Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

Management of Infection Prevention and Control Policy

Department:	Infection Prevention and Control Team
Originator:	Lara Bailey - Senior Infection Prevention and Control Nurse
Accountable Director:	Sarah Shingler - Chief Nursing Officer/Director of Infection Prevention and Control (DIPC)
Approved by:	Trust Infection Prevention & Control Committee
Date of approval:	23rd May 2024
Review Date: This is the most current document and should be used until a revised version is in place	23rd May 2027
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 March 2021 removed February 2024. Please see previous version for full audit trail.	
Feb 2024	Change of CNO role listed to include the role of DIPC, retaining lead executive accountability for IPC. Deputy DIPC role and responsibilities set out, separate to CNO/DIPC role. Removal of reference to the COVID BAF and replaced with reference to the National Infection Prevention and Control BAF Amendment to Infection Prevention and Control Organisational Chart (now Appendix 1, previously referred to	Lara Bailey

	as Appendix 2). Removal of Appendix 1 & 3	

Contents page:

1. Introduction

The Trust is committed to achieving excellent infection prevention and control 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*. As a result of the COVID-19 pandemic the Trust is also required to demonstrate compliance with the National Infection Prevention and Control Board Assurance Framework.

2. Scope of the Policy

This policy applies to all staff on all sites where the Trust delivers care, and 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 totality of arrangements in place to prevent and control infections across the Trust. This includes 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, *Clostridioides difficile,* COVID-19).

3.2 Healthcare Associated Infection (HCAI)

Any infection acquired because 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 the Board-level lead who also holds the role of the DIPC.

4.3 Chief Nursing Officer

The Chief Nursing Officer has the lead Executive Director accountability for IPC and holds the role of DIPC. They are supported by the Deputy DIPC. The CNO has executive responsibility for infection prevention activities across the Trust, with delegated responsibility to Divisional Directors of Nursing, Matrons and Ward Managers to maintain high standards. The CNO leads the organisation's clinical governance and patient safety teams and structures.

4.4 Deputy Director of Infection Prevention & Control (Deputy DIPC)

The Deputy DIPC is a core part of the Infection Prevention and Control Team, working in close collaboration with the Lead Consultant Medical Microbiologists (CMM) and Infection Control Doctors, and Infection Prevention and Control Team (IPCT). 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 deputy DIPC:

- Provides oversight and assurance on infection prevention (including cleanliness), reporting directly to QGC and the DIPC. The DIPC will then report to Trust Board any matters that require escalation.
- Is responsible for leading the organisation's infection prevention and control team.
- Oversees local prevention of infection policies and their implementation.
- Is a full member of the infection prevention team and antimicrobial stewardship committee and regularly attend its infection prevention meetings.
- Has the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions.
- Has the authority to set and challenge standards of cleanliness.
- Assesses the impact of all existing and new policies on infections and make recommendations for change.
- Is an integral member of the organisation's clinical governance and patient safety teams and structures in collaboration with the CNO/DIPC, and water safety group.

- Produces an annual report and provide it to the DIPC/CNO who will release it publicly as outlined in *Winning ways: working together to reduce healthcare associated infection in England.*

4.5 Chief Operating Officer

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

4.6 Chief Medical Officer

Works in close collaboration with the CNO/DIPC 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 including antimicrobial stewardship.

4.7 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.

4.8 Director of Finance

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

4.9 Director of Estates and Facilities

Will ensure the environment is suitably planned and maintained to support the implementation of effective infection prevention, and that the prevention of infection is considered as part of all building and refurbishment work.

4.10 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 and Control Team, reporting directly to the DIPC as the overall lead for the team.

4.11 Lead Consultant Medical Microbiologist

This role provides a source of expert microbiological, and IPC advice and supports the DIPC, CNO and CMO 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.

4.12 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.

4.13 Divisional Directors of Operations, Divisional 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, to ensure delivery of high standards of infection prevention practice.

4.14 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.

4.15 Trust Infection Prevention and Control Committee (TIPCC)

The TIPCC is co-chaired by the CNO/DIPC and the deputy 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 will be reviewed annually or sooner if national legislation and guidance chances by TIPCC.

4.16 Infection Prevention and Control Team (IPCT)

The team is led and managed operationally by the deputy DIPC supported by the Infection Prevention Nurse Manager, with overall leadership by the DIPC/CNO.

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 and challenging standards of practice including through audit and the surveillance of infection.

4.17 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 IPCT. They act as role models of good practice for colleagues, and a local change agent. Link staff support ward and department managers to create and maintain an environment which ensures the safety of patients, relatives, visitors, and other staff.

4.18 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 and maintaining risk registers.
- 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 IPCT 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 1).
- 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/ Clinical Effectiveness 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 be presented to the Trust Board for approval, in line with the Trust 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 in place as part of 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.

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 underwent major review in 2019, with minor amendments in 2021. It has been recirculated to key stakeholders prior to approval at TIPCC.

17. CONTRIBUTION LIST

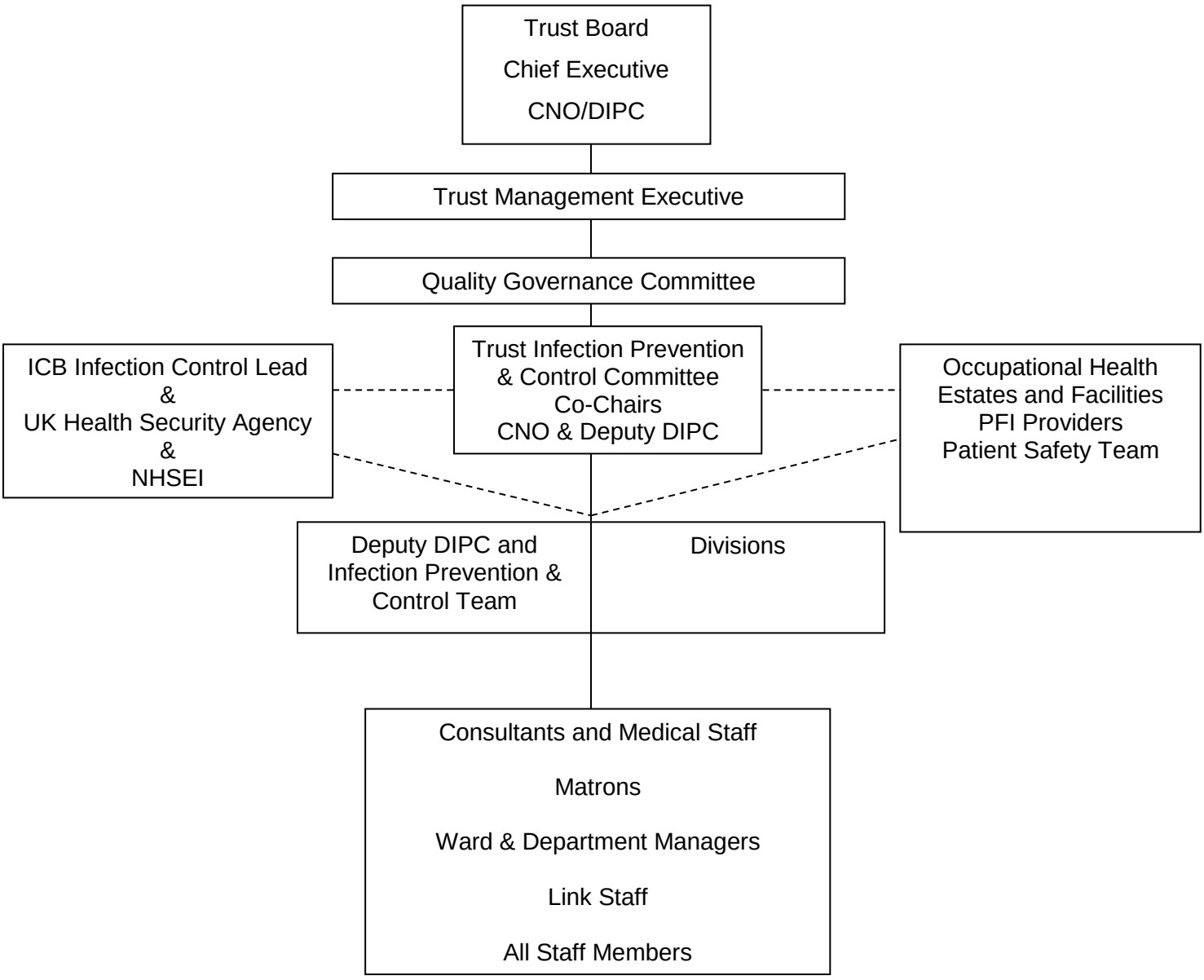
Key individuals involved in reviewing the document

Name	Designation
Lara Bailey	Senior Infection Prevention and Control Nurse
Julie Booth	Deputy Director for Infection Prevention and Control (Deputy DIPC)
Sarah Shingler	Director for Infection Prevention and Control (DIPC) and CNO

Circulated to the following Committees / groups for comments

Committee
Trust Infection Prevention & Control Committee

Appendix 1
INFECTION PREVENTION AND CONTROL
ORGANISATIONAL CHART / ASSURANCE FRAMEWORK



Groups reporting to TIPCC include:

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

Supporting Document 1 - 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.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Julie Booth**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Lara Bailey	**Senior Infection Prevention and Control Nurse**	**larabailey@nhs.net**
Date assessment completed	**07.02.2024**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Management of Infection Prevention and Control Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	To maintain patient and staff safety			
Who will be affected by the	❑	Service	❑	Staff

development & implementation of this activity?	❑ ❑ ❑	User Patient Carers Visitors	❑ ❑ ❑	Communities Other _____
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	National Guidance			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Deputy DIPC & CNO/DIPC			
Summary of relevant findings	N/A			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	**Potential positive impact**	**Potential neutral impact**	**Potential negative impact**	**Please explain your reasons for any potential positive, neutral or negative impact identified**
Age		x		
Disability		x		
Gender Reassignment		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		

Section 4

What actions will you take to mitigate any potential negative impacts? N/A	Risk identified	Actions required to reduce / eliminate negative	Who will lead on the action?	Timeframe

		impact		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	L Bailey
Date signed	07.02.2024
Comments:	
Signature of person the Leader Person for this activity	
Date signed	07.02.2024
Comments:	

Supporting Document 2 – 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:	No

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval

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 and Control Team
6	Clinical lead/s	Lara Bailey, Senior Infection Prevention and Control Nurse
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 and Control 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 & Dissemination
Briefly describe the steps that will be taken to ensure that this key document is implemented

Action	Person responsible	Timescale
The document will be circulated to all members of the Trust Infection Prevention & Control Committee.	L Bailey	May 24
The document will be uploaded to the Trust Intranet Page	L Bailey	Upon ratification

13. 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	CNO and Quality Governance Committee	Quarterly