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1.0 INTRODUCTION

1.1. This quarterly report outlines the activities of the Trust pertaining to Infection Prevention and Control from October 2008 – December 2008. It is presented to explain what arrangements the Trust has in place to allow the early identification of patients with infections in hospital and takes measures to reduce the spread of infections to others. It also identifies the accountability arrangements, policies and procedures relating to Infection Prevention and Control, audit, surveillance and feedback.

1.2. There continues to be much emphasis placed upon Infection Prevention and Control in Healthcare Provision by the Government, the media and the general public. All NHS organisations must ensure they have effective systems in place to control Health Care Associated Infections (HCAI). Infection Prevention and Control remains a high priority across the Trust.

1.3. The Trust places Infection Prevention and Control underpinned by excellent basic hygiene at the cornerstone of excellent management and clinical practice. The Trust is also committed to ensuring that appropriate resources are allocated for the effective protection of patients, visitors and staff. The main function of the Infection Prevention and Control Team is to work with the Trust to prevent the transmission of HCAI, to reduce antibiotic resistance and improve the cleanliness of the Trust.

2.0 STRUCTURE, ACCOUNTABILITY AND ASSURANCE

2.1 Team Configuration

2.1.1. Director of Prevention and Control (DIPC) - Dr. Harper

2.1.2. Team Configuration

<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>Mrs Johanne Lickiss</td>
<td>Nurse Consultant</td>
</tr>
<tr>
<td>Mrs Sharon Mawdsley</td>
<td>Senior Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Mrs Ann Cooper</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Mrs Sheena Cottam</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Mrs Louise Johnson</td>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Mrs Liane Moorhouse</td>
<td>Audit and Surveillance Nurse</td>
</tr>
<tr>
<td>Mrs Sharon Staff</td>
<td>Information and Data Analyst</td>
</tr>
<tr>
<td>Miss Joanne Newiss</td>
<td>Infection Prevention Team Secretary</td>
</tr>
<tr>
<td>Dr Ruth Palmer</td>
<td>Consultant Microbiologist</td>
</tr>
<tr>
<td>Dr Achyut Guleri</td>
<td>Consultant Microbiologist</td>
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2.2 Service Level Agreements
A number of Service Level Agreements are established, whereby the Infection Prevention and Control Team provide Infection Prevention and Control advice to three private hospitals. Fylde Coast Hospital part of the Classic Hospitals Group continues with an established Service Level Agreement. First Trust Broughton Preston Service Level Agreement and Lancashire Eye Clinic continue to have an ad hoc service including annual training, audits and Education.

2.3 **The Hospital Infection Prevention and Control Committee (HIPCC)**

The HIPCC is the main forum for discussion concerning changes to policy or practice relating to Infection Prevention and Control. The Committee now meets on a monthly basis and is chaired by the Chief Executive. The membership is multi-disciplinary and includes representatives from all directorates/divisions and senior management. The HIPCC is a sub-committee of the Clinical Governance Committee and reports formally to the Trust Board through this committee.

2.4 **Assurance**

The Assurance Process includes internal and external measures. Internally the accountability exercised via the committee structure described above ensures that there is internal scrutiny of compliance with national standards and local policies and guidelines. The External Assessments used are: -

**External Audit**

- 2.4.1 The Controls Assurance Infection Control and Decontamination Standard.
- 2.4.2 The National Health Service Litigation Authority (NHSLA) standards
- 2.4.3 The HealthCare Commission ‘Standards for Better Health’
- 2.4.4 The Patient Environment Action Team (PEAT) Assessment.

<table>
<thead>
<tr>
<th>Controls Assurance</th>
<th>The scheme has been superseded but the standards continue to be useful benchmarks and a good guide to practice.</th>
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<tr>
<td>NHSLA Standards</td>
<td>From April 2007 new NHSLA Risk management Standards will be introduced for Acute Trusts. For CNST Level 2 we need to demonstrate implementation of the approved documentation that describes the process for managing those risks. Work within the Infection Prevention and Control Department is on-going to achieve these standards through reviewing Policies and Procedures.</td>
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<tr>
<td>Healthcare Commission Standards</td>
<td>The HealthCare Commission conducted an unannounced visit on 17th and 18th December 2008 to assess the Trust compliance with The Health Act - Hygiene Code 2006. The Trust is awaiting the formal report.</td>
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<tr>
<td>PEAT</td>
<td>Is a formal assessment review of the environment and cleanliness in both public areas and wards/departments is completed annually using the PEAT inspection framework. PEAT Inspections spot checks are conducted throughout the year to all sites within the Trust – Infection Prevention and Control, Head of Estates and relevant Matron. Action Plan formulated by Head of Estates – Infection Prevention progressing on actions to date. The PEAT Inspections for this year have been completed</td>
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**Internal Audit**
2.4.5 Saving Lives – audits on the High Impact Interventions have been conducted and presented to the Hospital Infection Prevention and Control Committee. Measures and steps have been taken to increase compliance and the audits were repeated in April 2008 to monitor progress.

2.4.6 Wards and Departments conduct weekly Hand Hygiene Audits, the results of which are presented to each Division and the HIPCC. Compliance with Hand Hygiene is steadily improving.

2.5 The Health Act 2006 – Code of Practice for the Prevention and Control of Health Care Associated Infection

2.5.1 The Health Act 2006 and the Hygiene Code became law and imposed a statutory duty on NHS organisations from October 1st 2006 to observe provisions of the Code of Practice on Healthcare Associated Infections (HCAI) The Code is presented under three headings, which form the basic Code:

- Management, Organisation, and the Environment
- Clinical Care Protocols
- Health Care workers

2.5.2 The Code of Practice for the Prevention and Control of Health Care Associated Infection Compliance Assessment was presented to the Trust Board in June 2007.

2.5.3 The Health Act – Hygiene Code 2006 was revised by the Department of Health in January 2008 – following review the action plan has been updated and we remain compliant

2.6 Health Care Commission Inspection

2.6.1 The Health Care Commission inspection was conducted on 17th and 18th December 2008. The inspectors visited Clinical Decision Unit, Ward 25, Ward 26, Ward C, Central Sterile Services Department (CSSD) and Laundry. Any Infection Prevention and Control issues identified during the inspection were raised with and rectified immediately by the appropriate department. The team provided a verbal feedback of Infection Prevention and Control issues identified from the visit and an action plan was formulated. The action plan has been forwarded to the Health Care Commission Team. The board will monitor progress with the action plan.

2.7 Department of Health (DH) MRSA Screening Operational Guidance

2.7.1 The DH has issued further advice regarding the implementation of the MRSA Screening Operational Guidance. From April 2009 all elective admissions must be screened for MRSA in line with DH guidance. Plans must be in place to introduce MRSA screening for all relevant elective patients, a list of exemptions is provided by the DH. An action plan has been formulated addressing the guidance and will be reviewed and monitored by the board. By 31st March 2009 the Trust will need to publish its MRSA screening policy along with a statement that it is compliant with that policy.

3.0 INFECTION PREVENTION TEAM ACTIVITY
It is imperative that Infection Prevention issues are addressed; by every member of staff to ensure transmission of infection is minimized.

3.1.1 The team continues to provide a comprehensive education and training programme for all grades of staff and volunteers throughout the year.

3.1.2 The Infection Prevention Team holds meetings with the Domestic managers of ISS Mediclean, Sodhexo and In-House alongside the Monitoring Department to ensure that cleaning issues are addressed.

3.1.3 The team ensures that wards are visited on a daily basis to establish which patients are barrier nursed and discussions take place with the ward staff to ensure appropriate treatment and care is maintained.

3.1.4 The Link Nurse Group has been extended to include other Health Care Professionals.

3.1.5 The ‘Cleanyourhands’ Campaign Year Three was launched in January 2008, which will help to further address the need for hand decontamination.

3.1.6 Spot checks with the Estate Department, relevant Matron, Infection Prevention and Control and the Domestic Manager following the PEAT regulations to ensure environment issues are addressed.

3.1.7 Links are maintained with the Bed Management Team by attending Bed Management Meetings daily, to ensure patients are placed appropriately, and the Bed Management Policy has been reviewed and updated to reflect this.

3.1.8 The Infection Prevention and Control Team continues to work with and advise the Estates department to ensure new buildings, departments or upgrades meet Infection Control regulations.

3.1.9 IC Net has now been installed, fully interfaced with the Pathology System. There is currently an audit undergoing to ensure that the system is fully interfaced with the Hospital Data Systems.

4.0 SURVEILLANCE

4.1 Surgical Site Surveillance

Three month mandatory surveillance for Orthopaedic surgery will commence from January 2009. A programme of surgical site surveillance audits to incorporate the Cardiac and Surgical divisions has been devised.

4.2 MRSA and Clostridium Surveillance

4.2.1 MRSA reports are checked daily and information reviewed which it then relayed to the relevant ward to ensure barrier nursing is taking place and advice re treatment is given.

4.2.2 Every morning the Infection Control team monitors the positive MRSA Patients who have been admitted in the previous 24 hours, contact the relevant ward and advise them on barrier nursing and topical treatment.

The Infection Prevention and Control team liaises daily with the Pathology department to obtain new positive MRSA results and contact the appropriate ward to advise on barrier nursing and appropriate treatment.

4.2.3 MRSA Bacteraemia Route Cause Analysis data is reported on a monthly basis to Blackpool PCT and North Lancashire Primary Care Trust.

4.2.4 Following confirmation from the Pathology department of a positive MRSA Bacteraemia result the ward is visited by an Executive Director, Infection Prevention and Control Nurse, Head Nurse and relevant Matron. A discussion takes place with the Senior Nurse on the area and if possible the relevant Clinician. A Root Cause Analysis is completed by this team and
discussed at an Incident Meeting. The action plan is then formulated by the Nurse and Clinician and returned to the DIPC. The action plan is then presented to the Hospital Infection Committee. MRSA Bacteraemia are reported to the relevant Divisional/ Directorate Meetings.

4.2.5 Monthly totals of new cases of MRSA Bacteraemia and Clostridium Difficile are reported to the Hospital Infection Prevention and Control Committee.

4.2.6 Clostridium and MRSA Bacteraemia date is reported to Trust Board. Mandatory Surveillance of Clostridium Difficile is part of the mandatory Surveillance System. Since 1st April 2007, all specimens from patients aged 2 years and over are routinely tested for Clostridium Difficile as part of National mandatory surveillance.

4.2.7 **MRSA Bacteraemia**

The MRSA Bacteraemia trajectory has been set at the 26 by the SHA in line with the 2007/8 trajectory, which the Trust breached by 14.

Progress in the last quarter:

- **October** 2 - Infection performance management process
  - Performed
- **November** 1 - Blackpool PCT
- **December** 0

The following charts indicate the levels of MRSA Bacteraemia for the period April 2008 to December 2008.
4.2.8 **Clostridium Difficile**

The following charts indicate the levels of Clostridium Difficile for the year April 2008 to December 2008.

October 27  
November 18  
December 13

The Clostridium Difficile trajectory has been adjusted several times since initial agreement with the PCTs, which Blackpool PCT negotiated on behalf of both PCTs. The Department of Health directive remains for a 45% reduction in Clostridium Difficile infection (CDI) from the 2007/8 levels, in the North West of England by 2011. A pre-48hour separation is now applied to CDI positive patients, as there is for MRSA Bacteraemia. This attributes relatively more CDI cases to Primary Care than previously. The North West SHA has applied a different calculation for the 2010/11 target. Rather than using the percentage reduction, a target rate of 3.72 case per 1000 admissions has been applied to the hospital cases alone. This amounts to a CDI target of 176 cases in 2010/11. This is actually a 47% reduction from 2010/11 numbers. It is appropriate, given that the numbers are being analyzed in this manner to present the Trust’s performance, Primary Care performance and whole health economy (WHE) performance.
This graph indicates a position of 23 cases under WHE trajectory to date.

This indicates the Trust is under trajectory by 29 cases.
This indicates that relative to the WHE, the subtractive Primary Care performance is 6 over trajectory.

Whilst the Trust is performing adequately, it remains amber in terms of performance, as does the WHE performance. Relatively the Primary Care numbers are red. We continue to work closely with the PCTs to assist them in trying to address this problem, as well as continuing to drive the Trust forward. The next 2 years require similar reductions from year-end if the 2010/11 target is to be met.
## Audit Programme

<table>
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<tr>
<th>Objective/Action</th>
<th>Lead Person</th>
<th>Comments</th>
<th>Deadline</th>
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</table>
| **Audit and Surveillance and Investigation and incident monitoring**  
• Ensure Surgical Site Infection (SSI) | DIPC | Three month mandatory orthopaedic – January – March 2009  
To establish SSI surveillance incorporating the Cardiac and Surgical Divisions | March 2009  
April 2009 |
| **Ventilated Associated Pneumonia (VAP)** | DIPC | Incorporates all ventilated patients. Audits conducted by the Audit and Surveillance Nurse in conjunction with Intensive Care staff | Ongoing |
| **Monitoring of Central Venous Lines** | DIPC | Monthly audit of Central Lines to commence from April 2009.  
Audit tool compiled  
Database to be developed | Ongoing |
| **Promote Hand Hygiene Compliance** | DIPC | Weekly hand hygiene audits  
To ensure robust data Divisions to monitor compliance in other Divisions  
Monthly results presented to all Divisions | Ongoing |
| **Ensuring Compliance with MRSA Policy and Procedure** | DIPC | Quarterly monitoring of compliance with MRSA treatment | Ongoing |
| **Ensure Hospital Cleanliness is monitored** | DIPC | Annual PEAT Inspections  
Monthly Divisional PEAT spot checks  
Close monitoring with Domestic Contract Manager and Monitoring Services | Ongoing |
| **Environmental Audits** | Nurse Consultant | Ward Managers complete on a monthly basis  
Audit tool has been reviewed and improved | Ongoing |
| **Annual Environmental Audits** | Nurse Consultant | A programme of annual environmental audits has been devised and commenced utilising the national Infection Prevention and Control Audit Tool | Ongoing |

### To Maintain Saving Lives Audit Programme utilising the High Impact Interventions (HII) incorporating:

- Central venous catheter care  
- Peripheral intravenous canula care  
- Prevention of surgical site infection  
- Care for ventilated patients (or tracheostomies where appropriate)  
- Urinary catheter care  
- Reducing the risk of Clostridium difficile

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| **Maintain progress made in reducing MRSA Bacteraemia rates** | DIPC | Quarterly audit programme  
To attain 95% compliance  
Audit results presented to the HIPCC  
Audit results made available to Trust Staff | Ongoing |
| **Maintain ongoing reduction of Clostridium Difficile rates in line with directive from the DH** | | Trajectory set separating Trust and PCT/Pre 48 Hour results  
Across Health Economy working to ensure best practice  
Each Division performance managed to reduce HCAI rates  
Clostridium Difficile awareness week July 08 | Ongoing |