Central London Community Healthcare NHS Trust

Infection Prevention and Control Annual Report 2017/18

Infection Prevention Team

May 2018

Contents

Executive Summary

This infection prevention and control annual report of Central London Community Healthcare (CLCH) NHS Trust gives an overview of the work that the organisation and infection prevention and control (IPC) team undertook to prevent and control healthcare associated infections (HAIs) between April 2017 and March 2018. It describes the arrangements for the provision of the infection prevention service, as well as CLCH's performance against internal and external infection prevention and control performance indicators. This report also fulfils the organisations statutory duty under the Health and Social Care Act, 2008 (the Hygiene Code) to produce and publish an infection prevention and control annual report.

Ongoing IPC achievements for CLCH in 2017/18 include:

- Low rates of HCAI in in patient wards. No lapses in care identified from post infection reviews.
- 99.53% of our patients with a urinary catheter received harm free care.
- Continuing the programme of IPC clinical practice support assessments for teams and services across the trust, with ongoing support given to clinicians by the IPC nurses. These also provide a focus for clinical teams to improve clinical practice and promote safe care and treatment.
- The annual IPC environmental audit programme continues, ensuring that sites from which CLCH operates clinical services were audited for cleanliness and IPC standards.
- Providing IP support and risk assessment to mobilisation of new CLCH services.
- Systematic review of key infection prevention policies to reflect the diversity of clinical service provided by CLCH.
- CAUTI surveillance on the inpatient wards continues with post infection reviews for all infections that meet the CAUTI criteria and the implementation of any changes in practice required to help prevent future CAUTIs from occurring.
- Development of initial gram-negative blood stream infection reduction action plan with priorities identified
- The infection prevention team provided comprehensive support to both operational and corporate services in CLCH.

Plans for 2018/19 include further development of the antimicrobial stewardship programme in collaboration with medicines management, support for new clinical services to implement CLCH infection prevention policy and procedure and continued strengthening of supportive relationships across the organisation. Progress with the IPC annual plan will be monitored by the Infection Prevention Group during 2018/19.

1. Introduction

Central London Community Healthcare NHS Trust (CLCH) is committed to ensuring that effective prevention and control of healthcare associated infections (HCAIs) is embedded into everyday practice. The prevention and control of HCAIs is part of the Trusts overall quality and patient safety strategy. The Trust Board recognises and agrees its collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls HCAI risks.

The responsibility for Infection Prevention and Control (IPC) is designated to the Director of Infection Prevention and Control (DIPC), supported by the trust wide infection prevention and control team.

The IPC Annual Report (2017-18), together with regular reports to Trust Quality Committee as part of the Chief Nurse and Medical Director report and to the trust Patient Safety and Risk Group, the annual IPC plan and the annual Hygiene Code assessment are the means by which the Trust Board assures itself that there is evidence of compliance with the Hygiene Code and that the Trust remains registered with the CQC without conditions related to HCAI.

In addition, the Annual Report (2017-18) seeks to assure the Trust Board that progress has been made against the Annual Plan. It demonstrates that priorities identified in the Annual Plan last year have been addressed by employing a robust programme of work that have enabled key achievements on which to build in 2018-19.

2. Key Achievements 2017-18

The following is a summary of the key achievements in the past 12 months:

- Zero MRSA and MSSA bacteraemia
- Systematic review of key infection prevention policies to reflect the diversity of clinical service provided by CLCH
- Recruited to vacant IPN posts and established IPC divisional support structure
- Two cases of trust attributable *C difficile* infection, no lapses in care identified
- Evidence of the infection prevention audit and feedback cycle driving improvements in the clinical environment and clinical practice;
- Increased uptake of the Aseptic Non Touch Technique e-learning programme
- 99.53% of our patients with a urinary catheter received harm free care;
- Providing IP support and risk assessment to mobilisation of new CLCH services
- Development of initial gram-negative blood stream infection I reduction action plan with priorities identified

3. COMPLIANCE WITH THE HEALTH AND SOCIAL CARE ACT 2010

The Hygiene Code consists of 10 criteria, against which CLCH must demonstrate compliance. These criteria provide a framework by which the trust will reduce the risk HCAI and evidence of compliance and developments for each criterion is provided in the following section.

Criterion 1: Systems to manage and monitor the prevention and control of infection

a. Organisational accountability for Infection Prevention and Control

Roles and responsibilities

IPC is the responsibility of everyone in the organisation. However, there are clearly defined responsibilities which are detailed below:

Chief Executive

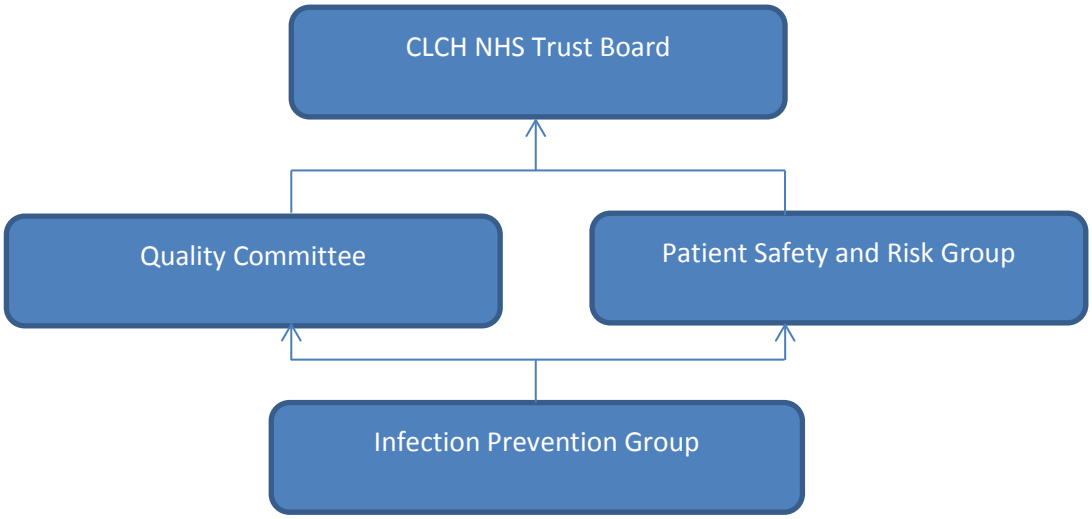
The Chief Executive has overall responsibility for ensuring that there are effective management and monitoring arrangements provided for IPC to meet all statutory requirements.

Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) responsibilities are designated to the CLCH medical director, Dr Joanne Medhurst. The DIPC has delegated responsibility for the management of IPC and is responsible for ensuring that systems and processes are in place in response to external and internal requirements to minimise risk to staff, service users and visitors and ensure compliance with the Code. The DIPC or a nominated deputy (usually the Head of Infection Prevention and Medical Devices) is the Chair of the Trust wide Infection Prevention Group.

Trust wide Infection Prevention Group

The Trust Infection Prevention Group is a mandatory requirement. It is a key forum for providing assurance that the Trust has in place structures and arrangements to meet all statutory requirements for IPC. The chart below demonstrates the IPC reporting arrangements:



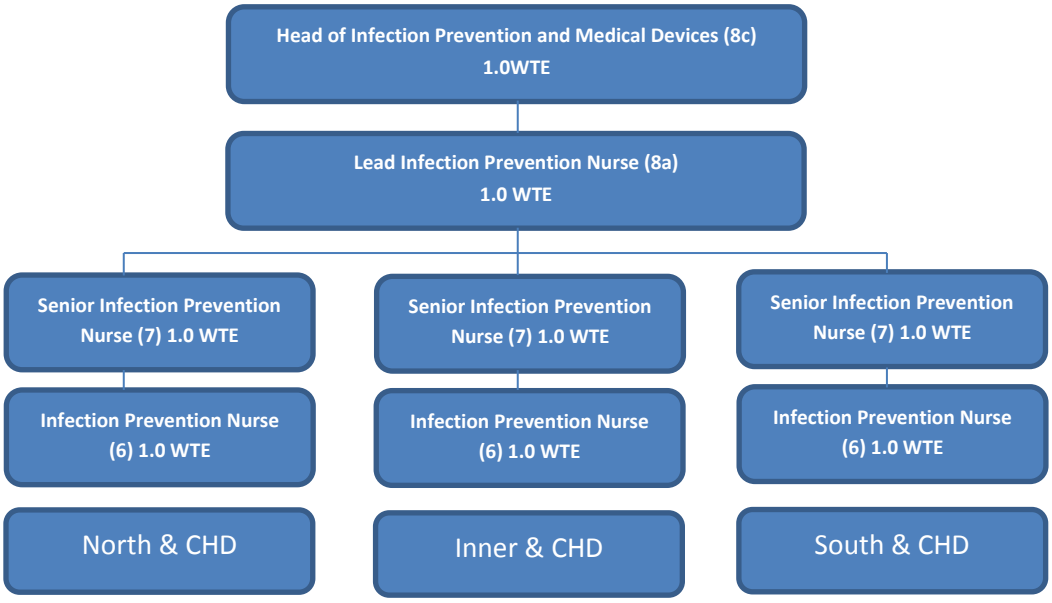
The CLCH Infection Prevention Group (IPG) meets every quarter. Key functions of IPG are:

- To monitor and report on compliance with national standards, targets and statutory responsibilities for infection control;
- To identify and register infection-related risks and to develop and monitor action plans to eliminate or reduce those risks;
- To develop infection prevention and control policy and to approve and monitor an annual infection prevention and control work programme;
- To receive quarterly assurance reports from Employee Health, Estates and Facilities and operational divisions.
- This group also monitors commissioned contractual performance, discusses and considers national and local infection prevention developments and acts an expert resource for the wider organisation.

Trust wide Infection Prevention and Control Service

The role and function of the IPC service is to provide specialist knowledge, advice, support and education for staff, patients and visitors of CLCH. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance with the hygiene code.

The IPC Team work trust wide with two IPN's allocated to a geographical clinical division, covering adult and children's services in that geography. The chart below gives an overview of the IPC team structure.



Community Infection Prevention and Control Doctor/ Microbiology Consultant

Access to a Community Infection Control Doctor / Microbiology Consultant Service is essential for compliance with Criterion 1 of the Health and Social Care Act. This provision is in place through the local health protection teams and the local acute NHS trusts. During 2017-18, this provision was

reviewed and funding agreed to implement internal provision of this function to support HCAI reduction and antimicrobial stewardship. This post will commence in 2018-19.

Infection Prevention and Control Link Professional Network

The IP Link Practitioner (IPLP) Network exists in order to support the function of the IPC team and is an important and effective means of disseminating information and good practice guidance. Link members act as visible role models and local IPC leaders and advocate high standards of IPC. They provide a link between their colleagues and the IPC team in order to facilitate good practice and improve standards within their team. Twice yearly meetings are held and IPLP's are encouraged to develop and implement local IP initiatives in their clinical areas with support from the IPC team.

b. Monitoring the prevention and control of infection

Surveillance of healthcare associated infections (HCAI)

Mandatory surveillance systems are in place to monitor HCAI such as Meticillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile infection (CDI). As a community NHS provider, Central London Community Healthcare NHS Trust is not allocated targets and reduction trajectories for alert organisms by NHS England. However as part of commissioning contracts, cases of HCAI are proactively monitored and investigated and findings shared with internal and external stakeholders as per NHS England guidance

Table 1 - CLCH Trust HCAI Data 2017-18; (2016-17 figures in brackets where available)

	North*	**South**	**Inner***	**Children's**
MRSA Bacteraemia	0 (0)	0 (0)	0 (0)	0 (0)
C. difficile infection (CDI)	2 (2)	0 (0)	0 (0)	0 (0)
MRSA wound infections	0 (0)	0 (0)	2 (0)	0 (0)
CAUTI	8	0	2	0

*CLCH bedded units are located in North and Inner division.

The surveillance data demonstrates that rates of infection are stable in 2017-18 and supports the effectiveness of the proactive zero tolerance approach used by the IPC team. There were no cases of MRSA bacteraemia and two cases of CDI attributed to CLCH.

In 2018-19, proactive HCAI surveillance will be expanded to include E.coli, Klebsiella spp and Pseudomonas aeruginosa will be included to ensure we are able to monitor rates as part of the national gram negative blood stream infection reduction objective.

Root cause analysis (RCA) and clinical case review

When reportable HCAIs occur, the process of RCA or Post Infection Review (PIR) is undertaken for MRSA bacteraemia, Clostridium difficile death (reported as 1a on a death certificate), cases of Clostridium difficile infection and outbreak of infection. This is to identify a root cause where possible and actions to prevent it reoccurring. The main issues and lessons learned identified are identified in Table 2.

Table 2 – Main issues and lessons learned during RCA/CCR process 2017-18

RCA/CCR type	Contributory factors	Lessons learned/service improvements
C. difficile infection (CDI)	Previous antibiotic therapy Previous laxative therapy	Case reviews are now carried out in collaboration with the specialist antimicrobial stewardship pharmacist and reviewed against trust antimicrobial policy
MRSA wound infections	Previous MRSA colonisation Long terms acute trust admission Chronic wounds	Review of MRSA screening policy in bedded units to ensure appropriate for patient cohorts

Infection Prevention Risks and mitigating actions and infection prevention incidents

At the end of 2017-18, there were 3 open risks on the infection prevention and control risk register; reduced from 7 at the beginning of the year.

Risk ID and Risk	Rating	Reason and actions
926 The principles of asepsis are not always observed and uniform standards of safe care in relation to Aseptic Non Touch Technique (ANTT) are not uniformly applied, increasing the risks of infection	6 (at target rating)	ANTT e-learning package was introduced for specific clinical staff groups at the start of 2017-18. At the end of the year, completion of training was at 93%. This risk has fundamentally changed and therefore it will be closed in its current format and a new risk opened related to organisational assurance of completion of ANTT competency assessments
1139 If staff do not attend Infection Prevention training, there is a clinical risk to patients and a reputational risk to the trust for non-compliance with the Hygiene code and CQC regulations	9	Compliance with mandatory infection prevention training for clinical staff remains below target during 2017-18. Individual CBU action plans are in place and additional training sessions being delivered and offered by the IP team. Review of e-learning package in progress.
1702 Currently there is staff in the Trust that we do not know the status of measles and varicella. These staff could be potentially be non-immune to measles or varicella or both and could contract infection and transmit to others	6	Information not available to temporary staffing and stoppage of face to face induction sessions. Induction sessions have re-commenced and review of bank staff lists completed. Work to ensure staff in new services are compliant is ongoing.

There were 134 IPC related incidents, and increase from 126 in the previous year (Figure 1). All incidents were in isolation, other than the sharps related incidents. There are no specific themes that emerged in relation to particular localities or services. Figure 1 provides a summary of infection prevention incident reports by clinical division. North division has the highest number of reports and this mirrors the total incidents reported by division in 2017-18. Reasons for this include the

presence of bedded areas and sexual health services in the division and the wider geographical area. South division reported the second highest number of IP related incidents and this reflects the presence of complex services such as dental, sexual health and podiatry within the division. Overall, IPC incidents account for 1.46% of the total incidents report in CLCH.

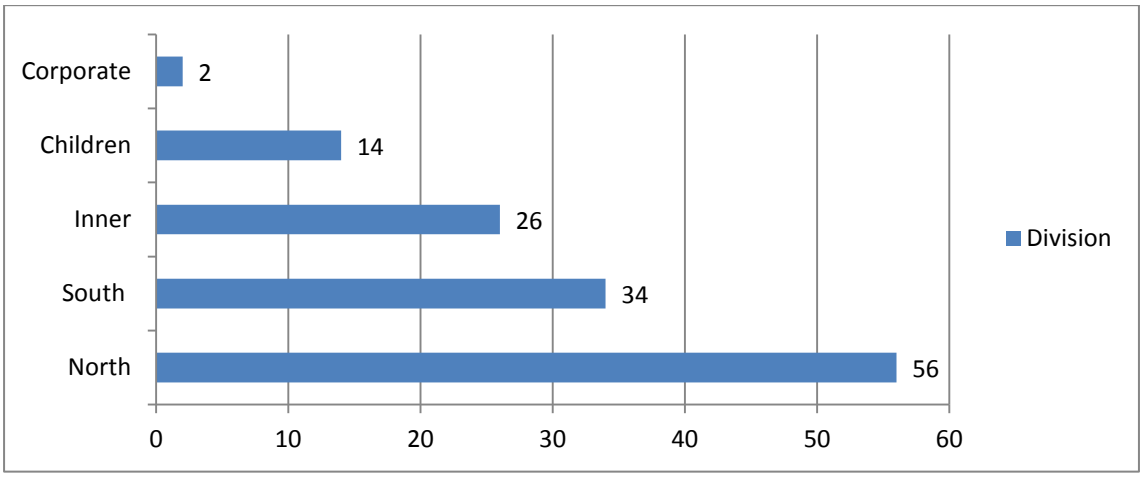


Figure 1: 2017-18 Infection Prevention incidents by division

Of the 134 incidents reported, sharps injuries and incidents were the most frequently reported (51). All were followed up as per policy by Employee Health and staff members involved in these incidents received a clinical support visit from a member of the infection prevention team. Clinical support visits provide an opportunity for the clinician involved in the incident to work alongside the IPN in their usual clinical environment to identify and address issues which may have contributed to the incident. In 2017-18, these included challenges with the practice setting and environment, application of policy in practice and appropriateness and availability of equipment. Figure 2 shows sharps incident by location.

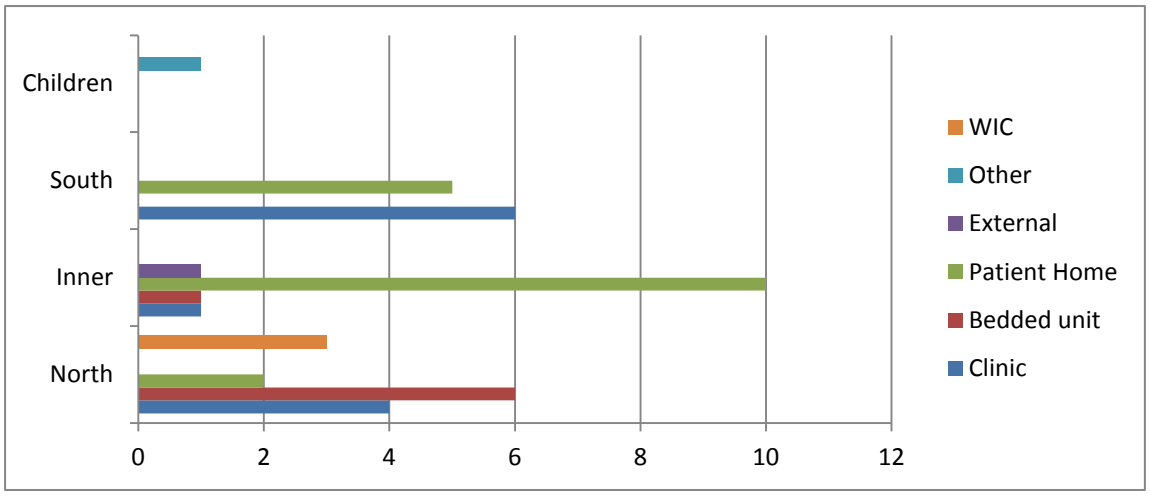


Figure 2: Location of sharps incident by division

Thematic review of sharps incidents found that they were most common during venepuncture and insulin administration activities. Although the majority of sharps were safety needles, clinicians still managed to cause harm, mainly due to the method of disposal. Review of datix information identified over full sharps containers with needles protruding out, temporary closure methods not in use, incorrect disposal of sharps into clinical waste bins and incorrect disposal following use.

There were 12 incidents related to alert organisms. These included exposure of individuals in walk in centre waiting rooms, lack of transfer documentation or handover for patients with known HCAI admitted into bedded units and staff exposure to transmissible infection. Again, these incidents were followed up with a clinical support visit to the service and clinician and feedback to referring organisations, where applicable.

c. IPC Audit Programme

The review of clinical practice and the overall environment through audit is an established means of monitoring and improving the quality of care and of supporting the implementation of change in practice.

Under the terms of the Hygiene Code, CLCH has a duty to provide a programme of audit to ensure that key policies and practices are being implemented and sustained appropriately. The IPC audit programme is led and managed through each geographical divisional IP team. The IPC teams promote clinical audit as a crucial part of clinical governance. All healthcare professionals are expected to be involved in the audit process to assist in enhancing the quality of patient care and service and environmental improvements. The IP audit programme includes clinical practice and environmental audits and specific audits are listed in table 3 below:

Table 3: Infection Prevention Audits

Audit type	Specialist topic	Frequency
Environment	Clinical Environment condition and suitability	Annual with repeat follow up if significantly non-compliant
Clinical Practice	Hand hygiene- bedded and community areas	Monthly
Clinical Practice	ANTT	Annual
Clinical Practice	Clinical support visit- overview of clinical practice, facilities and equipment	Annual or following and infection prevention related incident.

The following are some of the main themes identified as part of the audit process:

- Environmental cleaning standards
- Staff not adhering to the Bare Below the Elbows Policy
- Poor management of sharps disposal systems
- Glove not changed between procedures
- Integrity of estate (damage to walls and flooring)
- Access to hand hygiene facilities

In order to demonstrate assurance that the areas of concern highlighted during the audit process are being addressed, a completed action plan from the relevant teams is required demonstrating the actions implemented to address the issues identified. Returned action plans are recorded and it is noted that return of action plans is slow. Therefore it is proposed that a new system of audit report and action planning be introduced in 2018-19 with proactive follow up by the IPC team and monitoring at trust Infection Prevention Group. Key changes will include a move away from using a compliance score to providing qualitative detail around issues and the inclusion of photographs to provide visual representation of issues identified and of areas of good practice seen.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

a. Cleanliness

CLCH has systems in place to ensure that all healthcare premises provided are suitable and fit for purpose. The environments are monitored to ensure they are clean, maintained and in good physical repair and condition. Technical and managerial cleaning audits are completed by the estates and facilities team with the IPN's joining managerial audits as availability allows. Performance is monitored at divisional estates groups, trust strategic estates group and trust Infection Prevention Group.

During 2017-18, all clinical areas audited met scored above the target of 85% in both the technical and managerial audits, based on the national cleaning specification, with quarterly average scores found in table 4 below.

Table 4: Average Cleaning Scores by quarter

Property Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year average
Tier 1	94.2%	94%	93%	92.2%	93.4%
Tier 2	95.3%	95.3%	94.3%	93.7%	94.7%

Tier 1- CLCH owned or head leaseholder property with responsibility for providing domestic services
Tier 2- CLCH is a permanent tenant, landlord (e.g. NHSPS, CHP and others) provides domestic services

b. PLACE

In addition the Trust participates in the annual Patient-Led Assessments of the Care Environment (PLACE). PLACE assessments are a system for assessing the quality of the patient environment. Conducted via self-assessments with external validation, assessments are undertaken every year and the results are reported publicly to help drive improvements in the care environment. The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care. The nonclinical activities of concern are cleanliness; food and hydration; privacy and dignity and wellbeing and condition, appearance and maintenance of healthcare premises and a dementia domain which measures whether the premises are equipped to meet the needs of dementia sufferers against a specified range of criteria..

PLACE assessments were undertaken within each of the in-patient sites, which are managed and services provided by either NHS Property Services (NHS PS), Sanctuary Care (SC) or Community Health Partnership (CHP):

- Athlone Nursing Home (Rehab) - SC
- Princess Louise Nursing Home (Rehab) - SC

- Pembridge Palliative Care at St Charles - NHS PS
- Marjorie Warren Ward at Finchley Memorial Hospital - CHP
- Jade and Ruby Ward at Edgware Community Hospital - NHS PS

Results of the 2017/18 assessments have now been published, with a summary table of comparison with last year shown within the report. All areas in 2017-18 resulted in above average scores, with only cleanliness falling slightly below the National average by 0.31%. Pembridge Palliative care scored particularly high in Cleanliness in 2016, with a decreased score in 2017. A problem area for cleanliness was found to be at Athlone and PLK in 2016, which have both shown some improvement in 2017 to come closer to the national average but still with improvement required. In mitigation of this, additional cleaning checks have been commenced, provided by the trust cleaning services providers, ISS. The sites are being reviewed weekly by ISS and additional cleaning provided as required.

c. Water Safety

The trust water safety group (WSG) meets monthly and reviews progress against the trust water safety plan. During 2017-18 the WSG has established a programme of work which includes:

- Prioritising water safety actions
- Providing assurance of water safety from estates and facilities partners
- Review of escalation process for water safety incidents
- Review of low use outlet definition, identification and flushing regime requirements specifically for clinical staff

During 2017-18, six incidents regarding water safety were reported. In the main these incidents centred on loss of water supply. All incidents were rectified promptly or mitigating actions put in place to ensure clinical services were not disrupted. One incident related to raised counts of legionella at a health centre. Microbiological testing was undertaken following identification of hot water temperatures outside of required parameters during routine monitoring. Remedial works were completed and follow up testing showed that these actions had rectified the issue. No clinical services were disrupted during this time. Estates and facilities and the WSG are overseeing plans to improve water management at this site. A report of progress is provided to the Infection Prevention Group every quarter.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

During 2017-18 an antimicrobial stewardship pharmacist was appointed to commence work on the antimicrobial stewardship (AMS) programme. Since appointment in September 2017, a number of activities have commenced and are ongoing including:

- Networking with other antimicrobial pharmacists to build working relationships and share best practice e.g. CNWL, Hounslow & Richmond Community Services, Hertfordshire, and Birmingham Community Services

- Promoted antimicrobial guardian activities through the medicines management team during antimicrobial awareness week, and shared relevant AMS national resources with services to raise public awareness
- Working with procurement to set up SLA for Consultant Microbiologist
- Antimicrobial Stewardship Steering Group (ASG) is being set up – which includes the drafting terms of reference and scoping membership
- Completed NICE self-assessment toolkit and used this to draw up the AMS work plan
- Engaging with internal stakeholders and visiting services where antimicrobials are frequently used e.g. WICs, dental
- Developing audits to capture antimicrobial usage in community services
- Antimicrobial audit completed for bedded services
- Reviewed Trust's retrospective antimicrobial consumption data - first time this has been carried out
- Reviewed current practice within CLCH against relevant national guidance including NICE guidelines
- Using audits and surveillance to identify future priority AMS work streams.

Criterion 4: Provide suitable and accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Staff and patient engagement

A variety of methods are used to communicate IPC messages to patients, staff and other healthcare providers. The IPC Service works closely with clinical services to ensure that they are informed of IPC issues and significant changes.

The IPC section of the Trust intranet provides a useful resource giving staff access the most up to date and relevant information. The front page of the intranet and the weekly communications circular is also used to deliver key messages, such as norovirus awareness, influenza and IPC health promotion campaigns. IPC information leaflets are available in all bedded services and health centres. An extensive review and update was completed in September 2017.

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 infection to other people

a. HCAI Surveillance

Proactive surveillance of HCAI is carried out in the CLCH bedded units ensuring proactive follow up of HCAI as per national objectives and guidance. Weekly surveillance on bedded units captures cases of C difficile, MRSA bacteraemia, Gram negative blood stream infection, MRSA wound infection and catheter associated urinary tract infection. As all samples are reviewed, other HCAI's are also captured if they occur. Proactive surveillance of IV catheters is not currently carried out in CLCH bedded units as central venous catheters are rarely used in these services and peripheral intravenous line surveillance is not targeted in national surveillance schemes. A summary of HCAI in 2017-18 is shown in table 1.

b. Sepsis awareness

Sepsis is a life threatening condition that arises when the body's response to an infection causes injury to its own tissues and organs, leading to shock, multiple organ failure and death, particularly if

it is not recognised and treated promptly. During 2017-18, a sepsis awareness working group was convened to agree and implement actions to ensure that awareness of sepsis is raised across the trust and that relevant community setting assessment tools are readily available to clinical staff drive assessment and action. The group is chaired by the DIPC and members include clinical professional leads, medicines management and infection prevention.

Key work streams in progress are:

- Awareness raising of sepsis through continued use of trust wide communications
- Review of use of NEWS as a tool to identify sepsis in a deteriorating in patient
- Implementation of Skills for Health e-learning modules
- Development of level 1 learning materials on sepsis
- Review of tools and development of hub site to link to relevant community tools for ease of access and update of relevant Care of the Deteriorating Patient policy

c. Gram negative blood stream infection reduction programme

During 2017-18, proactive monitoring of Gram negative blood stream infections was included as part of weekly HCAI surveillance in CLCH bedded units. In addition, the IPC team work closely with commissioning partners to assist with post infection reviews of cases of gram negative blood stream infection in patients who have had contact with any of the CLCH community services to identify learning and required improvements. This mirrors the process that has been carried out for MRSA blood stream infection since 2010. There have been no cases of Gram negative blood stream infections associated with CLCH provided care during 2017-18.

In addition to this, the CLCH IP team are involved in wider collaborative working with commissioners and trusts across North West London to develop the reduction programme across the health economy/STP.

Criterion 6: Ensure all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection

a. Infection Prevention Mandatory Training

The Trust has two tiers of annual core skills IPC training: Level 1 for all staff and Level 2 for clinical staff.

Level 1 Training

All CLCH staff are required to complete level 1 mandatory training. Level 1 training is delivered via a booklet and provides a summary of the essential elements of infection prevention and control to reduce the risk of HCAI. This information is reviewed on an annual basis to ensure it remains up to date and relevant Rolling compliance with Level 1 is 97.22% at the end of March 2018.

Level 2 Training

All clinical staff are required to complete additional IPC training to comply with the national core skills framework. This is done annually and delivered either by e-learning or through face to face sessions delivered by the IPC team. Rolling compliance with Level 2 is 83.6% against a trust target of 95%. An extensive action plan is in place to ensure that uptake increases to target and has seen the IPC team delivering training to an additional 200 clinical staff across local clinic settings and has increase the rolling compliance from 70% at the start of 2017-18. Work to further increase compliance will continue as a priority during 2018-19 and includes a full review and relaunch of the trust IP e-learning package, provision of additional face to face sessions across the year and whole

organisation and continued increased scrutiny through divisional performance reviews to ensure that increasing compliance is a recognised divisional priority.

b. Other Infection Prevention Training

In addition to trust mandatory training, the infection prevention team have actively provided a range of other training in response to the season, incident or national objectives. This includes training on flu and norovirus during the winter season, ANTT training, training for newly joined overseas staff and training for nursing students. In total, across these sessions, training was delivered to an additional 420 clinical staff.

c. Professional development of the IP team

Professional development of the IP team is crucial in maintaining an expert team; particularly the development of junior band 6 IP nurses. Looking forward training needs for the team will focus on individual staff professional and educational development through PADR and inspiring a proactive, confident, self-sufficient IP work force.

d. Infection Prevention Link Practitioner Programme

The IPLP programme promotes two-way communication between the IP team and IPLPs whilst maintaining visibility of the IP team. Twice yearly meeting are held across the organisation to facilitate ease of attendance. These provide a forum for IPLPs to network and participate as part of a group in infection related activities and tasks.

Criterion 7: Provide and secure adequate isolation facilities

CLCH continues to provide adequate isolation precautions and facilities in bedded areas for in patients and has clear policies and processes in place for the management of communicable disease in all clinical settings. HCAI clinical case reviews, review of past outbreaks, and the absence of communicable disease outbreaks in 2017-18 demonstrate that isolation facilities are used appropriately and that policy around isolation and transmission precautions is implemented by clinical teams.

Criterion 8: Secure adequate access to laboratory support as appropriate

Laboratory support is provided by local acute trusts depending on the geographical origin of the specimen. A policy on specimen management is available and reflects the local protocols for each laboratory service accesses. The aim of the policy is to ensure that staff obtain samples appropriately and act on the outcomes accordingly. At present, the IPC team do not have proactive access to results and must rely on accessing results through the weekly surveillance programme and through follow-up with clinicians in bedded and other units. CLCH is rolling out access to a pathology cloud system and a priority for 2018-19 is to explore how the IPC team can gain access to this system, thus allowing proactive follow up of patients and results.

Criterion 9: Have and adhere to policies designated for the individual's care that will help to prevent and control infections

CLCH recognises the importance of providing staff with easy access to a full range of IPC policies, procedures and guidelines. Throughout 2017-18 the IPC team continued to review and revise these documents to take account of the latest IPC best practices.

Polices for IPC are reviewed and monitored collaboratively by the Infection Prevention Group to ensure consistency and relevance to CLCH services. Consideration of new national guidance such as National Institute for Clinical Excellence (NICE) Quality Standards, Department of Health directives and developments in practice for IPC are considered for inclusion. The IPC policy development process is monitored and approved through the Trust Infection Prevention Group and policies are then ratified by the trust wide Policy Ratification Group to ensure consistency of structure, formatting and governance.

During 2017-18 the following policies have been developed, reviewed and ratified:

- Clinical Waste management at the point of care policy
- Food Hygiene Policy
- Aseptic Non-touch Technique policy
- Inter-Healthcare Transfers policy
- Linen in Healthcare policy
- Guidance on animals and pets in healthcare facilities policy
- Communicable diseases policy
- Hand hygiene policy
- Management of antimicrobial resistant organisms policy
- Specimen management policy
- Standard infection prevention precautions policy
- Tuberculosis policy
- Post discharge cleaning checklist

Criterion 10: Ensure so far as reasonably practicable that care workers are free of and are protected from exposure to infections that 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

Flu programme

This year the Trust wide flu campaign achieved uptake of 51.9%.This compares favourably to the previous season where uptake was 42.7%. A review of the 2017-18 campaign was completed and proposes to use nudge theory during 2018-19 to improve the seasonal flu vaccination uptake by CLCH staff.

Measles and Varicella Immunity

At the end of 2017-18, the compliance with measles immunity was 92.52% and compliance with varicella immunity was 92.78%. This is an improvement on the position at the start of the year and has been brought about through significant engagement with CBU, service and team managers to engage clinical staff with the process.

4. PRIORITIES AND FUTURE DEVELOPMENTS (2018-19)

Priority	Action
Support divisions with increasing compliance with level 2 infection prevention mandatory training	Review and launch updated e-learning, with L and D, consider alternative delivery and assurance methods including competency based approach
Expand HCAI surveillance to include E.coli, Klebsiella spp and Pseudomonas aeruginosa blood stream infection in bedded areas	Update HCAI surveillance processes and templated to include expanded organism list. Support services with data collection.
Proactive response to Internal Audit and PLACE findings	Infection Prevention Group to ensure oversight and scrutiny of actions identified- summery of audit findings and progress on actions will be presented at quarterly IPG
To raise awareness of sepsis	Develop an summery for level 1 booklet on sepsis for all relevant staff Raise awareness of sepsis across the Trust Continue awareness campaign
Antimicrobial resistance (AMR)	To develop and embed collaboration with medicines management to achieve optimisation in relation to AMR
To increase the uptake of the flu vaccine within our staff groups	Continue to participate in the trust flu group to redefine and implement the annual flu plan
To further develop and implement plans for GNBSI reduction	Link with continence team to review catheter practice Engage in sector wide programme for reduction led by CCG
Review and improve IPC audit tool	To review tools and ensure standardise procedures for feedback and follow up of action plans. To engage with divisional quality forums to ensure action plans are completed and closed
IPC team to get access to pathology cloud	Submit request to CAB for review and editing access to system one and ICE Arrange training for IPC team
Provide expert IP advice and support to procurement to where required	Collaborate with Estates and Facilities and Procurement in the tender of waste management services contract
Support and develop IPC provision and hygiene code compliance in newly commissioned services	Ensure that IPC are represented and collaborate in service mobilisation

5. SUMMARY

This report sets out how the trust is achieving compliance with the Hygiene Code. It demonstrates the continued commitment of the Trust to maintain a high standard of IPC practice to reduce the risk of HCAI for patients and staff and recognises priorities for future work and IPC development.

The Trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working with colleagues across the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Looking forward to 2018-19, CLCH staff will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

6. Appendix 1

Infection Prevention and Control programme 2018-19

Vision: To lead on optimising the reduction of risk of HCAI across all CLCH services, to patients staff and others.

Infection Prevention Objectives 18-19

Ensure an implemented IP strategy and work plan to ensure the reduction of risk from HCAI across the Trust, enabling services to deliver high quality and safe care that meets national standard including the Hygiene Code

Area of Work	Objectives	Expected Outcomes	Timescales	Who	Lead
Strategy	To ensure IP strategy is up to date and make amendments following the update to national mandatory reporting processes and requirements for GNBSI reductions.	Agreed strategy in place	Apr-18		
		Agreed work plan in place	Apr-18		
		Annual Report to Board	Sep-18	**Head of IP**	**Clare**
IPG	To lead on the running of the IPG and facilitate implementation of the updated IP strategy and workplan	Meetings scheduled and minuted			
		Agreed terms of reference			
		Agreed minutes of meetings	Quarterly	**Head of IP/Team**	**Clare**
Hygiene Code Review	To complete annual review of HC to identify gaps for inclusion and prioritisation in workplan	Template review			
		Complete assessment against template			
		Agree additional priorities if identified	Jul-18	**Lead IPN**	**Amanda**
Audits	To complete an annual infection prevention audit workplan identifying audits to be carried out in compliance with CQC and Hygiene Code requirements, CD legislation/ NHSLA requirements	Agreed schedule of clinical support visits and environmental audits with identified	Annual	**Divisional IP**	**Band 7 IPN's**
		Community HH Audit	Quarterly	**Senior IPN**	**Stella Ojo**
		Bedded HH audit	Quarterly	**Divisional IP**	**Band 6**
		ANTT audit	Annual	**All**	**TBC**
		Sharps deep dive audit	Annual	**All IPN's**	**TBC**
		Dental Decontamination and environment audit	Annual	**Senior IPN**	**Steven**
Policies and Protocols	To ensure all IPC policies and protocols are developed and updated according to schedule	Agreed policy and protocol schedule of work with identified lead.	Update quarterly	**Lead IPN**	**Amanda**
		Review of each policy within agreed deadlines	As per policy schedule	**All**	**All**
		Distribution of all approved documents via agreed process in a timely manner and	Ongoing	**Lead IPN**	**Amamda**
Performance indicators	To ensure that relevant internal and external indicators are reported	Hand Hygiene Programme	Quarterly	**IP team**	**All**
		Hygiene Code assessment to be completed	Annual	**Lead IPN**	**Amanda**
		Infection Prevention Training and Education	Quarterly	**IP team**	**All**
		Ongoing work around sepsis awareness and education	Ongoing	**Head of**	**Amanda**
		Review progress against work plan	Quarterly	**IP team**	**All**

Infection Prevention Incidents and Risk (mapping and training to be done)	To ensure infection prevention incidents reported in CLCH are analysed for trends and recommendations made for changes in practice in liaison with relevant stakeholders.	Quarterly incident report to IPG including SIs	Quarterly	**Senior IPN**	**Steven**
		Updated Risk Register after each IPG & PSRG meeting	Quarterly	**Lead IPN**	**Amanda**
		Review Datix incidents, assess for further information and highlight those requiring a incident panel meeting.	Within 3 days	**Responsible**	**Divisional IP teams**
		Maintenance and regular review of process for reviewing Datix incidents	Annually	**Head of IP**	**Clare**
		Attendance at incident panels and contribute to investigation and final	Ongoing	**Senior**	**Band 7 or 8a**
		Lead on MM areas of work identified by incident panel	Ongoing	**Senior IPN**	**Band 7's**
		Identify and coordinate learning for areas where trends identified e.g. audits,	As required	**All**	**All**
Training	To agree and provide an annual training programme informed by Trust wide training needs analysis, policies, national policy and directives and infection prevention incidents.	Agreed schedule of training and coordinate with L&D	Annual	**Lead IPN/Team**	**Amanda/Funmi**
		Review of IP e-learning	Two yearly	**Head of IP**	**Clare**
		Develop ANTT e-learning	As required	**TBC**	**TBC**
		Ad hoc seasonal IP training to bedded units and other areas	As required	**Senior**	**All**
		Flu training	Annual	**Head of IP**	**Clare**
	To share new developments, policy, prescribing updates and national regulations and guidance with CLCH staff.	Spotlight On Quality	Ad hoc	**All**	**All**
		Weekly Trust News	Ad hoc	**All**	**All**
		Database of information published and cascaded	Ongoing	**Team**	**Funmi**
Antimicrobial Stewardship	To support the CLCH Antimicrobial Stewardship Programme	Attend CLCH Antimicrobial Stewardship Group		**Head of**	
		Review cases of HCAI in collaboration with AM pharmacist		**All**	
		Include AMS in IP training materials		**Head of IP**	**Clare/Amanda**
		Review and comment on antimicrobial audits		**MMG**	**TBC**

Flu	To provide IP support to training and annual flu programme by working with relevant stakeholders	Develop flu training materials	Annual	**Head of IP**	**Clare**
		Participate in flu working group	Annual	**Head of IP/Lead IPN**	**Clare/Amanda**
HCAI Surveillance	To proactively monitor HCAI in CLCH bedded units	Weekly surveillance monitoring in bedded units	Ongoing	**IPN's**	**IPN's**
		Follow up of reported cases including quartely reports for IPG, contribution to CCG PIR's where appropriate, case review of HCAI (C difficile, CLCH acquired wound infections, CAUTI, MRSA BSI, Gram negative BSI)	Ongoing	**IPN's**	**IPN's**
	Get access to system One and pathology cloud to support proactive review of patients	Request to be sent to CAB	One off- June	**Head of IP**	**Clare**
NICE and national guidance	To review any IP related NICE Guidance or national IP guidance and directives from other sources and lead on implementation across the Trust.	Feedback from and to NICE Core Group Meetings	Monthly	**By exception TBC**	
		Assess individual guidance and action plans developed and implemented	Monthly	**Lead IPN**	**Amanda**
Patient Safety Alerts, NHS England	To support implementation of IP related PSA alerts in conjunction with Patient Safety & Risk team and relevant stakeholders	Action plans for PSA alerts devised and implemented in conjunction with relevant leads of service with appropriate timescales - to be agreed at IPG	As required	**Senior IPN/Lead IPN**	**Stella/Steven/Mercy/Amanda**
IPLP Programme	To support an effective programme for IPLP's, sharing good practice and networking	Continued recruitment of IPLP's	Ongoing	**All**	**All**
		Twice yearly face to face meetings	Bi-	**IPN's**	**Band 6 & 7**
		Quarterly communications email with updates	Quarterly	**IPN's/Team Administrator**	**Band 6 & 7/Funmi**
		Agree with IPLP IP objective for their clinical area	Annually	**IPN's**	**Band 6 & 7**
National Gram negative BSI reduction objective	To develop and begin implementation of a Gram negative BSI reduction programme	Review NHSI guidance	ASAP		
		Identify short term working group stakeholders	ASAP		
		Develop action plan and prioritise action	Aug-18		
		Review programmes at other community trusts	Aug-18		
		Be an active member of the NWL CCG collaborative GNBSI working group	Ongoing	**Lead IPN**	**Amanda**
HCAI outbreaks	To provide support during outbreaks and periods of increased incidence of HCAI	Control of Communicable disease policy in place	2 yearly	**TBC**	
		Formation and administration of outbreak control group	As required.	**TBC**	
		Review learning and publish	As required.	**Lead IPN**	**Amanda and team**
IP Intranet page	To develop and maintain an informative and up to date team intranet site	Team site up and running and accessible on the intranet	Ongoing	**Team Administrator**	**Funmi**
CLCH Bids & Tenders	To provide IP input into newly commissioned services and existing services being decommissioned to support seamless transitions	Scoping level of IP requirement and IP systems in place	Ongoing as required	**Lead IPN/Senior IPN**	
		Assessment of mobilisation costs and BAU costs	Ongoing as required	**Lead IPN/Senior IPN**	
		Seamless transition of Services from mobilisation to business as usual	Ongoing as required	**Lead IPN/Senior IPN**	
		Business cases for ongoing resource	Ongoing as required	**Head of IP**	**Clare/Amanda/All**
External income generation	To explore business opportunities for income generation	Attendance at STP Meetings	TBC		
			TBC	**TBC**	**TBC**
Premises and Service Development	To ensure that IP standards are met in new services and premises developments and during premises refurbishment	Advise on refurbishments	As required	**Lead IPN/Senior IPN**	**Stella/Steven/Mercy/Amanda**
		Advise on new premises	As required	**Lead IPN/Senior IPN**	**Stella/Steven/Mercy/Amanda**
		Advise on water safety	As required	**Lead IPN/Senior IPN**	**Stella/Steven/Mercy/Amanda**
Procurement to provide quality safety and value related to IPC	To provide expert IP advice and support to procurement during contract tenders and product evaluation processes	Engage with the waste management tender to ensure compliance with clinical waste regulations	June-September 2018	**Head of IPC and Lead IPN**	