East of England Ambulance Service NHS Trust

Infection Prevention and Control Management Policy

Document Status	Approved
Version:	5.0 six-month extension

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author**
Infection Control Group	29th May 2008	External Advisor
Version	**Date**	**Comments (i.e. viewed, or reviewed, amended approved by person or committee)**
Final V1.0	October 2008	Approved by the Expert Strategic Clinical Group
Final V2.0	24th September 2010	Approved by Trust Board
Final V3.0	18th October 2012	Approved by EMB
Final V4.0	8th June 2015	Approved by EMB
Final V5.0	21 April 2016	Approved by Executive Leadership Board
Final V5.0	March 2019	Six-month extension approved by IPCG and subsequently by ELB

Document Reference	Health and Social Care Act 2012 (Regulated Activities) Regulations Code of Practice for the prevention and control of infection in Health and adult social care and associated guidance – the Hygiene Code Directorate: Clinical
Recommended at Date	Infection Prevention and Control Group 18th March 2019
Approved at Date	Executive Leadership Board Meeting
Review date of approved document	September 2019
Equality Impact Assessment	
Linked procedural documents	**Listed at 8. page 12**
Dissemination requirements	All staff and members of the public; to be placed on the Trust's intranet and public website
Checklist completed?	
Part of Trust's publication scheme	Yes

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.

1. Introduction

"Good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone.

Good management and organisational processes are crucial to make sure that high standards of infection prevention (including cleanliness) are set up and maintained"

Code of Practice (2015)

This policy sets out the ways in which the Trust will ensure its infection prevention and control systems, procedures and practices meet the best practice standards defined by *Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* and implemented by the *Code of Practice for the prevention and control of infections in health and social care and related guidance (2010)*

This policy updates the Infection Prevention and Control Management Policy V3.1 2015

2. Purpose

This Policy together with the safe practice guidelines will cover all the aspects of infection prevention and control and decontamination required to protect staff, patients and third parties as well as issues and procedures raised through Trust risk management processes or required for statutory purposes. This policy describes the processes to be operated within the Trust to enable and monitor all aspects of this policy. The associated Safe Practice Guidelines and the Decontamination Manual cover the specific Practical Procedures to ensure safe and effective practice.

Chemical, Biological, Radiological and Nuclear (CBRN) risks require specialist advice and training. The Department of Health provides guidance on this and the Trust has a team of specialists who are trained to deal with these risks. The key principles contained within this policy are relevant to CBRN activities within the Trust, however the Emergency Planning Team are responsible for providing policies, procedures, training and risk assessments relating specifically to CBRN. Where appropriate, cross-reference will be made to Trust IPC policies, safe practice guidelines and Decontamination Manual.

The purpose of the East of England Ambulance NHS Trust's Infection Control Management Policy, together with the associated safe practice guidelines and Decontamination Manual, is to state the Trust's infection control systems, describe the evidence-based clinical and decontamination practices to be adopted by staff and to facilitate infection prevention, control and safety systems being incorporated into every facet of ambulance service delivery.

3. Duties

The East of England Ambulance Service NHS Trust is the 'responsible body' and must make arrangements for ensuring compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and associated Code of Practice (2010). The IPC reporting structure is illustrated in Appendix A and the IPC team structure is illustrated in Appendix B

3.1 Trust Board

The Trust Board is responsible for receiving and reviewing reports from the Chief Executive on the effectiveness of the Trust's Infection Prevention and Control Management Policy and to ensure that action is taken to address any adverse incidents and infection trends. The Trust Board will also monitor compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 through the Patient Safety & Care Standards Committee.

The Trust Board has a collective responsibility for preventing and controlling infection risk. The Trust Board must ensure that there is an Infection Prevention and Control Management Policy and associated effective risk management systems in place. The Trust Board will annually review infection prevention and control arrangements and approve the Annual IPC Programme which provides clear activities, responsibilities and timescales for achieving compliance with the Code of Practice. The Trust Board will receive an annual Infection Prevention and Control report from the Director of Infection Prevention and Control (DIPC) providing details of performance achieved in compliance with the Annual Programme. They also receive monthly audit information.

3.2 Chief Executive Officer

It is the Chief Executive Officer's responsibility to ensure implementation of the Infection Prevention and Control Management Policy and that matters relating to infection prevention and control and decontamination are managed effectively.

The Chief Executive Officer is the 'responsible person' and has overall responsibility for the implementation of the Trust's Infection Prevention and Control Policy. The functions of the 'responsible person' may be performed by any person authorised by the 'responsible person' to act on their behalf. This responsibility has been devolved to the Director of Clinical Quality in their role as Director of Infection Prevention and Control (DIPC).

3.3 Director of Infection Prevention and Control (DIPC)

The Director of Infection Prevention & Control (DIPC) is accountable directly to the Chief Executive Officer and to the Trust Board for IPC activities.

The DIPC is responsible for: -

- Ensuring compliance with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Cleanliness and Infection Control) as defined in the Code of Practice for the prevention and control of infections in health and social care and related guidance (2010).
- Ensuring an Annual IPC Programme is in place to address all aspects of the Code for compliance purposes
- Providing reports on compliance with the Annual IPC Programme
- Chairing the Infection Prevention and Control Group which oversees all activities outlined in the Annual IPC Programme
- Advising the Trust Board on key risks relating to Infection Prevention and Control and Decontamination
- Presenting an annual report to the Board

- Ensuring that information is available to patients and the public about the organisation's general processes and arrangements for preventing and controlling healthcare acquired infections. Ensuring the IPC Annual Report is publicly available
- Ensuring that the Trust has access to suitably qualified infection prevention and control specialist advisors when needed
- Ensuring this Infection Prevention and Control policy is reviewed, monitored and updated annually

3.4 Quality Governance Committee

The Trust's Quality Governance Committee will report to the Trust Board on the operation of the Trust's Infection Prevention Control Audit Policy. The Committee will consider regular reports provided by the Infection Prevention and Control Group (IPCG) and make recommendations to the Trust Board as appropriate. The DIPC is a member of the Quality Governance Committee.

3.5 Clinical Quality and Safety Group (CQSG)

The Trust's Clinical Quality & Safety Group (CQSG) provides appropriate levels of assurance to the Information Governance Group (IGG) that risks relating to IPC have been identified, monitored and mitigated.

3.6 Infection Prevention and Control Group (IPCG)

The Infection Prevention and Control Group (IPCG) provides the DIPC and Executive Management Team with advice and guidance whilst acting as a working group of the CQSG. Its membership comprises senior Trust personnel with expertise and knowledge of infection prevention and control relevant to their role and responsibilities. Its Terms of Reference provide it with accountability and responsibility for the implementation of all Trust activity in relation to infection prevention and control and for providing assurance to the Trust Board in relation to compliance with the Code of Practice (2010).

3.7 Head of Infection Prevention and Control

The Head of IPC is responsible for: -

- Providing support to the DIPC
- Provide reports on all aspects of IPC to the Quality Governance Committee, CQSG and IPCG
- All aspects of day to day infection prevention and control management
- Co-ordinating all activities across the Trust in achieving compliance with the Annual IPC Programme
- Providing IPC input to the Trust's Learning and Development Programme relating to staff induction and continuing professional development
- Liaison with all Trust staff and communicating infection prevention and control practice issues to all locations
- Receipt, collation, analysis and reporting of relevant infection incident and audit data
- Supporting and co-ordinating the activities of named Trust infection prevention and control link persons and champions and establishing effective "two-way" communication with all Trust services via the link workers/ champions
- Facilitating access to appropriate advice and communication with other health care providers as and when necessary.

3.8 Managers and Supervisors

Managers in all areas of the Trust are responsible for ensuring this policy is communicated to staff and for ensuring compliance with this policy and the related safe practice guidelines in accordance with their role and responsibilities as defined in individual job descriptions.

Managers and Supervisors are responsible for the assessment of staff under their management as an integral element of annual performance appraisal.

3.9 Staff

All staff are expected to understand their role and responsibilities for IPC as defined in their job descriptions. Staff are expected to comply with this policy and related safe practice guidelines and Decontamination Manual to maintain and increase their knowledge of the subject relative to their role including completion of annual CPD training.

Operational performance and the implementation of the Infection Prevention and Control Policies is the responsibility of each individual member of staff as well as those who support the Trust in the delivery and discharge of its duty of care.

3.10 Voluntary Staff (including Community First Responders)

All voluntary staff have a requirement to abide by EEAST policies and procedures including the IPC Policies and to report any breaches in line with the Trust's Management of Incidents Policy. They are also required to attend relevant training including relating to IPC prior to commencement of their role.

3.11 Occupational Health

The Trust's Occupational Health provider is responsible for ensuring (incompliance with criterion 10 of the Code of Practice) that, so far as is reasonably practicable, all members of Trust staff (and contractors) are free of and are protected from occupational exposure to infections. This is achieved by:

- All staff having access to Occupational Health services
- Ensuring that Occupational Health policies on the prevention and management of occupationally acquired transmissible infections are in place and are cross-referenced in the IPC safe practice guidelines (as per Criterion 10 of the Code of Practice)
- Ensuring a comprehensive programme of immunisation is available to Trust staff based on local risk assessment as described in Immunisation against infectious diseases (DOH)-the Green Book and other relevant Department of Health Guidance as published
- Ensuring vaccines are available free of charge to employees if risk assessment indicates that it is necessary

The Occupational Health provider is a member of the Trust's IPCG and provides bi-monthly reports to the Group including accident / incident statistics.

3.12 External Agencies

A number of external agencies have a responsibility for supporting the Trust in achieving its objectives in relation to the Code of Practice. These agencies include the Clinical Commissioning Groups (CCG), Health Protection England and NHS England. There are representatives for Ipswich and Suffolk CCG, as the lead commissioner, and Health Protection England nominated as members of the IPCG.

3.13 Consultation and Communications with Stakeholders

Key Stakeholders are represented on the Trust Infection Prevention and Control Group which will review and approve this policy.

4. Definitions

4.1 The Trust

East of England Ambulance Service NHS Trust

4.2 The Policy

The Trust's Infection Prevention and Management Policy

4.3 Staff

Includes all Trust staff, contractors and volunteers working on behalf of the Trust

5. Development

5.1 Prioritisation of Work

This policy is essential to ensure that the Trust's infection prevention and control systems, procedures and practices meet the standards defined by *Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* and implemented by the *Code of Practice for the prevention and control of infections in health and social care and related guidance (2010).*

5.2 Identification of Stakeholders

The key stakeholders include the NHS England, Health Protection England and Ipswich & Suffolk CCG as lead commissioner of services and patients.

5.3 Responsibility for Document's Development

The policy was reviewed by the Head of Infection Prevention and Control in conjunction with the Infection Prevention and Control Group.

6. Infection Prevention and Control Management

The Infection Prevention and Control Management policy sets out the ways in which the Trust will ensure its systems, procedures and practices meet the best practice standards defined by *Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010* and implemented by the *Code of Practice for the prevention and control of infections in health and social care and related guidance (2010)*

7. Annual IPC Programme

The Code of Practice specifies the 10 criteria against which the Trust (as a registered provider of health care) will be judged on how it complies with the registration requirement for cleanliness and infection control.

Compliance with the criteria forms the basis of the Annual IPC Programme. The 10 criteria are as follows:

Compliance Criterion	**What the Trust is required to demonstrate**
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7*	Provide or secure adequate isolation facilities (Not applicable to Ambulance Trusts)
8*	Secure adequate access to laboratory support as appropriate (Not applicable to Ambulance Trusts)
9	Have and adhere to policies designed for the individual's care and provider organisations, that will help to prevent and control infections
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

*Criteria 7 and 8 are not applicable to Ambulance Service providers.

8. Assurance Framework

8.1 Risk assessment

The Trust has conducted an assessment of the risks associated with healthcare infection and those risks identified are detailed in the Trusts Infection Control Assurance Framework (ICAF). This framework provides structured assurances regarding the effective management of identified risks and that objectives are being delivered as part compliance with Code requirements. All activity (to address risks) is incorporated into the Annual IPC Programme and monitored by the IPCG.

8.2 Sources

Sources of assurance include policies and procedures, internal performance management, minutes of relevant meetings, reports presented to IPCG, audit reports, accident and incident reports and training records.

8.3 Reporting and monitoring

Reporting and monitoring of performance against the Code is provided thus:

- Annually to the Board by means of the DIPC annual report
- Bi-monthly to the Quality Governance Committee
- Bi-monthly as an agenda item at the IPCG
- Monthly through the IPC Monthly Update report
- Monthly through the Trust Quality report

The Trust monitors the level of severity of IPC incidents via the Datix Risk Management System.

Trend analysis is reported to the Trust Board via the Quality Governance committee within the Quality report.

Trends are also reported to the lead Commissioners (Ipswich & Suffolk CCG)

9. Equality Impact Assessment

The Equality Impact Assessment Executive Summary can be found in Appendix E

10. Dissemination and Implementation

10.1 Dissemination

The policy will be available electronically on the Trust Intranet site EAST 24. Printed copies will be placed in the Infection Prevention and Control Manual which is available at all stations. Staff will be informed of the revisions to the policy via Trust bulletins and emails.

10.2 Implementation

10.2.1 Training needs

In order to ensure compliance with criterion 10 of the Code, together with the health, safety and well-being of service users and staff, the Trust provides IPC training on both its mandatory corporate induction, clinical training courses and annual professional updates as defined in the Learning and Development Policy and Induction Policy.

All Trust procedural documents which have IPC training needs for staff are included in the *Corporate, Mandatory and Statutory Training Needs Analysis* document which is the

responsibility of the People Development and Education Team and is available on the Trust intranet, within the Learning and Development and Induction policies. This forms part of the Annual IPC Programme.

10.2.2 Duties in relation to training needs

Staff have a range of duties in relation to training needs:

- **Authors of procedural documents –** have responsibility for informing the Information Governance Team of updates / amendments to IPC-related procedures to ensure ratification through the Trust approved process
- **Ratification body (IPCG) –** is responsible for ensuring contracted staff are adequately trained in IPC procedures commensurate with their duties and work location and to monitor these training needs by means of regular reports from the People Development and Education Team
- **Staff responsibilities –** all staff have a responsibility for ensuring that they undertake / attend IPC training commensurate with their role and responsibilities as detailed at induction and staff PDR
- **Learning and Development Team –** have responsibility to provide access to training for all staff. • Learning and Development Team also have responsibility to maintain monitoring, reporting and review systems as per the Learning and Development Policy, the Induction Policy and the Personal Development Review Policy.

11. Process for Monitoring Compliance and Effectiveness

It is the responsibility of the IPCG to ensure compliance with this policy (as per criterion 1 of the Code).

Compliance monitoring is undertaken by means of an annual programme aligned against the Code of Practice and agreed by the IPCG. Details are laid out in the IPC audit strategy and annual audit programme. This is monitored with exception reporting through the IPCG to the Clinical Quality and Safety Group and Patient Safety & Care Standards Committee. Incidents relating to IPC are reported through the IPC monthly update report and to the Trust Board and Lead Commissioners via the Quality Report.

12. Standards/Key Performance Indicators

The key standards against which IPC performance is measured are: The Health and Social Care Act 2008 *Code of Practice for the prevention and control of infections in health and social care and related guidance (2011).* National patient Safety Agency National Specifications for Cleanliness in the NHS: Ambulance Trusts 2009 and NICE Infection Prevention and Control of health care associated infections in primary and community care (2014)

Key performance indicators for IPC are station and vehicle cleanliness; hand hygiene and uniform compliance and completion of mandatory IPC training. These are monitored via monthly technical audits and via Learning and Development Unit attendance records plus completion of QA10 assessments for operational staff. The results are submitted to the IPCG and CQSG and reported in the monthly IPC report, Quality Report and IPC annual report.

13. References

Health and Social Care Act 2008 Code of practice for the prevention and control of infection in health and social care and related guidance (2010)

National Patient Safety Agency National Specifications for cleanliness in the NHS: Ambulance Trusts (2009)

NICE Infection Prevention and Control of Health Care Associated Infection in Primary and Community Care (2014)

14. Associated Documents

This policy should be read in conjunction with a number of core Trust procedures and guidelines which are required in compliance with criterion 8 of the Code of Practice.

These include the following:

- IPC Safe Practice Guidelines
- Decontamination Manual
- IPC Audit Policy
- Major Incident Plan
- Pandemic and Seasonal Influenza Policy

Appendices

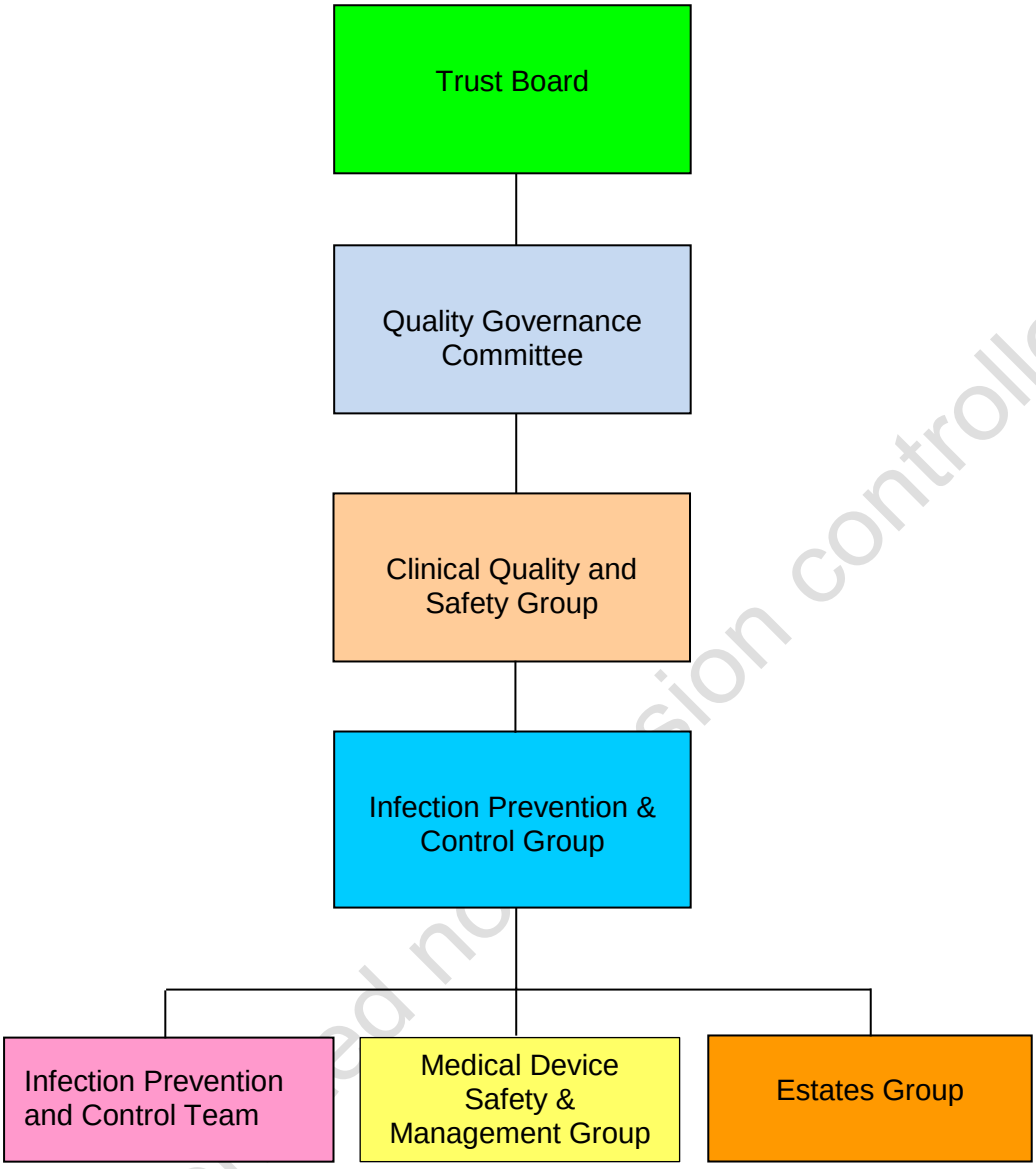
A - Infection Prevention and Control Accountability Structure

B - Checklist for the Development or Review and Approval of Procedural Document

C - Monitoring Table

D - Equality Impact Assessment: Executive Summary

Appendix A – Infection Prevention & Control Reporting and Accountability Structure



Committee / Group Membership:

Director of Infection Prevention & Control							
Head of Infection Prevention & Control							
Representatives from Operational Directorates							
Associate Director- Operational Support							
Waste Manager							
Operational Staff							

Appendix B – Checklist for Development /Review & Approval Procedural Document

This should be completed and attached to any procedural document when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ N/A	Comments
1.	**Purpose**		
	Are the reasons for the development of the Document stated?	Yes	
2.	**Definitions**		
	Have all key terms been clearly defined?	Yes	
3.	**Consultation**		
	Have relevant stakeholders and/or users been consulted with?		
4.	**Equality Impact Assessment**		
	Has the Trust Equality Impact Assessment Screening Form been completed and attached by the author and approved by the responsible Executive Director?		
5.	**Monitoring**		
	Has the Monitoring Table been fully completed and attached?		
6.	**References/Associated Documents**		
	Are key references cited?		
	Are linked documents identified where appropriate?		
6.	**Approval**		
	Does the Document identify which committee/group will approve it?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8.	**Review Date**		
	Is the review date identified?		

Information Governance Lead (or delegated authority)			
This Procedural Document complies with the Policy for the Development of Procedural Documents			
Name		Date	
Clinical Quality Team			
The Procedural Documents complies with the relevant NHSLA standards			
Name		Date	
Please attach to the procedural document and forward to the relevant committee for approval			

Appendix C – Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Compliance with the Health and Social Care Act 2008 and key national guidance (NPSA and NICE)	***Infection Prevention and Control Group*** ***Clinical Quality and Safety Group***	***Infection Prevention and Control Annual Programme and Work Plan.***	***The IPC work plan is a live document and is updated as required; it is reviewed bimonthly at the IPC Group meeting.***	*Copies of the IPC programme and work plan, quality indicators minutes of meetings, annual report, quarterly quality reports.*	*The IPC Group and CQSG monitor compliance The IPCG reports to the Trust board and lead commissioners.* *The lead or committee is expected to read and interrogate any report to identify deficiencies in the system and act upon them*	*The IPCG and IPC team undertake action planning and undertake recommendations. Other departments such as estates are also required to act on relevant issues.* *Required actions will be identified and completed in a specified timeframe.*	*Required changes to practice will be identified and actioned within a specific time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.*

Appendix D - Equality Impact Assessment: Executive Summary

Executive Summary Page for Equality Impact Assessment:	
Document Reference:	Document Title: Infection Prevention and Control Management Policy
Assessment Date: 11 March 2016	Document Type: Policy
Responsible Director: Sandy Brown	Lead Manager: Dave Cunningham
Conclusion of Equality Impact Assessment: This policy relates to the way in which the Trust will comply with the Health and Social Care Act 2008, it is not a procedural document and does not present any equality or diversity issues.	
Recommendations for Action Plan: None	
Risks Identified: None	
Approved by a member of the executive team:	
YES	**NO**
Name:	Position:
Signature:	Date:
This whole document should be stored with the master document and a final approved electronic copy must be sent to the Equality & Diversity Lead at Bedford Office	