Infection prevention and control commissioning toolkit:

Guidance and information for nursing and commissioning staff in England
Acknowledgements

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This is a joint publication by the Royal College of Nursing (RCN) and the Infection Prevention Society (IPS). The RCN supports the vision of the IPS that no person is harmed by a preventable infection.

The IPS and RCN’s *Infection prevention and control commissioning toolkit* was originally developed at a time when the NHS in England was undergoing considerable reform and transition to a new commissioning structure. The toolkit has been revised following the NHS reforms in April 2013, and reflects the learning that has taken place during the transition period. This updated version of the toolkit reflects many of the criteria and elements in infection prevention frameworks that were in existing policy and legislation. For example: *Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance* (DH, implemented 2011); *Prevention and control of healthcare-associated infections: public health guidance PH36* (NICE, 2011); *Essential standards of quality and safety* (CQC, 2010). The fundamental standards will be implemented later in 2014 subject to the passage of the Care Bill, which is currently going through the parliamentary process to become law.

The recently published *UK five year antimicrobial resistance strategy 2013 to 2018* (DH, 2013) guidance is also referred to in the toolkit.

The toolkit will benefit both commissioners and providers of health and social care, and specifically:

- clinical commissioning groups (CCGs) commissioning leads with responsibility for infection prevention and control (IPC)
- specialist IPC nurses supporting commissioning organisations
- infection prevention leads/directors of infection prevention and control (DIPCs) in provider organisations
- infection prevention teams/specialists
- local authorities.

For further information on the IPS and RCN IPC activity please visit [www.ips.uk.net](http://www.ips.uk.net) and [www.rcn.org.uk/ipc](http://www.rcn.org.uk/ipc)

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This publication is due for review in July 2015. To provide feedback on its content or on your experience of using the publication, please email [publications.feedback@rcn.org.uk](mailto:publications.feedback@rcn.org.uk)
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Infection prevention and control is fundamental in improving the safety and quality of care provided to patients. NHS England is pleased to support resources, such as this guidance, for providers and commissioners of care that will help them to establish a health care associated infection (HCAI) reduction plan, which reflects local and national priorities. This includes antimicrobial resistance (AMR), as stated in the national contract. Not only will this ensure that services are provided safely, but will also help commissioners to fulfil their obligations to drive improvement in services and will contribute to the further development of the nationwide work to combat AMR.

NHS England supports the use of expert guidance and encourages commissioners to utilise such resources and work closely with infection prevention and control teams to enable an understanding of local priorities and development of meaningful outcomes to support ongoing reductions in HCAI and improvements in patient safety.

Mike Durkin, Director of Patient Safety, NHS England
1. Introduction

Reducing health care-associated infections (HCAIs) remains high on the Government’s safety and quality agenda and in the general public’s expectations for quality of care. Since 2008, there has been a legal requirement on the NHS and all health and social care organisations to implement the Health and Social Care Act 2008, and to meet the standards of the Code of practice in the Act (DH, 2010).

Some of the other key drivers for change include:

- **the NHS mandate** (DH, 2013)
- **the UK 5 year antimicrobial resistance strategy 2013-2018** (DH, 2013)
- **Care Quality Commission registration requirements** (CQC, 2009)
- **Risk assessment framework** (Monitor, 2013)
- **Everyone counts: planning for patients 2014/15 to 2018/19** (NHSE, 2013)
- **Commissioning for quality and innovation (CQUIN): 2013/14 guidance** (NHSE, 2013)
- health building notes, technical memoranda and the Choice Framework for local Policy and Procedures (CFPP) that form a suite of evidence-based policy and guidance documents on the management and decontamination of reusable medical devices (DH, 2013)
- the Quality, Innovation, Productivity and Prevention (QIPP) collection of case studies designed as a resource
- a collection of case studies designed to help everyone in the NHS, public health and social care to make decisions about patient care or the use of resources
- National Institute for Health and Clinical Excellence (NICE) guidelines or quality statements eg, NICE Quality Standard - Infection prevention and control (QS61).

This toolkit provides an overarching framework to help meet the challenge of reducing and sustaining the reduction in HCAIs. It has been developed to support commissioning and provider organisations in England to ensure that the structures, objective setting, monitoring assurance arrangements, and resources for the prevention, control and reduction of HCAIs are in place and regularly reviewed.

2. Using the toolkit

The toolkit provides information for professionals involved in the commissioning or assurance of health and social care services. It relates specifically to the organisational approach to infection prevention and control.

The guidance suggests using a series of indicators to support performance management and assurance against provider contracts. When the indicators are used they should recognise and reflect the expanding provider landscape. The toolkit also provides an HCAI reduction plan for commissioners to adapt for local use (see appendix 2, page 17).

The toolkit should be read in conjunction with *Infection prevention and control within health and social care: commissioning, performance management and regulation arrangements (England)*, the joint RCN/IPS briefing paper (RCN, 2013) (currently under review) produced to support professionals during the transition of commissioning reforms.

**Who will find it useful?**

The toolkit may be a useful resource for:

- health and social care contracting teams
- performance monitoring teams
- safety and quality teams
- commissioning leads for infection prevention and control
- CCGs and commissioning support units (CSUs)
- NHS England and its associated area teams
- health and social care provider organisations in both acute and community settings
- provider organisations who sub-contract services
- general practitioners
- independent provider organisations
- organisations considering tendering for NHS provider services
- local authorities and associated health and wellbeing boards.
It may also help providers of health, social care and community services that are not regulated under the Health and Social care Act 2008, but still have responsibilities for maintaining standards of infection prevention and control.

The toolkit will be of particular value to commissioning organisations that do not have access to specialist infection prevention expertise. It should be used together with expert infection prevention advice that is available, to identify priorities and ensure monitoring strategies are used appropriately and proportionally.

3. Reducing the incidence of HCAI: zero tolerance to HCAIs

Expectations and the role of commissioning organisations

Commissioners and providers must not accept that HCAIs are an inevitable or an acceptable risk in health or social care. Commissioning organisations will hold providers to account for their performance, and assess their contribution to sustained improvement in infection prevention and control practices that reduce HCAIs and antimicrobial resistance.

To achieve this they will evaluate local objectives systematically across the organisations they commission services from. They will ensure that there is proportionality to risks associated with different care settings. Commissioning teams will review surveillance data so that they can monitor progress against nationally set objectives for specific organisms, other agreed indicators and learning identified from post-infection reviews (PIR) or root cause analysis of incidents.

Commissioning organisations should be assured that all services commissioned or contracted by them, or on their behalf, are compliant with a range of guidance, policy and regulations, as detailed below.

- Care Quality Commission compliance guidance (CQC, 2010) *Outcome 8: Cleanliness and infection control.*
- Achieving HCAI reduction in line with national and local objectives.
- Reporting HCAI deaths on any part of the death certificate according to local policy and procedures.
- Ensuring lessons learned from any incidents or regulatory recommendations are completed in a timely way.
- Contractual requirements relating to NICE guidelines, quality standards and other national policies.

All commissioning organisations require assurance about the systems and processes that are in place. This should include:

- evidence or service review
- receipt of appropriate and adequate information
- evidence of monitoring information
- evidence of action being undertaken when concerns are raised, there is failure to meet expected standard or discrepancies in data and information has been noted by the commissioner.

Expectations of provider organisations

There is a legal requirement on all provider organisations to implement the standards in the *Code of practice on the prevention and control of infections and related guidance* (DH, 2010). This is integral to CQC registration and ongoing compliance.

The best practice described in this toolkit emphasises that the following requirements are expected of provider organisations:

- be registered with the CQC to provide care that meets the requirements of the *Code of practice* (DH, 2010)
- have their own local infection prevention and control strategy or HCAI reduction plan, or annual programme of work tailored to meet locally identified priorities
- have an assurance framework that reflects the local commissioning organisation’s HCAI reduction plan and contractual requirements
• undertake assessments of their compliance with the Code of practice (DH, 2010) at intervals agreed with the commissioning organisation.
• submit compliance reports to the board for internal assurance and the commissioning organisation for external assurance
• actively engage with the processes for HCAI/infection prevention and control (IPC) performance and quality monitoring
• be active members of any relevant health economy infection prevention group or other appropriate forums.

4. Indicators

Using the IPC commissioning indicators

The IPS and the RCN have developed this toolkit for commissioning and provider health and social care organisations to support the commissioning of infection prevention and control. Our aim is that the toolkit will become an enabling resource. It has been designed to support commissioner and provider organisations to communicate and agree the content and ambition of their contract so that the quality and safety of care provided is continually improved.

The toolkit includes mandatory indicators, and a basket of indicators to consider for inclusion in local commissioning contracts (see appendix 1). There is also an example of a local HCAI reduction plan that can be adapted by commissioners for local use (see appendix 2).

Health and social care commissioners require provider organisations to guarantee clean environments and safe practices to prevent HCAIs. The assurance process should not mirror other compliance or regulations. It should focus on the improvements needed, based on local requirements. Some commissioning and provider organisations may be more highly developed in measuring and reporting indicators than others. However, there should be a common aim to standardise these where possible, while developing additional opportunities for quality improvement at local level. Ideally this should be a shared process between commissioners and providers based on local need and the aim of improving patient safety.

Indicators help organisations understand, compare, predict outcomes and improve care. They should align contractual requirements to compliance with NHS England’s Everyone counts, planning for patients 2014/15 to 2018/19 (2013) and Monitor’s Risk assessment framework (Monitor, 2013). They should be used to support the delivery of the Public health outcomes framework (DH, 2013). Indicators should also reflect requirements to implement national, regional and local best practice guidance. This will ensure that the priorities for infection prevention and control are in the contracts.

This toolkit presents the indicators in the format of the NHS national contract so that users can lift the detail and place it into individual provider contracts. This can also be adapted for inclusion in social care contracts.

Mandatory indicators

For 2014/15 (see appendix 1) there are only two mandatory objectives included in the national contract including the continued zero tolerance of MRSA blood stream infection, and an ongoing focus on reducing Clostridium difficile infections (NHSE, 2014).

Basket of suggested indicators

In addition to the national indicators there is a further basket of indicators listed below (see appendix 1) developed by the RCN/IPS. Commissioners may choose the indicators based on local surveillance data, information from provider compliance reports and other local intelligence. These can be included either as indicators or in the information schedule of the contract as regularly collated detailed information.

Commissioners can also decide that specific assurance for some of the suggested indicators is not required because they are confident that practice is well embedded. In effect, each provider should have its own unique set of indicators and information schedule requirements to facilitate the robust assurance of performance required on IPC for the specific provider. The IPS has developed quality improvement tools for infection prevention, which are available from the IPS website. They provide evidence-based tools.
designed to measure baseline compliance with standards and to identify areas for improvement.

**Quality requirement: threshold method of measurement and consequences of breach**

Quantifiable measurements are used to reflect the critical success of an organisation, service or provider. As indicators reflect goals, each indicator has a target or plan. The quality requirement serves as a benchmark for comparison or guidance against which a breach may be applied.

**Note about thresholds**

The table below (appendix 1) suggests thresholds that can be agreed through local negotiation between commissioner and provider to decide what is appropriate and proportionate.

**Note about using the information schedule**

The information schedule can be used as another option. Commissioners may choose to place one of the currently suggested indicators into the information schedule, and could replace the historical threshold requirement to reporting expectation. This is shown in this updated document.

Using this approach will help to hold the provider organisation to account in the event that the information supplied in the information schedule does not provide the level of assurance required of good infection prevention and control standards.
5. Appendices

1: Infection prevention and control indicator basket

Quality indicators provide commissioners and providers with clear guidance on what is required to support contract management. This ensures that the delivery of standards always reflects what is needed, what should be reported and how it will be measured to fulfil the contract requirements.

The table below reflects the NHS national contract local quality requirements table. Any breach would be subject to the appropriate clause in the contract, and is also mapped against the Chief Medical Officer’s strategy antimicrobial resistance strategy (AMR) to focus the impact of HCAI on AMR activity.

Note on 100% compliance with quality requirements

This guidance acknowledges the ambition to strive for 100 per cent compliance with the indicators suggested below as the 'quality requirement'. It is recognised however that many organisations are working towards 100 per cent compliance and are not yet in a position to report full compliance, and that on occasions 100 per cent compliance is not possible. The RCN and IPS both acknowledge and support the premise that patient safety overrides a focus on trying to reach a target or indicator on all occasions, and that learning identified from understanding why indicators have not been met should be used meaningfully to improve patient safety and sustained improvements in HCAI reductions.

<table>
<thead>
<tr>
<th>Quality requirement</th>
<th>Threshold (reporting expectation)</th>
<th>Method of measurement</th>
<th>Comments</th>
<th>Chief Medical Officer (CMO) AMR strategy action area</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of meticillin-resistant staphylococcus aureus (MRSA) bacteraemias notified by provider to commissioner by next working day and refer to post infection review (PIR) process.</td>
<td>Notification of MRSA bacteraemia.</td>
<td>Monthly confirmation of % of cases notified by next working day.</td>
<td>PIR process is a national requirement.</td>
<td>1, 5</td>
</tr>
<tr>
<td>Attendance of provider at MRSA PIR meetings and implementation of actions.</td>
<td>Contribution to the PIR process and implementation of actions.</td>
<td>Monthly submission of evidence demonstrating provider involvement in PIR meetings and progress with actions.</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>100% of eligible cases are screened for MRSA.</td>
<td>Monthly confirmation of % of eligible cases</td>
<td>Monthly receipt of screening data.</td>
<td>Detail of measurement method to be determined locally ie, protocol for eligibility. 100% compliance is for local determination.</td>
<td>1</td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold (reporting expectation)</td>
<td>Method of measurement</td>
<td>Comments</td>
<td>Chief Medical Officer (CMO) AMR strategy action area</td>
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<tr>
<td>100% compliance with locally agreed MRSA care pathway.</td>
<td>Monthly confirmation of % of MRSA-positive patients that follow and complete the MRSA care pathway.</td>
<td>Monthly receipt of MRSA care pathway compliance data.</td>
<td>Detail of measurement method to be determined locally. 100% compliance for local determination.</td>
<td>1</td>
</tr>
<tr>
<td>Providers undertake assessment of every confirmed <em>Clostridium difficile</em> (<em>C. difficile</em>) infection to determine if lapses in care contributed to infection.</td>
<td>Undertake <em>C. difficile</em> infection assessment process, identify lessons and implementation of actions.</td>
<td>Monthly submission of evidence demonstrating provider involvement in infection assessment meetings and progress with actions.</td>
<td>Assessment process to be determined locally.</td>
<td>1</td>
</tr>
<tr>
<td>100% compliance with locally agreed <em>C. difficile</em> care pathway.</td>
<td>Confirmation of % of <em>C. difficile</em> patients that follow and complete the care pathway.</td>
<td>Monthly receipt of <em>C. difficile</em> care pathway compliance data.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>1</td>
</tr>
<tr>
<td>100% of periods of increased incidence (PIIs) and outbreaks are reported to the commissioner.</td>
<td>PII and outbreaks are reported by the next working day.</td>
<td>Monthly reporting.</td>
<td></td>
<td>1,5</td>
</tr>
<tr>
<td>100% of HCAI-related serious incidents are reported to the commissioner within one working day, including where an alert organism such as <em>C. difficile</em> or MRSA is noted on any part of a patient’s death certificate.</td>
<td>Notification within one working day.</td>
<td>Monthly reporting.</td>
<td>Requirements for serious incident (SI) reporting of HCAI incidents to be determined locally.</td>
<td>1</td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold (reporting expectation)</td>
<td>Method of measurement</td>
<td>Comments</td>
<td>Chief Medical Officer (CMO) AMR strategy action area</td>
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</tbody>
</table>
| Actions and learning are identified following analysis of:  
  - *C. difficile* cases  
  - other significant HCAI incidents as agreed locally. | Monthly reporting of analysis completion and lessons identified. | Evidence of analysis and lessons identified. | | 1 |
| Learning is implemented following analysis of:  
  - *C. difficile* cases  
  - other significant HCAI incidents as agreed locally. | Monthly reporting of identified learning implemented following analysis. | Evidence of implementation of learning. | | 1 |
<p>| 100% compliance with national mandatory surveillance programme for methicillin-sensitive <em>S. aureus</em> (MSSA) bacteraemia. | Monthly upload of all cases with all relevant information (all cases are submitted and all data fields completed). | Completed dataset submission in required timescales. | | 1, 5 |
| 100% compliance with national mandatory surveillance programme for <em>E. coli</em> bacteraemia. | Monthly upload of all cases with all relevant information. | Completed dataset submission in required timescales. | | 1, 5 |
| The provider has a system in place to support preparedness or management of patients carrying carbapenemase-producing enterobacteriaceae (CPE). | The provider has a policy in place for CPE-management and has considered the implications of implementation on its service. | Confirmation of policy in place. | | 1 |</p>
<table>
<thead>
<tr>
<th>Quality requirement</th>
<th>Threshold (reporting expectation)</th>
<th>Method of measurement</th>
<th>Comments</th>
<th>Chief Medical Officer (CMO) AMR strategy action area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board-approved IPC plan is implemented and progress reported against the plan.</td>
<td>Quarterly progress reports and annual IPC report.</td>
<td>Quarterly receipt of reports detailing compliance and progress against plan.</td>
<td>The provider may wish to use the code of practice to develop an IPC plan.</td>
<td>1</td>
</tr>
<tr>
<td>Board-approved annual report includes details on IPC team (IPCT) resources.</td>
<td>Annual report includes details on service and specialist IPC (nurse/doctor/support staff) resource requirements and identifies where gaps or risks exist.</td>
<td>Inclusion in annual report.</td>
<td>IPC resources should include a rationale for staffing requirements including support staff such as admin, statistical analysis etc and both actual and agreed resources.</td>
<td>1</td>
</tr>
<tr>
<td>Provider makes copies of all reports and associated action plans in response to any external IPC focus visits/inspections available to the commissioner eg, from DH, CCG, CQC Monitor, NHS Trust Development Authority (NTDA).</td>
<td>Copies of reports and action plans sent to commissioner within three weeks of provider receiving report.</td>
<td>Receipt of report by commissioner.</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Attendance and active contribution by provider organisation to whole health economy strategic planning discussion and decision-making on HCAI reduction.</td>
<td>Attendance as per terms of reference. Progress against programme and provider’s remedial actions as appropriate.</td>
<td>Minutes of meetings.</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Patient experience data related to IPC is collated, reviewed and acted on.</td>
<td>Quarterly reporting of patient experience survey data relating to IPC including actions taken to improve patient experience.</td>
<td>Receipt of reports by commissioner.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>1</td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold (reporting expectation)</td>
<td>Method of measurement</td>
<td>Comments</td>
<td>Chief Medical Officer (CMO) AMR strategy action area</td>
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<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>100% compliance with local antibiotic policies.</td>
<td>Quarterly reporting of compliance including if there is evidence of justifiable clinical reasons for deviation from set formulary.</td>
<td>Audit of compliance with the antibiotic prescribing formulary.</td>
<td>100% compliance, method of measurement and inclusion criteria for local determination. Consider both prescribing and dispensing of antibiotics.</td>
<td>2</td>
</tr>
<tr>
<td>100% of prescribers meet their professional standards of education and competency, including Public Health England’s (PHE) Antimicrobial prescribing and stewardship competencies (2013).</td>
<td>Quarterly report for training and competency.</td>
<td>Quarterly report and analysis against quality requirement.</td>
<td>Information should be provided on the numbers of different professional groups receiving training and competency assessment as per the PHE’s Antimicrobial prescribing and stewardship competencies (2013) compared to those that are eligible.</td>
<td>2,3</td>
</tr>
<tr>
<td>100% of medical and registered nursing/midwifery staff receive education as part of mandatory training on AMR including best practice in medicines optimisation.</td>
<td>Quarterly report of training numbers and % of those who have completed training.</td>
<td>Quarterly report.</td>
<td>Education should focus on an holistic approach to antimicrobial agents including therapeutic management, prescribing and dispensing.</td>
<td>2,3</td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold (reporting expectation)</td>
<td>Method of measurement</td>
<td>Comments</td>
<td>Chief Medical Officer (CMO) AMR strategy action area</td>
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<td>---------------------------------------------------</td>
</tr>
<tr>
<td>The organisation participates annually in awareness-raising programmes that support best practice in antimicrobial prescribing/use eg, European Antibiotic Awareness Day (EAAD).</td>
<td>Inclusion in annual report.</td>
<td>Evidence and detail of participation in annual report.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>2,3,7</td>
</tr>
<tr>
<td>A local surveillance programme is in place to reflect local intelligence and risk assessment.</td>
<td>Local surveillance programme is in place and implemented.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>1,5</td>
<td></td>
</tr>
<tr>
<td>Participation in national surgical site infection surveillance programme.</td>
<td>Minimum of one three month orthopaedic module per year reported.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>100% compliance with infection prevention care bundles that include high impact interventions (HIIs) such as: Saving lives: reducing infection, delivering clean and safe care (DH, 2007); and Essential steps to safe, clean care: introduction and guidance (DH, 2005).</td>
<td>Monthly reporting of compliance.</td>
<td>Monthly confirmation of 100% compliance.</td>
<td>100% compliance and method of measurement for local determination eg, per ward/department/directorate.</td>
<td>1</td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold (reporting expectation)</td>
<td>Method of measurement</td>
<td>Comments</td>
<td>Chief Medical Officer (CMO) AMR strategy action area</td>
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<td>--------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Provider has in place an ongoing programme of work to reduce the use of unnecessary invasive devices.</td>
<td>Progress against programme and remedial actions.</td>
<td>Quarterly reporting of progress.</td>
<td>The organisation may consider a multidisciplinary and multi-professional programme to reduce inappropriate use of invasive devices.</td>
<td>1</td>
</tr>
<tr>
<td>100% of patients isolated as per agreed local policy and advice from IPCT.</td>
<td>Report compliance with isolation policy.</td>
<td>Quarterly reporting including exceptions of variation to policy.</td>
<td>Provider organisations should consider presentation of data to include non-isolation of patients per patient bed day.</td>
<td>1</td>
</tr>
<tr>
<td>Compliance with provider’s internal hand hygiene policy.</td>
<td>Monthly report.</td>
<td>Compliance audit with hand hygiene (HH) policy.</td>
<td>% compliance and method of measurement for local determination eg, per ward/department/directorate.</td>
<td>1</td>
</tr>
<tr>
<td>100% compliance with national environmental cleaning standards/local cleaning protocols.</td>
<td>Compliance with national standards/protocols for cleaning.</td>
<td>100% compliance and method of measurement for local determination eg, per ward/department/directorate.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>100% compliance with patient equipment cleaning standards/cleaning protocols.</td>
<td>Compliance with local equipment cleaning standards.</td>
<td>100% compliance and method of measurement for local determination eg, per ward/department/directorate.</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold (reporting expectation)</td>
<td>Method of measurement</td>
<td>Comments</td>
<td>Chief Medical Officer (CMO) AMR strategy action area</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Organisation has a multidisciplinary training and competency assessment programme in place for aseptic technique for all those who undertake aseptic procedures in their roles.</td>
<td>Progress against programme and remedial actions.</td>
<td>Quarterly reporting.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>1,3</td>
</tr>
<tr>
<td>Local mandatory IPC training programme is delivered as per locally agreed plan for each staff group.</td>
<td>Biannual reports and evaluation of training programme is received.</td>
<td>Biannual reporting.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>1,3</td>
</tr>
<tr>
<td>Information about infection risk shared between health and social care providers for all patients.</td>
<td>100% of patients.</td>
<td>Biannual reporting.</td>
<td>100% compliance and method of measurement for local determination.</td>
<td>1</td>
</tr>
<tr>
<td>Reporting on compliance of health care worker vaccination programme.</td>
<td>Quarterly confirmation of % confirmation of actual numbers and types of vaccination against eligible staff.</td>
<td>Quarterly reporting to commissioner including exceptions of variation to policy.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2: Example of a local health care-associated infection reduction plan

The [organisation/commissioning body] is committed to reducing the risk of health care-associated infection (HCAI) as a key priority. The prevention and control of infection lies at the heart of patient safety, quality patient care, good management, governance and effective clinical practice.

The purpose of this HCAI reduction plan is to outline the [organisation/commissioning body’s] approach to the prevention and control of HCAIs for the period April [year] to March [year] and to outline a plan for the future new commissioning structures and arrangements. The framework is designed to establish ownership of infection prevention and control at all levels throughout the organisations served by and accountable to the [organisation/commissioning body]. It supports a co-ordinated approach to the prevention and control of infection across all areas of responsibility. All providers will be expected to have in place annual programmes of work to ensure that standards and objectives are met according to agreed contractual indicators and national and local objectives for reducing HCAIs. This activity will be monitored on a locally agreed basis through formal reporting mechanisms established through the integrated quality teams and contract and performance monitoring systems. As the changing NHS welcomes any competent providers, incorporation of quality standards for infection prevention and control through all levels of the commissioning and contractual process is essential.

The overarching purpose of the infection prevention and control commissioning role is to ensure the infection prevention and control element of patient safety, quality and experience is embedded within the commissioning process.

The four main requirements to effectively commission for infection prevention and control include: development and leadership of the health and social care economy; contracting (including setting clear expectations of achievement eg, compliance with the code of practice for infection prevention and control); performance monitoring against the contract (gaining assurance); and organisational accountability.

Development and leadership of the health and social care economy

Aim: to support the above key requirements and all health care providers to develop and own a collaborative approach to the prevention and management of HCAIs

- Set up a health economy-wide infection prevention and control (IPC) network group with the aim of establishing a health and social care economy collaborative meeting that has sign up from chief executives and directors.

- Develop an IPC strategy based on a joint strategic needs assessment, which is supported by and agreed by the health economy. This in turn will support individual provider organisation IPC strategies, and sit as part of the overarching quality and safety strategy for the commissioning organisation.

- Develop systems in collaboration with all stakeholders that are fit for purpose, and which will support delivery of the HCAI/safety agenda.

- Agree an IPC infrastructure that will support providers to comply with standards of the Code of practice (DH, 2010). This should include your own strategy, assurance framework, risk assessment and work programmes with assurance reports to the provider board to demonstrate compliance with the code.

- To identify local needs develop capabilities and ensure that all providers aspire to a common IPC vision and goals.

- Commissioners should engage with social care providers to assist in their attainment of, and compliance with, the Code of practice. (Note: the legal responsibility lies with local authorities, but the expertise may sit within health or local authorities depending on local structures. Commissioning organisations have responsibility to the whole population).

- Commissioners should use the health economy network group to initiate and lead on the implementation of national/regional and local programmes in line with NHS England (2013) policies: Everyone counts, planning for patients 2014/15 to 2018/19; NHS outcomes framework 2014/15; and the Adult social care outcomes framework 2014/15.
For example:

- MRSA screening
- national HCAI surveillance programmes
- *Saving lives: reducing infection, delivering clean and safe care* (DH, 2007) and *Essential steps to safe, clean care: introduction and guidance* (DH, 2005)
- sharing of learning and findings from post-infection review and root cause analysis of HCAI
- antibiotic stewardship
- decontamination strategy
- safety thermometer
- long-term conditions and premature death due to communicable diseases.

**Contracting and setting the standards**

**Aim: to ensure national and local IPC standards are set at the correct level and included in contracts with provider organisations**

- When establishing IPC standards for provider organisations, regard must be paid to the following:
  - *Code of practice for infection prevention and control* (DH, 2010)
  - outcomes frameworks for the NHS, adult social care and public health (DH, 2013)
  - national and regional standards
  - local priorities.
- As a minimum, ensure that registration with the Care Quality Commission (CQC) and compliance with the *Code of practice* providers are included in contracts.
- Ensure there are service specifications for infection prevention and control (IPC), specific/relevant key performance indicators (KPIs) and quality indicators in provider contracts. As a minimum these should reflect the national objectives in the *Operating framework* and other national mandatory policies. See the basket of suggested indicators.
- Support engagement with quality improvement initiatives as appropriate through *Commissioning for quality and innovation* (CQUIN) development (NHSE, 2013).
- Use local infection prevention teams/experts to ensure infection prevention input occurs in the development of all new contracts, services and pathways.
- Ensure that there is specialist IPC practitioner input to IPC-related contracts such as: cleaning; catering; planned preventive maintenance (PPM); building construction and refurbishment; and waste management.

**Performance monitoring and gaining assurance from commissioners**

**Aim: to monitor performance against all shared objectives and KPIs from all providers**

- Commissioner organisations should participate in performance monitoring and quality assurance arrangements for each provider. For example, by:
  - attendance at provider infection prevention committees and review meetings with provider IPC leads as agreed locally
  - regular formal HCAI performance monitoring meetings with contract management staff
  - input into the overarching contract quality meeting/clinical quality review groups
  - receipt of regular infection prevention/HCAI dashboards from providers
  - unannounced inspection visits.
- Ensure there is appropriate IPC expertise in the commissioning organisation to interpret data or information received from providers.
- Analyse information submitted by providers and determine whether the information offers the required assurance.
- It is essential for independent contractors that the commissioning IPC team (IPCT) is part of internal performance monitoring arrangements for primary care such as performance management group or annual contract review processes. It is through this mechanism that environmental audits to assess environmental fitness for purpose can be fed into the overarching performance framework.
- IPC should feature in the commissioning framework about fitness to practise as commissioning decisions are made about the transfer of care from secondary to primary. For example, is the environment fit for purpose?
- Engage with primary care contracting to develop robust assurance of infection prevention practice across primary care providers as the commissioning processes evolve.
• Engage proactively with health and wellbeing boards to provide assurance that local population risks and needs are adequately understood, addressed and evaluated via existing commissioning processes in relation to IPC and antimicrobial resistance (AMR).

Organisational accountability in commissioning organisations

Aim: to ensure infection prevention and control is embedded and that board accountability/assurance is demonstrated

• The [organisation/commissioning body] has a clear understanding of its commissioned services IPC status and risks and has sufficient specialist IPC support/resources available to enable it to meet its responsibilities for quality and safety of the services provided IPC is included as an integral part of the [commissioning body/organisation] internal quality and safety monitoring and assurance systems.

• The [organisation/commissioning body] has a clear process for providing assurance to NHSE area teams with regard to HCAI and IPC standards and risks.

• The [organisation/commissioning body] has a strategic and operational plan for reducing HCAI and sustaining improvement of infection prevention practices that take into account the recent changes in NHS structures.

• Accurate and timely information that includes the quality dashboard and all other relevant performance matrix is reported to the organisational governance framework, and shared with relevant commissioning bodies.

• Information is monitored monthly by the infection prevention and integrated quality teams. Formal reports analysing quality and performance, action plans and exceptions are made to the approved committee in the commissioning organisation. Annual reports provide a summary of activity, assurance and risks to the board.

• IPC commissioning arrangements are embedded in the commissioning organisation’s governance processes.

• There is an escalation process in place. HCAI/AMR is added, where necessary, to the corporate risk register of the [organisation/commissioning body].

• Infection prevention is an integral part of the capital programme for new build premises and refurbishments to ensure IPC standards are met and buildings are fit for purpose.

• IPC is included as part of the emergency planning process.
6. Glossary of terminology

**Assurance** – the process by which confidence is provided that a product or service meets expectations such as quality or safety.

**Audit** – monitoring and evaluating practice against pre-existing standards.

**Care Quality Commission (CQC)** – the independent regulator of all health and social care services in England. Its role is to make sure that all care provided by hospitals, dentists, ambulances, care homes and services in peoples own homes and elsewhere meet government standards of quality and safety.

**Commissioning** – the process of assessing the health needs of a local population and putting in place services to meet those needs.

**Commissioning for Quality and Innovation (CQUIN) framework** – the CQUIN framework enables those commissioning care to pay for better quality care, helping promote a culture of continuous improvement.

**Contracting** – the legally binding arrangements that are agreed between service providers and commissioners to meet the health and social care needs of a specified population, including the quality and standards expected.

**Health care-associated infection (HCAI)** – an infection that develops as a result of health care, which was previously known as hospital acquired infection. It includes infections that occur as a result of medical care or treatment in hospital (in or outpatient), nursing homes or even the patient’s own home.

**Indicator** – a summary measure that aims to describe in a few numbers as much detail as possible about a system. It is designed to help health care staff understand, compare, predict, improve and innovate.

**Infection prevention and control team (IPCT)** – a team of specialist staff (usually comprised of nurses, doctors and support staff) that advises on proactive and reactive issues relating to infection prevention and control.

**Information schedule** – this is part of the contract between the commissioner and provider. It specifies the information required to assure the commissioner (in this instance) of compliance with the Code of Practice for infection control. This assurance is not measured against any set indicator.

**Key performance indicator (KPI)** – a type of performance measurement often associated with making progress toward strategic goals.

**Period of increased incidence (PII)** – emergence of clusters of symptomatic patients with as yet undiagnosed infection such as norovirus.

**Provider** – an organisation that provides services direct to patients, including hospitals, mental health services and ambulance services.
7. References


Further reading

NHS England resources for Clinical Commissioning Groups (CCGs) are available at [www.england.nhs.uk/resources/resources-for-ccgs](http://www.england.nhs.uk/resources/resources-for-ccgs).


Notes
The vision of IPS is that no person is harmed by a preventable infection

www.ips.uk.net

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