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Journal of Hospital Infection

journal homepage: [www.elsevier.com/locate/jhin](http://www.elsevier.com/locate/jhin)

## Opinion

# Patients, public perceptions and political pressures in the prioritization of surveillance of healthcare-associated infection

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## ARTICLE INFO

**Article history:**

Received 30 July 2018

Accepted 31 July 2018

Available online 4 August 2018

**Keywords:**

Surveillance

Public reporting

Political priorities

*Staphylococcus aureus*

Bloodstream infection

*Clostridium difficile* infection

Surveillance activities are essential in the prevention and control of healthcare-associated infection (HCAI). Surveillance is information for action because the mere collection of data and its analysis is not enough. The extent of surveillance activities over the last three decades has expanded, arising from clinical need, local, national and trans-national priorities.

In the first volume of the *Journal of Hospital Infection*, perspectives on surveillance of infection in hospitals centered on data from the USA and the need to balance the time spent

carrying out surveillance with other activities [1,2]. However, it was recognized that for data to be comparable, risk factors were required, to provide accurate infection rates [2].

In the United Kingdom, surveillance data has been used for generating improvements in practice including through the use of mandatory data collection [3]. Although the voluntary collection of data on methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infection (BSI) provided helpful information, when it was made mandatory in 2004, it became more relevant. In 2011 and subsequently, this was extended to methicillin-susceptible *S. aureus* (MSSA) BSI, *Clostridium difficile* infection (CDI) and *Escherichia coli* BSI. The ease with which healthcare practitioners as well as members of the public can compare the performance of various hospitals helps provide accountability for rates above what might be expected, and have been important drivers in successful intervention measures. Also, such surveillance systems have been used to monitor specific interventions such as restrictions in the use of fluoroquinolone and cephalosporin antibiotics, and have had a positive impact on CDI in certain regions [4].

Comparing international surveillance data can be enlightening, even if there are a number of inherent caveats. Since the establishment of the European Centre for Disease Control, point prevalent surveys of HCAI have been carried out, and the results from the latest one in 2017 are awaited. Data comparing CDI in England and in the USA using national administrative inpatient discharge data show that rates in the USA are generally higher but co-morbidities are more prevalent there [5]. This raises intriguing questions about diagnostic criteria, the use of case definitions and differences in the healthcare services. Borg and colleagues have looked at interventions to reduce MRSA BSI in European hospitals via an online questionnaire [6]. Hospitals from the UK & Ireland reported the highest uptake of infection control and antibiotic stewardship practices compared with Southern Europe, and isolation, the performance of root cause analysis, obligatory training, multi-

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disciplinary ward rounds and the involvement of hospital management were associated with lower MRSA prevalence [6].

Surveillance practices are driven by a variety of factors including political and cultural. Benchmarking and the public reporting of rates of HCAI have evolved and in many countries, are mandated, including in most states of the USA. However, there has been an initial reluctance to publicly disseminate HCAI rates in Germany for a variety of reasons [7]. The initial reporting of data generates public and media interest, and encourages the self-analysis of local infection rates, and how they compare with those in similar settings. This has been a positive, if initial controversial development, driving surveillance in the last decade and more.

As patients increasingly take responsibility for their own health and view the health services from the perspective of a consumer, there is increased scrutiny which has had a positive impact. While initially there was concern about the possible dissemination of non-comparable data, those undertaking surveillance are increasingly comfortable as such data can be used to make the case for additional resources or for highlighting the need for specific interventions. There is a need for infection prevention and control teams (IPCTs) to engage with both politicians and the public to highlight the limitations of any surveillance data, i.e. what it both tells us and what it does not. However, media controversies highlighting “superbugs” and educating the public about preventable fatal infections caused by MRSA BSI and CDI, have influenced politicians more than IPCTs or professional bodies. Consequently, there needs to be a stronger partnership between those mandating surveillance, IPCTs, patients and the general public in identifying priorities in to the future. Ultimately, the public are essential in setting priorities for the prevention of HCAI and IPCTs should actively foster such partnerships.

#### Conflict of interest statement

I have recently received research funding from Pfizer (WI 184374) & Astellas (PO8100326501). I have also provided professional advice to Pfizer.

#### Funding sources

The drafting of this manuscript was not funded.

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