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Dr Henrietta Campbell
Chief Medical Officer
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Dear Dr Campbell

JOINT COUNCIL RESPONSE TO “THE STRATEGY FOR THE PREVENTION AND CONTROL OF HEALTHCARE ASSOCIATED INFECTIONS - A CONSULTATION PAPER”

Councils would express their support for the view that “Infection Prevention and Control is Everyone’s Business” – including – with appropriate support – patients themselves and visitors.

We express our support also for a single strategic approach to Infection Control overall. The DHSSPS will be well aware of widespread public concern over MRSA and other infections coupled with – we believe – a general media response that serves to increase anxiety. We believe it is of vital importance that a single clear message is are given to the general public on HCAs, their nature and the reasons for infections in hospitals that – despite current efforts – are simply not getting through – the message that infections in hospitals cannot be eradicated, for example – or that they are a risk associated with severe illness and frailty.

We note the “patchy” compliance with Public Accounts Committee recommendations on HCAI and trust that through this strategy universal compliance with central recommendations will follow to the greater benefit of patients.

We welcome the placing of infection control in the centre of clinical and social care governance agendas of Trusts and the naming by the strategy of the Chief Executive of each healthcare organisation as the responsible officer when it comes to infection control.

The strategy states that “patients do not expect to contract any preventable but life threatening infection during their stay.” However, the strategy also states that only 15% of HCAI can be prevented. We would question whether this raises an important matter on the “messages given to patients – should they be encouraged to believe all HCAI infections can be prevented in accordance with their expectation? Or should they be educated on the actual risks and causes of HCAI without the expectation that they can be eradicated?”

We agree and support the principle that visitors and patients have a clear responsibility to help minimise infections in hospitals and care settings – the success of this, however will depend on very clear, unequivocal and high quality information and shared policies across all trusts – for example, on visiting.

With regard to equality – and given the primacy of good information for the benefit of patients, it is clear that such information and training requires to be presented in formats that are accessible to all. There is no statement that this will not be the case in the body of the document. However, there is no clear statement either that it will.

We wish to express our surprise that, given the profile given to HCAI by the general public, the media and politicians that comprehensive surveillance of the incidence of these infections does not take place. We believe that unified and comprehensive information presented openly will benefit patients and give a clearer basis for concerns expressed in the media and elsewhere. We do not feel that anything other than a comprehensive and thorough regional response will be adequate to address this problem.

We would support the priority given to addressing issues identified by the DHSSPS 2001/2002 survey of all hospital trusts that is : additional resources for infection control teams, increasing the complement of infection control nurses, improved co-ordination of data collection systems, support for hospital microbiology departments and increasing the priority given to Infection Control at Trust Board level. We welcome the introduction of mandatory monitoring of MRSA and the introduction of mandatory *c.difficile* monitoring from 2005 and presume that this will start to address the lack of comprehensive information earlier identified by the strategy. We would welcome monitoring on a universal basis of the implementation of Controls Assurance Standards in all Trusts as well as the monitoring of the infections themselves.

We welcome the strategy on environmental cleanliness and the link between this and infection control. However, this paragraph makes it clear that the link between environmental cleanliness and infection is not as clear as it is often presented to the general public.

We would caution against promoting any initiative that does not have a proven effect on infection but which is designed to address media and public perceptions of infection and would prefer to see better and clearer information on the sources and risk of infection instead.

Again, we would support the key themes outlined by strategies for infection control in England, Scotland and Wales that is: organisations that facilitate effective infection control strategies, clear governance and accountability, education and training for all staff; good surveillance influencing practices and monitoring outcomes.

We would welcome figures or further information on the effect of bed occupancy rates on HCAI. It would be a concern to us if this strategy – and its priorities – were being countermanded in any way by other DHSSPS strategies – for example, those on waiting times.

We would welcome mandatory training on Infection Control for all HPSS clinical and care staff involved in direct care and for this to be a requirement also on all bank and agency nursing staff used by the HPSS. We would like to see the Infection Control agenda rolled out to the community and to the independent sector with priority given to care, residential and nursing homes for the elderly.

We would like to see such training organised on a regional basis and delivered by members of Trust Infection Control Teams working in collaboration one with another.

STRATEGIC OUTLINE

We agree with and strongly support the principles underpinning the aims of the strategy. We agree with and strongly support the priority areas for action outlined in the strategy.

ORGANISATION AND CULTURE

We note the documents acknowledgement that throughput and productivity pressures may be a factor making it more difficult to adhere to high standards of infection prevention and control at all times. The DHSSPS should give a clear indication of its priority in this area ie that patient safety (risk of infection) has higher priority than patient throughput, for example. The efficiency and cost benefit of this will not be possible to demonstrate except through clear, comprehensive information on the incidence of infection and its overall impact on lengths of stay, delayed discharge and readmission (including emergency admissions)

EDUCATION, TRAINING AND PRACTICES

We would support a move to mandatory infection control training for all health care staff in direct contact with patients. This should be universal, have common content and delivery by infection control specialists. This may create pressures to augment Infection Control Teams in all Trusts. We think the various health professional training organisations should review their own curriculae to ensure universal adequacy of skill in managing and minimising HCAI by all health professionals.

GOVERNANCE, ACCOUNTABILITY AND AUDIT

We welcome the broad statements in this section on Governance, Accountability and Audit and agree that Infection Control should be a core part of this agenda. We welcome the fact that the Chief Executive of the organisation has direct responsibility for infection control in his/her area but believe that they should operate to a common and agreed set of standards and priorities. We are aware that the duty of quality along with Clinical and Social Care Governance and the establishment of HPSSRIA are all recent innovations very much in their infancy. We hope that allowing time for these initiatives to bed in will not delay progress on ensuring the necessary basic quality standards, training and resources for Infection Control

are in place. In our view, Infection Control is part of a clinical imperative for which knowledge and skills are in place and should not depend on the implementation of a wider strategic quality agenda to make progress.

SURVEILLANCE

We would prefer to see ongoing and comprehensive surveillance of organisations to minimise risk, map trends and inform practice at all times and across the Board. As this is not possible according to the strategy we would welcome a focussed, objectives driven, cross – service collaborative approach to targeting areas for investigation and for the content and outcome of such surveillance to be clear and transparent – including to the general public – especially where specific actions/resources are indicated.

PATIENT AND PUBLIC PARTNERSHIP

We would agree that clear and comprehensive guidance and information should be available to patients. In our experience, patients and their families will be very willing and able to participate – as a general rule - in the effective management of infection however, the information they require must be presented in a format that is intelligible to them and must be consistent. It would be better to have a single Northern Ireland leaflet on MRSA – for example – than a multitude of locally produced leaflets and there is a strong argument that Infection Control specialists’ time will be better used – in every sense – in contributing to the production of such accessible information than in seeking to provide their own local version.

RECOMMENDATIONS

In broad terms; we welcome and support the recommendations of the report but would wish to add the following comments:-

- That infection control is an issue for healthcare facilities other than hospitals should be made more explicit – particularly as regards care and residential facilities for elderly people in the Independent Sector.
- That it should be acknowledged more explicitly that additional resources are required for Infection Control Teams.
- That the effect of high bed occupancy on infection control is emphasised and is a priority area for continuous monitoring. The competing pressures between reduced waiting lists and good infection control practice shows the importance of the development of ‘joined up’ strategies.
- We would strongly support the recommendation that a unified approach to policy, information and guidance across DHSSPS will be taken through collaboration of Infection Control teams in all Trusts.
- That recommendations on staff changing should be expanded to include remedial development to ensure the maintenance of standards in existing, as well as new, healthcare facilities.

- That recommendations should be made on standards of dress for all health and care professionals in contact with patients where this will be to the benefit of patients.
- We would strongly support the recommendation that training on Infection Control becomes mandatory at the various stages of training and continuous professional development and that this requirement extends to bank and agency staff.

HSSCs welcome the priority given by the strategy to clear and intelligible public communication. It is important perhaps particularly for this strategy that it is accompanied by a media strategy.

2005 saw a regional “Bugwatch” survey by HSSCs, the outcome of which has informed this response. There is a consensus among Councils that they should continue to undertake “Bugwatch” surveys but that such surveys notes should in future be unannounced and should extend to non acute health and care facilities. HSSCs will review the “Bugwatch” toolkit with this in mind. HSSCs will seek formal annual meeting with HPSSRIA to discuss the outcomes of “Bugwatch” surveys and other initiatives undertaken by Council.

Yours sincerely

Richard Dixon
Chief Officer of the EHSSC on behalf of the
NI Health and Social Services Councils.