

# **Annual Report of the Director of Infection Prevention and Control 2009-10**

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## **1. Introduction**

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- 1.1 This is the report of the Director of Infection Prevention and Control for NHS Devon for the period 2009-10.
- 1.2 The purpose of this report is to inform the Trust Board and staff, patients and the public of the infection control arrangements and work undertaken in 2009-10.

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## **2. Background**

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- 2.1 Infection Control is governed by the Health Act 2006: Code of practice for the prevention and control of healthcare associated infections which was amended in January 2008. The Code of Practice is part of the Health and Social Care Act 2008.
- 2.2 The Health and Social Care Act sets out legally enforceable criteria by which managers of NHS organisations are to ensure that patients are cared for in a clean environment and where the risk of healthcare acquired infections is kept as low as possible.
- 2.3 The Act builds on the previous guidance from the Department of Health, for example “Winning Ways” (2003), “Towards Cleaner Hospitals” (2005), “Saving Lives” (2005) and “Essential Steps to Safe Clean Care” (2006).
- 2.4 Failure to meet the requirements of the Health Act will result in the risk of Improvement Notices being served by the Care Quality Commission or may be the source of litigation by patients, including corporate manslaughter.
- 2.5 The code applies to every part of the Primary Care Trust’s provider services and if any independent contractors are used, the Primary Care Trust must ensure that they have the correct procedures in place for patients, staff and visitors to ensure that they are protected from healthcare acquired infection.
- 2.6 New statutory registration requirements were introduced in 2009 in which NHS organisations covered by the Code of Practice for the prevention and control of health care associated infections were required to declare compliance with the Health and Social Care Act 2008 to the Health Care Commission (now the Care Quality Commission).

- 2.7 The current governing body is the Care Quality Commission and NHS Devon had to declare its compliance annually and was awarded unconditional registration on April 1<sup>st</sup> 2009. The Trust was awarded a certificate of compliance which can be found on the NHS Devon website, [www.devonpct.nhs.uk](http://www.devonpct.nhs.uk) under the section on the homepage entitled “Infection Prevention and Control”, which is at the following website address: (<http://www.devonpct.nhs.uk/default.asp?pg=191>).
- 2.8 The Care Quality Commission undertakes unannounced visits to Trusts to assess against the Hygiene Code. The Care Quality Commission made an unannounced inspection of NHS Devon Provider Services on 26<sup>th</sup> May 2010 and their report can be found on the NHS Devon website (as above).

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### **3. Infection control arrangements**

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- 3.1 The Director of Infection Prevention and Control is Dr Virginia Pearson, the Director of Public Health, who reports directly to the board on matters pertaining to infection control.
- 3.2 The Director of Public Health is supported by the Health Protection Team led by the Head of Health Protection assisted by a Health Protection Manager, Immunisation Co-ordinator and administrative support.
- 3.3 Infection control specialist services are provided via Service Level Agreements to the NHS Devon provider arm, Devon Provider Services, by service level agreements with three specialist infection control teams:
- Royal Devon and Exeter NHS Foundation Trust
  - South Devon Healthcare NHS Foundation Trust
  - Plymouth Hospitals NHS Trust
- 3.4 NHS Devon’s provider is now an arm’s-length body and has taken on responsibility for:
- Appointing a shadow Director of Infection Prevention and Control. This is Angela Edmunds, who is Assistant Director of Professional Practice for Devon Provider Services
  - Governance arrangements for Infection Prevention and Control have been reviewed and new structures are in place (Appendix 1)
  - The Service Level Agreements referred to in paragraph 3.2 have been reviewed and updated
- 3.5 During 2009-10 the Patient Safety and Quality Committee provided the line of accountability through to the Primary Care Trust Board and the Provider Committee as detailed in Appendix 1.
- 3.6 The NHS Devon Infection Control Committee met on 22<sup>nd</sup> April 2009, 29<sup>th</sup> July 2009, 6<sup>th</sup> November 2009 and 20<sup>th</sup> January 2010. The Infection Control Policy is attached at Appendix 2.

- 3.7 NHS Devon has signed a Service Level Framework Agreement to cover arrangements with the Health Protection Agency. NHS Devon works closely with the Devon Health Protection Unit, currently based at Dartington.
- 3.8 Devon Provider Services has an Infection Control Lead. This role is currently fulfilled by Jane Barr who is a senior nurse.
- 3.9 Our patients receive care from many NHS organisations. The local NHS Trusts which serve Devon patients are:
- Royal Devon and Exeter NHS Foundation Trust
  - Northern Devon Healthcare NHS Trust
  - South Devon Healthcare NHS Foundation Trust
  - Plymouth Hospitals NHS Trust
  - Devon Partnership NHS Trust
  - South Western Ambulance Services NHS Trust
- 3.10 Services are also provided by primary and social care contractors.
- 3.11 All our commissioned services are monitored through the organisations' annual submissions to the Healthcare Commission and Care Quality Commission. Regular performance monitoring is achieved through Clinical Quality Review meetings, annual reports, outbreak monitoring, patient advice and liaison service feedback, complaints and commendations, and reports from Patient and Public Involvement fora. Visits are also regularly made to independent contractors and providers by commissioners.
- 3.12 Devon Provider Services' shadow Director of Infection Prevention and Control Annual Report is included at Appendix 3.

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#### **4. Reports made to the Board**

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- 4.1 The Director of Infection Prevention and Control is accountable directly to the Trust Chief Executive and reports to the Trust Board.
- 4.2 The Healthcare Associated Infection Assurance Group is a subcommittee of the Patient Safety and Quality Committee.
- 4.3 In addition to the formal committee arrangements, performance against infection control targets are presented at each Board meeting as part of the monthly performance report.

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## **5. Budget allocation to infection control**

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- 5.1 The service is funded on a rolling basis via Service Level Agreements with the three specialist providers. Additional requirements are funded through the operational framework.

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## **6. Healthcare Associated Infection statistics**

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- 6.1 There are two types of infection control reporting – statutory and non-statutory.
- 6.2 Statutory reports are made to the Health Protection Agency. Some reports are made online monthly and others are quarterly.
- 6.3 In addition to these, the infection control teams conduct surveillance to monitor infections in several areas. These are only available at health care community level, by acute trust and primary care trust.

### **Meticillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia for the Trusts for whom NHS Devon is the co-ordinating commissioner**

- 6.4 Staphylococcus aureus is a bacterium commonly found colonising humans. Although most people carry this organism harmlessly, it is capable of causing a wide range of infections, particularly skin infections such as boils, pustules and wound infections. In hospitals it can also cause surgical wound infections and bloodstream infections (known as a bacteraemia). MRSA can therefore be defined as colonising (present on the skin without causing infection); causing an infection, or as the cause of a bacteraemia.
- 6.5 Results are expressed by the Health Protection Agency as total episodes of Staphylococcus aureus bacteraemia, and Meticillin-Resistant Staphylococcus aureus (MRSA) bacteraemias. Rates of bacteraemias episodes per 10,000 bed days are also calculated and can be benchmarked against hospitals of similar size. This is important as larger hospitals will tend to have more complex patients, and more likely to admit patients with serious infections.
- 6.6 Table 1 illustrates the performance against national targets for the two local NHS acute trusts for which NHS Devon was the co-ordinating commissioner in 2009-10.

**Table 1: Cumulative Meticillin-Resistant Staphylococcus Aureus targets, 2009-10**

Month	Provider					
	Royal Devon & Exeter NHS Foundation Trust			Northern Devon Healthcare NHS Trust		
	Plan	Actual	Variance	Plan	Actual	Variance
Apr-09	2	0	-2	1	0	-1
May-09	4	3	-1	2	0	-2
Jun-09	6	0	-3	3	0	-3
Jul-09	8	0	-5	4	0	-4
Aug-09	10	0	-7	5	1	-4
Sep-09	12	0	-9	6	0	-4
Oct-09	14	1	-10	7	0	-5
Nov-09	16	0	-12	8	0	-6
Dec-09	18	0	-14	9	1	-7
Jan-10	20	1	-15	10	1	-7
Feb-10	22	1	-16	11	1	-7
Mar-10	24	1	-17	12	0	-8
<b>Total</b>	<b>24</b>	<b>7</b>	<b>-17</b>	<b>12</b>	<b>4</b>	<b>-8</b>

6.7 The information on MRSA targets performance is illustrated graphically in Figures 1-4. All four providers had detailed action plans in place to tackle MRSA in 2009-10 which were provided to NHS Devon. The following data are for the Trusts for whom NHS Devon is the co-ordinating commissioner, namely: the Royal Devon and Exeter NHS Foundation Trust, Northern Devon Healthcare Trust, and Devon Provider Services.

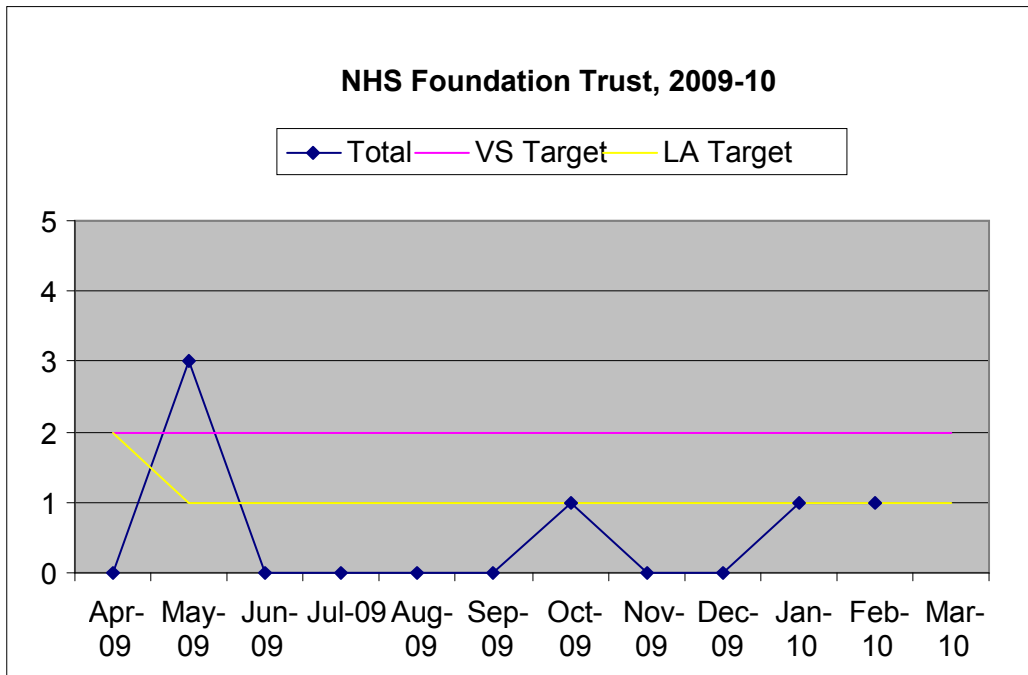
6.8 Information for Plymouth Hospitals NHS Trust is available on their website:

<http://www.plymouthhospitals.nhs.uk>

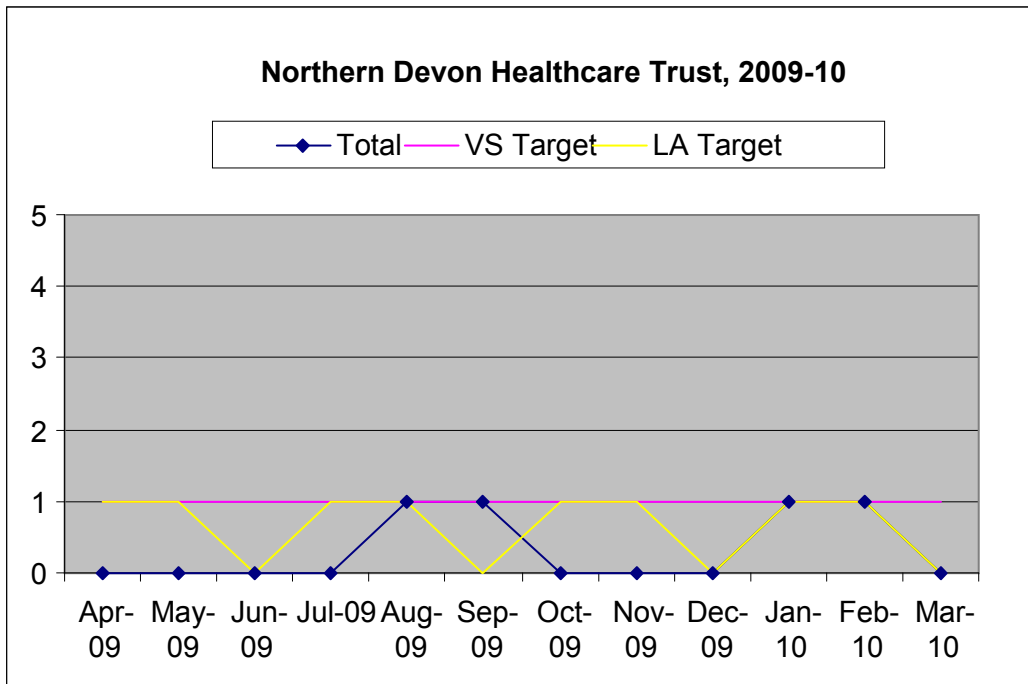
6.9 Information for South Devon NHS Foundation Trust is available on their website:

<http://www.sdhct.nhs.uk>

Figures 1 and 2: MRSA bacteraemia by month against target, 2009-10



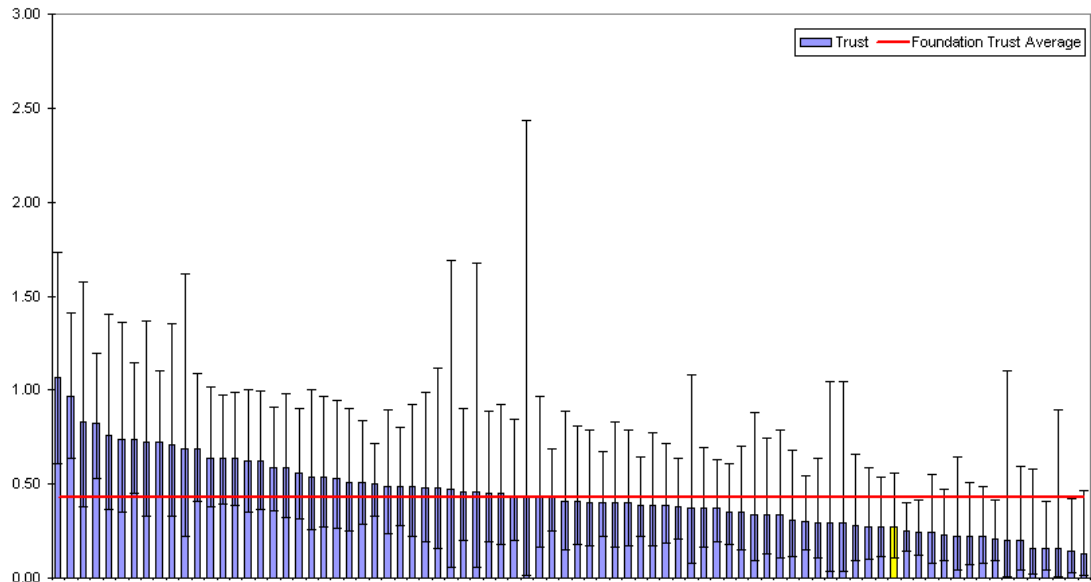
VS = NHS "Vital Signs" target  
LA = Local Area target



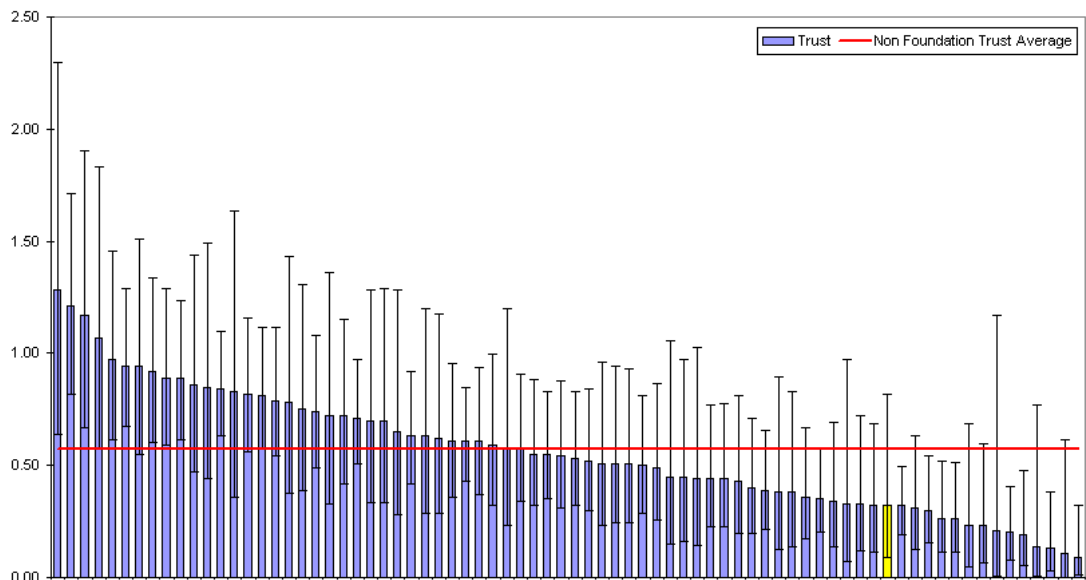
VS = NHS "Vital Signs" target  
LA = Local Area target

6.10 Figures 3 and 4 show performance benchmarked against similar size acute hospital units across England. Neither of our two local providers was significantly different from the average in 2009-10.

**Figure 3: MRSA bacteraemia per 10,000 bed days, Foundation Trusts, 2009-10 (Royal Devon and Exeter NHS Foundation Trust in yellow)**



**Figure 4: MRSA bacteraemia per 10,000 bed days, Non-Foundation Trusts, 2009-10 (Northern Devon Healthcare Trust in yellow)**



***Clostridium difficile* Infections for each of the healthcare communities in Devon for whom NHS Devon is co-ordinating commissioner**

- 6.11 *Clostridium difficile* is a bacterium that may grow in the bowel and cause diarrhoea and colitis which can be life-threatening in the elderly. It is mainly a complication of antibiotic therapy and particularly affects the frail and elderly who have been prescribed broad-spectrum antibiotics. Prudent antibiotic prescribing both in primary care and in the wider community is an essential component of preventing *Clostridium difficile*.
- 6.12 Mandatory surveillance for infection in people over the age of 65 has been undertaken since 2004. 'Episodes' are reported, which is one or more *Clostridium difficile* toxin positive stools in a 28-day period. These positive cases are reported through the Acute Trust's laboratory system and include community, pre-48 hour numbers. In each case, the Infection Control Team ensures that the investigation is completed and where appropriate, the Primary Care Trust has undertaken such an investigation. Analysis for those cases which occur in primary care but are not clients of the NHS Devon Trust Provider Services is being completed by the Public Health Directorate's Health Protection team.
- 6.13 Table 2 shows the cumulative *Clostridium difficile* targets for 2009-10 rates in our four main communities during 2009-10.

**Table 2: Cumulative *Clostridium difficile* Vital Signs targets, 2009-10**

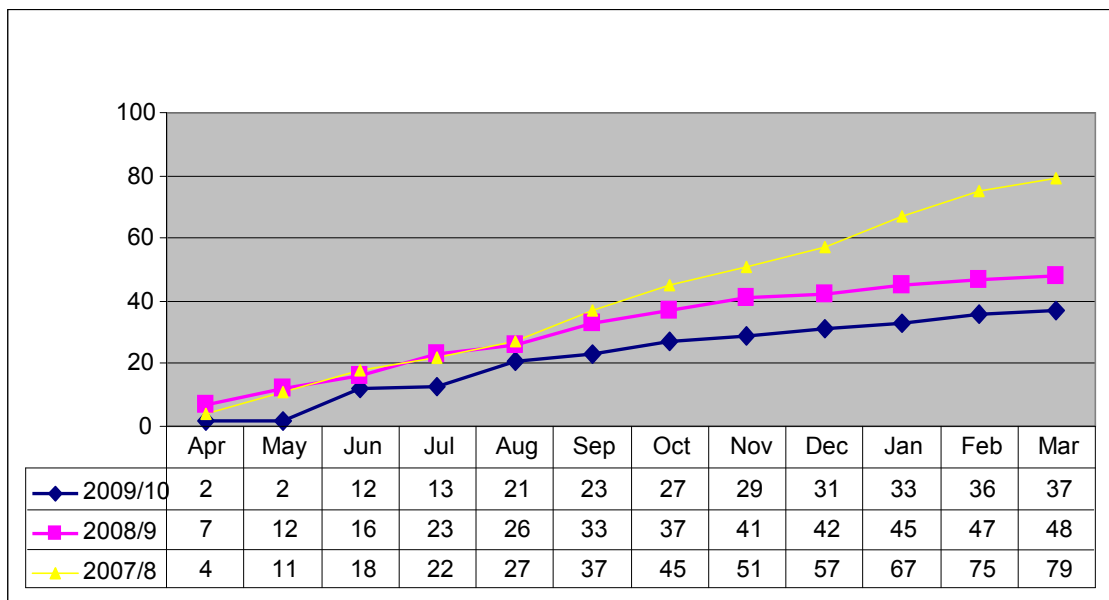
Month	Provider (acute trust attributable only)					
	Royal Devon & Exeter NHS Foundation Trust			Northern Devon Healthcare NHS Trust		
	Plan	Actual	Variance	Plan	Actual	Variance
Apr-09	18	10	-8	7	2	-5
May-09	14	6	-16	6	3	-8
Jun-09	12	5	-23	5	2	-11
Jul-09	14	5	-32	6	3	-14
Aug-09	12	6	-38	5	1	-18
Sep-09	11	3	-46	4	3	-19
Oct-09	10	17	-39	4	0	-23
Nov-09	11	13	-37	4	3	-24
Dec-09	10	7	-40	4	3	-25
Jan-10	21	10	-51	8	1	-32
Feb-10	18	7	-62	8	2	-38
Mar-10	17	10	-69	7	0	-45

6.14 Devon Provider Services does not have a Vital Signs target for *Clostridium difficile* but is expected to achieve a return of outbreaks or clusters. Table 3 shows Devon Provider Services performance over three years for *Clostridium difficile* infections. Figure 5 shows the *Clostridium difficile* infections by month in Devon Provider Services.

**Table 3: *Clostridium difficile* infections Devon Provider Services**

Month	Monthly			Cumulative		
	2007/8	2008/9	2009/10	2007/8	2008/9	2009/10
April	4	7	2	4	7	2
May	7	5	0	11	12	2
June	7	4	10	18	16	12
July	4	7	1	22	23	13
August	5	3	8	27	26	21
September	10	7	2	37	33	23
October	8	4	4	45	37	27
November	6	4	2	51	41	29
December	6	1	2	57	42	31
January	10	3	2	67	45	33
February	8	2	3	75	47	36
March	4	1	1	79	48	37
Annual Total	79	48	37			
Mean (Average)	6.6	4.0	3.1			
Median	6.5	4.0	2.0			

**Figure 5: *Clostridium difficile* infections by month for Devon Provider Services**



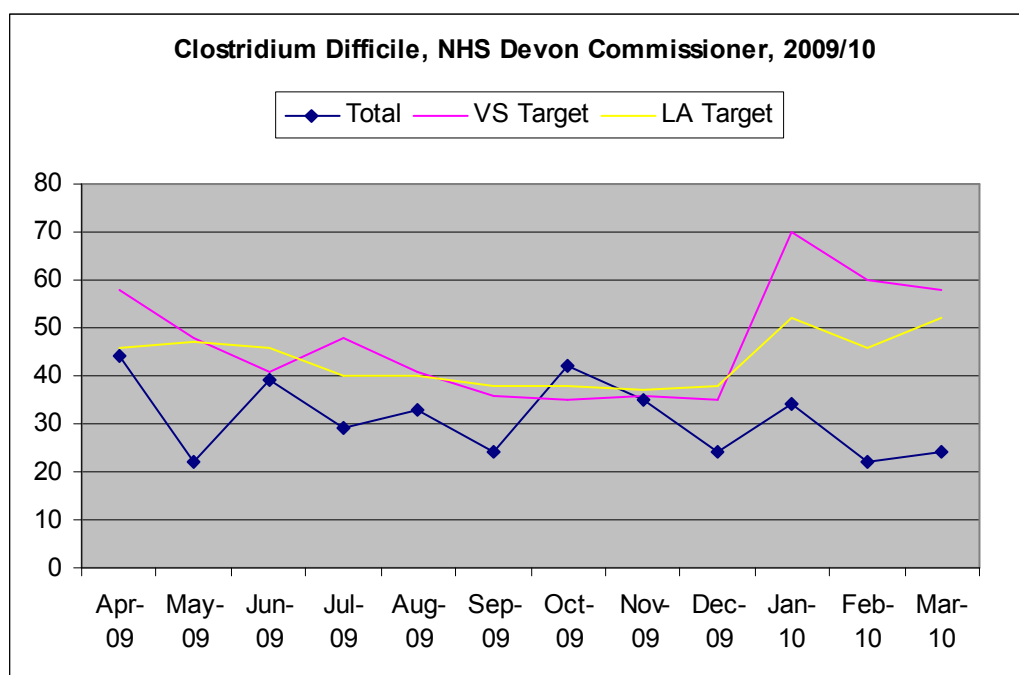
6.15 NHS Devon, as the NHS Commissioner, has the Vital Signs target for *Clostridium difficile* for patients who are registered to a general practice in the Primary Care Trust area. Table 4 and Figure 6 show the progress against this in 2009-10.

**Table 4: All cases of *Clostridium difficile* for patients registered with NHS Devon**

Measure	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Total	44	22	39	29	33	24	42	35	24	34	22	24
VS Target	58	48	41	48	41	36	35	36	35	70	60	58
LA Target	46	47	46	40	40	38	38	37	38	52	46	52
Cumulative Total	44	66	105	134	167	191	233	268	292	326	348	372
Cumulative VS Target	58	106	147	195	236	272	307	343	378	448	508	566
Cumulative LA Target	46	93	139	179	219	257	295	332	370	422	468	520
Variance VS Target	-14	-40	-42	-61	-69	-81	-74	-75	-86	-122	-160	-194
Variance LA Target	-2	-27	-34	-45	-52	-66	-62	-64	-78	-96	-120	-148

VS = DH Vital Signs national target  
LA = SHA Local Ambitions Stretch target

**Figure 6: Cases of *Clostridium difficile* against Vital Signs and Local Area targets for 2009-10**

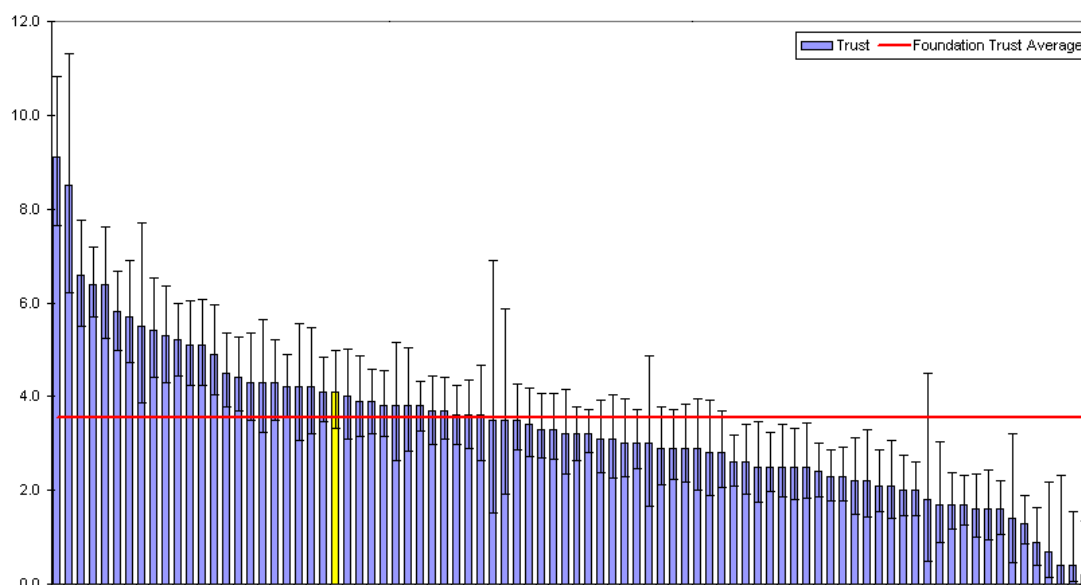


VS = NHS "Vital Signs" target  
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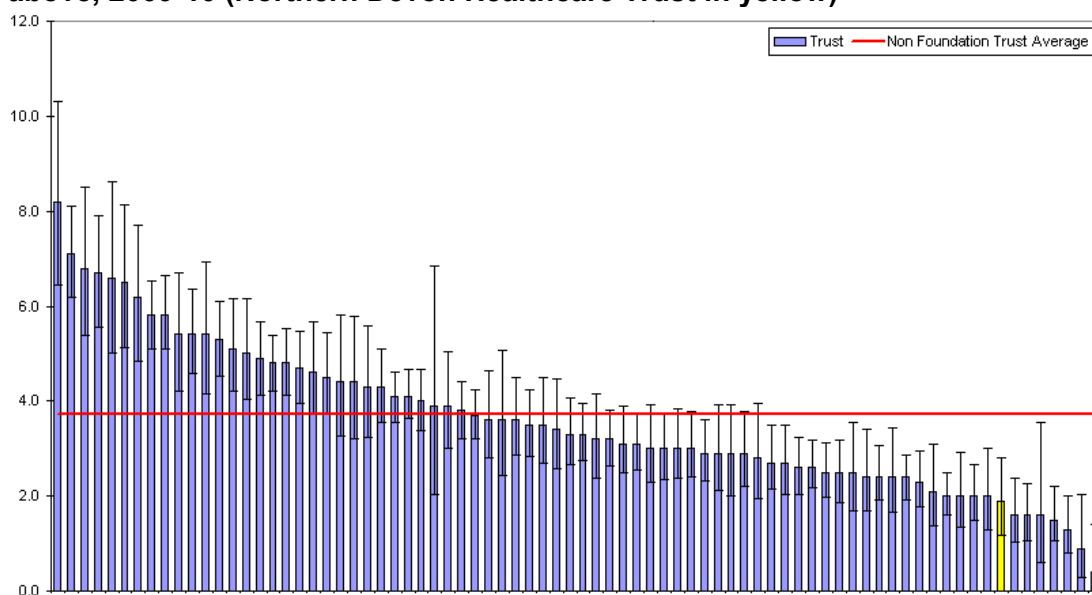
6.16 The cumulative total for 2009-10 was 372 against a cumulative Vital Signs target of 586, demonstrating the continued priority of the work in tackling Health Care Associated Infections across the health community.

6.17 Figures 7 and 8 illustrate performance benchmarked against similar size acute hospital units across England. Of our two local providers, Northern Devon Healthcare Trust was significantly below average. NHS Devon had a lower rate of infections per 10,000 population than the national average (Figure 9).

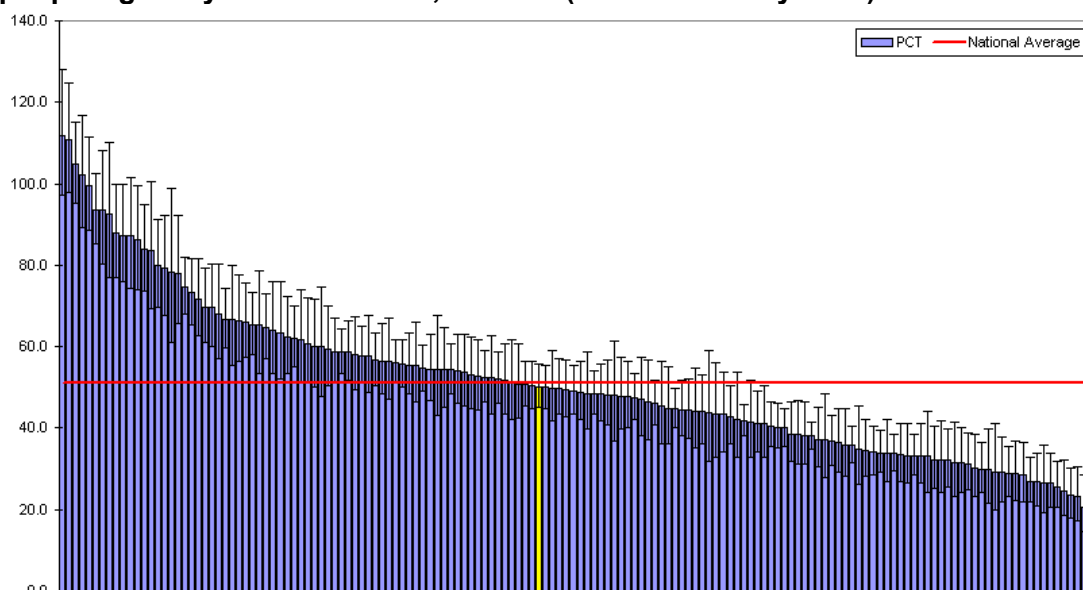
**Figure 7: Acute trust-attributable *Clostridium difficile* infections per 10,000 bed days for foundation trusts for people aged 2 years and above, 2009-10 (Royal Devon and Exeter NHS Foundation Trust in yellow)**



**Figure 8: Acute trust-attributable *Clostridium difficile* infections per 10,000 bed days for foundation trusts for people aged 2 years and above, 2009-10 (Northern Devon Healthcare Trust in yellow)**



**Figure 9: *Clostridium difficile* Infections per 10,000 population for people aged 2 years and above, 2009-10 (NHS Devon in yellow)**



### Glycopeptide resistant enterococcal bacteraemia

6.18 Enterococci are bacteria that are normally found in the gut. Although enterococci are a common cause of urinary tract infections, they can occasionally cause serious infections such as endocarditis (inflammation of the internal heart muscle). In patients with intravascular lines (to allow frequent injections of medication directly into the bloodstream), enterococci may cause bacteraemia. Glycopeptide-resistant enterococci are resistant to important glycopeptide antibiotics such as vancomycin and teicoplanin. The actual number of cases is usually low. Table 5 shows the number of cases over the last five available years.

**Table 5: Glycopeptide resistant enterococcal bacteraemia, reports by year**

Name of NHS Trust	Oct-03 to Sep-04	Oct-04 to Sep-05	Oct-05 to Sep-06	Oct-06 to Sep-07	Oct-07 to Sep-08
Royal Devon and Exeter NHS Foundation Trust	2	4	3	6	6
Northern Devon Healthcare NHS Trust	1	0	2	5	0
South Devon Healthcare NHS Foundation Trust	0	1	1	5	0
Plymouth Hospitals NHS Trust	6	9	13	17	11

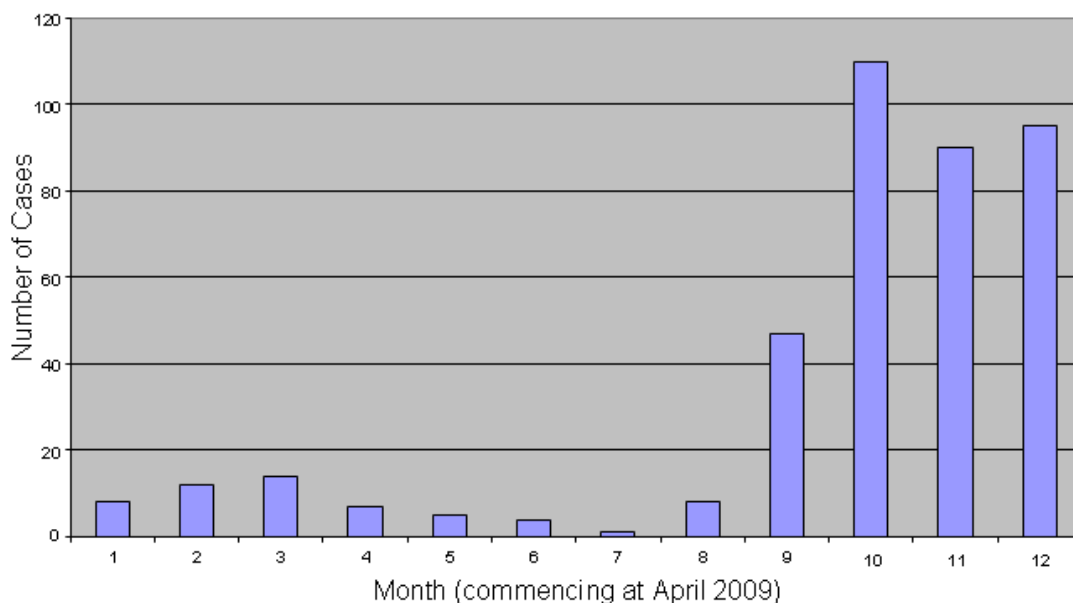
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## **7. Norovirus**

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- 7.1 Norovirus is also commonly referred to as Norwalk virus. While this is not a serious illness in itself, in that it rarely has long-lasting or serious effects, the vomiting is unpleasant and it is extremely infectious. Outbreaks of Norovirus in a healthcare setting can impact on services and delay recovery for individuals. There were also a large number of individual cases of Norovirus in the wider community during 2009-10.
- 7.2 Laboratory data for the 2009-10 Norovirus season in England (running from July to mid March) suggests that this season showed even more intense Norovirus activity than the same period in 2008-09, with identification of Norovirus showing an increase of 34% (from 6,453 to 8,631). Although laboratory-confirmed cases such as these represent the minority of cases, with the majority being self-diagnosed, or clinically diagnosed, the high level of activity is consistent with what has been seen locally. Actual identifications of Norovirus rose from 29 in 2008-09, to 402 in 2009-10, but this in part reflects the greater availability of rapid testing technology, rather than implying a massive increase in actual cases.
- 7.3 In the NHS Devon area, there were a total of 94 outbreaks of diarrhoea and vomiting, probably due to Norovirus. Of these, 18 were in nurseries, 12 were in pre-schools and schools, and 12 were community-based outbreaks (such as hotels) with the remaining 52 in nursing and residential care homes. On average, each outbreak affected about 10 people, but some affected many more, up to 50 people (residents and staff) in some large care homes. The overall pattern of outbreaks is similar to last year, with the majority of cases occurring in the winter. Outbreaks follow the same pattern of occurrence as the number of confirmed cases in the whole community (as might be expected).
- 7.4 This pattern suggests that a whole-community approach to prevention and control of Norovirus should be effective and this year NHS Devon, in common with other primary care trusts in the South West, has piloted a community-wide awareness campaign about Norovirus and how to limit its spread. This has involved schools, hospitals, GPs and the wider Primary Care Trust. The fundamental messages remain the same, that when an outbreak is recognised in an institution, then movements in and out of that place need to be minimised and controlled until the outbreak is over. Internally, the outbreak is best controlled by isolating the source of the infection, by ensuring scrupulous attention to hand hygiene and the correct use of Personal Protective Equipment, and by decontaminating the environment through enhanced cleaning regimens.
- 7.5 Figure 10 shows the confirmed Norovirus samples by month in NHS Devon for 2009 data supplied by the Health Protection Agency.

**Figure 10: Confirmed Norovirus samples by month, NHS Devon, 2009**



## **8. Hand hygiene and aseptic no-touch protocols**

- 8.1 One of the cornerstones of good infection control practice is ensuring that staff follow hand hygiene procedures. This includes ensuring staff have access to alcohol hand rubs in community hospitals and in the community.
- 8.2 Devon Provider Services undertook specific audits relating to hand hygiene, urinary catheterisation and surgical site infection, as noted in the quarterly board reports.
- 8.3 All the NHS Devon policies on infection control have been reviewed and adopted by Devon Provider Services and are available to staff electronically on the NHS Devon Intranet, Infopoint.
- 8.4 Clean and aseptic technique principles are provided as part of training and education of Primary Care Trust staff.
- 8.5 Infection control training is provided to all staff as part of their induction and mandatory update. Data on staff groups accessing infection control training are being audited by using the Electronic Staff Record.
- 8.6 The Primary Care Trust continues with its work in implementing the national “Clean Your Hands” and the “Bare Below the Elbows” campaigns.

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## **9. Decontamination**

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- 9.1 Decontamination in Primary Care remains a high priority for NHS Devon and has been incorporated in the Quality Outcomes Framework for General Practice for the second year.
- 9.2 Where there have been areas of concern highlighted in the regular audits, appropriate action plans have been developed and action taken to resolve

these. This is regularly reported at the Devon Provider Services Infection Control Committee and through this to the Board.

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## **10. Cleaning services**

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- 10.1 Cleaning services are managed in-house in some areas. All NHS Devon community hospitals participate in Patient Environment Action Team (PEAT) inspections and perform well. Results for 2009-10 are included in the Devon Provider Services Annual Report attached at Appendix 3.

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## **11. Training and education**

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- 11.1 Infection control is included as part of the mandatory training programme for NHS Devon staff through induction and updating processes. Information on a range of topics is delivered to staff, including nurses, health care assistants and housekeeping staff.
- 11.2 The role of independent care providers in reducing the morbidity from Healthcare Associated and other infections has been recognised by NHS Devon and a programme of education, audit and support delivered across the county. Particular emphasis is given to *Clostridium difficile* and infection control procedures. There are over 450 care establishments registered with the Care Quality Commission in Devon. The Health Protection managers in NHS Devon delivered 11 sessions of infection control linkworker development training during 2009-10 in Exeter, South Hams, Teignbridge and North Devon.
- 11.2 Changes in guidance or policy are cascaded to all NHS Devon staff as appropriate.
- 11.3 One Modern Matron in each area has lead responsibility for infection control.

**Dr Virginia Pearson**  
**DIRECTOR OF INFECTION PREVENTION AND CONTROL**

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## **Appendices**

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Appendix 1: Governance arrangements for infection control, 2009-10

Appendix 2: NHS Devon Infection Control Policy

Appendix 3: Devon Provider Services Infection Prevention and Control Annual Report

## **Governance Arrangements for Infection Control 2009-10**

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### **1. Introduction**

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- 1.1 The governance arrangements to bring together the aims and actions NHS Devon has agreed to adopt to ensure its services provided and commissioned are delivering clean, safe care. Reducing infections saves lives, is a national priority and a top priority for the NHS Devon Board.

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### **2. The Assurance Framework**

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- 2.1 The Trust will ensure that reports on Trust-wide performance inform the clinical and corporate governance structures to guarantee accountability. The Trust Board will receive regular data with clear action plans with review and completion dates. The Healthcare Associated Infection Assurance Group reports to the Patient Safety and Quality Scrutiny Committee. The reports will include:
- key performance indicators
  - compliance monitoring at Trust level and, where appropriate, unit level
  - root cause analysis to be used as a learning and prevention tool
- 2.2 Information on all of these areas will be shared across the Trust as a means of celebrating and promoting good practice and sharing learning.
- 2.3 Clinical areas have infection control scorecards identifying where action is needed and improvements that are made. These scorecards are available for staff, patients and public to provide assurance and demonstrate that the Trust places infection prevention and control central to its activity.
- 2.4 The Trust will identify risks and mitigating actions will be put in place. Actions will be reviewed at the appropriate meeting and updated to reflect new objectives and additional risks. The governance structure is outlined in Figure 1.

- 2.5 The terms of reference and membership of the Root Cause Analysis Group and the Healthcare Associated Infection Assurance Group are given at Annexes A and B respectively.

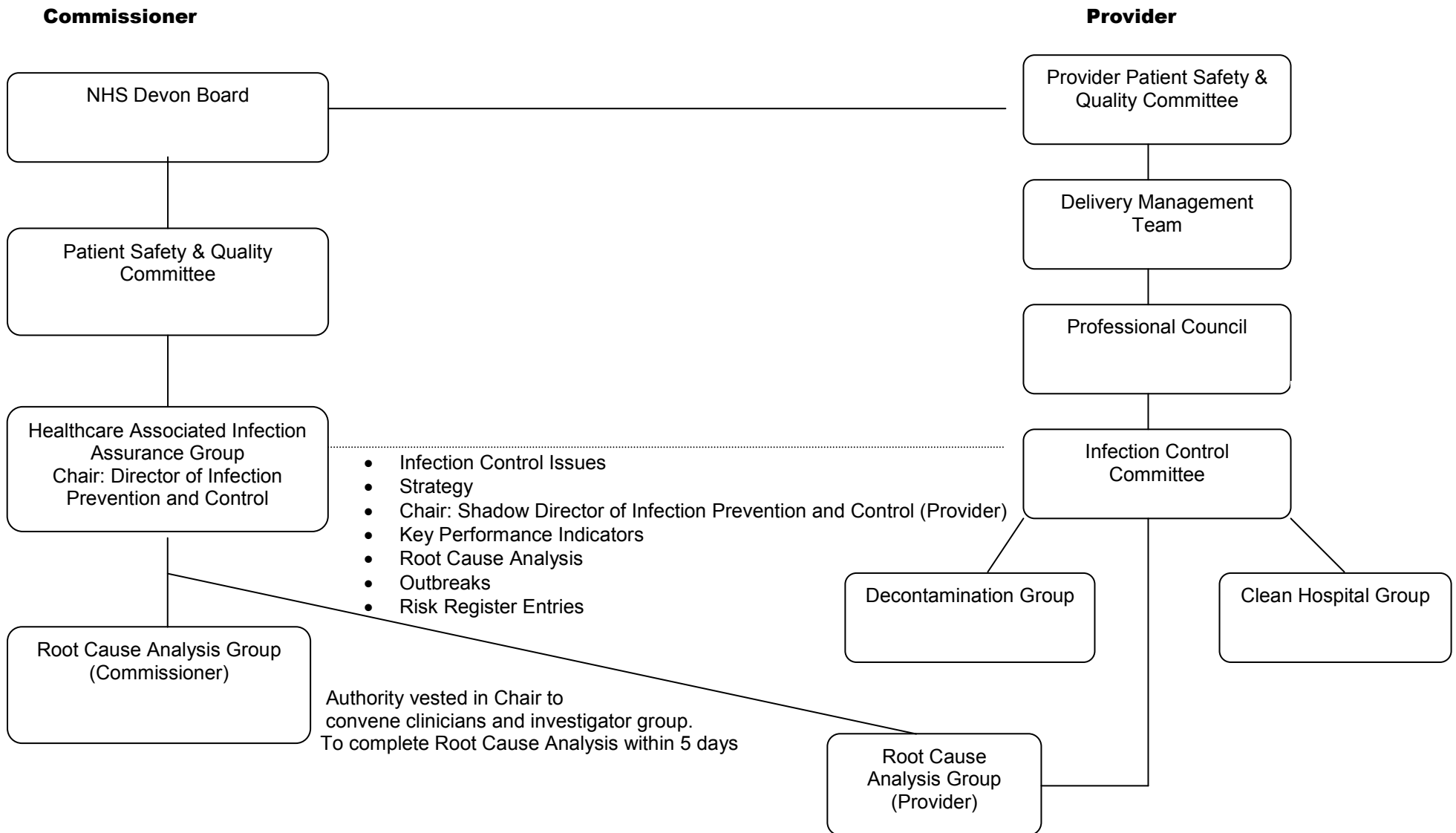
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### **3. Learning from others**

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- 3.1 NHS Devon is a large and diverse Trust encompassing care and services in many settings with a wide range of partner organisations. The challenge of sharing learning and disseminating good practice will involve many methods. Key to this will be the Learning and Development Directorate who has the central role in the delivery and monitoring of infection prevention and control training. Individual clinicians and professional leads should also be supported to share actions and achievements within their area across the Trust. Information and best practice innovation locally and nationally will help the Trust achieve its aims in infection prevention and control.

**Figure 1**



# Terms of Reference of the Infection Control Root Cause Analysis Group

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## 1. Terms of Reference

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- 1.1 This group is a subgroup of the Infection Control Committee.
- 1.2 The purpose of this group is to undertake Root Cause Analysis of MRSA and *Clostridium difficile*.
- 1.3 The group will meet and undertake the analysis within five days of the infection report to achieve the Department of Health timeframe for reporting. The Root Cause Analysis Algorithm on page 21 outlines the process for these investigations.
- 1.4 The reports and action plans will be communicated to:
  - the Strategic Health Authority
  - the quarterly Infection Control Review meeting
  - the clinical team involved
  - the Clinical Governance and Patient Safety Committee

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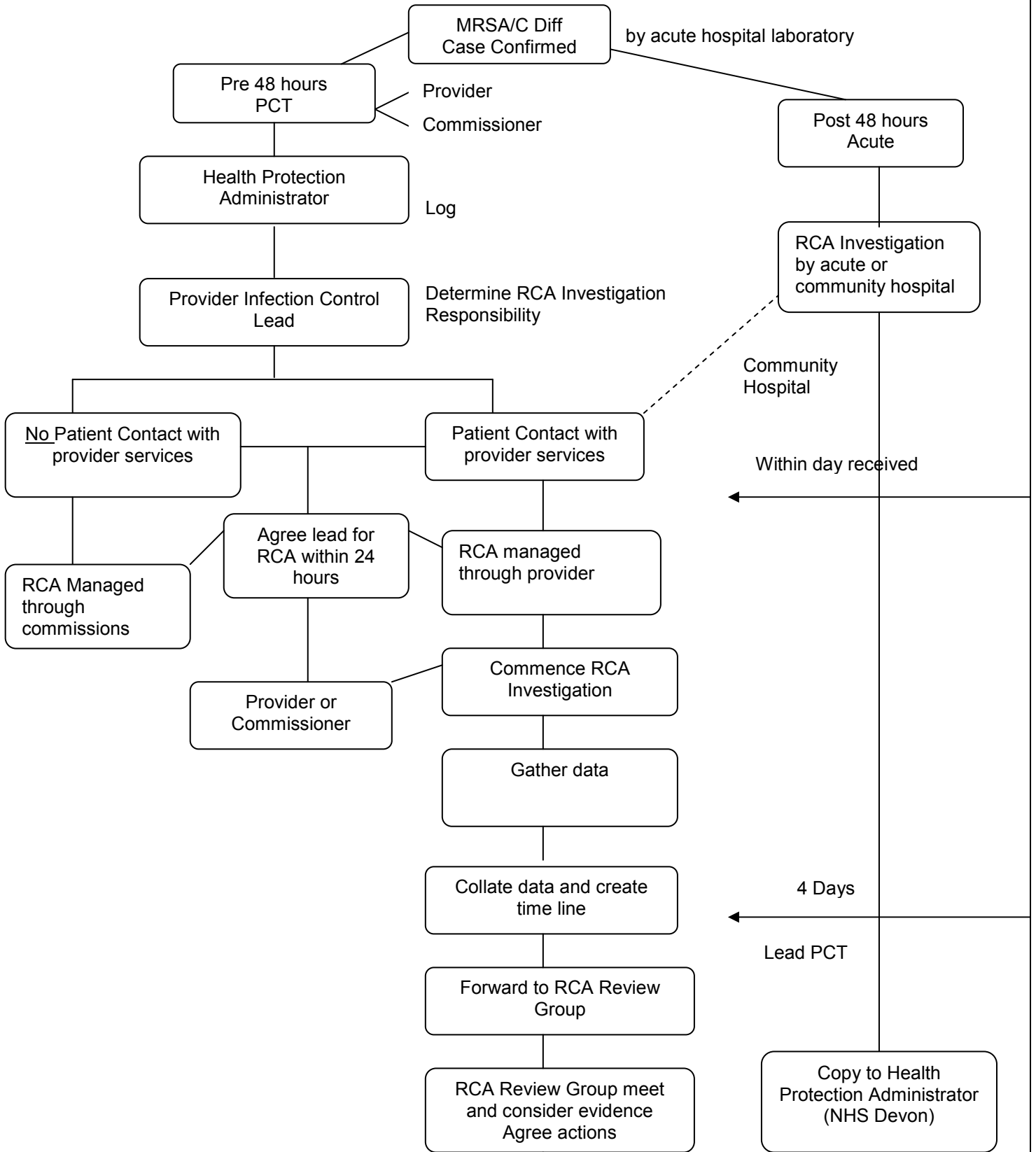
## 2. Membership

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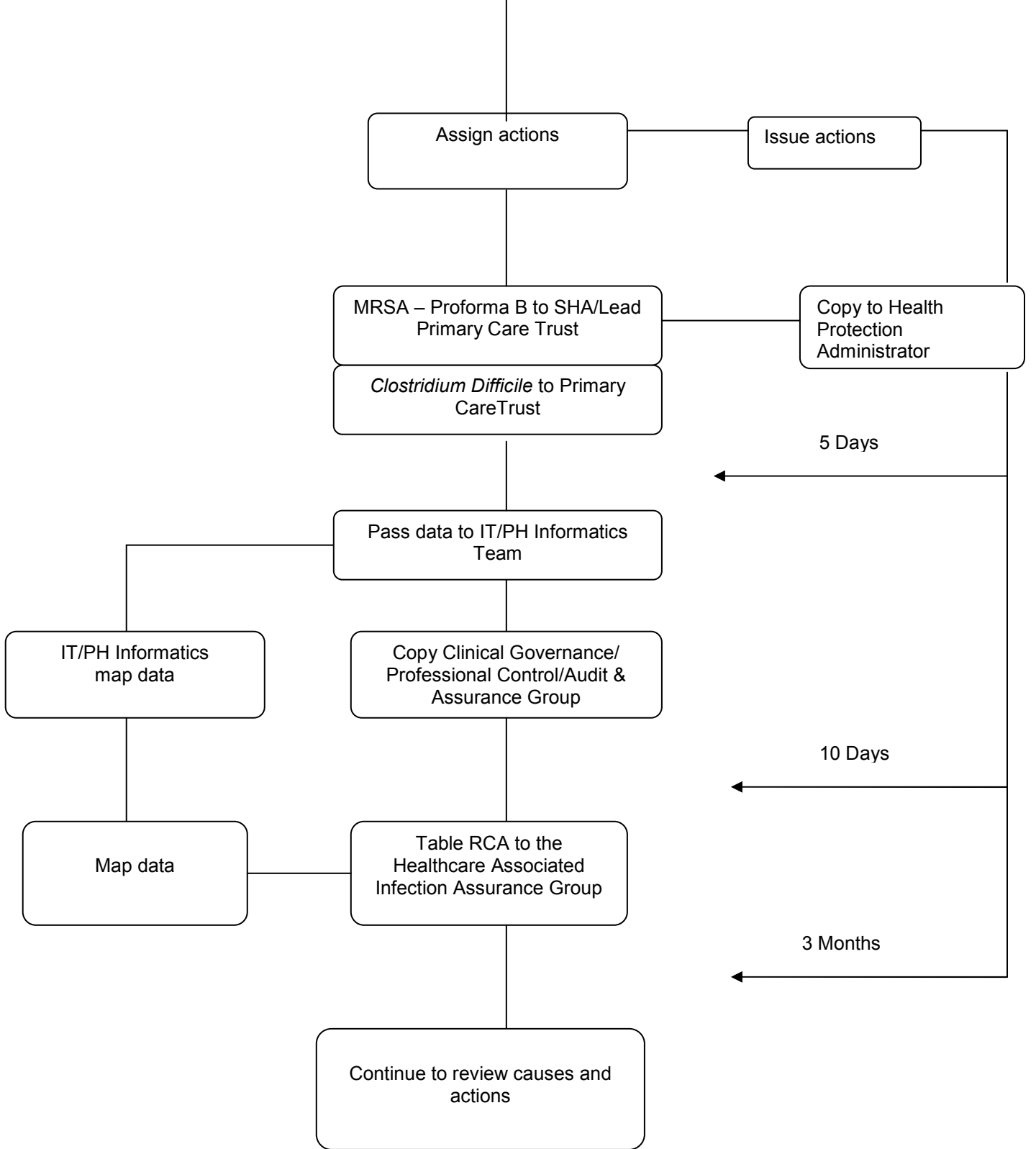
- Chair, who is the Clinical Governance Manager with the infection control portfolio, or the Head of Health Protection
- Health Protection Manager
- Health Protection Nurse
- Infection Control Doctor
- General Practitioner
- Specialist Infection Control Nurse
- Modern Matron hospital or community
- Administrator

# Root Cause Analysis Investigation Algorithm

Time Line



Continues on page 22



# Health Care Associated Infection Assurance Group

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## 1. Terms of Reference

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- 1.1 This group is a subgroup of the Patient Safety and Quality Scrutiny Committee.
- 1.2 The meeting will be held quarterly.
- 1.3 The aim of the meeting is to provide assurance to the Trust that the appropriate reporting and investigation has been undertaken and action taken.
- 1.4 The purpose of the meeting is to review infection control issues and Route Cause Analyses across Devon Primary Care Trust area (from a Commissioner perspective) and to monitor agreed action plans.

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## 2. Membership

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- Director of Infection Prevention and Control (Commissioner) – Chair
- Shadow Director of Infection Prevention and Control (Provider)
- Infection Control Doctor
- Head of Health Protection
- Health Protection Manager
- Specialist Infection Prevention and Control service provider representatives from the four acute trust providers
- Health Protection Nurse
- Assistant Director Patient Safety and Quality
- Assistant Director Provider Development - Primary Care
- Medicines Management representative
- Head of Health Care Her Majesty's Prison Service Devon Cluster
- Local Medical Committee representative
- Health Protection Agency representative
- Devon Doctors out of hours service provider representative

- Head of Estates Management
- Independent Care Homes Sector representative
- Invitees as appropriate



### IC 01a INFECTION CONTROL POLICY

**Document Status:** Approved  
**Version:** V2

#### **DOCUMENT CHANGE HISTORY**

**Version Date Comments (i.e. viewed, or reviewed, amended, approved by person or committee)**

V1 Draft 21.06.07 Infection Control Committee  
V1 Reviewed 23.07.07 Reviewed by Lead Infection Control Nurse group  
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**Authors:** Judy Potter on behalf of Devon Primary Care Trust - Infection Control Committee

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Devon PCT has made every effort to ensure this policy does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability. This policy will apply equally to full and part time employees. All Devon PCT policies can be provided in large print or Braille formats if requested, and language line interpreter services are available to individuals of different nationalities who require them.

# **Infection Control Policy**

## **1. Introduction**

1.1 Under the Health Act 2006, the Code of Practice for the Control and Prevention of

Health Care Associated Infection<sup>1</sup> requires all Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection, including the procedures to be taken in the event of an outbreak of infection.

Previous arrangements outlined in a series of national guidance documents and reports (Department of Health (DH) /Public Health laboratory Service (PHLS), 1995; DH, 2002; DH, 2003; DH, 2004a; DH, 2005; DH, 2006) have formed the basis for 'the Code' and are also reflected in this policy document.

## **2. Scope**

2.1 This policy applies to all healthcare personnel within the Devon Primary Care Trust:

2.2 It also applies to private contractors working on Trust premises, including GPs in Community Hospitals, locum and agency staff and volunteers.

## **3. Aim and objectives**

### **Aim**

3.1 This policy will ensure that:

3.1.1 Responsibility for infection control is embedded at all levels of the organisation

3.1.2 Effective arrangements are in place for the provision of a full infection control service including policy production, surveillance, education and training, and audit led by an Infection Control Team. (ICT)

3.1.3 Infection control advice is provided by a suitably qualified and resourced team, which includes an Infection Control Doctor and Infection Control Nurse, with administrative and information technology support.

3.1.4 The Infection Control Team is supported by an adequately resourced and staffed microbiology laboratory capable of promptly processing and reporting results on specimens sent for investigation.

3.1.5 A multi-professional Infection Control Committee is in place to advise and support the ICT.

3.1.6 All healthcare personnel working within the scope of this policy are aware of the rationale and responsibility to maintain high standards of infection control at all times. That all staff undertake annual infection control training within the mandatory training requirements of the Trust.

### **Objectives**

3.2 To reduce healthcare associated infection by providing the highest possible standards of infection control management within the limitations of available resources.

3.3 To provide locally adapted guidelines as statements of good practice based on systematic review of research and other evidence.

3.4 To generate infection surveillance data and feedback results to relevant parties in order to reduce mortality and morbidity and improve the quality of care.

3.5 To audit practice in relation to infection control policies and protocols and disseminate findings to appropriate groups.

3.6 To ensure an ongoing education programme, tailored to meet the needs of individual groups of staff, is available for all personnel.

## **4. Responsibilities**

4.1 The Trust Board, via the Chief Executive, are responsible for:

- Ensuring there are effective and adequately resourced arrangements for infection control within the organisation.
- Identifying a board level lead for infection control.
- Ensuring that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2004b)
- Approving the infection control annual programme and receiving the DIPC's annual report.

4.1.1 Ensuring that appropriate systems are in place for:

- reviewing reports and statistics on the incidence of alert organisms (e.g. MRSA, *Clostridium difficile*) and conditions, outbreaks and Serious Untoward Incidents
- ensuring that clinical responsibility for infection prevention and control is effectively devolved to:
  - All professional clinical groups in the Trust
  - Clinical specialties and directorates and, where appropriate,

support directorates and other similar units.

4.2 The Director of Infection Prevention and Control will:

- Oversee local control of infection policies and their implementation.
- Be responsible for the Infection Control Team within the healthcare organisation.
- Report directly to the Chief Executive and the Board and not through any other officer.
- Challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions.
- Assess the impact of all existing and new policies and plans on infection and make recommendations for change.
- Be an integral member of the organisation's clinical governance and patient safety teams and structures
- Produce an annual report on the state of healthcare associated infection in the organisation(s) for which he/she is responsible and release it publicly.

4.3 The Infection Control Team is responsible for:

- Ensuring advice on infection control is available on a 24-hour basis.
- Formulating an annual infection control programme in full consultation with the Infection Control Committee (ICC), health professionals and senior managers. The programme will include surveillance of infection and audit of the implementation of and compliance with selected policies.
- In liaison with other relevant staff preparing, reviewing and updating evidence based policies and guidelines in line with relevant Department of Health notifications and/or national guidelines. When available and applicable.
- Identifying and controlling outbreaks in collaboration with the Consultant for Communicable Disease Control and outbreak control group as appropriate.
- Ensuring the provision of education to all grades of staff working within the scope of this policy.
- Liaising with the Occupational Health Department, Consultant in Communicable Disease Control, the Health Protection Agency and other external services or agencies where applicable.

4.4 Responsibilities of the Infection Control Committee include:

- Advising and supporting the ICT;
- Drawing to the attention of the Chief Executive, either through the DIPC or, if necessary, directly, any serious problems or hazards relating to infection control;
- Considering reports on infections and infection control problems;
- Discussing and endorsing a plan for the management of outbreaks in the Trust and monitoring its implementation;

- Discussion and endorsement of a plan for the Trust's response to major outbreaks in the community – the Major Incident (outbreak) Plan – and monitoring of its implementation;
- Collaborating with the ICT to develop the annual infection control programme, monitor its progress, assist in its effective implementation and review the annual report;
- Providing advice regarding the most effective use of resources available for implementation of the programme and for contingency requirements;
- Advising on and approving all infection control policies before their submission to the Chief Executive for approval, and review of their implementation;
- Promoting and facilitating the education of all grades of staff in infection control procedures

#### 4.5 Healthcare Personnel

4.5.1 All healthcare staff have a duty to act on and report at the earliest opportunity conditions or incidents that may be deemed infectious to others e.g. communicable/notifiable diseases and resistant organisms.

4.5.2 All healthcare staff are required to adhere to the policies, guidelines and procedures pertaining to the prevention and control of healthcare associated infection which provide a framework for safe and best practice

4.5.3 These guidelines are based on the recommendations of recognised national organisations/bodies including:

Department of Health

Infection Control Nurses' Association

NHS Estates

Health Protection Agency

Health & Safety Commission

Royal College of Nursing

Health & Safety Executive

Association of Medical Microbiologists

Hospital Infection Society

National Patient Safety Agency

National Audit Office

Handwashing Liaison Group

Medicines & Healthcare Products Regulatory Agency (Formerly MDA)

## 5. References:

- DH (2003) *Winning ways. Working together to reduce Healthcare Associated Infection in England*. Report from the Chief Medical officer. London. DH. Available at <[http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT\\_ID=4095070&chk=J9Gyqw](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPAmpGBrowsableDocument/fs/en?CONTENT_ID=4095070&chk=J9Gyqw)> Accessed 21/01/07.
- DH (2004a). *Towards cleaner hospitals and lower rates of infection: A summary of action*. London: DH. Available at: <http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/HealthcareAcquiredInfection/HealthcareAcquiredGeneralInformation/fs/en> Accessed on 21/01/07.
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- DH (2006) The Health Act 2006. *Code of Practice for the Prevention and Control of Health Care Associated Infection*. London DH Available at: < [http://www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/RegulatoryImpactAssessmentArticle/fs/en?CONTENT\\_ID=4139338&chk=Mgjz1S](http://www.dh.gov.uk/PublicationsAndStatistics/Legislation/RegulatoryImpactAssessment/RegulatoryImpactAssessmentArticle/fs/en?CONTENT_ID=4139338&chk=Mgjz1S)> Accessed on 21/01/07.
- DH/PHLS(1995) *Hospital infection control: guidance on the control of infection in hospitals*. HSG(95)10. London. Department of Health Available at <http://www.dh.gov.uk/assetRoot/04/01/23/29/04012329.pdf> Accessed on 21/

## **Devon Provider Services**

### **Infection Prevention and Control Annual Report April 2009 – March 2010**

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#### **1. Context**

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- 1.1 This is the report of the Lead Nurse for Devon provider services for the period 2009-2010
- 1.2 The purpose of this report is to inform the Devon Provider Services Infection Prevention and Control and Patient Safety and Quality Committee, Provider Committee, NHS Devon staff, patients and the public of the work to ensure that we meet our statutory responsibilities under The Health Act 2006 audits the successor The Health and Social Care Act 2008.

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#### **2. Key issues**

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- 2.1 In October 2009, Devon Provider Services (DPS) appointed a Lead Nurse for Infection Prevention and Control. This appointment was made following unsuccessful recruitment to a Nurse Consultant post. This post is directly accountable to the Assistant Director of Professional Practice who is also the “shadow” Director of Infection Prevention and Control (DIPC). These designated roles strengthen and compliment the PCT Director of Infection Prevention and Control role (DIPC).
- 2.2 During this reporting year the organisation and management of DPS services practice was initially governed by The Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections. This has now been superseded by The Health and Social Care Act 2008. Managers of NHS organisations are required to meet the standards in this document in order to ensure that patients are cared for in a safe, clean environment, and minimise the risk of healthcare acquired infection.
- 2.3 The new Act builds on the previous guidance including: Getting Ahead of the Curve, Winning Ways: Working Together to Reduce Healthcare Associated Infection in England, Towards Cleaner Hospitals and Lower Rates of Infection: A Summary of Action: A Summary of Action; Clean Safe Care-Reducing Infections and Saving Lives; Saving Lives: Reducing Infection, Delivering Clean and Safe Care and Essential Steps to Safe Clean Care: Reducing Healthcare-Associated Infections.
- 2.4 The introduction of the Care Quality Commission in April 2009 required the corporate PCT to meet registration requirements. Full registration was achieved with no conditions. The Health and Social Care Act 2008 sets out how the CQC will monitor compliance with the statutory requirements of the registration related to Health Care Acquired Infection (HCAI).
- 2.5 The Act applies to every part of the provider service and any independent contractors that are used. There are robust procedures in place for patients, staff and visitors to ensure that they are protected from healthcare acquired infection

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### **3. Infection prevention and control arrangements**

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- 3.1 The PCT Director of Infection Prevention and Control is Dr Virginia Pearson reporting directly to the Board on matters pertaining to infection prevention and control. The “shadow “ Director of Infection Prevention and Control with specific responsibility for Devon Provider Services (DPS) is Ms Angela Edmunds, she reports to the Board via the Healthcare Acquired Infection Group and Patient Safety and Scrutiny Committee and for Devon Provider Services through the Provider Committee and Patient Safety and Quality Committee. In DPS these structures are also supported by the Adult Professional Council and Devon Provider Services Infection Prevention and Control Committee. **APPENDIX 1**
- 3.2 Infection Prevention and Control specialist services are provided via Service Level Agreements from three specialist infection control teams.
- Plymouth Hospitals NHS Trust
  - Royal Devon and Exeter NHS Foundation trust
  - South Devon Healthcare NHS Foundation trust
- Progress against work plans has been monitored throughout the year.
- 3.3 The PCT HCAI committee has met quarterly throughout this reporting year.
- 3.4 The formal sub committees of the PCT HCAI include the DPS ICC which in turn have subcommittees:- Decontamination Committee and the Cleaner Hospital Committee. Both of these are chaired by the provider services lead nurse and have met quarterly.
- 3.5 The Decontamination Committee has considered specific issues and detailed action planning related to dental, podiatry and overlay mattress decontamination in community hospitals.
- 3.6 The Cleaner Hospital meetings Terms of Reference have been reviewed and revised and this is now called the Cleaning Standards Meeting. This meeting allows detailed discussion and action planning between hotel services, estates and infection control. This approach has ensured the appropriate infrastructure support to the frontline clinical services in reducing the risk of HCAI’s by improving the facilities and environment in which they deliver healthcare and clinical activities. The results of this years PEAT audits have almost universally shown an increase in last years’ scores.

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### **4. Governance framework for Devon Provider Services**

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Please see **APPENDIX 1** attached.

- 4.1 The DIPC reports to the Board and the shadow “DIPC” to the Patient Safety and Scrutiny Committee as well as the internal structures illustrated above.

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### **5. Budget allocation**

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- 5.1 The specialist nursing and infection control doctor service continues to be funded through the Service Level Agreement process. Particular focus has been given to the funding of antimicrobial pharmacists posts and antimicrobial advice from microbiology. This is a requirement for compliance with The Health and Social Care Act 2008. The infrastructure costs for estates and hotel services are funded through their own budgets. Particular areas of worry or concern are the subject of capital bids or business cases to DMT.

- 5.2 The Dental Decontamination option appraisal supported full ventilation in order to comply with HTM0105. This scheme is currently being considered by the Capital Funding Group and is on the risk register in the meantime.
- 5.3 Capital funding for the replacement of 153 overlay mattresses was agreed in year in order to ensure compliance with MDA 2010-002.
- 5.4 Funding for a part time Band 5 post to support the Lead Nurse for the South part of the patch was not approved due to financial pressures. This post was to provide extra support to the SLA with SDHCT.

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## **6. Healthcare acquired infection statistics**

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6.1 Reports are made weekly and monthly on all MRSA isolates, Bacteraemia, C. difficile infections, and viral gastroenteritis outbreaks within our community hospitals. Statutory reports are made at the time of occurrence to the Health Protection Agency and SHA as appropriate.

### **6.2 MRSA isolates**

Please see **APPENDIX 2** attached.

6.2.1 MRSA is a bacterium commonly found colonising humans. Most people carry this organism harmlessly, however for some inpatients that have had invasive procedures the risk of the organism causing a wound infection or blood borne infection increase and with that associated morbidity and mortality. Health care workers may transmit the bacterium between patients and this is why stringent hand hygiene procedures are required.

6.2.2 Methicillin Resistant Staphylococcus Aureus figures for the DPS community hospitals year show a very low number of new cases. For the last half of this reporting year an incidence below the control limit has been maintained.

6.2.3 Screening for MRSA in accordance with the DoH guidance for elective cases has been introduced this year. Latterly further work has been undertaken in preparation to meet the DoH target of MRSA screening all emergency admissions by December 2010.

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### **6.3 MRSA bacteraemia**

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Please see **APPENDIX 3**

6.3.1 The figures in the table report hospital acquired cases and there have been nil this year. There has been one community acquired cases in this reporting year. This was a complex case and the patients second bacteraemia. Given the high risk of reoccurrence a robust action plan involving the community matron was put in to place and to date there has been no relapse of this patient.

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### **6.4 Clostridium difficile (c difficile)**

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Please see **APPENDIX 4**

6.4.1 C.difficile is a bacterium that may grow in the bowel causing diarrhoea and in extreme cases colitis which can be life threatening in the elderly. It is mainly a complication of prescribing broad spectrum antibiotics; prudent prescribing policy within the agreed formulary has been reinforced throughout this year.

- 6.4.2 There have been a total of 37 C.difficile cases contracted within 21 community hospitals across DPS throughout this reporting year. This figure shows a continuing reduction on last year's figures. All C. difficile cases in the southern cluster are subject to RCA and again the learning is shared throughout the provider service structures.
- 6.4.3 Key themes emerging from the RCA's continue to be the appropriate use of antibiotics for those with high risk factors and complex case presentations where differential diagnosis is difficult. The implementation of a GP practice based "flagging" system for all C.difficile positive patients has been suggested. It has also been suggested that this is shared with the Out of Hours Service where particular antibiotic prescribing issues have been identified.
- 6.4.4 This reporting year has seen 4 RCA's connected with C. difficile being recorded as either a primary or secondary cause of death. All these cases had a full RCA undertaken with attendances of the doctor responsible for signing the death certificate as well as specialist infection control nursing and microbiology advice.
- In the two cases where it was recorded that C.difficile was the primary cause of death, review confirmed that there was no clinical evidence documented in the notes to support this and it was more appropriate to recorded these as secondary cause of death.
- The two cases that recorded as C.difficile as a secondary cause of death were also reviewed and confirmed to be appropriate.
- 6.4.4 The DPS lead nurse attends cross healthcare community forums in South Devon and Plymouth to ensure learning across our organisational boundaries.

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## **6.5 Viral gastroenteritis**

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- 6.5.1 Whilst not strictly a Healthcare acquired Infection, the occurrence of and spread of viral gastroenteritis caused some disruption to services due to bed closures and staff sickness, reducing capacity even further.
- 6.5.2 There were 15 incidents of viral gastroenteritis that required formal closures of community hospital beds. These were reported through the Serious Untoward Incident system to ensure awareness across the healthcare community. Of the 15 outbreaks, 11 were confirmed as being Norovirus positive.
- 6.5.3 Other partner healthcare organisations experienced very high levels of Norovirus infection and the incidence within the local community was also noted.

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## **7. Hand hygiene audits and compliance standards**

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Please see **APPENDIX 5**

- 7.1 One of the key preventative actions in reducing HCAI is good hand hygiene practices for all healthcare staff. This includes the availability of alcohol rub and soap and water when and where it is needed to assist in preventing the spread of infection
- 7.2 The Lewisham Hand Hygiene tool has been used across the PCT and reinforced by link nurse training by the specialists for each hospital. These are completed monthly and submitted to the Matron. They are a standing part of the dashboard of indices.
- 7.3 The key messages for the national Clean Your Hands campaign have been reinforced with local events on National Clean Your Hands day, articles in staff papers, launching the new poster campaign and individual letters to all staff reminding

them of their responsibilities to comply with the Bare Below The Elbows campaign which is enshrined in the Staff Uniform policy which was approved in January 2009.

- 7.4 The Essential Steps audit for hand hygiene, aseptic technique and urinary catheter care and insertion have been conducted and will be undertaken every six months.
- 7.5 Infection Prevention and Control training, including hand hygiene practices has been part of the mandatory training, which has continued throughout the year for all staff. The programme has been reviewed and amended to ensure all staff are aware of their responsibilities under The Health and Social Care Act 2008 and the awareness of clinical staff of single use instruments symbol as this was detected during infection prevention and control audits.

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## **8 Infection prevention and control audits**

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Please see **APPENDIX 6**

- 8.1 The programme of audits of clinical practice and the environment across the health care community sites continues. The results of these audits are used as a way of prioritising estates works to ensure the environment for delivery of healthcare is optimum and following up other areas of practice education.

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## **8. Decontamination**

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- 8.1 The Decontamination Committee has continued to meet throughout the year; it is chaired by the lead nurse and has reported directly to the DPS ICC.
- 8.2 During this reporting year, the podiatry service has audited the hand hygiene compliance, environmental standards and single use instrument compliance. It remains fully compliant for single use instrument use, and action plan has been drawn to deal with the other issues.
- 8.3 Following the publication of Health Technical Memorandum 01-05, "Decontamination in Primary Care Dental Practices".the dental service manager and specialist nurse undertook a joint audit of all our dental services and an action plan developed to ensure compliance with Best Practice. The option for full ventilation to ensure complete compliance was supported by DPSICC. Capital funding is awaited and in the meantime this has been placed on the DPS risk register.
- 8.4 The upgrade of theatre facilities at Axminster community hospital has ensured compliance of endoscopy services with the new HTM.  
  
However in Tiverton funding of the required works for endoscopy to also be fully compliant needs reviewing as a result of the shared responsibilities with the RDE who have taken over the management of theatres. In the meantime this service remains on DPS risk register.
- 8.5 An audit of all the overlay mattresses in community hospitals identified non compliance against MDA2010.002. This resulted in a successful business case for founding replacements of 153 mattresses at a cost of £100k.  
  
A set of Standard Operating Procedures for ongoing audit and decontamination were also developed and approved.

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## **9. Hotel services**

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Please see **APPENDIX 6**

- 9.1 The delivery of hotel services within DPS has been restructured so that Matrons line manage these staff. Expert help and guidance is available across DPS to support the matrons. This complies with the Matrons Charter.
- 9.2 The Community Hospitals have participated in the Clean Hospital audits and the PEAT audits. The areas of non compliance are discussed at the Cleaning Standards Committee to ensure a priority action plan with the estates services. Infection prevention and control advice is included in all plans regarding refurbishment and upgrading of healthcare facilities.
- 9.3 The Credits for Cleaning audit system has been introduced across the community hospitals. A particular challenge has been the implementation of the personal recording tablets that allow automatic collation of information and production of reports.

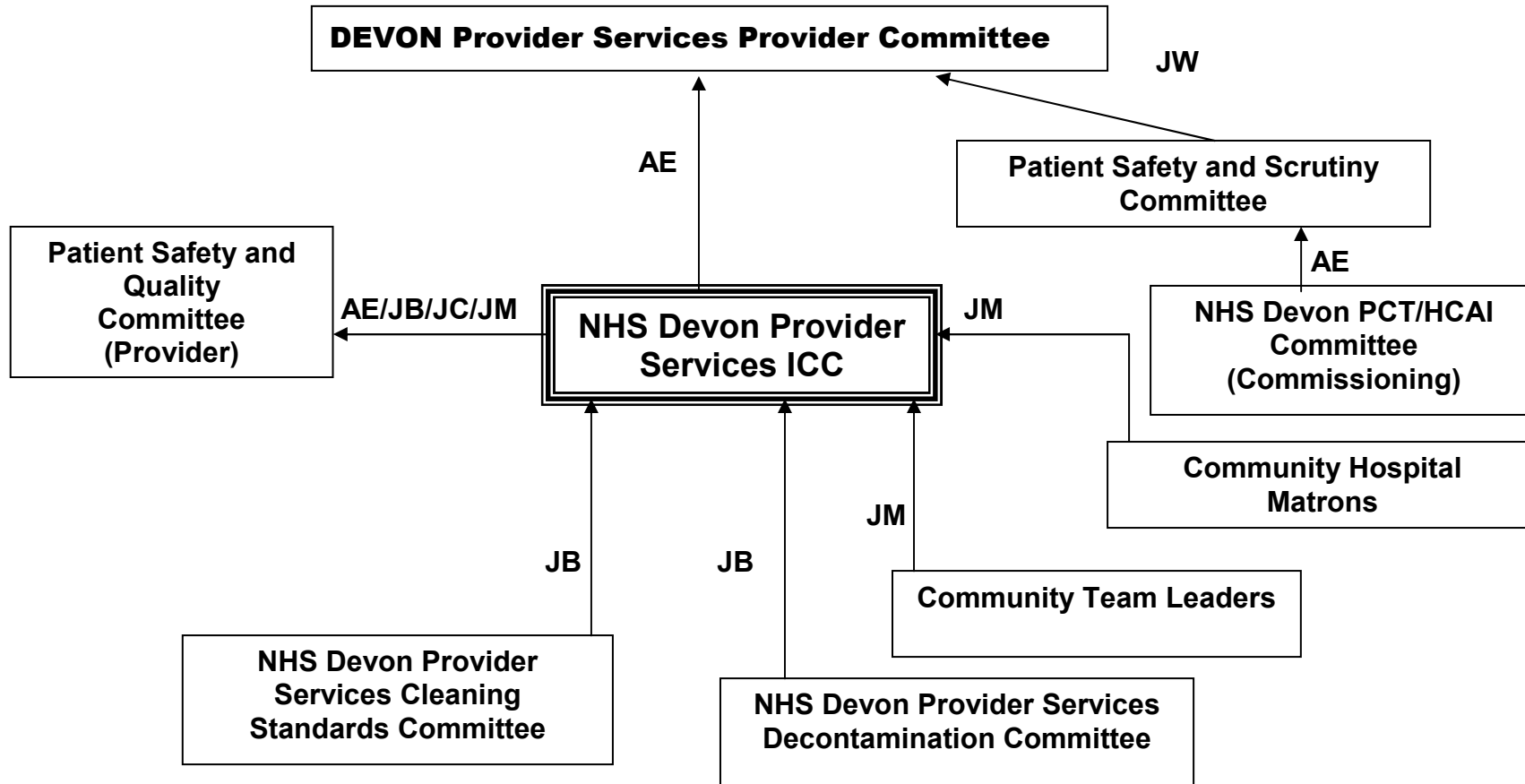
**Author: Jane Barr**

**Title: Lead Nurse Infection Prevention and Control Lead**

**DEVON PROVIDER SERVICES**



**Infection Control Committee Governance Framework**



Legend		
JB = Jane Barr	AE = Angela Edmunds	VP = Virginia Pearson
JC = John Coop	JM = Julie Mitchell	JW= Jenny Winslade

## Appendix 2

### MRSA Isolates, DPS Community Hospitals (Control Charts and Trajectories)

#### Devon Provider Services Community Hospitals

Month	Monthly			Cumulative		
	2007/8	2008/9	2009/10	2007/8	2008/9	2009/10
April	9	9	6	9	9	6
May	14	11	5	23	20	11
June	13	7	5	36	27	16
July	7	9	10	43	36	26
August	9	7	1	52	43	27
September	5	7	9	57	50	36
October	14	4	2	71	54	38
November	8	5	5	79	59	43
December	9	7	5	88	66	48
January	10	5	6	98	71	54
February	7	4	7	105	75	61
March	5	8	7	110	83	68
Annual Total	110	83	68			
Mean (Average)	9.2	6.9	5.7			
Median	9.0	7.0	5.5			

## Appendix 3

### MRSA Bacteraemia, NHS Devon Community Hospitals (Control Charts and Trajectories)

#### NHS Devon Community Hospitals

Month	Monthly			Cumulative		
	2007/8	2008/9	2009/10	2007/8	2008/9	2009/10
April	0	0	0	0	0	0
May	0	0	0	0	0	0
June	0	0	0	0	0	0
July	0	0	0	0	0	0
August	0	0	0	0	0	0
September	0	0	0	0	0	0
October	0	0	0	0	0	0
November	0	0	0	0	0	0
December	0	0	0	0	0	0
January	0	0	0	0	0	0
February	0	1	0	0	1	0
March	0	0	0	0	1	
Annual Total	0	1	0			
Mean (Average)	0.0	0.1	0.0			
Median	0.0	0.0	0.0			

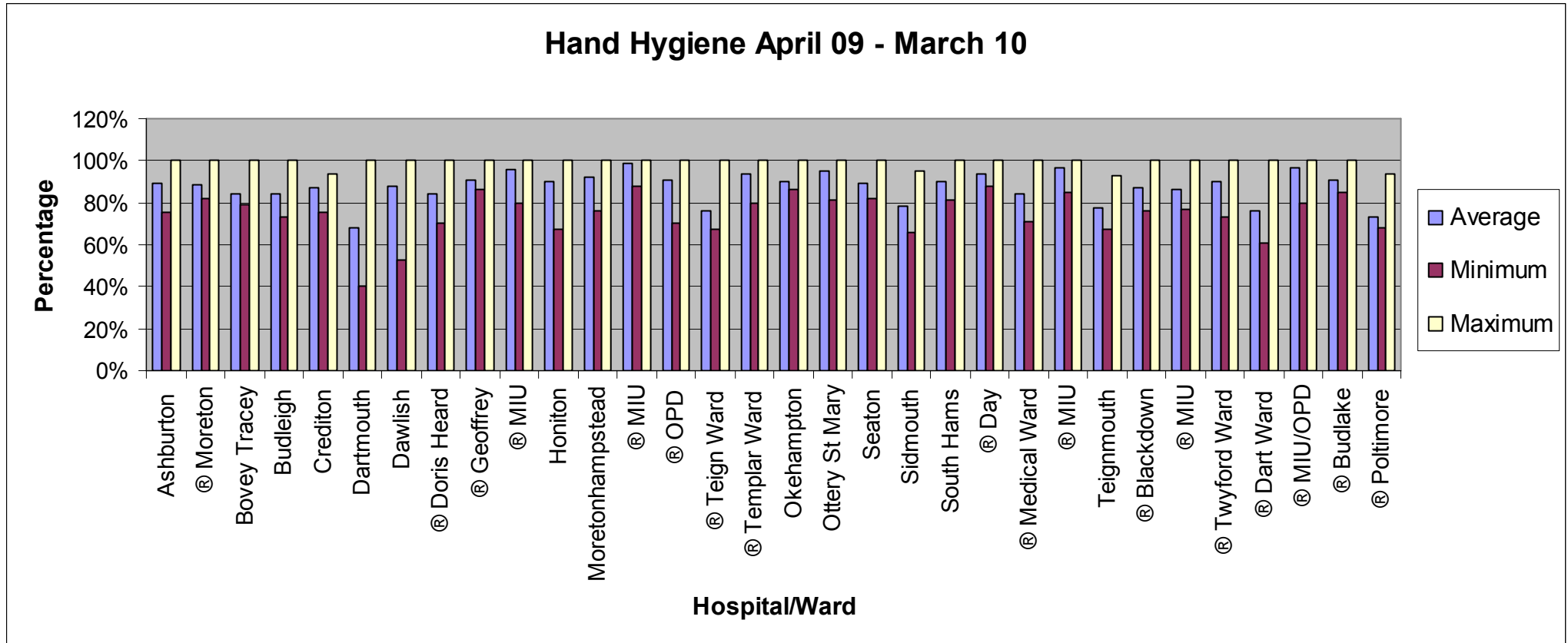
## Appendix 4

### C-Diff Infections, Devon PCT Community Hospitals (Control Charts and Trajectories)

#### NHS Devon Community Hospitals

Month	Monthly			Cumulative		
	2007/8	2008/9	2009/10	2007/8	2008/9	2009/10
April	4	7	2	4	7	2
May	7	5	0	11	12	2
June	7	4	10	18	16	12
July	4	7	1	22	23	13
August	5	3	8	27	26	21
September	10	7	2	37	33	23
October	8	4	4	45	37	27
November	6	4	2	51	41	29
December	6	1	2	57	42	31
January	10	3	2	67	45	33
February	8	2	3	75	47	36
March	4	1	1	79	48	37
Annual Total	79	48	37			
Mean (Average)	6.6	4.0	3.1			
Median	6.5	4.0	2.0			

**Average Results for Hand Hygiene using the Lewisham Tool**



**The average across all sites was 82%**

## Appendix 6

### DPS NHS Devon Health Care Facilities Key Performance Measures – April 2010

Health Care Facilities	CREDITS FOR CLEANING		CLEANLINESS AUDIT 2009 /2010 (Annual)	PEAT AUDIT 2009 (Annual)			ENVIRONMENTAL AUDIT 2009 (Annual)		INFECTION CONTROL AUDIT (Annual) – 2009- 2010			
	NOV 20 2010- FEB 26 2010			Environment Score	Food Score	Privacy & Dignity Score	Environment	Kitchen	Hand Hygiene Facilities	Sharps	Patient Equipment	Environment
ASHBURTON	5 Feb	98%	98.3%	Good	Excellent	Excellent	77	N/A	N/A	N/A	N/A	N/A
AXMINSTER				Good	Excellent	Excellent						
BOVEY TRACEY	5 Feb	89%	98%	Good	Excellent	Excellent	77	78	ward78	MIU 87 Ward 90	Ward 81	MIU -68
BUDLEIGH SALTERTON	23 Nov	93%	98%	Good	Acceptable	Good	0	N/A	MIU 87	Ward 88 MIU 87	Ward 89 MIU 73	N/A
CREDITON	11 Nov	88%	96.8%	good	Acceptable	Excellent	70/81	70/83	91/100	88/100	80/98	N/A
DARTMOUTH	5 Feb	92%	98.3%	Good	Excellent	Good	MIU-75	91	Ward82	MIU83	Miu86	Ward75
DAWLISH	3 Mar	93%	98%	Excellent	Excellent	Excellent	94	96	Ward87 MIU 91	MIU75	MIU 94	Ward 89 MIU -97
EXMOUTH	5 Feb	86%	96.8%	Good	Excellent	Excellent	DH – 74 GW - 78	DH – 83 GW - 91	DH – 95 GW – 83 MIU - 95	DH – 88 GW – 88 MIU - 96	DH – 95 GW – 94 MIU - 100	MIU -82
HONITON	14 Dec	96%	96.1%	Excellent	Excellent	Excellent	75 Maternity - 86	91 Maternity - 91	92 Maternity – 96 MIU - 86	92 Maternity – 92 MIU - 96	100 Maternity – 96 MIU - 91	MIU -100
MORTONHAMP STEAD	5 Feb	86%	92%	Excellent	Excellent	Excellent	87	96	83 MIU - 100	88 MIU - a/a	95 MIU - a/a	MIU -96
NEWTON ABBOTT	11 Nov	90%	98.8%	Excellent	Excellent	Excellent	Teign – 82 Templar - 85	Teign – 87 Templar - 87	MIU 88 Templar 88 Teign 83	MIU 96 Teign 92 Templar 92	MIU 96 Teign 79 Templar 92	MIU-87
OKEHAMPTON	15 Feb	88%	94%	Good	Excellent	Excellent	Dartmoor – 79 Maternity - 74	Dartmoor – 83 Maternity - 79	Dartmoor – 92 Maternity – 91 MIU - 86	Dartmoor – 91 Maternity – 96 MIU - 92	Dartmoor – 90 Maternity – 100 MIU - 88	MIU – 96
OTTERY ST MARY	16 Feb	93%	92.2%	Excellent	Excellent	Excellent	Maple – 83 Willow - 81	Maple – 87 Willow - AA	Maple – 96 Willow – 96 MIU - 91	Maple – 100 Willow – 100 MIU – 100	Maple – 94 Willow – 94 MIU - 100	MIU - 100

Health Care Facilities	CREDITS FOR CLEANING		CLEANLINESS AUDIT 2009 /2010 (Annual)	PEAT AUDIT 2009 (Annual)			ENVIRONMENTAL AUDIT 2009- 2010 (Annual)		INFECTION CONTROL AUDIT (Annual) – 2009- 2010			
	NOV 20 2010- FEB 26 2010			Environment Score	Food Score	Privacy & Dignity Score	Environment	Kitchen	Hand Hygiene Facilities	Sharps	Patient Equipment	Environment
SEATON	26 Feb	97%	95%	Good	Good	Excellent	75	78	87	96	93	
SIDMOUTH	15 Feb	94%	96.6%	Excellent	Excellent	Excellent	93	88	100 MIU - 91	88 MIU - 92	83 MIU - 78	MIU - 93
SOUTH HAMS/ KINGSBRIDGE	15 Dec	84%	93.5%	Good	Acceptable	Good	82	79	N/A	N/A	N/A	n/A
TAVISTOCK	3 Dec	88%	99%	Excellent	Excellent	Excellent	80	88	N/A	N/A	N/A	N/A
TEIGNMOUTH	12 Jan	85%	93.8%	Good	Excellent	Excellent	77	87	N/A	N/A	N/A	N/A
TIVERTON	18 Jan	93%	96.3%	Excellent	Good	Excellent	Twyford – 80 Blackdown – 82 Maternity - 85	Twyford - 70 Blackdown – AA Maternity - 95	N/A	N/A	N/A	N/A
TOTNES	15 Feb	91%	97.1%	Good	Excellent	Excellent			MIU 78 Ward 91	MIU92 Ward92	MIU 70 Ward 89	MIU 65 Ward-92
WHIPTON	21 Dec	90%	94%	Good	Excellent	Excellent			Budlake – 86 Poltimore - 95	Budlake – 96 Poltimore - 92	Budlake – 93 Poltimore - 90	
Sidwell Street (Contraceptive Services)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	76%	100%	95%	83%
Sidwell St (Gum)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	86%	92%	93%	97%
Sidwell St (WIC)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	86%	96%	96%	90%
Meadow Park	N/A	N/A	N/A	N/A	N/A	N/A	83	64	89	N/A	N/A	N/A
The Barnes	N/A	N/A	N/A	N/A	N/A	N/A	88	88	83	N/A	N/A	N/A
Hillcrest	N/A	N/A	N/A	N/A	N/A	N/A	77	88	81	N/A	N/A	N/A
Evergreen	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	65%	N/A	N/A	55%
Matford Lodge	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47%	N/A	N/A	56%
Larkby	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	58%
Coach House	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	58%

Scores for 2010 are shown in Green which allows a direct comparison year on year