NHS
Southend University Hospital
NHS Foundation Trust

Board of Directors Meeting Report – 4 December 2018

Agenda item 77/18

Title	Director of Infection Prevention and Control Report - October 2018
Sponsoring Director	Celia Skinner - Chief Medical Officer and DIPC
Author(s)	Denise Townsend – Director of Nursing and Site DIPC Emma Dowling – Deputy Director Infection Prevention and Control Laura Search – Office Manager
Purpose	To inform the Trust Board of compliance with mandatory Department of Health targets and other Key Performance Indicators for infection prevention and control To identify key infection risks to the organisation and their mitigation
Previously considered at	Senior Leadership Team Meeting (SLT)

Executive Summary:

- 1 case of MRSA Bacteraemia (MRSAb) year to date. 0 cases of post 48 hours of admission attributed to the Trust in October.
- 16 cases of *C diff* plus 72 hours of admission year to date, ceiling of 29 cases. 1 case reported in October.
- YTD performance against last year's IPC rates at this point in time is significantly improved. The further challenge is the continued sustainability of performance.
- MRSA screening compliance currently remains below the Trusts internal target of 95%. Due to data validation processes, screening data is not available at time of this report.
- It is pleasing to note that there have been no outbreaks to report.

Related Trust Objective	Excellent Patient Outcomes / Excellent Patient Experience / Engaged and Valued Staff
Related Risk	**Risk 1** - Failure to provide adequate patient safety , quality of care and patient experience due to capacity, demand and external agency stakeholder engagement **Risk 2** - Failure to meet constitutional and national performance targets **Risk 8** - Failing to meet CQC Health & Social Care regulations
Essex Success Regime	Re-structuring of the Infection Control teams across the three sites is in progress. Alignment of policies and process, including peer review audit process is also in progress. Effective utilisation of a group model will enable shared learning and good practice and will strengthen governance arrangements.
Legal implications / regulatory requirements	CQC non- compliance
Quality impact assessment	Risk assessments have been undertaken, potential harm identified and control measures implemented. Continuous auditing is undertaken to ensure adherence to controls measures is maintained
Equality impact assessment	As far as can be ascertained this paper has no detrimental impact for the 9 protected characteristics under the Equality Act 2010.

Recommendations:
The Board is asked to receive assurance from the report.

Mandatory Figures

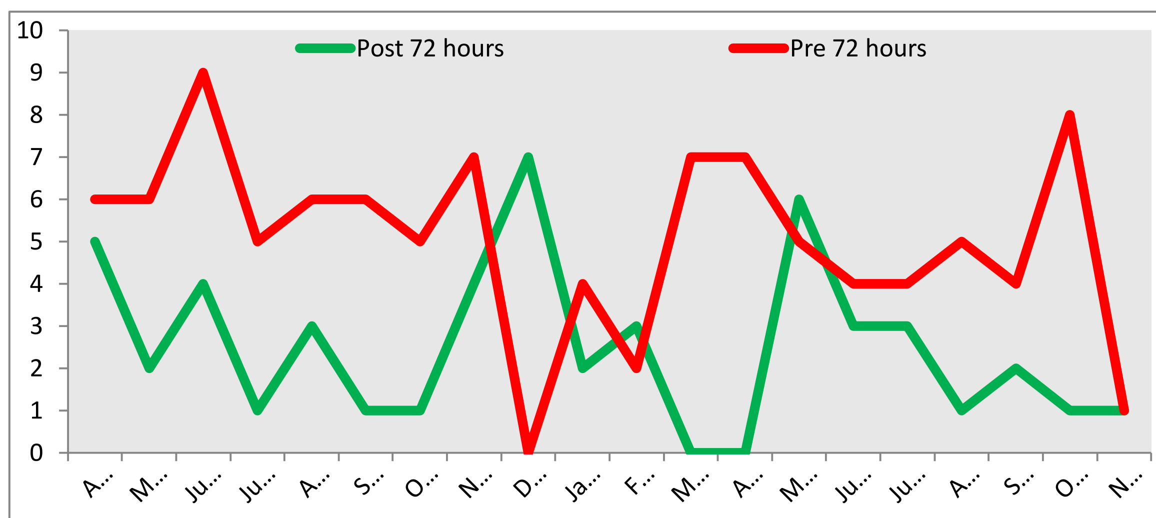
MRSA bacteraemia – 0 tolerance	October	0	Attributed to SUHFT	1	YTD
***Clostridium difficile* – ceiling 29**	October	1	Plus 72 hours	16	YTD
MSSA bacteraemia	October	1	Plus 48 hours	4	YTD
***E Coli* bacteraemia**	October	2	Plus 48 hours	19	YTD
Klebsiella bacteraemia	October	2	Plus 48 hours	7	YTD
Acinetobacter bacteraemia	October	0	Plus 48 hours	0	YTD
Pseudomonas bacteraemia	October	1	Plus 48 hours	7	YTD

Trend Analysis of SUHFT Infection Prevention Key Performance Indicators 2018/19 – *cases with asterisk are attributed to SUHFT

Number of MRSA bacteraemia cases – (0 tolerance)													
(April 18- March 19)		**Apr 18**	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Oct 18**	**Nov 18**	**Dec 18**	**Jan 19**	**Feb 19**	**Mar 19**
Pre 48 hour cases		0	0	0	0	0	0	0					
Post 48 hours cases		0	0	0	0	0	1	0					
Total		**0**	**0**	**0**	**0**	**0**	**1**	**0**					
Main themes from Root Cause Analysis	**April**	None											
	May	None											
	June	None											
	July	None											
	August	None											
	September	1 post 48 hour case, contaminant (wrong bottle inoculated) – addressed with Dr by DDIPC											
	October	None											
	November												
	December												
	January												
	February												
	March												

Number of cases of *C. difficile* – (ceiling 29)													
(April 18- March 19)		**Apr 18**	**May 18**	**Jun 18**	**Jul 18**	**Aug 18**	**Sep 18**	**Oct 18**	**Nov 18**	**Dec 18**	**Jan 19**	**Feb 19**	**Mar 19**
Pre 72 hour cases		7	5	4	4	5	3	8					
Post 72 hours cases		0	6	3	4	1	2	1					
Total		**7**	**11**	**7**	**8**	**6**	**5**	**9**					
Main themes from Root Cause Analysis	**April**	No plus 72 hour cases											
	May	All 6 RCA's reviewed, nil direct lapses in care identified											
	June	All 3 RCA's reviewed, nil direct lapses in care identified											
	July	All 4 RCA's reviewed, nil direct lapses in care identified											
	August	1 RCA reviewed, nil direct lapses in care identified											
	September	All 2 RCA's reviewed, nil direct lapses in care identified, 1 case to be signed off by JCT at time of report											
	October	1 case awaiting JCT sign off,											
	November												
	December												
	January												
	February												
	March												
Agreed Joint		**Outcome 1**				**Outcome 2**				**Outcome 3**			

Commissioning Team outcome from Root Cause Analysis	Direct lapse in care / breach in policy leading to CDI	Breach in policy leading Patient safety issue but not CDI	No direct lapse in care / breach in policy leading and Patient safety issue
	October 0	October 0	October 0
Comments	1 case awaiting JCT sign off		



Number of cases of *C. difficile* / Colitis – Reported on Death Certificate	
April	Less 72 hours case - *Clostridium difficile* colitis recorded on part 1b of death certificate
May	Post 72 hours case Part 1a Death Cert, SI raised
June	None
July	None
August	None
September	None
October	None

Audit of the Control and Management of *C. difficile* Policy IC017	
Outcome	Audit if the C. difficile policy is 100% compliant YTD. It is undertaken on all in patients with a confirmed stool culture which is C difficile toxin positive .These include both pre and post 72 hours of admission.

30 day Mortality of Deaths (30 days post positive sample)

(April 18- March 19)	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
MRSA bacteraemia	0	0	0	0	0	0	0					
Clostridium difficile	1	1	0	0	1	0	0					
April	Less 72 hours case - *Clostridium difficile* colitis recorded on part 1b of death certificate											
May	Post 72 hours case											
June	None											
July	None											
August	Post 72 hours case, part 2 of death certificate											
September	None											
October	None											

Number of MSSA bacteraemia cases

(April 18- March 19)	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Pre 48 hour cases	4	6	3	4	5	3	4					
Post 48 hours cases	0	0	1	1	1	0	1					
Total	**4**	**6**	**4**	**5**	**6**	**3**	**5**					

Bacteraemia due to MSSA is part of the mandatory surveillance programme. There is no objective set and no reduction targets in place. All cases are reviewed as best practice in order to identify any that could have been avoided. All of the cases are reviewed by an ICN using a MSSA bacteraemia data record form .This includes a review of the patients antibiotics, co morbidities, surgery, invasive device details and length of stay. Lessons learned are shared with the directorates, to date there have not been any breaches in policy or lapses in care identified.

Number of *E coli* Bacteraemia													
(April 18- March 19)		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Pre 48 hour cases		20	20	21	23	17	19	19					
Post 48 hours cases		4	4	4	4	0	1	2					
Total		**24**	**24**	**25**	**27**	**17**	**20**	**21**					
Main themes from Root Cause Analysis	**April**	1 bowel, 1 liver, 1 GI tract, 1 urinary tract.											
	May	1 LRTI, 1 GI tract, 1 urosepsis, 1 urinary tract.											
	June	1 gall bladder, 1 urinary tract, 1 unknown(Pt HIV), 1 urine											
	July	1 bowel, 1 prostate, 1 wound site, 1 catheter											
	August	No cases post 48 hour											
	September	1 Intestinal infection / gastro											
	October	1 C section wound, 1 Hepatobiliary											

Mandatory surveillance was extended to include bacteraemia due to *E.coli* in 2011. There is no objective set for this and no reduction targets. Due to the nature of this organism higher numbers of cases are identified on admission to hospital.
All of the cases are reviewed by an ICN using a bacteraemia data record form .This includes a review of the patients antibiotics, co morbidities, surgery, invasive device details and length of stay . Lessons learned are shared with the directorates, to date there have not been any breaches in policy or lapses in care identified.

MRSA screening compliance												
(April 18- March 19)	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Elective	86.98	86.87	91.88	86.26	87.77	84.24						
Emergency	92.01	91.94	91.43	92.93	90.56	90.50						
Average overall score	91.49	91.28	91.49	92.05	90.17	89.67						

A monthly review of categories and screening data continues to be undertaken by the DDIPC and missed screen data is sent to the relevant Matrons to action. Codes and exclusion criteria coding for procedures, length of stay and admissions are scrutinised on a monthly basis to identify exclusions that do not require being included the screening.
Screening data is discussed at all Senior Sisters meetings and is included in Directorate Performance Reports.
A MRSA screening improvement trajectory will be reported in the November report.

Number of Multi Resistant Acinetobacter baumanii (MRAB) colonisations	
Comments	2 colonisations in April, no further cases identified. In High risk areas including ICU and Wound Management Unit, we continue to screen for MRAB on admission and weekly and on patients that are transferred from other Trusts.

Hand Hygiene % compliance												
(April 18- March 19)	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Anaesthetic & Critical Care	99	100	99	99	100	100	100					
Diagnostic & Therapeutic	100	100	100	100	-	100	100					
Medicine	99	98	95	97	96	99	97					
Musculoskeletal	100	100	100	100	-	-	100					
Ophthalmology	100	100	99	100	99	99	100					
Surgery	99	100	97	99	97	97	98					
Women & Children	100	99	99	100	99	100	100					
Overall average %	**99**	**99**	**98**	**99**	**98**	**99**	**99**					

The IPCT continues to undertake regular spot checks of hand hygiene and BBE compliance to ensure that there is scrutiny of the compliance for the hand hygiene audits.

Surgical Site Infection(s)

Total hip replacement April 2018 – September 2018, 2 SSI's reported to date. This is below the National Rate for this category.

Ward closures/incidents/Other

Scabies

2 patients were admitted from a local Residential Care Home. The Residential Home was in the process of treating its residents for a suspected Scabies outbreak. Due to communication issues only 1 of the patients admitted received scabies treatment.
Following advice from Public Health England, patients who were identified as being inpatients on the ward at the same time as the potential patient incubating scabies were identified. During this period there was no evidence of hospital transmission. Both the patients and their GP's were informed by letter advising them to contact their GP if they became symptomatic.

Staffing

From August one band 7 Infection control nurse was seconded to MEHT to support the IPC Service for a period of 4 months due to the gaps in their staffing levels in the IPC team. Although this reduced the IPC at SUHFT we took this as an opportunity to develop other clinical staff successfully appointed both a band 3 Infection Control support worker and a band 6 Registered Nurse to develop their skills in IPC for a period of 6 months.

The monthly Infection Control MSB Meeting continues to discuss IPC issues and share learning .

Influenza

Influenza/ Norovirus

Flu vaccine uptake rate at end October 41% with incentives for staff to participate was launched.

No reported outbreaks of flu during the month of October.