What’s new?

In the context of the new Health and Social Care Bill, the Department of Health has asked National Institute for Health and Clinical Excellence (NICE) to prepare a series of public health briefings to support Directors of Public Health, elected members and senior officers in local authorities to find out which public health actions are most effective and provide best value for money.

The briefings are intended to raise awareness and provide information about the existing evidence-based recommendations and evidence reviews from NICE that can inform the commissioning of public health services. The briefings will cover a range of issues, including alcohol misuse, smoking, physical activity and obesity and workplace.

We are currently establishing a new committee to guide the development of the briefings, and the first briefings are planned for summer 2012.

Quality improvement and standards are an important focus in the reformed commissioning system. The Centre for Public Health Excellence, NICE has piloted, in partnership with the Health Protection Agency the development of a quality improvement guide for the prevention and control of healthcare-associated infections (HCAIs).

This guide was published in November 2011 and is profiled below.

Quality improvement guide for HCAIs (http://www.nice.org.uk/guidance/phg/hcai/QualityImprovementGuide.jsp)

The guide offers advice on management or organizational actions to prevent and control HCAIs in secondary care settings. It is aimed at trust boards and senior management in secondary care settings, including commissioners, auditors, managers and providers.

This guide is not mandatory but aims to help build on advice given in the code of practice on preventing and controlling infections (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.) and elsewhere to improve the quality of care and practice in these areas over and above current standards.

The term HCAI covers a wide range of infections. The most well known include those caused by meticillin-resistant Staphylococcus aureus (MRSA), meticillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) and Escherichia coli.

HCAIs pose a serious risk to patients, staff and visitors. They can incur significant costs for the National Health Service (NHS) and cause significant morbidity to those infected. Although major improvements have been achieved in infection control, evidence indicates a wide variation in trusts’ performance in reducing the impact of HCAIs. Reducing HCAIs will help trusts and other NHS organizations to avoid the costs of infections including drug therapies, hospital readmissions, litigation, ward closures and decontamination. NICE estimates that a 5% annual reduction in MRSA and C. difficile will reduce national NHS costs by an £4.9 million annually.

The 11 quality improvement statements provide clear markers of excellence in infection prevention and control at a management or organizational level. Each statement is supported by examples of the type of evidence that could be used to prove the organization has achieved excellence, and examples of what this would mean in practice on a day-to-day basis (Table 1).
Table 1  Quality in the prevention and control of healthcare associated infections

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<tr>
<th>Quality improvement statement</th>
<th>Practical examples of measures of achievement</th>
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| 1. Trust boards demonstrate leadership in infection prevention and control (IPC) to ensure a culture of continuous quality improvement and to minimize risk to patients. | • Annual improvement plans include comparative data on progress towards relevant quality improvement statement goals, as well as in areas covered by other relevant guidance.  
• Regular audit of board IPC accountability framework.  
• IPC features in the planned board development programme. |
| 2. Trusts use information from a range of sources to inform and drive continuous quality improvement to minimize risk from infection. | • A range of forums give staff the opportunity to learn from each others’ experiences in relation to IPC.  
• Audit of antimicrobial drug usage to check it complies with trust policy.  
• Audit of hand-hygiene practices and feedback given to relevant staff. |
| 3. Trusts have a surveillance system in place to routinely gather data and to carry out mandatory monitoring of HCAIs and other infections of local relevance to inform the local response to HCAIs. | • Surveillance data (for example, on antimicrobial resistance (AMR)) is routinely communicated to the board and to individual clinical units. This includes comparative data on performance within the trust over time and compared with other local or national data.  
• Regular publication of outputs from the surveillance system, for example, on post-surgical infection rates and rates of compliance with recommendations on surgical prophylaxis. |
| 4. Trusts prioritize the need for a skilled, knowledgeable and healthy workforce that delivers continuous quality improvement to minimize the risk from infections. This includes support staff, volunteers, agency/locum staff and those employed by contractors. | • An agreed performance indicator for the proportion of staff appraisals that include IPC.  
• Performance against this indicator is checked on a regular basis.  
• Monitoring of proportion of new staff who undergo pre-employment occupational health screening or assessment within a given timeframe. |
| 5. Trusts ensure standards of environmental cleanliness are maintained and improved beyond current national guidance. | • Mechanism is in place to ensure a rapid response cleaning is initiated within appropriate timeframe.  
• Clearly defined policy for cleaning and environmental decontamination (including roles, responsibilities and accountability). |
| 6. Trusts work proactively in multi-agency collaborations with other local health and social care providers to reduce risk from infection. | • Documented terms of reference for multi-agency collaboration to reduce HCAIs.  
• Audit of outputs from collaboration disseminated to relevant trust committees (for example, clinical governance and policy development groups). |
| 7. Trusts ensure there is clear communication with all staff, patients and carers throughout the care pathway about HCAIs, infection risks and how to prevent HCAIs, to reduce harm from infection. | • Audit of communications between different health and social care providers detailing any infections (for example, an audit of discharge summaries to GPs and admission letters from care homes).  
• Audit of patient records for communication about HCAIs (for example, their MRSA status) throughout their hospital episode. |
| 8. Trusts have a multi-agency patient admission, discharge and transfer policy which gives a clear, relevant guidance to local health and social care providers on the critical steps to minimize harm from infection. | • Audit of adherence to relevant policy on admissions/transfers/discharges of patients with an HCAI.  
• Reduction in the number of adverse events recorded as a result of discharge and transfer of a patient with an infection. |
| 9. Trusts use input from a local patient and public experience for continuous quality improvement to minimize harm from HCAIs. | • Audit of HCAI reviews and investigations that include comment from patients and the public. |

Continued
The aim is to help boards:
- assess current practice in relation to the prevention of HCAIs,
- identify areas for quality improvement,
- monitor progress,
- provide leadership and support to infection prevention and control teams and other staff working to implement the guide.

It covers key areas such as hand hygiene, antimicrobial stewardship and environmental cleanliness. Much of the information required to support the measures is already available and a range of other guidance can be used alongside this guide to assess and improve quality in secondary care settings.

The guide is being evaluated through a short on-line questionnaire.

### New referrals

The Centre for Public Health Excellence has received the following referrals for future guidance.

- Guidance for employers on management practices to improve the health of employees, with particular focus on the role of line managers. The guidance will cover support for managers, training and awareness of employee health issues including managing sickness absence, as well as policies and the organizational context.
- Guidance for employers and employees on effective and cost-effective approaches for promoting and protecting the health of workers with chronic diseases (including cancer, HIV, diabetes, musculoskeletal conditions and arthritis) and long-term conditions and for effective management of sickness absence associated with these conditions.
- Guidance for employers and employees on effective and cost-effective policies and approaches for promoting and protecting the health of older workers, including workplace adaptations and work adjustments to changing needs to extend working lives and as preparation for retirement.
- Guidance for dental health practitioners on effective approaches to promoting positive oral health behaviour, including a positive patient experience of attendance at the dentist and reducing any anxiety among ‘dental phobics’. This would include content and modes of communication of dental health messages for the public.
- Guidance for local authorities on needs assessment and commissioning of community dental health programmes to promote the oral health of their communities, particularly vulnerable groups at risk of poor dental health. Epidemiological surveys would contribute to needs assessment.
- Guidance for carers working in health and social residential care settings (including nursing homes and residential care homes) on effective approaches to promoting oral health, preventing dental health problems and ensuring access to dental treatment when required.

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<td>10. Trusts consider IPC when procuring, commissioning, planning, designing and completing new and refurbished hospital services and facilities (and during subsequent routine maintenance).</td>
<td>• Record of adherence to the trust estates policy, including the IPC team's involvement.</td>
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<td>11. Trusts regularly review evidence-based assessments of new technology and other innovations to minimize harm from HCAIs and AMR.</td>
<td>• Programme in place to consider current research activity and developments in HCAI innovation and technology.</td>
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