June 2018

Harrogate and District
NHS Foundation Trust

ANNUAL INFECTION PREVENTION AND CONTROL REPORT 2017/2018

Contents

2017/2018 summary

Month	CDI		MSSA BSI		MRSA BSI		*E*. coli BSI		Klebsiella BSI		*P. aeruginosa* BSI		Confirmed 'flu
	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	HAI	CAI	
April	0	2	0	1	0	1	1	9	2	3	0	0	0
May	0	2	1	2	0	0	1	11	0	3	1	0	0
June	0	0	0	5	0	0	3	10	0	3	0	0	0
July	0	1	0	4	0	0	1	15	1	2	1	0	0
August	0	0	1	1	0	0	4	14	0	4	0	0	0
September	2	2	1	3	0	0	2	13	1	1	0	2	1
October	1	6	0	1	0	0	1	10	0	1	0	1	7
November	2	1	0	2	0	0	0	3	0	4	0	1	3
December	0	2	1	5	0	0	1	6	0	0	0	0	37
January	0	2	0	4	0	0	0	15	0	2	0	1	73
February	1	2	0	3	0	0	0	14	0	3	0	0	34
March	1	1	1	4	0	0	0	12	0	1	0	1	35
Running total	7	21	5	35	0	1	14	132	4	27	2	6	190

C. difficile

The total number of Trust-apportioned CDI cases for 2017/2018 was seven, compared with 29 in 2016/2017 and 35 in 2015/2016. The annual objective of twelve or fewer cases was therefore achieved. Case 7 was deemed to be a lapse in care secondary to the use of cefuroxime in a patient with a previous history of *C. difficile*, which is disappointing, however, this was the only contributory lapse in care for the year.

According to the most recent YHFES report (October to December 2017), we are now right on the mean value for Trust apportioned CDI *rates.* The annual regional report, with rates, is usually published in July.

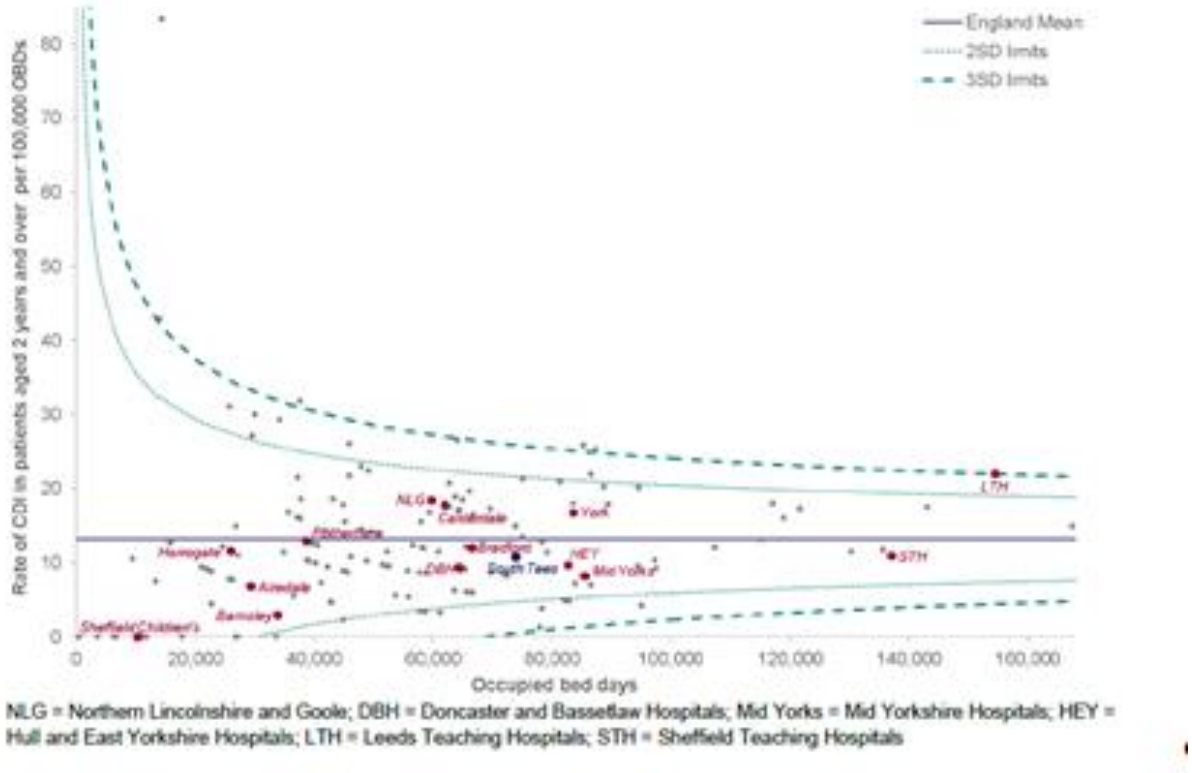

Figure 1: **Trust-apportioned CDI rates in patients over 2 years of age per 100,000 bed days for all England acute trusts from October to December 2017**

Source: YHFES Report Oct-Dec 2017, received March 2018 – HCAI Mandatory surveillance: Data points represent all acute NHS trust in England. Trusts within Yorkshire and Humber are highlighted in red. Dashed lines represent control limits at 2 and 3 standard deviations (SDs) around the national mean to allow identification of trust with significantly outlying rates.

The 2018/2019 annual objective has been set at eleven.

S. aureus bacteraemias (SABSI)

SABSI include both MRSA (methicillin-resistant) and MSSA (methicillin-sensitive) *S. aureus.* The numbers of both remain very low. We currently screen most admissions for MRSA, but not MSSA carriage.

MRSA screening

Despite DoH recommendations to reduce the number of MRSA screens to those in high risk groups (such as trauma and orthopaedics, adult and neonatal critical care units, transfers in from other hospitals and previously known carriers), at HDFT, we have continued with universal screening.

In 2017/2018, we carried out 7630 MRSA screens on 8699 elective patients (87.1%) and 11081 screens on 12790 non-elective patients (86.4%). The positivity rate for MRSA screens is very low (<1%). Each screen costs £4.00 (laboratory consumables and BMS time only), representing a total outlay of at least £74,848 for the year, or £473.72 to pick up each positive.

In the coming year, we will be reviewing the MRSA screening strategy.

E. coli bacteraemias

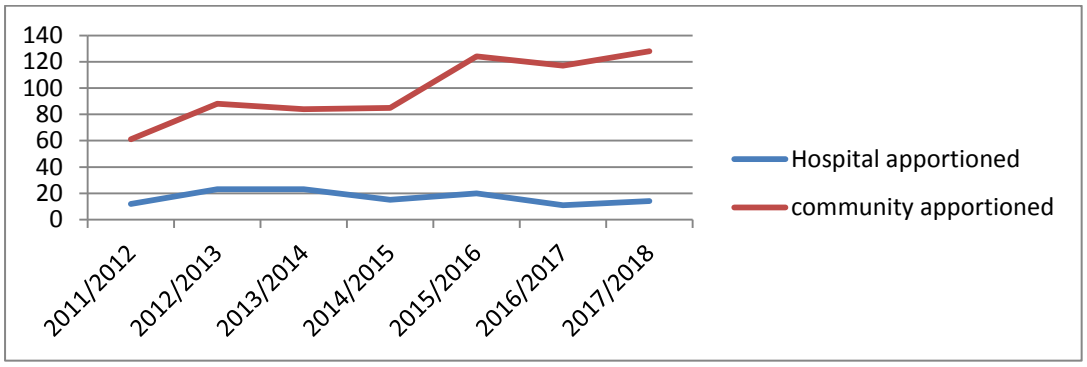

Figure 2: ***E. coli*** **bacteraemias, April 2011-March 2018, HDFT**

There was a slight increase in Trust apportioned *E. coli* BSI, from 11 in the previous year, to 14 this year. The total number is still low in comparison with many other Trusts. The community acquired *E. coli* BSI increased from 117 cases in 2016/2017 to 132 this year.

Of the total, 59 (41%) were thought to be secondary to a UTI, of which approximately two thirds were lower UTI. A majority of patients (115) had not had a urinary catheter in the 28 days before the bacteraemia. Only two *E. coli* bacteraemias were thought to have been secondary to a catheter associated UTI. A hepatobiliary infection was the second most common cause (32%); in 15% of cases, no underlying source was immediately obvious.

NHSI are demanding a 10% year on year reduction in *E. coli* BSI cases across the whole healthcare economy. For reasons that are not immediately obvious, the focus seems to be on the fraction that are hospital (here 11%) rather than community focused.
We aim to:-

- Increase awareness about UTI prevention through work in residential homes and GP surgeries.
- Increase the awareness of the importance of hydration, particularly in the summer months.
- Look in more detail at the *E. coli* BSI which have a urinary focus, regardless of whether they were community or hospital onset.

Multiply-resistant organisms

Multiply-resistant Gram-negative bacilli

A recent report issued by the Yorkshire and Humber Epidemiology Unit (Jan-March 2018) stated that the number of resistant organisms in the region is rising, slowly but surely. In the January-March quarter of 2018, 14.7% of blood culture *E. coli* isolates were reported as being resistant to piperacillin-tazobactam (Tazocin). Three years ago, that figure was 9.5%.

ESBL (extended-spectrum B lactamases) and AmpC are enzymes produced by Gram-negative organisms which confer resistant to some extended spectrum penicillins and cephalosporins. The genes which control them are passed from strain to strain on extra-chromosomal mobile genetic elements which more often than not also confer genes to several other antibiotic classes.

The number of ESBL and AmpC producers in blood cultures has been rising sharply over recent years. We have every reason to think that this trend is likely to continue. NB the figures in Figure 3 include any Gram-negative rod. Some will be non-reportable organisms such as Citrobacter and Proteus spp. The increase in blood-culture isolates producing either ESBL or AmpC is interesting. Many of the bacteraemias will be secondary to urinary tract infections.

The number of urinary isolates producing ESBLs and AmpCs is shown in Figure 4. Many of these will have been submitted by GPs and represent infections on the community. Because many of these will be multiply-resistant, it is not always possible to find an oral option for treatment. Patients requiring antibiotic treatment will therefore need home IVs or more probably, a hospital admission to be treated.

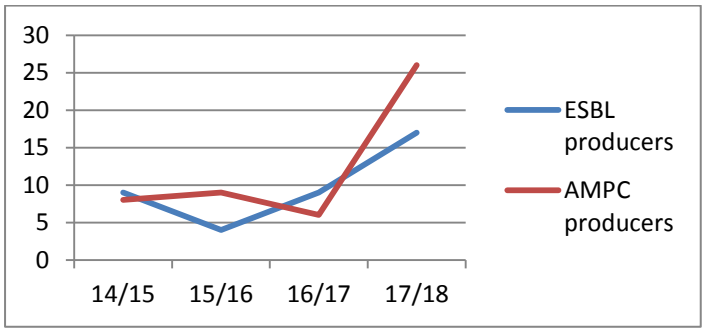

Figure 3: ESBL and AmpC producing organisms in blood cultures

Source: LabCentre, HDFT, courtesy of Lucy Jenkinson

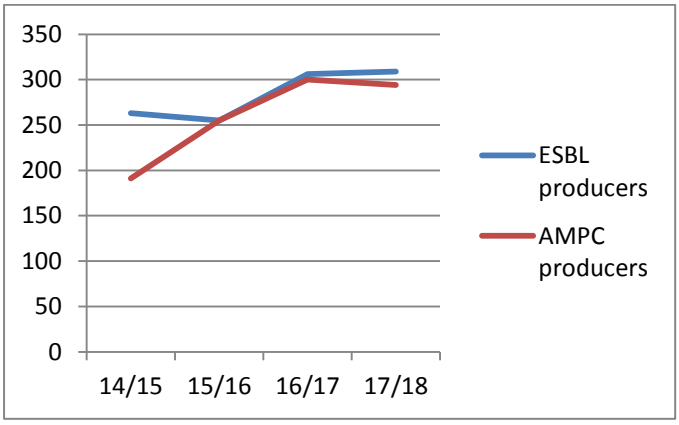

Figure 4: ESBL and AmpC producing organisms in urine specimens

Respiratory viruses

In November, we introduced a more streamlined respiratory virus policy which replaced several previous policies. The pandemic 'flu policy remains separate.

The winter of 2017/2018 was a particularly busy one for respiratory viruses, with nearly 200 cases on laboratory confirmed influenza alone. The last week of December 2017 and the month of January 2018 were especially busy. In addition, there were many cases of parainfluenza and RSV, in adults as well as children.

There were at least four main viruses circulating:

- Flu A (H3 seasonal; H1 "swine" flu; undifferentiated)
- 'Flu B
- RSV (data not shown)
- 'parainfluenza (September/October 2017, two of whom required ITU admission)

Figure 5 below, taken from a regional report, shows comparison with previous years.

It was unfortunate that in the 2017/2018 season, the trivalent vaccine which was given to staff and we believe to most patients vaccinated by their GPs, did not give good coverage for influenza B.

Laboratory Confirmations: Laboratory confirmed cases of respiratory infections by week

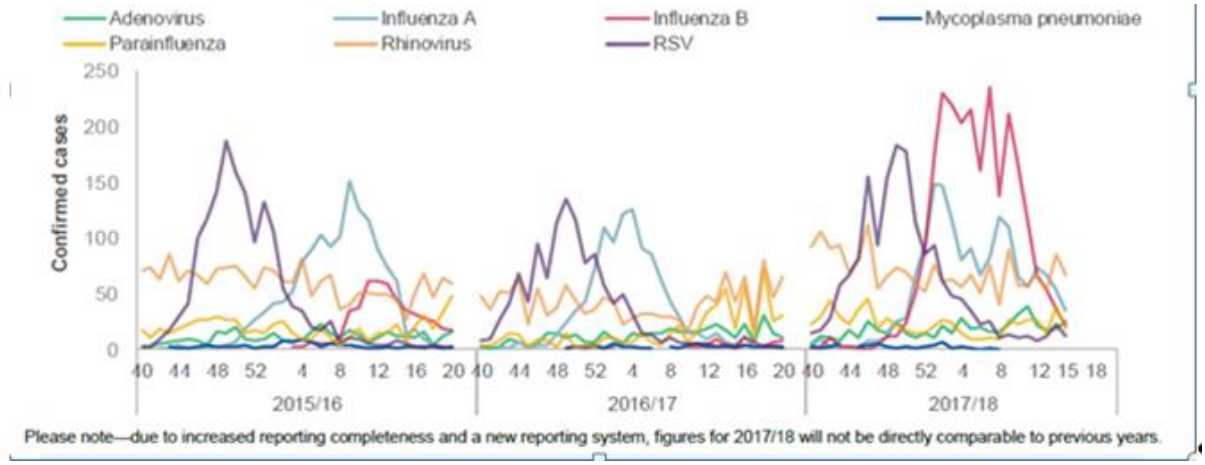

Figure 5: Local laboratory data for Yorkshire and Humber
Source: Public Health England (Yorkshire and Humber)

We had clusters on Byland, AMU, Jervaulx and Littondale.

The samples being sent off to Leeds were taking an average of three days for a positive, and five days (range 3-8 days) for a negative result, which were not telephoned through. The total processing time included the actual time taken at HDFT to send the specimen away and to manually validate the result and release it onto ICE. Negative results are as important as positive ones for making best use of side-rooms etc.

On the 19th January 2018, we introduced an in-house diagnostic testing using a rapid multiplex PCR system (GenMark) costing approximately £98 per test. The feedback from the IPCT and clinicians was overwhelmingly positive. Getting results back in a timely manner meant we were able to make better use of side rooms.

Dr Smith reported several patients who didn't get the antibiotics they might otherwise have done, and two patients who might otherwise have had a CTPA. The usefulness of this strategy was actually in shaping what we didn't then have to do as a consequence of making a positive diagnosis of a viral illness.

For the coming season, which usually starts at the end of September onwards, we intend to offer a similar in-house test. We are also looking into the feasibility of also introducing point of care testing for influenza and RSV in A&E and the new clinical assessment unit.

Decontamination report

Report title: **Annual report of Decontamination Committee**
Report to: **Providing a Safe Environment Steering Group**
Report author: **Richard Hobson**
Date: **March 2018**

Objectives for 2017/18

1) Oversee the installation of the new AERs as part of the wider new extension and major refurbishment of the existing Sterile Services Department.
2) To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-01(A-E): Management and decontamination of surgical instruments (medical devices) used in acute care (revised in July 2016).
3) To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-06 (A-E): Policy and Management Decontamination of Flexible Endoscopes (revised in July 2016).
4) To ensure compliance to ISO16442:2015 – Controlled environment storage cabinet for processed thermolabile endoscopes.

Report of progress against the objectives

1. Oversee the installation of the new automated endoscope reprocessors (AERs) as part of the wider new extension and major refurbishment of the existing Sterile Services Department (SSD)

This objective has been completed. The AERs are fully operational in the new Sterile Services Department.

2. To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-01(A-E): Management and decontamination of surgical instruments (medical devices) used in acute care (revised in July 2016).

This objective has not yet been completed.

It has been demonstrated that the protein detection system works with the chemicals currently available. However, a decision needs to be made as to how frequently protein testing needs to be done. The HTM does not make it clear which of its recommendations are mandatory and which are aspirational. Due to the lack of clarity advice is being sought from the Trust AE (D) about the use and frequency of carrying out these tests. Recommendations will be put to the Decontamination Committee for approval.

This objective will be carried over to 2018/19 with the aim of establishing frequency and testing parameters and introducing this in to regular practice.

3. To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-06 (A-E): Policy and Management Decontamination of Flexible Endoscopes (revised in July 2016).

This objective has been completed. The audit was carried out on the 29th November 2017 where the Notified Body, British Standards Institute stated the requirements of ISO 13485:2016 (which includes compliance to HTM 01-06) had been fully and effectively implemented.

4. To ensure compliance to ISO16442:2015 – Controlled environment storage cabinet for processed thermolabile endoscopes

This objective has not been completed because of the concentrated work involved with the SSD and EWD centralisation process (objective number 1). The item will be carried over into the objectives for 2018/19.

Terms of Reference

Revised terms of reference were agreed in January 2018. Only minor changes were made, which reflected changes in the services provided by HDFT and a realignment of some of the staff who attend the committee with their named roles.

Objectives for 2018/19

1) To fulfil all best practice requirements with the recently released Health Technical Memorandum 01-01(A-E): Management and decontamination of surgical instruments (medical devices) used in acute care (carried forward from 2017/18).
2) To ensure compliance to ISO16442:2015 – Controlled environment storage cabinet for processed thermolabile endoscopes (carried forward from 2017/18).
3) To comply with the recommendations of HTM 01-06 in reference to residual protein testing procedure. A system is to be trialled and implemented for the use in endoscope washer disinfectors comparable with existing system used in the instrument washer disinfectors.
4) Tracking and Traceability. Ensure that the Trust puts in place a process or processes to improve the tracking and traceability of surgical items sent for reprocessing.

Decontamination Report Appendix 1: Attendance monitoring

Membership	**Meetings**				**Total**	**%**
	29/03/17	28/06/17	04/10/2017	31/01/2018		
Consultant Microbiologist	✓	✓	✓	✓	4	100
Head of Decontamination Services	✓	✓	✓	✓	4	100
AP (D)	✓	✓	✓	✓	4	100
HIPCN	✓	✓	✓	✓	4	100
CIPCN	✓			✓	3	75
Deputy Manager Decontamination Services					1	25
Sister, Surgical Outpatients	✓	✓	✓ (Rep)		3	75
Manager, Endoscopy			✓		1	25
CIA representative		✓				25
Decontamination Link, Endoscopy						
Head of Community Equipment Service						
Sister, ENT						
Theatres/Critical Care/DSU Representative				✓✓✓	1	25
Director of Performance and Delivery						
Domestic Services Manager						
AE (D)	✓		✓		2	50
Medical Device Safety Officer	✓	✓	✓	✓	4	100
Deputy Director of Estates						
Quality Production Services Manager (Added to membership Dec 2016 at MD's request)				✓	1	25
Quoracy: Total members per meeting Quorum (8)	9	7	8	10		

Cleaning

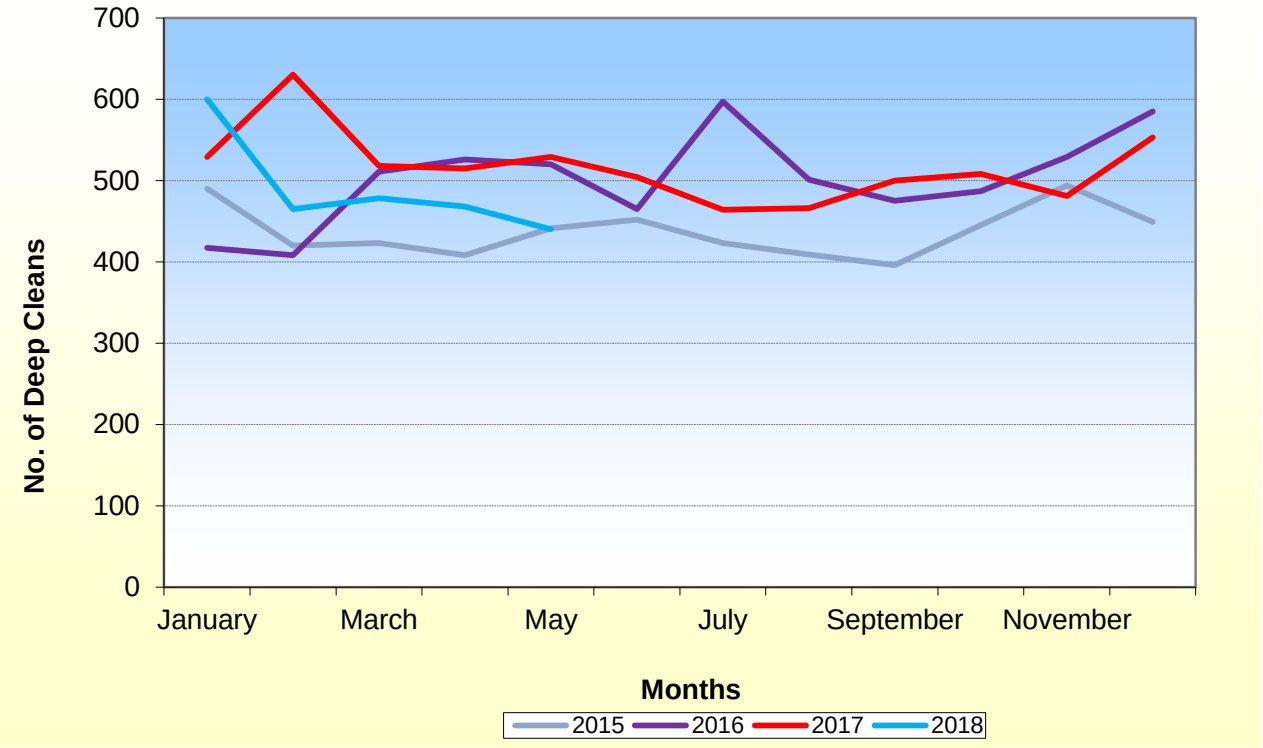

Figure 6: **Deep cleans undertaken by Domestic Services, 2015- current**
Source: Stuart Kelly

The environment is increasingly recognised as having a crucial role in the transmission of infectious agents in a hospital setting. Cleaning the environment properly is fundamental to minimising the spread of multiply-resistant organisms, *C. difficile* spores and some viruses within the environment.

The number of deep cleans has increased - in 2017, there were nearly 1,000 more deep cleans than in 2015, representing an overall increase of 18% between the two years.

We have replaced our old Bioquell HPV machines with two new ones, (Deprox) from Hygiene Solutions, which seem to be working well. The company loaned us a UVC machine free of charge as part of the deal, but regrettably, we were not able to make as much use of them as we'd hoped to. The planned rolling deep clean was abandoned.

Antimicrobial usage

The overall antimicrobial usage remains low in comparison with other Trusts in the region.

The prescribing of co-amoxiclav has remained low, but prescriptions of the cephalosporins and extended spectrum penicillins have risen slowly over time.

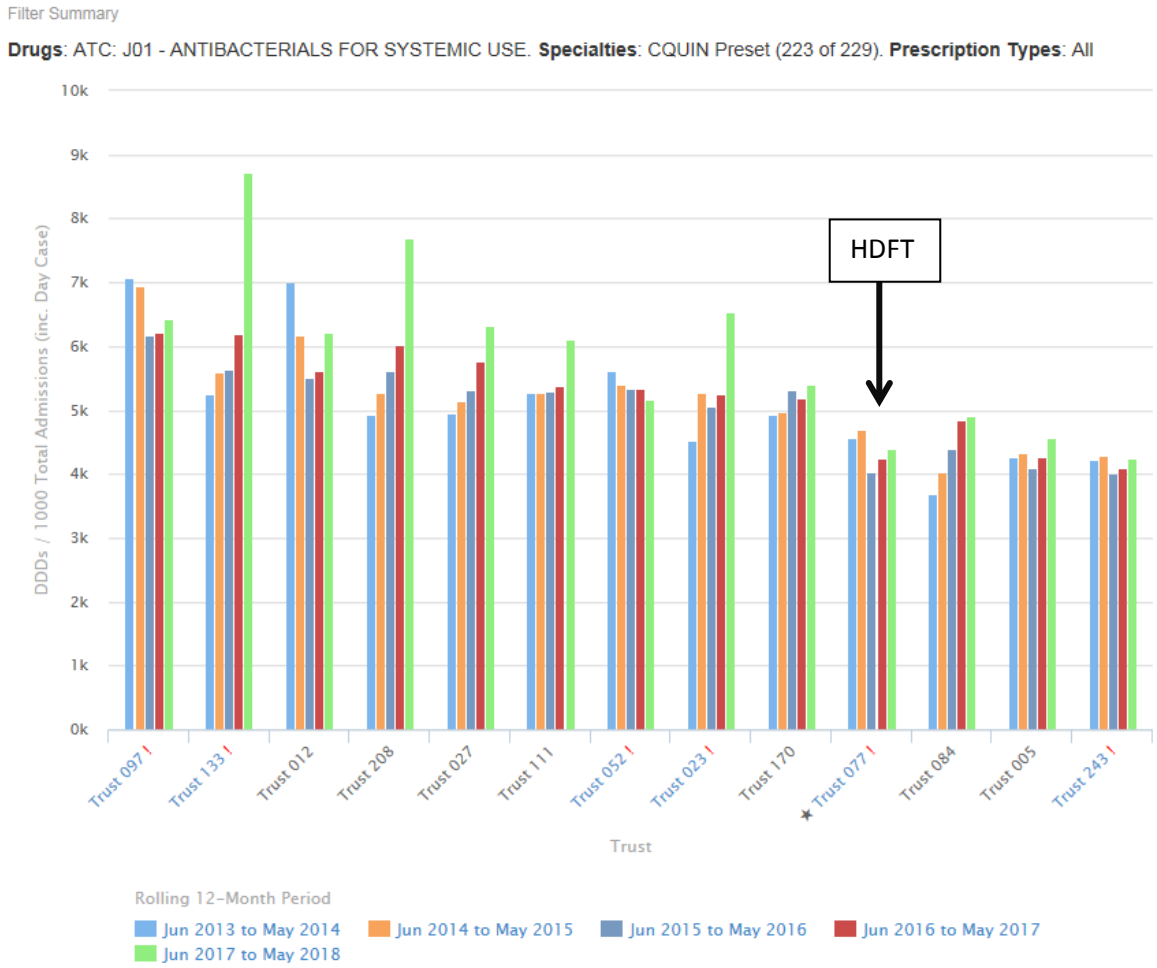

Figure 7: Antimicrobial prescribing, Y&H, June 2013-May 2018

Prescribing of individual agents

(NB scales on vertical axes are different!)

DDD- defined daily dose

OBD- occupied bed days

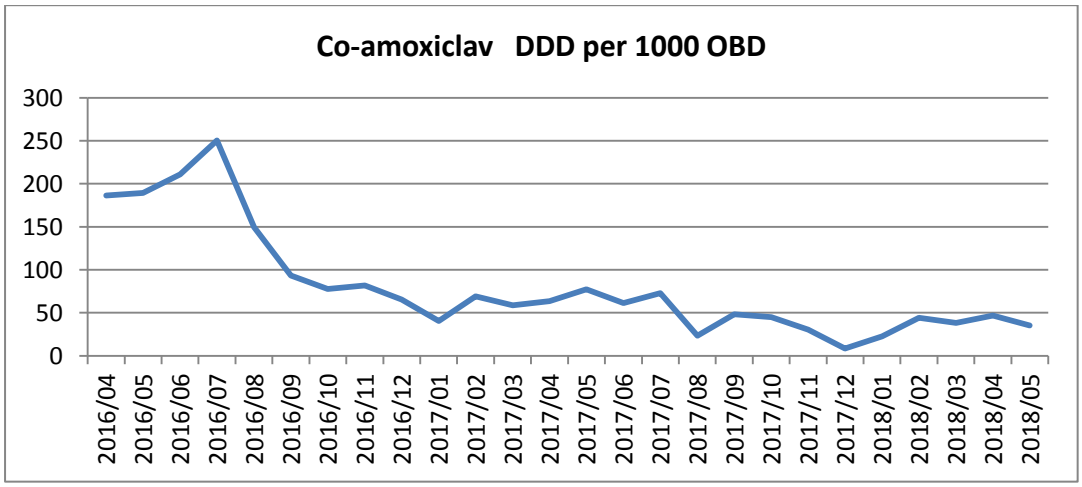

Figure 8: Prescribing trend for co-amoxiclav, April 2014- current, HDFT

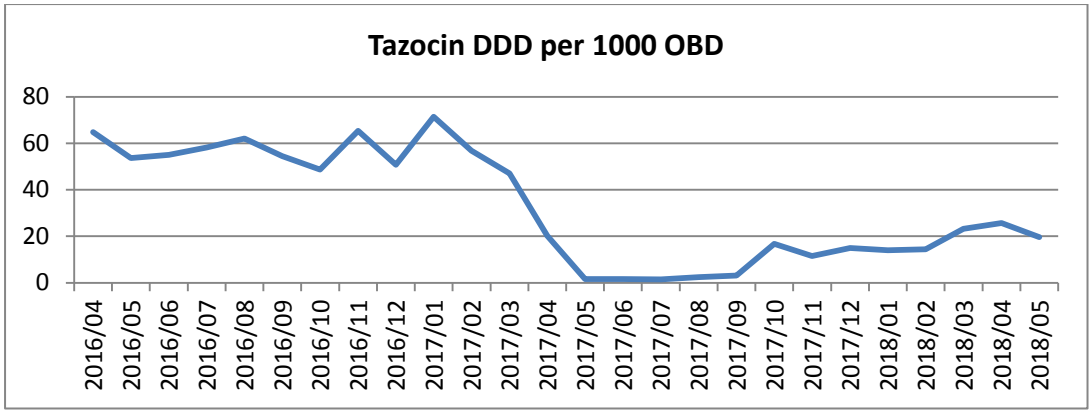

Figure 9: Prescribing trend for piperacillin/tazobactam (Tazocin), April 2014- current, HDFT

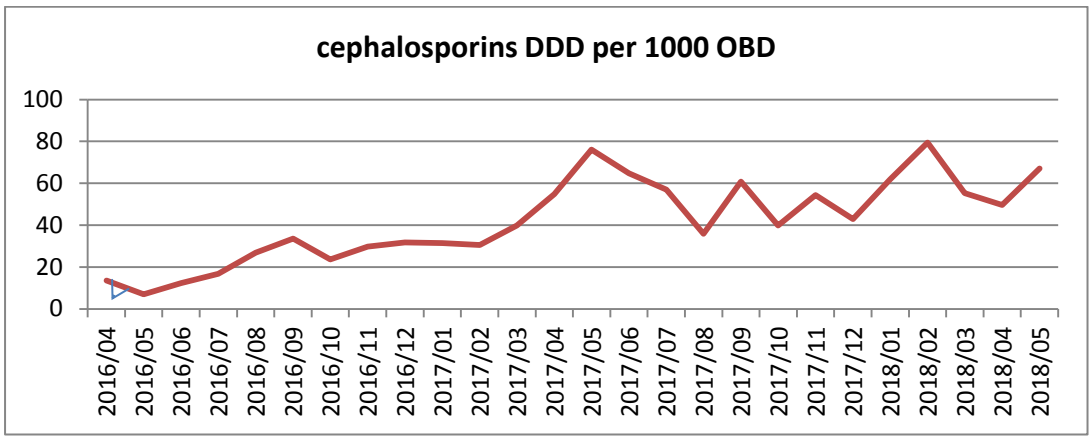

Figure 10: Prescribing trend for the cephalosporins, April 2014- current, HDFT

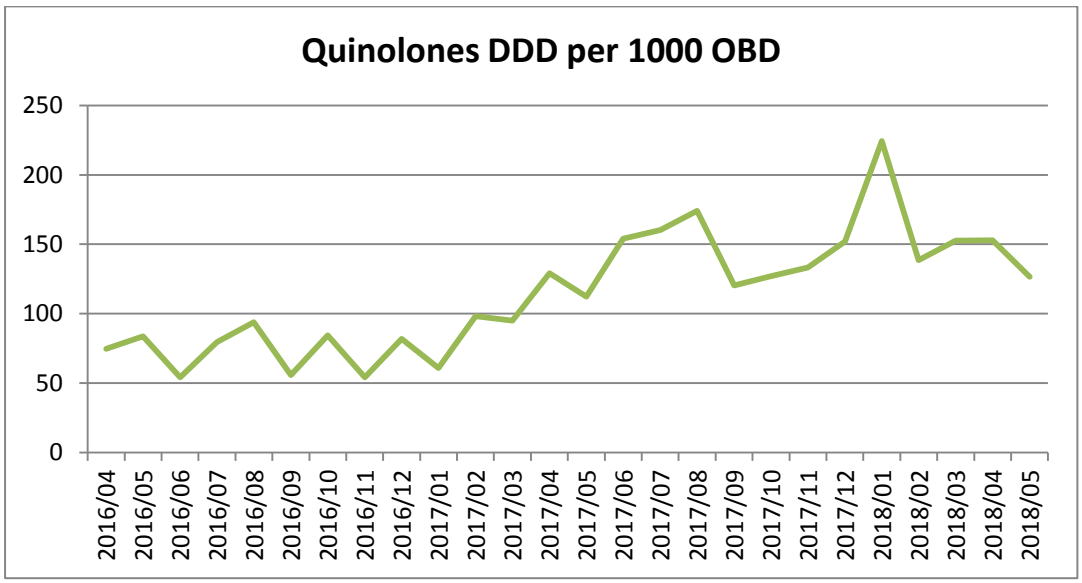

Figure 11: Prescribing trend for the quinolones, April 2014- current (HDFT)

Quinolones include ciprofloxacin and levofloxacin. The increase in early 2018 is a reflection of the number of respiratory tract infections at the time.

Quality improvement for surgical teams (QIST) initiative

HDFT has joined the QIST study, an initiative headed by Northumbria Healthcare NHS Foundation Trust, aiming to reduce the number of MSSA infections after primary hip and knee replacements.

The two arms of the study include

1. Infection- all patients undergoing primary hip and knee replacements to be given Octenisan body wash, with an option to screen all patients for MSSA and decolonise carriers, or to give all patients nasal decolonisation. We have decided to do the latter.
2. Optimising haemogoblin pre-op, with iron supplements or transfusion.

Prosthetic joint infections are the most expensive to treat in terms of length of stay, the need for revision operations and long antibiotic courses. A typical episode costs ~£22,000. The impact on patients' lives is considerable.

In summary

This has been a good year for Infection Prevention and Control. The number of CDI cases has remained lower than in previous years. The winter was particularly challenging, mainly because of the large increase in patients presenting with respiratory infections, mostly viral. The organisation coped remarkably well, and the introduction of a new diagnostic platform at three weeks' notice mid-season made a difficult situation much easier to manage from an infection control and patient management point of view.

The challenges for the coming year will be keeping the CDI numbers low, and maintaining a tight control on the rising multiply-resistant Gram-negative organisms.

Progress against infection prevention and control service annual work plan 2017/18

Monitored by: **Hospital and Community Infection Prevention and Control Team meeting**

Reports to: **Trust wide Infection Prevention & Control Committee**

Report authors: **Kath Banfield, Amanda Gooch & Sonya Ashworth**

Date: **April 2017 – April 2018**

Operational and Responsible Leads:

SA – Sonya Ashworth
KB – Kath Banfield
SC – Sarah Chadwick
JC – Jenny Child
CG – Caroline Gent
AG – Amanda Gooch
IG – Iona Goodwin
AZ – Alexia Zeniou
RH – Richard Hobson
WH – Ward Hygienist
GJ – Gillian Johnson
JM – Jessica Martin
GM – Gillian Mitchell
AP – Anna Padget
CR – Christopher Richardson

Infection Prevention and Control Annual Work Plan 2017/18

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
1	**Maximise collaborative working opportunities to impact infection prevention and control practices across HDFT hospital and also North Yorkshire community settings**	Evidence of integrated working systems across the whole health economy	Annual Infection Prevention and Control Time Out	KB	JC	Dec-17	Green
			Bi-monthly Quality of Care Team meetings	KB	JC	Mar-18	Green
			Evaluate effectiveness of HIPC AND CIPC service through user surveys	AG & SA	KB	Mar-18	Amber Green - community
			Review and revise IPCN On-Call Service	AG & SA	KB	Mar-18	Green
			Implement SystmOne to improve information exchange to/from CIPCT	SA	KB	Aug-17	Green
			Confirm timescale for WebV IPC module for HIPCT	AG	KB	Mar-18	Amber
			Continually review and revise IPC working systems and staffing establishment to ensure effective use of resources and achieve cost improvement target	AG & SA	KB	Mar-18	Green
			Undertake Gram-negative bacteraemia gap analysis to formulate a Plan to reduce Gram-negative bacteraemia cases. Work collaboratively with CCG key stakeholders, Continence Team, Urology Nurses and others to deliver this plan.	KB	JC	Mar-18	Green
2	**Revise IPC Policies to cover HDFT hospital and community services. Revise Community IPC Policies for Health and Social Care**	Publication of updated policies	Revise section 001 Management and Organisation to reflect review of HCAI Governance arrangements	KB	JC	Dec-17	Green
			Revise section 002 Isolation Principles	AG	JC	Sep-17	Green
			Revise section 008 Chicken Pox and Shingles	RH	JC	Jun-17	Green
			Upload revised section 017 Exclusion of Staff to intranet	CR	AG	Jun-17	Green
			Revise section 012 MRSA screening policy	JC	JC	Oct-17	Amber
			Revise section 014 Standard Precautions	IG	JC	Jan-18	Green
			Revise section 018 MRGNB	JM	JC	Mar-18	Green
			Revise section 019 Decontamination	RH	JC	Jul-17	Green
			Integrate section 023 Waste and Facilities Waste Policy	JC	JC	Jun-17	Green
			Integrate section 030 Legionella and Facilities Legionella Policy	JC	JC	Jun-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
			Revise section 032 Visitors	IG	JC	Dec-17	Green
			Revise section 036 VAP	AZ	JC	Feb-18	Green
			Revise section 039 VHF	IG	JC	Aug-17	Green
			Revise section 042 RCA to incorporate Gram-negative bacteraemia investigation	KB & AG	JC	Aug-17	Green
			Revise section 044 Mortuary	AG	JC	Oct-17	Green
			21 Community IPC Policies to be revised to develop specific policies for GP Practice.	SA	SA	July 2017	Green
3	Implement IPC Education and Training Strategy	Provision of a blended approach to training	Revise induction package	AG	KB	May-17	Green
			Revise IPC e-learning package:WFD to rename sections prior to making available, audit trail in place.	AG & KB	AG	Dec-17	Green
			Deliver CIPCT training 8 half day events across each CCG locality for General Practice, Care Home and Domiciliary Care staff	SA	SA	Mar-18	Amber, some cancelled due to low numbers
			Deliver the Preventing Infection 2 day course held twice a year for all Community Staff	SA	SA	Mar-18	Green
			Deliver IPC Masterclass for Domestic Staff: changed to package for band 2/3 Byland staff as responded to need.	AG	JC	Apr-18	Green
			Develop new resources to support improved HCAI knowledge, skills and practice (eg posters, aide memoirs)	AG & SA	KB	Mar-18	Green
			Confirm support for and once secured, lead delivery of a Safer Care Campaign working collaboratively with Specialist Nurse colleagues (Back to basics)	AG	KB	Mar-18	Green
			Deliver targeted education campaigns e.g. Reduction of catheter-associated UTI, Back to Basics ICED	AG	JC	Mar-18	Green
			Participate in Global Hand Hygiene Awareness Campaign and Antimicrobial Stewardship campaign	AG & SA	JC/JM	May-18 & Nov-17	Green
4.	Monitor compliance with IPC policies	Completion of IPC audit programme and demonstrable	Continue to review approaches for assurance relating to IPC practice including implementation of 2017 High Impact Intervention audits	AG & SA	KB	Mar-18	Green
			Introduce annual hand hygiene audits to lone working community staff	SA	KB	Oct-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
		improved compliance	Isolation – Audit of single room availability	GM & AG	AG	Oct-17 & Mar-18	Green
			Isolation – Shut the door	GM	AG	Dec 17	Green
			Isolation – Two hour isolation audit	AG & SC	KB	Dec-17	Green
			Isolation – Audit of Equipment	WH	AG	Sep-17	Green
			Isolation – Progress against Competency Assessment Process	CR & IG	AG	Sep-17	Green
			BBV – Audit of Sharps Disposal	AG	KB	Jan-18	Green
			CDI – *Saving Lives* Audit for every in-patient case	HIPCNs	AG	Apr-18	Green
			CDI – Fortnightly audit of sanitary equipment	WH	AG	Apr-18	Green
			CDI – PII review meetings and action planning	AG	KB	Apr-18	Green
			MRSA – Audit of decolonisation	GM	AG	Feb-18	Green
			MRSA – Audit of patient information	GM	AG	Sep-17	Green
			HH – Monthly audits	Ward/ Dept Mans	AG/SA	Apr-18	Green
			Water safety – Audit of augmented care HH facility use to be reported to Water Safety Group **SPEAK to IG /Jim still will sort if not done**	Ward/ Dept Mans	AG/IG	Jun-17 & Dec-17	Amber
			Correct use of water filters	WH	AG	Dec 2017	Green
			HH – Audit of posters and point-of-care hand foam	WH	AG	Feb-18	Green
			HH – Quarterly Secret Shopper Audit of patient hand hygiene promotion	GM	AG	Apr-18	Green
			IV – *Saving Lives* audit for insertion & on-going care	Ward/ Dept Mans	AG	Apr-18	Green
			CVC – *Saving Lives* audit for insertion & on-going care	Ward/ Dept Mans	AG	Apr-18	Green
			Decontamination – Audit of disinfectant availability	WH	AG	Apr-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
			Decontamination – Audit of spillage procedure	AG	AG	Apr-18	Green
			Decontamination – Blood glucose testing equipment	WH	AG	Apr-17	Green
			Asepsis – Progress Report of assurance framework implementation:planning in place	IG	AG	09/17	amber
			VAP & Tracheostomy – *Saving Lives* audit: ITU to take lead, will go onto their annual plan on completion	Ward/ Dept Mans	AG	Apr-18	Amber
			SSI – *Saving* Lives audit	Ward/ Dept Mans	AG	Apr-18	Green
			Audit Gram-negative bacteraemia cases August-October 2017 to determine proportion that have an indwelling urinary catheter prior to sepsis	SA	JC	Nov-17	Green
			CA-UTI – *Saving Lives* audit (IPQAT)	Ward/ Dept Mans	AG	Apr-18	Green
			Vertical audit of MSSA/MRSA and CDI RCA (e.g. carried out within target dates)	AG	KB	Apr-18	Amber
			HCAI information – Intranet & Internet	AP&CR	SA&AG	Sep-17	Green
			HCAI information – Audit of discharge documentation (including catheter passport)	SC & AG	JC	Dec-17	Green
			Annual IPC environmental audits of Ripon and Selby MIU Units, the GP OOH Service, Podiatry, Ripon Hospital including Trinity Ward, Outpatients, Physiotherapy, Maternity, Radiology	JC &CG	SA	Apr-18	Green
5	Monitor HCAI through implementation of surveillance programme	Achievement of DH objectives for MRSA Bacteraemia (0) and Clostridium difficile infection (12); Reports of year-on-year	Submission of mandatory reports to Public Health England via DCS – MRSA & MSSA bacteraemia; *Clostridium difficile* infection; glycopeptide-resistant enterococcal bacteraemia; bacteraemia Gram-negative;	AG	JC	Apr-17	Green
			Enable and support T&O department in conjunction with P&SC directorate to review and implement orthopaedic surgical site infection surveillance in addition to mandatory modules. (Hemiarthoplasty July-September 2017)	AG	JC	Oct-17	
			Establish a surveillance system to monitor central IV line-related infections central IV line: documented version in place	AZ	AG	Sep-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
		reduction of hospital attributed HCAI	Continue Alert Organism/Condition surveillance (Hospital-acquired MRSA; *Clostridium difficile* infection and colonisation; MRGNB; norovirus; MSSA in SCBU; Pseudomonas in ITU, SCBU & Haematology Ward; TPN-related inf; CPE; Urinary catheter prevalence)	AG/CR	AG	Apr-18	Green
			Interrogate 2016/17 Gram-negative bacteraemia case data to steer 2017/18 action plan	JFE/AZ	JC	07/17	Green
6	Further improve communication about HCAI with patients and carers	Increased engagement about HCAI with patients and carers	Review electronic IPC resources on Intranet and HDFT web site	CR & AP	JF/SA	Sept-17	Green - community
			Seek patient feedback re MRSA screening information via audit	GM	AG	Sept-17	Green
			Seek patient feedback /experience of patients with *Clostridium difficile* (hospital and community)	AG & SA	KB	Apr-18	Green - community
7	Improve cleanliness of equipment and the environment within inpatient settings	Reduction in HDFT-acquired CDI cases	Implement Ward Hygienist action plan and continually review service	AG	KB	Jul/17	Green
			Support implementation of Ward PMDC and HPV/UVC programme	AG	JC	Mar-18	Green
8	Contribute to reduction of HCAI across community settings	Achievement of DH objectives for MRSA Bacteraemia and *Clostridium difficile* infection for the NYY CCGs	Support PIR process for all NY cases of MRSA bacteraemia. Contribute to RCA review meetings for cases of CDI where indicated. Provide monthly reports for CCGs summarising RCA findings and 6 monthly trend reports.	SA	KB	Apr-18	Green
9	Improve HCAI management within NYY Care Homes	Reduction in cases with MRSA/*Clostridium difficile* infection/norovirus outbreaks	Provide service as per service description Use surveillance to identify and prioritise homes requiring additional support Provide IPC education and support for homes requiring additional support. Produce regular newsletters Support Care Home Forums across the CCG's Support Care Homes with outbreaks	SA	KB	Apr-18	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
10	Evidence of compliance with IPC Policies	Compliance assurance by implementation of an audit programme for HDFT Community Services	IPC Audit programme for HDFT community bases providing an annual environmental audit for: - MIU's at Selby and Ripon - Podiatry across North Yorkshire - Dental across North Yorkshire - Ripon Hospital – Trinity, OPD, Physiotherapy, Radiology, Maternity	SA	KB	Mar-18	Green
11	Continued development of Community IPC website. Maximise Marketing of resources and increase marketing projects	Increased number of hits to the website and achievement of cost improvement target (£73.5K)	Continue to develop and improve the website raising awareness nationally of IPC resources available to purchase and download. Email newsletters to care homes and GP Practice on alternative months.	SA	KB	Apr-18	Green
			Active marketing of IPC resources Regular communication messages and use of social media	AP	SA	Apr-18	Green
			Attend as an exhibitor at the IPS Conference to launch the new Dental Workbook and other resources	SA/GJ/ AP	SA	Sep-17	N/A not attended
			Optimise training/consultancy opportunities including CQC style inspections for Care Homes and GP Practices	SA	SA	Apr-18	Green
			Develop the 10th edition Care Home Workbook and other new educational resources	SA/AP	SA	Apr-18	Amber
			Produce a poster for the IPS conference on the Dental Workbook	GJ	KB	Sep-17	N/A
			Consider contracts with external providers	SA/KB	KB	Apr-18	Amber
			Achieve income generation target of £75k	SA	KB	Apr-18	Amber
12	Introduce electronic recording of all patient	Use of SystmOne by CIPCNs	Introduce System One for CIPCT	SA	KB	Aug-17	Green

ID No	Issue	Indicator (if relevant)	Action/s	Op. Lead	Resp Lead	Target Date	Progress 04/18
	interactions						
13	Reduction of Gram-negative bacteraemia cases in the community	Achievement of reduction target	Support campaign to improve diagnosis and management of UTIs in General Practice and Care Homes	SA	JC	Mar-18	Green

Infection prevention and control plan 2017/2018

- Introduce a MasterClass for HCAs, adapted from the highly successful MasterClass for Nurses programme
- Verbal update for doctors including consultants via the Directorates
- Work with the CCG to reduce *E. coli* bacteraemia, targeting urinary sepsis and infections in residential care first
- Introduce same-day laboratory screening for respiratory viruses
- Introduce point of care respiratory virus testing in A&E and the new Clinical Assessment Unit
- Support the T&O team in the successful implementation of the QIST project
- Review the screening strategy for key target organisms including MRSA and multiply-resistant Gram-negatives
- Review all current infection control policies and revise where necessary