Management of Infection Prevention and Control Policy

Department / Service:	Infection Prevention Team	
Originator:	Tracey Cooper	Deputy Director of Infection Prevention & Control
Accountable Director:	Vicky Morris	Chief Nursing Officer/Director of Infection Prevention and Control (DIPC)
Approved by:	Trust Infection Prevention & Control Committee	
Date of Approval:	29th April 2019	
Review Date: **This is the most current document and should be used until a revised version is in place**	29th April 2021	
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust	
Target Departments	All services	
Target staff categories	All staff categories	

This policy sets out the Trust arrangements for managing infection prevention and control.

This policy also provides a robust framework for management of corporate documents under the general title of 'Infection Prevention & Control': all policies, procedures, protocols and guidelines produced by the Infection Prevention and Control Team.

It covers the format, production, consultation process and approval of key documents as well as their accessibility, distribution, acceptance by designated staff, communication, revision and the archiving of obsolete documents.

Key amendments to this Document:

Date	Amendment	By:
	Note: Amendments between 2009 and Oct 2018 removed April 2019. Please see previous version for full audit trail.	
October 2018	Document extended until end of November	Heather Gentry
April 2019	Major amendment to roles and responsibilities, to reflect current Trust arrangements. Inclusion of new Deputy DIPC role. Current version of TIPCC terms of reference included.	Tracey Cooper

Contents page:

1. Introduction

The Trust is committed to achieving excellent infection prevention practices, and aims to be one of the best organizations in the UK for our rates of infection.

This policy sets out the mechanism for effective management of infection prevention and control across the Trust, and the associated policies and procedures.

The Trust must adhere to the statutory requirements set out in *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015).* This document is also known as *The Hygiene Code*.

2. Scope of the Policy

This policy applies to all staff on all sites where the Trust delivers care, and also covers agency staff, locums, visitors, contractors and others working on Trust premises. It details the Trust's arrangements for the management of Infection Prevention and Control (IPC), including the development and review of policies and procedures.

3. Definitions

3.1 Infection Prevention and Control (IPC)

The policies, practices and processes in place to minimise infection. These will reduce the risk of infection to individual patients, visitors and staff, and minimise the risk of cross infection from patient to patient within the healthcare setting (e.g. MRSA or *Clostridium difficile*).

3.2 Healthcare Associated Infection (HCAI)

Any infection acquired as a result of hospital admission or other healthcare intervention.

4. Responsibility and duties

4.1 Trust Board

The Trust Board has overall responsibility for ensuring that adequate resources are provided for the prevention of infection, and for monitoring the impact of Trust infection prevention activities. The Board receives assurance regarding the effectiveness of IPC policies and practice through regular reports from the Quality Governance Committee, which scrutinises infection prevention activity in detail on behalf of the Board. Reporting includes the annual report to the Board from the Director of Infection Prevention and Control.

4.2 Chief Executive

The Chief Executive accepts on behalf of the Trust Board ultimate responsibility for all aspects of IPC within the Trust. This responsibility is delegated to the Chief Nursing Officer (as DIPC).

4.3 Chief Nursing Officer / Director of Infection Prevention & Control (DIPC)

The Chief Nursing Officer has the lead Executive Director responsibility for IPC in their role as DIPC. This is supported by the Deputy DIPC, who has delegated operational responsibility for infection prevention activities across the Trust, along with delegated responsibility to Divisional Directors of Nursing, Matrons and Ward Managers to maintain high standards.

The CNO/DIPC is a core part of the Infection Prevention Team, and works in close collaboration with the Lead Consultant Medical Microbiologists (CMM) and Infection Control Doctors, Deputy DIPC and Lead Nurse for Infection Prevention and Control. This includes ensuring that national guidance is incorporated into local policy, KPIs are monitored and there is compliance with the annual Infection Prevention Improvement Plan.

In line with the Hygiene Code, the CNO(DIPC):

- Provides oversight and assurance on infection prevention (including cleanliness) to the Trust Board.
- Leads the Infection Prevention Team;
- Oversees local prevention of infection policies and their implementation;
- Is a full member of the infection prevention team and antimicrobial stewardship committee (Medicines Safety Committee) and regularly attends infection prevention meetings, including chairing the Trust Infection Prevention & Control Committee.
- Challenges inappropriate practice and inappropriate antimicrobial prescribing decisions
- Sets and challenges standards of cleanliness
- Assesses the impact of all existing and new policies on infections and make recommendations for change
- Is the executive lead for the clinical governance and patient safety teams and structures
- Maintains oversight of the Water safety group;
- Produces an annual report which is publically available.

4.4 Chief Operating Officer

Has responsibility for the Trust performance framework and for ensuring operational delivery supports the effective prevention of infection.

4.5 Chief Medical Officer

Works in close collaboration with the CNO to ensure high standards of infection prevention practice are maintained across clinical areas, and leads the medical contribution to infection prevention and control across the Trust.

4.6 Director of Human Resources

Will ensure that all staff job descriptions contain explicit reference to infection prevention & control, and that relevant Occupational Health policies and procedures are in place to protect staff from infection, and to minimise any risks of HCAI to staff.

4.7 Director of Finance

Will work with the Board to ensure that resources are available to support the management and control of infection, including outbreaks.

4.8 Director of Asset Management and ICT

Will ensure the environment is suitably planned and maintained to support the implementation of effective infection prevention.

4.9 Deputy Director of infection Prevention & Control

The Deputy DIPC will support the DIPC across the full range of DIPC responsibilities, working in close collaboration with the DIPC, Infection Control Doctors and other consultant Microbiologists.

They will act as a source of specialist infection prevention expertise, and are the operational management lead for the Infection Prevention Team, reporting directly to the DIPC as the overall lead for the team.

4.10 Lead Consultant Medical Microbiologist

This role provides a source of expert microbiological, and IPC advice and supports the DIPC as required. They lead the team of Consultant Microbiologists across the Trust, working in close collaboration with the Infection Prevention Team and Divisional leads as required.

4.11 Infection Control Doctor (ICD)

The Trust has nominated co-Infection Control Doctors, who jointly share the ICD role. They advise and support the DIPC on all matters relating to infection prevention and control, leading relevant aspects of the programme and working in close collaboration with the DIPC, Deputy DIPC, and Divisional leads as required.

They are supported in this work by other Consultant Microbiologists within the Trust, who may take a lead role on specific elements of infection prevention and control.

4.12 Divisional Directors, Divisional Medical Directors and Divisional Directors of Nursing

The Divisional Management leads have a professional and managerial responsibility to ensure Trust agreed infection prevention policies, practices and processes are in place within their Division.

They take a lead within their Division on all matters relating to infection prevention and control, to implement the annual infection prevention improvement plan within their Divisional quality improvement work.

4.13 Directorate General Managers, Clinical Directors, Matrons, Ward Managers, Consultants and Other Medical Staff

Divisional and Directorate management teams, Matrons and Ward Managers have responsibility for ensuring full compliance with infection prevention clinical practices, audit, training and policy requirements via their governance structures and

arrangements. They must ensure infection prevention roles and responsibilities are discussed as part of appraisal by all staff.

They are accountable for local performance management and action on HCAI in their area of responsibility, reporting to their relevant Divisional Management leads.

4.14 Trust wide Infection Prevention and Control Committee (TIPCC)

The TIPCC is chaired by the DIPC, and meets regularly in line with its Terms of Reference. It approves and monitors progress with the annual Infection Prevention Improvement Plan, rates of infection and all matters relating to the prevention of infection.

It is the key forum in providing assurance that the Trust has appropriate structures in place and arrangements to discharge its responsibilities for Clinical Governance and Risk Management with regards to the prevention of infection. The Committee reports to the Quality Governance Committee. Membership and terms of reference are contained in Appendix 1.

4.15 Infection Prevention and Control Team (IPCT)

The team is led and managed operationally by the Deputy DIPC supported by the Lead Nurse – Infection Prevention & Control, with overall leadership by the DIPC.

The team is responsible for supporting and advising all clinical and managerial staff on infection prevention matters including via policy production and education, and for monitoring standards of practice including through audit and the surveillance of infection.

4.16 Infection Prevention and Control Link Staff

The role of link staff is to act as an IPC resource in their clinical area and to provide liaison with the IPT. They act as a role model of good practice for colleagues, and a local change agent. Link nurses support ward and department managers to create and maintain an environment which ensures the safety of patients, relatives, visitors and other staff.

4.17 Individual Members of Staff

All members of staff have personal responsibility to protect patients from infection by following infection prevention practices, policies and processes, for reporting circumstances where infection risks occur, and taking action to prevent risk of infection. All staff must ensure that they undertake mandatory training as required by the Trust.

5. Equality requirements

The equality risk assessment for this policy has been undertaken and meets all the required standards (as attached to this policy).

6. Infection Prevention and Control Arrangements

The Trust manages risk related to healthcare associated infection through the following processes:

- Policies and protocols in line with Hygiene Code requirements; which are evidence based, and include national and other recommendations for best practice. These are regularly reviewed and updated as new guidance becomes available.
- Risk assessments to inform policy production, and clinical practice. This includes individual patient risk assessment regarding infection risk.
- Training and education for all staff relevant to their work.
- An audit programme to monitor compliance with policies, and identify where further action may be required.
- Infection surveillance of alert organisms and alert conditions, to actively detect infection issues as they occur, so that targeted control measures may be implemented.
- Maintaining a multi-disciplinary Infection Prevention Team to provide expert advice, support, training and monitoring of practice.
- A governance structure for scrutiny and assurance in relation to infection prevention activity, from clinical teams at ward level to the Chief Executive and Trust Board. (Appendix 2).
- Other Trust processes, including incident reporting and serious incident investigations.

7. Policies and Risk Assessments

- Infection prevention policies are approved by TIPCC, and are then made available via the Trust intranet site.

- The Deputy DIPC will maintain a policy review programme, to ensure all policies are reviewed in a timely manner.

- A lead clinician (key document author) will be responsible for review of existing policies and procedures by the policy review date. In addition review of policies or procedures may be triggered by new national or local guidance or changes to practice, which require documents to be updated before the agreed review date.

- Development of a new policy, if required, will also be co-ordinated by an agreed key document author.

- Once updated, obsolete versions of the policies will be archived by the Infection Control Administrative staff, and will not be available for viewing by general Trust staff.

8. Information for Patients and the Public

- Information for patients and the public about the organisation's general processes and arrangements for preventing and controlling HCAI is accessible via the Trust internet website.
- The DIPC Annual Report, and Trust Board minutes are also public documents.
- A series of information leaflets about individual infections is available to both patients and visitors. Information regarding MRSA bacteraemias and CDI and CQC or other assessments is also published and available to the public.
- In addition, information is made available via posters, through local media when appropriate (e.g. during outbreaks of infection where restrictions to visiting are implemented), and via social media and the WorcestershireWay monthly magazine.

9. Financial Risk Assessment

Where resources are required to support Infection Prevention and Control strategy or policy implementation, the financial implications will be identified through the Trust's business planning procedures. Divisions and Directorates will also identify financial implications of complying with policies and procedures (e.g. identifying staffing establishment requirements which are adequate to enable compliance with mandatory training requirements).

10. Consultation

All policies will conform to the Trust's standard structure and format and other requirements, as per Trust Policy for Policies (the development, approval and management of key documents – WAHT-CG-001).

All draft policies will be circulated to key stakeholders and representatives of the target audience for comment prior to finalisation before being submitted for approval.

11. Approval process

The final draft will be checked to ensure it complies with the correct format and that all supporting documentation has been completed appropriately.

Infection Prevention policies and procedures will be submitted to TIPCC for approval before document code and version number will be confirmed and the policies released for placement on the Trust intranet

This policy will also be presented to the Trust Board for final approval, as per the Trust's Policy for Policies.

12. Implementation arrangements

An implementation plan will accompany any policies submitted for approval to TIPCC, as per the Trust Policy for Policies. This will ensure awareness of roles and responsibilities, and training requirements are identified.

13. Dissemination process

Dissemination of documents will be as per the Trust Policy for Policies. Reference to relevant IPC policies will also be made during induction, annual and other update sessions for staff. The policies will be available to view on the Trust intranet. Line managers are also responsible for ensuring that their staff are kept up to date with new documents.

14. Training and awareness

- It is a mandatory requirement that all new Trust employees must attend corporate induction, which includes infection prevention training (commensurate with the Trust's Training Needs Analysis). It is the responsibility of the line manager to ensure that relevant issues are covered in all local inductions and that this is documented.

- It is a mandatory requirement that all clinical staff update their infection prevention training in line with the Trust policy on mandatory training, either by attendance at a formal session, or completing e-learning resources. It is an individual responsibility to ensure that this occurs, and a line management responsibility to check this has taken place.

- Line managers must discuss individual infection prevention roles and responsibilities as part of personal development plans and other reviews for staff.

- Records of staff training are kept centrally on the ESR database, and locally by Directorates as required.

15. Monitoring and compliance

- A programme of audit and monitoring is contained within the annual infection prevention improvement plan for the Trust.

- Leadership walkabouts and quality visits by leaders across the Trust also contribute to monitoring of clinical practices and standards.

- Where monitoring processes identify deficiencies, or there is a lack of assurance, a corrective plan will be produced and implemented to mitigate the risk and improve standards.

- Monitoring compliance with this document is the responsibility of the TIPCC.

- The Trust Board will monitor infection performance through the established governance and reporting framework, including the submission of regular DIPC reports and the Annual Infection Prevention Report.

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.
How will monitoring be carried out?
Who will monitor compliance with the guideline?

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	Implementation of this policy will be via the annual Infection Prevention Programme.	Reporting to QGC detailing HCAI performance and progress with the annual programme.	Quarterly	Deputy DIPC	DIPC and Quality Governance Committee	Quarterly

16. Development of the Policy

This policy was developed using Trust information relating to document control, including the Policy for Policies (WAHT-CG-001) and has been circulated to all key stakeholders for comment, and approved by the TIPCC.

It has undergone major review in 2019, and been recirculated to key stakeholders prior to approval at TIPCC.

17. CONTRIBUTION LIST

Key individuals involved in developing the original document

Name	Designation
Dr Anne Dyas	Consultant microbiologist
Dr Chris Catchpole	Consultant microbiologist
Dr Mary Ashcroft	Consultant microbiologist
Dr Thekli Gee	Consultant microbiologist
Dr Emma Yates	Consultant microbiologist
David Shakespeare	Associate Chief Nurse, IPC
Heather Gentry	Trust Lead IPCN
Lindsey Webb	Chief Nursing Officer

Circulated to the following Committees / groups for comments

Committee
Trust Infection Prevention & Control Committee

Appendix 1

Terms of Reference

Trust Infection Prevention & Control Committee

Version: 3.0

Terms of Reference approved by:

Trust Infection Prevention & Control Committee (TIPCC)
Chair: Vicky Morris, CNO/DIPC

Date approved: 10th May 2019 (Chairs action to approve)

Author: Tracey Cooper, Deputy DIPC

Responsible directorate: Corporate Nursing

Review date: April 2020

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Terms of Reference

1. Introduction

TIPCC is authorised by the Trust Management Executive to contribute to safety by receiving assurance of effective infection prevention & control and compliance with the Health and Social Care Act (2008): Code of Practice on the prevention and control of infections and related guidance 2015 (The Hygiene Code).

The Chair will ensure that the terms of reference and the Committees' conduct are consistent with the Trust's values.

2. Membership

2.1 Chief Nurse / Director Infection Prevention & Control (DIPC)
Deputy DIPC
Consultant Microbiologists/Co-Infection Control Doctors
Divisional Directors of Nursing and Midwifery
Lead & Senior Infection Prevention Nurses
Director of Pharmacy
Head of Facilities, Private Finance Initiative and Contracts
Head of Facilities
Head of Estates
Occupational Health Department Manager or representative
Antimicrobial Pharmacist
Infection Control Lead Nurse for Worcestershire CCGs
Public Health England (West Midlands West) representative
Patient Public Forum representative
Informatics representative

3 Arrangements for the conduct of business

3.1 Chairing the meetings

The Chief Nurse / Director Infection Prevention & Control (DIPC) shall chair the meeting and the Deputy DIPC or a Consultant Microbiologist will deputise in their absence.

3.2 The Chair of the Group is appointed by the Clinical Governance Group.

3.3 Quorum

The Group will be quorate when seven representatives are present of which one will be the DIPC or their nominated representative, a member of the Infection Prevention & Control Team/Consultant Microbiologist and a representative from each of the Clinical Divisions at the Trust.

3.4 Frequency of meetings

The Committee will meet bi monthly.

3.5 Frequency of attendance by members

Members are expected to attend each meeting, with a minimum of at least 3 meetings per year, unless there are exceptional circumstances. Members must send a deputy with the relevant level of authority to make decisions on their behalf if they are unable to attend.

3.6 Declaration of interests

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the subject consideration has been completed. All declarations of interest will be minuted.

3.7 Urgent matters arising between meetings

If there is a need for an emergency / extraordinary meeting, the Chair or their nominated representative will call one in liaison with the relevant members and clinicians.

3.8 Secretariat support

The secretarial function of the Infection Prevention Team is responsible for the administration of the Committee.

4 Authority

The Committee is accountable to Trust Management Executive, and provides assurance to the Quality Governance committee.

5 Purpose and Functions

5.1 Purpose

The purpose of TIPCC is to contribute to improving safety at the Trust by ensuring the effective prevention and control of healthcare associated infections (HCAI) and other communicable diseases of public health concern at the organisation.

The Committee will receive assurance of the organisation's compliance with The Health and Social Care Act (2008): Code of practice on the prevention and control of infections and related guidance 2015 (The Hygiene Code). It will scrutinise actions to ensure risks are identified, monitored and mitigated where actual and potential non-compliance is identified.

The Committee will provide a key role in monitoring the organisation's performance against the Annual Infection Prevention Improvement Plan and the Worcestershire Health and Social Care Infection Prevention Strategy.

The Committee will ensure there is demonstrable learning from IPC related incidents in order to maximise opportunity to ensure patient safety.

The Committee will ensure there is a strategic and operational response to new legislation and national guidelines in the context of the Trust's participation in a health and social care economy approach to infection prevention.

5.2 Duties

In discharging the purpose above, the Committee has the following duties:

a) Receive assurance on Trust compliance with the Hygiene Code; mitigation and actions where risks to compliance are identified.

b) Agree and monitor an Annual Infection Prevention Improvement Plan.

c) Review performance on HCAI, reporting progress and agreeing further action required.

d) Monitor compliance with Key Standards to Prevent Infection, scrutinising Divisional actions to ensure minimum standards are achieved and exceeded.

e) Review the local Infection Prevention & Control risk register, agreeing mitigations and further actions required.

f) Ensure that new innovations to reducing HCAI and enhancing environmental and medical device cleanliness are considered and implemented by the Trust.

g) Draw to the attention of the Clinical Governance Group, Trust Management Executive and Chief Executive any serious risks or hazards relating to infection prevention and control.

h) Receive for assurance updates regarding prudent antimicrobial prescribing and compliance with antimicrobial prescribing guidance and policy, including for high risk infections such as *Clostridium difficile*. Link across to the Medicines Safety Group in terms of antimicrobial stewardship within WAHT.

i) Receive for assurance updates from the Facilities Department to include compliance with the National Specifications for Cleanliness; and other environmental actions necessary to minimise risk from HCAI and maintain environmental cleanliness.

j) Receive for assurance updates with regard to water safety and ventilation systems at the Trust.

k) Ensure patient flow is supported at the Trust while maintaining infection prevention principles, through use of single rooms for isolation supported by risk assessment. Receive assurance that relevant risk assessment tools are available and appropriately used.

l) Contribute to safety at the Trust by monitoring and reducing device related infections.

m) Receive reports for assurance from the Occupational Health Department on staff influenza vaccination rates, measles immunity rates, sharps injuries, incidents requiring post exposure prophylaxis and other communicable disease issues affecting staff groups.

n) Monitor outbreaks of infection, and receive assurance that they are effectively managed with a health economy approach, ensuring staff and visitors are protected.

o) Receive assurance on completion of Commissioning for Quality and Innovation (CQUIN) initiatives where these are HCAI or communicable disease related.

p) Scrutinise for assurance the work programme on the decontamination of medical devices, risks to compliance with required standards, and mitigating actions being taken to address these.

q) Receive assurance that Trust staff have received relevant education and mandatory training in infection prevention and are competent in infection prevention & control practice.

r) Approve infection prevention related policies.

6. Relationships and reporting

6.1 This Committee is accountable to the Trust Management Executive and reports to Trust Management Executive and to Quality Governance Committee monthly, or sooner at the request of the Chair.

The Decontamination Group is a sub group of this Committee and will submit approved minutes after each Group meeting for review.

The Patient Environment Operational Group reports to the Committee via the Facilities report to TIPCC on a regular basis.

The Water Safety Group reports to the Committee, via the Head of Estates.

The Ventilation Group reports to the Committee, via the Head of Estates.

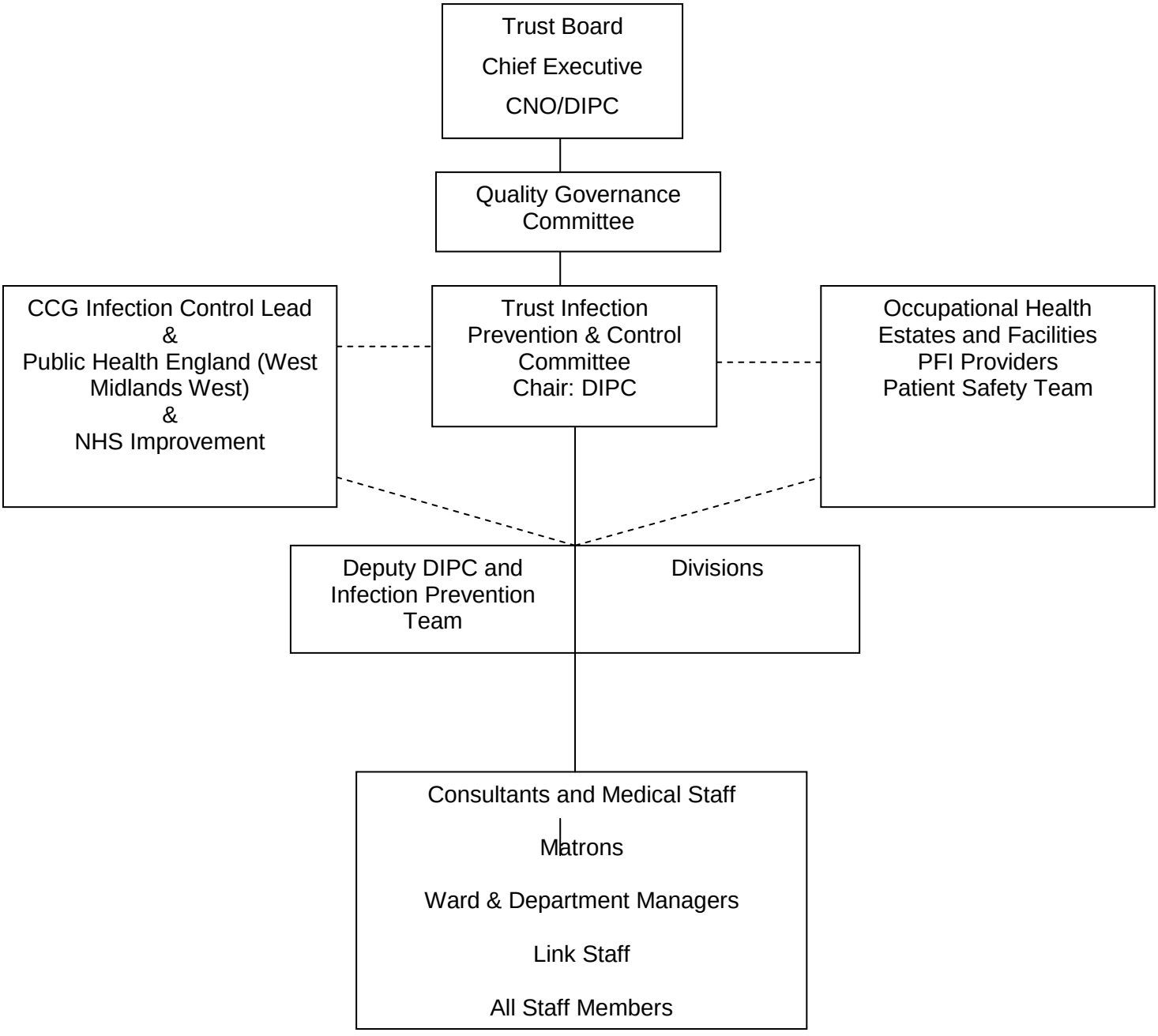
Any concerns requiring immediate escalation from any of the reporting groups will be raised with the DIPC between meetings.

7 Review of the Terms of Reference

These Terms of reference will be reviewed annually or sooner, if national legislation and guidance changes.

Appendix 2

INFECTION PREVENTION AND CONTROL
ORGANISATIONAL CHART / ASSURANCE FRAMEWORK



Groups reporting to TIPCC include:

- Water Safety Group
- Ventilation Group
- Decontamination of Medical Devices Committee
- Patient Environment Operational Group

Appendix 3 – Surveillance of Infection

Definition

Surveillance is defined as the systematic, active, on-going observation of the occurrence and distribution of a disease within a population and of the events that increase or decrease the risk of the disease occurring.

Surveillance methods

The infection related surveillance methods currently in use in Worcestershire Acute Hospitals NHS Trust are:

1. Alert organism surveillance, based on isolation or detection of organisms with transmission potential from clinical samples
2. Alert condition surveillance: ward based surveillance, monitoring clinical information and clusters/outbreaks indicating potentially transmissible infections
3. Laboratory report analysis over time (trend analysis)
4. Targeted surveillance providing infection rates for surgical procedures, including mandatory surgical site infection surveillance
5. Participation in local regional and national surveillance projects

Alert organisms include:

- Gastrointestinal pathogens
  e.g. *Salmonella, Shigella, Campylobacter, Yersinia, Aeromonas, E. coli 0157,Entamoeba, Giardia, norovirus,* and *C. difficile*
- Multi-resistant coliform organisms including Multi-resistant *Acinetobacter spp*. and carbapenemase producing *Enterobacteriaceae*
- ESBL producing organisms
- MRSA
- Glycopeptide resistant enterococci
- Group A streptococci
- Group B streptococci (in neonatal wards)
- Tuberculosis
- Penicillin-resistant pneumococci
- Hepatitis B
- Hepatitis C
- HIV
- Shingles/Chickenpox
- Erythrovirus (parvovirus)
- Measles
- Mumps
- Meningitis e.g. meningococcal, Haemophilus, viral, Listeria etc
- Influenza and other respiratory viruses
- New and emerging infections such as MERS CoV, Ebola

*This list is not exhaustive; less common alert organisms also occur and will be acted upon as necessary.

Action taken when alert organism or condition identified

The organisms listed above are considered to have a potential for transmission (cross infection). Microbiology Laboratory Standard Operating Procedures indicate where BMS (Biomedical scientist) staff should alert Medical Microbiology staff if these organisms are isolated from clinical samples. The following actions will then occur:

1. Medical Microbiology staff will inform the ward and/or medical staff caring for the patient, and ensure that immediate action is taken to reduce the risk of transmission (if appropriate). This may include recommending isolation of the patient, specific antibiotic therapy or other investigations.
2. The IPT are also informed, and the ICNet system is updated. This will result in a member of the team contacting the ward to advise on clinical management of the patient. Often a follow-up ward visit will take place to ensure that precautions have been initiated appropriately. Advice is given to the patient and visitors as necessary. A record of advice given is also recorded in the ICNet system.
3. Statutorily Notifiable infections (see Notifying Known or Suspected Infection, WAHT-INF-011) are reported to the Public Health England (PHE) via the local Health Protection Unit (HPU) as appropriate by the microbiology laboratory staff.
4. Infections as a result of possible food poisoning or other relevant conditions are reported to the relevant Environmental Health Department by the microbiology laboratory staff.
5. Surveillance data is also reported at least weekly to the West Midlands Communicable Disease Surveillance Centre (CDSC) and the local HPU electronically via the Co-surv system. In addition to the organisms listed above, data is also provided on organisms causing bacteraemia and other invasive infections. Periodic additional surveillance (e.g. respiratory pathogens in primary care) is also performed through this route (L.P.-WA-MIC-CoSurv).
6. MRSA, MSSA, *E. coli* and Glycopeptide resistant enterococcal bacteraemias, and *C.difficile* infections are also reported electronically by the IPT via the Department of Health HCAI data capture system. This information is 'locked down' by the Chief Executive every month.
7. Data is provided for internal monitoring purposes to clinical areas, directorates, TIPCC, and other Trust management forums.
8. Data is shared between the CCG, PHE, NHSi and the Department of Health in line with national and regional requirements and local data-sharing agreements.

Other surveillance

The Microbiology laboratory also participates in:

- The European Antimicrobial Surveillance System (EARSS) and other regional and national projects.
- Department of Health National Mandatory *C difficile* Surveillance strain typing programme.

Supporting Document 1 – Checklist for review and approval of key documents
This checklist is designed to be completed whilst a key document is being developed / reviewed.

A completed checklist will need to be returned with the document before it can be published on the intranet.

For documents that are being reviewed and reissued without change, this checklist will still need to be completed, to ensure that the document is in the correct format, has any new documentation included.

1	Type of document	Policy
2	Title of document	Management of Infection Prevention & Control Policy
3	Is this a new document?	Yes ☐ No ☒ If no, what is the reference number WAHT-CG-043
4	For existing documents, have you included and completed the key amendments box?	Yes ☒ No ☐
5	Owning department	Infection Prevention Team
6	Clinical lead/s	Tracey Cooper, Deputy DIPC
7	Pharmacist name (required if medication is involved)	
8	Has all mandatory content been included (see relevant document template)	Yes ☒ No ☐
9	If this is a new document have properly completed Equality Impact and Financial Assessments been included?	Yes ☒ No ☐
10	Please describe the consultation that has been carried out for this document	See document
11	Please state how you want the title of this document to appear on the intranet, for search purposes and which specialty this document relates to.	within Infection Prevention section.
Once the document has been developed and is ready for approval, send to the Clinical Governance Department, along with this partially completed checklist, for them to check format, mandatory content etc. Once checked, the document and checklist will be submitted to relevant committee for approval.		

Implementation
Briefly describe the steps that will be taken to ensure that this key document is implemented

Action	Person responsible	Timescale
The documents will be circulated to all members of the Trust Infection Prevention & Control Committee.	Deputy DIPC	May 2019

Plan for dissemination

Disseminated to	Date
Published on intranet	May 2019
Circulated to members of Trust Infection Prevention & Control Committee.	May 2019

Supporting Document 2 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	**Does the policy / guidance affect one group less or more favourably than another on the basis of:**		
	Age	No	
	Disability	No	
	Gender reassignment	No	
	Marriage and civil partnership	No	
	Pregnancy and maternity	No	
	Race	No	
	Religion or belief	No	
	Sex	No	
	Sexual orientation	No	
2.	**Is there any evidence that some groups are affected differently?**	N/A	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and / or justifiable?**	N/A	
4.	**Is the impact of the policy / guidance likely to be negative?**	N/A	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy / guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this key document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact Human Resources.

Supporting Document 3 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	