NHS
Rotherham

INFECTION PREVENTION AND HEALTH PROTECTION

ANNUAL REPORT

2011/12

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Approved by Strategic Infection Prevention and Control Committee May 2012

CONTENTS

1. BACKGROUND and OVERVIEW

The Health and Social Care Act 2008 (Code of Practice for the NHS on the prevention and control of infections and related guidance – Regulation 12) highlights the importance of good infection prevention and control practices across health and social care as a key part of the quality and safety agenda for patient care. The code emphasises the importance of strong leadership, management and governance arrangements, the design and maintenance of environment and devices, the application of evidence based clinical protocols and education, training and communication within commissioning and provider organisations, sharing the vision and responsibility to reduce and sustain a reduction in reducing the risk of Healthcare Associated Infections (HCAI's).

Compliance with the Code of Practice and registration with the CQC by primary Dental Practices came in to force from 1st April 2011, a process that has been supported by the Dental Public Health Team.

This report serves to provide assurance to the Board of NHS South Yorkshire and Bassetlaw, the Operational Executive of NHS Rotherham, the Rotherham Clinical Commissioning Group (CCG) and Local Authority Cabinet (shadow Health and Wellbeing Board) of the activities and risks related to the prevention and control of healthcare associated infections, communicable diseases, immunisation and where relevant wider health protection issues.

2. INFECTION PREVENTION AND CONTROL ARRANGEMENTS

2.1 Infection Prevention and Control Staff

Whilst there is no legal requirement for commissioning organizations to have a nominated Director of Infection Prevention and Control (DIPC), it is seen as good practice, this function is fulfilled by the Director of Public Health, supported by the Health Protection Manager. All providers commissioned by NHS Rotherham have nominated DIPC's or infection prevention Leads, and are members of the Strategic Infection Prevention and Control Committee.

2.2 Role of the strategic infection prevention and control committee

The Strategic Infection Prevention and Control Committee have continued to meet throughout the reportable period, providing assurance regarding compliance with all relevant guidance and legislation and escalating risks via the Operational Risk, Governance and Quality Management Group, respective contract quality review meetings or relevant member of the CCG. Terms of reference for the Committee are included as appendix 1; during the reportable period the terms of reference were reviewed to reflect the changing NHS architecture and ensure continued delivery of service and assurance throughout the transition period. Assurance from Yorkshire Ambulance Service is not provided directly to the Committee but is instead provided to NHS Bradford as the lead commissioner for ambulance services.

The purpose of the committee is not performance management, however in order to provide assurance to NHS Rotherham, each provider submits an assurance framework template stating assurance criteria, evidence provided/available, gaps in assurance/concerns and actions taken/required to each Committee meeting. In addition to this an annual programme, based on the NHS Operating Framework and local priorities is developed, agreed and monitored by the committee, escalating concerns as appropriate.

3. ORGANISATIONAL BOARD ASSURANCE

Minutes from each meeting are circulated to the Operational Risk, Governance and Quality Management meeting for information. These are reviewed and discussed at each meeting, with matters of concern been escalated to the Audit, Quality and Assurance Committee. In addition monthly patient safety and quality reports for MRSA and *C. difficile* are submitted to NHS South Yorkshire and Bassetlaw via the Lead Nurse at NHS Rotherham.

4. HEALTHCARE ASSOCIATED INFECTIONS

The reduction of Healthcare Associated Infections has remained a political and public priority, with commissioners of services and service providers being required to have in place a reduction plan to achieve and sustain a reduction in the number of MRSA bacteraemia and *C.difficile* infections, against the nationally agreed trajectories and plans formulated based on the previous year's outturn. In addition to monitoring by NHS Rotherham, the monthly outturns reported by The RFT are also monitored by Monitor as part of the governance assurance process. The use of broad spectrum antibiotics is well recognised as a risk for selecting resistant organisms and *C.diff*, Rotherham has continued to perform well in this area and has often been one of the top performers within Yorkshire and the Humber and the North of England (76 PCTS). Data from April 2010 to March 2011 shows NHS Rotherham to be the seventh lowest prescriber for Quinolones and 18th lowest prescriber for Cephalosporins. Whilst data for 2011/12 not available at time of writing this report, local monitoring suggests that this position will not be significantly different for the reportable period.

The mandatory reporting of Methicillin Sensitive *Staph aureus* (MSSA) bacteraemia introduced in January 2011 was followed by the introduction of enhanced E. coli bacteraemia mandatory reporting and surveillance from June 2011, although no reduction plan was imposed for either of these two elements.

4.1 Clostridium difficile (C.diff)

Nationally the downward trend for both MRSA bacteraemia and *C.diff* infections has continued. Rotherham health community continues to pursue a culture of zero tolerance in relation to preventable infection. Breaches against monthly plans were reported on four occasions for The Rotherham Foundation Trust (The RFT) and four occasions for NHS Rotherham, however both commissioner and provider organisations performed well against the annual plan. Breaches were discussed within the individual organisations with reports to the relevant committees. Health economy wide performance meetings were held with resulting action plans, which were monitored via the Strategic Infection Prevention and Control Committee.

The Commissioner out-turn includes isolates from laboratories and hospitals other than The RFT where NHS Rotherham is the accountable commissioning organisation i.e. where the patient is registered with a Rotherham registered GP and hence the NHSR responsible population. Out of areas isolates are followed up by the Health Protection Manager.

The trajectory and out-turn for 2011/12 was as follows:

	Trajectory (Annual Plan)	**Actual Annual Out-turn**
The RFT Provider	42	35
Commissioner	84	82

4.1.1 MRSA Bacteraemia

Outturn for 201/12

	Trajectory	**Actual**
RFT	2	1
Commissioner	6	4

The RFT have continued to perform well, having reported zero incidence of MRSA bacteraemia up to March 2012 (23 months). In March a baby was transferred to the RFT Special Care Baby Unit from out of area and whilst the baby was known to be colonized with MRSA at the time of transfer, went on to develop an MRSA bacteraemia some time after admission. Whilst the bacteraemia was reported as a serious incident, the root cause analysis confirmed appropriate care and management of the baby by the RFT. As the baby was registered with a Sheffield GP this isolate was not allocated to NHS Rotherham. Of the remaining 4 (NHS Rotherham allocated), one was confirmed to be a contaminant, one was a patient who underwent surgery at Bassetlaw and one patient who was a renal patient under the care of Sheffield and the Rotherham Renal Dialysis Satellite Unit had two samples taken more than 14 days apart, which therefore counted as two isolates. Following root cause analysis those areas where practice and management could have been improved were identified, as all three cases (4 isolates) could have possibly been prevented.

One outstanding action for an MRSA bacteraemia occurring in January 2011 which required prescribing training within a practice was completed and closed during the reportable period.

4.1.2 Methicillin Sensitive *Staph aureus* (MSSA) Bacteraemia

Whilst no trajectory was set for the reduction of MSSA bacteraemia there was the expectation that root cause analysis would be carried out to identify lessons that could be learned to reduce future risk and incidence, although it is widely accepted that there are far more variables in relation to MSSA than for MRSA. For the reportable period the following were reported:

The RFT	11
NHS Rotherham	48 (12 of these were reported by STH)

4.1.3 E. coli Bacteraemia

E. coli continues to cause nationally due an increasing level of drug resistance. In an attempt to address this growing concern mandatory reporting and enhanced surveillance was introduced in June 2011, although the complexities of these infections are well recognized. To date no reduction plans have been set. Between June 2011 and March 2012 the following was reported.

The RFT	163
NHS Rotherham	172 (21 of which were from STH and 7 of which were DBH)

4.2 Outbreaks

Information on outbreaks is received via a variety of sources, including Food, Health and Safety (RMBC), The Rotherham NHS Foundation Trust and The South Yorkshire Health Protection Unit. To aid detection of and ensure appropriate management of potential outbreaks in schools, the Local Education Department reported levels of absenteeism

above 10% to the Consultant in Public Health and Health Protection Manager at NHS Rotherham. In addition to the Norovirus outbreaks reported below the following outbreaks were reported:

- Flu like illness/confirmed influenza A – 4 outbreaks were reported, three involving care homes and one involving a primary school.
- Viral outbreak – an outbreak of sickness and diarrhoea was reported from people who had been to a hotel/restaurant. The investigation confirmed this was norovirus.
- There was a family outbreak of E.coli 0157 which involved excluding food handlers from work.
- Parasitic Infections – two outbreaks of scabies were reported within care homes and one outbreak of threadworm among staff in a care home.
- Enterovirus – 2 outbreaks were reported, one affecting a nursery and one affecting a secondary school.
- Water Quality Incident – this involved a family with raised blood lead levels. This investigation is ongoing at the time of writing the report.

4.3 Gastroenteritis/Norovirus

The winter period of 2011/12 saw high levels of Norovirus/gastroenteritis, which had a significant impact on both secondary care and care homes. However bed closures within secondary care were minimized as a result of cohorting affected patients in bays/side rooms. Due to the resulting pressures and potential impact on services, daily surveillance and monitoring was established supported by the South Yorkshire Health Protection Unit. Activity and impact was reported via the SitRep to the NHS South Yorkshire and Bassetlaw Executive Team.

Care Homes	20
Education	3
Hotel/Catering	1
Nursery	1

5. INFLUENZA

Flu activity throughout the 2011/12 season has remained relatively low, within baseline thresholds. Whilst this was reflected generally within Rotherham, the number of GP consultations for flu like illness was consistently higher from week 2 to week 14 compared to other areas across South Yorkshire and Bassetlaw. Whilst there were some reports of Influenza A H1N1 (2009) and influenza B, the predominant strain reported was influenza A (H3) and influenza A (unknown type), prescriptions for anti-viral treatment remained low. There was also generally a high level of other respiratory viruses such as Respiratory Syncytial Virus and Rhinovirus,

The number of patients requiring admissions to secondary care was low, all of these cases were confirmed as influenza A (unknown type), none of which required critical care intervention. There were no admissions during 2011/12 as a result of influenza A (H1N1 – 2009).

Location	Number confirmed	Number admitted to Critical Care	Number of Deaths	Risk Factors
The RFT Admissions	8 (3 children's unit, one to labour ward, 5 medical unit)	0	0	None identified
Community Isolates	1		0	
A/E	1 clinical diagnosis (no laboratory confirmation)		1	Asthma – patient was invited for vaccination on two occasions by the GP, but the patient failed to attend/respond to the invite

The age ranges of those where influenza was confirmed was as follows:

Under 10 years	3
ears	3
> 65 years	4

5.1 Influenza Immunisation Vaccination Programme

The flu vaccination programme remained unchanged from the previous year in terms of the eligible cohorts, however a target of 60% was introduced for the under 65 at risk groups. The campaign was actively supported by NHS Rotherham and its partners within primary care. Following a success pilot of Community Pharmacists to administer flu vaccine to eligible patients over the age of 18 years in 2010/11 the scheme was commissioned again via a service level agreement for a managed service. Eight pharmacists were commissioned to deliver this service, however only 167 vaccines were administered via this route. Contract variations were put in place with The RFT to administer vaccines to eligible groups within general medicine, care of older people wards and maternity services (in patient areas and ante-natal clinic only), however this arrangement failed to be delivered by The RFT, resulting in no additional vaccinations being administered. Despite a fairly quiet flu season and the lack of a lack of national media campaign uptake in Rotherham was generally good, with performance being above the national and the Yorkshire and Humber average in all elements other than pregnant women, however an improvement in all areas of the programme was noted compared to the previous year.

Year	Patients 65 and Over % Cover	National Average	Patients Under 65 at Risk % Cover	National Average	Pregnant Women NOT in clinical risk group	National Average	NHSR Staff	National Average
Sept.2007-Jan.2008	76.2		50.3					
Sept.2008-Jan.2009	76.1		51.2					
Sept.2009-Jan.2010	74.4	72.4	55.0	51.6			17.9	26.4
Sept.2010-6.Feb.11	74.9	72.8	50.8	50.3	38.2	37.7	52.7	Unavailable
September 2011-March 2012	76	74	53.6	51.6	All pregnant women 21.8	27.4	67.4	Unavailable

There was a strong media campaign aimed at carers, facilitated by NHS Rotherham, supported by Rotherham Metropolitan Borough Council, this resulted in an uptake by carers of 51.2%. As there is no definitive list of carers and not all are coded on the GP clinical system, the difficulty in identifying people in this group must be recognized. Engagement of this group often relies on the carers identifying themselves to the practice.

Influenza Immunisation Uptake for RMBC for eligible staff groups

2009 -10	10%
2010 - 11	34%
2011-12	176 staff vaccinated, although it is difficult to estimate as a percentage due to the constantly changing staff base.

Uptake for healthcare workers employed by The RFT was 62%, and whilst this was a slight reduction on the previous year, it should be noted that The RFT staff base now includes community services.

Planning for the 2012/13 programme/season has already commenced.

6. COMMUNICABLE DISEASES

6.1 Infectious Diseases in Pregnancy Screening

Following the completion of a gap analysis against the new standards in April 2011, a group consisting of representation from The RFT and NHS Rotherham was established to oversee implementation of the standards. A new policy document was developed by the Maternity Services at The RFT with support from colleagues in GUM, Hepatology, Paediatrics and Pathology, the policy was approved in March 2012 for full implementation from April 2012. It is intended that compliance against the standards will be audited during

2012/13, although there is regular monitored by the South Yorkshire and Bassetlaw Ante-natal and Newborn Screening Programme Board.

As a result of this work, the key outstanding area is in relation to the vaccination of Rubella susceptible women with 1st dose MMR prior to discharge. This issue is still under review, with work continuing through 2012/13 to ensure implementation of this standard.

6.2 Blood Borne Viruses

The multi-agency viral hepatitis steering group has continued to meet and has provided valuable contribution to the work of the regional HPA and public health department within the Strategic Health Authority on the development of a regional quality standards framework, to be used by commissioners and providers, to ensure access to hepatitis B and C services, testing and management in line with national standards. The group has continued to review the clinical pathway including testing methods and identifying ways to reduce the number of patients failing to attend appointments and improve treatment outcome. In July Rotherham participated in the World Hepatitis Day by having a stall in Rotherham Town Centre, to raise awareness, signpost people to their GP for testing where indicated and provide information and reassurance to anyone concerned regarding possible exposure – in addition to NHS Rotherham, the event was supported by Rotherham, Doncaster and South Humber Foundation Trust, Rotherham Foundation Trust and the South Yorkshire Health Protection Unit. A scoping exercise was undertaken to assess the possibility of a shared care protocol for Hepatitis C. whilst following review it was agreed with the Lead for the CCG not to pursue this at the present time, it was agreed that a shared care pathway for Hepatitis B should be developed, to include financial and resource implications – this work is still in progress at the time of writing this report and will be incorporated into the work plan for 2012/13.

The number of individuals within structured drug treatment recorded as being current or previous injectors who have received a Hep C Test shows an increase year on year with a significant rise over the last 2-3 years due to a strategic focus on Blood Borne Viruses, increasing from 22% in 2008/09 to 74% in 2011/12 (source: ndtms). Further local data indicates that a further 206 individuals have been screened during the reportable year with 83 positive tests being reported. Whilst referrals to treatment via the local pathway continue to increase, concerns remain regarding the DNA rate, investigation and analysis suggests this could be a reflection of 'readiness for treatment' for those individuals.

Rates of individuals entering drug treatment in year being offered and subsequently vaccinated for Hep B has been a local priority and is part of service improvement plans within the main contract with RDaSH. Whilst only 61% of these individuals have been vaccinated in year there is evidence that a wider group of drug treatment clients have also benefitted from this intervention. In an attempt to improve the take up of Hep B vaccinations a local six month pilot utilising a 100 hour town centre pharmacy commenced with a focus on those placed with the pharmacy for supervised consumption and also those accessing the pharmacy needle exchange provision. As the pilot had very limited take up by the client group the decision has been made by drug alcohol treatment (DAT) commissioning team not to roll the programme out wider. An evaluation of the pilot is available upon request from the DAT commissioning team.

6.3 TB Services

The multi-agency steering group facilitates a multi-faceted approach to the reduction, management and the provision of TB services to improve clinical outcome. Work streams have included reviewing the clinical pathway for children, adults and healthcare workers against the revised NICE Guidelines, identifying any gaps and service development needs. The group review and assess the impact of immunization provision, this has contributed to the work of the Rotherham Immunisation Steering Group and also the Rotherham Ante-

natal and Newborn Screening Operational Governance Group, as work progresses to introduce neonatal BCG vaccination prior to discharge. Changes have been made in relation to the diagnosis of latent TB, with the introduction of T-Spot testing, it is envisaged that this change will allow more patients with latent infection to be diagnosed and treated, reducing the risk of onward transmission due to reactivation on untreated disease. Rotherham has seen a significant increase in the number of new entrants, both direct and transferring from other towns and cities in the UK, who have a higher risk/incidence of TB, existing services and regional variances in screening do not necessarily allow for the timely and comprehensive follow up and assessment of these residents, which increases the risk of active infection to the individual and onward transmission to others. Work has commenced through one of the Public Health Specialists to develop a pilot new entrant health check/assessment which include assessment for TB, this would supplement the service that already exists for the asylum population. As of the 1st April 2011 the TB nursing service became integrated with TRFT and whilst this role is primarily a community service, due to the lack of TB specialist nursing resource within TRFT the transition has resulted in increased demand on current resources.

6.4 Sexual Health

6.4.1 Chlamydia

The Chlamydia screening programme is now commissioned from our local, core services in line with national guidance. Rotherham CaSH (Contraception and Sexual Health) service has been commissioned to deliver the programme until March 2013. The programme has changed nationally with the emphasis shifting from overall coverage to a model based on detection and prevalence rates. The delivery of the existing programme reflects this change by having a more targeted approach whilst still operating within an open access framework. As a result of the changes in provider and overall direction of the programme the overall screening during 2011 has dropped, however it is anticipated that rates will increase over the coming year. It is also anticipated that monitoring of Chlamydia testing via the newly implemented CTAD reporting system will provide more accurate information of the levels of infection within the population.

6.4.2 HIV

Whilst the rate per 100,000 population has increased from 41.11 in 2006 to 61.45 in 2010 Rotherham continues to manage relatively few cases of HIV and as such remains a low prevalence area having a rate lower than 2 per 1,000 population. Of new HIV diagnosis in Rotherham,14% are diagnosed late (CD4 count <350 cells/mm3). In line with new national guidelines, work has commenced involving NHS Rotherham Public Health Specialists and the Rotherham GP Champion for Sexual Health to raise awareness in Primary Care and to educate public and patients ensuring that patients do not present late to GUM clinics, to avoid delay in treatment, reduce the risk of complications, improve survival rates and reduce the risk for transmission of infection to others.

6.4.3 Sexually Transmitted Infections (STI's)

Although rates of STIs have shown an overall decrease Rotherham still has higher levels of infection than the average for the Yorkshire and Humber Region. An increase in the uptake of LARC (Long Acting Reversible Contraception) among young women in Rotherham has shown a decrease in teenage pregnancy but has not shown a corresponding decrease in STI levels within this population. We have also seen an increase in STIs among the 40 plus age group. This highlights a need to promote the use of barrier contraception as a preventative measure against the spread of sexually transmitted infections within these population segments. NHS Rotherham Public Health has commissioned a social marketing company to research both of these groups and develop and evaluate suitable marketing tools.

6.5 Food borne Illness

The Health Protection Agency report on calendar quarters, the data provided is therefore for 2011 (January – December 2011) as opposed to the reportable period (April 2011-March 2012).

	2010	2011
Campylobacter	374	368
Cryptosporidiosis	23	20
Giardiasis	10	10
Listeriosis	1	1
Rotavirus (b)	55 (Jan-Sept)	168 (Jan – sept) (175 total year)
E. Coli 0157	6	9
Salmonella	36	33

Whilst seasonal fluctuations were noted, the overall epidemiology remains largely unchanged, with increases noted in E.coli O157 notifications and rotovirus; these were mainly in the first six months of the year, with no specific reason being identified. A novel strain of E.coli O104 (H4) was identified in some parts of the UK; however this did not cause any problems for Rotherham residents.

7. VACCINATION AND IMMUNISATION

The reduction of vaccine preventable disease through timely immunization of eligible groups remains a priority for NHS Rotherham and public health. Work has continued throughout the reportable period to improve uptake of all programmes. Some key points include:

Ensuring there is a timely flow of data between GP practices and the Child Health Department about attendees and those children who failed to attend. Children/babies who do not attend are reported to and followed up by practice staff and health visitors.

For targeted programmes such as Neonatal BCG and Neonatal Hepatitis B, babies/children who fail to attend at The RFT are referred to and followed up by the Health Protection Manager. For children who are missing serology following 4th dose Hepatitis B vaccination dried blood spot testing may be used to check hepatitis infection status has been introduced.

Immunisation uptake data/QUILT is collated monthly and quarterly and is sent to all practices to allow benchmarking. Practices that do not meet the uptake targets for the quarter are asked to undertake a root cause analysis to identify possible reasons and identify actions/changes to practice to improve uptake.

A pilot project has been undertaken to improve the information provided to parents and engage children in an attempt to improve uptake of pre-school booster immunisations. This project will be evaluated and future plans agreed.

7.1 Childhood Immunisation Programme (0-5 years)

Uptake of this programme is monitored nationally via the Health Protection Agency COVER data. Whilst the targets for uptake were increased from a public health perspective, with the aim being to achieve herd immunity, the payment targets for GP's remain unchanged, this continues to pose a risk in that once the upper payment threshold (90%) is reached, and efforts will be reduced. Although the annual data shows a shortfall of less than 5% against the targets, there is still improvement on the previous year, with five of the six elements achieving above 90% and two out of six achieving above 95%, however the uptake

suggests that some parents continue to have concerns regarding the safety of the MMR triple vaccine and the preschool booster remains a difficult group to engage. Outbreak reported elsewhere in the country have been used to promote uptake among the population of Rotherham. Root cause analysis has identified the problems experienced by some practices as a result of changing demographics such as transient populations and Eastern European migrants for who healthcare in general is not a high priority. Work has commenced with partners to try and address some of these issues.

Vaccine / Age	Target 09/10	Actual 09/10	Target 10/11	Actual 10/11	Target 2011/12	Actual 2011/12
DTaP/IPV/Hib- age 1	92%	94.8	95%	96	97%	96.2
MMR- age 2	88%	88.4	92%	91.8	95%	92.2
Hib/MenC age 2	85%	94.7	90%	95.4	96%	95.3
PCV Booster- age 2	80%	90.0	85%	92.8	95%	93.8
MMR 2 - age 5	85%	85.5	90%	89.1	92%	89.5
DTaP Booster – age 5	85%	86.7	90%	90.8	93%	91.1

Source – HPA Cover Data

7.2 Immunisation Programmes (5-18 year olds)

7.2.1 MMR Catch-up (5-24 year olds)

The programme for the 5-18 year olds continues to be delivered via the School Nursing Service, which is now part of The RFT. The national report run by ImmForm for August 2011 showed an uptake of 85.6%, this showed no significant improvement on the previous year (85.5%). Vaccination has also been encouraged via GP's for the 19-24 year olds, although as there is no formal reporting mechanism or survey which covers this group uptake cannot be calculated.

Tetanus, Diphtheria and Polio 13-18 year olds (School Leavers Booster)

This element of the programme is delivered via the School Nursing Teams and reported to and by the Child Health Information Department. At the time of writing the report no uptake data is available however plans have been put in place to run reports based on the academic year, the report to the end of August 2011 is awaited.

7.2.2 HPV Vaccine

The HPV programme has continued in line with national guidance, the routine cohort being girls between the age of 12 and 13 years, with uptake based on academic year as opposed to financial year. Uptake for the 2010/11 academic year to July 2011 was 84.4% against a target of 90%.The programme has continued to be delivered by a designated team within Children and Young Peoples Services, although the number of staff within this team has been significantly reduced, which has had an impact on the number of catch up clinics they are able to deliver. Concerns have been raised regarding performance via the contracting team at NHS Rotherham, who have in turn raised these with the contract team at The RFT. Reassurance has been provided via this route that the planned schedule will deliver the target by the end of July 2012.

12-13 year olds	Dose 1	Dose 1+2	All Three doses
uptake as of the end of March 2012	83.8%	81.3%	05.%

7.3 Pneumococcal Immunisation Programme

Following a review by the Joint Committee for Vaccination and Immunisation (advisors to the Department of Health regarding efficacy and cost effectiveness of Pneumococcal vaccination in the over 65's, the decision was taken to continue with the current programme, which is therefore offered to those aged 65 or over and those under the age of 65 years with risk factors for invasive pneumococcal disease. Uptake is assessed by a single annual survey and whilst there is no national target for uptake for the over 65's, NHS Rotherham aimed for a year on year improvement.

2009/10	73.9%
2010/11	74.5%
2011/12	74.6%

7.4 Vaccine Efficiency and Supply

One incident has been reported by the ImmForm fridge failure and vaccine storage reporting template. This was a human error; the fridge door was left open, which resulted in a significant loss of vaccine. Vaccine wastage and fridge failures continue to be monitored by the Department of Health Immunisation Team.

7.5 Targeted Vaccination Programmes

7.5.1 Respiratory Syncytial Virus (RSV)

Following an evaluation by the JCVI on the cost effectiveness of this vaccine to provide passive immunization, NHS Rotherham worked with colleagues in Children and Young Peoples Services within Community Health Services and The RFT to ensure that all children in the identified risk groups received the appropriate course of vaccination as per the national guidance. A summary of year on year comparison is provided below.

Financial Year	Number of Children Requiring Vaccination
2004/05	2
2005/06	4
2006/07	8
2007/08	13
2008/09	11
2009/10	9
2010/11	15
2011/12	26 (£100.956.49)

7.5.2 Neonatal Hepatitis B

The multidisciplinary group has continued to meet to review the clinical pathway to ensure compliance with national standards. The audit carried out on mothers delivering in 2009 showed a significant improvement of outcomes compared to those delivering in 2008, particularly in relation to recording the mothers Hepatitis B positive status in the hospital notes, explanation of results, access to verbal and written information, babies receiving the fourth dose of vaccine and recording of subsequent doses on the Child Health Information System.

7.5.3 Neonatal BCG

Babies identified as being at an increased risk of exposure at birth require vaccination with BCG. Currently this is not always offered prior to discharge from the hospital. Babies are required to attend the children's outpatient department to receive vaccination, and whilst this is generally within 6 weeks of birth this system is not without failing, firstly it allows

continued exposure to a susceptible baby and secondly it is associated with a high failure to attend rate. Monitoring of failures to attend commenced in September 2011, with all such babies being referred to the Health Protection Manager for follow up. Between September 2011 and 31st March 2012 41 babies failed to attend for their first appointment for BCG vaccination.

7.6 Training

Staff requiring immunization training has been directed to the Core Learning Unit e-learning programme which consists of a number of modules covering the core elements of the Health Protection Training programme. Latterly training has been sourced from Sheffield University, funded by the Strategic Health Authority, whilst sessions have been planned; this programme of training will not come into effect until 2012/13.
Training will be available to all providers.

7.7 Policy Development

The Rotherham Mass Vaccination and Seasonal Flu plans were both reviewed and approved by NHS Rotherham Board (as stood at the time).

8. INFECTION PREVENTION AND CONTROL IN CARE HOMES

The Health Protection Manager continues to attend the Residential and Nursing Care Liaison Forum, providing support for the Local Authority Contract and Assurance Review Officers Care Quality Commission as required.

The pilot to improve the management of MRSA positive patients in the community commenced in March 2012 across the Central Locality of Rotherham, this pilot includes all practices, District Nursing Teams and three care homes within that area. The pilot will run for three months with monthly progress reviews by the steering group.

9. INCIDENTS

Local incidents**,** MHRA alerts and Food alerts have been reported and the appropriate action taken and assurance being received via organizational reporting mechanisms. Details of specific incidents are available upon request.

9.1 Child Death following Chicken Pox

A one year old child developed chicken pox, which initially followed the normal course for the infection. Four days later the child developed signs of secondary bacterial infection for which the parents sought medical attention, anti viral treatment was commenced by the GP. The child subsequently died two days later after a further 2 hospital attendances. Following the inquest a rule 43 letter was issued to the general practice concerned. It was concluded by the Coroner that had the child be managed differently by both the hospital and GP it is likely that they would have survived.

10. AUDITS

10.1. Primary Dental Care

The Dental Public Health Team have continued to support dental practices in ensuring compliance with HTM 01-05 and requirements for registration with care quality commission. Whilst practices are compliant with the essential standards required by HTM01-05 movement to and compliance with the best practice standards is more difficult to achieve and enforce due to the lack of mandatory timescales. The self audit was repeated early in 2012, the results of which are in the process of being analysed.

10.2 Cold Chain

In accordance with guidelines from the National Patient Safety Agency, an audit was carried out in March 2011 across The RFT (Health and Wellbeing, Child Health and Respiratory Outpatients), Primary Care (28 practices returned the audit, 31 failed to return) and HPV Team to assess compliance in maintaining the cold chain for vaccines. Areas within The RFT have developed action plans and are in the process of implementing these actions. Practices were required to develop individual action plans, which will be assessed by re-audit during 2011/12, however a generic summary and action will be collated and circulated to practices. Key themes identified include:

- Inventory's not being maintained
- Daily recording of fridge temperatures
- Items other than vaccines stored in the fridge
- Vaccine fridge not kept locked
- Vaccine fridge not having a dedicated marked or switchless socket
- Details of fridge failure and action taken not logged
- In Primary Care, Most Health Care Assistants administering vaccines do so under patient specific directives.
- Not all staff involved in immunisation have received two yearly update training

Audit work has also been commenced for the following areas, however the results cannot be reported on at the present time.

- Neonatal hepatitis B immunization pathway
- TB services
- Cold Chain

11. CONCLUSION

The Rotherham Health Economy has achieved much in ensuring safe quality care for the people of Rotherham, reducing the risks associated with Healthcare Associated Infections and improving uptake of vaccination to reduce the risk of potentially life-threatening and debilitating communicable infections in most areas across the majority of all of the programmes. The year ahead will continue to pose significant challenges as we move through a transition year into a new architecture for commissioning and public health. All organizations will be required to ensure robust plans for the continued and sustained reduction of healthcare associated infections such as RSA and C. diff and whilst no specific reduction targets exist for *E.coli* and MSSA bacteraemia very effort should be made to raise awareness and understanding to achieve a reduction in these areas.

Whilst separate outcomes frameworks exist for the NHS, Public Health and Adult Social Care, NHS Rotherham along with its partners across health and social care will need to work collaboratively focusing on shared goals and common priorities to ensure the commissioning and provision of safe high quality care during the remaining phases of transition.

Appendix 1

Strategic Infection Prevention and Control Committee

TERMS OF REFERENCE (2012/13)

Contact Details:			
Lead Director/ Clinician:	John Radford	Lead Officer:	Kathy Wakefield
Title:	Director of Public Health	Title:	Health Protection and Infection Prevention Manager

Purpose:
The purpose of the Committee is to provide strategic direction and oversee infection prevention and control activities and other associated health protection functions across the Rotherham health economy. Providing assurance during the period of transition to the South Yorkshire and Bassetlaw Cluster Board, Rotherham Metropolitan Borough Council and NHSR Operational Executive that all necessary actions are being taken to safeguard the people of Rotherham, reducing the risk of healthcare associated infections and other infection threats. To work collaboratively, exchanging information and sharing knowledge and where appropriate pool resources for mutual benefit to achieve a common purpose.

Responsibilities:
• Provide strategic direction to all providers to ensure high standards of care and practice in relation to infection prevention and control. • To ensure compliance with all relevant legislation, national and local guidelines and policies. • To receive assurance of the above. • Support and inform the commissioning process to promote health and well-being in relation to healthcare associated infections, communicable infections and threats to public health and vaccine preventable diseases including immunisation. • Identify issues that would present a health and safety or clinical risk to patients with regards to infectious agents, members of the public or staff and escalate to the appropriate Committee/Board or body. • Monitor performance of all providers with regards to reducing the risk of healthcare associated infections and communicable diseases. This includes compliance with educational requirements as stipulated in the Health and Social Care Act 2008 (Code of Practice). • Receive surveillance data and act accordingly. • Oversee the vaccination and immunisation programme – receiving reports and feedback from the Rotherham vaccination and immunisation steering group. • Ensure the provision of high quality front line services to patients. • Consult with and seek the views of stakeholders and partners as appropriate. • Monitor and review incidents and outbreaks, identifying the lessons to be learned and ensuring these are shared as appropriate. • Review and make recommendations following serious untoward incidents that occur in relation to Infection Prevention and Control and/or Vaccination/Immunisation and HCAI Root Cause Analysis/Reports. • Produce an annual report covering all aspects of the infection prevention and control agenda which will be presented to the Governance, Risk and Quality Committee each June. • Develop an annual work programme to incorporate all aspects of the infection prevention

and control together with the health protection agenda. • Provide expert advice and support as required to the Clinical Commissioning Group and RMBC/Health and Wellbeing Board during the transition period.

Chair:
Health Protection and Infection Prevention Manager – NHS Rotherham

Composition of group:
Health Protection and Infection Prevention Manager Representative from South Yorkshire Health Protection Unit Senior Representative The RFT Infection Prevention and Control Team Senior Representative for Infection Prevention and Control – RDASH RMBC Representative - Neighbourhood and Adult Services RMBC Representative – Children and Young People's Services Representative from Dental Public Health Representative for Performance and Risk Representative from Medicines Management Representative for Primary Care Representative from Food, Health and Safety (Environmental Health) Representative from Sexual Health NHSR Head of Clinical Services – Rotherham Hospice

In Attendance:
Director of Public Health (Director of Infection Prevention and Control for NHSR/RMBC) Contract Leads as appropriate Screening Co-ordinator Departmental Heads as appropriate RMBC Contracting Leads as appropriate

Deputising:
All members must make every effort to attend. If members are unable to attend they must send formal apologies and should send a nominated deputy where possible. Members who do not attend and who have not given formal apologies will be recorded as absent/did not attend.

Quorum:
Chair or Deputy Representatives from two external organisations

Accountability:
Reports to Operational Risk, Governance, Quality Management Group Accountability to the Boards of the South Yorkshire and Bassetlaw Cluster, NHSR and RMBC will be supported by the submission of an annual report. It is the responsibility of members to ensure appropriate feed back to their respective organisations.

Frequency of meetings:
Bi-monthly (alternate Months)

Order of business:
Normal Confidential Section will be applied.

Agenda deadlines:
Items to be received two weeks prior to meeting Agenda to be circulated within two weeks of meeting.

Minutes:
Minutes will be circulated within two weeks of the meeting. These will take the form of action points/notes as opposed to full minutes. Minutes will be circulated to all committee members plus the Director of Public Health. Minutes of non confidential section will be available to non members and members of the public upon request. Minutes will be forwarded to the Chair of the Operational Risk, Governance, Quality Management Group

Administration:
Chair

Attendance:
Members (or their nominated deputies) are required to attend a minimum of 4 meetings annually. This will be audited annually (April of each year). Where the standard has not been met, the individual member will be contacted with regards to addressing the issue, where non compliance persists; this will be reported to the Chief Executive of the relevant organisation.

Review Date:
April 2013 following establishment of the new NHS architecture.

Membership List

John Radford Director of Public Health (Director of Infection Prevention and Control NHSR – Commissioning)

Kathy Wakefield	Health Protection and Infection Prevention Manager
Suzanna Matthew	Consultant for Communicable Disease Control
Ann Kerrane	Matron for Infection Prevention and Control – RFT
Rachel Millard	Head of Clinical Assurance - RDASH
David Morgan	RMBC Representative – Neighbourhood and Adult Services
John Heyes	Dental Advisor Public Health
Claire Rees	Performance and Risk
Richard Potter	Representative for Primary Care
Jason Punyer	Medicines Management
Janice Manning	Food, Health and Safety, RMBC
Jo Abbott	Sexual Health Lead NHS Rotherham.
Dean Fenton	RMBC Representative Children's Services
Paula Hill	Head of Clinical Services, Rotherham Hospice