AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 6th February, 2009, at 10.00 am
Council Chamber, Sessions House,
County Hall, Maidstone

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

Tea/Coffee will be available from 9:45 am

Membership (21)

Conservative (12):	Mr B R Cope (Chairman), Mr A R Chell, Mr A D Crowther, Mr J Curwood, Mr C G Findlay, 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 and Mr R Tolputt
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
District/Borough Representatives (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 of the meeting held on 9 January 2009 - to follow	
4.	Audiology Updates (Pages 1 - 6)	
	Annual Health Check	
5.	East Kent Hospitals University Trust (Pages 59 - 110) *Julie Pearce, Director of Nursing, Midwifery & Quality Louise Dineley, Head of Patient Safety will be in attendance for this item.*	10:15 - 11:15 am
	Break 11:15 - 11:30 am	
6.	West Kent Primary Care Trust (Pages 111 - 142) *Daryl Robertson, Interim Deputy Chief Executive/Director of Planning and Performance, Barrie Collins, Director of Nursing/Director of Infection, Prevention and Control and Anne Carroll, Assistant Director of Clinical Quality will be in attendance for this item.*	11:30 am - 12:15 pm

7. Local Involvement Network (LINk) 12:15 - 1:00 pm

8. Date of next programmed meeting – Friday 20 March 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

29 January 2009

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

NHS
Eastern and Coastal Kent

Audiology Services in East Kent Briefing Paper
January 2009

This paper is intended to give an update on the services currently provided by the Audiology Service commissioned by Eastern and Coastal Kent PCT and the future plans of the service.

Background and need for change:-

Referrals for Audiology services are made through one of three routes, via ear nose and throat Services, via direct access referrals from GPs into Audiology and self referrals made by patients who are upgrading their analogue hearing appliance for a digital aid.

Just over a year ago the average wait for the Audiology service in East Kent was in excess of 52 weeks, peaking in July of 2007 when the average wait was 96 weeks.

In September 2007 East Kent recognised over 5000 patients waiting (see table 1 below) with an average wait of 85 weeks.

The challenge for East Kent was to radically reduce the long waiting list and to bring waiting times in line with the national commitment to the 18 week referral to treatment target.

Key milestone achievements:-

Significant developments have been made within this service over the last year, especially with regards to East Kent Hospitals University NHS Trust (EKHUT) waiting lists.

In direct response to the challenge to reduce the long waiting list the PCT commissioned Hearbase as independent audiologists to help reduce long waiters; they agreed to treat circa 2000 patients by the end of March 2008. Hearbase currently work out of four sites based in Folkestone, Ashford, Canterbury and Dover.

In addition the PCT commissioned a community audiologist to work out of three GP practices (Whitstable, Deal and Ramsgate) to further reduce the backlog of waiters.

At the end of March 2008 the number of people waiting for audiology services at EKHUT were reduced below the target to 1056 of these only 449 patients were waiting longer than 18 weeks through their own choice and the remaining 605 patients were all on 18 week pathways.

In recognition of the continued challenge to the provision and sustainability of audiology services in East Kent, Eastern and Coastal Kent PCT made provision for an additional £1.7m to be made available through the Local Delivery Plan process to

be used in securing additional capacity through the local hospital provider and an increase in community based services. In addition this funding will assist in dealing with an anticipated up turn in demand based on the success of securing reduced waits into the service, and the continued number of patients that might take up the opportunity to change their analogue aids for digital equipment.

April 2008

In April 2008 a fourth community audiology clinic was opened at Sittingbourne, to further support the drive for care closer to the home and to bring a much needed choice alternative to swale patients. Historically Swale patients have been referred to Medway NHS Foundation Trust for all audiology treatment.

November 2008

At the end of November 2008 the number of patients waiting for audiology services at EKHUT is 742 (see table 2 below); all patients are on 18 week pathway (assessment - fitting) which is in line with the national standard for all elective services. Direct access patients all have their assessment within 6 weeks and wherever possible and medically appropriate patients are often assessed and fitted on the same day. Over 95% of people on the current waiting list profile will be both assessed, and fitted with a hearing aid within 11 weeks. 67% of people identified on the profile will be assessed and treated within 6 weeks of referral.

Open ear testing is also widely used, again where medically appropriate

Table 1 Waiting List Progress

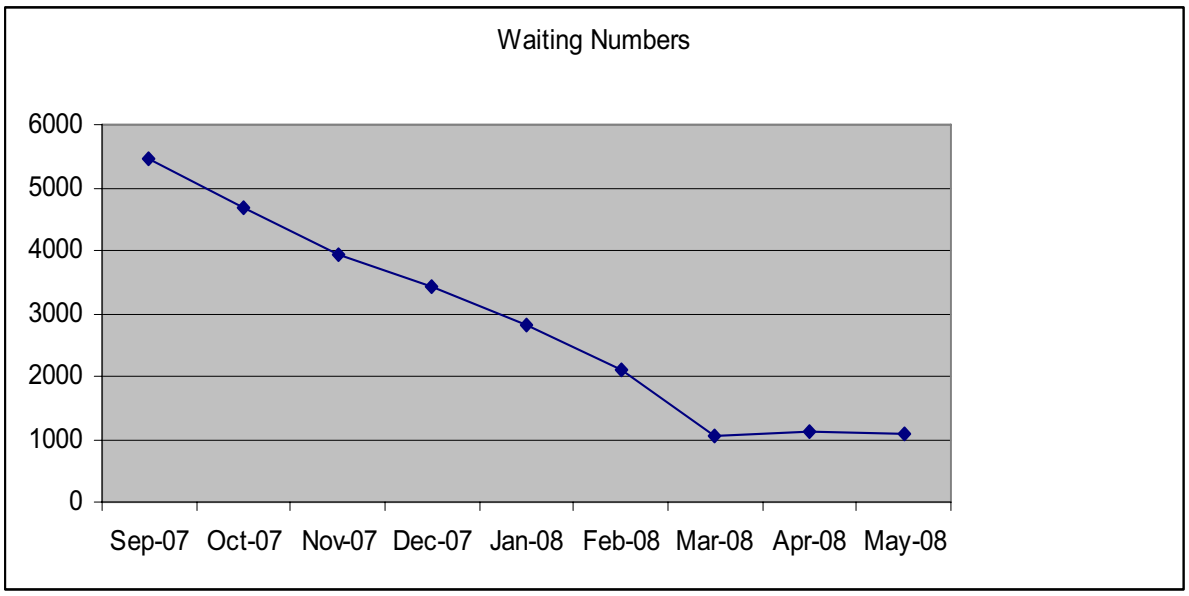
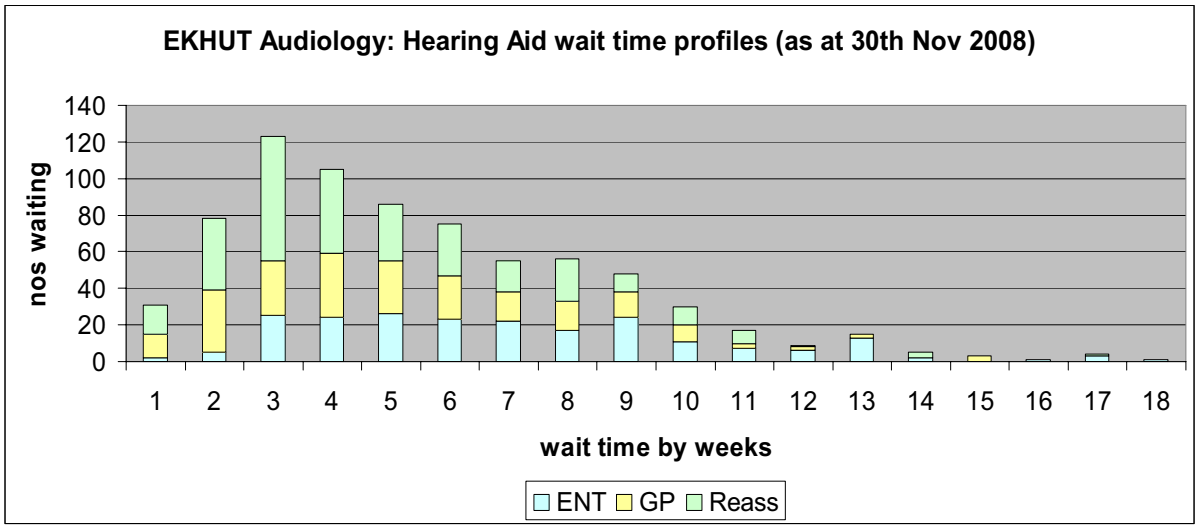


Table 2 Waiting List Profile



Choose and Book

Direct access to audiology at EKHUT is now available via Choose and Book and the waits are in line with the national diagnostic target of a maximum of 6 weeks.

Hearbase and the community based audiologist have been given extended contracts and are now receiving referrals via the Choose and Book system. Average waits for these services is 4 weeks, with a large majority of patients being seen with three weeks.

Performance Management

Throughout this time data collection has improved and the Audiology Service has been performance managed with the PCTs lead commissioner on a monthly basis on progress against the agreed action plan for full roll out of services. The following key performance indicators are also monitored and reported against:-

- Number of new referrals received by source
- Number of new patients seen
- Number of bilateral fittings

Much work has now been done to unbundle the block contract for work at EKHUT and Audiology work is now paid for on a cost per case basis, this enables a much more detailed understanding of performance as a whole.

In addition to the above a whole system service improvement group has been established that has a membership that includes GP's, Consultant Audiologists, Finance and Practice based commissioning representatives and a representative from HI-Kent.

Paediatric Audiology

The World Class Commissioning arrangements recently endorsed by Eastern and Coastal Primary Care Trust will require us to revise the commissioning of paediatric audiology services to ensure a coherent paediatric audiology pathway. This would

suggest that the children's lead commissioner should undertake the commissioning of paediatric audiology services collaborating closely with public health leads (for neonatal hearing screening) and head and neck commissioner (for ENT provision).

Until recently an adult audiologist employed by EKHUT provided the audiology assessments and services for children. However, the Clinical Services Manager recently made a successful internal Trust business case to develop a specific paediatric service. The Service now has a full time Specialist Consultant Community Paediatrician specialising in audio-vestibular medicine who is now leading the team and managing the newborn hearing screening programme. In addition EKHUT have now established two specialist paediatric audiologist posts. One post is now filled and the other is being covered by a locum whilst the second post is being recruited to (in progress). This means that as well as increasing the capacity of the overall audiology services, the standard and quality of provision for children is improved by the establishment of a more specialised paediatric service.

The Kent Children's Trust arrangements strengthen opportunities for collaboration at strategic and local levels and the Children's Commissioning Health Team will also work closely with KCC Education Deaf Services Team and Specialist Teaching Services thus ensuring a coherent pathway to enable children to have access to an early year's services, education and community provision.

In order to determine the level of the required commissioning budget an audit of need over the last three years has now been requested.

Children in the Swale area are provided for by West Kent PCT paediatric audiology team.

Future Planning

As commissioners we continue to proactively search for interested willing providers to declare their ability and desire to provide services in the future. As we establish the future levels of demand we will be working in partnership with all interested parties and stakeholders to establish a platform for sustainable service across the economy. And in addition ensure that services are established in rural and hard to reach areas.

ECKPCT continue to work with Medway NHS Foundation Trust to further establish links and opportunities for Swale residents to be able to receive services closer to their homes and enable swifter access to Audiology services and for GPs to be able to make such referrals through the Choose and Book system.

Audiology Services in West Kent Briefing Paper
January 2009

This update builds on the previous report submitted to the HOSC in July 2008.

During the past year considerable efforts have been made by NHS West Kent to reduce waiting times for digital hearing aids to the target level of 18 weeks from GP referral to treatment.

An additional contract was awarded to Clinicenta to enable this, with funding made available for 1200 new audiology assessments and hearing aid fittings for people from the Maidstone and Tunbridge Wells areas. Patients treated in this service are both those waiting for first fit hearing aids and those changing from analogue to digital.

This additional capacity extends the services already provided by Maidstone & Tunbridge Wells NHS Trust (MTW) for patients in the south of West Kent. Medway NHS Trust treats patients in the Dartford, Gravesham and Swanley areas. A number of other centres provide audiology services for the people of West Kent, including Bromley Hospitals Trust, Guys and St Thomas' NHS Foundation Trust and a number of other London Hospitals.

Since the previous HOSC update and our success in reducing waiting times, Clinicenta now accepts direct referrals from GPs. Patients referred in this way receive a hearing assessment within 10-14 days and have their hearing aids fitted within 4-6 weeks of referral.

Currently all patients referred for audiology across West Kent are assessed within 6 weeks and treated within 18 weeks.

In line with *"Transforming Adult Hearing Services"*, both MTW and Medway are redesigning their processes to ensure they can provide 3 year reviews for all patients. In the meantime best use is being made of other opportunities to offer such a review, for example Medway re-testing patients who attend for a repair.

Work on improving audiology services sits within the ENT stream of the Elective Care Programme. The Programme forms a key component of the overall Fit for the Future strategy and aligns with the NHS West Kent Operating Plan for 2008/09 for example in achieving and sustaining 18 weeks referral to treatment times, giving fast access to high quality care closer to home, aligning with pathway redesign work required to support the new hospital at Pembury, and the patient choice agenda. Through this Programme the PCT works in close partnership with Trusts across the local health economy.

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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.

Index for Annual Health Check Item

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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.

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.

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

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]. The latest version 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 Health Technical Memoranda. Element two refers to the requirements of the Hygiene Code.

[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

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.
- C. difficile is still a major problem for the NHS, but there are encouraging signs of recent improvement in dealing with it.

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

- 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."

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.

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[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 which contains the table comments that, "Both nationally and locally the duty that Trusts have the most difficulty achieving is Duty 4: particularly

[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

around premises that 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 earlier, 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.

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[15] South East Coast Strategic Health Authority, Hygiene code compliance report, December 2008, p.4, http://www.southeastcoast.nhs.uk/aboutus/theboard/papers/documents/101-08-HCAIReportDec2008.pdf
[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]

The main points from the Health Protection Agency commentary on *Clostridium difficile* from January 2009 are as follows:

- "Substantial reductions of C. difficile infection have been seen in the current quarter (July – September 2008) when compared to the previous quarter (18% reduction overall in patients aged 2 years and over). There have been similar reductions observed in most quarters since April 2007.
- For patients aged 65 years and over there was a reduction of 19% in the number of infections reported in July – September 2008 compared to the previous quarter, and this reflects a 35% and 45% reduction on the same quarters in 2007 and 2006, respectively.
- For patients aged between 2 and 64 years of age there was a reduction of 14% in the number of infections reported in July – September 2008 compared to the previous quarter, but this reflects a 26% reduction on the same quarter in 2007."[21]

For *Clostridium difficile* the most recent information available are the quarterly monitoring reports up to September 2008. These figures are available in Table 1 of Appendix F.

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

- "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]

[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, January 2009, p.1, http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1216193835563

[22] Ibid., p.10.

In addition, the latest publication of data relating to *Clostridium difficile*, "attempts to further address acute/community allocation through the separation of cases identified as acute Trust specimens by timing of detection. It is believed that any cases identified 3 or more days after admission to the reporting Trust can be assumed to have been acquired during that admission. This information is currently only provided for the two most recent quarters (April to June and July to September 2008)."[23]

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)."[24]

The main points from 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."[25]

For MRSA, the quarterly and six-monthly monitoring reports are available up to September 2008. The six-monthly reports are included in Table 2 of Appendix F and include the MRSA rates for the same period.

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

[23] Ibid., p.2.
[24] Health Protection Agency, Staphylococcus aureus, http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1191942169197?p=1191942169197
[25] Health Protection Agency, MRSA commentary, p.1, December 2008, http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1229502459877

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."[26]

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."[27]

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).

The following are extracts from *Criteria for assessing core standards in 2008/09 Primary care trusts (as providers and commissioners)*[28]:

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."[29]

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

[26] Ibid, p.5.
[27] 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
[28] 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
[29] Ibid, p.6

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.**"[30]

Third party commentaries and the Annual Health Check

A copy of the Healthcare Commission document *Your part in the annual health check 2008/09*[31] 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] Ibid, p.53
[31] Healthcare Commission, Your part in the annual health check, September 2008, http://www.healthcarecommission.org.uk/publicationslibrary.cfm?fde_id=9594

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 & Gravesham	Good	Excellent	Fully Met	Compliant	Compliant	Compliant
East Kent Hospitals	Fair	Fair	Fully Met	Compliant	Compliant	Compliant
Maidstone &Tunbridge Wells	Fair	Weak	Not Met	Compliant	Not met	Not met
Medway FT	Good	Fair	Partly Met	Compliant	Not met	Compliant
Eastern & Coastal Kent PCT	Good	Fair	Partly Met	Insufficient assurance	Insufficient assurance	Compliant
West Kent PCT	Fair	Weak	Not Met	Compliant	Not met	Compliant
Kent & Medway Partnership	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.

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	Rationale
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).	**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.

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

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	**Rationale**
Element one Reusable medical devices are properly decontaminated 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).	**Element one** The Hygiene code was revised in January 2008. Criteria C4c covers: • Hygiene Code Duty 3 (if related to decontamination) • 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 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).	**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 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 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. 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	**Independent contractors test**
Element one Not applicable	**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	**Independent contractors test**
Element one Not applicable	**For provider element one only** For independent contractors, the PCT

Element two Not applicable	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
	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	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

	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;	
	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 Hospital Laundry Arrangements for Used and Infected Linen, as revised from time to time; and	C21
	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 0000; 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 prevention and control	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
	10d. Isolation of patients	C4a
	10e. Safe handling and disposal of sharps	C4a
	10f. Prevention of occupational exposure to blood-borne	C4a

	viruses (BBVs), including prevention of sharps injuries	
	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 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 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 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.	C4a

prevention and control of infection is included in

	induction programmes for new staff, and in training programmes for all staff;	
	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

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.

[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 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.

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.

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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

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 - Sept 2008) [1]

Name of NHS Trust	April to June 2007			July to September 2007			October to December 2007			January to March 2008		
	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**
East Kent Hospitals	54	25	**79**	53	25	**78**	52	21	**73**	44	20	**64**
Maidstone & Tunbridge Wells	98	15	**113**	62	31	**93**	60	20	**80**	44	29	**73**
Medway	51	14	**65**	35	13	**48**	23	12	**35**	29	5	**34**

Name of NHS Trust	April to June 2008					July to September 2008				
	c	d	e	f	Total‡	c	d	e	f	Total‡
Dartford & Gravesham	6	14	0	5	**25**	13	26	1	20	**60**
East Kent Hospitals	16	26	0	12	**54**	7	28	0	23	**58**
Maidstone & Tunbridge Wells	8	20	0	22	**50**	11	18	0	24	**53**
Medway	7	20	2	6	**35**	12	21	2	11	**46**

‡ 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.
c. Specimens taken up to 2 days after admission.
d. Specimens taken 3 days or more after admission.
e. Non admitted specimens.
f. 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: Six-monthly reports and rates of MRSA bacteraemia (April 2006 - September 2008)[2]

Name of NHS Trust	MRSA bacteraemia reports									
	April 2006 - Sept 2006		October 2006 - March 2007		April 2007 - Sept 2007		October 2007 - March 2008		April 2008 - Sept 2008	
	Reports	Rate	Reports	Rate	Reports	Rate	Reports	Rate	Reports	Rate
Dartford & Gravesham	11	1.51	19	2.63	19	2.64	8	1.11	9	1.25
East Kent Hospitals University	39	1.71	22	0.97	17	0.80	15	0.71	16	0.75
Maidstone & Tunbridge Wells	29	2.38	12	0.99	11	0.92	13	1.09	12	1.01
Medway	28	2.65	15	1.43	12	1.16	9	0.87	8	0.78

$$\text{Trust Rate} = \left[\frac{\text{Numbers of MRSA bacteraemia reports from that Trust for the time period}}{\text{Average daily bed occupancy x Number of days in the time period}} \right] \times 10{,}000$$

[2] Data extracted from Health Protection Agency Six Monthly Monitoring Reports, http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1229502457958

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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20 January 2009

HEALTH AND SOCIAL CARE (COMMUNITY HEALTH AND STANDARDS) ACT 2003 as amended by the Health Act 2006

Healthcare Associated Infection (HCAI) Programme of Inspections

Dear Mr. Bain

I am writing to formally inform you of the outcome of an unannounced visit to East Kent Hospitals University NHS Trust by the Healthcare Commission on 9 and 10 December 2008. This was part of the annual programme of inspections to assess all NHS acute trusts' arrangements for the control and prevention of healthcare associated infections against the hygiene code.

We visited Kent & Canterbury Hospital, Queen Elizabeth the Queen Mother Hospital and William Harvey Hospital and assessed compliance with the following duties:

- **Duty 2** – to have in place appropriate management systems for infection prevention and control
- **Duty 4** – to provide and maintain a clean and appropriate environment for healthcare
- **Duty 8** – to provide adequate isolation facilities
- **Duty 10j** – to have in place an appropriate policy in relation to antimicrobial prescribing

I am pleased to inform you that the Healthcare Commission found no breaches of the hygiene code at East Kent Hospitals University NHS Trust. The Healthcare Commission will be taking no further action in relation to the hygiene code at this time.

Please find attached a copy of the summary report outlining the findings from the visit that will be published on our website. A copy of the full inspection report has been enclosed for your information.

Our findings have been subject to a quality assurance process within the Healthcare Commission. Please note this may have resulted in changes to the statements in the text or findings, therefore you are advised to check the summary report. If you have any comments please let us know within 2 working days of receipt.

The summary report will be published on the Commission's website on 23 January 2009.

Please contact me direct on 020 7448 9389 with any queries you may have.

Yours sincerely

pp

Louisa Power
HCAI Business Delivery Manager

CC: Candy Morris – Chief Executive of South East Coast Strategic Authority
Ann Sutton – Chief Executive of Eastern and Coastal Kent PCT

Healthcare Commission

Evidence table for HCAI inspection programme 2008/09

Region/area	South East
Trust name & code	East Kent Hospitals University NHS Trust (RVV)
Hospital(s) inspected	Kent and Canterbury Hospital William Harvey Hospital Queen Elizabeth the Queen Mother Hospital
Duty(s) inspected	2, 4, 8 & 10j
Lead assessor	Paula J Mansell
Specialist assessor/ Expert adviser(s)	Lesley Meech Stuart Barnhill Cheryl Nankevill
Date(s) of inspection	9 & 10 December 2008
Report version	Post factual accuracy draft for National

Evaluation of evidence

Duty 2: Duty to have in place appropriate management systems for infection prevention and control

a) The trust has 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.	
I: Line(s) of enquiry	
2a(1)	**The trust has an appropriate 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; and the trust has taken account of Annex 1.**
II: Evaluation of evidence	

The board-level agreement outlining its collective responsibility for infection prevention and control is reflected in a number of documents and was corroborated at interviews.

The trusts clinical governance assurance framework includes an objective with performance criteria for infection prevention and control (IPC). In addition the trust produced a framework for the management of risks associated with IPC in 2006, this was reviewed in October 2008. The framework states that:

- the trust board is responsible for providing as far as possible, suitable facilities and polices, that protect staff and patients from healthcare associated infection' and that it is responsible for ensuring that existing infection control management arrangements are effective in monitoring and controlling healthcare associated infection.

The arrangements for achieving this are detailed in the document. *(Framework for the Management of Risks Associated with Infection Prevention and Control in East Kent Hospitals University NHS Trust (EKHT) November 2006, Clinical Governance Assurance Framework August 2008)*

The trusts cleaning operational plan and subsequent review states that:

'The accountability for all aspects of cleanliness lies with the chief executive and the Trust board including:

- Listening to patients;
- Infection control;
- Developing, implementing and monitoring infection control policies; and learning from experience.
- Education and development;
- Monitoring'

- Whilst final accountability for all aspects of cleanliness lies with the chief executive, there are designated board members, the director of strategic development and capital planning and the director of nursing, midwifery and quality (DoNMQ) who are accountable for reporting to the chief executive and trust board and ensuring, in liaison with the director of infection prevention and control (DIPC), that proper systems and processes are in place to achieve high standards of cleanliness (via the infection control Leads Committee).

(EKHT Operational Plan June 2008, and review November 2008)

The line of accountability for infection control is directly to the chief executive and trust's board. The medical director and DoNMQ are joint executive leads for infection prevention and control. (J*ob description-medical director, director of nursing, midwifery and quality - job plan)*

The trust has appointed two non-executive directors (NEDs) with a lead for IPC, the chairman is one of these and has regular diarised meetings with the director of infection prevention and control (DIPC). The other is the chair of the trust's audit committee. We were told that the NEDs have received training from the DIPC on IPC during the board's afternoon training sessions. (*Interview notes - chairman, DIPC, DoNMQ)*

A handbook of information is provided to the NEDs of the trust. This contains a statement about the role of the NEDs with regard to IPC:

> External inspection bodies in particular, expect that NEDs will hold executives to account for the "quality" of service delivered and the patient experience, including, but not exclusively assurance on:
>
> - Clinical governance standards; safe equitable and consistent clinical practice; and the safety of the patient through systems that ensure staff are appropriately trained and skilled; the environment is clean and safe; and the opportunities for harm (e.g. through infection) are minimised.

(*NED Handbook, Interview notes - chairman, CEO)*

Interviews with the chief executive, DoNMQ and the trust's chairman confirmed the commitment of the board to IPC through receipt of monthly reports, executive walkabouts and integration of IPC measures into directorates' business and performance.

The trust's board formally agreed that a statement on accountability and responsibility for IPC should be included in all trust staff job descriptions and contracts of employment and that IPC be included by managers during staff appraisals. This was confirmed by staff interviewed and in staff job descriptions. IPC is a key component of the matrons' job descriptions. (*IC annual report 2007-2008, job descriptions, interview notes- ward staff, interview notes- executive and non-executive board members, appendix to all job descriptions*)

Every six weeks the chief executive meets with the 100 most senior managers and a member of their frontline staff, IPC is on the agenda for this meeting (*interview notes chief executive*). The DoNMQ, as part of her role as executive lead for IPC carries out infection control spot checks accompanied by IPC specialists and/or the head of soft FM services. (*Infection control spot checks: KC site-Aug 08, QEQM site-September 08, WHH-July 08)*

b) The trust has designated an individual as Director of Infection Prevention and Control (DIPC) accountable directly to the chief executive and the Board.	
I: Line(s) of enquiry	
2b(1)	**The trust has appropriately designated an individual as Director of Infection Prevention and Control (DIPC); and that person is accountable directly to the chief executive and the Board; and the trust has taken account of Annex 1.**
II: Evaluation of evidence	

The trust's DIPC is a consultant medical microbiologist and is supported by a deputy who is the lead IPC nurse specialist. The DIPC is responsible for leading the trust infection prevention and control team (IPCT) and reports directly to the chief executive and the trust board.

The DIPC has a job description with defined HCAI responsibilities and outcome objectives, including all the responsibilities laid out in annex 1. The DIPC has protected time identified in the job plan for the post holder, currently equivalent to 3 programmed activities of time (*DIPC job description*)

The DIPC formally attends the trust's board quarterly and presents the infection control annual report to the board. He will attend additional board meetings as required and has diarised meetings with the chief executive and chairman of the board.

The DIPC chairs a number of meetings related to HCAI including the infection control committee (ICC), and the IPCT meetings and the IC leads meetings. In addition he is a member of the clinical management board (CMB) and patient safety board. (*ICC minutes, CMB minutes, EKUHT IC organisational arrangements, interview notes- DIPC*)

The DIPC has a high profile in the trust with the authority to challenge IPC practice, all senior staff (matrons, ward manager, sisters) interviewed knew who the DIPC was and what his role encompassed. He assesses the impact of IPC measures and policies and makes recommendations to the trust's board for change and improvement. (*Observation tools, interview notes- matrons, nurses, DIPC, IC annual report 2007-2008*)

c) The trust Board must have mechanisms in place to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should include implementing an appropriate assurance framework, infection control programme and infection control infrastructure.

I: Line(s) of enquiry	
2c(1)	**The mechanisms by which the trust Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI include an appropriate assurance framework; and the trust has taken account of Annex 1.**

II: Evaluation of evidence

The trusts clinical governance assurance framework includes an objective with performance criteria for IPC. In addition the trust produced a framework for the management of risks associated with IPC in 2006, this was reviewed in October 2008. *(Framework for the Management of Risks Associated with Infection Prevention and Control in East Kent Hospitals University NHS Trust November 2006, Clinical Governance Assurance Framework, August 2008)*

The trust's ICC is chaired by the DIPC. The ICC meets quarterly (from January 2009 we were told that it will be meeting every other month) and is chaired by the DIPC. The ICC is comprised of the IPCT, the chief executive (or CE representative), the DoNMQ, nominated infection control leads from all clinical directorates and representatives from other relevant groups within the trust including:

- Hotel services
- Estates
- Pharmacy
- Occupational health
- Risk management

The ICC reports to the clinical governance steering group and is responsible for supervising the delivery of the annual infection control programme, including the programme of audit. (*Framework for the Management of Risks Associated with Infection Prevention and Control in East Kent Hospitals University NHS Trust, IC programme)*

The ICC receives reports on directorate performance and feeds into the CMB. The DIPC and CE are members of the CMB which receives minutes from the trust's ICC, regular infection control reports from the DIPC, and monthly summaries of the directorate reports. The CMB also receives monthly reports on directorates compliance performance relating to:

- hand hygiene, by directorate and staff group
- mandatory training compliance
- MRSA bacteraemia and *Clostridium difficile* data
- MRSA screening compliance
- Use of specified peripheral cannula packs and appropriate management
- Completion of IC RCA investigations within 5 days

The CMB receives results of IPC audit and monitors compliance with actions. The CMB feeds into the trust's board. The DIPC makes quarterly presentations to the trust's board and presents the infection control annual report. The board agreed the annual infection control programme for 2008-2009 at its June 2008 meeting. (*EKHUT Infection Control Organisational arrangements: August 2008, trust board minutes, TOR and minutes of the CMB, interview notes - board members*)

The trust's board monitors performance in relation to IPC through a number of reports. The DIPC formally reports to the trust's board quarterly, and annually presents the infection control report. He will attend additional board meetings as required and has diarised meetings with the chief executive. The trust's board receives monthly information via the DoNMQ's patient safety and quality report. The agreed HCAI key performance indicators (KPIs) are reported with assurance provided on a monthly basis internally to the CMB and externally to the PCT. This report details progress against the KPIs by directorate. (*EKHUT Infection Control Organisational arrangements, August 2008, Interview Notes - DIPC, DoNMQ, Chairman and CEO*, t*rust board minutes 2 May and June 2008, patient safety and quality report - Nov 08)*

The trust's matrons made a recent presentation to the board which included information about IPC (*interview notes* – c*hairman and chief executive*)

Infection control leads have been nominated for each clinical directorate and have responsibility for implementing specific IPC key performance targets for their directorate. The IC leads are responsible for implementing and monitoring infection control policies in their clinical areas. (*patient safety and quality report Nov 08, Annual Infection Control report, interview notes - director of nursing)*

The executives have a 'Walk the Floor' programme (*trust board minutes 2 May & June 2008*), supported by a proforma to guide questioning of staff about safety and environmental issues. All senior staff (matrons, ward manager, and sisters) stated that they had seen board members doing walk-arounds at some point and that this occurred about every 2-3 months. We were told that the board members talked to all grades of staff and reviewed cleanliness and processes on the ward in relation to HCAIs. The trust has two NED with lead roles for IPC (*observation tools, interview notes - board members*)

The IPCT report all MRSA bacteraemias (blood stream infections) to the Department of Health via the Strategic Health Authority/Health Protection Agency (HPA) notification and surveillance systems. RCA investigation reports following reported infections were provided and all contained the identified root causes and action plans to address the causes, all reports seen contained action plans and most had designated individuals and completion dates against the actions required to provide assurance that improvements were made. A summary of actions following RCA investigations is included in the DIPC's annual report to the board. The investigations are multi-disciplinary events, "owned" by the appropriate directorate and the RCA meeting is attended by the

following members of staff:

- Ward manager or senior nursing representative
- Matron
- Consultant or Registrar
- Infection prevention and control team
  (*MRSA policy September 2005/August 2008, RCA reports*)

There is evidence that the trust board receives information about infection outbreaks and that action is taken following assessment of the management of outbreaks. An example of this is the installation of automatic door openers in strategic areas across the worst affected site. (*IC annual report 2007-2008)*

I: Line(s) of enquiry	
2c(2)	**The mechanisms by which the trust Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI include an infection control programme; and the trust has taken account of Annex 1.**

II: Evaluation of evidence

The infection control annual programme for 2008/9 was agreed at the June meeting of the trust's board. (*minutes of the trust's board meeting June 27 June 2008*)

The programme sets out the objectives for the trust in relation to IP&C activity. Progress is monitored against the programme through action plans and key performance indicators for the clinical directorates by the ICC. The DIPC reports on progress against the programme in his annual report

The programme provides information on:

- MRSA bacteraemia and *Clostridium difficile* surveillance including frequency of reporting and feedback to wards/departments, Executive team and consultants
- Identification of risk areas e.g. the expansion of the haemodialysis facilities
- Incident reporting and investigation
- Performance management and audit of MRSA screening and decolonisation
- Key management aspects for IPC for *Clostridium difficile* including cleaning/hygiene practices
- Antibiotic management
- Surveillance of other alert organisms and post discharge surgical wound infection
- A review of policies and procedures contained in the IC manual and available on the trust intranet including:
  - Standard (universal) infection control precautions
  - Major Outbreak control policy
  - Isolation of patients
  - Safe handling and disposal of sharps
  - Management of occupational exposure to blood borne viruses
  - Admissions policy –including guidance on ward closure
  - Control of infection procedures for specific organisms including: MRSA, *Clostridium difficile* and TSE
- The programme of audit (not all have stipulated frequency)
- Implementation of Saving Lives High Impact Interventions
- Education in IPC
- Infection control link worker system
- Hand Hygiene campaign
- Management of invasive devices

- Aseptic technique
- Legionella management and monitoring
- Hospital Hygiene

(*Infection Control annual programme April 2008- March 2009*)

Prioritisation and monitoring of some activities detailed in the programme is undertaken via the directorate KPIs targets which include designated executive and operational leads, and timescales for improvement for each target. The KPIs have been developed to incorporate learning and action points from RCAs for MRSA and *Clostridium difficile* cases during 2007/2008. As a result, the programme states that the primary focus of the KPIs is on full implementation of key IPC policies related to the management of these infections and invasive devices.

Directorates report monthly on progress to the ICC. There is evidence that progress is monitored at the ICC and the CMB (*minutes of ICC and CMB*, *IPC performance monitoring, Key performance indicator targets for directorates (May 2008))*

I: Line(s) of enquiry	
2c(3)	**The mechanisms by which the trust Board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI include an infection control infrastructure; and the trust has taken account of Annex 1.**

II: Evaluation of evidence

The IPCT consists of:

4 WTE microbiologists (1 vacancy), one of whom is the DIPC
5 clinical nurse specialists in IPC (1 vacancy) one of whom is the deputy DIPC
1 WTE administrative support

There is 24 hour a day access to an on call ICN and an on call consultant microbiologist via the trust's switchboard (*Infection Control annual programme 2008-2009, isolation policy, interviews with staff*)

At the June 2008 meeting of the trust board it was noted that additional microbiologist and specialist pharmacist resources had been agreed for the IPCT. (*board minutes- June 2008*) A further business case has been approved to increase the numbers and seniority of the ICN specialists to accommodate the increasing workload of the team. (*Infection Control annual programme 2008-2009, extract from minutes of CE's group 23 July 2008*). The trust has identified that the William Harvey site would benefit from increased IP&C presence and are trying to recruit to increase the team. (*interview notes- DIPC & Deputy DIPC*, *business case – undated)*

At the time of our visit two full time antimicrobial pharmacists had been recently appointed. This is in addition to the existing antimicrobial technician.

It is the responsibility of the IPCT to review progress with the annual infection control programme, to be responsible for the day to day operation of the infection control service including maintenance of up to date polices, provision of advice to clinical and management colleagues, monitoring of infection risks in clinical areas, monitoring of compliance with infection control policies and response to outbreaks of hospital infection. (*IC annual report 2007-2008, framework for the management of IPC risks, Infection Control annual programme 2008-2009)*

The IPCT also provide IPC advice to a small private hospital at Hythe, this was not considered by the team to cause undue burden on the resources of the team. (*IP&C annual report, interviews with the IPCT*)

The ICC includes external representation from the HPA. It oversees the activity of the IPCT and supervises the implementation of the IPC annual programme.

The IPCT team meet monthly, the ICC has met quarterly, but from January 2009 it will meet every other month. The clinical governance steering group and the CMB receive the ICC meeting minutes. (*interview notes- DIPC, minutes of the ICC*)

Since 2006, the trust's directorates have had IPC clinical leads, the roles were reviewed and revised in 2008. The leads had been meeting monthly, chaired by the DIPC, this meeting has recently been amalgamated with the ICC. Each clinical area has at least one link nurse/worker including the five renal satellite areas. The link nurses are provided with training and information to cascade to the clinical teams. (*Infection Control annual programme 2008-2009, minutes of the ICC and directorate leads meeting minutes*)

The trust's infrastructure for IPC is described in the EKHT infection control organisational arrangements (August 2008). This document outlines the committees and reporting arrangements for IPC through committees and reports from clinical areas to the trust board.

d) The trust must ensure 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.

I: Line(s) of enquiry	
2d(1)	All relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, on the measures required to prevent and control risks of infection

II: Evaluation of evidence

Training in IPC is mandatory for all staff. The IPCT provide most of the IPC training and cover the chain of infection, key IPC principles, accountability and responsibilities and key policies.

Details of IPC training are laid out in the annual IC programme as follows:

- All clinical staff should have a one hour session on IPC at induction.
- Mandatory training is available as an e-learning package on the trust's intranet.
- Junior doctors have a short induction session supported by handouts on IPC practices. In addition all junior doctors should undergo mandatory training and assessment of competency on the insertion of peripheral venous cannulae, and phlebotomy skills provided by the practice development team
- All clinical staff involved in blood culture collection will be required to undertake the relevant training and education provided by the practice development team and complete an e-learning competency assessment.
- Participation in the F1 junior doctor programme should include the principles of IC, antibiotic prescribing and utilizing the microbiology laboratory
- Mandatory annual IC education programme for contracted domestic and portering staff
- Ad hoc sessions for specialist areas
- IC management of the highly dependent patient
- Management of urinary catheters for HCAs
- Completion of the Saving Lives programme for mandatory education for senior nurses in high risk areas
- Additional training for IC link workers including an annual IC link worker conference

Induction
IPCT provide training at induction for all new staff once a fortnight as part of the clinical awareness component of the induction. Failure to attend is followed up by a letter to staff managers from human resources (*interviews notes- IPCT, induction and mandatory training policy)*

Induction for medical staff includes a twenty minute session on IPC provided by the IPCT and a section on prescribing with a sub-section on antibiotic prescribing; this is undertaken as a sign-posting session so that staff know where to go for further information, advice and support. At induction the doctors are given the pocket sized prescribing guidance. (*interview notes-DIPC, pharmacists, presentations*)

Mandatory training
Mandatory training for clinical staff is provided in the form of an e-learning package, the annual report for 2007-08 shows that 4,277 staff completed the training. The trust's human resources department monitors attendance at mandatory training monthly and recorded that 77% of clinical staff had completed the mandatory e-learning session on IP&C during the year to 1st October 2008. Mandatory training is monitored by the board. (*IC annual report 2007-2008, interview with HR, education and training recorded rates for mandatory training*).

The trust has an induction and mandatory training policy, written to include both medical and non medical staff. All staff interviewed had completed infection control training within the last year. All were aware that it was mandatory to attend annually. The clinical decisions unit on the William Harvey site had had some difficulties in relation to getting all staff trained and were below the expected trust agreement so have employed a Band 5 'return to practice nurse' whose responsibility is to review training and ensure all relevant staff attend with the support of the ward manager. A training database was seen on ward computers. Staff confirmed that the ward manager would check that the mandatory training was completed and if not done the staff would receive a letter. Any additional study leave requested is not granted if the mandatory training has not been completed. The human resources department obtains figures, from their work force planning department, which show the percentage of completion of mandatory training within directorates. This information is passed onto directorate leads who then have the responsibility of ensuring line managers work to complete all mandatory training requirements within their ward or department. Directorate leads who head up directorates with poor mandatory training records may be at risk of disciplinary proceedings or financial penalties. (*Induction and mandatory training policy-undated, observation tools, interview notes- nurses, HR, Induction and mandatory training policy- undated*)

The pharmacists provide training on antibiotic prescribing for Foundation Year 2 (FY2) medical staff. The IPCT provide three sessions for FY1 junior doctors, this includes the principles of IPC and high impact interventions. The post graduate department follow up non-attenders junior medical staff are also provided with training on insertion of intravenous devices and aseptic blood culture collection. (*IC annual report interviews with pharmacists, interviews IPCT*).

A number of presentations were provided that were used for the medical staff training including : sensible and practical prescribing - junior doctors induction, antimicrobial prescribing FY1 & 2, antibiotic multiple choice questions, infection control & patient safety. (*PowerPoint training Presentations*)

Contractors and temporary staff
We were told that agency nursing and medical staff are employed through NHS Professionals (NHSP) who have received IP&C training through that organisation. Local inductions are carried out by ward staff and any temporary staff working at the trust for longer than three months are expected to attend the trust induction programme including IPC. (*Induction and mandatory training policy-undated, interview notes*)

IC is covered in the induction for contracted cleaning staff. They also receive a two week on the job

induction following the initial corporate induction and this includes the use of appropriate products and cleaning standards. Annual IC training is provided in an hour session onsite in conjunction with the IPCT. There is a training needs analysis matrix which is regularly reviewed to ensure all staff are up to date. The training is monitored and the IC annual report 2007-08 states that 510 contract cleaning staff attended IPC training. (*interviews notes- on site Manager and operation manager for cleaning contractors, IC annual report 2007-2008*)

Additional training
The IPCT provided other training sessions during 2007-08 as reported in the infection control annual report, including sessions on preventing infection - Saving Lives, two hour sessions for Link nurses/workers, HCA induction and development programme and practical hand washing sessions. Many of these were attended by different grades of medical staff. (*interviews IPCT, IC annual report 2007-2008*)

Compliance with mandatory training is included as an appendix to the IP&C annual report. (*IC annual report 2007-2008*)

I: Line(s) of enquiry	
2d(2)	**All relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient information, on the measures required to prevent and control risks of infection**

II: Evaluation of evidence

Staff interviewed on the wards all referred to the ward IP&C manual as the main source of information, together with the IPCT. Staff asked were aware of their key contact in the IPCT. The IPCT link nurses also cascade information to the clinical teams from the IPCT. The inspection team were also advised by staff that IP&C elements are included at appraisal. (*interviews with nurses and matrons*)

The IPCT will provide information to clinical areas regarding changes to practice for example the introduction of new skin preparation prior to insertion of peripheral cannulae was circulated via an e-bulletin and the IC&PT attended the directorate cluster groups, matrons meetings and ward/team meetings to inform staff of the new practice. In addition the team have produced a number of wipe clean notices containing '10 important points' for a variety of subjects, these include: hand washing, peripheral cannula care, central line care, management of *Clostridium difficile* infections, and urinary catheter care, these are delivered to clinical areas where the team discuss the contents with clinical staff and decide where the notices should be displayed. These notices were seen in most wards, where they were not seen it was following deep cleaning and they had been temporarily removed. A staff nurse interviewed cited the '10 important points' as useful information. (*interview notes- IP&CT, observation tools, interviews with staff*)

A recent review of the trust's IP&C policies has been undertaken and issued to all clinical areas and are available on the intranet. (*IC annual report 2007-2008, interviews with staff*)

MRSA bacteraemia and *Clostridium difficile* epidemiological data are reported on a monthly basis to all wards/departments, matrons, ward/department managers, consultants and junior doctors. (*Infection Control annual programme 2008-2009, interviews with staff*)

Information is available in the format of leaflets (seen but not retained) providing information on *Clostridium difficile,* MRSA and hand hygiene, posters on wards, the trust intranet and in ward folders which are regularly updated by the IC Link nurses. These folders have up to date information and also ward specific information relating to HCAI – for example issues specific to neonates in SCBU and surgery in orthopaedics. Link nurses are expected to give feedback at handover and at

ward meetings. Minutes of ward meetings were seen and all contained a standing agenda item for IC.

Contractors are provided with the contractors information booklet, this informs them that when working in patient areas, that they must report to the head of department to receive instruction on the relevant infection control procedures and includes information on hand washing procedures when working in patient or risk areas, as well as being able to see the posters displayed. (*observation tools, contractors information booklet 2005 ,updated July 2007*)

The trust's IC annual programme states that the IPCT will provide support and advice to hotel services and contractors as required as well as advising on day to day issues. Contractors and visitors are provided with an IP&C leaflet containing information on hand hygiene, needle stick injuries, and signs of ill health, they have to sign the leaflet on receipt (*infection prevention and control guidance for contractors, interviews with IPCT*).

Junior doctors are provided with a pocket size copy of the guidelines for the use of antibiotics. In addition there is an interactive web based antibiotic policy which provides advice based on information submitted and useful links, such as the BNF. (*interviews with pharmacists*)

I: Line(s) of enquiry	
2d(3)	**All relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive <u>suitable and sufficient supervision</u>, on the measures required to prevent and control risks of infection**

II: Evaluation of evidence

Supervision is carried out through direct observation, audits and practical sessions in clinical areas. Each ward has at least one IPCT link nurse/worker. Those interviewed confirmed that new staff 'shadowed' more experienced staff and were clear on their role and carry out supervision of hand hygiene in the clinical areas. There is a preceptorship programme in place for new staff. (*interviews notes*)

The IPCT undertake regular rounds of the clinical areas on their site and undertake spot checks on IPC processes. The IPCT and link nurses/workers carry out practical sessions and observations on hand hygiene and directorates provide monthly figures on compliance with hand hygiene and use and management of specified peripheral cannula packs. (*interviews with IPCT, directorate monthly reports, interviews notes*)

The DoNMQ, as part of her role as executive lead for IPC carries out infection control spot checks accompanied by IPC specialists and/or the head of soft FM services. This spot check includes checks on equipment cleaning, MRSA and *Clostridium difficile* management plans, and uniform and Bare Below the Elbows (BBE) guidance (*Infection control spot checks: KC site, Aug 08, QEQM site, September 08, WHH July 08)*

Contractor supervisors regularly visit wards and review cleaning standards. Each individual has sign off sheets which are checked and counter signed by senior staff on duty and checked by supervisors. Any issue is brought to their attention by ward staff. Cleaners are included in ward meetings where cleaning audits and performance are discussed. Other contractors are expected to report to the senior staff on the ward and are observed in relation to use of antibacterial hand rub. In addition they report on completion of the job and any concerns are raised with IPCT and Estates (*interviews notes- ward staff, estates management*)

e) The trust has a programme of audit to ensure that key policies and practices are being implemented appropriately.	
I: Line(s) of enquiry	
2e(1)	**The trust has a programme of audit to ensure that key policies and practices are being implemented appropriately**
II: Evaluation of evidence	

Audit programme
The trust's annual IC programme contains a programme of audit aligned to the programme of IPC work. The programme includes audits to be carried out by directorates as well as those carried out by the IPCT and others. All listed audits have designated leads and most detail the frequency of audit required. (*Infection Control annual programme 2008-2009)*

Environmental Audit
The IPCT undertake environmental audits every 12-18 months with the link worker or senior nurse in the clinical area. The IPCT report on the findings of the audit and the ward manager is responsible for producing and action plan. The ICPT check progress against the action plan in eight weeks. If problems are identified the area is re audited. The results are included as part of the directorates KPI report. (*interviews notes- IPCT, environmental audits*)

Antimicrobial prescribing audit
Four directorates completed antimicrobial prescribing audits during 2007/2008 as reported in the DIPC's annual report. Antibiotic usage is monitored monthly. (*antibiotic usage summary)*

The CMB received the report of an antibiotic prescribing audit on the QEQM site in August 2008 there were 13 recommendations to improve prescribing following analysis against the standards derived from the trust's antimicrobial guidelines. The committee agreed action and monitoring to be undertaken as a result of the recommendations. (*minutes of the CMB August 2008*)

Commode audit
Commode audit audits are undertaken weekly since September 2008. Following an audit of the cleaning of commodes during 2008 the IPCT initiated twice daily cleaning of commodes by the domestic staff using a chlorine based cleaning solution. Evidence of this twice daily cleaning was seen during the visits to the wards, checklists for the twice daily clean had been signed on that day by the domestic staff. (*IC annual report 2007-2008, observation tools, interviews notes, commode audit tool, commode audits*)

Cleaning audits
Cleaning audits are undertaken by the contracted cleaners with clinical staff. Areas are risk assessed from very high to low and audit frequencies are based on this. (*interview notes - on site manager and operation manager for cleaning contractors*)

Invasive device audits
The IC annual programme details plans to introduce software in December 2008 to facilitate trust wide participation and compliance monitoring of HII. At present only specialist areas such as ITU have implemented the HIIs. The trust is in the process of purchasing software to support the implementation of HIIs throughout the organisation. The new software will allow data to be collected simply, resulting in a customised dashboard showing percentage compliance levels at trust site and ward levels. Senior nurses throughout the trust have received Saving Lives training in preparation for the roll-out of the new software and implementation of the audits. (*IC programme, Implementation of Synbiotix Saving Lives for High Impact Interventions document - undated)*

The following trust-wide audits of invasive devices were carried out in May 2008, including

comparison of results with previous audits:

An audit of peripheral cannula was carried out to assess compliance with the standards of best practice set out in the trust's clinical guideline '*Venous cannulation management and removal (adults) (2006)'* and to determine whether there has been an improvement in the achievement of the standards since the previous audit. The audit findings and the headline key messages were circulated (*peripheral cannula audit, peripheral cannula audit flyer 2008)*

An audit of central venous cannula was carried and the results, comparison of results to previous audits and actions to improve practice were circulated to matrons and ward managers (*CV audit September 2008*)

An audit or urinary catheters was carried out and the results of the audit and an eye-catching key messages was produced (*Urinary catheter audit 2008 flyer*)

Following RCA investigation reports citing peripheral cannula as the site of MRSA infections and results of audit, the trust has instigated a number of actions including the use of standard peripheral cannula packs across the trust and weekly audits of compliance (*trust wide MRSA bacteraemia action plan – September 2008*) The directorate invasive devices audits consist of visual inspection phlebitis (VIP) scores and catheter days rather then processes. (*Observation tools, interview notes*). One of the matrons on the ward confirmed that peripheral cannula audits were carried out weekly and discussed at the weekly cluster meetings where the staff discuss results, share good practice and audit other areas to avoid bias. (*Interview notes - matron*). An intravenous access group was established in 2006 to ensure that practice, equipment and policies across the trust are standardised. (*IC annual report 2007-2008*)

Weekly audits
Weekly audits in place are for hand hygiene, commode cleaning, environmental cleaning, also for MRSA screening and decolonisation. (*Commode audit tool and audits, Directorate reports, Infection Prevention and Control Key Performance Indicator Targets for Directorates – Performance Metrics 2008 – 2009)*

The trust is also part of the Feedback Intervention Trial (FIT); with seven wards taking part in this national study of ways of improving hand hygiene (*IC annual report 2007-2008*)

There is evidence of compliance monitoring at the monthly CMB meetings for example at the September meeting the board asked for the three directorates with hand washing compliance below 90%, to provide their action plans to improve performance. (*CMB minutes September 2008*)

Audit results
Audit results are sent via email and to ward managers and matrons and discussed at 'cluster meetings' – which consist of matrons and senior staff from the directorate. Information is then expected to be cascaded during ward meetings and handover. Link nurses are expected to take any concerns back to the IPCT. This was corroborated by interviews with nurses on the wards. *(interview notes-ward staff)*

Training on audit
Various levels of staff do the audits from senior to junior all have had some form of training from the IPCT in relation to documentation to use and expectations. However on the William Harvey site one nurse stated that the training was cascaded by senior staff who did not know if the initial information that they had been given was sufficient. (*interviews with staff, observation tools*)

Action following outbreaks
The trust assessed the impact of a Norovirus outbreak which most severely affected the William Harvey site. Following this assessment the trust installed automatic door openers in strategic areas

across the site *(IC annual report 2007-2008, interviews notes)*

f) The trust has an appropriate policy that addresses, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities.	
I: Line(s) of enquiry	
2f(1)	**The trust has an appropriate policy that addresses where relevant, admission, transfer, discharge and movement of patients between departments, and within and between health care facilities**
II: Evaluation of evidence	

The trust has policies for the admission and discharge of patients that are linked to the trust's transfer of patients policy and the policy for the admission, movement/transfer and discharge of patients with an infection / infectious disease. (August 2008)

The **trust's transfer of patients policy** includes internal transfers between departments and sites, patients transferring to or from other hospitals, transferring patients home or to nursing/residential home by hospital transport.

The policy contains a paragraph about information to be provided about a patient's infection status prior to transfer. It also states that if a patient has an infection requiring isolation staff should refer to the infection control policy and contact the infection control nurse. The policy includes a patient transfer **risk assessment tool** which includes a link to the infection control policy and a checklist for transfer which includes information about HCAI. (*transfer of patients policy, January 2008*)

The **Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease** is appropriately referenced to other key policies including the Policy for the Isolation of Patients with Infectious Diseases. The policy states that in the event of any uncertainty, the Infection Prevention and Control Team must be contacted for advice.

The policy states that the allocation of single rooms to patients with suspected/confirmed infections must be a priority and take precedence over bed management / capacity issues. If there is no side room available, the Bed Manager / Site Co-Coordinator must ensure that the patients currently in side rooms are reviewed and patients who do not require a side room for isolation purposes are moved. It is the responsibility of the ward sister or manager to ensure that the Bed Manager / Infection Prevention and Control Team are contacted if there is difficulty allocating a side room. The IPCT provide advice on the movement of patients with infections and liaise with the bed managers, or site managers out of hours, regarding side room usage and the isolation ward on the William Harvey site. **(***Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease, August 2008)*

The trust's isolation policy clearly states that where there are competing demands for single rooms, bed managers in conjunction with the IPCT should jointly agree on the appropriate placement of patients. The isolation policy also includes an appendix 'admissions guidance for bed managers/matrons/site coordinators' including advice on 'high risk' categories of patients. The guidance states that the IPCT must be contacted for advice. The policy also includes guidelines for admission to the isolation ward which are coordinated via the clinical decisions unit and the IPCT. (*isolation policy*)

Side room usage is monitored on the Kent and Canterbury site, the smallest of the three main sites, by the bed managers/site managers who update the use of side rooms following calls to all wards. On the two larger sites a review of isolation rooms is conducted daily with a breakdown of side room

usage across all sites (*interview notes DIPC, DDIPC, transfer of patients policy, January 2008, Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease, August 2008, Isolation policy, Aug 2008, interview notes- ward staff and the IPCT*)

All nursing staff that were asked were aware of relevant policies for transfer, discharge and movement of patients. Adverse incident forms are completed when patients diagnosed with infections cannot be isolated on confirmation of diagnosis. Staff were aware of the importance of involving the IPCT if any concerns arise at an early stage. Support is sought from matrons if concerns are raised in relation to movement of an infected or suspected infected patient. (*interviews notes- ward staff)*

The trust has an operational escalation plan which includes managing infectious patients with limited bed capacity and managing a significant outbreak. At times of bed pressure, with no side rooms available, the need for patient isolation will be risk assessed on a patient by patient basis. This will be done in accordance with the 'Infection Control Admission Guide for Bed Managers', which provides advice on the priority of patients for isolation. The infection control team, through the hospital manager / site management team will be kept informed and contacted for advice as necessary. (*operational escalation plan 2006*)

Duty 4: Duty to provide and maintain a clean and appropriate environment for health care

a) The trust must have policies for the environment which make provision for liaison between the members of any infection control team ("the ICT") and the persons with overall responsibility for facilities management, with a view to minimising the risk of HCAI.	
I: Line(s) of enquiry	
4a(1)	**The trust has policies for the environment, which make provision for liaison between the members of any infection control team ("the ICT") and the persons with overall responsibility for facilities management; The trust has taken Annex 1 into account in forming its policies.**
II: Evaluation of evidence	

A statement is included in the annual infection control programme that the IPCT will advise on all new developments/reconfiguration projects relating to service and buildings within the trust based on national guidance and best practice (*annual infection control programme 2008-2009*)

The trust's provision for liaison between members of the ICPT and the staff with responsibility for facilities management is described in the trust's policy document for **environmental policies and infection control** developed in December 2008, it is still in draft but states that:

- the aim of the document is to ensure that all policies for the environment make provision for liaison between the Infection Prevention and Control Team (IPCT) and individuals with overall responsibility for facilities management.
- The objective of the policy is to ensure liaison with the IPCT in all environmental policies. The document states that when policies are reviewed, revised or developed this liaison with the IPCT will be incorporated, until such time this policy will provide the overarching assurance that this is occurring. (*Environmental policies and infection control December*

2008 Draft)

In addition the following documents further describe the provision for liaison with the IPCT:

Cleaning Operational Plan (June 2008)
This plan states that there must be the involvement of a board nominee who has a significant influence on combating healthcare associated infections and that the close involvement of matrons and patients in the setting and monitoring of standards is crucial to delivering consistently high levels of service. The plan states that:

a) IPCT, facilities and the service provider must be consulted in relation to the types of surface finishes suitable for trust premises and specific to the activity.
b) Introducing cutting edge innovation in consultation with IPCT, where appropriate within the cleaning regime, including the full use of information technology and systems.
c) The DIPC to liaise with the director of strategic development and capital planning and the DoNMQ to ensure that proper systems and processes are in place to achieve high standards of cleanliness.

(Cleaning Operational Plan – June 2008, East Kent Hospitals University NHS Trust Strategic Cleaning Plan Review November 2008)

Ward kitchens and food policy 2008 (including pest control)
The policy forms part of the infection control manual available in all clinical areas with details of how to contact the IPCT. The policy contains a section on pest control. The policy states that the infection control nurse will routinely inspect the ward kitchen as part of the ward audit. *(Ward kitchens and food policy 2008)*

Waste Strategy 2008

- providing all staff with explicit guidance (e.g. education, training, waste procedures etc) in the safe handling and disposal of all wastes in line with health and safety and infection control requirements;
- Waste management policy
- Waste management procedures
- Soft facilities management services waste specification

It will be monitored by a steering and working group to reflect all interested parties' views, this group includes the DIPC. *(Waste Strategy 2008)*

Legionella Policy (including Air Conditioning Systems and Air Handling Units and planned preventative maintenance)
The policy includes liaison with the IPCT in the event of a suspected outbreak or incident. (*Legionella Policy)*

Infection control in building and refurbishment policy December 2008
This is a draft document produced in December 2008 awaiting ratification. The policy makes provision for the involvement of the IPCT in any building or refurbishment work. It states that it is imperative that buildings are designed and refurbished with IPC in mind and that the team are contacted in the earliest stages of planning. (*Infection control in building and refurbishment policy December 2008)*

The aim of the policy is to ensure that the trust manages the infection risks associated with building construction and renovation. There is timely collaboration between estates and infection prevention and control with regard to any new build, renovation or repairs to trust buildings. The policy includes sections on the responsibilities of the estates department and the issues to be addressed by the

IPCT at different stages of any building or refurbishment work.

The policy includes an infection control risk assessment to be used during construction and/or refurbishment.

Discussions with staff and documentation regarding recent work confirms that this liaison between estates, facilities and the IPCT happens in practice The head of hotel services is a member of the IPC leads meetings and the ICC. The ICPT are members of the PEAT group and the cleaning standards group. The estates strategy was discussed at the ICC. (*interview notes with estates, facilities, IPCT, emails regarding recent building work, minutes of ICC meetings*)

b) The trust must designate lead managers for cleaning and decontamination of equipment used for treatment (a single individual may be designated for both areas), with a view to minimising the risk of HCAI.	
I: Line(s) of enquiry	
4b(1)	**The trust has designated lead managers for cleaning and decontamination of equipment used for treatment (a single individual may be designated for both areas); and has taken account of Annex 1.**
II: Evaluation of evidence	

The acting head of facilities is the trust's lead for cleaning. The head of soft FM services is the interim post holder currently in this role. This post reports to the director of strategic development and capital planning. The post holder is responsible for the day to day management of hotel services, transport, laundry and accommodation. The roles and responsibilities of this post are detailed in the job description and include:

- To assist in the development of a cleaning strategy and facilitate links with the DIPC and the DoNMQ in respect of cleanliness and the reduction of HCAI's
- To act as the facilities lead on the ICC.

(*Head of soft FM services job description)*

The decontamination lead was the director of facilities who left the trust at the beginning of November 2008. The trust has started the recruitment process for a new post: trust decontamination lead. The job description covers the roles and responsibilities as detailed in Annex 1 of the hygiene code. The post holder will report to the DoNMQ (*Job description - trust decontamination lead, November 2008)* In the interim, we were told that the DoNMQ has asked the DDIPC to cover elements of this role alongside the endoscopy matrons and the sterile services manager leading on decontamination in their areas, overseen by the decontamination working group which reports into the risk and clinical governance group. (*minutes of Decontamination of medical devices working Group 8 Dec 08*)

There is no equipment library at the trust, all wards and departments have their own equipment with clear schedules of cleaning. All patient equipment is registered with the trust's electronics and medical engineering (EME) department.

There is also a transition team that meets monthly and reports to the decontamination working group to oversee the planned move to the centralised decontamination facility during the summer of 2009.

(interview notes- head of patient safety, SSD manager, acting head of facilities, head of estates, head of soft FM support, minutes of the medical devices decontamination group 10 Oct 2008)

The DoNMQ undertakes spot checks on all sites that include checks on equipment cleaning, commode cleaning and mattress cleaning & soiled mattresses any failures to meet required standards are reported with actions for improvement. (*Infection control spot checks: KC site, Aug 08, QEQM site, September 08, WHH July 08)*

c) The trust must ensure that all parts of the premises in which it provides health care are suitable for the purpose, are kept clean and are maintained in good physical repair and condition, with a view to minimising the risk of HCAI.

I: Line(s) of enquiry

4c(1)	**The trust ensures that all parts of the premises in which it provides health care are suitable for the purpose, are kept clean and are maintained in good physical repair and condition.**

II: Evaluation of evidence

The trust's cleaning services are contracted to an external provider.

The trust has a cleaning operational plan and cleaning specification as documented under 4a, and cleaning is monitored by the directorates monthly, by the IPCT as part of the environmental audits and by the routine maximiser audits carried out by the cleaning contractor. *(cleaning operational plan 2008, maximiser audits, environmental audits*)

The cleaning specification details the cleaning service including:
scheduled and reactive cleaning;

- Planned cleaning
- Vacation cleaning
- Hydrotherapy pool cleaning
- Exceptional cleans
- Rapid response team cleaning

The schedule includes the categories of areas as defined in the NHS Estates National Standards of Cleanliness (August 2003) e.g., very high risk, high risk, significant risk and low risk functional areas.

The inspection team visited 13 clinical areas in three different hospitals within the trust. Overall the areas visited were clean, tidy and well maintained.

Areas visited were:

- Queen Elizabeth the Queen Mother Hospital: Fordwich Stroke Unit, Special Care Baby Unit, Endoscopy, ENT Endoscopy, Sea Bathing (emergency orthopaedic), Clinical Decision Unit (CDU)
- William Harvey Hospital: CDU, King C1, Cambridge J2, Endoscopy, Oxford (isolation ward)
- Kent and Canterbury: Emergency Care Centre, St Lawrence ward, Harvey ward

The on-site manager and the operation manager for the contracted cleaning services were interviewed on the QEQM site and outlined the arrangements for training of the cleaning staff and monitoring of the training. The managers have daily contact with the IPCT. They are involved in any outbreak meetings and undertake cleaning audits with the clinical staff with frequency of audit based on a risk assessment from very high risk to low risk. The managers stated that although they manage the contract the ward sister/manager needs to be in agreement in relation to processes and practices that best suit the individual wards*. (Staff interviews)*

The trust risk register identifies that providing an environment that is fit for purpose is constrained by the age of some parts of the estate (*trust corporate risk register 2008/09*)

The overall impression of the areas visited on the QEQM and Kent and Canterbury site were extremely positive, the clinical areas were clean and well maintained all patient equipment seen was clean. On the William Harvey site the general standard of cleanliness was still reasonably good however there was some evidence of less attention to detail, with some isolated issues identified including:

- Plastic boxes containing blood glucose testing equipment on two wards were spattered with blood. One was particularly bad and was immediately disposed of.
- Storage of items is an issue and lots of 'clutter' and old equipment that is no longer used was seen in some wards.
- Clean blood pressure cuffs stored under wet slipper pans.

More generally the inspection team noted that many of the domestic waste bins examined on the QEQM and WH sites contained used gloves and aprons that should have been disposed of in clinical waste bins. Staff interviewed were all aware of proper processes and the fact that the trust could be penalised for incorrect waste disposal. In addition bins clearly had labels stating 'No Gloves and No Clinical waste'. This was brought to the attention of the trust who indicated that immediate action would be taken (*observation tools, interviews with staff*)

A bath with jets was observed on one ward on the Kent and Canterbury site, staff were unaware how the jets were cleaned. This was brought to the attention of the IPCT who were aware of the bath through a recent environmental audit, and confirmed that they have requested information regarding specific arrangements for cleaning the jets. They had recently contacted the estates team for clarification and were awaiting the outcome. (*observation tool and interview with nurses and IPCT, IPC environmental audit November 2008*)

The team observed that eye catching and informative cleaning schedules were available as were floor and wall signs to improve compliance with hand hygiene

Staff interviewed were able to confirm the following:

- 24 hour cleaning staff
- 24 hour 'Blitz' team for post infection clean
- Good awareness of responsibilities for cleaning

d) The trust must ensure that cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available, with a view to minimising the risk of HCAI.	
I: Line(s) of enquiry	
4d(1)	**The trust ensures that cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available; and has taken account of Annex 1.**
II: Evaluation of evidence	

Contract cleaners provide the cleaning services for the trust. There is a cleaning (domestic) services and associated services output specification which contains key objectives and processes for cleaning services. This specification makes reference to the trust's IPCT as one of the 'key

customers and contains other references to the IPC manual (*Cleaning (Domestic) Services and Associated Services output specification*)

In all clinical areas visited, there was a very clear schedule of cleaning responsibilities and frequencies in pictorial form in public areas. All staff were aware of their responsibilities for cleaning: what to clean and the products to use. It was clear that there is an effective relationship between the IPCT and the contract cleaning managers. (*observation tools, interviews with staff*)

There are designated toilet cleaning teams who clean all toilets at regular intervals. They are also responsible for thorough clean of commodes twice a day in each area.

Charts were present in every cleaning cupboard for products and processes. There is also a schedule for stripping and cleaning of floors, vents, radiators, etc. (*planned schedule for cleaning*)

Domestic staff are invited to ward meetings and feel an integral part of the team. (*interview notes on-site manager and operational manager of the contract cleaning service*)

Following use by patients with infections the contract cleaners perform a 'vacation clean' with hot water and a chlorine based cleaning solution (*interviews with staff, isolation policy*)

The trust's IC annual programme stipulates the cleaning/hygiene practices for the management of *Clostridium difficile.* These include:

- the use of a sodium hypochlorite product
- the frequency of cleaning of isolation rooms and equipment used by patients infected with *Clostridium difficile* such as commodes, dynamic mattress systems

(*IC annual programme 2008/2009*)

The trust's 'Raising the bar' project was introduced in February 2008 with the specific aim of improving cleanliness and patient feeding standards across the Trust. This was a three month project undertaken between March and May 2008 where 65 ward managers across all 3 sites, were visited by the facilities department, accompanied by a cleaning contract representative, and on some occasions a matron, with the following objectives discussed:

- Explain what their expectations should be with regards to the content and standards as laid out in the cleaning and catering specifications.
- The monitoring regime.
- What an output specification is.
- The payment mechanism.
- Escalation.
- Rectification and response times.
- A walk round of their ward area (for 10 minutes) to spot check on the cleaning standards and to demonstrate how thorough the cleaning and monitoring should be.

(Raising the bar project document May2008, interviews with staff)

The DoNMQ undertakes spot checks on all sites that include checks on general cleanliness, clinical room/area and tidiness & clutter any failures to meet required standards are reported with actions for improvement. (*Infection control spot checks: KC site, Aug 08, QEQM site, September 08, WHH July 08)*

It was clear from interviews with staff that the IPCT have been involved with the development of cleaning standards and schedules

The cleaning contractors monitor the results of maximiser audits against infection control environmental audits. *(maximiser audits, environmental audits, interviews with DIPC and DDIPC)*

e) The trust must ensure that there is adequate provision of suitable hand wash facilities and antibacterial hand rubs, with a view to minimising the risk of HCAI.	
I: Line(s) of enquiry	
4e(1)	**The trust ensures that there is adequate provision of suitable hand wash facilities and antibacterial hand rubs.**
II: Evaluation of evidence	

The trust has assessed its provision of hand washing facilities on most wards on the three inpatient trust sites against the following standard: There are sufficient numbers of hand wash basins available in accordance with national and local guidelines. Hand wash basins conform to HTM 64. Comments were included where improvements are needed. (*Hand wash basin audits*)

Staff interviewed generally felt that hand wash facilities were adequate with the exception of Fordwich Stroke Unit where they have identified the need for a basin in the clinical room, this has been requested and should be in place within the next fortnight and the DVT clinic in the Kent and Canterbury emergency care centre, again this has been raised with estates who are investigating the waste pipes available. Some areas would like basins moved for easier access but have stated that this has been raised and is under review with the refurbishment plans. The new build at QEQM has been designed with consultation with the IPCT and facilities will be in line with recognised best practice. From observation it appears that there are suitable facilities and appropriate access to antibacterial hand rub in all areas visited. (*observation tools and interviews with staff, audits of hand wash basins*)

Antibacterial hand rub was seen to be readily available at the point of patient care and at entrances to wards and departments. (*Observation tools)*

Notices were seen above bed spaces encouraging hand hygiene and the use of wet wipes for individual patients to promote optimum hand hygiene (*observation tools, IC annual programme 2008/2009*)

The IC annual programme describes the IPCT promotion of effective hand hygiene including:

- Supporting phase 3 of the cleanyourhands campaign
- Seven ward in the trust are part of a national campaign (FIT study) to improve hand hygiene amongst ward staff
- Regular hand hygiene sessions on wards

Staff observed during the site visits were seen to be washing their hands and using the antibacterial hand rub provided. Floor and wall notices were in place to encourage hand hygiene compliance (*observation tools)*

f) The trust must ensure that there are effective arrangements for the appropriate decontamination of instruments and other equipment.

I: Line(s) of enquiry	
4f(1)	**The trust ensures that there are effective arrangements for the appropriate decontamination of equipment; and has taken account of Annex 1.**

II: Evaluation of evidence

East Kent Hospitals is part of the Kent cluster project for the centralisation of sterile services provision to an off site location. This project is in line with the national strategy and is due for completion in August / September 2009. Currently there are sterile services provided at the trust. A BSI (British Standards) audit was undertaken in December which we were told concluded that it was a well run unit with all appropriate training for staff. The unit is CE marked because the unit provides sterile supplies to the PCT. Quality meeting minutes with actions signed off were seen but not retained. The trust's hygiene code action plan states that the steam piping is non-compliant and will be addressed in the new facility due to be functional by September 2009, in the meantime regular monitoring is providing assurance on maintenance of quality. (*steam test purity reports, interview with head of patient safety and SSD manager*)

Endoscopy services have recently undergone a Joint Accreditation Group (JAG) review at the Kent and Canterbury site, there were no action points about the processing or decontamination of equipment raised. All washer disinfectors in the endoscopy units have either been replaced or are in the process of being replaced. The endoscopy unit at QEQM has been redeveloped and is about to open. This unit has a 'pass through' design with complete separation of dirty to clean. A reverse osmosis water plant has been installed and all of the commissioning tests have been completed. The ENT outpatient clinic is not HTM 20/30 compliant or JAG accredited, however a risk assessment has been completed and there is an appropriate work process in place to manage the identified risks. Training records were seen in both units and the lead from each area discussed the training and supervision of staff undertaking processing of endoscopes. The relevant daily testing records were viewed in the ENT department. (*observation tools, interviews with head of patient safety, JAG visit report 30 Sept 08)*

We were told that the ICPT audit the three endoscopy units every 12-18 months using the environmental audits and adapted ICNA tools, these are reported at the decontamination working group. Previous audits and completed action plans were provided but there were none for 2008. In addition the audit of endoscopy facilities and practice takes place bi-annually by the Authorised Person (sterilisers), DDIPC, endoscopy lead nurse and steriliser engineer. The trust's policy for the decontamination of reusable medical devices outside the sterile services department contains an appendix for the processing of flexible endoscopes. (*policy for the decontamination of reusable medical devices outside the sterile services department August 2008, Audit of Endoscopy department KCH 12 December 2007*)

The trust's decontamination policy states that the IPCT must sign off the purchase of any new equipment that requires decontamination outside SSD. (*policy for the decontamination of reusable medical devices outside the sterile services department August 2008*)

The trust's cleaning specification makes clear that contractors are responsible for cleaning all medical and patient equipment not being used or attached to patients under the direct instruction of ward staff unless specifically excluded. (*cleaning specification*)

We observed equipment storerooms that were generally clean and tidy. Most of the equipment inspected was clean. Staff interview were all very clear regarding their responsibilities for the decontamination of patient equipment in ward areas. Patient equipment is cleaned following use by nursing staff and the cleaners also ensure that it is cleaned daily when in the storage areas. Hoist slings were seen to be disposable. Plastic bags were covering patient fans to denote they had been cleaned. There were some isolated incidents of dust on blood pressure machines and the blood pressure cuffs were seen to be marked on one ward, this was brought to the attention of senior staff during observation round. (*observation tools*)

The trust's annual IC programme states that the IPCT will organise the annual commode audit. The audit for 2008 resulted in a change to include twice daily cleaning of commodes by the domestic staff using a chlorine based cleaning solution, in addition to the clean after use undertaken by the nursing staff. Commodes are left with the seat upturned and with tape applied to denote that they have been cleaned and are ready for use. All commodes seen during the inspection on all three sites were clean, apart from two old style commodes on one ward on the William Harvey site which were stained. Checking forms were available and signed to denote that the twice daily cleans were being undertaken. (*annual report, interviews with staff, observation tools)*

The trust has a policy for mattresses, including the management of dynamic mattress systems. The policy outlines the cleaning processes and solutions to be used. The trust uses a label to identify dynamic mattress systems used by patients with infections. The isolation and mattress policies states that it is the nurses responsibility to contact the tissue viability nurses to arrange for the external cleaning of dynamic mattress systems used by patients with infections. Interviews with staff confirmed that specialist mattresses are cleaned externally. (*IC annual programme 2008/2009, label observed on visit, not retained, Mattress policy August 2008, Isolation policy*).

g) The trust must ensure that the supply and provision of linen and laundry supplies reflects Health Service Guidance HSG (95)18, Hospital Laundry Arrangements for Used and Infected Linen, as revised from time to time, with a view to minimising the risk of HCAI.	
I: Line(s) of enquiry	
4g(1)	**The trust ensures that the supply and provision of linen and laundry supplies reflects Health Service Guidance HSG (95) 18, Hospital Laundry Arrangements for Used and Infected Linen, as revised from time to time.**
II: Evaluation of evidence	

Linen services are provided in-house and comply with HSG95(18). Calibration checks are carried out and monitored monthly. Evidence is kept at East Kent linen services on: soaps and bleaches, machine temperatures and UV whiteness checks. Monitoring records for independent checks were provided for September, October and November 2008. No issues were raised by staff in relation to collection and delivery, however there are some storage issues for dirty linen bags and this is to be reviewed as part of the refurbishment at QEQM and WH.(*email form linen and accommodation manager 9 Dec 08, Laundry technology reports*)

h) The trust must ensure that uniform and workwear policy ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose.	
I: Line(s) of enquiry	
4h(1)	**The trust ensures that uniform and workwear policy ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose.**
II: Evaluation of evidence	

The trust has a uniform policy, updated in April 2008. The policy includes guidance on the 'bare below the elbows' (BBE) initiative, action to be taken if uniforms become soiled and laundering arrangements. The policy covers the requirements for personal protective equipment (PPE) the uniform policy makes reference to HCAI and cross infection. (*uniform policy, updated April 2008*)

All staff were aware of the uniform policy and requirements. BBE is required for direct patient

contact and this was observed on all the wards visited. Medical staff in clinical areas with wrist watches were seen to remove these when approaching a patient. All staff seen were wearing uniforms that were clean, tidy and fit for purpose. (*observation tools*)

Duty 8: Duty to provide adequate isolation facilities

a) The trust must ensure that it is able to provide or secure the provision of adequate isolation facilities for in-patients sufficient to prevent or minimise the spread of HCAI	
I: Line(s) of enquiry	
8a(1)	**The trust ensures that it is able to provide or secure the provision of adequate isolation facilities for in-patients sufficient to prevent or minimise the spread of HCAI; and has taken account of Annex 1.**
II: Evaluation of evidence	

The trust has assessed the available provision for isolation and has recently opened four negative pressure isolation rooms, two at the William Harvey Hospital and two at Queen Elizabeth the Queen Mother Hospital. The IPCT were involved throughout the process. The trust has not identified a need for positive pressure facilities due to the nature of its work, however there is guidance for staff contained in the isolation policy to be followed if a patient does require protective isolation, the policy states which side rooms on designated wards should be used. (*IC annual report 2007-2008, email re progress on isolation ward – September 2008, interview with DIPC, isolation policy, updated Aug 08*)

The trust has an isolation ward on the William Harvey site. The trust have identified that further investment is required to provide more isolation facilities. This is addressed as part of the estates strategy which will provide 50% side rooms.

Current availability of side rooms is as follows:
Surgery: 330 beds, 18% side rooms, of which 43% are ensuite
Medicine: 617 beds, 16% side rooms, of which 54% are ensuite
Maternity/paediatrics: 176 beds, 23% side rooms of which 59% are ensuite
ITU: 24 beds, 33% side rooms, none of which are ensuite

The isolation policy states that if a patient has been diagnosed with an infection or an infection is suspected the IPCT should be informed. The policy advises that the most effective form of isolation is a single room and this should always be the first choice for the placement of an infected/colonised patient. However there is a contingency for cohorting (grouping of patients with one particular infection to isolate them from other patients) patients if required and for ward closures.

The policy provides guidance on action that must be taken by staff if there is no availability of a side room, including consultation with the IPCT and the policy contains an appendix 'guidance for bed managers/matrons/site coordinators' on the management of 'high risk' patients and guidelines for admission to the isolation ward which is coordinated via the clinical decisions unit and the IPCT. *(Isolation Policy – reviewed August 2008)*

The isolation policy is referenced to and supplemented by the MRSA policy, this includes more detailed guidance for staff and has as an appendix a management plan to be followed if a patient has confirmed MRSA colonisation/infection and a MRSA risk assessment tool for placement of

patients within the ward area. (*MRSA policy September 2005/August 2008*)

The trust also has a *Clostridium difficile* policy that contains an appendix: medical guidelines for patient management which lays out the nursing and medical management required, a *Clostridium difficile* patient management plan and a RCA tool designed for investigating *Clostridium difficile* cases. (*Clostridium difficile policy*)

Included in the trust's infection control manual are a number of other policies providing information on various types of infection and their management. The policy for the admission, movement/transfer and discharge of patients with an infection / infectious disease contains a patient transfer risk assessment tool. This is to be applied to all patients being transferred to departments or clinical area within the trust and to all inter and intra hospital transfers and is completed by the registered nurse / midwife responsible for the patient's care or the nurse in charge of the ward. The risk assessment includes information about HCAI and isolation requirements. *(IC Manual and transfer policy)*

Directorates are required to audit compliance with cohorting in line with directorate KPI targets (*Isolation policy*)

An audit of isolation of 64 patients with confirmed *Clostridium difficile* within six hours was undertaken between July and November 2008 showing that nearly all patients were isolated within the target. One patient was over the target time and for seven there was no data. (*audit of isolation of patients with Clostridium difficile)*

All staff interviewed were aware of the policies for isolation and the need to liaise with IPCT. Decisions to isolate patients are based on policy guidance and discussed with the IPCT if any concerns are identified. All areas have co-hort plans in place if the need arises and this is only instigated with discussion with IPCT. (*interview notes with staff)*

All staff are aware of relevant precautions and processes to follow if patient is isolated for infection. Different isolation notices are available depending on the type of infection present, for example one notice requests staff to use antibacterial hand rub, another, for *Clostridium difficile* infections requires personnel to wash hands with soap and water. (*Observation tools, copies of notices and interviews with staff*)

Gloves and aprons were seen to be readily available outside bays and single rooms. (*observation tools)*

Isolation audit
The planned audit of the trust's isolation wards was planned but not undertaken due to demands on the team. (*IC annual report 2007-2008)*

Duty 10: Duty to adhere to policies and protocols applicable to infection prevention and control

j) The trust must have in place an appropriate policy in relation to antimicrobial prescribing, which is monitored via the trust's Clinical Governance System. There must be evidence of a rolling programme of audit, revision, and update, and the policy must be marked with a clear review date.	
I: Line(s) of enquiry	
10j(1)	**The trust has in place an appropriate policy on antimicrobial prescribing. The policy is monitored via the trust's Clinical Governance System, and there is evidence of a rolling programme of audit, revision, and update, and the policy is marked with a clear review date. The trust has taken account of Annex 2 in forming its policy.**
II: Evaluation of evidence	

The trust's document: guidelines on the use of antimicrobial drugs are dated September 2003 but have been regularly updated, the last update in July 2007, the guidelines have an expiry date of June 2009. (*guidelines on the use of antimicrobial drugs*)

The trust's annual infection control programme details the trust's antibiotic management:

- The trust's drugs and therapeutic committee are to receive reports on antibiotic prescribing from directorates and from pharmacy staff carrying out surveillance at ward level
- Continuing close monitoring and control of the use of antibiotics known to present a higher risk of *Clostridium difficile* infection
- Improved systems for escalating and acting on non-compliance with the antibiotic policy
- Removal of broad spectrum cephalosporin from ward stock in surgical units
- The development of a pocket size antibiotic policy to be issued to all junior medical staff together with an interactive web based antibiotic policy rolled out during August 2008

(Infection control annual programme April 2008-March 2009)

Interviews with staff confirmed that these initiatives were in place. All junior doctors are provided with a pocket size copy of the guidelines for the use of antibiotics. The interactive web based antibiotic policy provides advice based on information submitted and useful links, such as the BNF. The antimicrobial pharmacist will be monitoring the usage of the web based policy. (*interview notes-pharmacists*)

The pharmacists stated that they had been limited by the amount of audit that they had been involved in due to lack of resources in their team. This has now been addressed with the recent appointment of two full time antimicrobial pharmacists. (*interview notes pharmacists*)

In spite of the above, antibiotic use by directorate and by site is collected monthly to monitor usage. In addition, four directorates completed antimicrobial prescribing audits during 2007/2008. There is routine monitoring of compliance with the policy by pharmacy and microbiology staff with microbiology conducting retrospective audits on the medical admission wards and point of prevalence studies on all general surgical and orthopaedic wards. (*IPC annual programme, IC annual report 2007-2008*). The pharmacy technician monitors antibiotic usage for each directorate by site. The information is then provided to the clinical directors and the stewardship group for monitoring. The information is updated monthly, if required the information can be broken down to individual prescribers and poor performance can be escalated via the clinical director to the medical director. These reports have resulted in the removal of some high risk antibiotics from clinical areas

e.g. cefuroxime has been removed from wards. (*antibiotic usage spreadsheets, interview notes - pharmacists, drugs and therapeutic committee minutes*)

The inspection team were shown a new prescription chart, currently in final print stage, with a number of pages, which has been designed so that whichever page is being used the patient details, including allergies are visible. The new chart has a separate page for antibiotic prescribing which provides triggers to prompt compliance with best practice, such as requiring a doctor's signature after five days, and microbiology approval at 10 days of antibiotic use. (*new prescribing policy, interview with pharmacists, prescription chart*)

Numerous presentations were provided that are delivered at medical staff training by pharmacists, microbiologists and the DIPC outlining best practice regarding antimicrobial prescribing and usage. (*PowerPoint presentations)*

Staff interviewed during the visits to the wards were aware of the antimicrobial prescribing policies and stated that it was part of their role to query prescriptions if they were concerned. Staff showed us the pharmacy intervention record form which is used if there is a problem identified with any prescription to provide details of the problem to the prescribing clinician and a range of outcomes to be documented. (*staff interviews, Pharmacy Intervention Record Form*)

Pharmacists visit the wards daily Monday to Friday and are available on Saturday morning and on-call at other times. Any concerns are raised with the DIPC/microbiologist and/or IPCT. The pharmacist places a 'Yellow Label' (seen but not retained) on any prescription chart that raises any concerns and information is copied to the microbiologist and clinical lead. Pharmacy monitors the use of anti- infectives. *(interview notes – pharmacists)*

Supporting evidence

Staff interviewed (list job titles)

- Director of Nursing, Quality and Midwifery
- Chairman
- Chief Executive
- Trust Sterile Services Manager and Head of Patient Safety (interviewed together)
- Head of Facilities and Head of Estates (interviewed together)
- Head of Human Resources and Workforce Planning (interviewed together)
- Chief Operating Officer
- Head of Pharmacy, Antimicrobial Pharmacist and Antimicrobial Technician (interviewed together)
- DIPC and deputy DIPC (interviewed together)
- Infection prevention and control team: three x ICN, and consultant microbiologist
- interviewed during observation visits:
    Matrons x 4
    Ward manager x 2
    Sister x 4
    Nurses x 22
    HCA x 8
    Domestic staff x 13
    Domestic supervisor x 1
    Contract cleaners on site manager x 2
    Doctors x 12
    X-ray technician x 1
    Physiotherapists x 3
    Porters x 4
    Pharmacist x 1

Areas where observations were conducted (Note: this is relevant to duty 4)

Kent and Canterbury

- Emergency Care Centre
- St Lawrence (medical ward)
- Harvey ward (medical)

Queen Elizabeth the Queen Mother

- Fordwich Stroke Unit
- SCBU
- Endoscopy
- ENT endoscopy
- Sea Bathing ward
- Clinical Decisions Unit

William Harvey

- CDU
- King C1
- Cambridge J2

- Endoscopy
- Oxford (isolation ward)

Documents reviewed

Reference	Document title	Date of document
HCAI RVV 001	Job description – Medical director	
HCAI RVV 002	Job description - DIPC	
HCAI RVV 003	Director of Nursing – Job plan	
HCAI RVV 004	EKHUT Infection Control Organisational arrangements	August 2008
HCAI RVV 005	Interview notes - DIPC	10 December 2008
HCAI RVV 006	Interview notes - chairman	9 December 2008
HCAI RVV 007	Interview notes - CEO	9 December 2008
HCAI RVV 008	NED handbook	
HCAI RVV 009	IPC Annual Report	April 2007-March 2008
HCAI RVV 010	Appendix to all job descriptions	January 2008
HCAI RVV 011	Job Description - DoNMQ	undated
HCAI RVV 012	Job description - Lead Nurse Head of Nursing	September 2007
HCAI RVV 013	Job Description - Matron	
HCAI RVV 014	Job description - Registered nurse band 5	
HCAI RVV 015	Minutes - ICC	
HCAI RVV 016	Interview notes matron	
HCAI RVV 017	Framework for the management of risks associated with IPC in EKHUT	November 2006
HCAI RVV 018	Clinical Governance assurance framework	August 2008
HCAI RVV 019	Infection control programme	April 2008 – March 2009
HCAI RVV 020	EKHUT Infection control organizational arrangements	August 2008
HCAI RVV 021	TOR Clinical Management Board	
HCAI RVV 022	Minutes – Clinical Management Board	
HCAI RVV 023	Minutes – Trust Board	May 2008
HCAI RVV 024	Minutes – Trust Board	June 2008
HCAI RVV 025	Patient Safety and quality report	November 2008
HCAI RVV 026	RCA investigation reports	various
HCAI RVV 027	MRSA policy September 2005/August 2008	
HCAI RVV 028	IPC performance monitoring	
HCAI RVV 029	Key Performance indicator targets for directorates	May 2008
HCAI RVV 030	Isolation Policy	August 2008
HCAI RVV 031	Business case	undated
HCAI RVV 032	Interview notes IPCT	10 Dec 2008
HCAI RVV 033	Minutes directorate leads meetings	
HCAI RVV 034	Induction Policy	
HCAI RVV 035	Interviews - Pharmacists	10 Dec 2008
HCAI RVV 036	Training PowerPoint presentations	
HCAI RVV 037	Interview – HR and Workforce planning	
HCAI RVV 038	Education and training recorded rates for mandatory training	
HCAI RVV 039	Induction and Mandatory training policy	undated
HCAI RVV 040	Interviews – onsite manager and operations manager for cleaning contractors	
HCAI RVV 041	Contractors information booklet	Updated July 2007
HCAI RVV 042	IPC guidance for contractors	
HCAI RVV 043	Interview – estates manager	
HCAI RVV 044	Environmental audits	November 2008

HCAI RVV 045	Antibiotic usage summary	
HCAI RVV 046	Commode audits	
HCAI RVV 047	Commode audit tool	
HCAI RVV 048	Implementation on Synbiotix Saving Lives for High Impact Interventions document	
HCAI RVV 049	Venous cannulation management and removal (adults)	2006
HCAI RVV 050	peripheral cannula audit,	
HCAI RVV 051	peripheral cannula audit flyer	2008
HCAI RVV 052	CV audit	September 2008
HCAI RVV 053	Urinary catheter audit flyer	2008
HCAI RVV 054	Transfer of Patients policy	January 2008
HCAI RVV 055	Transfer risk assessment tool	
HCAI RVV 056	Policy for the Admission, Movement/Transfer and Discharge of Patients with an Infection / Infectious Disease	August 2008
HCAI RVV 057	operational escalation plan 2006	
HCAI RVV 058	Draft policy document for environmental policies and infection control	December 2008
HCAI RVV 059	Cleaning Operational Plan	June 2008
HCAI RVV 060	cleaning specification	
HCAI RVV 061	East Kent Hospitals University NHS Trust Strategic Cleaning Plan Review	November 2008
HCAI RVV 062	Ward kitchens and food policy	2008
HCAI RVV 063	Waste Strategy	2008
HCAI RVV 064	Legionella Policy	
HCAI RVV 065	Infection control in building and refurbishment policy	December 2008
HCAI RVV 066	emails regarding recent building work	
HCAI RVV 067	Job description - trust decontamination lead	November 2008
HCAI RVV 0068	Job description - Head of soft FM services	
HCAI RVV 069	Minutes of Decontamination of medical devices working Group	8 Dec 08
HCAI RVV 070	Minutes of Decontamination of medical devices working Group	October 2008
HCAI RVV 071	JAG visit report	30 Sept 08
HCAI RVV 072	Maximiser audits	various
HCAI RVV 073	Email from linen and accommodation manager	9 Dec 08
HCAI RVV 074	Trust corporate risk register	2008/09
HCAI RVV 075	Cleaning (Domestic) Services and Associated Services output specification	
HCAI RVV 076	Planned schedule for cleaning	
HCAI RVV 077	Raising the bar' project document	
HCAI RVV 078	Hand wash basin audits	
HCAI RVV 079	Steam test purity reports	
HCAI RVV 080	Policy for the decontamination of reusable medical devices outside the sterile services department	August 2008
HCAI RVV 081	Mattress policy	August 2008
HCAI RVV 083	Monitoring records for independent checks (linen)	October and November 2008
HCAI RVV 083	Uniform Policy	Updated April 2008

HCAI RVV 084	Email re progress on isolation ward –	September 2008
HCAI RVV 085	MRSA policy September	2005/August 2008
HCAI RVV 086	*Clostridium difficile* policy	
HCAI RVV 087	Audit of isolation of patients with Clostridium difficile	July – November 2008
HCAI RVV 088	Isolation notices	
HCAI RVV 089	Minutes drugs and therapeutic committee	
HCAI RVV 090	JAG Action Plan	December 2008
HCAI RVV 091	Observation tools	
HCAI RVV 092	Guidelines on the use of antimicrobial drugs	Updated July 2007
HCAI RVV 093	Infection Prevention and Control Key Performance Indicator Targets for Directorates – Performance Metrics)	2008 – 2009

East Kent Hospitals University NHS
NHS Trust

Deep Clean Assurance

In response to the request from the SHA, this comprehensive update highlights EKHUT's approach to the continuing 'Deep Clean' programme, based on (at the very least):

- the latest national guidance/advice on cleaning
- an assessment of what worked well and not so well from the 07/08 Deep Clean
- an assessment of the level of decanting to enable a proper Deep Clean processes (especially where decanting may not have been carried out in the previous Deep Clean)
- a thorough needs assessment of the current position - e.g. prioritising areas using infection rates, cleanliness and public confidence scores
- agreed measures to be used to assess how well the plan has been implemented
- reporting of performance against these measures to the PCT

The update includes all relevant reports, action plans, a longer term approach to achieving excellent cleaning standards and improvement plans.

- There is on going review of the deep cleaning programme as indicated in the assurance document. The current cleaning specification (July 2004 – June 2011) meets the operational cleaning requirements of 'The national specifications for cleanliness in the NHS'

- The 'Deep cleaning programme' resulted in the 'Raising the Bar' initiative, to ensure continuity in improving the standard of cleanliness achieved and to reinforce awareness at ward level of the contract specification which included the standards to be maintained and escalation by the local managers in the event of default.

- The deep cleaning programme also resulted in the initiative to fully review cleaning services to ensure our service provider, Medirest, is adhering to the contract specification and a drive to achieve consistent excellence throughout in cleaning standards. A cleaning action plan was developed with identified time frames. Progress is monitored weekly (using red, amber, green indicators) with our service provider.

- In addition senior Trust representatives met with senior Medirest management, Medirest. From this an action plan was drawn up with identified time frames, with a commitment to improving consistent standards of excellence, and to identify areas of weakness in the delivery of the cleaning service.

- A comprehensive cleaning schedule has been produced with the involvement of senior nurses and IP&C. This will shortly be prominently displayed on all wards

and departments. The ward cleaning SLA's have been signed off across the Trust and there is evidence to support the ward managers increased awareness of the specification particularly in respect of their expectations from the cleaning. The Medirest supervisors are carrying out daily spot checks and are focused on the 49 cleaning elements.

- A further piece of work is that of bringing together all the strands around cleaning by identifying action points from relevant legislation and guidance and initiatives which is being coordinated and led by the Deputy Director of Nursing.

- A review of the cleaning strategy (approved by the Risk Committee- Trust board sign off imminent) and the cleaning operational policy plan has been undertaken.

- There has been a full review of mattress storage and segregation in accordance with the enhanced cleaning programme to ensure compliance with all relevant local and national guidance.

- Commode audits are carried out an ongoing monthly basis by Medirest in addition to the Infection Prevention and Control commode audits.

PEAT

The results for this year did not reflect the full effect of the deep cleaning programme as the assessments were undertaken during the on going activity of the programme. As a consequence of the results a report 'Life after PEAT' identified possible solutions which are being taken forward as part of the coordination of the cleaning strands with nursing.

Task lists were issued as a consequence of the exercise.

Annual Monitoring Programme (AMP)

There is an AMP for each site which is reviewed and agreed by Infection Prevention and Control. Medirest have specific site monitoring officers who monitor the 49 elements utilising Maximiser to this programme involving both Matrons and ward managers. There is consistent review of the scores as part of the Medirest monthly report with identification of those areas that do reach the specified standard of 95% and also the highlighting the 10 most common failures identified for targeting by the supervisors over the next month. The 13 week review is compiled in accordance with the National Cleaning specification and submitted to ERIC. The monitoring results, its associated risk category, along with patient cleaning survey results and patient complaints help to determine areas requiring a deep clean.

Public surveys.

Medirest carry out quarterly reviews to ascertain patient feedback and perception of the cleaning service.

- Introduction of more comprehensive audit trails. For barrier room cleaning, curtain changing programme, floor maintenance schedules, radiator cleaning

Environment

An Estates strategy is being developed to encompass the requirements as prioritised on each site by an identified representative group.

Things that did not go so well:

- Not being able to decant at the KCH, therefore the cleaning took place while patients were in the beds or wherever possible, one bay at a time! It did cause disruption and the cleaning generally could not be as thorough as we would have wanted.
- The initial hours submitted by our service provider (Medirest) were reduced, therefore this impacted on time available spent on wards to physically clean, leading to some ward managers being dissatisfied with the outcome. The time allocated for the wards to be thoroughly deep cleaned was insufficient taking into account that they were occupied, which meant that areas had to be revisited several times to complete the clean.
- The timescale imposed for such a large Trust, put unnecessary pressure on ward and cleaning staff, through working overtime.
- There was a lack of bed spaces to move patients at the WHH on areas where Norovirus was present. This created some confusion in March 2008 when the plan was changed around in Kings wards, Betherseden and CDU at WHH.
- Where major building works were being undertaken, these areas had to be re-visited, examples being, Endoscopy, Oxford, Outpatients and Maternity.
- The wards which were unable to decant gave Medirest operational issues as only 1 bay at a time could be cleaned and then patients had to be moved thus extending the time frame of deep cleaning these wards.
- It became apparent during the process that although we had originally allowed 3 days to fully deep clean a ward, Estates department were also instructed to complete minor repairs at the same time therefore in practice we only has 1.5 or 2 days to complete the task.
- There was also an expectation from the wards that when they returned to their ward from the decant that the ward would have had a “Make over”.
- Unfortunately there were a number of departments were the lack of co-operation and interest in the programme made it difficult for the team to carry out their work to the required standard.

Things that did go well:

- Being able to decant at the WHH and QEQM. The wards which were decanted gave Medirest the best opportunity to deep clean as we were able to use the high pressure steam cleaners to ensure that we got into all areas of the ward.
- Many of the different disciplines worked together to deliver the programme i.e. good examples of team working.
- It gave the opportunity for a structured process, led by hospital managers, for cleaning areas in greater depth e.g. storage areas.
- There was an opportunity to carry out minor building works, resulting in improved cleanliness (fabric easier to clean).
- There was a great deal of de-cluttering that took place which improved the tidiness of many areas and has enabled Medirest to complete cleaning since then with more accessibility.

- It gave an added focus on cleaning and the importance of it. It re-emphasised that cleaning is everyone's responsibility.
- The ward managers had the ability to formally sign off the deep clean and were therefore able to determine whether the standards had been achieved or not. This formal process was welcomed by many of the ward managers as they were able to ensure the required standards were met.
- Medirest rose to the challenge very well, especially at such short notice and were very supportive in the whole process.
- It enabled the Trust to purchase specialist equipment, e.g. dry steam pressure cleaners, which are still used on an ongoing basis all year round, leading to more effective cleaning.
- There was positive feedback from certain departments who were very pleased at having a thorough deep clean.

As a suggestion, the sum of money spent on the one off 'Deep Clean' potentially would be better employed on permanent deep clean teams all year round. I have attached the scoping document for 'Specialist Infection Control Clean teams' which describes our approach to assisting in the ongoing programme.

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FIRST DOMAIN: SAFETY **Patient safety is enhanced by the use of healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C1a	Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents and make improvements in practice based on local and national experience and information derived from the analysis of incidents	**Compliant**	**Compliant**
C1b	Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.	**Compliant**	**Compliant**
C2	Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.	**Compliant**	**Compliant**
C3	Healthcare organisations protect patients by following National Institute for Health and Clinical Excellence (NICE) interventional procedures guidance.	**Compliant**	**Compliant**
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 MRSA.	**Compliant**	**Compliant**
C4b	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.	**Compliant**	**Compliant**
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 the risks associated with decontamination facilities and processes are well managed.	**Compliant**	**Compliant**
C4d	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.	**Compliant**	**Compliant**

C4e	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment. **Commentary**: Following on from recommendations contained within correspondence from the Environment Agency in late February 2008, good progress has been made with the action plan to address these. 44 of the 54 recommendations have been achieved with the remaining 10 on target for completion before the end of March 2009. The Trust must be able to demonstrate that the standard has been fully met for the whole year to declare compliance, which will not be possible for 2008-09.	**Not met**	**Insufficient Assurance**

SECOND DOMAIN: CLINICAL AND COST EFFECTIVENESS

Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes.

Core Standards		Declaration 2007/08	Draft Declaration 2008/09
C5a	Healthcare organisations ensure that they conform to National Institute for Health and Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivery treatment and care.	**Compliant**	**Compliant**
C5b	Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.	**Compliant**	**Compliant**
C5c	Healthcare organisations ensure that clinicians' continuously update skills and techniques relevant to their clinical work.	**Compliant**	**Compliant**
C5d	Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.	**Compliant**	**Compliant**
C5d	Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.	**Compliant**	**Compliant**
C6	Healthcare organisations cooperate with each other and social care organisations to ensure those patients' individual needs are properly managed and met.	**Compliant**	**Compliant**

THIRD DOMAIN: GOVERNANCE **Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C7a	Healthcare organisations: apply the principals of sound clinical corporate governance.	**Compliant**	**Compliant**
C7b	Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.	**Compliant**	**Compliant**
C7c	Healthcare organisations undertake systematic assessment and risk management.	**Compliant**	**Compliant**
C7d	Healthcare organisations ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources.	**Separate Assessment**	**Separate Assessment**
C7e	Healthcare organisations challenge discrimination, promote equality and respect human rights.	**Compliant**	**Compliant**
C7f	Healthcare organisations meet the existing performance requirements.	**Separate Assessment**	**Separate Assessment**
C8a	Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.	**Compliant**	**Compliant**
C8b	Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under representation of minority groups.	**Compliant**	**Compliant**
C9	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	**Compliant**	**Compliant**

THIRD DOMAIN: GOVERNANCE **Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices, ensure that probity, quality assurance, quality improvement and patient safety are central components of all activities of the healthcare organisation.**			
C10a	Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.	**Compliant**	**Compliant**
C10b	Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice.	**Compliant**	**Compliant**
C11a	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.	**Compliant**	**Compliant**
C11b	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.	**Compliant**	**Compliant**
C11c	Healthcare organizations ensure that staff concerned with all aspects of the provision of health care participate in further professional and occupational development commensurate with their work throughout their working lives.	**Compliant**	**Compliant**
C12	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.	**Compliant**	**Compliant**
C13a	Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.	**Compliant**	**Compliant**
FOURTH DOMAIN: PATIENT FOCUS **Healthcare is provided in partnership with patients, their carers and relatives respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient wellbeing.**			
C13b	Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information.	**Compliant**	**Compliant**
C13c	Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where	**Compliant**	**Compliant**

	authorised by legislation to the contrary.		
C14a	Healthcare organisation have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.	**Compliant**	**Compliant**
C14b	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.	**Compliant**	**Compliant**
C14c	Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.	**Compliant**	**Compliant**
C15a	Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice that it is prepared safely and provides a balanced diet.	**Compliant**	**Compliant**
C15b	Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.	**Compliant**	**Compliant**
C16	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.	**Compliant**	**Compliant**
FIFTH DOMAIN: ACCESSIBLE AND RESPONSIVE CARE **Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway.**			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C17	The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.	**Compliant**	**Compliant**
C18	Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.	**Compliant**	**Compliant**

C19	Healthcare organisations ensure that patients with emergency health needs are able to access care promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.	**Separate Assessment**	**Separate Assessment**
SIXTH DOMAIN: CARE ENVIRONMENT AND AMENITIES			
Healthcare services are provided in environments which promote effective care and optimise health outcomes by being: a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation – Not a Domain Outcome			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C20a	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property and the physical assets of the organisation.	**Compliant**	**Compliant**
C20b	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.	**Compliant**	**Compliant**
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.	**Compliant**	**Compliant**
SEVENTH DOMAIN: PUBLIC HEALTH			
Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.			
Core Standards		**Declaration 2007/08**	**Draft Declaration 2008/09**
C22a	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by cooperating with each other and with local authorities and other organisations.	**Compliant**	**Compliant**
C22b	Healthcare organisations promote, protect and demonstrably improve the health of the community served and narrow health in equalities by ensuring that the local Director	**Compliant**	**Compliant**

	of Public Health's annual report informs their policies and practices.		
C22c	Healthcare organisations promote, protect and demonstrably improve the health of the community served and narrow health in equalities by making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.	**Compliant**	**Compliant**
C23	Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Framework and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.	**Compliant**	**Compliant**
C24	Healthcare organisations protect the public by having a planned, prepared and, where possible, practiced response to incidents and emergency situations which could effect the provision of normal services.	**Compliant**	**Compliant**

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Appendix 5

Waste Management Issues Briefing

Introduction

There is a distinct HCC core standard for waste management C4e as follows:

"Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment".

The Trust declared not met against this standard for 2007/2008 as a result of findings contained within the Environment Agency (EA) hazardous waste inspection report of the Medway Maritime Hospital issued in late February 2008. Both our Trust and Medway NHS Trust are members of the Kent and Medway 'Total Waste Management' consortium (a collaborative contract agreement of three acute Trusts, Mental Health Trusts and PCT's, over a seven year period, starting in November 2005, with a single service provider-Polkacrest Ltd). This report contained a number of legal requirements to be met (30), as well as a number of recommendations (24).

In addition the Trust were audited by South Coast Audit (November 2007) on its waste management practices and compliance with Health Technical Memorandum (HTM) 07-01 "Safe Management of Healthcare Waste". This report contained a number of recommendations (16).

As a number of the Medway Maritime Hospital requirements applied to this Trust, coupled with the South Coast Audit (SCA) report findings a 'not met' declaration was made. Examples of the main non compliance issues were as follows:

- The healthcare organisation should ensure that waste is properly segregated/stored:
    - Waste compounds do not meet the specification as laid in HTM 07-01 (Safe Management of Healthcare Waste).
    - Offensive waste stream (plaster casts, sanitary towels, nappies etc) not introduced. These were being disposed of in the infectious clinical waste stream.
    - Anatomical/sharps waste not correctly classified for transport i.e. wrong codes being used.
    - Incorrect coloured bags were being used in certain departments.
    - Incorrect disposal of saline bags.
    - Incorrect disposal of pathology waste.
    - Incorrect disposal of general waste in clinical waste.

- The Healthcare organisation should ensure that staff are properly trained and informed in their responsibilities and legal obligations:

    - The Trust Waste policy produced in April 2006 was not updated in line with HTM 07-01 issued in December 2006.

    - Although waste procedures had been updated they had not been issued)

    - The Trust did not have a training package developed for all it's staff e.g. e-learning, induction training.

    - The Trust does not have a dedicated waste manager for act as a single point of contact for all waste management.

In light of the 'not met' declaration the then Deputy Head of Hotel Services led on an initial three month project (later extended) to achieve 'part met' for 2008/2009 and to prepare for the impending EA inspection of the QEQM hospital in July 2008. A detailed waste management action plan was produced to ensure that the tasks and timescales were met. Initially there were a significant number of gaps but by the end of November 2008 the action plan reported a significant improvement in waste management compliance, enabling the Trust to declare 'part met' for 2008/2009. On the 19 December 2008 the Trust received the July 2008 EA report for the QEQM. Within this were 32 requirements and 8 recommendations to be met, the majority by the 31 January 2009 and the remainder by the 31 March 2009. A revised waste management action plan has been produced (attached) to ensure full compliance. The acting Head of Hotel services is leading on delivering to this plan and there is confidence that it will be delivered in the required timeframe.

It is important to note that **all** outstanding action points from the EA and SCA reports must be achieved by the end of March 2009 to enable the Trust to declare a 'fully met' declaration for 2009/2010 (as the criteria within any core standard is compliance for the full financial year). The major challenge is to complete the upgrading of our three waste compounds at the three acute sites (primarily due to planning applications and funding being made available).

Red =Not compliant
Amber =progress being made
Green =complete

Environment Agency Requirements (Absolute Legal Compliance Issue must be complied with)	Location	Issue	Detail of Action	Person Responsible	Comment	Actual Completion Date	Required completion Date
1	Facilities	EA advised of some errors in waste procedures	Ensure EKHUT waste procedures are updated as detailed	Deputy Head of Soft FM	Completed and revised in December 2008. Issued to wards in December 2008 and January 2009.		31st January 2009
2	Pharmacy	Pharmacy staff unclear on disposal of sharps	Pharmacy - Ensure that a procedure is implemented for disposal of unused, out of date sharps and that this is disseminated	Deputy Head of Soft FM/ Pharmacy	Posters were in place along with procedural guidance at time of inspection. There was a lack of consistent understanding by staff of use of sharps bins that can easily be addressed		31st January 2009
3	Ward - Cheerful Sparrows / Trust wide	Syringes were being placed in pharmi bins which are for medicines only	Wards - Ensure that a procedure is implemented for disposal of unused, out of date sharps and that this is disseminated	Deputy Head of Soft FM / Nursing/Medical Director/ all ward staff	Posters were in place by sharps bins . The issue appeared to be due to doctors not adhering to the posters		31st January 2009
4	Ward - Cheerful Sparrows / Trust wide	EA advise disposal of empty alcohol gels in general waste (or orange clinical waste bags) is illegal.	The hospital should review their procedures for disposal of alcohol gel bottles and ensure that these are followed	Deputy Head of Soft FM / Nursing/Medical Director/all ward staff	Waste procedures around alcohol gel disposal are being revised		31st January 2009
5	Ward - Cheerful Sparrows / Trust wide	Disposal of non-infectious clinical waste in orange bags	The hospital should review their procedures for disposal of intravenous products and ensure that these are followed	Deputy Head of Soft FM	An offensive waste stream has been introduced at QEQM since the EA inspection and waste procedures revised and updated.		31st January 2009
6	Ward - St Augustine's / Trust wide	General waste (card, paper) placed in labelled clinical waste bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM / Nursing/Medical Director/ all ward staff	99% of all bins are labelled as to use and have been for over 5 years. They are also colour coded. Written procedures have been in place regarding disposal of clinical waste.		31st January 2009
7	Radiology	Silver cartridges are removed by staff to KCH without waste consignment note or licence	Ensure that silver cartridges are transferred with an accompanying hazardous waste consignment note to an appropriately permitted site	Deputy Head of Soft FM/ Radiology	Future collections will be made directly from the QEQM.		31st January 2009
8	Radiology	Glass bottles that contained medicines were being recycled. EA advice is illegal.	The hospital should review their procedures for the disposal of medicinally contaminated glass bottles and ensure that these are followed	Deputy Head of Soft FM/ Radiology	Waste procedures have been updated.		31st January 2009
9	Radiology - Trustwide	General waste (sweet wrappers) placed in sharps bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM/ Radiology/all staff	Staff not adhering to waste procedures		31st January 2009
10	A&E	No evidence of list of Cytotoxic and cytostatic medicines	Ensure that Cytotoxic and cytostatic pharmaceuticals are readily identifiable and disposed of correctly	Deputy Head of Soft FM/ Pharmacy/A&E	Pharmacy advised lists were provided to all departments prior to inspection		31st January 2009
11	A&E	Syringes were being placed in pharmi bins which are for medicines only	Pharmacy - Ensure that a procedure is implemented for disposal of sharps and that this is disseminated	Deputy Head of Soft FM / Nursing/Medical director/all A&E staff	Posters on wards. E-mail communication. Written waste procedures and policy provided prior to inspection.		31st January 2009
12	A&E	General waste (sweet wrappers and syringe wrappers) placed in sharps bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM / Nursing/Medical director/all A&E staff	Bins are labelled. Waste Procedures were issued		31st January 2009
13	Dentaline	How do they dispose of amalgam waste?	Establish how waste from Dentaline is managed and disposed of and report this to the Environment Agency. Ensure that procedures are in place to correctly identify, classify and segregate these wastes.	Deputy Head of Soft FM	Dentaline to be contacted and their waste procedures and documentation sourced.		31st March 2009

14	Theatres	Small items of anatomical waste are placed in orange clinical waste bags which are sent for alternative treatment	Ensure all anatomical waste is correctly segregated for incineration.	Deputy Head of Soft FM	EA to be contacted with regard to Trust waste procedures which requires all recognisable anatomical waste to be placed in rigid containers for incineration.		31st January 2009
15 and 17	Theatres	General waste (hair net and paper towels, wrappers) placed in sharps bins	The hospital should ensure that their procedures for segregating different categories of hazardous waste and non-hazardous waste	Deputy Head of Soft FM / Nursing/Medical director/all Theatres staff			31st January 2009
16	Theatres	No evidence of list of Cytotoxic and cytostatic medicines	Ensure that Cytotoxic and cytostatic pharmaceuticals are readily identifiable and disposed of correctly	Deputy Head of Soft FM/ Pharmacy/Theatres	Pharmacy advised lists were provided to all departments prior to inspection		31st January 2009
18	Pathology	Chemical bottles incorrectly disposed	Ensure chemical bottles are correctly segregated into correct containers	Deputy Head of Soft FM/ Pathology			31st January 2009
19	Pathology	Flammable and corrosive chemicals kept less than 3 metres apart	Keep all incompatible chemicals separate, and store them appropriately.	Deputy Head of Soft FM Services/Pathology	A collection of unwanted chemicals was organised in September 2008 including QEQM Pathology	Sep-08	31st January 2009
20	Clinical waste Compound	Bins with inoperable locks	Waste bins need working locks to ensure that there is no general access to their contents while in public areas. Containers and bags should be clearly labelled and properly sealed. Unused packaging should be disposed of in general waste with labels removed or obliterated.	Deputy Head of Soft Fm services/Medirest	Written memo to Medirest Contract Manager. Medirest contract PMPM. Key Performance Indicators. Bin tagging		31st March 2009
21	Clinical waste Compound	Loose unbagged clinical waste	Waste should not be placed loose into bins – it should always be placed inside a bag or box first.	Deputy Head of Soft Fm services/all staff/Medirest	Written waste procedures		31st January 2009
22	Battery waste storage container	Lead acid and non hazardous batteries mixed	Hazardous and non-hazardous batteries must be kept segregated. Lead/acid batteries should be stored upright to minimise the risk of spills, even if in a secondary container.	Deputy Head of Soft FM			31st January 2009
23	Light bulbs storage	Fluorescent tubes mixed with non-hazardous light bulbs	Hazardous and non-hazardous lighting must be kept segregated.	Estates Manager/ deputy Head of Soft FM Services			31st January 2009
24	Segregation of electrical waste		Waste electrical equipment should be checked to determine if it contains any hazardous components which will make the complete item hazardous waste. Disposal arrangements for IT equipment and its transfer to HIS need to be clarified, particularly if it is apparent that the	Deputy Head of Soft FM Services/ HIS	Review of electrical waste storage into hazardous and non-hazardous. Discuss with HIS regarding disposal arrangements		31st March 2009
25	Spencer Wing	Disposal of non-infectious clinical waste in orange bags	The hospital should review their procedures for disposal of intravenous products and ensure that these are followed	Deputy Head of Soft FM / Spencer Wing	An offensive waste stream has been introduced at QEQM since the EA inspection and waste procedures revised and updated.		31st January 2009
26	Spencer Wing	alcohol gel disposed of with general waste	The Spencer Wing should assess whether of not the Hydrex hand gel is a hazardous waste and make appropriate arrangements for disposal if necessary.	Deputy Head of Soft FM / Spencer Wing	Waste procedures around alcohol gel disposal are being revised		31st March 2009
27	Spencer Wing	Fluorescent tube found in general waste	Facilities are required for keeping different categories of hazardous waste, such as fluorescent tubes, separate from other waste.	Deputy Head of Soft FM / Spencer Wing	Waste procedures have been issued to Spencer Wing		31st January 2009
28	Consignment Notes	Forms used by contractors not always compliant	Staff managing hazardous waste contracts should ensure that the format of the consignment notes used for each contract meets the requirements of the Hazardous Waste Regulations.	Deputy Head of Soft FM			31st March 2009
29	Consignment Notes	Training of staff	All staff supervising waste collections should be familiar with the format of hazardous waste consignment notes and only sign them when they are sure that all the required details have been completed and are correct.	Deputy Head of Soft FM / Medirest			31st March 2009

30	Consignment Notes	Notes are held at Ross House	Arrangements need to be in place for continuous access at the hospital to the producer copies of the hazardous waste consignment notes for at least three years from the date raised. The Environment Agency now accepts electronic access if there is still a requirement to hold the original copy at another location.	Acting Head of Facilities/ Deputy Head of Soft FM			31st March 2009
31	Consignment Notes	Dual registration of hospital as a hazardous waste producer	Staff disposing of waste should be aware of the hazardous waste arrangements to avoid registering the hospital more than once as a produce	Deputy Head of Soft FM	Deputy Head of Soft FM to discuss with EA as believed companies are dual registering		31st March 2009
32	Consignment Notes	Correct completion of paperwork and correct number of documents	The member of the hospital staff supervising the waste collections should ensure that all details are correct and there are the correct number of copies (3 for hazardous waste) in respect of duty of care or hazardous waste transfer notes before signing them. Care should be taken to ensure that confusion is avoided by only using one	Deputy Head of Soft FM / Medirest	Three part copies of consignment notes in use at QEQM, KOCH and WHH		31st March 2009
Environment Agency Recommendation (Best Practice)			Detail of Action	Person Responsible	Comment	Actual Completion Date	
1	Trust wide	Cytotoxic / cytostatic drugs are not labelled. Nurses have to refer to a list to identify	Consider implementing a procedure where the pharmacy identifies and labels all cytostatic drugs that are used in the hospital	Director of Pharmacy			
2	Viking Day	One bin was found without a label identifying its purpose	Ensure all bins are labelled to aid correct waste segregation	Deputy Head of Soft FM Services	The clinical waste bin without the label in Viking Day was relabelled. 99%+ of bins in the Trust are labelled. It has to be borne in mind that Medway maritime did not label any bins at the time of their inspections whereas this has been standard practice in our Trust for a number of years.	Jul-08	
3	A&E	Outside parties dispose of their waste in A&E	Ensure that procedure are in place to manage waste that may be brought into A&E by external parties (such as paramedics and police) and that those parties are made to follow those procedures	?	Posters are on site and bins are labelled. There is a major risk with the needle exchange scheme. There have been three sharps incidents since September (1 at WHH A&E, 2 at Buckland minor injuries due to drug users misdisposing of sharps in sani bins resulting in a needle stick injury at Buckland		
4	Pathology	Clean cardboard boxes are disposed of in general waste	Segregate uncontaminated packaging for recycling wherever possible	Deputy Head of Soft FM Services/Pathology	Extra recycling bins were provided subsequent to the inspection	Jul-08	
5	Pathology	EA advise that Pathology should not be requiring incineration of their clinical waste as it is already autoclaved	Treated laboratory waste could be disposed of as offensive/hygiene waste (tiger bags) if the autoclave meets STAATT level IV no further treatment of waste should be required.	Deputy Head of Soft FM Services/Pathology	EA to be invited to discuss with Pathology		
6	Pathology	Pathology use yellow lidded sharps boxes for phlebotomy waste	Please ensure that internal procedures are all updated - alternative treatment (i.e. orange sharps boxes) is suitable for phlebotomy sharps.	Deputy Head of Soft FM Services/Pathology	Deputy Head of Soft FM to discuss with Senior Biomedical Scientist		Orange for phlebotomy
7	Pathology/ trust wide	Unwanted/unused chemicals	Dispose of any unused/unwanted chemicals to an appropriately authorised site as soon as possible.	Deputy Head of Soft FM Services	A collection of unwanted chemicals was organised in September 2008 including QEQM Pathology	Sep-08	
8	QEQM Hospital	Separate clinical waste collections for Spencer Wing and Thanet Mental Health Unit	It may be more efficient if all the waste from the different units at the site could be bulked up by type and a single collection made for each type.	Deputy Head of Soft FM Services/ Spencer Wing. Kent & Medway Waste Manager	Discussion with Spencer Wing already underway prior to report		

Red =Not compliant
Amber =progress being made
Green =complete

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NHS West Kent

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

NHS WEST KENT WRITTEN SUBMISSION FOR MEETING 6TH FEBRUARY 2009

1. Introduction

NHS West Kent is committed to preventing and controlling Healthcare Associated Infections (HCAIs) and to a zero tolerance approach to all preventable infections, both as a commissioner and provider of services.

This report provides an update on the PCTs current compliance against core standards C4a, C4c and C21; and the Hygiene Code for 2008/09. In addition, an outline of key actions being taken to ensure continued improvements in health care associated infections across West Kent.

2. Core Standards Compliance

For 2008/9 the PCT will make 2 declarations of compliance with core standards. One in respect of it's commissioning function and responsibilities and the other for its provider services.

The current status for the two declarations is:

Standard	2006/07	2007/08	2008/09
C04a – infection control	Compliant	Compliant	Compliant
C04c – decontamination	Not Met	Not Met	Evidence under review – action plan for 2007/08 completed (see appendix 1)
C21 –clean, well designed environment	Compliant	Compliant	Compliant

Full summaries for these core standards can be seen in appendix 1.

In order to prepare for the core standards declarations, due for submission in April 09, and to provide the PCT Board with assurance regarding both the declaration, and process for preparation of the declaration, a number of actions have been completed or planned, including:

- focussed discussion of progress against core standards / indicators included within the internal business and performance review process
- evidence collation to demonstrate compliance by lead directors and teams in progress
- Core standards challenge sessions, led by the PCT Performance and Governance Managers, are in progress and include review of evidence against the Healthcare Commission inspection guides and latest criteria for assessing core standards. All core standards will be reviewed by mid February 09. These sessions include discussion with leads on the current level of compliance and evidence available; and will culminate in the production of a feedback report including the identification of gaps in evidence. Leads will then be asked to

ensure that any gaps in evidence are addressed or to review assessment of compliance.

3. HCAI monitoring

The Healthcare Associated Infections performance framework for PCTs for the next three years will be determined by the trajectories set in the Operational Plans agreed with the Strategic Health Authority (SHA) and Department of Health (DH). MRSA and C-diff are two of the top priorities, designated as 'National Requirements' in the Vital Signs indicator set.

At the time of writing this report, trajectories for MRSA have not yet been requested by DH. Interim guidance from DH and South East Coast SHA is to aim to maintain or reduce recent levels, with the local target for West Kent set at 35 bacteraemias for 2008/09. The SHA has agreed with the NHS across SEC to set a stretch improvement of zero avoidable hospital-acquired MRSA bacteraemias by 2011.

In this report, the definition of hospital acquired infections for both MRSA and Clostridium Difficile is all confirmed cases of infection where the sample was taken 48 hours after the date of admission to hospital. All other confirmed cases will be considered to be acquired in the community.

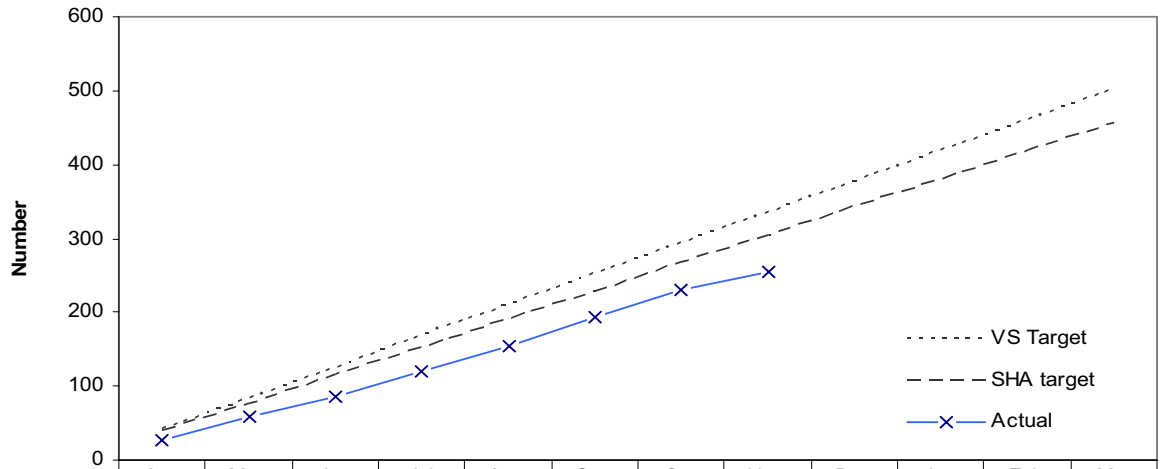
Clostridium Difficile Infection (CDI)

The numbers of CDIs for the period of April 08 – to end Nov 08 are as follows:

Chart 1

Cumulative Cases of Clostridium Difficile for patients registered with NHS West Kent 2008/09 (Sample taken at least 2 days after admission) - Ages 2 and over

Source: Health Protection Agency - Data Capture System website



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
VS Target	42	84	126	168	210	252	294	336	378	419	460	501
SHA target	38	76	114	152	190	228	266	304	342	380	418	455
Actual	28	60	85	119	154	194	230	255				

SEC SHA has adjusted the yearly targets and suggested a monthly trajectory which allows for higher number of cases during winter. PCTs are in the process of signing them off and future reports will reflect the agreed new trajectories.

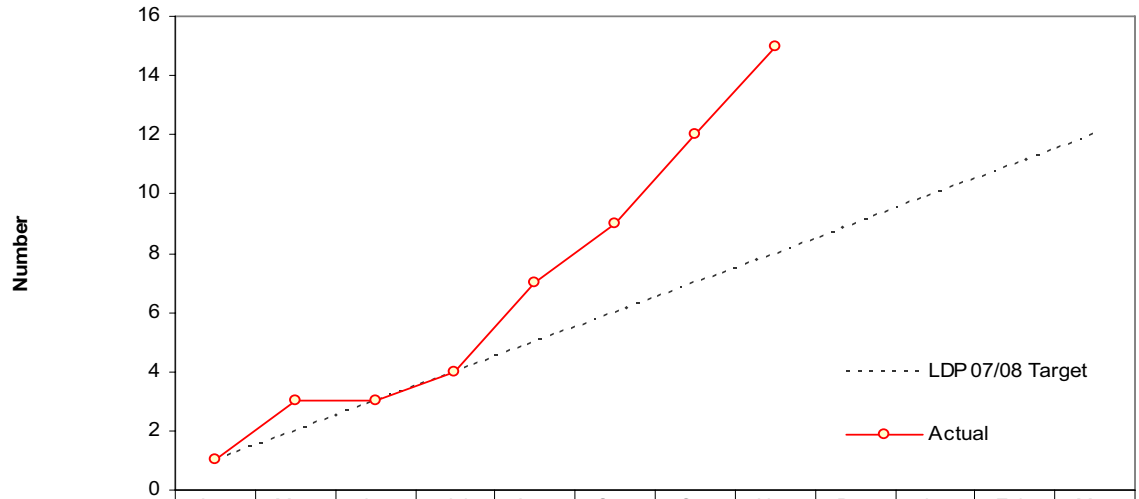
MRSA Bacteraemia

The numbers of MRSA bacteraemias for the period of April 08 – to end Nov 08 are as follows:

Chart 2

Cumulative Cases of MRSA reported by Dartford & Gravesham NHS Trust 2008/09
All Ages

Source: Health Protection Agency - Data Capture System website



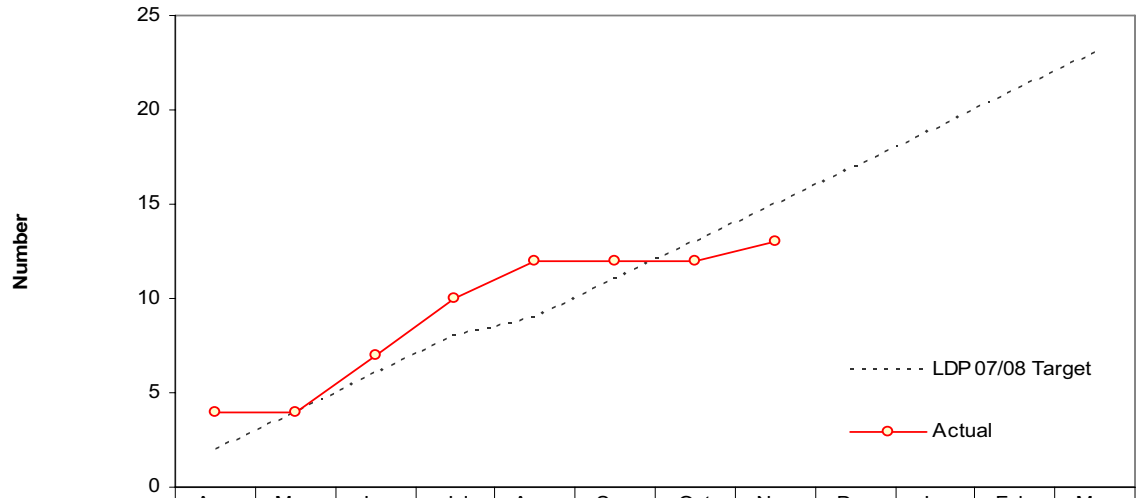
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LDP 07/08 Target	1	2	3	4	5	6	7	8	9	10	11	12
Actual	1	3	3	4	7	9	12	15				

Month

Chart 3

Cumulative Cases of MRSA reported by Maidstone & Tunbridge Wells NHS Trust 2008/09
All Ages

Source: Health Protection Agency - Data Capture System website



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
LDP 07/08 Target	2	4	6	8	9	11	13	15	17	19	21	23
Actual	4	4	7	10	12	12	12	13				

Month

The PCT and SHA are working closely with Dartford and Gravesham (D&G) NHS Trust to address the MRSA bacteraemia numbers, which are currently over trajectory.

Areas for actions include:

- Increased compliance auditing and reporting data to D&G Board and PCT DIPC
- Cross organisational approach to chronic wound management
- Accelerated Infection prevention and Control (IPC) training programme for all new and existing staff
- Delegation of IPC responsibilities e.g. auditing to matrons, enabling the IPC Team to focus on more complex issues
- Encouraging greater public and visitor awareness and participation in hand hygiene on entering the hospital and wards

4. Registering with the Care Quality Commission in relation to HCAI

- The Government is introducing a system of HCAI registration – one year ahead of a new general system of registration that will apply equally to all providers of health or adult social care.
- As the new regulator, the Care Quality Commission (CQC) will run the system.
- From April 2009, trusts that provide patients with care will be legally required to register with the CQC (subject to parliamentary approval) and, as a legal requirement of their registration, must operate in a way that protects patients, workers and others from identifiable risks of acquiring and HCAI.
- The new Act and regulations build on the existing duties for NHS providers to prevent and control HCAI under the Health Act 2006 and elements of the core standards in *Standards for Better Health* that specifically focus on dealing with infections.
- What is different is that trusts must, by law, comply with one overarching regulation about HCAI. Trusts must publically state, in their application form, whether they comply (and will continue to do so). Any unregistered trust that continues to provide healthcare would be committing a criminal offence and may be prosecuted.
- Trusts will not be required to pay a fee for HCAI registration in 2009/10
- Further information is available at http://www.cqc.org.uk/policies__reports/hcai_registration_system.aspx
- An update report of NHS West Kent Compliance with Hygiene Code can be seen at Appendix 4.

5. Root Cause Analysis (RCA) Report: *Clostridium difficile* infection

A cluster of three cases of *Clostridium difficile* infection (CDI) occurred at Livingstone Community Hospital in August 2008. Sadly, one of these affected patients subsequently died following transfer to Darent Valley Hospital.

A second cluster of patients who had been in the Livingstone Hospital were diagnosed with CDI in September 2008. Two of these patients died of causes not related to CDI.
In line with Department of Health requirements, a Root Cause Analysis was undertaken of the events surrounding the CDI-related patient death. Root Cause Analysis (RCA) investigations are a well recognised way of learning lessons, offering

a framework for reviewing patient safety incidents (and claims and complaints). Investigations can identify what, how, and why patient safety incidents have happened. Analysis can then be used to identify areas for change, develop recommendations and look for new solutions.
The Review did not identify any practice or omission that would have impacted on the death of the patient with CDI associated complications. However, it did identify areas from which the PCT could learn and improve patient care. In public Board meetings in September and November 2008, the PCT expressed its condolences to the family concerned.

The RCA investigation considered the emerging issues and root causes as follows:

- Sensitivity of laboratory testing resulted in reporting of "weak" or "mild" positive results. This caused confusion as to infection status of patients
- Staff not fully conversant with environmental cleaning requirements during outbreak situation, such as dilution of bleach products and use of disposable cloths
- Lack of clarity of responsibilities during outbreak situation

Recommendations emerging from the investigation relate to:

- Change in procedure relating to laboratory reporting of CDI testing. Advice from Microbiologist to include patient's symptoms and condition as well as microbiology tests.
- Additional support for Medical Officers managing patients with CDI in Community Hospitals through specific training and to proactively seek advice from Microbiologist
- Additional training for cleaning staff
- Formalisation of reporting arrangements on identification and during an outbreak of infection
- Review of data collection sheet for follow-up of reportable infections
- Development and availability of CDI information leaflet for patients, visitors and staff
- Implementation of initiatives to promote appropriate antibiotic prescribing in the community

Areas of good practice identified include:

- Prompt cohorting of patients following CDI diagnosis
- Prompt closure to admissions of Hospital following identification of two or more related cases (outbreak)
- Close joint working between PCT staff, DVH Infection Control Team and Health Protection Unit
- The RCA Review Team expressed a wish to commend the staff at the Livingstone Hospital for their hard work, dedication to patient care and professionalism during the outbreak situation.

Actions taken to address the recommendations include:

- Laboratory no longer reports "weak"/ "mild" CDI. Advice relating to management

of CDI positive patients is based on laboratory results plus patient's symptoms and request repeat sample

- A protocol for the medical management of patients with *c. difficile* is in place at Livingstone Hospital
- Best practice cleaning procedures were discussed and confirmed at the Kent and Medway Directors of IPC meeting in November 2008
- Cleaning information is available at each Community Hospital.
- Additional cleaning equipment purchased for Community Hospitals eg steam cleaners
- Cleaning training has been provided by Hotel Service Supervisor and ongoing cleaning programme being delivered by IPC Team.

6. Diarrhoea and Vomiting at Livingstone Hospital

In December 2008, a small number of patients and staff were affected with diarrhoea and/ or vomiting. Although no causative organism was identified from specimens, it is likely that symptoms were caused by norovirus (Winter Vomiting Virus).

The hospital was closed to admissions, all infection control measures were put in place and the PCT worked closely with the Health Protection Unit. The hospital was reopened following when patients and staff had been asymptomatic for 48 hours and a deep clean of the hospital had taken place.

Prior to the first affected patient developing symptoms, a visitor was reported to have had an episode of vomiting at the hospital. This demonstrates the importance of the PCT continuing to promote the message to the public that they should not visit patients in hospital if they are unwell.

7. "Essential Steps to Safe, Clean Care"

"Essential Steps" is a Department of Health initiative designed to support care-providers in non-acute areas, including Primary Care, Care Homes and General Practices Surgeries and in moving towards the goal of no avoidable infections.

The PCT is adopting the programme and to avoid duplication, is using the tools in conjunction with other programmes, such as Essence of Care, where possible. An initial baseline self- assessment has been undertaken by the PCT. Gaps in compliance and remedial actions are as follows:

- Full recruitment to IPC Team: subject to Human Resources processes, four staff in post, additional staff member expected to be in post by end Feb 09
- IPC input into processes for procurement and estates: IPC Lead Nurse will attend Estates Operational meetings
- Decontamination lead for PCT: IPC Lead Nurse is Decontamination Lead and has been in post since Oct 08. Interim cover was provide by the Assistant Director of Clinical Quality, who is a qualified IPC Nurse.

8. Deep Clean Programme

In October 2008, the Department of Health published "From deep clean to keep clean: Learning from the deep clean programme", available on

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_089716

This document included a collection of good practice examples outlining activities undertaken as part of the 2007/08 deep clean initiative. It reiterated that the deep clean programme was not a one-off exercise and placed an expectation on Trusts to examine the ongoing sustainability of their cleaning programmes and ensure that deep cleaning is an important component in their cleaning arrangements.

NHS West Kent had pre-empted the Department of Health's expectations. The 08/09 programme has been completed with all six PCT Community Hospitals having undergone a deep clean. The PCT has introduced emergency cleaning boxes and purchased extra steam cleaning machines. In addition to the planned cleans, these resources will support additional and targeted cleans, as and when required.

9. Training

Opportunity for funding to support HCAI improvements out of hospital

South East Coast (SEC) Strategic Health Authority has secured a non-recurrent total sum of £480K for HCAI improvements across the local health economy with a particular focus on the care home sector and primary care. This has been divided based on weighted capitation statistics (07/08). The funding allocated for NHS West Kent is £75,000, which must be used by the end of March 2009.

The PCT has successfully bid for non-recurring monies to support local out of hospital HCAI improvements. This is centred on training and education events for care homes and GP practices to improve awareness and look to embed best practice.

PCT HCAI Training

The PCT has made HCAI awareness training mandatory for all staff, and programmes tailored to the needs of differing staff groups, and provided in a variety of ways, are being prepared. It is planned that 95% of staff will have completed this training by 31st March 2009.

To date 1720 (78%) of the PCT's 2200 staff members have either received or booked on HCAI awareness training between April 2008 and end March 2009.

The Infection Prevention and Control Team are developing further strategies (such as e-learning opportunities) to work toward the 95% target.

10. Public Roadshows

In May 08 the PCT commenced a series of Roadshows in high streets in major population centres in West Kent. These events include handing out and explaining leaflets (an example is included in Appendix x) and other reminders which reinforce the importance of handwashing and reiterating avoidance of hospital visiting when unwell.

A fifth Roadshow was held in Gravesend in December 08. These have been very well received by the public (with over 1700 people speaking to the nurses at the stands) and supported by the local media.

In addition, the PCT launched a cartoon character called Moxy Malone in December 2008 to help raise awareness of the correct way to tackle all infections which aims to tackle the over reliance on antibiotics, which can lead to the growth in the number of superbugs like MRSA. (see Appendix 3).

11. South East Coast Ambulance (SECAmb) NHS Trust

Audit

SECAmb report that "Bare Below the Elbows" and bi-monthly hand hygiene audits are undertaken. These have identified areas to target education and training.

The Trust has also introduced the use of an audit tool to measure the implementation of policies and procedures relating to Infection Prevention and Control. The tool builds on previous work undertaken with the Kent Health Protection Unit and provides a standardised method for monitoring both clinical practice and the environment.

Training

Key skill training has been suspended due to commitment for operational pressures. The latest figure was 72% of clinical staff having received annual up-date training and a programme for non-clinical staff was being worked on by the Education Department. The Trust will advise as soon as normal day-day working for the Infection Prevention and Control Team is resumed.

SECAmb Hygiene Code: Update

An update report of compliance with the Hygiene Code describes full or partial compliance with each standard. Action plans are being implemented for each standard which is not fully met.

APPENDIX 1

Core standard 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).

Element 1:
The healthcare organisation 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 Health Care Associated Infections* (Department of Health, 2006)

Healthcare Commission Line of Enquiry	**PCT Assurance includes:**
(a) The Hygiene Code requires healthcare organisations to have in place appropriate management systems for infection prevention and control which must include the following: • 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 (Duty 2 a) • 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. (Duty 2b, Annex 1)	• Healthcare Associated Infection Report presented to every formal Board • PCT Hygiene Code Statement of Compliance update reports presented to Board in August 08 and January 09. • PCT's Patient Safety Strategy 2008 – 2010 includes a statement as to the Board's responsibility for patient safety, including Infection Prevention and Control • Board has signed up to national Patient Safety First Campaign (see Appendix 1) PCT has designated DIPC who discharges his responsibilities through: • Reports to every PCT Board and to Clinical Leadership Board • Accountable to CEO • Monthly meetings between CEO and DIPC. • Chairs monthly WKIPC Group meeting • Attends Kent and Medway DIPC meetings • Regular meetings with health economy DIPCs • Regular meetings/ discussions with DIPCs at Maidstone and

	Tunbridge Wells (MTW) and Dartford and Gravesham (D&G) Trusts • Bi-monthly meetings with Kent DIPCs and Health Protection Unit (HPU) • Regular events with DIPCs across SECSHA
• the mechanisms by which the board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should include implementing an infection control programme and infection control infrastructure (Duty 2c)	• PCT's Infection Prevention and Control (IPC) Team resources of 1 Lead Nurse, 3 IPC Nurses and Administrative support • Modern Matrons, including Community Hospital Matrons in West Kent Community Health have IPC and cleanliness responsibilities defined in job descriptions • PCT implementing national "Clean**your**hands" campaign. This includes promoting hand hygiene through training of staff, nomination of "Champions", posting of screen savers on computers and displaying posters at Community Hospitals • Annual Infection Prevention and Control Report • PCT IPC Group reports to Board via Clinical and Corporate Governance Committee • HealthCare Associated Infection (HCAI) report received at each formal Board meeting • Annual IPC audits, including IPC environmental, Essence of Care, Patient Environment and Action Team audits (PEAT) • Programme of IPC Public Roadshows, including issue to the public of merchandise eg mugs, pens, trolley coins to promote hand cleaning
• a policy addressing, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between healthcare facilities (Duty 2f)	• Information leaflet for public issued and available PCT website (see Attached) • PCT has adopted Health Protection Agency guidelines which include such guidance. • PCT has Community Hospital Admission criteria • Transfer/ discharge documentation

(b) The healthcare organisation should have in place appropriate management systems for infection prevention and control, including the following: • An appropriate assurance framework (Duty 2c); • 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 (Duty 2d); • A programme of audit to ensure that key policies and practices are being implemented appropriately (Duty 2e).	• IPC is included in PCT assurance framework and risk register PCT IPC training programme includes: • Specialist training for IPC nurses • Induction Training for all new staff (clinical and non-clinical) • 2008/09 target to deliver IPC awareness training to 95% of all PCT staff – clinical and non-clinical (78% compliance as at end Dec 08) • Annual audit programme of Community Services • Essence of Care audit programme of Community Services • Audit support available to independent contractors and care homes • Community Hospital Cleaning Audits • Patient Environmental Action Team (PEAT) results
(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: • made a suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI (Duty 3a) • identified the steps that need to be taken to reduce or control those risks (Duty 3b) • recorded its findings in relation to duties 3a and 3b (Duty 3c)	• PCT IPC guidelines include risk assessment • Patient care documentation includes risk assessments • Community Services Admission criteria • Risk register and Board Assurance Framework include IPC risks • Incident reporting procedures • Root Cause Analysis (RCA) of Serious Untoward Incidents (SUI) ensure investigation of action taken, lessons learned and remedial action to be taken • Clinical and Corporate Governance Committee and Board

• implemented the steps identified (Duty 3d) • 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 (Duty 3e)	receive SUI and RCA reports • Discussion of risks at WKIPC Group and Clinical and Corporate Governance Committee • Liaison with health community as described above (eg DIPC's responsibilities (a))

Independent Contractors
The PCT should take reasonable steps to ensure that the services provided by independent contractors are meeting the relevant aspects of this element. The following groups of independent contractors should be considered for this element:

	PCT Assurance
General practitioners	• Section 41 of the undated *Standard General Medical Services Contract* states that 'the contractor shall ensure that it has appropriate arrangements for infection control • Antibiotic formulary issued and monitored by PCT Medicines Management Team eg to promote appropriate use of antibiotics. • Moxy Malone campaign launched to remind about appropriate use of antibiotics (see Appendix 2) • PCT IPC Team available for advice and audit. • PCT investigates complaints or reported incidents relating to concerns, including those related to IPC • PCT employs 6 Practice Nurse Advisers to provide advice and mentorship to Practice Nurses
General dental practitioners	• PCT Clinical Governance visits include reviews of IPC • PCT employs Dental Advisers to provide advice and undertake reviews • PCT investigates complaints or reported incidents relating to concerns, including those related to IPC
Community optometrists	• PCT employs Optometric Adviser to provide advice and undertake reviews • PCT investigates complaints or reported incidents relating to concerns, including those related to IPC

Commissioned Services The PCT has appropriate mechanisms through which they could identify and, where appropriate, respond to any significant concerns arising from their commissioned services **with regard to the overall standard**

• Performance meetings/ reports
• WKIPC Group membership includes commissioned services ie West Kent Community Health, SEC Ambulance Trust, MTW and D&G Trusts representatives. Reports from each organisation received at each meeting
• PCT receives weekly reports from acute trusts re MRSA and C. difficile figures
 	
• The PCT, SHA and Department of Health are working closely with Dartford and Gravesham (D&G) NHS Trust to address the MRSA bacteraemia numbers, which are currently over trajectory.
 	
• Areas for actions include:
 	
  • Increased compliance auditing and reporting data to D&G Board
  • Cross organisational approach to chronic wound management
  • Accelerated Infection prevention and Control (IPC) training programme for all new and existing staff
  • Delegation of IPC responsibilities eg auditing to matrons, enabling the IPC Team to focus on more complex issues
  • Encouraging greater public and visitor awareness and participation in hand hygiene on entering the hospital and wards

Core standard 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.

Element 1: Reusable medical devices are properly decontaminated in appropriate facilities, in accordance with the relevant requirements of *The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections* (Department of Health, 2006)	
(a) The Healthcare organisation has designated a lead manager for decontamination of reusable medical devices used for treatment. (See Hygiene Code Duty 4b).	• Lead IPCN lead for decontamination
(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 (see Hygiene Code Duty 4f).	• Written guidance, procedures and protocols • Review of instrument decontamination being undertaken in response to changes in services within Kent and Medway ie relocation of acute trust decontamination to 2 purpose built Central Services in Kent • Programme to transfer to use of disposable instruments by podiatry services as opposed to use of bench top sterilisers by 1/2/ 09 • Audit programme, including specific audit of use of bench top autoclaves by podiatrists • Annual PEAT inspections • Annual “Deep Clean” programme, which includes dedicated team of cleaners • The PCT has a Service Level Agreement with facilities service to include the maintenance of medical and clinical equipment such as bench top sterilisers
(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.	• PCT uses Central Sterile Services Departments (CSSD) that are registered with MHRA approved notified bodies.

(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. This may, for example, be through meetings with the external agent to identify any risks, or through having appropriate service level agreements in place that are monitored effectively	• Formal written agreements in place with acute trusts to provide information relating to HCAIs • WKIPC Group includes standing agenda item for reporting of decontamination issues/ progress

(e) Re-usable medical devices (apart from flexible endoscopes) should be decontaminated in a suitable sterile services environment.	• Use of registered CSSD service or disposable instruments
	• Guidelines in place and compliance audited
	• Podiatry service main users of bench top autoclaves:
	  ○ Maintenance contract for sterilisers in place
	  ○ Audit of use of sterilisers
	  ○ Partial transfer to use of disposable instruments with plan to remove bench top sterilisers by 1/2/09

(f) Flexible endoscopes should have their own dedicated area for decontamination as outlined in medical devices agency bulletin DB 2002 (05)	• Only 2 flexible naso-endoscopes used in PCT Outpatient Departments • Decontamination protocol in place • Logging system used to evidence decontamination process
(g) If the healthcare organisation provides decontamination services for other organisations they should comply with (MDD) 93/42 and be registered with an MHRA approved notified body.	Organisation does not provide decontamination services for other organisations

Independent Contractors
The PCT should take reasonable steps to ensure that the services provided by independent contractors are meeting the relevant aspects of this element. The following groups of independent contractors should be considered for this element:

	PCT Assurance
General practitioners	• GPs in West Kent use a mixture of CSSD from registered body, disposable instruments and bench top sterilisers • Section 41 of the undated *Standard General Medical Services Contract* states that 'the

	contractor shall ensure that it has appropriate arrangements for decontamination • Quality and Outcome Framework requires that "the arrangements for instrument sterilisation comply with national guidelines as applicable to primary care" • Guidelines available for GPs • PCT IPC Team available for advice and audit. • PCT investigates complaints or reported incidents relating to concerns, including those related to IPC • PCT employs Practice Nurse Advisers to provide advice and mentorship to Practice Nurses • PCT reviewing CSSD provision in light of changes to service Kent-wide
General dental practitioners	• PCT Clinical Governance visits include reviews of decontamination • PCT employs Dental Advisers to provide advice and undertake reviews • PCT investigates complaints or reported incidents relating to concerns, including any relating to decontamination
Community optometrists	• PCT employs Dental Advisers to provide advice and undertake reviews • PCT investigates complaints or reported incidents relating to concerns, including any relating to decontamination
Community pharmacists	• The PCT undertakes Community Pharmacy Contract Monitoring visits which include review of decontamination, as appropriate
Commissioned Services The PCT has appropriate mechanisms through which they could identify and, where appropriate, respond to any significant concerns arising from their commissioned services **with regard to the overall standard**	
• Performance meetings/ reports • WKIPC Group membership includes commissioned services representatives. Reports from each organisation received at each meeting • PCT receives weekly reports from acute trusts re MRSA and C. difficile figures • PCT representative attends SHA Decontamination meetings and receives feedback about acute trust compliance with decontamination standards • PCT IPC Team available for advice and to undertake audits for other commissioned services eg Care Homes • IPC issues are reported to the Clinical Performance meeting with Se Coast Ambulance Trust. Meeting held bi-monthly and Chaired by PCT Director of Nursing/ DIPC	

Decontamination Action Plan

Following the Healthcare Commission's (HCC) review of PCT's decontamination, the 2007/08 statement of compliance with this standard was qualified. The HCC HC concluded that there was insufficient evidence for the full year but adequate evidence to demonstrate assurance of compliance by 31st March 08 for the following reasons:

- A lead staff member for decontamination was only appointed in the second half of the year
- There was no evidence for the first half of the year against element 1(f). The protocol for Decontamination of Naso-Laryngoscope and Endoscopes was undated.

Remedial action taken is as follows:

- The PCT has ensured that a lead member of staff is clearly identified i.e. a qualified IPC nurse via the Health Protection Agency prior to recruiting to the PCT Lead IPC nurse post.
- Lead IPC Nurse job description includes decontamination lead role (job description reviewed April 08) – lead appointed and commenced October 2008
- Evidence relating to decontamination of endoscopes is available for full year and protocol is dated

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.

Element 1: **The PCT 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, the Disability Discrimination Act 2005 and associated code of practice *N/A***	
Healthcare Commission Line of Enquiry	**PCT Assurance includes:**
a) The healthcare organisation should have taken steps to provide care in environments that are well designed and well maintained. This should include acting in accordance with	• 3 year rolling programme of backlog maintenance, which is incorporated into the annual capital programme • Capital programme is approved by Board and monitored by

Health Building Notes and Health Technical Memoranda (see point of information 1).	Capital Planning Group • Estates contract with Kent & Medway facilities makes specific reference to ensuring all new and redeveloped properties meet all relevant regulations and standards
b) The healthcare organisation should have made 'reasonable adjustments' to tackle physical features that act as a barrier to disabled people from accessing their services. This may mean to remove, alter or provide a reasonable means of avoiding physical features of a building, which make access impossible or unreasonably difficult. The health care environment should have been considered as part of the trusts disability equality scheme. Where the healthcare organisation has identified areas for action in relation to its environment the organisation should have started implementing the required changes (see point of information 2).	• DDA assessments form an integral part of the maintenance review with works undertaken as and where required (e.g. new automatic doors at Tonbridge Cottage Hospital) • The Disability Equality Scheme (2007-10) specifically details access to buildings as one of the 8 core objectives

Independent Contractors
The PCT should take reasonable steps to ensure that the services provided by independent contractors are meeting the relevant aspects of this element. The following groups of independent contractors should be considered for this element:

	PCT Assurance
General practitioners	• Within Strategic Services Development Plan (SSDP), the issue of DDA compliance was specifically highlighted and 5 premises identified as requiring attention. An action plan has been drawn up to identify precise work required and associated costs. • Business cases for new GP premises include a specific section on adherence to design guidance and advice from Department of Health
Community Pharmacists	• PCT processes for gaining assurance as to compliance by community pharmacists includes quality assessment visits, monitoring of complaints and PALS eg the PCT's Fire, Health and Safety Group reviews a report of all related reported incidents
General dental practitioners	• PCT processes for gaining assurance as to compliance by general dental practitioners includes quality assessment visits, monitoring of complaints and PALS eg the PCT's Fire, Health and Safety Group reviews a report of all related reported incidents

Community optometrists	• PCT processes for gaining assurance as to compliance by community optometrists includes quality assessment visits, monitoring of complaints and PALS eg the PCT's Fire, Health and Safety Group reviews a report of all related reported incidents

Commissioned Services
The PCT has appropriate mechanisms through which they could identify and, where appropriate, respond to any significant concerns arising from their commissioned services **with regard to the overall standard**

- Performance meetings/ reports
- Regular performance management meetings with Commissioned services
- Both D&G and MTW also have DES that make specific reference to physical access to buildings with associated action plans

Element 2:
Care is provided in clean environments, in accordance with the National specification for cleanliness in the NHS (National Patient Safety Agency 2007) and the relevant requirements of The Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections (Department of Health, 2006) *N/A*

Healthcare Commission Line of Enquiry	PCT Assurance includes:
a) The healthcare organisation ensures that all premises in which it provides health care are kept clean in accordance with the relevant aspects of duty four of the Health Act 2006: Code of Practice for the Prevention and Control of Healthcare Associated Infections and the National Specifications of Cleanliness Healthcare organisations should have: • A board approved strategic cleaning plan, including roles and responsibilities and provision for sufficient resources • An operational cleaning plan, which detail the standards of cleanliness required in each part of its premises, clear allocation of responsibility for cleaning all areas, and cleaning schedules and frequencies (where cleaning services are provided by an external contractor, these specifications should be written into	• Deep cleaning programme approved by PCT Board • Equipment purchased by PCT to carry out Deep Cleans to agreed schedules and ah-hoc if required • Monthly Infection Control meetings • Action Plan to ensure compliance with Hygiene Code, monitored by PCT Board • PCT working towards registration with care Quality Commission • Deputy Director for Community Services is named lead manager for Cleaning • PCT follows national specifications for cleanliness in the NHS`

the contract) • Consulted with the infection control team on the development of cleaning plans for both internal and contracted cleaning services (see points of information 1 to 3).	
b. Healthcare organisations should: • undertake cleanliness audits (where cleaning services are provided by an external contractor, audit arrangements should be written into the contract) • have evidence to demonstrate that any issues raised as a result of audits have been acted on (see point of information 4)	• Weekly cleaning audits by Hospital Matrons with action plans as required • Regular audit of cleaning by PFI partner at Gravesham Community Hospital which forms part of the service contract and is subject to failure points and financial penalties • Cleanliness forms part of regular PEAT inspections

Independent Contractors
The PCT should take reasonable steps to ensure that the services provided by independent contractors are meeting the relevant aspects of this element. The following groups of independent contractors should be considered for this element:

	PCT Assurance
General practitioners	• PCT processes for gaining assurance as to compliance by General practitioners includes quality assessment visits, monitoring of complaints and PALS eg the PCT's Fire, Health and Safety Group reviews a report of all related reported incidents
General dental practitioners	• PCT processes for gaining assurance as to compliance by General dental practitioners includes quality assessment visits, monitoring of complaints and PALS eg the PCT's Fire, Health and Safety Group reviews a report of all related reported incidents

Commissioned Services
The PCT has appropriate mechanisms through which they could identify and, where appropriate, respond to any significant concerns arising from their commissioned services **with regard to the overall standard**

- Performance meetings/ reports
  - All Trusts that provide healthcare to patients are legally required to register with CQC from April 2009
  - NHS WK (PCT) hosts monthly Infection Control meetings which includes delegates from MTW, D&G and SECAM
  -

APPENDIX 2

Patient Safety First Campaign

1. Background

1.1 The Chief Medical Officer's report, Safety First (Department of Health, 2006), set out a number of actions to improve patient safety and increase healthcare quality across England. A key recommendation was to develop and implement a high-profile campaign to ensure that all staff responsible for patient care understand that patient safety must become their first priority.

1.2 This campaign is supported by the NHS Institute for Innovation and Improvement, the National Patient safety Agency (NPSA), and The Health foundation.

2. Campaign

The campaign cause is:

"To make the Safety of patients everyone's highest priority".

The campaign aim is:

"No avoidable death and no avoidable harm".

2.1 Although the majority of the key interventions are acute focussed the campaigns cause and aim are applicable to the whole of the NHS. Leadership intervention and the reduction of harm from high risk medications are non acute trust focused.

2.2 By signing up to the campaign the PCT will agree to:

- To make a commitment to staff in writing that safety is our highest priority
- To implement the campaign leadership intervention, and at least one clinical intervention if possible, following the registration to the campaign
- To register to the campaign in September 2008
- To post our information/results as part of the campaign

2.3 An example of a commitment to staff is as follows:

The Patient Safety First campaign for England begins this summer. The campaign "cause" is to make the safety of patients everyone's highest priority, with the aim of achieving "no avoidable death, and no avoidable harm" across the NHS in England.

The Board have joined the Patient Safety First Campaign for England and confirms to staff that it regards the safety of patients as the highest priority. Whilst it is still important to meet national targets and to remain in financial balance, this must **not** be achieved at the expense of the safety of our patients. It is important that staff raise issues with their line manager or Director if they feel that the safety of patients is being compromised.

APPENDIX 3

31st December 2008

NHS West Kent recruits cartoon character in battle against MRSA

NHS West Kent today launched a cartoon character called Moxy Malone to help raise awareness of the correct way to tackle all infections including colds, coughs and sore throats and tackle the over reliance on antibiotics, which can lead to the growth in the number of superbugs like MRSA.

Antibiotics do not work against viruses that cause colds, most coughs and sore throats – although they are needed for some other infections.

The correct treatment can be very straight forward and Moxy Malone will be appearing on leaflets and posters across West Kent in the weeks ahead to help explain what you should do.

Dr Fiona Johnston, NHS West Kent's Prescribing Lead, explained: "We wanted to use a new character that would be easily recognisable and could help take a serious message to a wide audience.

"Colds, coughs and sore throats are extremely common at this time of year and in most cases they can be dealt with easily without antibiotics because they are caused by viruses.

"We need to keep antibiotics for those infections that respond. By being careful about use we can prevent the spread of superbugs.

"The reality is that the more people use antibiotics the more likely antibiotic-resistant superbugs such as MRSA, Clostridium difficile or resistant E.Coli will surface."

For most sore throats, lozenges and throat pastilles help. A blocked nose can be eased by steam inhalation. Taking cough medicine for dry, tickly or chesty coughs should help reduce coughing; and headaches, pains or a high temperature can often be reduced by taking paracetamol – although you must always check if any other medicines you are taking already contain paracetamol.

APPENDIX 4

NHS West Kent Local Health Economy Healthcare Associated Infections Statement of Compliance with the Hygiene Code: December 2008

NHS West Kent is committed to preventing and controlling Healthcare Associated Infections (HCAIs) and to a zero tolerance approach to all preventable infections, both as a commissioner and provider of services.

As a commissioner of health services, NHS West Kent seeks assurance that all providers are compliant with the relevant sections of the Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections, to ensure that patients are cared for in a safe environment and minimise the risk of HCAIs.

This action plan has been designed to incorporate the key policy components set out in the Health Act 2006 - the Code of Practice for the Prevention and Control of Healthcare Associated Infections (Annex 1: Management, Organisation and the Environment).

Performance against the action plan is monitored by NHS West Kent Infection Prevention and Control Group and reported directly to the Clinical Leadership Board and Trust Board.

STATUTORY DUTY	REQUIREMENTS	ASSURANCE	NAMED LEAD
1. General duty to protect patients, staff and others from HCAIs	Patients, staff and the public are protected against the risk of acquiring HCAIs through the provision of appropriate care in a suitable environment consistent with good practice	• Regular surveillance and significant issues reported to the Board • Annual reports produced by Trusts • Monthly reports received by WKIPC Group from trusts • Proactive work by IPCNs	DIPC
	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	• IPC policies • Reporting of infections via the incident and SUI reporting process	Dir. Community Services/ DIPC
2. Duty to have in place appropriate management systems for infection prevention and control	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	• Hygiene Code Statement of Compliance • Patient Safety Strategy 2008 - 2010	DIPC
	The designation of an individual as director of infection prevention and control (DIPC) accountable directly to the CEO and board	• Reports to PCT Board and Clinical leadership Board • Accountable to CEO • One-to-one meetings between CEO and DIPC. • Chairs monthly WKIPC Group meeting • Attends Kent and Medway DIPC meetings • Regular meetings with health economy DIPCs	DIPC
	Mechanisms by which the board intends to ensure that adequate resources are available to secure effective prevention and control of HCAI. These should include implementing an infection control	• DIPC in place • Resources for PCT IPC Team of 1 WTE Lead IPC Nurse, 3 WTE IPC Nurses and 0.5 administrator. Recruitment to 3rd IPCN post to be completed by end Jan. 09, resulting in full recruitment to team.	DIPC

STATUTORY DUTY	REQUIREMENTS	ASSURANCE	NAMED LEAD
	programme and infection control infrastructure	Agency cover in place to cover vacancy.	
	A policy addressing, where relevant, admission, transfer, discharge and movement of patients between departments, and within and between healthcare facilities	• Community Services Admission criteria (Step-up and step-down) • HPU Community and Mental Health Hospitals Infection Control Manual (section 4 page 3; section 13 page 6 & 7; section 21 page 4 & 5)	Dir Community Services
	An appropriate assurance framework , infection control programme and infection control infrastructure	• Reports to PCT Board, Clinical Leadership Board and Clinical & Corporate Governance Committee • One-to-one meetings between CEO and DIPC. • Alert organism surveillance reports to Board and WKIPC Group • RCA of outbreaks • Annual audit programme • Patient Safety Strategy • PCT IPC Team of Lead Nurse, 3 IPCNs, administrator • 24 hour access to IPC advice available via HPU	• DIPC • DIPC • DIPC • Lead manager • Dir. Community Services • AD Clinical Quality • HPU
	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	• Induction Training • Programme of relevant training for all PCT staff	AD Clinical Quality
	A programme of audit to ensure that key policies and practices are being implemented appropriately	• Annual audit programme of Community Services • Essence of Care audit programme of Community services • Audit support available to independent contractors	Dir. Community Services AD Clinical Quality

STATUTORY DUTY	REQUIREMENTS	ASSURANCE	NAMED LEAD
		and care homes	
3. Duty to assess the risk of acquiring HCAI and takes action to reduce or control such risks.	• Suitable and sufficient assessment of the risks to patients in receipt of health care with respect to HCAI • Identify the steps that need to be taken to reduce or control those risks , record these findings and implement the steps identified • 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	• HPU policies adopted by PCT and other NHS organisations, as relevant • Community Services Admission criteria • Risk assessments on risk register • Incident reporting procedures • RCA of SUIs, including PCT involvement in acute trust RCAs	• HPU • Dir Community Services • Lead IPCN
4. Duty to provide and maintain a clean and appropriate environment for healthcare	• Named lead manager for cleaning and decontamination • Liaison between facilities and IPC team • Premises suitable and clean and maintained • Cleaning arrangements detail standards and schedule of cleaning available to public	• Dep. Dir Community services lead for cleaning • Lead IPCN lead for decontamination • Facilities representative attends PCT IPC Group • Audits of premises via PEAT inspections are satisfactory. • National specifications for cleanliness in the NHS • 08/09 Deep Clean programme for Community Hospital to be completed by end Dec 08	• Deputy Dir. Community Services • Lead IPCN • Shared Services • Deputy Dir. Community Services
	Adequate provision of suitable hand washing facilities	• Audit programme • Clean**your**hands campaign being implemented – formal launch Oct 08 • Audit of hand wash facilities being undertaken	• Dir. Community services • AD Clinical Quality

STATUTORY DUTY	REQUIREMENTS	ASSURANCE	NAMED LEAD
			• Lead IPCN
	Effective arrangement for decontamination of instruments and other equipment	• Review of instrument decontamination being undertaken in response to changes in services within Kent and Medway • Programme to remove podiatry use of benchtop sterilisers by 1/2/ 09 • Audit programme • HPU policies • Annual PEAT inspections	• Lead IPCN for instruments • Dir Community Services. • Deputy Dir. Community Services for other equipment
	Supply and provision of laundry reflects HSG (95) 18 "Hospital Laundry Arrangements for Used and Infected Linen"	• Contract with NHS supplier • PEAT inspections • Use of disposable curtains in Community Hospitals	• Dir. Community services
	Uniform policy ensures that clothing is clean and fit for purpose	• Department of Health Uniforms and Workwear principles have been adopted by the PCT • Updated Uniform and Dress code policy to go to Staff Partnership Forum Jan 09 and then for final approval to Clinical and Corporate Governance Committee	• Dir. Community services
5. Duty to provide information on HCAIs to patients and the public	Information available to patients and the public about the organisation's general systems and arrangements for preventing and controlling HCAIs;	• Board Reports • Annual IPC Report • Leaflets detailing PCT approach to HCAIs developed. Information on specific infections available on website. • Infection Control Public awareness Roadshows commenced in May 2008 and ongoing	DIPC
	Information available to patients concerning:	• Leaflets detailing PCT approach to HCAIs developed.	• Lead IPCN

STATUTORY DUTY	REQUIREMENTS	ASSURANCE	NAMED LEAD
	• 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.	• Information on specific infections available on website • Hand washing facilities (including hand rub) available for public and patient use at clinical areas	• Lead IPCN • Dir. Community Services
6. Duty to provide information when a patient moves from the care of one healthcare body to another	Ensure provision of 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.	• Community Services Admission criteria • Transfer of patient information includes infection status	Dir. Community Services
7. Duty to ensure co-operation	Ensure 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	• IPC report to each PCT Board meeting to provide Board assurance • Reports from commissioned services at WKIPC Group meetings • Clinical Metrics in SLAs include IPC • Care home and domiciliary care provider staff have access to advice, training and audit support to facilitate meeting Hygiene Code standards. • Programme of audit of care homes and training sessions for independent contractors, care home staff and home care staff being developed • Annual IPC audit programme	• DIPC • Lead IPCN
8. Duty to provide adequate isolation facilities	Ensure provision of, or secure the provision of, adequate isolation facilities for patients sufficient to prevent or minimise the spread of	• PCT follows HPU policies on the management of specific infected conditions	Dir. Community Services

STATUTORY DUTY	REQUIREMENTS	ASSURANCE	NAMED LEAD
	HCAIs.		
9. Duty to ensure adequate laboratory support	Ensure that microbiology laboratory services have in place appropriate protocols and that they operate according to the standards required for accreditation by Clinical Pathology Accreditation (UK) Ltd.	• PCT uses Dartford and Gravesham and Maidstone and Tunbridge Wells microbiology laboratories, which are CPA Accredited	Lead IPCN
10. Duty to adhere to policies and protocols applicable to infection prevention and control		• Comprehensive clinical guidelines produced by the HPU for all areas of PCT and primary care; and adopted by the PCT • Compliance audited as part of PCT audit programme	Lead IPCN
11. Duty to ensure that healthcare workers are free of and are protected from exposure to communicable infections during the course of their work, and that staff are suitably educated in the prevention and control of HCAIs		• All new staff members require Occupational Health assessment prior to commencement of work • Occupational Health Department provides advice to staff and manager, as appropriate • Occupational health department provides inoculation injury service/ advice	Dir. Humans Resources

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How you can help

- Wash your hands and use alcohol gel provided by the hospital before and after visiting
- Wash your hands carefully at home too, especially before eating or preparing food
- Make sure any health professional examining you or your relative washes their hands first - remind them to do so if necessary
- Don't visit anyone in hospital if you have been sick or had diarrhoea in the previous 48 hours
- Always follow your doctor's instructions on taking antibiotics and finish the course

Other enquiries

If you would like a copy of this leaflet in a different format or language, have any concerns about our services or want to make a complaint, suggestion or pass on a compliment, please contact our freephone number:

0800 0 850 850

West Kent NHS Helpline

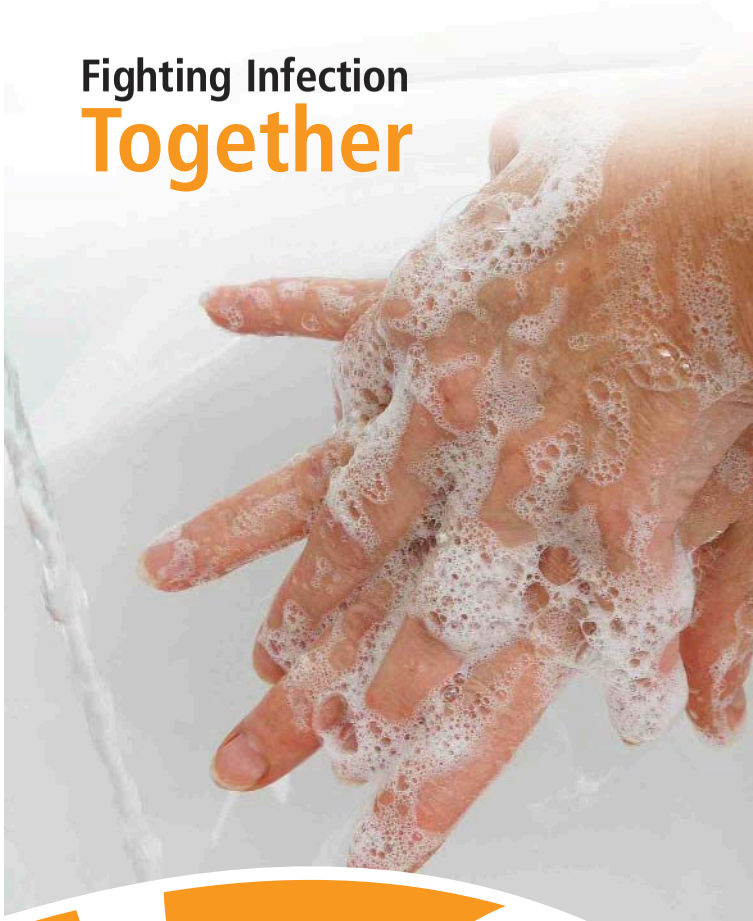
West Kent's NHS Information Gateway

Email: **customerservices@wkpct.nhs.uk**

Write to:
NHS West Kent Customer Services Team
Gravesham Community Hospital
Bath Street
Gravesend
DA11 0DG

NHS West Kent

Fighting Infection Together



What are healthcare associated infections?

Healthcare associated infections are infections that people occasionally pick up while being treated for something else.

The most common ones are MRSA (Methicillin-Resistant Staphylococcus Aureus) and C. diff (Clostridium difficile). Healthy people are very unlikely to catch them.

By hard work, the NHS is succeeding in bringing down the number of cases.

The best approach is prevention and everyone has a vital part to play: patients, families and friends as well as doctors, nurses and other health service staff.

What we are doing

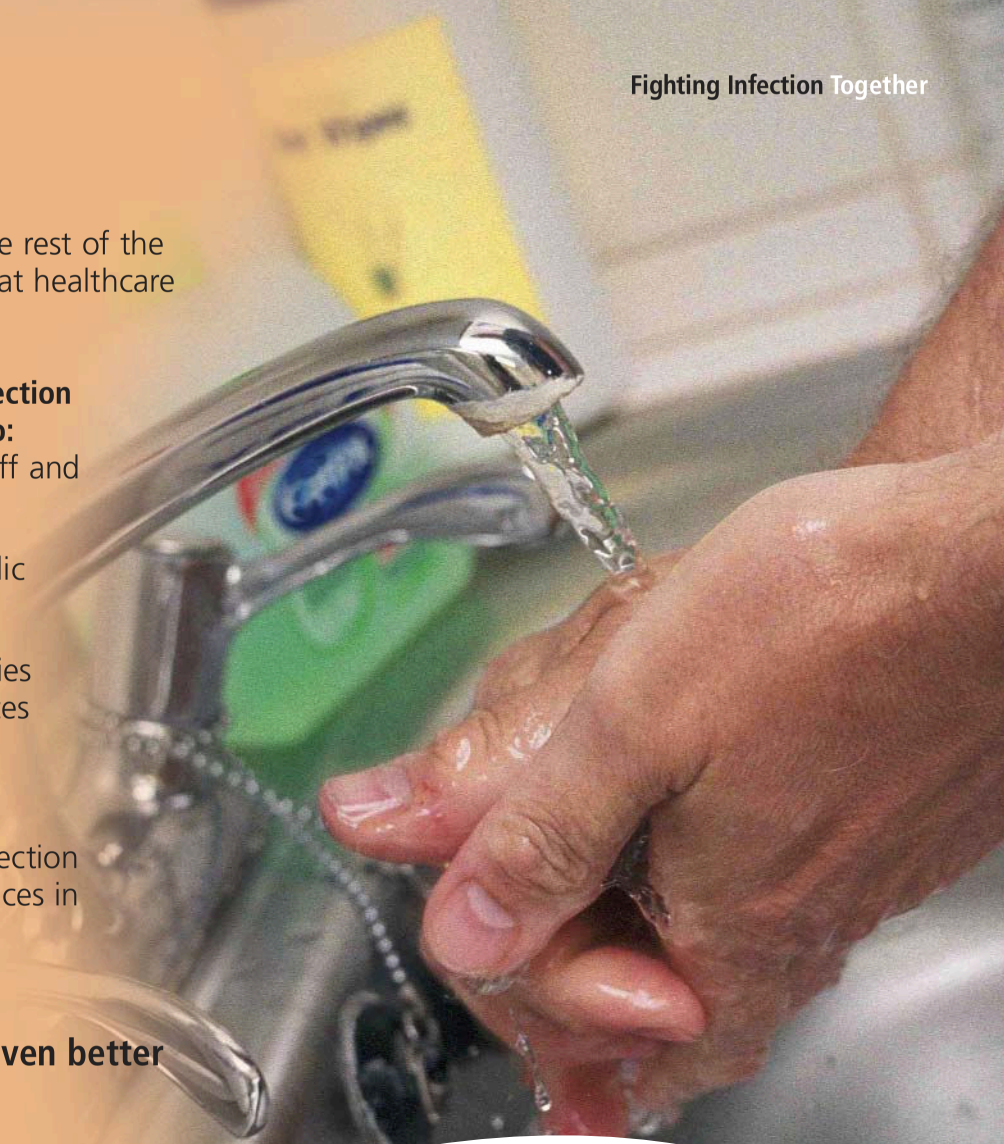
NHS West Kent, along with the rest of the NHS, is working hard to combat healthcare associated infections

We have invested in a new infection prevention and control team to:

- Improve training for our staff and other health professionals
- Run roadshows for the public on fighting infection
- Visit care homes, GP surgeries and other community services to give expert advice

We are also

- Increasing investment in infection prevention and control services in acute hospitals



We need your help to do even better