



Infection Control **Annual Report** **2007/2008**

CONTENTS

		Page
1	Introduction	3
2	Duty 1: General duty to protect patients, staff and others from HCAs	3
	Surveillance of Healthcare Associated Infection (HCAI)	3
	Duty 1 B: Prompt identification of infected patients	6
3	Duty 2: Management systems for infection prevention and control	7
	Committee Structures and Assurance Processes	7
	Compliance assessment and assurance	7
	Staff training, information and supervision	8
	Audit programme to ensure key policies are implemented	9
	Policy on admission, transfer, discharge and movement of patients	11
4	Duty 3: Assess risk of acquiring HCAI and take action	11
	Root Cause Analysis (RCA) for MRSA Bacteraemia	11
	Risk assessment and action	12
5	Duty 4: A clean and appropriate environment for healthcare	12
	Committee structures and monitoring processes	12
	Uniform standards	13
6	Duty 5: Provide information to patients and the public on HCAI	13
7	Duty 6: Provide information when patients move between providers	14
8	Duty 7: Co-operation within and between healthcare providers	14
	Health Economy Working	14
	SHA HCAI Forum	14
	Internal co-operation	15
9	Duty 8: Provide adequate isolation facilities	15
	Provision of a cohort ward	15
	Isolation practices audit – Good Hope hospital	15
10	Duty 9: Ensure adequate laboratory support	15
11	Duty 10: Policies and protocols	15
12	Duty 11: HCAI prevention among healthcare workers	15

1. Introduction

This report summarises the work of the infection control (IC) team during 2007-08, the progress made and the significant infection control and prevention challenges that have been faced by the trust. During the year the trust has implemented significant investment in the infection control team, trust infection control measures and infrastructure planned in 2006-2007. It has also revised assurance structures to enable the trust to tackle HCAI more effectively and achieve a significant reduction in infections moving forward into 2008-2009.

This report highlights that the IC team worked extremely hard to deliver the agreed work programme as well as rising to the tremendous extra challenges facing them in 2007-2008. The key objectives of the service have been:

- reducing MRSA bacteraemia and *Clostridium difficile* infection
- improving the quality of patient care by preventing and controlling healthcare-associated infection
- infection control involvement in all service development
- ensuring capability and resilience of the infection control service
- improve infection control knowledge and skills of all staff, patients and public
- improve isolation facilities
- completion of the audit programme.

The activity in the report is described in the context of the Health Act 2006 Code of Practice for the Prevention and Control of Healthcare Associated Infections (January 2008), so that it can be seen how the work of the trust relates to its statutory responsibility to maintain compliance with that Code.

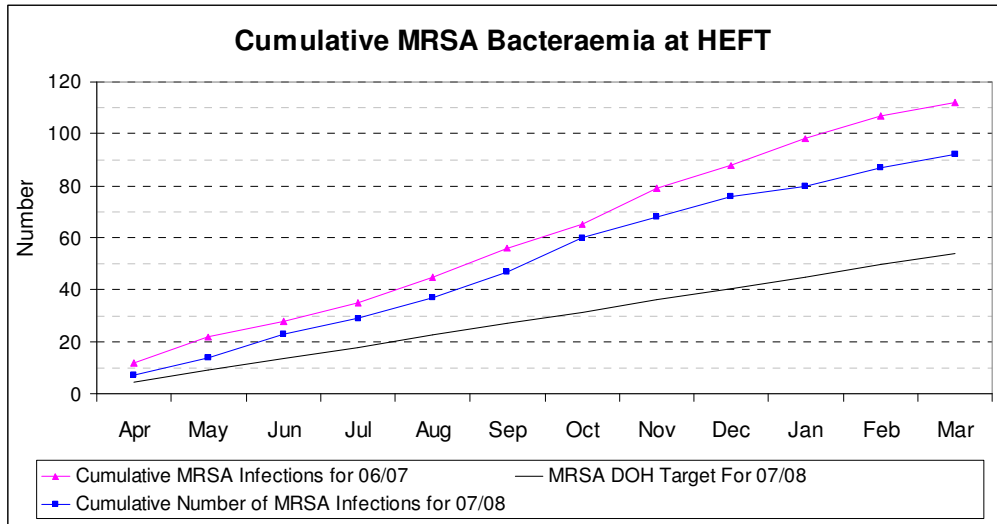
2. Duty 1: General duty to protect patients, staff and others from HCAs

2.1 Surveillance of Healthcare Associated Infection (HCAI)

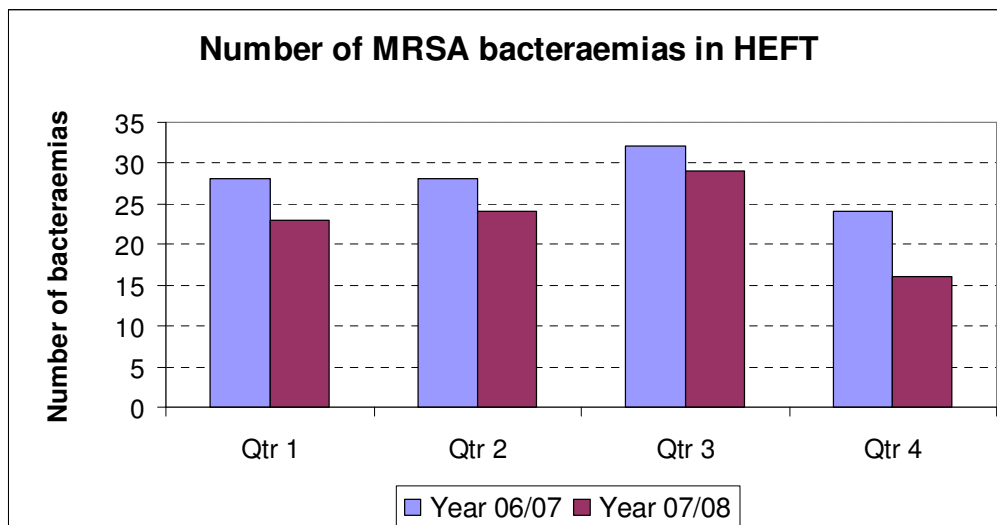
2.1.1 MRSA Bacteraemia

The Department of Health (DH) began mandatory surveillance of MRSA bloodstream infections (bacteraemia) in 2001. This includes all bloodstream infections with MRSA, whether acquired in the hospital or in the community and whether considered to be contaminants or not. Data is reported to the DH (via the Health Protection Agency) monthly and quarterly.

In 2003, the DH set a target of a 50% reduction in MRSA bacteraemia to be achieved by end of 2007/8. The trajectory for HEFT was 54 cases. The chart below shows monthly cumulative data against the trajectory for 2007/8. The total number of cases of MRSA bacteraemia for 2007-8 was 92 which represents an 18% reduction over the previous year although the trust did not reach trajectory.



Quarterly bacteraemia numbers are shown below for the trust and for boards of medicine and surgery (based on ward at time blood culture taken) together with the Trust trajectory.



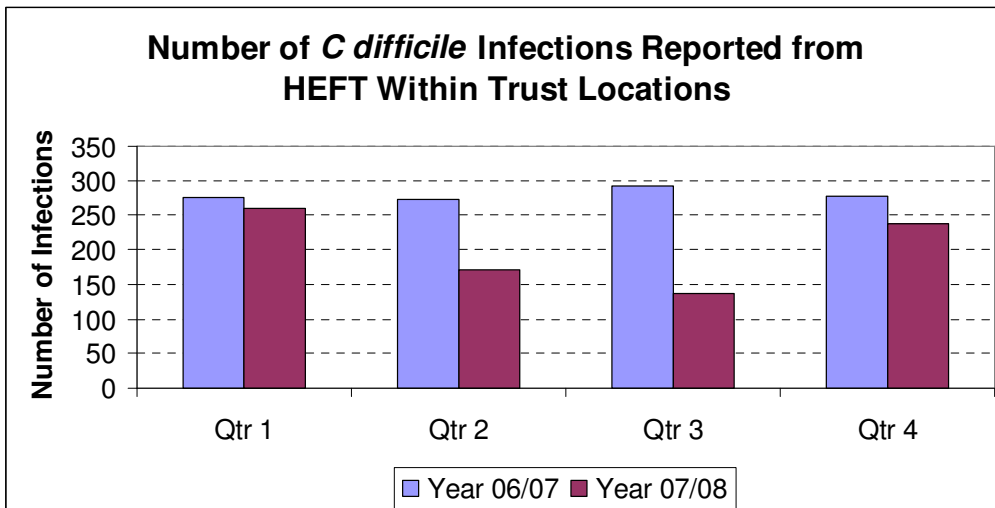
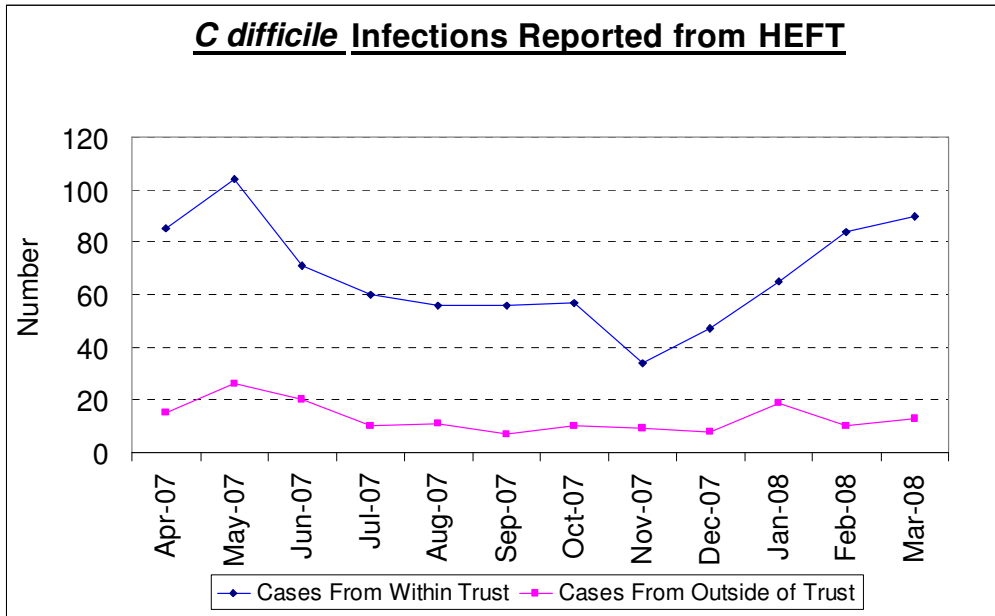
The trust has worked to reduce MRSA bacteraemias with a number of initiatives including:

- Further development of root cause analysis processes
- Introduction of new standard operating procedures for blood cultures
- Further development of the aseptic non-touch technique training programme
- Specific content in junior doctors induction training
- Improved infection control management and audit at ward level e.g. equipment cleaning, PVC monitoring
- Saving Lives High Impact Interventions audit launch in December 2007
- Introduction of MRSA screening for elective admissions (see further detail at Duty 1B).
- Introduction of PVC insertion packs
- Expansion of Critical Care Outreach team to monitor CVCs outside critical care

2.1.2 Clostridium difficile infection (CDI)

Mandatory national reporting of C.difficile

The DH began surveillance of this infection in January 2004. Acute NHS Trusts in England were required to report all cases of CDI from patients aged 65 years and over. This applied whether the *C. difficile* infection was considered to have been acquired in that Trust, in another hospital or in the community (e.g. in healthcare facilities, a nursing home, residential care facilities or from patients at home). In 2007-8, the reporting requirements changed to reporting all cases in patients aged 2yrs and above.



Local Target for C.difficile infection

In 2007-8, local reduction targets were set by commissioners as part of the LDP. The Trust was required to reduce CDI by 18.75% (across all sites) based on 2006 annual data. This annual target was achieved by HEFT.

The trust has worked to reduce *Clostridium difficile* infections with a number of initiatives including:

- Introduction of the cohort ward on the Heartlands Hospital site in July 2007
- Revised Antibiotic policies to reduce usage of “high risk” antibiotics
- Initial steps to appoint and train a dedicated team of Hygiene Technicians skilled in use of Sterinis (hydrogen peroxide vapour) and other deep cleaning techniques.
- Enhanced cleaning programme during winter 07-08, reported to the SHA.
- Enhanced environmental audits.
- Extension of weekly antibiotic ward rounds to cover all hospital sites.
- Monitoring of commode cleaning.

The increase in January-March 2008 was related to increased testing during Norovirus outbreaks and C.difficile outbreaks on a small number of wards. The number of C.difficile infections have decreased significantly from April 08 to the time of writing this report.

2.1.3 Glycopeptide Resistant Enterococcus (GRE) Bacteraemia

Enterococci are bacteria commonly found in the bowel and GRE are enterococci that have become resistant to vancomycin and similar antibiotics. Reporting of bacteraemia caused by GRE has been mandatory for NHS acute Trusts in England since September 2003. The trust continues to experience very low numbers of this type of infection, with 10 infections recorded for the Heartlands and Solihull site in 2007-2008.

2.2 Duty 1 B: Prompt identification of infected patients

2.2.1 MRSA Screening

Our NHS, Our Future (Department of Health, October 2007) sets out that all elective patients must be screened for MRSA prior to admission by March 2009. Following a gap analysis, MRSA screening was increased as follows during 2007-8:

- Renal dialysis patients – From April 2007, all chronic haemodialysis patients are screened for MRSA and MSSA 3 times a year.
- Elective orthopaedics. Pre-admission screening from December 2007.
- High risk elective surgery patients – vascular and thoracic surgery patients pre-admission screening from December 2007.
- All elective surgery. Pre-admission screening excluding day cases from January 2008.

2.2.2 Outbreaks of Infection

The IC team have continued to use the algorithm for diarrhoea and vomiting (see annual report, 2005-6) to identify when wards should be closed for suspected Norovirus infection and thereby contain the infection. The trust experienced a significant problem with Norovirus outbreaks during winter 2007-2008 compared to neighbouring trusts. A full review is planned for 2008-2009 to learn lessons internally and from peers, revise policy, and implement contingency planning to improve outbreak management during 2008-2009.

2.2.3 Research activity to enhance practice

The trust has engaged in research work into HCAI control during 2007-2008. The Evaluation of Molecular MRSA Screening (EMMS) study at Heartlands was completed at the end of April 2007. A methodological paper was published in the BMC Health Services Research Journal in October 2007. Poster presentations were accepted at two international conferences in 2007. The results of the study have been submitted to a peer-reviewed journal for publication. The aim of the EMMS study was to establish if early identification of MRSA colonised patients using rapid methods alone reduces transmission. Interpretation of

the study results found screening of surgical patients using rapid testing resulted in a statistically significant reduction in MRSA acquisition. This result was achieved in a routine

surgical service with high bed occupancy and low availability of isolation rooms, making it applicable to the majority of health-care systems worldwide.

3. Duty 2: Management systems for infection prevention and control

3.1 Committee Structures and Assurance Processes

The trust directs its infection control work at a strategic level through the monthly Infection Control Executive Committee (ICEC), chaired by the Chief Executive and reporting to Trust Board to ensure the Board addresses its collective responsibility for reducing and controlling infections. Trust executive job descriptions incorporate a statement detailing their responsibility for infection control issues.

The infection control service is provided through a structured annual programme of teaching, audit, policy development & review, advice on service development and 24 hour access to expert advice and support.

The annual programme for 2007-8 was set in collaboration with operations following a multi-disciplinary workshop held in March 2007 to agree the key objectives. It was agreed by the ICEC in June 2007. From October 2007, a series of fortnightly meetings of the Executive Group were held to accelerate/enhance tasks in the infection control programme of work. A brainstorming session at one of these resulted in a HCAI "RADAR" plan which was subsequently merged with the annual programme.

In January 2008, a trust Infection Control Operational Group (ICOG) was formed to support the ICEC, providing strong operational leadership and direction of resources, chaired by the Deputy Chief Executive. The trust integration manager worked with the infection control programme manager to divide the programme into 4 workstreams, overseen by ICOG. The workstream areas were: communications, environment, training, and control of infection.

The trust has a designated Director of Infection Prevention and Control (DIPC) in place, Dr. Savita Gossain, consultant microbiologist. The DIPC is accountable directly to the chief executive and trust board. In 2007-8, the DIPC reported quarterly to the Safety Committee. These reports were submitted to the Trust Board via the Trust Clinical Governance and Risk Committee. In addition, from January 2008, the CEO reports to the Trust Board included a report from the ICEC.

3.2 Compliance assessment and assurance

During 2007-2008 the trust had an ongoing process to evaluate its compliance with the Healthcare Standards in order to make a declaration of its position at year end, and continued to monitor compliance with the Code of Practice on Healthcare Associated Infections (Hygiene Code).

In February 2008, the Healthcare Commission undertook an unannounced inspection to determine compliance with its statutory duty to observe the Hygiene Code. All issues that were fed back verbally at the time of the visit were addressed and assurance reported to the Infection Control Operational Group. Logistical issues mean that the Healthcare Commission reported to the trust that no written report would be provided from the inspection.

Following the visit by the Healthcare Commission it was decided that further scrutiny of the related Healthcare Commission core standard C4a was required. In collaboration with executive and operational leads for these areas, an analysis of the assurance statements and assurance gaps was undertaken. This analysis, supported by positive statements from third party commentaries (SHA, Overview and Scrutiny Committee, PPI Forum, and

Governors), enabled the trust to submit a declaration of compliance with standard C4a. However a declaration of non-compliance was made for standard C11b, Mandatory Training, identified that the trust was aware of the need to strengthen mandatory training arrangements, including infection control.

3.3 Staff training, information and supervision

3.3.1 Staff information

- **Reports to Medicine and Surgery Business Units:** These monthly reports continued in 2007-8 to include feedback of data on MRSA bacteraemia, *Clostridium difficile* infection, outbreaks of infection, audit results and other information. A sample report is included at Appendix 1. Separate reports were provided for GHH and for BHH/Solihull. Following further integration of the infection control service, the reports have been amalgamated for 2008-9 so that one report is provided for each of the business units.
- **Ward Reports:** Monthly reporting of ward-based surveillance information on MRSA and *Clostridium difficile* diarrhoea to wards and directorates continued in 2007-8 using SPC charts. Cleaning scores and hand hygiene audit results were also added to these reports during the year. Following integration of the Infection control service and the Analyst gaining access to the GHH microbiology laboratory system, monthly reporting for wards at GHH began in October 2008.
- **Infection Control Week:** Following a successful event in 2006 Infection Control week was held again in 2007, during November, covering all hospital sites.
- **Intranet:** Infection control has an area on the trust intranet providing information, policy guidance and team contact details for staff.
- **Link nurse scheme:** As planned in 2006-2007, the infection control team supported development of the trust link nursing scheme, with every ward area having an infection control link nurse.
- **Heart and Soul:** The trust staff magazine has been used to promote issues to staff.

3.3.2 Staff training

Infection control training and education programmes during 2007/08 included a programme of mandatory sessions and presence on staff induction days. Other sessions included IV therapy and IV cannulation, portering and domestic updates, volunteers and HCA education. Link staff conducted cascade training on hand hygiene. The IC team provided updates to link staff in year. During 2007/08, training monitoring systems were changed, from an in-house database to a national standard module "OLM" on the Electronic Staff Record. This transition caused some difficulties in generating accurate attendance figures for 2007-2008. However, the trust is confident that a robust system is now in place and can report 1145 staff overall have received infection control training at the end of Quarter 1 of 2008-2009.

3.3.3 Staff supervision

Infection Control Team

The trust's efforts in relation to infection control are supported and monitored through the work of the infection control (IC) team. The IC team was significantly expanded during 2007-2008 following a successful business case of approximately £300,000 to increase funding. The team included a total of 14 nursing staff (6 practitioners, and 8 nurses). A new substantive Infection Prevention and Control Lead Nurse commenced in post in January 2008.

The infection control nursing team are deployed to provide training and expert advice, and monitor compliance by wards and departments with expected standards. In this way, the work of staff in the trust is subject to scrutiny and supervision.

The infection control team is based within the Health Protection Agency (HPA). In December 2007 the trust substantively appointed an Infection Control Programme Manager to provide oversight of the successful delivery of the trust infection control work programme and working arrangements between the trust and the HPA. The programme manager is supported by an Infection Control Information Analyst (commenced in post August 2007) who supports the performance reporting and mandatory data return requirements of the trust.

Infection Control Team Personal Development and Training

During 2007/08 all members of the Infection control team attended mandatory training. In addition, staff also attended national and local study days/seminars. All staff have participated in the annual appraisal process. An in-house training programme for the new team members has been developed, to build their specialist skills and knowledge.

The DIPC has attended national and international conferences covering Microbiology and Infection Control and has also undertaken the Q-Learning Leadership course as part of the Trust Organisational Development Programme.

3.4 Audit programme to ensure key policies are implemented

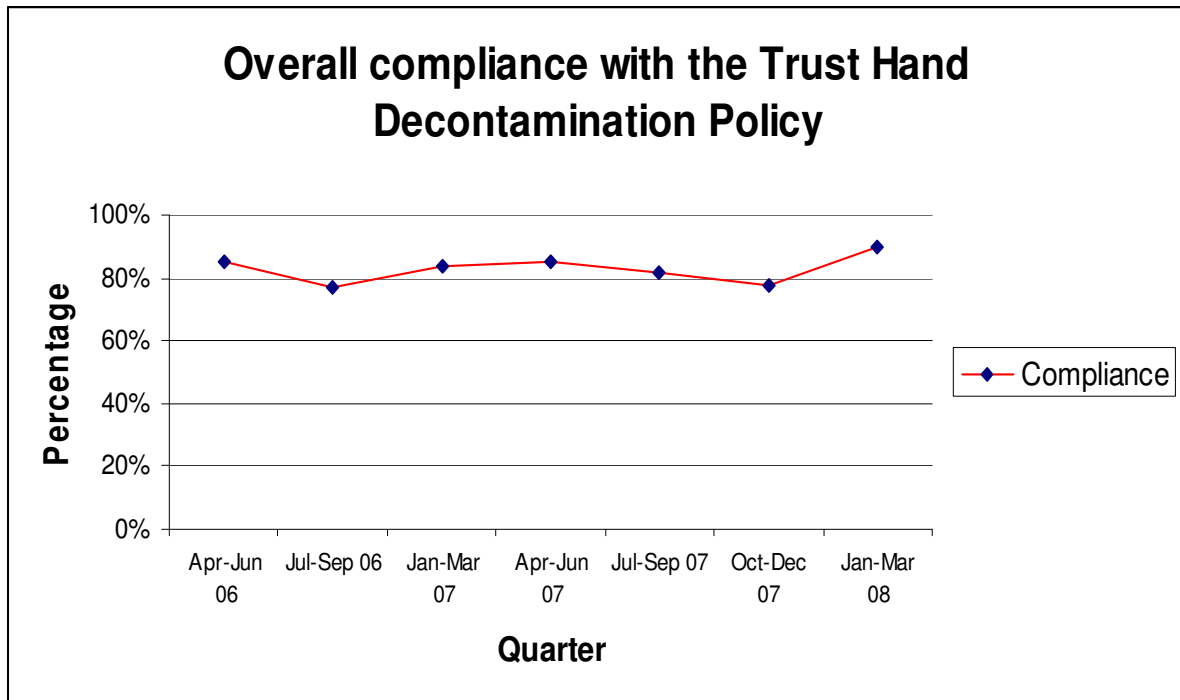
Audit Projects for 2007/8 completed by the IC team were:

- 1 Audit of hand hygiene practice
- 2 Audit of peripheral venous cannulae
- 3 Isolation practices (see Duty 9 section)
- 4 Audit of sharps practice
- 5 Personal Protective Equipment audit

Example summary findings of items 1 and 2 are included below.

3.4.1 Audit of hand hygiene practice

As in previous years, hand hygiene has been a key part of the infection control audit programme. The aggregated results for 2007/8 are shown in the graph below and indicate trust compliance broadly over 80%, with the majority of in-patient areas consistently participating in the audits. The trust plans to introduce in 2008-2009 a more stringent observational audit to enable peer comparison and encourage further improvements in practice. However it is recognized that upon introducing this new tool, it is likely that audit results will appear to deteriorate due to the differences in audit measures.



3.4.2 PVC Audit

Snapshot audits were undertaken in May and October 2007 to look at practice relating to certain aspects of the insertion and the ongoing care of peripheral venous cannulas (PVC). Two medical and two surgical wards were audited on each of the three hospital sites (Good Hope (GHH), Heartlands (BHH) Solihull (Sol) at the Heart of England Foundation Trust.

Number of PVCs in audit	Jan 07 (238)	May 07 (460)	Oct 07 (80)
PVC not indicated	14%	4.5%	6.25%
Trust dressing not used	3%	6.5%	7.5%
Insertion date not on dressing	66%	61%	33.5%
PVC in situ >72 hours	5%	5.6%	10%
No VIP documentation chart	69%	39%	28.6%
VIP scores are not being monitored	41%	24%	33.7%
Bandages in use	18%	15%	17.5%

As a result of these audits, changes in practice were introduced, namely: revision of PVC policy; introduction of cannula packs; labels for patient records; 2% chlorhexidine skin preparation as per Saving Lives; IC participation in trust IV therapy course; inclusion of insertion techniques in aseptic non-touch technique training.

In addition to this, ward areas began to audit PVC (and other topics including catheters and CVC) in accordance with the national Saving Lives tool in December 2007. This information was managed locally and in 2008-2009 plans will be developed to introduce a web-based monitoring system of the ward participation and audit results.

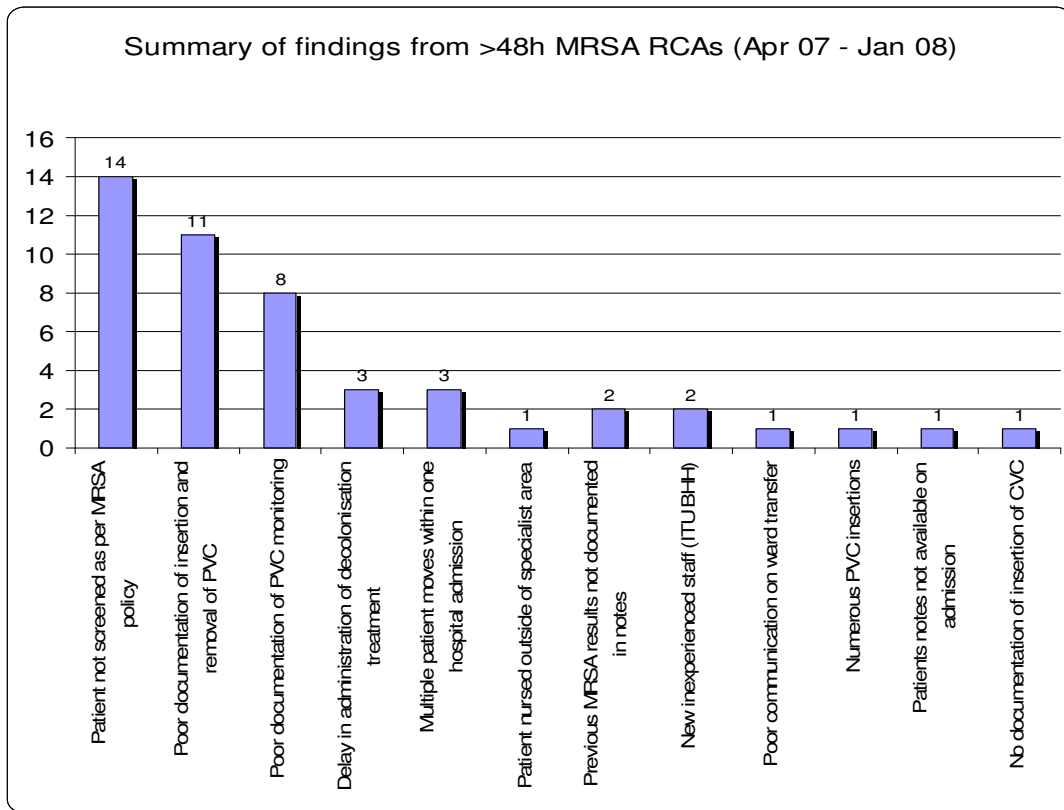
3.5 Policy on admission, transfer, discharge and movement of patients

The trust bed management policy addresses the admission, transfer and discharge of patients within and between healthcare facilities. The IC team liaises with bed management staff and operational managers as required to support compliance with this policy. For example, IC team members attended daily bed management meetings during outbreak periods to support operational managers.

4. Duty 3: Assess risk of acquiring HCAI and take action

4.1 Root Cause Analysis (RCA) for MRSA Bacteraemia

RCA for all cases of MRSA bacteraemia was introduced in November 2006 for all cases where the blood culture is taken 48 hours after the patient's admission (Post 48 hour). The investigation should be a multidisciplinary exercise led by the Consultant under whose care the patient was at the time of the blood culture. Overall themes from findings of RCAs were shared in a meeting with PCT partners in January 2008. RCA findings are also reported to health economy meetings. During December 2007 a web-based tracker facility was introduced for recording findings of root cause investigations and action plans.



4.2 Risk assessment and action

The ICOG maintains and responds to a risk register to deal with key risk issues for the organization. Additionally, the trust strategic risk register is shared with and contributed to by the infection control committee structure.

5. Duty 4: A clean and appropriate environment for healthcare

5.1 Committee structures and monitoring processes

The ICOG has a designated sub-committee to look at environment issues with Infection control team in attendance and there are related committees that report to the ICOG environment group, namely, Legionella and decontamination groups. There are designated lead managers for cleaning and decontamination. There is a trust waste manager who reports through the environmental sub committee. The Legionella Working Group for HEFT, which meets quarterly, is chaired by a Consultant Medical Microbiologist. The following work has been carried out over 2007-08 by the Legionella Group:

Measure	BHH	SOL	GHH
Legionella policy and working group	Policy updated and unified for all sites in the trust January 2008. Responsible person appointed for each site, ensuring detailed local knowledge. Approved person covers trust on behalf of Chief Executive. Working Group met quarterly, rotating through trust sites.		
Annual risk assessment	2007 complete. Summary of report and actions to be sent to WG.	2007 complete. Report just received. Summary to be sent to WG.	Not carried out in 2007. To be commissioned in 2008.
Water temperature monitoring	Building Management System monitors supply and return water temperatures. Monthly testing of Wards 2 and 19 & 3-monthly testing of Renal Unit. All sites comply with legislation cold water subject to heat gain.	BMS monitoring satisfactory	Monitoring programme identified. Awaiting appointment of fitter to carry out work.
Copper and silver ion treatment	Installed September 2007. Legionella and total bacterial counts improving rapidly.	Installed January 2008	Site surveyed. Remedial work required by South Staffs Water before system can be fitted. 3 systems required for 3 supplies
Flushing programme	<50% compliance with record keeping and lack of awareness found by audit of 50 wards in January 2008.	No problems detected but not formally audited.	Records satisfactory at all sites visited – approximately 30% of Trust sites.

Infection control team members attend Trust and site specific cleaning groups to monitor standards on a monthly basis. The trust level group is the Cleaning Standards Group, a multidisciplinary committee which promotes high standards, receives cleaning monitoring reports and oversees the PEAT monitoring process. The Group reported to the Infection Control Executive Committee. Separate Patient Environment Action Team (PEAT) inspections also monitored cleanliness. There is a Food Hygiene Committee is chaired by the Nursing Director and reports to the ICEC. There were no major issues for this area of work during 2007-2008.

PEAT scores for environment inspection 2007/2008

	2007	2008
Heartlands	Good	Good
Solihull	Excellent	Good
Good Hope	Acceptable	Acceptable

The IC team links regularly with the facilities structure on all 3 sites as part of routine working. Examples include:

- During Quarter 4, site walk rounds were completed by the IC team to evaluate sufficiency of provision of handwash facilities and provided to estates. Response work to this continues into 2008-2009.
- There has been IC attendance at service development meetings including upgrade and new build projects such as neonatal unit at Good Hope, MIDRU development at Heartlands, plans for new Critical care unit at Heartlands and the design of the Heartlands cohort facility.
- During quarter 4 2007-2008, a robust environmental audit programme for the coming year was devised and launched.
- During 2007-2008, CSSD facilities moved to the external contractor B Braun at the regional facility in compliance with current national guidance.
- Ensuring adequate provision of antibacterial handrubs across the trust.

5.2 Uniform standards

The trust revised its dress code in January 2008 to introduce doctors' uniforms and a bare below the elbows policy for all staff groups, in compliance with DH guidance.

6. Duty 5: Provide information to patients and the public on HCAI

During 2007-2008 the trust implemented a range of initiatives to provide information to patients and the public and raise awareness of infection control issues. Communications has a dedicated sub-group under the ICOG, with ongoing communications efforts an integral part of the work programme. Highlights include:

The trust continued to participate in the NPSA's "clean your hands" campaign with nationally provided resources displayed in wards, departments and communal areas. There have been several additional campaigns and initiatives to promote hand hygiene including:

- development of talking signage;
- life size cardboard figures at ward entrances;
- articles in trust magazines to raise awareness of what the public can do to reduce infection spread and understanding of Norovirus;
- SHA funding to purchase "globoxes" for hand hygiene training, used with both staff and the public.

The trust website promotes infection control issues, with trust magazines and press releases archived and links to the Health Protection Agency to guide people to performance information on MRSA and C.difficile.

The IC team run a monthly stand for the public on all sites so that people can ask questions and find out information. In 2007 there were drop in coffee mornings for visitors and patients at all three hospital sites to share the latest practices, including hand hygiene and combating hospital acquired infections. In February 2008 a short seminar about cross infection was provided as part of the trust membership programme.

A range of information leaflets are available for patients, public and staff, archived on the trust patient information database.

The team have also worked closely during the year with several patient forums and patient groups attending meetings and giving presentations on Infection prevention and control. These have included work with:

- Good Hope PPI Forum
- Solihull PPI Forum
- Birmingham PPI Forum
- PALS Meetings including coffee mornings
- Good Hope Carers Group
- Good Hope Prostate Group
- Breathe Easy Group
- DIPC provides annual update on control of infection to the Governors group

7. Duty 6: Provide information when patients move between providers

The IC team have limited direct involvement in relation to this duty. As part of assessment of the trust's compliance with the Hygiene Code, it is established that patient transfer information is shared by recording HCAI status on discharge summary letters and thereby GP notification. The Infection control nurses notify appropriate providers if patients have been discharged to them before results of tests are available.

8. Duty 7: Ensure co-operation

8.1 Health Economy Working

There is collaborative working at the operational level between HEFT infection control team and microbiologists, local PCT infection control teams, and the Birmingham & Solihull Health Protection Unit (HPU), including through a collaborative health economy wide HCAI group set up in March 2007.

The level of engagement at a more senior strategic level has improved since February 2008 with the formation of a monthly joint commissioning/performance group meeting hosted by BEN or Solihull PCTs (South Staffordshire PCT are also represented). The meeting is attended by the HEFT DIPC, the HPU, and the PCTs' provider arms. The BEN PCT DIPC has attended the HEFT Infection Control Executive Committee since March 2008 alongside a CCDC from the HPU.

As mentioned previously, the trust has worked to share root cause analysis findings with PCT partners (see section 3).

8.2 SHA HCAI Forum

The DIPC, or representative, has represented HEFT at SHA HCAI meetings held 2-3 times per year.

8.3 Internal co-operation

The IC team have worked with the nursing structure during the year completing joint audits. The senior nurses in the infection control team attend monthly meetings with the matrons for medicine and surgery and update them on audit results and current initiatives.

During the year, the trust has experienced positive collaboration from senior medical staff in delivering infection control priorities, and overall participation in the trust infection control committee structures and work programme by relevant parties has been satisfactory as demonstrated by meeting minutes and attendance.

9. Duty 8: Provide adequate isolation facilities

9.1 Provision of a cohort ward

During 2007-2008, a dedicated cohort ward for C.difficile infected patients was opened on the Heartlands site supported by DH funding, addressing the long-recognised risk that the Trust has insufficient isolation facilities. During Quarter 4, work began on a business case to make funding for this facility permanent into 2008-2009.

9.2 Isolation practices audit – Good Hope hospital

A total of 11 medical wards and 11 surgical wards were audited in October and November 2007. The overall compliance score for all medical inpatient areas was 78% (partial compliance), and 88% (compliance) in all surgical areas. Issues raised included: a lack of personal protective equipment outside isolation rooms or bays; signage of isolation rooms; correct equipment in place and unnecessary items removed.

10. Duty 9: Ensure adequate laboratory support

Laboratory services are provided through contractual arrangements with the HPA on the Heartlands and Solihull sites, and within the trust on the Good Hope site. All laboratory services maintained Clinical Pathology Accreditation during 2007-2008.

11. Duty 10: Policies and protocols

The areas of the work programme described in this annual report are relevant to the policy areas listed in Duty 10 of the Hygiene Code. The trust is confident it has policies to support trust practices as required by Duty 10. These are available through the trust intranet site and feedback to the IC team is that staff awareness of how to find policy guidance is good. Policies are within review dates, and were updated and approved by the ICEC according to review dates or changing practices. Policies are compared with peer performance and national guidance to ensure best practice is promoted.

12. Duty 11: HCAI prevention among healthcare workers

During quarter 4, roles and responsibilities guidance was developed for all staff groups explaining their particular responsibilities around infection control. All new job descriptions now include infection control responsibility. The infection control team participate in induction training and mandatory updates for all staff groups (see Duty 2). Occupational Health services are provided as required within the trust. The IC team has worked with the Occupational Health services in revising and developing policies relating to blood borne virus management. Further revisions to the policy are required in 2008-2009, as well as compliance auditing.