AGENDA

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Friday, 20th March, 2009, at 9.30 am	Ask for:	**Paul Wickenden**
Council Chamber, Sessions House	Telephone:	**(01622) 694486**
County Hall, Maidstone		

Tea/Coffee will be available from 9:15 am

Membership (17)

Conservative (12): Mr B R Cope (Chairman), Mr A R Chell, Mr A D Crowther, Mr J Curwood, 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, Mr R Tolputt, Cllr Ms A Blackmore, Cllr M Lyons, Cllr Mrs J Perkins and Cllr Mrs M Peters

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

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 - 9 January and 6 February 2007	
4.	Medway NHS Foundation Trust *Lois Howell, Company Secretary and Linda Dempster, Head of Infection Control will be in attendance for this item.*	9:45 - 10:30 am

Break 10:30 - 10:45 am

5.	Kent & Medway NHS & Social Care Partnership Trust *Erville Millar, Chief Executive and Donna Eldridge, Assistant Director of Nursing/Director of Infection Prevention and Control (DIPC) will be in attendance for this item.*	10:45 - 11:30 am

6.	South East Coast Ambulance Service NHS Trust *Andy Cashman, Assistant Director of Service Development will be in attendance for this item.*	11:30 am - 12:00 noon

Break 12:00 noon - 12:15 pm

7.	Local Involvement Network (LINk) *John Fletcher, Governor, Kent Local Involvement Network and Graham Hills, Director, KMN Ltd will be in attendance for this item.*	12:15 - 1:00 pm
8.	Date of next programmed meeting – Friday 1 May 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

12 March 2009

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

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 9 January 2009.

PRESENT: Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Mr C G Findlay, Ms A Harrison, Mr M J Northey, Mr R J Parry, Dr T R Robinson, Mrs E D Rowbotham, Ms B J Simpson, Mrs P A V Stockell (Substitute for Mr B R Cope), Mr R Tolputt, Cllr Ms A Blackmore, Cllr J Cunningham (Substitute for Cllr Mrs M Peters), Cllr R Davison and Cllr M Lyons.

ALSO PRESENT: Mr R Kenworthy, LINk Member, Mr M Cayzer, Wateringbury Parish Council, Mrs A Burnand, Performance Management Officer, KCC, Ms K Barkway, West Kent PCT and Ms G Alexander, Eastern & Coastal Kent PCT.

IN ATTENDANCE: Mr P D Wickenden (Overview, Scrutiny and Localism Manager) and Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee).

Mr Fittock presiding as Chairman

UNRESTRICTED ITEMS

1. Membership

The Overview, Scrutiny and Localism Manager reported that Mr C G Findlay had replaced Mrs E M Tweed on the Committee.

2. Minutes - 17 October 2008
(Item 3)

RESOLVED that the Minutes of the meeting held on 17 October 2008 are correctly recorded and that they be signed by the Chairman.

3. Matters Arising

A Picture of Health for Outer South East London

(1) The Overview, Scrutiny and Localism Manager reported that since the last meeting of the Committee the Joint Committee of London Boroughs and the County Council had referred the reconfiguration proposals for a Picture of Health for Outer South East London to the Secretary of State for Health as had the London Borough of Bexley separately.

(2) Notification had been received from the Secretary of State for Health that this matter had been referred to the Independent Reconfiguration Panel for consideration.

Accessing Healthcare – Transport

(3) The Overview, Scrutiny and Localism Manager reported that a commitment had now been received from the two Primary Care Trusts in the administrative county of Kent, the acute Hospital Trusts, Social Services and transport planners to this piece of work. A half day workshop to identify clearer service delivery objectives was being prepared for early February.

(4) In the spring it was hoped that an initial action plan for taking this work forward would be reported to the Committee.

Annual Health Check

(1) The Committee had before them a briefing note prepared by the Research Officer to the Health Overview and Scrutiny Committee which set out the key points for the Annual Health Check and the Committee's interest in looking at three core standards in detail relating to the Hygiene Code which included:-

- C4a – Infection Control;
- C4c – Decontamination; and
- C21 – Clean, well designed environment.

(2) The Committee noted that assessment of the Core Standards forms part of the "Quality of Services" score in the Annual Health Check. Any commentary from a Health Overview and Scrutiny Committee will form part of the evidence the Care Quality Commission (CQC) uses to cross reference the declarations made by each individual Health Trust. In the early part of 2009 NHS Trusts will have to register with the CQC. 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 2008/2009. 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.

(3) These Core Standards were derived from the 2004 Department of Health publication "Standards for Better Health" which set down 24 core standards and described the minimum level of service all Health Trusts were meant to provide. In October 2009 the CQC will publish the results of the Annual Health Check for 2008/2009.

4. Dartford & Gravesham NHS Trust

(Item 4)

Mr M Devlin, Chief Executive and Mrs I Smith, Director of Infection Prevention and Control were in attendance for this item.

(1) Mr Devlin and Mrs Smith made it clear that they did not want to say much in the way of introduction but leave the majority of the time for questions from those Members present. However, by way of introduction the Chief Executive indicated he had struggled with a low tolerance for infection control and in particular MRSA. The Trust allowed for 12 cases of MRSA per year and that included community acquired infections detected at hospital. However, the numbers of MRSA cases to date were

30% lower than the previous year. The Trust had taken a much higher profile with regard to prevention in terms of hand hygiene and alcohol gels.

(2) A programme of deep cleaning had been undertaken and was a continuous, on-going programme.

(3) In answer to a question about the risks associated with infection control in an emergency or for elective surgery. Colleagues from the Trust responded and talked about the processes that they had in place at the Dartford & Gravesham NHS Trust which included the pre-assessment clinics for elective surgery. Since July 2007, screening had taken place for all routine admissions of all adults. This had resulted in the reduction of post operative ward infections, e.g. levels of MRSA and had therefore been a successful strategy.

(4) The Committee were informed by Trust colleagues that screening would be extended to include emergency screening in accordance with the Department of Health advice by 2011.

(5) The Trust informed the Committee that by the end of March 2009 screening of all elective cases would begin. Guidance was still being issued and work was also be undertaken to assess the amount of inpatient days patients stayed which gave a measure of success for the pre-assessment.

(6) In answer to a question about the amount of time that it took to do the screening, Mrs Smith informed the Committee that with pre-assessments there was enough time to have the swab analysed. This generally took 2 days. However, there was provision, which was very expensive, to analyse a swab within 4 hours. This was particularly important in higher risk areas such as the Intensive Care Unit (ICU). The Trust continued to look at the use of new technology to assist in this process.

(7) The Committee noted that within the document that the Trust had prepared in advance for the Health Overview and Scrutiny Committee one of the sections related to success and challenges. The Trust had identified that the success of the IP Management pathway had been extended to urinary catheters as they were recognised as being a source of hospital acquired infection (HAI).

(8) Mrs Smith responded that the IV lines Management pathway had been a great success. She spoke about the importance of education and training, recognising new diseases and auditing what was going on. She said that there had been one incident of canula infection during the past year but this was one too many. The Trust had learnt an awful lot from the IV Management pathway and they were extending this to other parts of the organisation. Canulas and catheters presented a greater risk for infection.

(9) In answer to a question relating to the Trust's policy of "bare below the elbows" uniform policy, adopted by clinical staff thereby facilitating hand hygiene practice the Committee were informed that policy being adopted by the Trust of "bare below the elbows" was being dealt with where there were issues on an individual basis.

(10) The Committee were advised that this policy was not confined purely to the hospital and some colleagues were challenging this policy. Mr Devlin added that he did feel that the message was getting through to the staff concerned and this was a

consistent message from himself as Chief Executive, Iris Smith as the Director of Infection Prevention and Control (DIPC) and the Trust' Medical Director. Those members of staff who were not complying with this policy he did not feel were doing this wilfully. He said they were not covered by the evidence.

(11) The elective cases not screened were the day cases. The trust needed to look at elective day cases.

(12) In answer to a question as to whether children were screened Mrs Smith answered that they were not routinely screened, which was in line with the Department of Health Guidance.

(13) Asked about the challenges surrounding a patient's length of stay and the impact in terms of infection control Mrs Smith responded that the longer a patient stayed in hospital the more likelihood was that the general condition and not if infection would be increased, i.e. because of being in a shared environment and the immobility of a patient made them at a higher level of risk for hospital acquired infection and the spread of that infection. Mr Devlin informed the Committee that the Trust were undertaking a significant piece of work to achieve the outcome of reducing the length of stay of patients.

(14) One of the difficulties referred to was that many of the patients, before they even present to the hospital have a community acquired infection. What the public did not appreciate is that a percentage of the population already have MRSA and C Difficile but do not appreciate that they have it. What concerned the Member is where was the public awareness campaign, and what was happening in the community in terms of presentation and raising the awareness of community acquired infections. It was not joined up with the PCTs.

(15) Mr Devlin acknowledged that the statement made by the Member was very true and that this was another very important strand that the Trust would be tackling as part of the 'whole system's' approach with its Primary Care Trust colleagues.

(16) He added that Primary Care Trusts were building up their expertises in the area of community acquired infections. 50% of all infections were community acquired. Mr Devlin reaffirmed that it was important that the Strategic Health Authority, Primary Care Trusts, the community and the Department of Health were all working together and it was important that the education and public relations exercise was undertaken.

(17) Asked the question about whether it would be appropriate not to take in patients who had the infection because ultimately that costs the National Health Service more Mr Devlin responded that that clearly would not be appropriate. In an emergency urgent situation patients could not be turned away. For elective surgery the pre-assessment for infection was reducing the risk.

(18) However, he said that this continued to be a challenge for hospitals such as the Darent Valley Hospital because it was very different to somewhere like the Queen Victoria Hospital in East Grinstead which had no Accident & Emergency Unit – they run on elective services.

(19) In response to a series of questions about hospital cleanliness including what is a deep clean, how is cleaning physically undertaken, especially around the beds,

what was the Trust's advice relating to visitors and what physically happens on the ward.

(20) Mrs Smith responded that there were three cleaning processes that she wished to describe. The first was day to day cleaning, the second was cleaning of areas around patients with infection and the third was the deep cleaning process.

Day to day cleaning – with regard to the day to day cleaning each ward had a dedicated cleaner employed by Carillion, the external cleaning provider for the Dartford & Gravesham NHS Trust. The cleaning schedule was designed in consultation with the Matron and ward sister. There were also domestic supervisors who had a role of checking quality standards.

This was followed up by monthly monitoring which was normally unannounced and a number of unannounced meetings.

Deep cleaning – the challenge here was to initially empty an entire ward to thoroughly clean the ward bay by bay and room by room and then to carry out this process systematically throughout the hospital. The Trust had purchased six steam machines.

(21) The Committee noted the challenges associated with the deep cleaning process.

(22) Pushed further about the part of the question which had not been responded to on infection control Mrs Smith said that she was an advocate for soap and water as being one of the best preventions for infection. Alcohol does have its benefits (particular for visitors) and she reminded the Committee of the huge push that had been undertaken by the Department of Health. However, alcohol gel was not effective in terms of C Difficile.

(23) She added that education was key to prevention. With a regard to a patient who already had C Difficile then the process would be that that person would be isolated to a single room and Trust staff would talk to the patient and their visitors in terms of infection control management.

(24) In response to a Member's question relating to the role of nurses and how they are trained before they start work on the ward Mrs Smith stated that she too had been a nurse at the same time as the Member asking the question and the role had changed dramatically since she was nursing.

(25) The induction process for new nurses was fairly broad but it was important that part of this training was going "back to basics" in terms of hygiene.

(26) Mrs Smith advised the Committee of the processes student nurses go through. She explained that the Trust had set aside an area where there was a bed where nursing assistants and student nurses were trained on how to strip the bed and clean it. With regard to agency staff Mrs Smith informed the Committee that the number of agency staff within the Dartford & Gravesham NHS Trust had significantly dropped. However, agency staff had their own set standards but it was fair to say that those standards matched those standards that would be required by the Dartford &

Gravesham NHS Trust. Increasingly, as opposed to using agency staff, the Trust were relying on their own 'bank staff'.

(27) In answer to a question about the screening process Mrs Smith informed the Committee that with regard to MRSA screening there were three sites on the body where swabs for MRSA were taken. These sites were; underneath the arm; in the groin and nasal swabs. These swabs were generally taken by a nurse based on the ward and were then sent to the laboratory. If the results were negative this would be known within 24 hours but if the results showed that it was positive further tests would be undertaken and these would be known within about 48 hours. This was the general standard but there was a four hour rapid testing system available.

(28) In terms of an urgent admission or emergency, the process also involved an assessment of risk and in appropriate cases antibiotic cover would be provided.

(29) Mrs Smith was unable to answer directly the cost associated with these tests in terms of the swab and consumables.

(30) One Member spoke of recent visits to hospitals where innumerable people did not use the alcohol gels and parents not asking children who were visitors to the hospital to undertake the required level of hygiene.

(31) Mr Devlin responded to the Committee that the issue of hand hygiene needed to have a much higher profile. Engagement with the public was key. It was a case of continually refreshing and changing the message. He spoke of work that the Trust had undertaken within the hospital to insure that whilst the message was the same it was dealt with in a different way so always had an impact. Mrs Smith added that there was a need for a huge public campaign on hand hygiene and infection control.

(32) In answer to a question relating to infection control for community hospitals Mrs Smith said that community hospitals were managed by colleagues in the Primary Care Trusts.

(33) In response to a question relating to infection control in nursing and residential homes she said that this was an issue for the Health Protection Unit. The Committee noted that the registration process for nursing and residential homes for the new CQC was due to start next week. The CQC would have the right to make spot check inspections of these establishments.

(34) In answer to a question about the provision of domestic services the response from the Trust was that this was in-house.

(35) Asked whether staff were screened for infections Mrs Smith responded that the screening of staff would increase the cost to the Trust considerably. The Patients Association were advocating that staff should be screened but Mrs Smith said that she was not sure how that could be achieved, what the benefits were and how often it should be done.

(36) Mrs Smith responded to a question relating to the budget for infection control that initial screening was in excess of £30-50,000 per year on the initial part of the screening, but she could not give the exact cost at the meeting. What was important was to identify those areas of greater risk, e.g. orthopaedics. Ongoing training for all

staff was very important. Mrs Smith informed the Committee of the ongoing training programme which took place in the wards within the hospital rather than a thorough traditional tutorial approach. There was much more informal and ward based training.

(37) In answer to a question about the re-testing for infections for long stay patients Mrs Smith advised the Committee that this took place every 14 days if a patient remained in hospital.

(38) In conclusion, as a local Member, Mrs Angell said that she had recently been a 'mystery' shopper and she wanted to congratulate the professionalism of the staff and the services provided at a very good hospital.

5. Maidstone & Tunbridge Wells NHS Trust
(Item 5)

Sara Mumford, Director of Infection Prevention and Control, Flo Panel-Coates, Director of Nursing and Claire Roberts, Head of Quality and Governance were in attendance for this item.

(1) Attached as an appendix to these Minutes is a copy of the presentation that the Trust had prepared but was not delivered to the Committee and a Healthcare Commission press release which was positive for the Maidstone & Tunbridge Wells NHS Trust.

(2) All those Members who asked questions of colleagues from the Maidstone & Tunbridge Wells NHS Trust were very pleased to acknowledge the hard work of the Trust which had resulted in the Healthcare Commission press release and they hoped that this was reflected in the local community and by the local press.

(3) In answer to a number of specific questions the Trust were invited to explain to the Committee the development of the C Difficile Integrated Care pathway.

(4) In answer to a question about the screening processes within the Trust and the different processes in terms of those patients who present in an emergency situation at Accident & Emergency and elective care Ms Mumford answered in terms of the two organisms of major concern. Turning first to MRSA Ms Mumford advised the Committee that patients that were attending the hospital for elective treatment were screened and pre-assessed. For those patients presenting in an emergency setting not all of them were screened. Then it was an issue of identifying those areas of greater risk, i.e. orthopaedics, surgery patients, those that require coronary care, intensive care, whether the patients were at risk of bringing in a community acquired infection, for example from a nursing home setting or whether they had any chronic wounds that made them of higher risk, such as ulcers.

(5) Mrs Stockell said that the Trust must not become complacent. She had certainly noticed people within the Hospital that were not using the alcohol gels or hand washing and she asked how working together there could be a campaign for the public on the importance of using the facilities provided in a hospital to avoid infection as well as working with schools to change the culture and educate young people. Ms Mumford responded that it was important that the public were constantly

reminded of the importance of using the facilities to avoid infection as a means of infection control within the hospitals.

(6) The Trust had recently introduced new signage which was much more noticeable but she said they could not force the public to use the facilities available but they could be encouraged.

(7) Staff had spent time, sometimes up to an hour at a time, welcoming and greeting members of the public to advise them of the importance of using the gels or hand washing but it was not an optimum use of time to do this all the time.

(8) In answer to questions about staff walking from one ward to another and not using the facilities and the new culture that had been explained to the Committee of continuous development Ms Mumford responded that the importance of staff having it emphasised to them the importance of using the gels and appropriate hand washing. All wards now had dedicated domestics and they were part of the ward team.

(9) Members of the cleaning team management hierarchy also took part in the nursing and infection control meetings.

(10) In response to a question about deep cleaning Ms Mumford informed the Committee of the process within the Trust. She said that there was often pressure on beds but what they did in the case of a deep clean was to empty a ward where possible or if not possible then to systematically bay by bay thoroughly clean with steam and chemicals so that every 'nook and cranny' is cleaned.

(11) In answer to a question about spot checks Ms Mumford responded that these were periodically undertaken and of course the Trust was open to external scrutiny. Internal inspection, the cleaning of hospital wards, did take place on a fairly regular basis. As part of this deep cleaning disposable curtains around the bed were replaced annually.

(12) Mr Fittock then asked the question about how the deep cleaning was undertaken in public areas and also reminded the Trust that bed spaces had been an issue for the Trust before. The response was that there was a programme of deep cleaning and the first task was to identify those areas of high risk and these areas are prioritised. The Trust had pulled together various strands of evidence to produce one audit standard and spot checks were undertaken by Matrons against this standard.

(13) The issue of space between the beds had been addressed at both sites.

(14) Ms Mumford said that everything to do with the Hygiene Code was discussed at a monthly meeting which included the Director of Nursing, the Medical Officer, the Chief Operating Officer and the Director of Infection Prevention and Control and regular reports were made by the Trust Board.

(15) In response to a question and where children are playing with toys as to how often the toys are cleaned the answer was that the toys were cleaned on a regular basis.

(16) In answer to a question about how often the trolleys in Accident & Emergency were cleaned Ms Mumford said that this happened every morning. The incidents of infection arising from this area had reduced significantly.

(17) Asked about community acquired infection and what activities the Trust were undertaking to ensure that the public were aware of preventative measures the Trust said representatives they were putting a strategy in place, it was about the Trust being excellent at being proactive and trying to change the public's behaviour.

(18) In answer to why Trusts tended to only screen for MRSA and C Difficile Ms Mumford responded that there were other infections which would require other facilities and equipment to screen.

(19) The Committee noted that the Trust would not routinely screen for C Difficile as there was no reliable method for doing so.

(20) In answer to a question about the screening which takes place in London Ms Mumford responded that the challenges for London hospitals were very different to those such as the Maidstone & Tunbridge Wells NHS Trust.

(21) Asked about the separate treatment centre at the Maidstone Hospital site and whether they were compliant to infection control Ms Mumford responded that whilst they were a separate body she could confirm that the policies they had for infection control were compliant with the Trust's standards. Ms Mumford said that the treatment centre did not have the same issues with C Difficile or MRSA.

(22) In answer to a question about transferring patients from the Kent & Sussex Hospital, Tunbridge Wells to Maidstone or by ambulance from London patients to the Trust's hospitals and whether there would be additional resources for infection control made available by the Government to Trusts Ms Mumford responded that the funding for infection control was an ongoing funding stream.

(23) The current funds which had been made available by the PCT were for the Trust's recovery period following the Healthcare Commission's reports into the outbreaks of C Difficile which had contributed to the death of a number of patients. Pushed for an answer relating to whether patients from the Kent & Sussex had to be transferred to Maidstone because the Kent & Sussex Hospital, Tunbridge Wells did not have the facilities for treating a person with C Difficile Ms Mumford confirmed that there were facilities at the Kent & Sussex Hospital. However, the isolation ward had recently had to be closed in Tunbridge Wells which necessitated a patient being transferred to Maidstone.

(24) A Member asked whether, because of the pressure on beds, the opportunity to use these was reduced. Ms Mumford replied that this had been an issue the week before but it was an ongoing issue that she discussed with the Trust's Operational Director.

(25) In conclusion the Trust welcomed the opportunity for the discussion with the Health Overview and Scrutiny Committee and recognised that the Committee saw the positive contribution and continuous improvement the Trust had made since the outbreak of C Difficile.

6. Eastern & Coastal Kent Primary Care Trust

(Item 6)

Sarah Andrews, Director of Nursing and Infection Prevention & Control, Karen Benbow, Deputy Director of Provider Development and Assurance Carol Cassam, Head of Infection Control from Eastern & Coastal Kent PCT and Philip Greenhill, Chief Operating Officer, Sue Baldwin, Assistant Director of Adult Clinical Services and Joan Maudsley, Head of Infection Prevention from Eastern & Coastal Kent Community Services were in attendance for this item.

(1) Ms Andrews introduced the team attending the meeting and explained that they represented the two arms of the Primary Care Trust as commissioners through the Eastern & Coastal Kent Primary Care Trust and as a provider through the Eastern & Coastal Kent Community Services.

(2) Mr Greenhill informed the Committee that they, Eastern & Coastal Kent Community Services, were a separate organisation and employed some 3,500 people. They were largely a home based service. The Community Services organisation had their own management and governance arrangements.

(3) In answer to a Member question about screening Ms Andrews said that it was appropriate that screening took place in context. As a commissioner it was about having clear standards in place and looking at all opportunities to increase screening. She added that the Eastern & Coastal Kent PCT were on track for universal screening.

(4) Ms Maudsley referred the Committee to a letter which set out new guidelines for screening. She said that screening is not a control mechanism. She added that there were no cases of MRSA in the community hospitals. 80% of MRSA is transferred into the community hospitals from the Acute Trusts and others come straight from the community.

(5) In answer to a question about C Difficile the Committee were informed that within the Eastern & Coastal Kent PCT boundaries there were six community hospitals and there had been 18 cases of C Difficile in two years, seven last year and this year five cases. Asked by a Member how many of those five patients were out of a total the Committee were informed that that information was not readily available at this meeting. The Member was keen to explore the incidents of cases of infection within Eastern & Coastal Kent PCT area community hospitals with the community hospitals in other parts of the county.

(6) In answer to a series of questions about prevention and how the Trusts could be more proactive in training staff about good practice in terms of hygiene and hand washing Ms Andrews answered that there was very little extra funding available for this activity. However, the Trust were working with the care home sector and recognised that education and training on the Hygiene Code were key. Ms Andrews referred the Committee to the establishment of the Care Quality Commission as from 1 April 2009 which would have clear standards set out for providers. She added that patient through-put through hospitals was quicker than it had been in the past and the length of stay briefer. The challenge was to undertake the best of the modern world and some of the better aspects of the past. There was a correlation between modern

nursing methods and some of the old disciplines from nursing which she had been brought up with.

(7) With regard to the Community Services operation Mr Greenhill informed the Committee that within his service there was dedicated nurses' team and a dedicated community matron team. Ms Baldwin informed the Committee of the key relationship between students and support to ensure that there were standards of quality care. She informed the Committee of how the students acquired the skills within a competency framework. Ms Maudsley said that training was mandatory and she talked about the methods of training for hand hygiene and the Infection Control module taken by Matrons through the University of Greenwich.

(8) Asked about the morale of staff Ms Baldwin said that when there were incidences of C Difficile morale was very low because staff felt they had failed but now they take pride in what they do.

(9) Finally in answer to some questions about how GPs and staff within nursing homes are trained Ms Andrews responded that it was difficult to have any impact on the independent sector.

7. Plenary session
(Item 7)

Comments in the plenary session included:-

- The role of Public Health in running a campaign about the importance of hygiene in terms of infection control.

- Promoting hand hygiene in schools.

- It was refreshing to hear how nurses were being trained, particularly by Eastern & Coastal Kent Primary Care Trust, and that ignorance was not an excuse.

- The Committee recognised the importance of undertaking a root/cause analysis when outbreaks of infection occurred was reiterated.

- It was unclear what Primary Care Trusts responsibilities were when an outbreak of infection occurred and when patients needed to be isolated as to what the policy was in standards across Kent.

- The need to understand the relationship between Adult Social Services and nursing homes in terms of infection control

8. Date of next programmed meeting – Friday 6 February 2009 at 10.00 am
(Item 8)

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Maidstone and Tunbridge Wells NHS Trust

Compliance with the Hygiene Code, Core Standards C4a, C4c & C21

Flo Panel-Coates, Director of Nursing
Sara Mumford, Director of Infection Prevention & Control
Claire Roberts, Head of Quality & Governance

9th January 2009

in touch with your health

Governance arrangements:

- New governance structure
- New governance committee structure
- DIPC appointed
- Increased resource within infection control team
- Revised policies, procedures and audits

in touch with your health

Scrutiny:

- External scrutiny:
  - Department of Health
  - Strategic Health Authority
  - PCT
  - Specialists – e.g. Alan Bedford (most recent visit = 7th Jan 09)
  - Healthcare Commission – Hygiene Code Team
  - Healthcare Commission – Investigation Team
  - Health And Safety Executive
  - Health Protection agency HCAI mandatory surveillance
  - Joint Advisory Group on Gastrointestinal Endoscopy (JAG)
  - OSC

Scrutiny contd:

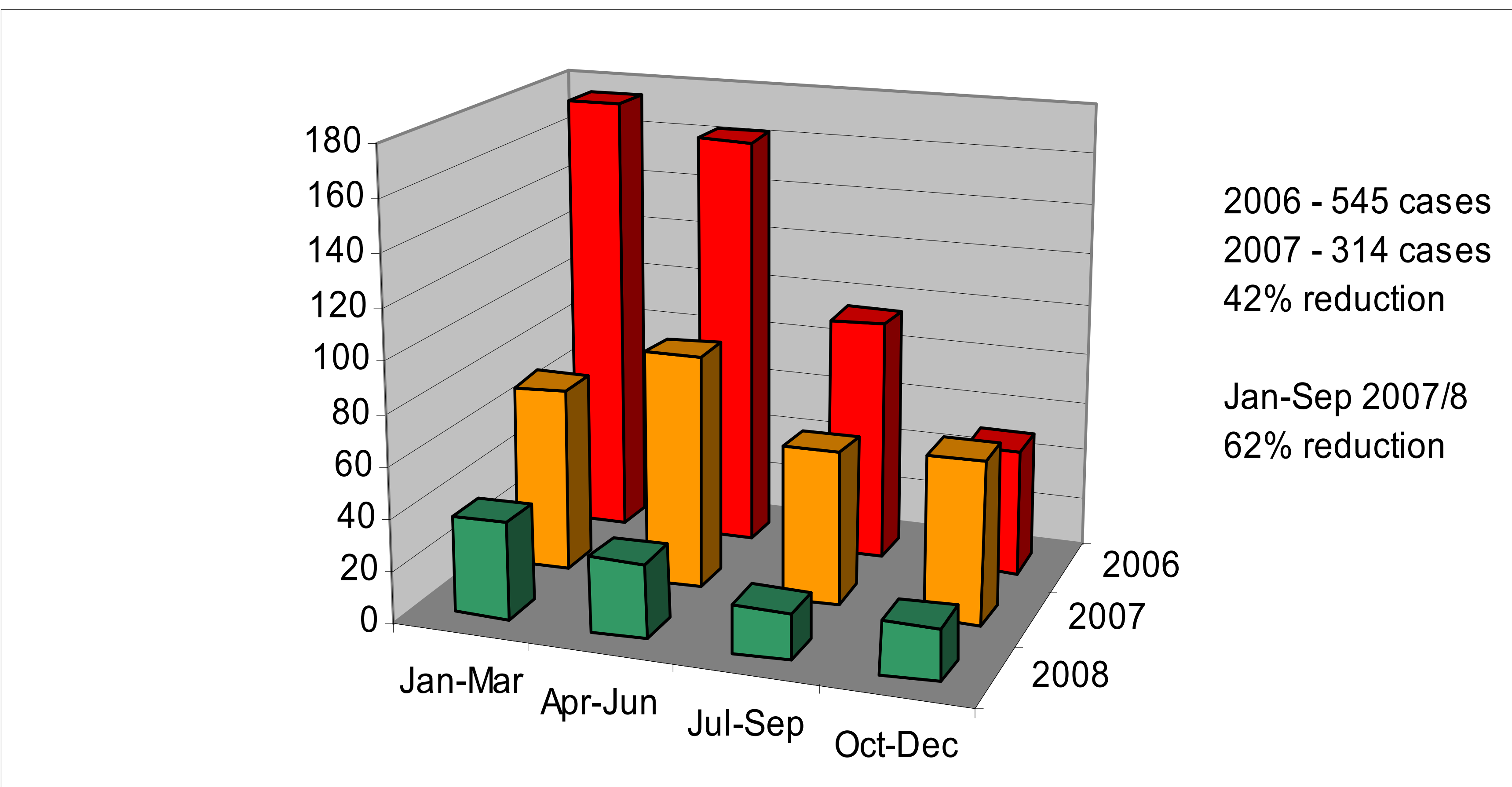
- Internal Scrutiny
  - DIPC reports weekly to Executive Team
  - DIPC reports monthly to the Trust Board
  - DIPC reports monthly to the Quality and Safety Committee
  - Q&S Committee reports monthly to the Trust Board
  - NED representation on Trust Board and sub committees
  - Audit programme e.g.PEAT, hand hygiene, “saving lives” actions, compliance with antibiotic policy
  - Root cause analysis of all C diff cases and MRSA bacteraemias
  - Weekly then monthly review of the action plan resulting from the investigation – SHA and PCT involved

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 MRSA

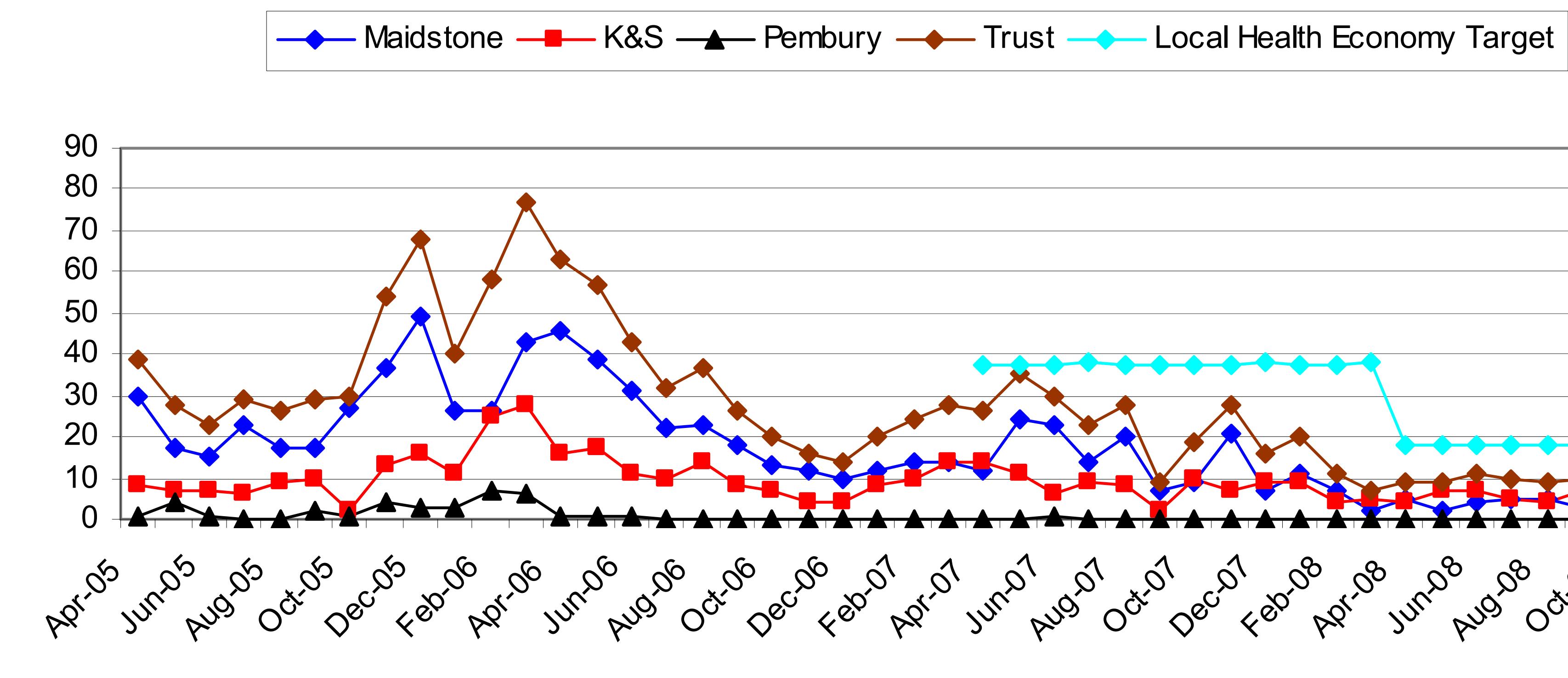
- Clear areas of responsibility and lines of accountability
- Weekly reporting of infection control rates to execs
- Monthly reporting to Trust Board
- Healthcare Commission and Hygiene code action plans monitored by IPCC and reported to Quality and Safety Committee (sub-committee of Board)
- Saving Lives Audit programme – daily audits - reviewed weekly
- “Bare below elbows” campaign
- Staff training programmes
- Root cause analysis of MRSA bacteraemias and C diff – learning cascaded stat and via IPCC

Maidstone and Tunbridge Wells NHS Trust

Quarterly C. difficile infections 2006-8



in touch with your health


Total number of new cases of C. difficile at Maidstone and Tunbridge Wells NHS Trust by hospital
Maidstone
K&S
Pembury
Trust
Local Health Economy Target
90
80
70
60
50
40
30
20
10
0
Apr-05
Jun-05
Aug-05
Oct-05
Dec-05
Feb-06
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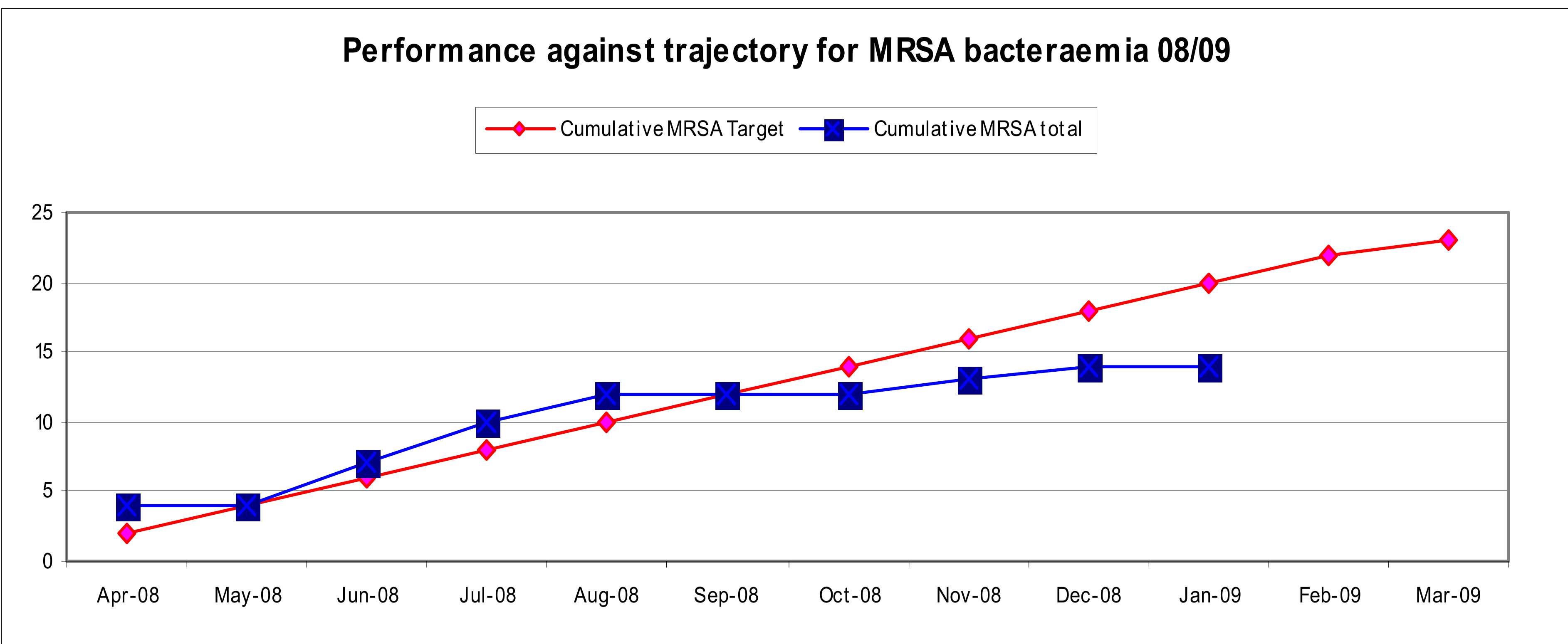
Maidstone and Tunbridge Wells NHS
NHS Trust
MTW MRSA bacteraemia against Target
Performance against trajectory for MRSA bacteraemia 08/09
Cumulative MRSA Target
Cumulative MRSA total
25
20
15
10
5
0
Apr-08
May-08
Jun-08
Jul-08
Aug-08
Sep-08
Oct-08
Nov-08
Dec-08
Jan-09
Feb-09
Mar-09
in touch with your health

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.

- JAG accreditation
- HC visit – recommendations made and being addressed
- Kent wide decontamination service by IHSS
- Medical devices library being set up

C 21 - 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.

- Bed spacing – remains an issues within the estate – reviewed and improved following investigation – estates strategy to improve existing estate and new hospital build
- DDA audits
- Isolation wards at Kent and Sussex and Maidstone Hospitals
- Cleaning Quality audits are completed using the NHS 'Cleaning for Credits' system
- 24 hour cleaning
- PEAT assessments
- Quality monitors
- Training and development for all staff groups

Healthcare Commission finds substantial improvement in infection control at Maidstone and Tunbridge Wells NHS trust

Published: 09 January 2009

Trust must maintain momentum and make further improvements

The Healthcare Commission today (Friday) welcomed substantial improvements in infection control at Maidstone and Tunbridge Wells NHS Trust since an investigation by the watchdog in 2007 identified serious failings.

An estimated 90 people definitely or probably died as a result of *Clostridium difficile*, during two outbreaks of the infection at the trust in 2005 and 2006. It is estimated that a further 30 patients definitely or probably died of *C. difficile* between April 2004 and September 2005.

Immediately following its investigation, the Commission called for a range of changes to the way the trust cares for patients with infections and to its wider systems of prevention and control.

Today, in line with its normal practice after an investigation, the Commission published a follow-up report detailing the trust's progress in implementing the recommendations. It also published a report outlining findings from a routine spot check made in October 2008 to assess compliance with the hygiene code.

The Commission says the trust has made "huge strides" putting considerable effort and resource into improving infection control. It commends the trust for reporting its lowest rate of *C. difficile* infection in three years, for the period January to March 2008.

However the Commission has highlighted some areas that still require further work such as recruiting more nursing staff and learning from complaints and incidents.

The spot check in October found a number of breaches of the hygiene code. The most serious breach related to decontamination of equipment in the endoscopy unit. This had been addressed by the time the Commission made its final investigation follow-up visit to the trust in November.

Key improvements identified in the investigation follow-up report include:

- A re-structured board with new non-executive directors and many new directors. This new structure has clear lines of reporting and processes for escalating issues up to the board. Infection control is a consistent item at the top of the board's agenda.
- New clinical governance and risk reporting structures which allow the trust to address key risks. A new head of governance and quality has been appointed who has revised the governance committee structure, creating four clinical governance directorates within the trust.
- Increased leadership, size and effectiveness of the infection control team led by a new director of infection prevention and control. There are two additional senior infection control nurses and a new microbiologist.

- *C. difficile* is now recognised as a serious diagnosis in its own right, and a 'care pathway' has been designed and implemented for patients with the infection, ensuring they receive timely and appropriate care.
- Specific wards have been allocated for the isolation of infected patients.
- Better standards of cleaning and improvements to the hospital environment. Extra cleaning staff have been appointed, new audit systems implemented, and nurses find urgent cleaning needs are more rapidly addressed.
- The removal of beds and the installation of new wash basins to ensure appropriate spacing between beds and improved levels of cleanliness.
- An ongoing process for infection control training has been implemented, including areas such as hand hygiene techniques and sharps handling. The infection control team also runs an extensive training programme for other members of staff.

Areas requiring further work include:

- The recruitment of further nursing staff and continued work to ensure good basic nursing care.
- Improvements to how the trust learns from complaints, incidents and serious untoward incidents (SUIs). The system for responding to complaints also needs to be reviewed.
- The trust is currently in the process of appointing a new medical director to the board. It must ensure this happens as soon as possible.
- The trust must embed the new clinical governance structure in day-to-day practice, ensuring that staff at all levels understand and follow the new ways of reviewing clinical care.

Healthcare Commission head of investigations Nigel Ellis said: "This is a very different trust to the one we investigated in 2007. It was never going to be easy to turn things around in just 12 months and indeed, there is still some way to go. But the substantial progress the trust has made to improve the prevention and control of infection is commendable.

"Staff at every level have put in considerable effort to make these improvements and should be recognised for their hard work. Senior staff have demonstrated strong leadership and it is clear that infection control is now a top priority at the trust.

"However now is not the time for the trust to relax. The trust's infection control systems still need further improvement. More nurses are needed and the trust must make sure it learns from complaints and serious incidents. Above all, it must make sure the changes they have made are embedded in day-to-day practice and that improvements are sustained.

"The trust must also address the remaining breaches of the hygiene code. Although these breaches are not considered to be an immediate threat to the safety of patients, they must be dealt with in order to ensure all necessary systems and processes are in place.

"What happened to patients at Maidstone and Tunbridge Wells NHS Trust was a tragedy. We have been working to make sure those lessons are learnt throughout the entire NHS so this is never allowed to happen again.

"Along with the South East Coast Strategic Health Authority, we will continue to monitor progress at the trust and we look forward to seeing further improvements in the future."

Throughout last year, the Commission made a number of announced and unannounced visits to the trust to check on progress in implementing the recommendations from the investigation.

In October, it also conducted a spot check to assess compliance with the hygiene code, as part of the Commission's ongoing programme of visits to every acute NHS trust in England.

On this inspection, the Commission found that the trust had invested in adequate isolation facilities, including a new *C. Difficile* ward. It also found that proper processes were in place to keep the board informed of issues relating to infection control and that the board demonstrated responsibility for infection control.

However, the Commission found the trust breached parts of Duty 2 relating to infection control audits not being reflected in all trust policies, low compliance with some audits and recommendations from audits not being followed through.

The trust also breached several areas relating to Duty 4 including having inaccessible hand wash basins in one ward and inconsistencies in the preparation of cleaning solutions.

More seriously, in an endoscopy suite on the Kent and Sussex site the Commission found unclear manual cleaning processes, inappropriate movement of equipment to and through the room and a hand wash basin which was not easy to access and had inappropriate taps.

Immediately following this inspection the Commission asked the trust to urgently conduct a risk assessment of all of the decontamination facilities in the endoscopy suite, identifying actions to be carried out.

The Commission checked the trust had addressed the issues in the endoscopy suite when it visited the trust a month later as part of its review of progress in November.

It found the trust had reviewed and revised protocols, training and the movement of equipment in and to the suite. The hand wash basin taps had been replaced and a double sink for manual washing and rinsing of endoscopes had been ordered.

The Commission will check with the trust in six months to ensure the remaining breaches identified in the hygiene code spot check have been addressed.

Information on the Healthcare Commission

The Healthcare Commission is the health watchdog in England. It keeps check on health services to ensure that they are meeting standards in a range of areas. The Commission also promotes improvements in the quality of healthcare and public health in England through independent, authoritative, patient-centred assessments of those who provide services.

Responsibility for inspection and investigation of NHS bodies and the independent sector in Wales rests with Healthcare Inspectorate Wales (HIW). The Healthcare Commission has certain statutory functions in Wales which include producing an annual report on the state of healthcare in England and Wales, national improvement reviews in England and Wales, and working with HIW to ensure that relevant cross-border issues are managed effectively.

The Healthcare Commission does not cover Scotland as it has its own body, NHS Quality Improvement Scotland. The Regulation and Quality Improvement Authority (RQIA) undertakes regular reviews of the quality of services in Northern Ireland.

For further information contact the press office on 0207 448 9401, or on 07917 232 143 after hours

http://www.healthcarecommission.org.uk/newsandevents/mediacentre/pressreleases.cfm?cit_id=1579&FAArea1=customWidgets.content_view_1&usecache=false

KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 6 February 2009.

PRESENT: Mr B R Cope (Chairman), Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr J Curwood, Mr D S Daley, Mr C G Findlay, Ms A Harrison, Mrs S V Hohler, Mr G A Horne MBE, Mr W V Newman, DL (substitute for Mrs E D Rowbotham), Mr M J Northey, Mr R J Parry, Ms B J Simpson, Dr T R Robinson, Mr R Tolputt, Cllr Ms A Blackmore, Cllr J Cunningham (substitute for Cllr Mrs M Peters), Cllr M Lyons and Cllr Mrs J Perkins

ALSO IN ATTENDANCE: Mr R A Marsh, Cabinet Member for Public Health

ALSO PRESENT: Mrs A Burnand, Mr N Caddick, Mr J Fletcher, Mr G Hills and Mr R Kenworthy

IN ATTENDANCE: Mr P D Wickenden (Overview, Scrutiny and Localism Manager) and Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee)

UNRESTRICTED ITEMS

12. Minutes of the meeting held on 9 January 2009
(Item 3)

The Chairman informed the Committee that the Minutes of the meeting held on 9 January 2009 were not yet available but would be presented together with today's Minutes to the meeting of the Committee on Friday, 20 March 2009.

13. Audiology Updates
(Item 4)

(1) Following the Committee's previous consideration of Audiology Services across Kent, the two Primary Care Trusts for the administrative county of Kent had been written to ask for an update on the progress in implementing some of the views expressed by the Committee when it had previously considered Audiology Services including the future plans for the audiology service.

(2) Within the papers for the meeting, were two updates from both Eastern and Coastal Kent and West Kent Primary Care Trusts.

(3) The Chairman indicated that should Members have any questions that the wished to raise with the two PCT's who were not present to respond to any questions, then these questions should be forwarded to the Research Officer to the Health Overview and Scrutiny Committee or the Overview and Scrutiny Localism Manager. As a consequence the following additional questions were raised by Members of the Committee:-

a. Given the importance of testing the hearing of newborns, can the PCTs provide further information on any newborn hearing screening programmes they have and how many children are being screened?
b. What provision is made for testing military personnel returning from conflict situations and are they given priority?
c. Can NHS West Kent clarify the situation regarding patients in the Dartford, Gravesham and Swanley areas? Your report refers to additional capacity extending capacity for patients in the Maidstone and Tunbridge Wells areas, but what about those patients who have audiology services provided by NHS Medway? Does the statement that patients across West Kent are assessed within 6 weeks and treated within 18 weeks include patients in north Kent?
d. Can NHS Eastern and Coastal Kent name the sites from which Hearbase operate in Folkestone, Ashford, Canterbury and Dover?
e. What provision exists for GPs to carry out hearing tests and what encouragement is there for GPs to advertise hearing tests?
f. Can the PCTs provide more information about progress in searching for willing providers as well as what plans are in place to ensure audiology services are sustainable in the future?
g. What plans are there for encouraging “high street audiologists” in the same way as there are high street opticians?
h. What public education campaigns around the dangers to hearing exist aimed at young people?
i. What plans are being made to provide services in Kent so that Kent patients do not have to travel to London hospitals?
j. The reports suggest that adult audiology serviced in Swale are provided by NHS Eastern and Coastal Kent and paediatric audiology services in the same area are provided by NHS West Kent. Can the trusts provide assurances that this does not create confusion in the provision of services?

14. East Kent Hospitals University Trust
(Item 5)

(Julie Pearce, Director of Nursing, Midwifery & Quality and Louise Dineley, Head of Patient Safety, East Kent Hospitals University Trust were in attendance for this item)

(1) In answer to a question about the East Kent Hospitals University Trust’s (EKHUT) approach to the continuing deep clean programme the response was that deep cleaning was an ongoing process for which there was a clearly agreed policy.

(2) Asked about how the deep cleaning process took place Ms Dineley explained to the Committee how this process worked from having a clear schedule for all departments to decanting the whole area which could cause problems if there were bed pressures, particularly if there was an outbreak, for example, of Norovirus.

(3) The schedule had to be changed because of an outbreak of Norovirus and this was a strong learning experience for the Trust but was more about the issue of logistics.

(4) In terms of the waste management element of the Hygiene Code the Committee noted that last year the Trust did not meet this particular requirement. An action plan had been put in place and all these actions would be completed by March 2009. However, the Trust would be declaring that it had insufficient assurance for this part

of the Healthcare Commission Core Standards. Ms Dineley explained to the Committee that in order to make a fully met declaration for 2009/2010, as the criteria within a Core Standard needs to be compliant for the full financial year, a major challenge to the Trust would be to complete the upgrading of the compounds for the three acute sites (primarily due to planning applications and funding being made available).

(5) Asked about the comments in the declaration from the Trust that "more generally the Inspection Team noted that many of the domestic waste bins examined on the Queen Elizabeth the Queen Mother (QEQM) and the William Harvey (WH) sites contained used gloves and aprons that should have been disposed of in clinical waste bins the 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)", one of the Members asked what actions and sanctions had been taken against these staff. Ms Pearce responded that the Trust were disappointed by these elements. She explained that any further lapses would result in disciplinary procedures being invoked. The Trust would also be reinforcing the message with staff training and ensuring that staff were aware the expectations that matrons and ward managers had of their behaviour.

(6) Representatives of the Trust added that staff morale in this area was good due to a positive recent report.

15. West Kent Primary Care Trust
(Item 6)

(Darryl Robertson, Interim 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, West Kent Primary Care Trust were in attendance for this item.)

(1) Mr Fittock raised the question of the trajectory for infections where Dartford and Gravesham NHS Trust were potentially going to be 20 patients over their trajectory. With respect to MRSA he noted that Maidstone and Tunbridge Wells NHS Trust were just under their trajectory and 40% of incidences of infection were due to community acquired infections.

(2) In response the Primary Care Trust indicated that they had made healthcare associated infections training mandatory for all staff and programmes tailored to the needs of different staff groups and provided in a variety of ways were being prepared. It was planned that 95% of staff would have completed the training by 31 March 2009. The Committee were informed that the Infection Prevention and Control Team were developing further strategies (such as e-learning opportunities) to work towards the 95%.

(3) Mrs Angell, the local Member for the area in which the Livingstone Hospital, Dartford was sited, said the report indicated that in December 2008 a small number of patients and staff were affected by diarrhoea and/or vomiting. The Committee was informed that although no specific virus was identified from specimens it was likely that the symptoms were caused by the Norovirus winter vomiting virus. Mrs Angell

asked whether the patients and staff had been wrongly diagnosed. Representatives from the Trust explained that C Difficile and Norovirus were different clinically and that the testing for Norovirus was not highly accurate.

(4) Asked about public campaigns the response was that public relations on hand washing was continuing. This was similar to what the Committee had heard from Eastern & Coastal Kent PCT. One Member referred to a visit to Kent & Sussex Hospital in Tunbridge Wells and asked whether the hospital still presented a challenge. He also referred to the standard of decontamination which had not been met in the last two years and he asked whether this was due to the attitude of staff.

(5) The response was that in terms of the decontamination Core Standard the Primary Care Trust could not provide sufficient evidence that the standard had been met rather than specific issues with decontamination.

(6) The Kent & Sussex Hospital as a site continued to present a significant challenge and would do until services were provided in the new Pembury Hospital in eighteen months time. The Primary Care Trust also had six community hospitals ranging from those built in the 1820s to Gravesend Community Hospital which was opened much more recently.

(7) Regarding the question relating to the attitude of staff PCT colleagues said that they spend a lot of time with staff and they were not sympathetic to any staff who did not adhere to the rules. This could result in disciplinary action being taken.

(8) In response to a question about the deep cleaning programme PCT colleagues stated that this was undertaken on an annual basis but areas could be prioritised where infection occurs. The Committee noted that the PCT had purchased their own steam cleaning equipment.

(9) In answer to a question of training and the roadshows that were referred to in the documentation from the PCT the Committee was informed that five or six roadshows were being planned for the year. The Committee discussed the relationship of the roadshows in terms of who the audience/public were concerning infection prevention and control and questioned the role of the public health programme and how success was measured. Reference was also made to individual behaviours and the role of education.

16. Local Involvement Network (LINk)
(Item 7)

(John Fletcher, Governor of the Kent & Medway Local Involvement Network (LINk) and Graham Hills, Director of Kent & Medway Network Ltd were in attendance for this item.)

(1) John Fletcher informed the Committee of the governance arrangements for the new LINk.

(2) Currently the LINk had 300 people who had signed up to be part of the LINk.

(3) The LINk would work through a number of panels including a panel of authorised visitors and a panel of representatives. The LINk were producing a

bulletin and the Committee noted that this would be circulated to all Members of the HOSC in the future.

(4) The LINk were currently undertaking a survey relating to the Annual Health Check Core Standards and the LINk hope to have this information for the Committee on 20 March 2009. In terms of the subject matters before the Committee in terms of the Hygiene Code Mr Fletcher informed the Committee that one of the reports left by the former Patient and Public Involvement Fora (PPIF) indicated that when hand washes and alcohol rubs were introduced the number of incidents went up. The former PPIF put more emphasis on infection control at the entrance to hospitals.

(5) Mr Fletcher then spent some time explaining to the Committee about the disinfectant used to combat hospitals and how the ratio between the liquid disinfectant and the water and the temperature of the water needed to be exactly right.

(6) In answer to a question about whether the 300 members currently of the LINk were strategically scattered across the county Mr Hills responded that more work was being undertaken to involve more people who wished to be involved in the health and social care service. The important thing was to get a blend of experience across the network. In response to a question about whether the LINk had the power to make change Mr Hills responded that the LINk did have statutory powers involving the right to access information, the right to enter and view an establishment, the relationship with CSCI and the direct referral right to the Health Overview and Scrutiny Committee.

(7) In answer to a question about the relationship between the LINk and the Patient Advisory Liaison Service (PALS) Mr Hills responded that there was a good working relationship with PALS. Some visits were undertaken with notice given to the organisations that a visit was to take place whilst others were unannounced visits. The relationship with Healthwatch/PALS was very much one of signposting. The relationship with the HOSC was for the LINk to be the eyes and ears for the HOSC.

17. Date of next programmed meeting – Friday 20 March 2009 at 10:00 am

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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.

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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.

[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.

Duty 2 – appropriate management for infection control

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

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

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

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

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

Duty 4 – cleanliness and maintenance of the environment

All 51 trusts were inspected in relation to this duty.

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

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

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

Duty 8 – isolation facilities

48 trusts were inspected in relation to this duty.

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

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

- Not having sufficient isolation facilities.

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

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

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

South East Coast Strategic Health Authority

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

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

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

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

The same SHA report 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

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[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.

Appendix B

Criteria for assessing core standards[1]

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

<table>
<tr><td colspan="2">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)</td></tr>
<tr><td>Elements

Element one
The PCT has systems to ensure the risk of healthcare associated infection is reduced in accordance with The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections (Department of Health, 2006 revised January 2008).</td><td>Rationale

Element one
The Hygiene Code was revised in January 2008.
All healthcare associated infection issues are covered by this criteria with the exception of the following:

Covered by C21 – Cleaning of the environment:

• Hygiene Code Duty 4 (a, b, (in relation to cleaning) c, d, e, g and h).

Covered by C4c – Decontamination of reusable medical devices:

• Hygiene Code Duty 3 (if related to decontamination)
• Hygiene Code 4b
• Hygiene Code 4f.

Note that, in complying with a provision specified in any duty contained in the Code, an NHS body must consider and, where appropriate, follow the content of each annex so far as it is relevant to the provision, including the content of guidance and other publications referred to in any relevant citation.</td></tr>
</table>

[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 **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).	**Rationale** **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	**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).	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

<table>
<tr><td colspan="2">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).</td></tr>
<tr><td colspan="2">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.</td></tr>
<tr><td>Elements

Element one
Not applicable</td><td>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)</td></tr>
<tr><td colspan="2">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).</td></tr>
</table>

Core standard C4c Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.	
PCT commissioned service test (for whole standard) For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.	
Elements **Element one** Not applicable	**Independent contractors test** **For each relevant provider element** For independent contractors, the PCT should have taken reasonable steps to assure itself that the services provided by independent contactors (general practitioners, dentists, community pharmacists and optometrists) are consistent with the relevant aspects of the element.* *(N.B. For the independent contractors test, PCTs will need to have regard to the **provider** criteria, which can be found in part 1 of this document)
C4c rationale (element one) • Not applicable as the Hygiene Code is targeting NHS providers who are commissioning services relevant to this standard (not PCT commissioning).	

Core standard C21 Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.	
PCT commissioned service test (for whole standard) For all commissioned services, the PCT has appropriate mechanisms through which it identifies and where appropriate responds to any significant concerns with regard to those commissioned services being consistent with the overall standard.	
Elements **Element one** Not applicable	**Independent contractors test** **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. prevention and control of infection is included in	C4a

	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

Appendix D

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.

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[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.

<u>Occupational health services</u>

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.

<u>Occupational health services for blood-borne viruses</u>

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.

<u>Induction, training programmes and ongoing education</u>

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]

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[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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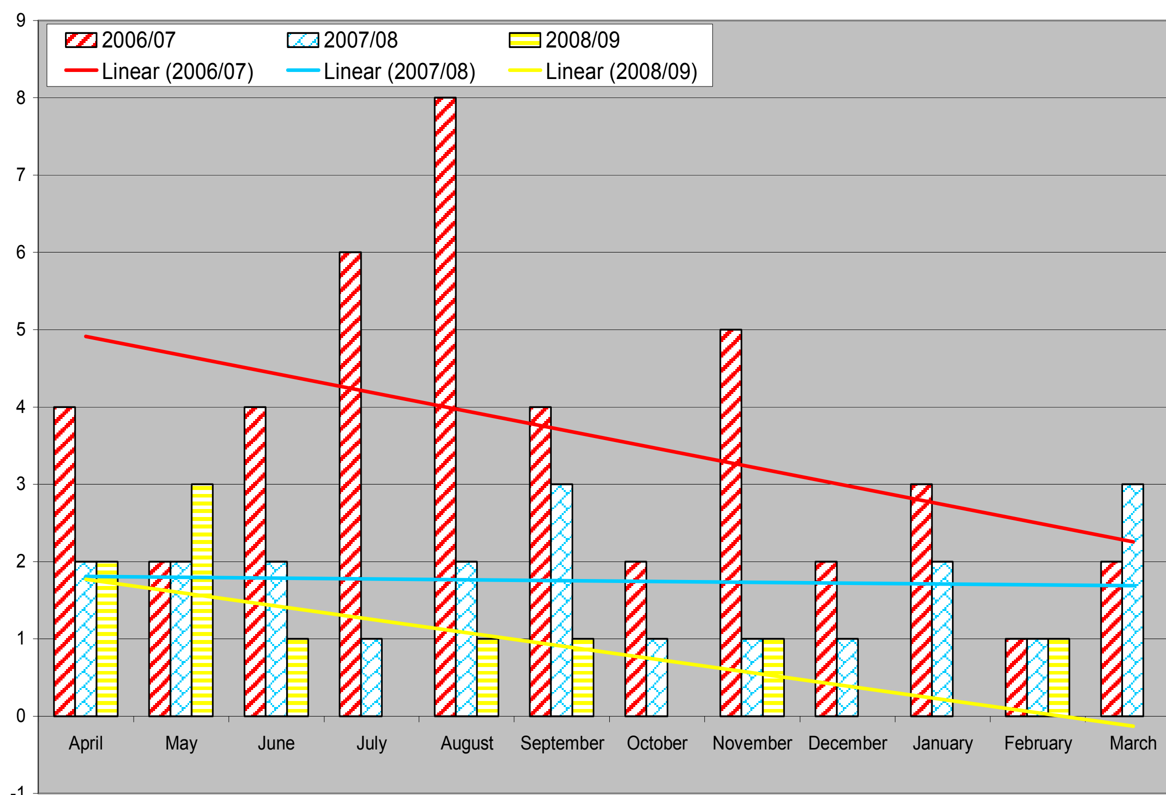
Medway NHS Foundation Trust
Health Overview and Scrutiny Committee
March 2009

1. Medway NHS Foundation Trust is committed to continually improving its performance in reducing healthcare associated infections and hospital cleanliness. Infection Prevention and Control remain amongst of the Board's key patient safety work streams, and the Trust has maintained a zero tolerance approach to health care associated infections. The Board receives a variety of information providing assurance that the trust's performance is improving and that patient safety is a top priority. This is essential for "Board to Ward" engagement.

2. There has been a marked improvement in the trust's performance in respect of the two national targets, Meticillin Resistant Staphylococcus *aureus* (MRSA) bacteraemia (table 1) and Clostridium *difficile* associated diarrhoea (CDAD) (Table 2). During 2007-8 the Trust met both of these targets and the 2008-9 performance has been the best to date. This improvement is due to a wide variety of reasons; the key driver has been getting it right for each patient, every time.

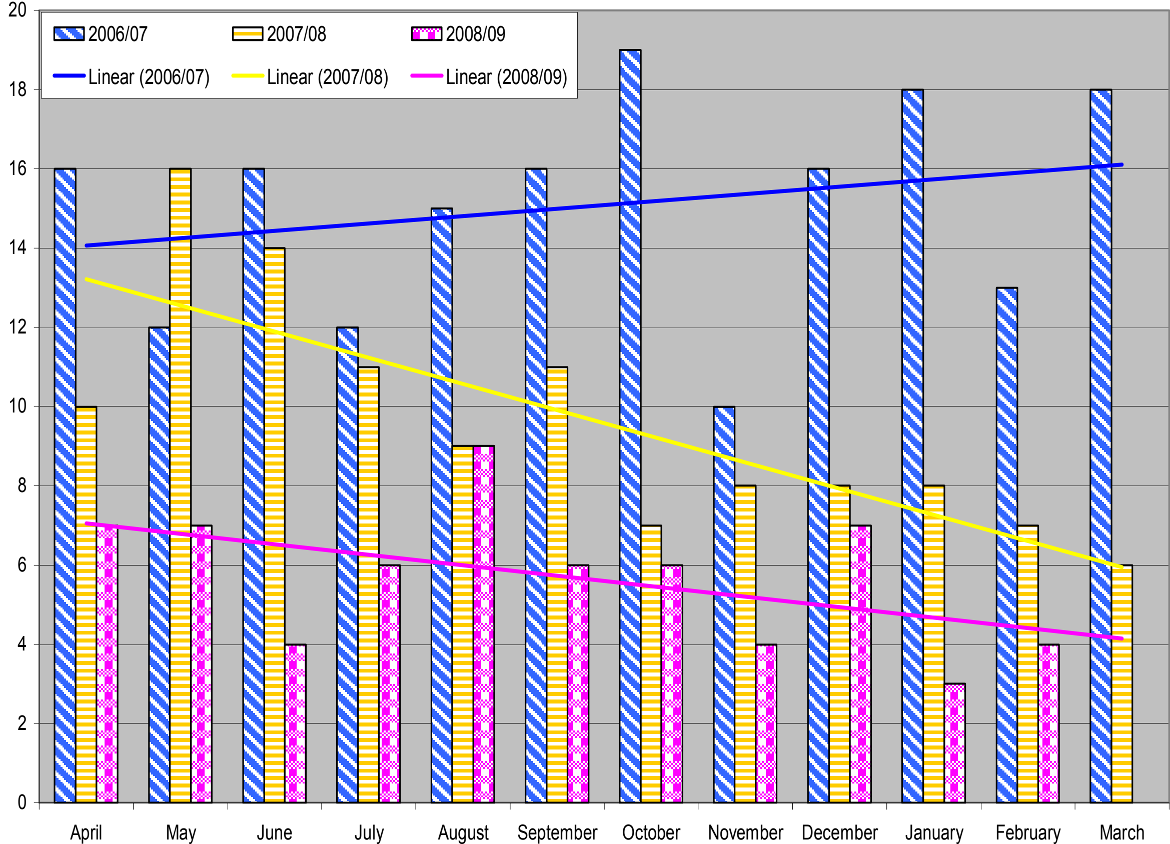
Table 1 MRSA Bacteraemia



3. Cases of MRSA bacteraemia have been reduced from 43 in 2006-7 to 21 2007-8 (51% reduction) and in the year 2008-9 to date, 10 - a 77% reduction from 2006-7. There has been sustained focus to achieve this performance with the clinical directorates taking ownership of the Infection Prevention and Control agenda. The Trust has implemented the screening of all day cases from August 2008, ahead of the March 2009 national target, and the screening of all admissions in May 2008, ahead of the national March 2011 target. This is as a result of the commitment of the Microbiology Team at Medway NHS Foundation Trust which has achieved this

increased work load by modernising its work practices. MRSA screens have increased from 100 a month in 2006 to 17000 screens in December 2008.

Table 2 CDAD (Post 48 Hour Cases)



4. The Trust has also seen a significant reduction in the number of cases of CDAD diarrhoea. Like MRSA this has been driven by directorate ownership of the agenda and learning from all cases. In the year 2008-9 to date, there have been 63 post 48 hour cases, significantly fewer than the SHA target of 106 for the period. The trust has been working in close collaboration with NHS Medway to achieve reductions across the health economy.

Table 3 CDAD Trajectory

Number of *Clostridium difficile* in period	2008/09 Trajectory												2008/09
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Medway Trust	8	9	8	7	7	8	9	10	10	10	8	6	100
Community/pre 48 hours NHS Medway	4	3	3	3	3	3	3	3	3	3	3	3	37
Community/pre 48 hours NHS Eastern & Coastal Kent	1	2	2	1	1	1	3	4	4	4	2	2	27
Community/pre 48 hours Other PCTs	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	13	14	13	11	11	12	15	17	17	17	13	11	164

Number of *Clostridium difficile* in period	2008/09 Actual Figures												2008/09
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Medway Trust	7	7	4	6	9	6	6	4	7	3			59
Comparison to trajectory	1	2	4	1	-2	2	3	6	3	7			27
Community/pre 48 hours NHS Medway	6	2	5	11	3	6	4	4	2	1			44
Comparison to trajectory	-2	1	-2	-8	0	-3	-1	-1	1	2			-13
Community/pre 48 hours NHS Eastern & Coastal Kent	0	3	0	1	1	2	3	1	1	0			12
Comparison to trajectory	0	-1	0	0	0	-1	0	3	3	4			11
Community/pre 48 hours Other PCTs	0	1	0	0	1	0	0	0	0	0			2
Comparison to trajectory	0	-1	0	0	0	0	0	0	0	0			-2
Total Infections	13	13	9	18	14	14	13	9	10	4	0	0	117
Comparison to Total trajectory	0	1	4	-7	-3	-2	2	8	7	13			23

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5. The Trust undertakes all mandatory surveillance as required (for example Glycopeptide Resistant Enterococci, Staphylococcus aureus bacteraemia, national surveillance of surgical site infections), and in addition the Trust undertakes surveillance of other conditions/infections, including Group A Streptococcal infections, Extended Spectrum Betalactamases and Tuberculosis.

6. Performance indicators and measures are monitored closely via a range of forums. Wards and departments are held to account by the Director of Nursing and Strategic Planning, and Directorates report quarterly on their Infection Prevention and Control key performance indicators to the Governance and Risk Committee, a sub-Committee of the trust Board chaired by a Non Executive Director, as well as to Directorate "dash board" meetings. The Director of Infection Prevention and Control reports to the Board on a 3- 6 monthly basis and the Governance and Risk Committee on a monthly basis. The Trust's Infection Control Committee meets quarterly.

7. Compliance with infection control policies and procedures is monitored and audited by the Infection Prevention and Control Team.

8. Medway NHS Foundation Trust reports monthly to NHS Medway as the lead commissioner and Infection Prevention and Control performance is scrutinised at the PCT's Infection Control and Decontamination Committee, in addition to at performance review meetings with the Trust.

9. The Trust resolved all the issues identified in the August 2008 report by the Health Care Commission. An unannounced Health Care Commission inspection was undertaken on the 3rd and 4th January 2009 and the report for the Health Care Commission has not yet been received by the Trust.

10. Compliance with antimicrobial prescribing continues to have an important place in the reduction of health care acquired infections. The Trust has an Antimicrobial Policy that restricts high risk antibiotics and gives clear guidance on prescribing issues. Medway NHS Foundation trust employs two Antimicrobial Pharmacists who work in close collaboration with the Infection Prevention and Control Team and the clinical Directorates. Regular audits have demonstrated significant reductions in the prescribing of high risk antibiotics. The work stream is lead by the Antimicrobial Stewardship Group Chaired by the Director of Infection Prevention and Control.

11. Medway NHS Foundation Trust has adopted the National Cleaning Standards and all areas of the Trust are monitored dependant upon the area of risk category, cleaning schedules and cleaning scores are publicly displayed. The Trust as just completed the 2009 Patient Environment Action Team (PEAT) assessment, an external assessor was present for this inspection, scores have yet to be verified by the Department of Health.

12. The Trust has reviewed and changed practice in several areas over the past year including:

- Extending MRSA screening
- Introducing Silver urinary catheters
- Strengthening the uniform policy (including "bare below the elbow")

- Performance management of attendance at mandatory training for Infection Prevention and Control
- Root cause analysis on all CDAD cases and MRSA bacteraemia
- Adoption of the Care Bundle approach
- Increased staff in the Infection Prevention and Control Team
- Enhanced cleaning services
- Reducing the number of beds in the MRSA surgical cohort ward by decreasing numbers of patients across the directorate.
- Use of 2% chlorhexidine skin preparation

13. Patient and staff involvement remains key to the success of the programme of work. There is a well established Infection Control Link Network across the Trust which meets quarterly and staff are given protected time to attend this meeting. There has been an independent audit of hand hygiene compliance using our volunteers. The organisation continues to be part of the “Cleanyourhands” campaign. Presentations have been given to the Foundation Trust Members’ meetings. The Infection Prevention and Control Team produces a wide range of patients’ information leaflets and posters which are readily available on the trust’ web-site.

14. Training and education of all staff is mandatory and attendance is monitored at the monthly Trust Board. The Trust is on target to achieve 100% attendance this year. There is agreement from April 2009 that staff who do not attended Infection Prevention and Control Updates will be suspended without pay.

15. The Trust will be declaring compliance against standards C4a and C21 and partial compliance against standard C4c. This is subject to approval and sign off by both the Trust Board and the Integrated Audit Committee during March.

16. The partial Compliance with standards C4c is due the fact that the upgraded centralised endoscopy unit was completed during September 2008. This unit is now reprocessing all endoscopes in line with current best practice. The Trust had not been fully compliant for the complete year, however systems were safe and compliant with practice. The ‘on site’ Sterile Services Department will be relocated to the Kent Cluster at the end of May 2009. This will then meet total compliance with ‘clean steam’.

Linda Dempster
Head of Infection Prevention & Control

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Our ref: EM/de/08-413

10 March 2009

Paul Wickenden
Overview, Scrutiny and Localism Manager
Democratic Services and Local Leadership
Legal and Democratic Services
Kent County Council
Sessions House
County Hall
Maidstone
Kent ME14 1XQ

Dear Paul

RE: HEALTH OVERVIEW AND SCRUTINY COMMITTEE [HOSC] MEETING ANNUAL HEALTH CHECK PROCESS

Thank you for your letter of 10 December 2008 regarding the above. I can confirm both myself and Donna Eldridge (Assistant Director of Nursing/Director of Infection Prevention and Control [DIPC]) will be attending the HOSC meeting on 20 March 2009, and I understand we will be expected to attend from 10.45 – 11.30 hours.

As requested, please find listed below our written submission in respect of the area identified in your letter as requiring a response at this time:

PROGRESS IN REDUCING THE INCIDENCE OF METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS [MRSA], CLOSTRIDIUM DIFFICILE AND OTHER HEALTHCARE ASSOCIATED INFECTIONS [HCAIS]:

The Department of Health's guidance on MRSA screening for Mental Health Trusts (December 2008) states that people admitted to Mental Health Trusts should not be routinely screened. There is no evidence of any significant risk of MRSA bacteraemia in this patient group.

The guidance states that there have been no reported MRSA bacteraemia in Mental Health Trusts in the past three years. In combined Trusts, where up to 60% of

admissions were mental health patients, there has been ten reported bacteraemia in the past three years, but none were in mental health specialties.

However, the Kent and Medway NHS and Social Care Partnership Trust [KMPT] recognises that service users may have other clinical conditions that may put them at risk of MRSA infection.

The Trust screens the following service users as set out by the guidance:

- Those who are admitted to mental health units following surgical procedures;
- Those that are admitted following admission to an Acute Trust;
- Intravenous drug users;
- Those who self harm;
- People with a possible diagnosis of delirium; or
- People with chronic wounds, e.g. leg ulcers, or with indwelling devices such as catheters.

Progress in other areas is as follows:

- **Staff Screening:** The Trust does not routinely screen staff for MRSA unless there are particular epidemiological features to indicate that a staff member or members may be the source of linked cases of MRSA infection. Staff who had contracted infections would of course be treated the same as any other patient. This is in line with the guidance as set out by the Department of Health.
- **Data Surveillance:** Data surveillance demonstrates a system for the data and risk surveillance; reporting systems for HCAIs Trust-wide and an assurance framework for the Trust. This is monitored through monthly Trust Board reports, the Trust-wide Infection Control Group, and the Risk and Governance Committee. The incidence of MRSA and Clostridium Difficile is low and all cases to date have been transferred into the Trust via the Acute Trusts. To this effect the Trust has a Transfer Checklist for patients. This is completed prior to admission from the Acute Trust/nursing home and is evidence of an appropriate checking and communication system to ensure prompt and appropriate treatment of transferred patients.
- **Infection Control Reporting Forms:** The reporting system for all infections Trust-wide is for the purposes of surveillance, advice and action. The Trust has a dedicated infection control email (infectioncontrol@kmpt.nhs.uk) which is accessed by all of the Infection Prevention and Control Team [IPCT]; this means infections are dealt with immediately by the Team.
- **Ward Closure Sign:** The Trust has ward closure signage that is used for all inpatient areas for ward closures during an infection outbreak ensuring that infections are not spread to other areas.
- **Antibiotic Prescribing Guidance:** Antibiotic Prescribing Guidance is available and monitored through the Drug and Therapeutics Committee; this demonstrates a system to ensure prompt and appropriate treatment of HCAIs and other infections.
- **Flu Pandemic Guidance and Contingency Planning:** This guidance and contingency planning demonstrates preparedness of the Trust in the event of a pandemic. This has recently been tested by the Strategic Health Authority [SHA] and the Trust scored 96% and is rated as Green.

CHANGES IN PRACTICE OVER THE LAST YEAR TO IMPROVE INFECTION CONTROL:

Changes in practice over the last year to improve infection control include:

- **Infection Control Policy:** The Trust has developed a robust Infection Control Policy which is continually updated to reflect national guidance.
- **Unannounced Infection Control Visits/Site Reports:** The Trust has implemented a programme of unannounced visits/site reports; this involves a rolling programme of six monthly spot checks to monitor and ensure compliance with the Hygiene Code and to provide support to services.
- **Monthly Infection Control Reports to the Trust Board:** Monthly Infection Control reports are submitted to the Trust Board; this demonstrates sign up by the Board of Directors.
- **Annual Infection Control Audit Report:** The Annual Infection Control Audit Report demonstrates annual audit of compliance on a site by site basis and includes hand hygiene.
- **DIPC Group:** The DIPC Group demonstrates evidence of the DIPC role within the Trust and wider health economy including sharing information Kent-wide to ensure effective and appropriate management systems within the Trust.
- **Posters and Protocols:** The Trust has considerable evidence of appropriate posters and protocols and guidance, which is available to all wards and other clinical areas.
- **Infection Control Link Group:** The Infection Control Link Group demonstrates a Trust-wide management system for dissemination, imparting and collection of information to clinical staff and provides support from Senior Infection Control staff.
- **Trust-wide Infection Control Group:** The Trust-wide Infection Control Group demonstrates surveillance of HCAIs, monitoring of the database, cleanliness standards and collaboration with the Health Protection Agency [HPA], Primary Care Trusts [PCTs] and Acute Trusts.

SUCCESSES, CHALLENGES AND ISSUES IN IMPLEMENTING THE HYGIENE CODE:

The Trust has experienced the following success, challenges and issues in implementing the Hygiene Code:

Successes: There has been a great deal of work undertaken by the IPCT in ensuring a very high standard within the Trust. The Trust Board is fully supportive to all issues in relation to HCAIs and has signed up to the Assurance Framework.

The Trust has a comprehensive rolling training programme for Infection Control. In addition the Train-the-Trainers Programme has commenced and a Training DVD Programme will be commencing for non clinical staff shortly. This provides a flexible approach in taking the training to front line staff, and assists the Trust in meeting training targets set by the Trust Board. The achievement with regard to a rolling Training Needs Analysis for 1 December 2007 to 31 December 2008 demonstrates that infection control is achieving an overall performance level of 94% based on a higher than 6% originally forecasted turnover of staff. The turnover is currently running at 14%. Statistics have been modified to take this into consideration. Training

courses continue to be well received by staff with staff booking and attending sessions as required

Staff are now reporting all infections and will over-report, which is supported by the IPCT. The structures have been put in place to fully inform all staff of issues around reporting and an aide memoire was disseminated, which was well received and has also generated interest in the wider health economy.

Challenges: The Trust covers 201 sites with 42 inpatient units. This is challenging for the Trust in relation to the vast area it covers. Although this is demanding for the IPCT it is manageable due to the low number of infections that occur.

It is important that all areas are aware of the Trust's Assurance Framework (Hygiene Code 2006) and this is achieved through the Modern Matrons Forums.

There are varying degrees of cleanliness standards within the Trust and this is predominately due to the fabric of some very old buildings, and due to some not having contracts within the Trust for cleaning, although this is currently be addressed.

An Operational Cleaning Plan is currently being developed and will be available shortly, but due to the vast number of sites this has been a challenge.

INFORMATION ON THE FRAMEWORK FOR ASSURANCE RELATING TO THESE THREE CORE STANDARDS (C4A, C4C AND C21):

Assurance Framework monitors compliance to the Hygiene Code 2006. It is monitored through the Trust-wide Infection Control Group. Modern Matrons monitor and update this through the Modern Matrons Forum.

The Trust's Lead Commissioners (Medway PCT) also monitor compliance of the Assurance Framework.

STAFF AND PATIENT INVOLVEMENT IN INFECTION CONTROL ISSUES:

There has been considerable staff and patient involvement in infection control issues, and these include:

- **Information Leaflets and Transfer Form:** This provides evidence of information on HCAI', prevention and management for patients, carers and staff. It also evidences communication of specific infection control information for other service providers at the point of patient transfer. Within all sites in the Trust there are cleaning schedules displayed in public areas on notice boards which highlights the cleaning routine, etc for that area.
- **Infection Control Link Group:** This Group demonstrates coordination of link staff to meet and disseminate information, provide education and support to promote wider cooperation.
- **Modern Matron Forum:** This Forum demonstrates coordination of link staff to meet and disseminate information; it provides education and support to promote wider cooperation and develops local leadership to the same end.
- **Cleanyourhands Campaign Data:** The Cleanyourhands Campaign data demonstrates education and prompting to all staff to promote cooperation with good practice and protocols.

- **Infection Prevention Control and Hand Washing Training Materials:** These demonstrate education and skills based training, which is mandatory for all staff, and promotes good practice and understanding.
- **Train-the-Trainers Course Materials:** These demonstrate action planning to ensure that training targets are met.
- **Infection Prevention and Control Policy:** This policy includes lists of all staff who should complete Infection Control Training as mandatory, including contractors and other non-clinical staff.
- **Control of Legionellae Bacteria Policy:** This policy demonstrates responsibility of the Trust when working with contractors on issues of infections.
- **Infection Control Aide Memoire:** This Aide Memoire is given to all staff and contractors.

ANY OTHER INFORMATION THAT WILL ASSIST THE COMMITTEE IN JUDGING COMPLIANCE WITH THE THREE CORE STANDARDS METIONED ABOVE:

Additional supporting information is as follows:

- **Privacy and Dignity Policy and Reports:** This policy and reports demonstrates availability of individual ensuite rooms for isolation purposes. Areas that have mainly bays have access to single rooms.
- **Safe Management of Clinical Medical Devices Policy:** This policy demonstrates compliance with the Hygiene Code 2006 for the decontamination of all equipment.
- **Cleaning Schedules:** These schedules demonstrate standards of cleanliness for each area Trust-wide.
- **Patient Environment Action Team [PEAT] Reports:** These reports provide a PEAT rating for all units with ten or more beds; action plans are produced and reviewed six monthly.
- **Cleanliness Reports:** These reports demonstrate quarterly cleaning audits are undertaken, and Trust-wide monitoring of the same.
- **Posters:** Waste Disposal Protocol posters are displayed in wards and other clinical areas, which offer guidance on correct disposal of waste using a universal colour coding system. This includes disposal of sharps.
- **Decontamination:** The Safe Management of Clinical Medical Devices Policy demonstrates compliance with the Hygiene Code 2006 for the decontamination of all equipment. The DIPC is the Responsible Lead Manager for decontamination within the Trust. This role is in conjunction with the Medical Devices Manager. Within the Trust, the Community and Mental Health Hospitals Infection Control Manual is followed for decontamination methods that apply to clinical medical devices held by the Trust, however there are other issues around decontamination for the Mental Health Trust such as:

    - Baths;
    - Wash Basins;
    - Hoists;
    - Beds;
    - Commodes, etc.

  The Trust has a robust Safe Management of Medical Devises Policy and within this policy it highlights all decontamination methods for commonly used items of equipment for the above. The Trust has just undertaken a £47K replacement

programme of all divan beds due to decontamination issues. Training for the use of medical devices and decontamination is via the Ward Managers/Team Leaders at the time of induction and through ongoing supervision. A Decontamination Certificate is also used within the Trust; the Declaration of Contamination Status is taken from the Medicines and Healthcare Products Regulatory Agency [MHRA] Management of Medical Devices prior to repair, services or investigation. The Trust does not contract out decontamination services to other contractors. The Kent HPA Policy is used for decontamination advice and issues throughout the Trust.

I have attached a number of supporting documents, as listed below, and I trust this meets with your satisfaction, however, should you have any further queries please do not hesitate to contact me.

With best wishes

ERVILLE MILLAR
Chief Executive

Cc: Pat Campbell, Executive Director of Corporate Services
Donna Eldridge, Assistant Director of Nursing / DIPC

Appendix 1 Data Surveillance
Appendix 2 Assurance Framework

Date Reported	Ward/Unit	Number of Outbreaks Patients	Number of Outbreaks Staff	Number of Outbreaks Other (visitors/ contractors)	Type of Infection Outbreaks	Action taken to control infection	Action taken to prevent further infection	Who has been contacted	Person Completing this form	Follow up Information and date
30/04/2007	Woodchurch, Thanet Mental Health Unit, 164 Ramsgate Rd Margate	1			**MRSA**		Universal precautions			Infection successfully contained & treated, patient discharged
30/04/2007	Sevenscore Ward, Thanet Mental Health Unit	5			**Gastroenteritis**		Universal precautions			Infection Contained
02/05/2007	Learning Disabilities Residential 320 Hempstead Rd	3			**Diarrhoea & Vomiting**	•2 residents vomited throughout the night. •Residents did not attend college on the following day. •2 residents had diarrhoea anone did not appear too well	•Await advice to ensure conditions do no deteriorate •Maintain all good hygiene controls. •Ensure clients are well before returning to college.	The Head of School		This illness isolated to 3 service users attending college.
11/06/2007	Edmund Ward St. Martins Hosp Canterbury	1			**Scabies**		Patient treated			Succesful treated
01/07/2007	St. Martin Hosp Facilities staff	1			**Legionellosis**	Required hospitalisation.	Source of infection investigated			Recovered now at work. Remedial Action taken by Facilities

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23/07/2007	Birch Ward, Little Brook Hosp, Dartford	1			**MRSA** admiited with infection from Nursing Home	Health Protection Agency informed.	Treatment given			MRSA Clear and dischaarged back to Nursing Home
02/08/2007	Russett Lea Ward Heathside House	1			**Eye Infection**	Patient developed eye infection and Swab taken	Chloramphenicol treatment commenced immediately			No further action
04/08/2007	Golding Cottage Heathside House	1			**Facial Rash**	Patient had facial rash for several months, recently became inflamed and weepy. Swab taken	Prescribed creams being less effective. GP prescribed antibiotics. Results phoned late Friday 03/08/07			No further action
24/09/2007	Jasmine Ward Darenth Wood Rd Dartford	1			**MRSA** - transferred from Daranth Valley with MRSA	Health Protection Agency informed.	All precautions in place. Patient treated			MRSA cleared within two weeks
10/09/2007	Sevenscore Ward, Thanet Mental Health Unit	1			**MRSA**	Health Protection Agency informed.	All precautions in place			Discharged to QEQM
25/10/2007	Newington Ward Arundel Unit William Harvey Hospital, Kennington Road, Ashford	1			**MRSA** - developed after admission	•Isolated in room as much as possible •daily changing of dressings. •Liaison with orthopaedics. Antibiotics changed	Re contact orthopaedics, regular dressings new antibiotics. Tissue Viability nurse Elizabeth Brown, Unit	Mike Curtin, Andrew Dickers Andy Oldfield, Liz Lloyd, Tissue Viability Nurse Elizabeth Brown, Unit	John Hedges ADWM Newington Ward	4th Jan 08 - not responded to treatment.

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16/10/2007	Woodchurch, Thanet Mental Health Unit, 164 Ramsgate Rd Margate	3			Diarrhoea	· Universal Precautions · Relatives to wash their hand before leaving ward · all grab rails, door handles arms on chairs toilets are wiped over with detergent 2 to 3 times a day. · Records to be kept in line with infection control guidelines	· Further phone call from nursing staff refusing to assist in carrying out wiping down of surfaces to reduce infection. · Infection Control Link Nurse to visit ward to speak to ward manage regarding non compliance with infection control on ward. · Sue Whitmore to offer support as Unit Link Nurse	Kent Protection Andrew Dickers Peter Hasler Jann Gilliland		Andrew Dickers visited and met with Modern Matron Jann Gilliland and Woodchurch Team to discuss Action Plan. Once patients were free from symptoms for 48 hrs ward was deep cleaned and reopened
31/10/2007	Woodlands Ward Little Brook Hosp, Greenacres, Bow Arrow Lane Dartford	1			MRSA admitted with this infection.30/10/07 no open wounds or sores. Patient is physically well.	•Trust Policies & Procedures followed. Infection control - use of yellow waste bags, own utensils, RCD linen bags for laundry. •All relevant professionals informed (Domestic staff)	Infection Control	Angela Shorter Peter Hasler Andrew Dickers	S O'Rourke S/N Woodlands Ward	discharged home in Dec 07 into the care of GP.
05/11/2007	Scarborough Ward, The Arundel Unit William Harvey Hosp., Ashford	1			MRSA - transferred with infection from a Mental Health Unit	Infection present on admission	Universal precautions. Treatment given		Ward Manager	Discharged home with + MRSA and Primary Care follow-up
12/11/2007	Woodchurch, Thanet Mental Health Unit, 164 Ramsgate Rd Margate	1			MRSA	MRSA universal precautions followed, room and aids wiped with disinfectant wipes, Kent Health Protection contacted, Infection Control/Wound Care Nurse informed.	Wound covered with actisorb dressing and tegadem	Peter Hasler Jann Gilliland Andrew Dicker Sue Whitmore	Tina Nichols Acting W/M	Patient died 5.1.07 unrelated to MRSA

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21/11/2007	Woodchurch, Thanet Mental Health Unit, 164 Ramsgate Rd Margate	3	3		Diarrhoea & Vomiting	Universal Precautions, Kent Health Protection Agency made aware and ward is now closed to further admissions at this time	All areas cleaned with detergent wipes, toilet seats, hand rails.	Kent Health Protection Agency Infection Control Lead Nurse	Tina Nichols Acting W/M	Re-opened after 2 weeks
24/11/2007	Robert Browning	2	0		MRSA - Both patients admitted from Daranth Valley with infection	Information not available	Universal Precautions and Treatment			Awaiting further information via infection control reporting proforma
27/11/2007	The Orchards Priority House Maidstone	1			MRSA	•Infection notified by doctor late on 24/11/07. •Case discussed. •As infection was first established 7/9/06 advice was that there was no specific action to be taken as infection is 'colonised'.	Continue current management	Kent Health Protection Agency Phil Smith	C Cole	Infection site is healing well.
02/12/2007	Winslow Ward The Arundel Unit Ashford	1			Colonization MRSA found on routine screening whilst at WHH	Universal precautions	Universal Precautions	Public Health Infection Control KMPT and Link Nurse	Simon Lockwood	Discharged to nursing home with GP follow-up
02/12/2007	Groombridge Ward TGU	6	6		Diarrhoea & Vomiting	Barrier Nursing and the ward is closed	The Unit was deep cleaned	The Health Protection Unit	Catherine Makawa Team Leader	re opened 48 hrs after being symptom free.

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03/12/2007	Ramsey Ward St. Martins Hosp Canterbury		5		Diarrhoea & Vomiting	Staff with symptoms off work and informed of need for specimen to go to GP after 3rd episode of Diarrhoea and not to return to work until they have been clear of symptoms for 48 hours	Universal Precautions	Michele Coleman	S Harrison	re opened 17 Dec 07

05/12/2007	Edmund Ward St. Martins Hosp Canterbury	4	1		**Diarrhoea**	Universal precautions remain in place. Infection Control Link Nurse informed & Health Protection Agency. Ward remains closed to discharges & admissions. Results from both stool samples have come back negative. Staff need to see their GP for advice & after last bout of diarrhoea remain off the ward for 48 hours	· Notice to visitors · Universal precautions · Samples from persons affected. · Soiled laundry to be placed in alginet bags. · Ward remains closed to admissions & discharges. · All visitors asked to wash their hand on arrival & departure · Management continue with support from HPA and Infection Control Link Nurse. · Ward to be deep cleaned on Wednesday 19th Dec.	Paula Campbell Modern Matron Maxine Love Deputy Ward Mgr Dagmar Whiting Hotel Services Supervisor	Amanda Hatfield-Tugwell, Ward Manager	re opened following deep clean

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18/12/2007	Edmund Ward St. Martins Hosp Canterbury	5	3	N/A	Diarrhoea	•Universal precautions remain in place. •Infection Control Link Nurse informed & Health Protection Agency. Ward remains closed to discharges & admissions. Results from both stool samples have come back negative. Staff need to see their GP for advice & after last bout of diarrhoea remain off the ward for 48 hours	· Notice to visitors · Universal precautions · Samples from persons affected. · Soiled laundry to be placed in alginet bags. · Ward remains closed to admissions & discharges. · All visitors asked to wash their hand on arrival & departure · Management continue with support from HPA and Infection Control Link Nurse. · Ward to be deep cleaned on Wednesday 19th Dec.	Paula Campbell Modern Matron Maxine Love Deputy Ward Mgr Dagmar Whiting Hotel Services Supervisor	Amanda Hatfield-Tugwell, Ward Manager	Reopened on 21/12/07 as 48 hrs clear from our outbreak of diarrhoea. Ward deep cleaned No further episodes of infections this week
31/12/2007	Robert Browning Ward, Medway Maritime Hospital	1	1		MRSA of Nasal area	Nursed in side room	· Hand washing and use of alcohol swabe/gel · Had treatment of both nostrils and Bactraband ointment application completed · Awaiting result of nasal swab due 28/12/07	Health Protection Unit	S/N Nisperos	
03/01/2008	Coleman House CMH Team Dover & Deal, Brookfield Ave., Dover	1			Diarrhoea	· Cleaning of individual and area. · Sealed off the room due to possible infection. Soiled wast contained in appropriate bags, awaiting collection. · Haz-tabs delivered for thorough clenaing to be completed	· Action taken to prevent further infection. · Haz-Tabs delivered for thorough cleaning to be completed. · To provide a small supply of clinical waste bags and bags, & bags for soiled materials.	Trust HQ - Simon Goodwin Dover HC Waste Management Waste Mgt Laura Rai H & S - Jim Michele Coleman Mike Curtin	Naomi Fuller Marion Betts	This patient was attending an OT session at the Day Hospital when she had a bout of diarrhoea. No further episodes reported - Michele Coleman.

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13/01/2008	Birch Ward Little Brook Hospital	7		N/A	Diarrhoea & Vomiting	Normal infection control techniques	Consultants contacted ward is closed/no visitors/other wards informed. Patiens nursed in their rooms	Unable to contact Publiic Health Specialist Mike Curtin informed and will contact PHS Rose Waters Service Manager emailed Duty Doctor Domestic Mgr	V Handley Deputy Ward Manager	Michele Coleman, Infection Control Nurse visited ward on 18/01/08 to discuss action plan with Acting Ward manager Adam Adkins. Michele contacted Birch Ward on 24/010/8 and was informed by S/N Nicolaou that there have been no further episodes of D & V since the 19/01/08 but then said a patient had vomited on the 22/01/08 once the ward has been symptom free for 48 hours they will have the ward deep cleaned and will contact the KHPU to inform them that this has been carried out. Ward has now had a deep clean and has re-opened - Michele Coleman.
14/01/2008	Elmstone Ward Thanet MH Unit		1	N/A	Diarrhoea & Vomiting	Staff member off sick until infection cleared		N/A	Christine Thompson	Staff returned to work after being asymptomatic for 48 hours clear - Michele Coleman

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17/01/2008	Sevenscore Ward, Thanet Mental Health Unit	1			**MRSA in wound on his right toe.**	· Full MRSA screen to be completed. · Staff to be aware of universal precautions · Patient to be seen in fracture clinicl next week re underlying cause of wound · Patient to be reviewed by the diabetic nurse.	Dressing changed to silver dressings and wound to be dresse3d and redressed in his bedroom. Seen by Doctor and hibiscrub and nasal batroban prescribed.	· Modern Matron · Trust · Peter Hasler · Andrew Dickers · Kent Protection	Sue Wrintmore	Update 05/02/08 The toe was swabbed and came back MRSA positive on the 17/01/08. Patient was prescribed Bactroban bd and Tricyclin tds. Michele Coleman advised S/N Mange Ndwandwe to reswab toe and asked for a medical review of the antibiotics due to the length of time this patient has been on them. Update 19/02/08 - Swab on toe reported from the lab to be negative for MRSA on the 8/02/08 - Michele Coleman.
17/01/2008	Brocklehurst Ward, Priority House, Maidstone	1 (possible)			Informal patient with **HIV** (Positive) had unprotected sex with a Section 3 inpatient, some time between 26/12/07 and 07/01/08	Female patient transferred to female ward in Dartford	Review ward procedures/protocols	· Health Protection Agency · Associate Nursing Director · Associate Director of Acute Care Services SWK	Gwen O'Brien	Ongoing treatment and support (counselling). HPA have advised to contact HIV nurse within acute services. Gwen O'Brien telephoned and spoke to Michele on 23/01/08 and enquired about SUI reporting. Gwen to complete the NPSA RCA SUI reporting form for Infection Control - Michele Coleman.
21/01/2008	Fant Oast CAMHS Upper Fant Rd Maidstone	1			**Head Lice**	Initially used conditioner and nit comb on scalp to treat infestation. Advice given on personal hygiene & the need to use own toiletries, towels, flannels, brushes, combes & headbands. If eggs hatch use lotion	Scalp checks of all patients and staff. Patients reminded of the need not to share towels etc. Head checks of all patients begun on 18/01/08 daily for 7 days & then review. Where possible encourage young people not to sit with heads together to prevent transference of nits.	· RMO · Parents · Nursing staff	Bonita King	Update 04.02.08 Treatment changed to Hedrin as advised by Kent Health Protection Unit continue to monitor for signs of head lice. Update-15/02/08- Michele informed by Bonita King, Team Leader that the child was free from headlice from the 11/02/08.
Date Reported	**Ward/Unit**	**Number of Outbreaks Patients**	**Number of Outbreaks Staff**	**Number of Outbreaks Other (visitors/ contractors)**	**Type of Infection Outbreaks**	**Action taken to control infection**	**Action taken to prevent further infection**	**Who has been contacted**	**Person Completing this form**	**Follow up information and date**
21/01/2008	Woodstock Frank Lloyd Unit Bell Road Sittingbourne	1			**MRSA**	Nursed in room and barrier nursed. Antibiotic nasal ointment & stellisept foam wash used	Universal precautions adhered to.	· Liaising with Kent HPA	S S Bowe	Update - Michele informed on 15/02/08 by SN V Harrison that the patients swab returned a negative result for MRSA on the 1st of Feburary.
21/01/2008	Elmstone Ward Thanet MH Unit	Nil	1	Nil	**Vomiting**	Staff member off sick until infection cleared	N/A	N/A	Christine Thompson	Staff returned to work after being asymptomatic for 48 hours clear.

21/01/2008	Edmund Ward St. Martins Hosp Canterbury	1	Nil	Not known	**MRSA on legs (skin)**	Patient was transferred to us on 21/01/08 from Winslow Ward, Arundel Unit, WHH. Few hours after transfer HPA contacted the ward & advised us that this pat was MRSA +ve & we should ask our Medical Officer to contact microbiology. Dr Kannagorsium contacted microbiology & spoke with Dr Nash who advised that we do nothing to physically treat this lady as she was well with no pen sores. The patient has been body mapped & marks on her legs have been recorded. Staff continue to use good hygiene & encourage the patient to keep good hyiene where possible. Universal precautions.	Spoke with Trust Infection Control Nurse who advised reswab in 1 weeks time. Patient to be swabbed on Monday 28/01/08. Staff to continue tocheck patient's body for more marks/open sores. Patient body checked this am, no further marks or sores reported.	· All persons connected with Infection Control · Paula Campbell Modern Matron · Health Protection Agency · Dr Nash Microbiology WHH · Michele Coleman Infection Control Nurse	Amanda Hatfield-Tugwell, Ward Manager	Michele Coleman, Infection Control Nurse telephoned W/M Amanda Tugwell, to discuss plan of action on 24/01/08 (please see action plan) Update 11.02.08 reswabbed MRSA isolated continue universal precautions. MRSA still present once re-swabbed. Michele advised Amanda to wait until the course of antibiotics had finished and re-swab on 20/02/08. Update 06/03/08 - swab returned a negative result for MRSA on 05/03/08
24/01/2008	The Springs 18 Tonbridge Road Pembury	Nil	1	Nil	**Vomiting**	Staff stayed off work	Advised not to return until clear for 48 hours		Member of staff Manager	Staff returned to work after being asymptomatic for 48 hours clear.

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29/01/2008	Elmstone Ward Thanet MH Unit	3			Diarrhoea	Put up notice for all staff, patients, visitors regarding washing hands	Put up notice for all staff, patients, visitors regarding washing hands	To report to Kent Protection Nurse	Christine Thompson	Update- 15/02/08 - Staff unable to get faecal specimens to send for analysis as all patients were free from symptoms within a day or two. No further bouts of diarrhoea reported.
29/01/2008	Winslow Ward The Arundel Unit Ashford	3			Diarrhoea	One specimen has been sent for culture with an outbreak code of 8HP035 placed on specimen.	The Ward was closed for admissions. Ward manager will contact Medirest housekeeper regarding extra input on the ward	· Sheena Fenn from the Kent Health Protection Unit · Michele Coleman Infection Control Nurse · Christine Marsh Service Mgr	Simon Lockwood and Barbara Morgan	Results from lab state that C.Diff and Noro Virus not detected. Update 5/02/08 Asymtomatic for 48 hrs as of this evening. W/M will contact KHPU this evening to inform. The ward will arrange a deep clean and will reopen. Update - 15/02/08 - Deep clean carried out on 14/02/08 and re-opened on 15/02/08. - Michele Coleman.

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05/02/2008	Littlestone Lodge Dartford	1			Clostridium Difficile	Received Path Lab result of C diff on 1 patent who was transferred from General Hospital. Universal Precautions and patient on a course of metronidazole for 10 days	Isolation of patient. Advice from HPA. Deep cleaning of room.	IC Team. HPA. Daranth valley Hospital. SUI Panel.	Adam Adkins	06.02.08 - Michele Coleman visited the ward to review current practice and patients environment and advice given. Ward closed to admissions and discharges. 11.02.08. Joint RCA organised with Daranth Valley Hospital. Patient continues to be nursed in isolation. Update 19/02/08 - Patients physical health has deteriorated overnight, watery stools, increased temperature. Fluid balance chart maintained. Another faecal specimen sent for analysis today. Last dose of Metronidazole given on 15/02/08. To be seen by medical team today. Update 21/02/08 - Patient transferred to Darenth Valley Hospital during the afternoon of 19/02/08 due to decline in urine output (patient has chronic renal failure) and was reported to be 'chesty'. Update 06/03/08 - patient remains physically unwell at the Daranth Valley Hospital. Ward deep cleaned and reopened.Patient died on 19/03/08 at Daranth Valley Hospital, cause of death is yet to be determined - Michele Coleman.
10/02/2008	Willow Suite Little Brook Hospital Dartford		1		Diarrhoea & Vomiting	Staff was sent home following complaint of diahorrea & vomiting on 10/02/08 am shift	Staff was contacted by link nurse and advised to send a stool sample to Occupational Health if sickness continues. Due to see OH Nurse on 13/02/08	Mr Venkia W/M Angela Short Modern Matron, Mike Curtin Peter Hasler	Ellen Madora	Staff member returned to work after she had been asymptomatic for 48 hours clear.
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17/02/2008	Amherst Ward Priority House Maidstone	1			MRSA	Patient transferred from Medway Maritime believing 1st swab was negative on checking found to be Positive. Will recommence swabs (Fri 22nd)	To notify her GP if discharged. Chase protocol relating to transfer. Ward Manager has spoken to Medway Maritime voicing concerns	Mike Curtin	Diane Tompsett	Infection control RCA form completed by ward manager. Update 06/03/08 - Patient discharged home on 27/02/08, GP to follow up.

19/02/2008	Edmund Ward St. Martins Hosp Canterbury	4			Diarrhoea	On Sunday 17th we gained 2 samples from the loose foul smelling patient's stools. Samples were sent to microbiology for testing on Monday 18th. Health Protection contacted on Tuesday 19th & advised us to close ward to admissions & discharges. Notices placed on outside of front enrances. Domestic made aware, as intense cleaning needed. Universal precautions and increase hand washing of patients,staff & visitors.	Await results of samples and any new cases to have 8HP052 on the sample bottle & form Any incidences of staff or others to remain off duty for 48 hrs and to attend Occupational Health. HPA to contact the ward on Friday 22n February. Domestic to increase cleaning of areas which patients/staff will touch. Universal precautions to be used and ensure good hygiene at all times.	· Michele Coleman · HPA · Ward Domestic & Supervisor Dagmar Whiting · Paula Campbell, Modern Matron	Amanda Hatfield-Tugwell, Ward Manager	26/02/08 - Update from A Hatfield-Tugwell, Ward Manager - All faecal samples sent to the lab for analysis returned a negative result regarding C-diff and norovirus. WM has contacted the KHPU to inform them of the results. To reopen the ward once it has been deep cleaned, domestic supervisor informed. Update - 06/03/08 - Ward deep cleaned and reopened on the 01/03/08.Michele Coleman.
18/02/2008	Robert Browning Ward, Medway Maritime Hospital	1			MRSA for wound on right lower foot	Daily dressing of wound with stellisept and wound was dressed and covered. Bactraband ointment to nostrils applied	Handwashing & use of alcohol swabe/gel everytime in contact. Also wearing of protective batrrier in doing nursting intervention. Clinical waste labelled for disposal. Maintain clean & free from clutter environment		S/N Nisperos	25/02/08 Helath Protection Unit notified. 03/03/08 Stellisept cream application completed. Wound re-swabe and awaiting results. Universal Precautions observed.
25/02/2008	Elthelbert Road, Canterbury		1		scabies	Staff member saw own GP and prescribed cream which was applied once. GP did not advise to refrain from work.	Michele Coleman advised for staff member to refrain from work until topical treatment had been applied and treatment was successful	KHPU, Occupational Health, Michele Coleman, infection control nurse	Kathleen Steeles	No further action. Refer to Occ Health .

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03/03/2008	Brooke Ward, A Block, Medway Maritime Hospital	9	1		Diarrhoea & Vomiting	Affected patients were isolated to prevented spread of infection. Staff was advised to improve ward hygiene. KHPU informed. Infection control nurse informed. Specimen sent to lab.	Ward was closed to admissions and transfers. No Visitors allowed on the ward.All appointments for in-patients outside the hospital was cancelled.Infected Patients Not allowed to go to Smoking room on Shelly ward.Patients not allowed to use kitchen.	Kent Health Protection Agency. Infection and Control Nurse. Site Practioner. Louise Clack (Modern Matron)	Lystra Madho Deputy Ward Manager Brooke Ward	Update 07/03/08 - ward remains closed to admissions and discharges. No further episodes of D & V since 06/03/08. Awaiting results of faecal specimens sent. Update 10/03/08 - Remains D & V free since 06/03/08. Discussed with MM Louise Clack. Deep clean to commence today, after which the ward can be reopened.Michele Coleman.
05/03/2008	Shelly Ward, A Block, Medway Maritime Hospital	2	2		Diarrhoea & Vomiting	Ward closed to new admissions. signs posted at the door. Local infection control office informed. alcohol gel deposited at strategic positions and the ward. Initially closed to visitor but advised to reopen and advise them of the risk. Patients infected have been put in a side room.	Sign posted at the front door to encourage hand hygiene.All staff have been made aware of the infection and have been advised to wash hands regularly.All patients has been made aware and have been advised to wash hands regularly.Signs posted on the ward to encouraged hand hygiene. Alcohol gel deposited at strategic positions around the ward.	Kent Health Protection Unit. Service Manager	Peterkin Ofori	Update 07/03/08 - ward remains closed to admissions and discharges. More staff are off sick due to D & V. Awaiting results of faecal specimens sent. Update 10/03/08 - Modern Matron Louise Clack stated that the ward reported a further episode of diarrhoea today (Currently 7 patients & 3 staff with D & V).No further reports for 48hrs after last episode.Ward deep cleaned and reopened.Michele Coleman.

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05/03/2008	Anselm Ward, St Martins Hospital	1			Suspected Tuberculosis	On 02.03.08 Patient GW was transferred to KCH with suspected chest infection. On the 04.03.08 KCH reported that GW was suspected of having TB.. Adiagnosis of TB is yet to be confirmed. Dr R. Harte has been informed that a sputum will be sent today – cultures will take 8 weeks but a smear result will be within 24 hours. If smear is positive this will mean he is positive. They will then begin treatment.	Advised by Dr Nash and Cathy Southwould (Kent health protection unit) at point where they confirm infection they will consider people who have been in contact with GW. These will usually be just home contacts. Explained circumstances of GW being an inpatient. People who could posibly be at risk would only be imuno suppressed patients IE: people with HIV/ Aids or on imuno depressing medication. All advised that until we have confirmation there is no need for action with patients or staff. Occupational health Dept visited ward today to speak to staff and reassurance given. A list of staff/ patients who have had contact with GW is being compiled in event of infection.	Dr Nash & Cathy Southwold, Infection control- Michele Coleman & Andrew Dickers. Rosarri Harte, ward team, David Tamsitts sectretary	WM Clare Balman	Update on 10/03/08 - WM Clare Balman informed (on the 07/03/08) that the recent test for TB have returned a **negative** result. The patient has a chest infection.

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05/03/2008	Woodlands ward, Little Brook Hospital	1			Suspected MRSA. Pressure sore to left foot with oozing blisters	Swab taken of foot and sent to Daranth Valley Hospital lab.Applied Tegaderm dressing.Reported to Tissue Viability Link nurse.Discussed with specialist.	Wound is covered with a dressing. client is advised and encouraged to continuously wear slippers when walking around	Tissue viability link nurse expected to assess today 05/03/08. Michele Coleman on 05/03/08	RN Lorna Whitton	Update 10/03/08 - Telephoned ward and spoke to Lorna. She will email a weekly reporting form with details of the swab result tomorrow.Update 11/03/08 - Patient prescribed antibiotics as follows Flucloxacillin 500mgms QDS and Erythromycin 500 mgms QDS for infection. The infection is Staphylococcus Aureus and Beta Haemolytic Streptococcus group G and NOT the Methicillin-resistant strain (MRSA). Michele Coleman.
11/03/2008	Crisis Team, Priority House, Maidstone		1		Clostridium Difficile	Staff member was a patient on Foster Clark ward, Maidstone Hospital undergoing surgery and whilst there he contracted C Difficle. He was not prescribed treatment for C difficile.	Staff member will refrain from work until he is asymptomatic for 48 hours. He will contact his GP & Occupational Health Department before returning to work.	Peter Hasler, Occupational Health, Michele Coleman	Lorraine Trainor (wife)	Update 11/03/08 - Staff member remains off sick. He is due to have another operation on the 11th of April. He will not return to work prior to his retirement at the end of May - Michele Coleman.
Date Reported	Ward/Unit	Number of Outbreaks Patients	Number of Outbreaks Staff	Number of Outbreaks Other (visitors/ contractors)	Type of Infection Outbreaks	Action taken to control infection	Action taken to prevent further infection	Who has been contacted	Person Completing this form	Follow up information and date
14/03/2008	Cranmer Ward, St Martins Hospital, Canterbury	7	3	1	Diarrhoea & Vomiting	Ward closed to admissions, transfers and discharges until free from further episodes for 48 hrs. Affected patients nursed away from main public areas where possible, and encouraged to take copious clear fluids only until clear of symptoms. Reviews by ward doctors.Affected staff to stay off-duty until symptom-free for 48 hrs.Enhanced cleaning regime instituted (door handles etc. cleaned with mild bleach solution for duration of outbreak). Universal precautions emphasised to staff. Samples sent to Path. Lab. for viral studies. Notice displayed outside ward.Explanatory letter and leaflet from Kent Health Protection Agency displayed inside ward.Specific relatives contacted.	Ward to be deep-cleaned once free from further episodes for 72 hrs.Outbreak code is 8HP081.	Michele Coleman (Infection Control Link Nurse); Health Protection Agency - Katie Allen; Paula Campbell (Modern Matron); Donna Eldridge; Peter Hasler [message left to ring ward] Dagmar Whiting (Domestic Supervisor).	WM Bob Watkinson	Update 17/03/08 - Weekly reporting form received today states that incidents of diarrhoea & vomiting have now increased to 8 patients, 5 staff & 2 visitors. Update 25/03/08 - No further cases of D & V for 72hrs. Ward is being deep cleaned today and will be open to admissions and discharges as of tomorrow (26th) - Michele Coleman.

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20/03/2008	Woodlands ward, Little Brook Hospital	1			**Heel infection with Heavy Growth of Anacrobes as described on the path lab result dated 14/03/08**	Antibiotic prescribed as follows Metronidazole 400 mg TDS for 7 days. Continue applying Tegaderm Dressings. Seen by Tissue viability Link Nurse who continues to assess progress	Dressing is replaces as necessary by ward team when it become detached otherwise dressing been changed by Tissue Viability Link Nurse S/N V Daus. Client now wearing slippers when walking around on team advice	Tissue Viability Link Nurse and Modern Matron A Shorter	L Whitton R/N	26/04/08 Result reviewed by ward SHO & discussed with Tissue Viability Link Nurse. Plan made not to prescribe further antibiotic, topical or systemic. Continue to change dressing on alternate days and continue regualr monitoring of progress by ward team & Tissue Viability Nurse

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25/03/2008	Willow Suite, Littlebrook Hospital, Dartford	1			MRSA in groin area and colonisation of abdominal wound.	1. Advice taken from East Grinstead Burns Unit. 2. Anti-biotics prescribed. 3. Patient advised to wash hands prior to leaving his room. 4. Bed linen to be changed daily and taken away in dissolvable red linen bags within red linen bags as infected linen. 5. Personal Clothing laundered according to protocol. 6. Protective clothing to be worn as per policy	1. Administer prescribed medication 2. Information given to nursing staff and housekeeping staff. 3. Raise awareness of infection and the use of universal precautions	1. Peter Hasler, 2. Infection Control Team 3. Mike Curtain 4. Michelle Coleman 5. Ellen Madora 6. Angela Shorter	Ellen Madora on behalf of Val Kiell	Update 26/03/08 - Lead Nurse, Mike Curtin visited the ward on 25/03/08. Awaiting the NPSA RCA form.Update 31/03/08 - NPSA RCA form completed and emailed to infection control from the ward. 06/04/08 Advice from Burns Unit to continue with nasal cream and groin cleanser until 5th April then swabs taken until 8th April. Had skin graft on 2nd April & currently being held in place by staples. Will attend the Burns Unit on 8th April for surgical removal of staples 13/04/08 Result of swab taken on 8th April NEGATIVE further swab taken on 12/04/08 Stapholococus Aureus (infection around the burn wound on his lower abdomen) swab taken on 8th April result 10th April POSITIVE started on antibiotics. Dressings to both abdominal wound and left thigh where skin was taken from skin graft carried out by the Burns Unit on 12/04/08 and advised for dressings to be changed 5-7 days. 7/05/08 No further swabs required as all three swab results are negative of MRSA
27/03/2008	Woodlands ward, Little Brook Hospital	1			Self inflicted wound on neck	Wound swab taken, awaiting results. Prescribed broad spectrum antibiotic as follows: ERYTHRHOMYCIN 500mgms TDS for 5 days	Advised patient not to tamper with wound/dressing also advised regular hand washing.	1. Infection Control Link Nurse 2. Modern Matron 3. Infection Control Team	L Whitton R/N	Results negative for MRSA, wound successfully treated
Date Reported	**Ward/Unit**	**Number of Outbreaks Patients**	**Number of Outbreaks Staff**	**Number of Outbreaks Other (visitors/ contractors)**	**Type of Infection Outbreaks**	**Action taken to control infection**	**Action taken to prevent further infection**	**Who has been contacted**	**Person Completing this form**	**Follow up information and date**
27/03/2008	Jasmine Ward Jasmine Centre Darenth Wood Road, Dartford	1			MRSA swab result from both legs have shown heavy growth of staphylococcus aureus	1. Prescribed on a course of antibiotices - erythromycine 250 mg TDS. 2. Universal Precautions to be used at all times to prevent the spread of infection	1. Ensure that saff are aware of the infection control policy and that appropriate measures are taken to manage infection 2. To repeat swab - post treatment.	1. Mike Curtin 2. Director of Nursing 3. Rose Waters 4. Nominated Infection control resource nurse	K Dullip	Swab was negative for MRSA, patient successfully treated and dischardged to Residential Care.
28/03/2008	Neuro rehab, Darrant House, Sevenoaks	3	1		Diarrhoea & Vomiting	Patients remaining in there own rooms. Universal precautions.	Information given to patients and visitors via leaflets	Kent Health Protection Unit	T A POWELL	Tests negative for Norovirus. Ward deep cleaned after 48hours since last episode

03/04/2008	Willow Suite, Littlebrook Hospital, Dartford	1			**Head Lice**	1. Advice taken from Medical Team 2. Permethrin prescribed 3. Patient assisted and observed with washing hair with shampoo 4.Personal clothing laudered according to protocol 5. Protective clothing to be worn as per policy	1. Seek further advice from medical team 2. Information given to nursing staff and housekeeping staff 3. Raise awareness of infection and the use of universal precautions	1. Peter Hasler, 2. Infection Control Team 3. Mike Curtain 4. Michelle Coleman 5. Ellen Madora 6. Angela Shorter	Michael Beebeejaun	06/04/08 To be reviewed on 7th April my medical team to review treatment. Universal precautions continue. 13/04/08 reviewed on 7th April and advised from Pharmacist to wash with shampoo twice a day and if by the 16th April head lice toninues then to re-treat with Permrtrin (Lyclear. 27/04/08 No evidence of nits this week. Patient assisted & observed with washing & wet combing hair on a daily basis with conditioner and nit comb. Will be reviewed on 28/04/08 and if head lice still apparent then contact Pharmacist for further advice for treatment. 7/05/08 Seen & examined by Ward Dr. on 29/04/08 and there was no evidence of head lice all cleared.

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07/04/2008	Ramsey Ward St. Martins Hosp Canterbury	1			**Suspected Herpes zoster (shingles). Not confirmed but treating as.**		Universal Precautions	1. Health Protection Unit Jill Ashford 2. Paula Campbell Modern Matron 3. Woodside Residential Home (to inform precaution with ex room mate) 4. Dermatology K& C 5. Care Manager Marion Chubb 6. Consultant Dr Scott	Sharon Harrison	14/04/08 NOW CONFIRMED AS SHINGLES 29/04/08 Infection as reported now resolved (Shingles) infection notices on doors removed
17/04/2008	Edmund Ward St. Martins Hosp Canterbury	2			**Diarrhoea**	First patient has had 2 bouts of foul smelling diaahorea 1 yesterday & 1 today (17/04/08) & staff will gain a sample. Second patient has had 1 bout of diahorea today, however this is not foul smelling as this lady was admitted for high up constipation concerns, which we are investigating & treating	1. Universal precautions in use as per policy 2. Sample to be gained & sent to lab for testing 3. Informed HPA who have advised us to isolate 1st patient which we are able to do and monitor other patients & inform staff to be aware & take greater precautions especialy with hand washing etc. 4. If we have furher concerns about 2nd patient contact them for advice & await the results of the sample, inform them of results & inform them of further outbreaks.	1. Paula Campbell Modern Matron 2. Michele Coleman 3. Health Protection Agency	Amanda Hatfield-Tugwell, Ward Manager	22/04/08 - On the 17th April 08 stool sample sent to Microbiology William Harvey Hosp., requested results via telephone, nothing abnormal detected. No further action taken.
19/04/2008	Woodlands ward, Little Brook Hospital	2			**Conjunctivitis**	Cleanliness and hygiene awareness: patients are empowered to look after their own hygiene and encouraged to wash their hands after touching their eyes. They are also having eye drops.	Hygiene awareness and treatment in progress (eye drops)	Ward Doctor	L Whitton R/N	26/04/08 Patient seen by ward SHO. Prescribed and commenced treatment with Chloromycetin Eye Drops. Objective and subjective monitoring of prorgress of inection by ward team.
19/04/2008	Sevenscore Ward, Thanet Mental Health Unit	3			**Diarrhoea**	Patients with symptoms encouraged to remain in their own bedroom. All surfaces in patients own bedroom wiped down with detergent and floors mopped daily in patients room.	1. Handrails, toilets, handles/seats/rails wiped down with detergent 2. Toilet identified for those patients with diarrhoea 3. Handwashing facilities identified for visitors so that they can use the soap and water. 4. Signs put up to explain to visitors.	1. Peter Hasler 2. Andrew Dickers 3. Michele Coleman 4. Infection Control Team	Sue Wrintmore	04/06/08 The ward was not closed as it was not infectious because 1 was due to medication, 1 to his general illness and the other they were not sure about.

21/04/2008	Gillingham CMHT, Kingsley House Balmoral Road, Gillingham		2		**Diarrhoea & Vomiting**	Staff members rang in sick and advised not to reutrn until they have been clear for 48 hours	Advised not to return until clear for 48 hours		Jacqui Jefferson	Two cases not related no specimens obtained asympomatic for 48 hours returned to work
21/04/2008	Elmstone Ward Thanet MH Unit		1		**Diarrhoea & Vomiting**	Staff of sick until symptoms cease	Promote hand washing		Christine Thompson	No action.
28/04/2008	The Orchards Priroty House Maidstone	5	1		**Vomiting**	Universal Precautions Clinical Service Manager informed	1. Front door signage 2. Minimum movement of patients 3. Ward closed to admissions	1. Kent Protection Agency 2. Infection Control Team 3. Hotel Services 4. Phil Smith 5. Peter Marsh	S.F. Murray	29/04/08 Patients no new cases 1 member of staff 30/04/08 No new cases 04/05/08 3 patients and 1 member of staff 06/05/08 No patients 2 staff 07/05/08 1 patient 11/05/08 1 staff

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29/04/2008	Edmund Ward St. Martins Hosp Canterbury	5	Not known	Not known	On Sunday 27th April 08 three patients had D&V we gained a sample from 1 patient. On Monday 28th no reported outbreaks, however overnight 2 patients had a foul smelling diahorea & 1 of them also had vomiting, this particular patient is currently on antibiotics & a stook sample has been gained & sent to the William Harvey Hospital microbiology dept. for testing. On Tuesday 29th so far 3 patients have also develped foul smelling diahorea & 2 have had vomiting. We gained another sample for 1 of these ladies.	1. Samples to be gained as episodes occur to both patients and staff & outbreak code is 8HP117. 2. Staff if affected to remain off ward for 48 hrs & to send samples to Occupational Health for testing. 3. Staff are using gloves, aprons & masks, universal precautions as per Trust Policy. 4. Regular hand hygiene & hand gel usage in place. 5. Notices on entrance points for visitors & staff & we are closed to admissions & discharges until further notice. 6. Domestic staff aware & using precept cleaning tablets.	1. Awaiting the results of the samples taken. 2. Where possible we are able to isolate the patients, however some patients do have wandersome traits & this may not always be possible. 3. Staff will move all affected patient to one area. 4. Staff to use universal precautions & good hand hygiene for both staff & patients. 5. Ward Closed until further notice. 6. Domestic supervisor aware as ward will need a deep clean once we are infectious free. 7. HPA will contact us mid week for further update.	1. Infection Control Team 2. Michele Coleman Infection Control Link 3. HPA 4. Paul Campbell 5. Microbiology WHH 6. Dagamar Whiting, Domestic Supervisor	Amanda Hatfield-Tugwell, Ward Manager	04/06/08 The ward has been cleaned and has now been open for admissions and discharges since 19th May 08
05/05/2008	Woodlands ward, Little Brook Hospital	1			Chest Infection	Commenced Broad Spectrum antibiotics and monitoring temperature & signs & symptoms of infection	Monitor outbreak or spread of similar infections in the ward environment	1. Infection Control Team 2. Ward SHO 3. Infection Control Link Nurse 4. Modern Matron	L Whitton R/N Infection Control Link	

08/05/2008	Edmund Ward St. Martins Hosp Canterbury	10	8	1	Diarrhoea & Vomiting	1. Results of samples have come back as clear 2. Samples to be gained as episodes occure to both patients & staff - outbreak code 8HP117 3. Staff if affected to remain off ward for 48 hrs & to send samples to Occupation Health for testing. 4. Staff are using, goves, aprons, masks & universal precautions as per Trus Policy 5. Regular hand hygiene & hand gel usage in place 6. Notices on entrance points for visitors & staff & we remain closed to admission & discharges until further notice. 7. Domestic staff aware & using precept cleaning tablets 8. HPA & Trust Infection Control Nurse have been informed & have made regualr contact with ward.	1. Results of samples taken have come back as clear 2. Where possible we have been able to isolate the patients, however some patients do have wandersome traints & this may not always be possible. 3. Staff remove all affecteds patients to one area. 4. Staff to use universal precautions & good hand hygiene for both staff & patients 5. Ward remains closed until further notice. 6. Domestic supervisor aware as ward will need a deep clean once we are infectious free 7. HPA have been contacting us every few days	1. Infection Control Team 2. Michele Coleman Infection Control Link 3. HPA 4. Paul Campbell 5. Microbiology WHH 6. Dagamar Whiting, Domestic Supervisor	Amanda Hatfield-Tugwell, Ward Manager	No outbreaks reported. Visit to ward on 11th June to assess situation and support staff. Discussed with ward maanger the need for review of cleaning staff protective clothing and hand washing for patients. 11th June PM ward manager has meeting with RW from hotel services to discuss training and support for staff. No outbreaks reported. Visit to ward on Monday 16th June to review situation. Discussed with Ward Manger hand washing training. MC has agreed to provide training to hotel and care staff on Thursday 19th June. Andrew Dickers. Update 03/07/08 - Training given to 14 staff at St Martins Hospital on the 19th/06/08 - Michele Coleman.
12.05/08	Ramsey Ward St. Martins Hosp Canterbury		3		Diarrhoea & Vomiting	Staff staying off work for 48 hours after last bout of D&V	Universal Precautions	1. Paula Campbell Modern Matron 2. Infection Control Team 3. Health Protection Agency 4. Donna Eldrdge	Sharon Harrison	14/05/08 2 patients wth D&V as well as 3 staff and ward closed to admissions and discharges 19/05/08 2 patients now resolved 1 patient with symptoms 22/05/08 3 patients now resolved 3 patients with symptons. 3 staff now returned to work. 27/05/08 No further patients with symptoms, all others now clear and a deep clean being arranged for this week to enable ward to reopen.
19/05/2008	320 Hempstead Road	2			Chronic Diarrhoea	Service Users kept at home from college, bland foods and fluids given, high observations. Hygeiene regime increased and all outside visitors to the house cancelled.	All linen washed separatly to prevent further infection. Goves remain to be worn for all personal hygiene. Contact G.P. if no improvement within 24 hours.	1. Chris Kennedy, Infection Control Nurse 2. Families have been advised.	Sarah Tsigarides	
8.05.08	Elthelbert Road, Canterbury	1			MRSA to Susan Smith foot	refered to consultant . Anti biotics prescribed.	universal precautions	HPA. MH care team.	Samantha Davies	20.05.08 Contacted home and signs of improvement to wound. Susan Seeing Consultant this PM. AD 17th June 2008 Progressing well no issues. AD

20/05/2008	Sevenscore Ward, Thanet Mental Health Unit	1			MRSA	All staff informed and Kent Protectio Agency notified. NPSA learning through action form completed and sent to appropriate contacts. Medical team notified and Mupiroin cream prescribed	Universal Precautions and treatment as prescribed	1. KPA 2. SUI 3. Infection control team	Michele Booth, Deputy W/M	04/06/08 A swab was taken on the 3rd June and awaing result. Recommenced bactrobam
21/05/2008	Edmund Ward St. Martins Hosp Canterbury	1			SHINGLES	Universal Precautions and single room	Universal Precautions	1. Health Protection Agency (Katie Allen) 2. Michele Coleman , Infection Control Link Nurse	Paula Campbell	29/05/08 Shingles although affected patients skin at present looks clear Ward Dr needs to check her over & inform ward if outbreak is cleared. Patient with condition isolated to double room on own and has been prescribed relevant
27/05/2008	Willow Suite, Littlebrook Hospital, Dartford		1		Diarrhoea	Advised to seek medical attenetion and take a stool sample	Member of staff off sick and will contact the ward when given the all clear	1. Infection Control Team 2. Karen Dorey-Rees Associate Director for Acute Services 3. Angela Shorter Acute Care Service Mgr 4. Ramanah Venkiah, W/M	Ellen Madora	No sample provided staff member sympton free after 48hours and returned to work
04/06/2008	Sevenscore Ward, Thanet Mental Health Unit	1			MRSA	All staff informed and Kent Protectio Agency notified. NPSA learning through action form completed and sent to appropriate contacts. Medical team notified and Mupiroin cream prescribed	Universal precaustions and treatment prescribed	1. KAP 2. Infection Control Team	Michele Booth, Deputy W/M	This is is addition to one reported on the 20th May 08 17th June 2008 Unannounced visit to Sevenscore on 11th June. Discussed both MRSA case. Both being managed. Ward Manager dealing well with treatment. Ward teams now using a Vacation Cleaning Approach to tackling cross infection. Followed up on RCA report which stated staff are too busy. Clarified meaning which was that it was a busy day when more than one admission took place and staff could not assess infection status of patients on entry to the ward. Outcome fo this is to ensure that Ward Transfer form is being used. Andrew Dickers.
06/06/2008	Rosewood Lodge Dartford	1			MRSA	Transferred from Redwood Ward, Darent Valley Hospital, Dartford	Universal Precausions	Infection Control Team and Donna Eldridge	Ranji Canty	17/06/2008 Tests done since her return shows that NO MRSA was isolated.
16/06/2008	Ramsey Ward St. Martins Hosp Canterbury	1			MRSA (only in nose)	Specimen sent	Universal Precautions	Infection Control and Paula Campbell	Sharon Harrison	No further action at present, MRSA in nose not an outbreak. Andrew Dickers

17/06/2008	Riverhill Ward Tarentfort Centre Dartford	1 confirmed 1 query	1 (not confirmed by GP		Diarrhoea	1. Patient on observations instructed to maintain personal hygiene 2. Patient moved to empty room to allow bedroom to be deep cleaned 3. Next stool sample to be sent to DVH	1. All staff maintaining unversal precautions & washing hands as well as alcohol gel 2. All soiled clothing to be washed on a sluice cycle 3. Instructions put up to all staff on Gastroenteritis infections	1. Gillian Ashford 2. Steve Driver Service Mgr 3. Dr clare Dunkley RMO 4. Mandy Arnett Site Manager	James Whittle	Update- 9th July 08- SN Niyi Jimoh reported that patients have been asymptomatic since the 1st july. Staff unable to obtain faecal samples - Michele Coleman.
30/06/2008	Elmstone Ward Thanet MH Unit	3			Diarrhoea & Vomiting	Promotion of hygiene with patients	Promotion of hygiene with patients		Christine Thompson	Update - 9th July 08 - Patients have been asymptomatic since 6th July 08. Unsure as to whether loose stools were due to alcohol abuse or infection. Unable to obtain faecal samples - Michele Coleman.
03/07/2008	Edmund Ward St. Martins Hosp Canterbury	1			MRSA	Patient admitted on 27th June 08 with MRSA up both nostrals. She is currently prescribed treatment & HPA are aware. Universal precautions maintained	Nostrals to be reswabbed 07/07/08	1. Paula Campbell 2. Health Protection Agency 3. Michele Coleman	Amanda Hatfield-Tugwell, Ward Manager	10th July 08 patient has been reswabbed on 07.07.08 and awaiting results 17th July 08 (a.m) still awaiting results of swab, Ward Doctor chased up result on the 14/07/08 yet they were not in the dept? Lost in transit, have asked staff to chase up results this afternoon. If results or swab not in microbiology dept then staff to reswab on Friday 18/07/08. Update- 22/07/08 - Recent swab returned a negative result on the 17/07/08 (p.m) - Michele Coleman.
07/07/2008	Rivendell, Residential Rehab Mill Lane, Eastry, Sandwich	1			Viral Gastroenteritis	Client transferred to CDU at QEQH nursed in side room. Awaiting confirmation of diagnosis from stool specimen	All areas disinfected. Toilet seats, taps, flush+handles disinfected daily. Handwashing policy strictly adhered to - clients also instructed on handwashing & food hygiene. Universal prescautions used.	Consultant Psychiatrist and Rehab Manager	S/N Rached Harris	Update - 22/07/08 - Patient has been asymptomatic since returning from the Queen Elizabeth Queen Mother (QEQM) Hospital (patient returned to the ward after 2 days) - Michele Coleman.

14/07/2008	Winslow Ward, The Arundel Unit, William Harvey Hospital, Ashford	1			MRSA	Ward closed to admissions/discharges, increased signage, infected patients isolation, good hand hygiene	Universal Precautions	Ward Contacted by KHP to inform of infection in patient and to give advice on tretment and management of infection	Joan McWilliams	Update - 22/07/08 - contacted ward on 18/07/08 to clarify ward closure as reported, as this is not necessary. WM Barbara Morgan informed me that the ward has not been closed to discharges and admissions - Michele Coleman. Update- 15/08/08 - Discussed with WM Barbara Morgan today. Patients infected burns healed and was discharged home on 04/08/08. Michele Coleman.
16/07/2008	Ruby Ward A Block Medway Maritime Hospital Gillingham	1			MRSA	Universal precautions are being taken by MDT and cleaning staff. Family have been notified and are aware of need to carry out universal precautions. Patient is prescribed Bactroban and Stllasept. The patient has been admitted to Medway Maritimes since the 02/10/07 and was transferred to Ruby Ward early April 2008. the patient has been in sideroom since admission due to very distrubed mental state, aprons and gloves have been used continuously for the care of this patient due to daily personal care needs. Wound is covered. Infection control team and Clinical Services Manager alerted 16/07/08	Continue to treat patient for the next 5 days and re-swab. Continue to carry out universal prescautions	1. Nicky Dawber 2. Louise Clack 3. Peter Hasler 4. Donna Eldridge 5. Micelle Collins 6. Sapphire + Emerald Wards	Shelley Carley, Acting Ward Manager (AWM)	Update - 22/07/08 - Discussed with AWM on the 17/07/08. Patient is currently being treated with Bactroban and Stellasept and will be re-swabbed on the 24/07/08 (which is 3 days after treatment has ceased) - Michele Coleman. Update - 30/07/08 - Another course of bactroban & stellasept has been prescribed for 5 days. Re-swab of wound to take place on the 5/8/08 and a review of medical treatment. Update - 11/08/08 - Swab results show that groin, nasal area, right wound to leg and mouth not isolated, but the left leg wound remains MRSA positive. Discussed with AWM Shelley Carley and advised that the medics contact the Consultant Microbiologist for advice as prior treatment has not been effective. Michele Coleman. Update - 15/08/08 - Contacted by WM to inform IP & C that the medics had contacted the Consultant Microbiologist. No further treatment was recommended. The WM reports that the wound has almost healed. She will consult microbiology as to

24/07/2008	Ramsey Ward St. Martins Hosp Canterbury	1			**MRSA**	Univerasl precautions.	Universal precautions	Michele Coleman, Kent Health Protection Unit, Paula Campbell, Modern Matron	Sharon Harrison DWM	Update - 24/07/08 - Michele Coleman was informed this morning by Sandra Tomlin, Clinical Nurse Specialist of results of recent swabs carried out within acute trust (KCH) on this patient. Immediately contacted the ward and informed WM P Gregson. Infection SUI form completed. Informed DWM S Harrison that the patient does not need to be isolated as the MRSA is colonized (nose & axilla). Also advised to inform medical team.Michele Coleman. Update - 15/08/08 - Patient was discharged to home address on the 04/08/08, GP is aware of MRSA colonization. Michele Coleman.
28/07/2008	Emerald Ward Medway Martime Hospital Gillinghamn	1			**Fungal Infection on finger nail**	Cream applied on infected area	Hand washing after direct contact with patient. Care on the fingernials by podiatry	Ward Doctor	Adela Nisperos	Update - 15/08/08- Discussed with WM. She informed me that the patient still has this infection and is currently undergoing treatment for it. Michele Coleman.
01/08/2008	Anselm Ward, St Martins Hospital	1			**MRSA**	Advised received from infecion Control Nurse. Seen by Dr. Ogada and prescribed Doxycycline x 5 days. Ward staff informed and document all laundry to be put in appropriate (red) laundry bag. Care plan for wound dressing completed using universal precautions. Wound to be dressed daily using aseptic techniques. Apron and glove to be worn during procedure. Patient informed of MRSA and the above procedures and copy of care plan given. Information leaflet given to patient. Patient encouraged to use Purell hygienic hand rub before and after carrying out any activities. Provide support to staff in team meeting.	Ensure everyone is aware of the infection and follow instructions as per care plan. Ensure staff wear protective equipment when dealing with identified potential infection risks/hazards. Ensure that staff wear green apron when serving meals. Ensure that staff report all incidents, record accordingly	Psychiatry Consultant Dr. A. Ismail, SPR Dr. Ogada, Microbiologist Mr. Nash, Modern Matron D. Weatherall, Infection Control Nurse M.Coleman Kent Health Protection Unit	DWM Kiran Gunnoo	Update - 04/08/08 - MRSA is isolated to several abdominal stab wounds. Update - 15/08/08 - patient was tranferred to Scarborough ward at the Arundel Unit last week. Discussed with both wards, relevant IC tranfer documentation had been completed. A swab sent to microbiology on 14/08/08 returned a 'MRSA not isolated' result on the 19/08/08. Michele Coleman.
15/08/2008	Emerald Ward Medway Martime Hospital Gillinghamn	1			Fungal Infection (skin)	Univerasl precautions.	Seen by ward doctor, Clostrimazale cream applied on affected area, universal precautions, proper disposal of bed linen.	1. Michele Coleman 2. Martine Fante, Emerald Ward Manager 3. Infection Control Department	Adela Nisperos	Update - 1/9/08 - Patient was deemed infection free from the 28/8/08 and was taken out of a side room. Patient discharged home on the 08/09/08. Michele Coleman.

28/08/2008	Emerald Ward Medway Martime Hospital Gillinghamn	1			SHINGLES	Advice given to patient to cover up the area of shingles. Medication prescribed for the condition. Advice sought from infection control. IRIS form completed.	ENSURE PATIENT COVER UP AREA AT ALL TIME MONITOR AND REPORT TO MEDICAL TEAM IF THERE IS ANY FURTHER DETERIORATION INFORM AND REPORT TO INFECTION CONTROL CONSIDER MOVING IF NECESSARY	MARTINE FANTE – WARD MANAGER SARAH BLAKE – KENT PROTECTION AGENCY MIKE CURTIN- INFECTION CONTROL	PETER RODRIGUE S – DEPUTY WARD MANAGER	16/09/08 - Patient is still undergoing treatment for shingles.Aciclovir cream applied on affected areas. Vesicles have been reported to appear dry, therefore no longer infectious. Michele Coleman.
09/09/2008	Sevenscore Ward, Thanet Mental Health Unit		1		**MRSA**	Staff member Jay Stubbings is due to have surgey on his nose in a few weeks time. He had preo op swabs taken last week and they indicate that he is MRSA positive in his nose.	To dispose of tissues used to wipe his nose in the clinical waste bin To adhere to universal precautions	Kent Health Protection, Andrew Dickers, Jann Gilliland, Michele Coleman	WM Sue Wrintmore	09/09/08 - Staff member does not have to refrain from work whilst receiving treatment as MRSA is colonised. Michele Coleman.
14/09/2008	Woodlands ward, Little Brook Hospital	1			**Lymph Node TB Patient was admitted following treatment in Darenth Valley**	Patient was not infectious and usual infection control techniques used	N/A	Kent Health Protection Dr Mustley, Medical Consultant treating patient for TB	Barbara Stone	
15/09/2008	Anselm Ward, St Martins Hospital		1		**Vomiting**	Staff member off sick for 1 day, until 24 hours of no vomiting	Hand hygiene promoted with nursing staff	Modern Matron	Christine Thompson	16/09/08 - Staff member has returned to work. Discussed with WM (for future reference), staff are required to remain off of work until asymptomatic for 48 hours. Michele Coleman.
17/09/2008	Willow Suite, Littlebrook Hospital, Dartford	1			**MRSA**	Universal Precautions	Repeat swabs/blood	Infection control nurse on Willow Suite	Usha Auchoybur	17/09/08 - Contacted the ward and informed them that they also need to contact the KHPU. Michele Coleman. Update - 30/09/08 - Nasal swabs sent to microbiology on the 24/09/08 returned a negative result for MRSA on the 29/09/08. Michele Coleman.
22/09/2008	Willow Suite, Littlebrook Hospital, Dartford	1			**MRSA colonisation in nose**	Patient had her last dose of bactroban and is due for another nasal swab 22-09-08. Patient informed of the colonisation and advised to maintain a good personal hygiene. Patient given hand hygiene leaflet containing most frequently missed areas.	Patient is to inform us of any wounds in the nose or nose-bleed. Teaching was carried out to all staff and to patient. Especially information on MRSA and difference between infection and colonisation	Infection Control Team via Infection Control (e-mail). Karen Dorey-Rees, Associate Director for Acute Services. Angela Shorter, Acute Care Services Manager Ramanah Venkiah, Ward Manager	Ellen Madora	15/10/09 - Discussed with Ellen Madora today. Nasal swab sent to the lab returned a negative result for MRSA on the 29/09/08. Michele Coleman.

01/10/2008	Gatland house tier three CAMHS		3		**Diarrhoea & Vomiting**	staff advised not to return to work until 48 hours after last symptoms	staff advised not to return to work until 48 hours after last symptoms	Donna Eldridge, Michele Coleman, KHPU	Jacqui Wilson, Service Manager	09/10/08- No further episodes of diarrhoea or vomiting for over a week. KHPU happy to close this case. Michele Coleman.
03/10/2008	Emerald Ward Medway Martime Hospital Gillinghamn		1		**Scabies**	Consultede her GP and prescribed cream for the scabies. Went home and advised to call Occupational Health for advice as suggested by Health Protection Unit	To follow advice of OH/GP. To ensure that all areas affected will be treated with anit scabies cream. Advise that all family members in contact with her will undergo treatment. To repeat the treatment after a week of first treatment.	Michele Coleman and KHPU	Adela Nisperos	Consulted her GP and prescribed cream for the scabies. Went home and advised to call the Occupational Health for advice as suggested by Health Protection Unit. Advise that all family members in contact with her will undergo treatment. Further treatment after a week of first treatment.
05/10/2008	Scotney Ward Trevor Gibbens Unit, Maidstone	1			**Patient vomittd three times shortly after eating breakfast and again three times afer eating midday meal. No episodes of diarrhoea.**	Physical observations checked. Duty Doctor contacted to assess situation. Treatment plan put in place. Patient's room thorougly cleaned/disinfected. Toilet and bathroom cleaned/disinfected. Other wards informed.	Staff to wear disposable overshoes when in Scotney. This to be reviewed tomorrow. Toilet/bathroom surfaces to be wiped with antiseptic/spirit wipe after use by patients.	On Call Manager Clinical Manager who is lead on infection control informed and agreed above measures	Barbara Alsion	06/10/08 - Discussed with Barbara Alison, Senior Service Manager. Patient has been commenced on a fluid balance chart. No further episodes of vomiting today. Michele Coleman.
06/10/2008	Sevenscore Ward, Thanet Mental Health Unit	1			suspected scabies	Patient PB as seen by the dermatology nurse on 04.09.08. She has documented that she suspected that PB has scabies. Derbac cream was prescribed	Cream applied. Infection control set up	Staff Nurse contacted HPA and ws told that the situation to be monitored and if there was a second case to contact them again	Sue Wrintmore	15/10/08 - SN Sean Orouke stated that the patient is still undergoing treatment. No further cases reported. Michele Coleman
06/10/2008	Emerald Ward Medway Martime Hospital Gillinghamn	1			Conjunctivitis	Seen by SHO on call and prescribed chloramphenicol eye drops. Chloramphenicol eye drops to be applied regularly as prescribed	Staff to folow universal precautions when in contact with Linda. To encourage Linda to clean her eyes or if she cannot do it by herself then staff to clean it daily or when required. Proper disposal of materials used in cleaning the eyes	Michele Coleman	Adela Nisperos	15/10/08 - SN stated that treatment had been successful. Michele Coleman.
13/10/2008	Ramsey Ward St. Martins Hosp Canterbury	2			**Diarrhoea - 2 had diarrhoea but may well not have been caused by infection 1 is prescribed suppositorys and is given senna ,the other has IBS no further episodes since 11/10/08**	UNIVERSAL PRECAUTIONS	UNIVERSAL PRECAUTIONS	KHPU, Michele Coleman, Paula Campbell	Sharon Harrison	15/10/08 - Discussed with DWM Sharon Harrison and Gill from the KHPU. Due to pre-existing medical conditions being reported and no further episodes of diarrhoea, this was not treated as an outbreak. Michele Coleman.

14/10/2008	Sevenscore Ward, Thanet Mental Health Unit	5	2		Diarrhoea	Universal Precautions	Universal Precautions	Infection Control contacted & KHPU	Victoria Awe	15/10/08 - Discussed with Staff nurse initially, then with WM Sue Wrintmore on 13/10/08. Outbreak code given to the ward by the KHPU, code to be stated when faecal samples are sent to lab. SN Sean Orouke stated this morning that the ward had been closed to admissions and discharges and a notice is displayed on the door to the ward informing visitors. Update - Last bout of diarrhoea was on the 15/10/08. Ward was deep cleaned and re-opened on the 17/10/08.Michele Coleman.
22/10/2008	Amberwood Ward Dartford	1			Scabies	Patient was examined by the Doctor and prescribed calamine lotion and derbac cream	Nursing staff to use gloves and apron when applying cream or lotion	Mike Curtin	Vera Dookeran	07/11/08 - Patient had been successfully treated and discharged home today. No further episodes reported. Michele Coleman.
01/11/2008	Anselm Ward, St Martins Hospital	3	1		Diarrhoea & Vomiting	Advised received from infecion Control Nurse Gillian Ashford Ward staff informed and document all laundry to be put in appropriate (red) laundry bag.Care plan for diarrheoa & Vomitting to placed in patients notes.Apron and glove to be worn when attending to patients.Patients to be nursed in own room whenever possible.Information leaflet to be given to patient the patients.Patients to be encouraged to wash hands before and after carring out any activities and to also use Purell hygienic hand rub.To clean toilet twice daily including door handles & flushes and check toilet after every use.Day area carpet to be deep cleaned.Nursing Staff affected need to remain off until sypmtoms free for 48 hours.Provide support to staff in team meeting.Advice sought from Consultant Microbiologist.	Ensure everyone is aware of the infection and follow instructions as per care plan and as per InfectionControl Manual.Ensure staff wear protective equipment when dealing with identified potential infection risks/hazards. Ensure that staff wear green apron when serving meals.Ensure that staff report all incidents, record accordingly & incidents forms are completed.Ensure Infection Control Policy is adhered to.Staff to be aware the need for increased hand haygiene.Posters diplayed in prominent areas on the ward.Ensure Hygienic Hand Rub gel is accessable for everyone.Visitors to be advised of same.	KHPU (Sophie Parson). Consultant Microbiologist. Duty Manager Peter Gregson & Modern Matron D. Weatherall. KHPU Nurse on call Gillian Ashford. DMO Khalifa.	Kiran Gunnoo, DWM	03/11/08 - Telephone report given to me by Gill Ashford, KHPU who was contacted over the weekend by Anselm ward. Suspected viral gastroenteritis reported and advised to obtain faecal specimens and send to the lab for analysis. Discussed with Yoon Drew, DWM who stated that one patient has had no further episodes of diarrhoea and vomiting today. Update 07/11/08 - Ward re-opened after a deep clean on 06/11/08 as no further episodes of diarrhoea or vomiting for 48 hours.One patient has had diarrhoea today (07/11/08), therefore Anselm ward is closed to admissions and discharges (no vacant beds at present) until asymptomatic for 48 hrs of D & V and the ward has had a deep clean before re-opening. Discussed with Modern Matron, Debbie Weatherall. 10/11/08 - Visited ward today and discussed situation with WM. Ward deep cleaned after being asymptomatic for 48 hrs and reopened on 12/11/08. Michele Coleman.

03/11/2008	Woodchurch Thanet Mental Health Unit Margate CT9 4BF	1			MRSA	MRSA positive screening (groin) by Acute Hospital - not informed except by pack prescribed on prescription chart on admission.	Ensured universal precautions taking place. Prescribed wash being used.	Family informed. Infection Control Lead	Janet Hatch, WM	Discharged back to William Harvey on 30/10/08 due to current issues with physical health (not MRSA). Discussed with WM, who assured me that an infection transfer form had been completed prior to admission and upon transfer back to WHH. Michele Coleman.
10/11/2008	Woodchurch Thanet Mental Health Unit Margate CT9 4BF	6	3		Diarrhoea & Vomiting	Staff sent home - To be 48 hrs clear of episode of D&V. Any patients having symptoms to use separate commode and not be in main ward area where possible. Clear fluids encouraged. Universal precautions	• Universal precautions • Cleaning of ward areas – door handles, phones etc • Ward closed to admissions, discharges, reduced traffic to essential only • Outpatient appts., postponed. • Visitors discouraged to unit and where possible seen in reception area • Notice displayed on ward door	• KHPA – outbreak code 8HP226 • Matron • Andrew Dickers	Janet Hatch, WM	13/11/08 - WM contacted the Senior Infection Control Nurse (SICN) as the number of staff and patients experiencing symptoms of D & V had increased to 8 staff and 4 patients. SICN visited the ward on the 13th. Outbreak Management meeting to be held on 17th/11/08. On 17/11/08 an infection reporting form sent to IC reports that 12 out of 15 patients and 8 staff had experienced D & V. The lab has identified Noro virus. Management meeting held and items on the agenda were discussed (short report to follow). Deep clean to commence once ward has been symptom free for 48 hrs. 18th/11/08 - WM telephoned to inform SICN that a female patient had vomited 3 times, therefore deep clean will take place on 21/11/08 if no further episodes reported.19/11/08 - WM phoned, no further episodes reported. 21/11/08 Deep clean carried out today. Ward will reopen on 22/11/08. Michele Coleman.

11/11/2008	Sevenscore Ward. Thanet Mental Health Unit. 164 Ramsgate Road Margate Kent. CT9 4BF.	3	1		Diarrhoea & Vomiting	Ward Closed to admissions transfers and discharges. All staff aware of infection control measures and these are being utilised. Access to ward is restricted. Persons are not permitted unless absolutely necessary. A notice has been displayed at the front of the ward advising the staff and visitors of the outbreak. Agency and bank staff will nurse clients who are infection free only. Hand gell sanitizer is located at various points throughout the ward. Hand washing posters displayed.	As stated in actions to prevent infection	Kent Protection Agency. Infection Control Dept. Service director. Modern Matron. Ward Managers at Thanet. Community staff. Staff visitors and carers	Cathy Dannahy Ward Manager	19/11/08 - Faecal specimens returned negative results from the lab for noro virus/C diff. On the 17/11/08 the WM stated that there had been no further episodes of D & V since the 12/11/08. 21/11/08 - Deep clean carried out on 19/11/08 and re-opened on the 20/11/08. Michele Coleman.
11/11/2008	Dudley Venables house	1			Diarrhoea & Vomiting	Advised received from infecion Adrew Dickers, Donna Eldridge & Kent Health Protection Unit. - Ward staff informed and document all laundry to be put in appropriate (red) laundry bag. - Care plan for diarrheoa & Vomitting to placed in patients notes. - Apron and gloves to be worn when attending to patients. - patients to be nursed in own room wheneverpossible. - patients to be encouraged to wash hands before and after carring out any activities and to also use Purell hygienic hand rub. - to clean toilet twice daily including door handles & flushes and check toilet after every use. - Provide support to staff in team meeting.	Ensure everyone is aware of the infection and follow instructions as per Care plan and as per infection Control Manual. Ensure staff wear protective equipment when dealing with identified potential infection risks hazards. Ensure that staff wear green Apron when serving meals. - Ensure Infection Control Policy is adhered to. - Staff to be aware the need for increased hand haygiene. - Posters diplayed in prominent areas on the ward. - Ensure Hygienic Hand Rub gel is accessable for everyone. - Visitors to be advised of same	KHPU. Modern Matron D. Weatherall. Donna Eldridge & Andrew Dickers Message left with Michelle Coleman	Daniel Lee	11/11/08 - SICN visited DVH. 25/11/08 - No further episodes reported. Ward deep cleaned and reopened on the 14/11/08 after being asymptomatic for 48 hours. Michele Coleman.

26/11/2008	Willow Suite, Littlebrook Hospital, Dartford		1		Chicken Pox	Staff was at home on the day that the infection was confirmed. However had been on shift 3 days previously. Kent HPU was contacted and we are awaiting feedback. Michele Coleman was contacted for advice. All staff to be informed of a potential outbreak. All vulnerable individuals were contacted by link nurse and advised to contact GP	Staff was contacted by link nurse and advised to stay at home until the Doctor gives her the all clear. Patients are to be observed for signs and symptoms of infection. Appropriate use of universal precautions to be maintained during patient contact. The staff have to complet a (Transfer of infections on discharge form) No restrictions regarding patient movement as advised by Infection Control Lead Nurse.	Mr Vekia Angela Shorter Mike Curtin Sheena Fenn Michele Coleman Occ Health	Ellen Madora	28/11/08 - Contacted SN Ellen Madora on 26/11/08 to advise that all staff that have not had chicken pox and are worried that they may contract it can contact Occupational Health to have their blood tested for antibodies. 1 pregnant member of staff has already had chicken pox, but unsure of the other staff members. Also advised to inform all staff and patients of chicken pox case. Transfer of patients from this ward to others was discussed with the KHPU. This was deemed okay to do so as long as the admitting ward was informed of the chicken pox case and to complete an infection transfer form. 08/12/08 - Staff member remains off of work with chicken pox. Michele Coleman.
12/12/2008	The Birches, 16 Salisbury Road, Tonbridge	4	3		Diarrhoea & Vomiting	Outings/appointments kept to minimum. Visitors kept to minimum. Increased awareness of hand jhygiene, including use of personal protective clothing, alcohol gel after handwashing, cleaning of all hard surfaces with anti bacterial, use of alginate bags for contaiminated clothing/towels. All staff off reminded to be 48 hours clear before returning to work. Staff on shift reminded to go off sick, at first indication of either diarrhoea or vomitting.	Outings/appointments kept to minimum. Visitors kept to minimum. Increased awareness of hand jhygiene, including use of personal protective clothing, alcohol gel after handwashing, cleaning of all hard surfaces with anti bacterial, use of alginate bags for contaiminated clothing/towels. All staff off reminded to be 48 hours clear before returning to work. Staff on shift reminded to go off sick, at first indication of either diarrhoea or vomitting.	Mike Curtin Lead Nurse KMPT, Wendy Barnes Service Manager, Sue Bromley, Assistant Director, GP Dr Bench	Sue Marsden	22/12/08 - No further episodes of D & V from patients and sfaff since the 14/12/08. Deep clean carried out after 48hrs from the last episode. Staff unable to obtain faecal specimens. Michele Coleman.

14/12/2008	Sapphire Ward, A Block, Medway Maritime Hospital	1			**Diarrhoea & Vomiting** (No further episodes of D&V reported by Milton Ward since her transfer on the 17/12/08. She was transferred for treatment of other physical health difficulties).	Barrier nursing, Isolation, Use of universal precautions.(use of aprons, gloves, hand-washing with soap and water) , stool sample taken for analysing, and still awaiting results	We are still awaiting results from sample taken. However In the event that the sample is confirmed to be noro-virus, or any more service users develop D&V the ward will be closed. There should be no further admissions to the ward, including movement of patients between wards. A sign will also be placed at the door advising all visitors, or staff entering the ward, that the ward is under Infection control procedures, and alcohol gel will be placed at the entrance and exit to the ward for all visitors to use. Side room to be deep cleaned when patient has recovered from D&V or room is vacated.	Michelle Coleman Louise Clack	Trader Chikoto	22/12/08 - Result from faecal specimen has returned a **negative** result for C diff on the 19/12/08. Patient transferred back from Milton Ward on the 19/12/08 without symptoms of D & V. No other person has been symptomatic. Michele Coleman.
22/12/2008	Scarburgh, Arundel unit	3	3		**Diarrhoea & Vomiting**	Ward Closed for transfers, Infection Controls Procedures implemented, notice put up on ward door advising of outbreaks. Staff off sick who have contracted infection.	Ward Closed for transfers, Infection Controls Procedures implemented, notice put up on ward door advising of outbreaks.	Jill Ashford, Public Health Protection Agency Oncall.	Guy Powell, MM	22/12/08 - Andrew Dickers contacted by WM this morning to discuss outbreak. 09/01/09 - After all patients and staff had been asymptomatic for 48 hrs, ward was deep cleaned and re-opened on 31/12/08. Michele Coleman.
23.12.08	Windslow ward Arundel Unit	5	0		**Diarrhoea & Vomiting**	Ward closed as from today. Sign on the entrance to increrased awareness of hand washing particularly staff that move form ward to ward.	Ward to inform of any further outbreaks via reporting form	HPU contacted with an outbreak code given	Barbara Morgan WM	23/12/08 - Telephoned WM at 1300hrs for update. A further patient has vomited (total now 6 with D or V). Update - After all patients and staff had been asymptomatic for 48hrs, the ward was deep cleaned and re-opened on the 06/01/09. Michele Coleman.
23/12/2008	Woodlands Ward, Littlebrook Hospital, Dartford	1			**Chicken Pox**	Barrier Nursing, Aqueous cream prescribed, monitoring of signs and symptoms	Barrier nursing Staff and patients informed of infection Poster at entrance of the ward informing visitors of infection (confidentiality maintained)	Angela Shorter (Acute Care Services manager), Dr Nwosu (Consultant), KPHU, Staff Occupation Health Dept, Infection Control Team.	Raj Kutowaroo (DWM)/ L Whitton (S/N)	09/01/09 - Treatment received and no further cases of chicken pox reported. Michele Coleman.

31/12/2008	Emerald Ward, Medway Maritime Hospital	5	1		Respiratory problems	Sputum samples to be obtained from all patients/staff with symptoms who have not previously given a sample to ascertain nature of infections	1. Ward closed following discussion with Nicky Dawber, lead nurse. 2. Public notices displayed at entry. 3. All ward staff reminded to wear and use personal hand gel and to use correct hand washing technique. 4. Universal precautions to be used. 5. Isolation nursing if necessary	1. All ward staff made aware of suspected outbreak. 2. Ruby Ward and Sapphire Ward managers made aware of suspected outbreak and ward closure. 3. Medway and Swale CRHT Teams made aware of suspected outbreak and ward closure to admissions. 4. MASTT Team made aware of suspected outbreak and ward closure to admissions.	Alexander Bridge, Acting Ward Manager, Emerald Ward.	09/01/09 - It was reported on the 05/01/09 that the sputum samples had returned negative results for bacterial infection, but 2 patients have a greenish coloured sputum. This indicates a bacterial rather than a viral infection - antibiotics (amoxicillin prescribed). The remainder of the patients are no longer symtomatic. Ward has now re-opened. Michele Coleman.
06/01/2009	Newington ward, Arundel unit	5	1		Diarrhoea & Vomiting	Ward Closed for transfers, Infection Controls Procedures implemented, notice put up on ward door advising of outbreaks. Staff off sick who have contracted infection.	Ward Closed for transfers, Infection Controls Procedures implemented, notice put up on ward door advising of outbreaks.	Oncall Manager, CRHT, Health Protection	Guy Powell, MM	09/01/09 - Telephoned ward for update - Only 1 patient is symptomatic on the ward (vomited last night). 12/01/09 - After being asymptomatic for 48 hrs, the ward has been deep cleaned and has re-opened today. Michele Coleman.
13/01/2009	Sevenscore Ward, Thanet Mental Health Unit	1			MRSA in open wound	1) All staff involved in care informed o f infection and aware of universal precautions and KHP guidelines 2) Doctor responsible for care contacted and awaiting appropriate treatment to be prescribed 3) Kent Health protection notified. Awaiting return call and advise on action to be taken. 4) Wound coverered as per KHP policy	1)All staff involved in care informed o f infection and aware of universal precautions and KHP guidelines 2) Doctor responsible for care contacted and awaiting appropriate treatment to be prescribed 3) Kent Health protection notified. Awaiting return call and advise on action to be taken. 4) Wound coverered as per KHP policy	1) Kent Health Protection Agency 2) Responsible Doctor 3) Michele Coleman	Michele Booth, DWM	19/01/09 - NPSA's RCA SUI form completed and sent to infection control and SUI as it has been discovered that the patient does NOT have an open wound with MRSA present. Lab report had been poorly written (according to DWM) which caused confusion regarding results. Michele Coleman.

14/01/2009	Sevenscore Ward, Thanet Mental Health Unit	2			Scabies	1) All staff involved in care informed o f infection and aware of universal precautions and KHP guidelines 2) Doctor responsible for care contacted and awaiting appropriate treatment to be prescribed 3) Kent Health protection notified. Awaiting return call and advise on action to be taken.	1) All staff involved in care informed o f infection and aware of universal precautions and KHP guidelines 2) Doctor responsible for care contacted and awaiting appropriate treatment to be prescribed 3) Kent Health protection notified. Awaiting return call and advise on action to be taken.	1) Kent Health Protection Agency 2) Responsible Doctor	Cathy Dannahy Ward Manager	19/01/09 - Contacted the ward on the 16/01/09 to discuss this. Informed DWM that the ward should be closed to admissions, transfers and discharges until outbreak has been resolved. Advised to contact Occupational Health as all staff will have to carry out treatment on the same day as all patients. Ward team, Medical team and pharmacy to arrange for the treatment of all patients on the same day as staff. Treatments may need to be repeated approximately 7 days later. 27/01/08 - On the 21/01/08 the ward was contacted. All patients and staff had undergone treatment the night before. 11/02/09 - No further cases reported. Michele Coleman.
20/01/2009	Scarburgh Ward, Arundel Unit, WHH, Ashford	3			**Repeated Vomitting x 2** **Diarrhoea x 1**	Ward Closed for Transfers / Admissions. Infection Control Procedures implemented. Notice displayed advising staff / patients of outbreak.	Notice advising of outbreak. Reminder to staff / patients re importance of handwashing. Ward 'closed'.	KHPU Infection Control Lead – Michelle Coleman Modern Matron (Arundel Unit) Bed Management Team.	Kevin Friel, W/M, Scarburgh Ward	27/01/09 - Ward have been in daily contact with the IC team. All thos reported with D &V have been asymptomatic for 48 hrs. Deep cleaned planned for 28/01/09, then to re-open. 02/02/09 - Deep clean carried out and ward re-opened on 29/01/09. Michele Coleman.

01/02/2009	Winslow Ward, The Arundel Unit, William Harvey Hospital, Ashford	6			**Diarrhoea**	WARD CLOSED ,UNIVERSAL PRECAUTIONS,RESTICTED VISITING,EXTA WARD CLEANING SCREENING,EXTRA SIGNAGE TO ENTRANCES OF WARD	WARD CLOSED ,UNIVERSAL PRECAUTIONS,RESTICTED VISITING,EXTA WARD CLEANING SCREENING,EXTRA SIGNAGE TO ENTRANCES OF WARD	KENT HEALTH PROTECTION AGENCY ,KMPT INFECTION CONTROL NURSE ,ASHFORD OPMHN LOCALITY MANAGER	Simon Lockwood Deputy Ward Manager	02/02/09 - Contacted the ward and spoke with WM. 2 faecal specimens have been sent for analysis with outbreak code on the samples.Attempted cohorting of patients. Ward closed to admissions/discharges/transfers at present. 11/02/09 - Only 1 patient (male) is symptomatic at present (2000hrs last night). All faecal specimens have returned a **negative** result for clostridium difficile and norovirus, but awaiting a result for the symptomatic male patient faecal specimen (3rd specimen sent). On the 16/02/09 it was reported that 1 patient and 1 staff member were symptomatic. After being asymptomatic for 48 hours the ward was deep cleaned and reopened on the 19/02/09. Michele Coleman.
05/01/2009	Woodstock Unit at the Frank Lloyd, Sittingbourne	2	3		**Diarrhoea & Vomiting - Patients: One patient (HD) vomiting on 3/02/09 • One patient experiencing diarrhoea today however was given Senna yesterday and does have Crohns Disease. • Staff: Two staff phoning in sick today with vomiting (JM & MB) • Another staff member is experiencing diarrhoea, whom has been working this morning, on her way home.**	Closed the unit and have advised visitors of this.Samples have been requested from sufferers. One patient experiencing diarrhoea today however was given Senna yesterday and does have Crohns Disease. However we have implemented barrier nursing and isolating her in her room. Patients/staff encouraged to ensure they have good hand hygiene at all times.	I have notified the Continuing Care units and we have ensured no cross working by staff, throughout the unit, and for them to be aware of symptoms.	Health Protection have been notified, as has Christine Marsh – Locality Manager. Notified CMHT so no team members visit	Jayne Loader, Ward Manager	06/02/09 - Contacted the unit and discussed with SN Debbie Chapman the need to wash hands with soap and water, rather than use alcohol gel as a precautionary measure and to ensure that faecal specimens are obtained and are to identify the HPA's outbreak code and to request testing for noro virus and clostridum difficile toxins as well as other gastrointestinal infections. Notices placed on main entrance and inside ward alerting visitors/staff of outbreak.I requested that they should report to infection control team daily using the reporting form (as per Trust policy). 11/02/09 - All patients asymptomatic, no further cases reported. Deep clean arranged and ward re-opened. Michele Coleman.

19/02/2009	Sevenscore Ward TMHU	1			**Herpes Z (Shingles)**	1. All Staff involved in care informed of infection and made aware of universal precautions KHP guidelines 2. Dr responsible for care aware. 3. KHPU notified and gave advice as stated in KHP folder. 4. Infected site to be checked twice daily to ensure dry and not exudate.	Infection to be discussed with all Consultants in order for them to assess whether individual patients have compromised immunity.	Kent HPU Responsible Doctor Infection Control Team (via this document as not available on phone) Modern Matron	Michele Booth	03/03/09 - Vesicles have dried up, patient is now well and no cases of chicken pox reported as a result of this case of shingles. Michele Coleman.
02/03/2009	Ramsey Ward St. Martins Hosp Canterbury	2			**Diarrhoea**	Universal precaustions/ward closed as instructed by infection control specimens to be collected and sent to lab/signs	Universal precaustions and treatment prescribed	Infection Control Team HPA Paula Campbell	Sharon Harrion	03/03/09 - Contacted the ward re update. The ward is closed to discharges/admissions/transfers. SN Beverley to contact the KHPU to ask for an outbreak code to put on any faecal specimens sent for analysis. 2 patients have been symptomatic today, no further cases reported. Michele Coleman.
02/03/2009	Anselm Ward, St Martins Hospital	1			**Possible TB**	Advice sought fromHPA as patient currently has no insight into either MH or possible physical concerns, she has complained that Dr's have referred her for a chest X-ray as she does not see she has a problem. TB specialist contacted and they will contact the ward tomorrow. HPA advice is until TB is diagnosed nothing can be put in place.	Patient advised to cough into a tissue if needed and dispose	HPA, TB Specialist Nurse, Donna Eldridge	WM Christine Thompson	

Kent and Medway
NHS and Social Care Partnership Trust

ASSURANCE FRAMEWORK

Development Plan for Infection Control to meet the Code of Practice 2006. Health Care Associated Infections (HCAI's)

1. General Duty to protect patients, staff and others from HCAI

Duty	Self assessment	action	responsibility	comments	Progress
1a. Staff and others are protected against risk of HCAI's.	Annual audits of all areas will monitor this point. Staff training and updates. Infection Prevention and Control policy in place. Trust IC Committee in place Monthly/quarterly reports to Board.	Reports to Board Continue with audits and training. Ensure all areas has a copy of the HPU Infection Control Folder,	DIPC Associate Director of Nursing Lead Nurses Modern Matrons	Continuous Process	Evaluate progress by December 2008
1b. Patients with HCAI's are managed accordingly.	The Trust Infection Control (I.C.) Policy identifies the reporting system and system for advice and support.	All managers and staff to read and ensure that staff are aware of the I.C. Policy	DIPC Associate Director of Nursing Lead Nurses Modern Matrons		update by November 2008

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

Duty	Self assessment	action	responsibility	comments	Progress
2a. Board level agreement outlining its responsibility for Infection Control	Infection Prevention and Control policy in place. Trust infection control Committee in place. Monthly/quarterly reports to the Board.	Reports to Board which incorporate minutes from the Trust IC Committee	DIPC Associate Director of Nursing		September 2008
2b. Director of Infection Prevention and Control accountable to the board	DIPC in place job description reflects roles and responsibility.	Non Required	CEO		In place October 2007 and re-assigned October 2008

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

Duty	Self assessment	action	responsibility	comments	Progress
2c. Mechanisms are in place to secure effective prevention and control of HCAI's.	Monthly/quarterly board reports includes: IC surveillance data Training attendance I.C. Committee will monitor audit plans and surveillance data Yearly Audits undertaken Unannounced IC visits	Board Reports Monitoring of surveillance data Audit Action Plans	DIPC Associate Director of Nursing Lead Nurses Modern Matrons		Continue to be monthly April 2008
2d. ensuring staff and others receive suitable and sufficient training, information and supervision on prevention and control of infection	Induction and training for staff is provided and records of attendance kept. I.C. Policy identifies levels of training needed. Link nurses meetings	Learning and Development Department to monitor the number of staff undertaking the training Lead nurses to ensure attendance of the link nurse meetings	Learning and Development Dept Associate Director of Nursing Lead Nurses Modern Matrons.	The induction is for all staff and Facilities provide this for contractors	Has been on going since April 2008

	for the Trust				

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

Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
2e. Programme of audit to ensure implementation of policy and practice.	Audits are carried out in all service areas.	implement audit plan 07/08. Implement PEAT Action plans	Associate Director of Nursing Lead Nurses Modern Matrons	Audit commencing September 08. Hand Hygiene Audits underway	Audits completed November 2008
2f. A policy for addressing admission, transfer, discharge and movements of patients between departments and health care facilities.	Transfer check list between Acute Trust and Mental Health Trust in place Infection Control policy in place	Ensure the Transfer check list is used Monitor the HCAI transferred into the Trust from the Acute Trusts	Modern Matrons	The I.C. policy addresses admission, transfer, discharge and the movements of patients between departments and health care facilitators.	Completed October 2008

3. Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks.
The NHS body must ensure that it has:

Duty	Self assessment	action	responsibility	comments	Progress
3a. Assessments of the risks to patients from HCAI's.	Covered by the audit and service action plans. Monthly board report	NPSA "learning through Infection control" SUI form in place	Associate Director of Nursing Lead Nurses Modern Matrons	Continuous Process	Ongoing from April 2008
3b. Identified the steps that need to be taken to reduce or control those risks	Weekly reporting by the wards Surveillance of the IC data Infection Control policy in place Unannounced visits to the wards	Covered by the audit system and service action and also covered by the Infection Control Policy.	Associate Director of Nursing Lead Nurses Modern Matrons	Continuous Process	Ongoing from April 2008

3. Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks. The NHS body must ensure that it has:					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
3c. recorded its findings in relation to items (a) and (b)	IC Surveillance data base NPSA - Learning through action reporting Trust IC Committee Board Reports/minutes.	Monthly board reports Monitoring data base	Associate Director of Nursing Lead Nurses Modern Matrons	Continuous Process	Ongoing from April 2008
3d implemented the steps identified	Audit Action Plans PEAT action plans Unannounced visits	Monitoring through the IC committee Implementation through the link nurse meetings Implementation through the modern matron forums	Associate Director of Nursing Lead Nurses Modern Matrons	Continuous Process	Ongoing from April 2008

3. Duty to assess risks of acquiring HCAI and to take action to reduce or control such risks. The NHS body must ensure that it has:					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
3e. appropriate methods in place to monitor the risks of infection such that it is able to determine whether further steps need to be taken to reduce or control HCAI	IC Committee monitoring Weekly reporting by the wards Surveillance data base	Board reports	Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from May 2008

4. Duty to provide and maintain a clean and appropriate environment for health care. The NHS body must , with a view to minimising the risk of HCAI, ensure that:					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
4a. Policies for the environment make provision for liaison between the members of the Infection Control Team and the person with overall responsibility for facilities management.	PEAT assessment undertaken by facilities clinical staff and IC staff. Attendance to IC Link meetings.	Hotel Services and Facilities as members of the I.C. committee	Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008
4b. Designated managers for cleansing and decontamination of equipment in clinical areas.	Hotel Services responsible for cleaning Hotel Services managers in each directorate	Hotel Services to monitor cleaning and contract cleaners Monitor/report to the IC committee	Associate Director for Hotel Services Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008

	Modern matrons responsible for ensuring that ward equipment is decontaminated	Board Reports Modern Matrons to ensure that commodes/beds/hoists are decontaminated in accordance with manufacturers guidance.			

4. Duty to provide and maintain a clean and appropriate environment for health care.
The NHS body must , with a view to minimising the risk of HCAI, ensure that:

Duty	Self assessment	action	responsibility	comments	Progress
4c. The environment is clean and maintained in good physical repair.	Link meetings to discuss problems and concerns and highlight risk. PEAT Audits IC Audits.	Peat Audits to be actioned and responsibility for implementation of action plans to be owned by the modern matrons	Associate director for Hotel Services Associate Director of Nursing Lead Nurses Modern Matrons	PEAT Completed	June 2008 Repeated January 2009
4d. Details of cleaning standards are required in each part of the premises and a schedule of cleaning frequencies is publicly available.	PEAT assessments	Cleaning arrangements and standards of cleanliness together with a public notice of the frequency of cleaning must be available in the service areas for the public.	Associate Director for Hotel Services Associate Director of Nursing Lead Nurses Modern Matrons		In all Areas January 2009

4. Duty to provide and maintain a clean and appropriate environment for health care.
The NHS body must , with a view to minimising the risk of HCAI, ensure that:

Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
4e. Adequate hand washing facilities are available	Alcohol hand rub at point of care. Individual hand gel bottles for staff available Hand hygiene notices above all sinks Part of "Cleanyourhands "campaign	Role our "*cleanyourhands*" campaign throughout the Trust	Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008
4f. There are effective arrangements for the appropriate decontamination of instruments and other equipment. (as per 4b)	Hotel Services responsible for cleaning Hotel Services managers in each directorate Modern matrons	Hotel Services to monitor cleaning and contract cleaners for cleaning of beds/hoists/commodes Monitor/report to the IC committee	Associate Director for Hotel Services Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008

	responsible for ensuring that ward equipment is decontaminated	Board Reports Modern Matrons to ensure that commodes/beds/hoists are decontaminated in accordance with manufacturer's guidance.			

4. Duty to provide and maintain a clean and appropriate environment for health care.
The NHS body must , with a view to minimising the risk of HCAI, ensure that:

Duty	Self assessment	action	responsibility	comments	Progress
4h. Clothing worn by staff when carrying out their duties (including uniforms) is clean and fit for purpose.	Uniform and Workwear Policy in place Appropriate protective clothing is available to staff	Modern Matrons to monitor	Associate Director of Nursing Lead Nurses Modern Matrons		Policy in place April 2008

5. Duty to provide information on HCAI to patients and the public. The NHS body must ensure that it makes suitable and sufficient information available:					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
5a. Suitable and sufficient information is available to patient and the public.	Information leaflets Signage Board minutes	Public information needs to be made available about the organisations general systems and arrangements for preventing and controlling infection.	Associate Director of Nursing Lead Nurses Modern Matrons	Information aid memoire available for staff Patient information leaflets developed	Ongoing from April 2008
5b. to each patient concerning:	Information leaflets.	Review/replace HCAI information leaflets	Associate Director of Nursing Lead Nurses Modern Matrons	As above	Ongoing from April 2008

Any particular considerations regarding the risks and the nature of any HCAI that are relevant to their care, and Any preventative measures relating to HCAI that a patient ought to take after discharge.		Develop the Trusts web site with IC information			
6. Duty to provide information when a patient moves from the care of one health care body to another.					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
Provide suitable and sufficient information on the patients infection status when arrangements are made for discharge or transfer to other areas.	The patients care plan (CPA3) will be the most appropriate communication with a plan of how to minimise cross infection.	As part of a patients Transfer or discharge the patients infection status must be recorded and communicated to people that may be at risk.	All Clinical Staff		Ongoing from April 2008

7. Duty to ensure co-operation					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
Staff visitors and on site contractors have a duty to ensure co operation to enable the Trust can meet its obligations in the Code.	IC policy in place	Statement or guidelines for visitors and contractors in relation to their duty to co operate with each other. *	Associate Director of Nursing Lead Nurses Modern Matrons Facilities Department		Ongoing from April 2008

8. Duty to provide adequate isolation facilities.					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
8 Isolated areas are needed in each clinical area.	All wards and residential areas have an area that can provide the isolation of patients with infections. The majority of wards have single bedrooms with en suite facilities	No required		All patients have individual bedrooms and those areas that still have bays have access to single rooms for isolation	

9. Duty to ensure adequate laboratory support.					
Duty	**Self assessment**	**action**	**responsibility**	**comments**	**Progress**
9. Arrangements with microbiology services have appropriate protocols to meet their standards.	SLA with Acute Trust's Microbiology Services	Non required			

10. Duty to adhere to policies and protocols applicable to infection prevention and Control

Clinical Care Protocol		**action**	**responsibility**	**comments**	**Progress**
10a Appropriate Core Policies are in place. These are:-. Universal Precautions. Available. Aseptic Techniques Major Outbreak of infection. Isolation of patients Safe handling and disposal of sharps.	The Core Policies are guidelines provided by the Health Protection Agency. These policies will need to be reflected in the audit process, audit, revision and update. Infection control Policy	Review content of each. Awareness through Induction and mandatory training. Monitor compliance with hand hygiene and use of PPE.	Lead Nurses	Continuous Process	Ongoing from April 2008 The HPA have updated their guidance November 2008

Prevention of occupational exposure to blood borne viruses Closure of wards Disinfection Policy Antimicrobial Prescribing. Reporting of Infection to the HPA . Control of Infections minimum, MRSA, C.diff,					
Duty		**action**	**responsibility**	**comments**	**Progress**
10c. Major outbreaks of communicable infection	All staff should be fully aware of Trust Infection Control Policy and the procedure for the management of outbreaks Pandemic Flu policy	Awareness through Induction and mandatory training. Early detection of outbreaks Compliance audits. Communication to all levels of staff	Associate Director of Nursing Lead Nurses Modern Matrons Director of Social Care	Pandemic Flu contingency plan will be available for sign off by the CEO December 08	Ongoing from April 2008 December 2008
10d. Isolation of patients.	Infection control Policy		Modern matrons		Ongoing from April

	Single Bedrooms available in all wards/units				2008

10. Duty to adhere to policies and protocols applicable to infection prevention and Control

Duty		**action**	**responsibility**	**comments**	**Progress**
10e. Safe handling and the disposal of sharps	Inclusion of information on policy in induction programme for all staff groups. Actions to reduce rate of needle stick injuries	Awareness through Induction and mandatory training. Joint work with Occupational Health to raise awareness for the prevention of needle sticks injuries.	Occupational Health Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008

10f. Prevention of occupational exposure to blood borne viruses (BBVs)	Use of universal precautions at all times	Awareness through Induction and mandatory training. Audit compliance with I.C. policies	Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008

10. Duty to adhere to policies and protocols applicable to infection prevention and Control

Duty		**action**	**responsibility**	**comments**	**Progress**
10g. Management of occupational exposure to BBVs and post exposure prophylaxis	Clear information to health staff about reporting potential exposure and the need for prompt action.	Review/audit IRIS incidents of needle stick injury. Cascade lessons learnt.	Occupational Health, Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008

10h. Closure of wards, departments and premises to new admissions.	Policy shows clear criteria for closure, provision of advice from HPU and guidance on environmental deep cleaning		Associate Director of Nursing Lead Nurses Modern Matrons	Part of the I.C. Policy from HPU.	Ongoing from April 2008

10. Duty to adhere to policies and protocols applicable to infection prevention and Control					
Duty		**action**	**responsibility**	**comments**	**Progress**
10k. Reporting HCAI to the HPA and SHA as directed by the DH.	All outbreaks and SUI to be reported as per Trust guidelines	Reports for all outbreaks Sharing lessons learnt	DIPC Associate Director of Nursing Lead Nurses Modern Matrons		Ongoing from April 2008

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11. Duty to ensure, so far as reasonably practicable, that health care workers are free of and are protected from the exposure to communicable infections during the course of their work and that all staff are suitably educated in the prevention and control of HCAI
The NHS body must ensure that policies and procedures are in place in relation to the prevention and control of HCAI such that:

Duty	Self assessment	action	responsibility	comments	Progress
11.a All staff access Occupational Health 11.b Policy on Occupational Health –prevention and management of communicable infections in health care worker.	In place In place In place	Up date as new guidance is issued Review and develop training sessions			Ongoing from April 2008

11.c Induction and on going Training for all new staff. 11.d A programme of ongoing education for existing staff, contractors and locum staff. 11.e There is a record of training updates for all staff. 11.f The responsibilities of staff in preventing and controlling infection are reflected in job descriptions , personal development plans and appraisals.	In place In place In place	across all services. Establish training data base Implement “cleanyourhands” campaign across non acute sectors. Develop and sign off Link Practitioner role description. Devise work plan for link Practitioners			

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South East Coast Ambulance Service NHS Trust

Annual Health Check Report – Kent Health Overview & Scrutiny Committee

1. Introduction

1.1. The Annual Health Check core standards assessment is a self-assessment process undertaken by all Trust on an annual basis. In 2008 – 2009 there are 42 standards that apply to ambulance trusts, for which South East Coast Ambulance Service NHS Trust (SECAmb) will declare compliance with all standards.

2. Annual Health Check: Core Standards Assessment 2008 – 2009

2.1. To ensure a robust assessment of the Trust's position, and to embed these standards in the day to day operations of the Trust, for each standard an Executive Director and Senior Manager lead have been identified at element level. Throughout the year the nominated lead managers were asked to undertake regular reviews of the Trust's performance against the core standards, in preparation for the Trust's annual declaration of compliance.

2.2. In January 2009 a workshop was held for lead managers and Assistant Directors, to provide information and further support when undertaking the final review of the Trust's performance against the core standards. Patient and public representatives, as well as a staff union representative were also in attendance at this workshop.

2.3. Following the workshop, lead managers were asked to undertake a final review of the core standards, at element level, indicating the Trust's current position, evidence to support this, and any areas where gaps were identified, or further action required. Based on this information, leads were asked to provide an indicative assessment of compliance, at element level, ensuring that there was reasonable assurance to support this position.

2.4. This initial position was then reviewed by the Compliance and Assurance Working Group, with particular focus on those elements that were new for 2008 – 2009, or where there had been significant modifications. This group was able to scrutinise the assessments made, and provide an additional level of assurance to the assessment process, prior to review by the Trust's Executive Team.

2.5. The Executive Team were then able to review this initial baseline assessment and add further supporting evidence where appropriate. As a result of this review, a proposed assessment at standard level was made.

2.6. This assessment was then shared with the Trust's Integrated Governance Committee (a formal Committee of the Trust Board, with delegated powers of responsibility), on Tuesday 3rd March 2009. The Integrated Governance Committee were charged with ensuring that there was reasonable assurance for the Trust's anticipated declaration position, considering whether there were any significant lapses during the assessment period, and that the reasonable assurance was based on documentary evidence that would stand up to internal and external challenge.

2.7. Following the review by this Committee, a recommendation will be made to the Trust Board, for sign off at the meeting on 31st March 2009.

2.8. As part of the self-assessment process, SECAmb is actively engaging with selected third party organisations, to invite comments on the Trust's performance over the year. These include the Strategic Health Authority, local Overview and Scrutiny Committees, Local Involvement Networks, Local Safeguarding Children Boards and Learning Disability Partnership Board. Any comments received directly by the Trust from any of these partners will be included verbatim within the Trust's declaration.

2.9. The Trust is on schedule to submit the declaration, via the online tool provided, in time for the deadline of midday, Friday 1st May. Following submission, the Trust will ensure that the declaration is made available to the local community by Friday 22nd May 2009.

2.10. Attached is a summary of the assessment made by the Trust, to help inform the Integrated Governance Committee and Board decision-making process.

3. Compliance with the Hygiene Code – Registration with the Care Quality Commission

3.1. On 1st April 2009 a requirement will come into force (subject to parliamentary approval) for the regulation of activities relating to healthcare associated infections (HCAI).

3.2. The requirement sets out that a service provider in respect of carrying on of a regulated activity must, so far as reasonably practicable, ensure that patients, healthcare workers and others who may be at risk of acquiring a healthcare associated infection, are protected against such identifiable risks of acquiring such an infection by the means specified in the regulations set out by the Care Quality Commission (The CQC became a legal entity in October 2008 and takes up its responsibilities for the quality of health and social care in April 2009).

3.3. In order to register with the CQC, trusts must comply with the *The Health and Social Care Act 2008 (Registration of Regulated Activities) Regulations 2009,* which are being introduced from 1st April 2009. A full registration system is being introduced from 2010, when trusts will have to comply with a number of regulations as well as those on HCAI.

3.4. Following review by the Trust Board, the Trust submitted a declaration of compliance with the requirement for the regulation of activities relating to healthcare associated infections.

3.5. This assessment is made, based on 9 criteria, for which the trust is required to declare whether it meets, partly meets or fails to meet these. It is proposed that SECAmb declares that it meets all criteria, with the following exceptions:

3.5.1. Criterion 4 - *The trust ensures patients presenting with an infection or who acquire an infection during care are identified promptly and receive appropriate management and treatment to reduce the risk of transmission* – the Trust declared

partly met for this criterion as only part of the criteria is applicable to South East Coast Ambulance Service NHS Trust, in its role as a provider of ambulance services. Whilst the trust ensures that patients presenting with an infection are identified promptly, the reference to "[those]...who acquire an infection during care..." is not applicable.

3.5.2. Criterion 6 – *The trust provides or can secure adequate isolation facilities* – the Trust declared not met for this criterion as the criterion is not applicable to South East Coast Ambulance Service NHS Trust, as an ambulance service provider.

3.5.3. Criterion 7 – *The trust secures adequate access to laboratory support* – the Trust declared not met for this criterion as the criterion is not applicable to South East Coast Ambulance Service NHS Trust, as an ambulance service provider.

4. Focus on Core Standards C4a, C4c and C21 in practice

4.1. As part of the core standards assessment, the following section focuses on those standards that relate to infection control, namely C4a, C4c and C21.

4.1.1. *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 MRSA*

The element against which ambulance trusts are assessed for this standard is as follows:

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, revised January 2008).

The Trust complies with the requirements to keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infections (HCAI) to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, where applicable and so far as reasonably practicable. The Trust complies with the requirements to minimise the risks of healthcare infection to patients taking account of published practices and guidance from the Ambulance Service Association, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 and the Infection Control Nurses Association infection control practices for ambulance services, DoH Winning ways, DoH Saving Lives care bundles and Essential steps to safe, clean care: introduction and guidance.

The Infection Control Working Group (chaired by the Director for Infection Prevention and Control) meets bi-monthly to monitor and review current practices and assess the risks to patients and staff in relation to HCAI. Infection control audits have been undertaken with the findings fed back to the relevant parties through the Infection Control Working Group for actioning. In attendance at the meetings as external specialists are nurse specialists from the Health Protection Agency to support the infection control programme. Minutes from these meetings are reported to the Risk

Management & Clinical Governance Sub Committee (RMCGSC) and then to the Board.

The Trust has in post an Infection Control Manager BSc (Hons) and an Infection Control Advisor who report to the Director of Infection Prevention and Control (DIPC) as the internal specialists. The Trust has recognised the importance of communicating Infection Control information to staff, patients and the public. Information is published and accessible in the Weekly Bulletin and on the SECAmb web site and intranet.

Training and Education for Infection Control takes place on the Corporate Induction Course and through key skills training for staff, an e-learning package is currently being sourced to further the scope and accessibility for staff and managers.

4.1.2. *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*

The element against which ambulance trusts are assessed for this standard is as follows:

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).

The Trust has procedures in place to fulfil this criterion, such as the Medical Devices Management Policy and the Infection Prevention and Control Policy. The operational model and Make Ready model also support this in areas where established. In addition, the roles and responsibilities of operational staff require compliance to the policy when using medical equipment, or disinfecting medical equipment intended for reuse.

4.1.3. *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*

The elements against which ambulance trusts are assessed for this standard are as follows:

The ambulance service has systems in place and has taken steps to ensure its fleet is well designed, 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).

The Vehicle fleet is designed to provide a safe environment to all users, however the need for safety does not necessarily comply fully with the Disability Discrimination Act. All vehicles are built to EN1789 and EN1865 standards relating to safety, in accordance with European law. Whilst the Disability Discrimination Act, associated code of practice and legislation do not specifically relate to 'ambulances' various elements have been included in the vehicle design to ensure that vehicles are as

accessible as possible (tail lift access, high visibility handles and step edging, audible 'vehicle reversing 'alert).

Care is provided in clean ambulances that meet the relevant requirements of duty four of The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections (Department of Health, revised 2008).

The design of vehicles has developed to assist in the effective cleaning of vehicles. Staff are trained extensively how to decontaminate vehicles and equipment. SECAmb has implemented a trust wide deep cleaning regime on a six weekly basis. The trust also has two pilot sites for Make Ready in Hastings and Chertsey. Make Ready refills, restocks and cleans the vehicle on a daily basis, in line with shift patterns. A single set of products (ACTIV8) for the cleaning and decontamination of vehicles and equipment has been implemented across the Trust. ACTIV8 is approved by the HPA for this purpose.

4.2. Practical examples of compliance with Infection Control standards:

4.2.1. The Emergency Dispatch Centres inform crews responding to patients with a declared infectious condition, as and when information is received from healthcare partners. Crews are trained in the treatment and transfer of patients accordingly.

4.2.2. Each vehicle has Personal Protective Equipment (PPE) that complies with standard (universal) Infection Control precautions. In extreme circumstances, assistance may be sought from a make ready team, deep cleaning team, infection control team, specialist contractor or HPA (dependent upon the type and severity of risk associated with the infection).

4.2.3. It is the responsibility of the staff in the first instance to keep the vehicle and equipment clean and fit for use. This responsibility extends both to normal procedures and for significant contamination which may present during the course of the shift including the period between patients.

4.2.4. In those areas supported by ‘Make Ready’ the vehicles and its equipment therein, will pass through an auditable preparation system, addressing the corporate and clinical governance aspects of vehicle and equipment cleanliness and functionality.

4.2.5. The deep cleaning cycle (which is fully operational across the 63 sites of the trust) is aligned to the maintenance cycle of the vehicle. In practice this means that every six weeks a deep clean of the vehicle and all ancillary equipment is undertaken, so as to supplement the routine cleaning undertaken by staff at station level. Swab tests are completed across a range of predetermined sites within the vehicle.

4.3. Basic background statistics:

- Year to date figures, as at 9th March 2009, indicate that in 2008 – 2009, SECAmb have undertaken 346,142 emergency transport journeys (109,267 in Kent). Further information and breakdown of this is shown in Annex 1.

- The Trust has 232 A&E double manned ambulances (81 in Kent), 83 Single Response Vehicles (28 in Kent), 50 Support Tier Vehicles (10 in Kent) and 169 Patient Transport Service vehicles (48 in Kent). This information and further breakdown is shown in Annex 2.

- As an ambulance service provider, we do not monitor figures in relation to infection control, as we do not directly undertake testing of patients using microbiology laboratory facilities. This is undertaken by acute trust providers, who keep us informed of risk of any occurrences. The Health Protection Agency also keep us updated and informed of any outbreaks.

South East Coast Ambulance Service NHS
NHS Trust

Performance report

To Save Query in 'My Reports' Please supply a report name and click Save Report. Save Report

Report options Date : Between 01 Apr 2008 and 09 Mar 2009

Grouping	Emr T/port-journeys (i)	CatA Trans-ports (i)	CatB Trans-ports (i)	CatC Trans-ports (i)	Urg Trans-ports (i)	Rou Trans-ports (i)
Medway	17989	6448	6862	2749	0	910
Brighton and Hove City	23252	7587	8664	3827	245	384
East Sussex	46138	14930	15904	7383	593	355
Hampshire	10152	3179	4136	1720	1	0
Kent	109267	36877	39489	15610	5	989
Surrey	76961	22567	29239	12672	3	1
West Sussex	61627	21195	21042	9438	768	578
Unknown	756	276	285	53	13	47
Totals	346142	113059	125621	53452	1628	3264

Drilldown target List of calls Switch grouping Show percentage variance over previous year

Return to main menu

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VEHICLE NUMBERS – THE OPERATIONAL FLEET				
Former Trust	**A&E (DMA)**	**SRVs**	**STVs**	**PTS**
Kent	81	28	10	48
Surrey	59	32	24	6
Sussex	92	23	16	115
SECAmb	**232**	**83**	**50**	**169**
% of Total Fleet	**33%**	**11.8%**	**7.1%**	**24%**
% of AE Fleet	**63.6%**	**22.7%**	**13.7%**	

A&E (DMA) – A&E Double Manned Ambulances
SRVs – Single Response Vehicles
STVs – Support Tier Vehicles
PTS – Patient Transport Service

	Ref		Element	Position	Compliance position
D	**1**		**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**		
CS	**1**	**a**	**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**
E	1a	1	Incidents are reported locally via the appropriate reporting route/s to the National Patient Safety Agency (NPSA), Healthcare products Regulatory Agency (MHRA), Healthcare Commission, the Counter Fraud and Security Management Service and all other national organisations to which the healthcare organisation is required to report incidents.	All Incidents are now recorded on Datix Integrated Reporting Software systems and all report to the NPSA -NRLS system. Fair blame and open learning culture adopted by the trust. Staff can report incidents anonymously through a confidential hot line. Incident reporting policy agreed and new incident report form introduced and working well from 01/04/2008. The Trust has now installed the Datix system and work has been completed in linking to the NPSA -NRLS system. The MHRA are advised of any issues we have in relation to clinical equipment and we comply with any directions / advice that they give. Data is provided to the CFSMS regularly and upon individual requests. Any safety incident that requires reporting is reported to the appropriate regulatory body e.g. SHA, PCT, HSE.	Compliant

E	1a	2	Individual incidents are analysed rapidly after they occur to reduce further immediate risks, and where appropriate, individual incidents are analysed to seek to identify root causes, likelihood of repetition and actions required to prevent the reoccurrence of incidents in the future	All incidents are reviewed and are graded in line with Trust guidance. They are assessed both at station / office level and by the Risk Department upon receipt. Serious incidents are identified rapidly and allocated to managers to identify root causes. In addition the Trust has a risk analyst and an integrated recording system (Datix) which unifies incident reporting trust-wide. Through Datix reporting the Trust has an overall picture of trends which feeds in to the governance reporting processes of the organisation (e.g. RMCGSC and Trust Board). The trends include incidents, PALS, Complaints and FOI requests.	Compliant
E	1a	3	NEW ELEMENT: Reported incidents are aggregated and analysed to seek to identify common patterns, relevant trends, likelihood of repetition and actions required to prevent the reoccurrence of similar incidents in the future, for the benefit of patients / service users as a whole	All incidents are recorded on DATIX incident reporting system. This is analysed on a regular basis, information and trends of incidents and injuries by geographic area and type are provided to relevant committees within the Trust. This information is considered and, where necessary, actions are instigated to reduce their reoccurrence.	Compliant
E	1a	4	Demonstrable improvements in practice are made to prevent reoccurrence of incidents based on information arising from the analysis of local incidents and the national analysis of incidents by the organisations stated in element one	Where trends are identified via internal reporting, action is taken in conjunction with relevant departments to prevent a similar reoccurrence. Where guidance is received from outside bodies, e.g. CFSMS, this is integrated into the training within the Trust.	Compliant
CS	**1**	**b**	**Healthcare organisations protect patients through systems that ensure patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required time-scales**		**COMPLIANT**

E	1b	1	All communications concerning patient safety issued by the National Patient Safety Agency (NPSA) and the Medicines Healthcare products Regulatory Agency (MHRA) via national systems, including the Safety Alert Broadcast System (SABS), the Central Alert System (CAS) and the UK Public Health Link System are implemented within the required timescales	All alerts are received by the Risk, Health and Safety Manager and acknowledged and circulated as appropriate Trust-wide. Those which require action are then distributed via an agreed system and signed off upon return when action is complete to demonstrate an auditable trail. This is done within the timescales specified by the circulating body.	Compliant
CS	**2**		**Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations**		**COMPLIANT**
E	2	1	NEW ELEMENT: The healthcare organisation has made arrangements to safeguard children under Section 11 of the Children Act 2004 having regard to statutory guidance entitled *Statutory Guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004*	Child protection / Vulnerable Adult policies and procedures approved for NHSLA and were compliant with level 1 assessment. New database created to analyse trend data and to ensure that procedures being followed. Child protection / Vulnerable Adult Activity reported on a bi-monthly basis to the Clinical Audit and Information Working Group and to Trust Board as part of dashboard. Approval to recruit Child protection / Vulnerable Adult Assistant to support processes / referrals	Compliant
E	2	2	The healthcare organisation works with partners to protect children and participate in reviews, as set out in *Working together to safeguard children (HM Gov 2006)*	Child Protection Lead Manager appointed. The Trust is a member of all Local Safeguarding Children's Boards and the Child Death Review Panel. Participation at multi agency training days.	Compliant

E	2	3	NEW ELEMENT: The healthcare organisation has agreed systems, standards and protocols about sharing information about a child and their family both within the organisation and with outside agencies, having regard to *Statutory Guidance on making arrangements to safeguard and promote the welfare of children under Section 11 of the Children Act 2004*	Record kept of all appraisals. Part of responsibility of practice development manager. To date none have applied. When Practice Development Manager in place. Any that are appropriate to R&D WG, which is chaired by Medical Advisor.	Compliant
CS	**3**		**Healthcare organisations protect patients by following NICE Interventional Procedures guidance**		**COMPLIANT**
E	3	1	NEW ELEMENT: The healthcare organisation follows NICE interventional procedures guidance in accordance with *The interventional procedures programme (Health Service Circular 2003/011)*. Arrangements for compliance are communicated to all relevant staff.	Practice Development Manager responsible for the review of all NICE guidance and making recommendations to the Trust. Database maintained with all guidance from 2008/09 and its relevance to SECAmb. NICE website is regularly reviewed by Head of Clinical Governance, and email alerts received notifying of new guidance being released. The Trust has a quarterly meeting with a representative from NICE, and has recently been asked to submit an article showing how SECAmb implements NICE guidance as an example of best practice.	Compliant
CS	**4**	**a**	**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 MRSA**		**COMPLIANT**

E	4a	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, revised January 2008).*	The Trust complies with the requirements to keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infections (HCAI) to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, where applicable and so far as reasonably practicable. The Trust complies with the requirements to minimise the risks of healthcare infection to patients taking account of published practices and guidance from the Ambulance Service Association, Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance PROC 12 and the Infection Control Nurses Association infection control practices for ambulance services, DoH Winning ways, DoH Saving Lives care bundles and Essential steps to safe, clean care: introduction and guidance. The Infection Control Working Group (chaired by the DIPC) meet bi-monthly to monitor and review current practices and assess the risks to patients and staff in relation to HCAI. Infection control audits have been undertaken with the findings fed back to the relevant parties through the ICWG for actioning. In attendance at the meetings as external specialists are nurse specialists from the Health Protection Agency to support the infection control programme. Minutes from these meetings are reported to the Risk Management & Clinical Governance Sub Committee (RMCGSC) and then to the Board. The Trust has in post an Infection Control Manager BSc (Hons) and Infection Control Advisor who report to the Director of Infection Prevention and Control (DIPC) as the internal specialists. The Trust has recognised the importance of communicating Infection Control information to staff, patients and the public. Information is published and accessible in the Weekly Bulletin and on the SECAmb web site and intra-net. Training and Education for Infection Control takes place on the Corporate Induction Course and through key skills training for staff, an e-learning package is currently being sourced to further the scope and accessibility for staff and managers.	Compliant

CS	4	b	**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**
E	4b	1	The healthcare organisation has systems in place to minimise the risks associated with the acquisition and use of medical devices in accordance with guidance issued by the MHRA.	An appointed director or board member with overall responsibility for medical devices management is in post - Director of Technical services and Logistics. An advisory group in the guise of TS&L team meeting and the Vehciles and Equipment development group is in place, including those staff involved in the use, commissioning, maintenance, decontamination and decommissioning of medical devices. An organisation-wide devices management policy that covers acquisition, record keeping and equipment inventories; availability of manufacturer's instruction for use; training; repair and maintenance; single use devices use; decommissioning; disposal and actions required on manufacturer's corrective actions notices exist within the trust - Medical device management policy recently updated and ratified by RMCGSC	Compliant
	4b	2	NEW ELEMENT: The healthcare organisation has systems in place to meet the requirements of the *Ionising Radiation (Medical Exposure) Regulations 2000 [IR(ME)R]* and any subsequent amendment.	**Statute Application** These Regulations shall apply to the following medical exposures - (a) the exposure of patients as part of their own medical diagnosis or treatment; (b) the exposure of individuals as part of occupational health surveillance; (c) the exposure of individuals as part of health screening programmes; (d) the exposure of patients or other persons voluntarily participating in medical or biomedical, diagnostic or therapeutic, research programmes; (e) the exposure of individuals as part of medico-legal procedures. Ambulance services do not undertake these actions, therefore this is not applicable to the Trust.	Compliant
CS	**4**	**c**	**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**		**COMPLIANT**

E	4c	1	NEW ELEMENT: 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).	Compliant - procedures within the trust already fulfil this criterion, medical devices management policy, infection prevention and control policy to name but two. The operational model and Make ready model also support this in areas where established, alternatively the roles and responsibilities of operational staff require compliance to the policy when using medical equipment, or defecting medical equipment intended for reuse.	Compliant
CS	**4**	**d**	**Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely**		**COMPLIANT**
E	4d	1	Medicines are safely and securely procured, prescribed, dispensed, prepared, administered and monitored including in accordance with the *Medicines Act 1968* (as amended and subsequent regulations, including the Medicines for Human Use (Prescribing) Order 2005), the Health and Safety at Work Act 1974, as amended, and subsequent regulations including the Control of Substances Hazardous to Health Regulations 2002; and the good practice identified in *The safe and secure handling of medicines: A team approach* (RPS, March 2005) should be considered and where appropriate followed.	Current policies and procedure comply with the standard, however procedures will vary across SECAmb to reflect legacy arrangements and existing contracts. The procurement and supply of pharmaceutical products will be re tendered and redesigned (to reflect the changing operational model and the development of make ready) in 09/10 in order to standardise the procedures and management of medicines across the Trust. This is a planned output from TS&L development, however a robust logistics structure needs implementing to fulfil this objective. There will then be a requirement to develop with other directorates Ops, Clinical and Corporate Affairs - Security and Risk Departments) common programmes for the auditing, dispensing, prescribing and use of medicines.	Compliant
E	4d	2	Controlled drugs are handled safely and securely in accordance with the *Misuse of Drugs Act 1971* and amendments, *Safer management of controlled drugs: Guidance on strengthened governance arrangements (Department of Health, 2006)* and *The Controlled Drugs (Supervision of Management and Use) Regulations 2006*	Several audits undertaken with Local Counter Fraud Specialists - reports currently being written. New pocket books for recording the use of CDs rolled out across SECAmb. Approval for 2 pharmacy assistants to undertake continually audits of CDs. Exception reports submitted to Local Intelligence Networks on a quarterly basis. Drug losses reported to FASC.	Compliant

CS	4	e	**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**		**COMPLIANT**
E	4e	1	The prevention, segregation, handling, transport and disposal of waste is properly managed to minimise the risks to patients / service users, staff, the public and the environment in accordance with all relevant requirements referred to in *Environment and sustainability Health Technical Memorandum 07 - 01: Safe management of healthcare waste (Department of Health, November 2006)* and *Environment and Sustainability: Health Technical Memorandum 07-05: The treatment, recovery, recycling and safe disposal of waste electrical and electronic equipment (Department of Health, June 2007)*	Existing policies and procedures apply - not yet SECAmb policies due to contractual obligations. PC confirms compliance. Contractors are responsible for the collection and transportation of waste. The contractor is responsible for the notification of 'origin' and 'destination'.	Compliant
D	2		**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**		
CS	5	a	**Healthcare organisations ensure that they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care**		**COMPLIANT**

E	5a	1	NEW ELEMENT: The healthcare organisation ensures that it conforms to NICE technology appraisals where relevant to its services. Mechanisms are in place to: identify relevant technology appraisals; take account of clinical views and current practice in decision-making; and where necessary assess costs, and develop, communicate, implement and review and action plan for relevant technology appraisals.	Safeguarding Manager in post. CP/VA Procedures approved which include the sharing of information. Safeguarding Manager member of all relevant internal and external committees and participates in child death review panels and serious case reviews in which data and information is shared. CP/VA report forms include information about the patient and their family and social history which are shared with appropriate agencies. Safeguarding Manager member of LSCBs.	Compliant
E	5a	2	The healthcare organisation can demonstrate how it takes into account nationally agreed best practice as defined in national service frameworks (NSFs), NICE clinical guidelines, JRCALC guidelines, national plans and nationally agreed guidance, when delivery care and treatment. The healthcare organisation has mechanisms in place to: identify relevant guidance; take account of clinical views and current practice in decision-making; and develop, communicate, implement and review an action plan for appropriate guidelines.	Retrospective review still on going. Meeting held with NICE Regional Manager to develop automated altering system. Practice Development Manager due to start in March 2009. Head of Clinical Governance a member of the JRCALC National Guideline Group. In addition to the above to satisfy this criteria this is supported by the Clinical Audit and Information Working Group who monitors audit results and changes to clinical practice and their implementation. Clopidogrel introduced ahead of national implementation following representation from clinical advisors	Compliant
CS	**5**	**b**	**Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership**		**COMPLIANT**

E	5b	1	The healthcare organisation ensures that appropriate supervision and clinical leadership is provided to staff involved in delivering clinical care and treatment. Where appropriate, staff also have the opportunity to receive "clinical supervision"; and where appropriate, this is in accordance with guidance from relevant professional bodies. Arrangements for clinical leadership and supervision (including "clinical supervision") are communicated to all relevant staff. The effectiveness of these arrangements is monitored and reviewed on a regular basis and action is taken accordingly.	Clinical Team Leaders (or equivalent) in post across the Trust to provide support and supervision at local level. PDR's for clinical staff. Area Clinical Leads in post who provide update training. Practice Placement Educators (for Foundation Degree students). New staff undergo robust training programmes under supervision including hospital and community placements. Clinical Peer Review procedure approved by RMCGSC for implementation by CSM's but no evidence used so far. Reflection newsletters. PTS team Leaders in post. Limited evidence that tutors or clinical leads are members of decision making groups. ACL's are invited to attend COMS meetings but do not make decisions. ACL will be member of the newly formed Education, Development and Training working group, which is yet to meet. Clinical Simulation Suites. Instructional Methods courses provided. IHCD guidelines state Trainee Technicians must undertake 47 weeks training with a qualified professional. We deliver the 47 weeks but cannot evidence always with a qualified crew mate.	Compliant
E	5b	2	NEW ELEMENT: The healthcare organisation ensures that it provides opportunities for clinicians to develop their clinical leadership skills and experience.	Staff have opportunities to; become Peer Reviewers; undertake Instructional Methods Courses; PDPs will identify developmental needs.	Compliant
CS	**5**	**c**	**Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work**		**COMPLIANT**

E	5c	1	The healthcare organisation ensures that clinicians from all disciplines participate in activities to update the skills and techniques that are relevant to their clinical work in accordance with relevant guidance and curricula. This includes identifying and reviewing skills needs and skills gaps; providing and supporting on-the-job training and other training opportunities; and where appropriate working in partnership with education and training providers to ensure effective delivery of training.	Training needs are identified both by line management/supervisory processes, personal development reviews and in response to PALS and complaints. There is a rolling programme of update (Key Skills) training: 1253 (81.62%) of operational staff have received their key skills updates, the remaining 18.32% need to receive training between Oct 07- Mar 09. Trust board agreed to deliver key skills training on a bi-annual basis for the period March 07 - March 09. A trajectory for the delivery of outstanding training has been developed in September 08 and agreed by the Executive Team. Plan submitted and agreed at the Oct 08 RMCGSC. Operations Directorate are committed to releasing the staff against the trajectory (3 x 12 staff per week) up to end March 09. Progress against the training trajectory to be reported to all Executive Team meetings. If staff are released as agreed, all training will be completed by mid February 09. Key Skills Course Programme details the clinical skills components for A&E staff. PTS Refresher Course programme does the same for non-emergency staff. Course registers demonstrating staff attendance. Achievement of outcomes can be evidenced with completed record books and assessment papers. SDP 08/09. Risk Register.	Compliant
CS	**5**	**d**	**Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services**		**COMPLIANT**

E	5d	1	The healthcare organisation ensures that clinicians are involved in prioritising, conducting, reporting and acting on clinical audits	The Trust has a Clinical Audit Manager and support staff to oversee the audit activity. The Trust has established a Clinical Audit working group to oversee the Trusts audit activity - the membership of this group includes operational and clinical staff. Staff are also involved in trials and evaluations of new equipment. Clinicians are involved in individual audits and are named as contributors on the audit reports. The Trust has an annual clinical audit plan which is RMCGSC approved. The Trust also participates in national audits as defined by the DOCCS group. Protocol C and Overdose trials include auditing of clinical records and staff completing audit forms around their use.	Compliant
E	5d	2	The healthcare organisation ensures that clinicians participate in regular reviews of the effectiveness of clinical services through evaluation, audit or research	Trust has an R&D working group with staff as members. Staff also identified to participate in local clinical evaluations e.g. CPAP, Activated Charcoal, Protocol C. Two R&D Managers, development opportunities provided for these staff; In year research proposals; Feedback from paramedics, pan SECAmb, re EZIO, CPAP Trial wasn't successful for funding. Currently working with Brighton and Sussex University Hospital to develop a SECAmb CPAP research project. Second R&D project being developed with member of ETD re spinal care, list of red projects approved by medical committee and RMCGSC, research project commenced relating to CPIs where interested staff participated following an advert in the weekly bulletin.	Compliant
CS	**6**		**Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met**		**COMPLIANT**

E	6	1	The healthcare organisation works in partnership with colleagues in other health and social care organisations to ensure that the individual needs of patients / service users are properly managed and met where responsibility for the care of a patient is shared between the organisation and one or more other health and / or social care organisations and / or where the responsibility for a patient's care is moved (due to admission, referral, discharge or transfer) across organisational boundaries. Where appropriate these arrangements are in accordance with Section 75 partnership arrangements of the NHS Act 2006 (previously Section 31 of the Health Act 1999) and The Community Care (Delayed Discharges etc.) Act 2003 and *Discharge from hospital pathway, process and practice (DH, 2003).* Where appropriate, these arrangements are in accordance with the relevant aspects of the following guidance, or equally effective alternatives: *Guidance on the Health Act Section 31* partnership agreements (DH, 1999), Guidance on partnership working contained within relevant National Service Frameworks and national strategies (for example, the National Service Framework for Mental Health (DH, 1999), the National	The Healthcare Organisation has, with PCT/Acute partners develop a system, known as the Directory of Service (DoS) which assesses and recommends eligible patients for referral to Intermediate care teams or falls teams. These PCT/Acute funded teams further assess the patient's home address and social conditions and take appropriate action to reduce/minimize the risk of further falls within the home. The DoS, uses the National Service Framework assessment tool for falls, to assure governance and appropriate referral. DoS requires 1 patient clinical record, 1 completed NSF assessment tool only to refer. For appropriate patients the attending clinicians (in hours) request a conference call (which is recorded) with the Intermediate care/fall teams via the Control Centres, providing a complete governance assurance. The management of the DoS is undertaken by the Dos Board which has members from PCT/Acutes, all issues including adverse incident (to date there have been none) are discussed. The DoS was implemented over a 12 week period. The pilot was formally assessed through an interim (December 2008) and final report (Due in February 2009). The basis of this report will ensure patient satisfaction and appropriate referral. The final stage is to implement SEC wide. The Healthcare organisation has a number of Direct Admission facilities available to it, including Coronary Care, pPCI and Stroke. In all areas locally agreed protocols and admission procedures have been agreed, this is not available across the whole SEC but the Healthcare organisation is committed to increase these facilities with Acute partners as and when they are available. The Service Development Team ensure that each pathway is	Compliant

		Service Framework for Older People (DH, 2001), and the Cancer Reform Strategy (DH, December 2007)), The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (DH, 2007).	implemented correctly using its experience and knowledge of implementing DoS/pPCI. The healthcare organisation has worked closely with local government and public health organisations to share information which is useful for clinical pathway development, especially those from ethnic or minority groups, as these groups can sometimes be small sharing larger datasets informs better decisions. These are clearly shared in respect of child abuse and vulnerable adults, where multiagency input is required. All policies and procedures are shared and made available to all internal staff, where appropriate media is used for recollection. All policies have appropriate staff side input. Where the healthcare organisation requires multiagency input into policies and procedures, these are developed at the appropriate programme board where external partners have the opportunity for input. Final sign off will be at the appropriate Board designated committee.	

E	6	2	NEW ELEMENT: Staff concerned with all aspects of the provision of healthcare work in partnership with colleagues in other health and social care organisations to ensure that the needs of the patient / service user are properly managed and met.	The Healthcare Organisation has, with PCT/Acute partners develop a system, known as the Directory of Service (DoS) which assesses and recommends eligible patients for referral to Intermediate care teams or falls teams. These PCT/Acute funded teams further assess the patient's home address and social conditions and take appropriate action to reduce/minimize the risk of further falls within the home. The DoS, uses the National Service Framework assessment tool for falls, to assure governance and appropriate referral. DoS requires 1 patient clinical record, 1 completed NSF assessment tool only to refer. For appropriate patients the attending clinicians (in hours) request a conference call (which is recorded) with the Intermediate care/fall teams via the Control Centres, providing a complete governance assurance. The management of the DoS is undertaken by the Dos Board which has members from PCT/Acutes, all issues including adverse incident (to date there have been none) are discussed. The DoS was implemented over a 12 week period. The pilot was formally assessed through an interim (December 2008) and final report (Due in February 2009). The basis of this report will ensure patient satisfaction and appropriate referral. The final stage is to implement SEC wide. The Healthcare organisation has a number of Direct Admission facilities available to it, including Coronary Care, pPCI and Stroke. In all areas locally agreed protocols and admission procedures have been agreed, this is not available across the whole SEC but the Healthcare organisation is committed to increase these facilities with Acute partners as and when they are available. The Service Development Team ensure that each pathway is implemented correctly using its experience and knowledge of	Compliant

				implementing DoS/pPCI. The healthcare organisation has worked closely with local government and public health organisations to share information which is useful for clinical pathway development, especially those from ethnic or minority groups, as these groups can sometimes be small sharing larger datasets informs better decisions. These are clearly shared in respect of child abuse and vulnerable adults, where multiagency input is required. All policies and procedures are shared and made available to all internal staff, where appropriate media is used for recollection. All policies have appropriate staff side input. Where the healthcare organisation requires multiagency input into policies and procedures, these are developed at the appropriate programme board where external partners have the opportunity for input. Final sign off will be at the appropriate Board designated committee.	
D	3		**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**		
CS	**7**	**a**	**Healthcare organisations apply the principles of sound clinical and corporate governance**		**COMPLIANT**
CS	**7**	**c**	**Healthcare organisations undertake systematic risk assessment and risk management**		

E	7ac	1	The healthcare organisation has effective clinical governance arrangements in place to promote clinical leadership and improve and assure the quality and safety of clinical services for patients / service users	SECAmb Risk Management Policy and other supporting policies, ratified by Risk Management Clinical Governance Committees and/or the board. To ensure integrated Governance is adopted and embedded within the trust an Integrated Governance Committee enhances the risk management link between the Board and RMCGSC. This committee oversees the approval of any sub-groups and requires their minutes to be forwarded for inclusion in the agenda. This committee's main function is to performance monitor risk reduction through the risk register and ensures information is shared with relevant Board sub-committees. Risk Management Clinical Governance Committee with Chief Executive as a member. Existing trust policies clearly defined responsibility & accountability for risk management and all its aspects. Head of Clinical Governance in post. Assistant Clinical Director in post. Clinical Governance Objectives within SDP.	Compliant

E	7ac	2	The healthcare organisation has effective corporate governance arrangements in place that, where appropriate, are in accordance with *Governing the NHS: A guide for NHS boards (Department of Health and NHS Appointments Commission 2003)* and the *NHS trust model standing orders, reservation and delegation of powers and standing financial instructions March 2006,* (DH, 2006).	The trusts Standing Orders, Scheme of Delegation and Standing Financial Instructions are in accordance with the NHS model standing orders March 2006 and include the implications of the Health Act 2006. The SOs, SD and SFIs are reviewed annually by the trust and that review includes legal advice. Strategic aims set out in the Trust Business Plan which is monitored and reported quarterly via the Strategic Development Plan update. Strategic objectives contained within the assurance framework which is monitored by the Board. Exception reporting of SDP progress highlighted at the Risk Management and Clinical Governance Sub Committee with escalation process to the Integrated Governance Committee. Involvement and consultation events held in summer 2008 to engage stakeholders in refreshing the Strategic Development Plan - patients, public, staff, healthcare providers, PCTs, SHA and local authorities. The Trust has regular meetings with its commissioners via a joint commissioning system for A&E contracts and with a range of trusts for PTS contracts. Monitoring meetings along with involvement in the wider context of PCT operating frameworks routinely informs plans. The Integrated Governance Committee is constituted as the Trust's Audit Committee and has a full remit on internal control. The Committee meets bi monthly and reports to the Board. One of the NEDs has significant, recent and relevant financial experience and chairs the Finance and Audit Sub Committee of the IGC. There is a Remuneration and Terms of Service Committee constituted and reporting as specified. The trust has an effective assurance framework in a compatible format which is regularly updated and reported to the Board.	Compliant

E	7ac	3	The healthcare organisation systematically assesses and manages its risks, both corporate / clinical risks in order to ensure probity, clinical quality and patient safety.	The Trust has a Risk Management strategy that is reviewed on an annual basis and available to staff on the Trust's intranet. SECAMB now has a Trust wide risk register which is categorised by directorate (e.g. Clinical, Operations, Finance etc.) and is a standing agenda item on a number of committees and the Trust Board. In addition the risk register is routinely discussed at Exec meetings and any amendments must now be authorised by the appropriate Director and notified to the Head of Risk Management. The Risk Register is now available via SharePoint with open viewing but restricted editing rights. Risks to the Trust's strategic objectives are recorded in the Trust's Assurance Framework. Board received risk management training via the Trust's appointed internal auditors, meeting the ALE criteria.	Compliant
CS	**7**	**b**	**Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources**		**COMPLIANT**

E	7b	1	The ambulance service actively promotes openness, honesty, probity and accountability to its staff and ensures that resources are protected from fraud and corruption in accordance with the *Code of conduct for NHS managers (Department of Health 2002), NHS Counter Fraud and Corruption Manual Third Edition (NHS Counter Fraud Service, 2006)* and having regard to guidance or advice issued by the CFSMS.	The Trust has a code of conduct policy in place which incorporates the code of conduct as well as the Nolan Principles. An effective counter fraud function is in place. Gifts and hospitality declarations along with declarations of interest are controlled by policy, widely communicated declaration process and the keeping of registers. Declarations are routinely invited at Board meetings. Staff conduct is set out in the adopted policy, the trust publicly sets out its performance and use of resources in public board meetings, accounts and annual report. The trust consults with Commissioners and the SHA regularly on performance, use of resources and service delivery and works through a PCT Lead Commissioner for A&E services. There is a lead LCFS function with appropriate training along with a security management function. Reporting is via the FASC up to the IGC. The Trust has a contract with South Coast Audit for supply of the Counter Fraud service, for which responsibility is retained by the Director of Finance and the Chief Executive.	Compliant
CS	**7**	**e**	**Healthcare organisations challenge discrimination, promote equality and respect human rights**		**COMPLIANT**

E	7e	1	The healthcare organisation challenges discrimination and respects human rights in accordance with: the *Human Rights Act 1998; No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse (Department of Health, 2000);* the general and specific duties imposed on public bodies in relation to race, disability and gender (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the "public body duties"; "Employment and equalities legislation" including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time. "Acting in accordance with 'public body duties'" means: Acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following statutes: Race Relations (Amendment) Act 2000; Disability Discrimination Act 2005; Equality Act 2006; and, where appropriate, having due regard to the associated codes of practice. "Acting in accordance with 'employment and equalities legislation'"	The SES and Action Plans were published in April 2008. This covers 6 equality strands and reference to Human Rights. The SES summary was published to ensure wider awareness and launched at a series of high profile public and staff engagement events. A framework has been developed for the delivery of robust Equality Impact Assessment [EIAs]. We are ensuring that disabled people are involved in the EIA process and that consultation relating to race and gender takes place. Training for staff on EIA has been provided. Three staff led equalities networks have been established – Pride in SECAmb [LBGT], Aspire [BME & Minority Faith] and Making Diversity Happen [Disability and Carers]. These groups will be involved through consultation in the EIA process. SECAmb has been awarded the Two Ticks – Positive about Disability status and has become a Diversity Champion through Stonewall. In addition the Trust is a Pacesetters Wave 2 Site and has been awarded Positively Diverse Lead Status by the NHS Confederation. Through this work SECAmb is making progress in looking at ways it can better address health inequalities and so challenge discrimination. The Trust has appointed two senior E&D Staff, who will contribute to promoting equality of access & opportunity, as well and supporting diversity in relation to our public and patient involvement work, as well as in the workforce - in line with our SES. SECAmb has also developed a framework and guidance for the delivery of robust Equality Impact Assessments. SECAmb's approach to Equality Impact Assessments is underpinned by the principles set down in the Codes of Practice. SECAmb has decided to adopt an approach based on risk and proportionality. SECAmb seeks to ensure where appropriate	Compliant

		means: Acting in accordance with relevant legislation including: Equal Pay Act 1970 (as amended); Sex Discrimination Act 1975 (as amended); Race Relations Act 1976 (as amended); Disability Discrimination Act 1995; Employment Equality (Religion or Belief) Regulations 2003; Employment Equality (Sexual Orientation) Regulations 2003; Employment Equality (Age) regulations 2006; Part Time workers (Protection from Less Favourable Treatment) Regulations 2000; Fixed Term Employees (Protection from Less Favourable Treatment Regulations 2002); Employment Rights Act section 80F-I relating to the right to request flexible working); Working Time Regulations 1998 (as amended); and, where appropriate, having due regard to the associated codes of practice.	disabled people are involved in the EIA process and that there is appropriate consultation on issues relating to race and gender. Staff have been provided with access to training and are currently being offered guidance and experiential training on Equality Impact Assessments. In addition community groups are being invited to contribute to the delivery of effective equality impact assessments in the future. SECAmb has provided support for the establishment of three staff led networks. The OD Manager is continuing to review the establishment of a wider Equality and Diversity training course. An Equality and Diversity Module continues to be offered to all new starters within the new starter induction programme and within Personal Skills Update days. This training includes reference to respect and dignity and promoting human rights. The PPI Manager -Diversity and Equality Manager, is working to ensure all the diverse groups served by SECAmb are involved in the development of plans and services, especially in relation to the core strands: age, disability, ethnicity, gender, religion, sexual orientation, gender identity and human rights. The PPI Manager – E&D Manager is continuing to ensure that: equality and diversity is embedded into our work and service delivery; partnerships with a wide range of stakeholders are being put in place; the Patient Experience Team are developing an understanding of the full diversity of community need, ensuring that the perspectives of all of our communities are included in our work.	

E	7e	2	The healthcare organisation promotes equality, including by publishing information specified by statute, in accordance with: the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under: The Race Relations (Amendment) Act 2000; The Disability Discrimination Act 2005; The Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.	The SES and Action Plans were published in April 2008. This covers 6 equality strands and reference to Human Rights. The SES summary was published to ensure wider awareness and launched at a series of high profile public and staff engagement events. A framework has been developed for the delivery of robust Equality Impact Assessment [EIAs]. We are ensuring that disabled people are involved in the EIA process and that consultation relating to race and gender takes place. Training for staff on EIA has been provided. Three staff led equalities networks have been established – Pride in SECAmb [LBGT], Aspire [BME & Minority Faith] and Making Diversity Happen [Disability and Carers]. These groups will be involved through consultation in the EIA process. SECAmb has been awarded the Two Ticks – Positive about Disability status and has become a Diversity Champion through Stonewall. In addition the Trust is a Pacesetters Wave 2 Site and has been awarded Positively Diverse Lead Status by the NHS Confederation. Through this work SECAmb is making progress in looking at ways it can better address health inequalities and so challenge discrimination. The Trust has appointed two senior E&D Staff, who will contribute to promoting equality of access & opportunity, as well and supporting diversity in relation to our public and patient involvement work, as well as in the workforce - in line with our SES. SECAmb has also developed a framework and guidance for the delivery of robust Equality Impact Assessments. SECAmb's approach to Equality Impact Assessments is underpinned by the principles set down in the Codes of Practice. SECAmb has decided to adopt an approach based on risk and proportionality. SECAmb seeks to ensure where appropriate	Compliant

				disabled people are involved in the EIA process and that there is appropriate consultation on issues relating to race and gender. Staff have been provided with access to training and are currently being offered guidance and experiential training on Equality Impact Assessments. In addition community groups are being invited to contribute to the delivery of effective equality impact assessments in the future. SECAmb has provided support for the establishment of three staff led networks. The OD Manager is continuing to review the establishment of a wider Equality and Diversity training course. An Equality and Diversity Module continues to be offered to all new starters within the new starter induction programme and within Personal Skills Update days. This training includes reference to respect and dignity and promoting human rights. The PPI Manager -Diversity and Equality Manager, is working to ensure all the diverse groups served by SECAmb are involved in the development of plans and services, especially in relation to the core strands: age, disability, ethnicity, gender, religion, sexual orientation, gender identity and human rights. The PPI Manager – E&D Manager is continuing to ensure that: equality and diversity is embedded into our work and service delivery; partnerships with a wide range of stakeholders are being put in place; the Patient Experience Team are developing an understanding of the full diversity of community need, ensuring that the perspectives of all of our communities are included in our work.	
CS	**8**	**a**	**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**

E	8a	1	Staff are supported, and know how, to raise concerns about services confidentially and without prejudicing their position including in accordance with The Public Disclosure Act 1998: Whistle blowing in the NHS (HSC 1999/198).	Whistle blowing policy in place. Summary of policy is given to all support groups (Listeners, Welfare Representatives and Bullying and Harassment Advisors). Whistle Blowing Posters in all stations, HQ and Area Offices. Whistle blowing information cards available on all stations, HQ and area offices. Summary of policy and poster available on the intranet. Reminders in the Bulletin.	Compliant
CS	**8**	**b**	**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**

E	8b	1	The healthcare organisation supports and involves staff in organisational and personal development programmes as defined by the relevant areas of the *Improving Working Lives* standard at *Practice Plus Level* and in accordance with *"employment and equalities"* legislation [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.	As part of work life balance, flexible approaches to working have been implemented throughout the Trust. This includes options such as annualised hours, part-time working, job shares, flexible retirement opportunities. Staff are involved in the drawing up of new rota parameters and shift patterns to support Call Connect requirements whilst adhering to AfC agreements. Operational Development Group attended by operational and clinical staff. Appraisal process developed by HR. Appraisals currently delivered in the clinical environment are as a result of performance issues with developmental programmes created as a result of these. Assistant Directors development programme. Trust Board development programme. Placements for some directors on the Kings Fund. Adverts for clinical care progression such as foundation degree, CCP's, PP's and instructional methods course do not discriminate. Evidence of BME staff selected for Instructional Methods course and BME staff on Instructor Qualifying Course. Qualifier course, however not able to evidence whether these numbers reflects the Trust BME staffing levels. The clinical directorate is not aware of any IWL Practice Plus follow up audits since accreditation. Training and Development opportunities are provided both through the Training Centres and through external resources. Staff are given protected time 'off the road' to attend training courses. Training is offered to staff at all stages of their careers from induction training when they first start through to preparation for retirement. This has included support for staff with literacy and numeric problems. Applications from staff for external management training are positively received and actively encouraged. This area of training provides the core skills for career development.	Compliant

E	8b	2	Staff from minority groups are offered opportunities for personal development to address under-representation in the workforce compared to the local population in accordance with "employment and equalities" legislation [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.	The IPDR system now in place applies to all staff giving access to opportunities to develop to all. Clear criteria for approving funding and release from duty to attend training and development opportunities which do not take account of individual's status, gender, ethnicity etc. Support available for staff in minority groups to access further training and development	Compliant
CS	**9**		**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**

E	9	1	The healthcare organisation has effective systems for managing records in accordance with *Records management: NHS code of practice (Department of Health April 2006), Information security management: NHS code of practice (DH, April 2007)* and *NHS Information Governance (DH, September 2007).* The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and demonstrate that they are complying with supplemental mandates and guidance if they are introduced during the assessment period.	The Trust has robust mechanisms in place for managing records in accordance with the Records Management Code of Practice. This is supported by staff training; confidentiality clauses in contracts; appropriate disciplinary procedures and information governance policies. These are readily accessible to staff on the Trust's Intranet. The Trust has centralised the management of health records; since mid April 2008, all records have been scanned and are held electronically. Data from these scanned records is downloaded and used to inform clinical audit. Data quality processes are in place to ensure the confidentiality, integrity and availability of records. Access to patient records are based upon a legitimate need to know and decisions are taken in accordance with Trust policies. The Trust has complied with the actions contained in the NHS Chief Executive's letter of 20th May 2008. Any information security issues/data losses are reported through the Trust's Incident Reporting Procedure and action taken to inform the SHA where appropriate. The Director of Corporate Affairs and Service Development is the Trust's appointed SIRO.	Compliant
E	9	2	NEW ELEMENT: The information management and technology plan for the organisation demonstrates how a correct NHS Number will be assigned to every clinical record, in accordance with *The NHS in England: the Operating Framework for 2008 / 2009 (DH, December 2007)*	Strategy for recording NHS Numbers first approved in March 2008. V2 approved at Feb 2009 RMCGSC. Links have been established with the NHS Tracing Service and data exchanged to collect/validate NHS numbers. The new CAD system will also have an NHS number field in readiness for e-prf.	Compliant
CS	**10**	**a**	**Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies**		**COMPLIANT**

E	10a	1	The necessary checks are undertaken in respect of all applications for NHS positions (prospective employees) and for staff in ongoing NHS employment in accordance with the NHS Employment Check Standards (NHS Employers 2008).	All newly appointed staff (new to the NHS or from an existing NHS employer) undergo pre-employment screening inline with the NHS Employment check standards 2008. Day to day responsibility for these checks being completed has been given to the Recruitment Coordinator/Advisor for the particular area of the organisation; these staff have a high awareness of the importance of this task and its link with patient safety. The checks comprise of the following: Criminal Record - Enhanced CRB's are requested for all patient interfacing staff inline with CRB guidance. Occupational Health - Questionnaires are completed for all new staff and telephone and/or face to face appointments arranged where deemed necessary by our health advisors. Following this the third party providers coordinate the necessary vaccinations for operational staff. Verification of Identity - Original copies of ID are reviewed and photocopied at either interview or assessment stage and held on an employee's personnel file. Registration and Qualification - Original copies of qualifications and registration are reviewed and photocopied at interview or assessment stage. HPC registration is checked online to confirm currency and/or restrictions in practice and held on personnel file/communicated to Clinical Education where appropriate. Employment History and References - References are sought from current and most recent employers. Any unexplained gaps in employment history are probed at interview and recorded accordingly. Where applicable the necessary immigration checks are also made in addition to our usual screening. Where an employee does not have employment references, an appropriate alternative referee will be approached. A folder with the current employment check standards (March 2008) is held by the Recruitment Services	Compliant

				Manager located in the Trusts Recruitment Service Centre at HQ. The auditing arrangements for pre-employment screening have recently been jointly reviewed by the Assistant Director of HR (West) and the Recruitment Services Manager and incorporated within the revised Recruitment & Selection Policy (2008). Internal applicants are also required to complete pre-appointment checks, where they are changing role within the organisation. These typically include occupational health (where the role varies significantly from their previous post), a new CRB disclosure, line manager reference and fitness test. Volunteers are subject to the same checks as paid employees. In all cases, employment offers are subject to meeting the above screening checks and failure to do so will result in withdrawal of the offer.	
CS	**10**	**b**	**Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice**		**COMPLIANT**

E	10b	1	The healthcare organisation explicitly requires all employed healthcare professionals to abide by relevant codes of professional conduct. Mechanisms are in place to identify, report and take appropriate action when codes of conduct are breached.	Professional Codes of Conduct only exist for registered healthcare professionals: for SECAmb this means Doctors, Nurses, Paramedics. PTS, ECSWs and Technicians are not covered by professional codes of conduct and would therefore need to be bound to Trust Codes of Conduct by their contracts and job descriptions. Scope of Practice Policy describes the range of practice for each clinical role. Clinical Supervision Policy: Describes the mechanisms in place to ensure that clinicians stay within their scope of practice and the supervisory mechanisms in place to monitor and support this. Clinical Peer Review Procedure: Describes the mechanism by which errors can be reviewed and turned into learning events for all clinicians. It also describes the events that require report to the registering bodies. Verification of Professional Registration Policy: describes the mechanism for ensuring clinicians are registered. Investigation Procedure: Describes the process for investigating possible breaches of codes of conduct, amongst other possible issues. Disciplinary Procedure: describes the process by which punitive sanctions can be made against an individual found to have breached codes of conduct. Capability Policy: describes the process for responding to inability to achieve and sustain satisfactory performance at work arising from lack of skill or aptitude.	Compliant
CS	**11**	**a**	**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**

E	11a	1	The healthcare organisation recruits staff in accordance with "employment and equalities legislation" [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.	The Recruitment function has been successfully centralised and a new Recruitment Service Centre set up at HQ. One of the key aims of the function is to ensure that all job applicants and employees receive equally favourable treatment regardless of sex, sexual orientation, race, colour, age, nationally, religious belief or disability. The Trust takes steps not just to avoid discrimination as required by law, but actively promote best practice. The only criteria used for assessing employees for recruitment, promotion and development is suitability, performance and merit. The procedure endorses best practice and has the full support for SECAmb's Trust board. The Trust has also launched a Single Equalities Policy and Action Plan and a summary of the scheme is freely available internally and externally. The scheme reinforces commitment to valuing diversity, equal access for patients and equality of opportunity for staff. As an employer, the Trust ensures that all employees work in an environment which represents and includes everyone and is free from discrimination, harassment and unequal treatment. Given the supply of UK based labour and internal staff development, it is rare to have to engage in international recruitment, however consideration is given to any individual and the Trust will advise overseas applicants regarding professional registration e.g. with the HPC when necessary. The HR department collates and monitors Equal Opportunities data on job applicants and this is reported to senior management on a regular basis. All of the recruitment service team have been trained by the Organisational Development department in best practice recruitment, including Equal Opportunities. Standards continue to be monitored on a day to day basis by the Recruitment Services	Compliant

Manager. Regular workshops are run for line managers involved in recruitment and selection interviewing, these have proved popular. Representatives of Recruitment Services have actively participated in Brighton & Hove Pride, a well attended event celebrating Gay, Lesbian, Bisexual and Transgender diversity. The Stonewall diversity champion logo is used on all advertisements. The Flexible Working Policy allows staff to request flexible working arrangements to enable them to care for children or dependants. This option is potentially available to all staff and details are available on the intranet. The Trust participates fully in the two-tick "Positive about Employing Disabled People" and has recently forged new links with Job Centre Plus's Disability Advisor and Shaw Trust, who assist clients of job centre plus in gaining employment. Application material can be made available in other formats that may be more accessible for some disabled people. The aim of this relationship is to promote the Trust to disabled applicants and ensure that they are supported and encouraged during and following their application. The logo appears on all recruitment advertisements. There are currently plans underway for key players in the employment and welfare process to meet and discuss support mechanisms for disabled staff joining the Trust i.e. for Managers of disabled staff and the staff themselves, this is an ongoing work stream. An Equality Impact Appraisal (EIA) has been conducted around Recruitment and Workforce, part of this will include consultation with under represented groups and diversity training for Recruitment staff has already taken place.

E	11a	2	The healthcare organisation aligns workforce requirements to its service needs by undertaking workforce planning, and by ensuring that its staff are appropriately trained and qualified for the work they undertake.	The Trust adopts a multi-disciplinary approach to Workforce Planning involving all Directorates. The Trust developed an integrated 5-year Workforce Plan in 2007, which was included in the Workforce Plan of West Kent PCT, our Lead Commissioner, and subsequently presented to the South East Coast SHA. Further revisions have been made to this Plan, the most recent of which was due for submission on 23 January09. These updates are a requirement of the Workforce Planning round for all Trusts. This plan is supported by a schedule of training courses which have been organised by the Clinical Directorate, to ensure staff undertake the appropriate training and acquire the relevant qualifications to meet service delivery requirements. The Finance Directorate is involved in the Workforce Planning process, to ensure all proposed changes to Establishment and skill mix are fully costed and represent value for money. The Trust has established a cross-directorate Workforce Planning Forum, to enable there to be a formal process in place for reviewing and updating the 5-year Plan and for keeping abreast of changes and developments in models of service delivery, which impact on staff numbers and skill mix requirements and are key to the business planning process.	Compliant
CS	**11**	**b**	**Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes**		**COMPLIANT**

E	11b	1	Staff participate in relevant mandatory training programmes as designed by the relevant sector-specific NHSLA Risk Management Standards.	Training needs are identified both by line management/supervisory processes, personal development reviews and in response to PALS and complaints. There is a rolling programme of update (Key Skills) training: 1253 (81.62%) of operational staff have received their key skills updates, the remaining 18.32% need to receive training between Oct 07- Mar 09. Trust board agreed to deliver key skills training on a bi-annual basis for the period March 07 - March 09. A trajectory for the delivery of outstanding training has been developed in September 08 and agreed by the Executive Team. Plan submitted and agreed at the Oct 08 RMCGSC. Operations Directorate are committed to releasing the staff against the trajectory (3 x 12 staff per week) up to end March 09. Progress against the training trajectory to be reported to all Executive Team meetings. If staff are released as agreed, all training will be completed by mid February 09. Key Skills Course Programme details the clinical skills components for A&E staff. PTS Refresher Course programme does the same for non-emergency staff. Course registers demonstrating staff attendance. Achievement of outcomes can be evidenced with completed record books and assessment papers. SDP 08/09. Risk Register.	Compliant
E	11b	2	Staff and students participate in relevant induction programmes	Corporate Induction programme fully in place. This is the first two days of any training programme for ECSWs, call takers, PTS staff, and non operational staff are allocated places on the first available corporate induction course after their start date. The Personal Orientation Pack is now also complete, and issued to every new member of staff on appointment	Compliant

E	11b	3	NEW ELEMENT: The healthcare organisation verifies that staff participate in those mandatory training programmes necessary to ensure probity, clinical quality and patient safety (including that referred to in element 1). Where the healthcare organisation identify non-attendance, action is taken to rectify this.	Attendance on Mandatory training is planned by Clinical Scheduling using Promis Software. Attendance at the training event is recorded using a register signed by all attendees. Non-attendance is reported to Clinical Scheduling as per the Bob-attendance at Mandatory training Policy. Re-attendance then arranged by Clinical Scheduling	Compliant
CS	**11**	**c**	**Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives**		**COMPLIANT**

E	11c	1	The healthcare organisation ensures that all staff concerned with aspects of the provision of healthcare have opportunities to participate in professional and occupational development at all points in their career in accordance with "employment and equalities legislation" [see C7e] including legislation regarding age, disability, gender, race, religion and belief, sexual orientation, part-time workers, fixed term employees, flexible working and working time; and in accordance with its "public body duties" [see C7e] in relation to employees, including, but not restricted to, its monitoring duties in relation to race, disability and gender; and where appropriate, having due regard to the associated codes of practice.; and in accordance with the relevant aspects of *Working together - learning together: a framework for lifelong learning for the NHS (Department of Health 2001)*	The majority of staff who join the Trust do so as trainee technicians, trainee PTS staff, or trainee EMD staff. The first week of their training programme is a comprehensive induction programme, which is relevant to the needs of the member of staff. The first two days of this week forms the corporate induction and includes information on the Trust, health and safety, moving and handling, fire safety and infection control. Non-operational staff also attend the corporate induction alongside their operational colleagues. When staff are deployed “on station” or join their department (non operational staff) they have a local induction checklist to work through with their line manager. On completion, these forms are returned to the HR Department, who monitor their return and place them on the individual’s personal file. The corporate induction course is mandatory for all new employees. Staff development has taken the form of ACAs developing as ECAs and Technicians, Technicians developing as Paramedics through the FD Programme and Paramedics developing as PPs and CCPs. Foundation degree has 207 students, with an additional 60 per year on the Tech-Para pathway. The PP programme is supporting 100 developing PPs. The current CCP cohort is 11, with a cohort of a maximum of 12 recruited for a November 2008 start. Continued activity at this rate will see requirements met by year-end for FD & PP programmes.	Compliant
CS	**12**		**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**

E	12	1	The healthcare organisation has effective research governance in place, which complies with the requirements of the *Research governance framework for health and social care , second edition (Department of Health 2005)*	Membership of CLRNs and appointment of R&D specialists. R&D Working Group established. R&D strategy and policy. Membership of DOCCs group. Membership of Sussex Research Consortium providing governance and guidance. Discussions held with HE research specialist to join the trust on an honorary basis.	Compliant
D	**4**		**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**		
CS	**13**	**a**	**Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect**		**COMPLIANT**
E	13a	1	The healthcare organisation ensures that staff treat patients / service users, carers and relatives with dignity and respect at every stage of their care and treatment, and, where relevant, identify, and take preventative and corrective actions where there are issues and risks with dignity and respect.	Lesson plans that reference dignity for vision or hearing impaired. Bad news training. Code of conduct for SET's, SOP's. SECAmb Code of Conduct. Professional Code of Conduct. Scope of Practice. SDP 2008/09. PP's Code of Practice. Scope of Practice. Bariatric vehicles. Palliative care policies agreed (external), rolled out in Sussex. Organisational objectives to develop codes of conduct and scopes of practice. Reviews undertaken by Critical Care Networks. A 'care of the elderly' session is delivered to all new entrants.	Compliant

E	13a	2	The healthcare organisation meets the needs and rights of different patient groups with regard to dignity including by acting in accordance with the *Human Rights Act 1998*, and the general and specific duties imposed on public bodies in relation to race, disability and gender (including among other things, equality schemes for race, disability and gender, along with impact assessments under the following "public body duties" statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006. The healthcare organisation should act in accordance with the requirements for the National Service Framework for older people (Health Service circular 2001/007) to ensure that older people are not unfairly discriminated against in accessing NHS or social care services as a result of their age.	The Trust has a Single Equalities Scheme and Action Plans that cover the six equality strands including: Age, Disability, Gender and Race. Dedicated Equality and Diversity staff have been appointed, including an Equality & Diversity PPI Manager – Diversity, who is progressing work to support engaging, listening and responding to different patient and carer groups. An Equalities & Diversity Steering Group, which includes representation from across the Trust, is meeting and actively monitoring progress. In addition staff are provided with an hour module at induction, which includes Equality, Diversity and Human Rights. Issues around dignity and respect are taught as part of basic training and are included within our Clinical Strategy 2007-2012. All staff are required to attend Personal Skills Updates, which place significant focus on equality and diversity and human rights. Staff also have access to Language Line. Minicom system in use in Kent. A portable induction loop is available for use across our seventy sites. Multi Lingual Phrase books are distributed to each operational member of staff, as well a guide to Cultural Diversity and Faith Awareness. Overshoes are located on all vehicles. Progress is being made to ensure the Equality Impact Assessment of key relevant policy and strategy including: Clinical Strategy, safeguarding policies, Organisational Development Strategy as well as policies relating to Patient and Public Involvement Strategy and related policies.	Compliant
CS	**13**	**b**	**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**

E	13b	1	Valid consent, including from those who have communication or language support needs, is obtained by suitably qualified staff for all treatments, procedures, investigations and decisions in accordance with the *Reference guide to consent for examination or treatment (Department of Health 2001)*, and having regard to the *Code of Practice to the Mental Health Act 2007* and the *Code of Practice to the Mental Capacity Act 2005.*	Consent and capacity procedure finished and due to be submitted to RMCGSC, staff pocket guides and posters advertising valid consent practices being finalised with Comms team, new non conveyance includes consent and capacity assessment, MCA papers presented to Trust Board, RMCGSC and Medical Committee, 3 courses delivered training managers in the MCA and valid consent. This is evidenced through course attendance records, consent and capacity procedure, non conveyance form, staff leaflets.	Compliant
E	13b	2	Patients / service users, including those with language and / or communication support needs, are provided with appropriate and sufficient information suitable to their needs, on the use and disclosure of confidential information held about them, in accordance with *Confidentiality: NHS code of practice (Department of Health 2003)*	Patient leaflet agreed and quotations being sought by Comms team. Previous legacy leaflet for Surrey health Community available throughout the trust. PALS policy directs patients to PALS for specific queries about treatment; Language line; staff pocket guides and posters being finalised with Comms team. Course attendance records	Compliant
E	13b	3	NEW ELEMENT: The healthcare organisation monitors and reviews current practices to ensure effective consent processes.	New Consent and Capacity Procedure produced together with staff information pocket guides. PHT checklists checked to ensure that patient's signature obtained. CP/VA report form includes a consent section to be completed when appropriate. PCR contains patient consent to refuse / decline treatment and these forms will be audited as part of the documentation audit to ensure compliance. Non conveyance guideline also references the patient's option to consent to refuse . Decline treatment and the Non Conveyance Checklist requires a patient / carer signature to indicate consent.	Compliant
CS	**13**	**c**	**Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary**		**COMPLIANT**

E	13c	1	When using and disclosing patients / service users' personal information staff act in accordance withthe *Data Protection Act 1998*, the *Human Rights Act 1998*, the *Freedom of Information Act 2000* and *Confidentiality: NHS code of practice (Department of Health 2003), Caldicott Guardian Manual 2006* (DH, 2006). The healthcare organisation complies with the actions specified in the NHS Chief Executive's letter of 20 May 2008 (Gateway reference 9912); and with supplemental measures and guidance if they are introduced during the assessment period.	Data Protection Policy. SIRO appointed (Dir of CASD); Subject Access request Policy & Procedure; Information Governance Policy; Internet and E-mail Policy; Information Security Policy; Physical and virtual access controls to areas containing confidential/sensitive information; Leaflets for staff: Confidentiality Explained; Data protection Best Practice Guidelines; Information Security and Confidentiality (DP & Caldicott principles); Staff contracts of employment; Confidentiality clauses with third parties; Head of IG holds ISEB qualification in Data protection; Requests for copies of PCRs channelled through web-based form in SharePoint which is fully auditable; All staff attend IG induction programmes; Articles in Staff Bulletin; Access to e-learning for staff; Up to date notification with the Information Commissioner.	Compliant
CS	**14**	**a**	**Healthcare organisations 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**

E	14a	1	Patients / service users, relatives and carers are given suitable and accessible information about, and can easily access, a formal complaints system, including information about how to escalate their concerns; and the healthcare organisation acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	The Trust triages most concerns and complaints via its Patient Advice and Liaison Service (PALS). Both PALS and the formal complaints process are explained to the enquirer and information is provided to enquirers and complainants about advocacy services such as the Independent Complaints Advocacy Service by both PALS staff and the Complaints Manager. Complaints acknowledgement letters also provide details of ICAS. The Complaints Policy and Procedure, PALS Policy and Procedure and the leaflet "How the Trust deals with Concerns and Complaints" are all available on the Trust's public website as well as its intranet. These documents can be made available in other languages and formats on request. Contact details for the Complaints Manager, PALS staff and the Head of Patient Experience are provided on the Trust's website. Questionnaires to assess complainants / 'enquirers' satisfaction with the handling of complaints and PALS were introduced in January 2009 and will be sent out following resolution of the complaint/concern. The Trust's complaints and PALS systems are explained to staff at induction sessions, where PALS / complaints staff have a 45-minute slot.	Compliant

E	14a	2	Patients / service users, relatives and carers are provided with opportunities to give feedback on the quality of services.	The Trust had a well-established Patient Advice and Liaison Service, providing an excellent mechanism for the population to provide feedback on the service they have received (both positive and negative) and all such comments, as well as concerns and complaints, are logged on the Trust's integrated risk management database (Datix). This data is analysed and reports are provided to the Trust's Risk Management and Clinical Governance Sub-committee (RMCGSC) on a bimonthly basis, as well as to the Trust's commissioners. The Trust has three Public Opinion Groups (POGs) established in Sussex, Surrey and Kent, comprising mainly patients, carers and members of the public plus some voluntary sector representatives, each of which meets three times a year. The Trust held three events held in Kent, Surrey and Sussex in Sept/Oct 08, entitled 'Shaping the future of your ambulance service' with interactive sessions eliciting patient and public involvement in the development of the Trust's business plan. A public Open Day was also held at Lingfield Racecourse. At all four events members of the public had an opportunity to put questions and comments about the service to a panel including directors and the Head of Patient Experience. The Trust also held two workshops, one in August and a follow-up in December, where patients, public and staff put forward their views, ideas and suggestions for the three-year PPI strategy. A patient and public satisfaction survey was undertaken by IPSOS Mori in the summer of 2008, and the preliminary results were shared with all at the public Trust Open Day on 29 September. A board and senior management briefing will take place early in 2009 and survey results will be incorporated into 09/10 business planning. The Trust held a PTS (Patient Transport Service) workshop in August	Compliant

				attended by PTS patients, staff, managers and the chief executive. The aim of the event was to listen to the views of those who use the service and those who provide it, with a view to incorporating comments and suggestions into the Trust's Non-emergency Strategy. Range of contact mechanisms listed on all recent corporate literature. PPI reps now on many Trust working groups, sub-committees, board. Questionnaires to assess complainants / 'enquirers' satisfaction with the handling of complaints and PALS were introduced in January 2009 and will be sent out following resolution of the complaint/concern. The Trust is building relationships with the newly-established Local Involvement Networks (LINks) across the patch (there are six) and attended and spoke at a recent Cross Border LINks event. The Trust has also offered to run an event specifically for LINks members and host organisations about South East Coast Ambulance Service - its services, they way it operates, its ethos, plans for the future, etc.	
CS	**14**	**b**	**Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made**		**COMPLIANT**
E	14b	1	The healthcare organisation has systems in place to ensure that patients / service users, carers and relatives are not treated adversely as a result of having complained.	The Trust's Complaints and PALS policies state that people will not be treated any differently as a result of complaining or raising a concern, and this information is imparted to all staff at induction, where there is a dedicated PALS/complaints session. Were the Trust to become aware of an incident whereby a patient was treated adversely as a result of their having complained previously, an investigation would be undertaken and measures put in place to mitigate any recurrence. Such a concern may be raised via PALS or the formal complaints process.	Compliant

CS	14	c	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
E	14c	1	The healthcare organisation acts on, and responds to, complaints appropriately and in a timely manner; and acts in accordance with the NHS (Complaints) Regulations 2004 (as amended) in so far as they are relevant to the healthcare organisation.	All complaints are acknowledged within two working days and, to date, the Trust has achieved 96% compliance in responding to complainants within 25 working days following investigation. If for any reason it is not possible to respond within 25 days, the Complaints Manager will contact the complainant explaining this to them. Concerns may also be investigated by the Trust's PALS should the enquirer prefer, which can provide a more speedy resolution. Whether handled by complaints or PALS, each stage of a complaint/enquiries is fully documented on the Trust's Datix database. In order to ensure that actions arising as a result of a complaint are implemented, the Complaints Manager keeps a Complaints Action Plans log. This log is circulated to investigating managers, assistant directors and directors on a monthly basis and the action is not removed from the log until the Complaints Manager receives confirmation that it has been implemented.	Compliant
E	14c	2	Demonstrable improvements are made to service delivery as a result of concerns and complaints from patients / service users, relatives and carers	PALS concerns and formal complaints are used to effect change/service improvement and action plans are monitored to ensure completion. Reflections newsletter disseminates lessons learned from PALS concerns, complaints, incidents, etc to all staff. Patient experience reports (PALS and Complaints information) now go to each RMCGSC meeting, detailing trends, possible causes and recommendations where appropriate. 'Staff attitude' has been the highest category for both PALS and complaints recently, and an internal 'customer care' course has now been established in order to address this. Patient Experience Report also provided to commissioners and PPI Liaison Group members on a quarterly basis.	Compliant

CS	16		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
E	16	1	The healthcare organisation has identified the information needs of its service population, and provides suitable and accessible information on the services it provides in response to these needs. This includes the provision of information in relevant languages and formats in accordance with the general and specific duties imposed on public bodies in relation to race, disability and gender (including among other things, equality schemes for race, disability and gender, along with impact assessments under the following "public body duties" statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006. And, where appropriate, having due regard to the associated codes of practice.	Region wide qualitative and quantitative research conducted into satisfaction and perceptions of patients and the public; part of this research looked at detail into how people find out about us now, and how they want to find out information about us moving forwards. This is being built into the Comms Strategy for 2009/10 which will go to the Trust Board on 26 March 2009; Shaping the future events: three interactive sessions with a range of patients, members of the public (including seldom heard groups) as well as staff. Discussion areas included access to services as well as ensuring equality for all. Feedback will be built into the business planning process along with the MORI results; All operational and EDC staff have access to Language Line as well as multilingual phrase books, allowing information about our services and treatment to be conveyed to patients whose first language is not English - both at the time of call, and at the time of treatment; Minicom and access to Enhanced Information Service for Emergency Calls (EISEC) ensuring that people who are unable to speak / hear, who call upon our service for help, still receive the same level of service. EISEC provides the information that auto populates the emergency call taker's screen with address and phone number if the caller isn't able to convey that information to us verbally or through type talk. We can therefore still send an emergency response; Research done into the six most commonly spoken languages in our region. Standard text about accessing information (corporate documents / website copy etc) is translated into these languages and is on the home page of our website and will also feature in all corporate literature from now on; SES and action plans been in place, and being implemented from 1 April 08. Three year plan currently being developed. Full and summary	Compliant

				SES published on website. Summary published in hard copy and launched at StF events; EIAs - both standard and detailed have been conducted throughout the year and are published on our intranet and website; Increased engagement with seldom heard groups through E&D PPI lead.	
E	16	2	The healthcare organisation provides patients / service users and, where appropriate, carers with sufficient and accessible information on their individual care, treatment and after care, including those patients / service users with communication or language support needs. In doing so, healthcare organisations must have regard, where appropriate, to the *Code of Practice to the Mental Capacity Act 2005* (Department of Constitutional Affairs 2007) and the *Code of Practice to the Mental Health Act* (Department of Constitutional Affairs 1983).	All frontline staff, where appropriate, are required to tell the patient what treatment they are administering and what drugs the patient is being given to ensure they are fully aware of the side-effects of any treatment they receive. If a patient is unable to converse with the crew they are able under the Data Protection Act to ask to see their Clinical Patient Record at a later date. All operational staff adheres to the informed consent protocol. All operational staff have access to Language Line which enables staff to communicate with patients whose first language is not English. A multi lingual phrase book is available on all front line vehicles. Minicom guidance is available in EDC.	Compliant
D	**5**		**ACCESSIBLE AND RESPONSIVE CARE: Patients receive services as promptly as possible, have a choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or the care pathway**		
CS	**17**		**The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services**		**COMPLIANT**

E	17	1	The healthcare organisation seeks and collects the views and experiences of patients / service users, carers and the local community, particularly those who are seldom listened to, on an ongoing basis when designing, planning, delivering and improving healthcare services as required by Section 42 of the *NHS Act 2006* in accordance with *Strengthening Accountability, patient and public involvement policy guidance - Section 11 of the Health and Social Care Act 2001 (Department of Health 2003)* and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation acts in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "public body duties" statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.	The Trust has three Public Opinion Groups (POGs) established in Sussex, Surrey and Kent, comprising mainly patients, carers and members of the public plus some voluntary sector representatives, each of which meets three times a year. The Trust held three events held in Kent, Surrey and Sussex in Sept/Oct 08, entitled 'Shaping the future of your ambulance service' with interactive sessions eliciting patient and public involvement in the development of the Trust's business plan. A public Open Day was also held at Lingfield Racecourse. At all four events members of the public had an opportunity to put questions and comments about the service to a panel including directors and the Head of Patient Experience. The Trust also held two workshops, one in August and a follow-up in December, where patients, public and staff put forward their views, ideas and suggestions for the new, three-year PPI strategy. Then, in January a group of patients/public/staff, representing various diversity strands, convened to undertake an Equality Impact Assessment of the strategy. A patient and public satisfaction survey was undertaken by IPSOS Mori in the summer of 2008, and the preliminary results were shared with all at the public Trust Open Day on 29 September. A board and senior management briefing will take place early in 2009 and survey results will be incorporated into 09/10 business planning. The Trust held a PTS (Patient Transport Service) workshop in August attended by PTS patients, staff, managers and the chief executive. The aim of the event was to listen to the views of those who use the service and those who provide it, with a view to incorporating comments and suggestions into the Trust's Non-emergency Strategy. Range of contact mechanisms listed on all recent corporate literature. PPI	Compliant

reps now on many Trust working groups, sub-committees, board. Questionnaires to assess complainants'/enquirers' satisfaction with the handling of complaints and PALS were introduced in January 2009 and will be sent out following resolution of the complaint/concern. The Trust is building relationships with the newly-established Local Involvement Networks (LINks) across the patch (there are six) and attended and spoke at recent Cross Border LINks event. The Trust has also offered to run an event specifically for LINks members and host organisations about South East Coast Ambulance Service - its services, they way it operates, its ethos, plans for the future, etc. The Trust appointed to a new post of PPI Manager, Equality and Diversity, in May 2008, who is proactively engaging with minority and seldom-heard groups. The Trust has attended various events and meetings for specific minority groups/communities, and is represented on several steering groups whose aim is to initiate contact with hard-to-reach groups and to ascertain their needs.

E	17	2	The healthcare organisation demonstrates to patients / service users, carers and the local community, particularly those who are seldom listened to, how it has taken their views into account when designing, planning, delivering and improving healthcare services, in accordance with *Strengthening Accountability, patient and public involvement policy guidance - Section 11 of the Health and Social Care Act 2001 (Department of Health 2003)* and any subsequent statutory guidance introduced in the assessment year. In doing so the healthcare organisation acts in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following "public body duties" statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.	All Trust board papers must evidence patient and public involvement before being approved by the board. The Trust's PALS ensures that service user comments, suggestions and recommendations are forwarded to the appropriate department/manager and acted upon where appropriate. PALS enquirers and complainants are informed, either verbally or in writing of the outcome of their concern and what action has been taken to mitigate recurrence and improve future service for all. Those who attended the PPI workshop in August received a copy of the draft PPI strategy developed as a result. They were invited to comment further on this and to be part of a smaller focus group which met in December to refine the strategy. The full Equality Impact Assessments of, for example, the PPI strategy, PALS Policy and Complaints Policy, and any amendments to these documents as a result of engaging the public in this exercise, provides evidence of the Trust listening to and acting on their advice, comments and suggestions.	Compliant
CS	**18**		**Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably**		**COMPLIANT**

E	18	1	The healthcare organisation enables all members of the population it serves to access its services equally, including acting in accordance with the general and specific duties imposed on public bodies (including, among other things, equality schemes for race, disability and gender, along with impact assessments) under the following “public body duties” statutes: the Race Relations (Amendment) Act 2000; the Disability Discrimination Act 2005; the Equality Act 2006; and where appropriate, having due regard to the associated codes of practice.	The Trust has a Single Equalities Scheme in place to assist in determining and addressing any potential inequity of access. New post (one of two new E&D posts) of PPI Manager, Equality and Diversity, appointed to in May 2008 in order to further the Trust's engagement with and involvement of marginalised groups across our catchment area. The Trust holds the "two tick" symbol for disability (Positive about disabled people). The Trust uses the AMPDS system to prioritise calls which ensures that the response to all calls is based solely on the patient's clinical needs. Language Line is available providing telephone interpreting for both operational and control centre staff when attending a patient whose first language is not English. In addition, staff have also been provided with a multilingual phrase book to help immediate communication. Community Responder Schemes have been established and continue to be developed to try to improve equity of response times across the Trust's catchment area, particularly in rural areas. In order to help to ascertain the needs of our population, the Trust's PPI Manager E&D has been making good progress in working with marginalised groups across the patch and is involved in a gypsy and traveller project in Brighton as well as a health-specific gypsy and traveller project in Surrey. Work is also underway with the Crawley Neighbourhood Network which works with vulnerable people, elderly people and the BME community. In Kent the Trust is working closely with Kent County Council on six different diversity strands, and in Brighton we are working with Spectrum, the local LGBT community forum. The Trust is also establishing a "People's Panel", which will be the forerunner to our FT membership, and giving out forms at all events attended. One of the Trust's PPI reps who is hard of	Compliant

				hearing has assisted the Trust with the procurement of a hearing loop and its usage. All recently produced Trust documentation includes a statement informing people of its availability in other languages/formats on request. The Trust has developed a policy and procedure for The Treatment of Complex Needs Patient. This aims to ensure that there is sufficient provision for those patients who, owing to their weight, size, shape or mobility, are not able to be safely removed into and transported by standard ambulance service vehicles.	

E	18	2	The healthcare organisation offers patients / service users choice in access to services and treatment, and those choices in access to treatment are offered on a fair, just and reasonable basis, including to disadvantaged groups and including acting in accordance with the general and specific duties imposed on public bodies as in Element 1 and including, where appropriate, having due regard to the associated codes of practice.	Callers who access the 999 system have their clinical need assessed utilising the AMPDS system, which ensures that, based upon the information provided by the caller, the most appropriate level of response is provided. If a call is categorised as a "green" call, the caller is passed to the Clinical desk, which is staffed by a suitably qualified clinician. If the caller agrees, and it is appropriate, the clinician will refer the caller to an alternative care pathway that will better suit the patients needs. Patients are also given the option not to be taken to hospital, for which they are asked to sign a "non-conveyance form". To support the Trust in offering access to services and treatment equitably, all crews and staff in the EDC have access to Language Line, providing translation services. In addition, it is recognised good practice, both within an A&E and PTS setting to allow a patient to travel with their assistance dog, where appropriate. With regards non-emergency transport, the Trust's Patient Transport Service provides the routine transportation for purposes such as outpatient appointments and day centre attendance. This service is developed to match the requirements of our commissioning authorities and it is anticipated that the care provider has already investigated and discussed the choices in relation to access to services with the patient. The Trust then facilitates those choices by providing transport at the time requested. With regards Category C calls, all 3 EDC's use AMPDS to determine the appropriate CAT C's that should be passed through PSIAM. Each EDC uses the PSIAM software and works within this and the SECAmb PSIAM Policy.	Compliant
D	**6**		**CARE ENVIRONMENT AND AMENITIES: Care is provided in environments that promote patient and staff wellbeing and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes of patients**		

CS	20	a	**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**
E	20a	1	The healthcare organisation effectively manages the health, safety and environmental risks to patients / service users, staff and visitors in accordance with all relevant health and safety legislation, fire safety legislation, the *Disability Discrimination Act 1995,* and the *Disability Discrimination Act 2005;* and by having regard to *The duty to promote disability equality: Statutory Code of practice (Disability Rights Commission, 2005).* It also acts in accordance with the mandatory requirements set out in *Fire code – fire safety in the NHS Health Technical Memorandum (HTM) 05-01: Managing healthcare fire safety* (Department of Health, 2006), in so far as the requirements are relevant to the healthcare organisation, and follows the guidance contained therein, or equally effective alternative means to achieve the same objectives. It also considers, and where appropriate follows, the good practice guidance referred to in *The NHS Healthy Workplaces Handbook* (NHS Employers 2007) or equally effective alternative means to achieve the same objectives	The organisation has delegated the responsibility for overseeing health and safety risk management across the whole organisation to the Director of Corporate Affairs and Service Development. He is responsible for the Fire Policy, however the management and maintenance of fire equipment is under the remit of the Director of Technical Services and Logistics. The Trust has appointed 2 Risk, Health and Safety Managers and there are a number of Health and Safety Staff Representatives across the Trust. All adverse incidents are reported and recorded on the DATIX incident reporting system. Committees: Risk Management and Clinical Governance Sub Committee (RMCGSC), Central Health and Safety Committee and two local Health and Safety Working Groups. Policies in Place: Risk Management Policy, Health and Safety Policy, COSSH Policy, Slips, Trips and Falls Policy. Risk Assessment Procedure. Workplace Inspection Procedure. Fire risk assessment completed at all workplaces. Building risk assessments currently being undertaken at all trust sites and regular inspections being completed. Prevention of Occupational Exposure to the Blood Borne Viruses - including prevention of sharp injuries. Safe Handling and Disposal of Sharps Policy.	Compliant

E	20a	2	The healthcare organisation protects patients / service users, relatives, carers and staff and their property, and the physical assets of the organisation, by ensuring that vehicles are safe and secure, including in accordance with *Secretary of State directions on measures to tackle violence against staff and professionals who work in or provide services to the NHS* (DH, 2003) and *Secretary of State directions on security management measures* (DH, 2004, as amended 2006).	The Trust ensures the safety of staff and patients in ambulances by purchasing vehicles which are compliant with BS EN1789:2000. This forms part of the fleet procurement system. All staff are given induction training which includes information on the need to protect patients relatives and Trust property. The Trust gives all new operational staff information and practical conflict resolution training to minimise the potential of them or patients being assaulted. They are also given information on how to report the incident should they be subject of an assault or discover a security breach, e.g. theft. Security has been increased in respect of new vehicles and all new ambulances will be fitted with internal CCTV. All controlled drugs are kept in secure cabinets. Crime prevention surveys are completed to identify security concerns. Security breaches are reported and remedial action, if appropriate is taken. The trust takes account of a professional approach to managing security in the NHS and has appointed a Security Management Director, a NED for security and a Local Security Management Specialist. It complies with the guidance. The Trust has the following policies and procedures:- Security Management Policy, Lone Worker Policy, Policy for managing the physical security of premises, vehicles and other assets, The procedure for reporting incidents of physical assault and verbal abuse.	Compliant
CS	**20**	**b**	**Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality**		**COMPLIANT**

E	20b	1	The healthcare organisation provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation, access to private areas for religious and spiritual needs and for confidential consultations. This should happen at all stages of care and during transfers.	Compliant and evidenced as of last inspection. Vehicle design supports confidentiality, privacy and dignity. The trust seek further clarification relation to the requirements needed for compliance 'during transfer'. An ambulance is neither a facility, nor accommodation and as such it is argued should be exempt.	Compliant
E	20b	2	NEW ELEMENT: The healthcare organisation has systems in place to ensure that preventative and corrective actions are taken in situations where there are risks and / or issues with patient privacy and / or confidentiality.	The vehicle design enables the confidential treatment within its confines, with dignity and privacy. Information governance procedures and policies uphold the confidentiality of the patient, both the Risk Management and Complaints policy and procedure enable the trust to react to incidents should they arise.	Compliant
CS	**21**		**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**
E	21	1	The ambulance service has systems in place and has taken steps to ensure its fleet is well designed, 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).	The Vehicle fleet is designed to give safe environment to all users, however the need for safety does not necessarily comply with DDA. All vehicles have to be built to EN1789 and EN1865 which is European law, relating to safety. DDA ACoP and legislation do not specifically relate 'ambulances' but the elements have been included in the vehicle design, (tail lift access, high visibility handles and step edging, audible 'vehicle reversing 'alert).	Compliant

E	21	2	Care is provided in clean ambulances that meet the relevant requirements of duty four of *The Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections (Department of Health, revised 2008).*	The design of vehicles has developed to assist in the effective cleaning of vehicles. Staff are trained extensively how to decontaminate vehicles and equipment. SECAmb is in the process of implementing a trust wide deep cleaning regime on a six weekly basis. The trust also has two pilot sites for make ready in Hastings and Chertsey. Make ready refills, restocks and cleans the vehicle on a daily basis, in line with shift patterns. A single set of product for the cleaning and decontamination of vehicles and equipment is being implemented. ACTIV 8 is that product, it is approved by the HPA for this purpose.	Compliant
D	**7**		**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**		
CS	**22**	**a & c**	**Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:a) cooperating with each other and with local authorities and other organisations; andc) making an appropriate and effective contribution to local partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.**		**COMPLIANT**
E	22ac	1	The healthcare organisation actively works with key strategic partners, such as coronary heart disease implementation groups and emergency care groups, to improve care pathways for patients.	Through the lead commissioner arrangements a system-wide group has been established to review clinical pathways across the SEC. These include Trauma, stroke, CHD/PCI and look to promote consistency and best practice in the pre/out of hospital phase of the pathway. Commissioners and clinical leads are involved ensuring that developments are communicated, supported and planned in a co-ordinated manner. SECAmb representatives also works at a local level to implement and monitor service change.	Compliant

E	22ac	2	NEW ELEMENT: The healthcare organisation contributes appropriately and effectively to nationally recognised and / or statutory partnerships such as the Local Strategic Partnership, children's partnership arrangements and, where appropriate, the Crime and Disorder Reduction Partnership.	The Trust is involved with partnership working as appropriate, some of which include: Involvement with Local Safeguarding Children's Boards; Attendance at Child Death Review Panels; Controlled drugs - Exception reports submitted to Local Intelligence Networks on a quarterly basis; Membership of Comprehensive Local Research Network; Membership of Sussex Research Consortium; Critical Care Networks attendance; Safe Drive, Stay Alive (with police, fire and schools); Bike Safe (with police and fire and local community groups); Prince's Trust work (Team and xcel); Links with Local Authorities on a host of different initiatives including Pacesetters etc; Involvement in Operation Rameses - a regular gold meeting at Kent police that monitors and makes decisions about operation stack. Partners in this meeting are Kent Fire and Rescue Service, Highways Agency, Dover Port Authority, Kent County Council, Local Councils, Health Emergency Planning and other key players; Shepway District Council - Community Safety Group (multi-agency group).	Compliant
E	22ac	3	NEW ELEMENT: The healthcare organisation monitors and reviews their contribution to public health partnership arrangements and takes action as required.	Director of Public Health appointed to SECAmb Medical Group; Links with PCTs on public health and information campaigns; Partnerships with the Stroke Association and BHF, as well as local stroke and cardiac networks.	Compliant
CS	**22**	**b**	**Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by ensuring that the local Director of Public Health's Annual Report informs their policies and practices**		**COMPLIANT**

E	22	1	NEW ELEMENT: The healthcare organisation's policies and practices to improve health and narrow health inequalities are informed by the local director of public health's (DPH) annual public health report.	Director of Public Health appointed to Medical Committee (now referred to as Medical Group). Practice Development Manager appointed (commences March 2009) who has responsibility for reviewing public health reports and implementing their recommendations. The Trust Clinical Director and Director of Corporate Affairs and Service Development have regular meetings with the SHA Director of Public Health regarding clinical issues that impact on the Trust, and the operationalisation of these. In addition, the Trust works with the Directors of Public Health in the local PCTsto consider the impacts of the Public Health agenda for SECAmb. Issues around reductions of health inequalities and ensuring the delivery of safe, effective stroke, cardiac and trauma care have been identified and are being taken forward in the Trust's plans.	Compliant
CS	**23**		**Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections. These elements for ambulance services are driven by the health improvement and health promotion requirements set out in NSFs and national plans with a particular focus on the following priority areas: * Encouraging sensible drinking of alcohol * Reducing drug misuse * Improving mental health and well being * Preventing unintentional injuries**		**COMPLIANT**
E	23	1	The healthcare organisation collects, analyses and shares data about its patients / service users and services, including where relevant data on ethnicity, gender, age disability and socio-economic factors, including with its commissioners, to influence health needs assessments and strategic planning to improve the health of the community served.	Dashboard reports presented to Medical Committee and Trust Board, new liaison meetings held with commissioners looking at CPIs, Clinical Audit reports shared with medical advisors to the Trust. Trust participation in snapshots audits looking at self harm and audits of activated charcoal which was run in conjunction with Guys poisons unit, participation in national CHI audits	Compliant

E	23	2	The healthcare organisation contributes as appropriate to disease prevention or health promotion programmes in relation to the public health priority areas, to improve health and narrow health inequalities.	Three Heads of Dept are now members of JRCALC and inform JRCALC guideline developments. Sussex Cancer Network is informed by Head of Clinical Governance around palliative care. Work with MacMillan Trust to produce SECAmb literature to educate and inform staff on the care of cancer patients. Pathways Coordinators appointed and in post. Work ongoing across SECAmb in relation to palliative care and mental health, advertising leaflets put on vehicles in relation to when to call an ambulance for chest pain.	Compliant
E	23	3	The healthcare organisation implements policies and practices to improve the health and wellbeing of its workforce.	Policies in place relating to Stress, Welfare, Smoke Free, Flexible Working and Special Leave. The trusts occupational health provider is ATOS Healthcare. The Counselling provider for staff and families on a self referral or manager referral basis is First Assist. A pilot project to provide in house flu vaccinations via a team has proved successful, lessons learnt will be incorporated into a programme for 2009.The workplace stress group continues to take forward the stress action plan and the HSE review was favourable. A SECAmb Workplace Stress Week is planned for September. The cycle to work scheme is receiving a good uptake from staff. There has been a review of the Smoke Free Policy, the implications for staff will be published via the bulletin, culminating in the smoke free (March 11th 2009) day activities. Articles are being produced around healthy living and the management of conditions such as asthma, by the Health, Childcare Carers coordinator and are published in the Bulletin and will be published in the staff magazine. There are health eating options in both canteens.	Compliant
CS	**24**		**Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services**		**COMPLIANT**

E	24	1	The healthcare organisation protects the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations (including control of communicable diseases), which includes arrangements for business continuity management, in accordance with Civil Contingencies Act (2004), *The NHS Emergency Planning Guidance (Department of Health 2005)*, and associated supplements (Department of Health, 2005, 2007) and *Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (DH, November 2007).	The SECAmb has a Major Incident Plan which is distributed to all managers and locations within the Trust. SECAmb also has a Business Continuity Management Plan which has also been distributed to every manager and location within SECAmb. Both documents are available in electronic format and is able to be accessed through the SECAmb Intranet. SECAmb has a Pandemic Flu Response Plan which has been subject to scrutiny by the SEC SHA and has been further refined during a series of Flu Pandemic Exercises. The series of Flu Pandemic Exercises called Exercise "Polygon" were held within each of the Local Resilience Forum areas and were attended by all relevant managers from SECAmb. The Major Incident Plan is generic in nature and seeks to establish a "Major Incident Footprint" regardless of the type of incident. The Plan is supported by a "Special Contingencies" section which provides more specific guidance to incident managers in relation to arrangements applicable to individual incident types. A "CBRN and Major Incident Aide Memoire" has been produced and has been issued to every member of SECAmb. A leaflet called "How prepared are we ?" has been prepared and circulated to all members of SECAmb and provides information in relation to Business Continuity Management. A System of "Accreditation in Major Incident Management" has been introduced for all SECAmb managers. The system is a CPD method of ensuring that all SECAmb managers receive Major Incident training and development annually . The system requires all managers to obtain 12 Major Incident CPD points on an annual basis.	Compliant

E	24	2	The healthcare organisation protects the public by working with key partner organisations, including through Local Resilience Forums, in the preparation of, training for and annual testing of emergency preparedness plans, in accordance with the *Civil Contingencies Act 2004*, *The NHS Emergency Planning Guidance 2005 and associated supplements (Department of Health 2005, 2007) and Pandemic Influenza: A National Framework for Responding to an Influenza Pandemic* (DH, November 2007).	SECAmb links with the Resilience Forums of Kent, Sussex and Surrey and (in a limited way) North East Hampshire. Representation is achieved across the whole spectrum of groups and meeting cycles within each of the LRF areas. SECAmb is also represented at the Regional Resilience Forum and sub-groups dealing with Media, Health and CBRN. SECAmb is also represented on other groups supporting emergency planning activity in areas covered by other legislation such as the COMAH regulations, Safety at Sports Grounds and the Pipeline Safety Regulations etc. SECAmb seeks to provide participation by appropriate level managers and staff at Major Incident training and exercise events organised by our professional partners. SECAmb participates in working with key partner agencies to ensure appropriate plans are in place to respond to key risk sites such as Gatwick Airport, Channel Tunnel and top tier COMAH Sites. SECAmb carries out training for all CBRN Providers in accordance with DoH requirements.	Compliant

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Annual Health Check: Kent LINk commentary

Introduction

The Kent Local Involvement Network (LINk) was established under the Local Government and Public Involvement in Health Act 2007 with a view to:

"(a) promoting, and supporting, the involvement of people in the commissioning, provision and scrutiny of local care services;

(b) enabling people to monitor........the commissioning and provision of local care services;

(c) obtaining the views of people about their needs for, and their experiences of, local care services; and

(d) making views such as are mentioned in paragraph (c) known, and reports and recommendations about how local care services could or ought to be improved, to persons responsible for commissioning, providing, managing or scrutinising local care services."

The LINk is an independent legal entity and is accountable to its local population and, through its Annual Report, to the Secretary of State for Health. The LINk's remit covers not only health issues but also social care services (particularly Adult Services).

The Kent County Council contracts with an 'arms length' body (the Host), currently Kent & Medway Networks Ltd, to provide funding and support for the LINk. The contractual arrangements made by the Council are a way of providing independence for the LINk.

The LINk's relationship with the Health Overview and Scrutiny Committee (HOSC) is a legal one in as much as the LINk can refer matters relating to health and social care services to the Committee who are required to acknowledge receipt and to keep the LINk informed of the committee's actions. Possibly, another important role for the HOSC is to make sure its Council's Executive/Cabinet are taking LINks seriously by assisting in its work to engage with local people and groups in relation to health and wellbeing and social care issues.

The LINk's approach to the Annual Health Check

In October last year the Health Care Commission approached the embryonic Kent LINk with a view to it submitting a third party commentary on Kent and Medway NHS Trusts' declarations as part of their Annual Health Check for the period April 2008 to March 2009. It was recognised that as the LINk had not been operational for the period under review it may not be in a position to fully contribute to this year's health check process. In view of this the LINk agreed to build on the legacy it had inherited from the former

Patient and Public Involvement Forums (PPIFs) and, in addition, to seek the views of the community and voluntary sector in Kent to produce a third party commentary.

Hospital Hygiene and Infection Control - Legacy from the PPIFs

Hospital acquired infections (predominantly caused by methicillin resistant *Staphylococcus aureas*, MRSA, and *Clostridium difficile*) are the concern of hospitals throughout the Country. It is not surprising that the Public and Patient Involvement Forums through Kent were involved in hospital hygiene surveys and studies. The urgency and need for this work was highlighted by the serious outbreak of *Clostridium difficile* in West Kent. When the West Kent Hospitals PPIF reported in 2008 they drew attention to the complexity of infection control pointing out that improvements in infection control are 'unlikely to be capable of resolution by changes in management alone'. Both West and East Kent Hospital Forums instigated surveys and inspections of various aspects of hospital hygiene. Bathrooms toilets and related facilities were included as was the use of hand applied alcohol dispensers and disinfectants. The legacy documents of all of the Kent Hospital and PCT Forums rated hospital hygiene as very important and recommended that work should be continues by the Kent LINk. Two major issues were highlighted:-

1. Whilst recognising that the use of hand cleaning fluids is important, surveys by PPIF in Kent has shown that the dispensers are used by about 50% of people that pass them. Infection control teams recognise the important of these dispensers but place a much greater emphasis on their use between beds rather than at hospital and ward entrances or in corridors. If this is accepted, then the use of numerous dispensers around a hospital is both confusing for the public and an unnecessary expense. It is reported that a very low percentage of people entering hospitals carry MRSA (figures between 2-6% have been quoted). At the lowest quoted level this is still 20 people for every 1000 that enter. This figure represents a very tangible risk and in view of this it was the East Kent PPIF view that emphasis should be put on hand cleaning at hospital entrances. If necessary the dispensers should be supervised during peak periods of the day to make certain that all entering and leaving used them properly. A rationalisation of the use of dispensers throughout hospitals could then be made restricting them to entrances, between beds and a few other strategic places. So far this suggestion has not been implemented.

2. Kent hospitals follow a policy of disinfection after infection rather than before. This is apparently a national policy. In the UK disinfection is detergent based whereas in the USA it is disinfectant based (Wilcox and Rawley, Hospital disinfectants and spore formation by *Clostridium difficile*. Lancet, 356, 1324, 2000). Kent hospitals rely on the efficacy of microfibre cloths and detergents restricting the use of the disinfectant chlorine to areas where there is a high risk of the presence of MRSA or *C.difficile* . Following the East Kent PPIF investigation, it has now become routine for commodes and toilets to be disinfected. Is this the case throughout Kent? The East Kent PPIF was of the opinion that the hospitals disinfectant policy should be reconsidered (together with the general use of antibiotics) in order to continue to improve hospital hygiene.

Hospital Hygiene and Infection Control – collecting other views

In addition to building on the legacy work of the PPIFs the LINk is currently collecting evidence from Kent LINk participants and from a range of community and voluntary sector organisations across Kent that could be used as a proxy for users of health care services in the County.

Conclusion

The Kent LINk will produce a third party commentary for each NHS Trust and Primary Care Trust by mid-April 2009. This will include the legacy of the former Patient and Public Involvement Forums in this area which could provide a measure of benchmarking against which users' current experience of health care in Kent can be assessed.

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