Bolton NHS
Primary Care Trust

Infection Control Annual Report 2007-8

COMMUNITY INFECTION CONTROL TEAM
Helen Clarke-Assistant Director of Nursing/DIPC
Kath Gough - Community Infection Control Nurse Specialist (CICNS)
Julie O'Malley Community Infection Control Nurse
Melanie Foy-Administrative Assistant

February 2008

CONTENTS

Section		Page
1	Purpose & Introduction	3
2	Management Arrangements and Clinical Leadership	3
3	Application of Evidence-Based Protocols	5
4	Design and Maintenance of the Environment and Medical Devices	8
5	Inspection, Audit and Surveillance	9
6	Education and Training	15
7	Working with Partner Agencies	17
8	Communicable Diseases	18
9	Looking Forward	19

INTRODUCTION

The Code of Practice for the Prevention and Control of Healthcare Associated Infection became law on 1st October 2006. This Code states that the systems within NHS organizations for the prevention and control of HCAI should address:

- Management arrangements to include access to accredited microbiology services
- Clinical leadership
- Application of evidence-based protocols and practices for both patients and staff
- The design and maintenance of the environment and medical devices
- Education, information and communication

The interim findings from the current review of the NHS being undertaken by Lord Darzi have indicated that the prevention, management and control of Healthcare Associated Infections remains one of the top priorities for the NHS and one of the greatest concerns that patients identify concerning NHS care and treatment.

This report aims to:

- Summarise the work of the Community Infection Control Team in supporting the prevention, management and control of infection within community services and settings
- Summarise the work undertaken in partnership with the Acute Trust Infection Control Team in the prevention, management and control of infection within hospital settings
- Highlight key issues that will inform the work programme for 2008/9

2.MANAGEMENT ARRANGEMENTS AND CLINICAL LEADERSHIP

Responsibility for the delivery and implementation of the DH's Infection Control agenda in the community lies with the PCT within normal working hours.
This responsibility includes the delivery of expert advice, support and training to:

- PCT staff
- Independent Contractors (GPs and GDPs)
- Care Homes
- Local Authority
- Other stakeholders within the PCT boundary.

The above responsibilities transfer to the Greater Manchester Health Protection Unit in the Out-of-Hours period.

The Commissioning Arm of the PCT has a performance monitoring role with all its Providers in relation to Infection Control. This is undertaken by setting and monitoring standards and targets within contracts and Service Level Agreements.
The North West SHA, in turn, has a performance monitoring role in relation to the PCT's effectiveness in achieving its Infection Control targets and standards.

The role of DIPC (Director of Infection Prevention and Control) was transferred from the Director of Public Health within the Commissioning Arm of the PCT to the Assistant Director of Nursing within the Provider Arm in April 2007. This has rightly embedded Infection Control leadership close to clinical practice, strengthening the accountability from front line practitioners directly up to the Board.

The role of the DIPC is to:

- Be responsible for the Infection Control team within the healthcare organization
- Oversee local control of infection policies and their implementation
- Report directly to the Chief Executive (not through any other officer) and the Board
- Have the authority to challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions
- Assess the impact of all existing and new policies on HCAI 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 HCAI in the organizations for which he or she is responsible and release it publicly

.

The Infection Control Team

The Community Infection Control Team is based within the Provider Arm of the PCT, under the line management of the Assistant Director of Nursing and in accordance with a Service Level Agreement with the Commissioning Arm.
The two Community Infection Control Specialist Nurses (CICNS) are based at Great Lever Health Centre.
Medical advice is provided by the Consultant Microbiologist (RBH) and Consultant in Health Protection from the Greater Manchester HPU.
The Royal Bolton Hospital has its own Infection Control Team, within the Diagnostics and Therapies Division and with clinical leadership provided by the Consultant Microbiologists and the Nurse Consultant in Infection Control.
It is hoped to appoint a second microbiologist within the next financial year.
Increasingly, the two Infection Control teams are working as one to address the Infection Control issues across the health economy.

Infection Control Committee

The PCT Infection Control Committee (ICC) draws members from all key service areas within the PCT as well as outside agencies, e.g. Environmental Health from Bolton Council, Occupational Health service from the Royal Bolton Hospital Trust and the Greater Manchester Health Protection Unit. The Clinical Nurse Manager for Bolton Hospice has recently become a member of the Committee.

The PCT Infection Control Committee meets quarterly to oversee the work programme for Infection Control, engaging all clinical services and departments.
All infection control policies are developed, reviewed and updated by this Committee.

The ICC receives regular updates on the following:

- Position of infection control within the PCT.
- Data on MRSA / other health care acquired infection in the PCT and commissioned services
- Progress of training provision within the PCT
- Health Care Commission Standards in Infection Control & Decontamination
- Incidents/Outbreaks
- Poor/exemplary practice
- Matters of concern
- Policy reviews and development
- National guidance / recommendations
- Surveillance
- Procurement issues
- Estates Developments

3. APPLICATION OF EVIDENCE-BASED PROTOCOLS

The following guidance has been received, discussed, disseminated and implemented where applicable via the Community Infection Control Committee in 2007/8:-

PL/CMO/2007/8 Health Care Associated Infections and Death Certification -this reinforced the message that death certification is a significant responsibility for doctors and doctors were asked to ensure that the entries in certificates reflect their best assessment of the causes of death and other contributory factors, in particular when a patient has had a HCAI during their terminal illness.

PL/CNO/2007/7 National Confidential Study of Deaths Following MRSA Infection-key findings were that :-
Most patients had significant co-morbidities and had short life expectancies irrespective of their infection
The most frequently identified source of MRSA bacteraemia was via invasive devices, particularly peripheral and central venous cannula
Deficiencies in the documentation of insertion, ongoing review and management of invasive devices were found
For cases identified on the basis of MRSA on the death certificate, MRSA was not considered an important factor by the expert panel for half of these patients
For cases identified on the basis of MRSA bacteraemia, MRSA or sepsis was not mentioned on over a third of the death certificates, when it was considered

by the expert panel to have played a role in the patient's death
Trust auditing of deaths associated with HCAIs was limited
Only half the Trusts were auditing compliance with policies regarding invasive procedures
Compliance with screening practices within the Trusts reviewed did not appear to be sufficiently comprehensive

Advice for dentists on the re-use of endodontic instruments and variant Creutzfeldt-Jacob Disease (vCJD)
This document advised dentists to ensure that:
Endodontic reamers and files are treated as single use
The highest standards of decontamination are observed for all dental instruments
Manufacturers' decontamination instructions are followed for all instruments, and where instruments are difficult to clean, single use instruments should be used wherever possible

2007 Clarification and Policy Summary-Decontamination of Re-usable Medical Devices in the Primary, Secondary and Tertiary Care Sectors (NHS and Independent Providers)
This document summarized the duty of care 'to provide a safe decontamination service that generates a clean and sterile product and is embedded as part of the Service culture in support of successful clinical outcomes and the associated wellbeing of patients and staff.'
It acknowledged the fact that previous decontamination guidance had primarily focused on the acute sector, where risks were perceived to be highest. This document aimed to reinforce the message that decontamination is an issue for all health care settings and recommended that all organizations develop plans to move progressively towards compliance with standards.

Hospital organization, specialty mix and MRSA
This report examined the factors behind the variation in MRSA rates between different hospitals. The aim of the paper was to understand contribution of organizational factors that can help to explain the variations and how these relationships have changed over time. The most important variables considered were bed occupancy, hospital cleanliness and the use of temporary nursing staff. These factors were found to be less related to MRSA rates then previously.

Clean Safe Care-Reducing Infections and Saving Lives (DoH)
This document was published in January and will provide the basis for much of the Infection Control work programme for 2008/9. Further details are found at the end of this report.

Uniforms and Workwear-An evidence base for developing local policy (DoH)
This document assembled the evidence base on the wearing and laundering of uniforms and outlined the existing legal requirements to support and advise employers when reviewing local policies in this area

'Essential Steps to Safe Clean Care'
This guidance was initially published on 15th June 2006 and has since been updated. It comprises a delivery programme to reduce healthcare associated infection outside the acute hospital setting. It contains a set of best practice tools and techniques, relating to :

- Preventing the spread of infection by means of hand hygiene, use of personal protective equipment, use of aseptic technique and safe disposal of sharps
- Urinary catheter care
- Enteral feeding

This package has been widely disseminated throughout the PCT and presented and discussed in all relevant professional meetings.
Staff have been encouraged to use the review tools and to undertake observations of care processes and score whether all risk elements have been performed.
Certificates of competence are provided in the packs and can be used as evidence to support competency achievement.
This can be linked to the Agenda for Change Knowledge and Skills Framework Portfolio development.
The package has also been distributed to all nursing and residential homes in Bolton.

Policy Development and Review
The following policies have been developed/reviewed by the Infection Control team and approved by the Infection Control Committee in 2007/8:-

- MRSA in the Community (updated)
- Hand Hygiene (updated)
- Cleaning Schedules (new policy and SOPs)
- Isolation and Bed Closure Policy (Intermediate Care)
- Waste Management Policy (complete revision)
- Blood Borne Virus Protocol (new policy)
- Managing Clostridium Difficile (updated)
- Spillage Policy
- Uniform Policy (undergoing consultation)
- ESBL (Extended Spectrum Beta-Lactamase) Policy
- Infection Control-new and Refurbished Buildings Guidance
- Standard (Universal) Infection Control Precautions in Primary and Community Care

These are all available on the PCT website.
Development and dissemination of policies is only the first step to implementation. The Infection Control Team work with a network of Clinical Leads within services; these Clinical Leads are responsible for ensuring that all relevant staff receive an induction programme which ensures they are aware of, and understand their individual responsibilities in relation to, infection control.

4.THE DESIGN AND MAINTENANCE OF THE ENVIRONMENT AND MEDICAL DEVICES

Advice on Buildings and New Service
Research and investigation have consistently confirmed that the healthcare environment is a secondary reservoir for organisms with the potential to infect patients.
Infection Control is 'designed in' at the planning stage of all health care facility new builds or refurbishments.
The Infection Control team has been fully involved and consulted in the following new builds and refurbishments:

PFI Build-Waters Meeting and Crompton Healthcare Facilities
In the new buildings 'state of the art' decontamination facilities have been installed to ensure patient safety and comfort and to provide an environment for staff that is practical and aesthetically pleasing.

LIFT Project-Breightmet-Eric Wright and all further projects that are under consultation

Renovation/refurbishment at Tonge Moor HC, Great Lever HC, Westhoughton DN Treatment Room and Lever Chambers: 3 new dirty/specimen facilities.
Tonge Moor has now a facility to decontaminate re-usable equipment for Dental and Podiatry Services.
New sinks and appropriate ventilation systems have been installed at the Walk-in Centre to comply with national guidelines
At Lever Chambers Dental Department a project is under way to provide the service with a facility to decontaminate re-usable equipment that complies with national recommendations.

Renovations at Darley Court: All patient rooms have had carpets removed and replaced with non-slip vinyl material. Improvements have also been made to the treatment room.
Further work is ongoing to replace all sinks in patient rooms, upgrade bathrooms, improve dirty utility rooms and storage facilities.

PCT-Wide: There is an ongoing programme of work to replace all sinks in clinical areas with ones that comply with HTM64, elbow-operated taps and thermostatically controlled valves, and to replace all carpets in clinical areas with non-slip vinyl.

New Sexual Health Clinic in Leigh and the refurbishment of older facilities in the Wigan Sexual Health and Family Planning Services

5. INSPECTION , AUDIT AND SURVEILLANCE

Hand Hygiene Audit
An extensive Hand Hygiene Audit was undertaken encompassing most of the PCT Provider Services.
The audit looked at organizational systems such as availability and awareness of policies, compliance with handwashing techniques, availability and quality of handwashing facilities and products.
The audit has been used to inform the planned programme of replacement and upgrading of sinks and to raise staff awareness of the uniform policy in areas such as the wearing of jewellery, nail extensions and varnish.
Extensive audit feedback has been provided both individually to departments and formally to the Infection Control Committee and services are being encouraged to re-audit and measure improvement.

Environmental Cleaning Audit
An environmental cleaning audit has been undertaken in partnership with the Caretaker and Domestic Team Leaders. Following this audit, cleaning schedules and Standard Operating Procedures were developed and approved by the Infection Control Committee to clarify the responsibilities for cleaning.

A **Glove Choice and Usage audit** is currently under way to provide assurance on compliance with the policy for glove usage.

A **sharps audit** is performed on an annual basis as part of the contract for the supply of sharps bins.

Darley Court
A full environmental audit was undertaken at Darley Court. This identified some areas for action which have now been addressed.

PCT Surveillance
The CICN collects and uses data on a range of key indicators of infection control compliance. These are:

- Alert organisms
- Outbreak reports
- Education and training

Alert organisms-a full range of alert organisms continue to be monitored within the community.
The following tables denote the number of cases of infection for MRSA, ESBL and CDT from January to December 2007:

MRSA January 2007- December 2007

Intermediate Care		Community		Nursing/ Residential Homes	
INF	Col	INF	Col	INF	Col
12	4	66	18	20	8

ESBL January 2007- December 2007		
Intermediate Care	**Community**	**Nursing/ Residential Homes**
5	53	18

CDT January 2007- December 2007		
Intermediate Care	**Community**	**Nursing/ Residential Homes**
19	15	2

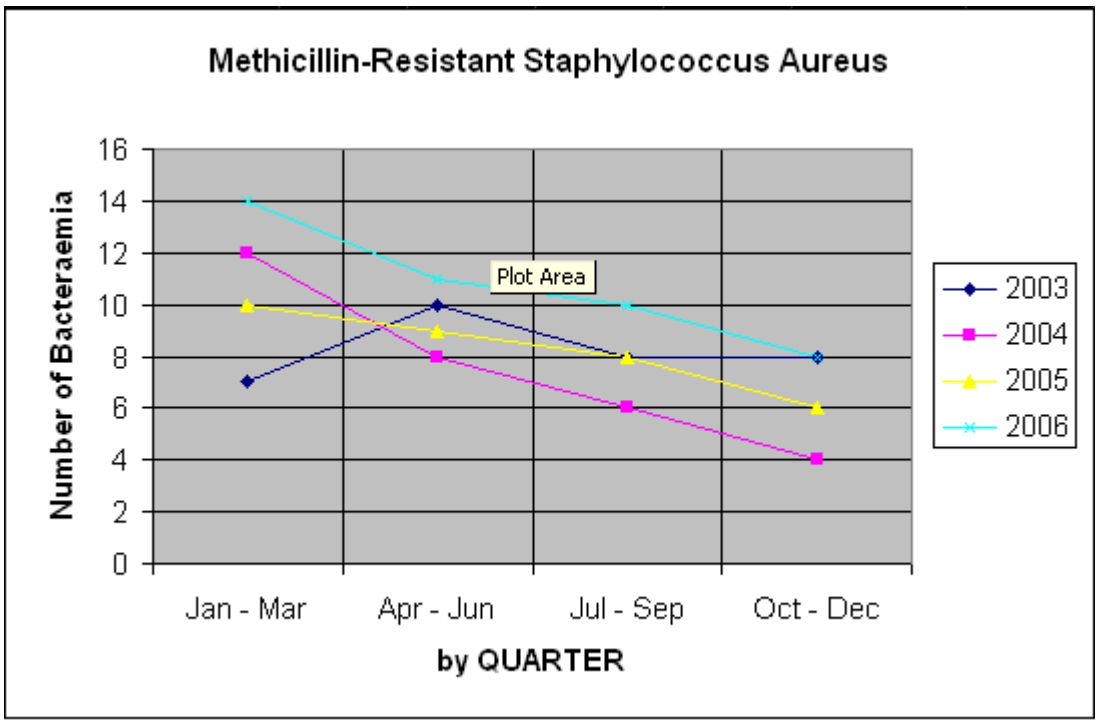
N.B. INF= Infection Col=colonization

Acute Trust Inspection and Surveillance

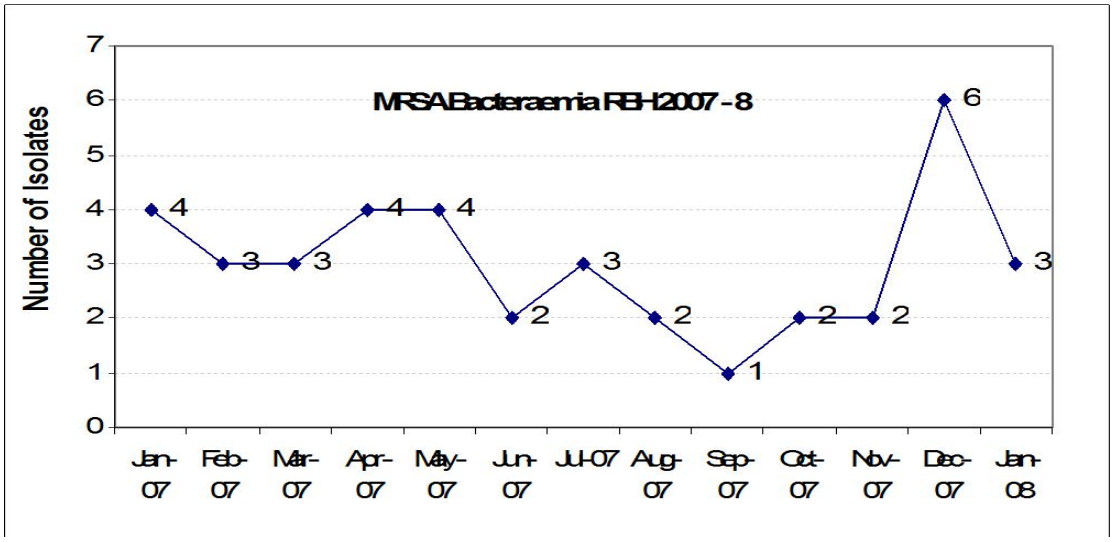
Within the Royal Bolton Hospital, The Director of Infection Prevention and Control role sits with the Director of Nursing and Performance.
The hospital has its own Infection Control Committee and a more operational 'Winning Ways' group, chaired by the Head of Clinical Practice. This meeting is attended by all the Divisional Matrons who have specific responsibilities for ensuring that care is delivered in a clean and safe environment.
The PCT DIPC has recently started to attend the Winning Ways meeting to ensure that work is co-ordinated across the health economy.

Since 2001, All NHS District General Hospitals have been part of a mandatory surveillance system for MRSA (Methicillin Resistant Staphylococcus Aureus) bacteraemia (bloodstream infection).
All Acute Trusts have been instructed to aim for a 50% reduction in MRSA bacteraemia by 2008 (compared with rates in 2003/4.)
The following table shows the number of MRSA cases from 2003-2006

MRSA Bacteraemia	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Annual Totals
2003	7	10	8	8	33
2004	12	8	6	4	30
2005	10	9	8	6	33
2006	14	11	10	8	43



The table below shows the number of cases of MRSA bacteraemia in 2007:-



Root Cause Analysis has been undertaken for every case of MRSA bacteraemia since the autumn of 2006.
The Root Cause Analysis requires a joint investigation to be undertaken by the Acute and Community Provider Infection Control Teams.
MRSA Bacteraemias have to be reported as Serious Untoward Incidents and infections which develop within 48 hours of admission to secondary care are reported separately to those which develop after 48 hours.
The rationale for this is that an infection which develop within 48 hours is often a 'community-acquired infection'. This can mean simply that the patient was colonised with MRSA prior to admission, and that an invasive procedure such as a catheterization or insertion of an intravenous line has provided a port of entry for the bacteria into the bloodstream.
The Root Cause Analysis attempts to discover the most likely port of entry for infection.
Examination of all the Root Cause Analysis reports from April to December 2007 has identified some themes:
22 out of 26 bacteraemias were medical patients, a further two were in augmented care and two were in surgery.
17 cases occurred over 48 hours after admission, 9 cases occurred within the first 48 hours of admission.

Department of Health Support Team Visit to RBH
A visit from the National Support Team for HCAI took place in July 2007. The top 3 priorities identified for further action from this visit were:

- To increase use of and compliance with High Impact Interventions
- To raise the profile of, and provide further training in, Root Cause Analysis.
- To clarify the responsibilities of Link Nurses for Infection Control within the Divisions

A detailed action plan was developed in response to the visit and progress against the plan has been monitored through reports to the 'Winning Ways' meetings.

National Allocation of Funding for Infection Control
In August 2007 the PCT was successful in a bid to secure a share of the £5 million allocation to improve Infection Control across the health economy.
The funding has been used to install new sinks in both the hospital and in community premises.
Funding was also granted to support the secondment of a band 6 post to promote the use of High Impact Interventions across the health economy, together with an audit post. These posts are currently going through the recruitment process.

Deep Clean and Matrons
In November 2007, it was announced that there were to be 5000 more Matrons nationally by May 2008 and that a Deep Clean programme was to take place before the end of March.
The Bolton health economy Matron target is to increase the number of Matrons from 16 to 21. The expectation was that these Matrons would be at the Acute Trust.
The role of the Matron is to:

- Provide a clean environment for care
- Ensure best practice in Infection Control
- Improve clinical care standards and treat patients with dignity and respect

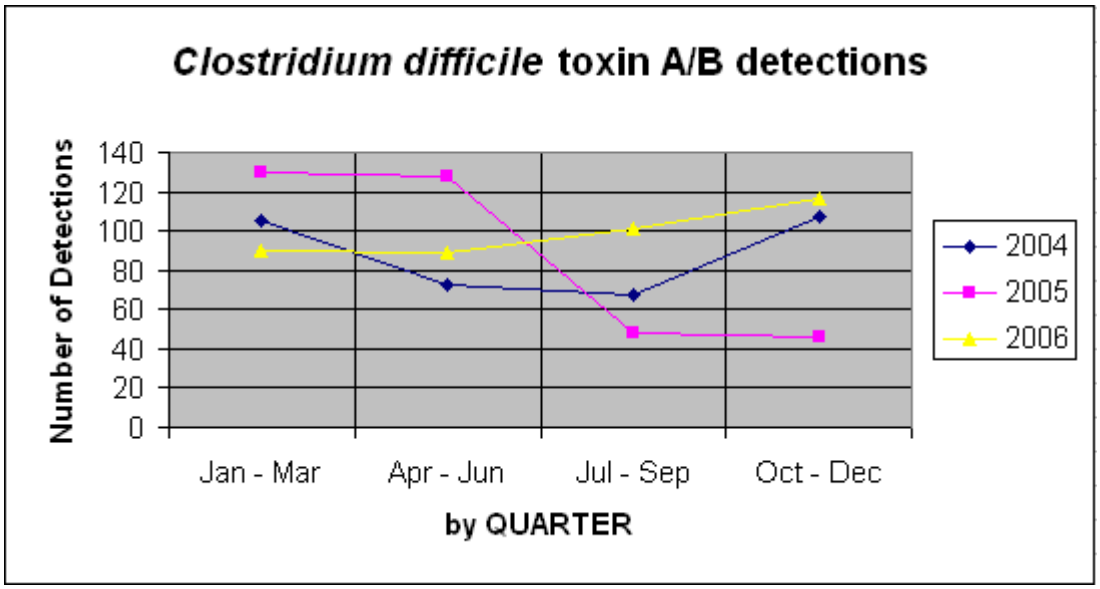
It was agreed that the PCT could contribute three Matrons towards this target, by appointing two Matrons for Darley Court Intermediate Care Resource Centre and a further one in the Bolton Community Unit.
At the Acute Trust, two further Matron posts have been created, one Theatre Manager and one in the Medical Division.
With regard to the Deep Clean Initiative, the view of the Acute Trust was that there was already a schedule for daily, weekly and periodic cleans. However, there were some issues surrounding backlog maintenance and replacement of equipment, fixtures and fittings.
The PCT has therefore allocated funding for the maintenance of bathrooms, toilets and shower areas, replacement floor coverings and for the purchase and installation of audible warning devices designed to remind people to wash their

hands.

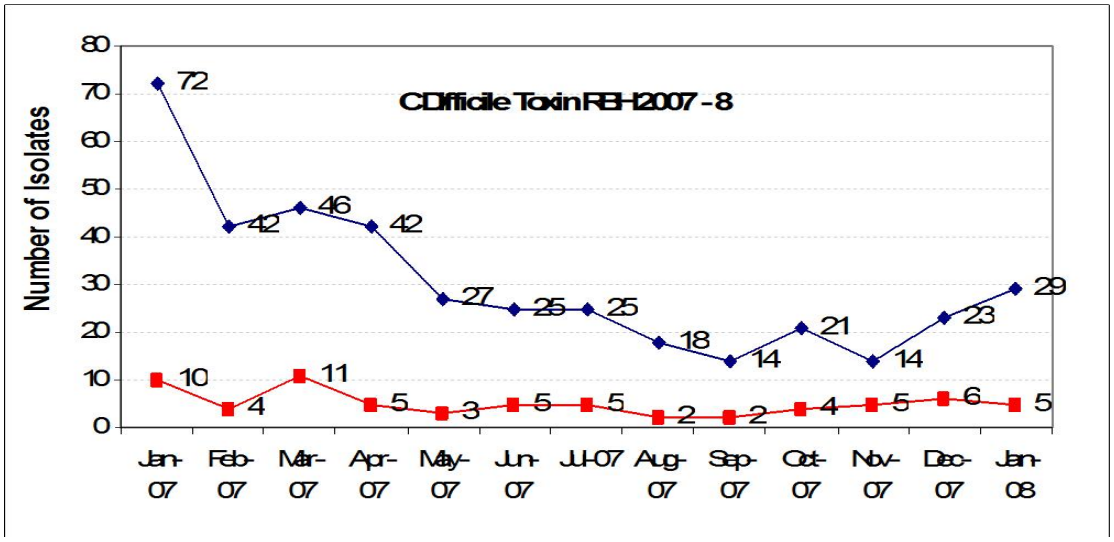
Clostridium Difficile

The second bacteria which is causing concern both nationally and in Bolton is Clostridium Difficile. This has been subject to mandatory surveillance in the over-65s since January 2004. From 2007, the requirement to undertake surveillance for all patients over the age of 2 years was introduced.
The PCT set a target of a 20% reduction in the number of cases of Clostridium Difficile at the Acute Trust in 2007/8.
This target is set to be overachieved.
All in-patients over the age of 2 years with diarrhoea have had samples tested for Clostridium Difficile.
This organism is naturally present in the bacterial flora of many people but can become pathogenic in the presence of certain antibiotics.
Once a patient has become infected by Clostridium Difficile they become a potential source of infection to other patients.
It is therefore important to minimize the prescribing of the relevant antibiotics by ensuring adherence to the antibiotic prescribing policy.
The other aspect of care that is crucial in management is handwashing, use of personal protective equipment and cleaning of the environment of care.
The number of Clostridium cases for the years 2004-6 is shown in the table below

Clostridium difficile toxin A/B detection	2003	2004	2005	2006
Jan - Mar		105	130	90
Apr - Jun		73	128	89
Jul - Sep		67	48	101
Oct - Dec		107	46	116
Annual Totals	**NA**	**352**	**352**	**396**



The chart below show the numbers of infections for 2007. It must be noted that figures prior to November relate to over-65s only. From November onwards, all patients over the age of 2 have been included in the figures.



6. EDUCATION AND TRAINING

All new starters in the PCT attend a basic awareness session on infection control.
For clinical staff, further departmental-specific induction is provided.
The Infection Control Nurse continues to provide induction training on a monthly basis to staff from the local authority, with 20-25 attendees every month.
Many education and training sessions have been provided on site within clinical departments, in particular within Intermediate Care. This training has been provided for both health and social care staff.

The appointment of a second Community Infection Control Nurse in March 2007 has enabled the PCT to deliver a much more comprehensive programme of education in the community.

25 Care Homes have been visited to date, with more visits planned. These visits have raised awareness of the Code of Practice for the Prevention and Control of HCAI and the Essential Steps to Safe Clean Care. Following the visits, the Care Homes have contacted the Infection Control team for advice and support on many occasions. This demonstrates the higher profile the Infection Control team has developed within the Care Homes, which previously would have tended to contact the team solely for outbreak

management advice.

Updates on Infection Control have been provided to the following internal and external committees and groups:-

- Practice Managers meeting
- Clinical Governance Committee
- Overview and Scrutiny Committee
- Primary Care Clinical Governance Forum Meetings
- Service Provision Operational Meetings

A full programme of CPD for dentists has been commissioned by the Clinical Governance Directorate. This included significant infection control content which was approved by the PCT Infection Control Team prior to delivery.
The programme was delivered to 25 practices initially, with roll-out to all other practices planned.
The educational aims and objectives were:

- To provide a clear understanding of the reasons for implementing effective infection control procedures
- To provide knowledge of the micro-organisms which may be transferred through dental procedures
- To introduce the legislative aspects which relate to infection control in the dental environment
- To provide a detailed explanation of the practices and procedures for implementing effective infection control as recommended in the British Dental Association Advice Sheet-A12-Infection Control in Dentistry'

.

7. WORKING WITH PARTNER AGENCIES

Greater Manchester Health Protection Unit
The Greater Manchester Health Protection Unit (GMHPU) on behalf of the PCT undertakes surveillance, prevention and control of communicable disease in the community.
There is an excellent working arrangement with the health protection staff and Consultants in Health Protection at the GMHPU with frequent contacts, exchanges of views, advice, shared approaches.The CICNS is a member of North West Community Infection Control Group chaired by members of the GMPHU, where there is a good working relationship and the sharing of best practice.

Bolton Environmental Health Department

There is a history of good working relationships with the Food Control Unit within the Environmental Health and Trading Standards Unit in the local authority, as well as the Health and Safety, Pollution and Public Health Units and regular liaison meetings are held to discuss cases and outbreaks of infection.

COMMUNICABLE DISEASES

The number of notifications of infectious diseases reported to Greater Manchester Health Protection Unit between January and December 2007 is shown in the table on the following page.

It should be noted that the number of notifications received do not always accurately reflect the actual number of cases within a PCT area and hence the true burden of disease. For example, it is well known that the number of food poisoning cases formally notified is often an underestimate of the actual number of occurrences.

COMMUNICABLE DISEASES

Disease	Q 1	Q2	Q3	Q4	Total current year	Total previous year
HIB Meningitis	0	0	0	0	0	0
Measles	2	3	5	4	14	18
Meningococcal disease	5	2	0	4	11	21
Mumps	7	4	9	7	27	39
Pneumococcal Meningitis	0	0	0	0	0	1
Rubella	2	1	1	2	6	14
Tetanus	0	0	0	0	0	0
Whooping Cough	1	0	1	1	3	1
Campylobacter	31	65	82	59	237	160
Cholera	0	1	0	0	1	2
Cryptosporidium	8	13	7	10	38	33
E.Coli (o157 and VTEC)	2	1	1	2	6	4
Giardia	1	4	6	0	11	13
Hepatitis A	0	0	1	1	2	1
Listeria	0	0	0	2	2	0
Paratyphoid	0	0	0	0	0	4
Salmonella	6	3	14	3	26	48
Shigella	6	1	1	1	9	5
Suspected food poisoning	1	1	2	2	6	9
Typhoid	0	0	1	0	1	0
Diphtheria	0	0	0	0	0	0
Encephalitis	0	0	0	0	0	0
Hepatitis B	2	0	0	1	3	3
Legionella	0	0	0	0	0	2
Leptospirosis	0	0	0	0	0	0
Malaria	1	0	1	0	2	0
Scarlet Fever	2	4	0	4	10	9
TB	18	9	20	25	72	88

.

The Community Infection Control Team plays an active part in the management of infection outbreaks across the health community.
Throughout the winter period, the Team has contacted each Intermediate Care Unit on a daily basis to identify any new cases of infection and to track the progress of existing cases.
This information is then distributed widely throughout Primary and Secondary care in the form of a daily update, including the bed occupancy and availability situation.
The Team has attended outbreak meetings at the hospital relating to outbreaks of Clostridium Difficile and Norovirus over the winter period.
The Team can advise on the best methods of infection containment and the advisability or otherwise of transferring patients from one care setting to another.
Within Intermediate Care, infection has often been contained to a single corridor, so that other parts of the unit can remain safely open for admissions.

11. LOOKING FORWARD

Safe Clean Care January 2008

The above document states that an investment of £270 million per year by 2010/11 will be made. This additional funding is reflected in the 5.5% increase in PCT allocations and the 2.3% uplift to the national Tariff-the latter specifically recognizing the importance of tackling HCAIs and improving cleanliness. There is an expectation that this funding will be used to employ additional specialist staff such as Infection Control Nurses and antibiotic pharmacists.

Commissioning Contracts with Providers
The Medical Director has been leading a programme of work to develop a set of local quality standards for inclusion in all healthcare contracts for 2008/9.
With regard to ensuring systems are in place to reduce the risk of Health Care Associated Infection, the minimum standard expected of all Providers is compliance with the national Code of Practice for the Prevention and Control of Infection.
The enhanced standard is to demonstrate significant changes in practice as a result of audits, e.g. cleaning schedules, antibiotic prescribing, hand hygiene.

The Operating Framework
The Operating Framework for 2008/9 requires Acute Trusts to maintain the 50% reduction in MRSA bacteraemias from the 2003/4 baseline.
As the Acute Trust did not achieve this target, the trajectory set for 2008/9 is to achieve the 50% reduction, then to improve year on year. The ultimate aim is to eliminate all ‘avoidable’ cases.
Recently the SHA has informed PCTs of the way success in achieving the 50% reduction from 2003/4 will be measured. This will be by comparing the average monthly figure in the quarter ending June 2008 with the average monthly figure in 2003/4. Therefore, it will be crucial to ensure that we have no more than 1

bacteraemia per month from April to June 2008.

For C.Difficile, the Operating Framework target is to achieve a national target of a 30% reduction from an agreed 2007/8 baseline, with local target adjustments to reduce the regional variations in incidence.
Acute Trusts are expected to contribute 62.5% of the national reduction and 37.5% of the reduction is expected to come from community cases.
The numbers are also going to be categorized as Community cases and hospital cases in much the same way as for pre-and post-48 hour MRSA bacteraemias. Community cases will be those cases that are diagnosed on the day of admission or the day after the day of admission.

The Operating Framework also requires the introduction of MRSA Screening for all elective surgical patients by March 2009 and for screening of all emergency admissions by as soon as possible within the next 3 years.

Elective and emergency admissions who meet certain defined criteria are currently screened for MRSA using a routine test which reports in 48 hours.

In addition, a rapid screening test is being trialled within Orthopaedics (G3, G4 and TSU). These tests cost £12-15 per patient and are only available between 9am and 5pm Monday to Friday. The results are available within a few hours.

In January 2007 the microbiology lab processed 3,200 patient MRSA screens (the same number as were screened in a 10 month period last year).

To be able to screen all emergency patients would require investment in both staff and equipment.

Conclusion

The above provides a summary of the ongoing work programme for the prevention and control of infection. Good progress has been made in reducing the number of Clostridium Difficile infections.
Further sustained efforts are required to achieve the MRSA target, which is proving to be so challenging despite the measures put in place to date.