NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Healthcare associated infections

Date of Quality Standards Advisory Committee post-consultation meeting:
29 October 2015

2 Introduction

The draft quality standard for Healthcare associated infections was made available on the NICE website for a 4-week public consultation period between 28 August and 24 September 2015. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 21 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the Quality Standards Advisory Committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the Committee as part of the final meeting where the Committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the Committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the Committee should read this summary alongside the full set of consultation comments, which are provided in appendices 1 and 2.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 2: How should objectives around infection control be appraised, and how often, for different types of staff working in hospitals?

5. For draft quality statement 3: What is the most important contribution of infection and control teams to maintenance work on hospital services and facilities, and at what stage of this work is it important?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard (QS).

- In general, support was received for this quality standard
- Comments highlighted a need to clarify the scope of the quality standard in relation to quality standards on infection prevention and control and antimicrobial stewardship and the Code of Practice on the prevention and control of infections
- It was suggested that the prevention content should be more clearly highlighted
- There was concern that the QS is focused entirely on adults, and that it should reflect different practices for HCAIs between adults and children
- Further clarity was requested over the roles and responsibilities of those involved in putting the statements into practice

Consultation comments on data collection

- In general it was felt that statement 1is more likely to be measurable. Data collection for the other quality statements was thought to be more challenging and clarity was sought over how some data could be collected
- Current work to consolidate data sources to provide information on healthcare associated infection and antimicrobial stewardship was highlighted. It was felt this will improve the feasibility of the measures included within the draft quality standard for which data collection is currently problematic

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Hospitals monitor the incidence of healthcare-associated infections, and the risk of infections in hospitals from community-wide outbreaks, to inform multi-agency action when alerts are identified.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- It was queried whether the scope of this statement is too vague due to the large number of healthcare associated infections and issues connected with these. It was therefore queried whether the statement should be more specific in terms of its focus

- Clarity required over how frequent and how extensive monitoring for HCAI should be, as well as what evidence should be collected.

- The focus of the statement was queried. It was suggested for example that the focus should be on a requirement to meet the minimum standards of compliance with the Hygiene Code

- Specific responsibilities for this statement should be clearly identified

- Clarity was requested over the actions needed to meet this quality statement e.g. do all wards need to display their own information on infection prevention and control on a monthly basis?

- In general it was felt the quality measures are not specific enough and there was some uncertainty over the availability of information to support them. A number of alternative suggestions were made for more specific measures including e.g. ward-level hand hygiene compliance and compliance with World Health Organization (WHO) best practice for hand hygiene

5.2 Draft statement 2

Hospital staff have an appraisal of their objectives on infection prevention and control.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- The statement could be reworded to: “all staff in acute hospital settings should be able to evidence that they are compliant with trust policies in relation to infection prevention and control (IPC)”

- Appraisals would not include an infection prevention and control objective. It was also suggested individual aspects of appraisals may not be recorded. A solution of including infection prevention and control objectives within job descriptions was suggested

- Should the statement focus on annual update training of infection control policies?

- It was suggested that this statement may be more of a priority to some hospital staff than others for example non clinical staff may not currently have the same awareness and training as clinical staff

- A reference to the Code of Practice on the prevention and control of infections was requested as this recommends that infection prevention and control is included within annual appraisals

- Stakeholders suggested appraisal objectives around:

    - ensuring all staff have completed mandatory training e.g. hand washing, appropriate clothing and jewellery

    - Completion of training course e.g. online learning modules

    - organisational strategy/risk assessment and development of aspirational needs

    - Departmental specific objectives e.g. theatre cleaning

- Highlighted that staff appraisal is generally an annual process. This could be monitored via the NHS electronic staff record (ESR) but may not be universally available

- A rewording of the structure measure was suggested: ‘Evidence that hospitals have written protocols, approved by the infection prevention and control

committee, for preventive measures when new build or maintenance activities are undertaken'

5.3 Draft statement 3

Hospitals involve infection prevention and control teams in the preventive and remedial maintenance of services and facilities.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- It was highlighted that the terminology is not consistent for this statement. It was requested that this be amended and the term 'infection prevention and control' should be used throughout
- Clarity over the focus of this statement was requested in terms of when this should apply as it was not thought to be relevant to all maintenance works
- The focus could be on the patient environment including all patient surroundings e.g. hand hygiene facilities and isolation facilities and cleaning of equipment
- New builds and refurbishment should be included within the statement wording and there should be a reference to the availability of hospital facilities to support staff with preventing HCAIs. In addition it was suggested that the word 'preventive' should be included within the statement wording
- Infection prevention and control teams are not always currently involved in the planning stage of maintenance works but this is important, especially in the early planning phases
- The role of infection control staff was noted in the planning of all building and maintenance work in clinical areas to provide a risk assessment. The important role of infection prevention and control teams in a number of areas was highlighted including disinfection systems, water supply and drainage systems, air

handling and ventilation systems, waste management and the decontamination of equipment pre and post procurement

5.4 Draft statement 4

People admitted to, discharged from or transferred between hospitals have information about any infections and associated treatments shared with their health and social care practitioners.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Stakeholders requested more specific detail on what information should be shared (e.g. information on MRSA status and positive culture results)
- A lack in clarity over whose responsibility it is to hand this information over and the format this should take was highlighted
- It was suggested that this should specify that information about infections and associated treatment must be provided in advance of the transfer or at the very least be available to the receiving clinicians immediately at the point of transfer
- A stakeholder felt the statement does not fully reflect the issue of transfer of dangerous pathogens between sites, and suggested alternative wording of 'When people are admitted to, discharged from or transferred between hospitals, information about any infecting or colonising organisms, associated treatments and required infection prevention measures should be shared with their health and social care practitioners'
- A concern was raised over how compliance with this statement could be monitored continually, other than through regular audits of case notes of patients being transferred between sites

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- Strengthening leadership and governance around infection prevention and control across and within healthcare settings

Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
001	Association of Independent Healthcare Organisations (AIHO)	General	It is always welcome to have NICE take an interest in Infection Prevention and Control however this document falls short of any standard for prevention of infections. We may have misunderstood the purpose of the document and if so maybe it needs to be clearer at the beginning as to why only some aspects of infection prevention has been included. The focus in the beginning of the document is on healthcare associated infections not prevention of HCAIs then there are a selection of quality statements that are valuable in prevention of infection however it fails to outline others that are equally, if not more valuable. WHO outlines core components of an infection prevention and control programme which succinctly outlines all the aspects broadly that need to be identified in a hospital Infection Prevention and Control Programme. http://www.who.int/csr/resources/publications/WHO_HSE_EPR_2009_1/en/ Why do the NICE quality statements only chose 4 quality statements? What about the other areas that are absolutely essential in preventing infections?
002	Association of Independent Healthcare Organisations (AIHO)	General	There is reference to the HPA Point Prevalence Survey however no references at the end of the document
003	Association of Independent Healthcare Organisations (AIHO)	General	The language in this section is very focused on the NHS. Services are not always commissioned in the private sector I don't think this section makes sense. The quality standard is about preventing healthcare associated infections but under the coordinated services it talks about the healthcare associated infection pathway. This is a pathway for someone with a HCAI eg. MRSA pathway. *The quality standard for healthcare associated infections specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole healthcare associated infection pathway.* Do you mean infection prevention pathway?
004	Association of Independent Healthcare	General	This is focused on patients with healthcare associated infections however family members also have a role to play in helping patients and preventing infections (eg. Maintaining hygiene and specifically hand hygiene, not coming in to

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
	Organisations (AIHO)		visit if they have infections etc)
005	British Infection Association	General	The BIA is content with this document. Thank you.
006	Deb Group Ltd	General	Deb Group strongly believes that the absence of reference to hand hygiene, in particular the monitoring of compliance with hand hygiene best practice, weakens the quality standard for the management and prevention of healthcare-associated infections in secondary settings. Hospitals do have infection prevention and control policies in place; however, the inaccurate and meaningless data collated from hand hygiene audits breaks the quality improvement cycle, misinforming quality initiatives. It is widely recognised, including by the Care Quality Commission just this year (HSJ, "The Case for Patient Safety: Financially, Professionally and Ethically", 2015), that data collected from the direct observation process for auditing hand hygiene compliance is ineffective. Studies have shown that compliance data is artificially inflated by more than 50% as a result of the Hawthorne effect, which in turn dramatically reduces the incentive or targeting of improvement at a ward or trust level. Deb Group's own evidence from UK pilots has found that compliance today in UK hospitals is actually 18-40%, rather than the 90-100% often recorded. Infection prevention and control professionals and staff throughout NHS organisations are therefore unsupported by the data required to implement quality improvement. Accurate and timely data, such as that collected through electronic hand hygiene monitoring, provides NHS staff with the information required to target and focus quality improvement for the prevention and management of healthcare-associated infections.
007	Department of Health	General	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.
008	Healthcare Infection Society	General	The introduction focuses on a small number of organisms that can be measured from laboratory outputs or infection syndromes that can also be measured – e.g. respiratory tract infection, for which the cause is often not known. It should now also cover the spread of antimicrobial resistance which also is a healthcare infection, but may be by mobile elements infecting bacteria in patients and staff rather than just bacteria themselves. In addition to the bullet points of improvements that quality standard is expected to contribute to • reduced spread of antimicrobial resistance is of major importance and interest
009	Infection Prevention Society	General	These statements add nothing of note to the regulatory requirements that currently exist for the prevention and management of healthcare associated infections including transfer between home/ social/ or other healthcare facilities. Although the introduction highlights the most common types of HCAI the standards seem to be primarily focused on

ID	Stakeholder	Statement number	Comments[1]
			outbreaks. The standards do not reflect key areas for quality improvement to prevent these most common HCAI. In addition, other parts of the introduction appear suggest treatment and management rather than prevention of HCAI is being addressed.
010	MSD UK Ltd	General	MSD believes that this draft Quality Standard accurately reflects several key areas for quality improvement. MSD would suggest that the content relating to prevention could be strengthened. Patients who are less exposed to hospital have a reduced chance of acquiring an infection. Appropriate opportunities for admission avoidance and early discharge should be proactively identified, to move more patient care into the outpatient setting. This is aligned with the goals of good Antimicrobial Stewardship (AMS).
011	NHS England	General	Thank you for the opportunity to comment on the above QS. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.
012	NHS Trust Development Authority	General	The title should include that it refers to secondary care providers only. The QS should clearly state a requirement to meet the minimum standards of compliance with the Hygiene Code in Statement 1. The other statements are then formed from this overarching principle of expectation. Requirement for IPC involvement: see notes below.
013	Public Health England	General	It would be helpful to explicitly state how adherence to this Quality Standard (QS) will also assist organisations in their efforts to contain antimicrobial resistance – this could be listed alongside the bullets on page 2.
014	Public Health England	General	Public Health England (PHE) PHE would find it helpful if NICE could articulate how these Quality Statements should be used alongside the NICE Prevention and control of healthcare-associated infections: Quality improvement guide (2011) which already includes surveillance, communication, workforce capability and Trust estate management.
015	Public Health England	General	The second Department of Health citation should be dated 2015.
016	Public Health England - Antimicrobial Resistance and Healthcare Associated Infections (ARHAI**)**	General	We suggest that there is a link to the Infection Prevention and Control Quality Standard 4 (QS61) around urinary tract catheters.
017	Royal College of Anaesthetists	General	Comment in response to 003 We agree that trusts should include recurrence rates. In some respects it is even more important to ensure these events are captured and investigated as to whether there is a subgroup of patient characteristics which predispose patients to recurrence. It is also important to assess them for the economic and financial implications to trusts as well as the morbidity and mortality of individual patients.
018	Royal College of	General	Comment in response to 004

ID	Stakeholder	Statement number	Comments[1]
	Anaesthetists		We agree that mortality rates should be published. This ensures transparency within the NHS and would help to allow patients to make an informed choice as to which hospitals they visit.
019	Royal College of Anaesthetists	General	Comment in response to 006 Why has antibiotic prescribing increased by 12%? Is this prescription of courses of antibiotic therapy or were single shots of antibiotic also included (as in A&E when a patient comes in clinically septic as part of sepsis 6 bundle; surgical antibiotic prophylaxis)? Does the figure include continuation of long term prophylactic antibiotic prescription for immunocompromised patients? If the answer to all of the above questions is 'yes' then it may not necessarily be a bad thing.
020	Royal College of Anaesthetists	General	Comment in response to 035 Good documentation and care reduces infections associated with indwelling catheters – This is not particularly referenced in the quality statements.
021	Royal College of Anaesthetists	General	General comment: Referencing the briefing paper, appendix I comment 004, here there could be mention of mortality in the first paragraph under the subheading 'why this standard is needed'? Something along the lines of "……..significant morbidity with the potential for mortality". This would highlight the potential deadly nature of HCAIs to a small proportion of patients clearly and early on in the document.
022	Royal College of Nursing	General	The Royal College of Nursing (RCN) welcomes the continued attention on reducing infections. We note the focus of this draft Quality Standard (QS) on Health care associated infections (HCAI) and the existing quality standard QS61 on Infection Prevention and Control. The RCN is unsure at this time of the value of a further quality standard given the overlap with QS61 and the recently updated Code of Practice (2015). Although the proposed quality standard for HCAI supports ambitions to move beyond minimal regulatory requirements we feel there is limited benefit due to: • the significant overlap with QS61 (the language focuses on HCAIs) and QS61 has not been evaluated since its publication in 2014, therefore, learning has not been identified as to how this draft quality standard might further improve reductions in infections.
023	Royal College of Nursing	General	The RCN would like to suggest that if a further quality standard is developed it should focus primarily on surveillance of infection and the provision of adequate laboratory support in all care settings to support antimicrobial stewardship efforts and existing guidance including the published NICE Antimicrobial stewardship guidelines and draft stewardship quality standard. We do not view any benefit in further repetition of organisational requirements (including leadership and governance) for infection prevention and control (IPC) or innovation. Innovation specifically requires a national focus to support procurement elements and harnessing of expertise to enable local adoption.
024	Royal College of Pathologists	General	It is worth noting that the recommendation to involve the IPCT in planning surrounding maintenance of the built environment is very welcome, since in my experience we are often consulted late or not at all about the priorities and

ID	Stakeholder	Statement number	Comments[1]
			impact of building works. Extending the recommendation to new builds and refurbishments would be equally welcome.
025	Royal College of Surgeons of England	General	•It also doesn't mention the problem some hospitals have with a general lack of side rooms for isolating infectious patients- is there a minimum number per population that hospitals should be available? •No mention of MRSA and other HCAIs and places like radiology, endoscopy, theatres etc •No mention of removing cannulas, urinary catheters etc as early as possible
026	Scottish Antimicrobial Prescribing Group	General	Data for statement 1 can easily be collected but data for statements 2, 3 and 4 will be more challenging to collect within current systems.
027	Scottish Antimicrobial Prescribing Group	General	The quality standard does reflect some of the areas for quality improvement but is very hospital focused and could have included more about staff in community settings, homecare settings as well as more on patients and the public.
028	St John Ambulance	General	From one of our Medical Officers; My only comment is that, although we are stakeholders, there is only the mention of out of hospital care in the opening paragraphs, with the rest of the document concentrating on hospital/secondary care/care home environments. Education of all staff with regard to IPC is important and that it is the attitude to infection that is the most important feature. I suppose that outside of hospital, roadside, back of ambulance, first aid post/tent is so diverse that it would not be possible to devise a standard that would cover everything.
029	St John Ambulance	General	From our Chief Medical Officer; My comment is that whilst there are multiple references to local data and to the community, and to 'evidence of local arrangements for hospital to ....' the standard appears to place the onus on hospitals to develop the local arrangements - perhaps a reflection of the wording rather than the intent. However, the responsibility for local arrangements outside hospitals should lie with the appropriate external organizations (PHE, primary and community services and ambulance services). The standards for secondary care should refer to hospitals co-operating with, and perhaps providing appropriate support, to such external organizations rather than having any responsibility for actions outside hospitals.
030	UK Clinical Pharmacy Association (UKCPA)	General	The UKCPA have no further comments to make on this Quality Standard.
031	Deb Group Ltd	1	The surveillance of the incidences of healthcare-associated infections is purely a management measure. In order to strengthen the prevention of healthcare-associated infections from an organisational level, the collation of meaningful, accurate and real-time data on ward-level hand hygiene compliance should be included in the quality statement. This would inform infection prevention and control practices. Improving hand hygiene is the single most effective way of cutting healthcare-associated infection rates; improving hand hygiene compliance rates by just 20% could save hundreds of lives across the NHS, and allow trusts to make considerable savings and ease operational pressures. Effective data can be a driver for change on the ground. Boosting transparency through timely, objective performance data will transform behaviours and drive up outcomes, whilst simultaneously reducing costs. Effective systems need

ID	Stakeholder	Statement number	Comments[1]
			to be put in at ward level to ensure compliance, and assure management of best practice throughout hospitals. Moreover, it is worth noting that the surveillance of healthcare-associated infections is included in other NICE guidance; however, the guidelines for hand hygiene compliance monitoring in existing guidance is weak and unhelpful for infection prevention and control. As such, the opportunity exists for this quality standard to strengthen the advice for monitoring hand hygiene compliance accurately.
032	Deb Group Ltd	1	Evidence of compliance with World Health Organization (WHO) best practice for hand hygiene through accurate and real-time data should be included as a quality measure.
033	Healthcare Infection Society	1	Hospitals monitor the incidence of healthcare-associated infections, and the risk of infections in hospitals from community-wide outbreaks, to inform multi-agency action when alerts are identified.
034	Healthcare Infection Society	1	The quality statement reflects a need in hospitals but should it not reflect the need across the healthcare environment. Many important threats originate from the community – norovirus and influenza and surveillance sources should acknowledge and recognise the importance of mechanisms to identify threats in the early stages before they are necessarily obvious in secondary care. Many healthcare infections first become apparent in the community. So for surveillance purposes an organizational division between primary care and secondary care is a significant barrier.
035	Healthcare Infection Society	1	At the moment much of the data that is necessary to support this statement is not available to IPCT in secondary care. Some of the structures implied require CCGs to commission services from community sources to monitor community wide outbreaks and indeed incidence of syndromes to detect changes that may not reflect true outbreaks. As well as the sources mentioned Primary Care should be specifically included and structures commissioned to enable PHE for example to monitor risk and infections in the community to feed into hospital structures. Evidence of collaboration is difficult to measure except subjectively
036	Infection Prevention Society	1	Hospitals monitor the risks within their control. HAI related to community wide outbreaks are not necessarily healthcare associated and are out with the Trusts sphere of control. Hospitals cannot collect data on community outbreaks and it is not clear what measures are expected for standard 1.A more appropriate focus for this standard would be evidence of communication between NHS Trusts and Public Health Departments/ and PHE
037	Infection Prevention Society	1	No response
038	NHS Trust Development Authority	1	Yes. Each appears measurable. However, how do you measure improvement to hospital admission as already inpatients unless via readmission rates for infection?
039	Public Health England	1	PHE believes it will be difficult to systematically collect all the data as suggested in this QS. PHE are developing a data portal that will bring together a range of currently disparate data sources to enable - over time – a more holistic assessment of health providers in relation to infection prevention and control (IPC), and antimicrobial stewardship. It is anticipated that this will be based on the National GP profiles http://fingertips.phe.org.uk/profile/general-practice

ID	Stakeholder	Statement number	Comments[1]
			model and that all these data will be publically available.
040	Public Health England	1	It would be preferable not to say "if the systems and structures are available" – but that they must be made available.
041	Public Health England	1	It would be helpful to state explicitly that surveillance means the ongoing systematic collection, recording, analysis, interpretation, and dissemination/feedback of data.
042	Public Health England	1	Under data source – local collection and feedback
043	Public Health England	1	Could NICE in the document specify how they can assist hospitals in monitoring the risk of healthcare associated infections from community wide outbreaks? PHE Centres can contribute to this process.
044	Public Health England	1	It would be helpful if NICE could specify how evidence of collaboration can be monitored.
045	Public Health England - DH Advisory committee Antimicrobial Resistance and Healthcare Associated Infections (ARHAI**)**	1	This should include a qualifier about how frequent and how extensive monitoring for HCAI should be. In addition to participation in mandatory requirements, hospitals should, as a minimum, be required to participate in the ECDC point prevalence survey which occurs approximately once every 5 years and extends to all areas of the hospital. Participation can readily be monitored in England by PHE.
046	Royal College of Anaesthetists	1	Comments about quality statement 1 Further details regarding what would be deemed as suitable evidence that monitoring was taking place would be very useful such as:- -How frequently data should be collected and collated with feedback to clinical staff. Should this be on a monthly basis for example or is this being too prescriptive? -A minimum dataset for this evidence of monitoring (e.g. patient sex and age, risk factors for acquiring HAI, which HAI acquired, impact on clinical course – M&M) -Which HCAIs are trusts expected to monitor and collect data on – note from the briefing papers that most trusts only look at MRSA bacteraemias and C.difficile infections. Is this enough or are we expecting trusts to look at a wider range of HCAIs (maybe the 'top 6' that are referenced throughout the paper)? Should we be expecting 100% wards to display their own information on infection prevention and control on a monthly basis per se. This would aid with transparency between healthcare providers and the general public.
047	Royal College of Anaesthetists	1	**Response to consultation questions** 1) Yes 2) Yes, but need to be specific about what data needs collecting (maybe a minimum data set as outlined above). It should be emphasised that it is the responsibility of the trust board to ensure this monitoring happens and that they should be encouraged to nominate a lead person within themselves to take this forward. 3) n/a
048	Royal College of Nursing	1	This statement reads *'Hospitals monitor the incidence of healthcare-associated infections, and the risk of infections in hospitals from community-wide outbreaks, to inform multi-agency action when alerts are identified.'* This statement is too vague due to the huge number of potential HCAIs and issues with defining these across the spectrum. Whilst the

ID	Stakeholder	Statement number	Comments[1]
			RCN acknowledges that more surveillance is required this needs to be more specific and within a national programme to support providers to undertake this to ensure quality data to drive improvement programmes.
049	Royal College of Paediatrics and Child Health	1	The whole report is geared to adult HAI. HAI in PICU/NICU has a different aetiology and does not reflect community reporting. Surveillance alone does not mitigate HAI in NICU/PICU. There are important differences between neonatal units (NICU) and those in other hospital departments that may affect the efficacy of these interventions. Compared to adult ITU, NICU HAI are most commonly associated with Gram-negative pathogens with high rates of antimicrobial resistance[4]. Additionally, HAI outbreaks in NICU involve a high patient burden (average of 23.9 patients vs. 6.9 in adult ITU). Gastmeier P, Loui A, Stamm-Balderjahn S, Hansen S, Zuschneid I, Sohr D, et al. Outbreaks in neonatal intensive care units - they are not like others. Am J Infect Control 2007,35:172-176
050	Royal College of Physicians and Surgeons of Glasgow	1	Monitoring the incidence of HAIs in hospital settings is feasible and there are established systems for doing this for specific HAIs. However we have concerns about the communication and collaboration between hospital and community Infection prevention and control (IPC) teams to fully implement this statement.
051	Royal College of Surgeons of England	1	• There is no mention of the role of the role of community and local Public Health departments, especially in community-wide outbreaks • They also suggest that diagnoses should be combined with data from other sources (clinical, epidemiological, pharmacy, microbiology) in real time- this could be a massive burden on a hospital infection control departments
052	Royal College of Surgeons of England	1	The data collection and dissemination of potential community-wide outbreaks should be co-ordinated by public health services with co-operation from admitting hospitals
053	Association of Independent Healthcare Organisations (AIHO)	2	Training and competencies should also be about prevention of infections. Staff should be competent in all aspects of prevention, not just managing healthcare associated infections.
054	Association of Independent Healthcare Organisations (AIHO)	2	This is quite NHS focused as it mentions the trust's objectives. The independent sector is not given objectives and are not called Trusts. Targets, or objectives related to prevention of infection may be worded in a different way such as an annual plan or strategy. Hospitals will have their own plans but they may not always call them objectives. I think this section needs to be reworded in a way that incorporates acute healthcare facilities outside the NHS. It would be extremely valuable to include some examples of what the objectives might be so that those who are not as knowledgeable will be able to complete this.
055	Association of	2	Examples of objectives for appraisal:

ID	Stakeholder	Statement number	Comments[1]
	Independent Healthcare Organisations (AIHO)		• All clinical staff will have completed their competence for ANTT annually • All staff will have successfully completed their mandatory training for infection prevention and control • All staff will have successfully completed their hand hygiene competence But each department would have specific competences that suit staff roles e.g. Cleaning, theatres, catering etc.
056	CR Bard	2	We strongly support the promotion of greater staff training and would argue that this should be more strongly reinforced within the quality standard. Increasingly, emphasis has focused on pro-activity and recognising potential problems which can only be achieved through effective training and knowledge of potential problems that could arise. Objectives around infection control could include a minimum amount of time staff should spend being trained on how to prevent healthcare-associated infections.
057	Deb Group Ltd	2	Individuals should be appraised through awareness of group/team achievement against hand hygiene compliance WHO best practice for hand hygiene compliance, and clear and precise improvement targets should be embedded in their objectives.
058	Healthcare Infection Society	2	Hospital staff have an appraisal of their objectives on infection prevention and control.
059	Healthcare Infection Society	2	Data could be collected at appraisal on compliance with infection control objectives. However the structures may not be available to develop individual objectives for most employees during appraisal, as this implies that the appraiser has particular competence in developing infection control personalised objectives. A generalised objective, apart from compliance with training for example, would be difficult to assess. Such a standard needs explicit guidance or should be tested.
060	Healthcare Infection Society	2	Requirements and responsibilities concerning infection control should be incorporated into job plans. Apart from measures such as attending induction and update training in infection control, and assessment of competence in relevant procedures it is difficult to see how infection control objectives can be measured at appraisal for all individuals. Thus this measure becomes a process audit. Outcomes relevant to infection control are usually measured at a level above the individual except in very specific cases, for example those responsible for improvement initiatives with their own specific objectives Appraisal could be an opportunity to collect information on compliance with training requirements and explore those who are non-compliant. Appraisal might not be the correct environment to measure general institutional objectives for all individuals.
061	Healthcare Infection Society	2	One of the barriers to sharing information is high level data, for example on CPE incidence. So a patient transferred from an area of UK with a significant risk of CPE should be isolated and tested as per PHE CPE toolkit. Information systems need to be available to inform this, a risk assessment determined by risk of referring institution - which is different from individual patient data
062	Infection Prevention Society	2	This quality statement is unrealistic. Infection prevention and control practice is subject to audit and competency assessment and the results fed back to staff. Appraisal focuses on role related performance and not an infection

ID	Stakeholder	Statement number	Comments[1]
			prevention and control objective. If the group are unclear who should be monitored and how it will be measured, we would suggest that it is removed.
063	MSD UK Ltd	2	MSD agrees with the inclusion of a quality statement for staff appraisal on their objectives around infection control. MSD would suggest that ongoing education on infection control is important for the whole multi-disciplinary team (MDT). An ongoing commitment to proactive learning in the area of infection control should be assessed a marker of quality, with peer to peer learning programmes established to support this locally. MSD supports the English Surveillance Programme for Antimicrobial Utilization and Resistance (ESPAUR)'s call for the development of standardised training material and competency assessments.
064	Public Health England	2	This statement does reflect key areas for quality improvement. PHE would also like to see a quality statement on strengthening leadership and governance around Infection Prevention and Control (IPC) across and within healthcare settings in light of the House of Commons Science and Technology Committee (2014) statement 'we are concerned that IPC does not appear to be delivered in a coherent fashion within the National Health Service'. http://www.publications.parliament.uk/pa/cm201415/cmselect/cmsctech/509/50902.htm The systematic review undertaken by the SIGHT study group demonstrated that an effective infection control programme in an acute-care hospital must include nursing staff , a dedicated physician trained in infection prevention and control, microbiological support, and data management support, and that lack of leadership is a barrier to establishing a successful programme. http://www.thelancet.com/pdfs/journals/laninf/PIIS1473-3099(14)70854-0.pdf
065	Public Health England	2	Suggest including a reference to Code of Practice on the prevention and control of infections as the guidance in the Code recommends that IPC is included in annual appraisals.
066	Public Health England	2	Suggest amending 'catering staff' to 'facilities management staff' as this will also be relevant to hospital engineers who have an important role in maintaining the environment, ventilation water supplies etc.
067	Public Health England - Antimicrobial Resistance and Healthcare Associated Infections (ARHAI**)**	2	How should objectives around infection control be appraised, and how often, for different types of staff working in hospitals? All staff members' job descriptions should include a statement regarding adherence to local policy and guidance for infection prevention and control relevant to the staff member's role. At annual appraisal, all staff should be required to provide evidence of attendance at or participation in local mandatory training for infection prevention and control at the locally-mandated frequency; as appropriate to the staff

ID	Stakeholder	Statement number	Comments[1]
			member's role. Records of completion of mandatory training by staff groups should be easily auditable from in-house e-learning systems. Staff members should not be identified from local audit data or incident reports as failing to adhere to appropriate infection prevention and control practice as set out in local policy or guidance.
068	Royal College of Anaesthetists	2	Comments about quality statement 2 -It would be interesting to know, as a starting point, how many healthcare professionals have 'infection prevention and control' as a specific outcome within their appraisal process. It is likely that those out of the field of infection prevention and control directly may not have this as an outcome and the second question would be whether they do indeed need to have this explicitly. -All clinical staff (nurses, physiotherapists, occupational therapists, doctors, nurses, midwives, radiographers etc.) should already actively engage in the annual appraisal process. Can the same be said for other clinical staff such as the porters and non-qualified members of staff? One could argue that it is perhaps even more important that these health care assistants and porters etc. have a robust method to ensure they are up to date with infection prevention and control practices as they are transporting patients all around the hospital, with massive implications with respect to cross contamination and transmission of infections. -Could the objectives be that all staff in acute hospital settings are able to evidence that they are compliant with trust policies in relation to infection prevention and control (IPC)? This could be achieved by ensuring that they attend at least annual updates or e-learning modules in IPC (as set out by individual trusts). It could be stated that we all, as staff working in an acute hospital have an individual responsibility to ensure that we are up to date with these matters but that line managers and ultimately the trust board are wholly responsible for ensuring concordance with all staff members.
069	Royal College of Anaesthetists	2	**Response to consultation questions** 1) Yes 2) Yes, but there is a risk of making things over complicated by mandating that staff should have personal objectives with regard to IPC. May be more achievable to suggest that staff should be seen to meet trust policy and objectives with relation to IPC. 3) Evidence of trust standards would be induction and mandatory training expectations and requirements. E.g. e-learning module with quiz to be completed prior to start of placement, face to face presentation from infection control team, specific clinical assessment of certain procedures where asepsis and technique are crucial in reducing the rate of HCAIs (i.e. urethral catheterisation, vascular catheterisation, blood culture taking, hand hygiene assessments) 4) This would depend on local policies. It may be worth a survey or questionnaire to hospitals to see what is already in place and listing examples of how this could successfully be achieved. All inductions have electronic and or face to face sessions on IPC. These could be used to set out expectations of trust as well as outlining the personal responsibilities that we have for keeping up to date in this field whilst working for said trust. The assessments should

ID	Stakeholder	Statement number	Comments[1]
			be reviewed at least annually and may be as frequent as 6 monthly for trainees rotating to different trusts (non-consultant training grade medical staff for example). In the briefing document statement 032 in appendix I stated that 'hand hygiene is the single most effective intervention to prevent HCAIs'. If this is the case then this should be a mandatory clinical assessment as part of this process?
070	Royal College of Paediatrics and Child Health	2	Sounds punitative. Would it not be better to ensure annual update training of infection control policies as part of clinical governance? Appraised then against achieving annual training.
071	Royal College of Physicians and Surgeons of Glasgow	2	This is a useful quality statement in highlighting the fact that all staff within a healthcare organisation have a role in preventing infection. However, we have concerns about the practicality of this being a stand-alone item in the annual appraisal of all staff groups, or for data on this to be collected. It would be feasible to collect data on proportions of each staff group undertaking annual mandatory training in infection prevention and control – such training should be tailored to each staff group, and therefore valuable and relevant to all staff roles.
072	Royal College of Physicians and Surgeons of Glasgow	2	Training in infection control will clearly be very different for different groups, both in content and in required frequency, for example catering staff who are handling food will need more frequent training, relating predominantly to preparation of food, while front line clinical staff will require other relevant training, for example, handling sharps, hand-washing, personal protective equipment, etc. The hospital IPC team (in collaboration with community colleagues) will be in the best position to develop and deliver appropriate training.
073	Royal College of Physicians and Surgeons of Glasgow	2	Another way of assessing the general level of training would be a 'mystery shopper' approach, where staff are approached and asked questions around infection control set within a context of reviewing the outcomes of this at a team, rather that individual level
074	Royal College of Surgeons of England	2	In the source guidance PH36 'Prevention and control of healthcare-associated infections' it specifically mentions staff in clinical settings not 'all staff'
075	Association of Independent Healthcare Organisations (AIHO)	3	The language in the rationale needs some consistency. You use 3 different terminologies 1. infection prevention and control 2. infection control 3. Infection and control teams. Infection Prevention and Control is the accepted terminology
076	Association of Independent Healthcare Organisations (AIHO)	3	Infection prevention and control teams input is to ensure that when maintenance activities are undertaken all the appropriate controls are in place to ensure patients are not at risk of infection from the building works (e.g. dust etc.). So this needs to be slightly reworded. For example:

ID	Stakeholder	Statement number	Comments[1]
			• Evidence that hospitals have written protocols, approved by the infection prevention and control committee, for preventive measures when new build or maintenance activities are undertaken.
077	Association of Independent Healthcare Organisations (AIHO)	3	Change infection control – to infection prevention and control
078	Association of Independent Healthcare Organisations (AIHO)	3	Infection and control team – change to infection prevention and control team
079	Association of Independent Healthcare Organisations (AIHO)	3	Should read “Preventive maintenance”
080	Association of Independent Healthcare Organisations (AIHO)	3	1. It is essential that patients are not put at risk of any dust or debris created when building works are in progress. This is particularly important for immunocompromised patients. So infection prevention and control teams should be involved in helping with this and signing off that daily cleaning processes are being completed and checked 2. They also need to be involved to ensure that new build or renovation incorporate all aspects of infection prevention and control in the built environment. For example; materials that can be easily cleaned, flooring that is coved, correct hand hygiene sinks (and enough of them), correct air handling units. This is a valuable journal paper
081	CR Bard	3	The April 2014 NICE quality standard infection prevention and control makes recommendations relating to urinary catheters stating: “Maintain a closed sterile system and the connection should not be broken unless clinically indicated.” Adhering to the standard has proven to reduce the number of healthcare associated urinary infections. This quality standard, therefore, should make a similar recommendation. For example, the Bard pre-connected closed system. The catheter and urine drainage bag are pre-connected with a removable seal. Having this seal in place means that the drainage bag can stay in place for up to 14 days and also significantly reduces the risk of the catheter and drainage bag becoming accidently disconnected, therefore reducing the risk of infection (CAUTIs). It may also result in cost savings by not having to change bags more frequently. Products such as this should be signposted to provide hospitals and commissioners a clear guide as to what recommended products/types of products are available. This innovation is also in line with Domain 4 of the NHS Outcomes Framework 2015-16, ensuring that people have a

ID	Stakeholder	Statement number	Comments[1]
			positive experience of care. By having all equipment contained within one pack the whole process is more streamlined and easier for healthcare professionals and the patient. Having the trays in place gives a much better impression to the patient; staff are no longer opening multiple packets and forgetting items, therefore promoting a more professional approach. This approach could be replicated across a number of interventions.
082	Deb Group Ltd	3	Deb Group find it at odds with available WHO evidence that, whilst there is a separate section for the maintenance of hospital facilities and the built environment, there is no provision for monitoring hand hygiene compliance
083	Healthcare Infection Society	3	Hospitals involve infection prevention and control teams in the preventive and remedial maintenance of services and facilities
084	Healthcare Infection Society	3	Infection Control teams should be involved at the very beginning of any project on the hospital estate, including preventative and remedial maintenance. This is to ensure that essential measures are not forgotten and that potential unforeseen consequences are avoided. Involvement potentially continues through each project and is also particularly important before signing off work involving changes which may impact on function of, for example water or ventilation systems. In these cases compliance with standards may need to be checked before patients are allowed into refurbished areas. All projects, not just maintenance and repair should have the same opportunity for in depth involvement with the infection control team.
085	Infection Prevention Society	3	It is unclear why this is seen as a high priority area for quality improvement. Infection control is not relevant to a significant proportion of maintenance work (changing light bulbs etc) or is already covered by systems of work and HTM regulations, which include infection control (such as those below). Expecting the IPCT to approve all maintenance work is both unnecessary and unrealistic and is likely to slow such work down and therefore be counterproductive.If retained this statement should focus on the inclusion of IPC teams at the design stage of estates and facilities (and refer to the relevant HTM) They should be integral to all plans to refurbish wards/ units/ patient areas throughout the planning, procurement and implementation of works.
086	Public Health England	3	IPC teams need to be given the opportunity to give advice at any point of the maintenance work on hospital services and facilities. The same holds true for new build and refurbishment.
087	Public Health England	3	Hospital IPC teams need to have expertise in (or access to) air handling and ventilation, water quality, waste management, linen and laundry, and decontamination. They also need to understand planning and commissioning in terms of new builds and refurbishment.
088	Public Health England	3	Add new builds and refurbishment
089	Public Health England	3	Local data collection add ‘and feedback’
090	Public Health England	3	Add – Health Building Note 00-09: Infection control in the built environment (2013)
091	Public Health England - Antimicrobial Resistance and Healthcare Associated Infections	3	What is the most important contribution of infection and control teams to maintenance work on hospital services and facilities, and at what stage of this work is it important? IPC team members should be consulted with sufficient notice prior to any work commencing. They should have an opportunity to contribute to and influence not only plans for maintenance of services and facilities but equally

ID	Stakeholder	Statement number	Comments[1]
	(ARHAI**)**		importantly to the development of new services and facilities. Challenging to audit adherence to this requirement.
092	Royal College of Anaesthetists	3	**Comments about quality statement 3** - Should this be a little bit of a broader statement and also cover cleaning of equipment and day to day IPC issues? It reads like this only applies to maintenance work by outside organisations or non-clinical staff. - Would it be better to talk about the patient 'environment' which is a broader term as mentioned in the briefing document (appendix I item 014) incorporating the whole of patient surroundings including hand hygiene facilities, patient placement and isolation facilities, fabric and cleanliness of building, patient equipment, related fixtures and fittings and services such as air and water supplies?
093	Royal College of Anaesthetists	3	**Response to questions** 1) Partially, please see comments above 2) Yes, data should be held by IPC team 3) Regular inspections of wards, hand hygiene particularly including regular practical assessment using UV light boxes (as it comments in briefing paper that many wards and clinical areas achieve 100% on hand hygiene spot checks, but do standards slip when people are not being watched?) 5) Contribution is important throughout the process, especially in the planning phases of planned works. This ensures that maintenance can be conducted in a timely fashion with appropriate safeguards in place to minimise disruption and delays. There should be a member of the IPC team as a point of contact throughout any works, even at weekends and out of hours. IPC teams should hand over planned and ongoing works so that on-call teams can be 'up to speed' on the situation if and when any problems do indeed arise.
094	Royal College of Nursing	3	'*Hospitals involve infection prevention and control teams in the preventive and remedial maintenance of services and facilities'.* This statement should explicitly refer to decontamination and include both the physical environment and decontamination facilities including equipment used (this should include relevant validation criteria and maintenance/replacement of old and worn equipment/instruments) to support patient care.
095	Royal College of Physicians and Surgeons of Glasgow	3	There is no mention of the involvement of IPC teams in new building works, and presumably this is because this is already a clear recommendation/requirement?
096	Royal College of Physicians and Surgeons of Glasgow	3	We agree that IPC teams should also be involved in maintenance work where this is over a certain monetary value (i.e. probably not worth asking for input for very minor maintenance). This could be achieved by requiring sign-off of projects by the IPC team prior to work commencing. However, for large projects clearly it would be useful for the IPC team to be involved at a much earlier stage in the planning process, as if there are IPC issues, these can be addressed as early as possible.
097	Royal College of Physicians and Surgeons	3	As regards the most important contribution of the IPC team, there are many potential areas where the IPC team would bring in expertise and ideas to reduce HAIs, including considering ventilation and air changes, spacing

ID	Stakeholder	Statement number	Comments[1]
	of Glasgow		between patients, provision of hand washing facilities, etc. These all potentially require structural changes, and therefore need to be considered early, before finalisation of the planned work and costing is carried out.
098	Royal College of Surgeons of England	3	It does not mention specifics about the availability of hospital facilities to support staff with preventing HCAIs - such as ensuring staff have adequate access to surgical scrub, wash basins, gloves, aprons etc
099	Association of Independent Healthcare Organisations (AIHO)	4	It would be excellent if organisations could collect these figures, but the only way to do this will be by recommending they collect it prospectively in the process of admission. Another way of completing this would be by auditing annually a selection of notes.
100	CR Bard	4	We strongly support the rationale within the quality standard that sharing information is crucial to improving outcomes. In order to reduce urinary infections, many NHS Hospital Trusts across the country have issued a 'passport' to all patients with a long term urinary catheter. Any health issues and current or previous infections can then be recorded in the passport, ensuring total transparency and consistency for all nursing, medical and healthcare staff when caring for patients. The passport can also be filled in by patients and carers, ensuring they are involved in their own care. Passports also contain information on where patients can go for help and more information should they have issues with their catheter. This concept of recording patient information in an easily accessible place, where various healthcare professionals and the individual themselves/their carers can input, should be more widely encouraged in order to ensure those involved in care delivery have all the relevant information they need.
101	Healthcare Infection Society	4	People admitted to, discharged from or transferred between hospitals have information about any infections and associated treatments shared with their health and social care practitioners
102	Public Health England	4	'…when people are admitted to, discharged from or transferred between hospitals add other care providers to ensure good quality communication across the care pathway.
103	Public Health England	4	It can be difficult to monitor which patients have had information transferred without some very labour intensive hand searching of notes. Good IT systems could make such a difference.
104	Public Health England - Antimicrobial Resistance and Healthcare Associated Infections (ARHAI**)**	4	This should include the qualifier that information about infections and associated treatment must be provided in advance of the transfer or at the very least be available to the receiving clinicians immediately at the point of transfer. Challenging to audit adherence to this standard.
105	Royal College of Anaesthetists	4	**Comments about quality statement 4** - Would it be useful to be a little more specific on information that should be shared (e.g. MRSA status, positive culture results, lines – when they were put in, indication plus intended duration, antibiotics and other treatments along with plans for further investigations and treatments and when these are due). - Whose responsibility it is to hand this information over and in what format (i.e. SBAR nursing handovers,

ID	Stakeholder	Statement number	Comments[1]
			medical discharge summaries, positive microbiology results flagged on electronic reporting systems).
106	Royal College of Anaesthetists	4	Response to questions 1) Yes 2) Data collection for denominator relies on accurate coding. Numerator data could be difficult to extract especially if there is no explicit standard as to where the data should be sought or indeed recorded and by whom Discharge letters in some Trusts contain a section specifically for documentation of patient infection status. The down side to this is that it would only be completed for patients who are discharged from the hospital and would not be completed for patients transferred to another hospital in the same trust for example. For these patients there would be a written nursing SBAR handover
107	Royal College of Anaesthetists	4	Comment in response to 038 We agree with this statement. An area definitely for further development. The majority of lines inserted in the pre-hospital environment are inserted aseptically. Handover to secondary care hospital staff should identify IO devices and IV lines which were not able to be placed aseptically/should be removed as soon as definitive IV access obtained. It is a rare circumstance that any vascular access line should be placed in a non-aseptic manner in any setting. The majority of the IV lines will be placed aseptically and therefore should be able to remain in situ as per local trust policy. Limiting unnecessary skin and vascular punctures will be better for all patients.
108	Royal College of Physicians and Surgeons of Glasgow	4	This statement is very important for transfer of patients between hospitals, particularly for patients in complex and high risk environments such as the intensive care unit. Information about infections causing illness in patients will virtually always be communicated between clinical teams as a matter of course, however communication may be less robust for patients who are colonised with organisms not causing disease, for example MRSA or vancomycin resistant enterococci. This is even more of an issue where patients are transferred from other countries with much higher rates of multi-resistant organisms. Information transfer at the moment relies on awareness of the clinical and IPC teams, and this statement will hopefully encourage healthcare organisations to develop more robust systems for ensuring full communication of infecting or colonising organisms that could spread to other patients and to staff.
109	Royal College of Physicians and Surgeons of Glasgow	4	We question how compliance with this statement could be monitored continually, other than through regular audits of case notes of patients being transferred between sites.
110	Royal College of Physicians and Surgeons of Glasgow	4	This statement as it stands does not fully reflect the issue of transfer of dangerous pathogens between sites, and we would suggest alternative wording: *When people are admitted to, discharged from or transferred between hospitals, information about any infecting or colonising organisms, associated treatments and required infection prevention measures should be shared with their health and social care practitioners.*
111	Royal College of	4	No comments

ID	Stakeholder	Statement number	Comments[1]
	Surgeons of England		
112	Royal College of Surgeons of England	4	No comments
113	St John Ambulance	4	There is no clear mention of those services that actually transport patients from the hospital home or to another provider venue; it is important that they are made aware of a patient's infection status so that they can plan and staff such journeys appropriately and ensure any vehicle used is effectively decontaminated as necessary.
114	NHS Trust Development Authority	Question 4	Objectives should be set around the organisational strategy/risk assessment and development/ aspirational needs. PDR is generally an annual process. This could be monitored via ESR but this may not be universally available. How would this be specifically recorded for large organisations? Appraisal is recorded but not individual aspects; may be too complex and time consuming. Including in JD may be measurable.
115	Royal College of Surgeons of England	Question 4	•Ensuring all staff have mandatory training on hand washing, appropriate clothing and jewellery etc •Consideration should be included on training of new staff and locum staff •Appraisal could be carried out through audit of HCAI events through microbiology
116	Scottish Antimicrobial Prescribing Group	Question 4	Objectives around infection control being appraised (QS2) could be included within the annual personal development review for all staff groups and for non-medical staff could be recorded with the eKSF system. Mandatory annual updates on infection control could also be utilised for all staff and would be easily captured if using an on-line training module.
117	NHS Trust Development Authority	Question 5	We feel that IPC should be involved in: 1. Following guidance in HBN 00-09 it is essential that IPC are involved at the commencement of any project. Currently this is not always the case. 2. Assessment of cleaning provision requirements as this is fundamental for ensuring a safe environment. 3. Decontamination of equipment pre and post procurement. 4. Water Safety.
118	Public Health England	Question 5	There needs to be recognition that there are different levels of competence required in IPC. For example: • There should be competence in the core principles of IPC for all staff • IPC leaders: competence plus ability to champion IPC
119	Public Health England	Question 5	Infection control teams are of most value when consulted before a change is made or a new piece of equipment is purchased in assessing the likely infection control impact eg dust created during works, need for decontamination of a new endoscope and best method of doing this. In some cases examination of the infection control requirements may mean rethinking the options for change – eg an endoscope requiring an additional expensive piece of special decontamination equipment may not be the best buy in comparison with an apparently more expensive model.
120	Royal College of	Question 5	•Ensuring adequate numbers and correctly placed wash basins, aprons, gloves etc

ID	Stakeholder	Statement number	Comments[1]
	Surgeons of England		•Regular and calendared testing of disinfection systems, water supply and drainage systems, air conditioning and ventilation systems •They should be consulted early in planning of any changes to wards or departments
121	Scottish Antimicrobial Prescribing Group	Question 5	Infection control staff have a role to play in the planning of all building and maintenance work in clinical areas to provide a risk assessment from an IC perspective. Their input should occur during the work planning stage.

Registered stakeholders who submitted comments at consultation

Association of Independent Healthcare Organisations (AIHO)

British Infection Association

CR Bard

Deb Group Ltd

Department of Health

Healthcare Infection Society

Infection Prevention Society

MSD UK Ltd

NHS England

NHS Trust Development Authority

Public Health England

Public Health England - DH Advisory committee Antimicrobial Resistance and Healthcare Associated Infections (ARHAI)

Royal College of Anaesthetists

Royal College of Nursing

Royal College of Paediatrics and Child Health

Royal College of Pathologists

Royal College of Physicians and Surgeons of Glasgow

Royal College of Surgeons of England

Scottish Antimicrobial Prescribing Group

St John Ambulance

UK Clinical Pharmacy Association (UKCPA)