GHK

NICE Field Testing for Advice on Healthcare Associated Infections in Secondary Care Settings

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Summary

Purpose and methodology

GHK Consulting Ltd (GHK) was commissioned by the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) to test draft advice on **healthcare associated infections (HCAI) in secondary care settings**.

This report presents the findings of a series of consultations undertaken with clinicians and managers, mostly in acute Trusts, and senior managers on Trust Boards. The aim of field testing is to gather practitioner knowledge to understand 'evidence into practice' and provide the basis for understanding whether and how the advice can be improved.

In this study, feedback was gathered from **93 practitioners** in England, including clinical and non-clinical managers and frontline staff. To do so, practitioners were asked questions about the relevance, utility and implementability of the quality statements on healthcare associated infections (HCAI) in secondary care settings.

We identified **a number of limitations** or caveats that are worthy of mention at the outset, either because they are relevant to the way in which practitioners interpreted the advice, or because they may have influenced our own interpretation of the evidence.

- The advice was intended for providers and commissioners as it concerned factors relevant to HCAI prevention and control at the organisational level, and it was thought that relevant parts of it would be filtered down from Board level. It quickly became evident that in most cases, responsibility for implementing any kind of external infection control advice would lie with the leading infection control specialist (e.g. a lead nurse) who would then interpret what was relevant in it to the Board. This was reflected in who we managed to recruit (i.e. many infection control practitioners) and the findings reflect the views of staff that would be charged with implementing the NICE advice. For instance, they mostly understood the advice as 'targets', which it was not intended to be.
- It was clear that most practitioners misunderstood that the advice was mostly building the quality statements on existing sources of guidance e.g. the Health and Social Care Act Code of Practice. Instead, they expected NICE and the HPA to produce something 'new' or something that added value to accepted best practice. This is likely to be why some practitioners found it helpful that existing guidance was being restated; on balance, however, a larger number of practitioners found the overlap to be confusing and did not understand why existing frameworks or guidance on infection control had been reproduced.
- In general, the Trusts that we consulted with in the focus groups had performed well in the 2009-10 CQC compliance process. Therefore their practice is likely to be reflective of best practice in the field of infection control and this may have informed their responses (electronic survey responses engaged with practitioners in a wider range of organisations). However, it should be noted that only a handful of Trusts were identified as having serious deficiencies during the CQC process.

Headline Findings

For the **quality statements as a whole**, we found that:

Practitioners across the field testing were ambivalent about the advice, their overall response to it was qualified by a number of concerns as outlined below:

- Practitioners were concerned about the overlap between the draft advice and existing sources of guidance (the CQC standards, Health and Social Care Act Code of Practice, 'Saving Lives'); this perceived duplication led to confusion among some practitioners.
- Practitioners were unsure of the purpose of the advice, and interpreted the advice as additional targets, perhaps because of a wider 'target-driven culture'.

- Practitioners wanted to see NICE and the HPA address whole-system issues and further emphasise the importance of integrated care, and the role of organisations other than NHS secondary care.
- Practitioners thought that the advice did not take the way in which Boards and Trusts would implement this advice into account. Frontline practitioners would be responsible for implementation of advice like this, while Boards might be more receptive to general guidance or principles.
- To varying degrees, most practitioners thought that their organisations were already implementing the quality statements and adhering to the general spirit of the advice.
- Many of the structures and measures were welcomed, but practitioners thought that implementing the advice in full – in particular, collecting evidence for all the proposed outcomes – was not a good use of limited resources.

Practitioners discussed ways in which the advice could be improved so it was more relevant and useful:

- Greater clarity on how this advice relates to CQC standards, the Health and Social Care Act Code of Practice and other key documents would be welcomed.
- Practitioners thought that alternative formats such as a 'toolkit' might improve the clarity of the advice. Some wanted the advice to go further than existing guidance or focus on areas of practice that were not covered in existing guidance; the advice was also perceived to be too long. Greater clarity about the purpose and intentions of the advice would help.
- Practitioners thought that in some cases, the terminology used throughout the advice could be made more precise. For example, some of them felt 'HCAI' was ambiguously defined.

These issues are explored more fully in the relevant sections of this field testing report. It should be noted that responses varied to the statements. Some of the statements – in particular those on patient involvement (8), estate management (10) and the research and development / innovation component of statement 12 were more welcomed than some others, largely because they were seen as adding value to existing guidance.

The **main findings for each quality statement** are listed below:

Quality Statement 1: HCAI Surveillance

- Practitioners already collect surveillance data (to varying degrees) and it was thought that the draft quality statement could have done more to address specific gaps. Analytical capacity at the local level was thought to be very important for interpreting additional surveillance data, if this was to be collected.
- The statement was too broad and the overlaps with existing documents made it difficult for practitioners to see where the draft advice was proposing distinct or new ideas, as they expected. Practitioners found it difficult to understand what was proposed.
- However, some of the processes and outcomes were thought by many practitioners to be too prescriptive or burdensome; secondary care practitioners did not want to be made responsible for collecting data on the parts of the patient pathway outside their Trust.

Quality Statement 2: General Communication

- The majority of practitioners said that communicating well with patients and staff is a priority for them; however, evidencing this in an effective way is challenging.
- The majority of practitioners said that there are overlaps with other quality statements in the advice, which made it more difficult to understand the advice.
- Practitioners raised some concerns regarding implementation (e.g. would auditing communication distract from learning about it?), and some gaps were identified, such as mention of carers.

Quality Statement 3: Communicating with patients affected by an HCAI

- Practitioners were broadly supportive of the aim of communicating clearly with patients; they thought that the standards for good communication with patients with HCAI were the same as those for other patients. Communication with patients affected by HCAI was thought to be good within the organisations where we held focus groups.
- Practitioners raised concerns about the processes and auditing mentioned in this quality statement; it was thought to be time consuming.

Quality Statement 4: Multi-agency working to reduce HCAIs

- Current practice in multi-agency working varies and in the view of practitioners, could be improved. However, the quality of multi-agency working was thought to be difficult to measure.

Quality Statement 5: Create a learning organisation

- The draft quality statement was thought to be important, but many practitioners thought that it was a summary of existing requirements that were already implemented well, as a result of the Health and Social Care Act and other statutory guidance.

Quality Statement 6: Admissions, discharge and transfer

- Common admission, discharge and transfer policies were thought to be important, as not all Trusts had multi-agency policies. However, many practitioners thought the proposed auditing processes were impractical and /or of limited added value.

Quality Statement 7: Board-level leadership for HCAIs

- Board engagement was thought to be important, and it was generally thought that Boards were already required to carry out most of statement 8. However the barriers to implementation were sometimes thought to be cultural because of a 'tick-box' approach, and practitioners were unsure if this draft quality statement would overcome that barrier.

Quality Statement 8: Patient and public involvement

- The majority of practitioners thought that patient and public involvement (PPI) in relation to HCAI were important.
- The implementation issues were thought to be broadly the same as for PPI more generally: it is resource-intensive, and it is difficult to get beyond the 'professional patient'; these challenges make it difficult to gather meaningful 'evidence'.

Quality Statement 9: Workforce capacity and capability

- Current practice varies in relation to workforce development; in some cases it was at odds with the draft quality measures but local practitioners felt that approaches that they had already developed locally, in response to existing guidance, were more appropriate than some of the suggested structures. For example, they wanted to move away from a notion of 'one size fits all' training.

Quality Statement 10: Trust Estate Management

- A quality statement about Trust Estate Management was largely thought to be helpful in the focus groups, and specialists saw this as adding value.

Quality Statement 11: Cleanliness

- Most practitioners were welcoming of the spirit of the quality statement, but thought that the content of this statement was adequately covered elsewhere in CQC standards and the Health and Social Care Act.
- However, practitioners and organisations had different views on what constituted best practice; some practitioners thought that their Trust went beyond the measures outlined in the quality statement.

Quality Statement 12: New Technology

- The vast majority of practitioners were confused by this quality statement; most were ambivalent about carrying out their own assessments of technology while a minority were hostile.
- On the other hand, references to promoting innovation (other than adopting new technologies) were thought to be helpful; this meant that the draft advice was adding something new to existing guidance.

Summary of suggested changes

Quality Statement	Changes proposed by practitioners
For the advice as a whole	▪ Introduce greater references to existing sources of guidance throughout the draft advice so that the links and overlaps are clear ▪ Give greater emphasis to the status and purpose of 'advice' as a tool and how it differs from targets / mandatory reporting, other NICE products and existing guidance on HCAI ▪ Shorten the advice to make it more relevant to its target audience – perhaps those sections most relevant to Boards could be separated from those relevant to the frontline. Some of the detailed measures and outcomes might require revision ▪ Clarify certain terms, especially where existing guidance might suggest a standard or definition in place e.g. 'regularly' or the term 'HCAI' itself ▪ Focus on those parts of the advice that could add value – for instance, things of particular importance to Boards e.g. multi agency working or promoting integrated care or the sharing of best practice ▪ Focus on advice that could 'stretch' and improve existing practice in Trusts that are already complying with the Health and Social Care Act Code of Practice e.g. improving patient communication or reducing bed blocking ▪ Clarify how this advice applies to private sector providers ▪ Recognise that in practice, Boards are most likely to delegate the detail of implementing this advice to DIPCs and other leading specialists in their organisations.
Quality Statement 1 HCAI Surveillance	▪ Introduce greater references to existing sources of guidance throughout the draft advice so that the links and overlaps are clear ▪ Further emphasise the importance of analysis and interpretation of surveillance at local level, and that responsibility for good surveillance lies at all levels in the organisation ▪ Revise the processes and outcome measures so that they are feasible (e.g. ward level data may be impractical for some), while perhaps also giving clearer definitions and detail about terms such as 'adequate resources', or what evidence states are important HCAI to be monitored
Quality Statement 2 General Communication	▪ Resolve various issues around overlap with draft quality statements 3, 6 and 8; linking in communication skills to learning and development may be helpful ▪ Evidencing the quality of communication is challenging, and more thought may be required on how best to do this (see draft quality statement 3)

Quality Statement	Changes proposed by practitioners
Quality Statement 3 Communicating with patients affected by an HCAI	▪ Resolve various issues around overlap with draft quality statements 2, 6 and 8; linking in communication skills to learning and development may be helpful ▪ Evidencing the quality of communication is challenging, and more thought may be required on how best to do this (see draft quality statement 2). The amount of auditing should be proportional to its added value ▪ Practitioners in acute trusts did not want to be held accountable for the quality of information produced by a range of partners in the context of admissions and transfers ▪ Mention could be made of the national inpatient survey as a means of collecting evidence for quality statement 3
Quality Statement 4 Multi-agency working to reduce HCAIs	▪ Emphasise the importance of sharing good practice and working together and ways that this could be done ▪ Emphasise the important part that other organisations outside the acute sector need to play in preventing and controlling HCAI
Quality Statement 5 Create a learning organisation	▪ Introduce greater references to existing sources of guidance throughout the draft advice so that the links and overlaps are clear ▪ Emphasise the quality and interpretation of RCAs as much as measuring their number, and the importance of moving away from a 'blame culture' ▪ Review the processes so they are clearer and explain how post-discharge surveillance might be accomplished
Quality Statement 6 Admissions, discharge and transfer	▪ Consider amending so that overlap with statements 2 and 3 is resolved; the link with the Health and Social Care Code of Practice also needs to be clearer ▪ Suggest ways in which difficulties surrounding paper-based communication might be tackled so that multi-agency policies can work ▪ Suggest removing the reference to the auditing of admissions, transfers and discharges as it is considered to be impractical ▪ Emphasise the importance of wider communication to prevent and control HCAI (link to statements 2 and 3)
Quality Statement 7 Board-level leadership for HCAIs	▪ Referencing the links to the Health and Social Care Act throughout is important ▪ It is important that Boards take their leadership responsibilities seriously; this should not be a 'tick-box' exercise; perhaps the approach to measuring progress regarding this quality statement could be reconsidered ▪ Clarity around terms such as 'balanced score card' and 'key performance indicators' may be needed
Quality Statement 8 Patient and public involvement	▪ Practitioners wanted to see a reference to PALS services and the role that they can play ▪ Practitioners wanted more information about best practice in engaging and working with a diverse group of patients and the public in infection control (as well as a broader agenda) ▪ Data collection and auditing were thought to be less important than adopting whatever best practice is in this field

Quality Statement	Changes proposed by practitioners
Quality Statement 9 Workforce capacity and capability	▪ Emphasis should be put on avoiding a tick-box mentality in regard to complying with this quality statement ▪ Consideration should be given to altering structure that proposes that all clinical staff have infection control training within one week ▪ Consideration should be given to reducing the perceived burden of evidencing the structures
Quality Statement 10 Trust Estate Management	▪ There are some aspects of this quality statement that could be made more forcefully – this could include a stronger lead on including infection control staff in estates management processes, and that contractors too should take note of this ▪ Estates staff wanted to see a reference to the Department of Health's Health Building Notes and Health Technical Memoranda
Quality Statement 11 Cleanliness	▪ Perhaps more detail could be included on best practice and how Trusts could exceed the minimum mandated requirements ▪ Clarity is needed on which minimum requirements are being referred to ▪ Hand hygiene could be emphasised more within the quality statement, although some of the proposed outcome measures for this could be revised
Quality Statement 12 New Technology	▪ Practitioners wanted to see a clearer distinction between technology and other forms of innovation, research and development ▪ Technology assessment ought to remain a process that takes place outside of Trusts, although it could be improved ▪ If the quality statement were to focus on encouraging Trusts to carry out research and development leading to improved practice in HCAI prevention, this would be more welcome ▪ Adequate resourcing was thought to be an important factor behind the uptake of new technologies

1 Introduction

1.1 Overview and purpose of field testing

GHK Consulting Ltd (GHK) was commissioned by the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) to field test draft advice on healthcare associated infections (HCAI) in secondary care settings.

This report presents the findings of a series of consultations undertaken with clinicians and managers, mostly in acute Trusts, and senior managers on Trust Boards.

The aim of field testing is to gather practitioner knowledge to understand 'evidence into practice' and provide the basis for understanding whether and how the advice can be improved.

In this study, feedback was gathered from **93 practitioners** in England, including clinical and non-clinical managers and frontline staff. To do so, **practitioners were asked questions about the relevance, utility and implementability of the quality statements on healthcare associated infections (HCAI) in secondary care settings**.

The views contained in this report and the conclusions derived from them are entirely based on the evidence given by the practitioners to whom we spoke. Some limitations were encountered or identified during the course of the field testing; these are described below in section 2.6.

GHK would like to thank all the practitioners who committed their valuable time in order to give their feedback during this study.

1.2 Background and scope

The Department of Health asked the CPHE at 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.

The **scope of the advice** envisaged a focus on organisational-level indicators of excellence in HCAI prevention and control; the scope envisaged that the advice would be aimed at service providers, healthcare professionals, commissioners, and trust boards and managers; as well as people using secondary care services.

The advice is intended to be used to compare performance against evidence-based measures of best practice, or to help providers, commissioners and auditors identify areas for quality improvement. It was also envisaged that the advice may be used to make investment decisions, or to provide patients and the public with information about the quality of treatment they might expect from secondary care.

1.3 Structure of this report

The full report continues in the following sections:

- **Methodology** (section 2), describing the selection and achievement of the sample, recruitment, and the analysis of data;
- **Responses to the quality statements as a whole** (section 3), analysing the evidence given by practitioners that is pertinent to the content and form of all the quality statements and their associated measures, structures and processes; and
- **Responses to individual quality statements** (sections 4 – 15), analysing responses to each individual recommendation.

This report also features four annexes:

- **Annex 1** – the final discussion guide used to facilitate the focus groups;
- **Annex 2** – the consent letter signed by all participants;
- **Annex 3** – the prior reading task set for focus group participants;
- **Annex 4** – the sign in sheets and equalities monitoring data forms completed by all participants.

2 Methodology

This section describes the aims and methodology used to carry out our field testing and analysis, including:

- the key field testing questions;
- sampling and recruitment; and
- techniques employed to conduct the field testing consultation and analysis.

2.1 Aims and questions for the field testing

The aim of the field testing was to examine the relevance, utility, acceptability, and implementability of the draft NICE and HPA advice on **prevention and control of healthcare acquired infections (HCAI) in secondary care and foundation trust settings**.

In particular, the analysis investigated the following key issues:

- particular issues or barriers in the different secondary care providers and the wider health system (e.g. the nature of partnerships between organisations, management and funding issues, attitudinal barriers, or training needs) that would help or hinder the effective implementation of the advice by different parts of the target audience;
- the views of professionals and practitioners on the relevance and usefulness of the draft advice to current practice, including measures and quality standards;
- the potential impact of the draft advice on day-to-day practice, organisations and across the wider health system, and the extent to which it is feasible to implement;
- the relative priority of, and emphasis that ought to be given to, each of the quality statements, measures and outcomes;
- the wider potential of advice as a NICE product that could influence day-to-day practice, organisations and across the wider health system; and
- any additional evidence or advice that ought to be taken into account in the final product.

2.2 Sampling – key principles and achieved sample

2.2.1 Selection of organisations

The draft advice is aimed at a wide audience across all acute care providers in the NHS, including Foundation Trusts (FTs). Because of this, we targeted four organisations with differing characteristics, to consult with their staff using focus groups. We expected that the advice might have a different impact on organisations of different sizes, with different specialisms and governance arrangements. As such we attempted to engage a sample of organisations to include:

- one large teaching hospital Trust – most of these are now FTs, so this would also ensure that FT staff are included;
- one generalist, medium-sized / small acute Trust (for example, based on an old district general hospital model) that is also a FT;
- one generalist, medium-sized / small acute Trust that is an NHS Trust (not a FT); and
- one specialised hospital Trust – such as an organisation that deals exclusively with children's or cancer care, for example. This may or may not be a FT.

We were not able to arrange a focus group with an NHS Trust (non-FT, although our online survey did engage with 21 practitioners from outside the FT sector).

However, due to the **high level of interest among practitioners** generated by our approach, we were able to conduct **five focus groups instead of the four planned**. The table below displays our achieved coverage by organisational type, for the focus groups:

Table 2.1 Target and achieved focus group samples by organisation type

Organisation type	Target	Achieved
Large teaching hospital trust	1	2
Generalist, medium-sized FT	1	2
Generalist, medium-sized NHS Trust	1	0
Specialist hospital trust	1	1

In general, all these Trusts had performed well in the 2009-10 CQC compliance process. Therefore their practice is likely to be reflective of best practice in the field of infection control and this may have informed their responses (electronic survey responses engaged with practitioners in a wider range of organisations). However, only a handful of Trusts were identified as having serious deficiencies during the CQC process.

Our five groups were held in the following regions:

- North East;
- North West;
- East of England;
- South West; and
- London.

In addition to the focus groups, we also targeted an **electronic survey at a larger number of trusts and individuals**, using the criteria listed above as a guide. This survey allowed us to capture the views of practitioners from targeted trusts who were not able to make it to the groups, as well as allowing staff in additional organisations and regions to respond to the consultation.

A total of **63 practitioners registered for the electronic survey**. However, 24 of these gave only their personal details and consent and did not go on to give any substantive feedback on the draft advice. Consequently we recorded **39 valid responses** overall, which are included in our detailed analysis.

2.2.2 Selection of individuals

As the advice is concerned with organisational characteristics, arrangements and practices that can prevent and control HCAI, the focus groups and electronic survey included a wider group of staff at all levels, beyond those that are directly responsible for infection control in secondary care.

Overall we achieved a final sample of 54 focus group participants and 39 survey respondents, a total of 93. This is a figure 19% in excess of the target of 78.

Table 2.2 Target and achieved participants by research method

Research method	Target participants	Achieved participants
Focus group	28	54
Survey	50	39
Overall	**78**	**93**

Most participants, both in the focus groups and electronic survey, were at a senior level:

- 82% were managers;
- 33% senior managers at Band 8b or above;
- 43% were clinicians at Band 6-8a, or managers with responsibility for a ward theatre or small clinical team;
- additionally, 6% were managers without such responsibilities;
- only 6% of participants were frontline delivery staff at Band 6 and below; and
- Governors, patient representatives and other practitioners made up the remainder.

This profile of response by practitioner level is broadly similar for both focus group and electronic survey participants.

As a result, we **successfully recruited a high number of managers at a senior level**, though relatively few of these were CEOs or other non-clinical directors/senior managers other than DIPCs or nurse directors (in spite of our attempts to involve these groups). Six consultees identified themselves as Very Senior Managers (VSMs) above the main Agenda for Change pay bands and sat on executive Boards.

Table 2.3 Achieved sample by practitioner level

Practitioner level	Number of practitioners consulted	Proportion of total number of practitioners consulted
Senior manager, Band 8b or above	31	33%
Manager or clinician, Band 6-8a	40	43%
Other managers (without responsibility for ward, theatre or small clinical team)	6	6%
Frontline delivery staff (Band 6 or below)	6	6%
Other e.g. non executive director, Governor, etc	10	11%
Total	**93**	**100%**

We found that **practitioners with a specific remit for infection prevention and control were most likely to respond to the consultation**, in particular, the electronic survey. Of the 93 participants, 44 fell into this category. Despite this, the range of practitioners that we engaged with was diverse and included:

- Six Very Senior Managers: Directors of Infection Prevention and Control, Director of Nursing and Quality, Deputy Medical Director, Chief Nurse, Hotel Services Director, and Head of Performance Assurance;
- Consultants in microbiology, communicable disease control, trauma, and respiratory medicine;
- Clinical matrons, matrons and nurses, including for infection prevention and control;
- Pharmacists;
- Operations managers and business analysts;
- Hotel services, facilities and estates management;
- Cleaners;
- Patient representatives;

- Chaplains; and
- Governors.

2.3 Recruitment methods

Recruitment was conducted using a purposive sampling process, designed to recruit a diverse group of participants.

The recruitment process was carried out as follows:

- A bona fides letter, explaining the field testing and its purpose, was sent to the infection control lead in each of the target organisations. We then worked with infection control staff to identify a suitable date and venue for the focus groups.
- Suitable participants in each organisation were identified in consultation with the infection control lead using a recruitment proforma highlighting the key groups that NICE and the HPA wished to consult with. Where participants did not find it convenient to attend a focus group or did not attend, they were invited to participate in the electronic survey.
- **For focus group participants,** Informed consent was obtained from each participant once they had agreed to take part (Annex 2), as well as a recruitment proforma collecting information on their job role. Shortly before the field testing took place, the draft advice was sent in full to all participants, along with a short pre-reading task designed to help structure their thoughts prior to attending (Annex 3).
- Participants who did not return consent forms were given the opportunity to complete them at the focus group. At this point, all participants were asked to complete a sign-in sheet to collect information about their job roles and organisation, and an ethnicity/disability status monitoring form (Annex 4).
- **In the case of potential survey participants that showed an interest**, email contact details were kept on file until the opening of the electronic survey in August. At this point, potential participants were emailed a link to the survey; they had approximately three weeks to respond. The survey included a consent letter, recruitment proforma and ethnicity/disability status monitoring form, identical to those given to focus group participants.

2.4 Methods used for the field testing

Focus groups were the main research method used. A discussion guide (Annex 1) helped the facilitator to structure discussions. However, researchers were careful to ensure that discussions were facilitated, rather than led. The facilitator's role was to guide the group towards an open discussion, with only as much prompting as was strictly necessary, of the advice's strengths, weaknesses, barriers and facilitators.

The focus groups were attended by one lead researcher and one scribe, who made field testing notes. All groups were digitally recorded to ensure the accuracy of quotes. The presence of two researchers allowed different interpretations of the data to be explored and resolved. Where possible, CPHE members observed field testing sessions to hear participants' views first hands; CPHE members did not take a speaking part in the group discussions.

In addition, an electronic survey was used to capture the views of a wider group of practitioners. We approached three or four trusts in each region that met the range of characteristics described in *Selection of organisations* above. Of these, nine trusts agreed to internally circulate our invitation to participate in an electronic survey. Additionally, the Infection Prevention Society kindly agreed to forward the invite to a further group of relevant practitioners. This was particularly helpful as it proved difficult to successfully engage staff not directly involved in infection prevention and control.

2.5 Data analysis

Once field testing notes were completed, data analysis took place using a content analysis approach. This involved the iterative use and immediate analysis of field notes through the field testing period. Using the field testing's key questions, the researchers identified core themes emerging from the data, defining concepts, providing explanations and finding associations and key differences between the views of different groups of participants. These were inserted into a analytic template, for synoptic analysis prior to reporting.

Regular briefing and debriefing sessions took place throughout the field testing process, to ensure that analysis was carried out in a robust manner.

2.6 A note on the limitations encountered during the field testing that have shaped the interpretation of the evidence

We identified a number of limitations or caveats that are worthy of mention, either because they are relevant to the way in which practitioners interpreted the advice, or because they may have influenced our own interpretation of the evidence.

- The advice was intended for providers and commissioners as it concerned factors relevant to HCAI prevention and control at the organisational level, and it was thought that relevant parts of it would be filtered down from Board level. It quickly became evident that in most cases, responsibility for implementing any kind of external infection control advice would lie with the leading infection control specialist (e.g. a lead nurse) who would then interpret what was relevant in it to the Board. This was reflected in who we managed to recruit (i.e. many infection control practitioners) and the findings reflect the views of staff that would be charged with implementing the NICE advice. For instance, they mostly understood the advice as 'targets', which it was not intended to be.
- It was clear that most practitioners misunderstood that the advice was mostly building the quality statements on existing sources of guidance e.g. the Health and Social Care Act Code of Practice. Instead, they expected NICE and the HPA to produce something 'new' or something that added value to accepted best practice. This is likely to be why some practitioners found it helpful that existing guidance was being restated; on balance, however, a larger number of practitioners found the overlap to be confusing and did not understand why existing frameworks or guidance on infection control had been reproduced.
- In general, the Trusts that we consulted with in the focus groups had performed well in the 2009-10 CQC compliance process. Therefore their practice is likely to be reflective of best practice in the field of infection control and this may have informed their responses (electronic survey responses engaged with practitioners in a wider range of organisations). However, it should be noted that only a handful of Trusts were identified as having serious deficiencies during the CQC process.

3 Feedback on the Advice as a whole

This section examines participants' responses to the NICE and HPA advice on the *prevention and control of healthcare associated infections (HCAI) in secondary care settings* as a whole. Subsequent sections then examine the responses to each of the quality statements individually.

For clarity, we have reproduced each of the draft quality statements that we consulted on at the start of each chapter.

Terminology used in this report

Throughout the report, we have used the following terms to give an indication of the weight of evidence given by practitioners. The following statements are used to preface and qualify each finding:

'**The vast majority of practitioners thought that…**' means that there was general agreement with the particular view expressed among the population to which we refer. This constitutes very strong evidence in favour of a particular view.

'**Many practitioners thought that…**' means that at least half of the population to which we refer agreed with the particular view expressed. This constitutes strong evidence in favour of a particular view.

'**Some practitioners thought that…**' means that a minority of the total population across all the focus groups to which we refer agreed with the particular view expressed. This evidence may be of interest because it gives a contrasting or complementary point of view, alongside the other findings, making it of relevance into account when read alongside the other evidence provided by practitioners.

Where the terms 'should ', 'could' are used in the text to denote the strength of feeling expressed by practitioners in relation to a particular idea, this is linked to the views of the group referred to in the sentence. For instance:

"*The vast majority of practitioners thought that the advice should have made the link with the Health and Social Care Act more explicit*" means that most practitioners expressed a strong view that this link be made more clear; and that there was general agreement across the focus groups.

"*Some practitioners thought that the advice could have been more like a toolkit for practice*" means that some practitioners thought that writing them like a toolkit would have been a good idea. Again, it implies that the rest of the population did not express a view or thought something else.

We also refer to staff from different sectors collectively. For example, we refer to infection control specialist nurse, estates teams, and so on.

The findings of the field testing are illustrated by quotes from participants, as well as examples of practice described by participants.

3.1 Findings

3.1.1 Practitioners across the field testing were ambivalent about the advice, their overall response to it was qualified by a number of concerns as outlined below:

- Overall, there was concern among practitioners about overlap and duplication between the draft advice and existing sources of guidance. However, some practitioners found it helpful that the advice reinforced existing messages (section 3.1.2)
- There was a strong suggestion that many of the consulted practitioners thought that the advice did not go further than current practice – indeed some thought that they were ahead of the advice (section 3.1.6)
- Throughout, practitioners raised concerns over the clarity and focus of the draft advice, and suggested possible improvements

- Some of the suggestions for implementation (the structures and measures) were not always perceived to be useful or appropriate (section 3.1.7). In the view of practitioners, some of the suggested outcome measures were not realistic; others had been superseded by better practice than that suggested in the advice – according to practitioners, these outcome measures were not part of existing guidance. Specific instances are explored further in this section and in the sections below.
- The overall findings are reinforced by the analysis of multiple choice questions in our electronic survey (section 3.2), which found that most practitioners consulted found the quality statements to be difficult to understand, of limited use, and unlikely to lead to any improvements in their practice.

3.1.2 Practitioners were concerned about the overlap between the draft advice and existing sources of guidance such as the Health and Social Care Act; this perceived duplication led to confusion among some practitioners

The vast majority of practitioners noted that there was significant overlap or duplication between the draft advice and existing sources of guidance or mandatory standards that secondary care had implemented in recent years. Feedback indicating that 'this would have been more useful a few years ago' was not uncommon in focus groups.

At the same time, some practitioners were confused because while many of the draft quality standards strongly reflected existing guidance, the advice introduced some new ideas (especially in the structures and measures). It is probable that because the quality statements themselves were not viewed as contentious, Trusts had already developed ways of measuring their 'compliance' with them (many practitioners discussed problems with the suggested processes and outcomes in the advice at length, where they differed from existing practice, and tended to perceive additional indicators as a burden). Existing sources of guidance and statutory requirements that were commonly mentioned in the focus groups and survey responses included:

- the Health and Social Care Act 2008 and its associated code of practice, known as the Hygiene Code;
- the DH 'Saving Lives' guidance; and
- the CQC standards to which Trusts had to comply.

"It's complete duplication of the Health Act … these recommendations [sic] are a halfway house between the DH Code of Practice, and the Saving Lives tools … they've taken the Health Act's guidance and translated it into specific targets to audit but it's not quite specific enough to be useful"

(Infectious diseases physician, Foundation Trust, focus group)

"There is nothing here not covered in the 2008 Act or what we're already doing"

(Assistant Director of hotel services, Foundation Trust, focus group)

"It is a very serious question as to whether NICE ought to issue a set of statements without making it absolutely crystal clear how they relate to the other sets of guidance. Otherwise it just generates confusion."

(Commissioner, Primary Care Trust, focus group)

As we go on to describe, many practitioners' concern was related to the auditing suggested in the structures and measures. In some cases, practitioners thought that alternative outcome measures were being suggested to evidence quality statements which broadly reflected existing guidance. Therefore, there was concern that adding new measures might not be the best use of resources, when existing measures (either local or national) to demonstrate compliance were already in place.

"I read this with huge disappointment. It is an assurance framework. This is already required under the Health and Social Care Act 2008 which we are all required to work to. I believe this draft advice makes for duplication of work already undertaken and will further keep infection prevention specialists in their offices rather than out in the clinical environments. If a framework is needed (which I don't believe is), then it must reflect the Health and Social Care Act. Many of the statements in the text are difficult if not impossible to prove/demonstrate and will mean staff wasting time trying to devise creative means to prove something on paper, rather than being out in clinical areas influencing practice, auditing and educating."

(Director of infection prevention and control, specialist Foundation Trust, survey)

This also reflects our finding (below) that practitioners in secondary care were generally confused about the status and purpose of the draft advice, interpreting it as 'targets'.

Some practitioners were more welcoming of the draft advice, stating that it was useful to have advice that reinforced existing guidance. However, this group of respondents also generally agreed that greater clarity would be helpful in answering their questions about the advice:

"How does this fit in with CQC [Care Quality Commission]? This is essential to understanding what the document is about. CQC compliance is the priority of infection control leads, and this document is not explicit enough in how it fits with CQC regulation."

(Associate Director of infection prevention and control, Foundation Trust, focus group)

"It would be better is there was more joined up thinking with other guidance. For example the guidance which is available from the Care Quality Commission and NICE"

(Lead infection control nurse, Foundation Trust, focus group)

It may be that commissioners may find the document more useful, although we did not consult with a sufficient number via the focus groups to be able to state with confidence that this finding is robust. For example, one commissioner said that it would be useful in helping her to draw up a basket of indicators in a forthcoming quality schedule with local providers of care. Even so, it was thought that more links within the draft advice to existing guidance would be welcomed:

The overlap [with the Health and Social Care Act Code of Practice] is really marked, [I] saw this as more supportive and to make the outcomes from the Code of Practice to support maybe how you implement some of those outcomes in a different way, [but I] wasn't sure how this sat with the CQC outcomes, they are probably vague in some places.

(Commissioner, Primary Care Trust, focus group)

3.1.3 Practitioners were unsure of the purpose of the advice, and interpreted the advice as additional targets, perhaps because of a wider 'target-driven culture'

The vast majority of practitioners in secondary care also interpreted the draft advice as 'new targets'. Even when the status of the advice was explained to them, practitioners explained that the culture of their organisations tended towards interpreting any kind of guidance around specific outcomes and sources of data to evidence them as mandatory – and even if secondary care Trusts did not implement the draft measures as 'targets', their commissioners would make them do so. Some practitioners stated that their commissioners had insisted on certain measures in the past, without necessarily following through with best practice (e.g. establishing a baseline of infection rates before demanding reductions).

Although some of this response might be attributed to the cultural norms surrounding the relationship between providers of care and commissioners, many practitioners gave a number of reasons for their confusion. For example:

- some practitioners wanted to know how the measures and outcomes in the draft advice fitted with existing mandatory reporting on HCAI;

- some practitioners mentioned that they report to a number of different bodies already, and did not understand why their board might want to ask about different measures / audit trails to those already required;
- some practitioners wanted to know who the evidence for the quality statements would be submitted to; and
- some practitioners thought that the overall language and tone of the document (e.g. 'numerators and denominators') made it sound like 'targets' rather than 'advice'.

Infection control practitioners and DIPCs were generally unclear about what the advice was trying to achieve, and thought that without clear statements about what was already mandatory and what constituted 'best practice' or 'stretch', the advice could introduce confusion:

"I cannot at present see the purpose of this advice .... In particular, what is its relationship to the Code/CQC assessments. Unless it provides users with a logical progression or link from the Code I am very concerned that it will increase confusion and definitely not add value to the people who will be tasked with addressing the document."

(Infection control practitioner, independent organisation, survey)

3.1.4 Practitioners wanted to see NICE and the HPA address whole-system issues and further emphasise the importance of integrated care, and the role of organisations other than NHS secondary care

Although practitioners understood the scope of the guidance was limited to secondary care, many practitioners thought that there ought to have been a greater emphasis throughout on the importance of integrated care, and the role of organisations other than NHS secondary care / Foundation Trusts. This finding may reflect that our field testing mainly engaged with workers in NHS secondary care; for some practitioners, there was an impression of 'advice fatigue' in that secondary care had again been made the focus of guidance and assigned responsibility for leading improvements across the whole health economy.

"Will there be a similar document for organisations other than secondary care trusts? Without this there will be little drive for primary care/social care organisations to co-operate on HCAI workstreams."

(Microbiologist, Foundation Trust, survey)

Some focus groups agreed that with the current policy focus on integrating care and care pathways, the draft advice could have placed a greater emphasis on the importance of this for controlling HCAI.

"Acute and secondary are separated [from the rest of the system]. The whole problem of HCAI is across the whole system. [By] Splitting it into two … [NICE are] missing a trick here, if you want to change behaviour, behaviours across the whole system have to change and it has to be much more integrated [using joint targets perhaps]."

(Infection control nurse, Foundation Trust, focus group)

"I wonder if it would be worthwhile explicitly stating that local Trusts develop communication systems between them. The city where I work is served by several hospitals and patients with recent CDT [clostridium difficile toxin] can appear at any one without us being alerted until too late."

(Consultant physician, Foundation Trust, survey)

Many practitioners were also unclear whether private providers of secondary care were also included in the audience for the draft advice, and some thought that their inclusion ought to be made more clear. One private sector nurse thought that the advice as a whole was only practicable for larger (i.e. NHS) providers, although the response recognised the importance of quality assurance systems covering both NHS and private providers:

"[The] document is 53 pages long, repetitive and clearly focused to reporting systems within the NHS that the private sector cannot access [sic] yet the private sector are asked to report the same data as the NHS"

(Chief nurse / DIPC, Private provider, survey)

3.1.5 Practitioners thought that the advice did not take the way in which Boards and Trusts would implement this advice into account. Frontline practitioners would be responsible for implementation of advice like this, while Boards might be more receptive to general guidance or principles

Many practitioners stated that the responsibility for implementing new advice and guidance on HCAI fell to the DIPC or senior nurse lead for infection control. It is also possible that this finding was reflected in the recruitment for the focus groups, where non-clinical directors and chief executives delegated attendance and the responsibility for feeding back to the infection control specialists (despite our attempts to involve other kinds of Board level staff).

Therefore, it is possible that the way in which the guidance is written or the 'level' at which it is pitched makes it difficult to Boards to engage with it in the way that NICE and the HPA might have intended. For example, some practitioners thought that it was not 'high-level' enough to make it general guidance or principles for secondary care, whilst not being specific enough for it to be of use to the ward level staff to whom implementation will be delegated. Many practitioners with experience of wards thought that a 'toolkit' of best practice might be more useful for them.

Other practitioners thought that there were parts of the advice that might be of greater relevance to boards could have been emphasised more, e.g. boards were thought to be very important for driving forward multi-agency work with their stakeholders (quality statements 4 and 6) and for providing adequate resources to support infection prevention and control (the importance of analytical capacity, to support the interpretation of surveillance and other data to a wider group of staff, was thought to be of particular importance by many focus group participants).

Some practitioners raised different ideas for inclusion in HCAI advice that differed from the general content of the draft advice, for example:

- some practitioners thought that the advice ought to mention that bed blocking was a major cause of HCAI, and therefore boards ought to focus on reducing it - many patients who are medically fit acquire a hospital infection while waiting to go home or be transferred to a non-clinical setting; and
- some practitioners in secondary care wanted a greater focus on the importance of sharing best practice among clinical leaders so that effective practices were disseminated throughout the NHS. It was thought that Boards or commissioners might help to facilitate these discussions.

3.1.6 To varying degrees, most practitioners thought that their organisations were already implementing the quality statements and adhering to the general spirit of the advice

Many practitioners, among both the focus group and survey participants, thought that their organisations were in agreement with, and compliant with the headline quality standards and the overall spirit of the advice. This is encouraging, although it should be noted that the organisations with whom we managed to consult in the focus groups scored well in the 2009 / 2010 CQC compliance process. Nevertheless, when prompted, practitioners said that even those (few) organisations where concerns had been identified by the CQC would have gone through a process of putting things right over a year ago. Trusts had also gone through a process of implementing the Health and Social Care Act Code of Practice, although in the case of detailed measures, outcomes and audit procedures, practice differed according to what was locally appropriate. Among many focus group participants, there was a broad consensus that the draft advice was somewhat 'out of date'. As with our other findings, practitioners referred frequently to existing sources of guidance and the overlap with the draft advice:

"Much of this is covered by the Code of Practice in principle, yet the standards do not relate directly to the Code of Practice. One would assume that if you are compliant with the code (required for CQC registration) then you meet the standards [in the draft NICE and HPA advice]. The standards should be able to support and provide evidence of compliance with the code"

(infection prevention manager / commissioner, Primary Care Trust, survey)

"Most of the principle [sic] statements are sound but as previously stated this is duplication of work already undertaken to demonstrate compliance with the Health and Social Care Act 2008. Most of the standards (1 2 3 4 6 7 9 10 11) are already evidenced well for compliance with the Health and Social Care Act 2008. With regard to number 12, most trusts will evaluate the existing literature and act according to published guidance"

(Director of infection prevention and control, specialist Foundation Trust, survey)

Some practitioners were more welcoming of the spirit and intentions of the advice, but thought it to be of limited use unless there was more 'stretch' and NICE and the HPA were thought to be able to usefully provide a synthesis of evidence-based best practice that could take Trusts further than simply complying with existing guidance. Senior clinical managers in at least two of the focus groups thought that they were already ahead of the draft advice in their current practice (albeit in large teaching hospitals generally considered to have international reputations).

"My worry is that if it's repetitive, it's going to be something that nobody really takes any notice of. If it's slightly different and there's some stretch in it then people will use it to develop practice"

(Associate Director for infection prevention and control, specialist Foundation Trust, focus group)

One practitioner suggested that a greater emphasis on the collection and effective use of 'soft intelligence' could be useful in taking the draft advice further:

"Organisations have to demonstrate what they are compliant with. For ourselves – compliant with the code of practice as the indicator, and you gather your soft intelligence as well as your hard data to support that – as a lead for infection prevention and working with the equality monitoring team that's her role to gather that soft intelligence and look at how they are performing and how they are improving quality care. Advice reinforces what is already there. Great to have this but can see that some people would cherry pick out some statements. Got something already in place that works very well – compliance with the code of practice covers a whole range of infection prevention issues from governance, care delivery, to facilities and estates"

(Commissioner, Primary Care Trust, focus group)

3.1.7 Many of the structures and measures were welcomed, but practitioners thought that implementing the advice in full – in particular, collecting evidence for all the proposed outcomes – was not a good use of limited resources

As already discussed above, it was generally thought that many of the detailed measures and outcomes were already implemented in current practice; however some of the remaining suggestions for implementing / evidencing the draft quality statements were not all that useful or appropriate (specific details that were mentioned by practitioners are outlined in the statements below). Therefore, many practitioners in the focus groups and surveys were unsure whether the advice would lead to any improvements in current practice. Again, it should perhaps be borne in mind that this feedback came from staff that would have responsibility for implementing the advice:

"They will not lead to improvements as we already do most of these things and to a high standard. Some of the structure statements in the text are unreasonable or impracticable which makes the whole unworkable without significant reworking"

(Director of infection prevention and control, specialist Foundation Trust, survey)

In the statements and measures suggested for some of the draft quality statements, it was thought that the added value of collecting more evidence would not be worth the added effort / cost, diverting resources from other infection prevention activities. The statement below was typical of many focus group respondents, who thought that most of the suggested outcome data in the draft advice *could* be collected, while questioning the desirability of collecting it. It was thought that Trusts could be overwhelmed by data, which would not be useful, without the dedicated extra resource to analyse it meaningfully:

"Collecting numerator, denominator data is possible in most cases but would require massive effort for no obvious gain … Ultimately the changes proposed threaten a diversion of resources towards auditing from areas of greater need"

(Consultant in infectious disease, Foundation Trust, focus group)

3.2 Findings from the survey – multiple choice questions

The supplementary findings from the survey, drawing on the multiple choice questions agreed by GHK and NICE, largely reflect the ambivalent attitude of practitioners that responded to our consultation. It is possible that they display some negative bias, in that practitioners who were less satisfied with the draft advice might have been likely to respond – but it is nevertheless useful to consider the overall response.

The tables below display the quantitative results of the electronic survey for questions regarding the usefulness, likely impact and ease of understanding of each quality statement[1], as well as the advice as a whole. We do not know whether respondents read the advice in detail, and commented on (for example) the usefulness of the statement text only, or the full statement including the structures and measures. It is possible that negative responses may also reflect the confusion amongst practitioners that was evident in the focus groups, as to the purpose and intentions of the advice as a whole; their response might have been different had the advice been explained to them more fully, or framed in a different way.

Electronic survey respondents represented 33 separate organisations in total. **18 of the 39 respondents worked at a Foundation Trust**; the rest (21) came from non-foundation NHS Trusts, Primary Care Trusts (commissioners) or private providers. Responses to all these quantitative questions were broadly similar across the senior manager, manager and frontline practitioner groups.

[1] The 'All' column in each table represents participant responses to specific questions asked about the advice document as a whole (it is not a mathematical average applied by our researchers *post hoc*).

Participants reported that their **understanding of the quality statements was low**. Of the 33 that responded to this question for the advice document as a whole, more than half (18) stated that they didn't understand the text at all. 36% understood some of the text, while just 9% understood 'most of the text' or 'the whole text very well.'

Quality statement 2 was the least well understood, with 75% reporting no understanding at all. Quality statement 6 was the best understood. 35% of those who responded had some understanding of this statement, with a further 12% professing to understanding most or all of it. However, nearly half (47%) still reported that they didn't understand the text at all.

Table 3.1 Electronic survey responses– How would you rate your understanding of the quality statements?

	All	1	2	3	4	5	6	7	8	9	10	11	12
I don't understand this text at all	18	23	27	25	22	21	18	21	21	23	23	22	21
I understand some of the text	12	11	8	9	8	8	12	10	9	10	7	11	10
I understand most of the text	2	3	1	2	3	4	3	1	2	1	3	1	2
I understand the whole text very well	1	0	0	0	2	2	1	1	1	0	0	0	1
No response	6	2	3	3	4	4	5	6	6	5	6	5	5

Participants felt that **the draft statements as a whole were not useful.** The level of response to this set of questions was lower – perhaps as a result of research fatigue after having responded to the questions on understanding. Of the 31 people who responded, more than half (54%) reported that the quality statements as a whole were not at all useful. 35% found the statements not very useful, while only 6% found them somewhat or very useful.

Statement 11 was the least useful, with 75% of the 32 valid responses reporting that it is not at all useful, and only 3% claiming that it is somewhat or very useful. Statement 4 was considered most useful. 12% considered it somewhat useful, and a further 4% very useful. It also had the fewest responses of the individual statements for 'not at all useful,' at 54%. However, 84% of respondents still considered this recommendation to be either not at all or not very useful.

Table 3.2 Electronic survey responses– How useful are the quality statements to you?

	All	1	2	3	4	5	6	7	8	9	10	11	12
This is not at all useful to me	17	18	21	19	17	18	20	23	17	21	22	24	17
This is not very useful to me	11	12	9	10	9	10	10	5	10	10	8	7	12
This is somewhat useful to me	1	1	1	2	4	2	1	4	4	0	1	0	1
This is very useful to me	1	1	1	1	1	1	1	1	1	1	1	1	2
I don't know	1	0	0	0	0	0	0	0	0	0	0	0	0
No response	8	7	7	7	8	8	7	7	7	7	7	7	7

Electronic survey respondents felt that **the quality statements would have either a detrimental effect on practice or no effect at all.** Of the 29 respondents who expressed an opinion on the statements as a whole, 41% claimed they would be detrimental to practice, while a further 45% reported that they would not enable a personal improvement in practice. Just 14% stated that the quality statements would enable a slight improvement in practice, while no respondent felt that any of the individual quality statements, nor the document as a whole, would enable them to improve a great deal.

Statement 10 was thought by the most to be detrimental to practice; while relatively few thought the same of Statement 3 (28%). Statement 3 was the most well received on this metric, though overall opinion is still poor. The majority of respondents felt that either it would not enable an improvement (45%) or would negatively affect practice (35%).

The response level for the questions on impact was marginally lower than those for usefulness, at around 77% of the total number of electronic survey participants. The set of questions on understanding had the highest level of responses, at 87%.

Table 3.3 Electronic survey responses– What effect would the quality statements have on your practice?

	All	1	2	3	4	5	6	7	8	9	10	11	12
This is detrimental to my practice	12	14	13	11	13	13	13	14	8	16	17	15	16
This will not enable me to improve	13	11	13	14	11	11	13	13	19	12	11	12	11
This will enable me to improve a little	4	6	5	6	6	6	5	2	4	3	3	4	4
This will enable me to improve a great deal	0	0	0	0	0	0	0	0	0	0	0	0	0
I don't know	1	0	0	0	1	1	0	1	0	0	0	0	0
No response	9	8	8	8	8	8	8	9	8	8	8	8	8

3.3 Implications for NICE

3.3.1 Greater clarity on how this advice relates to CQC standards, the Health and Social Care Act Code of Practice and other key documents would be welcomed

The main findings relating to the advice as a whole suggest that it is important that there is greater clarity on the links between the quality statements and their various components, and existing sources of guidance (principally the Health and Social Care Act Code of Practice, and CQC standards). The amount of perceived overlap and duplication was at the root of many practitioners' concerns outlined above, including the lack of understanding about the purpose of the advice. This response was typical:

"There should be direct reference to the Health Act Code of Practice on the prevention and control of infections and related guidance. The clinical guidance [i.e. the advice] should be set out to mirror the duties listed in the code"

(Clinical risk lead / commissioner, Primary Care Trust, survey)

3.3.2 Practitioners thought that alternative formats such as a 'toolkit' might improve the clarity of the advice. Some wanted the advice to go further than existing guidance or focus on areas of practice that were not covered in existing guidance; the advice was also perceived to be too long. Greater clarity about the purpose and intentions of the advice would help

Practitioners suggested various means of making the advice more clear and more useful, although there was little in the way of a strong consensus on how this ought to be done. Although many practitioners thought the draft advice to be too long, some others wanted more detail on particular aspects (see subsequent sections of this report). Some frontline practitioners, DIPCs and those with infection control responsibilities wanted the advice to be more of a 'toolkit', as the advice would be passed on to them by Boards to implement:

"We need less of these documents and more practical help"

(DIPC, Foundation Trust, survey)

Some other practitioners pointed out that the format of the advice differed from other clinical standards or guidance produced by NICE, perhaps suggesting a need for greater clarity on the potential role of 'advice'. Some other frontline staff thought that the advice should be based on an overarching theme, such as communicating with patients that they thought to be lacking the current sources of guidance (see also section 3.1.5 above). These two comments are taken from the same focus group:

"If it was half the size and more focused on patient outcomes, we would pay far more attention"

(Lead nurse for infection control, specialist Foundation Trust, focus group)

"The trust is already regulated in every respect covered by this document. This makes the document very repetitive. We have a raft of guidance for infection control. We don't need more guidance, we need something different that's more patient focused … My gut reaction is there are elements of this that I want to move forward because it does give me more detail at ward level and is saying more about the patient"

(Associate DIPC, specialist Foundation Trust, focus group)

The possible benefit of focusing on specific parts of the advice where existing guidance is less adequate or where some 'stretch' would be beneficial was also highlighted by some survey respondents:

"Use an non garonistic [sic: jargonistic] language that the average health care work[er] can understand and would talk about … It would be nice to see something that say , Treat a patient as you would wish for you or your own. Cleanliness is a courtesy and is common sense. Our trust had a significant problem and most of the things put into place are based around courtesy, common sense and not rocket science. Our figures have dramatically improved. [The] Evidence base should be nationally driven. This should be the role of the HPA/ NICE"

(Consultant physician in intensive care and DIPC, Foundation Trust, survey)

"There is too much emphasis on HCAI as caused by particular species of bacteria, ignoring the problems related to use of devices, procedures etc. I suggest requirements for surveillance of device/procedure related infections, while they may be difficult to fulfil, would be useful in directing further improvements"

(Consultant microbiologist and DIPC, Foundation Trust, survey)

Some suggestions were made by practitioners for merging or condensing the draft quality statements. There was little in the way of overarching consensus on which quality statements could better belong together, although it was thought by many practitioners that statements 2 and 3 (on different aspects of communication) were difficult to distinguish, and that statements 2 and 6 (the latter partly concerns communication in admission, discharge and transfer procedures) covered some of the same topics.

3.3.3 Practitioners thought that in some cases, the terminology used throughout the advice could be made more precise. For example, some of them felt 'HCAI' was ambiguously defined

Some practitioners also highlighted parts of the draft quality statements where terms were ambiguous or open to interpretation (however, this should be balanced against the views of other practitioners who thought that some of the structures and measures were over-prescriptive – see section 3.1.7). For example:

"One person's definition of 'regularly' is different to another's … in fact the term really depends on what you are looking to achieve"

(Microbiologist, Foundation Trust, focus group)

"In terms of there being a clear definition of HCAI, there is a difference between what is reportable and what is clinically relevant"

(Pharmacist, Foundation Trust, focus group)

"I think I understand most of the statements, but they really need a plain English translation - what is a culture of "continuous quality improvement"? - probably [it means] always asking I am/are we doing this well and could I/we do it better?"

(Consultant microbiologist in communicable diseases, generalist NHS Trust, survey)

A further idea that was suggested in some of the survey responses would be to separate out the elements of greater relevance to boards, and those of greater relevance to wards and clinicians' practice; this general 'tension' between the overarching themes of the headline quality statements and the detail of the structures and measures was also highlighted by some of the focus group practitioners:

"It seems there are two elements mixed up in the document – things that are done nationally, and things done at a clinical, ward level. These need to be separated out to make it less muddled"

(Pharmacist, Foundation Trust, focus group)

3.4 Key changes proposed by practitioners

Quality Statement	Changes proposed by practitioners
For the advice as a whole	▪ Introduce greater references to existing sources of guidance throughout the draft advice so that the links and overlaps are clear ▪ Give greater emphasis to the status and purpose of 'advice' as a tool and how it differs from targets / mandatory reporting, other NICE products and existing guidance on HCAI ▪ Shorten the advice to make it more relevant to its target audience – perhaps those sections most relevant to Boards could be separated from those relevant to the frontline. Some of the detailed measures and outcomes might require revision ▪ Clarify certain terms, especially where existing guidance might suggest a standard or definition in place e.g. 'regularly' or the term 'HCAI' itself ▪ Focus on those parts of the advice that could add value – for instance, things of particular importance to Boards e.g. multi agency working or promoting integrated care or the sharing of best practice ▪ Focus on advice that could 'stretch' and improve existing practice in Trusts that are already complying with the Health and Social Care Act Code of Practice e.g. improving patient communication or reducing bed blocking ▪ Clarify how this advice applies to private sector providers ▪ Recognise that in practice, Boards are most likely to delegate the detail of implementing this advice to DIPCs and other leading specialists in their organisations.

4 Quality Statement One

Quality Statement 1: HCAI Surveillance

Draft Quality Statement: Secondary care trusts have a surveillance system in place to gather data and monitor HCAIs. The data collected is used to inform responses to HCAI incidents in a timely and appropriate manner.

Draft quality measures:

Structure:

- Evidence of an adequately resourced local surveillance system with specific objectives and priorities which clearly defines and detects HCAI organisms and conditions and promptly registers any abnormal trends.
- Evidence of clearly defined responsibilities for the recording, analysis, interpretation and communication of surveillance outputs.
- Evidence of arrangements for regular review of the surveillance programme to ensure it supports the trust's quality improvement targets for infection prevention.
- Evidence of fit-for-purpose IT systems to support surveillance activity.
- Evidence of data validation processes that ensure data accuracy.
- Evidence of access to resources that can analyse and interpret surveillance data in meaningful ways.
- Evidence of surveillance systems that allow data from multiple sources to be combined in real time (epidemiological, clinical, microbiological, surgical and pharmacy).
- Evidence that surveillance systems capture post-discharge infections and provide data to improve infection prevention and control by other local health and social care organisations.
- Evidence that systems are in place for timely recognition of incidents through regular analyses over different spaces (for example, wards, clinical teams, clinical areas, the whole trust).
- Evidence that each ward has a register for every HCAI case, collected prospectively in a standardised format that is consistent with the trust's surveillance arrangements.
- Evidence of an arrangement for reviewing the case register on a regular basis to identify any infection trends that require investigation.
- Evidence of a process for surveillance outputs to feed into accountability frameworks, inform audit priorities and set objectives for quality improvement programmes in relation to HCAI prevention.
- Evidence of surveillance outputs being analysed alongside comparison data to ensure continual improvement.

Process:

- Evidence of dissemination of timely surveillance data reports to all relevant stakeholders in an understandable and useful format.
- Proportion of units (for example, ward, clinical speciality) with accurate, up-to-date surveillance data:

Numerator: Number of units within the trust with accurate, up-to-date surveillance data available

Denominator: Number of clinical units within the trust.

- Proportion of wards with an up-to-date, accurate HCAI case register:

Numerator: Number of wards within the trust with up-to-date, accurate HCAI case register

Denominator: Number of wards within the trust.

- Proportion of reporting periods when trust's mandatory and voluntary infection

surveillance data was reported to Health Protection Agency (HPA)

Numerator: Number of reporting periods over the last 12 months where voluntary and mandatory infection data was reported to Health Protection Agency

Denominator: Number of reporting periods over the last 12 months.

- After discussion of surveillance outputs actions are taken/changes in practice result.
- Are surveillance outputs fed into the setting and monitoring of local quality improvement objectives?
- Proportion of clinical units with surveillance outputs feeding into HCAI quality improvement objections:

Numerator: Number of clinical units within the trust with surveillance outputs feeding into HCAI quality improvement objectives

Denominator: Number of clinical units within the trust with surveillance outputs.

- Is there a monitoring system in place to ensure surveillance outputs are being analysed alongside comparison data?

Description of what the statement means for each audience:

Service providers ensure effective surveillance systems are in place to capture and monitor HCAIs and take appropriate action.

Healthcare professionals are aware of local surveillance procedures and documentation on HCAIs and have access to up-to-date information on HCAI levels within their unit.

Commissioners ensure commissioned services include appropriate surveillance systems for monitoring HCAIs.

Trust board and managers ensure adequate resources are available for local surveillance system and the analysis and interpretation of surveillance data.

People using secondary care services expect staff to be aware of HCAI levels within the trust and expect that they are taking action to prevent them.

Relevant existing indicators:

- VSA03 – Incidence of *C.difficile*
- PS39 – Incidence of MRSA bacteraemia
- HC21 – Surgical site infections – orthapaedic

Source document references:

National Audit Office (2009) Reducing Healthcare Associated Infections in Hospitals in England p53, 54, 55

Department of Health (2010) The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance p14, 34

Healthcare commission (2007). Healthcare associated infection: what else can the NHS do? p53, 54, 58

British Medical Association (2009). Tackling healthcare associated infections through effective policy action p14, 26, 29

Expert consensus

4.1 Findings

4.1.1 Practitioners already collect surveillance data (to varying degrees) and it was thought that the draft quality statement could have done more to address specific gaps in Trusts' current practice. Analytical capacity at the local level was thought to be very important for interpreting additional surveillance data, if this was to be collected

The majority of practitioners said that they already collect surveillance data and they were broadly welcoming of the spirit of the draft quality statement; they were largely unsurprised by its content. Data that is collected varies from Trust to Trust. For example, focus group participants from one Trust said that they collected MRSA and MSSA data, while others already collected data on surgical site infection. However, it was thought that national surveillance systems were only part of good practice and that Trusts also needed to be vigilant for specific infection related problems at Trust level:

"There are enough national bodies looking at surveillance telling us what to do. What this needs to do [i.e. what the advice should help with] is get down to the patient detail with other infections that are not on the national radar that are pertinent to the trust. It's going to be different everywhere."

(Associate Director, Specialist Foundation Trust, focus group)

Those with good surveillance systems have an advantage:

"Experience shows those trusts with good data capture and communication systems can identify risks sooner, make infection prevention everyone's business as those in the clinical areas know their data and are more likely to act on risks. This is also appropriate at board level as clear and accurate data can be trusted and understood in context." (HCAI Programme Specialist, Strategic Health Authority, Survey)

Practitioners felt that this statement did not add anything new, and did not further their knowledge or practice by defining HCAI more precisely, in a way that might focus Trusts' attention on anything other than national monitoring and surveillance:

"It's focused on a narrow part of HCAI. It doesn't acknowledge the breadth of all the things they do in this area e.g. wounds or cellulitis that get out of hand."

(Associate Director, Specialist, focus group)

For example, one practitioner said there is a difference between urinary tract infections, chest infections and the implications for monitoring at a Trust wide level. Therefore some practitioners called for a relevant minimum data set, as one Trust had already put in place.

Concern that the quality statement as a whole was insufficiently precise to lead to improvements was also expressed throughout. Although there are processes in place to collect surveillance data in the Trusts that we spoke to, not all Trusts have this data immediately to hand. Other Trusts may not have the level of knowledge of how many cases they have and where they have had them. This was also raised in the survey, where:

"Most trusts have little idea what surveillance really entails. Few monitor HCAI in any detail outside the mandatory requirements. This results in small problems becoming major issues because they are not noticed in a timely fashion, with the consequences for patients of increased morbidity and mortality. This statement needs much more detail (perhaps an annex) on exactly what is required."

(Consultant Microbiologist and CCDC, Foundation Trust, Survey)

Therefore, if improved, this quality statement could act as leverage to some acute Trusts that do not have better developed internal reporting (and learning) functions; for some practitioners it could be 'aspirational' and act as a spur to collect better surveillance data. However, this should be balanced against the concerns of some practitioners that the suggested measures were poorly defined (i.e. 'what is an HCAI?' or the concerns about an added burden on practitioners outlined in section 4.1.3 below).

The issue of analytical capacity was raised on several occasions within the focus groups, (i.e. that surveillance is only useful if there are sufficient staff who understand that data). Expertise was thought to be needed:

"It can be a challenge to present that in a way that is understandable for people who are not involved with infection control. There is no point of having data that isn't understandable and communicable"

(Infection control practitioner, Foundation Trust, focus group)

4.1.2 The statement was too broad and the overlaps with existing documents made it difficult for practitioners to see where the draft advice was proposing distinct or new ideas, as they expected. Practitioners found it difficult to understand what was proposed

The quality statement was described as too broad or vague by the majority of practitioners to add value to existing practice, as already highlighted above. Moreover, the quality statement overlaps with existing frameworks, such as the Hygiene Code and the Health and Social Care Act as highlighted in 3.1.2.

The majority of practitioners highlighted that the language and terms used in draft quality statement one was vague, for example, an 'adequately resourced local surveillance system' was not clear about what specific resources would be considered 'adequate'.

Some practitioners also pointed out that the advice also should mention that responsibility should lie at all levels and not just infection control. This is important when the culture of an organisation may not have adopted this approach.

4.1.3 However, some of the processes and outcomes were thought by many practitioners to be too prescriptive or burdensome; secondary care practitioners did not want to be made responsible for collecting data on the parts of the patient pathway outside their Trusts

Although it was generally agreed that more specific information on 'what to monitor' might be useful, some practitioners felt that the form of many of the processes and outcome measures were not practical. There were questions about who would collect the data, particularly when the patient has been discharged. The patient journey is very complex and there is an issue of them picking up infections in other settings:

"The patient journey is quite complex. They come into hospital for 2 days and then back out into the community. How do we know if they acquired the infection in hospital?"

(Pharmacist, Foundation Trust, focus group)

Therefore, many practitioners expressed concern about how far one could follow up a patient journey when acute Trusts had no control over part of it. This issue was also raised in the survey responses, as secondary care is only one part of the patient journey and therefore there is a need to include other health and social care providers. One practitioner said:

"We can't collect all data, this is too big."

(Pharmacist, Foundation Trust, focus group)

The suggestion in the draft advice about ward-level data was thought to be impractical at odds with best practice in the view of some specialists.

"To keep a record in a register on each ward would be cumbersome. To have a central system where HCAIs can be filtered for audit would be more useful and practical."

(Nurse Consultant Infection Prevention and Control, Foundation Trust, Survey)

Some practitioners also raised concerns over sharing information and investing in coherent IT systems, as they are different in different organisations:

"It [the quality measures] talks about IT systems, but the problem is we all have different IT systems ... this is where the uniformity could be usefully drawn in."

(Consultant Microbiologist, Specialist, Focus group)

4.2 Key changes proposed by practitioners

Quality Statement 1	Changes proposed by practitioners
	▪ Introduce greater references to existing sources of guidance throughout the draft advice so that the links and overlaps are clear ▪ Further emphasise the importance of analysis and interpretation of surveillance at local level, and that responsibility for good surveillance lies at all levels in the organisation ▪ Revise the processes and outcome measures so that they are feasible (e.g. ward level data may be impractical for some), while perhaps also giving clearer definitions and detail about terms such as 'adequate resources', or what evidence states are important HCAI to be monitored

5 Quality Statement Two

Quality Statement Two: General Communication

Draft Quality Statement:

Trusts ensure there is clear communication about HCAI infection risks and prevention for all staff, patients and carers.

Draft Quality Measures:

Structure:

- Evidence of ongoing and timely dialogue with patients and their carers throughout the care pathway regarding HCAI risks and prevention measures.
- Evidence that patients and their carers have access to up-to-date, accurate and accessible information about HCAI and any potential risk of infection.
- Evidence that arrangements are in place to identify and communicate about infection risks as the patient moves between providers and settings.
- Evidence of the availability and use of standardised patient and carer information on infection prevention and control within all local health organisations.
- Evidence of the availability of standardised, appropriate information on infection prevention and control which is used by all staff.

Process:

- Audit of communication between different health and social care providers (for example, discharge summaries to GPs, admission letters from care homes).

Description of what the statement means for each audience:

Service providers ensure all patients and staff have access to accurate information in an appropriate format.

Healthcare professionals have current information and surveillance data on local HCAI levels and risk, and communicate the risk and prevention measures to patients.

Commissioners ensure commissioned services include arrangements for communicating in a suitable format with staff, patients and carers about HCAI.

Trust board and managers ensure systems are in place for timely dialogue on HCAIs with patients and the public and to address any gaps in staff training identified during appraisals or in PDPs.

Patients and their carers in secondary care can expect accurate information about HCAI risks and prevention measures, in a format they find easy to understand.
Relevant existing indicators
None Identified.

Source document references:

Department of Health (2010) The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance p22

5.1 Findings

5.1.1 The majority of practitioners said that communicating well with patients and staff is a priority for them; however, evidencing this in an effective way is challenging

The majority of practitioners said it is standard practice for Trusts to focus on communicating effectively with their staff and patients. It was thought to be important to provide good quality information, not only because it benefits patients but because potential wider implications (the role of the media in health 'scares' was mentioned). However, some practitioners

pointed out that evidencing this can be difficult for a number of reasons. For example, patients are in a stressful situation and are increasingly in hospital for a short period only, making the quality of communication more difficult to measure. In particular, auditing the communication between different health and social care providers (see feedback for draft quality statement 3) was thought by many practitioners to be very difficult. Measuring information that patients receive when they first come in was suggested instead by some staff.

Some staff thought that an emphasis on patient communication in the quality statement and its importance was helpful. Although staff within Trusts do communicate with patients about HCAI, it is not done at all levels – therefore, some practitioners that we spoke to thought that this was a learning and development issue, best considered alongside that statement:

"It centres on people's knowledge and that is at ward level and how they convey that to a patient. That is not done well at all grades."

(Deputy Chief Nurse, Foundation Trust, Focus Group)

Practitioners pointed out there was an overlap with statement 6 and therefore thought that sharing information about patients with other clinicians was also important:

"Currently all patients should be discharged with a letter to their GP stating what has happened in hospital. This also applies to inter hospital discharge. They recognise that it is important to share information with clinicians about infection and being specific about what infections that this covers."

(Consultant Nurse, Foundation Trust, Focus Group)

5.1.2 The majority of practitioners said that there are overlaps with other quality statements, which made it more difficult to understand the advice

- Draft quality statements 3 (strongly) as well as 6 and 8 (less so) within this advice
- 'Saving Lives', the Hygiene Code and the Health and Social Care Act (this is relevant for most of the draft quality statements)

5.1.3 Practitioners raised some concerns regarding implementation (e.g. would auditing communication distract from learning about it?), and some gaps were identified, such as mention of carers

Some practitioners also raised the issue of whether implementing this draft quality statement would distract from learning how to improve communication, and questioned whether it would be suitable for many audiences among hospital workers:

"many don't read essential polices, and this [advice] can be heavy reading in places"

(Infection Control Nurse, Foundation Trust, survey)

Furthermore, they also said that if structures are not mandatory, then the advice will be low on the list of priorities.

Furthermore, some practitioners wanted to see more detail here as to how knowledge should be disseminated among staff (this is perhaps more relevant to quality statement 5) and others stated that mention of carers was absent (this is mentioned in draft quality statement 3).

5.2 Key changes proposed by practitioners

Quality Statement 2	Changes proposed by practitioners
	▪ Resolve various issues around overlap with draft quality statements 3, 6 and 8; linking in communication skills to learning and development may be helpful ▪ Evidencing the quality of communication is challenging, and more thought may be required on how best to do this (see draft quality statement 3)

6 Quality Statement Three

Quality Statement Three: Communicating with patients affected by an HCAI

Draft quality statement:

Trusts ensure there is clear communication about HCAI infection with all affected patients and their carers throughout the care pathway.

Draft quality measures:

Structure:

- Evidence that patients and their carers have access to up-to-date, accurate and accessible information about their own HCAI, and treatment and control measures.
- Evidence that arrangements are in place to communicate about infection risks as the patient moves between providers and settings.
- Evidence that staff are trained to (and can) communicate in an appropriate manner with patients and their carers about how to reduce the harm from HCAIs.

Process:

- Audit of patient records for communication about infection (for example, MRSA status, presence or absence of diarrhoea) throughout their hospital episode.
- Audit of communication between different health and social care providers (for example, discharge summaries to GPs, admission letters from care homes).
- Proportion of patients with an HCAI whose discharge information gave details of the HCAI:

Numerator: Number of patients with an HCAI discharged from trust whose discharge information gave details of the HCAI

Denominator: Number of patients with an HCAI discharged from trust.

Description of what the statement means for each audience:

Service providers ensure patients with an HCAI receive accurate information and relevant advice in an appropriate format throughout their hospital episode.

Healthcare professionals communicate with those who have an infection about the impact it will have on their care.

Commissioners ensure services include arrangements for communicating about HCAI in a suitable format with patients and carers.

Patients and their carers in secondary care who are diagnosed with an HCAI expect accurate information about their infection and any impact it may have on their care, in a format they find easy to understand.

Relevant existing indicators

None Identified.

Source document references

Department of Health (2010) The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance p22

6.1 Findings

6.1.1 Practitioners were broadly supportive of the aim of communicating clearly with patients; they thought that the standards for good communication with patients with HCAI were the same as those for other patients. Communication with patients affected by HCAI was thought to be good within the organisations where we held focus groups

Practitioners generally thought that their practice regarding communication within and between hospitals had improved in recent years and was high quality. Many practitioners based in the acute Trusts that we consulted with, agreed that there was an issue regarding partnership work with community care and the time it takes to organise discharge from hospital, communicating with GPs, social care staff and other care agencies within the community. Some of the survey responses wanted to see a stronger emphasis on the involvement of these parties within this statement or statement 4.

Some practitioners argued that the expectations for communicating with patients with HCAI were covered by the same standards that they would expect to be met for communication with all patients.

Some other frontline staff thought that in general, the advice would add greater value to existing practice if it focused more on how communication with patients could be improved; they thought this to be lacking the current sources of guidance. For example:

"If it [the advice] was half the size and more focused on patient outcomes, we would pay far more attention"

(Lead nurse for infection control, specialist Foundation Trust, focus group)

6.1.2 Practitioners raised concerns about the processes and auditing mentioned in this quality statement; it was thought to be time consuming

Many practitioners raised several concerns about who would do the auditing and how it would work in practice, as it was thought to be very time consuming and challenging to implement as it would involve examining the notes of many patients throughout their episode and at discharge:

"My concern is that the numerator/denominator here would require a huge amount of work – probably more than a full time employee – and to what benefit?"

(Infectious diseases physician, Foundation Trust, focus group)

"I feel that the numerator would be very difficult to collect."

(Pharmacist, Foundation Trust, focus group)

"It would be 'humongously' time consuming. It is an unrealistic expectation"

(Consultant microbiologist, specialist Foundation Trust, focus group)

The majority of practitioners thought that it would be difficult to measure one of the proposed processes, when acute Trusts are not responsible for the quality of admission letters from care home (this is also relevant for other draft quality statements). They often referred to the need for more effective action across the different agencies in this field (draft quality statements 4 and 6). As one practitioner put it:

"*There needs to be a distinction made between what is going to improve standards and what is worth measuring*"

(Commissioner, Primary Care Trust, focus Group)

Some practitioners felt that it was not practical to audit patient records for communication to prove that patients' understanding had increased. Difficulties with auditing patient feedback and monitoring the quality of communication were acknowledged by some practitioners, but it was also felt that these applied to all patients regardless of HCAI status.

Some practitioners pointed out that there were standard tools such as inter-healthcare transfer forms. Some of the Trusts in which we carried out focus groups with had worked

with other local partners to develop a uniform version of a transfer form across their local health economy that had been developed as a consequence of the Code of Practice. However, this did not necessarily mean that external partners (care homes, GPs etc.) filled these in correctly.

One Associate Director suggested measuring soft outcomes regarding patient communication; however, this would require further resources to review and assess this. Finally, some practitioner said that consideration should be given to using the information from the national inpatient survey; perhaps it might be more helpful for policymakers to focus on HCAI in that tool, and for Trusts to draw on that existing source of information about patient satisfaction.

6.2 Key changes proposed by practitioners

Quality Statement 3	Changes proposed by practitioners
	▪ Resolve various issues around overlap with draft quality statements 2, 6 and 8; linking in communication skills to learning and development may be helpful ▪ Evidencing the quality of communication is challenging, and more thought may be required on how best to do this (see draft quality statement 2). The amount of auditing should be proportional to its added value ▪ Practitioners in acute trusts did not want to be held accountable for the quality of information produced by a range of partners in the context of admissions and transfers ▪ Mention could be made of the national inpatient survey as a means of collecting evidence for quality statement 3

7 Quality Statement Four

Quality Statement Four: Multi-agency working to reduce HCAIs

Draft quality statement:

Trusts work proactively with multi-agency collaborations to reduce HCAIs within local health and social care organisations.

Draft quality measures:

Structure:

- Evidence that an executive director has been nominated as the trust's lead and representative for a multi-agency collaboration to prevent and manage HCAIs.
- Evidence of support for, and participation in, joint working initiatives beyond mandatory or contractual requirements, to reduce HCAIs locally.
- Evidence of an agreed policy for data sharing on HCAIs between local organisations.
- Evidence of a defined, shared and agreed governance structure, with clear lines of accountability, with other local health and social care organisations.
- Evidence of support and participation in the development and implementation of a joint local strategy, policy and pathway on HCAIs between local health and social care organisations.
- Evidence of participation in the development of shared targets with other local health and social care organisations to reduce the harm from HCAIs.

Process:

- Documented terms of reference for multi-agency collaboration to reduce HCAI.
- Minutes of meetings of multi-agency collaboration demonstrating involvement of trust, plus any evidence of actions from meetings being undertaken.
- Audit of outputs from collaboration disseminated to relevant trust committees (for example, clinical governance, policy development groups).

Description of what the statement means for each audience:

Service providers work collaboratively with other local health and social care providers to reduce harm from HCAIs.

Healthcare professionals work towards implementing HCAI policies developed by a multi-agency forum for local health agencies.

Trust board and managers ensure an executive director is nominated as the trust's lead on multi-agency working to prevent and control HCAIs. In addition, they ensure that a governance structure is in place to allow multi-agency working and lines of accountability.

Commissioners ensure the providers of commissioned services work with other local health providers to prevent and reduce harm from HCAIs.

The public expects health and social care providers to work together to agreed objectives to prevent HCAIs

Source document references:

Group consensus

7.1 Findings

7.1.1 Current practice in multi-agency working varies and in the view of practitioners, could be improved. However, the quality of multi-agency working was thought to be difficult to measure

Draft quality statement 4 was mostly thought to be reiterating and emphasising a good idea. Many practitioners welcomed the notion that integrated care should be at the heart of preventing and controlling HCAI. Current practice varied and it was thought that more could be done to spread good practice. According to practitioners, some organisations worked effectively when it came to working with other organisations, but for some, it was a different picture:

"We don't work well with local community colleagues at the moment; relationships can be really quite difficult."

(Deputy Chief Nurse, Foundation Trust, focus group)

Some practitioners were also concerned about the current changes affecting commissioners:

"This is what we have been aiming for the past few years. It's what commissioners would have been expecting two or three years ago. We're moving to the next level, almost, concerning resolving boundaries with GP consortia."

(Associate Director, specialist Foundation Trust, focus group).

Improving collaboration was thought to be important for improving patient outcomes; an example was given of care homes refusing to readmit patients. However, some practitioners also acknowledged that organisations could improve the way that they gave feedback to other healthcare providers:

"There are enormous amount of patients that come in with infections that we need to be able to feed back in a better way"

(Commissioner, Primary Care Trust, focus group)

An important aspect of multi-agency working was thought to be the sharing of good practice; some practitioners wanted to see the advice emphasise this further, as a key role of Boards and commissioners (see section 3.1):

"This area [multi agency working] is going to become more and more important when budgets are reduced, etc, we can't evolve in terms of strategies and ideas for fighting infections moving forward, we need to spend our money wisely, so it would be useful to know what works and what doesn't work between organisations and teams rather than different Trusts trying different things and not communicating with each other."

(Hotel Services Manager, Foundation Trust, focus group)

Specifically, sharing practice might include arriving at common definitions for certain activities and policies; for example, it was mentioned that 'deep cleaning' can mean very different things to different organisations. Policies may also differ across different Trusts in the same local area.

In general, there were many concerns as to whether the proposed structures and processes could appropriately measure the quality of multi-agency working, as opposed to the existence of formal structures to support it. Many secondary care practitioners again raised concerns as to whether similar obligations / advice would apply to primary care:

"For this to work it would have to be reflected in the NICE community guidelines. It can't be one-sided...It can't be continually led by the acute teams."

(Lead Nurse, Specialist, Focus group)

7.2 Key changes proposed by practitioners

Quality Statement 4	Changes proposed by practitioners
	▪ Emphasise the importance of sharing good practice and working together and ways that this could be done ▪ Emphasise the important part that other organisations outside the acute sector need to play in preventing and controlling HCAI

8 Quality Statement Five

Quality Statement Five: Create a learning organisation

Draft quality statement:

Trusts use a range of sources to inform and drive continuous quality improvement to reduce harm from HCAIs

Draft quality measures:

Structure:

- Evidence that processes have been put in place to learn from experiences outside the organisation in relation to infection prevention and control.
- Evidence of regular and systematic reviews of learning from trust's own experiences on infection control. This is based on multiple intelligence sources and feeds into clinical and risk management processes.
- Evidence that mechanisms are in place to disseminate learning among staff groups.
- Evidence that actions have been completed and there has been a change in practice as a result of root cause analysis of infection incidents.
- Evidence that the continuous quality improvement cycle is informed by robust HCAI root cause analysis conclusions.

Process:

- Minuted responses to infection incidents/enquiries, with details of action to be taken locally.
- Local gap analyses performed on official reports and action plan developed to address identified gaps in local practice.
- Wards and units regularly review surgical patients post-discharge in relation to HCAI.
- Dissemination of relevant information to staff for shared learning.
- Range of forums for staff to learn from others' experiences in relation to HCAIs.
- Proportion of root-cause analyses disseminated to staff across the trust:

Numerator: Number of root-cause analyses performed which were disseminated to staff across the trust

Denominator: Number of root-cause analyses performed

Description of what the statement means for each audience:

Service providers provide forums for staff participation to learn from their own and others' experiences in relation to managing HCAIs.

Healthcare professionals take the opportunity to learn from experience and share learning with others in relation to reducing harm from infection.

Commissioners ensure commissioned services reflect their own experience of how to drive quality improvement and reduce harm from infection.

Relevant existing indicators

Quality improvement indicators:

- NRLS1 – Consistent reporting of patient safety events reported to the Reporting and Learning System
- NRLS2 – Timely reporting of patient safety events reported to the Reporting and Learning System (RLS)
- NRLS3 – Rate of patient safety events occurring in trusts that were submitted to the Reporting and Learning System (RLS)

Source document references

Healthcare Commission (2007) p49–56

National Audit Office (2009) p9, 11, 41

Group consensus

8.1 Findings

8.1.1 The draft quality statement was thought to be important, but many practitioners thought that it was a summary of existing requirements that were already implemented well, as a result of the Health and Social Care Act and other statutory guidance

The majority of practitioners said that there were already systems in place to meet the proposed structures in draft quality statement 5; these requirements were already part of the Health and Social Care Act and the 'Saving Lives' guidance. The following responses were typical:

"We already do this very well. We look at problems and make action plans. It is a very detailed process, what we do."

(Lead Nurse, specialist Foundation Trust, focus group)

"The structures are too broad to be useful"

(Infectious diseases physician, Foundation Trust, focus group)

Some practitioners raised a concern that too much focus on auditing numerical outcome measures concerning root-cause analysis might distract from interpretation and analysis of the key learning – the number of root-cause analyses was not considered to be equivalent of their quality; other practitioners wanted a greater emphasis in the draft quality statement on reflective learning and moving away from a 'blame culture':

"*This is to identify what is working and what is not working. It's about learning not blaming, it's about learning about infection control through peer learning and best practice."*

(Gynaecology nurse, Foundation Trust, focus group)

In particular, some practitioners said that the process concerning post-discharge review was impractical[2] or would require more resources to implement:

"How would a nurse be able to review patients post-discharge? This does not make sense."

(Lead Nurse, specialist Foundation Trust, focus group)

"It is not very clear and not many people do post-discharge surveillance – that is hugely in the future. That's not even a mandatory requirement of the HPA surveillance yet. You have to have a way of contacting the patient in the recovery process."

(DIPC, Foundation Trust, focus group)

[2] Authors' note: perhaps there was confusion about the terminology used, with the reference to post-surgical discharge not being clear enough.

8.2 Key changes proposed by practitioners

Quality Statement 5	Changes proposed by practitioners
	▪ Introduce greater references to existing sources of guidance throughout the draft advice so that the links and overlaps are clear ▪ Emphasise the quality and interpretation of RCAs as much as measuring their number, and the importance of moving away from a 'blame culture' ▪ Review the processes so they are clearer and explain how post-discharge surveillance might be accomplished

9 Quality Statement Six

Quality Statement Six: Admissions, discharge and transfer

Draft quality statement:

Trusts ensure agreed, multi-agency patient admission discharge and transfer policies provide clear, concise guidance to organisations on critical steps to take to minimise harm from HCAIs

Draft quality measures:

Structure:

- Evidence of an agreed admission, discharge and transfer policy for patients with infection for all agencies involved in the patient's care pathway, including local public health teams.
- Evidence that the agreed policy includes assessment, on admission for HCAI.
- Evidence that the agreed policy includes a requirement to assess patients on admission to check the likelihood that they will infect others with HCAI.
- Evidence of a procedure for documenting and sharing information about infections and transfer/isolation arrangements for patients during admission, transfer and discharge.
- Evidence of locally agreed arrangements to reduce infection risk when patients are moved within the same organisation and into other local health organisations.

Process:

- Proportion of admissions/transfers/discharges with HCAIs where policy was adhered to:

Numerator: Number of patients admitted/transferred/discharged where policy was followed

Denominator: Number of patients admitted/transferred/discharged.

- Number of adverse events recorded as a result of poor discharge/transfer of a patient with an infection.
- Regular audit of HCAI data at admission, transfer and discharge

Description of what the statement means for each audience:

Health service providers have an agreed procedure for sharing information when admitting, transferring or discharging patients with an HCAI.

Healthcare professionals are aware of, and follow, the locally agreed procedure for information transfer when admitting, transferring or discharging patients with an HCAI.

Commissioners ensure commissioned services include a local procedure for information transfer when admitting, transferring or discharging patients with an HCAI.

People with an HCAI in secondary care should expect information regarding their infection status to be passed on to relevant health and social care providers when they are admitted, transferred or discharged.

Relevant existing indicators:

None identified.

Source document references:

Healthcare Commission (2007) Healthcare associated infection: what else can the NHS do? p67–74

Department of Health (2008b) Going Further Faster II: Applying the learning to reduce HCAI and improve cleanliness p18

Department of Health (2010) The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance p15

9.1 Findings

9.1.1 Common admission, discharge and transfer policies were thought to be important, as not all Trusts had multi-agency policies. However, many practitioners thought the proposed auditing processes were impractical and /or of limited added value

Policies and assessments on admission for HCAI were in place across all the Trusts where we carried out focus groups, and practitioners mentioned that this was already a requirement the Code of Practice. However, current practice varied in whether the policies were agreed to between more than one organisation, and how the data was captured and audited. Many practitioners thought that the differences in wording between the structures mentioned here and the requirements of the Code of Practice might lead to confusion, as did the overlap between this and earlier quality statements (2 and 3). The term "locally agreed arrangements" was also thought by some practitioners to be ambiguous.

Many practitioners thought measuring and auditing adherence to the current policies in the manner suggested would be impractical and would be of limited value:

"There would be no added value in auditing admission, discharge and transfer."

(Infection Prevention and Control Lead Nurse, Foundation Trust, focus group)

"It is unrealistic to expect the figures mentioned to be collected. At the moment the agenda is about focusing resources on frontline, however this guidance is about back office data collecting and analysis."

(Clinician Specialist Infection Prevention and Control, Foundation Trust, survey)

A commissioner in one of the focus groups suggested that it might be more feasible if Trusts had electronic record keeping, a point that was also emphasised by a respondent to the survey:

"It is quite difficult to find the evidence without going through individual patient records and if they do not have electronic record keeping that is onerous and labour intensive. Then there is the problem of defining a HCAI. Good idea but onerous. [The] delivery bit is beyond the capability of many organisations."

(Commissioner, Primary Care Trust, Focus group)

"The biggest barrier is that some of our hospitals are still using hand written discharge forms, which can be very difficult to read. Often the information has not come through to the last copy which is the copy given to the patient or the care establishment going on to."

(Clinician Specialist Infection Prevention Control, Foundation Trust, Survey)

On the other hand, in areas that did not have them, implementing multi-agency policies was thought to be difficult, but not insurmountable:

"It may be difficult to set up in the first place due to the wide range of staff involved; a clear communication strategy would be needed for dissemination of the policies. Involving staff in the development and review of the policies would make them more likely to accept them."

(Infection Prevention Nurse, Foundation Trust, Survey)

Therefore there is variability between Trusts in practice, technology and infrastructure that can be a barrier.

The biggest problem with multi-agency policies was considered to be the number of agencies that would be involved; for example, there are gaps when patients go home and come back into hospital again, and it takes time for GPs to obtain information about discharged patients, review this, and pass it on when patients are readmitted (which may be to a different provider).

"The difficult part is ensuring the information is transferable to each organisation as there are so many different forms to fill in. Staff will not have enough time to fill it all out correctly. They send information and it is not passed on to the relevant staff who need to know it."

(Community Infection Prevention and Control lead, Foundation Trust, Survey)

Therefore, some practitioners said that good communication between clinicians was as important as form filling so that relevant information about HCAI was passed on.

9.2 Key changes proposed by practitioners

Quality Statement 6	Changes proposed by practitioners
	▪ Consider amending so that overlap with statements 2 and 3 is resolved; the link with the Health and Social Care Code of Practice also needs to be clearer ▪ Suggest ways in which difficulties surrounding paper-based communication might be tackled so that multi-agency policies can work ▪ Suggest removing the reference to the auditing of admissions, transfers and discharges as it is considered to be impractical ▪ Emphasise the importance of wider communication to prevent and control HCAI (link to statements 2 and 3)

10 Quality Statement Seven

Quality Statement Seven: Board-level leadership for HCAIs

Draft quality statement:

Trust boards demonstrate leadership to ensure a culture of continuous quality improvement to minimise harm to patients from HCAIs.

Draft quality measures:

Structure:

- Evidence that the board is up to date with, and has a working knowledge and understanding of, infection prevention and control.
- Evidence that an agreed set of key performance indicators for infection prevention and control are used for board assurance purposes when interpreting the trust's infection prevention and control performance.
- Evidence that the trust's aims and objectives for infection control are included in the board's 'Balanced Score Card.'
- Evidence that a mechanism is in place for regular reporting to board meetings of important infection risks and the control measures that have been implemented.
- Evidence that the board agrees an infection prevention and control annual improvement programme linked to the business planning cycle, with identified actions and resources.
- Evidence of an infection prevention and control accountability framework which includes specific responsibilities for staff working in, or coming into contact with, clinical areas (reflected in job descriptions and appraisals).
- Evidence that the trust promotes a 'self-governance' culture for infection prevention and control accountability to ensure all staff, from board to ward, take ownership and responsibility for continuous quality improvement.
- Evidence that each clinical area is accountable for compliance with the Hygiene Code in their area of control, with evidence that monitoring mechanisms are in place.
- Evidence of regular communication from the chief executive on the trust's expectation of patients, visitors and staff in relation to infection prevention and control.
- Evidence that the director of infection prevention and control (DIPC) is involved in contract negotiations with commissioners on the key performance indicators (KPI) for this area.

Process:

- Infection prevention and control-related KPIs, with agreed targets, are linked to commissioning.
- Proportion of unmet infection prevention and control targets on each monthly directorate scorecard, with an action plan:

Numerator: Number of unmet infection prevention and control targets with an action plan
Denominator: Number of unmet infection prevention and control targets.

- Proportion of HCAI root-cause analyses (RCAs) that have led to trust-wide learning activities:

Numerator: Number of HCAI RCAs within the last 6 months that have led to relevant trust-wide learning initiatives

Denominator: Number of HCAI RCAs within last 6 months.

- Proportion of annual infection prevention and control improvement objectives achieved on time:

Numerator: Number of annual infection prevention and control improvement objectives achieved on time

Denominator: Number of annual infection prevention and control improvement objectives for year.

- Percentage of quality improvement finance allocated to infection control and prevention plan.
- Proportion of clinical units with evidence of compliance with Hygiene Code:

Numerator: Number of clinical units with evidence of compliance with Hygiene Code

Denominator: Number of clinical units.

- Regular audit of board infection control and prevention accountability framework.

Description of what the statement means for each audience:

Trust boards aim to continuously improve quality to minimise the harm to patients from HCAIs by regularly monitoring compliance with its aims and objectives on infection control.

Healthcare professionals ensure the Hygiene Code is followed in their area and take responsibility for continuous quality improvements in relation to infection prevention and control.

Commissioners ensure their local secondary care trusts are covered by contracts to ensure continuous quality improvement in infection prevention and control.

People expect all trust staff – from board level to the ward – to take responsibility for continuous quality improvements in relation to infection prevention and control.

Relevant existing indicators

None identified.

Source document references

Department of Health (2008a) Board to Ward: How to embed a culture of HCAI prevention in acute trusts p 7, 8, 9, 11,12,18
Department of Health (2008b) Going Further Faster II: Applying the learning to reduce HCAI and improve cleanliness p11,17
National Audit Office (2009) Reducing Healthcare Associated Infections in Hospitals in England p37
Healthcare Commission (2007) Healthcare associated infection: what else can the NHS do? p 6,18,19,26–30, 32
British Medical Association(2009) Tackling healthcare associated infections through effective policy action p24, 32

10.1 Findings

10.1.1 Board engagement was thought to be important, and it was generally thought that Boards were already required to carry out most of statement 7. However the barriers to implementation were sometimes thought to be cultural because of a 'tick-box' approach, and practitioners were unsure if this draft quality statement would overcome that barrier

Draft quality statement 7 was generally welcomed insofar as it reemphasised existing guidance (mainly in the Code of Practice / Hygiene Code). Many practitioners thought that their organisations and Boards were supportive and would be complying with the quality statement and most of the structures suggested:

"The Chief Executive leads from the front, and the Chairman is very concerned about infection. The board take a very active interest in all things relating to infection, it might be a cliché but it really is from the board to the ward. Infections are reported straight to the Chief Executive [and] there are no other channels I need to go through."

(Head of Infection control, Foundation Trust, focus group)

For example, one practitioner mentioned that her Trust actively assessed their risks regularly and depending on what infections were causing the most concern, reporting priorities changed regularly so that issues of concern were closely monitored. Reporting went up from 'link' practitioners via infection control to the Board.

This broadly positive view of this quality statement was also reflected in specific survey responses:

"This is highly relevant, from a strategic and regional perspective we use a process of communication and identification of the level of understanding of HCAI by the board as an indicator when there is a problem. Often we find this needs strengthening. The consequences to patients are that without Board engagement HCAI outbreaks are widely distributed across the organisation, unpredictable and slow to be managed appropriately."

(HCAI Programme Specialist, Strategic Health Authority, survey)

"Board engagement will ensure integration into the day to day business of the Trust focusing on patient safety in general so one system doesn't fail whilst another is being focused on."

(*Nurse Consultant in Infection Prevention and Control, Foundation Trust, survey)*

However, as with the rest of the advice, many practitioners pointed out that the draft quality statement did not add any knowledge or guidance that went further than existing guidance. This could mean that the quality statement might not lead to any changes:

"A lot of the referencing is repeated elsewhere in the document. The Health Act is the law and it needs to be enforced, those elements need to be demonstrated [in the advice]."

(Pharmacist, Foundation Trust, focus group)

Some practitioners thought that 'tick box' approaches to infection prevention and control were in place (of which the advice was thought to be an example) and means ought to be found to tackle the mentality or the culture of organisations, rather than generating advice that would perpetuate an already existing 'tick box' culture in some Boards:

"The barriers are traditions and cultures within workplaces whereby frontline staff feel intimidated to inform senior people about the problems they are facing. Middle management is another barrier as the middle management tend to walk around with executives during the executive walk rounds rendering the Board level system useless and a tick box exercise. To overcome this, the Trust executives must make unannounced visits to the wards or be like an undercover boss and work in clinical areas to gather the exact picture of what happens on the ground."

(Infection Prevention and Nurse Specialist, Foundation Trust, survey)

This issue was also raised in discussions about the input of infection control specialists into job descriptions (see also the feedback for quality statement 9, in section 12); the presence of a line in a job description does not guarantee that practice will improve – more in-depth engagement with staff is necessary:

"I spent 18 months trying to get this in place [in job descriptions], and then I was told you can only have two lines... it's incredibly difficult to audit. Dialogue with nursing staff is more meaningful to the patient than knowing there is a sentence in the job description. It's [a] tick box mentality. We're very good at finding evidence for frameworks, but seeing it reinforced at ward level, and the patient experiencing it, is where the gap is."

(Associate Director, Specialist Foundation Trust, focus group)

A few practitioners wanted to see certain terms such as 'balanced score card' and 'KPIs' clarified (were they the same thing?):

"It is very difficult to define what you mean by 'infection prevention and control targets' because there are targets for divisions, targets for directorates... targets for processes, targets for outcomes. It's an extremely complicated concept to distil into a single target."

(Infectious Diseases Physician, Foundation Trust, focus group)

10.2 Key changes proposed by practitioners

Quality Statement 7	Changes proposed by practitioners
	▪ Referencing the links to the Health and Social Care Act throughout is important ▪ It is important that Boards take their leadership responsibilities seriously; this should not be a 'tick-box' exercise, perhaps the approach to measuring progress regarding this quality statement could be reconsidered ▪ Clarity around terms such as 'balanced score card' and 'key performance indicators' may be needed

11 Quality Statement Eight

Quality Statement Eight: Patient and public involvement

Draft quality statement:

Trusts use local patient and public experience to drive a culture of continuous quality improvement to prevent and control HCAIs

Draft quality measures:

Structure:

- Evidence of mechanisms to involve patients and the public in the trust's decision-making to ensure continuous quality improvement in infection prevention and control.
- Evidence that a variety of information sources and participation methods are used to gain insight into patient experience of infection prevention and control.
- Evidence that patient and public involvement groups for infection prevention and control reflect local demographics.
- Evidence that a non-executive director or governor has been assigned to lead on patient and public involvement in infection prevention and control.
- Evidence that patients' and the general public's priorities on infection prevention and control feature prominently in the trust's quality improvement programme.
- Evidence of local arrangements to train infection control staff in the communication skills needed to discuss HCAIs with patients and the public.
- Evidence of mechanisms to ensure patient experience of HCAIs can be used to inform root cause analysis, and to provide patients/carers with transparent feedback on the outcome.

Process:

- Annual number of forums for patients and public involved in decision-making processes in relation to infection prevention and control.
- Proportion of infection prevention and control committees and other trust infection control groups with patient and public representatives:

Numerator: Number of infection prevention and control committees and other trust infection prevention and control groups with patient and public representatives
Denominator: Number of infection prevention and control committees and other trust infection prevention control groups.

- Proportion of clinical units using patient feedback to inform quality improvements in infection prevention and control:

Numerator: Number of clinical units using patient feedback to inform quality improvements in infection prevention and control
Denominator: Number of clinical units.

- Proportion of infection control staff receiving communications training on HCAIs:

Numerator: Number of infection control staff receiving communications training on HCAIs
Denominator: Number of relevant staff.

- Proportion of HCAI root-cause analyses (RCAs) that include comment from patients and the public:

Numerator: Number of HCAI RCAs that include comment from patients and the public
Denominator: Number of HCAI RCAs.

- Number of meetings between non-executive/governor and patient and public representatives on infection prevention and control

Description of what the statement means for each audience:

Service providers ensure mechanisms are in place to seek patient and public views and experience on infection prevention and control.

Healthcare professionals ensure patients and the public are regularly involved in decisions on trust activities related to quality improvement for infection prevention and control.

Commissioners ensure commissioned services engage patients and the public in decision-making on quality improvement for infection prevention and control.

Patients and the public expect to be involved with trust planning and decision-making on activities related to quality improvement on infection prevention and control

Relevant existing indicators

None identified.

Source document references

Group consensus

11.1 Findings

11.1.1 The majority of practitioners thought that patient and public involvement (PPI) in relation to HCAI were important

The majority of practitioners tried to ensure that there is patient representation on the infection control committee. Some practitioners thought that it was a good way to educate and inform the public about the realities of work in hospitals. In addition, practitioners in some of the Trusts that we consulted with thought that it was one of the few novel parts of the advice – patient engagement was neglected within the existing sources of guidance.

11.1.2 The implementation issues were thought to be broadly the same as for PPI more generally: it is resource-intensive, and it is difficult to get beyond the 'professional patient'; these challenges make it difficult to gather meaningful 'evidence'

Practitioners were broadly welcoming of the idea of patient and public involvement, although some queried whether the involvement of patients in infection control meetings would lead to clinicians becoming less open and honest about mistakes:

"You don't want to introduce patients into any sort of process where it may prevent clinicians from being as open and honest."

(Infection Control Nurse, Foundation Trust, focus group)

On the other hand, it was clear that some Trusts had tried to overcome this problem, by taking the time to explain the complex issues and ensuring that patient representatives had a deeper understanding of infection control than the simple messages portrayed in the media.

Practitioners also raised several issues connected with implementation, mostly connected with PPI in a more general sense. These issues included:

- the lack of people to fill places on various committees, some Trusts try to involve their patients on the most pressing issues of the day while others try to get the few patient representatives they have to understand the challenges faced by acute Trusts in a more holistic way:

"You would not get people together to discuss just infection control – there wouldn't be enough."

(Patient and public involvement specialist, specialist Foundation Trust, focus group)

- professional patients 'bringing their own agendas' into discussions;
- it is difficult to recruit people that adequately reflect local communities; there is a stereotype of participants in PPI being White, middle-class, and retired:

"It may not reflect local demographics. To overcome this, an acute trust may go out to community groups inviting people but you can't force people. The statement is setting up people to fail."

(Commissioner, Primary Care Trust, focus group)

"Reflecting local demographics would be difficult – people who get involved are likely to be White middle class."

(Patient and public involvement specialist, specialist Foundation Trust, focus group)

- One practitioner suggested that involving local councillors might be a better option, via representation on Boards and Foundation Trust Governors meetings, these people would be obliged to gather the views of local residents:

"To be truly representative, representatives should be counsellors who can represent a constituency of opinion."

(Infectious Diseases Physician, Foundation Trust, focus group)

The data collection / outcome measures aspect of this draft quality statement was felt to be problematic by some practitioners, for all the reasons given above; practitioners felt it would be more useful if they were given a statement of best practice on how to involve patients and the public more effectively – a 'how to' guide:

"You shouldn't have to create an industry to collect the data – some of it may not be meaningful. If this came out everyone would go away attempting to collect the data [first]. It wouldn't be really useful. What would be useful is to know how to do it properly"

(Consultant /Deputy Medical Director, Foundation Trust, focus group)

Finally, a few practitioners felt that there was some overlap between this quality statement and those on communication (2 and 3).

11.2 Key changes proposed by practitioners

Quality Statement 8	Changes proposed by practitioners
	▪ Practitioners wanted to see a reference to Patient Advice and Liaison Services (PALS) and the role that they can play ▪ Practitioners wanted more information about best practice in engaging and working with a diverse group of patients and the public in infection control (as well as a broader agenda) ▪ Data collection and auditing were thought to be less important than adopting whatever best practice is in this field

12 Quality Statement Nine

Quality Statement Nine: Workforce capacity and capability

Draft quality statement:

Trusts prioritise the development of a skilled and knowledgeable workforce that has the capacity and capability to deliver continuous quality improvement to prevent and control HCAIs

Draft quality measures:

Structure:

- Evidence of local arrangements to ensure individual staff have clear objectives and training obligations in relation to infection prevention and control that are linked to the trust's objectives.
- Evidence that all staff working in clinical areas have an appraisal and development plan that includes discussion of their infection prevention and control responsibilities and skills.
- Evidence that all staff working in clinical areas, including link practitioners, have sufficient time to fulfil their responsibilities on, and objectives for, infection prevention and control.
- Evidence that staff are provided with feedback on their performance in relation to infection prevention and control and are given support to fulfil this role.
- Evidence of local arrangements to ensure infection prevention and control training is completed by all staff working in clinical areas within one week of commencing work.
- Evidence that local workforce planning and workforce reviews explicitly consider, and are informed by, the trust's infection prevention and control strategy and local HCAI outcomes.
- Evidence of local arrangements for an annual review of training resources which ensures they are consistent with the national evidence base and professional and occupational standards.
- Evidence of local arrangements to ensure consultant medical staff from a range of specialities are identified to champion infection prevention control, and given protected time to achieve defined objectives.
- Evidence that all staff working in clinical areas are familiar with, and competent in applying, the trust's infection prevention and control policies and procedures.

Process:

- Proportion of staff with appraisal and personal development plans (PDPs) that include infection prevention and control responsibilities and skills linked to trust's infection prevention objectives:

Numerator: Number of staff with appraisal and PDP that included infection prevention and control responsibilities and skills linked to trust's HCAI objectives
Denominator: Number of staff with an appraisal and PDP.

- Trust programme review considers and reviews the skills, competence and capacity of the multi-disciplinary infection prevention and control team to confirm it can support the trust's infection prevention programme.
- Workforce planning explicitly considers the need to reduce HCAIs across the organisation.
- Proportion of staff provided with feedback and support on their performance in undertaking infection prevention and control:

Numerator: Number of staff provided with feedback and documented action and support on infection prevention and control at appraisal and in PDP.
Denominator: Number of staff with appraisal and PDP

- Presence of an infection prevention and control link practitioner or member of staff in every clinical and support unit (with protected time).
- Presence of identified medical consultant and medical staff champions for infection prevention and control with IPC responsibilities and objectives outlined in PDP or at appraisal
- Training needs analysis is informed by the trust's infection prevention and control strategy and local HCAI outcomes and is annually reviewed.
- Proportion of new staff undertaking mandatory infection prevention and control training within 1 week of commencing work.

Numerator: Number of new staff undertaking mandatory infection prevention and control training within 1 week of commencing work:
Denominator: Number of new staff in trust.

- Presence of escalation procedures and processes for individuals who repeatedly do not fulfill their specified infection control responsibilities.

Description of what the statement means for each audience:

Clinical/non-clinical managers responsible for clinical governance, or performance improvement: Ensure they receive feedback on any gaps in the skills set of the infection control and prevention team. Where appropriate, ensure sufficient time, resources and facilities are available to fill those gaps.

Lead infection control or health protection/infection nurse: ensures infection protection team skill sets and competencies are updated and checked annually.

Healthcare professionals have the skills and knowledge to undertake infection prevention and control.

Commissioners ensure they have (where required) access to services to support, update and provide training in infection control-related activities

Relevant existing indicators

None identified.

Source document references

Department of Health (2008a) Board to Ward: How to embed a culture of HCAI prevention in acute trusts p14,16

Department of Health (2008b) Going Further Faster II: Applying the learning to reduce HCAI and improve cleanliness p13,15

British Medical Association (2009) Tackling healthcare associated infections through effective policy action p25

King's College (2008) The Impact of Organisation and Management Factors on Infection Control in Hospitals: a Scoping Review p10,12,16,17

Healthcare Commission (2007) Healthcare associated infection: what else can the NHS do?p4, 6,35–39

Group consensus

12.1 Findings

12.1.1 Current practice varies in relation to workforce development; in some cases it was at odds with the draft quality measures but local practitioners felt that approaches that they had already developed locally, in response to existing guidance, were more appropriate than some of the suggested structures. For example, they wanted to move away from a notion of 'one size fits all' training

The vast majority of practitioners agreed with the spirit and general direction of this draft quality statement:

"The more knowledgeable staff are with regards to infection prevention and control, the less risk there is to patients, as their practice will reflect their knowledge."

(Infection Prevention and Control Nurse, Foundation Trust, survey)

Even though most practitioners agreed that the quality statement repeated the requirements of the Code of Practice, many felt that it was useful to have it emphasised because workforce development was vulnerable to cost pressures.

However, practitioners expressed varying concerns about different parts of the structures. In some cases, this focused specifically on the proposal of infection control training taking place within one week of starting work; in others, the draft structures and processes were thought to prioritise a 'tick-box' mentality to professional development before more in-depth learning and change:

"This could end up being box ticking with no quality assurance or tailoring to individual need."

(Infectious diseases physician, Foundation Trust, focus group)

For example, in one Trust, mandatory training in infection control for clinicians with specific infection control responsibilities takes place immediately. However, for all other clinical staff, one week was not thought to be realistic as most induction plans take place over three months. In general, any suggestion that 'one size fits all training' was recommended was thought to be ineffective.

Other practitioners were more positive in their response, but some of the expectations in the draft quality statement were thought to be unrealistic. As one nurse said, in relation to protected time for training:

"In reality they will never allow a member of staff to go on an infection link update if the ward is short of staff – it's a genuine problem."

(Deputy Chief Nurse, Foundation Trust, focus group)

In one Trust, discussion of workforce capacity prompted further discussion about the importance of appropriately skilled cleaning staff, who are not often required to have specific training:

"We invest very little in cleaning staff and should invest more. Cleaning is so important but receives little support. There are qualifications specific to hospital cleaning which should be made mandatory."

(Assistant Director of Hotel Services, Foundation Trust, focus group)

It was thought by most practitioners that measuring or evidencing this quality statement would be very difficult. Many practitioners agreed that the presence of a line in a job description does not guarantee that practice will improve – more in-depth engagement with staff is necessary. In addition, many practitioners thought that evaluating the impact of training was challenging – for example, attending an educational event may have different impacts on participants' understanding of infection control in their day to day practice.

One focus group noticed the particular mention on 'consultant medical staff' in the draft structures. This promoted a discussion as to whether other staff groups ought to be mentioned too, as they are equally important, although it was acknowledged that consultants were a particularly difficult group to engage in mandatory infection control training, and that a specific mention of their role in the draft advice might be helpful.

12.2 Key changes proposed by practitioners

Quality Statement 9	Changes proposed by practitioners
	▪ Emphasis should be put on avoiding a tick-box mentality in regard to complying with this quality statement ▪ Consideration should be given to altering structure that proposes that all clinical staff have infection control training within one week ▪ Consideration should be given to reducing the perceived burden of evidencing the structures

13 Quality Statement Ten

Quality Statement Ten: Trust Estate Management

Draft quality statement:

Trusts demonstrate an understanding of the importance of infection prevention and control when procuring, planning designing and commissioning new and refurbished hospital services and facilities (and during subsequent routine maintenance).

Draft quality measures:

Structure:

- Evidence of local arrangements for considering infection prevention and control in the planning and design of services and facilities used by the trust.
- Evidence of local procedures to ensure infection prevention and control is considered during the handover and operational commissioning of facilities and in the selection, installation and commissioning of equipment.
- Evidence that the infection prevention and control team is consulted when planning and undertaking building maintenance projects.
- Evidence of local arrangements (for example, a standing operational procedure) to involve the infection prevention and control team or other appropriate expertise in the development of estates policy.
- Evidence of a planning process that 'designs out' potential infection risks and issues and focuses on effective infection prevention.
- Evidence of local arrangements to ensure the risk of infection is considered and managed across all buildings housing clinical care services and patients.
- Evidence that estates team keep records of routine maintenance tasks related to HCAI risk and that these are regularly reviewed
- Evidence of local arrangements to ensure estate management is considered and integrated into clinical routine processes to reduce infection risk.
- Evidence that estates staff receive annual training in infection prevention and control which includes an assessment of relevant competencies.

Process:

- Proportion of estates management meetings with infection prevention and control (IPC) as an agenda item:

Numerator: Number of estates management meetings with IPC as an agenda item documented in meeting minutes

Denominator: Number of estate management meetings.

- A record of adherence to trust estates policy and IPC team's involvement, including sign-off of documents at relevant stages of the building and maintenance process. This is in compliance with current relevant Department of Health 'Health Building Notes', 'Health Facilities Notes' and other technical advice.
- A record of completed and due maintenance tasks.
- Proportion of estates risk assessments that consider infection prevention and control issues:

Numerator: Number of estate risk assessments that include an assessment of infection prevention and control risk from planned work

Denominator: Number of estate risk assessments undertaken on planned works.

- A record of IPC team-approved written protocols for routine planned preventive maintenance (PPM) and interventional and remedial maintenance activity.
- Proportion of planned preventive, remedial and interventional maintenance works that adhered to infection prevention and control team-approved protocols:

Numerator: Number of planned preventive, remedial and interventional maintenance works that adhered to infection prevention and control team-approved protocols

Denominator: Number of planned preventive, remedial and interventional maintenance works carried out.

- A record of sign-off/verification/confirmation by appropriately competent person of work delivered in accordance with protocols.
- Infection prevention and control staff (or another recognised source of appropriate expertise) have allocated time/availability to advise on IPC issues during the initiation, planning, design, procurement and construction stages of projects? They also have the opportunity to review work as it progresses.
- The presence of a record of specific maintenance tasks relevant to HCAI risk and evidence that these are reviewed on a regular basis

Description of what the statement means for each audience:

Head of estates: Ensures records are kept of adherence to, and compliance with, trusts estate policy and estates guidelines on infection control

Healthcare professionals: Ensure, where appropriate, that sufficient time, resources and facilities are available for the infection control team to provide estates with advice during relevant stages of a project.

Relevant existing indicators

None identified.

Source document references

Healthcare Commission (2007) Healthcare associated infection: what else can the NHS do? p44,

Department of Health (2008a) Board to Ward: How to embed a culture of HCAI prevention in acute trusts p5, 7

Department of Health (2010) The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance p 9, 20

Group consensus

13.1 Findings

13.1.1 A quality statement about Trust Estate Management was largely thought to be helpful in the focus groups, and specialists saw this as adding value

In contrast to most of the statements, draft quality statement 10 was well received. Although it was mentioned that much of the content of the quality statement was covered existing sources of guidance, practitioners found it useful to be summarised in one place, and most practitioners thought that this would enable them to improve their practice and improve the way that design, building and maintenance is carried out.

"It is very relevant. Unfortunately the Trust I work for do not always involve IP&C when carrying out any building work."

(Control/Specialist Infection Prevention and Control, Foundation Trust, survey)

"This [estates management] involves a lot of money and disruptions to services and must be right from the beginning."

(Infection Prevention and Control Nurse Specialist, Foundation Trust, survey)

"This guidance point could help us fine tune our record. Although we've got a lot of guidance and information covering these points, it's good to have it all summarised in this quality statement."

(Consultant Nurse, Foundation Trust, focus group)

The majority of practitioners said there were good working relationships between Trust Estate Management and infection prevention clinicians. There are a number of measures that are already examined in relation to estates management, such as ventilation, maintenance, water and preventing Legionnaires' disease. However, because infection control and estates staff are busy, consultation between estates and clinicians takes place, but it may not take place at the 'right' point and as some practitioners stated, the lack of a structured process means that staff have to learn from scratch each time they collaborate. For example, one practitioner said:

"[We] use informal systems as getting evidence is very difficult. We don't keep documentation. We're only a small part of what they have to consider".

(Soft Facilities Manager, specialist Foundation Trust, focus group)

Some Trusts were clearly ahead of others. One of the focus group Trusts was considering employing a clinician to work within the estates team:

"It's important to have that relationship at policy and operational level. We were hoping to part fund an infection control nurse that would work alongside estates."

(Hotel Services Manager, Foundation Trust, focus group)

Some practitioners highlighted parts of the quality statement that they wanted to see tightened:

- they wanted to see a reference to the Department of Health's Health Building Notes (HBN – advice to project teams designing and planning new buildings and adapting/extending existing buildings) and Health Technical Memoranda (HTM – guidance for the design, installation and running of specialised building service systems)
- they wanted contractors to be clearly included in the statement;
- they wanted infection control to be involved in all planning (not just 'considered'):

"*Collaboration between estates and infection control in planning is very important but is variable because of what stage the infection prevention team are included in the planning process – the wording here may 'consider' infection control it could be 'consider and decide not to use them', it should be changed to 'include' infection control – include them at the early stages)."*

(Commissioner, Primary Care Trust, focus group)

Only a few practitioners were sceptical about the impact of this draft quality statement, perhaps because it was phrased as advice:

"The advice won't fill the gap between what happens and what should happen."

(Lead Nurse, specialist Foundation Trust, focus group)

13.2 Key changes proposed by practitioners

Quality Statement 10	Changes proposed by practitioners
	▪ There are some aspects of this quality statement that could be made more forcefully – this could include a stronger lead on including infection control staff in estates management processes, and that contractors too should take note of this ▪ Estates staff wanted to see a reference to the Department of Health's Health Building Notes and Health Technical Memoranda

14 Quality Statement Eleven

Quality Statement Eleven: Cleanliness

Draft quality statement:

Trusts ensure standards of cleanliness above the national minimum requirement and can demonstrate this through visual and objective measurements.

Draft quality measures:

Structure:

- Evidence of arrangements to ensure the trust sets out clearly, and adheres to, a standard of cleanliness in all clinical areas which is above the minimum mandated nationally.
- Evidence of clear local policies on cleaning and environmental decontamination, including responsibilities and accountability, taking into account the needs of different clinical areas.
- Evidence of local arrangements for a risk-based, cleaning responsibility matrix and frequency schedule for each clinical area.
- Evidence of a local framework for routine and outbreak monitoring of cleanliness that includes patient feedback.
- Evidence that the results of routine and outbreak monitoring of cleanliness are being fed back, where appropriate, to cleaning providers and appropriate action taken
- Evidence of local arrangements to ensure awareness of health and safety and environmental issues regarding the use of disinfectant preparations for decontamination purposes
- Evidence of the provision of adequate hand-hygiene facilities across the trust.
- Evidence of regular, appropriate training and education of cleaning staff in the use of cleaning equipment and disinfectant.

Process:

- Proportion of infection incidents that required rapid response cleaning, where cleaning was initiated within timeframe:

Numerator: Number of infection incidents that required rapid response cleaning where cleaning was initiated within timeframe

Denominator: Number of infection incidents that required rapid response cleaning.

- Evidence of a clearly defined policy for cleaning and environmental decontamination (including roles, responsibilities and accountability). This includes evidence that individual staff understand their role and responsibilities.
- Evidence that objective scientific measures are used to monitor cleanliness (for example, adonosine triphosphate technology), and that the results are fed back and inform improvements to the cleanliness programme.
- Does the trust collect tangible environmental monitoring data for difference clinical areas using visual and scientific methods for both routine and outbreak environmental assessment?
- Proportion of clinical areas with a risk-based cleaning responsibility matrix:

Numerator: Number of clinical areas in trust that has a risk-based cleaning matrix and cleaning schedule

Denominator: Number of trust clinical areas.

- Trust incorporates patient feedback/patient involvement in its cleanliness monitoring programmes, with evidence that this impacts on standards.

- Trust collects procurement data relating to amount of alcohol hand rub (AHR) in mls per bed occupied, bed day at hospital, specialty and ward.

Description of what the statement means for each audience:

Service providers ensure that there are policies and procedures for monitoring levels of cleanliness so that the trust environment exceeds minimum hygiene standards.

Cleaning staff ensure there are adequate hand-hygiene facilities available and that cleanliness data is fed back, where appropriate, to trust cleaning providers and appropriate action taken.

Healthcare professionals collect environmental monitoring data using visual and scientific methods for both routine and outbreak environmental assessment.

Patients and the public expect secondary care settings to meet high standards of cleanliness, with each trust monitoring the condition of its premises to ensure levels exceed the minimum required standard.

Relevant existing indicators

None identified

Source document references

Department of Health (2010) The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance p16-1,20

Healthcare Commission (2007) Healthcare associated infection: what else can the NHS do? p7,72

14.1 Findings

14.1.1 Most practitioners were welcoming of the spirit of the quality statement, but thought that the content of this statement was adequately covered elsewhere in CQC standards and the Health and Social Care Act

The vast majority of practitioners said that the CQC compliance process, and the Health and Social Care Act Code of Practice already covered these points in much greater depth, and because of the CQC compliance process, practitioners said that their Trusts were already meeting the requirements set out in the statement. None of the structures generated any disagreement as such among practitioners. For example, in one Trust in which we carried out a focus group, two types of hand hygiene audits were carried out, where link nurses did an in-depth audit once a month, and the ward sisters did a more regular 15 minute observation.

Some practitioners were keen to point out the ways in which they thought their organisation met high standards for cleanliness:

"There is a deep cleaning calendar. This is done to complement the clinical needs. Generally done April to October to avoid winter when wards are busier."

(Soft Services Manager, Foundation Trust, focus group)

14.1.2 However, practitioners and organisations had different views on what constituted best practice; some practitioners thought that their Trust went beyond the measures outlined in the quality statement

Some of the focus group participants pointed out that since the CQC processes were put in place, they had gone further than the 'minimum mandated requirements' and were glad to see this acknowledged in the draft quality statement; they wanted more 'stretch' and up to date advice that recognised the progress that some Trusts had made. In some cases, carrying out basic procedures (visual inspection) well was thought to be better than using more expensive technologies:

"Trusts do different things and it's difficult to ascertain what works and what doesn't, with cleaning you can have all the technology in the world but what you actually need is good elbow grease and what we have is very simple – microfibre and chlorine solution if it's an infection. It's about how you monitor the compliance."

(Hotel Services Manager, Foundation Trust, focus group)

Monitoring was thought to be a very important aspect of cleanliness – and practitioners said that Trusts needed to be encouraged to monitor cleaning contractors carefully.

Furthermore, some practitioners thought that the draft advice ought to emphasise hand hygiene more, as this was distinct from environmental cleanliness:

"It's [the draft quality statement is] an opportunity to make hand hygiene a little bit more important. It's different to cleaning the floor which is important as well."

(Infection Control Nurse, Foundation Trust, focus group)

On the other hand, practitioners in two different focus groups (both Foundation Trusts that were meeting CQC compliance standards) agreed that they did not understand why the draft advice called for a standard of cleanliness that exceeded minimum requirements. Practitioners were also unsure of which minimum standards were being referred to (e.g. British Standard for Healthcare Cleaning / National Standards of Cleanliness – the former is more recent).

Practitioners sometimes engaged in debates about the merits of alcohol hand rub among other means of achieving a clean and safe environment, as well as the role of patient feedback regarding hand rub. While some practitioners thought that campaigns had raised patients' awareness, an overemphasis on hand rub could lead to more effective but less visible measures becoming less of a priority. Therefore, some practitioners thought that measuring cleanliness by the amount of hand rub purchased was not helpful.

14.2 Key changes proposed by practitioners

Quality Statement 11	Changes proposed by practitioners
	▪ Perhaps more detail could be included on best practice and how Trusts could exceed the minimum mandated requirements ▪ Clarity is needed on which minimum requirements are being referred to ▪ Hand hygiene could be emphasised more within the quality statement, although some of the proposed outcome measures for this could be revised

15 Quality Statement Twelve

Quality Statement Twelve: New Technology

Draft quality statement:

Trusts carry out an evidence-based assessment of new microbiological techniques, technology and innovation to reduce HCAIs and anti-microbial resistance (AMR).

Draft quality measures:

Structure:

- Evidence of a mechanism within the trust to identify and consider relevant research activity and developments in HCAI innovation and technology
- Evidence of a mechanism within the trust to ensure the evidence base underpinning technology and innovation in reducing HCAIs is assessed and incorporated into policies and procedures where relevant.
- Evidence of local arrangements to support individuals or clinical teams to conduct relevant research in reducing harm from HCAIs.

Process:

- Trust has a mechanism in place to consider relevant current research activity and developments in HCAI innovation and technology.
- Trust uses a local mechanism to consider relevant evidence- based practice and new findings in HCAI policy (and policy updates) and procedures
- Trust considers and appraises new products and procedures during the year:
- Trust has a mechanism that supports individuals who wish to conduct research in the areas of HCAI.

Description of what the statement means for each audience:

Trust research and development departments: Ensure there are mechanisms are in place to identify and consider relevant research and developments in HCAIs.

Service providers: Ensure infection prevention and control teams have capacity, time and resources to consider relevant research activity and developments in HCAIs.

Healthcare professionals: Consider relevant research activity and developments in HCAI innovation and technology.

Relevant existing indicators

None identified

Source document references

Group consensus

15.1 Findings

15.1.1 The vast majority of practitioners were confused by this quality statement; most were ambivalent about carrying out their own assessments of technology while a minority were hostile

Practitioners were confused by draft quality statement 12 for a number of reasons:

- many of them thought that the distinction between research and development, and uptake of new technology was blurred. Practitioners thought that Trusts ought to engage in the former, but decisions about the uptake of new technology lay elsewhere:

"I can't understand why this is here. You need the support of a national body to undertake this kind of work."

(Consultant Microbiologist, specialist Foundation Trust, focus group)

- many practitioners thought that the review of new technologies, products and procedures was better done by experts and that local arrangements for this type of review were unnecessary:

"Trusts do not have the skills or the resources for this ... it's potentially dangerous. We're already doing well, so why change"

(Infectious Diseases Physician, Foundation Trust, focus group)

"We won't jump in on something unless we've got experts supporting us. It's giving almost too much autonomy to organisations. People won't make big decisions about practice without national support."

(Associate Director, specialist Foundation Trust, focus group)

- some practitioners said that they thought that best practice was to review the recommendations of the Rapid Review Panel and leading microbiologists in relation to infection control technologies; Trusts ought not to act independently. However, Boards and Trusts should then act quickly once national recommendations were made. Some practitioners made the point that national review could sometimes be slow, or innovation being constrained by a lack of resources:

"The difficulty is that this links in with budget and most Trusts they have medical device groups who will look at consumables as well as hard equipment, and if there was a need to review then you have a look at what's out there, what's been reviewed – so you can say … those systems are in place."

(DIPC, Foundation Trust, focus group)

"In these times of financial restraint this is less likely to happen since new innovation is often costly. There is currently little money to spare for new equipment."

(Specialist Matron Infection Prevention, Specialist Trust, survey)

15.1.2 On the other hand, references to promoting innovation (other than adopting new technologies) were thought to be helpful; this meant that the draft advice was adding something new to existing guidance

Practitioners pointed out that there was no similar element in the existing CQC standards and Health and Social Care Act guidance; most were welcoming of the principle that Trusts should carry out more research:

"This is about research, it is about exploring all avenues of infection prevention, not just gadgets or chemicals, but also best practice. It's not just about science."

(Consultant Microbiologist, Specialist, focus group)

Therefore, many practitioners thought that this draft quality statement ought to be focused on research and innovation and be clear about this point.

Some practitioners said that NICE would be better addressing this to the relevant authorities that were responsible for reviewing technologies, so that they could work more effectively and be able to deliver more timely guidance to the NHS.

15.2 Key changes proposed by practitioners

Quality Statement 12	Changes proposed by practitioners
	▪ Practitioners wanted to see a clearer distinction between technology and other forms of innovation, research and development ▪ Technology assessment ought to remain a process that takes place outside of Trusts, although it could be improved ▪ If the quality statement were to focus on encouraging Trusts to carry out research and development leading to improved practice in HCAI prevention, this would be more welcome ▪ Adequate resourcing was thought to be an important factor behind the uptake of new technologies

ANNEXES

Annex 1 Final Discussion Guide

5 m	Introduction
Introductions About PH advice and the consultation Consent & confidentiality Start the recording Timekeeping	**Introduce GHK, the facilitator (and scribe).** **Introduce NICE and why the focus group / interview is taking place:** - why the public health advice on health care associated infections (HCAI) are being produced; introduce what public health advice is - why the audience's input is **important and valued** '*this is your opportunity to influence national advice on how best to reduce and control health care associated infections…*' , and how it contributes to the development of the final quality statements - explain the scope and aims of the consultation (to gather the views of practitioners at all levels, looking for feedback on **BOTH content and structure** - explain that NICE wishes to **learn from practitioners' / other staff's** experience to ensure that the quality statements, measures and outcomes are the right ones and will be relevant to day to day practice. Examples from practice are important. - introduce **NICE observer**, if necessary **<u>Introduce consent and confidentiality</u>** - focus groups will be recorded for audit purposes - all views will be treated in confidence and anonymised, neither individuals or their organisations will be named where feedback is quoted **Remind respondents that they must fill in the sign in sheet and give consent if they wish to take part** (if they have not already done so) - offer respondents the opportunity to ask questions at any point **Ask whether participants have read the draft public health advice. This is really important as there is only sufficient time to devote ten minutes to each quality statement.** - If most have not, explain that they will be introduced as the focus group progresses (ensure copies of the draft advice are on hand)
5 m	**Warm up**
	Ask respondents to introduce themselves, their role & main responsibilities Have you heard of NICE and what would you expect NICE's involvement in this area to achieve? Mention (if participants have read the advice) that we can also **discuss if there is overlap between some statements**, and participants may wish to discuss some together to keep the discussion focused e.g. Learning organisation v workforce capacity; PPI v communications**. It would be of interest to note where such overlap occur in practice/discussions** Emphasise again that the advice is relating to the **organisational and structural aspects and processes** that would be useful to implement and not about specific processes such as hand washing techniques or catheterisation procedures etc.

Approximately 10 m	**Quality statement 1:** *Secondary care trusts ('trusts') have a surveillance system in place to gather data and monitor HCAIs. The data collected is used to inform responses to HCAI incidents in a timely and appropriate manner.*
General questions	[Give no longer than 1m for participants to read, if this is necessary] [Be prepared to start with a general question and follow up respondents' feedback throughout] ▪ Think about infection surveillance systems in your ward / trust – think about case registers, incident reporting, from surgical sites to wards and elsewhere. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?
Approximately 10 m	**Quality Statement 2:** *Trusts ensure there is clear communication about HCAI infection risks and prevention for all staff, patients and carers.*
	▪ Think about how you communicate with patients and their carers in relation to infection risks and prevention. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? (*How could **patients' understanding of their infection status and implications** for their care be measured? **)*** ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?

Approximately 10 m	**Quality Statement 3:** *Trusts ensure there is clear communication about HCAI infection with all affected patients and their carers throughout the care pathway.*
	▪ Think about how you communicate with patients that are affected by infections, and their carers, across the care pathway. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?
Approximately 10 m	**Quality Statement 4:** *Trusts work proactively with multi-agency collaborations to reduce HCAIs within local health and social care organisations*
	▪ Think about how you work with other organisations, including data sharing and pathway development to reduce infection across your health economy. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?

Approximately 10 m	**Quality Statement 5:** *Trusts use a range of sources to inform and drive continuous quality improvement to reduce harm from HCAIs.*
	▪ Think about how your staff gain and update their knowledge about controlling infections and responding to incidents. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?
Approximately 10 m	**Quality Statement 6:** *Trusts ensure agreed, multi-agency patient admission discharge and transfer policies provide clear, concise guidance to organisations on critical steps to take to minimise harm from HCAIs.*
	▪ Think about how patients with infections are admitted and discharged, risk assessed, and how patients are handed over within your organisation. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?

Approximately 10 m	**Quality Statement 7:** *Trust boards demonstrate leadership to ensure a culture of continuous quality improvement to minimise harm to patients from HCAIs.*
	▪ Think about how your board leads on reducing infections and clinical governance, and how standards are maintained and improved upon. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?
Approximately 10 m	**Quality Statement 8:** *Trusts use local patient and public experience to drive a culture of continuous quality improvement to prevent and control HCAIs*
	▪ Think about how patients and the public are involved and made aware, and how patient experience shapes your response to infections and infections policy. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?

Approximately 10 m	**Quality Statement 9:** *Trusts prioritise the development of a skilled and knowledgeable workforce that has the capacity and capability to deliver continuous quality improvement to prevent and control HCAIs.*
	▪ Think about how staff gain the skills and the capabilities they need to reduce infections, are empowered to improve the quality of care, and champion infection control and reduction. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?
Approximately 10 m	**Quality Statement 10:** *Trusts demonstrate an understanding of the importance of infection prevention and control when procuring, planning and designing new and refurbished hospital services and facilities (and during subsequent routine maintenance).*
	▪ Think about how infection control relates to building maintenance and design in your organisation. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?

Approximately 10 m	**Quality Statement 11:** *Trusts ensure standards of cleanliness above the national minimum requirement and can demonstrate this through visual and objective scientific measurements.*
	▪ Think about how infection control relates to how cleaning takes place in your organisation. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ Is the statement **measureable**? ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate? ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?
Approximately 10 m	**Quality Statement 12:** *Trusts carry out an evidence-based assessment of new technology and innovation to reduce HCAIs and anti-microbial resistance (AMR).* **(This may require a bit more time as there are more questions)**
	▪ Think about how your organisation uses and keeps abreast of new technologies and innovations that can help to reduce and control infections. ▪ Is the quality **statement easily understood and clearly worded**? ▪ Is the **quality statement** appropriate, relevant and useful to your day to day practice? Why / why not? ▪ *Does the consideration of 'technology and innovation' by a Trust need to be considered separately from 'research and development' in the area of HCAI reduction?* ▪ Is the statement **measureable**? *How can we measure the consideration of innovation and technology?* ▪ Are the **measures** useful in the service you work for (including time periods, where these are given)? Are they comprehensive? Are there any gaps in the measures, or are there more appropriate or relevant measures? ▪ *Are there any relevant existing indicators or benchmarks in this area?* ▪ Have NICE identified all the **appropriate healthcare outcomes** for this quality statement? Are any outcomes inappropriate or missing? ▪ How **easy would it be to collect this data**? What are the **barriers** to / resource implications for implementing the collection of data and providing evidence for each measure? ▪ Is the **style and format of the statement and measures** appropriate?

	▪ *Would a Trust rely on approved guidance (such as NICE guidance) on technology / innovation before considering its uptake or would the decision be taken locally?* ▪ *Are there (apart from NICE guidance) any other forums or national data sources where such guidance would inform a trust's decision?* ▪ How suitable is the explanation of statements for the **different audiences** (should other audiences be included)?
15 m	**General overview**
It is unlikely that the summary can cover all these questions but these are listed in order of priority. Facilitators should choose the questions that have not yet been adequately answered in the earlier part of the focus group.	▪ To what extent will these quality statements influence your practice or the practice of your organisation? Are they useful and relevant? Why / why not? Which are the most important for you and your organisation? ▪ Do these **quality statements overlap each other or duplicate** any existing advice or guidance relating to HCAI? ▪ Are the measures and outcomes useful and relevant? Would length of stay be a suitable outcome indicator for any of these statements? ▪ Are there any overarching healthcare outcomes that could be shown to improve, if this advice was implemented, as a whole? ▪ How practical is it to implement these quality statements overall? Is it realistic to implement them – how confident are you that the vision of the quality statements can be achieved? ▪ What are the biggest barriers to implementing this advice likely to be, in your organisation? How can these be overcome? ▪ To what extent have NICE identified all appropriate healthcare outcomes for each individual quality statement? Do you think there are any gaps in the coverage of these quality statements? What are they? ▪ How clear is the wording of the quality statements? How easy are they to understand? How could clarity be improved? ▪ What do you think of the style and format of the advice as a whole? How can this be improved, so that senior Trust leaders and frontline staff take notice? ▪ What do you think of the order of the statements? Should the order be changed? ▪ Do the statements adequately cover the dimensions of quality: □ Effectiveness □ Acceptability □ Efficiency □ Access □ Equity □ Relevance ▪ Do you think the advice could be changed or better promote equity of access to high-quality services relating to age, disability, gender, gender identity, ethnicity, religion and belief, sexual orientation or socio-economic status? ▪ Are there any **potential negative impacts of these quality statements**? Why?

	▪ What could NICE do to **raise awareness of this advice** and communicate them to your professional group? ▪ Do you have **any more comments** about the quality statements?
5 m	**Close and thank respondents for their time**
	Remind participants to **leave sign in sheets and consent forms behind** and make sure these are collected at the exit. Ensure that the **event organiser is thanked** and that any **expenses for catering** are collected.

Annex 2 Consent Letter

Name

Address

Tuesday, 30 August 2011

Dear [insert name] / Focus Group Participant

Re: NICE / HPA field testing for Advice on Healthcare Acquired Infections (HCAI) – Draft Quality Statements and Consent

Thank you for agreeing to take part in [an interview / focus group] with our researchers as part of the above field testing. Your contribution is appreciated and will help ensure that the NICE advice is relevant, appropriate, useful, feasible and capable of being implemented effectively. Consulting practitioners through field testing is an integral part of the process in which NICE advice is produced. Thank you also for allowing us to use your facilities [insert as relevant].

Location and address of focus group: <<insert address>>

Date and time of focus group: <<insert date of focus group>>

The focus group will last no longer than the allotted time, but you have the right to end early if it is inconvenient.

Your signature below indicates that you give consent to the following:

- The focus group will be recorded on a digital recorder for the purposes of analysis, and this recording will be kept on a secure server that can be accessed only by GHK staff. The recordings will be handled in accordance with standard NICE practice, and will be held securely and destroyed after five years;
- All quotes used in the final report will be anonymised and no participants nor their organisations will be personally identifiable. The consultation is confidential to those people that have given their consent and attended the focus group.
- You understand that the final report summarising the field testing findings will be used by NICE to inform a final version of its advice to practitioners, and the report will be published on the NICE website.

The final report produced as a result of all the interviews/focus groups will be used by NICE to inform the final version of the quality statements, and the report will be published on the NICE website.

We would be grateful if you would complete the details below and bring this to the focus group, or email a copy of this letter to GHK. Your signature indicates that you have read and understood the information provided above, that you willingly agree to participate, that you understand your right to discontinue participation without penalty, and that you have received a copy of this letter. If you have any questions regarding the information in this letter or your rights as a participant, you can contact Aidan Moss (Project Manager) on aidan.moss@ghkint.com or 0207 611 1109.

Printed Name _____ **Organisation**_____

Signature _____**Today's Date** _____

Phone Number _____**Email**_____

Annex 3 Prior Reading Task

To what extent will these quality statements influence your practice or the practice of your organisation? Are they useful and relevant? Why / why not? Which are the most important for you and your organisation?

What are the potential consequences of advice, in particular the quality statements, for improving health?

Do these quality statements overlap each other or duplicate any existing advice or guidance relating to HCAI?

Are the measures and outcomes useful and relevant? Are there any overarching healthcare outcomes that could be shown to improve, if this advice was implemented, as a whole?

How practical is it to implement these quality statements overall? What are the biggest barriers to implementing this advice likely to be, in your organisation? How can these be overcome?

Are there important topics that the quality statements and associated measures, structures and processes do not cover?

How clear is the wording and style of the quality statements? How could clarity of the advice be improved?

Annex 4 Sign in sheets and Equalities Monitoring form and data

Please fill in the following sheet in order that we can know a little more about the background of people attending today:

Your name: _____

Your role: _____

Your organisation: _____

Q1) How would you define the level at which you work, in your organisation? (TICK ONE BOX ONLY)

Director – on the Trust Board	
Senior manager or clinical manager (at Band 8b or above) – other clinical or operational role with responsibility for a directorate or service unit	
Manager or clinician (between Bands 6-8a) – with responsibility for a ward, theatre or small clinical team	
Frontline delivery staff (Band 6 or below) – mainly responsible for the care of individual patients	
Other *Please state* :	

Q2) What is the field that you work in? (CAN TICK MORE THAN ONE BOX)

Infection Control (as the main part of my work)	
Very Senior Manager (VSM)	
Clinical governance	
Nursing	
Midwifery	
Doctor - Medicine	
Doctor - Surgery	
Coordinating the admission of patients	
Coordinating the discharge of patients	
Microbiology	
Pharmacy	
Epidemiology or Public Health	
Estates	
Human Resources / Learning and Development	
Cleaning	
Management	

Administration	
Commissioning	
Patient / public representative or liaison staff (e.g. FT Governor or Member, PALS, LINK staff)	
I am a patient	
Other *Please state* :	

What is your ethnic group?

White - British	
White – Any Other White background	
Mixed - White and Black Caribbean	
Mixed - White and Black African	
Mixed - White and Asian	
Mixed - Any Other Mixed background	
Black or Black British - Caribbean	
Black or Black British – African	
Black or Black British – Other Black background	
Asian or Asian British - Indian	
Asian or Asian British - Pakistani	
Asian or Asian British - Bangladeshi	
Asian or Asian British – Any Other Asian background	
Chinese or other ethnic group - Chinese	
Chinese or other ethnic group – Any Other ethnic group	

Do you consider yourself to have a disability?

Yes	
No	

Ethnic group of participants in field testing

Ethnic group	Number of participants
White – British	73
White – Any other White background	4
Mixed – White and Black Caribbean	0
Mixed – White and Asian	0
Mixed – Any other mixed background	1
Black or Black British – Caribbean	1
Black or Black British – African	1
Black or Black British – Other Black Background	0
Asian or Asian British – Indian	0
Asian or Asian British – Pakistani	0
Asian or Asian British – Bangladeshi	0
Asian or Asian British – Any other Asian background	0
Chinese or other ethnic group – Chinese	0
Chinese or other ethnic group – Any other ethnic group	0
I prefer not to say	9
No response	4

Disability status of participants in field testing

Participant considers self to have a disability	Number of participants
Yes	7
No	77
No response	9