

QUALITY COMMITTEE REPORT

Item

Purpose Information

Title	Annual Report of the Director of Infection Prevention & Control
Author	Beverley Aspin, Lead Nurse, Infection Prevention & Control
Executive sponsor	Dr Ian Stanley, Director Infection Prevention & Control

Summary: This annual report covers the period of April 2017 to March 2018. It details the HCAI figures and the work undertaken by the Trust to mitigate infections.

Recommendation: The Board is asked to note the report and support the action plan for the current year.

Report linkages

Related strategic aim and corporate objective

- Put safety and quality at the heart of everything we do
- Invest in and develop our workforce
- Work with key stakeholders to develop effective partnerships
- Encourage innovation and pathway reform, and deliver best practice

Related to key risks identified on assurance framework

- Transformation schemes fail to deliver the clinical strategy, benefits and improvements (safe, efficient and sustainable care and services) and the organisation's corporate objectives
- Recruitment and workforce planning fail to deliver the Trust objective
- Alignment of partnership organisations and collaborative strategies/collaborative working (Pennine Lancashire local delivery plan and Lancashire and South Cumbria STP) are not sufficient to support the delivery of sustainable, safe and effective care through clinical pathways
- The Trust fails to achieve a sustainable financial position and appropriate financial risk rating in line

with the Single Oversight Framework

The Trust fails to earn significant autonomy and maintain a positive reputational standing as a result of failure to fulfil regulatory requirements

Impact

Legal	No	Financial	No
Equality	No	Confidentiality	No

Previously considered by: Infection Prevention Committee May 2017

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Executive summary

1. This report summarises the work of the Infection Prevention and Control Team (IP&CT) during 2017/18, the progress made and the significant infection control and prevention challenges that have been faced by the Trust.
2. All NHS Organisations must ensure that they have effective systems in place to control healthcare associated infection (Appendix 1: Recent Publications Affecting Infection Control). The prevention and control of infection is part of the Trust's overall risk management strategy. Evolving clinical practice presents new challenges in infection prevention and control, which need continuous review. Emphasis is given to prevention of healthcare associated infection, the appropriate use of antibiotics and the improvement of cleanliness in the hospital.
3. The Infection Prevention & Control Team took part in the NHS Improvement IPC Collaborative in 2016. A Prompt to Protect Campaign was devised as a quality initiative in order to improve hand hygiene and basic infection prevention practices. A video was produced and is included in the back to basics teaching package. On the wards that have taken part in the campaign to date there has been an average of 29% improvement in hand hygiene.
4. The trajectory for MRSA blood stream infections for the year 2017/2018 was to have no more than 0 blood stream infections; the year end outturn attributable to the Trust was 2.
5. The post 3 days trajectory target set for *Clostridium difficile* infections for 2017/2018 was 28 cases and the outturn was 37 This included the mandatory inclusion criterion for reporting all diarrhoea samples from patients 2 years and above and also diagnosis of Pseudomembranous colitis (PMC) by CT and endoscopy.
6. From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England. This is to support the Government ambition to reduce Gram-negative bloodstream infections by 50% by 2021.
7. In the first year from April 2017 the ambition is to reduce E. coli bloodstream infections by 10% across the health economy. East Lancashire Hospitals NHS Trust were one of only 59 Trusts who achieved a >10% reduction in the hospital onset E.coli blood stream infections (based on 2016 data as baseline).
8. The national target of MRSA screening for all eligible elective and emergency admissions has continued satisfactorily.

9. There have been a number of outbreaks due to symptoms of Norovirus this year and we have had 2 outbreaks due to highly resistant organisms. Actions were implemented to prevent further spread and areas opened as soon as possible. This resulted in 102 bed loss days.
10. The Trust continues to work on the implementation of all current national initiatives to control hospital acquired infections. Work has continued to ensure compliance with the Care Quality Commission (CQC) standards and with the Health Act 2008.
11. New starters now have essential to role training such as ANTT and hand hygiene completed locally in the ward/department.
12. Hand hygiene remains pivotal to good infection control practice and every opportunity has been taken to re-enforce good practice. The "World Hand Hygiene Day" was held across both sites with stalls on main entrance, ward visits with Glo box and '5 moments' leaflets given to staff on wards.
13. The Infection Prevention & Control Team (IPCT) have had significant difficulties in recruiting to the vacant Consultant Microbiologist post over the past couple of years. The remaining vacant post has been advertised and we have now successfully appointed to this post. The post holder will start in August.
14. The Consultant Microbiologists and the Antibiotic Pharmacist continue to work together reviewing guidelines and embedding the Antimicrobial Formulary (available on the intranet) across the Trust, with Grand Rounds and FY1/FY2 teaching. The antibiotic audits during increased incidence of *C. difficile* on wards continued. The Trust antimicrobial formulary continues to be reviewed in 2017/18 by the Antimicrobial Stewardship Committee.
15. The ELHT antimicrobial app has been produced and is now available online.
16. The Divisional antimicrobial quarterly audits continued in 2017/18 with audit presentations in Medical Audit meetings and Grand Rounds. This information is disseminated via the Divisional Audit Lead and presented at Infection Prevention Committee.
17. Antibiotic Stewardship Programme continued to be pursued with weekly MDT *C. difficile* ward rounds, antibiotic audit ward rounds, Infection Prevention & Control Nurses (IP&CN) and ward pharmacist notifications.
18. There has been an active audit programme to include monthly commode, hand hygiene, blood culture contamination, MRSA screening, diarrhoea, urinary catheter and mouth care audits. During 2017/18, Infection Control policies have been developed or reviewed to ensure they incorporate current best practices.

19. Cleaning and domestic services continue to deliver a high standard of hospital cleanliness and have received encouraging Patient Led Assessment of the Care Environment (PLACE) inspection reports.

Foreword

20. The Annual Report of the DIPC for East Lancashire Hospitals NHS Trust covers the period from April 2017 – March 2018. It also contains the work plan for the period April 2018 – March 2019 (Appendix 2).
21. The report informs on the progress made and the processes in place including the key activities undertaken by the IP&CT and the Trust in managing and preventing infection and recognising this as a key element of patient safety.
22. The major challenge for the year was to continue making good progress against the Government's targets to reduce health care associated infections and the numbers of MRSA blood stream infections and *Clostridium difficile* infections, while maintaining other important activities required for compliance with the Health Act, such as policy development and review, education, audit and providing a responsive service to unpredictable occurrences such as outbreaks.
23. The IPCT, alongside colleagues across all disciplines within the Trust, have striven to reduce infection rates within East Lancashire Hospitals NHS Trust. Evidence of this work is contained within the main body of the report.
24. The Department of Health mandatory reporting of MRSA, MSSA, and E. coli blood stream infections and *Clostridium difficile* toxin positives continued.
25. From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa to Public Health England. This is to support the Government ambition to reduce Gram-negative bloodstream infections by 50% by 2021. Surveillance will be undertaken in line with current requirements (e.g. E. coli blood stream infections).
26. The reduction of health care associated infections, particularly MRSA and *Clostridium difficile* are challenging for the team and the rest of the organisation and require substantial effort from all to achieve.
27. The main focus of the team is compliance with the Health and Social Care Act and fulfilment of the operational plans for MRSA and *Clostridium difficile* reduction. Going forward, the team will also focus on embedding clinical accountability for infection prevention issues at Divisional level, reducing MSSA, gram negative blood stream

infections and strengthening compliance to infection prevention practice throughout the Trust.

Infection control arrangements

28. ELHT has an appropriately constituted IP&C Team supported by timely and effective UKAS accredited microbiological laboratory services with advice available on a 24 hourly basis.
29. The Trust DIPC is Dr Ian Stanley, Deputy Medical Director who has overall responsibility for the IP&CT.
30. Mrs Beverley Aspin, Lead Nurse IP&C continues to lead the Infection Prevention Nursing Team.
31. Infection control support is also provided by the Consultant Microbiologists. The Consultant Microbiologist Team continues to be depleted by one full time vacancy. Locum on-call cover has continued and a review and prioritisation of workload was carried out.
32. The Infection Prevention & Control Team (IPCT) have had significant difficulties in recruiting to the vacant Consultant Microbiologist post over the past couple of years. The remaining vacant post has been advertised and we have now successfully appointed to this post. The post holder will start in August.

Infection Prevention Committee

33. The Infection Prevention Committee (IPC) met bimonthly and was chaired by the DIPC or Lead Nurse, IPC. From January 2018 the face to face meetings are planned quarterly with monthly virtual meetings for urgent issues and dissemination of information.
34. Membership of the Committee includes senior representatives from each Clinical Division as well as Pharmacy, Estates and Facilities, Occupational Health, Learning and Development, PHE, CCG and Public Health Local Authority Infection Prevention Nurses.
35. Its purpose is to:
 - a) To provide strategic direction for the Prevention and control of Healthcare Associated Infection (HCAI) for the organisation.
 - b) Provide a key role in monitoring the Organisation's performance against the Trust's Infection Prevention and Control Strategy including external objectives/targets and compliance with the Health and Social Care Act 2008:

Code of Practice of the prevention and control of infections and related guidance (2015).

- c) Ensure there is a strategic response to new legislation, regulations, guidelines and evidence based practice.
- d) Receive and review reports on outbreaks and incidents of HCAI.
- e) Ensure there is adequate learning from incidents and health economy issues to minimise impact on patient safety/Trust business through robust monitoring of action plans.
- f) Receive and review surveillance figures related to HCAs and agree on actions to be taken.
- g) Receive and comment on ELHT Infection Prevention & Control and relevant Occupational Health & Wellbeing policies prior to submission to the Policy Council.
- h) Collaboratively work with health economy colleagues to effectively address outbreaks, to ensure outbreak preparedness and to ensure the optimal prevention of transmission of HCAs across the health economy.
- i) Monitor and respond to emerging issues or threats including resistant or highly infectious organisms.

Reporting Line to the Trust Board

36. The minutes from the IPC are received by the Quality Committee of the Trust which is a designated sub-committee of the Trust Board.



37. The DIPC meets regularly with the Chief Executive. The monthly performance is reported to the Operational Delivery Board (ODB) and Trust Board and includes data on infection control, including Health Care Associated Infection (HCAI) targets. Any infection control issues are reported as exceptions.
38. The Infection Prevention Committee formally reports through the governance structure to the Quality Committee.
39. A monthly DIPC Report incorporating HCAI performance data, screening compliance and outbreaks is discussed at the Divisional QSBs, IPC, and Quality Committee.
40. Any incidents or infection control issues occurring outside of Trust Board meetings, but requiring Trust Board notification, are discussed and actions undertaken as appropriately through the DIPC.
41. Implementation of the Annual Infection Control Action Plan is discussed with the DIPC and IP&CT, and reported to IPC. As part of incident reporting process, any infection control outbreaks are notified to the Governance Unit. More information on outbreaks is contained within section 4.2.
42. The minutes from the Trust Board meetings and copies of the clinical indicators are available on the Trust intranet.

Links for patient quality and safety

43. Day to day infection control issues are dealt with in the first instance by the IP&C Nursing Team with support and advice from the Consultant Microbiologists. The members of nursing team provide expertise with results of surveillance, audit, and alert organism reporting to a variety of groups and committees across the Trust, including the Emergency Preparedness Group, Operational Planning and Resilience Group, PLACE Group, Estates Planning, Decontamination, East Lancashire Nurse Leaders Forum, Divisional Service Quality Teams and Divisional SIRG meetings, Point Of Care Testing, Policy Council, IV forum
44. The Decontamination group, which reports to the IPC and is chaired by the Trust Operational Decontamination Lead, has continued to oversee Trust compliance with changing decontamination standards and legislation, thus providing assurances that any decontamination risks identified in the controls assurance framework or from the Trust's Datix system have been controlled accordingly. The bi-monthly meetings have taken place over the last 12 months with improved attendance from various Divisions.

45. The IP&CT are responsible for monitoring and implementing strategies to take forward national initiatives to combat HCAI's and to work with managerial, clinical colleagues to reduce risks. The combined infection control priorities are included in the work plan and high risks are fed into the Trust's risk register and also brought to the IPC and discussed monthly.
46. During the past year the following policies were updated and put on the Trust Intranet:
 - a) IC 00 Infection Control Overarching policy
 - b) IC 01 Hand Hygiene Policy
 - c) IC 05 Isolation of patients policy
 - d) IC 08 Severe respiratory illness policy
 - e) IC 09 MRSA policy
 - f) IC 22 Multi drug resistant organism policy
 - g) IC 24 ANTT policy
 - h) IC28 Urinary Catheter Policy
 - i) Bowel management SOP

Compliance with the Health and Social Care Act 2008

48. Compliance with the Health and Social Care Act has been an integral part of the work undertaken by the IP&CT and the Organisation.
49. The actions which were required to ensure the Trust complied with the 10 criterion laid out in the Hygiene Code have been incorporated in the work plan which is updated and reviewed and report presented in the IPC meeting.

Budget allocation for infection control activities

PbR

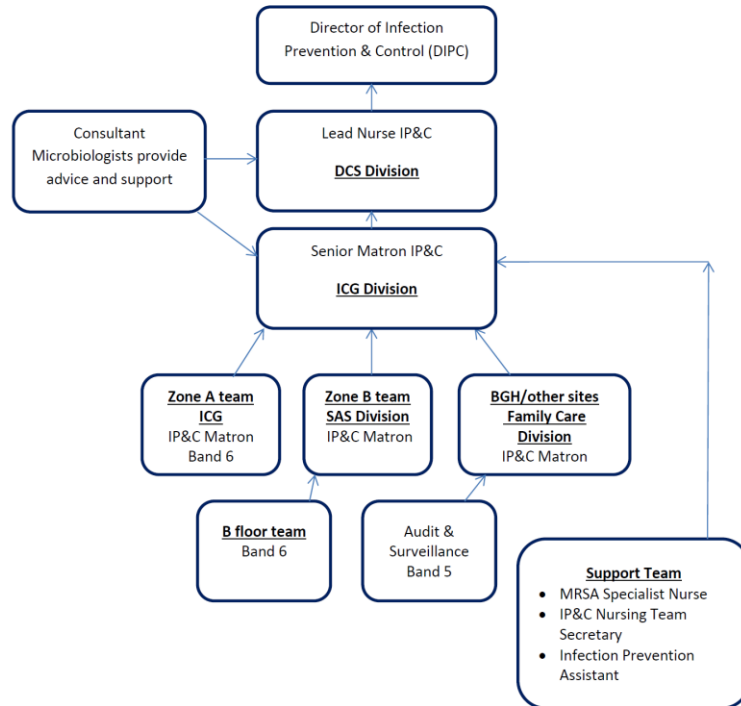
50. Since the introduction of the Payment by Results system, control of infection is a cost attributable to all areas as it covers the whole Trust. The expenditure budget sits within the Department of Clinical Laboratory Medicine which sits within the Division of Diagnostics and Clinical Support.
51. The IP&CT budget consists of staffing costs and for drugs (topical treatments for MRSA positive patients).

ICNet

52. ICNet is the software used by the Infection Prevention Team to provide information to support infection prevention and antimicrobial stewardship. It provides a communication tool between the Infection Prevention Matrons, the ability to track patients both from community and as new admission. The use of this software enables the Infection Prevention Matrons to easily identify critical issues and be able to intervene preventing serious issues, outbreaks and delays in patient flow. This tool reduces the burden of surveillance and enables prompt internal and external report.
53. The budget for this comes out of the Clinical Laboratory Medicine budget. We have extended the licences on this software for the next two years at a cost of £49386.52 annually with the aim for this to be one of the systems replaced when the electronic patient record is implemented in the Trust.

Staffing

54. The Infection Prevention Team consists of the following:
- a) 4.1 WTE Microbiology Consultants (1.0 WTE vacancy)
 - b) 1.0 WTE Lead Nurse, Infection Prevention & Control (Band 8b 0.6 WTE from Jan 18)
 - c) 1.0 WTE Senior Matron, Infection Prevention & Control (Band 8a from Jan. 18)
 - d) 2.0 WTE Matron, Infection Prevention & Control (Band 7)
 - e) 2.0 WTE Infection Prevention Nurse (Band 6)
 - f) 1.0 WTE Infection Prevention Nurse (Band 5)
 - g) 0.6 WTE MRSA Specialist Nurse (Band 5)
 - h) 1.0 WTE IP&C Nursing Secretary (Band 4)
 - i) 1.0 WTE Infection Prevention Assistant (Band 2)
 - j) 0.8 WTE Learning and Development Trainer (Band 7, budget sits within L&D)
 - k) 0.5WTE Antimicrobial Pharmacist (budget held in Pharmacy)
55. The Infection Prevention Nursing Team structure has been reviewed and through vacancy review has been refined this year to now give an improved team configuration which should aid the recruitment and training of future infection prevention expertise.



Administrative Support

56. 1.5 WTE Consultant Microbiology Secretaries to support the work of the Consultant Microbiologists.

Healthcare associated infections statistics 2017/2018

57. MRSA blood stream infections and *Clostridium difficile* infections have Trust trajectories set nationally and this year our tolerances were zero MRSA blood stream infections and 28 cases of post 3 day from admission *Clostridium difficile* toxin positive.

MRSA Blood stream infections

58. The Trust had a zero tolerance for MRSA blood stream infections for 2017/18.

ELHT laboratory tested MRSA blood stream infections	April 2017	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2018	Feb	Mar	Total
Trust attributed	0	1	0	0	0	0	0	1	0	0	0	0	2
CCG/third party attributed	0	1	1	0	0	0	0	0	0	1	0	0	3

59. Post Infection Reviews have been carried out across the health economy by ELHT Clinical Teams, Infection Prevention Team, CCG and Local Authority infection prevention staff on all MRSA blood stream infections. The Infection Prevention Team has supported the divisions in these reviews.

60. The cases attributed to the Trust were both from stroke patients who had screened MRSA negative on admission but then subsequently became colonised positive on the ward. The ward had no positive MRSA patients on the ward at the time and all patients are screened on admission. A subsequent screening programme was undertaken for 6 weeks and found no colonised MRSA patients on the ward. It was thought that the antimicrobials given at the time of illness selected out the MRSA which led to the infection. Actions undertaken have led to improvements in mouth care and the development of a pneumonia care bundle.

Clostridium difficile infections

	April 2017	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2018	Feb	Mar	Total
post 3 days of admission to Acute Trust	2	4	3	2	5	2	3	3	3	2	3	5	37
pre 3 days of admission to Acute Trust	4	10	5	4	10	5	10	6	8	5	10	6	83
TOTAL	6	14	8	6	15	7	13	9	11	7	13	11	120

61. There was an upper tolerance of reduction of incidence of *Clostridium difficile* toxin positive results on patients admitted to East Lancashire Hospitals NHS Trust for **more than 3 days** of **28 cases**. To the end of the year 2017/2018 we had 37 post 3 day *Clostridium difficile* toxin positive results.
62. Themes arising from PIR (more than one theme identified from some PIRs):
- No recent admission to ELHT
 - Not isolated promptly
 - Delay in sampling
 - Previously identified with CDT/GDH+ve and have relapsed
 - Inappropriate antimicrobials prescribed/extended course given
 - Proton Pump Inhibitors (PPI) prescribed (increases risk of CDI)
 - Treatment for constipation
 - Antimicrobial indications/stop or review dates not documented
 - Poor documentation with regards to bowel history
 - Recent antimicrobial treatment by GP
 - Diarrhoea thought to be from another source e.g. laxatives/malaena
63. Actions resulting from these have included amending the flowchart for sampling, education around isolation, labels on stool pots to highlight prompt isolation, cleaning, review of Bristol Stool chart which has now been made mandatory for completion on all patients daily, sampling, use of PPIs, antimicrobial audits,

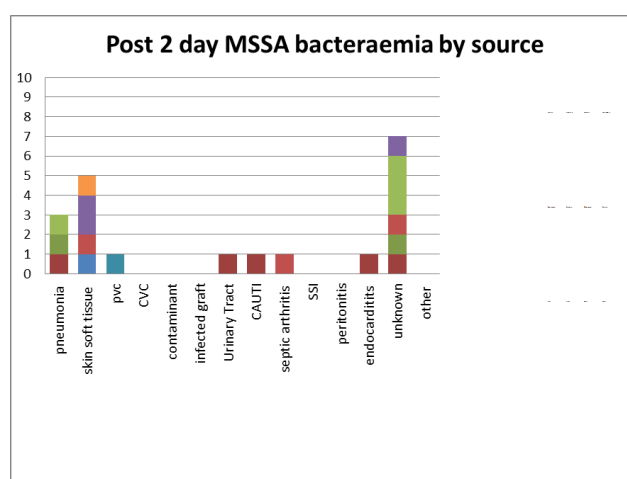
workshops on the treatment of UTIs for GPs. The Clinical Flow Team have allocated a single room to be kept vacant to try to allow for quicker isolation times.

MSSA Blood stream infections

64. Hospitals are required to monitor reported infections of *Meticillin Sensitive Staphylococcus Aureus* (MSSA) blood culture positive results which have been rising in recent years. From January 2011 MSSA blood stream infections information is now part of the mandatory surveillance.

	April 2017	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2018	Feb	Mar	Total
Post 2 days of admission	0	5	2	0	2	0	2	3	4	4	1	1	24 cases (18 %)
Total (pre and post 2 days)	8	13	11	10	11	12	9	17	13	14	11	7	136

65. Last year in 2016/17 we had a total of 26 (23%) post 2 day MSSA blood stream infections out of 112 in total.



66. The Secretary of State for Health has launched an important ambition to reduce health care associated Gram-negative blood stream infections by 50% by 2021.

Gram-negative blood stream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015. The initial focus is on reducing E. coli blood stream infections because they represent 55% of all Gram- negative blood stream infections.

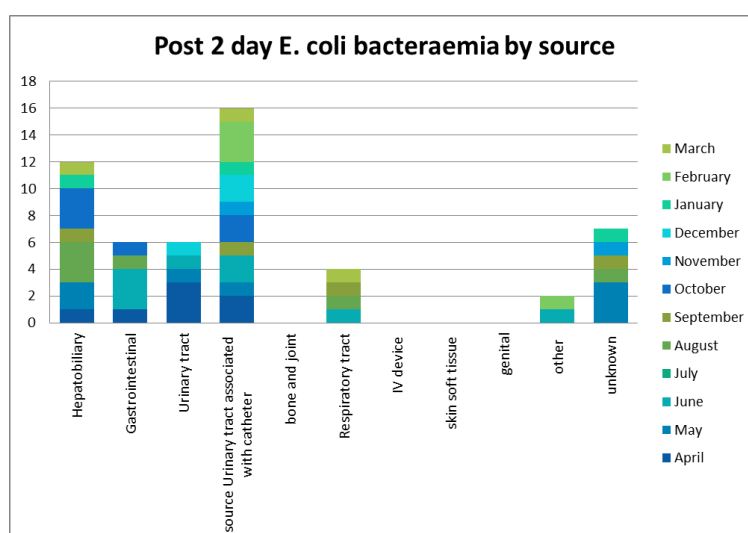
Gram negative Blood stream Infections

Escherichia coli Blood stream infections

67. From April 2017 there is an ambition to reduce E. coli blood stream infections across health economy by 10% by March 2017. Based on the 2016 data ELHT have made a 10.1% reduction in the hospital onset E. coli blood stream infections.

	April 2017	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2018	Feb	Mar	Total
Post 2 days	7	7	8	0	6	4	6	2	3	3	4	3	53 cases (13%)
Pre 2 day	37	35	31	33	31	24	21	28	28	18	19	35	340
Total	44	42	39	33	37	28	27	30	31	21	23	38	393

68. Last year in 2016/17 we had a total of 72 (17%) post 2 day E. coli blood stream infections out of 420 in total.



69. From April 2017, NHS Trusts must report cases of bloodstream infections due to Klebsiella species and Pseudomonas aeruginosa as well as E. coli to Public Health England. This is to support the Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021.

Klebsiella species blood stream infections

	April 2017	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2018	Feb	Mar	Total
Total	6	5	6	10	6	3	12	11	8	4	5	8	84
Pre 2 days	5	4	6	7	4	3	10	9	5	4	4	5	66
Post 2 days	1	1	0	3	2	0	2	2	3	0	1	3	18

70. 21% of cases were post 2 days of admission

Pseudomonas aeruginosa blood stream infections

	April 2017	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan 2018	Feb	Mar	Total
Total	3	2	1	0	3	1	0	1	1	1	0	3	16
Pre 2 days	3	2	1	0	2	1	0	1	0	1	0	2	13
Post 2 days	0	0	0	0	1	0	0	0	1	0	0	1	3

71. 19% of cases were post 2 days of admission

Glycopeptide Resistant Enterococci Blood stream infections

72. There have been 3 cases of Glycopeptide resistant Enterococci blood stream infections reported in the Trust during 2017/18 (2 post 2 days of admission and one pre 2 days of admission).

Orthopaedic surgical site infections

73. ELHT continues to participate in the National Surgical site Surveillance scheme (NSSIS), monitoring these all year round, as opposed to the mandatory 3 months annually. Infection Prevention & Control Matrons have continued to support the

Surgical Division in their mandatory Orthopaedic surveillance for hip and knee replacements.

Year 2016	Period	No. operations	Inpatient & Readmission No. (0% infected)	All hospitals this category (last 5 years)
Hip Replacement	Jan to Dec 17	316	0%	0.7%
Knee replacement	Jan to Dec 17	451	0%	0.5%

74. The Infection Prevention & Control Team is linked with each Division and provides feedback around their infection prevention & control issues and infection rates.

Outbreaks/Incidents

75. The following table shows outbreaks of confirmed/suspected outbreaks across the Trust in 2017/18.

Ward	Started	Patients affected	Staff affected	Organism identified	Opened	Bed days lost
B20	24/03/17	5	N/A	Carbapenemase-producing Enterobacteriaceae	31/03/17	75
C6	07/03/17	3	N/A	Multi resistant organism	Not closed	None
C9	11/05/17	3	2	Presumed Norovirus	15/05/17	2
Hartley	26/05/17	12	7	Confirmed Norovirus	05/06/17	8
Hartley	06/12/17	3	1	Presumed Norovirus	11/12/17	3
C7	16/12/17	6	0	Confirmed Norovirus	20/12/17	1

Ribblesdale	07/01/18	4	3	Presumed Norovirus	11/01/18	5
B4	24/03/18	5	8	Norovirus	01/04/17	8

76. The regional level of Norovirus during 2017/18 was lower than average and Rotovirus has reduced following the introduction of the Rotovirus vaccine in 2013.
77. In March 2017 we had an outbreak of Carbapenemase-producing Enterobacteriaceae (CPE) on the Vascular ward. A patient was admitted from a hospital abroad who was subsequently identified as being colonised. One further patient was identified through a clinical sample as being colonised. 4 more patients were identified through screening.
78. An outbreak committee was established with support from Public Health England and East Lancashire Clinical Commissioning Group in order to prevent further spread. An extensive screening programme was undertaken to ensure that there had been no spread prior to the second patient being identified. There was no further spread identified.

Chickenpox

79. There have been several patients/visitors attending the Trust who have subsequently been identified as having chickenpox. This has resulted in the need to contact trace other patients informing their GPs and Health Protection Agency in order to protect them. Occupational Health & Wellbeing Department have contact traced staff in order to ensure that they are fully protected or excluded in order to protect patients.

Influenza

80. There has been an increase nationally in the number of people with influenza. During 2017/18 we introduced an influenza algorithm that increased the number of patients that had previously been tested. This included not only typical presentations of influenza but also patient groups that may have also been affected by influenza such as those with chronic chest conditions.
81. This has resulted in 1067 patients tested; 14.8% patients who presented with typical influenza (53% +ve), 32% with chronic chest conditions (25%+ve), 53% with upper and lower respiratory tract infections (31% +ve).
82. This has resulted in the need to contact trace 1289 inpatients to ensure that they have had appropriate precautions if necessary.

Tuberculosis

83. There have been two patients admitted across the Trust who has subsequently been identified as having open pulmonary tuberculosis. This resulted in 24 patients being contacted and informed of their exposure. The GP's and Hospital Consultant were also informed to consider TB as a diagnosis if they presented with appropriate symptoms as per national guidance.

Periods of Increased Incidence of *Clostridium difficile*

84. The ICT declares a period of increased incidence of *Clostridium difficile* Infection when two or more new cases occurs post admission (not relapses), in a 28 day period on a ward. We have declared 3 ward areas with a Period of Increased Incidence. We have identified that on all these wards, once the samples were sent for typing, that we have not had any cross infection. We have worked with the wards to review practice and provided support and education where needed. One ward had one patient that cross matched the same as a previous patient.
85. The Infection Prevention & Control Team work with staff in all clinical areas and community infection control colleagues in the management of infection control issues.
86. Key elements of the IPCT activities are:
- a) Education
 - b) Audit and surveillance, both local and national
 - c) Monitoring of hospital hygiene and practice
 - d) Formulation of policies and guidelines
 - e) Outbreak management
 - f) Expert advice
87. The Infection Prevention & Control Matrons undertake daily monitoring and follow up of routine surveillance of alert organisms and alert conditions and take appropriate advice from Consultant Microbiologists when needed. These include MRSA, Tuberculosis, Glycopeptide-Resistant Enterococci (GRE), ESBL's, *Clostridium difficile* and other faecal isolates. They have undertaken daily ward rounds, provided advice and monitored patients to prevent the spread of infection.

Hand hygiene

88. Hand Hygiene is regarded as the most important single method of prevention and control of infection. Training is provided to staff during annual WHO Hand Hygiene Day, as a yearly 1:1 update from the IP&C Liaison Members to all staff and various formal training sessions as part of ANTT initiative.
89. The Hand Hygiene Policy is available to all staff and reviewed regularly.
90. The soap dispensers across the Trust have been updated and now include our logo and hand washing steps and 5 moments information.

Hand hygiene awareness

91. The Infection Prevention & Control Matrons held hand hygiene awareness sessions in May to celebrate “World Hand Hygiene Day”. This involved having a stand in the main entrance, challenging visitors to use the “Glo Box” to check the effectiveness of hand hygiene. The Glo Box was also taken around the wards for staff to use.
92. IC Liaison Members have undertaken individual staff training in their ward/dept with regards to effective hand hygiene, the 5 moments and care of skin.

Prompt to Protect

93. The Infection Prevention Team took part in the NHS Improvement 90 day Quality Improvement IPC collaborative. The aim of the collaborative was to deliver an improved experience and clinical outcome for patients through the delivery of best practice pathways in IPC, whilst also seeking to measure, monitor and reduce the cost of care by having a zero tolerance to avoidable infections.
94. The team devised a campaign programme “Prompt to Protect” to improve basic infection prevention practice and to improve hand hygiene by 20% on the ward. The campaign included teaching sessions, leaflets, posters, star charts and video/photographs. The Infection Prevention Matrons worked with link staff on the ward and provided support and external weekly audits of practice and hand hygiene.
95. Further wards have taken part in the campaign improving hand hygiene by an average of 29%. This is now being rolled out across the Trust.

Decontamination

96. The Decontamination group has continued to oversee Trust compliance with changing decontamination standards and legislation, thus providing assurances that any decontamination risks identified in the controls assurance framework or from the

Trust's Datix system have been controlled accordingly. The bi-monthly meetings have taken place over the last 12 months with improved attendance from various Divisions.

97. The group continues to review and look at any new legislation for decontamination, which includes the revised standards for ISO13485, ISO9001, Health Technical Memorandums 01-01 & 01-06 (HTM's) and the Medical Devices Directive 93/42/EEC. It also reports on what decontamination practices of medical devices are occurring across the Trust.
98. This group reports to the IPC and is chaired by the Trust Operational Decontamination Lead. It has membership from all concerned Divisions including the Infection Prevention & Control Team. There has been no change in the membership, however it was agreed that should the meeting not be quorate it would go ahead, however any decisions made wouldn't be agreed until the next quorate meeting.
99. Throughout the year of 2017/2018, a focus of the group has been developing the use of the Gas Plasma machine in HSDU. Initially the machine was purchased for the terminal sterilisation of the robotic equipment, with a view to develop its usage for other types of scopes that have previously just been high level disinfected. The Sterile Services and Endoscopy departments have been preparing for the transitional audits of the revised ISO standards and the HTM documents.
100. New controlled processes have been developed from risks that have been identified in Decontamination i.e. the decontamination of Ureterscopes which are now processed initially through Endoscopy and then sent for sterilisation in HSDU. There has been a reduction in the amount of kit we send off site for sterilisation that has now been brought back in house.

Authorising Engineer – Decontamination (AED)

101. The need to provide independent auditing and advice on decontamination equipment and to review, witness documentation and validation is a function that is carried out by the Authorising Engineer – Decontamination.
102. East Lancashire Hospitals NHS Trust has continued to employ Dr John A Kerry as an independent advisor to the Trust for all aspects of the decontamination programme.
103. Dr Kerry has reported on new guidance/legislation or findings for Decontamination that could have an impact on the Trust.
104. The Authorising Engineer has also been involved with auditing Sterile Services and Endoscopy Department decontamination equipment test records. Undertaking the

audit supplied by IHEEM for the annual review of flexible endoscope decontamination facilities in preparation for the JAG assessment that took place.

Decontamination Risks

105. ***Failure to designate lead managers for cleaning and decontamination of equipment used in treatment and to ensure that a decontamination programme is implemented which takes proper account of relevant national guidelines.***

All areas have designated lead managers that are responsible for signing off relevant testing documentation.

106. ***Decontamination programme will demonstrate that decontamination of reusable medical devices takes place in appropriate dedicated facilities.***

All Internal and external audits are scheduled. A new internal audit plan has been agreed for 2018/2019 with all reports and findings going through the Decontamination group for comments and actions.

107. ***Ensure compliance with standards for decontamination of endoscopes and reusable medical devices. All testing carried out, signed and audited.***

Endoscopy have quarterly and annual testing carried out by their machine manufacturer Getinge. In house decontamination engineers are responsible for carrying out weekly tests and RO filter changes in Endoscopy, with weekly, quarterly and annual testing of equipment in the Hospital Sterilisation and Decontamination Units (HSDU). The HSDU demonstrated their compliance by continuation of accreditation during the transitional period of the revised ISO standards.

108. ***Replacement Programme Lifecycle of Decontamination Equipment***

The Gas Plasma machine, washer disinfector and drying cabinets in Endoscopy have supported the replacement of decontamination equipment. A new programme is being developed for 2018/2019. An asset register is also being produced for decontamination equipment under the value of £5,000.

109. ***The decontamination programme should be ensure that appropriate procedures are used for the acquisition and maintenance of decontamination equipment.***

Procurement are members of the Decontamination Group and identify new business cases, requests from Directorates regarding purchasing new equipment. This is now included on the Decontamination agenda as and when requested to ensure any equipment purchased can be decontaminated correctly.

110. ***Establish monitoring systems to ensure processes are fit for purpose and to required standard.***

Audits that are carried out monitor the decontamination processes within the Trust. Any new risk assessments regarding processes being used for decontamination of equipment are tabled at the meeting and added to the assurance framework.

111. ***Identified staff trained in decontamination processes and hold appropriate competencies for their role.***

There are departmental training programmes established in areas where decontamination takes place. Records of competence are checked during audits to provide assurance for the principal risk. Companies provide training on decontamination equipment to staff and also on medical devices that are required to go through a decontamination process.

112. This framework will drive various decontamination issues forward within the Decontamination Group meeting. The framework forms part of the agenda for the Decontamination meeting. It is reviewed with any new risks identified as a result of an audit or safety/alert notice being added.

Decontamination Audits

113. The Sterile Service Departments across East Lancashire Hospitals are externally audited by SGS. Over the last 12 months, 2 audits have been conducted against the new revised standard, therefore transitional audits.

114. The first audit took place at the end of July through to August for five days. A number of minor and major corrective actions were raised which have since been signed off.

115. The second audit was conducted in February 2018, two major and ten minor corrective actions were raised. The majors have been carried out and signed off by SGS and the minors will be closed off at the next audit.

116. Following the audits, the Units continued with their accreditation, however to the revised standard BS EN ISO13485:2016, ISO 9001:2008, Quality Management Standard and to the Medical Devices Directive 93/42/EEC. They continue to provide a service to all their customers within the Trust's Theatres, Wards, Departments and external customers.

117. An internal audit schedule is in place to ensure continued compliance with the aforementioned quality standards. These are conducted on a monthly basis. HSDU Management Review Meetings are an essential requirement of ISO accreditation.

The outcome of departmental audits is reviewed at the HSDU Management Review and action plans are developed and implemented if appropriate.

118. The decontamination of flexible endoscopes is undertaken centrally in the Endoscopy units. The units had their Joint Advisory Group (JAG) assessment carried out in 2017, with a successful outcome.
119. The audit calendar for 2018-2019 has been updated and will be issued to audit decontamination practices across all services.

Decontamination Training

120. All Trust staff involved in the decontamination of re-usable medical devices are required to complete decontamination training specific to their area of work. Within the Sterile Services Departments new staff are required to complete an in-depth departmental training package to comply with the BS EN ISO 13485: 2016 quality standard within 18 months of commencement. All other existing staff are required to have an annual training update.

Decontamination Incidents and shared learning

121. All incidents are reported through the Trusts incident reporting system, Datix Incident Management System. Detailed risk assessments, incident investigation, root cause analysis has been discussed and received to ensure all reasonable actions have been taken and that appropriate external bodies have been informed if necessary.
122. Any incidents reported through the Trust Datix system and ones identified from the controls assurance framework have been tabled at the group. The group has also dealt with other perceived shortcomings in decontamination practice and encouraged the introduction of changes as appropriate.
123. Examples of Incidents / Challenges to Existing Practice / Controls Assurance Framework:
 - a) Endoscopy AER Test Reports

There were on going issues around the test report documents provided by the company which was tabled at the meeting.

Action Taken – The Decontamination group arranged a meeting with the company go through all the issues and agree actions.
 - b) Decontamination of Ureteroscopes

It was identified that this piece of kit wasn't being decontaminated in accordance with the manufacturer's instructions.

Action Taken – The group identified the correct method for decontamination and have taken the scopes from being high level disinfected to having them terminally sterilised through the gas plasma machine within the sterile services.

c) Standardisation of theatre instrumentation for ELHT.

Action Taken - The Decontamination Group have agreed with the long term plan for standardising theatre instrumentation kits across sites. This is in line with trying to reduce any migration of instruments across sets, the utilisation of equipment across sites (productivity) and reduce all missing instruments within sets.

Decontamination Strategy for 2018 – 2019 challenges / opportunities

123. The group will continue to build on the work undertaken in 2017 – 2018 and work on the long term strategy for decontamination.

124. Emphasis will be placed on the following for the year ahead:

- a) Continue to review disinfection/decontamination practices across the sites and identify which equipment could potentially be terminally sterilised through the gas plasma machine i.e. bronchoscopes. This will ensure all devices are fully tracked and traced using an automated system.
- b) Implement the full use of drying cabinets within the Endoscopy units in accordance with the standard.
- c) Develop and work with the Trust on the decontamination process for 3D reconstructive plates for cancer patients. The service is looking to increase the amount of plates being developed and will require a decontamination service.
- d) Review the equipment requirements for contaminant scanning in accordance with new guidelines produced by the Department of Health. This is to comply with guidance in respect of scanning for residual prion proteins using a validated method.
- e) Establish medical devices manufacturer's instructions for reprocessing across all departments that may undertake decontamination.
- f) Ensure all revised standards are fully embedded in the services with a focus on the medical devices directive changes.
- g) Develop a robust system for hazards/alerts regarding medical devices through theatres/HSDU – process review.

- h) Engage with other Divisions on Decontamination practices and the long term strategy for Decontamination.
 - i) Assist with the full implementation of the Decontamination Hub.
 - j) Continue to assist and support the operational decontamination lead in driving new technologies and developments forward.
125. The Decontamination group continues to support, develop and contribute to decontamination processes across the Divisions in the Trust.
126. The Decontamination Group will continue to ensure any new standards are put into practice and obtain assurance from the Divisions that they apply through 2018/19. All audit reports will be tabled at the meetings. The controls assurance framework, audits and the Datix system will continue to drive the group forward.

Cleaning services

Management arrangements (In-house)

127. The IP&CT has continued to work closely with the Facilities Team to provide advice, training and support for the cleaning and deep cleaning of wards and departments.
128. The IP&CT have continued support of Patient Services especially the Isolation Discharge Team to provide a service with an enhanced level of isolation cleaning practice. The IP&CT provided a training programme for Patient Services to support this enhanced cleaning service.
129. All domestic staff members attend yearly training updates on Infection control, hand washing and departmental updates – i.e. cleaning of isolation areas. Following the introduction of Microfibre and the use of Actichlor+ all staff attended initial training, and continue to be audited and re-trained annually to ensure their ongoing compliance.
130. The response team has continued to look after public areas and have redressed floors to enhance cleaning and concentrated on cleaning in public toilets, corridors, entrances, stairwells and lifts as specified in the National Specifications for Cleanliness.
131. This team are able to respond to urgent requests to ensure a safe, clean environment for patient's safety and experience.
132. Patient Services Supervisors have carried out a rotation of areas of responsibilities, before recently returning to a routine of monitoring their regular team of staff on a scheduled basis. This enables close working relationships to be further built between

matrons and Patient Services while fostering improved consistency in service levels, quality and standards.

133. The Isolation Discharge Team have continued to support wards to ensure a high level cleaning following discharge of patients with suspected infections.
134. The Bed Making team based on AMU A from Monday to Friday have continued to provide a valuable service, freeing up time for the ward team, although this now presents an unfunded pressure for Patient Services.

Monitoring arrangements

135. As per the requirements of the National Specification for Cleanliness in the NHS all areas are monitored by the Domestic Supervisors and the Ward and Departmental Manager according to risk:
 - a) Very high risk areas, including Theatres, NICU, ICU, are audited weekly
 - b) High risk areas, including wards, are audited monthly
 - c) Moderate risk, including departments, are audited monthly
 - d) Low risk areas, including offices, are monitored 3 monthly
136. In 2017 – 2018, an average of 95% of the areas across all sites was recorded, achieving the required standard of cleanliness.
137. Further inspections of cleaning performance carried out, in addition to the regular departmental technical and managerial audits with Matrons, include Patient Led Assessments of the Care Environment (PLACE) and Nursing Assessment and Performance Framework (NAPF) audits.

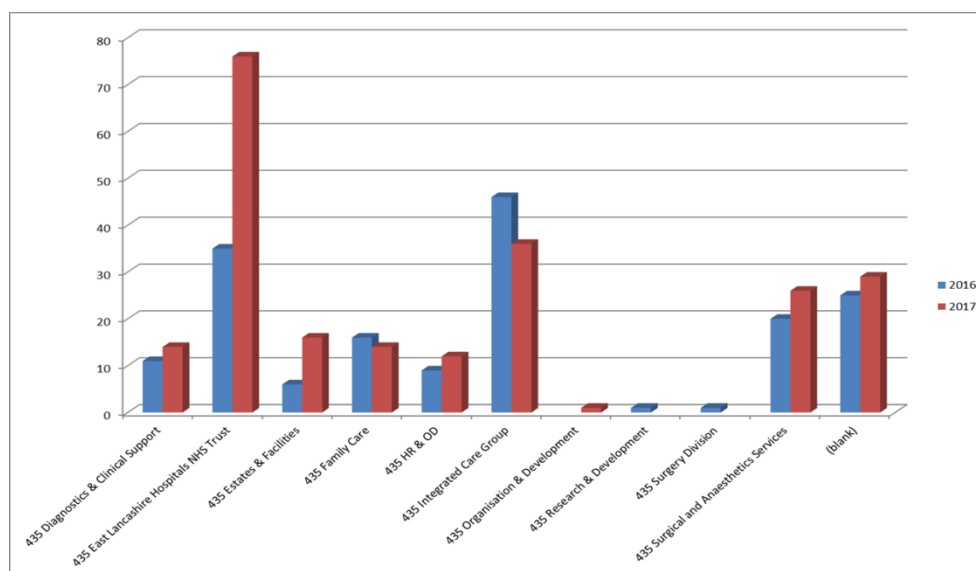
Occupational health & wellbeing

Sharps and Splash Injuries

138. From January to June 2017 there were a total of 113 sharps and splash incidents seen within Occupational Health. This demonstrates an increase of 29 incidents compared to the same period in 2016 with only 84 being reported. This demonstrates an increase in incidents for the organisation over the first 6 months of the year.
139. From July to December 2017 there were a total of 111 sharps and splash Incidents seen within Occupational Health. This demonstrates an increase of 27 incidents over the same period of time compared to the same period in 2016 with a total of 86 incidents being reported.
140. The year-end total for the whole of 2017 was 224. In comparison with 2016 total of 170 this highlights an increase by 54 incidents for the organisation for 2017

compared to that of 2016. The average number of incidents being seen in 2017 was 19 incidents. Compared to an average of 14 incidents in 2016 this has seen an increase of 5 incidents per month.

Sharps & Splash Injuries by Division 2016 versus 2017



Flu Vaccine Uptake Frontline Healthcare Workers 2017

141. The 2017 flu vaccination percentage was 92.3%. This is a 6.7% rise in uptake from the previous year's figure of 85.6%. These figures showed ELHT finish as the highest acute trust in the country for vaccination of front line health care workers.

Divisional infection prevention reports

Integrated Care Group

142. ICG has continued with a supportive and proactive approach to infection control with encouragement and support to all our staff to utilise the concept of 'Prompt and Protect.'
143. All clinical areas undertake a range of monthly audits which are used to inform improvements and identify areas for focussed attention. Compliance with audit completion is supported by a weekly email to the Ward Manager, Matron and ADNS.
144. From April 2018 audits will be streamlined to ensure inclusion of relevant data across ICG.
145. Patient-Led Assessments of the Care Environment (PLACE) monthly and Nursing and Assessment Performance Framework (NAPF) are supported within each directorate.

146. ICG Matrons produce a monthly report which incorporates infection control data, reporting exceptions/actions and celebrating achievements. These reports are submitted and discussed at directorate meetings and a summary is provided at the Divisional Management board by the ADNS.
147. A recent review of the reporting structure/process will provide assurances within ICG and this will be collated into a quarterly report which will include a directorate exception overview by each ADNS and summary from the ADNS Infection control lead.
148. Antimicrobial stewardship - continued engagement is required within ICG in relation to audit completion. Documentation of antibiotic review is crucial to ensure prudent prescribing and this will be raised within Division.
149. Identified learning following MRSA blood stream infections on ward B2 has promoted the need for a mouth care bundle. This is currently in the process of being created and is expected to be implemented throughout the Trust.
150. Post Infection Reviews are presented to the Divisional Serious Incident Review Group which is chaired by the Divisional Director.
151. Medical representation at the Infection control meeting and input into the infection control meeting is to be raised at DMB to enable support for the Division.
152. In conclusion the Division will continue to monitor infection prevention and control issues and completion of any action plans through the directorates, Clinical Effectiveness and DMB. Any breaches with IPC will be treated as a serious matter and managed with appropriate escalation and action. Staff engagement is paramount to ensure infection control is everyone's responsibility within ICG

Surgery

153. Over the past year the senior nursing team within SAS have developed a structured walk around based on the nursing assessment and performance framework. This is currently been revised and evaluated to address any failing quality issues (including infection control) within the Division.
154. The Division has made some significant improvements in terms of the NAPF assessment with a 90% of our wards being 'green'. Worked linked to this is the 'Prompt to Protect' On C14/18 which helped to improve compliance with principles of infection control across the two wards.
155. Particular emphasis has been placed on the Divisional approach to infection control and prevention of Hospital Acquired Infection after an 'outbreak' of CPE isolated to

one ward. Learning has been embedded on the ward and is helping to promote safe, harm-free care on all of the wards within the Division.

156. Work continues within the Division around antibiotic stewardship and the timeliness and appropriate use of antibiotics across the area. Compliance with formulary is managed throughout the Directorates and issues dealt with locally to improve. Issues which have led to acquisition of HCAs has been managed through the Divisional SIRG process with input from Infection Control.
157. The Division continues to learn from CDI acquisition and the issues relating to these are shared at the directorate's 'Share to Care' meetings and the divisional management board. The Division continues to monitor hand hygiene compliance with monthly audits.
158. Matrons have continued to participate in the PLACE assessments and attend the associated meetings and continue to embed the excellent feedback across the Division.
159. The Division continues in its work around surgical site infections (SSI) and is working towards a more robust process to map infections across other surgical specialties – not only the mandatory reporting for Orthopaedic SSIs. This is with the support of the Governance team and junior doctors.
160. Infection control issues mentioned above are regularly presented and/or discussed at DMB in the presence of the Clinical Directors and their triad business managers.

Family Care

161. Family care division throughout the year of 2017/2018 have continued to deliver a monthly performance report to ensure all areas of compliance have been met to the approved standard. Any exceptions noted have been aligned with a continuous action plan to reflect completed actions and assurances.
162. The actions formulated have been consistently shared as part of our two weekly governance meetings, monthly quality and safety meetings for women's health and share to care meetings within division. Infection prevention control (IPC) is a standing item on the share to care agenda.
163. The tasks remain to include both continuous and consistent monitoring of IPC compliance with procedures including High impact interventions (HII's), hand hygiene audits; Visual infusion phlebitis (VIP) score audits, ANTT compliance and anti-microbial audits.

164. Family Care Division fully supports the IPC policy, procedures and Corporate Team; monthly updates are shared via our IPC link nurse at monthly quality and safety board meetings. There is a designated matron who represents family care at the IPC committee meetings providing a deputy if unable to attend. All relevant feedback and actions are shared with other matrons to disseminate widely within each speciality.
165. We welcome as a division the IPC team for walk rounds, audits, observations and feedback to improve the principles of infection control where required. FC IPC link has visited all areas within division to update IPC leads in each area the recent IPC workbook and any good practice within environments, this has been extremely beneficial where space is limited in some clinical areas. One example over the last year has been the postnatal ward where capacity has been reduced, the IPC matron completed a bespoke walk around to support scope and enable best practice with IPC practices with leads in the area.
166. Within Division, we actively encourage the nursing, midwifery, support, medical and administration staff to actively prompt poor practice or dress code, in respect of infection prevention. Difficult or sensitive issues if apparent have been supported by the IPC team to support and achieve a resolution if required. There is a multi-professional collaborative approach within the division to prevent, support and do everything possible to prevent an infection occurring with any woman, new-born or child.
167. This collaborative approach is also evidenced by IPC being part of regular ward meeting agendas, nursing and performance framework templates and any improvement plans including general measures, wound care, line care and antibiotic stewardship. We have as a division managed to roster plan attendance for IPC leads at monthly IPC liaison group meetings in order to improve attendance and share up to date information received.
168. Bed and cot and incubator mattress audits remain well embedded within the division alongside audits of patient and infant wedges and resuscitaires. Within NICU, transitional and postnatal ward areas the bespoke designated template devised have provided more accurate assurances of mattress compliance. With external input a tool has been devised which is fit for purpose for both cot mattresses and incubator mattresses including wedges which are used just within the NICU environment in order to measure accuracy of the audit. Family care departments deliver mattress compliance rates on a monthly basis which is monitored through the directorate

Quality and Safety Boards. The method for cleaning static mattresses and bed frames information is clearly available to all staff.

169. Water flushing is also now well embedded as part of routine practice in all departments in accordance with the relevant ELHT - water testing policy. Including non- clinical areas and offices.
170. Paediatrics and neonatology are recognised within the division as areas of higher risk due to the level of care and invasive treatment infants and children require. With this rationale both areas of expertise have a dedicated multi-professional team who meet monthly with the consultant microbiologist and IPC team. Both areas also have designated IPC consultant lead that attend the MDT meetings and complete any improvement plans supported by minutes. A more robust approach to monitoring MDT training has been adapted where a designated person monitors our ANNT compliance for long standing medical staff and Consultants within Obstetrics. All Drs on rotation receive this training as part of their Induction to ELHT.
171. Family Care Division will continue to monitor infection prevention and control issues and completion of any action plans through the directorates Quality and Safety Boards. Minutes of these will be on the agenda for the directorate speciality boards the Divisional Management Board and discussed if necessary. Any breaches with IPC will be treated as a serious matter and managed with appropriate escalation and action.
172. The compliance reports and relevant exceptions will continue to be populated by the IPC leads in each department with assurance from the ward and department manager, matron and the medical infection control leads where required. Nursing and assessment performance framework (NAPF) or Patient-led assessments of the care environment (PLACE) infection prevention issues highlighted will also be monitored with the same approach demonstrating assurances through the rolling action plan.

Diagnostic and Clinical Support Division

173. Relevant directorates within DCS complete monthly HH and HII audits and complete the ANTT training. A number of areas within the Division have had patient safety walkrounds/ PLACE/PEAT assessments.
174. Any learning is shared across the relevant teams. Action plans are put in place for areas of low or non-compliance.

175. Infection control is a standard agenda item on directorate and divisional governance meetings and on weekly Share to Care meetings, throughout the division.
176. DCS supports the Infection Prevention Team and the OPAT Service within the Division.
177. Water flushing is now routine practice in all directorates with compliance rates submitted monthly.
178. Mattress audits are undertaken in relevant directorates with compliance rates submitted monthly.
179. The Division has had no representative on the IPC committee until December 2017. Improvements will be made going forward now a representative has been appointed.

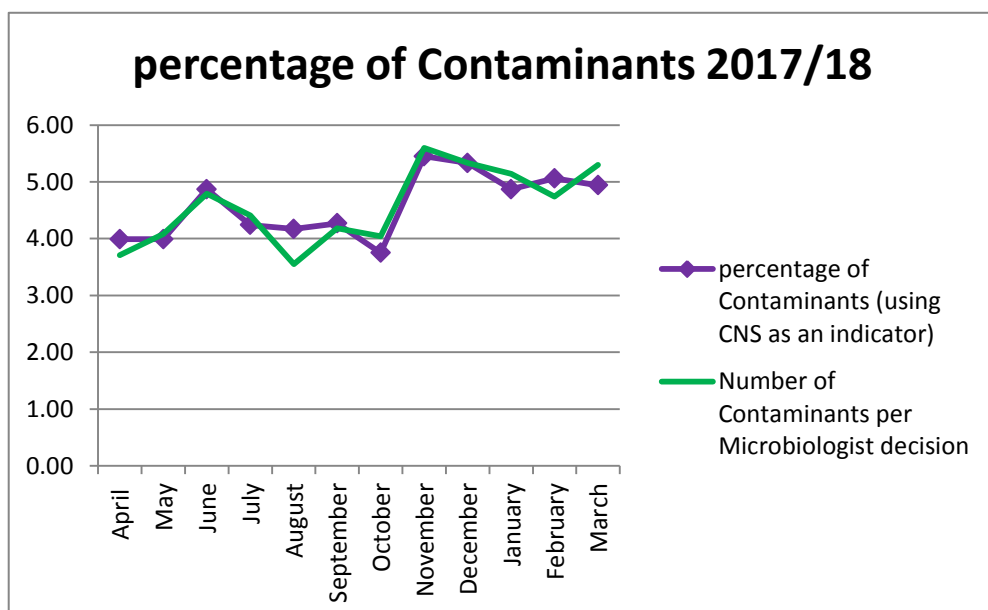
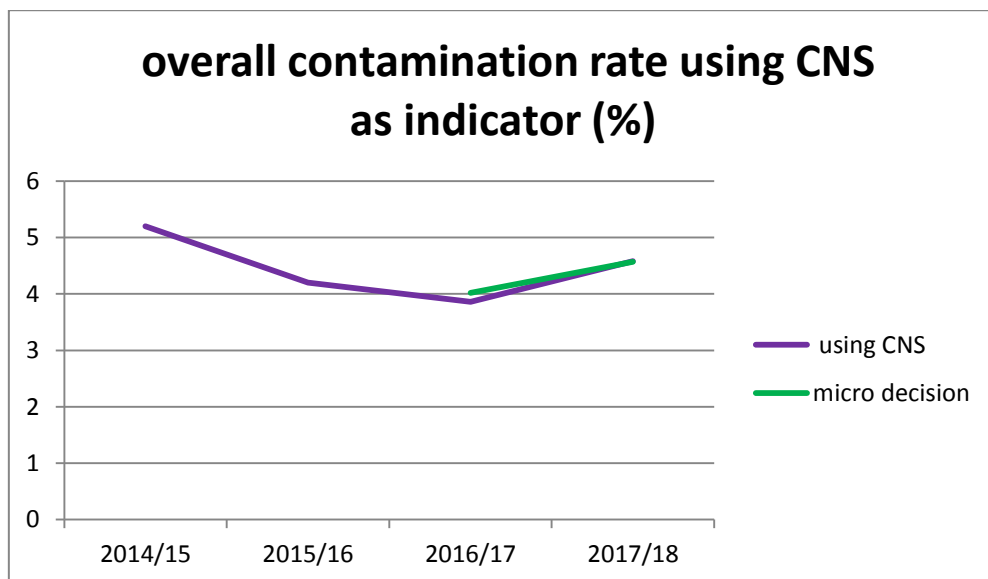
Infection prevention audits

180. The IP&C Nursing Team are regular members of the Nursing Assessment and Performance Framework ward audit team, Patient Environment monitoring audit team. Action plans are returned to areas to action and monitored within Division and reported to IPC.
181. The IP&C Nursing Team have completed the audit programme as per last year's HCAI Plan and provided reports to the IPC with recommendations for Divisions.
182. Community Services within Integrated Care Group have Infection Prevention and Control Audits undertaken to check compliance against ELHT policies within the community setting. From April 2017 8 external sites were audited. Within these centres there have been a total of 39 services have been audited.
183. A wide range of services have been audited. Examples of these include District Nurses, Podiatry, Treatment Room Services, Diabetic Retinal Screening Services, Anti-Coagulation clinic, Continence Team, Orthoptist and Domestic Services.
184. Audit results are reported to individual service teams. The Infection Prevention and Control Team offer support and advise to all Community services to raise awareness in relation to Infection Prevention and Control issues and assist community teams in implementing change.

Blood culture contamination audit

185. The blood culture audit is reported via the monthly HCAI report giving individual ward feedback

186. This rate is calculated using the Consultant Microbiologist clinical decision on contaminants this is also compared to the previous indicator of Coagulase Negative Staphylococcus (CNS).
187. In November 2017 blood culture packs were made available to all areas from the Medical Equipment Library that had all requirements in a bag along with guidance of the taking of blood cultures and stickers to aid documentation. Further information has been supplied to areas to ensure that these kits are being used correctly. A competency document has been developed and annual competency assessments are now expected from all staff taking blood cultures.



Sharps audit

188. Safe handling and disposal of sharps is a vital component of the Universal (Standard) Precautions approach to reduce the risk of injury and/or transmission of blood borne virus in the work place setting. With many health care workers using sharps in their everyday practice, it is important that correct use and disposal is of a high standard to safeguard both the staff and patients/visitors to the Trust or during care/intervention.
189. Sharps, which are handled incorrectly and not disposed of adequately, have the potential to cause injury.
190. Daniels Health Care representatives (audit Team) conducted a site survey with the aim to:
- Raise sharps awareness
 - Assess practice
 - Discuss problems
 - Advise on compliance to current legislation
191. 179 Wards/Departments were visited during the audit and 1203 sharps containers were sighted over 5 sites.
192. The audit found:
- 0** Sharps containers with protruding items.
 - 0** sharps containers incorrectly assembled.
 - 18** sharps containers with non-matching lid and label.
 - 5** sharps containers with items above fill line.
 - 3** sharps containers sited on the floor or at an unsuitable height.
 - 754/1203** sharps containers on brackets or in Mobiles holders
 - 26** sharps containers unlabelled whilst in use.
 - 121** sharps containers with significant inappropriate contents.
 - 70** sharps containers with temporary closure not in use
 - 102/179** small sharps containers are available for point of use disposal
 - 11** sharps container on the crash trolley were not empty
 - 15** containers were in use for more than 3 months.
 - 108/179** small sharps containers available
192. There has been an overall improvement in compliance to policy which will protect staff and patients; although staff do need to ensure that sharps bins are labelled and

that they do not contravene the waste policy and therefore put the Trust at risk of noncompliance with the Waste regulations by putting inappropriate items in the sharps bins.

193. Actions have been implemented within Divisions to ensure compliance to the policy.

Urinary Catheter audit

194. The Urinary catheter policy was updated and reintroduced in August 2017, and included the use of an amended version of the catheter tracking tool. This tool was introduced to reduce the incidence of urinary catheter related blood stream infections and support the Government initiative to reduce Gram-negative bloodstream infections by 50% by 2021.

195. The Infection Prevention & Control Team (IPCT) undertook a Urinary Catheter Audit in November 2017 to measure current practice and policies for urinary catheterisation and catheter care against the standards and to measure the quality of urinary catheter care.

196. 16 wards were audited across 5 sites. The object of the audit was to identify compliance regarding the urinary catheter policy including the use of the catheter tracking tool across all Divisions within the Trust.

197. The audit found that:

- a) Wards with the catheter tracking tool in use were not all using the new version.
- b) Theatres, ED and AMU do not regularly use the tracking tool when catheters are inserted initially in these areas.
- c) Not all staff are aware of the catheter passport.
- d) Not all staff give 7 days catheter hospital to home packs on discharge for long term catheters; some only give 3 days. Not all staff are aware of the process of ordering the catheter home discharge packs.

198. Actions have been implemented within Divisions to ensure compliance to the policy.

Diarrhoea audit

199. National guidelines around identification and treatment of Clostridium difficile infection highlight the importance of sending stool samples promptly when a patient presents in hospital with diarrhoea and when an infective cause is suspected.

200. The Infection Prevention Team undertook a Diarrhoea Audit in October 2017 to determine whether patients who reported diarrhoea were having stool samples sent to the laboratory and if the patients were being isolated within 2 hours of sampling.
201. The audit showed that some improvements appear to have occurred since the previous audit. Significantly, staff seem to be better at deciding if a person has non-infectious loose stools or not; this has increased from 23% to 70%. The audit also shows improvement in the total number of patients being isolated overall with loose stools and an increase is also seen in the numbers of patients being isolated immediately and/or on admission.
202. This may be as a result of implementation of a sticker attached to the faecal sample pots to be put in notes prompting isolation.
203. Documentation remains an issue with room for improvement. Several instances were found where patients had reported loose stools but there was nothing found in the notes/charts.
204. The stool chart has now been reviewed and incorporated in the daily intentional rounding booklet to be completed on a daily basis.

Commode audit

205. The monthly commode audit is undertaken by the Infection Prevention Matrons, wards are informed immediately of any failure and results fed back to divisions monthly via the DIPC report.

Mouth care audit

206. Poor oral health has been associated with systemic disease, mortality and morbidity. Many patients in hospitals are physically compromised and therefore need assistance maintaining and improving their oral health.
207. The Infection Prevention & Control Team (IPCT) undertook a Mouth Care Audit in January 2018 to measure current practice for mouth care and compliance with the mouth care for patient's policy (CP01 v1).
208. A total of 83 patients on 13 wards across all five hospital sites were audited; 9 wards from ICG and 4 from SAS.
209. The audit found that:
 - a) There is evidence that staff are providing mouth care for patients with 96% of patients who could not manage their own mouth care receiving assistance from staff.

- b) Although the wards were well stocked with oral hygiene products not all patients were offered these on admission and 17% of patients with dentures did not have a denture pot.
 - c) There was a large number patient that did not have their oral hygiene needs assessed on admission.
 - d) Only 28% of patients had a completed mouth care assessment in the GAD with the majority of staff saying they did not know about the assessment tool.
 - e) There was some inconsistency where mouth care was recorded.
210. Following presentation at IPC, Divisions have taken actions to improve care. The policy is also being reviewed in light of findings.

E. coli blood stream infections source due to Hepatobiliary audit

211. A deep dive of 20 cases of E. coli with likely source being hepatobiliary was undertaken to aid achieving the reduction in cases across the health economy.
212. The audit showed that:
- a) 12/20 had no health care interactions in the last 28 days (Community onset, non-health care associated)
 - b) 6/20 had recent admissions(in the last 28 days) or lived in nursing home (Community onset, health care associated)
 - c) 2/20 developed BSI post 2 days of admission; however both had underlying pathology and developing conditions from admission. (hospital onset, health care associated)
 - d) 13 patients were first presentation with the symptoms to East Lancashire Hospitals Trust.
 - e) 1 patient had a second blood stream infection after 20 days of first sample.
213. NICE guidance (CG188) highlights a variation in how gallstone disease is managed and provides recommendations how it should be identified, diagnosed and managed in adults.
214. It highlights that laparoscopic cholecystectomy should be offered early (to be carried out within 1 week of diagnosis) to people with acute cholecystitis.
215. A quality improvement project has already been undertaken on STU to reduce the number of patients with biliary colic being admitted by improving the patient pathway.
216. A further audit planned looking at compliance with NICE guidance across both surgery and medical patients to give a more accurate picture across the Trust.

National PLACE Assessment 2017

217. Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent/ private healthcare sector in England. The self-assessments are carried out voluntarily and were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which ran from 2000 – 2012 inclusive. These are the fifth results from the revised process.
218. PLACE aims to provide the principles established by NHS Constitution that focus on the following areas:
- a) Areas that matters to patients, families and carers;
 - b) Putting patients first;
 - c) Actively encouraging feedback from the public, patients and staff to help improve services;
 - d) Adhering to basics of quality care;
 - e) A commitment to ensure that services are provided in a clean and safe environment that is fit for purpose.
219. The programme encourages the involvement of patients, the public and bodies, both national and local, with an interest in healthcare (e.g. Local Health watch) in assessing providers. This is done in equal partnership with NHS staff to both identify how they are currently performing and to identify which services can be improved for the future.
220. In 2016, the assessments highlighted for the first time how well the premises from healthcare providers are equipped to meet the needs of people with disabilities. Note that the results collected don't represent a comprehensive assessment relating to disability but rather on a limited range of aspects with strong environmental or buildings associated components.

Principles

219. The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care. The non-clinical activities of concern are:-
- a) Cleanliness;
 - b) Food and Hydration;
 - c) Privacy, Dignity and Wellbeing (*the extent to which the environment supports the delivery of care with regards to the patient's privacy dignity and wellbeing*);

Safe | Personal | Effective

- d) Condition, Appearance and Maintenance of healthcare premises;
 - e) Dementia (*whether the premises are equipped to meet the needs of dementia sufferers against a specified range of criteria*).
 - f) Disability (*the extent to which premises are able to meet the needs of people with disability against a specified range of criteria*)
220. The criteria included in PLACE are not standards, but they do represent aspects of care which patients and the public have identified as important. It also represents good practice as identified by professional organisations whose members are responsible for the delivery of these services.
221. The Place assessment results are shared with the Care Quality Commission and NHS England, who will use the information in discharging their responsibilities for monitoring and reporting on Trust performance.

National PLACE Assessment 2017 – Timescale for delivery and reporting

220. National PLACE Assessment period between **27th February 2017 – 2nd June 2017**
221. Data Submission by **26th May 2017** to HSCIC EFM System (NHS Digital)
222. Final National PLACE Assessment 2017 publication date is **15th August 2017 – 9:30am**

National PLACE Results 2017 - Publication

223. The national PLACE Results publication was release on the 15th August 2017 at 9:30am.

NHS Digital Link to Publication Results 2017:

<http://content.digital.nhs.uk/pubs/place17>

224. The Trust has displayed ELHT results and PLACE Strategy Improvement Plan 2017 / 18 on the ELHT website (Under Patients / Patient Experience and PLACE section).

<http://www.elht.nhs.uk/patients/place.htm>

ELHT National PLACE Assessment 2017 Organisational Results

RXR - East Lancashire Hospitals NHS Trust - Organisational Results 2017												
YEAR	Org Code	Organisation Name	Organisation Type	Commissioning Region	Cleanliness	Food	Org Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia Friendly	Disability
2017	RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	ACUTE - LARGE	NORTH OF ENGLAND COMMISSIONING REGION	95.46%	82.32%	81.94%	82.63%	86.83%	92.69%	84.95%	87.15%
National Average					98.38%	89.68%	88.80%	90.19%	83.68%	94.02%	76.71%	82.56%
RXR - East Lancashire Hospitals NHS Trust - Organisational Results 2016												
YEAR	Org Code	Organisation Name	Organisation Type	Commissioning Region	Cleanliness	Food	org Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia Friendly	Disability (New 2016)
2016	RXR	EAST LANCASHIRE HOSPITALS NHS TRUST	ACUTE - LARGE	NORTH OF ENGLAND COMMISSIONING REGION	96.77%	81.78%	77.74%	83.06%	86.41%	93.35%	80.61%	79.40%
National Average					98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

National PLACE Assessment Results - Key Findings from the data 2017:

225. National Average for cleanliness was an increase result of **98.38%** compared to 98.06% in 2016.
226. National Average for food and Hydration was an increase result of **88.68%** compared to 88.24% in 2016.
 1. The organisational food assessment national average was an increase result of 88.80% compared to 87.01% in 2016.
 2. The ward – Based food assessment national average score was an increase result of 91.19% compared to 88.96% in 2016.
227. National Average for Privacy and Dignity and Wellbeing was a slight decrease in result of **83.68%** compared to **84.16%** in 2016.
228. National Average for Condition Appearance and Maintenance was an increase result of **94.02%** compared with 93.37% in 2016.
229. National average of the Dementia Friendly domain was an increase result of **76.71%** compared to 75.28% in 2016.
230. Disability national average was an increase result of **82.56%** compared to 78.8% 2016.
231. Please note that due to changes in the assessment methodology and scoring, the 2017 results for food and hydration, Privacy and Dignity and Wellbeing, condition and appearance, are not considered to be directly comparable with 2016.

ELHT PLACE Strategic Improvement Plan 2017 – 2018 – Investment Plan

232. PLACE Strategic Improvement plan 2017 – 2018 investment allocation is £300k to deliver the high risk elements of the improvement plan for 2017 – 2018, in agreement by the PLACE Group membership and Capital investment board.
233. PLACE Investment has been aligned to the improvements identified and all programmes off work have been completed as per target timeline off March 2018.

Improvement programmes

Patient bedside Lockers (Inclusive of PVD and Medicine management RFID drawer)

234. Investment aligned for completion of standardisation of Patient bedside lockers across ELHT for 2017/ 2018 has been agreed. Pendle Community Teaching Hospital Marsden Ward has received the new patient bedside lockers in January 2018.

Built Environment - (Disability) Lifts in the older ELHT Estate

235. The Estates team are currently undertaking a condition survey on the lifts a BGTH to look at refurbishment requirements to improve the facilities for the patients and public using our Hospital facilities.

Built Environment – (Disability) “Access” Waiting area seating Survey

236. A survey is currently being undertaken across ELHT waiting area, looking at condition, range of heights, seating with and without arms and bariatric availability. The areas will be rated high, low, medium priority which will allow consideration of where investment can be aligned, also identification of further investment requirements for 2018 / 2019.
237. Findings from completion of BGTH survey are as follows:
- a) Condition of seating is aged and numerous areas damaged seating
 - b) Differing heights are not available
 - c) Mixture off seating in a lot of areas which is not supporting best use of the waiting areas

Investment Development

238. At Burnley General Hospital investment has been aligned for replacement off the main waiting area in Lancashire Womens and New Born centre has had full replacement off seating.

239. At Burnley General Hospital investment has been aligned for replacement off waiting area furniture for 8 departments.

Built Environment / Privacy and dignity – Linen Management

240. A new Linen Management procedure has been introduced in line with new national standards (HTM 1040). A system change to plastic bags and new alternative linen receptacle to be used for soiled linen within the Trust, the installation and change programme commenced December 2017 - March 2018.

ELHT Trust Way Finding and Accessibility Strategy

241. The ELHT Trust signage Project Group was established in June 2014, and has been working towards a full review of the external and internal directional signage. The Project delivery plan has 6 work streams - Sub groups feeding in to the project group to ensure the Trust consider all aspects of change required for the ELHT Signage Strategy.
242. The project group has progressed well and currently working towards a design specification and cost analysis to support the capital investment bid for the 3 year ELHT Signage strategy.
243. The design company supporting the Trust with site specific strategy (20 / 20 design) presented the draft proposal for the Royal Blackburn Teaching Hospital Site to the project group which was received positively.
244. The project group has been disbanded until later in the year due to no funding allocation to continue with full installation at RBTH due to pressures on the Capital Investment plan this year. The work continues to progress within the work streams to ensure we are ready for enabling the project for delivery in the near future.
245. The work stream leads will be reportable to the PLACE Group going forward for monitoring of progress and assurance.
246. The following Timeline proposals are currently being worked towards:
- a) RBTH – Investment alignment for Project full delivery – Strategy developed for this site and full specification and cost investment bid is in place. This will be reviewed in February 2018 by the Capital Board for consideration of investment alignment in 2018 / 2019 financial year.

- b) BGTH – 20/20 Survey and design delivery are programmed to commence at BGTH in January 2018 – Feb 2018.

DisabledGo

247. DisabledGo.com is the UK's most popular and trusted Accessibility Checker, used by over 100,000 people every month. The organisation was established in 2000 and works on a not for profit model to deliver a social mission. The service changes lives, tackling social isolation and promoting independence.
248. Founded and developed by disabled people the organisation views comprehensive accessibility information as key to ensuring that disabled people and their families do not face inequality. Working with over 300 partners DisabledGo produces access guides to places people want or need to visit, including services provided by a diverse range of leading NHS trusts. DisabledGo has experience of working with large, multi-site acute trusts comparable to East Lancashire Hospitals NHS Trust.
249. This proposal sets out how DisabledGo and East Lancashire Hospitals NHS Trust could work together to enable DisabledGo's team of specialist surveyors to create access guides to each department, ward and facility at Royal Blackburn Hospital, Burnley General Hospital, Clitheroe Community Hospital, Accrington Victoria Hospital and Pendle Community Hospital. Access guides could also be created on request for any of the Trust's community sites.
250. The surveys and implementation of the access guides have been completed for both Royal Blackburn Hospital and Burnley General Hospital and can be accessed via the ELHT Website.
251. ELHT are currently establishing a project group to develop a communication and education strategy to support staff, public and patients use the information available to them, to improve their patient journey and experience while using our Hospital Facilities.

ELHT Environmental Management Link Nurse

252. Environmental Management Link Nurse is part of the re - launch of the "Link Nurses " model required across the Trust to support effective communication, delivery of key learning information, cascade education information and support the delivery of safe care.

253. The ELHT Environmental Management Link Nurse will support the Divisions drive the quality improvement requirements for the wards / department and importance of management of the environment that we provide patient care to ensure the delivery of safe care.
254. Review of current membership has been undertaken by the Matrons to ensure all area has representation on this group and the membership list is still current.
255. A re- launched of the ELHT Environmental Management Link Worker has been arranged for September 2017. Clinical engagement is being recognised as a requirement to ensure the environment we provide care for our patients in is safe.
256. There has been an increase in attendance and engagement to the ELHT Environmental Management Link nurses meeting in the last quarter since the re launch.

ELHT Dementia Strategy 2015 – 2018 (Launched 6th March 2015)

Dementia Friendly Environments (Aim 3 of the Strategy)

257. As part of the statutory refurbishment programme and the PLACE strategic improvement Plan investment we have completed the following significant work on the ELHT sites during the 2013 / 2015 period. All included the Trust agreed Dementia Friendly Environment principles to enhance the healing environment.
258. Refurbishment Programmes achieved:
259. Royal Blackburn Hospital:
 - a) Ward C6 (Completed 2013)
 - b) Ward D3 (Completed 2013)
 - c) Ward C5 (Completed 2014)
 - d) Ward D1 (Completed 2014)
 - e) Ward B2 (Completed 2014)
 - f) Ward B8 (Completed 2014)
 - g) Ward B6 (Completed 2015)
 - h) Ward C11 (Completed 2015)
 - i) Ward C9 (Principles applied Completed 2015)
260. Burnley General Hospital (2014- 2015)
 - a) Rakehead Garden
 - b) Rakehead Sun room / Conservatory

- c) Patient Kitchen Upgrade
 - d) Decoration Programme throughout the unit
 - e) Up Grade of treatment room and dirty Utility
261. Pendle Community Hospital: (2013 – 2014)
262. Ward refurbishments in relation to the Dementia Friendly Principles
- a) New Handrails
 - b) Decoration programmes
 - c) Upgrade of dirty Utilities
 - d) Up Grade of Public toilet areas
263. Clitheroe Community Hospital: (2014- 2015)
264. New Hospital build opened May 2015 – Dementia Friendly Environment principles embed throughout the Hospital and Ward areas.
265. The Dementia Friendly Environment principles that have been embedded within the organisation on the wards have enabled the trust provide an enhanced experienced in 272 patient beds spaces across ICG, which is an excellent achievement.

Project Completion (Quarter 3) (September - December 2017)

266. There has been some excellent work being carried out in Quarter 3 around Enhancing the Healing environment which will and is currently supporting an enhance patient Experience whilst using ELHT Hospital Facilities.
267. Enhancing the Patient Experience – Courtyard – Charitable Project (£15k Charitable project) “The T Garden” **Completion October 2017**
268. Enhancing the Healing Environment – Chemotherapy Department RBTH **Completion September 2017** - Charitable Projects (Teenage Cancer services – Adolescence room and Enhance Healing Environment “art work”)
269. Enhancing the Healing Environment – New Development Chemotherapy Department BGTH – **Completion December 2017**
270. Enhancing the Healing Environment – Waiting Area Ward 15 BGTH Completion January 2018
271. RBTH Enhancing the Healing Environment - Ward C14 Enhance Recovery – Day room – **Completion March 2018**

Water Committee

272. Whilst Healthcare premises are dependent upon water to maintain hygiene and a comfortable environment for patients and staff, and for clinical and surgical care, they also house vulnerable patients at risk of exposure to Legionella or Pseudomonas.
273. The main risks of unsafe water are:
- a) Failure to flush underutilised outlets regularly
 - b) Contamination of clinical hand wash basins
 - c) Dead legs on the system.
274. Actions to address this include:
- a) Monitoring of water temperature (hot and cold)
 - b) Design of buildings to remove dead legs (lengths of unused pipework)
 - c) Flushing of underutilised outlets
 - d) Descaling of shower heads
 - e) Appropriate cleaning of outlets
 - f) Microbiological monitoring when needed for when storage and distribution temperatures do not achieve those recommended under the temperature control regimen or those areas housing high risk immuno-compromised patients (Augmented care areas such as Critical Care/NICU/haematology)
275. The Water Safety Committee has:
- a) Reviewed the Water Policy. It has been made simpler and clearly identifies ward/department managers as responsible to flush all outlets twice weekly.
 - b) Developed a Water safety plan
 - c) Instigated documentation completion on flushing which is to be reported through Divisions to Infection Prevention Committee
 - d) Highlighted to staff regarding NOT using clinical hand wash basins for waste water and ensuring patients use wash bowls.
 - e) System instigated where Estates/PFI will report to Infection Prevention Team if outlet blockages are thought to be from staff emptying down a clinical hand wash basin
 - f) As a standard agenda item the temperature monitoring to be reported by Estates and PFI partners by exception to water committee (none reported).
 - g) Testing results to be reported to Water Committee
 - h) Reviewed tank capacity across all sites
 - i) Started to undertake schematic drawings of all pipework across the Trust to identify dead legs and remove where possible.

Issues highlighted 2017-18

276. *Pseudomonas aeruginosa* was identified in taps within NICU. Appropriate actions were taken in isolating, flushing and disinfection. Other actions taken were to review cleaning process, undertake gelling of hands after washing. On retesting this has proved difficult to gain 3 consecutive negative results across the unit. Further work was undertaken around cleaning and it was found that due to sensor taps being fitted to the sinks cleaning was compromised. Actions were put in place for domestic staff to access the water supply and switch it off prior to cleaning. This appears to have been effective and we have now had 9 months of clear results. Switches are now being fitted to all IPS panels where sensor taps are fitted across the Trust to ensure that effective cleaning occurs.
277. Renal unit AVH have had outlets in November and January showing *Legionella*. Appropriate actions were taken in isolating, flushing and disinfection. Other actions taken were to review cleaning training and increase cleaning frequency. We have now had one clear result in the unit but are monitoring the situation closely.
278. One of the outstanding issues on the water plan is for ELHT to employ an Authorising Engineer (Water). Quotes have been obtained and forwarded to the Divisional General Manager for Estates and Facilities. Members have considered using the PFI Authorising Engineer so that consistency is maintained. The Committee is awaiting decision on this appointment.

Antimicrobial Stewardship Committee

279. The Antimicrobial Stewardship Committee (ASC) meetings continued throughout 2017/18 chaired by a Consultant Microbiologist and supported by the Antibiotic Pharmacist. It was attended by Consultants from other specialties when required. An East Lancashire CCG representative joined the committee and attends on a quarterly basis to ensure good communication and team working between both primary and secondary care settings.
280. The Committee continued to work with Consultant colleagues to write and update guidelines related to their specialty when new national guidelines were published.
281. The Antimicrobial Resistance CQUIN formed a large part of the work plan for 2017/18. Guidelines were amended to support achievement of the CQUIN in conjunction with specialist clinicians in those areas.

282. ASC continues to support the Trust OPAT programme and individual cases are discussed on a weekly basis at a multi-disciplinary team meeting. The pharmacy team have supported the OPAT team in the use of continuous infusion devices which has allowed more patients to be discharged onto the service.
283. The ASC published a new antimicrobial app in late November 2016 which makes access to the guidelines easier for staff across the organisation. Development of the app continued in 2017/18; changes included the addition of sepsis bundles, paediatric and obstetrics/ gynaecology guidelines.
284. ASC took part in Antibiotic Awareness Week and promoted the Antibiotic Guardian Campaign to improve Antimicrobial stewardship. Social media was used to promote good antimicrobial stewardship to members of the public as well as Trust staff.
285. The ASC has also been involved in teaching to many groups including clinical leaders, Medical Grand Round, FY doctor training, medical students, anaesthetic trainees, pharmacists and practice educators around the safe use of antimicrobials.
286. A programme of junior doctors' antibiotic audits was developed and quarterly audits started in 2011, this continued in 2017/18. This information is disseminated on a quarterly basis via the DIPC report to divisions and the report is presented at Patient Safety and Risk Assurance Committee.
287. The once daily gentamicin guidelines for use in adults outside of critical care have been updated to incorporate an online dosage calculator and more robust level monitoring guide, in attempt to improve the safety and appropriateness of gentamicin prescriptions. An audit is ongoing to assess the impact of the guideline on prescribing accuracy.
288. The ASC provide support on a number of quality improvement (QI) projects including surveillance of broad spectrum, restricted antimicrobials, penicillin allergy documentation and gentamicin management.
289. In line with NICE guidelines, the ASC have introduced new antimicrobial agents to the formulary, to expand available treatment options for multi-drug resistant organisms.

Outpatient parenteral antimicrobial therapy (OPAT)

290. During the period of April 2017 to April 2018 the OPAT Team assessed a total of 654 patients for suitability to be discharged onto the OPAT service.
291. 464 patients were not deemed suitable for a variety of reasons such as being medically unstable or lifestyle choices which would result in an unsafe discharge.

292. A total of 190 patients were discharged onto the OPAT service.
293. This saved a total of bed 2761 days and a total of £642,170 in bed day savings.
294. Due to absence the OPAT service will have reduced capacity in the coming weeks. The District Nursing Teams have been informed and contingency plans have also been put in place for annual leave.
295. The Pharmacy Team is also in the process of changing the Homecare provider after Calea is ceasing to provide this service from 01/05/2018.

Training activities

296. The Learning and Organisational Development Department provides training for all wards and department across ELHT. The Clinical Activities Support Team (CAST) continues to promote and support Infection Prevention in various ways across several subject areas and is very much about:
- a) reducing harm and improving safety,
 - b) enhancing patient experience,
 - c) embedding a continuous learning process across the whole health economy
297. Over the last 12 months (1st April 17 – 31st March 18) the training activities have included the following:

Core Mandatory Training (CMT)

298. Programme for Infection Prevention and Control is part of the Trust Learning Hub Core Skills Framework accessible on line for all trust employees. All staff are required to undertake level one training annually, those staff caring for patients clinically must undertake level two (which now includes level 1). Included within the training is hand hygiene, wearing of personal protective equipment (PPE), waste management including clinical sharps and inoculation injuries, cleaning equipment and the environment, isolation, MRSA screening and prevention of bacteraemia, reduction of Clostridium difficile, the antimicrobial prescribing policy and Aseptic Non Touch Technique (ANTT). All managers are responsible for their own areas ensuring all staff remain compliant with Trust CMT.
299. Trust Corporate Induction (2 day event) includes time for all new staff to complete the Trust CMT on line. A practical hand hygiene assessment is no longer undertaken as part of this induction and must be undertaken in the local induction.

Junior doctors (foundation years 1 and 2) Induction ensured a 100% compliance with an update of hand hygiene. This included assessing their technique using the training gel with the glow box.

Aseptic Non Touch Technique (ANTT) and Blood Culture Collection

300. Aseptic Non Touch Technique is promoted constantly on all relevant training programmes delivered by the Clinical Activity Support Team, such as- venepuncture, cannulation, Intravenous therapies and urinary catheterisation training.
301. ANTT assessments are undertaken as necessary (dependent upon numbers and time permitting) within the venepuncture and cannulation training sessions. All staff are reminded of their responsibility and the importance of adhering to Trust policy and must ensure their ANTT assessments are up to date.
302. Part of the cannulation and IV therapies events includes training on the completion of relevant care plans, VIP score and the safe use of the invasive device, including correct application of film dressing, management and record keeping with regard to PosiFlush and flushing.
303. The FY1's ANTT assessments were completed using the collection of blood cultures; supporting the Trust actions in reducing contaminants at the same time undertaking product familiarisation training. Over 90% of the ANTT assessments were completed in the first 3 weeks of joining the Trust. All medical students are required to provide proof from their original base of attendance at IP&C and ANTT training. All FY2's completed a reminder of the importance of adhering to ANTT and their role in challenging staff failing to comply with best practice.
304. Various wards and departments request assistance with ANTT assessment sessions and these are delivered at source as required. Areas include for example AMU A & B, both Urgent Care Centres, Emergency Department, Wards B24, C1, C3, C10, C14b, D3, Reedyford, Occupational Therapies hand team, Paediatric medical staff, The Clinical Activities Support Team have supported several wards with ANTT and Hand Hygiene issues particularly when related to NAPF reports.
305. All clinical staff undertaking procedures where the bodies natural defence mechanisms is or has been breached must ensure they have an in date annual ANTT assessment. Having completed assessment staff must update and self-declare their own training records. The yearly assessments for individual staff members should be monitored at appraisal by line managers. Each ward/department must report on a monthly basis their ANTT assessment status as part of the division's

infection control performance data and exception report, a requirement for the Infection Prevention Committee.

306. Blood Culture Collection Training Sessions have been delivered to several groups of staff within Emergency Care, including the Urgent Care Centres on both main sites. This is raising the profile of best practice to prevent contamination of blood culture samples. The sessions covered theory based on Department of Health guidelines and included introduction to ELHT Blood Culture Collection pack and practical skills training.
307. Training for the Collection of Blood cultures has been delivered to groups of staff on STU and AMU A&B raising the profile of best practice to prevent contamination of samples. The session covered theory based on Department of Health guidelines and included practical skills training and assessment.
308. Blood Culture training sessions were delivered to the phlebotomists ensuring staff understand the importance of best practice, how and why to avoid contamination of the sample. Hand hygiene with the glow box and ANTT assessments were completed at the time.

Peripheral Intravenous Cannulae

309. Work has continued around promotion of correct application of peripheral IV cannula site film dressings. The training includes highlighting staff to changes to ELHT SOP 008 Standard Operating Procedure for use, insertion, care, maintenance and removal of a Peripheral Intravenous cannula. Medical, nursing and allied health care professionals all need to be aware the Peripheral Intravenous Care Plan has been updated in line with EPIC 3 guidance. The training is to ensure all staff understand that inadequate stabilisation and securement of the device (that is inappropriate application of the peripheral IV film dressing) can result in an increased infection risk. Staff applying the dressing must firstly clean the skin correctly, to reduce the possibility of patients developing an HAI. Ensure the dressing is applied properly securing the cannula correctly to help prevent both mechanical and bacterial phlebitis. This will prolong the life of the cannula safely so enhancing patient experience and helping to prevent HCAI's.

Preceptorship Programme

310. Preceptorship Programme for newly registered nurses and international nurses supports and promotes essential IP&C practices covering topics like:-

- a) IP&C back to basics, standard precautions, ensuring cleaning and decontamination is promoted protecting the patient and the environment
- b) IV therapies and injectable medicines
- c) Venepuncture and cannulation
- d) Nutrition and food hygiene
- e) Harm free care reducing HCAI's appropriate use and administration of anti-microbial, admission screening, specimen collection, monitoring changes in condition, caring for the isolated patient

Other Training

- 311. Neonatal (NICU) IP&C training for medical staff on induction continues 3 times a year.
- 312. Other Training covering IP&C Standard Precautions, essential IP&C topics and ANTT. This includes the understanding of how HCAI's occur and what practices are required to try and prevent the likelihood of them spreading is covered at various levels dependent upon the relevance to staffs roles. The majority of training sessions include hand hygiene practices and technique assessment with use of the Glow Box. The training provided is delivered to; - Nursing cadets, student nurses, and volunteers. Radiology students IP&C training dedicated for specific areas is delivered as requested by departments for example domestic and laundry services, general practitioners delivering care to patients in the community hospitals.
- 313. Infection prevention training for the American University of California medical students was delivered highlighting the importance of hand hygiene with the use of the glow box and all IP standard precautions. Clinical skills- venepuncture and cannulation also included product familiarisation for the Nexiva closed system cannula for IV access, PosiFlush and blood culture collection set. ANTT was included and an assessment of practice completed.
- 314. Food hygiene training is delivered to staff as requested including regular session delivered to cadets and volunteers.
- 315. Hand hygiene assessments and monitoring with the use of the glow box has been undertaken within several areas for example Theatres, Emergency Dept, Urgent Care Centres, NICU, various wards particularly when delivering ANTT support. Some liaison members have regularly borrowed the glow box to use for training purposes.
- 316. Face Filtration Particle (FFP) 3 mask fit tester training continues, in order to support wards and relevant departments so they have cascade fit testers within their specific

areas. This is to ensure staff are fit tested appropriately for their protection when caring for certain patient groups.

317. The children's community assisted ventilation service team have had several IP&C training sessions including hand hygiene technique using the glow box and ANTT updates.
318. In line with DoH and national guidance promoting the Healthcare Assistant care certificate, the Healthcare Assistant Induction day has been delivered on a regular basis. This includes essential IP&C aspects when caring for patients activities of daily living. These activities include staff having an understanding of how to ensure IP&C standard precautions are adhere to constantly whilst attending to all patient's needs. The day also includes a session on nutrition and food hygiene.
319. All newly employed substantial posts HCA's must attend the induction day and the day is also being used as a refresher for established staff.
320. Across ELHT training promoting best practice in relation to peripheral IV cannula care. Medical, nursing and allied health care professionals all need to be aware the Peripheral Intravenous Care Plan has been updated in line with EPIC 3 guidance. The training to ensure all staff understand that inadequate stabilisation and securement of the device (that is inappropriate application of the peripheral IV film dressing) can result in an increased infection risk. Points raised included
 - a) Changes to the care plan
 - b) Skin disinfection
 - c) Correct application of dressing to both secure and protect the device
 - d) Correct flushing to prolong the life of the cannula
321. Clinical observation was undertaken in several areas monitoring practices correcting areas of concern and or staff worries. This is to:
 - a) Promote and support best practice in order to ensure safe effective care is delivered at all times to our patients.
 - b) Ensure wards departments and staff are equipped with the skills and knowledge required to undertake appropriate care.

The Multi-Disciplinary IP&C Liaison Group

322. Training continues to be a high priority for the IPCT. The multi-disciplinary liaison groups (acute and community) meet every month and has an active participation from a variety of wards, services and departments. There are 278 members from areas across the Trust. The liaison group members cascade information back to the

wards, services and departments and are the primary link between the department and the IPCT. They have provided one to one hand hygiene training for every member of the ward/dept team, participated in Infection Prevention & Control audits, monitored the infection prevention practices on their areas.

323. The meetings cover a wide range of Infection Prevention & Control issues including the following topics:
- a) Annual Infection Prevention and role of liaison member Presentation
 - b) Hand Hygiene Training/5 Moments of Hand Hygiene
 - c) Urinary Catheter Care
 - d) Risk Assessment
 - e) Waste Audits
 - f) Basic Infection Control Practices
 - g) Carbapenemase Producing Enterobacteraceae
 - h) Managing Outbreaks
 - i) Reduction of Gram Negative Bacteraemias
 - j) Sharps and Good Practice
 - k) Waste Management
 - l) Laundry Management
 - m) Scabies
 - n) Winter Viruses
 - o) Influenza

Infection prevention study day

324. The Infection Prevention and Control Team held a successful half day study day in the auditorium at RBTH on the 6th October 2017. There were 98 attendees which included all members of the multidisciplinary teams.
325. Topics covered included:
- a) Beverley Aspin, Lead Nurse for Infection Prevention & Control discussed the issue of antibiotic resistance and how we may need to start looking at alternative medicines such as probiotics, symbiotics, faecal transplants.
 - b) Andrea Stewardson, Health Protection Nurse Practitioner discussed varicella and measles and highlighted the importance of vaccination programmes in helping to prevent outbreaks.

- c) Phil Denney, Head of Occupational Health & Wellbeing discussed how staff health can affect patient care and the importance of following protocol for the reporting of needlestick/splash incidents, seeking advice for skin conditions, flu vaccinations, reporting symptoms of sickness/diarrhoea.
 - d) Kirsty Holt, Infection Prevention Matron discussed the management of a CPE outbreak on one of the acute wards from earlier in the year.
 - e) John Mannion, Infection Prevention Matron gave an insight into healthcare ventilation and how it can help protect staff and patients from harmful organisms and toxic substances.
 - f) Vanessa Morris, Lead Nurse for Infection Prevention & Control ELCCG discussed Ecoli and other Gram Negative blood stream infections in the acute and community setting.
326. Stands were displayed promoting infection prevention and heightening awareness of topics such as hand hygiene, taking appropriate blood cultures using the new blood culture packs, ANTT and waste, as well as displays from Company representatives showcasing new and existing products. Occupational Health and Wellbeing were also offering flu vaccinations during the lunch break. All attendees were automatically entered into a free raffle which was drawn at the end of the event.

Courses and CPD Activities

327. During 2017/18 the Infection Prevention Team attended the following courses and conferences in addition to mandatory update training for the Trust:
- a) IC Study Day – RBH
 - b) IPS Northwest Conference, Ewood Park, Blackburn.
 - c) Band 7 Leadership Development Programme
 - d) ICNet training
 - e) PLACE training
 - f) Retirement Planning Seminar
 - g) Basic IPN training
 - h) Management of an Infection Prevention Service, University of Manchester
 - i) Team Leader course
 - j) ILM course
 - k) IPS branch meetings including education sessions
 - l) Adair training

- m) Authorised Person Practical water safety for health care premises, Eastwood Park
- n) Performance Improvement Network event (GNBSI reduction), Manchester
- o) IPS Conference, Manchester
- p) Don't Panic Conference, Sheffield
- q) WebEx ICNet updates
- r) WebEx reducing HCAI GNBSI
- s) AMR Scotland Conference, Glasgow
- t) Decontamination of Reusable invasive Endoscopes, Anglia Ruskin University
- u) Finance training
- v) Post Graduate Diploma, in Infection Control, University of Essex
- w) NW Regional Infection Group

Work plan 2017/18

328. The team continued to work hard to reduce the number of healthcare associated infections and along with Divisional Leads have implemented the following actions over the year to this effect:

- a) reinforced the ownership of infection prevention in divisions
- b) Strengthened the Infection Prevention Committee membership
- c) Involved Medical staff in post infection reviews and shared learning
- d) Review of the use IC surveillance software to include use for audits.
- e) Improved identification of patients with suspected/confirmed organisms/ conditions on the EPTS
- f) Back to basics and hand hygiene training undertaken by IC Liaison Members supported by ICNs
- g) Blood culture audits
- h) Trust wide mattress audit undertaken
- i) Monthly commode audits with results fed back to Divisions.
- j) PIRs undertaken on all C. difficile toxin positives identified in the laboratory and discussed across the Health Economy.
- k) Review of antimicrobial formulary
- l) Input of antimicrobial formulary to the app
- m) Antimicrobial audits
- n) Increase use of glo box for ward/dept training
- o) Undertaken regular mystery shopper hand hygiene audit

- p) Manned hand hygiene stands at main entrances
- q) Held annual infection prevention study day
- r) Provided Infection Prevention advice to Divisions/Estates on buildings/ refurbishments
- s) Incorporated a daily stool chart into the intentional rounding booklet
- t) Published a urinary catheter policy incorporating the use of a tracking tool and catheter passport for patients with long term catheters.
- u) Completed monthly MRSA screening audits

Appendix 1: Recent Publications Affecting Infection Control

- The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance. Public and International Health Directorate, Health Protection and Emergency Response Division, Infectious Diseases Branch 10200. July 2015
- Toolkit for Managing Carbapenemase-producing Enterobacteriaceae in Non-acute and Community Settings. PHE. June 2015
- Clinical advice on Zika: assessing pregnant women following travel; symptoms, transmission (includes sexual transmission), epidemiology. PHE Dec 2015
- Responding to the detection of legionella in healthcare premises : Guidance for PHE Health Protection Teams. PHE 2015
- Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use . NICE Guidelines (NG15) August 2015
- Health matters: antimicrobial resistance. PHE. Dec 2015
- Tuberculosis (TB) and other mycobacterial diseases: diagnosis, screening, management and data. PHE March 2016
- Annual Flu Programme. PHE
- Mandatory Health Care Associated Infection Surveillance: Data quality statement, PHE, June 2017
- Guidance on the definition of healthcare associated Gram-negative bloodstream infections, NHS Improvement/PHE July 2017
- Gram- negative Bloodstream Infections updates, PHE September 17
- UK 5 Year Antimicrobial Resistance (AMR) Strategy 2013-2018. Third Annual progress report, 2016. Global and Public Health Group/10200. 24th November 2017
- Update on the reporting and monitoring arrangements and post-infection review process for MRSA bloodstream infections. NHS Improvement. March 2018

Appendix 2: Infection Prevention & Control Forward Plan 2018/19

Background

1. The Health and Social Care Act 2008 requires Trusts to ensure that high standards of infection prevention and control are set up and maintained. It sets out 10 criteria against which a registered provider will be judged on how it complies with the Care Quality Commission registration requirement for cleanliness and infection control. One of these criteria requires Trusts to have an infection prevention and control programme.

Current Position

2. The Infection Prevention and Control Team provide advice and support to all wards, departments and staff within East Lancashire Hospitals NHS Trust. The Team also liaises with outside agencies in order to help provide a seamless service for patients and minimise the risk of infection.
3. The Chief Executive holds overall responsibility for Infection Prevention and Control (IP&C) for the Trust. He is supported in this role by Dr Ian Stanley, Director of Infection Prevention and Control (DIPC). He is supported by Mrs Beverley Aspin (Lead Nurse, IP&C), the Infection Prevention Nursing Team, Antimicrobial Pharmacist and the Consultant Microbiologists.
4. The Health Act 2008 outlines guidance for compliance with each criterion. The IP&C Team ensure by their routine work that the Trust is compliant with this. This work will continue this coming year. Examples of this are below.
 - a) Systems to manage and monitor the prevention and control of infection:
 - i. The Infection Prevention & Control Team will continue to monitor the activity of the Trust and ensure that there are robust arrangements in place in order to identify any risks and reduce or control them.
 - ii. The DIPC will continue to be directly accountable to the Chief Executive and to the board.
 - iii. The team will continue to provide infection prevention and control advice 24 hour 7 day/week with an on call rota.
 - iv. The team will continue to support divisions in the completion of post infection reviews for MRSA/MSSA/GNB blood stream infections and *Clostridium difficile* toxin positives.
 - v. The team will continue to collate and provide the national and local mandatory information required.

- b) Provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections
 - i. The Team will continue to be a part of the Nursing Assessment Performance Framework and PLACE Audits as far as staffing allows to ensure a high standard of experience for patients.
 - ii. The Team will continue to be a part of the Decontamination Committee and provide appropriate advice.
 - iii. The Team will continue to work closely with Estates and Facilities in order to ensure that a high standard of cleaning is maintained, the environment is fit for purpose and facilities provided are appropriate for the type of care provided.
 - iv. The Team will continue to provide advice on new buildings and alterations to site in order to protect staff, patients and visitors and ensure infection prevention is integral in the built environment.
- c) Provide suitable accurate information on infections to service users and their visitors
 - i. The Team will continue to review any new infection prevention & Control guidance produced and to provide education and information to the Trust.
 - ii. The Team will continue to provide expert advice and information to patients, visitors and staff.
 - iii. The Team will continue to liaise with the Communications department and prepare statements as required.
 - iv. The Team will continue to update the infection prevention intranet page as required.
- d) Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely manner
 - i. The IP&C Team will continue to liaise with outside agencies in order to facilitate the provision of optimum care and minimise the risk of inappropriate management and further transmission of infection.
 - ii. The Team will continue to support staff with advice on the appropriate management of patients on transfer from/to other departments/organisations.
 - iii. The team will continue to liaise with GPs and patients that have been identified as being colonised with MRSA whilst an inpatient and provide appropriate advice.

- iv. The team will continue to provide advice to patients and staff with regards to appropriate care prior to elective procedures if identified as colonised with MRSA.
- e) Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people
 - i. The IP&C Team will continue to provide surveillance on routine organisms and conditions in order to ensure that patients are managed appropriately. This will include regular visits to all wards to monitor patients to ensure that they are being managed correctly.
 - ii. The Team will continue to identify any outbreaks or serious infection occurrences and inform Public Health England and liaise with other community providers as necessary.
 - iii. The Team will continue to work closely with Occupational Health and Wellbeing Department.
- f) Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection
 - i. The Team will provide monthly figures for divisions and monitor infection rates.
 - ii. The Team will continue to provide support for the Orthopaedic Team with regards to orthopaedic mandatory surgical site infection surveillance.
 - iii. The IP&C Team will continue to chair the Infection Prevention Committee and ensure that infection prevention and control across all divisions and teams remains a high priority.
 - iv. The team will continue to undertake Multi-disciplinary Ward rounds for patients identified as *Clostridium difficile* toxin/antigen positive who are not resolving with treatment by their own clinical teams.
 - v. The Team continue to facilitate the auditing of antimicrobial prescribing quarterly across the Trust and feed the results back to each division.
 - vi. The Team will continue to undertake weekly antibiotic ward rounds to monitor compliance with the formulary, provide education opportunities and specific patient advice.
- g) Provide or secure adequate isolation facilities
 - i. The IP&C Team will continue to provide advice to staff on the appropriate placement of patients and the most effective use of isolation facilities.

- ii. The Team will continue to provide advice to the Clinical Flow Team and Domestic Services around the placement of patients/cleaning.
 - iii. The Team will continue to work alongside the Estates Department and divisions to ensure adequate isolation facilities are provided.
- h) Secure adequate access to laboratory support as appropriate
- i. The Team will continue to liaise with laboratory staff as necessary.
 - ii. The Team will ensure that all appropriate testing of samples is undertaken.
- i) Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections
- i. The Team will continue to ensure that all infection Prevention policies are easily accessible, relevant and compliance monitored.
 - ii. The Team will be a part of Policy Council in order to provide advice on other policies within the Trust that may have an impact on infection prevention and control.
 - iii. The Team will continue to support divisions in the use of the High Impact Interventions and local audits in order to monitor compliance with best practice.
- j) Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care
- i. The Team will continue to work closely with Occupational Health and Wellbeing Department and provide them with appropriate advice and support.
 - ii. The Team will continue to chair a monthly Infection Control Liaison Group and provide support and education to the liaison members.
 - iii. The Team will continue to provide education to all staff working within the Trust with regards to infection prevention practice.

Forward Plan

5. The Infection Prevention and Control team has been, and continues to be, faced with the many challenges resulting from current and emerging National policy initiatives. To meet these challenges it is important that Infection Prevention and Control remains embedded in everyday practices and that all staff within the organisation continue to have a responsibility in ensuring a safe environment is maintained for patients, themselves and their colleagues and that the risk of cross infection is

minimised. The Trust recognises that the effective prevention and control of Healthcare Associated Infections (HCAIs) is essential to patient and staff safety and to the overall performance of the organisation.

6. For the coming year, the Infection Prevention & Control Team along with Divisional Colleagues has identified certain priorities within the work plan in order to build on the good practices already in place.
7. Key priorities are the achievement of the key performance indicators for the Trust of the zero tolerance of MRSA blood stream infections and the reduction of Clostridium difficile toxin positive from last year to 27 and work towards the ambition of a 50% reduction in GNBSI by 2021;
8. The IPC Programme is divided into the following sections:
 - a) Reduction of blood stream infections
 - b) Clostridium difficile (C. difficile)
 - c) Hand Hygiene
 - d) Antimicrobial Prescribing
 - e) Environmental and Cleaning Issues
 - f) Education and Training
 - g) Audit and Review
 - h) Surveillance
 - i) Occupational Health

INFECTION PREVENTION & CONTROL WORK PROGRAMME 2018-2019

INFECTION PREVENTION WORK PROGRAMME 2018-2019 Objectives	Action	Responsibility	Evidence	Timescale	Division	RAG
Reduction of bacteraemias						
Introduction of prevention of Mouth care bundle	pilot mouth care bundle on stroke unit	Matron for Stroke Unit	care bundle	May-18	ICG	
reduction of CAUTI	audit of number of urinary catheters on each ward	ward manager	audit results	monthly	ICG	
					SAS	
					FC	
reduction of gram negative bacteraemias	undertake post infection reviews on all post 2 day gram negative bacteraemias	Divisional Directors	PIRs	monthly	ICG	
					SAS	
					FC	
	review compliance to NICE CG188	Divisional Governance Leads	audit results	Jun-18	ICG	
					SAS	
Clostridium difficile (C. difficile)						
Reduce incidence of C. difficile	post infection reviews will be completed within 7 days	Divisional Matrons	PIRs	Apr-18	ICG	
					SAS	
					FC	
	all relevant PIRs will be reviewed in DSIRG	Divisional Directors	DSIRG minutes	May-18	ICG	
					SAS	
					FC	
	all potential lapses in care will be reviewed in Senior HCAI meeting	DIPC	HCAI meeting minutes	Jun-18		
Hand Hygiene						
Reinforce hand hygiene	Stands for World Hand hygiene day	Infection Prevention Team	Stands	May-18		

	Scale up and spread prompt to protect campaign to additional wards	Lead nurse IP&C	Final audit results for each ward	Mar-19		
	promote hand hygiene with patients	IC champions	posters/use of hand wipes	Jul-18		
Environmental and Cleaning Issues						
Improve patient environments, ensure ward/dept cleanliness	Annual Mattress Audit	ELHT Mattress management Strategic Group	Audit report to IPC	Sep-18	All Divisions	
	ELHT Mattress Management Forward Plan	ELHT Mattress management Strategic Group	Forward Plan delivery 2018 / 2019	Mar-19	All Divisions	
	Enhanced in house cleaning review HPV Business Case and present to DCS DMB	Lead nurse IP&C	HPV business case	Nov-18		
	ELHT National place Assessment 2018 (Outcome Quality Improvement) (Assessment Period 15th Feb 2018 - 4th June 2018)	PLACE Lead	National PLACE Reports	Aug-18	All Divisions	
Education and Training						
Improve glove awareness	stands for glove awareness	Lead nurse IP&C	Stands/ MOD	May-18		
Improve IC Champion training. work with ward/dept IC champions focusing on:	ANTT	Lead nurse IP&C	audit results	Jun-18		
	back to basics	Lead nurse IP&C	audit results	Jul-18		
	urinary catheters	Lead nurse IP&C	audit results	Aug-18		
	antimicrobials	Lead nurse IP&C	audit results	Aug-18		
	cleaning products/wipes	Lead nurse IP&C	audit results	Sep-18		
	IV lines	Lead nurse IP&C	audit results	Oct-18		
Antimicrobial Prescribing						
To reduce antimicrobial	antibiotic prescriptions	Divisional Director	audit results	Quarterly	ICG	
					SAS	

resistance and inappropriate antimicrobial use	documented and reviewed by a competent clinician					FC	
	Documented outcome of review recorded	Divisional Director				ICG	
						SAS	
						FC	
	decrease in the total usage of Carbapenems	Divisional Director				ICG	
						SAS	
						FC	
	decrease in the total antimicrobial usage	Divisional Director				ICG	
						SAS	
						FC	
	increase the proportion of antibiotic usage with the Access group of the AWaRe category	Divisional Director				ICG	
						SAS	
					FC		
Audit and Review							
Annual audit plan							
	Monthly mystery shopper Commode audit	Lead nurse IP&C	Report to Divisions	Monthly			
	Monthly mystery shopper hand hygiene audit	Lead nurse IP&C	Report to Divisions	Monthly			
	Blood culture audit	Consultant Microbiologist	Report to Divisions	Monthly			
	Sharps compliance audit	Lead nurse IP&C	Report to IPC	Dec-18			
	MRSA screening audit	Lead nurse IP&C	Report to Divisions	Monthly			
	Antimicrobial audit	Divisional Directors	Audit Report	Quarterly	ICG		
					SAS		
					FC		
	Diarrhoea audit	Lead nurse IP&C	Report to IPC	Sep-18			
	NAPF audit (environment/practice audits)	Assistant Director of Nursing (Corporate)	reports to IPC	quarterly			
	water flushing audit	Lead Nurse IPC	audit report to water committee	Aug-18			
Surveillance							

Enhance patient care and review clinical practice	Identify staff time to facilitate surgical site surveillance (SSI)	Divisional Directors	Email	Jul-18	SAS	
					FC	
	Undertake local surgical site surveillance	Divisional Directors	SSI Reports to IPC	Jul-18	SAS	
					FC	
To ensure all areas with enhanced ventilation are working appropriately and safe for patients	Specialist ventilation must be tested to HTM standards and reports including those from PFI shared promptly with Dept managers	Director of Estates	Ventilation Report shared promptly	June 18	SAS	
	ventilation reports shared with all users of the area/Division	Ward/Dept Managers	Minutes of meetings	Jun-18	SAS	
			Posters			
To ensure that patients with suspected influenza are diagnosed promptly	obtain PCR point of care testing within COAU, ED, AMU A/B	Point of care testing	PCR machine evaluation, Machines insitu	Oct-18	DCS	
	review algorithm for use of machine	Lead Nurse IP&C	algorithm published	Oct-18	IC	
	provide training to staff to use the machines	Point of care testing	training records	Nov-17	DCS	
	monitor use of machines	Lead Nurse IP&C	results	continuous assessment during winter	IC	
	provide feedback of results of pilot	Lead Nurse IP&C	results, report	Apr-19	IC	
to ensure that all patients with alert organisms/conditions are alerted to all relevant staff	provide a secure method of alerting EPTS with relevant IC details	Head of System Support	EPTS	Sep-18		
	ensure full replacement for ICNet is available	Head of Informatics	new system	Dec-18		
Provide occupational health needs in relation to infection						
to ensure that all healthcare workers are protected	provide influenza vaccinations for all healthcare workers	Head of Occupational Health and Wellbeing	vaccination rates	Mar-19		

	Review immunisations of all frontline staff across the Trust	Occupational Health & Wellbeing Dept	Report to IPC quarterly	Quarterly		
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Appendix 3: Glossary of Terms Used

AER	Automated Endoscope Reprocessor
ANTT	Antiseptic Non Touch Technique
CCG	Clinical Commissioning Group
CDI	<i>Clostridium difficile</i> Infection
CDSL	Cross Divisional Saving Lives
CDT	Clostridium difficile Toxin
CQC	Care Quality Commission
DIPC	Director of Infection Prevention and Control
ESBL	Extended Spectrum Beta Lactamase
GDH	Glutamate Dehydrogenase (<i>Clostridium difficile</i> antigen)
GRE	Glycopeptide-Resistant Enterococci
GUM	Genito Urinary Medicine
HCA	Health Care Assistant
HCAI	Health Care Associated Infections
HII	High Impact Intervention
HSDU	Hospital Sterilisation & Disinfection Unit
ICN	Infection Control Nurse
ICNet	Database for Infection Prevention & Control
IPC	Infection Prevention Committee
IP&C	Infection Prevention & Control
IP&CT	Infection Prevention and Control Team
L&D	Learning and Development
MRSA	Meticillin Resistant Staphylococcus Aureus
NHSLA	NHS Litigation Authority
NICU	Neonatal Intensive Care Unit
NORWIC	North West Infection Control Practitioners
PEAT	Patient Environment Action Team
PGD	Patient Group Directive
PHE	Public Health England
PLACE	Patient – Led Assessment of Care Environment
POCT	Point of Care Testing
PPE	Personal Protective Equipment
RBH	Royal Blackburn Hospital
RCA	Root Cause Analysis

SSI	Surgical Site Infection
TB	Tuberculosis
TSE	Transmissible Spongiform Encephalopathies