1 Introduction

1.1 The Infection Prevention & Control team (IPAC team) endeavours to provide a comprehensive and proactive service to both Norfolk Community Health & Care NHS Trust (NCH&C) and its external clients. There is a clear commitment to the promotion of excellence within everyday practice of infection prevention and control.

1.2 The annual report outlines the activities of the Infection Prevention & Control Service, the team structure and reflects on the achievements and progress over the past year. Identified gaps and future plans are provided for within the Annual Programme for 2014-15.

2 Infection Control Service objectives

2.1 The strategic aim of Infection Control within NCH&C is to increase the organisational focus and collaborative working on Infection Prevention & Control and reduce the rates of healthcare acquired infections (HCAI).

2.2 The Infection Control Service Objectives were identified as:

2.2.1 Strategic Planning and Advice:
- Clearly defined responsibility for IP&C within NCH&C as the organisation moves towards Foundation Trust
- Effective management systems for the prevention and control of infection that are informed by risk assessment and analysis of incidents.
- Meet contractual targets set by commissioners

2.2.2 Operational Planning:
- To increase public confidence in NCH&C Infection Control Service
- To reduce the incidence of HCAIs across the Trust, specifically to meet the target for MRSA bacteraemias and *Clostridium difficile* cases as defined by NHS Norfolk Commissioners, and to actively participate in initiatives to reduce MRSA and *Clostridium difficile* across the Health and Social Care economy.
- To engage staff at all levels to develop and embed a culture to support infection prevention and control across the trust

2.3 These objectives reflect the requirements of The Health and Social Care Act (2008) which the Infection Prevention & Control Service maintains as its benchmark. It is recognised that these objectives will need to continue to be embedded, monitored and further developed during 2014-15.
3 Description of Infection Control Arrangements

3.1 Reporting Line to NCH&C Board and the Infection Control Structure

3.1.1 The IPAC team have spent the last year under the direct line management of the Medical Director but will move under the Director of Nursing in the very near future.

- Head of IPAC/Dep. DIPC 1.0 WTE
- IPAC Specialist Nurses 3.0 WTE
- IPAC Nurse Facilitator 0.8 WTE
- IPAC Liaison Nurse 1.0 WTE
- IPAC Administrative Post 0.5 WTE

3.1.2 The IPAC Nurse Facilitator has successfully completed a qualification in IPAC over the last year and over the coming year will review the job description in line with the other Nurse Specialist roles.

3.1.3 A Service Level Agreement with the Norfolk and Norwich University Hospital Foundation Trust (NNUHFT) Microbiology department provides NCH&C with the appropriate Consultant level support for infection control and anti-microbial prescribing. The IPAC team meet regularly with Dr. Ngozi Elumogo, Consultant Medical Microbiologist. This contract is regularly reviewed and due to be renegotiated to ensure the best possible service to the team and organisation.

3.1.4 This post is directly funded by CCGs and hosted by NCH&C. The IPAC Liaison post was vacant for a short while due to a resignation and time taken to recruit. However the new member of staff has been in post from March 2015 and is meeting all KPIs to date. Commissioners are receiving trend analysis on a monthly basis and Primary Care are receiving completed RCAs with summary and recommendations within a 2 month time frame.

3.2 Reporting Structure

3.2.1 Monthly

- **Corporate Performance Report**
  (Reports: Surveillance of alert organisms i.e. Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium difficile, Meticillin Sensitive Staphylococcus Aureus (MSSA) and Escherichia coli (E. coli) bacteraemia, Healthcare Acquired Infection (HCAI) root cause analysis, uncommon / serious infections, staff training data, Infection Prevention & Control (IP&C) report and plan, HCAI group attendance and Outbreak reporting i.e. Norovirus).

- **Schedule 4 report**
  (Reports: MRSA bacteraemia, Clostridium difficile, IPS and Hand Hygiene Audits to CCGs)

- **Out of Area**
  (Reports: MRSA bacteraemia, Clostridium difficile for any patients outside of Norfolk)

- **Liaison KPIs**
3.2.2 Quarterly

- Quality Report
  (Provides an overview of IC activity over the quarter for NCH&C)

- Quality and Risk Assurance Committee
  (Chairs report from Infection Control Committee detailing the previous quarter’s activity).

4 Strategic Planning and Advice

4.1 Infection Control Committee

4.1.1 The Infection Control Committee (ICC) is accountable to the Board and reports through the Quality and Risk Assurance Committee on a quarterly basis. Its primary focus is to provide IPAC leadership and strategic direction based on national guidance and the local needs of all services provided by NCH&C to support the development of an organisational culture ensuring staff at all levels prioritise and engage in infection prevention and control. As part of the annual review of effectiveness membership of the ICC has been revised during the year to position the committee towards meeting its aims and requirements effectively.

4.2 Links to Clinical Governance

4.2.1 An Infection Control Specialist is also represented on:

- NCH&C Health & Safety (H&S) committee
- All locality based H&S Committees
- Clinical Audit Committee
- Water Safety Committee
- Equipment Group
- Clinical Policies Group
- Facilities Management
- Locality based governance meetings

4.3 Links to other services

4.3.1 The IPAC team also has links with:

- Public Health England, Norfolk, Suffolk and Cambridgeshire (PHE)
- Norfolk and Norwich University Hospital Foundation Trust, Queen Elizabeth Hospital (QEH), James Paget Hospital (JPH)
- Microbiology Services at NNUHFT
- Various Infection Control networks across the East of England Strategic Health Authority area & nationally

5 Decontamination
5.1 The IPAC team has continued to participate in the ongoing work to ensure that NCH&C is compliant with national standards for the decontamination of re-usable instruments i.e. dental, podiatry and other surgical instrumentation. The Sterile Services Department (SSD) is run by NCH&C and currently processes all instrumentation for Podiatry services, Foot Surgery and all community nursing services. The plan to bring in-house SSD services currently supplied by other providers has also now been successful. A Working Group, chaired by the Service Manager for Podiatric Surgery and Specialist Services Project Lead, has been established to facilitate work enabling dental instruments to be processed within the SSD to ensure NCH&C meet the Best Practice standards as defined in HTM 01-05 Decontamination in Primary Care Dental Practices. The work regarding dentistry is following an ongoing plan to bring all areas in house for SSD. This process should be complete during 2015.

5.2 The SSD Manager is the Operational Lead for Decontamination and is a member of the Infection Control Committee. However the role of decontamination lead within the Trust has remained vacant to date, this has been part of an ongoing discussion within the Medical and Nursing & Quality Directorate and this position will now fall to the Director of Nursing. The new financial year will see the structure of the committee and terms of reference developed and a meeting structure put in place.

5.3 The IPAC team reviewed cleaning methods used by clinical staff across the organisation over the last year 2014-15 with a view to change. At that point in time it was noted that staff were engaging in a 2 tier system involving:

5.3.1 Detergent
5.3.2 Disinfection

5.4 There were several issues to managing cleaning in this way:

5.4.1 When using detergent wipes it is essential that the area being cleaned is also dried and not left to air dry, which IPAC staff were confident was not happening thereby causing a further risk.
5.4.2 Staff were confused when then should use detergent or disinfectant

5.5 Having reviewed several systems of wipes the Trust have moved all cleaning and disinfection products to Clinell wipes and have chosen to go with a 1 wipe system, using Clinell’s Universal wipes. The only exception is for patients with Clostridium difficile and in these cases a different wipe is used and/or Tristel (chlorine dioxide product)

5.6 The IPAC team worked closely with procurement on this project and are assured that not only have they the best product clinically but also a cost effective product. The support from Clinell has been outstanding to date.

6 Cleaning services
6.1 Cleaning services are currently contracted out to G4S. G4S have now been providing the cleaning contract for over a year with contract meetings will take place monthly where IPAC will take an active role.

6.2 The IPAC Nurses have participated in National Standards of Cleanliness Management audits and Patient Environment Action Team (PEAT), from 2013 replaced with PLACE (Patient Led Audit of the Care Environment), visits which assess the quality of cleaning services. However changes to both audits now mean that IP&C input is no longer required. The team is however still available for any problems with IPAC or cleanliness in any area.

7 NCH&C Estate

7.1 The IPAC team have been involved in the development of the following projects during this year:
- Simpson Centre, Kelling hospital
- 5 Mill Close, (children’s respite)
- 4 Walpole Road, Kings Lynn (Signpost)
- Birch Tree Close Bungalow 2, Kings Lynn
- St James clinic rooms, Kings Lynn
- Wymondham Health Centre, leg ulcer clinic
- Beetley Physio, Dereham Hospital
- Ogden Court upgrade, Wymondham

8 Health Care Associated Infections (HCAI) statistics

8.1 The following data shows all new MRSA (non-bacteraemias) and Clostridium difficile isolates identified from patients in NCH&C in-patient areas during 2014-15. Normally prior to 48 hours the infection/colonisation is regarded as incubating at the time of admission, and therefore would not be attributed to the hospital site taking the specimen. Previously, in the absence of pre-admission screening, the MRSA figures needed be treated with caution since a patient’s carrier status was up until March 09 unknown at the point of admission to one of our units. Data is now more explicit and meaningful with the introduction of admission screening.

9 MRSA Bacteraemias

9.1 MRSA bacteraemias (blood cultures) are reported by the NNUHFT and QEH microbiology laboratories under the Department of Health’s Mandatory MRSA surveillance scheme.

9.2 It is mandatory for trusts to report all MRSA bacteraemias identified by their laboratories. As most laboratories are housed within Acute NHS Trusts, these are broken down to identify specimens taken within 48 hours of admission and post 48 hours of admission to indicate which are community (pre 48 hours) or hospital acquired (post 48 hours).

9.3 Root Cause Analyses (RCA) are completed for all MRSA bacteraemias and action plans are carried out where possible contributory causes are identified.
9.3.1 Although the national target for MRSA bacteraemia is for Acute Trusts, NCH&C was set a local ceiling of nil cases of MRSA bacteraemia for 2014-15 against our in-patient beds only by NHS Norfolk, who also calculated the trajectory seen below. Working to the definition that the blood culture specimen is taken within 48 hours of admission to an Acute Trust following admission from one of NCH&C’s inpatient units.

9.3.2 All patients within NCH&C inpatient beds with any history of MRSA receive Octenisan body wash for the duration of their admission, which keeps NCH&C in line with other acute hospitals locally.

10 MRSA bacteraemia data for NCH&C 2014-15

![Graph showing MRSA bacteraemia cases against cumulative trajectory]

11 MRSA Admission Screening

11.1 The Department of Health issued instructions (Gateway Ref.10324 July 2008) requiring NHS Trusts to implement a programme for screening certain categories of ‘elective’ patients for MRSA by the end of March 2009. This was subsequently amended by East of England Strategic Health Authority to include all non-elective admissions as well. For NCH&C, these categories included all patients admitted to our Community Hospitals and patients admitted to undergo Foot Surgery at Norwich Community Hospital.

11.2 Discussions were held with stakeholders, principally the inpatient units, the laboratories and the Performance team to create a robust process for undertaking the screening and then subsequently reporting the numbers back via the UNIFY system to the Department of Health.

12 Inpatient Admission screening data for NCH&C 2014-15
12.1 The above graph details how many patients have had a positive screen for MRSA on admission to one of NCH&C’s in-patient units. This means that attribution for the acquisition of MRSA is apportioned to the previous location of the patient, whether it is an acute hospital or their own home.

12.2 All MRSA positive admissions to NCH&C inpatient units coming from an acute setting are traced through the system to determine their MRSA status on their acute admission. Those patients identified as acute admission negative and NCH&C admission positive (i.e. acquired within the acute) are highlighted to the acute hospital in question. Occasionally this will highlight issues within the acute services.

13 New MRSA isolates:

Beth Kimber
Head of Infection Prevention & Control
Post admission MRSA figures (i.e. developed within our inpatient unit)

13.1 The above graph details how many patients whilst in the care of one of NCH&C’s inpatient units have had a positive MRSA screen. In total, over the course of 2014-15, 6 patients have had a positive MRSA screen whilst in the care of NCH&C for 48 hours or more. This is an improvement on the 2013-14 figures of 10.

14 Clostridium difficile

14.1 NCH&C had a ceiling of 5 cases of C. difficile for 2014-15 set by NHS Norfolk as was the trajectory. NCH&C ended the year with 6 cases of C. difficile within our inpatient beds

14.2 This has been an increase on the previous two years cases; however NCH&C had a total of 13 cases of C difficile acquired across our inpatient units, 7 of which were removed from attribution through the Post Infection Review Process, a new process for 2014-15. See point 15

14.3 Worthy of note at this stage is the increase in cases of C difficile across the county and regionally. This has led to an increase of DH set ceilings for many organisations for the new financial year.

14.4 To highlight the general improvements made by NCH&C consider the total number of C.difficile cases identified within NCH&C Community Hospital inpatient units:
### Year Total

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009-2010</td>
<td>19</td>
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<tr>
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<tr>
<td>2012-2013</td>
<td>3</td>
</tr>
<tr>
<td>2013-2014</td>
<td>3</td>
</tr>
</tbody>
</table>

15 Clostridium difficile data for NCH&C for 2014-15 and PIR

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NB Please note that the graphs above/below show all cases of positive C. difficile cases including those that are non-trajectory but it also misses cases which were identified within an acute setting within 72 hours of transfer.
Also worthy of note is that all positive GDH cases are within the graph giving higher numbers than the official stats

The above graph details how many patients whilst in the care of one of NCH&C’s inpatient units have developed Clostridium difficile, by month and then by unit.

15. This financial year saw a process of Post Infection Review (PIR) of cases of C. difficile; A case will be considered suitable as non-trajectory for the organisation only as a result of:

- A timely, thorough and exhaustive multidisciplinary investigation between Providers and their Commissioners, using Root Cause Analysis (RCA) methodology supported by a CDI post infection review tool for specific data collection and
- when the RCA multidisciplinary team consensus view identifies either of the following outcomes:
  a. all care was delivered in line with best practice and the patients clinical condition (which was not clearly attributable to an underlying condition at the time of testing), was considered to be ‘colonisation’ with C. difficile and not infection
  b. all care was delivered in line with best practice but the infection still occurred

15.1 In cases of a successful non-trajectory infection the case will still be accounted for on the national database however it will not be held against the appealing organisations trajectory. As discussed in point 14.2, NCH&C had a total of 13 cases of C. difficile identified in patients within the inpatient units. Of these 13 cases 7 were successful in the PIR process and removed from NCH&C trajectory.

15.2 All cases went through the PIR process but 6 were unsuccessful and therefore sit on NCH&C trajectory
15.3 There were three key themes leading to the unsuccessful progress of the PIR process:

15.3.1 Unacceptable environmental cleaning scores (cleaning contractor) – 3 cases
15.3.2 Poor prescribing practice (medics) – 1 case
15.3.3 Lack of timely action by ward staff i.e. specimen taking, isolation, recognition of altered bowel habit (nursing staff) – 3 cases

16. Glutamate Dehydrogenase (GDH)

16.1 The laboratory carries out 2 types of tests for C. difficile infections. One is a GDH test, which if positive it is suggestive of the patient being colonised and whilst not an issue for the patient necessarily they can still contaminate the environment with spores and thus cause cross contamination of other patients.

16.2 If the patient is GDH positive the lab will then go on to test for Clostridium difficile infection (CDI).

16.3 Patients who have a positive GDH result will be managed exactly the same as a patient who is CDI positive due to the risks to other patients. They may well also be medically treated if the diarrhoeal symptoms are severe.

16.4 It has been necessary to have some patients undergo further testing of their stool using Polymerase Chain Reaction (PCR), due to prolonged period of diarrhoea and therefore prolonged isolation which inhibits rehabilitation.

16.5 PCR is a technology in molecular biology used to amplify a single copy or a few copies of a piece of DNA across several orders of magnitude, generating thousands to millions of copies of a particular DNA sequence.

16.6 This technology allows IPAC staff to assess whether the GDH result of a given patient is pathogenic or non-pathogenic, which in turn allows for re-assessment of the isolation status of a patient. This allows those patients who may be GDH positive but of no risk to other patients to come out of isolation for their rehabilitation and a speedy return home.

16.7 This technology is not currently available in the Norfolk and Norwich laboratory however a business case is being put forward, from within the laboratory, to request this facility. In the meantime where a particular case proves necessary we can access this test outside of the county.

17 Outbreaks

17.1 An outbreak is defined as two or more linked cases, in time and location, of the same infection. Norovirus is the leading cause of acute gastro-enteritis in individuals in the community and the cause of most outbreaks of infection in hospitals, nursing homes, schools and ships.
18. **Norovirus:**

18.1 There was 1 confirmed outbreak of Norovirus within the NCH&C Community Hospital inpatient areas during 2014-15. This is a testament to the hard work and vigilance of our staff with transfers of patients.

18.2 There was one confirmed outbreak of Norovirus was on Alder Ward, Norwich Community Hospital.

<table>
<thead>
<tr>
<th>Location</th>
<th>Month</th>
<th>Patients affected</th>
<th>Staff affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caroline House</td>
<td>Feb</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Alder</td>
<td>March</td>
<td>8</td>
<td>11</td>
</tr>
</tbody>
</table>

18.3 Norovirus outbreaks have a major disruptive effect on service delivery and can lead to the temporary closure of Inpatient Units.

18.4 An outbreak report was completed on this occasion including recommendations as appropriate by the Infection Control Nurse Specialists and sent to the following individuals:

- Director of Operations / Executive Nurse
- Deputy Executive Nurse
- Head of Infection Prevention & Control
- Modern Matron of the affected area
- Ward Sister
- Assistant Director and Service Manager for the appropriate Locality

20 **Waste**

20.1 **Community waste**

The community waste project is ongoing under the leadership of the Waste Manager. Documentation to support a trial of new policy arrangements for the management of community waste generated by NCH&C practitioners was developed and a trial undertaken by a community team in the South Locality – Dereham Integrated Team. To date documentation has been formulated inclusive of a risk assessment tool for assisting community staff to segregate waste, a flow chart, and a home collection request form. Transport boxes that comply with legislative requirements for the carriage of waste have been sourced and reviewed by clinicians. A list of non-hazardous waste generated from healthcare activities in the community has been drafted and circulated to the Local Authorities County wide for comment and feedback. This piece of work has now been agreed during the course of the year.

20.2 The final business plan which was approved involves community staff assessing waste for its state of infectivity and where necessary requesting a home collection. NCH&C have employed its own staff to carry out these collections and this service is due to begin in the new financial year.
21.1 Water safety and quality has become a focus for the IPAC team in the recent past; both the Head of IPAC and one other team member have attended the Responsible Persons Course for Legionella and continue with frequent updates. The role of Responsible Person for Legionella sits with the Director of Finance.

21.2 A robust Water Safety Group has been established meeting on a quarterly basis with an operational sub-group meeting monthly. Both groups have representation from IPAC, Estates, Health & Safety and clinical staff.

21.3 Specialist water consultancy advice has been sought and retained on an annual basis. A water safety plan inclusive of policy has been commissioned for the Trust and final delivery is expected early in the financial year.

22 Policies and Guidelines

22.1 NCH&C IPAC team are constantly reviewing and updating all infection control policies and guidelines ensuring that they are evidence based. All policies are sent for consultation to members of NCH&C Infection Control Committee and then to the Quality & Risk Committee for final ratification. The final version is available to all NCH&C staff on the intranet site. All staff are instructed during mandatory update training on how to access infection control policies.

22.2 Infection Control Committee and QRAC have signed off the following policies and information leaflets:

- Clostridium difficile
- ANTT
- Major Outbreak
- Sharps
- Standard Precautions
- Isolation
- VZV
- MRSA
- Multi-Resistant Organisms
- Linen
- Hand Hygiene
- Transport of Specimens
- TSE
- Head Lice

Policies for review 2015-16:

<table>
<thead>
<tr>
<th>POLICY</th>
<th>STATUS</th>
<th>TIMESCALE</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIL</td>
<td></td>
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</tbody>
</table>

New policies for development 2015-16

- Carbapenemase Producing Enterobacteriaceae (CPE)
The Enterobacteriaceae are a family of Gram negative bacteria (sometimes called coliforms) which are part of the normal bacterial gut flora. They include common pathogens such as *E. coli*, *Klebsiella sp*, *Proteus sp* and *Enterobacter spp*. These organisms are some of the most common causes of many infections such as urinary tract infections, intra-abdominal infections and bloodstream infections.

Carbapenems are a class of very broad spectrum intravenous antibiotics which are reserved for serious infections or when other therapeutic options have failed.

### 23 Hand Hygiene Audits

23.1 A programme of Hand Hygiene audits was originally introduced into the Inpatient Business Unit but is now in place across all Localities. The audits are owned and conducted by the staff and results fed back to the IPAC team who monitor standards and recommend actions to correct any areas of failure. The audits monitor compliance with a number of areas:

- ‘Point of Care’ alcohol hand sanitizer
- The display of 6 step technique posters
- Hand decontamination practice and knowledge
- ‘Bare below the elbows’ initiative and the Dress Code
- The facilitation of good hand hygiene for patients

23.2 The audits are repeated according to a frequency schedule which is determined by a unit’s audit performance. The focus on hand decontamination produced by the audit process has led to improvements in the compliance with standards.

Inpatient Units
The graph shows inpatient units as this is the area within which the IPAC team are able to carry out validation audits as a direct comparison to self auditing.

24 Training and Education

24.1 The IPAC team have been actively involved in the delivery of the Mandi Tory training sessions which have been well received within the four main geographical localities. The project began with inpatient staff and has subsequently been rolled out to community nursing and therapy staff. More recently this program of training has been delivered to the Specialist Locality where it has again been well received.

24.2 These training sessions are held at venues around the county ensuring equitable access for all staff and are organised by the Workforce Training Team.

24.3 The IPAC team also endeavours within its capacity to provide discipline-specific training within the community / clinic group of staff which is a very diverse mix of professional groups. This has included:

- Dental services
- Podiatry
- Therapists (Physiotherapy, OT & SALT)
- Children's services

25 NCH&C Infection Control Annual Conference

25.1 The IPAC team held their Annual Conference in October 2014 which was fully booked with 155 delegates. The audience consisted of NCH&C employed staff along with staff from private healthcare and General Practice. The focus of the day was mixed with sessions provided by Public Health England (PHE), Mental Health for Cambridge and Peterborough NHS Foundation Trust amongst others.

25.2 The purpose of this day is to offer an educational session, with internal and external speakers, to NCH&C staff as well as the general healthcare economy of Norfolk.
day raises the profile of NCH&C and the IPAC team across Norfolk and also generates income for the organisation.

26 Collaborative Working

26.1 The Infection Prevention & Control Service supports collaborative working. Examples include:

- The Head of Infection Prevention & Control attends DIPC – DIPC meetings with Public Health within Norfolk County Council on a quarterly basis to ensure collaborative working between the two organisations. There have been initial discussions into collaborative working for care homes within Norfolk which is in its infancy.

- The Head of Infection Prevention & Control attends the System Wide Health Care Acquired Infection (HCAI) which is chaired by Lucy McCloud (Interim Director of Public Health / DIPC). The aim of this group is to have a Norfolk wide (acute / community) approach to the reduction of HCAI

- The Infection Prevention Society has achieved local branch status within the East of England, which the NCH&C team attend regularly. The Head of IPAC took the role of Deputy Treasurer in June 2013.

- The IPAC team have had close working relations with the microbiology laboratory within the NNUH. The merge of the laboratories from Gt. Yarmouth and QEH within NNUH has seen improved collaboration across the county.

- The Head of IP&C attended the SHA HCAI taskforce group for some time throughout 2013. This meeting was discontinued during this time following the dissolution of the SHA but it has recently been reformed under the umbrella of NHS England.

27 Income Generation

27.1 NCH&C continue to provide an Infection Prevention & Control Service via Service Level agreements (SLA’s) to the following:

- Milestones, Salhouse
- Poringland Medical Practice
- St James Medical Practice, King’s Lynn
- Little Plumstead Hospital, Hertfordshire Partnership Foundation Trust
- Jeelsal, Cawston Park Hospital, Cawston
- All Hallows
- East Anglian Children’s Hospices
- Timberhill Walk in Centre
- Market St, Aylsham
- Drayton Medical Practice
- St Stephens Gate Medical Practice
- Grove Surgery, Thetford)
- Wymondham Medical Practice.
- Woodcock Road Medical Practice
• The Lawns, Diss

27.2 The IPAC team has also provided additional training sessions to other healthcare providers in line with capacity this year, and this is an area where there is scope to expand, subject to resources being available.

27.3 Infection Control continues to work closely with the Commercial Development Team to promote the service to independent healthcare and primary care.

28 Summary

28.1 The IPAC team have had a successful year and have engaged well with staff in clinical work places and have been able to be more visible out in clinical areas.

28.2 The main area of note is the breach in the Clostridium difficile ceiling at a time when the Norfolk Health economy generally has struggled with C. difficile.

28.3 The key items of progress to note include:
• Successful appeal of 7 Clostridium difficile cases
• Successfully re-appointed into the Infection Control Liaison Post with collaboration with Public Health
• More visibility of IPAC in clinical areas
• Successfully negotiated an increase in C. difficile ceiling for next financial year
• Successfully changed the process of decontamination in the Trust to a much simpler process

29 Key Risks to NCH&C for 2015-16

• Breach of alert organism ceilings (MRSA, C. difficile) set by CCGs
  Appeals process for C difficile to be implemented where appropriate. Continued focus on MRSA with mandatory training.

• Risk to external business as social enterprises compete in the market place. Continue close liaison with Commercial Development and Finance Team to ensure our service offers best value for money.

• Lack of engagement of NCH&C staff with regard to Infection Control
  Alter focus of audit over coming year from environment to clinical practice

• Change in mandatory training process for 2015-16 which takes IPAC specialists out of the training program
  IPAC staff have full control over training program for IPAC. Good communication between training and IPAC team necessary to ensure issues are fed back and addressed.

• Risk to team capacity as vacancy is not filled
  Consider the continuance of external income generating work if capacity is not sufficient for NHC&Cs own needs
30  Key Focus/Challenges for 2015-16

- Continue to work closely with staff in all settings regarding management of all alert organisms with particular reference to both MRSA and C diff.
- Work closely with procurement to ensure staff are using the most cost effective products available.
- Continue to embed a culture of Infection Control across the whole organisation and all disciplines by altering the IPAC team focus of audit from the environment and buildings to concentrate more closely on clinical practice.
- Work with SERCO and other external contractors to ensure their planned programme of maintenance for buildings meets the requirements to control the risk of Legionella and general water safety in our healthcare facilities.
- Close collaboration with cleaning contractor to ensure the estate meets the requirements as set out in National Standards of Cleanliness

31  Recommendations

31.1 The Board is asked to:

- Note the Infection Control Annual Report and approve the reporting mechanisms outlined within section 3.2 thereby providing assurance that sufficient resources are available to secure the effective prevention and control of HCAI.
- Approve the Infection Control Annual Plan thereby providing board level agreement of the collective responsibility for minimising the risks and general means by which it prevents and controls such risks.

The Infection Prevention & Control Team would like to thank other staff within NCH&C for their assistance and support in achieving its objectives during the year.