DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT
APRIL 2015 - MARCH 2016
## Annual Report

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Created: March 2016
Review: 2017
Author: Dr Tony Elston (Director of Infection Prevention & Control/Consultant Microbiologist)
1. Executive summary – Overview of Infection Control activities in the Trust

This has been a very challenging year for Colchester Hospital University Foundation NHS Trust as it continued to come under intense regulatory scrutiny. This was compounded by increasing staffing difficulties in clinical areas and problems in maintaining the flow of emergency patients through the hospital. Overall I can report that the incidence of Health Care Acquired Infections (HCAI) remained low; the trust had fewer cases of *Clostridium difficile* than expected in its nationally set objective.

The main focus of infection control activity was to continue the good work already established in maintaining the low levels of *Clostridium difficile* and MRSA colonisation acquired within the hospitals of CHUFT in the face of staffing issues throughout the hospital and within the Infection Control team.

We continued to use the Saving Lives High Impact Interventions and Hand Hygiene rates to monitor good infection prevention practice. These results were reported monthly to the board through a board sub-committee. The results are also discussed at local divisional governance groups and the Hospital Infection Control Committee.

The Antibiotic Management Team continued to review antibiotic guidelines and audit their use.

The Isolation ward continued to be a vital part of our approach to reducing *C difficile* and MRSA cases in the hospital.

There were 24 cases of hospital attributed *Clostridium difficile* disease; 10 of these were associated with one or more breaches of major policy, the other 14 received care with no breaches in policy. As in previous years all cases were followed up with an internal investigation and discussion at the North Essex HCAI Scrutiny Panel. Part of this process included a judgement as to whether any of the cases could have been managed better and thus possibly prevented; "were there breaches of policy or not?"

Most isolates were sent for typing and this showed that they were all different from one another, supportive of unlinked cases rather than an outbreak.

There were 2 cases of MRSA bacteraemia attributable to the hospital during the year. Both were discussed with commissioning colleagues at a Post Infection Review. In both cases there were minor suggestions as to how better care could have been provided but there were no breaches of major policy.

The Infection Prevention and Control Team (IPCT) held another successful annual conference for local healthcare staff (doctors, nurses, healthcare scientists) with 83 delegates attending.

**Key achievements**

- **Performance** – generally low levels of *C. diff* with a reduction in cases on the previous year
- **‘Governance’** – evidence that Saving Lives and Hand Hygiene data is discussed and acted upon at divisional and departmental level continues to improve.
- **Infection Control policies and guidelines** - Work took place in relation to Gram negative resistant organism – ESBL and CPE policies
• **Integrated computerised surveillance system** – system continue to generate clinical reports and is used as a patient case management system effectively and will be due for an upgrade in order to support the system in the next 18 months to tie in with Transforming Pathology Partnership and Portal systems

• **Annual Mandatory updates for all staff** – the uptake continues to increase year on year with the introduction of the antimicrobial training for trained staff as part of the Infection Control e-learning package

**On-going work**

• To continue the trend of minimal number of patients with MRSA and Clostridium difficile.
• To introduce improved management of peripheral IV devices.
• To reduce the number of urinary catheterisations in the trust
• To continue to participate in the development of the catheter passport
• To continue collect data on bacteraemia caused by “ordinary” Staph aureus (MSSA) and Escherichia coli
• Governance – to continue to embed throughout the organisation
• Mandatory annual updates for all Trust Staff

Dr Tony Elston
Director of Infection Prevention and Control /Consultant Microbiologist & Infection Control Doctor
2. Description of Infection Control Team arrangements

Dr Tony Elston
Consultant Microbiologist/Director of Infection Prevention & Control
☎ 01206 747316

Dr Sima Jalili
Consultant Microbiologist
☎ 01206 747313

Dr Gillian Urwin
Consultant Microbiologist
☎ 01206 747326

Heather Dakin
Head of Infection Prevention Control
☎ 01206 742706

Vicky Bywater
Senior Infection Prevention and Control Nurse
☎ 01206 744265

Marcia Hirst
Infection Prevention and Control Nurse
☎ 01206 744267

Allison Munson
Infection Prevention and Control Audit/Surveillance Nurse
☎ 01206 742708

Nikki Harding
Infection Prevention and Control Audit
☎ 01206 7424267

Paul Raven
Quality Hub Data Manager
☎ 01206 744266

Laura Bowen
Antibimicrobial Team Secretary
☎ 01206 744268

Janine Sawyer
Infection Prevention and Control Team Secretary
☎ 01206 744268
Infection Control Team Activities

Members of Infection Control Team visit clinical areas on a daily basis maintaining a high profile and are easily accessible. Each Clinical area has an Infection Control Nurse designated to them in order to support and maintain knowledge and skills.

Members of the team are involved in the following committees/meetings:

- Infection Control Team Meeting
- Hospital Infection Control Committee
- Medicine Management Committee
- Clinical Product Review Group
- Matron and Ward Sisters Meetings
- Procedures Development Advisory Committee
- Risk Management Committee
- Senior Management Advisory Group
- Service review meetings for facilities management
- Clinical Executive Board
- Intravenous Management Group
- Trust Clinical Governance Committee
- PLACE inspection team/annual and monthly
- PLACE Operational Steering Group Meeting
- Quality and Patient Safety Committee
- Capital Planning Update Monthly Meeting

The Director of Infection Prevention and Control attends and reports to the following:

- Trust Clinical Governance Committee, Trust Board, Quality and Patient Safety Assurance Committee.

There is an active North East Essex HCAI Operational Group. The group includes representatives from ACE, SEPT, PROVIDE, CHUFT, PHE - Essex and Essex County Council Social Services. The remit is to review progress in HCAI prevention in each of the organisations and to monitor progress against a joint action plan.
The number of enquiries captured continues to increase year on year, some of these enquiries may be dealt with quickly whilst others can lead to a major piece of project work. There has been an increase of 2% of admin and audit enquiries. There was a slight increase in diarrhoea and vomiting throughout the year and this is reflected in an increase of related enquiries. The three main themes remain consistent MRSA, D&V and Infectious diseases.

The *C. difficile* enquiries were separated out from the diarrhoea and vomiting category as there appears to be a significant increase in enquiries relating to this topic. This may well be related to the increased teaching relating to this subject as the Trust overall has seen a reduction in cases in 2015/16. However, testing in terms of *C. difficile* carriage without disease, has increased as has awareness in the Trust.

What must be remembered is that the data does not capture all of the enquiries and work generated within the Team; however it does assist in focusing what topics to plan for teaching and support for the coming year.
**Hospital Infection Control Committee**

Out of 5 meetings held, attendance is given as follows:

<table>
<thead>
<tr>
<th>Position</th>
<th>20/05/2015</th>
<th>24/08/2015</th>
<th>20/10/2015</th>
<th>30/03/2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of Infection Prevention &amp; Control (Chair)</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Consultant Medical Microbiologist</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Senior Infection Control Nurse</td>
<td>√</td>
<td>√</td>
<td>x</td>
<td>√</td>
</tr>
<tr>
<td>Head of Facilities Manager</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Head of Estates</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Health &amp; Wellbeing Manager</td>
<td>√</td>
<td>x</td>
<td>x</td>
<td>√</td>
</tr>
<tr>
<td>Chief Pharmacist</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Antibiotic Pharmacy technician/pharmacist</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Representatives from each of the four Clinical Divisions to include 1 medical, 1 nursing and 1 managerial / professional</td>
<td>x 3/4</td>
<td>2/4</td>
<td>2/4</td>
<td>0/4</td>
</tr>
<tr>
<td>Sterile Services / Trust Decontamination Lead</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>x</td>
</tr>
<tr>
<td>Patient representative</td>
<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>PHE – Essex - Representative</td>
<td>x</td>
<td>√</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

√ indicates attendance.

Created: March 2016
Review: 2017
Author: Dr Tony Elston (Director of Infection Prevention & Control/Consultant Microbiologist)
Organisational structure and reporting line to the Trust Board

Trust Board

QPS

Hospital Infection Control Committee

Barbara Shuttle, Director of Nursing

Dr Tony Elston, Consultant Microbiologist/DIPC

Heather Dakin, Senior Infection Control Nurse

Dr Sima Jalili, Consultant Microbiologist

Vicky Bywater, Infection Control Nurse

Marcia Hirst, Infection Control Nurse

Nikki Harding, Infection Control Nurse

Alli Munson, Surgical Site Infection Nurse

Paul Raven, Data Manager

Janine Sawyer, Team Secretary

Laura Bowen, Antibiotic Secretary
3. DIPC reports to the Trust Board – summary

The DIPC reported monthly to the Quality and Patient Safety Assurance Committee, which itself reports monthly to the board.

**Outbreaks**

<table>
<thead>
<tr>
<th>Date</th>
<th>Ward</th>
<th>Number of bays, ward closed</th>
<th>Number of days ward affected</th>
<th>Cases confirmed by PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/04/15</td>
<td>Peldon</td>
<td>Ward closed 07/04-14/04/15, A, C, &amp; D open 15/04/15, B bay open 16/04/15</td>
<td>8-9 days</td>
<td>Yes: Norovirus genogroup II confirmed</td>
</tr>
<tr>
<td>22/06-24/06/15</td>
<td>Peldon</td>
<td>1 bay</td>
<td>3 days</td>
<td>No</td>
</tr>
<tr>
<td>30/10-09/11/2015</td>
<td>Peldon</td>
<td>Ward closed</td>
<td>11 days</td>
<td>Yes: Norovirus genotype II confirmed</td>
</tr>
<tr>
<td>02/11-06/11/2015</td>
<td>Darcy</td>
<td>2 bays</td>
<td>5 days</td>
<td>Yes: Norovirus genogroup II confirmed</td>
</tr>
<tr>
<td>02/11-05/11/2015</td>
<td>Birch</td>
<td>1 bay</td>
<td>4 days</td>
<td>No</td>
</tr>
<tr>
<td>21/11-24/11/15</td>
<td>Stroke</td>
<td>5 bays 21/11-23/11, 1 bay 23/11-24/11</td>
<td>4 days</td>
<td>No</td>
</tr>
<tr>
<td>17/03-18/03/16</td>
<td>Birch</td>
<td>1 bay</td>
<td>1 day</td>
<td>No</td>
</tr>
<tr>
<td>28/03-29/03/16</td>
<td>Fordham</td>
<td>1 bay</td>
<td>2 days</td>
<td>No</td>
</tr>
</tbody>
</table>

**Actions taken**

- Wards visited daily by Infection Control Nurse and daily management plan agreed with local and Trust site team
- Decision to close bay or Ward agreed by Infection Control team
- Increased and enhanced cleaning in place
- Cohort nursing/care managed

**Water safety report**

During 2015/16 the Water Safety Committee met on a monthly basis and continued to make progress in improvements and maintenance of water management and quality. An Authorising Engineer from the Water Hygiene Centre now sits on the Trust Water Safety Committee to support with expert guidance.

The Trust Water safety plan was updated in 2015 and is available on the trust intranet.

The monitoring and management of *Psuedomonas aeruginosa* has developed with 6 monthly sampling and testing in augmented care areas. The Water Safety Committee sits monthly and all results and actions are discussed together with future plans as necessary. There were 10 positive results in West Bergholt Ward and Critical Care Unit resulting in a flushing programme being put into place by Estates to action and subsequent resampling taking place.

A new colour coding system for showerhead replacement management has been instituted whereby on a quarterly basis the showerheads and hoses are replaced with a different colour. This allows for easy visual checks. The initial outlay has been funded from the Infection Control Project monies.
The Water testing and site survey contract will be moved over from the Trust current provider Nalco to the new contractor, Clearwater Technologies in May 2016. Electronic reporting will ensure that all previous reports are migrated over to the new system and will be available on the Trust Estates Drive.

The Trust has a well-structured Legionella risk assessment and sampling programme in place. The electronic monitoring reports go directly to Estates to action and other members of the Water Safety Committee are involved in the monitoring and support of the actions.

Terry Cook - Estates and Compliance Manager

4. Budget allocation to infection control activities

Staff

<table>
<thead>
<tr>
<th></th>
<th>Month 1</th>
<th>Month 12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budgeted</td>
<td>Actual</td>
</tr>
<tr>
<td>Consultant</td>
<td>0.40</td>
<td>0.40</td>
</tr>
<tr>
<td>Nursing Band</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8a</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>7</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>6</td>
<td>2.84</td>
<td>2.84</td>
</tr>
<tr>
<td>A&amp;C Band</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1.50</td>
<td>1.10</td>
</tr>
<tr>
<td>5</td>
<td>1.00</td>
<td>1.00</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* staffing allocation shown as whole time equivalents (wte)

Annual Budget

At the end of the financial year there was a £7345 underspend relating to staffing costs. This past 12 months has seen some staff movement into and out of the team in both nursing and administration staff. There had been long term sickness in the administrative arm of the team and there is a cost pressure to appoint a Band 3 on a temporary contract since January 2016.

The surgical site infection surveillance/Audit Nurse post was recruited into in February 2015 and non- mandatory surveillance could once again be undertaken. The surgical division also contributed funding for an extra 0.2 wte (7.5 hours per week) in order to undertake Vascular Surgical Site infection surveillance continuously via the PHE SSiSS programme.

Project monies were spent as below:

- £5280 Inc. VAT to pump prime colour coded shower head replacement in clinical areas as part of actions supported by the water safety committee in relation to best practice for legionella risk reduction
- £1778.40 inc. VAT to purchase 2 portable hand wash sinks to support facilities when clinical areas require temporary support during works.
Training/education for IC Team 2015/16

1 member of Team undertook 1 module on BSc pathway Essex University (MH)
2 members of Team completed final module MSc Biomedical Sciences Distance learning (VB) (HD) achieving Distinction

Training requirements for the Team in the coming year 2016/2017

1 member of staff to attend Annual Infection Prevention Society annual conference
1 member of Team to undertake 1 module on BSc pathway (MH)

5. HCAI statistics

MRSA bacteraemia

The target for the year was 0 cases. However, there were 2 cases identified in December 2015 which were apportioned to the Trust. The Trust saw no further cases in the year 1st April 2015 to 31st March 2016. There has been learning from both cases relating to peripheral vascular line management in particular and actions have been taken locally and learning shared across the Trust. The number of cases of MRSA bacteremia has increased over the patch with some of the cases relating to patients with no known recent healthcare interventions.
Clostridium difficile

The graph and table above illustrate the number of cases per month apportioned to the Trust 2015/16.

The target was no more than 18 cases with no breaches in policy for the year 2015/16. The year ended with 24 cases overall with 14 cases successfully appealed following the review of cases at the post infection scrutiny panel appeals process with our partner CCG. Therefore the end of year position of potentially avoidable cases was 10 against a target of 18. This was a reduction of 7 cases on the previous year.
The enhanced testing for C difficile carriage has allowed earlier recognition of cases before they go on to develop disease. This has allowed timely isolation (utilisation of the isolation unit has supported the prompt isolation of these patients reducing spread in the wider hospital environment) and management of cases and may have some bearing on the reduction in cases in the past year. It may also explain the trend for a perception of higher number of "cases" overall compared to recent years as these carriers would previously not have been identified.

The plan for the coming year will be to focus efforts on all aspects of the C diff control measures as outlined in Saving Lives high impact intervention 7.

The disease processes do not appear to have been as aggressive as in years previously with patients with CDI generally recovering more quickly.

Further work with the antimicrobial prescribing guideline reviews and audit may assist in the reduction of inappropriate antimicrobial prescribing including course length.

- Panel reviews with clinical teams for each case to look at root causes for each case
- Close working with community colleagues relating to all cases including pre 48 hours to look at issues in the community care settings
- There has been a continual programme of reviewing antibiotic prescribing with changes to policy and regular feedback and education to clinical staff
- Planned decant, refurbishment and deep clean of Langham Ward planned took place
- Refurbishment and deep clean also took place on Wivenhoe Ward – reduced bays from 6 bedded to 4 bedded bays with ensuite facilities in each bay (Vascular Surgery); Hydrotherapy Unit, Layer Marney Ward (respiratory Medicine) Blood Sciences laboratory
- There are plans for 3 Ward refurbishments for the coming financial year (2016/17) to include the 2 COTE Wards and the Cardiac Care Unit

How does Colchester Compare with other like sized Trusts? - see charts below.
C.Diff 15/16 - Non Specialist
KH03 occupied overnight beds (per 100,000)

MSSA 15/16 - Non Specialist
KH03 occupied overnight beds (per 100,000)
**Carbapenemase Producing Coliforms (CPC’s)**

A CPE specific procedure based on the Public Health England Toolkit was drawn up and disseminated.

**Escherichia coli (E coli) blood stream infections**

Since June 2011 has been a requirement of the Department of Health for the Trust to input data to PHE on all E coli blood stream infections. In 2013 E coli accounted for 31% of all bloodstream infections in England.

![E-Coli Bacteraemia Cases Apr 15 - Mar 16](image)

The chart above illustrates that patients on the whole become unwell prior to their admission and over a third of cases were identified as urinary tract as the source of the bacteremia, which is in line with national data. The lead ICN working with colleagues from community practice in ACE and SEPT and Essex County Council developed a Train the trainer package for hydration/urinary continence and urinary catheter management this was delivered to teams from Nursing and Residential care Homes in the locality.

Urinary catheter passport another joint initiative with our community partners in ACE primarily, is on its third revision supporting the aim to reduce harm from urinary catheterization. Further work is required in order to reduce insertions where possible and review regularly the need for the device.

One of the concerns regarding the increase in E coli bacteremia is the increasing emergence of multi – antibiotic resistant strains of these infections, potentially leaving a limited selection of effective antibiotics available with which to treat infections CHUFT see these resistant strains in small but increasing numbers and utilize the Isolation unit in order to minimize the transmission of these organisms with the hospital.
Surveillance

ICNet

ICNet surveillance system was introduced to the Trust in 2007 and provides the Infection Prevention and control team and the Trust with tools to support the effective monitoring and management of HCAI’s. The system will require an upgrade in the next 18 months as the system will not be able to continue to be supported in its current version.

The system provides 3 times a day imports of relevant microbiological results to all for the timely review of patients and appropriate interventions to be managed. The system is starting to show value in supporting data production for antimicrobial resistance.

The system supports the data required for reporting to relevant internal and external agencies.

The continued investment in ICNet with the Link with Patient administration System – Medway going forward in the Transforming Pathology Partnership must not be lost and the value of this system for reporting and case management cannot be underestimated.

Surgical Site Infection Surveillance

<table>
<thead>
<tr>
<th>2015/16</th>
<th>Large Bowel</th>
<th>Small Bowel</th>
<th>Vascular</th>
<th>Abdominal Hysterectomy</th>
<th>Total Hip</th>
<th>Knee Replacement</th>
<th>Repair of Neck of Femur</th>
</tr>
</thead>
<tbody>
<tr>
<td>April – June 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0/74 0%</td>
<td></td>
<td>0/29 0%</td>
<td>0/122 0%</td>
<td>0/93 0%</td>
<td></td>
<td>3/128 2.3%</td>
</tr>
<tr>
<td>July – October 2015</td>
<td>1/68 1.5%</td>
<td>1/66 1.5%</td>
<td></td>
<td>2/131 1.5%</td>
<td>0/134 0%</td>
<td></td>
<td>2/151 1.3%</td>
</tr>
<tr>
<td>Oct – December 2015</td>
<td>1/63 1.6%</td>
<td>2/20 10%</td>
<td>1/84 1.2%</td>
<td>0/127 0%</td>
<td>0/128 0%</td>
<td></td>
<td>0/146 0%</td>
</tr>
<tr>
<td>Jan – March 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National average</td>
<td>12.4%</td>
<td>8.5%</td>
<td>4.8%</td>
<td>4.4%</td>
<td>1.1%</td>
<td>1.6%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

NB: The national programme for surgical site surveillance suggests that at least 50 cases need to be surveyed in a three month period in order to obtain good quality figures which are statistically significant.

NB: all participating hospitals % per period in brackets in bold.
Data for reporting period Jan – March 2016 awaiting ratification from PHE.

The surgical site surveillance /audit nurse post was recruited into February 2015. There was funding given from the surgical division of 7.5 hours per week band 6 nurse in order to participate in continuous surveillance for vascular surgery through PHE Surgical site
infection surveillance programme. The results of which can be seen to be favourable when benchmarked against other hospitals participating in this surveillance across England.

Monthly reports are generated for the respective teams each case where infection is noted is discussed by the relevant surgical teams and reviewed for possible learning.

There is a rolling programme for other modules including abdominal hysterectomy, large and small bowel surgery outcome were good and were within the national benchmarks.

In Orthopaedic surgery all 4 modules are participated in all of the time and have been since 2005. Consistently outcomes are under the national benchmark, where any infection is identified the Orthopaedic team review the cases to see if there is anything which could have been done differently to reduce the risk of infection.

6. Hand Hygiene

The Hand Hygiene policy was updated in February 2015. The Trust overall hand hygiene observation scores are achieving over 95% on a monthly basis, with between 2,500-4,500 observations per month. When compliance appears to drop this is recognised by divisions and remedial actions are taken. The IPCT frequently help with these additional training sessions.

7. Cleaning Services

Management Arrangements

The Housekeeping service is an In-house service which is managed by the Facilities Department along with other non-clinical support services. It falls directly within the remit of the Patient Environment Manager who manages it on a day to day basis through the Hotel Services Management & Supervisory Team in order that there is 'around the clock' supervisory cover for the cleaning staff on duty. These arrangements enable cleaning requests to be carried out with the minimum of delay.

Monitoring arrangements

All wards and departments are audited and monitored against the National Specifications for Cleanliness (2007) using 55 Elements approved by the Lead Infection Control Nurse, which includes the 49 detailed in the Specifications. The audits are generally carried out by a Matron or Ward Sister/Department Manager in conjunction with a member of the Housekeeping Management Team.

All areas are formally audited on a monthly basis.

Cleaning schedules

Cleaning schedules are available in all patient areas and updated as required to meet individual service needs with the Ward Sister/Department Manager.

Patient Led Assessment of the Care Environment (PLACE)
The Trust performed well with regards to patient perception of the cleanliness of the environment in the 2015 PLACE assessments as the table below details. The results of 2016 assessments which were carried out in late April will not be officially available until August 2016, but early indications are that the score for cleanliness will remain very similar to 2015.

<table>
<thead>
<tr>
<th></th>
<th>National Average</th>
<th>Colchester General 2015</th>
<th>Colchester 2014</th>
<th>General</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>97.57%</td>
<td>99.13%</td>
<td>99.15%</td>
<td></td>
</tr>
<tr>
<td>Food and Hydration</td>
<td>89.27%</td>
<td>90.61%</td>
<td>90.84%</td>
<td></td>
</tr>
<tr>
<td>Privacy, Dignity and Wellbeing</td>
<td>87.21%</td>
<td>89.33%</td>
<td>94.23%</td>
<td></td>
</tr>
<tr>
<td>Condition, Appearance, Maintenance</td>
<td>90.11%</td>
<td>93.00%</td>
<td>95.79%</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>74.51%</td>
<td>66.09%</td>
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<td></td>
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</tbody>
</table>

The Trust also holds six PLACE lite meetings throughout the year, and quarterly PLACE steering Group meetings to review and update the action plan.

**IPC training for housekeeping staff**

All Housekeeping staff receive Infection Control training as part of their mandatory training. They also receive on the job training which supports and underpins the Infection Control Training and covers topics such as the use of colour coded mops, and cleaning from clean to dirty, to prevent cross contamination and infection.

**NPSA**

The two charts below detail the overall NPSA audit scores over the past year as well as the scores achieved by the three specialties over the year.
Deep Cleaning

The Trust continues to support the process of environmental decontamination with hydrogen peroxide vapour (HPV) which is used as standard practice for Deep cleaning as per the Trust policy and as directed by the Nursing or Infection Control Team and where upgrades or refurbishments take place. There is an arrangement with each clinical department to release a room and undertake deep cleaning of ward based equipment on a monthly basis.

Fiona Sparrow – Head of Facilities

8. Decontamination

The importance of decontamination to ensure staff and patient safety needs to be recognised at all levels. The latest feedback shows that those responsible are continuing to learn from their audit experience and are keen to meet the essential requirements and best practice.

Following audits areas continue to carry out their agreed actions to reduce risks identified at the audit and this is reflected in improved scores. Other areas may be able to do very little
due to space issues, lack of funds and staff. Where appropriate business cases or projects will be developed and funds requested via normal Trust routes.

Centralisation of decontamination activities should always be the preferred option to minimise risk, realise cost savings, ensure best practice and free up time to allow clinical staff to carry out their core activities. At present this can be impractical due to lack of space and costs may be higher e.g. due to the cost of additional devices based on delayed turnaround.

A Trust decontamination strategy has been developed. Development of this strategy will be based on service requirements, risks identified by audits and action plans. This should aim to centralise wherever possible, practical and cost effective. Where centralisation is not feasible the environment, equipment, policies, procedures and staff training must meet the required standard. Currently this is not fully compliant in several areas due to space; audits will continue to show risks unless suitable environments are found. It should be understood that processes and procedures continue to become more technical but this is not often recognised when it comes to funding and staffing. Lack of funds will delay improvements and the risk will continue. A project team has been compiled, initial meetings have begun and figures are being sought to assist with determining the appropriate options.

The Sterile Service Unit should carry out all decontamination of reusable instrumentation as it is fully accredited and compliant with all required legislation. The Mortuary will continue to wash /disinfect its own instrumentation due to increased risk of prions.

**John McManus – Trust Decontamination Lead**

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**9. Audit**
Overall the scores for clinical practices audit compliance relating to infection prevention and control have improved in all areas as can be seen in the chart above. A total of 51 clinical areas were audited taking into account 14 standards as described above. The environment element takes into account estates and facilities issues in the main with the patient equipment picking up nursing team responsibilities on the whole.

department upgrades or refurbishments as standard. This will is use at the end of outbreak situations e.g. Norovirus. All wards have a day a month where as much equipment not attached to patients is given an enhanced clean using this process e.g. commodes, drip stand.

The aim is to reduce as far as possible cross contamination from equipment and the environment to patients. Reduce the bio-burden in the environment e.g. *C diff* spores.
Generally compliance with clinical practice procedures as above are to a high standard. The main issues relate to documentation of invasive devices, this is being supported through enhanced education and introduction of invasive device insertion packs with labels, in particular for urinary catheter insertion and intravascular cannulation packs revised.

There were some specific issues identified within the Renal Unit (Fresenius) and these were ultimately addressed through the contractual process.

These reports are reported by exception through local governance meetings and through the HICC.

10. Targets and Outcomes

1) Key issues relating to Infection control are now on the agenda of all directorate and divisional clinical governance group meetings.
2) Evaluation of Saving Lives data and Hand Hygiene audits throughout the division, strengthening the robustness and timeliness of data. This has been achieved by increasing understanding of the elements of the care bundle elements and increasing the numbers of observations of care within all areas.

3) A key role of Matrons is devoted to environmental monitoring, with matrons undertaking the NPSA environmental audit with the housekeepers. This enables issues to be addressed in a timely way in the vast majority of cases.

4) The on-going engagement of the clinical teams caring for the patients in undertaking RCA but supported by the Infection Control team continues to be a positive process in broadening knowledge and understanding of the root causes of the infection.

5) The IPCT is working closely with speciality matrons to improve performance around and awareness of infection control related incidents.

6) The IPCT were involved in the refurbishment of 3 wards in CGH; Langham, Layer Marney and Wivenhoe.
Policies Updated this year

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>113</td>
<td>Food Handling and Hygiene for Ward Based Staff Guidelines</td>
<td>31/08/2017</td>
</tr>
<tr>
<td>253</td>
<td>Decontamination Procedure (Elmstead Unit, Main and Constable Theatres)</td>
<td>31/05/2017</td>
</tr>
<tr>
<td>181</td>
<td>Control of Outbreaks of Infection in the Hospital Setting Procedure</td>
<td>01/04/2018</td>
</tr>
<tr>
<td>245</td>
<td>Clostridium difficile and Unexplained Diarrhoea Procedure</td>
<td>30/03/2018</td>
</tr>
<tr>
<td>246</td>
<td>Management of Chickenpox and Shingles Procedure, Including Immunization for Healthcare Workers</td>
<td>Procedure awaiting upload to intranet</td>
</tr>
<tr>
<td>124</td>
<td>Visiting Pets Procedure</td>
<td>Procedure awaiting upload to intranet</td>
</tr>
<tr>
<td>360</td>
<td>Procedure for the Management of Extended Spectrum Beta Lactamase (ESBL) Producing Organisms and Other Multi-Resistant Gram Negative Bacteria (including Carbapenemase Producing Organisms), and Prevention of Spread</td>
<td>30/04/2016 To separate out ESBL and CPE policies</td>
</tr>
<tr>
<td>361</td>
<td>Isolation Procedure</td>
<td>30/04/2016</td>
</tr>
<tr>
<td>080</td>
<td>Tuberculosis (TB) Management Procedure</td>
<td>31/05/2016</td>
</tr>
<tr>
<td>322</td>
<td>Isolation Unit Operational Procedure</td>
<td>30/06/2016</td>
</tr>
<tr>
<td>371</td>
<td>Viral Haemorrhagic Fever (VHF) Procedure</td>
<td>30/06/2016</td>
</tr>
<tr>
<td>343</td>
<td>Hydrogen Peroxide Vapour (HPV) Decontamination Procedure</td>
<td>31/12/2016</td>
</tr>
<tr>
<td>090</td>
<td>Hand Hygiene Procedure</td>
<td>28/02/2017</td>
</tr>
<tr>
<td>210</td>
<td>Infection Control Procedure</td>
<td>28/02/2017</td>
</tr>
<tr>
<td>112</td>
<td>Methicillin-Resistant Staphylococcus aureus (MRSA) Procedure</td>
<td>31/05/2019</td>
</tr>
<tr>
<td>368</td>
<td>Creutzfeldt Jacob Disease (CJD) – Procedure for the Management of Related Disorders in Hospital</td>
<td>30/09/2017</td>
</tr>
</tbody>
</table>
11. Antibiotic Management Team Report 2015-16

The Antibiotic Management Team (AMT) meets every 6 weeks to plan and monitor the strategy for Antimicrobial Stewardship within the Trust. The work of the team continues to follow the good practice principles set out in the Department of Health’s 2011 document Antimicrobial Stewardship: Start Smart – Then Focus (revised April 2015). Individual staff from multidisciplinary teams are encouraged to be involved in the AMT work when the focus is on a particular area or infection within the speciality and to help implement initiatives for improving the quality of prescribing.

In August 2015 NICE guidance on Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use were published. The guidance brings together recommendations from all recent publications relating to antimicrobial use and resistance and is used as a toolkit to demonstrate compliance to the Health and Social Care Act. Following publication a full gap analysis was conducted within CHUFT to help focus the work of the team and the AMT ensures that all work streams comply with this guidance by regular review. As a result of this document a successful business case application was made to appoint an Antimicrobial Stewardship Pharmacist.

Monthly trends on Datix (Trust electronic incident reporting system) are monitored as a regular agenda item by AMT. From identifying trends in incidents or near misses education can be enhanced and systems can be implemented to minimise the risks in the future, for example as a result of the monitoring small laminated cards continue to be available for all clinical staff detailing the antibiotics to be avoided or used with caution in patients with a confirmed penicillin allergy. Results of these actions are fed into the Medication Safety Committee for further monitoring.

Existing guidelines continue to be reviewed and new guidance produced working with the relevant lead clinicians. Enhancements to the team’s intranet pages have resulted in improved access to the guidance and the ability to access the most frequently used guidance in a timely manner. The team continue to liaise and build close links with other Trusts within the East of England to ensure that guidance is in line with other Hospitals within the region and follows best practice. An antimicrobial "app" was introduced Summer 2014 which allows Trust staff to download guidance for access via their mobile phones.

Recent download figures have shown that:

- **the Adult guidance has now been downloaded 1053 times and the Paediatric 246 during 2015/16. The guidance has been accessed 5063 times in total, an increase from the previous year.**
- **Data has shown, the guidance is used 24/7, every day.**

Work within the team has expanded to include Antifungal Stewardship. A change in recommended products and new guidance has been introduced to help implement this & patients receiving systemic antifungal agents continue to be monitored during AMT ward rounds.
Regular monitoring through audit continues. A rolling programme of audit looking at antibiotic prophylaxis during surgery has been expanded and the following surgical specialities are monitored:

- Vascular
- Gastrointestinal
- Urology
- Orthopaedics
- Breast
- Gynaecology
- Caesarean sections
- Pacemaker
- Interventional Radiology

Quarterly audits are conducted by Pharmacy & Infection Control staff to ensure adherence to guidance: course length, documentation and compliance with guidelines are all areas that are monitored. Results are feedback to ward managers, matrons, associate directors of nursing & divisional clinical directors. Ad-hoc audits are planned for specific indications or areas identified as having an increased antibiotic consumption following discussions at the AMT meetings.

The team continues the work initiated by the 2012 local CQUIN which was designed to reduce the number of omitted doses during an inpatient treatment course of antibiotics.

Involvement in the training and education of all staff that supply, prescribe or administer antibiotics continues to be a priority for the team. Monthly corporate induction is attended to provide a brief session to all new prescribers to the Trust. Junior doctors receive a session from the Consultant Microbiologist at the start of their training and have an opportunity to visit an information stand as part of the induction fayre. Pharmacy staff attend sessions during the year and these focus on supporting doctors and ensuring quality prescribing for all inpatients being treated with antibiotics. The antimicrobial e-learning package has been amalgamated with the Infection Control e-learning package making it mandatory for all staff to complete bi-annually. The packages are reviewed regularly to ensure that the contents reflect current recommended practice & themes identified from incidents/near misses. Currently new packages focusing on nursing staff working in both paediatrics and neonatal areas continue to be developed. The team also provide training on both speciality away days and at ward level for nursing staff when requested.

Ward rounds continue at least weekly and provide an opportunity to monitor current practice and for education and discussion with both the patient and their medical team. Complex patients are followed up and monitored during their inpatient stay and advice is given at discharge. Information is recorded onto ICNet to enhance collaborative working with the Infection Control Team. Figures for the number of patients seen and the outcome of discussions for 2015/16 are displayed below:
12. Training Activities

Induction and Mandatory update for all staff

Induction training pack is updated annually in order to take on board local and national trends with some key themes continuing to flow through relating to standard precautions.

E-Learning

E-learning package was updated twice this year in order to add some more information relating to antimicrobial stewardships and staff responsibilities.

The plan for the coming year in order to meet core leaning that the antimicrobial element will have to be removed and a separate antimicrobial e-learning package will be required as mandatory this will support the aim of prudent antimicrobial prescribing and management.

Link Nurses

The attendance at the meetings has remained high at a level of 15 – 20 of Infection Control Link staff per meeting.

The topics covered this year have included:

- Decontamination of reusable medical devices
- Varicella Zoster/Chicken Pox
- RSV/CMV
- Who Cleans What?
- Peripheral Cannula Associated Infections and Care
- MERS
- CPE
- MRSA Bacteraemia
- Common Themes from Yearly Infection Control Audits
The Infection control link role continues to extend to representatives from all staff groups.

**General**

Many staff have spent time with the Infection Control Team in order to broaden their clinical knowledge relating to Infection Prevention and Control. This supports the staff visiting and the IPC Nursing team in order to keep up to date with their Mentorship skills.

Student Nurses are allocated to the department from the 2 local universities whom complete 2 week placements. The feedback has been very positive from Students this past year.

The infection Control Nurses have completed 103 sessions and managed to train 1200 staff in the face to face sessions.

Total number of staff who have completed IC training in 2015/16 in one form or another is 3926, or 91.26% of staff.

**Training sessions recorded by IPCT**

![Pie chart showing training sessions by IPCT]

**Training sessions recorded by ESR**
<table>
<thead>
<tr>
<th><strong>Annual plan key points</strong></th>
<th><strong>Key points</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with Hygiene Code (2008 updated 2010)</td>
<td>• To review action plan against the code on a regular basis</td>
</tr>
<tr>
<td>Saving Lives audits</td>
<td>• Continue to support clinical teams in the education and use of the tools &lt;br&gt;• ICT data manager continues to work with local teams to tailor reports to department &lt;br&gt;• To target three ‘High Impact Interventions’ : &lt;br&gt;• Appropriate use of urinary catheters &lt;br&gt;• Appropriate use of Isolation Facilities for HCAI &lt;br&gt;• Effective use of risk assessments for HCAI &lt;br&gt;• To promote Peer review of audits to promote learning across the divisions</td>
</tr>
<tr>
<td>Annual IC audits</td>
<td>• Continue with annual rolling programme of Infection control audits with timely feedback to clinical teams</td>
</tr>
<tr>
<td>Facilitate the MRSA screening project</td>
<td>• To continue to assist divisions in achieving compliance with MRSA emergency admission screening procedure &lt;br&gt;• To support a robust system is in place to assure compliance with the target &lt;br&gt;• To support the feedback of data to support this work</td>
</tr>
<tr>
<td>Facilities Contract review</td>
<td>• To work with Trust Facilities management team to look at aspects of the contract which require Infection Control advice</td>
</tr>
<tr>
<td>Promote e-learning programmed and audit uptake</td>
<td>• Continue updating programmed annually &lt;br&gt;• To audit uptake and report to HICC bi monthly</td>
</tr>
<tr>
<td>Mandatory annual updates for Infection Control and antimicrobial management for all staff groups</td>
<td>• To continue to support the Trust programme at induction and Mandatory update sessions – update annually &lt;br&gt;• Programme available in e-learning format for induction</td>
</tr>
<tr>
<td>Update IC policies</td>
<td>• Ongoing programme</td>
</tr>
<tr>
<td>IC manual update</td>
<td>• Ongoing updating on web based Manual</td>
</tr>
<tr>
<td>ICNet surveillance system</td>
<td>• To continually evaluate effectiveness of the system &lt;br&gt;• The system requires upgrading at a financial</td>
</tr>
<tr>
<td>Continue with Surgical site surveillance</td>
<td>• Continue with agreed rolling programme of modules in addition to the mandatory modules &lt;br&gt;• Promote the adoption within the Trust of Surveillance in areas such as caesarian sections as the new modules become available</td>
</tr>
<tr>
<td>Infection Control Link System</td>
<td>• To continue to develop the link role into other healthcare disciplines &lt;br&gt;• To further develop the role of the Link role to enhance local infection control Induction</td>
</tr>
<tr>
<td>Surveillance</td>
<td>• E coli bacteraemia RCA and reporting &lt;br&gt;• MSSA bacteraemia RCA and reporting &lt;br&gt;• MRSA bacteraemia RCA and reporting &lt;br&gt;• C diff RCA and reporting &lt;br&gt;• CPC reporting and RCA</td>
</tr>
</tbody>
</table>
### 13. Infection Prevention and Control Programme 2016/17

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Operational Lead</th>
<th>Date of completion</th>
<th>Measure of Success</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve target for <em>Clostridium difficile</em> infection cases (where it is deemed by the Scrutiny panel process that the cases are deemed as no lapses in care these are removed from the performance trajectory) no more than 18 cases for 2016/17</td>
<td>Complete Root Cause analysis and Panel review of all hospital acquired cases of CDI</td>
<td>Matron where the case of CDI occurs</td>
<td>Ongoing</td>
<td>All cases of hospital CDI will have an RCA investigation and relevant action plan where learning is required. Trends will be monitored and identified by the IPC team</td>
</tr>
<tr>
<td>Standardise the recording of stools across the Trust</td>
<td>IPCT</td>
<td>September 2016</td>
<td>One standardised stool chart to be agreed and implemented across the Trust</td>
<td>1 stool chart in use across the Trust</td>
</tr>
<tr>
<td>All patients admitted into COTE, Oncology and Medical Wards will commence a stool chart from point of admission as standard practice</td>
<td>Matrons and IPCT</td>
<td>August 2016</td>
<td>All patients identified as CDI have evidence of appropriate use of the stool chart</td>
<td></td>
</tr>
<tr>
<td>Surveillance of Surgical Site Infections</td>
<td>SSI data collection for all Orthopaedic Modules and Vascular Module continuously Rotation of 2 further modules per quarter</td>
<td>Clare Johnston – Orthopaedic SSI and Joint registry Manager Ali Munson – SSIS Nurse</td>
<td>Continuously with reporting to PHE quarterly</td>
<td>Surgical Site Infection Surveillance at least meets mandatory requirements</td>
</tr>
</tbody>
</table>

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Created: March 2016
Review: 2017
Author: Dr Tony Elston (Director of Infection Prevention & Control/Consultant Microbiologist)
<table>
<thead>
<tr>
<th>Objective</th>
<th>Action</th>
<th>Operational Lead</th>
<th>Date of completion</th>
<th>Measure of Success</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divisions to develop HCAI improvement plans for 2016/17</td>
<td>Matrons/ ADONS to work with Clinical staff to develop division specific IPC programme</td>
<td>Matrons/ ADONS</td>
<td>August 2016</td>
<td>Matrons/ADONS to report progress back to HICC on a bi-monthly basis The IPC performance plan is tabled and discussed at Divisional Governance Meetings</td>
<td>Plans brought to HICC and evidenced in the minutes of both HICC and Divisional Governance meetings</td>
</tr>
<tr>
<td>IPC education</td>
<td>Update IPC e-learning annually – this year to be updated in order to ensure compliance with National Core learning</td>
<td>Heather Dakin SICN and Vicky Bywater ICN</td>
<td>End of July 2016</td>
<td>E learning programme updated and on Trust E-learning system The education supports national and local requirements</td>
<td>The E-learning will be available on the Trust system. Compliance with IPC mandatory training to be incorporated in Divisional mandatory update compliance</td>
</tr>
<tr>
<td>Antimicrobial e-learning and or face to face antimicrobial training to be mandatory on a bi-annual basis and at induction</td>
<td>Heather Dakin SICN and Vicky Bywater ICN</td>
<td>End of August 2016</td>
<td>The programme will be updated on Trust E-learning system The education supports national and local requirements</td>
<td>The E-learning will be available on the Trust system. Compliance with IPC mandatory training to be incorporated in Divisional mandatory update compliance</td>
<td></td>
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