INFECTION PREVENTION
&
CONTROL

ANNUAL REPORT

2007-08

Northern Devon Healthcare Trust

Carolyn Mills

David Richards

Directors of Infection Prevention & Control

Abbreviations:

AWG	Antibiotic Working Group
CDAD	*Clostridium difficile* Associated Disease
DIPC	Director of Infection Prevention & Control
GRE	Glycopeptide resistant enterococcus A form of the organism, enterococcus, which is resistant to the glycopeptide antibiotics, Vancomycin & Teicoplanin.
HCW	Healthcare worker
ICN	Infection Control Nurse
IPCC	Infection Prevention & Control Committee
IPCT	Infection Prevention & Control Team
MRSA	Meticillin resistant *Staphylococcus aureus* A form of the common organism *Staphylococcus aureus* which is resistant to penicillin and related antibiotics, but can usually be treated by a range antibiotics, both tablets and injection
NDHT	Northern Devon Healthcare NHS Trust
PEAT	Patient Environment Action Team
PPI forum	Patient & Public Involvement Forum
wte	whole time equivalent

NB The format of this report is based on a pro forma issued by the Inspector of Microbiology.

Contents

Executive summary:

Infection Prevention & Control continues to be one of the highest priority objectives within NDHT and nationally within the Department of Health, South West Strategic Health Authority, Devon PCT and with the public. MRSA, *Clostridium difficile* and spot inspections by the Healthcare Commission has ensured that Infection Prevention & Control has stayed in the headlines in 2007/08

In summary the key points for NDHT for 2007-08 are:

- Reduced rates of *Clostridium difficile* in 2006 have been maintained into 2007-08. The Devon Primary Care Trust set NDHT a target of no more than 174 cases in those over 65 years of age for 2007-08. There were a total of 99 cases for this year, well below the target. During 2007-08 a process of root cause analysis has been used by the IPCT and the clinical teams to look at factors, especially antibiotic use, that may have contributed to each case of *Clostridium difficile* that may have been acquired at the Trust. The results of this analysis are discussed at the IPCC and the antibiotic working group so that actions to improve practice can be shared and implemented.
- A continued rise in the overall rate of hand hygiene compliance across the Trust with a good improvement in the compliance by doctors Hand hygiene compliance is one of the cornerstones of good infection control practice. The audit results show that overall compliance has risen steadily over the year from 72% to 89%. However analysis of staff groups shows that the compliance of nurses is very good rising from 81% to 93% and that for doctors is not so good but has increased significantly from 63% to 81%. The aim is to demonstrate 100% compliance and to have continually improving results as the Trust approaches this goal.
- Rates of infection following total hip replacement surgery are below the national average
- The Trust is compliant with the Infection Prevention & Control element of Standard 4a of Standards for Better Health. The Trust self assess against

these standards and reports to the Healthcare Commission. Standard 4a includes compliance with the 'Code of Practice for the Prevention and Control of Health Care Associated Infections' (part of the Health Act 2006).

- Additional resources have been allocated to increase the numbers of staff in the Infection Prevention & Control Team, and a part-time Antibiotic Pharmacist was appointed.
- The Department of Health's target to reduce MRSA bacteraemias by 50% by 2007-08 has meant that the limit for the Trust for this year was reduced to twelve. The Trust failed to stay within this limit, recording 15 bacteraemias for the year. Six (40%) of these were related to infections acquired outside the Trust. However there were only 6 bacteraemias in the second half of the year which is within the limit set. Of the bacteraemias related to infections acquired inside the Trust the largest numbers are related to infections of lines (both central and peripheral lines) and urinary catheters. The Trust has implemented the Saving Lives programme to specifically address these areas.
- Infection Control training is in all annual update training for staff and some e-learning packages are now available on the Intranet.
- Monitoring of High Impact Interventions using the Saving Lives audit tools have been commenced with monthly reports on performance to the IP&CC.

Introduction

In North Devon the IPCT provides an integrated IPC Service via SLAs to North Devon. The team covers NDHT, a reactive service to GP practices and nursing homes in North Devon managed by Devon Primary Care Trust (DPCT), services provided on the NDDH site by Devon Partnership Trust (DPT), the Health Protection Agency (HPA) in North Devon and to Stratton Hospital. Thus what would otherwise be five very small teams can combine their staff.

Description of infection control arrangements

Staffing and Finance

2007-08 has seen the appointments additional members of the IPCT: a clinical manager Infection Control and Tissue Viability at band 8b (1.0 wte) and two ICNs (1 wte replacement post, 0.7 wte new post). Due to a national shortfall in qualified IPC nurses these posts are developmental posts initially appointed at band 6, but with agreement, once the relevant knowledge and skills have been acquired, to be moved to band 7 posts. There was also the appointment of an Antibiotic Pharmacist (0.5 wte) at band 8a.

There are two Consultant Medical Microbiologists who contribute medical input to the IPCT. One of these is the Infection Control Doctor and Joint Director of Infection Prevention & Control (DIPC) for the Trust. The DIPCs are directly responsible to the Chief Executive for Infection Control issues within the Trust and report directly to the Trust Board.

The Infection Control Team is available to provide advice 24 hours a day. The out of hours service is provided by the Consultant Medical Microbiologist on call.

Infection Prevention & Control Team members (on 31/3/08):

Band 8b	0.7	wte	Clinical Manager Infection Control
Band 8a	1	wte	Lead Infection Control Nurse, Clinical Nurse Specialist Infection Control
Band 7	1	wte	Clinical Nurse Specialist Infection Control (Developmental band 7 post)
Band 7	0.7	wte	Clinical Nurse Specialist Infection Control (Developmental band 7 post)
Band 6	1	wte	Infection Control Staff Nurse
Band 6	1	wte	Infection Control Support Nurse (fixed term contract)
Band 3	0.8	wte	Secretary
Medical	0.4	wte	Infection Control Doctor/ Joint Director of Infection Prevention and Control/ Consultant Medical Microbiologist
Medical	0.1	wte	Consultant Medical Microbiologist

Infection Prevention & Control Committee (IPCC)

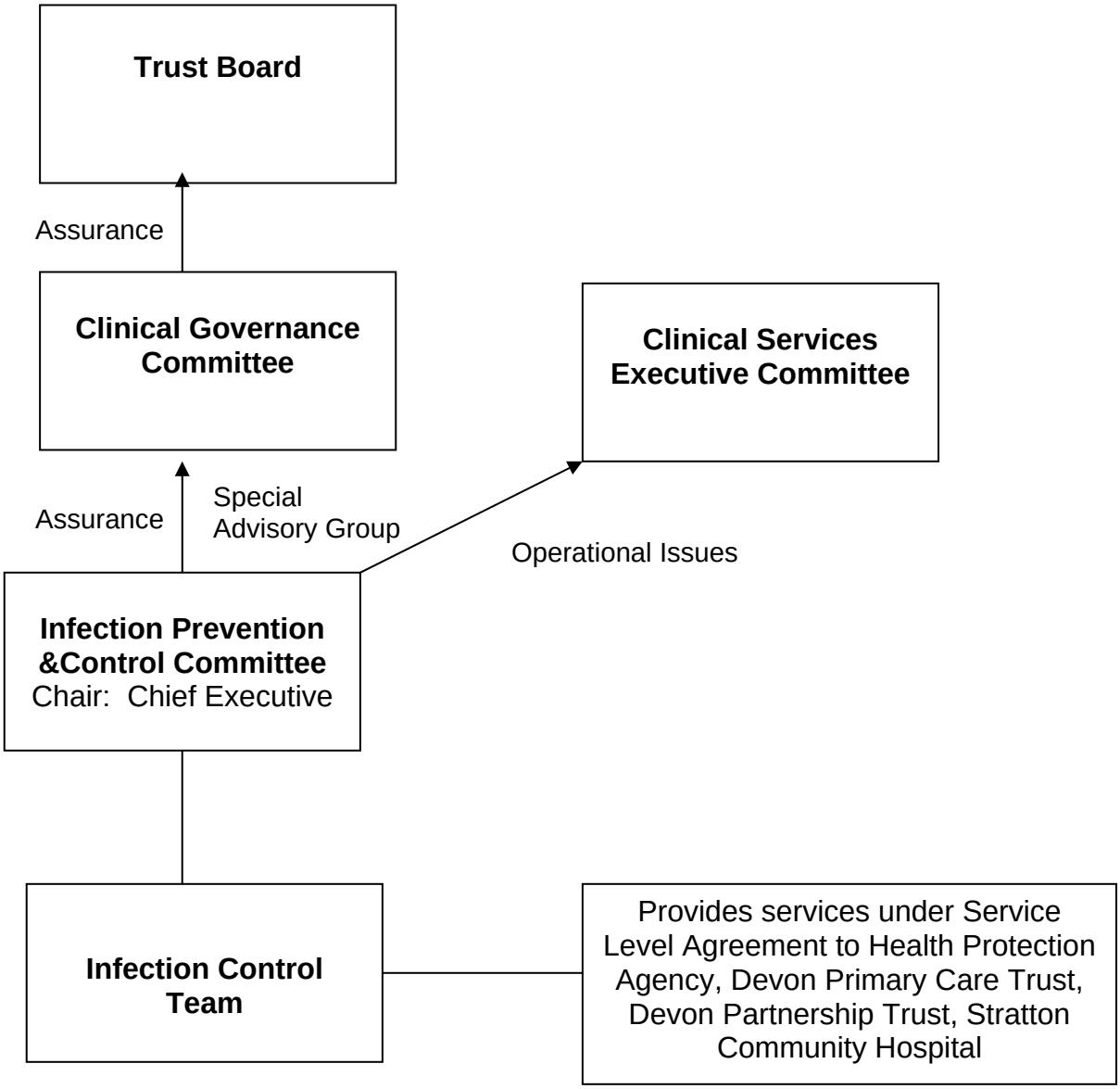
The IPCC is chaired by the Chief Executive and has strong representation from across the Trust, including the lead clinicians from medicine and surgery. The IPCC is a Special Advisory Group of and reports to the Clinical Governance Committee. The minutes are sent to the Clinical Governance Committee and are available on the Trust intranet. The IPCC agrees changes to the content of the Annual Plan for IPC which indicates key infection control activities for the coming year. The annual plan 2007-08 is included as an appendix to this report ('greyed out' lines show what has been achieved and that the item is closed). The annual report is sent to the Clinical Governance Committee and the Trust Board.

IPCC membership:

- Chief Executive (Chair)
- Medical Director
- Director of Nursing/DIPC
- Infection Control Doctor/DIPC
- Clinical Manager IC
- Lead ICN
- General Manager Medicine
- General Manager Surgery
- General Manager Women & Children
- Lead Clinician for Medicine
- Lead Clinician for Surgery
- Lead Nurse for Medicine
- Lead Nurse for Surgery
- Lead Midwife
- Pathology Representative
- Outpatient Services Representative
- Radiology Representative
- Community Directorate Representative
- Clinical Governance Representative
- Director of Pharmacy
- Antibiotic Pharmacist
- Occupational Health representative
- Decontamination Lead
- Estates & Facilities Representative
- Health & Safety Advisor
- Consultant in Communicable Disease Control (Health Protection Agency)
- PCT representative

There is an identified non executive lead for IPC who links closely with the DIPCs to provide additional assurance to the Board about IPC activity.

NORTHERN DEVON HEALTHCARE TRUST ORGANISATIONAL CHART OF INFECTION CONTROL ARRANGEMENTS



Director of Infection Prevention and Control:

- The post is held jointly by the Director of Nursing & Infection Control Doctor
- Reports directly to Trust Board and Chief Executive
- Member of Infection Control Committee and Clinical Governance Committee
- Leads Infection Control Team

Reporting line to the Trust Board

The DIPC reports to all the regular Trust Board meetings. The Annual Report is presented to the Trust Board.

Links to Prescribing and Formulary Committee

The Director of Pharmacy and the Antibiotic Pharmacist are each members of both the Drugs, Transfusions and Therapeutics Committee and the IPCC.

The Antibiotic Working Group is a subgroup of Drugs, Transfusions and Therapeutics Committee with authority to make decisions regarding antibiotic use in the Trust. Its membership includes Consultant Medical Microbiologists (who are part of the ICT) and pharmacists (including the Director of Pharmacy and the Antibiotic Pharmacist). Further details are given in Antimicrobial Prescribing section.

Links to Clinical Governance/Risk Management/Patient Safety

The IPCC is a 'Special Advisory Group' of the Clinical Governance Committee and reports to it with respect to governance issues. The minutes, annual plan, annual report and terms of reference are all sent to the Clinical Governance Committee. The DIPC is a member of the Clinical Governance Committee.

The lead ICN is a member of the Trust's Health & Safety Committee.

Link Practitioners

Link Practitioners are health care professionals usually one per ward or department, who have a particular interest in Infection Control. They attend regular study days, participate in audit and act as an initial point of contact for Infection Control enquiries in the work area. The Link Practitioners are an important resource which is supported by the Trust with funding of one day per month for this role.

DIPC reports to the Trust Board

Number and frequency

The DIPC has reported at least quarterly to the Trust Board since October 2004. IPC reports are now tabled at each regular meeting of the Board.

Annual Action Plan

The Infection Control Annual Plan is agreed by the IPCC and progress reports are made to each IPCC meeting.

Board decisions

The Board reports include the 'dashboard' IPC report which details MRSA bacteraemias, *Clostridium difficile* infections, hand hygiene audit results, cleanliness scores and compliance with High Impact Interventions. These are all discussed in depth along with the actions that the Trust is taking to address any areas for improvement.

Outbreak reports

The Board received reports of outbreaks as part of the routine reports, the Annual Report and other times as required.

Budget allocation to infection control activities

The budget for the combined ICT is mainly from NDHT and also through income from the Devon Primary Care Trust, Health Protection Agency, Devon Partnership Trust & Stratton Hospital as determined by service level agreements. The Infection Control budget covers pay for nurses and administrative staff but not medical staff who are funded from Pathology. The budget funds staff to the level indicated in the staffing structure. Non-pay budget is £3,561 including travel expense payments.

Additional Department of Health funding

In 2007 the Department of Health announced additional non-recurrent funds for acute trusts. NDHT secured funding for £130,000. The IPCT worked hard to submit the bid within a very short timescale and subsequently to arrange the spending of the funds.

The funding permitted:

- Secondment to the ICT of a Band 6 Infection Control Support Nurse to facilitate the Saving Lives initiative.
- Further replacement of conventional taps by sensor taps in ward areas across the acute hospital to aid hand hygiene
- Purchase of publicity material for staff and the public to promote IPC awareness and good practice

HCAI statistics including results of mandatory reporting

MRSA bacteraemia

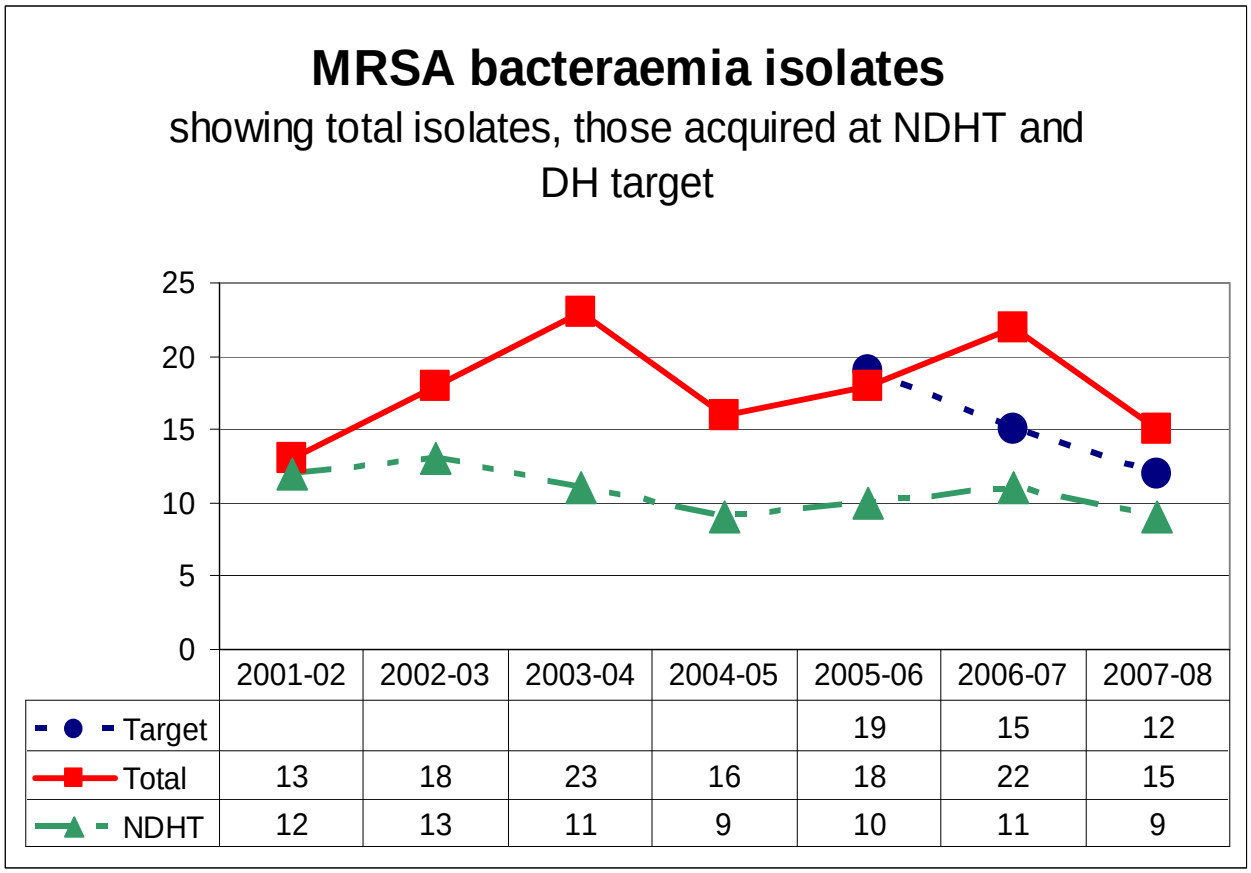
There were 15 MRSA bacteraemias identified by the Trust this year. This is a decrease from a total of 22 for last year. 9 of the isolates were from infections acquired in the Trust, a decrease from 11 for last year.

The sources of the infections, when identified, are similar to those seen in previous years being related to peripheral lines (2), central lines (1), skin infection (2), urine infection (2) and chest infection (1).

Target DH & SHA				**Total**	NDHT	Outside NDHT	SMKU	Out area
		2001-02		**13**	12	1	0	0
		2002-03		**18**	13	5	0	0
		2003-04		**23**	11	8	1	3
		2004-05		**16**	9	4	2	1
19		**2005-06**		**18**	10	3	4	1
15		**2006-07**		**22**	11	11	0	0
12		**2007-08**		**15**	9	5	0	1
		2007-08	Q1	5	2	3	0	0
			Q2	4	2	2	0	0
			Q3	3	3	0	0	0
			Q4	3	2	0	0	1

MRSA isolates from blood cultures by probable location of infection
SMKU – South Molton Kidney Unit

The IPCT have been leading a process of Root Cause Analysis for each of the bacteraemias acquired in the Trust. This involves the clinical team caring for the patient and aims to identify any areas of practice related to the bacteraemia where improvements could be made. The results of the Root Cause Analysis are reported externally to the Primary Care Trust and internally to members of the Infection Prevention & Control Committee. Any additional actions that are identified through this process are incorporated into the Annual Plan. The IPCT reports all bacteraemias to the Department of Health.



	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
Target					19	15	12
Total	13	18	23	16	18	22	15
NDHT	12	13	11	9	10	11	9

MRSA colonisation

The IPCT monitors the numbers and locations of patients newly diagnosed as colonised with MRSA. The figures are shown in the table. There are many difficulties in interpreting these data. Individuals may be found by screening to have MRSA, but not to have infection. The more screening that is carried out the more positive individuals will be found. The location of a patient when found to be positive does not necessarily relate to the location where the MRSA was acquired. MRSA could have been acquired at any time or location in the past. Indeed individuals are being recognised as MRSA positive that have had no contact with healthcare institutions in the past.

The total figures are largely static. This is encouraging as increased screening has been carried out over the last year, ie there is more searching for MRSA but no more is being found. Although the numbers identified in NDHT have increased there has been a corresponding decrease in those from the community. This probably represents that, by chance, patients are being identified in the Trust rather than the community.

Numbers of patients newly identified as MRSA colonised

	2004-05	2005-06	2006-07	2007-08
NDHT	229	212	149	203
Community	290	244	239	176
Total	***519***	***456***	***388***	***379***

Glycopeptide resistant enterococcus (GRE) bacteraemia

There were four reports of glycopeptide resistant enterococcus (GRE) bacteraemias for this year. These were isolated cases and occurred some months apart. The patients were not ill enough to require specific treatment for these organisms.

GRE are organisms that are resistant to many commonly used antibiotics, but can be treated with newer antibiotics. They do not usually cause serious infections unless the individual is severely immunocompromised. GRE bacteraemia is associated with renal and haematology units where there are immunocompromised patients and glycopeptide antibiotics are used frequently.

	2003-04	2004-05	2005-06	2006-07	2007-08
GRE bacteraemia isolates	0	1	1	2	4

Data for GRE bacteraemia isolates reported to DH for NDHT.

Clostridium difficile

The IPCT monitors the numbers of cases of *Clostridium difficile* associated disease (CDAD). These are individuals who have diarrhoea and have *Clostridium difficile* toxin (CDT) found in their stools. Since January 2004 NDHT has been required to report all cases from people over the age of 65 years, and from April 2007 all cases from those aged over 2 years of age.

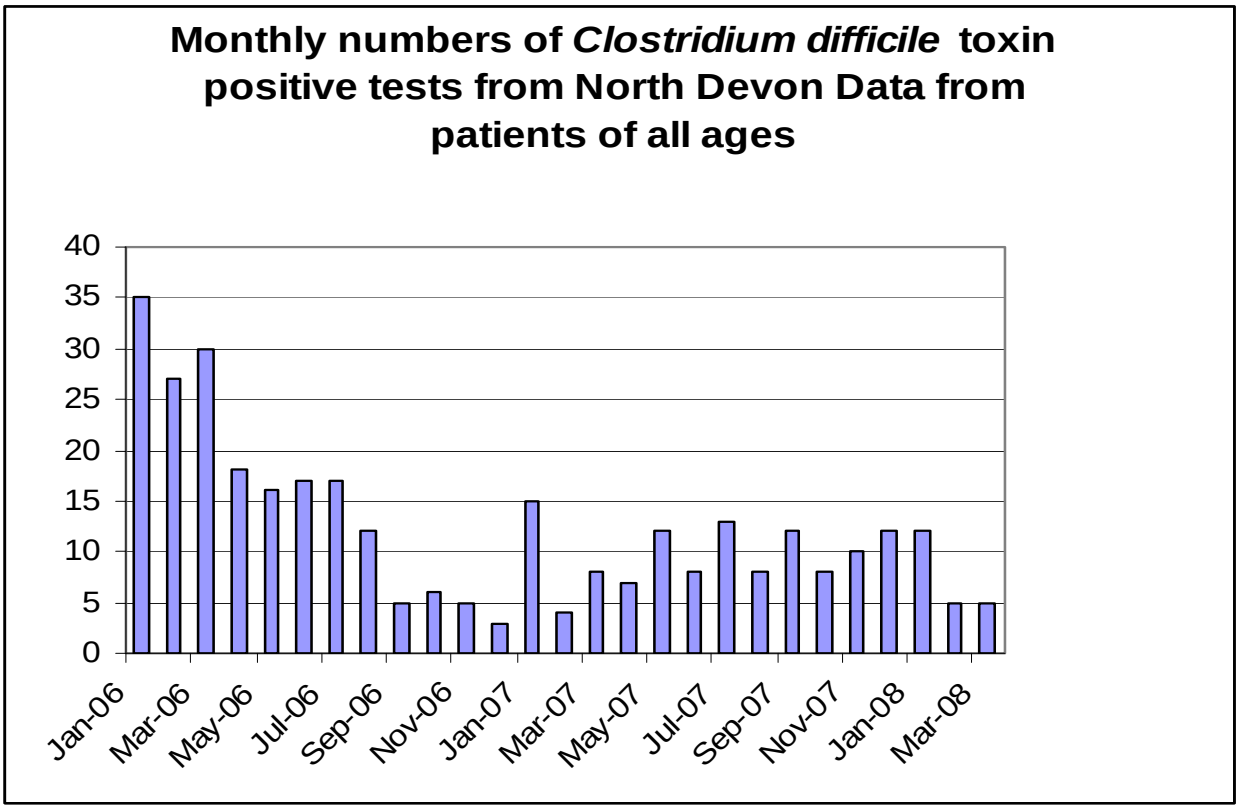
Risk factors for acquiring CDAD include increasing age (especially over 65 years), other medical problems, bowel surgery and antibiotic use.

	2004/5	2005/6	2006/7	2007/8
Number of episodes	91	226	126	111

Cases of *Clostridium difficile* reported by NDHT for patients of all ages in North Devon.

In early 2006 a range of specific measures were introduced locally to reduce the high number of *Clostridium difficile* cases. These included a change to the recommended antibiotics for treating chest infections and guidance on treating suspected cases of *Clostridium difficile*, including starting treatment on suspicion rather than waiting until a positive result is received. This resulted in a reduction in the number of cases of *Clostridium difficile* which has been maintained throughout 2007-08.

Nationally, outbreaks of *Clostridium difficile* have been associated with the new, more potent, 027 strain of *Clostridium difficile*. In common with many other hospitals across the country this strain has been isolated from patients in North Devon.



The Devon Primary Care Trust set NDHT a target of no more than 174 cases in those over 65 years of age for 2007-08. There were a total of 99 such cases for this year, well below the target.

During 2007-08 a process of root cause analysis has been used by the IPCT and the clinical teams to look at factors, especially antibiotic use, that may have contributed to each case of *Clostridium difficile* that may have been acquired at the Trust. The results of this analysis are discussed at the IPCC and the antibiotic working group so that strategies to improve practice can be implemented.

Mandatory surveillance of orthopaedic surgical site infection

Total Hip replacement

	No. of operations	No. of infections detected	Infection rate
Current surveillance 2007-08	104	0	0%
Total of all surveillance 2001-08	290	3	1.0%
National rate			1.3%

The Trust is mandated to perform surveillance of surgical site infections for one type of orthopaedic surgery for at least one quarter each year. This year the procedure of total hip replacement was chosen. No infections were detected in the 104 operations performed: a zero infection rate. If, however, all 290 operations studied since 2001 are considered the infection rate is still only 1.0% which is below the national rate of 1.3% for this procedure.

Untoward incidents including outbreaks

In common with other trusts across the country NDHT experienced outbreaks of viral diarrhoea and vomiting. These were primarily caused by Norovirus and occurred mainly in the winter months.

The Infection Prevention & Control Team has developed an 'outbreak pack' to assist the wards in managing outbreaks of diarrhoea and vomiting. This pack has been in use for some years now and was revised for 2006-07.

The impact of Norovirus on the Trust was less this year than in previous years. The Infection Prevention & Control Team, the Patient Management Team and ward staff worked hard to minimise the spread of infection and to arrange the admissions around the reduced number of available beds.

Antimicrobial resistance

MRSA and GRE data are mentioned elsewhere.

This year has seen a steady number of isolates of extended spectrum ßlactamase (ESBL) producing bacteria from patients in North Devon. The majority of these organisms were detected in urine specimens from patients in the community. Characteristically the organisms are resistant to most oral antibiotics but remain susceptible to certain intravenous antibiotics. This can make treating simple urinary tract infections difficult as a patient may need admitting to treat an infection that could otherwise have been treated with tablets at home.

To date very few of these organisms have been identified from in-patients, but if the national trend is to be followed North Devon will see an increasing number of these organisms from in-patients. The spread of these organisms from person to

person is prevented by the use of standard infection control precautions which are applied to every patient.

	2006-07	2007-08
ESBL isolates	34	57

ESBL isolates identified in North Devon.

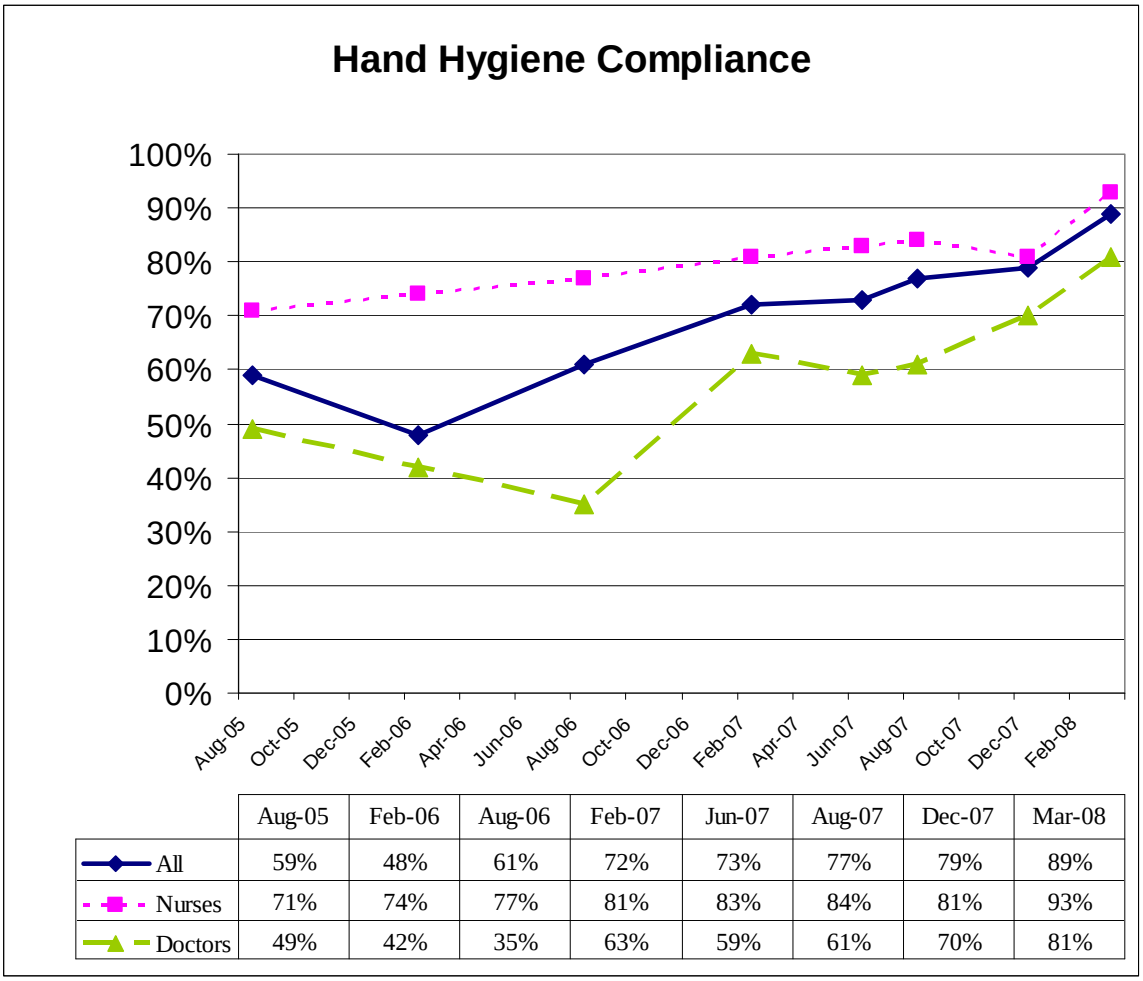
There have been a few isolates of multiresistant *Acinetobacter* species detected but these have not been associated with person-person spread nor the intensive care unit where these organisms have caused problems in other trusts.

Hand hygiene and Aseptic protocols

Implementation of 'cleanyourhands' campaign

The Trust continues to implement the cleanyourhands campaign which was launched in January 2005. This includes the displaying of posters and the distribution of badges to staff. The Trust continues to place alcohol hand gel on all patient lockers and ward entrances where appropriate. In some areas, such as the paediatric ward, it was not appropriate to use bedside alcohol gel. These areas use personal dispensers which can be clipped to the clothing of staff.

Hand Hygiene



	Aug-05	Feb-06	Aug-06	Feb-07	Jun-07	Aug-07	Dec-07	Mar-08
All	59%	48%	61%	72%	73%	77%	79%	89%
Nurses	71%	74%	77%	81%	83%	84%	81%	93%
Doctors	49%	42%	35%	63%	59%	61%	70%	81%

Audits of hand hygiene compliance are now undertaken twice every month by the link practitioners in each area. The results are fed back to the clinical areas and displayed on notice boards at ward entrances. The results are discussed at IPCC where directorates take responsibility for improving compliance in their area. The results are discussed at Trust Board where they form part of the dashboard.

The audit results show that overall compliance has risen steadily over the year from 72% to 89%. However analysis of staff groups shows that the compliance of nurses is very good rising from 81% to 93% and that for doctors is not so good

but has increased significantly from 63% to 81%. It is encouraging that the Trust is able to demonstrate increasing compliance with this basic but essential part of clinical care. The improving trend has continued into 2008-09. The aim is to demonstrate 100% compliance and to have continually improving results as the Trust approaches this goal.

Application of aseptic no-touch clinical protocols, IV catheters & urinary catheters

Policies are in place for these areas which take into account the EPIC guidance published in 2001 & 2007, they also comply with the requirements of the Health Act 2006 (The Code of Practice for the Prevention and Control of Health Care Associated Infections). The policies are regularly reviewed.

Decontamination

Arrangements

There is a central sterile services department situated next to the main theatre complex which processes all Trust items for sterile reprocessing. There are 3 double endoscope washer-disinfectors: one in CSSD and two in the endoscopy suite.

Discussions are underway to consider the formation of a 'super centre' which would serve several hospitals in the South West. Whilst there would be economies of scale there would be large set-up costs as more sets of instruments would be required and considerable risk as there would be a long road journey to the reprocessing centre. A full business case is planned to be presented to Trust Board in 2008.

Cleaning services

Management arrangements

Services are contracted out to Sodexo and monitored through a partnering agreement. There are regular (thrice-yearly meetings of the Partnering Board where the Trust and Sodexo formally discuss the cleaning arrangements. In addition there is a good and close working relationship between Trust staff including the ICT and the staff of Sodexo. There are 'zone co-ordinators' that liaise with ward managers concerning any local cleaning issues. The ICT liaise with the Sodexo team should any increased cleaning be required, such as during outbreaks.

The new revised cleaning standards have been considered. As there would be considerable costs in implementing the standards in full a gap analysis was performed to identify areas where current cleaning did not comply with the new standards. A risk assessment was then performed and cleaning enhanced where it was defined to be of benefit.

PEAT/Patient forum inspection results

In assessments performed by the patient environment action teams (PEAT) in 2007 NDHT achieved scores of:

- **'Excellent' and 'good'** for the environmental assessment
- **'Excellent'** for the food assessment

The PEAT assessments are discussed at the Matron's Charter group where the actions arising from the report are taken forward.

The Patient & Public Involvement forum have worked with the Infection Prevention & Control Team to develop an audit tool to be used for their ward inspections. The reports are fed back to the Trust and the recommendations considered and actioned by the Matron's Charter group. This year the forum conducted an inspection on the day surgery unit.

Audit

Infection control audits are coordinated by the Matron's Charter group on a rolling programme throughout the year. Audit results are discussed by the Matron's Charter group. Actions are agreed by the group and disseminated to individual areas and wider as appropriate. Most of the audits are undertaken by the link practitioners.

Audits undertaken this year include:

- Sharps audit – looking at availability and use of sharps bins. No major problems identified. Results fed back to staff.
- Sluice room audit
- Hand hygiene audit – see Hand Hygiene section.
- Ward cleanliness audit – see Matron's Charter section
- Patient environment & equipment
- Public & Patient Involvement Forum inspections
- Patient Environment Action Team (PEAT) cleanliness inspections

Antibiotic prescribing (report from Antimicrobial Pharmacist)

The Antibiotic Working Group (AWG) is a sub-group of the Drugs and Therapeutics Group with the power to make decisions regarding antibiotic use within the Trust. The primary purpose of the AWG is to ensure that antimicrobial prescribing practice throughout the Northern Devon Healthcare Trust is safe, effective, appropriate and economic. It also provides support for implementation of guidance and auditing compliance. The group will ensure appropriate prescribing policies are in place which are in line with best practice and take into account Department of Health Guidance. The minutes are sent to the Infection Prevention & Control Committee.

Current Membership of the Antibiotic Working Group is:

- Consultant Medical Microbiologists
- Director of Pharmaceutical Services
- Antibiotic Pharmacist
- Director of Infection Prevention & Control / Consultant Medical Microbiologist
- Consultant Physician in Emergency Medicine
- Consultant Surgeon
- Consultant Physician (Medicine)
- Others co-opted as required

Key recent developments and future plans:

1. Reducing Healthcare Associated Infection (including *C. difficile*)

The antimicrobial formulary was reviewed to reduce the use of antibiotics which are 'high risk' for *Clostridium difficile* including ciprofloxacin, 2nd/3rd generation cephalosporins and clindamycin. Such antibiotics were also removed from ward stock wherever possible.

2. Development of guidelines and education

Antibiotic summary cards have been produced to distribute to junior doctors to aid prescribing and improve compliance to changes in the antibiotic formulary. An intra-venous to oral switch policy was implemented. The AWG aims to extend this to a formal Antibiotic Stop/Review and Indication policy. This would aim to

ensure appropriate empirical antibiotics are chosen, reviewed daily by clinical teams and ward pharmacists and lead to a reduction in course lengths.

Guidance for the appropriate use of high cost restricted antibiotics (such as carbapenems) was produced for the Medical Directorate due to their increased use as alternatives to the 'high risk for *Clostridium difficile*' antibiotics.

3. Monitoring and audit of antimicrobial use

An audit database to monitor all antibiotic audits has been developed. This will provide a structured format to monitor compliance with local prescribing policies and oversee all antimicrobial audits within the trust. As part of this, NDHT took part in the annual regional point prevalence study of antibiotic use in February 2008 to compare our performance with other trusts within the region.

Antibiotic use is being analysed in each Directorate in the form of Defined Daily Dosage of antibiotic per Occupied Bed Day. This allows comparison with other trusts both within the region and nationally and will be used to feedback antibiotic use to lead clinicians within each directorate.

Antimicrobial pharmacist participation at the South West Regional Antibiotic Pharmacists group allows feedback and communication from other trusts.

It has been agreed that the antimicrobial pharmacist role will increase to full time and that a third Consultant Medical Microbiologist should be appointed. This post will act as lead on Antibiotic Stewardship, education and audit, development of guidelines and will chair the AWG.

Matron's Charter

Following the release of the Matron's Charter document in 2004 by the Department of Health, a group lead by the Acting Director of Nursing was set up. The group is chaired by the Director of Nursing and includes the IPCT, senior nurses from the Trust, representatives from facilities and the Patient & Public Involvement (PPI) Forum.

The agenda of the group is set by the Charter and therefore has a strong emphasis on cleanliness. The group has taken many issues forward including the new cleaning standards, PEAT inspections, MRSA, the 'cleanyourhands' campaign and training of staff. Through the group the Trust organises an annual successful 'declutter weekend' when unwanted equipment and furniture is removed from wards.

There is a rolling program of audits which include decontamination, ward cleanliness, PPI forum cleanliness, PEAT, sharps, sluice room and Sodexo's audit program. The results are discussed at the forum, actions decided and fed back to ward staff or wider, as appropriate.

The group produces a monthly bulletin which follows each meeting and is distributed across the Trust. The bulletin includes key points from the previous meeting as well as other relevant information on cleanliness and infection control topics that need to be relayed to staff.

Targets and outcomes

MRSA

The DH has set a target to reduce MRSA bacteraemias in all Trusts by 50% by 2007-8 using the figures for 2003-4 as a baseline. This equates to a target of 19 in 2005-06, 15 in 2006-07 and 12 in 2007-08.

The Trust failed to meet the target for this year; registering 15 bacteraemias. It should be noted that for the second half of the year the Trust registered 6 bacteraemias which is within the limit for that period.

This is an extremely challenging target for a number of reasons. Firstly, the target relates to all bacteraemias identified in North Devon regardless of their origin. Thus, as mentioned in the MRSA section, 6 of the 15 bacteraemias this year were acquired outside the Trust. The causes of these infections are outside the direct control of the Trust. Secondly, some of the blood cultures are contaminated which means that the patient did not have an infection but through poor technique the MRSA organism was introduced into the culture bottle. The ICT continues to address the importance of correct blood culture taking technique in training sessions.

The final challenge in reducing the number of MRSA bacteraemias is the prevention of actual MRSA infections within the Trust. Analysis of the causes of the bacteraemias shows that the commonest causes are related to vascular lines (plastic tubes inserted usually in the arm or neck used to inject drugs or fluids) and urinary catheters. As part of the Department of Health Saving Lives programme the IPCT is promoting best practice in this area through education and audit. The majority of the IPCT educational programme will, by improving practice of HCWs, work towards reducing MRSA colonisations and infections including bacteraemias.

Clostridium difficile

The Devon Primary Care Trust set NDHT a target of no more than174 cases in those over 65 years of age for 2007-08. There were a total of 99 such cases for this year, well below the target.

Standards for Better Health

Infection Control activities are included under standard 4a of the Standards for Better Health and are assessed by the Healthcare Commission. The Trust self assess against these standards and reports to the Healthcare Commission. Standard 4a includes compliance with the 'Code of Practice for the Prevention and Control of Health Care Associated Infections' (part of the Health Act 2006).

The Trust declared compliant with Standard 4a for 2007-08

The annual plan for 2007-08 is included as an appendix to this report

Training activities

Education of healthcare workers

Education of the Trust staff in the prevention and control of infection is a very important part of the Trust's strategy in containing the number of HCAIs. The IPCT are pivotal in co-ordinating and providing the majority of this education.

Infection Control training at induction for staff

At induction every member of staff receives Infection Control training by a member of the ICT. This ensures that every new member of the Trust is aware of the basic principles of Infection Control. Bank and many agency nursing staff receive training before starting work. There is now a basic electronic learning package with compulsory question and answer section at the end which is used for junior doctors prior to starting their posts.

Annual Infection Control training for staff

All staff receive annual Infection Control updates which are given as part of their essential training. This has required a significant amount of time from the ICT which has impacted on the other activities that the ICT can perform but has been prioritised as it is one of the most important activities in raising awareness of infection control issues and reducing healthcare associated infections.

The IPCT has been developing electronic learning packages which can be used by staff to access basic IPC and food hygiene training. This will be rolled out over 2008-09.

Other

Staff also receive education about particular aspects of Infection Control as for example part of training for venepucture / cannulation or IV drug administration. If a new policy is introduced then specific training is required to support this.

Delivery of 'Practice & Principles of Infection Control' course

The Infection Prevention & Control Team delivers an Infection Control course at diploma and degree level in partnership with the University of Plymouth. The course, 'Practice & Principles of Infection Control', provides 20 credits at level 2 and 3. It is open to registered nurses in the public and private sectors but the majority of attendees are from the Trust, many of whom are, or become, Link Practitioners. This is providing a valuable resource of staff with enhanced infection control training to improve practice across the Trust.

Link Practitioners

Link Practitioners are HCWs, usually one per ward or department, who have a particular interest in Infection Prevention & Control. They attend regular study days, participate in audit and act as an initial point of contact for Infection Control inquiries in the work area. The Link Practitioners are an important resource and are there is specific funding for each area to support this activity.

Doctors represent a particular group with respect to their educational requirements. Despite its importance Infection Prevention & Control has been poorly taught at medical school and doctors often not included in other teaching sessions because of their work commitments and the short-term contract of many junior doctors. All junior doctors receive Infection Prevention & Control training as part of their induction programme. IPC teaching occurs at regular departmental meetings and audit sessions. It is hoped to make this a regular part of the program. IPC is part of the mandatory training that all newly qualified doctors receive in their F1 & F2 years.

Education of the ICT

Members of the ICT attend educational events throughout the year. These include the Infection Control Nurses Association annual conference and DH events including those arranged specifically for DIPCs. The team are members of the South West Infection Control Forum which also provides regular meetings.

The ICNs are members of the regional Health Protection Nurse forum. The lead ICN has been elected coordinator of the Southwest regional Infection Prevention Society and also gained a postgraduate certificate in education.

Healthcare Commission Inspection

In August 2007 the Healthcare Commission performed an unannounced inspection of the Trust's compliance with duties 2, 3 & 8 of the Code of Practice of the Health Act. A report was received and areas where there was not full compliance were included in the IPC annual plan.

Department of Health MRSA Improvement Review Team

Since September 2007 NDHT has been working with the Review Team to learn from practices elsewhere and strengthen and improve practice at the Trust. The Trust participates in the 'Performance Improvement Network' which is a national programme to share best practice and improve standards of care.

Legionella control

The Facilities department has a program of control in place to reduce the risk of Legionella within the Estates water services; there are defined roles for all individuals in providing this. The planned Maintenance is base on national guidance.

The Trust has a named ‘Responsible Person’ for Legionella control who liaises closely with other professionals in various disciplines.

NDHT has an active and comprehensive Legionella control program which uses a temperature control process to control Legionella. This is enacted with a regular program of monitoring water temperatures across the Trust.
The Facilities Directorate is involved in all alterations involving the water systems in the Trust and ensures that they comply with Legionella control requirements.

There have not been any positive Legionella tests from patients or environmental samples associated with the Trust as source this year.

Appendix

NORTHERN DEVON HEALTHCARE TRUST	Project	31
INFECTION PREVENTION & CONTROL REDUCING HCAIs **Project Progress : Summary Document** **PLEASE UPDATE IN RED**	**Date of Report**	**1.04.08**
	Version	**1**

Aims

The aim of this project is to ensure that the IPC annual plan is kept updated and to monitor progress of delivery of the annual plan, highlighting areas of concern and raising and mitigating risks as they arise.

Project Objectives

Objectives	Timescale
To ensure delivery of the Trust's IPC annual plan for 2007/08	31.3.08
To raise the profile and importance of infection prevention & control across the organisation (acute and community sites)	30.11.07
To ensure that information regarding infection, prevention and control is made widely available to the public, patients and their carers	31.12.07
To promote and implement the hygiene code core duties	31.12.07
To ensure compliance with the HCC S4BH core standards, C4a, and that work towards compliance with the developmental standards is ongoing	31.3.08
To implement recommendations from recent Healthcare Commission review of Trust	31.3.08
To implement recommendations following Department of Health HCAI review in October 2007	31.3.08
To ensure that IPC best practice is delivered, embedded and sustainable across the organisation	31.3.08

Project Deliverables

- Maximum 12 MRSA cases by 31.3.08
- Reduced levels of Clostridium difficile infections
- Regular IPC performance information at ward / department, Directorate and Board level.
- Increased compliance with IPC best practice (measured by improvement in audit results e.g. hand washing compliance)
- Quality patient and public information available through Patient information centre, ward staff, website
- Regular staff attendance at mandatory infection control training sessions and updates.
- Infection prevention and control incorporated into Trust job descriptions.

Project Risks

- Capacity of learning and development team to deliver education & training actions in annual plan (e-learning etc)
- Clinical engagement regarding importance of compliance with infection prevention & control measures
- Compliance with hand washing before and after every patient and clinical contact

Corporate Risks

- Fabric of Estate – not all estate currently maintained to standard B – being addressed through development of Estates Strategy
- Inadequate number of side rooms – on Trust's corporate risk register (July 2004)

- Trust has no negative pressure isolation facility – on Trust's corporate risk register
- ICT resource / capacity to deliver all actions identified in annual plan – on Trust's corporate risk register
- Failure to meet MRSA reduction target and implement saving lives programme – on Trust's corporate risk register

Benefits Realisation
- Reduced patient infection rates
- Raised local community wide awareness of infection prevention & control measures
- Improved staff awareness of HCAI and their prevention and control
- Contribution to Trust's aim of reducing length of stay across the organisation

Financial Savings
- None specifically identified within this project.
- Additional ICT resource has been identified and is being appointed (cost pressure). Infection control budget requires review for 08/09 and this is highlighted as action within the annual plan.
- Implicit within reducing healthcare associated infections is the reduction of length of stay, contributing to improved patient flows with better patient outcomes. This will have a positive financial impact although direct attribution of specific savings will not be possible.

Mitigating actions to reduce identified new risks (where applicable):
- ICT resources being addressed by new appointments to team

Key Achievements Over Past 2 Weeks
- **MRSA, isolation, aseptic, decontamination, inoculation injuries and standard precautions policies all approved at Trust Board 1st April**
- **DoH MRSA Team revisit positive outcome**
- **S4BH standard C4a declared fully met by Board Assurance team on 1.4.08**
- **Capital funds all outstanding monies allocated and requisitions sent for purchases**
- **Isolation monitoring tool in use daily and includes monitoring of MRSA cases not in single room accommodation**
- **Hand hygiene audits showing increase in compliance from 85 - 90%**
- **Third High 5 IC monthly bulletin appended to Chief Exec Bulletin and distributed – explains the concept of the High 5**
- **E-learning expected ready for delivery and upload 2.4.08 – decision made to allow non-clinical staff to use e-learning route for IC update of essential training**

Key Milestones for Next 4 Weeks
- Complete as many of the outstanding policy revisions as possible
- Initiate the remainder of the HII audits from Saving Lives
- Identify outstanding capital funds and commit to relevant publicity materials and IC projects
- Complete non-clinical team part of the E-learning system
- Disseminate new MRSA screening policy details and implement
- Disseminate all policies approved at Trust Board 1.4.08

Project Director : **Carolyn Mills, Director of Nursing & Midwifery**
Project Manager: **Andrew Kingsley, Clinical Manager IPC & Tissue Viability**

NDHT DEPARTMENT OF HEALTH HCAI IMPROVEMENT REVIEW

Northern Devon Healthcare NHS

NHS Trust

PRIORITISED ACTION PLAN - 3.12.07 - 31.3.08

Plan update 1.4.08 — **Version 1**

Key:

AD = Alison Diamond, Associate Medical Director, Clinical Governance Lead
AK = Andrew Kingsley, Clinical Infection Control and Tissue Viability Manager
CM = Carolyn Mills, Director of Nursing
CO = Catherine Oliver, Director of Human Resources
DC = Deborah Critchley, DoH Improvement Review Team
CR = Caroline Raby, Patient Management Team Manager
DR = David Richards, Consultant Microbiologist, Infection Control Dr & DIPC
EC = Esther Coumbe, Antibiotic Pharmacist
ES = Emma Spouse, Programme Manager (Continuous Improvement)
FB = Fiona Baker, Senior Infection Control Nurse
HB = Heather Baynham, Occupational Health Manager
KW = Kathleen Wedgeworth CNS Fluid Management
JB – John Bronze Pathology manager
IR = Iain Roy, Director of Facilities
JK = Jac Kelly, Interim Chief Executive
LF = Lisa Ford, Facilities Co-Ordinator
LS = Lin Sanders, Learning & Development Manager
ML = Michael Lock, Planning & Performance Manager
MR = Mike Roberts, Medical Director
SM = Sarah Matthews, DoH Analyst (MRSA Improvement Team)
TH = Tricia Hawson, Facilities Manager
WD = Wendy Dale, Infection Control Support Nurse

ID	Ref	Links to other plans	Task	Owner	Start date	Completion date	Progress to date
1. INCREASE FREQUENCY OF HAND HYGIENE AUDITS							
1.b	**DoH**	PAd	Launch of phase 3 of Cleanyourhands campaign	AK	10/12/2007	12.2.08: Launched & ongoing	1.4.08 Posters distribution complete - spare in office – Launch actions complete 17.3.08 Remainder of posters arrived in IC office end last week – distribute to Bideford via Link Practitioners on 19th March 3.3.08 All community hospitals have posters CYH 3 except Bideford who are awaiting the reprint 6.2.08 Request for posters and leaflets from NPSA CYH coordinator – posters being reprinted – awaited 24.1.08 front entrance signage received roll out plans for community hospitals in place 8.1.08: Completed phase 1. New front entrance Boards coming tomorrow. Community hospitals – completed by 18.1.08. 14.12.07 - NDDH front hall public information stand with CYH3 posters, campaign leaflets and other giveaways; NDDH trolley dash to put up CYH3 posters and alert staff to main campaign messages; 'are your hands clean' NDHT IC Team logo mugs used by League of Friends teabar replacing existing crockery; radio and TV interviews by Medical director; new front entrance signage on handwashing for visitors (NDDH received and placed; community hospital signs awaited); community hospital launch planned now that posters

							received30.11.07: AK / FB has liaised with Katherine Smith / Glen Everton in Communications r.e. material to support launch
1.g.	**DoH2**		Review compliance targets – compliance targets need to be stretching as anything less than 100% poses risk to patients	AK	25/3/08	30/6/08	27.3.08 Targets for hand hygiene compliance debated at IP&CC – amber range lower limit raised to 80%
1.h	**DoH2**		Hand hygiene compliance by GPs in Community Hospitals reported to be low	JK	25/3/08	30/4/08	27.3.08 JK reported to IP&CC that she would be writing to GPs about compliance with NDHT hand hygiene standards
2. UNDERTAKE FULL RCA ON ALL MRSA BACTERAEMIA							
2.a	**DoH**	PAc	Confirmation of DoH/Trust expectations with PCT (Jackie Crang, DPCT) regarding RCA process for bacteraemia that appear to be community acquired	AK	03/12/2007	07/12/2007	1.4.08 PCT monitoring meeting held with Jackie Crang and Virginia Pearson 6.3.08; DoH MRSA team revisit 18.3.08 Jackie Crang in attendance, verbal and draft written feedback received – action complete 12.2.08: Meeting still awaited. 24.1.08 meeting on 6.3.08 awaited 8.1.08: PCT have requested assurance meeting on 6.3.08 11am. DR has met with Jackie Crang and established memorandum of understanding on PCT / Trust roles r.e. community based MRSA RCA. 3.12.07: JK has discussed new approach with Virginia Pearson (Director PH DPCT). DR to write to VP cc to Jackie Crang and CM, by 5.12.07, to confirm process and arrangements.
2.b	**DoH**	PAc	Meeting with PCT to formally share Trust's key learning / risk factors identified through RCA of community acquired MRSA bacteraemia to date	CM	02/01/2008	18/01/2008	6.3.08 done – with Virginia Pearson and Jackie Crang 12.2.08: Waiting for meeting to take place.12.2.08: Waiting for meeting to take place. 24.1.08 to discuss at meeting 6.3.08 8.1.08: CM to action ? piggy back onto March meeting in 2.a. above.

2.d	**DoH**	PAc, HC3	Formally review efficacy of new RCA process in 3 & 6 months (cross ref 8.c)	DR	01/03/2008	31/05/2008	12.2.08: Review starts in March.
3. CLARIFICATION OF ROLES & RESPONSBILITIES IN IPC							
3.b	**DoH**	**MTW HC2.b.1**	(The DIPC has a job description with HCAI responsibilities and outcome objectives and is appraised). Review awaited guidance on DIPC role and amend as required	DR	03/12/2007	21/12/2007	11.3.08 CM/DR write outcome based objectives 12.2.08: Completed apart from awaited guidance and outcome objectives. Action required by DR and CM. Changes approved at Board and CSEC. 8.1.08: Guidance still awaited. Existing DIPC job description & accountabilities based on operational policy needs to be reviewed by 31.1.08, pending further guidance. 4.12.07 Informal feedback received from Deborah Critchley of MRSA Improvement team
3.c	**DoH**		Review awaited Board to Ward publication and amend operational policy as required (cross ref. 9.b)	DR / CM	03/12/2007	21/12/2007	3.3.08 Release date May 08 8.1.08: Still awaited. DoH site to be checked by FB. 14.12.07 No publication yet received
3.d	**HCC DoH**	HCC14; 18 HC2	Agree what needs to be included in all Trust job descriptions re IPC responsibilities, including Executive JDs	CM	03/12/2007	21/12/2007	11.3.08 CM forward AK core nursing JDs and Nurse Director JD for evidence files 27.2.08 email from Catherine Oliver HR director on the phrase required for job descriptions 12.2.08: Message to be circulated via Chief Executive bulletin and HODs message. 8.1.08: Organisational message required. CM to agree job description content by 18.1.08. 3.12.07: Nursing JDs updated & approved by JNCC
3.e	**HCC DoH**	HCC14; 18 HC2	Develop and implement job description changes	CO	02/01/2008	31/03/2008	27.2.08 as 3.d. above 12.2.08: As above. 8.1.08: Communication to organisation by 25.1.08 and audit 10 job descriptions of 10 recent appraisees by 31.3.08
3.h	**DoH2**		IP&C Team need to become more strategic and less operational to ensure staff at appropriate levels on organisation take responsibility for actions	AK	25.3.08	31/12/08	
3.i.	**DoH2**		Feedback of audit results needs to be instantaneous, actions plans developed, implemented and monitored for sustained achievement	AK	25.3.08	30/6/08	1.4.08 Sharps audit materials sent out same day as received this week, sluice audit received in hard copy today and will be disseminated as soon as electronic copy arrives with call for action plans to be developed at ward and directorate level with clear onus of responsibilities indicated – AK put these audits onto IP&CC agenda for April with requirement for Directorate leads to produce their action plans
3.j.	**DoH2**		Trust needs to analyse the impact of withdrawing from SLA with PCT, risk assess and use formal process to enact any necessary change	CM	25.3.08	30/6/08	1.4.08 Risk assessment undertaken by CM following verbal feedback on 18.3.08 – Chief Executive and IP&CC aware of situation presented by current lack of PCT service
4. DEVELOP COMMUNICATION PLAN FOR REDUCING HCAI							

4.d	**AP**	AP8	Public awareness events and communications with key stakeholders	FB	01/10/2007	31/03/2008	12.2.08: Immediate actions completed and ongoing. ACTION CLOSED. 24.1.08 Press statement prepared in case of enquiry about sewage leak on level 0 last weekend 8.1.08: Lantern FM slot to give PH message about national norovirus outbreak + internal communication. Public event with PCT and PPI took place in Barnstaple shopping centre on 1.11.07, patient information centre opened on NDDH site and co-located with PALS 24.9.07
4.e	**HC**	HC5	Readers panel to comment on corporate publications e.g. annual report containing HCAI information prior to publication	AK	01/10/2007	31/03/2008	12.2.08: Ongoing. 8.1.08: Needs to be reviewed next meeting.
4.f.	**DoH2**		Zero tolerance culture for HCAI – introduce as part of 'Responsibility to Remind'	AK	25/3/08	31/8/08	
5. EVIDENCE OF ASSURANCE OF BEST PRACTICE OF IPC							
5.a.i	**DoH**		Intervention no. 1 - central venous catheter care bundle	WD	02/02/2008	01/03/2008	27.3.08 IP&CC receiving results on dashboard – ward and directorate managers receiving detailed information for action planning to improve results 12.2.08: Ongoing. 6.2.08 CVC ongoing care being undertaken in relevant areas by Link Practitioners – insertion bundle audit to be introduced into programme from March 8.1.07: Full data set required by end February
5.a.ii	**DoH**		Intervention no. 2 - peripheral intravenous care bundle	WD	02/01/2008	01/03/2008	27.3.08 IP&CC receiving results on dashboard – ward and directorate managers receiving detailed information for action planning to improve results 12.2.08: Ongoing 6.2.08 First Link Practitioner lead audits underway data to be collected in at LP meeting 20.2.08 24.1.08 Link Practitioner led audit programme starts today – WD undertaken piloting work to explore use of tool and arranged data input and output with Clinical Audit Dept 8.1.07: Full data set required by end February. Audit data acquired.
5.a.iii	**DoH**		Intervention no. 6 - Urinary catheter care bundle	WD	02/01/2007	01/03/2008	27.3.08 IP&CC receiving results on dashboard – ward and directorate managers receiving detailed information for action planning to improve results 12.2.08: Ongoing 6.2.08 First Link Practitioner lead audits underway data to be collected in at LP meeting 20.2.08 24.1.08 Link Practitioner led audit programme starts today – WD undertaken piloting work to explore use of tool and arranged data input and output with Clinical Audit Dept 8.1.07: Full data set required by end February. Audit data acquired.
5.a.iv	**DoH**		Intervention no. 7 - Care bundle to reduce the risk from C.Diff	WD	02/02/2008	01/03/2008	12.2.08: Ongoing 6.2.08 Underway by ICNs as part of C difficile RCA process 24.1.08 In progress 8.1.08: Full data set required by end February. Data to be collected

							in savings lives format and forwarded to audit for analysis. 14.12.07 ICT agreed to undertake this HII on receipt of new C. diff cases from lab
5.b	**DoH**		Implement Saving Lives best practice on Taking Blood Cultures	AK	03/12/2007	31/3/08	3.3.08 several changes made to products to reduce cost – poster issued to guide clinicians at point of use – cost issues raised at IPCC 26.2.08 12.2.08: Identify revenue consequences and training implications required. 6.2.08 Information released to relevant clinicians nurses and managers 5.2.08 – new skin prep products being distributed to wards via Materials Management – training for phlebotomists arranged for 16.2.08 – DR to arrange training for A&E and ICU 24.1.08 Information letter on new procedure drafted and with DR for finalising; Darren Proctor in Supplies has been requested to arrange for new skin disinfection products to be installed through Materials Management system; WD pursuing provision of butterfly and vacutainer system for BCs to prevent staff exposing to risk by use of needle and syringe 8.1.08: New procedure written and in pathology handbook. Procedure needs to be reissued and in place by end 18.1.08 (DR). Education and training for nursing, AHPs and Drs need to be informed. AK in contact with supplies r.e. equipment. DR arranging education sessions for blood cultures with A&E and MAU. FB arranging sessions with phlebotomy. 3.12.07: Saving Lives procedure in draft - to go to ICC for discussion and approval.
5.f	**PAP**	PAb AP4 AP13 HC10	Implement High Impact Interventions across whole Trust (Acute & Community):	AK	02/01/2008	29/02/2008	12.2.08: Piloting work underway with district nurses. 6.2.08 Underway first data to be collected in from Comm Hosp Link Practitioners due on 20.2.08 24.1.08 HII programme starts today in NDDH and Community Hospitals; Chris Thomas District Nursing Lead has incorporated HII into local action plan which was put on record at IP&C committee on 21.1.08
5.f.ii	**PAP**	PAb AP4 AP13 HC12	High impact intervention 4: Care bundle to prevent surgical site infection		02/01/2008	29/02/2008	12.2.08: Piloting work being planned. Revised schedule to ICC 26.2.08. 6.2.08 Added into Link Prac revised audit schedule – despatched to LPs with minutes of Jan meeting 7.2.08 – WD to contact theatre LPs AK to contact theatre manager 24.1.08 WD to pilot the tool in February prior to the Link Practitioner meeting later in that month
5.f.iii	**PAP**	PAb AP4 AP13 HC13	High impact intervention 5: Care bundle for ventilated patients (or tracheostomy where appropriate)		02/01/2008	29/02/2008	1.4.08 ICU daily chart now contains requirement to complete key clinical actions of the Saving Lives bundle as a matter of routine – reduce Saving Lives audit to quarterly as a check mechanism 6.2.08 Underway by WD 24.1.08 WD to pilot the tool in ICU in February prior to the Link Practitioner meeting later in that month
5.g	**HCC**	HCC19	The trust should ensure its audit programme is delivered, results acted on to ensure continuing	AK		31/3/08	27.3.08 IP&CC receiving HH and HII audit programme results on dashboard – ward and directorate managers receiving detailed information for action planning to improve results – action complete 3.3.08 Audit plan raised at IPCC 26.2.08; WD has created a

			improvement				spreadsheet to monitor monthly returns
5.h			Pilot introduction of enteral feeding audit from Essential Steps	AK	1/4/08	30/6/08	
5.i.	**DoH2**		Improve compliance with VIP scoring	AK	25/3/08	30/6/08	1.4.08 Intravascular policy being updated includes clear instruction to use VIP score – draft sent to KW today – policy to go to April IP&CC – AK emailed KW this week about need to improve VIP scoring which is part of her remit
5.j	**DoH2**		Review compliance targets – compliance targets need to be stretching as anything less than 100% poses risk to patients	AK	25.3.08	30/6/08	1.4.08 AK to raise at LP group 4/4/08 and discuss action planning for compliance failure 27.3.08 Targets for Hand hygiene compliance debated at IP&CC – amber range lower limit raised to 80% - as this was arbitrarily applied to HII the target should also be increased for consistency
5.k.	**DoH2**		Embedding a sustainable quality improvement through audits – stepping up frequency for poor results and stepping down for good results	AK	25.3.08	30/6/08	1.4.08 AK to raise at LP meeting about step up audit frequency and action planning for poor compliance
6. REVIEW SCREENING POLICY TO ENSURE COMPLIANCE WITH BEST PRACTICE & NATIONAL STANDARDS							
6.b	**DoH**		Revised screening policy (reviewing national guidelines and implications of Darzi recommendations) to January ICC with associated cost benefit analysis (to agree policy)	DR	03/12/2007	End February	1.4.08 Policy approved at Trust board today 3.3.08 MRSA policy with revised screening guidance approved at IPCC 26.2.08 update on potential cost implications for Pathology to be tabled at April IPCC 12.2.08: To February ICC with revenue consequences identified. Further revision to include Darzi recommendations. 6.1.08 Plan to table at Feb IP&CC 24.1.07 PIN meeting of 17.1.08 Prof Duerden says that the agenda to screen all admissions is now asap rather than by end March 2010 – screening options discussed with Dr Chris Catchpole visiting Microbiologist 8.1.08: Needs to be prioritised.
6.c	**DoH**		Review benefits for same day testing facility for MRSA / Norovirus - report to ICC February meeting	DR	03/12/2007	25/01/2008	1.4.08 Report expected at latest by May IP&CC 3.3.08 raised at IPCC 26.2.08 JB and DR to table potential costs at IPCC April 08 12.2.08: Awaiting feedback from Worcester pilot (Chris Catchpole) to inform revenue implications. To February ICC. ACTION – AK to chase CC8.1.08: Needs to be prioritised.
6.d	**DoH**		Implementation of new screening policy from Feb 08 (or as soon as any necessary equipment is acquired)	DR	01/02/2008	31/03/08	1.4.08 Policy approved at Trust board today 17.3.08 Inform/implement new screening policy after Board approval in April 3.3.08 MRSA policy approved at IPCC 26.2.08 awaiting Board approval April 08

							8.1.08: Dependent upon 6.b and 6.c. above.
6.e	**DoH**		Develop a process and time frame for auditing compliance with screening policy (include in audit programme appended to operational policy)	AK	01/03/2008	31/03/2008	8.1.08: Audit undertaken in orthopaedics – need to be analysed.
6.f	**DoH DoH2**		Audit change in policy to demonstrate impact – audit within 2 months of introducing new policy	AK & FB	01/04/2008	30/06/2008	
6.g	**DoH2**		Produce plan for how national screening targets will be met and shared with commissioners	DR	25.3.08	30/6/08	
7. INCREASE PACE OF IMPROVEMENTS AT CLINICAL INTERFACE							
8. INVESTIGATE CLOSTRIDIUM DIFFICILE UPWARD TRAJECTORY							
8.c	**DoH**	PAc, HC3	Formally review efficacy of new RCA process in 3 & 6 months (cross ref 2.d)	AK	29/02/2008	01/06/2008	
8.e	**DoH**		Review prescribing practice in secondary and primary care with DoH Microbiologist and identify any changes required	DR	03/12/2007	31/01/2008	1.4.08 PCT meeting on 6.3.08 implications discussed and PCTresponsibility to work on education/communication programme with GPs, involve DR as appropriate 12.2.08: Chris Catchpole and DR have discussed for acute on 15.1.08. Community implications to be discussed at meeting with PCT on 6.3.08. ACTION : DR to prepare key issues summary for meeting. 14.12.07 Awaiting visit - see 6a above
8.g	**HCC MTW**	HCC4	Develop a process for ensuring that patients with C.diff have regular clinical review	DR MR	1/1/08	31/3/08	1.4.08 Action complete 3.3.08 latest RCA process update to involve clinicians from beginning if this month 12.2.08: Side room monitoring tool – RCA for CDiff process in place since January.
8.h	**MTW**		Develop a review process for monitoring and reporting deaths and adverse events from C.diff	DR	1/1/08	31/3/08	1.4.08 Action complete 3.3.08 Report C.diff deaths on dashboard to IPCC from 26.2.08 12.2.08: Process being taken to ICC on 26.2.08. 6.2.08 Piloting by ICNs following up cases by death certificate analysis – dashboard summary has C diff deaths column
9. IMPROVE MONTHLY ICC PERFORMANCE REPORT WITH DASHBOARD SUMMARY							
9.e.	**DH**	HC 2-4	Review dashboard summary in May and August 2008 to ensure fit for purpose	Operational group	May 2008	September 2008	

9.b	**DoH**	HC2-4	Review Board to Ward report once published (cross ref. 3.c)	DR / CM	03/12/2007	31/12/2007	1.4.08 DoH MRSA Improvement Team require clear instructions on Bare Below Elbows to be communicated to staff – upgrade back to a policy document 17.3.08 Dress code document will be presented as guidance following discussion including at MAC 3.3.08 due for publication May 08 – Uniform and Workwear guidance note incorporated into Dress Code policy 12.2.08: Ongoing 24.1.08 Appears not to be published not available on clean safe care website 14.12.07 Not yet published
9.f	**HCC**	HCC3	The trust should ensure that risk assessments are included as a standing item on the clinical governance committee and IP&CC agendas	DR/CM		31.5.08	1.4.08 All risks currently on Risk Register presented to IP&CC on 27.3.08 3.3.08 Revised negative pressure room assessment agenda item at Feb IPCC and remaining risks for agenda March 08
10. DEVELOP EFFECTIVE ICT							
10.a	**DoH**		Organise a facilitated team building day	CM	Feb-08	Feb-08	17.3.08 discuss what the team feels it wants
10.b	**DoH**		Leadership development of senior team members	CM	01/03/2008	Ongoing	3.3.08 FB starts free to lead programme w/c 10.3.08 24.1.08 CM agreed at 1:1 meeting 20.1.08 to discuss this with AK at D&R which was to be scheduled for mid 2008 3.12.07: FB booked onto Trust's 'Free to Lead' programme in March 08
10.e	**HC**	HC2	Resource identification for IPC thorough commissioning and budget setting processes	AK	03/12/2007	31/03/2008	1.4.08 Case approved at Trust Board for 3rd Microbiologist who will focus on antibiotic stewardship and will mean that DR more able to concentrate on DIPC role 11.3.08 In contract negotiations with PCT for 2008/09 screening uplift 3.3.08 CM contacting Anthea Sussex in Finance re money to support ongoing saving lives facilitator/raised at IPCC 26.2.08 need for ongoing audit surveillance type post – business case needed 12.2.08: Requirements taken to contracting meeting in January 2008. ACTION: AK to develop business case for IC audit & surveillance nurse (currently refunded non-recurrently with Saving Lives funding) based on risk assessment. Must go to February ICC. Costs of increased screening to be worked up with Anthea Sussex.
10.f	**AP**		To monitor and provide assurance on spending of capital funding allocations	FB	2/1/08	31/01/08	1.4.08 Outstanding funds from 130K capital fund allocated to projects and requisitions sent to supplies last week – outstanding funds from 300K capital fund identified for continuance of Saving Lives facilitator for next 12 months 12.2.08: Ongoing. Proforma requires completing. ACTION : FB to complete with Anthea Sussex. 24.1.08 breakdown of spending to date received from Management accounts – awaiting further information from PH of Estates on taps – need to allocate remaining funds for suitable projects

							8.1.08: FB to chase with Karen Sandwell (Asst Finance Manager) and Estates (taps). 1st & 2nd allocations.
11. INCREASE ANALYTICAL SUPPORT TO ICT							
12. INCLUDE MANDATORY TRAINING IN IPC AT CONSULTANT APPRAISALS							
12.c	**DoH**		Lead Clinicians to incorporate into colleague appraisals	MR	02/01/2008	Ongoing	11.3.08 AK find MRs letter for evidence file
12.d	**DoH**		Evidence and assurance of inclusion to be documented	MR	02/01/2008	31/03/2008	12.2.08: ACTION: CM to remind MR that evidence is required.
13. TRAINING & E-LEARNING							
13.1 PROVISION OF SUPPORTIVE E-LEARNING							
13.1.a	**DoH**	PAh AP8 HC10,11	Complete localisation of e-learning package	FB	03/12/2007	31/12/2007	1.4.08 Decision made last week and communicated to L&D dept to allow non-clinical staff to either attend essential training or use e-learning package to fulfil essential training annual requirement – expect the go-live e-learning to be ready for upload tomorrow – FB now concentrate on non-clinical e-learning package 3.3.08 further draft received from Bluestream and being reviewed by FB after last changes 24.1.08 Days taken by FB and updates returned to company for them to make changes 8.1.08: FB to complete by 24.1.08. 2 days to be freed up to achieve this.
13.1.b	**DoH**	PAh AP8 HC10,12	Implement Trustwide IPC e-learning	LS	02/01/2008	Ongoing	1.4.08 E-learning ready to upload tomorrow 11.3.08 FB to advise LS 8.1.08: As above. 14.12.07 CM to discuss with Maureen Bignell as LS currently on sick leave
13.1.c	**DoH**	PAh AP8 HC10,13	Evidence and assurance to be reported at ward / directorate / Board level	LS	01/02/2008	Ongoing	11.3.08 DR/AK to discuss with ES what is going to happen to data stream on learning & Development – are dashboard figures helpful/representative of true picture - ? remove from dashboard 3.3.08 Training figures included on IPCC dashboard from 26.2.08 8.1.08: As above.
13.2 IPC STAFF TRAINING & RECORD KEEPING							
13.2.a	**HCC HC**	HCC11 HC2	Systems in place to record all IPC training attendance for all staff, providing assurance to Board level	LS	01/02/2008	Ongoing	12.2.08: Systems are in place locally with ICT and Trustwide assurance process. ACTION: Wider Trustwide system needs to be put in place e.g. ESR. 8.1.07: Monthly recording of statutory and mandatory in place.
13.2.b	**HCC HC**	**HCC13 MTW,** HC11	Infection control is included in induction programme and in ongoing training updates for all staff (includes estates and cleaning contract staff) , records of attendance in place and reported	LS	01/10/2007	Ongoing	3.3.08 Training department matrix confirmed with LS on who needs to undertake what 12.2.08: Data on new staff and induction attendance now being collected. 6.2.08 Awaiting reporting mechanism from L&D department 24.1.08 Training reported on in ICN report to IP&C committee 21.1.08

			at level of influence				8.1.08: In induction programme, mandated, reported to Execs. Monthly reporting in place and ongoing records will on ESR. Training to be included in education section of ICN report to ICC (FB)
14. ADDITIONAL ACTIONS							
14.b	**DoH**		DoH to contact DR with more details / process for becoming a member of the MRSA Improvement Review Team	DC	03/12/2007	31/12/2007	1.4.08 No contact made by MRSA Team – consider action complete 12.2.08: No change12.2.08: No change. 24.1.08 No contact to date 8.1.08: No contact to date.
14.f	**DoH**	DoH2 HC8	Side room conversion to be completed	IR	03/12/2007	29/02/2008	27.3.08 Revisited issue at IP&CC still outstanding work to do to identify if room conversion appropriate – issue raised of Roborough single rooms to be used as a potential set of isolation rooms 3.3.08 Directorate managers detailed to revisit what can be converted at IPCC 26.2.08 12.2.08: Work ongoing with operations team. 6.2.08 ICNs side room paper detailing what each was used for represented to estates following IP&CC 24.1.08 No side room conversions on Estates plan – reported following discussion at IP&C committee 21.1.08 8.1.08: CM to chase at Execs tomorrow . 14.12.07 2 rooms identified - CM to follow up
14.j	**DoH2**		New mattresses – KPIs with Hill Rom supplier to include annual audit and audit post outbreak of HCAI	CM	25.3.08	31/7/08	
14.k	**DoH2**		Bare below the elbows – make current guidance a policy and communicate clearly to staff what is expected	??CM & MR	25.3.08	31/7/08	
15. MANDATORY SURVEILLANCE REQUIREMENTS							
15.c	**HCC HC**	DoH2 HCC5 HC8	Review isolation policy and risk assessments for isolating / cohorting patients	DR	01/10/2007	31/12/2007	1.4.08 Policy approved at Trust board today; Isolation room monitoring being undertaken daily by ICNs and being communicated to PMT 3.3.08 Neg pressure room risk assessment revised and tabled at IPCC 26.2.08, remaining risks to be tabled at March IPCC 12.2.08: Policies going to ICC 26.2.08. 8.1.08: Ongoing – needs to go back to ICC for approval. 4.12.07: Policy reviewed and discussed at Infection Control Committee. Isolation room issues being incorporated into wider service and estates strategy work
15.c.ii			Cost out installation of new negative pressure isolation room	DR	11.3.08	30.6.08	

15.d	**HCC HC**	HCC6 HC10	Rolling programme of policy audit, revision and update on the safe disposal of sharps, including sharps protection mechanisms in all clinical areas(increase frequency and scope of audits and ensure results fed back to directorates)	FB	01/10/2007	29/02/08	12.2.08: On agenda for next ICC ??8.1.08: Sharps audit completed once per year. Way forward to be discussed at next ICT meeting.
15.e	**HC**	HC10	Prevention of occupational exposure to blood borne viruses (BBVs) including prevention of sharps injuries, and management post exposure prophylaxis	FB	01/10/2007	31/3/08	1.4.08 Sharps bin audit for NDDH received this week, traffic lighting added and disseminated widely for local action by relevant managers 27.3.08 AK tasked by IP&CC to take inoculation injuries issue to Health and Safety to raise a sub group to look at all issues of safer needle devices 11.3.08 AK devise policy audit tool and get Link Prac group to complete 3.3.08 Inoculation injury policies updated and approved at IPCC26.2.08 12.2. 08: 8.1.08: Way forward to be discussed at ICT. Audit timetable needs to be developed.
15.f	**HC**	HC10	Adherence to disinfection policy	FB	03/10/2007	31/3/08	1.4.08 Decontamination policy approved at Trust Board 8.1.08: Way forward to be discussed at ICT. Audit timetable needs to be developed.
15.g	**HC**	**MTW,** HC10	Adherence & audit of antimicrobial prescribing	EC	04/10/2007	31/3/08	1.4.08 trust Board approved 3rd Microbiologist who will focus on antimicrobial stewardship 3.3.08 full time antibiotic pharmacist post confirmed at IPCC 26.2.08 – business case for 3rd Microbiologist in development to lead antibiotic stewardship issues 12.2.08: Ongoing. Progress will be updated in next fortnightly report. 8.1.08: Being addressed through antibiotic working group, discussed at meeting this PM. DR to update.
15.h	**AP**	AP6	Compliance with S4BH standards C4a, C4c and C21, evidence collation	AK	03/12/2007	31/1/08	1.4.08 Complete - C4a signed off as fully met 11.3.08 Sign off with NED at Board Assurance meeting on 1.4.08 12.2.08: Audit report to ICC on 26.2.08. 6.2.08 Awaiting internal audit report on S4BH compliance 24.1.08 discussion with Nikki Pelmear of internal audit about what was outstanding evidence to support C4a – need to send remaining evidence via email to her by Monday 28.1.08 8.1.08: AK working to make sure evidence is listed. 4.12.07: Evidence collated and compliance declared.
15.i	**AP**	AP7	Demonstrable compliance with Code of Practice	AK	03/12/2007	31/03/2008	1.4.08 Complete – Trust Board declared C4a fully met for 07/08 12.2.08: Going to ICC on 26.2.08 for discussion. 6.2.08 Code self reassessment complete today overall scorecard shows each duty yellow or green 8.1.08: Recommendations received and to be cross referenced with existing action plan by 18.1.08. 4.12.07: Action plan in place following self-assessment.

15.n	**HC**	HC10	Antimicrobial prescribing data is analysed by the antimicrobial pharmacist and routinely fed back to clincial staff / DIPC / ICC	EC	10/10/2007	31/03/2008	11.3.08 AK get update from EC 12.2.08:Antimicrobial pharmacist attends ICC and antibiotic working group meeting planned. 3.10.07: To go onto Antibiotic working group agenda
15.p	**MTW**		Develop a process to ensure antibiotic prescribing is reviewed daily	EC	1/1/08	31/3/08	11.3.08 AK get update from EC 12.2.08: Process will be implemented in steps under guidance from antibiotic working group. To be discussed at next meeting
15.t	**HCC**	HCC9	The trust should develop and monitor policies for the segregation of elective and emergency patients	DR		31.7.08	
16. POLICIES & DOCUMENTATION							
16.a	**AP**	AP10	Review all policies relating to IPC and ensure updated policies are communicated appropriately and available on intranet	FB	01/10/2007	31/03/2008	1.4.08 Batch of policies given final approval at Trust Board today inc std precautions and isolation 3.3.08 A batch of updated policies approved at IPCC 26.2.08 12.2.08: Policies going to ICC on 26.2.08 for ratification. 8.1.08: System & resources need to be identified quickly.
16.c	**HCC HC**	HCC1; 2 HC3	Strengthen nursing documentation including HCAI assessment tool, develop patient treatment plan database including HCAI risk assessment outcomes	FB	01/10/2007	31/12/2007	11.3.08 FB to phone other Trust's ICNs to find out what they are doing on this 12.2.08: On hold pending reformation of documentation group (lead has left organisation). ACTION : AK to raise with CM. 8.1.08: With documentation group for progression. CM to pick up with AK.
16.d	**HC**	HC4	Laundry policy updated to reflect HCAI risks and identifies control measures	LF	01/10/2007	31/12/2007	12.2.08: Policy out for comment and raised at matron's charter group on 8.2.08. 8.1.08: Lisa Ford currently updating
16.g	**SHA**		Review Trust's policy for decolonisation of patients and / or staff	DR	02/01/2008	31/03/2008	1.4.08 Complete - MRSA policy approved at trust Board today 3.3.08 MRSA policy approved at IPCC 26.2.08 12.2.08: On ICC agenda 26.2.08. Staff won't be routinely screened – needs to be included in policy. 6.2.08 MRSA policy under revision for tabling at IP&CC Feb
16.h	**HCC**	HCC20	The trust should introduce a policy that takes account of admission, transfer, discharge and movement of patients between departments and healthcare facilities to ensure IC facilities to ensure IC risks are identified and mitigated	CR		31/3/08	1.4.08 Complete - Policy ratified but not yet on Tarkanet according to Caroline Raby – policy being operated by Patient Management Team 11.3.08 AK check with CR if policy ratified and disseminated Bed management policy draft v2.10 received from CR
17. FABRIC OF ESTATE							

17.a	**HCC HC**	HCC10 HC4	Estate is suitable for purpose, kept clean and maintained in good physical repair and condition	TH	01/04/2007	31/03/2008	1.4.08 Facilities Liaison Policy approved at Trust Board 3.3.08 Policy approved at IPCC 26.2.08 going to CSEC March and Board April 08 12.2.08: Facilities liaison policy to ICC 26.2.08 for ratification. 6.2.08 ICT and Facilities Director and management team met 1.2.08 to review interface and assurance – Estates Liasion Policy being updated as Facilities Liaison Policy – Deep Cleaning Programme underway with a specially hired team 8.1.08: Gap analysis of standardisation of housekeepers' roles complete. Good PEAT inspection. Deep cleaning plan developed. 3.10.07: Standards required gap analysis work in progress
17.b	**HC**	HC4	The estate is maintained to condition B, as defined in a risk based methodology for establishing and managing backlog	IR	01/04/2007	31/03/2008	3.10.07: Backlog maintenance is ongoing. Estates strategy developed and being aligned with service strategy.
17.c	**HC**	HC4	The Sterile Services Department is compliant with HBN13 - Business case to be developed and taken to Trust Board	IR	01/04/2007	31/03/2009	6.2.08 Trust Board decision delayed until April 24.1.08 Final staff meeting on SupaCentre held on 21.1.08 with no clear choice for the future being identified - business case to be presented to Board in February 1.10.07: NDHT is within South West Super Decontamination Centre Project Consortium.

Completed actions as at 617.3.08:

1.a	**DoH**	AP3, AP13	Commence weekly hand hygiene audits in December	AK	03/12/2007	21/12/2007	**24.1.08 Completed** – ward results displayed to public 8.1.08: Audits done, data needs to be analysed. Hand hygiene data needs to go onto Boar d reports and boards outside ward. 3 weeks December data needs to go onto wards by end this week. Results to be published. 14.12.07 - Commenced - week of 3rd part achieved; week of 10th complete; week 17th planned; week of 24th planned to complete sites not undertaken in week of 3rd
1.c	**DoH**	AP3, AP13	Fortnightly hand hygiene audits from January	AK	02/01/2008	31/03/2007	6.2.08 Completed for January – rolling programme implemented 24.1.08 first monthly round done by ICNs, second audit to be undertaken 24.1.08 by link practitioners 8.1.08: In place, audits being done and compliance improving. 14.12.07 - workplan given to Link Practitioners at meeting on 12.12.07 detailing this requirement
1.d	**HCC DoH**	HCC12 HC2	Report hand hygiene compliance at ward/directorate/Trust level	AK	10/12/2007	31/03/2008	6.2.08 Complete 24.1.08 Ward posters displayed and reports of Decemebr results made at IP&C committee on 21.1.08 and to January Board meeting by DIPC 8.1.08: To be completed by 18.1.08. 3.12.07: CM to obtain dashboard summary being utilised at RUHBT 14.12.07 - Data on the December audits being entered, Michael Lock to assist with production of output from the data (discussions planned for Monday 17.12.07 to work out format for output); report due to ICC 18.12.07.

							3.12.07: CM to obtain dashboard summary being utilised at RUHBT
1.e	**DoH**	PAa	Review data presentation reporting format r.e. hand hygiene in performance report	ML	07/12/2007	14/12/2007	**24.1.08 Done** IP&C committee see annexes 2a dashboard and 2b performance report DR and AK rediscuss with ML 8.1.08: Dashboard summary will be ready for ICC on 21st January, for March Board.
1.f	**DoH**	AP13	Include audit programme in operational policy	CM	03/12/2007	14/12/2007	**24.1.08 Done** Operational Policy approved by January Board 8.1.08: COMPLETED. Operational policy on agenda for CSEC on 15th and Board 16th January. 14.12.07 audit programme in final draft sent out with ICC agenda papers for 18.12.07 meeting. 3.12.07: Draft of operational policy completed
2.c	**DoH**	PAc	Include PCT on RCA flow chart (cross ref. 8.b)	AK	03/12/2007	07/12/2007	14.12.07 completed
2.e	**DoH**	PAa	Formal reports to wards/directorates and ICC to ensure organisational learning from matters arising (cross ref 8.d)	AK	17/12/2007	31/03/2008	17.3.08 Ongoing 3.3.08 Hand hygiene audit data now being placed fortnightly – detailed information going to dept and directorate managers12.2.08: Data needs to go up fortnightly in line with frequency of audits. 6.2.08 Hand hygiene data by staff group by ward and directorate distributed 5.2.08 24.1.08 IP&C committee 21.1.08 received updated action plan including action points arising from Maidstone and Tunbridge Wells report 8.1.08: 1st formal report with action plan presented to December ICC – requires revision before wider distribution. To represent at next ICC. 14.12.07 item 6 ICC agenda 18.2.07
3.a	**DoH**	PAf HC2, 8,10	Finalise and disseminate operational policy	CM	03/12/2007	16/1/08 07/12/2007	8.1.08: COMPLETED. Been to ICC. 14.12.07 Final draft to ICC 18.12.07, CSEC 15.1.08, Board 16.1.08
3.f	**DoH**	HC2	Review Link Practitioners role description with ward / department managers to ensure 'fit for purpose' and key deliverables are clear	FB	03/12/2007	31/12/2007	3.12.07: To be discussed at next LP meeting in Dec. Current role descriptions to be circulated prior to meeting 14.12.07 New role description discussed and agreed and 2008 work plan provided at LP meeting on 12.12.07. ACTION CLOSED
3.g	**DoH**		Formalise Link Practitioner meeting. Take minutes and disseminate with ward / department leads	AK	03/12/2007	14/12/2007	8.1.08: COMPLETED. Minutes also to go to senior nurses including community and CM .3.12.07: LP meetings already minuted. Minutes circulated to Ward Managers. Circulation to be expanded. 14.12.07 minutes taken to be prepared and circulated in week starting 17.12.07; plan to meet monthly agreed for a day long action meeting with protected time and backfll money to wards
3.h	**PAP**	PAg	Review Infection Control Committee meeting processes and functions	JK	18/12/2007	18.12.07	8.1.08: COMPLETED. ToR been revised.
4.a	**DoH**	PAe AP8,9 HC5	Append IC bulletin to Chief Executives bulletin	AK	03/12/2007	14/12/2007	**24.1.08 Done** first issue circulated this week 8.1.08: AK to contact Glen Everton to ensure goes out week commencing 16.1.08.14.12.07 High Five edition 1 sent to communication manager for appending to CE bulletin - not attached as requested to ulletin for week 10.12.07 - reminder sent for attachment to next CE bulletin edition

4.b	**DoH**	PAe	Bulletin to focus on 3 key messages	AK	03/12/2007	14/12/2007	8.1.08: COMPLETED. Bulletin circulation to take place 16.1.08. 3.12.07: 5 key messages sent to Katherine Smith on Friday. FB to contact Tracy Halliday.
4.c	**DoH**		Explore other mediums to deliver messages e.g. screen savers	AK	10/12/2007	02/01/2008	6.2.08 Complete 24.1.08 FB has followed up but as no action has occurred will need to make formal request for action 8.1.08: FB to chase Matt Beaman – to be achieved by 11.1.08. 14.12.07 CYH3 screensavers downloaded by FB who has requested computer services to make them available to all
5.a	**DoH**	AP4 HC10 AP13	Implement High Impact Interventions across whole Trust, including aseptic technique in all interventions	AK	03/12/2007	29/02/2008	6.2.08 Complete - HII programme underway by Link Practitioners – revised audit programme to include outstanding HIIs starting in March to be released with LP meeting notes from January 24.1.08 24.1.08 HII audits undertaken by WD reported to IP&C committee 21.1.08 8.1.08: WD undertaking HII prior to Link Practitioners meeting on 24.1.08. Data inputting onto DoH templated commenced 8.1.08. Audit support to be chased urgently. Need to be done by 31.1.08 for Board report by end February. 3.12.07: Agreed that implementation plan, including roll out by ward, to go to ICC on 18.12.07. AK to provide WD with work plan for 5.a.i - iv 14.12.07 Workplan given to WD - link practitioners at meeting on 12.12.07 aware of the forthcoming HII implementation plan
5.c	**DoH**		Provide clear audit programme for Trust (operational policy and feedback reporting)	AK	03/12/2007	31/01/2008	8.1.08: COMPLETED 14.12.07 audit programme in draft operational policy going to ICC on 18.12.07
5.d	**DoH**		Feedback experience of High Impact Interventions in North Bristol to AK & team (? Cheryl Etcher)	DC	03/12/2007	21/12/2007	6.2.08 Completed – PIN event provided suitable networking on this topic 24.1.08 AK attended PIN in London and met and exchanged ideas on HII data collection and feedback with other delegates 8.1.08: AK has contacted but no return call. 14.12.07 contact name and number received from Deborah Critchley of MRSA Improvement Team
5.e	**DoH**		Develop an implementation plan for above for approval at December ICC	AK	03/12/2007	18/12/2007	8.1.08: Complete. 14.12.07 completed for delivery to ICC 18.12.07
5.f.i	**PAP**	PAb AP4 AP13 HC11	High impact intervention 3: Renal catheter care bundle		02/01/2008	29/02/2008	**24.1.08 Remove to completed tasks list** 8.1.08: Not applicable to NDHT.
6.a	**DoH**		Arrange visit of MRSA improvement team microbiologist to meet with DR / AK	DC	03/12/2007	31/12/2007	**24.1.08 Done** - Chris Catchpole Cons Micro from Worcester visited with Deborah Critchley in January 8.1.08: DoH Microbiologist visiting on 15.1.08.
7.a	**DoH**		Compile clear prioritised action plan	ES	03/12/2007	07/12/2007	14.12.07 complete - this document and process
7.b	**DoH**		Inclusion of action plan in CIP and associated assurance & monitoring	ES	10/12/2007	21/12/2007	14.12.07 complete - this document and process

			processes				
7.c	**DoH**		Set up an operational group to review progress / variance on delivery of plan / issues	CM	03/12/2007	Ongoing	13.12.07 first meeting - ongoing dates diarised
8.a	**DoH**	**MTW,**PAc, AP1	Commence RCA for C. Diff	DR	03/12/2007	Ongoing	8.1.08: COMPLETED and ongoing. 3.12.07: RCA underway
8.b	**DoH**	PAc	Include PCT on RCA flow chart (cross ref. 2.c)	AK	03/12/2007	31/12/2007	14.12.07: Completed see 2.c.
8.d	**DoH**	PAc	Formal report back to ensure organisational learning (cross ref. 2.e)	AK	17/12/2007	31/03/2008	8.1.08: COMPLETED. Standing agenda item. 14.12.07 Commence in January 08 at ICC
8.f	**HC**	HC9	Laboratory information technology & support available to deliver C. Diff surveillance programme - on site testing	DR	03/12/2007	31/01/2008	8.1.08: COMPLETED. 4.12.07: C. Diff testing on site week commencing 10.12.07 – tbc
9.a	**DoH**	HC2	Sarah Matthews to work with Michael Lock and team to develop dashboard summary format	DC	03/12/2007	31/12/2007	6.2.08 Complete - Dashboard changes discussed with Paula Hunt of Performance team – to be in place for Feb IP&CC 24.1.08 Dashboard template taken to IP&C committee 21.1.08 and met with approval – some minor changes/additions to be made 8.1.08: No external contact. Dashboard being developed internally, reviewing other Trusts' dashboards.
9.c	**HCC** **DoH**	HCC16 HC2	Provision of good examples of cross organisation (ward/directorate/Trust) dashboard summaries	DC	03/12/2007	14/12/2007	6.2.08 Complete - Dashboard changes discussed with Paula Hunt of Performance team – to be in place for Feb IP&CC 24.1.08 Dashboard template taken to IP&C committee 21.1.08 and met with approval – some minor changes/additions to be made 8.1.08: Ongoing. Dashboard being developed. 3.12.07: Received and forwarded to ML for information and action
9.d	**HCC** **DoH**	HCC15 PAa, HC2	Ensure Board report gives detailed assurance on issues / actions to address, including audit compliance	CM / ML	03/12/2007	16/01/2008	6.2.08 Complete - Dashboard changes discussed with Paula Hunt of Performance team – to be in place for Feb IP&CC 24.1.08 Dashboard template taken to IP&C committee 21.1.08 and met with approval – some minor changes/additions to be made 8.1.08: Dashboard being developed. Interim report format to January Board. 3.12.07: Agreed CM to develop matrix of assurance for information to January Board meeting.14.12.07 IP&C performance report plus dashboard to January Board
10.c	**DoH**		Ensure all team members have a mentor	AK	01/02/2008	29/02/2008	3.3.08 raised at ICT and diary meetings in Feb 08, no one wished a mentor but know they can revisit this at any time 12.2.08: FB has identified a mentor. Other staff in team to be offered opportunity. 6.2.08 FB 1:1 meetings diarised
10.d	**AP**	AP12	IPC budget review with finance team for 08/09	AK	03/12/2007	31/03/2008	8.1.08: COMPLETED. Budget for 08/09 set. 4.12.07: Meetings with finance manager underway
11.a	**DoH**	PAa	IPC performance reports to be responsibility of Trust's	ML	03/12/2007	Ongoing	12.2.08: CLOSED. 6.2.08 DR and AK with ML and Paula Hunt agreed final changes to performance report to be taken to Feb IP&CC

			performance team				24.1.08 ML and colleague PH working closely with DR and AK to finalising performance reporting 8.1.08: Ongoing. Format being developed by performance team. Meeting arranged for 9.1.08.
11.b	**DoH**	PAa	Recruit additional clinical audit post to support ICT audit processes	AD	03/12/2007	31/01/2008	6.2.08 AK met Nicola Mitchell 5.2.08 who will be IC auditor 24.1.08 Support from temporary Clinical Audit person and dept manager being received on data entry for hand hygiene and HII audits 8.1.08: Ongoing.
12.a	**DoH**		Medical director to be briefed	CM	03/12/2007	07/12/2007	12.2.08: CLOSED.8.1.08: MR aware of action plan and actions required.
12.b	**DoH**		Medical director to brief Lead Clinicians	MR	03/12/2007	31/12/2007	12.2.08: CLOSED. 8.1.08: CM to check progress.
13.2.c	**AP**	AP8	All clinical staff who require food handling training will receive a yearly update, appropriate record keeping and reporting to provide assurance	LS	01/10/2007	Ongoing	3.3.08 Training department matrix confirmed with LS on who needs to undertake what 12.2.08: Trustwide system in place ACTION: Who needs it? Training matrix required. ESR issue. 6.2.08 ICNs providing training linked to essential training programme and induction – ES collects data on mandatory training monthly from department returns
14.a	**DoH**	AP6&7	Prioritise IPC action plan to ensure delivery against all DoH objectives, compliance with the hygiene code and core standards	ES	02/12/2007	18/1/08 07/12/2007	12.2.08: COMPLETE 6.2.08 Hygiene code repeat self assessment completed today 8.1.08: Hygiene code recommendations need to be translated into an action plans. Needs to be reviewed and cross referenced with existing action plan and additional actions to be incorporated where applicable.4.12.07 completed
14.c	**DoH**		Trust to register with Performance Improvement Network (PIN)	AK	03/12/2007	07/12/2007	24.1.08 Complete -Attended meeting – useful event worth continuing attendance to gain learning from other delegates 8.1.08: AK registered and attending 1st meeting. 14.12.07 AK booked onto 17.1.08 meeting - decide after that about future attendance
14.d	**DoH**		Develop local improvement teams after March 2008	AK	01/04/2008	31/05/2008	6.2.08 Clarification from Deborah Critchley by phone on 4.2.08 that this relates to development of regional PIN – Chris Perry at SHA plans to refocus the SWest IC Forum as local PIN
14.e	**DoH**		Clarify practical approach to 'back-filling' Link Practitioners	CM	03/12/2007	21/12/2007	24.1.08 **Done** 8.1.08: Finance need list of Link Practitioners to allocate money. AK and FB to action. 13.12.07 CM informed IPCOG that backfill funds would be sent to ward managers to cover 1 day per month for 2008 - CM to write to WMs
14.g	**DoH**	AP1 HC10	Clarify the requirement to report MRSA /C Diff cases as SUIs (clarification of Serious Untoward Incidents)	CM	03/12/2007	14/12/2007	8.1.08: ICNs to do forms for CDiff. ? ICNs for MRSA – raise at ICT meeting on 10.1.08. 3.12.07: DC has confirmed with Chris Perry - NDHT does not need to report as SUIs to SHA. ICT must report as high risk incident using Trust reporting structure. Subsequent RCA will address response to incident 13.12.07 Confirmed at IPCOG today that incident report forms labelled as high risk will be completed by ICNs on case by case basis

14.h	**DoH**		Identify office space away from ICT for AK	CM	03/12/2007	21/12/2007	24.1.08 temporary part time space available on level 5 on NHSP officers desk 8.1.08: Identified. 13.12.07 Possible place identified in Munro House - CM to confirm
14.i	**HC**	HC11	Introduce enhanced occupational health screening programme accessible to all staff, ensuring arrangements for identification, management and restrictions for those working with HepB&C, HIV infections comply with DoH guidance	HB	03/12/2007	31/03/2008	6.1.08 Assurance given by email 6.2.08 from Kath Turner Occ health
15.a	**AP**	AP1	Completion of module 1 of SSISS orthopaedics - of hip or knee replacements	FB	01/10/2007	31/12/2007	8.1.08: COMPLETED. 1.10.07: Not achieved, hips to be done Oct - Dec 07
15.b	**HC**	HC5	Duty to provide HCAI information to patients and the public	FB	01/10/2007	31/03/2007	6.2.08 Complete - Hand hygiene, C diff and MRSA rates now in ward public noticeboards – HII data to follow end of Feb 8.1.07: Transfer form being developed to include infection control information. 4.12.07: Being incorporated into work of Trustwide documentation group.
15.j	**AP**	AP14	Compliance with CNST Level 1	DR	28/11/2007	26/2/08	3.3.08 Policy changes approved at IPCC and Julie Poyner making final amendments as per NHSLA inspector recommendations today (these minor wording changes are for clarity and do not affect the body of policy approved by IPCC) 12.2.08: Comments need to be inserted in standard precautions and BBV policy. Policies need to be in Trust format and then ratified through ICC. ACTION: AK to check on agenda. 8.1.08: Reviewed and partially compliant with action plan being developed. Feedback to be circulated by DR.
15.k	**AP**	AP9 & 13	Evidenced rolling programme of PEAT and kitchen inspections	FB	01/04/2007	31/03/2008	8.1.08: Completed for 07/08. PEAT inspections well established at NDHT: 15.2.07 NDDH, 12.2.07 Torrington, 20.2.07 Holsworthy, 6.3.07 Bideford, 16.5.07 South Molton (Tyrrell 'too small' for PEAT inspections) Last kitchen inspection took place on 1.10.07
15.l	**AP**	AP13	Rolling audit programme and reporting on: - patient equipment - sharps - policies	FB	01/04/2007	31/03/2008	8.1.08: Sharps and policies audits closed – covered elsewhere. Patient equipment being done through matrons' charter. CLOSED.
15.m	**HC**	HC3	Infection control risks are assessed and reported appropriately. Risks and action plans should be monitored through infection control	AK	01/04/2007	31/03/2008	8.1.08: Being done. CLOSED.

			committee and clinical governance committee				
15.o	**SHA**		Daily review of side room use, colour coding prioritisation of patients using these rooms to inform any movement decisions	FB	02/01/2008	31/03/2008	3.3.08 Tool tabled at IPCC 26.2.08 12.2.08: Ongoing. Colour coding agreed by ICT. ACTION: AK to check scheme has been implemented. 6.2.08 Scheme piloting underway – review at ICT 7.2.08 24.1.08 Scheme designed by ICNs, being piloted this week
15.q	**HCC**	HCC7	The trust should develop systems to monitor the number of occasions on which it is not possible to isolate patients identified as an infection risk and should monitor compliance with infection control advice	AK		31.3.08	3.3.08 Trust Incident Report forms to be completed for these cases – AK contacted Caroline Raby today by email regarding addition to policy re use of IR forms
15.r	**HCC**	HC4 HCC17	The trust should ensure their mechanisms for monitoring the cleaning contract and environmental audits are sufficiently robust	TH		31.3.08	3.3.08 Cleaning audit cores included on IPCC dashboard for first time in Feb 08
15.s	**HCC**	HCC8	The trust should make an assessment to determine if the number of isolation rooms is adequate	AK		31.3.08	3.3.08 at IPCC 26.2.08 it was raised that in acute medicine and surgery wards at NDDH between 15.1.08 – 19.2.08 that required isolation on151 bed days was not possible therefore insufficient single rooms – Directorate managers detailed to go and reassess rooms that can be converted
16.b	**HC**	HC2	Develop patient placement policy incorporating patient movement, transport and bed management	CM	01/10/2007	30/11/2007	8.1.08: Bed management policy done. COMPLETED. 4.12.07: Bed management policy to October CSEC 3.10.07: Draft bed policy with ICT for review
16.e	**HC**	HC6	Strengthen records management systems	JG	01/10/2007	31/03/2008	8.1.8: Case not e tracking implemented November 2007. CLOSED. 4.12.07: HCR strategy and A&C project initiation document approved by Executive Directors. Case note tracking introduced at NDDH on 28.11.07
16.f	**HC**	HC10	Develop closure of wards policy in collaboration with patient transfer and management policy	AK	02/10/2007	31/12/2007	8.1.08: Check in outbreak policy
17.d	**AP11**	MTW	Ensure that IC requirements are given full consideration during redevelopment of the hospital	AK	1/1/08	31/3/08	6.2.08 ICT and Facilities Director and management team met 1.2.08 to review interface and assurance – Estates Liasion Policy being updated as Facilities Liaison Policy 24.1.08 IC & Estates meeting to take place on 1.2.08 10.1.08 Meeting with AK, Iain Roy and Tricia Hawson on 14.12.07 (AK invited to Projected Management Update meetings in order to review any final business cases to determine whether there is an IC element – see email from IR 14.12.07) TH made responsible by IR

							to be Facilities rep on IPCC rather than just Hotel Services in order to alert the IPCC to all new final business cases from Estates
	High Priority						
		Key to Links:	**AP =** Annual Plan 07-08 **DoH =** DoH Priority plan Dec 07 **DoH2** = DoH MRSA Improvement Team revisit 18.3.08 feedback letter **HC =** Hygiene code (self assessment) **PA =** Priority action plan (compiled November 07) **SHA =** Strategic Health Authority **HCC = Healthcare Commission Jan 08 report from 22.8.07 inspection visit**				
			Key to colour coding of action start dates:		December		
					January		
					February		
					March		
					April		
					Action closed		