NHS
Thurrock
Clinical Commissioning Group

# Infection Prevention & Control Annual Report 2013 – 2014

Report prepared by
The South Essex CCG Infection Prevention and Control Team
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## Glossary

| | |
|---|---|
| ARHA | Advisory committee on Antimicrobial Resistance & Healthcare Associated Infection |
| AT | Area Team |
| BHRT | Barking Havering & Redbridge University Trust |
| BTUH | Basildon & Thurrock University Hospital |
| CNS | Clinical Nurse Specialist |
| CCG | Clinical Commissioning Group |
| DH | Department of Health |
| DIPC | Director of Infection Prevention & Control |
| C.diff | Clostridium difficile |
| CDI | Clostridium difficile infection |
| CPE | Carbapenemase-producing Enterobacteriaceae |
| GDH | Glutamate Dehydrogenase positive (antigen positive) |
| HCAI | Health care acquired infection |
| HII | High Impact Intervention |
| IPC | Infection Prevention & Control |
| IPCN | Infection Prevention & Control Nurse |
| IPCT | Infection Prevention & Control Team |
| KPI | Key Performance Indicator |
| MMT | Medicines Management Team |
| MRSA | Meticillin resistant Staphylococcus aureus |
| MRSA BSI | Meticillin resistant Staphylococcus aureus Bloodstream Infection |
| MSSA | Meticillin sensitive Staphylococcus aureus |
| NELFT | North East London Foundation Trust |
| NHSE | NHS England |
| PCT | Primary Care Trust |
| PHE | Public Health England |
| PIR | Post Infection Review |
| RCA | Root Cause Analysis |
| SEPT | South Essex Partnership Trust |
| SSI | Surgical Site Infection |
| TTL | Time to Learn |

## 1.0 Executive Summary

The purpose of this report is to outline the work of the Infection Prevention and Control service and report on the progress of the work undertaken in the CCG in achieving the annual work plan. It highlights the year end performance within the South Essex cluster and gives examples of good practice and where practice improvements need to be made. The Infection Prevention and Control Team work across the 4 South East CCGs; this report covers activities within Thurrock and any related patient activities within the Basildon Brentwood CCG services. Thurrock CCG was assigned 2 MRSA bacteraemia against a zero tolerance and had 24 cases of Clostridium *difficile* against a ceiling of 26. Basildon Hospital reported 3 MRSA bacteraemia, of which 2 were deemed to be contaminants and had 20 cases of Clostridium *difficile* against a ceiling of 26. The key activities of the team are detailed at the end of this report.

These activities are founded on key documents and legislation including:

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2009
- Care Quality Commission (Registration) Regulations 2009
- Care Quality Commission Essential Standards of Quality and Safety 2009
- Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2010)
- Outcome 8 of Essential Standards of Quality and Safety 2009
- NHSLA risk Management Standard for PCTs 2011
- All relevant NHS / DH / NPSA Guidance
- All new relevant expert guidance / evidence-based practice including:
- Guidance on the Reporting & Monitoring Arrangements and Post Infection Review process for MRSA bloodstream infections (NHS Commissioning Board April 2013, updated by NHS England April 2014)
- Clostridium *difficile* Infection Objectives for NHS Organisations in 2014/15 and Guidance on Sanction Implementation
- Acute Trust Toolkit for the Early Detection, Management & Control of carbapenemase-producing Enterobacteriaceae (Public Health England (December 2013 )

## 2.0 Background Including CCG Infection Prevention & Control Team Arrangements

The Infection Prevention & Control Team (IPCT) comprises of:-
Sheila O'Mahony, part time Head of Infection Prevention & Control
Joanne Mayhew, full time Senior Nurse (started in July 2013 after the previous infection control nurse left the CCG in February 2013)
Barbara Mallia, full time administrative support

The IPCT is placed within the Quality Support Team with a strong lead on Patient Safety and Quality. The Team is well positioned to assist the Clinical Commissioning Groups (CCGs) to ensure only safe and good quality services are commissioned. The team are hosted by NHS Southend CCG and based in the Suffolk House offices Southend-On-Sea. The team report to the CCG Executive Nurses through the Quality Team Manager and give advisory expert advice and support across the 4 South Essex CCGs on all matters relating to infection prevention and control.

Commissioning Infection Prevention and Control Team continue to-:

- Monitor performance against national and regional targets to ensure and demonstrate organisational accountability
- Implement the national framework for IPC commissioning
- Have a specific role in monitoring and following up all serious incidents related to HCAIs
- Being able to respond with required amount of expert knowledge to situations as they occur (e.g. unexplained increase of HCAI)
- IPC commissioning for all provider services
- Have performance monitoring responsibilities for all health care providers
- To monitor compliance with the Code of Practice for infection prevention and control (as part of the Health and Social Care Act)
- Ensure compliance with the Code of Practice for infection prevention and control across the whole economy.
- Monitoring of premises and their appropriateness to be able to carry out specific procedures in a safe environment

## 3.0 Reports to Executive Nurses & NHS Clinical Commissioning Group Boards

Monthly assurance is provided to the Executive Nurses on performance against National KPIs and any exceptions through the Quality & Governance Committees

## 4.0 Health Care Associated Infections

The Commissioning Infection Prevention and Control Team ensure through a programme of monitoring that patients are kept safe and treated in an environment that is acceptable to them.

In 2013/14 there were only two mandatory key performance indicators (KPIs) included in the national contract:

> A reduction in MRSA Bacteraemia and
> Clostridium *difficile* (C. *difficile)* cases as per national objective.

Both MRSA Bacteraemia and C.*difficile* have been a national priority for many years with every case reported to Public Health England as part of a national surveillance programme.

### 4.1 Meticillin-resistant Staphylococcus aureus (MRSA)

#### 4.1.1 MRSA Bacteraemia

The Government considers it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting. It has set healthcare providers the challenge of demonstrating zero tolerance of MRSA BSI through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance. The zero tolerance approach to MRSA has been reiterated in Everyone Counts: Planning for Patients 2014/15 to 2018, which was published on 20th December 2013. Since April

2013 a new process for Post Infection Review (PIR) has been in place, set up by the NHS Commissioning Board. A Post Infection Review (PIR) is undertaken for all MRSA bloodstream infection cases from April 2013 and forms part of the government strategy for achieving a "zero tolerance" to HCAI. It aims to identify any possible failings in care and to identify the organisation best placed to ensure improvements are made.

The PIR process requires strong partnership working by all organisations involved in the patient's care pathway. This close collaboration enables organisations to jointly identify and agree both the possible causes and any factors contributing to the patient's MRSA BSI.

If a MRSA BSI sample was taken from the patient on or after the third day of an admission to an acute Trust, (where the day of admission is Day 1), the acute Trust is required to lead the PIR.

For all other MRSA BSI cases, the CCG responsible for the patient is required to lead the PIR. This includes in particular any patients not admitted at the time the specimen was taken, for example those in Accident and Emergency or outpatients.

**Basildon & Thurrock University Hospitals Trust BTUH**
BTUH reported 3 MRSA BSI this financial year.
Following the PIR investigation two of these cases were deemed blood culture contaminants and therefore not true MRSA BSIs. As per National guidelines blood culture contaminants must still be recorded as a MRSA Bacteraemia and assigned to the organisation responsible for taking the blood culture. Trust wide contaminant rate is approximately 5%, the national recommendation is 2% or below. Issues identified from the PIRs are being used to direct improvement plans, in particular staff training and competency based training for staff taking blood cultures and aseptic no touch technique (ANTT).
1 case was found to be a true BSI, MRSA acquisition and BSI occurred during the patient's admission.

**Improvement actions agreed to be undertaken following this review were as follows:**

- Review of documentation for insertion of invasive devices; there was evidence of good documentation of line insertion and removal, with the exception of some peripheral line insertions where the correct documentation was not used
- Review of local induction training available for agency staff
- Improve compliance with MRSA screening with regards to ensuring all relevant sites are included
- An anti-microbial body wash to be prescribed for all major thoracic cases prior to admission where possible and to be prescribed for all patients for the duration of their admission to the unit regardless of whether there is Central Venous Catheter in situ

Action plans are monitored through the Trusts Infection Control Committee which is attended by a member of the CCG IPCT, in addition as this is also reported as a serious incident progress against the action plan and lessons learnt are shared at the patient safety group.

**Thurrock CCG**
Thurrock CCG was assigned 2 MRSA BSI.

**Case One:**
This patient had complex medical needs and was cared for both in the community by the patient's GP, NELFT Integrated Community Care Team and in Acute Care.

This case went to arbitration and following an independent review by the Director of Public Health for Essex and experts across the region who agreed unanimously the case should be assigned to the CCG.

**Improvement action agreed to be undertaken following this review were as follows:**

- MRSA screening policy to be reinforced at all levels and compliance with policy audited
- Infection risk documentation to be completed for all patients being discharged from one care provider to another and compliance with policy audited.
- Review sepsis care bundle to consider modification to include daily recording of (suspected) cause of infection and antibiotic therapy.
- Haematology care pathway required – to include monitoring of blood results and referral to community services.
- The acute trust to ensure that staff in the A&E department are able to take cultures from central lines, and to undertake full MRSA screening in line with guidance.
- Continue to promote antimicrobial stewardship in primary care and community services.

**Case Two:**
It was not possible to attribute the aetiology of the MRSA bacteraemia to any preventable cause. This patient had no previous history of MRSA and a MRSA screen of nose and groin was completed on admission which was negative. All subsequent screens remained negative. This case also went to arbitration and following an independent review by the Director of Public Health for Essex who assigned the case to the CCG. This review highlighted a fault in the PIR process in that a 'don't know' option does not exist.

**Improvement action agreed to be undertaken following this review were as follows**:

- MRSA screening policy to be reinforced at all levels and compliance with policy audited
- The use of the IV care bundle to be reinforced at all levels
- Assurance to be obtained from staffing agencies that contracted staff training is up to date

Lessons learnt and action plan are shared and monitored through the South Essex HCAI Network meeting. Feedback to Primary Care Practitioners is through Time to Learn (TTL) sessions.

**Barking Havering and Redbridge University Trust (BHRUT)**
*The reader should note that we are an associate to this contract and are therefore reliant on colleagues in Barking, Havering and Redbridge CCGs to lead the assurance processes with this provider*

BHRUT reported 2 MRSA BSIs. These were deemed contaminants following PIR. Issues identified from root cause analysis are being used to direct improvement plans.

**Spire Hartswood**
Reported zero cases

**Nuffield Brentwood**
Reported zero cases.

### 4.1.2 MRSA Screening

The English Department of Health introduced universal mandatory MRSA screening of all elective admissions, except for paediatric, maternity and some day-cases (ophthalmology, endoscopy, minor dermatology) from April 2009 and of all emergency admissions to acute NHS hospitals from December 2010.

**NELFT**
Reported an average compliance of 95%. Data for the Essex locality only is not available. During quarter three a new system was implemented with robust data to underpin audit results becoming available that shows the trend working towards 100%

**BTUH**
**Elective**
Compliance with this directive was poor at the beginning of the year with an approximate 85% compliance only, however this did improve by year end in quarter three and four achieving approximately 95% compliance.
**Non-Elective**
Average compliance of 95%.

**BHRUT**
No data available.

**Nuffield Brentwood**
Reported 100% compliance with this directive

**Spire Hartswood**
The Spire Hartswood have implemented a new IT system and the compliance data is not available, however we have assurance that all NHS elective admissions are screened prior to surgery.

### 4.2 Clostridium *difficile* Infection (CDI)

All NHS trusts in England are required to participate in the Department of Health's mandatory CDI reporting system and to report all cases of CDI positive diarrhoea in patients over 2 years of age.

**Definition of cases:**
Following the national definition for attributing *C. difficile* cases, post 72 hours of admission cases are attributed to the acute trust and pre 72 hours cases are attributed to the Clinical Commissioning Group according to the patient post code.
Pre 72 hour cases are those where samples fall into 1 of 4 categories:

1. Samples taken within the first 72 hours of admission to an Acute Trust
2. Samples taken by a GP or nurse in general practice
3. Samples taken by a community healthcare service
4. Samples taken out of area including out of South East Essex and the East of England region.

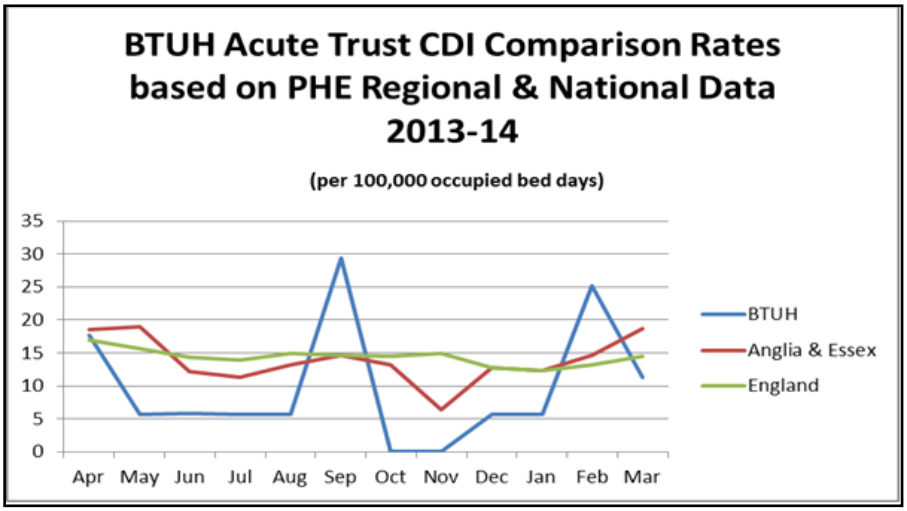
### 4.2.1 CDI Rates

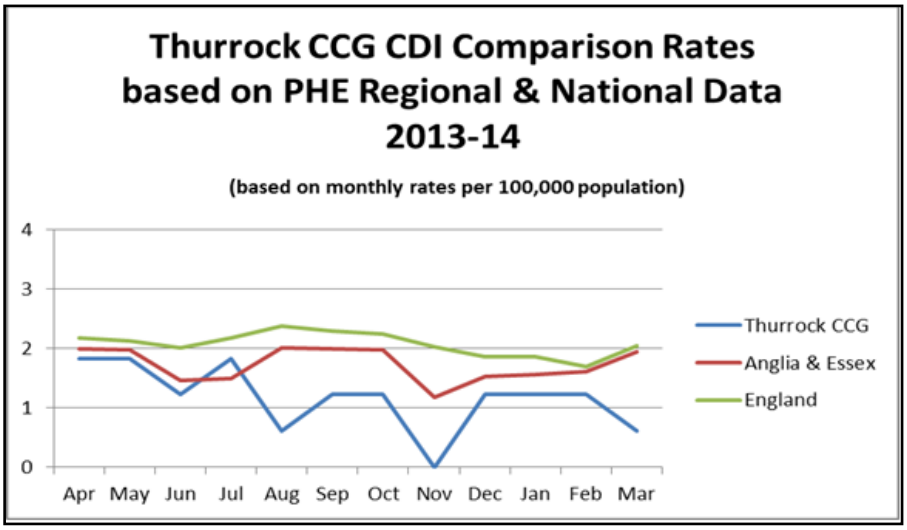
### CDI 2013-14 Trajectories for BTUH & Thurrock CCG

| Trust/Organisation | CDI Cases | Year End Ceiling |
|---|---|---|
| BTUH | 20 | 26 |
| Thurrock CCG | 24 | 26 |
| BHRUT | 24 | 40 |

There were no national trajectories for community service providers

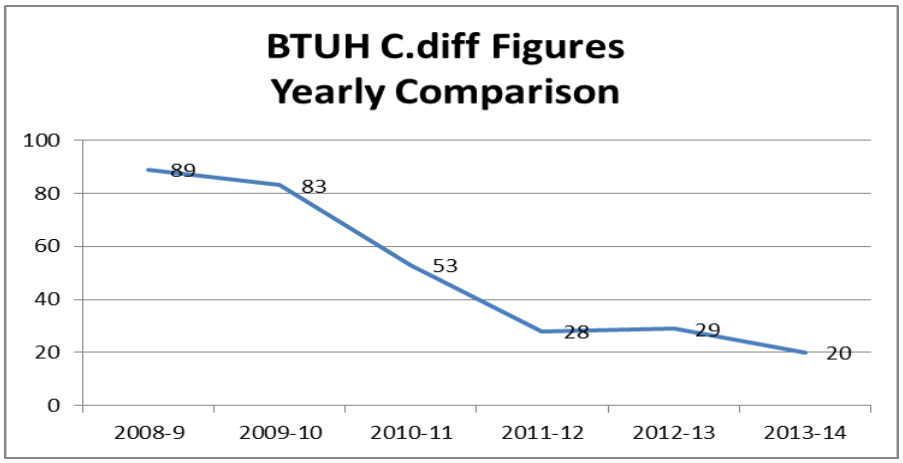
### 4.2.2 CDI Comparison Rates with National and Regional Data

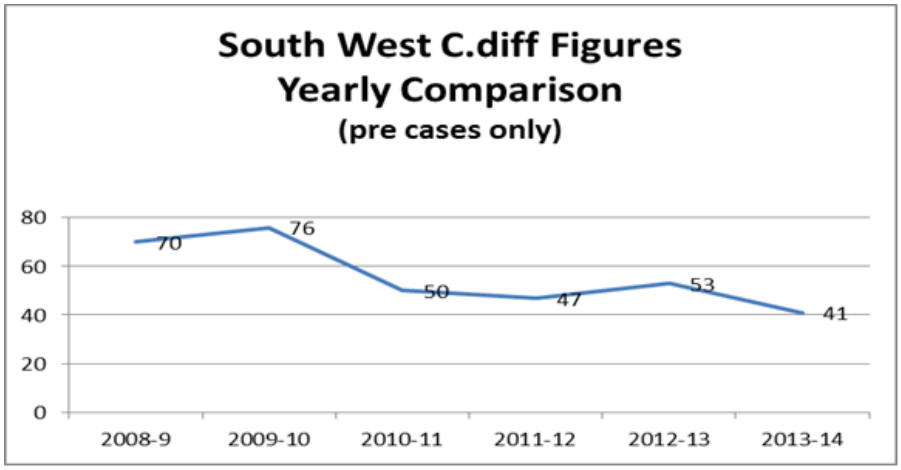





The graphs demonstrate that BTUH's rates per 100,000 occupied bed days were significantly higher in some months when compared with rates nationally. However it is pleasing to note that Thurrock rates per 100,000 population are reported as being significantly lower. It should be noted that nationally the numbers of reported *C difficile* cases have dropped by 74% since 2007/08. The current pattern of strains of *C difficile* infection, where they are located and who they are affecting – i.e. the epidemiological landscape – is now much more complex. Unlike in 2007/08, there are no particularly predominant strains of *C difficile* and new testing technologies that are now available are unable to show that significant numbers of cases are linked; suggesting that patient to patient transmission in hospital of particular strains of *C difficile* is not currently a major feature of reported CDIs. **(Ref: Clostridium difficile infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation, March 2014**

The following graphs demonstrate that BTUH and South West Essex have seen a significant reduction in the number of cases since 2008






The map below is a representation of GP practices with known *C.difficile* cases, colour coded by the number of cases


### 4.2.3 CDI Root Cause Analyses

Throughout South Essex, Root Cause Analyses (RCAs) are undertaken on all cases and assessed with a multi-disciplinary team to understand what, if anything, went wrong, and then to put it right. This is the most effective approach for delivering continuous improvement of patient safety. Out of area cases (i.e. occurred in another health care facility out of the South Essex region) were also followed up where possible.

**NELFT**

Reported 4 cases. Following RCA the cases were deemed unavoidable and not attributable to NELFT

**BTUH**
All Acute hospital cases were deemed unavoidable following Root Cause Analysis (RCA). There was no evidence of cross infection, periods of increased incidence or inappropriate antimicrobial prescribing. The average age of all BTUH cases was 81 (age range 62 – 94 years old). There were no CDI related deaths recorded on part 1 of death certificates of patients that died in the acute hospital but the CCG IPCT are aware of 1 patient who died with CDI on part 2 of the death certificate.

**Community onset**
A total of 24 *Clostridium difficile* infections were reported as being community onset within TCCG population.

These included:

- 4 cases reported from NELFT Intermediate Care beds. All NELFT in-patient cases were deemed unavoidable following RCA. There was no evidence of cross infection, periods of increased incidence or inappropriate antimicrobial prescribing.
- 5 out of area cases (i.e. occurred in another health care facility out of the South Essex region).
- 13 GP Cases. There was no evidence of cross infection or clusters of patients.

The average age range for all cases was 60 (age range 16 -95). The CCG IPCT are aware of 1 patient who died with CDI on part 2 of the death certificate.

**BHRUT**
Data from RCA's not available

**Spire Hartswood**
Zero cases

**Nuffield Hospital**
Zero cases

### 4.2.4. National Objectives for 2014/15

| **Thurrock CCG *(Year end 22)*** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MONTHLY** | | | | | | | | | | | | |
| **All cases** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
| Monthly C.diff cases | | | | | | | | | | | | |
| Monthly C.diff trajectory | 3 | 3 | 3 | 2 | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 |

| **BTUH (Year end 18)** | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **MONTHLY** | | | | | | | | | | | | |
| | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** |
| Monthly C.diff cases | | | | | | | | | | | | |
| Monthly C.diff trajectory | 3 | 3 | 3 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |

In response to advice from infection control experts, NHS England has made changes to the CDI objective setting and sanction process for acute providers to encourage greater assessment of CDI cases for 2014/15. These changes are primarily focussed on further encouraging organisations to look at each CDI case they identify to understand what lessons they are able to learn in order to improve the safety of patients. For 2014/15, the

RCA process will determine whether the case was linked with a lapse in the quality of care provided to patients. This will increase the organisation's understanding of the quality of the care they are providing and highlight areas where care could be improved.
A lapse in care would be indicated by evidence that policies and procedures consistent with national guidance and standards were not followed by the relevant provider.
Any learning should support the development of an action plan and subsequent improvement in care as well as forming part of the relevant contract management processes.

There are currently no national CDI objectives for community services providers, and no financial sanctions related to CDI are mandated in the NHS Standard Contract for community services providers. However any cases that occur whilst the patient is under the care of NELFT will be subject to the same scrutiny as for the acute providers.

### 4.3 Meticillin-sensitive Staphylococcus aureus Bacteraemia (MSSA)

Mandatory surveillance of Meticillin-sensitive *Staphylococcus aureus* (MSSA) started in January 2011, the surveillance programme was extended to include Escherichia Coli in June 2011**.**

Count of Thurrock CCG cases for the financial year (as reported by PHE) was 22.
NELFT reported zero within in-patient beds.
BTUH reported 7 Acute Trust apportioned.

### 4.4 Escherichia coli Bacteraemia

Count of all Thurrock CCG cases for the financial year (as reported by PHE) was 83.
NELFT reported zero with in-patient beds.
BTUH reported 214.

### 4.5 Key Priorities for 2014/15

- Raise awareness of the wider burden of Glutamate dehydrogenase (GDH), the test on stool samples that is an initial screening test to detect the presence of the chemical. If the chemical is found, the result is termed GDH positive which means C.diff is present in the bowel which may lead to a CDI
- Working with the SystmOne team to ensure that patients with an alert organism (e.g. MRSA, C.*difficile*) are flagged
- Report on all lapses in care following any RCA
- Ensure learning and sharing from all investigations are disseminated in a timely manner
- Closer collaboration with GPs
- Enhance surveillance of MSSA and E Coli
- As part of the routine admission procedure, ensure acute trusts assess all patients on admission for carbapenemase-producing Enterobacteriaceae

## 5.0 Water Safety

**NELFT**
Assurance has been sought that risk assessment are undertaken and remedial action is taken as necessary. New for 2014-15 are basic KPIs for Legionella based on the DH

Health Technical Memorandum 04-01, the control of Legionella, hygiene, “safe” hot water, cold water and drinking water systems

**BTUH**
Work to ensure that the remaining completion of the work to address the outstanding recommendations from the Joint SHA/PCT Review is underway. NHS Basildon & Brentwood CCG (BBCCG) is tracking the Trust’s progress at the monthly Legionella Review meeting which is attended by the Chief Nurse for BBCCG, deputised by the Head of Infection Prevention and Control.

**NHS Properties**
NHS Properties have comprehensive contract that covers South Essex with Essex Suffolk Water. Monthly monitoring inspections are carried within all premises. Any remedial actions as a result of monthly monitoring are rectified within an acceptable time parameter

### 5.1 Key Priorities for 2014/15

- The IPCT will continue to strengthen relationships with acute Trust estates department to gain assurance regarding water safety systems that include attendance at Water Safety Group Meetings including Pseudomonas.
- Ensure NELFT are reporting this data to the IPCT on a quarterly basis or by incident with remedial actions listed.

## 6.0 Outbreaks, Ward Closures, Periods of Increased Incidence (PII)

### 6.1 Respiratory Outbreaks

There were no reported respiratory outbreaks within Acute or NELFT in-patient beds

**Community**
Thurrock CCG commission NELFT to respond in a timely manner to reported respiratory outbreaks in care homes within the TCCG locality with the administration of anti-viral drugs undertaken by South Essex Emergency Doctor Service (SEEDS). The Essex PHE commissioned Provide (Provide is the trading name of Central Essex Community Services) to respond to outbreaks with the BBCCG locality. IPC advice is provided by the Essex Health Protection Team, Anglia & Essex Public Health England Centre

All outbreaks reported to the PHE are logged onto an incident and outbreak database developed by the HPA East of England Epidemiology Unit, the Eastern Region Medical Microbiology Development Group and Camart Ltd. This allows the CCG IPCT to monitor outbreaks and PII and identify any hotspots in a timely manner.

### 6.2 Norovirus Outbreaks

**NELFT**

| MONTH | Bay or whole ward Closure | Causative Organism |
|---|---|---|
| Feb 2014 | Whole Ward Closed | Norovirus |

**BTUH**

| MONTH | Bay or whole ward Closure | Causative Organism |
|---|---|---|
| April 2013 | Whole Ward Closed | Norovirus |
| Nov | 1 Bay Closed | Norovirus |
| Feb | Whole ward | Norovirus |
| Feb | Male side of ward | Norovirus |
| March | 1 Bay Closed | Nil |
| March | 4 Bedded Bay and Single side room | Norovirus |

The outbreaks were well managed and it was only necessary to close 2 wards.

**BHRUT**

| Time Period | No of patients affected | No of staff reported illness | No of bed days lost | Causative Organism |
|---|---|---|---|---|
| April 2013 – March 2014 | 108 | 15 | 83 | Norovirus |

## 7.0 Saving Lives: High Impact Interventions (HIIs)

The High Impact Interventions (HIIs) are an evidence-based approach that relate to key clinical procedures or care processes that can reduce the risk of infection if performed appropriately. They have been developed to provide a practical way of highlighting the critical elements of a particular procedure or care process (a care bundle), the key actions required and a means of demonstrating reliability.
Patient outcomes can be systematically improved when all elements of the care bundles are performed correctly and consistently.

**NELFT**
No data available

**BTUH**
Continue to report good compliance with all high impact interventions. This data is scrutinised at the Trust ICC and areas of concern are noted and if appropriate action plans developed. Data is displayed which is accessible to staff, patients and visitors in wards and departments.

**BHRUT**
No data available.

**Spire Hartswood**
RAG rate their compliance and all HIIs have been reported as GREEN.

**Nuffield Brentwood**
Report good compliance with all HIIs. Assurance has been given and is documented that areas of concern are addressed at the time of audit

### 7.1 Key Priorities for 2014/15

- Encourage peer review of HIIs.
- Closer scrutiny of results.
- Independent audit of results.

## 8.0 Compliance against Hygiene Code (Part of the Health & Social Care Act 2008 – Code of Practice on the Prevention & Control of Infections and Related Guidance)

Section 21 of the H&SCA 2008 enables the Secretary of State for Health to issue a Code of Practice about healthcare associated infections. The Code contains statutory guidance about compliance 5 with the registration requirement for cleanliness and infection control (regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010).
The law states that the Code must be taken into account by the CQC when it makes decisions about registration against the cleanliness and infection control requirement. (Outcome 8)

The regulations also say that providers must have regard to the Code when deciding how they will comply with registration requirements. So, by following the Code, registered providers will be able to show that they meet the requirement set out in the regulations.

Provider compliance against the code is monitored by the Commissioning IPCT through quarterly compliance reports which are reported through the Providers' Infection Control Committee and in quarterly reports to the CCG IPCT. Each criterion is RAG rated to demonstrate compliance as follows: (The ten criterions can be found in appendix 1 of this report).

| | |
|---|---|
| Red | Non-compliant due to insufficient evidence and processes to support compliance |
| Amber | Evidence and processes available to support compliance, further development required in areas |
| Green | Evidence and processes to support compliance available |

**NELFT**
Declared full compliance

**BTUH**
Declared amber compliance for criterions 1, 2 and 9 at the end of this reporting period.

Further development required to support compliance has been identified as follows:

- New decontamination lead to be identified following previous named post holder leaving Trust – this has been escalated to the corporate risk register
- Training and implementation of the use of an Ozone sanitiser
- Update of current IPC policies to include Viral haemorrhagic fevers and carbapenemase-producing Enterobacteriaceae (CPE)

Time scales and action plan are in place to ensure full compliance

**Nuffield Hospital**
No data submitted.

**Spire Hartswood**
No data submitted.

## 9.0 Summary of CCG Outcome 8 Visits

Further assurance is gained by undertaking a review of the commissioned Organisation compliance with outcome 8 – Cleanliness and Infection Control.

**NELFT**
Alistair Farquharson Centre (AFC)

AFC was visited in July 2013. Compliance with this standard was good with no major concerns identified.

**Mayflower Community Hospital (In-patient Unit)**
Mayflower was visited in January 2014. Compliance with this standard was good with no major concerns identified.

**Brentwood Community Hospital (BCH)**
NO visits were undertaken during this reporting period.

**Spire Hartswood**
Not assessed in this reporting period, although a 'meet and greet' visit was undertaken including a site tour during which there were no infection prevention or control issues identified.

**BTUH**
A visit was undertaken in April 2013. Overall compliance with this standard was good and all action identified have now been completed or processes are in place to ensure the recommendations are actioned.

**Brentwood Nuffield**
Not assessed in this reporting period although a 'meet and greet' visit was undertaken including a site tour during which there were no infection prevention or control issues identified.
In addition, a number of other quality visits with the CCG Quality Support Team have taken place, all of which have not raised any concerns for cleanliness.

### 9.1 Key Priorities for 2014/15

- To ensure there is a planned robust schedule in place to continue with 'Are Services Safe' - Outcome 8 visits within each commissioned service, based on local intelligence, performance reports and external visitor reports.
- Strengthen information sharing with NELFT and Private Hospitals.

## 10.0 Summary of IPC External Visits to Provider Services

**NELFT**
External CQC visits were not undertaken for the Outcome 8 standard

**BTUH**
**KEOGH**
Whilst the panel observed examples of good practice in infection control during the visit, issues were also noted in some areas including a number of infection control concerns identified on one ward observed.
Their recommendation: The Trust needs to ensure its infection control procedures are consistently applied in the organisation and undertake audits to gain assurance on this area.
Good progress continues to be evidenced against the recommendations from the Keogh Review.

**Care Quality Commission (CQC)**
Providers of services comply with the requirements of Regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
**CQC judgement -** People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

**Spire Hartswood**
Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
**CQC judgement -** People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment

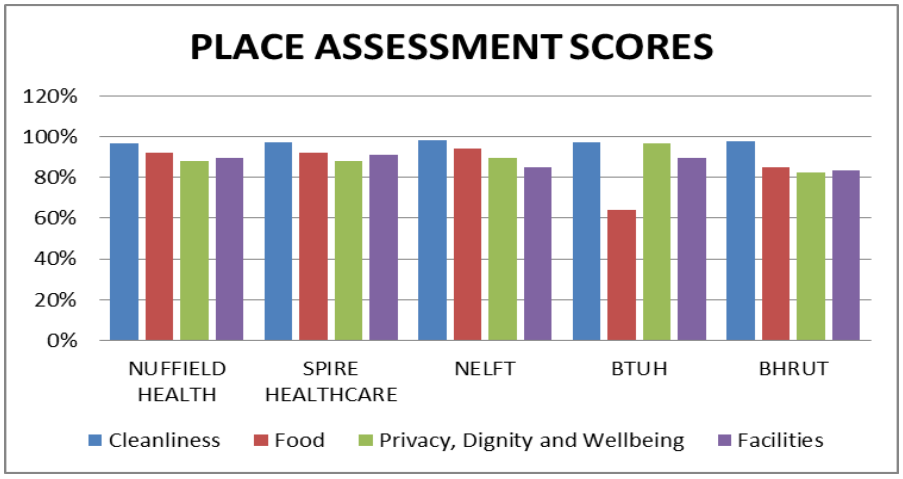
**Nuffield Brentwood**
Providers of services comply with the requirements of regulation 12, with regard to the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
**CQC Judgement -** The provider was meeting this standard.
People were protected from the risk of infection because appropriate guidance had been followed. People were cared for in a clean, hygienic environment.

## 11.0 Patient-Led Assessments of the Care Environment Inspections (PLACE)

Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of a range of non-clinical services which contribute to the environment in which healthcare is delivered in the both the NHS and independent/private healthcare sector in England. Participation is voluntary. These assessments were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which had been undertaken from 2000 – 2012 inclusive.

The PLACE programme aims to promote the above principles and values by ensuring that the assessment focuses on the areas which patients say matter, and by encouraging and facilitating the involvement of patients, the public and other bodies with an interest in healthcare (e.g. Local Healthwatch) in assessing providers in equal partnership with NHS staff to both identify how they are currently performing against a range of criteria and to identify how services may be improved for the future.
The assessments undertaken in 2013 were the first under this programme. It is the intention that they will be undertaken annually.

The table below shows the data reported in the Patient-Led Assessments of the Care Environment (PLACE): England - 2013, Experimental Statistics Report. Published September 2013:
Http://www.hscic.gov.uk/catalogue/PUB11575/PLACE%20Publication%20Report%2031%2010%2013.pdf




Where an organisation has more than one site, the calculation of an organisation-level score is weighted to take account of the relative sizes of the sites using bed numbers as a proxy for size in the same way as is used to calculate the national average.
****The reader is asked to note that the scores for independent hospitals is for all sites and not individual hospital scores***.

### National Average Scores

The national average score for Cleanliness was 95.75%
The national average score for Condition, Appearance and Maintenance was 88.78%

The national average score for Privacy, Dignity and Wellbeing was 88.90%
The national average score for Food and Hydration was 85.41%

It is pleasing to note that all our provider services scored above average for cleanliness.

## 12.0 IPCT Key Actions/Achievements

The Lead IPCN chairs the South Essex Health Care Associated Infection Network Group meetings – the meeting format has moved on from a performance related group to a more educational forum where all members can share incidents, actions and learning. This quarterly meeting has been well attended this year and has been a supportive network for collaborative working.

The IPCT have further developed working relationships with – PHE, AT, North Essex Commissioning IPCT and have been key members of the wider Quality Team hosted by Southend CCG.

Both IPCNs are members of the RCN commissioning group and have recently rekindled working relationships with the EoE Commissioning Network Group.

To capture data regarding Clostridium *difficile* positive results from GPs, a new GP RCA tool was developed in July 2013, and, after further review, was reformatted in March for use in 2014. Further work needs to be undertaken with GPs to fully participate in this process.

The IPCT hosted a Clostridium *difficile* summit meeting in March 2014 with experts in Epidemiology present along with colleagues and peers from the provider services to review ALL Clostridium difficile cases across South Essex. The team are still working with PHE to review any co-location of patients.

The RCA and PIR processes are continually developing and reviewed within the team to ensure patient safety is paramount.

From April 2013 the IPCT no longer serve GPs with IP&C advice, audit or training. This has caused concern and has been raised with the Executive Nurses involved. A short term solution has been to attend the TTL sessions and share any HCAI cases and the learning to date. This has been positively received.

### 12.1 Summary

Overall it has been a challenging but exciting year with the team forming and new guidance and developments in the CCGs allowing opportunities for change in practice. The IPCT are well respected amongst peers and colleagues and will continue to work to assist in the zero tolerance to HCAIs.

## 13.0 Appendices

**Appendix 1 –** Code of Practice for health and adult social care on the prevention and control of infections
**Appendix 2 -** Work Plan 2014-15

## APPENDIX 1

The table below is the 'Code of Practice' for health and adult social care on the prevention and control of infections under The Health and Social Care Act 2008. This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirement for cleanliness and infection control. Not all criteria will apply to every regulated activity.

| Compliance criterion | What the registered provider will need to demonstrate |
|---|---|
| 1 | Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them. |
| 2 | Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections. |
| 3 | Provide suitable accurate information on infections to service users and their visitors. |
| 4 | Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion. |
| 5 | Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people. |
| 6 | Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection. |
| 7 | Provide or secure adequate isolation facilities. |
| 8 | Secure adequate access to laboratory support as appropriate. |
| 9 | Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections. |
| 10 | Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care. |

**APPENDIX 2**

| Priority | Key Indicators/Rationale | Actions | Lead | Timescale |
|---|---|---|---|---|
| HCAI Surveillance | To work with Commissioned Services to demonstrate a zero tolerance to HCAIs through –<br>• Post Infection Review (PIR) process for MRSA bacteraemias<br>• Root Cause Analyses (RCAs) for Clostridium difficile Infections (CDI)<br>• Implementation of CPE Toolkit for Acute Trusts<br><br>Ensuring learning and improvement in practice are identified | To lead PIR investigations with all service providers in accordance with current guidance | SOM | As required |
| | | Review all RCA's with service provider at MDT meetings | SOM/ JM | Monthly/as required meetings |
| | | Assist GP's with Community CDI RCAS identity trends and produce ¼ reports for relevant CCG groups | | |
| | | Review all SI's pertaining to HCAIs monitor/review provider services action plans | JM/ SOM | As required |
| | | Provide timely reports to CCG Boards as required | SOM | As per agreed schedules |
| | | Work with PHE in mapping all CDI cases identified in S Essex | BM | |
| Leadership | All health care providers to develop and own a collaborative approach to the prevention and management of HCAIs | Chair South Essex HCAI Network group | SOM | 1/4 |
| | | Develop Sub –Economy wide HCAI Strategy | SOM<br>SOM | Completed |
| | | Develop and lead on project work to support the delivery of the HCAI/safety agenda. E.g. QUIPP/Care pathways pertaining to IPC | SOM | As required |
| | | Initiate and lead on the implementation of national/regional and local programmes as required | JM | As required |
| | Identify local needs, develop capabilities and ensure | Review providers IPC reports identify | SOM/ | ¼ |

| Priority | Key Indicators/Rationale | Actions | Lead | Timescale |
|---|---|---|---|---|
| | capacity with all providers | any gaps in assurance -reporting any identified risks are highlighted to the relevant CCG board | JM<br><br>JM | |
| | | Attendance at Provider ICC | | Bi-Monthly |
| | | Monthly meetings with Provider services | SOM/ JM | Monthly |
| | | Information sharing/monitoring with Independent Hospitals through quarterly returns | SOM/ JM/BM | 1/4 |
| | | Review of Compliance with H&S Code of Practice – all providers | | 1/4 |
| | Engage with Social care providers through PHE to assist in their attainment of compliance with the Code of practice | Attendance at PHE meetings | | ¼ |
| | | Participate in Quality Support Visits to Care Homes where IPC is identified as a concern | | As required |
| Contracting | Ensure national and local IPC standards are set at the correct level and included in contracts with provider organisations | Develop/review service specifications ensure they met the national objectives within the operating framework | SOM | Annually |
| | | Review new contracts to ensure requirements for providers are included in contracts to state the need for registration with the Care Quality Commission (CQC) and compliance with the Code of practice. | SOM<br><br>SOM | As required |
| | | Ensure IPC are involved and members of relevant committees in Estates issues working with landlords and leaseholders for<br>• New builds | JM | As Required |

| Priority | Key Indicators/Rationale | Actions | Lead | Timescale |
|---|---|---|---|---|
| | | • Water safety<br>• Ensuring all health care premises are fit for purpose<br>• Review of environmental audits scores undertaken by providers escalating when there are significant concerns and monitoring of subsequent action plans<br>• Cleaning contracts | JM<br>JM<br>JM/BM | |
| | Performance monitoring against Contracts | Review Providers compliance with H&S CA – Code of practice – identifying any gaps and how the organisation will address these gaps | JM<br>SOM | ¼ |
| | | Monthly and ¼ monitoring of Information sharing agreement within contracts – identifying gaps in assurance and how these gaps will be addressed | SOM<br>JM | Monthly |
| | | Review dash boards from provider services | | Monthly |
| | | Attendance at provider ICC | | As required in accordance with provider schedule |
| | | Provide expert advice to Executive Nurses pertaining to IPC before QPGs and Board | | |
| | | Announced and un-announced CQC Outcome 8 visits | | |
| Organisational Accountability | Infection prevention and control is embedded and that board accountability/ | Monthly HCAI reports to Board/QPGS/executive nurses | JM | Monthly |

| Priority | Key Indicators/Rationale | Actions | Lead | Timescale |
|---|---|---|---|---|
| | assurance is demonstrated | Annual report/quality account for CCG's | SOM | Annual |
| | | Ensure any HCAI risks which could affect CCG's are escalated and if necessary added to risk register | SOM<br>SOM | As required |
| | | Attend Emergency Planning meetings as necessary | JM | 1/4 |
| | | Provide Specialist Clinical advise for<br>• IPC queries<br>• Complements/Complaints<br>• FOI requests<br>• Safe guarding | | As required |
| Ad -Hoc | Become an Integral part of the Quality Support team | Work with other members of the team to ensure IPC is integral to service delivery | SOM<br>SOM | |
| | | Escalate when appropriate to Head of Quality Support Team | JM | |
| | | Attendance at fortnightly team meetings and informal meetings (as work schedule allows) | | Weekly |
| | Networking with other Commissioners/ Local Area Teams/PHE | Attendance at North Essex ICC Network group | JM | |
| | | Review minutes or attend meetings with EHPT outbreak and incident meetings | BM | |
| | | Attend outbreak meetings /extraordinary meetings as required with providers / PHE or LAT | JM | |