York Teaching Hospital NHS
NHS Foundation Trust

Director of Infection Prevention and Control

Annual Report

2011/12

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Governance: Presented to Board of Directors
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Contents

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.
- Hospital Infection Prevention and Control Committee (HIPCC)
- IP Annual Plan 2011/12 (Appendix 1)
- IP Performance Dashboard (Appendix 2)
- Operational Performance Management framework
- Internal Audit compliance reports

2. Executive Summary

Challenging objectives set in 2011/12 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 (App 2) 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 2007 (revised 2010)
- NHS Operating Framework (DH 2011/12)
- Evidence based Practice in Infection Prevention and Control (EPIC 2, 2007)

3. Infection Prevention and Control Arrangements

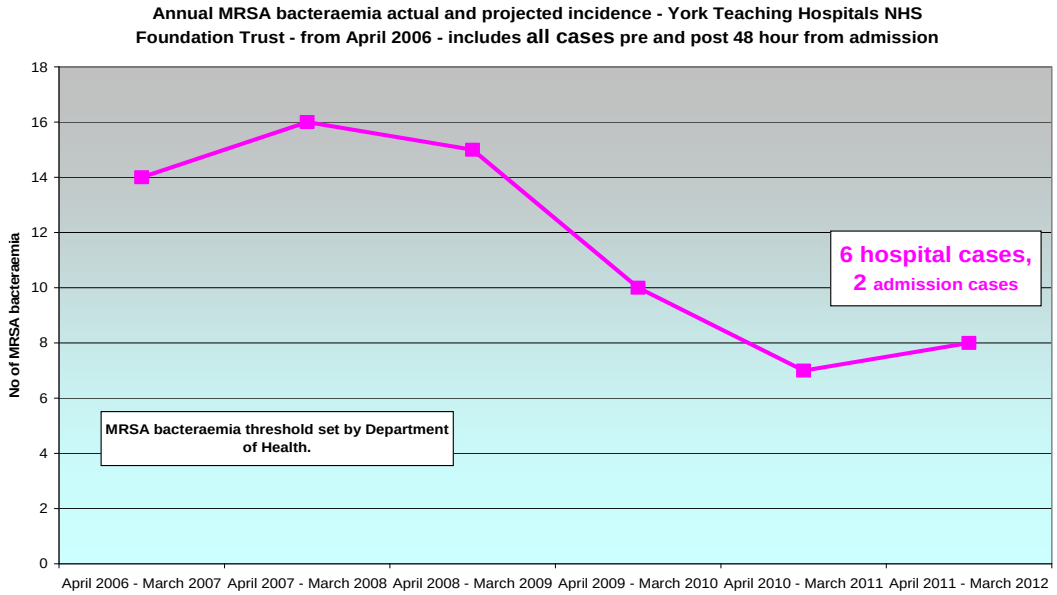
- Governance Structure – refer to Appendix 4 (This will change following integration with Scarborough)
- Reporting Framework – refer to Appendix 5
- Team Structure and establishment - refer to Appendix 6
- Exception reporting from the Hospital Infection Prevention and Control Committee (HIPCC) is made 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 11 to March 12 the Trust reported 6 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.



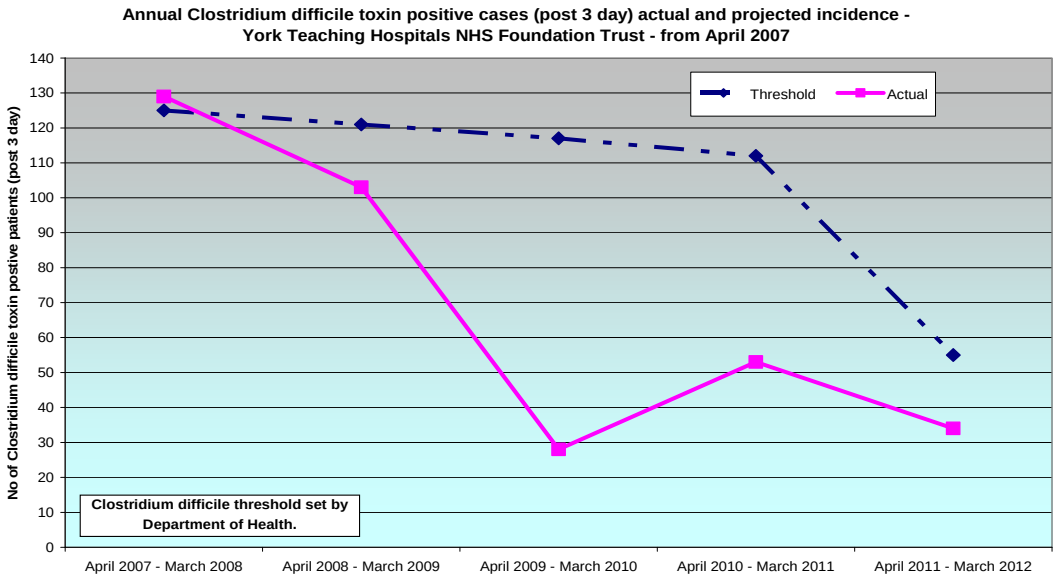
4.2 Screening of Emergency and Elective admissions for MRSA colonisation.

Refer to Appendix 2

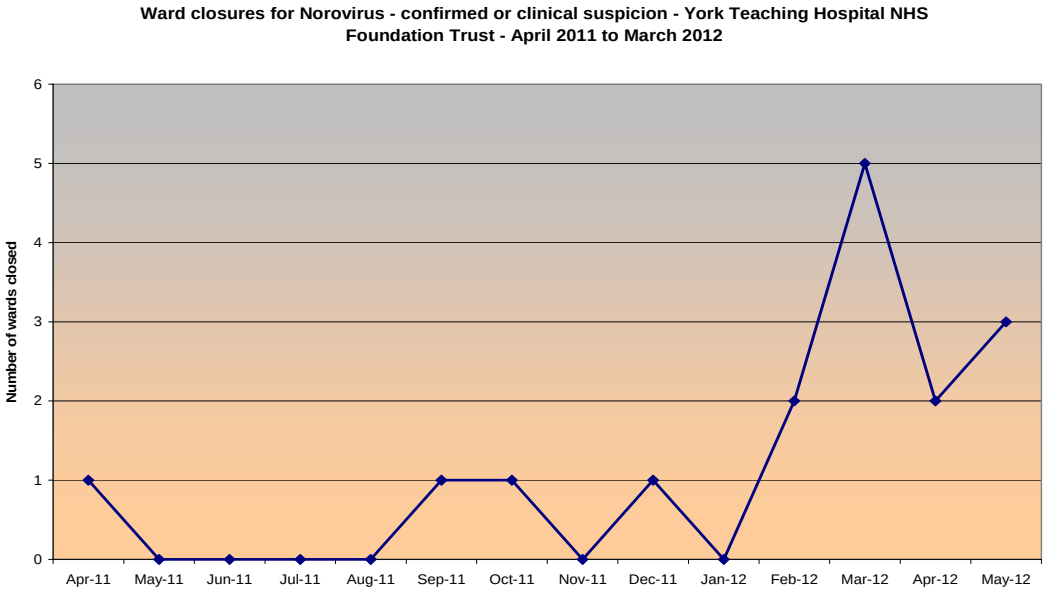
The MRSA screening coordinator works continually with Directorate Leads to identify areas/initiatives for sustained improvement.

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

For the year to March 2012, the Trust reported 34 hospital attributed cases against an objective of 55. Data below demonstrates incidence against the objective from 2007.



4.4 Norovirus



The peak in February and March reflects increased activity in the wider community of North Yorkshire with many care homes, nursing homes and other regional acute trusts similarly affected.

4.5 Directorate Infection Prevention Performance and Assurance

Directorate Infection Prevention performance data are captured and reported electronically via Signal. Data is used by Performance Directors to drive and monitor the performance agenda against key standards to hold Directorates to account and provide assurance to the Board**.**

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 E.Coli and Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia is initiated by the IPT following consultation with a Microbiologist and according to patient contact with the Trust. Outcomes are presented to Executive Board by the lead clinician. Lessons learned and actions required are agreed and disseminated throughout the Organisation via IP systems and processes, such as; education via mandatory training and bespoke sessions, presentation of case studies to reflect lessons learned and the updating policies. During the coming year the RCA process will be critically evaluated to measure the impact of learning and outcomes that are when required used to inform policies and practice standards.

Collaborative work has begun to develop engagement from GPs and Clinical Care Commissioning Groups (CCGs) when issues or concerns in relation to Community care and practice are identified.

5.1 Root Cause Analysis summary of MRSA and MSSA bacteraemia 2011/12 – Main issues raised

Key issues	Actions
Delay in taking blood cultures	Medical Director reiterated need for prompt action to all medical staff Included in medical staff training
Incomplete MRSA screening	Reminders included in staff training, clinical support visits, IPT newsletter.
Line insertion and care	Renal unit protocol for screening, insertion and ongoing care introduced for all line insertions
Cannula documentation	To be incorporated in the Trust wide review of documentation Potential to integrate into electronic observation system for ongoing monitoring; to introduce stickers for insertion thereby streamlining current documentation.

5.2 Root Cause Analysis summary of *Clostridium difficile* infection 2011/12 - main issues raised

Key issue	Actions
Antimicrobial stewardship prescribing variable	Antimicrobial stewardship team overseeing all issues relating to antibiotics. Engagement from CCG Management GP. Engagement of Antimicrobial Stewardship Team Champions via IPT link workers Antimicrobials stewardship grand round (MDT to inc. IPT) commenced to review use of restricted antibiotics. Development of a CDI reduction strategy
Stool charts not being completed to record when patient asymptomatic	Staff reminded in real time using ICR when case being reviewed by IPT. Included in staff training.
Poor performance reported for domestic environment cleaning	Reported to Domestic managers to address via training updates

6. Hand Hygiene

Compliance is sustained across the Trust at 98% – 100% alongside Bare Below the Elbows strategy.

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

Our Hand Hygiene Coordinator continues to identify initiatives that revitalise and re emphasise the impact of effective hand hygiene on patient safety and outcome, e.g. a current project to raise the profile of hand hygiene for children, using audio visual media, games and competitions.

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 is embedded in all educational resources and training programmes for medical, nursing and allied health care professionals, it is integral to hospital policy and its implementation is measured as a standard in clinical practice e.g. Saving Lives HII. ANTT principles are now being promoted and implemented in community settings.

9. Antimicrobial Stewardship Team (AST)

Initiatives as mentioned in the RCA C.Difficile actions, to include a grand antimicrobial ward rounds every Monday. 'Zero tolerance' for lack of review and stop dates on antibiotic prescriptions, ongoing work with medical teams on all hospital sites and G.P's to oversee antimicrobial prescribing practice. Full report to follow from Rob Swallow.

10. Policies

All core policies as required by the Hygiene Code 2009 are in place and are published on the IP intranet and Trust internet sites:

http://www.yorkhospitals.nhs.uk/?id=138&ob=1

Compliance is tested by IP questioning staff during Clinical Support Visits on basic policy knowledge relating to the safe management of patients with infections.

11. Training and Education

The IPT consider training and education as a core activity to ensure that trust members are knowledgeable and are a clinically competent workforce. It continues to deliver comprehensive programmes to registered and unregistered staff who attend according to their job profile. Content is tailored to specific 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.

The table below shows uptake for 2011/12 (data provided by CLAD) adequate numbers of training sessions are provided by the IPT to ensure compliance with training requirements but attendance is low.

			Headcount Total	Headcount Attended
Org P1	**Staff Group Summary**	**Staff Group**		
419 York Teaching Hospital NHS FT	**All**	**Add Prof Scientific and Technic**	270	77
		Additional Clinical Services	1048	336
		Administrative and Clerical	1279	283
		Allied Health Professionals	479	133
		Estates and Ancillary	673	123
		Healthcare Scientists	104	11
		Medical and Dental	555	6
		Nursing and Midwifery Registered	1838	749
		Students	2	0
Total			6248	1718

12. Environment Steering Committee (ESC)

The ESC is a multidisciplinary group that has collectively made significant improvements to the environment**.** Performance and accountability is monitored through and ESC dashboard with escalation and reporting through the HIPCC to Trust Board.

The role of the Committee is to;

- Ensure the patient environment is safe and clean through regular review of service standards.
- Review performance against National cleaning standards and the Hygiene Code
- 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) that in 12012/13 will focus on environment ownership as the driving principle for improvement of standards.

13. Internal Audit

During 2011/12 internal audit provided significant assurance that there are effective systems and controls in place to ensure the quality of data related to MRSA bacteraemia targets.

14. Transforming Community Services

A rolling programme of meetings and educational sessions are being delivered for all `virtual wards` including Malton, Scarborough and Whitby. The sessions focus on

increasing understanding and awareness of Infection Prevention in relation to improving and sustaining best practice. Plans are in progress to develop a system to measure, report and feedback compliance with best practice guidelines i. e the Saving Lives 2007 framework. The aim is for the sessions to inform Statutory and Mandatory training requirements specifically for Community based staff.

Over the next year IP policies will be evaluated and updated to meet the needs of Community staff who currently use existing PCT and HPA developed policies.

15. Conclusion and Recommendation

This report provides the assurance and evidence that all objectives within the Annual Plan 2010/11 were met or remain permanent ongoing priorities. The 2012/13 Annual Plan is available from the Infection Prevention Team.

The Hygiene Code Corporate Action Plan will provide additional assurance to the Board and external regulators of performance and compliance. This is currently under development with the compliance unit.

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

Infection Prevention Team Annual Plan 2011/12

1.0 Management

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
1.1 Continue to develop systems and processes for effective infection prevention (IP) that: • Ensure engagement and responsibility throughout the Organisation • Improve quality and safety of patient care through the prevention and reduction of HCAI • Assures patients, the Board, commissioners and regulators that IP is well established and remains a priority for the Trust	• Compliance with the Hygiene Code 2009 • Hospital Infection Control Committee (HIPCC) • Environment Steering Committee (ESC) • Risk registers – Infection Prevention Team (IPT) and ESC • Quarterly Board reports • Monitor Compliance Framework 2011/12 • NHSLA Risk Management Standards for Acute Trusts 2011/12 • NHS Operating Framework 2011/2012 • Root cause analysis (RCA) of HCAIs • Infection Prevention Policies • Saving Lives 2007 (revised) 2010 • Matrons Assurance Framework rev 2011	• DIPC Annual Report • Hygiene Code Corporate Action Plan • Infection Prevention policies • Compliance Audit reports • Directorate, Trust and Environment Steering Committee IP Dashboards • Committee and Board Terms of Reference and minutes • Antimicrobial Stewardship Team (AST) minutes • Job descriptions • SIGNAL Performance data	• Board of Directors • Corporate Leads identified within the Hygiene Code • Action Plan • Infection Prevention Control (IPC)Steering Group • Infection Prevention Team (IPT) • Matrons • Ward and Directorate Managers • Community Clinical leads • DIPC • Facilities – Director/Deputy Director	Permanent Trust objective	Q4 – Significant progress monitoring and reporting performance against high level metrics via Signal and the PMM framework. Implementation delayed following trial outcome that requires further amendments. Compliance Unit involved.
1.2 Contribute positively to whole health economy collaboration aimed at reducing the burden of HCAI's	• Trust Hygiene Code Corporate Action Plan • District Control of Infection Committee (DCIC) HCAI sub committee reports	• DCIC minutes and Terms of Reference • Trust Hygiene Code Corporate Action Plan • RCA Action Plans and reports	• Acute and Primary Care Trust infection prevention leads • Matrons • Pharmacy antimicrobial leads	Ongoing initiative	Q4 Saving Lives and MRSA screening is implemented at the inpatient

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
	• RCA process		• Community Clinical leads • AST		units. Processes are being developed for non inpatient units. Policies are available via internet, more work needed to evaluate for TCS sites
1.3 With the Director of Operations, Director of Infection and Prevention and Control (DIPC) and Clinical Leads, critically review the Trust's ability to provide safe and effective isolation.	• Hygiene Code Criterion 7 • Saving Lives (revised) 2010 • AIRS reporting • Trust Isolation policy • Management of Outbreak Policy • IP Risk Register • Electronic management of side room allocation via CPD • Real time reporting to nursing and medical staff using electronic ICR	• Trust Hygiene Code Corporate Action Plan • IP outbreak documentation – care plans, door notices, • CPD data • Policy audit reports • Outbreak meeting minutes and action plans • Saving Lives (revised) 2010 • HIPCC Risk & Assurance Committee meetings, minutes	• Board of Directors • DIPC • IPT • Trust Operations Directorate • Director of Strategy and Planning • Matrons, Ward Managers • Directorate Managers • Ward Managers • Director of Estates/Facilities • Capital Planning	Long Term objective incorporated into annual Resilience Planning	Q4 – No changes. Concerns emerging re: capacity risks on Scarborough site pre acquisition. To raise at HIPCG
1.5 Begin to develop unified working with Scarborough Trust	Scarborough & York: • Annual IP Plans • IP Policies Governance frameworks	To be generated	• DIPC's • IP leads • Microbiologists • Integration leads	To be agreed	Q4 TOD facilitated by Integration Team arranged to define and agree key objectives, priorities and risks
1.6 Begin to align IP systems and processes with those that exist in	• IP Policies • Annual Plans	To be generated	• DIPCs • IP Leads	Begin August 2011	Q4 See 1.2

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
Community Inpatient Units as part of Transforming Community Services. Through the Corporate Business Case, secure apportionment of existing Community IP budget for 1 WTE Band 6 nurse to enable delivery of effective IP to Community In-patient Units			• PCT's	August 2011	Q4 Band 6 now in post
1.7 Develop a process for capturing HCAI data from Death certificates.	• Hygiene Code Criterion 1.	• IP/Bereavement Services data base	• Clinicians • Bereavement Services • IPT	Dec 2011	Q4 Slow progress. Meetings with IT and Bereavement services arranged
1.8 Enhance IP Internet and Intranet site.	• Hygiene Code Criterion 1.	• Hygiene Code Corporate Action Plan	• IPT • Communication Lead		Q4 Core policies on internet

2.0 Clinical Standards and Practice

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
2.1 Through effective delivery of Saving Lives: Reducing Infection; delivering Clean ~Safe Care – revised 2010, improve the standards of and eliminate variations in clinical practice in order to achieve and sustain effective infection prevention and control.	• NHS Operating Framework 2011/12 • Risk and Assurance Committee (RAC) • Trust Infection Prevention Policies • IP Policy Audit Strategy • Saving Lives • IP Dashboards • RCA reports and action plans • Aseptic Non Touch Technique (ANTT) • Trust Hygiene Code Corporate Action Plan • Matrons' Assurance Framework • IP Clinical support visits • EPIC 2007 • NICE Guidance • Audits	• Audit reports and action plans • AIRS reports • Saving Lives compliance data • IP Dashboards • PMM minutes • Clinical support visits database • IPC database • Risk and Assurance Committee minutes reports and action plans	• DIPC • IPT • Matrons • Ward Managers • Community Clinical leads	Permanent IP objective	Q4– all revised Saving Lives High Impact Interventions (HII's) in place Dec 11. Clinical Support Visits – successful evaluation of clinical practice that identify variation and issues of compliance.
2.2 HCAIs: Deliver the MRSA Bacteraemia objective of 2 with a maximum threshold of 6 (NHS Operating Framework 2011/12. Monitor Compliance framework 2011/12)	• Hygiene Code Corporate Action Plan • Isolation policy • Saving Lives 2010 • MRSA Risk Assessment criteria • MRSA screening	• Hygiene Code Corporate Action Plan • Compliance audit reports • Saving Lives data • IP clinical visits database • IPC database • RCA reports and action plans	• DIPC • IPT • Matrons • Ward and Departmental Managers • Directorate Managers	Permanent Trust objective	Q4 – 6 cases attributed to Trust – within the de-minimus limit set by Monitor

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
	pathways • IP clinical support visits • RCA process	• SIGNAL	• Community Clinical leads		
2.4 Establish robust reporting criteria for MSSA and E.Coli Blood Stream Infection (BSI) ensuring healthcare and non healthcare cases are clearly identified	• 2011/12 NHS Operating Framework	• IPC Steering Group minutes • HIPCC minutes • HPA database	• DIPC • IPT • Microbiologists	August 2011	Q4 Reporting criteria in place
2.6 Provide IP Clinical Support Visits (CSV) to all directorates to evaluate IP clinical practice, standards and compliance. Develop CSV evidence data base Identify strategies for improvement	• IP clinical support visits standard checklist • Saving Lives revised 2010 • Trust IP policies • IPC door notices • Audits	• Clinical support visits database • Policy compliance audits • Saving Lives data	• IPT • Matrons • Ward Managers • Community Clinical Leads	Permanent IP objective July 2011	Q4 – Positive and well received. Facilitate evaluation of compliance with best practice and educational opportunities

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
2.7 Improve compliance with MRSA screening of elective and emergency admissions based on outcomes	• NHS Operating Framework 2011/12 • Screening compliance data • Trust MRSA Policy • Audit	• Screening compliance data • IP dashboards • PMM minutes • HIPCC minutes • Policy audit report	• Matrons • Ward/ Departmental Managers (DM's) • IPT • Community Clinical leads	Ongoing objective pending outcome of the DH prevalence study 2011	Q4 – Improvement work continues with DM's and Matrons.
2.8 Develop and improve hand hygiene initiatives aimed at sustaining high levels of compliance	• Hand hygiene policy • NHSLA standards • HH Competency Framework • NPSA facilities audit requirements 2008 • Clean Hands Saving Lives – DH Gateway refer. 10468 • Audit	• Hand hygiene facilities audit report • Hand hygiene compliance data • IP team minutes • IP Dashboards	• IPT Hand Hygiene Coordinator • Matrons • Ward Managers • Community Clinical leads	Permanent Objective	Q4– High level compliance sustained through rigorous observational audit, feedback and follow up.
2.9 Develop a risk assessment framework for the control and prevention of HCAI.	• Hygiene Code Corporate Action Plan 1.2 • Trust IP Policies.	• Hygiene Code compliance evidence. • IP documentation.	• IPT • Ward Sisters • Matrons • Clinicians		Q4 – Team objective for 2012/13

3.0 Surveillance and Audit

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
3.1 Surveillance - targeted surveillance of: 1. Readmissions with SSI 2. Surgical Site Infection – Saving Lives HII 4 4. Catheter associated UTI 5. 30 day Mortality associated with *C.difficile*	• Hygiene Code Corporate Action Plan • Saving Lives	• Hygiene Code Corporate Action Plan • Saving Lives data • Surveillance data and reports	• IPT • Matrons • Ward Managers • Clinicians	All projects to be established by March 2012	Q4 – All projects in early stages of development Q4 – SSI – surveillance report re: readmissions to be discussed at Surgical Board early 2012 Q4 Point prevalence completed. Policy being developed. Q4 – incorporated into e-isolate Sheet for rapid identification of relapsed cases within the 30 day limit.
3.2 Develop a business case for the procurement of IPC Software	• Hygiene Code 2009	• Business Case	• IPT • DIPC • IT leads • Finance • Managers	December 2011	Q4 – No progress. Urgently required to assist with effective integration with SGH site

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
	• Audit strategy	• Audit data and reports	• IPT • Matrons • Domestic Services • Facilities Dept Leads • Improvement Team	Dec 2011 MRSA Documentation, Oct 11.	Q4 – Audits completed. Reports available from IPT

4.0 Cleanliness and Environment

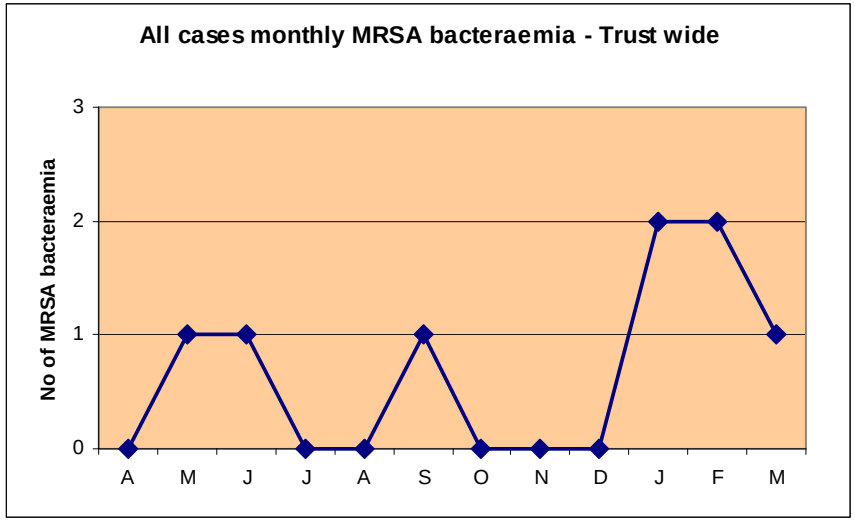
Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
4. 1 Sustain implementation of current and develop new initiatives aimed at improving and maintaining environmental cleaning standards to reduce potential reservoirs of infection	• Hygiene Code Criterion 2 • Environment Steering Committee (ESC) • PEAT • Matrons Environmental checklist • Saving Lives H118 • CQC outcome 8 • Nursing Care Indicators	• ESC Minutes and Terms of Reference • ESC and IP Performance Dashboard • Saving Lives HHI 8 data • Nursing Care Indicator (NCI) data	• ESC • Matrons • Ward Managers • Improvement Team	Permanent Initiative	Q4 – ATP monitoring in place
4.2 Improve cleanliness of the near patient environment	• Adenosine Tri-phosphate (ATP) technology	• ATP Monitoring data	• Matrons • Ward Managers • IPT	To commence August 2011	Q4 – See 4.1
4.3 Procure Hydrogen Peroxide vapour (HPV) disinfection facility (e.g. Bioquell)	• CQC Outcome 8 • Trust Decontamination Policy Decontamination Committee Hygiene Code Criterion 2	• Decontamination Committee minutes. • HPV performance and validation date/records • Hand Hygiene Action Plan	• Decontamination Committee • HIPCC • IPT	September 2011	Q4 – Possibility of using SGH service at York. On Decontamination Committee agenda

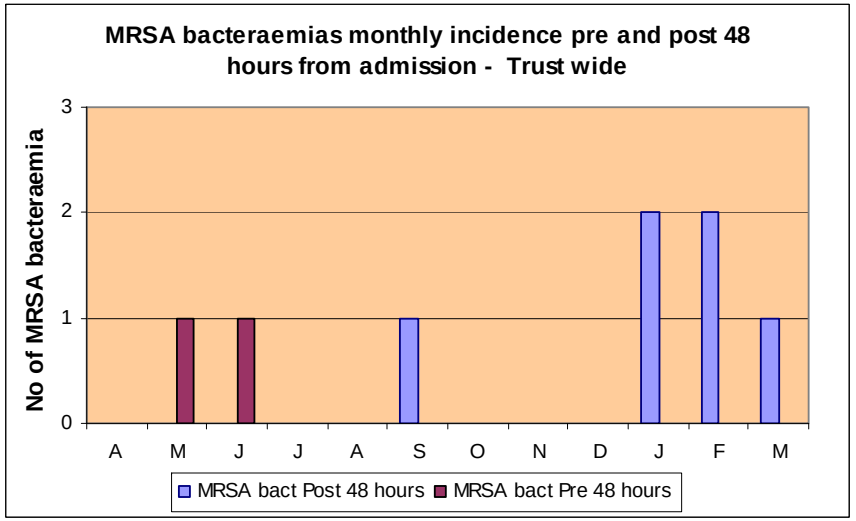
5.0 Education and Learning

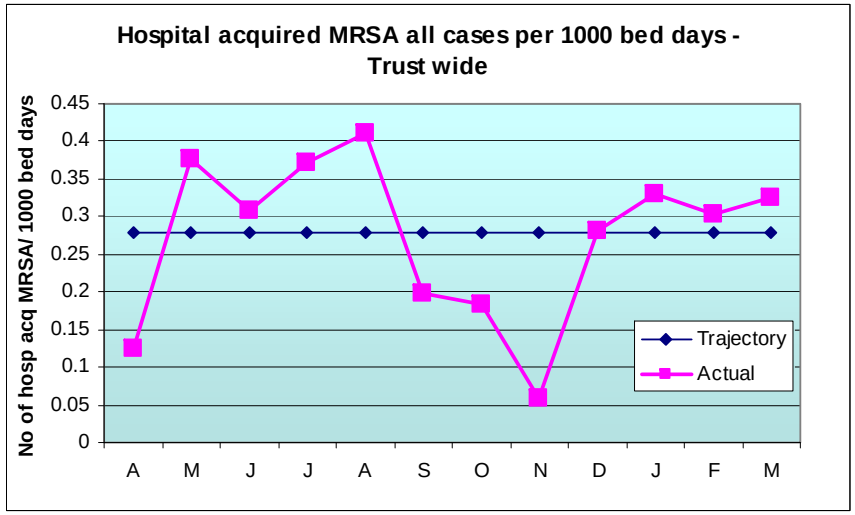
Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Quarterly Review
5.0 Ensure delivery of a programme of education for all staff including community services	• Hygiene Code Criterion 10.1 • Trust Training Needs Analysis (TNA)	• Hygiene Code Corporate Action Plan • Attendance records data via ESR	• CLAD • IPT	Ongoing initiative	Q4 – Integration of TCS staff into CLAD
5.1 Re-develop the Infection Prevention Link Worker Network (ICLW)	• ICLW role description • Hygiene Code	• ICLW meeting minutes		September 2011	Q4 Meetings now established
5.2 Promotion of IP via educational days and events	• Hygiene Code Criterion 10.1	• Attendance records	IPT	Ongoing initiative	Q4 – Excellent attendance at IP educational day and at a collaborative event re vascular access devices. National event planned for June 2012

Appendix 2

Charts

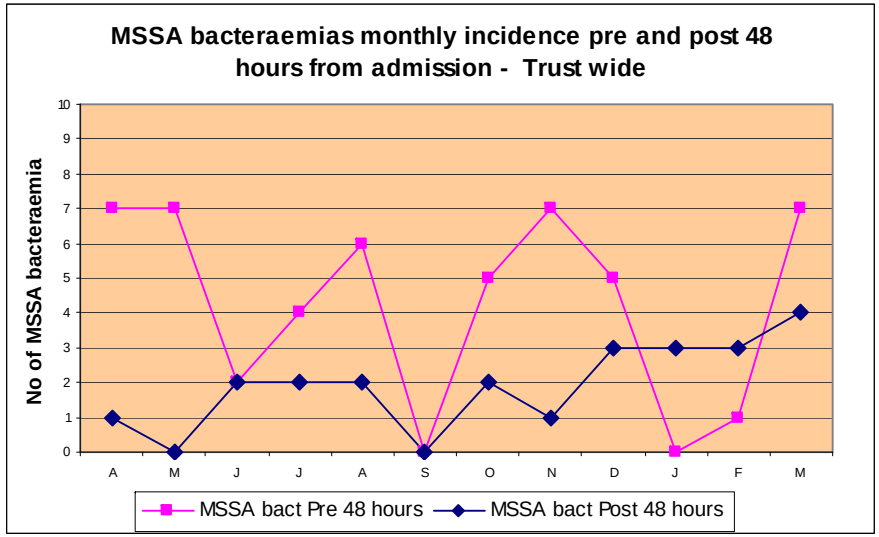


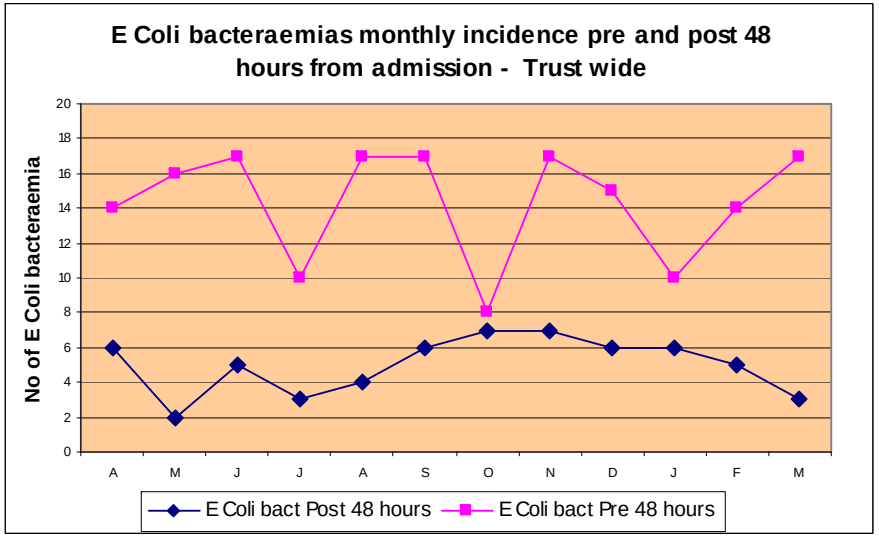


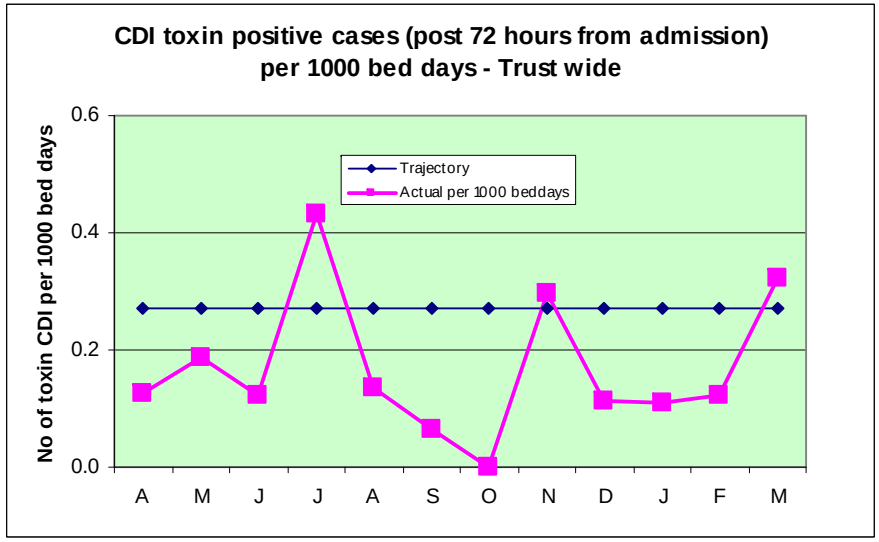


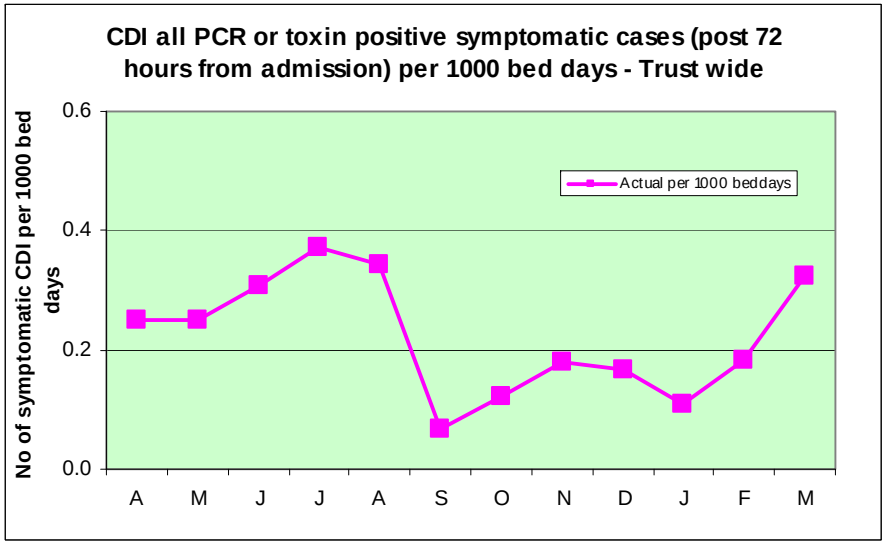
'Hospital acquired' defined as patients who have acquired MRSA after being in hospital for more than 2 days.
NB: number refers to all cases where MRSA is isolated - including nose, throat, perineum, wounds, invasive device sites, bloodstream, and urine.

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


MSSA bacteraemias monthly incidence pre and post 48 hours from admission - Trust wide
No of MSSA bacteraemia
0
1
2
3
4
5
6
7
8
9
10
A M J J A S O N D J F M
MSSA bact Pre 48 hours
MSSA bact Post 48 hours


E Coli bacteraemias monthly incidence pre and post 48 hours from admission - Trust wide
No of E Coli bacteraemia
0
2
4
6
8
10
12
14
16
18
20
A M J J A S O N D J F M
E Coli bact Post 48 hours
E Coli bact Pre 48 hours


CDI toxin positive cases (post 72 hours from admission) per 1000 bed days - Trust wide
No of toxin CDI per 1000 bed days
0.0
0.2
0.4
0.6
A M J J A S O N D J F M
Trajectory
Actual per 1000 beddays


CDI all PCR or toxin positive symptomatic cases (post 72 hours from admission) per 1000 bed days - Trust wide
No of symptomatic CDI per 1000 bed days
0.0
0.2
0.4
0.6
A M J J A S O N D J F M
Actual per 1000 beddays

Trust Infection Prevention Performance Dashboard

Appendix 2

MRSA and *C.diff*

Trust Targets 10/11	MRSA bacteraemia:	Clostridium difficile Infection:

Isolate	2010/11 baseline	2011/12 trajectory	Cases in 2011/12	A	M	J	J	A	S	O	N	D	J	F	M	Cases (to date)	Comments
MRSA Bacteraemia cases per year	Trust total 4 (Post 48 hours)	Six post 48 hour cases - de minimus threshold set by Monitor	All cases	0	1	1	0	0	1	0	0	0	2	2	1	8	Pre + post 48 hour cases
			MRSA bacteraemia Post 48 hours	0	0	0	0	0	1	0	0	0	2	2	1	6	Monitor de minimus threshold of 6 post 48 hour cases
			MRSA bacteraemia Pre 48 hours	0	1	1	0	0	0	0	0	0	0	0	0	2	
MRSA clinical isolates	63 hospital acquired = 0.31 per 1000 bed days	57# hospital acquired = 0.28 per 1000 bed days**	Actual hosp acquired per 1000 bed days	0.1	0.4	0.3	0.4	0.4	0.2	0.2	0.1	0.3	0.3	0.3	0.3	0.27	Threshold <= 0.28 per 1000 bed days.
***Clostridium difficile* Associated Diarrhoea**	53 (post 72 hours) = 0.26 per 1000 bed days*	55 post 72 hour" = 0.27 per 1000 bed days**	Post 3 day toxin positive trust incidence	2	3	2	7	2	1	0	5	2	2	2	6	34	
			Actual post 72 hour per 1000 bed days	0.1	0.2	0.1	0.4	0.1	0.1	0.0	0.3	0.1	0.1	0.1	0.3	0.17	Threshold <= 0.27 per 1000 bed days.
			All treated cases (PCR or Toxin +ve) Trust attributed	4	4	5	6	5	1	2	3	3	2	3	6	44	
			All Trust cases per 1000 bed days	0.3	0.3	0.3	0.4	0.3	0.1	0.1	0.2	0.2	0.1	0.2	0.3	0.22	Threshold <= 0.27 per 1000 bed days.
			027 cases - PRE AND POST	0	1	0	0	0	0	0	0	0	0	0	0	1	Excludes 027 community
MSSA Bacteraemia cases per year	Trust total (post 48 hours) 21 cases		MSSA bacteraemia Post 48 hours	1	0	2	2	2	0	2	1	3	3	3	4	23	
			MSSA bacteraemia Pre 48 hours	7	7	2	4	6	0	5	7	5	0	1	7	51	
E Coli Bacteraemia cases per year	Trust total (post 48 hours) 52 cases		E Coli bacteraemia Post 48 hours	6	2	5	3	4	6	7	7	6	6	5	3	60	
			E Coli bacteraemia Pre 48 hours	14	16	17	10	17	17	8	17	15	10	14	17	172	

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

** Using 2010/11 total bed days as baseline

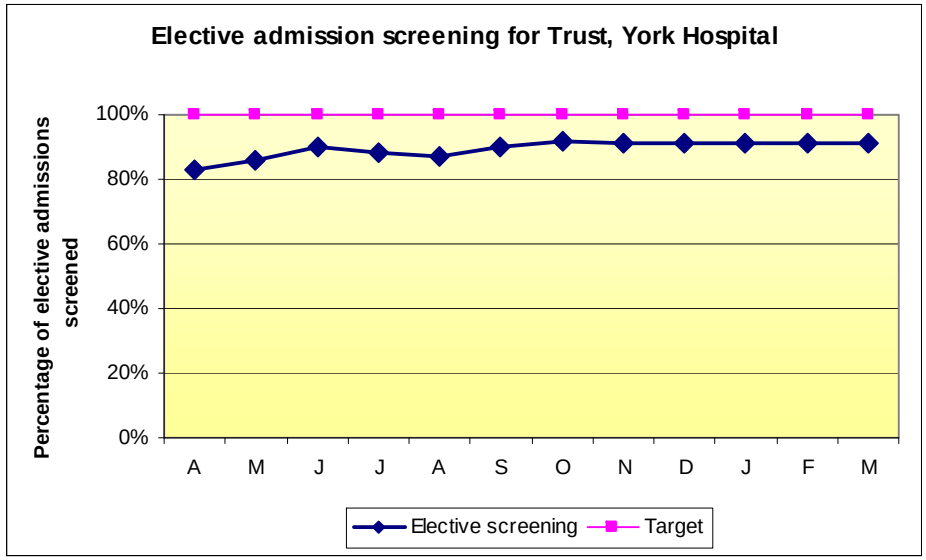
2011/12 trajectory based on 10% reduction of 2010/11 total

Trustwide Infection Prevention Performance Dashboard

Appendix 2

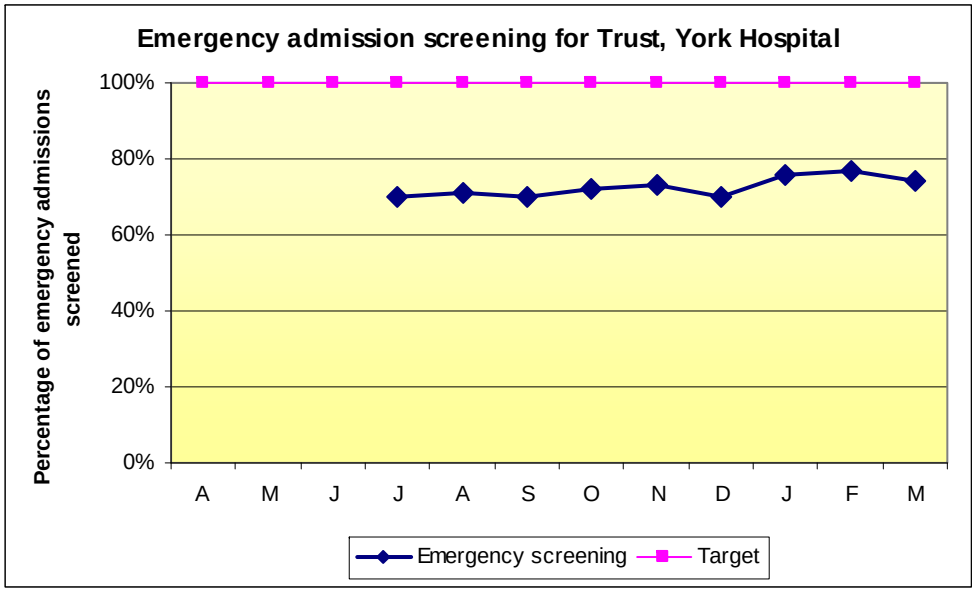
Elective screening	(percentage of elective admissions screened).	A	M	J	J	A	S	O	N	D	J	F	M
		83%	86%	90%	88%	87%	90%	92%	91%	91%	91%	91%	91%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Data provided by Information Department, YH



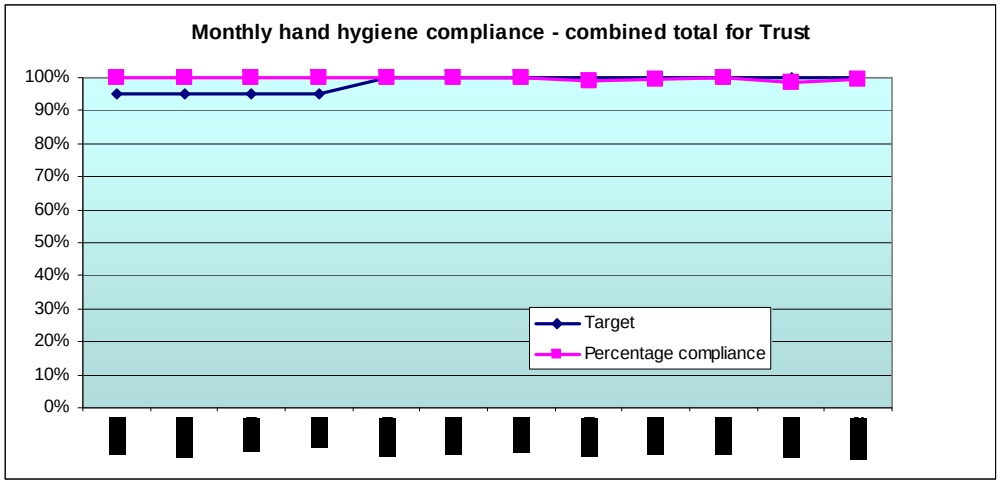
Emergency screening	(percentage of emergency admissions screened).	A	M	J	J	A	S	O	N	D	J	F	M
					70%	71%	70%	72%	73%	70%	76%	77%	74%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Data provided by Information Department, YH

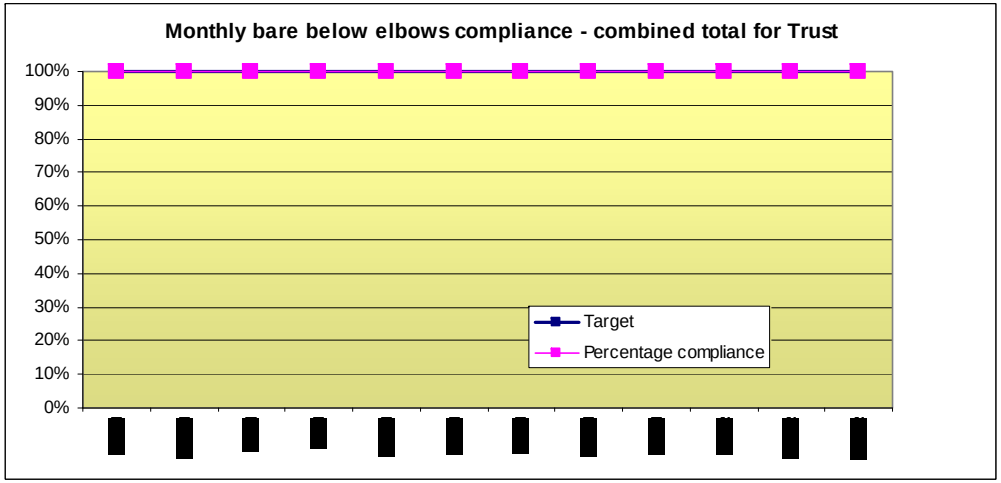


Hand Hygiene - Trust

Data from Hand Hygiene files on Q drive



Bare Below the Elbows - Trust



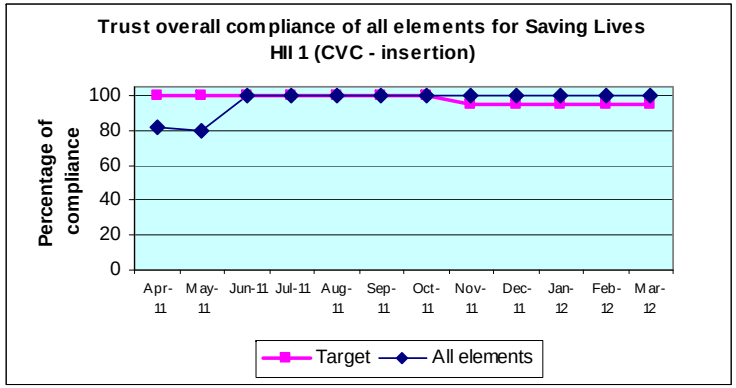
Trust Infection Prevention Performance Dashboard

Appendix 2

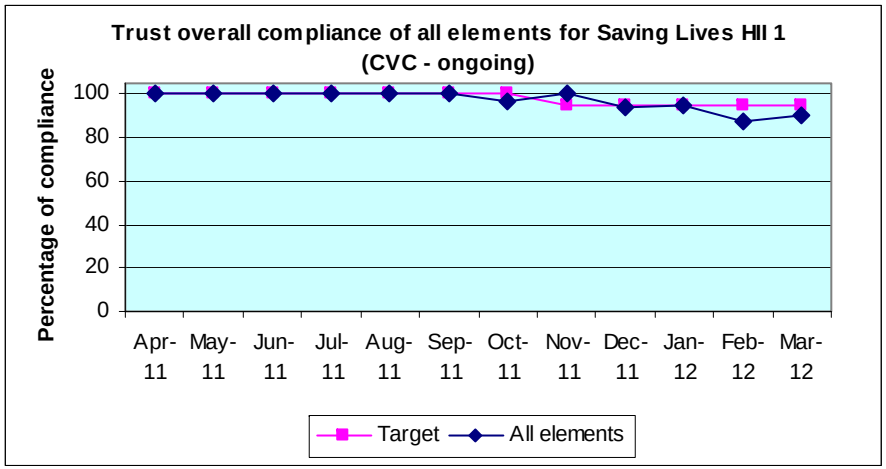
Saving Lives

Colour coding: from November 2011	>95%	75%-94%	<75%

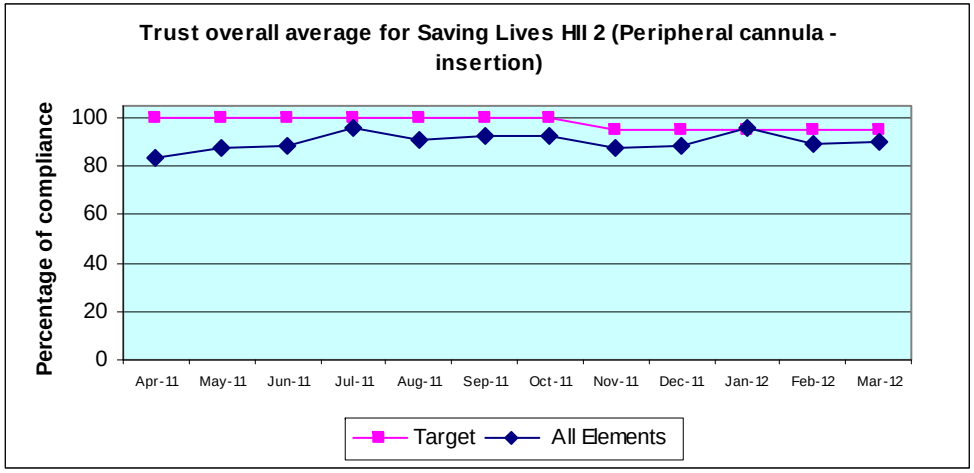
HII 1 (CVC care bundle - insertion_										
	Catheter type	Insertion site	Skin preparation	Personal Protective Equipment	Hand Hygiene	Dressing	Safe disposal of sharps	Documentation	All elements	Target
Apr-11	86	82	86	86	86	86	86	86	82	100
May-11	80	80	80	80	80	80	80	80	80	100
Jun-11	100	100	100	100	100	100	100	100	100	100
Jul-11	100	100	100	100	100	100	100	100	100	100
Aug-11	100	100	100	100	100	100	100	100	100	100
Sep-11	100	100	100	100	100	100	100	100	100	100
Oct-11	100	100	100	100	100	100	100	100	100	100
Nov-11	100	100	100	100	100	100	100	100	100	95
Dec-11	100	100	100	100	100	100	100	100	100	95
Jan-12	100	100	100	100	100	100	100	100	100	95
Feb-12	100	100	100	100	100	100	100	100	100	95
Mar-12	100	100	100	100	100	100	100	100	100	95



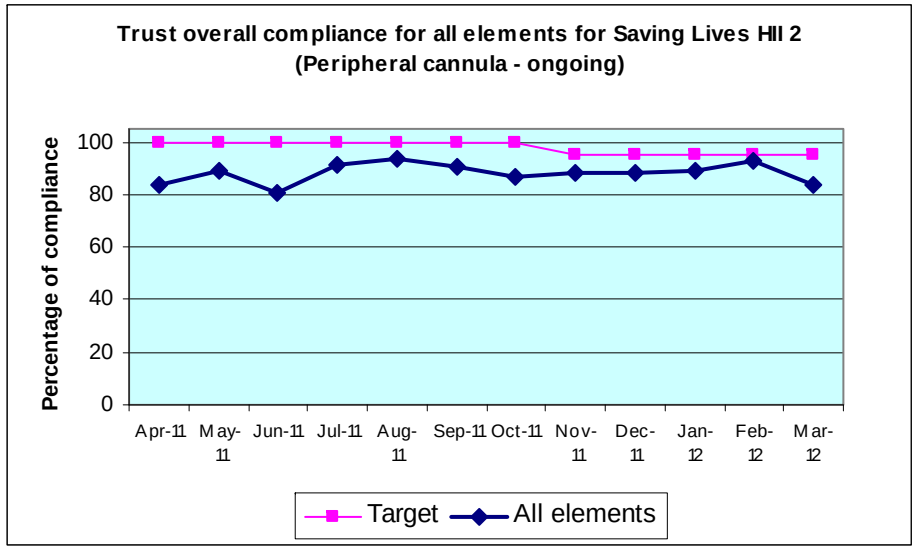
HII 1 (CVC care bundle - ongoing)									
	Hand hygiene	Catheter site inspection	Dressing	Catheter injection ports	Catheter access	Administration set replacement	Catheter removal	All elements	Target
Apr-11	100	100	100	x	100	100	x	100	100
May-11	100	100	100	100	100	100	100	100	100
Jun-11	100	100	100	100	100	100	100	100	100
Jul-11	100	100	100	100	100	100	100	100	100
Aug-11	100	100	100	100	100	100	100	100	100
Sep-11	100	100	100	100	100	100	100	100	100
Oct-11	97	100	100	100	100	100	100	97	100
Nov-11	100	100	100	100	100	100	100	100	95
Dec-11	100	94	100	100	100	100	100	94	95
Jan-12	100	95	100	100	100	100	100	95	95
Feb-12	88	88	88	86	86	80	75	88	95
Mar-12	97	91	100	100	100	100	100	91	95



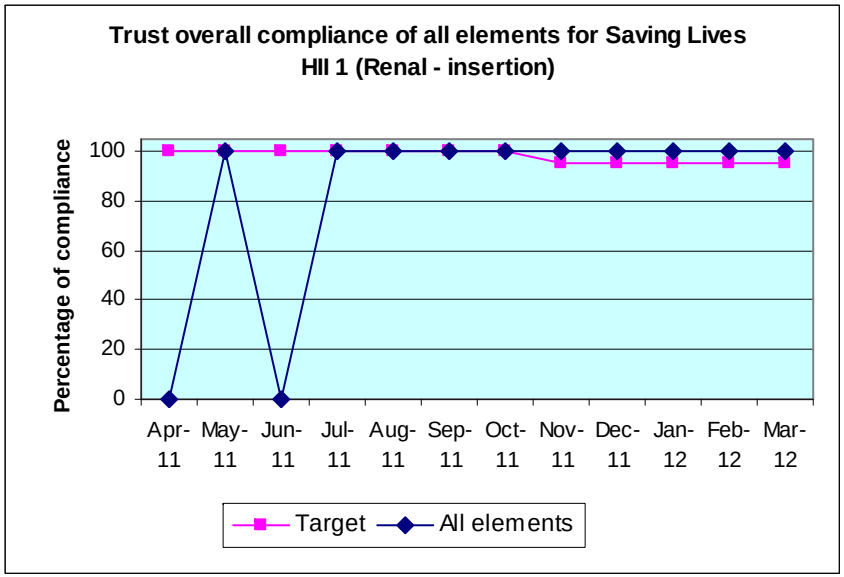
HII 2 (Peripheral cannula care bundle - insertion)								
	Aseptic Non Touch Technique	Hand hygiene	PPE	Skin preparation	Dressing	Documentation	All Elements	Target
Apr-11	89	93	92	93	93	88	84	100
May-11	96	97	96	95	97	89	88	100
Jun-11	94	94	94	92	94	88	88	100
Jul-11	100	100	100	100	100	96	96	100
Aug-11	99	99	99	100	100	91	91	100
Sep-11	99	99	99	99	99	94	93	100
Oct-11	97	97	97	97	97	92	92	100
Nov-11	95	98	97	98	98	90	88	95
Dec-11	99	99	99	99	99	88	88	95
Jan-12	99	99	99	99	99	95	95	95
Feb-12	98	98	97	97	98	90	89	95
Mar-12	96	99	98	99	99	91	90	95



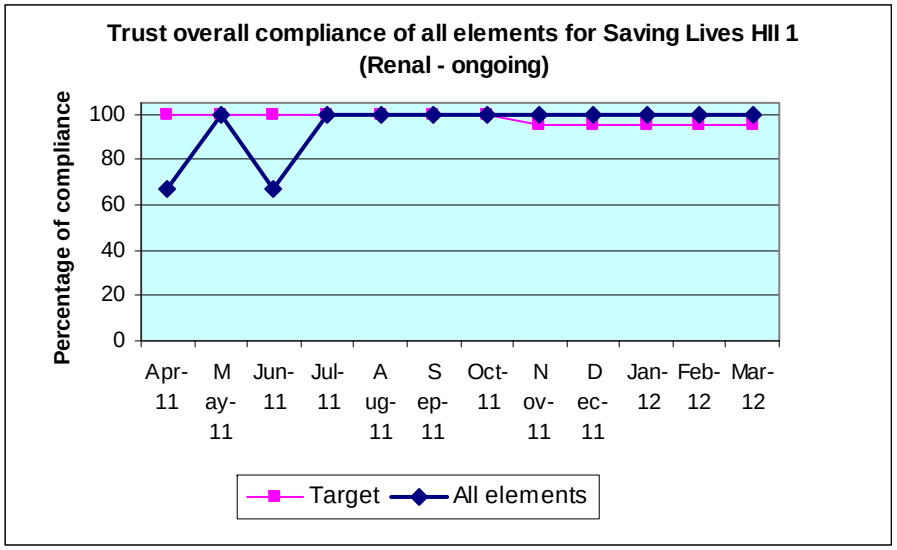
HII 2 (Peripheral cannula care bundle - ongoing)									
	Hand hygiene	Continuing clinical indication	Site inspection	Dressing	Cannula access	Administration set replacement	Routine cannula replacement	All elements	Target
Apr-11	92	87	88	88	87	89	82	84	100
May-11	93	90	92	93	92	89	84	89	100
Jun-11	92	90	90	87	91	86	83	81	100
Jul-11	100	97	96	98	100	96	98	91	100
Aug-11	96	94	94	95	95	93	94	93	100
Sep-11	99	96	97	97	98	93	80	91	100
Oct-11	95	94	94	94	93	94	93	87	100
Nov-11	99	95	94	95	96	90	95	88	95
Dec-11	100	94	95	98	100	93	88	88	95
Jan-12	100	93	93	94	97	96	93	89	95
Feb-12	96	94	95	95	95	95	93	93	95
Mar-12	97	92	90	89	91	93	87	84	95



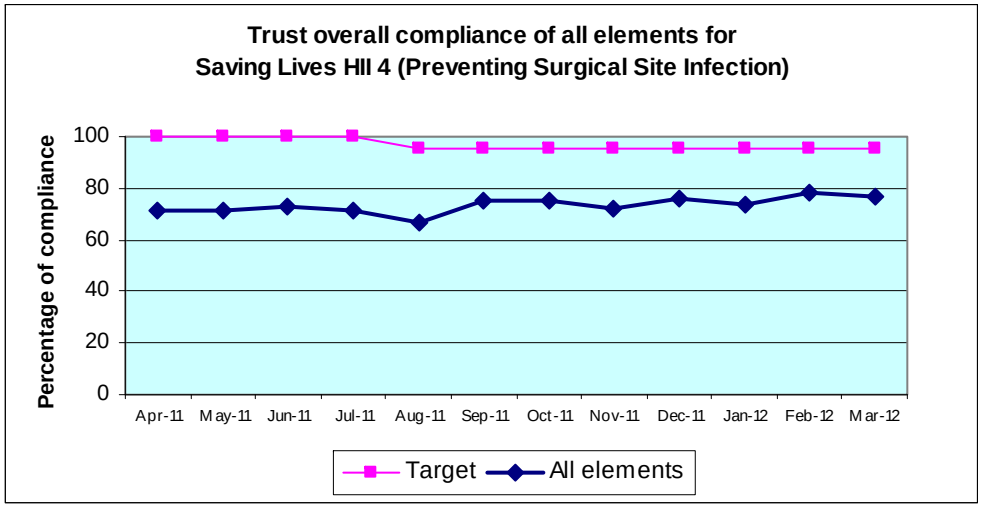
HII 3 (Renal lines care bundle - insertion_										
	Dialysis Catheter type	Insertion site	Skin preparation	Personal Protective Equipment	Hand Hygiene	Dressing	Safe disposal of sharps	Documentation	All elements	Target
Apr-11	0	0	0	0	0	0	0	0	0	100
May-11	100	100	100	100	100	100	100	100	100	100
Jun-11	0	0	0	0	0	0	0	0	0	100
Jul-11	100	100	100	100	100	100	100	100	100	100
Aug-11	100	100	100	100	100	100	100	100	100	100
Sep-11	100	100	100	100	100	100	100	100	100	100
Oct-11	100	100	100	100	100	100	100	100	100	100
Nov-11	100	100	100	100	100	100	100	100	100	95
Dec-11	100	100	100	100	100	100	100	100	100	95
Jan-12	100	100	100	100	100	100	100	100	100	95
Feb-12	100	100	100	100	100	100	100	100	100	95
Mar-12	100	100	100	100	100	100	100	100	100	95



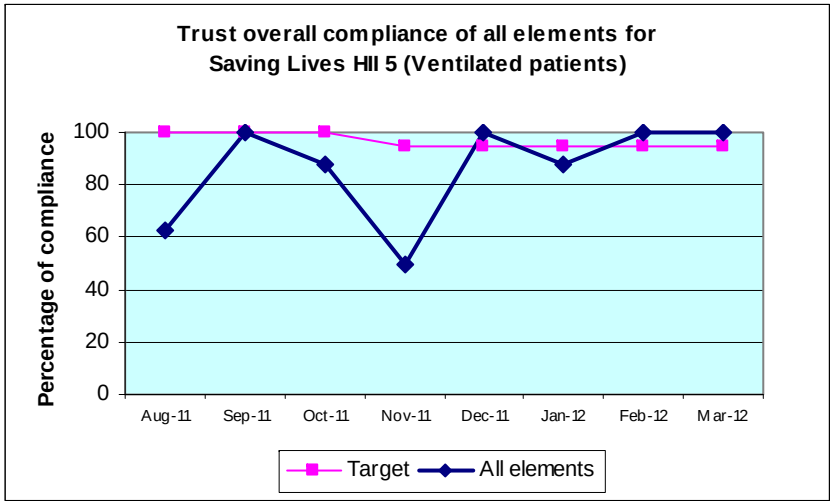
HII 3 (Renal lines care bundle - ongoing)									
	Personal Protective Equipment	Hand hygiene	Insertion Site inspection	Dressing	Catheter replacement	Catheter access	Antimicrobial lock	All elements	Target
Apr-11		67	67	67		67	67	67	100
May-11	100	100	100	100	100	100	100	100	100
Jun-11	67	67	67	67	50	67	67	67	100
Jul-11	100	100	100	100	100	100	100	100	100
Aug-11	100	100	100	100	100	100	100	100	100
Sep-11	100	100	100	100	100	100	100	100	100
Oct-11	100	100	100	100	100	100	100	100	100
Nov-11	100	100	100	100	100	100	100	100	95
Dec-11	100	100	100	100	100	100	100	100	95
Jan-12	100	100	100	100	100	100	100	100	95
Feb-12	100	100	100	100	100	100	100	100	95
Mar-12	100	100	100	100	100	100	100	100	95



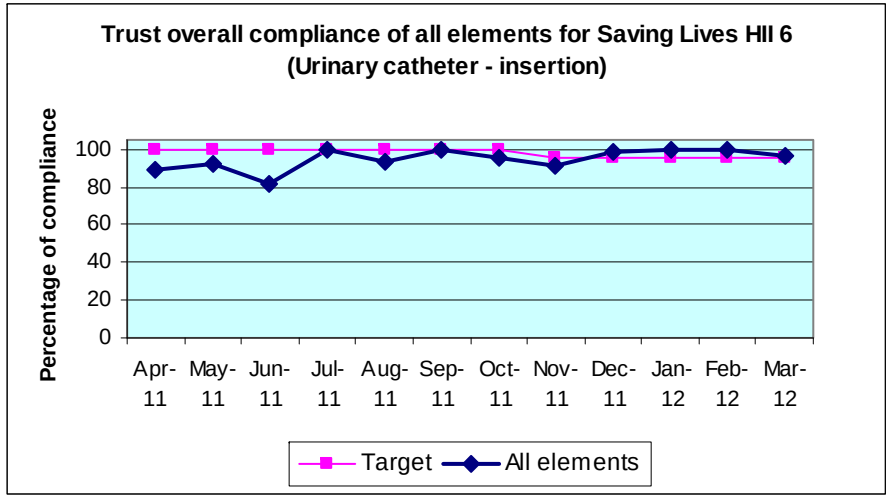
HII 4 (Preventing Surgical site infection)								
Trust	MRSA screening	MRSA decontamination	Hair removal	Prophylactic antimicrobial	Normothermia	Glucose control	All elements	Target
Apr-11	83	100	100	31	31	80	71	100
May-11	86	100	100	31	25	84	71	100
Jun-11	90	100	100	34	30	83	73	100
Jul-11	88	86	100	28	42	82	71	100
Aug-11	87	100	50	29	46	89	67	95
Sep-11	90	100	100	32	42	85	75	95
Oct-11	92	100	100	33	49	77	75	95
Nov-11	91	83	75	32	49	100	72	95
Dec-11	91	100	100	39	37	91	76	95
Jan-12	91	100	100	38	25	89	74	95
Feb-12	91	100	100	37	46	91	78	95
Mar-12	91	100	100	38	44	91	77	95



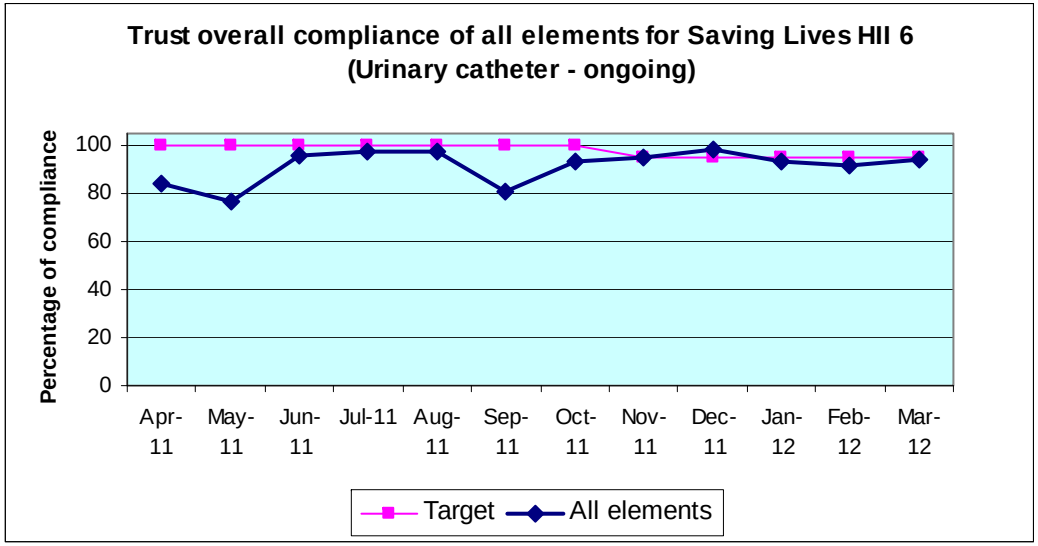
HII 5 (Ventilated patient care bundle)								
	Oral hygiene	Suglottic aspiration	Tracheal tube cuff pressure	Elevation of head of bed	Sedation level assessment	Stress ulcer prophylaxis	All elements	Target
	SCBU and ICU		ICU only				SCBU + ICU	100
Aug-11	75	100	50	75	100	100	63	100
Sep-11	100	100	100	100	100	100	100	100
Oct-11	100	100	75	100	100	100	88	100
Nov-11	50	50	0	0	0	0	50	95
Dec-11	100	100	100	100	100	100	100	95
Jan-12	100	100	100	75	100	100	88	95
Feb-12	100	100	100	100	100	100	100	95
Mar-12	100	100	100	100	100	100	100	95
	NB: from August 11 data collection changed in line with DH changes							



HII 6 (Urinary catheter care bundle - insertion)									
	Is the catheter needed?	Cleaning the urethral meatus	Sterile closed drainage system	Hand hygiene	Aseptic technique	PPE	Documentaion	All elements	Target
Apr-11	89	89	89	89	89	89	x	89	100
May-11	92	92	92	92	92	92	x	92	100
Jun-11	81	81	81	81	81	81	x	81	100
Jul-11	100	100	100	100	100	100	100	100	100
Aug-11	93	93	93	93	93	93	93	93	100
Sep-11	100	100	100	100	100	100	100	100	100
Oct-11	96	96	96	96	96	96	95	95	100
Nov-11	92	92	92	92	92	92	91	91	95
Dec-11	100	100	100	100	100	100	98	98	95
Jan-12	100	100	100	100	100	100	100	100	95
Feb-12	100	100	100	100	100	100	99	99	95
Mar-12	97	97	97	97	97	97	97	97	95

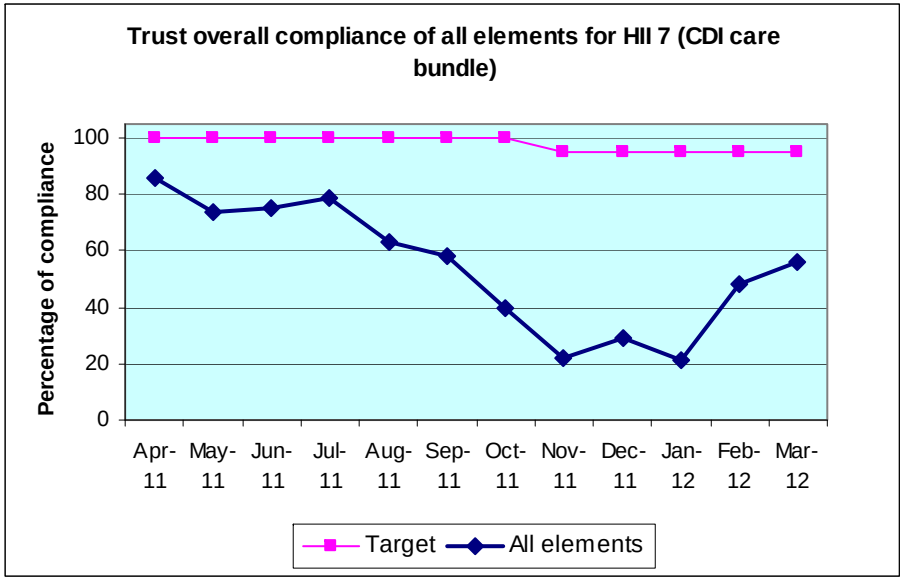


HII 6 (Urinary catheter care bundle - ongoing)								
	Hand hygiene	Catheter hygiene	Sampling	Drainage bag position	Catheter manipulation	Assessment of need	All elements	Target
Apr-11	92	88	91	90	92	90	84	100
May-11	92	90	92	87	92	83	77	100
Jun-11	100	98	100	100	100	98	96	100
Jul-11	100	100	100	98	100	100	98	100
Aug-11	100	98	100	100	100	100	98	100
Sep-11	100	96	100	98	100	88	81	100
Oct-11	100	98	100	100	100	96	94	100
Nov-11	100	100	100	100	100	95	95	95
Dec-11	100	100	100	100	100	98	98	95
Jan-12	100	97	100	100	100	97	93	95
Feb-12	100	100	95	100	93	98	92	95
Mar-12	100	97	100	100	100	97	94	95

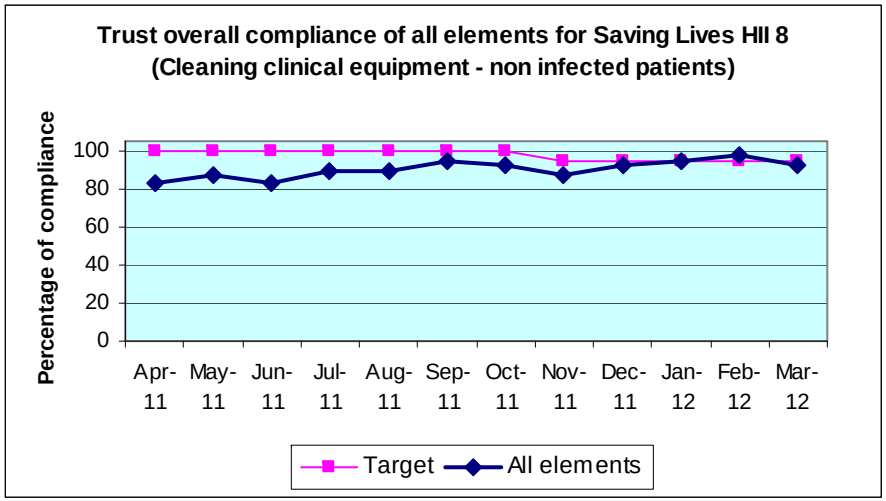


HII 7 (Clostridium Difficile Infection Care bundle)							
	Prudent antibiotic prescribing	Correct hand hygiene	Environmental decontamination	Personal protective equipment	Isolation/ cohort nursing	All elements	Target
Apr-11	86	86	86	86	86	86	100
May-11	74	74	74	74	74	74	100
Jun-11	81	83	76	76	76	75	100
Jul-11	72	83	79	83	83	79	100
Aug-11	72	75	73	75	65	63	100
Sep-11	58	58	58	58	58	58	100
Oct-11	82	100	56	83	96	40	100
Nov-11	59	50	30	100	100	22	95
Dec-11	60	100	49	95	84	29	95
Jan-12	48	100	48	100	72	21	95
Feb-12	47	100	67	100	93	48	95
Mar-12	51	100	87	100	100	56	95

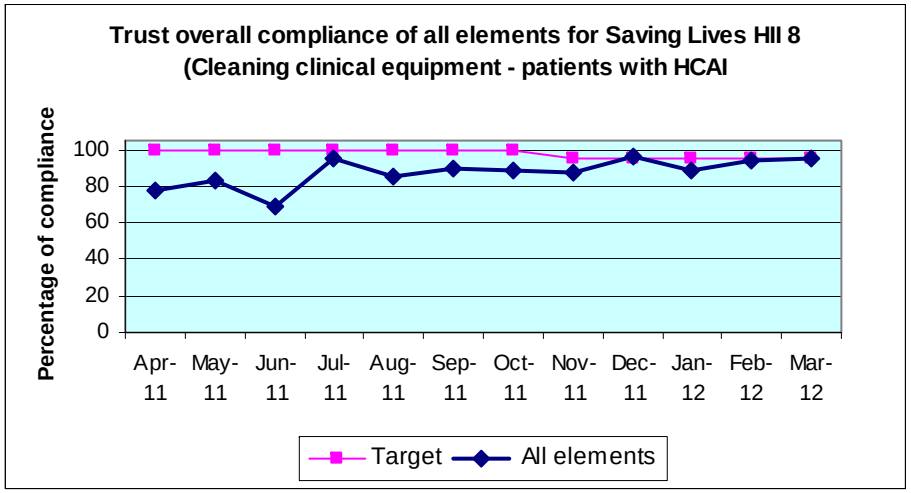
NB: from October 2011 data collection method changed - Infection Prevention Nurses complete 5 days observations for all symptomatic patients



HII 8 (Cleaning clinical equipment care bundle - non-infected)								
	Location of cleaning activity	Correct hand hygiene	PPE	Cleaning	Storage	Documentation	All elements	Target
Apr-11	88	89	86	88	86	87	83	100
May-11	90	91	90	91	90	88	87	100
Jun-11	86	86	84	87	85	86	83	100
Jul-11	92	92	91	92	91	90	89	100
Aug-11	96	94	94	96	95	93	90	100
Sep-11	99	99	97	98	98	96	94	100
Oct-11	97	96	96	97	95	96	93	100
Nov-11	91	92	90	91	90	88	87	95
Dec-11	97	96	97	97	96	94	93	95
Jan-12	98	98	98	98	97	96	94	95
Feb-12	100	100	99	99	99	99	97	95
Mar-12	96	96	95	95	96	93	92	95



HII 8 (Cleaning clinical equipment care bundle - patients with HCAI)								
	Location of cleaning activity	Correct hand hygiene	PPE	Cleaning	Storage	Documentation	All elements	Target
Apr-11	85	86	84	86	86	83	77	100
May-11	85	85	86	85	84	84	83	100
Jun-11	74	77	74	77	76	74	69	100
Jul-11	100	100	99	98	100	97	95	100
Aug-11	90	90	89	89	87	90	86	100
Sep-11	96	96	96	95	91	95	89	100
Oct-11	93	91	91	93	93	92	88	100
Nov-11	88	88	88	88	88	90	88	95
Dec-11	100	98	98	99	100	99	97	95
Jan-12	95	95	92	94	94	93	89	95
Feb-12	100	97	98	100	98	99	95	95
Mar-12	95	97	97	97	97	96	95	95



Trust Infection Prevention Performance Summary Dashboard

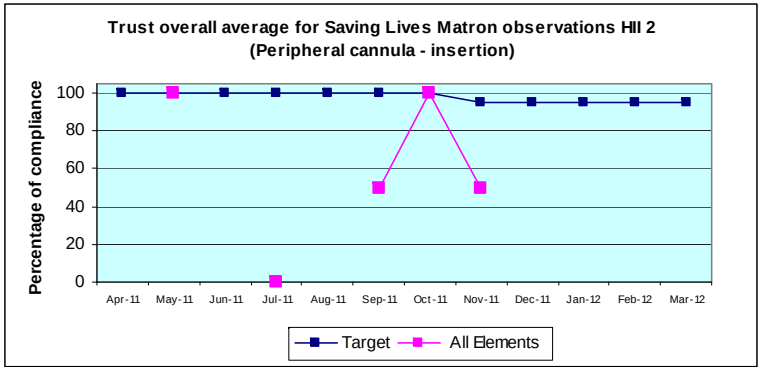
Matron Observations SL

Appendix 2

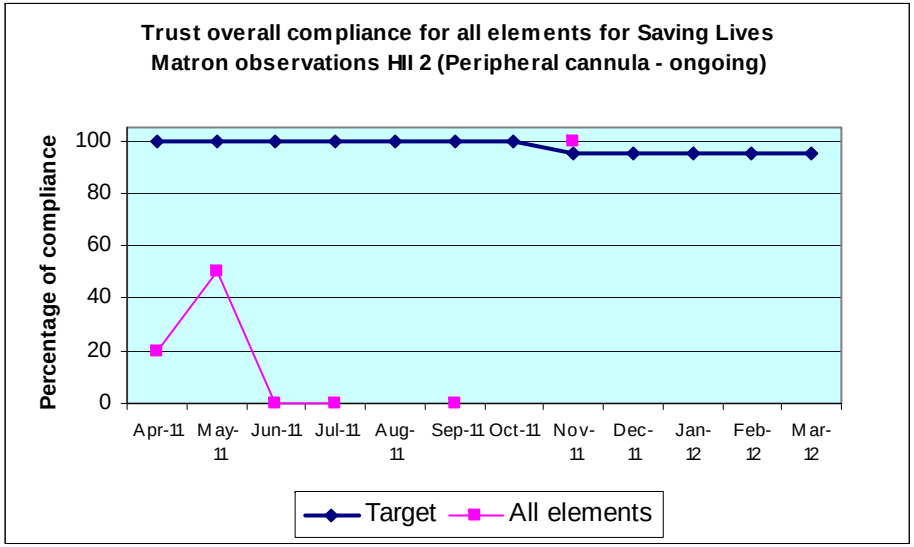
Colour coding: from November 2011	>95%	75%-94%	<75%

From December 2011 areas audited do not perform cannulation or urinary catheterisation

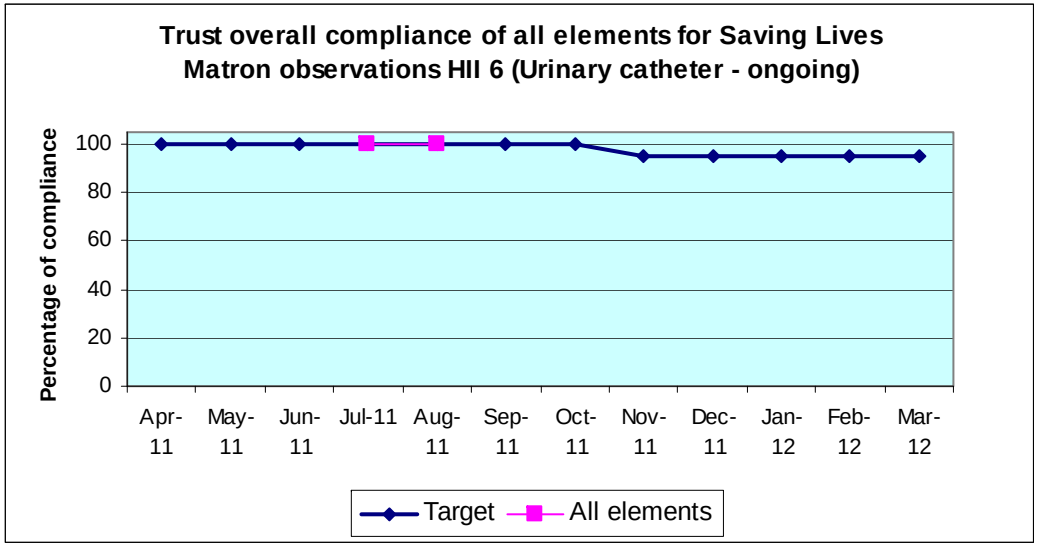
Matron observations HII 2 (Peripheral cannula care bundle - insertion)								
	Aseptic Non Touch Technique	Hand hygiene	PPE	Skin preparation	Dressing	Documentation	All Elements	Target
Apr-11	None observed							100
May-11	100	100	100	100	100	100	100	100
Jun-11	None observed							100
Jul-11	0	0	0	0	0	100	0	100
Aug-11	None observed							100
Sep-11	100	100	50	100	100	100	50	100
Oct-11	100	100	100	100	100	100	100	100
Nov-11	100	100	50	100	100	N/A	50	95
Dec-11	None observed							95
Jan-12	None observed							95
Feb-12	None observed							95
Mar-12	None observed							95



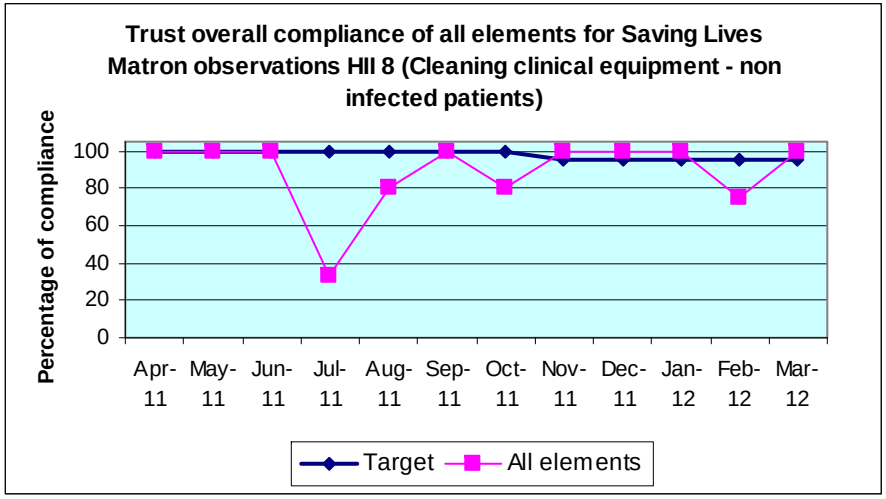
Matron observations HII 2 (Peripheral cannula care bundle - ongoing)									
	Hand hygiene	Continuing clinical indication	Site inspection	Dressing	Cannula access	Administration set replacement	Routine cannula replacement	All elements	Target
Apr-11	100	80	80	60	100	100	67	20	100
May-11	100	50	50	100	100	100	100	50	100
Jun-11	75	80	80	0	75	67	67	0	100
Jul-11	100	0	0	0	100	100	0	0	100
Aug-11	None observed								100
Sep-11	100	0	0	0	100	100	0	0	100
Oct-11	None observed								100
Nov-11	100	100	100	100	100	N/A	N/A	100	95
Dec-11	None observed								95
Jan-12	None observed								95
Feb-12	None observed								95
Mar-12	None observed								95



Matron observations HII 6 (Urinary catheter care bundle - ongoing)								
	Hand hygiene	Catheter hygiene	Sampling	Drainage bag position	Catheter manipulation	Assessment of need	All elements	Target
Apr-11								100
May-11								100
Jun-11								100
Jul-11	100	100	100	100	100	100	100	100
Aug-11	100	100	100	100	100	100	100	100
Sep-11	None observed							100
Oct-11	None observed							100
Nov-11	None observed							95
Dec-11	None observed							95
Jan-12	None observed							95
Feb-12	None observed							95
Mar-12	None observed							95



Matron observations HII 8 (Cleaning clinical equipment care bundle - non-infected)								
	Location of cleaning activity	Correct hand hygiene	PPE	Cleaning	Storage	Documentation	All elements	Target
Apr-11	100	100	100	100	100	100	100	100
May-11	100	100	100	100	100	100	100	100
Jun-11	100	100	100	100	100	100	100	100
Jul-11	100	100	0	100	100	67	33	100
Aug-11	100	100	80	100	100	100	80	100
Sep-11	100	100	100	100	100	100	100	100
Oct-11	100	80	80	100	100	100	80	100
Nov-11	100	100	100	100	100	100	100	95
Dec-11	100	100	100	100	100	100	100	95
Jan-12	100	100	100	100	100	100	100	95
Feb-12	100	75	100	100	100	100	75	95
Mar-12	N/A	100	100	100	N/A	100	100	95

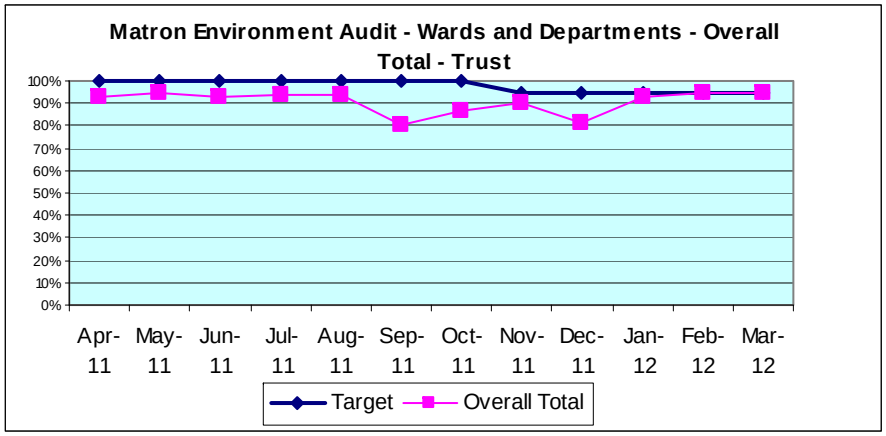


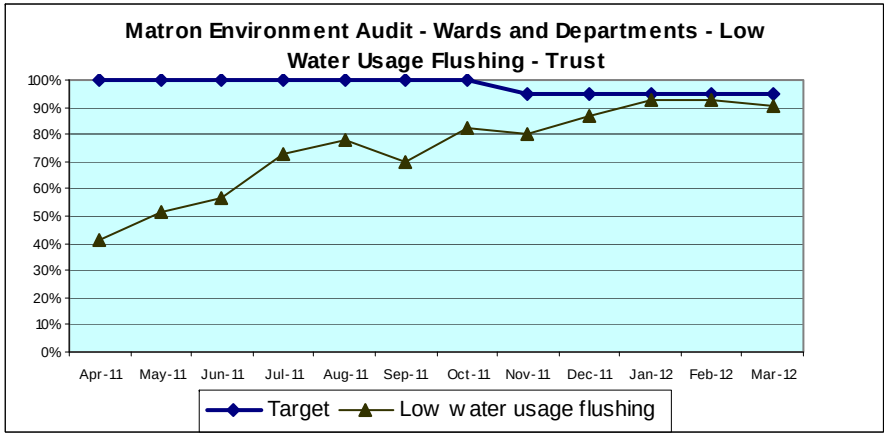
TRUST INFECTION PREVENTION PERFORMANCE DASHBOARD

Appendix 2

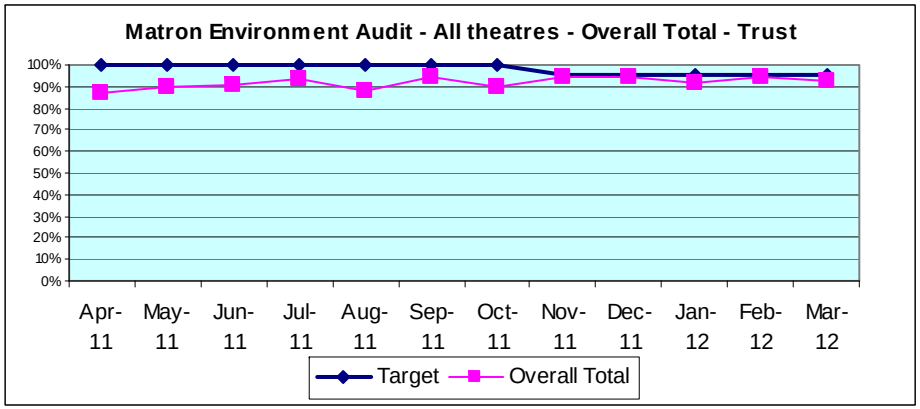
Matron Environment Audits

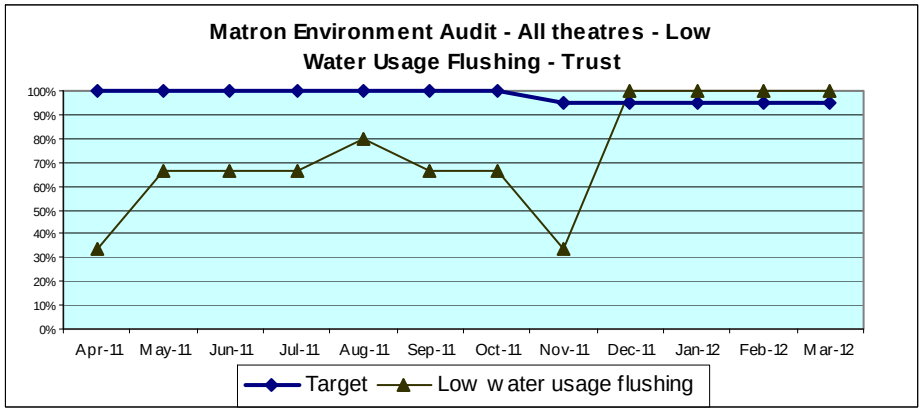
Trust Ward and Departments												
	100%	85% - 99%	<85%					95%-100%	85% - 95%	<85%		
	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
Ward/ Department Area	91%	92%	92%	92%	94%	81%	87%	90%	82%	92%	94%	94%
Patients' Toilets and Bathrooms	97%	98%	96%	97%	99%	81%	88%	93%	84%	97%	98%	97%
Linen	98%	98%	98%	99%	95%	79%	87%	94%	80%	96%	97%	98%
Storage Room	88%	90%	84%	88%	88%	75%	80%	81%	73%	89%	91%	93%
Treatment Room	95%	95%	94%	96%	93%	84%	94%	94%	94%	94%	95%	95%
Clinical Room	91%	93%	93%	94%	93%	76%	83%	88%	73%	92%	95%	95%
Sluice	93%	96%	95%	94%	94%	79%	85%	88%	76%	91%	94%	95%
Overall Total	93%	95%	93%	94%	93%	81%	86%	90%	81%	93%	94%	95%
Target	100%	100%	100%	100%	100%	100%	100%	95%	95%	95%	95%	95%
Low water usage flushing	41%	52%	57%	73%	78%	70%	82%	80%	87%	93%	93%	90%





All theatres												
	100%	85% - 99%	<85%					95%-100%	85% - 95%	<85%		
	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
General all areas	83%	85%	81%	89%	78%	88%	81%	88%	86%	87%	90%	87%
Scrub areas	93%	98%	100%	100%	98%	100%	96%	100%	100%	96%	100%	100%
Anaesthetic room	79%	77%	80%	89%	82%	89%	86%	100%	86%	92%	94%	96%
Prep room	75%	89%	93%	92%	82%	95%	84%	100%	92%	85%	94%	87%
Operating theatre	92%	92%	95%	97%	90%	97%	90%	95%	97%	93%	93%	91%
Sluice	72%	84%	85%	95%	78%	97%	90%	N/A	94%	90%	89%	79%
Storage	70%	75%	80%	73%	78%	100%	88%	100%	96%	85%	84%	72%
Linen	100%	100%	98%	93%	100%	96%	96%	100%	96%	92%	98%	98%
Waste	93%	95%	95%	96%	93%	96%	96%	87%	100%	98%	100%	98%
Overall Total	87%	90%	91%	93%	88%	95%	90%	95%	94%	91%	95%	92%
Target	100%	100%	100%	100%	100%	100%	100%	95%	95%	95%	95%	95%
Low water usage flushing	33%	67%	67%	67%	80%	67%	67%	33%	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	14	29	35	38
Registered staff - Nurses	59	166	179	250
Unregistered staff - HCAs	30	89	89	104
Medical staff	5	20	22	25

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%	98%	98%	98%	98%	98%	98%	98%	98%	98%	96%	98%
HR areas	98%	95%	94%	94%	95%	95%	93%	95%	93%	92%	94%	94%
SR areas	93%	93%	91%	97%	95%	97%	93%	94%	96%	94%	94%	93%
Trust overall	98%	97%	96%	97%	97%	97%	96%	97%	96%	95%	94%	96%

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	92%	94%	96%	96%	95%	95%	90%	97%		93%	90%	93%
HR areas	92%	91%	93%	93%	94%	90%	91%	95%	91%	89%	92%	91%
SR areas	92%	90%	93%	93%	93%	91%		93%	93%	94%	92%	87%
Trust overall	92%	92%	94%	93%	94%	92%	91%	95%	91%	91%	92%	91%

Appendix 3

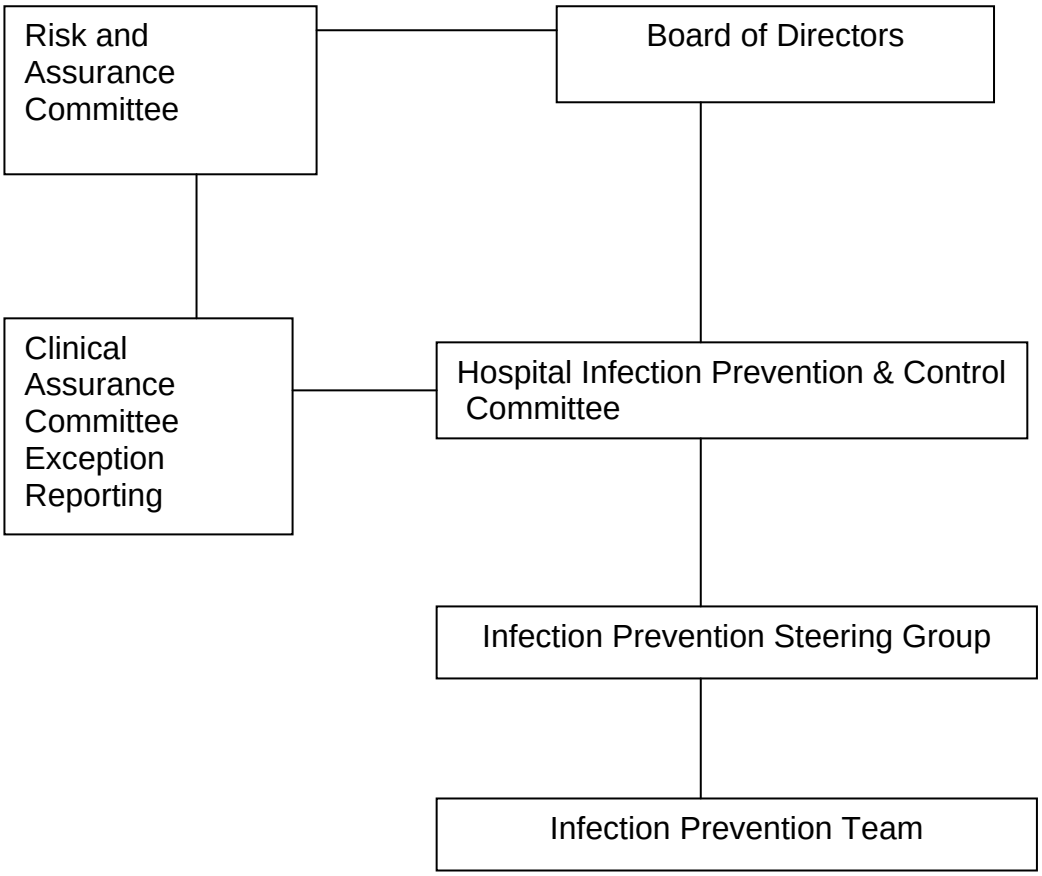
SURVEILLANCE and AUDIT PROJECTS

APRIL 2011 to March 2012

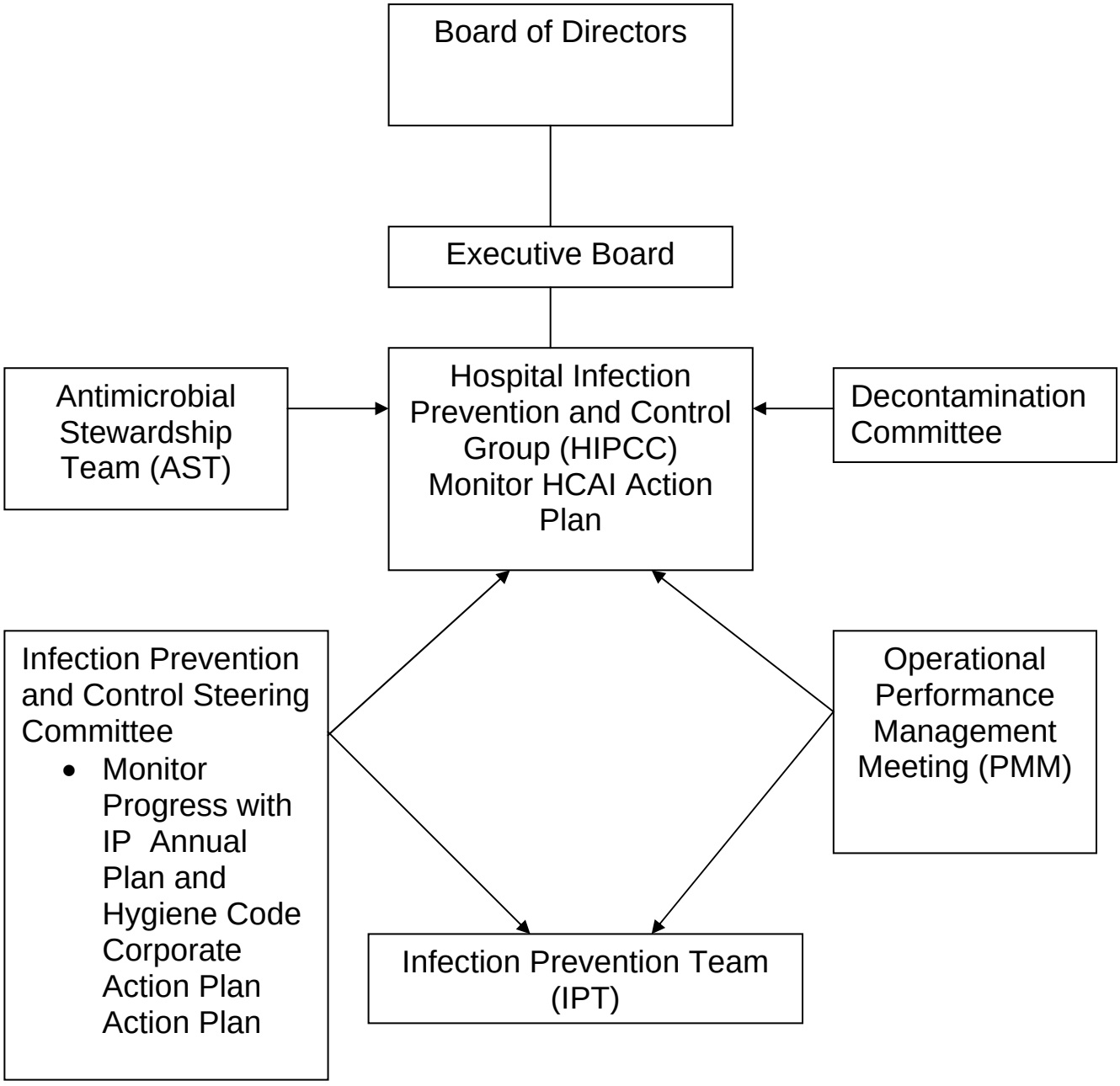
Commencement	Surveillance	Method	Comments and Outcome	Completion date
On-going	Mandatory MRSA, MSSA and E Coli bacteraemia and Clostridium difficile reporting	Web-link case reporting as occurs	MSSA bacteraemia mandatory reporting from January 2011 E Coli bacteraemia mandatory reporting from June 2012	On-going
On-going	Bacteraemia, MRSA, Clostridium difficile and ESBL incidence	Monthly reporting to Trust	Reported by ward, directorate and Trust.	On-going
November 2010	Caesarean Section surgical site infection surveillance	6-month wound observation using HPA surgical site infection criteria	Rate 7.8% where follow up documented (did not include all Caesarean Sections)	August 2011
August 2011	Catheter related Urinary Tract Infection surveillance	Review of patients clinical symptoms with positive catheter sample urine	Part of DH High Impact Action Point prevalence completed Sept 2011 Rate 4.1% To repeat April 2012 (6 months)	September 2011
January 2012	Mandatory Surgical Site Infection Surveillance Orthopaedic surgery	HPA SSISS protocol	Commenced January 2012	Data collection ends June 2012

Commencement	Audit	Method	Comments and Outcome	Completion date
2008	Compliance of IPCT policy audits	Individual methods for each policy	See Audit of Policies Evidence April 2011	On-going
On-going	Clinical environment audits	Monthly audits by matron/ clinical lead		On-going
On-going	Hand hygiene compliance audits	Trust wide monthly audits in each clinical area	Monthly from October 2010	On-going
On-going	Saving Lives High Impact Interventions	DH tools Trust wide monthly audits in each clinical area	Rolled out to Selby, Malton, Whitby and Easingwold All HII reviewed	On-going
May 2011	Hand hygiene and sharps facilities audit	Annual audit of hand hygiene facilities in all clinical areas	Feed back to clinical areas for action	Annual
March 2012	Chlorhexidine wipes for MRSA suppression – compliance audit	Point prevalence to assess compliance of use and documentation	Appropriate use but lack of documentation – to adapt admission proforma to record issue of wipes	March 2012

Infection Prevention Governance Framework Appendix 4



Infection Prevention Reporting Structure **Appendix 5**



Infection Prevention Team Structure **Appendix 6**

To be reviewed following full integration with Scarborough IPT