Southend University Hospital NHS
NHS Foundation Trust

Infection Prevention and Control Annual Report 2015/2016

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GLOSSARY	
ARHAI	Advisory committee on Antimicrobial Resistance and Healthcare Associated Infection
C. diff	*Clostridium difficile*
CAC	Clinical Assurance Committee
CCG	Clinical Commissioning Group
CDI	*Clostridium difficile* infection
CNS	Clinical Nurse Specialist
CPA	Clinical Pathology Accreditation
CQC	Care Quality Commission
DDIPC	Deputy Director of Infection, Prevention & Control
DIPC	Director of Infection, Prevention and Control
DoH	Department of Health
GRE	Glycopeptide resistant Enterococci
HCAI	Healthcare Associated Infection
HII's	High Impact Interventions
IOS	International Organization for Standardization
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCN	Infection Prevention and Control Nurse
IPCT	Infection Prevention and Control Team
MRSA	Meticillin resistant *Staphylococcus aureus*
MSSA	Meticillin sensitive *Staphylococcus aureus*
NHSLA	National Health Service Litigation Authority
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient Led Assessments of the Care Environment
RCA	Root cause analysis

GLOSSARY	
SEQOHS	Safe, Effective, Quality Occupational Health Service
SSI	Surgical Site Infection
SUHFT	Southend University Hospital Foundation Trust
UKAS	United Kingdom Accreditation Service

1. Executive Summary

- This is the report of the Deputy Director of Infection Prevention and Control on behalf of the Director of Infection Prevention and Control, and summaries the work undertaken in the organisation for the period 1st April 2015- 31st March 2016
- This has been a very challenging year for Southend University Foundation NHS Trust due to increasing staffing difficulties in clinical areas and problems with the flow of emergency patients through the hospital in the last quarter of the financial year
- There were 26 cases of Clostridium *difficile* during this period against a trajectory of 30. All cases were investigated via a Root Cause analysis (RCA), which concluded that 23 cases appropriate care had been delivered and 3 cases were classified using the Public Health England criteria as lapses in care
- There were 2 cases of MRSA bacteraemia against a trajectory of 0
- The mean hand hygiene compliance score was 98.48%. The IPCT also carried out ad-hoc hand hygiene audits
- Mitigation and enhanced monitoring continued to control pseudomonas and legionella in tap water in high risk areas

2. Summary of Infection Key Issues

MRSA Bacteraemia

- This year there were 2 cases against a trajectory of 0 (appendix 2)
- 1 case reported in September 2015 was deemed as a contaminant. The sample was taken from an arterial site of a known MRSA colonised patient
- 1 case reported was allocated to 'Third Party'. Following the Post Infection Review Meeting (PIR) it could not be established which organisation the MRSA bacteraemia should be assigned to. Therefore this case was not included in our figures.
- I case reported February 2016 was a neonatal case who had multiple congenital problems, an immature immune system, multiple lines/ cannula plus several courses of antibiotics. Following the Post Infection Review (PIR) it was agreed by all that the most probable root cause of this bacteraemia was the respiratory tract

- Education, training and support to improve practice in line management, protocols in relation obtaining blood cultures was undertaken

Clostridium difficile (C. diff)

- The Trust reported 26 hospital-attributed cases for this period (appendix 3). All hospital attributed case samples were sent to Colindale Public Health England (PHE) for typing. The strains identified were diverse reflecting the distribution and carriage in the community

- 3 cases were classified as direct lapses in care. It was identified that antibiotics that were not prescribed and delivered in accordance with the Trusts Anti biotic policy

- The root cause of the majority of the cases was associated with appropriate antibiotics in patients with serious infections which are not preventable and life threatening if not treated with the appropriate antibiotics. As in previous years, many of these cases were immuno-supressed

- Laxative usage was appropriate in the cases reviewed and often related to pain relief. Several cases had underlying bowel disease or had undergone bowel surgery

- The main learning points from the review of these cases for 2015/16 were associated with obtaining specimens early, delay in isolation, poor completion of stool charts and disseminating learning from the RCA process

Surveillance

Surgical Site Surveillance encourages hospitals (both NHS and private) to use surveillance to improve the quality of patient care by embedding them to collect and analyse data on Surgical Sire Infections (SSI) using standardised methods.

Surveillance of large and small bowel surgery was undertaken April-June 2015 followed by Total Hip Replacements (appendix 4) in line with our mandatory orthopaedic requirements for Surgical site surveillance. The IPCT would have ideally liked to have extended this surveillance with additional surgical techniques; however this was not achievable in the last year within the resources available, due to sickness levels within the IPC team.

MRSA screening

Continuing work to achieve 95% screening for all Emergency admissions and Elective admissions that meet the screening criteria continues. The DDIPC and Matrons regularly examine methods of achieving the 95% target. On examination the Emergency screening omissions tend to occur when the volume of patients' admissions is higher than usual or when staff are not substantive in that area. This has been addressed with training and embedding screening as part of the admission and pre elective procedures.
Elective screening has proved more challenging in light of on-going operational difficulties resulting in many elective operations being cancelled. There is large number of patients that have and will exceed the 18 weeks wait for their procedures. These patients who were originally screened at pre assessment or in outpatients have MRSA screens which may breach the18 week valid time period as stated in the current MRSA policy.
To address the potential missed/ lapsed screening issue patients who have breached this 18 week valid time line, will need to be re screened once an admission date has been given.
An initiative to rectify this screening problem is in the planning stage and will involve organising additional MRSA screening clinics.

Infection Control Policy audits

The Health and Social Care Act's Code of Practice (2010) requires that all NHS organisations have an audit programme in place to ensure that compliance with key polices and practice is being implemented. The audit programme is place to acquire assurance of the understanding and adherence to policies and is undertaken by the Infection Control Team. Results are reviewed at the IPCC. See appendix 6

Policies

- Existing policies continue to be reviewed and updated systematically and several new policies written/developed and ratified this year. See appendix 7

3. Other significant issues

3.1 The Occupational Health and Wellbeing Service

- The Occupational Health and Wellbeing Service successfully gained accreditation to SEQOHS in 2012 and have been successfully revalidated every year since. This demonstrates that as an organisation we meet the national quality standards for occupational health service provision both to our NHS clients and to external clients who use our services

- The Occupational Health service continues to work with Human Resources and Managers to support the effective management of sickness absence and staff health. The HR and Occupational Health departments meet monthly to review service activity so that trends can be identified and remedial measures put in place, and to discuss particular sickness absence cases to ensure that appropriate support is available both to the individual and to management teams

- The 2015 seasonal flu campaign saw a decrease in the uptake of flu vaccinations from 59% (2004) to 55% despite a sustained programme of workplace visits, positive communications, and increase in the number of workplace vaccinators across all shift patterns

- In the past year, the Occupational Health and Wellbeing service received 428 Management Referrals and 109 self-referrals, and 1284 new starter questionnaires were processed. In comparison to last year there was an over increase in both Management and Self Referrals but a reduction in the number of New Starter health Questionnaires (204 reduction)

3.2 Pathology Service

- The Pathology department at Southend Hospital is provided by a joint venture private company comprised of Southend University Hospital, Basildon and Thurrock University Hospital and IPP (Integrated Pathology Partnership); the company is called Pathology First and has a monitored contract to provide a clinically led service for all disciplines of Pathology. The Microbiology laboratory is accredited by CPA and is working towards ISO standards for accreditation to UKAS. The main laboratory services are situated off site at a central Hub laboratory and the clinicians are employed by the Trust and are based on site

3.3 Estates & Facilities

- The Infection Prevention and Control Team continue to support and provide advice to numerous schemes and projects to develop or create facilities and services

- Collaborative work with the Facilities Department continues to improve monitoring and reporting on cleaning standards and maintenance and monitoring of the estate
- A key issue this year has been the continuing water testing for *Pseudomonas* and *Legionella* in compliance with DoH guidelines and advice
- The Water Assurance Group has led on mitigation and management of all water safety issues with the support of the DDIPC. In some areas this has led to the removal and replacement of taps and showers, chlorination and removal of pipework

3.4 Outbreaks & Incidents

- There was one confirmed outbreak in the last year involving 4 confirmed cases of Multi-resistant Acinetobacter baumanii (MRAB) within the Critical Care Unit. This was contained within the unit. An examination of critical care practices and enhanced environmental decontamination was undertaken with continued promotion of good hand hygiene practices via IPC training. By way of controlling the outbreak, each MRAB patient was isolated and their immediate environment was terminally cleaned with enhanced use of disinfectants during their stay
- Control measures addressing these potential sources of MRAB were successful in terminating this outbreak. On-going surveillance and continued attention to hand hygiene and environmental cleaning have been essential in the prevention of a reoccurrence. No patient died as a result of MRAB and there was no apparent excess mortality in MRAB patients
- The Trust did not have any outbreaks of Noro - Virus

3.5 Education

- Staff training has continued throughout the year, both formally and informally. Much of the training is ad-hoc on a daily basis when IPCN's visit the clinical areas. Due to staffing issues the IPCT were unable to deliver the Link Nurse Sessions for 2015 and early 2016. The final infection prevention and control mandatory training compliance percentage for 2015/16 : 88% against an internal target of 85%

- Much work has gone to revamping the IPC on line training package (iLearn). It is planned to go live April 2016.Staff will be able to gain compliance in less than 15 minutes by viewing the bespoke core video via iLearn. The face to face sessions will continue on a monthly basis for those staff who do not have computer access or prefer the face to face training

Governance arrangements

The Board of Directors has a collective responsibility for keeping to a minimum the risk of infection. The Board discharges this responsibility in the following ways:
As from October 2015, the Chief Nurse took over from the Head Nurse of Infection Prevention and Control as the designated Director with responsibility for infection prevention and control (DIPC).

The Head Nurse for IPC is the Deputy DIPC
The DIPC reports directly to the Chief Executive and the Board of Directors. Infection rates are reported to the Board monthly and the Infection Prevention Control Committee reports activity to the Clinical Assurance Committee which is a sub-committee of the Board.

Infection Prevention and Control Programme

- The infection prevention and control programme is published annually and progress with the annual work plan are monitored through the IPCC (appendix 6)

The Infection Prevention and Control Committee

IPCC is a key forum for the development and performance management of the infection control agenda across the organisation. The Committee meets bi-monthly and is chaired by the DIPC with key representation from across the organisation. Membership includes the IPCT, a number of senior management and senior nurses, the Occupational Health Department, clinical governance staff, Pharmacy, Estates and Facilities staff and external bodies such as the local Public Health England (PHE) Health Protection Unit and Clinical Commissioning Groups Infection Control (CCG).

Assurance Framework

The hospital has an Infection Prevention and Control Strategy IC016. This sets out the clear objective for the hospital of ensuring that patients' safety in respect of IPC is delivered.

The DDIPC provides a monthly performance report on behalf of the DIPC to the Executive Team on a number of infection prevention and control measures. This includes the Trust's current position against Department of Health ceilings for MRSA bacteraemia and C*lostridium difficile* infections. The Trust Board receives a report on the incidence of MRSA bacteraemia and of *Clostridium difficile*, and of learning and practice changes instigated as a result of the outcome of root cause analysis and Post Infection Reviews (PIR).

Post Infection Reviews and Root Cause Analysis are undertaken for all cases of *Clostridium difficile* and MRSA bacteraemias that are hospital apportioned. Any case not hospital apportioned is investigated by the CCG to identify any links to the hospital or community issues.

The assurance process includes both internal and external measures. Internally the accountability is exercised via the IPCC ensuring that there is robust scrutiny of compliance with national standards, local policies, and clinical practice and following post infection reviews (PIR). External assurance is obtained through the Care Quality Commission (CQC) registration and unannounced visits, assessment by the National Health Service Litigation Authority (NHSLA) against their standards for infection control and the Patient Led Assessments of the Care Environment (PLACE).

Infection Prevention and Control Infrastructure

The Infection Prevention and Control Team structure is as follows:

- The Chief Nurse is the Director Infection Prevention and Control
- 1.0 WTE Head Infection Control Nurse /Deputy Director Infection Prevention and Control
- 2.0 WTE infection control nurses (ICN)
- 1.0 WTE Infection Control Office Manager
- Our Consultant Microbiologist left the Trust in April 2016 and since then we have been supported by our previous substantive Consultant Microbiologist. Two Consultant Microbiologist posts are now vacant, unfortunately the Trust has been unsuccessful in recruiting to these posts and they are currently covered by locums until the Trust are able to recruit It is worth noting that other local Trusts have had difficulty recruiting Consultant Microbiologists. This has been recorded on the Trust's risk register as a low risk, as the Locum Consultants are known to the Trust
- The budget for Infection Control is held by the Chief Nurse and managed by the Head of Infection Control/DDIPC

Appendix 2 - MRSA Bacteraemias

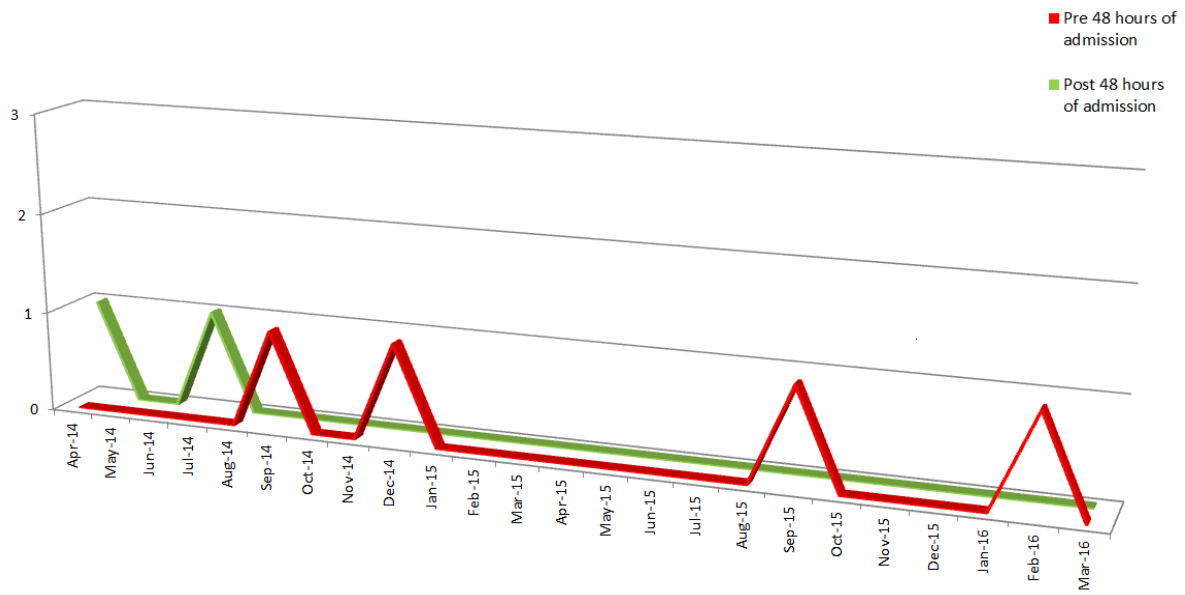
Meticillin Resistant Staphylococcus aureus (MRSA) Bacteraemia

Post Infection Review (PIR) of MRSA Bacteraemia Cases
The Trust undertakes a PIR following all cases of MRSA bacteraemia in order to identify any key issues and themes. Action plans are then put into place to address any issues. The PIR is completed by the clinicians and nursing teams involved in the care of the patient, a strategic review of the PIR is undertaken by the Consultant Microbiologist, antimicrobial pharmacist, CCG Infection Control , Infection Control Nurse and the Director of Infection Prevention and Control – the results of this review are then fed back to the clinical teams.
The PIR is required to be uploaded onto a PHE database within 14 working days of notification of the bacteraemia. This was achieved all three cases.

MRSA bacteraemia – number of post 48 hour cases Zero Tolerance												
Number of cases	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	0	0	0	0	0	1	0	0	0	0	1	0

For further information regarding our MRSA bacteraemia rates please contact the IPCT

MRSA Bacteraemia



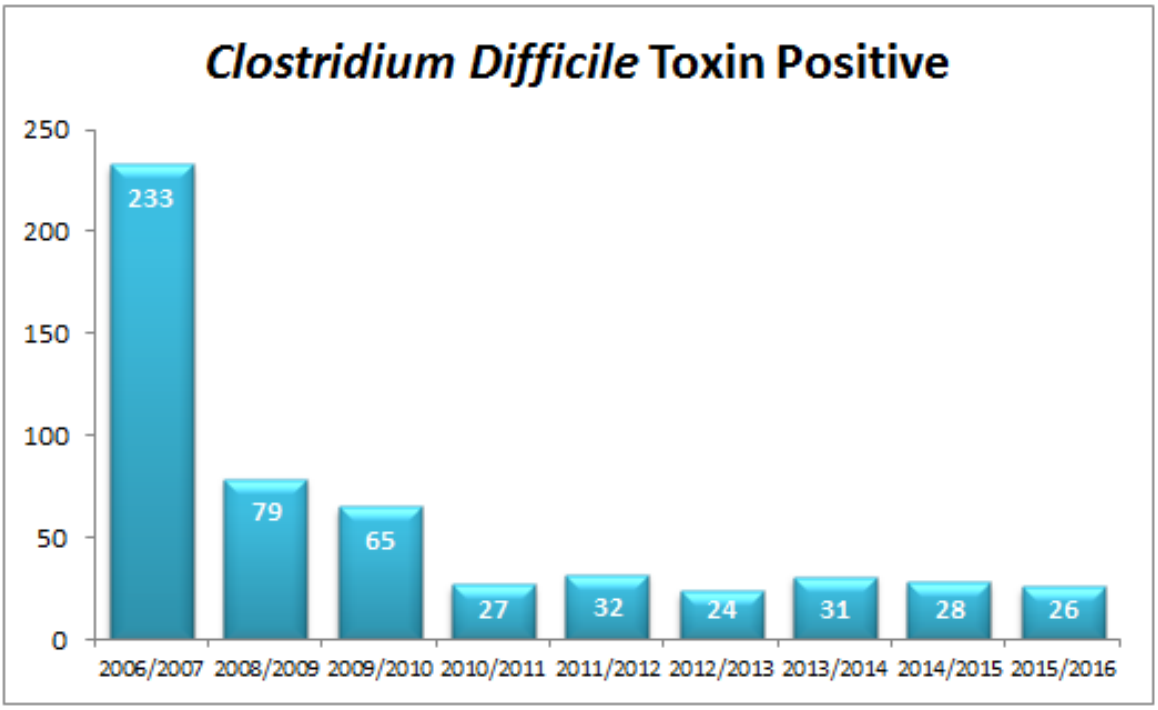
Appendix 3 - *C. difficile*

The table below shows the hospitals performance during the year. The annual ceiling for *Clostridium difficile* was 30 cases. The hospital reported 26; all cases were thoroughly investigated via a Root Cause analysis (RCA).

Clostridium *difficile* (Toxin positive) - number of post 72 hour cases Year total ceiling – 30												
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of cases	3	1	1	2	2	2	4	3	1	3	3	1

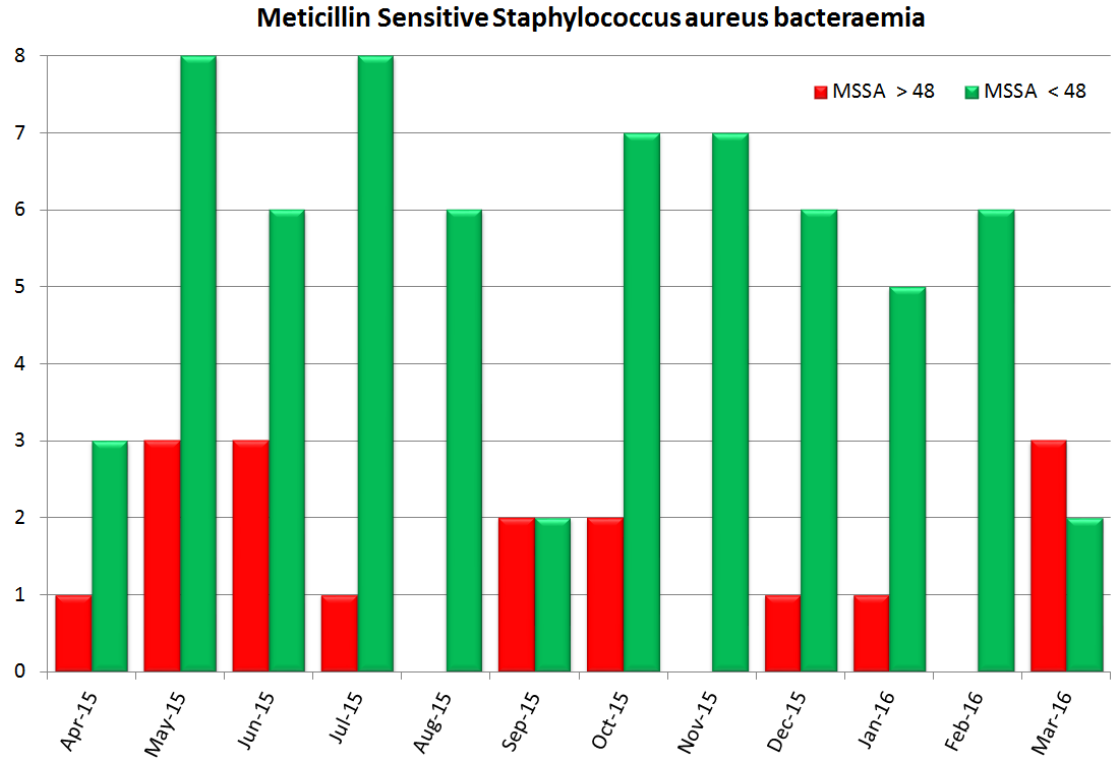
The Root Cause Analysis (RCA) process is completed by the relevant ward manager and clinical team for all hospital apportioned cases. The RCA is presented at the RCA meeting and reviewed by the Infection Control Team, Clinician, Consultant Microbiologist, Antimicrobial Pharmacist and a CCG Infection Prevention and Control Nurse.
The RCA process is required to identify direct lapses in care which may have resulted in C diff infection. This information is scrutinised by the Clinical Commissioning Group (CCG).

For further information regarding our CDI rates please contact the IPCT



Appendix 4 - MSSA

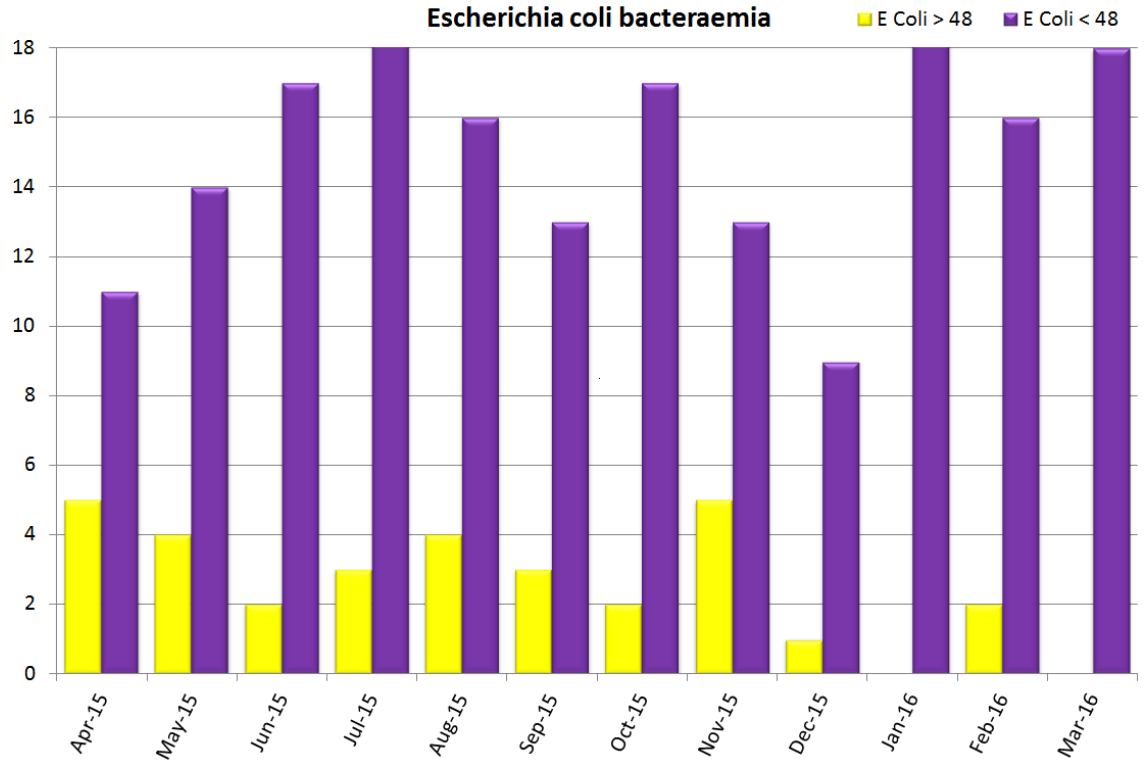
The IPCT continue to report all Meticillin Sensitive *Staphylococcus* aureus Bacteraemia (MSSA) cases via the MESS system on a monthly basis. It was anticipated that national trajectories would be set for individual Trusts for MSSA bacteraemias; however, to date that has not yet occurred. For each post 48 hours of admission MSSA bacteraemia case, a review is undertaken by the IPCT to identify any key themes which require actions.



Appendix 5 – E. Coli

There is no objective or ceiling associated with this bacteraemia and it is not included in our performance data.

However, there does appear to be a strong association of urinary catheters with genitourinary related bacteraemia. There has been a lot of work Trust wide and within primary care in relation to reducing unnecessary urinary catheterisation. This has included training and improved documentation.



Appendix 6 – Surgical Site Infection

There were a total of 37 Large Bowel procedures undertaken during this period and 5 infections reported 16 Small Bowel procedures and 2 infections reported. The ICN and relevant surgical teams undertook a review of the patients concerned and it was concluded that despite best practice the cases developed post-operative wound infections.
They noted the cases were extremely complex due to the patients presenting with multiple co-morbidities, multiple risk factors and undergoing complex surgical procedures. (5 patients had undergone chemotherapy and/or radiotherapy prior to their procedures

April-June 2015				July-September 2010 to April-June 2015		
Category	**Total number of SUHFT operations**	**Number of SSI's**	**SUHFT (%infected)**	**Total no. of operations for all hospitals**	**Total no. of SSI's for all hospitals**	**All hospitals (% infected)**
Large Bowel	37	5	13.5%	19316	2424	12.5%
Small Bowel	16	2	12.5%	4137	316	8.7%

NB: The national programme for surgical site surveillance suggests that at least 50 cases need to be surveyed in a three month period in order to obtain good quality figures which are statistically significant.

July-September 2015				October-December 2010 to July-September 2015		
Category	**Total number of SUHFT operations**	**Number of SSI's**	**SUHFT (%infected)**	**Total no. of operations for all hospitals**	**Total no. of SSI's for all hospitals**	**All hospitals (% infected)**
Hip replacement	64	1	1.6%	251275	2829	1.1%

Surveillance of orthopaedic surgical site infection (SSI) was undertaken for Total Hip Replacement line with our mandatory requirements for SSI (1 module of orthopaedic surgery for 1 quarter per financial year). The IPCT would have ideally liked to have extended this surveillance with additional surgical techniques; however this was not achievable in the last year within the resources available, due to sickness levels within the IPC team. The Trust reported just 1 surgical site for the period July- September 2015 compared very favourably with the National benchmarking.

Appendix 7 – Antimicrobial Stewardship

Department of Pharmacy Update on Antimicrobial Stewardship - May 2016

Antimicrobial stewardship continues to operate as an essential element in the Trust. Several systems are in place to tackle the growing challenges of antimicrobial resistance and improve the safety and quality of patient care.

Evidence based guidelines, organised antimicrobial ward rounds, teaching sessions, electronic prescribing system (EPS) and antimicrobial stewardship checklist are some of the measures within the Trust to reduce antimicrobial resistance, and prevent health care associated infections, whilst ensuring prudent use of antimicrobials.

Electronic Prescribing System

This quarter saw the roll out of EPS to all the surgical wards in the Trust. All admission wards now have EPS with the exception of critical care (CRC), which is currently work in progress.

The daily antimicrobial report generated by the EPS, facilitates an early identification of any patient requiring antimicrobial intervention.

As more wards are being covered by pharmacists, antimicrobial stewardship (AMS) has become one of the main focuses of the Department, and EPS has provided the support needed for this.

AMS checklist has also been implemented for pharmacists' use. This allows regular monitoring, and auditing patients on antimicrobials, to ensure they meet both the local and national standards for antimicrobial prescribing.

Antimicrobial Audit Programme

The audit of antimicrobial usage in the Directorate of Surgery was delayed due to the rolling out of EPS. However it is currently being carried out, and should be available for presentation to the Surgery clinical Governance team by July.

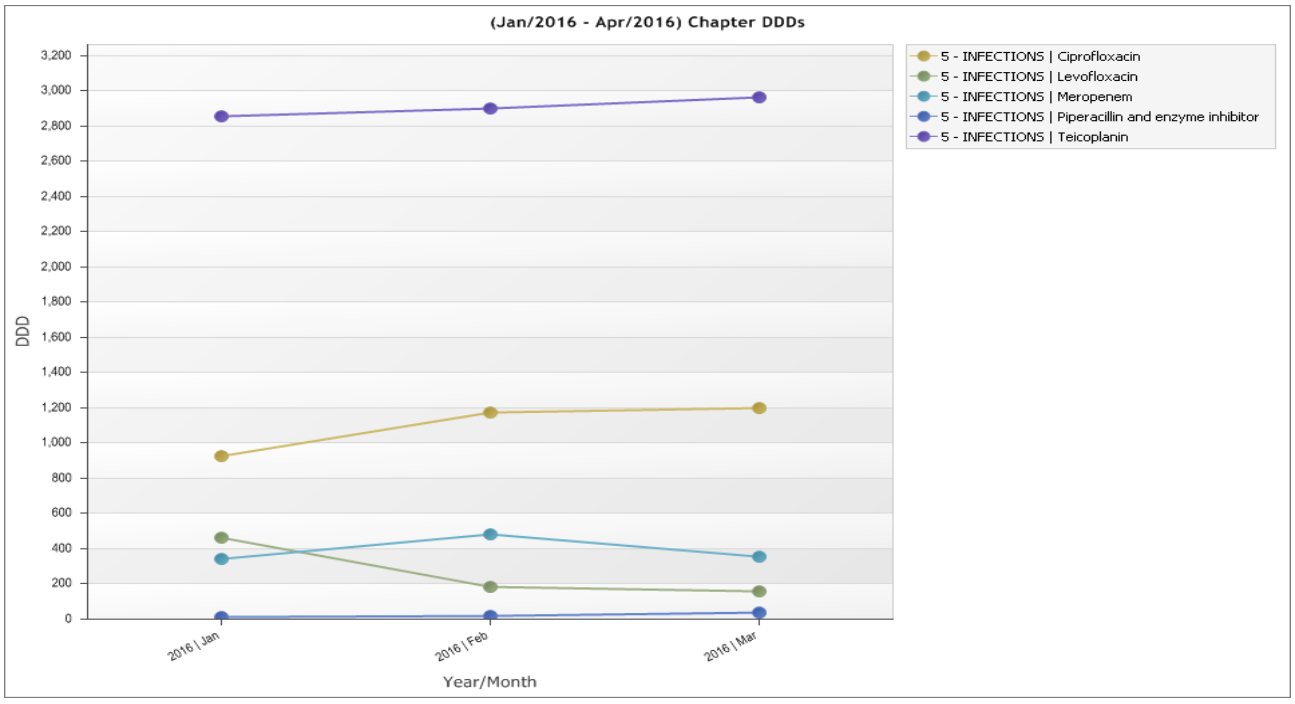
Antimicrobial Guidelines

A guideline for the use of amikacin was developed during the quarter. All the other antimicrobial guidelines that were out of date have also been reviewed and updated. These are awaiting Medicines Optimisation Committee (MOC) approval.

Antimicrobial Consumption & CQUIN

Targeting Antimicrobial resistance has been included as one of the goals of CQUIN scheme 2016/17. In order to reduce the level of resistance, regular monitoring of restricted antimicrobial usage using 'Report Plus' software continues in the Trust.

The graph below shows the usage of the restricted antimicrobials



Teicoplanin usage is on the upward trends as many patients from vascular surgery, orthopaedics and medicine are discharged home on long term intravenous antimicrobial therapy.

There's also a gradual rise in the use of ciprofloxacin in the Trust. This is commonly supplied to patients in urology; the new AMS checklist will be used to assess the quality of its use.

Antimicrobial smart phone

Work is currently in progress to implement antimicrobial smart phone application which will facilitate quick access to appropriate choice of antimicrobials, as well as provide evidence based information on antimicrobial treatment of common infections. This is expected to go live towards the later part of the year.

Appendix 8 – Policy Audits

Month	Audit	Score
April 2015	Hand Decontamination IC 009	98.8%
May 2015	Isolation Policy IC 019	97.5%
June 2015	MRSA IC 007 *C diff* IC 0017 Quarter 1	95.1% 98.95%
July 2015	Prevention of Sharps Injury HS06	93.90%
August 2015	Hand Decontamination IC 009	100%
September 2015	MRSA IC 007 *C diff* IC 0017 Quarter 2	100% 94.85%
October 2015	Isolation Policy IC 019 Care of the Deceased Patient Identified as Infectious or potentially Infectious IC013	100% 100%
November 2015	Diarrhoea and Vomiting IC025 Hand Decontamination IC 009	Nil audit 100%
December 2015	MRSA IC 007 Sharps Injury Prevention Policy HS06 *C diff* IC 0017 Quarter 3	98.3% 98.07% 94.6%
January 2016	Hand Decontamination IC 009	100%
February 2016	Standard Precautions IC 022	100%
March 2016	MRSA IC 007 Sharps Injury Prevention Policy HS06 *C diff* IC 0017- Q4	100% 100% 98.6%

Appendix 9 – Infection Control Policies

Policy Number	Policy Name	Updated / New Policy
HS06	Prevention of Sharps Injury	Aug-15
IC005	Infectious Patients in the Operating Theatre	May-15
IC006	Plan for the control of outbreaks in Southend Hospital	May-15
IC019	Isolation Policy	Jun-15
IC035	Linen Handling Policy	Nov-15
IC036	Microbiological Sampling of Theatres	Sep-15
IC038	Mattress Policy	Feb-16
IC039	Management of PVL-associated Staphylococcus aureus infections	Aug-15
IC040	Infection Prevention and Control Practice in the Operating Department	Aug-15
IC041	Toy Cleaning Policy	Nov-15

Appendix 10 - Summary of progress with the Infection Prevention & Control Work Plan

The work plan is for 2015 – 2017

	Issue	Key Actions	Progress
1	Infection prevention and control advice is required to deliver safe patient care to prevent transmission or infection or outbreaks	• Continue the delivery of the infection prevention and control advisory service This is provided 8am - 5pm during working hours • Microbiologist provides 24 hour cover for infection control • Quarterly Infection and Prevention reports to the IPCC and CCG • Provide HCAI statistics for performance reporting at Board of Directors and at the IPCC, including details of trends • Continue to undertake root cause analysis and Post Infection Reviews for HCAI (MRSA bacteraemia, Clostridium difficile). • Evidence of lessons learnt through the RCA process are shared and agreed .Evidence of actions implemented produced an action plan	On-going
2	Improve antibiotic management and prescribing practice	• The antibiotic pharmacist leads on this and produces regular reports • Compliance with the trust antibiotic prescribing and management guidelines is reported quarterly via the IPPC and Antibiotic Group	Quarterly
3	Provision of infection control policies and guidance	• IPCT continue to produce new policies as required review and update current policies, guidance and information in line with relevant current information legislation	On–going
4	Information for patients, relatives and staff will	• The IPCT continue to design and produce information	On–going

	Issue	Key Actions	Progress
	be provided	for patients, relatives and staff. The production of a CDI card for previous CDI cases is under production.	
5	Audits to ensure compliance with practice	• Continue with audit programme of IPC policies. Results sent to matrons for dissemination and is a standing agenda item at IPCC	As per auditing schedule
6	Improve the efficiency and quality of the service provided by the IPCT	• Sickness and other issues have hampered progress this year but this has now improved. A key action this year will be to raise the profile of the team and also of the Infection Control Link Nurses	On–going
7	Isolation improvements	• Delays in isolation continue due to limited capacity issues. Isolation practice and capacity continue to be monitored intermittently and report via IPCC Planned for 2016 is a review of IPC isolation signs	On–going
8	MRSA screening compliance	• Continue to monitor screening of emergency and elective patient's data on a quarterly basis and report to IPCC and CCG. Support matrons with screening compliance	Quarterly
9	Compliance with national decontamination guidance	• Work continues to ensure compliance with recommended practice	On–going
10	Provision of expert infection control advice on planning, building , renovations and other developments	• Provide expert advice to all service developments to ensure infection risks are considered and good infection prevention facilities/practices built into the development • In particular, ensure that infection prevention is considered in the built environment through provision of infection prevention expertise to capital projects from concept stages to commissioning, as well as more minor refurbishment projects	On–going
11	Facilitate and support the optimal cleaning of the environment and equipment	• Work to improve education and understanding of cleaning responsibilities	On–going
12	Facilitate and support the delivery of	• Continue to support effective monitoring and controls	On–going

	Issue	Key Actions	Progress
	environmental controls including water and ventilation		
13.	Specific environmental improvements to reduce the risk of HCAI	• In conjunction with the Matrons, the Domestic Services continue to promote and support cleanliness and support initiatives to improve cleanliness	On–going
14.	Optimal hand hygiene and infection control compliance	• Continue education and support for ward staff to undertake hand hygiene compliance. Hand hygiene compliance to be monitored in all in-patient areas monthly. Areas of non- compliance to be discussed at IPCC • A plan to review hand gel and soap for 2016/2017	On–going
15.	Prevention of sharps injuries in compliance with national and EC guidance which increases the requirement to prevent needle stick and other sharps injuries	• The Trust has already introduced a range of safer devices and this will continue • Yearly external sharps safety audit	On–going
16	Continued to participation in the Surgical Site Surveillance Schemes	• Reports circulated to relevant surgeons and SSI data reported at IPCC	On–going