SUMMARY REPORT

TRUST BOARD (IN PUBLIC) 2 August 2018  Agenda Number: 13

Title of Report  Director of Infection Prevention and Control Annual Report and Annual Programme of Work

Accountable Officer  Kim O’Keeffe, Chief Nurse

Author(s)  Louise Dickinson Associate Chief Nurse, Consultant Nurse and DIPC.

Purpose of Report  To provide the Committee with details of annual performance in relation to all aspects of Infection Prevention and Control and to present the programme of work for 2018/19

Recommendation  The Board is recommended to:

The Board is recommended to:
Receive the report and programme of work

Consultation Undertaken to Date  Hospital Infection Prevention and Control Committee 14th May 2018

Signed off by Executive Owner  20.06.18  Chief Nurse

Reviewed by Executive Team  -  -

Reviewed by Board Committee (where applicable)  23.07.18  Quality Assurance Committee

Reviewed by Trust Board (where applicable)  02.08.18  Trust Board

Next Steps  Quarterly reports will be submitted to the Quality Assurance committee to report on progress against the programme of work and performance in relation to healthcare associated infections.

Executive Summary

- There were 2 Trust apportioned MRSA bacteraemia in 2017/18 Post infection review was completed and concluded that one of the infections could not have been avoided, however the other potentially could have been avoided. Actions relating to antibiotic stewardship have been taken within the clinical team.

- The Trust met its Clostridium difficile (CDI) objective of no more than 23 avoidable Trust apportioned cases. A total of 30 cases were reported of which 7 were deemed to be avoidable following review by our Commissioners compared to 11 cases last year.

- Improvements were noted in antibiotic prescribing. RCHT was the best performing Trust in the South West for the second year running

- Surgical Site Infection Surveillance was conducted in orthopaedic surgery. RCH infection rates for the last 4 periods reported are 1.8% neck of femur repairs, 1.6% long bone, 2.3% total knee replacement, 0.5% total hip replacement. SMH infection rates for the last 4 periods reported are 0.9% Total hip replacement, 1.1% total knee replacement, 0% long bone. This compares to the following national figures: neck of femur repair 1.3%, long bone 1.5%, total knee replacement 1.3% and hip
replacement 1.0%.

- Norovirus affected the Trust twice during the year resulting in a number of complete and partial ward closures and disruption to hospital activity.
- Trust wide, data returned by clinical areas have reported hand hygiene compliance of 98% throughout the year. Peer review audits are conducted to ensure validity of the results with appropriate actions being taken where hand hygiene falls short of compliance.
- Environmental audits were carried out by the IPAC and clinical teams throughout the year.
- Average cleaning scores over this period are: - For very high risk areas 98%; High Risk areas 96%; Significant risk areas 95%. An improvement on last year.

The Director of Infection Prevention and Control Annual Report and Annual Programme of Work has been discussed at the Trust Management Group and Quality Assurance Committee. The complete report can be found on the Trust website.

<table>
<thead>
<tr>
<th>Financial Risks</th>
<th>Financial penalties for each case of MRSA bacteraemia and if the number of avoidable C. difficile cases exceeds 23.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Risks</td>
<td>The risk of inconsistent adherence to follow IPAC policies (including hand hygiene) is scored at 12 (3x4). Polices are all up to date, audits/surveillance are in place and review of HCAIs carried out. Residual risk rating is scored at 8.</td>
</tr>
<tr>
<td>Disclosure Statement</td>
<td>N/A</td>
</tr>
<tr>
<td>Equality and Diversity Statement</td>
<td>No negative impacts anticipated.</td>
</tr>
</tbody>
</table>
DIRECTOR OF INFECTION PREVENTION AND CONTROL

ANNUAL REPORT
April 2017 – March 2018
1. EXECUTIVE SUMMARY

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2. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

2.1 Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) role was shared by the Nurse Consultant Infection Prevention and Control and a Consultant Paediatrician until January 2018. Since January the post has been held by the Nurse Consultant. The Directors of Infection Prevention and Control oversee infection prevention and control policies and their implementation. The DIPC’s are responsible for Infection Prevention and Control within the Trust and report directly to the Chief Executive and the Board.

2.2 Infection Prevention and Control Team (IPAC)
The IPAC team provide specialist advice on matters relating to the identification, prevention and management of infection within the trust. The team works to an agreed annual programme of work, approved by the Trust Board. In addition, a service level agreement is held with Cornwall Hospice Care, which has been reviewed.

Infection Prevention and Control Team Structure 2017/18 (Appendix 1)

<table>
<thead>
<tr>
<th>Position</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Chief Nurse, Consultant Nurse Infection Prevention and Control Nursing Joint DIPC (Band 8c.)</td>
<td>1.0 WTE (0.6 from November 2017)</td>
</tr>
<tr>
<td>Infection Prevention and Control Lead Nurse(Band 8)</td>
<td>1.0 WTE form November 2017</td>
</tr>
<tr>
<td>Infection Prevention and Control Nurses (Band 6).</td>
<td>2.8 WTE, 3.6 from February 2018</td>
</tr>
<tr>
<td>Audit and Surveillance Co-ordinator/Administrator (Band 4)</td>
<td>0.82 WTE</td>
</tr>
<tr>
<td>Audit and Surveillance Support Worker (Band 3)</td>
<td>0.8 WTE</td>
</tr>
</tbody>
</table>
As well as the Infection Prevention and Control Doctor sessions, the team is supported by 3 clinical microbiologist who play an active role in the function of the team, providing an out of hours infection prevention and control advice service via the microbiology on call arrangements.

Additional microbiology support is provided by the Microbiology laboratory which is CPA accredited.

2.3 Infection Prevention and Control Reporting Arrangements

2.3.1 Infection Prevention and Control Steering Group
This group meets on a monthly basis and reports to the Hospital Infection Control Committee. The membership of the group comprises:
- Directors of Infection Prevention and Control
- Infection Control Doctor
- Consultant Nurse Infection Prevention and Control
- Clinical Nurse Specialist Infection Prevention and Control
- Antibiotic Pharmacist
- Consultant Nurse Infection Prevention and Control KCCG
- Infection Control Representative Cornwall Partnership Foundation Trust
- Representative from all Divisions

2.3.2 Hospital Infection Control Committee
During 2017/18 The Hospital Infection Control Committee met on a quarterly basis and reported to the Trust Quality Assurance Committee. Membership of the Group Comprised:
- Directors of Infection Prevention and Control (Chair)
- Chief Nurse
- Management Team Representative Division of Medicine, ED and West Cornwall.
- Management Team Representative Division of Women, Children and Sexual Health
- Management Team Representative Division of Surgery Theatres and Anaesthetics
- Management Team Representative Division of Cancer and Support Services
- Estates Representative
- Public Health England Representative
- Infection Control Doctor/Clinical Microbiologist
- Decontamination Lead
- Occupational Health Physician/Advisor
- Antibiotic Pharmacist
- Health and Safety Advisor

2.3.3 Quality Assurance Committee
During 2017/18 the DIPCs attended the Trust Quality and Assurance Committee on a quarterly basis providing the Committee with a written update of Infection Prevention and Control Issues.

2.3.4 Trust Board
During 2017/18 the Trust Board met on a monthly basis; the DIPCs provided data and a summary report for each meeting which was incorporated into the Integrated Performance Report.


2.3.5 Infection Prevention and Control Representation at relevant Groups
To provide infection prevention and control advice and ensure liaison between the IPAC team and key groups, IPAC representation was provided to the following key groups:
- Quality Assurance Committee (quarterly)
• Health and Safety Committee
• Divisional Governance Groups as requested
• Medical Devices and Clinical Product Review Group
• Clinical Site Development Plan Project Teams
• Resilience Committee (as necessary)
• Decontamination Risk Assessment Group.
• Antimicrobial Stewardship Committee
• Water Safety management Group
• Ventilation Group
• Chief Nurse Cabinet
• Senior Nurses and Midwives Group

3. HEALTH CARE ASSOCIATED INFECTION (HCAI) STATISTICS AND SURVEILLANCE.

The Infection Prevention and Control Team carries out an annual programme of surveillance to ensure compliance with mandatory requirements and that alert organism and conditions are identified in a timely manner to enable appropriate infection control measures to be put in place. The Department of Health requires mandatory surveillance of the following types of infections:

• MRSA bacteraemia
• MSSA bacteraemia
• E.Coli bacteraemia
• Clostridium difficile
• Infections associated with orthopaedic surgical procedures

3.1 Meticillin Resistant Staphylococcus aureus (MRSA) Bacteraemia

For the period April 2017 to March 2018, the Trust target for MRSA blood stream infections was 0 acute Trust apportioned cases. The Trust did not achieve this target with 2 MRSA bloodstream infections reported. The cases has been through the Post Infection Review Process (PIR) one was deemed to have been unavoidable and one avoidable. Prophylactic antibiotic prescribing for a patient with known MRSA has been discussed within the clinical specialty Governance meeting and advice provided by the microbiologists.

The Trusts MRSA bacteraemia rate is 0.86 compared to a South West rate of 0.82 and a National rate of 0.86.

3.2 Meticillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia

There were 29 MSSA bacteraemia reported that were acute Trust apportioned during 2017/18. This is above the locally agreed revised tolerance of 25. Root Cause analysis has been carried out on all cases with actions identified and implemented. A number of cases were identified as line related in the first month of the year. In response, detailed monitoring of all lines within the hospital was carried out for a minimum of 4 weeks and a review of all relevant staff compliance with Aseptic Non Touch technique conducted. All clinical areas that now report a line related bacteraemia are required to undertake detailed line monitoring and ANTT competence.
The MSSA bacteraemia rate for the Trust is 12.45; this compares with a South West rate of 9.37 and a National rate of 9.22.

3.3 E.coli bacteraemia
There were 34 cases of *E.Coli* bacteraemia that were acute Trust attributable during 2017/18 compared to 42 in the previous year against a target of 38 cases. Each case has been reviewed via the RCA process. The Trust has successfully reduced the number of *E.Coli* bacteraemia by 23.3% against the 2016 baseline which has been acknowledged by the Executive Director of Nursing NHSI.

3.4 *Clostridium difficile* (*C.difficile*)
Between April 2017 and March 2018, RCHT recorded 30 Trust-apportioned cases of *C. difficile* (cases occurring 72 hours or more following admission), of which 7 were considered ‘avoidable’, following review by NHS Kernow against an objective of fewer than 23 avoidable hospital apportioned cases.

The rate of *C.difficile* infections within the Trust is 12.87/100,000 bed days compared to the South West rate of 12.40 and the National rate of 13.84.

Our actions during the year to reduce the number of *C.difficile* cases were:
- To strengthen compliance with antimicrobial prescribing
- Continue to monitor the use of probiotics
- Ensure commodes and the environment are cleaned effectively
- Enhanced stool monitoring, assessment and prompt isolation where appropriate.
- Reviewed the diarrhoea risk assessment tool.

The Trust will be challenged further over the next 2 years as the objective for the coming year has been reduced to fewer than 22 avoidable hospital apportioned cases and the period for attributing to the Trust will reduce from 3 days to 2 days in the following year.

4.5 Surgical Site Infection Surveillance

Under the terms of the mandatory surveillance scheme, the Trust is required to submit data on orthopaedic surgical site infections for at least one quarter each year. From October 2017 to March 2018 data was collected and reviewed for total hip replacements, reduction of long bone fracture, total knee replacements and neck of femur repairs.

Data for the final quarter is still being collated however data for quarter 3 is summarised in the table below.

<table>
<thead>
<tr>
<th>Table 1. Royal Cornwall Hospital</th>
<th>Type of surgery</th>
<th>Rate of infection Rate of infection</th>
<th>National rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate of infection Q3</td>
<td>last 4 periods</td>
<td>previous 5 years</td>
</tr>
<tr>
<td>Total Hip replacement</td>
<td>2%</td>
<td>0.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total Knee replacement</td>
<td>0%</td>
<td>2.3%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Long Bone</td>
<td>2.9%</td>
<td>1.6%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Neck of Femur repair</td>
<td>2%</td>
<td>1.8%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2. St Michael's Hospital</th>
<th>Type of surgery</th>
<th>Rate of infection Rate of infection</th>
<th>National rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate of infection Q3</td>
<td>last 4 periods</td>
<td>previous 5 years</td>
</tr>
<tr>
<td>Total Hip replacement</td>
<td>1.1%</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total Knee replacement</td>
<td>1.2%</td>
<td>1.1%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Long Bone</td>
<td>0%</td>
<td>0%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

With the exception of Total knee replacements carried out on the RCH site, the surgical site infection rates for the last 4 periods are in line with National Rates. There were only three reported infection in the total knee replacement category in the last four periods however due to small numbers the percentage is high.
5. **ANTIBIOTIC STEWARDSHIP** *(Information provided by Neil Powell, Consultant Antibiotic Pharmacist)*

5.1 Antimicrobial stewardship management committee
The RCHT antimicrobial stewardship audit programme is overseen by the stewardship committee and follows that set out in the Start Smart Then Focus March 2015 publication.

5.2 Indication documentation and stop/review date documentation on the electronic prescribing system (EPMA).

Six weekly audit cycles capturing individual prescriber performance with indication and stop or review date documentation on the EPMA system continues. Individual emails are sent to doctors detailing their performance with a reminder of the Trust 95% standard.

![Graph showing Overall Trust percentage for indication and stop/review dates](image)

This data is reported by division and by specialty highlighting poor performing areas to governance and specialty leads and is reported on the Divisional Performance Assurance Framework. Specialty leads are invited to address deficiencies within their specialty.

5.3 VSL (probiotics) audits
VSL was introduced in June 2014 for patients over 60 years prescribed a high *Clostridium difficile* risk antibiotic without contra-indications to probiotics. Protocols have been set up on EPMA to aid the co-prescription of VSL with antibiotics that warrant it. The graph below shows performance this year against a Trust target of 90% The data is captured via a one day point prevalence audit.

![Graph showing Percentage of eligible patients prescribed VSL#3](image)

5.4 South West region antibiotic point prevalence audits
All seventeen Trusts in the south west region conduct a one day antibiotic point prevalence audit in March each year allowing Trusts to benchmark themselves against each other. Highlights of the Trust’s 2017 data below with the 2016 regional average data is presented below for comparison. For the second year running RCHT is the best performing Trust in the south west.

- Stop/review date on the chart/EPMA (RCHT 90% vs region 70%),
- Indication on the chart/EPMA (RCHT 89% vs region 72%),
- Compliance with antibiotic guidelines (RCHT 95% VS region 87%).
- Antibiotic courses beyond 72 hours without a documented antibiotic review (RCHT 5% vs region 16%)

5.5 Trust antimicrobial consumption (measured by defined daily doses/100 occupied bed days)
There was a national CQUIN for 2017/18 to reduce total, meropenem and piperacillin/tazobactam consumption by 1%, meropenem compared to 2016 consumption data and to ensure antibiotics are reviewed within 72 hours of commencing the antibiotic. We met three of the four targets;

1. Reduced piperacillin/tazobactam by 30%
2. Reduced carbapenems by 15%
3. 72 hour antibiotic review >90%
4. Increase in total antibiotic usage by 5%

6. UNTOWARD INCIDENTS

6.1 Outbreaks
An outbreak is usually defined as two or more cases linked in time and/or place or more pragmatically, as a greater than expected number of cases. However, sporadic cases may occur by chance in the same place and at the same time but are not linked in any causal way. This should be borne in mind when deciding if something really is an outbreak.

6.1.1 Norovirus
Norovirus affected the Trust at the beginning of the year and the end of the year.
7 wards and 5 bays were closed with confirmed norovirus during the year. 108 patients reported symptoms of diarrhoea and/or vomiting on the affected wards, 54 of which were confirmed to be norovirus. 38 staff reported symptoms. A total of 481 bed days were lost. There is no national benchmark for comparison however norovirus activity in the south west has been worse this year than last.

6.1.2 Influenza
The Trust has been significantly affected by Influenza this year reflecting the national increase in cases. Seven wards were affected by the virus resulting in complete or partial ward closure. From 01.11.17 to 28.03.18 1475 respiratory specimens were submitted to the laboratory compared to 468 specimens for the same period the previous year. This is a 315% increase. The total number of positive cases reported during Q4 is 344 (137 Flu A, 207 Flu B) compared to 42 cases reported in the same period last year. All appropriate infection control measures were implemented. Advice and support was provided by Public Health England. A debrief with clinical teams, occupational health, site co-ordination team, IPAC team and domestic services provider will be held in May to identify any improvements that can be made.

7. HAND HYGIENE

7.1 Audit Results
Hand hygiene audits are carried out on a monthly basis by all clinical areas as part of the Infection Prevention and Control Key Performance Indicators. Hand hygiene compliance reported by the clinical areas for the year is 98%. Spot checks were carried out by the IPAC team to validate these scores. Findings indicated
8. DECONTAMINATION (Information provided by Matthew Dyer Interim Decontamination Lead)

8.1 Sterile Services Department (SSD)
The low temperature sterilizer (Sterrad) is fully operational ensuring that the choledochoscope is sterilised in accordance with HTM 01-06. Further work has been completed with the low temperature sterilizer manufacture to product release the fast 30 minute biological indicator.

The Pro-Reveal protein detection equipment is now in operation in SSD. The residual protein can now be measured on a single side of a surgical instrument to comply with guidance HTM 01-01. The quarterly results from residual protein tests will be used to analyse trends with action being taken on that analysis. The trend analysis report form part of the risk analysis within the quality management system.

The first new washer/disinfector was installed and commissioned in 2017. A further two more washer/disinfectors have been purchased as part of the SSD capital replacement programme. Both washer/disinfectors will be installed and commissioned during the summer of 2018. This will complete the capital upgrade of all the washer/disinfectors in Sterile Services and meet the requirement to comply with HTM 01-01.

The upgrade to the air handling unit in the (IAP) clean room which maintains the class 8 clean room standards will be completed during 2018. Further work to the cleanroom airlocks, ductwork, ceiling, grills and lighting will be planned for 2019.

The SSD has had a successful year financially, and accreditation to all quality and technical standards has been maintained. Consequently the SSD remains registered with the MHRA as a compliant provider of reusable medical devices in accordance with MDD93/42/EEC.

8.2 Sterile Services Quality Performance
SSD right first time remains above the national target of 99.75%.

Damaged to theatre tray wrapped has been an issue particularly with the orthopaedic consignment sets and the laparoscopic sets. New sterilizing containers have been purchase for the critical sets and further work has been made with the manufacturing companies to provide solutions for compatibility for the decontamination process. The new EN ISO 13485:2016 will ensure compatibility of the medical device and any trays with local decontamination processes.

8.3 SSD external audit from Notified Body

The first transition audit visit from SGS (Notified Body) was carried out on 6th-8th February 2018. 9 major nonconformities and 4 minor nonconformities were raised. Both major and minor non-conformances will be closed before May 2018. The next interim audit visit is planned for June 2108.

8.4 Trust Wide Decontamination
The Authorised Engineer Decontamination completed an audit of the Trust decontamination facilities in December 2017. The decontamination processes at the Trust were deemed to be generally satisfactory however recommendations were made as follows:
- Carry out ‘Gap analysis’ of Decontamination Training for all Staff involved in Decontamination i.e. Decontamination Lead, Users, Operators etc. in all Departments.
- Change to Decontamination of Nasoendoscopes and Ultra Sound Probes by an automated process.
- Commence planning for Replacement of Sterilizers and associated Clean Steam Generators in Sterile Services plus Endoscope Washer Disinfectors in West Cornwall Hospital.
- Carry out risk assessment on use of storage rather than drying & storage cabinets and alternative methods of drying.
- Implement daily, weekly, quarterly and annual periodic testing of Mortuary Washer Disinfector.
- Repeat detailed Audit on RCH Mini Laundry in 3 months’ time.

The recommendations and findings from the report have been added to the Decontamination Action Plan which is overseen by the Decontamination Risk Assessment Group. Three of the six actions have been completed, 2 are currently being implemented and one action requires action.

9. CLEANING SERVICES – information provided by Jill Venables

9.1 Cleaning audit scores
The following table summarises the cleaning scores by risk category for the year:

<table>
<thead>
<tr>
<th>Risk category</th>
<th>Average actual score 16/17</th>
<th>Average actual score 17/18</th>
<th>Target score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High risk areas</td>
<td>97%</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>High Risk areas</td>
<td>93%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Significant Risk areas</td>
<td>92%</td>
<td>95%</td>
<td>90%</td>
</tr>
</tbody>
</table>

All scores indicate an improvement on last year’s performance.

**Compliance with the number of audits completed**
1653 (93%) audits were completed against a target of 98% compliance. 208 of these audits were validated by RCHT contract monitoring team.

Despite improvements in overall audit scores there are still some areas which require improvement. These areas are a focus for our provider Mitie and are subject to on-going audit by the contract monitoring team and are monitored by The Hospital Cleaning Operations Group.

### 9.2 Patient Led Assessment of the Care Environment (PLACE)

The PLACE assessments are led by the patient assessors, who are volunteers and independent of the Trust. The volunteers come from a cross section of the community and include Healthwatch Cornwall, Friends of the Royal Cornwall Hospital and independent assessors.

The assessments cover five areas but those relevant to Infection Control are:
- Cleaning
- Condition & Appearance

The assessments are mandatory, national and include both NHS and private care environments.

All three sites are assessed each year, with the whole of West Cornwall and St Michaels assessed. There is only a requirement to assess 25% of inpatient and outpatient areas at the Royal Cornwall Hospital due to the size of the estate.

The results for 2017 were officially released in August 2017 and showed very little change from the previous year.

**Figure 1 PLACE Results**

<table>
<thead>
<tr>
<th>%</th>
<th>Cleanliness</th>
<th>Condition &amp; Appearance</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCH</td>
<td>93.68</td>
<td>98.78</td>
</tr>
<tr>
<td>WCH</td>
<td>97.14</td>
<td>99.82</td>
</tr>
<tr>
<td>SMH</td>
<td>95.51</td>
<td>99.5</td>
</tr>
<tr>
<td>Org Ave</td>
<td>96.31</td>
<td>98.78</td>
</tr>
<tr>
<td>Nat Ave</td>
<td>97.57</td>
<td>98.06</td>
</tr>
</tbody>
</table>
9.3.1 Cleanliness
All three sites continue to score above the national average for 2017, but with a small drop in performance at WCH and SMH. RCH remained unchanged. Overall since 2013 there has been a significant increase in the cleaning performance noted by PLACE assessors.

9.3.2 Condition & Appearance
Further improvements were seen at WCH and RCH, but there was a 3.5% drop seen at SMH, which can be attributed to some environmental issues that are in the process of being corrected and some problems with condition of the fixtures, fittings and furniture.

There has been further investment through Backlog Capital and other local schemes in 2017/18.

9.3.3 UK Position (NHS Trusts only)
Taking into account all Trusts in the UK, our position in relation to Cleaning has remained about the same and above the national average, whilst Condition & Appearance has had a 1% improvement, but still remains below the national average.

We continue to invest in the Condition & Appearance of the Estate each year through the backlog programme, with £200k in 2017/18 and £100k in 18/19 for Painting and Flooring. Further investments in the upgrades to wards and departments, such as the work on Fracture Clinic, the new Birthing Suite, NNU and the ED GP Streaming project will also help with the scores.

Other areas of investment for 2018/19 that should impact on scores include; St Michael’s Hospital Reception redesign and Passenger Lift upgrade, £160k for IPAC related improvements, Pedestrian Safety improvements and signage.

9.3.4 PLACE action plan
Whilst there was no PLACE action plan developed for 2017/18, work has been undertaken through Backlog Capital and improvements to Facilities management through robust contract management that have seen improvements to the estate, including:

- Flooring & Painting Programme
- Ward refurbishments and improvements including Birthing Centre, and NNU
- Fracture Clinic improvement works
- GP streaming

10. INFECTION PREVENTION AND CONTROL AUDIT PROGRAMME

10.1 Infection Prevention and Control Performance Indicators
Each clinical area is required to undertake a series of audits based on the Department of Health Saving Lives Campaign. These include:

- Hand Hygiene
- Peripheral Line insertion and on-going care
- Urinary Catheter insertion and on-going care
- Correct management of patients with diarrhoea
- Compliance with aseptic non-touch technique (ANTT)

These results are reviewed by the Clinical Matrons and action plans put into place where non-compliance has been identified.

10.2 Infection Prevention and Control Environmental Audits
Audits are regularly undertaken by the Infection Prevention and Control team with each clinical area being audited against 10 categories. Sixty nine clinical areas were audited during the year.

Any ward/department with a score of 85% or more is deemed compliant and re-audited in 12 months. A score of 84% or less is deemed non-compliant. A report on the findings of the audit and any recommendations, are currently forwarded to the ward sister/charge nurse/departmental manager with a request for an action plan to be forwarded to the Infection Prevention and Control team within 2 weeks or receiving the audit report. Within a month of receiving the action plan, the IPAC team re-visit those wards with a score of less than 85% to monitor progress on the actions. An escalation process is in place in the event of not receiving the action plans within the allotted time frame and in the event of failure to progress against the actions.

11. INFECTION PREVENTION AND CONTROL POLICIES
As part of the annual programme of work, the IPAC team have a programme of development and revision of Infection Prevention and Control policies. During 2017/18 the following policies were completed.
- Policy for the management of patients infected/colonised with multidrug resistant organisms (MDROs)
- ANTT policy
- Hand Hygiene policy
- Policy for the Management of Patients with confirmed/suspected Influenza
- Panton-Valentine Leukocidin (PVL) Policy
- CJD policy
- Policy for Surveillance and Reporting of Infectious Disease, Healthcare Associated Infection and Antibiotic Resistant Organisms
- Policy for the Management of outbreaks of suspected/confirmed Norovirus
- Scabies Policy
- Standard Infection Prevention and Control Precautions Policy
- Viral Haemorrhagic Fever Policy

12. EDUCATION AND TRAINING
Education and training is a fundamental element of the Infection Prevention and Control Programme. The IPAC team contribute substantially to training activities within the Trust. The following table summarises the formal educational input of the IPAC team.

12.1 Mandatory Training Figures (data from Learning and Development)

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Percentage trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Scientific and Technical</td>
<td>83.40</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>82.12</td>
</tr>
<tr>
<td>Administrative and Clinical</td>
<td>87.45</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>89.87</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>66.67</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>88.33</td>
</tr>
</tbody>
</table>
Medical and Dental                  79.33
Nursing and Midwifery Registered   83.77
Total                              78.2

12.2 Additional Training

<table>
<thead>
<tr>
<th>Training session</th>
<th>Group of staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Link Practitioner Update 6monthly</td>
<td>Link Practitioners</td>
</tr>
<tr>
<td>Apprenticeship/Care programme</td>
<td>HCA’s</td>
</tr>
<tr>
<td>Infection Prevention and Control – an overview.</td>
<td>Health and social care students</td>
</tr>
<tr>
<td></td>
<td>Work experience students</td>
</tr>
<tr>
<td>Maternity Support Workers Update</td>
<td>Maternity Support workers</td>
</tr>
<tr>
<td>ANTT Update and assessment</td>
<td>Various wards, various staff groups</td>
</tr>
<tr>
<td>Infection Prevention and Control Module level 5</td>
<td>Trainee Assistant Practitioners.</td>
</tr>
<tr>
<td>Diploma Trainee Assistant Practitioner Training.</td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene drop-in sessions</td>
<td>All Staff</td>
</tr>
</tbody>
</table>

In addition to formal training, ad hoc informal training has been delivered during ward visits.

13. INFECTION PREVENTION AND CONTROL AND THE BUILT ENVIRONMENT/ ESTATES – Information provided by the Estates Team

13.1 Capital Projects
Ensuring Infection Prevention and control advice is sought for the development of any new service, capital build or refurbishment is essential in reducing reservoirs of infection. The Trust has a “Building and Refurbishment: Infection Prevention and Control in the Built Environment” policy which sets out responsibilities for all parties involved in building or refurbishment projects. During 2017/18, the Infection Prevention and Control team has been involved with the following projects:

- West Cornwall Hospital Imaging projects
- Cardiac Cath Lab
- Birthing Centre
- Delivery Suite
- MRI
- Fracture Clinic improvement works
- Winter pressures programme
- GP Streaming project

Infection Prevention and Control advice is sought for any new build/refurbishment/service developments to ensure that the environment is fit for purpose and reduces reservoirs of infection.

13.2 Water Sampling
There is a programme for the testing of water throughout the hospital. The water results for the Trust continue to evidence good systems under control. The Water Safety Policy has been updated during the year with support from the Authorised Engineer (water) to reflect the new HTM guidance.

The graphs below give details of the full volume of tests and the amount that indicate the presence of bacteria which were tested. Where there are positive results these are dealt with in line with the policy, although it is worth noting that overall these are minimal.
During 2017/18 copper silver ionization has been installed to Trelawny/Sunrise/Mermaid and The Cove. The copper silver is a biocide to supplement the primary control measure of temperature. The installation of copper silver ionization will take place shortly at St Michaels Hospital.

13.3 Ventilation

Renewed scrutiny is being applied to the Trust ventilation systems to identify areas of deficiency for example where medical procedures are undertaken. The annual validation of ventilation systems continues with remedial works undertaken where possible within the parameters of the ventilation plant. The ventilation committee has been resurrected to drive progress and ensure appropriate clinical input. The ventilation committee reports into the Trust’s Hospital Infection Prevention and Control Committee.

13.4 Ventilation Works

The ventilation in fracture clinic has been fitted with a larger fan and chiller battery to address the temperature problem as best as possible.

The progression of a ventilation system for Delivery Suite to deal with entonox levels is due to start on site shortly. These works will enable the increase of air changes within the emergency theatre on delivery suite to be increased to the 25 air changes recommended.

The ventilation system for Sterile Supplies Department Clean Room will be replaced shortly. Theatres 6 and 7 Trelawny Wing have had the ventilation system fully refurbished including new fans, heater batteries and controls.
13.5 Refurbished Areas by Estates Operations

Minor refurbishment works were completed in a number of locations including:

- Manual Handling and Cleaning Training room.
- 2nd Floor Corridor – vinyl, wall cladding handrail.
- Lowen Ward/Link Corridor flooring.
- Wheal Fortune/Wheal Prosper new isolation/roof covering.
- Radiology Reporting offices.
- Lowen Ward vacuum drainage/upgrade.
- West Cornwall Hospital waste compound.
- 10 cleaners cupboard, janitorial sink and upgrades.
- Urology decontamination room.
- Delivery Suite design.
- Superficial room Sunrise Centre.
- 2 x room changes for Sunrise Centre.
- St Michaels Hospital Reception/Coffee Shop.
- Replace flooring/hatching Education corridor.
- Replace flooring Haematology Clinic rooms and waiting area.
- Replace corridor flooring in Lowen Ward.
- Isolation ward ventilation.

14. NEEDLESTICK INJURIES

Needlestick and body (NSI) fluid incident reduction is a key agenda item for Occupational Health (OH), the Board and the Trust as a whole. OH monitors and reports on NSI/BFE incidents, and attends the Sharps Safety Group to assist the Trust to operate in line with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) legislation in collaboration with the Trust health and Safety team.

Reporting certain incidents is a legal requirement, and the process enables identification and targeting of where and how risks arise, and provides advice about how to avoid work-related deaths, injuries, ill health and accidental loss.

OH and Health & Safety meet fortnightly to collate Datix and OH reported NSI/BFE’s; this is to act as a safety net for non-reporting, and also to help identify trends.

14.1 Number of incidents

The total number of needlestick injuries reported during 2017/18 is 111.

14.2 Flu vaccination - CQUIN

Flu vaccination uptake for the year April 2017 to March 2018 is 53.3% for clinical staff. Vaccination clinics were provided by the occupational health team and each ward area had their own vaccinator to support staff vaccination. These percentages fall short of the CQUIN target of 70% for 2017/18. A regional Flu review meeting has been held by NHS England and Public Health England attended by the Occupational Health team who have identified a number of new initiatives for the coming flu campaign.
Royal Cornwall Hospitals NHS Trust
Infection Prevention and Control Structure

Appendix 1
### Domain: Infection Prevention and Control

#### Action: Sustaining/reducing the number of cases of Clostridium difficile

**Key Area:** The number of reported cases of Clostridium difficile will be less than anticipated target figure of **22**

<table>
<thead>
<tr>
<th>Action</th>
<th>Target Date</th>
<th>Accountable</th>
<th>Status</th>
<th>Measure of success</th>
<th>Progress / update</th>
<th>Date Completed</th>
<th>Evidence / outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.01</td>
<td>31.03.19</td>
<td>Antibiotic Pharmacist</td>
<td>Green</td>
<td>Audit results will indicate sustained compliance with recording stop/review dates and indication for use.</td>
<td></td>
<td></td>
<td>Audit results</td>
</tr>
<tr>
<td>1.02</td>
<td>31.03.19</td>
<td>Antibiotic Pharmacist</td>
<td>Green</td>
<td>Audit results will indicate sustained compliance with recording stop/review dates and indication for use.</td>
<td></td>
<td></td>
<td>Audit results</td>
</tr>
<tr>
<td>1.03</td>
<td>31.03.19</td>
<td>All antibiotic prescribers</td>
<td>Green</td>
<td>All prescribers will receive antimicrobial stewardship updates annually.</td>
<td></td>
<td></td>
<td>Training records</td>
</tr>
<tr>
<td>1.04</td>
<td>31.03.19</td>
<td>Clinical Teams</td>
<td>Green</td>
<td>Monthly audits will indicate sustained compliance with an in-house target of 90% eligible patients receiving probiotic.</td>
<td></td>
<td></td>
<td>Audit results</td>
</tr>
<tr>
<td>1.05</td>
<td>30.06.18</td>
<td>IPAC team</td>
<td>Green</td>
<td>All patients with a result of GDH will have been risk assessed and treatment amended/commenced appropriately.</td>
<td></td>
<td></td>
<td>Data report</td>
</tr>
<tr>
<td>1.06</td>
<td>31.10.18 - 31.03.19</td>
<td>IPAC team</td>
<td>Green</td>
<td>All areas to display SIGHT poster. Staff can state what SIGHT stands for.</td>
<td></td>
<td></td>
<td>Record of staff understanding and evidence of poster in the clinical area.</td>
</tr>
<tr>
<td>1.07</td>
<td>31.03.19</td>
<td>IPAC team</td>
<td>Green</td>
<td>All areas with 2 or more cases within 28 days will have completed the audits with evidence of improvement.</td>
<td></td>
<td></td>
<td>Audit results</td>
</tr>
<tr>
<td>1.08</td>
<td>31.03.19</td>
<td>IPAC team</td>
<td>Green</td>
<td>Bed spaces of all cases will have been appropriately cleaned as per policy</td>
<td></td>
<td></td>
<td>Mitie log</td>
</tr>
<tr>
<td>1.09</td>
<td>31.03.19</td>
<td>IPAC team</td>
<td>Green</td>
<td>Each case will have evidence of 3 month review</td>
<td></td>
<td></td>
<td>RCA records</td>
</tr>
<tr>
<td>Domain</td>
<td>Key Area</td>
<td>Action</td>
<td>Target Date</td>
<td>Accountable</td>
<td>Status</td>
<td>Measure of Success</td>
<td>Progress / update</td>
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<td>------------------</td>
</tr>
<tr>
<td>2.01</td>
<td>MRSA</td>
<td>Following risk assessment, review and amend MRSA policy</td>
<td>30.05.18</td>
<td>IPAC team</td>
<td>✔️</td>
<td>Policy will have been updated and available for staff</td>
<td>✔️</td>
</tr>
<tr>
<td>2.02</td>
<td>MRSA</td>
<td>Liaise with the surgeons regarding the changes</td>
<td>30.04.18</td>
<td>IPAC doctor</td>
<td></td>
<td>Surgeon in put to screening process</td>
<td>✔️</td>
</tr>
<tr>
<td>2.03</td>
<td>MRSA</td>
<td>Circulate amended policy, summarise changes in the newsletter.</td>
<td>31.07.18</td>
<td>IPAC team</td>
<td>✔️</td>
<td>Policy will have been updated and available for staff</td>
<td>✔️</td>
</tr>
<tr>
<td>2.04</td>
<td>MRSA</td>
<td>Monitor MRSA screening results monthly via the Infection Prevention and Control Steering Group</td>
<td>30.04.18</td>
<td>DIPC</td>
<td></td>
<td>Screening results will be scrutinised and actions taken accordingly</td>
<td>✔️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Area</th>
<th>Action</th>
<th>Target Date</th>
<th>Accountable</th>
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<th>Measure of Success</th>
<th>Progress / update</th>
<th>Date Completed</th>
<th>Evidence / outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.01</td>
<td>MSSA</td>
<td>Carry out RCA on all cases. Where themes area identified take action accordingly</td>
<td>31.03.19</td>
<td>IPAC team</td>
<td>✔️</td>
<td>All MSSA bacteraemia will have completed RCA and any themes identified will have been actioned and learning</td>
<td>✔️</td>
<td>Report</td>
<td>31.03.19</td>
</tr>
<tr>
<td>3.02</td>
<td>MSSA</td>
<td>Revise the feedback process to clinical areas and wider Divisions</td>
<td>30.04.18</td>
<td>DIPC</td>
<td></td>
<td>Sharing of learning process in place.</td>
<td>✔️</td>
<td>Feedback report</td>
<td>30.04.18</td>
</tr>
<tr>
<td>3.03</td>
<td>MSSA</td>
<td>Where the infection has been identified as being line related carry out month long focus on line care and documentation within the clinical area and provide assurance of ANTT compliance of all staff</td>
<td>31.03.19</td>
<td>Ward Sister/Charge Nurse</td>
<td>✔️</td>
<td>Success &amp; completion of line care audits and improvements noted.</td>
<td>✔️</td>
<td>Audit results</td>
<td>31.03.19</td>
</tr>
<tr>
<td>3.04</td>
<td>MSSA</td>
<td>All relevant staff to undertake annual ANTT refresher</td>
<td>31.03.19</td>
<td>Clinical Directors Associate Directors of Nursing</td>
<td>✔️</td>
<td>All relevant staff will be in date with ANTT</td>
<td>✔️</td>
<td>Training figures</td>
<td>31.03.19</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Area</th>
<th>Action</th>
<th>Target Date</th>
<th>Accountable</th>
<th>Status</th>
<th>Measure of Success</th>
<th>Progress / update</th>
<th>Date Completed</th>
<th>Evidence / outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.01</td>
<td>Hand Hygiene</td>
<td>Revise mandatory training programme for the year to ensure the focus is on Hand Hygiene - technique and how to challenge non-compliance</td>
<td>01.04.18</td>
<td>IPAC team</td>
<td>✔️</td>
<td>Mandatory training will focus on the key aspects of hand hygiene.</td>
<td>✔️</td>
<td>Training session</td>
<td>01.04.18</td>
</tr>
<tr>
<td>4.02</td>
<td>Hand Hygiene</td>
<td>Introduction of a glow box challenge for one month focussing on technique, 5 moments and challenge of non-compliance.</td>
<td>30.04.18</td>
<td>All staff</td>
<td>✔️</td>
<td>All Division will participate in the campaign.</td>
<td>✔️</td>
<td>Attendance sheets</td>
<td>30.04.18</td>
</tr>
<tr>
<td>4.03</td>
<td>Hand Hygiene</td>
<td>Provide monthly drop in hand hygiene sessions</td>
<td>31.03.19</td>
<td>IPAC team</td>
<td>✔️</td>
<td>Drop in sessions will be publicised and staff attendance recorded.</td>
<td>✔️</td>
<td>Attendance sheets diary entry</td>
<td>31.03.19</td>
</tr>
<tr>
<td>4.04</td>
<td>Hand Hygiene</td>
<td>Clinical areas to carry out monthly hand hygiene audits</td>
<td>31.03.19</td>
<td>Ward sisters/Charge nurses</td>
<td>✔️</td>
<td>Audits will be completed with scores above 85%</td>
<td>✔️</td>
<td>Quanta audit</td>
<td>31.03.19</td>
</tr>
<tr>
<td>4.05</td>
<td>Hand Hygiene</td>
<td>Spot checks to be carried out in all in-patient areas every 6 months.</td>
<td>30.06.18</td>
<td>IPAC team</td>
<td>✔️</td>
<td>Spot checks completed and feedback to Divisions and individuals</td>
<td>✔️</td>
<td>Audit data</td>
<td>30.06.18</td>
</tr>
</tbody>
</table>

30 cases of MSSA bacteraemia reported to date Expected outcome: Reduction in the number of MSSA bacteraemia cases compared to 2017/18

Expected outcome: Sustaining compliance with hand hygiene.

Expected outcome: Compliance with hand hygiene audits will be maintained above 85%
<table>
<thead>
<tr>
<th>Domain</th>
<th>Key Area</th>
<th>Action</th>
<th>Target Date</th>
<th>Accountable</th>
<th>Status</th>
<th>Measure of success</th>
<th>Progress / update</th>
<th>Date Completed</th>
<th>Evidence / outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.01</td>
<td>Review the cases reported in 2017/18 for any themes requiring action. Devise action plan accordingly</td>
<td>30.04.18</td>
<td>Lead Nurse IPAC, DIPC</td>
<td>All post 48 hour E. Coli bacteraemia from 2017/18 will have been reviewed and key themes identified.</td>
<td>review data</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.02</td>
<td>Complete RCA on all cases and feedback learning to clinical teams and the wider Divisions.</td>
<td>31.03.19</td>
<td>IPAC team, DIPC, Clinical Teams</td>
<td>Themes from learning will be shared on a quarterly basis and forwarded with the quarterly data.</td>
<td>RCA and feedback process.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.03</td>
<td>Ensure learning is discussed at the Infection Prevention and Control Steering Group</td>
<td>30.04.18</td>
<td>DIPC</td>
<td>All RCA’s will be reviewed at the meeting with updates provided on any actions</td>
<td>Agenda and minutes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.04</td>
<td>Review National Documents and Resources to ensure compliance.</td>
<td>30.07.18</td>
<td>Lead Nurse PAC, DIPC</td>
<td>Any new practices identified will be introduced Trust wide</td>
<td>Practice/policy change if required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.05</td>
<td>Attend any regional and National events relating to this.</td>
<td>31.03.19</td>
<td>Lead Nurse PAC, DIPC</td>
<td>Attendance and feedback from the national/regional events</td>
<td>Event information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
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<th>Progress / update</th>
<th>Date Completed</th>
<th>Evidence / outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.01</td>
<td>Attend NHSI CAUTI collaborative (if invited) sharing and implementing learning as appropriate.</td>
<td>31.12.18</td>
<td>DIPC</td>
<td>Active involvement in the collaborative with key actions for improvment identified</td>
<td>Collaborative project</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.02</td>
<td>Review current Catheter care guidelines to ensure they are in line with best practice.</td>
<td>31.07.18</td>
<td>Associate Chief Nurse</td>
<td>Updated guidelines have been uploaded onto the documents library and have been implemented.</td>
<td>Revised guidelines</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.03</td>
<td>Establish service improvement methodology in Trauma to effectively identify and reduce catheter usage and harms.</td>
<td>31.10.18</td>
<td>Clinical Teams</td>
<td>Reduction in the use of urinary catheters</td>
<td>Safety thermometer data</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.04</td>
<td>Monitor rate of CAUTI via Safety thermometer</td>
<td>31.03.19</td>
<td>DIPC</td>
<td>Reduction in the rate of CAUTI</td>
<td>Safety thermometer data</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domain</td>
<td>Key Area</td>
<td>Action</td>
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</tr>
<tr>
<td>7.01</td>
<td></td>
<td>Involve a wider audience in the flu planning session this year. Utilise feedback from Regional debrief meeting in our plans.</td>
<td>01.05.18</td>
<td>Flu Planning Group</td>
<td></td>
<td>Meeting will be held and will include: Associate Chief Nurse, Head of Health and Wellbeing, Occupational Health Team, CQUIN lead, clinical staff, DPC</td>
<td></td>
<td></td>
<td>Minutes of meetings</td>
</tr>
<tr>
<td>7.02</td>
<td></td>
<td>All wards to have as a minimum two Flu vaccinator who will be responsible for vaccinating all staff in their area mandated by Nurse Director.</td>
<td>30.09.18</td>
<td>Flu Planning Group</td>
<td></td>
<td>There will be at least 2 named vaccinators on each ward and in each nurse led clinical area.</td>
<td></td>
<td></td>
<td>Email and list of staff</td>
</tr>
<tr>
<td>7.03</td>
<td></td>
<td>Review training programme to ensure vaccinators can undertake training that is easy to access.</td>
<td>31.07.18</td>
<td>Occupational Health</td>
<td></td>
<td>All named vaccinators will have completed their training.</td>
<td></td>
<td></td>
<td>training programme</td>
</tr>
<tr>
<td>7.04</td>
<td></td>
<td>Introduce daily bleep system to enhance the ward based rota</td>
<td>01.10.18</td>
<td>Matrons Occupational Health IPAC team</td>
<td></td>
<td>Daily bleep system supported by Occ Health IPAC, site team and Matrons</td>
<td></td>
<td></td>
<td>rota</td>
</tr>
<tr>
<td>7.05</td>
<td></td>
<td>Once programme underway review compliance with uptake of the vaccine</td>
<td>08.10.18</td>
<td>Flu Planning Group</td>
<td></td>
<td>A live database will be available to review accurate compliance figures.</td>
<td></td>
<td></td>
<td>weekly compliance data</td>
</tr>
</tbody>
</table>

53% of frontline staff have received the flu vaccine 2017/18

Expected outcome: 75% of frontline staff will have been vaccinated against influenza.