer – PFI South.

Water AP's:

- Dean Redmond – Senior Facilities Manager (Secure Care).
- Roy Bradley – Senior Facilities Manager (Community).

Water CP's:

Refresher training is scheduled for all Estates maintenance teams for April 23 as per the below:

	19th April (Plymouth Room, Uffculme) 08:30 – 16:30		**20th April (Butterleigh Room, Uffculme) 08:30 – 16:30**		**27th April (Conference Room 2, Reaside Clinic) 08:30 – 16:30**	
	Name	Site	Name	Site	Name	Site
1	Michael Reid	Tamarind	Kevan Lewis	Tamarind	Mohammed Ifzal	Ardenleigh
2	Malcolm Linton	Tamarind	John Johnstone	Reaside	Tyrone Williams	Reaside
3	Stan Millwood	Reaside	Liam Crowe	Reaside	Lisa Flavell	Reaside
4	Mark Seymour	Reaside	Mark Barrett	Hillis Lodge	Asif Quayam	Tamarind
5	Oliver Higgins	Ardenleigh	Adrian Flanaghan	Hillis Lodge	Kevin Richards	Hillis Lodge

6	Derek Harley	Hillis Lodge		Daniel Wise	Hillis Lodge		Howard Moore	Hillis Lodge
7	David Bromley	Hillis Lodge						

- **Risk Assessments:**

Retained Estate:

Legionella Risk assessments have been carried out at the below sites with all remedial works completed:

Ref	Property	Postal Address	Gross internal floor area (m2)	Date of Last Survey
1	Adams Hill	190 Adams Hill, Bartley Green, B32 3PJ	180	17/08/2021
2	Ardenleigh inc Thomas Telford and Training Centre	385 Kingsbury Road, Erdington, B24 9SA	8,598	20/07/2021
3	B1	Unit 1 B1, 50 Summer Hill Road, B1 3RB	3,039	29/07/2021
5	Dan Mooney House	1 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	27/07/2021
6	David Bromley House	2-4 Woodside Crescent, Downing Close, Knowle, Solihull, B93 0QA	665	27/07/2021
9	Grove Avenue	32 Grove Avenue, Moseley, Birmingham, B13 9RY	397	28/07/2021
10	Hertford House	29 Old Warwick Road, Olton, Solihull, B92 7JQ	484	27/07/2021
11	Hillis Lodge	Hollymoor Way, Northfield, B31 5HE	1,095	25/07/2021
12	Juniper Centre	Moseley Hall Hospital site, Alcester Road, Moseley, B13 8JL	5,246	29/07/2021
13	Longbridge Health & Community Centre	10 Park Way, Birmingham Great Park, Rubery, B45 9PL	1,414	17/08/2021
14	Lyndon Resource Centre	Hobs Meadow, Solihull, B92 8PW	888	27/07/2021
15	Maple Leaf Centre	2 Maple Leaf Drive, Marston Green B37 7JB	1,752	17/08/2021
18	Newington Resource Centre	Newington Road, Hamar Way, Marston Green, B37 7RW	850	16/03/2021
19	Orsborn House	55 Terrace Road, Handsworth, Birmingham, B19 1BP	1,659	18/08/2021
22	Rookery Gardens	385 Kingsbury Road, Erdington, B24 9SA	1,239	03/08/2021
23	Shenley Fields	15 Shenley Fields Drive, Northfield, B31 1XH	487	25/07/2021
24	Tamarind	165 Yardley Green Road, Bordesley Green, B9 5PU	8,261	29/07/2021
25	Uffculme Centre inc (Main Building, Tall Trees / Estates, Staff Support, Gate House	52 Queensbridge Road, Moseley, B13 8QY	2,166	20/09/2021
26	Uffculme site (Tall Trees)	52 Queensbridge Road, Moseley, B13 8QY	628	28/07/2021
27	Warstock Lane	Warstock Lane, Billesley, B14 4AP	577	28/07/2021

North PFI:

All WRA's have been updated in 2022 with remedial works completed, these are not due a refresh until 2024 unless works are carried out which materially impact the water systems on site.

South PFI:

Property	**Address**	**Gross Area**	**Date of Last Survey**

Barberry	25 Vincent Drive, Edgebaston, B15 2SY	8,913m2	Q4 22
Oleaster	6 Mindlesohn Crescent, Edgebaston, B15 2SY	7,200m2	Q4 22
Zinnia	100 Showell Green Lane, Sparkhill, B11 4HL	4,331m2	Q4 22

Remedial works are currently being reviewed / undertaken across all sites.

➢ **Authorising Engineer Audits:**

Audits have recently been carried out by water AE across the following areas – audits being finalised before distribution.

- South PFI.
- Community Sites.
- Secure Sites.

➢ **Water Sampling Results and General Overview**

- Combined Sampling results are now collated into a single spreadsheet including actions taken (see below)

Combined Results.xlsx

Retained Estate:

Reaside:

Throughout the year Reaside has only seen 2No positive results as per the below:

- G64 Estates Cold (25 CFU's).
- G280 Severn Ward Kitchen Hot (500 CFU's).
- Current results are all clear.

Newington:

After sampling post installation of the new water heater we received 2 low positive results of 25 and 100 CFU's to the cleaners cupboard sink – a full clean and disinfection was carried out to the outlet with sampling weekly until 3 ND's – currently all clear.

Orsborn House:

As part of routine sampling by the landlord a count of 4 CFU's was detected within our demise to the 2nd floor kitchen sink (cold) – a full clean and disinfection of the outlet along with weekly sampling was carried out unit 2ND's – currently all clear.

General:

As part of a robust RFQ exercise from July 2023 the contractor that we use for legionella management and control will be changing from IWS to Acquiesce Environmental Compliance.

North PFI:

General: - see combined results spreadsheet for latest sampling results.

On the North PFI sites there have been numerous positive readings throughout the year but robust action plans have been put in place following the Action flow chart and discussions with the Strategic Water Safety Group.

Over the year the main sites where we have seen positive results continue @ Eden Acute & PICU, Forward House, William Booth & George Ward, the estates team have a clear action plan in place with Amey which includes:

- Reviewing risk assessments including carrying out actions in a timely manner.
- Following the action flow chart including chlorination's, installing POU filters, reviewing flushing frequencies, servicing TMV's, descaling outlets and aerators.
- Installing a Copper and Silver ionisation dosing plant @ Eden.
- Replacing pipework, TMV's and balancing the system at Forward House.

- Installing an independent localised hot water system @ William Booth to enable the hot water temps to be better controlled.

It must be noted that there has been in excess of £1,000,000 spent on water management across the North PFI sites over the last financial year.

Independent Review of Forward House:

Due to the closure of Forward House SSL commissioned an independent review of the Water safety processes used by BSMHFT/ SSL and their Supply Chain, this was carried out by Hydrop. The Audit included include both Operational and Governance Audits along with analysis of specific actions on Forward House and the North PFI premises in particular.

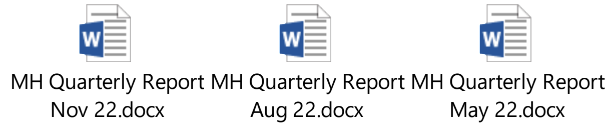
The report generally notes the below, with any actions included in the re written WSP.

- **General summary** - This detailed review did not identify a single acute incident which caused the identified Legionella contamination within Forward House. Instead, a building, typical in its management of Water Quality Risk Management regimen was observed. Whilst improvements can be made, to ensure tighter control of identified failures in control measures, can be instigated, it is doubtful that such improvements in the overall control measures would have prevented the incident.
- **Usage evaluation and flushing** – The process for the identification / notification to estates by the clinical teams of infrequently used outlets needs to be improved with the clinical teams taking ownership.
- **Sampling –** Carry out a review of the sampling process including which outlets and frequency of sampling inc methodology for when filters are installed – the full methodology has been reviewed and incorporated into the latest WSP.
- **Training of Trust Staff –** Training of all none estates members of the Strategic Water Safety Group is to be reviewed as in recent months we have had some new members. – The Trust water AE is going to carry out reviews and review training needs.
- **Formal suitability assessment and appointment of Responsible and Competent Persons -** Review and complete suitability assessments for all key Amey / Severn Trent personnel. – The Trust AE is going to carry out suitability assessments.
- **Water Safety Group (WSG) –** Review the attendees of the Strategic water safety group including TOR. – A revised TOR and attendance list has been included in the latest WSP.
- **Water Safety Plan –** An existing water safety plan is in place but this has been enhanced from lessons learned over the past 12 months.

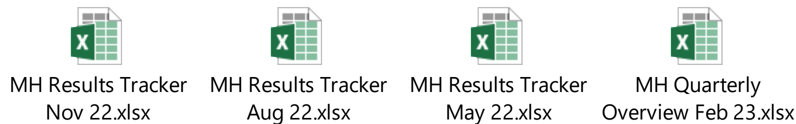
South PFI

The South PFI sites have continued to show clear results over the past year, below are the quarterly reports / sampling results formulated / taken by Equans.

Quarterly Reports below:



Quarterly Sampling Results below:



The CLO2 systems in Barberry, Oleaster and Zinnia were replaced in 2022. Careful adjustment and monitoring of the levels saw no significant change in sampling results.

Capital projects of note:

Location:	**Description of works:**
Ardenleigh	Coral Seclusion Suite
Ardenleigh	Various isolation valve and TMV replacement works
Lyndon Centre	Various environmental improvements
Reaside	Various works to heating and water distribution systems
Newington Centre	Replacement of hot water cylinder
Hillis Lodge	Replacement of boiler
Longbridge	Replacement of boilers and hot water cylinders
Eden	Installation of Copper / Solver Ionisation unit / various water safety works
George Ward	various water safety works
Newbridge	Heating System Controls - 15 x Actuator Valves, Heating System Pumps - 10 x sets twin head, Calorifiers - 1 x Andrews (Max Flow), 2 x state SBT 75
Willaim Booth	Hot Water Cylinder to provide HTM compliant water temperature
Forward House	Various Water safety works

LEE GOUGH

Head Of Facilities Management

Food Safety Report – Sue Ladkin

Birmingham and Solihull Mental Health
NHS Foundation Trust
Uffculme Centre
52 Queensbridge Road
Birmingham
B13 8QY

Main switchboard: 0121 301 0000
Website: www.bsmhft.nhs.uk