TRAFFORD COUNCIL

Report to:	**Health & Well Being Board**
Date:	**21 July 2017**
Report for:	**Information**
Report of:	**The Interim Director of Public Health**

Report Title

Health Protection Annual Report

Purpose

To provide an update on health protection and infection control in Trafford

Recommendations

To note

Contact person for access to background papers and further information:

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Trafford Community Infection Prevention & Control Annual Report (April 1st 2016- March 31th 2017)

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Executive Summary

High standards of infection prevention and control are essential to ensure people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday clinical and social care practice and must be applied consistently by everyone.

Good management and organisational processes are also crucial in ensuring high standards of infection prevention and control. This should result in effective prevention, treatment and containment of infection. Effective action relies on accumulating a body of evidence that also takes account of current guidance and best practices around hygiene and cleanliness.

It is the purpose of this Annual Report to evaluate such evidence and practice for compliance against the Infection Prevention and Control (IPC) work plans that were included as part of the previous 2016-17 Annual Report. Improvements in the delivery of the Infection Prevention and Control service aim to achieve zero tolerance to healthcare associated infections, by building on improvements made during the last 12 months and continuously reviewing priorities for improvement during 2017-18. The Infection Prevention and Control Plan work plan for commissioned services is included in the report and has been embedded in the work program for the Community Infection Prevention and Control Team within Pennine Care NHS Foundation Trust, the Operating Plan and Commissioning Corporate Objectives, Public Health Directorate, Health Protection and Resilience plans and objectives.

This report describes Infection Prevention and Control team activity, the arrangements and progress with the work plan for the period April 2016 – March 2017, and will highlight the achievements made by the service, in helping to reduce the burden of health care associated infections in the community, and to meet the challenges of organizational change and emergence of antimicrobial resistant organisms, such as Carbapenamase producing Enterobactericeae (CPEs).

1. Infection Prevention and Control Arrangements

1.1. Infection Prevention and Control service (IPCS)

The Trafford Community IPCS aims to provide a comprehensive proactive service which is responsive to the needs of service within the Trafford public health economy along with key stake holders, including Pennine Care Foundation NHS Trust (PCFT) provider services, independent contractors, private providers, and local authority commissioned services and the public. It is committed to the promotion of excellence within the everyday practice of infection prevention and control. Central to this is providing advice, support and education for all staff across all the disciplines within the community provider and commissioned services.

This remit extends to the provision of advice and support for schools, nurseries, care homes, general practitioners, dentists, local authority commissioned social care and care agency staff and the general public. The IPCS has responsibility for the monitoring, surveillance and investigation of infections and for advising on preventative and control precautions. This is done as a collaborative partnership between PCFT, Trafford CCG and Trafford local authority.

The IPCS is part of the Nursing Directorate within PCFT, Trafford borough. The Modern Matron (Infection Prevention and Control) is line managed by an operational manager with responsibility for specialist nurses, and the Infection Prevention and Control nurses are line managed by the Modern Matron.

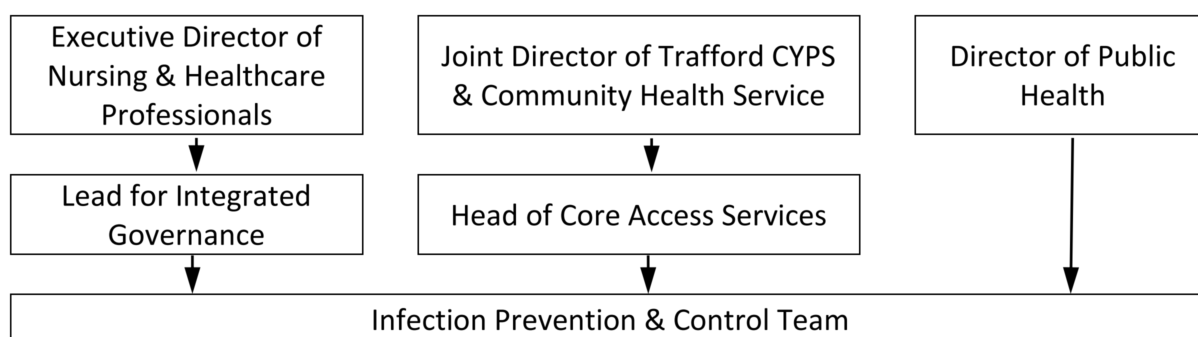

Figure 1 - Reporting and governance arrangements 2016/17

1.2. Trafford Director of Public Health (DPH)

The DPH for Trafford with responsibility for health protection including infection prevention and control is Eleanor Roaf. The roles of the DPH transferred to the Local Authority on 1st April 2013 as part of the Health and Social Care Act 2012 changes. The DPH has an assurance role for health protection, exercised through the Trafford Health Protection Forum. Health protection is a mandated service for the Local Authority and is included in the Memorandum of Understanding between Public Health, NHS Trafford CCG along with PCFT.

1.3. Microbiological Support

A Memorandum of Understanding is in place with Trafford Division of Central Manchester FT (CMFT) Microbiology Department to provide specialist microbiological advice to Trafford CCG. Arrangements

are in place which ensures CDI and MRSA results are communicated to the team daily, via telephone call/messages.

1.4. Trafford Health Protection Forum

The Health Protection Forum Infection Prevention and Control group is chaired by the Director of Public Health. The group meets quarterly to oversee the development and implementation of the Trafford Community Infection Prevention and Control work plan and strategy, and to monitor the performance of providers. It ensures that Trafford community including primary care have in place effective systems and processes to fulfil its responsibilities in the delivery of high standards of care and meet the standards within the Health & Social Care Act (2008), Code of Practice. The Infection Prevention and Control Group's terms of reference are shown in Appendix A.

1.5. Working in partnership with other agencies and organisations

Throughout 2016-17 the IPCS has promoted collaborative working with the local secondary and primary care providers across the full range of infection prevention and control issues. In addition to attending the meetings of the Trafford Health Protection Forum as members of the Infection Prevention and Control group, team members also attend meetings relating to the investigation of incidents of MRSA bacteraemia and community attributed Clostridium Difficile, providing further opportunities for sharing information, and for building and maintaining good working relationships with hospital IPC teams.

The IPCS also delivers infection prevention and control services to Local authority employed and commissioned care staff, developing strong collaborative links with key Social Service providers, private nursing and residential care homes, and care agencies. The Infection Prevention and Control service also attends Nursing Forum chaired by the CCG Personalized Care team.

The IPCS also attends the CCG performance group (POIG), where matters pertaining to IP&C support to primary care, along with the education sub group which develops training for primary care staff. Across the wider Greater Manchester (GM) footprint the Infection control team attends IP&C confederation meetings facilitated and chaired by NHS England, along with GM collaborative network meetings which are held across GM.

2. Meeting Infection Prevention and Control Standards

2.1. Legislation

The Health and Social Care Act 2008, establishes the CQC and sets out a legal framework for the regulation of health and social care activities. Regulations made under the Act describe health and social care activities that may only be carried out by registered providers, and provide details of the requirements for registration. Failure to comply with the statutory requirements set out is, therefore, a breach of registration, under the Health and Social Care Act 2008. The CQC has a wide range of enforcement powers which it can use to respond to such breaches, with information about enforcement activities being made available to commissioners of healthcare and the public.

2.2. Assurance Systems at NHS Trafford

The IPCS undertakes bi-monthly review of code of practice assurance for Pennine Care FT. Regular updates are given at the infection control committee meeting. The Trafford health protection system has the following arrangements and assurance systems in place for the management of healthcare associated infections:

- Director of Public Health for the Trafford
- Modern Matron Infection Prevention and Control Lead Nurse Post, 1x WTE
- Infection Prevention and Control Nurses X 2 1.4 WTE
- Trafford Health Protection Forum (chaired by the DPH) meeting quarterly
- Infection Prevention and Control annual report to Trafford Health Protection Forum
- Trafford CCG Governing Body and Trafford Health and Wellbeing Board
- Monthly infection control/public health updates provided to NHS Trafford CCG Performance
- Officers' integrated governance (POIG) meetings
- Updates by the Trafford DPH to the Trafford Health and Well Being Board

3. Enhancing Service Capability for Infection Prevention and Control

3.1. Education and Training

Infection Prevention and Control is a vital component of an effective risk management program which strives to improve the quality of patient care and the health of staff through the prevention and control of infection. "Infection Prevention and Control is everybody's business" is an adage widely promoted in PCFT, and central to overall strategy is the delivery of quality training and education.

With a rapidly moving agenda, provision of training to a wide range of front line health and social care staff, is deemed a priority for the IPCT. Within PCFT, clinical staff can undertake level 2 IPC training via an eLearning package or by attending a 45-minute face to face training session delivered by a member of the IPCT, non-clinical staff are also able to undertake training via an e-learning package. Staff directly employed/commissioned by the local authority and care home employees from throughout the borough are provided with a 2-hour training package, which includes a UV hand hygiene test. Training for care home staff is provided at their place of work, whilst sessions provided for Local Authority employees are delivered at Trafford Town Hall. GP practices are also provided with a 1½-hour face to face presentation, also including a UV hand hygiene test. Training content for all groups attending is tailored to meet their needs, with sessions throughout the year, receiving highly positive evaluations.

For the 18 nursing homes and 20 residential care homes settings from whom the local authority commission services IP&C, inspections/audits of the workplace are undertaken followed by a training presentation delivered on the same day, allowing observations to be linked into the core content of the presentation, thus giving the training greater relevance to the needs of staff working there (See Appendix B for the 2016/17 training figures).

3.2. Audits and Inspections

The IPCT endeavours to ensure that audit forms part of the proactive service, and that feedback action plans and re-inspection form part of the process of monitoring and quality assurance.

3.2.1. Health centres and clinics and GP practices

A clean, safe environment, in which clinical services are delivered, is a priority for all providers of health care. All Community Health Centre's and clinics previously managed and owned by NHS Trafford are inspected yearly by the infection prevention and control service as part of the cycle of premises inspections. Premises where Pennine care FT deliver services receive a yearly inspection, reports are forwarded to the Pennine audit department, and action plans followed up by the community IP&C team. GP practices which are co-located at the Health Centre's where Pennine Care FT deliver their services, along with standalone GP practices, are also inspected annually, with reports and action plans forwarded to Practice managers and the CCG performance lead, to seek the necessary assurance around progress. Also, included in the cycle of planned visits is the out of hours GP walk in Centre, based at Trafford General Hospital, and the Physiotherapy outpatient services based at Trafford and Altrincham hospitals.

With respect to the inspections listed below, a detailed focus on the management of vaccine fridges was undertaken to give full assurance to the CCG & NHS England, following problems identified at a Timperley practice.

3.2.2. GP Practices

Support for GPs includes an inspection of the practice setting, plus an associated RAG rated report and action plan, focusing on compliance with the 'Health and social care act (2008), code of practice on the prevention and control of infections and related guidance' in preparation for CQC registration inspection.

Over the three year period this method of assessment has been running, the scores recorded in the template testify to a measurable improvement across most of the standards notably: policy development, continuous monitoring standards of IP&C, a nominated individual leading on IP&C for each practice, patient education, vaccine fridge management, waste, sharps management, use of PPE, clinical practices with an IP&C focus, education, Estates issues, decontamination, standards of domestic cleaning, health promotion/patient education.

In the first year of inspections in 2014/15, 41% (n=14) of practices took part. The average inspection score was 75.9% (95% CI 71.8%-80.0%). In year 2 (2015/16), 85% (n=29) of practices took part and the average inspection score was 75.4% (95% CI 71.5%-79.3%). For the most recent round of inspections in 2016/17, 97% (n=33) of practices received an inspection, with just 1 practice declining a visit. The average inspection score was 90.9% (95% CI 88.7%-93.0%), which was a significant improvement on the previous 2 years' scores. The data is summarised in Figure 2.

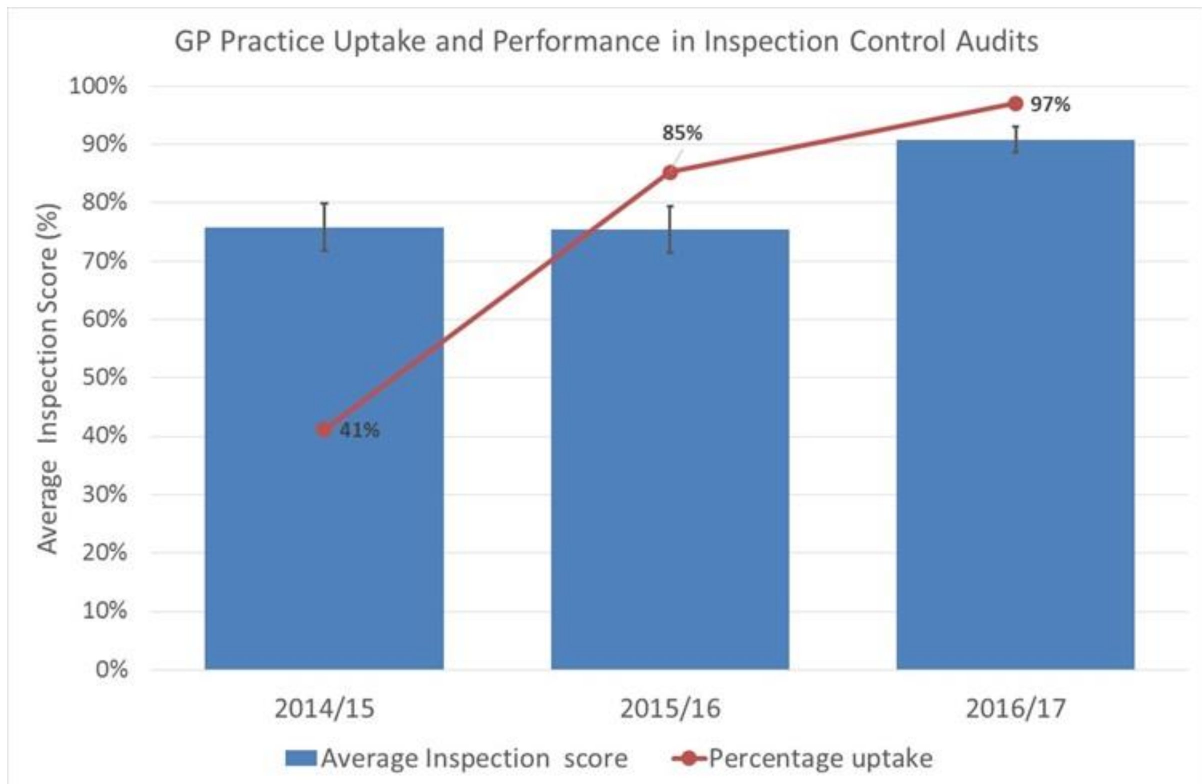

Figure 2 - Graph summarising uptake and performance 2014-2017

The inspections were generally well received by practices. All practices scored higher in the most recent audit than they had in previous years, which implies that inspection recommendations are being actioned.

3.2.3. Care Homes

For care homes with nursing registration, Infection prevention and control support is afforded a high priority. Settings are inspected on an annual basis, and progress with action plans monitored through re-inspection the following year. Where inspection results have fallen below an acceptable threshold, settings are re-inspected within a 3-6-month period to check progress with an agreed action plan.

Delivery of infection prevention and control training and audit to Trafford registered nursing homes 2016-17:

- 1 ½ hour inspection, follow by report and action plan
- 2 hours of infection prevention and control Training.
- Includes an individual UV light hand hygiene assessment
- Request minimum number of delegates 10
- Training to be undertaken by the workforce every two years

18 care home were inspected this year. The average inspection result score was 78%, scores ranged from 55-95% (Figure 3).

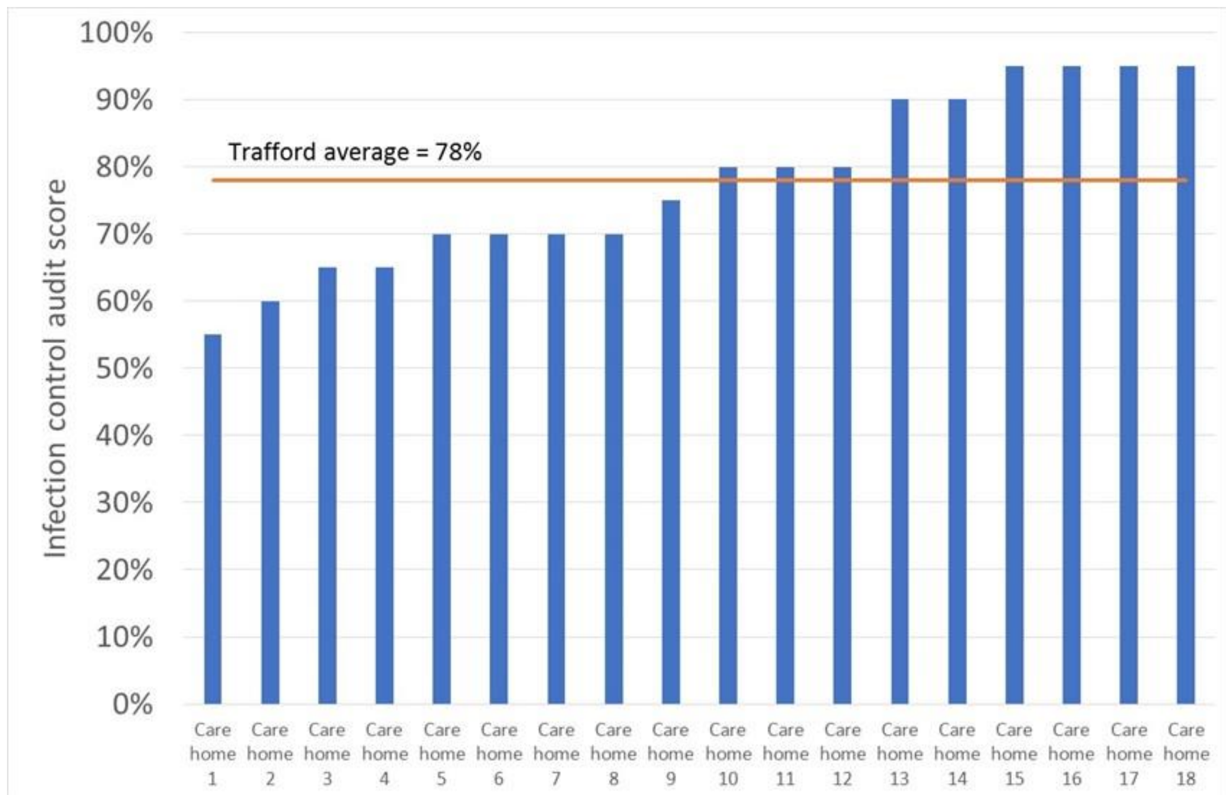

Figure 3 - Performance of care homes in infection control audit

A copy of the inspection report and action plan is sent to the CCG personalised care team, Director of public health, CQC (allocated inspector) and Local authority lead commissioner.

3.2.4. Residential homes

The IPCT have delivered infection prevention and control training and audit to Trafford's residential care homes this year, which consisted of:

- 2-hour inspection, with report/action plan
- 2 hours of infection prevention and control Training.
- Includes an individual UV light hand hygiene assessment
- Request a minimum number of 10 delegates
- Training to be undertaken by the workforce every two years

21 residential homes were inspected and scored using a Red, Amber, Green rating system. The results for this year are shown in Figure 4. This indicates an improvement from last year as 7 (vs 4 from 2015/16) homes achieved a green rating. However, of concern is the 1 facility which was scored red. Further work is underway with this home.

A copy of the inspection report and action plan is sent to the Director of public health, CQC (allocated inspector) and Local authority lead commissioner.

Figure 4 - Results from residential home audits in 2016/17

3.3. Infection Prevention and Control Policies

The Trafford based Community IPCT work collaboratively with Pennine Care IP&C colleagues to review policies for the trust, which are then submitted to PC FT IGC for approval. All IP&C policies have been reviewed in the current reporting year. For care homes and general medical and dental practice, in addition to resources produce by the DH and PHE (previously HPA), guidance developed locally within the local health economy and guidance policy documents supported by the CCG, such as the antimicrobial formula and cold chain policies is also promoted.

3.4. Decontamination

The Infection Prevention Control Nurse is delegated to lead on decontamination liaises with appropriate stakeholders within PCFT and with external independent contractors and agencies around the decontamination agenda, which includes compliance with the Department of Health, Health Technical Memorandum 01-05 Decontamination in Primary Care Dental Practices (2008).

The IPCN has been involved in offering advice and support to general dental practices (GDPs), reviewing plans for setting up Local Decontamination Units in practices, undertaking inspections and delivering staff training at the request of individual practices, and accompanying Commissioners and CQC on performance visits.

In the reporting period, no visits were undertaken in support of general dental practices, however visits have been booked for 2016-17. With respect to Pennine Care FT work stream the Community IP&C team undertake a yearly audit of the One Stop Resources Centre, which includes an inspection of the equipment decontamination unit.

3.5. Hand hygiene

The Hand Hygiene Strategy is embedded within the PCFT hand hygiene policy. The strategy describes the arrangements for monitoring hand hygiene practice, audit, and training, and for ensuring senior trust management, individual staff and members of public understand both their individual and collective responsibilities. Hand hygiene continues to be very much at the forefront of the local and national agenda for Infection Prevention and Control and the hand hygiene standards promoted within the provider service are also used for guidance purposes, to inform stakeholders in the wider health economy. With full backing of the Executive and senior management team, the IPC team, with the support of the hand hygiene champions, continues to place a high priority on raising awareness of correct hand hygiene practice amongst all services within PCFT. Hand hygiene is also given high priority in the current program of training for independent contractors and care home providers, including use of the UV hand hygiene assessment equipment and challenging non-compliance in the work place.

Infection control / Hand hygiene champions Pennine Care FT (Trafford division) have hand hygiene champions/links embedded within team s across all the teams, and contribute to undertaking quarterly hand hygiene audits amongst staff with patient contact. In 2016-17 overall pass rate was 98%, with most non-compliance issues related to the wearing of rings with stones, which is main issue also identified in primary care and the care home sector. Any action plans relating to area of

non-compliance are followed up by the infection control service who contact relevant stakeholders to provide the necessary assurance.

The IP&C works closely with the champions and membership of the group continues to grow, chairing quarterly meetings which provide an opportunity for discussion and support in relation the successes and challenges associated with optimizing hand hygiene compliance across the borough.

3.6. Infection prevention and control initiatives

Before the winter season the IPCS delivered training and education to the care home sector for the management of Outbreaks of D&V and respiratory illnesses. The training was very well received and positively evaluated by the delegates.

4. Healthcare Acquired Infections (HCAI)

A summary of Trafford HCAI performance is shown in the table below.

2016-17 MRSA Bacteraemia & Clostridium difficile infection (CDI)

Organism	Objectives	Actual
MRSA Bacteraemia (assigned to CCG)	Zero tolerance	0
		39 (tbc)
CDI (Trafford non-Trust apportioned)	--------	

4.1. MRSA blood stream infections (BSI)

Surveillance of MRSA blood stream infections is mandatory for acute, general and specialist Trusts; with figures made available to the public via the Department of Health and Public Health England web sites. The post infection review (PIR) carried out after each MRSA BSI, seeks to establish its cause and any contributory factors, assigning cases to the CCG, acute Trust or third party as appropriate. MRSA BSI a key performance indicator and a component of the CCG's quality management systems as commissioners.

There were 2 cases of MRSA Bacteraemia in Trafford patients in 2016-17. PIRs were carried out and both cases were assigned to secondary care, hence the figure of 0 in the table above.

MRSA Positive Results

Laboratory results are reported by telephone, by microbiology laboratory at CMFT. As appropriate, they are followed up with care home managers, clinical staff, General Practitioners and Provider services staff, to provide advice and support in relation to infection prevention and control precautions and treatments. In the 2016-17 reporting period 72 cases were followed up by the team.

4.2. Clostridium difficile infection (CDI)

Trafford has adopted the Clostridium difficile (*C.diff*) investigation tool for nursing and residential care homes document developed by the Health Protection Agency (now known as Public Health

England) in conjunction with an adapted version of the *C.diff* data collection tool provided with NHS England Guidance on *C.diff* objectives for 2016-17. Once again in 2016-17 there were no outbreaks of CDI reported from care home settings within Trafford.

The Guidance within the document has been developed to undertake effective management and care of patients with suspected or confirmed *C.diff* Infection (CDI), limit the transmission of the infection to other patients/residents and provide advice around the involvement of a medical officer. Its aims are to enable staff delivering care within Community care home settings to understand the multifactor causes of CDI, prevent CDI where possible, allow health care staff to appropriately manage and control the infection and minimise discomfort and suffering and maintain dignity and confidentiality.

Data from the HCAI data collection system indicate that Trafford was 25 cases below its cumulative monthly objective. Previous years have indicated a 50/50 +/- 5% split between hospital and community attributed cases. Analysis shows that both community and hospital attributed cases within objectives. Analysis of completed root cause analyses (RCAs) for community attributed CDI Toxin positive cases notified to the IPC service indicates no lapses in care have been identified from the GP.

A CDI prevention strategy is in place and RCA is carried out for 100% of community attributed cases, notified to IP&C team by the lab.

4.3. Medicines Management support

Antibiotic resistance poses a significant threat to public health. One of the roles of the Medicines Management Team (MMT) at the Trafford PCT is to reduce antibiotic resistance and unnecessary expenditure associated with inappropriate antibiotic prescribing.

Of particular concern is *Clostridium difficile* infection, which remains a key issue on which NHS organisations have been mandated to implement national guidance that includes restriction of broad spectrum antibiotics, and second and third-generation cephalosporin's and clindamycin.

Broad spectrum antibiotics, such as quinolones and cephalosporin's, need to be reserved to treat resistant disease, and should generally be used only when standard and less expensive antibiotics are ineffective.

The Trafford Medicines Management Team has works closely with the IPCT to reduce the incidence of *Clostridium difficile* infections (CDI) across Trafford. Work is ongoing and includes:

- Review of the Trafford Antibiotic Guidelines to reduce the use of antibiotics highly correlated with CDI. The majority of first line antibiotics are now those with a reduced risk of causing CDI, yet have a good evidence base for being effective for the relevant infection(s).
- Addition of a two-page alert in the new Antibiotic Guidelines to highlight medicines associated with CDI risk in susceptible individuals.

- The production and dissemination of prescribing alerts to all Trafford GP's, Dentists and non-medical prescribers on a regular basis to highlight the current trajectory of CDI cases versus the DOH target. In addition, tips to reduce the incidence of CDI are also included.
- Letters sent to the GP of any patient that has tested positive for C.Difficile toxin to highlight the need to be prudent with antibiotic prescribing and the use of other medicines that may increase the risk of relapse.
- Aiding root cause analysis when required information is missing by visiting the GP practice directly.
- Conducting practice based audits on vulnerable patients taking long term proton pump inhibitors (PPIs) to determine if the dose can be reduced or stopped altogether, as PPIs are a risk factor for CDI.
- Revision of the evidence base surrounding the use of probiotics as an alternative measure to reduce antibiotic associated CDI.

4.4. Outbreaks in Community Settings

Greater Manchester Health Protection Unit continues to monitor all statutorily notifiable diseases within the borough under the Public Health (Control of Disease Act) 1984 and the Public Health (Infectious Disease) Regulations 1988.

Preventing outbreaks largely depends on the prompt recognition of a single case of infection associated with a condition or organism likely to give rise to an outbreak. Specific organisms that pose a risk of transmission to others for example Clostridium difficile in a care home, or organisms with unusual antibiotic resistance are reported to the Primary Care Trust Infection prevention and control Nurse.

Management of outbreaks/incidents continues to take precedence over other work. There was a total of 14 outbreaks this year, the majority (57%) being diarrhoea and vomiting (D&V). There were also 3 flu outbreaks which took place in nursing and residential homes (Figure 5).

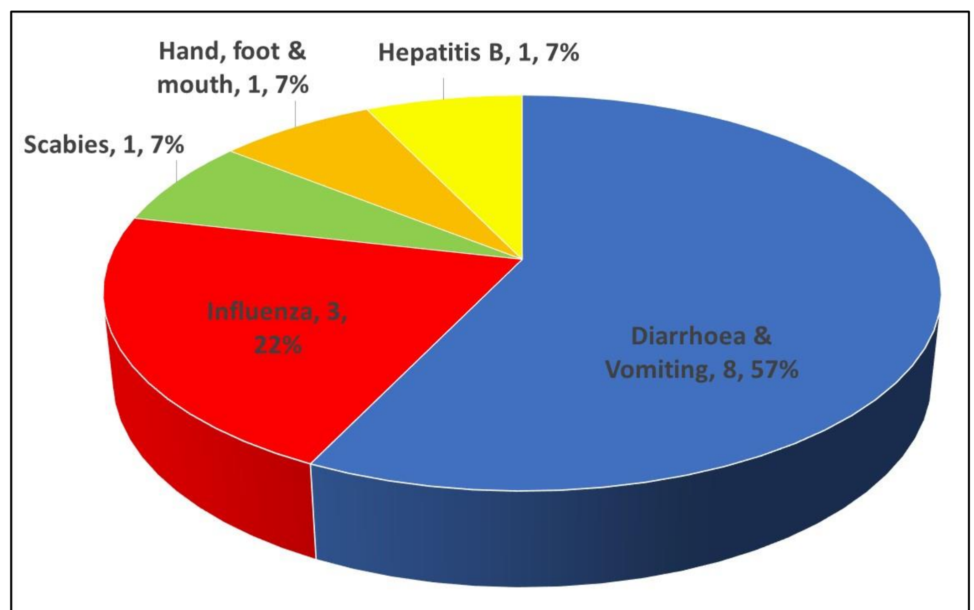

Figure 5 - Outbreaks by disease type

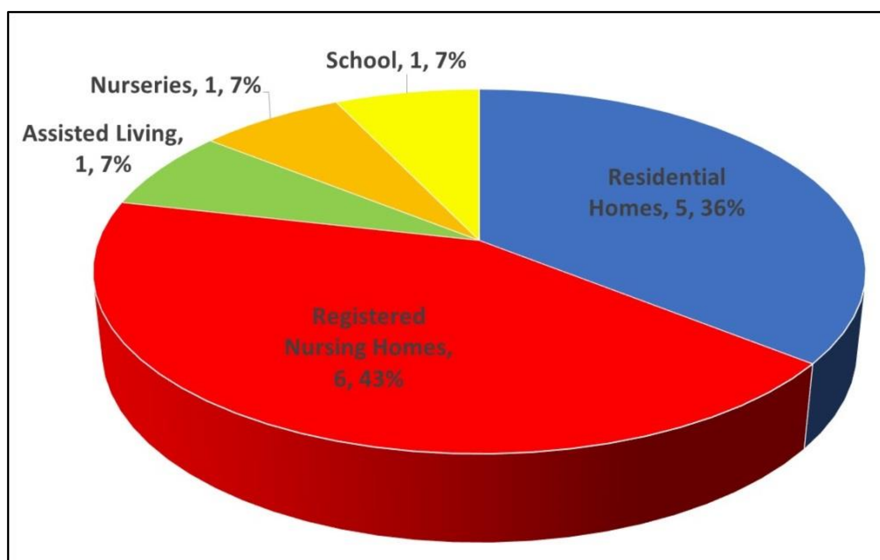

Figure 6 - Outbreaks by location

The majority of outbreaks took place in either residential or nursing homes (referred to collectively as care homes). The location of outbreaks is shown in Figure 6.

Management of D&V outbreaks in care homes

The IPCT responds immediately to all reported outbreaks, providing infection prevention and control support, advice, guidance, education, surveillance, ensuring multi agency reporting procedures are followed. Upon reporting an outbreak, the care home is provided with an outbreak pack, containing guidance on management of affected residents and staff, and the environment, in order to minimize risk of transmission and/or prolonged or deteriorating illness. Guidance provided emphasizes the importance of 48-hour isolation or exclusion for all affected residents or staff, and deep cleaning prior to lifting of restrictions on admissions and visiting. Good communication between secondary care and community health and social care providers is also strongly emphasized as a prerequisite for limiting transmission and prevention of wider community outbreaks.

Management of Influenza outbreaks in care homes

The three confirmed outbreaks of Influenza in care homes in 2016/17 were managed by the local infection control service in collaboration with the CCG medicine management and primary care teams, local laboratory service, Pennine care FT community nursing service, general practice, local health protection and support from PHE. This included the facilitation of viral swabbing, undertaking a risk assessment in respect to the option of prescribing of antivirals, liaising closely with the care home manager to receive daily situation reporting and updates, which are communicated to a range of stakeholders including local secondary care providers.

We now have in and out of hours access to viral swabbing kits; have improved the guidance on the transport of swabs to the labs, and have stocks of antivirals at an extended hours pharmacy. There are remaining issues with out of hours prescribing of prophylactic anti-viral medication, and this has been raised with the CCG.

4.5. Staff Seasonal flu immunisation uptake

Pennine care FT uptake for the 2016/17 campaign was **37.18%,** equating to **2,459 vaccines.** This is a lower than expected performance, given that the national average uptake among frontline healthcare workers was 63.4%. Nationally, NHS Employers has said that this is a record breaking number that has surpassed all expectations. We will be aiming to improve Trafford's performance in 2017/18.

PCFT flu steering group will begin to plan the 2017/18 campaign, which will launch around September 2017. This will take into account staff feedback and best practice from successful trusts across the country. Pennine Care has also been selected to take part in a research study looking at staff uptake of the flu vaccination, commissioned by the Department of Health. The Infection control inspections undertaken in Trafford GP practices highlighted that an average uptake by staff of seasonal flu was approx. 70%.

5. Emerging organisms

5.1. Avian influenza

Outbreaks of highly pathogenic avian influenza A (H5N8) continue to be reported across Europe, Asia and Africa. Detections of H5N8 in domestic poultry and wild birds continue in the UK. To date, no human cases of H5N8 have been reported globally, however WHO has called for heightened vigilance for any potential human cases.

In January 2017, there were increasing reports across Europe of detections of highly pathogenic avian influenza A (H5N5) and initial reports of H5N2 in wild and domestic birds. While neither strain has resulted in symptomatic human cases to date, sero-conversion in human contacts of H5N2 infected poultry has been reported in Asia. China experienced their fifth annual epidemic of avian influenza A(H7N9) resulting in the greatest number of cases in a single season since its first detection in 2013.

To 4 March 2017, 477 cases have been reported (an increase of 238 in the last month) representing more than a third of all cases reported (1,282). The majority of cases reporting recent exposure to infected poultry or contaminated environments, including live poultry markets. The vast majority of human cases remain sporadic in nature with a few small clusters. There is a continued risk of an importation of human infection from China to Europe, but the risk of spread in Europe is considered to be low.

The rapid geographical spread in the above incidents and the number of co-circulating avian influenza strains has resulted in WHO requesting member states to be on high alert for potential pandemic influenza since in 2013. There continues to be no evidence of sustained human-to-human transmission.

5.2. Zika Virus

This is no longer being categorised as a Public Health Emergency of International Concern. The coordination and response to Zika virus is being escalated into a sustained programme of work with dedicated resources to address the long-term nature of the disease and its consequences.

UK imported cases: A low number of cases continue to be diagnosed in UK travellers returning from areas with active Zika transmission. As of 22 February 2017, 295 travel-associated cases have been diagnosed since 2015. Of the total 295 travel-associated cases reported, seven have been diagnosed in pregnant women. In addition, one case of likely sexual transmission of Zika virus infection has been reported in the UK.

6. Antimicrobial resistance

The World Health Organization (WHO) announced its 1st list of antibiotic-resistant "priority pathogens" on Mon 27 Feb 2017, detailing 12 families of bacteria that agency experts say pose the greatest threat to human health and kill millions of people every year. The list is divided into 3 categories, prioritized by the urgency of the need for new antibiotics.

The WHO considers the highest priority are responsible for severe infections and high mortality rates, especially among hospitalized patients in intensive care or using ventilators and blood catheters, as well as among transplant recipients and people undergoing chemotherapy. Included in this highest-priority group are Carbapenem-resistant Enterobacteriaceae (CRE), along with Acinetobacter baumannii, which the infections associated with it typically occur in ICUs and other high dependency settings.

The type of infections the other bacteria tagged as a critical priority is Pseudomonas aeruginosa, which can be spread on the hands of health-care workers or by equipment that gets contaminated and is not properly cleaned/disinfected. The lists 2nd and 3rd tiers the high and medium priority categories -- cover bacteria that cause more common diseases, such as gonorrhoea, and food poisoning caused by Salmonella.

In February 2017 PHE launched a pilot awareness campaign across the Granada TV region (which includes Trafford) to support national efforts to reduce inappropriate prescribing through reducing patient pressure for antibiotics. A detailed report of antimicrobial resistance in Greater Manchester is available in appendix B.

7. Other Work Undertaken

7.1. Sepsis awareness

NICE guidelines on Sepsis: recognition, diagnosis and early management (NG51) were released in July 2016. Sepsis is a life- threatening condition caused by the body's severe inflammatory responses to infection. It has been estimated that there are around 200,000 cases of sepsis each year in the UK with 44,000 deaths. 70% of sepsis cases are said to originate in the community.

In response to the NICE guidelines the IP & C team have continued to deliver appropriate training in identifying people who might have sepsis to GP surgeries, residential care and nursing home staff. A sepsis awareness presentation was delivered to the PCFT IP & C link workers at their annual study day by the team. A member of the Trafford IP & C team is on a working group in PCFT to ensure full implementation of the NICE sepsis guidelines. The team continues to promote sepsis awareness with the general public in Trafford by displaying posters in health care settings.

7.2. Asepsis

Education on promoting asepsis has been given to GP's practices, residential and nursing care homes. A presentation on asepsis in General Practice by the team was well received at a GP forum.

This highlighted best practice during the undertaking of invasive procedures and was well attended generating lively discussion.

Following on from this the IP & C GP audits have highlighted substantial improvements in the understanding use of asepsis in GP surgeries. A programme of asepsis training continues to be delivered to PCFT employees by the IP & C team. It is mandatory 3 yearly and the team assist clinical teams in assessing staff competencies yearly.

7.3. Enquiries and Advice

The IPCT has also provided advice in response to of enquiries regarding a range of organisms and infectious illnesses which during 2016-17 has included CPE's, ESBL's, MRSA.

Appendix A - Trafford Health Protection Forum Terms of Reference

1. Background

1.1 Health protection – the control of infectious diseases, including healthcare associated infections and the health effects of non-infectious environmental hazards – presents considerable challenges in Trafford. Although good progress has been made in tackling some of the key problems, major challenges remain.

1.2 Many organisations have a role to play in protecting the public from infections and infectious diseases, and the overlapping roles and responsibilities of the main agencies/departments (particularly the NHS, Public Health in Trafford, Environmental Health and Public Health England), working with many different stakeholder organisations, can be complex.

2. Purpose of the group

2.1 The primary role of the Health Protection Forum is to enhance partnership working on health protection in Trafford and to assist the Director of Public Health, who will chair the group, to discharge their responsibility for ensuring oversight of health protection in Trafford, and in providing a "strategic challenge to health protection plans/arrangements produced by partner organisations".[1]

2.2 This will be done by receiving reports from partner organisation including evidence that such plans are in place.

2.3 The Forum will provide assurance to the Health and Wellbeing Board (HWB) that robust plans and arrangements are in place to protect the population of Trafford. It will draw to the attention of the Health and Well Being Board any matter of concern in this context.

3. Scope

3.1 The Forum will consider health protection issues in, or relevant to Trafford. Topics that are within the scope of the Forum include, but are not restricted to:

- Infectious/communicable diseases in the community.
- Healthcare acquired infections, especially MRSA, Cl. Difficile and including new organisms such as Carbapenease producing Enterobacteriaceae (CPE).
- Vaccine preventable diseases and national and all local immunisation programmes.
- Tuberculosis.
- Pandemic influenza.
- Sexually transmitted infections, including HIV.
- Blood borne viruses.
- Environmental hazards.
- Health services emergency planning arrangements and rapid response including CBRN and mass casualty plans.

[1] 'The new public health role of local authorities'. Department of Health, October 2012.

The forum will also take an overview of national screening programmes. Issues that are out of scope of the Forum are:

- Business continuity arrangements that are not related to public health emergencies (such as a fuel shortage or extreme weather events).
- Health and social care winter planning, except where there is a health protection element, such as flu vaccination.

4. Key responsibilities of the Health Protection Forum

- To provide assurance to the Health and Wellbeing Board as to the adequacy of local arrangements for the prevention, surveillance, planning for, and response to, health protection issues and problems in Trafford.
- To highlight concerns about significant health protection issues and the appropriateness of health protection arrangements for Trafford, raising any concerns with the relevant commissioners and/or providers or, as necessary, escalating concerns to the Health and Wellbeing Board or relevant Chief Executives.
- To provide an expert view on any health protection concerns on which the Health and Wellbeing Board request advice from the Forum.
- To monitor a 'health protection dashboard' in order to assess local performance in addressing the key health protection issues in Manchester
- To monitor significant areas of poor performance through the HPF dashboard and to seek assurance that recovery plans are in place.
- To identify the need for, and review the content of, local plans relevant to significant health protection issues.
- To make recommendations as to health protection issues that should be included in the local Joint Strategic Needs Assessment.
- To seek assurance that the lessons identified from any serious incidents or outbreaks are embedded in future working practices.
- Health protection intelligence or dashboards to be provided by the relevant lead agencies.
- Through the HBW the Forum will hold Greater Manchester PH England Centre, NHS England and Trafford CCG to account in terms of their health protection responsibility.

5. Meeting arrangements

5.1 The Group will be chaired by the Director of Public Health and will normally meet four times per year on a tri-monthly cycle. Meetings will normally be of no longer than two hours' duration.

5.2 The meetings will be convened by Public Health in Trafford who will provide secretarial support.

5.3 Items for inclusion on the agenda will be sought from all members in advance of each meeting. Draft minutes will be sent electronically to members and then approved at the next meeting.

5.4 Meetings will not be open to the public.

5.5 Conflicts of interest must be declared by any member of the group.

6. Reporting arrangements for the Health Protection Forum

The Health Protection Forum will report to the Health and Wellbeing Board on a six-monthly basis by submitting formal reports including any concerns or recommendations. An annual report will be produced.

7. **Membership and quorum**

The quorum for the Trafford Health Protection will be one third of its core membership. Representation within that number must include the Chair or Vice Chair. Membership is to be split into two sections, core members and extended member and is noted in the table below. The Chair and Vice-chair are indicated in the list of group members hereunder.

Role	**Representative**
Core Membership	
Director of Public Health (Chair)	Eleanor Roaf
Consultant in Public Health and Vice Chair	Helen Gollins
Consultant in Communicable Disease Control for Manchester, PHE	Dr Merav Kliner
Consultant Microbiologist and Infection Prevention and Control Officer Central Manchester Foundation Trust Hospital	Dr Barzo Faris
Head of the Community Infection Control Team - core member and Deputy Vice Chair in the absence of Chair and Vice Chair	Philip Broad
CYPS – Head of Services or representative	Paula Lee
Trafford Clinical Commissioning Group	Gina Lawrence
Medicines management link at Trafford CCG	Absar Bajwa
Immunisation/Screening Coordinator link (NHS England)	Graham Munslow
Practice nursing	Henrietta Bottomley
Health Economy Resilience Group representative	Kate Green
GM Commissioning Support Unit NHS HERG representative	Brian Dillon
CMFT Infection Prevention Control	Sue Jones
UHSM Infection Prevention Control	Jay Turner Gardner
LMC (GP) representative	Dr Iain Maclean
Extended Membership	
Trafford Council Resilience Forum representative	Nicky Shaw
Adults Social Services Representative	Angela Brown
Environmental Health – Head of Service or representative	I Veitch/Nigel Smith
TB Specialist Nurse	Tracy Magnall

Frequency of Meetings: In 2016 The Trafford Health protection forum meet bi-monthly. From 2017 moved to Quarterly meetings.

Appendix B – Antimicrobial Resistance across Greater Manchester

This is the quarter 4 2016 report for AMR in GM

Klebsiella pneumoniae

Higher rates of non-susceptibility were observed for third- generation cephalosporins (26.8%), imipenem/ meropenem (9.4%), gentamicin (13.4%), ciprofloxacin (18.4%) and piperacillin/ tazobactam (28.9%) for K. pneumoniae isolated in Greater Manchester compared to national averages this quarter.

E. coli

A higher than national average proportion for E. coli non-susceptibility to imipenem/meropenem was observed in Greater Manchester this quarter (0.8% compared to 0.3%). The proportion of E. coli non-susceptible to ciprofloxacin and gentamicin continued to be higher in Greater Manchester (13.0% and 8.1%), compared to the national averages of 11.2% and 7.0%. Non-susceptibility to piperacillin / tazobactam in E. coli was higher in Greater Manchester (13.4%) than the national average (9.4%).

Pseudomonas spp.

The proportion of non-susceptibility of Pseudomonas spp. to meropenem / imipenem in Greater Manchester remained high (9.8%), compared with the national average of 6.9%.

Streptococcus pneumoniae

The proportion of non-susceptibility of S. pneumoniae to penicillin in Greater Manchester was 11.5% compared to the national average of 7.7%.

Enterococcus spp.

A high proportion of non-susceptibility to vancomycin / teicoplanin was observed in Greater Manchester (34.6% compared to the national average of 20.0%). These results may be the result of increased screening activity.

Neisseria gonorrhoeae

Ceftriaxone resistance remains very rare in the UK. Reports of N. gonorrhoeae ceftriaxone and azithromycin resistance in SGSS (and this workbook) are unconfirmed - all isolates identified as resistant should be referred to the National Reference Service for confirmation.

Haemophilus influenzae

Higher than national average proportions for H. influenzae non-susceptibility to co-amoxiclav were observed in Greater Manchester over the last 9 quarters (18.4% this quarter)

Streptococcus pneumoniae

Higher than national average proportion for S. pneumoniae non-susceptibility to penicillin was observed in Greater Manchester (11.6% compared to the national average of 7.2%).