Infection prevention and control commissioning toolkit

Guidance and information for nursing and commissioning staff in England

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Contextual disclaimer

The Infection Prevention Society (IPS) and Royal College of Nursing (RCN)’s Infection prevention and control commissioning toolkit has been collaboratively developed at a time when the NHS (England) is undergoing considerable reform and transition to a new commissioning structure. It is acknowledged that the final detail on how new commissioning organisations will operate has not yet been finalised; therefore, the toolkit is designed to help ensure that commissioners and those providing health and social care services feel supported during this transition period based on currently available detail and assumptions.

This document will be reviewed and updated in March 2013, and as required thereafter, to ensure it is fit for purpose for contract negotiations for 2013/2014 and to reflect the expected guidance from the Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) due autumn/winter 2012.
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to use the toolkit</td>
<td>4</td>
</tr>
<tr>
<td>Who may find the toolkit useful?</td>
<td>4</td>
</tr>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Strategic vision: zero tolerance of HCAIs</td>
<td>5</td>
</tr>
<tr>
<td>Indicators</td>
<td>6</td>
</tr>
<tr>
<td>Infection prevention and control indicator basket</td>
<td>8</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>12</td>
</tr>
<tr>
<td>References</td>
<td>15</td>
</tr>
<tr>
<td>Further reading</td>
<td>15</td>
</tr>
</tbody>
</table>
Introduction

Reducing health care associated infections (HCAIs) remains high on the Government’s safety and quality agenda and in the general public’s expectations for quality of care. Since 2008, there has been a legal requirement on all NHS organisations to implement The Health and Social Care Act 2008, Code of Practice (DH, 2010) for the NHS on the prevention and control of HCAIs and related guidance. Other drivers for change, whilst not exhaustive, may include:

- Care Quality Commission (CQC) registration
- Commissioning for Quality and Innovation (CQUIN)
- The Operating Framework for the NHS in England 2012-2013 (DH, 2011)
- compliance with National Health Service Litigation Authority (NHSLA) criteria
- Health Building Notes and Health Technical Memoranda, and Choice Frameworks for local Policies and Procedures (CFPP)
- Quality Innovation Productivity and Prevention (QIPP) initiatives
- National Institute for Health and Clinical Excellence (NICE) standards or quality statements.

This toolkit provides an overarching framework to help meet the challenge of reducing and sustaining reduction of HCAIs.

It has been developed to support emerging commissioning organisations in England to ensure that the structures, objective setting, monitoring and governance arrangements, and resources for the prevention, control and reduction of HCAIs are in place. As health and social care commissioning develops, it is essential that processes are in place to ensure the smooth transfer of commissioning authority from one organisation to another, and that duties and accountabilities in relation to reducing HCAIs are maintained without detriment to patients or the quality of health and social care service provision.

How to use the toolkit

The toolkit provides information for professionals involved in the commissioning of infection prevention and control services. It forms the basis of a health care associated infection (HCAI) reduction plan for emerging commissioning organisations, and it suggests indicators to support performance management and assurance against provider contracts.

Who may find the toolkit useful?

The toolkit may be of use to contracting teams, performance monitoring teams, safety and quality teams, commissioning infection prevention and control leads, clinical commissioning groups (CCGs), commissioning and business support services (CBSS), the NHS Commissioning Board and provider organisations.

It may also be of particular value to commissioning organisations that do not have access to HCAI expertise.
Strategic vision: zero tolerance of HCAIs

Expectations of commissioning organisations

Commissioners and providers of health and social care must not accept that HCAIs are an inevitable part of or an acceptable risk related to health or social care. Commissioning organisations will support providers, whilst holding them to account for their performance, in the surveillance of infections and in the implementation and sustained improvement of infection prevention and control practices and procedures to reduce HCAIs.

In pursuit of the aspiration for zero tolerance of HCAIs, commissioning teams will systematically review local objective setting across the organisations from which they commission services. This will include the review of surveillance data to monitor progress against nationally set trajectories for specific organisms and other agreed indicators.

All commissioning organisations are obliged to be sufficiently assured that all services, commissioned or contracted by them or on their behalf are compliant with:

- National Health Service Litigation Authority (NHSLA) risk management standards
- reduction of HCAIs in line with nationally set objectives
- reporting of deaths where an HCAI is noted on any part of the death certificate according to local policy and procedures
- ensuring lessons learned from any associated root cause analysis (RCA) are completed in a timely way
- contractual requirements relating to Quality Standards, NICE guidelines and other national policies
- Care Quality Commission (CQC) requirements (Outcome 8). Notably, if concerns are identified by the CQC it can lead to regulatory enforcement activities, including suspension of services.

Expectations of provider organisations

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

This toolkit emphasises that the following requirements are expected of provider organisations. They must:

- be registered with the CQC to provide care that meets the requirements of the Code of Practice (DH, 2010)
- have their own local infection prevention and control strategy and assurance framework that reflects the their local commissioning cluster organisation’s HCAI reduction plan and contractual requirements, and provides evidence of their compliance with the Code of Practice (DH, 2010)
- undertake assessments of their compliance with the Code of Practice (DH, 2010), at intervals agreed with the commissioning organisation. Compliance reports are submitted to the provider board for internal assurance and the commissioning organisation for external assurance
- actively engage with the processes for HCAI/infection prevention and control (IPC) performance and quality monitoring, and be active members of any relevant cluster health economy infection prevention group (or other forums, as appropriate).
Guide to using the IPC commissioning indicators

The IPS and the RCN have developed this toolkit for existing and emerging commissioning organisations to support the commissioning of infection prevention and control, along with the development and implementation of the commissioning framework in practice. The toolkit consists of a ‘basket’ of indicators for consideration for inclusion in the commissioning contract and an example of a local HCAI reduction plan (see appendix 1).

It is recognised that some organisations may be more highly developed in their measuring and reporting of indicators than others, however there should be a common aim across the commissioning board to standardise these where possible, whilst fostering additional development opportunities for quality improvement at a local level.

Commissioners of health and social care require provider organisations to assure clean environments and safe practices to prevent HCAs. This assurance process should not seek to mirror other compliance or regulation requirements, moreover it should seek firm assurance by focusing on improvements needed, based on local requirements. Ideally this should be a shared process between commissioners and providers, with the overall joint aim of improving patient safety.

Indicators

Indicators help organisations to understand, compare, predict outcomes and improve care. They should align contractual requirements to compliance with The Operating Framework for the NHS in England 2012-13 (DH, 2011) and be used to assist in the delivery of the Public health outcomes framework (DH, 2012b). Indicators should reflect requirements to implement best practice guidance set at national, regional and local levels to ensure that the priorities for infection prevention and control are in the contracts.

This toolkit presents the indicators in the format of the national contract, to enable users to lift detail and place it into individual provider contracts. Note that this can be adapted for inclusion into social care contracts.
Infection prevention and control basket of suggested indicators

There is a further 'basket' of indicators listed below which commissioners may choose from based on local surveillance data, information/data from local provider compliance reports, and other local intelligence. These can be included either as indicators or to collate regular detailed information/data by using the information schedule of the contract; or commissioners may consider that specific assurance for some of the suggested indicators is not required as they know practice is well-embedded.

In effect, each provider should have its own unique set of indicators and information schedule requirements to facilitate the robust assurance of performance required on IPC for the specific provider.

Note about using an information schedule

The information schedule can be used as a 'softer' option; if the commissioner chooses to place one of the currently suggested indicators into the information schedule, they could replace the 'threshold' requirement to 'expectation'; thereby clearly stating (and agreeing) the standard required. This approach will assist in holding the provider organisation to account in the event that the information supplied within the information schedule does not yield the level of assurance required of good infection prevention and control standards.

Note about thresholds

In the table below are suggested thresholds; it is up to local negotiation between commissioner and provider as to what is considered appropriate.

<table>
<thead>
<tr>
<th>Quality requirement</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantifiable measurements used to reflect the critical success of an organisation, service or provider. As indicators reflect goals, each indicator will have a target or plan</td>
<td>The point that must be exceeded to begin to produce a given effect or result, or the minimum level that must be reached. The value/parameter serves as a benchmark for comparison or guidance against which a breach may call for review</td>
<td>Details the information/data required and the frequency</td>
<td>Details the information/data required and the frequency</td>
</tr>
</tbody>
</table>

Table 1: how the national contract is set out

In 2012/13 there are only two mandatory key performance indicators (KPIs) included in the national contract:

<table>
<thead>
<tr>
<th>Quality requirement</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in MRSA bacteraemias as per national objective</td>
<td>Refer to national objective</td>
<td>Monthly reporting from mandatory enhanced surveillance database</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>Reduction in cases of <em>Clostridium difficile</em> as per national objective</td>
<td>Refer to national objective</td>
<td>Monthly reporting from mandatory enhanced surveillance database</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
</tbody>
</table>

Table 2: mandatory key performance indicators (KPIs)
## Infection prevention and control basket of suggested indicators

<table>
<thead>
<tr>
<th>Quality requirement</th>
<th>Threshold</th>
<th>Method of measurement</th>
<th>Breach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of MRSA bacteraemia</td>
<td>100% of cases notified by next working day</td>
<td>Monthly confirmation of % of cases notified by next working day</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>Notification of all cases of <em>Clostridium difficile</em> infection</td>
<td>100% of cases notified by next working day</td>
<td>Monthly confirmation of % of cases notified by next working day</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>Root cause analyses are undertaken on the following:  • MRSA bacteraemia  • <em>C. difficile</em> cases  • other significant HCAIs.</td>
<td>90% completed within ten working days  100% shared with commissioner for upload onto a shared database</td>
<td>Monthly confirmation of % of achievement of threshold requirements</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>100% of elective cases are screened for MRSA</td>
<td>95%</td>
<td>Monthly confirmation of % of elective patients screened for MRSA</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>100% of emergency cases are screened for MRSA</td>
<td>95%</td>
<td>Monthly confirmation of % of emergency patients screened for MRSA</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>100% compliance with MRSA care pathway (or guidance provided following risk assessment by the infection prevention and control team (IPCT))</td>
<td>100%</td>
<td>Monthly confirmation of % of MRSA positive patients that followed the MRSA care pathway</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>IPC strategic plan implemented and reported against</td>
<td>Quarterly compliance reports to the commissioner</td>
<td>Quarterly receipt of reports detailing compliance against each criteria of the code of practice</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>100% compliance with local antibiotic prescribing formulary (acute and community trusts only), including if there is evidence of justifiable clinical reasons for deviation from set formulary</td>
<td>95%</td>
<td>Minimum of annual confirmation of % of compliance with the antibiotic prescribing formulary</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>100% returns completed 100% compliance with infection prevention care bundles (high impact interventions)</td>
<td>95% achievement of care bundle score</td>
<td>Quarterly confirmation of % of achievement of standard</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold</td>
<td>Method of measurement</td>
<td>Breach</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>100% compliance with internal hand hygiene policy</td>
<td>100% achievement of agreed threshold</td>
<td>Quarterly confirmation of % of achievement of standard</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>100% compliance with national cleaning standards for areas of:</td>
<td>100% achievement of national standards for cleaning</td>
<td>Monthly confirmation of % of achievement of standard in areas of:</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>• very high risk</td>
<td></td>
<td>• very high risk</td>
<td></td>
</tr>
<tr>
<td>• high risk</td>
<td></td>
<td>• high risk</td>
<td></td>
</tr>
<tr>
<td>• significant risk</td>
<td></td>
<td>• significant risk</td>
<td></td>
</tr>
<tr>
<td>100% compliance with national mandatory surveillance programme for MSSA bacteraemia</td>
<td>100% of cases uploaded</td>
<td>Monthly reporting from mandatory enhanced surveillance database</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>Compliance with national mandatory surveillance programme for <em>E. coli</em> bacteraemia</td>
<td>100% of cases uploaded</td>
<td>Monthly reporting from mandatory enhanced surveillance database</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>Compliance with national mandatory surveillance programme for <em>GRE</em> bacteraemias</td>
<td>100% of cases uploaded</td>
<td>Monthly reporting from mandatory enhanced surveillance database</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>Participation in national surgical site infections surveillance programme</td>
<td>Minimum of one three-month orthopaedic module per year</td>
<td>Data uploaded onto national database</td>
<td>Frequency is dependent on number and frequency of modules undertaken</td>
</tr>
<tr>
<td>100% of outbreaks are reported, eg gastrointestinal or respiratory</td>
<td>100% of outbreaks are reported by the next working day</td>
<td>Monthly confirmation of % of cases notified by next working day</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>100% of HCAI related serious incidents are reported within one working day –</td>
<td>100% notification of within one working day</td>
<td>Monthly confirmation of % of cases notified by next working day</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>including where an alert organism, eg <em>C. difficile</em> or MRSA, is noted on any part of the death certificate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information about HCAIs is shared between health and social care providers for all patients</td>
<td>100% of patients have a completed inter-health care transfer form</td>
<td>Confirmation of % of compliance</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarterly audit - terms of audit to be determined locally</td>
<td></td>
</tr>
<tr>
<td>Quality requirement</td>
<td>Threshold</td>
<td>Method of measurement</td>
<td>Breach</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Patients isolated as per agreed local policy/advice from IPCT</td>
<td>100% compliance to agreed local policy</td>
<td>Confirmation of % of compliance (including exceptions of variation to policy)</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarterly audit - terms of audit to be determined locally</td>
<td></td>
</tr>
<tr>
<td>Attendance by appropriate member of provider organisation to actively contribute</td>
<td>Attendance - as per terms of local IPC network group</td>
<td>Quarterly confirmation of % of compliance</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>to whole economy strategic planning discussion and decision making</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioner receives copies of all reports and associated action plans in</td>
<td>Copies of reports sent to commissioner within five working days of the</td>
<td>Confirmation of % of compliance</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>response to any external IPC focus visits/inspections (eg from DH, SHA, CQC,</td>
<td>provider receiving the report</td>
<td>As reports are received</td>
<td></td>
</tr>
<tr>
<td>Monitor)</td>
<td>Action plans to be submitted to commissioner within three weeks of</td>
<td>Quarterly summary</td>
<td></td>
</tr>
<tr>
<td>IPC training programme adhered to as per locally agreed plan for each staff group</td>
<td>receiving report</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experience survey data relating to infection prevention control is</td>
<td>100% of IPC related data is collated, reviewed and acted upon</td>
<td>Quarterly confirmation of % of compliance</td>
<td>Escalation through appropriate clause of contract</td>
</tr>
<tr>
<td>collated, reviewed and reported</td>
<td></td>
<td></td>
<td></td>
</tr>
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Appendix 1

Example of a local health care associated infection reduction plan

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

The purpose of this HCAI reduction plan is to outline the [organisation/commissioning body]'s approach to the prevention and control of HCAIs for the period April [year] to March [year] and to outline a plan for the future new commissioning structures and arrangements.

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

The overarching purpose of the infection prevention and control commissioning role is to ensure the infection prevention and control element of patient safety, quality and experience is embedded within the commissioning process. The four main requirements to effectively commission for infection prevention and control include:

i) development and leadership of the health and social care economy

ii) contracting (including setting clear expectations of achievement, e.g. compliance with the code of practice for infection prevention and control)

iii) performance monitoring against the contract (gaining assurance)

iv) organisational accountability.

a) Development and leadership of the health and social care economy

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

- Establish a health economy-wide infection prevention and control (IPC) network group (to aspire to a health and social care economy collaborative meeting, with sign up from CEOs and directors).

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

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

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

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

- Commissioners should engage with social care providers to assist in their attainment of and compliance with the code of practice. (Note: whilst the legal responsibility lies with local authorities, the expertise lies within health, and commissioning organisations have an intrinsic responsibility to the whole population.)

- Commissioners, through a health economy network group, should initiate and lead on the implementation of national/regional and local programmes in line with the NHS Outcomes Framework 2012/13 (DH, 2010), Healthy lives, healthy people: Improving outcomes and supporting transparency (the public health
outcomes framework) (DH, 2012b) and the Adult Social Care Outcomes Framework (DH, 2012b). For example:

- MRSA screening
- national HCAI surveillance programmes
- Saving Lives/Essential Steps
- sharing of learning and findings from root cause analysis of HCAI
- antibiotic stewardship
- decontamination strategy
- safety thermometer
- long-term conditions and premature death due to communicable diseases.

b) Contracting (including setting the standard)

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

- When establishing IPC standards for provider organisations, due regard must be paid to the following:
  - Code of Practice for Infection Prevention and Control (DH, 2010)
  - Department of Health operating frameworks (NHS, Public Health and Social Care) (DH, 2010, 2012a and 2012b)
  - current strategic health authority commissioning framework outcome documents (old vital signs)
  - national and regional standards
  - local priorities.

- As a minimum, ensure requirements for providers are included in contracts to state the need for registration with the Care Quality Commission (CQC) and compliance with the code of practice.

- Ensure there are service specifications for infection prevention and control (IPC) and specific/relevant key performance indicators (KPIs) and quality indicators within the provider contracts. As a minimum these will reflect the national objectives within the operating framework and other national mandatory policies – see basket of suggested indicators on page 8.

- Support engagement with quality improvement initiatives as appropriate through Commissioning for Quality and Innovation (CQUIN) development.

- Ensure infection prevention input (via local infection prevention teams/experts) occurs in all new contracts, services and pathways as they are developed.

- Ensure that there is specialist IPC practitioner input to IPC related contracts such as cleaning, catering, planned preventive maintenance (PPM), building construction and refurbishment, and waste management, etc.

c) Performance monitoring (gaining assurance) by commissioners

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

- Commissioner organisations participate in performance monitoring and quality assurance arrangements for each provider through, for example
  - attendance at provider infection prevention committees and review meetings with provider IPC leads as locally agreed
  - regular formal HCAI performance monitoring meetings with contract management staff
  - input into the overarching contract quality meeting/clinical quality review groups
  - receipt of regular infection prevention/HCAI dashboards from providers
  - unannounced inspection visits.

- Ensure there is appropriate IPC expertise within the commissioning organisation to interpret data or information received from providers.

- Analyse information submitted by providers and ascertain whether the information offers the required assurance.

- For independent contractors, it is essential that the commissioning IPCT is part of internal performance monitoring arrangements for primary care (eg performance management group or annual contract review processes). It is through this mechanism that the environmental audits that are undertaken to assess environmental fitness for purpose can be fed into the overarching performance framework.

- In addition, IPC should feature in the commissioning framework about fitness to practise as commissioning decisions are made about the transfer of care from secondary to primary (eg is the environment fit for purpose).
• Engage with primary care contracting to develop robust assurance of infection prevention practice across primary care providers as the commissioning processes evolve.

d) Organisational accountability (for the commissioning organisation)

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

• IPC is included as an integral part of the [commissioning body/organisation] internal quality and safety monitoring system.

• The [organisation/commissioning body] has a strategic plan and operational plan for reducing HCAI and improving infection prevention practices which takes into account the changing NHS architecture.

• Accurate information is reported into the organisational governance framework, reported on the quality dashboard and all other relevant performance matrix, and shared with relevant commissioning bodies.

• Information will be monitored monthly by the infection prevention and integrated quality teams. Formal director of infection prevention and control (DIPC) reports analysing quality and performance, action plans and exceptions will be made to the approved committee within the commissioning organisation and [insert name of cluster], and subsequently to the cluster board at a locally agreed frequency. An annual report would provide a summary of activity, assurance and risks to the board.

• The cluster will contribute to any cluster SHA assurance processes as agreed.

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

• There is an escalation process in place and HCAI is added, where necessary, to the corporate risk register.

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

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

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

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

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

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

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

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

**Health care associated infection** – an infection that arises as a result of health care. Previously known as hospital acquired infection it includes infections that arise from medical care or treatment in hospital (in or outpatient), nursing homes, or even the patient’s own home.

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

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

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

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

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

Department of Health (2011) Setting Levels of Ambition for the NHS Outcomes Framework, A technical annex to support Developing the care objectives for the NHS: A consultation on the draft mandate to the NHS Commissioning Board Chapter 7: Treating and caring for people in a safe environment and protecting them from harm, London: DH. Available at www.dh.gov.uk


Department of Health (2012b) Healthy lives, healthy people: Improving outcomes and supporting transparency, London: DH.


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

www.ips.uk.net

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