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Whittington Health Trust Board

25 September 2013

Title:	Director of Infection Prevention and Control Annual Report		
Agenda item:	**13/119**	**Paper**	**4**
Action requested:	For ratification		
Executive Summary:	This paper introduces the 2012-2013 Whittington Health Director of Infection Prevention and Control Annual Report. It covers the period 1 April 2012 until 31 March 2013 and focuses on all infection prevention control issues associated with Whittington Health. It is a 15-page document (plus three appendices) that has been put together in collaboration with the entire Whittington Health Infection Prevention and Control Team (IPCT), Decontamination Lead, the Health and Work Centre Team and the Antimicrobial Pharmacist. There are sections covering the following areas: • Report overview • Infection Prevention and Control (IPC) arrangements • Director of Infection Prevention and Control (DIPC) reporting to Trust Board • Budget allocation • IPC training • HCAI rates • Hand hygiene • Decontamination • Audit • Report from the antimicrobial pharmacist The DIPC Annual Report has already been approved by the Quality and Patient Safety Sub-Committee. The purpose of presenting this document to the Trust Board is for ratification prior to it being made a publically available document on the internet.		
Summary of recommendations:			

Fit with WH strategy:							
Reference to related / other documents:							
Date paper completed:		18 September 2013					
Author name and title:		**Dr Julie Andrews DIPC & Consultant Microbiologist**		**Director name and title:**		**Bronagh Scott Director of Nursing & Patient Safety**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Risk assessment undertaken?**		**Legal advice received?**	

Whittington Health NHS

Director of Infection Prevention and Control (DIPC)

Annual Report 2012-2013

Dr Julie Andrews
Consultant Microbiologist and
Director of Infection Prevention and Control

(Covering period 1 April 2012 – 31 March 2013)

1.0 Executive Summary and Overview

1.1 Organisation

On 1 April 2011 Whittington Health evolved from the amalgamation of Islington and Haringey Community Health Services and The Whittington Hospital. It currently serves a catchment of approximately 500,000 people with a turnover of around £281m (2012-13) and more than over 4000 staff.

During the financial year 2012/2013, the acute and community Infection Prevention and Control Teams (IPCT) combined their work plans and teams creating a single integrated Whittington Health IPCT. A single Director of Infection Prevention and Control (DIPC) covers all of Whittington Health. This report encompasses the activities of the ICO.

Whittington Health takes the prevention and control of all infection seriously. It remains a key corporate objective to deliver clean, safe care to all patients and provide a clean and safe working environment for staff employed by the organisation. Infection prevention and control is everyone's business, regardless of discipline or grade.

1.2 Activities

The activities of the IPCT and the wider community have continued to focus on sustaining reduction in incidence of healthcare associated infections (HCAI), in particular MRSA bacteraemia, *Clostridium difficile* diarrhoea, diarrhoea and/or vomiting outbreaks and surgical site infections. Ensuring that all our staff have the necessary knowledge and skills to achieve this reduction in HCAI incidence has also been a key activity.

In collaboration with the microbiology team, the IPCT reviewed ward and clinic patients with infection related problems Monday - Saturday. An increasing number of Infection consultations were carried out in an ambulatory care setting.

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. Outpatients and community patients were discussed with relevant healthcare workers directly or via telephone or email. Rapid and accurate diagnosis of infection, prudent antimicrobial prescribing and reduction in transmission of infection were the main focus of management.

1.3 Infection Prevention and Control (IPC) Action Plan

The 2012-13 Infection Prevention and Control (IPC) annual plan is outlined in Appendix A. The plan focused on continued zero tolerance to MRSA bacteraemia and other HCAI, enhanced clinical ownership including community sites, practical IPC training, IPC policy and guideline development and area based IPC audits presented as a performance dashboard. In line with divisional reporting the IPCT presented formally to the divisions each quarter.

Progress of the actions contained within the plan have been monitored closely over the year through the Infection Prevention and Control Committee and via a small IPC implementation group consisting of the DIPC, the IPC lead nurse and three senior nurses/midwives that met before each IPCC. 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.

Every MRSA bacteraemia and other significant HCAI events were reviewed using Root Cause Analysis (RCA) methodology and the HCAI RCA ongoing action plan was reviewed at regular intervals in conjunction with the annual IPC plan.

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 quarterly via the Quality and Patient Safety Sub-Committee. The Medical Director, Director of Nursing and divisional clinical leads also have key roles in ensuring that high standards of clinical care are delivered to patients.

For the first time in 4 years, the IPCT have all posts filled. The acute and community teams were fully integrated and comprise of one IPC lead nurse, four specialist nurses, one antimicrobial pharmacist, a surveillance co-ordinator, a part time policies co-ordinator and two full time support officers.

During 2012/2013, the IPCT worked closely with the Microbiology Team, Clinical Teams, Facilities Staff, Community Matrons and District Nurses, Bed Management Teams, Learning and Development Team, Prison Healthcare Staff, Public Health England staff and Health and Work Centre staff.

A team of around 42 IPC link practitioners, who receive additional training in infection prevention and control, also supported ward and clinic staff.

2.2 Infection Prevention and Control Committee

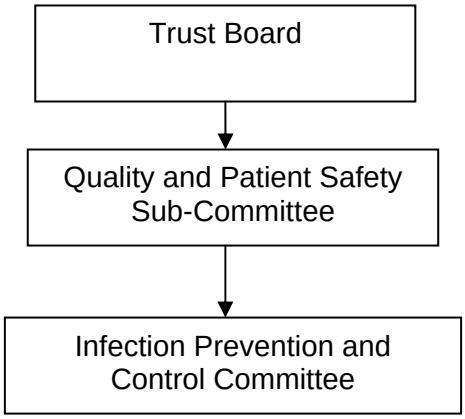
In September 2011, the terms of reference for the IPCC were revised to ensure widespread, high level membership from all relevant areas of Whittington Health. The IPCC is chaired by the Director of Nursing and Patient Experience and meets every other month. It currently reports directly to the Quality and Patient Safety Sub-Committee of Trust Board via a quarterly report.

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

IPC nursing staff also presented a detailed IPC report to the three divisional patient safety boards on a quarterly basis.

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 this report covers, the Drugs & Therapeutics Committee (DTC) and IPCC both reported to the Quality and Patient Safety Sub-Committee, which was chaired by a non-executive director. Continuity was assured as the DIPC and Head of Pharmacy both provided regular updates from their areas.

An antimicrobial steering group (ASG), chaired by the DIPC, was set up in April 2009 and meets six-monthly. The ASG reviews antimicrobial policies, expenditure and audits and plans further work as required. All divisions are represented and a community-based pharmacist attends. The ASG reports directly both to the DTC and IPCC.

3.0 DIPC Reporting to Trust Board

The Trust's performance against the targets for MRSA bacteraemia, *Clostridium difficile* and MRSA screening compliance were reported to Trust Board every month as part of the performance dashboard report.

The DIPC also provided detailed quarterly IPC updates to the Trust Board via the Quality and Patient Safety Sub-Committee. The report included as standard, the performance for the previous months against the agreed objectives for MRSA bacteraemia and *Clostridium difficile;* work being planned and undertaken to improve performance, including RCA reports; and results of the IPC audits. Where applicable, reports were also provided on any infection outbreaks and from external visits and resultant actions planned, for example following the visits from the Care Quality Commission (CQC) or Patient Environment Action Teams (PEAT) inspections. The report also includes a section on IPC training.

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 had the following staff in 2012/2013:

1 wte Lead Nurse (band 8b)
1 wte Antimicrobial Pharmacist (band 8a)
4 wte Specialist Infection Control Nurses (band 7)
1 wte Surveillance Co-ordinator (band 5)

1 0.6 wte Policies Co-ordinator (band 5)
2 wte Support Officers (band 4)

The allocated budget for infection prevention and control in 2012/2013 was:

Area	Pay	Non Pay	Training
Haringey and Islington Community Services	Incorporated with AALC	£0	Via Higher Education Institute contract and NHSL CPPD
ICO infection control – budget code AALC	£417,339	£3,746	£50 per person
Total	**£417,339**	**£3,746**	

This budget excludes the salary of the DIPC whose role is funded from within the Microbiology budget.

4.2 Support

The IPCT have support from a designated analyst within the IT department, who produces weekly monitoring graphs and undertakes other data analysis, for example, MRSA screening audits as requested. The weekly monitoring IPC flash report from 31st March 2013 is shown as Appendix B.

5.0 IPC Training

During 2012-13, the IPCT provided an extensive range of training as part of their role, both through individual IPC practitioner study days, ad-hoc mandatory training and as part of bespoke sessions delivered to various clinical groups. A decision to move to e-learning (without face-to face hand hygiene training) for mandatory clinical and non-clinical IPC training was taken in January 2012 by the Executive team and the IPCT have tried to ensure the ongoing quality of these training modules. Face-to-face hand hygiene training was continued to areas when requested. Many sessions have been held at health centres with reasonable attendance.

Face-to-face training was also provided for junior doctors by the DIPC through their regular education programmes, with a focus on prescribing antimicrobials, managing common infection scenarios 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 side and community based nursing/midwifery staff.

The Antimicrobial Pharmacist and DIPC provided training support for ward pharmacists and pharmacy students. The DIPC delivered face to face IPC training to individual departments and clinics 1-2 times a month.

The IPC link worker study days (6 per year) were suspended in January 2012 after consultation with the three Heads of Nursing/midwifery. They are now held twice yearly in April and October with high attendance and excellent feedback.

As of 31 March 2013, according to ESR records, 84% of all Whittington Health staff had received IPC training.

6.0 HCAI Rates and Other IPC Surveillance

6.1 Results of Mandatory HCAI Reporting

- **MRSA Bacteraemia**: For the period April 1 2012 to 31 March 2013 there were two trust attributable MRSA bacteraemia episodes against an agreed objective of one. One in a medical patient and the other in a patient on the Critical Care Unit. Unfortunately, our trajectory was, therefore exceeded. These were all fully investigated using the RCA process with wide sharing of learning. Each RCA and the actions identified were kept as an ongoing HCAI RCA action plan and discussed at the IPCC. There has been a marked improvement from performance in 2009/2010 and 2008/2009 when there were eight and 23 episodes respectively. There was 2 PCT attributable MRSA bacteraemia episodes within the 2012/2013 period investigated by NCL IPCT. A zero tolerance objective has been set for trust attributable MRSA bacteraemia for 2013/2014.

- **GRE Bacteraemia:** Whittington Health reported one case of glycopeptide resistant enterococci (GRE) bacteraemia in the period 2012/2013.

- **MSSA Bacteraemia:** There were three episodes of post-48 hour meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia in 2012/3. There are no set objectives associated with this organism. This is lower than the figure of 16 MSSA bacteraemia episodes seen in 2011/12 and is probably due to the ongoing level of audit work and training around peripheral and central line care.

- **E.coli Bacteraemia:** There were 18 episodes of post-48 hour E.coli bacteraemia in 2012/13. 3.2% of these (and urine isolates of E.coli and Klebsiella and blood culture isolates of Klebsiella) demonstrated extended Beta lactamase production (ESBL) meaning they were resistant to Beta-lactam antimicrobials such as co-amoxiclav and pipercillin-tazobactam. This is higher than the 1.8% ESBL rate seen in 2010/11. There were also 18 E.coli bacteraemia episodes in 2011/12.

- ***Clostridium difficile*:** From 1 April 2012 to March 31 2013, Whittington Health reported 16 cases of Trust attributable *C.difficile* diarrhoea against a locally set target of 20.

  There has been a further 9% reduction in the total number of cases of *C difficile* between 2011/2012 and 2012/2013. Each case was reviewed and actions for improvement rapidly dealt with. The Trust-attributable *C.difficile* objective for 2013/14 has been set at 10.

  From April 2010, it became compulsory to report and complete full NHS London STEIS investigations into *C.difficile* related deaths (part 1A/B). During 2012/2013 no patients died with *C. difficile* diarrhoea recorded in part 1 of their death certificate.

- **Orthopaedic Surgical Site Infections**: In the four reporting periods to 31 March 2013, the Trust entered surgical site infection surveillance data for hip replacements, knee replacements and surgical repair of fractured neck of femur. Our data demonstrated that infections rates in orthopaedic patients for knee replacements and fractured neck of femur

at Whittington Health were below the national average. There has been ongoing collaboration between the wider orthopaedic and IPCT teams to ensure improved compliance with pre, peri and post-operative factors known to affect infection rates such as length of stay and compliance with hand hygiene.

The hip replacement surgical site infection rate in 2012/2013 was 2% (3 out of 151 operations) compared to the national benchmark of 1.6%.

The knee replacement surgical site infection rate in 2012/2013 was 1.3% (2 out of 152 procedures) against the national benchmark of 2.6%. This is an improvement from the 2011/2012 rate of 1.5%.

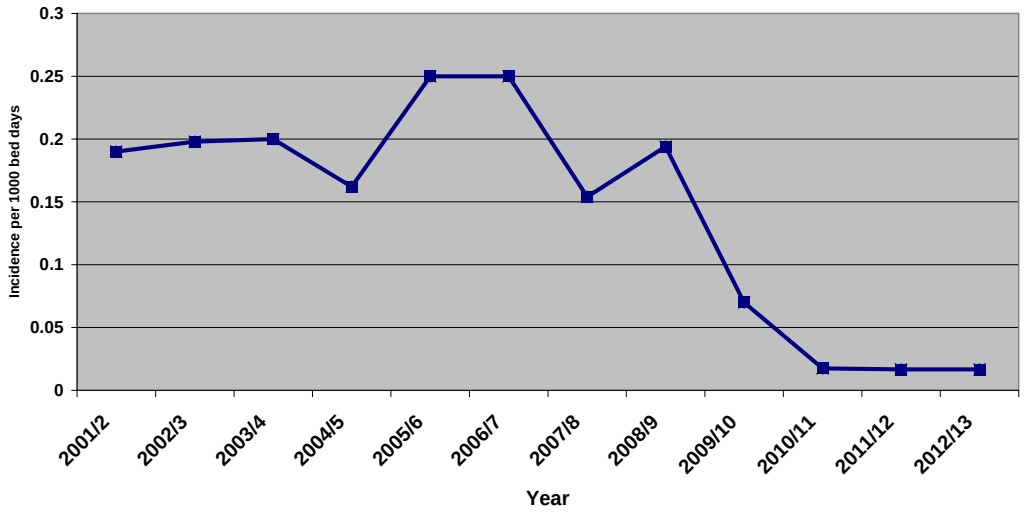
For patients having hip hemiarthroplasties and dynamic hip screws for fractured neck of femur the surgical site infection rate in 2012/2013 was 0% (0 out of 139 procedures) against a national benchmark of 1.9%. This is a significant improvement from the 2011/2012 rate of 1.5%.

6.2 Trends in HCAI Statistics

A summary of the monthly performance in the management of MRSA bacteraemia and *Clostridium difficile* is attached as the IPC flash report, March 2013 Appendix B. The Trust takes its responsibilities for reducing HCAI very seriously; these figures are monitored weekly by the Executive Committee and reported to Trust Board.

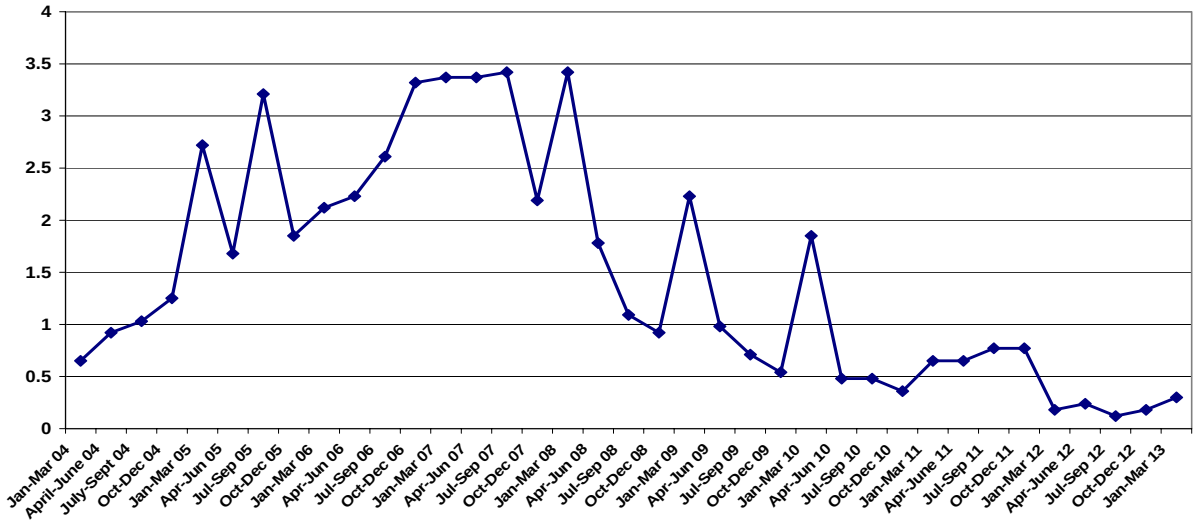
The following charts show the trends in HCAI rates from year to year since mandatory surveillance commenced.

Figure 1 - MRSA bacteraemia episodes per 1000 bed days at Whittington Health



As shown in Figure 1, MRSA bacteraemia rates per 1000 bed days reached a peak in 2005/2006; in 2010/11the rates were the lowest recorded since mandatory reporting started in 2001/2002. We have managed through continued hard work to maintain these low rates in 2012/13.

Figure 2 - *Clostridium difficile* incidence rate per quarter at Whittington (per 1000 bed days)



Incidence of *Clostridium difficile* cases in patients peaked in late 2006/early 2007 as shown in Figure 2. Recently we have seen a return to incidence per 1000 bed days figures last seen in 2004 when mandatory surveillance commenced.

From 2011/2012 to 2012/2013, there has been a further 9% reduction in the number of trust attributable *C.difficile* diarrhoea cases.

Figure 3 - Percentage of hemiarthoplasty (and from 2008 DHS) infections at the Whittington compared to the national average

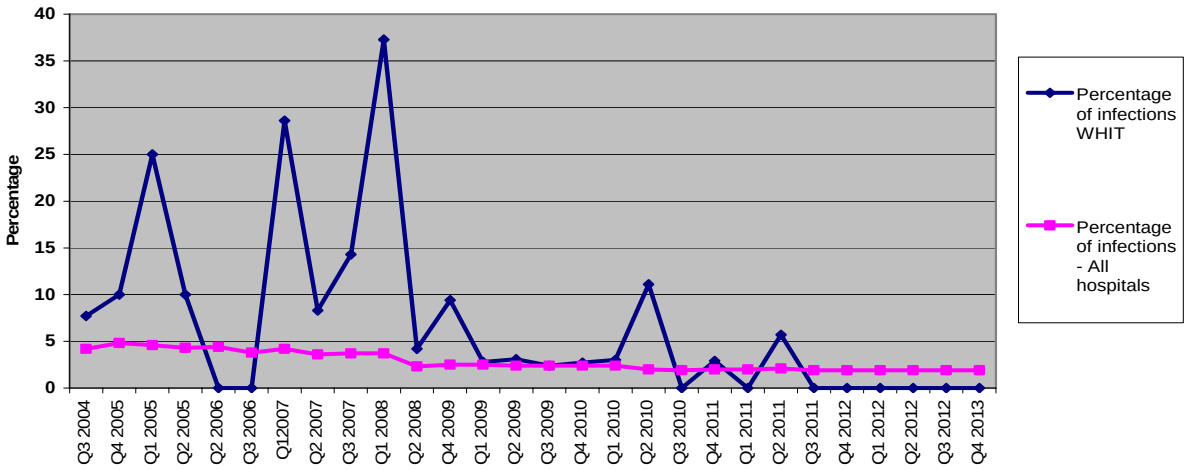


Figure 3 demonstrates the significant improvement that has been sustained since 2011 in the percentage of patients being diagnosed with surgical site infections following surgery for fractured neck of femur surgery since 2004. Since Q3 2011, there have been no surgical site infections diagnosed in these patients.

6.3 Serious Untoward Incidents, Including Outbreaks

There were no Serious Incidents (SI) Panel enquiries related directly to clinical infection prevention and control in the period 2012/2013.

There were MRSA colonisation outbreaks during 2012/3, in critical care and in one of the care of the older person wards. These were appropriately managed by the IPCT and clinical teams.

There were localised outbreaks of diarrhoea and/or vomiting in the period 2012/2013 that were associated with ward closures. All of the outbreaks occurred on medical wards and were rapidly dealt with through the implementation of an outbreak management group. There was limited service disruption.

There was 2 bed bug incidents on medical wards which were quickly identified and treated. The incidents were appropriately managed by the IPCT and the patients were transferred to a side room and their clothing was either heat treated or disposed of. The environment was assessed and treated by the facilities team and pest control.

6.4 Healthcare Worker Exposure to Blood Borne Virus

The number of needlestick and bloodsplash injuries (potentially exposing staff to blood borne viruses such as HIV and Hepatitis C) reported to the Health and Work Centre for the whole ICO incorporating both community and acute areas was 125 in 2012/2013. Following tests, no staff member was found to have been infected from the needlestick or bloodsplash injuries. More detailed reports containing information on staff groups affected, clinical areas involved, management and prevention are now provided by the health and work centre lead and feedback given regularly to staff and via the IPCC.

In 2009, the Trust moved to safety products for peripheral line cannulation following recommendations by the Code of Practice (Health Act 2006). Procurement is involved in a tripartite tendering project for other needle free access devices for venesection but the tendering process has been slow. A working group, lead by the Trust Health and Safety Lead and supported by the IPCT, on the European Legislation on the use of Safety Devices which came into effect in May 2013 has been set up and is working towards compliance.

Sharps training has been escalated in light of recommendations by the EU directive and this is being led by the health and work centre team concentrating on the higher risk areas of ED, community clinics and theatres.

7.0 Hand Hygiene and Aseptic Technique

The organisation made a concerted effort to ensure that hand hygiene compliance was a still a high priority. Locally designed posters have been used to maintain hand hygiene as a high profile topic. Specially designed hand hygiene packs have been designed and distributed to all relevant community staff.

Hand hygiene face-to-face training for all staff was discontinued because of the executive team decision to stop mandatory face-to-face training. However, the IPCT continued to deliver training to areas that requested training or when areas demonstrated reduced compliance.

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

Up to beginning of 2012, the results had shown consistent improvements since their introduction with most clinical areas having hand hygiene compliance scores over 95%. In 2012/13 we saw a reduction in the numbers of clinical areas that were compliant and also 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 were presented to areas immediately and as part of a ward IPC performance dashboard, see Appendix C.

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 difficil*e. Up to date evidence based guidelines for all these areas 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 and is now at a high level. For example, when audited in 2012, 100% of Critical care staff carried out all six steps of the central line insertion care bundle.

8.0 Decontamination

8.1 General Arrangements

8.1.1 The Director of Estates & Facilities is the ICO lead for decontamination. The Decontamination Advisor, who is also the designated lead manager for decontamination, supports him in this role.

8.1.2 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

8.1.3 The Terms of Reference for this committee have been reviewed in June 2013 reflecting changes in organisational structures and governance arrangements.

8.1.4 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 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, incident reporting and equipment availability.
- Compliance Framework; equipment validation and process audits.

- Exception Reports; progress update on incident action plans.
- Training report.
- Policy updates.

8.3 Audit

Audits are carried out and reported to the committee at every meeting. The following audits are carried out and results reported to the Decontamination Committee:

- Endoscope Processing Unit (EPU)
- Equipment Decontamination Unit (EDU)
- Mop Washing Room
- Mattress Decontamination Room
- New audits have been added from the community particularly in relation to dental facilities.
- Mattress store to be added when works complete
- IPS audit completed June 2013

Matters arising are identified and tracked through subsequent meetings.

8.4 Incidents or Failures Investigated

8.4.1 The decontamination of reusable surgical instruments is carried out at an offsite facility run by IH Sterile Services (IHSS). This has been of a greatly improved standard in the past 12 months due mainly to good management by Ricky Bartlett, now general manager at Park Royal and newly appointed as commercial manager for IHSS. The number of incidents is noted on the attached annualised dashboard.

8.4.2 There is a plan being developed by the new commercial manager to purchase the frequently used loan kits and rent them to us directly. This would be a significant advantage as the kits would all be then well known to IHSS staff and we would require them to be rented for a shorter amount of time. It would also improve the ability to effectively track and trace as the information would all be on one system. There are also plans to individually laser mark supplementary instruments this year. The Royal Brompton Hospital will be the first to receive this treatment. This should help reduce quarantine of trays due to incorrect instrumentation and improvements in tracking and tracing of instruments leading to further reducing incidents or non-conformance recorded on Datix.

8.4.3 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. Many local issues have been successfully resolved to the satisfaction of both parties. The Whittington has also led the way in dealing with the issue of contaminated sharps on the trays returned to IHSS. Our way of dealing with this problem is the

tray is quarantined at IHSS and the person identified as having used/checked the tray prior to return to IHSS is contacted via their manager and they are asked to visit IHSS Park Royal and correctly dispose of the sharp in person and apologise to their staff who opened the tray at the receiving end. We continue to be one of the minimal offenders from the group and our policy has been adopted by some of the other Trusts in the partnership.

8.4.4 Recording and reporting of incidents is undertaken electronically using Datix electronic reporting system throughout Whittington Health. The ability to input incidents and data more widely throughout Whittington Health was rolled out into the community on 01/04/2012. There continues to be some evidence of under-reporting of incidents.

8.4.5 At the end of March 2013, a total of 17 incidents had been electronically recorded for the year 2012/2013, down 13 on the previous year. Of these, seven were rated as medium risk, and 10 as high risk.

8.4.6 The Committee monitors progress with any action plan arising until all actions are complete.

8.4.7 The issue of decontamination of invasive ultrasound probes has been dealt with in paper 13/70. It should be noted that the purchase of Trophon Cabinets would be a step quality improvement in decontamination and patient safety.

8.4.8 The pipe work supplying water to EPU has been replaced and has improved the final rinse water TVC's to some extent however this remains an issue requiring attention some weeks. One machine is to be trialled with an alternative self disinfection chemical. It is also planned to send water samples to an outside laboratory for a period of time while continuing to send to our in-house in order to validate our internal lab use as we do not have accreditation for water testing.

8.4.9 Infection prevention and control audits of all areas in community health services have been completed including in Endoscopy Decontamination. Service specific reports and action plans issued. Overall scores for dental premises will show an increase in compliance this year reflecting the many improvements made to environment for decontamination. Ridge House has been closed for use as a dental provider site and the service moved to Forest Road, a notable improvement for patients and staff.

8.5 A review of the priorities for 2012/2013

8.5.1 Integration of the community and acute decontamination processes and facilities are almost complete. One area which remains of concern is the facility at Pentonville Prison. This has been placed on the risk register and an action plan is ongoing with a team review due shortly.

8.5.2 Stabilisation of the IHSS contract has been achieved but in order to retain this position close monitoring will continue.

8.5.3 The Healthedge automated tracking system is installed in endoscopy decontamination and functions in all areas of endoscopy use.

8.5.4 The equipment washer has been relocated but there continues to be operational issues.

8.5.5 The new pipe work for EPU has been installed.
8.5.6 The new laboratory autoclave has been purchased and is being installed July/Aug this year.
8.5.7 The vac-a-scope is in use for specialised areas such as theatres, ITU, ED and ENT.

8.6 Priorities for 2013/2014

Priorities for the current year are:

The purchase of an industrial quality washing machine to be installed and managed by decontamination staff.

Formulate plans for the development of a new endoscopy decontamination unit to include thermo self disinfect washers, a Gas Plasma low temp autoclave and new dryer cabinet which complies with new speed dry process and will enable extension of vac-a-scope system for potential use in the community.

There is a proposal to purchase disposable supplies of all types via IHSS in order to achieve a significant saving by reclaiming VAT. This proposal is in its infancy at present and need much investigation

The purchase and use of Trophon cabinets to perform high level disinfection for all invasive ultrasound transduscers.

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: -

- Saving Lives audits.
- Orthopaedic surgical site infection surveillance scheme.
- Compliance with antimicrobial policies.
- MRSA screening and interventions such as MRSA suppression.
- PEAT 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 as well as many forming part of the IPC dashboard which is presented to divisional boards and Quality committee, see Appendix C.

Community locations were all audited for environmental cleanliness and hand hygiene facilities as per work plan audit planner and the majority areas have demonstrated improvements compared to the previous year. Audits were repeated within three months for those areas found to be non-compliant.

9.2 Reasons for Audit Focus

The reason for carrying out all the above audits was to help the Trust to reduce the incidence of MRSA bacteraemia, *Clostridium difficile*, surgical site infections and other HCAI. Audits are also designed for detailed measurement of all

aspects of practice/environment and 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.

10.0 Report from the Antimicrobial Pharmacist

In April 2012, electronic prescribing (ePrescribing) system, which replaces paper drug charts, was rolled out across the Whittington Hospital. The system has a profound impact on the implementation of the hospital's antimicrobial stewardship programme, as it presents with different features and limitations compared to paper drug charts.

The Trust's core quarterly antimicrobial point prevalence audit was postponed while the ePrescribing system was implemented in stages throughout the hospital. Prescribing data was collected before the implementation of the ePrescribing system for the extended pre- and post- comparison audit.

An OPAT (Outpatient Parenteral Antibiotic Therapy) point prevalence survey was conducted in January 2013 to assess the feasibility of expanding the Ambulatory IV Antibiotic Service across the Whittington Health ICO. It was estimated that a structured multi-modal OPAT approach could potentially reduce length of stay by approximately 1500 days per annum with a cost saving of £302k. There is ongoing work to design and cost the different models of care of the OPAT service.

A vancomycin audit was undertaken in June 2012 following from an MRSA bacteraemia RCA that highlighted several issues with serum level monitoring of vancomycin. Action plans were developed to improve the safe use of vancomycin, which include revising the vancomycin guideline and utilising specific features of the ePrescribing system.

The overall antibacterial and antifungal expenditures for 2012/2013 was £547k and £62k respectively, with a total saving of £23k compared to the previous year.

11. Conclusions

Whittington Health has again been successful in delivering clean safe care to patients during 2012/2013. It has been a demanding year as the focus has been on achieving foundation status in an ever economically challenged environment. The task has been made easier by having an integrated and fully-staffed team that is supported by the Trust. We have raised our profile throughout the ICO and are proud to deliver a highly patient focused service.

This success is evidenced by achievements such as demonstrating a further 9% reduction in *Clostridium difficile* diarrhoea cases and having low orthopaedic surgical site infection rates. No patient undergoing surgery for fractured neck of femur in the last 12 months has had a diagnosed surgical site infection. This is a massive improvement and is the result of improved practices at all parts of the patient journey including reduced lengths of stay.

We did miss our MRSA bacteraemia objective of one but we continue to see improvements in other aspects of care that prevent bloodstream infections such as compliance with peripheral line care and reduction in the use of IV antimicrobials. These improvements have seen a significant reduction in our MSSA bacteraemia figures from 16 in 2011/12 to three in 2012/13.

The main objective going forward in 2013/2014 will be the continued zero tolerance approach to HCAI outlined in detail within the current IPC plan.

The wider IPC team would like to go back to basics and focus more effort into invigorating hand hygiene compliance throughout the trust by a combination of a revitalised communications strategy and a return to mandatory face to face hand hygiene training for all staff. This will also improve the number of staff that have had IPC training from its current level of 84%.

We have planned to expand our surgical site infection surveillance to include abdominal surgery such as our colorectal patients. We will aim to sustain the excellent progress that has been made in our orthopaedic patients.

We had a reasonable response to vaccination campaigns against influenza (60% of front line staff vaccinated up from 17% in 2011/12) and, with the excellent co-ordination between all involved teams, we hope to improve that this financial year.

Public Health England have recently released guidance around the recognition, control and treatment of carbapenem (a broad spectrum antimicrobial) producing enterobacteriaceae (organisms such as E. coli) and we have several plans on how to introduce this guidance into the organisation with the focus being on sharing of knowledge.

Appendix A

Whittington Health NHS

Infection Prevention and Control Strategic Action Plan 2013 - 2014

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 2013/14 across the integrated care organisation (ICO) to meet the standards and targets placed upon the ICO as outlined in NHS Operating framework 2013-2014, The Health and Social Care Act 2009, 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 2013/14 are:

1. To have no avoidable cases of MRSA bacteraemia acquired by patients while in our care.
2. To have less than 10 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 2013-2014.

Service objectives and operational details are contained within the annual report, service operating policy, and service workplan. This action plan should be read in conjunction with these three 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 Bronagh Scott, 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 compliance audits are undertaken by IPCT and added to dashboard for IPCC.	Monthly	HON SCD Delegated to relevant Ward Managers HON WCF Delegated to relevant Ward Managers HON ICAM Delegated to relevant Ward Managers	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 and be commenced on a MRSA positive patient care plan.	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. 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.	Monthly	***Ward Managers***	LNIPC	Monthly compliance audits undertaken by IPCT IPC dashboard presented at IPCC
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 data via ORMIS. Input and audit orthopaedic SSI rates.	Every other month	*Dr A Chekairi* *Mr H Charalambides* Graham Booth	Dr J Andrews	ORMIS to be used as audit tool when set up Orthopaedic SSI data reviewed at each IPCC

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
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. Data gathering exercise for all patients with *E.coli* bloodstream infections to commence to determine possible interventions in future.	Monthly	HON ICAM HON WCF HON SDC Head of Clinical Development Lead for Safety and Productivity Maxine Hammond Liz Bonner Fernando Garcia *Director of Postgraduate Medical Education*	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
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 RCA investigations.	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

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
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, (aim to isolate within two hours). Introduce *Clostridium difficile* management care plan.	Every other month	Bed Management Team Assistant Director of Facilities HON ICAM delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers	LNIPC	Quarterly Isolation compliance audits based on the ICO Policy carried out by IPC Team Weekly IPC Team ward visits Quarterly monitoring of 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 Lead Nurse for Neonatal Unit Nurse Consultant Paediatric Haematology and Oncology	Dr J Andrews	Annual audit of insertion and maintenance of CVCs

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
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.	Every other month	Dr S Gillis Dr A Badasconyi	LNIPC	Annual audit of compliance with guidance
		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 regularly.				
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 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.				
		Meetings with Pentonville and deliver training on how to clean to BICS and inmates to standardise cleaning practices in the prison and healthcare wing.				

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
		Annual IPCT enhanced quality improvement audits.				
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. 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.	Every other month	Jane Preece Claire Davies HON ICAM HON WCF HON SCD	LNIPC	Annual audit of compliance with HII9

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 ICAM HON WCF HON SCD	DIPC LNIPC	Quarterly 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	Quarterly report presented by DIPC to Quality Committee
Criterion 3 Provide suitable accurate information on infections to service users and their visitors.	To provide assurance to service users and their visitors.	Clinical areas to display key IPC quality indicators.	6 monthly	HON ICAM delegating to Clinical Area Managers HON WCF delegating to	LNIPC	Quarterly report presented by DIPC to Quality Committee

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
				Clinical Area Managers HON SCD delegating to Clinical Area Managers Dr J Andrews		
Criterion 4 Provide suitable accurate information on infections to 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	Quarterly report presented by DIPC to Quality
Criterion 5 Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.	To ensure that IPC advice delivered to front line staff is acted upon in a timely manner.	Integrated IPC and Microbiology team review of relevant patients in a timely manner.	6 monthly	Dr J Andrews	LNIPC	Quarterly report presented by DIPC to Quality Committee
Criterion 6 Ensure that all staff and those employed to provide care in all settings are fully involved 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 ICAM delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers	LNIPC	Quarterly report presented by DIPC to Quality Committee

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
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 ICAM delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD delegating to Clinical Area Managers	LNIPC	Quarterly report presented by DIPC to Quality Committee
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	Quarterly 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	Quarterly report presented by DIPC to Quality Committee
Criterion 10 Ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the	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	Quarterly report presented by DIPC to Quality Committee

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
provision of health and social care.						

Governance

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
1. A full RCA 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 RCA policy and 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 RCA/PIR training.	Every other month	LNIPC	LNIPC	Every RCA 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 ICAM delegating to Clinical Area Managers HON WCF delegating to Clinical Area Managers HON SCD 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 registers.	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 board quarterly reports.	Quarterly	LNIPC	LNIPC	Open risks discussed at each IPCC
Deliverable	**Outcome**	**Actions**	**Review Date**	**Clinical Lead**	**IPCT Responsible Lead**	**Evaluation/ Assurance**
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 June 2013
6. EU Directive on Safety	Compliance with EU Directive on Safety being introduced in May 2013.	Health and Safety Lead for the Trust to co-ordinate compliance monitoring from the three directorates.	Quarterly	HON	LNIPC	Report to be presented at IPCC
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 comprehensive IPC service to HMP Pentonville.	Clean safe care delivered to all offenders by staff with up to date knowledge and skills.	IPCT provide timely input as required.	Ongoing	Head of Prison Healthcare	LNIPC	Problems reviewed 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 catherisation). Review and update content of E-learning IPC modules.	April 2013	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.	April 2013	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	All staff knows how to access the IPC for advice/support.	Microbiology/Infection Prevention and Control Team contact details are easily available.	Ongoing	Dr J Andrews	DIPC LNIPC	Refresh communications to all staff

week	Timely and relevant advice given and advice logged for records.				Health Protection Agency	annually or sooner if significant changes

Clinical Leads

Name	Title
Alison Kett	Deputy Director of Nursing
Bronagh Scott	Director of Nursing & Patient Experience
Claire Davies	Lead Nurse Tissue Viability
Deborah Clatworthy	Head of Nursing for SCD
Dr Ahmed Chekairi	Consultant Anaesthetist
Dr Andrew Badacsonyi	Consultant Anaesthetist
Dr Martin Kuper	Medical Director
Dr Sarah Gillis	Consultant Anaesthetist
Dr Tim Blackburn	Consultant Anaesthetist
Fernando Garcia	Urology Nurse Specialist
Frances Davies	Head of Nursing for ICAM
Graham Booth	General Manager Theatres
Jane Preece	Tissue Viability Specialist Nurse
Jenny Cleary	Head of Nursing for Midwifery
Julie Teahan	Matron for Acute Services
Lisa Smith	Assistant Director of Nurse Education & Workforce
Liz Bonner	Lead Nurse Continence Haringey
Maxine Hammond	Lead Nurse Continence Islington
Michelle Johnson	Head of Nursing for WCF
Mr H Charalambides	Orthopaedic Consultant
Mr Omar Haddo	Orthopaedic Consultant
Nickola Amin	Matron for Emergency Department
Philip Ient	Director of Facilities
Steven Packer	Assistant Director of Facilities

Infection Prevention and Control Team

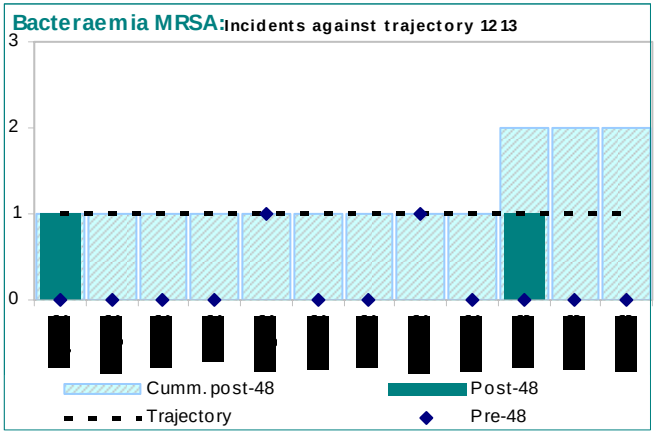
Name	Title
Dr Julie Andrews	Director Infection Prevention and Control (DIPC)
Dr Michael Kelsey	Consultant Microbiologist, Head of Laboratory
Ai-Nee Lim	Antimicrobial Pharmacist
Patricia Folan	Infection Prevention & Control Matron & Deputy DIPC
Gretta O'Toole	Infection Prevention & Control Nurse Specialist
Tracey Groarke	Infection Prevention & Control Nurse Specialist
Martin Peache	Infection Prevention & Control Nurse Specialist
Michael Coltman	Infection Prevention & Control Nurse Specialist
Jennifer Marlow	Surveillance Co-ordinator
Yvonne McCarthy	PA to Infection Prevention and Control Team
Vicki Pantelli	Infection Prevention & Control Policies Co-ordinator
Stephanie Bimpong	Infection Prevention & Control Service Co-ordinator

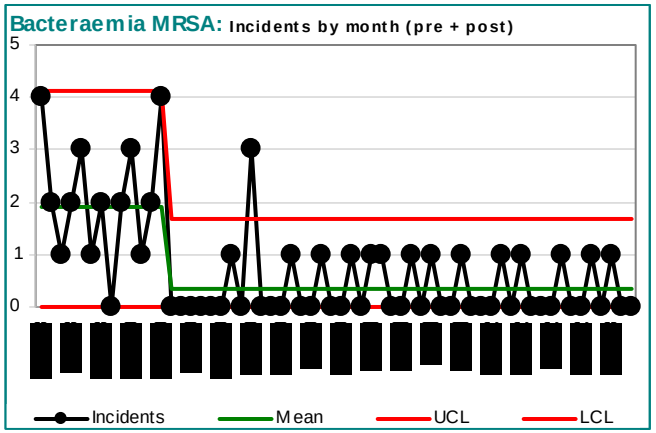
Abbreviations

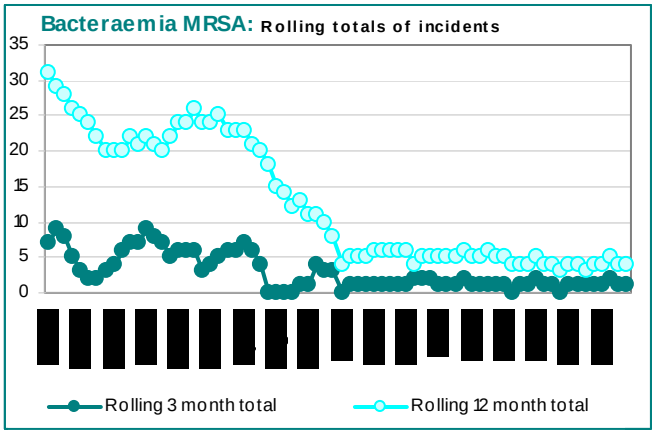
DIPC = Director of Infection Prevention and Control
LNIPC = Lead Nurse Infection Prevention and Control
IPCT = Infection Prevention and Control Team
HON = Head of Nursing
ICAM = Integrated Care and Acute Medicine
IPCC = Infection Prevention and Control Committee
SCD = Surgery Cancer and Diagnostic
WCF = Women's Children and Families

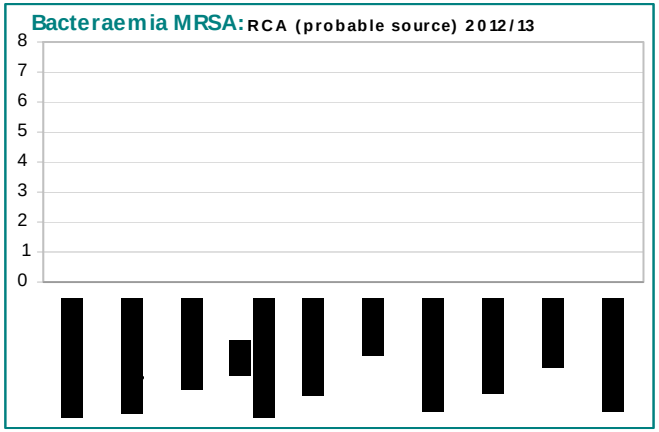
Appendix B

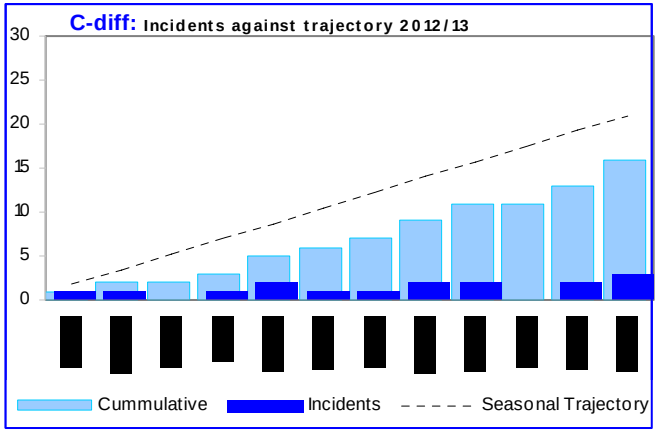
Healthcare Associated Infection Flash Reports

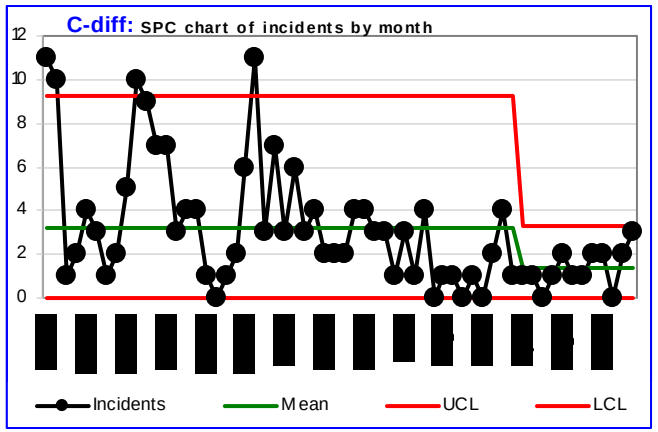


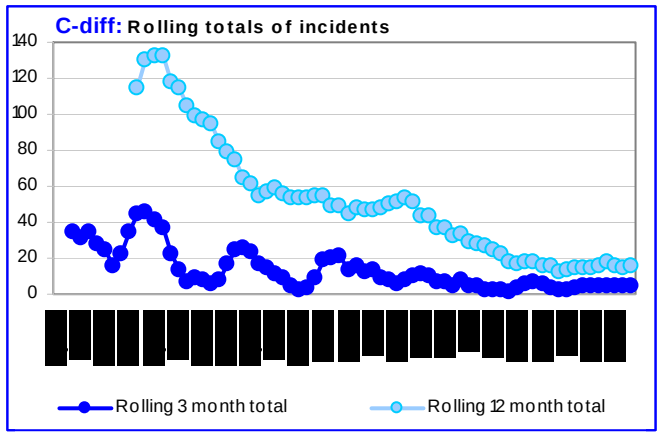


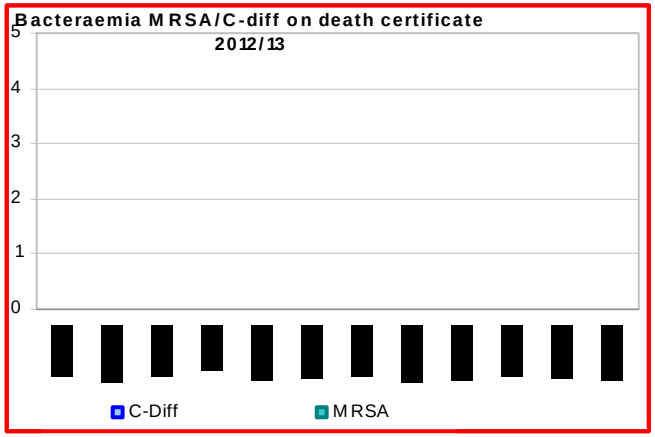


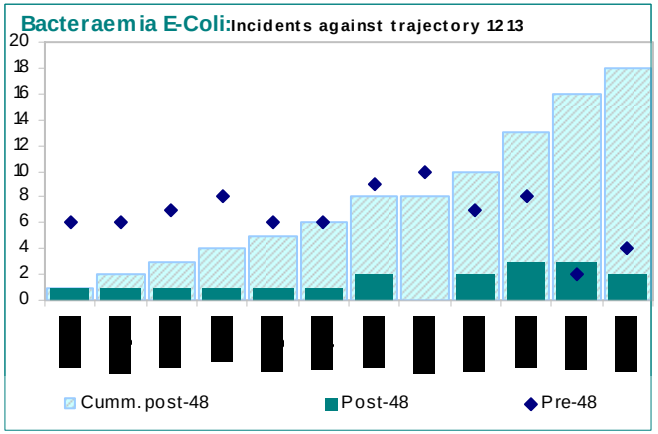


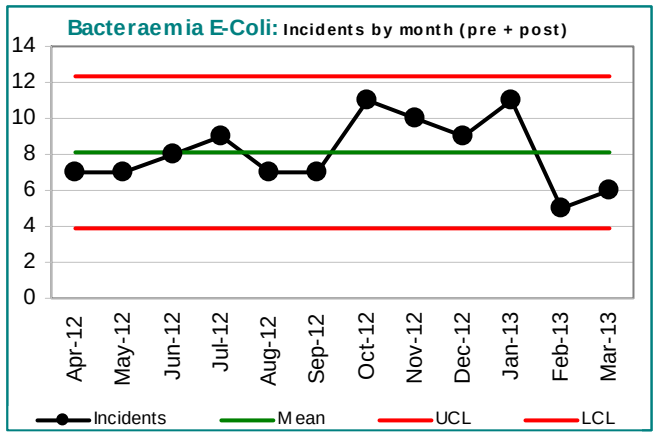


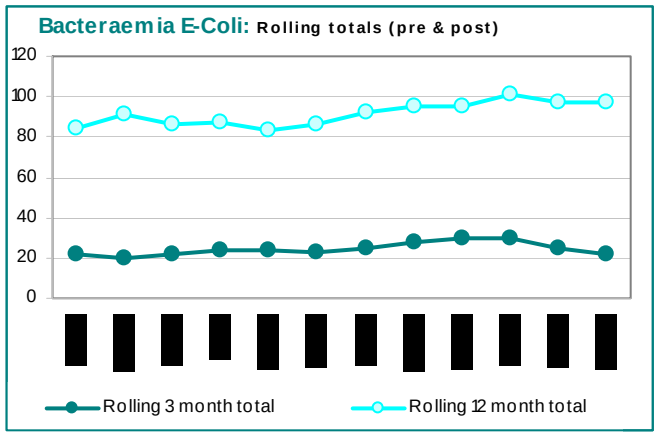


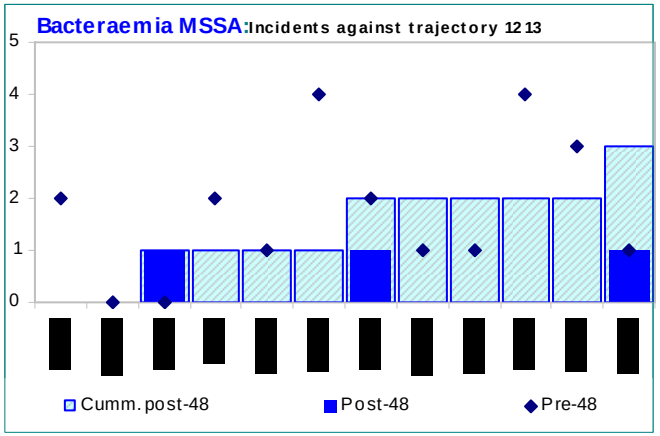

C-diff: Rolling totals of incidents
140
120
100
80
60
40
20
0
Rolling 3 month total
Rolling 12 month total

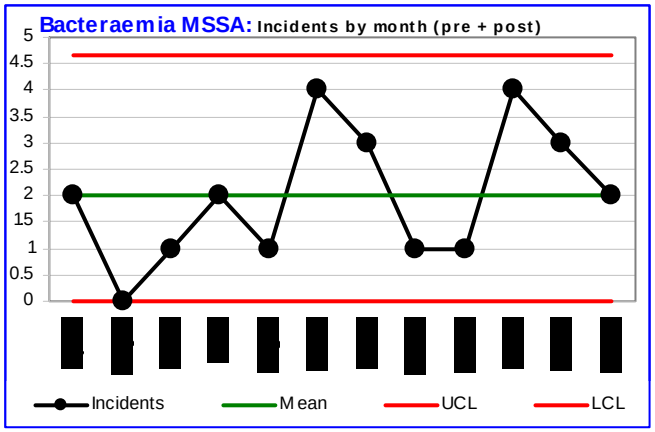

Bacteraemia MRSA/C-diff on death certificate
2012/13
5
4
3
2
1
0
C-Diff
MRSA

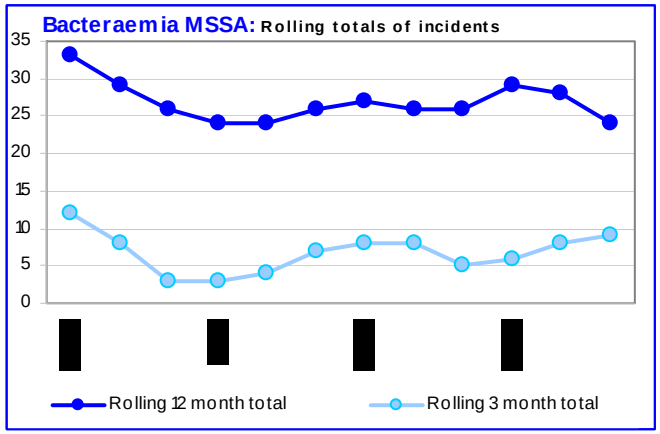

Bacteraemia E-Coli: Incidents against trajectory 12 13
20
18
16
14
12
10
8
6
4
2
0
Cumm. post-48
Post-48
Pre-48


Bacteraemia E-Coli: Incidents by month (pre + post)
14
12
10
8
6
4
2
0
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
Feb-13
Mar-13
Incidents
Mean
UCL
LCL


Bacteraemia E-Coli: Rolling totals (pre & post)
120
100
80
60
40
20
0
Rolling 3 month total
Rolling 12 month total


Bacteraemia MSSA: Incidents against trajectory 12 13
5
4
3
2
1
0
Cumm. post-48
Post-48
Pre-48


Bacteraemia MSSA: Incidents by month (pre + post)
5
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Incidents
Mean
UCL
LCL


Bacteraemia MSSA: Rolling totals of incidents
35
30
25
20
15
10
5
0
Rolling 12 month total
Rolling 3 month total

Appendix C

Whittington Health Infection Prevention and Control Dashboard Q4 Jan - Mar 2013

Acute Site								
Staff responsible for audit	IPCT	IPCT	IPCT	Clinical area staff	Clinical area staff	Clinical area staff	Clinical area staff	Facilities
						G > 95%	G > 95%	
						A < 90%	A < 90%	
Womens/Childrens	**Isolation**	**PPE**	**MRSA Protocol**	**Peripheral Lines**	**Catheters**	**Hand Hygiene**	**Environmental**	**Low Use Outlets**
Antenatal Clinic	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	A	R
Betty Mansell	G	G	R	G	G	G	R	G
Birth Centre	Not applicable	Not applicable	Not applicable	G	G	G	G	R
Cearns	Not applicable	Not applicable	Not applicable	Not performed	Not performed	Not performed	A	G
Cellier	G	G	Not applicable	G	G	G	G	G
Clinic 4C (Womens Health)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	G	Not applicable
Clinic 4d (Paeds)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	G	Not applicable
Emergency Dept (Paeds)	Not applicable	Not applicable	Not applicable	G	G	G	A	Not applicable
Ifor	G	G	Not applicable	Not performed	Not applicable	G	G	G
Bridges	Not applicable	Not applicable	G				Not applicable	Not applicable
Labour	G	G	Not applicable	G	Not performed	Not performed	R	G
Murray	Not applicable	Not applicable	Not applicable	G	G	G	R	R
NICU	G	G	Not applicable	G	Not applicable	G	A	G
SCBU	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	G
ICAM	**Isolation**	**PPE**	**MRSA Protocol**	**Peripheral Lines**	**Catheters**	**Hand Hygiene**	**Environmental**	**Low Use Outlets**
Cavell Rehab	G	R	Not applicable	G	G	G	A	R
Clinic 3a	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	R	R
Clinic 3b Dermatology	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	G	Not applicable
Clinic 3d	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	G	Not applicable
Cloudesley	G	G	A	G	G	G	R	R
Emergency Department/ Isis	G	G	Not applicable	G	G	G	R	Not performed
Mary Seacole N	G	R	G	G	G	G	G	R
Mary Seacole S	G	G	A	G	G	G	G	R
Mercers	G	R	R	G	G	G	R	R
Meyrick	G	G	A	G	G	G	G	R
Montuschi	G	G	A	G	G	G	G	G
Nightingale	G	G	G	G	G	G	G	R
Thalassaemia Unit	Not applicable	Not applicable	Not applicable	Not performed	Not applicable	Not performed	R	Not applicable

Surgery/Cancer	Isolation	PPE	MRSA Protocol	Peripheral Lines	Catheters	Hand Hygiene	Environmental	Low Use Outlets
Chemotherapy Unit	Not applicable	Not applicable	Not applicable	G	G	G	G	Not applicable
Clinic 1a Pre Assessment	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	Not applicable
Clinic 1b Orthopaedics	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	Not applicable
Clinic 3c Opthalmology	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	G	Not applicable
Clinic 4a General Surgery	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	Not applicable
Clinic 4b Urology	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	Not applicable
Critical Care	G	G	A	G	G	G	A	G
Coyle	G	G	G	G	G	G	A	G
Day Treatment Centre	Not applicable	Not applicable	Not applicable	G	G	G	G	R
Imaging	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	R	R
Theatres	Not applicable	Not applicable	Not applicable	Not performed	G	G	R	R
Thorogood	G	Not applicable	Not applicable	G	G	G	G	G
Victoria	G	G	G	G	G	G	R	G

Community Services	Environment (G>80%)	Hand Hygiene	PPE
Pentonville Health Services	G	G	G
Child Development Centre St Ann's	A	G	G
Sexual Health Services St Ann's	G	G	G
Bounds Green Health Centre	G	G	G
Broad Water Farm Community Health Centre	G		G
Edward Drive Unit 1	G	Not performed	G
Hornsey Central Health Centre	G	G	G
Lordship Lane Clinic	R	G	G
Stuart Crescent Health Centre	G	G	G
Stroud Green Clinic	G	G	G
The Laurels Healthy Living Centre	A	G	G
Tynemouth Road Health Centre	G	Not performed	G
Lansdown Road Health centre	A	G	G
Hornsey Rise Health Centre	G	G	G
Hanley Primary Care Centre	G	Not performed	G
The Northern Health Centre	G	G	G
Highbury Grange Health Centre	G	A	G
Goodinge Health Centre	G	G	G
River Place Health Centre	G	G	G
Finsbury Health Centre	A	G	G

Overall Score	240/261	91%
Red		20%
Amber		7%
Green		73%

Low Use Outlets Only

R= No Log

A= Log not in date

G= Log and in date