

EXECUTIVE SUMMARY**REPORT TO THE BOARD OF DIRECTORS MEETING – 21 JANUARY 2015**

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|------------------------------|---|
| Subject | Infection Prevention and Control (IPC) Update |
| Supporting TEG Member | Professor Hilary Chapman, Chief Nurse |
| Author | Mr Chris Morley, Deputy Chief Nurse |
| Status¹ | N |

PURPOSE OF THE REPORT

This paper provides the Board of Directors with:

- 1) The performance against the local Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia plan for December 2014.
- 2) The performance against the local Clostridium difficile (*C.diff*) plan for December 2014.
- 3) The performance against the Trust Methicillin Sensitive Staphylococcus Aureus (MSSA) bacteraemia plan for December 2014.
- 4) The performance on E.Coli bacteraemia.
- 5) Strategic issues related to Infection Prevention and Control (IPC).

KEY POINTS

- The Trust has had 1 case of MRSA bacteraemia during December 2014. The PIR process is currently determining the cause of this bacteraemia.
- *C.diff* target performance is off trajectory against both the internal and contract *C.diff* plan.
- Monitor are using the number of cases of *C.diff* with lapses in care to determine whether the Trust is meeting its governance requirement in respect of *C.diff*
- Discussions are ongoing with NHS Sheffield Clinical Commissioning Group about the Contract Penalties and how they will be applied if the Trust breaches its contract target
- MSSA performance is on trajectory against the MSSA plan.
- Strategic IPC issues.

IMPLICATIONS²

| AIM OF THE STHFT CORPORATE STRATEGY 2012-2017 | TICK AS APPROPRIATE |
|--|---------------------|
| 1 Deliver the Best Clinical Outcomes | ✓ |
| 2 Provide Patient Centred Services | ✓ |
| 3 Employ Caring and Cared for Staff | |
| 4 Spend Public Money Wisely | ✓ |
| 5 Deliver Excellent Research, Education & Innovation | |

RECOMMENDATIONS

The Board of Directors is asked to debate the contents of this report.

APPROVAL PROCESS

| Meeting | Date | Approved Y/N |
|---------------------------------|-----------------|--------------|
| Board of Directors | 21 January 2015 | |
| Clinical Management Board | 16 January 2015 | |
| Healthcare Governance Committee | 26 January 2015 | |

¹ Status: A = Approval
A* = Approval & Requiring Board Approval
N = Note

² Against the three pillars (aims) of the STH Corporate Strategy 2008-2012

1. INTRODUCTION

This report provides the Board of Directors with information on the year to date performance against the MRSA bacteraemia plan for 2014/15, the *C.diff* plan for 2014/15 and also the MSSA bacteraemia plan for 2014/15. Information is also included on the number of cases of E.Coli bacteraemia. In addition, attention is drawn to a number of key IPC issues.

2. 2014/15 MRSA PERFORMANCE

2.1 MRSA thresholds for 2014/15

Bacteraemia are either classified as Trust attributable or community acquired. Each case of MRSA bacteraemia is subject to a Post Infection Review (PIR). The responsibility for conducting the PIR is determined by when the bacteraemia is identified; for any bacteraemia identified on day 0 or day 1, the patient's Clinical Commissioning Group (CCG) organise the PIR, for any case identified after that the Trust organise the PIR.

NHS England adopted a zero tolerance approach to MRSA bacteraemia from 2013/14 and as such the Trust national target remains zero. Any cases attributed to the Trust will be subject to a contractual penalty of £10k.

Monitor no longer use MRSA bacteraemia as an indicator.

2.2 MRSA performance for December 2014

There has been 1 case of MRSA bacteraemia recorded for the month of December. The outcome of this PIR is awaited but it is likely to be attributed to the Trust as the sample was contaminated, meaning the patient did not actually have a bacteraemia.

The MRSA bacteraemia reported in October has been allocated to the Trust following the completion of the arbitration process.

The MRSA bacteraemia reported in November has been attributed to the Trust as the sample was contaminated meaning the patient did not have a bacteraemia.

The year to date performance is 3 cases of MRSA bacteraemia attributed to the Trust (1 case pending the outcome of a PIR) against the threshold of zero.

For 2014/15 the target for MRSA is zero.

2.3 MRSA Screening

The MRSA screening figures for November were 114% and the figures for December were 113%.

The MRSA screening figures are calculated using the number of screens processed by the laboratory for the month divided by the number of admissions for the month. This is used as a proxy measure as the Trust information systems are not able to reconcile individual screens with individual patients. A figure of over 100% may indicate that the volume of screens being undertaken is in line with all patients being screened for MRSA as per Trust policy.

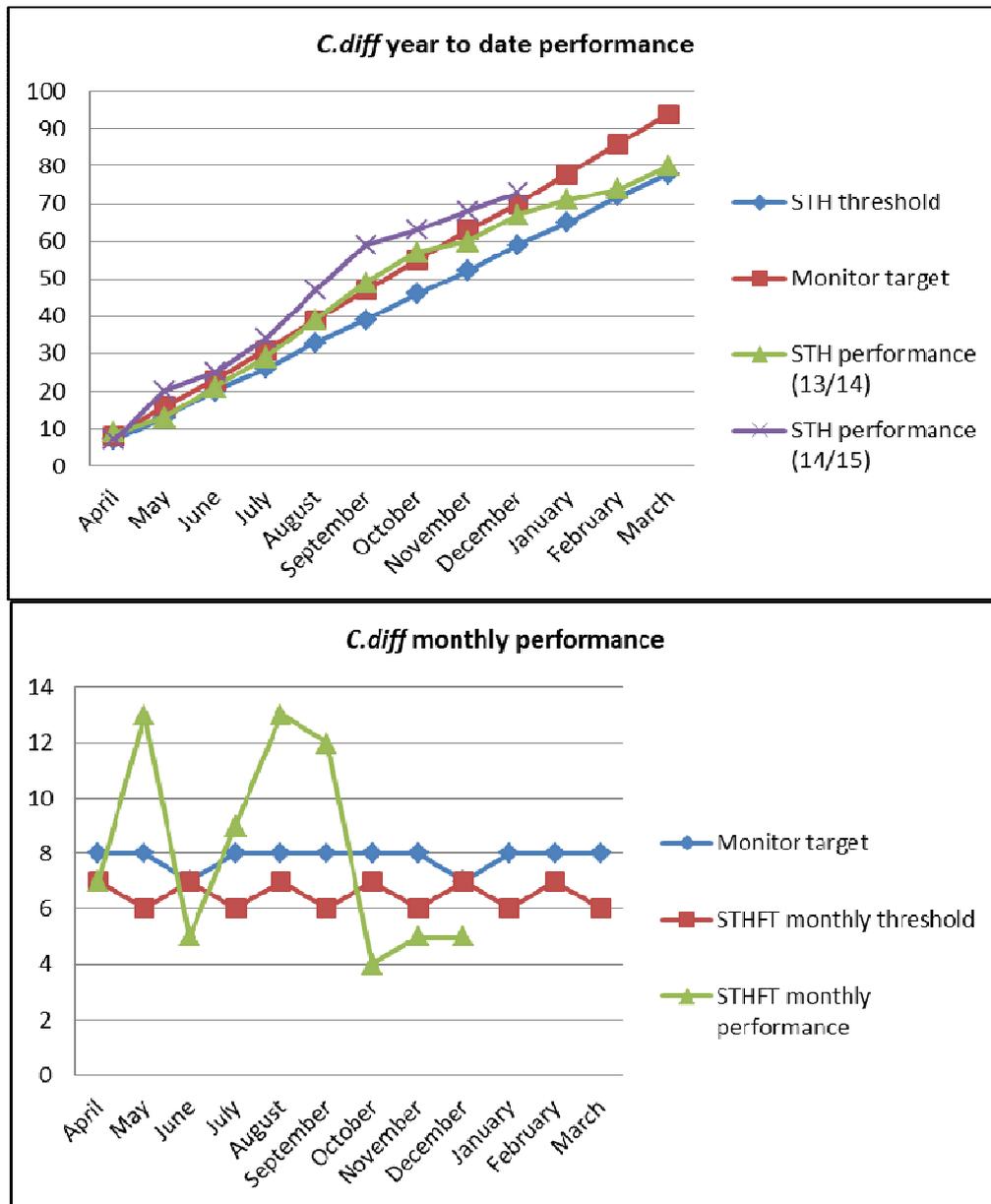
To ensure that MRSA screening protocols are being followed at ward and department level, the Infection Control Programme specifies how the IPC team will undertake MRSA screening compliance audits in each area each year.

3. 2014/15 C.DIFF PERFORMANCE

STHFT has recorded 5 positive samples for December. The year to date performance is 73 cases of *C.diff* against an internal threshold of 59 and a Monitor threshold of 70.

The Trust has been set a contract threshold of 94 cases, but to ensure that we aim to maintain a year on year improvement on the number of cases of *C.diff* attributable to the Trust an internal target of 78 has been set.

Monitor has retained *C.diff* as a target in the Risk Assessment Framework.



Discussions with Monitor have highlighted that although they continue to note the total number of cases attributable to the Trust; they are only considering those cases which were associated with a lapse in care against the target of 94.

The types of issues which would result in the infection being considered to be associated with a lapse in care could be any case where there was evidence of transmission of *C. diff* in hospital such as via ribotyping of the infection indicating the same strain is involved, where there were breakdowns in cleaning or hand hygiene, or where there were problems identified with choice, duration, or documentation of antibiotic prescribing. It must be noted that none of these would indicate that the infection was definitely caused by the provider organisation, only that it cannot be stated that best practice was followed at all times.

The Infection Control Doctors (ICD) have considered which of the 25 cases of *C.diff* attributed to the Trust in quarter 1 they believed to have been associated with lapses in care. Review of the root cause analyses from these cases led to the ICDs concluding that 8 cases were and 17 cases were not associated with lapses in care. These cases have subsequently been reviewed by NHS Sheffield Clinical Commissioning Group which agrees with these findings.

For quarter 2, there were 34 cases of *C.diff*. Analysis shows that 13 cases were and 21 cases were not associated with lapses in care. These cases have been sent to NHS Sheffield Clinical Commissioning Group for ratification.

For quarter 3 there were 14 cases of *C.diff*. Analysis shows that 3 cases were and 5 cases were not associated with lapses in care. The review of 6 cases is awaited.

For the first 3 quarters of the year, of 73 cases of *C.diff*, 24 cases were and 43 cases were not associated with lapses in care. There are 6 cases awaiting review.

Discussions are ongoing with NHS Sheffield Clinical Commissioning Group about the Contract Penalties and how they will be applied if the Trust breaches its contract target.

As the Trust is now above the contract and internal threshold, the Infection Control Operational Group has devised an action plan based on the Trust *C.diff* plan for 2014/15. Monthly review of the *C.diff* Action Plan commenced at the Healthcare Governance Committee in July 2014.

3.1 Surveillance

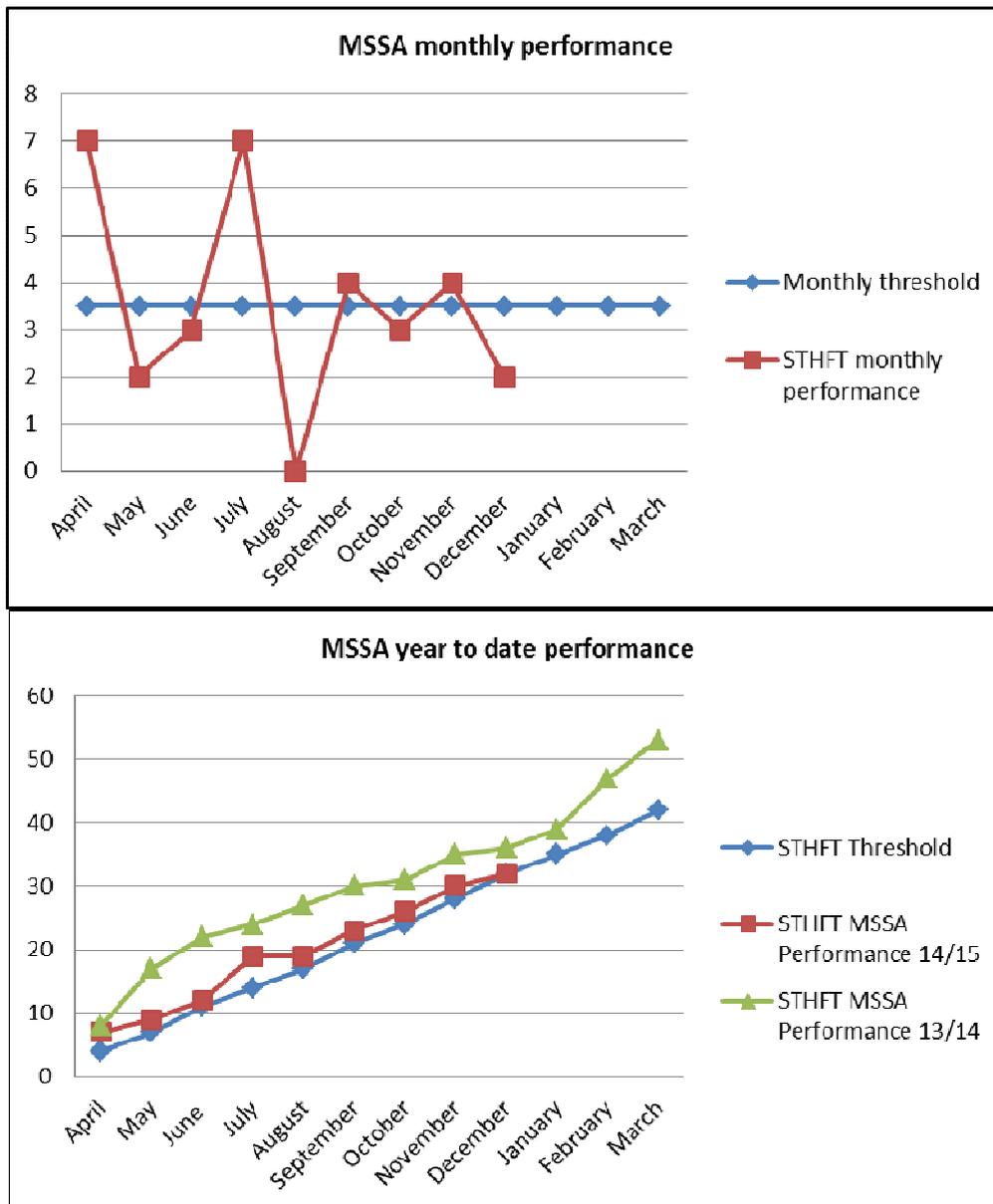
Huntsman 5 on the Northern campus is currently under surveillance for *C.diff* having had at least 2 episodes of *C.diff* within a 28 day period.

It is good practice to consider carefully any areas which experience more than 1 episode of *C.diff* within a 28 day period. The positive samples are tested to see if they are the same ribotype which may indicate that cross infection has taken place. A series of audits are undertaken by the IPC team to check performance on essential infection control standards such as commode cleanliness and hand hygiene regardless of whether the episodes of *C.diff* are thought to be linked or not.

4. MSSA

The Trust continues to return data on the number of cases of MSSA bacteraemia to Public Health England. Cases are labelled as either Trust attributable or community acquired. For December, 2 Trust attributable cases of MSSA bacteraemia were recorded; this is better than the monthly trajectory that the Trust has set itself.

The year to date performance is 32 cases against an internal threshold of 32. There is no threshold set for MSSA bacteraemia in 2014/15 however, alongside the MSSA improvement plan; the Trust set itself a target of having 42 or less cases for 2014/15.



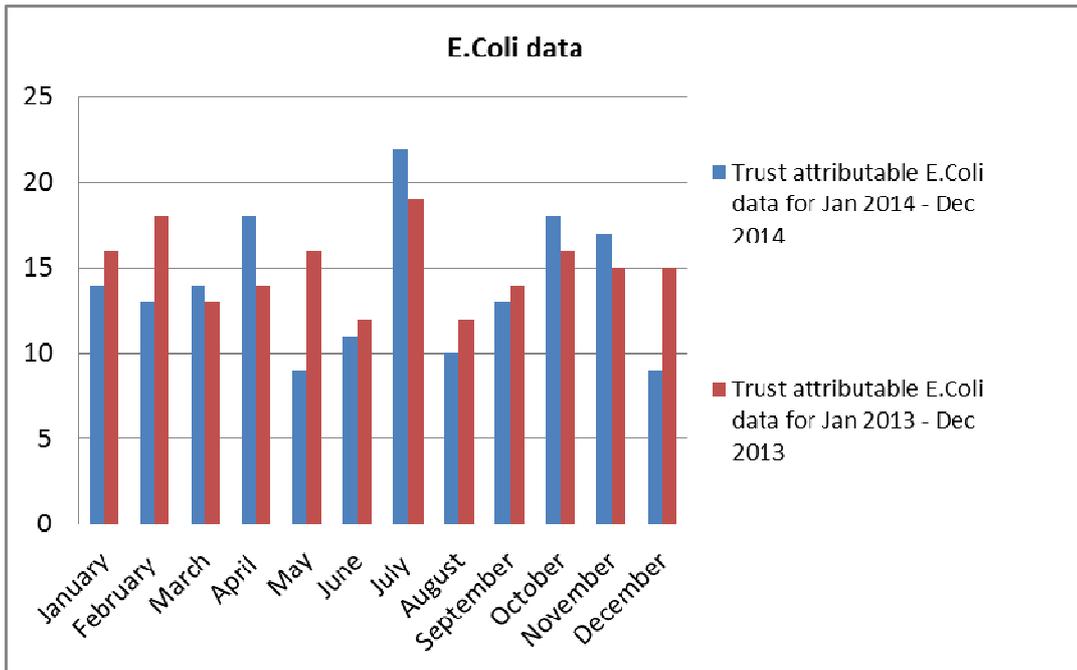
5. E.COLI

The Trust commenced returning data on the number of cases of E.Coli bacteraemia to Public Health England in June 2011. Cases are labelled as either Trust attributable or community acquired. For December, 9 Trust attributable cases of E.Coli bacteraemia were recorded.

Currently, it is not expected that the Trust will be set a reduction target for E.Coli bacteraemia as E.Coli bacteraemia is often not directly associated with healthcare.

For the last 12 months (January 2014 – December 2014) the total Trust attributable cases of E.Coli bacteraemia stands at 168 cases.

For the previous 12 months (December 2012 – November 2013) the total Trust attributable cases of E.Coli bacteraemia stood at 180 cases.



There are currently no national benchmarks available to allow the Trust to compare its performance with that of other Trusts.

6. INFECTION PREVENTION AND CONTROL

6.1 Norovirus

The Trust has not experienced many cases of Norovirus during December.

6.2 Influenza

During December, the number of weekly cases of influenza reported through the Trust laboratories increased by nearly ten times, from 17 cases a week at the beginning of the month to 168 cases per week at the end of the month.

This increase in influenza cases has also been reflected clinically, with a notable increase in Accident and Emergency attendances and admissions by patients complaining of symptoms consistent with influenza.

7. CONCLUSION

The Board of Directors is asked to debate the contents of this report.