South Tees Hospitals NHS
NHS Foundation Trust

Meeting / committee:	Trust Board	**Meeting date:**	26th August 2014

This paper is for: (Only 1 column to be marked with x as appropriate)	Action/Decision	Assurance X	Information

Title:	Healthcare-associated infection report for July 2014

Purpose:	To provide performance information on healthcare-associated infections.

Key issues / items for consideration in the report:	This report summarises surveillance information on MRSA and MSSA bacteraemia, *Clostridium difficile*-associated diarrhoea, bacteraemia due to glycopeptide-resistant enterococci, ESBL-producing coliform infections and other important healthcare-associated infections for the month of July 2014. • There is no official MRSA bacteraemia target for 2014/15. There has been 1 trust-assigned case in July 2014, with a total of 2 trust-assigned cases for the first 4 months of 2014/15. • There is no official MSSA bacteraemia target for 2014/15. There has been 1 trust-apportioned case in July 2014, with a total of 9 trust-apportioned cases for the first 4 months of 2014/15. • The *C. difficile*-associated diarrhoea target for 2014/15 is to have no more than 49 Trust-apportioned cases of *C. difficile* among patients aged over 2 years. There have been 4 trust-apportioned cases in July 2014, with a total of 19 trust-apportioned cases in the first 4 months of 2014/2015.

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Recommendation:	The Trust Board are asked to note current performance and to support the actions being taken.

HEALTHCARE ASSOCIATED INFECTION REPORT (DATA TO END OF JULY 2014)

1. SURVEILLANCE DATA

1.1 MRSA bacteraemia

MRSA	*Annual total 13/14*	*Aug 13*	*Sep 13*	*Oct 13*	*Nov 13*	*Dec 13*	*Jan 14*	*Feb 14*	*Mar 14*	Apr 14	May 14	June 14	July 14	Total 2014/15 to date	Target for 2014/15
Total cases	8	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*3*	0	0	1	1	2	NA
Not trust assigned	4	*0*	*0*	*1*	*0*	*1*	*0*	*1*	*1*	0	0	0	0	0	NA
Trust assigned	4	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*2*	0	0	1	1	2	**NA**

There has been 1 case of MRSA bacteraemia in July 2014. This case was trust-assigned and the cause was hospital-acquired pneumonia. The patient probably acquired MRSA infection in the Trust but there were no other deficiencies in care identified which contributed to the bacteraemia.

1.2 MSSA bacteraemia

MSSA	*Annual total 13/14*	*Aug 13*	*Sep 13*	*Oct 13*	*Nov 13*	*Dec 13*	*Jan 14*	*Feb 14*	*Mar 14*	Apr 14	May 14	June 14	July 14	Total 2014/15 to date	Target for 2014/15
Total cases	92	*8*	*8*	*7*	*6*	*3*	*9*	*16*	*8*	6	16	11	8	41	NA
Not trust apportioned	64	*5*	*8*	*2*	*5*	*1*	*7*	*13*	*5*	5	12	8	7	32	NA
Trust apportioned	28	*3*	*0*	*5*	*1*	*2*	*2*	*3*	*3*	1	4	3	1	9	NA

There have been 8 cases of MSSA bacteraemia in July 2014; 1 of which was classed as trust-apportioned. Root cause analyses have been requested from the clinical teams concerned. Work continues regarding the care and management of Hickman lines led by speciality medicine and includes standardised aseptic technique, equipment and competencies.

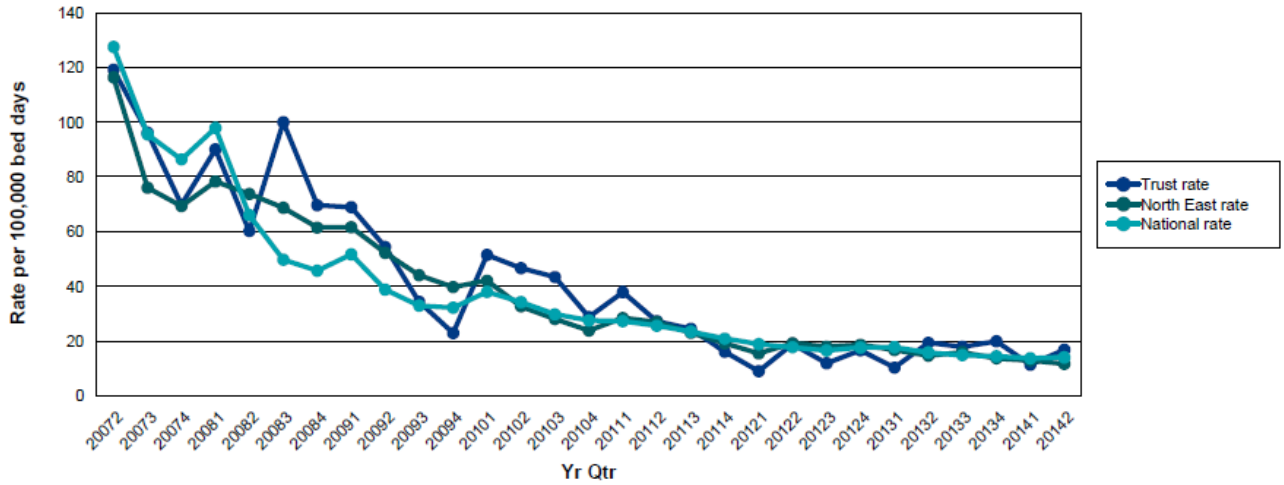
1.3 *Clostridium difficile*

C.difficile	*Annual total 13/14*	*Aug 13*	*Sep 13*	*Oct 13*	*Nov 13*	*Dec 13*	*Jan 14*	*Feb 14*	*Mar 14*	Apr 14	May 14	June 14	July 14	Total 2014/15 to date	Target for 2014/15
Total cases	*114*	*9*	*11*	*7*	*6*	*16*	*9*	*7*	*10*	11	15	11	10	47	NA
Not trust apportioned	*57*	*7*	*3*	*4*	*2*	*6*	*7*	*2*	*7*	7	8	7	6	28	NA
Trust apportioned	*57*	*2*	*8*	*3*	*4*	*10*	*2*	*5*	*3*	4	7	4	4	19	**49**
-JCUH	*46*	*2*	*6*	*3*	*4*	*10*	*2*	*4*	*2*	2	5	4	2	13	
-FHN	*3*	*0*	*2*	*0*	*0*	*0*	*0*	*0*	*0*	2	1	0	2	5	
-CBH	*2*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	*0*	0	1	0	0	1	
-RPCH	*2*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*1*	0	0	0	0	0	
-ECH	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	0	
-GGH	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	0	
-The Rutson	*3*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	0	
-The Friary	*1*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	0	
-The Lambert	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	0	0	0	0	0	

There have been 10 cases of *C.difficile* infection in July 2014, four of which are classed as trust-apportioned. The annual target is to have no more than 49 trust-apportioned cases. Deaths within 30 days after *C.difficile* diagnosis: for June 2014, 2/11 patients died during this period. Since April 2009, 201/975 (21%) have died during the 30 day follow-up period.

The graph below provides the most up-to-date data from Public Health England comparing the incidence of trust-apportioned *C difficile* cases with the regional and national average incidence to the end of June 2014. This shows us to be slightly above the national rates. The spike in May will have contributed to this.

Rate of Trust apportioned CDI per 100,000 bed days - National, Regional and Trust Comparison



***C.difficile* action plan**

The following actions were completed in July 2014:

Cleaning

- HPV business case was approved by formal management group.
- Touch point cleaning in-between patient use by portering staff has been introduced for patient transport chairs.
- Interactive IPC workshop completed at the Trusts Patient Safety Conference on 9th July 2014.

Antimicrobial prescribing

- The antibiotic awareness campaigns for prescribers and nurses, respectively entitled 'SPARED' and 'ERA' have continued.
- The A RED antibiotic audit has been incorporated into the antibiotic ward rounds enabling us to produce objective and timely audit data for most inpatient areas at JCUH and for some community hospitals. The first reports have been circulated to the chiefs and other relevant stakeholders. Centres will then be able to act upon the findings and share actions at performance meetings.

Communication

- Completion of a survey of frontline staff regarding the use of HCAI collaborative newsletter. A number of actions have been identified for August 2014, including reinforcing the need to share at each handover and meetings and increase the awareness around the 'focus on five', key points.
- A draft HCAI communications plan has been developed, to be discussed and agreed at infection prevention action group on 21st August 2014, with an aim to implement in September 2014.
- Deputy DIPC or IPCN's continuing to attend centre/directorate governance meetings to gain assurance around the sharing of and discussing key HCAI issues.

- Development of a draft *C.difficile* media campaign to improve greater understanding by the public; provide more information and potentially how they can help reduce overall HCAI's.
- Implementation of five key *C.difficile* related screensavers.
- Communication with Trusts from Salford, Bolton, Leicester, Coventry and Cambridge – where they have shared their action plans and successes regarding reducing *C.difficile*. A number of actions will be discussed and agreed at the infection prevention action group on 21st August 2014.

Performance monitoring

- The Trust has received the draft report following Professor Wilcox second review on 21st July 2014.
- Implementation of the clinical matron weekly HCAI monitoring checklist to provide evidence of the monitoring of routine HCAI related activity.

The following actions are planned for August 2014

The *C.difficile* action plan has been updated following Professor Mark Wilcox's report.

Cleaning

- Implementation of HPV business case to provide robust and timely terminal cleaning facilities at JCUH and FHN sites.

Communication

- Reinforcement of the use the weekly newsletter - to cascade key lessons learnt and information relating to *C.difficile* at every staff handovers, display copies in staff rooms, share at staff meetings and key groups.
- Prepare *C.difficile* media campaign for September 2014 launch.

Performance Monitoring

- Key recommendations from Professor Wilcox's second review are being incorporated into the *C.difficile* action plan.
- Monthly *C.difficile* performance reporting to Monitor to continue.
- Further Trust visits / communication planned for August / September 2014.

1.4 Surveillance for other healthcare-associated infections

	Total for 13/14	July 2014	Total 14/15
Bacteraemia due to glycopeptide-resistant enterococci	6	0	2
Bacteraemia due to *E. coli*	334	36	133
ESBL producing coliform infections	960	92	361
• sample taken in community	591	60	232
• sample taken in our trust	369	32	129
• bacteraemias	17	4	11
Other alert organisms	1	0	0

2. OUTBREAKS

Diarrhoea & vomiting outbreaks	Annual total 13/14	Aug 13	Sep 13	Oct 13	Nov 13	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	July 14	Total 13/14 to date
Total number	2	0	0	0	0	1	1	0	0	0	0	0	0	0
Total number of patients affected	43	0	0	0	0	29	14	0	0	0	0	0	0	0
Total number of staff affected	8	0	0	0	0	3	5	0	0	0	0	0	0	0

There was also a cluster of cases of MRSA infection and colonisation among post-partum women. We have had 6 cases in total and strain-typing indicates that three of them are linked. Two incident meetings have been held and an action plan implemented. We will ensure that appropriate measures are put in place to prevent a recurrence of this incident and to ensure there is no on-going risk to patients. The case has highlighted the need for staff with skin breaks on the hands to seek prompt occupational health advice.

3. EBOLA VIRUS

There is currently an outbreak of Ebola virus disease in West Africa. It is a serious disease, usually fatal, of which there are no licensed vaccines or treatments. But for people living in countries outside Africa, it remains a very low threat. Ebola was first identified in Africa in the mid-1970s but by 2014 it had killed more than 1,000 people across Guinea, Liberia, Sierra Leone and Nigeria. There have been no cases of Ebola in the UK, and experts studying the virus believe it is very unlikely the disease would spread within the UK even if it arrived in the country.

The trust has already got a detailed policy on infection control for viral haemorrhagic fever including Ebola. Professor Richard Bellamy, infection control doctor has reviewed the patient flow pathways if we were to get a case and has participated in regional teleconferences. Revised national guidance has been widely circulated to doctors in the Trust. We need to ensure:

- There are adequate PPE supplies including FFP3 masks in A&E, acute assessment units and ward 3 at JCUH and A&E, CDU and ITU at FHN.
- Staff working in the above areas need fit-testing for FFP3 masks.

A paper is to be presented at the infection prevention action group on 21st August 2014 to agree the procurement of a new range of FFP3 masks and fit testing programme.

4. RECOMMENDATIONS

All centres to continue to support and engage completely with all measures to reduce healthcare-associated infections.

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August 2014