

Reporting to:	Trust Board – 29 th October 2015
Title	Infection Prevention and Control (IPC) Annual Report 2014 - 2015
Sponsoring Director	Director of Nursing & Quality
Author(s)	Director of IPC (DIPC) - Dr Patricia O'Neill and the Infection Prevention and Control Team
Previously considered by	None
Executive Summary	<p>The purpose of the report is to update and assure the Board of the work undertaken during the fiscal year 2014/15; by the IPC team in improving performance and preventing the incidence of health care associated infections (HCAI).</p> <p>During the year, the DIPC and IPC team consolidated their previous work in reducing avoidable HCAI at Shrewsbury and Telford Hospital NHS Trust (SATH). There were two cases of MRSA bacteraemia apportioned to the Trust against a nationally agreed target of zero avoidable cases. However, this was a vast improvement since 2003/04 when there was a peak of 58.</p> <p>Clostridium difficile (<i>Cdiff</i>) numbers dropped slightly from 31 in 2013/14 to 29 cases in 2014/15. Therefore, the Trust met the national target of not more than 38 cases which again showed an improvement in performance from 208 cases in 2007/08.</p> <p>New challenges in prevention of HCAI include an international rise in other resistant organisms such as Carbapenemase Producing Enterobacteriaceae (CPE) and Vancomycin Resistant Enterococci (VRE).</p> <p>All HCAI are monitored and reviewed by the Trust IPC Committee; reporting to the Quality and Safety Committee on a monthly basis.</p> <p>The full IPC Annual Report is included in the Trust Board Information Pack.</p>
Strategic Priorities <input checked="" type="checkbox"/> Quality and Safety <input type="checkbox"/> Healthcare Standards <input type="checkbox"/> People and Innovation <input type="checkbox"/> Community and Partnership <input type="checkbox"/> Financial Strength	Operational Objectives <p>Reduce the number of health care acquired infections.</p>
Board Assurance Framework (BAF) Risks	<input checked="" type="checkbox"/> If we do not deliver safe care then patients may suffer avoidable harm and poor clinical outcomes and experience <input type="checkbox"/> If we do not implement our falls prevention strategy then patients may suffer serious injury <input type="checkbox"/> Risk to sustainability of clinical services due to potential shortages of key clinical staff <input type="checkbox"/> If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards

	<input type="checkbox"/> If we do not have a clear clinical service vision then we may not deliver the best services to patients <input type="checkbox"/> If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale and patient outcomes may not improve <input type="checkbox"/> If we are unable to resolve our (historic) shortfall in liquidity and the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties and address the modernisation of our ageing estate and equipment
Care Quality Commission (CQC) Domains	<input checked="" type="checkbox"/> Safe <input checked="" type="checkbox"/> Effective <input checked="" type="checkbox"/> Caring <input type="checkbox"/> Responsive <input checked="" type="checkbox"/> Well led
<input checked="" type="checkbox"/> Receive <input checked="" type="checkbox"/> Review <input type="checkbox"/> Note <input type="checkbox"/> Approve	Recommendation RECEIVE and REVIEW the report

ANNUAL REPORT INFECTION PREVENTION & CONTROL

**Covering the period
APRIL 2014 to MARCH 2015**



**Report compiled by Dr Patricia O'Neill and the Infection Prevention and
Control Team**

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1. Overview

In the year 2014/15 we consolidated our previous work in reducing avoidable Health Care Associated Infection (HCAI) at Shrewsbury and Telford Hospital NHS Trust (SATH).

We had only two cases of MRSA bacteraemia apportioned to the trust. Although we aim for zero avoidable cases this is a vast improvement since 2003/04 when we peaked at 58 number of cases.

C difficile numbers dropped slightly from 31 in 2013/14 to 29 cases in 2014/15. Therefore, we met our target of not more than 38 cases. Again this is a dramatic reduction from the peak of 208 in 2007/08.

New challenges in prevention of HCAI include an international rise in other resistant organisms such as Carbapenemase Producing Enterobacteriaceae (CPE) and Vancomycin Resistant Enterococci (VRE).

Dr Patricia O'Neill

Director of Infection Prevention and Control

2. Infection Control Arrangement

Infection Prevention and Control Team (IPC) (March 2013/14)

Dr Patricia O'Neill	Director of Infection Prevention and Control (DIPC) 0.5wte/Consultant Medical Microbiologist 0.6 wte
Janette Pritchard	Matron Infection Prevention & Control (1.0 wte Band 8a)
Sharon Toland	Nurse Specialist Infection Prevention & Control (1.0 wte Band 7)
Leeanne Giles	Nurse Specialist Infection Prevention & Control (1.0 wte Band 7)
Debbie Link	Infection Prevention & Control Nurse (1 wte Band 6)
Louise Fall Lynn Marston	Infection Prevention & Control Nurse (1 wte Band 6) Surveillance Nurse (0.8 wte Band 6)
Michelle Ellis	Infection Prevention & Control Team Secretary (1.0 wte Band 3)
Jennie Dagger	Infection Prevention & Control Team Secretary (1.0 wte Band 3)

The Trust Infection Prevention and Control Team had a few changes in personnel over the last year and new staff coming in. The team also had to deal with periods of low staffing levels due to delays in recruitment and illness. Despite this they were able to maintain a high presence in clinical areas to deal with urgent problems and were one of the specialist areas who supported the wards during periods of extreme pressure by working on the wards, supporting a discharge area and helping to move patients around the hospital. Throughout the winter pressures the team endeavoured to support frontline staff and continued to prioritise urgent IPC issues.

The Infection Prevention and Control (IPC) Team is managed by Janette Pritchard (Matron Infection Prevention and Control).

Dr Patricia O'Neill as DIPC works 5 PAs (0.5 wte) for IPC. She also works 0.6 wte as a consultant microbiologist. In addition another three consultant microbiologists continue to give support to the Infection Prevention & Control Team. The DIPC meets monthly with the Chief Executive Officer.

The Trust Infection Control Committee is held monthly and is chaired by the Director of Nursing & Quality or Deputy. Each Care Group is invited monthly to report on IPC performance and key actions.

Table 1 shows the attendance at the IPCC 2014/15

	28/04/2014	19/05/2014	25/06/2014	23/07/2014	28/08/2014	29/09/2014	27/10/2014	24/11/2014	22/12/2014	26/01/2015	23/02/2015	30/03/2015
Director Nursing and Quality (Chair)						✓	✓	✓	✓	✓	✓	✓
Medical Director (Deputy Chair)						✓	✓		✓	✓		
DIPC	✓	✓	✓	✓			✓	✓	✓	✓	✓	✓
Acting Deputy Director Nursing and Quality	✓	✓	✓	✓		✓	✓				✓	✓
IPC Matron	✓		✓	✓		✓	✓	✓		✓	✓	✓
IPC Surveillance Nurse	✓	✓	✓									
CCDE (PHE)	✓		✓	✓		✓	✓					✓
Head of Nursing (SC)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Head of Nursing (USC)	✓	✓	✓	✓		✓		✓	✓	✓	✓	✓
Estates Manager	✓					✓	✓	✓	✓	✓		✓
Lead Nurse Women and Children's	✓		✓							✓	✓	✓
Health and Safety Team Manager	✓		✓			✓	✓				✓	
Lead Superintendant Radiographer	✓	✓	✓			✓			✓	✓		✓
IPC Nurse Specialist		✓		✓		✓	✓	✓	✓	✓	✓	✓
PEIP Member		✓	✓			✓	✓		✓		✓	✓
Head of Facilities		✓	✓	✓		✓		✓	✓	✓	✓	✓
Antibiotic Pharmacist		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Head of IPC CCG		✓	✓			✓	✓			✓	✓	✓
Deputy Head of Midwifery				✓			✓					
Occupational Health Manager				✓			✓				✓	
Matron Scheduled Care				✓							✓	
Consultant Microbiologist						✓						
Medical Director (Women and Children's)							✓					
Director of Estates								✓			✓	
Head of Nursing (PHE)											✓	

✓ Attended

☑ Representative Sent

Infection, Prevention & Control issues are raised at the monthly meetings of the Quality and Safety Committee, which reports directly to Trust Board and is attended by the Director of Nursing & Quality, Medical Director and Associate Director of Patient Safety. Members of the IPC team are also invited to the committee on occasions to present IPC items.

The IPC service is provided through a structured annual programme of work which includes audit, teaching, policy development and review as well as advice and support to staff and patients. The main objective of the annual programme is to maintain the high standard already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. The annual programme is agreed at the IPC committee and then reported to the Quality and Safety Committee.

The Infection Control Committee within the Trust Committee Structure is shown in the diagram below.

Board Committee Structure

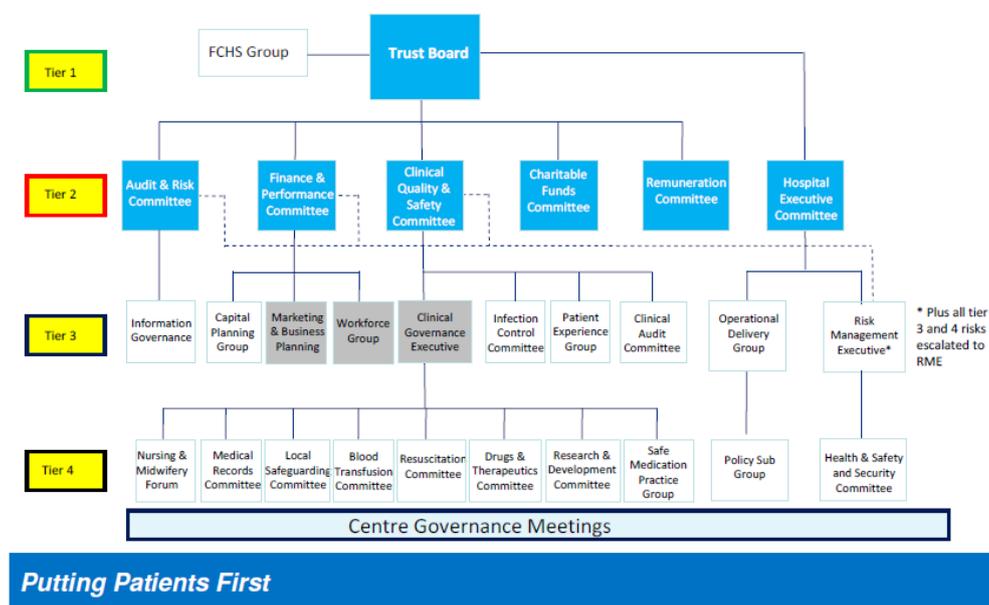


Fig 1 Board Committee Structure

Infection Prevention & Control Team budget 2014/15

The infection control team had a budget of £267,123 pay budget (nursing and administration/clerical staff) and £17,445 non-pay and finished the financial year in balance.

3. Healthcare associated infections statistics

3a MRSA Bloodstream Infections

MRSA, or Methicillin Resistant Staph aureus, is a highly resistant strain of the common bacteria, Staph aureus. Bloodstream infections or bacteraemia cases are the most serious form of infection where bacteria, in this case MRSA, escape from the local site of infection, such as an abscess or wound infection, and spread throughout the body via the bloodstream. All cases of MRSA detected in the blood are reported by the trust.

A post infection review is carried out for each case. This is a new way of analysing the cause of infection looking at the whole patient journey and does not apportion cases on the basis of the time after admission but instead looks at where the infection was acquired.

Our target for MRSA bacteraemia cases in 2014/15 was zero trust apportioned cases. This is the target for all trusts. We had two cases apportioned to the trust during 2014/15 so were unable to achieve this target. All cases have an in depth post infection carried out.

In one case it was thought that the blood culture sample had been contaminated at the time of collection as the patient had no symptoms consistent with an MRSA infection. So this was not a genuine MRSA infection. The staff member who took the blood culture received additional training and assessment of their blood culture collection technique. In the other case cross infection seems to have occurred on the ward. Genetic typing of the two strains showed that the patient probably acquired the strain of MRSA from another patient who was admitted with it. Actions following this case included a review of hand hygiene training and screening of staff.

Ongoing work to continue reducing MRSA bacteraemia and less severe infections from MRSA includes; improving compliance with screening of emergency admission patients, continued emphasis on isolation and clearance of colonised patients, and continued improvement in compliance with hand hygiene and prevention of line associated infections.

We also monitor less severe infections and colonisations with MRSA and investigate any clusters which occur.

3b Clostridium difficile

The Trust reports all cases of C difficile diagnosed in the hospital laboratory to Public Health England. However only cases where the sample was taken more than 72 hours after admission are considered attributable to the trust. Our target for C difficile in 2014/15 was to have not more than 38 trust apportioned cases in patients over the age of 2 years.

We ended our year with 29 trust apportioned cases so achieved our target. This was also slightly lower than the number of cases we had the previous year (31).

It has been recognised nationally that it is becoming more and more difficult to continue to reduce C difficile cases as 5 to 10% of older patients carry C difficile in the bowel as part of their “normal flora”. If they then require antibiotics to treat an infection this may cause the C difficile to multiply and cause diarrhoea. However; it is vital that we continue to prevent avoidable cases. This year all Trusts started to conduct formal reviews of each case to see whether there was a “lapse in care” such as cross infection or unwise antibiotic prescribing. We carry out a root cause analysis on each case to identify the likely cause and any remedial actions that may reduce future infections. These are fed back to the wards and clinicians. In 2014/15 we considered that there had been a “lapse in care” in four cases, all of which were thought to be likely to be due to cross infection. The other cases were due to antibiotic prescribing, but this was in line with hospital guidelines.

In 2015/16 there will be a more rigorous decision making process for “lapse in care” with cases where the trust did not feel there was a lapse in care being sent for appeal to be reviewed by an external panel comprising members of the Clinical Commissioning Groups for Shropshire County and Telford and Wrekin, Public Health England, and the Trust Development Agency.

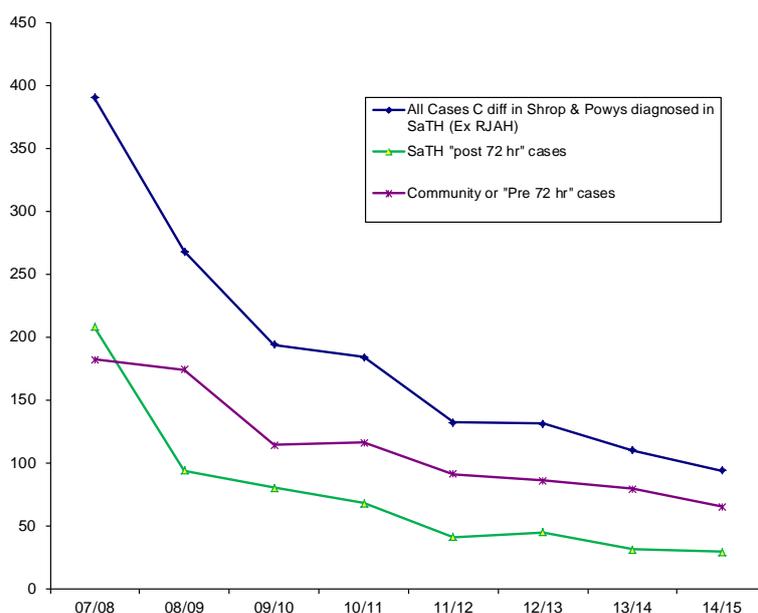


Fig 2 C difficile cases in Shropshire since 2007/08

The graph above (Fig 2) shows the drop in cases of C difficile in Shropshire since 2007/08. Definitions of SaTH apportioned cases have changed but this graph uses the current definition of cases diagnosed later than the third day after admission. As can be seen the total number of cases including those diagnosed in the community has dropped by 76% while those diagnosed as inpatients for more than 3 days has dropped by 86%. It is likely that actions to reduce C difficile in SaTH have also caused a reduction in the community as we know that many of these cases are in patients who have recently been in hospital.

Reduction in C difficile cases relies on prudent antibiotic prescribing, rapid recognition, diagnosis and isolation of affected cases, environmental cleanliness and excellent hand hygiene. We continue to work on all these areas.

3c MSSA Bacteraemia

MSSA, or Methicillin Sensitive Staph aureus, is the more common sensitive strain of Staph aureus. Up to 25% of us are colonised with this organism. Mostly it causes us no problems but it is a frequent cause of skin, soft tissue and bone infections. As with its more resistant cousin MRSA, sometimes the infection can escape into the bloodstream producing a “bacteraemia” i.e. bacteria in the blood. Unlike MRSA, the majority of the infections will be acquired in the community, and are not associated with health care. However, some may arise as a consequence of health care, and like MRSA, it can arise from infected peripheral and central intravenous lines and other health care interventions. We were asked by the Department of Health in 2011 to report all MSSA bacteraemia cases, whether acquired in the community or in hospital, so that we can review the sources and identify potentially avoidable cases. So far no targets have been set and we do not have easily comparable information with other hospitals. However, interventions to further reduce infections are being put into place as we gain new information.

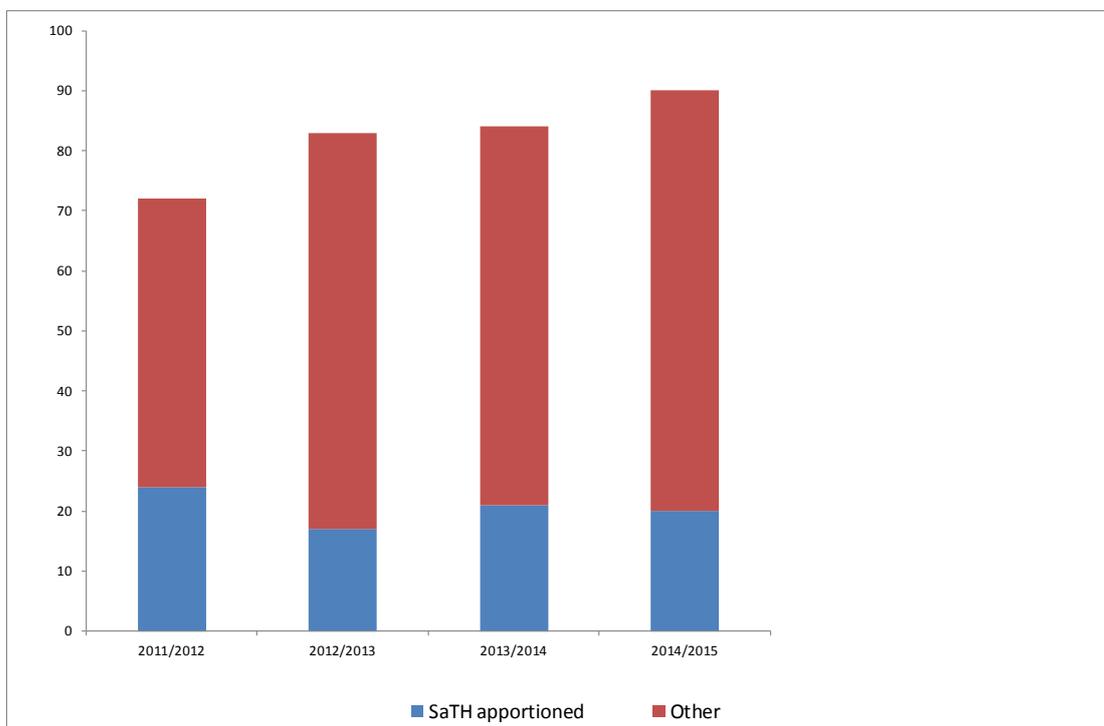


Fig 3 Cases of MSSA bacteraemia diagnosed in SaTH (excluding RJAH) since April 2011

As the graph above shows the number of cases of MSSA bacteraemia has increased slightly year on year since 2011/12 when there were 72 cases, to 90 cases in 2014/15. This increase has predominantly been due to an increase in infections acquired in the community while cases diagnosed more than 2 days after admission to SaTH, which are more likely to have been acquired in the hospital, have remained fairly static with 24 in 2011/12 and 20 in 2014/15. This is in line with

national data, with the total number of cases in England rising from 8767 in 2011/12 to 9827 in 2014/15 but hospital apportioned cases dropping slightly from 2854 in 2011/12 to 2795 in 2014/15. The increase in total numbers probably reflects an ageing population as increasing age is a risk factor.

For the year 2014/15 there were 20 out of 90 cases (22%) where the sample was taken more than 2 days after admission and therefore the infection was more likely to have been acquired in the trust.

All cases are reviewed by a consultant microbiologist to find the source of infection. The causes of infection in the 20 cases taken more than 48 hours after admission were as follows:

- 9 probably had the infection on admission i.e. were not health care acquired (mostly joint infections, deep seated abscess and endocarditis)
- 2 were associated with an infected intravenous dialysis lines
- 2 had infected urinary catheters
- 1 had an infected surgical wound
- 1 peripheral intravenous line infections
- 1 hospital acquired pneumonia
- 2 unknown
- 2 contaminated samples

As seen from these cases, infections of invasive devices such as intravenous lines and urinary catheters are the commonest avoidable source of health care acquired infection from MSSA. We continue to work in this area to reduce infection by monitoring compliance with care in insertion and ongoing management of lines and catheters and also reducing use of such devices or length of time they are kept in as much as possible. Dialysis patients are now routinely screened for MSSA as well as MRSA and given a decolonisation regime to reduce their carriage as they are at high risk of infection with this organism.

3d E coli Bacteraemia

E coli is an organism we all carry in our gut, and most of the time it is completely harmless. There is a particular strain, E coli O157, which can cause food poisoning, but it is rare and most strains do not cause any symptoms while being carried in the gut. Instead ordinary E coli forms part of our "friendly" colonising gut bacteria. However when it escapes the gut it can be dangerous. E coli is the commonest cause of blood stream infections (bacteraemia) in the community. The most frequent problem it causes is a urinary tract infection, but it can also cause infections in the abdomen such as gallbladder infections or following perforations of the bowel. As E coli bacteraemia cases have been rising nationally and internationally over the last few years, the Department of Health asked us to start reporting all these infections from June 2011 to see how many were associated with contact with health care. As with MSSA no targets have been set but we act on any obvious preventable cause to reduce health care acquired cases.

For E coli we assess each case to see if it is likely to be healthcare acquired rather than simply going by the "48 hour rule" i.e. considering that any cases that arise more than 48 hours after admission are likely to be health care acquired. This rule is not very reliable for E coli.

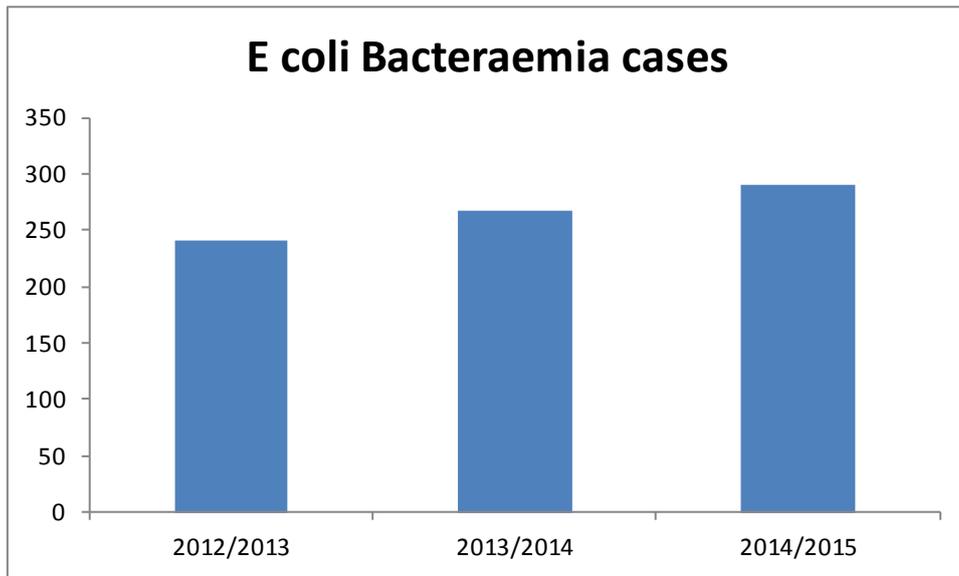


Fig 3 E coli bacteraemia cases diagnosed in SaTH (excluding RJAH) since April 2012

The graph above shows three years of complete data on E coli bacteraemia cases. We have seen a year on year rise in cases from 241 in 2012/13 to 290 in 2014/15. This follows the national pattern of a continuing rise in cases. As with MSSA bacteraemia this is most likely to be due to an ageing population.

The majority of infection (194 cases or 69%) were not thought likely to be associated with health care. 52% of these (101 cases) were caused by urinary infections but liver and gallbladder infections were also common causing 61 cases (31%).

Figure 4 shows the distribution of cases between healthcare associated infections acquired in an acute trust (most frequently SaTH), cases from healthcare delivered in the community, and infections not associated with healthcare.

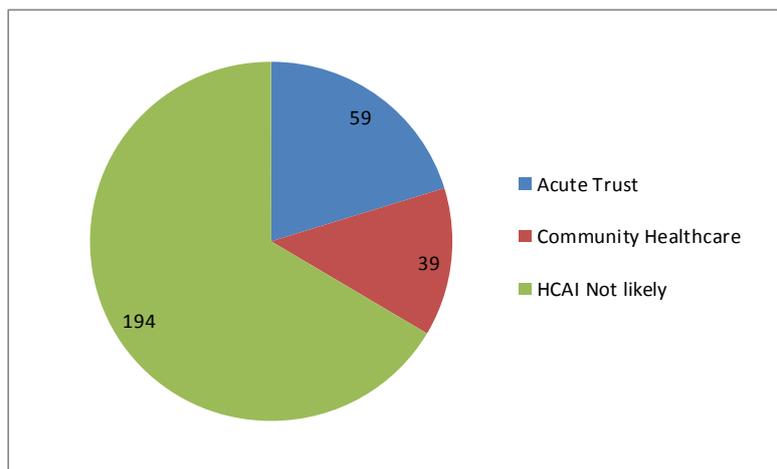


Fig 4. E coli bacteraemia cases 2014/15 – Association with Healthcare

In 98 (34%) cases we judged that the infection was probably associated with recent health care. However in 39 (13.5%) of cases this care was being delivered in the community – almost all were patients in nursing homes or in their own homes who had long term urinary catheters. One patient had an infected long term intravenous line.

In 59 (20.5%) patients the infection was thought to have arisen either during their current admission in SaTH or a recent inpatient stay.

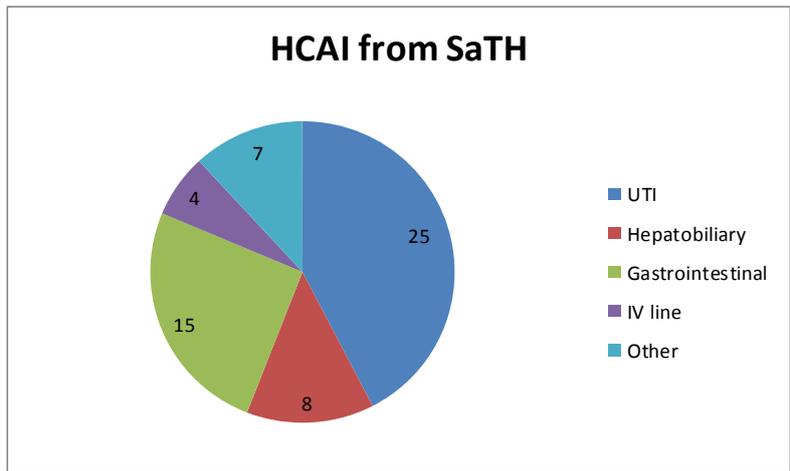


Fig 5. Source of infection – E coli bacteraemia associated with healthcare in SaTH

Figure 5 shows the source of infection for E coli bacteraemia cases acquired in SaTH. The most common source was a urinary tract infection (UTI). In 22 of these 25 cases, the cause of the infection was a current or recent urinary catheter. The next most common source was gastrointestinal (15 patients). In 11 of these patients this was due to recent chemotherapy which allows bacteria from the gut to cause invasive infections because it destroys the white cells which normally protect us. We also saw 4 infections caused by intravenous lines becoming infected.

The most frequent health care related risk factor is the presence of a urinary catheter with 60 of the 290 patients having one. So over half of the health care associated infections were catheter related. Of these 40 were long term catheters and 20 were short term. In hospital we usually use more short term catheters, inserted as part of the acute care. In the community there are more long term catheters, often in residents of nursing homes.

This is a very similar picture to last year but we have seen a rise in catheter related cases of E coli Bacteraemia over the last three years, both from catheters used in the community and in the acute trust (Fig 6). This may relate to increased use of catheters but as the numbers of catheters used is not routinely monitored this is very difficult to ascertain.

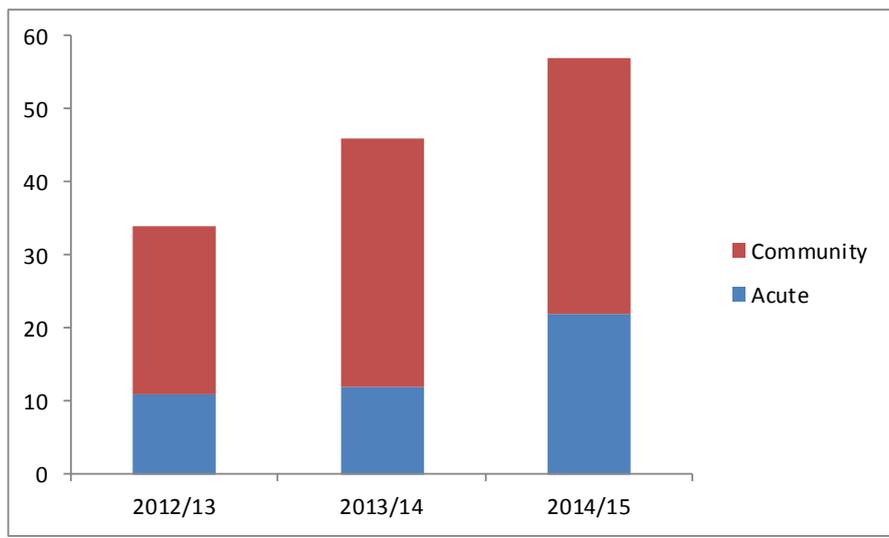


Fig 6 Urinary catheter associated E coli bacteraemia cases

Both SaTH and our partners in the community continue to work to reduce urinary catheter related infection. This will be achieved by monitoring compliance with correct technique during insertion of the catheter and ongoing management. As with intravenous lines we also need to avoid using catheters except where essential and remove them as soon as possible.

The other common risk factor is cancer chemotherapy, which by temporarily destroying white cells, leaves the body at risk of infection from bugs within our own gut. Without the normal immune defences, these can cross from the gut into the bloodstream causing severe infections. These infections show up on Fig % as gastrointestinal. It is impossible to completely stop these infections, which are a well recognised risk of chemotherapy. Instead patients are put on prophylactic antibiotics by mouth during the period when their white cell count will be very low. This reduces this risk but cannot prevent all cases. Therefore patients are warned to come to hospital very quickly if they feel unwell, so that they can immediately receive intravenous broad spectrum antibiotics. We monitor the organisms which cause infections in these patients and periodically adjust which antibiotics we give to ensure the best protection for the patients. However, it is difficult to stop these infections completely.

Going forward we will be monitoring the avoidable cases of E coli bacteraemia i.e. those related to devices such as urinary catheters, intravenous lines and post surgical infection.

3e Surgical Site Infection Surveillance Scheme (SSISS)

The Health and Social Care Act 2008 recommends that there should be evidence of local surveillance of wound infections which develop whilst the patient is in hospital, also that trusts carry out surveillance for infections after discharge. We carry out in-hospital surveillance and report the results to Public Health England through the national Surgical Site Infection Surveillance Scheme (SSISS). This allows us to compare our infection rates with other hospitals.

We also report post-discharge surveillance to SSISS. This is less reliable than in-hospital surveillance as it relies on self reporting by the patient rather than diagnosis by a doctor or nurse. National comparative data for post-discharge infections are now available but the reliability of this data is much more questionable.

Surveillance of orthopaedic surgical site infection using the national surveillance scheme became a mandatory requirement in April 2004. We are required to perform surveillance on at least one category of orthopaedic surgery for at least one quarter per annum.

Surgical site surveillance was carried out in all 4 quarters. Results of the surveillance carried out in SaTH from 1st April 2014 to March 31st 2015 are shown in the table below.

Type of surgery	Number of Months	Number of cases	Number of In-patient/re-admission Infections (%) National Infection Rate	Post Discharge Infections
Abdominal Hysterectomy	12	186	1 (0.5%) cf 1.3% E&W	5 (2.7%)
Large Bowel	3	118	8 (6.8%) cf 10.1% E&W	3 (2.5%)
Breast	3	189	1 (0.5%) cf 1.0% E&W	8 (4.2%)
Small Bowel	3	44	1 (2.3%) cf 6.9% E&W	1 (2.3%)
Gastric Surgery	3	27	0 (0%) cf 2% E&W	0
Neck of Femur	12	478	9 (1.9%) cf 1.4% E&W	2 (0.4%)
Total Hip Replacement	12	271	5 (1.8%) cf 0.6% E&W	0
Total Knee Replacement	12	231	1 (0.4%) cf 0.5% E&W	4 (1.7%)

We monitored abdominal hysterectomy for twelve months; there was one inpatient/readmission infection (0.5%). This takes us below the national infection rate of 1.3%. Post discharge surveillance was carried out on all but one of the 186 patients (76.2% return rate), five of these patients reported a problem with their wound healing, giving us a patient reported infection rate of

2.7%, which is well below 4.7% nationally. The Gynaecology ward staff will continue surgical site surveillance in abdominal hysterectomy surgery which will include post discharge.

In large bowel surveillance we had eight inpatient/readmission infections in 118 operations, a SaTH infection rate of 6.8%. This is lower than the national infection rate of 10.1%. Post discharge questionnaires were sent out to the 99 eligible patients and were returned by 84 patients (84.8% return rate). Three of these patients reported a problem with their wound, giving a patient reported infection rate of 2.5%, the national rate being 4.8%.

Breast surgery surveillance was carried out for one quarter, in which day case procedures are also included. We had one inpatient/readmission infection in 189 operations, an infection rate of 0.5%, which is half the national rate of 1.0%. 188 patients were eligible and subsequently contacted post discharge, 91.4% of patients returned their questionnaire. Eight (4.2%) patients reported wound healing problems; this is slightly higher than the national rate of 3.7%. The Breast Care Specialist Nurses continue to review their patients post discharge via clinic appointments.

In small bowel surgery our in-patient/re-admission infection rate was 2.3%, one infection in 44 operations, this is considerably lower than the national infection rate of 6.9%. Post discharge surveillance was also carried out. 35 patients were eligible to be followed up; we received an 82.9% returns rate. One patient reported having signs and symptoms suggestive of infection. This gives us a post discharge infection rate of 2.3%, which compares well to the national patient reported rate of 2.9%. This was the first time we had carried out surgical site surveillance in this category of surgery.

Gastric surgery was also a new category for SaTH. Surveillance was carried out for a quarter. We reviewed 27 operations and found 0 inpatient/readmission infections; the national infection rate is 2%. No patients recorded problems with their wound post discharge.

We have carried out repair of neck of femur surveillance over 12 months across SaTH. We had 9 inpatient/readmission infections in 478 operations this gives SaTH an infection rate of 1.9% which is slightly higher than the national rate of 1.4%. Of these patients 411 were eligible for contact, (82.7% returns rate) two patients (0.4%) reported a problem with wound healing. This compares well to the national post discharge rate of 0.5%. Due to the slightly high infection rate we will continue to monitor repair of neck of femur for a further 6 months.

We have continued to supply a full time service of total hip and total knee replacement surgeries, giving us more robust data by increasing the number of operations we review. In total hip replacement surgery there were five (1.8%) inpatient/readmission infections in 271 operations, which is higher than the national rate of 0.6%. 267 patients were eligible for post discharge contact, we received a 90.2% postal return rate. No patient's reported a wound healing problem. A root cause analysis has been completed on all the inpatient/readmission infections.

In total knee replacement surveillance there was one inpatient/readmission infection from 231 operations, giving us an infection rate of 0.4%, this compares well to the national infection rate of 0.5%. All but one of these patients were eligible for post discharge contact (90.4% returns rate) four patients reported problems with their wounds, giving us a patient reported infection rate of 1.7%. The national patient reported infection rate is 1.8%. All four patients had been treated with antibiotics from their GP.

In-house surgical site surveillance was also carried out for three months in cholecystectomy. Information was collected through Medeanalytics using the OPCS code J183. Patients were contacted 4-6 weeks following their operation either by telephone (98 patients) or post discharge questionnaire (65 patients). 31 did not respond to the questionnaire, giving an overall response rate of 81%.

163 operations were recorded. Three were open procedures, with the remainder laparoscopic. One of the open cases became infected.

Open procedures	Laparoscopic procedures	Total No of Reported Infections	Readmissions for infection
3 (1 infection)	160 (13 infections 8.1%)	14 (8.6%)	1 (0.6%)

Further review was carried out on all the infected cases; risk factors identified that 7 of the 14 infections had a BMI of over 30, 12 were female patients, only 4 of the 14 had been given antibiotic prophylaxis.

Gender	Age Range	Antibiotics on induction	ASA score	Operation time	Positive microbiology swabs	Antibiotics given (All infected cases)	BMI
12 Female 2 Male	7 < 50y 7 > 50y	4 Yes 10 No	11 < 2 3 > 2	8 < 60mins 6 > 60 mins	6	20 (6 given as a precaution)	4 < 25 3 25-30 7 > 30

Signs for infection included redness, inflammation, heat, malodour, pus discharge, pain and separation of incision edges. Patients described in the majority of cases the umbilicus incision as the area of infection. Patients who were given antibiotics by their GP were told it was due to infection or as a precaution. Microbiology swabs include MSSA, anaerobes, coliform, viridans strep and beta haemolytic strep.

The national in-patient/re-admission infection rate for open cholecystectomy is 4.8%. Unfortunately there are no national figures for laparoscopic surgical site infection.

3f Outbreaks

During 2014/2015 period there were a range of outbreaks, the 'winter vomiting bug' Norovirus made its seasonal return on a number of wards across the two sites, towards the end of the 2013/14 Influenza season an outbreak of Flu A closed 2 bays at Royal Shrewsbury Hospital and an unprecedented number of VRE cases emerged from an investigation following a cluster of cases first reported and investigated on RSH ITU.

Norovirus

The highly infectious winter vomiting bug is the commonest cause of gastroenteritis (infectious diarrhoea and vomiting) in semi-closed environments such as nursing/residential homes and hospitals.

There were a total of 12 outbreaks of diarrhoea and/or vomiting affecting 71 patients across the Trust during the last financial year, of which resulted in the closure of bays or side rooms, no wards were closed to admissions. Stool samples were collected and sent for 35 symptomatic patients and Norovirus was confirmed in 20 of these samples. Staff were also reported symptomatic in 10 of the outbreaks totalling 24 healthcare staff absent from work until 48 hours clear of symptoms.

Bed days lost due to empty beds in closed bays/side-rooms totalled 45. See table below for data.

Site	Ward	Month	Symptoms first reported	Nature	Bay or ward closed	Dates closed	Bed days lost	No. of Patients affected	No. of Staff affected	No. of samples tested	No. of confirmed causative organism
RSH	25G	Apr	07/04/14	Diarrhoea	Bay 2,3	07/04/14-09/04/14	0	4	5	4	Norovirus x 1
RSH	24C	Oct	01/10/14	Diarrhoea	Bay 3,4	01/10/14-07/10/14	20	6	4	5	Norovirus x 3
RSH	28N	Oct	04/10/14	Diarrhoea	Bay 5	04/10/14-07/10/14	0	3	0	2	0
PRH	6	Oct	04/10/14	Diarrhoea	Bay B	05/10/14-07/10/14	0	2	0	2	0
PRH	6	Oct	29/10/14	Diarrhoea	Bay B	29/10/14-31/10/14	5	4	2	2	0
PRH	4	Oct	27/10/14	Diarrhoea	2 bed s/rm	31/10/14-04/11/14	4	3	1	2	Norovirus x 1
PRH	17	Nov	07/11/14	D&V	Bay A,C,D	07/11/14-19/11/14	0	15	3	10	Norovirus x 7
PRH	AMU	Nov	26/11/14	D&V	Bay A	26/11/14-28/11/14	2	2	1	1	0
PRH	7	Dec	08/12/14	D&V	Bay C, D	08/12/14-11/12/14	7	7	1	3	Norovirus x 2
PRH	6	Jan	08/01/15	Diarrhoea	Bay A	12/01/15-15/01/15	3	4	1	4	0
PRH	17	Feb	13/02/15	D&V	Bay B	13/02/15-16/02/15	0	3	1	2	Norovirus x 2
PRH	9	Feb	13/02/15	D&V	Bay A,B,C,D	13/02/15-19/02/15	4	18	5	4	Norovirus x 4
TOTALS							45	71	24	35	

Commodes were reported to be clean and correctly stored during each of the outbreaks, acceptable compliance of hand hygiene and PPE compliance during the outbreaks was also reported. Outbreak Reports were circulated accordingly and signage was displayed in the hospital and ward entrances. Appropriate cleaning was undertaken during each of the outbreaks.

Documentation i.e. Bristol Stool Charts and Outbreak Forms were not always accurate and up to date, in one case this resulted in a bay being re-opened during the night by the clinical site manager whilst patients were still symptomatic in a bay, the bay was re-closed by IPC the following morning. Delay in isolation was noted in one outbreak, where the patient was admitted with D&V but not isolated. Unfortunately in another outbreak it was identified that symptomatic visitors had visited a bay which had previously been closed then re-opened, the patients became symptomatic again, thus the bay was closed for a further 4 days. One patient was admitted from a Care Home which was closed due to D&V, unfortunately this information was not handed over on admission and the patient was moved to an open bay where they subsequently became symptomatic. This incident was reported to the CCG who are currently investigating it.

Influenza A

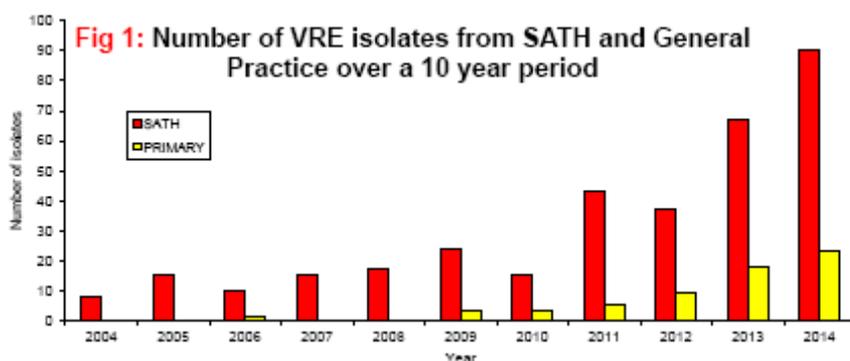
During the 2014/15 period the Trust has seen a number of positive influenza cases reported, however it was at the tail end of the 2013/14 winter flu season when ward 27 had two bays closed due to a number of positive patients. The onset of this incident occurred prior to the Easter bank holiday weekend, when the first patient was reported symptomatic and swabs were subsequently sent. Unfortunately, this patient was not isolated when they became symptomatic as per Trust policy and when the positive result was reported there were other high risk patients in the same bay who were also symptomatic, the bay was thus closed. Unfortunately two more patients in the next bay tested positive to Flu A following the holiday weekend, this bay was also closed to admissions. No beds were empty during this period and all of the high risk contacts in each bay received prophylactic treatment and the positive patients were treated as per Trust policy.

Vancomycin Resistant Enterococcus (VRE)

Like many other trusts, SaTH has seen a rise in cases of VRE over the last 5 years (see graph below). Following a High Risk Case Review of a cluster of VRE cases on ITU at RSH, where three of the cases were reported to have the same genetic type, it was identified that these patients had a link to the colorectal team and wards 25 and 26. A decision was therefore made to screen all patients on wards 25 and 26 at RSH, with swabs/samples grown on specific VRE plates. The result of this screening identified a significant number of patients positive to VRE, although the vast majority of these were colonised only (gut carriage); there were a number of patients who tested positive in clinical samples such as wounds and catheter urines. This was reported as an SI and an Interim VRE Outbreak meeting took place. Genetic typing returned a number of the samples of the same strain; EC 3/9.

During the investigation into this outbreak, VRE was also identified on RSH ward 28 and PRH wards 9 and 17, although these cases were of different genetic types, SI investigations took place for each of these, but they were not declared as part of the outbreak.

Environmental swabbing was undertaken on wards 25 and 26, where VRE was identified on a number of items; Flowtron pump, notes trolleys and radiator covers. Both of these wards and ward 28 were deep cleaned. Post cleaning environmental swabs were taken on wards 26 and 28; ward 26 swabs were clear, however VRE was grown from swabs of the notes trolley and computer on wheels on ward 28. Since this cluster we have continued to send all strains of VRE for typing and we continue to monitor any clusters. Various different strains have been identified. Fortunately most patients have been colonised and not required treatment.



Serious incidents (SI) and Period of increased incidents (PII)

On identification of a SI or PII a ward inspection is carried out by the IPCN team. Staff are asked to complete weekly hand hygiene audits and practice is validated by the IPCN team. Once Root Cause Analysis is completed and an action plan is put together the actions are then monitored by the IPCN team, Ward Manager and Matron for that area and review meetings are held to assure us that the actions identified are being implemented. SIs and PIIs are also reported to the monthly Infection Prevention and Control Committee. Care groups, when invited to the committee, give an update with regards to outstanding RCA and action plans.

Over the past twelve months the IPCN team has reported seventeen incidents as a PII or SI. PII is defined as two or more new cases within a ward or unit in a twenty eight day period. This is a similar number to previous years; however there has been a change in the distribution of these in terms of causative organisms, most notably:

- An increase in VRE PII's: 2 in the year 2013-2014, 7 this year (including an outbreak involving a significant number of patients)
- A reduction in C.diff PII's: 9 in the year 2013-2014 and 3 this year

Pulmonary Tuberculosis SI

The Trust had one SI reported due to pulmonary tuberculosis by the TB Nurse Specialist.

Ward	Month Reported	Number of patients affected	Number of staff affected
AMU/22T&O/27R	March	1	0

MRSA bacteraemia SI

The trust has had two SIs reported due to MRSA bacteraemia

Ward	Month Reported	Number of patients affected	Number of staff affected
A&E	October	1	0
Ward 15	December	1	0

MRSA PII

The trust has had four PII of MRSA this year.

Ward	Month Reported	Number of patients affected	Number of staff affected
Ward 22TO	April	2	0
TITU	June	2	0
Ward 9	July	2	0
Ward 25G/25CR	July	4	0

Clostridium difficile PII

The trust has had 3 separate PII of Clostridium difficile this year.

Ward	Month Reported	Number of patients affected	Number of staff affected
Ward 27R	June	2	0
Ward 25G/25CR	June	3	0
Ward 25G/25CR	January	3	0

Pseudomonas aeruginosa PII

The trust has had no PII of Pseudomonas aeruginosa this year

Vancomycin Resistant Enterococcus (VRE) PII

The trust has had seven incidents of PII VRE this year. The incidents reported on Ward 25G/CR, Ward 26 in February and RITU in November were potentially linked and were ultimately reported as a single SI. The numbers of patients involved obviously constitute outbreaks rather than simply periods of increased incidence and the Trust Outbreak Policy, including Outbreak Meetings (including attendance of PHE and the CCG) was implemented. Further detail can be found in the Outbreak Section of this report

Ward	Month Reported	Number of patients affected	Number of staff affected
Ward 26	July	4	0
RITU	November	4	0
Ward 9	December	2	0
Ward 25G/25CR	February	24	0
Ward 26	February	18	0
Ward 28	February	4	0
Ward 17	March	2	0

Extended Spectrum Beta Lactamase (ESBL) E.coli PII

The trust has had no PII of ESBL this year.

Influenza A PII

The trust has had one PII of Influenza this year.

Ward	Month Reported	Number of patients affected	Number of staff affected
Ward 27R	April	4	0

4. Progress against 2014/15 work programme

From April 2009 the Trust was legally required to register with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 *code of practice for the NHS on the prevention and control of healthcare associated infections and related guidance* (usually called “the Health Act”). As a legal requirement of registration, the trust must protect patients, workers and others who may be at risk of acquiring a HCAI. Compliance by the Trust will be judged against the ten criteria set in the Health Act.

Our work programme is based on this which includes teaching, audit, policy development and review and progress against the 2014/15 IPC work programme is reported to the Trust Infection Prevention & Control committee (IPCC)

The Infection Prevention and Control HCAI Action plan has now been revitalised by the Associate Director Patient Safety who undertook an assessment of compliance aligned to the Health and Social care Act with assistance from the Infection Prevention & Control Team. The Trust will need to act on any deficiencies & this will need to be reported quarterly to the Trust Infection Prevention & Control committee (IPCC)

Staff Health

The IPC team continues to work with the Occupational Health providers, Team Prevent to ensure that staff are protected from infection and do not pose a risk to others including patients from their own infections. Updating of the Infection Prevention & Control Policies Exposure to Blood Borne Viruses and Management of Infection in Staff come under this duty. The Occupational Health Team, “Team Prevent” are also responsible for the vaccination programme for staff, including influenza. A number of staff including three members of the IPC Team helped support the OH Team to vaccinate staff. In 2012/13 the uptake of influenza vaccination throughout the Trust was 46.7%, In 2014/15 this was increased to **68.6%** against a national average of 54.9%

Education

Throughout 2014/15 the IPC Team continued to provide Infection Prevention and Control training to as many groups of staff as possible within the Trust.

All staff employed by SaTH are required to undertake IPC education at the beginning of their employment (usually as part of their induction to the hospital) and have mandatory annual updates during their employment. These education sessions concentrate on current IPC issues essential to reducing HCAI in the Trust & highlight best practice.

Attendance on this training is monitored via the training and education department and attendance is updated on the staff electronic record. The following table shows the number of attendees from April 2014 to March 2015 who had IPC training.

Attendance on Induction and Statutory training courses with Infection Control included April 14 - March 15 by staff group			
	Number of staff required to attend	Number of staff attended	% Completed
Add Prof Scientific and Technic	68	55	81%
Additional Clinical Services	754	607	81%
Administrative and Clerical	5	3	60%
Allied Health Professionals	288	224	78%
Estates and Ancillary	90	55	61%
Healthcare Scientists	6	0	0%
Medical and Dental	402	263	65%
Nursing and Midwifery Registered	1533	1200	78%
Students	6	5	83%
Totals	3390	2103	62%

The following education has also been undertaken:

- Hand decontamination training,
- Healthcare Assistant Induction Training,
- Medical students IPC education,
- FY1 and FY2 Induction
- Student Nurse education.
- Individual Ward training sessions, as requested.
- Overseas IPC nurse training
- Visual Inspection of Phlebitis Scoring (VIPS)
- Preparing for potential Ebola, the IPCT have done extra training with areas that have requested it with donning and doffing of PPE.

Each year the Infection Prevention and Control Team aim to hold four Link Worker meetings on both sites. Link Workers are encouraged to attend at least three out of the four sessions.

Unfortunately the attendance rate has fallen for April 2014 to March 2015 and was only 27% compared to 2013/2014 which was 33%.

It is important that staff are supported to attend these meetings to improve the quality of education as the programme provides an opportunity to network with their peers and to take back important elements to clinical areas that have the potential to reduce infections by promoting optimal practice. This will improve the patient experience.

The IPCT have been carrying out regular quality and safety ward walks at both sites. This has given the IPCT enhanced opportunity to reinforce education on a regular basis in key areas; such as device care including the importance of documentation. This has also given the team the opportunity to liaise with some link workers whilst on duty to remind them of the importance of attending meetings and give advice on current issues for their area.

The team are planning to use the patient experience approach and incorporate it into training sessions to enhance education and reinforce the importance of IPC from the client's perspective.

Due to new staff members being appointed, the 2014 annual regional Infection Prevention and Control Conference was unfortunately unable to take place as originally planned.

5. Compliance with the Health and Social Care Act 2008

Implementing the Code of Practice for Health and Adult Social Care on the prevention and control of infections and related guidance (Health and Social Care Act 2008) is a legal requirement for acute trusts and other health care providers. The table below is the 'Code of Practice' and sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirement for cleanliness and Infection Prevention and Control.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and others may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	Provide suitable accurate information on infections to service users and their visitors
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for individual's care and provider organisations that will help to prevent and control infections.
10	Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

The Infection Prevention and Control HCAI Action plan has now been revitalised by Corporate Nursing who completed an assessment of compliance. This action plan will be monitored on a quarterly basis by the IPC Committee.

6. Hand Hygiene

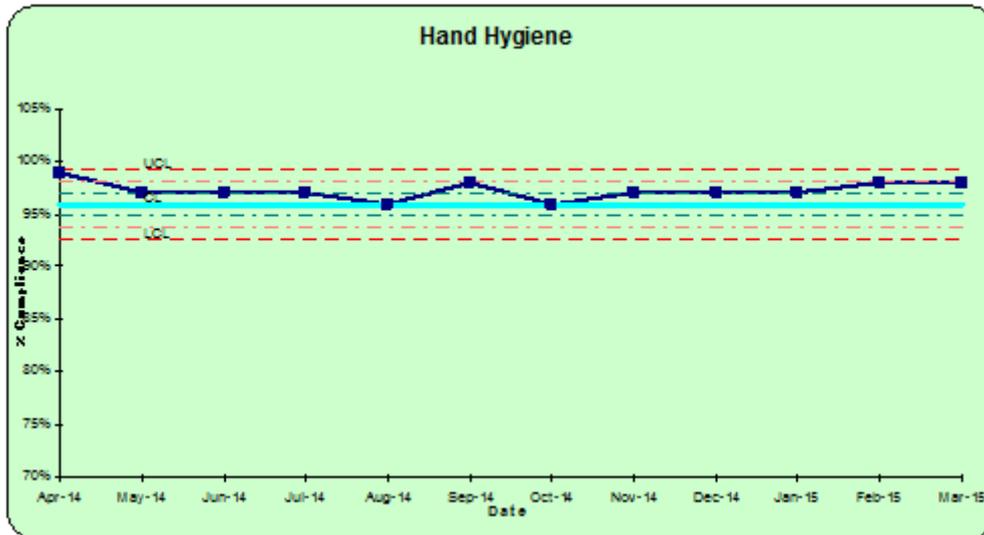
Timely and effective hand hygiene in preventing and controlling infections is a foundation of infection prevention and control practice. Hand hygiene therefore remains a focus for the IPCT and continues to be one of the fundamental messages to all staff. The trust continues to support the work that empowers staff to challenge poor hand hygiene compliance at all grades, and has maintained the Bare Below the Elbows standard for staff in clinical areas

The hand hygiene policy is available to all staff via the trust intranet.

The Trust target for hand hygiene compliance rates is 95%. Audits of compliance are completed every two weeks within all clinical areas. It is the responsibility of all ward managers to ensure that the audits are completed. The IPCT continue to provide training and support to the staff nominated to complete these audits. The results are reported monthly via an electronic report produced by the

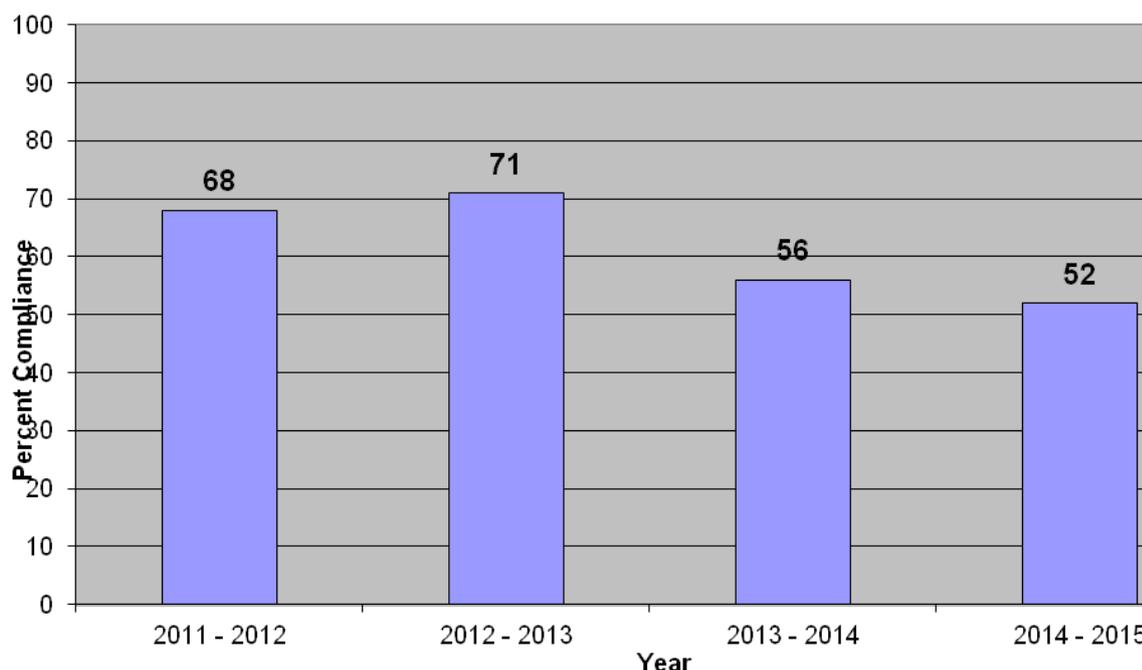
clinical audit department. These reports are reviewed by the IPCT and are discussed at the trust Infection Control committee meetings. The IPCT continue to meet with the managers of areas where the compliance rate has fallen below 95%, action plans are agreed and the impact of these actions is monitored through the ongoing audit programme. The frequency of the audits is increased to weekly when the compliance rate falls below 95% as well as when an outbreak or a period of increased incident of a particular organism has been identified in a ward. The IPCT has also increased the number of validation audits for hand hygiene, to support wards with internal auditing. The team has especially focused on areas where there have been identified infection incidents or outbreaks

The overall compliance rate for 2014/2015 was 97%.



The Trust Hand Hygiene Policy stipulates that staff have their hand hygiene technique assessed within one month of starting their employment and every three years thereafter. It is the responsibility of the IPCT link nurse to ensure these assessments are carried out. The IPCT monitors compliance quarterly through reports produced by the Training and Development Team. The quarterly reports are presented at the Infection Prevention and Control Committee. The graph below shows the actual compliance for the last 4 years against the Trust target of 100%. The IPCT is aware that compliance is significantly below target and has dropped in the last two years. The IPCT's annual programme and ongoing operational plans for 2015-2016 acknowledge this and include actions to increase compliance going forward

% Compliance with Hand Hygiene Assessments by Year



Gojo remain the Trust contracted supplier of Hand Hygiene products. The company has continued to support the IPCT by joining them on ward visits to assess hand hygiene and promote hand and skin care. This continues to provide useful opportunities to sustain positive messages around the importance of compliance with hand hygiene and reinforce the 5 Moments of Hand Hygiene approach.

This year, as previously, Gojo also attended a joint meeting with the IPCT and the Occupational Health department to discuss their products and how to support staff with skin issues.

7. Audits (including High Impact Intervention)

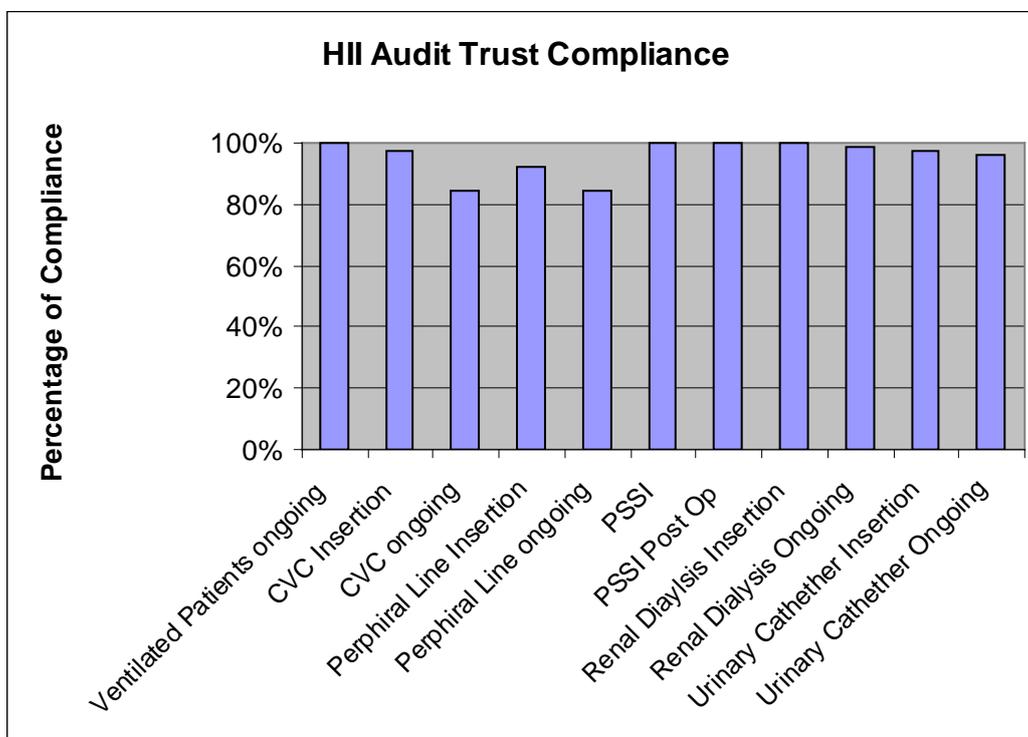
Audit is a key component of Infection Prevention and Control. Knowing how we are doing is vital to delivering safe quality care. High Impact Intervention (HII) audit tools issued by the Department of Health are used throughout the Trust to monitor practice and implement improvements where necessary. The term “High Impact Intervention” refers to a procedure carried out as part of health care which carries a risk of infection. To minimise the risk staff must comply with nationally agreed steps – often called a “care bundle”. Trends in compliance are monitored locally via Clinical Audit, the Matrons, the Infection Prevention and Control Committee and the Centres.

The High Impact Interventions audits include:

- Central Venous Catheter Care (CVC); Insertion / Ongoing care
- Peripheral Intravenous Cannula Care; Insertion / Ongoing care
- Renal Dialysis Catheter Care; Insertion / Ongoing care
- Prevention of Surgical Site Infection (PSSI)
- Care of the Ventilated Patients
- Urinary Catheter Care; Insertion / Ongoing care
- Decontamination of equipment

A Commode Cleaning Audit was introduced by the Trust in Dec 2013, following the findings of audits undertaken by the IPC Nurses in March and May 2013, however this audit has since been removed from the High Impact Audit Programme, as it is now picked up in the IPC Quality Ward Walks. Environmental Audits (with lead nurses) and spot-checks are carried out by the IPCT, Ward Managers and Matrons.

All the above audits are carried out by all Wards and Departments as applicable, on a one to three monthly basis, via the audit programme. Some areas are still struggling to sustain above 95% compliance rates in all audits throughout the year. Support from the IPC Team is always available and any dip in compliance is addressed at the time by Ward Managers and Matrons. Throughout the year we have seen areas with a poor compliance rate make improvements and aim to achieve 100%.



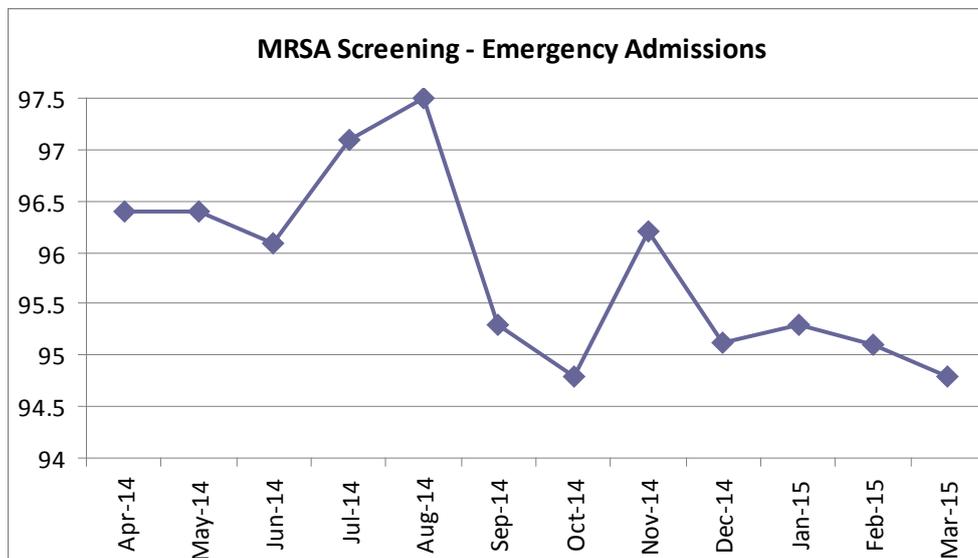
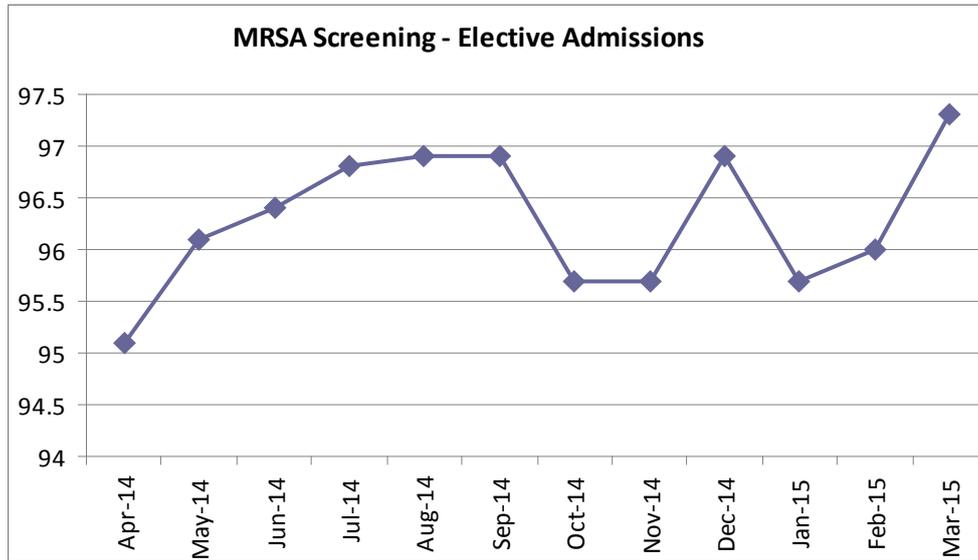
Other audits have been completed during this period covering specific practices and within specific departments. These include:

Planned Audit	Comments and Results
Correct Use of Personal Protective Equipment (PPE) November 2014	Reported December 2014 To ascertain the availability and correct use of PPE and appropriate placement of PPE. The IPC Link Workers were tasked with collecting the relevant data from their own areas. The audit showed some misuse of PPE and some good practice. 37 Ward areas were audited across the Trust. 32 areas had PPE available for use in the sluice 32 areas felt the placement of the PPE around the ward was appropriate/adequate 23 areas had face masks available for use 29 areas had eye protection available for use 25 areas reported 100% compliance with PPE usage
Isolation/Side Room Availability and Utilisation Audit, including Placement and Management of Diarrhoea Patients June 2014	Undertaken Aug/Sept 2014 To ascertain if all patients requiring isolation were placed in side rooms on wards. To ascertain availability of side rooms To ensure all patient who have diarrhoea are isolated as per Trust policy. On the day of the audit, there were 50 patients requiring isolation for IPC reasons, 7 of these patient were not isolated at the time of audit, however 4 were subsequently isolated once escalated, the remaining 3 were not isolated due to valid reasons i.e. requiring ICA care, imminent discharge.

	An SQL report, showing patients with type 5-7 stools documented on VitalPac was also audited at the same time, however this was not useful as when each case was audited, there were valid reasons for this i.e. laxatives, feeds, normal for patient etc. All patients with unexplained diarrhoea were in single side rooms at time of audit.
Sluice Audit October 2014	This was not completed as objectives of the audit have been changed – This is now planned for June 2015.
Commode Audit May 2014	Undertaken June 2014 – looked at commode condition, types of commodes used and display of commode cleaning station poster and supply of cleaning products as per policy. 74 commodes were audited across the Trust (35 at RSH and 39 at PRH) Three types of commodes are used; Vernacare, James Spencer and Bristol Maid. A total of 7 Vernacare commodes required replacing due to poor repair (5 at PRH, 2 at RSH). Commode cleaning station posters were missing in 7 sluices at RSH and 1 at PRH, there were also no wipes available at the cleaning station of 6 wards across the Trust, and 11 wards did not have Tristel available for cleaning. Outcome: broken commodes were removed from use and replaced where necessary, alternative cleaning products (chlorine wipes) have been introduced to simplify the cleaning process. New commode cleaning video has been produced. New commode cleaning station posters are currently in production.
Segregation of Linen Audit May 2014	Reported June 2014 - To ascertain if linen was stored and handled appropriately within the Trust and if clinical areas are receiving sufficient linen supplies for a 24 hour period. 48 areas were audited. 15 areas scored above 95% = 31% compliance compare to 53% compliance in 2013.
Validation of information that is provided at Pre-op Clinics around infection prevention prior to admission.	To ascertain whether IPC leaflets were given to elective patients at their Pre-op assessment. The expectation being that the following leaflets are provided: Hand Hygiene Reducing the Risk of Infection in hospital – Patient Information Reducing the Risk of Infection in hospital – Visitor information. A formal audit has not taken place, extensive work has been undertaken with updating and reformatting the IPC leaflets and Booking Support Services are currently working on producing these. A snapshot audit in pre-op would indicate that the current Reducing the Risk of Infection in Hospital leaflet is being given out, unfortunately there has been little response from the postal audit. Plan to repeat this audit in 2015.
MRSA Screening Compliance (Elective / Emergency Screening) Monthly	An ongoing report for both Elective and Emergency MRSA screening was and still is generated through IT systems. The graphs below show the compliance rates for the year. The SQL systems can be accessed by the Centres, so that they can address the non-compliance locally.
MRSA & C.Diff Care Pathway Audits September 2014	These were planned for September 2014, however due to planned changes to the current Trust care plans, IPC nurses designed a combined care plan to include all known isolates. This was trialled on wards 17 and 22TO with positive feedback. This new care plan has now been published on the intranet (01/04/15) along with all of the new care plans (IPC to change the orientation of the IPC one), IPC will highlight this new care plan in the next Hot Topic to launch Trust-wide use and plan to audit this after 3 months of use (Aug 15).
Mattress Audit	Planned for August 2014, however the Trust purchased new mattresses in October, audit not undertaken
Audit of Medical	Undertaken March 2015 (Report due)

Discharge Letters of patients with known infection
September 2014

Audit to ascertain if the relevant infection status of patients with a known isolate during their admission is recorded on discharge letters and transfer of care paperwork.
10 sets of notes were audited (5 from each site). Only 30% (3/10) discharge letters recorded the infection status and 100% (3/3) of patients transferred to continuing care recorded the infection on the 'transfer of care' paperwork completed by the ward staff. A letter from Microbiology was sent informing the GP of the recent infection for all relevant isolates.



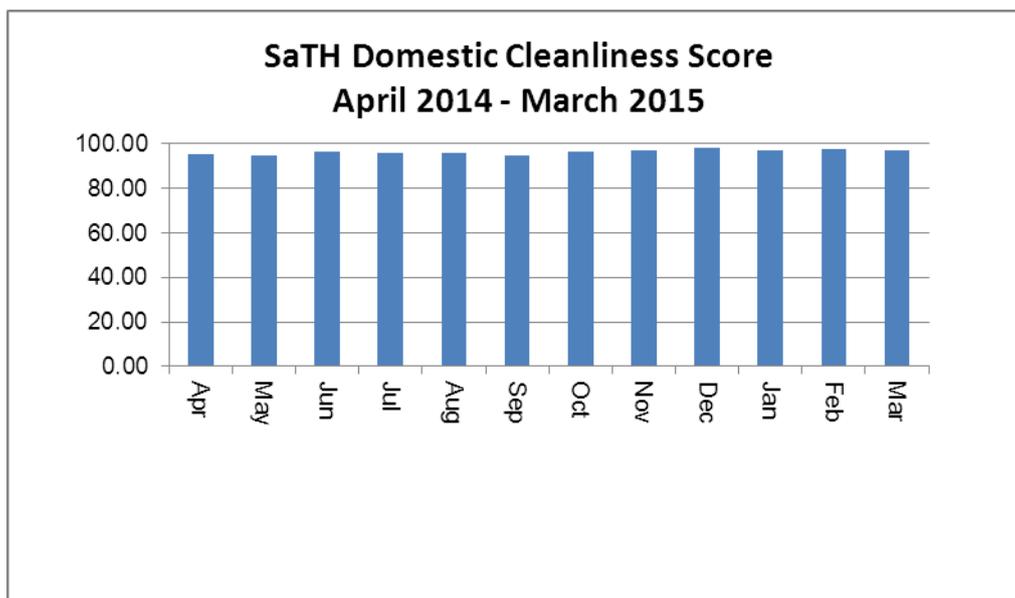
A programme of Audit has been established for 2014/2015. This forms part of the Infection Prevention and Control Annual Programme.

8. Environmental Cleanliness

Domestic Service Monitoring 2014 – 2015

All areas are monitored monthly

	2014-2015											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trust Average %	95.20	94.96	96.65	95.92	95.88	94.91	96.80	96.92	98.45	96.84	97.54	97.29



The average Trust wide score for Domestic Cleanliness Monitoring for 2014/2015 was 96.45% which is above the target of 92%.

Cleanliness and Hygiene

Formal PLACE assessments for 2014 were undertaken for the following areas:-

- Princess Royal Hospital
- Oswestry Maternity Unit
- Royal Shrewsbury Hospital
- Bridgnorth Maternity Unit
- Ludlow Maternity Unit

The results of the assessment are shown in the table below.

PLACE Results for 2014

	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance
2014 Assessment Score	98.76%	86.25%	78.89%	92.23%
National Average 2014	97.25%	88.79%	88.73%	91.97%

As can be seen from the above table we were around the national average for all except privacy and dignity and the issues that cause the score to be reduced are:-

- The Trust has no lockable facilities for patients possessions
- The PSAG boards are on public display on wards
- There was a privacy and dignity issue in Fracture clinic at PRH which needs to be resolved – the issue is created due to space and the Department Manager and the Estates Manager are looking at a resolution to the issue

Actions from the PLACE inspections are monitored via our Patient Environment Group. Feedback from these inspections has been presented to the Patient Environment Group.

The 2015 PLACE programme is already underway and results will be available from the Health and Social Care Information Centre around September time.

9. Overview of 2015/16 Annual Programme

The 2015/16 programme reflects the requirements of the Health and Social Care Act 2008. Its function is to provide a clear measurable plan for the management and delivery of the Infection Prevention service. Delivery of Infection Prevention and Control service is unpredictable & can challenge service delivery. During winter months for example outbreaks of Influenza or 'Winter vomiting' virus can increase workload suddenly with little warning, therefore the Annual Programme of work is designed for flexibility and if necessary project dates may need to be reallocated.

Our focus for 2015/16 will be:

- Ensure cleanliness issues within wards and departments is a priority and review basic standards of practice such as cleanliness and use of commodes in the environment
- To prevent and reduce the incidence of Clostridium difficile infection in SaTH based on a strong health economy partnership approach including surveillance, implementation of best practice, audit and root cause analysis
- Strengthen governance around decontamination of instruments/equipment outside of CSSD and continue to work with decontamination lead to focus on outstanding issues.
- Urinary Tract Infections (UTIs) are the most common healthcare associated infection in acute hospitals. The risk of developing a catheter associated urinary tract infection (CAUTI) increases the longer a urinary catheter remains in situ. The IPC Team will continue to support the urology specialists nurses aim to develop a campaign to reduce UTIs.