

APPENDIX 6 - INPATIENT CARE CHARACTERISTICS

6.1 Antimicrobials

Appendix Table 6-1: Acute Hospitals. Number and percentage of antimicrobials prescribed for surveyed inpatients

Antimicrobial	Prescribing Frequency	
	N	%
Abacavir	1	0.0
Aciclovir	103	1.8
Amikacin	2	0.0
Amoxicillin	330	5.8
Amphotericin	10	0.2
Ampicillin	6	0.1
Atazanavir	1	0.0
Azithromycin	8	0.1
Benzylpenicillin	117	2.1
Caspofungin	1	0.0
Cefaclor	1	0.0
Cefalexin	79	1.4
Cefotaxime	78	1.4
Cefpodoxime	2	0.0
Cefradine	3	0.1
Ceftazidime	43	0.8
Ceftriaxone	230	4.1
Cefuroxime	155	2.7
Chloramphenicol	94	1.7
Ciprofloxacin	483	8.5
Clarithromycin	366	6.5
Clindamycin	69	1.2
Clotrimazole	70	1.2

Antimicrobial	Prescribing Frequency	
	N	%
Co-Amoxiclav	834	14.7
Co-Trimoxazole	41	0.7
Colistin	10	0.2
Demeclocycline	1	0.0
Doxycycline	30	0.5
Ertapenem	1	0.0
Erythromycin	46	0.8
Ethambutol Hydrochloride	5	0.1
Famciclovir	2	0.0
Flucloxacillin	288	5.1
Fluconazole	135	2.4
Fusidic Acid	30	0.5
Ganciclovir	4	0.1
Gentamicin	99	1.8
Imipenem With Cilastatin	2	0.0
Isoniazid	1	0.0
Itraconazole	19	0.3
Ketoconazole	2	0.0
Lamivudine	4	0.1
Levofloxacin	21	0.4
Linezolid	24	0.4
Lopinavir With Ritonavir	1	0.0
Meropenem	73	1.3
Metronidazole	586	10.4
Miconazole	7	0.1
Minocycline	2	0.0
Moxifloxacin	24	0.4
Mupirocin	70	1.2
Neomycin	7	0.1

Antimicrobial	Prescribing Frequency	
	N	%
Nevirapine	1	0.0
Nitrofurantoin	18	0.3
Norfloxacin	19	0.3
Nystatin	258	4.6
Ofloxacin	11	0.2
Other Drugs	18	0.3
Oxytetracycline	16	0.3
Penicillin	84	1.5
Phenoxymethylpenicillin	7	0.1
Pyrazinamide	5	0.1
Rifabutin	2	0.0
Rifampicin	45	0.8
Ritonavir	1	0.0
Silver sulphadiazine	2	0.0
Sultrin Cream	1	0.0
Tazocin	78	1.4
Teicoplanin	52	0.9
Tenofovir disoproxil	2	0.0
Terbinafine	3	0.1
Tetracycline	3	0.1
Ticarcillin	1	0.0
Tioconazole	1	0.0
Tobramycin	4	0.1
Trimethoprim	206	3.6
Valganciclovir	1	0.0
Vancomycin	189	3.3
Voriconazole	12	0.2
Zidovudine	1	0.0
Total	5 662	100.0

Appendix Table 6-2: Non-acute Hospitals. Number and percentage of antimicrobials prescribed for surveyed inpatients

Antimicrobial	Prescribing Frequency	
	N	%
Aciclovir	6	1.5
Amoxicillin	25	6.1
Benzylpenicillin	1	0.2
Cefalexin	13	3.2
Cefotaxime	2	0.5
Cefuroxime	3	0.7
Chloramphenicol	14	3.4
Ciprofloxacin	30	7.3
Clarithromycin	10	2.4
Clindamycin	2	0.5
Clotrimazole	41	10.0
Co-Amoxiclav	53	13.0
Co-Trimoxazole	3	0.7
Doxycycline	12	2.9
Erythromycin	4	1.0
Flucloxacillin	18	4.4
Fluconazole	6	1.5
Fusidic Acid	8	2.0
Metronidazole	34	8.3
Miconazole	3	0.7
Minocycline	2	0.5
Mupirocin	14	3.4
Neomycin	1	0.2
Nitrofurantoin	4	1.0
Nystatin	25	6.1
Other Drugs	1	0.2

Antimicrobial	Prescribing Frequency	
	N	%
Oxytetracycline	14	3.4
Penicillin	7	1.7
Rifampicin	1	0.2
Silver sulphadiazine	1	0.2
Teicoplanin	1	0.2
Terbinafine	3	0.7
Tetracycline	1	0.2
Tioconazole	1	0.2
Trimethoprim	36	8.8
Vancomycin	9	2.2
Total	409	100.0

6.2 Invasive devices

Appendix Table 6-3: Acute Hospitals. Invasive device usage for burden study inpatients categorised by specialty group

Specialty Group	Mechanical Ventilation		Peripheral Catheter		Central Catheter		Urinary Catheter		Total Inpatients
	N	%	N	%	N	%	N	%	N
Care of the Elderly	0	0.0	85	13.8	0	0.0	161	26.1	616
Gynaecology	0	0.0	5	33.3	0	0.0	5	33.3	15
Haematology	0	0.0	15	48.4	10	32.3	1	3.2	31
Medicine	3	0.2	509	33.8	35	2.3	278	18.5	1 506
Obstetrics	0	0.0	10	10.2	0	0.0	4	4.1	98
Oncology	0	0.0	8	34.8	2	8.7	7	30.4	23
Orthopaedics	0	0.0	85	32.4	3	1.1	55	21.0	262
Psychiatry	0	0.0	0	0.0	0	0.0	0	0.0	59
Surgery	13	2.2	255	43.9	50	8.6	120	20.7	581
Urology	0	0.0	15	20.8	4	5.6	29	40.3	72
Total	16	0.5	987	30.2	104	3.2	660	20.2	3 263




Appendix Table 6-4: Non-acute Hospitals. Invasive device usage for burden study inpatients categorised by specialty group

Specialty Group	Mechanical Ventilation		Peripheral Catheter		Central Catheter		Urinary Catheter		Total Inpatients
	N	%	N	%	N	%	N	%	N
Care of the Elderly	0	0.0	3	42.9	0	0.0	21	26.9	141
Medicine	1	100.0	4	57.1	0	0.0	50	64.1	193
Psychiatry	0	0.0	0	0.0	0	0.0	7	9.0	293
Total	1	100.0	7	100.0	0	0.0	78	100.0	627

APPENDIX 7 - PREVALENCE AND INCIDENCE CALCULATIONS

Appendix table 7-1 shows a comparison of SSHAIP inpatient surgical site infection incidence surveillance data and HAI Prevalence acute burden study data from 1 October 2005 to 31st September 2006 by procedure. LN=mean length of stay for inpatients who acquire one or more nosocomial infections; LA=mean length of stay for all inpatients; INT=mean interval between admission and onset of first nosocomial infection for those inpatients who acquire one or more nosocomial infection; P=Prevalence rate; Ic= Calculated incidence rate; I=Incidence rate.

Table key

-  Procedures where no LOS data were available
-  Pale blue- Procedures where either no prevalence or no incidence data were available
-  White- Procedures where comparable data for prevalence and incidence were available.

Appendix Table 7-1: Comparison of SSHAIP inpatient surgical site infection incidence surveillance data and HAI Prevalence acute burden study data from 1 October 2005 to 31 September 2006 by procedure¹

SSHAIP Procedure	No of operations (SSHAIP)				No of HAIs (by type) from SSHAIP Data				Average LOS (days) from SSHAIP		Mapped to Prevalence Procedures	No of inpatients in Prevalence		No of Inpatients with SSI related to one Procedure	No of Inpatients with Prevalent SSI related to Multiple Procedures	Prevalence (P)	Calculated Incidence (I ^c)	Incidence (I)		
	Superficial	Deep	Organ	Not Recorded	Total	SSI (LN)	All Inpatients (LA)	Average time to infection (days) (INT) from SSHAIP	Cardiovascular – Cardiac Surgery	58		2	2						2	3.4%
Cardiac Surgery	24	0	0	0	0	0	0	0	0	N/A	9.4	N/A	Cardiovascular – Cardiac Surgery	58	2	2	2	3.4%	N/A	0.0%
CABG	208	1	0	0	1	2	18	7.1	11	11	7.1	11	Cardiovascular - CABG	47	3	2	2	6.4%	6.5%	1.0%
Breast Surgery	411	2	0	0	0	2	23	3.1	12.5	12.5	3.1	12.5	Endocrine and Breast – Mastectomy	7	0	0	0	0.0%	0.0%	0.5%
Abdominal Hysterectomy	802	11	2	0	2	15	7.8	4.6	6.2	6.2	4.6	6.2	Female Genital – Abdominal Hysterectomy	13	0	0	0	0.0%	0.0%	1.9%
Caesarean Section	5199	91	1	3	8	105	7.1	3.8	5.4	5.4	3.8	5.4	Pregnancy – Caesarean Section	17	0	0	0	0.0%	0.0%	2.0%

¹ LN=mean length of stay for inpatients who acquire one or more nosocomial infections; LA=mean length of stay for all inpatients; INT=mean interval between admission and onset of first nosocomial infection for those inpatients who acquire one or more nosocomial infections; P=Prevalence rate; I^c= Calculated incidence rate; I=Incidence rate

SSHAI Procedure	No of HAI's (by type) from SSHAI Data				Average LOS (days) from SSHAI		Mapped to Prevalence procedures/	No of inpatients in Prevalence	No of Inpatients with SSI related to one Procedure	No of Inpatients with multiple Procedures	Prevalence (P)	Calculated Incidence (I ^c)	Incidence (I)			
	Superficial	Deep	Organ	Not Recorded	Total	SSI (LN)								All Inpatients (LA)		
Operations for Fractured Neck of Femur	2024	38	14	0	3	55	22.6	13.1	12.2	Bones and Joints – Open reduction of fracture	60	0	1	0.0%	0.0%	2.7%
Hip Replacement	4403	33	9	0	1	43	13	7.1	12.9	Bones and Joints – Hip Prosthesis	112	2	5	1.8%	126.8%	1.0%
Knee Replacement	3589	14	4	0	0	18	15.4	6.9	14.2	Bones and Joints – Knee Prosthesis	20	2	2	10.0%	57.5%	0.5%
Major Vascular Surgery	227	17	4	0	2	23	N/A	11.8	12.7	Arteries and Veins –Vascular surgery	50	3	2	6.0%	N/A	10.1%

APPENDIX 8 - USE OF ANTIMICROBIALS AS AN INDICATOR OF HAI

8.1 Diagnostic tests

Assume that the true status of disease in a person is known (Disease Yes/No). Assume Test + means the person tests positive for the disease.

Appendix Table 8-1: Explanation of the measures of diagnostic test validity

	Disease Yes	Disease No	Total
Test +	TP	FP	TP+FP
Test -	FN	TN	FN+TN
Total	TP+FN	FP+TN	

There are 4 main measures of diagnostic test validity:

- Sensitivity
- Specificity
- Positive Predictive Value (PPV)
- Negative Predictive Value (NPV)

True Positives (TP): person has disease and tests positive

True Negatives (TN): person does not have the disease and tests negative

False Positives (FP): person does not have the disease but tests positive

False negative (FN): person has the disease and tests negative

8.2 Sensitivity

The sensitivity of a test is the probability that the test result will be positive when applied to people with the disease. A sensitive test detects a high proportion of the true cases. It is defined to be

Equation 4: Formula for the calculation of sensitivity

$$\text{Sensitivity} = \frac{TP}{TP+FN}$$

8.3 Specificity

The specificity of a test is the probability that the test result will be negative when applied to people without the disease. A specific test has few false positives.

Equation 5: Formula for the calculation of specificity

$$\text{Specificity} = \text{TN} / (\text{TN} + \text{FP})$$

8.4 Positive Predictive Value (PPV)

This is the probability that a person with a positive test will have the disease.

Equation 6: Formula for the calculation of positive predictive value

$$\text{PPV} = \text{TP} / (\text{TP} + \text{FP})$$

APPENDIX 9 - VALIDATION

9.1 *Validation methods*

Surveillance investigations require collected data to be both reliable (consistent) and valid (accurate), but there is a wide range of factors that can affect these requirements, particularly when data is collected from a working healthcare environment. A crossover design, where all data collectors survey the same group of inpatients, was selected as a method to repeatedly examine InterRater Reliability (IRR). Every precaution was taken to ensure the patient care pathway remained free from interference during normal data collection. To minimise disruption during the IRR exercise, data collectors were split into two groups, assigned to two separate wards and selected five patients to be surveyed. After completing the first ward, data collectors moved to the other ward and surveyed the same patients as the previous group.

Up to 100 data items could be collected for each patient in the survey. A representative sample of these data items, located at all levels of the data collection tool, including Ward, Patient, Antimicrobial, Surgery, Invasive Device and Infection, were assessed for reliability. Data in a relational database creates unique issues for analysis of reliability. A set of rules were developed to consistently deal with records when, for instance, data was missing due to earlier responses, or it was recorded in one of several similar fields.

Mean percent agreement was calculated for all of the selected data items. While the percent agreement statistic has some weaknesses, notably its inability to account for agreement through chance, its applicability and simplicity makes it useful for revealing inconsistencies (80). Kappa statistics correct for chance agreement but are only applicable where the number of possible responses is small, the number of observations is large and all possible responses have been recorded at least once (81). Where appropriate, this statistic has also been included in our analysis.

9.2 Validation results

Appendix Table 9-1: Level, field name and data type of data items evaluated with percentage agreement and kappa statistic for the inter-rater reliability (IRR) exercise

Level	Field	Data Type	Percent Agreement	Kappa
Ward	WARD NAME	Free text	100	NA
Ward	DATE OF CENSUS	dd/mm/yyyy	100	NA
Ward	TRAINED NHS STAFF	Number	100	NA
Patient	GENDER	M / F	100	1.00
Patient	DOB	dd/mm/yyyy	100	NA
Patient	ADMISSION TYPE	Unplanned / Planned	100	NA
Patient	Boarder	Y / N	100	NA
Patient	PATIENT IDENTIFIER	Free text	100	NA
Patient	SPECIALTY	Controlled list	95	NA
Patient	ADMISSION DATE	dd/mm/yyyy	93	NA
Antimicrobials	ANTIBIOTIC THERAPY	Y / N	100	1.00
Antimicrobials	ANTIBIOTIC START DATE	dd/mm/yyyy	82	NA
Antimicrobials	ANTIBIOTIC TYPE	Controlled list	94	NA
Antimicrobials	ANTIBIOTIC ADMIN.	Controlled list	94	0.21
Antimicrobials	ANTIBIOTIC INDICATION	Controlled list	94	0.21
Invasive	HAD INVASIVE DEVICE	Y / N	87	0.70
Invasive	PERIPHERAL CATHETER	Y / N	87	0.75
Invasive	CENTRAL CATHETER	Y / N	100	1.00
Invasive	URINARY CATHETER	Y / N	93	0.87
Surgery	HAD SURGERY	Y / N	93	0.79
Surgery	SURGERY TYPE	Controlled list	82	NA
Infection	CURRENT HAI	Y / N	100	1.00
Infection	INFECTION TYPE	Controlled list	100	NA
Mean			95%	0.75

Most of the data items examined in the IRR exercise revealed high levels of agreement. Some inconsistency was observed at the patient detail level for Specialty and Admission Date, which on further investigation, related to differences in the interpretation of definitions and the source of data, respectively. Reduced consistency at the Antimicrobial level stemmed from a singular disagreement, which cascaded down to related fields, resulting in other disagreements. Kappa of 0.21 was calculated for Antimicrobial Administration and Indication, but this was exaggerated by the low occurrence of some responses.

All data collectors identified two patients with a HAI and 100% agreement was recorded for their diagnoses of infection type.

9.3 *Validation discussion*

In practice, significant limitations were encountered collecting data for IRR analysis in a busy healthcare environment.

The time dependent nature of many prevalence survey variables was evident when Antimicrobial, Surgery and Invasive Device data were analysed for each group of data collectors. Several inpatients were discharged during the exercise and data was continuously updated in case notes, undermining attempts to assess consistency between data collectors. This issue affected an earlier attempt at using gold standard investigators in the healthcare environment and has also compromised a subsequent IRR exercise.

An additional drawback, affecting all of our quality assessment exercises, is the relatively low prevalence of naturally occurring HAI. Consistent and accurate HAI diagnosis was considered to be the most important function in the HAI Prevalence Survey but is also one of the most challenging to assess.

There is a broad range of data types collected in the Prevalence survey with a bewildering number of reasons to explain inconsistencies. No one analytical method was identified that could be applied universally to the data set and account for agreement by chance. We adopted the strategy of using several separate statistics, while keeping in mind the purpose of the analyses and the complexity of their calculation.

This IRR assessment ultimately allowed us to identify and discuss data collection issues. Further, targeted training could be developed to ensure high data quality standards were maintained during the survey period.

APPENDIX 10 - CALCULATIONS FOR SURVEY TIME AND COST TABLES

10.1 HPS team

A pilot study was undertaken in 3 general hospitals within different regions of Scotland (West, East and South). This gave an estimate of the number of inpatients each data collector was able to survey per day on average. During the pilot survey the average number of beds per ward was 22.

Appendix Table 10-1: Time taken for data collection during pilot prevalence survey for HPS data collectors, infection control staff and clinical staff

Variable	Observations	Mean Time per Inpatient (min)	Total Time (min)	St.Dev	Min	Max
HPS Data Collectors	1403	10.1	14030	8.5	3	90
Infection Control Staff	1403	0.6	758	2.2	0	35
Clinical Staff	1403	0.6	836	3.8	0	25

PERT (Program Evaluation and Review Technique) requires an estimate of the shortest possible time each activity will take, the most likely length of time, and the longest time that might be taken if the activity takes longer than expected. This helps to bias time estimates away from the unrealistically short time-scales normally assumed.

Equation 7: The formula to calculate the time to use for each project stage using PERT analysis

$$\text{Planned time} = \frac{\text{shortest time} + 4 \times \text{likely time} + \text{longest time}}{6}$$

Using a PERT analysis it was calculated that it would take a data collector 22 minutes on average to survey a single patient. This meant that a single data collector could survey an average ward within approximately 8 hours. In practice this calculation held true throughout the main survey. The data collectors worked in teams of two where possible, and visited two wards per day each. This ensured that there was another data collector to assist with interpretation of the CDC definitions and that each ward was completed on the same day it was begun.

It was recognised during the pilot survey that the data collectors would need to have a day during each week in order to validate and send data to HPS. It was also acknowledged that travelling to each hospital took up a considerable part of each working day. The team worked to a flexible working pattern, during the four days data collection the team would work longer shifts and on the home based day they worked a slightly shorter shift. This pattern allowed the team to maximise the data collection, since one ward must be completed in one day and reduced the potential fatigue of travelling to collect data in hospitals 5 days per week. This strategy was successful and allowed flexibility for both the data collection team and the ward staff since data collectors could arrange to visit when ward rounds were completed.

10.2 Local ward staff and data collectors

There was a small impact on the nursing staff when data collectors visited each ward. Approximately 0.6 minutes of nursing staff time per patient (calculated during the pilot survey) was multiplied by 13 800 patients to give a total of 138 hours for all Scotland.

Data collectors also spent approximately 10 minutes per ward introducing themselves to the charge nurse. Visiting 840 (See REF) wards gives a total of 140 hours for the entire survey.

Infection control nurses

Infection control teams played a very large part in the success of the survey. The nominated link member of the infection control team was required to liaise with hospital senior management regarding the survey visits, arrange security passes for the data collectors, where possible arrange a meeting for the Project Manager to inform senior clinical staff about the survey, distribute the information packs and posters and address any queries about the prevalence survey from ward staff. After the survey was complete the nominated link member of the ICT was required to use the local hospital records management system to report discharge dates for the patients within the burden study.

It is estimated that ICNs spent 30 minutes per ward distributing the information packs and posters and addressing any queries about the prevalence survey. Based on an estimate of 840 wards ICNs spent a total of 420 hours informing the local staff about the prevalence survey.

Psychiatric hospital staff

Some Psychiatric Care hospitals provided escorts for the data collectors in certain psychiatric wards costing an additional £500 (approximately 30 hours).

In summary, the total time provided by all hospital staff to the national HAI prevalence survey was 728 hours.

Appendix Table 10-2: Tolerance defined in the Project Initiation Document (PID) for the national HAI prevalence survey.

Tolerance	+	-	Comment
Time %	2%	20%	There was very little tolerance available for time in this project. The data collectors were not all working at the same time. Due to the short term nature of the positions it is anticipated that some of the team members would find permanent positions before the end of their contract and therefore to mitigate the risk of losing some staff, additional resources were recruited on short term contracts.
Days	15	146	
Cost %	5%	20%	The main costs were salaries, which are predictable, and there is not anticipated to be a great variation from predicted cost.
£ ¹	£30 000.	£118 935.	

¹ Costs have been rounded to the nearest £5

APPENDIX 11 - ACRONYMS

Appendix Table 11-1: List and expansion of acronyms

Acronym	Expanded Acronym
BJ	Bone and Joint Infection
BSI	Blood Stream Infection
CAUTI	Catheter Associated Urinary Tract Infection
CDC	Centre for Disease Control (US)
CNO	Chief Nursing Officer
CNS	Central Nervous System Infection
CVC	Central Vascular Catheter
CVS	Cardiovascular System Infections
DoH	Department of Health
EENTM	Eye, Ear, Nose, Throat or Mouth Infection
EPINE	[Evolución de la Prevalencia de las Infecciones Nosocomiales] (Spanish)
GI	Gastrointestinal Infection
GP	General Practitioner
HAI	Healthcare Associated Infection
HAITF	Healthcare Associated Infection Task Force
HEAT	Health, Efficiency, Access and Treatment
HELICS	Hospitals in Europe Link for Infection Control through Surveillance
HIS	Hospital Infection Society
HPS	Health Protection Scotland
IC	Infection Control
ICD 10	International Classification of Disease Version 10
ICM	Infection Control Manager
ICN	Infection Control Nurse
ICNA	Infection Control Nurses Association
ICT	Infection Control Team
ICU	Intensive Care Unit
IPC	Infection Prevention and Control
IQR	Interquartile Range
IRR	InterRater Reliability

Acronym	Expanded Acronym
IT	Information Technology
KISS	[Krankenhaus Infektions Surveillance System] (German)
LOS	Length of stay
LRT	Lower Respiratory Tract Infection other than Pneumonia
MRSA	Meticillin Resistant <i>Staphylococcus aureus</i>
MSSA	Meticillin Sensitive <i>Staphylococcus aureus</i>
NHS	National Health Service
NI	Nosocomial Infection
NNIS	National Nosocomial Infection Surveillance
NV	norovirus
PC	Personal Computer
PERT	Program Evaluation and Review Technique
PII	Patient Identifiable Information
PNE	Pneumonia
PVC	Peripheral Vascular Catheter
RAS	Remote Access Service
ROI	Republic of Ireland
RSI	Reproductive System Infections
SA	<i>Staphylococcus aureus</i>
SAB	<i>Staphylococcus aureus</i> bacteraemia
SEHD	Scottish Executive Health Department
SIRN	Scottish Infection Research Network
SI	Systemic Infection
SOP	Standard Operating Procedure
SSHAIP	Scottish Surveillance of Healthcare Associated Infection Programme
SSI	Surgical Site Infection
SST	Skin and Soft Tissue Infection
UK	United Kingdom
US	United States of America
UTI	Urinary Tract Infection
VAP	Ventilator Associated Pneumonia

APPENDIX 12 - STEERING GROUP AND TEAM MEMBERSHIP

Appendix Table 12-1: National HAI prevalence survey project team

Project sponsor:	Mr Paul Martin, CNO, SEHD
Project Director:	Dr Jacqui Reilly, HPS
Project Manager:	Sally Stewart, HPS
Project Administration:	Netta Horn
Project consultants:	Dr Ahilya Noone Professor Chris Robertson Dr Gwen Allardice Dr Andrew Walker
Data collectors:	Margaret Kennedy Liz Lothian (Pilot only) Andrew Rideout Donald Saunders Julie Wilson Shona Cairns Iveta Krupova Eisin Shakir
Data Manager:	Simon Coubrough
Information Analyst:	Simon Coubrough
Systems Developer:	Chiara Zachary Greg Allan

Appendix Table 12-2: National HAI prevalence survey project working group

Project Director:	Dr Jacqui Reilly, HPS
Project Manager:	Sally Stewart, HPS
Project consultants:	Dr Ahilya Noone Dr Gwen Allardice Dr Andrew Walker Dr Julie Bruce

Appendix Table 12-3: National HAI prevalence survey strategic steering group

Dr Jacqui Reilly, Project Director, HPS (Chair)
Miss Sally Stewart, Project Manager, HAI Prevalence Study, HPS
Dr Ahilya Noone, Consultant Epidemiologist
Mr Tim Brett, Director, HPS
Dr Peter Christie, Senior Medical Officer, SEHD
Mrs Margaret Tannahill, Nurse Adviser HAI and Communicable Disease, SEHD
Dr Andrew Walker, Economist, HAI Prevalence Study, Glasgow University
Mrs Shona Halley, Senior Health Protection Nurse, ICNA
Mrs Val Leitch, ICN Manager, Fife HB
Mrs June McAlpine, ICN Co-ordinator, Lanarkshire HB

Appendix Table 12-4: National HAI prevalence survey technical steering group

Dr Jacqui Reilly, Project Director, HPS (Chair)

Miss Sally Stewart, Project Manager, HAI Prevalence Study, HPS

Dr Ahilya Noone, Consultant Epidemiologist

Mrs Marjorie Russell, Lay Representative, HAITF

Dr Peter Christie, Senior Medical Officer, SEHD

Mrs Margaret Tannahill, Nurse Advisor HAITF, SEHD

Dr Mary Hanson, Chair Scottish Microbiology Forum

Mr Roelf Dijkhuizen, Medical Directors (Deputy)

Dr Gwen Allardice, Statistician, HPS Statistics Group

Dr John Coia, Consultant Microbiologist, Microbiologists SMF

Prof Chris Robertson, Statistician, HPS Statistics Group

Mrs Gillian Stevenson, ICN Representative, ICNA

Mrs Lisa Ritchie, ICN Representative (Deputy), ICNA

Mr Tim Brett, Director, HPS

Dr Andrew Walker, Economist, HAI Prevalence Study, Glasgow University

Representative from Directors of Public Health

APPENDIX 13 - PROJECT TIMETABLE

Appendix Table 13-1: Timetable for national HAI prevalence survey project

	2004			2005			2006			2007									
	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	
Finalise Protocol																			
Funding for pilot confirmed																			
Pilot survey																			
Analysis for pilot study																			
Report of pilot survey																			
Funding for main study confirmed																			
Recruit staff																			
Staff in post																			
Software design																			
Train researchers																			
Meetings with hospitals																			
Undertake surveys –acute hospitals																			
Confidential briefing papers – acute hospitals																			
Survey non-acute hospitals																			
Confidential briefing papers – Non-acute hospitals																			
Data analyses																			
Final collated Non-acute and Acute Confidential briefing paper																			
Prepare Final Report																			
Submit final report																			

VOLUME 2 - Protocol for NHS Scotland National HAI Prevalence Survey (Separate Document)

- See additional document for Survey Protocol