BOARD OF DIRECTORS MEETING (Open)

Date: 12 September 2018 **Item Ref:** 19i

TITLE OF PAPER	Infection Prevention and Control Annual Report, 2017 – 2018 and Infection Prevention and Control Programme for 2018-2019
TO BE PRESENTED BY	Liz Lightbown, Executive Director of Nursing, Professions and Care Standards
ACTION REQUIRED	Members to receive the Annual Report for Information & Assurance & Approve Publication on the Trusts Website.

OUTCOME	Members to be assured on all aspects of infection, prevention and control for the Trust and satisfied with the progress achieved during 2017/18
TIMETABLE FOR DECISION	September 2018 Meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	▫ Infection Control Programme 2017 – 2018 ▫ Safety and Risk Strategy
STRATEGIC AIM STRATEGIC OBJECTIVE BAF RISK NUMBER & DESCRIPTION	Strategic Aim: Quality Safety Strategic Objective: Objectives: A102: Deliver safe care at all times. BAF Risk No: N/A BAF Description: N/A
LINKS TO NHS CONSTITUTION & OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	▫ Board Assurance Framework ▫ NICE Quality Standards (61, 113, 139) ▫ Care Quality Commission Fundamental Standards ▫ Code of Practice on the Prevention & Control of infections and related guidance ▫ NHS Litigation Authority ▫ Safety Thermometer Framework ▫ NHS Outcomes Framework 2016-17, Domain 5
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	If financial implications are identified during the delivery of this programme, individual business cases will be developed and put forward to the Board for consideration
CONSIDERATION OF LEGAL ISSUES	Legal Requirement to comply with The Health and Social Care Act 2008 (2015)

Authors of Report	Katie Grayson and Liz Lightbown
Designation	Senior Nurse - Infection Prevention and Control
Date of Report	31 August 2018

SUMMARY REPORT

Report to: **BOARD OF DIRECTORS MEETING**

Subject: **Infection Prevention and Control Annual Report 2017 – 2018 and Infection Prevention and Control Programme for 2018 - 2019**

Authors: **Katie Grayson, Senior Nurse Infection Prevention & Control Lead**
Liz Lightbown

1. Purpose

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

2. Summary

The Annual Report on the performance of the Infection Control Annual Programme for 2017 - 2018 was received and approved at the July 2018 Quality Assurance Committee. It is here for Board's Information, Assurance and Approval for Publication on the Trust's Website.

The Infection Prevention & Control Annual Programme follows/meets the requirements of the Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

Looking forward the Annual Report incorporates the Infection Prevention and Control Programme for 2018 - 2019 which identifies a number of strategic objectives which the Trust will work towards to ensure its continued compliance with Code of Practice in meeting our regulatory requirements against the 10 compliance criteria in the Code.

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

Excellent progress has been made towards completion of the annual programme against the 31 actions contained within; which are split into 7 key work streams. 2 actions remain outstanding; 1 regarding antibiotic auditing which the Pharmacy Department are responsible for achieving and the other is facilitating an IPC full day's conference. Please refer to the Dashboard on page 5 for details.

The report retrospectively and succinctly highlights the achievements of the team over the preceding year. In brief this encompasses exceeding the Quality Account target for hand hygiene training set by Sheffield CCG, successfully delivering innovative training for Infection Prevention and Control link workers and despite not meeting the CQUIN targets for staff uptake of flu vaccine, the campaign planning and implementation was imaginative and used the EAST (Easy, Attractive, Social, Timely) Framework, developed by the Cabinet Offices

Behavioural Insights Team and resulted in a significant increase on last year's vaccination rate of Frontline Healthcare workers from 24% to 56% and we were the 5th most improved Trust in the country .

Alongside the substantial Annual Infection Control Audit Programme; two other extensive audit projects have been facilitated which were re-audits of the mattresses and sharps containers across the Trust.

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

Dashboards on page 4 and 5 visually displays pertinent information for your reference.

3. Next Steps

i. For the Infection Prevention and Control Team to continue their proactive approach to reducing the risk of infection within the Trust; in line with the infection control annual programme for 18/19.
ii. For the Annual Report 2017 - 2018 and the Infection Control Programme 2018 - 2019, to be published on the Trust's website, once received by the Board of Directors.

4. Required Actions

Members are asked to:

i. Note the achievements and on-going progress, which will continue into the Infection Prevention and Control Programme for 2018 - 2019.
ii. Note Quality Assurance Committees approval of the Infection Control Programme for 2018-2019, which incorporates revised directions from The Health Act 2008, to ensure compliance by the Trust.
iii. Be assured that all aspects of infection, prevention and control for the Trust; through annual reporting, are in accordance with the requirements of The Health Act.
iv. Approve this report for publication on the SHSC website

5. Monitoring Arrangements

i. Quarterly Infection Prevention & Control Committee.
ii. Monthly performance reports to the Clinical Care Networks (18/19).
iii. Quarterly performance reports to the Executive Directors Group (EDG) and Quality Assurance Committee.
iv. Annual Report to the Board of Directors.

6. Contact Details

For further information please contact:

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Infection Prevention and Control Annual Report 2017 – 2018

Infection Prevention and Control Programme 2018 - 2019

Contents

1. Introduction

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

1.2 The Annual Report of the Infection Prevention and Control Team provides a retrospective overview of the activities carried out to progress the prevention, control and management of infection within Sheffield Health and Social Care NHS Foundation Trust (SHSC) during the last year (April 2017 – March 2018).

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

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

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

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

2. Governance Arrangements

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

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

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

- Trust Boards Monthly Quality & Safety Dashboard.
- Quarterly Infection Prevention & Control Committee.
- Quarterly and Annual Reports to the EDG and Quality Assurance Committee.
- Annual Report to the Board of Directors.
- From Q2 18/19: Monthly Performance Reporting to the Clinical Care Networks Governance Meeting.

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

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

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

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

2.2 Infection Control Committee (ICC)

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

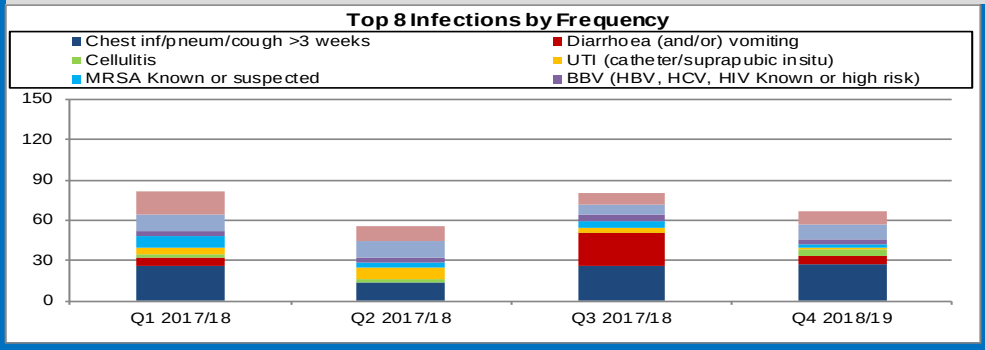
A review of committee membership is being progressed due to the new Trust-wide Governance Structure being in place and the creation of the new Clinical Care Networks. Arrangements regarding attendance of Senior Operational Managers (SOM's) / or their nominated deputies and Trust medical representatives is to be confirmed in the next committee meeting, this is being progressed by the Deputy Director of Nursing.

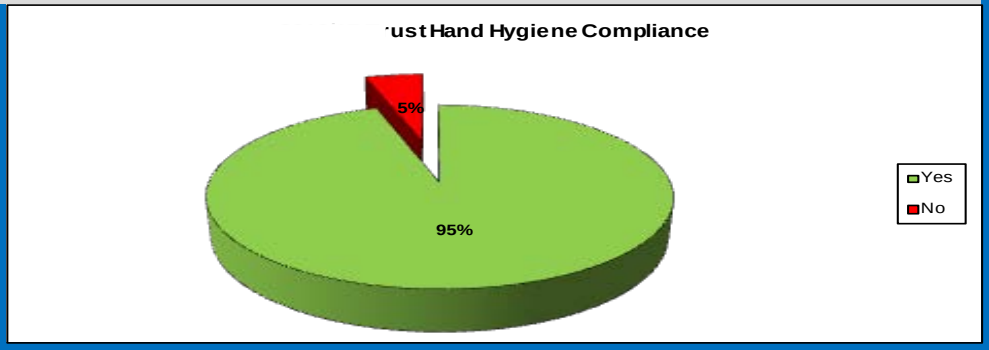
2.2.2 Key objectives:

- To oversee all infection prevention issues and adverse incidents.
- Provide advice to the Infection Prevention and Control Team, the Director for Infection Prevention and Control (DIPC, the Executive Director of Nursing) and the Board of Directors to ensure appropriate actions are taken.
- Report exceptions, adverse incidents and receive up-dates as necessary.

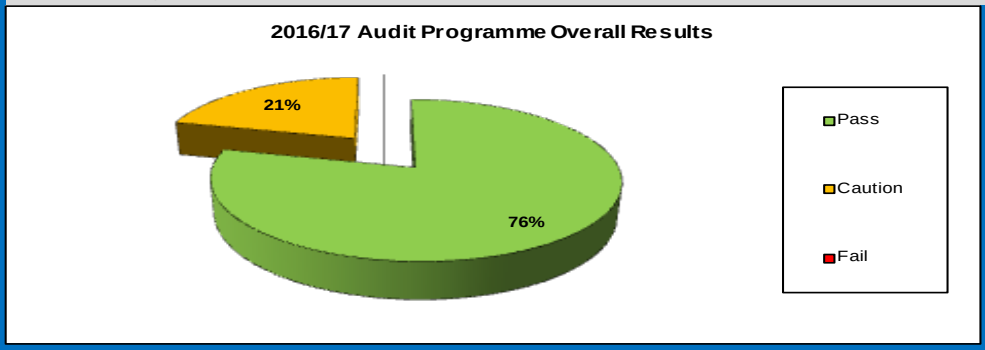
Infection Control Dashboard: April 2017 - March 2018

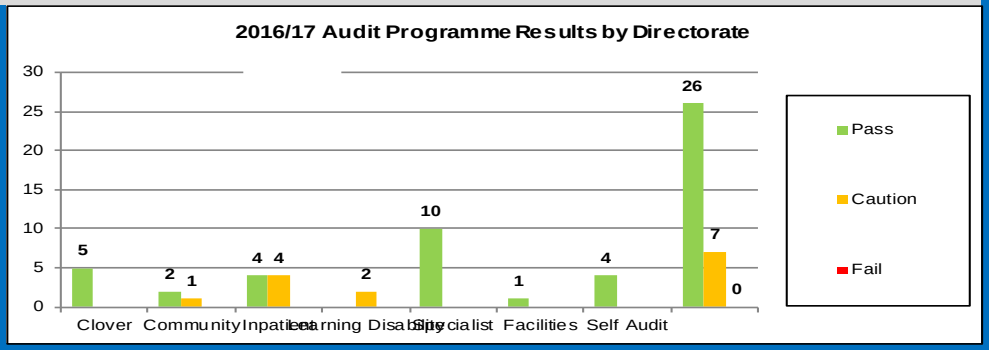
Infections / Hand Hygiene



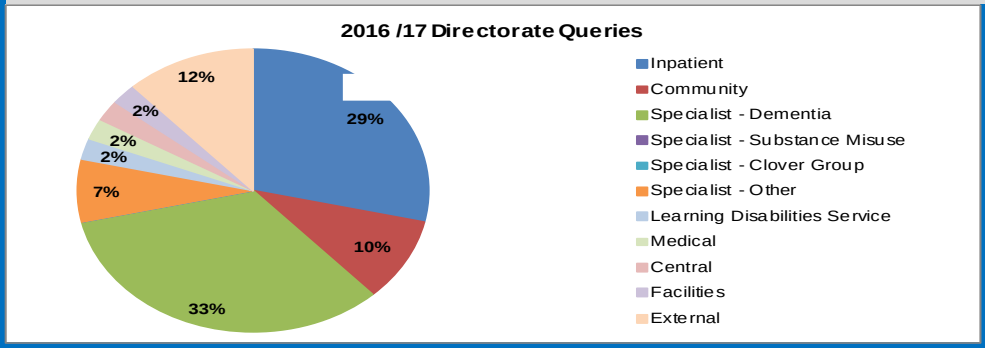


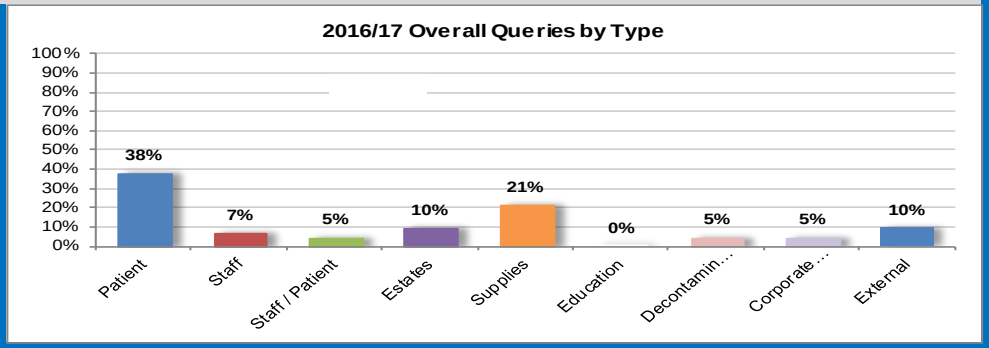
Audit Programme



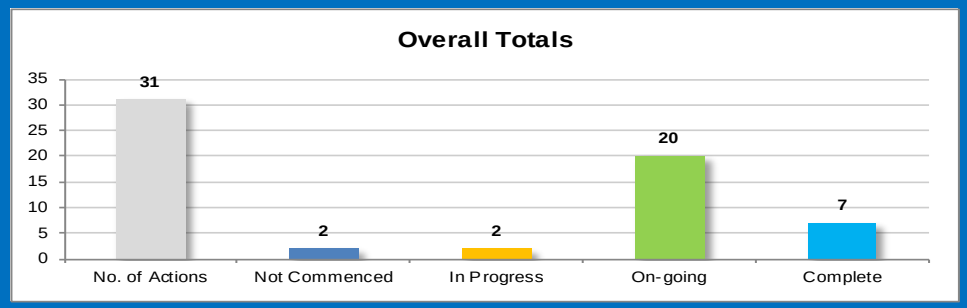


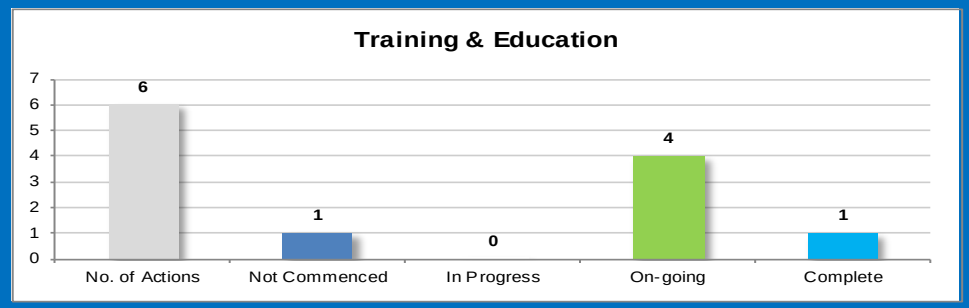
Queries

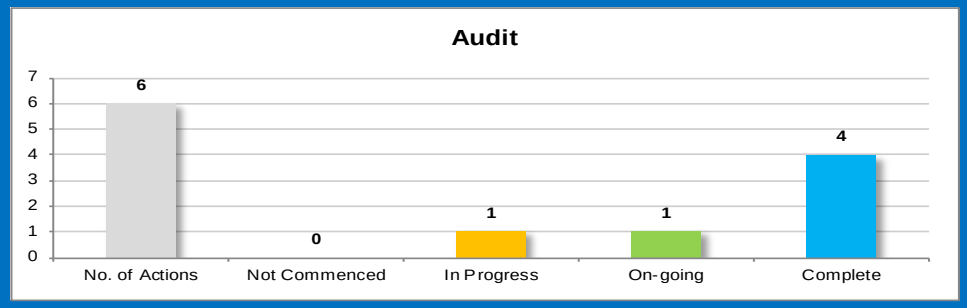


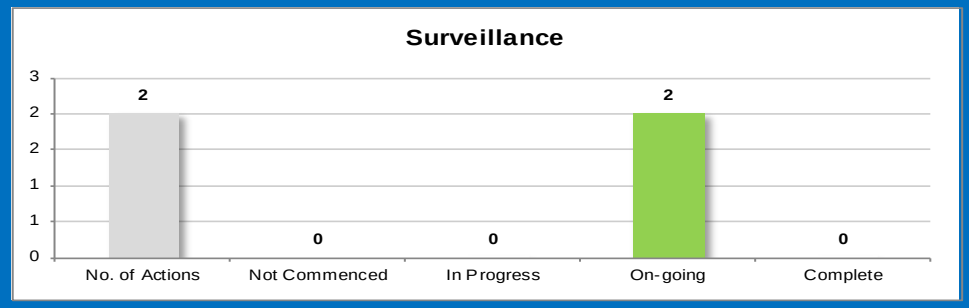


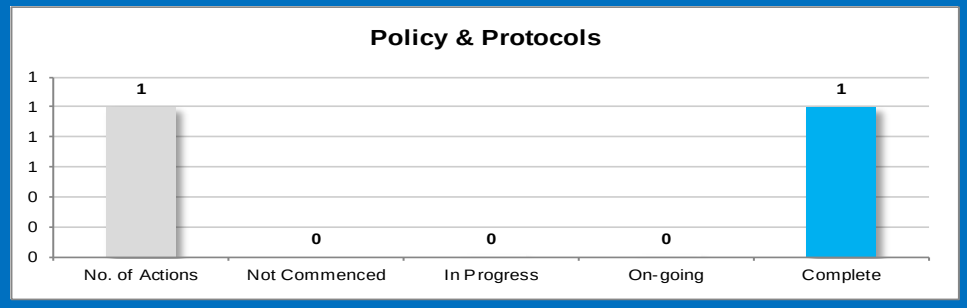
Annual Programme

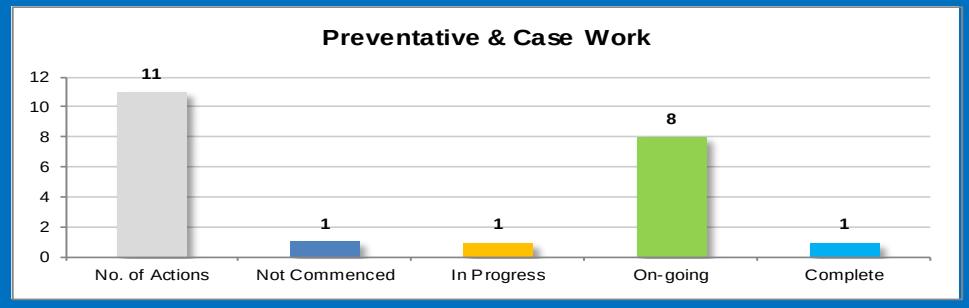


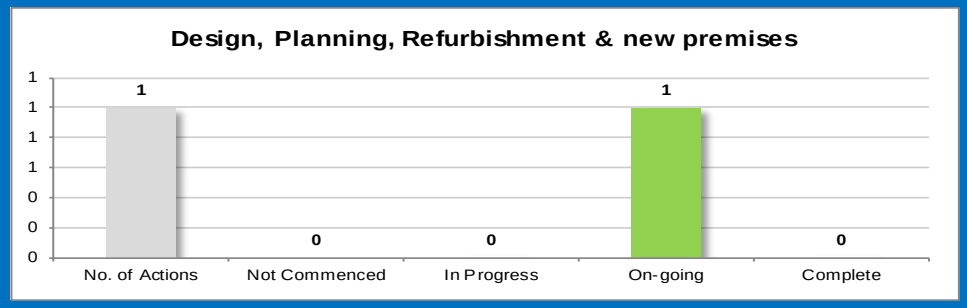


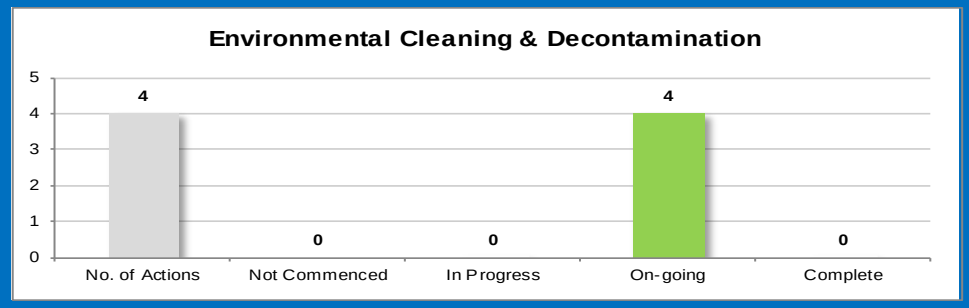












3. Progress Summary - Annual Infection Control Programme for 2017 – 2018: See Dashboards pages 9 & 10

3.1 Hand Hygiene

3.1.1 It is well evidenced that hand hygiene is the simplest and least expensive intervention that can actively reduce the risks of cross contamination between staff, Service User and visitors. Body secretions, surfaces of inanimate objects and hands of all human beings can carry bacteria, viruses and fungi that are potentially dangerous to them and others. Therefore the promotion of effective hand hygiene coupled with "Bare Below the Elbow" (BBE) within the Trust continues to be high on the agenda.

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

3.1.3 To this end the Infection Prevention and Control Team continually work with Supplies and Estates to ensure that products are consistently available. In addition the audit of hand hygiene facilities has been performed by the IPCT and where facilities were identified as insufficient these issues are being addressed.

3.2 Education and Training

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

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

3.2.3 The minimum standards are for all new staff to receive training on corporate induction (known as Core Mandatory); which covers the basic principles of Standard Infection Control Precautions (SICP). SICP training includes appropriate hand hygiene with soap & water and alcohol handrubs, the use of Personal Protective Equipment (PPE), decontamination of equipment, sharps safety, healthcare waste management, laundry management, spillage management and isolation precautions. Since April 2016 all staff with direct care contact receive an IPC refresher session delivered by colleagues in the training department known as 'Mandatory Update'. This ensures a robust process to training the workforce regularly in regards to IPC practices for assurance purposes and improved recording of training data.

3.2.4 The Table below provides an overall picture regarding a collective total of all the mandatory training offered throughout the year and compares figures to previous years. The Quality Account target set by NHS Sheffield Commissioning Group is to have trained 80% of staff in hand hygiene (HH) practices. The Trust has met this target by achieving **95%.** This is a substantial improvement whereby only 52%-57% compliance has been reported for a number of years previously.

3.2.5 The table below shows how many staff has received training and compared to previous years appears lower due to a decrease in the overall employee headcount and compliance covers a 2 year period. Positively over half of the workforce has been trained this year.

	2015 - 2016	2016 -2017	2017 - 2018
Staff Trained in IPC & HH Training	2,001	2,165	1,421

3.2.6 The Infection Prevention and Control Team (IPCT) continue to deliver regular face-to-face training commitments e.g. Core Mandatory (corporate induction); to ensure that new staff are trained appropriately in IPC practices. Additionally the IPCT continue to provide either roadshows or more bespoke presentations and ad hoc training sessions according to need; often identified post auditing or following-up on incident reporting trends or outbreaks of infection. Additionally IPC have been approached by external organisations e.g. The Salvation Army to deliver training, this has been facilitated as service users of the Trust use this organisation on a regular basis.

3.2.7 A Link Worker Forum study session was organised in April 2017 with 11 staff in attendance. Guest speakers included representation from Herida Healthcare on mattress inspection and cleaning regimes followed by Frontier Medical on Repose products for pressure care.

3.2.8 To retain credibility and validity of the infection prevention roles, the Senior Nurse and the Infection Prevention Control Co-ordinator (IPCC) have undertaken professional development through a variety of sources. Both staff are members of the Infection Prevention Society (IPS), which provides opportunities for networking at a regional and national level and access to appropriate educational study days and conferences. This year's 3 day international conference was held in Manchester during September 2017. Both staff members attend the IPS Special Interest Group (SIG) for Mental Health & Learning Disabilities; as well as their regional IPS branch meetings. Since April 2016 the Senior Nurse has held a Branch Officer role in IPS Yorkshire Branch as the Educational Lead working at a regional and national level. Also the Co-Ordinator volunteered to be the SIG's secretarial officer; in which this 2 year tenure has now finished. This ensures both staff are competent and remain up to date in their respective roles.

3.2.9 The Senior Nurse in IPC has successfully completed 3 MSc modules via distance learning and continues with her studies. The Co-Ordinator has commenced a coaching course within the Trust.

3.2.10 Traditionally May is the recognised month in which the World Health Organisation (WHO); globally calls for action to promote 'safe care is clean care' across all health organisations. To celebrate this global initiative the May 2017 IPC roadshows focused on Sepsis and took the opportunity to promote awareness of this medical emergency; regarding the early recognition of deteriorating Service User within Mental Health settings and ensuring prompt admission to the Acute Trust for urgent medical attention, when Sepsis is suspected. 60 staff members attended the Roadshows which were held across the Trust in different clinical settings.

3.2.11 This Roadshow really connected with staff as many shared their personal stories of Sepsis and how it had affected people who were either related to them or their friends. The IPCT received email messages from staff saying how glad they were that the team were proactively raising awareness of this serious condition and were not aware of how quickly Sepsis can develop.

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

3.3 Surveillance

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

3.3.2 The IPCT acknowledge that the data provided is not statistically robust due to areas not complying fully with the requirement to gather the requested surveillance information or submit it in a retrospective timely manner. The Tables below identify the level of compliance by Clinical Care Network in providing the relevant information and shows a comparison to last year's data. If the areas provide data more than 75% **(GREEN)** of the time (over the 12 month period); they are deemed as compliant. Returning data 50% - 75% of the time during the year equates to a caution **(AMBER)** and areas providing data less than 50% of the time are recorded as non-compliant with data returns and colour-coded **(RED).**

3.3.3 Outstandingly only Birch Avenue Care Home have consistently provided data 100% of the time throughout the last year and in the previous year and are highlighted in **(BLUE)** for this achievement. Subsequently Forest Close, Beech Cottage, Willow Cottage, Wainwright Crescent and Buckwood View have also returned consistently and achieve a blue status.

These Tables clearly show where areas have either improved or fallen below expected standards. The level of compliance has been shared at the Infection Control Committee and referred to in the quarterly reports for Clinical Care Networks to address directly in the areas of which they are responsible. To progress the monitoring aspect of this further next year; it is proposed that the submission of this data is monitored via the Governance Officers working into the Clinical Care Networks.

In 18/19 The IP&C Senior Nurse will attend the Monthly Clinical Care Networks Governance & Performance meeting to report on performance and work with Director's, Clinical leaders & Senior Operational Managers (SOMs) to drive improvement in performance on IP&C at Ward & Community Team level.

Surveillance Compliance April 2016 – March 2017	
Area	**Compliance %**
Acute Directorate	
Burbage	66%
Dovedale	58%
Forest Close	75%
Forest Lodge	50%
Endcliffe	50%
Maple	50%
Stanage	33%
Specialist Directorate	
Birch Avenue	100%
G1	50%
Woodland View Cottages	
• Beech	66%
• Oak	50%
• Willow	75%
Community Directorate	
Wainwright Crescent	75%
Learning Disability Directorate	
Buckwood View	88%
Firshill Rise	16%

Surveillance Compliance April 2017 – March 2018	
Area	**Compliance %**
Acute Directorate	
Burbage	17%
Dovedale	25%
Forest Close	100%
Forest Lodge	75%
Endcliffe	25%
Maple	34%
Stanage	92%
Specialist Directorate	
Birch Avenue	100%
G1	50%
Woodland View Cottages	
-Beech	100%
-Oak	83%
-Willow	100%
Community Directorate	
Wainwright Crescent	100%
Learning Disability Directorate	
Buckwood View	100%
Firshill Rise	25%

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

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

3.3.5 The surveillance data on *Clostridium difficile* (C-diff) has recorded 2 cases; which have been detected in the Clover Group GP Practices. Both cases have been subjected to Root Cause Analysis (RCA) investigations to determine if any lapses in care could be identified. As such the community acquisition of C-diff in both these cases was 'unavoidable' and no lapse in care was identified.

3.3.6 45 Urinary Tract Infection (UTI) cases (Service User who are not catheterised) have been reported. Chest infections are the most reported type of infection at 99 cases along with 260 Service User's prescribed inhalers or nebulisers. 80 Service Users are reported to have an invasive device insitu and 44 Service Users are known to have self-harmed by breaking the skin; both of which increases their risk of infection as natural body defences are compromised. Wounds are reported as 46.

3.3.7 The reported numbers of antibiotics prescribed during this period is 283. It shows a high prevalence within the Emergency / Crisis Clinical Care Network (previously known as Specialist Directorate) recorded at 224. In comparison to last year a slight increase in antibiotic prescription activity has occurred from 273 in 16/17 to 283 in 17/18.

Annual Infection Surveillance Data: April 2017- March 2018

	Number of patients with known or suspected infections / infestations																							
	Infections																							
Directorate	MRSA Known or suspected	Other multi-resistant organisms e.g. ESBL, CPE	Diarrhoea (and/or) vomiting	Clostridium difficile (known or suspected)	Blood borne virus e.g. HBV, HCV, HIV Known or high risk	Known/suspected IV drug user	History of self-harm (breaking the skin only)	Invasive devices e.g. catheters, PEG or other	Number of patients had MRSA screens done this month	Chest infections/pneumonia or cough lasting 3 weeks or more	Influenza like illness	Urinary tract infection (no catheter insitu)	Urinary tract infection (catheter/suprapubic insitu)	Prescribed antibiotic treatment	Transferred from another hospital	Transferred from residential or nursing care homes	Wounds – include leg ulcers/surgical	Infestations(parasitic) e.g. head lice, pubic lice, scabies, thread worms	Cellulitis	Prescribed inhalers or nebulisers	TB – known history or suspected	Ear infections	Eye infections	Any other infections – please provide details
Acute	7	0	13	0	14	21	44	2	48	2	6	6	0	18	37	2	17	1	4	40	0	0	1	3
Community	0	0	0	0	2	0	0	0	0	3	0	1	0	7	0	0	0	0	0	2	0	1	0	1
LDS	0	0	0	0	0	0	0	10	2	20	1	9	0	34	1	1	1	0	2	35	0	0	1	1
Specialist	12	0	24	0	0	0	0	68	52	74	5	29	15	224	25	8	28	0	2	183	4	3	7	12
Overall Annual Totals	**19**	**0**	**37**	**0**	**16**	**21**	**44**	**80**	**102**	**99**	**12**	**45**	**15**	**283**	**63**	**11**	**46**	**1**	**8**	**260**	**4**	**4**	**9**	**17**

3.4 Outbreak Summary

3.4.1 The Table below summarises all the reported outbreaks over this reporting period. 2 enteric outbreaks and 1 respiratory outbreak have been reported to the IPCT. The enteric outbreak on Woodland View Nursing Home was confirmed as Norovirus infection. No causative organism was identified, this can be explained partly due to not providing specimens in a timely manner, Service User' symptoms resolving before a specimen could be obtained, Service user declining samples to be taken or not enough of the pathogen could be detected within the specimen for diagnostic purposes or the specimen was not tested for a particular pathogen.

3.4.2 The confirmed Influenza A outbreak at Woodland View Nursing Home; 2 of the affected individuals in the outbreak recovered from Flu and 2 of the symptomatic individuals were transferred to the Acute Care Hospital and have sadly passed away. The cause of death recorded on both death certificates under 1a was 'Pneumonia – Influenza A'. Both Service Users had been vaccinated by the GP covering the care home.

Date	Location	No of days closed	No of Service User	No of Staff	Outbreak Type	Causative Organism
Oct / Nov 17	G1	13	10	11	Enteric	Unknown
Nov / Dec 17	Woodland View	9	8	14	Enteric	Norovirus II
March 18	Woodland view	5	4	0	Respiratory	Influenza A

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

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

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

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

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

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

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

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

3.5.7 This year 45 Service Users should have been offered screening based on their admission source. However 19 individuals had screening identified by the admitting clinician; although this doesn't necessarily mean that these Service Users were actually sampled. For example the service user might refuse swabbing. This equates to (19/45) **42%** of Service Users offered screening. IPCT continually reinforce to clinical staff the importance of identifying and offering MRSA screening to Service Users deemed high risk who are admitted to the Trust. This issue will be audited by admission rates as part of the Clinical Care Networks Governance Processes to increase compliance.

3.5.8 To further improve screening activity the SNIPC has submitted an application to the Insight Designers to make alterations to the existing Physical Health Assessment (PHA) – to create a mandatory field.

3.6 Annual Audit Programme

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

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

3.6.3 The IPCT have successfully completed **30** supportive observational site visits and **4** areas participated in self-audit. The environmental aspects of the audit look at the 'totality' of the healthcare environment i.e. assessing the standard of cleanliness and the 'fabric of the building'. The audits carried out this year have been 'unannounced' attempting to capture a realistic snap-shot of current cleanliness standards and compliance with IPC practices.

3.6.4 Compliance with the IPC audit is set at 90% and above; positively 76% of areas are achieving a pass rating compared to last year where 67% achieved a pass rating. Areas achieving a caution rating have remained static at 21%. This means that those areas are reaching an audit score between 80% - 89%. Improvement action plans are in places for these areas. However the SNIPC is very pleased to report that no areas of the Trust have failed this year's audit.

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

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

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

- Bare Below the Elbow - compliance is poor e.g. staff on duty wearing false nails, nail varnish and silk/gel wraps, wrist watches and jewellery whilst on duty in Clinical Care giving areas relating to Inpatient Wards / Nursing Home areas.
- Lack of departmental cleaning schedules for items/equipment which care staff are responsible for cleaning

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

3.7.1 The PLACE is a Standards Monitoring Observational Assessment that focuses on environmental and non-clinical aspects of the service user's experience. The process requires equal numbers of staff to service user / carer to be part of the inspection team. The standards consider multiple aspects which are food, privacy and dignity, condition / appearance and maintenance of the premises. For the purpose of this report cleanliness is the focal point. It is positive to note that Grenoside Grange has achieved 100% again.

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

Site	2014 Cleanliness %	2015 Cleanliness %	2016 Cleanliness %	2017 Cleanliness %
Firshill Rise	-	99.01	98.67	98.64
Forest Close	96.79	97.47	-	99.74
Forest Lodge	97.95	99.86	100.00	99.52
Grenoside Grange	99.68	100.00	100.00	100.00
Longley Centre	96.36	98.73	99.56	99.59
Michael Carlisle Centre	99.16	99.47	98.67	97.96
Longley Meadows	98.98	99.25	closed	closed
SHSC Average	**98.15**	**99.11**	**99.32**	**99.02**
National Average (all Trusts)	**97.75**	**97.57**	**98.06**	**98.38**

3.8 Mattress / Commode Audits

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

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

3.8.3 Following the successful mattress replacement programme undertaken in November 2016; a subsequent Trust-wide audit was undertaken by our mattress provider Herida Healthcare in June 2017. A total of 137 mattresses were inspected. 85 mattresses passed the audit and 52 mattresses failed; equating to a failure rate of 37.96%. In some circumstances it was appropriate to replace the mattress cover only rather than the whole mattress. This is a cost effective method of mattresses remaining IPC compliant. 11 covers were purchased and 41 new mattresses. The next audit will take place in November 2018 to again ascertain how clinical areas are maintaining this piece of vital equipment.

3.9 Antimicrobial Stewardship

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

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

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

3.9.4 Early this year efforts have been made to increase audit and monitoring of antibiotic prescribing within the Trust by the Pharmacy department. However the pharmacist leading on this piece of work has now left the organisation. The new chief pharmacist commencing duty in July 2018 will be reviewing pharmacy resource requirements and work priorities & an update will be provided to the IPC of how this auditing will take place.

3.10 Incident Reporting: Sharps Practice & Audit

3.10.1 A total of 51 incidents have been reported to the IPCT during this reporting period. This is a slight increase from last year (42).

3.10.2 There have been 27 reported incidents of human bites/deliberate spitting of blood or saliva at staff, which accounts for 53% of incidents reported under the IPC categories and represents a doubling compared to last year (26%). It is suspected this number maybe significantly higher if combined with the category "assault to staff".

3.10.3 SNIPC has noticed an increasing trend in reporting of bites but of more concern is the deliberate spitting of blood or saliva into staff member's faces and/or eyes. The SNIPC has raised this issue at Service User Safety Group, with the Risk Department, Head of Clinical Governance, Health & Safety Lead and the Respect Team; and it has been recommended that further investigation into these incidents is required. Not all incidents are during 'Respect' restraint situations; many are during ordinary 'everyday' interactions with agitated Service User/s.

3.10.4 Other types of incidents reported are below:

- Used sharps & drug taking paraphernalia inappropriately disposed of e.g. toilets
- Deliberate spillages of body fluids e.g. urinating & smearing of faeces
- Clean needlestick injuries
- Animal bites e.g. dogs biting staff
- Specimen mismanagement

3.10.5 There have been 4 contaminated/dirty sharp related incidents reported which is an increase from last year (2).

Date	2014 - 2015	2015 - 2016	2016 - 2017	2017 - 2018
Contaminated Needlestick injuries sustained by staff	10	6	2	4

3.10.6 Daniels Healthcare facilitated an annual Trust-wide audit during February 2018. 31 Trust areas/departments were visited and a total of 57 bins were observationally audited this year. Overall many elements remained consistent; however the following areas remain a concern:

- 2 bins found with the wrong lid on the wrong base
- 14 bins unlabelled whilst in use
- 10 bins with significant inappropriate contents
- 4 bins left unattended without the temporary closure activated

3.11 Staff Influenza Vaccination Campaign

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

3.11.2 Every year influenza vaccination is offered free to NHS staff as a way to reduce the risk of staff contracting the virus and transmitting it to the Service Users in their care; protecting themselves and their own families. This year the SNIPC opted to purchase the Quadrivalent influenza vaccine, which provided the best level of protection for our staff.

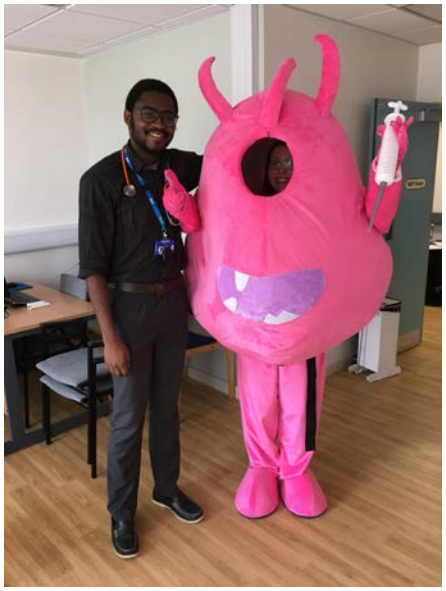
3.11.3 Encouraging more staff to get vaccinated remains a significant challenge to the Trust and as with previous years there continues to be a core cohort of staff that refuses the vaccine due to personal attitudes that they believe that the annual influenza vaccine will not be of benefit to them. Traditionally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

3.11.4 However the Trust's Flu Fighter Team led by the SNIPC achieved a remarkable result this year in which NHS Employers acknowledge that we were one of the top five most improved Trusts nationally regarding vaccine uptake in front-line staff. Our uptake has increased by a staggering **129%** from last year! The SNIPC nominated the Flu Fighters for the Chairs Special Award at the Trust's annual Recognition & Achievement Ceremony and were shortlisted in the top three. Additionally PHE Vaccination & Immunisation Co-Ordinator for Yorkshire & Humber nominated the Trust for a national award for the 'most improved trust' via NHS Employers, and although we did not win we were the 5th most improved NHS Trust in the country.

3.11.5 The CQUIN target for frontline staff was an uptake rate of 70%. The uptake figure for the full duration of the campaign (October 2017 to February 2018) was **1,09**1 frontline staff. Three key staff groups showed an increase in vaccination rates compared to last year: Doctors **65** (42); Nurses **298** (178); & Allied Health Professionals **205** (124).

3.11.6 Performance wise this equates to a total Trust percentage of **57.6%**. In 2017 the Trust achieved 25% and in 2016 uptake was 22%. Vaccine uptake in frontline staff has more than doubled in one season which is a fantastic achievement.

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



3.12 Decontamination & Cleanliness of the Environment

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

3.12.2 When new items of equipment are considered for purchase, the manufacturer's advice on cleaning must be sought and training if necessary must precede use. The IPCT promote that careful consideration should be given to the consequences of the purchase of any item of equipment that is not capable of being cleaned or decontaminated to appropriate IPC standards; unfortunately this is not always the case in the Trust.

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

3.12.4 In April 2017 the Hotel Services Manager introduced the Senior Housekeepers to a monthly paper-based audit tool for the formal monitoring of environmental cleanliness. The results of these audits have been reported in this year's quarterly IPC reports. We have had a slow start in some areas to provide data; with two bed based areas not returning any audits in Q4, this has been addressed; the Hotel Services Manager has been proactively supporting staff with the audit process. The Senior Housekeepers undertake peer review on a quarterly basis and the SNIPC and Hotel Services Manager undertake an annual 'management review' to validate/review the consistency of the audit process and monitor the standards of cleanliness. In 18/19 The SNIPC will present the monthly Environmental Cleanliness Audit results as part of the new IP&C Performance Report to the Clinical Care Networks.

3.12.5 In April 2017 a study day was facilitated jointly by the SNIPC and Hotel Services Manager called 'Strictly Come Cleaning'; which evaluated extremely well; and provided the ideal launch for the 'Specification for the Supply of Housekeeping Services' which is a joint document authored by the SNIPC and Hotel Services Manager. This document draws together a plethora of best and current practice relating to domestic cleaning activities and ensures one domestic cleaning schedule is insitu. The domestic cleaning schedule can be localised to each individual care area depending on what rooms/areas require cleaning; however it sets the standards, frequencies and cleaning methodology expected.

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

3.13 Water Quality & Safety

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

- All Trust-owned and leased properties have up-to-date legionella risk assessment.
- Estate services management and maintenance personnel have completed training and have the expertise to fulfil statutory requirements.
- The Trust appointed Water Quality consultants and Authorising Engineer (AE) reported that the Trust has a robust system in place to prevent the build-up of organisms such as legionella and pseudomonas in its water systems.

- Planned preventative maintenance continues to be carried out at all properties though frequencies vary due to availability of maintenance personnel. It is hoped that with the employment of additional personnel completion of ppm will improve
- The Water Quality Steering Group (WQSG) is well attended with clinical and non clinical representatives. The group was set up to comply with recent legislation and implement actions to ensure water quality is maintained throughout trust premises. The group also comments and makes recommendations as a result of Audits and Risk Assessments. Crucially it provides advice and input into Capital Schemes. The group recently ratified the sampling at MCC and Woodland View to be reduced due to a water samples over a 6 month period not detecting bacterial growth, this action will be reviewed at future meetings. Reports are received at the ICC.
- A Water Safety Plan has been developed and its requirements enforced
- Sampling for Pseudomonas continues to be carried out on an annual basis as agreed at the ICC
- Action plans have been drawn up for all remedial work highlighted in Risk Assessments
- It is envisaged that over the coming 12 months Water Quality ppm will be completed by the use of a new web based software system and a hand held device, this will be real time and should enable completion of statutory documentation

Annual Site Summary in Brief

Michael Carlisle Centre
The site overall has had good water quality results from samples taken. Legionella at low levels was detected on the mains supply from Lyndhurst Road. The pipework was traced and deadlegs removed. Pipework was also disinfected.

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

Longley Centre and PICU
The water system appears to be under control with no bacterial counts from recent samples. The water supply to Rowan Ward, Hawthorn and Pinecroft has been isolated with the exception of the kitchen corridor. One of the Cold Water Storage Tanks remains isolated. On the PICU problems with the cold water storage tanks and disinfection of the water supply have been rectified, though further alterations to the system will be made when the next phase of the Longley Centre redevelopment progresses.

A Water Quality consultant has been employed to advise on the new water system for the Longley Centre, information will be shared with the WQSG as the project progresses. The enabling work on Rowan Ward is due to commence in July, water system plans have been received, the Trust AE and a Water Quality consultant will advise and audit the installation.

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

Forest Lodge
En suite sinks in bedrooms on Forest Lodge have been changed to the Wallgate antiligature type. Water samples were taken and elevated total Viable Counts (TVC's) were detected. Enhanced flushing was enforced and counts reduced when subsequent sampling occurred.

Forest Close
Had several low E-coli and coliform counts, outlets were flushed but bacteria could not be eliminated. Taps and pipes were removed, new installed and disinfected, sampling continues and bacterial counts have been negative. Bungalow 3 is currently unoccupied and all outlets flushed on a daily basis.

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

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

4.0 Acknowledgements

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

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

Appendix 1 INFECTION PREVENTION & CONTROL 2018 - 2019 ANNUAL PLAN

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

Objective Area (41)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
Training & Education ***Providing opportunities for all staff to fulfil mandatory requirements to receive IPC training.(6)***	Continue to facilitate a Link Worker Forum; providing suitable training & education for their role – aim for 2 sessions a year.	March 19	KG / JPW		
	Start to plan, organise & facilitate a full day's IPC conference on behalf of the Trust (This action may be postponed due to HQ moves)	March 19	KG / JPW		
	Continue to facilitate Corporate Induction & Mandatory IPC session along with Education Departmental Trainers	March 19	KG / JPW / E&T		
	Provide ad-hoc sessions on a variety of IPC related elements/topics as and when approached by services/areas	March 19	JPW/ KG		
	Facilitate IPC themed Road Shows at various sites across the Trust promoting evidence-based best practice	March 19	JPW		
	Develop & deliver a teaching session to the medics on Antimicrobial Resistance & Stewardship	April 18	RT		
Audit ***Monitor compliance with IC policies & guidance through a Programme of audit.(8)***	Develop and carry out a unannounced programme of audit in the newly reconfigured Care Networks across the trust: • Single Point & Crisis Hub • Acute Bedded Based Services • Secondary Care • Primary Care • Clover Practices x5 **Areas where suboptimal compliance is identified; areas must produce a remedial action plan to address findings.* **Services/areas to take ownership regarding progression of action plans and to report issues hindering completion both at a directorate governance level and via the ICC*	Sept 18	KG / JPW		
	Local Audit Tool to be reviewed	June 18	KG		

Objective Area (41)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
	To receive the audit data collected by Daniels in relation to Sharps Policy & practice.	April 18	KG / JPW		
	To carry out an audit regarding staff compliance with BBTE	Feb 19	KG / JPW		
	To carry out an audit of the hypodermic safety needles used within the Trust supported by B'Braun. (EU Safer Sharps Directive)	Aug 18	KG / CS		
	To receive the quarterly audit data collated by pharmacy in relation to antibiotic prescribing findings and make recommendations for improvements in antibiotic stewardship (Antimicrobial Resistance Strategy DH,2013). **To promote prudent antimicrobial prescribing for the management of antibiotic resistance and reducing antibiotic related Clostridium difficile Infection and other Healthcare Associated Infections*	Quarterly Until March 19	Pharmacy		
	Develop & carry out a programme of audit on mattresses across the Trust to ascertain how the new Herida mattresses are performing	Nov 18	KG / JPW		
	Participate in the multi-disciplinary PLACE Assessments trust wide	May 18	KG / JPW		
Surveillance – Mandatory & Voluntary ***In line with National/Local requirements and designed to achieve reduction in HCAI (2)***	Continue to collate & monitor the voluntary prevalence data to understand how many individuals are affected by a disease or infection at a particular time, and monitor any trends which develop.	March 19	KG / JPW		
	Continue to monitor & report against the Mandatory Alert Organisms (MRSA, MSSA, E-coli Bacteraemia's & Clostridium difficile) **Supporting the reduction in Gram Negative infections*	March 19	KG / JPW		
Policies & Protocols ***Ensure compliance with current guidance & legislation to promote quality, evidence based best practice (2)***	To review the IPC Policy and present it for ratification	May 18	KG		
	To contribute to all policies or protocols that has relevance to infection prevention and control.	March 19	KG		

Objective Area (41)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
Preventative & Case work ***Activities to demonstrate that effective IPC is central to providing safe, high, quality service user-centred healthcare (13)***	Facilitate *Clostridium difficile* Root Cause Analysis (RCA) Investigations in a timely manner as required. *Lessons Learned to be shared within the service and brought to the attention of the Service User Safety Group & ICC*.	As cases arise	KG / RT KG		
	Complete MRSA Bacteraemia Post Infection Reviews (PIR) within the timescales specified by the DH. *Lessons Learned to be shared within the service and brought to the attention of the Service User Safety Group & ICC.*	As cases arise As cases arise	KG / RT KG		
	To work collaboratively across the city with the CCG to reduce Gram Negative BSI arising from E-Coli UTI	March 19	KG / RT		
	To work collaboratively with the H&S Lead and wider MDT regarding IPC related Safety Alerts.	As released	KG		
	To review and interpret any new IPC national guidance for its relevance and introduction into the Trust (e.g. NICE)	As released	KG		
	IPC related incidents to be monitored and lessons shared appropriately.	March 19	KG		
	IPC risks being appropriately reported/escalated for inclusion on the Directorate Risk Register.	March 19	KG		
	Continue to support the compliance with the EU Sharps Directive particularly around safety devices; review the risk assessment following audit	Sept 18	CS / KG		
	'Spearhead' the Annual Seasonal Staff Flu Campaign Trust Wide.	Feb 19	KG		
	Support all areas whereby facilitating outbreak management and to promote appropriate 'terminal cleaning' prior to re-opening to admissions	On-going	KG /JPW		
	All service user results are management as a priority e.g. MRSA Bacteraemia's / C-diff / CPE. Liaise with appropriate services/clinicians/GP's	On-going	KG		
	To ensure that there is IPC involvement into the procurement process to confirm that equipment & therapeutic devices can be appropriately cleaned & decontaminated.	On-going	KG / Procurement		
	Explore the possibility of changing hand hygiene products to a more cost effective brand.	March 18	KG / Procurement		

Objective Area (41)	Action/Activity – to support CQC Fundamental Standards and Health & Social Care Act, Code of Practice	Timescale	Lead	Quarterly Progress/Assurance	RAGB
Design, Planning refurbishments & New Premises ***To ensure that premises are designed & furbished to enable IPC practices to flourish. (1)***	Provide specialist advice and decontamination requirements of all proposed capital refurbishments and new developments from design, planning through to final commissioned state. **To ensure that the fabric of the environment facilitates the cleaning process & that IPC is 'designed-in'.*	March 19	KG / GR / JB RT		
Estates Functions Water Quality & Safety **Promoting holistic management towards water systems to control waterborne pathogens & the ongoing maintenance of our healthcare premises (3)**	Support Estates with monitoring Water Quality including active participation in the Water Safety Group	March 19	MG / KG / RT		
	Support Estates with quarterly reviewing the Water Quality risk assessments	March 19	MG / KG / RT		
	Commence quarterly Estate visits to all areas to identify IPC issues relating to the *'fabric of the building'* before they become problematic	Quarterly	DM / KG		
Establish IP&C Performance Reports for the Clinical Care Networks	Produce an IP&C report for each Clinical Care network	Monthly	KG & Associate Clinical Directors		