1. INTRODUCTION

The Trust Board recognises their collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks. The responsibility for infection prevention and control is delegated to the Director of Infection Prevention & Control (DIPC).

The DIPC Reports together with the monthly Key Quality Performance Indicators (KQPI) Report are the means by which the Trust Board assures itself that prevention and control of infection risks are being managed effectively.

The purpose of the six monthly DIPC Report is to inform the Tu( )1(w)1he T of id [(t)urols-11( )de-2(s)-17(

6. MANDATORY SURVEILLANCE

6.1 Surgical Site Infection Surveillance (SSIS)

Alert organism and alert condition surveillance data is collected and used by the Trust to detect outbreaks and monitor trends. The ICNs coordinate data collections for the national SSIS programme of various surgical procedures, which are applicable to the Trust.

Where orthopaedic surgical procedures are performed, Trusts are required to undertake mandatory SSIS every year. This must be for a minimum of a three months surveillance period or until a cohort of 50 cases has been achieved, in at least one of these categories listed below:

- Hip (prosthesis) replacement
- Knee (prosthesis) replacement
- Repair of neck of femur
- Reduction of long bone fracture

The Trust complies with this annual requirement to undertake SSIS. Formal reports outlining progress with SSIS were presented at the IPCC meetings and disseminated to relevant Trust personnel. There were no identified deep infections for knee replacement surgery during quarters 1 and 2 of 2018/19.

6.2 Methicillin Resistant Staphylococcus aureus (MRSA)

The PHE Mandatory enhanced MRSA bacteraemia surveillance scheme (updated March 2016), is used to measure the effectiveness of infection prevention and c

Table 1: Breakdown of total number of Trust cases recorded April 2018 to September 2018 (Figures in brackets show number of cases recorded April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**0 (0)**	**1 (0)**	**0 (0)**	**0 (0)**	**0 (0)**	**0 (0)**							**1 (0)**
Non Trust apportioned cases	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**0 (0)**
Trust apportioned cases	0 (0)	1 (0)	0 (0)	0 (0)	0 (0)	0 (0)							**1 (0)**

6.3 Clostridium difficile

The control of this infection is managed by the combination of adherence to the correct infection control practices, environmental cleaning, equipment decontamination and prudent antibiotic stewardship.

The Trust continues to apply DH guidance for C.difficile testing and the previously agreed revised C.difficile testing and reporting algorithm. All C.difficile positive stool samples that test toxin positive are reportable to PHE. (Of note: from April 2017, changes were made regarding the mandatory reporting requirements for Trusts. This is in relation to the classification of C.difficile cases with a focus on previous healthcare interactions/episodes. Following further clarification from PHE, the definition of Trust apportioned and non-Trust apportioned cases has not changed).

In accordance with PHE definitions, C.difficile Trust apportioned cases include patients that are –

1. Inpatients, day patients and emergency assessment patients; **AND**
2. have had a specimen taken at an acute Trust; **AND**
3. specimen is **4 or more** days after date of admission (admission date is considered day '1').

Non-Trust apportioned cases include all cases that are **NOT** apportioned to the acute Trust.

All patients with a stool sample confirming the presence of C.difficile require the implementation of strict infection control measures and practices e.g. isolation nursing in a sideroom facility, the completion of terminal and enhanced cleaning by Housekeeping and a review by the relevant clinicians to determine if C.difficile treatment is indicated. The formal reporting process to PHE is managed by the ICNs under direction of the DIPC and ICD, and has had an impact on the team's workload.

Table 2 below relates to the breakdown of all inpatient reportable cases of C.difficile and **Table 3** relates to the total reportable cases of C.difficile recorded by the Trust

Table 2: Breakdown of reportable cases recorded for all inpatients April 2018 to September 2018 (Figures in brackets show number of inpatient reportable cases April 2017 to September 2017)

Table 3: Breakdown of total number of reportable C.difficile cases recorded April 2018 to September 2018 (Figures in brackets show total number of reportable cases recorded April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3	Quarter 4	Total
	April	May	June	July	Aug	Sept	Oct		

6.5 Gram-negative bloodstream infections (GNBSIs)

6.5.1 Escherichia coli (E.coli)

The Trust continues to input enhanced surveillance data for E.coli bloodstream infections (BSI) in accordance with current guidance from the DH and PHE. From 1st April 2012, the Trust has applied the definition criteria used for MRSA bacteraemia cases to the E.coli bacteraemia cases recorded within the Trust. This allows the cases to be classified as either Trust apportioned or non-Trust apportioned.

Table 5: E.coli Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to September 2018 (Figures in brackets show total number of cases recorded from April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total patients	**4 (9)**												

6.5.2 Klebsiella sp. and Pseudomonas aeruginosa

From April 2017, the incidence of GNBSIs for Klebsiella sp. and Pseudomonas aeruginosa reported at the Trust now requires enhanced investigation and data entry onto the PHE DCS website. This work has been undertaken by the ICNs.

Table 6: Klebsiella sp. Bacteraemias figures recorded for blood cultures from inpatients and Emergency Department April 2018 to September 2018 (Figures in brackets show total number of cases recorded from April 2017 to September 2017)

	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Total
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
Total Inpatients	**2 (0)**	**0 (0)**	**3 (2)**	**3 (2)**									

From the data reviewed and provided by the ICNs, there have been no externally reportable infection alert organisms identified for this patient group.

7. WATER SAFETY MANAGEMENT (information for this section has been provided by Terry Cropp, Responsible Person (RP)

7.2

- Moment 1: Before patient contact
- Moment 2: Before a clean/aseptic procedure
- Moment 3: After body fluid exposure risk
- Moment 4: After patient contact
- Moment 5: After contact with patient surroundings

For quarters 1 and 2 of 2018/19, the overall compliance rate from 15 external audits completed across 13 clinical areas at different times was 75.85%, with several areas being audited more than once during the quarters. This is a slight decrease on the previously reported overall compliance rate of 78.2% from 12 external audits completed across 10 clinical areas (several areas audited more than once).

Detailed analysis was undertaken to identify the key areas of non-compliance, which was predominantly staff missing moment number 5, handwashing after contact with patient surroundings. The results were reported via the DIPC and the IPCC and feedback was provided to the clinical leaders and DMTs to address the shortfall in practice. Additional education and support has been provided by the ICNs to staff groups focusing on these audit findings.

The ‘Red, Amber and Green’ rating for the hand hygiene compliance audits continues and includes
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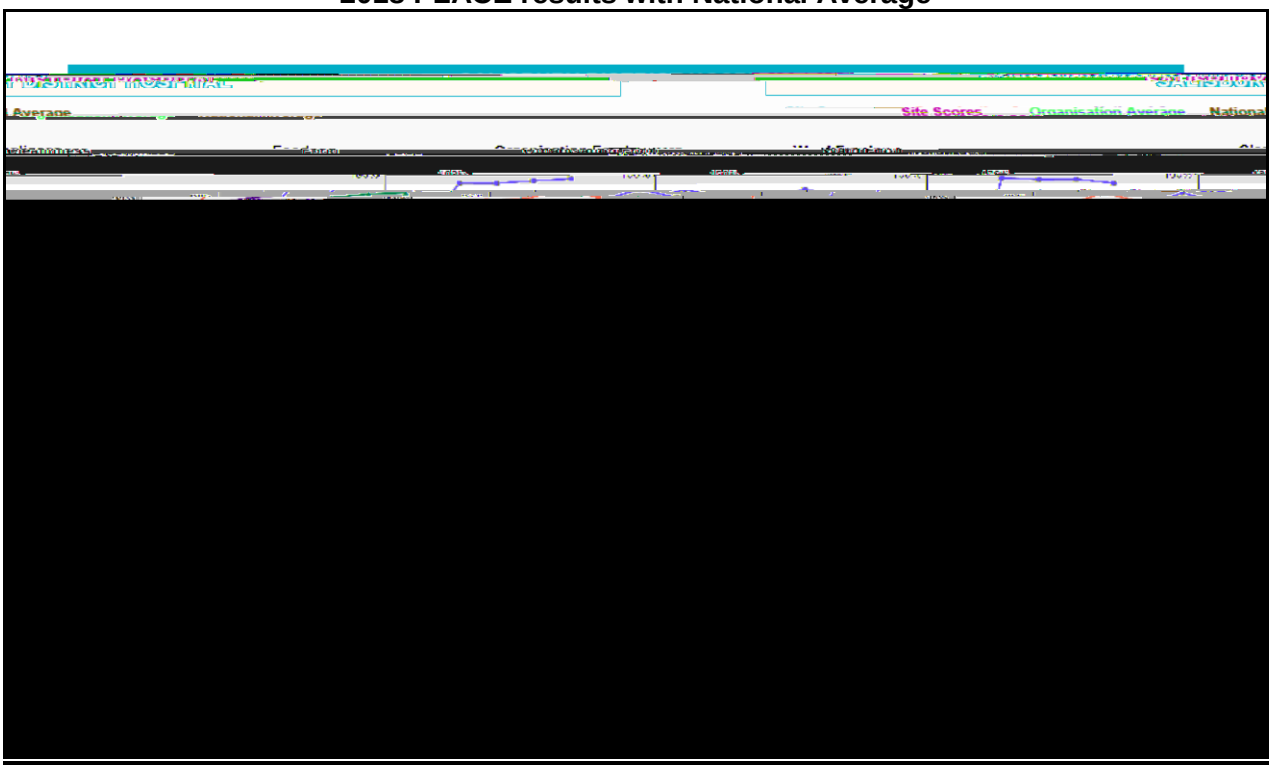
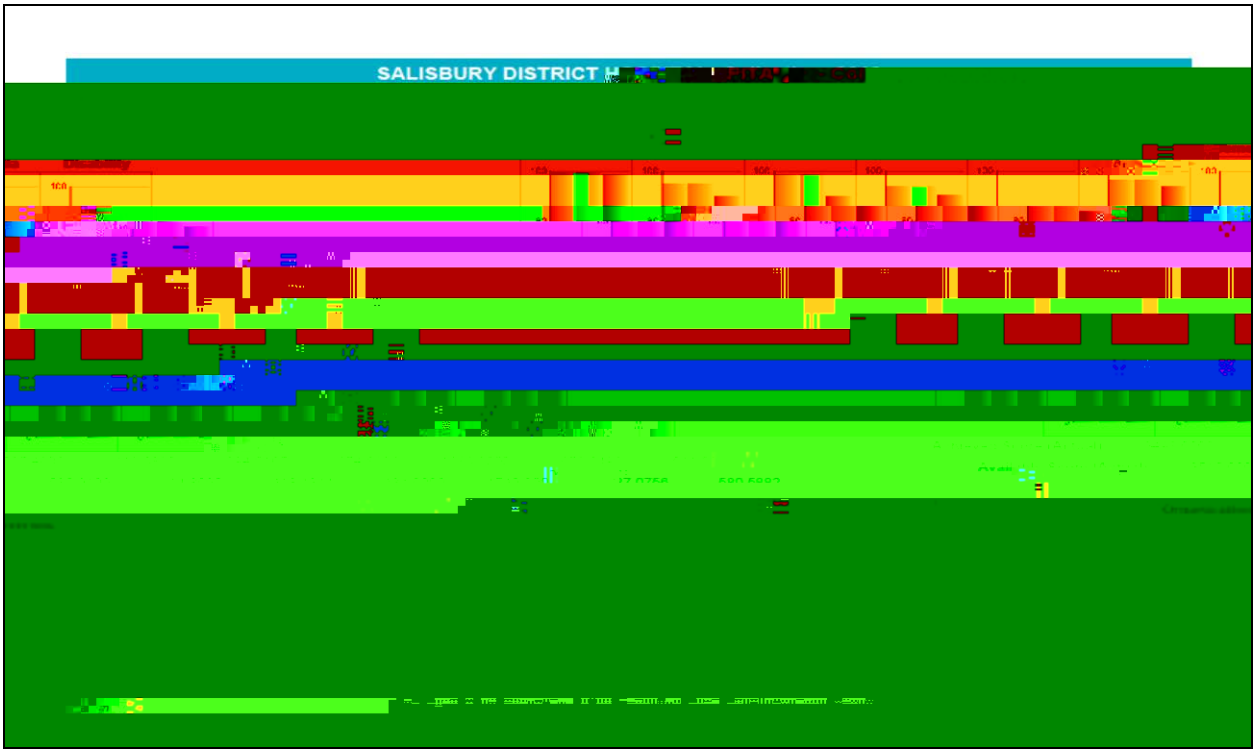
2018 PLACE results with National Average





10.3 Deep clean programme and rapid response team

The deep clean and decorating programme commenced in May 2018 (a copy of the Deep Clean programme is available from the Housekeeping Department). A monthly review of this plan is undertaken at MMG and discussed with the ICNs and DSNs at weekly meetings.

Concerns have been raised that the Housekeeping Team cannot access a number of bays and siderooms due to bed pressures. For those areas that are not deep cleaned, a contingency "scrub" plan of action has been agreed. This contingency scrub plan will continue to be monitored to better ensure all areas have a level of annual deep clean. These areas will be prioritised should they

72 hours that met all three criteria. We hope to achieve our quarter 2 target of 50%. The results of the quarter 2 audit will be available shortly.

CQUIN part 2d – Reduction in antibiotic consumption as Defined Daily Doses per 1000 admissions:
This is divided into 3 parts:

- Reduce all antibiotics – Reduction in antibiotic consumption per 1000 admissions: This part of the CQUIN is most challenging for us. Our target for reducing antimicrobials is to achieve a 2% reduction in total antibiotic usage compared to our 2017/18 target. So far our rolling data for quarters 1 and 2 of 2018/19 suggests we have seen an increase of 8.7% in our antibiotic usage.
- Reduce Carbapenems – We achieved an excellent reduction in Carbapenems last year and so this year the target is to maintain that 12.5% reduction. Our Carbapenem usage is very small and so one or two patients can dramatically affect the results. So far, however, our usage has remained low with quarter 1 and 2 data suggesting a 17.9% reduction compared to our 2017/18 target.
- Increase Proportion of antibiotics in the Access group of the AWaRe category – The new target for part of the part 2d CQUIN is to increase the proportion of narrow-spectrum antimicrobials. All antibiotics have been divided into 3 categories – Access, Watch and Reserve. The target is to have at least 55% of our total antibiotic usage in the Access group or increase by 3% from 2016 calendar year data. Our 2016 data shows we had 50.17% of our antibiotics in the Access group therefore we need to increase this to 53.17%. Data for quarters 1 and 2 of 2018/19, shows a small increase to 50.3%. We need to review all our antimicrobial policies to ensure we are encouraging the use of antibiotics in the Access group of the AWaRe list. Due to workload and time constraints, this is proving challenging.

To raise awareness of the new CQUIN, a Consultant Microbiologist and the Antimicrobial Pharmacist attended clinical governance sessions for Medicine, Urology, Orthopaedics, Spinal and Elderly care. We updated the Consultants on the requirements of the new CQUIN and the challenges facing us with antimicrobial resistance. Feedback suggested that as part 2c of the CQUIN required specific documentation of an antibiotic review, a sticker may be helpful for the notes that can be completed on the ward round. A sticker has therefore been designed, approved at ARG and the Drugs and Therapeutics Committee (DTC) and is currently at the printers.

The Trust has recently approved the funding for Multiguide, a new platform and application which will replace the Integrated Clinical information Database (ICID). All antimicrobial guidelines will transfer to Microguide. Use of this application in University Hospitals Southampton (UHS) led to a reduction in the prescribing of high-risk broad-spectrum antibiotics from 40% to 28% and we are hoping for similar success here.

We would like to carry out an antimicrobial ward round in order to try and reduce inappropriate antibiotic prescribing. Last year we carried out a successful pilot of an antibiotic ward round with a Consultant Microbiologist and the Antimicrobial Pharmacist. This, along with other published evidence, suggested a ward round reduces the usage of antibiotics by stopping inappropriate courses and encourages switching from Intravenous (IV) to oral antibiotics sooner, resulting in a potential reduction in length of stay and nurse time savings.

11.2 Action plan

We plan to roll out the use of the CQUIN antimicrobial review stickers as soon as they are delivered from the printers. We hope this will help achieve part 2c of the CQUIN, which will become more challenging as the year progresses.

The Microbiology Team have produced a business case to increase resources available. The aim of this would be to implement a Consultant Antimicrobial ward round to try and achieve the benefits described above.

This year, 'World Antibiotic Awareness' week takes places from the 12th – 18th November 2018. We annually plan a campaign to raise awareness of the need to use antibiotics responsibly and this year will be planning a range of actions to promote awareness, including the use of posters throughout the hospital, the Pharmacy Team engaging with staff on the wards and via a Broadcast message.

12. AUDIT

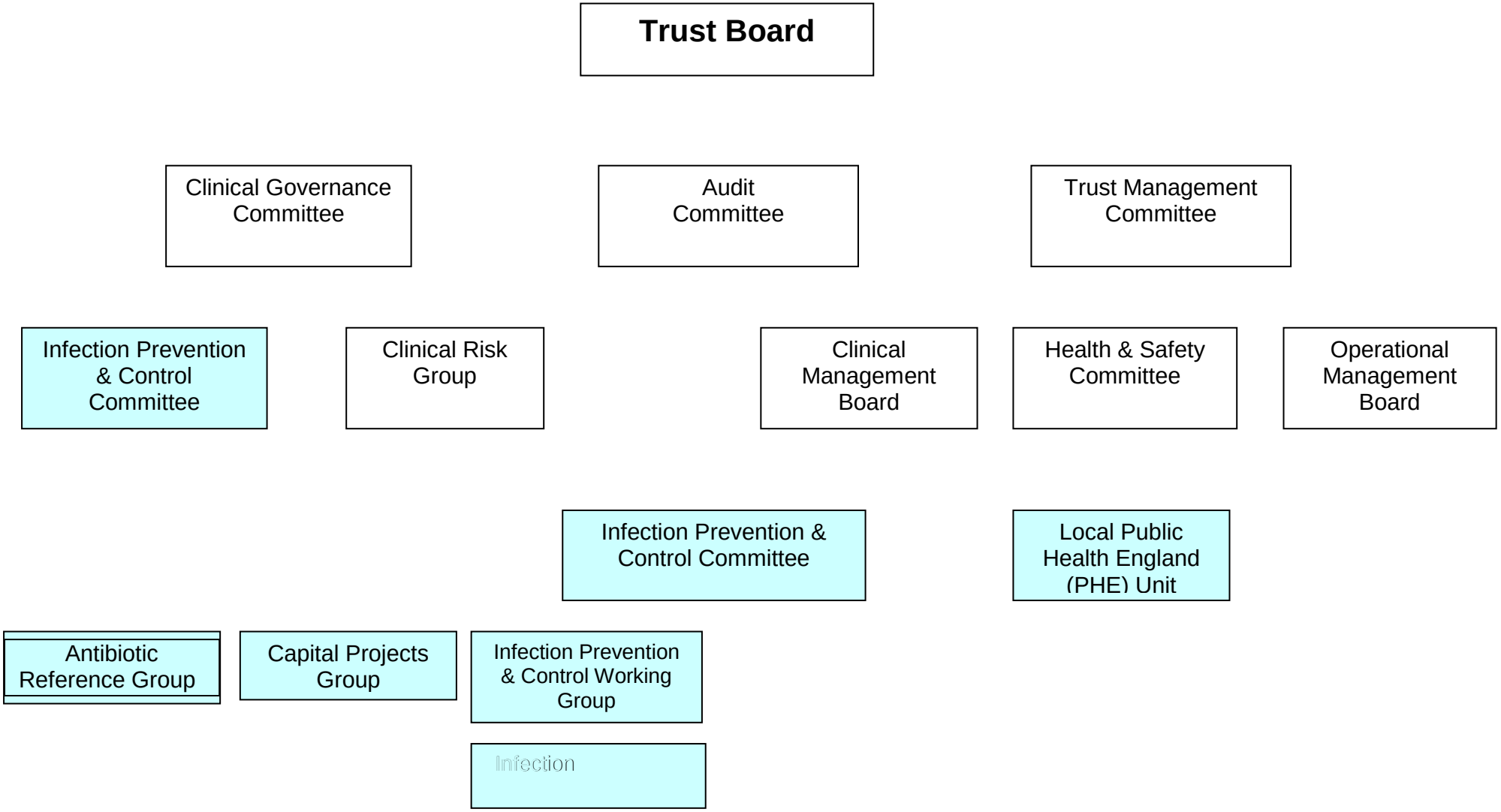
In line with the requirements of the Health and Social Care Act 2008, a programme of infection prevention and control audits is illustrated in the annual audit programme. The programme ensures that audit is clinically focused and targeted at improving infection prevention and control practices for all disciplines across the Trust.

The ICNs have been involved with the following audit work during quarters 1 and 2 of 2018/19, including the follow up and outcomes from auditing against infection control policies. Final reports are generated for each completed audit, with resulting action plans approved by the IPCWG before submission to the IPCC and Clinical Management Board (CMB):

- Handling and Disposal of Linen Reaudit – data collection was completed during quarter 159 Pass ille

Domain and Key Actions	Who By	Status

Domain and Key Actions	Who By	Status
1.11 Duty to ensure, so far as is reasonable 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.		
Ensure all staff can access relevant occupational health & safety services (OHSS)	PH	Continuous
Ensure occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisations, are in place	PK	MCIe62J.08 r(MCn2s05 3n2 TD [/P <
Continue the provision of infection prevention and control education at induction	IPCT	
Continue the provision of ongoing infection prevention and control education for existing staff	IPCT	
Continue recording and maintaining training records for all staff via the MLE	Education Dept.	
Ensure infection prevention and control responsibilities are reflected in job descriptions, appraisal and objectives of all staff	DIPC/DMTs	
Enhance and monitor the role of the Infection Control Link Professionals	DSNs/ICNs	

APPENDIX B

Formal Trust Reporting Structure