HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th January, 2009

9:30 am

Council Chamber
Sessions House, County Hall, Maidstone

Kent County Council

AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 9th January, 2009, at 9:30 am
Council Chamber, Sessions House
County Hall, Maidstone

Ask for: **Paul Wickenden**
Telephone: **(01622) 694486**

Tea/Coffee will be available from 9:15 am

Membership (17)

Conservative (12):	Mr B R Cope (Chairman), Mr A R Chell, Mr A D Crowther, Mr J Curwood, Mrs S V Hohler, Mr G A Horne MBE, Mr M J Northey, Mr R J Parry, Ms B J Simpson, Dr T R Robinson, Mr R Tolputt and Mrs E M Tweed
Labour (4):	Mr M J Fittock (Vice-Chairman), Mrs C Angell, Ms A Harrison and Mrs E D Rowbotham
Liberal Democrat (1):	Mr D S Daley
Borough and District Councillors (4):	Cllr Ms A Blackmore, Cllr M Lyons, Cllr Mrs J Perkins and Cllr Mrs M Peters

UNRESTRICTED ITEMS

(During these items the meeting is likely to be open to the public)

Item		Timings
1.	Substitutes	
2.	Declarations of Interests by Members in items on the Agenda for this meeting.	
3.	Minutes - 17 October 2008 (Pages 1 - 10)	9:30-9:45 am
	Annual Health Check	
4.	Dartford & Gravesham NHS Trust (Pages 63 - 68)	9:45-10:45 am
	Break - 10:45-11:00 am	
5.	Maidstone & Tunbridge Wells NHS Trust (Pages 69 - 104)	11:00 am - 12 noon
6.	Eastern & Coastal Kent Primary Care Trust (Pages 105 - 116)	12:00-12:45 pm
7.	Plenary - Members review of the key points	12:45-1:00 pm
8.	Date of next programmed meeting – Friday 6 February 2009 at 10:00 am	

EXEMPT ITEMS

(At the time of preparing the agenda there were no exempt items. During any such items which may arise the meeting is likely NOT to be open to the public)

Peter Sass
Head of Democratic Services and Local Leadership
(01622) 694002

31 December 2008

Please note that any background documents referred to in the accompanying papers maybe inspected by arrangement with the officer responsible for preparing the relevant report.

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 17 October 2008.

PRESENT: Mr B R Cope, Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Ms A Harrison, Mrs S V Hohler, Mr G A Horne MBE, Mr W V Newman, DL (Substitute for Mrs E D Rowbotham), Mr M J Northey, Ms B J Simpson, Dr T R Robinson, Mrs P A V Stockell (Substitute for Mr A R Chell), Mr R Tolputt, Mrs E M Tweed, Cllr Ms A Blackmore and Cllr M Lyons

IN ATTENDANCE: Ms D Fitch, Assistant Democratic Service Manager (Policy Overview), and Mr T Godfrey, Research Officer to Health Overview Scrutiny Committee.

UNRESTRICTED ITEMS

46. Membership
(Item 1)

(Mr Fittock, Vice Chairman, presiding)

(1) It was reported that the Borough and District Councils had now agreed their four voting members on the Committee. The Members are as follows:-

Councillor Marilyn Peters, Dartford Borough Council
Councillor Annabelle Blackmore, Maidstone Borough Council
Councillor Jackie Perkins, Canterbury City Council
Councillor Michael Lyons, Shepway District Council

Colleagues from West Kent would have a pool of substitutes should Councillors Peters or Blackmore be unable to attend. The pool of Members are:-

Councillor Janet Sergison, Tonbridge and Malling Borough Council
Councillor John Cunningham, Tunbridge Wells Borough Council
Councillor Diane Marsh and Councillor Leslie Hills, Gravesham Borough Council
Councillor Richard Davison, Sevenoaks District Council.

(2) That the Borough and District Council Membership on the Committee, as set out above be noted.

47. Election of Chairman
(Item 3)

RESOLVED That Mr B R Cope be elected Chairman of the Committee.

Proposed by Mr G A Horne, Seconded by Mr M J Northey

48. Minutes - 5 September 2008
(Item 5)

RESOLVED that the Minutes of the meeting held on 5 September 2008 are correctly recorded and that they be signed by the Chairman.

49. Update on various issues
(Item 6)

(1) The Committee received a report which updated them on the Access to Healthcare (Transport) piece of work and the "Picture of Health in Outer South East London.

(2) RESOLVED that the report be noted.

50. Delayed Transfers of Care from Acute Hospital Trusts
(Item 7)

(Steve Phoenix, Chief Executive, Sharon Jones, Director of Community Services and Daryl Robertson, Director of Performance & Delivery, West Kent Primary Care Trust; Nikki Luffingham, Chief Operating Officer, Maidstone & Tunbridge Wells NHS Trust; Jessica Scott, Head of Clinical Site and Operational Safety, Medway Foundation Trust; Sarah Andrews, Director of Nursing, Simon Perks, Deputy Director of Commissioning and Sue Baldwin, Assistant Director, Intermediate Care Services, Eastern & Coastal Kent Primary Care Trust; Andy Schofield, Head of Nursing for Medicine and Lesley White, Acute and Emergency Services Manager, East Kent Hospitals Trust; Anne Tidmarsh, Head of Adult Services, East Kent, Janice Duff, District Manager, East Kent, KASS and Margaret Howard, Director of Commissioning and Provision, West Kent were in attendance for this item).

(Mr Clark, MP, joined the meeting during this item)

(1) The Chairman welcomed colleagues from the NHS and Social Care to the meeting and invited Members to ask questions and to raise any issues on this subject.

(2) Ms Harrison referred to reports of a situation where patients seemed to be kept at Medway Acute Hospital rather than being moved to Sittingbourne and Sheppey and that families were told that there were no beds available at Sheppey when there actually were. She stated that the system should be made easier for all families to access.

(3) Ms Baldwin, Assistant Director, Intermediate Care Services, Eastern and Coastal Kent PCT stated that she did not understand why there was a delay in moving patients from Medway to the community hospitals in Swale. She stated that assessments beds were being rolled out to Sittingbourne and Sheppey hospitals and that a new community matron was being recruited. A Health colleague explained the discharge process from the acute beds at Medway Hospital to the Swale Community Hospital's. They had a multi-disciplinary team and cases were looked at individually to determine whether assessment, rehabilitation or end of life beds were needed, all of which were available at Sittingbourne and Sheppey Community Hospitals.

(4) Mrs Angell commended the excellent procedures for discharge that were in place at Darent Valley Hospital for planned procedures. However, it was a more complex situation when people had been admitted through A&E or had MRSA, she asked how these complexities were dealt with to ensure that delayed discharges did not occur.

(5) Ms Howard (Director of Commissioning and Provision, West Kent) explained that social care services across East and West Kent worked closely with colleagues from the health service in relation to providing intermediate care and avoiding delayed discharges. Social care had staff based in or near hospitals.

(6) Mr Tolputt asked the following questions. If a self funder is offered a place away from home and they refuse to take it, is that bed blocking? A lot of nursing homes have a two tier funding system, does this cause a problem? Does the new Dover Community Hospital have any in-patient beds?

(7) Mrs Tidmarsh (Head of Adult Services, East Kent) clarified that self funders could refuse to leave hospital until accommodation that they were happy with was found, as could anybody, else and there were protocol in place on how best to work with patients to get a satisfactory outcome. Regarding two tier funding, the reality was that care homes could charge what they wanted but social care were working with care homes owners on this. A problem was caused with self funders when their depleted assets meant that they then came under social care funding.

(8) In relation to the question on Dover Community Hospital Ms Baldwin (Assistant Director, Intermediate Care Services, Eastern & Coastal Kent Primary Care Trust) explained that she was meeting with Dover GP's to develop the services. She stated that she did not think that the GP's had ruled out having in-patient beds but they wanted to make sure that what was put in place in Dover was right for the health economy. There was a two year strategy for intermediate care for Kent. Mrs Tidmarsh confirmed that she was working closely with the Commissioners in relation to the Dover Community Hospital and bed provision. They were working jointly for a joint solution. She referred to other in-patient bed provision within the area.

(9) Mr Horne asked whether acute trusts and primary care trusts could help one another financially to reduce delayed discharges.

(10) Mr Phoenix stated that it was a common misconception to say that PCT's were allocated blocks of money for particular sectors. He stated that he received £862m for West Kent and it was up to the PCT to deploy it for the health care of the residents of that area. The PCT was free to deploy this as it saw fit. There was not an allocation to the PCT which was ring fenced for acute trust provision.

(11) In relation to issues raised around the number of bed days in West Kent, Mr Phoenix stated that a huge amount of work had been done on bringing down the bed day figures. The current rate was below the national target and was 3.5%. In one particular week Maidstone and Tunbridge Wells had had no delayed transfers. The opening of beds at Tonbridge Cottage Hospital had created a greater focus on rehabilitation and had improved throughput by 40%. Beds were handled by more modern nursing and rehabilitation techniques. He predicted that Maidstone and Tunbridge Wells would show significant improvement. He stated that he and colleagues worked closely in an integrated way with those from social care. In March

2007, when they had received and approved the Community Hospital Review, they had opened up all beds, which it was clinically safe to do, and increased the number of patients seen. It remained a focus for the PCT to keep delayed discharges to the minimum. This was not something that could be solved once and for all and it was important to keep working on this. He stated that because of issues at Maidstone Hospital, they had taken been distracted from delayed discharges but they were now focusing more on it.

(12) Mr Horne asked that if the interface between the Primary Care Trust and the Acute Care Trust was so close, it raised the issue of whether there was a need to have different Trusts and could not one Trust deal with both issues.

(13) In relation to the question of acute trusts managing PCT beds, there was a preliminary meeting being held on 21 October to look at any opportunities for working in an integrated way across primary, secondary, acute and social care services. In order to find evidence of any efficiencies in relation to this, it was necessary to look internationally. He stated that he had an open mind about what might be effective, but there were arguments about integration on a number of levels. While it could be argued that it would be logical to integrate GP's and social care, it was not a simple answer and the assumption should not be made that if a community hospital was run by another part of the health service, it would make if more effective.

(14) Mr Curwood referred to Mr Clarke MP's letter and the figure of 6,467 bed days being lost at Maidstone and Tunbridge Wells NHS Trust due to delayed discharges from 15 October 2007 to 6 July 2008.

(15) Mr Phoenix stated that on any one day in West Kent there were 8 to 14 community hospital beds not occupied, this was to facilitate a fluid system with flexible capacity. He referred to other bed pressures which had occurred last winter when the wards were undergoing a deep clean. Colleagues had worked hard to make sure the system was not put under undue stress. In the year to date the number of bed days had continued downwards and he believed it could go down even further.

(16) Mrs Tweed referred to tables on page 48 of the papers circulated with the agenda and asked whether some of the delayed discharges were caused by patients and/or family choice and the time taken to realise these choices.

(17) Ms Howard stated that Social Services were responsible for identifying a range of care homes that would be appropriate and the families were given two weeks to make a decision. If things went beyond that period it was covered by the Hospital Choice Protocol.

(18) Mrs Tweed asked what could be done to help families make quicker informed choices.

(19) Mrs Tidmarsh referred to a pilot on assessment beds that was being carried out in East Kent, part of which involved helping patients and families make informed choices. If this pilot was successful in reducing delayed discharges it would be rolled out over the whole of East Kent.

(20) Mrs Duff (District Manager, East Kent KASS) stated that there were a number of categories in relation to choice, some issues revolved around the choice of home and availability, others around the financial situation and there were a further category where the family did not wish to engage. As part of the pilot, they were compiling a breakdown of these different categories to see where the majority of issues lay and how they could be targeted.

(21) Ms Robertson (Director of Performance & Delivery, West Kent Primary Care Trust) stated that work was needed in West Kent around delayed transfers, especially ways to improve pathways. The aim was to plan the right pathway with patients and carers when patients were admitted. Although it was acknowledged there were occasionally complex issues which hindered this.

(22) Ms Howard referred to occasions where there may be an inter-agency disagreement but there was a protocol that would mean that this would not delay discharge. They worked across partnerships to resolve partner problems.

(23) Mr Fittock stated that there were a couple of issues that he would like to see addressed, the first was preventative measures i.e. stopping people going into hospital who should not be there in the first place and secondly, in West Kent, particularly in Dartford/Swanley, there was a problem in finding suitable social care accommodation that was affordable. This made the choice for people very hard if at times there was nowhere in the areas that was affordable on the social care scale.

(24) Mr Phoenix stated that in relation to prevention care, he referred to a pilot at Maidstone Hospital in the Emergency Care Centre where over 12 weeks GP's were involved with assessing patients. This resulted in 153 fewer patients needed to be admitted. There were a whole raft of community and primary care measures which were aimed at trying to ensure that people were looked after at home and supported via the GP service rather than going into hospital, work on this was continuing.

(25) Mrs Tidmarsh referred to the work in East Kent on the Urgent Care Project which looked at the whole pathway in and out of hospital and the preventative services in Kent. Based on the Swedish model they had integrated discharge teams at all hospital sites who met on a daily basis. As in West Kent, they had found that having a high involvement of GP's in A&E prevented admissions and Health and Social acted together in relation to community services. She referred to the issue of transferring of funding. In East and Coastal Kent PCT, in order to keep people at home, it was necessary to transfer some funding from the PCT to social care to support care packages in the home. It was about the market and having good domiciliary care services which were integrated. She referred to work with care service providers and having a block contract so that care workers had a variety of services to provide which made it more attractive to them. She confirmed that there was close working relationships between the social care team and primary care colleagues.

(26) In relation to a question on the occupational therapy services, Mrs Tidmarsh stated that colleagues were focused on getting people back to their home and made sure that occupational therapy provision was in place. Ms Howard stated that there were never enough Occupational Therapists. However, hospital discharges were prioritised and temporary equipment was put in if necessary once an occupational therapy assessment had been carried out. This was done as quickly as possible,

and there was liaison between the district and borough councils to seek more permanent provision, if necessary.

(27) The Chairman welcomed Mr G Clark MP to the meeting and invited him to ask questions and raise issues.

(28) Mr Clark thanked the Committee for holding this session on delayed discharge and referred to the letters that he had submitted. He stated that he, along with a colleague, Sir John Stanley MP, had been involved in a series of meetings across the healthcare sector following the Healthcare Commission's report on c Difficile. What became apparent to them was that there was an issue around Accident and Emergency (A&E) in that ambulances were not able to discharge patients as the A&E facility was full. He understood that the problem caused at A&E was due to no beds being available through delayed discharge from acute to community hospitals. He referred to the recently published Healthcare Commission's Annual Report which put Maidstone and Tunbridge Wells at the bottom 4% of Trusts nationally. He stated that the Trust had failed in 2007/08 to meet the target for the four hour consultation in A&E. He mentioned the figure of 6,467 bed days lost in Maidstone and Tunbridge Wells between 15 October 2007 and 6 July 2008, due to delayed discharge. These delays could create problems in A&E. He stated that there was an issue as to whether there were enough beds available both in acute and community hospitals. There should be the right management arrangements over beds in community hospitals. It was important to look at whether the handover arrangements between the Acute Trusts, PCTs and social care were right. He stated that it was important to get to the bottom of the problem of delayed discharges and the knock on effect these had at A&E which could cause serious problems over the winter months.

(29) Mr Phoenix replied that he was disappointed with the Healthcare Commission's report results, the A&E figures had focused on the 4 hour waiting time which he acknowledged last year in Maidstone and Tunbridge Wells was poor and unacceptable. However, if you looked at the total way urgent cases were handled across the country, West Kent was one of the best in the country. It was important to look at a more detailed piece of work rather than the narrow measures around A&E and to focus on the standard rather than just the targets. He acknowledged that during the summer and winter of 2007/08 delayed transfers were at an unacceptably high level. However, he stated that the MP's had visited at a difficult time and a contributory factor to the increase in delayed transfers was the deep clean that was being carried out. He presumed that other hospitals as well were obliged to close wards to do the deep clean which would have had an impact. Since January 2008 there had been a reduction in delayed transfers and that both acute trusts in West Kent were now below the national target of 3.5%. He acknowledged that during the winter months these figures often increased but the challenge was across the system to make sure that it remained within the target level.

(30) Mr Phoenix stated that all community hospital beds had been opened with the exception of the ward at Sevenoaks which needed capital building funding and there were eight to ten beds available on any day.

(31) Mr Clark then left the meeting.

(32) Mrs Angell asked what effect the reduction of waiting lists and waiting times from 18 months to 18 weeks had had on delayed discharges.

(33) Ms White (Acute and Emergency Services Manager, East Kent Hospitals Trust) stated that the reduction in waiting times had not affected delayed discharges as most people undertaking elective procedures were generally fit and delays tended to relate to more complex and often elderly cases. She stated that 5% of in-patients took up 35% of bed days, it tended to be complex medical problems that caused delays. Health service and social care colleagues worked as a whole team to help patients to get to where they wanted to go. Ms Scott, (Head of Clinical Site and Operational Safety, Medway Foundation Trust) confirmed that the reduction in waiting times had not had an impact on delayed discharges as there was a pre-assessment process which captured the patients needs at that point so plans were able to be put in place at an early stage.

(34) Ms Luffingham (Chief Operating Officer) Maidstone and Tunbridge Wells NHS Trust stated that the 18 week waiting period had highlighted the complexity of delayed discharges as an issue.

(35) Mrs Angell asked whether there was access to an advocacy service for patients having to make difficult choices prior to discharge as some patients may not have any family or may wish to talk through options with somebody outside of their family.

(36) Mr Schofield, Head of Nursing for Medicine, East Kent Hospital Trust stated that nurses were able to be advocates for patients and that within hospitals large multidisciplinary teams were established to link between social services and nurses and patients families. Miss Tidmarsh explained that Kent Social Services funded several advocacy agencies and sometimes an advocate was necessary to help the family and patient arrive at an independent decision.

(37) Mrs Angell noted that there did not seem to be a consistent approach across Kent in relation to advocacy for patients.

(38) Councillor Davison from Sevenoaks District Council asked about the usage figures for beds in community hospitals and also whether the money followed the patient from the acute hospital to the Community Hospital.

(39) Mr Phoenix confirmed that the data on bed occupancy levels was available and regularly reported to PCT Trust Boards. He explained that there had been a policy change and that they tried to keep bed occupancy levels that related to planned admissions at around 95% so that there was some flexibility. There was a different kind of occupancy level for intensive/acute beds. At times occupancy had been 100% because medically it appeared to be the right thing to do.

(40) In relation to funding following the patient, Mr Phoenix explained that the sum of money applied to the patient depended on the complexity and severity of their needs. If the patient was discharged earlier than anticipated, then that would be an advantage financially for the Trust. However, if the patient was transferred to the community hospital, there was a transfer of resources and this depended on what point in the patients journey that happened. He stated that this was called splitting the tariff.

(41) Mr Northey referred to the scheme of assessment beds as set out on page 42 of the papers for the meeting, which had been a successful pilot scheme and asked whether it was planned to roll out this scheme across the rest of Kent.

(42) Ms Baldwin (Assistant Director, Intermediate Care Services, Eastern and Coastal Kent PCT) stated that she worked closely with Social Services in Kent. She referred to the pilot scheme that had been running in the Canterbury area for the past five months where they used social services residential units in Whitstable and Herne Bay for intermediate care. This was run under the Urgent Care Board banner and because the scheme had used residential beds it could be rolled out where there were no community hospitals.

(43) Ms Duff (District Manager, East Kent, KASS) stated that as an individual moved into an assessment bed on a waiting programme they became part of a red, amber, green system and it was aimed for them not to stay for more than four weeks. There was a multi-disciplinary team to assist with this. Self funding clients had been included in the pilot and had benefited from it. The pilot also involved carers and worked through support plans. It was also being tested with clients who had dementia, to ensure that it incorporated the right skills to support this.

(44) Councillor Blackmore, Maidstone Borough Council, acknowledged the good work that was going on and congratulated health care and social care colleagues. She asked what best practice there was elsewhere and whether it was being taken into account in Kent. Also, in relation to the aging population, what contingencies were taken into consideration in modelling services?

(45) Mr Phoenix explained that at the end of the year the PCT's would produce its next five year strategic plan and there was some service modelling. The PCT's knew what the demographical changes were and they would come back to the Committee later to talk specifically about initiatives in West Kent. He stated that they had one of the healthiest populations in the country but inevitably as people got older they sometimes got sicker. There was a partnership strategy to help keep people healthy and living at home longer and joint work needed to continue to be done around that. In relation to the Maidstone and Tunbridge Wells Trust's new hospital at Pembury, service modelling was being done. However, the further forward ahead the modelling went more tenuous the outcomes tended to be.

(46) Mr Phoenix stated that in relation to the pilot in Maidstone and Tunbridge Wells he was aiming to reduce the discharge target down to 1.4%.

(49) Mr Horne stated that it would be worthwhile revisiting the issue of "Splitting the Tariff" in relation to West Kent PCT. He also said that given the assurances given today, it is not pleasant to hear that the Maidstone Hospital is in the lower 4%. If a Trust is in that position, we assume that it is working hard to do something about that. He raised the point that the new hospital in Pembury will have less beds than the other two hospitals it will be replacing and asked whether we can be confident that there will be enough beds available. He also said that there must be programmes to enhance community hospitals given the issues raised at the meeting.

(50) Ms Jones, Director of Community Services, West Kent PCT confirmed that modelling had been carried out at Pembury and it was clear that they needed to reduce the length of stay as long, as it was clinically safe, and was benchmarked nationally. There were other factors to be taken into account, such as the community hospital and day care facilities and they had linked into services plans for Pembury. In relation to the split tariff she stated community hospital funding was as it should be and there was no financial issue in the transfer of patients.

(51) Councillor Lyons, Shepway District Council, asked who monitored the number of beds available in nursing and care homes. Ms Howard replied that Kent Social Services had good intelligence in relation to the supply of care beds and in Kent there was currently an over supply.

(52) Mrs Tidmarsh stated that they monitored nursing and care home beds. She gave the example of planning applications in East Kent for several homes and commented that if all of those homes that have received planning permission were built there would be over capacity. There was a balance to be struck and she worked with district councils to ensure that they looked at their planning permission for nursing and care homes carefully.

(53) Mr Fittock asked whether delays in getting drugs from the pharmacy particularly at weekends, affected the statistics for delayed discharge, Ms White stated that work was in hand to ensure that there were no delays in pharmacies dispensing medicine on discharge.

(54) The Chairman thanked Health and Social Care colleagues for attending the meeting and commended the way they were working together and thanked them for answering Members questions.

(55) RESOLVED That the Chairman and Spokesmen would agree recommendations based on the issues raised during the discussion.

The following recommendations on the issue of delayed transfers of care following the meeting of the Health Overview and Scrutiny Committee on 17 October 2008:-

1. The Committee congratulates social services and the NHS on their partnership working in tackling delayed transfers of care and, once the different pilots have been fully assessed, the Committee asks that the Trusts and KASS look at the possibility of spreading best practice across the whole county, as well as looking closely at best practice in other areas of the country.

2. The Assessment Beds Pilot in East Kent has the full support of the Committee and requests an update by July 2009 containing an evaluation of the pilot and details as to how it has been taken forward.

3. The Committee supports the aims of the Discharge Planning Pilot in West Kent and requests an update by July 2009 containing an evaluation of the pilot and details as to how it has been taken forward.

4. The Committee commends the establishment of a joint agreement on non-weight-bearing patients in West Kent and asks to be informed by the three parties involved whether, at the end of its first year of operation, it will be continued.

5. The Primary Care Trusts in Kent and KASS shall be asked to provide a yearly written update to the Committee containing the numbers of community, nursing and residential beds available to people in Kent so as to provide information on capacity in the county.

6. The Committee shall request further information from KASS and NHS Trusts in Kent regarding existing patient advocacy service provision.

51. Date of next programmed meeting – Tuesday 2 December 2008 at 1:00 pm
(Item 9)

RESOLVED that the date of the next meeting be noted.

Annual Health Check

As a result of considering compliance with the three core standards relating to the hygiene code in this and subsequent meetings, the Committee will produce third party commentaries that will form part of the Annual Health Check process.

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Briefing Note

Annual Health Check – Core Standards C4a, C4c, C21

Key Points

- Assessment of the core standards forms part of the "Quality of Services" score in the Annual Health Check.
- Any commentary from the Health Overview and Scrutiny Committee will form part of the evidence the Care Quality Commission uses to cross-reference the declarations made by each trust.
- Three core standards relate specifically to the hygiene code:
-
    - C4a – infection control.
    - C4c – decontamination.
    - C21 – clean, well designed environment.
- To date, the Annual Health Check has been carried out by the Healthcare Commission. From 1 April 2009, the Commission will be succeeded by the Care Quality Commission (CQC).
- In the early part of 2009, NHS trusts will have to register with the Care Quality Commission. Registration is contingent on compliance with the hygiene code.
- There will be a separate assessment of Primary Care Trusts as providers of services and commissioners for 2008/09.

The Annual Health Check Process 2009

In October 2009, the CQC will publish the results of the Annual Health Check for 2008/09.

Between 15 April and 1 May 2009, trusts will be asked to submit self-declarations on how compliant they are against the core standards, including the three relating to the hygiene code.

These core standards derive from the 2004 Department of Health publication, 'Standards for Better Health.'[1] This set down 24 core standards and described the minimum level of service all health trusts were meant to provide. These 24 standards are broken down into 44 component parts (a full list can be found in Appendix G).

The CQC will cross-check these declarations using a wide range of sources of information and may conduct follow up visits to trusts based on a risk assessment (there are also a number of random visits). Third-party commentaries provided by Overview and Scrutiny Committees are one of these sources.

All acute trusts will be visited in relation to the arrangements which have been made for reducing healthcare associated infections (HCAI) as will some non-acute trusts.

[1] Department of Health, Standards for Better Health, July 2004, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665

The final ratings given for compliance with the core standards is aggregated together with scores relating to how far trusts have met two sets of national targets and gives the Quality of Services score in the Annual Health Check.

A table of selected results from the 2007/08 Annual Health Check can be found in Appendix A.

The Core Standards and the Hygiene Code

The Health Act 2006 gives the Secretary of State the power to issue a code of practice relating to healthcare acquired infections (HCAIs). The document that has been produced is referred to as The Hygiene Code. Its formal title is *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections*[2]. This was last revised in January 2008.

The code is set by government and the Healthcare Commission/CQC checks on compliance.

In the guidance on how compliance with the core standards is assessed, three of them explicitly refer to the Hygiene Code, so that compliance with different parts of the code translates into compliance with the core standard.

These three core standards are:

No.	Short name	Full description
C4a	infection control	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).
C4c	decontamination	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.
C21	clean, well designed environment	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

The majority of the Code is covered by C4a, infection control. Both C4a and C4c are assessed solely in relation to the Code.

There are two elements to assessing compliance with C21. Element one looks at disability discrimination legislation along with various health Building Notes and

[2] Department of Health, The Health Act 2006: Code of practice for the prevention and control of healthcare associated infections, revised January 2008, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081927

Health Technical Memoranda. Element two refers to the requirements of the Hygiene Code.

The Healthcare Commission publishes detailed criteria as to how they assess the core standards, and there are some differences depending on the type of trust. The criteria in relation to C4a, C4c and C21 can be found in Appendix B.

The Hygiene Code consists of the following 11 duties, many of which are broken down into a number of sub-duties:

Duty	Description
1	General duty to protect patients, staff and others from HCAIs
2	Duty to have in place appropriate management systems for infection prevention and control
3	Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks
4	Duty to provide and maintain a clean and appropriate environment for healthcare
5	Duty to provide information on HCAIs to patients and the public
6	Duty to provide information when a patient moves from the care of one healthcare body to another
7	Duty to ensure co-operation
8	Duty to provide adequate isolation facilities
9	Duty to ensure adequate laboratory support
10	Duty to adhere to policies and protocols applicable to infection prevention and control
11	Duty to ensure, so far as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs

A more detailed version of the hygiene code can be found in the form of a table, with the relevant core standard for each part, in Appendix C.

There are three sections to the hygiene code – Management, organisation and the environment; Clinical care protocols; and Healthcare workers. There is an annex in the documentation giving further information on each section and follows the table mentioned above (this can be found in Appendix D).

The Hygiene Code – the National Picture

On 10 December, the Healthcare Commission published its annual report, State of Healthcare 2008. The main points from the chapter entitled "Tackling healthcare-associated infections" are as follows[3]:

- "The NHS has made a major impact on reducing MRSA infections, and the national target for reducing infections has been met. But almost half of trusts did not meet their individual targets for reducing or minimising MRSA infections during 2007/08.

[3] Healthcare Commission, State of Healthcare 2008, December 2008, p.36, http://www.healthcarecommission.org.uk/_db/_documents/State_of_Healthcare_2008.pdf

- C. difficile is still a major problem for the NHS, but there are encouraging signs of recent improvement in dealing with it.
- Trusts are clearly tackling infection prevention and control vigorously. However, few trusts fully comply with the hygiene code, but we have found few breaches of the code that posed an immediate risk to patients. Trusts do need to ensure they have comprehensive systems in place to maintain the decrease in infection rates.
- Healthcare providers need to ensure that they improve their systems to tackle all infections, and not just focus on MRSA and C. difficile. This should be underpinned by agreement at a national level on what infections should be measured and how."

Table: Figures for % trusts in England compliant with core standards relating to the hygiene code, 2007/08 (Results for 2006/07 are in brackets):[4]

NHS Trust Type	C4a	C4c	C21	All applicable standards
Acute	90% (81%)	85% (93%)	92% (91%)	74% (73%)
Ambulance	82% (83%)	n/a (100%)	100% (83%)	82% (75%)
Mental Health	92% (93%)	n/a	90% (90%)	81% (83%)
PCT	86% (84%)	68% (70%)	88% (83%)	58% (59%)
All trusts	88% (84%)	77% (85%)	90% (88%)	69% (69%)

The Hygiene Code and CQC Registration

Starting in 2010, there will be an integrated registration system across health and social care. 2009/10 will be a transitional year and health trusts which provide services are required to submit an application of registration to the Care Quality Commission. For 2009/10, registration will be contingent on compliance with the Hygiene Code.

A modified Hygiene Code will go before Parliament early in the New Year. Between 12 January and 6 February 2009, and trusts will have to submit an application form declaring their compliance, or otherwise, with this new Hygiene Code. The CQC will cross-check the applications and discuss any issues with the trusts. By 14 March, one of four decisions will be made by the CQC:

- Registered
- Registered with an action plan
- Registered with conditions
- Not registered

The CQC will have a range of enforcement powers to deal with trusts that fail to register or that fail to maintain the standards required for registration[5].

[4] Ibid, p.40.
[5] Department of Health, Changes to arrangements for regulating NHS bodies in relation to healthcare associated infections for 2009/10: a consultation for the NHS, August 2008 http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_086926 and also, Care Quality Commission, Registering with the care Quality Commission in relation to healthcare associated infection, October 2008, http://www.cqc.org.uk/pdf/CQC_registration_HCAI_guidance_27_10_2008.pdf

Healthcare Commission Report on the Hygiene Code

On 24 November 2008, the Healthcare Commission published a report entitled *Inspections of cleanliness and infection control: how well are acute trusts following the hygiene code?*[6] Part of the reason for doing so was to help trusts prepare for CQC registration by highlighting some of the most common issues.

The report was based on an analysis of 51 inspections related to HCAI conducted between 1 January 2008 and 5 June 2008. Medway NHS Foundation Trust was the only trust based in Kent and Medway that formed part of the detailed study.

Given the range of areas the hygiene code covers, inspections are mainly based on risk-assessments and concentrate of specific duties. Of the 51 trusts analysed in the report, 45 had assessors inspect compliance with three duties. The remaining 6 were inspected concerning compliance with four duties. The duties with which compliance was assessed were 2, 3, 4, 5, and 8.

Non-compliance is classified as being either a **breach** or a **material breach**.

A breach indicates a trust is not following the hygiene code fully but the problem may not pose an immediate risk to patients. Recommendations are provided for the trust.

A material breach indicates a more immediate risk to patients. The trust will be informed on the day of the visit or soon after. Depending on the response of the trust and the actions taken, an improvement notice may or may not be issued. If one is issued, they are made public and the Secretary of State, SHA and Monitor are informed as appropriate.

Due to the size of the samples and number of trusts involved, the report concentrates on providing detailed information on duties 2, 4 and 8. Overall, 5 out of 51 trusts were considered to have complied with all the sub-duties in these three. Material breaches accounted for 3% of the total number of breaches.

<u>Duty 2 – appropriate management for infection control</u>

49 trusts were inspected in relation to this duty. There were no material breaches under this duty. Most trusts had a board level agreement about their collective responsibility and had appointed an appropriate person as director of prevention and control of infection (DIPC).

11 of the 49 did not comply with 2d, which relates to training and supervision. For example, some trusts had suitable training programmes but did not monitor attendance effectively.

The report comments that, “Although the sample size is too small to allow definitive conclusions to be drawn, the distinguishing factor in the five trusts that achieved compliance with all three duties appears to be their focus on implementation – these trusts used a ‘board-to-ward’ approach. All five provided clear evidence of a

[6] Healthcare Commission, How well are acute trusts following the hygiene code? November 2008, http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9683

programme of audit and the feedback of results, the supervision of practice and the active engagement of staff in relation to policies and practices on infection control."[7]

Duty 4 – cleanliness and maintenance of the environment

All 51 trusts were inspected in relation to this duty.

A high number of trusts complied with sub-duties 4b, 4g and 4h. These relate to having lead managers for cleaning and contamination, linen and laundry and uniforms and workwear.

The two sub-duties most likely to be breached were 4c (27/51) and 4d (31/51) and there was a strong correlation between the two (18 did not meet either sub-duty). 4c relates to premises being clean and well-maintained. Problems related to areas not being cleared often enough or being too cluttered to allow effective cleaning. There was one material breach relating to 4c. 4d relates to cleaning arrangements being specified and schedules of cleaning being publicly available. The phrase 'publicly available' is not defined in the code but the Healthcare Commission's expectation is that patients should be "made aware that they have access to cleaning schedules and for this to be easily done – for example by trusts displaying the schedules in areas accessible to the public."[8]

4e relates to facilities for hand-washing and antibacterial hand rubs and was not complied with by 11 out of 51. The same number failed on 4f, decontamination. A material breach of 4f was found in three trusts. "In these three trusts, problems included poor segregation of clean and dirty items, a lack of ability to trace equipment that had been decontaminated, poor staff understanding of the correct procedures for decontamination, and a lack of assessment of the risks associated with decontamination."[9]

Duty 8 – isolation facilities

48 trusts were inspected in relation to this duty.

In a 2007 report[10] on healthcare associated infections (HCAIs), the Healthcare Commission concluded that in order to prevent and control HCAIs effectively, effective isolation arrangements were necessary. In assessing compliance, the Commission looks at "whether the trust has estimated its likely provision and can either meet it from existing resources or has made adequate contingency arrangements."[11]

"Only six trusts did not comply fully with this duty. Of these, the reasons for non-compliance included:

- Not having sufficient isolation facilities.

[7] Ibid, p.15
[8] Ibid, p.16-17
[9] Ibid, p.17
[10] Healthcare Commission, Healthcare associated infection: What else can the NHS do? July 2007, http://www.healthcarecommission.org.uk/_db/_documents/HCAI_Report_2_200801223430.pdf
[11] Healthcare Commission, How well are acute trusts following the hygiene code? November 2008, P.18, http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9683

- A lack of adequate assessment of the trust's overall requirements for isolation facilities.
- A lack of facilities for patients who need negative-pressure ventilation.
- Inadequate systems for risk assessment of individual patient's needs."[12]

The full conclusions from this report can be found in Appendix E.

South East Coast Strategic Health Authority

In the board papers for the meeting of the South East Coast Strategic Health Authority on 11 December, was a Hygiene code compliance report[13]. The Healthcare Commission have carried out a series of inspections to assess compliance with the hygiene code. The board paper included a table representing hygiene code compliance at the time of the Healthcare Commission visit. It concentrates on the most commonly inspected duties – 2, 4, and 8 (see also section above on Healthcare Commission Report on the Hygiene Code).

Table: Key findings for Healthcare Commission inspection on cleanliness and infection control[14]

Trust / Duty	Dartford and Gravesham	East Kent Hospitals	Medway NHS Foundation Trust	Maidstone and Tunbridge Wells
2a	NB	NB	NB	Awaiting feedback from Healthcare Commission
2b	NB	NB	NB	
2c	NB	NB	NB	
2d	NB	NB	B	
2e	NB	NB	NB	
2f	NB	NB	NB	
4a	B	NB	NB	
4b	NB	NB	NB	
4c	B	NB	B	
4d	NB	NB	NB	
4e	NB	NB	B	
4f	NB	NB	NB	
4g	NB	NB	NB	
4h	NB	NB	NB	
8	NB	NB	NB	
HCC Inspection	Sep 08	Jan 08	Aug 08	Oct 08

NB = not breached
B = breached (not material breach)

The same SHA report comments that, "Both nationally and locally the duty that Trusts have the most difficulty achieving is Duty 4: particularly around premises that

[12] Ibid, p.18.
[13] South East Coast Strategic Health Authority, Hygiene code compliance report, December 2008, http://www.southeastcoast.nhs.uk/aboutus/theboard/papers/documents/101-08-HCAIReportDec2008.pdf
[14] Adapted from South East Coast Strategic Health Authority, Hygiene code compliance report, December 2008, p.3, http://www.southeastcoast.nhs.uk/aboutus/theboard/papers/documents/101-08-HCAIReportDec2008.pdf

are suitable, clean and well maintained, and decontamination of instruments. A common issue raised on HCC visits is that cleaning schedules are not clearly displayed in clinical areas. Another common issue is general clutter and excess of equipment which can prevent access to and proper cleaning of all areas."[15]

Under the heading, "Solving the issue: Actions taken by trusts to improve compliance", the report also makes the following comments:

- "The SHA has worked with the Department of Health to facilitate an event for matrons focusing on cleaning, board to ward assurance and other aspects of the Hygiene Code. We are planning another event in the New Year.
- Trusts have undertaken a range of activities to improve compliance with duty 4; these include decommissioning bathrooms to be replaced with assisted showers and provide additional storage space. Implementation of Productive Ward has also improved reduction of clutter through the implement action of 'waste walks' and application of 'lean approaches'.
- A common issue addressed by Trusts was the displaying of cleaning schedules and frequencies for patients staff and visitors for all wards and departments (Duty 4d)."[16]

Incidences of MRSA and *Clostridium difficile*

As mentioned above, the Quality of Services score for trusts is derived from an assessment against core standards and two sets of national targets. There are different sets of targets depending on the trust type.

For acute trusts in 2008/09, there are two targets of particular relevance to infection control:

Incidence of *Clostridium difficile*[17]

Incidence of MRSA bacteraemia[18]

Incidence of Clostridium difficile is also a commissioning indicator for PCTs[19].

Mandatory monitoring of MRSA bacteraemia began in April 2001 and *Clostridium difficile* in January 2004. Since then the Health Protection Agency has produced regular monitoring reports along with commentaries. For *Clostridium difficile* the most recent information available is the quarterly monitoring reports up to June 2008. For MRSA, the quarterly monitoring reports are available up to September 2008.

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[15] Ibid, p.4
[16] Ibid, p.4
[17] Healthcare Commission, http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09/qualityofs/incidenceofclostridiumdifficile.cfm
[18] Healthcare Commission, http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09/qualityofs/incidenceofmrsabacteraemia.cfm
[19] Healthcare Commission, http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09/qualityofs/incidenceofclostridiumdifficile-primarycaretrusts.cfm

Clostridium difficile

"Clostridium difficile infection ranges from mild to severe diarrhoea to, more unusually, severe inflammation of the bowel (known as pseudomembranous colitis). People who have been treated with broad spectrum antibiotics (those that affect a wide range of bacteria), people with serious underlying illnesses and the elderly are at greatest risk – over 80% of Clostridium difficile infections reported are in people aged over 65 years.

"Clostridium difficile infection is usually spread on the hands of healthcare staff and other people who come into contact with infected patients or with environmental surfaces (e.g. floors, bedpans, toilets) contaminated with the bacteria or its spores. Spores are produced when Clostridium difficile bacteria encounter unfavourable conditions, such as being outside the body. They are very hardy and can survive on clothes and environmental surfaces for long periods."[20]

There are some important points to bear in mind regarding the HPA figures on Clostridium difficile:

- "The definitions used for C. difficile infection and Trust reports (case episodes) include cases from GP practices, nursing homes and other Trusts, as well as cases from the reporting Trust. Data for each Trust are thus likely to include a variable number of cases from outside the Trust. We have already taken steps towards the identification of the patient's location when the specimen was taken (separation of specimens taken in acute Trusts and elsewhere) and will be developing this further. It is expected that future publications (from January 2009) will include a breakdown of cases apportioned to the Acute Trust."[21]
- "There were major changes to improve the mandatory reporting system in 2007. This will have impacted on ascertainment and had an effect on the continuity of the surveillance. Given the recent changes to the definition announced in the Chief Medical Officer letter dated January 2008, any apparent trends in the data should be treated with caution."[22]

MRSA

"Staphylococcus aureus is a bacterium that is a common coloniser of human skin and mucosa. Staphylococcus aureus can cause disease, particularly if there is an opportunity for the bacteria to enter the body.

"Illnesses such as skin and wound infections, urinary tract infections, pneumonia and bacteraemia (blood stream infection) may then develop. It can also cause food poisoning. Most strains of this bacterium are sensitive to many antibiotics, and infections can be effectively treated. Some S. aureus bacteria are resistant to the antibiotic methicillin, termed methicillin-resistant Staphylococcus aureus (MRSA)."[23]

[20] Health Protection Agency, Clostridium difficile, http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1179744911867?p=1179744911867

[21] Health Protection Agency, Commentary for Clostridium difficile, October 2008, p.2, http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1216193835563

[22] Ibid, p.7

[23] Health Protection Agency, Staphylococcus aureus, http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942169197?p=1191942169197

The main points of the Health Protection Agency MRSA commentary from December 2008 are as follows:

- "There continues to be a downward trend in MRSA bacteraemia with a 13% decrease in the number of reported cases received in July to September 2008 compared to the previous quarter (April to June 2008) and a 33% reduction compared to the corresponding quarter of 2007 (July to September).
- There was a 30% decrease in the number of reported MRSA bacteraemia received in the financial year 2007/08 compared to financial year 2006/07, with a decrease in the rate from 1.67 to 1.19 cases per 10,000 bed days."[24]

There are some important points to bear in mind regarding the HPA figures on MRSA:

- "Data are collected at Trust level and are not published by the HPA for individual hospitals within a Trust.
- These data should not be used as the basis for decisions on the clinical effectiveness of interventions in individual Trusts without further investigations. It is also important to note that MRSA-positive blood cultures are reported by the Trust whose laboratory processes the specimen, which may not always reflect where the bacteraemia was acquired.
- The HPA are aware of a number of cases of MRSA bacteraemia, included in the current tables that may involve patients in unusual circumstances (patients with intractable infections, for example). We are in the process of considering how best to report this information in the future and it is intended that this issue will be addressed in future publications."[25]

The most recent quarterly figures available from the Health Protection Agency for Clostridium difficile and MRSA can be found in Appendix F.

Changes to the assessment of Primary Care Trusts for 2008/09

In the document setting out how the Annual Health Check for 2008/09 will be implemented, the Healthcare Commission say the following:

"Our assessment of primary care trusts (PCTs) for the performance rating in 2008/09 will have a different structure from previous years. This will allow us to report separately on the performance of services that a PCT provides itself (such as community health services), and its role as a commissioner of health and healthcare services for its local community. The assessment of the PCT as a commissioner will have a strong focus on progress against the national priorities set out in the Department of Health's vital signs indicators."[26]

The document produced by the Healthcare Commission setting out the criteria for assessing core standards gives different sets of criteria for PCTs as providers and as commissioners (see Appendix B for criteria relating to hygiene code core standards).

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[24] Health Protection Agency, MRSA commentary, p.1, December 2008, http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1229502459877

[25] Ibid, p.5

[26] Healthcare Commission, The Annual Health Check in 2008/09, June 2008, p.25 http://www.healthcarecommission.org.uk/_db/_documents/The_annual_health_check_2008_09_Assessing_and_rating_the_NHS.pdf

The following are extracts from *Criteria for assessing core standards in 2008/09 Primary care trusts (as providers and commissioners)*[27]:

PCTs as providers

"Trusts' boards should consider **all** aspects of their services when judging whether they have reasonable assurance that they are meeting the published criteria for assessment. Where healthcare organisations provide services directly, they have primary responsibility for ensuring that they meet the core standards. However, their responsibility also extends to those services that they provide via partnerships or other forms of contractual arrangement (for example, where human resource functions are provided through a shared service). When such arrangements are in place, each organisation should have reasonable assurance that those services meet the requirements of the standards."[28]

PCTs as commissioners

"For the purposes of assessing PCTs as commissioners, the core standards, and their component elements, have been considered from three perspectives, which are combined into a single declaration. Each of these is described below:

- **PCT commissioners (as corporate bodies)** – i.e., standards as they apply to any organisation, regardless of its functions. These standards are about how organisations function. Examples of standards in this category include those which relate, for example, to the wellbeing of staff.
- **PCT commissioners (commissioning functions)** – i.e., the standards that are relevant to a PCT's role as a commissioner. There are aspects of many of the standards applicable to PCTs which relate to their commissioning function. In addition there are a number of standards that **particularly** concern commissioning activities, namely: C5a, C6, C7e, C17, C18, C22 a&c, C22 b, C23 and C24. These cover issues such as assessing the health needs of the population.
- For the purposes of this overview section, when we refer to PCTs commissioning services, we are referring to commissioned services in their broadest sense (including those commissioned from NHS providers, the independent sector, and independent contractors) unless otherwise specified. However, within the detail of the criteria, the "commissioned services" and "independent contractor" tests remain distinct from one another.
- **PCTs' role in relation to the quality and safety of its commissioned services** – i.e., whether it has 'appropriate mechanisms' in place and has taken 'reasonable steps' with regard to commissioned services and independent contractors respectively. **These tests apply to every standard, in the same way as they have in previous years.**"[29]

[27] Healthcare Commission, Criteria for assessing core standards in 2008/09 Primary care trusts (as providers and commissioners), December 2008, http://www.healthcarecommission.org.uk/_db/_documents/Criteria_for_assessing_core_standards_08-09_for_PCTs.pdf
[28] Ibid, p.6
[29] Ibid, p.53

Third party commentaries and the Annual Health Check

A copy of the Healthcare Commission document '*Your part in the annual health check 2008/09*'[30] is included in the agenda pack. This provides an explanation of the role of overview and scrutiny committees in the annual health check and information about how third party commentaries are constructed and subsequently used by the Healthcare Commission.

Tristan Godfrey
Research Officer, Health Overview and Scrutiny Committee

[30] Healthcare Commission, Your part in the annual health check, September 2008, http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9594

Appendix A

Table of Selected Results from Annual Health Check 2007/08[1]

	Headline Scores		Core Standards			
				Selected Core Standards		
Trust	Use of Resources	Quality of Services	Core Standards (overall score)	C04a - infection control	C04c - decontamination	C21 - clean, well designed environment
Dartford and Gravesham	Good	Excellent	Fully Met	Compliant	Compliant	Compliant
East Kent Hospitals	Fair	Fair	Fully Met	Compliant	Compliant	Compliant
Maidstone and Tunbridge Wells	Fair	Weak	Not Met	Compliant	Not met	Not met
Medway FT	Good	Fair	Partly Met	Compliant	Not met	Compliant
Eastern and Coastal Kent PCT	Good	Fair	Partly Met	Insufficient assurance	Insufficient assurance	Compliant
West Kent PCT	Fair	Weak	Not Met	Compliant	Not met	Compliant
Kent and Medway Partnership Trust	Fair	Fair	Almost Met	Not met	Not applicable	Compliant
SEC Ambulance Service	Good	Good	Almost Met	Compliant	Not applicable	Compliant

NB: Ambulance trusts and mental health trusts were not assessed for C4c last year, but will be in 2008/09.

Glossary[2]

Quality of services assessment

Excellent – This score means that a trust received the highest score of either 'fully met' or 'excellent' for all applicable assessments that contribute to the overall quality of services score.

[1] Taken from individual trust reports available from The Healthcare Commission at: http://2008ratings.healthcarecommission.org.uk/informationabouthealthcareservices/overallperformance.cfm

[2] Taken from http://2008ratings.healthcarecommission.org.uk/_db/_system/What_do_these_scores_mean.pdf

Good – This score means that a trust received at least the second highest score of either 'almost met' or 'good' for all applicable assessments that contribute to the overall quality of services score.

Fair – This score means that a trust has performed adequately, in that it has not received the lowest score of 'not met' for either core standards or existing national targets. However, it has not performed sufficiently well across the applicable assessments that contribute to the overall quality of services score to score any higher.

Weak – This score means that a trust received the lowest score of 'not met' for either core standards or existing national targets.

Core standards

Fully met – This score means that a trust met all of the core standards set by Government by the end of the assessment year. A trust can only receive this score if it declares no more than four failings during the year. These failings must have been corrected by the end of the year.

Almost met – This score means that a trust met almost all of the core standards set by Government.

Partly met – This score means that a trust met many of the core standards set by Government. However, it was not able to demonstrate that it had met a number of standards.
Not met – This score means that a trust did not meet several of the core standards set by Government.

Appendix B

Criteria for assessing core standards[1]

Criteria for Primary Care Trusts as Providers, Acute Trusts, Mental Health Trusts and Ambulance Trusts

Core Standard C4a Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of health care acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Elements **Element one** The PCT has systems to ensure the risk of healthcare associated infection is reduced in accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	**Rationale** **Element one** The Hygiene Code was revised in January 2008. All healthcare associated infection issues are covered by this criteria with the exception of the following: **Covered by C21 – Cleaning of the environment:** • Hygiene Code Duty 4 (a, b, (in relation to cleaning) c, d, e, g and h). **Covered by C4c – Decontamination of reusable medical devices:** • Hygiene Code Duty 3 (if related to decontamination) • Hygiene Code 4b • Hygiene Code 4f. Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.

Core Standard C4c Healthcare organisations keep patients, staff and visitors safe by having systems all reusable medical devices are properly decontaminated prior to use and that the associated with decontamination facilities and processes are well managed.	
Elements **Element one** Reusable medical devices are properly decontaminated in	**Rationale** **Element one** The Hygiene code was revised in January 2008. Criteria C4c covers: • Hygiene Code Duty 3 (if related to decontamination)

[1] Taken from the relevant documents from the Healthcare Commission, available from http://www.healthcarecommission.org.uk/guidanceforhealthcarestaff/nhsstaff/annualhealthcheck/annualhealthcheck2008/09.cfm

accordance with *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections* (Department of Health, 2006 revised January 2008).	• Hygiene Code 4b • Hygiene Code 4f. All other aspects of healthcare associated infection and duties of the Hygiene Code are covered by C4a or C21. Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation. In 2006/07, this standard was not assessed for ambulance trusts and mental health trusts as the focus for assessment was on the sterilisation of invasive medical equipment that presented a known risk of infection. However, this criteria will apply to all trust types on 2008/09 because: • Decontamination has a wider meaning than sterilisation alone and is defined as a combination of processes, including cleaning, disinfection and sterilisation, used to render a reusable item safe for further use on patients / service users and handling by staff. • Medical devices refers to all products, except medicines, used in healthcare for diagnosis, prevention, monitoring or treatment. A single use medical device is a device that is intended to be used on an individual patient during a single procedure and then discarded. Therefore, any device which is not single use must be considered a reusable medical device. These devices are used by ambulance and mental health trusts.

Core Standard C21 (see below for criteria relating to ambulance trusts) Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	
Elements	**Rationale**
Element one The PCT has systems in place and has taken steps to ensure that care is provided in well designed and well maintained environments, including in accordance with all relevant	**Element one** Modified wording to focus on assurance systems as well as the technical guidance. Health Building Notes and Health Technical Memoranda contain both legal requirements and good practice guidance. While the guidance in the

legislative requirements referred to in Health Building Notes (HBN) and Health Technical Memoranda (HTM), and by following the guidance contained therein, or equally effective alternative means to achieve the outcomes of the HBNs/HTMs. The healthcare organisation should also act in accordance with the *Disability Discrimination Act 1995*, the *Disability Discrimination Act 2005*; and have regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005).	memoranda assists healthcare organisations to achieve well designed and well maintained environments, there may be alternative ways of achieving the same objectives. Where alternative solutions are proposed, healthcare organisations should demonstrate that equally effective outcomes are achieved. The *Disability Discrimination Act 1995* has been amended by the *Disability Discrimination Act 2005* and includes a new duty of disability equality. The associated code of practice provides public authorities with guidance on how to understand and meet the general duty and specific duties, which include undertaking an impact assessment of its policies and practices on equality for disabled persons and having due regard to the requirement to take steps to take account of the needs of disabled persons.
Element two Care is provided in clean environments, in accordance with the relevant 18 requirements of duty four of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, revised 2008).	**Element two** The hygiene code was updated in January 2008. The overarching duty 4 is to provide and maintain a clean and appropriate environment for healthcare. Sub-duty 4d states that “the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available". Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and where appropriate follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation. The *National specification for cleanliness in the NHS* (NPSA, 2007) is referenced in the revised version of the Hygiene Code (2008) and provides guidance for trusts on cleaning standards. However, this guidance is not mandatory and a trust may specify its cleaning standards in a different manner to those set out in the NPSA specification so long as the standards meet the overall objectives set out in duty four. This standard only considers specific aspects of duty four of the Hygiene Code. These are sub duties 4 a, b (in relation to cleaning), c, d, e, g and h. The decontamination of reusable medical device

	related aspects of sub-duties 4b and 4f of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections are covered by standard C04c.
Core standard C21 (for Ambulance Trusts) Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	
Elements	**Rationale**
Element one The ambulance service has systems in place and has taken steps to ensure its fleet is well designed and well maintained including in accordance with the *Disability Discrimination Act 1995, the Disability Discrimination Act 2005*; and have regard to *The duty to promote disability equality: Statutory Code of practice* (Disability Rights Commission, 2005).	**Element one** Wording amended to be consistent with acute services.
Element two Care is provided in clean ambulances that meet the relevant18 requirements of duty four of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, revised 2008).	**Element two** The hygiene code was updated in January 2008. This standard only considers specific aspects of duty four of the Hygiene Code. The overarching duty 4 is to provide and maintain a clean and appropriate environment for healthcare. Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and where appropriate follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation. The decontamination of reusable medical device related aspects of sub-duties 4b and 4f of the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections are covered by standard C04c. *National guidance and procedures for infection prevention and control: Managing Healthcare*

	Associated Infection & Control of Serious Communicable Diseases in Ambulance Services (Ambulance Service Association, 2004) has been moved to Appendix 2 as the primary focus of the criterion is based on the requirements of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, revised 2008). However, the ASA guidance is the only document that gives any advice on what constitutes acceptable cleaning standards for ambulances. All other guidance is very 'hospital' focused.

Criteria for assessing Primary Care Trusts as Commissioners

Core standard C4a Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in Methicillin-resistant Staphylococcus aureus (MRSA).	
PCT commissioned service test (for whole standard) For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.	
Elements **Element one** Not applicable	**Independent contractors test** **For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
C4a rationale (element one) • Not applicable to this standard, as the Hygiene Code is targeting NHS providers who are commissioning services relevant to this standard (not PCT commissioning).	

Core standard C4c Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.
PCT commissioned service test (for whole standard) For all commissioned services, the PCT has appropriate mechanisms through which

it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.	
Elements **Element one** Not applicable	**Independent contractors test** **For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
C4c rationale (element one) • Not applicable as the Hygiene Code is targeting NHS providers who are commissioning services relevant to this standard (not PCT commissioning).	

Core standard C21 Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	
PCT commissioned service test (for whole standard) For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.	
Elements **Element one** Not applicable **Element two** Not applicable	**Independent contractors test** **For provider element one only** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
C21 rationale (elements one and two) • Not applicable as concerns provision of clinical care	

The Hygiene Code (as revised January 2008)[1]		
Management, organisation and the environment See also Annex 1		Core Standard
1. General duty to protect patients, staff and others from HCAIs	An NHS body must ensure that:	
	1a. so far as is reasonably practicable, patients, staff and other persons are protected against risks of acquiring HCAIs, through the provision of appropriate care, in suitable facilities, consistent with good clinical practice; and	C4a
	1b. patients presenting with an infection or who acquire an infection during treatment are identified promptly and managed according to good clinical practice, for the purposes of treatment and to reduce the risk of transmission.	C4a
2. Duty to have in place appropriate management systems for infection prevention and control	An NHS body must ensure that it has in place appropriate arrangements for and in connection with allocating responsibility to staff, contractors and other persons concerned in the provision of healthcare in order to protect patients from the risks of acquiring HCAIs. In particular, these arrangements must include:	
	2a. a Board level agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks;	C4a
	2b. the designation of an individual as director of infection prevention and control (DIPC) accountable directly to the chief executive and the Board;	C4a

[1] Adapted from *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections.* *http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081927* and Healthcare Commission, Criteria for assessing core standards in 2008/09, Acute trusts, http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9651

	2c. the mechanisms by which the Board intends to ensure that adequate resources are available to secure the effective prevention and control of HCAIs. These should include implementing an appropriate assurance framework, infection control programme and infection control infrastructure;	C4a
	2d. ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection;	C4a
	2e. a programme of audit to ensure that key policies and practices are being implemented appropriately; and	C4a
	2f. a policy addressing, where relevant, the admission, transfer, discharge and movement of patients between departments, and within and between healthcare facilities.	C4a
3. Duty to assess risks of acquiring HCAIs and to take action to reduce or control such risks	An NHS body must ensure that it has:	
	3a. made a suitable and sufficient assessment of the risks to patients in receipt of healthcare with respect to HCAIs;	C4a C4c (if related to decontamination)
	3b. identified the steps that need to be taken to reduce or control those risks;	C4a C4c (if related to decontamination)
	3c. recorded its findings in relation to items (a) and (b);	C4a C4c (if related to decontamination)
	3d. implemented the steps identified; and	C4a C4c (if related to decontamination)

	3e. appropriate methods in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAIs.	C4a C4c (if related to decontamination)
4. Duty to provide and maintain a clean and appropriate environment for healthcare	'The environment' means the totality of a patient's surroundings when in NHS premises. This includes the fabric of the building and related fixtures, fittings and services such as air and water supplies. An NHS body must, with a view to minimising the risk of HCAIs, ensure that:	
	4a. there are policies for the environment that make provision for liaison between the members of any infection control team (ICT) and the persons with overall responsibility for facilities management;	C21
	4b. it designates lead managers for cleaning and decontamination of equipment used for treatment (a single individual may be designated for both areas);	C4c C21 (in relation to cleaning)
	4c. all parts of the premises in which it provides healthcare are suitable for the purpose, kept clean and maintained in good physical repair and condition;	C4a C21
	4d. the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available;	C21
	4e. there is adequate provision of suitable hand washing facilities and antibacterial handrubs;	C21
	4f. there are effective arrangements for the appropriate decontamination of instruments and other equipment;	C4c
	4g. the supply and provision of linen and laundry supplies reflect Health Service Guidance(HSG) (95)18	C21

	Hospital Laundry Arrangements for Used and Infected Linen, as revised from time to time; and	
	4h. uniform and workwear policy ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose.	C21
5. Duty to provide information on HCAIs to patients and the public	An NHS body must ensure that it makes suitable and sufficient information available to:	
	5a. patients and the public about the organisation's general systems and arrangements for preventing and controlling HCAIs; and	C4a
	5b. each patient concerning: • any particular considerations regarding the risks and nature of any HCAI relevant to their care; and • any preventive measures relating to HCAIs that a patient ought to take after discharge.	C4a
6. Duty to provide information when a patient moves from the care of one healthcare body to another	**6.** An NHS body must ensure that it provides suitable and sufficient information on a patient's infection status whenever it arranges for that patient to be moved from the care of one organisation to another, so that any risks to the patient and others from infection may be minimised.	C4a
7. Duty to ensure co-operation	**7.** An NHS body must, so far as is reasonably practicable, ensure that its staff, contractors and others involved in the provision of healthcare co-operate with it, and with each other, so far as is necessary to enable the body to meet its obligations under this Code.	C4a

8. Duty to provide adequate isolation facilities	**8.** An NHS body providing in-patient care must ensure that it is able to provide, or secure the provision of, adequate isolation facilities for patients sufficient to prevent or minimise the spread of HCAIs.	C4a
9. Duty to ensure adequate laboratory support	**9.** An NHS body must ensure that if services are provided by a microbiology laboratory in connection with the arrangements it makes for infection prevention and control, the laboratory has in place appropriate protocols and that it operates according to the standards from time to time required for accreditation by Clinical Pathology Accreditation (UK) Ltd.	C4a
Clinical care protocols See also Annex 2		
10. Duty to adhere to policies and protocols applicable to infection	Policies An NHS body must, in relation to preventing and controlling the risks of HCAIs, have in place the appropriate core policies concerning the matters mentioned in paragraphs (a) to (l) below: The sufficiency and suitability of any policy implemented in accordance with this provision of the Code must be monitored via the clinical governance system, and there must be evidence of a rolling programme of audit, revision and update. All policies must be clearly marked with a review date.	
	10a. Standard (universal) infection control precautions	C4a
	10b. Aseptic technique	C4a
	10c. Major outbreaks of communicable infection	C4a

prevention and control	**10d.** Isolation of patients	C4a
	10e. Safe handling and disposal of sharps	C4a
	10f. Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries	C4a
	10g. Management of occupational exposure to BBVs and post-exposure prophylaxis	C4a
	10h. Closure of wards, departments and premises to new admissions	C4a
	10i. Disinfection policy	C4a
	10j. Antimicrobial prescribing	C4a
	10k. Reporting HCAIs to the Health Protection Agency (HPA) as directed by the Department of Health. This includes a mandatory requirement for the trust's chief executive to report all cases of meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia and cases of Clostridium difficile infection in patients aged 2 years or older.	C4a
	10l. Control of infections with specific alert organisms, taking account of local epidemiology and risk assessment. These infections must include, as a minimum, MRSA, Clostridium difficile infection and transmissible spongiform encephalopathies.	C4a
Healthcare workers See also Annex 3		
11. Duty to ensure, so far	A healthcare worker is any person whose normal duties concern the provision of treatment, accommodation or related services to patients and who has access to patients in the normal course	

as is reasonably practicable, that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that all staff are suitably educated in the prevention and control of HCAIs	of their work. This term includes not only front-line clinical and paraclinical staff, but also some staff employed in estates and facilities management, such as cleaning staff and engineers. An NHS body must ensure that policies and procedures are in place in relation to the prevention and control of HCAIs such that:	
	11a. all staff can access relevant occupational health services	C4a
	11b. occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisation, are in place;	C4a
	11c. prevention and control of infection is included in induction programmes for new staff, and in training programmes for all staff;	C4a
	11d. there is a programme of ongoing education for existing staff (including support staff, agency/locum staff and staff employed by contractors);	C4a
	11e. there is a record of training and updates for all staff; and	C4a
	11f. the responsibilities of each member of staff for the prevention and control of infection is reflected in their job description and in any personal development plan or appraisal.	C4a

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Annexes to the Hygiene Code[1]

Annex 1: Management, organisation and the environment

This annex relates to the 'Management, organisation and the environment' section of the Code.

Appropriate management systems for infection prevention and control

Arrangements to prevent and control HCAIs should be such as to demonstrate that responsibility for infection prevention and control is effectively devolved to:

- all professional groups in an NHS body; and
- clinical specialties and directorates and, where appropriate, support directorates or other similar units.

Director of infection prevention and control (DIPC)

The role of the DIPC is to:

- be responsible for the ICT within the organisation;
- oversee local control of infection policies and their implementation;
- report directly to the chief executive (not through any other officer) and the Board;
- have the authority to challenge inappropriate clinical hygiene practice as well as inappropriate antibiotic prescribing decisions;
- assess the impact of all existing and new policies on HCAIs and make recommendations for change;
- be an integral member of the organisation's clinical governance and patient safety teams and structures; and
- produce an annual report on the state of HCAIs in the organisation for which he or she is responsible and release it publicly.

Assurance framework

Activities to demonstrate that infection control is an integral part of clinical and corporate governance should include:

- regular presentations from the DIPC and/or the ICT to the Board;
- quarterly reporting to the Board by matrons* and clinical directors;
- review of statistics on incidence of alert organisms (e.g. MRSA, Clostridium difficile) and conditions, outbreaks and serious untoward incidents;
- evidence of appropriate actions taken to deal with infection occurrences; and
- an audit programme to ensure that policies have been implemented.

* The term 'matrons' includes nurses who do not hold that specific title, but who operate at a similar level of seniority, and who have control over similar aspects of the patients environment.

Infection control programme

The infection control programme should:

- set objectives;
- identify priorities for action;
- provide evidence that relevant policies have been implemented to reduce HCAIs; and
- report progress against the objectives of the programme in the DIPC's annual report.

[1] Taken from Department of Health, The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections, pp.10-19, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081927

Infection control infrastructure

An infection control infrastructure should encompass the following elements:

- in acute trusts, an ICT consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection control) and appropriate administrative and analytical support, including adequate information technology;
- in other NHS bodies, an infection control nurse or another designated person responsible for infection control matters; and
- 24 hour access to a nominated qualified infection control doctor, or a consultant in communicable disease control.

Movement of patients

There should be evidence of joint working between the ICT and the bed managers in planning patient admissions, transfers, discharges and movements between departments and other healthcare facilities. Where necessary, ambulance trusts may need to be involved in such planning.

Policies on the environment

Premises and facilities should be provided in accordance with best practice guidance.

The development of local policies should take account of infection control advice given by relevant expert or advisory bodies or by the ICT, and policies should address but not be restricted to:

- cleaning services;
- building and refurbishment, including air-handling systems;
- clinical waste management;
- planned preventive maintenance;
- pest control;
- management of potable and non-potable water supplies; and
- food services, including food hygiene and food brought into the organisation by patients, staff and visitors.

Cleaning services

The arrangements for cleaning should include:

- clear definition of specific roles and responsibilities for cleaning;
- clear, agreed and well-publicised cleaning routines;
- consultation with ICTs on cleaning protocols when internal or external contracts are being prepared; and
- sufficient resources dedicated to keeping the environment clean and fit for purpose.

Decontamination

The decontamination lead should have responsibility for ensuring that a decontamination programme is implemented in relation to the organisation and that it takes proper account of relevant national guidelines.

The decontamination programme should demonstrate that:

- decontamination of reusable medical devices takes place in appropriate dedicated facilities;
- appropriate procedures are used for the acquisition and maintenance of decontamination equipment;
- staff are trained in decontamination processes and hold appropriate competencies for their role; and
- there is a monitoring system in place to ensure that decontamination processes are fit for purpose and meet the required standard.

'Medical devices' refers to all products, except medicines, used in healthcare for

diagnosis, prevention, monitoring or treatment. The range of products is very wide and includes contact lenses, condoms, heart valves, hospital beds, resuscitators, radiotherapy machines, surgical instruments and syringes, wheelchairs and walking frames.

Linen, laundry and dress

(Users are referred to duty 4g of the basic code).

Particular consideration should be given to items of attire that may inadvertently come into clinical contact with a patient. Uniform and dress code policies should specifically support good hand hygiene.

Duty to provide information on HCAIs to patients and the public

Areas relevant to the provision of such information include:

- general principles pertaining to the prevention and control of HCAIs;
- the role and responsibilities of individuals in the prevention and control of HCAIs when visiting patients;
- encouraging vigilance in patients;
- compliance by visitors with hand washing and visiting restrictions;
- reporting breaches of hygiene and cleanliness;
- explanation of incident/outbreak management;
- feedback that is focused on the patient pathway; and
- providing information across organisational boundaries, such as pre-admission screening and postoperative wound surveillance.

Isolation of patients

Policies should be in place concerning the allocation of patients to isolation facilities, based on local risk assessment. The risk assessment should include consideration of the need for special ventilated isolation facilities.

Laboratory support

Protocols should include:

- a microbiology laboratory policy for investigation of HCAIs and surveillance; and
- standard operating procedures for the examination of specimens.

Annex 2: Clinical care protocols
This annex relates to the 'Clinical care protocols' section of the Code.

a. Standard (universal) infection control precautions

- Policy should be based on evidence based guidelines, including those on hand hygiene and the use of personal protective equipment.
- Policy should be easily accessible to all groups of staff, patients and the public.
- Compliance with the policy should be audited.
- Information on the policy should be included in induction programmes for all staff groups.

b. Aseptic technique

- Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis.
- Education, training and assessment in the aseptic technique should be provided to all persons undertaking such procedures.
- The technique should be standardised across the organisation.
- Audit should be undertaken to monitor compliance with the technique.

c. Major outbreaks of communicable infection

The degree of detail in the policy should reflect local circumstances. A low-risk single-specialty facility, for example, will not require the same arrangements as a district general hospital.

- Policies for major outbreaks of communicable infection should include initial assessment, communication, management and organisation, and investigation and control.
- The contact details of those likely to be involved in outbreak management should be reviewed at least annually.
- Major outbreaks should be reported as serious untoward incidents.
- Formal arrangements should be in place to fund the cost of dealing with outbreaks.

d. Isolation of patients

- Isolation policy should be evidence based and reflect local risk assessment.
- Indications for isolation should be included in the policy, as should procedures for the infection control management of patients in isolation.
- Information on isolation should be easily accessible to all groups of staff, patients and the public.

e. Safe handling and disposal of sharps

Relevant considerations include:

- risk management and training in management of needle stick injuries;
- provision of medical devices that incorporate sharps protection mechanisms;
- policy that is easily accessible to all groups of staff;
- auditing of policy compliance; and
- inclusion of information on policy in induction programmes for all staff groups.

f. Prevention of occupational exposure to blood-borne viruses, including prevention of sharps injuries

Measures to avoid exposure to BBVs should include:

- immunisation against hepatitis B;

- the wearing of gloves and other protective clothing;
- the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection; and
- measures to reduce risks during surgical procedures.

g. Management of occupational exposure to blood-borne viruses and post-exposure prophylaxis

Management should include:

- designation of one or more doctors to whom healthcare staff and others may be referred immediately for advice following occupational blood exposure;
- provision of clear information to healthcare staff about reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to human immunodeficiency virus (HIV);
- arrangements for post-exposure prophylaxis for hepatitis B and HIV, and follow-up; and
- follow-up of hepatitis C exposures.

h. Closure of wards, departments and premises to new admissions

- A system should be in place for the provision of advice by the ICT to the chief executive and medical director.
- There should be clear criteria in relation to closures.
- Management arrangements for redirecting admissions should be drawn up with ICT input.
- The policy should address the need for environmental decontamination prior to re-opening.

i. Disinfection policy

- The use of disinfectants is a local decision, and there should be local policies on disinfectant use that focus on specific infection risks.
- If appropriate, the role of high-level disinfectants to kill bacteria, viruses and spores should be considered.

j. Antimicrobial prescribing

- Local prescribing should, wherever possible, be harmonised with that in the British National Formulary (BNF).
- All local guidelines should include information on drug, regimen and duration.
- Procedures should be in place to ensure prudent prescribing.

k. Reporting HCAIs to the Health Protection Agency as directed by the Department of Health

- Reporting should include procedures for dealing with serious untoward incidents.

l. Control of infections of specific alert organisms

MRSA

The policy should make provision for:

- admission screening, which should include screening of all elective admissions by March 2009 and provision for screening of emergency admissions at presentation as soon as is practical;
- decontamination procedures for colonised patients;
- isolation of infected or colonised patients;
- transfer of infected or colonised patients within NHS bodies or to other healthcare facilities; and

- antibiotic prophylaxis for surgery.

Clostridium difficile infection

The policy should make provision for:

- surveillance of Clostridium difficile-associated disease;
- diagnostic criteria;
- isolation of infected patients and cohort nursing;
- environmental decontamination;
- antibiotic prescribing policies; and
- a statement concerning contraindication of anti-motility agents in symptomatic antimicrobial-associated diarrhoea.

Transmissible spongiform encephalopathies

The policy should make provision for the management of known or high-risk patients.

Relevant policies for other specific alert organisms

The specific alert organisms and matters mentioned below are also relevant to any acute trust.

They may also be relevant to certain other NHS bodies to which paragraph (l) of provision 10 applies, depending on their spectrum of activity.

- Glycopeptide-resistant enterococci:
  - screening of high-risk groups;
  - isolation and prevention of cross-infection;
  - decolonisation of colonised patients;
  - prophylaxis for surgical procedures.
- Acinetobacter and other antibiotic-resistant bacteria:
  - surveillance of identified patients at risk and high-risk environments;
  - procedures for managing infected patients to prevent spread of infection.
- Control of tuberculosis, including multi-drug-resistant tuberculosis:
  - isolation of infected patients;
  - transfer of infected or colonised patients within NHS bodies or to other healthcare facilities;
  - treatment compliance.
- Respiratory viruses:
  - alert system for suspect cases;
  - isolation criteria;
  - infection control measures;
  - terminal disinfection and discharge.
- Diarrhoeal infections
  - isolation criteria;
  - infection control measures;
  - cleaning and disinfection policy.
- Viral haemorrhagic fevers (VHF):
  - patient risk assessment and categorisation;
  - all staff to be aware of the special measures to be taken for nursing VHF patients, and to be properly trained in the application of full isolation procedures;
  - confirmed cases to be handled under full isolation measures in a high-security infectious diseases unit or equivalent;
  - handling of patient specimens at Laboratory Containment Level 4;
  - follow-up of all staff in contact with the patient at every stage of care;

- special measures for the handling of all clinical waste.

- Legionella:
  - Premises should be regularly reviewed for potential sources of infection, and a programme should be prepared to minimise any risks. Priority should be given to patient areas, although the exact priority will depend on local circumstances.

Annex 3: Healthcare workers

This annex relates to the 'Healthcare workers' section of the Code.

Occupational health services

Occupational health services should include:

- health screening for communicable diseases;
- management of exposure to HCAIs, which should include provision for emergency treatment out of hours; and
- relevant immunisations.

Occupational health services for blood-borne viruses

Occupational health services in respect of BBVs should include:

- arrangements for identifying and managing healthcare workers infected with hepatitis B, HIV or hepatitis C and restricting their practice as necessary in line with Department of Health guidance; and
- liaising with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses when advice is needed on procedures that may be carried out by BBV-infected healthcare workers, and when patient tracing, notification and offer of BBV testing may be needed.

Induction, training programmes and ongoing education

Induction and training programmes for new staff and ongoing education for existing staff should all incorporate the principles and practice of infection prevention and control.

These include:

- ensuring that policies are up to date;
- feedback of audit results;
- examples of good practice; and
- action needed to correct deficiencies.

Appendix E

Conclusions and Next Steps section of Healthcare Commission report *Inspections of cleanliness and infection control: how well are acute trusts following the hygiene code?*

"Conclusions

This programme of inspection was requested by the Government to help drive change on behalf of patients. We have seen the number of cases of some infections come down, such as MRSA bacteraemia, but there are many types of HCAI that pose a risk to the safety of patients. A robust approach to prevention and control of infection by complete and careful following of the hygiene code is a powerful way for trusts to combat HCAI.

We have been encouraged by the extent to which trusts have taken seriously this responsibility to prevent and control HCAI and are endeavouring to comply with the hygiene code. All trusts have put systems in place. Where there were issues, trusts often made changes to put things right straight away and, where we issued an improvement notice, subsequent compliance was assured.

However, most trusts' systems require further improvements so that they are consistently meeting the standard required. Of the total number of breaches that we saw in this sample, only a minority (3%) were material breaches that gave us real cause for concern.

Many trusts have fed back to us that they found it helpful to have an independent view, and many boards have acknowledged shortcomings that they had inadvertently overlooked. All have accepted our recommendations.

Infection control teams have widely welcomed the programme of inspection as invaluable in raising the profile of their work in helping their trusts to establish robust systems for preventing and controlling HCAI. Some patients have expressed pleasure in seeing us in the hospitals carrying out inspections and, in one case, took our assessors to see things that caused them concern.

It is essential that trusts review their performance in meeting targets on infection control and in following the hygiene code. They need to make sure that their framework for governance allows them to monitor the quality of their arrangements for preventing and controlling HCAIs effectively and to review the outcomes of this monitoring.

Boards must take a lead in infection control, supporting their DIPC and infection control teams in ensuring that adherence to the principles of infection control becomes second nature to everyone. Our inspections have shown that good leadership is crucial.

Trusts must focus on setting up good systems, and make sure that these are implemented and are achieving the right result.

Next steps

What the Healthcare Commission will do this year

- Publish guidance on our website to help trusts to comply more easily with the aspects of the hygiene code that they have found more difficult to interpret or take action on.
- Continue to develop our approach to including the views of local people in our assessments.
- Extend our assessments to include prescribing of antimicrobial medicines and the management of intravenous lines.
- Begin to extend our programme of inspection to non-acute trusts.
- Complete our inspections in relation to HCAIs for 2008/09 and publish a further briefing at the end of the year.

What trusts should do this year

- Assess their compliance with the hygiene code.
- Ensure that their board genuinely takes a lead in infection control.
- Make sure that their arrangements for governance really allow them to monitor the prevention and control of infection effectively.
- Make sure that key policies and practices for prevention and control of infection are being implemented.
- Develop 'good habits', so that prevention and control of infection becomes second nature to everyone.
- Stay focused on reducing the rates of HCAIs.
- Between 12 January and 6 February 2009 apply to register with the Care Quality Commission in relation to HCAI."[1]

[1] Healthcare Commission, *Inspections of cleanliness and infection control: how well are acute trusts following the hygiene code?* Pp.19-20, http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9683

Appendix F

Health Protection Agency Monitoring Reports for Clostridium difficile infections and MRSA bacteraemia

Table 1 – Clostridium difficile: Quarterly reports of C. difficile for patients aged 2 years and over (April 2007 - June 2008) [1]

Name of NHS Trust	April to June 2007			July to September 2007			October to December 2007			January to March 2008			April to June 2008		
	a	b	Total ‡	a	b	Total ‡	a	b	Total ‡	a	b	Total ‡	a	b	Total ‡
Dartford & Gravesham	31	10	41	31	8	39	21	16	37	27	7	34	20	5	25
East Kent Hospitals	54	25	79	53	25	78	52	21	73	44	20	64	42	12	54
Maidstone & Tunbridge Wells	98	15	113	62	31	93	60	20	80	44	29	73	28	22	50
Medway	51	14	65	35	13	48	23	12	35	29	5	34	29	5	34

‡ Includes cases where specimen location is unknown.

Key

a. Reported specimens taken in an Acute Trust

b. Reported specimens taken in non-acute Trusts or elsewhere.

[1] Data extracted from Health Protection Agency Quarterly Monitoring Reports, table 4c, http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1216193834850

Table 2 – MRSA: Quarterly reports of MRSA bacteraemia (April 2006 - September 2008)[2]

Name of NHS Trust	MRSA bacteraemia reports									
	April 2006 - June 2006	July 2006 – Sept 2006	October 2006 - December 2006	January 2007 - March 2007	April 2007 - June 2007	July 2007 – Sept 2007	October 2007 - December 2007	January 2008 - March 2008	April 2008 - June 2008	July 2008 – Sept 2008
Dartford & Gravesham	9	2	12	7	13	6	6	2	3	6
East Kent Hospitals University	22	17	6	16	12	5	8	7	10	6
Maidstone & Tunbridge Wells	17	12	11	1	4	7	8	5	7	5
Medway	10	18	9	6	6	6	3	6	6	2

[2] Data extracted from Health Protection Agency Quarterly Monitoring Reports, http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1229502457803

Appendix G

List of Core Standards

No.	Name[1]
C01a	Incidents - reporting and learning
C01b	Safety alerts
C02	Safeguarding children
C03	NICE interventional procedures
C04a	Infection control
C04b	Safe use of medical devices
C04c	Decontamination
C04d	Medicines management
C04e	Clinical waste
C05a	NICE technology appraisals
C05b	Clinical supervision
C05c	Updating clinical skills
C05d	Clinical audit and review
C06	Partnership
C07a & c	Governance
C07b	Honesty, probity
C07e	Discrimination
C08a	Whistle-blowing
C08b	Personal development
C09	Records management
C10a	Employment checks
C10b	Professional codes of conduct
C11a	Recruitment and training
C11b	Mandatory training
C11c	Professional development
C12	Research governance
C13a	Dignity and respect
C13b	Consent
C13c	Confidentiality of information
C14a	Complaints procedure
C14b	Complainants discrimination
C14c	Complaints response
C15a	Food provision
C15b	Food needs
C16	Accessible information
C17	Patient and public involvement
C18	Equity, choice
C20a	Safe, secure environment

[1] These are the short names for the core standards used in the summary reports for each trust available from: http://2008ratings.healthcarecommission.org.uk/informationabouthealthcareservices/overallperformance.cfm

C20b	Privacy and confidentiality
C21	Clean, well designed environment
C22a & c	Public health partnerships
C22b	Local health needs
C23	Public health cycle
C24	Emergency preparedness

Healthcare Commission

Your part in the annual health check 2008/09

A step-by-step guide for local authorities, strategic health authorities, local involvement networks (LINks), overview and scrutiny committees, local safeguarding children boards and foundation trusts' boards of governors

Tell us how you think your local trust is performing

The Healthcare Commission keeps a check on local healthcare organisations and provides information that is of interest to patients and the public about their local health services – safety and cleanliness, dignity and respect, standards of care, keeping people healthy, waiting to be seen, and good management.

By checking trusts' performance and providing information, we aim to help trusts to improve their services.

From April 2009, trusts will again be gearing up for the declaration part of the annual health check. We need your comments to make sure that we get the full picture about their performance in 2008/09.

Last year we invited patient and public involvement forums, overview and scrutiny committees, strategic health authorities (SHAs), local safeguarding children boards and foundation trusts' boards of governors to comment and they responded well. We really appreciate the hard work that went into providing commentaries that produced so much useful intelligence. One way we used this information was to influence our decision on which trusts were inspected as part of our core standards assessment.

For 2008/09 we are also inviting local involvement networks (LINks) to tell us how you think your local trust is performing against the standards set by Government, and to give us the views and experiences of people in your community. We are determined to put the interests of patients and the public at the heart of our work, so your feedback is very important to us.

As in previous years, where you have sent comments to trusts for inclusion in their declaration, these must be included – word for word – in the declarations they submit to us. But if you are invited to comment and say no, neither you nor the trust will be penalised.

We recognise that LINks will be at different stages of establishment across the country and that not all will be able to contribute to the annual health check to the same degree. Therefore we have put in place options that recognise this and they are set out under heading 2 of this document.

1. Getting ready

The Government published *Standards for Better Health* in July 2004, which set out 24 core standards. These core standards describe a minimum level of service, which patients have the right to expect. We are again asking trusts to tell us how they have performed against the core standards this year through a declaration, which must be submitted by midday on 1 May 2009. As part of this process, trusts are responsible for inviting 'third parties' to comment on their performance. Third parties include local authorities, SHAs, LINks, overview and scrutiny committees, local safeguarding children boards and foundation trusts' boards of governors.

Your local trust should contact you in early 2009 to agree a timetable for including your comments in their declaration. You may also want to start discussing what you might say, so you are prepared.

You can comment on your trust's performance against any of these standards. You do not have to comment on all of them. Your comments should relate to your group's views on the performance of the trust during the period from 1 April 2008 to 31 March 2009. You are not expected to sign off or comment directly on the declaration given to us by your local trust.

If you agree to comment, you may want to set up regular meetings with your members as soon as possible, so that you have enough time to seek the views of others in your community. You may also want to contact the other third parties in your area, so that you can discuss your respective roles, exchange views about local trusts and coordinate your efforts.

You may find it useful to share your draft comments with your trust or with a regional assessor from the Healthcare Commission. You don't have to take their feedback into account, but working together may benefit everyone involved.

2. LINks

On 1 April 2008, new government legislation introduced local involvement networks (LINks), which aim to give local people a greater say in the way that health and social care services are commissioned and provided. Each local authority has until the end of September 2008 to appoint a LINk 'host' to support the set up and running of their LINk.

LINks effectively replace the former patient and public involvement forums but, in this first year, we recognise that not all LINks will be able to contribute to the annual health check to the same extent that third parties have done in previous years. In order to ensure your comments are included in the annual health check there are three options:

a) Where a LINk lead / host has been identified, we advise that the LINk submits its comments to the trust for inclusion in the declaration.

OR

b) The LINk lead / host can coordinate the comments of up to ten voluntary organisations and submit these to the trust for inclusion in the declaration.

OR

c) The LINk lead / host can coordinate the comments of up to ten voluntary organisations and submit these comments via the engage website (**https://engage.healthcarecommission.org.uk**). Please note LINk users will need to register to log in to the feedback forms through the 'contact us' section of the website. Comments must be submitted by 1 May 2009.

Options a) and b) will enable us to include your comments with the trust's declaration when we publish it on our website. Unfortunately, we will not be able to publish comments submitted via the engage website (option c). They will, however, still be used to cross-check the declarations submitted by the relevant trusts.

We would also encourage overview and scrutiny committees and foundation trusts' boards of governors to contact their local authority to offer to work with the emerging LINks to identify the best way of feeding in their comments.

Further details are included in our LINks guide to working with the Healthcare Commission, which can be found at **https://engage.healthcarecommission.org.uk/static/handbook**

3. What's new in 2008/09

Primary care trusts (PCTs) currently have two functions: as commissioners (purchasers) and as providers of care. For 2008/09, the annual health check will reflect this by providing separate assessments on the provider and commissioning functions of PCTs. When drafting your commentary for PCTs it may be useful to consider these two separate functions.

4. How will your comments make a difference?

Your comments, if submitted through your trust's declaration, will be made publicly available. You could make a difference to your local health services just by putting your views on record.

Your comments (including those submitted via the engage website if the LINk has chosen option c) will be taken into account when we make our final assessments of how trusts have performed in 2008/09.

They are more likely to influence our assessments if they are supported by facts.

5. Submitting your comments

There is no standard template for giving your comments to trusts – use a format that works best for you. Consider allowing the chair of your group to 'sign off' your comments. This could help you to finalise them more quickly.

It is important that trusts have enough time to include your comments in their declarations before the deadline. They must send us their declaration no later than midday on 1 May 2009 and we will check that they have included your comments.

They should also send you a copy of their declaration once they have submitted it to us so that you can check your comments.

They do not have to share the content of their declaration with you before it is submitted.

The engage website has been set up to allow comments to be sent to us throughout the year. However, if a LINk is submitting comments via the Engage website for the annual health check 2008/09 (option c), then they need to be submitted before 1 May 2009.

Tips to help ensure your comments make a difference

- Think about what matters most to you and the people in your community – what are the most important points you want to get across?
- Think about examples of good practice as well as problems and areas for improvement.
- Familiarise yourself with the 24 core standards and guidance relating to them. Aim to match the standards with the points you want to make.
- Try to find facts and examples to back up your comments. These may include notes of a meeting or visit to a trust, the results of a local survey, or personal stories from individuals with supporting dates and documents. Please note your comments must not include confidential or personal information and we may not be able to accept those that do.
- Do not submit the supporting information with your comments, but be prepared in case we need to clarify some aspect of your comment.

6. Learning from last year's annual health check

When writing your comments for this year's annual health check, please note that we use them to identify and extract 'items of information'. These might consist of several paragraphs or a single sentence and will relate to one or more core standard.

In 2008, we received 1,930 comments from third parties. We extracted and coded 8,779 items of information from these comments because they related to one or more of the standards. Each coded item was weighted 'high', 'medium' or 'low':

- 'High' meant the item had a strong association with a particular standard, was closely aligned to the criteria in our inspection guides and provided clear information to support the opinions expressed.
- 'Low' meant the item related to a small aspect of a standard, or was about one department rather than a whole trust, or had little back-up information.
- In total, 451 (5%) of the items were weighted as 'high', 5,206 (59%) as 'low' and 3,122 (36%) as 'medium' weighting.

7. Cross-checking and follow up

Your comments will be one of the many sources of information that will be used to check the trust's declaration. This helps to ensure our assessments are as fair and accurate as possible. We will also carry out follow-up inspections with approximately 20% of trusts – some of these trusts will be chosen at random and some will have been identified as being most at risk of not meeting the core standards.

If your local trust gets a follow-up inspection, you may be contacted by one of our regional assessors to discuss your comments. We will want to see your supporting information at this point.

Key dates

- **Early 2009**
  Establish the deadlines for submitting comments to your trust.

  If you do not wish to submit any comments for the 2008/09 annual health check, it would be helpful if you could write formally to your trust advising them of this.
- **15 April 2009**
  Trusts can begin to submit their declaration to us.
- **Midday 1 May 2009**
  Deadline for trusts to submit their declaration to us.
- **22 May 2009**
  Trust declarations made public.
- **October 2009**
  Results of the annual health check published.

8. Find out more

Our LINks guide to working with the Healthcare Commission gives details of how LINks can contribute information for the annual health check in 2008/09. It is available from the engage website at:

https://engage.healthcarecommission.org.uk/static/handbook

A companion guide to working with the Commission for Social Care Inspection will be available in autumn 2008.

The annual health check in 2008/09: Assessing and rating the NHS gives further information about the annual health check and can be downloaded from the Healthcare Commission website at **www.healthcarecommission.org.uk**

We will shortly be publishing sets of criteria for NHS trusts to give them more information about the assessment of core standards for this year's annual health check. These will also be available to download from the Commission website once they are published.

Healthcare Commission

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This information is available in other formats and languages on request. Please telephone 0845 601 3012

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Dartford and Gravesham NHS Trust

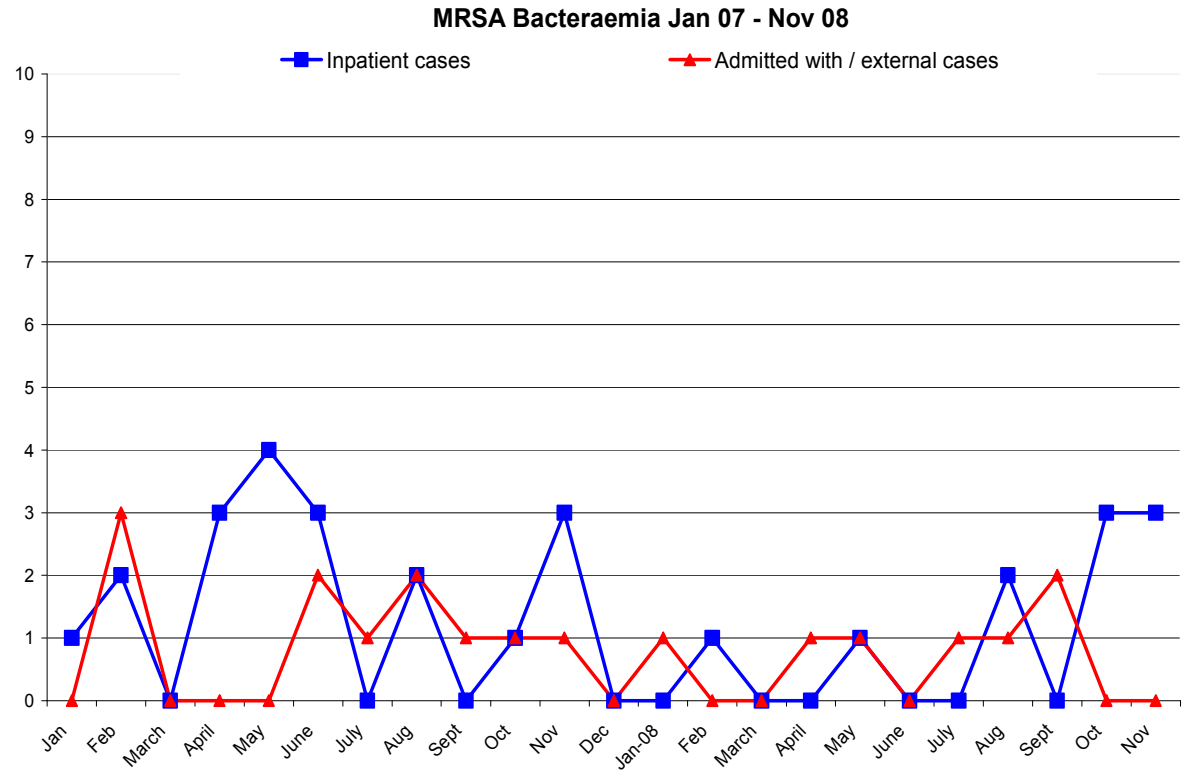
In November 2007 the Trust Board issued a public statement on Infection Prevention and Control to send a clear message to all, that infection prevention and control is a top priority for the organisation.

No patient should acquire an infection in Darent Valley Hospital. We are committed to supporting staff in employing best clinical practice and the highest hygiene standards in order to ensure the protection of all patients. For those patients at particular risk of infection as a result of their underlying condition or with pre-existing infection, clinical staff should take every measure to treat appropriately to minimise the risk of infection developing or spreading.

We believe that by effectively involving patients and the public in this agenda, we can raise awareness of how everyone can contribute to their own and others' safety and well-being.

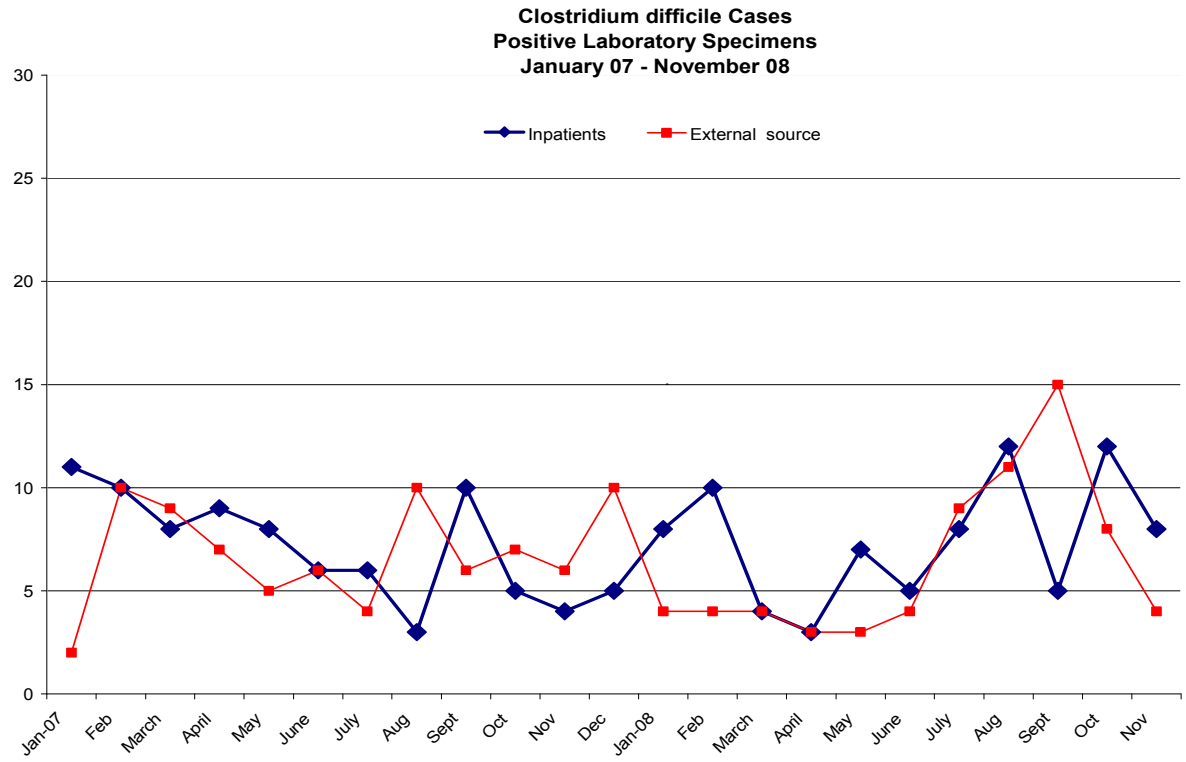
Rates of HAI

MRSA



MRSA target for all cases 08/09 = 12, currently 2 above target Hospital acquired bacteraemias account for 9 of the 14 cases. Root cause analysis of all cases has identified chronic lower limb wounds as the predominant source of recent infections.

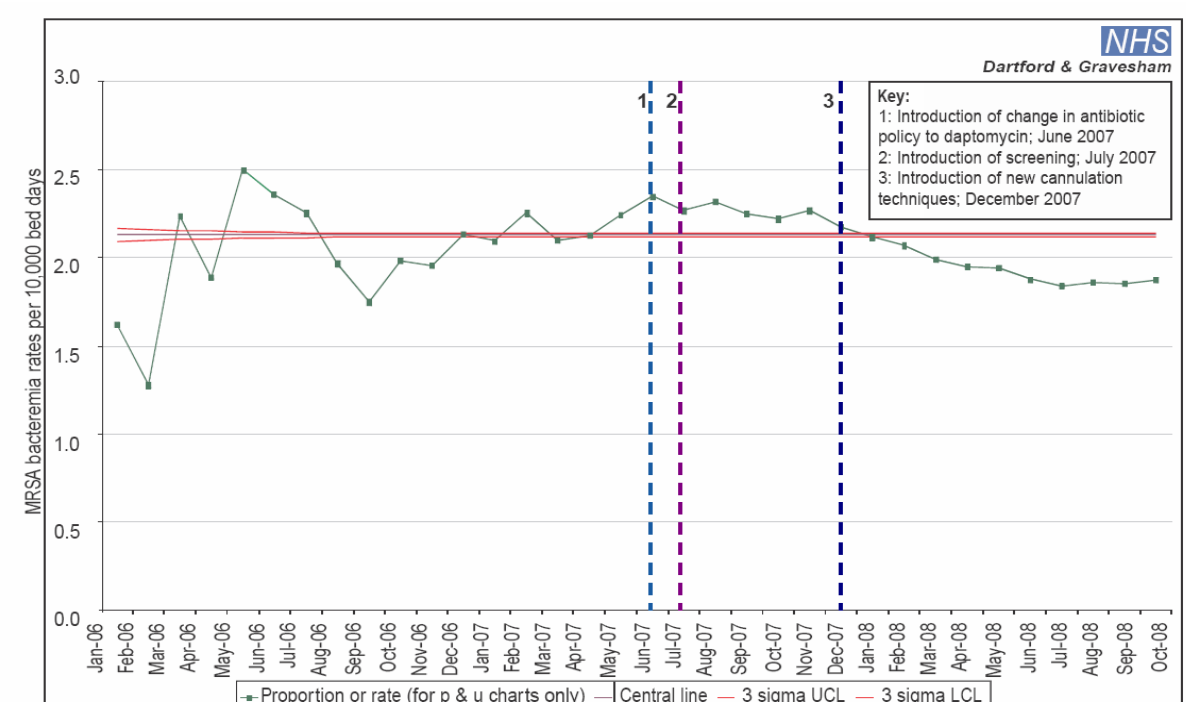
C. diff



C. diff Hospital acquired limit for 08/09 = 84, currently 63

Changes in practice

The most significant change was a review in IV cannula insertion and management at the end of 07. Where IV cannulae had been associated with a significant proportion of MRSA bacteraemias there has only been 1 cannula related bacteraemia since Nov 07.



In addition the appointment of 2 additional Infection Control Nurses has allowed greater input in the clinical areas, audit of practice and education. The Tissue Viability Nurse is now also managed by the DIPC as infection control has an integral part in reducing the risk of infection in wounds.

Successes & challenges

The success of the IV management pathway has been extended to urinary catheters as they are recognised as being a source of HAI. 'Bare below the elbows' uniform policy has been widely adopted by clinical staff thereby facilitating hand hygiene practice. Infection control education has been extended to all medical and nursing students attending the Trust.

Infection control scored 6/7 in the Healthcare Commission Annual Ratings report contributing to an excellent rating for quality of care.

The HCC unannounced inspection in August 08 identified 2 sub duty breaches of the Hygiene code (dust on Patientline equipment and no policy document for environmental management). Both issues have now been rectified.

Challenges – The long length of stay of some patients present risks and we are closely monitoring this issue.

Assurance framework

In addition to the reporting structure (Appendix 1) the DIPC provides the CEO with a monthly performance report on MRSA, C. diff and audits of Infection Control Practice in clinical areas. An additional 5 audit topics are being added in January with the frequency being increased to weekly. From January 09 all audits will be undertaken by the Matrons.

Infection control audits

No	Performance indicator	Target 2008	Frequency	01	02	03	04	05	06	07	08	09	10	11	12	RAG Rating
1	Hand hygiene/ dress code	100 %	Monthly	81	91	98	98	98	97	99	99	96	99	99		
2	Risk Assessment	100 %	Monthly					71	76	82	90	85	85	86		
3	MRSA Admission Screen	100 %	Monthly	51	76	87	98	93	88	93	93	92	90	86		
4	Peripheral cannula	100 %	Monthly	61	75	79	88	98	99	97	94	98	90	93		
5	Commodes	100 %	Monthly							81	85	84	92	96		

(RAG rating of green reflects three month rolling average performance above 90%)

Staff and Patient Involvement

Staff across the Trust at all levels are fully involved and committed to infection control as a key element in providing a safe environment for patients. The ranges of patient information leaflets have been expanded and together with a short video highlighting infection control are available on the Trust web site. A large display stand has been erected in the main hospital street where information on MRSA, C diff rates and patient leaflets are also provided. Leaflets are also made available on all wards.

Hand gel dispensers and 'clean your hands' signage is widely distributed.

Iris Smith
Director of Infection Prevention and Control
Dartford and Gravesham NHS Trust

Trust Infection Prevention & Control Structure & Reporting

Trust Board

↑

Clinical Governance Committee

↑

Infection Control Committee (Quarterly Meetings)

Medical Director (Chair)
Director of Infection Prevention and Control
Consultant Microbiologist Associate Specialist in Microbiology
Senior Nurse Infection Control
Consultant Physician Consultant Surgeon Director of Nursing
Assistant Director of Governance Sterile Services Manager Carillion Services Manager
Occupational Health Physician/Nurse Health Protection Unit Representative

↑

Infection Control Team

Director of Infection Prevention and Control
Consultant Microbiologist Associate Specialist in Microbiology
Matron In Infection Control Senior Nurse Infection Control

Senior Leads in Infection Control

Matron Surgical Specialities	Matron Medicine
Matron Elderly Medicine	Matron Emergency Medicine
Matron Day Care Unit	Matron Critical Care
Matron Critical Care Outreach Team	Manager Paediatric Services
Manager Theatre Services	Manager Physiotherapy Services
Manager Radiology Services	Manager Midwifery Services
Bed Bureau Manager	

↑

Infection Control Link Staff
All wards & departments have a nominated member of staff with specific responsibility for infection control in their area

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Maidstone and Tunbridge Wells NHS
NHS Trust

Chief Executive and Chairman's Office
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Maidstone
Kent ME16 9QQ

Tel: 01622 226412
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Paul Wickenden
Overview and Scrutiny Manager
Legal and Democratic Services
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

19th December 2008

Dear Paul,

Re: Health Overview and Scrutiny Committee Meetings

Further to your letter I write to provide an update with respect to the progress we have made in relation to the Hygiene code, with particular reference to core standards – C4a, C4c and C21.

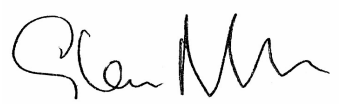
You are well aware of the issues that we have faced as a trust since the publication of the Healthcare Commission's investigation report. The trust has carried out significant work over the last year to improve the service we offer to patients in all respects, but particularly with respect to the management of infection prevention and control. We are please to be able to report, demonstrated by the evidence attached, that we have reduced the infection rates for C diff and MRSA bacteraemias significantly and are below target levels. We continue to work towards increasing standards of care and compliance with the Hygiene Code.

Attached are updates for each of the core standards you refer to.

In addition we are anticipating publication of the reports from the Healthcare Commission's Hygiene Code inspection visit and the investigation follow up visit, carried out in November, at the beginning of January. We have seen the draft reports for these and believe they provide assurance of the progress we have made with respect to the hygiene code.

My apologies that I shall not be able to attend the meeting on 9th January, however, Flo Panel-Coates, Director of Nursing and Claire Roberts, Head of Quality and Governance, will be representing me.

Yours sincerely,



Glenn Douglas
Chief Executive

Maidstone & Tunbridge Wells NHS Trust

Governance Processes

The trust has reviewed its governance processes to ensure there are clear lines of reporting and accountability. The committee structures have been reviewed in line with this (see attachment).

The DIPC provides weekly updates and monthly reports to the executive team and monthly reports to the Quality and Safety Committee and the Board – these are published on our website.

The Infection Prevention and Control Committee (IPCC) has been reconfigured and now meets monthly. This is the key committee for monitoring action plans relating to infection control issues such as the hygiene code.

Until the beginning of December meetings were held, initially weekly and then monthly to review progress against the action plan developed as a result of the Healthcare Commission Investigation report. At the beginning of December it was agreed that the few remaining actions aligned to hygiene code duties so these have now been added to the hygiene code action plan and will be reviewed by the IPCC

Core Standard C4a

The trust anticipates declaring this standard to be met for 08/09

Please see attached action plan and update from our DIPC re actions taken.

Core Standard C4c

The trust declared compliance for 07/08 but was qualified by the Healthcare Commission (HC) and found to be compliant by the end of year, not the full year.

The trust had a hygiene code inspection in October 2008 during which the HC found some areas with respect to decontamination, despite the board having received accreditation by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) in the summer. The recommendations have since been addressed and we anticipate declaring end of year compliance for 08/09.

Please see attached action plan.

The trust has recently reorganised its estates and facilities department and a new structure for the management of decontamination services has been put in place (attached). The new director of facilities is due to take up post in January 2009.

The trust is to be part of the planned Kent-wide provision of decontamination services by IHSS. This service is due to commence summer 2009. Currently internal services are compliant with required standards.

The trust is currently setting up a “Medical devices library” to enhance the management of the decontamination of reusable devices.

Core standard C21

Progress has been made with respect to this standard and we anticipate declaring it to be met for the 08/09 declaration.

Please note the attached action plan.

Challenges remain with respect to compliance with bed spacing within the hospitals. Since the investigation report, however, an external report was commissioned to review the situation and bed spacing has been increased. The Board is due to receive a further update in February regarding this issue.

In considering actions that the trust is taking to address environmental issues the development of the new hospital at Pembury is key. This hospital will have single rooms for patients and so be able to overcome the issues of both single sex accommodation and bed spacing.

A number of ward areas have successfully been upgraded. The trust is meeting its targets for the deep clean programme that is in place though out the clinical areas in the trust.

There has been a thorough review of policies and procedures with respect to cleanliness. A robust auditing system has been put in place and includes a review of compliance with the National Credits for Cleaning.

We have regular PEAT reviews and the team includes a lay representative.
Immediately after the investigation two lay people were employed to carry out cleanliness audits throughout the organisation.

Audits and inspections are reported through an identified committee structure.

Core Standard C4a infection control – Maidstone & Tunbridge Wells NHS Trust

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin resistant *Staphylococcus aureus* (MRSA)

Core Standard Key Line of Enquiry **a. The Hygiene Code requires healthcare organisations to have in place appropriate management systems for infection prevention and control which must include the following:**								
Hygiene code duty cross reference	**Core Sub Duty**	**Assurance Statement**	**Action**	**Director Lead**	**Ops Lead**	**Review Date**	**Target**	**Progress/ Evidence**
2a	A Board level agreement outlining its collective responsibility for minimizing the risks of infection and the general means by which it prevents and controls such risks.	IPC is incorporated into all executive job descriptions with identified outcome measures	In place	CE/TC				• Letter from Chief Executive amending job descriptions and outlining executive responsibility
2a		The Chief executive, lead non-executive director and Board receive regular reports and presentations (quarterly as a minimum) from the Director of Infection Prevention and Control (DIPC)	In place	DIPC				• Infection control reports to Board incorporated inot integrated governance reports bimonthly • Weekly IC update sent to all Board members and senior managers • Annual infection control report to Board Sept 08

2a		Monitoring of compliance and improvement plans are incorporated into the governance and performance frameworks	In place	FPC/NL				• Integrated Governance reports to Board incorporate infection control. • Annual IC report to Board Sept 08. • Weekly Exec updates sent to all Board members. • HCC and HCAI action plans. • Facilities Director appointed October 2008 (as per org chart)
2a		Monitoring, review and action to improve clinical practice and prevent and control HCAI is part of the routine business of every service area/clinical directorate	• Full implementation of Saving Lives programme. • Include Saving Lives & Hand Hygiene Audits in performance dashboard. • Saving Lives and hand hygiene audits regular agenda items at Divisional meetings and Infection Prevention and Control Committee (IPCC) • Balanced scorecard for HCAI, consultant by consultant and ward by ward reporting	JL / FP-C/SM	DD's & ADNS's		Completed 31/10/08	• Saving Lives Audit programme. (N. Drive) • Hand hygiene ward audits. • Minutes from divisional meetings to show reporting. • IPCC work to Board. • Balanced scorecard completed and circulated to divisions, IPCC and Board monthly • Annual programme agreed. • Decontamination report to the Trust Board in October 2008

2b	The designation of an individual as Director of Infection Prevention and Control (DIPC) with the role as defined in the Code and accountable directly to the Board and, from January 2008, directly to the Chief Executive	The DIPC has a job description with defined HCAI responsibilities and outcome objectives, is regularly appraised against those objectives, and reports directly to the Chief Executive and the Board	In place					• DIPC in post since Nov 2007 • DIPC job description • DIPC attends Board meetings
2c	The mechanisms by which the Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should	Within the commissioning and budget setting process, resources are identified for the management if infection prevention and control. This resource allocation is regularly reviewed within the organisation	In place					• IC budget

2c	include implementing an appropriate assurance framework, infection control programme and infection control infrastructure	The infection prevention and control committee (IPCC) who reports to the DIPC and the Board agrees and reviews the HCAI programme of work and audit schedules and provides reports to the DIPC for onward communication to the Board	In place					• Annual IC programme and plan • Annual IC report to Board • IPCC annual planner • Minutes of IPCC
2c		Defined governance and performance outcomes and reporting frameworks are identified at a directorate/divisional level	Develop governance and performance outcomes and reporting frameworks within divisions.	JL/FPC	DD's & ADNS's		Completed	• Link nurse programme • Trust Assurance framework includes infection control • HCAI balanced scorecard • RCA reports • Agreed governance agenda for divisions which includes IPCC embedding as new committees
2c		The is cross representation between the Infection Prevention and Control Committee and the Drugs and Therapeutics Committee	In place					• Minutes of meetings

2c		Responsibility and accountability for infection control is clearly allocated in each clinical area (i.e. to the manager of that area)	In place					• Ward managers accountability agreement
2c		Infection prevention and control is included in the personal development plans of all infection control leads.	• Jim Lewis to write to Divisional Directors and CDs to ensure IPC included in PDP of all leads • Clarify IPC leads. • Agree role responsibilities • Confirm link nurse PDPs	Jim Lewis	DD's/ADNSs + JO		Completed 31/10/08	• Link nurse PDPs • Link nurse role description • Divisional Director JD • Clinical director JD • Letter from Medical Director
2c		The responsibilities of each member of the ICT are clearly defined and the contracted sessions of the Infection Control Doctor are defined and agreed	In place					• IC team structure • IC team job descriptions • DIPC/ICD job description and job plan

2f	A policy addressing, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities	The policy for patient movement/bed management explicitly identifies infection control risks and sets out plans for how they are to be mitigated. The policy is regularly monitored at Directorate level for compliance and fitness for purpose.	• Need to review infection control bed management. • Policies to be reviewed at Divisional level. • Audit and review	Nikki Luffingham	Gail Locock/ADNS's		30/12/08	• Bed Management Policy, • Transfer policy • Discharge/transfer forms for C.difficile patients. • Isolation ward operational policy • Admission/discharge/ transfer policy for C. difficile patients • Isolation facility audit • Review of side room provision at IPCC • Active management of side room use by infection control - twice daily reports
2f		There is regular liaison between the bed /operational manager, the ICT, ward manager and other relevant staff in respect of patient transfers within the hospital	In place					• Twice daily side room reports • infection control patients lists • ICT attends bed meeting at least once per day • outbreak policy • patient transfer policy • bed management and site sheet. • Time to isolate audit
Core Standard Key Line of Enquiry **b. The healthcare organisation should have in place appropriate management systems for infection prevention and control, including the following:**								
2c		An appropriate assurance framework	• Develop separate assurance framework for infection control	DIPC	GL/JH		31/01/09	• Infection control included in Trust assurance framework

2d	Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection	Resources are identified and available for appropriate IC training, information and supervision	In place • Training programme currently under review					• Induction training handouts and slide presentations. • Mandatory update training resources. • Link nurse training days programme. • Protected time for link nurse training • Mandatory HCAI training - slide presentations. • Link nurse network. • E learning package
2d		Mechanisms exist to monitor compliance with the IPC training policy/plans and the outcomes are audited and incorporated into directorate and Board reports.	• Audit outcomes. • Reporting on training attendance to Divisions and Board	DIPC/TC	Gail Locock/ADNS's		30/12/08	• Attendance monitored- evidence available • Training attendance reporting in the Board performance report
2e	A programme of audit to ensure that key policies and practices are being implemented appropriately.	A balanced scorecard or equivalent framework is used to monitor compliance with statutory/mandatory/local policies and standards and is reviewed by the senior management team (SMT) and Board at least quarterly.	• Final 2009 audit plan to go to January IPCC	SM	Gail Locock/ADNS's		31/01/09	• New Committee Structure • Saving lives audits and framework • IP&CC minutes. • 2008 audit plan in place • Draft audit plan for 2009 presented at IPCC November • HCAI balanced scorecard presented monthly to divisions and bimonthly to Board

2e		Directorates review the results of compliance audits, and incorporate these into their plans for continuing improvement.	• Implement web based monitoring system for Saving lives and hand hygiene audits	SM	Gail Locock/Belinda Regan/ADNSs		31/01/09	• Clinical governance programmes i.e. balanced scorecard, RCA, saving lives • Minutes of divisional meetings and divisional ops meetings
Core Standard Key Line of Enquiry **c. The healthcare organisation assesses the risk of acquiring HCAI and takes action to reduce or control such risks. In doing so they must have:**								
3a	Made a suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI.	There is appropriate analysis of infection data and surveillance of alert organisms	In place					• Weekly IC reports to Board and senior management • Surveillance of alert organisms using ICNet • SSSI reports to IPCC • Root cause analysis
3a		This analysis is incorporated into the organisation's risk assessment process and is used to prioritise local and corporate action through the organisation's risk register	In place	F lo Panel-Coates	Jeff Harris/ CR			• Risk register & assurance framework. • Root cause analysis. • Minutes IPCC

3a		Infection control is incorporated into individual patient assessment and identified risks are communicated and acted upon.	In place	Flo Panel-Coates/SM	Belinda egan/ADNS's/Gail Locock		30/12/08	• C. difficile care pathway • ADLs/Care plan • Rapid risk assessment for diarrhoea
3a		National guidance and local data informs the local screening policy/guidance and mechanisms for assessing compliance are identified and implemented.	In place	Sara Mumford	Gail Locock			• MRSA Screening policy. • Compliant with national guidance • SHA monthly screening audit • Weekly monitoring reports to SHA • GRE screening giudance
3b	Identified the steps that need to be taken to reduce or control those risks.	Individual patient treatment plans reflect the outcome of HCAI risk assessment	ADLs and individual care planning to include IPC	Flo Panel-Coates	ADNS's/Matrons		Completed	• C. difficile care pathway. • Diarrhoea rapid risk assessment and pathway • ADLs. In place and monitored daily

3c	Recording its findings in relation to items a) and b)	Infection control risk assessments are a standing item on the Infection Control Committee, clinical governance/risk management/patient safety committee agenda	Risk assurance framework IPC to be included on Quality and Safety Committee agenda	Sara Mumford	Gail Locock		Completed	• Discussion of current risks at IPCC • Quality and Safety minutes – monthly report from IPCC • IPCC minutes • RCA/SUI reports
3d	Implementing the steps identified	Compliance with Infection control guidance, treatment/care plans and risks assessments are audited and monitored at directorate/divisional/ corporate level as appropriate	Develop monitoring at divisional level Framework for IPC assessments	SM/Flo Panel-Coates	Gail Locock/ADNS's		Complete	• Infection control is standing item at divisional meetings and divisional operations committee • Saving lives audits reported to divisions and IPCC. • PEAT report to IPCC • Cleaning standards audits report to divisions and IPCC • HCAI balanced scorecard • RCA as part of framework. • Final 2009 annual audit plan to be agreed at Jan 09 IPCC

3e	Appropriate methods in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAI.	Root cause analysis (RCA) is undertaken at directorate level for all patients with severe infections such as MRSA bacteraemias and *C. difficile associated infections*, and is investigated in a timely manner and the outcomes reported through local/directorate and corporate governance and performance frameworks.	Develop divisional responsibility for RCA – report to clinical governance meetings DIPC as Trust lead for HCAI RCA Draft process to go to divisions and Clinical directors	Sara Mumford/Flo Panel-Coates	DD's & ADNS's		Complete	• RCA process agreed at divisions and IPCC • DIPC is Trust lead for HCAI RCA • RCA reports reviewed at IPCC • Action plans monitored at IPCC • DIPC reports to Board.

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Infection Prevention and Control update for Health Overview and Scrutiny Committee – Maidstone & Tunbridge Wells NHS Trust

Key interventions 2008

Board to ward responsibility and accountability for infection prevention and control.

Zero tolerance of avoidable healthcare associated infections.

Director of Infection Prevention and Control (DIPC) reports to every Board meeting.

DIPC sends out weekly reports to all Board members and senior management.

Ward by ward and Consultant by Consultant Healthcare associated Infection (HCAI) data published.

Isolation wards on both Maidstone and Kent and Sussex sites. The ward on the Maidstone site is specifically for C. difficile patients.

Patients with C. difficile in Kent and Sussex hospital are transferred to the Maidstone Isolation ward.

Development of a C. difficile integrated care pathway.

Multidisciplinary rounds on C. difficile isolation ward.

Twenty four hour per day cleaning on Maidstone and Kent and Sussex sites and available if required on Pembury site.

Strict antibiotic policy.

Every C. difficile infection and MRSA or Glycopeptide resistant enterococcal blood stream infection has full root cause analysis with action plans. Implementation of action plans is monitored by the Infection Prevention and Control Committee.

Infection Control team expanded with recruitment of two senior matrons.

Implementation of ‘Bare below the Elbows’ across the Trust.

Mandatory 20 minute training session for every member of staff on hand hygiene and the saving lives programme.

Responsibility for infection control is included in the job description of every member of staff.

Strict policy in place for the management of patients with diarrhoea.

The link nurse network has been strengthened with ring-fenced time for training.

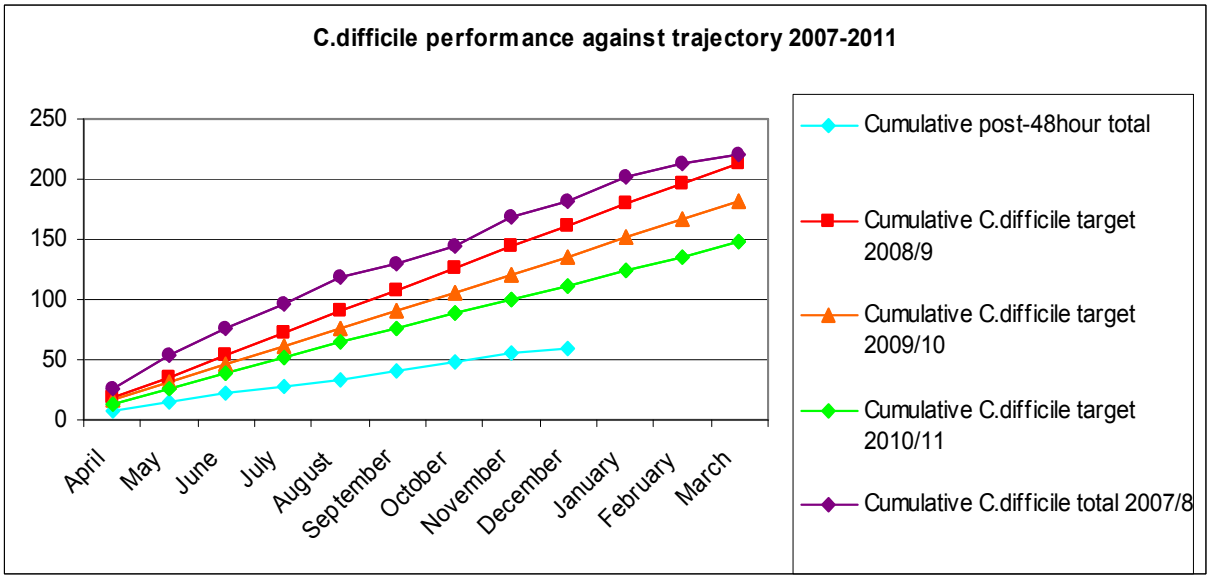
Improved laboratory testing for C. difficile with twice daily testing during the week and once daily at weekends.

All inpatients with diarrhoea are tested up to three times per week for C. difficile to ensure that cases are not missed.

Use of hydrogen peroxide fogging to enhance cleaning following C. difficile outbreaks/incidents.

Data

C. difficile



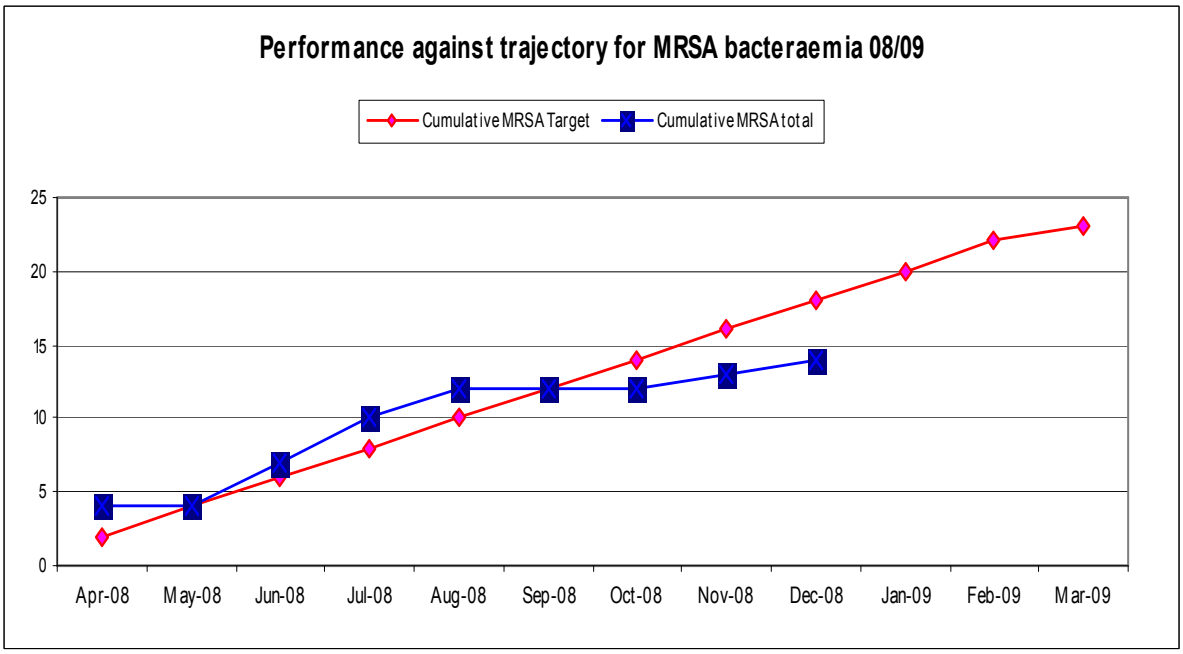
Numbers of C. difficile are well below the SHA stretch target as shown above. For the first half of 2008/9 there were 57 C. difficile infections diagnosed in inpatients (40 of which were post 48 hours) compared with 160 diagnoses in inpatients for the same period of 2007/8, a reduction of 64% year on year. This reduction is continuing and the Trust currently has the lowest rate of C. difficile infection in the South East Coast SHA.

MRSA

At the end of March 2008 the Trust achieved the national target of a 50% reduction in MRSA bacteraemia (blood stream infection).

Against the current year trajectory the number of cases seen in the trust is 14 (YTD target 18) – see graph below.

The trust has increased MRSA screening to all elective cases to comply with DoH guidance and will be further increasing screening over the next year to eighteen months to achieve universal admission screening.



Sara Mumford
DIPC
18 December 2008

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Core Standards C4c Decontamination – Reporting & Learning – Action Plan – Maidstone & Tunbridge Wells NHS Trust

Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

Element:

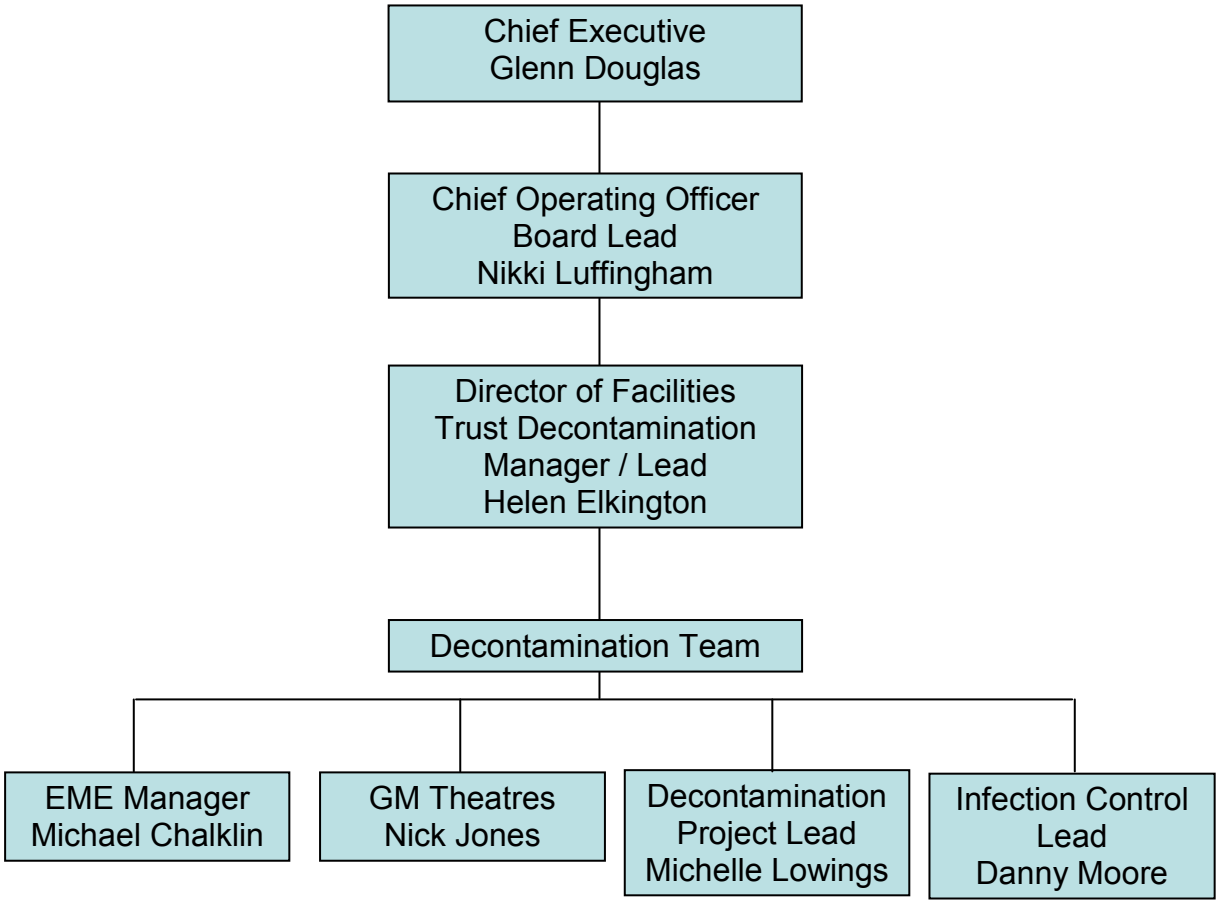
	Line of Enquiry	Action	Success Criteria	Review Date	Lead	Update & Evidence
a	The healthcare organisation has designated a lead manager for decontamination of reusable medical devices used for treatment	Post to be appointed	Director of Facilities briefed on decontamination issues	January 2009	Director of Facilities	Post commencement January 2009
b	The healthcare organisation must, with a view to minimising the risk of HCAI, ensure that there are effective arrangements, including a decontamination programme for the appropriate decontamination of reusable medical devices.	Update policies Medical Devices Decontamination Policy Review Medical Devices Policy Liaison between infection control team and medical devices committee and decontamination project lead Expand maintenance	Policy implementation Policy implementation Monitoring of	Monthly January	Infection control committee Infection control committee S Smith M Lowings M Chalklin	Written policies and procedures Draft awaiting approval December 08 Draft awaiting approval December 08 Minutes of meetings from infection control committee, medical devices committee, decontamination project Maintenance plan to

		year plan	decontamination programme Concise plan of events for decontamination	2009		be review January 2009
c	The healthcare organisation should ensure that decontamination services are provided by an agency that accords with MDD 93/42 and that are registered with an MHRA approved notified body.	Ensure standards of decontamination services meets requirements Work to quality monitoring systems as provided by external bodies (IHSS) Complete national online training	Audit of sterile services Report to In health sterile services technical group Certification for all staff	February 2009 Ongoing review	M Lowings M Lowings	Audit March 08 Action Plan completed and reviewed November 08 Minutes of technical group meetings twice monthly Ongoing for all sterile services staff Technical group sign off on completion expect March 08
d	When commissioning services, the healthcare organisation should satisfy itself that contractors have appropriate systems in place to keep patients, staff and visitors safe from healthcare associated infection, so far as reasonably practicable	External provider vetted and agreed by Trust board New services endorsed by infection control Trust Board final agreement and sign	Service contract agreed Infection control agreement Agreement to readiness by	April 2008 January 2009 June/July 2009	Chief Executive Director of infection control Chief Executive	Contract agreed April 2008 Plans endorsed and signed ongoing signatures required at different phases of the project to be complete by May 2009 External provider commences service in

		off readiness to transfer document	Project Lead, GM Theatres, Directors and Trust Board			July 2009
e	Re-useable medical devices (apart from flexible endoscopes) should be decontaminated in a suitable sterile services environment.	Infection control audit of sterile services Evaluation of existing services Transition to new external services	March 2008 Audit by DOH representative(initial review) 2nd Visit to establish readiness Transfer of services July 2009 national decontamination project (Kent Cluster)	November 2008 November 2008 February 2009 June/July 2009	Daniel Moore M Lowings M Lowings Nick Jones (GM for Theatres) & M Lowings	Audit plan reviewed Nov 2008 all actions completed where feasible remaining actions not addressed due to services going to off site provider July 2009 Audit and action plan review by technical group December 2008 Ongoing reviews of new services Minutes of meetings: (once fortnightly) Project Board: Transition Management Team: Joint Management Board: Technical Group: HR Group: Local Implementation Group:
f	Flexible endoscopes should have their own dedicated area for decontamination as outlined in	Current review of existing environment for decontamination	Service developments achieved in line	November 2008 & Ongoing	D Gaughan	Minutes of meetings held 4th/5th November 2008

	medical devices agency bulletin DB 2002(05)	of endoscopes following HCC visit November 2008 Staff updates and equipment training from company to ensure correct use of decontamination equipment	with healthcare commissions recommendations Washer disinfector/ steriliser training for all endoscopy staff and external users: areas selected staff trained urology investigations unit: Intensive care: Theatres:	 December 2008		Relevant departmental changes to take place scheduled for completion by March 2009. Company approved Certification December 2008

Decontamination Responsibility – Maidstone & Tunbridge Wells NHS Trust



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Core Standard C21 clean, well designed environments – Reporting & Learning – Action Plan Exec Lead. Estates Director – Maidstone & Tunbridge Wells NHS Trust

Statement: Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

Element 1: The healthcare organisation has taken steps to provide care in well designed and well maintained environments including in accordance with Building Notes and Health Technical Memorandum, the *Disability Discrimination Act 1995* and the *Disability Discrimination Act 2005* and associated code or practice.

	Line of Enquiry	Action	Success Criteria	Review Date	Lead	Update & Evidence
C21	The healthcare organisation should have taken steps to provide care in environments that are well designed and well maintained. In taking these steps the organisation should have taken into account the guidance and recommendations from *Developing an estates strategy*, *Estatecode: essential guidance on estates and facilities management*, *A risk based methodology for establishing* and *Managing backlog* and the *NHS Environmental assessment tool*. (please see point of information below for details of each piece of guidance)	The Trust holds a comprehensive library of design information and complies with NHS Guidance, HTM and HBN documents where appropriate. Backlog is assessed and managed in line with the risk based methodology.	No issues raised by patients, visitors and staff.	Ongoing	Phil Marsden	Library and design documentation available.
	The healthcare organisation should also be complying with the Disability	Comprehensive reports have been	No issues raised by patients,	Ongoing	Phil Marsden	DDA reports available

	Discrimination Act 1995. The Disability Discrimination Act 1995 makes discrimination on the grounds of disability, unlawful in respect of, amongst other things, access to goods, facilities, services and premises. The healthcare organisation should ensure that the design and maintenance of its premises do not 'make it impossible or unreasonably difficult for disabled persons to make use of' their services. The organisation should have considered its environment with regards to access to and use of services, and suitability of accommodation and facilities for disabled people.	completed for all our sites identifying DDA issues, these have been reviewed and actions taken where appropriate. All new schemes are design to ensure where possible DDA compliance. Improvement to DDA issues will be taken forward with the opening of the new hospital at Pembury and the development of the estate strategy at Maidstone.	visitors and staff.			
	The Healthcare organisation should be 'able to demonstrate that wards and departments are kept clean'	Quality Audits	Quality audits are programmed to be undertaken in accordance with the NSC risk categories.	Ongoing	Sue Hedges	Quality audits are available to be reviewed. Quality audits are reported quarterly to the IPCC committee. (All evidence is available in a hard copy file which is kept in the facilities office)

	The healthcare organisation should: • Have identified cleaning outcomes based on the national specifications • Have planned cleaning procedures based on levels of risk and priority • Have a system of technical and managerial audits in place to monitor cleanliness levels.	Quality Audits	Quality audits are programmed to be undertaken in accordance with the NSC risk categories.	Ongoing	Sue Hedges	Quality audits are available to be reviewed. Quality audits are reported quarterly to the IPCC committee.
		Domestic staff work schedules.	Work is monitored in additional to the audit programme.	Ongoing	Sue Hedges	Work schedules and rectification sheets.
		Draft Operational Cleaning policy		Under review	Jim Scott	Draft Operational cleaning policy
		The National Specifications for Cleanliness in the NHS: A Framework for setting and measuring performance Operational Plan		Board approved September 2007	Jim Scott	The National Specifications for Cleanliness in the NHS: A Framework for setting and measuring performance Operational Plan (All evidence is available in a hard copy file which is kept in the facilities office)

	The organisation should have in place clear local policies, which include cleaning methods and frequencies, risk protocols and local service level agreements for each functional area	Infection Control policy and procedures. BICSc methods for cleaning. Frequencies are based on NSC guidelines. Service level agreements not yet in place.	Reduced infection rates. Improved standards Improved standards	Ongoing Ongoing Ongoing March 2009	Sue Hedges Sue Hedges Sue Hedges Sue Hedges	Policy and Procedure Training records NSC Guidelines (All evidence is available in a hard copy file which is kept in the facilities office)
	The healthcare organisation should have adopted the commitments of 'A matron's charter'. This document 'sets out 10 broad commitments that should be adopted everywhere in the NHS' The document states that the commitments should be used as a basis for discussion, as a spur to teams to audit their practice, as a foundation for developing service ideals and as a tool to enable local targets for improvement to be set.	Facilities Manager Soft FM attends the weekly Site meetings to update ward managers and matrons on any cleaning related issues. All ward managers and matrons receive copies of audit reports. Patient Environment Strategy Group	Improved communication Improved understanding of cleaning issues. High level group allowing any specific issues to be raised to Board level.	Ongoing Ongoing Ongoing	Sue Hedges Sue Hedges Jim Scott	Meeting Minutes Audit reports Meeting Minutes

		National Standards of Cleanliness operational group	Review trends and highlight areas of concern to feed into the PESG group	Ongoing	Sue Hedges	Meeting Minutes (All evidence is available in a hard copy file which is kept in the facilities office)
	Revised guidance on contracting for cleaning states that the organisation should have systems in place to assess the effectiveness of its cleaning programmes and should have benchmarked its performance and outcomes against other healthcare organisations of a similar type and size.	ERIC reports PEAT Assessments	 Continued improvements in scores	Ongoing Ongoing	Sue Hedges Jim Scott	ERIC Data PEAT Scores (All evidence is available in a hard copy file which is kept in the facilities office)

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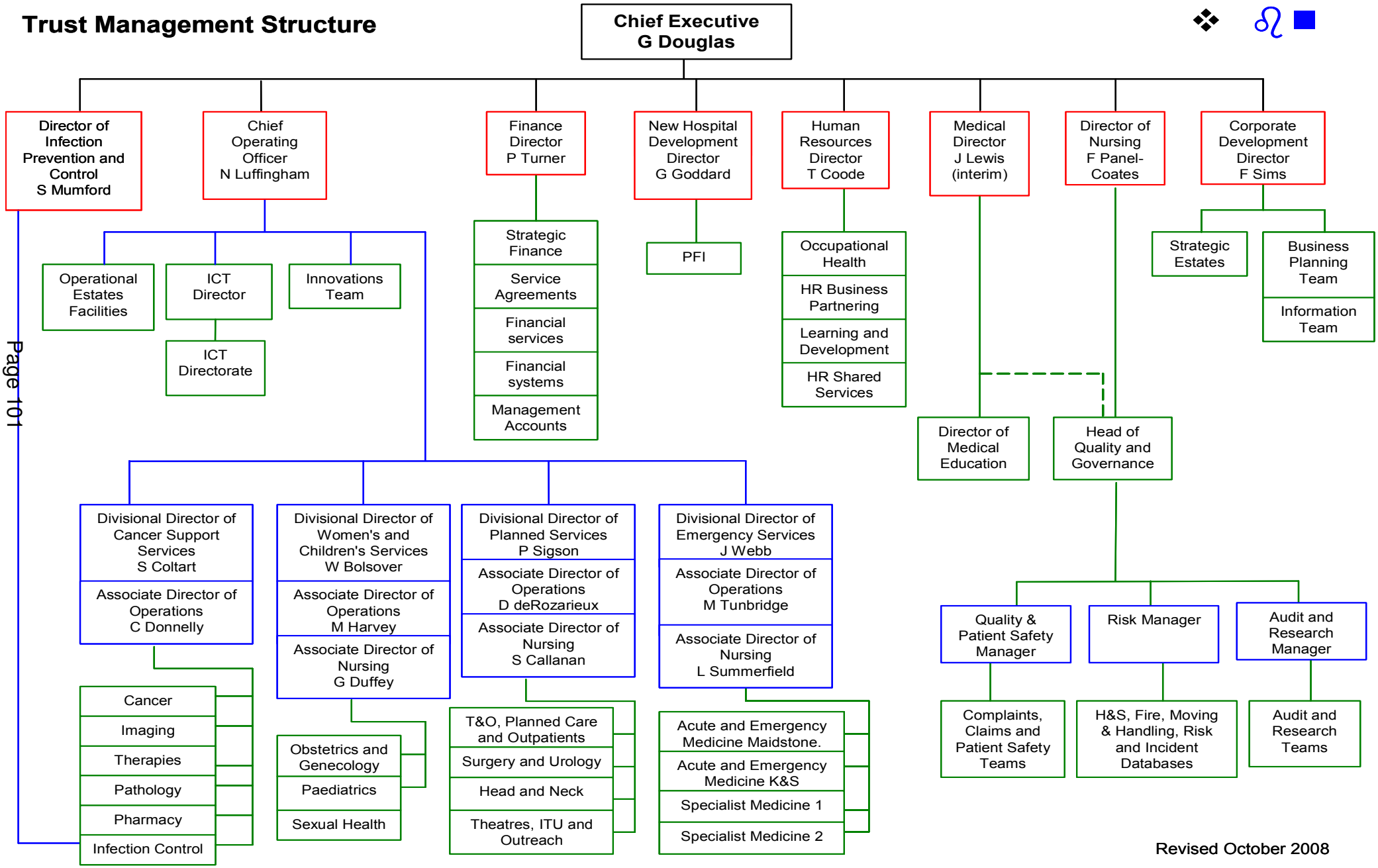
Maidstone & Tunbridge Wells NHS Trust

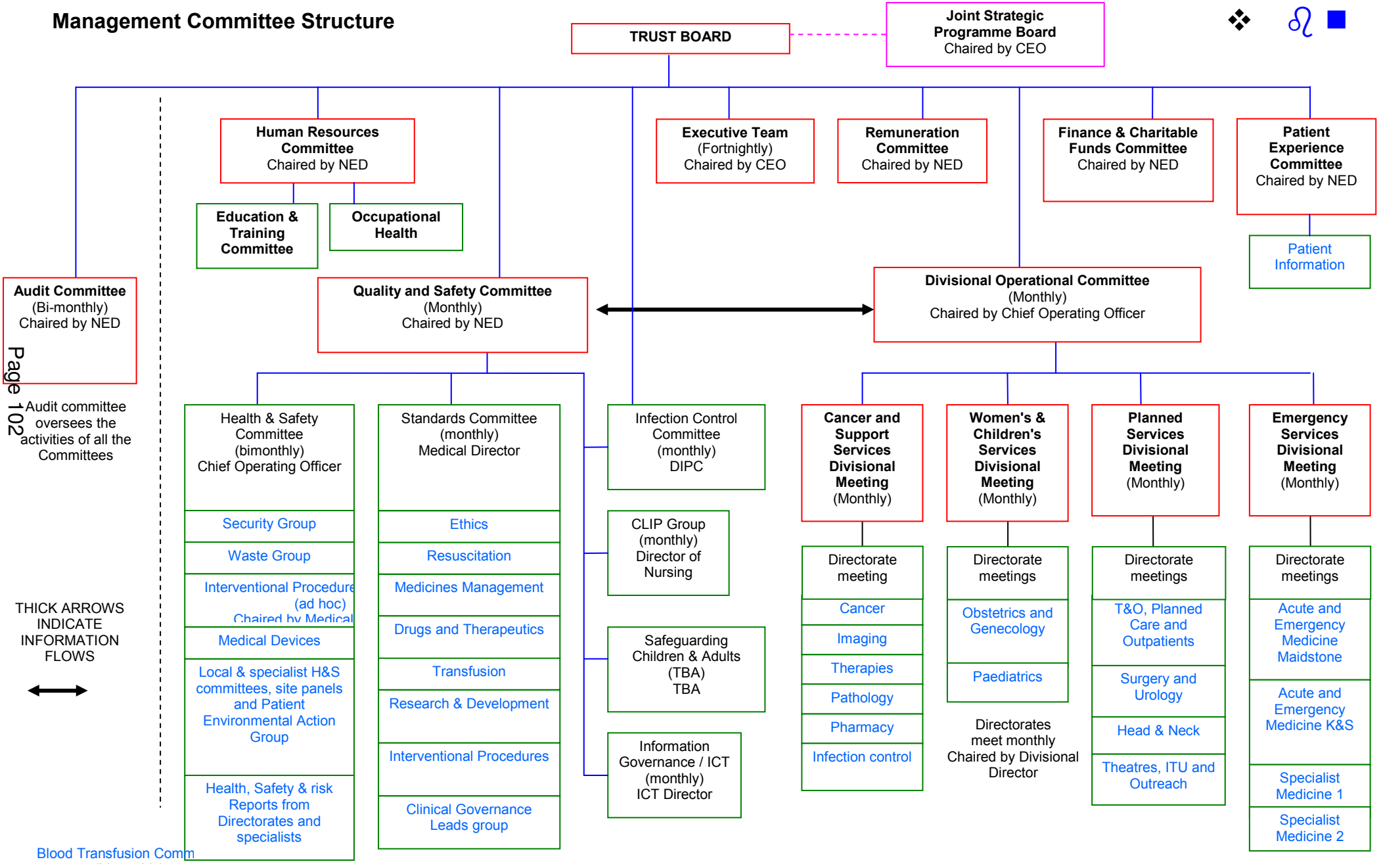
Trust Management Structure



Revised October 2008

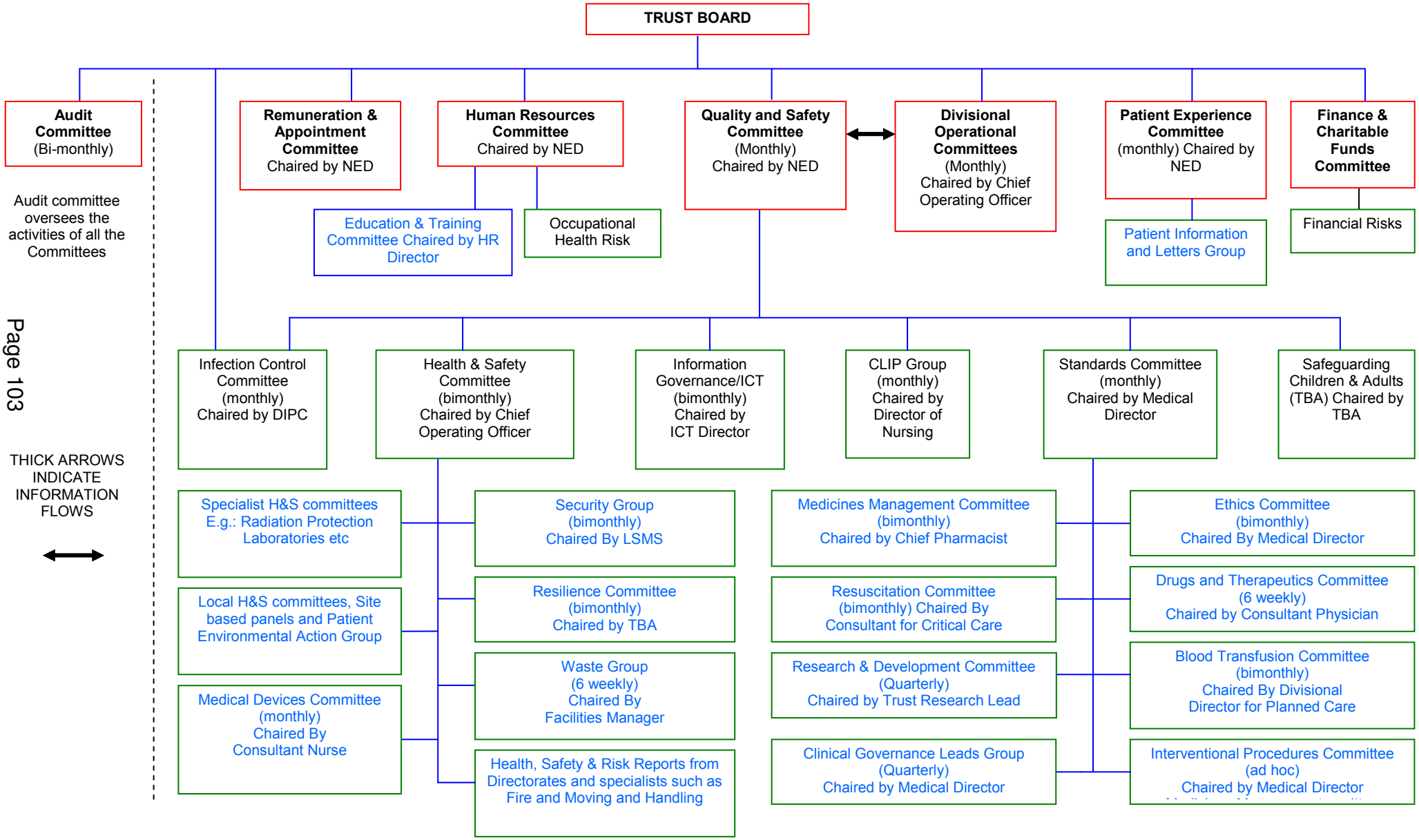
Maidstone & Tunbridge Wells NHS Trust

Management Committee Structure



Maidstone & Tunbridge Wells NHS Trust

Governance Structure



Revised October 2008

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NHS
Eastern and Coastal Kent

Report to the KCC. Health Overview and Scrutiny Committee
January 9th 2008

Hygiene Code and Standards for Better Health Compliance

1. Introduction

Eastern and Coastal Kent Primary Care Trust has two components:

- Eastern and Coastal Kent Community Services – Health Care Service Provider
- NHS Eastern and Coastal Kent – Commissioner

The following report has two sections to capture both the provider and commissioning elements of the organisation.

The report gives an update for the HOSC on the process for ensuring improved compliance against Standards for Better Health and the Hygiene code in 2008/09.

The paper explains the current position in relation to the relevant standards outlines progress achieved for the current year and explains the assurance processes within the PCT to ensure improvement against the core standards.

SECTION 1

2. Current Position for Eastern and Coastal Kent Community Services

2.1 Standards for Better Health Compliance

Standard	2006/07	2007/08	2008/09 estimated	Notes
C4a Infection control				Compliant from end March 2008
C4c Decontamination of medical devices			**Compliant by end March 2009**	No SLA with Medway Foundation Trust for Swale decontamination activity. Now rectified. More stringent guidance on management of bench top sterilizers. Action plans in place and monitored to mitigate risks
C21 Clean Safe Environments				All clinical sites audited monthly to assess cleaning standards, scores averaging at 93%

Figure 1

2.2 MRSA Bacteraemias

MRSA Bacteraemias	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Year to date
Eastern and Coastal Kent Community Services	0	0	0	0	0	0	0	0	0
Other Community Healthcare providers	1	2	1	1	1	1	0	0	7

Figure 2

Figure 2 shows the number of year to date MRSA bacteraemias attributed to the community.

The community sector includes GP practices, the care home sector, independent sector and prisons.

From 2009/10 community MRSA bacteraemia trajectories will be set:-

- There have been no cases attributed directly to Eastern and Coastal Kent Community Services
- Robust Root Cause Analysis is undertaken for each individual case

2.3 Clostridium Difficile Infection

Clostridium difficile	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Year to date
Eastern and Coastal Kent Community Services	0	0	0	0	0	1	2	2	5
Other Community Healthcare providers	10	8	9	6	8	12	4	11	71
Combined Community Trajectory	16	16	16	16	16	15	15	15	125

Figure 3

Figure 3 shows the number of year to date *Clostridium difficile* cases attributed to Eastern and Coastal Kent Community Services. The community sector includes GP practices, the care home sector, independent sector and prisons.

- A root cause analysis is undertaken for each case of Clostridium difficile infection.

- There has been a year on year reduction in Community Hospital cases as indicated in Figure 4

Year	Number of *Clostridium difficile* cases
2006/07	18
2007/08	7
2008/09	5 Year to date

Figure 4

2.4 Deal Hospital Outbreak

Of the 5 cases, 3 occurred in an outbreak in Deal Hospital:-

- The outbreak was reported and investigated as a serious untoward incident.
- Unable to determine the source of infection as the first two patients had been in the local acute Trust as well as a Community hospital
- Third case attributed to Community hospital

Root Cause Analysis Findings:-

- A delay in communicating of laboratory results resulting in a delay in deep cleaning, as infection status of patient not known
- No clear documented rationale for the prescribing of antibiotics

Changes in Practice as a result of Root Cause Analysis:-

- Robust communication system now in place for informing Community Hospitals of laboratory results.
- Dr Chandrakumar (Director Kent Health Protection Unit) has written to all GPs reminding them of antibiotic prescribing guidelines and the need for good documentation.
- Antibiotic prescribing documentation will be audited by the antibiotic prescribing advisor

3. Hygiene Code Performance Report

Appendix one shows the monthly performance report against the hygiene code for Eastern and Coastal Kent Community Services. The reasons for the 5 indicators still designated as amber are explained with the actions planned to address these gaps.

4. Changes made in practice to improve infection control

- The infection prevention link worker network expanded from 30 at the beginning of the year to over 150, and includes representatives from all clinical services.
- Link workers ensure policies are available in the workplace and that staff are aware of these, they assist in the induction of new staff
- The link workers are at the forefront of promoting good hand hygiene, which is the single most effective intervention to prevent HCAIs.

- The link worker programme includes all disciplines of clinical staff and hotel services staff, to promote cooperative working and an understanding of the rationale behind different cleaning requirements.
- The National Patient Safety Agency 'cleanyourhands' campaign has been made available to community services, implementation commenced in July 2008.
- Each member of staff has their hand hygiene knowledge and technique assessed annually (by the infection prevention link worker); which is reported to the Performance Board on a monthly basis.
- Community Hospital staff have training and support in the assessment of patients with diarrhoea in order to ensure prompt isolation and treatment of patients if necessary

5. Successes, challenges and issues in implementing the Hygiene Code

5.1 Community Services

- A more educated workforce by improving the quality and accessibility of training
- Infection prevention and control training now includes all clinical and non-clinical staff that have any contact with service-users, equipment or premises.
- All clinical services maintain their own database of training, thus ensuring compliance with training
- Expansion of the link worker programme to support engagement and ownership of infection prevention at the service level.
- The major challenge has been in creating an infection prevention service from scratch, as prior to December 2007 this was not coordinated as no specialist was in post.

6. Framework for assurance in Standards for Better Health

Following the April 08 declaration an action plan was developed picking up the gaps in evidence identified in the validation panels. Clear milestones for actions were identified and monitored monthly by a community services performance group attended by the community services chief operating officer and deputy director of assurance for the PCT.

An interim report was presented to the November Board outlining any changes to the guidance, process for assurance for 08/09 declaration and progress against the action plan.

The process for assurance is mirroring that of last year which was assessed by the internal auditors as having:

"Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that the processes applied by the PCT stand up to scrutiny and should result in an accurate declaration."

6.1 Eastern and Coastal Kent Community Services

- Community Services are managing their own validation process before presenting to the PCT validation panels in February. A standards for better health co-ordinator has been appointed to ensure a robust process is in place.
- In November 08, senior managers heard presentations from each standard lead and had the opportunity to question the evidence presented to ensure it was sufficient to show compliance.
- A report was developed outlining the themes and gaps identified which was presented to the December 08 integrated governance sub committee.
- The Hygiene code is monitored monthly by the community services performance group, as is progress against Standards for Better Health.

7. Performance management

7.1 Community Services

- The above information is reported to the community services infection prevention and cleanliness group.
- The infection prevention and cleanliness group reports to the clinical quality and safety sub committee, community services management board, community services performance management committee and the commissioning local health economy infection prevention and control committee.
- Additional reports are made to the medical devices and decontamination group.

8. Staff and Patient involvement in infection control issues

- The NPSA “cleanyourhands” campaign promotes patient involvement by the ‘OK to Ask’ initiative. Leaflets and posters are distributed on the wards encouraging patients to ask staff if they have cleaned their hands before any contact.
- Infection prevention is a standing item on local governance group agenda, with a cascade of information and feedback throughout the organisation.
- Over 150 Staff link workers in place.

SECTION 2

NHS Eastern and Coastal Kent Commissioning

1. MRSA Bacteraemias and *Clostridium difficile*

The Infection Prevention and Control Team and Committee monitor incidence of MRSA and *C.diff*icile against trajectory and scrutinise root cause analysis and action plans that address breaches. Trends are monitored, emergent themes are discussed and actions agreed to share learning and improve practice across the local health economy.

2. Hygiene Code Compliance

The Infection Prevention and Control Committee, scrutinise and monitor compliance against the statutory hygiene code monthly, providers are asked to submit detailed action plans to address deficits and shortfalls. Milestones of action plans are monitored to ensure implementation and improve compliance.

3. Changes made in practice to improve infection control

- The Health Care Associated Infections Project development group scrutinises all root cause analysis and monitors actions to ensure identified learning is implemented in practice.
- The Infection Prevention and Control Committee, discuss the findings of root cause analysis and share learning, to improve practice across the local health economy
- Facilitation of workshops and conference to share learning and best evidence based practice across the local health economy.
- Have taken national drivers and initiatives for infection prevention and control and translated to local operational level
- Identified non NHS Health and Social Care providers and allocated resources to optimise principles and learning for robust hand hygiene practice.
- Participated in the national pilot and rollout of a standardised approach for root cause analysis.

4. Successes, challenges and issues in implementing the Hygiene Code

Infection Control Team in place:

- Head of Infection Prevention & Control
- HCAI Project Manager
- HCAI Data Analyst
- Team Secretary

Projects completed:

- Local Health Economy Transfer of Care Benchmarking Document
- RCA Train the Trainers
- Cleaning Standards Benchmarking Policy
- Hand Hygiene Media Campaign
- Antibiotic Prescribing Benchmarking Project
- Media Campaign

Benchmarking documents produced for:

- Management of Patients with *Clostridium difficile*
- Transfer of Care for Patients with *Clostridium difficile*/Diarrhoea
- Transfer of Care for patients with a Known or Suspected Infection/Colonisation
- Cleaning Standards Benchmarking Document

- Infection prevention and Control Key Performance Indicators for Hospital Matrons
- Key Performance Indicators in Provider Contracts
- Infection prevention and Control Key Performance indicators in EKHUT contract

World Class Commissioning framework

- Have a World Class Commissioning model in place to ensure infection prevention and control is a priority when seeking assurance of patient safety and quality with all commissioned services
- Have shared NHS Eastern and Coastal Kent's Infection Prevention and Control model across the South East Coast region

Root Cause Analysis

- Participated in the national pilot and rollout of a standardised approach for root cause analysis

5. Framework for assurance in Standards for Better Health

- Meetings have been held with each of the standard leads going through the guidance and making sure the leads are aware of what needs to be evidenced.
- Validation panels have been organised for the second week in February 09; they will be made up of a non-executive director and a director, neither of whom have any responsibility for the area of work in question, and an assistant director who is familiar with the area of work to provide additional clarification where necessary.
- The panel will examine the evidence provided to ensure there is sufficient to support a declaration of compliance. The Board will sign off the declaration in March ready to submit to the Care Quality Commission in April 2009

6. Performance Management

- Infection Prevention and Control is a standing agenda item for the Patient Safety and Quality Sub Committee
- Infection Prevention and Control is the first standard agenda item at Trust board meetings.
- The monthly local health economy infection prevention and control committee, monitors performance, progress and actions in the following areas:

    - Scrutinises provider performance against MRSA and Clostridium difficile targets
    - compliance with the statutory Hygiene Code
    - Deaths attributed to MRSA bacteraemia
    - Deaths attributed to *Clostridium difficile*
    - Deep cleaning and cleaning standards

- Clinical Quality Performance indicators, including MRSA screening, Hand Hygiene, Isolating and cohorting, Mandatory infection control training
- Immunisation and Vaccination data
- Health protection Unit reported outbreaks themes and trends
- Root cause analysis is scrutinised and assurance sought that actions and learning are implemented in practice
- Delays in transfer of care as a result of a healthcare associated infection
- Outbreak information and data for winter planning

7. Staff and Patient involvement in infection control issues

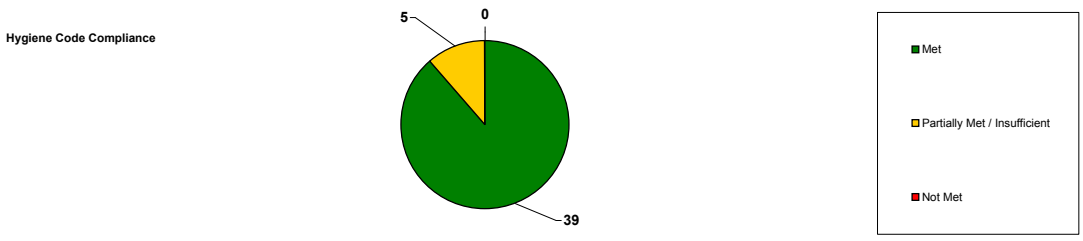
- Road shows were held in each of the 5 PCT localities on health and wellbeing. Members of the Board were available for a question and answer session and a presentation on infection control was undertaken at each of them.
- A media campaign was launched with KMFM and Kent on Sunday – Clean Hands, comprising of a series of "infomercials" regularly transmitted on the radio, interviews on the radio with our head of infection prevention and control and articles in the newspaper.
- Phase two of the media campaign working with schools to promote awareness of hand hygiene in the community.
- Members of our health matters group (members of the public) sit on 3 of our key committees that monitor infection prevention and control, the local health economy infection prevention and control sub committee, patient safety group and the clinical and quality sub committee.
- The PCT held a clinical conference in Dover "Engaging in Excellence" which was attended by clinicians and members of the public.

8. Conclusions

Infection Prevention and Control is a top priority for Eastern and Coastal Kent Community Services and NHS Eastern and Coastal Kent, as such it is embedded throughout the whole organisation. We have adopted a zero tolerance approach to all avoidable infections.

The systems and processes in place ensure robust and timely monitoring of incidences of healthcare acquired infection, thorough root cause analysis of each incidence and learning across the health economy.

Hygiene Code Compliance (Nov 08)



		Status					
Duty	**Indicator**	**Apr 08**	**Oct 08**	**Nov 08**	**Action**	**Action Owner**	**Deadline**
1a	As so far as is reasonably practicable, patients, staff and other persons are protected against risks of acquiring HCAIs, through the provision of appropriate care, in suitable facilities, consistent with good clinical practice.	Green	Green ►	Green ►	i) Maintain and improve sites as needed, linked to infection risks. ii) Ensure alcohol hand rubs are available at point of care. iii) Cleaning Audits.	Head of sites Hotel Services Manager & Clean your hands leads Hotel Services Manager	In place, now ongoing monitoring and improvement as necessary
1b	Patients presenting with an infection or who acquire an infection during treatment are identified properly and managed according to good clinical practice, for the purposes of treatment and to reduce the risk of transmission.	Amber	Green ▲	Green ►	i)All staff adhere to infection prevention manual (provided by Kent Health Protection Unit) ii) Introduce care pathways for C.Diff and MRSA management of in-patients, using EKHT model	Heads of Service Community Hospital Matrons Head of Infection Prevention	In place, ongoing monitoring Oct 2008 C.diff management plan in place. EKHUT MRSA not appropriate so will not be shared (as we do not screen)
2a	A Board level agreement outlining its collective responsibility for minimising the risks of infection and the general means by which it prevents and controls such risks.	Green	Green ►	Green ►	No action required, target achieved.		Completed
2b	The designation of an individual as director of infection prevention and control (DIPC) accountable to the Chief Executive and the Board.	Green	Green ►	Green ►	Assistant Director Adult Clinical Services confirmed as DIPC. Head of Infection Prevention confirmed as Deputy DIPC.	Chief Operating Officer DIPC	Completed Published: November 2008 Edition
2c	The mechanisms by which the Board intends to ensure that adequate resources are available to secure the effective prevention and control of HCAI's. These should include implementing an appropriate assurance framework, infection control programme and infe	Amber	Amber ►	Amber ►	i) Healthcare Associated infection rates are monitored monthly, reporting to PCT Commissioning Infection Prevention and Control sub committee which is chaired by Director of Nursing and attended by Medical Director of PCT, the Community Services Management Board chaired by Non Executive Director. Performance data is reported to the Board monthly as part of a wider patient safety report. ii) Progress against infection prevention programme monitored bi-monthly at Infection Prevention Cleanliness Group and Clinical Quality & Safety Committee. The only reason this indicator remains amber is that the community services infection prevention and control team continues to be incomplete is due to the outstanding vacancy of Lead Nurse - infection prevention and control. Closing date for applications is December 17th 2008.	Head of Infection Prevention & DIPC Head of Infection Prevention Head of Integrated Governance Head of Infection Prevention Hotel Services Manager Heads of Service Head Infection Prevention	Ongoing reporting with resultant action to correct anomolies. Staff member in place by end March 09
2d	Ensuring that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks	Green	Green ►	Green ►	i) Numbers of staff needing annual mandatory training to be identified ii) Face to face training sessions to be commissioned via external provider iii) Monitor training monthly, taking steps to deal with non-compliance via discipline policy.	Heads of Service Head of Sites Head of Infection Prevention Learning and Development Lead Head of Infection Prevention Heads of Service	September 08 complete July 08, sessions to start Sept 08 1000 places made available On-going
2e	A programme of audit to ensure that key policies and practices are being implemented appropriately.	Amber	Amber ►	Amber ►	Hand hygiene compliance audits are in place and each community hospital has an annual infection prevention audit, howeveran overall audit programme is not yet complete as we do not have a complete cycle of audit and reporting through the relevant governance groups.	Head of Infection Prevention	Audits commenced re hand hygiene, but need to progress essential steps.
2f	A policy addressing, where relevant, the admission, transfer, discharge and movement of patients between departments, and within and between healthcare facilities.	Amber	Green ▲	Green ►	Incorporated in HPU policy, to be incorporated within documentation re admission risk assessment, transfer and discharge in Community Hospitals.	Deputy Clinical Services Manager - Community Hospitals	Oct. 08 Complete

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3a	Made a suitable and sufficient assessment of the risks to patients in receipt of healthcare with respect to HCAIs	Amber	Green ▲	Green ►	Infection prevention risk assessment to be added to inpatient admission documentation. Infection risk assessment to be added to initial assessment of new patients/clients referred to other clinical services.	Deputy Heads of Service – Community Hospitals Heads of Clinical Services Louise Cameron	Oct 08 Local RA complete for inpatients, compliance with this documentation to be addressed by Matrons. Dec 08 RA for other services going to records management group for approval
3b	Identified the steps that need to be taken to reduce or control those risks	Amber	Green ▲	Green ►	As 3a	As 3a	As 3a
3c	Recorded its findings in relation to items (a) and (b)	Amber	Green ▲	Green ►	As 3a	As 3a	As 3a
3d	Implemented the steps identified	Amber	Green ▲	Green ►	As 3a	As 3a	As 3a
3e	Appropriate methods in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAIs	Amber	Amber ►	Amber ►	Infection control risks included on the community services risk register, the commissioning risk register and a specific commissioning patient safety risk register. They are reported into the PCT integrated governance sub committee and the patient safety and quality sub committee, all sub committees of the PCT Board. The reason this indicator remains amber is that community services are improving their infection surveillance programme, to cover more than just MRSA and C. Diff, this will be accompanied by training to support clinical staff	Head of Infection Prevention	Dec. 08
4a	There are policies for the environment that make provision for liaison between the members of any infection control team (ICT) and the persons with overall responsibility for facilities management	Green	Green ►	Green ►	Infection prevention Cleanliness Group attended by Hotel Services Manager. Include Hotel Services draft in Link Worker Programme	Hotel Services Manager Head of Infection Prevention	Ongoing
4b	It designates lead managers for cleaning and decontamination of equipment used for treatment (a single individual may be designated for both areas).	Green	Green ►	Green ►	No action required, target achieved.		Completed
4c	All parts for the premises in which it provides healthcare are suitable for the purpose, kept clean and maintained in good physical repair and condition.	Green	Green ►	Green ►	Monthly cleaning audits by Hotel Services. Quarterly involving Hotel services and Matrons	Community Hospital Matrons Hotel Services Manager	Ongoing
4d	The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available.	Amber	Green ▲	Green ►	Cleaning schedules available in some areas, to be made available in all areas	Hotel Services Manager	Completed
4e	There is adequate provision of suitable hand washing facilities and antibacterial handrubs.	Green	Green ►	Green ►	No action required, target achieved.		Completed
4f	There are effective arrangements for the appropriate decontamination of instruments and other equipment	Green	Green ►	Green ►	No action required, target achieved.		Completed
4g	The supply and provision of linen and laundry supplies reflect Health Service Guidance (HSG) (95) 18 **Hospital Laundry Arrangements for Used and Infected Linen**, as revised from time to time.	Green	Green ►	Green ►	No action required, target achieved.		Completed
4h	Uniform and workwear policy ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose.	Green	Green ►	Green ►	No action required, target achieved.		Completed
5a	Duty to provide information on HCAIs to patients and the public about the organisation's general systems and arrangements for preventing and controlling HCAIs	Amber	Amber ►	Amber ►	Department of Health leaflets (simple guide to CDiff, simple guide to MRSA, NICE guidance MRSA outside hospital) are made available in some areas to patients. To be made more widely available in hospitals and health centres.	Communications Team Head of Infection prevention	Feb. 2009
5b	Duty to provide information on HCAI's to patients and the public, to each patient concerning: • Any particular considerations regarding the risks and nature of any HCAI relevant to their own care • Any preventative measures relating to HCAIs that a p	Amber	Amber ►	Amber ►	As 5a	As 5a	As 5a
6	Must ensure that it provides suitable and sufficient information on a patient's infection status whenever it arranges for that patient to be moved from the care of one organisation to another, so that any risks to the patient and others from infection can	Green	Green ►	Green ►	Infection prevention risk assessment to be added to inpatient admission documentation. IP risk assessment to be added to initial assessment of new patients/clients referred to other clinical services.	Deputy Heads of Service - Community Hospitals Heads of Clinical Services	Oct 08 - achieved Nov 08
7	So far as is reasonable practicable, ensure that its staff, contractors and others involved in the provision of healthcare co-operate with it, and with each other, so far as is necessary to enable the body to meet its obligations under this Code	Green	Green ►	Green ►	Continue to engage with other providers in root cause analysis for MRSA bacteraemias, cases of C.diff across provider boundaries	Head of Infection Prevention	Ongoing
8	An NHS body providing in-patient care must ensure that it is able to provide, or secure the provision of, adequate isolation facilities for patients sufficient to prevent or minimise the spread of HCAIs	Green	Green ►	Green ►	No actions		Completed
9	If services are provided by a microbiology laboratory in connection with the arrangements it makes for infection prevention and control, the laboratory has in place appropriate protocols and that it operates according to the standards from time to time re	Green	Green ►	Green ►	No actions		Completed
10a	Standard (universal) infection control precautions	Amber	Green ▲	Green ►	KHPU policies in place, review date has passed. KHPU given completion date of 0ct 08. Rolling programme of policy audits to be set up.	Kent Health Protection Unit Head of Infection Prevention Audit Leads Heads of Services	Completed manual to go to CQ&S for adoption then to be printed and distributed to community hospitals Available in hard copy for community
10b	Aseptic technique	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a

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10c	Major outbreaks of communicable infection	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a
10d	Isolation of patients	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a
10e	Safe handling and disposal of sharps	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a
10f	Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries.	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a
10g	Management of occupational exposure to BBVs and post-exposure prophylaxis.	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a
10h	Closure of wards, departments and premises to new admissions	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a
10i	Disinfection policy	Amber	Green ▲	Green ►	As 10a	As 10a	As 10a
10j	Antimicrobial prescribing		Green	Green ►	Antibiotic prescribing audits	Head of Community Pharmacy	Antimicrobial prescribing policy in place, pharmacy technician appointed, will commence audits.
10l	Control of infections with specific alert organisms, taking account of local epidemiology and risk assessment. These infections must include, as a minimum, MRSA, CDiff infection and transmissible spongiform encephalopathies	Amber	Green ▲	Green ►	Infection prevention risk assessment to be added to inpatient admission documentation. IP risk assessment to be added to initial assessment of new patients/clients referred to other clinical services.	Deputy Heads of Service - Community Hospitals Heads of Service	Oct 08 - achieved Nov 08 See duty 3
11a	All staff can access relevant occupational health services	Green	Green ►	Green ►	No action required, target achieved.		Completed
11b	Occupational health policies on the prevention and management of communicable infections in healthcare workers, including immunisation, are in place.	Green	Green ►	Green ►	No action required, target achieved.		Completed
11c	Prevention and control of infection is included in all programmes for new staff, and in training programmes for all staff.	Green	Green ►	Green ►	No action required, target achieved.		Completed
11d	There is a programme of ongoing education for existing staff (including support staff, agency/locum staff and staff employed by contractors)	Green	Green ►	Green ►	No action required, target achieved.		Completed
11e	There is a record of training and updates for all staff	Green	Green ►	Green ►	All training to be recorded locally on staff records, and corporately on ATL system	Heads of Service Learning and Development Lead	Ongoing
11f	The responsibilities of each member of staff in the Prevention and Control of Infection is reflected in their job description and in any personal development plan or appraisal	Green	Green ►	Green ►	Infection prevention incorporated into JDs, PDP and appraisal.	Heads of Service	Ongoing

* Updated monthly

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