Whittington Health NHS

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Whittington Health Trust Board

3 September 2014

Title:	Director of Infection Prevention and Control Annual Report for Whittington Health 2013-2014		
Agenda item:	**14/129**	**Paper**	**4**
Action requested:	For sign off so the report can be uploaded onto the Trust intranet and sent to our Commissioners.		
Executive Summary:	This report is the annual DIPC report covering IPC activities across Whittington Health ICO. The main findings of the report are: 1) We reported 2 cases of MRSA bacteraemia against an objective of zero. These cases and the actions from the investigations are discussed. 2) We diagnosed 21 cases of *C.difficile* associated diarrhoea against an objective of 10. The themes from our learning from these cases are discussed. 3) Other relevant data is presented including our orthopaedic surgical site surveillance demonstrating our results in line with national benchmark data. 4) Audit and training are discussed in detail. We had another successful year with audit and quality improvement and this report provides assurance regarding that. Despite enhanced activity, our IPC training figures did not increase beyond 85% however different methods to raise compliance over 95% have been developed for 2014/2015.		
Summary of recommendations:	• Follow the IPC annual strategy in detail and review progress at regular intervals. • Focus on how to improve uptake of IPC training. • Approve DIPC report for presentation on internet and to Commissioners.		
Fit with WH strategy:	Efficient and effective care Culture of innovation and improvement.		
Reference to related / other documents:			
Reference to areas of risk			

and corporate risks on the Board Assurance Framework:							
Date paper completed:		14 August 2014					
Author name and title:		**Dr Julie Andrews DIPC and Consultant in Medical Microbiology**		**Director name and title:**		**Philippa Davies Director of Nursing and Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**		**Quality Impact Assessment complete?**		**Financial Impact Assessment complete?**	

Whittington Health NHS

Director of Infection Prevention and Control (DIPC)

Annual Report 2013-2014

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

1.0 Executive Summary and Overview

1.1 Organisation

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

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

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

During the financial year 2013/2014, the Infection Prevention and Control Team (IPCT) provided a full service to acute and community sites under the Whittington Health remit. A single Director of Infection Prevention and Control (DIPC) covers all of Whittington Health. This report encompasses the activities of the ICO.

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

1.2 Activities

The focus for 2013/14 has been to ensure:

- A sustained reduction in incidence of healthcare associated infections (HCAI), in particular MRSA bacteraemia, *Clostridium difficile* diarrhoea, diarrhoea and/or vomiting outbreaks, respiratory tract viral infections, *E. coli* and MSSA bacteraemia and surgical site infections.

- Our staff have the most up to date knowledge and skills to achieve this reduction in HCAI incidence

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

A significant part of the activities of the wider IPCT this year have revolved around securing assurance data from audits and deep dive reviews. This

data has provided us with the evidence that we are delivering on most aspects of our IPCT strategic action plan.

We have collaborated widely with the Health and Work team this year on the delivery of flu education and vaccination. The Trust achieved over 75% vaccination rate in our relevant workforce.

1.3 Infection Prevention and Control (IPC) Action Plan

The 2013/14 Infection Prevention and Control (IPC) annual plan is outlined in Appendix A. The plan focused on continued zero tolerance to MRSA bacteraemia, reduced incidence of other HCAI's, developing enhanced methods to provide assurance, expanding IPC training and strengthening area based IPC audits. In line with divisional reporting, the IPCT presented a IPC report formally to the divisions each quarter via their patient safety committee.

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

Every MRSA bacteraemia and other significant HCAI events were reviewed using Post Investigation Review (PIR) methodology and the HCAI PIR ongoing action plan has been 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 and through 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.

The IPCT comprises 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 2013/2014, the IPCT worked closely with many teams including Microbiology, Facilities Staff, Community Matrons, Access, Learning and Development, Public Health England staff and Health and Work Centre staff.

A group of approximately 38 IPC link practitioners, who receive enhanced training in infection prevention and control, also supported ward and clinic staff.

2.2 Infection Prevention and Control Committee

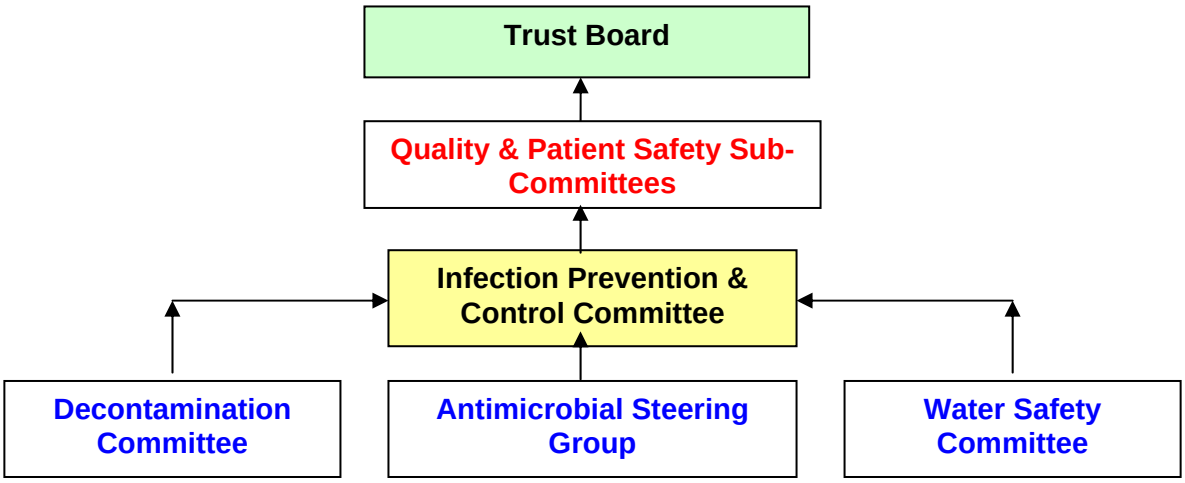
In February 2013, the terms of reference for the IPCC were revised to ensure widespread high level membership from all relevant areas of Whittington Health. The IPCC is chaired by the Director of Nursing and Patient Experience and meets bi monthly.

Membership of the IPCC includes divisional nursing and medical representatives, the antimicrobial pharmacist, 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 present a detailed IPC report to the three divisional patient safety boards on a quarterly basis. This report includes updates on HCAI data, critical events, training, decontamination issues and new guidelines and policies.

2.3 Reporting Line to the Trust Board

The current reporting line of the IPCC is below:



2.4 Links to Drugs and Therapeutics Committee

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

The Antimicrobial Steering Group (ASG), chaired by the DIPC, meets quarterly. The ASG reviews antimicrobial policies, expenditure and audits

and plans further work as required. All divisions are represented and the ASG reports directly both to the DTC and IPCC.

3.0 DIPC Reporting to Trust Board

Performance against ceiling targets for MRSA bacteraemia and *Clostridium difficile* has been reported to Trust Board every month as part of the performance dashboard report. In addition to detailed quarterly IPC updates to the Quality and Patient Safety Committees. Reports have included as standard, the performance for the previous month against the agreed objectives for MRSA bacteraemia and *Clostridium difficile* and orthopaedic surgical site infection incidence. Ongoing work to improve performance and results of IPC audits and other assurance data was also detailed. Reports were provided on infection outbreaks and actions taken as a result of external visits, for example the Care Quality Commission (CQC). The report also includes a section on IPC training compliance.

4.0 Budget Allocation for Infection Prevention and Control Activities

4.1 Staff

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

The Infection Prevention and Control Team comprised of the following staff in 2013/2014:

1 wte Lead Nurse (band 8b)
1 wte Antimicrobial Pharmacist (band 8a)
4 wte Specialist Infection Control Nurses (band 7)
1 0.8 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 2013/2014 was:

Area	Pay	Non Pay
ICO infection control – budget code AALC	£434,330	£3,746
Total	£434,330	£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 good support from IM&T to provide MRSA and *C. difficile* monitoring graphs to the Trust Board. There was a major change in the Trust's core Patient Administration System in September 2013, which

resulted in some reporting not being available during 2013/14 which has since been resolved.

5.0 IPC Training

During 2013-14, the IPCT provided an extensive range of education and training, through two individual full day IPC link practitioner study days, ad-hoc mandatory training and as part of bespoke sessions delivered to a variety of clinical groups. 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 regular education programmes, with a focus on prescribing antimicrobials, managing common infection scenarios, influenza and infection prevention. A practical procedures course was introduced in 2009 for Foundation Year 1 Doctors focusing on aseptic technique for basic procedures such as insertion of peripheral cannulae, blood cultures and urinary catheterisation. Practical aseptic skills training was also provided to relevant acute side and community based nursing/midwifery staff.

Staff are encouraged to participate in a two hour IPC E-learning module. The IPCT also delivered an additional two weeks of daily IPC training in January 2014 with an aim to increase compliance with IPC training.

Despite enhanced training activity, compliance did not exceed 85% in 2013/14. A number of options are being explored to increase compliance in 2014/15.

6.0 HCAI Rates and Other IPC Surveillance

6.1 Results of Mandatory HCAI Reporting

MRSA Bacteraemia: For the period 1 April 2013 to 31 March 2014, Whittington Health reported two trust attributable MRSA bacteraemia episodes against an agreed objective of zero. These were fully investigated using the PIR process with wide sharing of learning at the IPCC and relevant divisional committees.

There has been a marked improvement from performance in 2009/201and 2008/2009 when there were eight and 23 episodes respectively and we have sustained this improved performance. There were four community attributable MRSA bacteraemia episodes within the 2013/2014 period investigated by the relevant CCG. A zero tolerance objective has again been set for trust attributable MRSA bacteraemia for 2014/2015.

GRE Bacteraemia: Whittington Health reported no cases of glycopeptide resistant enterococci (GRE) bacteraemia in the period 2013/2014.

MSSA Bacteraemia: There were eight episodes of post-48 hour meticillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia in 2013/4. There were no set ceiling targets associated with this organism. Each case was

reviewed by the IPCT to look for modifiable risk factors such as peripheral or central line insertion non-compliance.

E.coli Bacteraemia: There were 97 reported episodes of E.coli bacteraemia in 2013/14, 79 of these were pre 48 hour episodes and 18 post 48 hour. The post 48 hour patient cases were investigated to ascertain any obvious modifiable risk factors. 9% of the E. coli bacteraemia isolates demonstrated extended Beta lactamase production (ESBL) meaning they were resistant to Beta-lactam antimicrobials such as co-amoxiclav and pipercillin-tazobactam. This is considerably higher than the 3.2 per cent ESBL rate seen in 2012/13.

***Clostridium difficile*:** From 1 April 2012 to 31 March 2013, Whittington Health reported 21 cases of Trust attributable *C.difficile* associated diarrhoea (CDAD) against a locally set ceiling objective of 10. Breaching this objective was disappointing for all involved, however our position was similar to surrounding organisations. In April 2012 a new screening method for *C.difficile* was introduced which involved a more sensitive two stage procedure. Nationally a 30% increase in prevalence has been seen through the introduction of this two stage procedure.

Of the 21 cases, each was reviewed in detail and aspects of care relating to isolation, testing, communication, cleaning, use of personal protective equipment and antimicrobial prescribing were independently scrutinised.

In summary 3 of the 21 cases of Trust attributable *C.difficile* associated diarrhoea cases could have been prevented by improved compliance with the *C.difficile* care bundle. One case should have been diagnosed earlier and if so, would have been designated a community case. The other two cases (one on a medical ward and one orthopaedic) were found be cross contamination cases from another patient or the environment. The other 18 cases were deemed non-preventable however minor non-compliances were determined in around six of these cases. These non-compliances relate to issues such as minor delays in testing or isolating of a patient or failure to document the duration and indication of antimicrobials. 13 of the 21 CDAD cases occurred in medical patients. 4 out of 21 patients had *C. difficile* 005 ribotype and the other cases were all individual ribotypes.

One patient died from CDAD and a full PIR and serious incident report occurred with involvement from the Coroner and wide sharing of learning. There were no breaches in isolation or antimicrobial prescribing but delays in testing for *C.difficile* occurred in addition to issues relating to escalation of the acutely unwell patient and poor documentation.

The Trust-attributable *C.difficile* ceiling objective in 2014/15 has been set at 19.

Orthopaedic Surgical Site Infections: In the four reporting quarters up to 31 March 2014, the IPCT entered surgical site infection surveillance (SSI) data each quarter for hip implants, knee implants and surgical repair of fractured neck of femur. This is above what is required for Public Health England mandatory reporting.

The hip implant SSI rate in 2013/2014 was 1.9 per cent (three out of 157 operations) slightly higher than the national benchmark of 1.5%.
For patients having knee implant surgery the SSI was 2.8 per cent (five procedures out of 179), this compares to the national benchmark figure of 2.5%.

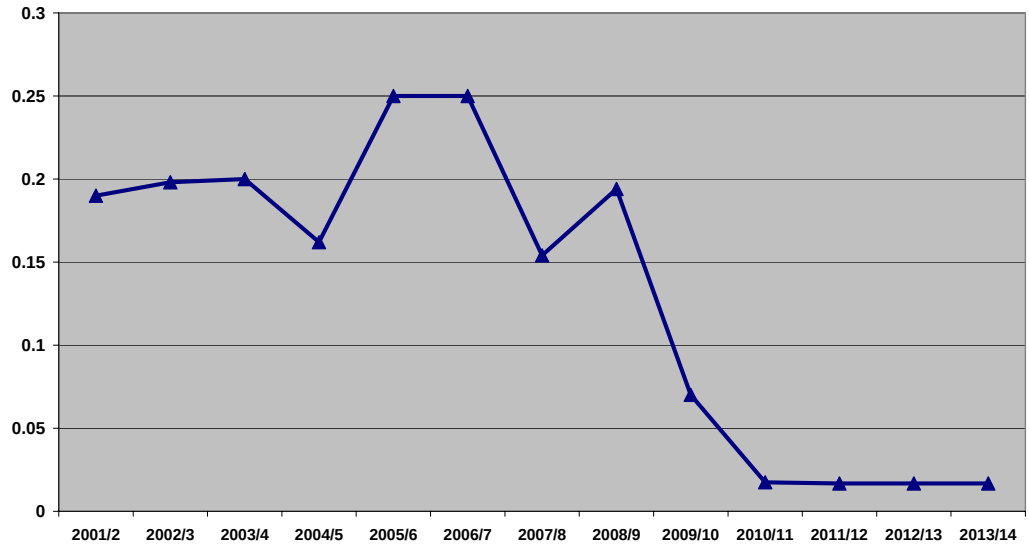
For patients having hip hemiarthroplasties or dynamic hip screws for fractured neck of femur the SSI rate in 2013/2014 was 3% (four out of 132 procedures) against a national benchmark of 1.8 %.The rates are higher than the national benchmark in part due to a cluster of surgical site infections (five in total) diagnosed in September 2013. This cluster involved different teams and different theatres and wards. There were two deep prosthetic joint infections in patients undergoing surgery for fractured neck of femur. One of these required prosthesis replacement surgery. There were three deep prosthetic infections in patients that had elective joint replacements, one patient required replacement prosthesis surgery. As a result of these, urgent review meetings were held and an immediate action plan put in place which was monitored through both the IPCC and the SCD Divisional Board. The cluster of infections were declared serious incidents and the Serious Incident (SI) panel findings were monitored and closed through the SCD divisional board.

6.2 Trends in HCAI Statistics

A summary of HCAI performance by month is detailed in 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.

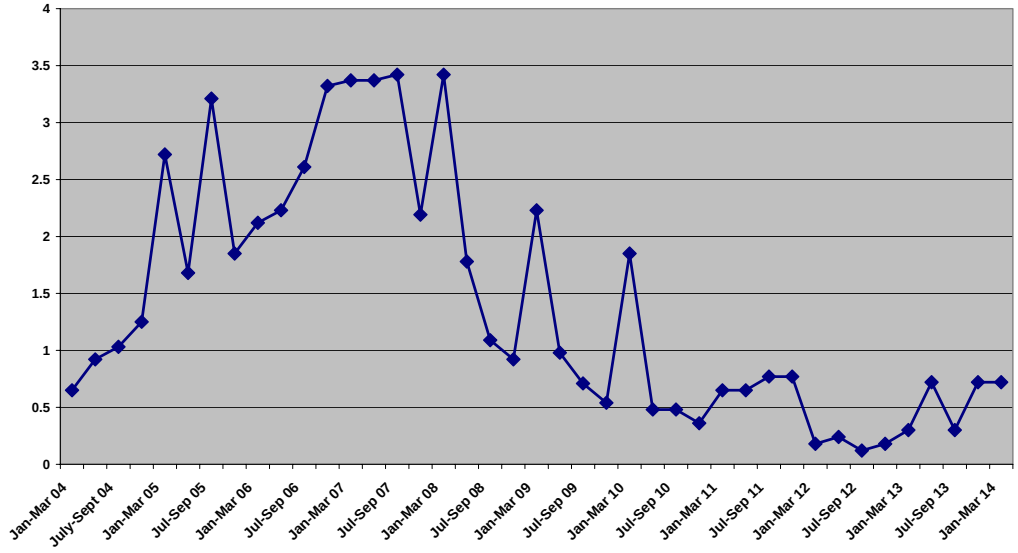
The following trend charts detail HCAI rates year on year since the commencement of mandatory surveillance.

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 2010/11 the rates were the lowest recorded since mandatory reporting commenced. We have achieved and maintained this through continued hard work in the past year.

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



Incidence of *Clostridium difficile* cases peaked in late 2006 early 2007 as shown in Figure 2. Since 2011, the Trust has seen a return to incidence figures last seen in 2004 when mandatory surveillance commenced. We achieved our best performance in 2012/13 and are striving to return to those figures.

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

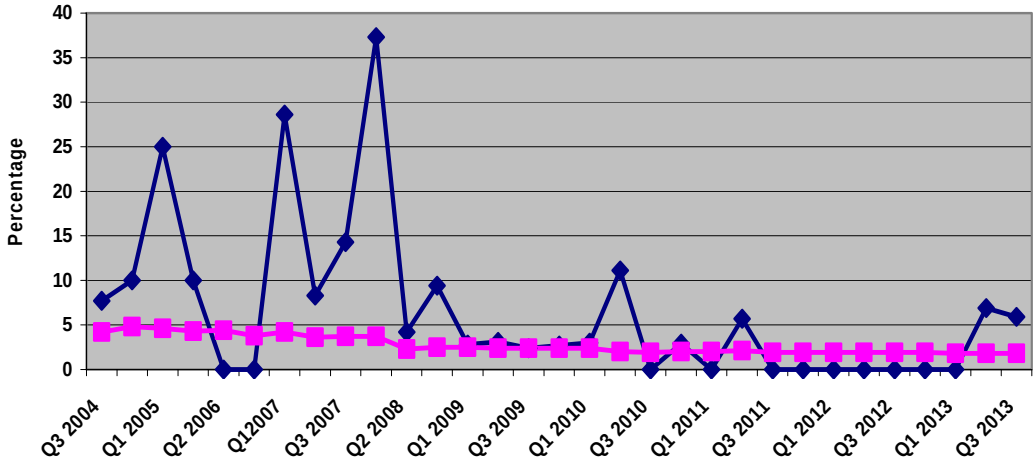


Figure 3. demonstrates the significant improvement that has been sustained since 2011 in the percentage of patients being diagnosed with surgical site infections following surgery for fractured neck of femur surgery.

6.3 Serious Untoward Incidents, Including Outbreaks

There were two Serious Incident (SI) Panel enquiries directly related to clinical infection prevention and control in the period 2013/2014. One relating to the death of a patient from *C. difficile* associated diarrhoea discussed above, the second was reported to IPCC and SCD divisional

board following the cluster of surgical site infections in orthopaedic patients.

There were two separate MRSA colonisation outbreaks during 2013/4, in two surgical wards. These were appropriately managed by the IPCT and clinical teams.

There were localised outbreaks of diarrhoea and/or vomiting in the period 2013/2014 with associated ward closures. All declared outbreaks occurred on medical wards and were rapidly dealt with through an outbreak management group. There was limited service disruption.

6.4 Healthcare Worker Exposure to Blood Borne Virus

We have had more reported 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 financial year 2013/2014. A total of 135 incidents were reported for the whole ICO, incorporating both community and acute areas. It is worth noting that we had a 3% decrease in the number of needle stick injuries and a 3% increase in mucocutaneous incidents, however both were up overall. Following tests, no staff member was found to have been infected from these needlestick or bloodsplash injuries. The reporting structure for needlestick and bloodsplash injuries and the education around this subject has improved and this increase may represent an increase in awareness rather than more events.

More detailed reports containing information on staff groups affected, clinical areas involved, management and prevention are provided by the Occupational Health Lead and feedback given regularly to staff and the IPCC. In 2009, the Trust moved to safety products for peripheral line cannulation following recommendations by the Code of Practice (Health Act 2006). A working group, focusing on the European Legislation on the use of Safety Devices, which came into effect in May 2013, was set up and the hospital is now fully compliant with regard to safety devices. The working group has now been disbanded and safety devices are now monitored by the Health & Safety Committee.

Sharps training has been escalated in light of European Union recommendations. This directive is being led by the health and work centre team concentrating on the higher risk areas of Emergency Department (ED), Obstetrics, Gynaecology, community clinics and theatres.

7.0 Hand Hygiene and Aseptic Technique

The organisation made a concerted effort to ensure that hand hygiene compliance was still a high priority. A new “Whittington Warriors” hand hygiene campaign was launched and the first phase of the campaign, new signage in the acute site, has been introduced. Further phases, including floor and wall signage and a virtual nurse hologram for the main entrance will be introduced in July 2014.

The IPCT delivered face to face training to staff who had not received infection control training via E-learning. The team also offered training to services on request or when areas demonstrated poor compliance.

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

Up to the beginning of 2013, the results had shown consistent improvements, with most clinical areas having hand hygiene compliance scores over 95%. In 2013/14 there was a reduction in the numbers of clinical areas that were compliant and a staff survey reported a perception of reduced access to hand hygiene facilities. The IPCT responded with targeted training, increased auditing by link staff and concentrating on improving access to hand hygiene stations or alcohol gel. Areas that scored below 95% were audited more frequently with targeted feedback. Results 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 difficile*. Evidence based guidelines can be found on the Clinical Guidelines section of the intranet. Compliance with these guidelines forms part of the ward IPC dashboard. Compliance has improved steadily since the introduction of the Saving Lives campaign and is now at a high level.

8.0 Decontamination

8.1 General Arrangements

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 the Decontamination Lead.

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. The new Health Assurance software will also be used to compile easily accessible evidence and encourage self assessment with relation to the appropriate outcome.

8.1.3 The Terms of Reference for this committee have been reviewed in 2013 reflecting changes in organisational structures and governance arrangements. The new template has been adopted for 2014.

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 Decontamination 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 the following:

- Performance indicators; dashboard, incident reporting and equipment availability.
- Compliance framework; equipment validation and process audits; for 2014 there will be an area chosen on a rotational basis to present and discuss their audit at Decontamination Committee.
- Exception reports; progress update on incident action plans.
- Evidence of on going training in regard to innovation and existing activity.
- Policy review and updates.

8.3 Audit

The following audits are carried out and the 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.
- The bed store
- IPS audit of Endoscopy Processing Unit completed June 2013 with an excellent score. Minor storage issues were highlighted; these are now rectified.

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 In-Health Sterile Services (IHSS).

8.4.2 Over the next year we are planning to individually laser mark supplementary instruments. This should help reduce quarantine of trays due to incorrect instrumentation and improve how instruments are tracked and traced

8.4.3 The careful monitoring of recurrent issues is carried out by a Decontamination Users Group. This allows end users, such as theatre staff, to have face to face discussions with IHSS managers, facilitated by the Decontamination Advisor and IHSS Contracts Manager.

8.4.4 Recording and reporting of incidents is undertaken electronically using the Datix electronic reporting system. Staff are advised to report any concerns or issues on decontamination using Datix.

8.4.5 At the end of March 2014, a total of 54 incidents had been electronically recorded for the year, This is higher than previous years and reflects an increase in reporting and a higher number of contaminated trays.

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

8.4.7 Over the past year we have improved the environment in health centres and clinics across the community and also in the hospital. This with enable greater compliance with Infection Control and Decontamination standards.

8.5 A review of the priorities for 2013/2014

8.5.1 Pentonville Prison was identified as a priority due to it being an area of concern but subsequently removed from the risk register following termination of the prison healthcare contract .

8.5.2 The IHSS contract has been under close monitoring due to an increase in non-conformances and a change in management. This will continue along with partnership initiatives such as exchange visits.

8.5.3 The new Drying Cabinet has been installed in Endoscopy Processing. This enables greater use of the Vac-a-Scope for emergency scopes in addition to enhanced storage.

8.5.4 The equipment washer has been in use since September 2013.

8.5.6 The new laboratory autoclave has been operational since September with additional training in April 2014.

8.5.7 The vac-a-scope is in use for specialised areas such as theatres, ITU, ED and ENT.

8.5.8 The Trophon cabinets used to perform high level disinfection for all invasive ultrasound transducers are now in use in Women's Health and Imaging.

8.6 Priorities for 2014/2015

Priorities for the current year are:

1. A Sharps Awareness study half day. This would feature a session from Health and Safety, Infection Control, Occupational Health and Decontamination, with a guest speaker from IHSS. Attendance for all persons involved in sharps incidents would be mandatory but all staff would be welcome.

2. The purchase of an industrial quality washing machine to be installed and managed by decontamination staff. The potential area for this has been identified as the current Endoscopy processing unit, the mop washers would also be relocated to this area.

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

4. There is a proposal to purchase disposable supplies of all types via IHSS in order to achieve a significant saving by reclaiming VAT. This remains on the drawing board for the present.

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 of 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 to measure baseline practice with standards identifying areas for improvement. Audits help to raise awareness, impart knowledge and skills measure performance and enable focused actions to be taken to improve. They form part of the assurance framework to ensure we achieve our annual IPCT strategic action plan.

10.0 Report from the Antimicrobial Pharmacist

Quarterly Antimicrobial Point Prevalence Audit

The Trust's Quarterly Antimicrobial Point Prevalence Audit has been running for six years and continues to be an integral part of the trust's antimicrobial stewardship programme.

Face-to-face feedback and score cards have been shown to be useful in raising awareness and embedding a culture where antimicrobial stewardship is everyone's business. The audit was also useful to identify areas where further development and training were required.

Daily IV Antibiotic Report

The Daily IV Antibiotic Report was introduced in February 2014 to support the Trust's Enhanced Recovery Project. Real-time reports of patients on intravenous (IV) medications were sent to Doctors, Charge Nurses, Pharmacists and Microbiologists every morning.

The purpose was to encourage the reviews of patients on IV antimicrobials, promote switching from IV to oral route and promote appropriate referrals to the outpatient IV antimicrobial services. This will help encourage patient's mobility and allow for earlier discharges. Overall, it will reduce the risk of hospital acquired infections, improve patient's experience, improve patient flow, and promote effective use of time and resources.

NCL Outpatient Parenteral Antibiotic Therapy (OPAT)

Whittington Health has led on the North Central London Outpatient Parenteral Antibiotic Therapy (NCL OPAT) Collaborative Working Group. The aim was to facilitate integration of care through the development of sector wide guidance. The first meeting was held in August 2013 which was attended by representatives from hospitals and district nursing services across North Central London sector. The group continue to expand with Barnet, Camden and Edgware Community Services and Homerton Hospital expressing interest in joining the group.

NCL TB South Hub Centre

The new NCL TB South Hub Centre was opened at The Whittington Hospital on April 2014. Whittington Hospital team led the multidisciplinary collaboration working group to develop the NCL TB Guideline - which provides important guidance on Infection Control Procedures and treatment management of *Mycobacterium tuberculosis*.

The NCL TB South Hub was the first outpatient clinic in Whittington Hospital to adopt a paperless system – using the electronic prescribing and electronic patient records. Physicians will be able to utilise protocols on the electronic prescribing system to prescribe complicated TB regimens safely, easily and accurately.

Expenditure

The total trust antibacterial and antifungal expenditure in 2013/2014 was £570,000 and £100,000 respectively. There has been a 4.2% increase in antimicrobial expenditure 2013/14 compared to the previous year which corresponds to increased ambulatory antimicrobial expenditure.

11. Conclusions

The wider IPCT of Whittington Health has had another busy year where we have tried to focus on broader aspects of infection prevention and control rather than simply the mandatory objectives surrounding *C. difficile* and MRSA bacteraemia.

We have had many successes, for example; embedding a new invigorated hand hygiene campaign, becoming the first organisation to achieve the staff influenza vaccine target and improving the IPC audit compliance results especially in our community sites.

We failed to achieve our 2013/14 HCAI objectives for both MRSA bacteraemia and *C. difficile* associated diarrhoea. However our IPCC are confident that each case was fully investigated and that lessons learnt from each case have been carried forward and shaped the IPC strategy going forward. Our orthopaedic surgical site infection rates are around the national benchmark and we continue to work closely and successfully with our colleagues in theatres, orthopaedics and our community staff to ensure we deliver clean safe care to these patients. We have expanded our SSI scheme to include colorectal patients.

The main objective going forward in 2014/2015 will be the continued zero tolerance approach to HCAI outlined in detail within the current IPC plan. We will introduce phase two of our hand hygiene strategy to ensure that full hand hygiene compliance remains at the top of the agenda. We will be introducing new technology with the aim of further improving compliance with antimicrobial prescribing. We have struggled this year to ensure that all our staff have received IPC training so we are looking at different methods of reaching all staff in 2014/15, including a shortened IPC educational session and holding clinical team leaders to account for their staff.

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

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 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
4. Clinical staff all comply with best practice in urinary catheter care as	The number of catheters placed will reduce.	Continence/ bladder and bowel team to deliver refresher training on urinary catheterisation to relevant staff.	Monthly	HON ICAM HON WCF	LNIPC	Competency assessment records

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
set out in the Saving Lives HII6.	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.	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.		HON SDC Head of Clinical Development Lead for Safety and Productivity Maxine Hammond Liz Bonner Fernando Garcia Director of Postgraduate Medical Education		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	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.				

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
		Meetings with Pentonville and deliver training on how to clean to BICS and inmates to standardise cleaning practices in the prison and healthcare wing.		Managers		
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 Clinical Area Managers HON SCD delegating to Clinical Area Managers Dr J Andrews	LNIPC	Quarterly report presented by DIPC to Quality Committee
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

Deliverable	Outcome	Actions	Review Date	Clinical Lead	IPCT Responsible Lead	Evaluation/ Assurance
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
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

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

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 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 week	All staff knows how to access the IPC for advice/support. Timely and relevant advice given and advise logged for records.	Microbiology/Infection Prevention and Control Team contact details are easily available.	Ongoing	Dr J Andrews	DIPC LNIPC Health Protection Agency	Refresh communications to all staff 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

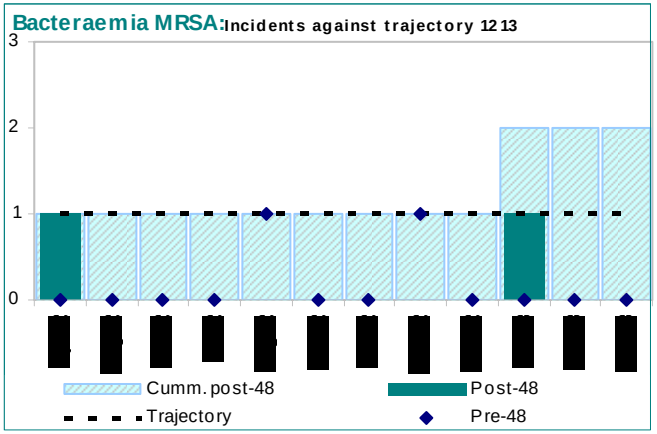
Name	Title
Dr Julie Andrews	Director Infection Prevention and Control (DIPC)
Dr Michael Kelsey	Consultant Microbiologist, Head of Laboratory
Ai-Nee Lim	Antimicrobial Pharmacist
Patricia Folan	Infection Prevention & Control Matron & Deputy DIPC
Gretta O'Toole	Infection Prevention & Control Nurse Specialist
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

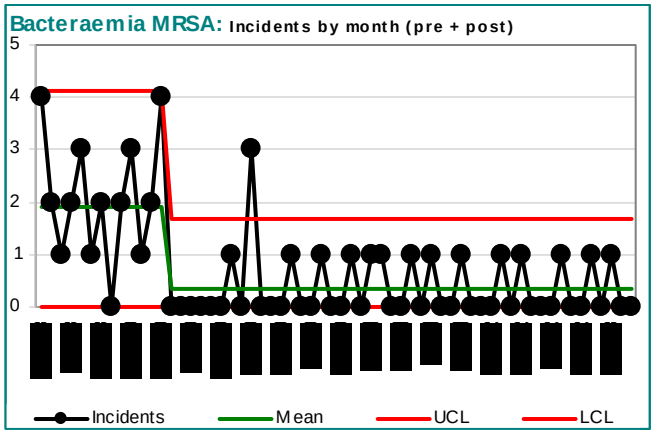
Abbreviations

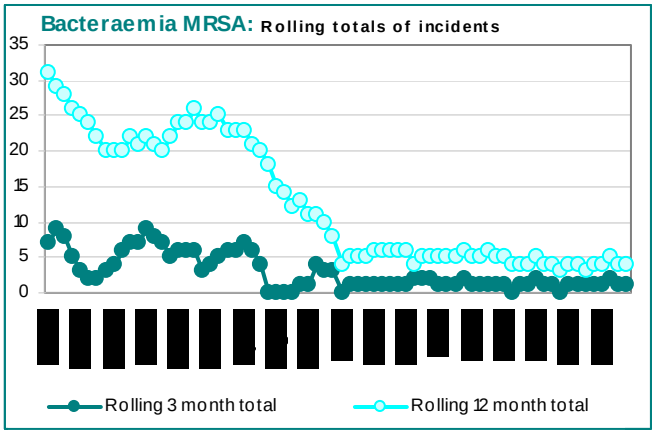
DIPC = Director of Infection Prevention and Control
LNIPC = Lead Nurse Infection Prevention and Control
IPCT = Infection Prevention and Control Team
HON = Head of Nursing
ICAM = Integrated Care and Acute Medicine
IPCC = Infection Prevention and Control Committee
SCD = Surgery Cancer and Diagnostic
WCF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

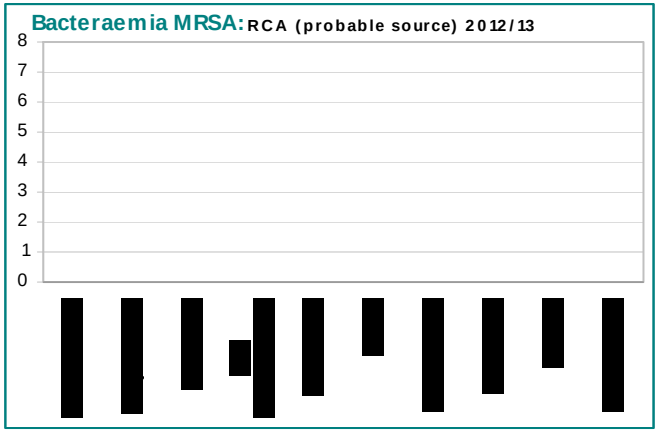
Appendix B

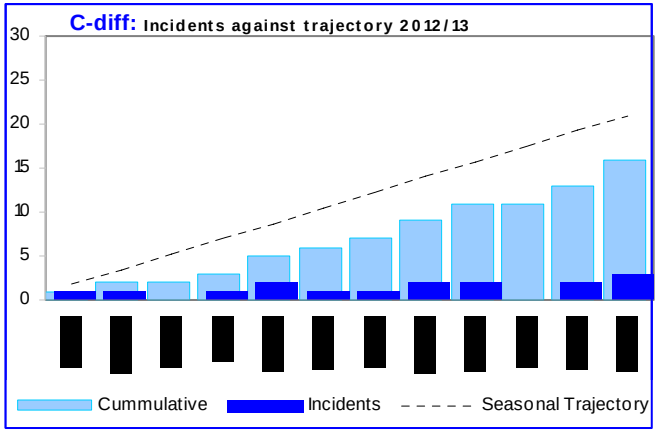
Healthcare Associated Infection Flash Reports

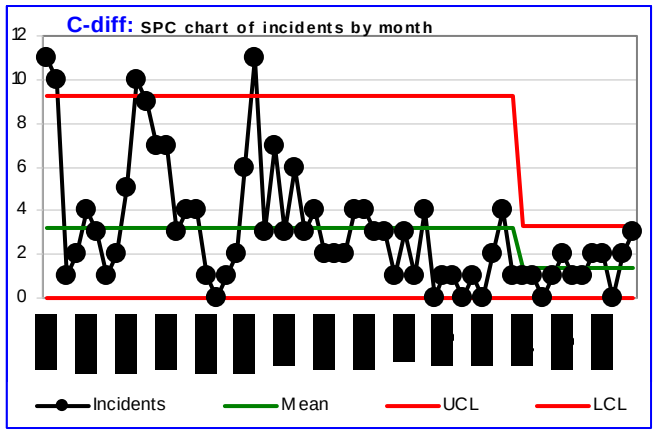


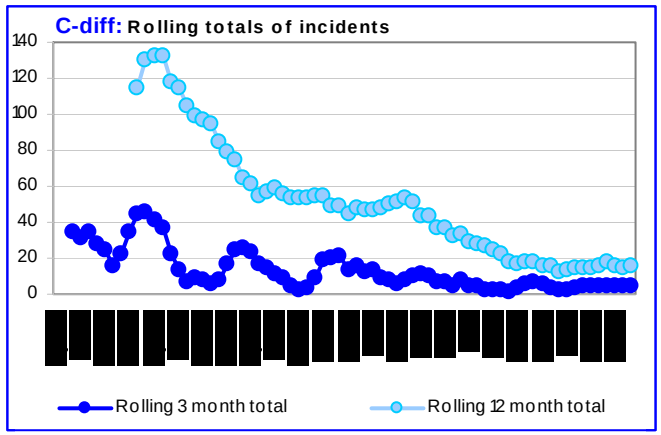


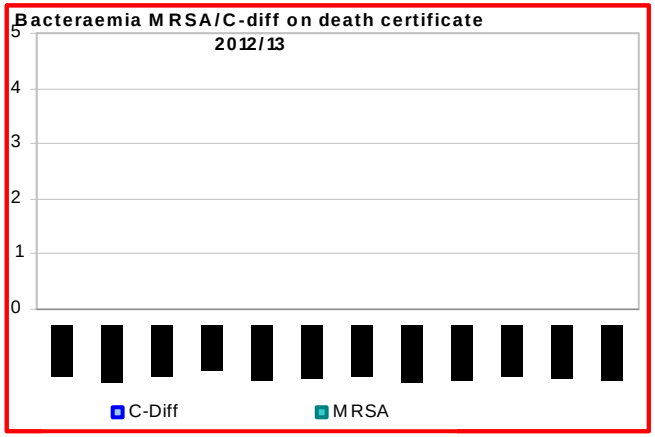


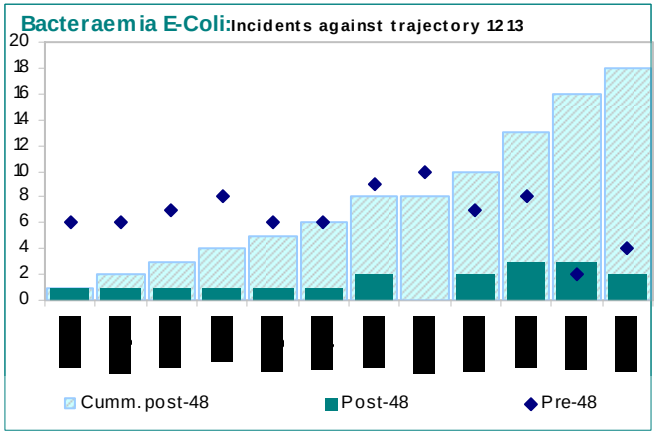


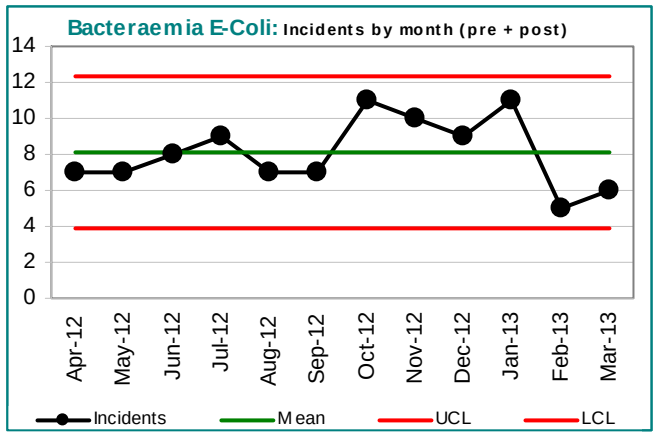


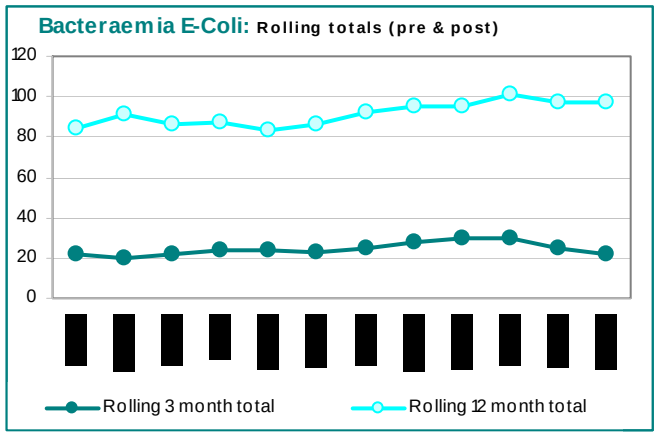


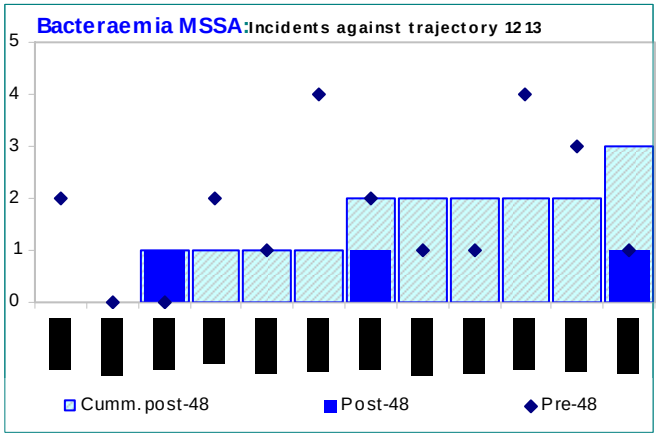

C-diff: Rolling totals of incidents
140
120
100
80
60
40
20
0
Rolling 3 month total
Rolling 12 month total

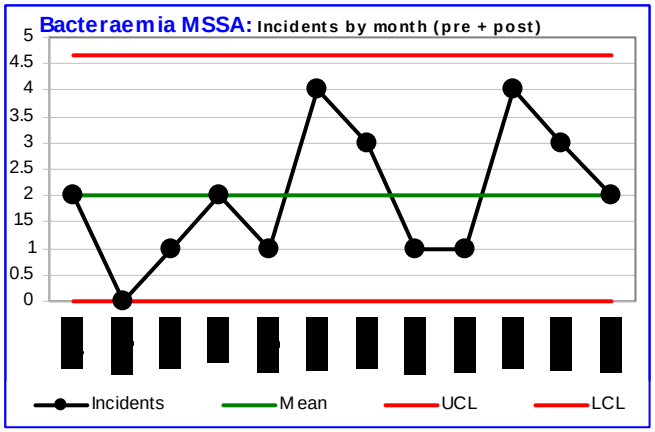

Bacteraemia MRSA/C-diff on death certificate
2012/13
5
4
3
2
1
0
C-Diff
MRSA

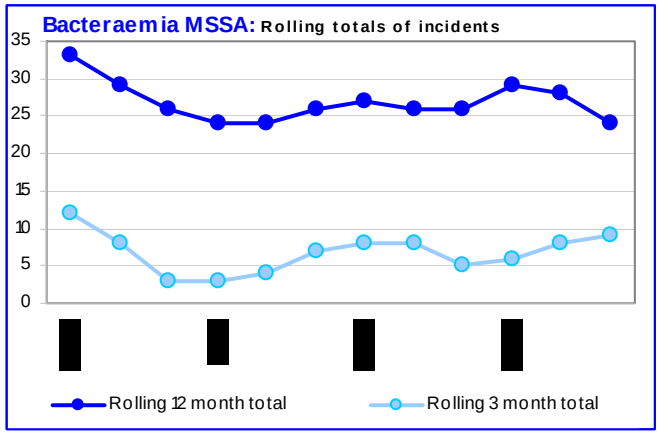

Bacteraemia E-Coli: Incidents against trajectory 12 13
20
18
16
14
12
10
8
6
4
2
0
Cumm. post-48
Post-48
Pre-48


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 2014

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	G	G	G
Betty Mansell Women Diagnostic OPD	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	G	R
Birth Centre	Not applicable	Not applicable	Not applicable	G	G	G	A	G
Cearns	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Cellier	Not applicable	Not applicable	Not applicable	G	G	G	G	G
Clinic 4C (Womens Health)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	G
Clinic 4d (Paeds)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	G
Emergency Dept (Paeds)	Not applicable	Not applicable	Not applicable	Not performed	Not performed	Not performed	G	R
Ifor	G	G	Not applicable	Not performed	Not performed	G	G	G
Labour	G	G	Not applicable	G	G	G	G	G
Murray	G	G	Not applicable	G	G	G	G	G
NICU	A	G	Not applicable	G	Not applicable	G	G	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	G	G	G	G	G	G	G
Bridges	Not applicable	Not applicable	A	G	G	G	Not applicable	R
Dorothy Warren	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	G	G
Clinic 3a	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	R	R
Clinic 3b Dermatology	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	R	R
Clinic 3d	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	A	R
Cloudesley	G	R	A	R	G	G	A	G
Emergency Department/ Isis	Not applicable	Not applicable	A	G	A	G	G	R
Mary Seacole N	G	G	R	G	G	G	G	R
Mary Seacole S	G	G	R	G	G	G	G	R
Mercers	G	G	R	G	G	G	G	G
Meyrick	G	G	G	G	G	G	G	G
Montuschi	A	G	G	G	G	G	G	R
Nightingale	G	G	A	G	G	G	G	G
Physiotherapy Outpatients	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not performed	R	R
Thalassaemia Unit	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	G	G	R

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

Community Services	Environment (G>80%)	Hand Hygiene	PPE	Low Use Outlets
Pentonville Health Services	G	G	G	G
Child Development Centre St Ann's	A	G	G	R
Sexual Health Services St Ann's	G	G	G	R
Bounds Green Health Centre	A	G	G	A
Bingfield Primary Care Centre	G	G	G	A
Broad Water Farm Community Health Centre	G	G	G	A
Edward Drive Unit 1	G	G	G	G
Hornsey Central Health Centre	G	G	G	R
Holloway Health Centre	G	G	G	A
Lordship Lane Clinic	R	G	G	G
Stuart Crescent Health Centre	G	G	G	R
Stroud Green Clinic	G	G	G	A
The Laurels Healthy Living Centre	A	G	G	G
Tynemouth Road Health Centre	A	G	G	R
Lansdowne Road Health centre	R	G	G	G
Hornsey Rise Health Centre	A	G	G	R
Hanley Primary Care Centre	G	G	G	R
The Northern Health Centre	R	G	G	A
Highbury Grange Health Centre	G	G	G	G

Low Use Outlets Only
R= No Log
A= Log not in date
G= Log and in date

Overall scores	293/306	95%
Red		19%
Amber		10%
Green		71%

Goodinge Health Centre	A	G	G	R
River Place Health Centre	G	G	G	G
Finsbury Health Centre	A	G	G	R
Partnership Primary Care Centre	G	G	G	A
Killick Street Health Centre	G	G	G	R