Wigan Borough Clinical Commissioning Group

MEETING: **Item Number:**

DATE:

REPORT TITLE:	**Health Care Associated Infection Monthly Update**
REPORT AUTHOR:	**Christine Sweeney**
PRESENTED BY:	**Christine Sweeney**
RECOMMENDATIONS/DECISION REQUIRED:	**To receive this report and support its recommendations.**

EXECUTIVE SUMMARY

A zero tolerance approach towards avoidable infections continues to be highlighted as a quality requirement in the NHS Outcome Framework 2012/13. Reducing health care associated infections including Clostridium difficile and MRSA are a key part of this.

For the year 2011/12 there were 9 cases of MRSA bacteraemia (2 over trajectory) and 123 cases of Clostridium difficile (12 over trajectory).

Root cause analyses have been carried out and the co-morbidities of cases are outlined in the report. Training of home care and care home staff continues. Work continues to improve antibiotic prescribing in primary care.

The report makes the following recommendations:

- Urgent implementation – To put alerts on the GP electronic patient records to flag high risk patients.
- Further work needs to be done with regards to patients receiving treatment out of area to ensure that the health protection team receives timely information on which to act.
- The health protection team to provide high level infection control support for GPs on a case-by-case basis recognising that many GPs rarely see C. diff cases.
- That C. diff/MRSA bacteraemia be a regular item on the GP locality meeting agendas with the health protection team presenting case studies and lessons learned.
- Continue to work with GP's regarding antibiotic prescribing.
- That the board receives monthly updates on HCAI performance.

FURTHER ACTION REQUIRED:	

TRACKING

Committee /Meeting	CCG Operations	Clinical Governance	Corporate Governance	Finance & Performance	Locality Audit Group	CCG Strategic Leadership	CCG Board	NHS GM Board
Consideration required y/n								
Date of submission								

Health Care Associated Infection Monthly Update

1. Purpose of Report

1.1 The purpose of this report is to provide an updated position to the Wigan Borough Clinical Commissioning Group Board on the end of year performance with regards to healthcare associated infections. It describes the last three months performance (January – March 2012) and highlights some of the issues in performance. It identifies areas for improvement and makes recommendations.

2. Introduction

2.1 A zero tolerance approach towards avoidable infections continues to be highlighted as a quality requirement in the NHS Outcome Framework 2012/13, to ensure that people are treated in a safe environment and protected from harm. Clostridium difficile (C. diff) infection is, therefore, included as a performance measure with reduction targets set for the locality. The trajectory for 2011/2012 was **111** and for MRSA was **7**. The trajectory for C. diff for 2012/13 is **91** and the trajectory for MRSA bacteraemia is **6**.

3. Headline

3.1 For 2011/12 there were 9 cases of MRSA bacteraemia (2 over trajectory).

3.2 For 2011/12 there were 123 cases of Clostridium difficile (12 over trajectory).

4. Performance data (January – March 2012)

4.1 Target Performance - Clostridium difficile

Target Month	Jan	Feb	March
Cumulative PCT Actual	104	113	123
Cumulative Trajectory	94	101	111 (End of Year trajectory)
Variance	+10	+12	+11

4.2 Target Performance - MRSA Bacteraemia

Target Month	Jan	Feb	March
Cumulative PCT Actual	7	7	9
Cumulative Trajectory	5	6	7 (End of year trajectory)
Variance	+2	+1	+2

5. Performance issues and actions

5.1 Clostridium difficile

5.1.1 Root cause analysis (RCA) has identified that a number of cases are relapses with previous episodes of Clostridium difficile. There have been two cases that have previously tested positive for norovirus during the outbreaks we as a Borough have encountered. Two patients have history of strokes and their gut motility has been affected (Risk factor for C. diff). There have been a number of cases with a bowel cancer diagnosis (Risk factor for C. diff). One patient was diagnosed with pancreatitis appropriately treated with antibiotics and a number of cases were treated appropriately for urinary tract infections.

5.1.2 Training has been given to care home staff on the management of residents with C.diff, norovirus and outbreak management. The health protection team has started attending GP locality meetings.

5.2 MRSA

5.2.1 Root cause analysis has identified that three patients have had sepsis as a result of urinary catheterisation. Three patients have unknown origin of sepsis. One patient had sepsis as a result of cellulitis. One case was a contaminant with the patient showing no adverse effects. One case had been identified and treated out of area following insertion of a central venous line.

5.2.2 Discussions have been held with social care and domiciliary home care staff regarding urinary catheter management training. Training of home care staff on the management of urinary catheters and ongoing care is planned for May/June 2012.

6. Conclusion

6.1 A great deal of good work as been undertaken to improve the number of cases and management of health care associated infections (HCAIs). It was disappointing to miss the target for 2011/12. To date we have not seen any secondary cases in the community which indicates that we have had no person-to-person spread.

6.2 A full recovery plan for C. diff has been developed and implemented. We continue to work as a health economy in reducing the incidence of HCAIs. A workshop is planned for 23 May 2012 to raise awareness and discuss the way forward in improving the rates of C. diff. Work continues to improve antibiotic prescribing in primary care. Training for home care staff on the management of urinary catheters and ongoing care is planned for May/June 2012.

7. Recommendations

7.1 The board is asked to receive this report and to support the following:

- Urgent implementation – To put alerts on the GP electronic patient records to flag high risk patients.
- Further work needs to be done with regards to patients receiving treatment out of area to ensure that the health protection team receives timely information on which to act.
- The health protection team to provide high level infection control support for GPs on a case-by-case basis recognising that many GPs rarely see C. diff cases.
- That C. diff/MRSA bacteraemia be a regular item on the GP locality meeting agendas with the health protection team presenting case studies and lessons learned.
- Continue to work with GP's regarding antibiotic prescribing.
- That the board receives monthly updates on HCAI performance.