



Department of Health and Stakeholders
Healthcare Associated Infections Event
(Review of the day)

30 July 2008

Inmarsat, London



*“Without a record there is no memory...
...with no memory there is no follow-through”*

idenk when the answer is anything but black and white
think → act → succeed

idenk is a consulting firm advising and supporting business leaders and their teams on issues of strategy and organisation

This document is designed to be read on screen

To get an overview of the whole slide pack in 5 minutes, it is possible to skim by reading only the heading of each slide

(only looking at the further detail on each slide at points you are particularly interested in)

Key sections to note are:

Executive Summary

Slides 4 to 6

Process for the workshop

Slides 7 to 26

Outputs and actions

Slides 27 to 40

Annexes - cards, Q&A and feedback

Slides 41 to 63

Executive summary

Executive summary

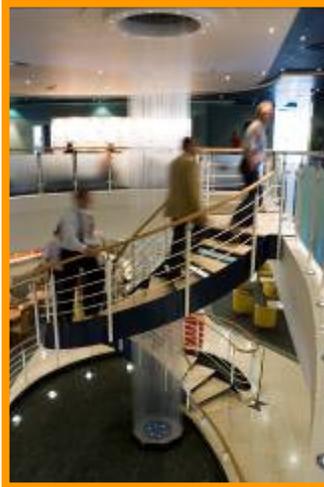
- An event was held on 30th July at the Inmarsat Conference Centre in London, hosted by the Department of Health's Cleaner Hospitals team, with a view to answering the question:
 - ◆ **What can we do to increase patient and public confidence that activities aimed at reducing Healthcare Associated Infections (HCAs) are working?**
- The event was attended by over 40 people including patient, public and charity representatives, and staff from the department itself
- This slide pack provides a record of the event, and summarises the key findings and outputs from the day's work.

Executive summary

- The day gave participants an opportunity to find out much more about what has been happening in terms of HCAI prevention, to ask questions of the Department of Health, and to show the Department of Health what they are doing to encourage cleaner hospitals
- Out of the discussions came two significant findings and actions:
 - ♦ **That many nurses and patients remain confused by the information and literature that is available from different sources - this elicited a commitment to look at the guidance being circulated and to address inconsistencies**
 - ♦ **That many people do not know of clear guidance that has been published - it was agreed that even more effort needed to go into communicating the availability of advice**
- Group work in the afternoon identified a list of specific information, help and guidance that the public and patients would require when MRSA screening takes place - this can be found on slides 28-34
- It was also agreed that the organisers would follow up the day with a report on proceedings, and would find out how the external stakeholders present would like to continue their involvement and engagement.

Process for the workshop

The event was held at the Inmarsat Conference Centre in London



The day was designed to answer one key question

What can we do
to increase patient
and public confidence
that activities aimed at
reducing Healthcare Associated
Infections (HCAs)
are working?



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Janice Stevens kicked off the event with an update on the programme to reduce HCAI

- 3 years into programme - we must look back to move forward
- Without doubt MRSA bacteraemias are coming down. Starting to see some progress in C.Difficile
- There is a long way to go but early signs are promising
- 3 years ago people were saying it would be impossible to make the improvements we have made
- There are some excellent examples of organisations making tremendous improvement.



MRSA/HCAI Improvement Programme

NHS
National Orthopaedic Programme

Lots going on.....

- From Board to Ward
- Ambulance guidance
- Further faster II
- Advice "outside hospital"
- More Matrons
- Deep Clean
- New target for *C. diff*
- Uniform advice, bare below elbows
- Improvement Team support
 - Worked with 130 Trusts

Advice for those affected by MRSA outside of hospital

If you have MRSA this leaflet provides information and advice for managing your day-to-day life.

NHS

DH Department of Health

Brian Duerden added more detail about specific initiatives designed to change mindsets

- Our focus is not just MRSA - we are concerned to drive down incidence of infections associated with healthcare generally
- We are trying to change the mindset



Reducing HCAI....

Change the mindset

■ From:

- 1) create a system to deliver specialist clinical care
- 2) take measures to prevent infection

■ To:

- 1) create a safe environment for patient care
- 2) deliver specialist clinical care within that environment

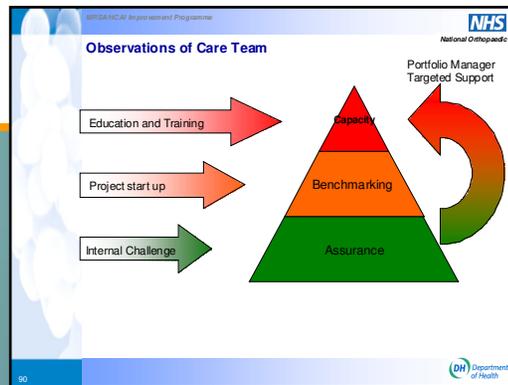
- Some bad habits are still there. We need to keep reducing them through management, surveillance, clinical practice, cleanliness and hygiene, training and performance management.

Liz Jones talked about the talismanic importance of cleaning



- What can we do to give the public confidence we are on top of HCAs? - work on cleanliness. It is hugely talismanic. It makes a difference at a subconscious level
- Most people will see the building before they see a doctor or nurse. If what you see outside is a mess, it makes clinicians' jobs that much harder. If we let hospitals get dirty or untidy we make our own jobs more difficult. We have to make them look the way patients expect them to
- Patient ratings - way up there is cleaning. People will make choices based on cleanliness.

Michael Dickson then talked about work to improve front-line practice

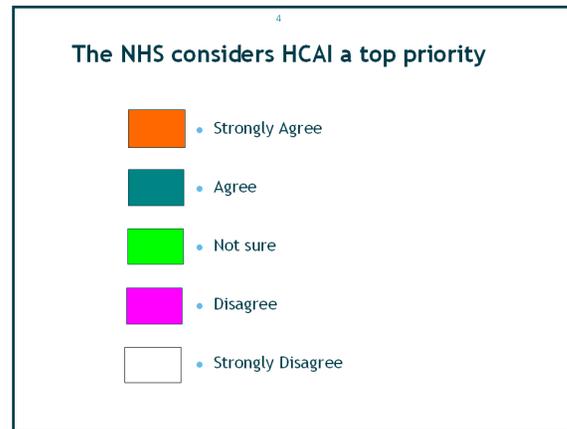


- The care team was established to address capacity, benchmarking and assurance. We needed to show capacity does not need to be enormous
- Example of results - one organisation said no problem with hand hygiene - but the care team found significant variability. It's hard to monitor yourselves
- Assuming competence is not sufficient. This is an absolutely key message. Practice has to be followed all the time, every time.

Then there was an opportunity to ask the speakers questions



Peter checked what participants think about various aspects of the NHS's approach to HCAI



Derek Butler from the MRSA Action group set out some challenges



- We have all been affected by infections. We know that in many cases things went wrong and could be done better. Our work is to look at what happens and use our experience to make things better
- Reducing C.Difficile by 30% is not an aspirational goal - tens of thousands of people are still getting avoidable infections
- Zero tolerance is not a number - it is a vision.

The NCHI gave a short presentation about its activities to raise HCAI awareness

- Our objective is to raise HCAI awareness - if it's not top of the agenda things don't get done
- We try to keep information as practical as we possibly can - a lot of info is pitched too high for most people out there
- We believe in breaking down the barriers between patients and healthcare providers. There is a blame culture. We should be working in collaboration.



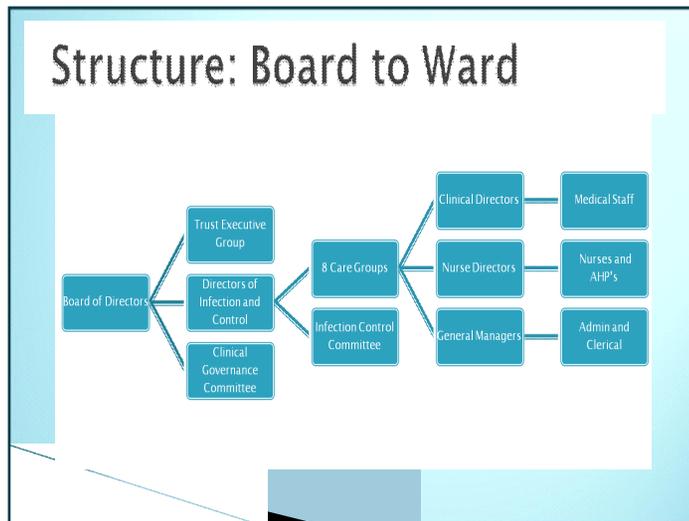
After lunch Ashley Brooks introduced the Max campaign

- The Max campaign - Our aim is to save lives around the world
- We talk about infections with an 's' - there are others beyond MRSA and C.Difficile
- It's a marketing / advertising campaign
- We have two difficult jobs - getting people (NHS staff) to listen to us, and always trying to think of different things
 - ◆ Posters on walls don't save lives. If you see something on a wall long enough it does not register
- Max = maximise your health.



Richard and Graham from the Sheffield Teaching Hospitals discussed strategies their organisation has used against HCAI

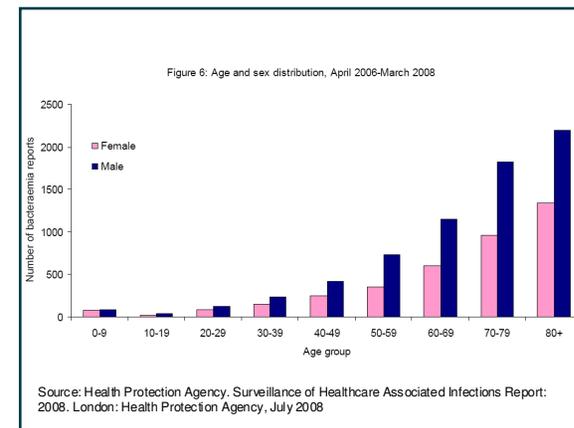
- Board accreditation scheme pioneered in Sheffield - working very well
- There is competition between wards not to be in the lower part of the accreditation.



Andrew Pearson talked the group through the latest data about HCAI rates



- The MRSA programme is only of value if the interventions from that spread out to other causes
- MRSA is a small part only - but very important - we must show improvements there and develop markers for other areas; we must think how we apply all the learning.



Paul Cryer revealed the progress made in developing new technologies to fight HCAI

- A new programme started in January this year as part of CNO's overall responsibility for HCAIs
 - development and adoption of new technology - not to solve HCAIs but to help
- Deals in short-term matters
- How do we get ideas through the system and red tape quickly?
- It's not about 'does the technology kill bugs?' We need to know that a technology can be shown to reduce infection and we need to know how it works in comparison to others.



There was some more discussion - about patient and visitor responsibility and availability of literature



Then Lindsay introduced group work looking at how patients might be better supported through the MRSA screening process

- We are going to look at MRSA screening - in particular the support and types of information patients might need at different stages
- One table to look at support before screening, one to look at time of screening, one to consider what happens when we get results, and one to look at what happens at the point of decolonisation
- Agree one key point to feed back per table.



Screening – how best can we support patients?

<p>Group 1</p> <ul style="list-style-type: none"> • What information will patients and the public need before they come into hospital about screening, who should give it to them and when should they receive it? 	<p>Group 2</p> <ul style="list-style-type: none"> • What will be the public & patients concerns about screening in general and specifically whilst being screened? How can we best address these?
<p>Group 3</p> <ul style="list-style-type: none"> • What will be the public & patient perspective once screening results are through – positive and negative results, how are these shared and what information is needed? 	<p>Group 4</p> <ul style="list-style-type: none"> • Will public & patients be OK with de-colonising themselves? What advice or support will they need re decolonising and how can this be delivered?

www.clean-safe-care.nhs.uk


The participants worked up ideas on flip charts...



...and then presented them back



Janice wrapped up the event with a summary of what she had taken from the day



Key things from today...

- Responsibility for reducing infection has to lie with hospitals and staff; but the public has a role to play
- Information for patients and nurses is confusing - we'll take a look at this and work with you to address this
- You can never communicate enough - we have a template for hospitals to use on MRSA and C. Difficile, but people don't know about it; so we have to communicate more
- We talk about progress being made - and things are happening - but the variation in the system matters to us too, and we are working to reduce that variation
- It is clear there is no one solution - no golden bullet - we are on a huge journey towards a transformational change in the NHS
- We must continue to listen to each other, learn from each other and work together.

Outputs and actions

What information will patients and the public require before coming to the hospital for screening?

- 6 wise men - the what, where, why, when, how and who
 - Explain why it's important to screen for specific procedures, and also the importance of screening particular areas MRSA is known to colonise
 - Advice should be given pre-assessment
- National campaign needed to help get message over
 - To raise awareness of screening, but advise that specific information will be provided locally
 - National guidance should reflect the variety of scenarios
 - De-stigmatize colonisation
- What happens when someone refuses to be screened?
- Lot of decisions to be made locally by clinicians depending upon the situation
- Look at measures used to put in place standard HIV testing for pregnant women.

What will be the public's and patients' concerns about screening in general and specifically while being screened? #1

- Headlines:
- Public information campaign to educate people - what is MRSA?
- Informed consent
- What happens if result +ve?
- Where should screening take place?
At GPs?
- What does it mean for me and my family?
- Notes from flip charts:
- Uncontrollable - may need reassurance
- Speed and process of tests and result
- Concern over informed consent
- Emphasize patient confidentiality
- Bite-sized pieces of information.

What will be the public's and patients' concerns about screening in general and specifically while being screened? #2

- Notes from flip charts continued...
- What will it mean for my grandchildren / family / insurance policy?
- Why am I being screened?
- Where should screening take place - if elective, more comfortable if with GP?
- What if:
 - ♦ I don't want to be screened?
 - ♦ I'm positive? Will I have to stay in longer?
 - ♦ It comes back later?
- What is MRSA?
- What will it mean if I'm positive?
- I've been screened already - why do I need to do it again?
- If I contract MRSA in hospital, what happens? Can I sue?
- Why are you screening?
- Will I be isolated?
- **What does it mean for me and my family?**

What will be the public's and patients' perspective once screening results are through, how are these shared and what information is needed? (#1)

- Headlines:
 - Explain to people what happens next?
 - What does it mean?
 - Timescales?
 - Implications for lifestyle changes
- Notes from flipcharts:
 - Results and feedback should be meaningful
 - Staff should be trained in how to provide that feedback
 - Context / personal circumstances should be appreciated
 - Resource to enable follow-on questions / additional information
 - Designated member of staff for providing feedback.

What will be the public's and patients' perspective once screening results are through, how are these shared and what information is needed? (#2)

- Notes from flip charts continued...
- As a starting point we need to explain WHY patients are being screened in the first place
- Need to explain colonisation v bloodstream infection angles
- Explain what happens next and any timescales for delay to elective treatment
- Information into the wider healthcare system as required (as opposed to allowed under DPA)
 - To GPs? Carers? County healthcare workers?
- Lifestyle implications?
 - Contacting others / work and leisure.

Will public and patients be OK with de-colonising themselves? What advice or support will they need *re* decolonising, and how can this be delivered? (#1)

- Headlines:
- The stigma. Where do you buy the products?
- If got news you are carrying MRSA - dispel fear, correct advice and communicate clearly
- Notes from flip charts:
- Internal versus external colonisation
- Colonised versus infected
- Worry
- Need for information
- Self-cleaning
- Info to cater for all
- Family and friends to be decolonised?
- Would everyone be ok to decolonise themselves?
 - Ok, but need info
 - Yes
- Different population groups will need different info / help
- Possibly like taking a prescription
- Visuals / pictures
- Elderly - additional help required.

Will public and patients be OK with de-colonising themselves? What advice or support will they need *re* decolonising, and how can this be delivered? (#2)

- Notes from flip charts continued...
- Level of worry will differ
- Early info - if positive what does it mean?
 - What is it?
 - What happens if you don't decolonise?
 - How to use the decolonisation 'stuff'
 - What will happen when you come back?
- Stigma - will they ask for help? Won't want to go to Boots for the product
- What happens if decolonisation does not work?
- Consistent info
- Assessment at point of contact - can a patient decolonise themselves?
- Many questions will be thrown up - e.g. can I touch a door handle after I have been decolonised?
- Need to address why everyone does not need to decolonise
- Allergies to products? What to do?
- GPS - can they provide the decolonisation packs?

Janice's wrap-up speech notes (#1)

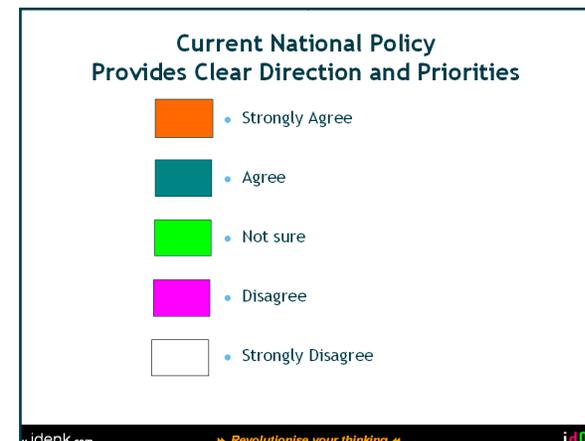
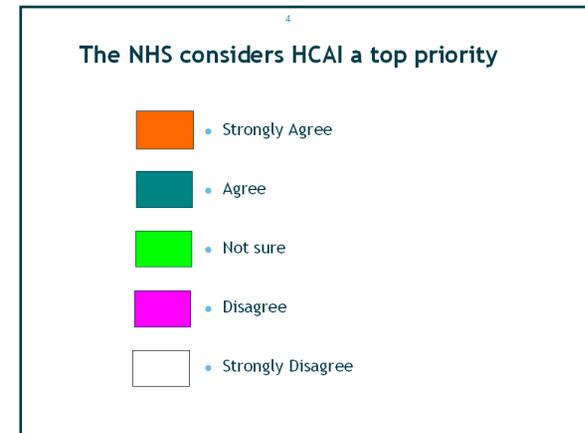
- We'll take your ideas and pull them into ideas for other things we can do
- Key things from today:
 - Responsibility for reducing infection has to lie with hospitals and staff; but the public have a role to play
 - **Info for patients and nurses is confusing - we'll take a look at this and work with you to address this**
 - **You can never communicate enough - we have a template for hospitals to use on MRSA and C.Difficile, but people don't know about it; so we have to communicate more**
 - We talk about progress being made, and things are happening, but the variation in the system matters to us too, and we are working to reduce that variation
- **From today, we will produce a note. Ready in 2 to 3 weeks. We will send it out to you. We'll ask you what you want from here and how do you want us to continue to work with you.**

Janice's wrap-up speech notes (#2)

- A day like today is always challenging - it should be. For my DH colleagues and myself it's a good reminder that however much we think we are doing, there is always more to do
- It is uncomfortable to be reminded that there are too many professionals not providing the services we want
- It is easy when we get together to become quite despondent; but this group has not done that. **I applaud all of you that despite being infected you can still see that many staff are doing a great job, and that there are still examples of excellent practice, and you are still prepared to take time out. A really big thank you to you for that**
- We sometimes seem to come from different perspectives, but we all share the same passion
- It is also clear there is no one solution - no golden bullet - we are on a huge journey towards a transformational change in the NHS
- **We must continue to listen to each other, learn from each other and work together.**

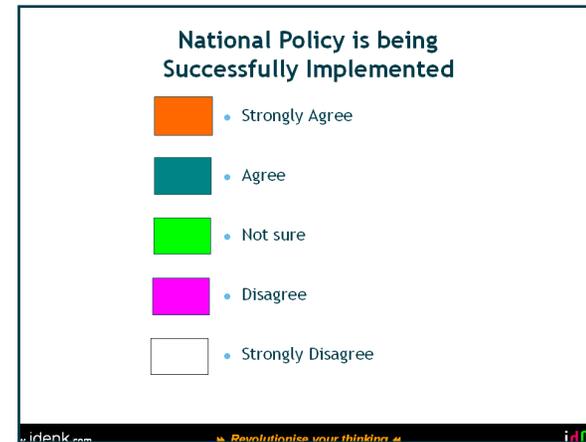
Voting: participants mostly agreed HCAI is a priority for the NHS but were less sure that policy guidelines are consistently clear

- Participants were either not sure whether the NHS considers HCAI a top priority, or they strongly agreed that it does
- Most agreed or strongly agreed that current policy provides clear direction and priorities - but there was a cluster of whites and pinks
 - ♦ General confusion; the guidance from different organisations collectively is confusing
 - ♦ It was agreed there was a need for practical action to ensure consistent clear messages to the public
- Also, there is a culture of ignoring the guidance.



Voting: opinion was split over whether policy is implemented successfully

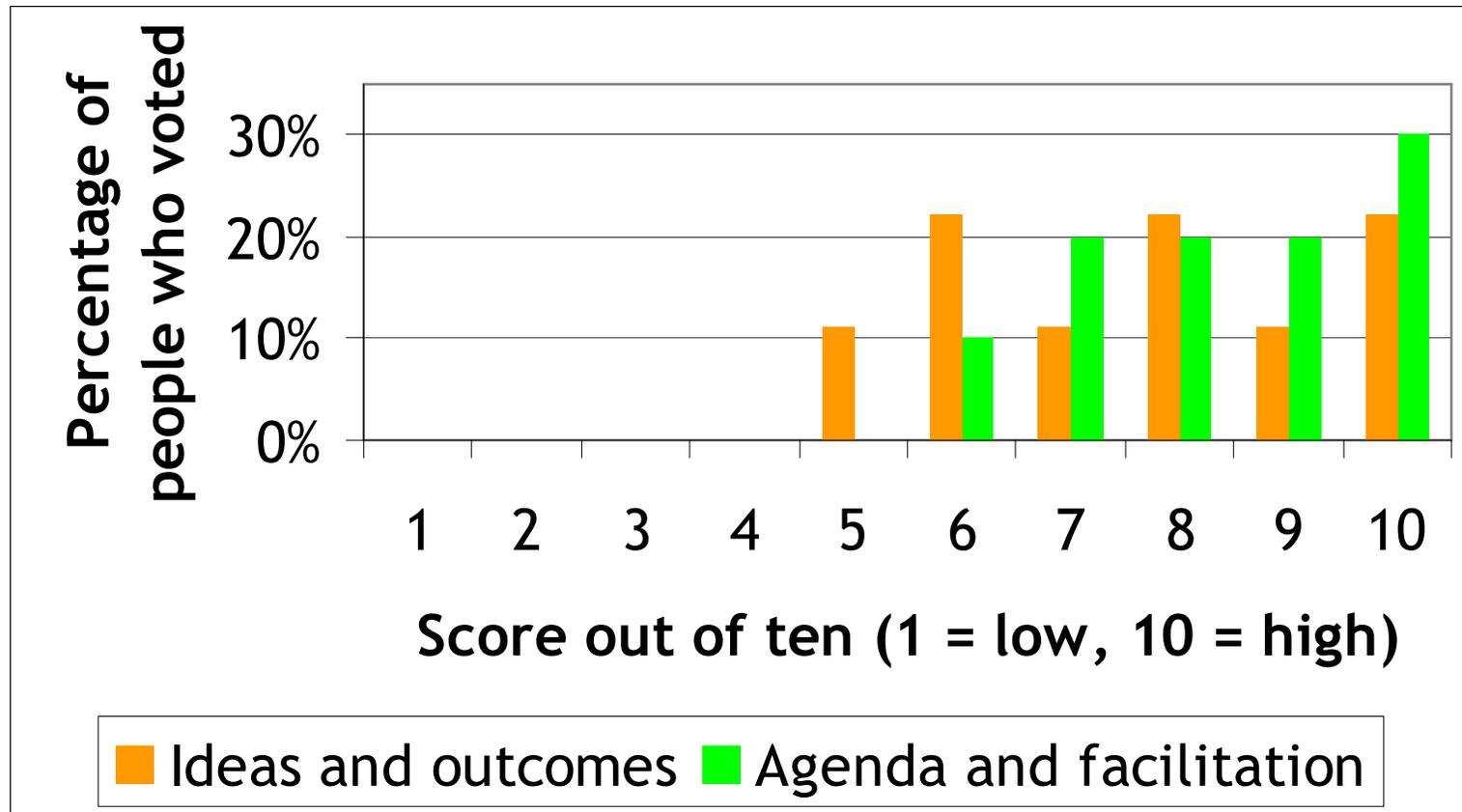
- Half and half blues and pinks - why?
 - Everyone is confused - if policy was implemented well, no one would be confused, so it is not working
- Instructions to trained nurses - asking us in MRSA Support what they should be doing. Some of the things they are told in classrooms defies belief
- On that particular issue - there is clearly a lot of work to be done in relation to the education departments; the Chief Nurse is working very hard through the SHAs



- We do have to look at education; training is about a partnership between training institution and the hospital
- We are very well aware of the issue in clinical education - infection has not been a priority in the clinical subjects for 20 years. We are getting that back now.

Annex: Feedback and review cards

Participants scored the event quite highly



What was great about this event?

- The organisation
- The video at the end
- Paul Cryer's talk was great
- Learning from the different groups and meeting new people with the same goals
- I think we continue to improve the NHS with innovation in the field of prevention of infection
- To know that progress has been made and that complacency will not be allowed to develop
- Networking / new technology ideas
- Finding out what other people's problems and concerns are in other trusts
- The variety of the people involved and the immediateness of the outcomes
- The interface between the specialist support groups, and PPI reps and patient governors. People were truthful
- The quality of the speakers and the obvious dedication and passion by all involved
- Debate among patient groups about how to address issues.

What would have got you to 10/10?

- More control of the debate at the end
- Fewer acronyms in the presentations. More information on the way forward - what's happening in respect of the wide range of legislation that is currently proceeding through parliamentary and DoH implementation schemes?
- More about technology / who is doing it right
- Nil
- Nothing can be perfect
- The afternoon session on group work could have been longer
- Greater time for discussions.

What will I do differently after today?

- Invite the patient groups into our trust to see what we are doing
- Adopt different ideas for collaborative working
- More publicity for new technologies
- Take on concerns of patients and families
- I will know what screening is, and what decolonising consists of, if I should need an operation
- Take back the message.

What I want someone else to do after this meeting

- Stop pushing the league tables. Sheffield has very different issues to many other providers. It shouldn't be about them being first and others being last
- Stop pushing Max
- To work together to achieve the same goals
- DoH to consider establishing a single point of contact for information on HCAs. Information provided in plain English which is easily understandable by patients and the public
- End postcode board attitude - top priority for all
- Listen to me
- Wash their hands - whether staff, or patients or visitors
- To produce national guidelines and a national campaign of screening
- Maintain the momentum
- Develop consistent national guidelines
- Put a search engine on the CSC web site - it takes ages to find anything
- Professionals to be more professional.

The one word that summarises how I feel about today is...

Thought-
provoking

Hopeful

Worthwhile

Good

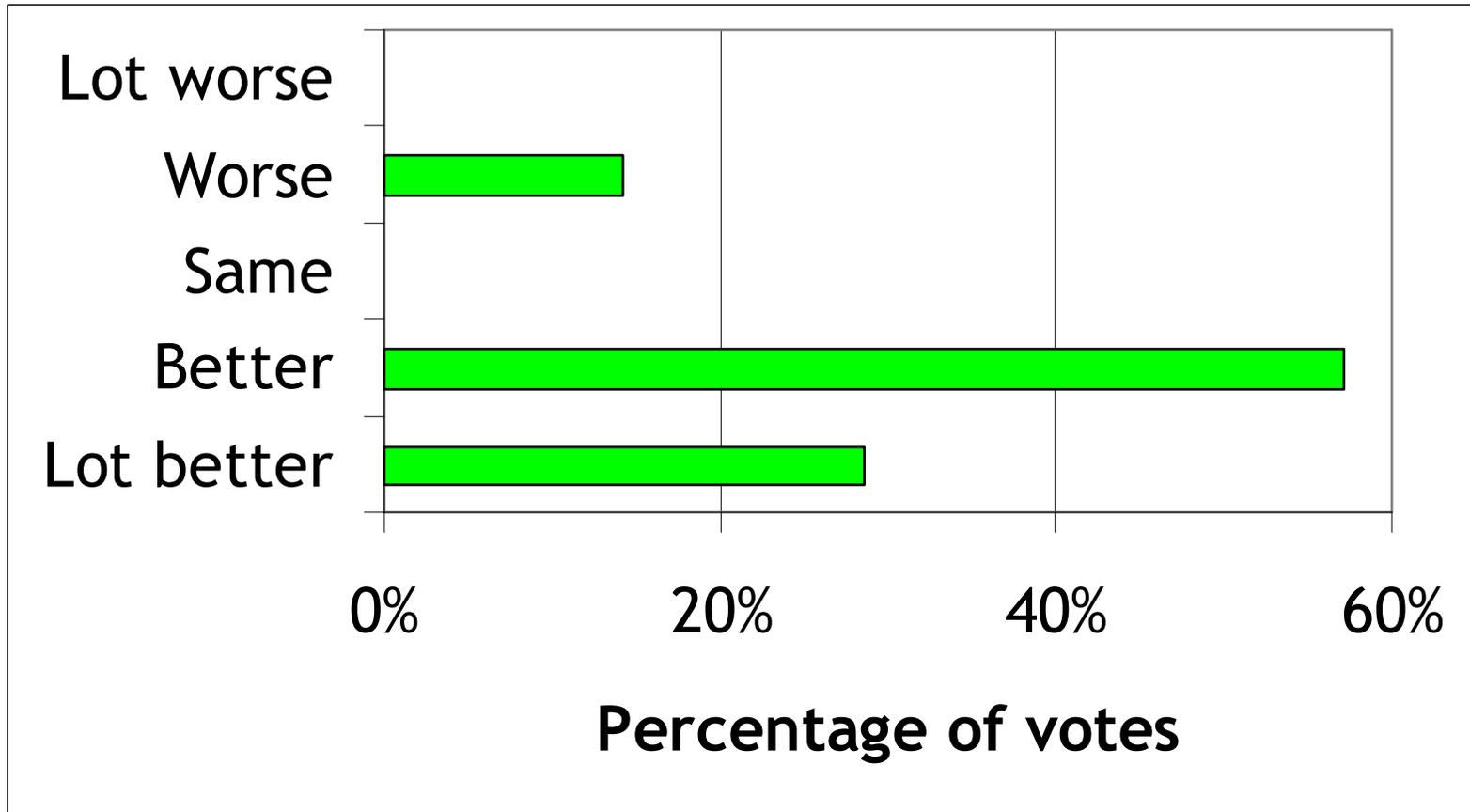
Great

Understanding

Bemused

Annex: starting cards

How has the management of HCAI infection changed over the last three years?



The 'worse' scores were averages - respondents scored MRSA the same and C.Difficile lot worse

How has the management of HCAI infection changed over the last three years? (comments)

- Improved, but more to be done
- More people are engaged now - not just infection control staff
- Better but still too patchy and not standardised
- Efforts being made but outcomes need analysing. With C.Difficile increasing more attention to technology and isolation facilities needed
- Some trusts brilliant; others not improving
- Better but the increase in C.Difficile has not been addressed quickly enough
- Huge effort at local and national effort has gone into reducing HCAI
- The campaign to reduce HCAs is not universal. More focus needed on areas of concern
- NHS now properly engaged
- Changed - but for the better? - Who knows!

What I think is the best work I have seen in the prevention and management of HCAI (#1)

- Neil Wigglesworth in Salford - small changes rolled out and measured
- S Manchester - Prof Cooke - antibiotic prescribing
- Portsmouth - Commissioning Education Programme for children
- Fully engaged trust board with supportive / challenging NEDs promoting the board to ward culture
- Clean hands campaign
- The work we are doing in our own trust (UCLH) *re* technology
- The appointment of a dedicated infection control matron in a matrons' group committee - closely involved with infection control steering committee
- Generally better awareness.

What I think is the best work I have seen in the prevention and management of HCAI (#2)

- Doctors / nurses who believe they can make a difference
- Hospital trusts who have taken prevention and control seriously from board to ward. Wolverhampton - good leadership and champions; Guy's and St Thomas's & UCLH making every effort with trials and finding out what works
- Use of bundles and care pathways - high impact interventions
- Trusts that have grasped the nettle. The best have leadership driving improvements from board to ward and back again. Having a vision and clear focus is critical
- More focus has been put on HCAI in recent years which has made people aware and changes made
- Training and retraining of medical staff and signage in hospitals for visitors although not 'brilliant'
- Sheffield introduction of the Ward Accreditation Scheme

What I think are the key issues to be faced in preventing and managing HCAI (#1)

- Funding (ring fenced) and resources
- Better education generally
 - Training on hand hygiene (patients and staff)
 - Aseptic technique
- Antibiotic prescribing
- Engaging all clinical staff
- Managing patient / public expectations
- Time spent developing guidance across all organisations
- Research
- Early identification of incoming patients for prior / incoming infection, including checking if they have had MMR
- Staff wearing uniforms to and from work, or when nipping out; theatre staff leaving theatre in blues
- Good hygiene in homes and schools
- Anticipating what will happen next
- Encourage ward / theatre staff to observe prevention routines
- Knowledge
- Learning from mistakes
- Leadership - Board to Ward needs to be national in Acute and Primary care.

What I think are the key issues to be faced in preventing and managing HCAI (#2)

- Prevention and control is key - can't rely on antibiotics
- Attitude - everyone taking responsibility
- Public awareness of their responsibilities *re* cleanliness and its effect on hospitals
- Improved hand hygiene at the heart of IC
- Restoring confidence in the NHS
- Breaking through the myths that surround HCAI
- Acknowledgement of responsibility of NHS / DoH to prevent / manage HCAI
- Vision
- Sustaining the progress
- Communication / partnerships
- Ongoing advertising
- Stop faffing
- The Max campaign
- Get trusts to follow national guidelines
- Remove confusion over advice given
- Ensure records are accurate
- Proper redress and recompense for patients who contract HCAI.

What I think are the key issues to be faced in preventing and managing HCAI (#3)

- Public information
- Continuing good practice
- Cleaners employed by trusts and allocated to specific wards
- Board to be involved in promotion of IPC and recognised by staff and public
- Accountability.

Annex: Q&A notes and comments

Q&A notes (#1)

- After the deep clean. Any laid-down guidance about continuance?
 - ♦ We are asking hospitals to do deep clean to create a platform for ongoing cleaning; but not as one off. Trusts must have a plan for deep cleaning on routine and *ad hoc* basis.
- Can observational care teams only go in when invited?
 - ♦ We have been to a huge number of organisations. We have used a range of techniques to work with them. It's about working with, not inspecting. We have been into organisations that have been reluctant. The national approach is not about turning up on the doorstep
 - ♦ Concern behind the question - some trusts not doing as well as others. My concern is you have to be invited
 - Example: we were in an organisation, but the scope we were given was very small. Working with them we were able to expand the scope once we were in.

Q&A notes (#2)

- Ring fencing of IC budgets is an issue. It is the first budget to get hit. We are hearing stories in trusts where hotel services budgets are being squeezed. Any way to ring fence them?
 - It is difficult - no one will pretend it's easy. Hard decisions for trusts to make, but those decisions must be made locally. It's not appropriate for us to say how much should be spent in each locality
 - You have to work out what resources you need locally - but there are the resources in place to help understand if local decisions being taken are the right ones. E.g. if an organisation reduces the budget, but infection rates are higher, then the organisation will get a level of scrutiny about whether the decisions it has taken are right
 - Ring fencing can be appropriate for some small specific pieces of work; but it's not appropriate for telling people how to run and spend all funds
 - I disagree with assertion that cleaning / facilities / special services budgets are the first to be cut - it was the case. These areas are now getting more investment than I have ever seen.

Q&A notes (#3)

- Deep cleaning was done to get rid of bacteria in hospitals - but recent report said only 10% of trusts did deep clean in line with guidance. 85% used wrong detergents. Any comment on this?
 - Removing micro organisms from the environment was not one of reasons for deep clean. There is an important IC angle to deep clean. It was also about whole confidence and creating basis for sustainable improvements to cleaning
 - £7 million spent on deep clean - what is the evidence about whether this could have been spent better elsewhere?
 - Public perception of deep cleaning - caused by media. Perceived as panic move, as new thing. The people who can contact the news media should put them right
- Rise of measles very concerning - how many staff have had the MMR?
 - It is not necessarily HCAI - but it does impinge on hospital performance. So it is something we are concerned about (not necessarily in this team, but wider team).

Q&A notes (#4)

- How confident can we be in recording of statistics?
 - ♦ There are two aspects to recording of infections:
 - Yes there should be good recording. That needs training. As regards those on mandatory basis (e.g. MRSA), that's on a very sound basis. 100% difficult to achieve but I am confident the great bulk of cases are captured
 - When we started three years ago the numbers went up because of the emphasis on capturing every case
 - Death certification - fully agree that has not been as accurate as it should have been. Reminders to doctors to do better have pushed up recording
- Varying guidelines - the public are confused about what products kill what bacteria, and laundry processes etc
- I would like to support idea there is mass confusion about what can tackle C.Difficile
 - ♦ It is unfortunate there is confusion; but there has been absolute consistency in formal official guidance from the DH
 - ♦ If you are picking this up as an issue - e.g. HPA guidance - we'll look at that, and are happy to take that on.

Q&A notes (#5)

- ECS1153 - works to cure MRSA?
 - ♦ You have to be very careful about saying a new drug will be a bullet. They will only help in short term. And new drugs are increasingly nearly as toxic as the things they are trying to treat. We have to use other techniques and use the drugs we have more prudently and cleverly
 - We also need more non-invasive methods
- Use of copper as anti-microbial surface - any news?
 - ♦ Work is ongoing - waiting for the results. There is some good science behind it.

Q&A notes (#6)

- We have an issue - there are a number of people who cannot take responsibility for their own hygiene - staff must step in here
 - In a hospital staff have responsibility for ensuring cleanliness. Visitors and public have additional role, but you have to be careful not to push responsibility too far their way - or there is a danger they start to get blamed for their infections
 - We have said it's OK too ask. And staff should be told it's OK to be asked.

Q&A notes (#7)

- The posters produced as part of the cleaner hands campaign are very confusing. Is there a successful example of communication about hand washing?
 - A local hospital used pictures of their own staff washing their hands which worked. Signs need to be bigger and where they are seen, and more hand washing facilities must be made available
- Everything needs to be in plain English - a lot of stuff put out is in words people don't understand. They need the info, in plain English and no acronyms
 - With Max - whatever we do it has to be simple. A lot is image based. No huge amounts of text. So anyone can understand
 - Message has always got to be as simple and visual as you can make it
 - But stuff in the public domain for highly trained staff must be in professional language
 - Having multi-language materials costs so much.

Q&A notes (#8)

- Is there patient-understandable literature available for HCAs?
 - ♦ Each hospital is responsible for its own literature. Some is good, some is bad
 - ♦ There are two nationally available, generic pieces on the “Clean, safe care” web site that local hospitals are encouraged to use
 - ♦ There is also a film for patients on the NHS Choices site - one on MRSA - there is one coming on C.Difficile too.

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