Report to:	Public Board of Directors	Agenda item:	8
Date of Meeting:	26 July 2017		

Title of Report:	**Infection Prevention and Control Improvement Plan**
Status:	**For approval**
Board Sponsor:	**Helen Blanchard, Director of Nursing and Midwifery and Director of Infection Prevention and Control (DIPC)**
Author:	**Rob Eliot, Quality Assurance and Clinical Audit Lead**
Appendices	**Appendix A: Infection Prevention and Control Improvement Plan – post NHS Improvement Review** **Appendix B: NHSI Letter (to follow)**

1.	Executive Summary of the Report

This report highlights findings following a review of Infection Prevention and Control performance and assurance processes at the Trust by NHS Improvement in February 2017. 16 recommendations for improvement were made. An improvement plan (Appendix B) has been developed which details the actions that will be taken to address these recommendations. Each action has been RAGB (red, amber, green, blue) rated to indicate whether they are progressing according to the timescales identified in the improvement plan.

2.	Recommendations (Note, Approve, Discuss)

The Board is requested to approve the improvement plan that has been developed from the NHS Improvement visit to the RUH in February 2017 and approve the Infection Prevention and Control Committee monitoring the implementation of the plan.

3.	Legal / Regulatory Implications

It is a legal requirement to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12 (Safe care and treatment) sets out the requirements for providers to prevent and control the spread of infection.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)

A failure to demonstrate systematic quality improvement in the delivery of patient care could risk the Trust's registration with the Care Quality Commission.

5.	Resources Implications (Financial / staffing)

The costs of compliance are embedded within operational delivery costs.

6.	Equality and Diversity

Equality and Diversity legislation is an integral component to registration.

7.	References to previous reports

None

8.	Freedom of Information

Public

Infection Prevention and Control Action Plan

1 Introduction

1.1 The Head of Infection Prevention and Control (South) NHS Improvement was invited to review the Infection Prevention and Control performance and assurance processes at the Trust by the Director of Nursing and Midwifery.

1.2 The main focus of the review was on Clostridium difficile infections (CDI) due to the higher rate within the Trust compared to other surrounding trusts. CDI performance at the time of the visit was, up to December 2016, 26 attributable against a trajectory of 16.

1.3 Prior to the site visit, a request for documents was received. These were reviewed and triangulated by NHS Improvement with information collated during the site visit.

1.4 The site visit took place on 7 February 2017. Meetings were also arranged with trust staff with key roles in the Infection Prevention and Control agenda.

2 Key Findings

2.1 Feedback was provided by NHS Improvement at the completion of the visit and a full summary of the findings provided on 9 May 2017.

2.2 NHS Improvement made 16 recommendations for improvement of which issues related to antimicrobial stewardship, including the role of the antimicrobial pharmacist, and consistency of cleaning standards, systems and processes were identified as the top risks.

2.3 Appendix B details the actions that are planned in response to each of the 16 recommendations.

2.4 Each action has been RAGB (red, amber, green, blue) rated to indicate whether the actions are progressing according to the timescales identified in the improvement plan. The comments / action status column has been updated to reflect progress towards implementing the actions.

2.5 Delivery of the improvement plan will be monitored by the Infection Prevention and Control Committee and incorporated into the work programme of the committee. Progress will also be reported to Management Board and the Board of Directors on a quarterly basis.

2.6 In order to test whether completed actions have been effective in addressing the recommendations, Key Performance Indicators (KPIs) or examples of evidence have been suggested, where applicable, to assess whether there has been a resulting improvement in performance. These will be monitored at the Infection Prevention and Control Committee.

3 Recommendations

3.1 The Board is requested to approve the improvement plan that has been developed from the NHS Improvement visit to the RUH in February 2017 and approve the Infection Prevention and Control Committee monitoring the implementation of the plan.

Appendix A: Infection Prevention and Control Improvement Plan – post NHS Improvement Review

Recommendation No:	1
Recommendation:	Focus and refresh the Trust agenda to encompass the wider patient safety agenda, to include AMR, diarrhoea, urinary tract infections and catheter associated infections
Lead:	Helen Blanchard, Director of Nursing and Midwifery

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Refresh the Infection Prevention and Control (IPC) Strategy which includes key IPC objectives for the Trust, IPC initiatives and Key Performance Indicators (KPIs).	31/08/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Green	Strategy is being reviewed. It will be submitted to the Infection Prevention and Control Committee in August 2017.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	2
Recommendation:	Share what is working well across the Trust. For example: the work on 'to dip or not to dip' has not been shared widely, ABCD review, urinary catheter passports.
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse Helen Blanchard, Director of Nursing and Midwifery

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Share use of the catheter passport across the Trust	31/05/2017	Jackie Robinson, Senior Sister Urology	Blue	Training rolled out, included on Continence Ambassador's Study Day, added to Continence web pages on the intranet. Has also been shared with several other acute trusts, CCGs, community health care providers and NHS England.
Audit catheter passport awareness	30/06/2017	Jackie Robinson, Senior Sister Urology	Blue	Audit completed 24/05/2017, results awaited
Introduce 'to dip or not to dip' project for patients over 65	31/08/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse Julia Papps, Matron	Green	Provisional meeting held in June 2017. It was agreed to do a survey on knowledge of the principle of 'dip or not to dip'. Results of the survey show that additional training would be beneficial for medical staff in the OPU setting. A flow chart will be introduced and trialled in MAU and ACE wards during July 2017. Snapshot audit of all patients treated for a UTI within the Trust will be undertaken in July 2017. Core skills and corporate induction training slides are being updated to include 'to dip or not to dip' and feature in the Infection Prevention Control newsletter and next study day. Ad hoc training sessions for ward staff will also be provided. Learning from the work undertaken by BaNES CCG is also being shared and is helping to inform this project.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	3
Recommendation:	Review of Antibiotic Prescribing policy and antimicrobial stewardship, this may require external expertise.
Lead:	Tim Craft, Medical Director Wendy Fletcher, Senior Pharmacist

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Review "Antibiotic Prescribing Policy" (review date November 2016)	31/08/2017	Wendy Fletcher, Antimicrobial Pharmacist	Green	Current policy is in line with "start smart then focus" principles. Review commenced 27th June 2017. No major changes anticipated.
Review of "Antibiotic Guideline: Empirical Treatment of Infections in Adults" - Ensure up to date with current evidence/national guidelines - Ensure choices are in line with local laboratory testing and epidemiology - Ensure treatment recommendations for likely empirical indications included - Ensure antibiotics with a low risk of causing CDI are included where possible	30/06/2017	Jane Liu, Consultant Microbiologist Wendy Fletcher, Antimicrobial Pharmacist	Blue	Amendments frequently made to guidelines to reflect available evidence, CQUIN achievements and antibiotic availability. Guidelines last updated 12th June 2017.
External review of "Antibiotic Guideline: Empirical Treatment of Infections in Adults" and "Surgical Prophylaxis in Adults" and Antibiotic stewardship	31/08/2017	Sarah Wexler, Clinical Lead for Pathology	Green	External review of microbiology services scheduled for 14th/15th August 2017 by Dr Mumford (Consultant Microbiologist). Review of guidelines and antibiotic stewardship to be included in this visit.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	4
Recommendation:	Review of the role of the antimicrobial pharmacist and explore the potential for additional resource.
Lead:	Helen Blanchard, Director of Nursing and Midwifery & Director of Infection Prevention and Control

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Review of how the time is used to fulfil the role of the antimicrobial pharmacist	30/06/2017	Helen Blanchard, Director of Nursing and Midwifery & Director of Infection Prevention and Control	Blue	Review undertaken.
Recruitment of a 0.5WTE antimicrobial pharmacy technician to lead on audit data collection and CQUIN.	30/09/2017	Wendy Fletcher, Antimicrobial Pharmacist	Blue	Antimicrobial pharmacy technician recruited, commencing in post mid-September. Once in post the frequency of the audits will increase to monthly trust-wide.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	5
Recommendation:	Review of the Antimicrobial stewardship action plan to establish key risks and deliverable actions.
Lead:	Tim Craft, Medical Director Wendy Fletcher, Senior Pharmacist

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Review membership and attendance at Antimicrobial Stewardship team meetings	12/07/2017	Jane Liu, Consultant Microbiologist	Blue	Medical Director has contacted lead clinicians for paediatrics and surgery to nominate a clinician to attend or send deputy.
Update the antibiotic stewardship team plan to reflect risks, priorities and achievable actions	12/07/2017	Jane Liu, Consultant Microbiologist Wendy Fletcher, Antimicrobial Pharmacist	Green	Action plan updated. For review/approval at quarterly antibiotic stewardship team meeting 12th July 2017.
Medical Director to provide executive leadership and support of antimicrobial stewardship team	12/07/2017	Tim Craft, Medical Director	Green	Quarterly update meetings with the Medical Director, Consultant Microbiologist and Antimicrobial Pharmacist set up. Medical Director to receive minutes of meetings.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Any lapses in care identified at the time of the antimicrobial audits are, where possible, followed up with the team on the ward there and then. The audit results are sent out to all consultants directly and via governance leads. Non-compliance with audit criteria are reviewed by the Antimicrobial Pharmacist / Consultant Microbiologist and at Antimicrobial Stewardship team meetings for any emerging themes.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	6
Recommendation:	Review of the use of infection control nurse specialists and AMR pharmacists to free up specialist time for example, the practice of IPC nurses checking side rooms daily and AMR pharmacist undertaking data entry.
Lead:	Helen Blanchard, Director of Nursing and Midwifery & Director of Infection Prevention and Control

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Review of responsibilities for collecting data for usage of side rooms	28/02/2017	Helen Blanchard, Director of Nursing and Midwifery & Director of Infection Prevention and Control	Blue	This has been reviewed and the site team and bed management now collect the side room data. Infection Control are only asked for advice about movement of patients

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
This has resulted in release of time for the Infection Prevention and Control Team to carry out their specialist role.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	7
Recommendation:	Review the deep clean process and ensure it is clear, standardised and covers all the necessary elements.
Lead:	Timm Schofield, Deputy Hotel Services Manager

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Review of the current cleaning audit tool for suitability.	30/06/2017	Timm Schofield, Deputy Hotel Services Manager	Blue	
Recruitment of an auditor to carry out the cleaning audits	30/05/2017	Timm Schofield, Deputy Hotel Services Manager Annie Paines, Training and Auditing Manager	Blue	New auditor recruited May 2017. This provides greater assurance of the validity of the audit results through external scrutiny of performance.
Update the cleaning policy to: • Clarify responsibilities for routine cleaning schedules for clinical areas in line with National Cleaning Standards (NCS) including responsibilities for specific ward based equipment • State the schedule, requirements and responsibilities for the special clean process including cleaning of radiators and ventilation grills • State the requirement to ensure special cleans are signed off by the clinical teams before the bed space is used for the next admission	31/08/2017	Timm Schofield, Deputy Hotel Services Manager	Green	Cleaning policy updated with cleaning schedules and responsibilities for specific ward based equipment and requirement to sign off special cleans. Revision needed to state inclusion of cleaning of radiators and ventilation grills. Agree with Estates commitment to the stated schedules.
Agree estates cleaning schedule at clinical level areas.	30/09/2017	Timm Schofield, Deputy Hotel Services Manager Estates	Green	Meeting arranged for July 2017.
Review the reporting structure for cleaning standards.	30/09/2017	Timm Schofield, Deputy Hotel Services Manager Estates Infection Prevention and Control Committee Cleaning Working Group	Green	This forms part of the cleaning strategy. Testing formats based on previous experience and principles laid out by NCS 2007 guidance.
Review of all policies to ensure consistency in cleaning terminology to describe deep / infections cleaning.	31/08/2017	Timm Schofield, Deputy Hotel Services Manager	Green	Policies to include Cleaning, Clostridium difficile, Isolation, MRSA and Management of Outbreaks of Diarrhoea and / or Vomiting (D&V) policy. Awaiting ratification.

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Inform key stakeholders of correct terminology to describe deep / infections cleaning.	31/08/2017	Timm Schofield, Deputy Hotel Services Manager Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	Stakeholders include: Nursing Leads Infection Prevention and Control Committee Cleaning Working Group
Improve awareness of correct terminology to describe deep / infections cleaning including lamination of signs on wards.	31/08/2017	Timm Schofield, Deputy Hotel Services Manager Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	Signs to be put up on cleaning cupboards and main ward boards. This has also been promoted through discussions at the Cleaning Working Group and Infection Prevention and Control Committee (IPCC).
Review the documentation, including the request form, for sign off of special cleans	31/07/2017	Timm Schofield, Deputy Hotel Services Manager Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	Agreed at IPPC in June 2017. New flow chart produced for special cleans. This is being trialled on MAU and SAU.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Cleaning audit scores will be monitored to assess whether there have been improvements in cleaning. All cleaning scores for each ward / department are now on a shared drive that all Heads of Nursing, matrons and ward managers can access to monitor performance for their areas. Audits to also check cleanliness of equipment (yearly) and sign off of special cleans by the clinical teams prior to the bed space being used for the next admission. Post C diff case reviews also review cleanliness of equipment. Audits to be undertaken of the special clean process - to check whether radiators and ventilation grills are included in the clean Audits to be presented at the Cleaning Working Group and the Infection Prevention and Control Committee.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	8
Recommendation:	Review and standardise the systems and processes for cleaning of equipment for which the nursing staff have responsibility.
Lead:	Caroline Gilleece, Matron Jo Miller, Head of Nursing Medicine

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Revise Environmental audit tools – modified from PLACE tool 2017 • Greater focus on equipment and fabric of ward environment. • Separate form for wards and outpatient areas • Test via PDSA cycles	30/06/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	
Implement audit of nurse led cleaning using the Inovise software	31/08/2017	Timm Schofield, Deputy Hotel Services Manager	Amber	In the process of talking with Inovise (software company providing the audit tool) in regards to putting nursing elements onto the current audit tool to ensure the nursing elements are captured and a result/score is given. This nursing element will be added in to all rooms and areas.
Update the cleaning policy with responsibilities for specific ward based equipment	30/06/2017	Mike Newport, Head of Hotel Services Timm Schofield, Deputy Hotel Services Manager	Blue	Policy updated – Appendix 4 details responsibilities for cleaning of equipment.
Develop and implement the process and system for cleaning of equipment, for which the nursing staff have responsibility	31/08/2017	Caroline Gilleece, Matron	Amber	
Explore potential opportunities to appoint Band 1 support workers for wards / departments to support nursing staff with • Stock rotation • Cleaning of equipment (Discuss at June 2017 ward managers meeting)	31/07/2017	Heads of Nursing	Green	
Clarify and agree the process for escalating issues to facilities customer services manager where actions have been identified from the environmental audits that need addressing.	30/10/2017	Brian Gubb, Head of Estates Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Green	For discussion at IPCC in August 2017. Propose to include as part of the process for completion and review of peer audits.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Environment audit scores and nurse led cleaning audits to be monitored to assess whether there have been improvements in equipment cleaning. Findings to be reviewed at the Infection Prevention and Control Committee.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	9
Recommendation:	Forward planning during outbreaks to ensure contingency plans are in place to prevent patients being admitted to closed bays.
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Revise the Management of Outbreaks of Diarrhoea and / or Vomiting (D&V) policy	30/04/2017	Nichola Hartley, Infection Prevention and Control Nurse	Blue	
Develop a D&V action card for staff when they suspect an outbreak	30/06/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Amber	

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Review of data from outbreaks to confirm that no patients are admitted to closed bays. Performance to be monitored at IPCC.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	10
Recommendation:	Review the audit process; consider the option of instituting patient pathways audits as the current process does not provide assurance
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Peer auditing to be introduced and will include hand hygiene, PVC, environment and the new High Impact Intervention (Saving Lives) audit tools.	30/10/2017	Lisa Cheek, Deputy Director of Nursing and Midwifery Rob Eliot, Quality Assurance and Clinical Audit Lead	Green	Audits are currently under review. A timetable for audits has been developed. Plan to go live with peer auditing in October 2017.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Review of peer audit results following introduction of the peer auditing process and comparison of scores with previous audit results to identify whether there has been an improvement in practice.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	11
Recommendation:	Consider reviewing the Infection Control Group TOR and reporting to ensure Divisions and clinical teams are held to account for IPC. It would also be helpful for it to be an assurance committee.
Lead:	Helen Blanchard, Director of Nursing and Midwifery

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Review the Terms of Reference of the Infection Prevention and Control Committee	31/08/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Green	Assurance reporting bi-monthly from the divisions to commence in August 2017 using a standardised approach. Terms of Reference to be revised to reflect the change in the committee's purpose.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	12
Recommendation:	Review of the assurance in regards to the CDI action plan to ensure the sustainability of actions that have been achieved.
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Monitor attendance at C diff RCA meetings and completion of RCAs: report through the C diff Working Group	31/03/2018	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Green	All RCAs reviewed through C diff Working Group. Record kept of attendance at meetings.
Evaluate effect of sporicidal and disinfectant wipes	31/07/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Green	In progress.
C diff workbook to be completed by 95% of nursing staff on adult assessment and inpatient areas	31/03/2018	Heads of Nursing and Midwifery	Green	The Infection Prevention and Control Nurse will request C diff workbook compliance from the matrons and ward managers. The Infection Prevention and Control Team is setting a shared drive that will be accessible to matrons and ward managers to upload compliance figures for the workbook.
All patients with C diff infection to be given an alert card and letter. A letter will also be sent to their GP.	31/05/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	Commenced in May 2017. Positive feedback received from GPs via Dr Hubbard.
C diff ward rounds to be undertaken at least once a week with the microbiology team.	31/03/2018	Yvonne Pritchard, Senior Infection Prevention and Control Nurse Rachel Mayer, Microbiologist	Green	Attendance has improved. Also refer to recommendation 13 by the Microbiology Team.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Target of 95% compliance for trained staff having completed the C diff workbook (bi-annually). Compliance to be reviewed at the IPCC through the divisional report.

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	13
Recommendation:	Reconvene the CDI weekly rounds to review the CDI patients.
Lead:	Rachel Mayer, Consultant

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Continue weekly C diff ward rounds	24/11/2017	Dr Mayer, Consultant	Green	

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	14
Recommendation:	Clinical Microbiologist to attend the CDI RCA meetings to offer expert advice and challenge to antimicrobial prescribing and the CDI working Group.
Lead:	Rachel Mayer, Consultant

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Appoint locum cover for microbiology department	16/06/2017	Dr Wexler, Consultant	Amber	Waiting on Staffing solutions to identify a suitable candidate who is willing to work part time with no on call within budget.
Feedback to consultant microbiologist regarding details of antibiotics prescribed, duration, indication etc. prior to RCA to allow microbiologist to provide a report for use in RCA meeting.	30/11/2017	Rachel Mayer, Consultant	Amber	For a third of time prior to substantive post start date (24/11/17) there is only a single microbiologist on site. Without locum cover it is impossible for this person to attend meetings without gaps in provision of clinical advice and delays to turn around of samples. This has an unacceptable impact on patient care
Involve microbiology consultant team in decision regarding date of RCA meeting so that it falls on a day where there is a second microbiologist to attend the meeting.	TBC (ongoing)	Rachel Mayer, Consultant	Amber	Resource issue. For many weeks there are only 1 or 2 days where there are 2 microbiologist on site.
Attend CDI working group	TBC (ongoing)	Rachel Mayer, Consultant	Red	For a third of time prior to substantive post start date (24/11/17) there is only a single microbiologist on site. Without locum cover it is impossible for this person to attend meetings without gaps in provision of clinical advice and delays to turn around of samples. This has an unacceptable impact on patient care and is recorded on the risk register with a score of 12.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken

Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	15
Recommendation:	Focused input /support to wards following a single case of CDI
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
C diff 'swarm' to be implemented	31/05/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	This includes cleaning environment, hand hygiene and PPE audits which are undertaken by IPCT
Provide teaching sessions for staff on ward where case has occurred	30/05/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	This has been offered as cases have occurred. Ongoing.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)

Status	
Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

Recommendation No:	16
Recommendation:	Consider a review of the training needs analysis as IPC training is currently 3 yearly for non-clinical staff and two yearly for clinical staff
Lead:	Yvonne Pritchard, Senior Infection Prevention and Control Nurse

Actions required *(specify "None", if none required)*	**Action by date**	**Person responsible** *(Name and grade)*	**Status**	**Comments/action status** *(Provide examples of action in progress, changes in practices and current performance; which can be attached as a separate document))*
Meet with Head of Learning and Development to identify whether frequency of training can be increased.	16/006/2017	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	The Trust is signed up to the National Core Skills Framework which includes non-clinical IPC training to be carried out 3 yearly and for clinical staff 2 yearly. This has been agreed by the Strategic Workforce Committee.
Identify staff whose IPC training is out of date and contact them to request that training is completed.	30/06/2017	Heads of Nursing and Midwifery	Amber	Training compliance figures have identified significant gaps, with 595 staff recorded as not being in date with training by the end of June 2017. In addition, a further 656 staff will require refresher training by the end of December 2017. The e-learning package has been updated to assist with uptake of training.
Contact the Learning Support Officer to provide support for staff if they are having difficulty accessing the e-learning module	31/03/2018	Yvonne Pritchard, Senior Infection Prevention and Control Nurse	Blue	To be done when staff have been identified as requiring e-learning support. Ongoing. Ad hoc training providing to portering staff due to issues in access to computers. Annie Paines also provides training for housekeepers.
Develop a 6 month trajectory and plan for achieving 90% compliance by 31 March 2018	30/09/2017	Julie Blackman, Head of Learning and Development Nichola Hartley, Infection Prevention and Control Nurse	Green	The Infection Control Nurses are establishing dates that the IPC core skills and level 1 sessions can be run and these will be circulated to all ward and department managers so staff can be booked onto training.
Continue to provide C diff champion training for ward staff	31/03/2018	Nichola Hartley, Infection Prevention and Control Nurse	Blue	Rolling programme throughout the year.

Examples / evidence of how these actions have led to improvements. Include any relevant KPIs (Process and Outcome Measures)
Monitor training compliance for IPC.

Status

Red	Cause for concern. No progress towards completion. Needs evidence of action being taken
Amber	Delayed, with evidence of actions to get back on track
Green	Progressing to time, evidence of progress
Blue	Action complete

NHS Improvement

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21st July 2017

For the Attention of Director of Nursing and Midwifery

Dear Helen

Re: Head of Infection Prevention and Control visit to Royal United Hospitals of Bath NHS Foundation Trust. 7th February 2017

Background

The Head of Infection Prevention and Control (South) NHS Improvement was invited to review the Infection Prevention and Control (IPC) performance and assurance at the Trust by the Director of Nursing and Midwifery with a particular focus on *Clostridium difficile* Infections (CDI) as the Trust has a higher rate than surrounding Trusts. Prior to the visit several documents were requested and provided by the Trust, these were reviewed and enabled a triangulation of the assurance and areas for further exploration. The Director of Nursing and Midwifery has Executive responsibility for IPC and is the Trust's Director of Infection Prevention and Control (DIPC). The DIPC has a strong understanding of the agenda. The regional Head of Quality for NHS Improvement accompanied the Head of IPC on the visit. This was a supportive visit aimed at offering advice about potential areas for improvement.

CDI performance at the time of the visit was, up to December 2016, 35 post 72 hour cases, of which; 31 were RUH attributable (11 were agreed via the appeals process as having no lapses in care with the CCG , leaving 20 cases with lapses). Four cases were from patients in St Martins Community Hospitals, which get recorded against RUH on the Public Health England (PHE) data capture system but are not counted against RUH performance. †There is an agreed process with the local Clinical Commissioning Group (CCG) to undertake a 'Lapses of Care' /appeals review. The Trust demonstrated a keen desire to learn and reduce the number of CDI cases; however at the time of the visit they were challenged by an outbreak of Noro virus and influenza.

Please Note: *Letter amended 20/7/17 to reflect information received from the trust regarding the community hospital cases. National published rates are based on the total number of trust assigned cases and will not therefore reflect the rates with the community hospital cases removed.*

A previous review had been undertaken in November 2015 with the CCG and PHE, and actions arising from this review were incorporated into an overarching CDI improvement plan. Despite this many findings from this visit remain similar.

The visit was coordinated by the Trust and meetings were arranged with a range of staff with key roles on this agenda. All were honest, open and showed clear commitment to this important agenda.

Board Assurance

There is an Infection Control Group and regular reporting to the Board via the Management Board. Key performance indicators were providing assurance that did not triangulate with the IPC teams audit data for example hand hygiene audits.
The minutes of the Infection Control Group, when reviewed did not demonstrate sufficient clinical challenge on this agenda, and although there appeared to be strong nursing leadership there seemed to be little medical engagement. The Board data showed high compliance with areas such as hand hygiene and cannula management this does not reflect the compliance scores from audits t that the IPC team undertake.
Cleaning data presented did not demonstrate that appropriate follow-up measures had always been taken if areas had failed to meet the cleaning standard. In addition departments/wards were not being re audited unit the next routine cleaning audit was due. An example of this was seen in the A&E waiting area.

The DIPC reports to the Board via the Quality committee and presents an annual infection prevention and control report to the Board.

Infection and prevention control team

There was an experienced IPC nursing team, who are well supported by the DIPC, with skills and competency to lead decision making; however; the team appeared to be reliant on decision making by microbiologists who do not attend outbreak meetings and this resulted in deferred decision making.

The IPC team were involved with the management of the outbreaks; however there were examples where patients without infections were being admitted into closed bays as a result of decisions made by the site management team. These decisions were being made without discussions with the IPC team about the risks.

Medical Microbiologists

The microbiologists were not in a position to offer proactive support to the clinical teams and were working in a reactive way to deal with current issues as they arose. The CDI policy states that there will be weekly ward rounds to review CDI patients, at the time of the review this was not been undertaken due to vacancies in the

microbiology team. At the time of the visits the medical microbiologist vacancies were being advertised

Microbiologists do not routinely attend the CDI Root Cause analysis meetings or CDI working Group meetings. Directorate teams also identified that currently there is not the required support available from the clinical microbiologists.

Clostridium difficile Policy

There is a CDI policy that is based upon the current guidance and evidence. It does not include a risk assessment tool for the assessment of potentially infectious diarrhoea. A CDI workbook has been developed and is used with the clinical teams to target education. Details on stool sampling are not consistent, for example the CDI work book says obtains two stool samples; however this is not recommended in the CDI Policy.
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Root cause analysis of CDI cases is undertaken, and the vast majority of the cases reviewed had repeated courses of antibiotics. The RCA findings always appear to classify this as compliance however this practice warrants further exploration and challenge.

Antimicrobial Stewardship

Limited audit is undertaken due to the time the antimicrobial pharmacist has to fulfil the role. Audit data is fed back at consultant level; however this does not allow interventions for improvements in prescribing compliance to be made. The Antimicrobial Pharmacist is a part-time role of 1.5 days per week, and the post holder has other pharmacy duties to deliver that distract from the role.

Some areas were identified as having low compliance with AMR, and it was not clear what interventions were being offered to these areas.

There is an antimicrobial stewardship team action plan, which at the time of the visit had several actions rated as red.

The Antibiotic prescribing policy was due for review in November 2016. The policy uses the Start Smart and Focus toolkit. No review of the Guidelines for Empirical Treatment of infections in Adults was undertaken as part of this visit; however it is understood that the risk of CDI is identified within the guidelines.
There is a view that the guidelines would benefit from expert review.

Cleaning and environment

The Head of Facilities recently commenced work with the trust and was keen to review systems and processes as he had identified gaps in the current ways of working. The review will be in close collaboration with the IPC team. There has been commitment by the trust to support additional resource for cleaning including the

recruitment of more staff. There are good working relationships between the site management and the IPC team.

The Head of facilities identified that the Trust is auditing against the 2007 standards and does not include the estates and nursing issues. This has resulted in cleaning scores appearing to be higher than they actually were.

There are a range of terms used to describe deep/infections cleaning. For example in the MRSA policy, following patient discharge a special clean is ordered, whilst in CDI policy following patients discharge staff have to carry out a deep clean. The isolation policy states staff should carry out a special clean for CDI rooms. This does not align with the Cleaning Policy for Clinical and Public areas (review due October 2016)

There are gaps in the special clean process following ward outbreaks, this does not cover areas such as radiators or ventilation grills These cleans are undertaken often in bays with no empty beds, and consequently has the potential to impact on the quality of the deep clean process and in addition expose patients to additional risk.

Special cleans are meant to be signed off by the clinical teams before the bed space is used for the next admissions, this does not occur on a regular or consistent basis.

Divisional ownership of the IPC agenda

The Divisional team were aware of the issues that affect their own wards and departments; however there was not sharing of Trust wide issues and learning. The teams were able to give clear examples of actions taken to reduce HCAI and improve patient outcomes. This included the use of stool charts and the CDI collaboration. It would be helpful if these actions could be shared widely and adopted via a quality improvement programme.

The frailty flying squad were able to give examples of how early intervention at the front door could prevent admission and improve compliance with antimicrobial stewardship due to early senior medical review. A suggestion was made that team presents this work at an upcoming conference hosted by NHS Improvement and the team have kindly agreed.

Clinical Visit

We visited one clinical area and identified several pieces of equipment that were the responsibility of the nursing team which were not clean, not all ward equipment was included in sign off sheets, there was not a standardised approach to the application of the green ‘I am clean’ labels. There were also areas of the ward that were not on the cleaners’ schedule, for example the linen cupboard and store room.

Summary

Issues were identified on the visit which should, if resolved help to improve outcomes for patients at the Trust.

My overview is that Antimicrobial stewardship remains your top risk, in addition there are issues with regards to consistency of cleaning standards, systems and processes. The last of these relates particularly to the cleaning processes to be followed once patients with infections are discharged and wards reopening following outbreaks.

Suggested recommendations (in no particular order of priority.)

- Focus and refresh the Trust agenda to encompass the wider patient safety agenda, to include AMR, diarrhoea, urinary tract infections and catheter associated infections.
- Share what is working well across the Trust. For example: the work on 'to dip or not to dip' has not been shared widely, ABCD review, urinary catheter passports. A reduction in infections and antibiotic consumption will support reductions in the cases of CDI.
- Review of Antibiotic Prescribing policy and antimicrobial stewardship, this may require external expertise. NHS Improvement should be able to assist in this process.
- Review of the role of the antimicrobial pharmacist and explore the potential for additional resource.
- Review of the Antimicrobial stewardship action plan to establish key risks and deliverable actions.
- Review of the use of infection control nurse specialists and AMR pharmacists to free up specialist time for example, the practice of IPC nurses checking side rooms daily and AMR pharmacist undertaking data entry.
- Review the deep clean process and ensure it is clear, standardised and covers all the necessary elements.
- Review and standardise the systems and processes for cleaning of equipment for which the nursing staff have responsibility.
- Forward planning during outbreaks to ensure contingency plans are in place to prevents patients being admitted to closed bays.
- Review of the audit process; consider the option of instituting patient pathways audit as the current audits are not providing assurance.
- Consider reviewing the Infection Control Group TOR and reporting to ensure Divisions and clinical teams are held to account for IPC. It would also be helpful for it to be an assurance committee.

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- Review of the assurance in regards to the CDI action plan to ensure the sustainability of actions that have been achieved.
- Clinical Microbiologist to attend the CDI RCA meetings to offer expert advice and challenge to antimicrobial prescribing and the CDI working Group.
- Reconvene the CDI weekly rounds to review the CDI patients.
- Focused input /support to wards following a single case of CDI
- Consider a review of the training needs analysis as IPC training is currently 3 yearly for non-clinical staff and two yearly for clinical staff.

Please thank all the staff I meet on the visit for their time and commitment to this subject. I hope that this is helpful, I apologise again for the delay in getting this report to you, however immediate feedback was given at the time to ensure that you could commence improvement interventions following the visit.

Kind regards

Linda Dempster
Head of Infection Prevention and Control

NHS Improvement
cc. Sarah Hughes Head of Quality

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