Infection prevention and control within health and social care: commissioning, performance management and regulation arrangements (England)
First published in October 2013\(^1\), this joint paper was developed by the Infection Prevention Society (IPS) and Royal College of Nursing (RCN) to describe the organisational and regulatory structures in place to support infection prevention and control (IPC) in England following the implementation of the Health and Social Care Act 2012 and to complement the publication of the IPC commissioning toolkit\(^2\). The change in focus from national to local clinical commissioning of NHS-funded care had a significant impact on commissioning support systems for IPC and alignment of new agencies. The experience of implementing these substantial changes, and learning that has arisen since, has shaped a review of this document to continue to support our members and those involved in the commissioning of services\(^3\). It describes how IPC sits within the national outcomes framework and associated levers to meeting these ambitions.

Our earlier briefing highlighted inconsistencies towards ongoing reductions in health care associated infections (HCAs) by different regulators and risks associated with the continuing complex commissioning and assurance landscape. Since first publishing the briefing paper in 2013 the RCN and IPS are pleased to see the removal of MRSA and *Clostridium difficile* from the quality premium of Clinical Commissioning Groups (CCGs), and removal of MRSA from Monitor’s Risk assessment framework (RAF). These changes have resulted in greater clarity and expectations for all organisations regarding MRSA.

This document sets out the current (as at October 2014)\(^4\) approaches to IPC and current organisation of agencies including those responsible for commissioning, performance management and regulation in the NHS in England. It does not seek to provide answers to some of the continuing challenges but to enable ongoing discussion regarding how further clarity within the NHS and wider policy landscape can be developed and highlight where risks exist and further improvements may be realised to support IPC as a core element of patient safety.

Note: this paper is written to support NHS-commissioned services in England only due to differences in the commissioning processes in the devolved administrations.

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3. Information available for IPS members on member web pages www.ips.uk.net Information for RCN members is available at www.rcn.org.uk/ipc
4. Based on publicly available information researched during August 2014 and valuable insights from nurses working in infection control between June and July 2014.
Background

IPC is a crucial component of safe systems for those providing health and social care. It is inextricably linked to antimicrobial resistance (AMR) and therefore has a central role in health and social care and public health services. Its importance is emphasised within the UK five-year AMR strategy (DH, 2013). We believe that achievement of ongoing improvements in reducing HCAI requires sustained provider and commissioner commitment and regular review of how systems and agencies interact in order to protect patients and support reductions in AMR.

Commissioning is the process by which NHS health and social care services are developed, reviewed, contracted and paid for. Its function is to ensure that health and care services are provided effectively and to a high standard and meet the needs of the population requiring them. IPC is not commissioned independently, but is integral to all contacts with providers of care.

From April 2013 commissioning of health and prevention services has been shared across a range of commissioning bodies including NHS England (NHSE) area teams (ATs) (recently replaced with sub regions) with clinical commissioning groups (CCGs) supported as appropriate by commissioning support units (CSUs) as well as local authorities (LAs). All these organisations require support in terms of IPC expertise. LAs have assumed statutory responsibilities in relation to health protection, which includes any threat to the health of their resident population including infectious diseases (including those that are health care associated^5). Public Health England support LAs both in relation to health protection and HCAIs through their relationships with care providers.

This document will be of benefit to:

- NHS England
- Public Health England
- Regulators of health and social care (CQC/Monitor)
- NHS Trust Development Authority (NHS TDA)
- Health and wellbeing boards
- Directors of public health
- Local authority commissioners
- Provider organisations within local authorities
- IPC specialists and quality/safety leads working within or supporting commissioning teams including CCGs, CSUs and local authorities
- IPC specialists working in, with, or on behalf, of NHS providers of care.

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Overview of national agencies and their role(s) in relation to infection prevention and control

RCN and IPS members report that following the changes to the NHS in April 2013 there remains significant variation and a lack of consistency in approach and management of IPC with the potential risk of the IPC-commissioning function and benefit being overlooked or insufficiently supported. The continuing variation in provision of specialist IPC practitioners supporting commissioning and provider organisations remains a cause of concern. The current level and scope of variation and risk was described during a meeting of specialist IPC commissioning nurses in June 2014. This highlighted that one year following implementation of the new NHS structures, significant concerns remain regarding accountability and transparency of IPC service provision. Examples of members’ personal experiences relating to difference in roles, placement and impact are described in the Appendix.

Identified potential risks associated with variation in service include:

- communication between the increased number of commissioning organisations (for example, LA, CCG, CSU) and specifically those without any dedicated IPC resource
- retention of IPC specialist staff within this speciality with an impact on building future capacity and skills
- the ability to react and respond to ‘cross-organisational boundary’ incidents or outbreaks
- lack of clarity around accountability and responsibility when dealing with incidents/performance, leading to risk of duplication of effort or gaps in learning or improvements
- inconsistency of standards required from different providers commissioned by different organisations
- overlap and discrepancies in advice where elements of care pathways are commissioned and inspected by different organisations
- loss of the dedicated IPC specialist advisory and educational function within primary care as resources have transferred to CCGs, CSUs and LAs. An example includes a lack of clarity over the current provision of IPC advisory function to schools, nurseries, nursing homes, GP surgeries and dentists
- decommissioning of CSUs and loss of associated IPC advisory posts leading to a lack of clarity regarding how IPC advice is procured by these CCGs
- how variation in assurance regarding performance of IPC by regions and local agencies is managed.

In addition to current risks the following opportunities are recognised to support improvement in infection prevention across the health and social care sector:

- improved communication between social care organisations and greater prominence of IPC within LAs
- the opportunity to review current roles and responsibilities and gaps in service/performance delivery in relation to IPC across the health and social care system.

Table 1 describes national agencies and their role in relation to IPC, along with examples of where IPC support may be provided from. This is based on information available in October 2014, and the understanding of our members.
**Table 1: Overview of national agencies and their role in IPC**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Function summary in relation to IPC</th>
<th>IPC advice provided by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Health (DH)</td>
<td>Responsible for leading health and care. This includes creating national policies and legislation to meet current and future challenges – for example, setting national objectives for performance monitoring of IPC and AMR.</td>
<td>A variety of sources, for example, advisory groups such as ARHAL.</td>
</tr>
<tr>
<td>NHS England national office (NHSE)</td>
<td>An independent arm’s length agency to the DH. The main aim of NHSE is to improve the health outcomes for people in England. One of its core roles is supporting, developing and assuring the commissioning system for health and implementing government policy.</td>
<td>HCAI lead at NHSE based in Patient Safety Directorate (also covers AMR).</td>
</tr>
<tr>
<td>Monitor</td>
<td>Responsible for authorising, monitoring and regulating NHS foundation trusts and is the new sector regulator for providers of NHS care. The Care Quality Commission (CQC) is responsible for regulating the quality of health and adult social care services. Monitor looks to the CQC to provide it with assurance that essential standards of quality and safety are being met.</td>
<td>Resource not identified.</td>
</tr>
<tr>
<td>NHS Trust Development Authority (NHS TDA)</td>
<td>Responsible for providing leadership and support to the non-foundation trust sector of NHS providers. It oversees the performance management of these NHS trusts, ensuring they provide high quality sustainable services which are inclusive of IPC, and provides guidance and support on their journey to achieving foundation trust status. NHS TDA is responsible for assuring clinical quality, governance and risk in these NHS trusts.</td>
<td>Four TDA HCAI leads.</td>
</tr>
<tr>
<td>Care Quality Commission (CQC)</td>
<td>CQC exists to ensure all providers of regulated care activity in England (for example, hospitals, care homes, dental and GP surgeries) provide people with safe, effective, compassionate and high quality care. All organisations’ compliance with mandatory standards for quality and safety are assessed and monitored by CQC. IPC is primarily included in Outcome eight of the current CQC standards. Moving forward compliance with the CQC fundamental standards will shape regulatory requirements for IPC in England.</td>
<td>Resource not identified.</td>
</tr>
<tr>
<td>Public Health England (PHE)</td>
<td>Public Health England’s overall mission is to protect and improve the health and wellbeing of the population, and to reduce inequalities in health and wellbeing outcomes. PHE is an arm’s length agency to the Dept of Health. PHE helps local authorities understand and respond to health threats. The responsibilities and functions of PHE (formerly the Health Protection Agency) in the prevention and reduction of HCAIs are described in the Health Protection Agency (HPA) <em>Operational guidance</em> (HPA, 2012). Core responsibilities include promoting best practice, surveillance and feedback of HCAI data and risk assessments, support, co-ordination and leadership of HCAI-related outbreaks and other situations.</td>
<td>Consultants in Communicable Disease Control (CCDC), consultants in health protection and health protection nurses in PHE local centres.</td>
</tr>
</tbody>
</table>
Overview of regional and local agencies and their role(s) in relation to IPC

In addition to national agencies influencing IPC, a number of regional and local organisations also affect and shape IPC provision and assurance. Some of these align with national agencies and are described below.

Table 2: Regional and local agencies and their role in IPC

There is a degree of variation at the regional and local level in the provision of IPC advice. This is particularly difficult to map and arrangements are changing over time, however our current understanding is set out in Table 2 below. Where the number of organisations has altered since 2013 these are provided in brackets).

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Function summary in relation to IPC</th>
<th>IPC advice provided by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>30,261 providers of health and adult social care – as of 31 March 2013 (CQC, 2013).</td>
<td>All providers of health and adult social care must meet the CQC essential standards of safety and quality and have their performance managed by their commissioners. Their commissioners may include both CCGs, NHSE or LAs.</td>
<td>Specialist staff employed or contracted by providers.</td>
</tr>
<tr>
<td>211 clinical commissioning groups (CCGs) (previously 229).</td>
<td>Responsible for commissioning care for their covered population excluding primary care and specialised care (which are the responsibility of NHSE). Commissioners may also include IPC as part of their local Commissioning for Quality and Innovation (CQUIN).</td>
<td>Varies. CCGs may employ and/or share IPC expertise across CCGs, with their LA or buy in expertise from the CSU.</td>
</tr>
<tr>
<td>17 commissioning support units (CSUs) (previously 19).</td>
<td>This varies but some CSUs offer expertise on IPC. A number of CSUs have recently decommissioned with services incorporated into the relevant CCGs.</td>
<td>Varies.</td>
</tr>
<tr>
<td>Four regional NHSE teams.</td>
<td>Provide strategic leadership across their regions, including clinical expertise and the support and oversight of NHSE area teams (ATs) (now sub regions) and CCGs. Fulfils its assurance function via the area teams.</td>
<td>Varies. No specific IPC resource identified but some local IPC advisory contracts in place.</td>
</tr>
<tr>
<td>12 NHSE sub regions created (in shadow form from January 2015) to replace 27 NHSE area teams.</td>
<td>Exact details of function summary and relationships/responsibility to IPC unclear at present.</td>
<td>Unclear at present</td>
</tr>
<tr>
<td>Four NHS TDA regions.</td>
<td>NHS TDA Heads of IPC work closely with trusts to support and challenge them on delivery of improvements. This requires close collaborative working for organisations supporting IPC including TDA, commissioner and provider IPC practitioners, health regulators (Monitor and CQC) etc to ensure clear and consistent advice. A partnership agreement exists between TDA and NHSE.</td>
<td>Four TDA IPC regional leads.</td>
</tr>
<tr>
<td>433 local authorities (LAs).</td>
<td>LAs work with local partners to ensure threats to health are understood and properly addressed. The LA cannot ensure other statutory bodies have plans in place, but it can advise, challenge and escalate issues. Councils have powers of ‘health scrutiny’ which they can use to hold commissioners and providers of health and social care services to account for quality and safety. At the local level, the health and wellbeing board provides a forum for oversight of the comprehensive health service. The director of public health (DPH) is a statutory member of the health and wellbeing board (HWB). The HWB’s role is to ensure leaders from health and care systems and the public work together to improve health and wellbeing for their local population and reduce health inequalities. Directors of public health may also establish a local health protection forum to review plans and issues that need escalation. LAs also have a role in commissioning social care and mandated public health services.</td>
<td>IPC practitioners may be employed as part of the wider public health team based in the LA. These staff may have a service level agreement or MOU with a CCG to provide expert IPC advice around CCG commissioned services. Where it exists, the IPC role within a LA (as part of the PH team) includes providing expert advice and support to the commissioners and contract monitoring officers of social care.</td>
</tr>
<tr>
<td>Public Health England (PHE).</td>
<td>Nurses/specialists working in PHE do not provide routine IPC advice to provider organisations such as nursing homes or GP practices as these are required to source access to specialist advisers in order to meet the requirements of the Code of Practice (DH, 2010).</td>
<td>Health protection nurses and consultants in health protection provide reactive services to outbreaks and incidents involving IPC. However this could be locally determined as HPUs can function differently.</td>
</tr>
</tbody>
</table>

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6 www.institute.nhs.uk/commissioning/pct_portal/cquin.html for an example.  
7 www.neessexccg.nhs.uk for an example.  
Patient outcomes and IPC

Reductions in HCAIs are identified as a clear outcome of expected NHS-funded care. These are currently supported in different ways through commissioning and regulatory process and are described below.

**IPC and the NHS Outcomes Framework**

The NHS Outcomes Framework sets out expected patient outcomes and corresponding indicators that are measured and used to hold NHSE to account. They are used to sustain improvements in health outcomes, as part of the government’s Mandate to NHS England. IPC continues to be part of the NHS Outcomes Framework for 2015/16. Maintaining IPC in the NHS Outcomes Framework helps to sustain a national focus on IPC and IPC is included in Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm. Two central elements for IPC in the outcomes framework are MRSA (bloodstream infections only) and C difficile infections (CDI).

**IPC and NHS England**

NHSE is responsible for assuring the provision of quality care in line with the NHS Outcomes Framework as well as setting ambitions for organisations to achieve. For MRSA, NHSE has set out a ‘zero tolerance’ approach, explicitly targeting an ambition for zero cases of MRSA. NHSE says: “With around a sixth of trusts reporting zero cases of MRSA bloodstream infection over the past year, a point has been reached where preventable MRSA bloodstream infections should no longer be acceptable in NHS-funded services.”

As such, the position is that there is now no longer an MRSA objective for health care organisations to support the continued reduction in the number of these infections. Objectives have been replaced by the expectation that all organisations will achieve zero cases in the near future. Guidance has been produced to support organisations conducting post-infection reviews (PIR) to identify why an MRSA occurred, how learning from these can help avoid future cases and also determine apportionment for the case.12

For C difficile, NHSE has altered their approach and acknowledge that “there are indications that, for some organisations at least, the level of C difficile infections may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided” (NHSE, 2014). In line with this, NHSE has also amended the contractual sanction that can be applied to each C difficile case in excess of an acute organizations objective, reducing the penalty from £50,000 to £10,000.

Additionally, for CCGs, when considering whether an individual case of C difficile should count towards the number of cases used for contractual sanctions, they can now take into account information about the extent to which C difficile infections are linked or not, with identified lapses in care by the organization reporting the infection. This process involves assessing each infection allowing IPC teams to focus their efforts on areas where problems have been identified to ensure that lessons are learned to support future prevention of infections. If the CCG accepts no lapse in care, then this will not count towards the number of cases used for contractual sanctions13.

CCGs will no longer be penalised for exceeding their locally set objectives for incidence of MRSA and C difficile infection as this measurement has been removed from the Quality Premium for CCGs (essentially a pay for performance framework for CCGs)14.

Urinary tract infections in patients with an indwelling urethral catheter continue to be part of a national CQUIN using the NHS safety thermometer methodology15.

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11 www.england.nhs.uk/ourwork/patientsafety/zero-tolerance
Infection prevention and control and Monitor

Monitor acquired new responsibilities as a regulator as of 1 April 2013, regulating not only NHS foundation trusts (FTs) but over time regulating other providers of NHS care. Currently the NHS provider license (Monitor’s main tool for regulating providers of NHS services) covers FTs and eligible independent sector providers. Monitor oversees FTs’ governance through a specific licence condition.

Monitor’s Risk Assessment Framework for NHS foundation trusts (RAF), published in October 2013 (and updated in April 2014\(^\text{16}\)) sets out how Monitor oversees the financial viability and governance of FTs. As part of this governance oversight, Monitor has historically considered the effectiveness of FTs’ infection control procedures. Where FTs are breaching nationally assigned thresholds on a material (ie breaching the full-year threshold before the final quarter of the year) or ongoing (regularly ahead of its in-year trajectory), Monitor may consider reviewing the governance of the organisation.

While Monitor historically considered \textit{C difficile} and MRSA levels in its governance oversight frameworks, Monitor removed MRSA from this in 2013. Monitor took this decision because the number of MRSA cases has fallen and reached levels where changes in the trend are not always a reliable indicator of a concern in the governance of an organisation. The framework has retained \textit{C difficile} infection and a new de minimis.

While Monitor is not routinely monitoring MRSA levels at FTs, Monitor does include third party information in its oversight of FTs. If Public Health England, for example, expressed concerns regarding an MRSA outbreak at an FT, Monitor may use this to trigger an investigation into the governance of the FT.

Further notes in the Risk assessment framework state that:

For \textit{C difficile} (p53):

“[Measuring of performance against the \textit{C difficile} objective] will apply to any inpatient facility with a centrally set \textit{C difficile} objective. Where an NHS Foundation Trust with existing acute facilities acquires a community hospital; the combined objective will be an aggregate of the two organisations’ separate objectives. Both avoidable and unavoidable cases of \textit{C difficile} will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health NHS Foundation Trust without a \textit{C difficile} objective acquires a community provider without an allocated \textit{C difficile} objective) we will not apply a Clostridium difficile score to the NHS Foundation Trust’s governance risk rating. Monitor’s annual de minimis limit for cases of \textit{C difficile} is set at 12. However, Monitor may consider scoring cases of <12 if Public Health England, indicates multiple outbreaks.

See the table below (Monitor’s table 3) for the circumstances in which we will score NHS foundation trusts for breaches of the \textit{C difficile} objective.”

Monitor also notes that; “If Public Health England, indicates that the \textit{C difficile} target is exceeded due to multiple outbreaks, while still below the de minimis, Monitor may apply a score. Monitor considers it a matter of routine reporting for trusts to report any risk to achieving its targets, including those relating to infection control.”

The RAF is supplemented by additional guidance on thresholds for 2014/15 set out in the FT Bulletin in April 2014\(^\text{17}\). This states that “Monitor will generally only consider investigating a trust where it is satisfied that the trust has either (i) breached its annual threshold; or (ii) breached its

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in-year trajectory for three quarters with cases of *C difficile* resulting from a ‘lapse in care’.
However, Monitor may also choose to investigate if there is a seemingly poorly controlled outbreak of *C difficile* (or other infectious disease) at a trust, particularly if there is evidence of cross contamination in a group of patients.”

Monitor will publish an updated RAF, covering 2015/16 in late March 2015, and currently plans to reflect this revised.

**IPC and the Care Quality Commission (CQC)**
Legislation underpinning the CQC sets out requirements on cleanliness and IPC and is covered in the *Guidance on essential standards of quality and safety from the CQC as outcome eight*. This guidance refers to the *Department of Health Code of Practice* (Department of Health, 2010) – currently under review.

The CQC draws on information about IPC to inform their work. For acute care providers, they consider sources such as:

- NHS Staff Survey – for example, percentage of staff saying handwashing materials are always available
- MRSA and *C difficile* mandatory surveillance data
- Patient surveys – such as observing staff perform hand hygiene.

CQC does not always look at every standard when they inspect, but IPC can be part of the inspection. MRSA, MSSA, and *E coli* infections are part of the CQC’s new surveillance model as part of its ongoing changes to regulation.

The underpinning legislation for CQC is subject to change, with the essential standards of quality and safety being replaced by fundamental standards. These include “Safe care and treatment” which encompasses “assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated”.* The draft legislation is subject to the approval of Parliament but should receive Royal Assent in April 2015.

**IPC and Public Health England**
Public Health England (PHE) has replaced the Health Protection Agency (HPA). PHE has a memorandum of understanding with CQC which includes the sharing of information in relation to infection outbreaks.

PHE is now the agency collating surveillance data on MRSA, *C difficile* and other infections* and Public Health England has responsibility for delivering local health protection specialist services (including incident and outbreak management) and is delivered through local health protection units. The relationship between LAs and local directors of public health is important as both reactive health protection and proactive public health and health activity is complementary and links to both HCAI and AMR.

**The RCN and IPS position**
The RCN and IPS are pleased to see that IPC continues to be a high priority and a core focus for many key agencies within the NHS in England. However, we are concerned about:

- **loss of experience and fragmentation** – as a result of the broader 2013 NHS reforms and restructure some specialist IPC nurses posts were lost as a result of transfer to a variety of employing organisations, for example NHSE, CCGs, LA, CSUs, etc. No data or guidance on the level of current specialist IPC support required is available to these employing organisations. Concerns remain relating to how effective communication is between multiple organisations involved in commissioning and assurance of safety
- **inconsistencies** – we are pleased to note that the inconsistencies seen between NHSE and Monitor in their approach to MRSA have been removed in the new Risk assessment

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18 http://www.cqc.org.uk/content/essential-standards
framework. However, we remain concerned that there may be inconsistencies across organisations on their approaches to IPC simply because so many different organisations have a role to play in IPC. In the future we believe that Monitor may need to re-consider *C difficile* as an indicator of governance as we reach the point where cases are less often due to lapses in care.

- **Incentives** – providers and commissioners must decide the priority that they place on IPC among a variety of others, for example prevention of pressure ulcers or falls. Which ‘targets’ are incentivising behaviour is currently unknown. The financial pressure on organisations currently is significant in light of the need to reduce NHS spending by £20 billion. Even where CQUINs are met and money released by CCGs it remains difficult to know if such incentives are producing ongoing improvements in care and quality as experienced by patients.

As a result of this review the following proposals should be considered:

1. Commissioning of IPC and the provision of specialist IPC advice should be considered by Public Health England as a core element of any future national infection prevention and control national strategy and to support reductions in AMR

2. All commissioning organisations should have in place a formal process to provide assurance to their respective boards of the level of infection prevention support available to them and to what extent this meets the organisation’s needs. This assurance should be provided to the DPH and health and wellbeing boards locally. Where necessary, risks relating to IPC resources should be placed on commissioning organisations’ risk registers

3. Information should be detailed by each provider organisation within their annual report on how budgets and resources relating to IPC are set and utilised (including information on how the number or WTE posts within teams is set according to need) so that improvements in performance and incidence of infection can be compared and monitored over time

4. A system to support LAs assess the strength of local IPC services and risks associated with information, communication, and availability or provision of specialist advice should be explored.
References


Further resources

Davies SC (2013) Annual report of the Chief Medical Officer, Volume two, 2011, Infections and the rise of antimicrobial resistance, Department of Health: London

RCN (2014) Employing nurses in local authorities, RCN: London

Acknowledgements

RCN and IPS members that reviewed the development of this document.

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IPS contributors
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Glossary

ARHAI The Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections

AT Area team

CCDC Consultants in commissioning disease control

CDI Clostridium difficile infection

CCG Clinical commissioning groups

CQC Care Quality Commission

CQUIN Commissioning for Quality and Innovation

DH Department of Health

DPH Director of Public Health

FT Foundation Trust

HCAI Health care associated infection

HPA Health Protection Agency

HPU Health Protection Unit

HWB Health and Wellbeing Board

IPC Infection prevention and control

IPS Infection Prevention Society

KPI Key performance indicator(s)

LA Local authority

MOU Memorandum of Understanding

NHSE NHS England

NHS TDA NHS Trust Development Authority

PCT Primary care trust

PHE Public Health England

PIR Post-infection review

RAF Risk assessment framework

RCA Root cause analysis
Appendix

This appendix includes information from a range of IPC specialist nurses involved in commissioning and the provision of specialist IPC advice. It describes the variation in roles, employers, role functions and challenges experienced by a sample of nurses working in these roles.

Case study 1

<table>
<thead>
<tr>
<th>Location/based in:</th>
<th>Local authority, Health Protection and Control of Infection Unit, public health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous role:</td>
<td>I have worked in the field of IPC for 14 years. My previous post was Senior Health Protection Nurse for a PCT.</td>
</tr>
</tbody>
</table>

Outline description of role

I provide expert advice to one CCG covering a large metropolitan borough, assuring them that their provider organisations have good structures in place regarding IPC. I developed the HCAI reduction plan for the CCG in conjunction with the quality lead for the CCG and lead nurse for IPC in the acute provider. I also work closely with commissioning partners within the local authority who are commissioning care services for residents such as nursing and care homes or domiciliary care. With the further integration of health and social care services, this is a role that I can see increasing in importance in the near future.

Provision of IPC advice

I attend the infection control committee at the local NHS acute provider organisation. I attend outbreak meetings as necessary. I conduct PIRs into all pre-48-hour cases of MRSA bacteraemia, involve relevant services, complete the paperwork and return this to PHE. I am involved in all PIR's into post-48-hour cases of MRSA bacteraemia. I investigate all community acquired cases of *C difficile* and coordinate the health economy working group on the reduction of *C difficile*. I work in conjunction with the Acute Provider and CCG to decide if cases are due to lapses in care. I write and review annual reports and work plans, to check these for clarity and provision of assurance back to the CCG regarding compliance. I report back to the CCGs Quality Meeting where *C difficile*, MRSA Bacteraemia, MSSA bacteraemias, device-related bacteraemia and other key performance indicators.

How the role influences improvements in HCAI reduction

I provide support to the quality lead within the CCG via the Public Health Core Offer back to the CCG and am responsible for meeting the requirements of an MOU between the CCG and my IPC team. CCGs will hold organisations to account, however commissioners are not always from a clinical background and therefore do not always understand the detail and significance of information behind individual cases – my role enables me to provide insight.

How can the role be enhanced/strengthened or challenges overcome?

There are challenges in being placed in a local authority, however these can be overcome if all organisations are willing to work together. Good relationships are central to ensuring that patients and residents within the health economy are cared for in a safe and clean environment, wherever their treatment or care is provided.
Case study 2

**Location/based in:** Based in CCG as part of the Quality and Patient Safety Team

**Previous role:**

Member 1: Twenty years’ experience as an IPC specialist nurse at a University Hospital NHS Trust. I joined the PCT in 2012 as part-time Head of IPC. Transferred to CCG October 2013, on a part-time basis.

Member 2: Five years’ experience as an ICN in acute trust. Four years’ experience as a matron in a PCT as part of the Governance team providing IPC advice and support to Community Services, independent contractors, prison health care service and NHS-funded care homes. Also part of the local Health Protection Unit public health on call team. Transferred to Community Services as IPC lead Nurse following the commissioner/provider split in 2009. Transferred to CCG in 2013 to support Head of IPC (member 1, above) in a full-time role.

**Outline description of role**

Our roles sit within the Quality Support Team employed by a CCG which is subject to a collaborative arrangement across a total of four CCGs. This collaborative relationship is managed by the CCG Executive Nurses and is underpinned by an explicit and documented agreement that assures equal input and ownership of the service. A collaborative commissioning agreement describes the relationship and the systems and processes for operating it. The main IPC role objective is to develop, lead and implement a comprehensive commissioning service for the prevention, investigation, surveillance and control of infection within the four CCGs.

**Provision of IPC advice**

As commissioners we ‘hold to account’ and monitor the commissioned services on their progress to reduce HCAIs. We host dedicated quality review meetings, receiving assurance reports, exception reports on all quality and patient safety aspects of care and monitoring actions taken following external reviews e.g. Care Quality Commission Inspections. Specifically we:

- provide professional advice to provider trust boards, and act as specialist advisor to all staff and related agencies
- improve standards of infection control through communication, involvement and awareness of clinical practices and service provision, providing advice and support to all staff in service development and promotion of best practice for the prevention and control of infection
- support the CCGs in commissioning and monitoring services, ensuring the consideration of IPC across all functions within the CCGs to ensure that it is embedded in all elements of the commissioning cycle. Developing and monitoring quality and safety specifications, KPIs and CQUINs
- implementation of the infection prevention and control national commissioning framework.

**How the role influences improvements in HCAI reduction**

We work with Commissioned Services to demonstrate a zero tolerance to HCAIs through Post-Infection Review (PIR) process for MRSA bacteraemias root cause analyses (RCAs) for *C difficile* infections (CDI) and implementation of the CPE Toolkit for Acute Trusts.

We work to ensure that learning and improvement in practice are identified. Some of this is achieved at the local HCAl network group that meets quarterly to share any of the above, new guidance, new products etc. Attendance includes acute and community provider representation, independent hospitals, PHE, GP attendance (on occasions) and a consultant microbiologist. There is an IP&C strategy to support this group.

We engage with social care providers through PHE to assist in their attainment of compliance with the Code of practice, infection prevention and control is embedded and that board accountability/assurance is demonstrated.

**How can the role be enhanced/strengthened or challenges overcome?**

Numerous challenges exist. Prior to the formation of the CCG, NHS-funded primary care services (GP services, dentists and nursing homes) had access to the IPC nursing team for specialist advice and audit and education support. This service no longer exists. GP services hold regular multi-disciplinary meetings as part of GP ‘time to learn’ development days which IPC commissioning nurses attend. This allows opportunities to discuss IPC issues and feedback MRSA bacteraemia of *C difficile* data and learning. IPC specialist advice by CCG IPC nurses does not extend to audit and educational activities. Dental and nursing home providers no longer receive the service that was in place under the PCT. CCG IPC nurses are concerned at potential or actual gaps in oversight of IPC service provision to both NHS and independent service providers and monitoring of these services due to the impact on patient outcomes including AMR when accessed by patients. The establishment of IPC lead post within the local Area Team would support IPC at the commissioning level and help support greater scrutiny and assurance of quality and standards across services.
Case study 3

<table>
<thead>
<tr>
<th>Location/based in:</th>
<th>Hosted by a CCG for 30 hours per week with an allocation of 15 hours for each of two local CCGs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous role:</td>
<td>I was a part-time infection control nurse for a PCT within the quality team. My role was primary care orientated and supported the HCAI reduction agenda within general practice. On abolishment of the PCT I was transferred from the quality team to the public health team and relocated to a local authority without a job description or objectives. Despite no initial resource allocated for an IPC role within the local CCG a limited resource was identified half way through 2013 leading to this shared post as CCG ICN.</td>
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</tbody>
</table>

Outline description of role

My role is shared across two CCGs. I sit within quality teams for both organisations. My main objectives are to lead HCAI reduction for the two CCGs. Time is allocated to each CCG according to weekly/monthly requirement and priority of workload – flexible working and joint approaches to processes etc wherever possible.

Provision of IPC advice

My role focuses on the following elements:

- analysis of locally enhanced surveillance of MRSA BSI with PIR of each pre-48-hour case and contribution to post-48-hour cases completed by local trust also for assurance that learning and actions are shared. I support the process for any concerns raised around assignment by of MRSA BSI with PHE
- analysis of locally enhanced surveillance of CDI with RCA assessment for lapse of care with trust cases and assurance that learning and actions shared
- supporting a collaborative RCA approach for pre-72-hour/community assigned CDI. This role involves both a process element for leading the process and a governance oversight role
- as the coordinating organisation's specialist adviser I am a member of local acute trust's infection control committee and IPC action groups of all providers that are commissioned by CCGs
- IC advice and support for primary care of both CCGs – organisation of link nurse forum, signposting info and guidance, IC audit support etc
- provision of IC advice and guidance for the CCG quality team and for wider CCG support teams, for example primary care development and organisational development teams.

How the role influences improvements in HCAI reduction

My role focuses on the use of locally enhanced surveillance of HCAI and a collaborative whole health economy approach to PIR/ RCA of HCAI. This focuses on:

- the sharing of IC guidance and information
- feeding information into quality assurance processes and CCG governance process
- influencing practice, policy decisions using surveillance/PIR/RCA feedback across whole health economy
- raising the profile of HCAI reduction and leading organisation towards a culture of board to point of care IC responsibility.

How can the role be enhanced/strengthened or challenges overcome?

- National/regional network of ICNs in CCG roles – local networks need to be developed for consistency for CCG’s that share providers – processes, tools, guidance, etc.
- Acknowledgement of the IPC Commissioning toolkit as national template for all CCGs to refer to will go a long way to support my role.
- More resources allocated/support for CCGs with challenging population/identified with high rates of HCAI.
- CCGs with lower rates of HCAI to actively share processes/tools/guidance/learning/success stories – at the moment we have to go hunting for it.
- PHE DCS for HCAI to include the patients General practice on it.
- Timely feedback of learning from national MRSA BSI PIR data base.
### Case study 4

**Location/based in:** CSU  
**Previous role:** I have worked in the field of IPC for the past 10 years. My previous post was lead nurse for IPC/Deputy DIPC at a specialist tertiary hospital. I provided strategic leadership for the creation and management of IPC.

**Outline description of role**

I provide expert advice to 12 CCGs in north east London. My role is to provide assurance that provider organisations have good structures in place regarding IPC. Additionally I oversee the primary care audit team who conduct IPC audits within GP and dental practices. This is a separate contract with NHSE.

**Provision of IPC advice**

I attend the provider organisations IPCCs and attend outbreak meetings as necessary. I conduct PIRs into pre-48-hour cases of MRSA bacteraemia, involve relevant services, complete relevant paperwork and return to PHE. I am involved in all PIRs into post-48-hour cases of MRSA bacteraemia. I have agreed to review provided assigned cases of *C difficile* to help commissioners decide if cases are due to lapses in care. I review annual reports and work plans, to check these for clarity. I support commissioners regarding questions they need to raise at the local multi-professional clinical quality review group regarding seek assurance on IPC-related issues. My role involves relationship building and close working with other organisations such as the NHS TDA. I support the arbitration process for MRSA and *C difficile*.

**How the role influences improvements in HCAI reduction**

I provide support to local IPC teams to drive forward improvements. Sometimes this requires an external influence to add weight to the issue which an IPC team are trying to solve. CCGs will hold organisations to account, however commissioners are not always from a clinical background and do not always understand the detail behind individual cases and therefore make clinical judgements, I am able to provide objective insight.

**How can the role be enhanced/strengthened or challenges overcome?**

The CSU is a relatively new organisation and its future is uncertain as neighbouring CSU are decommissioned. I have however received very positive feedback from CCGs. This is a role I believe I can influence and shape.

### Case study 5

**Location/based in:** CCG  
**Previous role:** Senior Infection Control Nurse in a provider organisation.

**Outline description of role**

I am employed for 15 hours a week predominantly to focus on review of all *C difficile* cases across three CCGs. My role is to provide a rapid review tool to primary care, collate risk factors and assist the CCG in reducing CDI cases.

**Provision of IPC advice**

I work with provider organisations in offering support on HCAI and monitor cases. I review serious incidents reports from provider organisations and advise on the management of outbreak and periods of increased incidence. The majority of role currently focuses on performance review.

**How the role influences improvements in HCAI reduction**

The influence of my role focuses on the promotion of the HCAI agenda within the CCGs and primary care.

**How can the role be enhanced/strengthened or challenges overcome?**

I have been employed since May so therefore this is a very new role and will grow once processes have been embedded within primary care and provider organisations. I feel greater collaboration is required across the local area team in delivering a consistent HCAI agenda and working closer with social care to reduce HCAIs across the health economy.
The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies

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