South Staffordshire & Shropshire Healthcare

NHS Foundation Trust

A Keele University Teaching Trust

Infection Control Annual Report

January 2015 – December 2015

1. Introduction

This Annual Report provides an overview of the infection prevention and control (IPC) activities, carried out for South Staffordshire and Shropshire Healthcare NHS Foundation Trust during 2015. It provides assurance that there are robust systems and processes in place to manage risks associated with the prevention and management of infection and makes recommendations for the future through the IPC programme 2016

2. Background

IPC has continued to have a high priority across the Trust in order to ensure that all personnel including service users, carers, families and staff are protected from infectious disease.

As a provider of diverse health services, there are differing challenges facing the Trust in the management of IPC. Many of our service users are physically fragile through age, illness, self-neglect or through life style choices such as drug and alcohol abuse. They can be at risk from conditions such as blood borne viruses, tuberculosis, Clostridium difficile and respiratory and urinary tract infections. Other service users are at risk from invasive procedures for example those requiring input from the Complex Care team or those using Genito Urinary Medicine (GUM) services.

Good management, organisation and implementation of best IPC practice are crucial to establishing high standards of IPC. The Health and Social Care Act 2008: (revised 2015) *Code of practice for the prevention and control of infections and related guidance* sets out ten criterions for providers of healthcare, to ensure that systems to prevent healthcare associated infections (HAI) and compliance with policies are embedded in practice and are corporate responsibility.[1] The Trust acknowledges these responsibilities and works to demonstrate compliance with the Code of Practice.

3. National Context

The 2014/15 NHS Outcomes Framework, in domain 5, "*Treating and caring for people in a safe environment and protecting them from avoidable harm*" identified reducing the incidence of Healthcare Associated Infections (HCAIs), in particular Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia and *Clostridium difficile* infections (CDI) as an area for improvement.

NHLSA standard 4.6 refers to the need for hand hygiene training and standard 4.7 refers to management of infection control and inoculation injuries.[2]

The Trust is registered with the Care Quality Commission (CQC) and declared full compliance with the ten compliance criteria as detailed in Figure 1.

[1] The Health and Social care Act 2008: *Code of practice for the prevention and control of infections and related guidance*

[2] NHSLA Risk Management Standards 2012-13 for NHS Trusts providing Acute, Community, or Mental Health & Learning Disability Services and Non-NHS Providers of NHS Care

Figure 1

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing / medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6	Systems to ensure that all care workers (including contactors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational needs and obligations in relation to infection.

As a requirement of the Trust's registration with the CQC the Trust must comply with the ten criteria in the Health and Social Care act 2008 (revised 2015).

Progress against this during the year 2015 is shown below;

4.0 Criteria 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

4.1 Trust Infection Control Arrangements

4.1.1 *Director of Infection Prevention and Control (DIPC) and Non-Executive Director*

The DIPC is also the Medical Director and receives daily when appropriate, reports from the Associate Director Physical Healthcare/Deputy DIPC on IPC issues including outbreaks. The DIPC reports to the Infection Control Committee, Quality Governance Committee and to the Trust Board. A direct line of accountability and reporting from the DIPC to the Chief Executive is well established. Reporting lines are illustrated in Appendix 1. There is also a Non-Executive Director (NED) with an IPC brief. The NED undertakes regular inspections across the Trust and attends relevant infection prevention and control meetings.

4.1.2 *The Infection Prevention and Control Team (IPCT)*

The Trust has a Service Level Agreement with Burton Hospitals for the Consultant Microbiologist who provides expert IPC advice; the rest of the team is comprised of the NED, the Associated Director for Physical Health /Deputy DIPC and three specialist nurses. From January till August 2015 due to the sad and untimely death of one of the IPC nurses the team functioned with two IPC nurses.

The team provides:

- A specialist resource for all health care workers, providing advice on the prevention and control of infection.
- Education for all staff, clinical and non-clinical.
- Monitoring of infection control and decontamination procedures.
- Development and implementation of infection control policies and strategic direction.
- Management of outbreaks of infection. In the event of an outbreak, the DIPC and the infection control team will take charge and report directly to the Chief Executive.
- Surveillance of infection rates.
- Audit and assist in root cause analysis of an infection.

4.1.3 *Infection Control Committee*

The Infection Control Committee meets bi-monthly and is chaired by the Consultant Microbiologist. The aim of the Committee is to drive forward an IPC programme, based on national guidelines and evidence-based research. The Committee also undertakes the development of policies and Standard Operating Procedures related to IPC and has corporate responsibility for all infection prevention and control issues.

4.1.4 *Facilities, Estates, Modern Matron, Physical Health Care and Infection Control Meetings*

Meetings are held on a monthly basis in order to address issues that will ensure provision of a clean, safe care environment across the Trust.

4.1.5 *Link Champions*

Each ward and some community teams have a link champion. Meetings are held bi-monthly and take place in Stafford and Shrewsbury. The meetings have an educational session and a chance to update the link champions on IPC initiatives within the Trust. The 2015 educational topics included Ebola, antibiotic resistance, *Clostridium difficile*, cleaning of medical equipment, outbreak management and sharp safety. News-letters are also produced for the wards that reflect the themes of the meetings.

4.1.6 *Assurance Framework*

The Trust's annual infection control programme for 2015 was followed and reviewed by the IPCT and with the Infection Control Committee throughout the year. The programme incorporates the requirements in all relevant documents including The Health and Social Care Act *(2008, revised 2015) Code of Practice on the prevention and control of infections and related guidance.* The programme identified for the Infection Control Committee, areas for development and prioritised the actions required. The new programme for 2016 is included in appendix 2.

4.1.7 *Risk Assessment*

In order to risk assess the care given by the Trust the IPC team in partnership with the Audit team and link nurses have undertaken IPC audits and surveillance during 2015. These included:

- IPC practice audit on all inpatient areas and high risk areas, for example electroconvulsive therapy departments (ECT)
- IPC Monthly ward improvement audits
- IPC audit of new services in the Trust
- Hand hygiene audits in inpatient areas
- Weekly Alert organism/alert condition surveillance on the older adult wards
- Retrospective Audit or post infection and outbreak reviews

4.2 Infection Prevention and Control Practice

4.2.1 Audit

IPC audits based on national standards were conducted in inpatient areas and high risk areas during the year. All the ward areas scored over 90%. All areas were supported to develop action plans from the findings. The action plans are also considered at the Matrons, Facilities and Estates and Infection Control meetings and inform the Assurance Plan that is presented bi-monthly to the Trust Board. Monthly by exception reporting is part of the essential standard of the RAG report. Key themes and actions from the audits are shown in Figure 2 below:

Figure 2
Infection Control Good Working Practice Audit, June 2015

Key Results Main project results arising from the project	Cleaning schedules not always completed in clinical rooms Clinical room cluttered Fridge temperatures not always monitored Patients' laundries not organised Some non-sharp safety devices found Some staff not bare below the elbow in clinical practice

Actions arising from the results	Monthly improvement audits are undertaken, considering the points above and results fed back to ward staff and to Matrons meeting.

4.2.2 *Monthly Ward Improvement Audits*

Since the beginning of November 2015 key themes from the IPC audits were picked up and then re-audited on a monthly basis. The results are fed back directly to the ward managers and link nurses and through the Matrons meeting in order that the necessary actions can be taken

4.2.3 *Audit of New Services in the Trust*

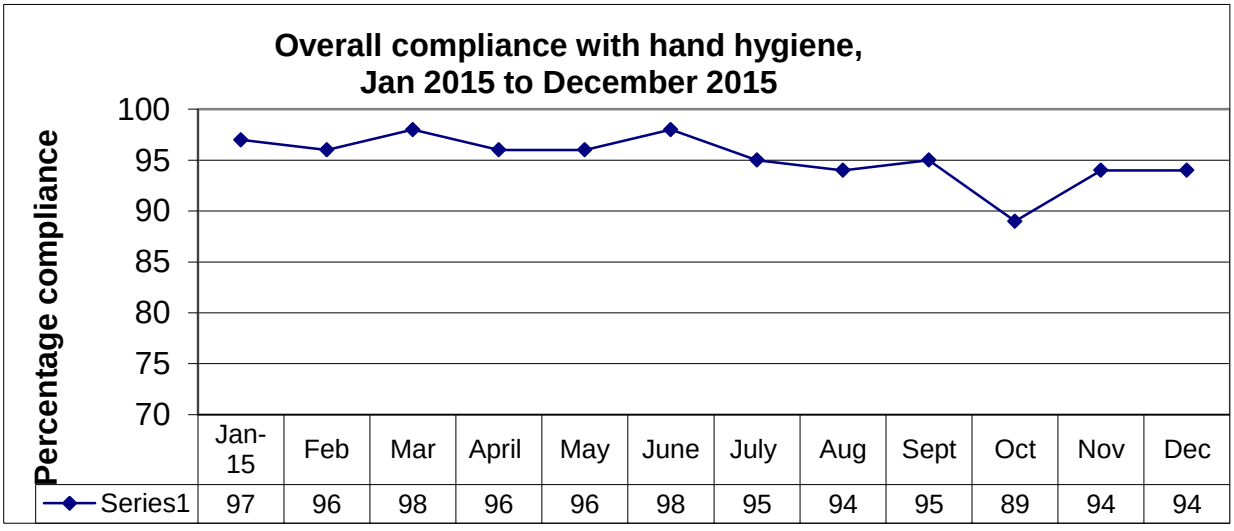
New services in the Trust have had IPC audits to ensure that they reach national IPC standards. All the new services have been supported by the IPC team to make necessary changes.

4.2.4 *Hand Hygiene Audits in Inpatient Areas*

Hand hygiene is considered to be the most important procedure to prevent infections and we all need to ensure that this is given prominence to protect patients, visitors and colleagues. The recent initiative by nursing staff in some parts of the trust going into uniform is supporting the 'bare below elbows' approach. However, it is important that all staff entering and working in clinical environments, especially when undertaking personal care, examination, or treatment, adopt bare below elbows to promote effective hand decontamination, thorough hand washing or use of alcohol hand sanitiser.

The Lewisham monthly hand hygiene observation tool has been used in inpatient areas through the Link Champions. The tool is designed to assist staff in observing and recording hand hygiene behaviour over a period of time, working out the level of compliance and feeding the information back to the staff to help improve practice. When ward hand hygiene compliance falls the IPC team implement a programme of extra training and re-audit. Figure 3 below shows Trust compliance with hand hygiene during 2015.

Figure 3
Hand Hygiene Compliance 2015



4.2.5 *Weekly Alert Organism/Alert Condition Surveillance on the Older Adult Wards*

The IPC team undertake alert condition surveillance each week either through telephone contact or by visiting the wards. The IPC team is also alerted by staff of any other patients with alert organisms by the ward staff.

4.3 MRSA

Surgical and other invasive procedures are rarely performed in the Trust and therefore there are low numbers of MRSA isolates. In the main the confirmed positive status cases are in patients in elderly care wards.

Figure 4 below outlines the numbers of reported MRSA isolates in the Trust for the period January– December 2015. Often these patients had existing wounds and were transferred from acute hospitals or from community settings. There are no reported cases of cross infection in the Trust's ward settings.

Figure 4
MRSA Isolates January 2015– December 2015

Ward													
	Jan 15	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Cum Total**
Norbury		1											1
Oak											1		1
Baswich							1						1
Monthly Total	0	1	0	0	0	0	1	0	0	0	1	0	3

4.4 Retrospective Audit or Post Infection Reviews, MRSA, Clostridium Difficile Infection

Post infection reviews (PIR) should be completed for all patients who developed a *Clostridium difficile* infection (CDI) or MRSA Bacteraemia.

During 2015 there were no cases of MRSA Bacteraemia and one case of CDI on a ward.

The patient had a CD PCR positive result earlier in the year at an acute hospital and had been treated for a CDI. Unfortunately this information had not been relayed to our staff and following a course of antibiotics for an infected elbow wound on our ward the patient developed diarrhoea again and tested positive for CDI.

The PIR showed that

- Antibiotics that were used for the infection of the elbow wound were compliant with guidelines and were an appropriate treatment.
- Hand hygiene audit scores were 100% and environment cleaning scores for the Ward area 93.44% at the end of July.
- Once CDI was recognised, ward staff took all the appropriate IPC precautions and no further patients acquired CDI.

Areas for action included

- Reinforcing the need for staff to use the Bristol stool chart
- Increase staff awareness of the need to send samples appropriately
- Reinforce the need to get a complete medical history from patients and relatives on admission

4.5 Outbreak Reviews

During 2015 there were two cases of whooping cough outbreaks affecting staff, one outbreak of Influenza like illness and four outbreaks of gastroenteritis in inpatient areas.

4.5.1 *Whooping Cough (pertussis)*

The first incident of whooping cough in November 2015 involved staff working in the Learning and Development department in the Flannigan Centre office, Stafford. Of these, two cases of whooping cough were confirmed and five members of staff who reported Influenza like illness (ILI) including coughs were not confirmed to be whooping cough cases. Staff were reminded of the importance of respiratory hygiene and extra cleaning was put in place in the office environment; there were no more cases. Neither of the confirmed staff with whooping cough had patient contact during the infectious period.

The second incident of whooping cough involved three staff working in the Telford crisis team. Two cases were confirmed and a third had whooping cough symptoms. There was no contact with patients during the infectious period and no further cases have been reported.

4.5.2 *Influenza Like Illness (ILI). Norbury Ward*

One patient started with ILI on 3 December 2015. By the 27 December 2015 it was evident that the ILI had spread. Four patients had ILI which led to three of the patients being admitted to the acute sector for treatment for chest infections/ pneumonia. All patients returned to Norbury. A further patient had slight ILI symptoms and remained on the ward throughout. Two of the patients tested positive for human metapneumovirus which is known to cause ILI. Symptoms can range from mild to severe illness.

Twenty one staff also suffered ILI with two being admitted to the acute sector for treatment of chest infections and the remainder with symptoms ranging from mild to severe.

The ward was closed to admissions on 27 December. Outbreak precautions were put in place including high levels of cleaning and the use of Personal Protective equipment where possible. In an attempt to contain the virus, Norbury staff were removed from 136 Suite responsibilities.

To prevent staff movement, agency staff and housekeeping staff were allocated by block booking to work only on Norbury Ward.

An outbreak meeting led by Dr James Paton, consultant microbiologist, and including the Chief Executive, ward and Facilities staff, IPCT, the Deputy DIPC and Public Health England took place on the 8 January. Actions agreed included:

- Ensuring any further swabs were tested for human metapneumovirus,
- Staff not to return to work for six days from the onset of symptoms
- Ward closure to continue for new admissions
- Staff support and involvement from Team Prevent Occupational Health Service

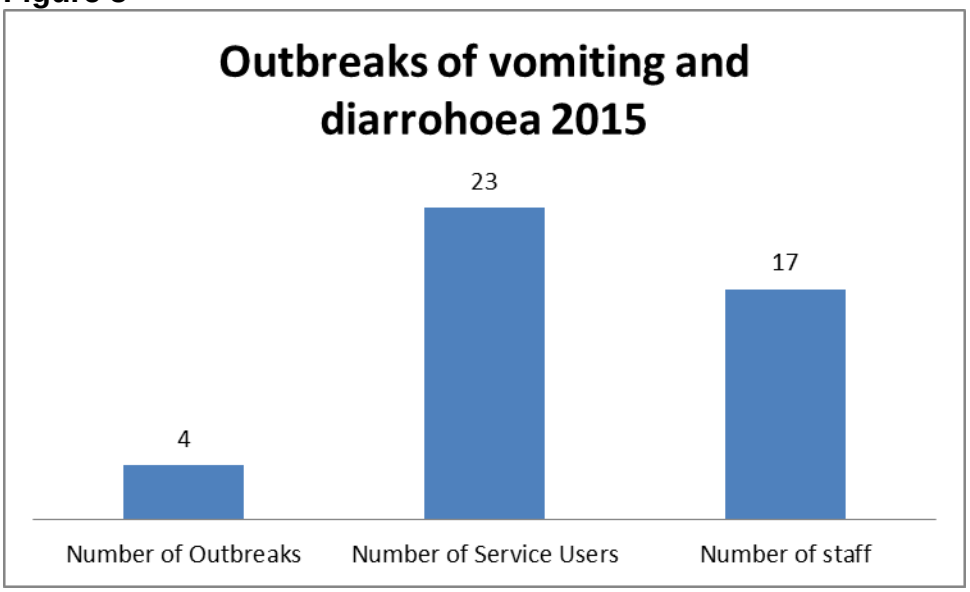
By 14 January 2016 following no new patient cases since the 5 January 2016 and no new staff cases since the 8 January 2016, the ward was deep cleaned and reopened to admissions.

4.5.3 *Gastro-enteritis*

During 2015 there were four outbreaks of gastroenteritis within in-patient areas. All outbreaks were reported to the Trust Board and Commissioners. The causes of the outbreaks were either confirmed or suspected as viral, a common cause of sporadic cases and small clusters of gastro-enteritis. The outbreaks were short in time frame and were managed and contained well by the clinical teams. There were no long term effects to any patients and the conclusion from all the outbreaks was that clear robust infection control policies had been observed and implemented.

Figure 5 below shows the total number of patients and staff involved in gastro-enteritis outbreaks over the course of 2015.

Figure 5



5.0 Criteria 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

The IPC team has worked closely with the Facilities and Estates staff to ensure the Trust meets criteria 2. This has been achieved through:

- Joint working on policies and SOPs using the relevant national guidance
- Environmental Audit
- PLACE

5.1 *Policies and Standard Operating Procedures*

The Standard operating procedures (SOP) taken through the Infection control committee and the Policy and Procedure Group during 2015 are listed below in figure 6

Figure 6

Cleaning of the environment, SOP
Waste management SOP

5.2 *Environmental Audits*

Environmental cleanliness and hygiene are not only pivotal in preventing infection, they are important in promoting service user and carer confidence in the care which they will receive on our premises.

IPC standards for the environment and equipment are monitored through technical and managerial audits. The format of these audits is drawn from the 49 elements of the National Standards of Cleanliness 2007.

Technical audits take place monthly on each inpatient area with the unit manager and domestic supervisor. Managerial audits take place on a quarterly basis to validate the data from the technical audits and include the IPCT and managers from Facilities and Estates.

These audits generate action plans for both the Facilities and Estates department and inpatient staff and are reviewed each month to ensure actions are completed. The results and action plans are monitored through the Infection Control Committee.

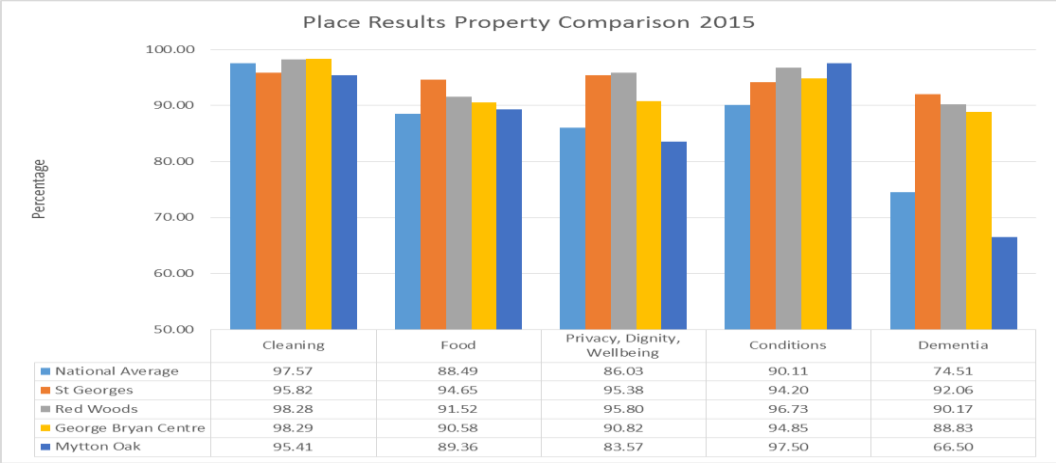
5.3 PLACE

PLACE assessments were undertaken by patient representatives and ex-service users who work as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance.

The assessment is designed to capture the patient's perception relating to the provision of services and the environment and what matters to them. This is fundamental to the Health and Wellbeing of service users and visitors. The score is based on the condition seen at the time of the assessment in the five categories including cleanliness, privacy, dignity and well-being, dementia, food and condition, appearance and maintenance.

The IPC team contributed to the PLACE inspections. Results are shown in figure 7

Figure 7



	Cleaning	Food	Privacy, Dignity, Wellbeing	Conditions	Dementia
National Average	97.57	88.49	86.03	90.11	74.51
St Georges	95.82	94.65	95.38	94.20	92.06
Red Woods	98.28	91.52	95.80	96.73	90.17
George Bryan Centre	98.29	90.58	90.82	94.85	88.83
Mytton Oak	95.41	89.36	83.57	97.50	66.50

Following the assessment there were 68 actions identified across all units, 90% of these have received some or complete corrective action from F&E and Clinical Leads. Action plans are in place to address the remainder and should be addressed under the ward improvement program, none are considered to be a significant risk.

5.4 *Water Safety Group*

A new joint SSSFT and Shropshire Community Health NHS Trust water safety group was formed in 2015. The Water Safety Group provides the framework to ensure compliance for the co-ordination of activities related to the management, procurement, development, maintenance, training requirements and safe use of water systems in use within the SSSFT and SCHT premises. SCHT are represented by Estates, Hotel Services and IPC. The meetings are bi-monthly at present. It is intended that the Group will monitor risk assessments especially around Legionella, flushing regimens, annual disinfection. The water safety group report to the IPC meeting as a standing agenda item.

5.5 *New builds and Refurbishments*

The IPC team was involved with advising on the refurbishment on the wards at St Georges, the new community centre at Severn fields in Shrewsbury and the new GUM services

6.0 Criteria 3

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

This is a new criterion in light of the national work to help combat antimicrobial resistance. The Trust has worked with colleagues in primary care for many years to develop and deploy anti-microbial prescribing guidelines. In 2015 the pharmacy department undertook an audit focusing on :

- documentation of indication for antibiotic prescribing
- appropriateness of prescribing an antibiotic for recorded indication
- choice of antibiotic for recorded indication
- dose of antibiotic

♦ duration of antibiotic

Actions from this audit are show in Figure 8

Figure 8

Action
Antibiotic prescribing guidelines to be reinforced during pharmacy junior doctor training.
Explore the role of EPMA in order to support antibiotic prescribing and monitor compliance with guidelines
Establish the feasibility of prescribing indicators in order to support the monitoring of antibiotic prescribing once EPMA has been introduced
Standard Operating Procedures to include directions for checking of antibiotic prescriptions and compliance with formulary.
Inpatient ward stock and emergency cupboard stock lists to be reviewed to ensure availability of formulary approved antibiotics
Lead nurse, NMP lead, and deputy director of nursing to ensure NMP compliance. Clinical directors and supervising consultants to ensure medical staff competence and compliance.
Set up a Patient Group Direction (PGD) for 'common ailments' to support the 'appropriate' use of antibiotics

7.0 Criteria 4

Provide suitable accurate information on infections to any person concerned with providing further support or nursing / medical care in a timely fashion

The Standard Operating Procedure for moving patients and transferring patients who are known to have or suspected to have an infection was reviewed in July 2015 and includes a form for staff to use when transferring patients to other healthcare facilities.

IPC team has shared infection rates and outbreak information with other provider and Commission Trust as appropriate.

IPC information boards are available on all wards displaying IPC data and audit results

IPC Standard Operating procedures are available on the intranet site and IPC information is available on the internet and in leaflet form on the wards

8.0 Criteria 5

Ensure prompt identification of people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

Patients admitted to the Trust are assessed for the risk of infection by the physical health pathway within 24 hours of their admission

Staff are supported by the IPC team for patients with infections and outbreaks of infection with either visits or telephone support.

IPC advice is available for any enquires in normal office hours and then for urgent issues outside office hours through the Consultant Microbiologist at Queens Hospital Burton.

9.0 Criteria 6

Systems to ensure that all care workers (including contactors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Education and training are key factors to ensure that IPC is embedded into everyday practice and applied consistently by everyone. The IPCT provide staff with clear and practical up to date and evidence based information on all aspects of infection prevention and control in order that they can translate this philosophy into their working practice.

All staff undertake the e-learning module for IPCT with annual refresher updates.
The IPC team provides bespoke training for staff and volunteers. Link nurses receive an educational session at each bi-monthly meeting.
Link champions, ward managers and Matrons were also provided with the opportunity to undertake the "Developments in Infection Prevention and Control" module at Staffordshire University.

9.1 *Overall Compliance*

Overall compliance for Infection Control training at 31 January 2016 is 79%. This is split into two different courses, dependent upon whether staff are working in a clinical or non-clinical role. Compliance by course is shown in Figure 9.

These figures have been reported from ESR. F&E are still following a mixed approach of moving to core mandatory training – some via eLearning and some via workbooks. This month's ESR figures have also been reported to include those who have started in the trust from day one.

Figure 9

Course	Meets requirement	Does not Meet Requirement	Grand Total	% Compliance
Core Mandatory Block Clinical Directorates	2033	460	2493	82%
Core Mandatory Block - Non Clinical staff (F&E)	172	126	298	58%
Grand Total	2205	586	2791	79%

Please note – Infection control is only one subject within the core compliance. For F&E who are still moving fully to the approach, some staff have completed the infection control workbooks but have not completed the other requirements therefore do not have the core compliance. Therefore, for this Directorate, Infection Control only is reported at 77%.

9.2 *Compliance by Directorate*

Compliance by each individual Directorate is shown below in Figure 10.

Figure 10

Directorate	Meets Requirement	Does not Meet Requirement	Grand Total	% Compliance
301 Armed Forces Directorate	5	1	6	83%
301 Directorate of Psychological Services	22	12	34	65%
301 DMT Shropshire Mental Health	544	59	603	90%
301 Facilities and Estates Directorate	172	126	298	58%
301 Forensic & Criminal Justice Directorate	186	67	253	74%
301 Inclusion Services Directorate	246	109	355	69%
301 Medical Directorate	43	17	60	72%
301 Mental Health Staffordshire Directorate	626	94	720	87%
301 Occupational Therapy Lead Services	4		4	100%
301 Specialist & Family Services Directorate	257	85	342	75%
301 Specialist Learning Disabilities Directorate	100	16	116	86%
Grand Total	**2205**	**586**	**2791**	**79%**

9.3 *Hotspots*

Hotspots identified are those teams where compliance is less than 70% and teams consist of more than 10 people these are detailed below in Figure 11.

Figure 11

Team	Meets Requirement	Does not meet requirement	Total	% Compliant
301 Medical - Doctors in Training	5	5	10	50%
301 Mental Health Shropshire Doctors in Training	6	5	11	55%
301 F&E-Catering Redwoods	3	8	11	27%
301 Winchester Hub	5	7	12	42%
301 F&E-Telephonists St Georges	8	5	13	62%
301 Fareham Hub	3	10	13	23%

Team	Meets Requirement	Does not meet requirement	Total	% Compliant
301 CSS Prison In reach Staffordshire	9	5	14	64%
301 F&E-Maintenance West Staffs		14	14	0%
301 DART Inclusion Bucks Cluster	10	5	15	67%
301 IAPT North Staffordshire	10	7	17	59%
301 Cambridgeshire Alcohol Services	14	7	21	67%
301 F&E-Housekeeping Redwoods	3	21	24	13%
301 IFOR Willow Shropshire	19	9	28	68%
301 Trainee Psychologists	18	10	28	64%
301 CAMHS West	19	15	34	56%
301 IFOR Newport House Stafford	18	18	36	50%
301 IFOR Ashley House Stafford	21	18	39	54%
301 Community Complex Care Team East	24	16	40	60%

10.0 Criteria 7

Provide or secure adequate isolation facilities

All the accommodation in the Trust is single rooms with the vast majority being en-suite, this helps to enable effective isolation nursing when required.

11.0 Criteria 8

Secure adequate access to laboratory support as appropriate

The Trust has Service Level Agreements (SLA) for microbiology from Queens Hospital Burton, University Hospital of the North Midlands and Royal Shrewsbury Hospital.

12.0 Criteria 9

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

During 2015, following new Trust guidelines the IPC overarching strategy has been reviewed and rewritten as a policy and all the IPC policies have been reviewed and rewritten as standard operating procedures (SOP).

The IPC policy and Standard operating procedures taken through the Infection control committee and the Policy and Procedure Group during 2015 are listed below in Figure12.

Figure 12

Infection Control and Decontamination Policy
Pandemic Influenza SOP
Enteral feeding SOP
Outbreaks or other Infection Control Incidents, SOP
Movement of patients between wards & departments Infection prevention and control SOP
Parasites SOP
Standard Precautions and Personal Protective Equipment SOP
Reducing the risk infection associated with indwelling urinary catheters SOP
Cleaning Spillages, SOP
Antibiotic Resistant organisms SOP
Clostridium Difficile, SOP
Gastroenteritis, SOP
Gloves, SOP
Handwashing, SOP
Isolation, SOP
MRSA,SOP
Aseptic technique, SOP

13.0 Criteria 10

Providers have a system in place to manage the occupational needs and obligations in relation to infection.

The IPC team work with Team Prevent to ensure that staff are protected from infection and do not pose a risk to others, including patients, from their own infections**.**

13.1 *Influenza Vaccination Programme*

The seasonal flu vaccination programme commenced in September 2015 and continued until February 2016. Extending the programme into 2016 ensured that staff returning from leave and new starters had the opportunity to take up the vaccination.

A team of nurses together with Team Prevent delivered the programme in a variety of ways and settings including:

- Weekly clinics on both sides of the Trust for inpatient and community staff
- Ward visits to eliminate inpatient staff leaving the wards for vaccination
- Vaccinators providing clinics in outlying areas
- Vaccinators available at the start and finish of Trust meetings
- Vaccinators available for non clinical services including Facilities & Estates staff, HIS, finance and administrative staff
- Vaccination available for staff attending occupational health services

The Trust has invested in a significant amount of promotional material from NHS Employers and this has been distributed across the organisation. In addition,

information and updates are provided on the Trust's intranet site. Directors are briefed weekly on staff uptake and details of the programme are included in meeting agendas.

Figure 13 shows the percentage of staff vaccinated in the Trust by year.

Figure 13
Percentage of staff vaccinated at time of data submission

2010/2011	2011/2012	2012/2013	2013/ 14	2014/2015	2015/2016
39%	55%	71%	70%	72%	53%

Although the uptake for 2015/2016 is lower than in previous years, the Trust has maintained its reputation by achieving the highest uptake figures for all mental health Trusts in the West Midlands and many of the acute Trusts. The lower figure and feedback from staff is attributed to the national problem concerning the efficacy of the vaccine in the previous vaccination year.

Figure 14 shows vaccination uptake 2014/2015 for all mental health trusts in the West Midlands. The data reflects uptake at time of submission in January 2015. This Trust continued after the official submission date and those data are not reflected below.

Figure 14
Vaccination Uptake 2015/16

	2015/16			2014/15		
TRUST	NUMBER OF STAFF	NO. OF VACCINES GIVEN	VACCINE UPTAKE	NUMBER OF STAFF	NO. OF VACCINES GIVEN	VACCINE UPTAKE
Birmingham & Solihull Mental Health NHS Foundation Trust	3050	904	29.6	3082	1118	36.3
Black Country Partnership NHS Foundation Trust	1517	478	31.5	1629	501	30.8
Coventry and Warwickshire Partnership NHS Trust	2969	975	32.8	1873	1319	45.9
North Staffordshire Combined Healthcare NHS Trust	1170	524	44.8	1168	501	42.9
South Staffordshire & Shropshire Healthcare NHS Foundation Trust	2291	1218	53.16	2155	1389	64.5
Worcestershire Health and Care NHS Trust	3041	1309	43	3139	1560	49.7

Figure 15 shows the staff broken down into staff groups.

Figure 15
Percentage Totals by Reporting Code of Vaccination Uptake 2015 /2016

Staff Groups	***October***	***November***	***December***	***January***			***Total***
Group 1 - Doctors	33	31	11	9			**84**
Group 2 - Nurses	138	129	49	36			**352**
Group 3 - Staff with patient contact	230	176	69	27			**502**
Group 4 - Staff with no patient contact	111	114	24	31			**280**
	512	**450**	**153**	**103**			***1218***

14. Conclusion

The report has summarised the infection control activities over the year 2015 and concludes that the infection control risk in the Trust remains low and that the Trust is compliant with the Health & Social Care Act: *Code of Practice on the Prevention of infections and related guidance.*

The IPCT team has continued to focus infection prevention and control activity on three main areas:

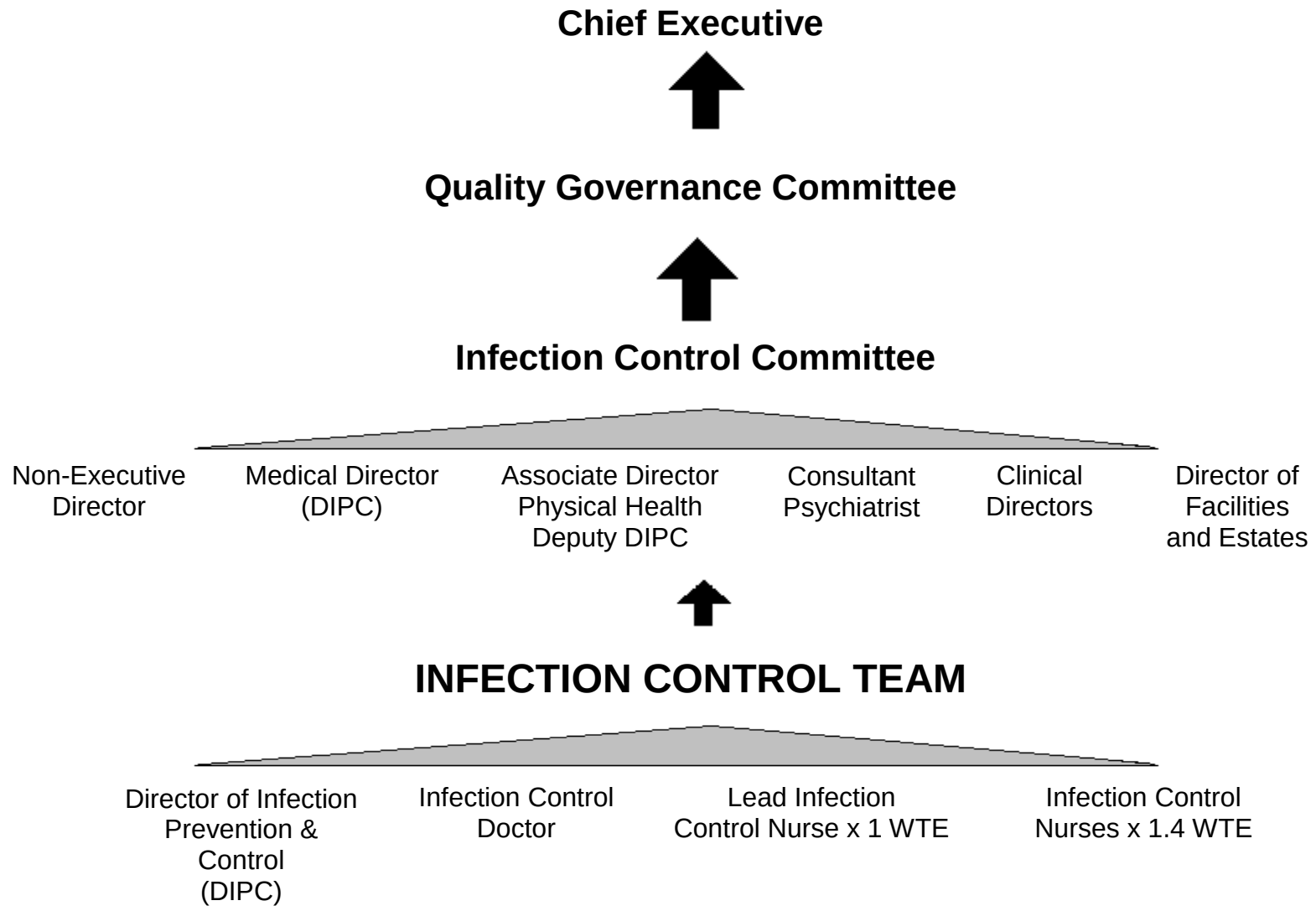
- Raising awareness and reducing the incidence of health care associated infection.
- The training of staff to ensure the successful management of infection.
- Embedding all aspects of infection control through the philosophy that infection control is everyone's responsibility.

With support from the Consultant Microbiologist, the IPCT will continue to maintain training programmes, guide staff and ensure implementation of national infection control directives.

The Infection Prevention and Control Programme for 2015 in appendix 2 will be monitored through the Infection Control Committee.

Appendix 1

INFECTION PREVENTION & CONTROL MANAGEMENT



Appendix 2

Infection Prevention and Control Programme 2016

Update January 2016

DDN	**Deputy Director of Nursing**
LIPCN	**Lead Nurse Infection Prevention and Control**
IPCT	**Infection and Prevention and Control Team**
CP	**Chief Pharmacist**
CATL	**Clinical Audit Team Leader**

Duty Code of Practice	**Objective**	**Action**	**Progress/ Evidence**	**Date to be Achieved**	**Lead Officers**
1. Audit. To demonstrate compliance with infection control standards					
1,2,8	To provide a programme of audit to ensure that key policies and practices are being implemented appropriately including decontamination of equipment, laundry and safe sharp practice	Annual audits of inpatient areas to commence April 2016. Finish August 2016. Audits of GUM services and Children's services	Report to IPC committee	**November 2016** **March 2016**	LIPCN
1,8	To provide audit on compliance with hand hygiene practice	Regular Hand hygiene observational audits to be completed by inpatient areas. New audit tool for 5 moments and essential steps	Report to IPC committee Overall compliance 93% January 2016 Trial on Bromley ward	**Bi monthly** **May 2016**	IPCT
2. Surveillance, To identify and monitor trends, incidence and variance of infections					
1	To monitor trends in infection	Monitor outbreaks and trends on wards Initiate Root cause analysis for Clostridium Difficile and MRSA bacteraemia as required	Report to IPC committee	**As required**	IPCT LIPCN
3. Cleanliness & Environment					
2	To ensure that environment and equipment is clean and fit for purpose	Joint working with estates and Hotel services with quarterly managerial audits and annual PLACE visits	Results returned to areas for action as necessary. Action through matrons F&E meetings and Link champions meetings. Results to be fed back to IPC committee	**Reported at IPC committee bi monthly**	DEF/ IPCT
2	The IPCT are involved at all stages in the design and building of new healthcare facilities or the	Liaise with Facilities and Estates	IPC Team involved with new builds for community services at Shrewsbury and GUM services in Stafford and Telford	**As required 2016**	IPCT

Duty Code of Practice	Objective	Action	Progress/ Evidence	Date to be Achieved	Lead Officers
	refurbishment of existing facilities.		IPC team part of team visiting new services for ISHS in Telford and Shropshire.		
4. Education & Training, To ensure all workers with in the Trust have the ability to apply appropriate infection prevention and control knowledge and skills to their practice					
9	Prevention and control of infection is included in induction programmes for new staff	Induction programme now includes Infection control, input coordinated by the Learning and Development team	Training records. Monitored through Board reports and IPC committee	**Reported at IPC committee**	LIPCN
9	To undertake a programme of ongoing education for existing staff (including support staff, agency/locum staff and staff employed by contractors)	E learning to be rolled out	Training records Monitored through Board reports and IPC committee. In-depth IPC training to be provided for ward managers January 2016 achieved 79%	**Reported at IPC committee**	LIPCN
5. Policy And Guidance, To produce evidence based, standardised, policies to inform/support practice					
8	To ensure the provision of evidence based up to date and relevant infection control policies and SOP in line with the Code of Practice for the NHS on the prevention and control of healthcare associated infections (2008)	Policy/ SOP Decontamination of re-usable Medical Equipment SOP	Presented to March 2016 IPC committee	May 2016	LIPCN
6. Patient Management, To improve patient experience To ensure effective management of patients with HCAI					
1	To ensure that specialist infection control advice is provided where infection control input will minimise risks to patients	Review the patient caseload weekly to ensure appropriate management of patients, including ward visits as required An IPCN to attend meetings of relevant committees • Facilities and Estates and Modern Matrons meeting • Medical Devices committee • Link Nurses • Water safety group	Weekly assessment information Minutes of relevant committees	**Ongoing**	LIPCN
8,4	To identify outbreaks promptly and manage following policy	Provide information for staff when to contact and who to contact Ensure daily review of outbreak	Contact details across Trust Records in Infection control folder		IPCT

Duty Code of Practice	Objective	Action	Progress/ Evidence	Date to be Achieved	Lead Officers
		Ensure effective communication between relevant organisations and clinical leads Provide an incident report/RCA or PIR analysis, where appropriate Provide education of staff, when relevant	HPA and SHA informed of ward closures Infection control committee report to include outbreaks	**Reported at IPC committee bi monthly**	
	To provide link champion group	Bi monthly meetings to provide education, networking opportunities and promote good practice Study day	Minutes of meetings, Link nurses news letter	**On going** **July 2016**	IPCT
7. IC Team Professional Development, To ensure provision of an effective and appropriate infection control service To ensure appropriate skill mix within infection control team and enable ongoing registration to appropriate parts of the nursing register					
7	Ensure that the IPCN receive specialist infection prevention and control development opportunities	Identify training needs and development needs through personal development reviews	Continue attendance at Infection Prevention Society study days	**Ongoing**	LIPCN