Central and North West London NHS
NHS Foundation Trust

BOD XXX 2015

This report is for publication

Board of Directors

Infection Prevention & Control Annual Report

April 2014 – March 2015

Objective:

This report provides an update on Infection Prevention & Control activities and information on actions in place to provide assurance to the Board o
Associated Code of Practice for the Prevention &

The Board is asked to:

- To note the DIPC annual report for inform
- To agree to the IPC work programme for t

Executive Summary:

Infection Prevention & Control (IPC) continues avoidable Health Care Associated Infection's (H Public Health England's (PHE's) quality outcome on year demonstrate that cleanliness within hea concern regarding the National Health Service patient safety data published on NHS Choices s indicator that patients can access when making c

Central North West London Foundation Trust (CN innovation and takes a proactive approach regard report. It will also demonstrate how the IPC te national IPC agenda. It is important to note IPC i the overarching Quality & Patient Safety Agen organisational visions and values, linking specific

- *We will provide integrated, high-quality, tir*
- *We will involve, inform, empower and be g*
- *We will ensure our healthcare facilities are*

Assurance of patient safety practice, clinical effe on a quarterly basis through the monitoring of ir and measured against Care Quality Commissioning (CQC) compliance. These in turn are monitored via the Infection Prevention & Control Committee (IPCC), Divisional Subgroups, Quality Governance subgroups and the Executive Board of Directors.

To reduce HCAI's, every Trust is required to ensure that they have effective systems in place for the prevention and control of infections. These systems must incorporate national guidance and good practice while engaging staff to ensure IPC is 'everyone's business'.

The IPC Assurance Framework (Appendix B) demonstrates compliance with the 10 criterion outlined in the The Health & Social Care Act 2008, *and The Code of Practice for the Prevention & Control of Healthcare Associated Infections.*

At the end of the financial year 2014 - 2015 CNWLFT declared compliance (green) across 75% of the organisation. Through integrated reporting mechanisms across Divisions, such as improved accuracy of audit, surveillance data, reviewing reports at Divisional subgroup meetings, and at the Infection Prevention & Control Committee (IPCC) meetings, have assisted in substantiating the Trust's declaration for the IPC agenda.

Throughout 2014/2015 great strides have been made towards embedding standardised IPC integrated practices across all Divsions. CNWLFT has restructured service lines across Divisions. This has had an impact on the IPC teams. IPC teams work across the Divisions which are known as Diggory, Goodall and Jameson. As a result of the diversity within these divisions, IPC support and advice is given across multiple service lines.

Specific achievements for this year have included:

- Overall for 2014 -2015 compliance for Outcome 8 (CQC) across the Trust was demonstrated.
- Surveillance of alert organisms continued. A zero tolerence approach to MRSA bacteraemias continued throughout 2014/2015. No cases of MRSA bacteraemia were reported.
- The numbers of *Clostridium difficile* toxin-producing cases have continued to decline, whilst there has been an increase in patient population as the Trust continues to expand in size.
- Across the inpatient units there have not been any episodes of outbreaks.
- This Essential Steps (ES) audit was undertaken quarterly across all clinical services. It provides assurance that there is adherence to CNWLFT policies and national guidelines on best IPC practice. The ES is an observational tool which audits the following: Hand Hygiene (HH), Personal Protective Equipment (PPE), correct Aseptic Non Touch Technique (ANTT) and Sharps Management. The aim of the quarterly audit is to ensure that there is >95% compliance achieved by Health Care Workers (HCW's). It is also to ensure best practice by reviewing what we are doing, compared with what we should be doing. This has been achieved across all Divisions.
- The Infection Prevention & Control Team (IPCT) supported antimicrobial stewardship across all relevant services, and this needs to continue for 2015/2016.
- Continuous development and strengthening of the role of the IPC Link Practitioners (IPCLP). IPCLP's are vital to the achievement of high standards of IPC within a diverse group of services across CNWL.
- The CNWL IPC policies have been integrated across all service lines. New policies have been developed – Bare Below the Elbows (BBE), Multi Drug Resistant Gram-Negative Bacteria Policy.
- The IPC intranet site has been developed. Due to the development of the website, it is easier for staff to access policies, leaflets and information on IPC issues.
- IPC mandatory training is provided to both clinical and non clinical staff. Due to a change in the training matrix there was an initial drop in training figures. However, quarter on quarter, the training figures have increased. At end of 2014/2015 Level 1 (non clinical) = 94%, and Level 2 (clinical) = 84%. This is set against a target of 95%. The IPC team also provided service specific training where required.
- Across clinical service lines there is a representation of 97% IPC link practitioners.

- Seasonal influenza immunization is led by the Occupational Health (OH) Department and has achieved the highest uptake rate recorded for CNWLFT, with 37.2% of frontline staff immunised against influenza.
- Corporate Key Performance Indicators (KPI's) for IPC were introduced for 2014/2015 and have been achieved throughout the year.

Challenges:

- The management and monitoring of antimicrobial stewardship.
- To continuously engage service leads and staff in the delivery and sustainability of the IPC agenda.
- To continue with improved integration of the IPC service with hotel services, and estates and facilities, to improve and develop robust services.

Conclusion

There has been ongoing achievements made by the IPC team throughout the year. Despite capacity issues within the team and major changes across the organization, the IPC Team have pro-actively embraced the challenges. Good IPC practices have been maintained, and prioritized against the national IPC agenda.

The national priorities for 2014/15 as determined by the Department of Health and Public Health England are: antimicrobial stewardship; multi drug resistant organisms; and Hand Hygiene; with an overall objective of zero tolerance to avoidable HCAI's.

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1. Introduction

This annual report provides an overview of the (IPC) activities throughout the Trust over the past twelve months. This report provides evidence towards the regulatory requirements of the Health & Social Care Act (2008) Regulation 12, detailed in the *Code of Practice for the Prevention & Control of Infections*. The DIPC reports quarterly to the Trust Board of Directors. The IPCT work plan / strategy focuses on implementing systems that embed IPC into the everyday practice of all CNWL staff.

At the end of the year 2014/2015, CNWL Trust declared compliance (green) across 78% of the services in IPC practices. In the event that non-compliance is demonstrated with IPC practices, action plans, recommendation and timeframes are given to address issues. Monitoring is quarterly and fed back to the IPC subgroups and to the IPCC. The IPC service aims to substantiate the Trust's declaration by triangulation of local IPC intelligence, improved accuracy of audit and surveillance data, and the integration of IPC reporting across the organisation. Where possible data is presented in an integrated manner across Divisions.

During the year significant progress has been made to ensure patients are cared for in a safe and clean environment, where the risk of HCAI's are minimised. The IPC Team's workplans focus on implementing integrated systems that embed IPC into everyday practice.

2. IPC Organisational Structure and Governance

In January 2014, the IPC governance and management structures were reconfigured, bringing about changes across CNWL. The Director of Infection Prevention & Control (DIPC) is both an Executive member of the Board and also the Executive Director of Nursing & Quality. The Divisional Director of Nursing (DDON) for Diggory Division, leads on the operational implementation of IPC for CNWL. The IPC Leads report to the Deputy DIPC. The Deputy DIPC reports to the DDON and to the DIPC.

Through organizational restructuring in Jan 2015, an IPC Lead Nurse was appointed to the Jameson Division, and an IPC Nurse was appointed into Goodall Divison. The Trust has access to two Microbiologists, one of whom holds the position of an Infection Control Doctor. Specialist advice and microbiology support is provided on a 24hour basis. The Advanced Antimicrobial Pharmacist for the Trust is available during office hours Monday to Friday.

2.1 Infection Prevention & Control Team Establishment

Role
DIPC & Executive Director of Nursing & Quality
Divisional Director of Nursing (Diggory Division)
Deputy Director of Infection Prevention & Control
Lead Nurse IPC - Goodall Division WTE 1.00 split between provider and commissioning WTE 0.5
IPC Nurse Advisor – Goodall Division WTE 1.00 split between provider and commissioning WTE 0.5
IPC Nurse Advisor Band - Goodall Division
Lead Nurse IPC - Diggory Division
IPC Nurse Advisor – Diggory Division
IPC Nurse Advisor – Diggory Division (Currently Vacant)
Lead Nurse IPC – Jameson Division
IPC Nurse Advisor - Jameson Division
IPC Doctor
IPC Microbiologist

2.2. The Infection Prevention & Control Committee (IPCC)

The IPCC is a key forum for the development and performance management of the IPC agenda across the organisation. The IPCC meets quarterly and is chaired by the DIPC with key stakeholders from across the organisation. An overview of the IPC agenda and progress throughout the year is discussed at this meeting. A standardised IPC template is used across all Divisions. It captures, HCAI's alert organisms, outbreaks, scoring on environmental audits, and scoring on (ES) across the Divisions. Comparable data can be analysed. A quarterly report is submitted to the Executive Board.

2.3 Internal Reporting Arrangement

All Divisional subgroups meet quarterly and provide written reports which are submitted to the IPCC on a quarterly basis. IPC Divisonal Sub groups are chaired by the DDONS. A quarterly report is submitted to the Executive Board. The IPC Team meet monthly. The IPCT is managed by the Deputy DIPC. All members of the IPCT work closely with Public Health England (PHE) where appropriate.

2.4 IPC Risk Register

IPC risks are presented to the quarterly Sub group meetings and to the IPCC meetings. Prioritisation of tasks and activites are discussed. Throughout the year there has been ongoing monitoring and management of risk.

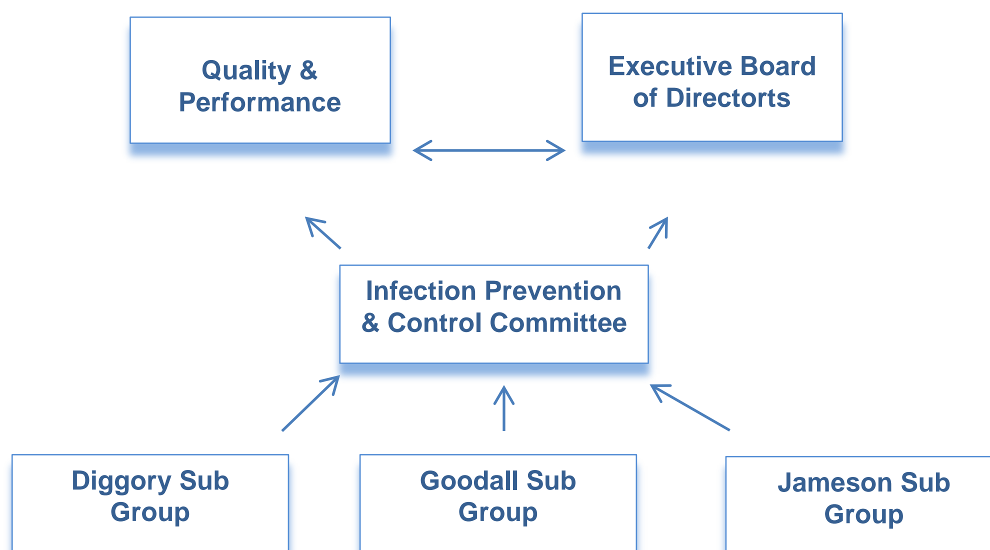
2.5 IPCT Resources

The IPCT continues to have a budget that is predominately staff pay. The team continue to work closely with the procurement department to ensure the Trust purchases quality products that are fit for purpose and deliver value for money. IPC products, such as detergents and disinfectants among other products, have been standardised across the Trust. Details can been found on the Trust website on the IPC webpage.

2.6 IPC Policies and Leaflets

IPC policies are reviewed every two years, or in the light of best practice and guidance. Currently all IPC policies are being reviewed. Policies can be found on the IPC web page on Trustnet. All polices follow the Trust permitted format, and all policies are ratified at the IPCC. Leaflets for service users and staff are available on Trustnet.

3. Reporting Structure



4. Healthcare Associated Infections (HCAI's) Definition

Nosocomial infections are infections that are acquired in hospitals and other healthcare facilities. The patient must have been admitted for reasons other than the infection.

5. Surveillance and Data Reporting

Mandatory surveillance and data reporting of infections illustrate national trends on infections. They are monitored by Public Health England (PHE) via the Data Capture System (DCS). Surveillance can be used as a measure of progress and as an indicator of standards. The IPC strategy has systems and procedures in place to investigate HCAI's. This is undertaken by completing a Root Cause Analysis (RCA). However, locally and nationally, certain HCAI's are monitored to provide information on the prevalence and trends in disease. Nationally a target driven system is used to monitor the numbers of specific pathogens. MRSA bacteraemia and *C. difficile* have targets attached whereby penalities are incurred.

6. Zero Tolerance To Avoidable HCAI's (MRSA and *C.Diff*)

MRSA defined:

Staphylococcus *aureus* is an organism that approximately one third of the population carry without any associated problems. Although Staphylococcus *aureus* is capable of causing infection, most of these are easily treated with antibiotics. However, some strainis of Staphylocossus *aueres* have developed resistance to common antibiotis: these are known as Meticillin Resistant Staphylococcus *aureus* (MRSA).

A zero tolerance approach to MRSA is the current national target. A national target for *C.Diff* for Provider Community Services and Mental Health Services has not been set. This is in contrast to targets set for clinical commissioning groups (CCG's). Across the Trust there were no episodes of MRSA bacteraemias during the year. It is accepted that not all HCAI's are avoidable, however, the aim for the Trust is to adopt a zero tolerance approach to all avoidable HCAI's.

Patients in community intermediate care units are routinely screened for MRSA colonization. This entails taking a nasal swab on admission. This is not a requirement for mental health sites as stipulated by the Department of Health Guidelines.

MRSA Bacteraemia Cases Across the Organisation:

March 2014-March 2015	Diggory	Jameson	Goodall	CNWL Total
MRSA Bacteraemias	**0**	**0**	**0**	**0**

6.1 Toxin Producing Clostridium difficile (C.Diff) Surveillance

***C.difficile* defined:**

Clostridium difficile (*C. diff*) is a bacterium that lives harmlessly in the gut of about 3-5% of healthy adults. It is normally kept in check by the 'good' bacteria in the gut but when these are killed off by some antibiotics, the *C. diff* bacteria can multiply and cause diarrhoea. It especially affects the elderly, the debilitated, and patients who have had broad-spectrum antibiotics. Prevention of CDI infection relies on ensuring the patients do not become susceptible through disruption of their normal gut flora (e.g. through use of antibiotics), and on preventing as far as possible cross infection.

The organism also produces spores resistant to simple cleaning methods and survives well in the hospital environment. There were three cases of *C. difficile* in Diggory Division this year, a slight increase on 2012/2013. Since 2011/2012, seven cases were known across the Trust., This year shows an overall downward trend. It also needs to be taken into account there has been an increase in patient population as the Trust has expanded.

March 2014-March 2015	Diggory	Jameson	Goodall	Total
Clostridium difficile	**3**	**0**	**1**	**4**

In all cases RCA's are undertaken. Action plans are developed to address identified contributory issues. Where *C.Diff* has been found in the inpatient units, the IPC team work closely with staff, providing support and education around the identification, prevention, and management of *C.Diff.*

6.2 Lessons Learnt Windsor Intermediate Care Unit (Diggory)

- There must be good clear effective communication between WICU and the acute trust. An inter-healthcare transfer form has been introduced to assist with this.
- Antibiotic prescribing must be done on the basis of clinical presentation and in line with local guidelines. Meetings have been held between medical staff, the IPC team, and the antimicrobial pharmacist to provide feedback on these findings.
- There is a sound assessment process, on and during, admission for patients who have an unexpected change in bowel habit. Patients normal bowel habit is now consistently assessed on admission and stool records kept for each patient.
- Staff should be aware of the risk factors associated with C.diff and act proactively to avoid infection and spread. In light of this, a risk assessment tool is now carried on all patients at admission to assess risk factors for C.diff.

7. Other Alert Organisms/Incidents

For the purposes of this report, other alert organisms are used to describe communicable diseases which are not directly associated with healthcare provision, but can be difficult to control in this setting. The table below illustrates the types of other alert organism that occurred across the Trust during the year. In all instances there has been no evidence of onward transmission to patients, visitors, or staff within CNWL.

St Pancras (Goodall Division) is a rehabilitation unit. It receives admissions from a number of the London Hospitals. Increasingly, as noted not only in St Pancras but nationally, there is evidence of increasing multi-drug resistance. An antimicrobial strategy has been launched across CNWL to manage and monitor the increasing concerns around antimicrobial stewardship.

March 2014-March 2015	Diggory	Jameson	Goodall
Tuberculosis (TB)			OakTree Ward Hillingdon MH
Human Immunodeficiency Virus (HIV)			Horton Haven
Human Immunodeficiency Virus (HIV), non compliance with medication			Crane Ward Hillingdon MH
Hepatitis A		Northwick Park Hospital	
Tuberculosis (TB)		The Gordon	
Escherichia coli (E coli)			St Pancras
Pseudomonas urine			St Pancras
Extended-spectrum beta-lactamases (ESBL) urine			St Pancras
VRE			St Pancras

March 2014-March 2015	Diggory	Jameson	Goodall
Gentamycin resistant e-coli sputum heavy growth of stenotrophomonas maltophilia			St Pancras
Gentamycin resistant e- coli in urine			St Pancras

8. Outbreak Management

An outbreak is often defined as two or more cases presenting with similar symptoms associated by time and place. In healthcare settings, the most common cause of gastroenteritis outbreak is Norovirus, a highly contagious virus which causes short-lived, but severe, vomiting and/or diarrhoea. The Norovirus Policy and leaflets are available on Trustnet.

March 2014-March 2015	Diggory	Jameson	Goodall
Norovirus	**0**	**0**	**0**
C.Diff	**0**	**0**	**0**

The Occupationa Health Service (OHS) did not have to participate in any outbreak management programmes during the year. However, the service supported staff in "inpatient areas" where a patient was diagnosed with infectious TB. Advice was also provided by the IPCT and OH advisors to staff in relation to the Ebola crisis in West Africa. The former Deputy DIPC went to Sierra Leone for a month to assist with the Ebola plight.

9. Seasonal Flu Vaccination Uptake

The table below outlines flu vaccination uptake amongst staff in the 2014/2015 season (based on staff data provided by CNWL HR / workforce information). The flu campaign was promoted using material from the Department of Health (DoH). The OHS continue to offer seasonal flu vaccine in a manner that promotes convenience and accessibility with least disruption to frontline services. Numerous site visits and out of hours services, both early morning and in the evenings, were offered in addition to the open access arrangements at the St Pancras Hospital (SPH) site.

CNWL achieved an uptake of **37.2%** amongst frontline staff reported to Immform, a decrease of 0.8% from the 2013/14 reported figure, despite a vigorous, well publicised campaign. There was an increase in the annual total of vaccines given to all CNWL staff of **9%** maintaining the "year on year" improvement.

Central and North West London NHS
NHS Foundation Trust

Seasonal Flu Vaccination Uptake

Seasonal influenza vaccination uptake	Front line staff immunised										Non FL Other	Total given	Traffic light system
CNWL Division	**Doctors**		**Nurses**		**OPs**		**Support**		**Total No**	**%**			>50%
Brent Adults	7	20%	27	23%	16	18%	18	31%	69	23.1%	2	71	>30% & <=50%
Harrow Unified Mental Health	14	50%	29	31%	19	26%	24	51%	87	35.8%	5	92	<=30%
Horton Haven			16	48%			10	24%	26	31.2%	3	29	
Kensington & Chelsea Adults	16	36%	33	18%	22	30%	19	33%	91	25.4%	4	95	
Learning Disabilities	4	17%	8	24%	8	53%	10	17%	31	23.8%	3	34	
Westminster Adults	15	22%	50	37%	47	39%	22	51%	135	36.8%	5	140	
Subtotal (Division A)	**56**	**28%**	**163**	**27%**	**112**	**30%**	**103**	**34%**	**435**	**29.4%**	**22**	457	
Camden Community	16	100%	81	44%	36	37%	87	64%	222	51.1%	20	242	
Child & Adolescent Mental Health	10	22%	16	34%	28	17%	13	72%	68	24.2%	3	71	
Hillingdon Community Health	5	33%	74	29%	42	30%	63	58%	185	35.8%	5	190	
Hillingdon Mental Health	9	38%	21	26%	15	23%	17	36%	63	29.2%		63	
Older People & Healthy Ageing	15	38%	30	20%	19	27%	27	26%	92	25.1%	2	94	
Vincent Square Clinic	2	29%	8	44%	5	26%			16	33.3%		16	
Subtotal (Division B)	**57**	**39%**	**230**	**31%**	**145**	**26%**	**207**	**49%**	**640**	**34.4%**	**30**	670	
Addictions	3	12%	15	18%	12	34%	7	41%	38	23.4%	1	39	
Milton Keynes	26	47%	132	32%	77	44%	128	67%	364	49.6%	70	434	
Offender Care	6	32%	27	14%	4	11%	10	15%	48	15.5%	2	50	
Sexual Health & HIV	22	26%	39	39%	2	6%	33	87%	97	38.4%	2	99	
Subtotal (Division C)	**57**	**31%**	**213**	**27%**	**95**	**34%**	**178**	**57%**	**546**	**35.2%**	**75**	621	
Subtotal (Divisions A, B, C)	**170**	**32%**	**606**	**29%**	**352**	**29%**	**488**	**47%**	**1,621**	**33.2%**	**127**	**1,748**	
FL Non division based e.g. OHS	**16**		**62**		**33**		**84**		**195**	**40.6%**	**104**	**299**	
Sum total CNWL staff	**186**		**668**		**385**		**572**		**1,816**	**37.2%**	**231**	**2,047**	

9.1 Sharps Update

The OHS continue to work closely with the IPCT to minimize IPC risks associated with sharps injuries such as needles, lancets and intravenous catheters. Risks associated with body fluid exposure such as bites, and body fluid in contact with mucosal membranes are also monitored. From 1st April 2014 to 31st March 2015, there have been 74 blood/body fluid exposure incidents and sharps injuries reported to OHS from CNWL, an increase of 60% from the 2013/14 report. (The OH service included Milton Keynes incidents from 16th October 2014) It is estimated that the increase of 60% is attributed to better reporting across CNWL.

All staff were followed up by OH in accordance with Trust Policy. The OHS and Clinical Governance units compare data on a quarterly basis regarding incidents reported to both units. The purpose of this is to ensure staff compliance with both the immediate reporting standards and the incident reporting standards are monitored.

9.2 Safer Sharps

In accordance with the implementation of the EU Directive on safer sharps 2013, CNWL have demonstrated compliance where practicable**.** It is not practical in all service lines such as sexual health (derma fillers), or in some areas where injections are pre-drawn, to use safer devices. Exceptions across service lines are recorded.

10. Decontamination of Medical Devices

Inadequate decontamination can result in the transmission of a range of micro-organisms from blood-borne viruses such as HIV or Hepatitis B, to fungal and common bacterial infections. Safe and effective decontamination of all re-usable equipment between uses is imperative as an essential part of routine IPC practice.

The DDON (Diggory Division) is the designated lead for decontamination across CNWL and is supported by the Medical Devices Safety Officer. The Medical Devices Subgroup and the Medical Device Committee meet quarterly. A Trustwide Decontamination Policy is available on Trustnet.

The IPC have contributed to the development of a monitoring decontamination log book for reusable medical devices. This has been developed across all service lines. This is to encourage staff to provide evidence and record when decontamination of reusable medical devices has taken place. Through the Decontamination Sub Group, IPC Link Practitioners, and IPC training, the IPC team continue to educate and promote effective decontamination. This also includes basic principles and risk assessments on decontamination of products used for cleaning and disinfection.

10.1 Single Use Devices (SUDS)

A single-use device is used on an individual patient, during a single procedure, and then discarded. The device is not intended to be reprocessed and used on another patient. The labelling identifies the device as disposable, and is not intended to be reprocessed and used again. All service lines across CNWL conform with Europen Legislation. SUDS are denoted by this symbol:

Do Not Reuse

11. Estates & Facilities

11.1 Catering and Cleaning

Catering and cleaning for most sites in the Trust was provided by Outsourced Client Solution (OCS). The exceptions were Milton Keynes, Camden, Sexual Health, and some Offender Care sites in Her Majesty's Prisions (HMP's). The Trust is now in the second year of the two year extension for the OCS contract, which was negotiated providing significant cost savings to the Trust. The contract continues to perform well, achieving cleaning audit scores of over 98% throughout the year across all Divisions. In addition, for the reporting period, OCS have been monitoring the replenishment of hand-washing consumables, and areas audited during the initiative achieved a score 99% throughout the year.

Within Milton Keynes, cleaning services are provided by an inhouse team which forms part of the overall Facilities Department within the Division. All staff within the inhouse team are required to meet CNWL mandatory training levels, as well as local induction training and development procedures. Due to the difference in service provision, a dedicated Environmental Cleaning Policy is in place within Milton Keynes and cleanliness monitoring is completed in line with that Policy

The IPCT continue to provide input into the management of the services provided by OCS. IPC is a standard agenda item at contract review meetings, centrally and locally, relating directly to IPC issues. The IPCT perform quarterly environmental audit across CNWL sites in order to assure the Board of Directors that the Trust is compliant with "PCA Outcome 8; Regulation 12 – Cleanliness and IPC".

In most HMPs there is a practice of unsupervised cleaning by prisioners, hence standards of cleanliness can be variable. The prison environment is not conducive to easy cleaning as some buildings are very old. IPC training is mandatory for all OCS and EF staff on induction. All staff who are responsible for the preparation and serving of food are trained in food hygiene. CNWL centrally monitor training records for OCS staff to ensure compliance with training requirements.

11.2 PLACE (Patient Led Assessment of the Care Environment)

PLACE is an annual programme which replaced the Patient Environment Action Team (PEAT) audits in 2013. Under PLACE, all NHS funded healthcare providers in the UK are required to undertake an indepth assessment of qualifying inpatient settings as part of a national programme, overseen by the Health & Social Care Information Centre (HSCIC) on behalf of NHS England.

The purpose of PLACE is to assess how the healthcare environment supports patient care and looks at areas such as cleanliness, food, maintenance, condition/appearance, privacy and dignity, and dementia compliance. PLACE is undertaken from the patient's perspective, and is based on practice, not policy, and is intended as a visual audit with no scientific or technical processes.

PLACE assessment teams are made up of a combination of staff and patient assessors, with the patient representation having to equate to at least half the scoring team. PLACE patient assessors are local people, who are provided by organisations such as Healthwatch and Mind, and through use of the CNWL Service User and Carer Group. Two of the 2014 assessments also included independent validators (Reviewers) from other healthcare trusts.

CNWL undertook 20 assessments during 2014 across all qualifying inpatient services. The 2014 CNWL PLACE assessment programme took place between March and June. Organisations were assigned a six week window in which to organise and complete each assessment.

CNWL PLACE Scores

The information below focuses on the two scoring areas which are relevant to IPC which are 'Cleanliness' and 'Condition, Appearance & Maintenance':

Cleanliness

The assessment of cleanliness covers all items commonly found in healthcare premises including patient equipment; baths; toilets and showers; furniture; floors; and other fixtures and fittings. In addition this section covers availability and suitability of hand hygiene facilities.

The national average score for Cleanliness was 97.25%. The CNWL Trust score was 98.74%, with all but one site scoring above the national average and 9 sites scoring between 99% and 100%. The national average score for mental health and learning disabilities sites was 96.9%. The national average score for community sites was 97.1%.

Condition, Appearance & Maintenance

The assessment of condition, appearance and maintenance includes the above items as well as a range of other aspects of the general environment including décor, fixtures and fittings, floors, furniture, tidiness, signage/information, linen, waste management, and the appearance and maintenance of the external buildings and grounds.

The national average score for Condition, Appearance and Maintenance was 91.97%. The CNWL Trust score was 91.67%, with sites ranging from 96.34% to 82.43%. The Trust score has improved by 2% compared to 2013. The national average score for mental health and learning disabilities sites was 92.2%. The national average score for community sites was 90.3%.

Nine CNWL sites scored above the national average, and fifteen sites scored equal to, or above, their 2013 scores. The variation in scores between the highest and lowest scoring CNWL sites has decreased significantly from 24% in 2013 to 12% in 2014.

National Release

The national release of the PLACE scores, as an official statistic, took place on the 27th August 2014 and is available from http://www.hscic.gov.uk

11.3 Waste Management

Waste management is a component of the IPC annual environmental audit, and correct segregation of clinical waste is taught by the IPC team at mandatory and induction training. Pre-Acceptance Waste Audits are a legal requirement, introduced to ensure that waste producers are meeting current regulations around waste management. All Pre-Acceptance Waste Audits completed this year passed the required standard, with no high risk areas of concern. The IPC & E&F conduct a quarterly meeting to address any issues or concerns.

11.4 Water Safety

There have been a number of issues with water safety over the past 12 months at sites across the Divisions, where there have been colonised with Legionella (Group 1 and Group 2:14), in particular, St. Pancras and Mortimer Market sites, where extensive actions have been taken to mitigate risk, including water dosing systems, removal of *dead legs*, and replacement of pipes and pall filters fitted to problematic outlets. All sites continued to be monitored for water quality by the Estates & Facilities Department and by external contractors.

A Trust water meeting is held quarterly. IPC, along with a specialist microbiologist, attend this meeting to provide specialist advice. The focus of the group is to review Legionella risk assessment, testing regimes, assessing results and subsequent actions. During 2014/2015 Legionella was managed in sites by Galliford Try. Every case of Legionella is a risk to any organisation. However, there are robust and reactive measures in place to manage Legionella.

It needs to be noted that some properties are owned by landlords not CNWL, and old builds exist that require capital works which are programmed in order of priority. All risks are recorded on the risk register. Exception reports are produced for action and scrutiny at the water meeting and are tabled at the IPCC as evidence and assurance of risk mitigation across the Trust.

12. Essential Steps (ES) Audits

Introduction / Background:

Good hand hygiene, appropriate use of personal protective equipment (PPE), appropriate use of aseptic non touch technique (ANTT) and the safe disposal of sharps, are all important in reducing the risk of microbial contamination in everyday practice, and in minimising the risk of infection to patients, clients, staff, and visitors. This audit report is supplementary to other sources of information on IPC practices within CNWL, for example environmental audits, relevant questions in the staff surveys, and declarations made in relation to the hygiene code. ES audits the following areas:

- **Hand Hygiene**
- **Personal Protective Equipment (PPE)**
- **Aseptic Technique**
- **Safe Handling of Sharps**

12.1 Aims and Objectives:

This audit aims to measure adherence to key IPC policies.

12.2 Criteria and Standards:

The criteria and standards used in this audit have been drawn from CNWL IPC policies and the *'Essential Steps to Clean, Safe Care'* programme (Department of Health, 2006).

12.3 Data Source:

Peer Observation of Clinical Practice.

12.4 Method:

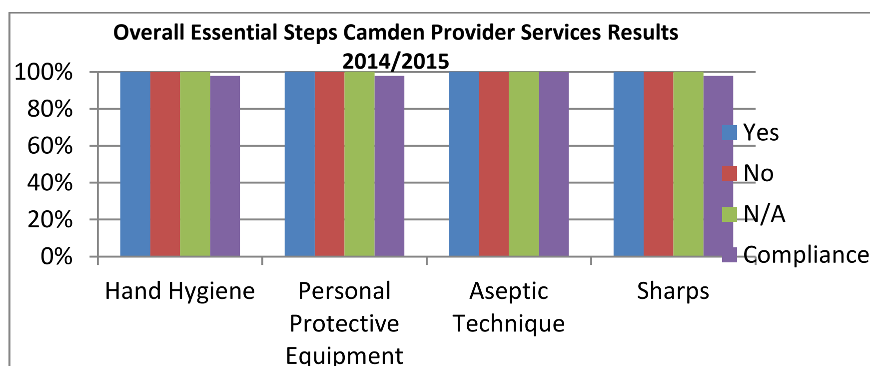
Episodes of direct patient/client contact take place. This is observed across all services to determine whether *'Essential Steps'* were undertaken in accordance with current IPC policies.

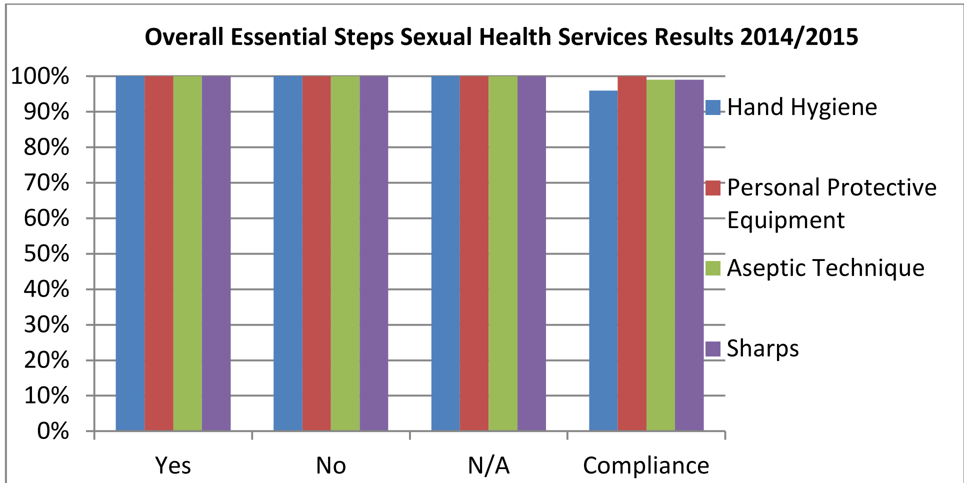
12.5 Target

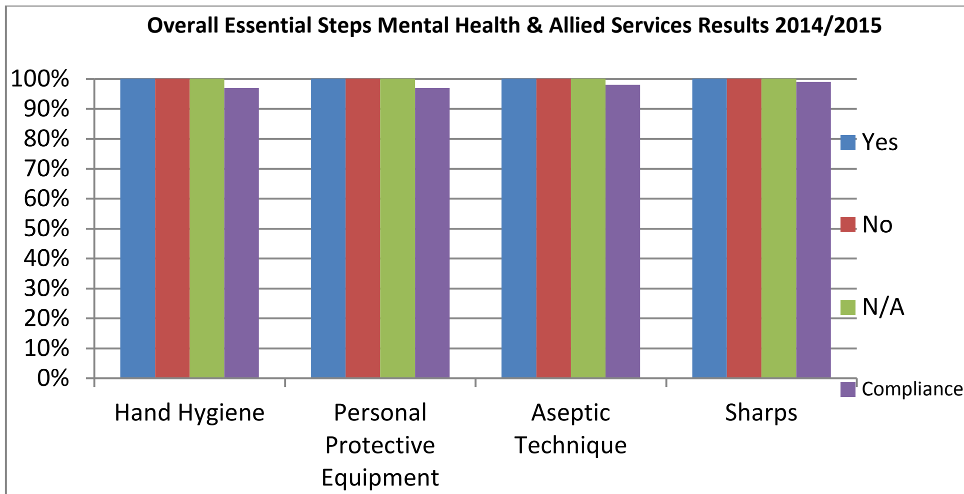
The aim of the quarterly audit is to ensure that there is >95% compliance achieved by Health Care Workers (HCW's). It is also to ensure best practice by reviewing what we are doing, compared with what we should be doing.

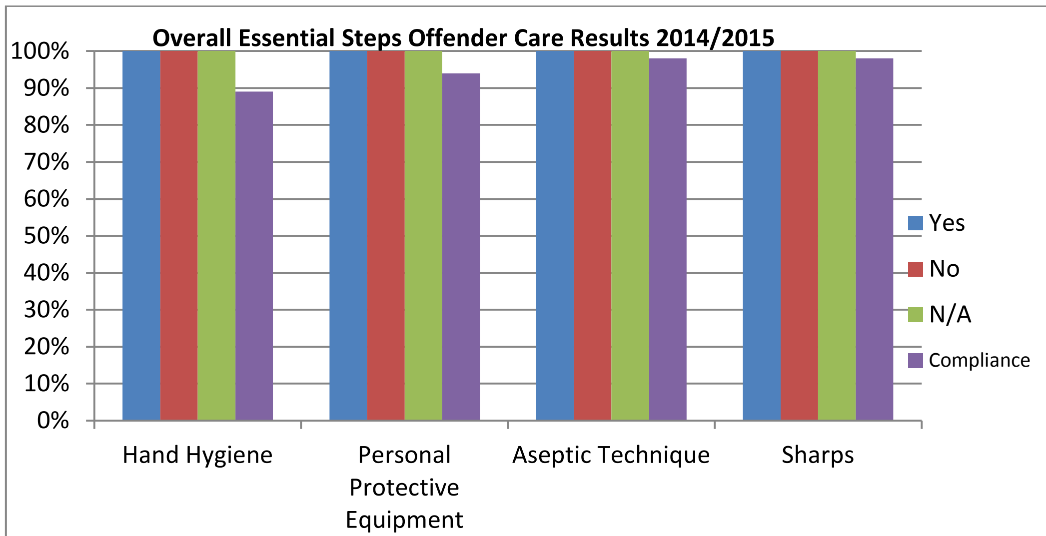
12.4 Essential Steps Results Across Divisions

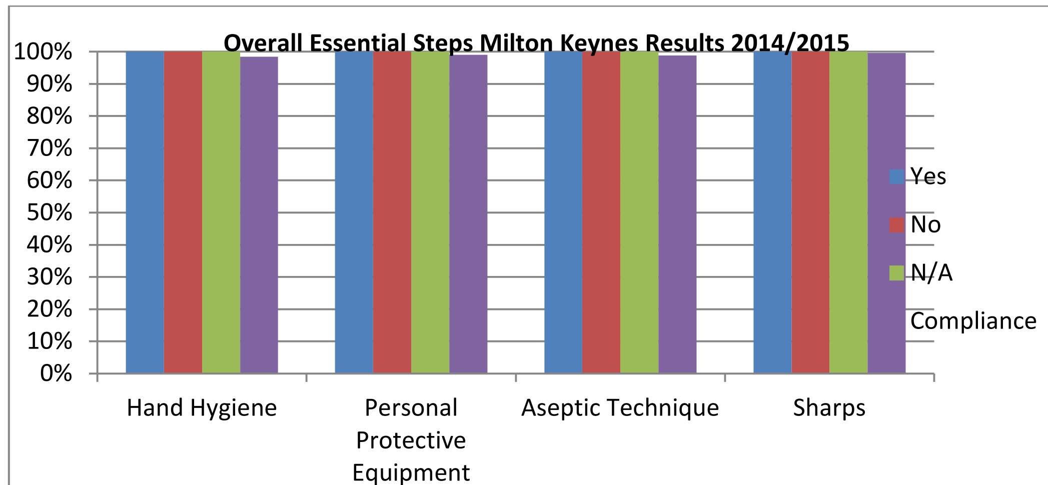
Any deficits are addressed locally and an action plan is formulated. Results are submitted quarterly to the Divisional Subgroups, the quality governance and link practitioner meetings, and are shared at team meetings and escalated to the IPCC. Throughout the year the Trust has achieved> 95%.




Overall Essential Steps Sexual Health Services Results 2014/2015
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Yes
No
N/A
Compliance
Hand Hygiene
Personal Protective Equipment
Aseptic Technique
Sharps


Overall Essential Steps Mental Health & Allied Services Results 2014/2015
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Hand Hygiene
Personal Protective Equipment
Aseptic Technique
Sharps
Yes
No
N/A
Compliance


Overall Essential Steps Offender Care Results 2014/2015
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Hand Hygiene
Personal Protective Equipment
Aseptic Technique
Sharps
Yes
No
N/A
Compliance



13. IPC Environmental Audits

Across all Divisions there are planned annual rolling IPC clinical environmental audits. The environmental audits are predominately carried out by IPC nurses. The plan going forward is to empower staff working in low risk areas to undertake their own audits with support from the IPC Team. Recommendations and action plans are drawn up following the audit. The results are RAG rated. Timeframes are given for actions to be completed where practicable. The results are sent to all clinic/site supervisors, link practitioners and managers for actioning.

Results are also escalated to the Divisional Subgroups, Quality Governance, and to the IPCC. A standardised audit tool is used across all Divisions which is RAG rated. This allows for comparable data and benchmarking across sites.

14. Mandatory Training

In April 2014 the Trust moved to a new mandatory training matrix that aligns with the requirements of the national framework of core skills for staff working in the health sector. At the same time the opportunity was taken to review the content of the IPC mandatory training modules. An online workbook was developed for IPC mandatory training level 1 and level 2. At the end of the year, the compliance position for IPC mandatory training across the organisation was 85%.

15. Infection Prevention and Control Link Practitioners (IPCLP's)

The IPCLP's continue to provide essential and invaluable support to the IPC Team. Membership is made up of a variety of grades and professions, reflecting the diversity of services across the organisation. IPCLP's meetings occur quarterly across the three divisions. These meetings provide education, support, and direction to IPC organisational priorities and audits. It also aims to ensure that the IPC agenda is disemminated across service lines and ensure that IPC is a standing item at all team meetings.

16. Antimicrobial Prescribing Report

Antimicrobial resistance is a significant risk to public health. The volume of antimicrobial prescribing, globally and locally, directly influences the development of antimicrobial resistance. Without effective antibiotics many of the advances made in modern medicine such as chemotherapy and surgery will become unsafe. Antimicrobial stewardship is essential for preserving the effectiveness of the antimicrobials available. Monitoring antimicrobial use is an essential part of this and it is for this reason that antimicrobial prescribing audit is carried out regularly.

This annual report summarises the key findings of the antimicrobial prescribing audit between April 2014 and March 2015. This audit is used to monitor antimicrobial prescribing trends and quality indicators, in order to guide training and development of healthcare staff, and to optimise prescribing practice. This audit is also used to demonstrate compliance with the Trust's Antimicrobial Prescribing and Administration Policy, and associated local and national guidelines. This audit also provides evidence to support compliance with the Health and Social Care Act 2008, and the Department of Health UK Five Year Antimicrobial Resistance Strategy 2013 to 2015. (See Appendix A.)

Results: Key Points

There have been some moderate improvements in total compliance across some divisional services during 2014/2015. Due to limited data from some services we are unable to make any final conclusions regarding compliance to antimicrobial prescribing guidelines. The main areas of concern, highlighted throughout the year, are appropriate treatment choice, and course length in line with microbiology advice and guidance.

Total compliance with antimicrobial prescribing guidelines and microbiology advice is good across most divisions and services; however there has been no overall improvement. The main areas of concern are appropriate treatment choice and course length in line with microbiology advice and guidance. These aspects of antimicrobial prescribing have already been included in ongoing initiatives to improve antimicrobial prescribing and usage across the Trust.

17. Specific achievements for this year have included:

- Overall for 2014/2015 compliance for Outcome 8 (CQC) across the Trust was demonstrated.
- Surveillance of alert organisms continued. A zero tolernence approach to MRSA bacteraemias continued throughout 2014/2015. No cases of MRSA bacteraemia were reported.
- The numbers of *Clostridium difficile* toxin-producing cases have continued to decline, whilst there has been an increase in patient population as the Trust continues to expand in size.
- Across the inpatient units there has not been any episodes of outbreaks.
- This Essential Steps (ES) audit was undertaken quarterly across all clinical services. It provided assurance that there is adherence to CNWLFT policies, and national guidelines on IPC best practice. The ES is an observational tool which audits the following: Hand Hygiene (HH), Personal Protective Equipment (PPE), correct Aseptic Non Touch Technique (ANTT), and Sharps Management. The aim of the quarterly audit is to ensure that there is >95% compliance achieved by Health Care Workers (HCW's). It is also to ensure best practice, by reviewing what we are doing, compared with what we should be doing. This has been achieved across all Divisions.
- The Infection Prevention & Control Team (IPCT) supported antimicrobial stewardship across all relevant services and this needs to continue for 2015/2016.
- Continuous development and strengthening of the role of the IPC Link Practitioners (IPCLP). IPCLP's are vital to the achievement of high standards of IPC within a diverse group of services across CNWL.
- The CNWL IPC policies have been integrated across all service lines. New policies have been developed – e.g. the Bare Below the Elbows Policy (BBE), and the Multi Drug Resistant Gram-Negative Bacteria Policy.
- The IPC intranet site has been developed. Due to the development of the website, it is easier for staff to access policies, leaflets, and information on IPC issues.

- IPC mandatory training is provided to both clinical and non-clinical staff. Owing to a change in the training matrix there was an initial drop in training figures. However, quarter on quarter the training figures have increased. At end of 2014/2015 results were: Level 1 (non clinical) = 94%, and Level 2 (clinical) = 84%. This is set against a target of 95%. The IPC team also provided service specific training where required
- Across clinical service lines there is a representation of 97% IPC link practitioners.
- Seasonal influenza immunization is led by the Occupational Health (OH) Department and has achieved the highest uptake rate recorded for CNWLFT, with 37.2% of frontline staff immunised against influenza.
- Corporate key performance indicators (KPI's) for IPC were introduced for 2014/2015 and have been achieved throughout the year.

Challenges:

- The management and monitoring of antimicrobial stewardship.
- To continuously engage Service Leads and staff in the delivery and in the sustainability of the IPC agenda.
- To continue with improved integration of the IPC service with hotel services, and estates and facilities, to improve and develop robust services.

18. Conclusion

The national priorities for 2014/15 as determined by the Department of Health and Public Health England are: Antimicrobial stewardship, Multi Drug Resistant Organisms and Hand Hygiene, with an overall objective of zero tolerance to any HCAI's.

The annual work programme for 2015/16 will continue to deliver compliance within CNWL of national standards, in particular the Health and Social Care Act (2008), and new Regulations for the Code of Practice for Healthcare Associated Infections (2009).

This Report was written with contributions from:

Gill Case	Lead Nurse IPC - Diggory
Judith Greening	Lead Nurse IPC - Jameson
Sue Yasee	IPC Nurse Advisor - Jameson
Lee Peddle	Environment Assurance Manager
Martin Gallop	E&F Manager
Keith Davis	Estates Manager
Claire Pinfold	Procurement Manager
Kathy Hammond	IPC Team Administrator (Diggory)
David Gallop	Galiford Try
Salma Choudhry	Advanced Antimicrobial Pharmacist
Pam Duke	Senior Occupational Health Advisor

APPENDIX A

Annual Antimicrobial Prescribing Audit Report 2014/15

Executive Summary

Introduction:

Antimicrobial resistance is a significant risk to public health. The volume of antimicrobial prescribing globally and locally directly influences the development of antimicrobial resistance. Without effective antibiotics, many of the advances made in modern medicine such as chemotherapy and surgery will become unsafe. Antimicrobial resistance hampers the control of infectious diseases and drives up the cost of healthcare. Antimicrobial stewardship is essential for preserving the effectiveness of the antimicrobials available. Monitoring antimicrobial use is an essential part of this and it is for this reason that antimicrobial prescribing audit is carried out regularly.

This annual report summarises the key findings of the antimicrobial prescribing audit between April 2014 and March 2015. This audit is used to monitor antimicrobial prescribing trends and quality indicators, in order to guide training and development of healthcare staff and to optimise prescribing practice. This audit is used to demonstrate compliance with the Trust's Antimicrobial Prescribing and Administration Policy and associated local and national guidelines. This audit also provides evidence to support compliance with the Health and Social Care Act 2008, and the Department of Health UK Five Year Antimicrobial Resistance Strategy 2013 to 2015.

Compliance:

The CNWL pharmacy team collect data on all inpatient units during the first week of every month. For each antimicrobial prescription found during the audit period, the clinical notes and medication chart are reviewed and compared against antimicrobial guidelines and/or microbiology advice provided. For each prescription, compliance is measured against 5 standards, which are derived from the CNWL Antimicrobial Prescribing and Administration Policy. This Policy defines the processes which ensure that antimicrobial prescribing within CNWL is safe, effective, and appropriate. The audit standards are as follows:

1. **Specification of a stop date:** A minimum of 90% of all antimicrobial prescriptions should have a clearly documented course stop date.
2. **Course length:** A minimum of 90% of all antimicrobial prescriptions should have a clearly documented course length which is appropriate for the indication, and is in accordance with recommendations in the relevant local or national guideline, or microbiology advice.
3. **Appropriate treatment choice:** A minimum of 90% of all antimicrobials prescribed should be in accordance with the recommendations in the relevant local or national guidelines or microbiology advice.
5. **Completion of the allergy box:** 100% of antimicrobial prescriptions should also have a clearly documented allergy status for the patient on the prescription chart.
6. **Total compliance:** A minimum of 90% of all antimicrobial prescriptions should be appropriate/ correct overall.

The total compliance score is where the pharmacy team member must decide whether the antimicrobial prescription is appropriate overall, taking into consideration all elements of the prescription. All total compliance scores are reviewed by the antimicrobial pharmacist, and used to calculate overall compliance for each divisional service, which is then RAG rated. ,The RAG rating parameters are set as follows:

RAG Rating	Required parameter
Red – Poor Compliance	Below 50% total compliance
Amber – Good Compliance, improvement needed	Total compliance between 50% - 89%
Green – Excellent Compliance	Above 90% total compliance

Analysis

At the start of Quarter 4 (January 2015) the new CNWL divisional structure was implemented. This audit report has been aligned to the new structure, and audit data from Quarters 1-3 has also been aligned to allow for trend monitoring and comparison.

Between April 2014 and March 2015 a total of 824 antimicrobial prescriptions across 33 inpatient sites were submitted for audit. 65 prescriptions were eliminated due to missing or incomplete data, and a total of 759 prescriptions were included in this analysis (see table 1).

Table 1: Total number of antimicrobial Prescriptions submitted and analysed 2014/15

Number of Antimicrobial Prescriptions	2014/15											
	Q1			Q2			Q3			Q4		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Div A - Mental Health (MH) - St Charles Hospital	1	0	0	1	3	0	2	1	2	4	0	1
Div A - Mental Health (MH) - Gordon Hospital	0	0	0	0	0	3	2	0	0	0	0	0
Div A - Mental Health (MH) - Northwick Park	0	0	3	2	0	0	0	1	0	2	1	3
Div A - Mental Health (MH) - Park Royal Mental Health	0	0	0	0	2	4	3	0	1	2	0	2
Div A - Mental Health (MH) - SK&C	0	0	0	0	0	0	0	1	0	0	0	0
Div B - Camden Provider Service (CPS)	0	4	6	0	0	0	1	0	0	10	0	13
Div B - Hillingdon Community Health (HCH)	6	6	4	0	7	7	3	5	12	6	0	5
Div B - Hillingdon Mental Health (HMH)	2	1	0	1	5	1	3	3	6	4	1	4
Div B - Child & Adolescent Mental Health (CAMH) and Eating Disorders (ED)	0	0	0	0	0	1	0	2	0	1	0	0
Div B - Mental Health Rehabillitation (MHREHAB) - Brent	0	0	0	0	0	0	0	0	0	0	1	0
Div B - Mental Health Rehabillitation (MHREHAB) - Harrow	1	2	1	0	0	0	0	0	0	1	0	1
Div B - Mental Health Rehabillitation (MHREHAB) - Horton Rehab Services	0	0	0	0	0	3	8	3	4	2	2	3
Div C - OC - HMP Woodhill	0	18	1	9	18	18	15	17	15	14	17	7
Div C - OC - HMP Winchester	15	17	7	0	27	14	21	9	11	11	16	15
Div C - OC - HMP&YOI Holloway	13	12	10	0	0	22	29	12	16	18	19	14
Div C - OC - Haslar IRC	0	0	4	0	2	2	0	3	3	1	2	1
Div C - OC - Tasman & Java ward	0	0	0	0	0	0	1	0	0	0	0	0
Div C - Milton Keynes Community Health (MKCH)	0	6	3	0	0	0	0	0	5	6	0	1
Div C- Milton Keynes Mental Health (MKMH)	0	1	2	7	4	3	3	2	8	0	0	3
Total	**38**	**67**	**41**	**20**	**68**	**78**	**91**	**59**	**83**	**82**	**59**	**73**
		146			**166**			**233**			**214**	
						759						

Results: Key Points

There have been some moderate improvements in total compliance across some divisional services during 2014/2015. Due to limited data from some services we are unable to make any final conclusions regarding compliance to antimicrobial prescribing guidelines. The main areas of concern highlighted throughout the year, are appropriate treatment choice, and course length in line with microbiology advice and guidance (see table 2).

Jameson Division

- Total compliance scores for all Jameson division services lines have been consistent through the year with no significant improvements demonstrated (see graph 1).
- Park Royal (69% of 14) and St Charles Hospital (78% of 15) have a RAG rating of amber indicating that total compliance with antimicrobial prescribing guidance is good, with further improvement needed.
- The exception to this is Northwick Park Mental health which scored an annual total compliance score of 96% (of 12) and is therefore excellent (see table 2).

- The Gordon Hospital, and South Kensington and Chelsea Mental Health have not been RAG rated as there is very limited data available for these services, and therefore it is not possible to make any firm conclusions about compliance from this.
- From the available data, the areas of non-compliance in this division are: appropriate treatment choices which are inline with guidelines and microbiology advice, appropriate course lengths, allergy status documentation, and stop date specification.

Goodall Division

- There have been moderate improvements in total compliance across all services in 2014/15 (see graph 2).
- Hillingdon Mental Health had a total compliance score of 33% (of 3) in Q1 which improved to 89% (of 9) in Q4. Good improvement has been seen in this area.
- Horton Rehabilitation Services have also demonstrated consistently good total compliance throughout the year. Annual total compliance was 89% (of 25) and RAG rated as amber.
- There has been limited data available from Camden Community Health Services due to staffing issues during Q2 and Q3, however, despite this and based on the available data, total compliance for the year was 89% (of 34).
- There has been limited data available from Brent and Harrow Mental Health Rehabilitation, and the CAMHS and Eating Disorders ervice areas. For this reason these services have not been RAG rated as it is not possible to make any firm conclusions.
- The main areas of concern across this division are appropriate treatment choice, and course length in line with microbiology advice and guidance.

Diggory Division

- In Diggory division significant improvements have been seen at HMP Woodhill where total compliance improved from 21% (of 19) in Q1, to 97% (of 38) in Q4 (see graph 3).
- Improvements in total compliance were also seen at HMP & YOI Holloway. In Q1 total compliance was below 50%, but improved to 65% (of 51) in Q4.
- Milton Keynes Community Health and Mental Health services began participating in this audit in May 2014.
- Due to staffing changes during the year there was no data on antimicrobial prescribing collected for Milton Keynes Community Health Services during Q2 and Q3. In Q4 staffing issues were resolved and data collection has resumed. Based on the available data, total compliance for the year for MKCH service was 76% (of 21).
- Annual total compliance for HMP Winchester was 51% (of 163). Quarterly compliance thoughtout the year has remained consistent with no significant improvements seen (see graph 3).
- Tasman and Java ward have not been RAG rated as there was only one prescription audited for this service during the 2014/15 period. Due to this very limited data, it is not possible to make any firm conclusions from this.
- Haslar Immigration Removal Centre (IRC) had an annual total compliance of 35% (of 18). This service is no longer part of CNWL.

The most common indication for which antimicrobials were prescribed was for skin and soft tissue infections which represented 31% (of 763) of all prescriptions audited (see graph 4 and table 3). 74% (of 237) of all antimicrobials prescriptions for skin and soft tissue infections were from Offender Care in Diggory Division. Respiratory tract infections (20% of 763), Urinary tract infections (17% of 763), and dental infections (16% of 763), were also prevalent.

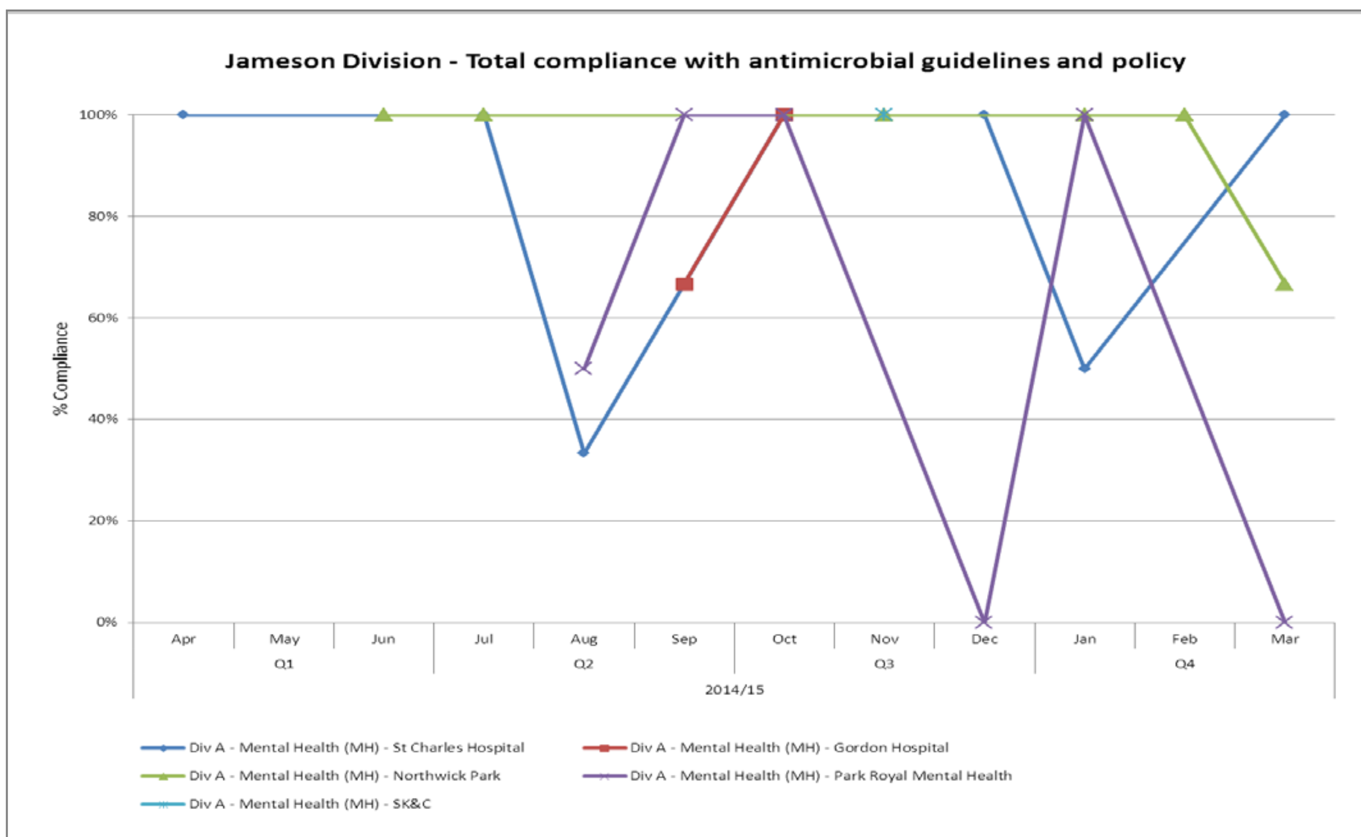
For the first time since commencing this audit broad-spectrum antimicrobial usage was reviewed. This is in response to the NHS England 2015-16 Quality Premium, and has been added to this audit for good practice. The antimicrobial agents considered are co-amoxiclav, all cephalosporins, and quinolones.

During 2014/15, 15% (of 763) of all antimicrobial prescriptions audited were for one of these broad-spectrum antimicrobials. Of these prescriptions 74% (of 114) were for co-amoxiclav.

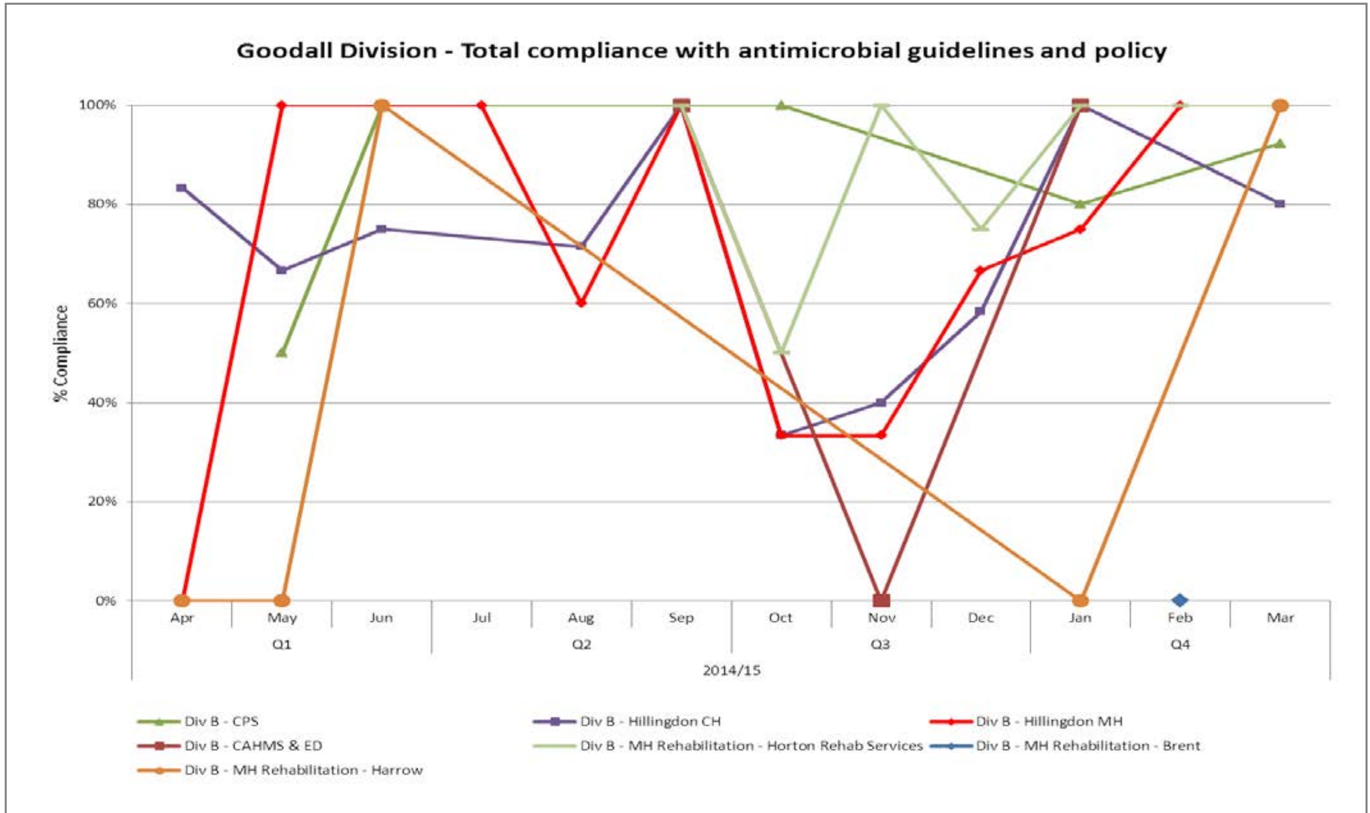
Table 2: Divisional service annual compliance scores

Division	Annual Compliance	n	Audit Standards				
			Total Compliance	Stop date specification	Appropriate course length	Appropriate treatment choice	Completion of allergy status
Jameson	Mental Health (MH) - St Charles Hospital	15	78%	88%	95%	90%	95%
	Mental Health (MH) - Gordon Hospital	5	83%	100%	100%	83%	100%
	Mental Health (MH) - Northwick Park	12	96%	100%	100%	96%	100%
	Mental Health (MH) - Park Royal Mental Health	14	69%	100%	94%	75%	100%
	Mental Health (MH) - SK&C	1	100%	100%	100%	100%	100%
Goodall	Camden CH	34	89%	88%	89%	99%	100%
	Hillingdon CH	61	75%	91%	89%	82%	98%
	Hillingdon MH	31	61%	100%	75%	78%	96%
	CAHMS & ED	4	67%	83%	83%	83%	100%
	Mental Health Rehabillitation (MHREHAB) - Brent	1	0%	100%	0%	100%	100%
	Mental Health Rehabillitation (MHREHAB) - Harrow	6	38%	50%	63%	63%	100%
	Mental Health Rehabillitation (MHREHAB) - Horton Rehab Services	25	89%	100%	89%	73%	100%
Diggory	OC - HMP Woodhill	149	59%	98%	91%	87%	72%
	OC - HMP Winchester	163	51%	100%	67%	75%	89%
	OC - HMP&YOI Holloway	165	66%	100%	76%	84%	97%
	OC - Haslar IRC	18	35%	100%	73%	67%	100%
	OC - Tasman & Java ward	1	0%	100%	100%	0%	100%
	MKCH	21	76%	90%	72%	89%	96%
	MKMH	33	63%	96%	78%	77%	100%

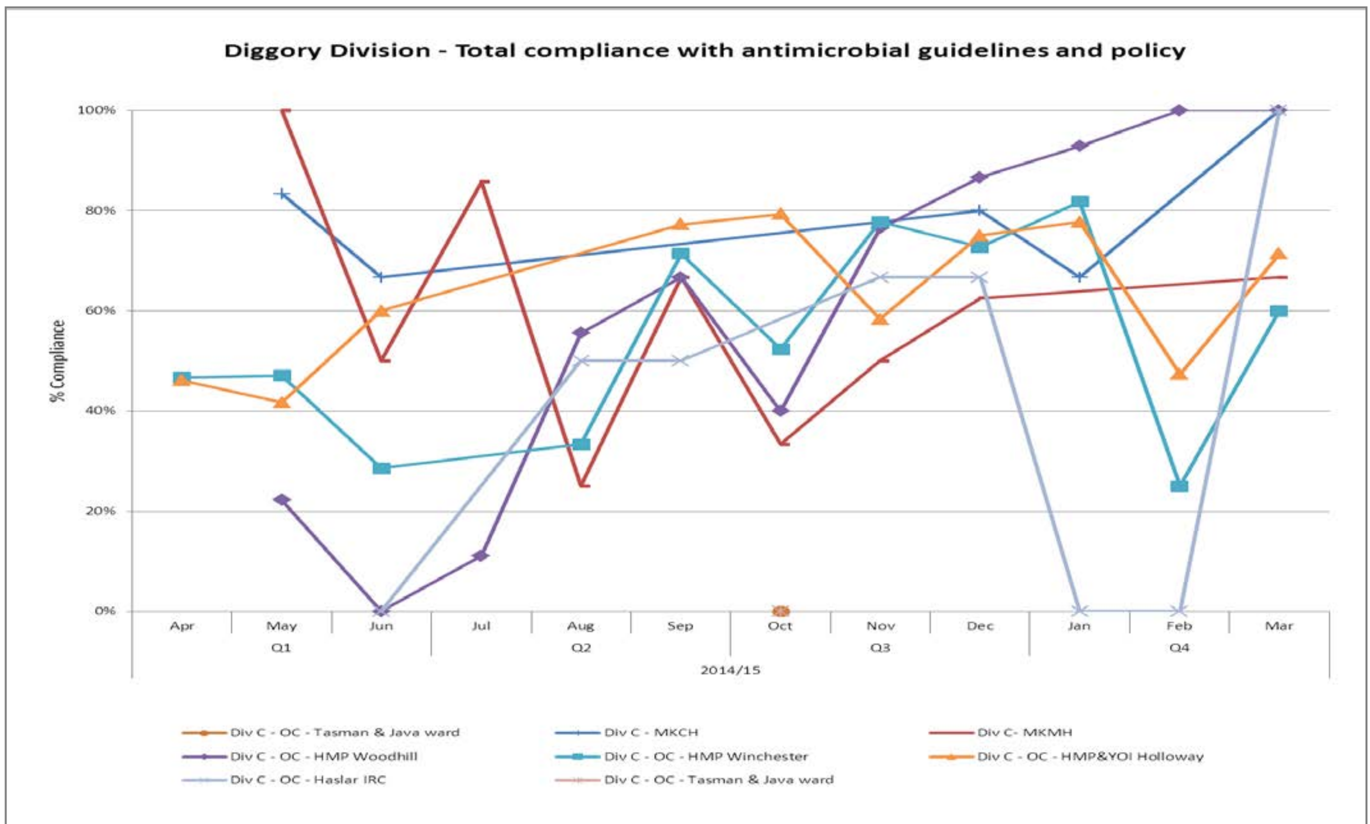
Graph 1: Percentage total compliance for each service in Jameson Division 2014/15



Graph 2: Percentage total compliance for each service in Goodall Division 2014/15



Graph 3: Percentage total compliance for each service in Diggory Division 2014/



Graph 4: Antimicrobial prescribing indications from audited prescriptions across all divisions 2014/15

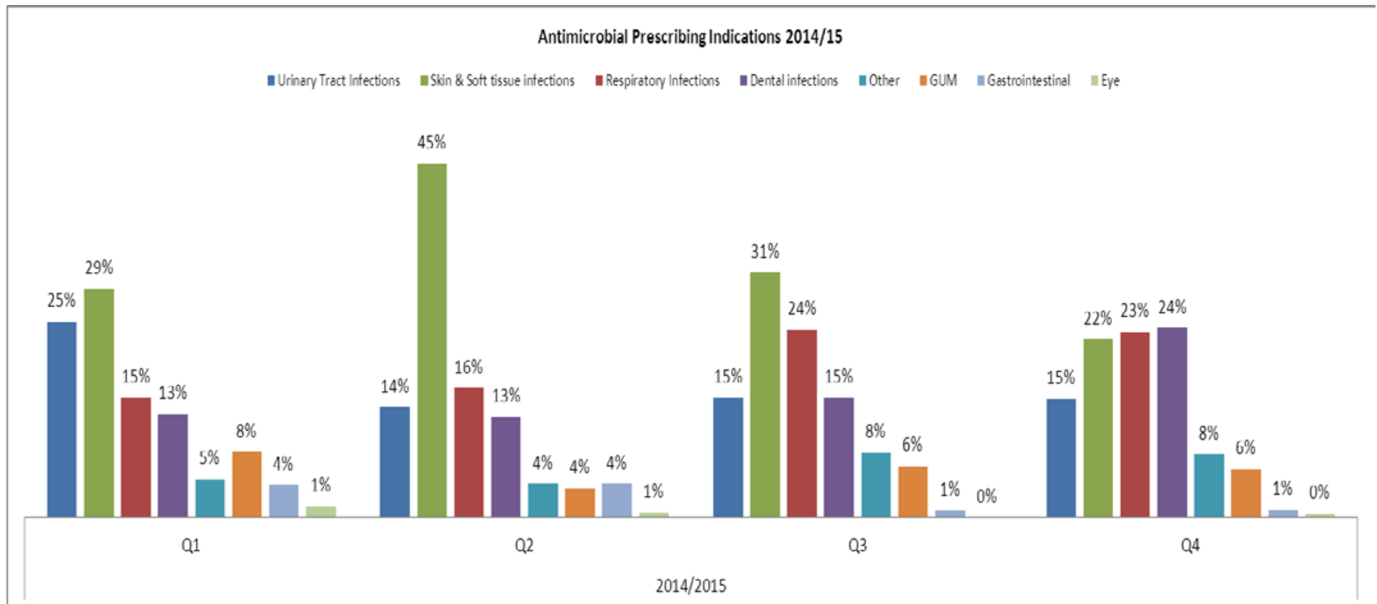


Table 3: Antimicrobial prescribing indications as a percentage of prescriptions audited:

	Annual
Skin and soft tissue Infections	31%
Respiratory tract infections	20%
Urinary tract infections	17%
Dental infections	17%
Genitourinary infections	6%
Gastrointestinal Infections	1%
Eye infections	1%
Other	7%
Total number of prescriptions	**759**

Conclusion

Total compliance with antimicrobial prescribing guidelines and microbiology advice is good across most divisions and services; however there has been no overall improvement. The main areas of concern are appropriate treatment choice, and course length in line with microbiology advice and guidance. These aspects of antimicrobial prescribing have already been included in ongoing initiatives to improve antimicrobial prescribing and usage across the Trust.

Discussion and Action plan

During the previous year an antimicrobial link pharmacist group was set-up to tackle local problems around antimicrobial prescribing and usage (see appendix 4 and 5). An antimicrobial link pharmacist was recruited within each of the divisional services. The specialist antimicrobial pharmacist will work closely with these link pharmacists to identify areas for improvement locally, and develop an action plan to tackle these (see appendix 6).

The 18th of November 2014 was European Antibiotic Awareness Day (EAAD) which is a Europe-wide campaign to raise awareness of antimicrobial resistance, and what we can all do to preserve the effectiveness of our antimicrobials. A number of activities took place across the Trust during November for EAAD. These were aimed at staff, patients, and service users, and promoted awareness of this important issue (see appendix 2). Activities for the 2015 EAAD awareness campaign are currently being developed.

To influence and optimise antimicrobial prescribing a Trustwide memo was issued by the Specialist Antimicrobial Pharmacist on effective antimicrobial prescribing in December 2014. This memo was endorsed by Dr Berge Azadian – Consultant Medical Microbiologist, and Rebecca Stretch – Deputy Director for Infection Prevention and Control (see appendix 3). The memo highlighted the top tips on antimicrobial prescribing, as well as useful resources and links to further information on antimicrobial prescribing.

To ensure efficient data collection, the data collection tool for this audit was reviewed in December 2014. As previously mentioned, of the 824 prescriptions submitted for audit, 65 prescriptions were eliminated due to missing or incomplete data. To improve the quality of data collected, the data collection tool was updated to include a guidance section on how to complete the form, and what data should be included (See Appendix 1).

65% (of 763) of all prescriptions audited during 2014/15 were from an Offender Care setting. Due to regular data collection, there is a rich data set for the CNWL Offender Care Service. There are however considerable challenges associated with implementing antimicrobial stewardship initiatives in this care setting. This is an area which has not been extensively researched, and therefore during 2015/16 the CNWL antimicrobial pharmacist will begin looking indepth at what antimicrobial stewardship measures can be effectively utilised in the Offender Care setting.

It was not possible to assess and RAG rate a number of services due to limited data. It is unclear if this is due to low antimicrobial usage in those areas, or poor data collection. 'Define' is a software system which allows NHS Trust pharmacies to monitor their own prescribing practices against peers. For future reports Define data on antimicrobial usage will be included to highlight areas of missing data and compare services.

The following action plan has been formulated to address areas of non-compliance and concern, as well as some overarching antimicrobial stewardship objectives in order to improve use of antimicrobials:

Action No.	Action	Deadline
1	Circulate report to all Pharmacists, Prescribers, and Divisional Medical Directors to discuss at respective quality and governance meetings. Also present findings of the audit to each Divisional IPC Subgroup and the IPC Committee.	July 2015
2	Develop local action plans to improve antimicrobial prescribing within each divisional service. Work closely with antimicrobial link pharmacists within each service to develop and implement actions identified.	September 2015
3	Use Define data to monitor antimicrobial usage and in particular broad-spectrum antimicrobial usage across the Trust.	September 2015
4	Plan activities for European Antibiotic Awareness Day 2015. Develop a pocket sized guide of top tips on antibiotic use for all healthcare professionals.	November 2015
	LONGER TERM OBJECTIVES	
5	Develop Trustwide antimicrobial strategy.	July 2015
6	Scope the feasibility to develop CNWL antimicrobial guidelines.	October 2015
7	Review and update the current CNWL Antimicrobial Prescribing and Administration Policy. Include NICE recommendations on antimicrobial stewardship.	November 2015
8	Develop key antimicrobial competency assessment for all clinical staff (delivered via the Trust's Learning and Development Zone), involved with antimicrobials.	November 2015
9	Review audit report/tool to ensure it captures key antimicrobial data as part of antimicrobial resistance strategy and align reporting to new Trust divisional structure.	December 2015
10	Review current antimicrobial stewardship initiatives available and scope implementation within Offender Care settings.	December 2015

References

1. Central & North West London NHS Foundation Trust (2012) Antimicrobial Prescribing and Administration Policy.
2. Health and Social Care Act 2008. London: The Stationary Office.
3. Department of Health (2013) UK Five Year Antimicrobial Resistance Strategy 2013-2018.
4. NHS England (2015) Quality Premium: 2015/16 Guidance for CCGs.

INFECTION PREVENTION AND CONTROL ASSURANCE FRAMEWORK 2014 - 15					
Criteria Standard Required	**Assurance/Evidence required from CNWL**	**Current status**	**Compliance**	**Key Actions to be undertaken**	**Lead person (including role)**
A board-level agreement outlining the board's collective responsibility for minimising the risk of infection and the general means by which it prevents and controls such risks	Board Level Agreement is in place outlining the Board's responsibility for reducing the risks of Infection. Infection Prevention Control (IPC) is incorporated into all job descriptions. Quarterly IPC reports are sent to the CNWL Exec Board of Directors.				Director of Infection Prevention & Control (DIPC)
The designation of an individual as Director of Infection Prevention and Control (DIPC) to be accountable directly to the Chief Executive and the Board	Andy Mattin DIPC				
	Reports directly to the Executive Board				
	Has the authority to challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions				
	Responsible for CNWL Infection Prevention & Control team (IPCT) Monitors compliance with the IPC agenda				
	Oversees local IPC and related policies and their implementation				DIPC/DDIPC

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The mechanisms by which the Board intends to ensure that sufficient resources are available to secure the effective prevention and control of HCAI's. **These should include implementing an appropriate assurances framework, an infection prevention and control programme, an infection control infrastructure, and information systems**	There should be a mix of both nursing and consultant experience. and links into all services				DIPC
	The IPCT must be responsible for infection matters with specialist expertise.				DIPC/DDIPC/IPC Leads
	Must have 24 hr access to nominated Infection Control Doctor.	IC doctor is available for advice on a 24hour basis.			DIPC/DDIPC
	All new staff have access to IPC Control in their induction and training	A yearly mandatory training programme is in place for clinical staff. A 2 yearly is available for non-clinicians.			DIPC/ DDIPC/L&D
	The IPC programme must: • Set objectives. • Formulate a work planner with clear objectives. • Identify priorities for action. • Provide evidence that policies have been implemented. • Report progress against objectives of the programme in the DIPC report.	IPC work planner in situ. Priorities have been set. All IPC policies are available on Trustnet			DIPC/ DDIPC/L&D

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	Resources and capital bids are discussed at the CNWL Estates and Facilities meeting on an annual basis.	To mitigate against Healthcare Associated Infections (HCAI's). All sites across CNWL have environmental rolling audits on an annual basis. Recommendations and actions are outlined following each audit. Timeframes are set to rectify any issues where practibable. Capital Investment programmes are ongoing.			Estates & Facilities. IPCT, DIPC, DDIPC.
	To comply with HTM64, no plugs, no overflow water	Programme in progress			
Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information on, and training and supervision in, the measures required to prevent and control risks of infection	IPC I Annual report				DIPC / DDIPC / IPC Leads / E&F
	Quarterly updates to the Board.				

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A programme of audit to ensure that key policies are being implemented appropriately	A Programme of Audits are available to ensure that all IPC policies and procedures are implemented and available on Trustnet.	Examples: Essential Steps, PLACE, cleaninig audits and environmental audits are undertaken quarterly.			IPC Leads Service Leads E&F Matrons Ward Managers
A policy addressing, where relevant, the admission, transfer, discharge and movement of patients between departments and within and between healthcare facilities	A policy exists outlining the admission, transfer and discharge processes for patients transferred across healthcare systems.	An overarching admission and discharge Policy exists across CNWL. An interhealth care transfer form is used for patient transfers outlining any infectious conditions.			DIPC/DDIPC DDONS Service Leads
Designation of a decontamination lead	Named Decontamination Lead.	Helen Willetts - Divisional Director of Nursing, Diggory			DIPC/DDIPC Decontamination Lead
	Ensure that the programme is implemented in relation to the organisation and takes account of relevant National Guidelines	Policies and a standard operating procedure (SOP) on decontamination of reusable medical devices were ratified in 2014. They are available on Trustnet.			Helen Willetts
	Decontamination of the environment is in line with policies and guidelines. Fabric, fixtures and fittings	The CNWL Decontamination Policy is available on Trustnet.		Medical Devices Officer	Helen Willetts / OCS / Service Leads / Medical Devices Officer

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	Decontamination of reusable medical equipment is in line with policies and guidelines.	Standard operating procedures are available.			DIPC/DDIPC Helen Willetts Service Leads
	Staff are trained on decontamination process.	Staff are trained briefly on decontaminationn during induction training. Log books are available			DIPC/DDIPC Service Leads with support from IPC Leads.
	Monitoring system in place to ensure that decontaminated equipment is fit for purpose and meets the required standards.	BCAS monitors and audits equipment. Local programmes for decontamination of equipment are located in each site. Competencies on the use of reusable medical devices is assessed during appraisals.		Ongoing	Decontamination Lead / Medical Device Officer / Service Leads / Estates
It has policies for the environment that make provision for liaison between the members of the ICT and the persons with overall responsibility for facilities management	Environmental Audits are included in the audit programme. The tool is based on the national/local recognised audit tools. (IPC Nurse Association)	Ongoing across CNWL through a rolling programe across sites.			IPCT
	Estates Plan incorporates guidance from HTM Health Building Note across landlord CNWL Sites.	Ongoing			Estates & Facilities

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	Performance Report to inform the Board of cleanliness issues within the Trust.	Monthly cleaning audits are undertaken by OCS (cleaning contractor). They are submitted to the IPCT and to the CNWL ICC.			Cleaning contractor (OCS)
	Cleaning schedules and standards to include additional cleaning support and routinely required. Should include cleaning frequencies based on NHS national cleaning standards. All staff have access to cleaning and decontamination policies.	The cleaning schedules are available across all CNWL sites.			Service Line Manager, OCS
	Potable - Non-potable Water Supplies Policy	On Trustnet			E&F
	Policies for the purchase and maintenance of all clinical equipment	Available in the Decontamination Policy			DIPC/DDIPC Decontamination Lead / Officer
	Waste Management Policy	Renewed in 2015		.	E&F
	Legionella Policy	Renewed in 2015			E&F
	Planned Preventative Maintenance Policy and schedules.	Schedules in situ across CNWL in sites with maintenance schedules		The CNWL environmental audits highlight the maintenance work that needs to be undertaken across all sites on a regular basis. A rolling schedule of works is maintained by the Clinical Services Manager.	E&F / IPC input

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	Protocol for rapid response to unexpected occurrences and facilities management. Monitored by IPC. Incidents reported to Datix	Spillage kits available in all CNWL health sites and in the bedded units. Spillage Policy available on Trustnet. Spillage kits availability checked on environmental audit.			Service Lead in bedded area and clinic supervisor in health centres.
It designates lead managers for cleaning and *decontamination of equipment used in treatment (a single individual may be designated for both areas)	Ward managers have personal responsibility and accountability for delivering a safe and clean care environment, and that the nurse in charge of any patients had direct responsibility for ensuring that cleanliness standards are maintained throughout the shift.	Cleaning rotas outlined by OCS across CNWL			DIPC / DDIPC / OCS / Ward Managers
	Decontamination Lead responsible for ensuring that the programme is implemented in relation to the organisation.	Medical Devices Policy available on Trustnet.			Decontamination / Medical Devices Officer
	Procedures are followed for the acquisition and maintenance of decontamination of equipment.	Outlined in the Decontamination Policy and local SOPs. Single use devices are available across CNWL except for Dental.			Decontamination Lead / Medical Devices Officer
	Audit compliance of decontamination standards and cleanliness. Decontamination audits take place.	This schedule is in place for dishwashers across CNWL with Galliford Try.			Galliford Try

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Lead managers involve Directors of Nursing, Matrons, and the IPCT in all aspects of cleaning services from contract negotiation and service planning, to delivery at ward level	IPCT involvement with cleaning contracthas occurs.	IPCT are involved in tendering processes.			E&F Cleaning contractors (OCS)
Matrons have personal responsibility and accountability for delivering a safe and clean care environment, and that the nurse in charge of any patient areas has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift	All staff must adhere to the correct uniform policy and support good hygiene.				Service Leads/HR
	Well publicised hand hygiene posters in all patient areas.	Yes, posters are available in all sites.			Team Leads IPCT / Service Leads / Matrons
	Sufficient resources have been dedicated to keep the environment fit for purpose	Any deficiencies in the environment are escalated following environmental audits to estates & facilities or health and safety groups where seen fit, and apropriate. SLA's exist across E&F		Evidence requested estates plan supports the HTM and HBN. Any required works are carried out in accordance with these requirements. E&F manage and maintain IC issues across CNWL.	E&F with support from IPCT.
The cleaning arrangements detail the standards of cleanliness required in each part of its premises, and that a schedule of cleaning facilities is publicly available.	Cleaning schedules in situ.	National specification standards for cleaning are adhered. Cleaning audits are undertaken monthly.			E&F OCS/IPCT

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	Risk Assessments of premises in order to maintain standards of cleanliness	Premises are risk assessedd during audits. Appropriate actions and recommendations are made.			E&F/OCS/IPCT
	Wall mounted soap, alcohol gel and hand cream are available in all sites and in the bedded area. Paper towels available.	This is captured during the environmental inpatient and outpatient audits. National specification standards for cleaning are adhered to. Cleaning audits are undertaken monthly.			E&F/OCS/IPCT
	Foot operated lidded pedal bin which are in close proximity to hand wash basins.	Pedal operated bins - solid fire-retardant bins are to be found in all clinical areas.			E&F/OCS/IPCT
	Designated hand wash basin in all clinical areas	Yes			
	All sinks in clinical areas are compliant with HTM 64.	There are designated clinical hand wash basins across CNWL which are HTM64 compliant.			
	Taps not directly situated above plug hole.	Work in progress capital bids programme		Ongoing	E&F
There are effective arrangements for the appropriate decontamination of instruments and other equipment - these should be incorporated within appropriate disinfection and decontamination policies	Reusable medical devices and other devices should be decontaminated in accordance with manufacturers guidelines.	CNWL IC standardised procedures have been agreed.		Ongoing	E&F / Service Lead / Medical Devices Officer.

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	Reusable medical devices are used in the dental service. Best practice of HTM 01-05 are demonstrated in the dental areas across CNWL.	There is regular ongoing self audits against the HTM 01-05 across CNWL.			E&F / Service Lead / Medical Devices Officer.
	Policy for handling of instruments designated for single use.	Policy is available on Trustnet			
	Staff are trained and competent in decontamination.	Undertaken at IPC mandatory training. Training records are available with L&D			
The supply and provision of linen and laundry supplies reflect Health Service Guidance (HSG) 18, Hospital Laundry for uses and infected linen	Policy for the supply of linen and laundry.	Policy is available on Trustnet. Due for renewal 2016			E&F OCS
Uniform and work wear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose	Uniform and Work Wear Policy ensures clothing worn by staff carrying out their duties is clean and fit for their purpose. Uniform and Dress Policy to support good hygiene.	Policy available on Trustnet			HR / Service Leads / Matrons
General principle pertaining to the prevention and control of HCAI and key aspects of the provider's policy on infection prevention and control	IPC annual report is available for the public on the Trust Website.	Yes			DIPC / DDIPC
	Leaflets are available on theTrustnet. Information is available in health centres, e.g norovirus, ebola.	Yes			Comms with input from the IPCT

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The role and responsibilities of individuals in the prevention and control of HCAI, to support them when visiting patients	Information and policies are available in the event of an outbreak.	Yes			Service Leads / Ward managers with support from the IPCT
	Personal protective equipment is available if required. In the event of a root cause analysis, information is shared with relatives.	Yes			Service Leads with support from the IPCT
Supporting vigilance in patients	Quarterly reports are sent to the IPC divisional SubGroups and the IPCC on alert organisms. In the event of a bacteraemia in the bedded unit a Root Cause Analysis (RCA) is undertaken. Lessons learnt are discussed.	Ongoing			DDIPC/IPC Leads
	Discharge information is given to the community matron and appropriate staff for those being discharged to the community with HCAI's such as MRSA.	Ongoing			Ward Manager / Matron
The importance of compliance by visitors with hand hygiene and visiting restrictions	Clear signage is put in situ to guide and assist restrictions on visiting where required.				Ward Manager with support from the IPCT
Reporting breaches of hygiene and cleanliness	Reporting system in order to report cleanliness incidents via Datix. Any breaches are also reported at the OCS contract meetings.	This is also reported to the Divisioanal subgroups and IPCC.			Ward Managers, Clinic supervisors/ Team Leads with support from the IPCT.
Feedback that is focused on the patient pathway	MDT meeting post a c.diff for example				

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Provision across organisational boundaries, such as pre-admission screening and post-operative care	Currently all patients in intermediate care units across CNWL are screened for MRSA on admission. This currently does not apply to mental health units. Discharge information is given to the community matron and appropriate staff for those being discharged to the community with HCAI's.				Ward Managers / Matrons with support from the IPCT
	Clinicans have been trained to observe for signs of infections e.g UTI or leg wounds and act appropriately. In the event of a communicable disease, policies and protocols are available for staff to read on Trustnet.	Ongoing			Ward Managers
	Registered providers, should ensure that advice is received from suitably informed practitioners and Public Health England of any outbreaks or serious infection occurrences.	Weekly bulletins on local, national and global issues are sent from Public Health England. CNWL are alerted of any notifications of Norovirus by PHE.			Microbiologist/ PHE
	Progress to be reviewed against Essential Steps Programme	Essential Steps programme is undertaken on a quarterly across CNWL.			Link Practitioners with support from IPC Leads.

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	Individual Treatment Plans reflect the outcomes of HCAI risk assessments. Infection control risk assessments to be embedded in patient care.	MRSA and c.diff care pathways were introduced. RCA's undertaken where appropriate			Ward Manager / Matron with support from the IPC Leads.
CNWL must ensure that they gain the cooperation of all staff, contractors and others in the provision of healthcare in preventing and controlling infection	IPC is included in all job descriptions of employees across the organisation. Staff are encouraged at training to report any IPC issues to the IPCT.	IPC issues are reported via the Datix system.			Ward Manager / Matron with support from the IPC Leads
A healthcare registered provider delivering inpatient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection.	Not all sites have adequate isolation facilities.Through capital bids risk assessments are undertaken.	Ongoing			Estates & Facilities with support from the IPC Team
	There are a number of bays where patients can be cohorted if required.	Ongoing			Ward manager, Matron with support from hte IPC Team
	Isolation Policy is available on Trustnet.	Yes			DIPC / DDIPC and IPC Leads
	Microbiology facilities are CPA accredited.	Yes			
Standard (universal) infection control precautions	Policy to be evidence based and accessible.	Available on Trustnet. Updated in 2015.			DIPC / DDIPC / IPC Leads
	Monitor compliance. Audited by IPCT and peer review.	Incorporated in the Essential Steps Audit / PLACE / Environmental Audits			DIPC / DDIPC / IPC Leads / link practitioners

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	Training to be included to all staff at inductions.	This is identified in training slides and in the e-learning workbook. Monitored by L&D and recorded in LDZ.			Learning and Development with support from the IPCT
Aseptic Technique	Clinical procedures are carried out to promote principles of asepsis.	Incorporated in the Essential Steps. ANTT Policy available on Trustnet.			Ward Managers / Matron with support from IPCT
	Training of all staff carrying out procedure takes place.	Competencies of undertaking procedures is signed off by Ward Manager.			Ward Managers / Matron with support from IPCT
Outbreaks of communicable infections and isolations procedures	Policy to include at risk patients and clinical specialities	Policy is available on Trustnet. Risk assessments are undertaken on an individual patient basis.			DIPC / DDIPC / Ward Managers / Matrons with support from PHE
	Isolation Policy in place for major outbreaks to include initial assessment communication management. Organisation and control.	Yes			DIPC / DDIPC / Ward Managers / Matrons with support from PHE.
	Contact details for those involved in outbreak available.	Contact details of all IPC nurses listed alongside PHE sites across CNWL.			
Safe handling and disposal of sharps	All staff to adhere to the policy. Audit compliance as per audit. .	This is captured in the Essential Steps Audit. Any needlestick injuries are recorded on Datix. Actions, recommendation and lessons learnt are reviewed. Safer devices have been introduced across CNWL where practicable.			DIPC / DDIPC / Health & Safety / Ward Manager / Matrons

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	Risk management and training and prevention of needle stick injuries.	This is taught at CNWL inductions and through the online IPC workbook.			Learning and Development with support from the PCT
Prevention of occupational exposure to blood-borne viruses, including prevention of sharps injuries	Policy available on Trustnet. .	"Safer needles" have been introducted across CNWL where practicable in accordance with the EU Directive Safe Sharps 2013.			DIPC / DDIPC / OH / Clinical staff with support from the IPCT
		Posters are available across CNWL demonstrating how to contact the Occupational Health advisor. Needlestick injures are reported on a quarterly basis to all subgroups and the CNWL ICC, and the the Health and Safety committee.			OHS and OD Doctor with support from the IPC Team.
Management of occupational exposure to blood-borne viruses and post-exposure prophylaxis	OH Service avaialbe in St Pancras for all CNWL staff.	Contract in place across CNWL.			DIPC / DDIPC / OH, Doctor and Advisors
	Provision of clear information to healthcare staff about potential exposure.	Information supplied by the Occupational Health advisors. Disposal of sharps safely and body fluid exposure advice is available on Trustnet.			
Closure of rooms, wards, departments and premises to new admissions	Algorithms are available across CNWL inpatient beddded units to illustrate what steps to take in HICU in the event that the ward needs to be closed in the event of an outbreak for example.	This is available in the Outbreak Management Policy.			DIPC / DDIPC / On-call manage r/ ward manager / service lead / matron

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	Clear criteria for closure and decontamination.	Outlined in the Outbreak Management Policy.			DIPC / DDIPC / On-call manager / ward manager / service lead / matron
Environmental Cleaning Policty	In Outbreak Policy available on Trustnet.				OCS with support from the IPCT OCS
Antimicrobial Prescribing	Local prescribing should, where appropriate, be harmonised with that in the British National Formulary. Guidelines to be in place to show information on the regimen and duration of drug prescribing.	An agreed antimicrobial prescribing formulary across CNWL is work in progress			DIPC, DDIPC, IPC Doctor, Advanced Antimicrobial Prescriber
	Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update. In healthcare this is usually monitored by the antimicrobial management team.	Quarterly antimicrobial prescribing audits are undertaken across CNWL. Results are shared at subgroup meeting and at the CNWL ICC meeting. Currently an Antimicrobial Stewardship Policy is being developed.			DIPC, DDIPC, IPC Doctor, Advanced Antimicrobial Prescriber
Reporting HCAI to PHE by the Department of Health	Mandatory surveillance requirement for NHS Trust Chief Executives to report all cases of MRSA bacteraemia and all cases of Clostridium difficile infection in patients aged two years or older (as directed by the Department of Health).	In the event of a bacteraemia in a bedded area, this is reported to PHE and recorded on the data capture system. Leaflets are available on Trustnet on HCAI acquired infections such as C.Diff and MRSA.			DIPC, DDIPC, IPC Nurse

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Control of outbreaks and infections associated with specific alert organisms	CCG should ensure that they take into account local epidemiology and risk assessments.	This is monitored by the Infection Control Nurse through post infection reviews undertaken (PIR). Lessons learnt are shared.			Goodall Division IPC Nurses
	MRSA - The Policy should make provision for: • screening of NHS patients on emergency, or relevant elective, admission to a unit that provides surgical, diagnostic or other medical care; • decontamination procedures for colonised patients when appropriate; • isolation of infected or colonised patients; • transfer of infected or colonised patients within organisations or to other care facilities; • antibiotic prophylaxis for surgery.	In accordance with national guidelines, all patients are screened on admission to intermediate care units. Results are recorded in the patients admission nursing and medical notes. Suppression treatment is given in accordance with the local protocol. Monthly MRSA colonisation positive patients are recorded. An audit trail of suppression treatment is also monitored. In the event that patients are in the unit over a month rescreening is undertaken.			DIPC, DDIPC, Ward managers, ward staff with support from the IPC team
	Clostridium difficile - The Policy should make provision for: • surveillance of Clostridium difficile infection; • diagnostic criteria; • isolation of infected service users and cohort nursing; • environmental decontamination; • antibiotic prescribing policies; • and contraindication of anti-motility agents.	The C.Diff Policy is located on Trustnet and makes provision for the management of C.Diff from diagnostic criteria to patient isolation and management.			DIPC, DDIPC

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	Gram Negative Multidrug Resistant Policy available. The Policy should make provision for: identification of high-risk groups;.	This Policy is completed and will be uploaded to Trustnet in November 2015.			DIPC, DDIPC, IPC doctor and input from the IPC team
	Viral Haemorrhagic Fevers (VHF) Policy -. The Policy should make provision for: • appropriate staff to be aware of the special measures to be taken for nursing VHF patients, • to be properly trained in the application of full isolation procedures; • and patient risk assessment and categorisation	The VHF Policy is available on Trustnet.			DIPC, DDIPC
CJD / VCJD - handling of instruments and devices	Advice on the handling of instruments and devices in procedures on patients with known or suspected CJD/VCJD, or at increased risk of CJD/VCJD, including disposal/quarantine procedures, is provided in guidance from the Advisory Committee on Dangerous Pathogens (ACDP) TSE Working Group.	The CNWL Dental Service is in compliance with best practice as outlined in HTM 01-05. Self auditing undertaken on a regular basis.			DIPC, DDIPC, Dental service Leads, IPC doctor and input from the IPC team
Safe handling and disposal of waste	The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves: assessing risk; developing appropriate policies; putting arrangements in place to manage risks; monitoring the way in which arrangements work, and being aware of legislative change. Precautions in connection with handling waste should include; appropriate procedures for handling such waste; appropriate packaging and labelling; suitable transport on-site and off-site; clear procedures for dealing with accidents, incidents and spillages, and appropriate treatment and disposal of such waste..	The Waste Management Policy is due for renewal in 2015..			E&F with support from the IPC Team.

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Packaging and handling and delivery of laboratory specimens	Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation.	Packaging and the handling and delivery of laboratory specimens is done in accordance with THHFT guidelines. No difficulties experienced.			The Hillingdon Hospital Foundation Trust.
Immunisation of service users	Registered providers should ensure that policies and procedures are in place in relation to the immunisation status of service users such that there is a record of relevant immunisations; the imunisation status and eligibility for immunisation of service users are regularly reviewed in line with Immunisation against infectious disease ('The Green Book') and other Department of Health guidance; and all service users can access relevant health services that provide immunisation.	Influenza immunisation is offered to all staff.			DIPC, DIPCC OH Doctor, OH Advisors Service line managers, all staff members
All staff can access relevant Occupational Health services.	All staff across CNWL have access to Occupational Health services.	The service: • Provides re-employment screening and management of exposure to HCAI's. • Immunisation • A Councilling Service • Follows national guidelines.			DIPC, DIPCC OH Doctor, OH Advisors Service line managers
Occupational Health policies on the prevention and management of communicable diseases in healthcare workers, including immunisation are in place.	Occupational Health Policies.	Safe Use and Disposal of Sharps Policy available on Trustnet. Body fluid spillages Policy available on Trustnet.			DIPC, DIPCC OH Doctor, OH Advisors Service line managers, all staff members

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There is a record of training and updates for all staff	Training Plan.	Compliance with the training matrix is monitored through the Learning & Development Zone (LDZ) Optimum target of 95% has not been achieved to date (Nov)			L&D/Service Leads
The responsibilities of each member of staff for the prevention and control of infection is reflected in their job description and in any personal development plan or appraisal	All job descriptions to include Infection Control.	IPC is addressed in all job descriptions.			DIPC, DIPCC HR