User Documentation:

Risks, contracts and infectious disease in the UK NHS managed market

1. **Description of the originating project**
   This project aimed to determine how risks associated with infections and infection control were affected by the quasi-market reforms that reconfigured the health sector in the UK following the white paper, Working for Patients (DoH 1989). The reforms erected monetary boundaries between providers and purchasers of services. The boundaries were maintained, with reduced emphasis on competition, by the Labour government (DOH 1997). The NHS was transformed from a unified system of governance into one that charged purchasers with responsibility for using contracts (now called agreements) to purchase for the needs of the population from quasi-competitive providers. In hospitals these reforms recommended the extension of resource management involving a form of devolved budgeting to ensure greater financial accountability (DHSS 1986). Managers of clinical directorates, support service directorates and central services were provided with cash limited budgets thus erecting financial boundaries within the hospital.

2. **The specific objectives of the study were:**
   - to evaluate the effectiveness of formal contracts, regulations and informal practices relating to risks of infection and their likely effectiveness.
   - to consider how agency relationships within professional and managerial systems affect the implementation of programmes to reduce risk and cope with outbreaks of infections;
   - to consider how contracting agents perceive risks associated with infectious disease and the values placed on risk avoidance practices compared with preventive practices;
   - to consider how risks, financial, social and psychological, are distributed amongst NHS agencies, other agencies, patients and families; to consider how initial allocation of risk in the contracting process affects the eventual distribution of this burden; and to consider attempts to pool risks.

3. **Methods**
   **Case study sites**
   The case studies examined the arrangements for managing the risks of infectious disease in five health districts. A purposive sampling technique was used to select sites that included large conurbations and county towns, and district general hospitals and specialist teaching hospitals. Sites were guaranteed anonymity. Semi-structured in-depth interviews were conducted between November 1997 - November 1998 with CsCDC and Directors of Public Health (DsPH) in health authorities, ICDs and
ICNs in Trusts, and financial officers (or others involved in contracting). Interviews with key actors in each site enabled multiple perspectives to be obtained (Britten 1995). Thirty-seven people were interviewed at 35 interviews. Interviews were either fully or partly transcribed (depending on quality of tape recording – competing background noise hampered some interview recordings). Transcripts of the interviews are in Word (standard word-processing package). One interviewee declined to be taped and one asked for the tape to be turned off part way through the interview. Interviewees are identified by job title i.e. Contracts Manager and site number. Interview transcripts were circulated to the project team to minimise reporter bias (Britten 1995).

A modified form of grounded theory analysis (Glaser and Strauss 1967) was used to analyse the interviews. Theories and knowledge guiding the project aim and objectives were used to generate categories to code the interview data. If necessary the classificatory system was amended (Silverman, 1993).

**Telephone Survey**

It was originally intended that the first outbreak in each site following the visit would be a case study. As a result of a survey with public health laboratories, and discussion with Trusts the original study design was modified to include a systematic account of all outbreaks that occurred in each site in the six months following the initial meeting. This took the form of a telephone survey of CsCDC and ICNs. Most ICNs were contacted (27/30 interviews) but not all CsCDC (17/30 interviews) could be contacted systematically. Twenty-three outbreaks were reported by ICNs and 13 by CsCDC. Data were entered into a database, checked and analysed. Qualitative responses were coded and interpreted by the interviewer and a second researcher.

The two interviewers had a standard proforma, which they used for each telephone contact. Data was originally entered into epi-info (a statistics package). However, to enable all members of the project team to access the data it was translated into Excel (a spreadsheet package) and summarised.

**National survey**

Based on case study site data, separate questionnaires were developed for CsCDC, ICDs and ICNs. Each questionnaire was piloted with appropriate professional colleagues who provided feedback. The questionnaires were subsequently sent to all: Consultants in Communicable Disease Control, Infection Control Doctors and Infection Control Nurses in England at end 1998. Each questionnaire was coded with a unique ID number and sent with a personalised letter and SAE. The questionnaires were initially sent in February 1999. Two reminder letters and further copies of the questionnaire with SAE were sent out in April and June 1999 to non-respondents.
Valid responses to the questionnaire survey were scanned using formic and then translated into SPSS, where each variable was defined and missing values were assigned (Missing variables have been assigned = 99 Not applicable = 88). Open ended text responses were entered into a standard word-processing package. Text responses can be found in the corresponding question number file for each professional group. Each questionnaire was individually checked to correct any mis-coding as a result of the scanning process. Once the data had been cleaned frequencies and cross tabulations were run to check again for data errors and deviant cases. Internal validity of responses was checked by looking at responses to particular questions from ICDs and ICNs in the same Trust. Print outs of all data analysis and open ended comments were given to each member of the project team, allowing qualitative and quantitative data to be analysed together. The coding frame generated by the case study data was applied to the qualitative responses. Valid responses were received from 55% of ICNs, 47% of ICDs and 52% of CsCDC.

Anonymity
In all three methods data have been anonymised (by removal of personal/ area/ trust/ health authority/ regional names and ID numbers have been used.)
Bibliography


Department of Health (1989) *Working for Patients; the Health Service in the 1990s* Cm 555 HMSO: London.


Department of Health and Social Security (1986) *Health Service Resource Management (Management Budgeting) in Health Authorities* HN (86)34.


**Telephone questionnaire**

**Background to telephone survey**

The research proposal form submitted to the ESRC proposed that “outbreaks that have an impact on hospitals services will be identified, research will be undertaken into the impact of infection on infection control teams, laboratories, hospitals, community services and those infected and their carers”

It was recognised that the size, type and location of outbreaks infections studied cannot by their nature be determined in advance, but it was thought likely that each study area would experience at least one hospital or community outbreak during the study period.

Initially, it was hoped that all outbreaks in the sites would be documented and the first outbreak would be studied. “When an infection occurred it was proposed that [award holder] would initiate enquiries, interview the major actors and set up the study; the research fellow will distribute questionnaires and collect information about the costs and explore the contractual arrangements that relate to the outbreak and follow up the subsequent funding implications.”.... “Costs to the relevant budget holders in the hospital, costs to laboratories and public health services and costs to patients and families, and the costs associated with managing contractual issues, will be identified for each case study.”

The issue relating to whether there would be sufficient outbreaks in the four main sites (excluding pilot site) during the proposed study period was explored. Results were obtained from an epidemiological investigation of likely number of outbreaks in any district over a 3 month period, November 1996 - January 1997 inclusively. 49 Public Health Labs were surveyed, of which 34/49 were involved in 266 outbreaks (average 8 each). 45% of these outbreaks occurred in hospitals and 55% in the community. 85% were Gastrointestinal (mostly SRSV), also MRSA / Influenza / other Staphylococcus / Meningococcal. Only 20% required an outbreak control group meeting.

**Surveillance of sites for outbreaks**

The initial protocol suggested choosing a number of outbreaks for more detailed analysis. The problems included which criteria to use when selecting outbreaks, when to visit the site, i.e. during or after outbreak, how would the co-ordinator be alerted to the occurrence of an outbreak amongst all the potential sites? and if the analysis involved questioning patients either directly or by questionnaire, it would be necessary to gain ethical approval for each site, and indeed for all potential Trusts in each site.

**Reasons for choosing a telephone survey**

It was anticipated that several of these problems could be overcome by the use of a telephone survey of all the sites (ICN/CCDC), on a monthly basis, for a period of 4-6 months. This would document the outbreaks and provide a denominator of outbreaks occurring. Where any were deemed to have a significant impact, a retrospective
analysis could be done. This survey will also enable the respondents perception of risk to be explored.

In addition, the co-ordinator of the project would have an almost up-to-date record of the occurrence of the outbreaks, and would develop a strong working relationship with the CsCDC and ICNs/ICDs in the sites.

It was decided to omit the checking of patient records and patient interviews, since this in itself would form a major piece of work, and may deviate from the main thrust of this study. In place of this, data generated by another study will be used as a proxy measure of cost of infection (Socioeconomic Burden of hospital infection)

**Pilot Study**

The piloted questions were transferred to an Epi Info questionnaire and used for the remainder of the period, taking on board amendments to content following the pilot.

The intention was to use the same questionnaire for HAs and Trusts, and to administer it every three to four weeks for up to 6 months. The co-ordinator would contact the CCDC, and [award holder] the ICNs in the Trust. The pilot study showed that HAs and Trusts recognise, and deal with, outbreaks in different ways. For example, they often deal with different organisms within different populations and the organisational structures are different.

**Method**

The questionnaire was administered by the co-ordinator and award holder respectively, at approximately monthly intervals for six months within the 4 sites.

A database in EPI-INFO was created.

The Trusts are labelled 1,2,3,4,5 in the order in which they entered the study.

**Results and commentary**

*Analysis of Epi-Info data for the ICN Telephone questionnaires*
(data from March 1998 to the end of March 1999)

The following microorganisms were identified as causing outbreaks (no. outbreaks in brackets):

**23 Outbreaks as listed below**

- Acinetobacter 2
- Influenza 1
- Staphylococcus 6 (1 MSSA, 5 MRSA)
- Measles 1
- Chicken pox 1
- C. Difficile 6
Viral Gastroenteritis 2
RSV 1
VRE 2
MDR organisms 1

Location of outbreak (and frequency of outbreak)

Pilot study  Acinetobacter

Intensive care

ICU  Acinetobacter (1) (site 3)

NICU  Flu A (1) (site 2)
RSV (1) (site 4)
Chicken pox (1) site 2

Medical

Hepatology  MRSA (1) site 2

Renal  VRE (2), Site 4
MRSA(2) Site 2
C. Difficile (1) Site 4

Haematology  MDR organisms (1) Site 2

Neurology  MRSA (1) Site 2

Rehabilitation  C. difficile Site 4

Medical (general)  C. Difficile (3) Site 4
viral gastroenteritis (3) Site 4

Surgical

Neurosurgical  MSSA (1) Site 2

Orthopaedic  MRSA (1) Site 2

Vascular  MRSA (1) Site 3

Length of outbreak

2, 2, 6, 6, 7, 10, 11, 14, 17, 18, 27, 27, 34, 39, 49 days
range 2 days to 49 days
mean 17.2 days

Number of deaths associated with involved organisms

- Acinetobacter: 2
- C diff: 1
- VRE: 3

Media Interest

23 responses of which 2 were positive. These were for Acinetobacter and Staphylococcus (MSSA)

There was no significant difference between the two instances of media interest and the perceived risk score (median 7, mean 7), compared to those outbreaks with no media interest (median score 5, mean 5.4)

Premises closed

- Acinetobacter: 1
- C. Diff: 3
- MRSA: 5
- Viral gastro: 2

Perceived additional time spent (hours) in dealing with the 23 outbreaks

- 0 hours: MRSA: 2
- 1 hour: Flu A
- 2 hours: RSV
- 3 hours: MRSA, VRE, MDR organisms
- 4 hours: MRSA, C Diff
- 6 hours: MRSA
- 10 hours: C Diff, MSSA, VRE, Chicken pox, viral gastro
- 12 hours: C. diff
- 24 hours: Acinetobacter
- 31 hours: Measles
- 50 hours: Acinetobacter
- 60 hours: MRSA

Time spent by organism

- MRSA: 73 hours (6 outbreaks)
- VRE: 13 hours (2 outbreaks)
- Acinetobacter: 74 hours (2 outbreaks)
C Diff 24 hours (3 outbreaks)

CCDC involved

Analysis of Epi-Info data for the CCDC Telephone questionnaires

The following microorganisms were identified as causing outbreaks (no. outbreaks in brackets):

**11 Outbreaks as listed below**

<table>
<thead>
<tr>
<th>Microorganism</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>1</td>
</tr>
<tr>
<td>Measles</td>
<td>1</td>
</tr>
<tr>
<td>Cryptococcus</td>
<td>1</td>
</tr>
<tr>
<td>Meningococcal disease</td>
<td>3</td>
</tr>
<tr>
<td>Salmonella Typhi</td>
<td>1</td>
</tr>
<tr>
<td>Pneumococcal pneumonia</td>
<td>1</td>
</tr>
<tr>
<td>Scabies</td>
<td>1</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>1</td>
</tr>
<tr>
<td>SRSV</td>
<td>1</td>
</tr>
</tbody>
</table>

Also one HIV lookback

**Location of outbreak (and type of outbreak)**

- **childrens hospital**: Salmonella typhi
- **hostel**: Hepatitis B virus
- **community**: Cryptococcus / meningococcal disease x 2
- **labour ward**: HIV lookback
- **nursery**: Meningococcal disease
- **nursing home**: SRSV / pneumococcal pneumonia
- **primary school**: Influenza
- **renal dialysis unit**: Hepatitis B virus
- **transplant unit**: Measles

**Length of outbreak**

12, 16, 16, 5, 17, 7, 35, 3, 2, 8, 3, 3, 1
range 1 day to 35 days
mean

**Number of deaths attributed to involved organisms**

Meningococcus, 2 outbreaks / incidents with 2 deaths each
Pneumococcal pneumonia, 3 deaths
Media Interest

4 positive responses including each of the meningococcal incidents and the HIV lookback

Media interest and the perceived risk score

<table>
<thead>
<tr>
<th>media interest</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>9</th>
<th>12</th>
<th>total score</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>23/4=5.8</td>
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<tr>
<td>no</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>52/8=6.5</td>
</tr>
</tbody>
</table>

Premises closed

Funding

One outbreak with contingency funds £1000

Discussion

The questions on resource use were unfamiliar to the ICNs

Site 3 went through major staff changes, and for some months the ICNs were impossible to contact. For the purpose of the quantitative analysis, this Trust is excluded, but it is included in the qualitative analysis.

Site 2 reported nine outbreaks, including four of MRSA. Site 4 reported 11 outbreaks, mainly C. difficile. Site 5 has had no outbreaks, but remains in the study until May. All the Trusts are teaching hospitals.

The ICNs spoke on behalf of the ICT, good working relationships with the ICD being a feature of their practice. From the first, the ICNs never gave simple answers to the questions. They always included context, such as the influence of pressure on beds.

Personality and communication skills are emerging as the major competencies in effective practice.

There was an unwillingness to burden clinical staff already working at capacity. The effect is that the ICT is seen to own the problem, except in Site 5. Here the ICT makes it a policy for clinical staff to own their own problems. Site 4 is moving in this direction.
The study accepts the ICT's definition of an outbreak, and this appears to differ according to several factors: organisational pressure on beds and other resources, sensitivity to MRSA, previous experience with an organism, organisational culture. All Trusts have MRSA, but only Site 2 reported MRSA outbreaks, which they define as five cases/colonisations in the same ward in seven days. In contrast, Site 5 considers each MRSA on its merits, and responds according to a flexible protocol. MRSA is endemic in its catchment area. During one call, the ICN reported 32 MRSA scattered throughout the Trust hospitals, but this is not considered an outbreak. *C difficile* may also be dealt with differently. Site 4 had six *C difficile* outbreaks. Site 4 has 6-7 *C difficile* on an elderly care ward, but uses standard procedures rather than declare an outbreak. In all the Trusts, uncommon infections have a tighter definition of an outbreak. The definition is also open to seasonal pressure on beds, and the waiting list initiative. When pressure is high, they do not declare an outbreak or close a ward. One ICN said, ‘Four years ago I would have done a lot more about MRSA, including closing wards, but I wouldn’t do that now. I couldn’t do it with the pressure on beds.’ This Trust last reported an acinetobacter outbreak in ICU. The ICU has seven, beds but only enough staff for six. The Regional Office pressed the hospital to open the seventh bed, and provided funds for staff, but it proved impossible to recruit staff. As a result, existing staff worked back-to-back shifts. Then the outbreak happened, and was only controlled by closing the ICU. The knock-on effect of this was that there was nowhere in the hospital to ventilate burns patients from their regional burns unit, so patients needing ventilation had to be diverted to other hospitals.
Infection Control Doctor Questionnaire:

"Infectious Disease and Risk"

Research funded by the Economic and Social Research Council (ESRC) Risk and Human Behaviour Programme
Section 1 - About you

Q1 Identifier - for office use only

Instructions:
Please place a cross in the appropriate box(es) in this questionnaire (see example below)

DK = Don't Know

Please complete using black biro

Please write in boxes only; a large box is provided on the final page for additional comments

Q2 Are you

- male
- female

Q3 Which age group are you in?

- 35-40
- 41-45
- 46-50
- 51-55
- 56-60
- 60 plus

Q4 What speciality do you work in?

- Microbiology
- Infectious disease
- Other (use box below)

Q5 When were you appointed as a consultant?

- D
- M
- Y
- Y
- Y

Q6 How long have you been the infection control doctor?

- (years)

Q7 Are you the:

- sole ICD?
- or, do you rotate with others?
- or, do you job share?

Q8 Who is your contract of employment with?

- NHS
- PHLS
- University
Section 2 - About your Trust/organisation

Q9 How many acute hospitals are you responsible for as the ICD?
- one
- two
- three
- more than three

Q10 How many Infection Control Nurses are there in each acute hospital?

<table>
<thead>
<tr>
<th>Hospital</th>
<th>State Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ 1]</td>
</tr>
<tr>
<td>Hospital 2</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ 1]</td>
</tr>
<tr>
<td>Hospital 3</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ 1]</td>
</tr>
<tr>
<td>Hospital 4</td>
<td>[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ 1]</td>
</tr>
</tbody>
</table>

Q11 Are you responsible for a Community Trust?
- Yes
- No

Q12 Which Directorate is infection control in?

Section 3 - Professional Networks

Q13 In your opinion, what is the relative importance of contracts, networks and protocols/guidelines in the negotiation, specification and monitoring of communicable disease (CD) issues with the Health Authority (where 0 = not important, 1 = quite important and 2 = very important)

<table>
<thead>
<tr>
<th></th>
<th>Negotiation of CD issues</th>
<th>Specification of CD issues</th>
<th>Monitoring CD issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracts</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
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<tr>
<td>Professional networks</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
</tr>
<tr>
<td>Protocols / Guidelines</td>
<td>[ ] [ ] [ ]</td>
<td>[ ] [ ] [ ]</td>
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</tr>
</tbody>
</table>

Q14 Outline the extent of any non-contractual arrangements you have with members of the Health Authority, for the negotiation, specification and monitoring of communicable disease control
Section 4 - About contracts (also known as service agreements)

Q15 How many types of contract does your Trust have with different purchasers?
- Multiple [ ]
- Single [ ]
- Don't know [ ]

Q16 Is the infection control specification the same in all contracts or are there differences?
- different [ ]
- the same [ ]
- don't know [ ]

Q17 Describe the nature of the variation in the contracts below

Please answer the following questions in this section with respect to the acute Trust contract with the lead Health Authority (HA):

Q18 Does the current contract between the Trust and the HA contain clauses relating to particular requirements for infection control?
- Yes [ ]
- No [ ]
- Don't Know [ ]

Q19 Describe any clauses relevant to infection control below
Q20 Were you involved in the process of development of the Trust infection control specifications within the current contract with the Health Authority?

Yes ☐  (go to Q21)
No ☐  (go to Q23)

Q21 Indicate below what part you played in the development of the current contract, and the time spent.

<table>
<thead>
<tr>
<th>ADVICE</th>
<th>TIME SPENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>verbal</td>
<td>&lt;1 hour</td>
</tr>
</tbody>
</table>

- Pre contract negotiation with the Trust ☐ ☐ ☐ ☐ ☐
- Pre contract negotiation with the CCDC ☐ ☐ ☐ ☐ ☐
- Pre contract negotiation with other HA staff ☐ ☐ ☐ ☐ ☐
- Present during formal contract meetings between Trust and HA ☐ ☐ ☐ ☐ ☐
- Monitoring the contract ☐ ☐ ☐ ☐ ☐
- Subsequent revisions to contract ☐ ☐ ☐ ☐ ☐

Q22 Did you feel that your participation in the negotiation for the current contract was effective in achieving your aims for infection control?

Yes ☐  (give reasons in box)
No ☐

Q23 Were you shown a copy of the current contract between the acute Trust and the HA before it was finally agreed?

Yes ☐  No ☐

Q24 From your experience as an ICD, has the current or previous contract been used to deal with any disputes regarding infection control?

Yes ☐  (go to Q25a)
No ☐  (go to Q27)
Don't Know ☐  (go to Q27)
Q25 (a) Indicate below in what way the contract was used in the dispute

<table>
<thead>
<tr>
<th>Relevant clauses referred to</th>
<th>Yes</th>
<th>No</th>
<th>TIME SPENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>&lt;1 hour</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revisions of contract negotiated with HA</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
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</table>

Q25 (b) Please give details below of any other way in which the contract was used in the dispute

Q26 Give examples of issues/events which triggered off the dispute(s) in Q24, and resulted in reference to, or re-negotiation of the contract

Q27 Do you feel that the wording of the current contract is comprehensive enough to deal with issues which arise during the course of the year?

Yes  □
No   □
Don't know □

(give reasons for your answer below)

Q28 Does the HA require surveillance of hospital acquired infection (HAI) in its current contract?

Yes  □
No   □
Don't Know □

(If 'Yes' specify in box below)
Q29 Does the HA require its providers to meet specific standards for infection control?

Yes [ ]
No [ ]
Don't Know [ ]

(If 'Yes' specify in box below e.g. King's Fund Accreditation)

Q30 Do contracts between the Trust and providers of ancillary services (e.g. cleaning, catering, laundry, waste disposal services) incorporate any clauses which specify ways in which infection control is dealt with?

Yes [ ]
No [ ]
Don't Know [ ]

(If 'Yes' give examples)

Q31 Are any of the following services contracted out?

Cleaning [ ] No [ ] Don't know [ ]
Catering [ ] No [ ] Don't know [ ]
Laundry [ ] No [ ] Don't know [ ]
Waste Disposal [ ] No [ ] Don't know [ ]

Q32 Were you involved in the negotiation and/or writing of contracts for the following services?

Cleaning [ ] No [ ] Don't know [ ]
Catering [ ] No [ ] Don't know [ ]
Laundry [ ] No [ ] Don't know [ ]
Waste Disposal [ ] No [ ] Don't know [ ]

Q33 What was the level of your involvement?

Cleaning [ ]
Catering [ ]
Laundry [ ]
Waste Disposal [ ]
informal pre-contract negotiation

present at formal contract meetings

monitoring
Q34 Do you have a role in the specification of infection control clauses relating to staff employment?

Yes [ ]
No [ ]

(If 'Yes', specify)

Q35 Do you have a role in the specification of infection control clauses relating to your local ambulance Trust?

Yes [ ]
No [ ]

(If 'Yes', specify)

Section 5 - Funding of Infection Control

Q36 Is there a separate budget for infection control? Yes [ ] No [ ]

If 'yes', state how much is in budget

Q37 Which of the following items does the budget for infection control include?

- ICD time [ ]
- ICN time [ ]
- Clerical support [ ]
- Laboratory costs [ ]
- Computer equipment [ ]
- Manuals (print & disseminate) [ ]
- Education Aids [ ]
- Training / books / journals [ ]

Other (please state below)
Q38 Who holds the budget for infection control?

- Trust Chief Executive
- Finance Director of Trust
- Infection Control Directorate
- Infection Control Team
- Microbiology Department
- Other, please state below

Q39 Where does funding for infection control come from?

- Top sliced from Trust budget
- Taken from each directorate budget in equal amounts
- Taken from directorate budgets in variable amounts
- Taken from pathology budget
- Part of general microbiology budget
- Charitable Trust funds
- Private companies
- Don't know
- Other, please state below

Q40 Do internal budgets (e.g. directorate budgets, ward managers budgets) have any impact on the way you manage infection control?

- Yes
- No
- Don't Know

(please explain with examples)

Q41 Have you ever had to take financial matters into consideration when managing an outbreak?

- Yes
- No
- Don't Know

(If 'Yes' give examples)
Q42 Specify an outbreak in which you have been involved, (giving its cause and size and approximate date), which greatly increased the laboratory workload.

Q43 When you dealt with the outbreak above, did you do any of the following?

- postpone other activities
- got extra staff
- asked staff to work extra hours
- give time off 'in lieu' to staff
- got the PHLS or other laboratories to carry out work for you
- have to purchase extra consumables (media etc)
- other (please provide details in box below)

Q44 Who were the key people you liaised with to mobilise these resources?

Q45 What financial arrangements are there for dealing with major outbreaks?

- contingency fund (set up in advance) □ (go to Q46)
- ad hoc arrangements (spur of the moment) □ (go to Q47)
- don't know □ (go to Q48)

Q46 Do you know how much money is held in the contingency fund(s)?

Yes □

No □

Don't Know □
Q47 Who holds the contingency fund(s) or agrees the ad hoc arrangements?

- Chief Executive of Trust
- Finance Director of Trust
- Directorate containing infection control
- Infection control team
- Health Authority
- Other (please provide details in box below)

Yes ☐ No ☐

Q48 Would your laboratory or Trust differentiate between nosocomial outbreaks and those outbreaks originating from outside the hospital?

Yes ☐ No ☐ Don't Know ☐

(If 'Yes' state in what way)

Q49 (a) Who do you consider _should_ pay for the costs associated with large outbreaks originating within the community, which require extensive microbiological or other resources?

Q49 (b) From your experience, who _does_ pay for the costs associated with large outbreaks originating within the community, which require extensive microbiological or other resources?
Q50 Is there a formal budget setting process for the longer term management of infection control in which you are involved?

Yes [ ] (go to Q51)
No [ ] (go to Q52)
Don't know [ ] (go to Q52)

Q51 Is the budget setting process with the directorate managers [ ]
finance department [ ]
other (state in box below) [ ]

Q52 How do you secure resources required for infection control measures for longer term planning?

Q53 Are you aware if your Trust has made any representation to the Health Authority for additional funding for infection control? (If 'yes' give approximate dates)

Yes [ ] (If 'Yes' give examples, stating how much funding was requested and received)
No [ ]
Don't Know [ ]

Q54 (a) Have you approached any of the following for additional funding for infection control?

Chief Executive of Trust [ ]
Directorate budget holders [ ]
PHLS [ ]
Other (please state in box below) [ ]

Q54 (b) Outline circumstances and response of person(s) approached:
Section 6 - Hospital Infection Control Committee (HICC)

Q55 (a) Who is on your Hospital Infection Control Committee?

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control Doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Microbiologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Control Nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust finance representative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Chief Executive Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other member of Trust management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing manager</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nursing colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other surgical colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medical colleagues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCDC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please state in box below)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q55 (b) What is the seniority of the Trust management member of the HICC? (give job title)


Q55 (c) How often does this Trust management member attend?

Regularly [ ] Occasionally [ ] Rarely [ ]

Q56 Do important recommendations from the HICC:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get onto the Trust board agenda?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get put into the Trust board annual report?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q57 Do you feel that you personally have been able to influence decisions in the Trust regarding prioritisation and funding for infection control issues?

Yes  No  Don't know

Q58 Give examples of ways in which you personally have, or have not, been able to influence decisions:


Q59 Do you feel that the HICC helps in securing funding for the infection control priorities?

Yes  No

Don't know

Section 7 - Organisational Risk

Risk may be defined in a number of ways. In this section you are asked to choose work constraints which you consider are potentially hazardous, and thus pose a risk to the population from infection.

Q60 Are there any constraints that you personally feel hinder your ability to protect the hospital population from infection risks?

Yes  (go to Q61a)

No  (go to Q62)

Don't know  (go to Q62)
Q61 (a) Please specify below the constraints which hinder your ability to protect the hospital population from infection risks. Please rate the importance of each criterion.

<table>
<thead>
<tr>
<th>Constraint</th>
<th>Not Important as constraint</th>
<th>Some Importance as constraint</th>
<th>Great Importance as constraint</th>
<th>Very Great Importance as constraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microbiology staffing levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing staffing levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning staffing levels</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge of infection control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour of others on Infect. control team</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour of others on HICC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour of others in laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour of ward staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour of theatre staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existing routine practice in laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Existing routine practice in theatres</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust board</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chief Executive officer of Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local or national media</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q61 (b) Specify any other constraints in the box below.

Q61 (c) Which two of the constraints in Q61(a) or 61(b) do you regard are most important in the management of the risk of infectious disease? Give reasons why.
Q62 What organisation or managerial changes would help you with your work in protecting the hospital population from infection risks?

Q63 What is the role of the infection control team in dealing with patient complaints relating to hospital acquired infections?

Q64 To your knowledge, has the Trust assessed its potential liability from patients' litigation as a result of hospital acquired infections? (If 'yes' give examples below, stating effect on infection control arrangements)

- Yes
- No
- Don't Know

Q65 Has this affected infection control arrangements with respect to:

- Budget
- Staffing
- Existing practices
- Training

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Section 8 - Perception of risk: specific infections

We are interested in your own understanding of the term 'risk' and ask you to choose microorganisms which you consider pose a major 'risk' to the hospital or community and score them against a number of criteria.

Q66 Choose two organisms which you consider cause major infection 'risk' within hospital

<table>
<thead>
<tr>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
</table>

Q67 Choose two organisms which you consider cause major infection 'risk' within the community

<table>
<thead>
<tr>
<th>Example 3</th>
<th>Example 4</th>
</tr>
</thead>
</table>

Q68 Indicate on the scales below how you rate the four infections with respect to the given criteria (lowest = 0, highest = 4).

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virulence of organism (capacity to cause severe disease)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential transmissibility of infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health consequences within the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microbiological workload</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult to control effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public concern or political forces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely media interest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of litigation to organisation (e.g. Trust / lab. / HA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q69 Please add any additional comments concerning any of the questions

Q70 If you wish to receive a copy of the final report, please indicate by placing a cross in the box below:

☐
Infection Control Nurse Questionnaire:

“Infectious Disease and Risk”

Research funded by the Economic and Social Research Council (ESRC) Risk and Human Behaviour Programme
Section 1 - About you

Q2 Are you male [ ] female [ ]

Q4 How long have you been an infection control nurse?
   [ ] (years)

Q5 Who are you accountable to professionally?
   ICD [ ]
   Chief Nurse [ ]
   Director of Quality [ ]
   Other (please indicate in box below) [ ]

Q7 Who is your contract of employment with?
   NHS [ ]
   PHLS [ ]

Instructions:
Please place a cross in the appropriate box(es) in this questionnaire (see example below).

DK = Don't Know
Please complete using black biro
Please write in boxes only; a large box is provided on the final page for additional comments.
Section 2 - About your Trust/organisation

Q8 How many acute hospitals do you work in?
- one [ ]
- two [ ]
- three [ ]
- more than three [ ]

Q9 How many Infection Control Nurses are there in each acute hospital?

<table>
<thead>
<tr>
<th>Hospital</th>
<th>State Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1</td>
<td><img src="state_number_1" alt="State Number" /></td>
</tr>
<tr>
<td>Hospital 2</td>
<td><img src="state_number_2" alt="State Number" /></td>
</tr>
<tr>
<td>Hospital 3</td>
<td><img src="state_number_3" alt="State Number" /></td>
</tr>
<tr>
<td>Hospital 4</td>
<td><img src="state_number_4" alt="State Number" /></td>
</tr>
</tbody>
</table>

Section 3 - Professional Networks

Q10 In your opinion, what is the relative importance of contracts, networks and protocols/guidelines in the negotiation, specification and monitoring of communicable disease (CD) issues with the Health Authority? (where 0 = not important, 1 = quite important and 2 = very important)

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional networks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocols / Guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q11 Outline the extent of any non-contractual arrangements you have with members of the Health Authority for the negotiation, specification and monitoring of communicable disease control.
Section 4 - About contracts (also known as service agreements)

Please answer questions in this section with respect to the acute Trust contract with the lead Health Authority (HA):

**Q12** Do you know what is in the current contract between the Trust and the Health Authority with respect to infection control?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

(12) (go to Q13)

**Q13** Were you involved in the process of development of the Trust infection control specifications within the current contract with the Health Authority?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

(13) (go to Q14)

**Q14** Indicate below what part you played in the development of the current contract, also state the time spent:

<table>
<thead>
<tr>
<th>ADVICE</th>
<th>TIME SPENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>verbal</td>
<td>&lt;1 hour</td>
</tr>
<tr>
<td>written</td>
<td></td>
</tr>
</tbody>
</table>

Pre contract negotiation with the Trust

Pre contract negotiation with the CCDC

Pre contract negotiation with other HA staff

Present during formal contract meetings between Trust and HA

Monitoring the contract

Subsequent revisions to contract

**Q15** Did you feel that your participation in the development of the current contract was effective in achieving your aims for infection control?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

(Please comment in box below)

| Don't know | |
|-----------||
| ☐         | |

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Q16 Were you shown a copy of the current contract between the acute Trust and the HA before it was finally agreed?

Yes ☐
No ☐

Q17 From your experience as an ICN, has the current or previous contract been used to deal with any disputes regarding infection control?

Yes ☐ (go to Q18a)
No ☐ (go to Q20)
Don't Know ☐ (go to Q20)

Q18 (a) Indicate below in what way the contract was used

Yes No

TIME YOU SPENT ON PROCESS
<1 hour 1/2 day 1 day >1 day

relevant clauses referred to ☐ ☐ ☐ ☐
revisions of contract negotiated with HA ☐ ☐ ☐ ☐

Q18 (b) Was the contract used in any other way? Please give details below

Q19 Give examples of issues/events which triggered off the dispute(s) in Q17, and resulted in reference to, or re-negotiation of the contract

Q19 Give examples of issues/events which triggered off the dispute(s) in Q17, and resulted in reference to, or re-negotiation of the contract

Q19 Give examples of issues/events which triggered off the dispute(s) in Q17, and resulted in reference to, or re-negotiation of the contract

Q19 Give examples of issues/events which triggered off the dispute(s) in Q17, and resulted in reference to, or re-negotiation of the contract
Q20 Does the HA require surveillance of hospital acquired infection (HAI) in its current contract?

Yes ☐
No ☐
Don't Know ☐

(If 'Yes' specify in box below)

Q21 Does the HA require your Trust to meet specific standards for infection control?

Yes ☐
No ☐
Don't Know ☐

(If 'Yes' specify in box below e.g. King's Fund Accreditation)

Q22 Do contracts between the Trust and providers of ancillary services (e.g. cleaning, catering, laundry, and waste disposal services) incorporate any clauses which specify ways in which infection control is dealt with?

Yes ☐
No ☐
Don't Know ☐

(If 'Yes' give examples of clauses)
Q23 Are any of the following services contracted out?  

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste Disposal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q24 Were you involved in the negotiation and/or writing of contracts for the following services?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste Disposal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q25 What was the level of your involvement?

<table>
<thead>
<tr>
<th>Service</th>
<th>Informal pre-contract negotiation</th>
<th>Present at formal contract meetings</th>
<th>Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaning</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laundry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste Disposal</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q26 Do you have a role in the specification of infection control clauses relating to staff employment?

Yes

No

(If ‘Yes’ specify)

Q27 Do you have a role in the specification of infection control clauses relating to your local ambulance Trust?

Yes

No

(If ‘Yes’ specify)
Section 5 - Funding of Infection Control

Q28 State which directorate 'Infection Control' is in

Q29 Is there a separate budget for infection control?
   Yes □ No □ if 'no', go to Q32
   If 'yes' state how much

Q30 Which of the following items does the budget for infection control include?
   ICN time □
   ICD time □
   Clerical support □
   Laboratory costs □
   Computer equipment □
   Manuals (print & disseminate) □
   Education Aids □
   Training / books / journals □
   Other (please state below) □

Q31 Who holds the budget for infection control?
   Trust Chief Executive □
   Finance Director of Trust □
   Infection Control Directorate □
   Infection Control Team □
   Microbiology Department □
   Other (state below) □

Q32 Where does funding for infection control come from?
   Top-sliced from Trust budget □
   Taken from each directorate budget in equal amounts □
   Taken from each directorate budget in variable amounts □
   Taken from pathology budget □
   Taken from microbiology budget □
   Charitable Trust funds □
   Private companies □
   Don't know □
   Other, please state below

---

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Q33 Do internal budgets (e.g. directorate budgets, ward managers budgets) have any impact on the way you manage infection control?

Yes [ ]
No [ ]
Don't Know [ ]

(If 'Yes' give examples)

Q34 Have you ever had to take financial matters into consideration when managing an outbreak?

Yes [ ]
No [ ]
Don't Know [ ]

(If 'Yes' give examples)

Q35 Who are the key people you liaise with to mobilise resources during outbreaks?


Q36 What financial arrangements are there for dealing with major outbreaks?

Contingency Fund [ ] (set up in advance) (go to Q37)
Ad hoc arrangements [ ] (spur of the moment) (go to Q39a)
Don't know [ ] (go to Q40)
Q37 If using a contingency fund would your Trust differentiate between nosocomial outbreaks and those outbreaks originating from outside the hospital?

(If 'Yes' state in what way)

Yes ☐
No ☐
Don't Know ☐

Q38 Do you know how much money is held in the contingency fund(s)?

Yes ☐
No ☐
Don't Know ☐

Q39 (a) Who holds the contingency fund(s) or agrees the ad hoc arrangements?

Chief Executive of Trust ☐
Finance Director of Trust ☐
Directorate containing infection control ☐
Infection control team ☐
Health Authority ☐
Other (please provide details in box below) ☐

Q39 (b)

____

Q40 Is there a formal budget setting process for the longer term management of infection control in which you are involved?

Yes ☐ (go to Q41)
No ☐ (go to Q42)
Don't know ☐ (go to Q42)

Q41 Is the budget setting process with the

directorate managers ☐
finance department ☐
other (state in box below) ☐
Q42 How do you secure resources required for infection control measures for longer term planning?

Q43 Are you aware if your Trust has made any representation to the Health Authority for additional funding for infection control in the last two years?

Yes ❑
No ❑

(If 'Yes' give examples)

Q44 Which of the following have you approached for additional funding for infection control?

Chief Executive of Trust ❑
Directorate budget holders ❑
PHLS ❑
Other (please state in box) ❑
Section 6 - Hospital Infection Control Committee (HICC)

Q45 (a) Who is on your Hospital Infection Control Committee?

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control Doctor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Microbiologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Control Nurse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust finance representative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust Chief Executive Officer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other member of Trust senior management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nursing colleagues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other surgical colleagues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medical colleagues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCDC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (state in box below)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q45 (b) What is the seniority of the Trust management member of the HICC? (give job title if possible)

Q46 How often does this Trust management member attend?

- Regularly □
- Occasionally □
- Rarely □

Q47 Do the recommendations of the HICC:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Yes</th>
<th>No</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get onto the Trust board agenda?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Get put into the Trust board annual report?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 7 - Organisational Risk

Risk may be defined in a number of ways. In this section, you are asked to choose work constraints which you consider are potentially hazardous, and thus pose a risk to the population from infection.

Q48 Are there any constraints that you personally feel hinder your ability to protect the hospital population from infection risks?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="yes" alt="Checkmark" /></td>
<td><img src="no" alt="Checkmark" /></td>
<td>![Checkmark](don't know)</td>
</tr>
</tbody>
</table>

Q49a Please specify below the constraints which hinder your ability to protect the hospital population from infection risks. Please rate the importance of each criterion.

<table>
<thead>
<tr>
<th>Constraint</th>
<th>Not Important as constraint</th>
<th>Some Importance as constraint</th>
<th>Great Importance as constraint</th>
<th>Very Great Importance as constraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td><img src="resources" alt="Checkmark" /></td>
<td><img src="resources" alt="Checkmark" /></td>
<td><img src="resources" alt="Checkmark" /></td>
<td><img src="resources" alt="Checkmark" /></td>
</tr>
<tr>
<td>Microbiology staffing levels</td>
<td><img src="microbiology" alt="Checkmark" /></td>
<td><img src="microbiology" alt="Checkmark" /></td>
<td><img src="microbiology" alt="Checkmark" /></td>
<td><img src="microbiology" alt="Checkmark" /></td>
</tr>
<tr>
<td>Nursing staffing levels</td>
<td><img src="nursing" alt="Checkmark" /></td>
<td><img src="nursing" alt="Checkmark" /></td>
<td><img src="nursing" alt="Checkmark" /></td>
<td><img src="nursing" alt="Checkmark" /></td>
</tr>
<tr>
<td>Cleaning staffing levels</td>
<td><img src="cleaning" alt="Checkmark" /></td>
<td><img src="cleaning" alt="Checkmark" /></td>
<td><img src="cleaning" alt="Checkmark" /></td>
<td><img src="cleaning" alt="Checkmark" /></td>
</tr>
<tr>
<td>Knowledge of infection control</td>
<td><img src="knowledge" alt="Checkmark" /></td>
<td><img src="knowledge" alt="Checkmark" /></td>
<td><img src="knowledge" alt="Checkmark" /></td>
<td><img src="knowledge" alt="Checkmark" /></td>
</tr>
<tr>
<td>Behaviour of others on Infect. control team</td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
</tr>
<tr>
<td>Behaviour of others on HICC</td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
</tr>
<tr>
<td>Behaviour of others in laboratory</td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
</tr>
<tr>
<td>Behaviour of ward staff</td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
</tr>
<tr>
<td>Behaviour of theatre staff</td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
<td><img src="behaviour" alt="Checkmark" /></td>
</tr>
<tr>
<td>Existing routine practice in laboratory</td>
<td><img src="existing" alt="Checkmark" /></td>
<td><img src="existing" alt="Checkmark" /></td>
<td><img src="existing" alt="Checkmark" /></td>
<td><img src="existing" alt="Checkmark" /></td>
</tr>
<tr>
<td>Existing routine practice in theatres</td>
<td><img src="existing" alt="Checkmark" /></td>
<td><img src="existing" alt="Checkmark" /></td>
<td><img src="existing" alt="Checkmark" /></td>
<td><img src="existing" alt="Checkmark" /></td>
</tr>
<tr>
<td>General management</td>
<td><img src="general" alt="Checkmark" /></td>
<td><img src="general" alt="Checkmark" /></td>
<td><img src="general" alt="Checkmark" /></td>
<td><img src="general" alt="Checkmark" /></td>
</tr>
<tr>
<td>Trust board</td>
<td><img src="trust" alt="Checkmark" /></td>
<td><img src="trust" alt="Checkmark" /></td>
<td><img src="trust" alt="Checkmark" /></td>
<td><img src="trust" alt="Checkmark" /></td>
</tr>
<tr>
<td>Chief Executive officer of Trust</td>
<td><img src="chief" alt="Checkmark" /></td>
<td><img src="chief" alt="Checkmark" /></td>
<td><img src="chief" alt="Checkmark" /></td>
<td><img src="chief" alt="Checkmark" /></td>
</tr>
<tr>
<td>Local or national media</td>
<td><img src="local" alt="Checkmark" /></td>
<td><img src="local" alt="Checkmark" /></td>
<td><img src="local" alt="Checkmark" /></td>
<td><img src="local" alt="Checkmark" /></td>
</tr>
</tbody>
</table>

Q49b Which two of the constraints listed in Q 49a, (or others), do you regard are the most important in the management of the risk of infectious disease? Give reasons why.
Q50 Do you feel that you have personally been able to influence decisions in the Trust regarding prioritisation and funding for infection control issues?

Yes ☐ No ☐ Don't know ☐

Q51 Give examples of ways in which you have or have not been able to influence decisions.

Q52 Do you feel that the HICC helps in securing funding for the infection control priorities?

Yes ☐ (elaborate below)

No ☐

Don't Know ☐

Q53 What organisation or managerial changes would help you with your work in protecting the hospital population from infection risks?

Q54 What is the role of the infection control team in dealing with patient complaints relating to hospital acquired infections?

Q55 To your knowledge, has the Trust assessed its potential liability from patients' litigation as a result of hospital acquired infections?

Yes ☐ (if 'Yes' give examples)

No ☐

Don't Know ☐
Section 8 - Perception of risk: specific infections

We are interested in your own understanding of the term risk, and ask you to choose microorganisms which you consider pose a major 'risk' to the hospital or community, and then score against a number of criteria.

Q56 Choose two organisms which you consider cause major infection 'risk' within hospital

Example 1

Example 2

Q57 Choose two organisms which you consider cause major infection 'risk' within the wider community?

Example 3

Example 4

Q58 Indicate on the scales below how you rate the four infections with respect to the given criteria (lowest = 0, highest = 4).

![Scoring Scales](image)

- Virulence of organism (capacity to cause severe disease)
- Potential transmissibility of infection within hospital
- Potential public health consequences within the community
- Personal workload
- Difficult to control effectively
- Public concern or political forces
- Likely media interest
- Risk of litigation to organisation (Trust/lab/HA)
Q59 Please write any additional comments concerning any of the questions, in the box below

Q60 Please indicate whether you would like to receive a copy of the final report by placing a cross in the following box

☐
Consultant in Communicable Disease Control Questionnaire:

“Infectious Disease and Risk”

Research funded by the Economic and Social Research Council (ESRC) Risk and Human Behaviour Programme
Section 1 - About you

Q2 Are you
- male
- female

Q4 What speciality is your main qualification in?
- Public Health
- Microbiology
- Infectious disease
- Other (use box below)

Q3 Which age group are you in?
- 35-40
- 41-45
- 46-50
- 51-55
- 56-60
- 60 plus

Q6 When were you first appointed as a CCDC / MOEH?

Q7 Who are you accountable to:
- professionally
- managerially

Q8 Who is your contract of employment with?
- NHS
- PHLS
- other

Instructions:
Using a black biro, please place a cross in the appropriate box(es) in this questionnaire (see example below)

DK = Don't Know

Please write in boxes only, a large box is provided on the final page for additional comments.
### Section 2 - About your organisation

<table>
<thead>
<tr>
<th>Q9 What size population does your health authority serve?</th>
</tr>
</thead>
<tbody>
<tr>
<td>200,000 to 300,000</td>
</tr>
<tr>
<td>300,000 to 400,000</td>
</tr>
<tr>
<td>400,000 to 500,000</td>
</tr>
<tr>
<td>500,000 to 600,000</td>
</tr>
<tr>
<td>more than 600,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q10 Who else are members of your communicable disease control team within the Health Authority?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secretary</td>
</tr>
<tr>
<td>Administrative assistant</td>
</tr>
<tr>
<td>Public Health Nurse(s)</td>
</tr>
<tr>
<td>Environmental health officer</td>
</tr>
<tr>
<td>Information officer</td>
</tr>
<tr>
<td>other (state in box below)</td>
</tr>
</tbody>
</table>

### Section 3 - Professional networks

Q11 In your opinion, What is the relative importance of contracts, networks and protocols / guidelines in the negotiation, specification and monitoring of communicable disease (CD) issues with the Trusts: (where 0 = not important, 1 = quite important and 2 = very important)

<table>
<thead>
<tr>
<th></th>
<th>negotiation of CD issues</th>
<th>specification CD issues</th>
<th>monitoring CD issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracts</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Professional Relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protocols / Guidelines</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q12 Outline the extent of any non-contractual arrangements you have with members of the Trusts for the negotiation, specification and monitoring of communicable disease control.
Section 4 - About Contracts (also known as service agreements)

Q13 Does the current Health Authority contract with **acute Trusts** contain clauses relating to particular requirements for infection control / management of communicable disease?

- **Yes** (go to Q14)
- **No** (go to Q15)
- **Don't Know** (go to Q15)

Q14 Describe relevant clauses below eg assistance from staff, use of facilities, infection control standards

Q15 Does the current Health Authority contract with **community Trusts** contain clauses relating to particular requirements for infection control / management of communicable disease?

- **Yes** (go to Q16)
- **No** (go to Q17)
- **Don't Know** (go to Q17)

Q16 Describe relevant clauses below eg assistance from community staff, use of facilities, infection control standards
Q17 Were you involved in the process of development of the infection control / communicable disease control specifications within the current contracts with the Trusts?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>(if 'no' to both, go to Q22)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q18 Indicate below what part you played in the development of the current contract, also estimate time spent.

<table>
<thead>
<tr>
<th>TRUST CONTRACT</th>
<th>APPROX. TIME SPENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>acute</td>
</tr>
<tr>
<td></td>
<td>&lt;1 hour</td>
</tr>
<tr>
<td>Pre contract negotiation with the Trust</td>
<td></td>
</tr>
<tr>
<td>Pre contract negotiation with the ICD</td>
<td></td>
</tr>
<tr>
<td>Pre contract negotiation with other HA staff</td>
<td></td>
</tr>
<tr>
<td>Present during formal contract meetings between Trust and HA</td>
<td></td>
</tr>
<tr>
<td>Monitoring the contract</td>
<td></td>
</tr>
<tr>
<td>Subsequent revisions to contract</td>
<td></td>
</tr>
</tbody>
</table>

Q19 Were you shown a copy of the current contract between the Trusts and the HA before final agreement?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Trust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q20 (a) Indicate below what issues you discussed in the contracting process:

<table>
<thead>
<tr>
<th></th>
<th>acute Trust</th>
<th>community Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory specifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roles and responsibilities during outbreaks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contract relating to longer term programmes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please comment in box overleaf)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q20 (b) Please comment on other contracting issues below:


Q21 Did you feel that your participation in the development of the current contract was effective in achieving your aims for infection control / communicable disease control?

Yes ☐
No ☐
Don't know ☐

(Give reasons for your answer in box below)

Q22 From your experience as a CCDC, has the current or previous contract been used to deal with any disputes regarding infection control / communicable disease control?

Yes ☐ (go to Q23a)
No ☐ (go to Q25)
Don't Know ☐ (go to Q25)

Q23 (a) Indicate below in what way the contract was used in the dispute

TIME SPENT BY YOU
<1 hour 1/2 day 1 day >1 day

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

relevant clauses referred to

revisions of contract negotiated with HA

Q23 (b) Please give details below of any other ways in which the contract was used in the dispute


Scanning by Formic Ltd, London, (+44) 0171 924 1730
Q24 Give examples of the issues/events which triggered off the dispute(s) in Q22, and resulted in reference to, or re-negotiation of the contract

Q25 Do you feel that the wording of the current contract is comprehensive enough to deal with issues which arise during the course of the year?

Yes ☐

No ☐

Don't know ☐

(give reasons for your answer in box below)

Q26 Do you have a role in the specification of infection control clauses relating to your local ambulance Trust?

(please specify)

Yes ☐

No ☐

Q27 Does the HA require surveillance of hospital acquired infection (HAI) in its current contract?

Yes ☐

No ☐

Don't Know ☐

(If 'yes' specify in box below, eg the production of infection rates)

Q28 Does the HA require the Trusts to meet specific standards for infection control?

Yes ☐

No ☐

Don't know ☐

(if 'yes' specify in box below, eg Kings Fund Accreditation)
Q29 Has the HA considered the cost of avoidable HAI compared to the additional cost of the necessary changes in infection control among any of its providers?

Yes ☐
No ☐
Don't know ☐

(if 'Yes' specify in box below)

Q30 Has the HA considered the effect of HAI on the availability of hospital services it commissions?

Yes ☐
No ☐
Don't Know ☐

(if 'Yes' specify in box below)

Section 5 - Resources for Communicable Disease Control / Infection Control

Q31 Do you have your own budget for communicable disease control?

Yes ☐ (go to Q32)
No ☐ (go to Q34)
Don't know ☐ (go to Q34)

Q32 How much is in your budget?

Q33 Which of the following items does the budget cover?

CCDC time ☐
Public Health Nurse time ☐
Clerical support ☐
Computer equipment ☐
Manuals (print & distribution) ☐
Education Aids ☐
Training / books / journals ☐
Other, please state ☐

Q34 Have you ever had to take finances into consideration when managing an outbreak?

Yes ☐
No ☐

If 'Yes', please give examples

(...)

Survey: 117
Page: 7
Q35 (a) Give examples of times when you had to mobilise resources (finances / manpower) to deal with an outbreak. Give approximate costs, date and size of outbreak.

Q35 (b) Who were the key people you liaised with to mobilise these resources?

Q36 (a) When managing a communicable disease situation originating in the community, have you ever had problems mobilising resources from the:

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Trust</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Trust</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Q36 (b) Please outline any occasions below:

Q37 What financial arrangements are there for dealing with major outbreaks involving the HA?

<table>
<thead>
<tr>
<th>Financial Arrangement</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency funds (set up in advance)</td>
<td>(go to Q38)</td>
</tr>
<tr>
<td>Ad hoc (spur of the moment)</td>
<td>(go to Q39)</td>
</tr>
<tr>
<td>Don't know</td>
<td>(go to Q41a)</td>
</tr>
</tbody>
</table>
Q38 Do you know how much money is held in the contingency fund(s)?
- Yes □
- No □
- Don't Know □

(If 'Yes' state how much)

Q39 In the absence of there being a contingency fund, describe any ad hoc arrangements you have been involved with, giving approximate date:

Q40 Who holds the contingency fund(s) or agrees the ad hoc arrangements?
- Chief Executive of HA □
- Finance Director of HA □
- Director of Public Health □
- CCDC □
- Trust Chief Executive □
- Other (state below) □

Q41 (a) Have you been involved in a 'look-back' involving an infected health care worker?
- Yes □
- No □

Q41 (b) If 'yes', when was this?

Q41 (c) How many patients were involved?
- 1-100 □
- 101-500 □
- 501-1000 □
- more than 1000 □

Q42 Who paid for the 'look-backs' involving infected health care workers?
- HA □
- Trust (s) □
- Don't know □

Q43 How much did the exercise(s) cost (approx.)?
Q44 Who do you consider *should* pay for the costs associated with large outbreaks originating within the community, which require extensive microbiological or other resources?

Q45 From your experience, who *does* pay for the costs associated with large outbreaks originating within the community, which require extensive microbiological or other resources?

Q46 Are you aware if any Trust has made representation to the Health Authority for additional funding for infection control? Give examples with approximate dates

- Yes
- No
- Don't Know
### Section 6 - Status of communicable disease control within the HA

<table>
<thead>
<tr>
<th>Q47</th>
<th>Do you feel that you have been able to influence the decisions regarding allocation of resources for communicable disease control in the HA?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>☐</td>
</tr>
<tr>
<td>No</td>
<td>☐</td>
</tr>
</tbody>
</table>

(If 'Yes' give examples)

<table>
<thead>
<tr>
<th>Q48</th>
<th>Are you involved in the HA Planning Cycle?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>☐</td>
</tr>
<tr>
<td>No</td>
<td>☐</td>
</tr>
</tbody>
</table>

(If 'Yes' give examples)

<table>
<thead>
<tr>
<th>Q49</th>
<th>Are you involved in the Health Improvement Plan?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>☐</td>
</tr>
<tr>
<td>No</td>
<td>☐</td>
</tr>
</tbody>
</table>

(If 'Yes' give examples)

<table>
<thead>
<tr>
<th>Q50</th>
<th>Do you feel that communicable disease issues are given appropriate weighting in your HA?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>☐</td>
</tr>
<tr>
<td>No</td>
<td>☐</td>
</tr>
</tbody>
</table>

(Please comment)
Section 7 - Organisational Risk

Risk may be defined in a number of ways. In this section you are asked to choose *work constraints which you consider are potentially hazardous, and thus pose a risk to the population from infection.*

Q51 Are there any constraints that you personally feel hinder your ability to protect the population from communicable disease risks?

<table>
<thead>
<tr>
<th>No.</th>
<th>Resource/Constraint</th>
<th>Not Important as constraint</th>
<th>Some Importance as constraint</th>
<th>Great Importance as constraint</th>
<th>Very Great Importance as constraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Resources in HA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Staffing levels in HA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Resources in acute Trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Resources in community Trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Staffing levels in acute Trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Staffing levels in community Trusts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Your Personal knowledge of communicable disease control</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Behaviour of others in HA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Behaviour of others in acute Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Behaviour of others in community Trust</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Local or national media</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) Specify any other constraints in box below.
Q53 Which two of the constraints listed in Q 52(a) or (b) do you regard are the most important in the management of the risk of communicable disease? Give reasons why.

Q54 Have you experienced constraints in attempting to ensure that money is allocated for longer term investments in communicable disease control? Please comment and give examples

Yes ☐
No ☐

Q55 What organisational or managerial changes would help you with your work in protecting the population from communicable disease risks?

Q56 Who in the HA is generally responsible for determining when there is sufficient risk to disclose information to the public?

Q57 Have you ever taken a personal professional risk to disclose information to the public without backing from your DPH / DHA / DOH?

(give examples)

Yes ☐
No ☐
Section 8 - Perception of risk: specific infections

We are interested in your own understanding of the term 'risk' and ask you to choose microorganisms which you consider pose a major 'risk' to the hospital or community and score them against a number of criteria.

Q58 Choose two organisms which you consider are major infection risks within hospitals?
Example 1
Example 2

Q59 Choose two organisms which you consider are major infection risks within the community?
Example 3
Example 4

Q60 Indicate on the scales below how you rate the four infections with respect to the given criteria (lowest = 0, highest = 4).

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Example 1</th>
<th>Example 2</th>
<th>Example 3</th>
<th>Example 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virulence of organism (capacity to cause severe disease)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential transmissibility of infection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential Public health consequences within the community</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal workload</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficult to control effectively</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public concern or political forces</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely media interest</td>
<td></td>
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<tr>
<td>Risk of litigation to organisation (e.g. Trust / HA)</td>
<td></td>
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</tbody>
</table>
Q61 Please add any further information regarding any of the questions.

Q62 Please indicate whether you would like a copy of the final report, by placing a cross in the following box:

☐
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>Agency relationships exist when one person acts on behalf of another. The motivation of the agent may not operate entirely in the interests of the principal</td>
</tr>
<tr>
<td>CCDC</td>
<td>Consultant in Communicable Disease Control</td>
</tr>
<tr>
<td>Colonisation</td>
<td>The ability of some micro-organisms to reside on, or in, a host without causing disease</td>
</tr>
<tr>
<td>DPH</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>ECR</td>
<td>Extra Contractual Referral: the mechanism used in the internal market by purchasers and providers to pay for cases not covered by a contract</td>
</tr>
<tr>
<td>Endemic</td>
<td>A disease that is widespread in the community</td>
</tr>
<tr>
<td>Epidemic</td>
<td>The occurrence in a community or region of a disease or infection in excess of that usually expected</td>
</tr>
<tr>
<td>Governance</td>
<td>The institutional arrangements or rules within which economic activity occurs. Markets and hierarchies are two examples of alternative governance structures</td>
</tr>
<tr>
<td>HAI</td>
<td>Hospital Acquired Infection - an infection that was neither present nor incubating at the time of the patients’ admission to hospital.</td>
</tr>
<tr>
<td>Health Authority</td>
<td>The NHS organisation charged with purchasing health care from NHS Trusts on behalf of its local population</td>
</tr>
<tr>
<td>Health Authority (district health authority)</td>
<td>The NHS organisation charged with purchasing health care from NHS Trusts on behalf of its local population</td>
</tr>
<tr>
<td>HICC</td>
<td>Hospital Infection Control Committee</td>
</tr>
<tr>
<td>ICD</td>
<td>Infection Control Doctor</td>
</tr>
<tr>
<td>ICN</td>
<td>Infection Control Nurse</td>
</tr>
<tr>
<td>ICT</td>
<td>Infection Control Team</td>
</tr>
<tr>
<td>ITU</td>
<td>Intensive Therapy Unit</td>
</tr>
<tr>
<td>Lookback</td>
<td>A ‘look back study is a retrospective study of cases who may have been inadvertently exposed to an infection.</td>
</tr>
<tr>
<td>MDU</td>
<td>Medical Defence Union</td>
</tr>
<tr>
<td>MLSO</td>
<td>Medical Laboratory Scientific Officer</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>--------------</td>
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<tr>
<td>MRSA</td>
<td>Methicillin resistant Staphylococcus aureus</td>
</tr>
<tr>
<td>MSSA</td>
<td>Methicillin-sensitive Staphylococcus aureus</td>
</tr>
<tr>
<td>MDRTB</td>
<td>Multi-drug resistant tuberculosis</td>
</tr>
<tr>
<td>NAO</td>
<td>National Audit Office</td>
</tr>
<tr>
<td>NHS Executive Regional Offices</td>
<td>The NHS is administered through eight regional offices, to which district health authorities are directly accountable</td>
</tr>
<tr>
<td>NHS Trust</td>
<td>Publicly owned self-governing organisations which provide health care</td>
</tr>
<tr>
<td>NINSS</td>
<td>Nosocomial Infection National Surveillance Scheme</td>
</tr>
<tr>
<td>Nosocomial</td>
<td>Hospital Acquired Infection</td>
</tr>
<tr>
<td>Opportunism</td>
<td>Opportunistic behaviour is behaviour that allows one party to gain at the expense of another. It is made possible because of information imbalances between the parties</td>
</tr>
<tr>
<td>Outbreak</td>
<td>Respondents used different definitions of an outbreak, one was: two or more infections linked either clinically, microbiologically or epidemiologically. The second was an infection rate in excess of that usually expected.</td>
</tr>
<tr>
<td>Pathogenicity</td>
<td>The capacity of an organism to cause disease (number with symptoms/number infected)</td>
</tr>
<tr>
<td>Public Health Laboratories</td>
<td>A network of laboratories throughout the country that are funded by the Public Health Laboratory Service Board</td>
</tr>
<tr>
<td>PHLS</td>
<td>Public Health Laboratory Service</td>
</tr>
<tr>
<td>Public good</td>
<td>A public good is a service or good, which has two characteristics. First, property rights are costly to define, which means that it benefits individuals regardless of whether they have paid for it. Non-payers are therefore said to be able to ‘free-ride’ on its benefits. Secondly, it is costless to provide the benefits of the good or service to additional users, and hence it is inefficient to exclude non-payers. Note that there can also be ‘public bads’ often called negative externalities</td>
</tr>
<tr>
<td><strong>Quasi-market</strong></td>
<td>The term used to describe reforms to a number of government services in the late 1980s/early 1990s, when purchasing was separated from providing, while both activities remain in the public sector</td>
</tr>
<tr>
<td><strong>Reference Laboratories</strong></td>
<td>Laboratories that provide a level of microbiological analysis not routinely available.</td>
</tr>
<tr>
<td><strong>SRSV</strong></td>
<td>Small Round Structured Virus</td>
</tr>
<tr>
<td><strong>SSI</strong></td>
<td>Surgical site infection</td>
</tr>
<tr>
<td><strong>Transaction cost</strong></td>
<td>A cost incurred in running an economic system. Associated with concepts used in institutional economics. See O. Williamson 1985.</td>
</tr>
<tr>
<td><strong>VRE</strong></td>
<td>Vancomycin resistant enterococci</td>
</tr>
<tr>
<td><strong>Virulence</strong></td>
<td>The capacity of an organism to cause severe disease (number with severe disease or death/number with symptoms)</td>
</tr>
</tbody>
</table>