Dear Sir/Madam

Thank you for your Freedom of Information request concerning healthcare acquired infections.

The Trust can provide the following information:

Please see below and attachments

1. Do you measure the aggregate number of nights patients stayed in hospital longer owing to a healthcare acquired infection? If so, please provide it for the years (a) 2008/09, (b) 2009/10, (c) 2010/11, (d) 2011/12 and (e) 2012/13. We do not measure this information

2. Do you collate the total number of (a) cases and/or (b) associated deaths from (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus? If so, please provide for the above years. We do not collect this information.

3. Does your Trust have a strategy for surveillance of healthcare associated infections (other than the mandatory surveillance requirements for MRSA/MSSA/Ecoli bacteraemia, C. difficile, SSI in orthopaedic surgery)? If yes, (i) what HCAI are included? and (ii) what period does the strategy cover?

We monitor colonisation for GRE on ITU (since January 2013) and multi resistant gram negative colonisation by performing admission screening on ITU (since 2006) and NICU (since October 2013), pseudomonas in critical care (since 2012), invasive group a strep (since 2012)

4. Did your Trust receive instructions in (a) 2008/09, (b) 2009/10, (c) 2010/11, (d) 2011/12 or (e) 2012/13 to reduce expenditure on infection, prevention and control? No

5. What strategy does your Trust have in place for the surveillance and minimisation of harm caused by infections not covered in the mandatory surveillance programme? Please see attached surveillance and incident reporting policy

6. Does the Trust carry out any surgical site infection surveillance that it does not report to Public Health England? If yes, please specify the protocol, the types of surgeries included and results. No

7. Does the Trust carry out any post discharge surgical site surveillance on any category? If yes, what are the numbers of readmission linked to surgical site infection at your Trust? No

8. Does the Trust carry out any financial analysis on the cost or operational impact of infections locally? If yes, please share this. If not, please could you give reasons why? No. We focus our time on preventative measures.

9. Does the Trust carry out any post discharge surgical site surveillance on any category? If yes, what are the numbers of readmission linked to surgical site infection at your Trust? No

10. What surveillance systems and processes did you have for active infection control in 2012/13? Please see attached surveillance policy and IPC operational policy

11. How many staff were dedicated to the surveillance of infections and/or the analysis of that data in 2012/13? We do not have dedicated staff this it is part of the remit of the infection prevention and control team.

12. How many staff were on your infection prevention and control team in (a) 2008/09, 2 doctors, 3 nurses (b) 2009/2010, 2 doctors, 3 nurses (c) 2010/11, 2 doctors, 3 nurses (d) 2011/12 12 2 doctors, 4 nurses and (e) 2012/13 2 doctors, 4 nurses ?

13. What was the ratio of infection control staff (ie infection control doctors, infection control nurses, dedicated infection control surveillance auditors) to beds in Acute care at your Trust in 2012/13? 1 staff member to 72 beds (6 staff and 430 beds)

14. On how many wards did you do device surveillance in 2012/13? All wards monitor compliance with practice interventions relating to invasive devices but do not monitor number of invasive devices or infection rates.

15. On how many wards did you not do device surveillance in 2012/13?

16. How many times in (a) 2008/09, (b) 2009/2010, (c) 2010/11, (d) 2011/12 and (e) 2012/13 was a member of the Board present at an infection prevention and control committee meeting? All meetings a board member is present

17. How many business cases were submitted by Infection Control in (a) 2008/09, (b) 2009/2010, (c) 2010/11, (d) 2011/12 and (e) 2012/13? For each year, how many of the above business cases were successful? None submitted.

18. What was your budget for infection prevention and control in (a) 2008/09, (b) 2009/2010, (c) 2010/11, (d) 2011/12 and (e) 2012/13? There is no dedicated budget. If money is required the Trust makes it available

19. Do you have standardised infection control protocols and technology utilisation across all wards of the Trust? Yes all policies and protocols are available on the Trust intranet

If you have any queries about this response please contact the information governance manager at foi@homerton.nhs.uk , in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email www.informationcommissioner.gov.uk to take them further.

Yours sincerely

James Cook
Information Governance Administrator

James Woollam
Interim -Information Governance Manager

Homerton University Hospital NHS
NHS Foundation Trust

Infection Prevention and Control Operational Policy

Author(s)	Vickie Longstaff (Infection Control Nurse Consultant)
Version	9 (Updated from January 2013 version)
Version Date	March 2014
Implementation/approval Date	March 2014
Review Date	March 2015
Review Body	Infection Control Committee
Policy Reference Number	48\tw\ic\icp\

Contents:

1 Introduction

The Trust's Infection Prevention and Control Team (IPC team, IPCT) is a small team of staff with specialist knowledge within the field of infection prevention & control. The Team comprises the following staff:

Consultant Microbiologist and Director of Infection Control and Prevention (DIPC) (acting in their role as Infection Control Doctor)
Consultant Microbiologist (Laboratory Director)
Microbiology Specialist Registrar
Antibiotic pharmacist
Nurse Consultant (ICNC)/Deputy DIPC. , 1 WTE
Band 7 infection control nurses (ICNs). , 3 WTE for Homerton acute and community and 1 WTE for ELFT
Band 2 infection prevention & control team administrator, 0.5 WTE

The team will be recruiting into two new posts in 2014 comprising of an IV access /OPAT nurse and 3rd Consultant Microbiologist.

This operational policy outlines the assurance framework with arrangements for infection prevention and control at the Homerton University NHS Foundation Trust.

This operational policy was developed by the IPC team, and then distributed to all Members of the Infection Control Committee for endorsement and ratified by the Trust Policy Group.

Scope

This policy applies to all employees of the Trust in all locations including the Non-Executive Directors, temporary employees, locums and contracted staff.

2 Roles and Responsibilities

The IPC team and service sits within the Children's Services, Diagnostics, and Out-patients (CSDO).

The Director of Infection Prevention and Control (DIPC) for the Trust is also the Infection Control Doctor and one of the Microbiology Consultants. They report to the Chief Executive Officer and Board whose responsibility it is to ensure that there are effective arrangements for Infection Prevention & Control within the Hospital. The DIPC deputises for the Consultant microbiologist laboratory Director in their absence.

The Consultant microbiologist Laboratory Director or 3rd Microbiology Consultant deputises as infection control doctor in absence of the DIPC.

The IPC team reports to the Infection Control Committee (ICC), which is a sub committee of the Trust Board (see below for ICC Terms of Reference).

The Infection Control Nurse Consultant (ICNC) is also the Deputy DIPC, is responsible for the management of the infection prevention and control service and team and reports to the DIPC and Chief Nurse.

The infection control nurses are responsible for ensuring that clinical, audit and education activities are in place and are accountable to and managed by the Infection Control Nurse Consultant.

The Infection control and prevention accountability framework is available in Appendix 1.

3 Infection Control Committee Terms of Reference

Authority
The Infection Control Committee has been established to evaluate and report on all aspects of infection prevention and control and compliance with the Health and Social Care Act on behalf of the Board of Directors. The committee is a subcommittee of the Trust Board and reports directly to the Board.

Purpose
The purpose of the committee is to ensure that there is a managed environment within the Trust that minimises the risk of infection to patients, staff and visitors. The committee provides the Board of Directors with assurance that it has control of the HCAI agenda through compliance with HCAI regulatory requirements.

Duties
To ensure strategic and operational infection prevention and control risks are identified, assessed, evaluated and managed according to the risk management and assurance frameworks.
To provide strategic direction and guidance to facilitate the development and implementation of infection prevention initiatives Trust wide.
To promote a culture in which infection prevention and control will continue as an integral and seamless component of the healthcare process.
To receive and approve the Infection Prevention and Control annual programme and audit programme ensuring the programme has clearly defined objectives.
To monitor progress against Infection Prevention and Control performance key performance indicators using the balanced score card.
To consider and respond to reports on:

- Incidence and prevalence of alert organisms and important infectious disease
- Serious untoward incidents
- Infection prevention and control education and training
- Infection prevention and control practice and hospital hygiene
- Outbreaks of infection
- Audit

To ensure structures and processes are in place that enable hygiene code self-assessment and compliance.
To define priorities based on current risk ratings detailed in the Infection Prevention and Control risk register.
To review and endorse trust policies for infection prevention and control, procedures and guidance and monitor their implementation through an annual programme of audit.
To receive reports and monitor progress from the Infection Prevention Monitoring group
To review and monitor outbreak management plans and monitor their implementation.
To review other infection control issues as necessary, including those relating to catering, decontamination, engineering, ventilation and water services, employee health, pharmacy, procurement, capital strategy etc.
To promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection.

To monitor the performance of the infection control team and make suggestions for improvement.
To review the performance of the committee.

Membership

Director of infection prevention and control (DIPC) - CHAIR
Chief Nurse/Executive Director for infection control – DEPUTY CHAIR
Members
Medical Director
Clinical Risk Manager
Consultant Microbiologist
Employee Health Lead
Infection Control nurse consultant/Deputy DIPC
Senior Nurse Children's services, diagnostics & outpatients
Senior Nurse Integrated medical & rehabilitation services
Senior nurse Surgery, Women's and sexual health services
Head of Midwifery
Infection control nurses
Director of Environment (Trust Decontamination Lead)
Trust decontamination manager
Facilities manager
Estates water/ventilation lead
Health Protection Team representative (nurse or CCDC)
Non-Executive Director

Secretary
The Infection Control Nurse Consultant shall act as secretary of the Committee.

Quorum
The quorum necessary for the transaction of business shall be six members, one of which must be the DIPC or Deputy Chair.

Frequency of meetings and reporting
Meetings shall be held quarterly
The committee and DIPC will report to the board quarterly.
It will be the responsibility of the relevant division leads to:
Devise and implement appropriate action plans
Report progress to the Committee.

Review
The Terms of Reference of this committee shall be reviewed annually.

4 Infection Prevention and Control Team

The Infection Prevention and Control (IPC) Team meets monthly. The IPC team (as above) and a Health Protection Unit representative attend.
The regular agenda items for meetings are:
Clinical items:
MRSA

C. difficile
MSSA bacteraemias
E.coli bacteraemias
GRE
Pseudomonas in NICU/SCBU
Pseudomonas in ITU
Invasive and Maternity cases of GAS
Incidents and outbreaks
Policy review programme
Antimicrobial prescribing
Audit programme
Education programme
PHE update
Division updates
ELFT update
AOB

Issues discussed at the IPC team meetings may be included on the Infection Control Committee agenda as necessary.
The DIPC provides a report to the Board quarterly.
The Nurse Consultant/Infection control nurse attends the Trust Health and Safety and Patient Safety Committee meetings
The IPC team provides specialist advice, formulates, monitors and evaluates the implementation of policies.
The use of evidence-based practice is supported and used in the writing and reviewing of policies.
The IPC team are responsible for the daily management and advice on infection control clinical cases and incidents. They also advise the Trust at a strategic level on service and building developments which will impact control and prevention.
The IPC team develop and provide education to all Trust staff on infection prevention and control.
The IPC team develop and complete a programme of audit relating to infection prevention and control.
An Annual Report is produced by the DIPC and Deputy DIPC and presented to the ICC and Trust board.
An Infection Prevention and Control Team Annual Plan is produced by the ICNC and DIPC and presented to the ICC for agreement.
All members of the IPC team are registered for and fulfil Continuing Professional Development requirements.
The IPC team will identify requirements for additional resources to support and promote infection control practices and present these to the ICC.
The IPC team will fulfil the requirements of any SLA for a service with outside organisations. Currently SLAs are held with the St Josephs and Mildmay Hospital.
The Trust provides a full Infection control service for mental health and community services to ELFT.
The IPC team report to the Infection Control Committee.

5 Key Areas of Infection Prevention and Control Activity

Clinical Activity

Daily - The ICNs are informed of alert organisms from the microbiology laboratory daily. These are checked for new or existing cases. On identification of new cases the ICNs collect the demographic data on the patient and complete the MRSA, C.difficile and other alert organism surveillance spread sheets with the details. Data is entered onto the PHE Enhanced Surveillance Website as required. The ward is visited or community clinical team contacted and care pathways, patient information, advice on isolation/infection control precautions and appropriate treatment provided.

Three times weekly – The ICNs visit every inpatient area three times a week to review any patients known to the service, provide advice or information to staff on any existing patients not known to the service. This list is provided to the clinical site team on a 3 x weekly basis to assist in bed management and patient placement. This process allows for early identification of reduced capacity in side rooms for isolation. If there is a possibility of an inability to isolate this will be highlighted, risk assessments completed and contingency plans devised.

Weekly – The IPC team carry out a C.*difficile* ward round and visit all wards with symptomatic cases of C.*difficile* and patients who are carriers of toxigenic strains of *C.difficile* (*C.difficile* toxin gene PCR positive) to review current and future case management.

As required – Telephone advice or visits to wards/clinical areas to deal with any clinical queries. This also includes the control of outbreaks which involves the appropriate isolation of cases, support for staff, contact tracing, investigation of sources/reasons for outbreaks and planning of appropriate actions.

Policy/Guideline Development

The infection prevention and control policies (appendix 3) are available on the Trust intranet and undergo regular review. The policies are evaluated and updated following risk assessment and as new guidelines or evidence become available or, alternatively as a matter of Trust policy, every 3 years. There is a planned programme for the review of infection control policies and this process is reported to the ICC. The IPC team is also involved in advising departments on infection prevention & control aspects of their individual policies.

Audit Activities

There is an annual audit programme of Infection Control/Environmental audits for clinical areas using a revised version of the IPS audit tool in conjunction with the Domestic services, ward sisters and Hotel Services Manager. The audit programme details dates for audits and a follow up meeting is arranged 4-6 weeks later to check on action points.
There is an audit of compliance with key policies/practice areas. The planned audit programme is part of the Infection Prevention and Control annual plan. An audit report and action plan is prepared by the ICNs and distributed to the Clinical Divisions for action at Directorate level.
High Impact Intervention monitoring is performed by clinical areas as part of the IPC annual programme. The monitoring takes place monthly using an Infection Prevention and Control Audit System (IPAS) and all results are sent to clinical managers, matron, clinical directors and executive directors.

All audit activity is reported to the ICC and board as part of the Infection Prevention and Control Balanced Score Card.

Surveillance Activities
There is a Trust 'Surveillance and Incident Reporting of Health Care Associated Infections' Policy which contains more detailed information on the surveillance activities of the Trust.
The surveillance activity is carried out using various methods such as laboratory system searches, and manual collation of data.
This data is then used by the directorates for their performance reports and is a key performance indicator on the Trust Infection Prevention and Control Balanced Score Card.

Incident reporting and investigation
There is a Trust 'Surveillance and Incident Reporting of Health Care Associated Infections' Policy which contains more detailed information on the process for incident reporting in the Trust.
All HUH attributable MRSA bacteraemia and C.difficile cases are reported as part of the Trust Serious Incident (SI) procedure (regardless of outcome).
All non HUH attributable MRSA bacteraemia and C.difficile cases are reported are reported as an incident with a Root Cause Analyses performed.
All C.difficile and MRSA-related deaths (Part 1 of death certificate) are also reported as part of the SI process.
All incidents requiring contact tracing are reported and investigated.
All Serious Incidents and PIRs/RCA's are reported to the Patient Safety Committee as per Incident reporting policy and ICC.

Promotional Campaign Work
The IPC Team aim to raise the awareness of staff across the Trust on infection prevention and control issues. This is done in various ways:

- Hand hygiene awareness weeks (at least annually)
- Articles in the staff magazine (Homerton Life)
- Continuous updating of the Infection Prevention & Control service page on the Trust intranet.
- Monthly/bi-monthly IPC newsletter
- Promotion of various hand hygiene or new posters.
- Presentations to various members of staff and public on infection control issues.
- Clean Your Hands campaign.
- IPC team Twitter feed

Patient and Public Information
The IPC team works with public and service users via the Patient Experience Group and various presentations at members meetings. The Trust website contains information on management of MRSA and C.difficile and a link to the PHE website for the Trust's surveillance figures. There are information leaflets available on specific infections such as MRSA and C.difficile and infection prevention advice in the visitors information leaflet.

6 Infection Prevention and Control Service Cover and Business Continuity

The DIPC, the other Microbiology Consultant (Head of Department), the new 3rd Microbiology consultant and ICNC plan leave to ensure that one is available for service cover.

The infection control nurse service leave is arranged to ensure that, where possible, there is no more than one of the three on annual leave at any one time.
A 24-hour infection control nurse service is not available. Out-of-hours, the Trust's Microbiologists provide infection prevention and control cover for the Trust. Infection prevention and control advice is provided by the Microbiology SpR or Consultant on-call. If the Microbiology SpR is 1st on call, there is always a Microbiology consultant 2nd on call for further expert advice as required. Individual doctors may access this service for infection prevention and control queries on individual patients, otherwise this service is usually accessed through the Clinical Site Managers e.g. for out-of-hours outbreak management advice. The infection prevention and control advice given is then handed back to the Homerton IPC team at the beginning of the next working day for further action.
A Business Continuity Plan has been developed to ensure service provision if multiple staff members are on prolonged unavoidable leave (Appendix 5). This also covers the ability to continue to provide the SLA with other organisations.

7 Education

Infection Prevention and Control training is part of the trust mandatory training programme contained in the Trust Mandatory training Policy available on the intranet/

Monitoring of training requirements, attendance and non-attendance is the responsibility of the line managers of staff. Attendance compliance is monitored by the Training Committee, Infection Control Committee and reported to the Trust Board via the mandatory training balance score card and infection prevention and control balance score card. Divisions are responsible for monitoring their staff attendance and addressing non-attendance.

The Trust has a cohort of Infection Control Link Practitioners for all clinical areas. The link practitioner days are run quarterly with the specific training sessions and feedback of recent audit reports.

8 Review

This policy will be reviewed annually. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

9 Monitoring/Audit

All aspects of this operating policy will be monitored by the ICC via IPC team reports and evidenced by committee minutes. Key outcome indicators for service provision include the number of MRSA bacteraemia cases, *C.difficile* cases and SUIs, these are all reported to and monitored by the ICC and reported to the board in the DIPC quarterly reports.

Measurable Policy Objective	Monitoring/Audit	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/committees, inc responsibility for reviewing action plans
Clinical activities Surveillance activity Training data Promotional work	Infection control reports to the ICC	Quarterly	Infection control team	Quarterly reports to ICC and included in DIPC reports to the board.

10. References / Bibliography

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Department of Health. Getting ahead of the curve: a strategy for combating infectious diseases (including other aspects of health protection). A report by the Chief Medical Officer. London: Department of Health; 2002

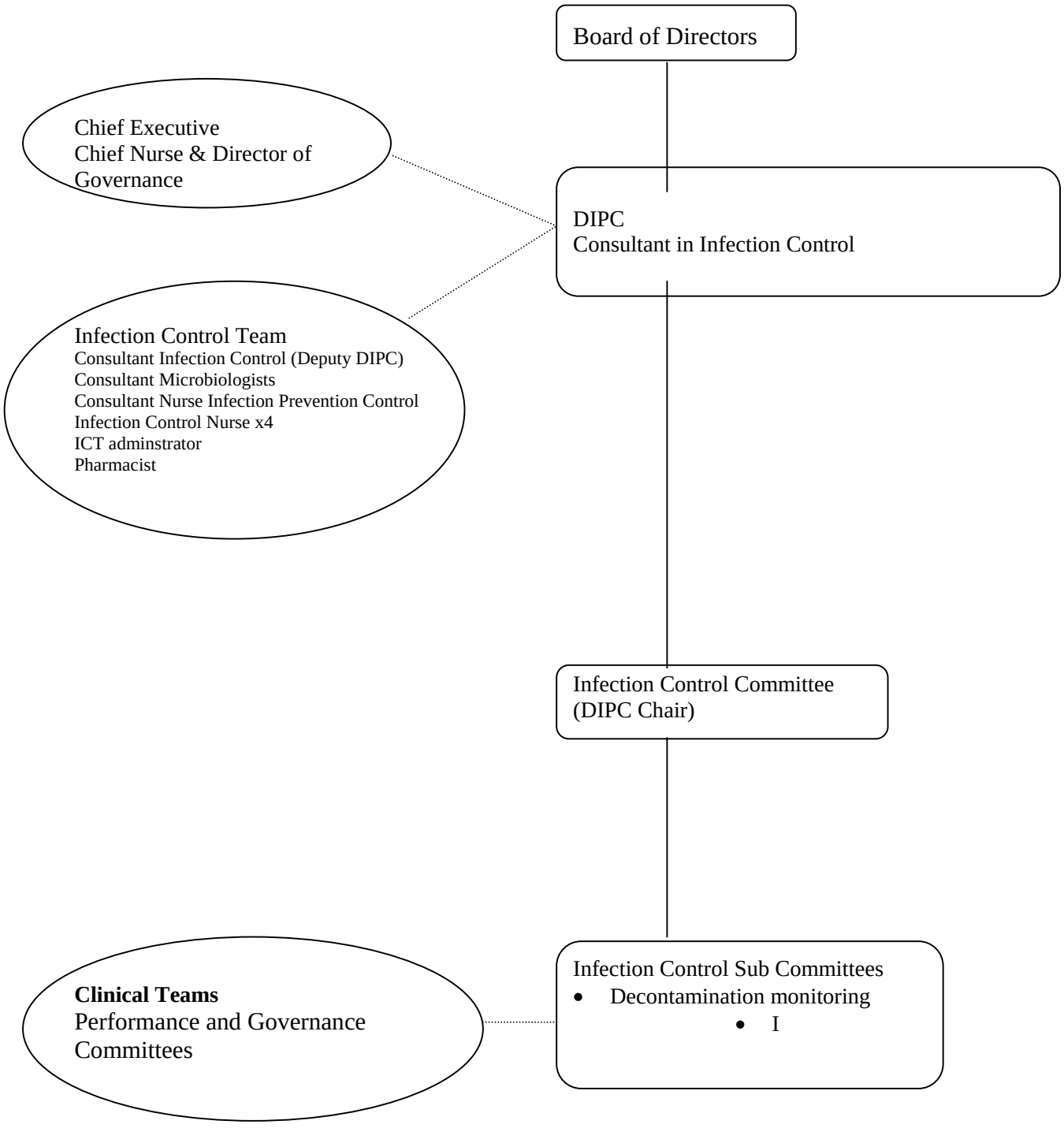
Department of Health Standing Medical Advisory Committee Sub-group on Antimicrobial Resistance. The Path of Least Resistance: summary and recommendations. London: Department of Health; 1998.

Department Of Health. Saving Lives. A Delivery programme for reducing health care associated infections including MRSA, 2005.

Department of Health. The Health and Social care Act 2009. The Code of practice for the reduction in health care associated infection.

Appendix 1

INFECTION PREVENTION & CONTROL ACCOUNTABILITY AND ASSURANCE FRAMEWORK



Regularity	Information Tree	Reporting	Response to Variance
Quarterly	Trust Board	DIPC report – surveillance data, incidents and outbreaks, SUIs, audit programme, matron monitoring group, education programme, IPC BSC, risk register, cleaning standards, estates and facilities reports (Legionella, ventilation, decontamination) and employee health reports	Frequency of meetings may be increased or decreased in response to specific situations such as an outbreak. This would be reflected in IPC reports and DIPC reports to the Board.
Quarterly	Infection Control Committee	Surveillance data, incidents and outbreaks, SUIs, audit programme, matron monitoring group, education programme, IPC BSC, risk register, cleaning standards, estates and facilities reports (Legionella, ventilation, decontamination) and employee health reports	
Quarterly	Health and Safety Committee	Needle stick injuries, latex allergy	
Quarterly	Water Safety Group	Monitors the water safety plan and arrangements.	
Quarterly	Antimicrobial Management Group	Antimicrobial stewardship issues e.g. new antimicrobials, antibiotic prescribing incidents, antibiotic policy updates	
Monthly Ad hoc	Chief Executive and DIPC Director of Nursing and DIPC Director of Nursing and Infection Control Nurse Consultant	Key issues Instant reporting of HCAI issues	
Monthly	Quality Improvement Committee	IPC issues in the Divisional reports	
Monthly	Domestic and Catering Services Review Group	Performance against National Standards of Cleanliness	
Monthly	Patient Safety Committee	RCAs, SIs	
Monthly	Joint Prescribing Group	Antimicrobial prescribing	
Quarterly	Decontamination Monitoring Group	Decontamination of equipment, SSD audits and compliance, endoscopy audits and compliance	
Monthly	Infection Control Team meetings	Surveillance data, SUIs, policy review programme, audit programme, antimicrobial prescribing, education	
Monthly	Divisional Governance/Performance meetings	HII, audit, cleanliness, decontamination, SUIs and education	
Weekly	DIPC and ICN meetings	Key issues Instant reporting of HCAI issues	
Monthly Daily Ad hoc	Wards	HII, audit, C.difficile, MRSA and cleaning	

Appendix 2 – Infection Prevention and Control Policy List

	Current policy status	Planned review date
Aseptic (ANNTT) technique policy	2011	Mar-14
Blood Culture policy	2011	May-14
CJD/TSE	2010	Nov-16
Clostridium difficile	2012	Mar-15
Control of MRSA	2011	Jul-13
Control of viral haemorrhagic fevers	2011	May-14
Death of an infectious patient	2010	Nov-16
Decontamination of re-usable medical Equipment	2011	Dec-14
Endoscope decontamination	2012	Mar-15
Environment and isolation room cleaning	2011	Mar-14
Food Hygiene	2012	Sep-15
GRE	2011	May-14
Hand hygiene	2011	Nov-16
Infection Control Operating policy	Jan-13	Jan-14
Inoculation/NSI injury	2013	2016
Invasive Group A Step	2012	Nov-15
Isolation policy	2010	Nov-16
IV Line associated infections	2012	Mar-15
Laundry disposal	2011	Jul-13
Major outbreak policy	2011	Mar-14
Meningococcal meningitis	2011	May-14
Multi-resistant gram negative policy	2011	Jul-13
Norovrius Diarrhoea and Vomiting policy	2013	May-16
Notification of infectious diseases	2010	Jul-13
Pandemic Flu plan	Aug-13	Jun-14
Pest control	2011	2014
Protection against BBV and NSI	2013	Apr-16
Rabies Policy	Feb-13	Feb-16
Safe handling of body fluid spillages	2011	Mar-14
Single use medical devices	2011	Jul-13
Specimen collection	2011	Mar-14
Standard Infection Control Precautions	2012	Feb-15
Surgical Site Infection Policy	2011	Mar-14
Surveillance policy and reporting HACI	2011	Jul-13
TB	2013	May-16
Tunnelled CVC/ Hickman line	2012	Mar-15
Varicella zoster virus	2012	Nov-15
PICC policy	new	

Appendix 3 Infection Control Business Continuity Plan

The Trust IPC team is a small team of staff with specialist knowledge within the field of infection prevention and control. The team comprises of:

Consultant Microbiologist and Director of Infection prevention and control (DIPC) (acting in their role as Infection Control Doctor)
Consultant Microbiologist laboratory Director
Microbiology Specialist Registrar
Antibiotic pharmacist
Nurse Consultant (ICNC). , 1 WTE
Band 7 infection control nurse (ICN). , 4 WTE
Band 2 infection control team administrator. 0.5 WTE

The IPC Business Continuity Plan would be required if there were severe reduced staff levels and/or long term reduced levels of staff within the Infection Prevention & Control Team or as part of the Trust Business Continuity. The team's leave is planned to ensure that there is always clinical staff available at an appropriate level. The Director of Infection Prevention and Control, Consultant Microbiologist laboratory Director, the new 3rd Microbiology consultant and Nurse Consultant plan leave so that there is little or no over lap to ensure that there is advice available at a senior level. The other team members leave is planned so that there are usually at least 2 infection control nurses available to reduce risk of the service being left uncovered.
The BCP would need to be considered if the DIPC and nurse consultant were not available for a prolonged period of time (over 3 weeks). It would also need to be considered if there were to be reduced levels of staffing for prolonged periods of time, for example if there was no admin support available due to long term sickness or leave or if one or two of the band 7 infection control nurses were on unplanned prolonged leave. For the purpose of considering this BCP unplanned prolonged periods of leave should include leave of over 4 weeks depending on number of staff involved.

Management Action
The IPC Team's Operational Procedure and Surveillance and Incident Reporting Policy contains information on specific actions in relation to mandatory surveillance procedures. Team members regularly cover each other's leave and therefore any specific procedures relating to mandatory requirements should be known to another team member. The impact of any changes in service provision would need to be discussed with the Chief Nurse and the Chief Executive made aware if there are possible risks relating to compliance with statutory requirements (e.g. Health and Social Care Act 2009). The ability to continue to provide the SLA to Mildmay and St. Joseph's would need to be considered and contingency plans put in place. The full service provided to East London Foundation Trust would need to be covered by other means (e.g. locum cover for SLA).

Escalation to Major Incident
In the event of a major incident relating to IPC team, such as a major outbreak and a sudden reduced staffing capacity, the Health ProtectionTeam (PHE), London Borough of Hackney be contacted. If the major outbreak was part of a flu pandemic then some of the pro-active work may need to cease and the IPC Team staffing resources would be acting as part of the pandemic flu plan and be advising the Trust and staff on reducing risk and managing cases.

Action	By Whom	Expected Outcome
In the absence of the DIPC the consultant microbiologist laboratory Director or 3rd Microbiology consultant will deputise as infection control doctor	Consultant microbiologists	There would continue to be infection control doctor cover.
In the absence of the DIPC or nurse consultant the other would take over the team position in relation to continuing to comply with all mandatory surveillance reporting. Where necessary any actions will be taken over or allocated to other team members. All processes are contained within the team operational procedure or surveillance and incident reporting policy.	DIPC or nurse consultant	The service would continue with a probable reduction in the pro-active strategic work.
In the absence of the nurse consultant the ICNs with the DIPC would review and rationalise the groups, meetings and diary commitments of the nurse consultant.	DIPC and band 7 ICN	The ICT would run a day to day clinical service with reduced capacity for proactive work. The re-active clinical activity of the service would continue. The strategic developmental work under taken by the nurse consultant would need to be on hold.
In the absence of the DIPC and nurse consultant the consultant microbiologists would be expected to become more involved in the activities of the ICT to support the junior team members.	Consultant Microbiologists	The ICT would run a day to day clinical service with reduced capacity for proactive work. The re-active clinical activity of the service would continue. The strategic developmental work would be on hold.
In the absence of one of the ICN's the infection control pro-active programme would need to be reviewed. This would involve a reduction in the amount of education and audit work performed.	Nurse Consultant	The reactive clinical service would continue. The pro-active audit and education programme would be run at a reduced level due to reduced team capacity.
In the absence of 2 of the infection control nurses the infection control pro-active programme would need to be reviewed. This would involve a reduction in the amount of education and audit work performed. Arrangements for locum cover would need to be considered.	Nurse Consultant/ DIPC	The reactive clinical service would continue. The pro-active audit and education programme would need to be suspended depending on locum cover provision.

Resumption of Normal Business Activity/Debriefing and Analysis

Normal services would resume when the IPC team is up to the recommended team establishment in the beginning of the BCP. On resuming normal business the effectiveness of the BCP will be reviewed and any alterations made.

Equalities Impact Assessment

This checklist should be completed for all new Corporate Policies and procedures to understand their potential impact on equalities and assure equality in service delivery and employment.

Policy/Service Name:	**Infection Control Operational Policy**
Author:	**Vickie Longstaff**
Role:	**Nurse consultant**
Directorate:	**Childrens services, diagnostics & outpatients**
Date	**January 2014**

Equalities Impact Assessment Question	**Yes**	**No**	**Comment**
1. How does the attached policy/service fit into the trusts overall aims?	Yes		Compliance with health and social care act 2009
2. How will the policy/service be implemented?			Systems already in place as any changes have already been implemented
3. What outcomes are intended by implementing the policy/delivering the service?			Compliance with health and social care act 2009
4. How will the above outcomes be measured?			Compliance with health and social care act 2009
5. Who are the key stakeholders in respect of this policy/service and how have they been involved?			Infection control committee given opportunity to comment
6. Does this policy/service impact on other policies or services and is that impact understood?		No	
7. Does this policy/service impact on other agencies and is that impact understood?		No	
8. Is there any data on the policy or service that will help inform the EqIA?		No	
9. Are there are information gaps, and how will they be addressed/what additional information is required?		No	

Equalities Impact Assessment Question	Yes	No	Comment
10. Does the policy or service development have an adverse impact on any particular group?		No	
11. Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?		No	
12. Where an adverse impact has been identified can changes be made to minimise it?		N/A	
13. Is the policy directly or indirectly discriminatory, and can the latter be justified?		No	
14. Is the policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment? If so is this lawful?		N/A	

EQUALITIES IMPACT ASSESSMENT
FOR POLICIES AND PROCEDURES

2. If any of the questions are answered 'yes', then the proposed policy is likely to be relevant to the Trust's responsibilities under the equalities duties. Please provide the ratifying committee with information on why 'yes' answers were given and whether or not this is justifiable for clinical reasons. The author should consult with the Director of HR & Environment to develop a more detailed assessment of the Policy's impact and, where appropriate, design monitoring and reporting systems if there is any uncertainty.

3. A copy of the completed form should be submitted to the ratifying committee when submitting the document for ratification. The Committee will inform you if they perceive the Impact to be sufficient that a more detailed assessment is required. In this instance, the result of this impact assessment and any further work should be summarised in the body of the Policy and support will be given to ensure that the policy promotes equality.

Policy Submission Form

To be completed and attached to any policy or procedure submitted to the Trust Policy Group

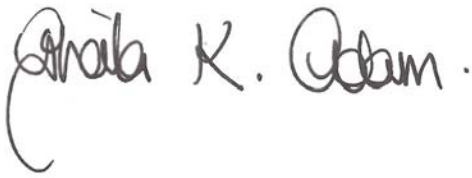
1	**Details of policy**	
1.1	Title of Policy:	Infection Prevention and Control Operational Policy
1.2	Lead Executive Director	Chief Nurse and Director of Governance
1.3	Author/Title	Vickie Longstaff (Nurse Consultant)
1.4	Lead Sub Committee	Infection control committee
1.5	Reason for Policy	Compliance with health and Social Care Act 2009
1.6	Who does policy affect?	All Trust staff
1.7	Are national guidelines/codes of practice incorporated?	Yes
1.8	Has an Equality Impact Assessment been carried out?	Yes
2	**Information Collation**	
2.1	Where was Policy information obtained from?	Health and Social care act 2009
3	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure if the policy is implemented?	No
3.2	If YES attach a copy to this form	N/A
3.3	If NO explain why	Systems already in place
4	**Consultation Process**	
4.1	Was there internal/external consultation?	Internal – Infection control committee
4.2	List groups/Persons involved	Infection control committee – January 2014 group
4.3	Have internal/external comments been duly considered?	Yes
4.4	Date approved by relevant Sub-committee	30th January 2013

4.5	Signature of Sub committee chair	
5	**Implementation**	
5.1	How and to whom will the policy be distributed?	All staff via IPC newsletter
5.2	If there are implementations requirements such as training please detail?	Already covered in Infection Control training
5.3	What is the cost of implementation and how will this be funded?	none
6	**Monitoring**	
6.1	List the key performance indicators e.g. core standards	CQC essential standard 6 Health and Social Care Act
6.2	How will this be monitored and/or audited?	See section 9 of the policy for monitoring table
6.3	Frequency of monitoring/audit	See section 9 of the policy for monitoring table

Date policy approved by Trust Policy Group:

18 March 2014

Signature of Trust Board Group chair:



Surveillance and Reporting of Healthcare Associated Infections (HCAIs) and Incidents

Author(s)	Vickie Longstaff (Infection Control Nurse Consultant)
Version	4 (Review of 2011 version)
Version Date	September 2013
Implementation/approval Date	September 2013
Review Date	September 2016
Review Body	Infection Control Committee
Policy Reference Number	55\tw\ic\hi\

Contents Page

1. Introduction

Infection can complicate healthcare in any setting and the growth of treatment in primary care and community facilities means that the settings in which patients can acquire such infections are now very diverse. The two strongest risk factors linked with healthcare associated infections (HCAIs) are the degree of underlying illness, which often prolongs the length of hospital stay, and the use of medical devices.

Healthcare associated infection was one of the areas identified as needing intensified control measures in the Chief Medical Officer's Infectious Diseases Strategy for England, *Getting Ahead of the Curve* (2002). Since then there has also been the Saving Lives delivery program for reducing healthcare associated infections, the Health Act 2006 with the Code of Practice and now the Health and Social Care Act 2009.

The purpose of this policy is to provide clear guidance and a structured systematic strategy for surveillance and reporting of healthcare associated infections that meets national mandatory requirements and the local requirements of the Trust.

This policy was developed by the Infection Prevention and Control team (IPCT), and then distributed to all Members of the Infection Control Committee for endorsement and sent to the Trust policy group for ratification.

2. Scope

This policy applies to all employees of the Trust in all locations including the Non-Executive Directors, temporary employees, locums and contracted staff.

3. Roles and Responsibilities

The Director of Infection Prevention and Control (DIPC) for the Trust is responsible for the IPCT and reports to the Chief Executive Officer and Board, whose responsibility it is, to ensure that there are effective arrangements for Infection Prevention and Control within the Hospital. At this Trust, the DIPC is also the Infection Control Doctor (ICD).

The IPCT reports to the Infection Control Committee (ICC), which is a sub-committee of the Trust Board.

The Infection Control Nurse Consultant (ICNC) is also the Deputy DIPC and is responsible for the management of the infection prevention and control service and reports to the DIPC and Chief Nurse.

The infection control band 7 nurses are responsible for ensuring surveillance activities take place and are accountable to and managed by the ICNC.

4 Surveillance of Healthcare associated infection

4.1 Mandatory Surveillance of HCAI:

- The Trust participates in all Department of Health mandatory surveillance systems. Data iscollected and collated primarily by the infection prevention and control team in collaboration with the clinicians working in that area (e.g. orthopaedic teams for orthopaedic surgical site infection).
- The results are fed back to the ICC via the IPCT quarterly report and the Trust Board as part of the DIPC quarterly report to Board.
- The results of the orthopaedic surgical site infection reports are also fed back to the orthopaedic teams and division by the infection control nurses for divisional action.

At the time of writing this policy the mandatory surveillance includes:

- Monthly Public Health England (PHE) Health Care Associated Infection (HCAI) website returns for MRSA bacteraemias, *Clostridium difficile* infection (CDI) cases, MSSA and *E.coli* bacteraemias. These data are entered on to the PHE HCAI website in 'real time' as the results are made available from the microbiology laboratory.
- Quarterly PHE HCAI website Mandatory Laboratory Returns on: Total number of blood culture sets examined; Total number of positive blood culture sets; Total number of *S.aureus* positive blood culture episodes; Total number of Glycopeptide resistant-*enterococci* (GRE) positive blood culture episodes; Total number of stool specimens examined; Total number of *C.difficile* toxin tests done; Total number of *C.difficile* toxin positive results ≥ 65 years; Total number of *C.difficile* toxin positive results 2-64 years.
- Quarterly Surgical site infection surveillance for total hip and total knee replacements.

The full data collection protocol is available in Appendix 1 and 2

4.2 Internal Surveillance of 'Alert Organisms':

- The Infection Prevention and Control Team (IPCT) produces local detailed data on all cases of MRSA (colonised/infected and bacteraemia), *E.coli* and MSSA bacteraemias and CDI cases monthly and feeds this back to the clinical staff. These figures are fed back to the senior nurses, lead nurses, Executive Directors, all Consultants and other doctors.
- Surveillance of pseudomonas isolates in NICU/SCBU and ITU takes place and is fed back to the clinical teams.
- Other surveillance of organisms with infection prevention and control implications takes place as part of the IPC annual programme and is reported to the ICC.
- The figures for mandatory surveillance reporting are reported to the Infection Control Committee and Trust Board every quarter.
- The 'alert organisms' identified by the Infection Prevention and Control Team are formally reviewed on an annual basis as these may be altered to meet the needs of the Trust and the current relevant local epidemiology of organisms. The annual update of the surveillance plan is part of the annual programme for infection prevention and control (which is formally reviewed and taken to the ICC on an annual basis).
- All surveillance data of 'alert organisms' will be produced in the Infection Prevention and Control annual report.

4.3 MRSA surveillance

All cases of MRSA are reported by the laboratory IT system to the infection prevention and control team.
The infection control nurses identify acquisition of MRSA based on the definitions below:

Hospital acquired	Negative or no screen on admission
Admitted +ve	Specimen taken in first 48 hours of admission
Previously Positive	Known MRSA positive from previous admission/GP swabs

Data is collated for all cases of MRSA colonisation, infection and bacteraemias in monthly spread sheets and 'alert organism' feedback reports are produced monthly for the clinical teams and wards. These figures are also fed back to the senior nurses, lead nurses, Executive Directors, all Consultants and other doctors.

All hospital acquired MRSA colonisation cases are reported as an incident on Datix by the IPC team. If further cases are identified in that clinical areas and there is an epidemiology link then additional actions would be taken as required and be reported as an incident on Datix.

MRSA Bacteraemia

The Government considers it unacceptable for a patient to acquire an MRSA bloodstream infection (MRSA BSI) while receiving care in a healthcare setting. It has set healthcare providers the challenge of demonstrating zero tolerance of MRSA BSI through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance.

All cases of MRSA bacteraemia are reported by the laboratory IT system to the IPC team and formally followed up on the daily clinical or weekly Infection Prevention and Control ward round depending on the stage of treatment of the patient.

On identification of a case of MRSA bacteraemia the IPC team will report this as an Incident regardless of outcome as part of the Trust incident reporting system to emphasise the Trust's zero tolerance approach to MRSA bacteraemias. The case will then be assessed to determine if it is required to be reported as a serious incident. All cases of MRSA bacteraemia are presented at the Trust's Patient Safety Committee.

The Trust follows the DH Post Infection Review (PIR) process (Appendix 1). The guidance has been developed by DH in conjunction with the NHS Commissioning Board to facilitate delivery of the zero tolerance MRSA objective set out in the NHSCB Planning Guidance Everyone counts: Planning for Patients 2013/14. Further information available at http://www.england.nhs.uk/ourwork/patientsafety/zero-tolerance/

The organisation to which the case is initially assigned (either the acute trust or CCG) will be the lead organisation responsible for completing a PIR within one week of the date of assigning. The outcome of the PIR should establish the organisation to which the BSI should be finally assigned. The final assignment will identify the organisation best placed to ensure that any lessons learned are acted upon. The final assignment must be logged on the DCS within 7 days of the initial assigning.

If a patient *was not* an inpatient of an acute trust (e.g. GP or non-acute hospital took the sample)	PIR to be led by the **CCG**

If the patient *was* an inpatient in an **acute** trust, and if the sample was taken on:

▪ Day of admission:	(Day 1)	PIR to be led by the **CCG**
▪ Day of admission day + 1	(Day 2)	PIR to be led by the **CCG**
▪ Day of admission day + 2:	(Day 3)	PIR to be led by **acute trust**

Once the lead organisation has been notified by the DCS that they will be coordinating a PIR they will begin to call on the necessary multidisciplinary expertise. This will include, but is not limited to:

- The staff who provided care;
- any other organisation recently involved (e.g. in the last two weeks) in the care of the patient;
- local infection prevention and control (IPC) team;
- Director of Infection Prevention and Control (DIPC);
- the CCG responsible for the patient; and
- in some circumstances, Public Health England (PHE).

The CCG will also be able to use the DCS PIR information to demonstrate their adherence to good practice to the NHS Commissioning Board with respect to patient safety under the Mandate.

The PIR will be reported to the Trust Patient Safety Committee.

The findings and recommendations of the report and RCA will also be shared with partner organisations across the health economy as appropriate for the incident.

The monthly 'alert organism' feedback and infection prevention and control newsletter update includes information on MRSA bacteraemia root cause analyses and lessons to be learnt.

THE KEY POINTS

The PIR process will:

- Enable organisations involved to understand the causes of the MRSA BSI;
- Establish where it happened;
- Establish why it happened;
- Establish what went well with the care given;
- Establish what could be improved;
- Understand the expectations and perspectives of all those involved;
- Generate insight into lessons learned, and
- Lead to greater awareness, changed behaviours and agreed improvements in care.

Successful use of this tool depends on the PIR:

- being done quickly;
- being open and honest;
- being multidisciplinary, all professions and grades contribute as experts in their field;
- yielding lessons that will be acted on to drive improvements in care,
- being integrated into governance systems.

Communication with patients

- When an MRSA BSI is identified, notify the patient (and/or family) promptly of the infection.
- Advise the patient that a PIR will be undertaken to understand why the

4.4 C.*difficile* infection (CDI) surveillance

- All cases of CDI are reported by the laboratory IT system to the infection prevention and control team and formally followed up on the weekly Microbiology/Gastroenterology Consultant joint CDIward round.
- On identification of a case of HUH attributable CDI the infection prevention and control team will report this as an incident as part of the Trust incident reporting system and an RCA will be completed, presented to the Patient Safety Committee and shared across the health economy. The case will be assessed and if it fulfills the Trust criteria it will be reported as a serious incident and investigated as per Trust policy.
- On identification of a case of non-HUH attributable CDI the infection prevention and control team will report this as an incident as part of the Trust incident reporting system and an RCA will be completed, presented to the Patient Safety Committee and shared across the health economy.
- Cases of CDI reported to the IPCT but originating from a sample from a GP will be entered on to the PHE HCAI website since the sample has been processed by the Trust's Microbiology laboratory. No further action will routinely be taken.
- The findings and recommendations of the SI report or RCA will also be shared with partner organisations across the health economy as appropriate for the incident.
- The monthly 'alert organism' feedback and infection prevention and control newsletter includes information on MRSA bacteraemia root cause analyses and lessons to be learnt.
- For acute Trusts the basis of the assessment is the number of positive CDI specimens (more than 28 days apart) taken from inpatients, excluding specimens taken on the day of admission or on the two days following the day of admission (i.e. date of sample minus date of admission is less than 3 days). Also attributed to the acute Trust are specimens from admitted patients where an admission date has not been recorded.
- The IPCT also carries out local surveillance of stool samples where the C.difficile toxin gene PCR result is positive but the C.difficile toxin EIA (toxin production test) is negative.

CDI trigger event criteria for Infection Prevention and Control team ward-based intervention:
If there are two cases in one ward in a 4 week period despite isolation of affected patients and infection control precautions the ward/bay will have a deep clean, including curtain changes as per Trust Environmental and Isolation Room Cleaning Policy.
Further cases will require additional actions as directed by the IPCT.

4.5 E.coli and MSSA bacteraemia surveillance

All cases of *E.coli* and MSSA bacteraemia are reported by the laboratory IT system to the infection prevention and control team.
A brief investigation is performed by the IPCT to determine the source, cause and if the bacteraemia was preventable.

4.6 Other alert organism surveillance

Surveillance of invasive Group A streptococcal (iGAS) isolates (from inpatients, peri-partum patients, neonates and post-operative wounds) and pseudomonas isolates from ITU and NICU/SCBU are reported to and reviewed at the monthly IPCT meeting.
Other alert organism surveillance is performed and reviewed at the monthly IPCT meeting as required. The focus of alert organism surveillance may be directed by clinical incidents, increases in number of cases in the hospital or community or presence of an organism from the environment (e.g. pseudomonas in water).

4.7 Reporting of surveillance activities

- All surveillance data will be formally reviewed by the IPCT at the monthly meeting and any actions already undertaken will be reviewed and any further actions required identified.
- The results of the surveillance activities will be used as internal/external key indicators of the effectiveness of the infection prevention and control programme and will form the basis for any reviews in policies and procedures that may be required.
- The results of surveillance will be reported back to local areas monthly with recommended actions where necessary.
- The quarterly DIPC reports to the Trust Board include the surveillance data and actions undertaken/required.
- The surveillance activities of the Trust and Infection Prevention and Control Team will be presented in the annual infection prevention and control report and annual programme.

5 Reporting of Infection Prevention and Control Incidents

The clinical teams are responsible for reporting infection control incidents that occur in their areas. These will include:

- Failure to isolate patients as per Trust policy (e.g. patients with TB, MRSA, diarrhoea and vomiting)
- Breakdown in communication between departments if patients require infection control precautions above standard precautions.
- Breakdown in decontamination process of re-usable equipment used for invasive procedures

The Infection Prevention and Control Team will report all infection control incidents where:

- Trust criteria are met for reporting as Serious Incidents
- Contact tracing of patient and/or staff is required
- Failure to follow correct procedure as per Trust isolation or screening policy and has led to the Infection Prevention and Control team being unaware of a patient who requires Infection Prevention and Control team follow up

When an outbreak of an infection occurs in the Trust and the outbreak plan is implemented, local branch of Public Health England will be informed so it can provide appropriate advice and support for management and control of the incident. The Trust SI policy may also be implemented.

5.1 Infection Control Serious Incidents (SIs)

Serious Incidents (SIs) associated with infection prevention and control are those that produce, or have the potential to produce serious unwanted effects involving the safety of patients, staff or others. Reportable incidents are those that:

1/ result in significant morbidity or mortality and /or
2/ involve highly virulent organisms and / or
3/ are readily transmissible and / or
4/ require control measures that have an impact on the care of other patients, including limitation of access to healthcare services

When point 4 is associated with the first three this will commonly be an SI. Any of the first three bullet points by themselves may not be an SI – for example chickenpox is highly transmissible but a single case should not be an SI. Necrotising fasciitis caused by Group A Streptococci involves a highly virulent organism but a single case is not an SI. Recognition of a single case of smallpox or Lassa fever on an open hospital ward would constitute an SI.

It has been decided at a Trust Executive level that all Trust-attributable MRSA bacteraemias and CDI are reported as potential SIs and the appropriate level of investigation is reviewed at the 24h SI meeting as per Trust policy. . All SI reports go to the Patient Safety Committee as per Trust Incident Reporting policy.

5.2 Infection-related incidents types

- **Outbreaks - two or more linked cases in a healthcare setting:**
  An outbreak is defined as two or more cases of the same pathogen in the same location within a week or three or more cases in the same location within a month. Any infection is considered to be hospital-acquired if the patient was admitted without the pathogen and developed symptoms after 48 hours post-admission.

- **Infected healthcare worker or patient incidents necessitating look-back investigations:**
  e.g. Tuberculosis, variant Creutzfeldt - Jakob disease, blood borne infections.

- **Significant breakdown of infection control procedures with actual or potential for cross-infection:**
  MRSA bacteraemias
  Release of products from a failed sterilisation cycle
  Contaminated blood transfusion
  Isolation of *Legionella* suggesting an environmental source there is a potential risk to others

- **Patient deaths related to Trust-attributable hospital acquired infection:**
  Any patient that dies and MRSA infection/bacteraemia or CDI is put on the death certificate as the primary cause of death (Part 1 of the death certificate) and that infection/bacteraemia is Trust-attributable must be investigated as an SI.

All SIs are investigated and reported as per Trust Incident Reporting policy available on the Trust intranet.

6.0 Collaborative Working

The Health Protection Agency (known as Public Health England from April 2013) published 'Health Care Associated Infection OperationalGuidance and Standards for Health Protection Units' in 2012. The HUH IPCT acknowledges this report and will continue to work collaboratively with the HPA/PHE to reduce the risk of HCAIs. The local HPU nurse consultant is a member of the Trust ICC, attends the monthly ICT meetings and is informed of any incidents or outbreaks at the HUH.

7.0 Training and awareness

Infection Prevention and Control training is part of the Trust mandatory training programme contained in the Trust Mandatory Training policy available at on the intranet. Managers are responsible for identifying staff training requirements, booking and following up attendance/non attendance of Infection Control mandatory training.

The infection prevention and control team all attend training or conferences as part of their personal and professional development plans to ensure that they have the necessary knowledge and skills to fulfil the requirements of their roles.

8.0 Review

This policy will be reviewed in 3 years time as per Trust policy. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

9.0 Monitoring/Audit

Measurable Policy Objective	**Monitoring/Audit**	**Frequency of monitoring**	**Responsibility for performing the monitoring**	**Monitoring reported to which groups/committees , inc responsibility for reviewing action plans**
Mandatory alert organisms surveillance	HPA/PHE HCAI enhanced surveillance website	Monthly Quarterly	IPCT	Chief Nurse sign off Trust board Infection Control Committee DIPC report to Trust board
Internal surveillance reporting	Surveillance of alert organisms	Monthly	IPCT	IPCTmeeting
Outbreak management/ SI/RCA	All outbreaks, SI or RCA are reported via the Trust incident reporting system. RCA is performed and report produced.	As required	Clinical staff/ Infection control nurses	Infection Control Committee/ Patient Safety Committee

	Any instances of non-compliance with this policy will be reported as an incident on the Trust incident reporting system and investigated accordingly.	As required		Incident review group

Sources of Evidence; References / Bibliography

Department of Health, The Operating Frame work for the NHS in England 2011/12, Dec 2010.

Department of Health, Winning Ways. Working together to reduce Healthcare Associated Infection in England. Report from the Chief Medical Officer. Dec 2003.

Department of Health. Getting ahead of the curve: a strategy for combating infectious diseases (including other aspects of health protection). A report by the Chief Medical Officer. London: Department of Health; 2002

Department of Health Standing Medical Advisory Committee Sub-group on Antimicrobial Resistance. The Path of Least Resistance: summary and recommendations. London: Department of Health; 1998.

Department Of Health. Saving Lives. A Delivery programme for reducing health care associated infections including MRSA, 2005.

Department of Health. The Health Act 2006. The Code of practice for the reduction in health care associated infection.

Department of Health. The Health and Social Care Act 2009.

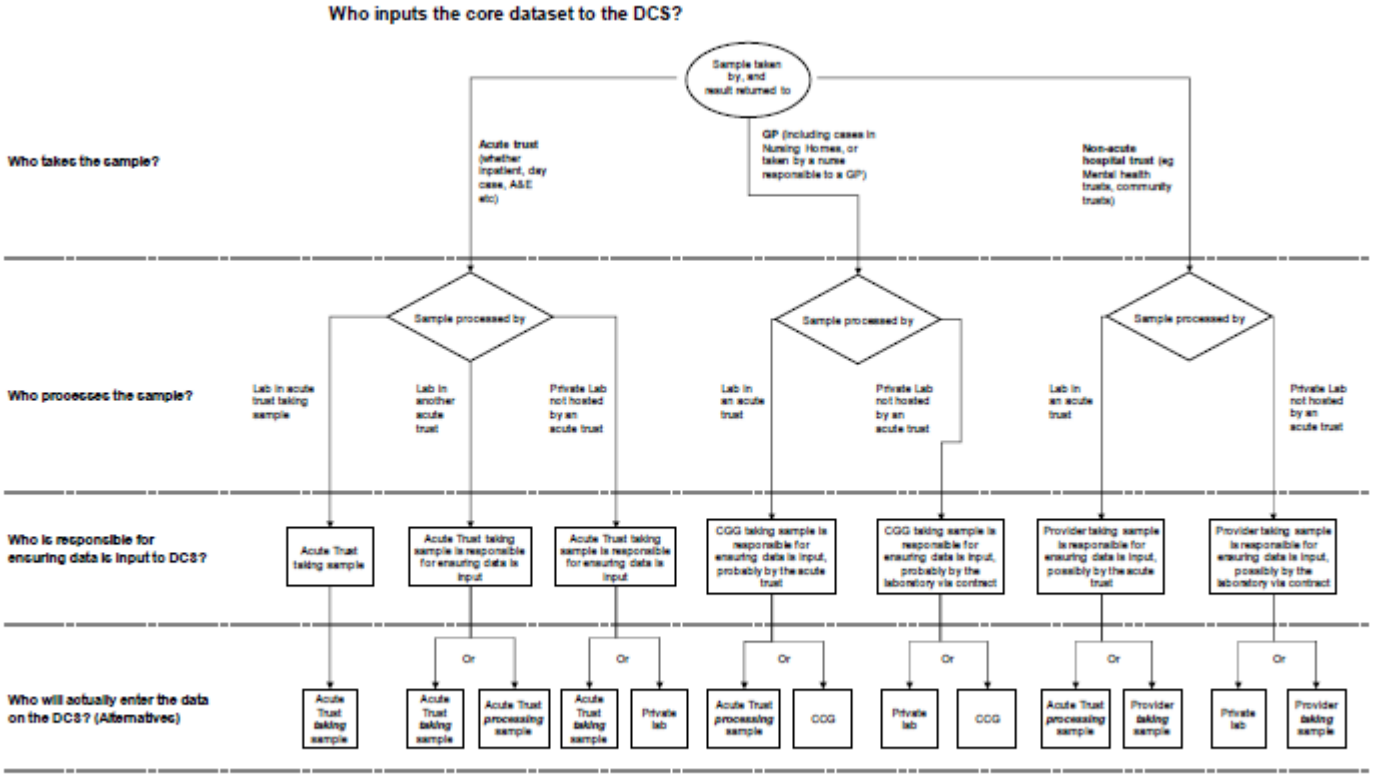
Health Protection Agency. Health Care Associated Infection Operational Guidance and Standards for Health Protection Units. 2012

NHSCB Planning Guidance Everyone counts: Planning for Patients 2013/14.

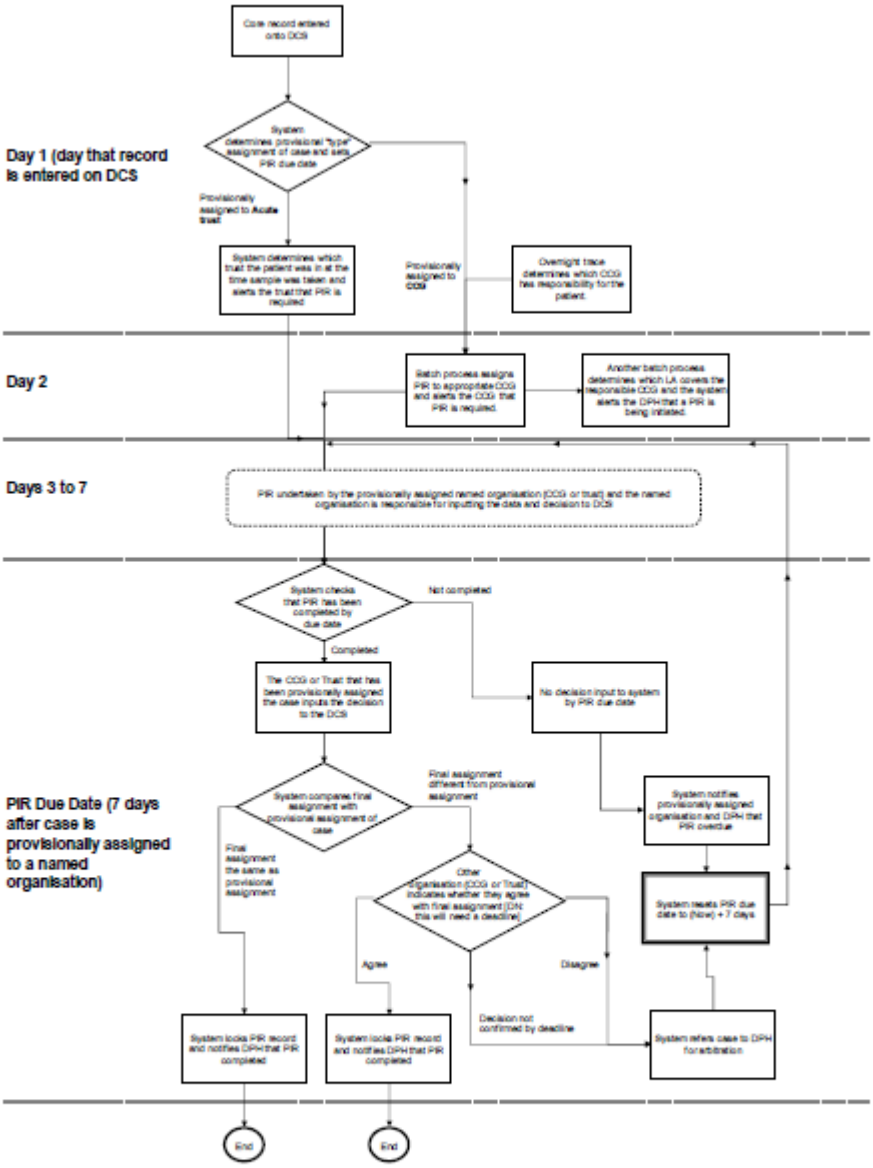
Further details about the new DCS can be found at:
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI/HCAIDataCaptureLaunchNHSWorkshop/

Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April. NHS Commissioning Board. 2013.
http://www.england.nhs.uk/ourwork/patientsafety/zero-tolerance/

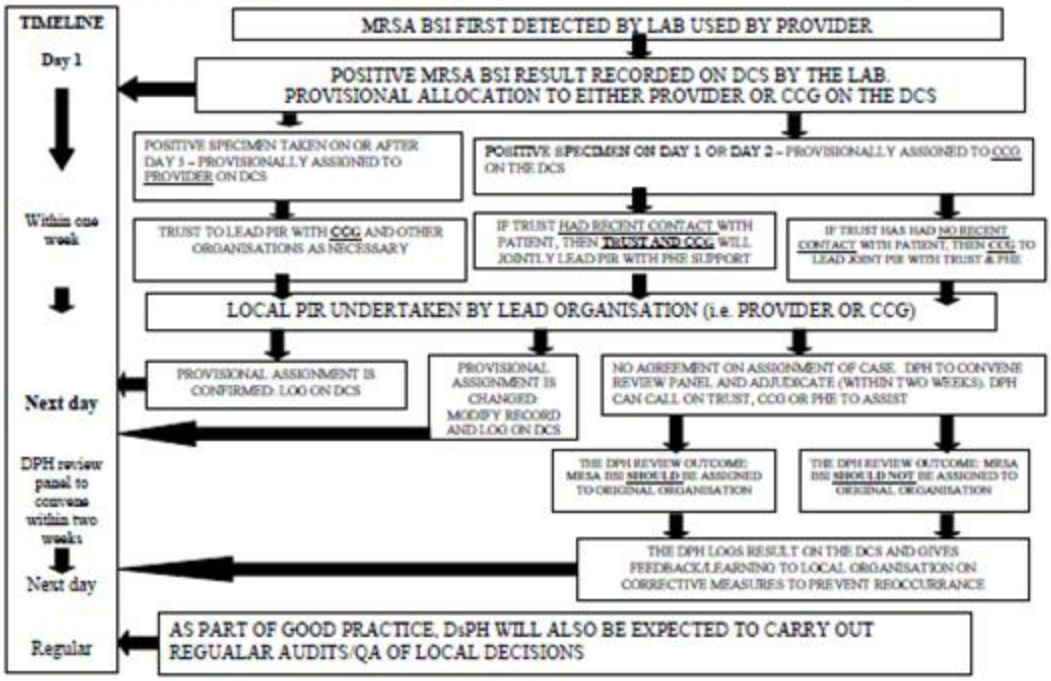
Appendix 1 MRSA bacteraemia Post Infection Review process



Completing the PIR



MRSA BLOODSTREAM INFECTION (BSI): GENERAL REPORTING ARRANGEMENTS FROM 2013



Appendix 2

Mandatory MRSA blood cultures returns

- On identification of a MRSA bacteraemia, a PIR is performed (see appendix 1) and the case reported as an incident as per Trust Incident Reporting policy. The ICNs complete the data on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password.
- By the 14th of every month (at the latest) the DIPC or ICNC checks the results of the search done on the laboratory system for all MRSA positive blood cultures taken in the previous month.
    - The DIPC or ICNC informs the Chief Nurse who signs off the Trust's MRSA bacteraemia returns for the previous month (including nil returns) on behalf of the CE by the 15th of the month.
    - On a quarterly basis the quarterly return form is completed on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password within 6 weeks of the quarter end.

Mandatory MSSA blood cultures returns

- On identification of a MSSA bacteraemia, a history of risk factors and source of the bacteraemia is determined by the ICNs. The ICNs then complete the data on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password.
- By the 14th of every month (at the latest) the DIPC or ICNC checks the results of the search done on the laboratory system for all MRSA positive blood cultures taken in the previous month.
    - The DIPC or ICNC then informs the Chief Nurse who signs off the Trust's MSSA bacteraemia returns for the previous month (including nil returns) on behalf of the CE by the 15th of the month.
    - On a quarterly basis the quarterly return form is completed on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password within 6 weeks of the quarter end.

Mandatory *E.coli* blood cultures returns

- On identification of an E.coli bacteraemia, a history of risk factors and source of the bacteraemia is determined by the ICNs. The ICNs then complete the data on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password.
- By the 14th of every month (at the latest) the DIPC or ICNC checks the results of the search done on the laboratory system for all MRSA positive blood cultures taken in the previous month.
    - The DIPC or ICNC then informs the Chief Nurse who signs off the Trust's MSSA bacteraemia returns for the previous month (including nil returns) on behalf of the CE by the 15th of the month.

Mandatory C.*difficile* infection (CDI) returns

- On identification of a Homerton-attributable CDI, a root cause analysis is performed and the case reported as an incident as per Trust Incident Reporting policy. The ICNs complete the data on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password.

- By the 14th of every month (at the latest) the DIPC or ICNC checks the results of the search done on the laboratory system for all CDI positive specimens in the previous month.
    - The DIPC or ICNC then informs the Chief Nurse who signs off the Trust's MRSA bacteraemia returns for the previous month (including nil returns) on behalf of the CE by the 15th of the month.
    - On a quarterly basis the quarterly return form is completed on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password within 6 weeks of the quarter end.

Mandatory Glycopeptide Resistant *enterococci* returns

- The DIPC or ICNC completes the quarterly return form on the HPA HCAI data capture website https://nww.hpanw.nhs.uk/MRSA/ with the Trust specific password within 6 weeks of the quarter end.

Surgical site infection surveillance

- The orthopaedic nurse practitioners collect patient specific surveillance data.
- On discharge, death or completion of the surveillance period the form is returned to the ICNs.
- The IPC team will obtain notes if further information is required and input the data on the SSIS data capture website https://nww.ssiweb.hpa.nhs.uk/ssiweb/ssiapp/Welcome.aspx?ReturnUrl=%2fssiweb%2fssiapp%2fSelectTask.aspx with the Trust specific password.

Equalities Impact Assessment
This checklist should be completed for all new Corporate Policies and procedures to understand their potential impact on equalities and assure equality in service delivery and employment.

Policy/Service Name:	**Surveillance and Reporting of Health Care Associated Infections and Incidents**
Author:	**Vickie Longstaff**
Role:	**Nurse consultant**
Directorate:	**CSDO**
Date	**June 2013**

Equalities Impact Assessment Question	**Yes**	**No**	**Comment**
1. How does the attached policy/service fit into the trusts overall aims?	Yes		Compliance with health and social care act 2009 and NHSLA level 2 and Department of Health mandatory surveillance
2. How will the policy/service be implemented?			Systems already in place
3. What outcomes are intended by implementing the policy/delivering the service?			Compliance with health and social care act 2009 and NHSLA level 2 and Department of Health mandatory surveillance
4. How will the above outcomes be measured?			Compliance with health and social care act 2009 and NHSLA level 2 and Department of Health mandatory surveillance, NHSCB Planning Guidance Everyone counts: Planning for Patients 2013/14
5. Who are they key stakeholders in respect of this policy/service and how have they been involved?			Infection control committee given opportunity to comment
6. Does this policy/service impact on other policies or services and is that impact understood?		NO	
7. Does this policy/service impact on other agencies and is that impact understood?		No	
8. Is there any data on the policy or service that will help inform the EqIA?		No	
9. Are there are information gaps, and how will they be addressed/what additional information is required?		No	

Equalities Impact Assessment Question	Yes	No	Comment
10. Does the policy or service development have an adverse impact on any particular group?		No	
11. Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?		No	
12. Where an adverse impact has been identified can changes be made to minimise it?		N/A	
13. Is the policy directly or indirectly discriminatory, and can the latter be justified?		No	
14. Is the policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment? If so is this lawful?		N/A	

EQUALITIES IMPACT ASSESSMENT
FOR POLICIES AND PROCEDURES

2. If any of the questions are answered 'yes', then the proposed policy is likely to be relevant to the Trust's responsibilities under the equalities duties. Please provide the ratifying committee with information on why 'yes' answers were given and whether or not this is justifiable for clinical reasons. The author should consult with the Director of HR & Environment to develop a more detailed assessment of the Policy's impact and, where appropriate, design monitoring and reporting systems if there is any uncertainty.

3. A copy of the completed form should be submitted to the ratifying committee when submitting the document for ratification. The Committee will inform you if they perceive the Impact to be sufficient that a more detailed assessment is required. In this instance, the result of this impact assessment and any further work should be summarised in the body of the Policy and support will be given to ensure that the policy promotes equality.

Policy Submission Form

1	**Details of policy**	
1.1	Title of Policy:	Surveillance and Reporting of Health Care Associated Infections and Incidents
1.2	Lead Executive Director	Chief Nurse
1.3	Author/Title	Vickie Longstaff (Infection Control Nurse Consultant)
1.4	Lead Sub Committee	Infection control committee
1.5	Reason for Policy	Compliance with health and Social Care Act 2009, NHSLA level 2 and Operating Frame work for the NHS in England 2011/12, NHSCB Planning Guidance Everyone counts: Planning for Patients 2013/14
1.6	Who does policy affect?	All staff
1.7	Are national guidelines/codes of practice incorporated?	yes
1.8	Has an Equality Impact Assessment been carried out?	Yes
2	**Information Collation**	
2.1	Where was Policy information obtained from?	See reference list/sources of evidence
3	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure if the policy is implemented?	No
3.2	If YES attach a copy to this form	N/A
3.3	If NO explain why	Infrastructure already in place
4	**Consultation Process**	
4.1	Was there internal/external consultation?	Infection Control Committee

4.2	List groups/Persons involved	Infection control committee
4.3	Have internal/external comments been duly considered?	Yes
4.4	Date approved by relevant Sub-committee	
4.5	Signature of Sub committee chair	
5	**Implementation**	
5.1	How and to whom will the policy be distributed?	On Trust intranet
5.2	If there are implementation requirements such as training please detail?	No
5.3	What is the cost of implementation and how will this be funded?	None
6	**Monitoring**	
6.1	List the key performance indicators e.g. core standards	Compliance with health and Social Care Act 2009, NHSLA level 2 and Operating Frame work for the NHS in England 2011/12, NHSCB Planning Guidance Everyone counts: Planning for Patients 2013/14
6.2	How will this be monitored and/or audited?	See section9
6.3	Frequency of monitoring/audit	See section 9

Date policy approved by Trust Policy Group:

.....13/9/2013.....

Signature of Trust Board Group chair:

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Shala R. Adam