York Teaching Hospital NHS
NHS Foundation Trust

Director of Infection Prevention and Control

Annual Report

2010/11

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Governance: Presented to Board of Directors
Date of Report: 17th November 2011

1. Introduction

The profile of and commitment to Infection Prevention (IP) is well established within York Teaching Hospital NHS Foundation Trust (YNHSFT). Assurance of performance and compliance with standards and regulatory requirements is provided to the Trust Board through the following legislative and management frameworks.

- The Hygiene Code Corporate Action Plan developed from The Health & Social Care Act 2008 Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Regulated Guidance 2009 – known as the Hygiene Code
- Quarterly Director of Infection Prevention and Control (DIPC) reports to Trust Board.
- IP Annual Plan 2010/11 Appendix 1
- IP Performance Dashboard Appendix 2 – high level metrics reported via Signal electronic performance monitoring system.
- Operational Performance Management framework
- Internal Audit compliance reports

2. Executive Summary

Challenging objectives set in 2010/11 by the DH in relation to reducing Healthcare Associated Infection (HCAI) requires the Trust to maintain Infection Prevention as a high profile quality and safety indicator and key priority in relation to healthcare governance. The Trust continues to perform well in relation to mandatory surveillance objectives for MRSA bloodstream infection, *Clostridium difficile* infection(CDI) and screening of elective and emergency admissions for colonisation with MRSA (refer to Section 4 and Appendix 2).

This annual report and the Trust IP Performance Dashboard detail progress made against the IP Annual Plan (App 1) that outlines key IP objectives, reflects the requirements of the Hygiene Code 2009 and other relevant DH directives:

- Saving Lives: reducing infection, delivering clear and safe care
- NHS Operating Framework (DH 2010/11)
- Evidence based Practice in Infection Prevention and Control (EPIC 2, 2007)
- CNO High Impact Actions for nursing and midwifery (2009)

3. Infection Prevention and Control Arrangements

- Governance Structure – refer to App 5
- Reporting Framework – refer to App 6
- Team Structure and establishment - refer to App 7
- Exception reporting from the Hospital Infection Prevention and Control Committee (HIPCC) is made to the Clinical Assurance Committee a sub committee of the Risk and Assurance committee.

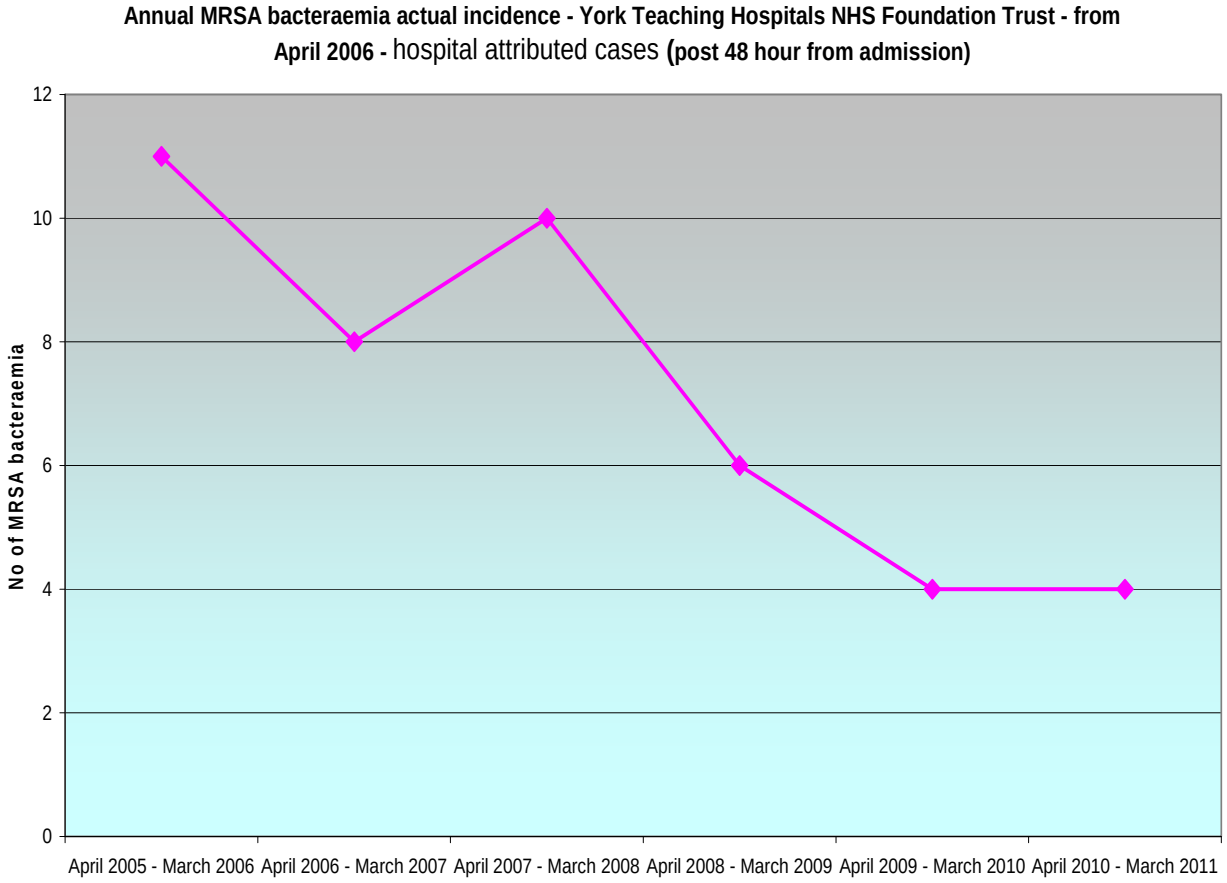
4. HCAI and IP Performance

Refer to Appendix 2 – Trust IP Performance Dashboard.

4.1 Hospital Attributed MRSA Bloodstream Infection – those cases which occur >48 hours after admission

For the year April 10 to March11 the Trust reported 4 hospital acquired infections against a threshold of 2. However Monitor (the regulators of Foundation Trusts) requires that where an NHS Foundation Trust has an annual objective of 6 cases or fewer (the *de minimus* limit) *and* has reported six cases or fewer in the year to date, the MRSA objective will not apply.

The following data demonstrates sustained reduction in MRSA bloodstream infection since2005.



4.2 Screening of Emergency and Elective admissions for MRSA colonisation.

Using the internal reporting mechanism i.e the number of patients screened as a proportion of those eligible:

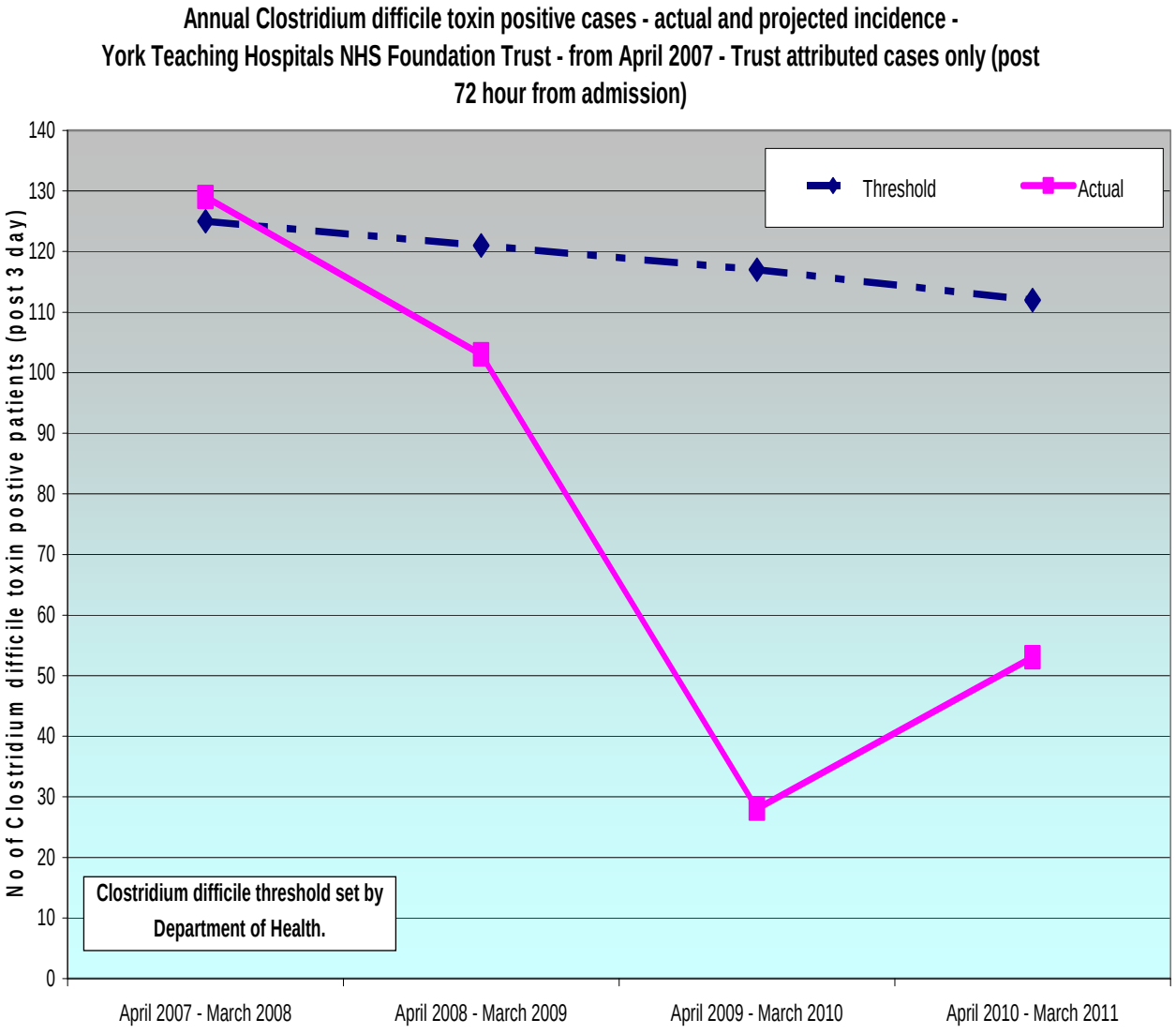
Emergency Admissions –69% of those eligible were screened during the first four months of implementation from Dec 2010.

Elective Admissions - average compliance was 88% of eligible elective admissions compared to 63% from implementation in 09/10

The MRSA screening coordinator works continually with Directorates to identify areas/initiatives for improvement.

4.2 Hospital Attributed Clostridium difficile Infection (CDI), those cases which occur >72 hours after admission

For the year to March 2011, the Trust reported 53 hospital attributed cases against an objective of 112. Data below demonstrates incidence against the objective from 2007.

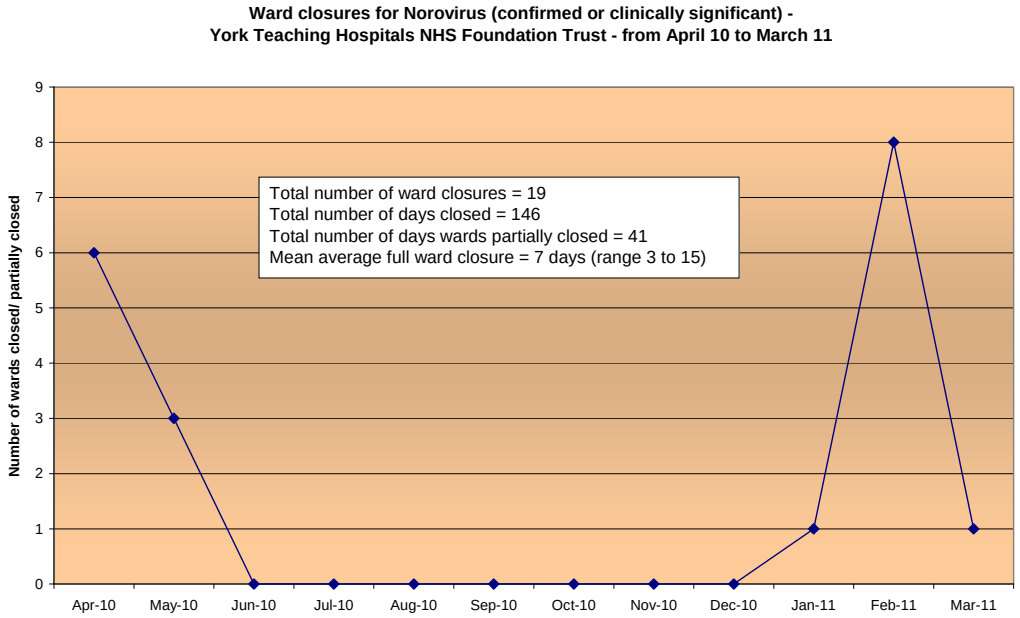


4.3 Norovirus

The Norovirus season began in January 2011.
Strict outbreak control measures that included enhanced environmental disinfection were implemented across affected areas. The IP Team worked collaboratively with the Health Protection Unit and Consultant in Communicable Disease Control to monitor incidence and compliance with control measures.

Norovirus has a significant impact on capacity and finance through several, sometimes prolonged ward closures. The IP Norovirus action plan incorporates the evaluation of new technologies and the installation of automated door closure systems

attempts to attenuate the impact of future outbreaks. Data below outlines the impact on the Trust during the 2010/11 season.



4.4 Directorate Performance and Assurance

To continue to enhance the process of devolving responsibility and accountability for IP compliance and performance to clinical level, all Directorates are now provided with their own IP dashboard that focuses on high level clinical and environmental metrics. These are discussed and actions agreed at Operational Performance Management meetings (PMM`s). Escalation when required is via Executive PMM to the Director of Operations and the DIPC.

Key IP metrics will be reviewed and reported via Signal for evaluation at PMM`s in 2011/12.

5. Root Cause Analysis (RCA) of HCAIs

As required by the Hygiene Code, all cases of MRSA bacteraemia and *C.difficile* infection are investigated using a multidisciplinary RCA process. RCA for Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia is initiated by the IPT according to patient contact with the Trust. Outcomes are presented to Executive Board by the lead clinician. Lessons learnt and actions required are agreed and disseminated via IP systems and processes throughout the organisation.

A summary of directorate results of RCA elements is fed back through the IP dashboard.

5.1 Root Cause Analysis summary of MRSA bacteraemia 10/11 – main issues raised

Date issue first raised	Key issue	Actions
Dec 10	Staffing levels in critical care – staff vacancies + staff sickness	Recruiting more staff – interviews January 2011
Dec 10	Not following ICU central line pathway for timely removal of line	To hold an education event for all staff as a reminder of the care pathway

5.2 Root Cause Analysis summary of *Clostridium difficile* infection – main issues raised

Date issue first raised	Key issue	Actions
April 09 (ongoing issue)	Antimicrobial prescribing issues (all patients)	Antimicrobial stewardship team overseeing all issues relating to antibiotics
April 09 (ongoing issue)	Delay in collecting and sending stool samples	Advice included in staff training Ward posters distributed with advice on how to send specimens Extra porter round added at end of working day. More PODS purchased
April 09 (ongoing issue)	Delay in starting stool charts	Advice included in staff training Charts available to print from Horizon

6. Hand Hygiene

Compliance is sustained across the Trust at 98% – 100% as is Bare Below the Elbows

The Observational audit tool has been amended to reflect the World Health Organisation (WHO) `5 moments for Hand Hygiene` initiative

With Play leaders, a bespoke Hand Hygiene package has been developed for Children's Services that will then be implemented in all areas of the Trust where children access care. Aimed at increasing understanding, awareness and

compliance, children will be provided with a colouring book depicting organisms as cartoon characters supported by information about the importance of clean hands, stickers for good hand hygiene practice and a pack of crayons. Funding and sponsorship are being sought through charitable funds and external agencies

A `fun` hand hygiene station has been erected in the play area on ward 17 so that children can learn through play with their parents.

7. Audit and Surveillance

Appendix 3 provides a summary of IP audit /surveillance activity and outcome**.**

8. Aseptic Non Touch Technique (ANTT) Theoretical Framework for Clinical Practice

ANTT Clinical Guidelines are based upon a set of foundation principles set out in the ANTT Theoretical Framework for Clinical Practice. It has been shown to improve the clinical (aseptic) behaviour of staff when implemented robustly. The framework has 10 foundation principles and it is used for all clinical procedures.

Summary:

All areas allocated workbooks, Saving Lives data collection for IV access now includes acknowledgement of ANTT being used to a satisfactory standard.
Post launch audit shows improvement in ANTT technique (100% compliance), but illustrates lack of correct hand hygiene technique with steps being missed.
Still require feedback from some wards and clinical areas of staff signed off as competent.

Post Implementation Audit:

- Pre equipment prep Hand Hygiene (HH) – 75% (however 7 stage technique only used in 50% of occasions)
  (Pre launch – 40% compliance with 7 stage technique)
- HH pre drug prep- 63% (however 7 stage technique only used on 25% of occasions)
  (Pre launch 50% compliance with 7 stage technique)
- Tray clean – 75%
  (Pre launch 30% compliance with 7 stage technique)
- Appropriate glove use – 63%
  (Pre launch 80% appropriate use)
- Key parts protected - 100%
  (Pre launch 80%)
- Non Touch Technique used - 100%
  (Pre launch 90%)

9. Antimicrobial Stewardship Team (AST)

Continued activity to drive improved antimicrobial use across the Trust 2010- 11 has seen significant effort on a range of fronts:

The team has maintained focus on developing multidisciplinary antimicrobial ward rounds, actively reviewing reserved antimicrobials on wards and responding to case referrals. Rational antimicrobial use extremely important in maintaining the relatively low *C.difficile* infection rates in the Trust.

A strengthened Pharmacy Infection and Antimicrobials team is now Consultant Pharmacist led with Directorate Pharmacist and Senior Secretary Support. A Specialist Pharmacy Technician also being appointed in May, significantly improving resource. It is hoped this would equate to £46000 cost savings. Technician support has allowed the Antimicrobials Emergency Cupboard system to be reviewed in response to the NPSA delayed and missed doses alert.

Concerns around adequacy of some antibiotic cover led to a comprehensive review of the Surgical Prophylaxis Formulary. This has required ongoing engagement with directorates, in particular Head and Neck, ENT and Obstetrics and Gynaecology. Compliance with existing guidelines was evaluated as part of the process, targeting change where appropriate. In addition a system of reviewing surgical team case referrals post-operatively has been established.

A multi-professional project group has been formed in conjunction with Bradford Institute for Health Research NPSA injectable medicines safety alert. The group is exploring whether behavioural changes are key to further improve Trust use of some antibiotics.

The work of the AST has proved of interest in work alongside the Antimicrobials Team (currently Directorate Pharmacist for Antimicrobials) and other colleagues at Scarborough District General Hospital. Specific collaboration with Acute Medicine Consultants, Microbiologist and a Specialist Nurse in the Emergency Department developed a new cellulitis pathway. This has led to a strengthening and broadening of the AST remit to involve clinical and pharmacy colleagues from Scarborough and to the first joint AST meeting in September 2011. We now have the beginnings of an AST for both hospitals, capitalising on the success achieved in York over the last three years backed by vital support from the DTC governance model at both ends.

Positive links were also formed with a number of GP practices; in Selby, Strensall and Gillygate plus Selby In-Patient Unit, to ensure that the antimicrobials work taking place in secondary care ties with that going on in primary care.

The Trust is currently taking part in the Health Protection Agency co-ordinated European-wide Point Prevalence Survey of antimicrobial use and healthcare associated infection. The results of this survey allowing us to compare our organisation with hospitals across Europe are expected early in 2012. Alongside this effort a Technician coordinated Poster Presentation is being held on European Antibiotic Awareness Day. This aims to educate patients and members of the public, with a press release from the media office and hopefully through the BBC.

Going forward an updated Antimicrobial Stewardship Team work plan has been approved. Specific objectives focus on clinical engagement, control of reserved antimicrobials, crisis management, guideline implementation, education and audit.

10. Policies

All core policies as required by the Hygiene Code 2009 are in place and have been published on the IP intranet and Trust internet sites:
http://www.yorkhospitals.nhs.uk/?id=138&ob=1
Flow charts are included to facilitate implementation by users. IP care plans have been amended in line with the policies. Appendix 4 provides a summary of evidence of policy compliance audits.

11. Training and Education

The IPT consider training and education a core activity key to the success of ensuring a knowledgeable workforce and effective IP in clinical practice. It continues to deliver comprehensive programmes to those registered and unregistered staff who attend according to their job profile. Content is tailored to specific staff group needs that are identified through audit and surveillance outcomes or as required by the Hygiene Code. Quarterly report to the Board and at the HIPCC have identified that uptake of IP training should be made a priority by Directorate Clinical Leads.

404 (8.5%) of multidisciplinary staff attended statutory Corporate Induction training that includes an IP `signposting` session. Data below outlines uptake of IP annual update training by staff group.

	Headcount Total	Headcount Attended	% Attended
Staff Group			
Add Prof Scientific and Technical	239	145	60.7%
Unregistered staff	703	442	62.9%
Administrative and Clerical	1086	372	34.3%
Allied Health Professionals	322	127	39.4%
Estates and Ancillary	547	280	51.2%
Healthcare Scientists	105	82	78.1%
Medical and Dental	458	18	3.9%
Nursing and Midwifery Registered	1305	861	66.0%
Students	3	0	0.0%
	4768	2327	48.8%

12. Environment Steering Committee (ESC)

Re developed in 2010, the Environment Steering Committee is a sub committee of the Hospital Infection Prevention and Control Committee (HIPCC).

Purpose of the Committee is to ensure that hospital cleanliness and the patient environment meets Department of Health standards and user expectations. It oversees implementation of the Standards set out in the Hygiene Code, Department of Health Clean Hospitals programme and National Cleaning Standards:

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

- Ensure the patient environment is safe, clean, warm and welcoming through regular review of service standards.
- Review performance against National cleaning standards.
- Develop and review Estate maintenance standards for the Trust.
- Give Patients the opportunity to provide feedback on the hospital environment so that the hospital can respond sensitively to these needs.
- Give Ward/Department Managers greater control over the cleanliness and overall appearance of their wards/departments.
- Monitor and improve the environment through the Patient Environment Action Teams (PEAT).

Much work has been and continues to be done to enhance cleanliness of equipment and the environment. Ward cleaning schedules that outline actions and responsibilities are in place in all areas and reflect the National Cleaning standards 2007 – work that the CQC commented positively on at their inspection. Matrons and Ward Managers have responsibility to monitor compliance by both Domestic and ward staff via monitoring and observational checklists, action plans are initiated when compliance falls below the standard for the risk profile of the area. Data is also fed back via the IP dashboard to ensure Directorate IP leads are aware of poor compliance/monitoring scores.

New cleaning and disinfection processes have been implemented to assist with accessible and more efficient decontamination of communal clinical equipment.

The Trust is committed to significantly improving the environment. The Director of Strategy and Planning has developed a detailed plan to achieve this.

13. Internal Audit

The following compliance audits were undertaken by the Trust Internal Audit Dept from whom full reports are available.

Linen and Laundry

Objective

The aim of this review was to ensure that systems exist to ensure the reliability of the management and provision of laundry and linen services by the Trust.

Screening of Elective Admissions for MRSA Colonisation

Objective

To provide assurance to the Board that systems and processes for the management and reporting of the screening of elective patients for MRSA colonisation are effective.

Inter Hospital Transfers

Objective

To provide Board assurance that systems and processes exist are robust and ensure that patient safety, continuity and quality of care are maintained during inter-hospital transfer of patients. The IP objective within the report was to observe that nursing documentation contained all the salient points about infection prevention risks and that treatment plans detailed what was required to control and prevent the spread of HCAI.

Conclusion & Recommendation

This report provides evidence that all objectives within the Annual Plan 2010/11 were met or remain permanent ongoing priorities, the 2011/12 Annual Plan (available from the IPT) will address these.

The Hygiene Code Corporate Action Plan due to be implemented in 2011/12 will provide additional assurance to the Board and external regulators of performance and compliance.

The Board is asked to note and comment on this report.

Appendix 1

Infection Prevention Team Annual Plan 2010/2011

Key Regulation and Assurance Standards:

- The Health and Social Care 2008: Code of Practice for the NHS on the Prevention and Control of Healthcare Associated Infections and related guidance (HCIA) (The Hygiene Code).
- Monitor Assurances
- The Operating Framework for the NHS in England 2010/11
- NSLA Risk Management Standards for Acute Trusts 2010/11
- National Evidence Based Guidelines for Preventing Healthcare Associated Infections in NHS Hospitals in England 2006 (EPIC)
- Saving Lives: Reducing infection, delivering clean, safe care 2007
- The Trust Antimicrobial Stewardship Team (sub group of Hospital Infection Prevention and Control Committee (HIPCC))

1.0 Management

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment March 2011
1.1 Develop responsibility for the prevention, reduction and control of HCAI from Board to ward	• Compliance with the Hygiene Code • HIPCC • CAC – exception reporting • Risk registers • Executive Board Reports • Monitor Assurances • RMSAT • NHS Operating Framework 2010/2011	• DIPC Annual Report • Hygiene Code Corporate Action Plan • Trust policies • Compliance Audit Projects	• BoD • Corporate Leads identified within the Action Plan • IPC Steering Group • Matrons • Committee and Board minutes	Permanent Trust objective	Hygiene Code Corporate Action Plan Process almost complete – implementation date August 2011. All other controls and assurances in place.
1.2 Develop whole health economy collaboration to help meet key performance indicators to reduce the burden of HCAI	• Hygiene Code Corporate Action Plan • Root Cause Analysis (RCA) Outcome • DCIC HCAI sub group • CIPN meetings	• Minutes of bi-monthly meetings with Community Infection Prevention Team. • DIPC minutes • Hygiene Code Corporate Action Plan • RCA Action Plans	• Acute and Primary Care Trust • Infection Prevention Leads	Ongoing initiative	Controls and assurances in place.

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment March 2011
1.3 With the Director of Operations, Director of Infection and Prevention and Control and Clinical Leads, critically review the Trust's ability to provide safe and effective isolation, including the provision of a negative pressure facility	• Hygiene Code Criterion 6 • Saving Lives 2007 • AIRS System • Trust IP Policies: Isolation • Risk register • Control and Management outbreaks	• Hygiene Code Corporate Action Plan • Outbreak documentation • Policy audit reports • Outbreak meeting minutes and actions	• Executive Board • DIPC • IPT • Associate Director of Operations • Director of Strategy and Planning		Reported to board through DIPC quarterly reports. On IP risk register
1.4 Anti-microbial stewardship (Team) (AST)	• Directorate prescribing formularies • Audit reports • AST minutes	• Prescribing audit data • AST minutes	• Consultant Pharmacist • Clinicians	Permanent objective	Directorate prescribing formulary in place or being developed.

2.0 Clinical Standards and Practice

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment March 2011
2.1 Eliminate variations in clinical practice and performance to bring about sustainable reductions in HCAI's	• NHS Operating Framework 2010/2011 • Trust Infection Prevention Policies • IP Policy Audit Strategy • Saving Lives 2007 • IP Dashboards • Root Cause Analysis (RCA) • ANTT	• Audit Reports Action plans • ANTT data • Saving Lives compliance data • IP Dashboards and operational PMM minutes • RCA reports and action plans	• IPT • Directorate IP Leads • Matrons • Ward Managers	Permanent objective reviewed and evaluated through audit surveillance activity	All controls and assurances in place.
2.2 Critically review facilities for and management of Norovirus to reduce incidence and spread, including the consideration of new technologies	• Hygiene Code Criterion 6 • Trust IP policies - Isolation - Management of Outbreaks • Saving Lives best practice summary 2007 • Norovirus action plan 2010	• Hygiene Code Corporate Action Plan • Compliance audit reports • Norovirus action plan	• DIPC • Executive Board • Director of Strategy and Planning • IPT	Ongoing Objective against national and regional guidance August 2010 for new technologies	Annual review of policies, control and management strategies using previous year as baseline and standard.

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment March 2011
2.3 Continue sustained reduction in MRSA, BSI and *C.difficile* Infection to achieve 2010/11 trajectories.	• NHS Operating Framework 2010/11 • Trust IP policies - Control and Management of MRSA - Control and Management of *C.difficile*	• HCAI incidence data • Policy Audit data • Saving lives	• Directorate Clinical Leads • Matrons • IPT	Permanent imitative	Trajectories met. Refer to Trust IP dashboard, appendix 2
2.4 Screening all relevant emergency admissions by December 2010	• NHS Operating Framework 2010/2011 • National Quality Board 2009	• Screening compliance data	• Directorate Clinical Leads • Matrons • Ward Managers	Implemented December 2010	December 2010
2.5 Continue to develop the Hand Hygiene strategy and action plan to sustain compliance at 95% **2.5.1** Develop hand hygiene competency framework	• NPSA Alert 2009 • Hand Hygiene policy • RMSAT	• Observation compliance data • Policy audit data • Competency assessments	• Hand Hygiene Coordinator/IPN • Matrons	Permanent objective Early 2011	Compliance sustained, refer to Trust IP dashboard, appendix 2 On target
2.6 Implement the Aseptic Non Touch Technique framework (ANTT)	• Asepsis Policy • ANTT framework	• ANTT compliance data • Competency checks	• IPNs • Matrons • Ward Managers	May 2010	Objective met

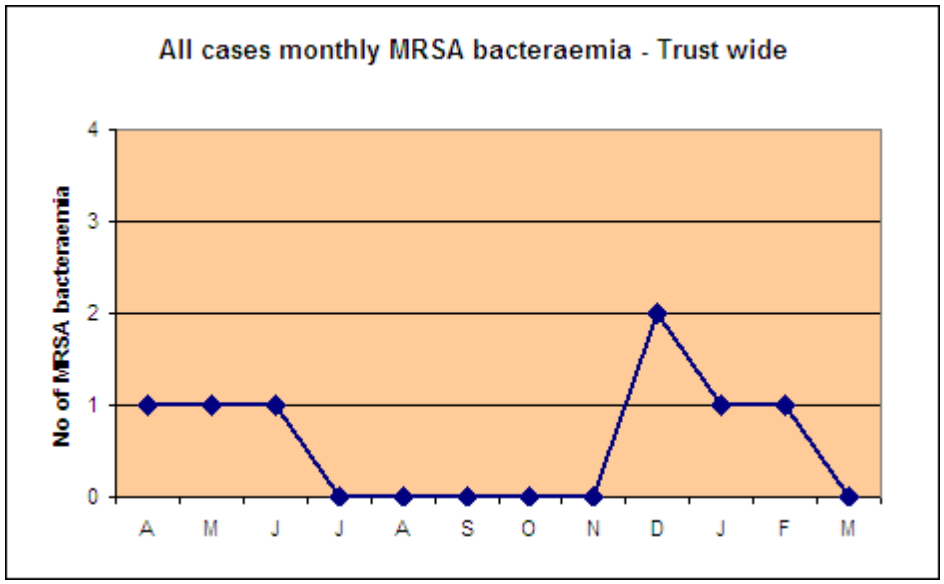
3.0 Surveillance and Audit

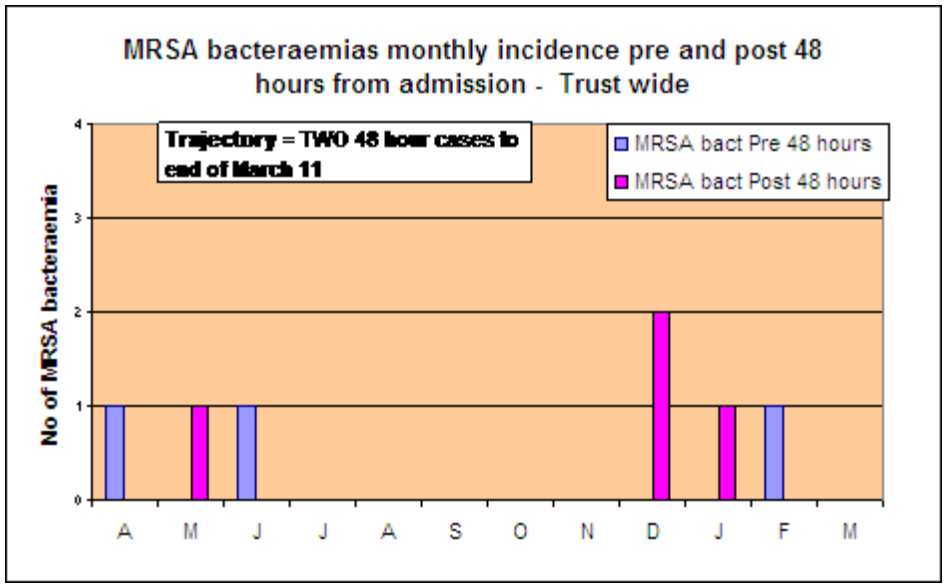
Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment March 2011
3.1 Develop and implement: • Surgical Site Infection (SSI) surveillance • Surveillance of Urinary Catheter Associated Urinary Tract Infection (CAUTI)	• Hygiene Code • Saving Lives High Impact Intervention 6 • High Impact Action • CQUIN Framework	• Hygiene Code Corporate Action Plan • Saving Lives data • Surveillance Data • CQUIN data	• IPT • Directorate IP leads • M Carrington, Asst Chief Nurse	September 2010 Spring 2011	Framework still in progress Point prevalence project developed and to be implemented July 2011
3.2 Procure Infection Prevention and control software Have 'live' performance data (dashboards) available via Signal	• Hygiene Code	• Robust audit and surveillance data that is timely and meaningful to underpin quality and patient safety.	• IPT • IT department • Finance Manager	2013 April 2011	BC being developed – slow progress. Due for development November 2011
3.3 Re-implement audit of the clinical environment	• Saving Lives High Impact Intervention 8 • Trust IP policy - Antiseptic and Decontamination • Decontamination Steering Group	• Saving Lives data • Policy audit report • Matrons assessment tool • Decontamination Group minutes	• IPT • Matrons • Ward Managers • Decontamination Lead/Director of Estates and Facilities	September 2010 August 2010	Objective met. Refer to Trust IP dashboard, appendix 2

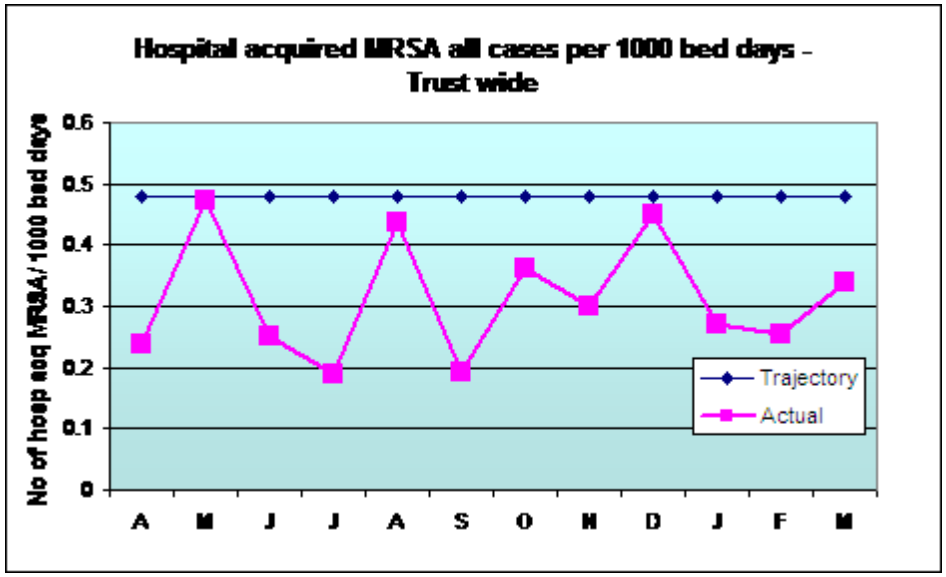
4.0 Education and Learning

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment March 2011
4.1 Continue to develop and deliver statutory and mandatory training to all Trust staff utilising traditional and alternative methods **4.1.1** Evaluate alternative methods of delivery for difficult to access groups i.e. Porters, Domestics.	• Hygiene Code • RMSAT • Trust Training Needs Analysis (TNA)	Hygiene Code Corporate Action Plan RMSAT inspection report Attendance data via ESR	• CLAD • IPT • Risk and Legal Services	Annual Initiative December 2011	All sessions delivered as scheduled Requires progress

Charts

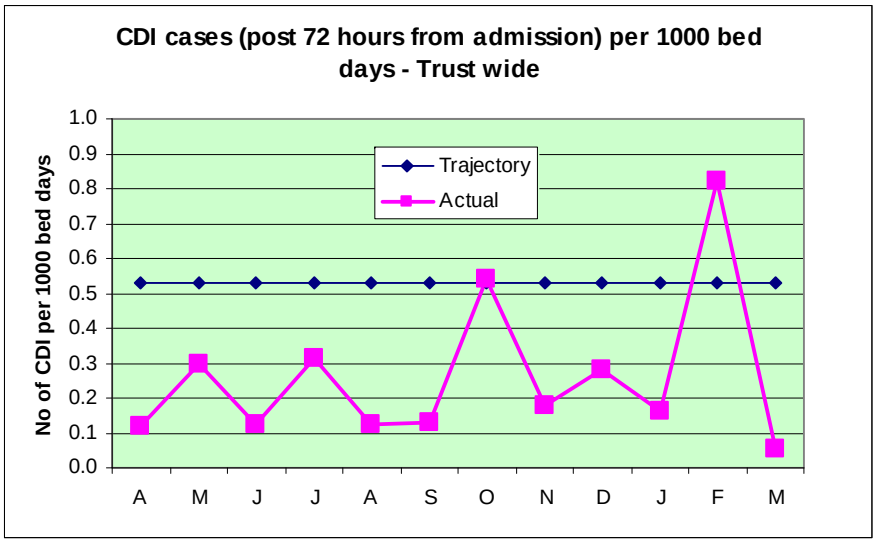


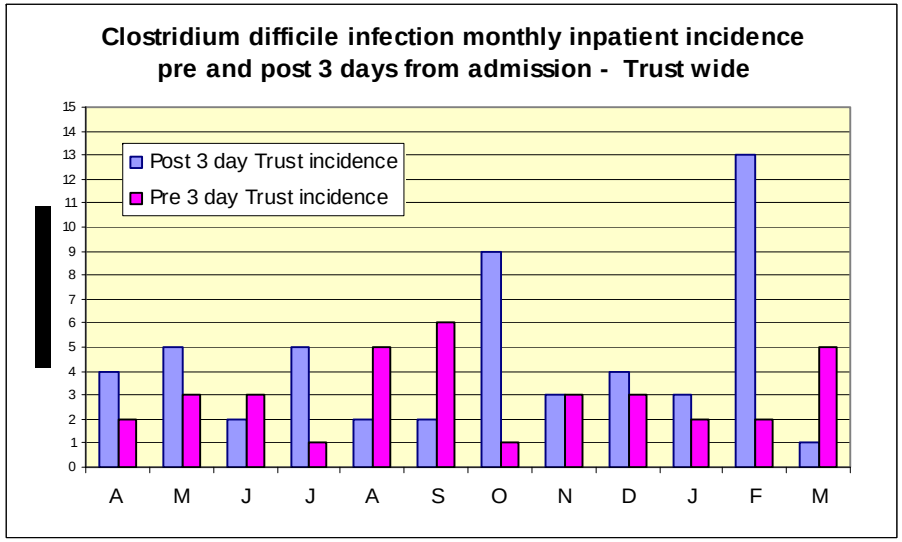




'Hospital acquired' defined as patients who have acquired MRSA after being in hospital for more than 2 days.
NB: number refers to all cases where MRSA is isolated - including nose, throat, perineum, wounds, invasive device sites, bloodstream, and urine.

Presence of MRSA is not a sign of infection - patient requires assessment for other clinical signs


CDI cases (post 72 hours from admission) per 1000 bed days - Trust wide
No of CDI per 1000 bed days
1.0
0.9
0.8
0.7
0.6
0.5
0.4
0.3
0.2
0.1
0.0
Trajectory
Actual
A
M
J
J
A
S
O
N
D
J
F
M


Clostridium difficile infection monthly inpatient incidence pre and post 3 days from admission - Trust wide
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
Post 3 day Trust incidence
Pre 3 day Trust incidence
A
M
J
J
A
S
O
N
D
J
F
M

Trust Infection Prevention Performance Dashboard

MRSA and *C.diff*

Appendix 2

Trust wide Infection Prevention Performance Dashboard															App.2
Trust Targets 10/11		MRSA bacteraemia: TWO post 48 hour cases						Clostridium difficile Associated Diarrhoea: To be agreed							
Isolate	**2009/10 baseline**	**2010/11 trajectory**	**Cases in 2010/11**												**Cases (to date)**	**Comments**
				A	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**	**J**	**F**	**M**		
MRSA Bacteraemia cases per year	Trust total 10	TWO post 48 hour cases	All cases	1	1	1	0	0	0	0	0	2	1	1	0	7	Pre + post 48 hour cases
			MRSA bact Pre 48 hours	1	0	1	0	0	0	0	0	0	0	1	0	3	
			MRSA bact Post 48 hours	0	1	0	0	0	0	0	0	2	1	0	0	4	No scrutiny up to 6 cases.
MRSA clinical isolates	112 hospital acquired = 0.54 per 1000 bed days	101# hospital acquired = 0.48 per 1000 bed days**	Actual hosp acq per 1000 bed days	0.2	0.5	0.3	0.2	0.4	0.2	0.4	0.3	0.4	0.3	0.3	0.3	0.31	Target <= 0.48 per 1000 bed days.
***Clostridium difficile* Associated Diarrhoea**	28 (post 72 hours) = 0.13 per 1000 bed days*	112 hospital acquired = 0.53 per 1000 bed days** (NB:trajectory decided by DH)	Post 3 day Trust incidence	4	5	2	5	2	2	9	3	4	3	13	1	53	
			Pre 3 day Trust incidence	2	3	3	1	5	6	1	3	3	2	2	5	36	
			027 cases - PRE AND POST	2	1	1	1	0	0	2	3	0	3	5	2	20	Excludes 027 community
			Actual post 72 hour per 1000 bed days	0.1	0.3	0.1	0.3	0.1	0.1	0.5	0.2	0.3	0.2	0.8	0.1	0.26	Target <= 0.53 per 1000 bed days.

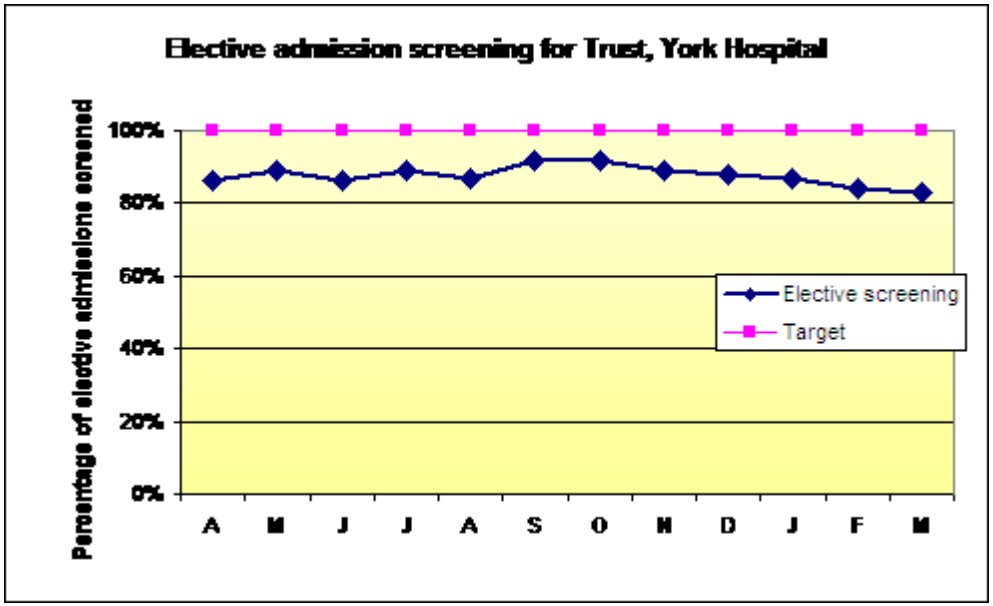
*Bed days include all Trust inpatients. Data provided by Information Dept, YH

** Using 09/10 total bed days as baseline

2010/11 trajectory based on 10% reduction of 09/10 total

		A	M	J	J	A	S	O	N	D	J	F	M
Elective screening	**(Percentage of elective admissions screened).**	**86%**	**89%**	**86%**	**89%**	**87%**	**92%**	**92%**	**89%**	**88%**	**87%**	**84%**	**83%**
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Data provided by Information Department, YH



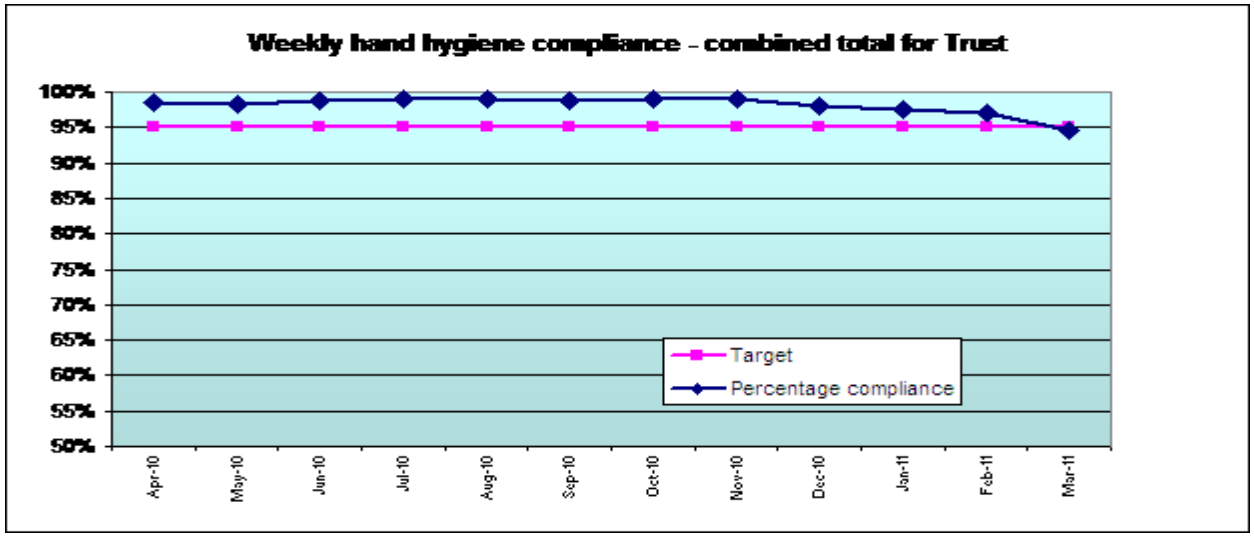
Trust Infection Prevention Performance Dashboard

Appendix 2

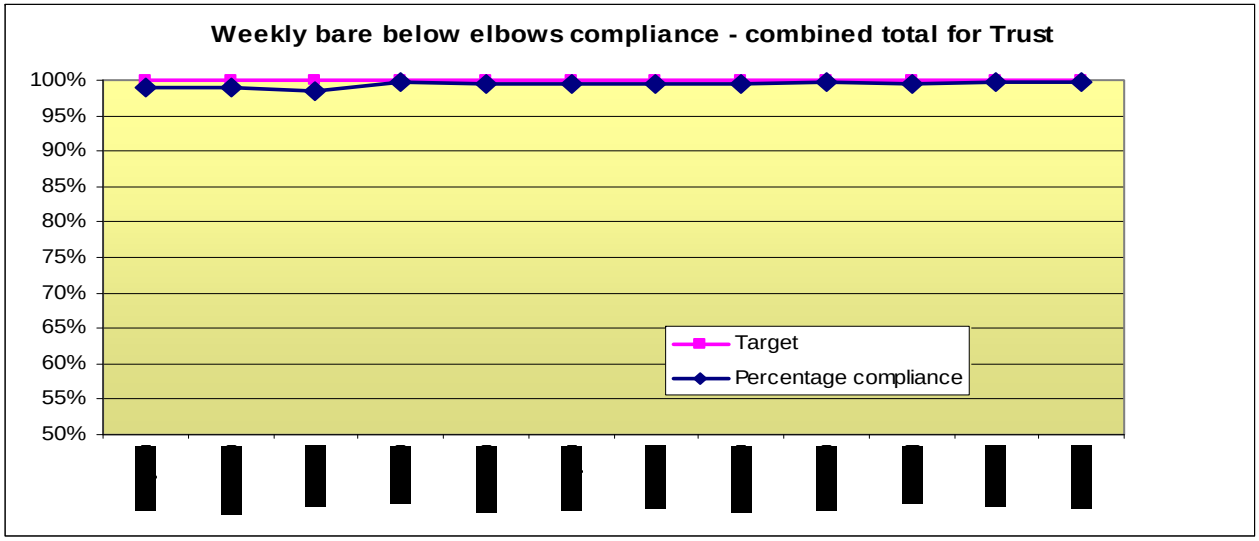
Hand Hygiene - Trust

Data from Hand Hygiene files on Q drive

NB: Data collection changed to monthly from October 2010



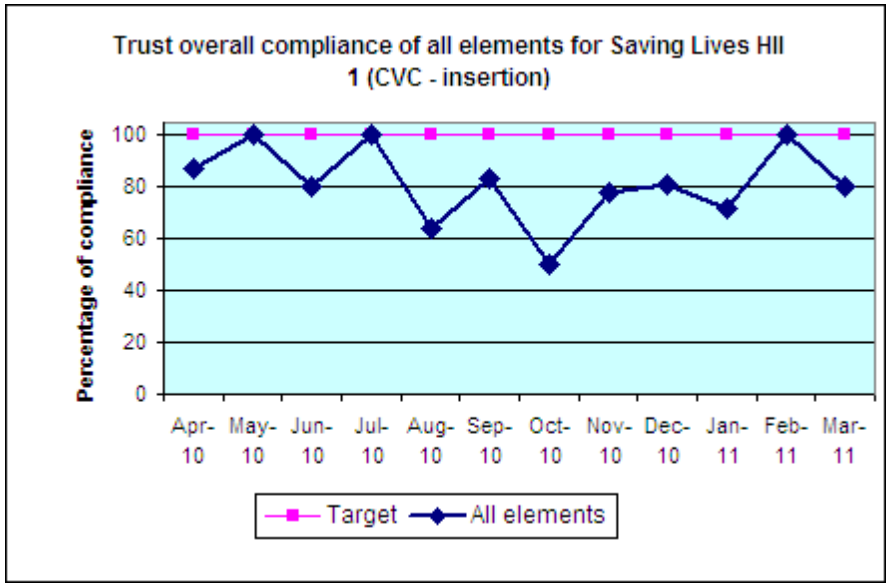
Bare Below the Elbows - Trust

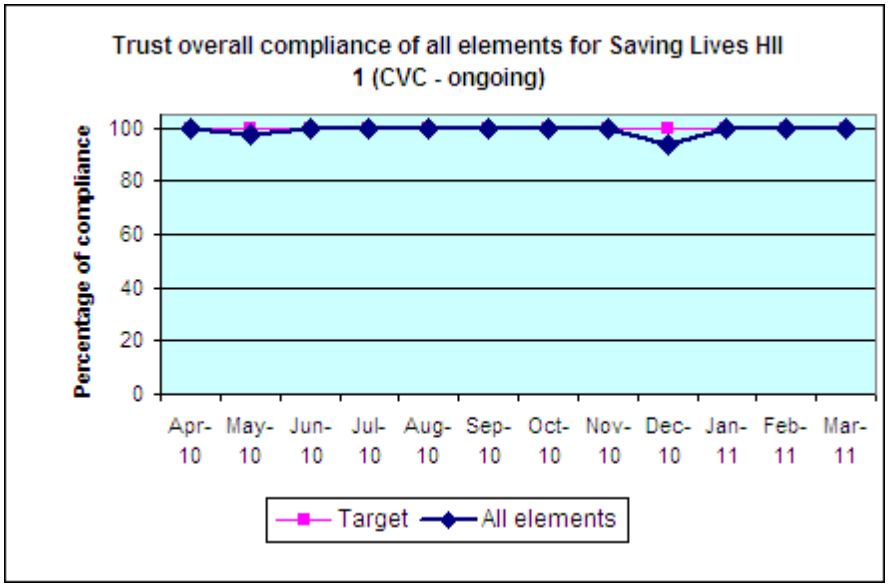


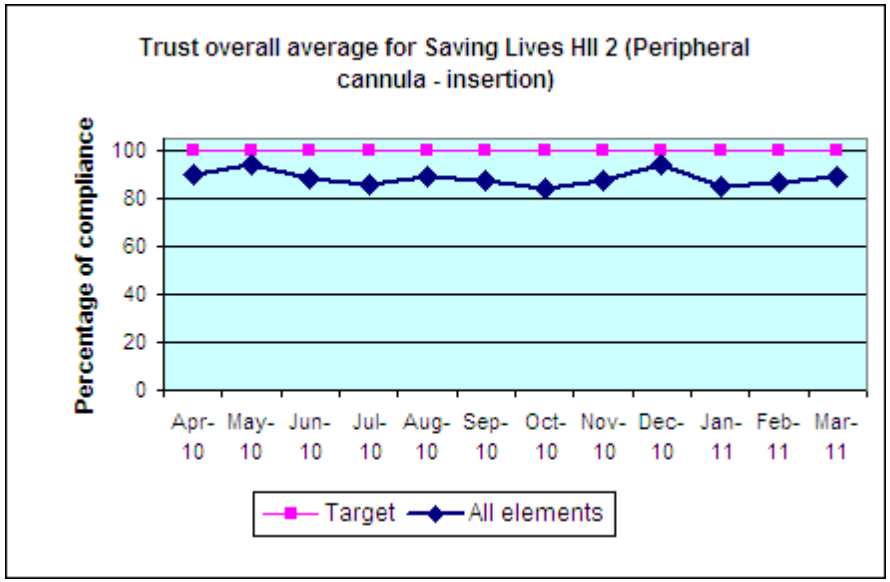
Trust Infection Prevention Performance Dashboard

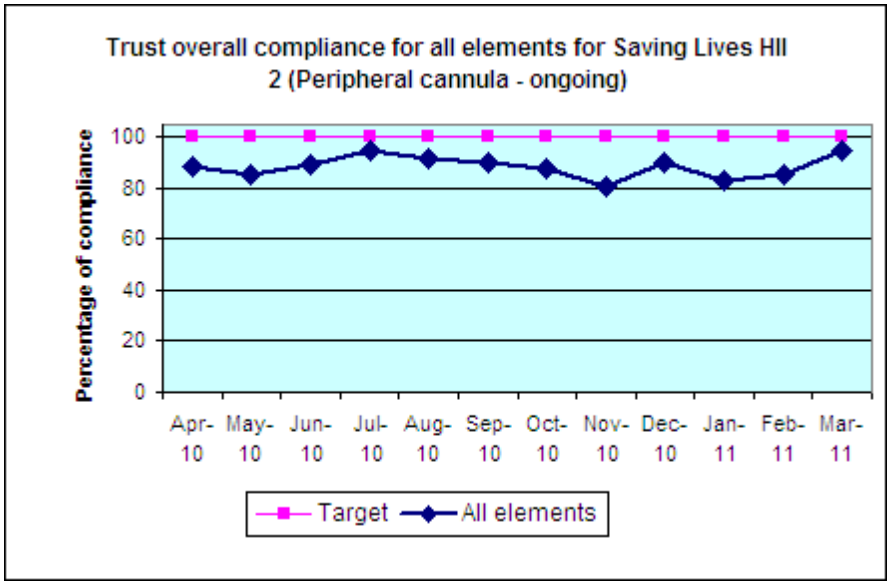
Appendix 2

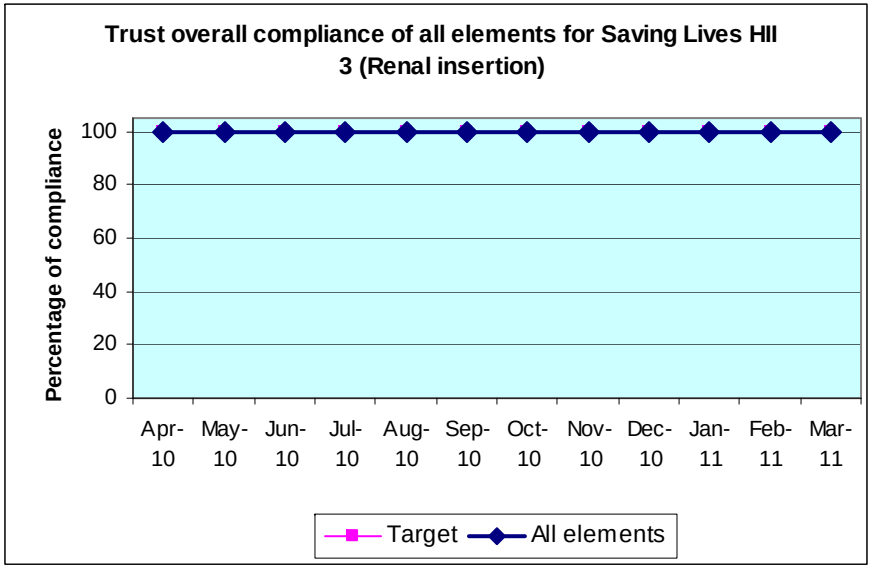
Saving Lives

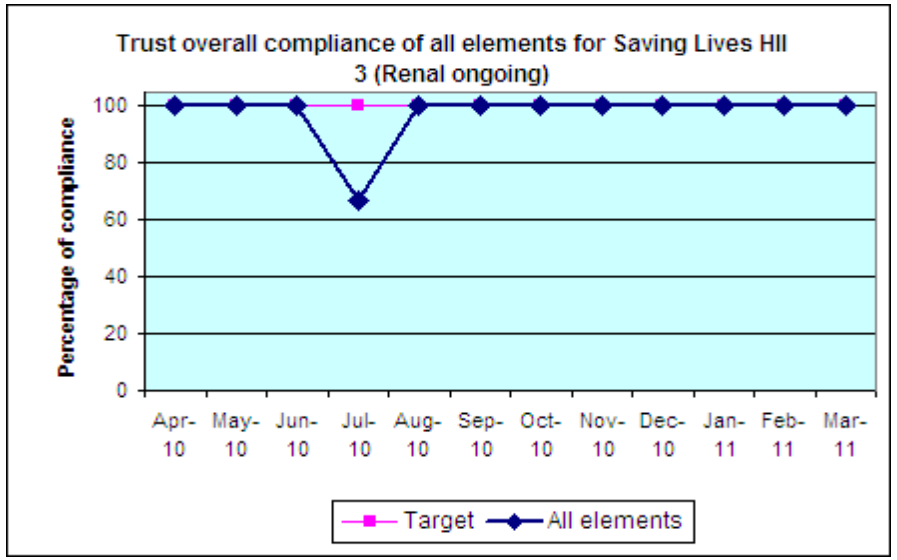




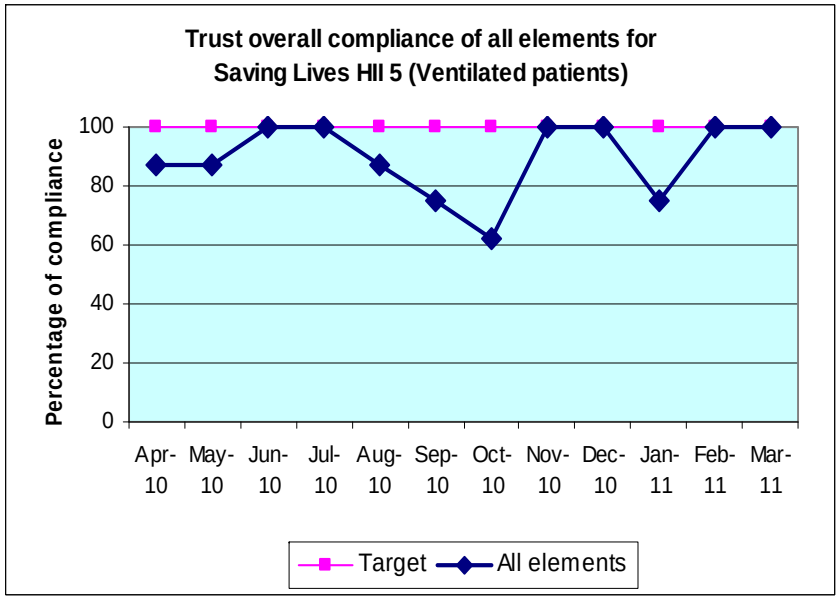


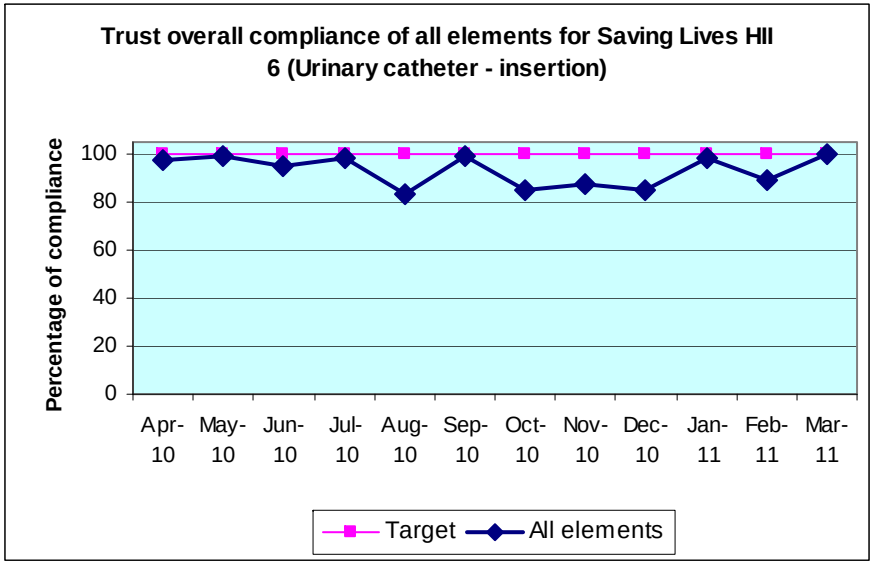


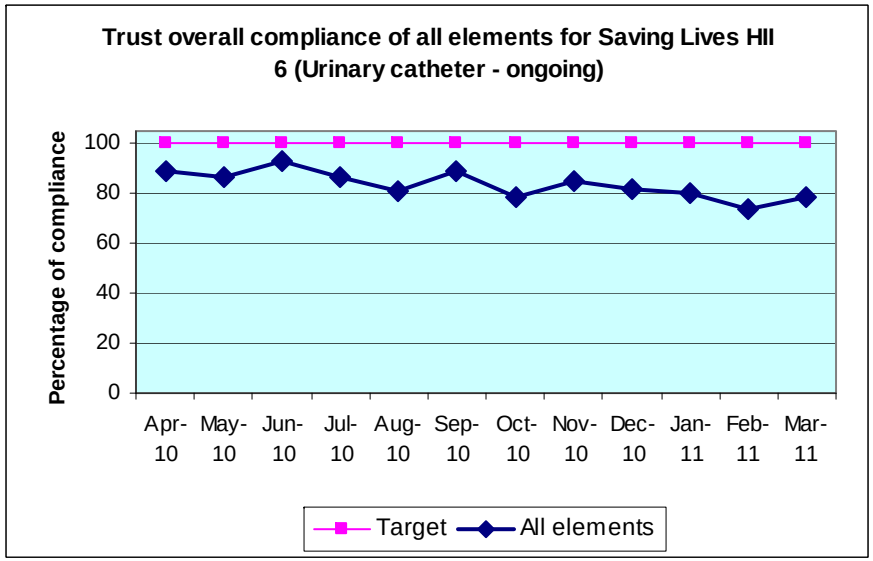


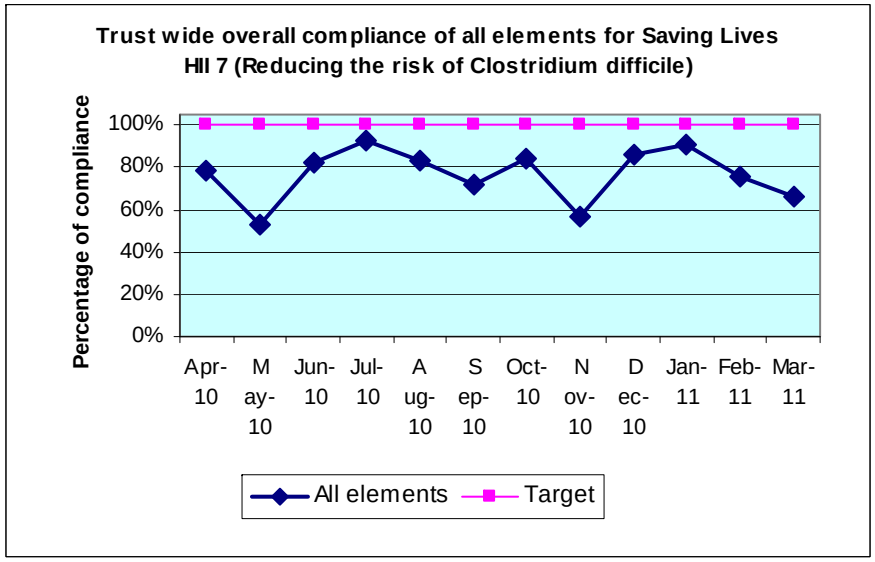


HII 4 (Preventing Surgical site infection)						
Trust	MRSA screening	MRSA decontamination	Hair removal	Prophylactic antimicrobial	Normothermia	Glucose control
Apr-10	86	100	100	23	31	86
May-10	89	100	100	27	36	87
Jun-10	86	100	100	25	46	90
Jul-10	89	100	100	25	36	75
Aug-10	87	100	67	24	25	89
Sep-10	92	100	75	26	40	93
Oct-10	92	100	75	32	22	92
Nov-10	90	88	75	28	37	100
Dec-10	88	100	75	33	35	96
Jan-11	87	100	100	30	34	93
Feb-11	84	88	100	33	34	79
Mar-11	83	91	100	30	37	76

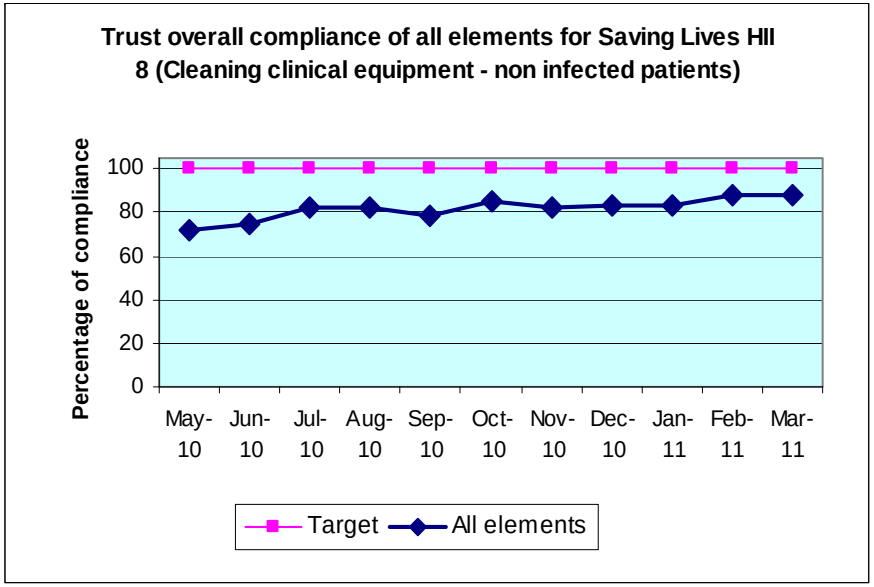


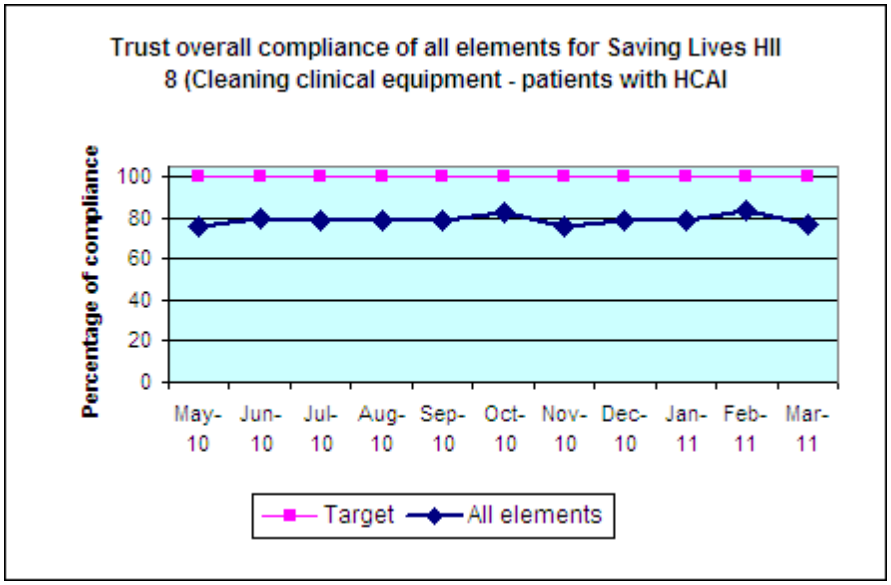






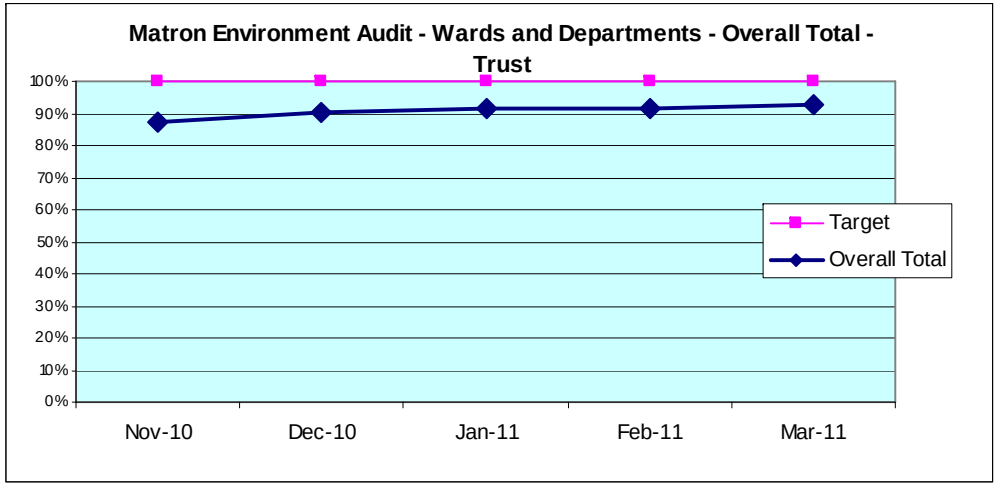
All audits require 100% compliance


Trust overall compliance of all elements for Saving Lives HII 8 (Cleaning clinical equipment - non infected patients)
Percentage of compliance
100
80
60
40
20
0
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Target
All elements

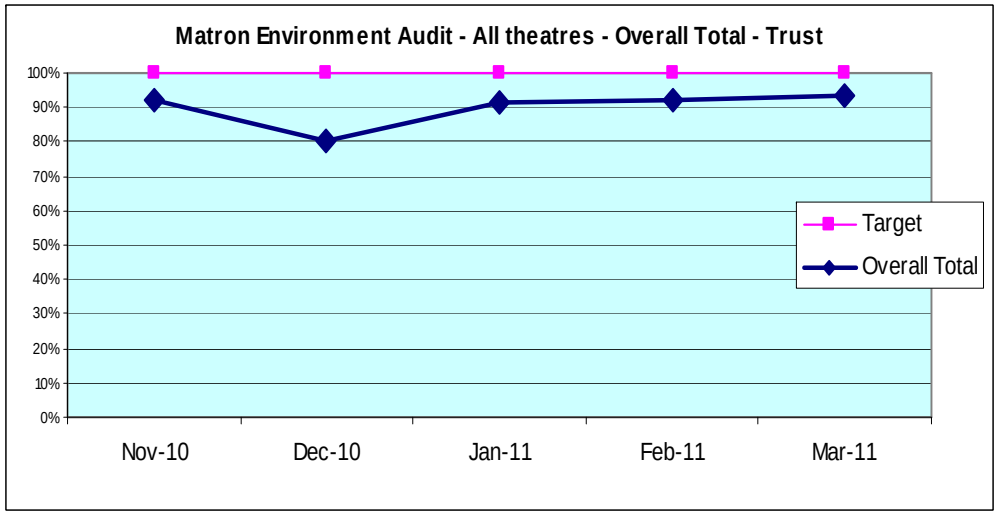

Trust overall compliance of all elements for Saving Lives HII 8 (Cleaning clinical equipment - patients with HCAI
Percentage of compliance
100
80
60
40
20
0
May-10
Jun-10
Jul-10
Aug-10
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Target
All elements

Matron Environment Audits

Trust Ward and Departments							
100%	85% - 99%	<85%	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
Ward/ Department Area			88%	90%	91%	90%	91%
Patients' Toilets and Bathrooms			96%	97%	98%	97%	97%
Linen			96%	97%	97%	97%	99%
Storage Room			73%	79%	81%	82%	85%
Treatment Room			90%	92%	94%	94%	97%
Clinical Room			80%	85%	88%	89%	91%
Sluice			87%	91%	93%	94%	93%
Overall Total			87%	90%	92%	92%	93%
Target			100%	100%	100%	100%	100%



All theatres							
100%	85% - 99%	<85%	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
General all areas			89%	78%	91%	82%	90%
Scrub areas			100%	80%	94%	98%	98%
Anaesthetic room			100%	80%	86%	93%	92%
Prep room			89%	83%	98%	96%	93%
Operating theatre			92%	83%	93%	92%	98%
Sluice			N/A	66%	82%	84%	85%
Storage			60%	76%	80%	100%	85%
Linen			100%	88%	98%	98%	100%
Waste			87%	70%	93%	90%	93%
Overall Total			92%	80%	92%	92%	93%
Target			100%	100%	100%	100%	100%



Infection Prevention and Control Mandatory Training by Staff Group

	April to June	July to September	October to December	January to March
Allied Health Professionals	22	33	31	15
Registered staff - Nurses	174	260	256	123
Unregistered staff - HCAs	88	136	157	65
Medical staff	26	27	3	1

Domestic Monitoring % Score.
Very High Risk (VHR): Directorate Priority 93% and under. Urgent Action Required 94-97%. Compliant 98% and above**.**
High Risk (HR): Directorate Priority 84% and under. Urgent Action Required 85-94%. Compliant 95% and above.
Significant Risk (SR): Directorate Priority 79% and under. Urgent Action Required 80-84%. Compliant 85% and above.

	A	M	J	J	A	S	O	N	D	J	F	M
VHR areas	98%	99%	99%	98%	98%	99%	98%	99%	99%	98%	98%	99%
HR areas	97%	95%	97%	97%	96%	95%	96%	96%	95%	96%	96%	97%
SR areas	96%	93%	88%	96%	95%	95%	92%	92%	92%	95%	95%	94%
Trust overall	97%	97%	97%	98%	97%	97%	97%	97%	97%	97%	97%	98%

Peat Reporting % Score.
Very High Risk (VHR): Directorate Priority 93% and under. Urgent Action Required 94-97%. Compliant 98% and above**.**
High Risk (HR): Directorate Priority 84% and under. Urgent Action Required 85-94%. Compliant 95% and above.
Significant Risk (SR): Directorate Priority 79% and under. Urgent Action Required 80-84%. Compliant 85% and above.

	A	M	J	J	A	S	O	N	D	J	F	M
VHR areas	95%		94%	94%	95%	92%	92%	95%	90%	96%	97%	96%
HR areas	90%	92%	93%	93%	92%	94%	92%	95%	94%	94%	93%	94%
SR areas	89%	68%	87%	95%	89%	92%	83%	94%	94%	94%	93%	93%
Trust overall	90%	85%	91%	95%	92%	93%	91%	95%	93%	95%	93%	94%

Surveillance and Audit Reports April 2010 – March 2011 Appendix 3

Commencement date	Surveillance	Method	Comments and Outcome	Completion date
On-going	Mandatory MRSA bacteraemia and Clostridium difficile reporting	Web-link case reporting as occurs	MSSA included from January 2011	On-going
On-going	Mandatory MRSA, MSSA, GRE bacteraemia and Clostridium difficile reporting	3-monthly reporting to Health Protection Agency		On-going
On-going	MRSA and Clostridium difficile surveillance	Monthly reporting to Trust		On-going
On-going	Data collection of bacteraemia organism incidence	Monthly data collection		On-going
January 2010	Mandatory orthopaedic surgical site infection surveillance (SSIS)	SSISS protocol	Surgical site infection incidence within national benchmarks	June 2010
January 2010	Post discharge surveillance of surgical sites	Trial to link with mandatory orthopaedic SSIS	Part of Safer Patient Initiative. Concerns about cost and staff implications if surveillance is to be established effectively.	June 2010

Commencement date	Audit	Method	Comments and Outcome	Completion date
2008	Compliance of IPCT policy audits	Individual methods for each policy	See policy	On-going
November 2010	Clinical environment audits	Monthly audits of each clinical area	Matrons/ clinical leads carry out monthly audits	On-going
On-going	Hand hygiene compliance audits	Trust wide weekly audits in each clinical area	Monthly audits from October 2010	On-going
On-going	Saving Lives High Impact Interventions	Roll out programme from January 09 to June 09	All High Impact Interventions to be revised in line with DH changes	On-going
Annual	Peripheral cannula documentation audit	Documentation check on all wards – snapshot audit	Poor compliance. Link with safety team to revise documentation.	July 2010
To be decided	Hand hygiene and sharps facilities audit	Annual audit of hand hygiene facilities in all clinical areas	Planned start April 2011	Annual
Start November 2010	Caesarean section surgical site infection surveillance re-audit	6 month data collection and follow up of all Caesarean section patients	Surgical site infection incidence unchanged from previous surveillance	July 2011

Commencement date	Audit	Method	Comments and Outcome	Completion date
March 2010	AMU peripheral cannula documentation audit	Documentation check re timely removal of cannula	To link with introduction of consultant 'checklist' on AMU ward round – June 2010 checklist trial.	January 2011
June 2010	Surveillance of surgical site infections gastro intestinal patients	Review of patients with surgical site infections in gastro intestinal surgery	Perceived rise in surgical site infections. Case note review. All cases high risk of infection.	July 2010

Summary of Evidence for the Audit of Compliance with Infection Prevention Policies Appendix 4

From April 2011

The Health and Social Care Act 2008 states that policies must be monitored, and compliance to the policies audited. Each Infection Prevention policy has an integral monitoring section outlining the methods specific to the policy. In addition there are a number of ongoing audit and surveillance methods used as evidence of compliance for several policies as outlined below.

Evidence	Method used	Frequency	Evidence/reporting method	Policies (see below)
Saving Lives High Impact Interventions 1 to 8	Clinical area observations (wards/ departments/ theatres self assess)	Monthly	Q drive excel file reports by • Ward/ department/ theatre • Directorate/ matron patch • Trust	A. B. C. D. E. H. M. N.
Matron Environment audit	Matron/ lead staff observations of clinical environments	Monthly	Q drive excel file reports by • Ward/ department/ theatre • Directorate/ matron patch • Trust	C. G. N.
Hand Hygiene + Bare Below the Elbows observation audits	Clinical area observations (wards/ departments/ theatres self assess)	Monthly	Q drive excel file reports by • Ward/ department/ theatre • Directorate/ matron patch • Trust	D. N. J.

Evidence	Method used	Frequency	Evidence/reporting method	Policies (see below)
Hand Hygiene Facilities audits	Infection Prevention Team observations in clinical areas	Annual	Q drive excel file reports by • Ward/ department/ theatre • Directorate/ matron patch • Trust	D. N.
Sharps facilities audits	Infection Prevention Team observations in clinical areas	Annual	Q drive excel file reports by • Ward/ department/ theatre • Directorate/ matron patch • Trust	M.N.
Aseptic Non Touch Technique	Clinical area observations (peer assessed) Incorporated into Clinical Development Team training	Initial assessment and sign off	• Part of Saving Lives High Impact Intervention 1, 2, 3, 6	A. D. H. M. N.
Root Cause Analysis (RCA) of MRSA bacteraemia and *Clostridium difficile* infection (CDI)	Summary of key points raised in case summaries	Monthly	By Infection Prevention dashboard to • Directorate • Trust • Exec board	B. E. H. I. J.

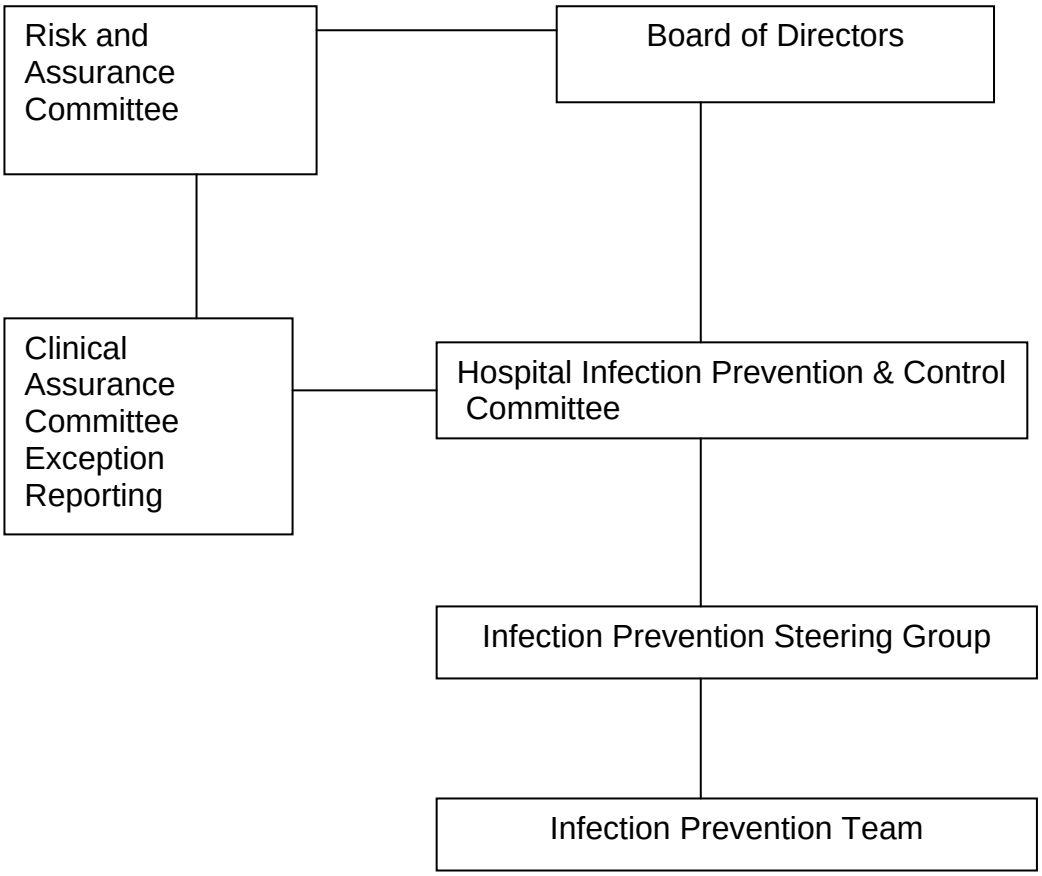
Evidence	Method used	Frequency	Evidence/reporting method	Policies (see below)
Surveillance of alert organisms	Infection Prevention Team data collection	Monthly	Q drive excel file reports by • Ward • Directorate/ matron patch • Trust	B. I. K.
Clinical evaluation visit check list	Infection Prevention Team observations	At least monthly	Q drive excel file reports by • Ward • Directorate/ matron patch	A. B. C. D. E. G. H. I. J. L. M. N. O.
IPT follow up of cases/ incidents*	Infection Prevention Team review	Daily	• Real time whiteboard notes • Hand over notes • AIRS forms	B. E. I. J. K. O.
C. difficile weekly ward round	Infection Prevention Team and gastroenterology review	Weekly	• Documented in medical notes	B.

* IPN daily follow up of isolates reflects ward activity regarding implementation of guidelines for management of cases of infection.

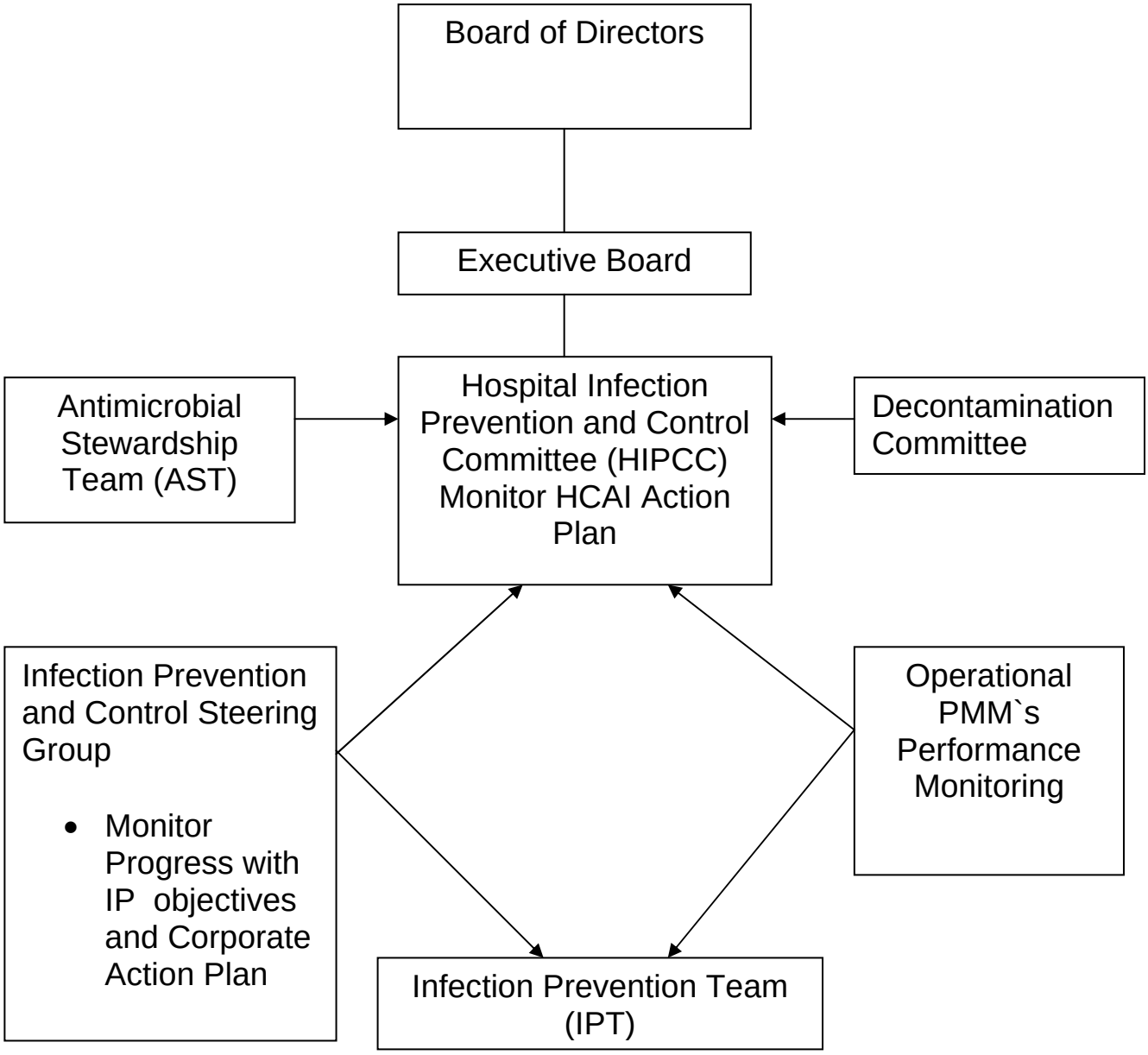
Key for Infection Prevention policies

A. Asepsis
B. *Clostridium difficile*
C. Decontamination
D. Hand Hygiene
E. Isolation
F. Last Offices
G. Laundry
H. Lines management
I. MRSA
J. Outbreaks
K. Reporting HCAI to HPA
L. Respiratory viruses
M. Safe use of sharps
N. Standard precautions
O. Tuberculosis
P. Viral Haemorrhagic Fever

Infection Prevention Corporate Governance Structure Appendix 5



Infection Prevention Reporting Framework **Appendix 6**



Infection Prevention Team Structure

Appendix 7