BOARD OF DIRECTORS MEETING (Open)

Date: 11th September 2019 **Item Ref:** 18

TITLE OF PAPER	Infection Prevention and Control Annual Report, 2018 – 2019 Infection Prevention and Control Programme for 2019 – 2020
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing and Professions
ACTION REQUIRED	Members to receive the report for Information & Assurance

OUTCOME	Members to be assured on all aspects of infection, prevention and control for the Trust and satisfied with the progress achieved during 2018/19
TIMETABLE FOR DECISION	September 2019 Meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	▫ Infection Control Programme 2019 – 2020 ▫ Safety and Risk Strategy
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: Quality and Safety Strategic Objective: A102ii: Deliver safe care at all times. BAF Risk No: A102ii BAF Description: Inability to provide assurance regarding improvement in the safety of patient care.
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	▫ NICE Quality Standards (61, 113, 139) ▫ Care Quality Commission Fundamental Standards ▫ Code of Practice on the Prevention & Control of infections and related guidance ▫ NHS Litigation Authority ▫ Safety Thermometer Framework ▫ NHS Outcomes Framework Domain 5
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	If financial implications are identified during the delivery of this programme, individual business cases will be developed and put forward to the Board for consideration
CONSIDERATION OF LEGAL ISSUES	Legal Requirement to comply with The Health and Social Care Act 2008 (2015)

Author of Report	Katie Grayson & Liz Lightbown
Designation	Senior Nurse, Infection Prevention & Control
Date of Report	1st August 2019

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Subject: **Infection Prevention and Control Annual Report 2018 – 2019**
Infection Prevention and Control Programme for 2019 – 2020

Author(s): **Katie Grayson, Senior Nurse, Infection Prevention & Control & Liz Lightbown**

1. Purpose

For Approval	*For a collective decision*	*To report progress*	*To seek input from*	*For information*	*Other (please state below)*
				✓	Assurance

2. Summary

The annual report was received at the QAC on 29th July and approved on 1st August following some amendments to provide further assurance.

The Annual Report on the Infection Control Annual Programme for 2018 - 2019 follows The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

Looking forward, the Annual Report incorporates the Infection Prevention and Control Programme 2019 – 2020, which identifies a number of strategic objectives which the Trust will work towards to ensure its continued compliance with Code of Practice in meeting its regulatory requirements against the 10 compliance criteria in the Code.

The Infection Prevention and Control Team provide a comprehensive service to all the Clinical and Corporate Services within SHSC and aims to optimise delivery of individuals' care; whilst aiming to protect service users, staff and members of the public from the risk of cross contamination and outbreaks of infection.

Excellent progress has been made towards completion of the Annual Programme against the 41 actions contained within; which are split into 8 key work streams. The main action which remains outstanding regarding antibiotic auditing which the Pharmacy Department are responsible for achieving. Please refer to the Dashboard on page 5 for details.

The report retrospectively and succinctly highlights the achievements of the Team over the preceding year. In brief this encompasses exceeding the Quality Account target for hand hygiene training set by Sheffield CCG and achieving 'Significant Assurance' when audited by the Trust's Internal Auditors (360° Assurance).

Alongside the substantial Annual Infection Control Audit Programme, three other extensive audit projects have been facilitated which were re-audits of the mattresses and sharps containers across the Trust and an inaugural audit of Bare Below The Elbow (BBTE).

The report provides an overview of both the voluntary infection/human aliments and the mandatory alert organism surveillance carried out.

3. Annual Performance Summary

Training: Hand Hygiene compliance is 88% which exceeds the Quality Account target set by NHS Sheffield Clinical Commissioning Group (Section 3.1).

Surveillance: The mandatory surveillance of alert organisms (MRSA/MSSA/E-Coli Bacteraemias and toxin producing *Clostridium difficile)* is continually monitored. The Trust has had zero cases of MRSA/MSSA Bacteraemia. 9 cases of E-Coli Bacteraemia cases have been identified and investigated by NHS Sheffield CCG. 2 cases of toxin producing *Clostridium difficile* have been identified / reported and investigated through the Root Cause Analysis process. As such the community acquisition of C-diff in these cases was 'unavoidable' and no lapse in care was identified (Section 3.3).

Positively voluntary surveillance by individual areas continues to improve. Last year 6 areas were non-compliant in returning their data, and this has reduced to 3 areas (Burbage, Endcliffe & G1) this year. Further support will be provided to these areas. Please see section 3.3.2 for further information.

Outbreaks/Clusters: Three enteric outbreaks of Noro Virus in the last year have been reported to the IPCT. Learning from the Incident on G1 Dementia Ward will be shared in 19/20. Further details are in (Section 3.4).

MRSA Screening: This year 61 Service Users should have been offered screening based on their admission source. 20 individuals had screening identified by the admitting clinician which equates to **33%** of Service Users offered screening. In 19/20 IPCT will be undertaking targeted & specific work with individual Ward Managers, Consultant Psychiatrists & their Ward teams to increase their screening rates (Section 3.5).

Audit Programme: The IPCT have successfully completed 24 supportive unannounced observational site visits and this programme is fundamental in monitoring and measuring standards across the Trust. The benchmark for a pass equates to a score above 90% which 68% of areas are achieving. Clinical areas are required to take ownership of this process and are responsible for developing an action plan to address any identified areas for improvement / deficits. Action plans are formally monitored by the SNIPC & via the Infection Control Committee. Areas failing to progress their actions are invited to attend the Committee for additional support. Areas attaining a caution or fail result receive another re-audit after 3 months from IPC receiving the action plan. This is an announced visit so that the action plan progress can be discussed with the ward manager. Another unannounced visited is planned to assess progress & follow-up afterwards (Section 3.6).

Inaugural Bare Below the Elbow Audit: With the exception of dementia services, clinical staff working in bed based areas do not currently wear uniform. From observations concerns about compliance with the BBTE requirements and dress code standards were identified and an audit was undertaken focused upon BBTE standards. The two Dementia Nursing Homes, Adult Mental Health Step Down/Respite Unit and all twelve In Patient Wards were audited. Four areas achieved / met the required standards: The Rehabilitation Wards at Forest Close;

the Learning Disability Ward at Firshill Rise; Stanage Acute Admission Ward; and Birch Avenue Dementia Nursing Home, which achieved the highest score of all the areas (a Dementia service where uniform is worn). Improvements in IP&C practice in respect of BBTE and adherence to dress code policy are required across all clinical inpatient areas. To help improve adherence to required standards a decision to introduce uniforms for nursing & health care support workers across all in patient areas has been made and these are being introduced from autumn 19/20 (Section 3.7).

Internal Audit 360° Assurance: It is pleasing to report that the IPC service has been audited by the Internal Auditors, 360° Assurance, who undertook an independent audit of the governance, controls, systems and processes in place for IP&C to determine if they are being managed effectively. Four Clinical areas were audited. The auditors gave a **'Significant Assurance' Opinion** (Section 3.8).

Patient Led Assessment of the Care Environment (PLACE): The Trust continues to perform very well in this assessment, with an overall score of 99.71% (across six clinical sites) compared to the national average of 98.50%. Four of the clinical sites achieved a score of 100%. The programme is co-ordinated by the Hotel Service Manager closely supported by the IP&C Team (Section 3.9).

Mattress Audit: The annual mattress audit, undertaken by mattress provider Herida Healthcare was completed in December 2018. A total of 193 mattresses were inspected. 120 mattresses passed the audit and 73 mattresses failed equating to a failure rate of 38%. In some circumstances it was appropriate to replace the mattress cover only rather than the whole mattress. This is a cost effective method of mattresses remaining IPC compliant. 12 covers were purchased and 61 new mattresses (31.6%). Direct feedback to the Ward Managers was undertaken by the Senior Nurse IP&C and mattresses replaced accordingly. The next audit will take place in November 2019 (Section 3.10).

Incident Reporting: A total of **20** incidents have been reported to the IPCT during this reporting period, a significant decrease from last year (51). To our knowledge no harm resulted to staff or service users as a consequence. In 19/20 the Senior Nurse IP&C will continue to monitor incidents, their context and with clinical services make any required changes to policy, procedure and / or practice / supervision (Section 3.12).

Staff Influenza Vaccination Campaign: the Trust achieved a vaccination rate of 53% of Frontline Staff a slight decrease from 2017/18 (56%) (Section 3.13).

A dashboard on pages 4 and 5 of the Annual Report visually displays pertinent information for your reference.

4. Next Steps

i. The Infection Prevention & Control Team will continue their proactive approach to reducing the risk of infection within the Trust in line with the Infection Control Annual Programme.

ii. The Annual Report 2018 - 2019 and the Infection Control Programme 2019 – 2020 has been published on the Trust's website.

5. Required Actions

i. Board Members are asked to receive the 18/19 Annual Report for information & assurance in respect of achievements, on-going progress and areas for improvement.

ii. Members are asked to receive the Infection Control Programme for 2019-2020, which incorporates revised directions from The Health Act 2008, to ensure compliance by the Trust.

iii. Members are assured that all aspects of infection, prevention and control for the Trust; through annual reporting, are undertaken in accordance with the requirements of The Health Act.

6. Monitoring Arrangements

- Quarterly Performance Reports to the Clinical Care Networks (19/20).
- Quarterly Infection Prevention & Control Committee Meetings.
- Quarterly Performance Reports to the Executive Directors Group (EDG)
- Quarterly Assurance Reports to the Quality Assurance Committee (QAC).
- Annual Report to the Board of Directors.

7. Contact Details

For further information please contact:
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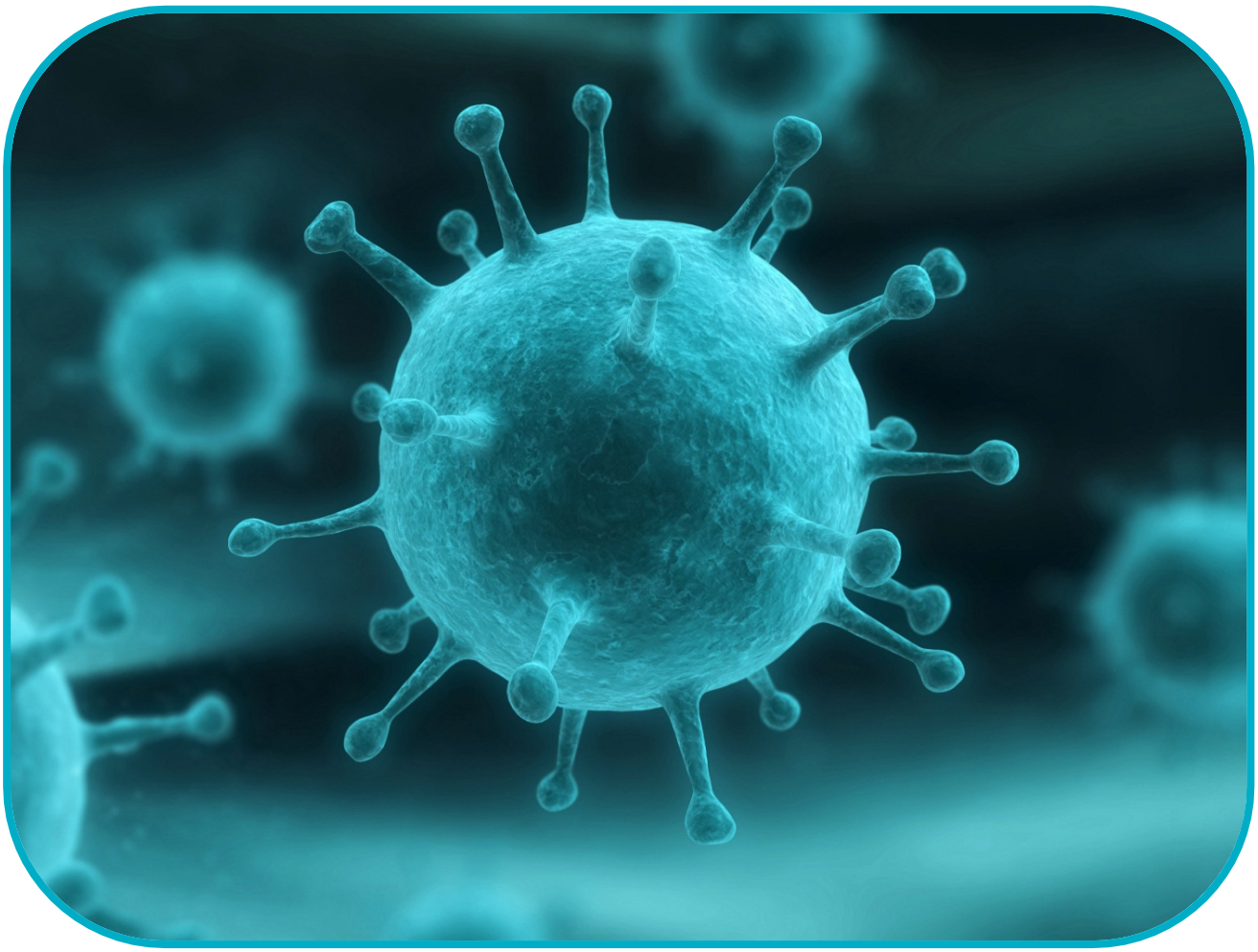
Katie.Grayson@shsc.nhs.uk

Infection Prevention & Control Annual Report 2018 – 2019

Infection Prevention & Control Programme 2019 - 2020



Contents

1. Introduction

1.1 Infection prevention and control (IPC) is a practical, evidence-based approach which prevents service users and health workers from being harmed by avoidable infections. Preventing health care-associated infections (HCAI) avoids unnecessary harm and at times even death, saves money, reduces the spread of antimicrobial resistance (AMR) and supports high quality, integrated, people-centred health services.

1.2 The Annual Report of the Infection Prevention and Control Team provides a retrospective overview of the activities carried out to progress the prevention, control and management of infection within Sheffield Health and Social Care NHS Foundation Trust (SHSC) during the last year (April 2018 – March 2019).

1.3 The Infection Prevention and Control Team provide a service to all the Clinical and Corporate Services within SHSC and aims to optimise individuals' care; whilst protecting Service users, staff and others from the risk of cross contamination and outbreaks of infection.

1.4 The Infection Prevention and Control Team strive to promote and embed current evidenced-based best practice guidance regarding the prevention of infection and control when necessary in accordance with:-

- The Health & Social Care Act 2008 (2015): Code of Practice on the Prevention and Control of Infections and related Guidance. (Hereafter referred to as the 'Health Act 2008').
- Board Assurance Framework
- NHS Litigation Authority Standards for Mental Health and Learning Disabilities
- CQC Fundamental Standards

1.5 The core aim of the Infection Prevention and Control Team is to support the organisation at all levels, to both deliver clean safe care and provide assurance that the Trust is complying with standards set out in the Health Act 2008 and the Care Quality Commissions' Fundamental Standards.

2. Governance Arrangements

It is noted within the Health Act (2008) that the Board of Directors has a duty to have in place *"Appropriate Management Systems for Infection Prevention and Control".*

The NHSLA Risk Management Standards for Mental Health and Learning Disability Trusts specifies that the Trust must *"Have a Process for Managing the Risks associated with Infection Prevention and Control. Infection Prevention and Control should be an integral part of Clinical and Corporate Governance".*

The overall monitoring of the Infection Control programme is via:-

- Trust Boards Monthly Quality and Safety Dashboard
- Quarterly Infection Prevention & Control Committee.
- Quarterly and Annual Report to the EDG and Quality Assurance Committee
- Quarterly performance reporting to the Clinical Care Networks Governance Meeting.

2.1 The Role of the Infection Prevention and Control Team (IPCT)

2.1.1 The role of the Infection Prevention and Control Team (IPCT) is to provide expert advice to minimise the risk of infection. Its primary functions are to:

- Minimise the risk of infection to Service Users, staff and visitors.
- Provide and update infection prevention and control policies.
- Provide an infection control annual report, which incorporates the infection control programme.
- Develop audit tools and facilitate the audit programme.
- Lead on the educational content of the Trust's infection control curriculum.
- Provide expert advice regarding infection control in the built environment and support the appropriate purchase and decontamination of medical devices; supporting the Trust's Medical Device Liaison Officer and Decontamination Lead.
- Provide expert advice regarding hygiene standards and cleaning frequencies, cleaning materials and equipment, and input on contracts/specifications for healthcare waste and laundry.
- Advise the Trust regarding government guidance and legislation (in relation to infection prevention and control) and measure compliance and provide a Trust action plan when required.
- Work with Public Health England and the Sheffield Clinical Commissioning Group regarding surveillance and notification of infections.
- Provide advice to all areas of the Trust and to all people who are involved in providing services or in receipt of our care. The advice given is varied, ranging from estate issues to the management and control of infections.
- Play an active role on a number of Trust-wide groups including the Water Safety, Service User Safety and Nurse Leadership.
- Provide advice to Estates and Clinical Care Networks regarding refurbishments, new builds and issues around water quality, healthcare waste and linen management.
- Have close contact with Procurement and provide advice on any infection control related issue pertaining to equipment and devices to be purchased by the Trust by supporting the Medical Devices Liaison Officer.
- Together with Health and Safety Officer and Clinicians, address the Trust's requirement to comply with the European Directive (Council Directive 2010/32/EU) to prevent inoculation injuries and infections to Health Care Workers from Contaminated sharps.

2.1.2 The IPCT have worked creatively and currently the team consist of one WTE senior clinical nurse specialist, one WTE non-clinical co-ordinator and via a Service Level Agreement with Sheffield Teaching Hospitals, Consultant Microbiology / Infection Control Medical input from Professor Rob Townsend.

2.2 Infection Control Committee (ICC)

2.2.1 The committee meets quarterly chaired by the Deputy Chief Nurse. The role of the Infection Control Committee is to endorse the infection control programme, monitor and oversee its implementation and progress during the year and initiate changes as required to ensure compliance with the Health Act 2008, NHSLA and the CQC Fundamental Standards. The Terms of Reference for this group remain current for this reporting period.

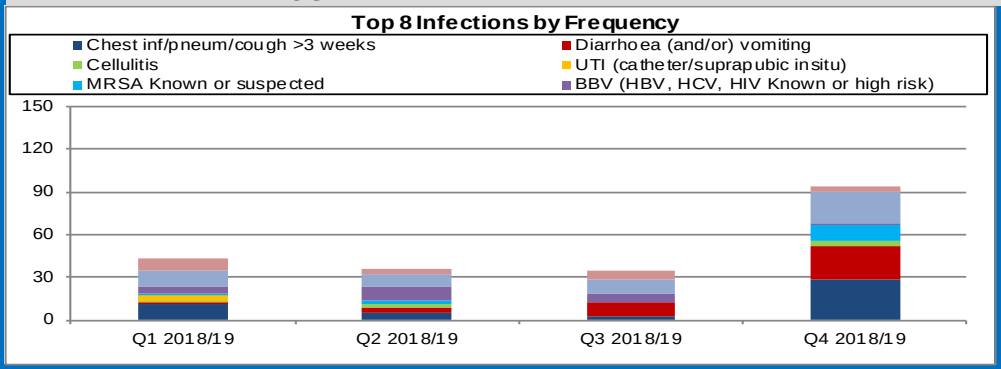
A review of committee membership is being progressed due to audit findings from the Internal Audit undertaken by 360° Assurance.

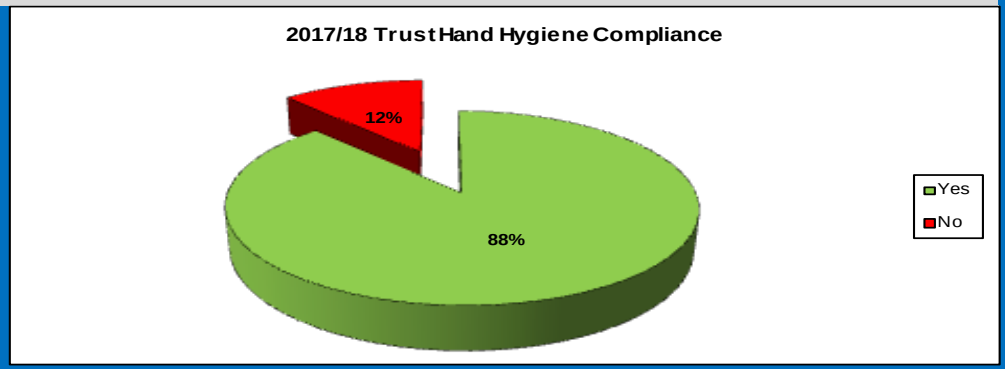
2.2.2 Key objectives:

- To oversee compliance with national standards/targets in relation to IPC and HCAI.
- Provide advice to the Infection Prevention and Control Team, the Director for Infection Prevention and Control (DIPC, the Executive Director of Nursing) and the Board of Directors, to ensure appropriate actions are taken.
- Monitor and report exceptions, adverse incidents and receive up-dates as necessary.
- To oversee all infection prevention issues and adverse incidents.
- Policy development and review
- Audit and monitoring of action plans produced by individual areas/services
- Education and training
- Review RCA and PIR reports, identify and disseminate lessons learnt and monitor any action plans developed following investigations
- To inform the Executive Directors Group and Quality Assurance Committee of progress and exceptions for onward reporting
- To monitor compliance for IPC training.

Infection Control Dashboard: April 2018 - March 2019

Infections / Hand Hygiene





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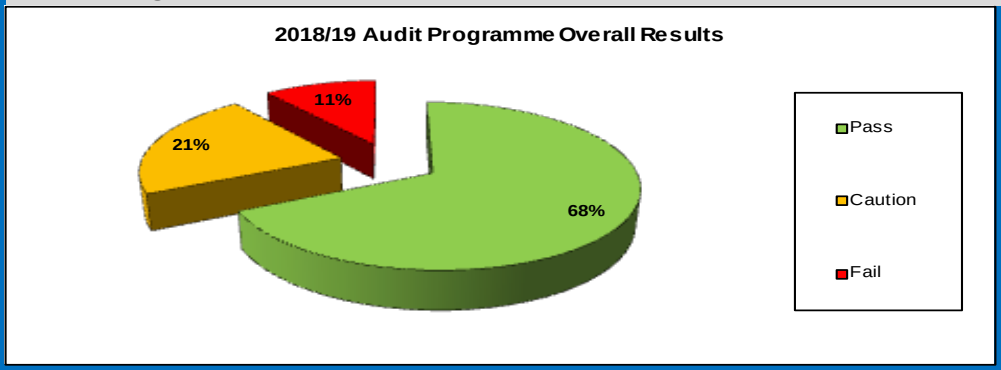

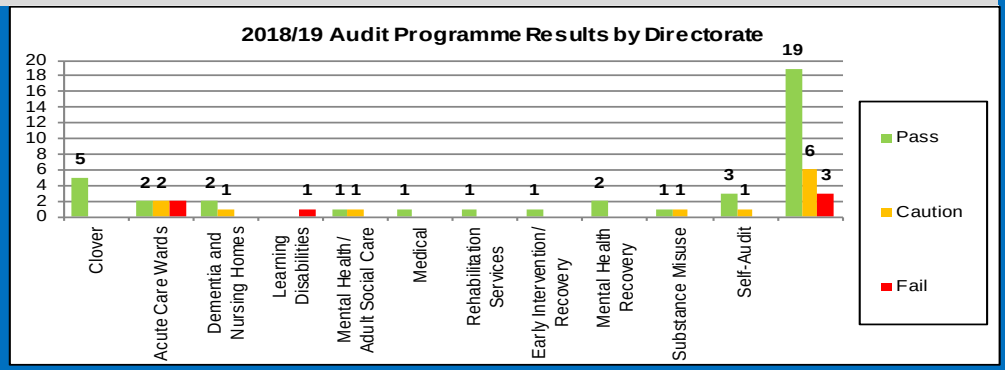

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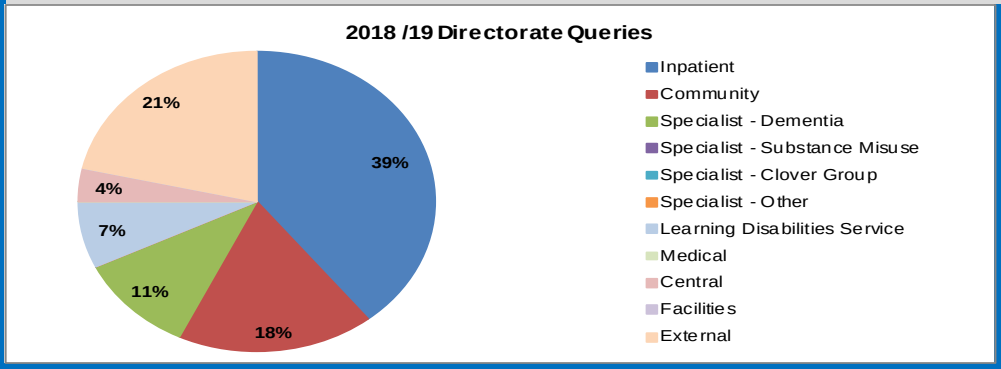

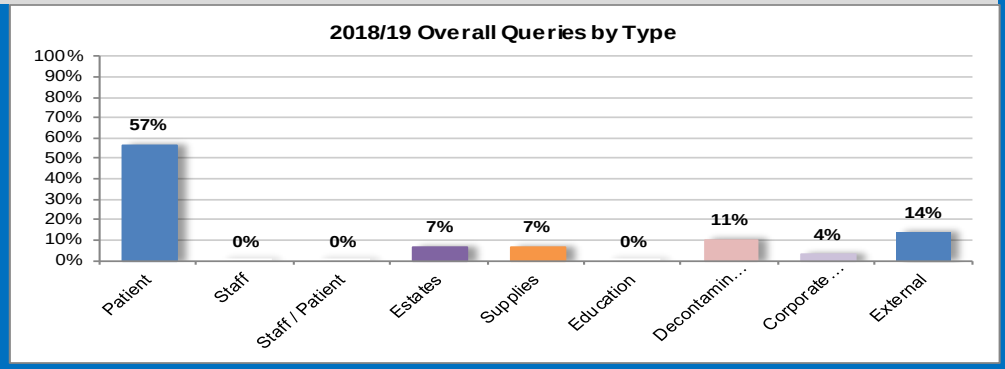

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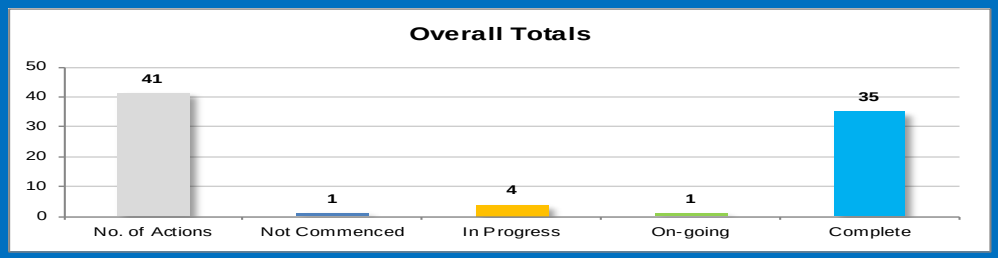

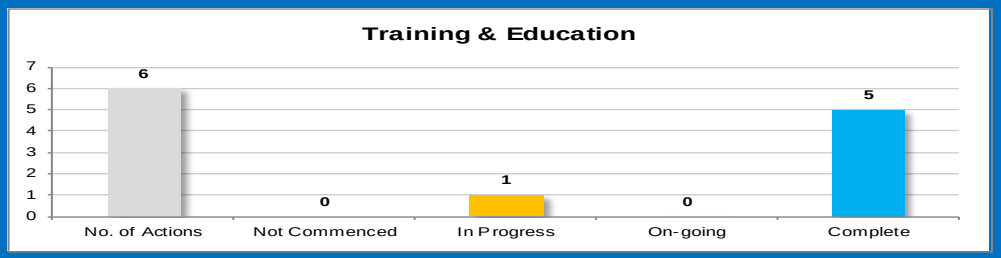

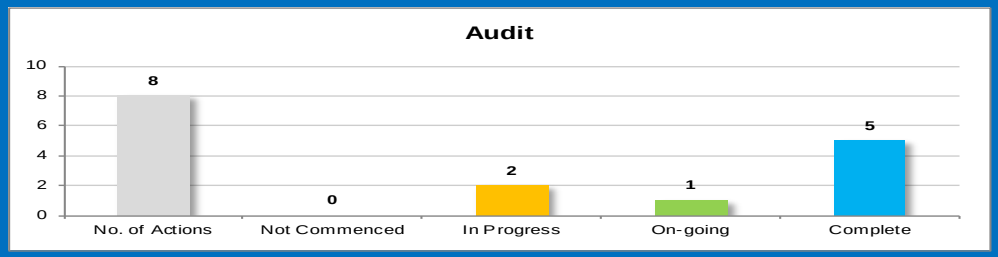

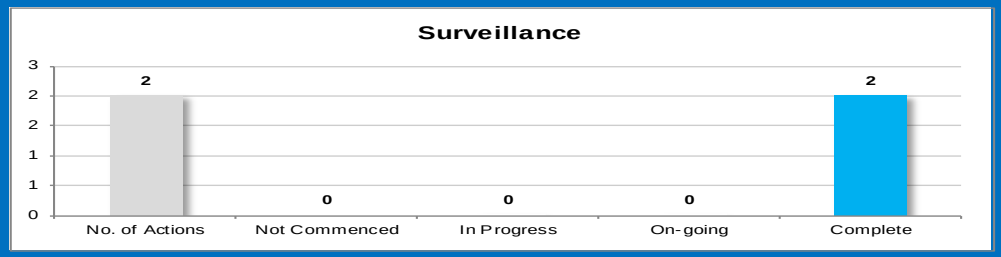

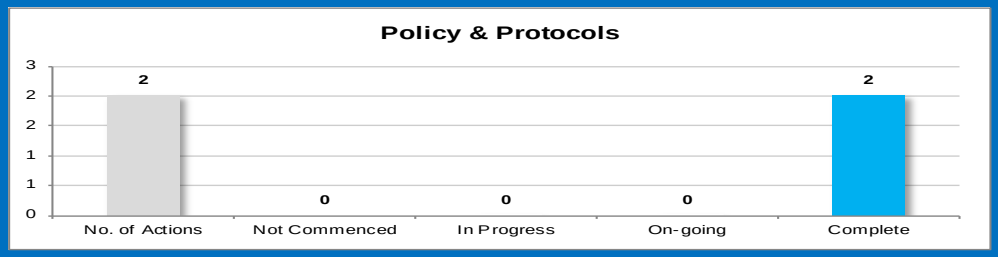

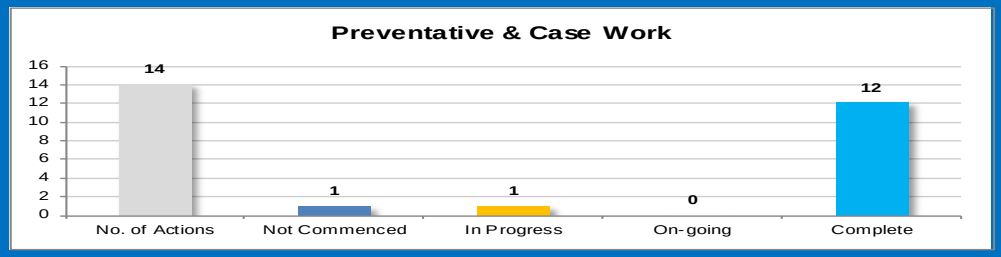

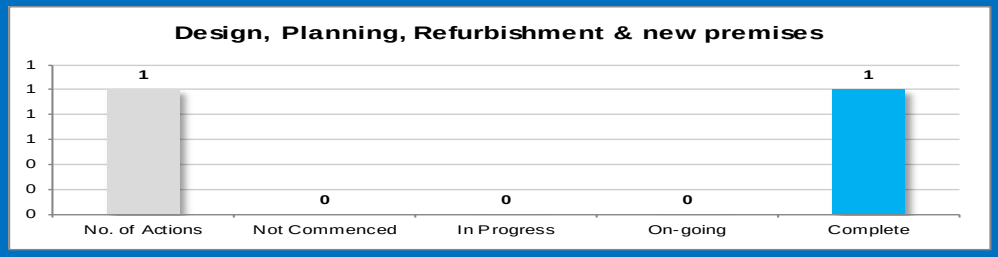

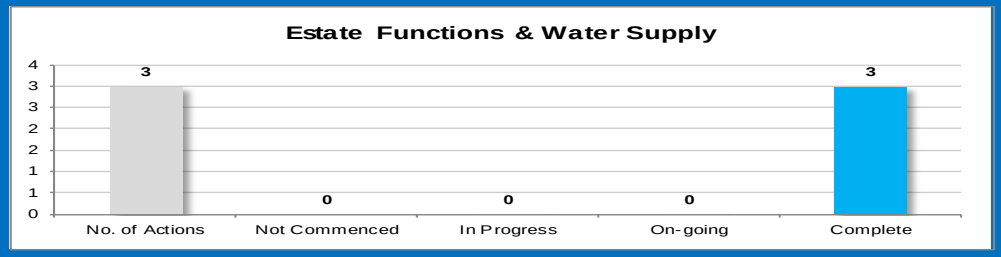

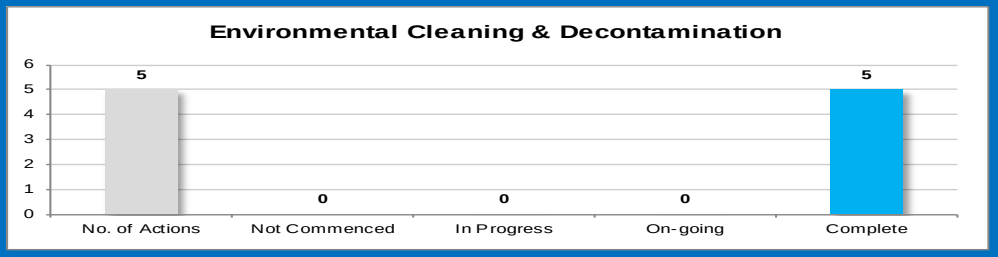

3. Progress Summary - Annual Infection Control Programme for 2018 – 2019: See Dashboards pages 4 and 5

3.1 Hand Hygiene

3.1.1 It is well evidenced that hand hygiene is the simplest and least expensive intervention that can actively reduce the risks of cross contamination between staff, Service Users and visitors. Body secretions, surfaces of inanimate objects and hands of all human beings can carry bacteria, viruses and fungi that are potentially dangerous to them and others. Therefore the promotion of effective hand hygiene coupled with "Bare Below the Elbow" (BBE) within the Trust continues to be high on the agenda. Additionally this year we have completed an inaugural BBE audit across inpatient bed based services. Further details of this audit can be found in section 3.7.

3.1.2 The Trust is required to have effective systems in place to prevent irreducible infections; this includes the provision of appropriate well maintained facilities, ample supplies of quality consumables (liquid soap, paper towels, alcohol handrubs and moisturiser); the display of promotional materials and relevant training in hand hygiene techniques and skin care.

3.1.3 To this end the Infection Prevention and Control Team continually work with Procurement and Estates to ensure that products are consistently available. NHS Supply Chain is currently undergoing considerable reorganisation at present. In addition the audit of hand hygiene facilities has been performed by the IPCT and where facilities were identified as insufficient, these issues are being addressed.

3.2 Education and Training

3.2.1 The Health Act 2008 requires that all staff require appropriate on-going education which should incorporate the principles and practice of prevention and control of infection. Clinical staff should have an on-going understanding of the risk from existing, new and emerging infectious diseases and take this into account when assessing Service Users.

3.2.2 The Trust's education and training needs matrix contains the infection prevention and control requirements for all staff groups/disciplines. Managers continue to be provided with information on who is compliant with the minimal level of hand hygiene and infection prevention education on a quarterly basis via colleagues in the Training Department.

3.2.3 The minimum standards are for all new staff to receive training on corporate induction (known as Core Mandatory); which covers the basic principles of Standard Infection Control Precautions (SICP). SICP training includes appropriate hand hygiene with soap & water and alcohol handrubs, the use of Personal Protective Equipment (PPE), decontamination of equipment, sharps safety, healthcare waste management, laundry management, spillage management and isolation precautions. All staff with direct care contact receives an IPC refresher session delivered by colleagues in the training department known as 'Mandatory Update'. This ensures a robust process to training the workforce regularly in regards to IPC practices for assurance purposes and improved recording of training data.

3.2.4 The Table below provides an overall picture regarding a collective total of all the mandatory training offered throughout the year and compares figures to previous years. The Quality Account target set by NHS Sheffield Commissioning Group is to have trained 80% of staff in hand hygiene (HH) practices. The Trust has met this target by achieving **88%** at the end of Quarter 4. This is a substantial improvement whereby only 52%-57% compliance has been reported for a number of years previously.

3.2.5 The table below shows how many staff has received training and compared to previous years.

	2016 -2017	2017 - 2018	2018 - 2019
Staff Trained in IPC & HH Training	2,165	1,421	1,726

3.2.6 The Infection Prevention and Control Team (IPCT) continue to deliver regular face-to-face training commitments e.g. Core Mandatory (Corporate Induction); to ensure that new staff are trained appropriately in IPC practices. Additionally the IPCT continue to provide either roadshows or more bespoke presentations and ad hoc training sessions according to need; often identified post auditing or following-up on incident reporting trends or outbreaks of infection.

3.2.7 To retain credibility and validity of the infection prevention roles, the Senior Nurse and the Infection Prevention Control Co-ordinator (IPCC) have undertaken professional development through a variety of sources. Both staff are members of the Infection Prevention Society (IPS), which provides opportunities for networking at a regional and national level and access to appropriate educational study days and conferences. This year's three day international conference was held in Glasgow during September 2018 and the Senior Nurse attended. Both staff members attend the IPS Special Interest Group (SIG) for Mental Health & Learning Disabilities; as well as their regional IPS branch meetings. More recently a newly formed SIG has been introduced to support infection control teams nationally who support and provide advice to Care Homes.

During 2018 the Senior Nurse for IPC was nominated and shortlisted by regional IPC peers for the 'IPS Practitioner of the Year Award'. The award is presented to an IPS member who stands out *'above and beyond'* by implementing infection prevention strategies and initiatives within their immediate area or more widely across their organisation or community. On this occasion the Senior Nurse was runner-up for this national award.

The Senior Nurse has held a Branch Officer role in IPS Yorkshire Branch as the Educational Lead working at a regional and national level; in which this two year tenure has now finished. Also the Co-Ordinator's tenure as the MH SIG's communications officer has also ended. Both members of staff have continued to work at a national level. The Senior Nurse is now the Communications officer for the newly formed Care Homes SIG and the Co-ordinator is the Deputy Communications Officer for IPS Trent branch. This ensures both staff are competent and remain up-to-date in their respective roles.

3.2.8 The Senior Nurse in IPC has successfully completed four MSc modules via distance learning and continues with her studies and will be commencing dissertation in September 2019.The Co-ordinator has completed a recent coaching course within the Trust.

3.2.9 Traditionally May is the recognised month in which the World Health Organisation (WHO); globally calls for action to promote 'safe care is clean care' across all health organisations. To celebrate this global initiative the May 2018 IPC roadshows focused on appropriate disposable examination glove use and took the opportunity to promote awareness of this issue and skin care; following the campaign by the Royal College of Nursing. 71 staff members attended the Roadshows which were held across the Trust in different clinical settings.

3.2.10 The IPC staff intranet page has been updated considerably over the last year whereby the resources offered to staff on a variety of IPC issues can be located centrally for easy access.

3.3 Surveillance – Mandatory & Voluntary

3.3.1 The Health & Social Care Act 2008 (2015) requires organisations to provide quality information on Health Care Associated Infection (HCAI) antimicrobial resistant organisms and infectious diseases. This information is essential to monitoring the progress, investigating underlying causes and instigating prevention measures. The IPCT have developed a simple monitoring process for collecting voluntary data that involves a monthly surveillance survey, plus ad hoc reporting directly into the team by inpatient areas and care home settings. However; this does not extend to monitoring in the Clover Group GP practices under the Trust as this is undertaken by the Syndromic Surveillance Systems established by Public Health England (PHE).

3.3.2. The tables below identify the voluntary surveillance data reporting for Inpatient Wards & Nursing Homes compared to last year's data. If the areas provide data more than 75% **(GREEN)** of the time (over the 12 month period) they are deemed as compliant. Returning data 50% - 75% of the time during the year equates to a caution **(AMBER)** and areas providing data less than 50% of the time are recorded as non-compliant with data returns and colour-coded **(RED).** Areas highlighted in **(BLUE)** have consistently submitted their data every month and in the required timeframe.

The level of compliance has been shared at the Infection Control Committee and referred to in the quarterly reports for Clinical Care Networks to address directly in the areas of which they are responsible.

Surveillance Compliance April 2017 – March 2018	
Area	**Compliance %**
Acute, Rehab & Forensic Wards	
Burbage	17%
Dovedale	25%
Forest Close	100%
Forest Lodge	75%
Endcliffe	25%
Maple	34%
Stanage	92%
Dementia Care	
Birch Avenue	100%
Beech	100%
Oak	83%
Willow	100%
G1 Ward	50%
Adult Mental Health Step Down / Respite	
Wainwright Crescent	100%
Learning Disability	
Buckwood View	100%
Firshill Rise Ward	25%

Surveillance Compliance April 2018 – March 2019	
Area	**Compliance %**
Acute, Rehab & Forensic Wards	
Burbage	25%
Dovedale	83%
Forest Close	100%
Forest Lodge	83%
Endcliffe	50%
Maple	83%
Stanage	100%
Dementia Care	
Birch Avenue	100%
Beech	closed
Oak	100%
Willow	100%
G1 Ward	50%
Adult Mental Health Step Down / Respite	
Wainwright Crescent	92%
Learning Disability	
Buckwood View	100%
Firshill Rise Ward	92%

In addition the Senior Nurse IP&C will be working closely with Burbage, Endcliffe & G1 Wards to support them to improve their reporting and working with all the wards & homes in 19/20 to further improve overall performance monitoring & reporting (see Annual Work Programme pg. 20 & 21).

3.3.4 Mandatory surveillance of Alert organisms continues to be collected and the table below shows the number of positive cases we have had for each organism this year.

Alert Organism	Annual Cumulative Case Total
MRSA Bacteraemia	0
MSSA Bacteraemia	0
***Escherichia Coli* Bacteraemia**	9
***Clostridium difficile* Toxin producing diarrhoea**	2

3.3.5 Escherichia coli (E-coli) bacteria are frequently found in the intestines of humans and animals. There are many different types of E-coli, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment. E-coli bacteria can cause a range of infections including urinary tract infection, cystitis (infection of the bladder), and intestinal infection. E-coli bacteraemia (BSI bloodstream infection) may be caused by primary infections spreading to the blood.

CCGs nationally are leading on achieving the Quality Premium aiming to reduce all E-coli BSIs by 10% in Year 1.The Quality Premium (QP) scheme is about rewarding CCGs for improvements in the quality of the services they commission. The scheme also incentivises CCGs to improve patient health outcomes and reduce inequalities in health outcomes and improve access to services. This data is kindly provided by the Infection Control Team at Sheffield CCG on a quarterly basis; who are responsible for collecting the information from GP's across the city and investigating these cases.

A total of 9 cases have been reported throughout the year. Cases 1-4 were reported in Q1, cases 5 and 6 in Q2, no cases reported in Q3 and cases 7-9 were reported in Q4. All cases have been reviewed and the Clover Group Practices submitted the relevant information to the CCG.

3.3.6 The surveillance data on toxin producing *Clostridium difficile* (C-diff) has recorded 2 cases. 1 case was detected in the Clover Group GP Practice and the other case was in a patient at Birch Avenue under the care of another city GP. The cases have been subjected to Root Cause Analysis (RCA) investigations to determine if any lapses in care could be identified. As such the community acquisition of C-diff in these cases was 'unavoidable' and no lapse in care was identified.

3.3.7 37 Urinary Tract Infection (UTI) cases (Service User who are not catheterised) have been reported. Reported chest infections have decreased from 99 cases last year to 31this year. 98 Service User's prescribed inhalers or nebulisers this year compared to 260 in the previous year. . 21 Service Users are reported to have an invasive device insitu and 45 Service Users have a history of self-harming by breaking the skin; both of which increases their risk of infection as natural body defences are compromised. Wounds are reported as 19.

3.3.8 The reported numbers of antibiotics prescribed during this period is 113. The majority of prescriptions for antibiotics have been issued in our Care Homes.

Annual Infection Surveillance Data: April 2018- March 2019

	Number of patients with known or suspected infections / infestations																						
	Infections																						
Directorate	MRSA Known or suspected	Other multi-resistant organisms e.g. ESBL, CPE	Diarrhoea (and/or) vomiting	Clostridium difficile (known or suspected)	Blood borne virus e.g. HBV, HCV, HIV Known or high risk	Known/suspected IV drug user	History of self-harm (breaking the skin only)	Invasive devices e.g. catheters, PEG or other	Number of patients had MRSA screens done this month	Chest infections/pneumonia or cough lasting 3 weeks or more	Influenza like illness	Urinary tract infection (no catheter insitu)	Urinary tract infection (catheter/suprapubic insitu)	Prescribed antibiotic treatment	Transferred from another hospital	Transferred from residential or nursing care homes	Wounds – include leg ulcers/surgical	Infestations(parasitic) e.g. head lice, pubic lice, scabies, thread worms	Cellulitis	Prescribed inhalers or nebulisers	TB – known history or suspected	Ear infections	Eye infections	Any other infections – please provide details
Acute Care Wards	2	0	14	4	11	5	22	8	46	7	2	13	1	35	40	4	10	0	4	58	2	2	3	1
Dementia and Nursing Homes	6	0	12	1	0	0	0	11	10	20	0	15	2	52	4	3	6	0	1	29	2	1	4	2
Forensic Services	0	0	0	0	10	6	22	0	7	1	0	5	0	16	5	0	2	0	0	4	0	0	0	0
Learning Disabilities	0	0	0	0	0	0	0	2	0	3	0	4	0	10	0	0	1	0	1	6	0	0	0	0
Mental Health Adult Social Care	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation Services	0	0	0	0	0	0	1	0	3	0	0	0	0	0	2	0	0	0	0	1	0	0	0	0
Overall Annual Totals	**8**	**0**	**26**	**5**	**22**	**11**	**45**	**21**	**66**	**31**	**2**	**37**	**3**	**113**	**51**	**7**	**19**	**0**	**6**	**98**	**4**	**3**	**7**	**3**

3.4 Outbreak Summary

3.4.1 The table below summarises all the reported outbreaks over this reporting period. 3 enteric outbreaks have been reported to the IPCT.

Date	Location	No of Patients	No of Staff	Outbreak Type	Causative Organism
December 18	Woodland View	8	9	Enteric	Norovirus
November 18	Wainwright Cres	7	3	Enteric	Norovirus
February 19	Grenoside G1	15	21	Enteric	Norovirus

3.4.2. During November a confirmed Norovirus outbreak affected clients at Wainwright Crescent. The building layout and lack of toilet facilities severely hindered outbreak control measures significantly. None of the 12 bedrooms are en-suite and clients communally share three toilets.

3.4.3. During February Grenoside Grange experienced an extensive and prolonged enteric outbreak affecting a total of 36 individuals and lasted 45 days. Due to patients presentations traditional outbreak measures such as isolation could not be implemented.

3.5 Summary of Meticillin Resistant *Staphylococcus Aureus* (MRSA) screening

3.5.1 MRSA stands for Meticillin Resistant *Staphylococcus Aureus*. *S.aureus* is a bacterium which is found on the skin and in the nose of up to 30% of healthy individuals; known as colonisation. It can cause a range of infections in susceptible individuals, including wound infection, abscesses and more serious blood stream infection known as bacteraemia. MRSA is a strain of *S.aureus* which has become resistant to a range of commonly used antibiotics such as Penicillin and Flucloxacillin.

3.5.2 People admitted to Mental Health Trusts do not need to be screened routinely for MRSA as there is no evidence of any significant risk of MRSA bacteraemia in this service user group. However, Service Users may have other clinical conditions that may put them at an increased risk of MRSA (see below) and thus a Bacteraemia; in this instance offering screening will be required.

3.5.3 The following Service User groups are considered to be at high risk of acquiring MRSA and therefore should be screened on admission to our services or upon transfer:

- those who are admitted to inpatient areas following surgical procedures.
- those that are admitted following admission to an Acute Trust.
- those who are admitted from prison, nursing or residential care home.
- intravenous drug users.
- those who self-harm by breaking the skin.
- people with chronic wounds e.g. leg ulcers, or with indwelling devices such as urinary catheters or PEG feeding tubes.
- those who have previously been identified as positive for MRSA should be screened on admission or transfer.

3.5.4 To report screening data this year the admission source categories have been used to assist in data collection to identify where 'high risk' Service User sources may be admitted from.

3.5.5 The admission categories which were used are Service User admitted from special hospitals, NHS general hospitals, NHS psychiatric hospitals, NHS secure hospitals, private secure hospitals, NHS nursing homes, private residential care, private nursing homes, private hospital, private hospice and private psychiatric hospitals to SHSC. All Service User admitted to the Trust should receive a Physical Health Assessment (PHA) and the relevant section should be completed on our Insight patient record system.

3.5.6 MRSA screening forms part of this physical health assessment in that it asks clinical staff if MRSA screening is required; but does not record if individuals have consented / declined.

3.5.7 This year 61 Service Users should have been offered screening based on their admission source extrapolated from Insight. 20 individuals had screening identified by the admitting clinician; although this doesn't necessarily mean that these Service Users were actually sampled. For example the service user might refuse swabbing. This equates to (20/61) **33%** of Service Users offered screening. IPCT continually reinforce to clinical staff the importance of identifying and offering MRSA screening to Service Users deemed high risk who are admitted to the Trust. This issue has been raised at Clinical Care Networks Governance meetings to increase compliance.

3.5.8 To further improve screening activity the SNIPC has submitted an application to the Insight Designers to make alterations to the existing Physical Health Assessment (PHA) – to create a mandatory field. This has not yet been done and is a priority for the Deputy Chief Nurse to address in 19/20 with IMST. Another issue relates to Wards not centrally recording screening activity on the PHA which makes accurate reporting difficult. In 19/20 this is a priority for the Senior Nurse IP&C to work directly with Ward Managers & Consultant Psychiatrists to improve the wards recording & reporting which will be further supported by the introduction of the updated & revised physical health policy (Annual Work Programme Policy & Procedure pg.21).

3.6 Annual Audit Programme

3.6.1 The infection prevention and control audit programme is fundamental in monitoring and measuring standards within the Trust. The different audit tools utilised enable a robust picture to be demonstrated and encompasses the following domains: environment, care practices e.g. sharps practice, hand hygiene facilities, waste & linen management, decontamination of equipment, laundry rooms and personal protective equipment provision.

3.6.2 The use of the 3M CleanTrace device enhances visual observation during audits by detecting Adenosine Triphosphate (ATP) upon an inanimate object to determine acceptable cleanliness & hygiene standards. The device continues to be a successful way of supplementing the visual inspection conducted by the IPCT. The current ATP parameters set within the Trust are as follows: **Pass** = <500, **Caution** = 501 – 1,000 **Fail** = >1,001.

3.6.3 The IPCT have successfully completed **24** supportive observational site visits and **4** areas participated in self-audit. The environmental aspects of the audit look at the 'totality' of the healthcare environment i.e. assessing the standard of cleanliness and the 'fabric of the building'. The audits carried out this year have been 'unannounced' attempting to capture a realistic snap-shot of current cleanliness standards and compliance with IPC practices.

3.6.4 Compliance with the IPC audit is set at 90% and above; positively 68% of areas are achieving a pass rating. Areas achieving a caution rating have remained static at 21%. This means that those areas are reaching an audit score between 80% - 89%. However 11% of areas have failed their audit and Improvement action plans are in places for these areas; monitored by the Infection Control Committee.

3.6.5 The dashboard on page 4 shows a Pie Chart displaying the overall results attained this year and the Bar Chart provides a breakdown of pass/caution results by directorate.

3.6.6 Where audit deficits had been identified, areas/services are responsible for producing their own action plans to address these issues. The transfer of ownership and responsibility of action plans directly to the clinical or care setting has retrospectively worked really well for a third year. Once the action plan has been developed it is monitored at a local level via the Clinical Care Networks Governance arrangements and progressed. Should any challenges hindering completion of action plans be identified at a local level; they are escalated to the Infection Control Committee. All action plans are formally monitored by the Committee in their quarterly meetings. Areas failing to progress their actions are invited to attend the Committee for additional support and advice.

3.6.7 The audit results have highlighted some examples of common themes Trust-wide which require attention and or improvement, these are:

- Bare Below the Elbow – compliance remains poor – see section 3.7.
- Decorative, condition and appearance of the fabric of the building in a number of clinical areas has been noted and escalated to Estates.

3.7 Inaugural Bare Below the Elbow Audit

3.7.1 During December 2018 the IPC Team conducted an inaugural 'Bare Below the Elbow' (BBTE) audit. The decision to introduce uniforms by the Chief Nurse to the Inpatient and bedded unit areas of the Trust has prompted this audit to be conducted.
This audit was limited to BBTE standards only and did not assess staff footwear or general appearance, as this falls under Health and Safety and professional image. Individual managers are responsible for enforcing dress code and appearance in their respective areas.

3.7.2 The audit tool was sourced from colleagues in Australia. The tool specifically looked at the following standards.

- Sleeves above the elbow.
- No wrist jewellery (bracelets/bangles/charity bands etc…) A wrist watch is deemed acceptable in that they can be removed when performing a clinical procedure and it is acknowledged that wrist watches in mental health settings may be required for conducting observations.
- No rings however it is acceptable to wear a plain wedding band.
- Short, clean natural nails - no nail enhancements such as polish, artificial nails, tips, wraps, acrylics, *gels, infill, and inlays.*

3.7.3 The overall compliance with the standards audited is as follows and only 4 areas have 'passed' and one area has achieved above 95%. 8 areas are either cautions or fails

Some individuals when audited have been marked non-compliant in more than one standard if they met the criterion e.g. wearing numerous rings and nail polish would count as 2 separate non-compliances.

A range of staff were included in the audit e.g. housekeepers, support workers, nurses, assistance practitioners, nurse consultants, managers, medics etc. Audits were unannounced. All staff on duty at the time of the visit was asked to participate in the visual audit process.

Excessive false nails, nail polish and rings are the major issues identified, and are widespread across these areas.

It is anticipated that uniforms will be introduced into the Longley Centre during autumn 2019. A BBTE audit will be carried out during December 2019 or January 2020 with a predetermined number of staff.

Area	Overall compliance	Number of staff audited
Firshill Rise	92%	9
Birch Ave	96%	22
Forest Close	90%	15
Forest Lodge	83%	20
Grenoside Grange	86%	14
Endcliffe Ward	75%	11
Maple Ward	77%	25
Burbage Ward	88%	19
Dovedale Ward	73%	16
Stanage Ward	90%	10
Woodland View	85%	20
Wainwright Crescent	85%	5

3.8 360° Assurance - Internal Audit of the Infection Control Service

This year the IPC service has been audited by Assurance 360° to gain independent assurance that governance controls, systems and processes are being managed effectively and undertook onsite testing of infection control practices in a sample of 4 areas.

360° Assurance reviewed the following key objective areas:

- There is a robust governance structure in place with assigned responsibilities for monitoring Infection Control.
- The Trust has clear policies and guidelines which align to national guidance to support the staff to manage and fulfil responsibilities.
- Staff are appropriately trained in order to provide appropriate care for patients.
- The Trust demonstrates evidence of compliance with Trust and National requirements in practice.
- There are robust systems in place for assessing, responding to and escalating identified risks.

It is pleasing to report that **'Significant Assurance'** can be provided that there is a generally sound system of control designed to meet the system's objectives. However, some weakness in the design or inconsistent application of controls put the achievement of particular objectives at risk. The review has identified 3 medium and 5 low risk issues and an action plan to address and rectify these deficiencies has been agreed and will be addressed by the IPCT over the next 12 months before re-auditing takes place. The full report was noted and discussed at the ICC in February 2019.

3.9 Patient-Led Assessment of the Care Environment (PLACE)

3.9.1 The PLACE is a Standards Monitoring Observational Assessment that focuses on environmental and non-clinical aspects of the service user's experience, which is led by the Hotel Services Manager. The process requires equal numbers of staff to service user / carer to be part of the inspection team. The standards consider multiple aspects which are food, privacy and dignity, condition / appearance and maintenance of the premises. For the purpose of this report cleanliness is the focal point

3.9.2 The overall Trust average for this year is higher than the national average.

Site	2015 Cleanliness %	2016 Cleanliness %	2017 Cleanliness %	2018 Cleanliness %
Firshill Rise	99.01	98.67	98.64	100.00
Forest Close	97.47	-	99.74	100.00
Forest Lodge	99.86	100.00	99.52	100.00
Grenoside Grange	100.00	100.00	100.00	100.00
Longley Centre	98.73	99.56	99.59	99.73
Michael Carlisle Centre	99.47	98.67	97.96	99.31
SHSC Average	**99.11**	**99.32**	**99.02**	**99.71**
National Average (all Trusts)	**97.57**	**98.06**	**98.38**	**98.50**

3.10 Mattress/ Commode Audits

3.10.1 Currently both the mattresses and commodes are audited monthly by the individual Wards / Nursing homes and remain their responsibility. To monitor this compliance areas are asked to complete the relevant sections on the Surveillance returns which should be submitted monthly to the IPCT.

3.10.2 Mattresses have always been fundamental Medical Devices in healthcare; but often very unappreciated and overlooked. Mattresses remain the most consistently utilised service user surface, and without effective cleaning, maintenance protocols, and inspection regimes pose a serious risk to infection control practices and standards in the care environment. To ensure mattresses remain 'fit for purpose' and clinically effective it is recommended that their condition should be checked on a regular basis. Mattresses are currently being asset tagged in a piece of work led by the Medical and Therapeutic Devices Group.

3.10.3 Our mattress provider Herida Healthcare completed our annual audit in December 2018. A total of 193 mattresses were inspected. 120 mattresses passed the audit and 73 mattresses failed equating to a failure rate of 38%. In some circumstances it was appropriate to replace the mattress cover only rather than the whole mattress. This is a cost effective method of mattresses remaining IPC compliant. 12 covers were purchased and 61 (31.6%) new mattresses. Direct feedback to the Ward Managers was undertaken by the Senior Nurse IP&C and mattresses replaced accordingly. The next audit will take place in November 2019 to again ascertain how clinical areas are maintaining this piece of vital equipment.

3.11 Antimicrobial Stewardship

3.11.1 An antimicrobial is a substance that kills or inhibits the growth of microorganisms (germs) such as bacteria, fungi, and viruses; and covers the effective use of antimicrobials (i.e. antibacterial, antiviral, antifungal and antiparasitic medicines) to reduce the emergence of antimicrobial resistance (loss of effectiveness of antimicrobials) to treat infections.

3.11.2 Antibiotic stewardship refers to a set of coordinated strategies (supported via NICE Guidance) to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics and decreasing unnecessary costs.

3.11.3 Antimicrobial stewardship is a core responsibility for all Trusts and the Pharmacy Department take a lead on this to ensure antibiotic compliance. An overview of the numbers of Service User receiving antibiotics throughout the year is recorded by the Infection Prevention Team via the surveillance forms submitted by each inpatient area; which is shared with the Pharmacy department to assist with their auditing process.

3.11.4 The process of auditing the use of antibiotics is currently under review in line with resource provision. Pharmacy and IPC will be working together to ensure prescribing and use of antimicrobials is reviewed on a consistent basis and feedback provided to prescribers on inappropriate choices in order to improve appropriate usage and have better antimicrobial stewardship.

3.12 Incident Reporting: Sharps Practice & Audit

3.12.1 A total of **20** incidents have been reported to the IPCT during this reporting period. This is a significant decrease from last year (51).

3.12.2 Other types of incidents reported summarised below:

- Used sharps and drug taking paraphernalia inappropriately disposed of.
- Clean needlestick injuries.
- Animal bites e.g. dogs biting staff.
- Clean Sharps Injury.
- Hep C positive patient deliberately smearing fresh blood onto staff, other patients and contaminating soft furnishings.
- Deliberate biting and spitting of saliva towards staff.
- Deliberate scratching Injury to staff by a confirmed HIV patient.

3.12.3 There have been **5** contaminated/dirty sharp related incidents reported which is small increase from last year (4).

Date	2015 - 2016	2016 - 2017	2017 - 2018	2018 - 2019
Contaminated Needlestick injuries sustained by staff	6	2	4	5

3.12.4 Daniels Healthcare facilitated an annual Trust-wide audit during March 2019. 34 Trust areas/departments were visited and a total of 82 bins were observationally audited this year. Overall many elements remained consistent; however the following areas remain a concern:

- 3 bins found with the wrong lid on the wrong base.
- 6 bins unlabelled whilst in use.
- 6 bins with significant inappropriate contents.
- 2 bins left unattended without the temporary closure activated.

The Senior Nurse IP&C is responsible for ensuring direct feedback to Ward & Community Team Managers on the audit findings and where required asking for an improvement plan which will be jointly monitored by the IP&C team & the relevant Manager. There will be a reaudit in 19/20 (Annual Plan: Audit see pg 21.)

3.13 Staff Influenza Vaccination Campaign

3.13.1 Influenza can cause a spectrum of illness ranging from mild to severe, even among people who consider themselves as previously well, fit and healthy. The impact on the general population varies from year to year depending on how many people are susceptible, any changes to the influenza virus and the severity of the illness caused by the strain in circulation. The capacity for the virus to mutate/change and the duration of the protection from the vaccine (about one season), are the reasons that the vaccine is tailored each year to protect against the most commonly circulating strains and why annual vaccination is necessary.

3.13.2 Every year influenza vaccination is offered free to NHS staff as a way to reduce the risk of staff contracting the virus and transmitting it to the Service Users in their care; protecting themselves and their own families. This year the SNIPC opted to purchase the Quadrivalent influenza vaccine, which provided the best level of protection for our staff along with a Trivalent vaccines for staff aged 65 and over (as per PHE Guidance lines).

3.13.3 Encouraging more staff to get vaccinated remains a significant challenge to the Trust and as with previous years there continues to be a core cohort of staff that refuses the vaccine due to personal attitudes that they believe that the annual influenza vaccine will not be of benefit to them. Traditionally we are one of the lowest performing Trusts in the country; and have been for a considerable number of years.

3.13.4 However the Trust's Flu Fighter Team led by the SNIPC achieved an uptake of **53%** in Frontline Staff this year; a slight decrease from last years 57.6%

3.13.5 The CQUIN target for frontline staff was an uptake rate of 75%. Although NHS England had an ambition to have 100% of Frontline HCW vaccinated. The uptake figure for the full duration of the campaign (October 2018 to February 2019) was **1,078** frontline staff.

3.13.6 Positively the 'Jab Cafes' organised by the IPCT were a huge success & an innovative way of staff being able to access the vaccine.

3.14 Decontamination & Cleanliness of the Environment

3.14.1 While significant progress has been made in improving cleanliness across the Trust standards must be maintained and improvements sustained. All staff should be aware of their roles and responsibilities with regard to cleaning and decontamination. Clinical and support staff undertaking the cleaning of reusable equipment must be trained in the correct cleaning and decontamination procedures.

3.14.2 When new items of equipment are considered for purchase, the manufacturer's advice on cleaning must be sought and training if necessary must precede use. The IPCT promote that careful consideration should be given to the consequences of the purchase of any item of equipment that is not capable of being cleaned or decontaminated to appropriate IPC standards; unfortunately this is not always the case in the Trust. However; during this year the Medical Devices and Therapeutic Equipment Group has been re-established which should help to improve processes regarding standardisation and purchasing.

3.14.3 A visibly clean environment will provide reassurance to Service User that they are receiving safe care in a clean environment. A clutter-free environment and the adoption of local 'clean as you go' attitude will provide the foundation for delivering high-quality care in a clean, safe place.

3.14.4 The Hotel Services Manager has been proactively supporting staff with the monthly Environmental Cleaning Audit process. The Senior Housekeepers undertake peer review on a quarterly basis and the SNIPC and Hotel Services Manager undertake an annual 'management review' to validate/review the consistency of the audit process and monitor the standards of cleanliness. Cleanliness scores are reported quarterly via the IPC Performance reports which are received by the Clinical care Networks.

3.14.5 Inspections of main kitchen environments are now audited as a separate process by the IPCT and Hotel Services Manager on an annual basis. These supplements any inspections carried out by the Local Authorities Environmental Health Officers.

3.15 Water Quality & Safety

3.15.1 Annual Audit by a Trust-Appointed Independent Water Consultant:

- All Trust-owned and leased properties have up-to-date legionella risk assessment.
- Estate services management and maintenance personnel have completed training and have the expertise to fulfil statutory requirements.

- The Trust's appointed Water Quality consultants and Authorising Engineer (AE) reported that the Trust has a robust system in place to prevent the build-up of organisms such as legionella and pseudomonas in its water systems.
- Planned preventative maintenance (ppm) continues to be carried out at all properties though frequencies vary due to availability of maintenance personnel. It is hoped that with the employment of additional personnel completion of ppm will improve.
- The Water Quality Steering Group (WQSG) is well attended with clinical and non-clinical representatives. The group was set up to comply with recent legislation and implement actions to ensure water quality is maintained throughout trust premises. The group also comments and makes recommendations as a result of Audits and Risk Assessments. Crucially it provides advice and input into Capital Schemes. It is hoped that the group will be attended by a range of representatives from Trust Directorates. Reports are received at the ICC.
- A Water Safety Plan has been developed and its requirements enforced.
- Sampling for Pseudomonas continues to be carried out on an annual basis as agreed at the ICC.
- Action plans have been drawn up for all remedial work highlighted in Risk Assessments.
- Water Quality pre-planned maintenance at some sites is being completed by the use of a new web based software system and a hand-held device, this is real time and enables completion of statutory documentation. Trials at sites are also underway for staff to complete flushing records via the new web based software.
- The Water Quality Policy is under review and due to go to the Trust's Policy Governance Group.

Annual Site Summary in Brief

Michael Carlisle Centre
The site overall has had good water quality results from samples taken. Various small schemes of work have been carried out in accordance with Policy

Grenoside Grange
Samples taken from the site show no evidence of bacterial build up; the chlorine dioxide unit continues to disinfect the water system. The planned upgrade of the hot and cold water distribution system is currently on hold.

Longley Centre and PICU
The water system appears to be under control with no bacterial counts from recent samples. The water supply to Hawthorn and Pinecroft remains isolated with the exception of the kitchen corridor. One of the Cold Water Storage Tanks remains isolated.

Rowan Ward is now the Decisions Unit, a new water system was installed, disinfected and commissioned for use. Hydrop were consulted on the installation, recommendations following an audit will be implemented

Woodland View Nursing Home
The new hot water generation system continues to provide the required hot water supply for the whole of the site. Chlorination of the system and reduced cold water storage has resulted in better water quality. Flushing on Chestnut continues to be monitored as elevated cold water temperatures have been detected which indicates little use of the water system. Water to Beech cottage has been isolated following vacation of the ward

Forest Lodge
Alterations to clinic rooms required some disinfection, sampling confirmed water quality had been maintained

Forest Close
Bungalow 3 is currently unoccupied and all outlets flushed on a daily basis.

Longley Meadows
The unit is currently unoccupied; Estates colleagues continue to carry out daily flushing of all outlets

Cold Water Storage Tanks
All cold-water storage tanks are monitored and currently there is no evidence to say that imminent cleaning and disinfection is required

4 Acknowledgements

The SNIPC wishes to acknowledge the following colleagues in providing the information used to produce this report:

- Jill Perlstrom-Wright - Infection Prevention and Control Co-ordinator
- Tracy Green – Governance Data Management Officer
- Marion Sommaire - Training Admin Support Officer
- Mark Gamble – Head of Estates / Water Responsible Person
- Janet Mason - Hotel Services Manager
- Paul James - Information Assistant, Risk Management Team
- Abiola Allison – Chief Pharmacist

Appendix 1

INFECTION PREVENTION & CONTROL 2019 - 2020 ANNUAL PROGRAMME

	= Work not commenced
	= Work in progress
	= Action on-going
	= Complete

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
1. Training & Education ***Providing opportunities for all staff to fulfil mandatory requirements to receive IPC training.(5)***	i. Continue to facilitate Corporate Induction & Mandatory IPC session along with Education Departmental Trainers	March 20	KG / JPW / E&T		
	ii. Start to plan, organise & facilitate a full day's IPC conference on behalf of the Trust	June 19	KG / JPW / KV / CT		
	iii. Provide ad-hoc sessions on a variety of IPC related elements/topics as and when approached by services/areas	March 20	JPW/ KG		
	iv. Facilitate IPC themed Road Shows at various sites across the Trust promoting evidence-based best practice	March 20	JPW		
	v. Develop & deliver a teaching session to the medics on MRSA and screening requirements.	Oct 19	RT		
2. Audit ***Monitor compliance with IC policies & guidance through a Programme of audit.(8)***	i. Develop and carry out a unannounced programme of audit (including re-audit of BBTE) across Clinical Care Networks in: a. Crisis & Emergency Care: Single Point of Access b. Scheduled & Planned Care Network c. In patient Wards d. Nursing Homes x 3 e. Clover GP Practices x 5 *Areas where suboptimal compliance is identified areas must produce an improvement plan to address findings.* *Services/areas to take ownership regarding progression of action plans and to report issues hindering completion both at a directorate governance level and via the ICC*	Feb 20	KG / JPW		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
	ii. Local Audit Tool to be reviewed	July 19	KG		
	iii. To receive the audit data collected by Daniels in relation to Sharps Policy & practice.	May 19	KG / JPW		
	iv. To carry out an audit of the hypodermic safety needles used within the Trust supported by B'Braun. (EU Safer Sharps Directive)	Nov 19	KG / B'Braun		
	v. To receive the quarterly audit data collated by pharmacy in relation to antibiotic prescribing findings and make recommendations for improvements in antibiotic stewardship (Antimicrobial Resistance Strategy DH,2013). vi. **To promote prudent antimicrobial prescribing for the management of antibiotic resistance and reducing antibiotic related Clostridium difficile Infection and other Healthcare Associated Infections*	Quarterly Until March 20	Pharmacy		
	vii. Develop & carry out a programme of audit on mattresses across the Trust to ascertain how mattresses are performing	Dec 19	KG / JPW		
	viii. Participate in the multi-disciplinary PLACE Assessments trust wide	Feb 20	Hotel Services		
	ix. Continue to action and complete the action plan produced by Audit 360°	Dec 19	BR / KG		
3. Surveillance:– Mandatory &Voluntary ***In line with National/Local requirements and designed to achieve reduction in HCAI (2)***	i. Continue to collate & monitor the voluntary prevalence data to understand how many individuals are affected by a disease or infection at a particular time, and monitor any trends which develop.	March 20	KG / JPW		
	ii. Continue to monitor & report against the Mandatory Alert Organisms (MRSA, MSSA, E-coli Bacteraemia's & Clostridium difficile) *Supporting the reduction in Gram Negative infections*	March 20	KG / JPW		
4. Policies & Protocols ***Ensure compliance with current guidance & legislation to promote quality, evidence based best practice (2)***	i. To review the Decontamination: Environmental Cleanliness and Reusable Equipment Policy and present it for ratification	Oct 19	KG		
	ii. Ensure compliance with Trust Policy & Procedures in all clinical areas with effective performance monitoring & reporting at clinical ward / nursing home / community team level.	Dec 19	KG / BR		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
	iii. To contribute to all policies or protocols that has relevance to infection prevention and control.	March 20	KG		
5. Preventative & Case work ***Activities to demonstrate that effective IPC is central to providing safe, high, quality service user-centred healthcare (11)***	i. Facilitate *Clostridium difficile* Root Cause Analysis (RCA) Investigations in a timely manner as required. *Lessons Learned to be shared within the service and brought to the attention of the ICC and Care Network via quarterly reporting*	As cases arise As cases arise	KG / RT KG		
	ii. Complete MRSA Bacteraemia Post Infection Reviews (PIR) within the timescales specified by the DH. *iii. Lessons Learned to be shared within the service and brought to the attention of the ICC and care Network via quarterly reporting*	As cases arise As cases arise	KG / RT KG		
	iv. To work collaboratively across the city with the CCG to reduce Gram Negative BSI arising from E-Coli UTI	March 20	KG / RT		
	v. To work collaboratively with the H&S Lead and wider MDT regarding IPC related Safety Alerts.	As released	KG		
	vi. To review and interpret any new IPC national guidance for its relevance and introduction into the Trust (e.g. NICE)	As released	KG		
	vii. IPC related incidents to be monitored and lessons shared appropriately.	March 20	KG		
	viii. IPC risks being appropriately reported/escalated for inclusion on the Directorate Risk Register.	March 20	KG		
	ix. Continue to support the compliance with the Sharps Directive particularly around safety devices; review the risk assessment following audit	March 20	CS / KG		
	x. Support all areas whereby facilitating outbreak management and to promote appropriate 'terminal cleaning' prior to re-opening to admissions	On-going	KG /JPW		
	xi. All service user results are management as a priority e.g. MRSA Bacteraemia's / C-diff / CPE. Liaise with appropriate services/clinicians/GP's	On-going	KG		
	xii. To ensure that there is IPC involvement into the procurement process to confirm that equipment & therapeutic devices can be appropriately cleaned & decontaminated.	On-going	KG / Procurement		

Objective Area (38)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
6. Design, Planning refurbishments & New Premises ***To ensure that premises are designed & furbished to enable IPC practices to flourish. (1)***	i. Provide specialist advice and decontamination requirements of all proposed capital refurbishments and new developments from design, planning through to final commissioned state. **To ensure that the fabric of the environment facilitates the cleaning process & that IPC is 'designed-in'.*	March 20	KG / GR / JB RT		
7. Estates Functions Water Quality & Safety **Promoting holistic management towards water systems to control waterborne pathogens & the ongoing maintenance of our healthcare premises (3)**	i. Support Estates with monitoring Water Quality including active participation in the Water Safety Group	March 20	MG / KG / RT		
	ii. Support Estates with quarterly reviewing the Water Quality risk assessments	March 20	MG / KG / RT		
	iii. Collaborative Estate visits to all areas to identify IPC issues relating to the *'fabric of the building'* before they become problematic	Quarterly as required	DM / KG		
8. Environmental Cleaning & Decontamination ***Activities to demonstrate that IPC & cleanliness are an integral element of the quality agenda (6)***	i. Support Hotel Services with reviewing standards of cleanliness across sites; report monthly environmental audit scores and Senior Housekeeper 'peer review' auditing cycle	March 20	JM / KG		
	ii. Continue with annual Management Review Cleanliness Inspections/ walk-rounds.	March 20	KG / JM / JPW		
	iii. Support Hotel Services with annual Kitchen inspections to all main food producing sites	March 20	JM / KG / JPW		
	iv. Support Hotel Services in finding an alternative to Virusolve	March 20	JM / KG		
	v. Support clinical staff/teams in devising/renewing their departmental cleaning schedules	March 20	KG / JPW		
	vi. Review of the Housekeeping Specification Document	Oct 19	JM / KG		