The Whittington Hospital NHS
NHS Trust

Director of Infection Prevention and Control

Annual Report
2007/8

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(Acting DIPC October 2007 – September 2008)

1.0 Executive Summary and Overview

1.1 Organisation

The Whittington Hospital takes the prevention and control of infection very seriously, and it is a key corporate objective. Infection prevention and control is everyone's business, regardless of discipline or grade.

1.2 Activities

The activities of the DIPC and team have focused on working to reduce the incidence of infection within the trust, particularly MRSA bacteraemia and *Clostridium difficile*, and therefore on ensuring that all our staff have the necessary skills and knowledge to achieve this. This included rolling out hand hygiene training to all trust staff, focusing on maintaining clean ward environments, including always having clean commodes, and continuing to implement and audit against the Saving Lives High Impact Interventions.

The trust has also worked closely with the Department of Health's MRSA Improvement Support Team, who were invited by the Chief Executive to visit the trust in September 2008 to review practice and advise on additional measures to reduce the rate of MRSA bacteraemia within the trust.

1.3 Infection Control Action Plan

The main focus of the infection control action plan for 2007–08 was to ensure that the findings and recommendations following the MRSA improvement support team (IST) visits were implemented. The Department of Health was, and is, concerned that the trust is above trajectory with regard to the numbers of patients developing MRSA bacteraemia. This plan covered key aspects of infection control, including improving clinical practice, the environment, and organisational management (see Appendix C).

1.4 Progress in "Winning Ways"

"Winning Ways" (DH, 2003) sets out best practice to reduce healthcare associated infection in England. More recent guidance, such as Saving Lives (DH, 2004 & 2007) has added to this; they are key documents in influencing our aims and work agenda. They are reflected in the infection control action plan, the daily working of the infection control team, and the audits undertaken by the senior nurses in the visible leadership team.

2.0 Infection Control Arrangements

2.1 Infection Control Team

At the Whittington Hospital the agenda is led by the DIPC, who reports directly to the CEO and the Trust Board. The director of nursing & clinical development and the medical director also have key roles in ensuring that high standards of clinical care are delivered to our patients, and they support the DIPC in her role.

The infection control team is managed by the DIPC, and during 2007–08 comprised a part time senior infection control practitioner, two specialist nurses and an

antimicrobial pharmacist. Following the departure of one of the nurses, the post was upgraded and a new infection control matron appointed in February 2008, who now manages the team and reports to the DIPC. The infection control team also work closely with the microbiology team.

A team of link nurses, one nurse on each ward, who receive additional training in infection control and regularly liaise with the infection control team, also supports ward staff.

During 2007, the director of nursing & clinical development established the visible leadership team. It is led by the director of nursing & clinical development and comprises the matrons and assistant directors of nursing, who work on the wards in uniform every Monday. A major focus for this team is educating staff and auditing practice around infection control guidance, including hand hygiene, peripheral cannula care, urinary catheter care and environment cleaning standards.

A new DIPC, a consultant microbiologist, was appointed in September 2007. She was on maternity leave from October 2007, and the director of nursing & clinical development then covered the post until her return in September 2008.

2.2 Infection Control Committee

The infection control committee is chaired by the chief executive and meets every two months. It reports to the clinical governance committee, which receives regular updates on progress against the infection control targets for MRSA bacteraemia and *Clostridium difficile*, and monitors the infection control action plan.

Membership includes key directors, directorate representatives, the infection control team, microbiology team, Health Protection Agency representative and Islington PCT representative. (Appendix A)

2.3 Reporting Line to the Trust Board

The infection control committee reported directly to the Trust Board until the end of 2007, when a review of the Trust Board structures was undertaken. The current reporting line of the Infection Control Committee is below:

Trust Board
▼
Audit Committee
▼
Clinical Governance Committee
▼
Infection Control Committee

The DIPC reports directly to the CEO and Trust Board.

2.4 Links to Drugs and Therapeutics Committee

The drugs & therapeutics committee and infection control committee both now report to the clinical governance committee, which is co-chaired by the medical director and the director of nursing & clinical development. Continuity is assured as

the DIPC and head of pharmacy are both members of the clinical governance committee and provide regular updates from their areas.

2.5 Links to Risk Management

The infection control team have a close working relationship with the risk management team, which is headed by the assistant director of nursing (risk management). She is also a member of the Clinical Governance Committee.

3.0 DIPC Reports to Trust Board

The trust's performance against the targets for the headline infections of MRSA bacteraemia and *Clostridium difficile* are reported to the Trust Board every month, as part of the trust's performance dashboard report.

The DIPC also provides detailed monthly infection control updates to every Trust Board meeting. Included as standard are the trust's performance for the previous month against the national targets for MRSA bacteraemia and *Clostridium difficile*, work being planned and undertaken to improve performance, including root cause analysis reports, and results of the visible leadership team's audits. Where applicable, reports are also provided on any infection outbreaks and from external visits and resultant actions planned, for example following the visits from the MRSA improvement support team.

All Trust Board decisions are recorded in the minutes and then taken to the clinical governance and infection control committees for further action.

4.0 Budget Allocation for Infection Control Activities

4.1 Staff

The Director of Infection Prevention and Control (DIPC) is a consultant microbiologist, who has specific sessions designated for this role. The DIPC was on maternity leave from October 2007, and the role was covered by the director of nursing & clinical development. A new post of infection control matron was created during the year, when one of the two existing infection control nurses left. This has given additional senior clinical leadership to the team.

The infection control team had the following staff in 2007/8:
1 wte matron (band 8a) appointed in February 2008
0.7 wte senior infection control practitioner (band 8a)
1 wte infection control nurse (band 7) (2 posts until September 2007)
1 wte antimicrobial pharmacist (band 8a)
0.5 wte administrator (band 3)

The allocated budget for infection control in 2007/8 consisted of £203,193 pay and £6,034 non-pay. This excludes medical staff, who are funded from within the microbiology budget.

4.2 Support

The infection control team have support from a designated analyst within the IM&T department, who produces their weekly monitoring graphs, and undertakes other data analysis as requested.

4.3 Training

The trust does not have a separate budget for infection control training. The infection control team provide a wide range of training as part of their role, both through individual study days, and as part of the trust's regular induction and mandatory refresher training days. Training is also provided for junior doctors through their regular programmes, with a focus on prescribing antimicrobials. The antimicrobial pharmacist also provides training support for the ward pharmacists.

Additional training on hand hygiene was given to over 2,200 staff between January and March 2008 by the visible leadership team, supported by the infection control team and the trust's practice development nurses. The sessions were a practical 40 minute refresher for staff on basic hand hygiene and expected practice when in a clinical area. It included the use of ultraviolet gels and hand wash, and was supported by the Trust Board, who also received the training. The programme also introduced a "bare below the elbows" standard for all clinical areas.

5.0 HCAI Statistics

5.1 Results of Mandatory HCAI Reporting

- MRSA Bacteraemia: there were 21 cases reported during the year, against a maximum target of 12 cases. Although the trust did not achieve the target, the performance did represent a reduction on the 31 cases reported in 2006/7.

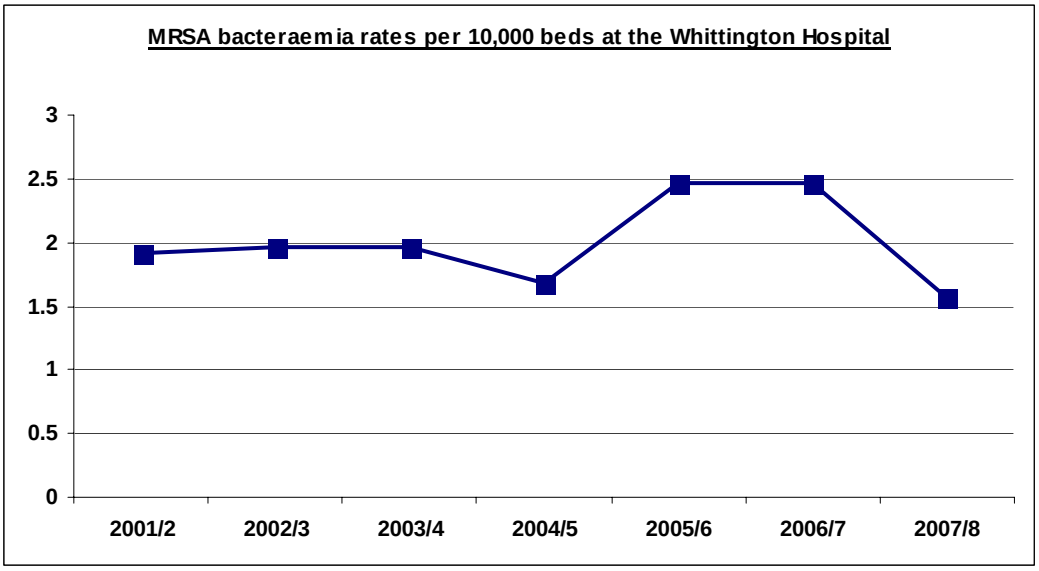
- GRE Bacteraemia: there were 2 cases of VRE bacteraemia during the year

- Clostridium Difficile: the trust reported 164 cases in patients over the age of 65 years, against the local target of a maximum of 168 cases set by the PCT.

- Orthopaedic Surgical Site Infections: Over the four reporting periods to June 2008, there were no infections in total hip or total knee replacements. 15.2% of the hemiarthroplasty procedures developed an infection.

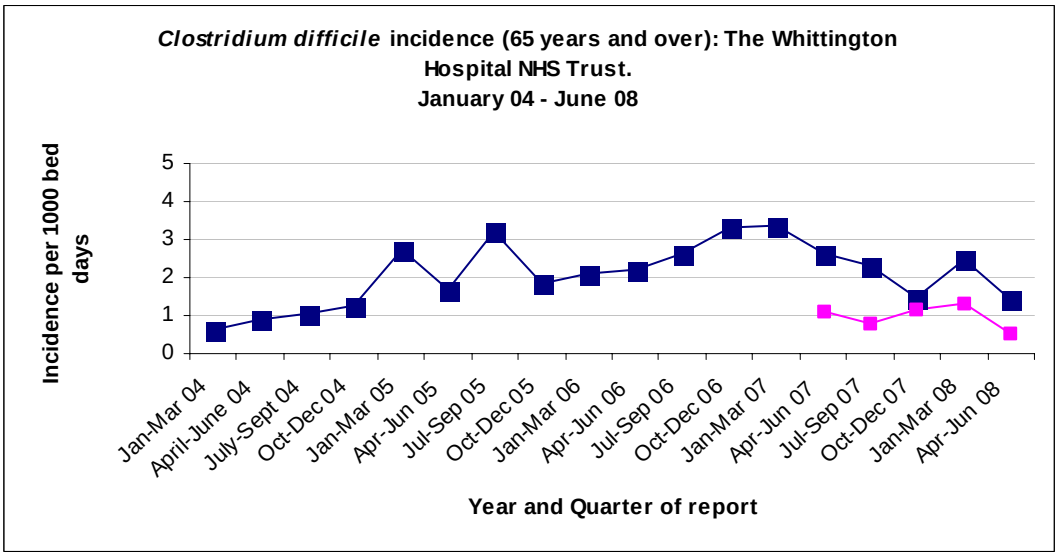
5.2 Trends in HCAI Statistics

A summary of the monthly performance in the management of MRSA bacteraemia and *Clostridium difficile* is attached at Appendix B. The trust takes its responsibilities for reducing healthcare associated infections very seriously; these figures are monitored weekly by the executive committee and are reported to every trust board meeting.



Source: Health Protection Agency

MRSA bacteraemia rates per 10,000 beds reached a peak in 2005/6; in 2007/8 the rates were the lowest recorded since mandatory reporting started in 2001/2.



Source: Health Protection Agency

Incidence of *Clostridium difficile* cases in patients aged 65 years and over (shown in the blue lines) peaked in late 2006/early 2007. Recently we have shown a return towards rates seen in 2004 when mandatory surveillance commenced. The pink line shows the incidence of *C. difficile* cases seen in 2-64 year olds; this data collection became mandatory from April 2007.

5.3 Serious Untoward Incidents, including Outbreaks

NHS London decided during 2007-08 that all cases of MRSA bacteraemia, and outbreaks of, or deaths caused by, *Clostridium difficile* should be classified as SUIs.

During January and February 2008, the trust had 7 cases of children with measles (4 cases in January and 3 in February). The infection control team followed all of them up, contact tracing was carried out, and the Health Protection Agency informed. There were no known secondary cases.

There was one outbreak of *Clostridium difficile* declared in March 2008, involving eight patients across the three older peoples wards. One of the three wards was designated as an outbreak ward, with the patients cohorted there and the ward closed to new admissions. The outbreak was closed after three weeks, when all eight patients' symptoms had subsided and most had been discharged from hospital. No other patients developed symptoms.

In July 2007, concerns arose that the incidence of MRSA bacteraemia was not reducing from the previous year's rate. The Chief Executive therefore invited the Department of Health MRSA improvement support team (IST) to visit the hospital and review practice in clinical areas. Their visit took place in September 2007, and they made the following key recommendations:

- Review the role of the DIPC, following which a new DIPC was appointed
- Implement a regular cleaning audit programme, which was instigated by the visible leadership team in September 2007
- Strengthen the root cause analysis process; RCAs are undertaken for every case of MSRA bacteraemia, led by the DIPC
- Close monitoring of action plans: all action plans were reported to every meeting of the infection control committee, so that progress could be robustly tracked.

The Trust Board received update reports on this programme at every board meeting. The IST revisited the trust in February 2008, and provided positive feedback on the progress that had been made.

6.0 Hand Hygiene and Aseptic Protocols

During the year, the trust made a concerted effort to ensure that hand hygiene was top of the agenda across the trust. The trust had previously signed up to the National Patient Safety Agency's Clean**your**hands campaign; the lead for the programme is the matron for emergency care, who ensured that all the relevant posters and campaign materials were shared across the hospital. Following the release of the new materials in January 2008, the campaign's screensaver was installed on all computers across the trust, as an ongoing reminder to staff.

The trust also rolled out mandatory hand hygiene training for every employee. The success of this programme has resulted in a decision to provide this on an annual basis by the visible leadership team; sessions will next run from January 2009.

Compliance has been monitored through monthly hand hygiene audits across all clinical areas. The first trust-wide audit in September 2007 showed overall compliance with hand hygiene standards of 65%; by April 2008, following the completion of the training, this had improved to 91%.

With regard to aspect protocols, the trust agreed to follow the guidance set out in the Saving Lives High Impact Interventions, supported by best practice as set out in the Marsden Manual of Clinical Procedures. This includes the management of central

venous catheters, peripheral cannulae, renal dialysis catheters, urinary catheters and tracheostomies, and the prevention of surgical site infection and *Clostridium difficile.*

This work was led by the senior infection control practitioner. The regular audits undertaken were presented at the infection control committee. Whilst making a good start, more work is needed, and the trust will continue to work on these areas during the coming year.

7.0 Decontamination

7.1 Arrangements

The director of facilities is responsible for decontamination at board level. The sterile services manager, who is also the designated lead manager for decontamination, supports him. The director of facilities is a member of the infection control committee. The trust's decontamination arrangements are in line with the duties of the Hygiene Code, and are supported by a number of policies, which are available on the hospital's intranet.

7.2 Audit

The trust's decontamination committee meets every month, where it receives an audit report presented by the sterile services manager. There are two different audits, one of which covers the sterile services department, and the other the endoscopy processing unit. Both audits make use of national audit tools. In the case of the sterile services department, the audit tool is provided to the Whittington by AVM services, which act as the trust's "authorised person". The audit is completed and reviewed monthly, and is independently validated by AVM on an annual basis.

The endoscopy processing unit completes a flexible endoscopy audit tool developed and provided by the Healthcare Commission. This tool provides the basis for the JAG assessment of endoscopy units, which is due to take place in 2008/9.

7.3 Incidents or Failures Investigated

The decontamination committee reviews incidents or failures associated with decontamination every month. At the end of March 2008 a total of 18 incidents had been recorded for the year 2007/8. Of these, eight were risk rated as 'low risk ', two were risk rated as 'medium risk', and eight were rated as 'high risk'.

For each of the incidents reported, an incident form is completed and an investigation carried out by the sterile services manager. The committee monitors on a monthly basis progress with both the investigation and any subsequent action plan arising.

7.4 The Northwest London Decontamination Project

7.4.1 In 2002 it was agreed at a national level that the NHS would go through a major modernisation programme to update the provision of sterile services within the entire NHS. The impetus for the project came from a Department of Health survey in 1999 that found in many instances decontamination processes fell short of the required standards, increasing the risk of cross

infection between patients or patients and staff. It found buildings and equipment requiring replacement, and management and training systems in need of improvement. It became clear that many hospital decontamination and sterilisation departments did not comply with European legislation. As part of this national strategy to improve decontamination sterilisation of reusable medical instruments in the NHS it was proposed there would be significant cooperation between NHS Trusts and the private sector.

7.4.2 The Northwest London decontamination project was formed in 2004 as part of this national strategy to improve decontamination services. A confederation of trusts from Northwest London was formed, with the Whittington Hospital confirming its intention to join the confederation in 2006.

7.4.3 Following the establishment of the collaboration in 2004, governance of the project was undertaken by a project board made up of executives of each of the participating hospital trusts, a representative PCT chief executive, a specialist procurement adviser, the national decontamination programme director and the local project manager.

7.4.4 Once the strategic direction had been agreed a project team was established to undertake the day-to-day activities. The procurement process commenced with the publication of a tendering notice in the Official Journal of the European Union in August 2005.

7.4.5 The tendering process was very detailed and extensive with potential bidders being assessed against a number of criteria based on eight work streams.

7.4.6 In October 2007 a preferred bidder was identified, and financial close was reached on 1 April 2008, which confirms that In Health Sterile Services (IHSS) would be the service provider. The contract with IHSS is initially for a 15-year period.

7.4.7 Following financial close a detailed transfer schedule has been drawn up with the first service transfers due to take place in April 2009. The proposed transfer to the Whittington Hospital is July 2009 with all sterilisation due to be supplied from the Park Royal site. Assuming the transfer is successful the existing sterile services department will close shortly after that date.

7.4.8 In November 2007 the incumbent sterile service manager left the trust. In order to ensure that the trust was fully prepared to transfer decontamination services to a remote location, the full-time post was disestablished, and funding transferred to the operations directorate. The aim was to establish a dedicated resource to ensure that the trust met the obligations placed on it by the project agreement.

7.4.9 In order to ensure that operational standards were maintained within the sterile services department, a part-time manager was recruited from the hospital bank. This individual has been posted now for nine months, and has undergone intensive training to allow her to fulfil the obligations of post.

7.5 Priorities for 2008/9

The priorities for the forthcoming year are focused on four areas;

- Continue to support the Local Implementation Team in transferring sterile services offsite
- Construct and commission a new medical equipment washer and service
- Commence development of a new endoscopy processing unit.
- Develop the role of the decontamination services manager to encompass the new medical equipment washer and the redeveloped endoscopy processing unit.

8.0 Cleaning Services

8.1 Management Arrangements

An in-house team, comprising 160 Facilities Service Assistants (FSAs), 6 full time team leaders, 2 part-time evening team leaders and a housekeeping manager, undertakes cleaning at the Whittington. The teams are responsible for maintaining the cleanliness standards throughout the hospital wards, departments and public areas.

In addition, the facilities department manages 10 service contracts for external contractors who carry out services including window cleaning, deep cleaning, pest control and waste disposal.

8.2 Monitoring Arrangements

Each ward has a service level specification that outlines the priority duties and tasks to be performed by the FSAs. As well as the general ward and toilets cleaning schedules, they also include instructions for the cleaning of cubicles and bed areas following the discharge of an infected patient. These schedules are displayed publicly in all wards.

Each month the visible leadership team carries out monthly audits using the NHS cleaning standards. Following the introduction of these audits in September 2007, each ward was required to maintain a minimum of 80% compliance with the standards. From April 2008, the trust board has raised that standard to 90%. During the six months from September 2007 to March 2008, cleaning standards saw a measurable improvement across the hospital. In September 2007, 41% wards achieved the standard of 80%. By April 2008, this had improved to 60%, with further significant improvements achieved in the subsequent months. Immediate feedback is provided to wards at the time of the audit and the results are reported widely across the hospital, including to the hospital management board, the infection control committee, clinical governance committee and the ward managers meetings. The cleaning results are also reported on the trust board's performance dashboard report.

8.3 Budget Allocation

The housekeeping pay budget for 2007/8 was £4,670,553. Approximately three quarters of the budget is for the domestics and facilities services assistants, with the remaining quarter allocated to portering services

Non-pay allocation was £407,512, the majority of which is for cleaning materials

8.4 Clinical Responsibility

Although the management of cleaning sits in the facilities directorate, the clinical and facilities teams work closely together. The ward managers include the FSAs as part of their team and this helps ensure ownership and pride. The matrons' job descriptions include ensuring the cleanliness of their areas, and they carry out inspections with the housekeepers, in line with the requirements of the Matrons Charter (DH 200?). The assistant director of facilities personally contributes to the visible leadership team's cleanliness audits, and attends the feedback sessions.

8.5 PEAT Results

The PEAT self assessment was carried out on Tuesday 4 March 2008

Locations visited:

Emergency Department	Murray Ward
Betty Mansell Ward	Montuschi Ward
Critical Care	Meyrick Ward
Cavell Ward	Thorogood Ward
Ifor Ward	Mary Seacole Ward
Clinic 3A	Clinic 3B

PEAT team members

Steven Packer	Assistant Director of Facilities
Cecil Douglas	Assistant Director of Facilities
Greta O'Toole	Infection Control Nurse
Tina Jegede	Matron for Medicine
Jacqueline Davidson	Matron for Maternity

Areas are scored between 1 and 5, where 1 is unacceptable and 5 is excellent. The scores are amalgamated into four categories and expressed as a percentage. 80% represents 4, which is classified as "good".

Area	**2007 Score**	**2008 Score**	**+ / -**
Cleanliness and the Environment	80%	81%	+ 1%
Food	84%	91%	+ 7%
Privacy and Dignity	78%	80%	+ 2%
Infection Control	N/A	100%	-

8.6 User Satisfaction Measures

There are a number of ways that users are able to feedback their opinions on how clean the hospital is. Having a clean hospital is the first clause of the Whittington

Promise and is therefore a key measure in our patient satisfaction survey, which is used trust wide.

The trust's website includes our "Housekeeping Department Customer Charter", which sets out what they aim to achieve and invites feedback from users by e-mail or telephone.

We also ensure that users know how to make a complaint; historically cleanliness has been a recurrent theme, however, pleasingly the numbers of complaints received about this has been consistently decreasing.

9.0 Audit

9.1. Extent of Audit Programme

Audit of infection control practice is conducted as part of the trust's main clinical audit programme, as part of the infection control team's work and by the visible leadership team, as follows: -

- Infection Control Team
    - Saving Lives audits
    - Surgical site surveillance scheme (NINSS)
    - Antimicrobial seven day stop policy
    - Compliance with antimicrobial policy
    - Compliance with intravenous to oral antibiotic switch policy
    - Deaths due to MRSA bacteraemia or Clostridium difficile
    - MRSA screening and interventions

- Visible leadership Team
    - Hand hygiene
    - Environmental cleanliness
    - Peripheral cannula care

9.2 Reasons for Audit Focus

The reason for carrying out all the above audits was to help the trust to reduce the incidence of MRSA bacteraemia and *Clostridium difficile* cases. Audits help to raise awareness, measure performance and enable focused actions to be taken to improve.

As the same principles of best practice apply whatever the infection type, by raising performance in these two key areas, performance should improve in the prevention and control of all infections.

9.3. Antibiotic Prescribing (Report from Antimicrobial Pharmacist)

This audit was presented to the Infection Control Committee on 14 March 2008, and is attached at Appendix D.

10. Conclusion

The Whittington has maintained a high focus on reducing healthcare associated infections during 2007/8. Although the MRSA bacteraemia target was not achieved, the trust did see a reduction in the rate of MRSA bacteraemia cases per 10,000 bed days to the lowest level for the trust since mandatory reporting began. The target reduction in *Clostridium difficile* infections in patients over the age of 65 was also achieved.

All of the work outlined in this report enabled the trust to declare compliance against three of the Healthcare Commission's core standards, for the 2007/8 annual health check:
C4a the risk of healthcare acquired infection to patients is reduced
C4c the risks associated with decontamination facilities and processes are well managed
C21 cleanliness levels in clinical and non-clinical areas meet the national specification for clean NHS premises.

The work put in place during 2007/8 has provided a solid foundation for further control of infection in 2008/9.