The future for infection prevention and control in English primary care trusts

Pickles H[1]*, Nunkoo B[2], Sadler K[3]

1. *Director of Public Health and Director of Infection Prevention and Control, Hillingdon Primary Care Trust, Kirk House, 97–109 High Street, Yiewsley, West Drayton, Middlesex UB7 7HJ. Email: hilary.pickles@hillingdon.nhs.uk*
2. *Infection Control Nurse (address as above)*
3. *Strategic Programme Manager (address as above)*

**Corresponding author*

Accepted for publication: 22 September 2007

Key words: Primary care trusts, NHS reorganisation, infection prevention and control

Abstract

Although less well developed than in the hospital sector, the infection prevention and control function is important to primary and community care. In each reorganisation in the NHS, any specialist workforce needs to align with that part of the system that holds the relevant responsibilities and duties. This paper describes how infection control nursing has shifted its focus over the past decade. It questions whether the primary care trust (PCT) will remain an appropriate employing organisation in the future, as those provider functions currently within PCTs move away. The challenge will then be to ensure that infection prevention and control remains prominent within the decision making of PCTs and practice-based commissioners, with expert infection control advice and support also remaining available to independent primary care practitioners. A market for infection prevention and control advice and support services would be possible, provided suitable employment conditions could be ensured.

Introduction

Infection prevention and control in primary care and the community has had a low profile for many years, being overshadowed by the prominence given to healthcare associated infection within the hospital sector (Judge and Hill, 2004). An additional challenge has been the frequent reorganisations within the NHS. In this paper, the experience of the changes in the past decade and how it has affected the employment of community-based infection control nurses (ICNs) is used to indicate what the next round of changes may bring. NHS reform is intended to bring benefits to patients from greater clarity in the expected standards, patient choice and more transparency in NHS spending, but may also bring new challenges to infection control.

Infection prevention and control in primary and community care

Whereas infection prevention and control is easily defined in hospitals, the definition is more fluid in the community. The most recent focus has been on prevention of transmission of infectious disease from one person to another as a consequence of health care (NICE, 2003). However, the same basic principles and training can be applied to prevention of the spread of communicable diseases more generally, including within social care and custodial settings. The focus is on person to person spread, either directly or through inadequately decontaminated equipment.

If infection control is defined by the role of infection control nurses, then this has been shifting over the years, as ICNs adapt to their circumstances and new central initiatives, with many different titles being used by community infection control nurses (PHLS, 2002). Training and advice on hand hygiene, sterile techniques and local decontamination have remained throughout, but the extent of involvement in outbreak investigation and control, immunisation and infection control standards for commissioned services have varied over the years. This can be illustrated by the differences between the situation in 2000 and that seen at present.

Infection control in the late 1990s

Although healthcare associated infection was already starting to be of political interest (NAO, 2000), infection prevention and control was poorly developed in the community. Although hospitals were explicitly advised to have infection control committees (DH, 1995), there was no equivalent requirement for health authorities (HAs). Although ICNs were in short supply, where HAs were able to make appointments, these nurses tended to act to support the communicable disease consultant (CCDC). Community trusts meanwhile employed their own infection control nurses, working largely on in-house training and audit. In many places, nursing and residential homes and independent contractors such as GPs and dentists had minimal input from the health authority's infection control nurse, perhaps only the free supply of local policies and occasional training and help with audit. Although there was a controls assurance standard that related to infection control, this self-declaration for HAs was not challenging (DH, 1999).

Infection control at present (2007)

Several significant events have changed the climate and landscape in the past decade (Table 1).

Firstly, the political interest in healthcare associated infection has meant increased investment and emphasis on infection prevention and control, mostly but not entirely in the hospital sector. Many guidance documents have been issued and new national targets (for example Department of Health recommendations such as *High Impact Interventions*, *Saving Lives*, *Essential Steps*, and more recently the MRSA taskforce recommendations), together with a code of practice backed by primary legislation – the Health Act 2006 (DH, 2006). All NHS bodies, including PCTs, are now required to have a board-level lead for infection control – the director of infection prevention and control (DIPC). The Healthcare Commission has standards for infection control and a new national target for year on year reductions in meticillin resistant *Staphylococcus aureus* (MRSA) levels.

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SAGE Publications, Los Angeles, London, New Delhi and Singapore.
10.1177/1469044607085005

Table 1. Some of the recent changes affecting infection prevention and control in primary care and the community

- Enhanced interest in healthcare associated infections
- District health authorities go, primary care trusts arrive
- Nursing home inspection moved from health authorities to the Commission for Social Care Inspection
- Community trusts disband
- Health Protection Agency established
- Contracts of independent contractors
- Healthcare Commission standards
- The Health Act 2006

Secondly, district HAs were disbanded in 2002 as PCTs were formed, and more recently many PCTs merged to cover larger populations. Further changes were taking place meanwhile to the old regional offices and strategic health authorities. Community trusts were also disbanded over this time, with functions moving into PCTs or into specialist mental health trusts. As a result, all infection control staff based outside hospitals will have experienced changes in employer at least once and many will also have had changes in line management.

Thirdly, following a report from the English chief medical officer (DH, 2002), an organisation originally to be called the Health Protection and Infection Control Agency was established as the Health Protection Agency (HPA) in 2003. The CsCDC transferred to the HPA from HAs, often accompanied by their infection control nurses many of who transformed into health protection nurses. Actual accountability for local health protection was largely unaffected by this new advisory body (Pickles, 2004). The split of responsibilities between the HPA and the PCT is determined by a memorandum of understanding, agreed locally and based on a national template. Infection control remains an area where the pattern is not consistent across the country, nor between the home nations (Rowland, 2006).

Fourthly, the contracts for independent contractors such as GPs and dentists have had major revision and are now held by PCTs rather than centrally. The self-declaration that the Healthcare Commission requires from PCTs is expected to apply to standards within primary care, even though powers to influence that are limited. GPs meanwhile are being encouraged to take greater responsibility for commissioning services for their patients, with initial focus on activity in the acute sector that might be suitable for delivery outside of hospital.

The changes in recent years have been taking place at a time when the funding available to the NHS has increased without precedent, increased efficiency has accelerated the throughput in hospitals, and clinical outcomes and life expectancy have improved. Concern about infection control is one of the reasons why public opinion has not matched these demonstrable improvements and may be why infection prevention and control is likely to remain a high priority, as NHS funding settles back to a lower level of growth in the coming years (Wanless et al, 2007).

Changes anticipated for the next few years

Several policy initiatives have been initiated or signalled that will impact on the infection control function in PCTs (Table 2).

Although aspects of the chief executive's letter on commissioning a patient-led NHS were rescinded soon after (DH, 2005), the overall direction of travel is clear. PCTs are expected to focus on a few key functions, which do not include the direct provision of services (Harvey et al, 2007). Various models have been suggested for this (Smith et al, 2006), and in the meantime a clear separation is expected within PCTs, with the 'commissioning' of provider services. Practice-based commissioners, ie GPs, will increasingly decide what those services should be and how they should be specified and delivered.

Another national policy direction is contestability, whereby services paid for by the NHS should only be provided by the NHS if they can meet the required checks of contestability. In order for there to be a level playing field between potential competitors for service provision, there will need to be transparency about costs, with no hidden subsidies. High standards of infection prevention and control will need to be an inescapable requirement on any provider. When provider units separate from PCTs, perhaps merging or forming community foundation trusts or third sector organisations, they are likely to want their own ICNs, presumably transferred under TUPE (Transfer of Undertaking Protection of Employment) from PCTs together with the bulk of the other staff, or else bought in under contract. The net effect of the new arms-length arrangement is that the majority of the function now delivered by ICNs within PCTs is likely to travel with the PCT's current provider functions and leave the core PCT.

Table 2. Anticipated changes that may affect the PCT infection control function in the coming years

- Separation of provider services from primary care trusts
- Greater transparency on costs
- Increased contestability
- Private sector involvement in commissioning and provision of services
- Increasing shift of service provision from the acute sector to primary care
- Public health moving closer to local authorities
- Health Protection Agency concentrating on core business that may not include routine infection control

Other changes expected to affect PCTs are the increasing use of private sector expertise in the commissioning of services (DH, 2007b); increased joint working with local authorities, including the joint appointment of the director of public health (DPH); and the joint commissioning of services, with children's services through children's trusts becoming a priority in the short term. Meanwhile the range of providers may be extending, with an increasing proportion potentially falling outside the Healthcare Commission's definition of 'health body', as GP commissioners increasingly undertake work previously done in acute care.

Meanwhile, the HPA has been rethinking its core functions and routine infection control may no longer be part of the service provided for PCTs (HPA, 2007).

Discussion on future challenges for PCTs in infection prevention and control (Table 3)

PCTs are expected to remain for some years, though further mergers and modifications to boundaries are possible. As NHS bodies, they will need to retain a board-level interest in infection control—the DIPC. They will also remain subject to Healthcare Commission standards with declarations in relation to the services provided by their independent contractors such as GPs and those commissioned for their populations from foundation trusts, the independent sector and other NHS and third sector bodies. A certain level of expertise will be needed in order to exercise this DIPC role, but PCTs of the future are unlikely to have board-level posts for nurses, and the DPH will have to share time with the local authority, or for some, several local authorities. In order to keep up to speed with what will be a minor part of their overall duties, the DIPC will need expert advice and support from someone for whom infection control is their main interest. At present this is provided by ICNs employed by PCTs, but the presumption is those ICNs will be needed to work alongside those who are currently in PCT provider arms. The infection control infrastructure for 'other NHS bodies' such as PCTs simply requires 'an Infection Control Nurse or other designated person responsible for infection control matters' (DH, 2006).

An area that has been poorly developed to date is using the commissioning process to push up infection control standards. This is

Table 3. Forthcoming challenges for infection prevention and control in primary care and the community

- Expert support to PCT DIPCs and commissioners, including practice-based commissioners
- Improved levers over independent contractors who fail to meet infection control standards
- Filling any gap if the Health Protection Agency leaves local infection control service provision
- Capacity to support primary care practices, nursing and residential homes
- Tension between, and potential separation of, performance monitoring and specialist support functions
- Alignment of the costs and burdens of infection control, if this is thought to matter

especially important because MRSA rates are currently one of the top NHS performance standards, applied to PCTs as commissioners and not just to the hospitals that record the infections. Public recognition of poor standards may affect patient choice, but the payments by results system is not easily adapted to reflect this sort of quality standard, where poor ascertainment can give misleadingly good outcomes. Knowledge and experience in infection control have not been among the criteria required of those commercial companies invited to bid for PCTs' commissioning business, nor are healthcare associated infections part of the schedule expected to be monitored by outsourced commissioners (DH, 2007b). When aspects of the commissioning function are outsourced, expertise will need to be retained by the PCT to enable it to act as intelligent customer, ie to understand the policy agenda and to know what infection control standards need to be applied by the outsourced commissioner. Increasingly, that may become the DIPC role in a PCT.

Improved performance monitoring and control may also be required in relation to services provided through the primary care contracts. These contracts, like that for general medical services – the nGMS contract – are negotiated nationally and at present good infection control is not a specific feature attracting extra payments. Although poor infection control may prevent GPs from providing additional services such as minor surgery, the only formal sanction in relation to the generality of primary care services is the blunderbuss of removal from the Performers List (DH, 2004). However, the threat of litigation may prove a more powerful driver for change than formal performance monitoring by the PCT. With the primary responsibility for infection control resting with the independent contractor (Portsmouth, 2007), the PCT is left in an advisory and supportive role, assisting with training of practice staff and the running of audits.

Emergency planning is a function for PCTs that is expected to remain even if all aspects of commissioning are contracted in from the commercial sector. When the emergency in question is pandemic flu, then infection control will be of prime importance, not least in primary care (BMA/RCGP, 2006).

With loss of ICN capacity from PCTs, firstly to the HPA and now as the provider functions become distanced, serious issues arise over capacity and critical mass to support those functions that are to remain with PCTs. A large PCT with commitment to supporting its independent contractors may be able to support a single ICN, but working in isolation may not be attractive, nor the work seen as rewarding as working more directly with clinicians in the same organisation. If the HPA accepts that strategic leadership and specialist advice are its core business (HPA, 2007), then the next iteration of the memorandum of understanding with PCTs may ensure that this is always available to support the PCT, DIPC and the commissioning and performance managing function in relation to infection control.

A model for local service provision that could be satisfying to infection control practitioners could be an infection control service that employed several ICNs and supported several organisations, as a shared service. Internal cross-cover would be possible and could ensure a year-round service. The HPA is considering making such a service available, though through a charged service level agreement (SLA) rather than through the memorandum of understanding (HPA, 2007).

If the funding has to be separately identified and hence a market in community infection control advice develops, then any organisation could host the staff, though existing staff are unlikely to be interested except where NHS terms and conditions are retained. At present this is a likely block to some potential third sector and commercial models, although the recently initiated Department of Health-sponsored social enterprise pathfinders may smooth the way for this development (DH, 2007a). An alternative could be a specialist network or federation of infection control staff across several organisations, assuming transparency about costs could be achieved. The cost might appear higher than at present, but the return on investment should mean the value for money remained high. It could also be available to be contracted in by GPs and other independent contractors, residential and nursing homes. Were the HPA to provide both the advice to commissioners and expert advice to the provider, a potential conflict of interest would arise, but no greater than that currently experienced by the PCT infection control nurse.

Whatever model develops for infection control could be relevant to other specialist quality-enhancing NHS functions which at present have that difficult balance between local availability and critical mass. A possible model is outlined in Table 4.

Conclusion

The infection prevention and control function in PCTs has grown out of that which came from health authorities and community trusts. Increased interest in infection control enabled it to survive the loss of capacity to the HPA. However, further loss to support the soon-to-be-distanced provider units may require new approaches to enable essential core PCT functions to continue. These functions include ensuring infection prevention and control is not marginalised within commissioning even if it is outsourced, the support of infection control within primary care, and whatever else is required to enable the DIPC and the board to satisfy themselves that the relevant healthcare standards are met. This will be needed at a time when the growth in NHS spending reduces back to more modest levels than have been enjoyed recently.

In order to make jobs that are satisfying and varied, and to ensure the high standards that come from critical mass, the model being recommended here is of specialist infection control services, each employing several ICNs. These could be contracted to support a range of providers (including community Foundation Trust and GPs) and be based within a potential range of organisations, including the HPA. The same specialist service, or the HPA if it is not itself that service, would also be available to support PCTs in their strategic and commissioning functions.

Discussion and debate on this would be timely.

Table 4. Possible future model

PCT DIPC and commissioners

- Expert advice provided from the Health Protection Agency through the memorandum of understanding

Community-based provider services (ie ex-PCT provider services, independent contractors, polyclinics, nursing and residential homes)

- Expert infection control provision by contract from a specialist infection control provider (based in a community Foundation Trust, third sector body, independent sector, or the Health Protection Agency)

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