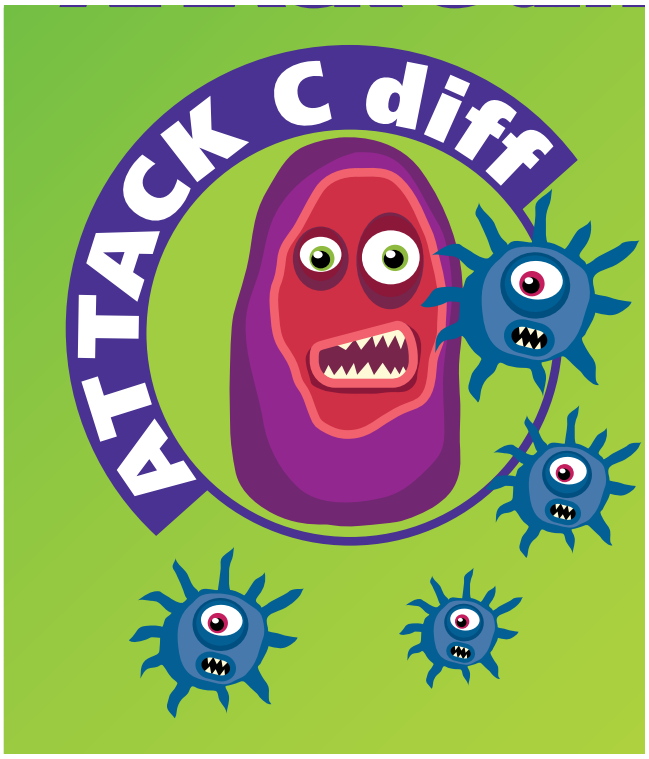
Wye Valley NHS Trust

Director of Infection Prevention Control Annual Report

2013/14



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1. Introduction

This report covers the period April 2013 to March 2014. The purpose of this report is to inform patients, public, staff, the Trust Board and Herefordshire Clinical Commissioning Group of the infection prevention work, the management arrangements, the state of infection prevention and control within Wye Valley NHS Trust (WVT) and progress against performance targets.

Prevention of healthcare associated infection (HCAI) remains a top priority for the public, patients and staff.

In December 2010 a revised code of practice was introduced for the prevention and control of health care associated infections: The Health Act (2008), Code of Practice on the Prevention and Control of Infections and Related Guidance. The code of practice is also referred to as the Hygiene Code and is regulated by the Care Quality Commission. The Trust remains fully compliant with the Hygiene Code. The Hygiene Code requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the state of HCAIs in the organisation. This report is structured in a way which summarises the actions the Trust takes to remain compliant with the code.

There is continuing national focus on trajectory objectives for the reduction of Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infection rates and *Clostridium difficile* rates and these are monitored by Public Health England. In addition mandatory reporting of Meticillin – Sensitive *Staphylococcus Aureus* (MSSA) and *Escherichia coli* bacteraemias continues with no nationally set trajectory at present.

- In 2013/14 the year ended at 0 cases of MRSA bacteraemia, this was against a limit of 0 cases set for 2013/14. As of, 31st March 2014, the Trust had been 401 days without an MRSA bacteraemia.
- In 2013/14 the ended with 17 cases of MRSA colonisation identified greater than 1 day after admission, compared to 28 cases in 2012/13.
- In 2013/14 the year ended with 17 cases of *Clostridium difficile* against a final trajectory limit set at 12 cases. The County hospital had 13 cases, the community hospitals 3 cases and there was 1 case that had been an inpatient in the County Hospital but was diagnosed in a community hospital. These figures were very similar to the previous year when there were 16 cases and maintain the improvement against the 38 cases seen in 2011/12. The community hospitals improved on last year's total of 6 cases.
- In 2013/14 the year ended at 5 cases of MSSA bacteraemias identified greater than 2 days after admission, compared to 3 cases in 2012/ 13
- In 2013/14 the year ended at 13 cases of *E.coli* bacteraemia identified greater than 2 days after admission, compared to 14 cases in 2012/13
- In 2013/ 14 the year ended with 2 ward closures due to Norovirus, compared to 5 ward closures in 2012/13
- Maintenance of excellent results on blood culture contaminants
- The Trust has made significant improvements in reporting all mandatory training, including infection prevention and control. This process is now managed by WVT, previously Hoople. The training programme has been devised to be interactive and has consistently received positive feedback for learning outcomes. The end of year compliance for 2013-14 year-end was 59%. This is a reduction on 2012/13 and reflects the collection of accurate internal data – this is now a baseline for improvement.

2 Compliance Criterion 1: Effective management systems for prevention and control of HCAI informed by risk assessments and analysis of infection

2.1 Committee structures and assurance processes

In 2013/14 the Trust maintained its Infection Prevention Committee (IPC) structure. The committee was chaired by the Director of Infection Prevention & Control (DIPC), met monthly and reported to the Quality Committee. Each service unit is represented by a senior nurse and consultant and reports a set of key performance indicators which include MRSA, bacteraemia, MRSA screening compliance, *Clostridium difficile,* blood culture contaminants, hospital acquired bacteraemias and antibiotic stewardship.

The Trust Director of Infection Prevention and Control position is held by the Director of Nursing and Quality, the DIPC is accountable directly to the Chief Executive and Trust Board.

The Lead Infection Prevention Nurse and Director of Estates and Facilities jointly held the lead for the decontamination role, with Director level leadership provided by the DIPC. The Decontamination Committee was chaired by the Infection Control Doctor. Minutes from the decontamination committee were received at the IPC by exception.

The Infection Prevention Team (IPT), reporting to the DIPC, consisted of an Infection Control Doctor 0.4 whole time equivalent, a Lead Infection Prevention Nurse 0.8 wte and 3.4 wte Infection Prevention Nursing staff. The IPT is supported by many other staff and departments, particularly by the Microbiology department, the Trust antibiotic pharmacist, Health@Work, Heads of Nursing and the Estates and Facilities department.

2.2 Compliance assessment and assurance

The Health and Social Care Act 2008 (DH, 2010) published by the DH provides Trusts with a code of practice for the prevention and control of healthcare associated infections and makes clear their statutory responsibilities. Each Trust is expected to have sufficient systems in place to apply evidence based protocols and to comply with the relevant provisions of the act so as to minimise risk of HCAI to patients, staff and visitors.

Wye Valley NHS Trust has continued to declare compliance against the 10 criterion as outlined below through 2013/14.

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Provide suitable accurate information on infections to service users and their visitors.
4	Provide suitable accurate information on infections to any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	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.
6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections.
10	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.

The Infection Prevention strategy, IPC, DIPC and IPT set the standards by which the risks of HCAI are minimised. This is achieved through the following proactive measures:

- Improving infection prevention and control capability and capacity in Service Units
- Facilitating programmes of education
- Undertaking audit and targeted surveillance
- Formulating policies and procedures
- Providing advice on all aspects of infection prevention and control
- Interpreting and implementing national guidance at a local level
- Involvement with new building and equipment projects
- Managing outbreaks of infection

2.3 Surveillance of Healthcare Associated Infection (HCAI)

2.3.1 Meticillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia, infection and colonisation.

MRSA Bacteraemia

The Department of Health (DH) began mandatory surveillance of MRSA bloodstream infections (bacteraemias) in 2001. This includes all bloodstream infections with MRSA, whether acquired in the hospital or in the community and whether considered to be contaminants or not. Data is reported to the DH (via Public Health England) monthly and quarterly.

In 2013/14 the Trust identified 0 MRSA Bacteraemias.

Blood culture sampling

Throughout 2013/14 the Trust has continued to utilise blood culture packs to support best practice. All blood culture contaminants were followed up by the IPT. The individual taking the blood culture was notified of the contaminant by a Consultant Microbiologist and then competency assessed by a member of the IPT. The process was also formalized with an escalation procedure, ultimately to the Trust Medical Director if a member of staff did not comply with the process. During 2013/14 there was a continued reduction in blood culture contaminants. Contaminant rates are a service unit Key Performance Indicator and are challenged through the IPC. The average blood contaminant rate for 2013/14 was 2.5%, better than the allowable rate of 3%. This is an improvement of 0.4% from 2012/13 contaminant rates of 2.9%.

MRSA Infection/ Colonisation

Rates of MRSA cases identified more than 2 days after admission have continued to reduce with the Trust's universal MRSA screening programme. In 2013/14 there were 17 cases across WVT, compared with 28 cases in 2012/13, a reduction of 40%. In 2013/14 the IPT continued with a strategy entitled the enhanced review period for MRSA. When 2 or more cases of MRSA identified as post admission cases are identified within a clinical setting, an enhanced programme of audit, education and review is implemented. This is reviewed weekly by a member of the IPT and there is a weekly IP audit until the department has achieved 3 weeks of compliant audit scores and no further cases. There were 0 cases of enhanced review period for MRSA related cases in 2013/14. This is an 100% improvement on 2012/13, compared to 7 cases in 2012/13.

Non-Elective MRSA screening.

All patients admitted to the Trust via Accident & Emergency are screened for MRSA using an efficient cost effective test methodology known as the Universal broth method. Compliance with this is monitored and reported monthly to the IPC and monitored as a Service Unit KPI. The average monthly compliance of non-elective admission MRSA screening in A&E at the acute Trust was 98% and the Community hospitals also at 98%. Data is fed back to the units for review and improvement.

Elective MRSA screening.

The Trust continued through 2013/14 with its elective screening programme aligned to the national guidance for MRSA screening. Compliance was at 98% for the County Hospital and 100% for podiatric surgery.

2.3.2 Meticillin Sensitive Staphylococcus Aureus (MSSA).

Through 2013/14 the Trust continued to monitor and report all MSSA bacteraemia cases. Each case of MSSA bacteraemia was investigated to establish potential causative factors. In 2013/14 there were 5 cases identified more than 2 days after admission. None were related to potentially preventable causes such as a peripheral intravenous cannula.

2.3.3 *Clostridium difficile* infection (CDI).

In 2013/14 the County Hospital reported 17 cases against the externally set limit of 12 cases for the year. There were no *C. difficile* outbreaks and no evidence that any of the cases were linked. There were 16 cases in

2012/13. When it became apparent that the Trust was going to exceed its trajectory, a review group was formed. The review group consisted of:

- Dr D. Adams, Lead infection prevention nurse Trust Development Authority
- Dr A Johnson, Consultant microbiologist Wye Valley NHS Trust
- Dr A Milestone, Gastroenterologist Wye Valley NHS Trust
- Michelle Clarke, Director of Nursing & Quality Wye Valley NHS Trust
- Emma Sneed, Lead Infection Prevention Nurse Herefordshire Clinical Commissioning Group (CCG)
- Gillian Hill, Lead Infection Prevention Nurse Wye Valley NHS Trust
- Infection Prevention Team, Wye Valley NHS Trust
- Representatives of Public Health England

Overall most measures were in place but the Trust was asked to ensure that clinicians, including doctors, were involved in the root cause analysis process for all *C. difficile* and that action planning was undertaken as a continuous and real time process. All the outcomes from the review will feed into the 2014/15 *C. difficile* prevention action plan.

An increase in cases is managed with a formalised procedure referred to as a period of increased incidence with enhanced surveillance, cleaning and audit when there are 2 or more cases within a 28 day period in a clinical area. There were 2 periods of increased incidence in the Trust in 2013/14. Once typing of cases was complete, there was no evidence of transmission of *C. difficile* from patient to patient in these periods.

2.3.4 National Nosocomial Infections Surveillance (NNIS) System

Orthopaedic NNIS

A detailed action plan, which included a raft of measures to reduce infection rates following hip and knee replacements, puts the Trust in a healthy position with no infections following these procedures between April and June 2013, and from October to December last year.

The catalyst for the action plan was a notification from Public Health England that the infection rate in total knee replacements stood at 1.7 per cent – higher than the national average.

This applied to data collected until the end of 2012 and, due to the small numbers involved, included data from as far back as 2010.

The action plan included a range of measures, including temperature control, theatre ventilation, wound dressings, aseptic practice, information for patients etc. The current infection rates are summarised below.

Type of Surgery	April – June 2013	October – December 2013
Hip replacements	0%	0%
National Rate for SSI Period	0.8%	0.9%
Knee replacements	0%	0%
National Rate for SSI Period	0.9%	0.9%.

This shows no infections in hip and knee replacements from April-June 2013 and October-December 2013.

2.4 Audit programme to ensure key policies are implemented

Audit projects for 2013/14 completed by the IPT were:

- Annual performance audit against Infection Prevention Society (IPS) performance improvement tool audit criteria.
- Cleanliness of commodes and toileting aids spot checks
- Observation and practice audits.
- Peripheral Venous Cannula prevalence audits quarterly.
- Indwelling Urinary Catheter prevalence audits quarterly.
- Admissions due to urinary tract infections - diagnosis

All audit data is fed back to the department managers with action plans where issues requiring action are identified.

Audit data is available from the infection prevention team on request. Audit action plans are fed into service unit improvement plans for monitoring and action through service unit governance meetings.

Ward/ Department led infection prevention audits

All wards and departments undertake the infection prevention audits below. The results of these are reported in the Infection Prevention Trust dashboard monthly.

- Clinical Environment Monitoring Assurance Tool – Monthly
- Infection Prevention Assurance Tool - Monthly
- Hand Hygiene – Monthly
- Saving Lives audits – Monthly
- Mattress audit – Monthly
- Commodes and toileting aids - Monthly

Audit data is monitored through the estates and facilities performance meeting and infection prevention committee.

Audit data is available for individual areas on request.

Saving Lives audits

Ensuring we know what to do to avoid infection and actually doing this every time are two crucial components of delivering safe, clean care. Undertaking clinical procedures such as line insertion or wound or catheter care requires all relevant healthcare professionals to perform evidenced-based practice consistently. Saving Lives High Impact Intervention audits support this requirement.

All relevant Saving Lives High Impact Intervention (HII) audits are rolled out throughout appropriate areas of the Trust.

Results are fed into and displayed in the department infection prevention dashboards.

2.5 Root Cause Analysis

Root cause analysis (RCA) is a set of problem solving methods aimed at identifying the root causes of problems or events. The practice of RCA is predicated on the belief that problems are best solved by attempting to address, correct or eliminate root causes, as opposed to merely addressing the immediately obvious symptoms. By directing corrective measures at root causes, it is more probable that problem recurrence will be prevented.

RCA for *Clostridium difficile*

The Trust undertakes RCA on all *C. difficile* deaths where it is on part one of the death certificates. All cases of *C. difficile* are reviewed by the IPT and consultant microbiologist and lessons learnt fed to clinical teams and the IPC. There were no deaths where *C. difficile* (identified more than day of admission plus 2 days) was recorded on part one of the death certificate in 2013/14. This mirrors the previous year 2012/13.

2.6 Risk assessment and action

The IPC reviews the risk register for all infection prevention risks logged in the Trust, the IPT are regularly involved in risk assessment recording.

2.7 Staff information, training and supervision

2.7.1 Staff training

The team continues to have a strong training role. Infection prevention training and education programmes during 2013/14 included a programme of mandatory sessions and training to all staff on induction days. Annual training is also delivered to all Medical staff, Nursing staff, Allied Health Professionals, Sodexo and voluntary staff. Training is delivered through formal and informal methods.

Training data is reviewed by the service unit leads and Trust Board. Compliance for the year end was 59%. Reporting for all mandatory training has been revised as it has been brought back into WVT. This record now more fully reflects the levels of training, including breakdown by professional group and service unit. In 2014/15, this will enable activity to be more effectively focused.

2.7.2 Staff information

Ward Dashboards: Infection prevention data is collated on to dashboards. These summarize performance against key criteria including surveillance data, audit compliance, antibiotic prescribing & sharps injury data; these are locally displayed and monitored at service unit governance meetings.

Notice Boards: A Trust wide communications initiative is in place in the form of infection control notice boards for each ward, enabling staff to review their own performance.

Intranet: Infection prevention continues to make use of the intranet for providing staff with an easy access portal for information, policy guidance and team contact details.

2.8 Staff supervision

The IPT is deployed to provide training and expert advice, and monitor compliance by wards and departments with expected standards. In this way, the work of staff in the trust is subject to scrutiny and supervision.

IPT Personal Development and Training:
During 2013/14 members of the team have attended relevant/ required study days and are up to date with mandatory training. All team members are formally trained in infection prevention..

3. Compliance Criterion 2: A clean and appropriate environment for healthcare

3.1 Committee structures and monitoring processes

In addition to the IPC already outlined there are the following committees to address individual issues:

Cleanliness Committee

The Trust has a cleanliness committee chaired by the consultant microbiologist, on behalf of the DIPC, with representation from the Service units, meeting bi- monthly to monitor and deliver against a cleanliness strategy and report in to the Quality Committee. Estates issues are managed through the Estates and Facilities Performance group which meets monthly.

Water Management Group

The Trust has a water quality group chaired by the Trust Engineer which meets three monthly to review monitoring data and compliance with standards. This reports in to the IPC.

Decontamination

The Decontamination Committee is responsible for monitoring decontamination arrangements and compliance overall and reports directly to the IPC.

The committee meets bi-monthly and is chaired by the Consultant Microbiologist who reports to the Trust Executive lead.

The Trust subcontracts with an independent authorised engineer in order to ensure compliance with HTM 01-01. He provides independent auditing and advice to oversee Endoscopy, ENT, Dental and Podiatry decontamination requirements.

The Sodexo managed Hospital Sterilisation and Decontamination Unit, which reprocesses all surgical and other invasive reusable instruments, conducts internal audits to ensure compliance with ISO9001/2000, ISO13485 and the Directive 93/42/EEC + 2007/47/EC and is externally audited twice a year by a notified body.

3.2 Patient Led Assessment of the Care Environment (PLACE)

PLACE inspections were completed in 2013/14 of all the acute and community inpatient sites. The results were favourable from a cleanliness perspective and actions created for every site to address continued compliance and future improvements.

3.3 IPT involvement in service development including reprovision and new build projects

During 2013/14, a new radiotherapy unit has been constructed on the Trust site. The IPT have attended weekly meetings during the planning and constructive phases.

4. Compliance Criterion 3: Provide information to patients, the public and between service providers on HCAI

4.1 Communications programme

During 2013/14 the infection prevention team has continued with the Pull Together to Prevent Infection campaign and has launched and implemented the Herefordshire-wide *C. difficile* ATTACK campaign. This has publicized key messages about the diagnosis and management of *C. difficile* in multiple formats including posters, bespoke training and badges.

4.2 Trust website and information leaflets

The Trust website promotes infection prevention for patients and visitors and includes details on the MRSA screening programme and information for patients and visitors for use prior to admission or visiting. There is a dedicated Infection Prevention section in the hospital handbook available to all patients. Patient information leaflets related to specific conditions/ infections are available from the Trust intranet site.

4.3 IPT meetings with stakeholders

The IPT was represented at the Trust Annual Public Meeting on 23rd July 2013 and championed the Trust Pull Together to Prevent Infection campaign.

4.4 Providing information when patients move between providers

As part of assessment of the Trust's compliance with the Hygiene Code, it is necessary that patient transfer information is shared by recording HCAI status on discharge summary letters and thereby GP notification and transfer documentation. Trust documentation supports the flow of this information. In addition the IPT notify appropriate providers of infective status information as appropriate.

5. Compliance Criterion 4: Promptly identify, manage and treat infected patients

5.1 MRSA screening

The Trust has continued with its successful Universal MRSA screening strategy ensuring all emergency and elective admissions to the Trust are screened so that positive cases can be identified within 24hrs of admission for appropriate management and treatment.

5.2 Managing outbreaks of infection

5.2.1 Norovirus

There was a reduction of 75% in the numbers of Norovirus outbreaks in 2013/14 in comparison to 2012/13. There were 8 ward closures in 2012/13 and only 2 in 2013/14. The Trust continues with its robust outbreak management policy with timely closure, effective management and support and rigorous review on reopening times and post outbreak cleaning regimes.

Location & Date	Patients Affected	Staff Affected	No. of days closed
Arrow 03/04/13- 11/04/13	13	1	8
Wye 28/06/13- 03/07/14	12	3	5

5.2.2 Water contamination

In line with the new addendum to Health Technical Memorandum 04-01, the Trust has introduced 6 monthly testing of taps in augmented care areas, such as the Intensive Care Unit and the Special Care Baby Unit, for pseudomonas. If pseudomonas is detected – low levels were detected on two occasions in 2013/14 - the taps are cleaned and retested and additional infection prevention precautions are initiated. There have been no cases of infection in patients associated with these incidents. In addition, the Trust's private finance initiative partner carries out testing of water outlets for legionella. If detected, this is reviewed by an incident group and remedial actions are implemented. Again there have been no patient cases associated with any detection of legionella

5.2.3 Theatre ventilation

In October 2013, as part of assurance monitoring of the Trust environment, the Estates and Facilities department identified that not all theatre ventilation systems met required standards. This resulted in suspension of hip and knee replacements for a short period until the issues were resolved. The Trust reviewed infection rates with Public Health England and the decision was that further investigation into past surgical site infections was not required

6. Compliance Criterion 5: 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.

The Trust has access to specialist advice with the resource of the IPT and Consultant Microbiologist, advice is available 24hrs a day. Regular communication with Public Health England and the Trust Development Authorityy is well established with robust systems in place to escalate issues where appropriate, such as outbreaks or serious incidents. The Trust has a well embedded ethos of infection prevention being the responsibility of all.

7. Compliance Criterion 6: Co-operation within and between healthcare providers

7.1 Health Economy working

The Trust participates in a health economy HCAI Forum chaired by the Lead Nurse, Herefordshire CCG with Trust membership from the DIPC, Infection Control Doctor and Lead Infection Prevention Nurse. The forum has membership from provider and commissioning organisations and reviews the health economy outcomes and strategies for infection prevention.

The Trust IPT meets regularly with the CCG lead infection prevention nurse to undertake joint working and share strategies for preventing infection across both organisations.

8. Compliance Criterion 7: Provide adequate isolation facilities

The Trust has en-suite rooms for the isolation of patients identified to have diagnosed or undiagnosed infection. These isolation rooms are reviewed daily by the IPT and a dedicated database shared with the clinical site managers is updated then colour coded to manage isolation rooms optimally. This system has worked very

effectively in ensuring appropriate patients are isolated and enables the IPT staff to review all isolated patients daily to ensure their infection related management is appropriate.

9. Compliance Criterion 8: Ensure adequate laboratory support

The IPT is supported by a fully accredited Microbiology Department.

10. Compliance Criterion 9: Policies and protocols

10.1 Antibiotic Stewardship

Key developments for this 2013-14

- Roll out of a patient information leaflet about antibiotics which is included in all discharge packs
- Introduction of key performance indicators for antibiotic prescribing with quarterly feedback of data to consultants
- Establishment of a Herefordshire-wide antimicrobial stewardship group to promote good antibiotic prescribing in secondary and primary care and in veterinary practice and to raise awareness of antibiotic resistance in the general public
- Purchase of an antibiotic app to ensure guidelines are readily available

Overall antibiotic consumption remained similar to previous years.

Qualitative data regarding antimicrobial prescribing is obtained from a monthly antimicrobial prescribing point prevalence study. Four criteria are audited, documentation of allergy status, adherence to local antimicrobial guidelines, documentation of a duration or review date, and documentation of indication. These are taken from the antimicrobial "care bundle" and the latest DH guidance for antimicrobial stewardship in hospitals. Overall compliance is between 75-80%.

10.2 Policies and Procedures

The areas of the work programme described in this annual report are relevant to the policy areas listed in the Hygiene Code. The Trust is confident it has policies to support Trust practices as required. These are available through the Trust intranet site. Policies are updated and approved by the IPC according to review dates or changing practices. Policies were compared with peer performance and national guidance to ensure best practice was promoted.

During 2013/14 7 number of polices were ratified. This included:

- Hand Hygiene Policy
- Management of Infection Free (Including MRSA) Joint Replacement Ward Policy
- Viral Haemorrhagic Fever Policy
- Pulmonary Tuberculosis Policy
- Notification of known or Suspected Infection Policy
- Creutzfeldt-Jakob (CJD) & Variant CJD (vCJD) - Minimising the Risk of Transmission
- Glycopeptide Resistant Enterococci (GRE) Policy

11. Compliance Criterion 10: HCAI prevention among healthcare workers

Roles and responsibilities guidance, available on the intranet and circulated to wards and departments, are available for all staff groups explaining their particular responsibilities around infection prevention. Job descriptions include infection prevention responsibility. The IPT participates in induction training and mandatory updates for all staff groups. Health@Work services are provided as required within the Trust. The IPT work with Health@Work services to support the flu and MMR vaccination campaigns and needle stick injury prevention programme. Compliance is monitored through the IPC.

12. Conclusion

Eliminating avoidable healthcare associated infection remains a top priority for the public, patients and staff. In response, a robust annual programme of work has, yet again, been implemented over the last year which has been led by an experienced and highly motivated Infection Prevention Team. Particularly notable successes include:

- Zero MRSA bacteraemias with more than a year free of MRSA bacteraemias
- A reduction in the number and duration of norovirus outbreaks
- Maintenance of excellent results on blood culture contaminants
- Continued reduction in MRSA cases identified more than 2 days after admission

The challenges of *C. difficile* prevention remain, especially as numbers fall and this will be a focus of work next year. The DIPC and IPT would like to thank all staff for their continuing efforts in Infection Prevention and Control.