SUMMARY REPORT

Meeting Date: 27 July 2017
Agenda Item: 8.1
Enclosure Number: 6

<table>
<thead>
<tr>
<th>Meeting:</th>
<th>Trust Board</th>
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<tbody>
<tr>
<td>Title:</td>
<td>Infection Prevention and Control Annual Report 2016/17</td>
</tr>
<tr>
<td>Author:</td>
<td>Liz Watkins, Head of Infection Prevention and Control</td>
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<tr>
<td>Accountable Director:</td>
<td>Steve Gregory, Executive Director of Nursing and Operations and Director of Infection Prevention and Control</td>
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<th>Other meetings presented to or previously agreed at:</th>
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<tr>
<td>Committee</td>
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<tr>
<td>Infection Prevention and Control Governance Meeting</td>
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<td>Quality and Safety Committee</td>
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Purpose of the report

To provide the 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 2016 to March 2017.

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 2017/2018 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:

<table>
<thead>
<tr>
<th>To deliver high quality care</th>
<th>To support people to live independently at home</th>
<th>To deliver integrated care</th>
<th>To develop sustainable community services</th>
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Summary of key points in report

- Zero MRSA bacteraemia attributed to SCHT
- Zero post 72 hour cases of Clostridium difficile infections attributed to SCHT
- A 96.07% compliance for MRSA admission screening was achieved against a target of

1 Accountable Director: Steve Gregory
Board Meeting: 27 July 2017
### Key Recommendations

The Board is asked to:
- Consider and approve the content of the report

<table>
<thead>
<tr>
<th>Is this report relevant to compliance with any key standards? YES OR NO</th>
<th>State specific standard or BAF risk</th>
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<tbody>
<tr>
<td>CQC</td>
<td>Yes</td>
</tr>
<tr>
<td>IG Governance Toolkit</td>
<td>No</td>
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<tr>
<td>Board Assurance Framework</td>
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#### Impacts and Implications?

<table>
<thead>
<tr>
<th>Impacts and Implications?</th>
<th>YES or NO</th>
<th>If yes, what impact or implication</th>
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<tbody>
<tr>
<td>Patient safety &amp; experience</td>
<td>Yes</td>
<td>The report and delivery of the annual IPC programmes will provide a basis for assurance on patient safety and experience</td>
</tr>
<tr>
<td>Financial (revenue &amp; capital)</td>
<td>Yes</td>
<td>Healthcare associated infection has a significant financial impact within the NHS</td>
</tr>
<tr>
<td>OD/Workforce</td>
<td>Yes</td>
<td>IPC training required for staff</td>
</tr>
<tr>
<td>Legal</td>
<td>Yes</td>
<td>Legal requirement to publish annual report</td>
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ANNUAL REPORT OF INFECTION PREVENTION AND CONTROL

April 2016 to March 2017
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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 Infection Prevention and Control Annual report which has been developed in collaboration with the Head of Infection Prevention and Control 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 2016 to March 2017 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.
- Zero post 72 hour cases of Clostridium difficile.
- A 96.1% compliance for MRSA screening was achieved.
- Mandatory Infection Prevention and Control e-learning completed by 86.50% of clinical staff.
- 99.68% of non-clinical staff up to date with IPC e-learning as at March 2017.
- The Care Quality Commission visited the Trust in March 2016 and the full report was received in September 2016. The main IPC related issue was the cleaning of toys in shared premises which has now been addressed.

Looking forward to 2017-2018, 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 and Control
Section One: Introduction

The purpose of this report is to provide assurance to the Shropshire Community Health NHS Trust (SCHT) Board of Directors and the public for the reporting period 1 April 2016 - 31 March 2017 regarding the Infection Prevention and Control (IPC) activity including compliance with the Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised July 2015) (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 Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (Revised July 2015), 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)

<table>
<thead>
<tr>
<th>Compliance criterion</th>
<th>What the registered provider will need to demonstrate</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>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</td>
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<tr>
<td>2</td>
<td>Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections</td>
</tr>
<tr>
<td>3</td>
<td>Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance</td>
</tr>
<tr>
<td>4</td>
<td>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</td>
</tr>
<tr>
<td>5</td>
<td>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</td>
</tr>
<tr>
<td>6</td>
<td>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</td>
</tr>
<tr>
<td>7</td>
<td>Provide or secure adequate isolation facilities</td>
</tr>
<tr>
<td>8</td>
<td>Secure adequate access to laboratory support as appropriate</td>
</tr>
<tr>
<td>9</td>
<td>Have and adhere to policies, designed for the individual’s care and provider organisations that will help to prevent and control infections</td>
</tr>
<tr>
<td>10</td>
<td>Providers have a system in place to manage the occupational health needs and obligations in relation to infection.</td>
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</table>
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 2016/17 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 2011 together with the 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 2016-31 March 2017 by SCHT. The report is aligned to the 2016/17 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 470,000 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 NHS Improvement (NHSI), 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 (1.0 WTE)
- Infection Prevention and Control Nurse (0.8 WTE)
- Infection Prevention and Control Secretary (1.0 WTE)

The retirement of the previous head of IPC created an opportunity to evaluate the way that the team operated and utilised the clinical teams in a more owned way.

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.

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 PHE 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 74 IPC link staff, with 56 working in community services, 17 from the community hospitals and one from HM Prison Stoke Heath, 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 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 and the IPC Annual report are presented to the Quality and Safety Committee meetings.

Infection Prevention and Control Governance (IPCG) 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 PHE; Shropshire and Telford & Wrekin Clinical Commissioning Group (CCGs) and from the patient panel. The meeting is chaired by the 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.

Local 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.

Heads of Nursing, 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 Heads of Nursing’s reports to the IPCG 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 Heads of Nursing’s reports submitted to the IPCG meeting.

**Organisational Development Team** – Arrangements are in place for staff to attend corporate induction and complete 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 in both clinical and non-clinical roles within the Trust 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 MRSA Bacteraemia, MSSA Bacteraemia, Escherichia coli (E.coli) Bacteraemia infections and CDI, to 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 CCGs 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 fifth consecutive year with zero cases in 2016/17.

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

<table>
<thead>
<tr>
<th></th>
<th>Apr 16</th>
<th>May 16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
<th>Feb 17</th>
<th>Mar 17</th>
<th>Total</th>
<th>Year End Target</th>
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<tr>
<td>Actual</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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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.

Figure 1 – Incidences of MRSA Bacteraemia in SCHT since 2012/13

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Actions taken to prevent MRSA Bacteraemia

In 2016/17 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 IPCG 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.
- Post infection review (PIR) is undertaken on patients who develop an MRSA Bacteraemia whilst receiving care in community hospitals and/or whilst receiving care from our community services using the management protocol and care pathway.
- Completion of isolation checklists by ward staff on commencement of source isolation and weekly thereafter whilst patient remains in isolation.
- Continued 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 reviewed antimicrobial prescriptions and undertook 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.
- MRSA and Infection Prevention and Control 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 CCGs.

An Internal IPC audit in September 2016 reviewed the data capture system for MRSA screening in the Community Hospitals and revealed anomalies in the data provided by the wards showing missed screenings which had been reported and recorded as taken. To ensure that the data reported is robust and accurate the IPC team will now verify all MRSA monthly screenings.

The Head of IPC met with the community hospital ward managers and CSMs to review the data capture systems in place and to ensure all staff were aware of the importance of screening admissions within 24 hours of admission. Further missed screenings resulted
in an internal improvement notice issued to the community hospitals to improve the data capture and accurate completion of specimen request forms. The data received for the subsequent months showed a further decline in compliance and resulted in the target set by the CCGs for the year 2016-2017 not being met. Missed screenings are recorded via the Datix system.

Ward managers are responsible for investigating reasons for non-compliance and to instigate actions to improve. This includes ensuring that all specimens sent to the laboratory are recorded; ensuring that the porters and delivery drivers sign for specimens collected; ensuring that any missed specimens are investigated by the ward and that this is discussed in the ward and team meetings.

The Head of IPC shares the monthly compliance reports of all four sites with Ward Managers, Heads of Nursing, CSMs and with the Community Hospital Service Delivery Group Manager and Quality and Safety Committee.

Table 3: MRSA Screening Compliance for SCHT

<table>
<thead>
<tr>
<th></th>
<th>Bishops Castle</th>
<th>Bridgnorth</th>
<th>Ludlow</th>
<th>Whitchurch Team 1</th>
<th>Whitchurch Team 2</th>
<th>Overall</th>
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<tbody>
<tr>
<td>Apr-16</td>
<td>100.00%</td>
<td>100.00%</td>
<td>83.33%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>95.24%</td>
</tr>
<tr>
<td>May-16</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>95.24%</td>
<td>100.00%</td>
<td>99.29%</td>
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<tr>
<td>Jun-16</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
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<td>Jul-16</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
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<tr>
<td>Aug-16</td>
<td>96.15%</td>
<td>94.12%</td>
<td>97.14%</td>
<td>94.12%</td>
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<td>Sep-16</td>
<td>94.44%</td>
<td>96.30%</td>
<td>87.88%</td>
<td>100.00%</td>
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<td>Oct-16</td>
<td>91.30%</td>
<td>97.62%</td>
<td>88.89%</td>
<td>100.00%</td>
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<td>Nov-16</td>
<td>96.67%</td>
<td>94.74%</td>
<td>93.02%</td>
<td>96.97%</td>
<td>95.73%</td>
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<tr>
<td>Dec-16</td>
<td>90.63%</td>
<td>88.89%</td>
<td>97.14%</td>
<td>96.00%</td>
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<td>Jan-17</td>
<td>100.00%</td>
<td>93.55%</td>
<td>94.44%</td>
<td>100.00%</td>
<td>97.48%</td>
<td></td>
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<tr>
<td>Feb-17</td>
<td>100.00%</td>
<td>94.44%</td>
<td>96.77%</td>
<td>95.45%</td>
<td>96.09%</td>
<td></td>
</tr>
<tr>
<td>Mar-17</td>
<td>95.83%</td>
<td>95.00%</td>
<td>82.05%</td>
<td>95.65%</td>
<td>91.10%</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>97.20%</td>
<td>95.86%</td>
<td>93.22%</td>
<td>97.88%</td>
<td>96.01%</td>
<td></td>
</tr>
</tbody>
</table>

MRSA Screening
Green - >97%
Amber - 91-96%
Red - <90%

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. Zero cases were recorded as seen in Table 4.

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

<table>
<thead>
<tr>
<th></th>
<th>Apr 16</th>
<th>May 16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug 16</th>
<th>Sep 16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec 16</th>
<th>Jan 17</th>
<th>Feb 17</th>
<th>Mar 17</th>
<th>Total</th>
<th>Year End Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>No more than 2</td>
</tr>
</tbody>
</table>
Figure 2 below shows the cases of CDI diagnosed in SCHT Community Hospitals since 2012/13 against the target set by the CCGs.

![CDIs in SCHT Community Hospitals](chart.png)

**Figure 2 – Incidences of CDI in SCHT since 2012/13**

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 2017. 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**

<table>
<thead>
<tr>
<th>Year/12</th>
<th>Total Number of Cases in LHE</th>
<th>Community Hospital Attributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008/09</td>
<td>285</td>
<td>2 (0.7%)</td>
</tr>
<tr>
<td>2009/10</td>
<td>206</td>
<td>3 (1.5%)</td>
</tr>
<tr>
<td>2010/11</td>
<td>191</td>
<td>4 (2.1%)</td>
</tr>
<tr>
<td>2011/12</td>
<td>147</td>
<td>1 (0.7%)</td>
</tr>
<tr>
<td>2012/13</td>
<td>139</td>
<td>6 (4.3%)</td>
</tr>
<tr>
<td>2013/14</td>
<td>112</td>
<td>2 (1.8%)</td>
</tr>
<tr>
<td>2014/15</td>
<td>98</td>
<td>3 (3%)</td>
</tr>
<tr>
<td>2015/16</td>
<td>125</td>
<td>5 (4.0%)</td>
</tr>
<tr>
<td>2016/17</td>
<td>96</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

**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 2016/17 we continued to focus on the key actions to reduce the number of cases of CDI.

Actions specifically targeted at reducing CDI in 2016/17 included:

- Promotion of, and referral to, the CDI guidance sheet in the IPC GP information pack. The pack was updated 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 in-patients 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 IPCG meeting.
- Rapid isolation (within two hours) of patients presenting with diarrhoea in community hospitals and an isolation checklist performed.
- Isolation checklists are now performed weekly in the Community Hospital to ensure compliance with isolation procedures.
- Revision of community hospital cleaning policy and cleaning schedules.
- Continuation of increased cleaning, including use of chlorine based disinfectants.
- A new programme of annual deep cleans at each of the Community Hospitals was introduced.
- Continued 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 – 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 computer 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.

![Image 1 – CDI card (front)](image1)

![Image 2 – CDI card (reverse)](image2)

- 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 2016/17 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 card sized ‘SIGHT’ cards for reference:

![Image 3 – SIGHT card (front)](image3)

![Image 4 – Sight card (reverse)](image4)

**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 2016/17 no PII were reported in 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 2016/17.

Table 6: Total outbreaks declared in Community Hospitals in 2016/17

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Date Started</th>
<th>Date Declared Over</th>
<th>No of Patients/Staff Affected</th>
<th>Symptoms</th>
<th>Causative Organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whitchurch Team 2</td>
<td>14/04/2016</td>
<td>19/04/2016</td>
<td>3/0</td>
<td>ILI</td>
<td>Three swabs all Negative for Flu A&amp;B and RSV.</td>
</tr>
<tr>
<td>Whitchurch Team 1</td>
<td>15/07/2016</td>
<td>18/07/2016</td>
<td>3/2</td>
<td>D&amp;V</td>
<td>Unknown</td>
</tr>
<tr>
<td>Whitchurch Team 2</td>
<td>19/10/2016</td>
<td>25/10/2016</td>
<td>2/4</td>
<td>D&amp;V</td>
<td>Unknown – CDI and Noro negative.</td>
</tr>
<tr>
<td>Whitchurch Team 1</td>
<td>27/12/2016</td>
<td>05/01/2017</td>
<td>3/3</td>
<td>ILI</td>
<td>Influenza A confirmed as positive on 04/01/17</td>
</tr>
<tr>
<td>Whitchurch Team 2</td>
<td>29/12/2016</td>
<td>05/01/2017</td>
<td>4/3</td>
<td>ILI</td>
<td>Influenza A confirmed as positive on 04/01/17</td>
</tr>
<tr>
<td>Bridgnorth Female Ward</td>
<td>02/01/2017</td>
<td>08/01/17</td>
<td>5/4</td>
<td>D&amp;V</td>
<td>Norovirus</td>
</tr>
<tr>
<td>Whitchurch Team 2</td>
<td>11/01/2017</td>
<td>17/01/2017</td>
<td>3/1</td>
<td>ILI</td>
<td>Unknown – negative for RSH flu A and B</td>
</tr>
<tr>
<td>Bridgnorth Female Ward</td>
<td>31/01/2017</td>
<td>06/02/2017</td>
<td>4/0</td>
<td>D&amp;V</td>
<td>Norovirus positive</td>
</tr>
</tbody>
</table>

Gastrointestinal Infection

Norovirus is the most common cause of gastroenteritis in the community but also causes outbreaks in hospitals as it is very infectious. During 2016/17 there have been four gastrointestinal infection outbreaks in SCHT’s community hospitals, two 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 cohort 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 emailed to IPC for assurance and advice if required.

Outbreak debrief meetings were not required following the diarrhoea and vomiting outbreaks as all the appropriate actions were taken at the time.

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 NHSI. All outbreaks are reported to Risk Management via Datix.

**Influenza Outbreaks**

Whitchurch Community Hospital dealt with four outbreaks of influenza like illness, two of which were confirmed as being Influenza. Enhanced cleaning of the hospital was immediately introduced, symptomatic patients were isolated where possible and cohort nursed in the same bay. It was difficult to establish from where patients acquired the virus. However, following the outbreak debrief meetings with the Hospital and Ward Managers and local GP, it was acknowledged that influenza like illness were circulating in the local community.

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

IPC surveillance of antibiotic resistance organisms also includes GRE/VRE. SCHT Community Hospitals cared for 10 patients with a known VRE in 2016/17.

In all cases of GRE/VRE, IPC recommend source isolation precautions for all Community Hospital patients as prevention of transmission is through effective standard precautions. Ward staff are required to complete isolation checklists on commencement of source isolation and weekly thereafter whilst patient remains in isolation. A GRE/VRE policy is available for all staff for reference and an information leaflet is available for patients and visitors.

**Extended Spectrum Beta-Lactamase (ESBL) including Escherichia coli. and Klebsiella**

ESBLs are also included in IPC’s multi resistant organism surveillance. Within the community hospitals the most common site for ESBLs is in patients’ urine. SCHT Community Hospitals cared for 17 patients with an ESBL in 2016/17. Upon notification of
a positive result, the IPC team contact the ward to discuss with staff IPC precautions and whether any treatment is required. Ward staff are required to complete isolation checklists on commencement of source isolation and weekly thereafter whilst patient remains in isolation. Patients’ hand hygiene is also important and advice is included in the A Guide to Multi Resistant Gram Negative Bacteria information leaflets available to all staff, patients and visitors.

**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. CPE continues to be included in the SCHT revised Prevention and Control of Multi-Resistant Gram Negative Bacteria including Acinetobacter; Carbapenemase-producing Enterobacteriaceae (CPE); Extended Spectrum Beta-Lactamase (ESBL); Klebsiella; New Delhi Metallo-Beta-Lactam (NDM) and Pseudomonas policy and advice is included in the A Guide to Multi Resistant Gram Negative Bacteria information leaflets available to all staff, patients and visitors.
Section Four: Progress against 2016/17 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 2016/17 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.

- Infection Prevention and Control Arrangements and Responsibilities policy 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.
- IPCG 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.
- The IPC team continued to work with the Trust in ‘Getting to Good and Beyond’ following the CQC inspection.
- All infection outbreaks reviewed and service improvement plans developed so that relevant learning was appropriately communicated and acted upon.
- RCA would be completed for all patients who developed a CDI whilst an in-patient at community hospitals and report tabled at the IPCG 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 were issued to service areas with audit compliance scores of 95% and above and Silver certificates were issued with compliance score 91-94%.
- The IPC team have developed and delivered IPC training programmes.
• IPC team have developed and delivered IPC training on the induction programme for all new staff.
• 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.
• A new programme of annual deep cleans at each of the Community Hospitals was introduced.
• 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.
• Terminal cleaning checklists are completed when patients are discharged or isolation precautions are discontinued.
• Further consideration of in-house community hospitals’ laundry facilities.
• 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 continues to advise on refurbishment/redevelopment and new build projects to ensure IPC is adequately considered at all stages.
• DH Patient Led Assessment of Care Environments (PLACE) undertaken with focus on service user representation.
• The Head of IPC is a member of the SCHT Feedback Intelligence Group which reviews all Observe and Act visits, Friends and Family Feedback and in-patient surveys.

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.

PLACE

Formal assessments using PLACE continue. The PLACE 2016 visits were undertaken between 29 March-17 June 2016. An overall cleanliness score of 98.42% was awarded to SCHT compared with 99.75% in 2015. Table 7 shows the Community Hospitals’ scores.

Table 7: Community Hospitals’ PLACE scores

<table>
<thead>
<tr>
<th>Site Name</th>
<th>Cleanliness</th>
<th>Food</th>
<th>Privacy, Dignity and Wellbeing</th>
<th>Condition, Appearance and Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ludlow Hospital</td>
<td>95.97%</td>
<td>81.16%</td>
<td>82.41%</td>
<td>91.27%</td>
</tr>
<tr>
<td>Bishop’s Castle Hospital</td>
<td>99.10%</td>
<td>79.07%</td>
<td>81.4%</td>
<td>95.29%</td>
</tr>
<tr>
<td>Whitchurch Hospital</td>
<td>98.81%</td>
<td>91.12%</td>
<td>77.08%</td>
<td>93.35%</td>
</tr>
<tr>
<td>Bridgnorth Hospital</td>
<td>99.84%</td>
<td>94.68%</td>
<td>91.82%</td>
<td>99.47%</td>
</tr>
<tr>
<td>Overall SCHT Scores</td>
<td>98.42%</td>
<td>87.59%</td>
<td>82.94%</td>
<td>94.73%</td>
</tr>
<tr>
<td>National Average Scores</td>
<td>98.06%</td>
<td>88.24%</td>
<td>84.16%</td>
<td>93.37%</td>
</tr>
</tbody>
</table>

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:

- HM Prison Stoke Heath Dental Department
- Upgrade to clinical hand wash basins and taps in the community hospitals in Whitchurch and Bridgnorth
- Upgrades to the Domestic Water System at Whitchurch Community Hospital

Ludlow Community Hospital

Planned conversion of toilet to a sluice in Minor Injuries Unit.
Whitchurch Community Hospital
Remedial work and replacement of pipework, clinical hand wash basins and tap review.

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. All four Community Hospitals have access to washing machines and tumble dryers to process mop heads and the decision has been taken to contract Mid Cheshire Laundry for the reprocessing of laundry.

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. Medical devices and associated issues are addressed at Service Delivery Group meetings.

The Decontamination of Reusable Surgical and Dental Instruments policy incorporating Decontamination of Flexible Nasendoscopes, Trans-vaginal Probes, Sigmoidoscopy Light Sources and Cryo-cautery Equipment 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’.

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

Nasendoscopes
The Decontamination of Reusable Surgical and Dental Instruments Policy incorporating Decontamination of Flexible Nasendoscopes, Trans-vaginal Probes, Sigmoidoscopy Light Sources and Cryo-cautery Equipment 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 Health Technical Memorandum (HTM) 01-06 the Decontamination of Flexible Endoscopes (June 16). The manufacturers of the Tristel wipe system provide free-of-charge training to staff required to use this method of decontamination. An e-learning package provided by Tristel has also been used to ensure staff remain up to date with their training.

Endoscopes
The policy for the decontamination of flexible endoscopes 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.

**Automated Endoscopy Reprocessor (AER) at Bridgnorth Community Hospital**

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

The IPC team is notified of results and follow up any abnormal results. The results are reported to the IPCG meeting and Quality and Safety meetings. There have been no raised or abnormal results reported during 2016/17.

PuriCore have continued to service the unit in accordance with the testing standards.

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**

The SSSFT, Staffordshire and Stoke-on-Trent Partnership (SSOTP) and SCHT attend the Water Safety Group chaired by SSSFT and the group continued to meet on a bi-monthly basis. SCHT are represented by the Head of IPC. The Terms of Reference of this group are being reviewed to reflect the working arrangement of SSSFT and SCHT. The Group continues to monitor risk assessments especially around Legionella, flushing regimens, annual disinfection and AERs. The Water Safety Group report to the IPCG 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 policies available e.g. MRSA, CDI
- 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
Medicines Management Report

There are several services in the community trust where we would expect to see antibiotic prescribing. There is a mixture of prescriber roles e.g. doctors, dentists and non-medical prescribers

**Community Hospitals:**
The medicines management clinical team monitor antibiotic prescribing on a regular basis to support the antibiotic stewardship agenda.
Elements monitored include:
- Choice of antibiotic as compared to the formulary recommendation
- Duration of the antibiotic course
- Allergy status correctly completed
- Challenge to prescribers where several courses of antibiotics had been prescribed
- Review of co-prescription of proton pump inhibitor drugs

Medical staff are required to record the indication and duration of the antibiotic on the drug chart and the drug chart facilitates this. Antibiotic guidance is available on each ward and on the organisation’s website.

**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.

**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. Only a small proportion of dental prescriptions in hours are for antibiotics.

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

**DAART:**
The DAART service provides prompt treatment for patients who do not necessarily need a hospital admission. Various parenteral and oral antibiotics are used in accordance with the guidelines.

**District Nursing:**
Non-medical prescribing by community nurses is monitored via retrospective ePACT data by the trust medicines management team and the CCG. Appropriate justification for prescribing is sought where necessary.

**Summary:**
In summary, no concerns have been raised by either the pharmacy team or the consultant microbiologist regarding antibiotic stewardship.

Rita O’Brien, Chief Pharmacist, SCHT 26th April 2017
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.
- The Head of IPC has undertaken Observe and Act visits with SCHT Volunteers.
- The Head of IPC is a member of the SCHT Feedback Intelligence Group which reviews all Observe and Act visits, Friends and Family Feedback and in-patient surveys.
- 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 CCGs, PHE and NHSI.
- 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 policies available e.g. MRSA, CDI.
- Patients screened for MRSA on admission.
- Community antibiotic policy available to all clinicians.
- PIRs have been undertaken on all MRSA Bacteraemias and an RCA would be undertaken 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.

To assist staff with managing outbreaks, an outbreak pack is available and is on SCHT website for ease of access. This 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 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 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 and weekly thereafter. 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.

**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 policies were reviewed in 2016/17:

Policies Reviewed:

- Decontamination of Reusable Surgical and Dental Instruments policy
- Management of Glycopeptide-Resistant Enterococci GRE also known as Vancomycin-Resistant Enterococci (VRE) policy
- Outbreak Management incorporating Bed and Ward Closure policy
- Management of Scabies policy
- Management of Pulmonary Tuberculosis policy
- Standard Precautions including Surgical Hand Scrub, Gowning and Gloving policy
- Transmissible Spongiform Encephalopathies (TSEs) 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:

- Uniform and Dress Code policy
- Indwelling Catheter policy
- Oral Herpes Simplex Virus protocol
- Estates Policies including the Water Safety Plan

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.
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) policy; 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 IPCG 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 2016/17, 72.3% of SCHT frontline staff were vaccinated against influenza which is an increase of 3.9% on last year’s uptake. 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 patient’s notes.
Figure 3 - SCHT inoculation incidents for the past three years.

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 training days 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 12 Induction Programmes for all new staff, both clinical and non-clinical, which 297 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 a 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 mandatory training for all clinical staff was delivered via e-learning and out of a possible 1074 clinical staff, 929 (86.5%) were up to date with mandatory IPC training as at March 2017. The format for IPC mandatory training will be kept under review and amendments made as necessary for the year 2017-18. Non-clinical staff already undertake IPC training via e-learning.

The National IPC e-learning training package was available to all staff via Organisational Development (OD) for non-clinical staff to complete every three years and at March 2017, 1534 out of total staff of 1539 (99.68.%) were compliant.
Additional and Bespoke Training

The IPC team continued to provide IPC training to as many groups as possible including:
- Community Hospital and Community Facilities were regularly visited by the IPC team allowing quality discussion regarding practices and procedures often on a 1:1 basis.
- Attendances at link staff meetings.

Table 8: Bespoke and additional IPC Training

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Number Attended</th>
<th>Number of sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link staff meeting attendances</td>
<td>68</td>
<td>3</td>
</tr>
<tr>
<td>Link staff study day attendance</td>
<td>29</td>
<td>1</td>
</tr>
<tr>
<td>GPs’ Training</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Bridgnorth RCA CDI Training</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>134</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

Antibiotic Awareness

In conjunction with Medicines Management the IPC team promoted the annual global antibiotic awareness day on 18 November 2016 with a flyer placed on Trust staff computer desktops.

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.

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 clinical services/areas are required to appoint an IPC link person and protected time is allocated to attend meetings and undertake IPC audits, Check to Protect peer assessments and other IPC related activities. A Link Staff Roles and Responsibilities Agreement is signed by each link person and their immediate line manager which ensure all parties are aware of their accountabilities. The Terms of Reference of the IPC Link Group are reviewed annually. 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 influenza, antibiotics awareness, isolation and catheter specimens of urine.

**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 and community facilities 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**

SCHT introduced Check to Protect for Clinical staff which is a set of nine peer assessment tools including Catheter Care, Enteral Feeding, Assisting at Mealtimes, Aseptic Technique, Specimen Handling, Disposal of Sharps, Sharps Safety, Personal Protective Equipment and Waste, which have been designed to be used by staff to ensure that safe, effective standards of infection prevention and control are being met and maintained within clinical services both in the community and community hospitals. 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.

**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 Royal Wolverhampton NHS Trust conference entitled "Infection Prevention and Control – What’s new and what does the future hold?” in October 2016. The interesting programme included new thoughts on the management of *Clostridium difficile*, CPE screening and management and developments in the use of hydrogen peroxide for decontamination of the environment.

In March 2017 the Head of PC attended the IPS study day on blood stream infections and urinary tract infections focusing on *E-coli*.

IPC Nurse attended the half day Diabetic Foot Conference at Shropshire Education Conference Centre (SECC" in March 2017 which related infection to treatment and management of the diabetic foot.
The IPC nurses spent time in the microbiology laboratory at SaTH observing the laboratory specimen examination process.

The monthly IPC team meeting with the consultant microbiologist is viewed as an educational opportunity for the IPC nurses as is IPC Team 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. 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 indwelling catheter encrustation and blockage, sepsis care, a variant of MRSA found in pork, and the level of incidence of CPE carriage in London.

The IPC team have maintained 100% 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. 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. Volunteers were included as a separate category in the hand hygiene audit. Results of the audits were monitored by the CSMs and reported to the IPCG 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; 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: 2016/17 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 54 audits were undertaken by the IPC team, 37 audits were undertaken in the community hospitals and 17 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 IPCG 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. Non-compliant clinical hand wash basins have been recorded on the SCHT Operations risk register and a Capital Investment programme is planned for 2017/18 to upgrade the taps in Bridgnorth and Whitchurch Community Hospitals

Self-audits/checklists

IPC have encouraged the use of the audit/checklist by ward staff and community 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
• Hand washing assessments – all clinical staff are required to pass a hand washing assessment annually
• Check to Protect peer audits

This year, HCAI Prevention self-audits were developed by the IPC Team for all clinical areas and following their trial introduction and promotion the IPC team have started to receive completed audits. For 2017/18 a planned programme of self audit has been developed for these audits to be undertaken at least every six months.

Sharps Audit

Daniels Healthcare undertook an audit of sharps practice in the community hospitals and SCHT community facilities on 14 February 2017. The audit was very positive showing high levels of compliance. The report identified that no incorrect waste items had been disposed of in sharps containers and only 2 out of the 81 (2.47%) sharps containers audited were found to be assembled incorrectly and 8 out of the 81 (9.88%) sharps containers audited were not labelled correctly.

Reports for each community hospital and community setting were shared with the respective CSM and presented at IPCG meeting in April 2017.

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 including corporate induction for new starters to the Trust.
Section Seven: Looking Forward to 2017/18

An Overview of Infection Prevention and Control Programme 2017/18

This section gives an oversight of the work planned to prevent and control infections in 2017/18 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 as positive an 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 IPC for the next three years.

The key aims in 2017/18 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.

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 our Community Hospital wards to achieve a compliance rate of over 97% for MRSA screening.
- Support the LHE in the reduction of Blood Stream infection (BSI) by 10% for the year 2017/18 and by 50% by the year 2020.
- Establish an LHE BSI Reduction Group.
- Manage and control antibiotic-resistant bacterial infections.
- Support Medicines Management with the antibiotic stewardship agenda and the reduction in antibiotic prescribing.
- 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 2017/18 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 IPC Check to Protect peer assessment tools 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.
• Review and follow up microbiology laboratory reports in a timely manner.
• Encourage twice annual HCAI Prevention self-audits to be undertaken in all areas.
• In collaboration with the Occupational Health Department the IPC team will continue to promote the annual influenza vaccine for staff and patients.
• The IPC team will continue to raise awareness of SEPSIS.

2017/18 Local Infection Prevention and Control Objectives as agreed with Commissioners

2017/18 Infection Targets
The local infection targets agreed for 2017/18 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)

2017/18 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 2016/17. 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:

Steve Gregory – Executive Director of Nursing and Operations and DIPC,
Liz Watkins – Head of Infection Prevention and Control,
Liz Jones – Infection Prevention and Control Nurse,
Alison Davies – Infection Prevention and Control Team Secretary,

in conjunction with:
Rita O’Brien – Chief Pharmacist
Peter Foord – Corporate Risk Manager.
### Section Nine: Glossary of Terms

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AER</td>
<td>Automated Endoscopy Reprocessor. A specialised machine for washing and disinfecting endoscopes</td>
</tr>
<tr>
<td>Bacteraemia</td>
<td>A bloodstream infection</td>
</tr>
<tr>
<td>BSI</td>
<td>Blood Stream Infection</td>
</tr>
<tr>
<td>CCGs</td>
<td>Clinical Commissioning Groups. The two commissioning organisations in Shropshire and Telford &amp; Wrekin are Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group.</td>
</tr>
<tr>
<td>CDI</td>
<td><em>Clostridium difficile</em> infection. <em>Clostridium difficile</em> is a bacterium which lives harmlessly in the intestines of many people. <em>Clostridium difficile</em> 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.</td>
</tr>
<tr>
<td>CHEG</td>
<td>Community Hospital Environment Group</td>
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<tr>
<td>CPE</td>
<td>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.</td>
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<tr>
<td>CSM</td>
<td>Clinical Services Manager</td>
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<tr>
<td>CSSD</td>
<td>Central Sterile Services Department</td>
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<tr>
<td>D&amp;V</td>
<td>Diarrhoea and vomiting</td>
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<tr>
<td>Datix</td>
<td>Patient safety organisation that produces web-based incident reporting and risk management software for healthcare and social care organisations</td>
</tr>
<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DIPC</td>
<td>Director of Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>E.coli</td>
<td><em>Escherichia coli</em>. <em>E. coli</em> is the name of a type of bacteria that lives in the intestines of humans and animals</td>
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<tr>
<td>ESBL</td>
<td>Extended-Spectrum Beta-Lactamases are enzymes that can be produced by bacteria making them resistant to many of the commonly prescribed antibiotics</td>
</tr>
<tr>
<td>GRE/VRE</td>
<td>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.</td>
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<tr>
<td>HCAI</td>
<td>Healthcare Associated Infection</td>
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<tr>
<td>NHSI</td>
<td>NHS Improvement</td>
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<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
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<tr>
<td>IPCG</td>
<td>Infection Prevention and Control Governance</td>
</tr>
<tr>
<td>IPS</td>
<td>Infection Prevention Society</td>
</tr>
<tr>
<td>LHE</td>
<td>Local Health Economy</td>
</tr>
<tr>
<td>MRSA</td>
<td>Meticillin Resistant <em>Staphylococcus aureus</em>. Any strain of <em>Staphylococcus aureus</em> that has developed resistance to some antibiotics, thus making it more difficult to treat.</td>
</tr>
<tr>
<td>MSSA</td>
<td>Meticillin Sensitive <em>Staphylococcus aureus</em>. <em>Staphylococcus aureus</em> 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.</td>
</tr>
<tr>
<td>OHD</td>
<td>Occupational Health Department</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PII</td>
<td>Period of Increased Incidence</td>
</tr>
<tr>
<td>PIR</td>
<td>Post Infection Review</td>
</tr>
<tr>
<td>PLACE</td>
<td>Patient Led Assessment of the Care Environment</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment e.g. gloves, aprons and goggles</td>
</tr>
<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
</tr>
<tr>
<td>SaTH</td>
<td>Shrewsbury and Telford Hospital NHS Trust</td>
</tr>
<tr>
<td>SCHT</td>
<td>Shropshire Community Health NHS Trust</td>
</tr>
<tr>
<td>SENDS</td>
<td>Safety engineered needleless device systems</td>
</tr>
<tr>
<td>SIGHT</td>
<td>Suspect, Isolate, Gloves and Aprons, Hand washing, Test for Toxins</td>
</tr>
<tr>
<td>SIP</td>
<td>Service Improvement Plan</td>
</tr>
<tr>
<td>SSSFT</td>
<td>South Staffordshire and Shropshire Healthcare NHS Foundation Trust</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
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