1. Introduction to validation activities for HCAI draft advice

The Department of Health asked the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE), in partnership with the Health Protection Agency (HPA), to develop advice on the prevention and control of healthcare-associated infections (HCAI) in secondary care settings. A Topic Expert Group (TEG) was established to advice NICE and the HPA on the advice, which was developed using an approach based on the process and methods used to develop quality standards at NICE.

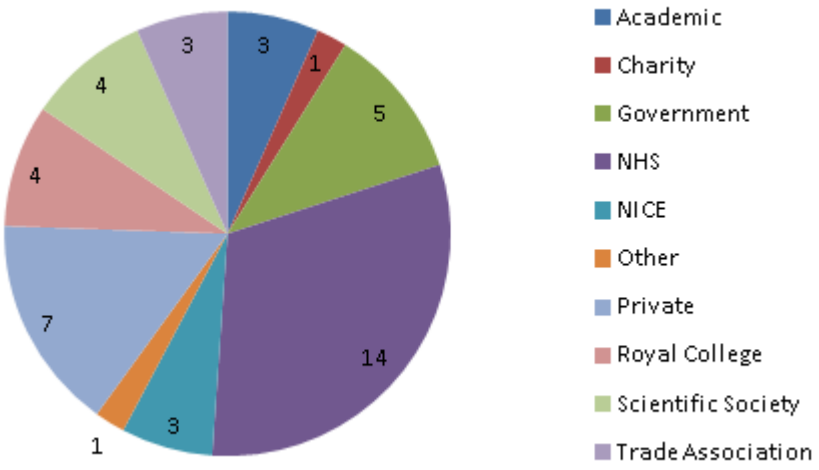
A draft version of this advice was published on the NICE website for consultation from 4 July 2011 to 9 August 2011. Stakeholders were emailed inviting individuals and organisations to comment. Additionally, a leaflet was distributed at the NHS Confederation Conference in July by staff on the NICE stand signposting the consultation. NICE also commissioned research company GHK Consulting to independently undertake field testing of the draft advice with professionals (to be reported separately).

This document summarises key themes identified in stakeholder responses to the web consultation. A full table of responses is appended to this summary, for information. The field testing is reported in a separate summary report. Key issues and themes identified in both documents will be used to guide amendments to the advice document at the final Topic Expert Group meeting in September 2011.

2. NICE Stakeholder comments

The NICE stakeholder consultation consisted of a set of specific questions (15 questions see Appendix 1) and general feedback on the entirety of the draft advice. Comments were received from 45 individuals – the breakdown of representation is presented in Figure 1; approximately one third of responses are from an NHS organisation (including 5 foundation trusts, 1 PCT, 1 SHA and 7 hospital trusts). Five government departments/agencies responded including HPA, DH and Care Quality Commission. A full list of organisations that responded are detailed in Appendix 2.

Figure 1. Breakdown of organisations responding to the consultation



This document is broken down into general feedback and feedback on the draft quality statements and measures.

3. General feedback received from Stakeholder organisations

The feedback was generally positive. The majority of the comments focused on the quality measures (structures and processes) rather than the statements themselves. The key issues coming out from the stakeholder consultation are:

- Need for clarity on the intended purpose, audience and use of the advice
- Overlap with Health and Social Care Act
- Applicability to other healthcare providers
- Audience for the advice may not have been clear – only NHS?
- Clarity and further details on measures
- Consistency in language and terms used

- Units for measures – should they be measured at trust level, ward level, speciality level?

- Gaps

    - Antimicrobial Stewardship/Antimicrobial resistance (5 respondents)
    - Hand-washing (5 respondents)
    - Decontamination (3 respondents)
    - Outbreak
    - Isolation, gowns, gloves, PPE
    - Device related and post-procedural infections
    - Occupational health aspect

- NHS ICT systems are not robust enough to cope with the data collection suggested in the advice.
- concerns that the new commissioners of the future may use the quality statements as for contracting and performance management purposes
- Evidence base used is very limited
- Level of burden to collect metrics – needs to be worthwhile
- Compliance with code of practice may be useful measure for lots of statements
- Need to make sure clear about which pathogens or procedures covered as only really give reference to MRSA and *C.diff* in the measures
- Lots of criticism of anything on post discharge surveillance.

4. Statement specific feedback

Draft statement 1

- Mixed views on a case register as a suitable measure, may be that only in certain settings or infections that its feasible.
- Concerns about IT infrastructure to support comprehensive surveillance
- Apprehension about evidence base for surveillance

- Does statement need to focus on the action as a result of surveillance?
- Timely element of statement isn't reflected – probably a point for consideration throughout
- Not clear which infections/sites should be covered by surveillance (is that for TEG to state?)
- Concerns that MRSA and *C.diff* orientated plea for it to be broader

Draft statement 2

- Communication or tasks involving other providers emphasis needs to be on the actioning trust i.e. this trust
- Process measure needs changing – also is it all patients or just those with a HCAI
- Where does it go beyond the hygiene code
- Equity issues around standardised information – needs to be rephrased around bespoke information relevant to service users and organisation specific
- Addition to measures - use of patient surveys
- proportion of areas that audit communication

Draft statement 3

- Need to be clearer about differentiating from draft QS2
- Process measure (numerator and denominator) needs to change
- Healthwatch may be useful for monitoring and getting patient input
- Statement shouldn't just be about communicating – patient needs to understand it as well
- Example of absence of diarrhoea should be removed
- Difficult to assess patients understanding – could consider using monitoring of complaints relating HCAI and see if communication is coming up
- Community infection prevention teams could liaise with trust IPC teams to find suitable patients for fiollow-up/audit to improve practice
- Needs to be made specific to the individual trust

- Some people may come into hospital with an infection how does this link in

Draft statement 4

- Multi-agency working – given the focus of the product should this statement only comment on secondary care trust element
- Evidence of joint working to improve outcomes
- Criticism of some of the measures
- Positive reception to data sharing between organisations
- Expand to include more professional bodies
- Senior not executive director – some conflict about whether as DIPC would normally take the lead but may not be an executive.
- clarity over who should be in the partnership group
- -suggestion that this may not be relevant for all trusts

Draft statement 5

- Suggested new measures:
    - Interviews with staff
    - Forums for staff
    - Patient experience
    - Proportion of remedial actions implemented identified by an RCA
- RCA should involve wider health community
- RCA only should be used if relevance to HCAI – in draft could be interpreted as all RCA
- Measures do not really mention surveillance outputs
- May be useful to link in more with governance structures

Draft statement 6

- Terminology infections or HCAI
- Assessment on admission for HCAI – clinical or microbiological assessment
- Clarity over structures – request for more detail

- Process measures may be difficult to collect as crosses organisational boundaries
- Numbers of adverse events recorded relating to discharge/transfer is inappropriate.

Draft statement 7

- Accountability deserves a statement of its own
- Combine QS5 & QS7
- Include a non-exec director as champion of HCAI
- Bullet 4 should extend beyond mandatory reporting
- Process measures need refinement and clarification – eg. what percentage? Are measures evidence based?
- Some of the processes are not directly linked to leadership or the Board.
- Bullet 8 - It will be difficult to measure whether clinical areas are compliant with the Hygiene Code as it is broad and overarching.

Draft statement 8

- Bullet 5: change to 'patient priorities *are considered*' rather than feature prominently. Concerns exist around patient knowledge and priorities.
- Bullet 6: training on communication skills. What training is recommended? Is this for all ICT staff?
- Bullet 7: Clarity is needed around 'ensure patient experience of HCAIs can be used to inform root cause analysis'. There are various logistical issues. And you cannot always 'ensure' that they participate
- Patient forums: it would be better to gather the views of patients with a history of HCAI than other non-representative groups. There are also problems with ensuring groups are representative as they are always self-selecting.
- National patient groups may be more or as relevant as local
- Patient experience questionnaire on discharge could be an indicator.
- The Board should be included in the 'audience' section

- Include: Trusts should be able to demonstrate to the public that they are listening to what they have said and effectively communicate this to the public.

Draft statement 9

- The Skills for Health National Occupational Standards could be used as a source document for this QS
- There is no mention of Occupational health requirements
- Bullet 4: how is 'performance' in relation to IPC measured?
- Bullet 8: all consultant staff should act as IPC champions

Draft statement 10

- Consideration of: Level at which action to takes place and roles within/variability of set up in trust (delegation of roles): Trust board member would have responsibility for agreeing estate management protocol but head of estates would be responsible for day to day implementation or delegate to managers this could (in some trusts) occur:
    - under the direction of the DIPC or
    - in consultation with consultant medical microbiologist or
    - arrangements with IPC
- Consideration of: Third party contractors
- Competencies: Is it more a case of having IPC expertise on hand rather than estates being fully up to speed on HCAI?
- Uptake: IPC expertise is not currently a requirement for Estates (as provided elsewhere); Make reference to "*producing briefs and specifications for* procuring, planning, designing and commissioning new and refurbished hospital services and facilities"

- Gaps: Clean water; Equipment purchasing; waste regulation
- More detail: *"risk assessments in controlled area* should be explicit*"* ; do we need to allocate roles specifically
- Current policy context (New HBN, current waste management, water and purchasing policy) ;
- Consideration of all secondary care settings- is the whole statement and measures applicable to all secondary care trusts
- reliance on identifying cross infection and contamination points is one of the few measures that can be applied to the built infrastructure
- A need for cost benefit analysis

Draft statement 11

- Overlap and linking of Estates management, design and cleanliness
- Monitoring of cleanliness: Should mention monitoring of cleanliness
- Variation in the trust set up for responsibility for establishing and adhering to minimum standards of cleanliness
- Do we need to be specific about who we suggest take action and what action they take:
    - a specifically named person for overall responsibility?
    - Hotel Services; Domestic and Facilities Managers
    - Reference to non executive directors and walkabouts where the environment can also be considered and addressed;
    - Should the role and involvement of IPC in cleanliness be outlined

- Reference to current policy and best practice context:
    - *IPC with reference to NHS Cleaning Manual and the Revised Guidance on Contracting for Cleaning; monitored by Domestic Services, IPCT, Matrons, PEAT and others*
- Hand hygiene:
    - Does this require its own QS;
    - needs to be mentioned more prominently
    - *cross refer to existing hand-hygiene facilities clinical audit tools?*
- Accountability and responsibility: Do we need to be making reference to aspects of accountability and responsibility as opposed to levels of check done etc?
- Reaction to incidence/outbreaks- the ability to rapidly scale up cleaning requirements
- Commissioning of services and contracted staff
- Occupational health and current staff hygiene practice: training needs
- A suggestion that the adherence or evidence of utilisation of scientific objective measures to monitor cleanliness is *not consistent with PAS5748*
- More specifics on how and where and when patient/public involvement should occur?
- Definition of terms more clarity needed and time frames/deadlines e.g. adequate hand hygiene
- Should the decontamination of devices be included (as well as environments)?

- Should there be other measures apart from ATP cleaning
- Evidence base for the statement

Draft statement 12

- Lack of clarity as to what was meant by this statement
- Infrastructure for this statement - resources, funding and expertise at Trust level - should/could this happen at Trust level or is this a more regional/national element:
    - Regional and national contextualisation (BASC guidance; Rapid review panel) rather than at trust level?
    - A suggestion that National level (CEP?) guidance on innovation and technology should be made with justification for lack of uptake made by trusts.
    - reference to national standards in this area? Or what should be done in the absence of such guidance regarding innovation and technology
    - Suggestion that Trusts should conduct assessments of technology
    - Consideration of New technology and innovation should be taken centrally
- Separate Technology and innovation from research and development to allow trust needs to be more carefully reflected
- QIPP leads and innovation groups: where do they fit in?
- Time lag:
    - A lack of indicators for the uptake of Technology perhaps look at “why recommended technologies have failed to be taken up”?

    - R & D may take years to bed in and to expect individual setting to do this is unrealistic; Innovation may be more feasible setting by setting

- Definitions: What do we mean by “new microbiological techniques, technology and innovation”: Technological innovation; technology and innovation, and research and development are seen by different organisations as different things:
    - IT infrastructure, new technical equipment, methods of prescription and prescribing and infrastructure to track this etc;
    - guidelines, approaches, and organisational processes
- Ethics/Governance panels?
- What is considered “consideration of innovation and technology”?
- Consideration of issues of patient safety (use of unapproved technologies)
- Duplication of effort
    - (RRP)
    - NIHR schemes

Appendix 1 – Specific questions asked in consultation

Question 1	The Government's White Paper 'Equity and Excellence: Liberating the NHS' sets out how the NHS will focus on improvements in healthcare outcomes. Can you suggest a relevant, overarching, measurable healthcare outcome that would be improved through the implementation of this quality standard?
Question 2	Have we identified all appropriate healthcare outcomes for each individual quality statement?
Question 3	Would length of stay be a suitable outcome indicator for this advice?
Question 4	What order should the statements be in?
Question 5	Which of the statements would be easiest to implement, and why?
Question 6	Which of these statements would be most difficult to implement, and why?
Question 7	In your opinion, has the advice missed any key areas or issues? What are they? (Please cite any relevant guidance on these areas.)

Other general points to consider:

- How appropriate are the statements of quality?
- Is the description of the statement clear?
- Are there more appropriate measures?
- Are the measures useful?
- Would suggested time periods for measurements be useful?
- How easy would it be to collect data for the statements?
- Is the style and format of the advice appropriate?
- Do the statements adequately cover the following dimensions of quality:
    - Effectiveness

<table>
<tr><td colspan="2">

Acceptability
Efficiency
Access
Equity
Relevance

How suitable are the statements for the different audiences cited – should other audiences be included?
Could the advice be improved more to promote equity of access to high-quality services relating to age, disability, gender, gender identity, ethnicity, religion and belief, sexual orientation or socioeconomic status?
What are the most appropriate sources of information and data about the cost of implementing some or all of these statements?

</td></tr>
<tr><td colspan="2">Statement-specific questions for consultation:</td></tr>
<tr><td>Question 8</td><td>For draft statement 1: Is it appropriate to include a case register? Are there some settings where it would not be relevant?</td></tr>
<tr><td>Question 9</td><td>For draft statement 3: How could patients’ understanding of their infection status and the implications for their care be measured?</td></tr>
<tr><td>Question 10</td><td>For draft statement 5: How could the statement be measured?</td></tr>
<tr><td>Question 11</td><td>For draft statement 7: What indicators could be used to assess progress?</td></tr>
<tr><td>Question 12</td><td>For draft statement 10: Would the head of estates be responsible for:
1) development of protocols for planned preventive maintenance (PPM) and interventional and remedial maintenance?
2) ensuring estates staff have appropriate skills and competencies?</td></tr>
</table>

Question 13	For draft statement 10: Who would have responsibility for ensuring the estates department has infection prevention and control (IPC) expertise? Would this be a collaborative joint working exercise?
Question 14	For draft statement 11: Who would have responsibility for establishing – and adhering to – a minimum standard of cleanliness in all clinical areas?
Question 15	For draft statement 12: Do trusts need to consider ‘technology and innovation’ separately from ‘research and development’ in relation to reducing HCAIs?
Question 16	For draft statement 12: How can ‘the consideration of innovation and technology’ be measured? Are there any existing indicators in this area?
Question 17	For draft statement 12: Would trusts rely on approved guidance (such as NICE guidance) on technology/innovation before considering its uptake – or would the decision be taken locally?
Question 18	For draft statement 12: Is there (apart from NICE guidance) any other type of guidance that would inform the decision? Are there any national data sources covering innovation and technology for reducing HCAIs?

Appendix 2 – List of stakeholders who submitted feedback during consultation

3M Healthcare
Aintree Hospital NHS Foundation Trust
Association of British Healthcare Industries Limited
Barking Havering & Redbridge University Hospitals NHS Trust
British Infection Society
Care Quality Commission
Cepheid
College of Optometrists
Danone Ltd
DH Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections
Devon Partnership Trust
DH
Dyson
Hand Hygiene Alliance
Harrogate and District NHS Foundation Trust
NICE CCP
Health and Care Innovation Research and Information Centre
Healthcare Infection Society
HPA
ICNet International Ltd
Independent Healthcare Advisory Services
Infection Prevention Society
JBOL Ltd
Johnson & Johnson Medical Ltd
NHS Northwest
NHS Sheffield
NICE Implementation
NICE PPIP
Nottinghamshire Healthcare NHS Trust

Papworth Hospital NHS Foundation Trust
Patients Association
RCN
Rotherham NHS Foundation Trust
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal Liverpool and Broadgreen University Teaching Hospitals NHS Trust
Sandwell PCT
Sheffield Children's Hospital
Sheffield Teaching Hospitals NHS Foundation Trust
The British In Vitro Diagnostics Association
The Health and Safety Laboratory
University of West London - (HCAI SURF)
UCL Medical School
University Hospitals Leicester NHS Trust
Urology Trade Association