Review of the Year 2013/14
HOW WE DO IT
KEEPING YOU SAFE
The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) recognises that the effective prevention and control of healthcare-associated infections (HCAIs) is essential to patient and staff safety. The overriding principle in our delivery of care is to treat patients to the standard they would expect for their own family or loved ones.

During 2013/2014 the Trust has continued to review infection prevention and control (IPC) services in response to the continuing challenges of reducing rates of Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemiae and Clostridium difficile (C. difficile) and meeting targets, the requirements of the Hygiene Code 2006 (revised Jan 2008), the Healthcare Commission’s report on an investigation at Maidstone and Tunbridge Wells (2007), and Mid Staffordshire (2009). These drivers have been largely superseded by the Health and Social Care Act (2008) published in December 2009, providing focus for the refinement of the IPC strategy. Further guidance has been published by NICE (CG 139 Infection Prevention and Control of healthcare-associated infections in primary and community care) and HPA (epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England); these have been reviewed and where possible/practical are followed.

Ten criteria, which the Trust Board recognise and accept as the Framework for delivery of appropriate safe care, were incorporated in the current HCAI Strategy with associated policies and selected audit to Monitor compliance. The criteria set are:

- To have in place systems to manage and monitor the prevention and control of infection
- To provide and maintain a clean and appropriate environment in managed premises that facilitate the prevention and control of infections
- To provide suitable accurate information on infections to service users and visitors
- To provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion
- To ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people
- To ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection
- To provide or secure adequate isolation facilities
- Secure adequate access to laboratory support as appropriate
- To have and adhere to policies, designed for the individual’s care and provider organisations, that will help to prevent and control infections
- To ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.

HCAI Prevention and Control Strategy

The principal objective of the strategy is to set out the Board level agreement in terms of IPC. It also seeks to provide the Board of Directors with assurance that appropriate structures and processes are in place to minimise the risks of HCAI to patients, staff and visitors. The Nursing & Patient Services Director and Director of Infection Prevention and Control (DIPC) are responsible for the monthly update provided to the Trust Board.

The aims of the strategy are to ensure that:

- Robust HCAI prevention and control has a positive effect on the quality of care, safety and wellbeing of patients, staff, volunteers and visitors, and on the business, performance and reputation of the Trust
- The organisation recognises HCAI prevention and control, and wider infection control issues, as a key element of clinical and non-clinical governance
- HCAI prevention and control systems and processes are embedded across clinical Directorates and in corporate services including business planning, service development, financial planning, project and programme management and education
- The organisation adopts a co-ordinated and multi-disciplinary approach in managing HCAI prevention and control through a systematic process of identification, analysis, learning, and management of risk. This approach extends to partnership working with other providers and Commissioners
The organisation has standardised IPC principles across acute and community setting resulting in improvements in patient pathways. The organisation strives to be amongst its best performing peers nationally. The organisation continues to ensure that all HCAI is reduced and there are mechanisms for addressing emerging problems such as highly resistant carbapenemase-producing organisms.

It is recognised that effective IPC requires commitment and active involvement of all employees. It is therefore vital that IPC process is communicated and embedded throughout the organisation. In addition to the corporate responsibilities outlined, Clinical Directors, Matrons, Directorate Managers, and Department Heads are responsible for ensuring effective IPC within their own specialist areas. These include primary responsibility for identification, investigation and follow up of all IPC issues. Where initial assessment indicates a high level of risk or need for expert advice and/or where the level of risk warrants reporting to an external body, the Matron, Directorate Manager, Clinical Director or Department Head is responsible for bringing the issue to the attention of the DIPC, the Clinical Governance and Risk Department and, where appropriate, a Board Director, to agree decisions about subsequent management of the issue.

A Trust HCAI Action Plan has been developed and operationally supports the HCAI Strategy; this is reviewed by IPCC on a six-monthly basis. In addition, Directorate-based Action Plans are submitted to the IPC Operational Group bi-annually, providing evidence of engagement and Directorate actions to prevent HCAI occurrence.

IPC Assurance Framework

The IPC Committee (IPCC) continues to meet on a monthly basis, chaired by the DIPC. The IPCC ensures that IPC policy and strategy is developed, implemented and monitored; and that an integrated IPC service is maintained with consistent high standards, protocols and policies. Issues surrounding audit, education and training, communication and any other emerging matters are also dealt with in a timely manner. The IPCC is represented at the monthly Trust Board by the Nursing & Patient Services Director and is supported by the IPC Operational Group, which meets on a fortnightly basis.

MRSA

Methicillin Resistant Staphylococcus aureus (MRSA) is a gram positive organism that can colonise patients. MRSA is resistant to first line antibiotics for Staphylococcus aureus and therefore can be difficult to treat; it is life-threatening when bacteraemia leads to sepsis. The Trust’s MRSA Policy reflects national and local policy and includes the Post Infection Review (PIR) process. The Trust continues to comply with the national requirement to screen patients prior to/on admission. However, new guidance is awaited which may lead to a change in current policy.

There has been a significant reduction in the number of MRSA bacteraemia. There is a zero tolerance for MRSA bacteraemia in 2013/2014 at a national level; this year there were 8 cases of MRSA bacteraemia.

Exhibit 1 - NuTH Cumulative MRSA Bacteraemia 2013-14

There has been a year-on-year reduction in bacteraemia from over 70 cases 2006/7 to 8 in 2013/2014 (Graph 2). Reducing the number of MRSA bacteraemia to zero is a significant challenge. All cases have been reviewed in Serious Infection Review Meetings (SIRM) and key lessons disseminated to departments and to the Trust as a whole. All cases were in patients with previous history of colonisation and the majority had significant co-morbidities and serious long-term illnesses requiring complex treatment. No serious breakdown of infection control procedures was found in any of the cases but documentation was occasionally lacking.
The overall reduction in MRSA bacteraemia is due to a large number of interventions including:

- Universal admission screening
- Comprehensive use of eradication therapy
- Continued monitoring of hand hygiene
- Introduction of Aseptic Non-Touch Technique (ANTT)
- Application of the Matching Michigan strategy in all clinical areas involved with insertion and management of central lines
- Reviewing and ensuring use of chlorhexidine/skin decontamination in theatres
- Enhanced environmental cleaning
- Ensuring correct pre-operative antibiotics are given for high risk procedures.

All of these initiatives are under active review.

Exhibit 2: MRSA Bacteraemia Seven Year Trend
March 2014
Clostridium Difficile (C. difficile)

C. difficile, a gram positive spore-forming anaerobic bacillus, is part of the normal flora of the human bowel (3% in healthy adults, 16-35% in hospitalised patients). It is the leading identified cause of nosocomial (hospital-acquired) diarrhoea associated with antibiotic therapy. Symptoms range from mild to severe diarrhoea, pseudomembranous colitis to toxic mega colon and fatal colonic perforation. The pathogenesis of C. difficile is multi-factorial, involving altered bowel flora due to antibiotic use and the production of toxins (A and B) by overgrown C. difficile in a susceptible host.

Risk factors:
- Older patients
- Increased severity of underlying disease
- Non-surgical gastrointestinal procedures
- Presence of naso-gastric tube
- Anti-ulcer medications
- Intensive Care Unit patients
- Duration of hospital stay
- Duration of antibiotic course
- Administration of multiple antibiotics or multiple courses.

The national incidence of C. difficile has previously increased in the past decade.

All cases of C. difficile in patients over the age of two and occurring 72 hours after admission are attributable to the Trust (healthcare associated, HCAI) and are mandatorily reported to Public Health England via the national Data Capture System. There has been a year-on-year requirement to reduce the incidence thus reflecting improved levels of hygiene and adoption of prudent antibiotic stewardship. The nationally set target for the year 2013/14 was 66; this target was based on a year-on-year reduction of 20% for all trusts and therefore reflected our excellent performance in 2012/13. Unfortunately, this target was exceeded and the end of year total for the trust was 86 cases. In recognition of the fact that some cases of C. difficile are difficult to avoid (i.e. a significant proportion of the population carry C. difficile and patients in hospitals sometimes require life-saving antibiotic treatment which leads to C. difficile-associated diarrhoea), an appeals process has been established. We appealed 18 cases and were successful in 11 appeals; therefore our year-end number of HCAI C. difficile was 75 cases (Graph 3). Overall, our rate of infection was similar to national average rates at around 66 cases per 1000 bed days. This has been recognised and the target for this year is 80 cases for the year.

The overriding principle in our delivery of care is to treat patients to the standard they would expect for their own family or loved ones.
2) Early isolation: The majority of patients were isolated at onset of diarrhoea; where isolation has not been achieved this is reviewed. On ITU the lack of isolation is due to the fact that over 50% of patients have diarrhoea and therefore an active multi-disciplinary review is required to assess the need for isolation. On other wards there have been occasions when there has been difficulty in isolating a patient due to lack of isolation rooms. Isolation is essential and this has been fed back to Directorates.

3) Not sending stools early in onset of diarrhoea: The majority of these instances have been due to difficulty in obtaining a sample due to incontinence. In some cases diarrhoea was considered secondary to laxatives therefore samples were only referred to microbiology after these have been stopped. A strong message has been fed back about when to send stool samples and the importance of reviewing patients with diarrhoea.

Periods of increased incidence (PII - defined as more than one case of \textit{C. difficile} within 28 days) are reported and investigated urgently with meetings between the Ward Sister, Microbiology, IPCNs and senior clinicians. There have been nine PIIs across the Trust this year, with meetings between the Ward Sister, Microbiology, IPCNs and senior clinicians. There have been nine PIIs across the Trust this year, in some cases diarrhoea was considered secondary to laxatives therefore samples were only referred to microbiology after these have been stopped. A strong message has been fed back about when to send stool samples and the importance of reviewing patients with diarrhoea.

C. difficile Saving Lives audits are performed weekly following designation of PII status. These audits continue for a maximum of four weeks. During two PII investigations there has been evidence of some environmental contamination. Extensive typing of \textit{C. difficile} isolates has also shown that, on two occasions, patients being cared for in the same clinical area had identical strains suggesting likely cross-contamination.

The affected clinical areas undergo “deep cleaning” along with repair and replacement of any damaged furniture and/or potentially contaminated equipment. On two occasions, wards have been decanted to enable this and to use Hydrogen Peroxide Vapour (HPV) throughout the ward. The learning from these PIIs has been disseminated.

There are integrated care pathways for diarrhoea and \textit{C. difficile}. This documentation is to be used in conjunction with the \textit{C. difficile} Infection Management Policy and clinical algorithm introduced in November 2009, complying with the DoH document “\textit{Clostridium Difficile infection: How to deal with the problem}” and the updated guidance on the diagnosis and reporting of \textit{Clostridium difficile} (2012).

In line with the recommendations from the Chief Medical Officer, arrangements continue in relation to death certification and \textit{C. difficile}. Any patient where the cause of death is attributable to \textit{C. difficile} a Consultant is required to complete the death certificate. A Root Cause Analysis (RCA) is carried out which is subject to review by the DIPC, the Medical Director and the Nursing and Patient Services Director. This applies to both parts 1 and 2 of the death certificate and all are reported to the Commissioners as serious untoward incidents (SUIs). Quarterly RCAs are summarised, presented to the IPCC and a quarterly report is produced that highlights the main learning outcomes this is disseminated via Matrons Forum and CPG. RCAs are completed by the relevant Matron, Ward Sister/Charge Nurse, IPCN and medical representative for each incidence of \textit{C. difficile} infection that is attributed to the Trust.

SIRM have been carried out for all cases of \textit{C. difficile} related deaths and in cases where problems have been identified in the RCA. Lessons from these are distributed through the quarterly HCAI report to CPG and Matron Forum.

There was a \textit{C. difficile} Awareness Campaign in March of this year, which provided an opportunity to promote best practice in relation to all aspects of \textit{C. difficile} prevention and management. An annual \textit{C. difficile} action plan is developed and progress is reviewed quarterly by IPCNs, the IPC Healthcare Scientist, IPC Doctors, the Antimicrobial Pharmacist, a Head of Nursing, the DIPC and the rest of the IPCC. This is a robust and active document with significant outcomes as indicated below:

- To monitor prompt isolation of symptomatic patients and appropriate use of personal protective equipment
- To gain assurance around appropriate antibiotic usage within NuTH
- To raise awareness in all groups of staff to promote compliance with national guidance and NuTH policies
- To ensure all equipment and the environment are decontaminated effectively
- To ensure only clinically appropriate specimens are investigated
To review testing against national guidance
To monitor and analyse practice regarding management of patients prior to and following confirmed *C. difficile*
To establish best practice in achieving organisations in the ‘Shelford Group’ – we have previously direct with three trusts and phone contacted three; an update has been produced. This gives assurance that we were facing similar problems and introduced many processes that were similar. Looking at rates of *C. difficile* per 1000 bed days we compared very favourably with these trusts.

This Trust-wide team approach has been demonstrably effective in reducing the incidence of healthcare-associated *C. difficile* infection but commitment must remain to ensure further necessary improvement.

**ANTT**

The principles of the Saving Lives strategy continue to be built upon and consolidated with clinical leads in all areas.

Aseptic Non-Touch Technique (ANTT) as a principle to underpin asepsis has been further enhanced by including education on ANTT into all the appropriate IPC mandatory training e-learning packages. This includes the ANTT principles of venepuncture, cannulation and blood culture collection into the programme for medical staff. At present we are introducing a system to ensure that all medical new starters who undertake ANTT procedures must demonstrate competence in ANTT at induction and are assessed individually.

ANTT compliance during invasive procedures such as cannulation, CVC insertion and blood culture collection is also documented. Cannulae across the Trust have been reviewed and a standard non-reported cannula has been introduced in all in-patient areas to improve infection rates and ensure that there is consistency and standardisation in the product. ANTT observation work has been embedded in CAT and this helps to ensure that knowledge of ANTT is raised.

Step-by-step guidelines for commonly performed aseptic procedures are available on the Trust intranet and in clinical areas to enable application of ANTT.

An IV project nurse was appointed for a year in September to undertake assessments of ANTT and IV practices and undertake education and training to improve clinical practice in these areas. The findings of these audits have been disseminated throughout the Trust including through CPG. This is an important role and we are seeking ongoing funding for this.

A Saving Lives webpage and an e-learning package are available on the Intranet for staff to access.

**The Surgical Guardian**

**Surgical precision £2m robot transforms medical operations**

Under the glare of an operating theatre lamp, Paul Renforth at the Freeman hospital in New-castle demonstrates the £2m Da Vinci robot that has transformed surgery on patients. The four-armed robot is operated by a surgeon from a booth using two finger grips that move the arms and control the instruments on the end of each.

All in, the robot is about 2 metres high and 1.5m across. Its arms go inside the patient though small incisions in the skin. Looking through a 3D viewfinder hooked up to a camera on the robot, the surgeon can magnify, grasp, cut and cauterise tissue inside.

The dexterity of the robot means surgeons can operate with more precision. They can find and remove cancerous tissue nearly impossible to reach otherwise.

The robot is already used for heart bypass operations and to remove cancers throughout the body, including those in the lungs, throat, pro-state, bladder, spleen and colon. The next specialty to adopt the robot surgeon will be gynaecology later this year.

“You can rotate the instruments 360 degrees, so they are more dextrous than the human hand,” said Renforth, Da Vinci co-ordinator at the hospital. “We are going into places now that we couldn’t get into before.”

“We treat laryngeal tumours at the back of the tongue, where we can down and underneath and access and cut away the tumours. Normally that would be done by splitting the lower jaw and going in from the side,” he said.

At the end of each operation the instruments on each arm are taken off, sterilised and autoclaved, and reused on the next patient. Most tools can be used up to 10 times before they are discarded.

**Clinical Assurance Tool (CAT)**

The CAT is now well established within the organisation as a Trust-wide tool to provide continuing clinical assurance to the Board of Directors as an overview of performance for each Ward/Department and Directorate. The aim of the CAT is to measure and demonstrate compliance with published documents and national drivers such as High Impact Interventions (HI), Saving Lives as well as providing useful data to support, verify and offer assurance for external inspectorates. This is highlights good practice in hand hygiene and cleanliness in >98% of reviews.

In the coming year, all IPC questions will be refreshed in CAT and a new Care Summary report created, drawing together a number of nurse-sensitive indicators to give a broader picture of assurance.

The Essential Steps audit programme is also well established and provides assurance on practice in community teams that do not undertake CAT. This is completed on a quarterly basis and results reported to IPCC.
Hand Hygiene

All members of staff in the Trust are required to adhere to and practice good hand hygiene technique. All members of staff are also expected to comply with the “5 Moments for Hand Hygiene”. This is vital to ensure a safe environment for patients, visitors and staff by reducing the transmission of potentially harmful microorganisms.

An extensive hand hygiene audit programme, which monitors adherence to Bare Below the Elbow (BBE), opportunity and technique has continued to demonstrate sustained improvement and compliance (>98% compliance in the most recent review). Hand hygiene audits are now incorporated into CAT and a monthly ‘by exception’ report is submitted to IPC by the Matron IPC.

Hand hygiene with soap and water is essential for patients symptomatic of diarrhoea, it is also important to wash hands regularly during the day in addition to using alcohol hand gel (which is not effective against C. difficile spores). These messages continue to be propagated through Matrons, Clinical Policy Group (CPG) and also Clinical Governance meetings.

A new hand hygiene campaign was launched in July 2013 to promote hand hygiene to patients, visitors and staff. This involved the production of new hand hygiene posters and boards which can be seen throughout the Trust, a new hand hygiene leaflet, a revised 5 moments for hand hygiene poster to raise awareness of these critical times for hand hygiene, a community staff card detailing how to prevent HCAIs, OPD TV adverts and a patient survey conducted via the Hospedia bedside TV units. There will also soon be a bedside information card educating patients on good hand hygiene practices to keep themselves healthy.

The Hand Hygiene Policy has been reviewed and up dated, including an update of hand hygiene promotional material for patients, visitors and staff. An extensive review of hand washing products has been undertaken that has led to an update of products, which have been introduced across the Trust.
Antibiotic Prescribing

The initiation in 2010 of the restriction of cefuroxime and substitution with lower risk agents (in Emergency Department, Care of the Elderly and inpatients over 65 years in medical wards) resulted in a Trust-wide reduction in use by 33% and is currently being maintained at 50% of the pre-restricted use. The use of the Cerner electronic prescribing system continues to play a large part in the implementation of the restriction, with the utilisation of pop-up messages. The use of cefuroxime is under review in other instances such as surgical prophylaxis, again with a view to replacing it with lower C. difficile risk agents. There is concern that this has been replaced by piperacillin-tazobactam and education continues on appropriate use of antibiotics in a number of settings. The resistance pattern for gram negative bacteria for Newcastle Hospitals indicates a drop in resistance to cefuroxime and slight increase for piperacillin-tazobactam.

Antimicrobial stewardship is essential at all levels of the organisation, from committee and policy level to the prescription at the bed side, and is promoted across the Trust. The indications for antibiotics and their course duration have been emphasised. Monitoring of antibiotic usage and resistance rates continues through the antimicrobial steering group (AMSG), which reports to IPCC. Recommendations on antibiotics are disseminated through medical meetings, antibiotic guidelines and antibiotic cards that are given to all antibiotic prescribers. The ‘start smart and focus’ agenda is followed to ensure antibiotics are given where appropriate, prescribed appropriately and reviewed with lab results and the clinical condition of the patient.

Antibiotic education continues with direct teaching sessions to all F1 doctors at induction; antibiotic usage and guidance is incorporated into induction for all staff. At the point of prescribing, eRecord requires a duration of prescription for antibiotics before the prescription can be signed off. There are also a number of order sets for common infections which ensure standard courses of antibiotics are given. IV antibiotics have a review pop-up after 48 hours to ensure early IV-oral switch where appropriate. Proton pump inhibitors (PPIs) may increase the risk of C. difficile infection; if PPIs are prescribed for someone on antibiotics a pop-up is triggered to warn of this potential risk and reminds doctors to review.

Antibiotic Champions have been appointed in all clinical areas and are key to the dissemination of messages to staff members and the audit of antimicrobial usage in their areas. Audit of antimicrobials occurs via quarterly antibiotic audit in the majority of clinical areas where antibiotics are prescribed. The audits are led by the Antibiotic Champions with feedback give from the auditors to the Champions. A large point prevalence audit was carried out in December 2013 to January 2014 – 663 antibiotic prescriptions were reviewed over a day by pharmacy and an infection expert (Infectious Disease or Microbiology team). Overall appropriateness of antibiotic prescribing was around 88% and Graph 5 shows the Directorates’ individual performance, the denominator in these varies significantly.

The Antibiotic Stop/Review and Indication Policy was first introduced in August 2007. On most wards where electronic prescribing is in place, compliance with the addition of a stop/review date is now greater than 95%.

Exhibit 6 shows the point prevalence audit results of whether a review of antibiotics took place at 48 hours. Where this could be recorded, this showed that the majority of antibiotics were reviewed at 48 hours. N/A was recorded for those antibiotics that had either not been prescribed for 48 hours or were stat doses, hence from the audit it can be deduced that 73% (13% of the 49% which were applicable) did have a documented review in the patient’s notes.

All antibiotic audit results are broken down to directorate and feedback through directorate antibiotic champions and to CPG.
Estates & Facilities

The IPC Team work in collaboration with the Estates & Facilities Directorate to ensure a clean and safe environment is available in which to deliver high quality patient care. This approach ensures the Trust has robust operational and strategic cleaning plans in place; the management of compliance and safety issues relating to the built environment are aligned and that building works relating to new / refurbishment schemes are reviewed to ensure a safe patient environment is maintained.

A forward plan of Ward refurbishment and improvement of the environment is being developed to ensure that wards are refurbished in a proactive way and not reactively. This requires decant facilities. A decant Ward is available at the Freeman Hospital and used twice on two occasions to ensure thorough cleaning after PII. However a decant Ward still needs to be identified at the Royal Victoria Infirmary.

Water Safety Group

A Trust Water Safety Group has been established with a remit to accept ownership of and be accountable for, on a joint and several basis, water safety risk management in accordance with all current legislation and guidance documentation including:

- Health & Safety Executive (2013) Approved Code of Practice & Guidance - The Control of Legionella bacteria in water systems L8 fourth edition
- Health & Safety Executive (2013) Technical Guidance HSG274 Part 1 to 3
- Department of Health (2014) Health Technical Memorandum HTM00: Policies and principles of healthcare engineering
- Department of Health (2013) Health Building Note HBN 00-10 Part A to D
- Department of Health (2013) Health Building Note HBN 00-10 Part A to D

The Water Safety Group meets on a monthly basis and receives regular reports on engineering issues and water quality matters including Legionella, Pseudomonas and other waterborne pathogens. This group reports to IPCC.

A new Water Safety Policy incorporating Legionella and Pseudomonas aeruginosa, “safe” hot water, cold water, drinking water and ventilation systems management and control has been ratified by the Water Safety Group and IPCC.

Legionella & Pseudomonas Management & Control

A dedicated Water Quality Team was established within the Estates & Facilities structure to act on risk assessments, which are being carried out by independent auditors (Hydrop Ltd.) for all Trust owned sites. The risk assessments carried out to date have identified issues in the water systems on all main sites, including: dead legs, poor temperature regulation in some areas and poor documentation of review and process. Some of these issues have been remedied immediately but significant engineering upgrades to the water system infrastructure are required to bring systems up to the necessary standard as the problems identified provide an environment conducive to the growth of waterborne pathogens and therefore present a risk to patients, staff and the public. Work is underway to address central infrastructure defects and work at ward level is being prioritised by a multidisciplinary team and is planned to start in Ward 35 SCBU RV1 in the near future.

Research has established that poorly designed and configured sanitary fixtures and fittings can increase the risk of colonisation by Legionella, Pseudomonas and other bacteria. A fresh set Trust standard configurations for sanitary ware have been agreed upon and in areas where there is a need for replacement, a more dynamic approach integrated apropos refurbishment of Wards and Departments.

Legionella and Pseudomonas awareness training has been delivered to a range of disciplines including Microbiologists, IPC Nurses, Matrons, Sisters, Department Managers and Estates & Facilities staff.

Community Based Services

The Estates & Facilities Department work in partnership with the Community IPC Team to ensure environmental standards within non-Trust owned premises that facilitate the delivery of Trust Community Services are regularly monitored and inspected around compliance with all Trust standards/policies. Together, we undertake annual Community Environmental Action Team (CEAT) inspections and respective interim spot-checks of all premises. NHS Property Services and the Domestic Service Provider are asked to be in attendance to ensure all issues can be clearly identified and subsequently resolved in a timely manner.

NHS Property Services engage Hydrop Ltd. to undertake Legionella Risk Assessments in all their owned/leased properties and provide the Trust with copies of all reports. Due to differing organisational policy requirements, flushing regimes have been implemented in all of our Community premises and are conducted/recorded and monitored by Trust staff.

Surveillance

Mandatory surveillance and reporting by the Trust is now required for the following HCAI:

- C. difficile
- MRSA bacteraemia
- MSSA bacteraemia
- E.coli bacteraemia

Declaration of MSSA (Methicillin Sensitive Staphylococcus Aureus) bacteraemia has been mandatory from January 1st 2011 with mandatory E.coli bacteraemia reporting from June 1st 2011. Currently there are no targets associated with MSSA or E.coli bacteraemiae. The Department of Health is using this information to establish baseline trends for both infections.

This has shown that we have below average rates of hospital acquired E.coli bacteraemia. We continue to highlight ANTT in the use of urinary catheters with training on ANTT and e-learning packages highlighting this. We have ensured the policy on antibiotic prophylaxis for catheter changes is robust. There has been a drive to improve management of urinary catheters in the community nursing homes through “Prevent CAUTI” initiative. This has led to an improvement in catheter management in the community and a consequent reduction in catheter usage, reduction in admissions (18 admissions avoided) and a decrease in catheter associated infections.

MSSA bacteraemia appear to be higher than other trusts. The two areas that have the largest number of MSSA bacteraemia are Renal and Cardiothoracic reflecting the large number of lines used in these areas and the vulnerability of their patient groups. A large amount of work has been undertaken to screen for MSSA in vulnerable groups, use of chlorhexidine washes in high risk patients is occurring in Renal and Cardiothoracic and a programme of introducing this in Critical Care locations is being actively pursued. SIRM are used to investigate bacteraemic episodes where IPC issues are identified. Any lessons learned during the SIRM or in RCA are promptly fed back to Directorates.

Matching Michigan, a tool for central line placement, audit and monitoring of central line infections, has been rolled out across the Trust. Last year, CQUN targets were set against the process of central line placement, care and rates of bacteraemia, with targets to reduce bacteraemia in areas where this was being rolled out.
This was highly successful with reduction of line-associated bacteraemia rates in Haematology/Oncology and Paediatrics. Line-associated bacteraemia have reduced in Haematology/Oncology (5.41/1000 catheter days in 2012; to 2.18/1000 catheter days in 2013) and Paediatric ITU (5.41/1000 catheter days in 2012; to 2.18/1000 catheter days in 2013). There was also an increase in compliance and knowledge of line placement and care pathways/guidelines. In all adult ITU across the trust where Matching Michigan has been in place for some time, the rates of infection have remained below the Matching Michigan rates in adult ITU across the trust.

Mandatory reporting of Orthopaedic knee and hip surgical site infections (SSI) and voluntary reporting of Spinal SSI via the Public Health England Surgical Site Infection Surveillance Service (SSISS) continues on a quarterly basis. The Trust is continuing to perform well nationally for elective total knee replacements and elective total hip replacements. A number of initiatives such as chlorhexidine pre-operative washes given to patients having operations continue. There have been higher rates of SSI in patients undergoing spinal surgery, which may be related to case mix but an RCA has been developed and modified for use when a deep infection has been identified. These have shown a need to standardise some practice such as post surgical dressings and skin preparation. Reassurance has been sought involving observation of practice relating to wound care and IPC practice in the operating department and ward. Patients undergoing surgery are being given chlorhexidine washes to apply prior to surgery and nursing staff are encouraged to discuss good hygiene practices with the patient prior to theatre where practical and apply further washes where needed; this practice is being reviewed to improve compliance. Furthermore, there is a planned expansion of the spinal ward to increase side rooms and allow for complex patients to be managed in a four-bedded bay to improve the overall management of these patients. Further discussion is underway to consider a programme of monitoring SSI in other surgical specialities.

In addition, the IPC Healthcare Scientist has established a comprehensive surveillance programme for all “alert” organisms. Microbiology culture results are used to populate monthly spreadsheets which are used as indicators of clinical quality assurance. The IPC team responds proactively to any demonstrable change. Microbiology data collation is an expanding service that reacts promptly to any new trust wide requests.

Examples of “alert” organisms under continual surveillance are:

- Invasive Group A Streptococci (IGAS)
- Mycobacteria
- Multi-drug resistant gram negative bacteria

**Multi-Resistant Organisms**

**Glycopeptide Resistant Enterococci (GRE)**

GRE (also known as Vancomycin Resistant Enterococci or VRE) is mainly acquired in the community from the food chain and many people have GRE in their gut naturally. Patients who are hospitalised and treated with glycopeptides very occasionally experience a GRE infection as a result, and outbreaks of cross-infection could potentially occur. However, the Trust continues to have a low incidence of GRE infection with only one bacteraemia identified during the past year.

**Carbapenemase-producing Enterobacteriaceae (CPE)**

Carbapenemase-producing Enterobacteriaceae (CPE) are multi-resistant and are likely to become an increasing challenge over the next year. A small number of patients have been identified with these organisms. The major risk at present is patients who have been hospitalised abroad or who come from other hospitals in the UK that have a high rate of CPE amongst their patients. Guidance on screening is being reviewed and the IPC Team are assessing how this can be incorporated into local policy. Recent cases have been identified early. Further work is needed to ensure patients colonised or infected are identified effectively and managed appropriately.
Norovirus
As expected, frequent cases of Norovirus have been identified throughout the year. A proactive approach is being taken with biannual meetings – one after the Norovirus season in spring to review the practices and issues that have arisen; and the second in autumn to look at practices for the winter. This involves representatives from acute admissions and Emergency Department (ED), bed managers and the IPC team. In accordance with national guidance, wards are partially or fully closed depending on the circumstances with active cleaning. Excess visitors are discouraged. Posters are visible during the seasons when outbreaks occur to highlight to both staff and patients not to come in/visit if symptomatic of diarrhoea and vomiting within 48hrs. Hand washing is mandated when staff see patients with diarrhoea and vomiting. There has been collaborative working with Patient Services Coordinators, Infectious Diseases and IPC to proactively locate cubicles at the height of outbreaks. Symptomatic patients have been transferred to isolation facilities on ED when necessary.

Influenza/Measles/Novel Coronavirus
Influenza remains a sporadic problem; this season has not been as severe as previous years.
Fit testing of FFP3 masks occurs in appropriate clinical areas delivered by a cascade training approach. New guidance on the use of PPE is being reviewed and where appropriate incorporated into policy.
This year's staff vaccination campaign was highly successful: over 95% of medical staff and 76.2% of all frontline healthcare workers received vaccination. This Trust's was the best performing trust in the region this year, and ranked towards the top nationally. Members of the Occupational Health Service have attended post-vaccination feedback workshops to inform this coming year's campaign planning. Barbara Goodfellow, Interim Lead Nurse OHS, is a member of the regional flu advisory group, providing campaign planning. Barbara Goodfellow, Interim Lead Nurse OHS, is a member of the regional flu advisory group, providing campaign planning. Members of the Occupational Health Service have attended post-vaccination feedback workshops to inform this coming year's campaign planning. Barbara Goodfellow, Interim Lead Nurse OHS, is a member of the regional flu advisory group, providing campaign planning. 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Cleaning routines, specifications and audits
All patients admitted to NuTH must be cared for in a clean environment with clean equipment and as such, all staff have a responsibility to ensure compliance. A policy has been produced, ‘Decontamination of the Patient Environment (which includes Terminal Cleaning)’, to provide detailed guidance for staff and identify specific areas of responsibility.
Over the last year, routine environmental cleaning continues to be provided by an in-house team of staff, including a Rapid Response Team to undertake terminal cleans following isolation.
A number of initiatives have improved the efficiency of cleaning. Increasing the workforce and consolidating teams to enable increased efficiency with improved turnaround time and the ability to be more proactive into the evening and during busy times, in order to reduce delays in bed turnaround. Hydrogen peroxide vapour (HPV) decontamination has been introduced in certain circumstances as part of a deep cleaning programme or as part of the terminal cleaning process following known or suspected infectious diarrhoea.
Monitoring of cleanliness standards is performed by a range of audits using a multidisciplinary approach comprising Nursing, Hotel Services and Estates. The Matrons Monthly Checklist has been incorporated into CAT to provide further evidence of environmental and decontamination compliance.
Hotel Services continue to use ‘Credits for Cleaning’ to monitor cleanliness standards in all clinical areas on a monthly basis. At present, ATP monitoring to test for presence of residual organic matter following cleaning is being assessed. There is potential to incorporate this technology into local assessment strategies to monitor the effectiveness of cleaning. Hotel service managers are currently performing an evaluation.
All mattresses in clinical areas are subject to an annual audit conducted by Tissue Viability with support from the IPC team. In addition, mattresses are inspected by ward staff on a quarterly basis. Further assurance is also provided by CAT on a monthly basis.

Education and Training
Education and training continues to be one of the key elements of the IPC strategy to reduce HCAIs. Ensuring that staff have knowledge and understanding of correct infection prevention and control practice is fundamental to its implementation. Education and training has been provided throughout the year in the following ways:

E-learning
IPC mandatory training has been delivered to the majority of staff through online training programmes. There are six training bespoke programmes to ensure that education has the appropriate contains for different staff groups to ensure there is sufficient knowledge and understanding for their role in the delivery of patient care. These programmes are:

• IPC for non-clinical staff
• IPC level 1 for clinical staff
• IPC level 2 for registered nurses and midwives (these staff also complete level 1)
• IPC for medical staff
• IPC for dental staff
• IPC for community staff
These programmes are currently being reviewed to improve user engagement and to ensure that training continues to be current and evidence based.

Induction
The IPCNs have commenced a new education session which is delivered as part of the new Trust induction programme. The IPCNs also deliver induction training to student nurses, work experience students, medical students and at Directorate level.
induction days. The IPC team are working with HR to improve the process of giving information to medical staff entering the trust. We are looking towards introducing mandatory ANTT training to all medical staff entering the Trust.

**Healthcare Assistant (HCA) Development Programme**

It is recognised that Healthcare Assistants (HCAs) have a vital role in the delivery of clean, safe care to our patients and as such, the continued education and training of this staff group is essential. The IPCNs have continued to be involved in the development programme for HCAs and the Healthcare Assistant Academy; a training programme for all new HCAs joining the Trust.

**IPC Newsletter**

Staff have been informed and updated on correct IPC practice through many forums, one of which is the IPC section in the Nursing & Midwifery Newsletter. This aims to communicate information through avenues which capture the interest of staff including poems and pictures.

This type of communication route has recently been re-introduced for medical staff with the launch of the Microbiology newsletter, which incorporates key messages about good antimicrobial stewardship as well as IPC practice.

**IPC Education Forums**

The IPC team are now running two IPC Education Forums. The forum for multi-disciplinary staff continues to deliver a varied programme to capture the interests of a wide audience, however to enhance the knowledge and skills of arguably the staff group with the greatest patient contact, the IPC Education Forum for Nurses was launched this year which runs on a quarterly basis.

Both forums encourage participation and discussion and aim to deliver IPC information through different ways such as presentations, quizzes and videos, with CPD being offered to doctors who attend.

**IPC Link Group**

The link group members (approx. 250) are multidisciplinary staff and support the IPC team within their wards/departments. The group meet on a monthly basis where the IPCNs communicate and discuss new initiatives, changes in practice/policy and concerns over areas of poor IPC practice. The community link group includes staff from trust community services and also includes staff from nursing and residential homes in the Newcastle area.

The IPCNs have held two very successful study days for acute and community staff this year, providing the foundations for new link staff and enhancing the knowledge of our current staff. A review of the acute link group role and programme is in progress to promote engagement with the role.

**Medical Staff**

The IPC team continue to participate in the education and training of medical staff through the following:

- Hand hygiene education and training sessions to medical students in their first, second, third, and final years
- Second year student session on HCAs
- A specific training programme for third year students prior to their placements on the wards, to increase their skills in ANTT, cannulation and venepuncture was held for the first time this year, and was very well received
- An IPC education session to EJR students in their third year by an IPCN

**Additional Education and Training**

The IPCNs also continue to deliver many other bespoke education sessions to a variety of staff groups such as; the preceptorship programme for newly registered staff nurses, the Catheter Care Study Day, Clinical leader’s Forum and the Dental Registrar Training programme.

The IPC Team are currently offering an education programme to GP practices and the local authority for home carers, to continue to work towards enhanced collaborative working with these stakeholders.

Whenever there have been concerns about rising HCAI levels in specific areas or Trust-wide the IPC team have responded appropriately to address any gaps in knowledge and training. This has resulted in many extra education sessions on a variety of subjects, including hand hygiene, at ward / department level.

There has been a large number of ad-hoc meetings with departments by various members of the IPC team and Trust management to ensure that key messages are cascaded. All members of staff are encouraged to challenge where they see poor practice.

The IPC Team continues to work proactively and collaboratively throughout the organisation to improve communication, education and training in IPC practice in order to create a work force that is fit for practice.

**Conclusion**

Considerable success has been achieved in IPC throughout the Trust, spearheaded by the IPC Team with good engagement from staff throughout the Trust. This has led to maintenance of the previous dramatic reductions of the total number of MRSA bacteraemia. The success lies with staff across the Trust. The overriding principle that IPC is everyone’s responsibility has become ingrained into the working ethos. We need to continue to consolidate on this success such that it continues and avoid complacency.

MSSA bacteraemia need to be focused on and we need to see continued reductions here, through the implementation of some of the policies and improvements outlined.

_C. difficile_ still remains the greatest concern from the point of view of HCAs within the Trust. Whilst cleanliness of the environment, asepsis and decontamination remain pivotal, the role of antibiotics in the development of _C. difficile_ cannot be overestimated. The prescription and continuation of antibiotics remains the responsibility of the medical staff; their future response is vital to successfully reducing _C. difficile_ and reducing the emergence of resistant strains of micro-organisms.

Overall there are a large number of ongoing issues and future challenges that need to be tackled in the forthcoming year. The IPC Team and the Trust are well placed to meet these challenges.

**Contributors:**

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**Dr Ashley Price**

Director of Infection Prevention & Control
The extent of the financial crisis facing the NHS is laid bare today in a series of letters from hospitals pleading for bailout loans to replace defunct equipment and even to avoid having the electricity switched off.

Details of desperate requests for emergency financial aid sent to the Department of Health reveal that patients at one hospital faced “increased clinical risk” from machines used for examinations “failing to meet appropriate standards”. Another warned that its operating theatres “have in effect reached the end of their useful life”.

The 15 loan requests, made in February and March this year, which were released following Freedom of Information requests, paint a stark picture of the impact of the NHS financial crisis on England’s most hard-up hospitals.

Sixty-five NHS trusts in England are already in deficit, while a recent survey of NHS finance directors revealed that two-thirds are concerned their trust will go into the red in the year of the general election.

In further evidence of the pressure on NHS hospitals, an investigation broadcast today will show that hundreds of thousands of patients are being discharged in the middle of the night, with elderly patients often being left to make their own way home.

All three political parties are under pressure to declare their plans for the future of NHS funding, with an “NHS tax” understood to be under consideration by both Labour and the Conservatives.

Meanwhile a loan request sent by University Hospitals of Coventry and Warwickshire (UHCW) Trust for £9m warned of an “untenable level of equipment breakdown and obsolescence”, with important medical equipment such as dialysis machines for patients with kidney failure coming to the end of their operable life.

Several trusts which sent loan requests, disclosed by the Health Service Journal, predicted a bleak financial outlook. Medway Foundation Trust said it projected a £15m deficit in 2014-15 while Bedford Hospital Trust expected to be in deficit by £7.6m by next year.

A spokesperson for the NCUH trust said that the building threatened with having its electricity cut off was a “domestic building” where no clinical activity took place. Steve Shanahan, director of finance for NCUH, said that the trust’s bid for support was successful.

Gail Nolan, chief finance officer for the UHCW trust said: “While the majority of our equipment is replaced as part of our private finance initiative contract, there is one-off capital expenditure which falls outside this programme.”
NHS hospitals flatlining

- Fifth of trusts will be in deficit by end of the year, says report
- Quality of care at risk as staff morale approaches all-time low
- Government’s NHS reforms blamed for ‘financial panic’
- Medical unions warn of an exodus of talent

However, here in Newcastle upon Tyne we see things differently...
Within Newcastle upon Tyne Hospitals NHS Foundation Trust ‘Clinical Governance’ supports a systematic, sustained approach to Quality Improvement and identifies the statutory duty for the Trust to have in place arrangements for monitoring and improving Quality in order to deliver safe and effective care. The Trust is committed to ensuring its services meet the patients needs through robust Clinical Governance arrangements, keeping the patient experience as central.

The Clinical Governance and Risk Department (CGARD), led by the Medical Director and Director of Quality and Effectiveness, works to support and engage staff across the Trust in the development and delivery of Clinical Governance and Trustwide Quality Improvement programmes, aligned with regulatory requirements and the Trusts Quality Strategy.

In early 2014 the Medical Director instructed a review of existing clinical governance processes to streamline and improve the organisational structures and accountability for Clinical Governance and Quality. As a result of the review the reporting arrangements from supporting groups to the Clinical Governance and Quality Committee have been strengthened to integrate and focus them and a new Patient Safety and Quality Review process implemented.

Patient Safety and Quality Review Process

Continual improvement in the quality and safety of care delivered to patients is both a requirement of recent reports (Francis 2013, Keogh 2013, Berwick 2013) and is desired by all healthcare professionals who provide care to patients. Boards of NHS organisations are responsible for ensuring high quality care is delivered to patients and avoidable harm is eliminated where possible. The purpose of the Patient Safety and Quality Review (PSQR) process is to provide Board assurance that high quality care is being delivered across all services and that it can quickly identify and respond where improvement is required.

The PSQR process serves to strengthen existing corporate clinical quality assurance processes. More importantly it should provide patients and service users with confidence that they will receive the best experience and the best care at all times. The process is closely aligned to the Care Quality Commission (CQC) approach to monitoring the safety and quality of healthcare services.

On an annual basis representatives from each Directorate are invited to attend a Patient Safety and Quality Review Panel. Attendees include the Clinical Director, Directorate Manager, Clinical Governance Lead, Matron, Junior doctor, Specialist trainee. Other members of staff are welcome to attend as deemed appropriate by the respective...
Directorate Management Team. The Panel consists of the Medical Director (Chair), Director of Quality and Effectiveness, Clinical Directors for Quality and Safety, Executive Director of Nursing and Patient Services or nominated deputy, Head of Nursing.

An information pack is produced and circulated in advance of the meeting. The datapack includes Directorate specific quality and safety metrics e.g. PSI (patient safety incident) reporting rates and trends; VTE risk assessment rates; Mortality data; MEWS compliance; Friends and Family Test data; Never Events/SUI's. The panel meeting provides an opportunity for open healthy debate and challenge between the clinical specialty teams and the Executive panel members focussing on the patient safety and quality metrics provided. Where areas for improvement are identified support can be provided and necessary improvement actions identified. The PSQR Panel reports directly to the Clinical Governance and Quality Committee.

Mortality Review Process

In accordance with NCEPOD (National Confidential Enquiry into Peri-operative Deaths) recommendations a comprehensive mortality review programme has been successfully introduced into the Trust and is detailed within the 2013/14 Quality Account. Multidisciplinary mortality review meetings take place in all clinical specialties positively supported by senior medical and nursing staff.

The publication of the Trust Quality Account aims to enhance accountability to all stakeholders and ensure that a continuous Quality Improvement agenda continues to be a Trust priority. Acknowledging that essential to the successful delivery of the Clinical Governance agenda is the achievement of a positive patient experience many initiatives and projects have underpinned continued improvement in the management of patient care as set out in the Quality Account. In addition to those detailed in the Quality Account is the continued investment by the Trust in the successful delivery of national and local practice development initiatives. The Clinical Governance and Risk Team work closely with the Heads of Nursing, Clinical Directors for Patient Safety and Nursing Practice Development Team to develop staff training and educational opportunities within the Trust to introduce and facilitate evidence based practice development initiatives.
In the absence of major change during the preceding year, annual reports inevitably tend towards the repetitious, and this report is no exception, with the activity and duties of the Clinical Effectiveness, Audit and Guidelines Committee (CEAGC) continuing much as in previous years. As its name suggests, the role of the CEAGC is to oversee audit activity and its governance within directorates, but more importantly, to monitor compliance with, and implementation of, national guidance within the Trust. Guidance may come from several different sources, including the medical Royal Colleges, the General Medical Council, and the Care Quality Commission, but the principal (and most prolific) producer is NICE (National Institute for Health and Clinical Excellence). NICE guidelines are issued in a number of different categories – Clinical, Interventional Procedures, Medical Technology, Public Health, Technology Appraisal, and most recently, Quality Standards.

Over the last year, the CEAGC considered some 87 different items of guidance. The large majority of these were already followed in the Trust, albeit with some minor variations. Occasionally, however, local clinicians cannot endorse a particular guideline, either because they are already using a preferred alternative (produced by a specialist professional group, for example), or because they feel that the evidence base for the guideline in question is inadequate. In all such cases, significant deviations have to be presented to and approved by the CEAGC. Rarely, the matter may require referral to the Trust Clinical Governance and Quality Committee (parent committee for the CEAGC) for further consideration, and a final ruling.

In its supervisory role, the CEAGC received reports of audit activity from 24 different clinical directorates during the year. The majority of directorates appear to have a reasonably well-organised approach to clinical audit, although inevitably some are more robust than others. Recurring areas of concern were the appropriate prioritisation of audit activity (assessment of national guidance should come first), a lack of time, and inadequate IT support – there are no easy answers to the latter two. All of the above ensures a full agenda every month when the CEAGC meets, and occasionally, an extra meeting is required to accommodate the workload.

Recently, the CEAGC was asked to present a review of its activities to the Clinical Governance and Quality Committee, and this review helped to crystallise two particular concerns. Neither is new, but both have become more pressing. The first (relatively minor) concerns the lack of consistent medical representation on the CEAGC. Apart from the chairman, there is quite often no other medically qualified member present, which can mean that the review of audit activities or guideline compliance may be less rigorous than would be desirable, particularly if they concern a specialist area of practice. It has been difficult to retain medical members on the Committee, partly because its activities are not of interest to every individual, and partly because of clinical workloads. So far, the Committee has not found an answer to this problem, although recent organisational changes in the Trust may provide a solution.

The other concern is more challenging. As I have mentioned in previous reports, by virtue of its size and diversity, practically every guideline issued applies to some area of the Trust, and consequently, its implementation has to be assessed. As the amount of guidance produced continues to increase, monitoring it becomes an ever more complex and demanding task. The problem has been exacerbated by the introduction by NICE in June 2010 of Quality Standards. So far, more than 60 of these have been released, with many more to follow. They tend to be general and wide-ranging, and because of this, usually apply to several different areas/directorates. For example, the first Standard issued, concerning the management of dementia, is clearly relevant to Care of the Elderly, but may also apply within Internal Medicine and its subspecialties, Orthopaedics, and other surgical specialties. For a number of reasons, obtaining a reliable baseline assessment of compliance across several different areas is considerably more difficult than dealing with a defined condition affecting a single specialty only. This means that the CEAGC is unable to provide as reliable assurance as it would wish...
to senior management regarding compliance with guidelines. A related issue is the not infrequent failure of Directorates to record non-compliance on the Risk Register. While these concerns may not seem particularly important, it must be emphasised that without a proper assessment and record of guideline compliance, the Trust can have no clear grasp of its adherence to guidance, nor where significant gaps exist. Furthermore, while guidelines are what they say they are – guidance, not protocols – in reality, deviation from nationally advised courses of treatment or management must be clearly justified to avoid exposing the Trust to criticism, reputational damage, or worse.

In light of these difficulties, one might ask whether the plethora of national guidelines is as helpful as intended, and indeed over the past few years, there have been several articles in the medical press critical – for a number of reasons - of excessive central guidance. Nonetheless, staff in the Clinical Governance and Risk Department have to work with the status quo, and are currently trying to improve both the audit and recording of guideline status, although I suspect that this problem may not be amenable to rapid solution - we shall see!

I will end, as always, by recording my sincere appreciation of my colleagues on the CEAGC whose advice and support have been invaluable throughout.

Dr Ian R Fletcher
Consultant Anaesthetist, Chairman,
Clinical Effectiveness Audit and Guidelines Committee

Clinical Governance and Risk Department staff are currently trying to improve both the audit and recording of guideline status