# HEALTH SCRUTINY PANEL

A meeting of the Health Scrutiny Panel was held on 23 August 2006.

**PRESENT:** Councillor Dryden (Chair); Councillors Biswas, Ferrier, Lancaster and Rooney.

**OFFICIALS:** J Bennington and J Ord.

** **PRESENT BY INVITATION:**

Representatives of South Tees Hospitals NHS Trust:

Richard Bellamy, Infection Control Doctor
Tricia Hart, Director of Nursing & Director of Infection Prevention & Control
Alison Peevor, Head of Infection Prevention and Control

Ann Raw, Patient & Public Involvement Forum
Philip Matson, Patient & Public Involvement Forum.

**** APOLOGIES FOR ABSENCE** were submitted on behalf of Councillors Harris and Mawston, and David Charlesworth, Clinical Lead for Infection Prevention and Control.

**** DECLARATIONS OF INTEREST**

No declarations of interest were made at this point of the meeting.

**** MINUTES**

The minutes of the meeting of the Health Scrutiny Panel held on 17 July 2006 were submitted and approved.

**HEALTHCARE ASSOCIATED INFECTIONS – TERMS OF REFERENCE**

The Scrutiny Support Officer submitted an introductory report to the Panel's first topic to be reviewed in relation to Healthcare- Associated Infections (HCAIs) which was considered to be a high profile topic which often received significant exposure in the media. It was acknowledged that the most high profile HCAI was referred to as MRSA although this was far from the only HCAI in existence.

The matter of HCAI and facility cleanliness was a current priority for the Department of Health and played a significant part in the assessment of Trust performance.

The Panel considered the following draft terms of reference for its review into HCAI as it affected the residents of Middlesbrough:-

a) To establish the historical and current prevalence of HCAI in Middlesbrough, within the context of regional and national statistics and how the local health economy is performing against national standards.

b) To investigate what current local initiatives there are to reduce the prevalence of HCAIs and consider their measurable and/or likely impact.

c) To investigate the facts pertaining to how HCAI are contracted.

d) To investigate how the local NHS reacts to incidences of HCAIs.

e) To investigate current cleaning arrangements in relevant medical facilities, including the contractual arrangements of cleaning services and the operational management of the cleaning services.

f) To investigate what steps (if any) patients and visitors could take to reduce the prevalence of HCAI.

g) To investigate what further steps the local NHS could take to reduce the prevalence of HCAI.

h) To seek evidence in relation to HCAI from whomever the Panel wishes to approach.

i) To prepare and publish a Final Report detailing the evidence gathered during the review.

**AGREED** that the terms of reference for the Panel's investigation into Healthcare-Associated Infections as outlined be approved.

**HEALTHCARE ASSOCIATED INFECTIONS – SOUTH TEES HOSPITALS NHS TRUST**

The Scrutiny Support Officer submitted an introductory report regarding the evidence to be sought from the South Tees Hospitals NHS Trust.

The Chair welcomed representatives from the South Tees Hospitals NHS Trust who gave an overall briefing of the main issues pertinent to HCAIs. The presentation focussed on the following key areas:-

a) Healthcare- Associated Infection – Definition:

- an infection acquired by the patient while in hospital or NHS health facility;
- the organism may be acquired in hospital or may be part of the patient's normal flora;
- the term hospital acquired referred to organisms identified more than 48 hours after hospital admission;

b) Common HCAIs were associated with urinary tract infection (40%), surgical wound (22%), respiratory (15%), blood (11%) and others the most common of which was gastrointestinal infection (12%);

c) Government collected data for monitoring purposes in respect of the following:

MRSA bacteraemia:

- gained the most recent public attention;
- resistant to commonly used antibiotics;
- data on MRSA was easier to compile given the tests which were carried out on patients;

MSSA bacteraemia:

- same as MRSA but sensitive to antibiotics;
- whilst more prevalent than MRSA such information was not publicised to the same extent as MRSA
- was present in the community, likely to be carried by 1 in 3 people;

Clostridium Difficile – associated diarrhoea:

- because of the difficulty in producing definitive data the Government had restricted such data to those aged over 65 years;
- it was shown in some studies to account for up to 20% of HCAIs;
- there were difficulties in comparing data with other Trusts owing to different screening practices;

Orthopaedic surgical site infection:

Glycopeptide-resistant Enterococci:

- other antibiotic –resistant organisms such as viral gastroenteritis, insect infestation, TB, CJD;
- there had only been one recent case locally but it was more of a problem in some hospitals in South of England;

d) National Target for HCAIs:

- Department of Health had set a target of reducing MRSA bacteraemia by 60% by 2007/08 compared to the 2003/04 baseline;
- there were currently no targets for the other mandatory surveillance organisms;
- it was pointed out however that no account was taken of what happened before 2003/04 in that Trusts had varying rates and pressures and therefore for those hospitals which had already undertaken significant work to reduce MRSA it was proving more of a challenge to achieve a 60% reduction;

e) Changes in MRSA bacteraemia numbers between 2001 and 2006 in respect of JCUH and FHN:

- between 2001 and 2004 the Trust had achieved a 40% reduction in MRSA bacteraemia numbers;
- during the last two years the numbers had remained relatively stable;
- the stable numbers reflected continued efforts to reduce risk as the number of 'at risk' patients was rising such as renal dialysis, cardiac surgery, ICU;
- considerable efforts would be required to produce further reductions by 60% from the current 76 to 27 cases (2.3 cases per month compared to 6.3) while the numbers of complex at risk patients at JCUH continued to rise;

f) Comparative Data:

- as performance was now based on reductions it was considered very difficult to make meaningful comparisons between Trusts given different medical circumstances;
- prior to 2003/04 South Tees had been the only Trust in the region to have achieved sustained and consistent reductions in MRSA although it was noted that there had been a high baseline which had made the task easier than other Trusts;
- as demonstrated by the statistical information provided, all Trusts in the region were finding it challenging to meet the 20% annual reduction target;
- nationally some of the London Trusts had made large reductions in MRSA in the last 12 months but it was acknowledged that such Trusts had started with

high baselines and therefore they had a much easier task for reducing the MRSA bacteraemia than other Trusts in the Northern region;

- nationally Guy's and St Thomas' Hospitals NHS Trust had the best performance, 75 episodes of MRSA bacteraemia under target but their rate in 2003/04 had been 4.5 per 10,000 bed-days and in 2005/06 it had been 2.3 in comparison to a rate of around 1.8 in respect of South Tees in 2005/06;

g) Action Plan:

- South Tees had joined the national performance improvement network and had asked them to make an assessment to help identify any further improvements which could be made;

- an assurance was given that the South Tees Hospitals NHS Trust had a strong commitment to controlling healthcare-associated infections and achieving the DOH MRSA target;

- the following actions had been identified to improve the likelihood of achieving the MRSA target:

  a) developing wider responsibility for infection control using the Government's 'Saving Lives' delivery programme for which a Team had been employed to specifically implement;
  b) improving the infection control knowledge of all staff through appropriate training with particular emphasis on more detailed training for clinical matrons and ward managers;
  c) highlighting compliance with key policies aimed at reducing MRSA and other healthcare-associated infections, performance audits and quality control measures to ensure compliance;
  d) learning lessons from MRSA bacteraemia by treating each case as a clinical incident, investigating and disseminating lessons learned;
  e) improving dissemination and feedback of surveillance and audit information;
  f) using surveillance and clinical incident information to focus efforts where they will have the greatest impact;
  g) defining the roles and responsibilities of the infection prevention and control team.

In conclusion it was reiterated that the Trust was strongly committed to protecting patients from healthcare-associated infections and that substantial efforts were being made to achieve the MRSA targets. Opportunities for improvement had been identified and recommendations made for improving practice.

The subsequent deliberations centred on the following: -

i) it was acknowledged that the data currently complied was considered to be more reliable and consistent following more specific national guidance on the collection of such data;

ii) in response to clarification sought as to the rationale of having hand alcohol gel at the point of care outside of a ward and at the bedside rather than staff carrying a stock it was stated that it was considered to be more effective and acted as a visual reminder;

iii) although the above would be the subject of further debate at a future meeting the importance of ensuring appropriate signage on the availability and use of the hand alcohol gel was emphasised;

iv) whilst it was confirmed that cleaning arrangements would be discussed in detail at the next meeting of the Panel an indication was given of evidence which had demonstrated that certain hospitals outside of the UK with a high standard of cleaning still had high infection rates, higher than in the UK;

v) it was acknowledged that in some cases the pressures of achieving different NHS targets in recent years may have impinged on the efforts to reduce HCAIs;

vi) although HCAIs had been around for the past 30 years it was suggested that there was no overall higher risk but there had been a rise in recent years of two specific infections namely MRSA and Clostridium Difficile which may be as a result of over use of antibiotics or as a consequence of infections establishing and allowed to spread;

vii) with reference to the use of side rooms for patients who had contracted MRSA it was indicated that lowering the risk of infection had to be balanced against the fact that it was not so easy to observe a patient for changing medical circumstances which may result in the need for increased staffing levels;

viii) although improvements were being made with an increased focus on the availability of side rooms and individual washing and bathing facilities in new hospitals the ratio of single to multi occupancy rooms was lower than elsewhere outside of the UK;

**AGREED** that the representatives from South Tees Hospitals NHS Trust be thanked for the information provided which would be incorporated into the overall review.

**HEALTHCARE ASSOCIATED INFECTIONS – PATIENT AND PUBLIC INVOLVEMENT FORUM**

By way of introduction the Scrutiny Support Officer submitted a report regarding the evidence to be sought from representatives of the Patient & Public Involvement Forum (PPIF) attached to the South Tees Hospitals NHS Trust.

The Chair welcomed the representatives of the South Tees PPIF who outlined their areas of work with specific regard to HCAIs.

It was noted that the PPIF had been established at the end of 2003 at a time when MRSA was a high profile topic within the media.

The PPIF had a close working relationship with the Trust and met on a regular basis with the Infection Control Doctor and nursing staff for the exchange of information and highlighting concerns expressed by the members of the public.

Whilst the need for a high standard of cleanliness within hospitals was regarded by all to be of prime importance there was a public perception that this was directly related to the incidence of HCAIs.

As part of the work of the PPIF they had legal rights to make visits to medical facilities and to assess and report upon the condition of those facilities including areas such as cleanliness. It was confirmed that inspections, some of which were unannounced spot

checks, were undertaken on a regular basis. Such visits focussed on the standards of cleanliness and checks made on the availability of hand alcohol gels. The PPIF monitored the Trust's progress on reducing HCAIs by reviewing the monthly statistics and attending meetings on the subject.

Specific reference was made to the Hospital's complaints procedures and support provided to patients by the Patient Advice & Liaison Services.

It was reported that each hospital Trust was required to submit an annual audit from Patient Environmental Action Teams (PEAT) comprising managers of domestic services, infection control teams and patient representatives. Over recent years the national audit had become more targeted on issues of cleanliness.

It was acknowledged that some of the issues regarding cleanliness would be the subject of debate at the next meeting of the Panel.

In response to continuing concerns by members of the public, specific reference was made to a public meeting organised by the PPIF held in November 2005. Although the event had been well publicised the attendance by members of the public had been disappointing. Apart from providing information on HCAIs the focus of the meeting had been on the measures to tackle HCAIs and the monitoring arrangements for such action.

Members expressed the importance for the PPIF to be consulted on the Trust's action plan and afforded the opportunity of ensuring the compliance of such measures.

**AGREED** that the representatives from the PPIF be thanked for the information provided which would be incorporated into the overall review.

**** OVERVIEW AND SCRUTINY BOARD UPDATE**

In a report of the Chair of the Health Scrutiny Panel, Members were advised of the key matters considered and action taken arising from the meeting of the Overview and Scrutiny Board held on 25 July 2006.

NOTED