Whittington Health NHS

Director of Infection Prevention and Control (DIPC)

Annual Report
1 April 2016 – 31 March 2017

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Consultant Microbiologist and
Director of Infection Prevention and Control

1.0 Executive Summary and Overview

1.1 Organisation

Whittington Health is an integrated care organisation (ICO) – providing both hospital and community care services to 500,000 people living in Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney.

Our current organisation was established in April 2011 following the merger of The Whittington Hospital and NHS Islington and NHS Haringey community health services.

Whittington Health has an income of £297m and more than 4,000 staff delivering care across North London from in excess of 30 locations including a number of health centres and The Whittington Hospital.

During the financial year 2016/2017, the Infection Prevention and Control Team (IPCT) provided a full service to acute and community sites under the Whittington Health remit. A single Director of Infection Prevention and Control (DIPC) covers all of Whittington Health.

Whittington Health takes the prevention and control of all infection seriously. It is part of the strategic objective to deliver efficient and effective care by delivering safe care to patients and providing a clean and safe working environment for staff employed by the organisation. Infection prevention and control continues to be everyone's business.

1.2 Activities

The focus for 2016/2017 has been to ensure:

- An ongoing reduction in incidence of healthcare associated infections (HCAI), in particular MRSA bacteraemia, *Clostridium difficile* diarrhoea, diarrhoea and/or vomiting outbreaks, respiratory tract viral infection including influenza and surgical site infections.

- Our staff have the most up to date knowledge and skills to achieve excellence in Infection prevention and control

In collaboration with the Microbiology team, the IPCT reviewed ward, clinic and community patients with infection related problems daily. An increasing number of infection consultations were carried out in our ambulatory care setting (walk in service where patients do not stay overnight). An on-call Infection Prevention and Control service was available 24 hours a day, 7 days a week through a joint Microbiology Speciality Registrar and Consultant rota.

We have collaborated widely with the Health and Work team this year on the delivery of influenza education and vaccination. The Trust achieved an 80% vaccination rate in our relevant workforce placing us first on the

London hospitals leader board after being second in London last year and first for the two previous years running.

Infection Prevention and Control in the built environment

Despite financial restrictions, the Trust has recently undergone significant refurbishment in many clinical areas and has invested in equipment and projects both in the acute and community settings. The Infection Prevention and Control Team have been involved in refurbishment projects from the planning stage and has provided expert advice on key factors within the built environment which can impact on the control of infection. The IPC Team have been able to provide expert advice on every stage which will minimise the risk of transmission of infection within the healthcare environment;

1.3 Infection Prevention and Control (IPC) Strategic Action Plan

The 2016/2017 Infection Prevention and Control (IPC) annual strategic action plan is outlined in Appendix A. The plan focused on continued zero tolerance to MRSA bacteraemia, reduced incidence of other HCAI's, developing enhanced methods to provide assurance, expanding IPC training and strengthening environmental based IPC audits.

Progress of the actions contained within the plan are monitored closely over the year through the Infection Prevention and Control Committee and a small IPC implementation group consisting of the DIPC, the IPC Lead Nurse and Senior Nurses/Midwives. As in previous years, each action area had a named lead from the senior nursing, medical or management team and an IPC team member to act as a support to ensure deliverability in a timely manner. We have strengthened the plan by providing updated evidence bi-monthly. There are new parts of the IPC action plan to accommodate the rising incidence of infection with resistant Gram negative organisms

Every MRSA bacteraemia and other significant HCAI events were reviewed using Post Infection Review (PIR) methodology and Consultant led PIR meetings held. The HCAI PIR ongoing action plan has been reviewed at regular intervals in conjunction with the annual IPC plan and presented at every IPCC meeting.

2.0 Infection Prevention and Control Arrangements

2.1 Infection Prevention and Control Team

At Whittington Health, the IPC agenda is led by the DIPC and her team, who report directly to the Trust Board bi-monthly through the Quality Committee. The Medical Director, Director of Nursing and ICSU clinical leads also have key roles in ensuring that high standards of clinical care are delivered to patients.

The IPCT comprises of one IPC lead nurse, three full-time specialist nurses, one part-time specialist nurse, one full-time trainee specialist

nurse, one antimicrobial consultant pharmacist, a part-time IPC lead administrator and two full-time co-ordinators.

During 2016/2017, the IPCT worked closely with many teams including Microbiology, Facilities staff, Community Matrons, Access, UCLP procurement team, Middlesex University, CCGs, Learning and Development, NHS England, Voluntary Organisations, Public Health England staff and Health and Work Centre staff.

A group of approximately 40 IPC link practitioners, who receive enhanced training in infection prevention and control, also support ward and clinic staff.

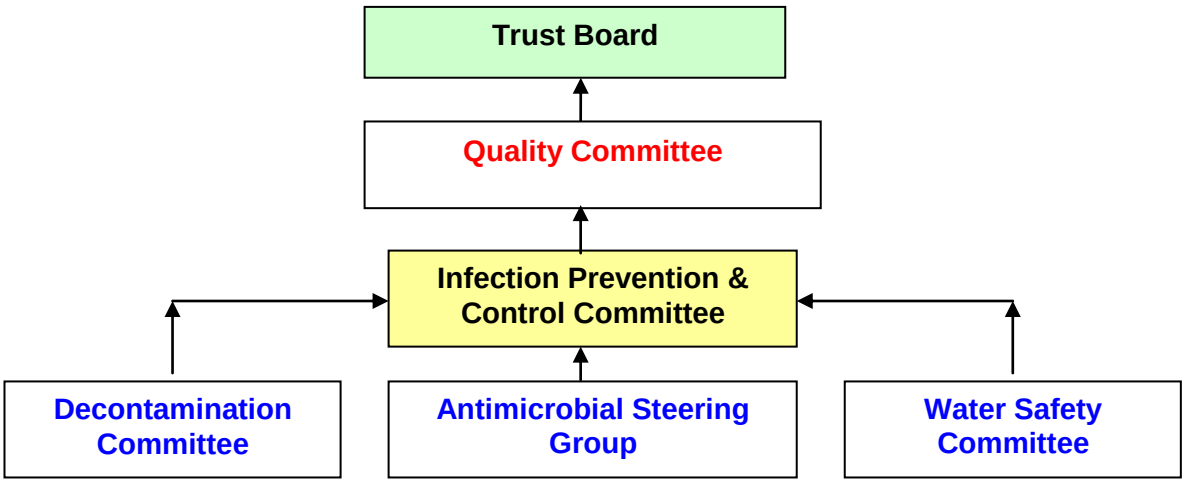
2.2 Infection Prevention and Control Committee

In March 2016, the terms of reference for the IPCC were revised to ensure widespread high level membership from all relevant areas of Whittington Health. The IPCC is chaired by the Director of Nursing and Patient Experience and meets bi-monthly.

Membership of the IPCC includes ICSU nursing and medical representatives, the Antimicrobial Pharmacist, the IPCT, Microbiology Team, Public Health England representative, representatives from higher risk community services such as Community Dental Services, Health and Work Centre staff and a Learning and Development Team representative.

2.3 Reporting Line to the Trust Board

The current reporting line of the IPCC is below:



2.4 Links to Drugs and Therapeutics Committee

During the period covered within this report, the Drugs & Therapeutics Committee (DTC) and IPCC both reported to the Quality Committee, chaired by non-executive directors. Continuity was assured as the DIPC and Head of Pharmacy both provided regular updates from their areas. In addition, the chair of the DTC is a member of the IPCC.

The Antimicrobial Steering Group (ASG), chaired by the DIPC, meets twice yearly. The ASG reviews antimicrobial policies, expenditure and audits and plans further work as required. All ICSUs are represented and the ASG reports directly both to the DTC and IPCC.

3.0 DIPC Reporting to Trust Board

Performance against ceiling targets for MRSA bacteraemia and *Clostridium difficile* have been reported to Trust Board through the Quality Committee bi-monthly as part of the performance dashboard report. Reports have included as standard, the performance for the previous month against the agreed objectives for MRSA bacteraemia and *Clostridium difficile* and orthopaedic surgical site infection incidence. Ongoing work to improve performance and results of IPC audits and other assurance data was also detailed. . The report also includes a section on IPC training compliance.

4.0 Budget Allocation for Infection Prevention and Control Activities

4.1 Staff

The DIPC is a Consultant Microbiologist, who has one programmed activity designated for this role.

The Infection Prevention and Control Team comprised of the following staff in 2016/2017:

1 wte Lead Nurse (band 8b)
1 wte Antimicrobial Pharmacist (band 8a)
3 wte Specialist Infection Control Nurses (band 7)
1 0.4 wte Specialist Infection Control Nurse (band 7)
1 wte Trainee Specialist Infection Control Nurse (band 6)
1 0.8 wte IPC Lead Administrator (band 5)
2 wte Co-ordinators (band 4)

The allocated budget for infection prevention and control in 2016/2017 was:

Area	Pay	Non Pay
ICO infection control – budget code AALC	£ **503,618**	£ **9,097**
Total	£ **503,618**	£ **9,097**

4.2 Support

The IPCT have good support from IM&T to provide MRSA and *C. difficile* monitoring graphs to the Trust Board.

5.0 IPC Training

During 2016/2017, the IPCT provided an extensive range of education and training, through two individual full day IPC link practitioner study days, all day rolling training sessions, face to face mandatory training and bespoke sessions delivered to a variety of clinical groups. Sessions have also been held at health centres with reasonable attendance. All training materials are evidence based and updated on a regular basis. New materials are developed and made available based on PHE guidance.

Face-to-face training was also provided for Junior Doctors by the DIPC through regular education programmes, with a focus on prescribing antimicrobials, managing common infection scenarios, influenza and infection prevention. A practical procedures course was introduced in 2009 for Foundation Year 1 Doctors focusing on aseptic technique for basic procedures such as insertion of peripheral cannulae, blood cultures and urinary catheterisation. Practical aseptic skills training was also provided to relevant acute and community based nursing/midwifery staff. Student nurses from Middlesex University also received induction, mentorship and clinical skills training.

Despite enhanced training activity, compliance did not exceed 85% in 2016/2017.

6.0 HCAI Rates and Other IPC Surveillance

6.1 Results of Mandatory HCAI Reporting

MRSA Bacteraemia: For the period 1 April 2016 to 31 March 2017, Whittington Health reported two trust attributable MRSA bacteraemia episodes identified in the same patient against an agreed objective of zero. This was fully investigated using the PIR process with wide sharing of learning at the IPCC.

There has been a marked improvement from performance in 2009/2010 and 2008/2009 when there were 8 and 23 episodes respectively and we have sustained this improved performance. There was one community attributable MRSA bacteraemia episode within the 2016/2017 period investigated by the relevant CCG. A zero tolerance objective has again been set for trust attributable MRSA bacteraemia for 2017/2018.

GRE Bacteraemia: Whittington Health reported one case of glycopeptide resistant enterococci (GRE) bacteraemia in the period 2016/2017.

MSSA Bacteraemia: There were six episodes of post-48 hour meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia in 2016/2017. There were no set ceiling targets associated with this organism. Each case was reviewed by the IPCT to look for modifiable risk factors such as peripheral or central line insertion non-compliance.

E.coli Bacteraemia: There were 129 reported episodes of E.coli bacteraemia in 2016/2017, 115 of these were pre 48 hour episodes and 14 post 48 hour. The post 48 hour patient cases were investigated to ascertain any obvious modifiable risk factors. 9.2% of the E. coli

bacteraemia isolates demonstrated extended Beta lactamase production (ESBL) meaning they were resistant to Beta-lactam antimicrobials such as co-amoxiclav and pipercillin-tazobactam. This is considerably higher than the 3.2 per cent ESBL rate seen in 2012/13.

***Clostridium difficile*:** From 1 April 2016 to 31 March 2017, Whittington Health reported 7 cases of Trust attributable *C.difficile* associated diarrhoea (CDAD) against a tolerance of 17 finishing the year well under trajectory. In April 2012 a new screening method for *C.difficile* was introduced which involved a more sensitive two stage procedure. Nationally a 30% increase in prevalence has been seen through the introduction of this two stage procedure.

Of the 7 cases, each was reviewed in detail using the post infection review (PIR) template and aspects of care relating to isolation, testing, communication, cleaning, use of personal protective equipment and antimicrobial prescribing were independently scrutinised.

In summary, none of the Trust attributable *C.difficile* associated diarrhoea (CDAD) cases were considered lapses in care and all were deemed unavoidable. Side rooms were not always immediately available to isolate patients however patients were suitably co-horted in a bay until a side room became available. There were no cases of cross-transmission.

The Trust-attributable *C.difficile* ceiling objective in 2017/2018 has been set at 17.

Carbapenemase Producing Enterobacteriaceae (CPE): There were nine patients diagnosed with CPE in 2016/2017. No cases were attributable to the Trust and there was no cross-transmission. Screening for CPE commenced in October 2014 and a recent audit highlighted 87% compliance in completion of screening questionnaires.

Orthopaedic Surgical Site Infections: Surgical site infection surveillance (SSI) data for three out of the four quarters in 2016/2017 for hip implants, knee implants and surgical repair of fractured neck of femur. This is above the expected mandatory reporting requirement of Public Health England.

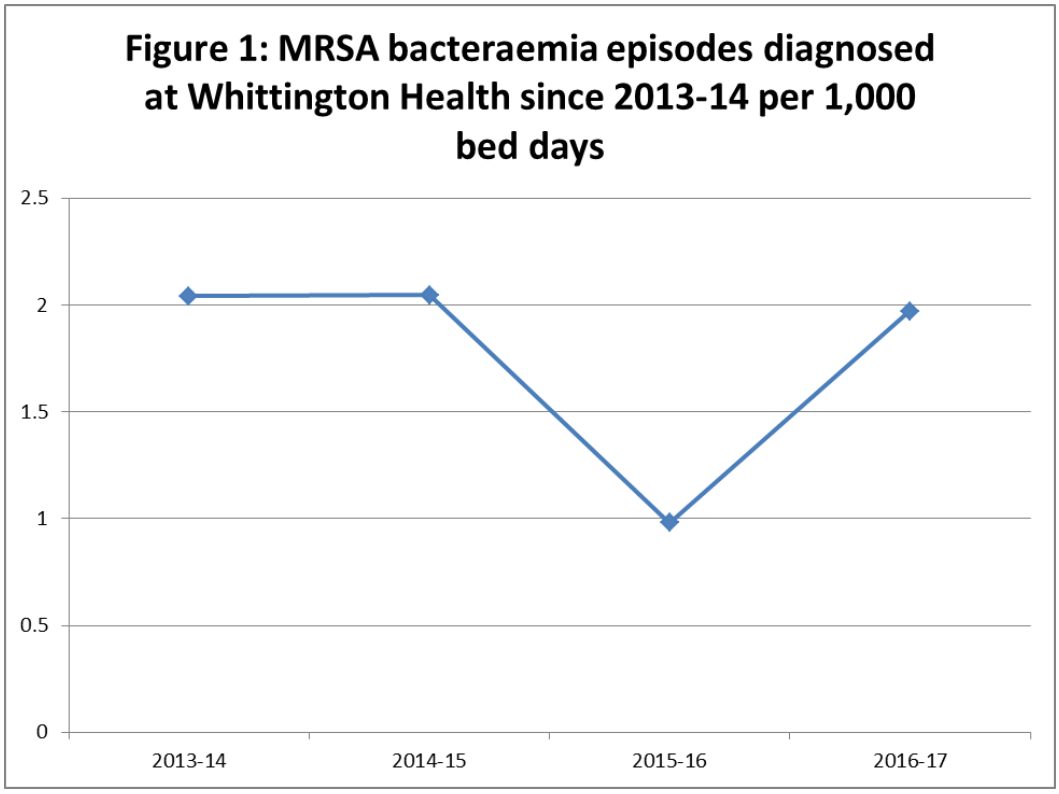
Total figures for the year from 1 April 2016 to 31 March 2017 are as follows:

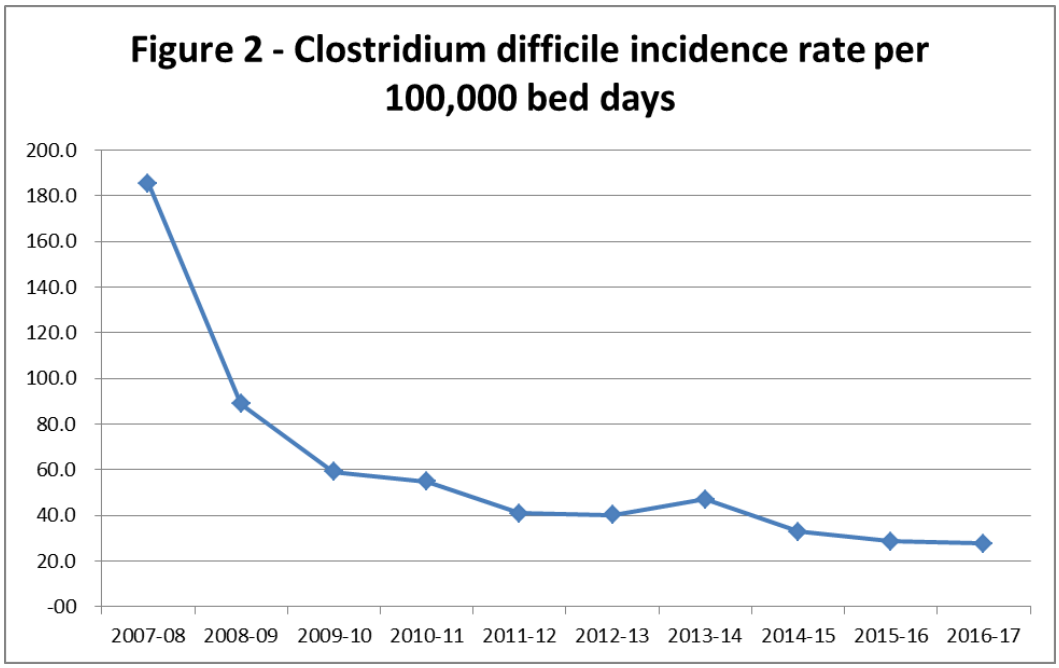
- Total Hip Replacements (THR) 0.6% against a national benchmark of 1.0% (1 infection out of 162 procedures)
- Total Knee Replacements 0.7% against a national benchmark of 1.5% (1 infection out of 141 procedures)
- Fractured Neck of Femur (#NOF) 0.8% against a national benchmark of 1.4% (1 infection out of 125 procedures).

6.2 Trends in HCAI Statistics

The Trust takes its' responsibilities for reducing HCAI very seriously; these figures are monitored weekly by the Executive Committee and reported to Trust Board.

The following trend charts detail HCAI rates year on year since the commencement of mandatory surveillance.





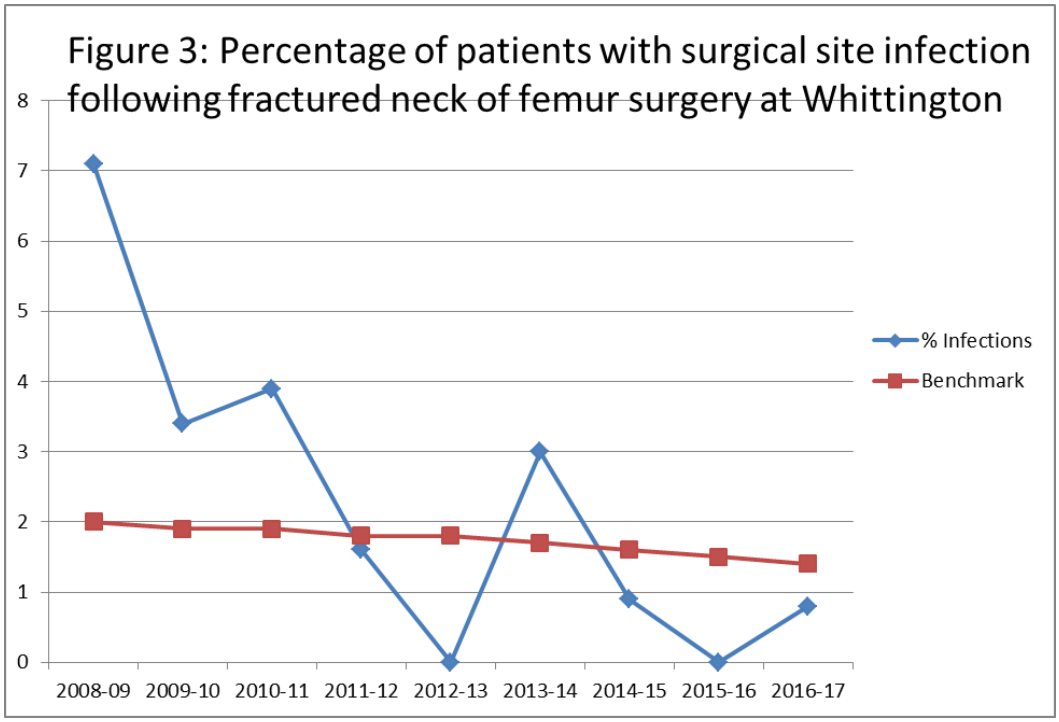


Figure 3 demonstrates the significant improvement that has been sustained since 2011 in the percentage of patients being diagnosed with surgical site infections following surgery for fractured neck of femur surgery.

6.3 Serious Untoward Incidents, Including Outbreaks

There was 2 Serious Incident (SI) Panel enquiries directly related to clinical infection prevention and control in the period 2016/2017 relating to the MRSA bacteraemia identified in the same patient in October 2016 and January 2017.

There was a high prevalence of influenza but due to rapid ward response there was only one ward closure during the 2016/2017 period. In the entire influenza season there were 32 acquisitions of influenza in hospitalised patients, (up from 19 acquisitions in 2015/16). There were two hospital acquired influenza deaths which have been investigated internally using the SI process. Learning from this demonstrated that timeliness of sending flu swabs to the Microbiology laboratory needed to improve; and written documentation by the Infection Prevention & Control Team required improvement.

There was one norovirus outbreak.

6.4 Healthcare Worker Exposure to Blood Borne Virus

The number of needle stick injuries fell from 112 in 2015/16 to 84 in 2016/17. However, mucocutaneous incidents rose from 14 in 2015/16 to 22 in 2016/17). The majority of sharps incidents occurred while suturing in theatres and ED. Needlestick injuries in the community remains constant with 26 reported incidents therefore the training focus will be on both the community, ED, theatres and Labour ward in the coming year. The most common cause of community incidents relate to insulin needles and blood

sugar testing usually because the patient's reuse their own equipment in the community.

There were three RIDDOR reported incidents in 2016/17:

1) A HIV positive source in ED (splash incident – no goggles worn);
2) A Hep C source positive splash in Nightingale ward; and
3) A Hep B source positive needle stick injury in Labour ward.

We are still seeing incidents related to over filled sharps bins, re sheathing of needles and incorrect disposal of used needles. These will be investigated individually and followed up by OH and the infection prevention and control team using a two pronged approach.

We reviewed all sharps being used in the Trust and have removed all non-safe sharps from the Trusts ordering system. Non-safe sharps can only be ordered if they are on an agreed exemption list following risk assessment. Notably, we have also had incidents while using safer sharps where the safety guards did not fully engage. This was followed up with the supplier.

We issued 5 post-exposure prophyalxis (PEP) prescriptions in 2016/17 to reduce the risk of HIV sero-conversion compared to 6 in 2015/16

Following tests, no staff member was found to be infected from a needle stick or body fluid splash with either HIV, Hep B or Hep C.

7.0 Hand Hygiene and Aseptic Technique

The organisation made a concerted effort to ensure that hand hygiene compliance was still a high priority. A new "Whittington Warriors" hand hygiene campaign was launched in 2014 and all phases of the campaign: new floor and wall signage in the acute site together with a virtual nurse hologram for the main entrance have been introduced.

The IPCT delivered face to face training on mandatory induction days. The team also offered training to services on request or when areas demonstrated poor compliance.

Hand hygiene compliance was measured through monthly hand hygiene audits (by various different staff groups) across all clinical areas. Hand hygiene compliance amongst community staff was completed and monitored by the IPCT via telephone audits. Access to hand hygiene facilities was recorded in health centres and other community sites on our regular visits.

Up to the beginning of 2017, the results had shown consistent improvements, with most clinical areas having hand hygiene compliance scores over 95%. In 2013/14 there was a reduction in the numbers of clinical areas that were compliant and a staff survey reported a perception of reduced access to hand hygiene facilities. The IPCT responded with targeted training; increased auditing by link staff and concentrating on

improving access to hand hygiene stations or alcohol gel. Areas that scored below 95% were audited more frequently with targeted feedback. Results are presented to areas immediately and as part of a ward IPC performance dashboard, see Appendix B.

With regard to aseptic protocols, the ICO continues to follow the guidance set out in the Saving Lives High Impact Interventions and Essential Steps. This includes the management of central venous catheters, peripheral cannulae, urinary catheters, prudent antimicrobial prescribing, prevention of surgical site infection and *Clostridium difficile*. Evidence based guidelines can be found on the Clinical Guidelines section of the intranet. Compliance with these guidelines forms part of the ward IPC dashboard. Compliance has improved steadily since the introduction of the Saving Lives campaign and is now at a high level.

8.0 Decontamination

8.1 General arrangements

The Director of Estates and Facilities Phillip Ient has retired and has been replaced by Adrien Cooper who is Director of Environment. The Director of Environment is the decontamination lead for Whittington Health. The Decontamination Advisor who is also the designated lead manager for Decontamination supports the Decontamination Lead.

Decontamination and related matters are reported and managed at the Decontamination Committee, which is a sub-committee of the Infection Prevention and Control Committee. Records of these committee meetings are kept and made available for the CQC during an inspection.

A report from the Decontamination Committee is submitted to the IPCC on a quarterly basis. These lines of reporting are in accordance with the hygiene code and are supported by a number of policies and standard operating procedures (SOPs) which are available on the intranet. Some policies, which pertain to local facilities and services in the community, are only available in the area of use.

8.2 Committee Activities

The Decontamination Committee reports and meets quarterly. The committee agenda is arranged to ensure that over a 12-month cycle all aspects of decontamination governance and operational performance monitoring and are reviewed. Each meeting covers of the following:

- Performance Indicators; dashboard which includes incident reporting.
- Compliance Framework; equipment validation and process audits; there will be an area chosen on a rotational basis to present and discuss their audit at Decontamination Committee.
- Exception Reports; progress update on incident action plans.

- Evidence of ongoing training in regard to innovation and existing activity.
- Policy review and updates.

8.3 Audit

The following audits are carried out and results reported to the Decontamination Committee in rotation:

- Endoscope Processing Unit (EPU)
- Equipment Decontamination Unit (EDU)
- Mop Washing Room
- Mattress Decontamination Room
- The bed store
- Community Dental facilities.

Matters arising are identified and tracked through subsequent meetings.

8.4 Incidents or failures

Recording and reporting of incidents is undertaken electronically using Datix electronic reporting system throughout Whittington Health

The decontamination of reusable surgical instruments is carried out at an offsite facility run by InHealth Sterile Services (IHSS). We continue to work with IHSS in partnership by offering experience days in theatre at the Whittington and sending Whittington staff to IHSS for learning opportunities. There have been relatively few reported incidents relating to IHSS over the past 12 months, once again generally reflecting an improved and stable picture. There have been some changes in the management structure at IHSS and the persons fulfilling the respective roles but this has had no negative impact on the service. This demonstrates the success of our collaborative approach and key improvements by IHSS in quality monitoring such as the introduction of cameras monitoring all aspects of production.

The careful monitoring of recurrent issues is carried out by a Decontamination Users Group. This allows end users to have face to face discussions with IHSS managers facilitated by the Decontamination Advisor and IHSS Contracts Manager. The Whittington continues to take the issue of sharps returned on used trays to IHSS very seriously; unfortunately incidents of this nature continue to occur on an occasional basis. Offenders are usually identified, their senior managers informed. In order to educate the non-compliant staff member they are asked to attend the Park Royal IHSS facility and remove the used sharp from the tray and dispose of it correctly to remind all that actions have consequences. This is usually followed by a tour of the facility and meeting with the decontamination staff at the facility to reinforce our partnership working ethos. We continue to offer Sharp safety training days at intervals which have good attendance and positive feedback. IHSS continue to support

these study days and express gratitude to Whittington Health for their diligent approach to this issue. We are the only Trust in the partnership to address the problem in such a proactive manner.

Decontamination Incident table of April 2016 – March 2017

IHSS	Non IHSS	Low risk	Moderate risk	High risk	ungraded
5			5		
	1	1			
7		7			
	1				1

The table above details decontamination incidents for the preceding 12 month period. No high risk issues or serious incidents.

8.5 Risks associated with Decontamination

There are 3 risks under Decontamination listed on Datix risk register

542 – Failure to make funds available for redevelopment of EPU prior to failure of existing facility Graded extreme

682 – Availability of scopes for patients should present AER's in EPU fail. Graded extreme

250 – Return of medical equipment to Medical library incorrectly decontaminated. Graded moderate

Identification number and initial risk rating	Risk description	Risk Review date and current rating
250 - High	If medical equipment is not decontaminated before it is returned to the library or to medical physics for repair, this presents an infection control risk to patients and staff	18/07/2017 - Moderate
682	If scope re-processing unit fails scopes to treat and/or diagnose emergencies, planned scope procedures to diagnose problems in Urology, Respiratory/bowel screening and ENT will become unavailable for use. It will also mean that emergency scopes for intubation will be unavailable leading to a risk to life. This will seriously impede the work of doctors and the solution will be to re-direct patients to other hospitals leading to delay and inconvenience, with possible serious consequences . 05/05/2016 No Change	11/07/2017 - extreme
542	If we fail to make available funds for the	11/07/2017 -

	construction and commissioning of a new endoscopy decontamination unit, the existing unit will cease to function effectively due to the equipment being at the end of its life cycle and will cease to function. This will reduce our ability to service bowel screening commitments and existing endoscopy procedures.	extreme

Risks 682 and 542 are being addressed by the re-development of the Endoscopy Processing Unit. This project is headed by Adrien Cooper, Director of environment supported by Debbie Hoar, Decontamination Advisor and Neil Bates, Decontamination Re-Development Consultant.

Risk 250 remains stable and managed having been downgraded from the initial high risk rating due to action such as education of users. Audit records continue to monitor risk status.

8.6 A review of priorities for 2016/2017

The re-development project for Endoscopy Processing Unit has been revised under the new Director of Environment in a manner which reflects the reality of the present financial climate whilst remaining compliant and able to deliver production targets.

8.7 Priorities for 2017/2018

Continue and complete planning and execution of Endoscopy Processing re-Development whilst maintaining HTM 01-06 compliant production. Estimated completion date March 2018.

Continue working within the NWL partnership with IHSS to deliver a compliant and reactive service which meets legislative standards and new guidelines with particular reference to cleaning efficacy and protein residue measurements.

Continue to build, train and educate an excellent decontamination production team to meet the growing needs of Whittington Health.

9.0 Audit

9.1 Extent of Audit Programme

Audit of infection prevention and control practice is conducted as part of the ICO's main clinical audit programme as follows: -

- Orthopaedic surgical site infection surveillance scheme.
- Annual large bowel surgical site infection surveillance.
- Compliance with antimicrobial policies.
- MRSA screening and interventions such as MRSA suppression.
- PLACE inspections.
- Hand hygiene.
- Environmental cleanliness including commodes.

- IPCT enhanced quality improvement audits.
- Compliance with flushing low use outlets.
- Compliance with isolation and personal protective equipment policies.

All results are presented immediately to front line staff. Specific audit results also form part of the IPC dashboard which is presented to divisional boards and Quality committee, see Appendix B.

Community locations were audited for compliance with processes and procedures, environmental cleanliness, fabric of the infrastructure and hand hygiene facilities using IPCT enhanced quality improvement audit tools. There is a work plan audit planner and the majority of areas have demonstrated improvements compared to the previous year. Action plans are disseminated after all audits and reviewed within three months for those areas found to be non-compliant. Areas of moderate concern will be reported using the Trust risk register.

9.2 Reasons for Audit Focus

One of the many rationales for carrying out all the above audits was to help the Trust to reduce the incidence of MRSA bacteraemia, *Clostridium difficile*, surgical site infections and other HCAI. Audits are also designed for detailed measurement of all aspects of practice/environment and to measure baseline practice with standards identifying areas for improvement. Audits help to raise awareness, impart knowledge and skills measure performance and enable focused actions to be taken to improve. The IPCT also have an opportunity to offer advice directly as/when necessary. The audit results form part of the assurance framework to ensure we achieve our annual IPCT strategic action plan and adhere to CQC best practice guidelines, and the Health and Social Care Act 2012.

10.0 Report from the Antimicrobial Pharmacist

The trust's antimicrobial stewardship programme is overseen by the Antimicrobial Steering Group (ASG), which is a sub-committee of the Infection Prevention and Control Committee (IPCC). The ASG provides assurance to the trust on all matters relating to antimicrobial prescribing and works in collaboration with the Drug and Therapeutics Committee (D&TC) and Clinical Guidelines Committee (CGC). The ASG meets quarterly and a report is submitted to the IPCC.

The quarterly point prevalence audit and antimicrobial consumption reporting have been running for nine years and continues to be an integral part of the trust's antimicrobial stewardship programme. These have since been revised to comply with the national Anti-Microbial Resistance (AMR) Commissioning for Quality and Innovation (CQUIN) requirements.

Audit results for 2016/17 shows that antibiotic prescribing compliance achieved the national CQUIN target with more than 90% of antibiotics prescriptions were appropriately reviewed within 72 hours of initiation. Results of the CQUIN also showed that the trust has successfully

achieved reductions in the use of critically important antimicrobials such as piperacillin-tazobactam and carbapenems, and the total antimicrobial consumption by 2%, 7% and 22% respectively. The volume of antimicrobials consumption appropriately reflects the expected usage of an Integrated Care Organisation that encompasses an acute hospital and a wide ranging community services.

The trust has also contributed to the 5th National Point Prevalence Survey on Healthcare-associated infections and 2nd National Point Prevalence Survey on antimicrobial prescribing quality indicators.

Various technologies have been implemented that have helped to embed antimicrobial stewardship into clinical practices. Electronic prescribing enables the trust to perform antimicrobial stewardship more efficiently, with real time prescribing data being generated and automatically sent to lead clinicians and the antimicrobial stewardship team. Prescribing support tools that are available on the electronic prescribing system such as order sets, allergy and interaction alerts, and stop date facility, help to encourage safer prescribing. MicroGuide app is available for staff to access antimicrobial guidelines easily and conveniently on smart phones and tablets. Essential guidelines can be accessed at the point of care anywhere within the hospital and in the community, and life-saving antimicrobial treatments can therefore be initiated promptly.

The antimicrobial guidelines that were recently published include the antibiotic lock therapy to treat colonised central venous catheter (CVC) guideline and the obstetric and gynaecology antimicrobial guideline.

In September 2016, Whittington Health has appointed a Consultant Pharmacist in Antimicrobials to help deliver the trust's clinical strategies in providing high quality care for patients and our community, and lead in education, research and innovation.

11. Conclusions

We have had many successes, for example; embedding a new invigorated hand hygiene campaign, improving single use equipment availability introducing the new MicroGuide® mobile application, again achieving a high staff influenza vaccine rate, re-introducing IPC to face to face induction training and improving the IPC audit compliance results especially in our community sites.

We failed to achieve our 2016/2017 HCAI objectives for MRSA bacteraemia but came in well under trajectory for *C. difficile* associated diarrhoea. The IPCC are confident that each case was fully investigated and that lessons learnt from each case have been carried forward and shaped the IPC strategy going forward. Our orthopaedic surgical site infection rates were below the national benchmark and we continue to work closely and successfully with our colleagues in theatres and orthopaedics. Our focus on improved bed placements and diagnostics in the flu season greatly assisted us in avoiding outbreaks and ward closures.

Our rates of resistant Gram negative infections have increased as evidenced by our E. coli bloodstream infection data. We have also implemented the Public Health England guidance around the recognition, control and treatment of Carbapenemase producing Enterobacteriaceae (a broad spectrum antimicrobial) producing Enterobacteriaceae (organisms such as E. coli, that can then be resistant to the carbapenem class of broad-spectrum antibiotics). The content of IPC annual strategic plan has been altered to take into account the increasing burden of resistant Gram negative infection.

The main objective going forward in 2017/2018 will be the continued zero tolerance approach to HCAI outlined in detail within the current IPC plan which will now also include post infection review of all trust-attributable E-Coli cases in line with new guidelines set by the Government which came into effect in April 2017.

Appendix A

Whittington Health NHS

Infection Prevention and Control Strategic Action Plan 2016 - 2017

The Whittington Health (WH) strategic action plan for infection prevention and control (IPC) has been divided into key sections and aims to set out the work required in 2016/17 across the integrated care organisation (ICO) to meet the standards and targets placed upon the ICO as outlined in NHS Operating framework 2016-2017, The Health and Social Care Act 2008, NICE guidance 36 Prevention and control of Healthcare associated infections 2011 and the Care Quality Commissions (CQC) Outcome 8, of regulation 12 in order to fully meet the judgement framework for inspections, allowing WH ICO to continue registration without restrictions with the CQC.

The key infection prevention and control objectives for 2016/17 are:

1. To have no avoidable cases of MRSA bacteraemia acquired by patients while in our care.
2. To have less than 17 cases of *Clostridium difficile* associated diarrhoea acquired within the ICO.
3. To achieve a compliance rate of 95% or above for all environment audits.
4. To achieve a compliance rate of 95% or above for all hand hygiene audits.
5. To achieve compliance of over 90% in all antimicrobial prescribing targets.
6. To ensure more than 95% of Whittington Health staff receive infection prevention and control training by end of 2016-2017.

Service objectives and operational details are contained within the annual report and progress report of the strategic action plan. This action plan should be read in conjunction with these two documents.

This action plan provides a comprehensive tool against which progress may be assessed and reported at the Infection Prevention and Control Committee (IPCC) and forms part of the self-assurance framework of the trust for CQC self-declarations. It is intended that this is a live document and therefore progress against this will be reported to divisions at quarterly reports but also reported to the IPCC as a standing item.

All infection prevention and control policies referred to are available on the ICO's intranet.

The Executive Director with overall accountability for the delivery of the plan is the Director of Nursing and Patient Experience. The Director of Infection Prevention and Control (DIPC) is Dr Julie Andrews.

Actions to meet Saving Lives High Impact Interventions (HII's)

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
1. Every adult patient admitted either as an emergency or electively will be screened in the Emergency Department, Pre-operative assessment clinic or on admission to a clinical area as detailed in the ICO's MRSA screening policy.	All elective and emergency admissions are screened for MRSA.	All adult patients admitted via ED to be screened in ED. Receiving ward staff to check screen has been undertaken as part of admission procedure, and if not, take it. Bed Management Team to allocate a bed post screen. All adult elective patients to be screened in the pre-operative assessment or outpatient clinic. Ensure all relevant staff are aware of which patients are to be screened when and how.	Monthly	HON Surgery & Cancer (S&C) Delegated to relevant Ward Managers HON Children's and Young Person's Services (CYPS) Delegated to relevant Ward Managers HON Medicine Frailty & Networked Services (MFNS) Delegated to relevant Ward Managers HON Women & Family Services (WFS) Delegated to relevant Ward Managers	Lead Nurse Infection Prevention & Control (LNIPC)	Monthly compliance audits Weekly IPCT ward checks and visits
2. Every MRSA positive patient will have suppression therapy prescribed and given for required number of days	All MRSA positive patients receive full suppression therapy at the correct time for the correct duration.	When result is positive, suppression therapy to be prescribed via the pre-printed prescription/or drop down menu (electronic prescribing), by relevant doctors/nurses/midwives.	Monthly	***Ward Managers***	LNIPC	Monthly compliance audits undertaken by IPCT

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
and be commenced on a MRSA positive patient care plan.		Suppression therapy to be given for correct length of time as soon as possible. Failure to administer full course to be treated as a drug error.				
3. Every surgical patient will receive optimal peri-operative care as set out in Saving Lives HII4.	Surgical site infection rates in patients undergoing surgical intervention will be reduced.	All recommendations to prevent surgical site infection to be implemented as per Saving Lives guidance and monitored via patient safety check list. Input and audit SSI colorectal data via ORMIS once a year. Input and audit orthopaedic SSI rates year round.	Every other month	*Mr Omar Haddo* *Mr Chetan Bhan*	Dr J Andrews	Orthopaedic SSI data reviewed at each IPCC Colorectal data to be reviewed by Colorectal Surgeons in collaboration with Consultant Microbiologists
4. Clinical staff all comply with best practice in urinary catheter care as set out in the Saving Lives HII6.	The number of catheters placed will reduce. The number of catheter associated infections will reduce. The duration of use of catheter will be reduced. The use of catheter will be appropriate and relevance reviewed regularly.	Continence/ bladder and bowel team to deliver refresher training on urinary catheterisation to relevant staff. Practice Development teams/clinical leads to assess non-medical staff every 3 years to ensure they maintain their competency. Junior doctors to receive training and competency assessment via the post graduate medical centre. Compliance with the care bundle in in-patients assessed by Energising for Excellence audit monthly. All in-patients with catheter to have daily Catheter checklist completed.	Monthly	HON MFNS HON CYPS HON S&C HON WFS Head of Clinical Development Lead for Safety and Productivity Maxine Hammond Liz Bonner Fernando Garcia *Director of Postgraduate Medical*	LNIPC	Competency assessment records available for all relevant staff ESR updated locally Quarterly audits presented as part of IPC dashboard *E.coli* blood-stream infection rates monitored through IPCC

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
				Education		
5. Clinical staff comply with best practice in the taking of blood cultures as set out in the Saving Lives guidance.	Reduced false positive blood culture results.	Training programmes to be delivered for new, untrained staff including medical staff. Training should include the use of blood culture stickers and documentation.	Monthly	Head of Clinical Development	Dr J Andrews LNIPC	Audit number of blood culture contaminants Competency assessment record available for all relevant staff
6. Clinical staff comply with best practice in peripheral cannula care as set out in the Saving Lives HII2 Care Bundle.	No peripheral cannulae insertion, care of or management issues identified by MRSA post investigation review (PIR).	Provide cannulation training to all relevant clinical staff to deliver the actions in the care bundle. Provide updates to current staff to support them in maintaining their competency. Ward Managers to carry out quarterly audits using the Saving Lives.	Every other month	***Clinical Education Team*** Clinical Area Managers supported by Link Practitioners	LNIPC	Audits as part of IPC dashboard
7. The ICO complies with best practice with regard to isolation of patients, as set out in the Saving Lives guidance.	Patients who are subject to transmission precautions are ideally isolated in side rooms or cared for in cohort bays with patient with similar conditions in order to reduce transmission of alert organisms or conditions.	Ensure all site managers understand and use the LIPS, allocate known and potentially infected patients to single rooms, or cohort nursing accordingly. Ensure that transmission precautions are in place and followed at all times. Ensure that transfer and movement of patients is kept to a minimum. Ensure that correct decontamination of equipment and the environment is carried out where patients are seen. Quarterly monitoring of time to isolation, (objective to isolate within two hours).	Every other month	Bed Management Team Assistant Director of Facilities HON MFNS delegating to Clinical Area Managers HON CYPS delegating to	LNIPC	Quarterly Isolation compliance audits based on the ICO Policy carried out by IPC Team Weekly IPC Team ward visits Quarterly monitoring of

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
		Introduction of diarrhoea and *Clostridium difficile* management core care plan.		Clinical Area Managers HON Surgery delegating to Clinical Area Managers HON WFS delegating to Clinical Area Managers		time to isolation times for patients with diarrhoea
8. Clinical staff in augmented care areas all comply with best practice in temporary central venous catheter care as set out in the Saving Lives HII1 Care Bundle.	No CVC related *Staphylococcus aureus* bacteraemia cases.	Ensure all new staff are trained to deliver the actions in the care bundle. Ensure current staff receive updates and maintain their competency. Continue CVC insertion care bundle documentation in Critical Care areas. Carry out regular audits using the Saving Lives Audit tool.	Every other month	Dr T Blackburn Dr A Badasconyi Dr S Gillis Lead Nurse Critical Care Nurse Consultant Paediatric Haematology and Oncology	Dr J Andrews	Annual audit of insertion and maintenance of CVCs
9. Critical care staff comply with best practice in caring for ventilated patients as set out in the Saving Lives High Impact Intervention 5 Care Bundle.	Reduce the prevalence of ventilator-associated pneumonia.	Ensure all new critical care staff are trained to deliver the actions in the Ventilator Associated Pneumonia care bundle. Ensure current staff receive updates and maintain their competency. Carry out annual audit using the Saving Lives Audit tool. Measure prevalence of Ventilator Associated Pneumonia.	Every other month	Dr S Gillis Dr A Badasconyi	LNIPC	Annual audit of compliance with guidance

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
10. The ICO's medical and relevant pharmacy staff all comply with best practice with regard to antimicrobial prescribing, as set out in the Saving Lives guidance and ICO's Antimicrobial Policy and HII7.	Every patient receives antimicrobials in accordance with principles of prudent antimicrobial prescribing.	Ensure all relevant medical and pharmacy staff understand and follow the antimicrobial prescribing guidance.	Every other month	Divisional and Clinical Directors	Dr J Andrews Ai-Nee Lim	Audits of compliance with the Antimicrobial Policy HII7 audits undertaken on every case of post-48 hour *Clostridium difficile* Diarrhoea Detailed review of audits at each quarterly Antimicrobial Steering Group meeting
	Reducing the incidence of *Clostridium difficile* associated Diarrhoea HII7.	Carry out a rolling programme of monthly audits at ward level to ensure compliance.				
11. The ICO monitors environmental cleanliness and decontamination of equipment as outlined in HII8.	The clinical environment looks and is visibly clean at all times.	Deep cleans undertaken as per identified programme held by Estates & Facilities, and Infection Prevention & Control Team.	Monthly	Assistant Director of Facilities Heads of Nursing Clinical Area Managers	LNIPC	Audit of compliance with HII8 monitored through audits on IPC dashboard
		Monthly environmental audits of higher risk clinical areas by clinical leads.				
		Quarterly meetings with NCL sector facilities managers for both boroughs, discuss cleaning audits, issues and SLI's.				
12. The ICO complies with best practice with regard to reducing risk of infection in chronic wounds as set out in HII9.	Reduce the risk and incidence of chronic wound infections and chronic would related blood stream infections.	Embed wound care and patient management care bundles into care of all patients with chronic wounds.	Every other month	Jane Preece HON MFNS HON CYPS HON S&C HON WFS	LNIPC	Annual audit of compliance with HII9
		TTA's to include wound packs and dressings.				
		Community teams to use dressing packs and knowledge of when to use then and how to facilitate ANTT in patients home.				
		Integrated wound care formulary.				

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
13. Every patient admitted as an emergency or electively who has received in-patient hospital treatment abroad or in a London hospital in the last 12 months will be screened for Carbapenemase Producing Enterobacteriaceae (CPE)	Reduce the risk of the introduction of CPE into the Whittington Hospital via appropriate screening of suspected cases.	Rectal screen all patients to be admitted who have answered yes to having received in-patient hospital treatment abroad or in a London hospital within the last 12 months.	Annually	ED senior nursing staff Access team	Martin Peache	Review of implementation By IPCT
		Liaison with bed management to ensure immediate isolation of suspected CPE patients.				
		Create standard operating procedure for laboratory.				
		Patient pathway flowcharts for assessing, screening and isolating.				
		Training presentation to be delivered to all relevant staff.				
		To be incorporated in to Trust induction training.				
		Policy to be finalised and placed on the Trust intranet.				

Actions to meet Health & Social Care Act; Care Quality Commission Regulations

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
Criterion 1 Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.	The ICO is compliant with Regulation 12 of Health & Social Care Act 2008 and outcome 8 of CQC guidance and thus able to maintain registration with the CQC.	Capture all relevant IPC work and audits findings to demonstrate compliance.	6 monthly	Director of Nursing and Patient Experience HON MFNS HON CYPS HON S&C HON WFS	DIPC LNIPC	Bi-monthly report presented by DIPC to Quality Committee
Criterion 2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	The clinical environment looks and is visibly clean at all times.	See Saving Lives item 11 above.	6 monthly	Assistant Director of Facilities	LNIPC	Bi-monthly report presented by DIPC to Quality Committee
Criterion 3 Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	To reduce the risk of adverse events and antimicrobial resistance.	Continue point prevalence antibiotic audits. Ensure thorough education programme caters for all junior medical/pharmacy staff.	6 monthly	Dr J Andrews	Lead Antimicrobial Pharmacist	Quarterly report to Infection Prevention & Control Committee
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.	To provide timely accurate IPC advice to front line clinical staff.	ICO has an accessible reactive timely Infection Prevention & Control Team.	6 monthly	Dr J Andrews	LNIPC	Bi-monthly report presented by DIPC to Quality
Criterion 5 Ensure prompt identification of people who have or are at	To ensure that IPC advice delivered to front line staff is acted upon in a timely	Integrated IPC and Microbiology team review of relevant patients in a timely manner.	6 monthly	Dr J Andrews	LNIPC	Bi-monthly report presented by

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	manner.					DIPC to Quality Committee
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.	To ensure that patients receive clean safe care at all times.	To maintain and review the delivery of training and implementation on all IPC related matters.	6 monthly	HON MFNS delegating to Clinical Area Managers HON CYPS delegating to Clinical Area Managers HON S&C delegating to Clinical Area Managers HON WFS delegating to Clinical Area Managers	LNIPC	Bi-monthly report presented by DIPC to Quality Committee
Criterion 7 Provide or secure adequate isolation facilities.	Patients who are subject to transmission precautions are ideally isolated in side rooms or cared for in cohort bays with patient with similar conditions in order to reduce transmission of alert organisms or conditions.	See Saving Lives item 7 above.	6 monthly	Director of Facilities HON MFNS delegating to Clinical Area Managers HON CYPS delegating to Clinical Area Managers HON S&C	LNIPC	Bi-monthly report presented by DIPC to Quality Committee

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
				delegating to Clinical Area Managers HON WFS delegating to Clinical Area Managers		
Criterion 8 Secure adequate access to laboratory support as appropriate.	To provide accurate diagnostic information for patients and service users.	Maintain Clinical Pathology Accreditation (CPA).	6 monthly	Dr M Kelsey	DIPC	Bi-monthly report presented by DIPC to Quality Committee
Criterion 9 Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Staff and patients have access to relevant information/education material for education and governance purposes.	Co-ordinated review of all IPC and Microbiology policies. Review of all patient information leaflets.	6 monthly	Director of Nursing and Patient Experience	DIPC LNIPC	Bi-monthly report presented by DIPC to Quality Committee
Criterion 10 Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	Healthcare workers are protected from exposure to infections.	All clinical and non-clinical staff undertake relevant IPC e-learning modules.	6 monthly	Director of Nursing and Patient Experience Medical Director	LNIPC	Bi-monthly report presented by DIPC to Quality Committee

Governance

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
1. A full PIR using post infection review tool is carried out for every case of MRSA bacteraemia and outbreaks or death from post 48 hours cases of *Clostridium difficile.*	The ICO has a robust investigation processes owned by the relevant operational clinical staff that facilitates identification of the root causes of infections, and identifies and implements corresponding actions to reduce reoccurrence. The ICO has adopted a zero tolerance approach to all avoidable healthcare associated infections.	HCAI action plan by IPCT and reviewed regularly. Relevant staff to attend PIR training.	Every other month	LNIPC	LNIPC	Every PIR identifies the likely root causes and actions needed to improve practice Action plan reviewed every other month and presented at IPCC
2. The ICO uses relevant clinical indicators to monitor IPC performance.	The ICO has a dashboard of IPC indicators to monitor performance and share with relevant internal and external staff groups and committee members.	Use dashboard to monitor performance over time at local and corporate levels. Use information to identify where prompt remedial action is needed.	Quarterly	HON MFNS delegating to Clinical Area Managers HON CYPS delegating to Clinical Area Managers HON S&C delegating to Clinical Area Managers HON WFS delegating to Clinical Area Managers	LNIPC	Dashboard is standing agenda item at IPCC Shared at local level with clinical area managers and consultants
3. The ICO record all Infection prevention and control risks on service specific and corporate risk	IPC risks are reviewed on a regular basis.	ICO corporate IPC risks added to the HCAI action plan and reviewed regularly. Divisional IPC risks added to divisional	Quarterly	LNIPC	LNIPC	Open risks discussed at each IPCC

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
registers.		board quarterly reports.				
4. The ICO Infection Prevention and Control action plan is regularly reviewed.	The Infection Prevention and Control Committee agenda and action plan reflect progress made, and identify work still required.	Progress with plan reviewed prior to each IPCC by small implementation group.	Every other month	LNIPC Heads of Nursing all divisions	Dr J Andrews	Monitoring every two months of delivery of actions as per IPC Plan by implementation group presented at IPCC
5. An annual IPC report is written and widely distributed to relevant committees and made publically available.	Staff, ICO board, and public have access to information and assurance of infection prevention and infection control measures implemented by IPCT, and performance against HCAI targets.	DIPC to write annual report.	Annual	Dr J Andrews	Dr J Andrews	Report to be presented at IPCC in July 2016
6. EU Directive on Safety	Compliance with EU Directive on Safety introduced in May 2013.	Health and Safety Lead for the Trust to co-ordinate compliance monitoring from the three directorates.	Quarterly	HON	LNIPC	
7. IPCT member present at all relevant ICO committees.	Committees have up to date IPC advice as required.	IPC membership of all committees is reviewed.	Every other month	LNIPC	LNIPC	Attendance at committees is monitored
8. IPCT provides input at all stages of commissioning services/ re-builds/refurbishments and relocations.	Infection Prevention & Control at forefront of services.	IPCT provide timely input as required.	Ongoing	LNIPC	LNIPC	Problems reviewed at IPCC
9. IPCT provides full assistance to Occupational Health Team to deliver influenza vaccinations to all Whittington Health staff.	Target of 80% of staff vaccinated.	IPCT provided ICNs to assist with vaccinations as and when required.	Annual	Occupational Health Department	Dr J Andrews	Monitored at IPCC

Education, Training & Communication

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
1. Programme of training delivered as per IPC action plan. This includes induction, mandatory training and on request/as required/ bespoke training.	All staff know how to access the IPCT and resources available to them.	Continue rollout of ICO-wide practical competency training programme (BCs, ANTT, and urinary catheterisation). Review and update content of E-learning IPC modules.	Annual	IPCT Learning Development Team	LNIPC	Attendance monitored and reported by ESR Compliance with training is reported via the individual directorates monthly
2. Training is tailored to the needs of the individual and the environment they work in.	Staff feel supported with and are competent with their IPC knowledge and skills.	Programme of training as per Training Needs Analysis - Induction training and mandatory training via E-learning.	Annual	IPCT Learning Development Team	LNIPC	Attendance monitored and reported by ESR
3. Regular updates to Link Staff via e-mail	Link staff are kept up to date and aware of current trends in IPC.	Circulate IPC dashboard and other relevant information on IPC to link staff.	Annual	LNIPC	LNIPC	At master class events link staff report usefulness of communications
4. Planning and deliver National Infection Control Week	Raised awareness in both staff and patients/public around IPC.	Organise promotional stand, campaign, and attend key events to raise awareness of IPC annually to coincide with national event.	Annual	LNIPC	LNIPC	Raised awareness within workforce of IPC
5. Making public information available on IPC for staff and patients	Regular information on a display or newsletter on IPC. Continued raised profile and high awareness amongst workforce around IPC.	Provision of ward boards to display IC information to staff, patients and the public. Provision of regular updates / posters on IPC.	Annual	LNIPC	LNIPC	Feedback from staff and patient surveys demonstrates material is effective
6. IPC Team are contactable for advice 24 hours per day 7 days per week	All staff knows how to access the IPC for advice/support. Timely and relevant advice given and advice logged for records.	Microbiology/Infection Prevention and Control Team contact details are easily available.	Ongoing	Dr J Andrews	DIPC LNIPC Public Health England	Refresh communications to all staff annually or sooner if significant changes

Clinical Leads

Name	Title
Alison Kett	Head of Nursing for Integrated Medicine
Catherine McNally	Matron for Theatres
Deborah Clatworthy	Head of Nursing for Surgery & Cancer
Dr Ahmed Chekairi	Consultant Anaesthetist
Dr Andrew Badacsonyi	Consultant Anaesthetist
Sarah Hayes	Deputy Director of Nursing
Dr Richard Jennings	Medical Director
Dr Sarah Gillis	Consultant Anaesthetist
Dr Tim Blackburn	Consultant Anaesthetist
Fernando Garcia	Urology Nurse Specialist
Jane Preece	Tissue Viability Specialist Nurse
Kerry Wykes/ Fiona Long	Matron for Emergency Department
Lisa Smith	Assistant Director of Nurse Education & Workforce
Maxine Hammond	Lead Nurse Continence
Manjit Roseghini	Head of Nursing for Midwifery
TBC	Head of Nursing for CYPS
Mr Omar Haddo	Orthopaedic Consultant
Mr William Bartlett	Orthopaedic Consultant
Mr Chetan Bhan	General & Colorectal Surgeon
Adrien Cooper	Director of Facilities
Philippa Davies	Director of Nursing & Patient Experience
Steven Packer	Assistant Director of Facilities

Infection Prevention and Control Team

Name	Title
Dr Julie Andrews	Director Infection Prevention and Control (DIPC)
Dr Michael Kelsey	Consultant Microbiologist, Head of Laboratory
Ai-Nee Lim	Antimicrobial Pharmacist
Martin Peache	Acting Lead Nurse Infection Prevention & Control & Deputy DIPC
Gretta O'Toole	Infection Prevention & Control Nurse Specialist
Tracey Groarke	Infection Prevention & Control Nurse Specialist
Raquel Lopez-Parish	Trainee Infection Prevention & Control Nurse Specialist
Yvonne McCarthy	Infection Prevention & Control Service Co-ordinator
Vicki Pantelli	Lead Administrator for Patient Safety and Infection Prevention & Control

Abbreviations

DIPC = Director of Infection Prevention and Control
LNIPC = Lead Nurse Infection Prevention and Control
IPCT = Infection Prevention and Control Team
HON = Head of Nursing
MFNS = Medicine Frailty & Networked Services
IPCC = Infection Prevention and Control Committee
S&C = Surgery & Cancer
WFS = Women & Family Services
CYPS = Children's and Young Person's Services

Whittington Health Infection Prevention & Control: Dashboard Q4 Jan - March 2017

Acute site	Rotated 6 monthly	Rotated 6 monthly	Monthly	Monthly	Monthly	Rolling Audit Programme
Staff responsible for audit	VLT	VLT	IPCT	Clinical area staff	Clinical area staff	Clinical area staff / IPCT
					G > 95%	G > 95%
					A 90% - 94.9%	A 90% - 94.9%
					R < 90%	R < 90%
Medicine, Frailty & Networked services CD C. Murdoch	**Isolation**	**PPE**	**Peripheral lines**	**Catheters**	**Hand Hygiene**	**Environmental**
Bridges Rehab	Not applicable	Not applicable	G	G	A	A
Cavell	Not applicable	Not applicable	G	G	G	G
Cloudesley	G	G	G	G	G	G
Endoscopy	Not applicable	Not applicable	G	Not applicable	G	G
Meyrick	G	G	G	G	G	G
Nightingale	G	G	G	G	G	G
Physiotherapy Inpatients	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
TB service	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Thalassaemia Unit	Not applicable	Not applicable	Not applicable	Not applicable	G	A
Montuschi	G	G	G	G	G	G
Victoria	R	R	G	G	G	A
Emergency & Urgent care CD R. Landau	**Isolation**	**PPE**	**Peripheral lines**	**Catheters**	**Hand Hygiene**	**Environmental**
Ambulatory care and community Virtual ward	Not applicable	Not applicable	G	Not applicable	G	G
CDU	Not applicable	Not applicable	G	Not applicable	R 80%	G
Emergency Department	Not applicable	Not applicable	G	Not applicable	A	G
Mary Seacole N	G	G	G	G	G	G
Mary Seacole S	G	G	G	G	G	G
Urgent care centre	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Surgery and Cancer CD N. Harper	**Isolation**	**PPE**	**Peripheral lines**	**Catheters**	**Hand Hygiene**	**Environmental**
Clinic 1a Pre Assessment	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Coyle	G	G	G	G	G	A
Critical Care unit	Not applicable	Not applicable	G	G	G	G
Day Treatment Centre	Not applicable	Not applicable	G	Not applicable	G	A
Mercers	Not applicable	Not applicable	G	G	G	G

Theatres Main	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Thorogood	Not applicable	Not applicable	G	G	G	G
Chemotherapy	Not applicable	Not applicable	G	Not applicable	G	G
Medical Physics	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Medical Devices	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Patient Access, Prevention & Planned Care CD Sarah Hayes, HoN Dorian Cole	**Isolation**	**PPE**	**Peripheral lines**	**Catheters**	**Hand Hygiene**	**Environmental**
Physiotherapy Outpatients	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	R 70%
Access centre	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Clinic 3a EEG / ECG	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Clinic 3b Dermatology	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Clinic 3d	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Clinic 1b Orthopaedics	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Clinic 3c Ophthalmology	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Clinic 4a General Surgery	Not applicable	Not applicable	Not applicable	Not applicable	G	A
Clinic 4b Urology	Not applicable	Not applicable	Not applicable	Not applicable	G	A
Children's Services CD N Patel	**Isolation**	**PPE**	**Peripheral lines**	**Catheters**	**Hand Hygiene**	**Environmental**
IFOR	G	A	G	G	G	G
NICU	G	G	G	Not applicable	G	G
OPD 4D	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Paeds Ambulatory care	Not applicable	Not applicable	Not applicable	Not applicable	A	Not applicable
Paeds ED	Not applicable	Not applicable	G	Not applicable	G	G
SCBU	G	G	Not applicable	Not applicable	G	G
Roses day care	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Women's Health Services CD C. Biswas	**Isolation**	**PPE**	**Peripheral lines**	**Catheters**	**Hand Hygiene**	**Environmental**
Antenatal Clinic	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Betty Mansell Women Diagnostic OPD	Not applicable	Not applicable	G	Not applicable	G	G
Birth Centre	Not applicable	Not applicable	G	G	G	G
Cearns	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Cellier	G	G	G	G	G	G
Labour	Not applicable	Not applicable	G	G	G	G
Murray	G	G	G	G	G	G
OPD 4C	Not applicable	Not applicable	Not applicable	Not applicable	G	G
Clinical support services CD H Taylor	**Isolation**	**PPE**	**Peripheral lines**	**Catheters**	**Hand Hygiene**	**Environmental**

Radiology / imaging	Not applicable	Not applicable	G	Not applicable	G	G
Pathology	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Phlebotomy	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G
Pharmacy	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Mortuary	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G

Community services / premises Haringey / Islington	**Environment (G>95%)**	**Hand Hygiene**	**PPE**
Audiology Clinic Block K St Anns	R 78%	G	G
Bounds Green Health Centre	G	G	G
Broad Water Farm Community Health Centre	G	G	G
Child Development Centre St Ann's	A	G	G
Crouch End HC Middle Ln	Not applicable	G	G
Edward Drive Unit 1	R 89%	G	G
Hornsey Central Health Centre	G	G	G
Lansdowne Road Health centre PPP	G	G	G
Lordship Lane Clinic	G	G	G
MSK-Physio St Anns PPP	R 84%	G	G
Nutrition & Dietetics St Anns PPP	Not applicable	G	G
Partnership Primary Care Centre	A	G	G
PAU Gr Flr St Anns	Not applicable	G	G
Sexual Health Services St Ann's	A	G	G
Simmons House	G	G	G
Stroud Green Clinic	G	G	G
Stuart Crescent Health Centre	G	G	G
The Laurels Healthy Living Centre	A	G	G
Tynemouth Road Health Centre	G	G	G
Wheelchairs Unit St Anns	G	G	G
Bingfield Primary Care Centre	G	G	G
Community Rehabilitation Team	G	G	G
Finsbury Health Centre	G	G	G
Goodinge Health Centre	G	G	G
Highbury Grange Health Centre	A	G	G
Holloway Health Centre	G	G	G
Hornsey Rise Health Centre	G	G	G

Overall scores	**259/259 100%**
Red	**3%**
Amber	**6%**
Green	**91%**

***not performed**

Michael Palin Health Centre	**G**	**G**	**G**
River Place Health Centre	**G**	**G**	**G**
The Northern Health Centre	**A**	**G**	**G**
Dental Belsize Priory NW6	Not applicable	**G**	**G**
Dental Clinic Evergreen N9	Not applicable	**G**	**G**
Dental Clinic St Anns N15	Not applicable	**G**	**G**
Dental Crowndale NW1	Not applicable	**G**	**G**
Dental Forest Rd N9	Not applicable	**G**	**G**