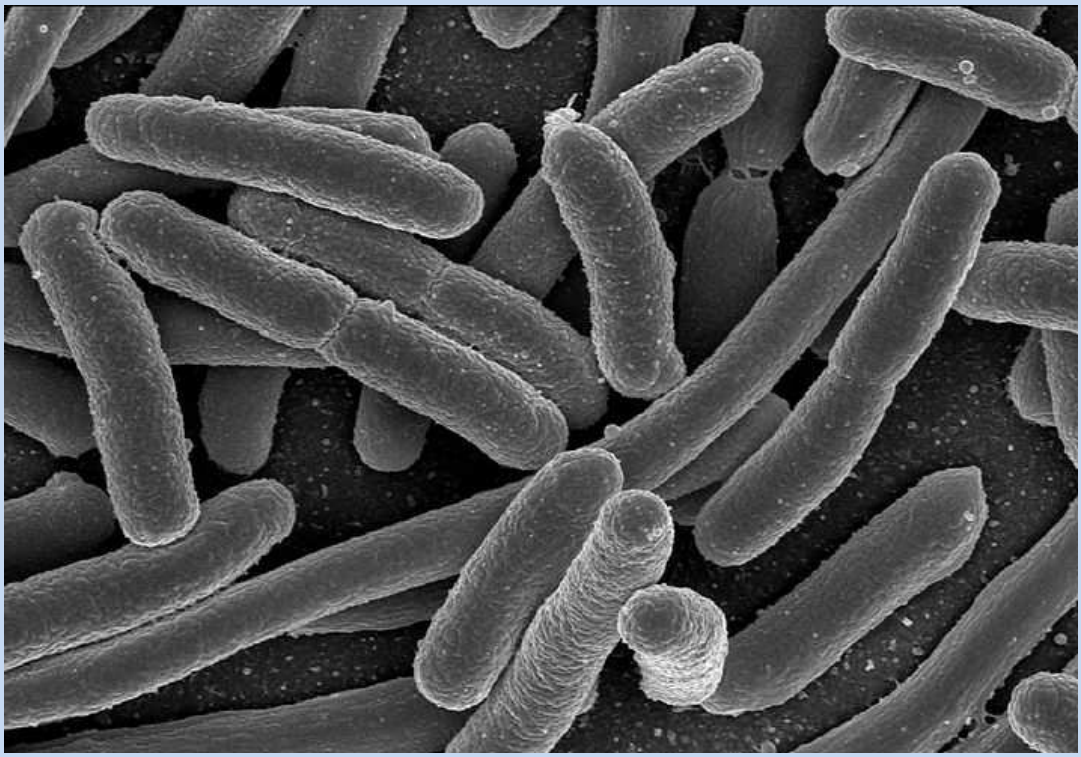
NHS Haringey

Infection Prevention and Control

Annual Report

1st April 2010- 31st March 2011



Kris Khambhaita

Lead Nurse Infection Prevention & Control
Decontamination & Waste Lead

June 2011

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Executive summary

The Infection Control Service (ICS) has been focusing on the investigation, prevention, surveillance and control of infection during this reporting period enabling staff to provide care in a safe environment. This has involved working closely with clinical governance and risk management team, and building strong co-operative links with nearby acute Trusts and PCTs in order to meet national targets.

ICS is committed to improving health care services by promoting excellence in the practice of infection prevention and control. The team strives to promote these principles through the reactive and proactive elements of the annual infection control programme.

The contribution made by the team continues to deliver quality improvements in all aspects of service provision. Examples of quality improvement initiatives that the ICS has been involved / taken a lead on include refurbishment of the clinical environments that services are delivered in, providing supervision for clinical staff on infection prevention issues pertaining to their area of work, shadowing staff groups to gain a better understanding into the unique challenges faced in the community while delivering care closer to the patients home or within the patients own home, and maintaining the excellent clinical standards instituted and put in place during previous years.

NHS Haringey is able to demonstrate compliance with the Code of Practice for the Prevention and Control of Health Care Associated Infections.

A total 17 specimens out of 217 tested were reported positive for MRSA colonisation within the reporting period, all these patients were treated. None of these were acquired on Chestnut Ward.

Zero MRSA bacteraemia have been detected on Chestnut Ward within this reporting period.

There have been zero *C. difficile* positive stool specimens over the last 12 months, this data is a very encouraging and is a direct result of continuing to ensure the C.difficile action plan implemented in the previous year and its recommendations have been maintained in practice.

There are no outbreaks to report for this reporting period either in the inpatient areas or within the community, similarly there are no significant incidents to report this reporting period which relate to infection control.

Infection Control training is provided throughout NHS Haringey and its independent contractors are invited to also attend**.** A total of 816 staff have received face to face training on a variety of different topics relating to infection prevention and control.

Audit aimed at assessing the work and clinical environment from an infection control perspective forms part of the proactive infection control programme in each area of the PCT. Annual audits are conducted within all provider services, and issues are highlighted to individual services via a detailed report incorporating recommendations to reach current best practice.

The Infection Control Team continues to provide specialist advice in relation to the decontamination of equipment. All general dental practices still use Bench Top Sterilisers, and will continue to do so. The release of the HTM 01-05 document from the Department of Health (DH) provided further comprehensive guidance on decontamination best

practice in the general dental practice (GDP) setting. GDP's who sought advice and support to meet with recommendations contained within HTM 01-05 in order to register with the CQC in 2011 were assisted fully.

The Infection Control Team has continued to include all GP practices in the full range of reactive and proactive infection control initiatives facilitated by the Infection Control Service. Unfortunately uptake has, as in previous years been very limited from the collaborative and individual GP practices. Audits during this reporting period have not been undertaken by the primary care directorate and ICS has no capacity to undertake these.

The trust fully participated in the annual PEAT inspections, and signed up to the Essential Steps to Safe Clean Care sixth consecutive year, the over-all score achieved in 2009 was 97%, and this was maintained throughout this reporting period. Work continues to achieve progress to remedy gaps identified and this is monitored by the infection prevention and control committee.

The Infection Control Service, working with clinical and environmental services, has ensured that NHS Haringey (NHSH) has been compliant with the Health and Social Care Act and therefore able to register with the Care Quality Commission (CQC) without restrictions.

1. Introduction

1.1 This annual report reflects the activities, substantial achievements and challenges faced by the ICS in the delivery of the infection control programme for the period 1st April 2010 to 31st March 2011.

1.2 ICS provides a reactive and proactive level of service to all provider side services within NHSH. The lead nurse also works with commissioning teams to ensure that infection control advice has been available on request.

1.2.1 The prevention and control of healthcare-associated infection is currently a top priority for the National Health Service (NHS). NHSH, and its Board, has obligations as both a commissioner and provider of healthcare services to ensure that, as far as reasonably practicable, patients are protected from the risks of healthcare-associated infection, as detailed in the Health and Social Care Act 2008 Code of Practice for the Prevention and Control of Healthcare-Associated Infection.

1.3 ICS is committed to improving health care services by promoting excellence in the practice of infection prevention and control. The team strives to promote these principles through the reactive and proactive elements of the annual infection control programme.

1.4 The key components of the Infection Control programme are:

- Specialist advice
- Policy and clinical protocol / care bundle guidance development and review
- Environmental audit of provider services, duty of care visits to commissioned services
- Health Care Acquired Infection (HCAI) surveillance within services where there is directly provided care / residential clients and in- patients
- Education delivery to all staff employed by the PCT
- Outbreak prevention and control
- Investigation of incidents related to infection control and completion of root cause analysis (RCA) for pre 48 hour MRSA bacteraemias and C.difficile detected.

2. Infection Control Service

2.1 Team structure

2.1.1 During this reporting period the Infection Control team has remained the same as the previous year. There were additional funds made available through resource from Primary Care Commissioning (PCC) and Provider Side restructure of the practice development team to recruit into a 1.0 WTE band 6 infection control nurse. Due to withdrawal of funding from PCC it has not been possible to recruit into this post. The remaining resource was used to create a band 5 assistant post which was recruited into.

2.2 Staffing Resource

2.2.1 The available resource during the reporting period is illustrated in the table below:

Post	WTE	Filled/Vacant
Band 8B	1.0 WTE	Filled
Band 4 (non clinical)	1.0 WTE	Permanent staff member left trust 04.10. Filled with bank staff 1.4.10 – 31.12.10 This post was then deleted as part of the organisational restructure
Band 5 clinical	1.0 WTE	Filled 01.07.10 until 04.11

2.2.2 It is acknowledged that effective resourcing of infection control is critical and has a significant impact on the quality of patient/client care (Chief Medical Officer, 2003; NICE, 2003; Comptroller and Auditor General, 2000 Plowman et al 2000).

A report from the National Audit Office 'Improving Patients Care by Reducing the Risk of Hospital Acquired Infection' was published in July 2004. This included a range of recommendations for the DH, the Healthcare Commission, and NHS Trusts, including the recommendations that NHS Trusts 'review infection control team staffing and other resources, and evaluate the adequacy of resources compared with the demands on the team' (pg 7).

2.3 Service Delivery

2.3.1 The Infection Control programme continues to be delivered on a multiple project basis whereby the lead nurse delivers on a number of projects concurrently in addition to meeting local and government targets. A copy of the service objectives for this reporting period can be found at appendix 1; these have been fully met during the reporting period despite limited staffing. Service objectives for 2011/12 agreed by the infection prevention and control committee are located at appendix 2.

2.3.2 Infection control information pages on the internet and intranet have been regularly revised to always ensure the most accurate and correct information is displayed.

2.3.3 Leaflets have all been reviewed to provide information for staff and patients and have been placed on the internet so as to make them accessible. Leaflets have also been re- printed and re- distributed to all community areas during this reporting period. This has again assisted in raising the profile of infection prevention within the community. The range of information available has been extended to include other infections than just MRSA and C.difficile which most members of public are aware of through the media. Infections featured in the media have been noted and leaflets for staff and patients in response to this have been developed.

2.3.4 To further enhance the work of building community knowledge around infection prevention ICS has continued to work in partnership with local schools in Haringey to

deliver hand hygiene training for children and parents, for interpreters working with our patients/clients, and carers in the community who regularly look after long term patients. This has also been extended to staff working in organisations where SLA's are in place for service delivery and these staff are working in Haringey but not directly contacted, and on call managers.

2.3.5 Infection Control team have contributed to all requests for IC information toward trust policies that were being reviewed. Part of the service objectives for 2011 will be to review and update the existing IC policies in collaboration with HPA, acute hospitals and other providers with close liaison into our services.

2.3.6 ICS has also fully met all Freedom of Information requests and requests placed from the public via PALS department within trust timescales for response. The numbers of requests during this reporting period have further decreased from that of previous which is encouraging evidence that the partnership working detailed above is making a positive impact.

2.4 Director of Infection Prevention & Control.

2.4.1 In accordance with the CMO's 'Winning Ways' (2003) document on the provision of actions necessary to reduces HCAI's, each organisation has a designated Director of Infection, Prevention and Control (DIPC). NHSH Arrangements are as follows:

Susan Tokley – Associate Director Quality Assurance/Executive Nurse

2.4.2 The role of the DIPC is defined in Winning *Ways: Working Together to Reduce Healthcare Associated Infections* (HCAI), action area six:

- Oversee local control of infection policies and their implementation
- Be responsible for the Infection Control team within the health care organisation.
- Report directly to the Chief Executive and the board and not through any other officer.
- Produce an annual report on the state of health care associated infection in the organisation for which he/she is responsible and release it publicly.

This report is intended to address this responsibility.

2.5 Community Infection Control Doctor (ICD)

2.5.1 The Lead Nurse takes responsibility for prescribing care pathways, treatment pathways and other infection prevention and control aspects of clinical care in any given patient receiving care within NHSH. Lead Nurse also actions any request for advice on refurbishments and new builds, which in other organisations is included within ICD role. Advice and clarification is occasionally sought from microbiology doctors based at North Middlesex University Hospital Trust (NMUHT) following positive results regards sensitivities and resistance of organisms detected.

2.5.2 Sessional Infection Control Doctor Advice has been available through the common services SLA with NMUHT, efforts have been made to fully utilise this within the

reporting period to support ICS with microbiology and policy based advice where required, however due to limited capacity within NMUHT this has been delivered in a very limited manner. This SLA will not be renewed in 2011/12.

2.6 Governance

2.6.1 Infection Control Quality and Performance Standards

- The Infection Control Service operates 08.30 -18.00 hours Monday – Friday (excluding Bank Holidays).

- Routine telephone calls and enquiries are answered within the following parameters:

Monday – Friday	24 hrs
Weekends	48 hrs
Bank Holidays	72-96 hours (depending on length of break)

- Urgent calls are dealt with as soon as possible, and the Lead Nurse carries a mobile phone to facilitate this. Out of hours, the senior on-call rota handles urgent calls, and the individual may liaise with the health protection agency (HPA) as and when required. An on-call hand book is available which contains all the necessary information required to manage issues over night and at weekends until normal service resumes. Training has been provided to all those that cover the rota to enhance and update exiting knowledge of infection prevention and control measures out of hours.

- An outbreak pack containing all the interim advice, charts and other useful documentation developed and distributed in the previous reporting period has been reviewed and updated to assist should there be an outbreak reported out of hours. This has been ratified by the Infection Prevention and Control Committee and approved by the Health Protection Unit and Public Health Consultant at NHSH. ICS has contributed towards training on-call managers on dealing with and responding to infection prevention and control matters utilising the pack.

- Managers are sent a written report following site visits and/or audits within 30 working days of the visit; whenever this is not possible due to unexpected emergencies they are notified of the delay by email and provided with interim summary information until a full report can be made available.

- Baseline audits feedback is in the form of verbal feedback at the time of the visit and followed by an email with any other relevant information.

- Incidents/accidents with infection control implications are investigated within 48 hours of receipt of information.

- Root cause analyses (RCA's) are commenced with 5 working days of notification of positive HCAI with in NHSH areas or a pre-48 hour bacteraemia detected within the local acute sector.

- RCA's provide useful insight into the areas where improvements to clinical practice and existing protocols are required and any shortfalls in standards of care, however they require a considerable amount of time invested into them in order to complete a thorough investigation, capture the lessons to be learnt, and produce a summary report. Notification processes were strengthened with the acute sector within this reporting period and therefore the PCT were alerted to a large number of cases than in previous years. All RCA's where Community Health Services (CHS) were involved had been completed. Due to limited capacity cases where CHS are not involved, RCA's reports have not been formulated, but findings have been reported to the infection prevention and control committee and shared with commissioners so for discussion during contract reviews.

2.6.2 The Infection Control Team has fully complied with all the above standards during this reporting period.

2.6.3 Quality of care and continued improvement in that quality, along with value for money has become a focus of today's healthcare agenda. ICS continues to work closely within the clinical governance framework of the organisation. The contribution made by the team continues to deliver quality improvements in all aspects of service provision. Examples of quality improvement initiatives that ICS has been involved / taken a lead on include refurbishment of the clinical environments that services are delivered in, providing supervision for clinical staff on infection prevention issues pertaining to their area of work, shadowing staff groups to gain a better understanding into the unique challenges faced in the community while delivering care closer to the patients home or within the patients own home. This allows the provision of useful expert advice to overcome barriers and constraints taking into account these challenges that exist. Additionally support has been provided to services where required to identify ways of working that further reduce cross contamination so that the emphasis remains on infection prevention wherever possible.

2.7 NHSLA and Care Quality Commission Quality Framework

2.7.1 Infection Control is one of the standards within Standards for Better Health. The Infection Control Service continues to be actively involved in undertaking assessments, developing action plans and feeding back information pertaining to Infection Control Standards (C4a, C4c, and C21). During this reporting period ICS has assisted all provider services service managers with developing templates of evidence that demonstrated compliance. This has been in collaboration with the clinical governance team.

2.7.2 The Infection Control Service actively contributes to improving compliance in other areas related to infection prevention and control; decontamination, waste management, minor surgery, product procurement and medical devices management, this is achieved through attendance at working groups, specific training to staff via education programme, involvement in policy development and audit.

2.7.3 We are very pleased to note that work completed to date continues to have a positive and tangible impact on the infection control programme delivered and overall improvements have been seen in relation to compliance with these standards across the trust, however it must be recognised that much work still remains to be done particularly with the independent contractors.

2.7.4 The trust applied for NHSLA level 1, and underwent inspection during the last quarter of 2009 NHSH was awarded a level 1 overall. The infection control elements of the standards expected were reported as fully met when inspected. During this reporting period the provider side alliance (Islington and Haringey providers) underwent NHSLA level 1 re-assessment. The evidence for infection control was scrutinised and reported that it exceeded level 1, meeting almost all of level 2 expectations.

2.8 Care Quality Commission (CQC) Health and Social Care Act Compliance

2.8.1 NHSH Community Health Services is registered with the CQC with no restrictive conditions. The trust have undertaken a self assessment against the Hygiene Code and identified areas for further work, progress with this is monitored at the infection prevention and control committee meetings.

2.8.2 The CQC conducted an unannounced inspection of Chestnut Ward within Greentrees Unit on 28th November 2010. The report following the inspection usefully identified some areas to strengthen practice in general, and ICS received a very positive review overall. A copy of the findings against outcome 8 can be found at appendix 3.

2.8.3 The Code of Practice for the Prevention and Control of Health Care Associated Infections (The Health Act 2006) was launched in October 2006. Every NHS organisation implemented this Code from April 2007 and NHSH are able to demonstrate compliance to this. The Code was revised in 2008 and is now The Health and Social Care Act 2008. From 2011/12 the newly revised edition of the code of practice will be in place with additional requirements.

2.9 Infection Control Committee

2.9.1 Established in May 2003, in accordance with the Controls Assurance Standard for Infection Control (NHS Executive, 2000), the Committee has representatives from across the organisation, the local Health Protection Team and the acute trusts. The committee continues to meet four times a year; terms of reference and committee membership are at appendix 4.

2.9.2 The reporting mechanism of the proceedings of the committee have been clarified with each organisation in this reporting period, i.e. acute trusts & Great Ormond Street Hospital, and NHSH commissioning.

2.10 Reporting line to the Trust Board

2.10.1 The DIPC meets with the Chief Executive to discuss progress and any issues pertaining to infection prevention and control. The DIPC sits on the NHSH board and takes forward any relevant developments.

2.10.2 Quarterly surveillance reports detailing the surveillance figures from Chestnut Ward activity are sent to clinical governance team, Health Safety and Risk Committee, Infection Control Committee and provider services management team. Copies of these reports are available from the Infection Control Team. ICS has attended and fully contributed to the Productive Ward series implementation and subsequent Releasing Time to Care meetings, where infection prevention and control has been included

within stock management and handover modules. ICS provided financial and advisory support within this work.

3. Surveillance of Healthcare Associated Infections (HCAI's)

3.1 Surveillance

3.1.1 There has been a significant amount of continued effort invested in using and maintaining the surveillance systems set in 2007 for monitoring HCAI's during this reporting period. These systems assist in the identification of outbreaks/ and infection trends at an early stage so that immediate action can be taken to identify and control the source, identify problem areas, set priorities for infection control activity and meet national standards with an aim to reducing rates of HCAI's in the PCT. It also enables us to report thoroughly and accurately on the state of healthcare associated infections within the in-patient rehabilitation unit.

3.1.2 An electronic database has been maintained that captures all the microbiological activity within the inpatient area. Systems have been strengthened so that there is any one time access by 4 key individuals to the data and if electronic data is lost there are back up versions electronically and in paper format that can be drawn upon. Monthly reports are provided to the ward for the public notice board, and reported at the Releasing Time to Care meetings.

3.1.3 As with previous years records have been kept of all positive community MRSA and *C. difficile* specimens in a GP setting tested at North Middlesex University Hospital Trust microbiology laboratory, this data has been passed onto the commissioners for analysis and feedback into quality meetings with the acute sector. It has not been possible to obtain data from The Whittington Hospital and Barnet & Chase Farm Hospital where Haringey GP's also send specimens for analysis despite requesting this. While this data is limited as we often don't screen or routinely test people, it does provide a starting point from which we can begin to monitor rates in the wider community and form a baseline. HPA have continued to provide monthly infection reports of notifiable diseases reported by residents and medical practitioners of Haringey. The reports show that infection rates remain within average or below average.

3.1.4 During this reporting period some joint working with the acute sector has been explored and commenced around prevention and control of HCAI. Meetings were held and joint action plans for C.difficile and MRSA reduction formulated. Additionally management of chronic wounds in the community to prevent the development of Cellulitis requiring hospital attendance has been completed in collaboration and with liaison from Tissue Viability team.

3.1.5 Single assessment and referral forms used have been reviewed to include infection status, and NMUHT have been undertaking discharge screening for MRSA prior to transferring patients to our care, this has allowed us to better plan patients placement and care while we rehabilitate them.

3.1.6 Reduction of HCAI's requires commitment from all clinical teams, infection control team and managers. It is everyone's responsibility. The link practitioner's for infection control have been involved in assisting with capturing and collating data on the ward

on request.

3.1.7 ICS has worked closely with continence; bowel and bladder team to look at uniform use of catheter products across the community and acute hospitals; thus facilitating education and training, consistency of product realising the cost savings but also allowing ease of use for the multiple staff involved in a patients care.

3.1.8 The recommendations of the high impact actions for nursing have been looked at and those relating to infection prevention and control implemented.

3.1.9 The infection control surveillance system focuses on the following issues:

- MRSA colonisation (in-patients and community)
- MRSA bacteraemia (in-patients and community)
- MRSA admission screening (in-patients)
- *Clostridium difficile* (in-patients and community)
- *E.Coli* (in-patients)
- Alert organism surveillance (in-patients and community)
- UTIs (in-patients)

3.1.10 In-patient area surveillance results are fed back to clinical and managerial staff so that specific action is planned as necessary on a quarterly basis in the form of quarterly surveillance reports. These are also taken to the provider side management team amongst other meetings so that prevention and reduction strategies can be discussed.

3.1.11 In-patient area microbiology results are fed back to clinical and managerial staff so that specific action is planned as necessary to each patient within the set parameters; within the hour – within 2 working days during normal working hours. It is dependant on staff and medical notes being available at the time of visiting the in-patient area to communicate this information.

3.1.12 Due to limited data available from the laboratories who undertake specimen testing for Haringey, small numbers of community results currently, and staffing limited resource it has been impossible to complete a similar analysis and report back on the community data. The data has shown that there are between 0 – 2 patients a month reporting to GP who positively test for MRSA, and approximately 1-2 a month who are symptomatic and subsequently test positive for *C. difficile*. This is similar to the last reporting period; therefore it is encouraging to note that overall rates are not rising.

3.1.13 The Infection Control Team takes part in the North Central London Control of Infection Network group (COIN). The purpose of which is to work towards a cohesive response to both national and local initiatives aimed at reducing the incidence and risks associated with healthcare associated infection.

3.1.14 The Infection Control Team has also taken an active part in the North Central London cross organisation working and learning (COWL) initiative for infection control teams

funded by NHS London.

3.1.15 ICS has worked closely with Tissue Viability nurse at NHSH and DIPC at NMUHT to implement setting up community clinics to improve access for patients outside of hospital who have a wound. The review of Guidelines for the Management of Cellulitis was also contributed to, as well as the review of antibiotic guidance.

3.2 MRSA colonisation and Admission screening results

3.2.1 MRSA colonisation reflects the carriage of MRSA on the body, without clinical signs of infection. The numbers of patients' colonised in-patient areas are outlined below.

3.2.2 MRSA screening and treatment policy exists, a target of 100% of admissions into Chestnut ward should be swabbed on admission for MRSA colonisation as outlined in the Department of Health screening guidelines is in place. Audits show that 99 - 100% screening was reached during this reporting period.

3.2.3 In-Patients

The Greentrees Rehabilitation Unit is an in-patient facility, which provides dedicated in- patient rehabilitation care for adults in Haringey. There is 1 ward (32 beds) Chestnut Ward.

There is also one further inpatient area: Edwards Drive Unit 1 and unit 2

Both of these are in-patient facilities in which patients with learning difficulties are cared for.

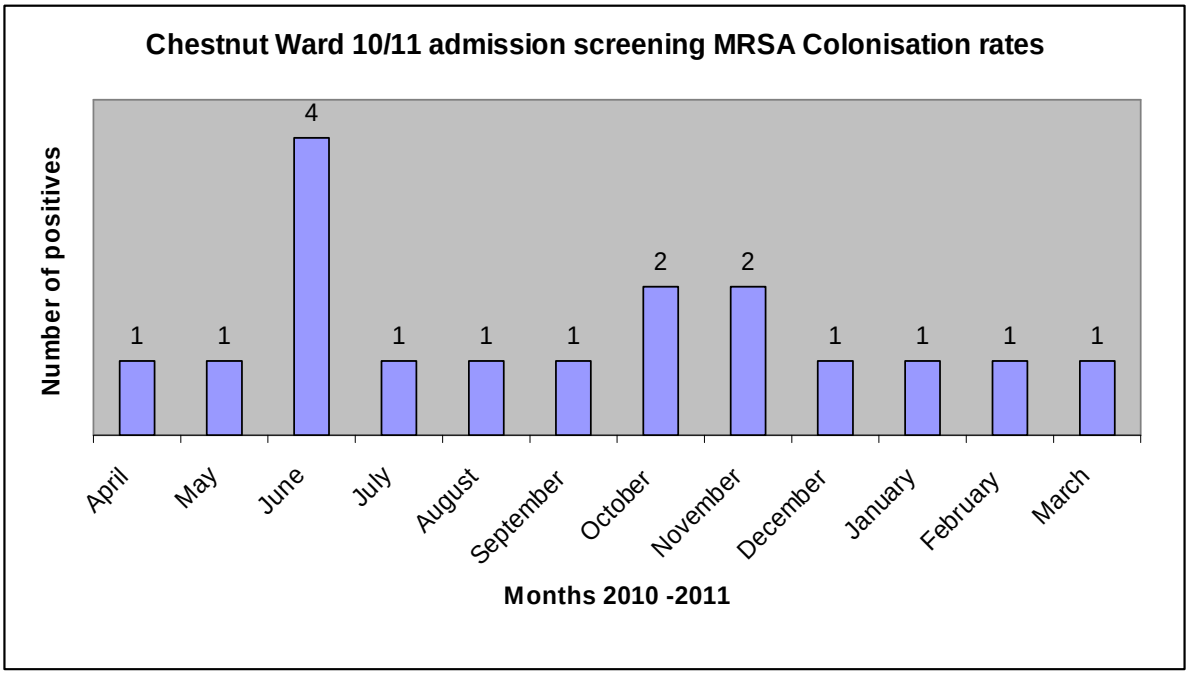

Figure 1 Graph showing numbers of patients with MRSA colonisation by month in the reporting period.

3.2.4 Figure 1 shows rates of patients colonised with MRSA during the time scales indicated. This data is formed from screening all admissions into the ward within

48 hours of transfer and anyone who is symptomatic. The Infection Control Team has continually at regular intervals reviewed and compared the colonisation rates to the previous reporting period so as to gain a better understanding of the routes of MRSA acquisition and transmission.

3.2.5 The data shows that a total 17 specimens were reported positive for MRSA colonisation within the reporting period, all these patients were treated. None of these were as a result of acquisition of MRSA while on the ward. In comparison figure 2 below shows the data for the previous reporting period. It is noted that there were a total 44 positives over 12 months. There is a significant reduction from the current and last reporting period despite bed occupancy remaining full at all times and length of stay reducing.

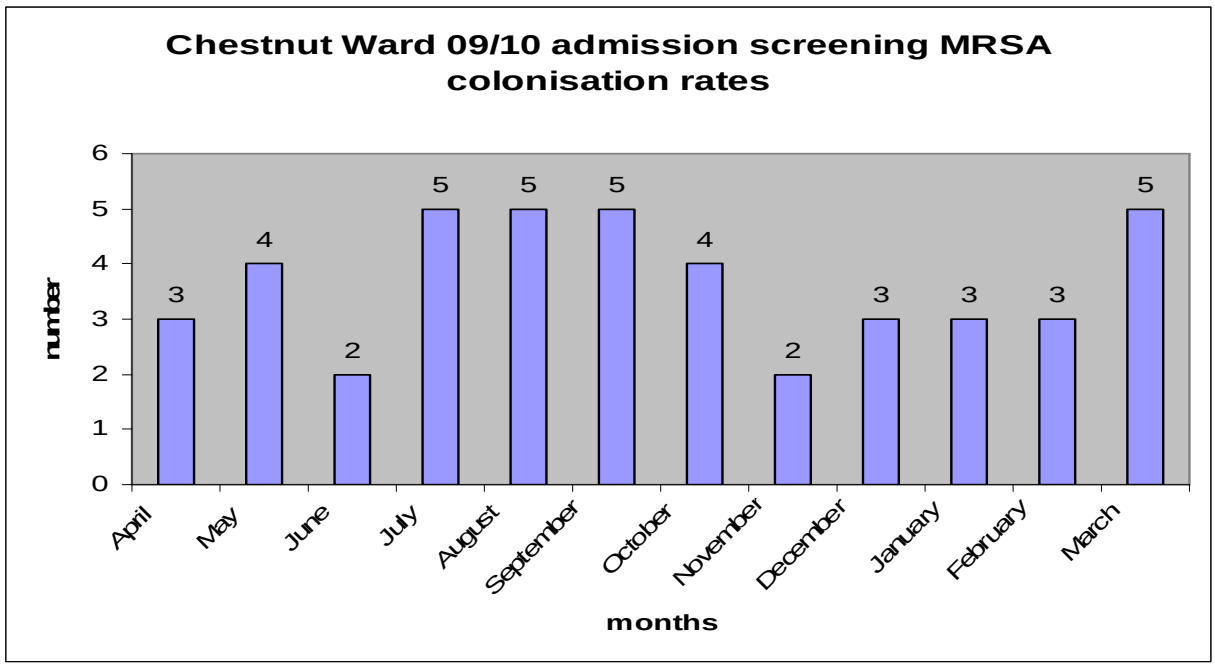

Figure 2 Graph showing numbers of patients MRSA colonisation positive by month in the previous reporting period.

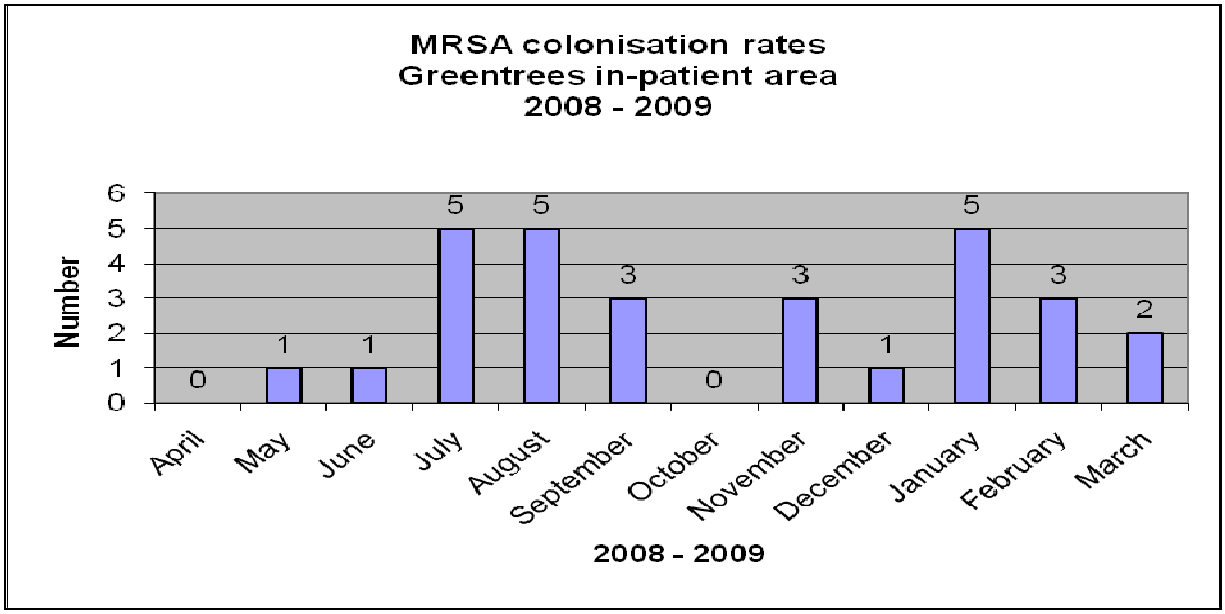

Figure 3 Graph showing comparison numbers of patients MRSA colonisation positive by month in the previous years

3.2.6 MRSA admission screening allows us to determine the prevalence of MRSA colonisation amongst patients admitted to our in-patient areas and to compare this to other hospitals, wards and by geographical areas.

3.2.7 These results allow appropriate management strategies so the risk of cross infection is reduced. Monitoring of MRSA admission sources has enabled the Infection Control Team to work in partnership with the acute sector Infection Control Teams so that there is good communication between staff when patients are transferred and any problems are identified and acted upon at an early stage.

3.2.8 The Community is defined as all other services in the PCT, which the Infection Control Team provides a service to. Management of MRSA infection and/or colonisation in the community continues to be assessed on an individual basis and in partnership with the client/patient and carer, taking into account for example, planned surgical intervention or planned hospital admission. This approach has been agreed with the Health Protection Agency Team, and complies with current national evidence based practice.

3.2.9 The work undertaken by ICS continues to demonstrate year on year reduction of MRSA colonisation detected, thus saving money on treatment and ensuring the length of stay is not impacted by HCAI.

3.3 MRSA bacteraemia rates

3.3.1 MRSA bacteraemia reflects the burden of serious (bloodstream) infection caused by and associated with MRSA infections.

3.3.2 Acute Trusts in England have been involved in the mandatory surveillance of MRSA bacteraemia since April 2001.

3.3.3 During this reporting period there has been zero MRSA bacteraemia detected in an in-patient in Chestnut Ward. There has only been 1 recorded bacteraemia for the past 4 years.

3.4 *Clostridium difficile* Rates

3.4.1 When *Clostridium difficile* is transmitted to vulnerable patients, often older people who have been treated with antibiotics, it produces symptoms of varying severity, from diarrhoea to severe inflammation of the bowel. This may cause considerable morbidity and mortality among older people and imposes a substantial financial burden on healthcare services, including prolonged hospital stay, requirements for isolation, more intensive nursing, extra treatment, laboratory and infection control costs.

3.4.2 The Chief Medical Officer and Chief Nursing Officers letter (December 2005) outlined actions required of Directors of Infection Prevention and Control, in order to minimise the risk of infection caused by *Clostridium difficile*

3.4.3 NHSH has an individualised action plan for the management of *Clostridium difficile,* which outlines lead responsibilities and actions to be taken to allow full compliance with these requirements and so that the risk of cross infection is minimised. ICS has reviewed the previously produced *Clostridium difficile* leaflets for both staff and patients/visitors. These leaflets are widely available across the trust, are available on the website, and in areas where independent contractors deliver services.

3.4.4 Training has been provided on *C. difficile* so as to further raise the knowledge of frontline staff on the appropriate early detection and prompt management of any patient suspected to have *C. difficile*.

3.4.5 There have been zero cases of *C.difficile* detected in patients stool samples tested during this reporting period. This is a significant achievement and it is hoped this can be continued within the next 12 months. In comparison figure 4 below shows the trend for the previous year.

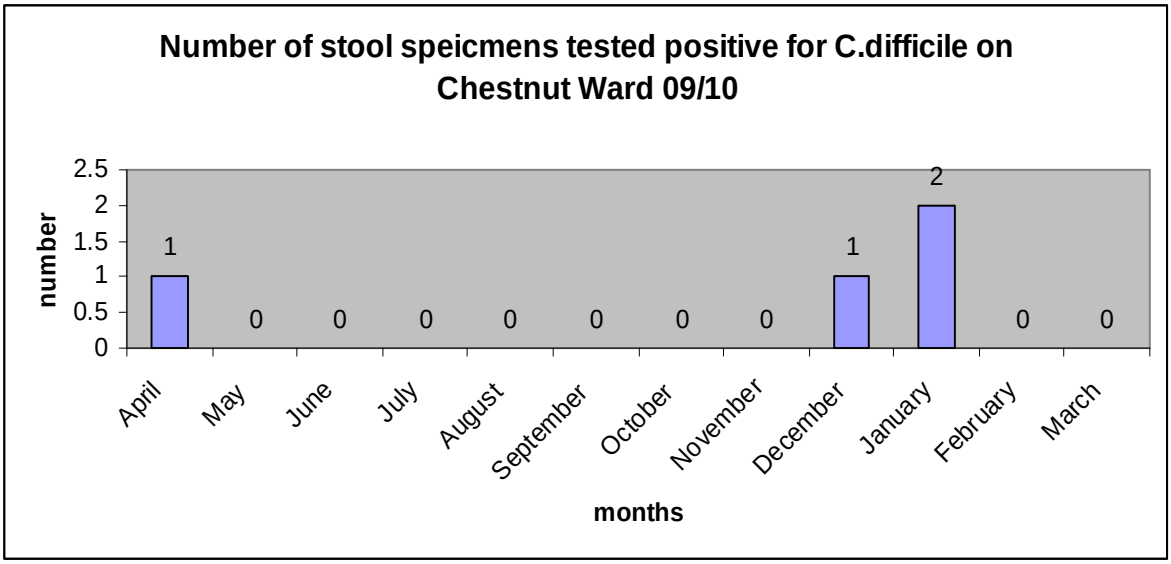

Figure 4 Graph showing numbers of patients who tested positive for *C. difficile* (stool sample) while in-patient at Chestnut Ward, by month in the previous reporting period.

3.4.6 This trend will continue to be monitored by ICS and partnership working with the Infection Control Team at NMUHT will be maintained. There will be continued monitoring of the number of patients transferred with active symptoms of *Clostridium difficile* as this represents not only a financial burden (antibiotic usage for *C. diff treatment*, additional staff time caring for patients in isolation, use of protective clothing etc) but also higher mortality rates.

3.5 Alert Organism Surveillance

3.5.1 The Community Infection Control Service continues to complete alert organism surveillance in community and in-patient areas. This involves continuous monitoring of the incidence of healthcare associated infections so that outbreaks are identified early and control measures are implemented promptly.

3.5.2 The Infection Control Team continue to support and advise healthcare professionals involved in the care of patients/clients with communicable diseases and/or colonised/infected with resistant organisms.

3.5.3 The documentation forms utilised for recording MRSA decolonisation, care plans and treatment pathways have all been revised during this reporting period in line with current best practice.

3.5.4 An integrated care pathway to capture information on multi professional input into the management of MRSA colonisation was developed and circulated, the outcome of the review panel was that it would not further aid the care of patients on the ward at this time and therefore the use of ICP should be delayed until the next reporting period when the service maybe different as a result of working in an integrated care organisation. This has been added to the service objectives for exploring in 2011/12.

4. Outbreaks and Incident Management

4.1 Outbreaks

4.1.1 The Infection Control Team continues to react to outbreaks and incidents of infections and develop appropriate control strategies in collaboration with clinical staff and management across the trust, not just in the inpatient areas.

4.1.2 There are no outbreaks to report for this reporting period either in the inpatient areas or within the community.

4.2 Incidents

4.2.1 There are no significant incidents to report this reporting period.

4.2.4 The community clinics of Stuart Crescent, Bounds Green, Tynemouth Road, Crouch End, and Audiology, Sexual Health, the Wheelchair Service all on site at St. Ann's Hospital have undergone an extensive programme of upgrade and refurbishment,

infection control advice has been provided post completion of works so as to ensure due consideration is given to infection control requirement within the buildings. It is recommended that with all future refurbishment projects the infection control team should be an integral part of the planning group so as to provide timely accurate information on infection control in the build environment.

4.2.5 There have been no new build projects during this reporting period.

5. Hand Hygiene Strategy

5.1 Hand hygiene remains the single most important factor in the prevention of healthcare associated infection. In spite of recognition of its importance, increasing compliance with hand hygiene practices has been a continuing challenge for infection control teams nationally and internationally.

5.2 Hand hygiene has been promoted in a variety of ways by the Infection Control Team:

- At Corporate Induction which is attended by all staff within 3 months of their employment.
- Hand hygiene techniques of at least 2 practitioners are assessed during the environmental audits conducted by the Infection Control Team.
- Hand hygiene is a key feature of all educational sessions facilitated by the Infection Control Team.
- Infection Control hand hygiene training is an annual mandatory session for all NHSH staff, staff have to achieve 80% compliance with the technique when assessed, with those who fail re-attend the session until they achieve this level.
- Delivery of infection control training to BEHMHT facilities staff (domestic, portering, housekeeping, and post room staff) that provides services to Chestnut Ward and out-patient areas.
- Promotion of hand hygiene at a variety of education events, conferences, and public events.
- Achieving and maintaining full compliance with the recommendations contained within the NPSA clean hand save lives reissue of safety notice 4.

5.3 The work of previous years and this year has ensured that all points contained within the hand hygiene strategy have been completed.

5.4 Progress: -

1. The infection control service have continued to recommend one product of choice for hand decontamination, this is linked to all training events so staff know and recognise what to look for, development of hygiene stations and exit / entry stop signs within all provider services has been completed.

2. A video outlining cross contamination and the role of hand hygiene has been shown as part of the presentation at all training events held by the infection

control team. NHSH employees have had a yearly update on hand hygiene with over 70 different sessions available where staff could access training within this reporting period.

3. Hand Hygiene Information leaflets for staff and for patients/visitors has been reviewed and re-distributed widely throughout the organisation, and wider community via LINKs.

4. Alcohol gel shots have been promoted and given out to promote and educate the workforce in the appropriate and correct use of alcohol gel.

5. A large piece of campaign work around the standardisation and use of detergent and disinfectant wipes has been completed so that staff know how to access and use, and which wipes to use, for hand and surface decontamination.

6. Two hand hygiene banner stands have been purchased and located in strategic locations to promote hand hygiene for staff and public.

7. Hand hygiene leaflets and clean your hands campaign leaflets were sent out with payslips to ensure all staff has access to this information.

8. Over the winter months of this reporting period hand hygiene week campaigns were run promoting good hygiene while there was a seasonal increase in respiratory infections

5.5 Clean**your**hands Campaign

5.5.1 In September 2004 the National Patient Safety Agency launched the Clean**your**hands Campaign for Acute Trusts, which was estimated to save 450 lives and £140 10million a year nationally. For a trust with 500 beds this would mean savings of £460,000 a year, or a reduction in 1,540 bed days. It has been extended from acute NHS hospitals to other care settings, such as primary care organisations, GP practices, community hospitals, nursing/care homes; ambulances; hospices; and dental surgeries for three consecutive years; NHSH has participated from the outset.

5.5.2 The Campaign aims to address poor standards of hand hygiene compliance and reduce levels of transmission of HCAI's. The PCT has Trust Board level responsibility to improve patient safety and are therefore the PCT Trust Chief Executive has continued to sign up and support the Clean**your**hands campaign following recommendation from Lead Nurse.

5.5.3 All the prescriptive recommendations contained within the NPSA re-launched the Clean Hands Save Lives alert notice in October 2008 have been maintained within this reporting period and audit of facilities available identified any areas that required strengthening. Shadowing of community staff was completed so as to ensure this extends into care delivered in a patient's home.

5.5.4 Hand hygiene station boards have been purchased and installed in all health centre entrance areas to further improve hand hygiene compliance.

5.5.5 Credit cards with hand hygiene information for staff have been developed and were distributed via the payroll (attached to staff payslips). Similarly tissues with the campaign slogan were designed and handed out to reinforce the catch it bin it kill it message but also hand hygiene. Carrier bags with the clean hands saves lives logo were are used at training events to distribute training materials. Patient and visitor information cards have been printed and distributed for all services that see patients.

6. Education & Training

6.1 Infection Control updates

Infection Control training is provided throughout the year at regular intervals and on request to all NHSH staff including its independent contractors**.**

A total of 816 staff received face to face training on infection control in this reporting period. Table 1 below provides the break down of staff training delivered.

Infection control in practice half day update	Total number of Link practitioners who attended meetings (all four included)	Corporate Induction	Seasonal flu update	Bespoke sessions	Hand hygiene training
41	33	80	170	0	635

Table 1: breakdown of training provided and numbers of attendance

Work undertaken with the education programme this reporting period includes:

- Reviewed content of session – far more interactive with use of differing media types

- Lead Nurse Infection Prevention and control visits the department, clinic or practice to deliver the training where asked to do so and feasible

- Heavy advertising of the courses and training available by Infection Control Team and staff development.

Further data on staff groups who received training and subjects covered is available on request.

6.1.1 A comprehensive proactive infection control programme has been shown to facilitate the consistent application of the principles of infection control (Comptroller and Auditor General, 2000; Plowman et al, 2000) and is compulsory for PCT's as part of ensuring full compliance towards NHSLA, and CQC standards.

6.1.2 Provision of infection control education and training are considered a priority. Since October 2007 when the education programme was reviewed and revamped a variety

of educational initiatives have been utilised, a broad outline of the approaches taken are detailed below.

6.1.3 The Infection Control Team has been promoting since its launch the free National Infection Control e-learning programme for all clinical and non-clinical staff; uptake information for this reporting period is detailed below. Staffs are able to register and work through topics such as hand hygiene, protective clothing, environmental cleanliness, and disposal of waste. With scenarios to go through and an ongoing individual record of how much staff have learned, this is an invaluable tool to get everyone in the NHS focused on protecting both staff and patients from avoidable infection but the barriers listed in 6.1.4 are preventing uptake.

Staff group	Numbers accessing the modules
Nursing	2
Other	1
Admin staff	3

Table 2: E-learning uptake data by staff group

6.1.4 The main constraints reported are unavailability of protected study time to complete these modules, and the technology infrastructure the trust currently has does not allow full access to all the videos and pictures contained within the course, and it has been very difficult to persuade IT to relax security rules to allow students to complete these modules.

6.1.5 In the latter part of 2009 the course was withdrawn nationally undergoing a revision and alterations. It came back on line late in 2010 staff development department e-learning officer took over the promotion, running and monitoring of this course.

6.2 Bug of the Month Newsletter

6.2.1 This newsletter formulated to provide up to date information on infection prevention and control and has been circulated on a quarterly basis or more frequent following media attention around infections / outbreaks, to the link workers which contained evidence based current information on a variety of infection prevention and control topics. Copies of the newsletter are available on request from the Infection Control Team. These were also displayed on notice boards in public places for staff and public to view.

6.3 Link Practitioner Programme

6.3.1 The role of the Link Practitioner is to contribute to the proactive infection control programme and to act as infection control champions in their clinical area and with their peers.

6.3.2 The Link Practitioner programme has continued to run, with 5 meetings spread over the 12 month period. There have been 16 active members during this time.

6.3.3 An average of 75% attendance has been noted. Each session is approximately 2 hours in duration.

6.3.4 All the link workers have been provided the opportunity to attend the Infection Prevention Society Annual London Conference on Health Care Associated infections, amongst other free complimentary conference places offered by companies.

6.4 Infection Control in Practice

6.4.1 This inter-professional programme runs as a half-day course repeated 6 times per year and can be accessed by all healthcare professionals in the organisation, including contracted services.

6.4.2 The educational philosophy, course programme, learning outcomes, and assessment tools relating to the course are available from the Infection Control Team on request and have all been updated during this reporting period as part of a formal review of the ICS education programme.

6.5 Student Nurse Induction

6.5.1 Provision of infection control educational slot during study days planned and put in place by the trust student nurse placement coordinator has been completed. An over view and update of infection control in the community within a 1.5 hours slot has been delivered each month on request.

6.6 Notice Board

6.6.1 Notice board for information on infection prevention and control installed in public location within Chestnut Ward has been updated monthly with new and current educational and informative updates for staff, visitors and patients, on a rolling programme of topics responding to current trends in the wider community nationally and internationally.

6.6.2 ICS portable board has been used throughout the year to display educational information for staff at all educational and conference events. This is not only been used during educational events, but also displayed in strategic locations throughout the trust when not in use as a health promotion initiative.

6.6.3 Portable banner stand has been updated and used throughout the year to demonstrate the importance of hand hygiene and display the correct technique for hand decontamination.

6.7 Corporate Induction

6.7.1 The Infection Control Team continue to provide a 45 minute interactive update within the induction day which covers all the essential infection prevention and control information that new staff will require within their work. Hand hygiene training is delivered during this session and relevant policy plus handouts provided.

6.8 Health Care workers Training

6.8.1 This half-day course for Health Care workers and all other non-registered staff is an established part of the education programme, with 3 sessions available throughout the year. It has been accessed by healthcare non - professionals in the organisation, including contracted services.

6.9 Other training

6.9.1 Bespoke sessions have also been provided upon request from services so as to ensure the needs of all services are met. These have been very popular with specialist teams where infection prevention and control policy implementation maybe a unique challenge due to the diversity of the setting where care is delivered but also due to the specialist procedures performed.

6.9.2 These sessions have helped to ensure training is accessed and applicable which captures the attention of the audience and allows full engagement from participants, where previously they may not have attended generic training as the information was felt to be too broad.

7. Audit Programme

7.1 Audit aimed at assessing the work and clinical environment from an infection control perspective forms part of the proactive infection control programme in the PCT. Standardised tools previously developed for directly managed services, were reviewed and circulated ahead of the planned visit so that audit was not perceived as a policing activity; and services were encouraged to work with ICS in an open and transparent way to raise environmental standards.

7.2 The tools for General Practice and General Dental Practice were also reviewed in line with preparing practices for CQC registration preparation. These tools were circulated to contractors and primary care commissioning (PCC); responsible for implementing an audit planner with an annual audit of practices that score below 70% and a self audit for practices scoring higher than 70%. This system complies with the audit tools for monitoring Infection Control Standards recommended by the Department of Health and enables us to complete the audit cycle and hence effect change.

7.3 The system of scoring previously in place contributed to the perception that a high score indicated a good level of compliance. In practice it is relatively easy to achieve a high score but still perform below standard. The scoring is used to indicate how much support a service / area requires and how soon the ICS to re-visit. It also allows reporting into the governance and assurance processes in a fair and consistent manner across the variety of locations and service types.

7.3 Traffic light audit tool

RED If the overall standard achieved fails to reach 70%, the department will be re-audited within 3 months.

AMBER If the standard achieved is between 70%-85% the department will be re-audited within 6 months of the original audit. If the standard achieved fails to reach 85% on re-audit the lead nurse should be informed.

GREEN If the standards achieved are above 85% a repeat audit will be undertaken as part of the continuing annual audit programme**.**

7.4 Minimum annual audits are conducted within all provider services, and issues are highlighted to individual services via a report. Audits in directly managed services have been completed with at least two audits for each service in the reporting period, action plans in place and monitored using the traffic light system as detailed in 7.3. These reports have also been circulated to Head of property and senior managers within the APO so that service improvements can be factored into capital bids.

7.4.1 Issues to report include limited ownership of the environment by services especially in areas where there is multi occupancy, very late or no advice is sought during planned refurbishment projects which has lead to non compliant equipment furniture, fixtures and fittings being installed and in use. A programme of refurbishment continues throughout CHS occupied buildings. Services are encouraged to reduce the amount of space used for storage by ordering small quantities frequently, and regularly clear out to prevent build-up of extraneous items. A targeted project (Project Order Wise) was put in place to assist with this however the impact was limited as service managers did not engage with the changes proposed to the frequency, and method of ordering stock as well as quantity, and quality. This work has been passed onto the business team to further explore as part of the QUIPP agenda.

8. Decontamination

8.1 National Decontamination Strategy

8.1.1 The Lead Nurse continues to act as the specialist advisor in relation to the decontamination of equipment and has fulfilled the role of trust Decontamination Lead.

8.1.2 Previous achievements with regards meeting decontamination regulations have been sustained in the PCT and in particular, in directly managed services.

8.1.3 All general dental practices still continue to use Bench Top Sterilisers (BTS), and will continue to do so. The release of the HTM 01-05 document from the DH provided long awaited comprehensive guidance on decontamination best practice in the general dental practice (GDP) settings. GDP's will require infection prevention and control support to meet with recommendations contained within HTM 01-05 in order to register with the CQC in 2011.

8.1.4 All areas within provider services with exception of Dental services are now using single use / single patient use devices and instruments. This significantly reduced the risk of contamination associated with reusable and decontamination of devices. ICS has been involved in and contributed to the revision of the medical devices policy, decontamination audits have been completed, and decontamination certificate has been produced to use with equipment that is sent outside the department / trust for service or return following loan.

8.1.5 The community equipment store that provides the PCT with equipment for patients in their own home was re-audited. The environment continues to be a concern as it is not suitably set up for decontamination of equipment. This has been raised to the CEO and commissioners.

8.2 PEAT

8.2.1 PEAT is self assessed and provides a framework for inspecting standards to demonstrate how well individual healthcare organisations believe they are performing in key areas including:

- food
- cleanliness
- infection control
- patient environment

8.2.2 PEAT is an annual assessment, established in 2000, of inpatient healthcare sites in England with more than ten beds. St. Ann's Hospital is owned by Barnet Enfield Haringey Mental Health Trust (BEHMHT) and Haringey PCT delivery community services from a number of buildings on site. Haringey PCT has only 1 in-patient ward; Chestnut Ward. NHSH participated in the annual PEAT inspections and in this reporting period. The estates and facilities' services required by the ward are provided via a service level agreement with the mental health trust. Domestic and housekeeping is "in-house" within BEHMHT.

8.2.3 PEAT uses a 5-point scale to grade hospitals. The results represent an overall view of standards at the hospital. The scores demonstrate how well individual healthcare providers believe they are performing in key areas including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas).

8.2.4 NHS sites and NHS trusts are each given scores from 1 (unacceptable) to 5 (excellent) for standards of environment, food and dignity and privacy within buildings.

- **Excellent** - Standards almost always meet and frequently exceed expectations. Performance in key areas is uniformly high;

- **Good** - Standards almost always meet and often exceed expectations. Performance in key areas in uniformly good and in some cases excellent;

- **Acceptable** - Standards usually meet expectations, though there is room for improvement in some areas. No failings in key areas;

- **Poor** - Standards regularly fail to meet expectations and significant room for improvement. Some failings in key areas;

- **Unacceptable** - Standards fail to meet expectations in most areas and improvements required urgently. Significant failings in key areas.

8.2.5 Assessments are carried out by NHS staff (nurses, matrons, doctors, catering and domestic service managers, executive and non-executive directors, dieticians and estates directors). Patients, patient representatives and members of the public are also part of this assessment process.

8.2.6 The PEAT results are shared with the Care Quality Commission (CQC). The CQC would then compare the PEAT scores with other performance information gathered relating to an individual trust before making an overall assessment.

8.3 PEAT Scores

8.3.1 Peat scores for 2010/11 as published by the NPSA:

Year	Results		
	ENVIRONMENT	**Food**	**Privacy and Dignity**
2010	GOOD	GOOD	EXCELLENT
2009	ACCEPTABLE	EXCELLENT	EXCELLENT
2008	GOOD	EXCELLENT	**Not assessed**
2007	ACCEPTABLE	GOOD	
2006	GOOD	GOOD	
2007	ACCEPTABLE	GOOD	

8.3.2 The environment score has improved, and NHSH has maintained the excellent score for dignity and privacy. Unfortunately the food choice score has fallen from excellent in 2008/2009 to good in 2009/2010. NHSH have an SLA with BEHMHT to provide all patient food, BEHMHT have changed food supplier and procurement methods during this reporting period which has affected the range and choice of food NHSH are able to provide to patients.

8.3.3 It is recommended that the areas of concern identified (a score of less than 5) during the last inspection are reviewed and actioned prior to re-inspections later in 2011 in order to provide an opportunity to demonstrate an improvement.

8.4 Essential Steps to Safe Clean Care

8.4.1 The Trust signed up to the Essential Steps to Safe Clean Care, a Department of Health initiative, in 2006. Each year a review has been completed. There are 7 challenges within the self-assessment each containing a number of specific questions. The ratings for compliance are: Full compliance = 100%, Action required = 71- 99%, Urgent action required = 50 – 75%, Organisational priority = 0 – 49%.

8.4.2 The self-assessment scoring is undertaken at the infection prevention and control committee in March each year and progress monitored as a standing agenda item. Overall score for this reporting period was 90%. The areas requiring attention during year 2010/11 were:

Challenge 1 Current vacancy of band 5 infection control nurse, Authorised Engineer Decontamination and Infection Control Doctor to be recruited into.

Challenge 2 Transfer policy to be completed, and amending the Single Assessment Process form to include infection control status section.

Challenge 5 Infection control to be included in the annual appraisals for staff.

Challenge 6 Service managers and Head of property to including infection control at the planning stage

Visits to laundry contractor and waste contractor to be undertaken in liaison with BEHMHT facilities.

SLA's for cleaning to be revised and cleaning services retendered.

Cleaning companies to align policies and schedules with NHS cleaning manual.

9. General Medical Practice

9.1 The Infection Control Team continues to work with individual practices to improve infection control standards where issues are highlighted or incidents have occurred. Individual practices are included in the full range of reactive and proactive infection control initiatives facilitated by the Infection Control Service. Unfortunately there is very limited uptake from the collaborative and individual GP practices of this support at present.

9.2 Update on GP Practice audits (information obtained from Alexandra Hawkins – Primary care manager) No GP practices have been visited for an audited during this reporting period.

10. General Dental Practice (GDP – independent contractors)

10.1 The Infection Control Team has fully assisted PCC with practices that were under close supervision following concerns, post remedial notices.

10.2 The audits have highlighted that GDP's require a lot of specialist support to implement infection control guidelines as set out in HTM 01 -05 and to meet with registration requirements of the Health and Social Care Act (2008). Some practices operate from very challenging environments as the premises are not designed to support the delivery of high quality accessible dental care.

Appendix 1

Infection Control Team Objectives 2010 - 2011

In order to continue to improve infection prevention and control across the organisation areas that the team provide a service to, the following objectives have been agreed:

1. Work closely with the Director of Infection Prevention and Control (DIPC) so that infection control is given due consideration at a senior level of the organisation. Take direction from DIPC on service priorities.

2. Undertake surveillance of MRSA admission screening, MRSA colonisation, MRSA bacteriaemias, and *Clostridium difficile* rates, Urinary Tract Infection rates in in-patient areas and report on these rates/trends as appropriate.

3. Undertake alert organism surveillance in the community to monitor the incidence of infections to allow early detection of outbreaks or infection trends and early implementation of control procedures.

4. Review the existing *Clostridium difficile* action plan and re-launch so that measures are in place so that the risk of cross infection is minimised.

5. Set up and participate in joint working across the geographical area of Enfield, Haringey and Islington though a working party aiming to enhance communication, reporting and early detection of infections in order to prevent HCAI.

6. Implement the relevant section/ actions contained within the High impact actions for Nursing and Midwifery – Essential Collection.

7. Lead on and implement a review of the CHS stock ordering and storage system in-order to ensure high quality care is delivered consistently using approved products and wastage is minimised.

8. React to outbreaks of infection and develop appropriate control strategies in collaboration with clinical staff and managers.

9. Work with estates and facilities departments on limiting infection risks associated with water and air quality, cleaning and also clinical waste management.

10. Carry out an annual rotational audit programme reporting on areas that require improvements.

11. Lead on decontamination and the decontamination elements of CQC declaration.

12. Improve the scores and compliance against PEAT and Essential Steps guidance.

13. Develop and implement an integrated care pathway for MRSA.

14. Review the existing infection prevention and control policies

15. Review and write a dress code and uniform policy to the alliance

16. Bid for additional resources to support the development of the service so as to strengthen the organisational resource in relation to the control of infection and further contribute to the quality of services provided.

17. Ensure full compliance with the Health and Social Care Act 2009 is maintained.

18. Provide advice and support in retendering of cleaning services.

19. Provide specialist advice on healthcare new builds and renovation projects so that infection control is given due consideration during planning and commissioning of these buildings, contributing to the CHS estates strategy formulation and implementation.

20. Alliance working with Islington ICS

Appendix 2

Service objectives 2011/12

Following restructure and integration into the new organisation the vacant posts to be recruited into.

Review of all policies, incorporating equality impact assessment.

Redesign and delivery of education programme in order to meet the criteria listed in NHSLA level 2.

Review of staff and patient information leaflets, review and adjust intranet and internet information

Set up IPC subcommittee meeting to report into Infection Prevention & Control Committee meeting

Undertake a baseline of audits in all community sites where community services are run, work with services to raise standards so as to ensure Haringey and Islington community properties are all at the same environmental standard

CQC report on findings against Outcome 8 findings at unannounced inspection of Chestnut Ward Greentrees Unit 28. 11.10

Outcome 8: Cleanliness and infection control

What the outcome says

Providers of services comply with the requirements of regulation 12, with regard to the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

What we found

Our judgement

The provider is compliant with outcome 8: Cleanliness and infection control

Our findings

What people who use the service experienced and told us
All patients spoken to rated the cleanliness on the ward highly. One person advised that the ward was 'always immaculate,' another noted 'they are always cleaning.'

Other evidence
We inspected the majority of communal and private areas on the ward, including bedrooms, bathrooms and toilets, lounges, corridors, the dining room and gym area. There were no concerns about cleanliness or infection control. There were anti-bacterial hand wash units at regular intervals around the ward, and a particular individual bedroom that was set aside for patients with infections with the potential to spread on the ward. This room was not in use at the time of the visit as there were no patients with infectious conditions at that time.

Prior to the visit, the Trust provided us with information about actions taken to address a concern regarding infection control in the case of one patient who had MRSA. They advised that following this incident a lead nurse had been given responsibility for infection prevention and control, working alongside ward staff to educate and support them. Updated protocols had also been written and communicated to all staff.

Our judgement
The provider is compliant with outcome 8
Patients on the ward are provided with a clean environment, with measures in place

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to ensure appropriate infection control to ensure their safety as far as possible.

NHS Haringey

Community Health Services

Infection Prevention and Control Committee

Terms of Reference: Revised September 2010

1. Purpose of Committee

The Infection Prevention and Control Committee will assure the systems for controlling infection throughout the Community Health Services of NHS Haringey (NHSH), maintain infection control policies and procedures on all NHSH sites, and for all NHSH staff working in non-NHSH sites, to protect patients, staff, relatives and carers from infection. The Infection Prevention and Control Committee will also advise the commissioning division where appropriate. In addition, Independent Contractors (GPs, Dentists, Optometrists, and Pharmacists), need to ensure that they are managing infection control appropriately. The Infection Prevention and Control Committee will support, guide and monitor Independent Contractors in fulfilling their legal and professional responsibilities around Infection Prevention and Control.

While the Infection Prevention and Control Committee is responsible for Infection Prevention and Control of NHSH Community Services, it will work closely with representatives of the Mental Health Trust especially those on the St Ann's site to ensure cooperative working and congruence of actions and policies with that of the Mental Health Trust.

2. Accountability and delegated powers

The Infection Prevention and Control Committee minutes will be forwarded to the Health, Safety and Risk Group and then to the Audit and Governance Committee and through to the Trust Board to which, the Director of Infection Prevention and Control will report.

In addition they will be forwarded to the Alliance Joint Clinical Governance Committee and through to the Quality and Workforce Committee which is a sub committee of the Alliance Joint Provider Services Board.

3. Terms of Reference

Monitor progress made on meeting the Infection Prevention and Control standards within the Care Quality Commission Standards.

To develop and monitor the Infection Prevention and Control Programme for NHSH Community Health Services including implementation of Essential Steps.

Ensure there is a safe clinical environment in NHSH Community Health Services and in all non

NHSH areas where NHSH Community Health staff work, in terms of infection control, decontamination and that the high standards of cleanliness are maintained.

To ensure that infection control and decontamination audits are carried out and monitor the implementation of audit recommendations.

To ensure the development of and approve all infection control and decontamination policies and advise on their implementation for NHSH Community Health Services.

To act as a steering committee for the Infection Control Service.

To ensure that infection control considerations are included within all new service developments.

To consider reports on infection control incidents to identify any learning or changes in practice that may be required including lessons learned from any out-break that may occur.

An annual report on infection control will be presented to the Trust Board and the Quality and Workforce Committee.

To ensure appropriate liaison with other stakeholders, such as representatives of the Barnet Enfield and Haringey Mental Health Trust, North Middlesex University Hospital and the Whittington Hospital in respect of the St Ann's site and other shared premises, and NECL HPA, to ensure good communication, and shared policies, procedures, protocols and systems where relevant.

The Lead Nurse in Infection Prevention and Control or DIPC will represent the NHSH at the North Central Sector Control of Infection Network meetings and feedback to the ICC.

To maintain links with other relevant committees within NHSH (e.g. Health, Safety and Welfare committee, Medical Devices Management Group, Imms and Vaccs Committee and other committees when relevant).

Monitor the implementation of NICE guidance with regard to Infection Control.

Develop and monitor the implementation of a NHSH Infection Control Strategy.

To define key performance indicators for infection control and monitor progress of the indicators.

4. Committee Chair

Chair – Director of Infection Prevention and Control - Susan Tokley

5. Membership of Committee

Director of Infection Prevention and Control	Susan Tokley – Associate Director of Professional & Business Development – Chair
Adult Nursing Service Manager	Frances Rourke
Primary Care Commissioning	David Lyons
Assistant Director Dental Services	Catherine Gizzi
Occupational Health	Cathy Ferguson
Sexual Health Service Manager	Claire O'Connor or Kavita Dass
Immunisation Lead	Helen Donovan
Learning Disabilities – Nurse Consultant	Gwen Moulster
Podiatry service manager	Rupa Thacker
Lead Nurse Infection Prevention and Control, Decontamination & Waste Lead	Kris Khambhaita
Clinical Governance Manager	Jonathan Rowe
Health Protection Agency	Joanne Ashmore / Shona Perkins
Risk Advisor	Bryn Shaw
North Middlesex Hospital	Devinder Kaur / Carol Kelly
Greentrees, Respiratory and ICCT Service Manager	Delia Thomas
Audiology and Dietetics Service Manager	Fiona Yung√
Wheelchair Service Manager	Mishal Akpan
Consultant Public Health	Tamara Djuretic
BEHMHT REP	
Infection Prevention and Control Assistant	Asmara Tabot-Eban

List of members to receive minutes:

Children's Services Great Ormond Street Hospitals Trust (GOSH)	John Hartley
NMUHT – Director of Infection Prevention and Control	Ian Hosein
Community Children's Team	Pat Loizou
Director of Estates & Facilities - BEH MHT	Diane Jenner
Pharmacy representative	Lorna Cady
Lead Nurse Infection Prevention and Control – BEHMHT	Agatha Katsande
Commissioning Division – Primary Care - Head of Medicines Management	Pauline Taylor

Vice chair/secretary/other roles

Vice Chair: Kris Khambhaita

Secretary: PA to Infection Control Service

Other Roles: Named attendees will ensure a representative is co-opted onto the committee in their place if the named attendee is unable to attend.

Deputies and attendees: The Infection Prevention and Control Committee will, as appropriate, co-opt additional members to meet specific planning requirements and obligations. Such members will be co-opted for the duration of specific and identified business only. Other Medical or senior staff will be invited to attend as and when appropriate.

6. Quorum

A quorum will be four members of the committee. A quorate meeting requires the presence of the chair or deputy chair and one PCT senior manager and one clinical member from the PCT and one other committee member. An extraordinary meeting would be convened is response to an outbreak or other relevant SUI.

7. Confidentiality and Freedom of Information

In the main all committee minutes and papers are discloseable under the Freedom of Information Act. There are limited exemptions but copies may still need to be produced in a more limited format (i.e. where patient information is included. The Committee must set out a statement of what information falls within exemptions if any and ensure that papers and minutes are prepared appropriately and bearing this in mind. It is the responsibility of the Executive lead to ensure that there are appropriate secretariat arrangements in place in respect of the production, storage and archiving of Committee minutes. All Board level committee minutes and agendas must be on the NHSH website with an archive of last 12 months minutes and agendas and up to date Terms of Reference.

8. Administration

Minutes/papers will be sent out at least 5 working days in advance of the next meeting. Papers will be written in Tahoma 12 and will adhere to the template format laid down in the Communications Toolkit.

9. Meetings

The Committee will meet a minimum of four times per year.

10. Revision of Terms of Reference

Membership and composition of the Infection Prevention and Control Committee will be reviewed every six months and at the same time as review of the terms of reference (next due January 2011).

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