

DIRECTOR OF INFECTION PREVENTION AND CONTROL
ANNUAL REPORT
2009/2010



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Governance: Presented to Board of Directors
Date of Report: May 2010

1. Executive Summary

1.1 Effective Infection Prevention (IP) and sustainable reduction in Healthcare Associated Infections (HCAI) requires a zero tolerance approach from Board to Ward. Success relies on a whole health economy approach underpinned by strong, effective leadership and performance management supported by robust evidence based infection prevention strategies and policies that are integrated into corporate risk, governance and quality frameworks. As we continue our commitment to prevent avoidable infections, the Trust continues to foster an IP culture that is embedded throughout the organisation.

1.2 This annual report provides a summary of Trust performance against local and national IP initiatives used to inform IP objectives as outlined in the 2009/10 Annual Plan.

The Health Act – Code of Practice for the prevention and control of healthcare associated infections (DH 2008) – Hygiene Code
Saving Lives (DH 2007)
Essential steps to clean safe care (DH 2006)
Standards for Better Health (DH 2004)
NHS Operating Framework (DH 2010/11)
Matrons Charter (DH 2004)
EPIC 2 (2007)
CNO High Impact Actions for nursing and midwifery (2009)

1.3 09/10 Key IP Objectives

- Achieve sustainable reductions in MRSA Bacteraemia and *Clostridium difficile* infection (CDI) in line with national and local trajectories.
 - Introduce MRSA screening of elective cases
 - Antimicrobial Stewardship – introduce narrow spectrum prescribing formularies
 - Sustain compliance with effective Hand Hygiene and 'Bare Below the Elbows'
 - Develop the Trust Corporate Action Plan for monitoring compliance with the Hygiene Code
 - Improve cleanliness and the environment.
 - Develop an IP intranet site
 - Audit and surveillance of HCAI (mandatory and local)
 - Critical review and audit of the implementation of key IP policies
 - Audit of clinical practice through full implementation of the Saving Lives Programme
 - Governance and assurance – measuring Directorate IP performance - Directorate IP Performance Dashboards
 - Mandatory training and education programmes for all staff
- Appendix 1, Trust IP performance dashboard outlines performance against these objectives.

1.4 Inspection by the Care Quality Commission in July 2009 found the Trust to be in breach of criterion 2 of the Hygiene Code – Provide and maintain a clean and appropriate environment that facilitates the prevention of HCAI. Following implementation of an action plan to address recommendations, significant improvements have been made but there is still work to be done in changing culture and embedding sustained improvements.

Initiatives for 2010/11 are being developed in line with Corporate and health economy objectives. Continued focus on responsibility and accountability at all levels within the Organisation will help sustain and bring about further improvements.

1.5 Conclusion & Recommendation

The Board of Directors and Executive Board have demonstrated a commitment to the IP agenda. Progress has been considerable but there is still much to be made to better reflect a zero tolerance to IP and the reduction of HCAI.

1.6 The Board is asked to note and comment on this report and on the 2010/11 IP annual plan (Appendix 2) that links IP with national and corporate objectives.

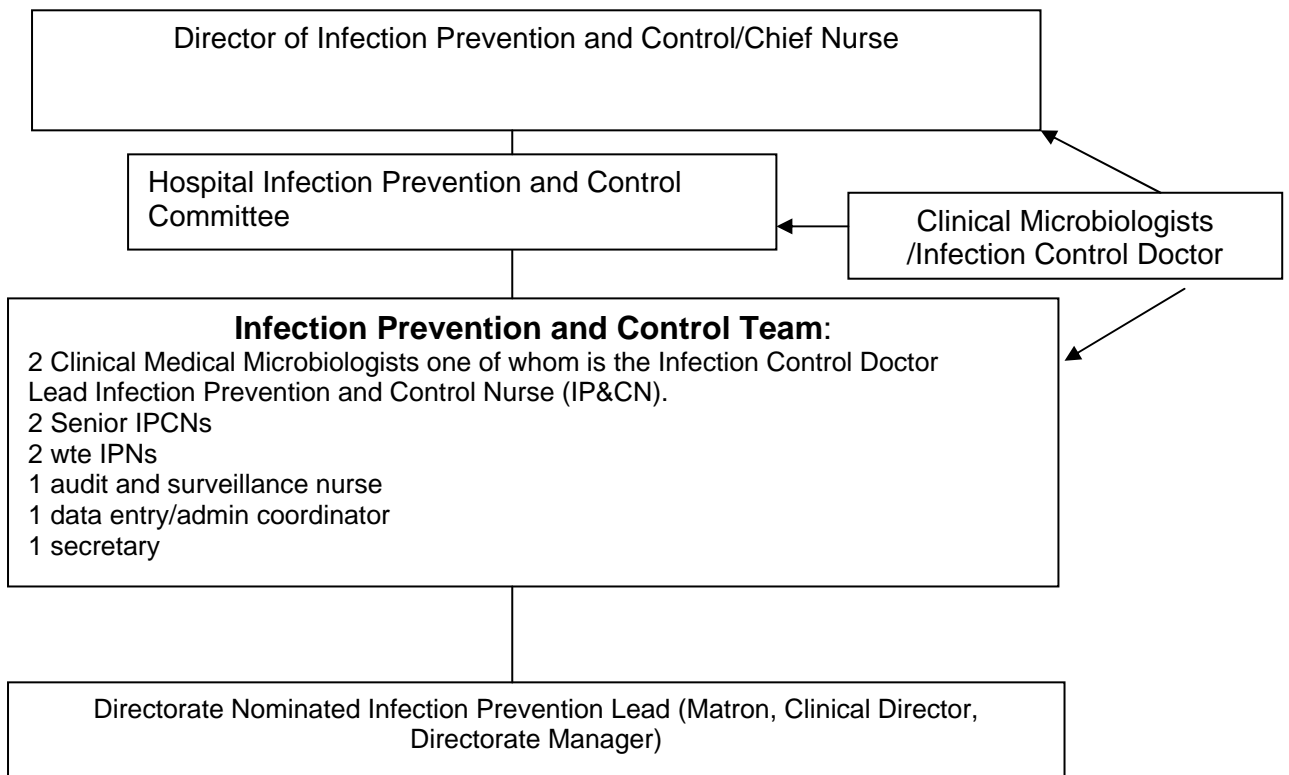
2. Infection Prevention and Control Arrangements

- IP is the responsibility of everyone in the organisation;
- The Director of Infection Prevention and Control (DIPC) oversees the implementation of the IP programme through her role as co chair of the Hospital Infection Prevention and Control Committee (HIPCC);
- The IP team is managed by the Lead Nurse who reports directly to the DIPC;
- The DIPC is a member of the Board and reports directly to the Chief Executive;
- Through reports received at the HIPCC and Executive Board the DIPC is able to challenge IP practice;
- Exception reporting from the HIPCC is made to the Clinical Assurance Committee a sub committee of the Risk and Assurance committee.

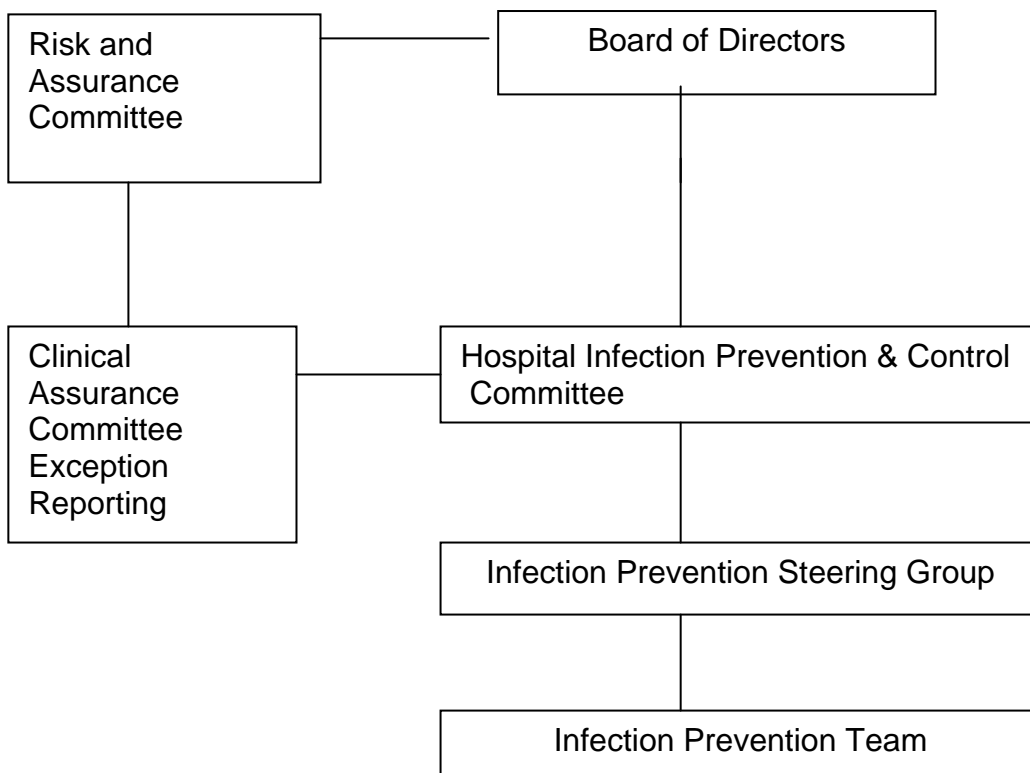
2.1 Role of the Director of Infection Prevention & Control

- Be responsible for the organisation's Infection Prevention and Control Team (IPCT);
- Oversee local control of infection policies and their implementation;
- Be a full member of the IPCT and to attend regularly its infection control meetings;
- Report directly to the chief executive or equivalent (not through any other officer) and the board or other senior management committee;
- Have the authority to challenge inappropriate clinical hygiene practice and inappropriate antibiotic prescribing decisions;
- Assess the impact of all existing and new policies on HCAI and make recommendations for change;
- Be an integral member of the organisation's clinical governance and patient safety teams and structures; and
- Produce an annual report on the state of HCAI in the organisation for which he or she is responsible and release it publicly.

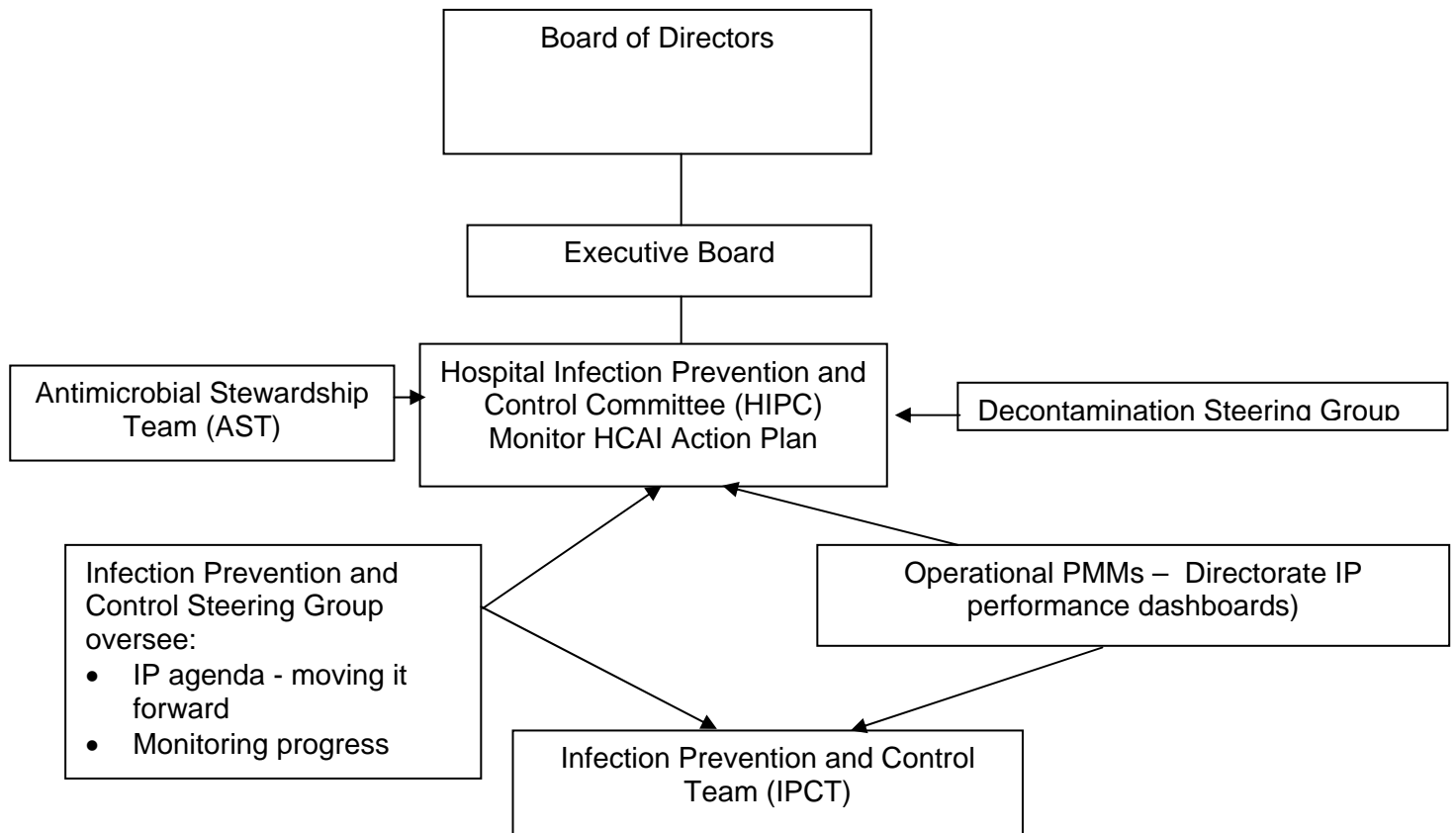
2.2 Infection Prevention Team (IPT) structure



2.3 IP Governance Structure



2.4 Infection Prevention Reporting Framework



2.5 Hospital Infection Prevention and Control Committee

2.5.1 Membership

- Director of Infection Prevention and Control (DPIC) – Chair (Director of Nursing & Improvement)
- Medical Director
- Director of Strategy & Facilities
- Microbiologists – one of whom is Infection Prevention and Control Doctor and Co-Chair
- Lead Infection Prevention and Control Nurse
- Clinical Directors
- Directorate Managers
- Matrons
- Chief Pharmacist and/or Antimicrobial Pharmacist
- Occupational Health Manager
- Health Protection Unit Representative
- Decontamination Lead

2.5.2 Purpose and functions of the HIPCC

Meets bi-monthly to evaluate delivery of and performance against the Trust Hygiene Code Corporate Action Plan IP Annual Plan and HCAI trajectories.

3. IPT Establishment:

09/10		
Band	WTE	Role
Band 8a	0.85	Lead IPN
Band 7	1.80	Senior IPN
Band 6	2.00	IPN with designated responsibility for hand hygiene and MRSA screening
Band 6	0.64	IPN – Audit and Surveillance
Band 3	0.80	Secretary
Band 2	1.00	Data entry/Admin Support

4. DIPC reports to the Board

4.1 Quarterly reports are submitted to Executive Board and Board of Directors to inform on Trust IP performance:

- MRSA and *Clostridium difficile* trajectories
- Outcome of Root Cause Analysis of MRSA and *C.difficile* (reports available from the IPT)
- Mrsa elective screening compliance
- Hygiene Code compliance
- Hand Hygiene and 'Bare Below the Elbows'
- Antimicrobial Stewardship
- Mandatory training and education
- Environmental cleanliness and Domestic issues
- Outbreak reports
- Decontamination
- Other initiatives

5. HCAI and IP Performance

Refer to Appendix 1 – Trust IP Performance Dashboard.

5.1 MRSA Bacteraemia

For the year April 09 to March10 the trust has reported 4 hospital acquired infections against a threshold of 12. We also reported 6 cases already positive on admission and therefore defined as community acquired.

In 04/05 the Department of Health imposed targets on acute Trusts aimed at reducing MRSA Bacteraemia incidence by 50% by 2009. The Trust has exceeded this target however, the DH has imposed an even more difficult challenge for 2010/11 and we must ensure that our current plans are able to deliver this new objective and mitigate any known or potential risks.

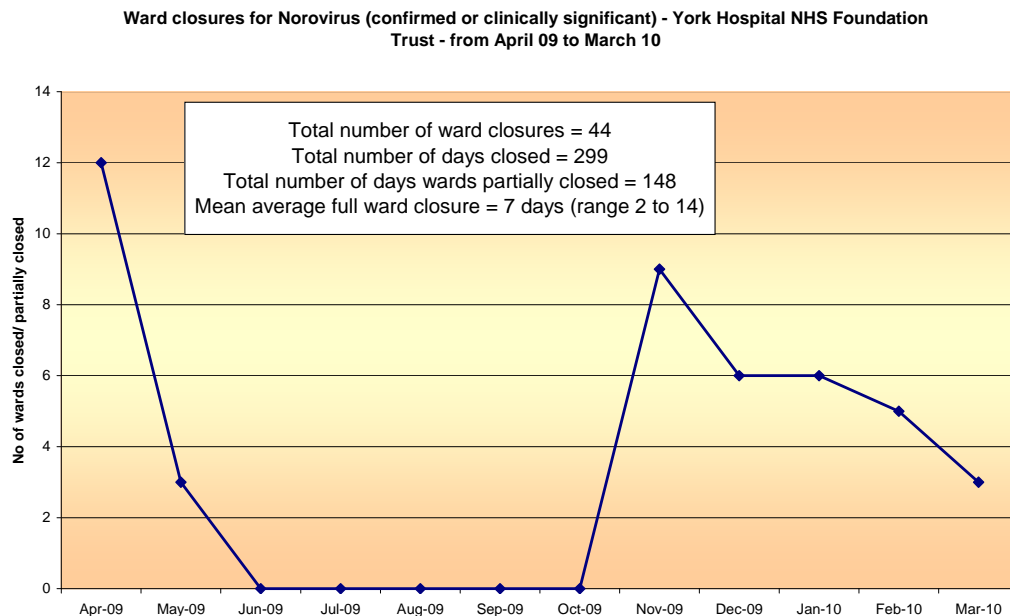
5.2 Clostridium difficile

For the year to March 2010, the trust has reported 28 cases against a trajectory of 117 cases. The challenge for 2010/11 is to further reduce incidence by 30%, this presents a further challenge for the Trust for which our plans and objectives must be able to deliver.

6. Norovirus

The season began in 09-10. The data below illustrates the 09/10 seasonal incidence. Strict outbreak control measures that include enhanced environmental disinfection are implemented across affected areas. The IP Team continue to work 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.



7. Root Cause Analysis (RCA)

As required by the Hygiene Code, all cases of MRSA and *C.difficile* are investigated using the RCA process. Outcomes are presented to Executive Board by the lead clinician. Lessons learnt and actions required are disseminated throughout the organisation. We will further strengthen this within Directorate performance and clinical processes.

8. Audit and Surveillance

Refer to Appendix 3 for summary of audit and surveillance activity.

9. Antimicrobial Stewardship

The Team has negotiated a limited list of antibiotics in each main specialty to make sure prescribing is evidence based and best practice. These lists together with the policies that underpin them ('clear pathway') are taught and communicated widely.

Team members monitor antibiotics use and focus on patients with complex infection problems to improve clinical outcomes, keep their hospital stay short, and make sure they are discharged healthily back into the community.

A Consultant Pharmacist was appointed to drive teaching, research and clinical practice in the use of antimicrobials. This was an innovative three way partnership between the Trust, the Comprehensive Local Research Network, and the Hull York Medical School. All of these have made a major contribution to the reduction in healthcare acquired infection - the Trust is a beacon site for best practice in infection control.

10. Directorate Performance and Assurance

Every clinical directorate is now provided with IP performance data via individual dashboards. These are disseminated to Matrons, Clinical Directors and Directorate Managers i.e IP leads for discussion at Operational Performance Management meetings where action plans and escalation are agreed. It is felt by IP leads that this process has been fundamental in devolving responsibility and accountability for IP to clinical level however some work is required in raising the profile further alongside business and finance.

11. Hand Hygiene

The National Patient Safety Agency (NPSA) "Clean Your Hands Campaign" (CYHC) continues to drive effective hand hygiene in York. Weekly hand hygiene audits continue as we monitor compliance and initiate action plans for 95% and below. Areas of poor or non compliance are targeted by the Hand Hygiene Coordinator and action plans for improvement agreed.

York is identified by the NPSA as a pioneer site. The next stage of the campaign starts in May with new resources becoming available.

The World Health Organisation has issued a Global Challenge to save lives by reducing the rate of Hospital Acquired Infections through effective hand hygiene, the “Clean Care is Safer Care” programme. The Trust is involved with the challenge and has received a letter of commendation from the World Health Organisation for its work and commitment to hand hygiene and patient safety.

The IPT is developing a competency framework for hand hygiene which will ensure that all staff performs hand hygiene to the same standard all of the time. This will involve training and assessment of staff. The Clean Your Hands Champions will continue to audit hand hygiene compliance weekly and will also be involved in competency assessments. The hand hygiene coordinator will oversee the campaign on behalf of the NPSA and WHO and manage implementation across the Trust. The future of hand hygiene in York is for everyone to be responsible and accountable for ensuring delivery of effective hand hygiene at the point of care if we are to reflect a zero tolerance to HCAs and keep patients safe in our care.

12. Policies

The Trust has in place the key IP policies required by the Hygiene Code. Implementation is audited at least yearly, all audits are registered with Clinical Audit. Reports are available from the IPT.

13. Training and education

Training is mandatory for all Trust staff. Programmes have been developed for individual staff groups and are informed by surveillance and audit outcomes. Attendance at session needs to improve and this is flagged up to Directorate leads via the performance dashboards.

14. Environmental Cleanliness

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.

A Business case has been approved to enhance cleaning and disinfection frequencies during outbreaks and this is now in place. IP and Domestic Services have a very positive working relationship which is of profound benefit in striving to achieve good standards.

New cleaning and disinfection processes have been implemented to assist with accessible and efficient cleaning 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.

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
- CQUIN Framework
- 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
<p>1.1 Develop zero tolerance to HCAI from Board to ward</p>	<ul style="list-style-type: none"> • Compliance with the Hygiene Code • HIPCC • CAC – exception reporting • Risk registers • Executive Board Reports • Monitor Assurances • RMSAT • NHS Operating Framework 2010/2011 	<ul style="list-style-type: none"> • DIPC Annual Report • Hygiene Code Corporate Action Plan • Trust policies • Compliance Audit Projects 	<ul style="list-style-type: none"> • BoD • Corporate Leads identified within the Action Plan • IPC Steering Group • Matrons • Committee and Board minutes 	<p>Permanent Trust objective</p>	
<p>1.2 Develop whole health economy collaboration to help meet key performance indicators to reduce the burden of HCAI</p>	<ul style="list-style-type: none"> • Hygiene Code Corporate Action Plan • Root Cause Analysis (RCA) Outcome • DCIC HCAI sub group • CIPN meetings 	<ul style="list-style-type: none"> • Minutes of bi-monthly meetings with Community Infection Prevention Team. • DIPC minutes • Hygiene Code Corporate Action Plan • RCA Action Plans 	<ul style="list-style-type: none"> • Acute and Primary Care Trust • Infection Prevention Leads 	<p>Ongoing initiative</p>	

<p>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</p>	<ul style="list-style-type: none"> • Hygiene Code Criterion 6 • Saving Lives 2007 • AIRS System • Trust IP Policies: Isolation • Risk register • Control and Management outbreaks 	<ul style="list-style-type: none"> • Hygiene Code Corporate Action Plan • Outbreak documentation • Policy audit reports • Outbreak meeting minutes and actions 	<ul style="list-style-type: none"> • Executive Board • DIPC • IPT • Associate Director of Operations • Director of Strategy and Planning 	<p>TBA with HIPCC and responsible leads</p>	
<p>1.4 Anti-microbial stewardship (Team) (AST)</p>	<ul style="list-style-type: none"> • Directorate prescribing formularies • Audit reports • AST minutes 	<ul style="list-style-type: none"> • Prescribing audit data • AST minutes 	<ul style="list-style-type: none"> • Consultant Pharmacist • Clinicians 	<p>Permanent initiative</p>	

2.0 Clinical Standards and Practice

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment
<p>2.1 Eliminate variations in clinical practice and performance to better reflect a zero tolerance approach to preventable infections</p>	<ul style="list-style-type: none"> • NHS Operating Framework 2010/2011 • Trust Infection Prevention Policies • IP Policy Audit Strategy • Saving Lives 2007 • IP Dashboards • Root Cause Analysis (RCA) • ANTT 	<ul style="list-style-type: none"> • Audit Reports Action plans • ANTT data • Saving Lives compliance data • IP Dashboards and operational PMM minutes • RCA reports and action plans 	<ul style="list-style-type: none"> • IPT • Directorate IP Leads • Matrons • Ward Managers 	Ongoing development	
<p>2.2 Critically review facilities for and management of Norovirus to reduce incidence and spread, including the consideration of new technologies</p>	<ul style="list-style-type: none"> • Hygiene Code Criterion 6 • Trust IP policies <ul style="list-style-type: none"> - Isolation - Management of Outbreaks • Saving Lives best practice summary 2007 • Norovirus action plan 2010 	<ul style="list-style-type: none"> • Hygiene Code Corporate Action Plan • Compliance audit reports • Norovirus action plan 	<ul style="list-style-type: none"> • DIPC • Executive Board • Director of Strategy and Planning • IPT 	<p>Ongoing development</p> <p>August 2010 for new technologies</p>	

<p>2.3 Continue sustained reduction in MRSA, BSI and <i>C.difficile</i> Infection to achieve 2010/11 trajectories.</p>	<ul style="list-style-type: none"> • NHS Operating Framework 2010/11 • Trust IP policies <ul style="list-style-type: none"> - Control and Management of MRSA - Control and Management of <i>C.difficile</i> 	<ul style="list-style-type: none"> • HCAI incidence data • Policy Audit data • Saving lives 	<ul style="list-style-type: none"> • Directorate Clinical Leads • Matrons • IPT 	<p>Permanent initiative</p>	
<p>2.4 Screening all relevant emergency admissions by December 2010</p>	<ul style="list-style-type: none"> • NHS Operating Framework 2010/2011 • National Quality Board 2009 	<ul style="list-style-type: none"> • Screening compliance data 	<ul style="list-style-type: none"> • Directorate Clinical Leads • Matrons • Ward Managers 	<p>December 2010</p>	
<p>2.5 Continue to develop the Hand Hygiene strategy and action plan to sustain compliance at 95%</p> <p>2.5.1 Develop hand hygiene competency framework</p>	<ul style="list-style-type: none"> • NPSA Alert 2009 • Hand Hygiene policy • RMSAT 	<ul style="list-style-type: none"> • Observation compliance data • Policy audit data • Competency assessments 	<ul style="list-style-type: none"> • Hand Hygiene Coordinator/IPN • Matrons 		
<p>2.6 Implement the Aseptic Non Touch Technique framework (ANTT)</p>	<ul style="list-style-type: none"> • Asepsis Policy • ANTT framework 	<ul style="list-style-type: none"> • ANTT compliance data • Competency checks 	<ul style="list-style-type: none"> • IPNs • Matrons • Ward Managers 	<p>Permanent initiative from May 2010</p>	

3.0 Surveillance and Audit

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment
3.1 Develop and implement: <ul style="list-style-type: none"> • Surgical Site Infection (SSI) surveillance • Surveillance of Urinary Catheter Associated Urinary Tract Infection (UTI's) 	<ul style="list-style-type: none"> • Hygiene Code • Saving Lives High Impact Intervention 6 • High Impact Action • CQUIN Framework 	<ul style="list-style-type: none"> • Hygiene Code Corporate Action Plan • Saving Lives data • Surveillance Data • CQUIN data 	<ul style="list-style-type: none"> • IPT • Directorate IP leads • M Carrington, Asst Chief Nurse 	September 2010	
3.2 Procure Infection Prevention and control software Have 'live' performance data (dashboards) available via Signal	<ul style="list-style-type: none"> • Hygiene Code 	<ul style="list-style-type: none"> • Robust audit and surveillance data that is timely and meaningful to underpin quality and patient safety. 	<ul style="list-style-type: none"> • IPT • IT department • Finance Manager 		
3.3 Re-implement audit of the clinical environment	<ul style="list-style-type: none"> • Saving Lives High Impact Intervention 8 • Trust IP policy - Antiseptic and Decontamination • Decontamination Steering Group 	<ul style="list-style-type: none"> • Saving Lives data • Policy audit report • Matrons assessment tool • Decontamination Group minutes 	<ul style="list-style-type: none"> • IPT • Matrons • Ward Managers • Decontamination Lead/Director of Estates and Facilities 	September 2010 August 2010	

4.0 Education and Learning

Objective	Key Controls	Assurance and Evidence	Responsible Lead/s	Completion Date	Six Monthly Review and Comment
<p>4.1 Continue to develop and deliver statutory and mandatory training to all Trust staff utilising traditional and alternative methods</p> <p>4.1.1 Evaluate alternative methods of delivery for difficult to access groups i.e. Porters, Domestic.</p>	<ul style="list-style-type: none"> • Hygiene Code • RMSAT • Trust Training Needs Analysis (TNA) 	<p>Hygiene Code Corporate Action Plan</p> <p>RMSAT inspection report</p> <p>Attendance data via ESR</p>	<ul style="list-style-type: none"> • CLAD • IPT • Risk and Legal Services 	<p>Annual Initiative</p>	

SURVEILLANCE and AUDIT PROJECTS

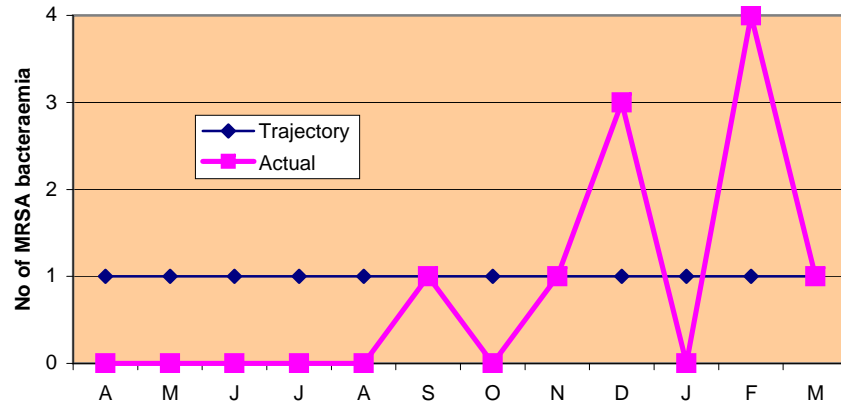
APRIL 2009 – March 2010

Commencement date	Surveillance	Method	Comments and Outcome	Completion date
On-going	DH Mandatory MRSA bacteraemia and Clostridium difficile reporting	Web-link case reporting as occurs	National comparative data available on Health Protection Agency website.	On-going
On-going	DH Mandatory MRSA, MSSA, GRE bacteraemia and Clostridium difficile reporting	3-monthly reporting to Health Protection Agency	National comparative data available on Health Protection Agency website	On-going
On-going	MRSA and Clostridium difficile surveillance	Monthly reporting to Trust	Data available on hospital Q drive.	On-going
On-going	Data collection of bacteraemia organism incidence	Monthly data collection	Data available from Infection Prevention Team	On-going
January 2010	DH Mandatory orthopaedic surgical site infection surveillance (SSIS)	SSISS protocol	Data available from Infection Prevention Team	June 2010
January 2010	Post discharge surveillance of surgical sites	Trial to link with mandatory orthopaedic SSIS	Part of Safer Patient Initiative. Methods previously trialled were unsuccessful. Concerns about cost and staff implications if surveillance is to be established effectively.	June 2010

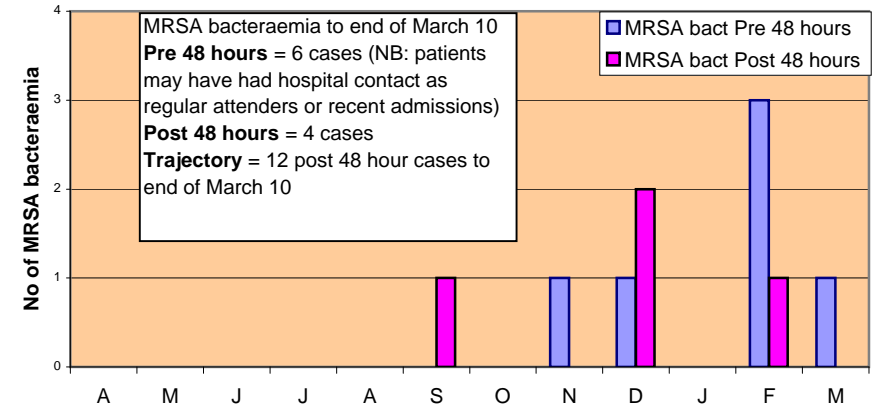
Commencement date	Audit	Method	Comments and Outcome	Completion date
2008	Compliance of IPCT policy audits	Individual methods for each policy	Refer to Audit of Policies Strategy available from IPT.	On-going
June 2010	Clinical environment audits	Annual audits of each clinical area	Commenced 2006 but annual audits not continued by clinical areas. To re-launch following Saving lives roll out in 2009	On-going
On-going	Hand hygiene compliance audits	Trust wide weekly audits in each clinical area	Compliance data available on hospital Q drive.	On-going
On-going	Saving Lives High Impact Interventions	Roll out programme from January 09 to June 09	Programme rolled out across the organisation June 2009.	On-going
July 2009	MRSA decolonisation and documentation compliance audit	Documentation and treatment check of all MRSA inpatients for 3 months	Revision of treatment record and 'care plan' introduced. To review success of changes 12 months.	September 2009
October 2009	Re-audit of peripheral cannula documentation audit	Documentation check on all wards – snapshot audit	Poor compliance. Documentation redesigned - May 2010 trial underway.	October 2009
November 2009	Audit of use of bed space posters and checklist	Snapshot audit of compliance in using posters and checklist	Poor compliance. To be included in Nursing Care Indicators (from January 2010)	November 2009
March 2010	Hand hygiene facilities audit	Annual audit of hand hygiene facilities in all clinical areas	Initial audit completion date August 2010	Annual

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
March 2010	Catheter related Urinary Tract Infection surveillance	Review of patients clinical symptoms with positive catheter sample urine	Part of DH High Impact Action	September 2010

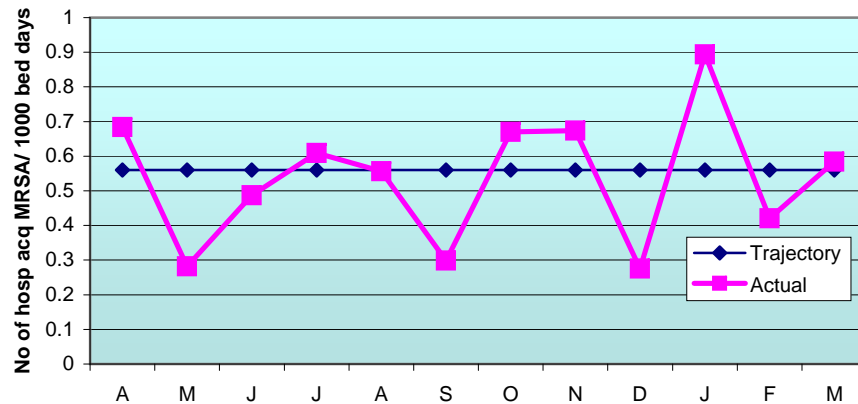
Monthly MRSA bacteraemia all cases - actual and projected incidence - Trust wide



MRSA bacteraemias monthly incidence pre and post 48 hours from admission - Trust wide



Hospital acquired MRSA all cases per 1000 bed days - Trust wide

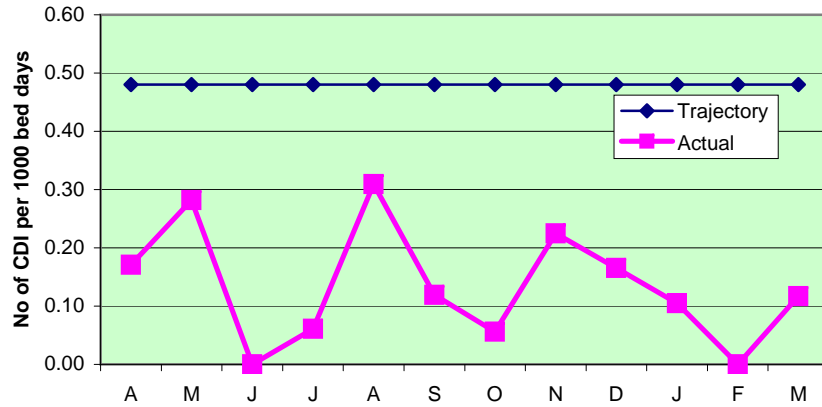


'Hospital acquired' defined as patients who have acquired MRSA after being in hospital for more than 2 days.

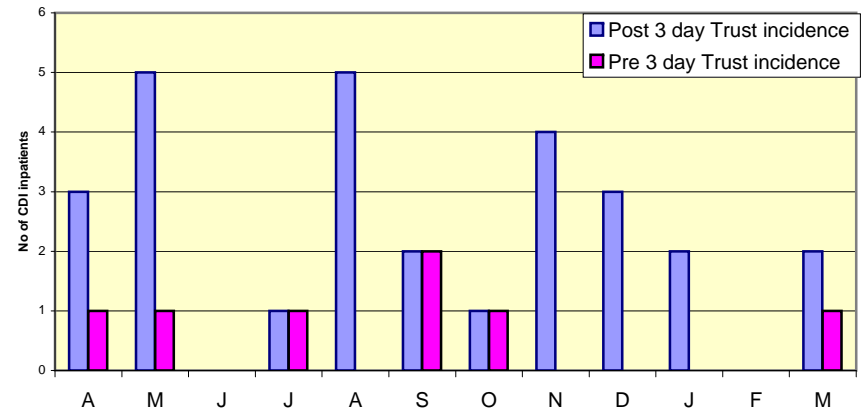
NB: number refers to all cases where MRSA is isolated - including nose, throat, perineum, wounds, invasive device sites, bloodstream, urine.

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



Clostridium difficile infection monthly inpatient incidence pre and post 3 days from admission - Trust wide



CDI to end of March 10
Pre 72 hours = 7 cases (NB: patients may have had hospital contact as regular attenders or recent admissions)
Post 72 hours = 28 cases
Trajectory = 117 post 72 hour cases to end of March 10

TRUSTWIDE INFECTION PREVENTION PERFORMANCE DASHBOARD

Trust Targets 09/10

MRSA bacteraemia: 12

Clostridium difficile Associated Diarrhoea: 117

Isolate	2008/09 baseline	2009/10 trajectory	Cases in 2009/ 10													Cases (to date)	Comments
			A	M	J	J	A	S	O	N	D	J	F	M			
MRSA Bacteraemia cases per year	Trust total 15	12 (post 48 hour cases)	Trajectory	1	1	1	1	1	1	1	1	1	1	1	1		
			Actual	0	0	0	0	0	1	0	1	3	0	4	1	10	Pre and post 48 hour cases
			MRSA bact Pre 48 hours	0	0	0	0	0	0	0	1	1	0	3	1		
			MRSA bact Post 48 hours	0	0	0	0	0	1	0	0	2	0	1	0		
MRSA clinical isolates	132 hospital acquired = 0.62 per	119# hospital acquired =	Actual hosp acq per 1000 bed days	0.7	0.3	0.5	0.6	0.6	0.3	0.7	0.7	0.3	0.9	0.4	0.6	0.54	Target <= 0.56 per 1000 bed days.
Clostridium difficile Associated Diarrhoea	103 (post 72 hours) = 0.48 per 1000 bed days*	117 (post 72 hours) DH trajectory	Post 3 day Trust incidence	3	5	0	1	5	2	1	4	3	2	0	2		
			Pre 3 day Trust incidence	1	1	0	1	0	2	1	0	0	0	0	1		
			Actual post 72 hour per 1000 bed days	0.2	0.3	0.0	0.1	0.3	0.1	0.1	0.2	0.2	0.1	0.0	0.1	0.13	Target <= 0.48 per 1000 bed days.

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

** Using 08/09 total bed days as baseline

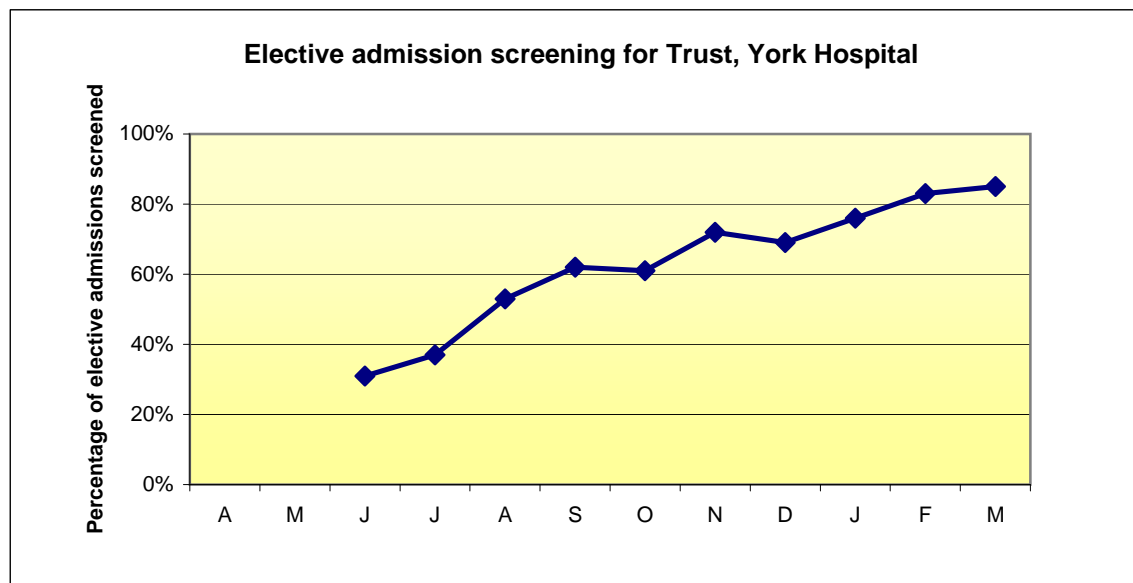
2009/10 trajectory based on 10% reduction of 08/09 total

TRUSTWIDE INFECTION PREVENTION PERFORMANCE DASHBOARD

Appendix 1

Elective screening (percentage of elective admissions screened). Target 100%	A	M	J	J	A	S	O	N	D	J	F	M
				31%	37%	53%	62%	61%	72%	69%	76%	83%

Data provided by Information Department, YH

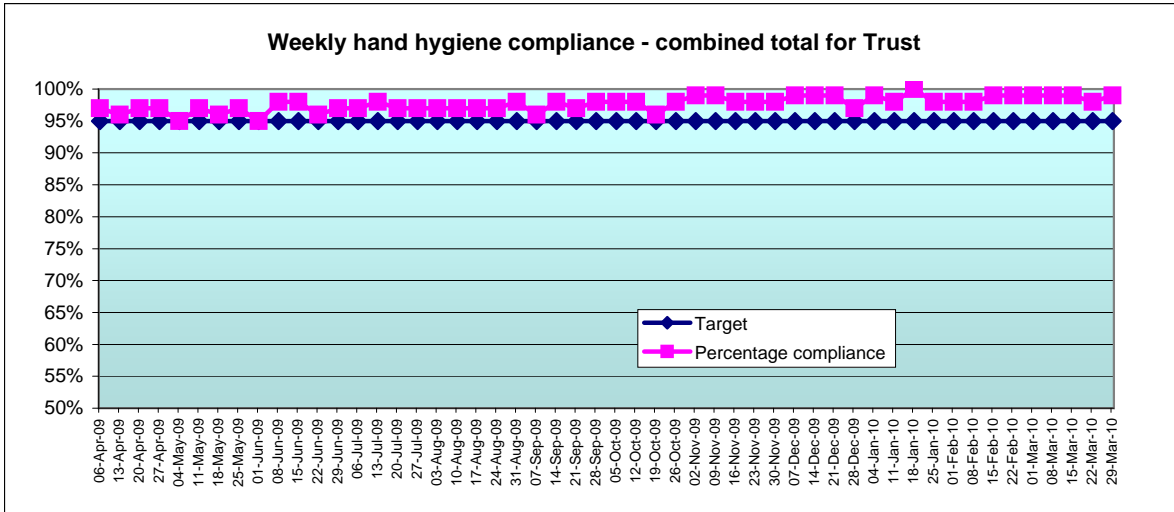


NUMBER OF OUTLIERS WITH AN INFECTIOUS CONDITION

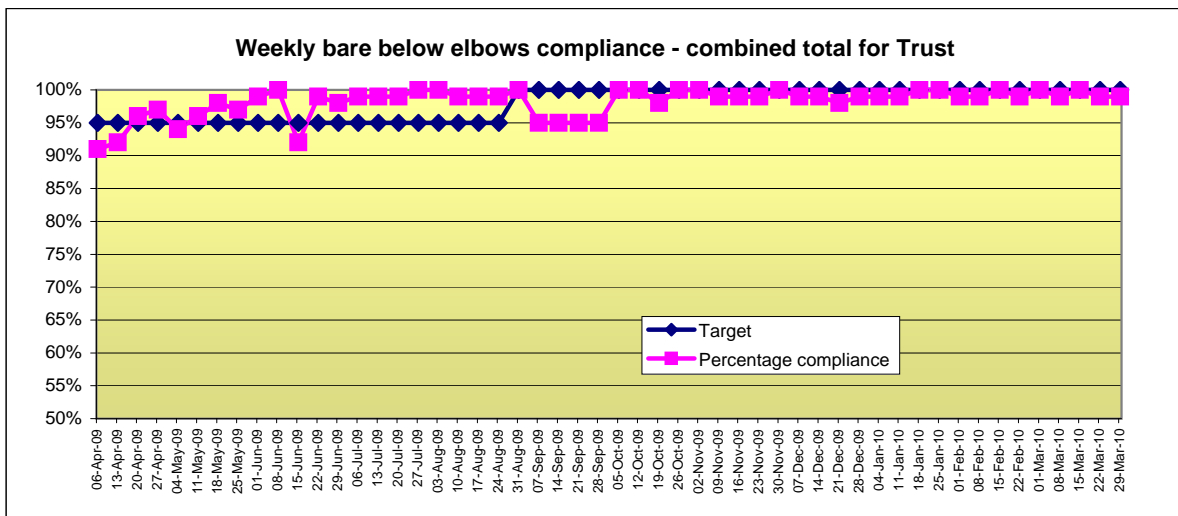
Number of patients outlying	A	M	J	J	A	S	O	N	D	J	F	M
		0	0	0	0	0	0	1	1	1	1	1

HAND HYGIENE - Trust

Data from Hand Hygiene files on Q drive

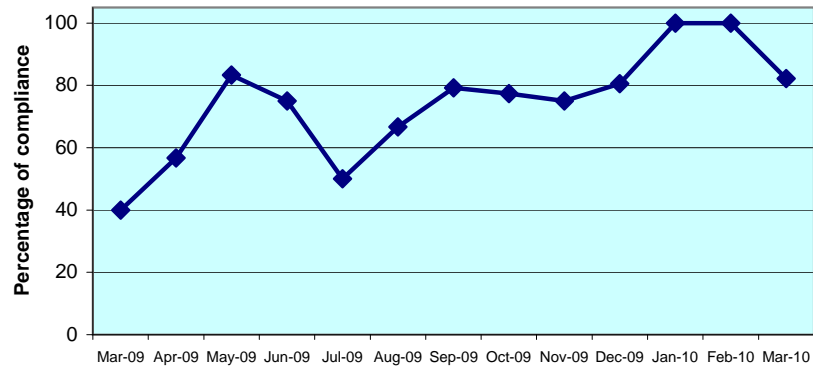


BARE BELOW THE ELBOWS - Trust

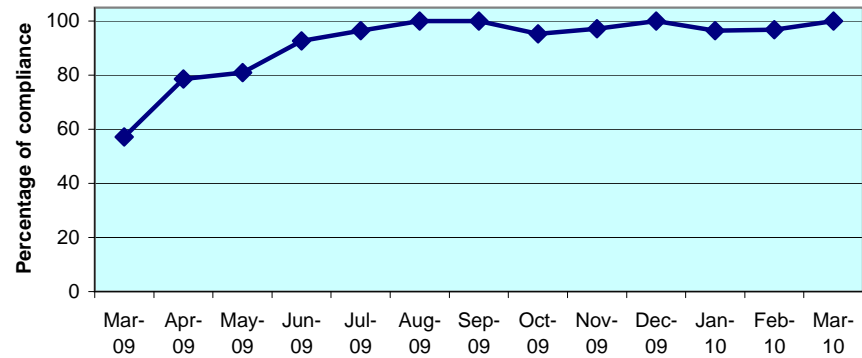


SAVING LIVES

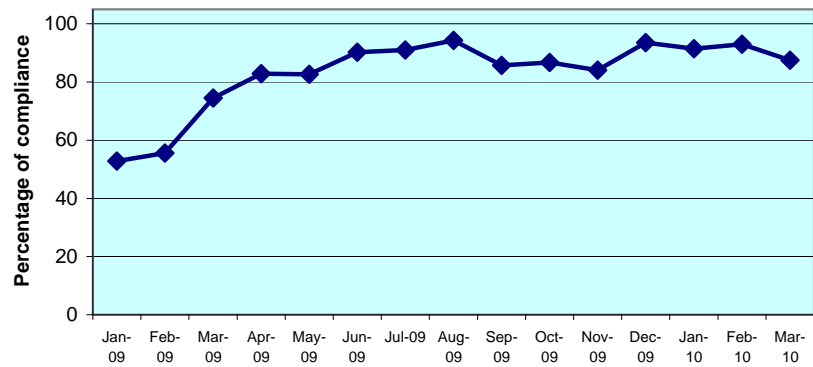
Trust overall compliance of all elements for Saving Lives HII 1 (CVC - insertion)



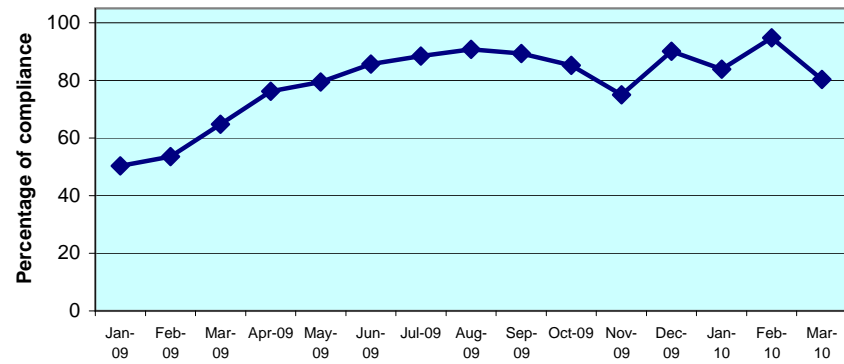
Trust overall compliance of all elements for Saving Lives HII 1 (CVC - ongoing)



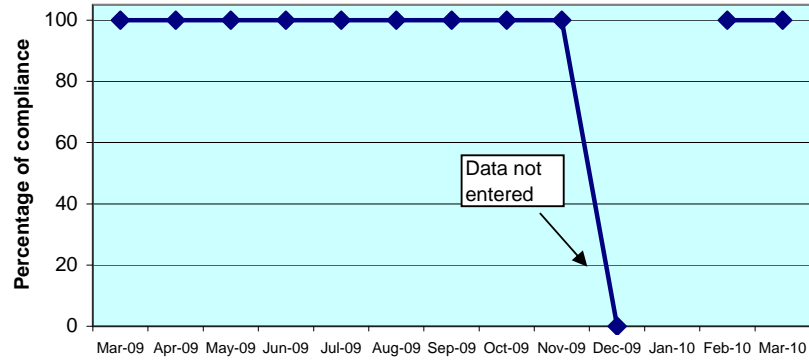
Trustwide overall compliance of all elements for Saving Lives HII 2 (Peripheral cannula - insertion)



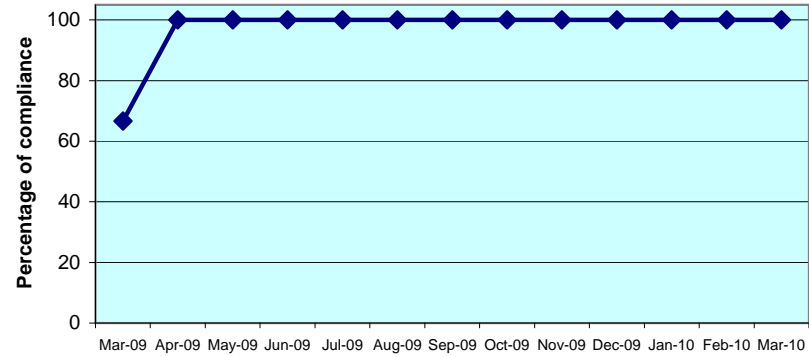
Trustwide overall compliance of all elements for Saving Lives HII 2 (Peripheral cannula - ongoing)



Trust overall compliance of all elements for Saving Lives HII 3 (Renal - insertion)



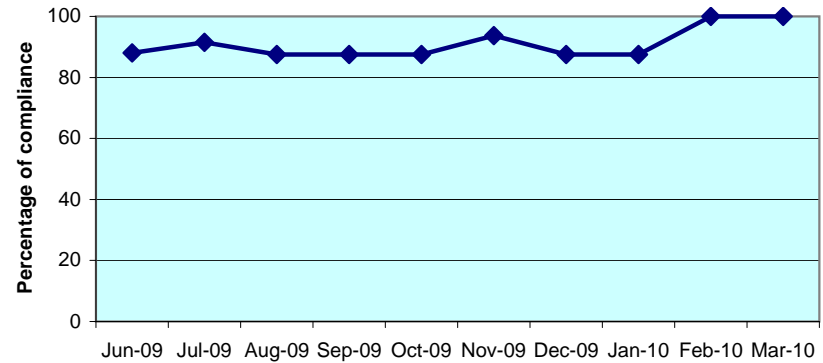
Trust overall compliance of all elements for Saving Lives HII 3 (Renal - ongoing)



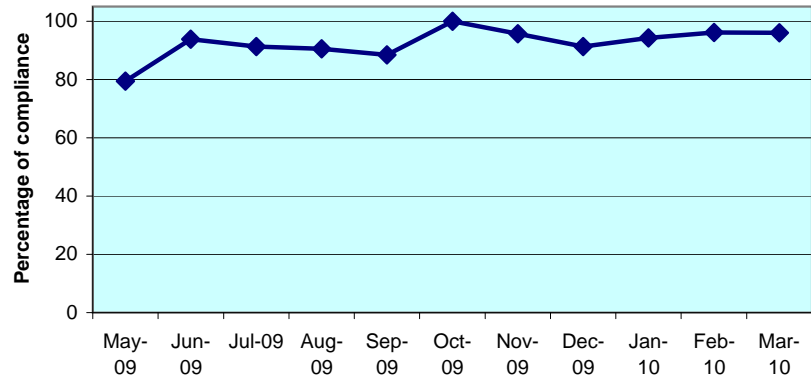
HII 4 (Preventing Surgical site infection)

Trust	MRSA screening	MRSA decontamination	Hair removal	Prophylactic antimicrobial	Normothermia	Glucose control
Jun-09	31	100		32	67	84
Jul-09	37	100		27	47	74
Aug-09	53	100	100	30	56	100
Sep-09	62	100	100	34	32	90
Oct-09	61	100	100	30	48	95
Nov-09	72	100	100	29	21	83
Dec-09	69	100	100	28	31	81
Jan-10	76	100	100	29	57	96
Feb-10	83	100	100	22	41	90
Mar-10	85	83	100	22	37	93

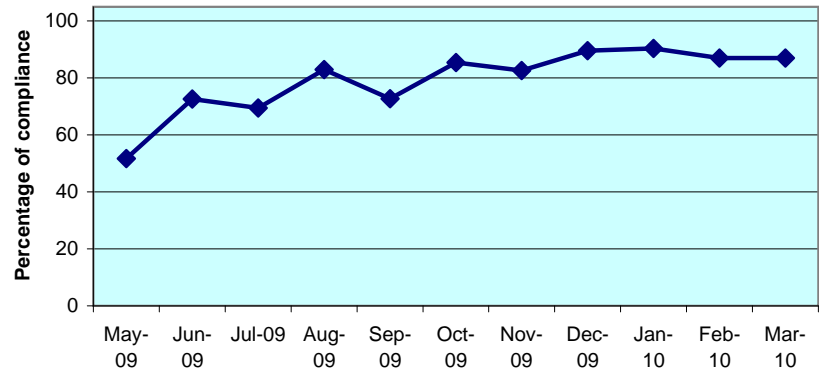
Trust overall compliance of all elements for Saving Lives HII 5 (Ventilated patients)



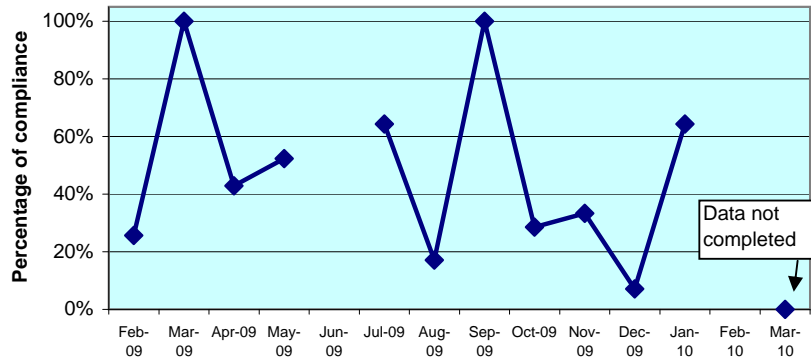
**Trustwide overall compliance of all elements for Saving Lives
HII 6 (Urinary catheter - insertion)**



**Trustwide overall compliance of all elements for Saving Lives
HII 6 (Urinary catheter - ongoing)**



**Trust wide overall compliance of all elements for Saving Lives HII
7 (Reducing the risk of Clostridium difficile)**



Nil return (no cases to audit) is indicated by a gap on the chart.

All audits require 100% compliance

All audits have been rolled out

TRUST INFECTION PREVENTION PERFORMANCE DASHBOARD

Appendix 1

INFECTION PREVENTION AND CONTROL MANDATORY TRAINING BY STAFF GROUP

	April to June	July to September	October to December	January to March
Registered staff - Nurses	138	212	255	100
Unregistered staff - HCAs	52	68	35	6
Medical staff	39	4		11

Percentage of staff who attended from April 2009 to end of December 2009

Registered staff – Nurses	47% of registered nurses employed by the Trust
Unregistered staff - HCAs	32.5% of HCA employed by the Trust

DOMESTIC MONITORING % Score. FROM SEPT 09

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%	99%	99%	99%	99%
HR areas						91%	91%	95%	97%	96%	95%	96%
SR areas						92%	87%	95%	94%	91%	92%	96%
Trust overall						94%	94%	97%	97%	97%	96%	97%

PEAT REPORTING % Score. FROM OCTOBER 09

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						97%	93%	94%		97%	96%	91%
HR areas						89%	89%	91%	92%	90%	92%	92%
SR areas						77%	87%	91%	87%	91%	91%	91%
Trust overall						88%	89%	92%	90%	93%	92%	92%