

Infection prevention and control within health and social care:

commissioning, performance management and regulation
arrangements (England)



Purpose and aim of the briefing

During transition of commissioning arrangements the Royal College of Nursing (RCN) and Infection Prevention Society (IPS) supported members working within commissioning organisations, developed tools for decision making and published the Commissioning Toolkit in order to support members and organisations in the commissioning of services¹. This briefing has been developed as a result of enquiries received from members regarding the performance management and regulatory processes supporting improvements in infection prevention and control (IPC) post implementation of the Health and Social Care Act 2012.

This document sets out the current (as at October 2013)² approaches to IPC and current organisation of agencies including those responsible for commissioning, performance management and regulation in the NHS in England. This is not only relevant for IPC, but is one way of exploring the alignment of key new agencies in the ‘new’ NHS. This paper does not seek to provide answers to some of the existing challenges but to enable discussion regarding clarity within the NHS landscape and highlight where risks exist and where further improvements may be realised to support IPC as a core element of patient safety.

Introduction

IPC is a crucial component of safe systems providing health and social care. It is inextricably linked to anti-microbial resistance and therefore has a central role in health and social care and public health services. Its importance is underlined within the Annual Report of the Chief Medical Officer (Davies 2013) and forthcoming UK five year Anti-microbial Resistance Strategy.

Achievement of ongoing improvements in reducing health care associated infection requires both provider and commissioner commitment. Prior to implementation of the Health and Social Care Act 2012, NHS provider services were predominantly commissioned by primary care trusts (PCTs). From April 2013 this function is shared across a range of commissioning bodies including NHS England (NHSE) Area Teams (ATs) and Clinical Commissioning Groups (CCGs), 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)³.

The RCN and the IPS support the Government’s continued focus on IPC as a core element of patient safety and quality health care provision. Both organisations acknowledge current challenges associated with the embedding of the new health architecture.

1 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

2 Based on publicly available information researched during August 2013 and valuable insights from nurses working in infection control over June and July 2013.

3 Public Health in Local Government Factsheet. December 2011, DH Gateway ref: 16747
<https://www.gov.uk/government/publications/public-health-in-local-government>

Who may find this document useful?

This document will be of benefit to:

- NHS England
- Public Health England
- regulators of health and social care
- local authorities
- IPC specialists and quality/safety leads working within or supporting commissioning teams (regardless of the organisation) including CCG and Commissioning Support Unit (CSU) health care associated infection (HCAI) leads and IPC specialists within local authorities
- IPC specialists working in, with, or on behalf of NHS providers of care.

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

Prior to implementation of the changes to NHS structures the majority of IPC specialists supporting commissioners were employed by primary care trusts (PCTs), although there was no formal model regarding how they functioned to support the delivery of outcomes.

Following the changes to the NHS in April 2013 there is now no single employer for this specialist expertise which previously existed within PCTs. Given the subsequent increase in the number of NHS commissioning organisations there is now significant variation and a lack of consistency in approach and management with the potential risk of this important function being overlooked or insufficiently supported.

Whilst it is acknowledged that there was variation in how IPC specialist support was implemented (as opposed to employment structure) prior to April 2013, the potential variation and subsequent support from organisations now hosting those practitioners in IPC commissioning roles is a cause of concern. Potential risks associated with the current variation in service include:

- communication between the increased number of commissioning organisations
- retention of IPC specialist staff within the 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 where different elements of pathways are commissioned by different organisations
- loss of the IPC specialist advisory function within primary care due to reduced availability in some areas – as resources have transferred to CCGs and LAs

- 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 (page 5) describes key agencies and their role in relation to infection prevention and control, along with examples of where IPC support may be provided from. This is based on information available in August 2013 (although we have updated regulation by Monitor as at 1 October 2013), and the understanding of our members. However, the situation is changing as organisations bed down and responsibilities are clarified.

Table 1: National agencies and their role in IPC

Organisation	Function summary in relation to IPC	IPC advice provided by:
Department of Health (DH)	Is responsible for leading on government policy and legislation for health and social care. This includes national objectives for performance monitoring of IPC.	A variety of sources, for example, expert advisory groups such as ARHAI or short life working groups.
NHS England national office (NHSE)	NHSE is 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.	HCAI lead at NHSE (awaiting appointment).
Monitor	Monitor is 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.	Unknown.
Trust Development Authority (TDA)	TDA provides leadership, support and development for the remaining NHS trusts which are not foundation trusts. Following abolition of Strategic Health Authorities it supports NHS trusts moving forward to foundation trust (FT) status. It is responsible for ensuring quality services are provided and its role includes performance management of trusts and that trusts have robust arrangements in place for clinical quality, governance and risk management.	Four Regional TDA HCAI leads.
Care Quality Commission (CQC)	CQC exists to ensure all hospitals, care homes, dental and GP surgeries, and providers of regulated care activity in England provide people with safe, effective, compassionate and high quality care. Organisations' compliance with mandatory standards for quality and safety are assessed and monitored by CQC. IPC is primarily included in Outcome eight.	IPC specialist inspectors, HCAI lead to be appointed.
Public Health England (PHE)	Will help 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) Services Framework Agreement. 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.	Consultants in Communicable Disease Control (CCDC) and health protection nurses in PHE local centres.

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

There is a degree of variation at the regional and local level. This is particularly difficult to map and arrangements are changing over time, however our current understanding is set out in Table 2 below.

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

Organisation	Function summary in relation to IPC	IPC advice provided by:
Providers of health and adult social care. 30,261 as of 31 March 2013 (CQC 2013).	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 Clinical Commissioning Groups (CCGs), NHSE or local authorities.	Specialist staff employed or contracted by providers.
Clinical Commissioning Groups (CCGs). 229 CCGs currently	Responsible for commissioning care for their covered population excluding primary care and specialised care (which are the responsibility of NHSE). Commissioners may also include infection control as part of their local Commissioning for Quality and Innovation (CQUIN)s. ⁴	Clinical Commissioning Groups may employ and/or share infection prevention and control nurses across CCGs ⁵ , with their LA or buy in expertise from the CSU.
Commissioning Support Units (CSUs). 19 CSUs created.	This varies but some CSUs can offer expertise on IPC.	Varies.
NHSE Regional Teams. Four regions created.	Provide strategic leadership across their regions, including clinical expertise and the support and oversight of NHSE Area Teams (ATs) and CCGs. Fulfils performance management function via the Area Teams.	Varies.
NHSE Area Teams (ATs). 27 ATs created.	ATs are responsible performance management of CCGs and directly commissioning and oversight of primary care commissioning, specialised commissioning, military health, offender health and public health, for example, screening and immunisation. In addition to performance management of CCGs including ensuring the provision of quality care in that area.	Memorandum of understanding (MOU) regarding IPC being developed between some ATs and CCGs or LA infection prevention teams. Some ATs link with IPC Leads based in CCGs/LA to establish area wide ways of working. No known specific IPC resources within ATs.
Trust Development Authority (TDA). One TDA created.	TDA IPC support should enable providers to meet mandatory outcomes and standards as part of the FT application process. It requires close collaborative working between TDA, commissioner and provider IPC practitioners to ensure clear and consistent advice.	Four TDA regional leads.
Local Authorities (LAs)	LAs work with local partners to ensure threats to health are understood and properly addressed. The local authority cannot ensure other statutory bodies have plans in place, but it can advise, challenge and escalate issues. 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). HWBs 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. Local authorities also have a role in commissioning social care and mandated public health services.	Director of Public Health within LA will provide advice, challenge and advocacy. This is particularly noticeable in the post-infection reviews (PIR). These are carried out to identify why an MRSA bacteraemia occurred, how learning from these can help avoid future cases and also determine apportionment for the case. ⁶ Infection prevention and control practitioners may be employed as part of the wider public health team based in the LA. These staff may have usually have a service level agreement or MOU with the CCG to provide expert infection prevention and control advice around CCG commissioned services. The infection prevention and control role within the LA includes providing expert advice and support to the commissioners and contract monitoring officers of social care.
Public Health England (PHE).	Nurses 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).	

⁴ See www.institute.nhs.uk/commissioning/pct_portal/cquin.html for an example. However, this example relates to very specific local improvements and not IPC in its broadest sense.

⁵ See www.neessexccg.nhs.uk for an example.

⁶ www.england.nhs.uk/wp-content/uploads/2013/03/pir-guidance.pdf

In detail: national agencies and the current infection prevention and control policy priorities

IPC and NHS England

NHS England has set out a ‘zero tolerance’ approach which is explicitly targeting zero cases of MRSA blood stream infections. NHS England 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.”⁷

Everyone counts: Planning for Patients 2013/14 sets a zero tolerance approach to MRSA bloodstream infections. NHS England, states that “This means that each organisation is expected to achieve zero MRSA bloodstream infections”. 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 on conducting post-infection reviews (PIR) to identify why an MRSA bacteraemia occurred, how learning from these can help avoid future cases and also determine apportionment for the case.⁸

For *Clostridium difficile* (*C. difficile*), NHS England sets out the expectation of significant ongoing reductions in incidence.⁹

Reducing both the incidence of MRSA and *C. difficile* infections will be one of the national measures used to calculate the quality premium for clinical commissioning groups (essentially a pay for performance framework for CCGs). Incidence of MRSA and *C. difficile* are also part of the NHS Outcomes Framework for 2013/14.¹⁰ Organisations that report an MRSA bacteraemia are likely to receive a financial penalty if the infection is attributed to their care (including contaminants). CCGs may find that their quality premium is reduced as a result of not achieving this outcome.

Urinary tract infections in patients with an indwelling urethral catheter are part of a national CQUIN using the NHS safety thermometer methodology.¹¹

IPC and Monitor

Monitor has new responsibilities as a sector regulator as of 1 April 2013. Currently the new NHS provider licence covers FTs only, and includes ongoing monitoring of the governance of FTs in the future. As part of its overall approach to assessing governance, Monitor looks at infection control and monitor has set out a new Risk Assessment Framework which was applied from the 1 October 2013. This new framework has removed MRSA and therefore MRSA will no longer be observed by Monitor. The framework does include *C. difficile* infection and a new de minimis.¹²

Further notes in the Risk Assessment Framework state that:

For *C. difficile* (p46):

“[Measuring of performance against the *C. difficile* objective] will apply to any inpatient facility with a centrally set *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 *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 *C. difficile* objective acquires a community provider without an allocated *C. difficile* objective) we will not apply a *C. difficile* score to the NHS foundation trust’s governance risk rating.

Monitor’s annual de minimis limit for cases of *C. difficile* is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency, now part of Public Health England, indicates multiple outbreaks.

7 www.england.nhs.uk/ourwork/patientsafety/zero-tolerance

8 www.england.nhs.uk/wp-content/uploads/2013/03/pir-guidance.pdf

9 Details are set out here: www.england.nhs.uk/wp-content/uploads/2013/04/ccg-prov-c-diff-2013-14.xls

10 www.gov.uk/government/uploads/system/uploads/attachment_data/file/127106/121109-NHS-Outcomes-Framework-2013-14.pdf.pdf

11 www.england.nhs.uk/wp-content/uploads/2012/12/cquin-guidance.pdf

12 www.monitor.gov.uk/sites/default/files/publications/RAF_Final_August2013_o.pdf

See Table 3 for the circumstances in which we will score NHS foundation trusts for breaches of the C. difficile objective.”

Table 3: Monitors approach to scoring C. difficile

Criteria	Will a score be applied
Where the number of cases is less than or equal to the de minimis limit.	No.
If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective.	No.
If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective.	Yes.
If a trust exceeds its national objective above the de minimis limit.	Yes (and a red rating applied).

Monitor also notes that; “If the Health Protection Agency, as part of Public Health England, indicates that the 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.”

IPC and the Care Quality Commission (CQC)

Legislation underpinning the CQC sets out requirements on cleanliness and infection control and is covered in the Guidance on Essential Standards of Quality and Safety from the CQC as outcome eight.¹³ The guidance refers to the Department of Health Code of Practice (Dept of Health 2010).

The CQC:

- draws on information about infection control as part of their Quality and Risk Profile. For acute care providers, they consider sources such as:¹⁴
 - NHS Staff Survey – per cent saying hand washing materials are always available
 - MRSA and C. difficile surveillance data
 - Patient surveys – such as seeing clinicians wash their hands
 - NHS Litigation Authority data
- CQC has reported that some providers are not compliant with outcome eight (for example, nine per cent of NHS providers were not compliant in 2011/12).¹⁵
- CQC does not always look at every standard when they inspect, but infection control 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.¹⁶

IPC and Public Health England

Public Health England (PHE) now replaces the 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.¹⁷

¹³ www.cqc.org.uk/sites/default/files/media/documents/essential_standards_of_quality_and_safety_march_2010_final_o.pdf

¹⁴ www.cqc.org.uk/sites/default/files/media/documents/acute_nhs_trusts.pdf

¹⁵ www.cqc.org.uk/sites/default/files/media/documents/cqc_soc_201112_final_tag.pdf

¹⁶ www.cqc.org.uk/public/about-us/our-inspections/our-new-acute-hospital-inspection-model

¹⁷ www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HCAI

Discussion

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 NHS reforms some specialist IPC nurses have been lost as a result of transfer to a variety of employing organisations, for example NHSE, CCGs, LA, CSUs, etc. This represents a change from the previous model of advice, support, facilitation and performance monitoring to one of performance management and assurance. Restructuring of NHS services has also resulted in a loss of some specialist posts and concerns relating to how effective communication will be 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 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.
- **Incentives** – providers and commissioners must decide the priority that they place on infection prevention and control 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 is difficult to know if such actions are producing ongoing improvements in care and quality as experienced by patients. Will providers respond to NHSE ambitions, their local CCGs CQUIN, or rather focus on not exceeding Monitor’s de-minimis? This is an important question to answer as whoever is seen locally to determine the greatest reward or threat from a financial perspective may be successful in influencing local practice and outcomes based on this scenario.

Recommendations

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

1. It is recommended that 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 also 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.
2. Information should be detailed by each provider organisation within their annual report on how budgets 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.
3. A further review should be undertaken jointly by the RCN and IPS in one year to assess IPC specialist provision.

References

Care Quality Commission (2013) *Annual Report and Accounts 2012/13*. London:HMSO

Protecting the health of the population: the new health protection duty of local authorities under Local authorities, May 2013
www.gov.uk/government/publications/health-protection-in-local-government

Public Health in Local Government Factsheet. December 2011, DH Gateway ref: 16747
www.gov.uk/government/publications/public-health-in-local-government

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

Royal College of Nursing and the Infection Prevention Society (2013) *Infection prevention and control commissioning toolkit*. RCN: London

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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

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

LA Local authority

MOU Memorandum of understanding

NHSE NHS England

PCT Primary care trust

PHE Public Health England

PIR Post-infection review

TDA Trust Development Authority



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promotes excellence in practice and shapes
health policies

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