Shropshire Community Health NHS
NHS Trust

SUMMARY REPORT	Meeting Date:	24 November 2016
	Agenda Item:	8.2
	Enclosure Number:	6

Meeting:	**Trust Board**		
Title:	Infection Prevention and Control Annual Report for 2015/2016		
Author:	Liz Watkins, Head of Infection Prevention and Control		
Accountable Director:	Steve Gregory, Executive Director of Nursing and Operations / Director of Infection Prevention and Control		
Other meetings presented to or previously agreed at:	**Committee**	**Date Reviewed**	**Key Points/Recommendation from that Committee**
	Quality and Safety Committee	21 July 2016	

Purpose of the report

To provide the Trust Board with a summary of the activities undertaken by Shropshire Community Health NHS Trust to comply with the Health and Social Care Act 2008: Code of Practice on the control and prevention of infections and reduce the risk of healthcare associated infection for the year from April 2015 to March 2016.

In addition, this annual report outlines the performance of the Trust against targets set for MRSA bacteraemia, *Clostridium difficile* infections and MRSA screening.

It also reviews accountability arrangements, policies and procedures relating to infection prevention and control, audit, and education necessary in order to support prevention and control of infection.

The report gives a brief overview of the work programme for 2016/2017 which is essential for the Trust to maintain compliance with the Care Quality Commission registration requirements and continue to improve patient safety in relation to infection prevention and control.

Consider for Action	✓
Approval	
Assurance	✓
Information	✓

Strategic goals this report relates to:

To deliver high quality care	To support people to live independently at home	To deliver integrated care	To develop sustainable community services
✓			

Summary of key points in report

- Zero MRSA bacteraemia attributed to SCHT
- Although the set target of no more than two post 72 hour cases of *Clostridium difficile* infections was not achieved, the Root Cause Analyses undertaken did not reveal that SCHT could have prevented any of these infections. All were deemed to have been unavoidable and following treatment the five patients were discharged home.

- A 99% compliance for MRSA screening was achieved
- Care Quality Commission (CQC) visited the Trust in March. Whilst the full report has yet to be received, the only Infection prevention and control issue highlighted in the initial feedback was regarding the cleaning of toys in shared premises. This has now been addressed.

Key Recommendations

The Trust Board is asked to:

- Note and approve the content of the report

Is this report relevant to compliance with any key standards? YES OR NO		**State specific standard or BAF risk**
CQC	Yes	Outcome 8 – "Cleanliness and Infection Control"
IG Governance Toolkit	No	
Board Assurance Framework	No	

Impacts and Implications?	**YES or NO**	**If yes, what impact or implication**
Patient safety & experience	Yes	The report and delivery of the annual IPC programmes will provide a basis for assurance on patient safety and experience
Financial (revenue & capital)	Yes	Healthcare associated infection has a significant financial impact within the NHS
OD/Workforce	Yes	IPC training required for staff
Legal	Yes	Legal requirement to publish annual report

Shropshire Community Health NHS
NHS Trust

ANNUAL REPORT OF INFECTION PREVENTION AND CONTROL

April 2015 to March 2016

CONTENTS

Executive introduction from the Executive Director of Nursing & Operations and Director of Infection Prevention & Control

Dear Staff, Patients, Carers, Service Users and Partners

Welcome to Shropshire Community Health Trust's (SCHT) Infection Prevention and Control Annual report which has been developed in collaboration with the Head of Infection Prevention and Control (IPC) and the Infection Prevention and Control team.

The purpose of this report is to outline the activities of SCHT relating to infection prevention and control for the year from April 2015 to March 2016 and discuss the arrangements SCHT have in place to reduce the spread of infections. It also reviews accountability arrangements, policies and procedures relating to infection prevention and control, audit, and education necessary in order to support prevention and control of infection.

Our key achievements were:

- Zero MRSA bacteraemia attributed to SCHT
- Although the set target of no more than two post 72 hour cases of *Clostridium difficile* infections was not achieved, the RCAs undertaken did not reveal that SCHT could have prevented any of these infections. All were deemed to have been unavoidable and following treatment the five patients were discharged home.
- A 99% compliance for MRSA screening was achieved
- Mandatory training including Infection Prevention and Control attended by 65.77% of clinical staff
- 91% of non-clinical staff were up to date with IPC e-learning as at March 2016
- Care Quality Commission (CQC) visited the Trust in March. Whilst the full report has yet to be received, the only IPC-related issue highlighted in the initial feedback was regarding the cleaning of toys in shared premises. This has now been addressed.

Looking forward to 2016-2017, the IPC team and all SCHT staff will continue to work hard and focus on the prevention of all infections.

Steve Gregory

Executive Director of Nursing & Operations and Director of Infection Prevention & Control

Section One: Introduction

The purpose of this report to provide assurance to the Board of Directors and the public for the reporting period 1 April 2015 – 31 March 2016 regarding the Infection Prevention and Control (IPC) activity including compliance with the Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (commonly known as The Hygiene Code) and also in relation to National Institute for Health and Clinical Excellence (NICE) guidance.

This annual report fulfils its statutory requirements under the Health & Social Care Act 2008: Code of Practice on the prevention and control of infections, which sets out 10 compliance criteria against which a registered provider will be judged on how it complies with the registration requirements for cleanliness and infection prevention and control. It sets the basis of our annual programme which is monitored at the Shropshire Community Health Trust (SCHT) Infection Prevention and Control bi-monthly meeting. The aim of the Infection Prevention and Control team is to increase organisational focus and collaborative working so to ensure continued compliance and quality improvement.

SCHT is registered with the Care Quality Commission (CQC) and declared full compliance with the ten compliance criteria as detailed in Table 1.

Table 1: The requirements of the Health and Social Care Act (2008: revised 2015)

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion
5	Ensure prompt identification of people who have or are at risk of developing so that they receive timely and appropriate treatment to reduce the risk of transmitting the infection to other people
6	Systems to ensure that all care workers (including contractors volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7	Provide or secure adequate isolation facilities
8	Secure adequate access to laboratory support as appropriate
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections
10	Providers have a system in place to manage the occupational health needs and obligations in relation to infection.

The SCHT Board and ultimately the Chief Executive carries responsibility for IPC throughout SCHT and is a vital component of Quality and Safety. The day to day

management is delegated to the Director of Infection Prevention and Control (DIPC). All managers and clinicians ensure that the management of IPC risks is one of their fundamental duties. Every clinical member of staff demonstrates commitment to reducing the risk of Healthcare Associated Infections (HCAI) through standard infection prevention and control measures. The IPC team endeavours to provide a comprehensive proactive service, which is responsive to the needs of staff and public alike, and is committed to the promotion of excellence within everyday practice of IPC.

As with the previous year the 2015/16 NHS Outcomes Framework included reducing the incidence of Healthcare Associated Infections (HCAIs), in particular Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* infections (CDI) as areas for improvement. Within Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm of the Outcomes Framework reducing all HCAIs remained a priority.

As previously reported, the extension to the mandatory surveillance to include Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Escherichia coli (E.coli) bacteraemia infections since 2011together with the Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* national reduction targets set for Acute and Clinical Commissioning Groups (CCGs) reflects the zero tolerance approach for all avoidable HCAIs.

This report will provide information of the activities and performance of Key Performance Indicators (KPI) for IPC during the period 1 April 2015 to 31 March 2016 by SCHT. The report is aligned to the 2015/16 Infection Prevention and Control Programme, informing progress against the objectives set and outlines performance of SCHT against the MRSA bacteraemia and CDI reduction targets.

In addition the report aims to reassure the public that reducing the risk of infection through robust infection prevention and control practice is a key priority for SCHT and supports the provision of high quality services for patients and a safe working environment for staff.

Section Two: Who we are, our duties, arrangements and assurance

Who we are

SCHT provides community-based health services to around 475,500 people in Shropshire and Telford and Wrekin. These include, for example, four community hospitals, community nursing and inter-disciplinary teams, health visiting, advanced primary care services and children's services.

SCHT has a committed IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that infection prevention and control is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients. The IPC team utilises a proactive approach with the emphasis on being visible so making their accessibility for guidance and advice a priority. This in turn has led to an improved IPC team image i.e. being a regular familiar face rather than only visiting to audit or when there are problems.

Looking forward, it is critical that we maintain this level of commitment. As in previous years, we will continue to work with Shrewsbury and Telford Hospital Trust (SaTH), Robert Jones and Agnes Hunt Hospital, Shropshire Clinical Commissioning Group (SCCG), Telford and Wrekin Clinical Commissioning Group (TWCCG) in the Local Health Economy (LHE) as well as experts in other organisations, Public Health England (PHE) and the NHS Trust Development Authority (TDA), Midlands and East of England.

Our Duties and Arrangements

Infection Prevention and Control Service:

- Director of Infection Prevention & Control (also Executive Director of Nursing and Operations)
- Head of Infection Prevention and Control (0.8 WTE)
- Infection Prevention and Control Nurses (1.6 WTE)
- Infection Prevention and Control Secretary (1.0 WTE)

Reduced staffing in 2015/16 has proved to be challenging however, it created an opportunity to review the team's priorities and introduce new ways of working.

The IPC team is led by Steve Gregory, Executive Director of Nursing and Operations who is the Director for Infection Prevention and Control (DIPC) and reports directly to the Chief Executive.

LtoR: Steve Gregory, Rachael Allen, Liz Jones, Liz Watkins, Alison Davies

The IPC team devises and implements a robust Annual Programme of Work to reduce HCAI. This is achieved by working in collaboration with all SCHT services and staff. The IPC team perform a number of activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at local level, alert organisms surveillance and managing outbreaks of infection.

SCHT has a Service Level Agreement for specialist support from a Consultant Microbiologist at SaTH to act as SCHT's IPC Doctor. SCHT also sought advice from Public Health England when required.

Medical microbiology support is provided 24 hours a day, 365 days a year through on-call arrangements by SaTH.

The IPC team also works with a team of 75 IPC link staff, with 56 working in community services, 18 from the community hospitals and one from Stoke Heath Prison, who receive additional training in infection prevention and control and act as a resource and role model and liaise between their clinical area and the IPC team.

Assurance and Reporting to the Board

Trust Board – SCHT's performance against the Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* infection (CDI) national reduction targets and the MRSA screening threshold are included in the Performance Report and Quality Safety Report which are presented at each SCHT Board meeting.

Quality and Safety Committee – Quarterly IPC reports are presented to the Quality and Safety Committee meetings.

Infection Prevention and Control Meeting – The membership is multi-disciplinary and includes representation from the operations and quality directorates, estates department and medicines management. Additional members are representatives from Public Health England (PHE); Shropshire and Telford & Wrekin CCGs and from the patient panel. The meeting is chaired by the Director for Infection Prevention and Control (DIPC) and meets bi-monthly. The Terms of Reference (TOR) and membership are reviewed annually to ensure responsibility for IPC continues to be embedded across the organisation. This meeting monitors the progress of the annual IPC programmes, approves IPC policies and monitors compliance with them.

Health Economy Infection Prevention and Control Group – This pan-Shropshire group including SCHT aims to ensure a strategic overview across the local health economy and is represented by the SCHT Head of IPC. To facilitate and engage all agencies, a five year strategy for 2015-2018 was developed to support the ability to identify local needs and aspires to a common vision for infection prevention and control for Shropshire and Telford and Wrekin. The strategy outlines five strategic objectives which are based on the NICE Guidance Prevention and Control of Infection – Quality Improvement Guide (NICE 2011) which forms the basis of the system wide approach. An assurance framework based on the five objectives is updated at least annually and provides the assurance that IPC is embedded across Shropshire.

Infection Prevention and Control Team – The IPC nurses meet formally on a monthly basis with the IPC Doctor to offer a supportive environment within which clinical issues are discussed and a consensus obtained.

Infection Prevention and Control Link Staff – All IPC link staff and their line managers have signed a roles and responsibilities pro-forma which are reviewed and updated annually. The aim of our IPC link staff is to enhance the IPC knowledge of healthcare professionals working within SCHT, ensuring the delivery of high standards of quality and patient safety in relation to IPC. They are also responsible for undertaking IPC audits where required and for disseminating IPC information to colleagues.

Clinical Service Managers, Sisters, Charge Nurses and Team Leaders – Clinical Service Managers (CSMs), sisters, charge nurses and team leaders are responsible for ensuring that their work environments are maintained at high levels of cleanliness. Bi-monthly cleanliness audits are undertaken with ward and hotel services/housekeeping staff. These audits are reported in the CSM's reports to the IPC meeting. The CSMs, sisters, charge nurses and team leaders are responsible for ensuring the link staff are supported in performing their role and have appropriate time and resources to do this effectively. Audit and ongoing work undertaken by the link staff is included in the CSM's reports submitted to the IPC meeting.

Organisational Development Team – Arrangements are in place for staff to attend induction and mandatory training programmes which includes IPC. Arrangements are in place for staff training to be effectively recorded and maintained in staff records. Alerts inform managers of their staff's non-compliance with mandatory training.

Role of all Staff – All staff are responsible for ensuring that they follow the standard IPC precautions at all times and are familiar with IPC policies, procedures and guidance relevant to their area of work. All staff have a duty of care to report any non-compliance and take action as appropriate.

Section Three: Position in Relation to Health Care Associated Infections

The local acute Trust, whose microbiology laboratory process specimens from SCHT patients, submit data on SCHT's behalf on Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia, Meticillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemia, *Escherichia coli* (E.coli) bacteraemia infections and *Clostridium difficile* infections (CDI), to Public Health England (PHE), as part of the national mandatory surveillance programme for HCAIs.

SCHT does not have nationally set targets for reducing HCAIs. These targets are set for acute Trusts and CCGs. However, SCHT recognises it does have a responsibility in contributing to the overall reduction targets of both Shropshire and Telford & Wrekin CCGs and therefore agreed local infection targets with commissioners using the new 2014/15 NHS England methodology for calculating organisational CDI objectives.

MRSA Bacteraemia Trust Target

Table 2 below outlines the performance of SCHT against MRSA bacteraemia and confirms that SCHT succeeded in meeting its target for the third consecutive year with zero cases in 2015/16.

Table 2: Pre 48hr MRSA Bacteraemia cases assigned to SCHT

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Total	Year End Target
Actual	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SCHT has a policy in place with details of actions SCHT must take including a Post Infection Review (PIR) in the event of an MRSA bacteraemia.

Actions taken to prevent MRSA bacteraemia

In 2015/16 the focus continued on key interventions to prevent cases of MRSA bacteraemia. These included:

- MRSA policy available
- Screening of emergency and elective admissions to community hospitals for MRSA. Compliance monitored by the IPC Meeting and included in the Performance Report – see Table 3 for details
- Continued emphasis on isolation and clearance treatment of MRSA infected and colonised patients within community hospitals
- Completion of isolation checklists by ward staff on commencement of source isolation and weekly thereafter whilst patient remains in isolation
- Continue to monitor the care of patients with MRSA within community hospitals using the management protocol and care pathway
- Continued emphasis on hand hygiene compliance with alcohol hand rub available in every bedspace
- MRSA screening of high risk patients prior to urinary catheter change
- Urine specimens taken prior to and/or at urinary catheterisation
- Urinary catheter practices included in a urinary catheter checklist and self-audit programme
- Community antibiotic guidelines promoted and placed on computer desk tops within community hospitals

- Ward pharmacists review antimicrobial prescriptions and undertake regular antibiotic prescribing audits
- Insertion and on–going care of peripheral vascular devices included in self-audit/checklist programme
- Discharge letter sent to GPs informing them of MRSA diagnosed whilst an in-patient
- MRSA staff screening/treatment policy available
- Continued emphasis on importance of the cleanliness of the environment: revision of community hospital cleaning policy and schedules
- Certificates awarded to areas who achieved an annual 100% MRSA screening compliance
- MRSA and Reducing the Risk of HCAIs information leaflets available to all services and on SCHT website

MRSA Screening

In addition to the local infection targets, a compliance threshold of 97% for MRSA screening for patients on admission was agreed with the CCG.

Again in 2015/16 the threshold has been achieved with an overall MRSA screening compliance of 99.35% a slight improvement compared with last year's 99.29%. The Head of IPC shares the monthly compliance reports of all four sites with Ward managers, CSMs and with the Community Hospital Service Delivery Group Manager.

As shown in Table 3 below, Teams 1 and 2 at Whitchurch Community Hospital have consistently achieved 100% each month throughout the year and in recognition have been awarded a certificate to acknowledge this achievement (see below). Ward Managers are responsible for investigating reasons for non-compliance and to instigate actions to improve.

Table 3: % Compliance in each Community Hospital with the MRSA screening policy

	Bishops Castle	Bridgnorth	Ludlow Dinham	Ludlow Stretton	Whitchurch Team 1	Whitchurch Team 2	Overall
Apr-15	100	100	100	100	100	100	100.00
May-15	100	100	100	100	100	100	100.00
Jun-15	97	100	100	96	100	100	98.83
Jul-15	100	100	100	100	100	100	100.00
Aug-15	100	100	100	N/A	100	100	100.00
Sep-15	100	98	97	N/A	100	100	99.00
Oct-15	100	100	100	N/A	100	100	100.00
Nov-15	100	96	100	N/A	100	100	99.20
Dec-15	100	100	89	N/A	100	100	97.80
Jan-16	100	100	100	N/A	100	100	100.00
Feb-16	100	100	100	N/A	100	100	100.00
Mar-16	100	97	91	N/A	100	100	97.6
Overall	99.75	99.25	98.08	99.00	100	100	99.35

Green - >95% Amber - 90-95% Red - <90%

The pictures above show Staff Nurse Dawn Benoit and Sister Karen Meal from Team 1, Whitchurch Hospital (left) and Sister Karen Meal and Staff Nurse Wendy Grey from Team 2, Whitchurch Hospital (right) with their certificates for achieving 100% MRSA screening in 2015/16.

Clostridium difficile Infection (CDI) Targets

The local target set for SCHT by the CCGs was to have no more than two cases of CDI diagnosed post 72 hours after admission in the community hospitals attributed to SCHT. Five cases were recorded as seen in Table 4.

Table 4: Post 72hr *Clostridium difficile* infections cases diagnosed in Community Hospitals

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Total	Year End Target
Actual	**0**	**1**	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**0**	**1**	**0**	**5**	**No more than 2**

The first patient diagnosed with a post 72 hour CDI was in May 2015.). The patient had been previously diagnosed with CDI in an acute hospital. A subsequent faecal specimen was taken which also diagnosed CDI but as more than 28 days had elapsed this counted as a new case against SCHT's target. The patient did not require treatment and was subsequently discharged.

The second and third CDIs were both diagnosed at the same Community Hospital. The first patient was admitted from the acute trust with cellulitis and anaemia. Another patient in the bay also had symptoms of diarrhoea and vomiting and a member of staff also had similar symptoms. It was noted that that one patient had received numerous antibiotics which were all were prescribed in line with the antibiotic policy. The other patient was found to be a *C.diff.* carrier, ribotyping on both samples identified different strains and therefore no cross infection had occurred. A Root Cause Analysis (RCA) review meeting was held where the identified issues and good practices were discussed. A service improvement plan (SIP) has been agreed and the Episode of Care form completed.

The third case was in November; the patient had received several courses of antibiotics and had numerous co-morbidities and therefore was a high risk for CDI. The overall conclusion was that there was nothing that could have been done differently to prevent the infection. It was found to be a different ribotype therefore cross-infection again was not implicated. A SIP was developed and the Episode of Care completed.

In January, a fourth CDI was diagnosed in a patient who was admitted to a Community Hospital from the acute trust and was known to be a *C.diff.* carrier. The CDI RCA assessment tool was completed and discussed at the review meeting. Subsequently a SIP was developed and the Episode of Care was completed. It was agreed that the Community Hospital was not responsible for CDI as the patient was a carrier and had received multiple antibiotics prior to admission.

In February, a fifth patient was diagnosed in a Community Hospital with CDI. An RCA was completed and a meeting held to review the case where it was agreed that the appropriately prescribed antibiotics were a contributing factor; however, that there had been no lapses of care.

In line with the CDI policy all five infections were notified to and discussed at the IPC Meeting, where it was reported that all five patients had been discharged home.

Table 5 shows the total number of CDI in Shropshire and Telford Health Economy in patients over two years of age from April 2008 to March 2016. The number of CDI in the local Health Economy is the highest for five years and also in line with National figures. There are a number of possible factors including the rise in the average age of the population which results in more patients having conditions which require antibiotics, increasing their susceptibility to CDI. Measures to attempt to address CDI are actively considered as part of the Shropshire and Telford Health Economy *Clostridium difficile* Action Plan.

Table 5: Total number of CDI in Shropshire and Telford Health Economy and the proportion deemed to be attributed to SCHT Community Hospitals

Year	Total Number of Cases in LHE	Community Hospital Attributed
2008/09	285	2 (0.7%)
2009/10	206	3 (1.4%)
2010/11	191	4 (2.1%)
2011/12	147	1 (0.6%)
2012/13	145	6 (4.1%)
2013/14	112	2 (1.8%)
2014/15	98	3 (3%)
2015/16	159	5 (3.1%)

CDI 30 day mortality rate

A consultant microbiologist at SaTH monitors the local health economy CDI mortality data which includes patients in SCHT. Routinely the IPC team follows the progress of our CDI patients and therefore would be aware if they died before 30 days. If the cause of death is recorded as CDI on section 1 of the death certificate it is automatically reported as a Serious Incident (SI). To improve future care and patient outcomes all Community Hospital deaths are scrutinised by the Community Hospitals' mortality group with a checklist approach, and any unexpected deaths are subject to a review, which would include HCAI/infections including CDI.

Actions to reduce CDI

In 2015/16 we continued to focus on the key actions to reduce the number of cases of CDI.

Actions specifically targetted at reducing CDI in 2015/16 included:

- Promotion of, and referral to, the CDI guidance sheet in the IPC GP information pack. The pack was developed for GPs working in community hospitals, to support measures which need to be adopted to assist in reducing CDI and improving patient care
- Continued monitoring of antibiotic prescribing by the community hospital pharmacists in line with community antibiotic guidelines and any non-compliance brought to the attention of the prescribing doctor
- Review of proton pump inhibitors in inpatients by community hospital pharmacists
- Continuation of 7 day rapid testing for *Clostridium difficile* and use of typing to search for clusters or linked cases
- Continual surveillance, RCA and monitoring of the care of patients who develop CDI whilst an in-patient in community hospitals and/or whilst receiving care from our community services using the management protocol and care pathway
- Multi-disciplinary team review meeting held after RCA completion to ensure SIP developed as appropriate
- Presentation of each CDI case at next IPC Meeting
- Rapid isolation (within two hours) of patients presenting with diarrhoea in community hospitals and on-going isolation checklist performed
- Revision of community hospital cleaning policy and cleaning schedules
- Continuation of increased cleaning, including use of chlorine based disinfectants
- Continuation of promotion of use of decontamination status bands identifying equipment which is clean and ready for use
- Continued emphasis on de-cluttering, cleanliness and efficient use of ward space
- Antibiotic Awareness information board in November in William Farr House – to reinforce key messages and remind staff about the importance of prudent antibiotic prescribing and of the need not to ask for unnecessary antibiotics
- Continued improvement in compliance with hand hygiene and emphasis on the need to use soap and water, not alcohol hand gel, with *Clostridium difficile* and other gastrointestinal illnesses
- Hand hygiene observation audits completed monthly by ward link staff and reported to IPC
- IPC training programmes focused upon *Clostridium difficile* prevention, management of individual cases including isolation practices
- Reinforced public health messages regarding inappropriate use of antibiotics, through Inform and staff desktops
- Continued to issue the CDI passport (see below) to help clinicians improve patient outcomes and increase patient understanding of *Clostridium difficile* and involvement in decisions regarding their care

- Issuing of letters to GPs informing them of CDI diagnosis (both infection and carrier status) whilst an in-patient on hospital discharge summary
- SCHT worked in conjunction with the Health Economy IPC Group on the CDI reduction programme through the 2015/16 CDI action plan
- Continued to promote the SIGHT mnemonic protocol when managing suspected potentially infectious diarrhoea
- Issued and encouraged all ward based staff to carry the credit sized 'SIGHT' cards for reference :

S	**S**uspect that a case may be infective where there is no clear alternative cause of diarrhoea
I	**I**solate the patient (within 2 hours), clean vacated bed space and consult with the infection prevention and control team while determining the cause of diarrhoea
G	**G**loves and aprons must be used for all contacts with the patient and the patient's environment
H	**H**and washing with soap and water should be carried out before and after each contact with the patient, their environment and following removal of PPE
T	**T**est faeces, by sending a specimen immediately

- Hand wash with soap and water
- Use personal protective equipment (PPE)
- Keep all doors closed and avoid use of fans
- Designate patient equipment (commodes, bedpan holders, hoist slings, glide sheets, BP cuffs, stethoscope)
- Allocate staff to work on affected or non-affected areas
- Use stool record chart and fluid balance chart
- Use Tristel Fuse and Jet for cleaning and disinfecting
- Avoid patient transfers unless clinical emergency
- Inform visitors of infection risks
- Terminal clean when patient 48 hours free of symptoms

Periods of Increased Incidence

Since April 2010 all Trusts have been asked to report periods of increased incidence (PII) of cases of MRSA bacteraemias and CDIs. The definition of a PII is two or more cases within a ward in a 28 day period. In 2015/16 no PII were reported in the SCHT's four community hospitals.

Outbreaks

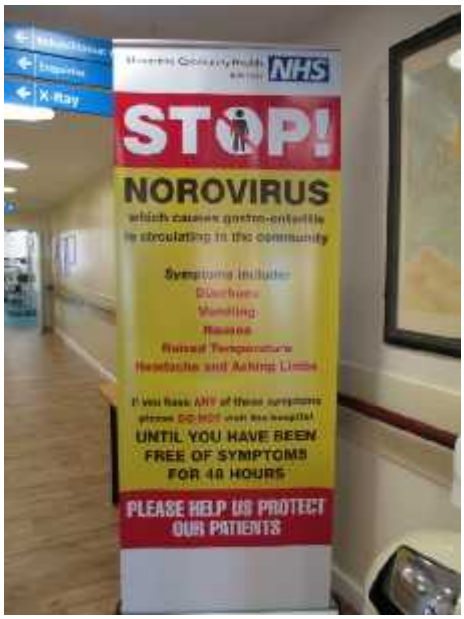
An outbreak of infection is described as two or more people with the same disease or symptoms or the same organism isolated from a diagnostic sample and are linked through a common exposure, personal characteristics, time or location.

Table 6 below summarises the outbreaks declared in the Community Hospitals during 2015/16.

Table 6: Total outbreaks declared in Community Hospitals in 2015/16

Hospital & Ward	Date Commenced	Date Declared Over	Patients Affected/ Staff Affected	Symptoms	Causative Organism
Bishops Castle	22/09/2015	01/10/2015	4/4	Diarrhoea and vomiting	Norovirus
Ludlow	03/11/2015	10/11/2015	5/1	Diarrhoea and vomiting	Norovirus
Ludlow	29/01/2016	03/02/2016	5/2	Diarrhoea and vomiting	Unknown
Bridgnorth	30/01/2016	08/02/2016	3/5	Diarrhoea and vomiting	Norovirus
Ludlow	17/03/2016	24/03/2016	11/3	Diarrhoea and vomiting	Norovirus
Bishops Castle	13/03/2016	24/03/2016	2/1	Influenza Like Illness	Influenza
Bridgnorth	25/03/2016	06/04/16	15/2	Diarrhoea and vomiting	Norovirus

Gastrointestinal Infection



Banner at entrance of ward advising visitors of signs and symptoms of norovirus

Norovirus is the most common cause of gastroenteritis in the community but also causes outbreaks in hospitals as it is very infectious. During 2015/16 there have been six gastrointestinal infection outbreaks in SCHT's community hospitals, five of which were confirmed by the laboratory to be caused by Norovirus. In all the outbreaks Norovirus was known to be circulating in the local communities. Despite continual requests and communications it was acknowledged that some visitors did not heed the advice discussed below.

As part of a campaign to help reduce the introduction and spread of Norovirus within the community hospitals, all four sites erected their display banners in October (acknowledged as the start of the Norovirus season) at the entrance to the wards/reception areas. These advised visitors of the signs and symptoms of Norovirus and requested they do not visit the hospital if they are unwell or not clear of symptoms for at least 48 hours. In addition, in partnership with SaTH the IPC team used the local media and the SCHT website to reinforce these key messages.

In each of the outbreaks, enhanced cleaning of the wards was immediately introduced and symptomatic patients were either nursed in a single room or cohorted in the same bay. To support the efforts of all staff in their attempts to keep these outbreaks under control, the IPC team communicated at least once daily with the affected area to offer guidance of patient management and placement, adherence to control measures and advised the use of a range of tools designed to assist in the care and monitoring of affected patients. Close monitoring in this way meant that the disruption to patients and SCHT was kept to a minimum.

Throughout the outbreaks the ward staff were encouraged to complete the isolation checklist to ensure adherence with the isolation policy. The rationale being that staff address any issues immediately to ensure safety for all; therefore a Service Improvement Plan (SIP) is not required. A copy of the checklist is faxed to IPC for assurance and advice if required.

Outbreak debrief meetings were not required following four of the Norovirus outbreaks as all the appropriate actions were taken at the time.

A debrief meeting was held following the outbreak in Bishop Castle Community Hospital in October. It was difficult to establish where the index patient acquired the virus. However, it was acknowledged that Norovirus was circulating in the community and one patient had a gastrointestinal related medical problem which possibly delayed recognition of an outbreak. A number of other issues were discussed including isolation practices and encouraging patients to have minimal items on bedside table and lockers to aid cleaning. Following some gaps in knowledge regarding outbreak and isolation management, IPC decided to arrange isolation roadshows in all community hospitals to be held before end of December.

A debrief meeting was held on 26 November 2016 to discuss the outbreak of Norovirus at Ludlow Hospital. An audit had been undertaken by the Head of IPC during the outbreak and a number of issues found including clutter but these issues were all addressed on the same day.

A SIP was developed following the review meeting. Lessons learnt and best practice was shared with staff via the community hospital sisters' and ward manager forums, IPC link staff meeting and the IPC meeting.

Informing colleagues within the local health economy is a vital strategy to help contain the spread of Norovirus. The IPC team email all organisations involved with health and social care to alert them of outbreaks declared within SCHT. Equally, SCHT is informed of outbreaks elsewhere within the local health economy.

To enable accurate regional and national surveillance of diarrhoea and vomiting the IPC team submitted reports of outbreaks to PHE and the TDA. All outbreaks are reported to Risk Management via Datix.

Influenza Outbreaks

In March Bishops Castle Community Hospital dealt with an outbreak of influenza. Enhanced cleaning of the hospital was immediately introduced and symptomatic patients were cohort nursed in the same bay. It was difficult to establish where the index patient acquired the virus. However, it was acknowledged that influenza-like illness was circulating in the community.

An outbreak debrief meeting was not required following as all the appropriate actions were taken at the time.

Glycopeptide-Resistant Enterococci (GRE) also known as Vancomycin-Resistant Enterococci (VRE)

IPC surveillance of antibiotic resistance organisms also includes VRE. The year 2015/16 has seen a rise in the number of SCHT patients identified as colonised and or infected with VRE.

Thirteen patients known to have VRE have been admitted to the community hospitals. In all cases IPC recommend source isolation precautions for 48 hours while an assessment of the patient is made. Prevention of transmission is through effective standard precautions. A GRE/VRE policy is available for all staff for reference and an information leaflet is available for patients and visitors. To date IPC are not aware of any patients acquiring VRE while in the community hospitals.

Extended Spectrum Beta-Lactamase (ESBL)

ESBL is also included in IPC's multi resistant organism surveillance.
Within the community hospitals the most common site for ESBL is in patients' urine. On receipt of a positive result, IPC contact the ward to discuss with staff IPC precautions and whether any treatment is required. Patients' hand hygiene is also important and advice is included in the ESBL information leaflet.

Carbapenemase-producing Enterobacteriaceae (CPE)

Further to the published PHE toolkit for acute trusts, a Toolkit for managing CPE in non-acute and community settings was published in June 2015. IPC have reviewed the toolkit and the SCHT CPE policy is in line with the national advice/guidance issued. A key aspect of the control measures is to take special precautions for patients recently treated in countries known to have high levels of CPE or in UK hospitals with recent clusters or outbreaks of CPE. CPE continues to be included in the SCHT revised Multi resistant gram negative policy.

To date the IPC team is not aware of any in-patients diagnosed with CPE within the community hospitals.

Safe Care Shropshire

Catheter-associated Urinary Tract Infection (CAUTI) Sub Group

SCHT is represented at Safe Care Shropshire and dedicated to the success of the project. The objectives are:

- The aim of the CAUTI sub group is to facilitate the reduction of urethral urinary catheterisations and thus the number of CAUTIs; implement urinary catheter best practices across all health and social care providers in Shropshire and Telford. The group continue to follow a work plan which is central to the group's work, the process of which was reviewed at the quarterly meetings with the focus on the following key priorities:
- Catheter assessment – insertion and removal
- Care and management of urinary catheter including policies and pathway
- Training
- Prescribing - catheter products and antibiotics
- Reinforcement of key policies
- To continue to develop and share best practice in relation to the reduction of avoidable harm to patients across all care settings within Shropshire and Telford & Wrekin
- To work together to increase the number of patients across the Local Health Economy who are harm free as defined by the NHS Safety Thermometer point prevalence data collection and through the "sign up to safety" campaign
- To develop working relationships with other work streams and organisations across the Local Health Economy
- Patient information

The NHS Trust Development Authority (TDA) visit February 2016

The NHS TDA provides support, oversight and governance for all NHS Trusts to help deliver high quality and safe services. In a supportive role, the Head of IPC for Midlands and East, NHS TDA visited Oswestry Health Centre and attended the IPC Meeting in February 2016. SIPs were developed, led by the Heads of Nursing, to address the issues and areas requiring improvement. These SIPs are now near completion. The Trust DIPC has informed the TDA of actions taken and the progress made.

Section Four: Progress against 2015/16 Infection Prevention and Control Programme

SCHT is legally required to register with the CQC. As a legal requirement of their registration, SCHT must protect patients, workers and others who may be at risk of acquiring an infection. Compliance is judged against the ten criteria laid down in the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections (Revised in 2015)

The 2015/16 IPC work programme is based on this and progress shown under the relevant criterion of the Code of Practice.

Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risk that their environment and other users may pose to them.

- IPC Policy – Arrangements and Responsibilities reviewed to reflect management and reporting structure of SCHT, outlining its collective responsibility for IPC and demonstrating responsibilities are devolved to all staff/groups in the organisation
- IPC Meeting TOR and membership reviewed
- Head of IPC has provided regular reports to Quality and Safety Committee including targets, risks and progress against objectives
- The Annual IPC Report is produced and made available for public viewing via the SCHT website
- Risks associated with infection have been entered on the Operations Directorate risk register
- The IPC team continued to identify IPC risks and areas of weakness in policy and practice though audit and surveillance
- Governance and reporting frameworks in relation to IPC have been strengthened across the Operations Directorate
- CQC Provider Compliance Assessments completed
- All infection outbreaks reviewed and service improvement plans developed so that relevant learning was appropriately communicated and acted upon
- RCA completed for all patients who developed a CDI whilst an in-patient at community hospitals and report tabled at the IPC meeting
- Delivered the IPC Annual Audit Programme
- IPC audit tools adapted in 2011/12 from the Department of Health (DH) /Infection Prevention Society Quality Improvement Tools and DH Saving Lives care bundles have been revised and updated to incorporate new guidance
- Verification of HCAI audit SIPs to assure completion of the audit cycle
- In recognition of high IPC standards, Gold Certificates are issued to Community Hospitals with audit compliance scores of 95% and above and Silver certificates are issued with compliance score 91-94%
- The IPC team have developed and delivered IPC training programmes including a one hour update on the annual core mandatory day for clinical staff

- IPC team have developed and delivered IPC training on the induction programme for all new staff
- IPC training delivered to volunteers
- Alert organism/alert condition surveillance by the IPC team continues
- Local peer assessment of hand washing technique for all new clinical staff and yearly for existing clinical staff continued

Criterion 2 – Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

This criterion includes cleanliness and hand hygiene, but also includes the fabric of the building and services such as air and water supplies, laundry, waste disposal and decontamination of instruments. Control of MRSA bacteraemia and CDI also come within this criterion. Actions to reduce them have already been described under their specific sections but are briefly mentioned below.

General Environment Issues

- Publicly Available Specification (PAS) 5748:2014, the framework for monitoring cleanliness standards implemented in April 2012 continues
- In collaboration with the Community Hospital Environment Group (CHEG), Community Hospitals' cleaning policy and schedules revised
- CHEG continued to meet to address and support the implementation of environmental issues, share best practice, promote effective use of resources and implement service improvement initiatives including a standardised approach across all four sites
- Weekly quality reviews are undertaken in community hospitals' clinical areas and prison healthcare unit; including general cleanliness of areas, and discussions with patients regarding their experiences of the cleanliness of the environment and staff hand hygiene practices
- Ad hoc Community Hospital cleanliness validation audits by IPC team continue
- Further consideration of in-house community hospitals' laundry facilities – see section 4.
- Periodic validation audits continue to be performed by the IPC team to assess the cleanliness in community facilities cleaned by South Staffordshire and Shropshire Healthcare NHS Foundation Trust (SSSFT)
- IPC Team continue to advise on refurbishment/redevelopment and new build projects to ensure IPC is adequately considered at all stages
- Monthly report submitted to the Operations Directorate Estates Divisional meeting by IPC team noting estate issues identified through audit and or during visits
- DH Patient Led Assessment of Care Environments (PLACE) undertaken with focus on service user representation

Community Hospital Cleanliness Audit

The ward areas and departments within the community hospitals continued to monitor core cleanliness standards using the Publicly Available Specification (PAS) 5748:2014 provided a risk based system for the planning application and measurement of cleanliness.

The audits, undertaken jointly by nursing, hotel services and domestic staff, were carried out bi-monthly. If compliance rates fell or there was recurrence of specific issues then they would be completed more frequently. The IPC team also undertook validation audits to ensure compliance was being reported correctly. The compliance scores were publicly displayed on the IPC notice boards.

Formal assessments using PLACE continue. The PLACE 2015 visits were undertaken between 2 February and 12 June 2015. An overall cleanliness score of 99.75% was awarded to SCHT compared with 99.17% in 2014. Table 7 shows the Community Hospitals' scores.

Table 7: Community Hospitals' PLACE scores

Site Name	Cleanliness	Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance
Ludlow Hospital	100%	91.47%	89.87%	90.14%
Bishop's Castle Hospital	99.46%	63.13%	75.51%	86.84%
Whitchurch Hospital	100%	93.14%	90.63%	98.74%
Bridgnorth Hospital	99.56%	91.81%	85.42%	98.76%
Overall SCHT Scores	**99.75%**	**84.89%**	**85.36%**	**93.62%**

New Builds and Refurbishments

The IPC team has been involved in reviewing and supporting refurbishments and new builds within the SCHT. It is paramount that IPC implications for planning, construction and renovation are considered at all stages. In addition the infection risk posed during construction, demolition, refurbishment and planned preventative maintenance works must be considered and action taken to minimise the risk due to environmental organisms e.g. *Aspergillus fumigatus* by the use of dust screens.

The IPC team have advised on the following projects:

Fire Remedial Works – Community Hospitals

The IPC team were consulted and advised on the fire remedial works carried out at the Community Hospitals to minimise the dust produced and to protect patients and staff safety. Enhanced cleaning was undertaken during the procedures.

Ludlow Hospital

Planned conversion of toilet to a sluice in Minor Injuries Unit.

Dawley Dental Practice

Conversion of existing kitchen to become a separate clean and dirty utility and the installation of washer disinfectors, a building plan and estimate of cost is currently being prepared.

Whitchurch

A water softener has been installed at Whitchurch Community Hospital and if effective will be installed in all community hospitals.

Laundry

A laundry group was set up to review the provision of laundry facilities in each of the four community hospitals to ensure that best practice and compliance was being achieved. The group met in March to undertake a survey of all items that were laundered on site and will re-convene in June to review.

Decontamination

Decontamination is a standing item on the IPC meeting agenda and the Chair is the SCHT Lead for Decontamination. It is acknowledged that the level of risk is low, as the Central Sterilizing Services Department (CSSD) in Telford, operated by SaTH, undertakes most of the decontamination for SCHT including instruments used by the SCHT's day surgery unit and minor injuries units. The SCHT podiatry service changed to single use instruments in March 2015. Medical devices and associated issues are addressed at Service Delivery Group meetings.

The Decontamination of Reusable Surgical and Dental Instruments policy is available to support all staff involved in the decontamination of these instruments at a local level as well as services which send instruments for reprocessing at the CSSD.

Local Decontamination

Dental

The SCHT dental service is compliant with the 'essential quality' requirements contained in the Health Technical Memorandum 01-05 – Decontamination in Primary Care Dental Practices. Plans are in place for each clinic site to progress to 'best practice'. Castle Foregate (downstairs) and Oswestry Health Centre clinics are now fully compliant with 'best practice'. Dawley Dental is currently being assessed to consider the best way forward to progress to 'best practice' which includes conversion of existing kitchen to become a separate clean and dirty utility and the installation of washer disinfectors, a building plan and estimate of cost is currently being prepared

A quarterly and annual maintenance contract for ultrasonic baths is in place and reviewed by Dental department.

Nasendoscopes

The Decontamination of Flexible Nasendoscopes Policy is in place to provide guidance on the decontamination of flexible nasendoscopes as undertaken in community hospitals and Advanced Primary Care Services (APCS).

A specific disinfectant wipe system is used by all SCHT locations undertaking nasendoscopy as validated in the national guidance Choice Framework for local Policy and Procedures (CFPP) 01-06 on the Decontamination of Flexible Endoscopes (June 12). The manufacturers of the Tristel wipe system provide free-of-charge training to staff required to use this method of decontamination.

Endoscopes

The policy for the decontamination of flexible endoscopes was reviewed in 2015/16 and is in place to support safe practices for the use of an automated endoscope reprocessor (AER) for washing and disinfecting these instruments. It includes national guidance on the testing for microbiological quality of the final rinse water from the AER. The IPC team is notified of results and follow up any abnormal ones. The results are reported to IPC Meeting and Quality and Safety meetings.

Validation of AERs is a national requirement. PuriCore have continued to service the unit in accordance with the testing standards.

Automated Endoscopy Reprocessor (AER) at Bridgnorth Community Hospital

Full validation and water testing has continued to be undertaken on the AER and the unit staff have received appropriate training.

A raised aerobic Colony Forming unit (cfu) of 28 was recorded on 16 June 2015. Advice was taken from the consultant microbiologist who advised the list to continue, the machine receive a double strength disinfection and a repeat water sample be taken. The machine was not to be used again until the results were satisfactory. Fortunately the results were satisfactory and no clinics cancelled. Levels have been satisfactory other than this.

A specialised storage cabinet with a high-efficiency particulate air (HEPA) filter is used to store the disinfected endoscopes for up to 31 days and prevent contamination rendering them safe for immediate use and enhances efficiency.

Water Safety Group

This Group continued to meet on a bi-monthly basis. SCHT are represented by Estates and IPC. The Group continues to monitor risk assessments especially around Legionella, flushing regimens, annual disinfection and AERs. The Water Safety Group report to the IPC Meeting as a standing agenda item.

Criterion 3 – Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

- IPC specific organism e.g. MRSA, CDI policies available
- Community antibiotic policy available
- Ward pharmacists review prescription charts
- Antibiotic audits undertaken by medicine management
- Timely microbiology diagnosis
- Antimicrobial Stewardship
- Use of Start Smart then Focus and TARGET toolkits
- Involvement of the National Awareness Campaign(s)
- NICE guidance promoted and incorporated into policies as applicable
- Awareness of the National Ward Sepsis Screening and adaption of action tool for SCHT

Criterion 4 – Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

- IPC produced an annual report covering the organisation's approach to prevention and control of infections for publication on the SCHT website
- Hand hygiene included in patient/visitor/volunteer/staff/agency staff information leaflets
- Strategically placed hand hygiene products available for use with information on how to use
- Signage to nearest hand wash basin for visitors displayed at all ward entrances
- Continued to encourage patient and public involvement in hand hygiene and cleanliness campaigns and services' Quality Review process, satisfaction surveys and PLACE inspections
- In conjunction with the SCHT Communication Team key IPC messages were promoted through internal and external media communications including the SCHT website, in particular prior to and during 'Norovirus season'
- Large display boards were erected at each of the community hospitals to raise public awareness during the months when Norovirus is prevalent in the community
- IPC information boards designated in all community hospitals display IPC data and audit results
- Polices related to specific organisms and care pathways remind staff of the need to give affected patients and relatives leaflets about the infection
- IPC page on the SCHT website further developed and now includes monthly HCAI data
- Quarterly IPC newsletter produced and published as aide memoire and resource for all staff
- Information leaflets revised and placed on the SCHT website informing patient/public on specific infections and hygiene measure they can adopt to reduce the risk of infection
- IPC information leaflet for agency staff developed and used for all temporary and agency staff working with patients in community hospitals
- The IPC team and other members of staff continue to respond to ad hoc requests for information related to IPC under the Freedom of Information Act
- IPC requirements are included in the health economy transfer/discharge form
- IPC team share infection rates and outbreak information with appropriate services based upon local, regional and national surveillance
- MRSA bacteraemia and CDI data published on the SCHT website
- Alert organism surveillance by the IPC team
- IPC policies available
- MRSA screening compliance shared with CSMs

Criterion 5 – Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Arrangements to prevent and control infection come within this criterion and should be such as to demonstrate that responsibility for IPC is effectively devolved to all groups involved with delivering care.

- IPC Arrangements and Responsibilities Policy reflects the management and reporting structure of SCHT outlining its collective responsibility for IPC and demonstrating responsibilities are disseminated to all staff/groups in the organisation
- Responsibilities of groups and staff included in IPC policies
- Support provided by IPC team included visits and telephone contact
- Continued to develop link Staff and support their role
- Link Staff Roles and Responsibilities revised and updated
- Continued to audit compliance with IPC polices and care pathways
- IPC team access to SaTH Laboratory IT systems allowed enhanced alert organism surveillance
- IPC team reported outbreaks and incidents of infection to our commissioners, PHE and the TDA
- IPC team emailed all organisations involved with health and social care to alert them of outbreaks of infection declared within SCHT
- IPC received notification of outbreaks of infection within the local health economy
- IPC specific organism e.g. MRSA, CDI policies available
- Patients screened for MRSA on admission
- Community antibiotic policy available to all clinicians
- PIR undertaken on all MRSA bacteraemias and a RCA on CDI involving community hospitals or community services involved with the patient's care
- Use of SIGHT mnemonic
- Ward staff advised to use isolation checklist to ensure compliance with isolation policy
- Awareness of the National Ward Sepsis Screening and adaption of action tool for SCHT

Criterion 6 – Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Continued to work with NHS providers and facilitated by the LHE group, to reduce all avoidable infections including MRSA bacteraemia and *Clostridium difficile*

- Continued to address the agreed maintenance *Clostridium difficile* plan through the LHE IPC group
- Compliance with MRSA screening policy audited monthly
- As appropriate, joint investigations and reviews held between SCHT and the acute trust on cases of MRSA bacteraemia and CDI
- Quarterly IPC link staff updates/meeting and information disseminated from the IPC team back to the individual services
- Half-day Study Day for community hospital link staff to focus on audits, self-audits, outbreaks and isolation

- Isolation Roadshow for staff held in the four community hospitals
- To assist staff with managing outbreaks an outbreak pack was developed and placed on SCHT website for ease of access. Pack includes door notices, posters, monitoring forms, checklist which is also emailed by IPC nurse to the member of staff on notification of outbreak.
- IPC team continued to support SCHT to take forward national initiatives which have an IPC element including the Safe Care: Harm Free Project locally known as Safe Care Shropshire
- IPC team supported the development of SCHT clinical policies/procedures
- IPC Always Events Poster displayed in all clinical services/areas
- IPC pack reviewed and redistributed to medical staff (including ShropDoc) who work in community hospitals
- 'Clean safe hands' poster featuring Shrewsbury Town's goalkeeper displayed in all SCHT premises

Criterion 7 – Provide or secure adequate isolation facilities

Due to the nature of the patient population, it can at times be difficult to isolate patients to minimise the spread of infection. The Isolation policy includes an Isolation Risk Assessment Tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case by case basis.

- IPC Isolation policy in place to support staff
- Encourage ward staff to undertake isolation checklists when patients isolated. Support and advice with undertaking these
- Ad-hoc audits of compliance with Isolation policy undertaken in community hospitals by IPC team when incidents of infection and outbreaks occurred
- Risk assessments performed by ward staff with support from the IPC team when insufficient isolation facilities were available to meet demand
- Cohort approach taken as necessary within community hospitals during outbreaks of diarrhoea and vomiting
- All episodes where staff are unable to isolate patients are reported to Risk Management via Datix
- Isolation and outbreak roadshow delivered to all community hospitals to promote good IPC practices

Criterion 8 – Secure adequate access to laboratory support as appropriate

- Laboratory services provided by SaTH
- The microbiology laboratory at SaTH compliant with the standards required for accreditation by Clinical Pathology Accreditation (UK) Ltd.
- Continuation of seven day rapid testing for *Clostridium difficile* and use of typing to search for clusters and linked cases
- Continuation of local test for Norovirus to speed up diagnosis and outbreak management of patients with infection
- Continuation of local test for influenza to speed up diagnosis and outbreak management of patients with infection
- Adequate resources available in laboratory for MRSA screening in line with national guidance
- Mandatory surveillance also included MSSA and *E.coli* bacteraemia infections

- Consultant Microbiologist at SaTH is SCHT's IPC Doctor
- Monthly Consultant Microbiologist and IPC nurses meetings
- Medical microbiology support provided by SaTH 24 hours a day 365 days a year

Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

- Rolling programme of policy review continued
- Published evidence reviewed whenever policies were developed or reviewed on publication of new national guidance to ensure they reflect up to date, evidence based, best practice national guidance
- New policies developed as need identified
- Community hospital pharmacists and technicians reviewed drug charts
- In collaboration with Medicines Management team commenced work to implement the relevant recommendations of the national 5-year strategy for antimicrobial resistance issued by the Department of Health in March 2015

The following polices were reviewed in 2015/16:

Policies Reviewed:

- Prevention and Management of Needlestick Injuries: including Inoculation Incidents and Exposures to Blood Borne Viruses (BBV) Policy
- Management of Chickenpox and Shingles Policy
- MRSA
- Clostridium difficile
- Linen and Laundry
- Isolation
- Decontamination and Storage of Flexible Endoscopes Policy

Compliance with policies was audited locally through the hand hygiene, cleanliness and IPC audit tools/checklists, specific competency tools and peer assessments. Specific audits undertaken by the IPC team as part of their annual programme, clinical incident reporting and root cause analysis of infections including debrief meetings were also used to monitor compliance. Community hospital pharmacists reviewed antibiotic prescriptions and advised in accordance with local antibiotic policy. Antibiotic audits were undertaken by pharmacists.

The IPC team has also contributed to the development/review of the following policies:

- Community Hospital Cleaning Policy
- Estates Policies – water management policy waste management policies

The IPC team have continued to be members of the Clinical Policies Group which reviews and approves all clinical policies. As members it ensures accurate and relevant IPC advice is included in all clinical policies.

Medicines Management Report

Community Hospitals:

The medicines management clinical team have undertaken antibiotic audits on a regular basis to support the antibiotic stewardship agenda.

Elements measured included:

- *Choice of antibiotic as compared to the formulary recommendation. Off formulary antibiotics were challenged with the prescriber. Exceptions included antibiotic recommendations made by the SaTH microbiologists where these were documented in the patients' notes.*
- *Duration of the antibiotic course*
- *Allergy status*
- *Challenge to prescribers where several courses of antibiotics had been prescribed*

Medical staff have been encouraged to record the indication and duration of the antibiotic on the drug chart and the drug chart facilitates this. The main reminder given to prescribing medical staff is around defining the length of the course. Antibiotic guidance is available on each ward and on the organisation's website.

Proton Pump Inhibitor drugs are reviewed as part of the normal medicines review process and recommendations for change given to the GP prescribers.

District Nursing:

Non-medical prescribing by community nurses is monitored via retrospective ePACT data. Where higher risk antibiotics (cephalexin, co-amoxiclav, 4-quinolones) appear on the data being scrutinised, the prescriber is required to provide assurance that the prescription was appropriate.

Patient Group Directions:

Some antibiotics are available to patients via Patient Group Direction e.g. in Minor Injury Units. As part of the development process, consultant microbiologist advice and approval is sought.

Dental emergencies:

Some to take out (TTO) packs of a restricted range of antibiotics have been made available to the dental service where supply at the point of consultation is in the best interests of the patient e.g. out of hours, and only initiated by a dentist.

Prison healthcare:

The electronic patient record available in prison (SystmOne) allows reporting of antibiotic use. Monitoring of prescribing has found all prescriptions for antibiotics to be appropriate for the presentation.

Medicine Management report written by: Rita O'Brien, Chief Pharmacist, SCHT

Criterion 10 – Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Staff Health

The IPC team continued to work with the Occupational Health Department (OHD) to ensure that staff are protected from infection and did not pose a risk to others, including patients, from their own infections. The use of hand moisturisers continues to be encouraged to protect care workers' hands from the effects of frequent hand decontamination.

Information regarding MRSA in staff is available in the MRSA policy to help support any member of staff and their manager(s) to ensure that they do not put others at risk of acquiring the organism. In addition to the MRSA policy a number of OHD policies, including staff immunisation policy, are available. The IPC policies Prevention and Management of Needlestick Injuries including inoculation incidents and Blood Borne Viruses (includes safe sharps handling); Standard Precautions policy and the Hand Hygiene policy all support staff health.

The IPC nurses reviewed all infection prevention and control incidents including sharps injuries and followed up with OHD to ensure the policy had been followed. In addition all IPC incidents were reported to and monitored bi-monthly at the IPC Meeting.

Influenza

The OHD led the successful influenza campaign. The IPC team promoted the vaccination at every opportunity e.g. while training, auditing and in the IPC newsletter.

All staff were offered and actively encouraged to have the seasonal influenza vaccination and the communications team assisted by promoting key messages. Attendance by OHD at various meetings, corporate induction, staff awards and training sessions was also undertaken and a series of health and wellbeing events held during the campaign also gave staff the opportunity to have their influenza vaccination along with a mini lifestyle check including blood pressure and cholesterol tests.

For the year 2015/16, 68.4% of SCHT frontline staff were vaccinated against influenza which albeit small, is an increase of 1.2% on last year's uptake of 67.2%. SCHT was the top performing NHS Community Trust in England. This is testament to all those who worked so hard on the campaign resulting in an increased awareness and uptake.

Sharps safety

As previously reported the EU Directive 2010/32/EU was to be implemented by May 2013. This directive required all healthcare providers to introduce further protection for health care staff exposed to the risk of sharps injuries, and actions. Availability of Safety Engineered Needleless Device Systems (SENDS) and progress with the implementation is included in IPC audits and monitored at the bi-monthly IPC meetings. Occasionally it is inappropriate to use a SENDS device in which case a formal risk assessment is undertaken and recorded on the Datix risk register and patients notes.

Figure 4 below shows SCHT inoculation incidents for the past three years. In 2015/16 there has been a slight reduction in the number of injuries reported with 22 injuries compared with 23 reported in 2014-15 and 28 in 2013-14.

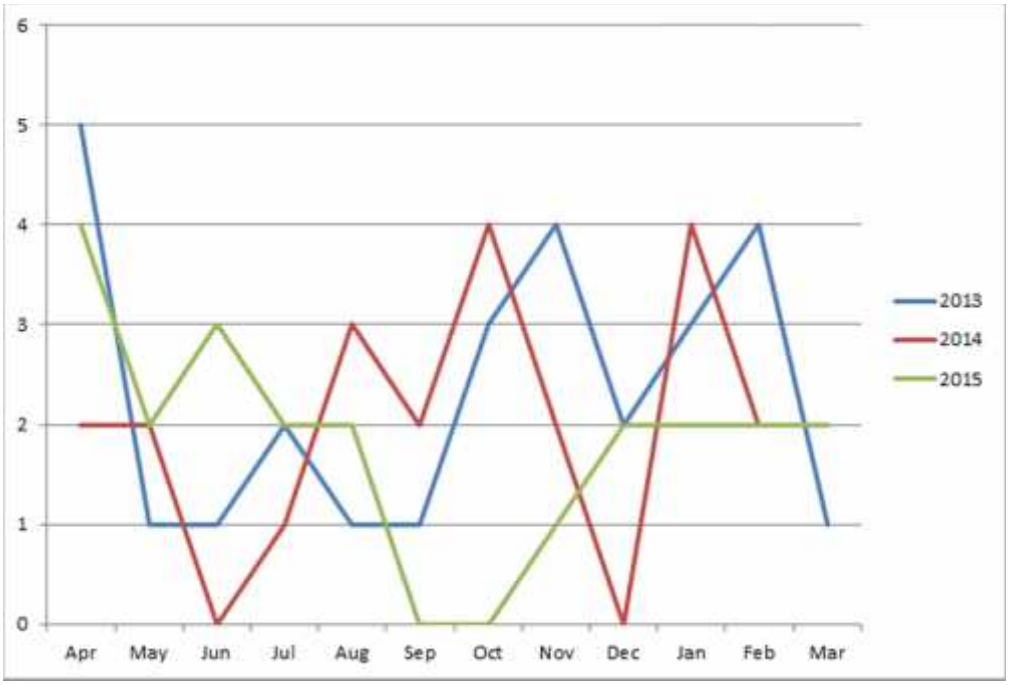


Figure 4: SCHT Inoculation incidents reported April 2013-March 2016

Education

As an organisation, SCHT is committed to the principle that IPC is the responsibility of all, facilitated through a programme of education, both formal and informal, throughout the organisation. One of the principal functions of the IPC team is to inform all clinical staff of the standards expected of them. The team continued to contribute to SCHT's induction and core mandatory training days staff and provided additional ad hoc tailored training to staff to ensure that IPC remained a high priority for all.

Induction Programme

The IPC team participated in the Induction Programmes for all new staff, both clinical and non-clinical, which 171 staff attended. The objective of the team's participation was to inform staff how they could contact the IPC team, access IPC policies and raise awareness of IPC national guidelines and local initiatives. It also provided an opportunity to highlight main IPC principles and to raise awareness of the responsibility and role of IPC for all members of SCHT. A local IPC induction for the new member of clinical staff is facilitated by their manager and includes the hand washing assessment to be undertaken within the first week.

Mandatory Training

IPC face to face mandatory training for all clinical staff continued to be organised by SCHT's Organisational Development (OD) team as part of the Core Mandatory Training Day and out of a possible 1,224 clinical staff, 805 (65.7%) were up to date with mandatory IPC training as at March 2016. The one hour of training focused on Standard IPC precautions, multi-drug resistant organisms, newly published national guidance and changes to current practices and policies.

The National IPC e-learning training package was made available to all staff via OD for non-clinical staff to complete every three years and at March 2016, 1517 out of total staff of 1666 (91.06%) were compliant.

Additional and Bespoke

The IPC team continued to provide IPC training to as many groups as possible including:

- A total of 116 volunteers were trained across the four community hospitals
- Isolation and outbreak roadshows were visited by 41 ward staff and allowed quality discussion regarding practices and procedures often on a 1:1 basis
- HCA Education day at Shropshire Partners in Care (SPIC) – 6 staff
- 77 attendances at link staff meetings

Table 8: Bespoke and additional IPC

Link staff meeting attendances	77
Isolation and Outbreak Roadshow	41
Volunteers Training	116
HCA Education Day	6
Total	**240**

Antibiotic Awareness

In conjunction with Medicines Management the IPC team promoted the annual global antibiotic awareness day on 18 November 2015 with a display board erected in William Farr House during November and a flyer was placed on Trust staff computer desktops. The December IPC newsletter was dedicated to antibiotic awareness and information leaflets appropriate to healthcare professionals as well as to patients and visitors were made available.

The aim of this initiative is to promote key messages and raise awareness of antibiotic resistance which is driven by overusing antibiotics and prescribing them inappropriately. It is important that antibiotics are used correctly to reduce the risk of antibiotic resistance and make sure these life-saving medicines remain effective now and in the future. It is vital we focus on preventing infections and not the treatment.

Isolation in Ten Minutes Roadshows

The IPC team held Isolation and Outbreak roadshows in November and December, visiting all four community hospitals to provide the key points to consider when isolating patients and managing outbreaks.

Infection Prevention and Control Link Staff

Link Staff are critical in the delivery of IPC within all services. Link staff meetings are held quarterly and provide opportunities for networking, emphasising the service provision throughout SCHT and between services.

This continues to be an extremely effective way of educating, distributing information and generates valuable question and answer sessions. All link meetings include information on national infection targets, RCA/PIR feedback, outbreak summary, safety notices, incident reports, new or revised IPC policies and discussion of IPC

audit findings. All are important elements to be taken back to clinical areas and have the potential to reduce infections by promoting optimal practice. The link person disseminates the information to their area of work usually as a standing item on team meeting agendas.

The link staff in community hospitals manage an IPC board in their area where possible to display a different theme each quarter. Subjects this year have been patient's hand hygiene; awareness of sepsis; influenza; specimen taking.

During IPC audit

The IPC team use audit visits as an educational opportunity to reinforce good practice and make suggestions how practices can be adapted and standards improved. This was consolidated through the audit report subsequently sent by the IPC nurse and in the development and return of a SIP where the score is less than 100%. If the audit scores less than 90% the area is sent a self-audit for completion and review by the IPC team to ensure that issues have been resolved, standards have been raised and compliance with IPC practices is maintained

Informal Education/Awareness

The IPC team continued to raise awareness of IPC issues using a variety of mediums including regular visits to community hospitals, local road-shows and service-specific clinical governance events. Posters and information leaflets were used to promote good IPC practices and advice given accordingly, including ad hoc telephone advice to all services within SCHT.

Check to Protect for Clinical Staff

This initiative has been developed to replace Essential Steps. Check to Protect is for clinical staff and comprises of a set of eight assessment tools, including Aseptic Technique, Catheter Care, Disposal of Sharps and PPE. It is designed to be easy to use and a straightforward peer assessment tool. Intended to be used by staff to assess their peers annually, it ensures safe, effective standards of IPC are being met and maintained within all clinical services and also identifies areas for improvement. These assessment tools continue to be promoted by the SCHT Heads of Nursing and clinical staff have been encouraged to use them towards Revalidation. The tools were viewed by the TDA when they visited in February and they felt that they were a valuable toolkit to ensure IPC practices were being maintained.

IPC Team Development

The IPC nurses continue to be supported to increase their knowledge, understanding and skills to assist in the delivery of improved quality of care for our patients by relieving the burden of avoidable healthcare associated infections.

The Head of IPC attended the East and West Midlands Infection Control Conference held in Birmingham in October 2015. The interesting programme included Sepsis, Carbapenemase-producing Enterobacteriaceae and Tuberculosis.

An IPC nurse undertook the Antimicrobial Stewardship: Managing Antibiotic Resistance e-learning course provided by University of Dundee which covered the use of antibiotics in the community and the development of resistance and the Influenza e-learning course by the University of Lancaster which concentrated on the prevention of spread of influenza like illness, pandemics and the promotion and use of vaccines.

The monthly IPC team meeting with the consultant microbiologist is viewed as an educational opportunity for the IPC nurses as is IPC nurses' meeting with feedback from meetings and study days a standing item on the agenda again to ensure information is shared.

The team are members of IPS and the Healthcare Infection Society and receive weekly emails with up to date National and International IPC guidance/alerts/memos etc. Monthly journals are received which are a valuable medium for acquiring evidence-based up to date research and ensures best practice is used when writing policies. Within the team, the monthly journal club has continued where a peer reviewed journal article is discussed. These included articles on MRSA in the community, mattress cleanliness and antibiotic stewardship.

The IPC team have maintained compliance with their own mandatory training programme and personal development reviews completed.

Section Five: Hand Hygiene

Effective and timely hand decontamination is acknowledged as the most important way of preventing and controlling infections. The IPC team continued its concerted efforts to ensure that hand hygiene compliance remained a high priority.

Training on the importance of hand hygiene, being 'bare below the elbow' and the World Health Organisation (WHO) '5 moments for hand hygiene', was provided locally to new clinical staff on induction and was reinforced by members of the IPC team at all IPC training events, during clinical visits and whilst auditing.

Hand Washing Assessments

In 2012 a local peer assessment of hand washing technique was introduced and has continued since for all new staff within one week of commencement of employment, with on-going yearly assessment for existing staff and includes PAMS, pharmacists and medical staff. The assessments are peer assessed by competent assessors within the area or department. Failed assessments were reported to the ward manager/team leader and repeated within the week. In the event of a second failed assessment it would be reported to the IPC team. Reassuringly, there were no such reports. A 'Healthy Hands' educational leaflet was given to the member of staff at the time of the assessment and the assessment record was retained by the service manager and a copy given to the staff member. Hand washing assessments are included in clinical areas' reports to the IPC Meeting.

A number of hand hygiene 'train the assessor' sessions were delivered by the IPC team ad hoc when identified that it was required. The support was important to the clinical staff in their role as an assessor, as it is it vital to ensure that all assessments are consistent and subject to the same protocol and standard.

Hand Hygiene Observational Audit

The IPC link staff continued to undertake monthly hand hygiene observational audits in all four community hospitals wards and ensured the compliance scores were displayed on the IPC notice boards. If compliance fell below 95%, weekly audits were required until 95% compliance was achieved. Agency staff were included as a separate category in the hand hygiene audit and this has enabled ward managers to discuss poor compliance direct with the agency. Results of the audits were monitored by the CSMs and reported to the IPC Meeting and the Quality and Safety Committee.

Bare Below the Elbows

SCHT's uniform policy and dress code promotes the bare below the elbow protocol in that to ensure effective hand hygiene while working clinically, all staff MUST be 'bare below the elbow'. This message continues to be reinforced through IPC mandatory, induction and bespoke training and is monitored during IPC audits and visits.

Section Six: 2015/16 Infection Prevention and Control Team Audit Programme

As in previous years audit continued to be an important activity that assists the monitoring and improvement of practice. In total 57 audits were undertaken by the IPC team, 32 audits were undertaken in the community hospitals and 25 in community services. The objectives of the audits were to inform services of their level of compliance to national IPC standards, local policies and procedures and allow improvements to be made based upon the findings. It also identified target areas for training. A rolling programme of IPC audit was developed and implemented in clinical and non-clinical areas, using the adapted DH/IPS audit tools. A baseline audit was undertaken when new services were developed or relocated. The results were used to determine the frequency services will be re-audited.

Overall Score and Compliance Rating

For the purpose of these audits the aim is for a 100% compliance score. A SIP is generated for scores of less than 100%.

Reporting and Monitoring

At the time of audit the IPC nurse verbally reported any areas of concern and of good practice to the member of staff accompanying them and/or the person in charge at the time of the audit. A written summary report and detailed recommendations in the form of a SIP was developed by the IPC nurse within three weeks and shared with the relevant clinical area and manager for action. Support from the IPC team was offered to implement changes required to improve practice.

Services were requested to return the completed SIP within three weeks to the IPC nurse, detailing the actions taken and a timescale for completing any outstanding actions. Progress was monitored locally and reported to the IPC meeting.

Summary of audit findings and actions taken:

The compliance scores remain variable, confirming that further work must continue to improve and sustain IPC standards. However, it should be recognised that some areas did achieve 100% compliance and generally improvements made in all areas on subsequent visits have been noted. Staff have been receptive to discussion and comment, and the SIP completed and findings addressed.

The standard most frequent to be found non-compliant continues to be the hand wash basins which had a build-up of limescale and/or were not in a good state of repair. A new water softener has been installed at Whitchurch Community Hospital which will assist to address this and it is planned that the same will be installed at the other three community hospitals. Non-compliant clinical hand wash basins have been recorded on the SCHT Operations risk register.

Self-audits/checklists

IPC have encouraged the use of the audit/checklist by ward staff as an aide memoire. The intention is that any issues identified are addressed immediately to ensure safety for the individual patient and other patients and staff. Self-audits/checklists undertaken:

- Hand Hygiene Observations – monthly

- Urinary Catheter – on admission/insertion and weekly thereafter
- Isolation Practices – at time of isolation and weekly thereafter
- Vascular Access Device – at time of insertion
- Enteral Feeding – on admission and weekly thereafter

Sharps Audit

Daniels Healthcare undertook an audit of sharps practice in the community hospitals and SCHT community facilities on 21 March 2016. Findings included: the temporary closure on sharps bin was not in use; sharps bins not labelled or assembled correctly. Whereas this serves as an important reminder about sharps safety, the Male ward at Bridgnorth, Team 1 Whitchurch and Bishops Castle all scored 100%.

Reports for each community hospital were shared with the respective CSM and presented at IPC group in June 2016.

The Trust IPC team continues to reinforce the correct and appropriate use of sharps containers during audits and visits to community hospitals and is included in all IPC training sessions.

Surgical Site Infection (SSI) Surveillance

An SSI surveillance to establish the SSI rate in patients undergoing hand surgery within the Day surgery unit at Bridgnorth Community Hospital was undertaken in 2015/16

The aims and objective of the surveillance were:

- To establish the number of patients included in the surveillance at the Day surgery unit, Bridgnorth Community Hospital who experienced an SSI following their procedure
- To consider if any changes to policies, practices and procedures require amendment

A total of 18 responses were received which equates to a response rate of 30%. A total of 61 questionnaires were sent out of which 18 were returned. None of the respondents that returned the survey had suffered a post-operative infection or suffered any undue post-operative symptoms.

No actions or recommendations were identified as a result of the audit except that as no infections were identified it was felt that there was little value of repeating this in the near future.

Section Seven: Looking Forward to 2016/17

An Overview of Infection Prevention and Control Programme 2016/17

This section gives an oversight of the work planned to prevent and control infections in 2016/17 and to achieve external targets and comply with the Code of Practice on the prevention and control of infections. It is designed to reflect SCHT's Quality Strategy for 2015-2018 to deliver care that is clinically effective; care that is safe; and care that provides a positive experience for patients as possible. The programme is also developed to deliver the objectives in the LHE IPC 2015-2018 Strategy which will provide a system wide innovative vision for infection prevention and control for the next three years.

The key aims in 2016/17 will be to build on the work that has been done in previous years to prevent HCAIs, and improve the lives of the people who come into contact with SCHT services. Patient safety is at the heart of IPC, and to ensure our work is sustainable, SCHT promotes that every member of staff takes responsibility for IPC in order that that no person is harmed by a preventable infection.

The current Head of Infection Prevention and Control will be retiring at the end of May and it will be a challenge to continue to provide a full service while her replacement is appointed, especially in view of the fact that a full time IPCN post was lost in 2015. The IPC team will prioritise claims on their time in order to best provide a full service to the Trust.

Our focus will be to:

- Strengthen governance around estates, decontamination and water quality
- Achieve zero tolerance for MRSA bacteraemia
- Achieve the local reduction target of no more than two CDIs
- Support wards to achieve a compliance rate of over 97% for MRSA screening
- Manage and control antibiotic-resistant bacterial infections
- Support medicine management with the antibiotic stewardship agenda
- Review IPC, clinical and estates polices in line with review dates, revised national guidance and as a result of incidents and RCA/PIR
- Deliver IPC team 2016/17 Audit Programme.
- Continue to review the audit programme regularly to ensure that the audit is meaningful and helpful in generating best practice
- Enhance local monitoring and self-checklists of IPC practice using adapted tools
- Continue to promote the Check to Protect IPC peer assessment and competencies
- Challenge existing assurance mechanisms and validate self-assessment and provide local support to areas of poor performance
- Continue to develop and support the role of the IPC link staff with quarterly meetings and an annual IPC study day
- Develop and review IPC patient/public information leaflets in line with review dates or revised national guidance
- Deliver IPC training on Induction days
- Deliver bespoke IPC training as need identified
- Maintain high standards of hand hygiene
- Improve the monitoring of hand hygiene compliance

- Continue to support SCHT to comply with European Directive 2010/32/EU sharps safety devices
- In collaboration with SCHT Medicines Management, continue to monitor antibiotic prescribing in community hospitals and implement the national 5-year strategy for antimicrobial resistance
- In collaboration with SaTH, review the possibility of a commercial surveillance system that facilitates more effective identification / prevention of infections
- Continue to provide support to all SCHT Staff
- Timely review and follow up microbiology laboratory reports

2016/17 Local Infection Prevention and Control Objectives as agreed with Commissioners

2016/17 Infection Targets

The local infection targets agreed for 2016/17 are:

- MRSA bacteraemia – Zero tolerance
- Post 72 hrs *Clostridium difficile* infection – no more than two cases diagnosed on the third day or later of an admission to one of the four community hospitals (where the day of admission is day one)

2016/17 IPC Key Performance Indicator (KPI)

In line with SaTH, SCHT continue to undertake MRSA screening for all relevant elective and emergency admissions.

- MRSA screening – Threshold of 97% of all admissions to community hospitals

Other KPIs

- Compliance with Trust hand hygiene policy – threshold of 95%
- Compliance with IPC checklists (adapted from the high impact interventions) – threshold of 100%
- Compliance with national environmental and equipment cleaning standards (Publicly Available Specification (PAS) 5748:2014) /and local cleaning protocols – threshold of 95%

Section Eight: Acknowledgements and Further Information

Thank you for reading the IPC Annual Report for 2015/16. If you require any further information about IPC in SCHT please email the team at ipc.team@shropcom.nhs.uk

This report was prepared by SCHT's IPC team – Rachael Allen, Liz Watkins, Liz Jones and Alison Davies, in conjunction with Steve Gregory, Executive Director of Nursing and Operations and DIPC and Rita O'Brien, Chief Pharmacist.

Section Nine: Glossary of Terms

AER	Automated Endoscopy Reprocessor. A specialised machine for washing and disinfecting endoscopes
APCS	Advanced Primary Care Services
Bacteraemia	A bloodstream infection
CAUTI	Catheter Associated Urinary Tract Infection
CCGs SCCCG and TWCCG	Clinical Commissioning Group. The two commissioning organisations in Shropshire and Telford & Wrekin are Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group.
CDI	*Clostridium difficile* infection. *Clostridium difficile* is a bacterium which lives harmlessly in the intestines of many people. Clostridium *difficile* infection most commonly occurs in people who have recently had a course of antibiotics. Symptoms can range from mild diarrhoea to a life-threatening inflammation of the bowel.
CHEG	Community Hospital Environment Group
CPE	Carbapenemase-producing Enterobacteriaceae. Enterobacteriaceae are a large family of bacteria that usually live harmlessly in the gut of all humans and animals. They are also some of the most common causes of opportunistic urinary tract infections, intra-abdominal and bloodstream infections. Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance.
CSM	Clinical Services Manager
CSSD	Central Sterile Services Department
D&V	Diarrhoea and vomiting
DH	Department of Health
DIPC	Director of Infection Prevention & Control
E.coli	*Escherichia coli. E. coli* is the name of a type of bacteria that lives in the intestines of humans and animals
ESBL	Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics
GRE/VRE	Glycopeptide-Resistant Enterococci/Vancomycin Resistant Enterococci. Enterococci are bacteria that are commonly found in the bowels/gut of most humans. There are many different species of enterococci but only a few that have the potential to cause infections in humans and have become resistant to a group of antibiotics known as Glycopeptides; these include Vancomycin.
HCAI	Healthcare Associated Infection
IPC	Infection Prevention and Control
IPS	Infection Prevention Society
LHE	Local Health Economy

MRSA	Meticillin Resistant *Staphylococcus aureus.* Any strain of *Staphylococcus aureus* that has developed resistance to some antibiotics, thus making it more difficult to treat.
MSSA	Meticillin Sensitive *Staphylococcus aureus. Staphylococcus aureus* is a bacterium that commonly colonises human skin and mucosa (e.g. inside the nose) without causing any problems. It most commonly causes skin and wound infections.
OD	Organisational Development
OHD	Occupational Health Department
PHE	Public Health England
PII	Period of Increased Incidence
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment e.g. gloves, aprons and goggles
RCA	Root Cause Analysis
SaTH	Shrewsbury and Telford Hospital NHS Trust
SCHT	Shropshire Community Health NHS Trust
SENDS	Safety engineered needleless device systems
SIGHT	Suspect, Isolate, Gloves and Aprons, Hand washing, Test for Toxins
SIP	Service Improvement Plan
SSI	Surgical Site Infection
SSSFT	South Staffordshire and Shropshire Healthcare NHS Foundation Trust
TDA	Trust Development Authority
TOR	Terms of Reference
TTO	To Take Out