Trust Board

Agenda Item	11b.	**Date: 27 September 2017**	
Title of Report	Infection Control Annual Report		
Purpose of the report and the key issues for consideration/decision	For the Board to receive for approval. The report has been reviewed at the Quality & Safety Committee.		
Prepared by: Name & Title	Infection Control team		
Presented by:	Pauline Law, Director of Nursing		
Action Required (please X)	**Approve** x **Adopt** **Receive for information**		
Strategic/Corporate Objective(s) supported by this paper	BAF Objective: To deliver safe, high quality, effective, evidence-based patient care		
Is this on the Trust's risk register?	**No** On the BAF **Yes** **If Yes, Score**		

CQC	x
NHSLA	x
BAF Objectives	x
WWL Wheel	x

Have all implications related to this report been considered?

	Yes/No/NA	Any Action Required		Yes/ No/NA	Any Action Required
Finance Revenue & Capital	Na	Na	Equality & Diversity	Na	Na
National Policy/Legislation	Y		Patient Experience	Y	
NHS Contract	Y		Governance & Risk Management	Y	
Human Resources	Na	Na	Terms of Authorisation	Y	
Consultation/Communication	Na	Na	Human Rights	Na	Na
Other:	Na	Na	Carbon Reduction	Na	Na
If action required please state:					

Previous Meetings

Please insert the date the paper was presented next to the relevant group

ECC	Audit Committee	Quality & Safety Committee	Finance & Investment Committee	Management Board	Strategy Committee	Workforce Committee	NED	Other
Na	Na	13.09.17	Na	Na	Na	Na	Na	Na

Wrightington, Wigan and Leigh NHS Foundation Trust

DIRECTOR OF INFECTION PREVENTION AND CONTROL ANNUAL REPORT 2016/2017

Author: Director of Infection Prevention and Control
Date: March 2017

Prepared by: Dr R Nelson, Mrs L Barkess-Jones, Mr N Bastow, Ms T Mak, Mr S Mellor

Your hospitals, your health, our priority

**AT ALL TIMES, STAFF MUST TRE
AT EVERY INDIVIDUAL WITH RESPECT
AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.**

1 EXECUTIVE SUMMARY

This is the thirteenth Director of Infection Prevention and Control's (DIPC) report, covering the period April 2016 to March 2017. The DIPC Report is produced on an annual basis and incorporates the Trust's Annual Infection Prevention and Control Report. The DIPC Report consists of an overview and progress report on the Infection Prevention and Control management arrangements (including budgetary control), together with other Infection Prevention and Control activities. This document also provides summary reports on the following:-

- Description of Infection Prevention and Control Team Arrangements
- Infection Prevention and Control Budgetary allocation
- Healthcare Associated Infection statistics
- Decontamination
- Cleaning Services
- Audit
- Targets and Outcomes

2 DESCRIPTION OF INFECTION PREVENTION AND CONTROL TEAM ARRANGEMENTS

See: Appendix 1, Wrightington, Wigan and Leigh NHS Foundation Trust: Infection Prevention and Control Policy and Appendix 2 for the Infection Prevention and Control Committee Terms of Reference.

3 DIPC REPORTS TO THE TRUST BOARD

The Director of Infection Prevention and Control has presented the Trust Board with the following agenda items on Infection Prevention and Control in 201/2017.

- The DIPC Annual Report 2015/2016 – endorsed.
- Infection Prevention and Control Committee Annual Programme 2016 - 2017 – endorsed.
- Bimonthly Infection Prevention and Control Committee minutes highlighting outbreaks and areas of concern and progress.
- The Trust MRSA Bacteraemia trajectory progress and areas of concern.
- The Trust *Clostridium difficile* trajectory progress and areas of concern.
- Trust MSSA and E. coli bacteraemia results.

The Director of Infection Prevention and Control acts as the liaison between the Trust Board, Infection Prevention and Control Committee and Infection Prevention and Control Team.

4 BUDGET ALLOCATION TO INFECTION PREVENTION AND CONTROL ACTIVITIES

- The Infection Prevention and Control budget for 2016/17 is (£236836) (non-pay = (£228212)).
- Microbiology services were provided as part of the PAWS Consortium and individual budget information was not available for 2016/17.
- Infection Prevention and Control staff: = 4.43 WTE.
- Infection Prevention and Control Doctor = 0.5 WTE.
- Consultant Microbiologist = 1.5 WTE.
- Antimicrobial Pharmacist = £35,000

5 INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME 2016-2017 AND REVIEW OF PROGRESS – SEE APPENDIX 3

6 HEALTH CARE ASSOCIATED INFECTION STATISTICS

Results of Mandatory Reporting of Health Care Associated Infection

- See Table One.

Trends in Health Care Associated Infection Statistics

- MRSA bacteraemia – See Graphs One and Two.
- *Clostridium difficile* diarrhoea – See Graph Three.

Trust performance against Health Care Associated Infection reduction targets.

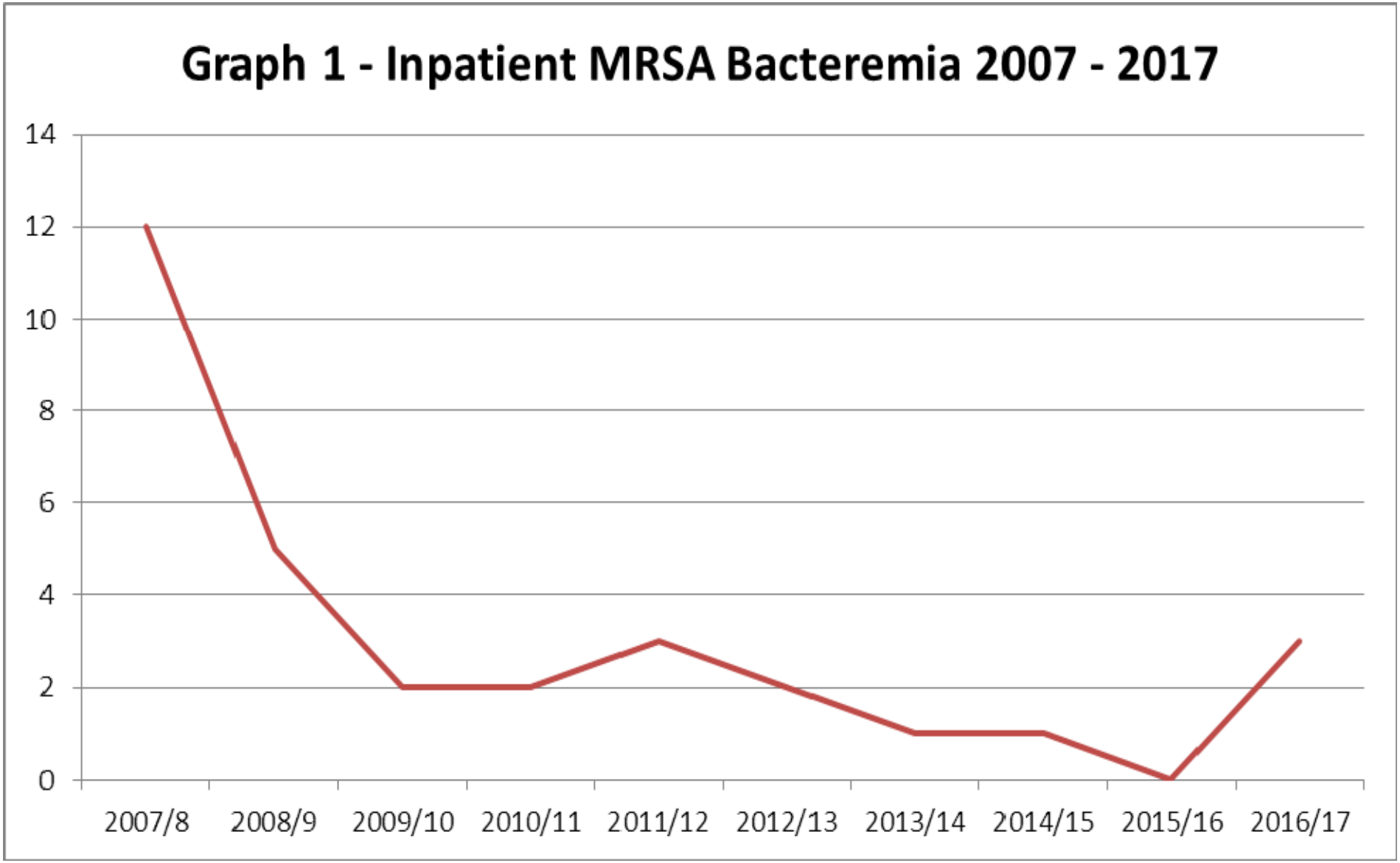
- MRSA bacteraemia – See Graph 4.
- *Clostridium difficile* diarrhoea – See Graph 5.

Antimicrobial Use and Resistance

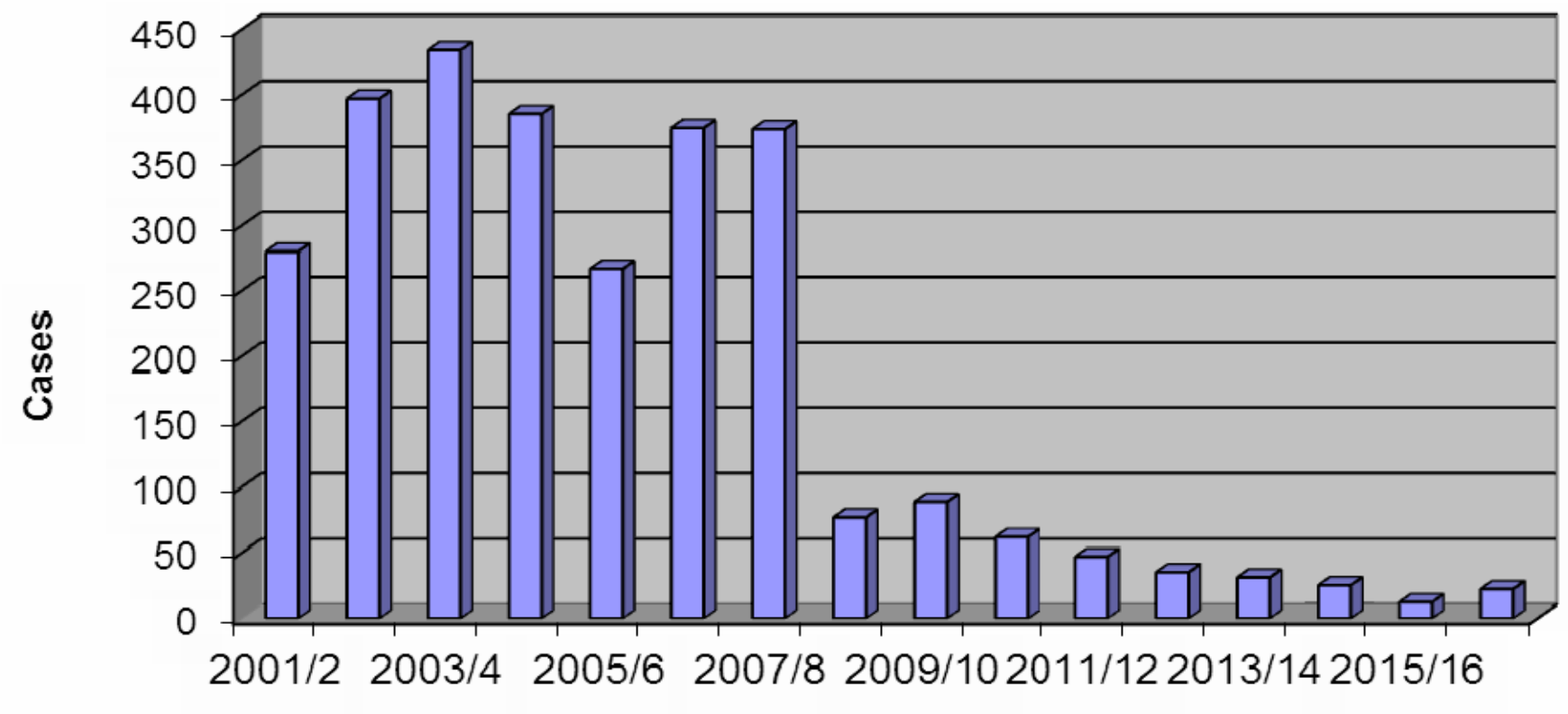
- Antimicrobial Pharmacist's report is given in item 10.

TABLE 1 – RESULTS OF MANDATORY REPORTING – INDIVIDUAL CASES

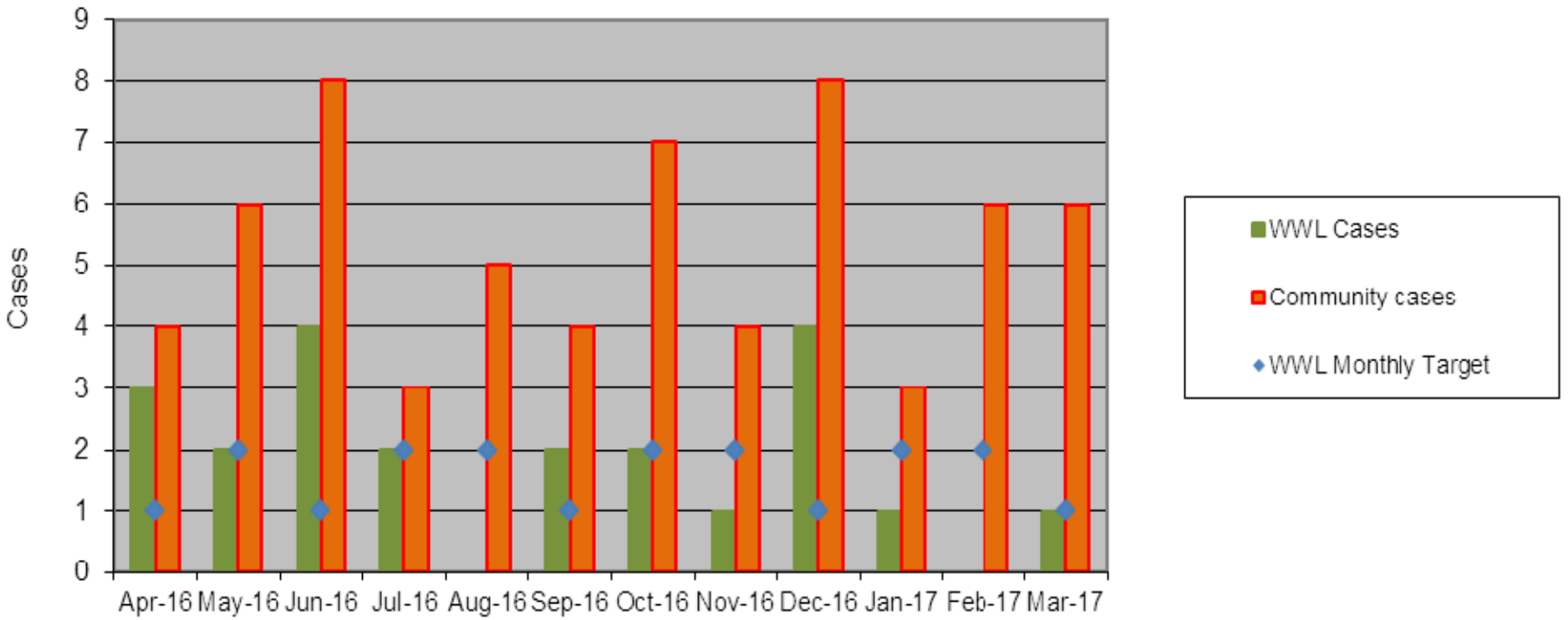
YEAR		**2016**			**2017**	**TOTAL**
Quarter		**2**	**3**	**4**	**1**	
MRSA Bacteraemia (cases)	**Ascribed to community source**	0	1	0	0	1
	Ascribed to Acute Trust	0	0	2	1	3
	Ascribed to 'Third Party' category	0	0	0	0	0
MSSA Bacteraemia (cases)	**Within 48 hours of admission**	8	11	11	4	34
	> 48 hours post admission	3	7	2	0	12
E. coli Bacteraemia (cases)	**Within 48 hours of admission**	28	30	32	29	119
	>48 hours after admission	7	7	14	10	38
***Clostridium difficile* (cases)**	Within 3 days of admission or taken in the community	18	12	19	15	64
	> 3 days post admission	9	4	7	2	22
Orthopaedic surgical site Infection - % of cases	Hip replacement	0%	0.9%	Data awaited	Data awaited	
	Long bone fracture	0%	0%	Data awaited	Data awaited	
	Fractured neck of femur	0.8%	1.3%	Data awaited	Data awaited	
	Knee replacement	0%	0.4%	Data awaited	Data awaited	
Central line infection on ICU/HDU ("Matching Michigan" cases)		0 line related infections	0 line related infections	1 line related infection	0 line related infections	


Graph 1 - Inpatient MRSA Bacteremia 2007 - 2017
14
12
10
8
6
4
2
0
2007/8
2008/9
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17

Graph 2 - Inpatient C.difficile 2001 - 2017



Graph 3 - Clostridium difficile - Monthly Performance 2016/17



7 UNTOWARD INCIDENTS (INCLUDING OUTBREAKS)

2016 Second Quarter

- A Medical and an Orthopaedic ward were affected by Norovirus gastroenteritis. This was introduced from the community and lead to brief closures of both wards. These were rapidly reopened following a terminal clean without further issues.

- A patient present in the bay on a Medical ward was subsequently found to be suffering from Influenza A. Prophylactic anti-influenza treatment was given to contacts exposed to the individual. There was no evidence on further cases of influenza.

- A baby was found to be colonised with MRSA on the Neonatal Unit. Screening of other neonates did not reveal evidence of spread. Further screening suggested that the MRSA had been introduced into the Unit by a previously colonised relative.

2016 Third Quarter

- A patient was found to be colonised with a multi-resistant CPE type organism on a Medical ward. The affected bay was closed to admissions and contacts were screened. There was no evidence of spread within the area and appropriate terminal cleaning was performed at the end of the incident.

- An increased incidence of *Clostridium difficile* colonisation/infection was detected on a Medical ward. Investigation did not reveal a common source and typing of the isolates demonstrated that these were all unrelated to each other. Infection control precautions were reinforced with cessation of this issue.

2016 Fourth Quarter

- An increased incidence of *Clostridium difficile* infection was detected at Wrightington hospital. Investigation did not reveal any common link between cases. Infection control precautions were reinforced and no further cases were detected.

2017 First Quarter

- An increased number of patients suffering from Influenza A were admitted to the General Medical wards. The source for these individuals was ongoing outbreaks in nursing home residence in the community. This occurred despite high uptake of influenza vaccination amongst nursing home residents. Appropriate infection control precautions were implemented immediately for all individuals originating from affected nursing homes. This prevented any secondary cases occurring within the Acute Trust.

- A Medical ward was affected by Norovirus/gastroenteritis. This affected significant numbers of both patients and staff and led to a six day closure of the ward. The ward reopened following a terminal clean without evidence of spread to other clinical areas.

8 DECONTAMINATION

Decontamination of Surgical Instruments

Background

The Sterile Services and Decontamination Unit (SSDU) based near Horwich in Bolton was opened in December 2010 and provides a Surgical Instrument Decontamination Service to all theatres/wards/clinics in WWL and Salford Royal (SRFT) Trusts. SSDU provides all re-usable surgical instruments that are required as Sterile or Disinfected at point of patient use to enable a patient treatment episode to be performed, as a Shared Service between both organisations.

Capacity

Table to Demonstrate Activity and SMV:

Year	Activity			SMV		
	SRFT	WWL	Total	SRFT	WWL	Total
2010/11	Activity only collated from April 2011 when both trusts officially transferred.					
2011/12	169,258	148,440	317698	2,729,969	2,539,878	5,269,847
2012/13	163,654	145,613	309267	2,846,809	2,599,952	5,446,761
2013/14	163,962	143,406	307,368	2,619,806	2,390,493	5,010,299
2014/15	141911	142486	284397	2,579,613	2,555,438	5,135,051
2015/16	148576	136528	285104			
2016/17	148576	136528	285104	2681395	2429418	5110813

At the start of the year the service had a combined budget of £4,117,526 and a CIP savings target of £125,000, both CIP and budget have been achieved.

Validation

Further to the re certification audit in September 2014, and subsequent surveillance audit in June 2016 and December 2016 the unit remains compliant with one non-conformance noted to the following standards

- Production Quality Assurance , Directive 93/42/EEC for Medical Devices, Annex V
  During the verification audit in June 2016 no non-conformances were found. In December 2016 a further verification audit took place where 1 minor non-conformance was found.
- EN ISO 13485:2012 (The decontamination, assembly, packing, inspection and sterilisation of: Sterile instruments sets/trays and ward packs.

Issues

In July 2016 amendments to ISO 14644 Cleanrooms and associated controlled environments part 2: monitoring to provide evidence of cleanroom performance related to air cleanliness by particle concentration became effective. The unit is compliant with the amendments.
EN ISO 13485:2012 (The decontamination, assembly, packing, inspection and sterilisation of: Sterile instruments sets/trays and ward packs has been amended and a new version has been released with an implementation date of 2019. A gap analysis has been produced and Fiona Kennedy quality consultant for medical devices has been invited to review the gaps and help with improvements to our quality system. We intend to convert to the new standard in 2017 to coincide with our re-certification audit; however, there is a risk that our accredited body Intertek may not be in a position to audit to the new standard. A risk assessment has been completed. As the standard is not required to be implemented until 2019 the risk rating is low and mainly a financial impact.

CFPP 01 01 and CFPP 01 06 have been withdrawn and HTM 01 01 and HTM 01 06 have been released. The new guidelines call for protein detection “in situ” and advise that swabbing instruments does not deliver satisfactory results. There is currently only 1 device on the market that can perform this task and there is much debate on its effectiveness.

One item remains on the Divisional Risk Register and none on the Corporate. The divisional risk relates to injury to staff caused by contaminated sharps.

There have been no SUI (Serious Untoward Incident) in the last 12 months and no product recalls.

The major Health & Safety item remains sharps and single use item returns from the users, in particular needles and blades. No serious accidents resulting in clinical care for staff have yet occurred with all technicians trained to spot and deal with all such incidents. The return of single use instruments has increased has remained high over the past 12 months whilst SSDU procedures are robust and to date have we captured and disposed of all single use instruments, there is an increased risk related to the current levels that are being sent back.

Endoscopy Processing

An Endoscopy project, led by Estates is nearing completion this will centralise and upgrade endoscopy decontamination by employing a standalone decontamination facility situated in the Christopher home building. Go live date is scheduled for the first week in June 2017 and will decontaminate flexible endoscopes for the RAEI site.

The Hanover Diagnostic and Treatment Unit opened in June 2013 with SSDU managing the endoscopy decontamination on site in a dedicated state of the art unit.
It processes, on average, 40 to 50 Gastroscopes, Colonoscopes & Cystoscopes for the relevant departments within the building every day and is also used to help business continuity for the endoscopy department at RAEI.

9 CLEANING SERVICES

The domestic management structure is as follows:

Associate Director of Estates & Facilities
↓
Facilities Manager
↓
Hotel Services Manager
↓
Domestic Services Manager
↓
Domestic Supervisors
↓
Domestic Assistants

The Director of Performance is the designated director who has the strategically responsibility for the domestic services provided throughout the organisation, who engages in regular meetings with the Associate Director of Estates and Facilities.

The Trust Facilities Manager is able to access the clinical access through the director of nursing and regular meetings with the associate director of infection prevention control and team.

The Domestic Assistants/Supervisors work to planned rotas, this is managed by the service requirements of our patient environment; this in in turn is measured by the National Cleaning

standards on a monthly basis and monitored by service level agreements' which are tailored to every clinical area within the Trust. There is a mobility agreement in place to transfer Domestic assistants within the organisation to other hospital sites and outpatient clinics to undertake cleaning duties if required.

The two Domestic Services Managers based on designated sites have the operational management responsibility for their respective sites and reports in their structure to the Hotel Services Manager whom in turn manages the services operationally Trust-wide.

The Trust Facilities Manager has the overall the strategic management responsibility for the services provided implementing initiatives and guidelines, monitoring the National Cleaning standards promoting a proactive service meeting the needs of the Trust and in turn reporting to the Associate Director of Estates & Facilities.

Cleaning services forum

The Trust has a regenerated 'Cleaning Services Forum' chaired by the Deputy Director of Nursing and Patient Services. The forum comprises of members from multi-disciplinary backgrounds and patient representatives. The group's remit is to improve the Trust Cleaning Standards, domestic provision and associated services delivered to the Trust. It also Implements quality measures, innovations and uniformity in Cleaning Practices.

Examples include:

Monitoring the Deep Clean schedule

Reviewing methodology, monitoring, developing and enhancing the standards of cleanliness within the Trusts Clinical areas. Fulfilling the organisations aspirational target of 95% and maximising on its staff efficiency costs.

Review the Service Level Agreements supplied to the clinical areas within the Trust.

Evaluate and standardise the cleaning products and equipment currently used across the Trust.

National Cleaning Standards

The Trust maintains the National Cleaning Standards code and monitors its standards using the Service track monitoring system. The domestic supervisors audit the clinical areas on a monthly basis supplemented with daily & weekly visual checks, the Ward Manager receives the audit sheet and accompanies the Domestic Supervisor to assess the levels of hygiene and environmental standards within their area. The Heads of Nursing and Matrons can accompany the Deputy Hotel Services Manager on a quarterly basis ensuring that the ward areas are maintained to a high standard.

The average annual National Cleaning Standard Trust score for its clinical areas has met its internal aspirational target of 95.00 %.

The 2016 PLACE verification inspection was accompanied by the external validator who supported the Trusts submission as good and noted the many excellent practices for patient environment and food on the RAEI, Wrightington and Leigh sites. This year the Trust has submitted the highest number of scores than in any other of the previous year's attaining our three Hospital sites receiving 100% score for cleanliness for the third year running the only acute hospital in the country to achieve this score. WWL is ranked 6th in the Country; this was reflected by the annual Information Centre for Health and Social Care publication. The senior team who asses this score is once again a multi- disciplinary team with the inclusion of patient representatives working in

partnership to promote good practice across our sites. Picker results showed our results patients scored the Cleanliness Excellent at 99% within the 75 Trusts benchmarked.

The Domestic provision budget is £ 3,819,279 (pay) and £ 455,472(non-pay) totalling £4,274.750, which is managed by an in-house service. All the domestic frequencies and hygiene scores are publically displayed at the entrances of the wards as in line with good practice. The Trust Facilities Manager has evaluated the Lord Carter Report and measured the Trust performance against the report's recommendations. The Domestic service has demonstrated a high performance approach to its standards of quality and remaining in the medium quartile demonstrating value for money

Disposable Curtains

The Trust continues to have disposable cubicle curtains and maintains this facility throughout all of its wards. This quality innovative decision has improved the privacy and dignity of its patients due to the strap message displayed through the curtain.

24 hour Cleaning Team

The Trust has a 24 hour cleaning team on the main acute site which targets high usage areas such as the Emergency Care Floor, Clinical Decisions Ward and the out of hour's bed space cleaning.

Additional Toilet Cleans

The Trust continues its additional toilet cleans which takes place across all the wards during the afternoons and evenings once again maintaining the Trust quality standards. This has been received as a quality measure by our patients whom in the recent patient survey put the toilet cleanliness score consistently at 99%.

Deep Clean Team

The Trust has a designated deep cleaning team, which works across the sites, striving to provide the very best patient environment and working towards the reduction of HAI's. The deep clean schedule is produced at the beginning of the financial year The Trust has achieved in 2015/16 the deep cleaning of its wards. This work is undertaken by a designated cleaning/estates team.

The deep clean process undertakes the environmental restoration, cleaning, steam sanitising of the clinical environment including the cleaning of the lighting and ventilation equipment. There is a secondary enhanced ward clean which takes place six months after the deep clean on medical wards. A hydrogen Peroxide Vapour decontamination process also takes place on the discharge of patient's rooms with a known positive CDT & PCR+ status. This scheduled enhanced clean is tailored to meet the individual needs and activity of the wards.

A detailed programme of the deep cleans are displayed at the entrances of the sites advising our patients and visitors of the progress. The scheduled dates are prioritised throughout the year to meet the organisations winter pressures.

Satisfaction Surveys

The Domestic Services department participates with patient satisfaction surveys. The indications show our patients are happy with the standard of cleanliness delivered the independent score is currently standing at good to excellent at above 99%. The Trust Domestic Services Department regularly meet with to assess the patient's scores and comments to look at ways of improving the services provided. There have been no formal complaints received detailing the standard of cleanliness within clinical areas levied against the Trust again this year.

10 ANTIMICROBIAL PRESCRIBING/STEWARDSHIP

Antimicrobial Stewardship Group Annual Report

June 2017
Dr Robert Nelson, Consultant Microbiologist
Dr Camelia Faris, Consultant Microbiologist
Tsz Shan Mak, Specialist Pharmacist for Antimicrobials

Antimicrobial Stewardship is defined as an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness.

CQUIN for Antimicrobials

To combat antimicrobial resistance, Public Health England has devised the national CQUIN initiative with an aim to reduce inappropriate antimicrobial use. The CQUIN targets set for 2016/2017 financial year are as follows:

- Reduction of 1% or more in total antibiotic consumption per 1000 admissions
- Reduction of 1% or more in Piperacillin/Tazobactam consumption per 1000 admissions
- Reduction of 1% or more in Carbapenem consumptions per 1000 admissions
- Empirical review of antibiotics prescriptions within 72hrs of initiating treatment for at least 90% of cases sampled

The above reduction should be made against the baseline consumption data for 2013/2014 financial year as outlined by PHE. However, after analysing the consumption data at the start of the financial year, it became apparent that a reduction of Piperacillin/Tazobactam consumption against 2013/2014 baseline would not be possible, therefore the trust have managed to negotiate a different baseline year of 2015/2016 for Piperacillin/Tazobactam only with the local CCG.

The results are reported to PHE at the end of each quarter, and the results are compiled at the end of the financial year. The table below is a summary of our achievements as a trust at the end of 2016/2017 financial year.

Consumption in Daily Defined Dose per 1000 admissions	% Change since 2013/2014	% Change since 2015/2016
Total Antibiotic	-2.58%	
Piperacillin/Tazobactam		-1.02%
Carbapenems	-17.40%	

96% was achieved for empirical review of antibiotics prescriptions within 72 hours of initiating treatment.

The plans for 2017/2018 CQUIN is currently under discussion with the local CCG.

Audits

The antimicrobial pharmacist completed a one day, Trust wide, snap-shot Antimicrobial Point Prevalence Study in March 2016 and October 2016. These audits are conducted to assess compliance with the trust antimicrobial policies and the results compared to previous point prevalence data.

These audits will continue to be repeated twice a year to monitor prescribing compliance Trust wide. The results are summarised below.

	Number of patients audited	% of patients on antibiotics	% of antibiotics reviewed in 48 hours	% Initial decision documented in notes?	% of antibiotics with indication	% of antibiotics with stop/review date	% Compliance to policy
March 2016	419	32%	89.5%	95.3%	98.3%	84.3%	94%
October 2016	468	35%	95.1%	95.1%	100%	100%	89%

The Trust Divisional Rolling Antibiotic Audit Programme was introduced in January 2009 and is ongoing. Each Division is audited twice a year and the results fed back to the Divisions via presentations at audit meetings and the Infection Prevention and Control Committee. Full audit reports are also on the microbiology webpage of the Trust intranet. The audit now includes information to report compliance not only at ward level but at consultant team level too.

	Number of patients audited	% of patients on antibiotics	% of antibiotics reviewed in 48 hours	% Initial decision documented in notes?	% of antibiotics with indication	% of antibiotics with stop/review date	% Compliance to policy
MSK - April 2016	67	28%	85.2%	92.6%	100%	92.6%	100%
Surgical - June 2016	89	26%	100%	100%	90%	93%	97%
Medicine - August 2016	232	24%	90.7%	95%	95%	99%	97%
MSK - September 2016	95	31%	100%	100%	100%	97.4%	94.9%
Surgical - December 2016	78	32%	94.6%	100%	100%	100%	83.8%
Medicine - Feb 2017	256	36%	100%	100%	100%	100%	95.7%

An antibiotic audit programme still continues on a weekly basis on individual wards that have reported an increased incidence of *Clostridium difficile* Infection. Results are fed back to individual wards, the Infection Prevention and Control Committee and the Division.

New Drugs / Products

The following products have been discussed:

- **IV Fosfomycin** – This would not be stocked due to its many disadvantages, but may be ordered if all trust approved antibiotics have been exhausted.
- **IV Aztreonam** – This is a product we would like on our formulary, but due to cost and availability,

the acquisition have not been successful. Pharmacy will continue the attempts to source this product.

- **IV Ceftolozane/Tazobactam** – This product was deemed expensive, and currently would not fit into the trust formulary, but may be ordered if all trust approved antibiotics have been exhausted.
- **Elastomeric infusion devices for 24 hours infusion** – This is available by Baxters for antibiotics such as flucloxacillin. This may be a good alternative for ceftriaxone in the hospital at home setting. The use of this product is still under review.
- **IV Dalbavancin** – This is a once weekly agent licensed for cellulitis, it is a high cost product but can potentially reduce nursing time, therefore its application was discussed with acute physicians. Currently still waiting for their feedback.

Education

Education has been provided to all pharmacists and new junior doctors on how to use the new MicroGuide app.

New junior doctors were given a teaching session on safe antimicrobial prescribing in August 2016 which was well received. A hand-out have been produced and given out to the new junior doctors regarding the safe prescribing of antimicrobials, and the safe prescribing of gentamicin.

Ongoing teaching sessions for junior doctors have been provided by our microbiologists.

Ward Rounds

Antimicrobial ward rounds with a consultant microbiologist now occur on a weekly basis, this ward round aims to guide doctors in following the start smart then focus objectives to review antibiotics in a timely manner as well as advising a switch to appropriate antibiotics whenever possible. These interventions are logged on an audit form.

Guidelines

The Trust antibiotic guidelines are now available as a downloadable application to the iPhone, iPad, android and window devices. Usage figures show that this information source is widely used and well received within the trust.

The MicroGuide has been reviewed regularly and updates completed. All antibiotics monograph have been updated according to the latest version of “The Renal Drug Handbook”.

Stock Shortages

There is an ongoing shortage of the following products:

- **Piperacillin/Tazobactam** – There is an ongoing national shortage on this product, this shortage is likely to continue until the end of the year. Pharmacy has managed to source sporadic supplies of this but supplies are limited. Ward round to reduce its use are ongoing. Physicians have been advised to review the use of Piperacillin/Tazobactam within 48 hours of prescribing, and if appropriate de-escalate to a narrow spectrum antibiotics/switch to oral route.
- **IV co-amoxiclav** – Due to the ongoing Piperacillin/Tazobactam shortage, this has impacted on the supply of co-amoxiclav, and currently pharmacy is unable to obtain further stocks. Physicians have been advised to use second line antibiotics in this period of shortage.
- **Ceftazidime** – Manufacturer is unable to supply this product currently, the root of this issue is currently being explored. This product is primarily used for home IV bronchiectasis patients. The hospital at home team have been informed and physicians are advised to liaise with microbiology should a need for this product arises.

11 AUDIT

The following audits have been undertaken:

- Hand washing audit – compliance with hand washing guidelines performed on a monthly basis on all clinical areas within Trust.
- Recurrent audit of accuracy of death certification in cases of *Clostridium difficile* diarrhoea.
- Recurrent audit of compliance with MRSA elective screening policy.
- Recurrent audit of compliance with MRSA emergency screening policy.
- Audit of blood culture contamination rates.
- Audit of *Clostridium difficile* specimen transport.

12 SEASONAL FLU IMMUNISATION PROGRAMME

Occupational Health commenced the Trust's annual vaccination programme in October 2016 as soon as the season's vaccine was released. Uptake amongst front line staff was 66% which compares to 53% in 2015/16.

13 TARGETS AND OUTCOMES

MRSA Bacteraemia

Three cases were ascribed to the Trust in 2016/17:

- An individual with complex surgical problems, already known to be colonised with MRSA underwent a change of central venous line. The individual became unwell following the procedure and was found to be suffering from an MRSA bacteraemia. MRSA was grown from the tip of the original line. This was felt to be the source of the bacteraemia.

- An individual with a complex medical history became unwell and blood cultures subsequently grew MRSA. Source was felt to be an infected cannula site on the individual's arm which grew MRSA. The cannula had been appropriately managed up until the time of onset and was removed when evidence of infection was detected.

- Probable contamination of blood culture specimen at the time of taking with MRSA.

Clostridium difficile Diarrhoea

Eighty-six episodes of *Clostridium difficile* were reported via the Mandatory Surveillance System in 2016/17. This includes both hospital and community patients. This compares with sixty-seven episodes in 2015/16. Hospital acquired cases (onset more than three days following admission) stood at 22 episodes in 2016/17. This is an increase over the 12 episodes reported in 2015/16. The rise in reported numbers in 2016/17 was common to all Trusts in Greater Manchester over this time period. Typing of the *Clostridium difficile* isolates did not reveal a common source or linkage between episodes. Increased testing levels following outbreaks of Norovirus both within the hospital and the community are likely to have contributed to increased number of isolates. In addition, the Trust suffered from significant admission pressures during late 2016/early 2017. Increased bed occupancy is known to contribute towards higher levels of healthcare associated infection.

MRSA Screening of Elective Admissions

Preoperative screening of elective admissions to hospital became mandatory for Trust in England from 01st April 2009. The Trust has continued to work closely with community services to develop pathways to manage patients found to be carrying MRSA to ensure treatment was not delayed.

Regular audits of compliance with the MRSA screening policy are performed with at least 95% coverage of elective admissions being achieved each month.

MRSA Screening of Emergency Admissions

Screening of patients admitted as emergencies became compulsory for NHS Trusts in England from 1st January 2011. Implementation in Wrightington, Wigan & Leigh NHSFT commenced in advance of this in July 2010. Audits of compliance with screening policy regularly demonstrated coverage of greater than 85% for eligible emergency admissions.

14 TRAINING ACTIVITIES

Induction

- All staff, including medical staff, had Infection Prevention and Control training included within their induction sessions. This includes instruction on handwashing, use of Infection Prevention and Control Guidance and accessing Infection Prevention and Control advice. In addition, medical staff received instruction on antimicrobial prescribing.

CPD for all Staff

- Annual updates on Infection Prevention and Control are mandatory for all staff and are delivered via the electronic mandatory training system. Compliance is monitored regularly.
- Junior medical staff received educational sessions on Infection Prevention and Control and prudent antimicrobial prescribing as part of their educational programme.
- Consultant Microbiologists regularly contributed to staff training, giving educational sessions on Infection Prevention and Control, Infection Management and Antimicrobial Prescribing.

Training for Infection Prevention and Control Specialists

- Infection Prevention and Control Doctor is fully up to date with CPD requirements.
- Infection Prevention and Control Team members attended national and local courses and updates as required.

Training for the DIPC

- Attended Department of Health meetings/updates as required.

15 CONCLUSION

Addressing the challenge of Healthcare Acquired Infections remains a key priority for the Trust, its Board members and the senior Divisional teams. The Trust understands that accountability for Infection Prevention and Control lies with each and every employee and also raises awareness with visitors, patients and their relatives. The Trust is compliant with the Hygiene Code and the Key Core Standards of the Healthcare Commission. The Trust has completed a robust Deep Clean Programme, and increased the number of matrons in line with the DH guidance.

16 RECOMMENDATION

The Trust Board is asked to note the contents of this report and approve the forward programme.

APPENDIX 1 – INFECTION PREVENTION AND CONTROL POLICY

NHS Wrightington, Wigan and Leigh NHS Foundation Trust

POLICY NAME:	**INFECTION PREVENTION AND CONTROL POLICY**
POLICY REFERENCE:	**TW10-042**
VERSION NUMBER :	**8**
APPROVING COMMITTEE:	**INFECTION PREVENTION AND CONTROL COMMITTEE**
DATE THIS VERSION APPROVED:	**JANUARY 2016**
RATIFYING COMMITTEE:	**PARC (Policy Approval and Ratification Committee)**
DATE THIS VERSION RATIFIED:	**February 2016**
AUTHOR(S)	**INFECTION PREVENTION AND CONTROL DOCTOR ASSOCIATE DIPC**
DIVISION/DIRECTORATE:	**CORPORATE**
TRUST WIDE POLICY (YES/NO)	**YES**
Links to other Strategies, Policies, SOP's, etc.	**See Appendix 4**

Date(s) previous version(s) approved: (if known)	**Version:** **1** **2** **3** **4** **5** **6** **7** **7.1**	**Date :** **October 2000** **April 2002** **August 2006** **July 2008** **November 2008** **September 2010** **July 2012** **May 2014**
DATE OF NEXT REVIEW:	**February 2019**	
Manager responsible for review:	**Infection Prevention and Control Doctor Deputy DIPC**	

AT ALL TIMES, STAFF MUST TREAT PATIENTS WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY.

1. INTRODUCTION

This policy details the provision of Infection Prevention and Control services within the Trust.

2. POLICY STATEMENT AND KEY PRINCIPLES

1.1. Wrightington, Wigan and Leigh NHS Foundation Trust provides a range of high quality health care for the local community, in which the Executive Trust Board endorse a zero tolerance towards Healthcare Associated Infections. This policy is in line with the Duties of Care set out in the Healthcare Act 2006.

1.2. Wrightington, Wigan and Leigh NHS Foundation Trust has developed this overarching policy underneath which will be Infection Prevention and Control procedures, policies and SOPs which will be reviewed at least every two years or as nationally agreed guidance dictates. It is the policy of Wrightington, Wigan and Leigh NHS Foundation Trust to ensure that all policies, SOPs and procedures are available on the intranet and accessible to all staff.

1.3. To work effectively the Infection Prevention and Control Team needs the collaboration and active support of all Trust staff. The Infection Prevention and Control Committee (IPCC) represents the main forum for regular consultation between the Infection Prevention and Control Team, the Trust Directorates and local Health Protection Units. This process generates the Annual Infection Prevention and Control Programme for the Trust. The Infection Prevention and Control Committee meets bi-monthly and is responsible for approval of policies/guidance and monitoring of progress against the Trust's Annual Infection Prevention and Control Programme. The committee reports to the Governance and Risk Sub-committee. Policies and procedures will reflect current evidence based practice.

3 ROLES AND RESPONSIBILITIES

3.1 Trust Board

3.1.1 The Trust Board has overall responsibility for ensuring there are effective strategic, corporate and operational arrangements in place to maintain an effective Infection Prevention and Control programme and that appropriate financial resources are place to support that programme. The Trust board ensures that appropriate arrangements are in place to identify, prevent and control where necessary any healthcare associated infections that may occur within the environment (building/clinical) or services.

3.2 Director of Infection Prevention and Control (DIPC)

3.2.1 To oversee local control of Infection Prevention and Control policies and procedures.
3.2.2 To report directly to the Chief Executive and the Board.
3.2.3 To have the authority to challenge inappropriate clinical hygiene practice as well as inappropriate antibiotic prescribing decisions.
3.2.4 To assess the impact of all existing policies on Healthcare Associated Infection (HCAI) and make recommendations for change.
3.2.5 To be an integral member of the organisations clinical governance and patient safety teams and structures.
3.2.6 To produce an annual report on the state of HCAI in the organisation for which he/she is responsible and release it publicly.
3.2.7 To be responsible for the IPCC within the organisation.

3.3 **Deputy DIPC**

3.3.1 To guide and support clinical staff in preventing and controlling infection.
3.3.2 To develop in conjunction with the DIPC, Infection Prevention and Control Doctor, (IPCD) and IPCC the strategy for Infection Prevention and Control monitoring and reporting of HCAI as required by national guidelines.
3.3.3 To Identify and lead control of outbreaks in conjunction with IPCD.
3.3.4 To facilitate education across the Care Trust, including independent Contractors.
3.3.5 To prepare Infection Prevention and Control (IPC) policy documents in collaboration with the IPCD.
3.3.6 To provide in collaboration with the ICD, an annual report to the Trust Board (after approval by the IPCC).
3.3.7 To liaise with the Occupational Health Department on relevant staff or patient health issues.
3.3.8 To develop local IPC standards as agreed by the IPCC and agree on an appropriate audit cycle.
3.3.9 To promote good hygiene within the Trust.
3.3.10 To provide advice to the Trust on purchases or procurement to ensure Infection Prevention and Control issues are considered.
3.3.11 To be involved at an early stage and throughout in re-development/building projects within the Trust.
3.3.12 To advise and support the safe handling of sharps and clinical waste in compliance with local policies.

3.4 **Infection Prevention and Control Doctor (IPCD)**

3.4.1 To guide and support clinical staff in preventing and controlling infection.
3.4.2 To identify and lead on controlling outbreaks in conjunction with the Infection Prevention and Control Nurse (IPCN).
3.4.3 To develop in conjunction with the DIPC, IPCN and IPCC the strategy for Infection Prevention and Control monitoring and reporting of HCAI as required by national guidelines.
3.4.4 To collate, enter and verify monthly data returns required for mandatory MRSA and *Clostridium difficile* reporting.
3.4.5 To provide education on Infection Prevention and Control issues to medical staff at induction and during training programmes.
3.4.6 To be involved at an early stage and throughout in re-development/building projects within the Trust.
3.4.7 To prepare IPC policies and SOPs in conjunction with the IPCN.
3.4.8 To ensure regular, minuted meetings of the Infection Prevention and Control Team occur.
3.4.9 To liaise with the Occupational Health Department on relevant staff or patient health issues.

3.5 **Infection Prevention and Control Committee (IPCC)**

3.5.1 IPCC members to have clear lines of responsibility and accountability within their areas of practice to implement the Trust's annual Infection Prevention and Control programme.
3.5.2 To ensure effective training programme in place to meet identified needs.
3.5.3 To receive a report at each meeting on outbreaks/adverse incidents.
3.5.4 IPCC members will feedback to the IPCC on progress within their area of practice.
3.5.5 To formulate and monitor the annual Infection Prevention and Control programme.
3.5.6 To identify to the Trust the necessary resources to implement the annual Infection Prevention and Control programme.
3.5.7 To ensure the Trust is aware of and response to the external 'drivers' of Infection Prevention and Control e.g. DOH, National Clinical Standards, NHS Litigation Authority (NHSLA), The epic Project: Developing National Evidence-based

Guidelines for Preventing Healthcare Associated Infections, Mandatory Surveillance, "Getting ahead of the Curve" and "Winning Ways", The Health Act 2006.

3.5.8 Divisional Infection Prevention and Control Committee members in combination with their General Manager must develop a communication framework within their Division to ensure a two-way transmission of information between the Division and the Infection Prevention and Control Committee. This will ensure compliance with Infection Prevention and Control SOPs, advice and Root Cause Analysis etc.

3.5.9 The Infection Prevention and Control Committee will ensure that all advice and SOPs are in line with the Healthcare Act 2006, Infection Prevention and Control Best Practice or National Guidance, (Saving Lives, Winning Ways, Working Together to Reduce Healthcare Associated Infection in England (2003), Getting Ahead of the Curve, Standards for Better Health, etc).

3.6 **Infection Prevention and Control Team**

Wrightington, Wigan and Leigh NHS Foundation Trust has an Infection Prevention and Control Team which has the primary responsibility to advise on all aspects of prevention and control of infection across the Trust.

3.7 **Managers' Roles and Responsibility**

Divisional Managers, Clinical Directors and Heads of Nursing have a prime responsibility to ensure that the Infection Prevention and Control Committee's findings, Infection Prevention and Control Guidance, audit results and Infection Prevention and Control advice is operationally implemented and documented within their Divisional communication structures.

3.8 **All Healthcare Workers**

3.8.1 All healthcare workers have a responsibility to comply with all Infection Prevention and Control policies, SOPs and procedures.

3.8.2 External staff or contractors who are contracted to provide support/cover/treatment in Trust hospitals must abide by all Trust IPC policies and SOPs.

3.9 **Patients/service users/visitors**

The Trust will be required to comply with Trust IPC policies and SOPs to reduce risk of HCAI for themselves and others.

4. WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST DUTIES IN RELATION TO INFECTION PREVENTION AND CONTROL UNDER THE HEALTH AND SOCIAL CARE ACT 2008 - CODE OF PRACTICE ON THE PREVENTION AND CONTROL OF INFECTIONS AND RELATED GUIDANCE (henceforth referred to as the code)

4.1 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to have in place appropriate management systems for Infection Prevention and Control**

These arrangements include:

4.1.1 A Board level agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risk. (This policy).

4.1.2 The designation of an individual as Director of Infection Prevention and Control (DIPC) accountable directly to the Board.

4.1.3 The mechanisms by which the Board ensures that adequate resources are available to secure effective prevention and control of Health Care Associated Infection (HCAI). These include implementing an appropriate assurance framework, Infection Prevention and Control programme and Infection Prevention and Control infrastructure.

4.1.4 Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection, as identified within the Trust's training needs analysis.

4.1.5 A programme of audit to ensure that key policies and practices are being implemented appropriately.

4.1.6 A document addressing, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities.

4.1.7 Infection Prevention and Control Committee members must ensure that there is an effective programme and communication strategy for Infection Prevention and Control within the sphere of their responsibility, in order to provide a Divisional Assurance Framework.

4.2 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to assess risk of acquiring HCAI and to take action to reduce or control such risks:**

4.2.1 To ensure a suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI.

4.2.2 To identify the steps that need to be taken to reduce or control those risks.

4.2.3 To record its findings in relation to items (4.2.1) and (4.2.2).

4.2.4 To implement the steps identified.

4.2.5 To ensure that appropriate methods are in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAI.

4.3 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide and maintain a clean and appropriate environment for health care.**

4.3.1 "The environment" means the totality of a patient's surroundings when in Trust premises. This includes the fabric of the building and related fixtures, fittings and services such as air and water supplies.

4.3.2 Wrightington, Wigan and Leigh NHS Foundation Trust will, with a view to minimising the risk of HCAI, ensure that:

4.3.3 There are policies for the environment which make provision for liaison between the members of any Infection Prevention and Control Team (IPCT) and the persons with overall responsibility for facilities management.

4.3.4 It designates lead managers for cleaning and decontamination of equipment used for treatment.

4.3.5 All parts of the premises in which it provides care are suitable for the purpose, are kept clean and are maintained in good physical repair and condition.

4.3.6 The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available.

4.3.7 There is adequate provision of suitable hand wash facilities and antibacterial

hand rubs.

4.3.8 There are effective arrangements for the appropriate decontamination of instruments and other equipment.

4.3.9 The supply and provision of linen and laundry supplies reflects Health Service Guidance HSG (95) 18, Hospital Laundry Arrangements for used and infected linen.

4.3.10 Clothing worn by staff when carrying out their duties (including uniforms) is clean and fit for purpose. (See TW13-005 uniform policy).

4.3.11 Divisional Matrons (in conjunction with Domestic Supervisors/Ward Managers) will ensure effective monitoring arrangements are in place for their areas of responsibility to provide assurance to their Heads of Nursing and Divisional Leads.

4.4 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide information on HCAI to patients and the public**

4.4.1 Wrightington, Wigan and Leigh NHS Foundation Trust will ensure that it makes suitable and sufficient information available to:

4.4.1.1 Patients and the public about the organisation's general systems and arrangements for preventing and controlling HCAI.

4.4.1.2 An Annual Director of Infection Prevention and Control Report, consisting of progress and performance against the Infection Prevention and Control Annual Programme, Department of Health's Healthcare Associated Infection (HCAI)Targets, Department of Health's Deep Clean Programme, Outbreaks of Infection and Untoward Adverse Incidents, and Decontamination

4.4.2 To each patient concerning:

4.4.2.1 Any particular considerations regarding the risks and nature of any HCAI that are relevant to their care.

4.4.2.2 Any preventative measures relating to HCAI that a patient ought to take after discharge.

4.5 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide information when a patient moves from the care of one health care body to another**

Wrightington, Wigan and Leigh NHS Foundation Trust will ensure that it provides suitable and sufficient information on each patient's infection status whenever it arranges for a patient to be move from the care of one organisation to another so that any risks to the patient and others from infection may be minimised.

4.6 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to ensure co-operation**

Wrightington, Wigan and Leigh NHS Foundation Trust so far as reasonably practicable will ensure its staff, contractors and other involved in the provision of health care co-operate with it, and with each other, so far as necessary to enable the body to meet its obligations under this Code.

4.7 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to provide adequate isolation facilities**

Wrightington, Wigan and Leigh NHS Foundation Trust will endeavour to provide or secure the provision of adequate isolation facilities for patients sufficient to prevent or minimise the spread of HCAI.

4.8 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to ensure adequate laboratory support**

The Trust Microbiology Laboratory provides services in relation to Infection Prevention and Control. The Laboratory will have in place appropriate protocols and will be accredited by Clinical Pathology Accreditation (UK) Ltd.

4.9 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to adhere to policies and protocols applicable to Infection Prevention and Control**

The core documents are:

4.9.1 Standard (universal) Infection Prevention and Control precautions.
4.9.2 Aseptic technique.
4.9.3 Major outbreaks of communicable infection.
4.9.4 Isolation of patients.
4.9.5 Safe handling and disposal of sharps.
4.9.6 Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries.
4.9.7 Management of occupational exposure to BBVs and post-exposure prophylaxis.
4.9.8 Closure of wards, departments and premises to new admissions.
4.9.9 Disinfection Policy.
4.9.10 Antimicrobial prescribing.
4.9.11 Reporting HCAIs to the Health Protection Agency (HPA) as directed by the Department of Health.
4.9.12 Control of infections with specific alert organisms: MRSA, *Clostridium difficile* infection and transmissible spongiform encephalopathies.
4.9.13 Hand washing SOPs
4.9.14 Inoculation Accident SOPs
4.9.15 The Trust will ensure that there is a rolling programme of audit, revision and update.
4.9.16 All documents will be clearly marked with a review date.

4.10 **Wrightington, Wigan and Leigh NHS Foundation Trust has a duty to ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs.**

The Trust will ensure that policies and procedures are in place in relation to the prevention and control of HCAIs such that:

4.10.1 All staff can access relevant Occupational Health services.
4.10.2 Occupational Health policies on the prevention and management of communicable infections in healthcare workers, including immunisation, are in place.
4.10.3 Prevention and control of infection is included in induction programmes for new staff, and in training programmes for all staff.
4.10.4 There is a programme of ongoing education for existing staff (including support staff, agency/locum staff and staff employed by contractors).
4.10.5 There is a record of training and updates for all staff.
4.10.6 The responsibilities of each member of staff for the prevention and control of infection is reflected in their job descriptions and in any personal development plan or appraisal.

5. ASSURANCE FRAMEWORK

This demonstrates that Infection Prevention and Control is an integral part of clinical and corporate governance:

5.1 Regular presentations from the DIPC to the Board.
5.2 Review of statistics on incidence of alert organisms (MRSA, *Clostridium difficile*).
5.3 Evidence of appropriate actions taken to deal with infection occurrences.
5.4 An audit programme to ensure that policies and SOPs have been implemented.

6. INCIDENTS OF HCAI

Incidents of HCAI will be reported through the risk management system Datix, following the TW10-020 Incident Reporting Policy and Procedure. This reporting will be in addition to local and national reporting requirements as set by the SHA and Department of Health.

7. INTRODUCTION OF NEW INFECTION PREVENTION AND CONTROL SOPs

Infection Prevention and Control SOPs will be endorsed by the Infection Prevention and Control Committee and adopted by the Trust Board. All Infection Prevention and Control SOPs will be accessible via the Policy Library Intranet site. The launch of new SOPs will be undertaken via means of a global e-mail, roadshows where applicable, via Divisional Quality Executive Committee and Induction and Mandatory Training. Local training will be undertaken in conjunction with Divisional Managers and the Infection Prevention and Control Team.

8. INFECTION PREVENTION AND CONTROL ANNUAL PROGRAMME

The Infection Prevention and Control programme will:

8.1 Set objectives.
8.2 Identify priorities for action.
8.3 Provide evidence that relevant policies have been implemented to reduce HCAI.

9. REPORTING SYSTEMS

9.1 IPCC Meeting minutes to be circulated for action to committee members and from them to relevant personnel within their Directorate/Division.
9.2 Infection Prevention and Control Annual report from the IPCC to go to Trust Board.
9.3 Reporting of outbreaks/adverse incidents.
9.4 Outbreak reporting to Greater Manchester PHEC, Health Protection Team.

10. HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this policy and they have, where appropriate, been fully reflected in its wording.

11. EQUALITY & DIVERSITY

The Policy has been assessed against the Equality Impact Assessment Form from the Trust's Equality Impact Assessment Guidance and as far as we are aware, there is no impact on any Equality Target Groups.

12. MONITORING & REVIEW

12.1 Infection Prevention and Control within Wrightington, Wigan and Leigh NHS Foundation Trust will primarily be audited in compliance with reducing Healthcare Associated Infections, Annual Health Check and Infection Prevention and Control Audit Programme and the results will be actioned and monitored via the Quality and Safety Committee, Infection Prevention and Control Committee and the Trust Board.
12.2 Trust Induction / Infection Prevention and Control Mandatory Training as per the Trust Training Needs Analysis (TNA) will be monitored as documented within the Corporate and Local induction policy and the Compulsory Training Policy.
12.3 The Infection Prevention and Control Policy and Infection Prevention and Control SOPs will be reviewed every two years or sooner if required and approved by the Infection Prevention and Control Committee.
12.4 The Infection Prevention and Control SOPs will be monitored minimum monthly using the internal CQC audit tool.
12.5 Hand Hygiene Guidelines clinical application is assessed by the "WHO" 5 moments audit tool, a minimum of monthly monitoring to the Divisions and bi-monthly by the Prevention Control Committee. Action Plans are completed by the Divisions.
12.6 Hand Hygiene Training compliance will be audited in line with the audit and monitoring arrangements contained in the Mandatory Training Policy TW10/010. The results of

audits undertaken will be monitored via Divisional Quality Executive Committees and reviewed at the Risk and Environmental Management Committee.

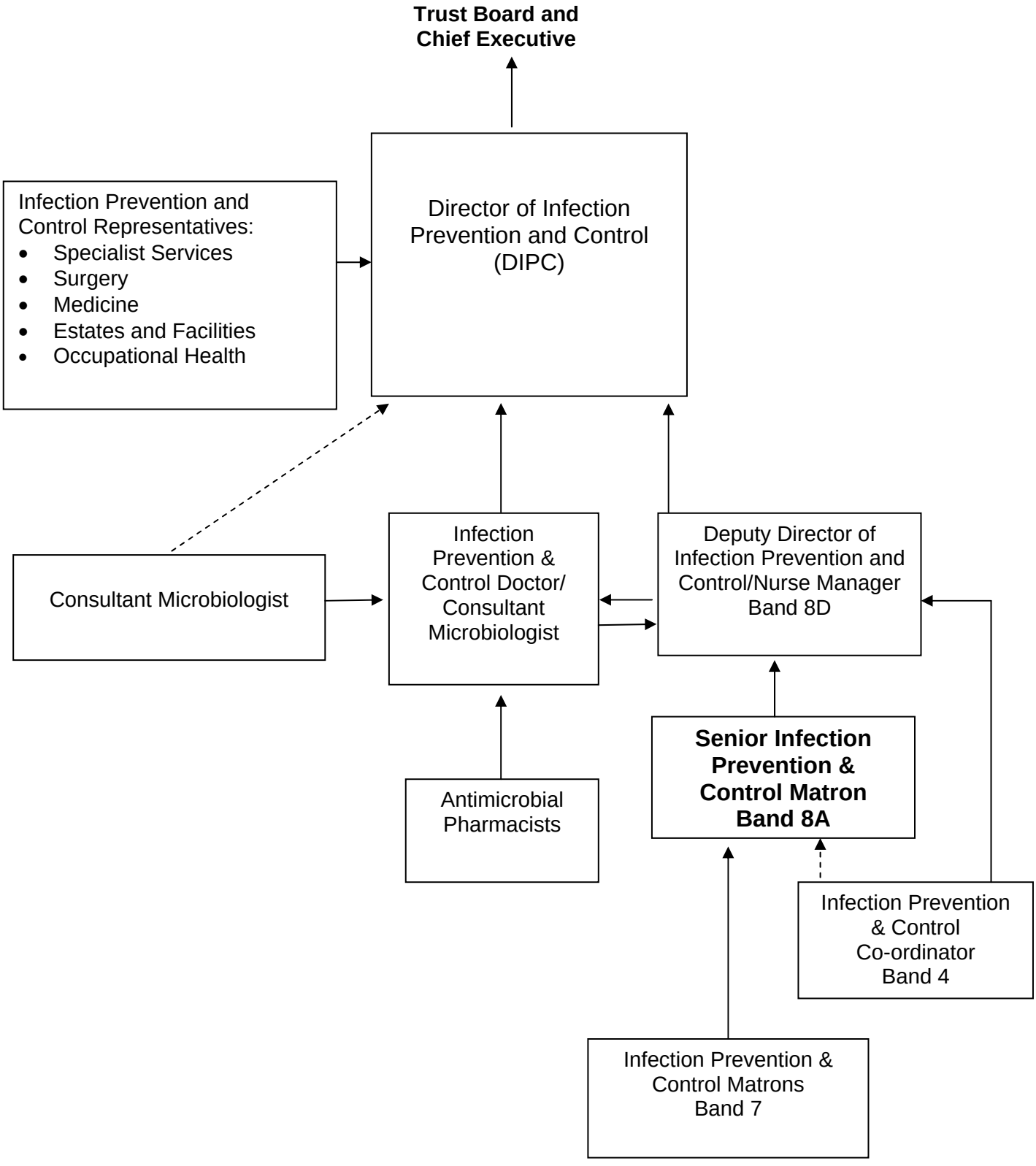
13. ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats, e.g. large print, Braille and audio cd.

For more details please contact the HR Department on 01942 77 (3766) or email equalityanddiversity@wwl.nhs.uk

APPENDIX 1

INFECTION PREVENTION AND CONTROL ORGANISATIONAL CHART



APPENDIX 2

REFERENCES:

Department of Health. The Health Act 2006: code of practice for the prevention and control of Healthcare Associated Infections January 2008 (accessed at www.dh.gov.uk 06th June 2008).

Department of Health. Winning ways: working together to reduce healthcare associated infection in England. December 2003 (accessed at www.DOH.gov.uk 06th June 2008).

Department of Health. Getting ahead of the curve: a strategy for combating infectious diseases. January 2002 (accessed at www.doh.gov.uk 06th June 2008).

Department of Health. Saving lives. June 2005 (accessed at www.clean-safe-care.nhs.uk).

APPENDIX 3

GLOSSARY OF TERMS

HCAI: Health Care Associated Infection. Infection acquired in hospitals or as a result of other healthcare interventions. Also known as nosocomial infection.

APPENDIX 4

STANDARD OPERATING PROCEDURES RELATING TO THE TW10-042 INFECTION PREVENTION AND CONTROL POLICY

SOP NAME	SOP NUMBER
Inoculation Incident	TW10-042 SOP 1
Post Exposure Prophylaxis for Healthcare Workers Occupationally Exposed to HIV	TW10-042 SOP 2
Prevention and Management of Body Fluid Exposure	TW10-042 SOP 3
Standard Infection Prevention and Control Procedures	TW10-042 SOP 4
Single Use Devices	TW10-042 SOP 5
Varicella and Herpes Zoster	TW10-042 SOP 6
Respiratory Viruses (RSV and Influenza) - Infection Prevention and Control	TW10-042 SOP 7
Viral Haemorrhagic Fever	TW10-042 SOP 8
Spillage of Potentially Infectious Material	TW10-042 SOP 9
Handwashing	TW10-042 SOP 10
Aseptic Non-touch Technique for all Clinical Aseptic Procedures	TW10-042 SOP 11
Control of Outbreaks of an Infectious Conditions	TW10-042 SOP 12
Clostridium difficile Treatment (CDI) for Adults	TW10-042 SOP 13
Decontamination and Disinfection	TW10-042 SOP 14
Diarrhoea (Infectious) Infection Prevention and Control	TW10-042 SOP 15
Funding of Outbreaks of an Infectious Nature	TW10-042 SOP 16
Bed Closure for Infectious Control Purposes	TW10-042 SOP 17
Patient Isolation	TW10-042 SOP 18
Sharps, Safe Use and Disposal	TW10-042 SOP 19
Surveillance of Communicable Diseases	TW10-042 SOP 20
PVL Toxin Producing Staphylococcus aureus – Infection Prevention and Control Management	TW10-042 SOP 21
Respiratory Protective Equipment (RPE) Training Guidance for Selection and Testing for Infection Prevention and Control Purposes	TW10-042 SOP 22
Tuberculosis - Infection Prevention and Control	TW10-042 SOP 23
Clostridium difficile – Infection Prevention and Control	TW10-042 SOP 24
Scabies – Infection Prevention and Control	TW10-042 SOP 25
Carbapenemase Producing Organism – Infection Prevention and Control	TW10-042 SOP 26
Protection of Healthcare Workers and Patients from Hepatitis B	TW10-042 SOP 27
Protection of Healthcare Workers and Patients from Hepatitis C	TW10-042 SOP 28
Influenza – Infection Prevention and Control (covers seasonal influenza H1N1/"Swine 'flu' Virus")	TW10-042 SOP 29
Neonatal Unit: Screening for Management of Antibiotic Resistant Organisms	TW10-042 SOP 30
Streptococcus Group A: For the Investigation, Control and Prevention of Infection within Trust Premises	TW10-042 SOP 31
Viral Gastroenteritis (Norovirus): Management of Hospital Outbreaks	TW10-042 SOP 32
Admission and Transfer of Infected/Potentially Infected Patients with Transmissible Conditions	TW10-042 SOP 33
Asplenic and Hyposplenic Patients Management	TW10-042 SOP 34
Severe Acute Respiratory Syndrome – Infection Prevention and Control	TW10-042 SOP 35

Animal Visits (excluding guide dogs and other assistance animals) to Trust Premises – Infection Prevention and Control Precautions	TW10-042 SOP 36
Antibiotic Resistant Organisms	TW10-042 SOP 37
SOP NAME	**SOP NUMBER**
Blood borne Viruses (Hep B, C and HIV)	TW10-042 SOP 38
CJD Transmissible Spongiform Encephalopathy	TW10-042 SOP 39
Glove Selection for Clinical Purposes	TW10-042 SOP 40
Measles Management and Control	TW10-042 SOP 41
Parvovirus B19 Infection	TW10-042 SOP 42
Pertussis Management and Investigation of Suspected Cases	TW10-042 SOP 43
Transport of Water Samples to Preston Laboratory	TW10-042 SOP 44
Cadaver Bags – Infectious Conditions Requiring their Use	TW10-042 SOP 45
Pseudomonas Aeruginosa Infection Prevention and Control Areas	TW10-042 SOP 46
Post Exposure Prophylaxis for HIV Following Sexual Exposure or Following Non-Occupational Needle Stick or Bite Injury	TW10-042 SOP 47
Herpes Simplex Oral Infections	TW10-042 SOP 48
Collection, Validation and Submission of Trust Data to Public Health England's Agency HCAI Data Capture System (includes MRSA/MSSA/E. Coli bacteraemia and Clostridium difficile Infection)	TW10-042 SOP 49
Faecal Microbiota Transplantation for Treatment of *Clostridium difficile* Infection	TW10-042 SOP 50
Meningococcal Infection Prevention and Control and Prophylaxis Procedure	TW10-042 SOP 51
Control and Prevention of Tuberculosis	TW10-042 SOP 52

APPENDIX 5

EQUALITY IMPACT ASSESSMENT FORM – STAGE 1
INITIAL ASSESSMENT (PART 1)

FOR USE WITH POLICY'S AND SOP'S

Division:	Corporate			**Department:**	Infection Prevention and Control
Title of Person(s) Completing Form	Acting Director of Infection Prevention and Control			**New or Existing Policy?**	Existing Policy
Title of Policy being assessed:	Infection Prevention and Control Policy			**Implementation Date (Policy)**	January 2016
What is the main purpose (aims / objectives) of this policy?	Inform all Healthcare workers within the Trust of the roles and duties in preventing Healthcare Associated Infections (HCAI's).				
Will patients, carers, the public or staff be affected by this policy? Please delete as appropriate.	**Patients**	**Yes**			
	Carers	**Yes**			
	Public	**Yes**			
	Staff	**Yes**			
	If staff, how many individuals / Which Groups of Staff are likely to be affected? All staff who are in contact with patients both directly and indirectly.				
Have patients, carers, the public or staff been involved in the development of this policy? **Please delete as appropriate.**	**Patients**	**Yes**			
	Carers	**Yes**			
	Public	**Yes**			
	Staff	**Yes**			
	If yes, who have you involved and how have they been involved: Patient Representative and Infection Prevention & Control Divisional Representative circulate for comments and feed back to Infection Prevention & Control Committee incorporated. Comments from Ground force staff via training session and audit of compliance.				
What consultation method(s) did you use?	Via Quality Board and Trust Infection Prevention and Control Committee.				
How are any changes / amendments to the policy communicated?	Infection Prevention and Control Committee, Quality Board Minutes, Global e-mail, Corporate Induction, Annual Mandatory Training, Policy Library.				

EQUALITY IMPACT ASSESSMENT TABLE – POLICIES (PART 2)

Equality Group	Positive Impact High Low None	Negative Impact High Low None	Reason/Comments for Positive Impact (Why it could benefit any / all of the Equality Groups)	Reason/Comments for Negative Impact (Why it could disadvantage any / all of the Equality Groups)	Resource Implication Yes / No
Men	Low	None	Prevent the patient from acquiring an HCAI and subsequent suffering	All patients admitted to WWL will require Infection Prevention and Control Precautions to ensure their safety is maintained throughout their care pathway.	
Women	Low	None			
Younger People (17-25) and Children	Low	None			
Older People (60+)	Low	None			
Race or Ethnicity	Low	None			
Learning Difficulties	Low	None			
Hearing Impairment	Low	None			
Visual Impairment	Low	None			
Physical Disability	Low	None			
Mental Health Need	Low	None			
Gay/Lesbian/ Bisexual	Low	None			
Transgender	Low	None			
Faith Groups (specify)	Low	None			
Marriage & Civil Partnership	Low	None			
Pregnancy & Maternity	Low	None			
Carers	Low	None			
Other Group (specify)		Very seldom when patients do not comply with Infection Prevention and Control precautions and place other patients and/or staff at risk of HCAI.	The Trust will seek to protect other patients and/or staff from HCAI by applying its duties of care under the Infectious Diseases Act.		
Applies to ALL Groups					

High: There is significant evidence of a negative impact or potential for a negative impact.
Low: Likely to have a minimal impact / There is little evidence to suggest a negative impact.
None: A Policy with neither a positive nor a negative impact on any group or groups of people, compared to others.

INITIAL ASSESSMENT (PART 3)

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

No

(b) How are you going to gather this information?

N/A

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following Equality Groups?

(Please **delete YES/NO** as appropriate**)**

Age (Younger People (17-25) and Children / Older People (60+)		**NO**
Gender (Men / Women)		**NO**
Race		**NO**
Disability (Learning Difficulties / Hearing Impairment / Visual Impairment / Physical Disability / Mental Illness)		**NO**
Religion / Belief		**NO**
Sexual Orientation (Gay / Lesbian / Bisexual)		**NO**
Gender Re-assignment		**NO**
Marriage & Civil Partnership		**NO**
Pregnancy & Maternity		**NO**
Carer		**NO**
Other		**NO**

Any other comments

Assessment completed by: Deputy Director of Infection and Prevention Control
Date Completed: January 2016

If 'NO IMPACT' is identified **Action: No further documentation is required.**

If 'YES IMPACT' is identified **Action: Full Equality Impact Assessment Stage 2 form must be completed. Refer to link below:**
http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

PLEASE RETURN A COPY OF THE COMPLETED ASSESSMENT FORM (STAGES 1, 2 & 3) VIA E-MAIL TO:

DEBBIE JONES, EQUALITY AND DIVERSITY PROJECT LEAD (for Service related policies)
debbie.jones@wwl.nhs.uk
EMMA WOOD, EQUALITY AND DIVERSITY PROJECT LEAD (for HR / Staffing related policies)
emma.wood@wwl.nhs.uk

APPENDIX 6

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

POLICY MONITORING AND REVIEW ARRANGEMENTS

NAME OF POLICY/SOP or CLINICAL GUIDELINE:

Para	Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
TW10/042 Infection Prevention and Control Policy	Policy is monitored and reviewed every two years.	Via relevant policy approval processes	Policy author	Two yearly	Infection Prevention and Control Committee / PARC	Minutes of meeting	Microbiology Department RAEI
12.4	Infection Prevention and Control SOPs	CQC Audit Tool	Associate DIPC	Monthly	ADIPC & Infection Prevention & Control Committee & DQEC	Minutes of Meetings	Infection Prevention Control Office
12.5	Hand Hygiene SOPs training clinical application	WHO 5 moments audit tool	Associate DIPC	Monthly	Infection Prevention Control Committee & DQEC	Minutes of Meetings	Infection Prevention Control Office
12.6	Hand Hygiene Training compliance	Compulsory Training Compliance Audit Tool	Training Dept.	Monthly	DQEC	Minutes of Meetings	Divisional Governance Office

APPENDIX 5

EQUALITY IMPACT ASSESSMENT FORM – STAGE 1
INITIAL ASSESSMENT (PART 1)

FOR USE WITH POLICY'S AND SOP'S

Division:	Corporate			**Department:**	Infection Prevention and Control
Title of Person(s) Completing Form	Acting Director of Infection Prevention and Control			**New or Existing Policy?**	Existing Policy
Title of Policy being assessed:	Infection Prevention and Control Policy			**Implementation Date (Policy)**	July 2012
What is the main purpose (aims / objectives) of this policy?	Inform all Healthcare workers within the Trust of the roles and duties in preventing Healthcare Associated Infections (HCAI's).				
Will patients, carers, the public or staff be affected by this policy? Please delete as appropriate.	**Patients**	**Yes**			
	Carers	**Yes**			
	Public	**Yes**			
	Staff	**Yes**			
	If staff, how many individuals / Which Groups of Staff are likely to be affected? All staff who are in contact with patients both directly and indirectly.				
Have patients, carers, the public or staff been involved in the development of this policy? **Please delete as appropriate.**	**Patients**	**Yes**			
	Carers	**Yes**			
	Public	**Yes**			
	Staff	**Yes**			
	If yes, who have you involved and how have they been involved: Patient Representative and Infection Prevention & Control Divisional Representative circulate for comments and feed back to Infection Prevention & Control Committee incorporated. Comments from Ground force staff via training session and audit of compliance.				
What consultation method(s) did you use?	Via Quality Board and Trust Infection Prevention and Control Committee.				
How are any changes / amendments to the policy communicated?	Infection Prevention and Control Committee, Quality Board Minutes, Global e-mail, Corporate Induction, Annual Mandatory Training, Policy Library.				

EQUALITY IMPACT ASSESSMENT TABLE – POLICIES (PART 2)

Equality Group	Positive Impact High Low None	Negative Impact High Low None	Reason/Comments for Positive Impact (Why it could benefit any / all of the Equality Groups)	Reason/Comments for Negative Impact (Why it could disadvantage any / all of the Equality Groups)	Resource Implication Yes / No
Men	Low	None	Prevent the patient from acquiring an HCAI and subsequent suffering	All patients admitted to WWL will require Infection Prevention and Control Precautions to ensure their safety is maintained throughout their care pathway.	
Women	Low	None			
Younger People (17-25) and Children	Low	None			
Older People (60+)	Low	None			
Race or Ethnicity	Low	None			
Learning Difficulties	Low	None			
Hearing Impairment	Low	None			
Visual Impairment	Low	None			
Physical Disability	Low	None			
Mental Health Need	Low	None			
Gay/Lesbian/ Bisexual	Low	None			
Transgender	Low	None			
Faith Groups (specify)	Low	None			
Marriage & Civil Partnership	Low	None			
Pregnancy & Maternity	Low	None			
Carers	Low	None			
Other Group (specify)		Very seldom when patients do not comply with Infection Prevention and Control precautions and place other patients and/or staff at risk of HCAI.	The Trust will seek to protect other patients and/or staff from HCAI by applying its duties of care under the Infectious Diseases Act.		
Applies to ALL Groups					

High: There is significant evidence of a negative impact or potential for a negative impact.
Low: Likely to have a minimal impact / There is little evidence to suggest a negative impact.
None: A Policy with neither a positive nor a negative impact on any group or groups of people, compared to others.

INITIAL ASSESSMENT (PART 3)

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

No

(b) How are you going to gather this information?

N/A

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary?

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following Equality Groups?

(Please **delete YES/NO** as appropriate**)**

Age (Younger People (17-25) and Children / Older People (60+)		**NO**
Gender (Men / Women)		**NO**
Race		**NO**
Disability (Learning Difficulties / Hearing Impairment / Visual Impairment / Physical Disability / Mental Illness)		**NO**
Religion / Belief		**NO**
Sexual Orientation (Gay / Lesbian / Bisexual)		**NO**
Gender Re-assignment		**NO**
Marriage & Civil Partnership		**NO**
Pregnancy & Maternity		**NO**
Carer		**NO**
Other		**NO**

Any other comments

Assessment completed by (Job Title) Acting Director of Infection and Prevention Control
Date Completed: January 2016

If 'NO IMPACT' is identified **Action: No further documentation is required.**

If 'YES IMPACT' is identified **Action: Full Equality Impact Assessment Stage 2 form must be completed. Refer to link below:**
http://intranet/Departments/Equality_Diversity/Equality_Impact_Assessment_Guidance.asp

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Monitoring and Audit Arrangements **APPENDIX 6**

Policy: - TW10/042 Infection Prevention and Control Policy

Para	Audit / Monitoring requirement	Method of Audit / Monitoring	Responsible person	Frequency of Audit	Monitoring committee	Type of Evidence	Location where evidence is held
TW10/042 Infection Prevention and Control Policy	Policy is monitored and reviewed every two years.	Via relevant policy approval processes	Policy author	Two yearly	Infection Prevention and Control Committee / PARC	Minutes of meeting	Microbiology Department RAEI
12.4	Infection Prevention and Control Guidelines	CQC Audit Tool	Senior Infection Prevention and Control Matron	Monthly	ADIPC & Infection Prevention & Control Committee & DQEC	Minutes of Meetings	Infection Prevention Control Office
12.5	Hand Hygiene guidelines training clinical application	WHO 5 moments audit tool	Senior Infection Prevention and Control Matron	Monthly	Infection Prevention Control Committee & DQEC	Minutes of Meetings	Infection Prevention Control Office
12.6	Hand Hygiene Training compliance	Compulsory Training Compliance Audit Tool	Training Dept	Monthly	DQEC	Minutes of Meetings	Divisional Governance Office

APPENDIX 2 – Infection Prevention and Control Committee Terms of Reference

Terms of Reference

NHS Wrightington, Wigan and Leigh NHS Foundation Trust

Committee Name:	Infection Prevention and Control Committee
Chairperson	Infection Prevention and Control Doctor
Date:	January 2016
Version:	9
Reports to:	Quality and Safety Committee
Receives reports/ minutes from:	Antibiotic Stewardship Management Group/ Occupational Health Department
Meeting and attendance Frequency:	Maximum six times per year, minimum four times per year.
Definition of Quorum:	Six members, including senior member of Infection Prevention and Control Team
Membership:	Current list available from Microbiology secretary.

Core Membership : (must attend should the relevant director not be able to attend)	All members expected to attend every meeting or send appropriate representative in their absence
Associate Membership: (must attend on an ad hoc basis dependent on the agenda)	-
In Attendance: (to support the committee)	-
Authority:	

Scope of Responsibilities (duties)	See below:

WRIGHTINGTON, WIGAN & LEIGH NHS FOUNDATION TRUST
INFECTION PREVENTION AND CONTROL COMMITTEE
TERMS OF REFERENCE

Infection Prevention & Control is a high priority within Wrightington, Wigan & Leigh NHS Foundation Trust in order to ensure adherence and maintenance of standards as set out by the NHS Litigation Authority, Care Quality Commission and the Health Act 2006.

The Trust Board devolves and discharges this responsibility through the Infection Prevention and Control Committee, which is thereby bound by these Terms of Reference that follow.

1. Organisation and Management

1.1. The Infection Prevention and Control Committee shall meet six times per year with a minimum frequency of four times per year. It shall be considered quorate with the attendance of at least six members, one of whom should be a senior member of the Infection Prevention and Control Team i.e. Infection Prevention and Control Doctor, Director of Infection Prevention and Control (DIPC) or Deputy DIPC.

1.2. The Committee shall be chaired by the Infection Prevention and Control Doctor or an Executive Director or Deputy DIPC in his/her absence.

1.3. The Committee shall produce a register of attendance, and shall identify non-attendance (see below for list of Members).

1.4. The Committee shall keep the membership and terms of reference under review and in accordance with Clinical Governance arrangements.

2. Purpose of the Committee

2.1. To provide strategic direction for the prevention and control of Healthcare Acquired Infections (HCAI) for the Trust.

2.2. To provide a key role in monitoring the organisation's performance against the Trust's Infection Prevention Strategy.

2.3. To ensure there is a strategic response to new legislation and national guidelines.

3. Functions of the Committee

3.1. To receive and review reports from the Infection Prevention and Control Team against national and local HCAI targets.

3.2. To approve the Infection Prevention and Control Annual Report from the Director of Infection Prevention and Control in the first quarter of the following financial year for submission to the Trust Board for their endorsement.

3.3. To receive, consider and endorse the Trust Annual Infection Prevention and Control Programme for submission for approval by the Trust Board, including the development and review of priorities and strategies in relation to Infection Prevention and Control ensuring most effective utilisation of resources.

3.4. To review progress against the Trust Annual Infection Prevention and Control Programme, and assist in its effective implementation, and to review the final results.

3.5. Endorse the targeted surveillance of infection programmes developed by the Infection Prevention and Control Team, and agree on objectives and priorities in this area.

3.6. To advise on, ratify and monitor the implementation of Trust Infection Prevention and Control policies, procedures and SOPs.

3.7. To provide assurance to the Trust Board through bi-monthly reports of progress by the Director of Infection Prevention & Control against the annual activity plan and performance targets.

3.8. To draw to the attention of the Chief Executive and Trust Board, any serious problems or hazards relating to Infection Prevention and Control.

3.9. To discuss and review all matters relating to outbreaks of infection in Trust premises and make recommendations to address shortcoming and avoid recurrences.

3.10. To discuss, evaluate and action initiatives and developments relating to Infection Prevention and Control and ensure matters are taken forward at local level.

3.11. To promote and facilitate education and the application of evidence based practice in relation to Infection Prevention and Control.

3.12. To circulate the Infection Prevention and Control Committee minutes widely to the relevant Trust Committees, senior medical and nursing staff.

3.13. To work collaboratively with Clinical Commissioners Groups and associated service providers to consider the impact of their service developments for the Trust.

3 Membership of the Infection Prevention and Control Committee

- Infection Prevention and Control Doctor.
- Director of Infection Prevention and Control/Director of Nursing.
- Medical Director.
- Deputy Director of Nursing.
- Deputy Director of Infection Prevention and Control.
- Consultant Microbiologist.
    - Infection Control Representatives: Wigan Council.
    - Infection Control Nurse: Five Boroughs Mental Health Trust.
    - Consultant in Communicable Disease Control (CCDC): Greater Manchester and Lancashire/Cumbria.
- Occupational Health Physician.
- Divisional Consultant Representative(s).
- Heads of Nursing and Midwifery.
- Patient Representative.
- Staff Governor.
- Senior representatives from Estates and Facilities.
- Antimicrobial Pharmacist.
- Wigan Clinical Commissioning Group, Infection Control Representative(s).
- Bridgewater Trust Infection Control Representative.
- Manager HSDU.
- Other members may be co-opted as appropriate. For example:

Catering Manager. T B Nurse.
Environmental Health Officer.

Deputies will be accepted with the prior agreement of the Chair only.

Non-executive Directors have an open invitation to attend any meeting of the Committee.

Current Membership List

Available from the Secretary to the Consultant Microbiologist on request.

4 Accountability Arrangements

These are given in chart form in Appendix 1.

5 Communication Strategy

Communication will occur between all stakeholders including Infection Prevention and Control Committee members, Divisions/Directorates, Other Trust staff and patients. Communication mechanisms will include the following:

- Committee minutes – distributed to all Committee members and those detailed on the circulation list (available from secretary to Consultant Microbiologist). They will also be forwarded to the Clinical Governance and Risk Committee.
- Surveillance graphs – these are distributed to Committee members and also on a monthly basis to Ward Managers, General Managers and Clinical Directors. They will be made available to patients by display at the entrance to wards and departments.
- Infection Prevention and Control SOPs and Policies – these are to be disseminated through Directorates by their representatives on the Committee. They will also be placed on the Intranet.

- Training – all staff will be involved in Mandatory Infection Prevention and Control Training which provides a means to communicate the findings of the Committee.
- Director of Infection Prevention and Control Annual Report – this is made available for general release after the end of each financial year. It details the Trust progress against its Annual Infection Prevention and Control Programme together with information on surveillance findings and outbreaks/adverse incidents.

It is the responsibility of Committee members to disseminate the Committee's findings within their Directorate. Members are required to ensure that relevant SOPs and policies are communicated and implemented in a timely fashion. The feedback mechanism for Divisions is via their Committee members' attendance at the Infection Prevention and Control Committee meetings.

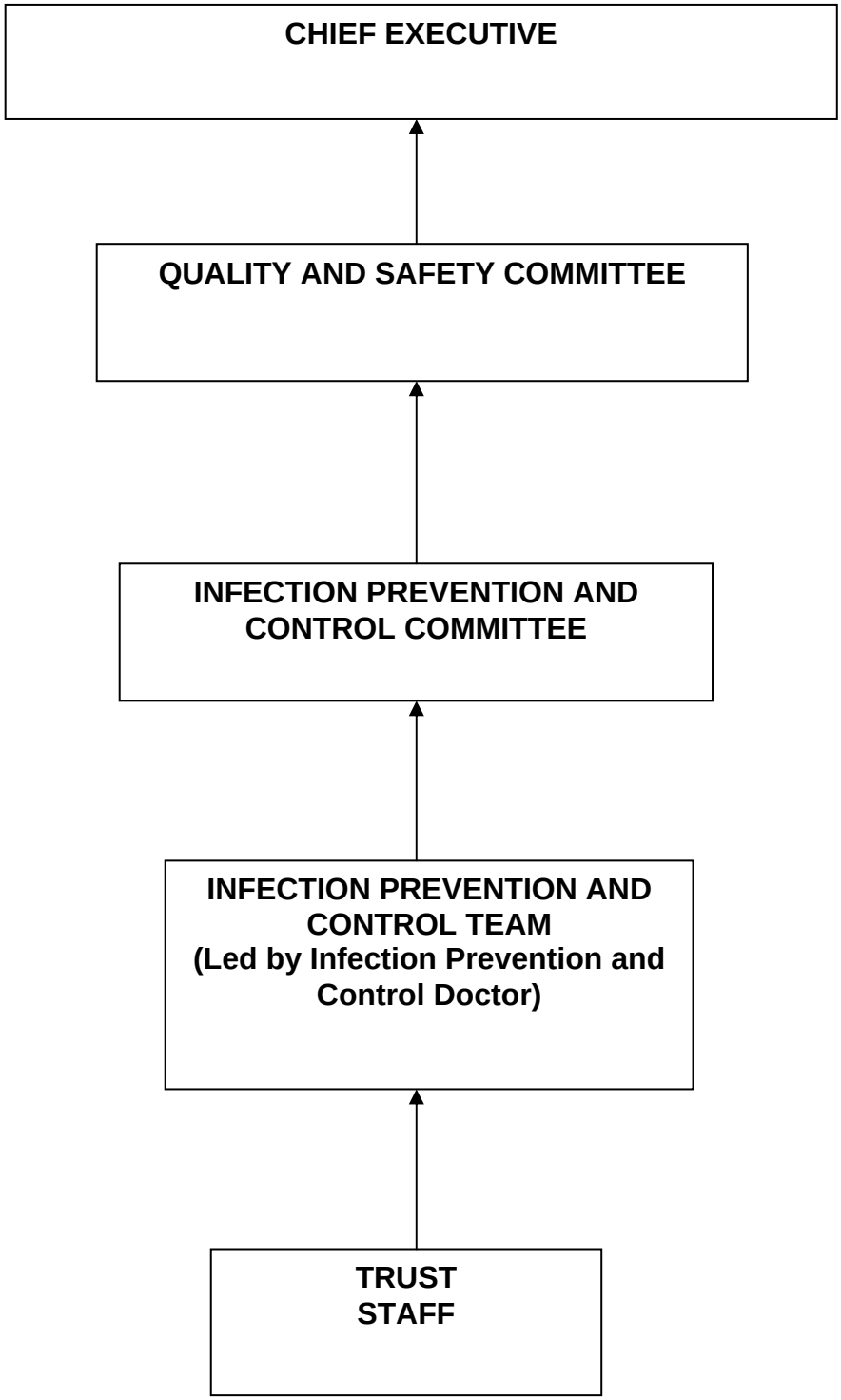
Unexpected events such as outbreaks or adverse incidents will be communicated via outbreak meetings at which representatives from the appropriate Divisions will be required to attend in accordance with the Trust guidance. Feedback will be expected in the form of a summary report for the Committee.

6 References

Hospital Infection Working Group. Hospital Infection Control – Guidance on the control of Infection in Hospitals. Department of Health/PHLS 1995.

Department of Health. The Health Act 2006. Code of Practice for the Prevention and Control of Health Care Associated Infection. Revised Edition January 2008 (accessed 11th May 2015 at www.doh.gov).

Appendix 1: **Accountability Arrangements for Infection Prevention and Control, Wrightington, Wigan and Leigh NHS Foundation Trust.**



Other Matters:	
Review Date:	January 2018
Monitoring of T of R:	Bi-annually

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

INFECTION PREVENTION AND CONTROL PROGRAMME 2015/2016

Final Report - March 2016

Author	**Dr R Nelson, Mrs L Barkess-Jones, Mrs P Jones, Mrs P Law**
Date	**March 2016**
Approving Committee	**Infection Prevention and Control Committee**
Date	**March 2016**

Your hospitals, your health, our priority

	Code of Practice Point	Programme of Work 2015/2016	By Whom (lead)	(Date) To be Achieved by	Outcome
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessment and consider how susceptible service users are and any risks that their environment and any other users may pose to them.	a) Infection Prevention and Control Programme for **2015/2016** to be disseminated by Infection Prevention and Control Committee members throughout their Directorate. Programmed actions to involve all staff members and Directorates, not solely members of the Infection Prevention and Control Team.	Infection Prevention and Control Committee Directorate Representatives	May 15	Achieved May 15
		b) Quarterly reporting by DIPC to Trust Board on Infection Prevention and Control issues.	DIPC	Quarterly	Achieved
		c) DIPC to present the DIPC Annual Report for 2014/15 to the Trust Board.	DIPC	July 15	Achieved June 15
		d) DIPC to present the Infection Prevention and Control Programme for 2015/16, to the Trust Board.	DIPC	July 15	Achieved June 15
		e) Divisions to ensure they are represented at all Infection Prevention and Control Committee meetings in 2015/16.	Divisional Chair/Head of Nursing	March 2016	Achieved
		f) Infection Prevention and Control Committee to be quorate and to meet on a minimum of four occasions in 2015/16.	Infection Prevention and Control Committee Chairman	March 2016	Achieved
		g) Infection Prevention and Control Committee to consider all outbreaks and adverse incidents relating to infection and disseminate findings/recommendations via Directorate representatives.	Infection Prevention and Control Committee	Throughout 2015/16	Achieved
		h) Infection Prevention and Control audits of all wards to be performed at a minimum of monthly, covering adherence to Infection Prevention and Control policies and guidelines.	Senior IC Nurse Manager	Monthly throughout 2015/16	Achieved
		i) Progress against MRSA bacteraemia and *Clostridium difficile* reduction targets to be monitored monthly.	Infection Prevention and Control Team, DIPC, Ward Managers	Monthly in 2015/16	Achieved
		j) Surveillance of ventilator associated pneumonia cases to continue on ICU.	Consultant Microbiologist/ICU Matron/ICU Clinical Lead	Through 2015/16	Achieved
		l) Mandatory surveillance of orthopaedic surgical infections to be performed on a continuous basis.	Musculoskeletal Division	Throughout 2015/16	Achieved
		m) Continue E. coli and MSSA bacteraemia surveillance in line with national requirements and monitor totals of hospital acquired cases.	Consultant Microbiologist/Senior IC Nurse	Throughout 2015/16	Achieved

	Code of Practice Point	Programme of Work 2015/16	By Whom (lead)	(Date) To be Achieved by	Outcome
1	Continued	n) Continue surveillance for central line infection on ICU/HDU using 'Matching Michigan' methodology.	Consultant Microbiologist/ICU Matron/ICU Clinical Lead	Throughout 2015/16	Achieved
		o) Incorporate new Mandatory Surveillance requirements into Trust Surveillance System as these are released.	DIPC/Infection Prevention and Control Doctor/IC Nurse Manager/General Managers	As required during 2015/16	Achieved for CPE ERS Reporting commenced September 15
		p) Monitor mortality rate within 30days of *Clostridium difficile* infection for inpatients and update Infection Prevention and Control Committee on an annual basis. Relevant cases to be reported via 'STEIS' system.	Infection Prevention and Control Doctor	Throughout 2015/16	Achieved
		q) Member of WWL Infection Prevention and Control Team to attend CCG *Clostridium difficile* case review meetings.	Infection Prevention and Control Doctor/Senior IC Nurse or Deputy	Throughout 2015/16	Achieved
		r) Attend NHS North Local Area Team Infection Prevention and Control Group meetings.	Infection Prevention and Control Doctor/Senior IC Nurse or Deputy	Throughout 2015/16	Achieved
		s) Monitor progress against Divisions' *Clostridium difficile* action plans and raise any deficiencies for discussion at Infection Prevention and Control Committee.	Infection Prevention and Control Doctor/Senior IC Nurse or Deputy	Throughout 2015/16	Achieved
		t) Incorporate requirements of revised Hygiene Code into Trust guidance as it is published.	Infection Prevention and Control Doctor/Senior IC Nurse or Deputy	As required during 2015/16	Achieved

	Code of Practice Point	**Programme of Work** 2015/16	**By Whom (lead)**	**(Date) To be Achieved by**	**Outcome**
2	Provide and maintain a clean and appropriate environment (including decontamination areas) which facilitates the prevention and control of infection.	a) Continue with implementation and monitoring/audit of hand hygiene '5 moments' programme.	DIPC / Senior ICN	Throughout 2015/16	Achieved
		b) Plan, perform and monitor annual programme cycle of Trust 'Deep clean'/ 'Keep clean' programme.	DIPC /Senior ICN/Director of Estates	March 2016	Achieved
		c) Continue monitoring of SSDU to ensure that National Standards are maintained.	DIPC/Decontamination Lead/Manager HSDU/Director of Estates/Consultant Microbiologists/Senior IC Nurse Manager	Throughout 2015/16	Achieved
		d) Maintain sampling programme for Pseudomonas in water supplies to augmented care areas.	Infection Prevention and Control Team/Estates and Facilities Manager	Throughout 2015/16	Achieved
		e) Minimise/eliminate pseudomonas from taps in new Oncology building, RAEI.	Infection Prevention and Control Team/Estates and Facilities Manager	As required in 2015/16	Clear results achieved November 15
		f) Monitor results from validation and verification of operating theatre ventilation systems across the Trust and advise on necessary remedial actions.	Director of Estates and Facilities/Senior IC Nurse/Infection Prevention and Control Doctor	Throughout 2015/16	Achieved
		g) Work with Estates to ensure new build 'Barn' Theatres comply with national Infection Prevention and Control requirements.	Senior IC Nurse Manager/Infection Prevention and Control Doctor	As required in 2015/16	Achieved In operation January 16
3	Provide suitable, accurate information on infections to service users and their visitors.	a) DIPC Annual Report for 2014/2015 to be published.	DIPC	July 2015	Achieved June 15

	Code of Practice Point	Programme of Work 2015/2016	By Whom (lead)	(Date) To be Achieved by	Outcome
4	Provide suitable, accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.	a) Communicate results of public health significance to the relevant Health Protection Unit as these occur.	Infection Prevention and Control Team, Consultant Microbiologists	As required in 2015/16	Achieved
		b) Attend CCG Infection Prevention and Control Group.	Infection Prevention and Control Doctor and/or Senior IC Nurse	Throughout 2015/16	Achieved
		c) Send appropriate *Clostridium difficile* cases to *Clostridium difficile* appeals panel for consideration of removal from annual trajectory.	Consultant Microbiologist/Senior IC Nurse	As required	Achieved
5	Ensure patients presenting with infection or who acquire infection during their care are identified promptly and receive appropriate care and treatment to reduce the risk of transmission.	a) Maintain continuous surveillance of MRSA/MSSA /E. coli bacteraemias and *Clostridium difficile* diarrhoea cases. Data to be fed back monthly to wards, General Managers and DIPC.	Infection Prevention and Control Team	Throughout 2015/16	Achieved
		b) Maintain continuous surveillance for alert organisms defined in Trust Surveillance Policy.	Infection Prevention and Control Team	Throughout 2015/16	Achieved
		c) Continue to implement revised high impact intervention for *Clostridium difficile* where one or more new, hospital-acquired cases are detected on a ward.	Infection Prevention and Control Team, Ward Manager	As required in 2015/16	Achieved
		d) Monthly charts detailing progress against National MRSA/MSSA/E. coli bacteraemia and *Clostridium difficile* targets, to be produced.	Consultant Microbiologist	Monthly in 2015/16	Achieved
		e) Enhanced screening for Carbapenemase Producing Organisms for at risk admissions.	Infection Prevention and Control Team	Throughout 2015/16	Achieved
		f) Modify MRSA screening protocols to reflect updated PHE recommendations where judged appropriate.	Consultant Microbiologist, Senior Infection Prevention and Control Nurse OLPC	December 2015	Not required

	Code of Practice Point	Programme of Work 2015/2016	By Whom (lead)	(Date) To be Achieved by	Outcome
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	a) Infection Prevention and Control training to be included in Trust Mandatory Training programme for all staff groups. Compliance to be monitored.	Infection Prevention and Control Team/General Managers	Throughout 2015/16	Achieved
		b) Directorates' involvement in monitoring compliance with hand hygiene and improving performance to continue, action plans being provided where deficiencies are found.	Infection Prevention and Control Team/General Managers/DIPC/Medical Director	Throughout 2015/16	Achieved
		c) Use "WHO Five Moments" hand hygiene audit tool for all hand hygiene audits.	LBJ/KC	Throughout 2015/16	Achieved
7	Provide or secure adequate isolation facilities.	a) Monitor isolation of patients with transmissible conditions to determine any deficiencies in isolation provision.	Infection Prevention and Control Team	Throughout 2015/16	Achieved
		b) Ensure plans for new clinical areas contain sufficient isolation facilities.	Infection Prevention and Control Team	Throughout 2015/16	Achieved
		c) Maintain an empty side-room on Pemberton Ward to allow immediate isolation of newly diagnosed *Clostridium difficile* toxin positive patients.	Nurse Manager, Pemberton Ward/IC Nursing Team/DIPC	Throughout 2015/16	NOT achieved due to bed pressures
8	Secure adequate access to laboratory support.	a) Ensure Microbiology services provided off site by PAWS remain appropriate and timely.	Consultant Microbiologist/PAWS Manager	Throughout 2015/16	Achieved
		b) Ensure appropriate information continues to be available to the Infection Prevention and Control from off site laboratory.	Consultant Microbiologist/Senior IC Nurse	Throughout 2015/16	Achieved
		c) Ensure proposed takeover of Microbiology work from Christie NHS Trust does not adversely impact processing of WWL specimens.	Consultant Microbiologist	As required during 2015/16	Achieved

	Code of Practice Point	Programme of Work 2015/2016	By Whom (lead)	(Date) To be Achieved by	Outcome
9	Have and adhere to policies designed for the individual's care that will help to prevent and control infections.	a) Update of Infection Prevention and Control Guidance as necessary before expiry date.	Consultant Microbiologist/Senior IC Nurse Manager	As required during 2015/16	Achieved
		b) Update Occupational Health Guidance maintained on Infection Prevention and Control Intranet site.	Consultant Occupational Health	As required during 2015/16	Achieved
		c) Monitor adherence to Antibiotic Treatment Guidelines.	Antibiotic Pharmacist	As per audit programme 2015/16	Achieved
		d) Infection Prevention and Control audits of all wards to be performed at a minimum frequency of monthly, covering adherence to Infection Prevention and Control policies and guidelines.	Infection Prevention and Control Team	Monthly throughout 2015/16	Achieved
		e) *Clostridium difficile M*ulti-disciplinary Team to meet weekly to ensure patients with C. difficile infection are managed in accordance with local and national policy.	Consultant Microbiologist/Consultant Gastroenterologists/Infection Prevention and Control Team/Ward Manager, Pemberton Ward	Throughout 2015/16	Achieved
		f) Review C, difficile RCA data collection form and incorporate PHE 2015/16 collection tool.	Consultant Microbiologist/Senior Infection Prevention and Control Nurse, DIPC	June 2015	Achieved May 15
10	Ensure, so far as is reasonably practicable that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work and are suitably educated in infection prevention and control of HCAI.	a) Occupational Health services in place and to be maintained.	Consultant Occupational Health	Throughout 2015/16	Achieved
		b) Audits of needle stick injuries and relevant corrective action to be presented on a regular basis to Infection Prevention and Control Committee.	Consultant Occupational Health Medicine	Throughout 2015/16	Achieved
		c) Influenza vaccination programme to be in place during 2015/16 flu season and uptake monitored by Infection Prevention and Control Committee.	Consultant Occupational Health	Throughout 2015/16	Achieved

Responsible people: DIPC – Director of Infection Prevention and Control.