Policy for Surveillance and Reporting of Infectious Disease, Healthcare Associated Infection and Antibiotic Resistant Organisms

V5

20.09.17
Summary.

Surveillance and reporting of Infectious Disease, HCAI and Antibiotic resistant Organisms

The Audit and Surveillance support worker oversees the mandatory orthopaedic and other Surgical Site Infection Surveillance modules. They collect, collate and input data, required to undertake targeted surveillance of hospital acquired infections.

The Medical Microbiologist is responsible for informing clinical teams when a clinical significant alert organism has been identified.

Clinical staff must to inform the IPAC team when a patient is admitted with suspected or confirmed infection.

The IPAC team will ensure a Special Condition alert is added to PAS.

Clinical staff must inform IPAC of any alert conditions identified through clinical diagnosis (see 6.4).

RCA is undertaken for the applicable infection (see 8.). Actions owned by the relevant Division, lessons learned discussed at Divisional Governance meetings and progress monitored via the Infection Prevention and Control Steering Group.

The clinician in charge of the patient has a statutory duty to report notifiable communicable diseases (see 6.5).

Intermittent targeted surveillance of other types of infection or sub groups of patients should be determined in response to local need and should be detailed in the annual infection control programme.
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1. Introduction

1.1. Surveillance is a systematic method for continuous monitoring of diseases in a population in order to be able to detect changes, analyse the data, disseminate the results and put into practice effective prevention and control mechanisms. This policy should be read in conjunction with other relevant infection control policies on the document library.

Surveillance provides good information to patients and clinical teams and is the cornerstone of infection control (DH 2003a). It consists of the routine collection of data on infections among patients or staff, its analysis and the dissemination of the resulting information to those who need to know, so that appropriate action can result. Surveillance also forms part of clinical audit and clinical governance: it assists in reducing the frequency of adverse events such as infection or injury. High quality information on infectious diseases, healthcare associated infection and antimicrobial resistant organisms is essential for monitoring progress, investigating underlying causes and applying prevention and control measures (DH, 2003a).

All surveillance systems have four key components (DH/PHLS, 1995):

1. Data collection using standard case definitions
2. Collation of data
3. Analysis and interpretation
4. Timely dissemination of information

Surveillance will be undertaken as part of a national surveillance scheme and may involve the use of a locally defined protocol. Some national surveillance schemes are mandatory, others are voluntary.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

The purpose of the document is to provide clear guidelines on the responsibilities for Infection Prevention and Control Surveillance and ensure that mandatory surveillance directed by the Department of Health is complied with. Timely feedback is given to staff/managers in order that any plans can be formulated and necessary action taken.

3. Scope

This document has been developed to outline procedures the Infection Prevention and Control team (IPAC) will use to monitor healthcare associated infections. These procedures will assist the IPAC and Hospital Infection Prevention and Control Committee to identify risks of infection and reinforce the need for good practice.

4. Definitions / Glossary

4.1. Definitions are contained within the text.
5. Ownership and Responsibilities

5.1. Role of the Director of Infection Prevention and Control
The DIPC is responsible for providing reports on the surveillance of infection directly to the Chief Executive and the Trust Board.

5.2. Role of the Hospital Infection Prevention and Control Committee
The Hospital Infection Prevention and Control Committee is responsible for:
- Approving this policy
- Monitoring compliance with this policy

5.3. Role of the Divisional Management Teams
Divisional Management Teams are responsible for reviewing data relating to their Division and ensuring that any appropriate actions are being taken.

5.4. Role of line managers
Line managers are responsible for:
- The implementation of and compliance with the guideline within their own clinical area and that the guidelines are accessible to their staff.
- To ensure staff attend all relevant training, including updates at the required frequency.

5.5. Role of the Medical Microbiologists
The microbiologist will ensure results are reported promptly to relevant Clinicians responsible for care of the patient/staff member.

5.6. Role of the Infection Prevention and Control Team (IPAC)
The IPAC team is responsible for feeding back surveillance data to wards and departments, including new cases of MRSA colonisation/infection, Clostridium difficile associated diarrhoea and any other alert organisms.

The infection control team will work with matrons/departmental leads and infection prevention and control link practitioners to improve surveillance and reporting of infections to strengthen the prevention and control of infection. This will include alert conditions and identification of outbreaks.

5.7. Role of the Audit and Surveillance support worker
The Audit and Surveillance support worker is responsible for overseeing the mandatory orthopaedic and other Surgical Site Infection Surveillance modules. They are responsible for timely collection, collation and input of data, required to undertake targeted surveillance of hospital acquired infections. The Audit and Surveillance support worker is responsible for the analysis and collation of results and in liaison with the Consultant Nurse, presentation of findings to multi-disciplinary teams within the Trust.
5.8. **Role of Clinicians**
The clinician in charge of the patient has a statutory duty to report notifiable communicable diseases, to the Consultant in Communicable Disease Control (CCDC) who is based in the Devon, Cornwall and Somerset Health Protection Team.

5.9. **Role of Individual Staff**
All staff members are responsible for:
- All healthcare staff have a responsibility to both individual patients and the wider population to actively participate in systems of surveillance.
- All staff should be aware of the policy and have read and understood its content.
- All staff should know how to contact the Infection Prevention and Control team to notify them of any health care associated infections, alert conditions or potential outbreaks.

6. **Alert Organism and Condition Surveillance**
Alert organisms and alert conditions are those that may give rise to outbreaks. Using ICNet, the IPAC team will collate laboratory data and ward reports of alerts and organisms for day-to-day electronic case management.

6.1. **Alert Organisms**
Alert organisms are identified in the microbiology laboratory and include organisms such as MRSA and other antibiotic resistant organisms e.g. Glycopeptide Resistant Enterococci (GRE) and Extended Spectrum Betalactamases (ESBLs), Clostridium difficile, Streptococcus pyogenes, Norovirus and Respiratory Syncytial Virus (RSV). The Medical Microbiologist is responsible for informing clinical teams when a clinical significant alert organism has been identified.

Advice on the control measures, if needed, will usually be provided by the IPAC team who will also investigate clusters of cases.

6.2. **Using Alert Organism Surveillance to Monitor Progress**
MRSA and C. difficile pose particular challenges in acute hospital settings. Therefore, acute wards/units at the RCHT should receive feedback from the IPAC on the number of new cases in the Trust per month. This will enable wards and units to determine the impact of prevention and control strategies. Trends in MRSA, C. difficile, ESBL producing organisms, MSSA bacteraemia, E.coli bacteraemia and GRE bacteraemia acquisition should be reviewed at Divisional Governance meetings.

The Executive team including senior managers should receive a daily report from the IPAC team of new cases of C. difficile, GRE, E.Coli, MRSA and MSSA bacteraemia.

The IPAC team should provide quarterly reports of trust wide data to the Hospital Infection Prevention and Control Committee. The DIPC should report these details monthly to the Trust Board. Additionally the DIPC should provide an annual report to the Trust Board.
6.3. Infection Control Flag

Some patients may become long term carriers of alert organisms following infection. Patients who have had MRSA, C.difficile, ESBL, Glycopeptide Resistant Enterococci (GRE), Panton Valentine Leukocidin (PVL), Carbopenemase Producing Enterobacteriaceae (CPE), or are symptomatic or at high risk of Transmissible Spongiform Encephalopathy including CJD, should have a Special Condition (SC) alert put onto the Patient Administration System by the IPAC team. Additionally an alert sticker should be placed in the case notes by the Medical Records Department. It is the responsibility of the clinical staff to inform the IPAC team when a patient is admitted with suspected or confirmed infection for information about management of these patients.

6.4. Alert Conditions

Alert conditions are identified through clinical diagnosis, not laboratory tests, and therefore staff in clinical areas must inform the Infection Prevention and Control Team of any suspected occurrence of these conditions at the earliest opportunity. Alert conditions include:

- Chicken pox/shingles (Herpes zoster)
- Diphtheria
- Food poisoning
- Influenza
- Measles
- Meningitis
- Meningococcal septicaemia
- Mumps
- Ophthalmia neonatorum
- Other childhood rashes of unknown origin
- Poliomyelitis
- Pyrexia of unknown origin with history of foreign travel
- Parvovirus
- Rubella
- Scabies
- Scarlet fever
- Severe soft tissue infections including necrotising fascitis
- Suspected infective diarrhoea and/or vomiting
- Suspected legionellosis
- Tuberculosis
- Typhoid/Paratyphoid
- Viral haemorrhagic fevers
- Hepatitis B and C
- Whooping cough
- Bronchiolitis/croup

6.5. Notifiable Diseases

Some ‘alert’ conditions are ‘Notifiable diseases’ (see list below). This is a legal term denoting diseases that must, by law, be reported to the ‘proper officer’ i.e. the Consultant for Communicable Disease Control (CCDC), based in Public Health England South West Centre Health Protection Team. Notification books are kept in each clinical area.

It is the responsibility of the physician in charge of each case to make the notification.

Diseases that are notifiable are:

- Acute encephalitis
- Anthrax
- Leprosy
- Leptospirosis
- Malaria
- Meningococcal septicaemia
- Viral hepatitis
- Ophthalmia neonatorum
- Paratyphoid fever
- Scarlet fever
- Rabies
- Relapsing fever
- Smallpox
- Tetanus
- Typhus
- Yellow Fever
- Food poisoning
- Dysentery (amoebic or bacillary)
- Measles
- Rubella
- Meningitis
- Typhoid fever
- Diphtheria
- Poliomyelitis
- Viral haemorrhagic fevers
- Cholera
- Plague
- Tuberculosis
- Mumps
- Whooping cough

6.6. RIDDOR Reporting
Any infection reliably attributable to the performance of the work of an employee within the Trust is reportable to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). Reporting is normally undertaken by Health and Safety on the advice of the Occupational Health Service.

In addition, certain exposures to micro-organisms may also be reportable as dangerous occurrences e.g. exposure to HIV or Hepatitis B/C as a result of an inoculation injury. Once again reporting is undertaken by Health and Safety.

7. Voluntary Targeted Surveillance
The need for intermittent targeted surveillance of other types of infection or sub groups of patients should be determined in response to local need and should be detailed in the annual infection control programme.

8. Mandatory Surveillance
The Trust must comply with all requests for Mandatory Surveillance of Healthcare associated Infection in accordance with the requests made by the Department of Health.

8.1. Laboratory Based Surveillance
Under current requirements, the RCHT reports all of the following, regardless of the source of the specimen, to the Communicable Disease Surveillance Centre of Public Health England:

- Staphylococcal bacteraemia (all),
- *Clostridium difficile* toxin positive results
- Bacteraemia caused by Glycopeptide-resistant Enterococci
- E.coli bacteraemia
- All other organisms covered by national COSURV surveillance system

8.2. *Clostridium difficile* Surveillance
*Clostridium difficile* is a cause of antibiotic associated diarrhoea. *Clostridium difficile* is included in national mandatory surveillance for health- care associated infections

*Clostridium difficile* acquisition is based on the following definition
8.3. MRSA Bacteraemia Enhanced Surveillance Scheme

MRSA bacteraemia data are used as the basis of a performance indicator (DH, 2003b). An enhanced data set for Staphylococcus aureus bacteraemia was introduced in 2005. The IPAC team are responsible for collecting and reporting the additional data via a dedicated secure website. The Chief Executive must ensure that the data is entered on the site and is ‘signed off’ by the 15th of each month.

MRSA bacteraemia acquisition is identified based on the following definition.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust Attributable</td>
<td>MRSA negative on admission, positive result confirmed from blood culture taken after 48 hours</td>
</tr>
<tr>
<td>Attributable to Community</td>
<td>Blood cultures taken within the first 48 hours of admission</td>
</tr>
</tbody>
</table>

MRSA Bacteraemia represents a small proportion of all MRSA infections and colonisations. The IPAC team must be notified of all such admissions immediately to enable prevalence to be monitored.

8.4. Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemia enhanced surveillance

Mandatory reporting of MSSA bacteraemia commenced on 1st January 2011. The IPAC team are responsible for collecting and reporting enhanced data via a dedicated secure website. The Chief Executive must ensure that the data is entered on the site and is ‘signed off’ by the 15th of each month.

MSSA bacteraemia acquisition is identified based on the following definition.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust Attributable</td>
<td>Positive result confirmed from blood culture taken after 48 hours of admission</td>
</tr>
<tr>
<td>Attributable to Community</td>
<td>Blood cultures taken within the first 48 hours of admission</td>
</tr>
</tbody>
</table>

8.5. E. coli bacteraemia enhanced surveillance

Mandatory reporting of E. coli bacteraemia commenced on 1st June 2011. The IPAC team are responsible for collecting and reporting enhanced data via a dedicated secure website. The Chief Executive must ensure that the data is entered on the site and is ‘signed off’ by the 15th of each month.

E. coli bacteraemia acquisition is identified based on the following definition.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust Attributable</td>
<td>Positive result confirmed from blood culture taken after 48 hours of admission</td>
</tr>
<tr>
<td>Attributable to Community</td>
<td>Blood cultures taken within the first 48 hours of admission</td>
</tr>
</tbody>
</table>
8.6. Root Cause Analysis (RCA)
RCA is undertaken for the investigation of all Clostridium difficile, MRSA, MSSA, E.Coli and GRE bacteraemia cases. The clinical teams responsible for the patients care are responsible for participating in the RCA. Review meetings should be held on a weekly basis, following consultation with all relevant clinical teams, to identify any areas of concern and to develop appropriate action plans. These action plans should be owned by the relevant Division, lessons learned discussed at Divisional Governance Meetings with progress on actions monitored via the Infection Prevention and Control Steering Group.

8.7. Orthopaedic Surgical Site Infection Surveillance
Surgical site infection following elective orthopaedic surgery is important as it could lead to infection of an implanted prosthesis. Surgical site infection following Trauma and Orthopaedic surgery forms part of the Department of Health’s mandatory requirement for the surveillance of healthcare associated infections. Data collection is currently undertaken by the Audit and Surveillance Support Worker and reported to the Hospital Infection Prevention and Control Committee on a quarterly basis.

9. Serious Untoward Incidents
Serious untoward incidents associated with infection must be reported via the normal reporting system for serious untoward events (Refer to Serious Incident Management Policy and Procedure). In addition the Devon, Cornwall and Somerset Health Protection Team should be informed.

The DH (2003) define untoward events associated with infection as those that “produce, or have the potential to produce, unwanted effects involving the safety of patients, staff or others”. Reportable incidents are those that:
- Result in significant morbidity or mortality, and/or
- Involve highly virulent organisms; and/or
- Are readily transmissible; and/or
- Require control measures that have an impact on the care of other patients, including limitation of access to healthcare services

This may include:
- Outbreaks
- Infected healthcare worker or patient incidents requiring a lookback exercise e.g. TB, vCJD, blood borne viral infections
- Significant breakdown of infection control procedures, such as the use of invasive instruments released from a failed sterilisation cycle or the use of contaminated blood products.

10. Dissemination and Implementation
This policy to be implemented via the following routes:
- Information regarding the policy will be included in the Infection Prevention and Control newsletter.
- The policy will be uploaded onto the Trust’s Document Library and will replace any previous versions.
- The policy will be circulated to all Link Practitioners and Matrons
## 11. Monitoring compliance and effectiveness

### Element 1

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Root Cause analysis of C. difficile, MRSA. MSSA bacteraemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Director Of Infection Prevention and Control</td>
</tr>
<tr>
<td>Tool</td>
<td>Root Cause Analysis tool which will be reviewed at the Health Care Associated Infection RCA review meeting.</td>
</tr>
<tr>
<td>Frequency</td>
<td>As each occurs and at the weekly review meetings. Actions to be reviewed monthly at the Infection Prevention and Control Steering Group</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>All RCA’s to be reviewed at the weekly HCAI RCA review meetings. Actions to be reviewed on a monthly basis at the Infection Prevention and Control Steering Group. Divisional Management Team to report back on progress with actions at Hospital Infection Prevention and Control Committee.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The Divisional Management Team from which the RCA has been generated is responsible for implementation of the actions. The Infection Prevention and Control Steering Group will monitor progress on the actions.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within an identified timeframe (this is dependant on what the action is). A lead individual will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
</tbody>
</table>

### Element 2

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Reporting of Mandatory Surveillance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Director Of Infection Prevention and Control</td>
</tr>
<tr>
<td>Tool</td>
<td>No tool as such, minutes of meetings</td>
</tr>
<tr>
<td>Frequency</td>
<td>Monthly, quarterly and annually</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Daily email to all relevant parties. Monthly figures provided to Trust Board Quarterly figures provided to Hospital Infection Prevention and Control Committee. Annual Report to Trust Board.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The Hospital Infection Prevention and Control Committee will oversee any recommendations</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within an identified timeframe (this is dependant on what the action is). A lead individual will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
</tr>
</tbody>
</table>
12. **Updating and Review**  
This policy will be reviewed within three years.

13. **Equality and Diversity**  
13.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

13.2. **Equality Impact Assessment**  
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th><strong>Document Title</strong></th>
<th>Policy for Surveillance and Reporting of Infectious Disease, Healthcare Associated Infection and Antibiotic Resistant Organisms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>6th November 2017</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>29 November 2017</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>28 November 2020</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Infection Prevention and Control Team</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 254969</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>This document provides clear guidelines on the responsibilities for Infection Prevention and Control Surveillance and ensures that mandatory surveillance directed by the Department of Health is complied with.</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>Surveillance, MRSA, MSSA, Clostridium difficile, E.coli bacteraemia, PVL, CPE</td>
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<tr>
<td><strong>Target Audience</strong></td>
<td>RCHT ✔ PCH CFT KCCG</td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Chief Nurse</td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>21st September 2017</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>Policy for Surveillance and Reporting of Infectious Disease, Healthcare Associated Infection and Antibiotic Resistant Organisms. August 2014 Version 4</td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>Hospital Infection Prevention and Control Committee</td>
</tr>
<tr>
<td><strong>Divisional Manager confirming approval processes</strong></td>
<td>Louise Dickinson</td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories</strong></td>
<td>Not required</td>
</tr>
<tr>
<td><strong>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
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</tbody>
</table>
Publication Location (refer to Policy on Policies – Approvals and Ratification):

| Internet & Intranet | ✓ | Intranet Only |

Document Library Folder/Sub Folder

| Clinical / Infection Prevention & Control |

Links to key external standards

| Regulation 12 |

Related Documents:

- Department of Health (2010), *The Health Act, code of practice for the prevention and control of Healthcare associated infections* (needs link)

Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>November 2007</td>
<td>1</td>
<td>New Document</td>
<td>IPAC team</td>
</tr>
<tr>
<td>October 2009</td>
<td>2</td>
<td>Document reformatted to comply with policy on policies</td>
<td>IPAC team</td>
</tr>
<tr>
<td>Date</td>
<td>Revision</td>
<td>Changes</td>
<td>Author</td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>August 2011</td>
<td>3</td>
<td>Document reformatted to comply with policy on policies. Updated to reflect changes in mandatory surveillance</td>
<td>IPAC team</td>
</tr>
<tr>
<td>July 2014</td>
<td>4</td>
<td>Re-formatted. Updated references. Updated reporting information</td>
<td>IPAC team</td>
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<tr>
<td>Sept 2017</td>
<td>5</td>
<td>Re-formatted. Updated references and updated to reflect changes in mandatory surveillance and reporting.</td>
<td>IPAC team</td>
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</tbody>
</table>

**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of service, strategy, policy or project (hereafter referred to as <em>policy</em>) to be assessed:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy for Surveillance and Reporting of Infectious Disease, Healthcare Associated Infection and Antibiotic Resistant Organisms</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Procedure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate, Infection Prevention</td>
<td>Existing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Telephone: 01872 254969</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise Dickinson</td>
<td></td>
</tr>
</tbody>
</table>

1. **Procedure Aim***

To ensure the Trust complies with all mandatory surveillance of healthcare associated infections.

2. **Procedure Objectives***

This document provides clear guidelines on the responsibilities for Infection Prevention and Control Surveillance and ensures that mandatory surveillance directed by the Department of Health is complied with.

3. **Procedure – intended Outcomes***

To ensure all relevant personnel are informed of those healthcare associated infections that are reported as part of the Department of Health’s mandatory reporting scheme.

4. **How will you measure the outcome?***

Through daily, monthly quarterly and annual reports

5. **Who is intended to benefit from the Procedure?***

All Staff and patients at risk.

6a. **Is consultation required with the workforce, equality groups etc. around this procedure?***

Yes

b. **If yes, have these groups been consulted?***

Yes

c. **Please list any groups who have been consulted about this procedure.***

Hospital Infection Prevention and Control Committee Members of the Infection Prevention and Control Steering Group
7. The Impact
Please complete the following table.

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✔</td>
<td></td>
<td>Infections may affect any age</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>✔</td>
<td></td>
<td>Infections may affect any gender</td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>✔</td>
<td></td>
<td>Infections may affect any groups.</td>
</tr>
<tr>
<td>Disability - Learning disability, physical disability, sensory impairment and mental health problems</td>
<td>✔</td>
<td></td>
<td>Infections may affect all regardless of disability</td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>✔</td>
<td></td>
<td>Infections may affect any religion</td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>✔</td>
<td></td>
<td>Infections may affect all people – married or otherwise</td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>✔</td>
<td></td>
<td>Infections may affect any pregnant woman. Pregnant members of staff may need to take additional precautions depending on the organism involved.</td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>✔</td>
<td></td>
<td>Infections may affect all regardless of sexual orientation</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | No |
9. If you are not recommending a Full Impact assessment please explain why.

None of the equality strands have been identified in the initial impact assessment

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise Dickinson</td>
<td>25th July 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Louise Dickinson</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD
A summary of the results will be published on the Trust’s web site.

Signed: Louise Dickinson

Date: 25th July 2014

IPAC Surveillance Policy v5.0