TO: **Gloucestershire Partnership NHS Foundation Trust Board**

FROM: **Hazel Watson, Director of Nursing, Social Care and Allied Health Professionals**
Co-authored with Philippa Moore, Director of Infection Prevention and Control

DATE: **26th November 2007**

SUBJECT: **INFECTION CONTROL, INTERIM REPORT 2007/2008**

1. PURPOSE OF REPORT

1.1 To update the Board on the Infection prevention and control measures in the Trust.

1.2 To bring the attention of the Board to a letter from the Chief Nursing Officer and Director General of the NHS regarding 'Improving Cleanliness and Infection Control'.

2. RECOMMENDATIONS

2.1 It is recommended that the Board notes the report.

3. LINKS TO TRUST OBJECTIVES

3.1 The Code of practice for Infection Prevention and Control forms part of the Health Act 2006, placing a legal obligation upon compliance. Compliance with the guidance features on the Trust's Risk Register.

4. STANDARDS FOR BETTER HEALTH

4.1 Compliance is monitored as part of Standards for Better Health.

5. FINANCIAL IMPLICATIONS

5.1 Part of the Director of Infection Prevention and Control (DIPC) function requires microbiological expertise. The Trust currently funds 0.75 sessions from Dr Philippa Moore to discharge that element of the DIPC role on behalf of the Trust. Given the requirements of the Health Act, this needs to be increased by half a session to 1.25 sessions. This will be negotiated as part of the SLA with the PCT for the Infection Control 'service'.

6. RISK MANAGEMENT

6.1 This paper describes how the risks of non-compliance with the code are being managed.

7. EQUALITY ISSUES

7.1 There are no equality issues associated with this paper.

8. CONSULTATION

8.1 N/A

9. AUDIT/REVIEW

9.1 Infection Control is subject to audit. The Infection Team audit services to ensure compliance. The DIPC also audits the organisation against the requirements of the Health Act.

10. BACKGROUND

10.1 Gloucestershire has a county-wide approach to Infection Control. The County-wide group monitors compliance with the Health Act as a health and social care community. GPFT has an Infection Control Committee, constituted as a sub-committee of Practice Standards Committee.

10.2 The DIPC is required to report on the incidences of Clostridium Difficile and MRSA.

11. DISCUSSION

Clostridium Difficile

11.1 Introduction

Clostridium difficile (hereafter C. difficile) is the primary cause of antibiotic associated diarrhoea, a healthcare associated infection that has been rising in incidence. It is more common than MRSA bacteraemia, and causes more deaths in acute trust hospitals. Issues around controlling this disease have been highlighted by two Healthcare Commission reports into outbreaks at Stoke Mandeville Hospital, and more recently Maidstone and Tunbridge Wells hospitals. (For more information on C. difficile, the organism and its associated disease, see appendix 1).

11.2 Surveillance for C. difficile

11.2.1 <u>The national picture</u>

Voluntary reporting showed a national increase in C. difficile from 2000 to 2006 from 15,081 to 42,901. Mandatory surveillance for C. difficile began in January 2004, adding 30% extra to the numbers culminating in a national 55,620 cases in 2006. Seasonal variation is noted with higher numbers of cases in the first quarter of each year.

Surveillance has been for diarrhoeal specimens from inpatients and outpatients over 65 years old, not repeated within a 28 day period. Rates were calculated as a sum of all cases divided by a denominator figure of acute trust bed days occupied.

11.2.2 Gloucestershire cases

11.2.3 Countywide data

From the start of mandatory reporting, Gloucestershire had high rates of C. difficile compared to the national average:

Rate >65 yrs per 1000 bed days	Jan – Dec 2004	Jan – Dec 2005	Jan – Dec 2006
National average large acute trust	1.90	2.18	2.34
GHNHSFT (includes all cases in the county)	2.82	3.97	3.91
GHNHSFT case numbers >65yrs	763	1073	1058

There is an ambitious countywide target to reduce cases among inpatients by 40% during the financial year 07/08.

11.2.4 Gloucestershire Partnership Trust (GPT) data

Since April 2007, there have been 3 patients diagnosed with C. difficile in GPT. 2 of these had had prior GHNHSFT admissions and also had MRSA. One of these two had previously been diagnosed with C. difficile in GHNHSFT. The 3rd patient had had no prior GHNHSFT or community hospital admissions and developed C. difficile diarrhoea 27 days post GPT admission. This patient had received antibiotics during their GPT inpatient prior to onset of CDAD.

12. MRSA

12.1 Introduction

MRSA (Meticillin Resistant Staphylococcus aureus) is the antibiotic resistant form of a commonly carried bacterium (Staphylococcus aureus). 30-50% of the population may carry S. aureus in their nose, but only 1-2% carry MRSA. Most carriage does not lead to infection, however the bacteria may gain access to normally sterile sites in vulnerable patients and cause infection. The most serious of these infections is bacteraemia (blood stream infection) but bacteraemias only comprise < 1% of all MRSA colonisations and infections. There is national mandatory surveillance of MRSA bacteraemias.

12.2 Surveillance of MRSA bacteraemias

12.2.1 The national picture

Since 2001 the national trend in MRSA bacteraemias has been progressively upward until 06/07 when practice changes implemented in trusts have started to have an effect in reducing the numbers of bacteraemias. For the last 5 quarters, the numbers of bacteraemias nationally have been falling.

12.2.2 Gloucestershire cases

12.2.3 Countywide data

The numbers of cases of MRSA bacteraemia reported by national mandatory surveillance have been increasing since 2001 reaching 1.69 per 10,000 bed days in 06/07 corresponding to 68 cases. Since April 2007, the numbers of cases have reduced markedly with 24 cases in the first 6 months of this year.

12.2.4 Gloucestershire Partnership Trust data

Since the last infection control report for the last financial year, there have been 0 MRSA bacteraemias in GPT.

12.3 MRSA carriage and infection other than bacteraemia

12.3.1 National context

There is no national surveillance of MRSA carriage or infection other than bacteraemia and GPT does not operate a policy of screening all patients for MRSA. Patients previously known to have MRSA may be rescreened. There is a national recommendation for screening all emergency and elective admissions to acute trusts that will be implemented in GHNHSFT and GPCT this financial year. GPT needs to consider routine screening on high risk inpatient areas; this assessment will be undertaken by the Infection Control Committee once the GHNHSFT laboratories have the capacity to process an increased number of specimens.

12.3.2 GPT MRSA carriage/infection other than bacteraemia

There have been 4 new diagnoses of MRSA carriage within GPT since April 2007. The patients were aged between 31 and 81 years. 3 samples were from clinically inflamed legs/feet indicating a superficial infection may have been present and one sample was from an MRSA screen in the absence of known infection. Of interest 3/4 patients were from the west side of the county, all with ciprofloxacin sensitive MRSA isolates; these are often associated with non acute trust acquisition and normally account for 1-2% of all MRSA isolates. 2 of these patients had never had a previous admission to GHNHSFT or a community hospital, one had had a 5-day admission to GHNHSFT prior to transfer to GPT. The 4th patient from the east of the county probably acquired her MRSA during a prolonged GHNHSFT admission prior to her transfer to GPT. The 3 patients from

the west side of the county had their MRSA diagnosed 6, 12 and 56 days after GPT admission respectively. These data cannot exclude the possibility of MRSA cross infection occurring in association with GPT.

Of note, these data are for new MRSA diagnoses. They do not include patients previously known to have MRSA that are transferred in to GPT.

13. OUTBREAKS AND INCIDENTS

Since April 2007 there have been no outbreaks of infectious disease within GPT. No incidents due to issues of infection prevention and control have been reported to the Infection Control Team (ICT) during this time period. The ICT provided advice in relation to Gloucestershire floods.

14. ESTATES AND INFECTION CONTROL

The board was made aware earlier this year of the lack of controls assurance around prevention of legionellosis. The Estates service is required to put in place a programme of controls assurance according to the standards set out in HTM 04-01. An initial risk assessment of high risk (inpatient) areas was undertaken. It was identified that there will be work to ensure that the time temperature parameters are within specification for the supply of hot and cold water in order to prevent the occurrence of conditions favourable to Legionella growth. There were delays due to the Gloucestershire floods but now the full risk assessment for the county has been put out to tender this week. Overall there is slow but steady progress with this work. A county wide group to monitor Water, Environment and Buildings (WEB) issues has been started with GPT representation included.

15. INFECTION PREVENTION AND CONTROL TEAM

Since April 07, Dr Philippa Moore has taken up the position of Director of Infection Prevention and Control, shared with Hazel Watson, in order to comply with all requirements of the DIPC role. A new senior nurse lead for the infection control team has been recruited, Sam Lonnen, who started on June 28th. We also have a new secretary, Carolyn Meddings who started October 15th. We are recruiting for our third ICN post as Lesley Chandler accepted a promotion to senior infection control nurse at GHNHSFT.

16. HEALTHCARE COMMISSION REPORT STOKE MANDEVILLE AND MAIDSTONE AND TUNBRIDGE WELLS HOSPITALS

Common themes were found at both the hospitals investigated around:
the role of the board, strategic priorities and leadership, risk and governance systems, appointment to the DIPC position, relations of the infection control team with the trust management systems, policies and training, infection practice and procedure, levels of nursing staff employed, environmental cleaning including equipment, antibiotic prescribing, clinical care of patients, bed occupancy and patient movement, and information provided to the public. Expected standards are set out in the Health Act 2006: Code of Practice for the prevention and

control and of Healthcare Associated Infections (HCAI). GPT is ensuring these standards are met via the work coordinated by the Infection Control Committee.

17. LETTER FROM CHIEF NURSING OFFICER AND DIRECTOR GENERAL OF NHS 'IMPROVING CLEANLINESS AND INFECTION CONTROL'

Letter attached at appendix 2.

Increasing number of Matrons. Philippa's advice is that this requirement of Acute Hospitals will not apply to Mental Health Trusts. The recent management restructure has ensured that our inpatient services – Adult, Older Adult, and Learning Disability – now have full-time Matron Managers responsible for services.

Reporting on Cleanliness. This will be reported to the Board quarterly.

Practice requirements of the letter will be discussed at the Infection Control Committee on 21st November.

18. CONCLUSIONS

GPT still has more work to do in order to meet the standards of the Health Act, but this work has been identified. The numbers of patients affected by MRSA or C. difficile are relatively low in GPT. There are however known patients affected by both organisms and it is therefore necessary to remain vigilant, and to promote high standards of infection control practice and procedure. The work of the Estates department needs to be closely monitored to ensure timely progress. Systems within the organisation have been set up that should address all issues.