Enclosure 3

Sandwell and West Birmingham Hospitals NHS
NHS Trust

REPORT TO THE TRUST BOARD

DOCUMENT TITLE:	Infection Service Annual Report (April 2018 - March 2019)
SPONSORING DIRECTOR:	Paula Gardner – Director of Infection prevention and Control (2018-19) and Chief Nurse
AUTHOR:	Dr Tranprit Saluja – Consultant Microbiologist/Infection Prevention and Control Doctor Infection Prevention and Control Nursing Service Dr Jonathan Swindells – Consultant Microbiologist/Antibiotic Lead Richard Anderson – Informatics Officer. Pathology Clinical Group Julie Booth – Lead Nurse IPC (from November 2018)
DATE OF MEETING:	

SUMMARY OF KEY POINTS:

- The Trust annual target for *C. difficile* was met (15 against a trajectory of 29). This equated to:-
  - 9- Sandwell site 8= unavoidable 1= avoidable
  - 3- City Site 3= unavoidable 0 = avoidable
  - 2 - Intermediate Care 2 = unavoidable
- In relation to MRSA bacteraemia, there was 1 MRSA bacteraemia attributed to the Trust, no lapses in care identified.
- Target set for 2019/2020 for *C.difficile* is now 41 cases, the case attribution criteria has changed, with a reduction in one day and there is a requirement to assess whether the patient has been in receipt of healthcare in our Trust, in the previous four weeks.
- The Trust adopts a proactive approach to the identification and monitoring of period of increase incidence [PII] and outbreaks. During the period April 2018 - March 2019 there were 3 outbreaks reported, 1 ward with bay closure and two ward closures due to suspected and confirmed norovirus.
- A significant number of patients were admitted with flu over the winter season, not all could be isolated and contacts were managed with Tamiflu prophylaxis to prevent further spread. Capacity issues continue to be a challenge during outbreaks.
- Influenza immunisation uptake was 83% for the patient facing staff delivered by Occupational Health and peer vaccinators. Protecting staff from flu is important for staff health and well-being but also as a means of protecting vulnerable patients
- High standards of hand hygiene compliance have been maintained
- Antimicrobial stewardship continues to be one of the key measures to reduce the risk of Clostridium difficile infection and the single most important measure to reduce the selection of multiple antibiotic resistant bacteria.
- The emergence of multi resistant organisms. National guidance recommends increased surveillance and microbiological screening of patients. Trust has identified an increasing number of periods of increased incidence and outbreaks attributed to a variety of micro-organisms to include: -
  - Clostridium difficile [CDI] there were **0** PIIs
  - One Vancomycin resistant (VRE) PII on Sandwell CCS remains under review until typing results are received.
  - The neonatal unit experienced an outbreak of Pseudomonas.
  - There have been incidences of TB acquisition. These incidents are ongoing with tracing and testing of a number of further patient and staff contacts in liaison with the TB nursing services.
  - In all incidences post infection reviews have been undertaken and multi-disciplinary and agency meetings held to identify lessons learnt and outcome of lessons learnt.
- Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by Clinical and non-Clinical Groups and healthcare personnel.

PURPOSE OF THE REPORT *(Indicate with 'x' the purpose that applies)***:**

Approval	Receipt and Noting	Discussion
To advise the Trust Board of the work undertaken by the Infection Service at Sandwell & West Birmingham Hospitals NHS Trust for the period April 2018 - March 2019.		

The Trust Board is asked to receive and note the Annual Report for the period April 2018 - March 2019.

ACTIONS REQUIRED, INCLUDING RECOMMENDATION:

ALIGNMENT TO OBJECTIVES AND INSPECTION CRITERIA:

Strategic objectives	• Compliance with National & Local Targets for to include MRSA and *C.difficile* • Ensure systems are in place for the prevention and control of healthcare associated infections. • To meet the statutory requirements as set out in 'The Health and Social Care Act 2008' [amended July 2015] – *Code of practice for health and adult social care on the prevention and control of infections and related guidance'*
Annual priorities	
NHS LA standards	NHS LA Risk Assessment **-** 2.2.8 – Infection Control
CQC Essential Standards of Quality and Safety	1. CQC • Outcome 8 (Regulation 12) • Outcome 11 (Regulation 16) 2. The Health and Social Care Act 2008 [amended July 2015]. Code of Practice on the prevention and control of infections and related guidance.
Auditors' Local Evaluation	

IMPACT ASSESSMENT *(Indicate with 'x' all those that apply in the second column)***:**

Financial	**x**	Ensure finance is available for the management and control of outbreaks to include microbiological sampling.
Business and market share		
Clinical	**x**	Continual improvement and maintenance of infection control standards prevents and reduces HCAI
Workforce		
Environmental	**x**	Identification of environmental issues that have an impact on Infection, Prevention and Control
Legal & Policy		
Equality and Diversity		

Patient Experience	**x**	Continual improvement and maintenance of infection control standards contributes to a positive patient outcome and prevents and reduces HCAI
Communications & Media	**x**	Compliance with infection control is high on the public agenda and can influence patient choice.
Risks		

CONTENTS

INFECTION PREVENTION SERVICE
ANNUAL REPORT APRIL 2018 TO MARCH 2019

1. SUMMARY

The annual report for Infection Prevention and Control outlines the Trust's Infection Prevention and Control (IPC) activity in 2018/19. In addition it highlights the role, function and reporting arrangements of the Director of Infection Prevention and Control (DIPC) and the Infection Prevention Service (IPS).

The aim of the Infection Prevention Service (IPS) is to provide an efficient, cost effective service for Sandwell and West Birmingham Hospitals NHS Trust (SWBH). To develop, utilise and promote infection prevention and control practices that are cost effective, safe and efficient, minimising the risk of patients acquiring infections, during or as a result of their stay in hospital. Working in partnership with health care professionals across the health economy, SWBH is committed to a zero tolerance ambition to eliminate all avoidable HCAI.

There are national contractual reduction objectives for MRSA bloodstream infections and Clostridium difficile infections and there are infections that are mandatory for reporting to Public Health England listed below. These will be included in the report.

- Meticillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- *Clostridium difficile* infections
- Meticillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections
- Escherichia coli (*E.coli*) bloodstream infections
- *Klebsiella* spp.
- *Pseudomonas aeruginosa*

Summary of compliance against key objectives for the period 2017/2018

Target	Agreed target/rate [Year end]	Trust rate [End March 2018]	Compliant	Comments	
MRSA bacteraemia	0 tolerance	1 attributed to SWBH	Yes	*Pre 48hrs - laboratory identified* 0= Sandwell 5= City	***Post 48hrs- laboratory identified*** **0 = Sandwell** **1 = City**
				Post 48 hour – no lapses in care identified, source likely to be chest infection.	
C.difficile acquisition toxin positive	29	15 attributed to SWBH	Yes	14 Unavoidable 1 Avoidable due to Antimicrobial Prescribing.	
MRSA Screening - Elective [YTD]	85% (locally agreed	86.1%	Yes	This target has been achieved, however we would like to see an increase in the percentage compliance for high risk areas and we will be working on how we improve the data quality	
MRSA Screening	85%	85.6%	Yes	Work is being undertaken to improve the	

- Non Elective [YTD]	(locally agreed			target although the locally agreed target has been achieved.
Post 48hrs MSSA Bacteraemia (*rate per 100,000 bed days*)	N/A	10 *(4.28 per 100,000 bed days)*		

Blood culture contamination rates (Target = *3% by Ward,dept. and site*.)	**Site**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	City	3.3%	2.0%	2.0%	1.7%	2.4%	2.7%	3.6%	1.4%	3.8%	3.1%	2.7%	2.2%
	Sand	4.8%	2.4%	2.1%	5.0%	4.1%	3.1%	2.7%	5.6%	5.6%	5.1%	4.8%	4.2%
	It has been a challenging year for achievement of this target. There have been changes in leadership and there has been difficulty in formulation of improvement trajectories, however we are now in a position to enable improvements.												

The Trust adopts a proactive approach to the identification and monitoring of period of increase incidence [PII] and outbreaks. During the period April 2018 - March 2019 there were 3 diarrhoea outbreaks reported, 1 ward with bay closure and two ward closures due to suspected and confirmed norovirus.

The table below demonstrates what went will and areas that we need to improve upon.

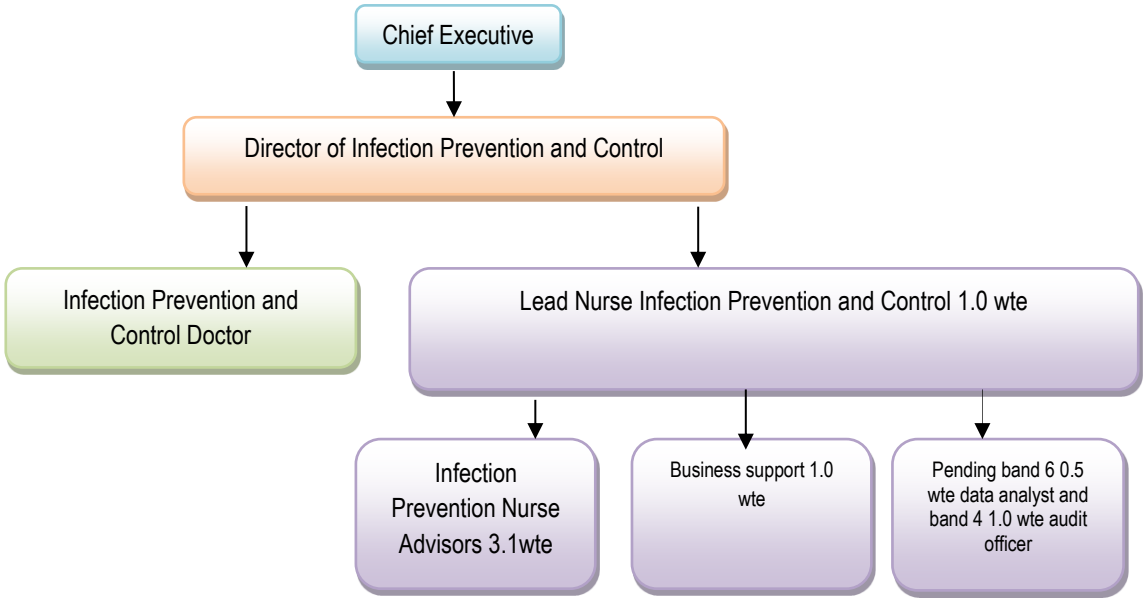
Clostridium Difficile	
What Went Well	*What we need to improve*
• We have are well below the trajectory and we have benched marked against similar local organisations and are we the lowest in the benchmarked group. This is an excellent achievement and we aim to continue the success in the coming year. • Lapse in care meetings happened in a timely manner and any learning disseminated in a prompt manner.	• Timely antibiotic reviews to ensure that the whole process is thoroughly completed and we quickly identify any learning.
MRSA Bacteraemia	
What Went Well	*What we need to improve*
• MRSA BSI – robust systematic way of looking at any infections and we adhere to the national guidelines	• MRSA samples being lost – systematic checking process that CCS and microbiologist are now reviewing whether the samples have been reported. Staff need to ensure that the when they take a sample that the results have been reviewed and actioned.
Fit Testing	
What Went Well	*What we need to improve*
• We have developed a program of fit testing and most areas have fit testers and we currently have73 members of staff that are able to fit test, with this number increasing as training is rolled out. • The compliance will be added to mandatory training.	• We need to improve engagement and the numbers of medical staff that have been fit tested to ensure that safety maintained.

• We have over a thousand staff members that have been fit tested across all specialities. • We also have accredited fit test trainers; they are the only 2 nurses in the country that have this qualification.	

2. ORGANISATIONAL GOVERNANCE AND ACCOUNTABILITY FOR THE INFECTION PREVENTION CONTROL SERVICE

The IPS is a fully integrated service incorporating the Acute, Community and Intermediate Care. Partnership working with the Clinical Commissioning Groups (CCG), NHS Improvement [formally TDA] and Public Health England (PHE) through the Health Economy Groups for Infection Prevention and Control continues.

2.1 Organisational Governance and Accountability structure for the Infection Service



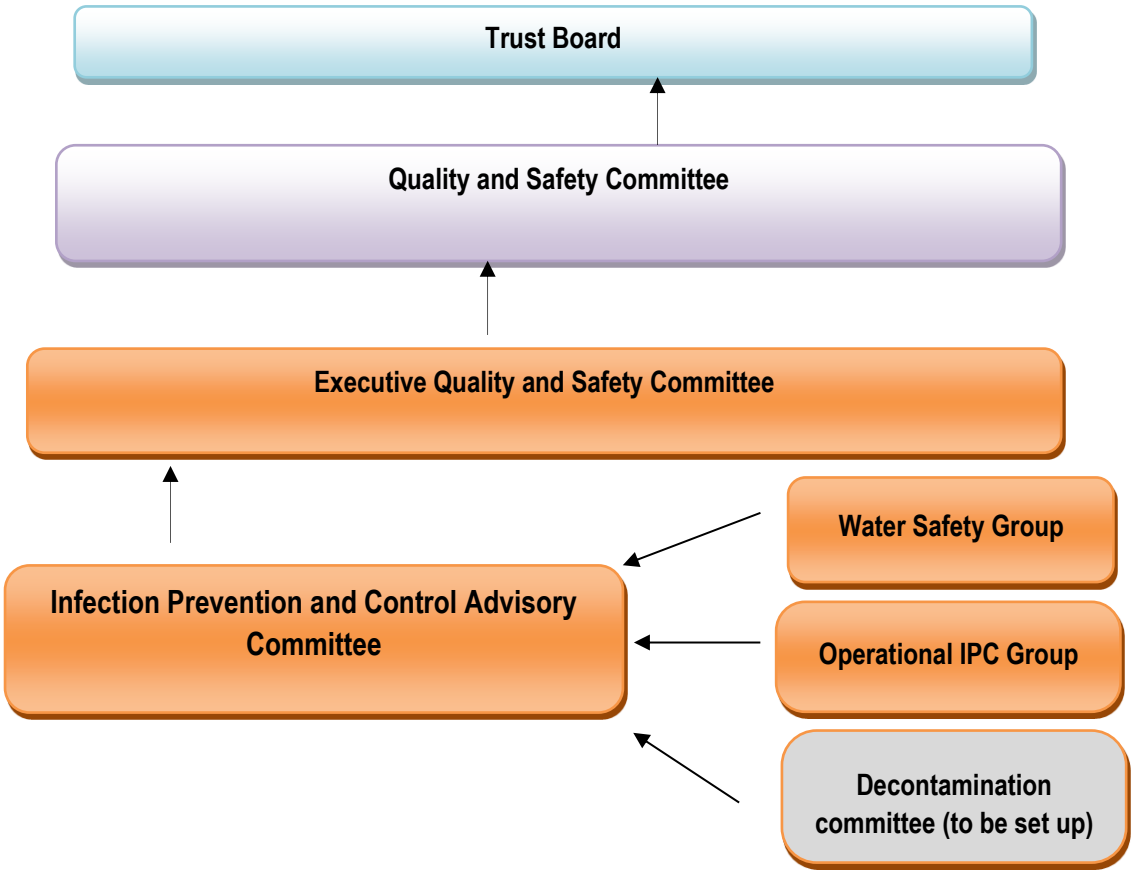
2.2 Infection Prevention and Control Advisory Committee

The Infection Prevention and Control Committee [IPCAC] is chaired by the Director of Infection Prevention and Control [DIPC] or IPCD with attendees from the IPS, Clinical and Non Clinical Groups, Health Protection Unit and the Consultant in Communicable Disease Control [CCDC]. The aim of the IPCAC is to provide a formal forum for monitoring compliance against Infection Prevention and Control [IPC] standards, ratification of IPC policies, addressing key IPC issues and providing a forum for formal discussion for Groups on IPC issues.

Overall compliance against IPC issues and standards is monitored in the form of an action plan which forms part of the overall Trust Assurance Framework. It is designed as a working document to monitor compliance against key IPC issues and includes compliance with the 'The Health and Social care Act 2008' [Amended July 2015], NHS Improvement [formally TDA], CQC and CCG. This is currently under review in order to streamline the information and raise the profile of infection prevention in all areas. We are reviewing and revising the Assurance Framework and are developing a Healthcare Reduction Plan that will support the IPC work program.

The Infection Prevention and Control Assurance Committee are responsible to the Chief Executive and the Trust Board.

Accountability structure for Infection Prevention Control Advisory Committee



3. ALERT ORGANISM SURVIELLANCE

Microbiological surveillance is undertaken by the IPS from clinical specimens received in the hospital laboratory which focuses on organisms which are known to have the ability to cross-infect, are resistant to multiple antibiotic and not normally present in high numbers in the patient population – 'Target organisms'. An increase in numbers of these 'target organisms' isolated in a particular ward/department, or in similar clinical sites may indicate a problem in either the short or long term, requiring investigation and action.

The infection prevention and control nurse advisors [IPCNA] follow up all significate results to ensure the patients are managed appropriately and to reiterate the care and management from an infection prevention and control perspective (i.e. need for isolation, infection prevention and control precautions e.g. PPE and the need for barrier/terminal cleaning).

In addition to ongoing surveillance and as part of the initiatives from the DH to prevent and reduce health care associated infections (HCAI), the DH has identified key target organisms that are required to be notified to professional bodies on an ongoing basis. The aim is to monitor compliance against pre-defined targets with the outcome that reduced numbers coincides with more robust health care practices and in turn a reduction in HCAI. The key targets currently being monitored by external agencies include: - *Clostridium difficile*, Methicillin resistant *Staphylococcus aureus* and MRSA screen compliance. Outlined below are key target organisms that are monitored on an ongoing basis by the IPS. These organisms may exclude isolates identified as part of outbreaks and periods of increased incidence.

We also screen for Carbapenemase-Producing Enterobacteriaceae (CPE). This is a type of bacteria that are extremely resistant to antibiotics. These bacteria carry a gene for a Carbapenemase enzyme that breaks down Carbapenem antibiotics. Carbapenems are a class of very broad-spectrum intravenous antibiotics which are used to treat serious infections or conditions where other therapeutic options have failed.

All patients admitted to hospital should have a risk assessment to find out if they are at high risk of carrying CPE. The following patients are considered to be at high risk of CPE colonisation:

1. Patients who have been an inpatient at another hospital in the last 12 months
2. Patients who have been in close contact with someone who has been colonised or infected with CPE in the last 12 months
3. Hospitalisation in another country

To ensure patients are identified SWBH have has robust screening programme in place to identify individuals admitted from other healthcare establishments, here and abroad. A number of individual cases of CRO have been identified via the screening programme imported from other hospitals locally and abroad thereby preventing outbreaks at SWBH. Where cases are identified, contacts within a bay are screened for carriage to identify and prevent ongoing spread.

We were informed PHE of a patient that has been identified as being CPE positive and resistant to nearly all antibiotics, this is an unusual case and the patient requires strict infection and control practices to be adhered to and also isolation precautions, however this has to balance with the patient need and the potential impact of prolonged isolation. We are supported the ward staff in order to minimise the risk to other patients and are putting in place actions that mitigate the risk of cross contamination.

3.1 *Clostridium difficile*

Following the identification of each case of *C.difficile* (CDI) the IPS undertake a post infection review (PIR) to identify any issues, lessons learnt to facilitate the prevention of further cases and determine if acquisition was avoidable or unavoidable. The Trust has adopted the DH template for CDI to ensure a consistent health economy approach is undertaken to aid the identification and rectification of key issues. In addition to this adopting the National tool enables a more robust analysis of issues influencing the acquisition of CDI nationally.

The outcome of all reportable CDIs are discussed and agreed with the Infection Prevention and Control Lead for SWBH CCG. Lapses in care are discussed with clinical staff concerned and review meetings called when appropriate.

For 2019/2020 the guidance for the identification of cases of *C.difficile* has changed.
Acute provider objectives for 2019/20 will be set using these two categories:

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

We have reviewed last year's cases and based on the new criteria we are likely to see an increase of four cases.

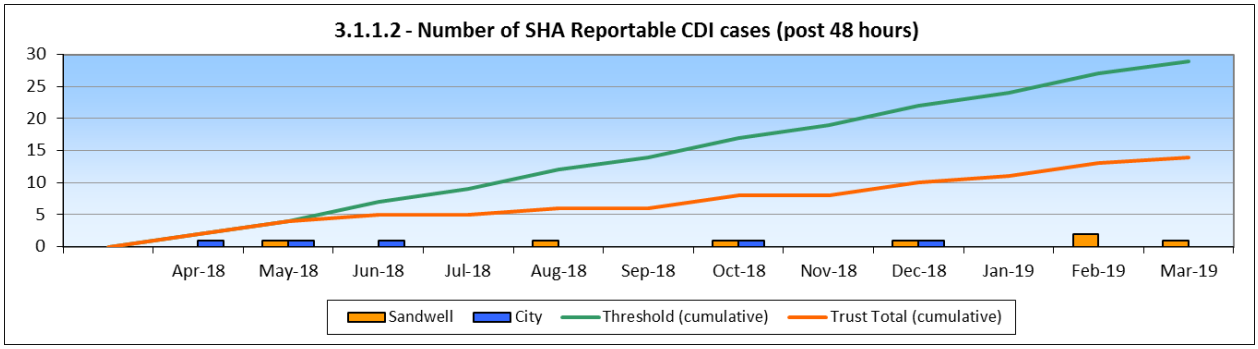
Antibiotic reviews form part of the patient review, we only identified one case where antimicrobial prescribing was a causative factor, this would have been discussed with the prescriber and education provided to the individual.

We continue to work with the CCG and all post-48 hour cases as required, there is a robust confirm and challenge processes in place.

The tables below indicate the number of pre and post 48 hour *Clostridium difficile* reported for April 2018 – March 2019. There were 15 cases against a threshold of 29 for post 48 hour cases.

3.1.1 Reportable - *Clostridium difficile*

3.1.1.2 Cumulative number of Post 48hrs *Clostridium difficile* infections (CDI) against trajectory



The chart above represents the acute cases by site and excludes the intermediate care case.

3.1.2 *Clostridium difficile* – Period of Increased Incidence

There are none to report, which demonstrates that there was no transmission and good infection control practices adhered to.

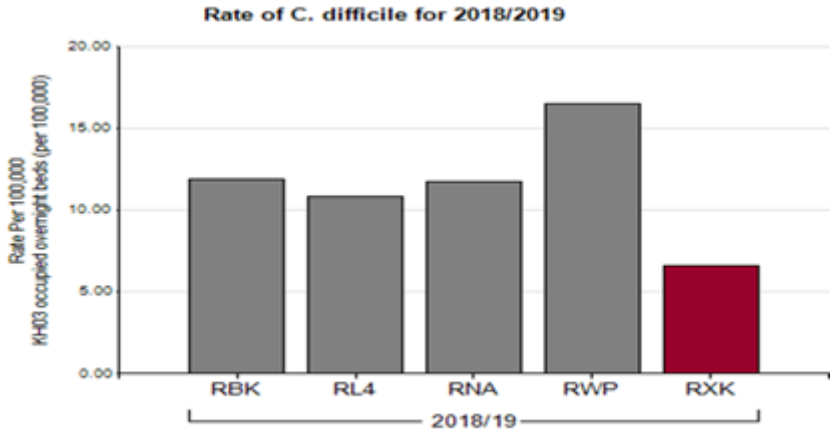
3.1.3 Lesson Learnt/ Outcome of Lessons Learnt

For the 15 acute Trust reportable cases 1 was considered avoidable due to antibiotic prescribing outside trust guidelines. Other lapses in care not considered to have contributed to acquisition however formed the outcome of lessons learnt.

Lessons Learnt	Outcome of Lessons Learnt
Lack of isolation facilities in monitored areas	There are portable monitors available for side rooms however wards have to ensure they have staffing capacity to incorporate this. This is an issue as there is not often nursing capacity to be able to allocate staffing to care for patients requiring monitoring and isolation. We are working with the admission areas to look at how the risk is managed.
Closure of side room doors	Further education and training has been facilitated for staff on wards to highlight the importance of isolation doors remaining closed. This was escalated to matrons and Group Directors of nursing through the IPCAC committee. We are also investing in better isolation posters to provide information at source.
Signage	We have redesigned isolation signs to make them more visible and user friendly.
Timely reviews of patients	We have introduced Clostridium Difficile ward rounds that include a Microbiologist, IPC nurse Advisor and pharmacist
Delay in isolation	Further education and training has been facilitated for staff on wards to highlight the importance of isolation doors remaining closed. This was escalated to matrons and Group Directors of Nursing through the IPCAC committee.

Benchmarking

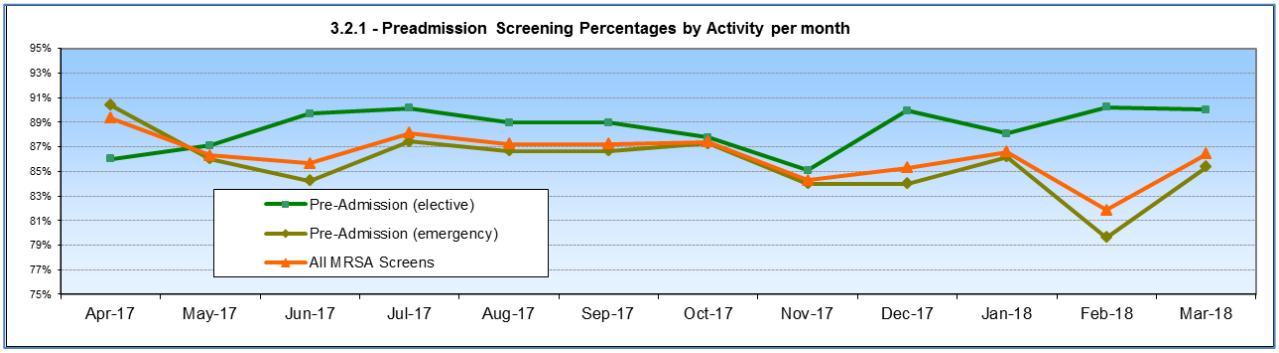
The graph and table below indicates our benchmarking rate of C.difficile per 100,000. The Acute providers have comparable demographics to the Trust. We have lower rates of C.difficile in comparison to the other providers.



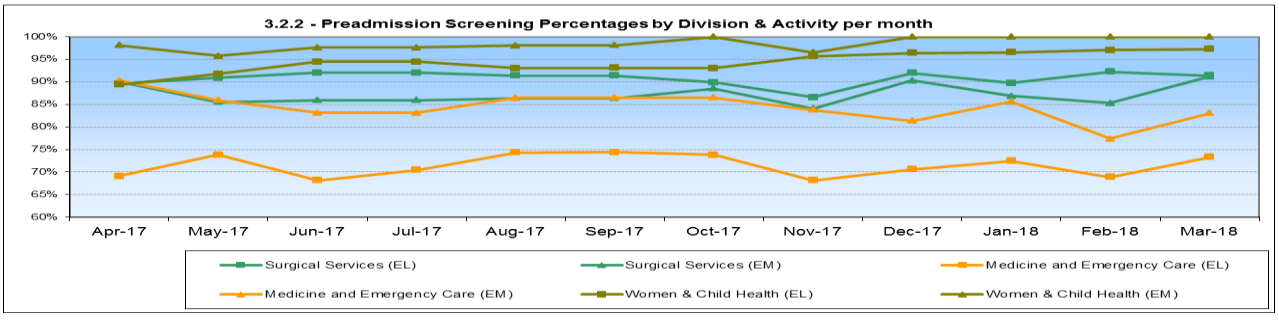
Organisation Name	Code	2018/19
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	RXK	6.59
THE DUDLEY GROUP NHS FOUNDATION TRUST	RNA	11.75
THE ROYAL WOLVERHAMPTON NHS TRUST	RL4	10.87
WALSALL HEALTHCARE NHS TRUST	RBK	11.95
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	RWP	16.54

3.2 Meticillin Resistant *Staphylococcus aureus* (MRSA) Screening

3.2.1 MRSA Screening undertaken by month for the period April 2017- March 2018



3.2.2 Pre-admission MRSA screens by Division and month for the period April 2018 - March 2019



We are achieving the internal target for both elective and none elective, against our internal target of 85%. We recognised that there was a proportion of screens that were not in line with national screening guidance and from the 1st April 2019 we have moved the screening away from A&E.This will enable more accruate data to be captured and be a true reflection of our MRSA screening status.

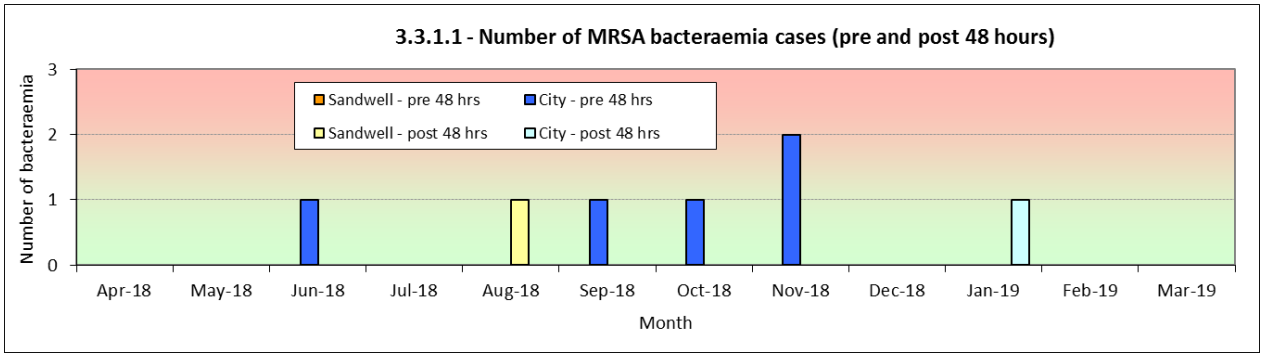
3.3 Bacteraemia

SWBH undertake bacteraemia surveillance in accordance with Public Health England's mandatory surveillance programme. The overall aim of enhanced bacteraemia surveillance is to capture information for MRSA, MSSA and gram negative organisms. The gram negative bacteraemia data has expanded to include Pseudomonas aeruginosa and Klebsiella spp in addition to E.coli. The data gives Trusts and clinical commissioning group a more accurate picture of their situation allowing targeted intervention in problem areas and to contribute to building better evidence base regarding risk factors for infection.

3.3.1 Meticillin Resistant *Staphylococcus aureus* [MRSA] bacteraemias

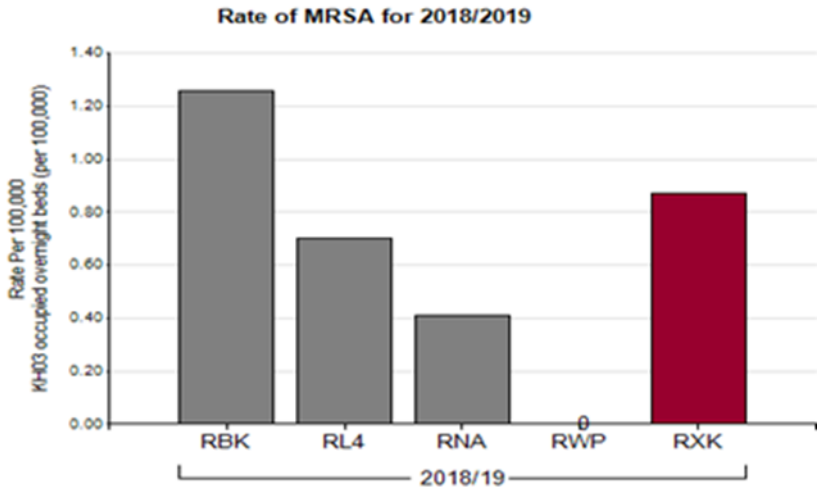
In accordance with PHE enhanced bacteraemia surveillance, SWBH undertakes a Post Infection Review when a patient is identified as having an MRSA bloodstream infection. The PIR is a multidisciplinary review which helps to demonstrate why the infection may have occurred, how future cases can be avoided and the lessons learnt. **For 2018/19 there was 1 MRSA bacteraemia attributed to the Trust.** Although not mandated a post infection review was conducted. The post infection review enabled a high level of scrutiny of the case, there were no lapses in care identified, however there were lessons learnt and processes have been reviewed and altered to ensure that there are vigorous checks in place for MRSA screening, although this would not have altered the outcome for this patient. The case reported in August 2018 was a contaminated specimen and not a true case.

3.3.1.1 Mandatory Reporting of MRSA bloodstream infections for the period April 2017- March 2018



Benchmarking

The graph and table below indicates our benchmarking against the same group of providers for our MRSA bacteraemia rates per 100,000 bed days. We have had 1 contaminant and I case that was attributable to the Trust.

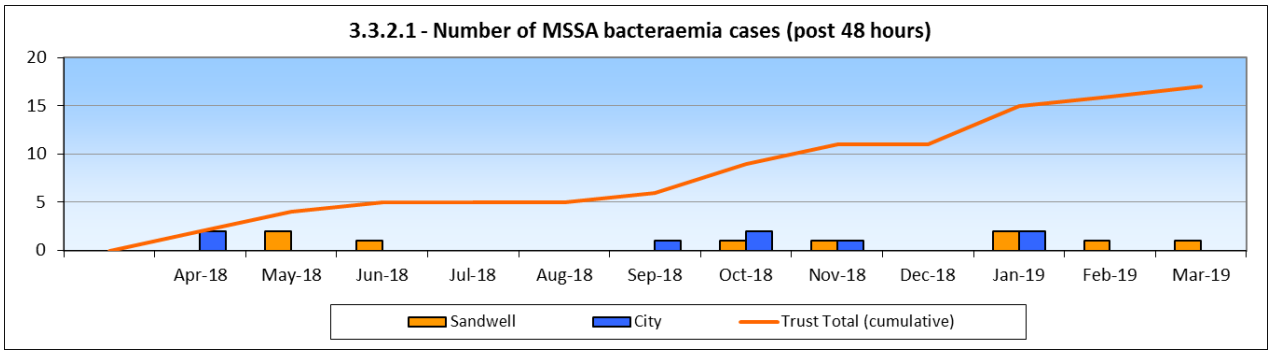


Organisation Name	Code	2018/19
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	RXK	0.87
THE DUDLEY GROUP NHS FOUNDATION TRUST	RNA	0.41
THE ROYAL WOLVERHAMPTON NHS TRUST	RL4	0.70
WALSALL HEALTHCARE NHS TRUST	RBK	1.26
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	RWP	0.00

3.3.2 Methicillin Sensitive *Staphylococcus aureus* (MSSA) bacteraemias

The IPCT undertake PIRs for all MSSA bacteraemia, where a health care intervention has been given by SWBH relevant to the acquisition of the MSSA bloodstream infection. For the same reasons as MRSA bloodstream infections the PIR is undertaken to identify possible root cause and how future cases can be avoided through lessons learnt. We have identified that a large proportion of cases are community onset, and we have not identified any themes and trends with regards to the post 48 hour cases. We will continue to review all future cases.

3.3.2.1 Post 48 Hours MSSA



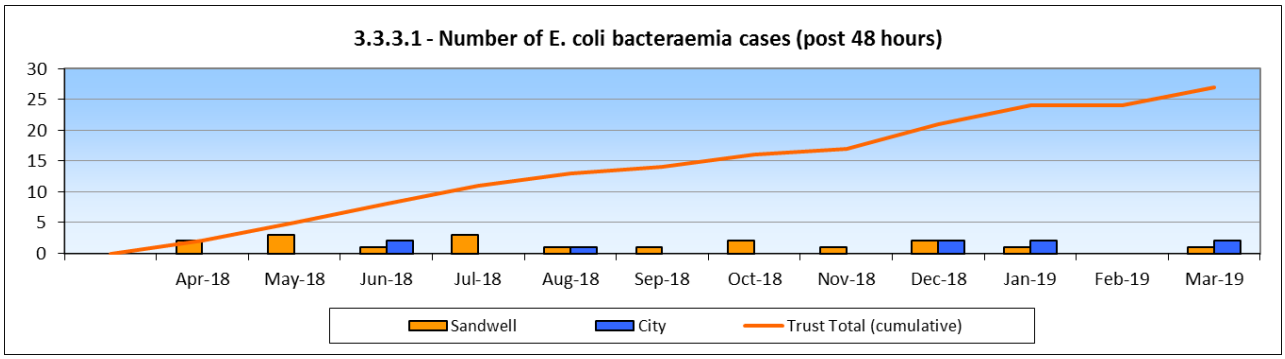
3.3.3 *Gram negative* bacteraemia

Any gram negative bacteraemia that have been identified as having had SWBH care are investigated to establish if the root cause was avoidable, how the infection may have occurred, how future cases can be avoided and lessons learnt.

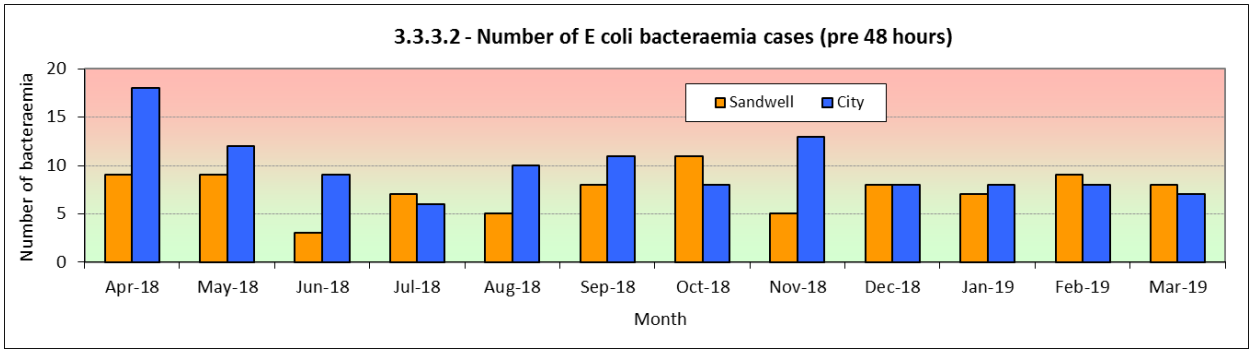
The government plans to reduce the number of healthcare associated Gram-negative bloodstream infections by 50%, by financial year 2020 to 2021. In response to this, PHE expanded their

collection of Gram-negative blood stream infections from E.coli, Pseudomonas aeruginosa and Klebsiella spp. SWBH continue to have a low incidence of hospital onset gram negative bloodstream infections. E.coli is the predominant infection.

3.3.3.1 Post 48 Hours *E. coli* Bacteraemia

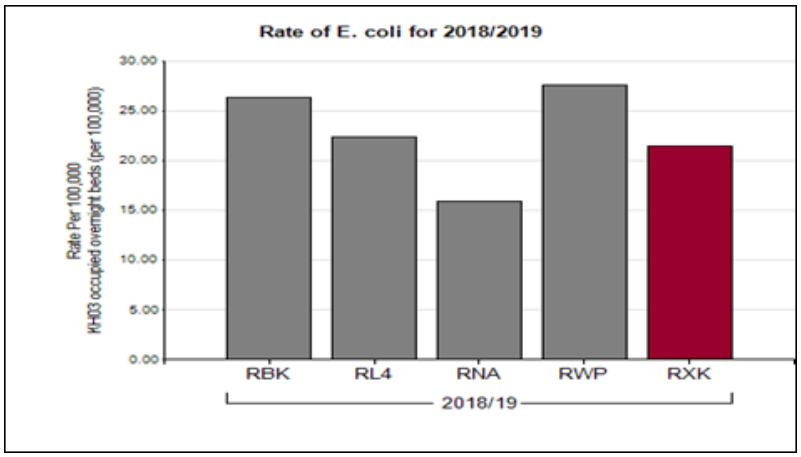


3.3.3.2 Pre 48 Hours *E. coli* Bacteraemias.



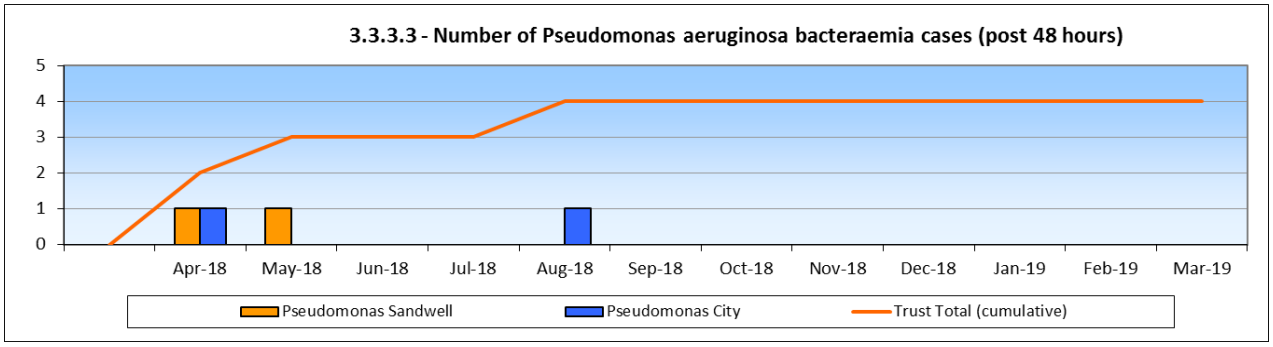
Benchmarking

The graph and table below indicates our benchmarking against the same group of providers for E.coli, rate per 100,000 bed days. We have the second lowest rate for the benchmarked group.

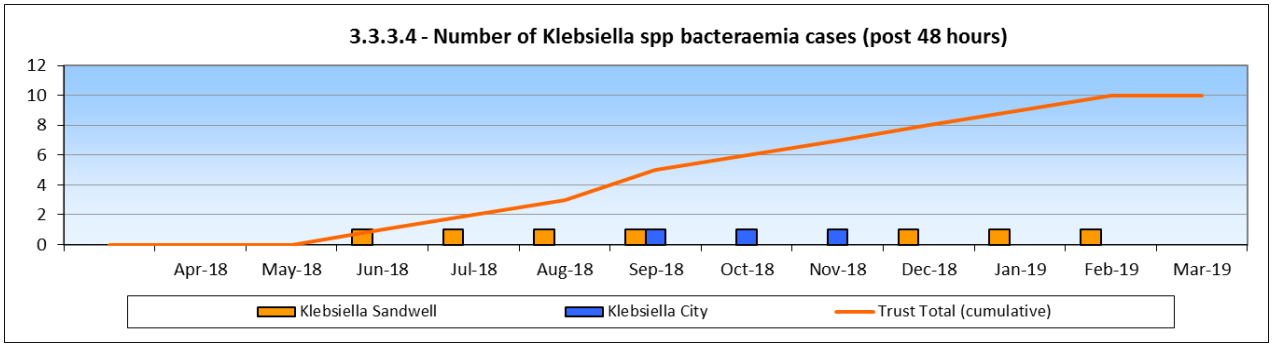


Organisation Name	Code	2018/19
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	RXK	21.54
THE DUDLEY GROUP NHS FOUNDATION TRUST	RNA	15.95
THE ROYAL WOLVERHAMPTON NHS TRUST	RL4	22.45
WALSALL HEALTHCARE NHS TRUST	RBK	26.41
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	RWP	27.69

3.3.3.3 Post 48 Hours Pseudomonas aeruginosa Bacteraemia



3.3.3.4 Post 48 Hours Klebsiella spp Bacteraemia



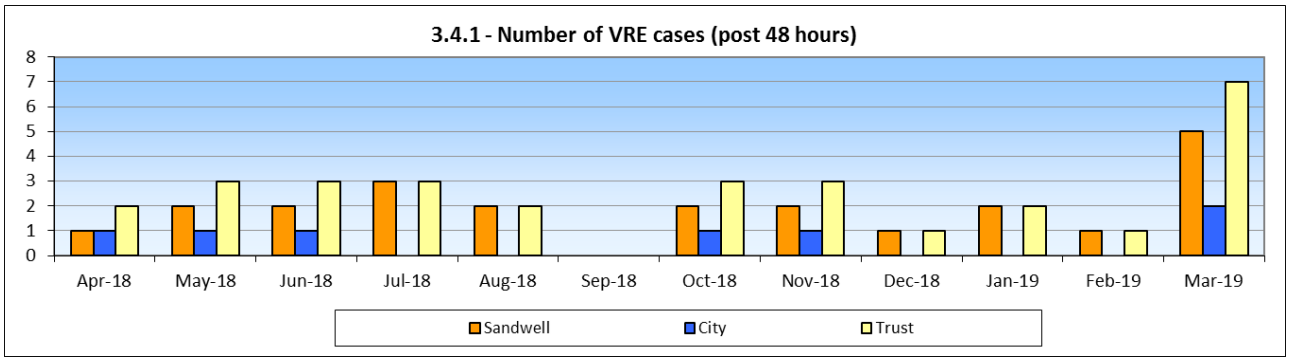
3.4 Vancomycin resistant *enterococcus* (VRE) Isolates

As part of an ongoing screening programme on the Sandwell Critical Care Unit, the IPS continue to monitor the number of patients with VRE both pre and post 48 hours of admission to the Trust. It needs to be recognised that this screening is over and above the recommended screening, and currently screening for VRE is not standard practice in other Organisations. The VRE screening has not resulted in a clear reduction in overall colonization rates of VRE. Going forward this level of screening will not be undertaken, clinical isolates will be treated accordingly. There is no intervention for colonisation of VRE only infection therefore the screening adds no value to the patient pathway.

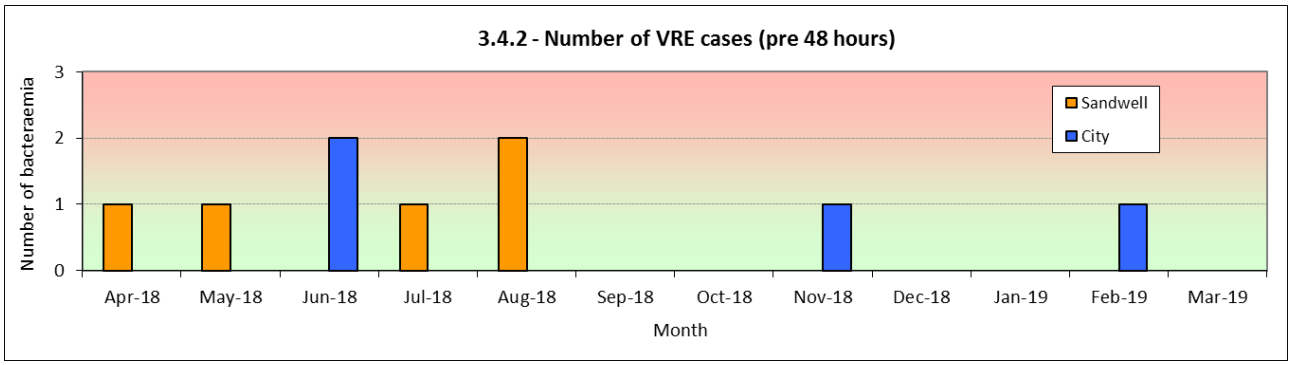
One Vancomycin resistant (VRE) PII on Sandwell CCS similar typing results, confirms colonisation outbreak. Lapse were around isolation and same Critical Care Staff looking after both the patients.

In all incidence post infection reviews have been undertaken and multi-disciplinary and agency meetings held to identify lessons learnt and outcome of lessons learnt, these are described in the body of the report. Key to maintaining standards is continued commitment and compliance with infection prevention and control policies by Clinical and non-Clinical Groups and healthcare personnel. Audit and training continues to a means of monitoring and delivering continuous improvements.

3.4.1 Number of post 48hrs VRE isolates



3.4.2 Vancomycin resistant *enterococcus* isolates – Pre 48 hrs



3.5 Carbapenamase Resistant Organisms [CRO/CPE]

Carbapenemases are enzymes that destroy Carbapenem antibiotics, conferring resistance. A key strategy to control the spread of these bacteria is to identify and isolate patients at risk and then screen them for carriage.

3.6 Blood Culture Contaminants

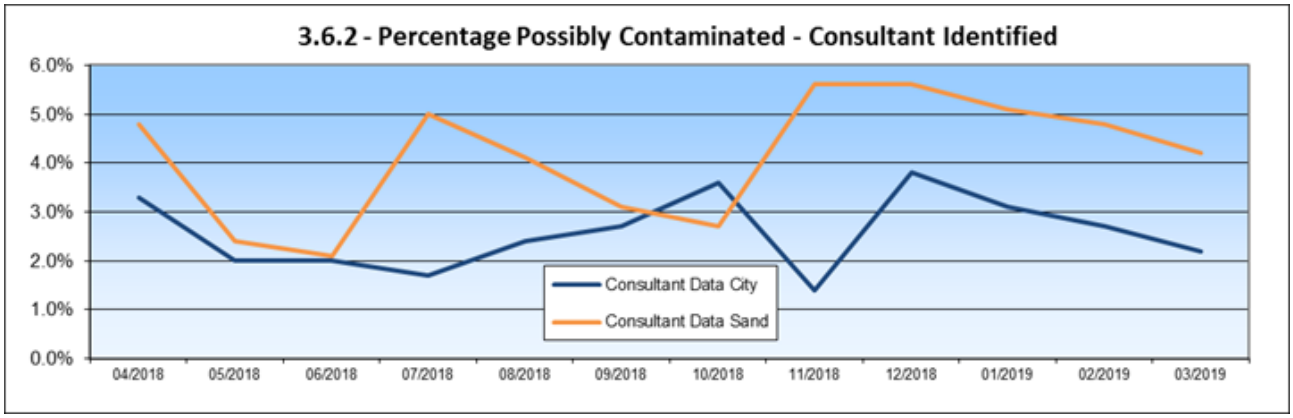
3.6.1 Percentage of possibly contaminated blood cultures

The percentage of potentially contaminated blood cultures is monitored closely by the IPC service as a marker of compliance against good practice when taking blood cultures. All blood cultures received in the laboratory are monitored. Any specimens identified as a contaminant are highlighted to the clinical teams and contamination rates monitored. Contamination rates are fed back to Clinical Groups on a monthly basis in the form of the Infection Prevention and Control report. Re-training of the healthcare professional is requested, when a specimen is identified as a contaminant and the operator can be identified. In addition to these strategies Clinical Groups within wards/departments who have contamination rates above the 3% threshold are required to provide an action plan to the Infection Prevention and Control Advisory Committee.

Changing leadership in departments and the action plan not being developed to a robust standard has been an issue and we are working with the new department lead to help reduce the rates of blood culture contaminants. We also identified issues with the supply of blood culture packs, as the Trust currently have a bespoke pack supplied, we are working with procurement to ensure that any packs are easily accessible via NHS logistics to enable ordering to be more simplistic, this will reduce any delay in obtaining packs.

3.6.2 Percentage of all positive blood cultures that are possible contaminates by month for the period April 2018 – March 2019, by site and Trust

Blood culture contamination rates	Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
(Target = *3% by Ward, dept. and site.*)	City	3.3%	2.0%	2.0%	1.7%	2.4%	2.7%	3.6%	1.4%	3.8%	3.1%	2.7%	2.2%
	Sand	4.8%	2.4%	2.1%	5.0%	4.1%	3.1%	2.7%	5.6%	5.6%	5.1%	4.8%	4.2%



It should be noted that if the location of the patient has not been documented on the microbiology request form, then the Blood Culture may be booked in as SGH. Therefore SGH may have falsely raised contaminates, this should be rectified once EPR is in place.

4.0 SURGICAL SITE SURVIELLANCE (SSI)

On reflection we have completed the mandatory requirements for hips and knee replacement surgeries; however we recognise that SSI is a key requirement to ensure we deliver better outcomes for our patients. We will be participating in the national Getting it Right First Time (GRIFT) program for orthopaedic, breast, ophthalmology, general surgery. We are also collecting baseline data for general surgery and fracture neck of femur to enable a greater understanding of our SSI rates and to the develop plans to improve the rates if applicable.

4.1 Table to identify the number of caesarean section wound infections for the period April 2018 - March 2019

The table below represents the number of SSIs identified against the number of completed forms returned to the IPS. Caesarean section SSI results continue to be reported to WCH on a monthly basis to include recommendations. It is recognised that there continues to be a low return rate of SSI wound questionnaires therefore it is difficult to draw a conclusion on specific SSI rates.

Operative Procedure	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total
Emergency Caesarean Section	81	82	66	99	74	82	81	79	65	58	68	71	**906**
Elective Caesarean Section	54	47	42	41	54	39	47	37	43	38	43	41	**526**
TOTAL	135	129	108	140	128	121	128	116	108	96	111	112	1432
% of SSI rate based on the number of SSI's reported	2.2% (3)	0.8% (1)	0	0	1.6% (2)	1.6% (2)	0.8% (1)	0	0.9% (1)	5.0% (5)	1.8% (2)	0	**1.2% (17)**

5.0 WATER SAFETY

The criteria for the management and testing of water systems are outlined in the Organisations Water Safety Plan; this document is aimed at the management of Legionella, *Pseudomonas, Stenotrophomonas, Mycobacteria* and other waterborne pathogens.

The Water Safety Group (WSG) has met regularly to identify and discuss any issues relating to water safety and ensure robust action plans are in place to monitor compliance. Members of the WSG include: - Infection Prevention and Control Doctor; Head of Estates; delegated members of Estates; Third Party involvement from our PFI colleagues and Nursing representation. There has been a lot of work undertaken to update the Water Safety Plan and this work is near completion, this will ensure that there are robust frameworks in place for the delivery of control schemes.

Water from outlets in these areas are collected and tested in line with the guidance provided in 'Health Technical Memorandum 04-01: Safe water in healthcare premises Part C: *Pseudomonas aeruginosa* – advice for augmented care units. There is 100% compliance with water collection and sampling against the planned testing schedule. There has been development of a system to ensure that all results and remedial actions are captured.

We have plans to improve and increase the water testing for the birthing pools. We also need to work with the clinical areas to determine how we are monitoring low usage water areas, we need to continue to raise the importance of this and work with the clinical areas to enable greater compliance and understanding.

6.0 HAND HYGIENE COMPLIANCE

As part of the Trust's on going initiatives for the reduction and prevention of HCAI, staff, patients and visitors are encouraged to challenge any poor practices relating to hand hygiene and promote best practices. All clinical areas are required to demonstrate compliance with hand hygiene either through the use of audits or where, staff work on a one to one basis clinical teams are required to monitor compliance through the use of patient satisfaction surveys

The aim of the audit is to:

- Review compliance with hand hygiene for healthcare staff and visitors entering clinical areas.
- Identify point of care compliance in line with the World Health Organisation (WHO) hand hygiene recommendations, *'Save Lives – clean your hands'* and *'your 5 moments for hand hygiene'*.
- Data is to be accessible by all, via the Trust Intranet.

Responsibility for monitoring compliance

- Responsibility lies with the Clinical Groups to action plan areas where compliance falls below 95%.
- Actions plans should be presented at the Infection Prevention and Control Advisory Committee as part of Clinical Group Compliance Report.
- Monthly summary reports are compiled and sent to circulated to key staff across the Organisation to include:- Members of the Executive Team, Clinical Leads, Matrons, Ward Managers. In addition the report is presented at the IPCAC

Chart outlining overall Trust compliance for hand hygiene for the period April 2017- March 2018

Overall Trust Compliance 2018-2019		
Date	**Compliance (%)**	**Total number of observations**
March 2018	93%	15398
April 2018	97%	12670
May 2018	96%	20949
June 2018	97%	23150
July 2018	96%	22128
August 2018	97%	23385
September 2018	97%	23052
October 2018	98%	4625
November 2018	96%	16337
December 2018	98%	19884
January 2019	99%	20288
February 2019	98%	18751
March 2019	98%	14979

The table above clearly demonstrates that the overall Trust compliance for hand hygiene is consistently high, however there are areas that it is difficult to implement the audit tool, community services are predominantly lone workers, so we have worked with the Team leaders to look at compliance from a different angle, we are currently look at audit against the bare below the elbow requirements to see if this offers a degree of assurance.

We would like to develop a robust monitoring system for hand hygiene that covers all staff members and concentrates on the 5 moments of hand hygiene.

7.0 IPC EDUCATION AND TRAINING

The IPC team have provided bespoke training to the Neonatal unit, AMU, Transport and also provide ad-hoc training on request. The majority of this year has seen a lot of time taken up with fit testing and there has been a lot of time committed to making this program of work successful.

7.1 Induction and mandatory training

The IPS continues to support the mandatory training and induction programme across the organisation. All mandatory training is monitoring by Learning and Development with Clinical Group responsibility for ensuring compliance with training.

7.2 Blood Culture and Hand Decontamination Education and Training

All new doctors to the organisation are educated in hand decontamination and the correct application Aseptic None Touch Technique [ANTT] for the taking of blood cultures with an aim of obtaining blood cultures that are clinically significant and reducing the number of blood culture contaminants. IPC have produced a DVD for this and training is provided by the clinical fellows. In addition, where blood culture samples have been identified as a contaminant doctors identified are re trained by the IPS to reiterate correct technique.

7.3 Clinical teaching sessions

The IPS continues to undertake teaching sessions in clinical and non-clinical areas and participate when team numbers allow in regular teaching sessions as part of the Trust's induction for Consultants, Specialist Registrars and junior doctors. IPS team members teach on Quality Improvement Half Days (QIHD) throughout the Trust when requested.

8.0 OUTBREAKS (OB) /PERIOD OF INCREASED INCIDENCE (PII) /CONTACT TRACING (CT)

The Trust adopts a proactive approach to the identification and monitoring of period of increase incident [PII] and outbreaks. This includes outbreaks of D&V and monitoring periods of increased incidence and outbreaks attributed to a variety of micro-organisms to include: - Clostridium difficile [CDI], Extended Spectrum βeta lactamase organisms [ESBL], Carbapenamase resistant organisms [CRO]; Vancomycin resistant enterococci [VRE], MDR Acinetobacter. In all incidence strains have been typed to determine any outbreaks and post infection reviews undertaken and multi-disciplinary and agency meetings held to identify route causes and lessons learnt.

8.1 Diarrhoea and or Vomiting

During the current reporting period the number of outbreaks remains significantly reduced from previous years. All outbreaks present an increased cost to healthcare settings and thus require quick action and a structured management approach to control their impact. Communication with the wider health economy (e.g. PHE, CCG) is intrinsic to the management of outbreaks.

In order to prevent the spread of enteric infections it is policy to isolate any patient admitted with or developing symptoms of diarrhoea and/or vomiting into a single side room, implementing enteric precautions. Outbreaks of diarrhoea and/or vomiting are monitored by IPS on an on-going basis in line with national and local guidelines.

During the period April 2018 - March 2019 there was 1 ward with bay closures due to norovirus and 2 ward closures., due to suspected and confirmed norovirus.

8.2. Other outbreaks and PIIs period April 2018 – March 2019

A significant number of patients were admitted with flu over the winter season not all could be isolated and contacts were managed with Tamiflu prophylaxis to prevent further spread. No ward or bay closures were required. Staff flu vaccination was again good. There were no PIIs due to CDI.

Table 1 summarising Outbreaks (OB); Period of Increased Incident (PII); for the period April 2018 to March 2019

Site	Organism	2018-19 Month	PII or outbreak	Ward or bay closure
Sandwell Lyn 5	Norovirus	October	Outbreak	Bay
Rowley Regis ET	Norovirus	December	Outbreak	Ward
Sandwell Lyn 4	Norovirus	March	Outbreak	Ward
City NNU	ESBL	June	Outbreak	NA
City NNU	Pseudomonas	August	Outbreak	NA
Sandwell	VRE	November	PII under review waiting typing	NA
Sandwell	TB	May (cases identified in later months on typing)	Acquisition - ongoing investigation	NA

Lessons Learnt

Lessons learnt for norovirus were that the Templates were again successfully used for all wards and departments this year to provide a visual representation of D&V and Flu outbreaks on a daily basis and provide a record of daily actions and lessons learnt. Ward staff download the templates from the IPC webpage and complete following guidance of the IPCNs.

Daily teleconferencing with the DIPC, clinical area, infection control, domestic services CCG and capacity worked well. Domestic services responded very well in providing deep cleans at short notice.

Tuberculosis

There has been a case of TB acquisition and this is currently under investigation, initial lessons learnt identified problems with adequate isolation facilities, in particular at the Sandwell site, however there is a good dialogue with the bed management team and we have worked together to facilitate appropriate patient transfers based on clinical need. This incident happened towards the end 2018/19; we have worked with the TB nursing team and microbiology to conduct patient contact tracing clinics in early May 2019 so there will be more detail provided in the 2019/20 report.

The TB pathway and policy will be reviewed as part of the investigation. We are in the process of obtaining bespoke posters to support and inform the decision making with regards to isolation requirements.

Neonatal Unit Infections

The NNU has a robust microbiological screening process in place to facilitate the detection of potentially harmful organisms, it is recognised that SWBH screen for organisms above and beyond most other Neonatal Units. As part of this process all babies are screened on admission to NNU and then weekly until the baby is discharged. From this screening NNU has identified two periods of increased incidents of colonisation, which were subsequently confirmed as outbreaks which relate to colonisation of bacteria and not clinical infection.

Following on from the outbreak it was identified that the current space in the intensive care unit was not sufficient to support robust infection prevention practices due to the environmental constraints. This has been a historic issue with the hope that the move to Midland Metropolitan Hospital would have negated the environmental issues, however due to the delay in the move, a decision was made to have remedial works completed in the form of a modular unit, thereby increasing the space available in the ITU area and also allowing other remedial works to be completed during the decant. This will reduce the environmental issues and support IPC practices. This work is planned for later in 2019. The IPC team continue to support the project and have worked closely with the NNU team and the projects office in order to mitigate any infection prevention risks.

9.0 DECONTAMINATION

Decontamination is a combination of processes starting with cleaning and culminating with either disinfection or sterilisation, it is term applied to Medical Devices and the environment to include furniture. Decontamination is a key function which helps to prevent and reduce healthcare associated infection (HACI).

Decontamination processes such as Trans Vaginal Ultrasound probes have been reviewed. We have supported the successful introduced UV light high level disinfection for decontamination of semi critical probes. This will improve the decontamination process, improve efficiency and support the patient safety agenda.

There was an incident reported following the use of a Nasendoscope. The IPC team reviewed the incident and there were immediate remedial actions put in place. The process was reviewed in the BTC outpatient's area and an amendment has now been made to improve the process and reduce the risk of further incidents happening. It is now 1 scope, one tray, one ticket method that ensures tracking and traceability is more effective and improves patient safety.

We are in the process of introducing TDOC at city hospital to improve tracking and traceability of scopes.

We have supported the laser clinic in reviewing their decontamination processes and have introduced Tristel Trio in the Laser clinic for the decontamination of lasers and laser attachments, this again will improve decontamination processes and sustain patient safety.

A member of the team is has been sent on a recognised decontamination course to help facilitate the team increase the knowledge base, we aim to develop a strategy, decontamination assurance frame and have more robust governance processes in place.

10.0 AUDITS

It is recognised that due to capacity issues within the team there has not been an extensive audit program, there has been minor audits conducted to review the cleanliness and whether the commodes are fit for purpose. Some areas have replaced several of their commodes due to damage.

IPC team have participated in the PLACE audits, the findings are fed back to the ward areas post review.

An audit plan needs to be developed and order to support this work a band 4 role has been devised.

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11.0 ANTIMICROBIAL STEWARDSHIP

Antimicrobial stewardship contributes to slowing the development of resistant organisms and is an essential component of reduction of healthcare associated infections. The Department of Health has issued clear guidance of best practice, updated in March 2015 (Start Smart then Focus), together with the NICE guidance on antimicrobial stewardship (NG 15) in August 2015 and a Cochrane review on interventions to improve antimicrobial prescribing published in 2016. We are aiming to make the recommendations in these documents part of routine practice across the trust to improve medical practice and assist in reducing HCAIs. The focus on antimicrobial prescribing includes quarterly ward point prevalence surveys on antimicrobial prescribing practice. This year, the Serious Infections CQUIN target has continued the focus on the review of antibiotic prescriptions between 24-72 hours for patients with sepsis, as well as reducing consumption of Carbapenem antibiotics, total antibiotic consumption and increasing the proportion of antibiotics used which are listed in the World Health Organisation Access group.

The point prevalence surveys show consistently high compliance with trust antibiotic prescribing guidelines, as rated by the assessors on the ward – the ward pharmacists. An improved drug chart, introduced gradually from June 2017, with a dedicated section for prescribing antibiotics has improved the compliance with the requirement to document the indication for antibiotics and the duration of therapy or review date, but even so, this is not always done. The implementation of Unity will help with this, as the recording of the indication for antibiotic prescribing will be mandatory, and the system will prompt a review of the antibiotic prescription between 48-72 hours, with recording of the outcome of the review.

The antibiotic pharmacists continue to conduct regular ward rounds to review antibiotic prescribing and provide advice. The use of restricted antibiotics and high risk antifungals is closely monitored to ensure prescribing is appropriate and is reported to the Drugs and Therapeutics Committee on a monthly basis. In addition, antibiotic ward rounds led by a consultant microbiologist are normally performed once weekly on each site to review patients on prolonged courses of antibiotics or broad spectrum agents, and ad hoc for patients with complicated infections or in need of review. Staff shortages in the microbiology department have meant that since late 2017, the ability to undertake fixed multidisciplinary ward rounds has been compromised and therefore there has been greater reliance on the ad hoc consultant microbiologist reviews. In addition, the focus on Unity implementation has meant that a significant portion of the time available for antimicrobial stewardship activities by the antibiotic pharmacist team has been spent on routine clinical pharmacy duties such as ward cover, dispensary cover and population/maintenance of weekly pharmacy rotas.

There was no dedicated standalone session on antimicrobial prescribing at the junior doctor induction in August 2018, due to changes in the provision of infection prevention and control teaching. One teaching session for FY1 doctors by the antibiotic pharmacists took place in March 2019 at Sandwell hospital; the microbiologists took part in routine teaching of medical students and junior doctors. As in previous years, European Antibiotic Awareness day was marked in the trust in November 2018 with information stands at both sites for staff and visitors, with quizzes, crosswords and prizes given out. This was led by staff from Pharmacy, with support from Infection Control and microbiology and life and health science students from Aston University and the University of Birmingham.

In December 2018, the pharmacy department launched a ‘Think Pink’ campaign, which aimed to highlight patients on IV antibiotics for 48-72 hours and prompt nursing staff to seek a review of the need for the intravenous route by the medical teams. This was seen as a useful way of engaging nursing staff with antimicrobial stewardship, as they are an underutilised resource, with benefits of saving nursing time and reducing expenditure on IV antibiotics for the trust. The campaign will continue until the implementation of Unity, as there are high levels of IV antibiotic consumption in the trust, and many patients can be switched to oral therapy safely.

Supply problems with key antibiotics continued to be a problem throughout 2018-19, and resulted in changes to the trust guideline for hospital acquired pneumonia as one example. This will have resulted in increased antibiotic consumption as a combination of antibiotics was required to replace the agent which was unavailable. Ongoing, low level supply problems for a number of antimicrobial agents continue to be a problem and are likely to continue into 2019-20. These disruptions can require a considerable amount of time to manage and mitigate for by the pharmacy department, work which is often unseen and unnoticed by the rest of the trust.

There was an increase in antibiotic consumption in the trust, the reasons for which are not absolutely clear, but will be investigated further. The shortages of some antibiotics, as discussed above, will have contributed, as will have the sustained pressure from high levels of activity in medicine. Point prevalence survey results indicated that almost 40% of the hospital inpatient population were on antibiotics in January 2019, which is some of the highest levels of antibiotic prescribing seen in the trust, but not out of line with results from other trusts in the region. Nonetheless, this is a cause for concern and explains the fact that the trust failed to meet the Serious Infections CQUIN for 2018/19 target to reduce total antibiotic consumption by 2% compared to the 2016 baseline. The principal focus for the antimicrobial stewardship team for 2019-20 will be to safely reduce the levels of antimicrobial prescribing, working in collaboration with the clinical teams to achieve this.

The trust was successful in meeting its CQUIN target to reduce Carbapenem consumption by 3%, and actually reduced consumption by almost 10% compared to the baseline of 2017/18. This reversed the trend of increased consumption in 2017/18 and was achieved by amending trust antibiotic guidelines which recommended Carbapenems to alternative options, and close monitoring and review of patients on these agents by the antimicrobial stewardship team and ward pharmacists.

The trust also achieved its CQUIN target for the Access group of antibiotics, with 55.2% of total antibiotic consumption comprising of agents from this group. This was achieved by careful amendment of the trust antibiotic guidelines where appropriate, to recommend these narrower spectrum agents, as well as promotion of IV to oral antibiotic switch and 48-72 hour review of patients on antibiotics.

The 2019-20 CQUIN target relating to antimicrobials and infection is focusing on the diagnosis and management of lower urinary tract infections in elderly patients and the use of single dose surgical prophylaxis for colorectal surgery. There is a new focus on antifungal stewardship with an associated CQUIN target. The focus on reducing total antibiotic consumption remains, and this will form part of the standard contract for the trust, rather than being a specific CQUIN target.

The Antibiotic Management Group met during 2018-19, but representation from medical, surgical and nursing colleagues was limited or non-existent. This was raised at the Infection Prevention and Control Advisory Committee in 2018 and resulted in some nursing representation, but the group still needs input from the medical and surgical specialities to be more effective. The group will continue to seek to increase its membership to include these representatives. The group has an annual work plan and audit plan and continues to work to progress these.

12.0 FFP3 MASK FIT TESTING

Face piece fit testing is a method of checking that a tight-fitting face piece matches the wearer's facial features and seals adequately to their face. It will also help to identify unsuitable face pieces that should not be used.

RPE (Respiratory Protective Equipment at Work) will only provide effective protection if the wearer is clean shaven. Health & Safety Executive (2013) HSG53

Masks may be necessary if a suspected or confirmed infection may be spread by an airborne route – for example, multi-drug resistant tuberculosis or other high-risk infections transmitted via the respiratory route.

Previously fit testing has been conducted using the qualitative method. Qualitative fit testing is a pass/fail test based on the wearer's subjective assessment of any leakage from the face seal region, by sensing the introduction of a test agent. Duration of the test is around 30 minutes.

The infection prevention team have successfully introduced a quantitative method of testing which provides a numerical measure of the fit, called a fit factor. We currently have three portacount machines that staff can use following training to fit test staff.

Two members of the IPC team have been successful in completing the accredited training and they are the only two nurses in the country that have this qualification. This makes the testing more vigorous and evidence based. There are currently 73 members of staff that are able to fit test colleagues, with the majority being trained by the IPC team. There has been extensive effort made

to ensure that the correct educational material is available and accessible, all relevant information can be found on the intranet site.

There are over a thousand members of staff that have been fit tested and this figure is growing on a weekly basis, we will continue to deliver the fit testing program. It will be a mandatory training requirement that will be managed locally and compliance monitored via the Operational Infection Prevention Committee.

Forward Plan

- Fit testing clinics will be held over the coming year.
- Further training courses will be provided to train more staff to be able to fit test.
- Responsive fit testing will take place on request.

13.0 REFURBISHMENT AND NEW BUILDS

The Estates and Facilities Department ensured that the IPCT have been regularly involved, consulted and engaged in the planning stage of numerous work projects. This has enabled IPC expertise to actively influence improvements to IPC in the built environment.

IPC are asked for input on two broad aspects of work:

A. Planning – IPC are asked for input in reviewing plans to ensure that any refurbishments or new builds offer the best facilities to reduce the risk of infections in line with any relevant Health Building Notes and Health Technical Memorandum
B. Operation – IPC are asked to review methods to reduce the risk of any infections presented by the actual refurbishment/build process.

This is supported by the completion of Q711 forms that clearly set out the interventions required to minimise the risk of infection.

14.0 CORPORATE IPC OBJECTIVES 2018/2019

Appendix 1 identifies the Organisations core infection prevention and control objectives. Where quantitative data is available pre-defined targets have been set, however it needs to be recognised that due to the nature of some objectives quantitative data is not relevant. In these instances a qualitative approach will be adopted.

Equally, due to the unpredictable nature of infection prevention, emerging micro–organisms and the potential for outbreaks on a local and national scale it is recognised that objectives will change and be amended throughout the year to meet demand if required.

15.0 IPC KEY QUALITY GOALS

Safe Care – Reducing Harm

- A reduction the numbers of patients with CDI </= 41 cases
- Zero patients with trust apportioned MRSA bacteraemia

Data Quality Improvement

- Business case to be developed for the provision of ICNET
- Appointment of a data analyst to support the IPC team

16.0 TEAM OBJECTIVES AND KPIS 2019-20

- To change the process for MRSA screening in line with National Guidance
- To improve the current process of CDI monitoring and ensure that the process reflects the change in National Guidance
- To reenergise the hand hygiene campaign to improve compliance amongst healthcare staff, patients and the general public, to include a review of the communication strategy around hand hygiene and the use of effective visual aids
- To maintain the momentum for Fit Testing and to provide training to enable each area to have sufficient staff that are fit testers, and monitor areas to ensure that they are achieve 85% compliance for staff that have been fit tested
- Development of an education strategy
- Development of an assurance framework for decontamination
- To support the ambition in reducing blood culture contaminants
- Completion of post infection reviews and dissemination of lessons learnt Trust wide
- Development of an audit program for clinical areas

Internal KPI 2019-20

- CDI Management and Antibiotic Reviews, (reviews to be undertaken within 2 weeks)
- Review of outbreak management, with the aim of streamlining processes and ensuring good communication and the impact of the outbreak on number of bed days lost.

Appendix 1

TABLE TO IDENTIFY INFECTION SERVICE CORE OBJECTIVES 2019/2020

No	Objective	Remit	Measurable target	Responsibility	Monitored
1	Hand Hygiene	• To improve compliance for hand hygiene audits within the Organisation to reenergise the hand hygiene campaign to improve compliance amongst healthcare staff, patients and the general public, to include a review of the communication strategy around hand hygiene and the use of effective visual aids • Update hand hygiene audit with more focus on 5 moments of hand hygiene – initially start with a 2 step recording before and after patient contact only	• Compliance 95% and above for Clinical Group hand hygiene audits	• Update hand hygiene audit with more focus on 5 moments of hand hygiene – initially start with a 2 step recording before and after patient contact only • IPCT for collating data from clinical group audits and by using volunteers and secrets shoppers and distributing the compliance results	• Monthly IPC reports • Infection Prevention Control Advisory Committee [IPCAC] • SWBH – CCG • Scope the use of volunteers auditing the process
2	Nationally agreed targets				
	C.difficile	To ensure systems and process are in place for the prompt identification, management and monitoring of patients with *C.difficile* infection [CDI]	• No more than 41	• Clinical Groups to ensure prompt identification and management of patients with CDI • IPS to collate and distribute data	• Specimens received in the laboratory. • HCAI data base • Monthly IPC reports • Infection Prevention Control Advisory Committee [IPCAC] • SWBH – CCG • Review of lapses of management of Cdiff
	MRSA bacteraemia	To ensure systems and process are in place for the	0	• Clinical Groups • To ensure prompt	• Specimens received in the laboratory.

		prompt identification, management and monitoring of patients with MRSA bacteraemia's		identification and management of patients with MRSA bacteraemias • IPS to collate and distribute data	• Monthly IPC reports • IPCAC • SWBH – CCG • Review of lapses of management of MRSA
	MRSA screening	To ensure systems and process are in place for the prompt identification, management and monitoring of patients requiring MRSA screens	85% of all eligible patients. Trust will continue to work together to achieve our ultimate goal of a screening rate of 95% and to improve on our rates of elective screening and high risk areas to 95%	• Clinical Groups ensure to adherence to screening protocols • IPS to collate and distribute data	• Specimens received in the laboratory. • Monthly IPC report • IPCAC • SWBH – CCG
3	Audit	General Infection control audit programme currently under review to be set for this year's programme.	Overall Trust score 95%	• Clinical Groups ensure to compliance of 95%	• IPC data distributed to clinical area and discussed at IPCAC and Operational group.
5	Blood culture contaminants	• To monitor compliance with practices for the taking of blood cultures to ensure microbiological results are clinically significant and reduce unnecessary treatment of patients • Engender ownership and work with clinical teams to comply with and adhere to infection control practices to reduce blood culture contaminants	< 3% contamination rate Trust wide	• Clinical teams • IPS for collating and distributing data to relevant clinical groups	• Specimens received in the laboratory. • Monthly IPC reports • IPCAC • Review of blood culture packs and implementation of packs
6	Fit Testing	Continue Implementation of FFP3 Masks Fit Testing/using Portacount Trust wide.	85% compliance of key area- A/E, AMU and Respiratory wards	• Increase in key trainers for each area – clinical areas/non clinical areas	• Monthly IPC reports • IPCAC • ESR • Mandatory training

					requirement
7	Education and Training	• Ensure mandatory training programme is relevant and up to date. • Focussed training on isolation to be provided including delivery of infection control master classes for matrons and senior nurses	• 100% of staff complete IPC Mandatory training module • 80% of matrons and senior nurses to attend	• Clinical Groups responsible for ensuring staff compliance with Infection Control Modules • Clinical groups to allocate staff to attend	• ESR data base identifies compliance with Mandatory Training • Learning & Development • Infection Control operational meetings • Education strategy
8	Decontamination Assurance	• To ensure that the Trust has robust decontamination processes that are evidence based and supported by quality assurance processes	• Members of the team to attend decontaminati on training • Assurance framework to be developed	• IPC lead • Engagement with all clinical groups, to increase compliance •	• Decontamination committee (subcommittee of IPAC) • Decontamination strategy reporting