Salisbury NHS Foundation Trust

Report to:	Trust Board (Public)	**Agenda item:**	SFT4147
Date of Meeting:	06 December 2018		

Report Title:	Director of Infection Prevention & Control (DIPC) Mid Year Report 2018/19			
Status:	**Information**	**Discussion**	**Assurance**	**Approval**
	X		X	
Prepared by:	Fiona McCarthy – Lead Nurse			
Executive Sponsor (presenting):	Lorna Wilkinson – Director of Nursing and DIPC			
Appendices (list if applicable):	Included within the report			

Recommendation:

The Board is asked to:

1. Note the report, and the performance against Infection Prevention and Control requirements at mid year.

2. Minute/document that the Board continues to acknowledge their collective responsibility as described within the DIPC report and confirm receipt of assurance on IPC actions and controls at mid year.

Executive Summary:

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC).

The DIPC Reports together with the monthly Key Quality Performance Indicators Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of the mid-year DIPC Report is to inform the Trust Board of the progress made against the 2018/19 Annual Plan, to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The reported six month period has been full of activity for Infection Prevention & Control (IPC) and the Trust has achieved good outcomes to date and maintained compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Department of Health, 2015).

This report takes the opportunity to celebrate the successes and highlights the increasing challenges moving forward:

1. There has been one reported Trust apportioned Clostridium difficile (C.difficile) case against a trajectory of 18 for 2018/19.

2. There has been one Trust apportioned Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infection against a target of zero for 2018/19. Key learning includes improving MRSA screening and decolonisation, and management of indwelling catheter devices.

3. Mandatory surveillance of orthopaedic surgery has continued with no identified deep infections for knee replacement surgery.

4. The Trust has maintained a safe water system, although due to complex and aged water system this requires continuous oversight as detailed within the report, particularly regarding the management of legionella counts. There are robust monitoring and mitigation activities in place.

5. A robust decontamination audit plan continues for the decontamination of reusable medical devices. The Decontamination Lead continues to work closely with others to ensure that a fully compliant sterilisation service is maintained until the new SSL facility is fully operational

6. Environmental cleanliness standards, which are monitored regularly and validated quarterly, are maintained to a high standard. The Patient Led Assessment of the Care Environment (PLACE) scores showed an improvement to what was already a high standard of environmental cleanliness and is above the national average.

7. Perfect Ward App was implemented and gives transparency of infection prevention and control practices through monthly audit in each ward area which has been carried out by the IPC team

8. Antimicrobial stewardship continues to be one of the key measures to reduce the risk of Clostridium difficile infection and the single most important measure to reduce the selection of multiple antibiotic resistant bacteria.

   There have been considerable achievements with antibiotic prescribing standards over the years. Concerted effort continues with antimicrobial stewardship and decreases in consumption for the use of all antibiotics. Although we are currently challenged with this due to resource constraints there is a clear improvement plan in place for Q3&4, not only to be reduce overall consumption but to increase the proportion used in the *Access* group of the AWaRe category. Further detail can be found in section 11.

Board Assurance Framework – Strategic Priorities	Select as applicable

Local Services - We will meet the needs of the local population by developing new ways of working which always put patients at the centre of all that we do	☒
Specialist Services - We will provide innovative, high quality specialist care delivering outstanding outcomes for a wider population	☒
Innovation - We will promote new and better ways of working, always looking to achieve excellence and sustainability in how our services are delivered	☐
Care - We will treat our patients, and their families, with care, kindness and compassion and keep them safe from avoidable harm	☒
People - We will make SFT a place to work where staff feel valued and are able to develop as individuals and as teams	☐
Resources - We will make best use of our resources to achieve a financially sustainable future, securing the best outcomes within the available resources	☐

Salisbury
NHS Foundation Trust

DIRECTOR OF INFECTION PREVENTION & CONTROL (DIPC) REPORT

6 MONTHLY UPDATE (QUARTERS 1 AND 2 OF 2018/19)

LORNA WILKINSON
DIPC

DECEMBER 2018 (FINAL DRAFT v.3.1)

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APPENDICES

1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC).

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of the six monthly DIPC Report is to inform the Trust Board of the progress made against the 2018/19 Annual Action Plan (Appendix A), to reduce healthcare associated infections (HCAI) and sustain improvements in infection prevention and control practices.

The action plan focuses on the Trust achieving the standards identified in 'The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance' (2015), to ensure that patients are cared for in a clean and safe environment, where the risk of HCAI is kept as low as possible.

2. GOVERNANCE ARRANGEMENTS

The work towards achieving the objectives of the Annual Action Plan 2018/19 is monitored via the Infection Prevention and Control Working Group (IPCWG), which reports to the Infection Prevention and Control Committee (IPCC) and onto the Clinical Governance Committee (CGC), which completes the governance arrangements (Appendix B).

3. INFECTION PREVENTION & CONTROL ARRANGEMENTS

A comprehensive infection prevention and control service is provided Trust wide. The Infection Prevention and Control Team (IPCT) provides a liaison and telephone consultation service for all inpatient and outpatient services, with additional arrangements for seven day service cover by an Infection Control Nurse (ICN) during declared Norovirus outbreaks.

The IPCT currently comprises an Infection Control Doctor (ICD)/Consultant Microbiologist, and 3.0 whole time equivalent (wte) ICNs and secretary (0.6 wte). In addition, there are 2 Consultant Microbiologists, one of whom is the Trust Antimicrobial Lead.

From 1st April to August 31st 2018, an additional team member was recruited on secondment (0.5 wte) to provide additional support for the team whilst the Senior ICN continued the interim role of Decontamination Lead.

4. ASSURANCE ACTIVITIES

The IPCC monitors the action plan on behalf of the Trust Board, which is achieved through the following actions:

- Agree an annual infection control programme and monitor its implementation
- Oversee the implementation of infection control policies and procedures
- Monitor and review the incidence of HCAI
- Develop and review information regarding infection prevention and control
- Monitor the activities of the IPCT (Infection Prevention and Control Team)
- Benchmark the Trust's delivery of control of infection standards in various accreditation systems, and against CQC Regulations
- Monitor the implementation of infection prevention and control education
- Receive regular updates from the Antibiotic Reference Group (ARG)
- Receive regular updates from the IPCWG

- Monitor compliance and formal reporting on Legionellosis and Pseudomonas water management, via the Water Safety Group (WSG)
- Receive regular reports from the Decontamination Working Group (DWG)
- Provide regular assurance reports to the CGC

5. HEALTHCARE ASSOCIATED INFECTION (HCAI) MANAGEMENT & STATISTICS

5.1 HCAI

The investigation and management of communicable and hospital acquired infections in the Trust is the role that is most often associated with infection control and is an important and visible function of the service.

The Trust is required to report any HCAI outbreaks externally as a serious incident (SI). An outbreak is defined as the occurrence of two or more related cases of the same infection over a defined period. When a HCAI outbreak is declared, the Trust initially reports the outbreak to the relevant Clinical Commissioning Group (CCG) and other regulatory bodies, e.g. NHS Improvement, within 2 working days, and must undertake an investigation and submit a formal written report within 45 working days.

The Trust is also required to record these incidents on the strategic executive information system (STEIS) in line with the Serious Incident Framework: Supporting learning to prevent recurrence (NHS England, 2015), and the Health Protection Agency HCAI Operational Guidance & Standards (2012), Health Protection Agency now Public Health England (PHE) from 1st April 2013.

During quarters 1 and 2 of 2018/19, the Trust has had **no** declared outbreaks of:

- Viral gastroenteritis (Norovirus)
- Clostridium difficile (C.difficile)
- *Staphylococcus aureus*, including Methicillin Resistant *Staphylococcus aureus* (MRSA)
- Methicillin Sensitive Staphylococcus aureus (MSSA)
- Carbapenemase producing enterobacteriaceae (CPE)
- Invasive Group A Streptococcus (iGAS)
- Multi-drug resistant Acinetobacter baumannii (MDRAB)
- Chickenpox (Varicella zoster)
- Extended Spectrum Beta Lactamase (ESBL) producers, including Klebsiella Pneumoniae
- Pertussis
- Respiratory Syncytial Virus (RSV)
- Vancomycin Resistant Enterococcus (VRE)
- Tuberculosis (TB)

Additional information regarding alert organisms can be accessed from the Public Health England (PHE) website: https://www.gov.uk/government/organisations/public-health-england

The ICNs provide clinical teams with infection control advice, support and education on a daily basis to all inpatient areas. The management of patients admitted with suspected and known alert organisms is discussed, and risk assessments undertaken. The Isolation Risk Assessment Tool (IRAT), Flowchart for the Management of Inpatients with Diarrhoea, and Diarrhoea Pathway have been developed and implemented to assist staff competency and confidence in the management of cases.

The availability of sideroom facilities across the Trust site to isolate infected patients can be limited at times when demands on capacity are high. In such instances, risk based decisions are necessary. Patients with alert organisms can be safely managed either within cohort bays, or isolation nursed in a bed space. The ICNs continue to review patients nursed in siderooms on a daily basis to prioritise high risk patients. Information and guidance is communicated to the ward nursing and medical teams and the Clinical Site Coordinators, with additional written documentation provided to support staff in the ongoing management of these patients.

6. MANDATORY SURVEILLANCE

6.1 Surgical Site Infection Surveillance (SSIS)

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust.

Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved, in at least one of these categories listed below:

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

The Trust complies with this annual requirement to undertake SSIS. Formal reports outlining progress with SSIS were presented at the IPCC meetings and disseminated to relevant Trust personnel. There were no identified deep infections for knee replacement surgery during quarters 1 and 2 of 2018/19.

6.2 Methicillin Resistant *Staphylococcus aureus* (MRSA)

The PHE Mandatory enhanced MRSA bacteraemia surveillance scheme (updated March 2016), is used to measure the effectiveness of infection prevention and control practices in all NHS Trusts. The rationale for the surveillance is that it is sometimes difficult to distinguish between colonisation and true infection caused by MRSA, but culture of the bacterium from blood almost always represents significant infection.

The Trust has continued to report MRSA screening rates for all elective and emergency admissions to ensure continued improvement in reducing infections. These screening compliance rates are monitored by the Directorate Management Teams (DMTs) and reported as a KQPI. The ICNs undertake a monthly emergency admission MRSA screening audit, and a quarterly elective admission MRSA screening audit.

Feedback is provided to DMTs about compliance rates and any identified missed screens for follow up actions. The Trust compliance rate for MRSA emergency screening ranged from 80.89 – 91.2% and for MRSA elective screening, 82.75 – 84.51%. Outcomes of any follow up of actions undertaken by the clinical directorates are included within their current reporting processes and to include any shared learning.

The Trust reports mandatory enhanced surveillance in line with PHE requirements onto the national HCAI Data Capture System (DCS) website. The Trust adheres to the classification of cases in accordance with the set definitions. This is applicable to MRSA bacteraemia cases and C.difficile cases, and differs from previous classification reporting formats. Results are provided in the summary below, and include the definitions of ‘Trust apportioned’ cases and ‘non-Trust apportioned’ cases. The Trust's MRSA Trust apportioned cases target for 2018/19 is zero.

During quarter 2 of 2018/19, PHE revised the apportionment algorithm to reflect how data is presented on the HCAI DCS website. ‘Trust apportioned’ has changed to ‘Hospital-onset’ and non-Trust apportioned has changed to ‘Community onset’. This has not changed the way the algorithm works; it is simply the name change. This will be reflected within the next DIPC report.

MRSA Bacteraemia Trust apportioned cases include patients that are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **3 or more** days after date of admission (admission date is considered day ‘1’).

Non-Trust apportioned cases include all cases that are **NOT** apportioned to the acute Trust.

Table 1: Breakdown of total number of Trust cases recorded April 2018 to September 2018 (Figures in brackets show number of cases recorded April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**0 (0)**	**1 (0)**	**0 (0)**	**0 (0)**	**0 (0)**	**0 (0)**							**1 (0)**
Non Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**0 (0)**
Trust apportioned cases	0 (0)	1 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**1 (0)**

During May 2018, a Trust apportioned MRSA bacteraemia case was identified for an inpatient within the surgical directorate (Downton Ward) and a post infection review (PIR) investigation process was undertaken.

The purpose of the PIR process was to review the patient information and data collected following the identification of the MRSA bacteraemia case. The review process included the participation of key personnel from the Trust, and communication with the relevant staff groups. A meeting was held and followed the format of the MRSA bacteraemia PIR toolkit with direct group discussion, in order to populate the document in full and agree any identified actions. It was emphasised that the meeting and PIR process should be viewed as a positive learning exercise.

Key learning from the PIR investigation:

1. The case was not linked with any other cases.
2. In addition to the completion of the PIR toolkit, an action plan was generated and learning outcomes agreed by the relevant personnel/DMTs:
    a. For a full MRSA screen to be completed for all emergency admissions to the Trust, and ensure that all required sites are included and documentation reflects the actions taken.
    b. Ensure all staff aware of Trust policy regarding the requirement to commence prescribed topical decolonisation therapy in a timely manner with no delay, once positive MRSA result identified.
    c. Ensure all staff aware of Trust urinary care bundle for indwelling catheter devices.
    d. Ward team to liaise with the Urology Nursing Team and other NHS Trusts regarding the management and care of supra-pubic catheters and sites.
    e. Reinforce the importance of hand hygiene and ensure all staff up to date with hand hygiene assessment.

Progress updates for the agreed actions plan are to be provided to the IPCWG by the directorate and shared across the Trust at appropriate forums. There is also identified work for the IPCWG around the ongoing revision of the Trust Peripheral cannulation policy to ensure that all the appropriate actions including documentation and care requirements are included. This work will be completed by April 2019.

Following this MRSA bacteraemia case, the Trust will **not** be reducing the number of MRSA screens for patients **not** admitted to identified ‘high risk’ areas, as per Department of Health (DH) guidance (2015), as previously reported.

6.3 Clostridium difficile

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply DH guidance for C.difficile testing and the previously agreed revised C.difficile testing and reporting algorithm. All C.difficile positive stool samples that test toxin positive are reportable to PHE. (Of note: from April 2017, changes were made regarding the mandatory reporting requirements for Trusts. This is in relation to the classification of C.difficile cases with a focus on previous healthcare interactions/episodes. Following further clarification from PHE, the definition of Trust apportioned and non-Trust apportioned cases has not changed).

In accordance with PHE definitions, C.difficile Trust apportioned cases include patients that are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **4 or more** days after date of admission (admission date is considered day '1').

Non-Trust apportioned cases include all cases that are **NOT** apportioned to the acute Trust.

All patients with a stool sample confirming the presence of C.difficile require the implementation of strict infection control measures and practices e.g. isolation nursing in a sideroom facility, the completion of terminal and enhanced cleaning by Housekeeping and a review by the relevant clinicians to determine if C.difficile treatment is indicated. The formal reporting process to PHE is managed by the ICNs under direction of the DIPC and ICD, and has had an impact on the team's workload.

Table 2 below relates to the breakdown of all inpatient reportable cases of C.difficile and **Table 3** relates to the total reportable cases of C.difficile recorded by the Trust

Table 2: Breakdown of reportable cases recorded for all inpatients April 2018 to September 2018 (Figures in brackets show number of inpatient reportable cases April 2017 to September 2017)

	Quarter 1			**Quarter 2**			**Quarter 3**			**Quarter 4**			**Total**
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**0 (1)**	**1 (1)**	**0 (2)**	**0 (0)**	**3 (0)**	**0 (2)**							**4 (6)**
Non Trust apportioned cases	0 (0)	1 (1)	0 (2)	0 (0)	2 (0)	0 (1)							**3 (4)**
Trust apportioned cases	0 (1)	0 (0)	0 (0)	0 (0)	1 (0)	0 (1)							**1 (2)**

Table 3: Breakdown of total number of reportable C.difficile cases recorded April 2018 to September 2018 (Figures in brackets show total number of reportable cases recorded April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Inpatients	**0 (1)**	**1 (1)**	**0 (2)**	**0 (0)**	**3 (0)**	**0 (2)**							**4 (6)**
Community Hospitals	1 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**1 (0)**
General Practitioners (GPs)	0 (1)	0 (2)	2 (2)	1 (0)	1 (1)	1 (0)							**5 (6)**
Residential/Nursing Home	0 (0)	0 (0)	0 (0)	1 (0)	0 (0)	0 (0)							**1 (0)**
Other (e.g. Coroner, Private Hospital, Day Attender, ED, Outpatient)	1 (0)	0 (0)	0 (1)	0 (0)	0 (0)	0 (0)							**1 (1)**
Total	**2 (2)**	**1 (3)**	**2 (5)**	**2 (0)**	**4 (1)**	**1 (2)**							**12 (13)**

(Of note: In a single patient, a positive test occurring after a previous positive test is considered a new episode after 28 days).

For quarters 1 and 2 of 2018/19, the Trust has reported one Trust apportioned C.difficile case, which does not exceed the target set for the Trust by NHS England of <18 for the full year. For each inpatient episode, an infection control incident investigation is completed using a 'SWARM' approach. This process has been led by the ICNs, with the increased involvement of nursing and medical staff in the relevant clinical areas and the Antimicrobial Pharmacist (or area Pharmacist), to complete the required documentation.

This aids ownership and identification of any learning that needs to be implemented by staff. The ICNs continue to provide additional support to facilitate this process. However, the directorate remain responsible for agreeing any resultant action plan and submitting progress with completion to the IPCWG members. Actions taken include continued patient education and completion of High Impact Intervention (HII) auditing, to ensure the safe management of these patients. Action is taken when non-compliance with Trust policy is identified.

Monthly 'Share & Learn' SWARM meetings have been held to facilitate shared learning, identify key themes and agree actions to contribute to the reduction the key areas of falls (with major harm), hospital acquired pressure ulcers and Trust apportioned C.difficile cases. The group also advise the Clinical Risk Group (CRG) of any key concerns that are unresolvable at ward level and require escalation. Learning has identified improvements required for the use of the Diarrhoea Pathway and completion of stool chart; timeliness of patient reviews and sampling of symptomatic patients. (Of note: since quarter 2 of 2018/19, other Trust apportioned HCAI cases are shared at these meetings).

C.difficile ward rounds have continued to be held by the ICNs with the involvement of the ICD and/or Consultant Microbiologist when available, with any concerns regarding antibiotic prescribing identified from the clinical visits followed up with the Antimicrobial Pharmacist. Attendees can include the DIPC, Deputy DIPC and Medical Director. These rounds provide an opportunity to formally review and assess the patient's progress and management in relation to C.difficile. This includes the review of previous C.difficile positive patients as well as current C.difficile positive patients. The ICNs also ensure that information is shared with the ward teams and this is supported by an entry within the patient healthcare records. The membership of this group has been reviewed, and a Gastroenterologist and Dietician will be involved as required.

During quarters 1 and 2 of 2018/19, no Trust apportioned reportable cases have been submitted to the 'Appeals Panel Process' for the relevant CCG. *(Of note: for the August case, the stool sample was sent to the Reference Laboratory for ribotyping. The result identified that C.difficile was not isolated from the specimen sent).*

6.4 Methicillin Sensitive *Staphylococcus aureus* (MSSA)

The Trust continues to report MSSA bacteraemia cases via the HCAI DCS website. Currently, there is no national guidance for data definition of MSSA bacteraemia cases for targets to be set. Therefore, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the MSSA bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 4: MSSA bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to September 2018
(Figures in brackets show number of cases recorded April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**5* (2)**	**3 (2**)**	**3* (1)**	**3 (6)**	**2 (1)**	**2 (1)**							**18 (13)**
Non Trust apportioned cases	2 (2)	2 (2)	2 (0)	2 (4)	2 (0)	2 (1)							**12 (9)**
Trust apportioned cases	3 (0)	1 (0)	1 (1)	1 (2)	0 (1)	0 (0)							**6 (4)**

**May 2017 – 2 additional MSSA bacteraemia cases noted: one identified from blood cultures taken whilst the patient was attending Salisbury Dialysis Unit and later admitted to the Trust via the Emergency Department (ED): one identified from blood cultures taken whilst the patient was attending an outpatient clinic, and later admitted to the Trust from the clinic.
*April 2018 – 1 additional MSSA bacteraemia case noted: identified from blood cultures taken whilst the patient was attending an outpatient clinic, and not admitted to the Trust from the clinic. However, the patient was admitted after the positive result was identified.
*June 2018 – 1 additional MSSA bacteraemia case noted: identified from blood cultures taken whilst the patient was attending Salisbury Dialysis Unit.

During quarters 1 and 2 of 2018/19, there have been six Trust apportioned cases identified. The ICNs undertake an infection control incident investigation for all Trust apportioned inpatient cases, in conjunction with relevant staff from the clinical area concerned. Emphasis has been placed on the need for continued monitoring of all invasive devices by staff, adherence to the relevant Trust policies relating to the taking of blood cultures and skin disinfection/decontamination and maintaining the required care documentation.

6.5 Gram-negative bloodstream infections (GNBSIs)

6.5.1 Escherichia coli (E.coli)

The Trust continues to input enhanced surveillance data for E.coli bloodstream infections (BSI) in accordance with current guidance from the DH and PHE. From 1st April 2012, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the E.coli bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 5: E.coli Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to September 2018 (Figures in brackets show total number of cases recorded from April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**4 (9)**	**4 (9)**	**6 (10)**	**8 (8)**	**4 (9)**	**7 (9)**							**33* (54)**
Non Trust apportioned cases	3 (7)	4 (6)	5 (10)	5 (7)	2 (8)	7 (8)							**26 (46)**
Trust apportioned cases	1 (2)	0 (3)	1 (0)	3 (1)	2 (1)	0 (1)							**7 (8)**

*June 2018 – 1 additional E.coli bacteraemia case noted: identified from blood cultures taken for a patient at Newhall Hospital. The patient was later admitted to the Trust via the Emergency Department.

Following the identification of a positive blood culture result for E.coli, a Consultant Microbiologist completes a PHE mandatory enhanced surveillance form. In consultation with the relevant clinician, key patient factors are considered in order to establish if the case is likely to be healthcare related. However, it may not be possible to determine.

Of the 7 Trust apportioned cases identified during quarters 1 and 2 of 2018/19, two were unknown or unclear source of infection and the remaining five cases had a source of infection identified. Of these unrelated five cases, the sources of infection were:

- Lower respiratory tract (1 case)
- Urinary tract, including lower urinary tract (3 cases)
- Gastrointestinal, related to a surgical intervention/intra-abdominal (1 case).

The Trust recognises the importance of continuing improvement work with the appropriate recognition and treatment of infections and adherence with NICE guidelines. This data was entered onto the HCAI DCS website. Where concern is highlighted by the Microbiologist for an individual case, further investigation is undertaken by the ICNs. For these Trust apportioned cases, no further follow up was identified.

The Trust will continue to work towards reducing the incidence of these GNBSIs. The ICNs are working collaboratively with the relevant CCGs who are leading on achieving the Quality Premium (from April 2017, for 2 years), aiming to reduce all E.coli BSIs by 10% in year 1.

6.5.2 Klebsiella sp. and Pseudomonas aeruginosa

From April 2017, the incidence of GNBSIs for Klebsiella sp. and Pseudomonas aeruginosa reported at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work has been undertaken by the ICNs.

Table 6: Klebsiella sp. Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to September 2018 (Figures in brackets show total number of cases recorded from April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**2 (0)**	**0 (0)**	**3 (2)**	**3 (2)**	**2 (0)**	**2 (1)**							**12 (5)**
Non Trust apportioned cases	2 (0)	0 (0)	2 (2)	1 (2)	2 (0)	2 (1)							**9 (5)**
Trust apportioned cases	0 (0)	0 (0)	1 (0)	2 (0)	0 (0)	0 (0)							**3 (0)**

Table 7: Pseudomonas aeruginosa Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to September 2018 (Figures in brackets show total number of cases recorded from April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**0 (0)**	**1 (3)**	**3 (0)**	**1 (1)**	**0 (1)**	**0 (0)**							**5 (5)**
Non Trust apportioned cases	0 (0)	1 (2)	2 (0)	0 (1)	0 (1)	0 (0)							**3 (4)**
Trust apportioned cases	0 (0)	0 (1)	1 (0)	1 (0)	0 (0)	0 (0)							**2 (1)**

6.6 Infection in Critical Care Quality Improvement Programme (ICCQIP)

From April 2017, the Trust has participated in the surveillance of BSIs in patients attending the ICU and Neonatal Unit (NNU). Data collection and submission has previously been coordinated by the Lead ICU Nurse, with the support of the ICNs and involvement of the NNU staff. At the end of quarter 2 of 2018/19, the Senior ICN had taken over this data submission role in the interim until a permanent Lead Nurse in ICU is appointed. From the data submitted so far, no further updates have been provided by PHE.

6.7 Private Healthcare Information Network (PHIN)

The Trust is now mandated to report externally regarding private patients via PHIN. In relation to infection prevention and control, this involves the ICNs undertaking monthly cross checking of a dedicated SharePoint database of private patients. If it is identified that a patient has a HCAI that is externally reportable (as per national mandatory reporting definitions), then this is added to the SharePoint database for the relevant patient, for submission to PHIN by the Trust.

From the data reviewed and provided by the ICNs, there have been no externally reportable infection alert organisms identified for this patient group.

7. WATER SAFETY MANAGEMENT *(information for this section has been provided by Terry Cropp, Responsible Person (RP) for Water and Head of Estates)*
This section summarises the water safety management precautions that the Trust has taken over quarters 1 & 2 of 2018/19.

The Trust manages the safety of water systems in line with the Health Technical Memorandum (HTM) 04-01 (Pt B) Safe Water in Healthcare Premises and HTM 04-01 (Pt C) Pseudomonas (guidance for augmented care units), together with the technical guidance document HSG274 part 2.

To assist the management process in respect of the water systems across the site, regular meetings of teams (Responsible Person (RP) and designated Responsible Person (dRP) for water) from Estates Technical Services (ETS) and FES Ltd (PFI maintenance contractor) are held on a monthly basis, to review progress with planned preventative maintenance (PPM) and actions in respect of water safety.

The Trust continues to keep the domestic hot water temperature elevated above 65°C as a precaution in the challenge of Legionella control. The water systems within hospitals are complex; therefore the testing and controls we have in place are designed to mitigate the risks to our patients and staff.

Emergency review meetings have taken place in the Trust as a result of positive sample results, the actions and results of the ongoing checks have been circulated to senior members of the Trust in a series of emails as events occur, and as regular reports to the Water Safety Group (WSG) and IPCC. Actions taken have included the cleaning and disinfection of outlets with temperature checks and increased flushing where necessary (Durrington Ward and Pembroke Suite).

7.1 Achievements for quarters 1 and 2 of 2018/19
Capital funding (£250K) secured for significant investment in the facilities that generate the hot water for Maternity, Post Natal and Neonatal Unit (NNU). The existing systems/plant that feeds these areas is located in the Spinal Unit. This system is a challenge to maintain good temperature and circulation due to its size and the design. This vital work will improve the temperature and reliability of the system and will assist in the safe management of these water systems for these key wards and departments.

Continued improvements with the levels of flushing achieved of 'little used outlets'. This is being achieved by the use of dedicated 'Bank' staff that can support this without the risk of being diverted to other tasks, which was often the case when delivered solely by the ETS Operations Maintenance Assistants. Flushing compliance for quarters 1 and 2 of 2017/18, were recorded at 54.5%, for quarters 1 and 2 of 2018/19, 'Priority 1' recorded at 94.4% and 'Priority 2' recorded at 99.1% *(IPCC Reports for quarters 1 and 2 of 2018/19).*

Reduction in the leaks and subsequent impact on clinical services associated with drain blockages, though the total number of recorded incidents related to this is up by 17% in comparison to quarters 1 and 2 of 2017/18.

Formation of a Hydrotherapy Pool Group (Spinal Unit) which will meet six monthly (first meeting held on 11th June 2018) and will be supported by key members of the WSG and the Trust's Water Authorised Engineer (AE). A Hydrotherapy Pool Policy and 'Terms of Reference' have also been drafted.

7.2 Key challenges for quarters 3 and 4 of 2018/19

- Resolving the ongoing high counts from Legionella sampling in Durrington Ward, with the guidance of the Trust Water Authorised Engineer (AE). The water system is going to be disinfected on 24th October and then re-sampled.
- Maintaining the temperature of the hot and cold water systems across the Trust.
- Ensuring sufficient resource (labour and financial) to complete all PPM's directly associated with water safety.
- Engagement of key members of the WSG in supporting action plans and quarterly meetings of the WSG.
- Delivery of Competent Persons (CP) training for water safety, initial focus will be on CPs for ETS staff. This will include all grades from craft workers to maintenance assistants who work on and maintain the water systems.
- Continued work and messaging on the 'Prevention of Drain Blockages' with regular broadcasts and key meetings with the clinical teams.
- Completion of risk assessment for the sites water systems. This now required due to significant changes of the system allied to the ward reconfiguration project and includes the Acute Medical Unit (AMU) and Pembroke Unit.

8. HAND HYGIENE

All inpatient and outpatient clinical areas are required to undertake monthly hand hygiene audits. Compliance rates are calculated, and individual tables are produced for each area within the directorates. These are provided to clinical leaders, DMTs and DIPC via the monthly Matrons Monitoring Group (MMG) meetings.

To promote hand hygiene best practice, a Uniform Policy and Workwear Guidance including 'Bare Below the Elbow' (BBE) policy remains in place. Compliance with the policy and audit results is monitored by the DMTs and feedback provided to the DIPC.

The Trust target for hand hygiene compliance rates is >85%, with formal reporting by the directorates of measures implemented to improve non-compliance. This target is reflected in the clinical leaders and Directorate Senior Nurses (DSNs) personal objectives, with ongoing work required by the DMTs to sustain improvements. To promote hand hygiene compliance the ICNs continue to train identified staff and update the Infection Control Link Professionals (ICLPs) to undertake hand hygiene assessments for staff in their own areas. This has proved successful in raising the profile of hand hygiene behaviour and compliance with BBE. It also provides an alternative opportunity for staff to complete their annual mandatory hand hygiene assessment. The directorates are encouraged to share successes within individual areas at the MMG meetings.

Analysis of the hand hygiene audit data demonstrates that key factors influencing the compliance scores are:

- Non completion of audits by areas
- Non-compliance with hand decontamination in areas by all staff group, lowering the overall score for the area concerned (nursing staff, doctors, allied health professionals and other staff groups)

When compliance is poor, the ICNs support individual clinical areas and staff groups promoting patient safety and hand decontamination. The audit results continue to be disseminated according to staff groups for each area. This action has provided evidence to strengthen the feedback process for the directorates to take the necessary action.

The ICNs have continued to facilitate the completion of hand hygiene audits by an external auditor, the Healthcare Manager for GOJO Industries, across selected clinical areas. The external auditor utilised the World Health Organisation (WHO) hand hygiene audit tool, and assessed the hand hygiene practices of all staff groups against the '5 moments for hand hygiene':

- Moment 1: Before patient contact
- Moment 2: Before a clean/aseptic procedure
- Moment 3: After body fluid exposure risk
- Moment 4: After patient contact
- Moment 5: After contact with patient surroundings

For quarters 1 and 2 of 2018/19, the overall compliance rate from 15 external audits completed across 13 clinical areas at different times was 75.85%, with several areas being audited more than once during the quarters. This is a slight decrease on the previously reported overall compliance rate of 78.2% from 12 external audits completed across 10 clinical areas (several areas audited more than once).

Detailed analysis was undertaken to identify the key areas of non-compliance, which was predominantly staff missing moment number 5, handwashing after contact with patient surroundings. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

The 'Red, Amber and Green' rating for the hand hygiene compliance audits continues and includes actions to be identified for areas that do not achieve the 'pass threshold' of 85% or show improvements. This RAG rating was further revised and the impact of these measures is being monitored by the IPCWG, DMTs and MMG.

9. DECONTAMINATION *(information for this section has been provided by Fiona McCarthy, Interim Decontamination Lead)*

9.1 Progress against Decontamination Strategy

The Decontamination Strategy has been updated with regard to 2016 Health Technical Memorandum (HTM) guidance and a review of decontamination in terms of Essential Quality Requirements (EQR) and Best Practice (BP) is ongoing. Key objectives are reviewed at the Decontamination Working Group (DWG) meetings, and risk assessments are monitored and updated when necessary.

9.2 Activity to promote compliance with decontamination arrangements

- The Decontamination Policy is current and has been rewritten to reflect the joint venture, Salisbury Sterile Services (SSL), and new HTM regulations.
- Local decontamination audits and standard operating procedures (SOP) development continues.
- Tray tracking for instrumentation is in place and software for endoscope traceability is being developed for potential implementation.
- Theatre tray wraps have changed from linen to paper although there are still a number of holes being reported. Audits have been undertaken to review practice through from SSL to receipt/storage and use in the Main Theatres Department (MTD) to identify if there are any trends in damaged wraps. An action plan detailing the work undertaken has been created as additional evidence.
- A trial to use a 'Vac pack' system in MTD has been implemented to create storage capacity within the department.
- The use of an agreed 'moisture spray' has been implemented for used instrumentation in MTD, Day Surgery Unit (DSU) and Obstetrics Theatre due to potential collection delays.
- Instrument inventory review continues with tray rationalisation in orthopaedic theatres and the use of caskets. To support and progress this work, a Surgical Instrument Coordinator, commenced in post during quarter 1 of 2018/19.
- SSL are laser marking identified individual instruments for tracking purposes.
- SSL continue to process flexible endoscopes as per HTM 01-06. During quarters 1 and 2 of 2018/19, the 5 endoscope washer disinfectors (EWDs) have all been out of use at one point due to failures and high total viable count (TVC) levels. This is largely due to the age

of the machines and the constant use of them; more so when one or more is out of use. Contingency plans and actions to maintain the current service are regularly discussed.

9.3 Decontamination Audit plan

- Re-audits have been performed in 10 areas during quarter 2 of 2018/19 and have included: Breast Care Unit, Dermatology Treatment Centre, Emergency Department, Gynaecology Clinic, Radnor Ward (ICU), IT devices, Laser Clinic, Maternity Unit, Neonatal unit and Urology Clinic. Most areas have provided good assurance for compliance with local decontamination processes as per agreed SOP created following their first audits in 2017/18. Other areas have been asked to provide additional evidence. Findings and updates on identified actions from these audits are discussed and fedback direct to the areas (including DMTs), and reported to the DWG.
- Post procedure cleaning (PPC) and manual high level disinfection of nasoendoscopes has been revisited with the Ear Nose and Throat (ENT) Outpatients Department (OPD) following 2 decontamination incidents reported. SOPs have been reviewed and fully accepted by the relevant departments.
- SOPs are also in use for a number of other areas performing agreed local decontamination of devices including Spinal pressure clinic, Dermatology Unit, Vascular OPD, Radnor Ward (ICU), Urology Clinic and Medical and Surgical OPD.
- Standards for the decontamination of semi-invasive ultrasound probes used intra cavity or on broken skin have been followed up with Vascular OPD and Radiology Departments. Since July 2018, the Radiology Department have been using an automated decontamination process for probes using Trophon Units (Trust owned). The Lead for Radiology Ultrasound has secured an ongoing revenue budget for consumables.
- There is ongoing work required to ensure robust processes are in place to ensure that the decontamination processes for Transvaginal Ultrasound (TVUS) probes meet EQR as a minimum. The Decontamination Lead has been working with the department and a decision regarding meeting EQR/BP is to be expedited through DMT.

9.4 Joint Advisory Group (JAG) Accreditation Inspection for Endoscopy Services

Following this inspection during August 2018, re-accreditation had been deferred for 6 months. A 'Task & Finish' Group has been established to address the actions identified to ensure a robust response with the measures and evidence required. This included improvements with data collection systems across the Endoscopy Suite and SSL Department.

9.5 Maintaining a fully compliant sterilisation facility (SSL)

The Decontamination Lead continues to attend a monthly SSL Operational Management Board (OMB) and also meets weekly with SSL to discuss any issues arising. Implementation of HTM guidance for endoscope process challenge checks and residual protein testing of instrumentation needs to be managed between SSL and Estates Technical Services (ETS).

9.6 The Decontamination Working Group (DWG)

The DWG continue to meet quarterly and during 2017/18, the Terms of Reference including membership were reviewed in light of recommendations from the TIAA audit undertaken during 2017/18. The DWG reports up to the IPCC.

9.7 Key challenges for quarters 3 and 4 of 2018/19

- Continue with the agreed local decontamination audits and development of SOPs.
- Agreed SOP for the decontamination processes for TVUS probes used within the Fertility Clinic.
- To progress with the development and implementation of software for endoscope traceability.
- Completion of actions identified from the JAG inspection to obtain full re-accreditation of the Endoscopy Services.
- Reduction in the number of incidents related to holes in theatre tray wraps.

- Continue instrument inventory review and tray rationalisation in orthopaedic theatres and the use of caskets.
- To support maintaining safe and functional decontamination equipment (EWDs) within SSL as part of the joint venture working.
- Full implementation of HTM guidance for endoscope process challenge checks and residual protein testing of instrumentation.

10. CLEANING SERVICES *(information provided by Michelle Sadler, Facilities Manager)*
This section summarises the key components of the Trust's cleaning programme, to ensure the provision of a safe clean environment for patients and their relatives, visitors and staff. This ongoing work is provided by the Housekeeping Department and Facilities Directorate.

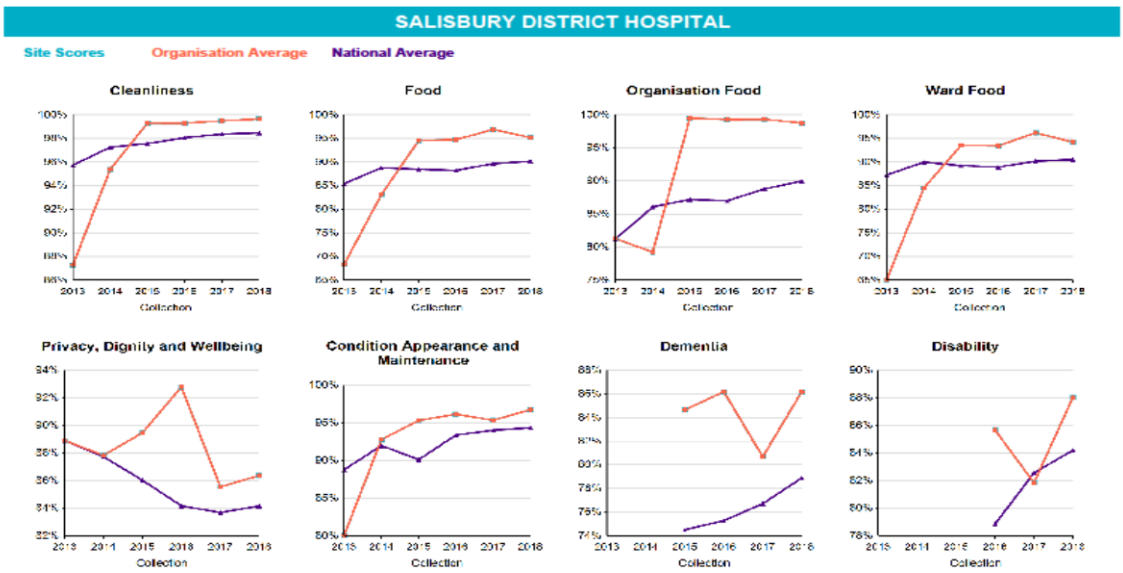
10.1 Patient led assessment of the care environment (PLACE) internal audits
The Trust has developed and implemented a programme of PLACE audits for 2018/19 and plans to undertake 58 internal PLACE assessments between June 2018 and March 2019 using the PLACE criteria.

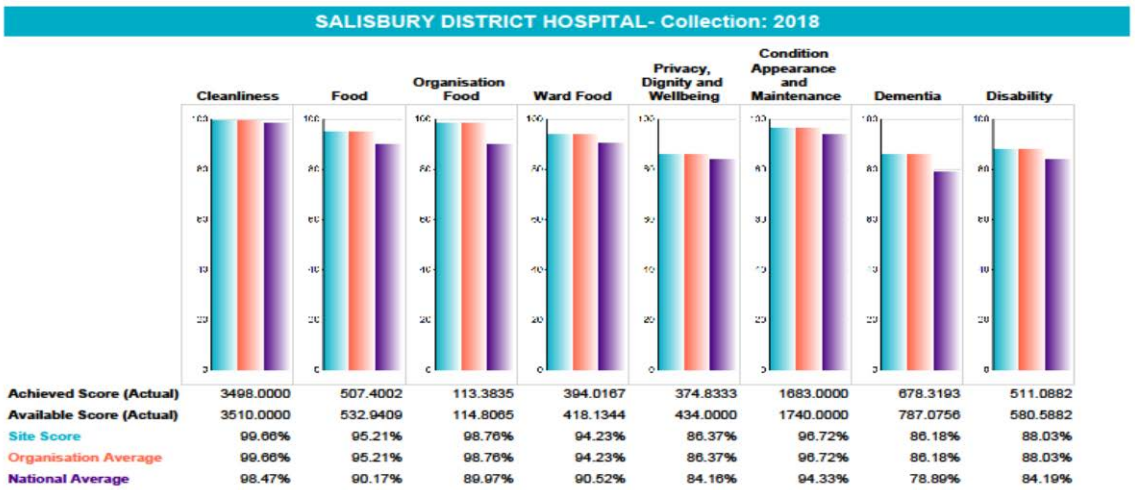
We continue to achieve active engagement and good support from Governors, Volunteers and the local Health watch representatives to undertake the audits. Each ward produced their own action plans and reported progress via MMG meetings. Focus is given to themes from the ward or department and learning that can be shared with other areas. The PLACE internal audits have produced evidence that supports capital bids and decorating programmes so funds are appropriately allocated. The Dementia Lead for the Trust has also engaged with the PLACE programme, with a joint approach to environmental aspects to ensure this patient group is well supported within these criteria. A table top PLACE exercise is now also being undertaken at the planning stage, with ETS and ArtCare, for any new/refurbished departments and/or wards to better ensure that consideration is given to the criteria prior to its building completion.

The result of each assessment is submitted using the PLACE 'Lite' Tool linked to the Health and Social Care Information Centre.

10.2 National PLACE
The Trust participated in the National PLACE assessment on 10th May 2018. A total of 10 wards and the Emergency Department (ED) were visited, 4 food assessments undertaken, 6 outpatient areas as well as external spaces and communal areas were also assessed as required under the PLACE criteria. The results reflect improvements have been made in most areas. The Trust score was published in August 2018. The results from PLACE are analysed and key themes form the basis of improvement plans within the Trust. Below are the Trust scores against the national average for 2018.

2018 PLACE results with National Average





	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3498.0000	507.4002	113.3835	394.0167	374.8333	1683.0000	678.3193	511.0882
Available Score (Actual)	3510.0000	532.9409	114.8065	418.1344	434.0000	1740.0000	787.0756	580.5882
Site Score	99.66%	95.21%	98.76%	94.23%	86.37%	96.72%	86.18%	88.03%
Organisation Average	99.66%	95.21%	98.76%	94.23%	86.37%	96.72%	86.18%	88.03%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%

10.3 Deep clean programme and rapid response team

The deep clean and decorating programme commenced in May 2018 (a copy of the Deep Clean programme is available from the Housekeeping Department). A monthly review of this plan is undertaken at MMG and discussed with the ICNs and DSNs at weekly meetings.

Concerns have been raised that the Housekeeping Team cannot access a number of bays and siderooms due to bed pressures. For those areas that are not deep cleaned, a contingency “scrub” plan of action has been agreed. This contingency scrub plan will continue to be monitored to better ensure all areas have a level of annual deep clean. These areas will be prioritised should they

become available and the deep clean and hydrogen peroxide vapour (HPV) treatment will be undertaken.

10.4 Improvement work over the past 6 months
The Housekeeping Management Team submitted a capital bid for the purchase of a replacement hydrogen peroxide vapour (HPV) system. This bid was successful and the Trust purchased two Bioquell HPV systems to support the decontamination of potentially infected areas. Training was undertaken in June and July 2018 and the Bioquell systems were operational in August 2018. The Bioquell system calculates the capacity of each room/area and items present to determine the duration of the cycle. To date this has reduced the duration of time to decontaminate a sideroom facility by approximately 1 hour.

Housekeeping were successful in achieving a PLACE score average, the national average (SFT 99.66% = National average 98.38%), at a cost significantly lower than the peer group average (Estates Return Information Collection (ERIC) scores for 2018: SFT = £29.23 per square metre, and ERIC medium = £38 per square metre).

A saving of £15k per annum was achieved by the reduction of office cleaning for non-clinical areas. Housekeeping now delivers a service to these communal areas (kitchen/bathrooms/emptying of communal bins) and visit non-clinical offices less frequently.

During the past six months, the Housekeeping Team supported the response for the two major incidents, with a significant demand upon resources. Decontamination was undertaken in all areas across the Trust and all the necessary documentation/paperwork fully completed as a record of this work. In addition to the Actichlor plus clean, a '50/50' bleach clean was also required in a number of areas. The number of cleans linked to the major incidents totalled 213.

Housekeeping have undertaken 2501 terminal cleans in the past 6 months with only 14 falling outside of our key performance indicators (KPIs), to commence the clean within 3 hours of request. 99% of terminal cleans commenced within 3 hours.

10.5 Challenges for the coming 6 months
Recruitment and retention remains a challenge going forward as we continue to have limited applicants for vacant posts. The tendered staff agency supplier is unable to provide sufficient staff to meet our demand. There will be a continued drive to promote this role over the coming months with the increase challenge of winter pressures and the uncertainty around the proposal to create a wholly owned subsidiary.

A continued increase in the number of terminal cleans proves to be an ongoing challenge with the continued need to review and redeploy staffing to meet the demand to turnaround bed spaces quickly.

11. ANTIBIOTIC STEWARDSHIP *(information for this section has been provided by Louise Williams, Principal Pharmacist Antibiotics)*
11.1 Achievements for quarters 1 and 2 of 2018/19
Over the last 6 months the Antibiotic Reference Group (ARG) has focused on reducing the impact of serious infections (Antimicrobial resistance and sepsis) Commissioning for Quality and Innovation (CQUIN) as well as ensuring our antimicrobial guidelines are up to date. We have continued to carry out our fortnightly antimicrobial audits where we use this opportunity to feed back to prescribers on the ward and also identify areas where antibiotic reviews are not completed in line with the CQUIN.

CQUIN part 2c – Antibiotic review: Assessment of clinical antibiotic review between 24 – 72 hours of initiation in patients with sepsis who are still inpatients at 72 hours: We met our quarter 1 target of 25% with 70.2% of the prescriptions audited having a documented antibiotic review within 24 –

72 hours that met all three criteria. We hope to achieve our quarter 2 target of 50%. The results of the quarter 2 audit will be available shortly.

CQUIN part 2d – Reduction in antibiotic consumption as Defined Daily Doses per 1000 admissions:
This is divided into 3 parts:

- *Reduce all antibiotics – Reduction in antibiotic consumption per 1000 admissions:* This part of the CQUIN is most challenging for us. Our target for reducing antimicrobials is to achieve a 2% reduction in total antibiotic usage compared to our 2017/18 target. So far our rolling data for quarters 1 and 2 of 2018/19 suggests we have seen an increase of 8.7% in our antibiotic usage.
- *Reduce Carbapenems* – We achieved an excellent reduction in Carbapenems last year and so this year the target is to maintain that 12.5% reduction. Our Carbapenem usage is very small and so one or two patients can dramatically affect the results. So far, however, our usage has remained low with quarter 1 and 2 data suggesting a 17.9% reduction compared to our 2017/18 target.
- *Increase Proportion of antibiotics in the Access group of the AWaRe category* – The new target for part of the part 2d CQUIN is to increase the proportion of narrow-spectrum antimicrobials. All antibiotics have been divided into 3 categories – Access, Watch and Reserve. The target is to have at least 55% of our total antibiotic usage in the Access group or increase by 3% from 2016 calendar year data. Our 2016 data shows we had 50.17% of our antibiotics in the Access group therefore we need to increase this to 53.17%. Data for quarters 1 and 2 of 2018/19, shows a small increase to 50.3%. We need to review all our antimicrobial policies to ensure we are encouraging the use of antibiotics in the Access group of the AWaRe list. Due to workload and time constraints, this is proving challenging.

To raise awareness of the new CQUIN, a Consultant Microbiologist and the Antimicrobial Pharmacist attended clinical governance sessions for Medicine, Urology, Orthopaedics, Spinal and Elderly care. We updated the Consultants on the requirements of the new CQUIN and the challenges facing us with antimicrobial resistance. Feedback suggested that as part 2c of the CQUIN required specific documentation of an antibiotic review, a sticker may be helpful for the notes that can be completed on the ward round. A sticker has therefore been designed, approved at ARG and the Drugs and Therapeutics Committee (DTC) and is currently at the printers.

The Trust has recently approved the funding for Multiguide, a new platform and application which will replace the Integrated Clinical information Database (ICID). All antimicrobial guidelines will transfer to Microguide. Use of this application in University Hospitals Southampton (UHS) led to a reduction in the prescribing of high-risk broad-spectrum antibiotics from 40% to 28% and we are hoping for similar success here.

We would like to carry out an antimicrobial ward round in order to try and reduce inappropriate antibiotic prescribing. Last year we carried out a successful pilot of an antibiotic ward round with a Consultant Microbiologist and the Antimicrobial Pharmacist. This, along with other published evidence, suggested a ward round reduces the usage of antibiotics by stopping inappropriate courses and encourages switching from Intravenous (IV) to oral antibiotics sooner, resulting in a potential reduction in length of stay and nurse time savings.

11.2 Action plan
We plan to roll out the use of the CQUIN antimicrobial review stickers as soon as they are delivered from the printers. We hope this will help achieve part 2c of the CQUIN, which will become more challenging as the year progresses.

The Microbiology Team have produced a business case to increase resources available. The aim of this would be to implement a Consultant Antimicrobial ward round to try and achieve the benefits described above.

This year, 'World Antibiotic Awareness' week takes places from the 12th – 18th November 2018. We annually plan a campaign to raise awareness of the need to use antibiotics responsibly and this year will be planning a range of actions to promote awareness, including the use of posters throughout the hospital, the Pharmacy Team engaging with staff on the wards and via a Broadcast message.

12. AUDIT

In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme. The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have been involved with the following audit work during quarters 1 and 2 of 2018/19, including the follow up and outcomes from auditing against infection control policies. Final reports are generated for each completed audit, with resulting action plans approved by the IPCWG before submission to the IPCC and Clinical Management Board (CMB):

- *Handling and Disposal of Linen Reaudit* – data collection was completed during quarter 1. A breakdown of results for each of the clinical areas identified key themes relating to storage of clean and used linen, and practices including the wearing of personal protective equipment (PPE).
- *'Perfect Ward' Application'* – The ICNs continue to complete IPC inspections for 20 identified clinical areas. Findings are fedback verbally to the clinical leader/nurse in charge at the time with instruction to access the results report to identify any required actions. The results are also available for the DSNs to access (via the app), with formal reports fedback via MMG meetings. (Completion of these audits has been in addition to the 'spot checks' and observational practice audits undertaken by the ICNs during daily clinical visits to ward areas).

13. EDUCATION AND TRAINING ACTIVITIES

It is widely recognised that ongoing education in infection control is required in order to improve healthcare worker compliance with infection prevention and control practices. The ICNs undertake a number of induction and educational updates to a wide range of key staff within the Trust. The ICNs keep attendance data from these sessions and supports the Trust in its delivery of mandatory education for all staff. The infection prevention and control (IPC) computer based learning (CBL) package is accessible for all staff on the management learning environment (MLE) via the Trust intranet site.

During quarters 1 and 2 of 2018/19, the ICNs continued to work with the Education Department to review the compliance data generated from the MLE system for both hand hygiene assessments (HHA) and IPC CBL modules. Further cleansing of the data was stipulated by the DIPC and this was progressed with the Education Department. Compliance scores, 80% for staff completion of hand hygiene assessments and 92% for staff completion for IPC CBL package (MLE) as of 1st October 2018.

The ICNs have continued to focus on the promotion of opportunities for staff to complete their hand hygiene assessment. This has included arranging extra sessions within specific work areas and enabling identified staff to be trained to undertake hand hygiene assessments. Furthermore, the clinical directorates facilitated the completion of hand hygiene assessments for staff by utilising a ultra-violet (UV) light box for rotation through their directorate areas and departments.

The ICNs have contributed to formal and informal teaching sessions within clinical areas and other Trust departments. These include core induction sessions in addition to specific topic requests. The facilitation of learning has also involved members of staff shadowing of the ICNs in addition to the monthly scheduled ICLP meetings. Details of education opportunities provided are available from the ICNs.

14. CONCLUSION

This six monthly update report has provided the Trust Board with evidence of the measures in place that have made a significant contribution to improving infection prevention and control practices across the Trust.

The report has detailed the progress against the Action Plan for 2018/19 in reducing HCAI rates for the Trust and the key priorities have included:

- Continued focus on the reduction of all reportable Trust HCAIs and ensure preventable infections are avoided.
- Ongoing reinforcement to improve compliance with hand hygiene practices and behaviours.
- Continued focus on antimicrobial stewardship.
- Monitor and manage decontamination services.
- Sustain progress with education, training and audit relating to infection control practices and policies.
- Monitor and manage water safety.
- Maintaining a clean and safe environment for patients and staff through the Trust Housekeeping service.

APPENDIX A

Infection Prevention & Control – Annual Action Plan 2018/19

Please note: The numbering **does not** depict the order of priority for the Trust, but reflects the numbered duties within the Hygiene Code.

Domain and Key Actions	Who By	Status
1 Management, Organisation and the Environment **1.1 General duty to protect patients, staff and others from HCAIs** **1.2 Duty to have in place appropriate management systems for Infection Prevention and Control**		
Continue to promote the role of the DIPC in the prevention & control of HCAI	Chief Executive	Continuous
DIPC as Chair of the Infection Prevention and Control Committee	Chief Executive	In place
Lead infection prevention & control in the Trust and provide a six monthly public report to the Trust Board	DIPC	In place
Monitor and report uptake of mandatory training programme	IPCT	In place
Continue contribution to implementation of the Capacity Management policy	DIPC	In place
Ensure a programme of audit (incorporating Saving Lives High Impact Interventions) is in place to systematically monitor & review policies, guidelines and practice relating to infection prevention & control	IPCWG/IPCC	Monthly
Continue to review staffing levels via Workforce Planning	DDIPC	Continuous
Complete bedpan washer replacement and dirty utility room upgrade programme within the Trust (for inpatient clinical areas), including the Spinal Unit.	DIPC	Complete
1.3 Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks		
Maintain the role of DIPC as an integral member of the Trust's Clinical Governance & risk structures (including Assurance Framework)	Chief Executive	Continuous
Ensure active maintenance of principle risks relating to infection prevention and control, and that the system of Root Cause Analysis (RCA) is used to review risks relating to these	DIPC/JH/IPCT	In place
Active Surveillance & Investigation:		
Continue implementation of mandatory Surveillance Plan for HCAI & produce quarterly reports for IPCC	ICNs	In place
Review implementation of 'alert organism' & 'alert condition' system	JH/SC/PR	Continuous
Use comparative data on HCAI & microbial resistance to reduce incidence & prevalence	JH/SC/PR	In place
Promote liaison with Public Health England (PHE) for effective management & control of HCAI	DIPC/JH/IPCT	Continuous

Domain and Key Actions	Who By	Status
1.4 Duty to provide and maintain a clean and appropriate environment for health care		
Ensure maintenance and monitoring of high standards of cleanliness via policy management and audit, and environmental audits	DIPC/IR/MS	Monthly
Review schedule of cleaning frequency and standards of cleanliness, making them publicly available	DIPC/IR/MS/ Matrons	Monthly
Ensure adequate provision of suitable hand washing facilities, hand products/alcohol gel and continued implementation of 'WHO - Five Moments' and use of 'CleanYourHands' resources	IPCT	Continuous
Continue IP&C involvement in overseeing all plans for construction & renovation	TC	Continuous
Ensure effective arrangements are in place for appropriate decontamination of instruments and other medical devices/equipment	DIPC/FM	Continuous
Ensure the supply and provision of linen and laundry adheres to health service guidance	IR	Continuous
Ensure adherence to the uniform and BBE policies and workwear guidance through audit and formal reporting via the monthly Matrons Monitoring Group meetings	DIPC/DSNs	Continuous
1.5 Duty to provide information on HCAIs to patients and the public **1.6 Duty to provide information when a patient moves from one health care body to another** **1.7 Duty to ensure co-operation**		
Ensure publication of DIPC report via the Trust website	DIPC	6 monthly
Review Capacity Management policy & documentation to ensure communication regarding an individual's risk, nature and treatment of HCAI is explicit	DIPC	Completed
Include obligations under the Code to appropriate policy documents	DIPC	Ongoing
1.8. Duty to provide adequate isolation facilities		
Continue implementation and monitoring of the Isolation policy and monitoring of practice via audit	DSNs/IPCT	Ongoing
1.9. Duty to ensure adequate laboratory support		
Ensure the microbiology laboratory maintains appropriate protocols and operations according to standards acquired for Clinical Pathology Accreditation	JH/SC/PR	Continuous

Domain and Key Actions	Who By	Status
1.10 Duty to adhere to policies and protocols applicable to infection prevention and control		
Core policies are:		
Standard infection control precautions	ICNs	In place
Aseptic technique	ICNs	In place
Major outbreaks of communicable infection (Outbreak policy)	ICNs	In place
Isolation of patients	JH	In place
Safe handling and disposal of sharps	PK/GL	In place
Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	ICNs	In place
Management of occupational exposure to BBVs and post exposure prophylaxis.	PK	In place
Closure of wards, departments and premises to new admissions (Outbreak & Capacity Management)	SK	In place
Disinfection policy	MS	In place
Antimicrobial prescribing	JH/LW	In place
Mandatory reporting HCAIs to the HPA	JH	In place
Control of infections with specific alert organisms; MRSA and C.difficile	IP&CT	In place
Additional policies:		
Transmissible Spongiform Encephalitis (TSE)	JH	In place
Glycopeptide Resistant Enterococcus (GRE)	JH	Included in
Acinetobacter species	JH	Isolation
Viral Haemorrhagic fever (VHF)	JH	Policy
Prevention of spread of Carbapenem resistant organisms	JH	In place
Diarrhoeal infections	JH	In place
Surveillance	ICNs	In place
Respiratory viruses (RSV)	JD	In place
Infection control measures for ventilated patients	MF	In place
Tuberculosis	JH	In place
Legionellosis risk management policy and procedures, including pseudomonas	TC	In place
Strategic Cleaning Plan & Operational Policy	MS	In place
Building & Renovation – Inclusion of Infection Control within Building Change, Development & Maintenance	TC	In place
Waste Management Policy	TC	In place
Linen Management Policy	ICNs	In place
Decontamination of medical devices, patient equipment & endoscopes	FM	In place

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.		
Ensure all staff can access relevant occupational health & safety services (OHSS)	PH	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	PK	Continuous
Continue the provision of infection prevention and control education at induction	IPCT	Continuous
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	Continuous
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	Continuous
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	In place
Enhance and monitor the role of the Infection Control Link Professionals	DSNs/ICNs	Continuous

KEY INITIALS

DIPC	Lorna Wilkinson, Director of Infection Prevention & Control (DIPC)
DDIPC	Denise Major & Fiona Hyett, Deputy DIPCs
FM	Fiona McCarthy, Senior ICN & Interim Trust Decontamination Lead *(until 31st August 2018) Sarah Jennings returned to this Trust role post external secondment.*
JH	Julian Hemming, Consultant Microbiologist & Infection Control Doctor (ICD)
SC	Stephen Cotterill, Consultant Microbiologist & Deputy ICD
PR	Paul Russell, Consultant Microbiologist & Antimicrobial Lead
IR	Ian Robinson, Head of Facilities
TC	Terry Cropp, Responsible Person for Water & Head of Estates
DSNs	Directorate Senior Nurses
SK	Sarah Knight, Head of Patient Flow
PK	Paul Knight, Health & Safety Manager, OH Department
GL	Geoff Lucas, Safety Advisor, OH Department
LW	Louise Williams, Principal Pharmacist
JD	Jacqui Dalley, Neonatal Unit Sister
MF	Maria Ford, Nurse Consultant in Critical Care
PH	Paul Hargreaves, Director of Human Resources
MS	Michelle Sadler, Facilities Manager

APPENDIX B

Formal Trust Reporting Structure