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AGENDA ITEM: 4

HEALTH SCRUTINY PANEL

8 FEBRUARY 2007

HEALTHCARE ASSOCIATED INFECTIONS DRAFT FINAL REPORT

PURPOSE OF THE REPORT

1. To present the findings of the Health Scrutiny Panel, following its review into Healthcare Associated Infections (HCAIs).

RECOMMENDATIONS

2. That the Panel reviews the evidence it has gathered, considers the conclusions it has reached and whether it would like to make any recommendations.

BACKGROUND

3. There can be few health topics which have a higher profile in society today, than Healthcare Associated Infections. The most high profile infection (and often mistakenly thought to be the only one) is known as Methicillin Resistant Staphylococcus Aureus or MRSA. There are others, however, which are increasingly virulent, including Clostridium Difficile (C-Diff) which local health economies are required to guard against.

4. It is with this high profile nature of the topic that the Panel resolved to consider the matter in detail, in an attempt to ascertain the local position over rates of infection and what is being done to address the matter. Having seen some of the national coverage of the matter, the Panel was determined to consider the local picture based on the strength of the evidence presented.

5. During the course of the review, considering the evidence of witnesses and consideration of academic papers, it is clear that HCAI are not a uniquely British or NHS problem. Whilst it is a matter which affects the NHS and without doubt requires constant vigilance, it is important to note that HCAIs are a problem affecting healthcare environments on a global scale and are by no means exclusive to the NHS.

6. The World Health Organisation states that such infections occur world-wide and affect both developed and developing countries. At any one time, over 1.4million people around the world suffer from infectious complications acquired in healthcare environments. The highest frequency of infections have been reported from hospitals in the Eastern Mediterranean and South East Asia regions.

7. The WHO states that the most frequent infections are of surgical wounds, urinary tract infections and lower respiratory tract infections. Studies to date have shown that intensive care units, acute surgical and orthopaedic wards have the highest rate of infection. Infection rates are higher among patients with increased susceptibility because of old age, underlying disease or chemotherapy[1].

8. The Panel was interested to investigate as to why HCAIs remain a problem in modern healthcare. Modern medical techniques ensure that more and more people survive conditions and or treatments than have ever done before. Whilst this is to be welcomed, it does contribute to the creation of a cohort of patients who are still very ill following invasive procedures, with suppressed immune systems, who are more susceptible to infection. It should also be noted that historical mis-prescribing of antibiotics has contributed to the emergence of a generation of antibiotic-organisms, which now cause MRSA.

9. The Panel as part of its evidence gathering outlined below, also investigated as to whether HCAIs can be prevented. The answer seems to be that not all HCAIs can be prevented and it is a matter that local health economies will be required to stay on top of. The Panel has learned that the Health Protection Agency (HPA) has said that not all HCAIs can be prevented, as they are often the price paid for advances in treatments. It has, however, been estimated that 15% to 30% could be prevented through strengthened arrangements for prevention and control, better application of existing knowledge and good practice. The HPA states that one of the most important prevention activities for HCAIs is handwashing after patient contact. [2]

10. It is with the above in mind that the Health Scrutiny Panel engaged with the local health economy to consider HCAIs and their impact on local health services.

TERMS OF REFERENCE FOR THE REVIEW

[1] Please see Prevention of hospital-acquired infections, a practical guide, 2nd edition. World Health Organization. www.who.int/emc

[2] Please see "General Information – Healthcare-associated infections" www.hpa.org.uk/infections/topics_az/hai/gen_inf.htm

11. 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.

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

11.2 To investigate the facts pertaining to how HCAI are contracted.

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

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

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

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

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

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

MEMBERSHIP OF THE PANEL

12. Councillor Eddie Dryden (Chair), Councillor Harris (Vice-Chair), Councillors Biswas, Ferrier, Lancaster, Mawston, Rooney

METHODS OF INVESTIGATION

13. The Health Scrutiny Panel met between August 2006 and January 2007 to consider evidence in relation to the scrutiny review. A detailed record of the meetings is available through the Commis system. The Panel received evidence from a wide range of sources

EVIDENCE FROM SOUTH TEES HOSPITALS NHS TRUST

14. The Panel gathered a substantial amount of evidence from the South Tees Hospitals NHS Trust (South Tees Trust) for this review, given the South Tees Trust's very close involvement with combating HCAIs.

15. The Panel's first meeting with the Trust to discuss the topic was 23 August 2006, where an introduction to HCAIs was provided. The Panel heard that a HCAI is an infection acquired by the patient while he/she is in a hospital or any other healthcare facility. The offending organism may be acquired in hospital or may be part of the patient's normal flora. On this point, it was

explained to the Panel that all people have a collection of such organisms living naturally on their skin, which are usually harmless. The risk of such organisms causing problems increases significantly when there are open wounds and such like when people are in hospital. It was confirmed to the Panel that the term 'Hospital Acquired' is usually used to refer to organisms identified more than 48 hours after a patient's admission to hospital.

16. The Panel heard that of the common HCAIs there are a number of body sites which can be infected. Urinary tract infections would account for 40%, surgical wounds 22%, respiratory 15%, whilst blood infections (which could be caused by IV canulars such as drips) and other types would account for 12%.

17. The Panel heard about the current types of infections, which whilst causing a large amount of concern for healthcare facilities, are also the most measurable.

18. The first one mentioned was the Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia, which is probably the most high profile type of infection. It was stated that MRSA has developed a resistance to antibiotics, and is intrinsically associated with hospitals. The Panel heard that the Government believes it is quite easy to compare hospitals' performance in relation to MRSA and does so. MRSA is the most easily measured HCAI.

19. The second type covered was methicillin sensitive staphylococcus aureus (MSSA). The Panel heard that around 1 in 3 people in the community carries this, fairly harmlessly. Whilst it is not necessarily so closely related with hospitals, people in a hospital environment will naturally be more susceptible to its impact. The Panel heard that in all probability, MSSA would be responsible for more deaths in any given year, although it is not so high profile as MRSA.

20. The Panel also heard about Clostridium difficile (C-Diff). This is very closely associated with diarrhoea and seems to be more of a concern to those over 65 years or age. The Panel heard that because of the difficulty in producing definitive data, the Government has restricted such data to those aged over 65.

21. The Panel heard that C-Diff is present in the gut of around 2% or 3% of the general population, although some evidence indicates that it is responsible for around 20% of HCAIs. It was confirmed to the Panel that there are difficulties in comparing data with other Trusts owing to different screening practices. The Panel heard that C-Diff is increasing in incidence and it is likely that the wider public will hear a lot more about it in the near future. The Panel has also noted high profile instances concerning C-Diff recently, involving significant numbers of associated deaths.[3] One of those cases even led to an investigation at a hospital in Stoke Mandeville, Buckinghamshire, ordered by Patricia Hewitt, Secretary of State for Health carried out by the Healthcare

[3] Please see http://news.bbc.co.uk/go/pr/fr/-/1/hi/england/leicestershire/5396800.stm & http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/5209330.stm

Commission. Indeed, according to *The Times* Newspaper, more than 50,000 patients contracted C-Diff in 2005, which was a 17% increase on 2004.[4]

22. The Panel also received evidence on orthopaedic surgical site infections, such as Glycopeptide-resistant Enterococci. It was noted that this was more of a problem in the South of England. Other antibiotic resistant organisms such as viral gastroenterisis, insect infestation, Tuberculosis (TB) and Creutzfeldt-Jakob Disease (CJD) were also areas of concern.

23. The Panel was interested to hear about national targets for HCAIs. The Department of Health has set a target of reducing the prevalence of MRSA bacteraemia by 60% by2007/08 compared to Trust's 2003/04 baseline. It was noted that there are currently no other targets for the other mandatory surveillance organisms, nor was any account taken of what happened before 2003/04. The fact that there were no other targets for any other organisms struck the Panel as rather odd, as evidence gathered to this point had indicated that infections other than MRSA were as just, if not more dangerous than MRSA. As MRSA is by quite a way the most high profile of HCAIs, the Panel expressed the hope that the Department of Health was not simply seeking to respond to high levels of media interest in the prevalence of MRSA.

24. The Panel considered that the Department of Health's 60% reduction target in relation to MRSA was rather arbitrary. It takes no account of what has 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. It was also noted that a under such a score, a Trust could be perceived to be the 'best performing' with reference to MRSA, when it reality it is the most improved, when it might have had plenty of room to improve sue to poor past performance.

25. In terms of the South Tees Trust's own performance, the Panel heard that between 2001 and 2004, the Trust achieved 40% reduction in the MRSA numbers, whilst during the last two years the numbers have remained relatively stable. The Panel heard that those stable numbers reflected the continued efforts to reduce risks, even as the number of 'at risk' patients is rising, such as those accessing renal dialysis, cardiac surgery and Intensive Care Units.

26. Further, the Panel heard that considerable efforts would be required to produce further reductions while the numbers of complex 'at risk' patients continue to rise. It was emphasised to the Panel that an important point to bear in mind is that efforts to combat HCAIs have to increase year on year, to secure the same rates, such was the rising threat.

27. For the South Tees Trust, meeting the Department of Health's target of a 60% by 2007/8 would mean reduce the current number of cases of 76 per annum

[4] See *The Times* Newspaper, 25 July 2006.

to 27. This equates to a drop from 6.3 cases per month to 2.3 cases per month. The South Tees Trust emphasised that this was a reduction expected, in addition to the 40% reduction made before 2003/4.

28. The Panel was interested to hear about the MRSA rates across the South Tees Trust's two sites, namely James Cook University Hospital in Middlesbrough and Friarage Hospital Northallerton. It was noted that the MRSA rate at James Cook was falling until 2004, since when it has remained largely constant. The MRSA rate at the Friarage has remained low. It was noted however, that although the Friarage has better results than James Cook, both hospitals implement exactly the same procedures. The critical point was that James Cook Hospital, due to its nature, happened to house all of the high-risk patients dealt with by the South Tees Trust.

29. The Panel was interested to hear whether there were any comparisons that could be done between the South Tees Trust and similar organisations. The panel heard that as performance data is based on reductions, it is very difficult to make meaningful comparisons between Trusts, given different medical circumstances. It was said that prior to 2003/04 South Tees had been the only Trust in the region to have achieve 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.

30. The Panel noted from the statistical information provided that all Trusts in the region were finding it challenging to meet the 20% annual reduction target. It was said that on a national basis, there was prima facie evidence to suggest Trusts in London were doing particularly well in combating MRSA. It was important, however, to note that such Trust had started with very high baselines and as a result reducing incidences of MRSA was, as such, easier. As an example, Guy's & St Thomas' Hospitals NHS Trust had the 'best' national performance with 75 MRSA episodes under target. Their rate, however, was 4.5 incidences per 10,000 bed days in 2003/4 and 2.3 in 2005/6. The Panel was mindful that the rate for 2005/6 was still higher i.e. worse than South Tees Trust's rate for 2005/6 at 1.8. The Panel thought, therefore, that the standard used was somewhat misleading as it did not actually highlight those organisations with the lowest incidences.

31. It was emphasised that the important goal for Trusts now is to achieve the targets and not particularly concentrate on other Trusts, as their fortunes will not impact upon how the South Tees Trust is viewed. It will have either reached or not reached its target.

32. The South Tees Trust has also joined the performance improvement network and asked them to assess the Trust to see what more could be done.

33. The Panel heard that the South Tees Trust has an action plan in place to reduce MRSA and other HCAIs, which is wholly consistent with the Department of Health's *Saving Lives* Delivery Programme. The Panel heard that as a result of the action plan, a number of measures have been put in place. A selection of these is outlined below:

33.1 The South Tees Trust is developing wider responsibility for infection control using the *Saving Lives* delivery programme.

33.2 The South Tees Trust is improving the infection control knowledge of all staff through appropriate training, with particular emphasis on more detailed training for clinical matrons and ward managers.

33.3 Highlighting compliance with key policies aimed at reducing MRSA and other HCAIs.

33.4 Learning lessons from MRSA bacteraemia by treating each case as a clinical incident and disseminating the lessons learned.

33.5 Improving dissemination and feedback of surveillance and audit information.

33.6 Using surveillance and clinical incident information to focus efforts where they will have the greatest impact.

33.7 Defining the roles and responsibilities of the infection prevention and control team.

EVIDENCE FROM THE SOUTH TEES TRUST PATIENT & PUBLIC INVOLVEMENT FORUM.

34. In an attempt to conduct a well-rounded study of the topic at hand, the Panel felt it very important that the Panel speak to patient representatives. To that end, representatives of the Patient & Public Involvement Forum (PPIF), attached to South Tees Trust were invited to speak with the Panel and put forward their perspective.

35. The Panel heard that the PPIF has very close links with the Trust on the matter of HCAIs. This was evidenced by the fact that Members of the PPIF were part of the PEAT inspection teams, which also included senior members of Trust staff. It was noted that the PEATs are also able to send their reports directly to the Department of Health, should be sufficiently concerned with the state of facilities and/or the response they received from the Trust.

36. The Panel considered PPIFs statutory right to visit facilities (unannounced) as important in combating HCAIs and thought it regrettable that the upcoming LINks will not have a similar power.

37. Asked what was the biggest issue of concern to the PPIF was presently, the Panel heard that the condition of toilets, especially that of public toilets.

38. The Panel also heard that the JCUH cleaning contracts were up for renewal during 2007, which would be an opportune time for the Trust to be able to take into negotiations any areas of concern they would have. The Panel stressed that the PPIF would be key in identifying those areas of concern or indeed areas of good practice which should be held onto. Further on this

point, the Panel felt that the views of the PPIF should be actively sought by the Trust when considering the contractual arrangements for cleaning.

FURTHER EVIDENCE FROM THE SOUTH TEES HOSPITALS NHS TRUST AND STRATEGIC PARTNERS

39. The Panel received further evidence from the South Tees Trust and partners on 28 September 2006.One of the Panel's terms of reference for this review centred on the cleaning arrangements at James Cook University Hospital and as such, the Panel used this meeting to investigate that area.

40. At the start of the meeting, the Panel heard of a Department of Health initiative known as Patient Environment Action Teams (PEATs), which are active in each Trust, with a mix of membership, including patient representation. It was confirmed to the Panel that the PEAT assessment had 5 scores which were:

    1: Unacceptable
    2: Poor
    3: Acceptable
    4:Good
    5:Excellent

41. The Panel heard that the most recent PEAT self-assessment identified the James Cook site as '3', which is 'acceptable'. PEATs attention is focussed on Infection control, uniforms, laundry, environment, access, safety, security, food, privacy and dignity.

42. The Panel enquired as to the status of the cleaning services at James Cook University Hospital (JCUH).

43. The Panel heard that hospital-cleaning services had been subject to compulsory tendering from 1983 and was contracted out in the South Tees Health Authority area in 1986. Those cleaning services were re-tendered on a three yearly basis, until the Private Finance Initiative (PFI) in August 1999 for the development of a single site hospital. As part of that PFI agreement, all cleaning services transferred to the private sector partner, together with all other non-clinical support services.

44. It was confirmed to the Panel that under the PFI contract, the 'soft' support services (such as cleaning) were subject to benchmarking/competitive tendering five yearly during the 30-year contract. The Panel heard that this process was rather different to traditional tendering process, as the initial output specification was very detailed, leaving bidding entities with very little doubt as to what was required.

45. The Panel heard that all soft services will be re-tendered for contractual commencement in August 2008, which would reflect the changing nature of hospital activity, the reality of a large single site and the changing environment

of care. The Panel heard that South Tees Trust had already started considering the requirements for a market testing exercise in 2007, with a view to it starting in 2008. The point was stressed again that over recent years and the operation of a single site at JCUH, requirements for cleaning services had altered significantly and such market testing and tendering processes would have to take cognisance of that.

46. At this stage, the Panel was taken through the process for a contract agreement. It was confirmed that parties interested in bidding would be provided with an output specification, which is a requirement of the central Government PFI Unit. The Trust negotiated the level of service required over two years and in November 1999 all support services signed off under the contract as agreed. It was confirmed that the preferred bidder had to satisfy the Trust that requirements to be met were understood and that level of staffing was unavailable.

47. The Panel was interested to learn about the frequency of cleaning services available at JCUH. It was confirmed that cleaning services are available from 7am until 8.30pm. From Monday to Friday, sanitary areas are cleaned 3 times daily and twice daily on Saturdays and Sundays. The Panel heard that there was a degree of flexibility on start and finish times, which was applied following clinical guidance and consideration of the clinical needs of the area in question. As an example, it was suggested that cleaning may start later in the morning on an elderly ward.

48. The Panel heard that the time and frequencies of cleaning practices were developed and documented in Service Level Agreements, which usually had senior ward staff input. The frequency of cleaning arrangements for any given area and the level of staff deployed there, very much depends on the area being considered, with priority being given to the clinical need. As an example, the High Dependency Unit has one domestic for six patients, Cardiothoracic Intensive Care Unit has two domestics for eighteen patients and general wards have around one domestic for fifteen patients.

49. The Panel heard that JCUH has 264 domestics and 219 housekeepers, which equates to 9400 hours per week. For clarity, a domestic's areas of responsibility tend to be floors, sanitary and any other shared areas, whereas housekeeping staff are concentrated more on patient areas such as around beds. On duty at any one time are 40 domestics per shift for wards, 36 housekeepers per shift for wards and 30 domestics for clinical departments and general areas.

50. The Panel raised the question of what happens if there is a need for cleaning activity between normal rounds. Firstly, it was established that the Modern Matron on the ward was 'in charge' and responsible for the ward's condition. If the Matron is not happy with the condition of the ward, she can call the Sovereign Helpdesk[5] and request a further cleaning. The Panel heard that it can sometimes be a challenge keeping the cleaning teams fully staffed,

[5] Sovereign is the private partner at JCUH, responsible for support services such as cleaning.

although there are also bank staff to call upon. The Sovereign helpdesk operates a rapid response team and calls to it are categorised as A, B, C or D, depending on their level of clinical priority. It was confirmed that the hospital as a whole also has high, medium and low risk areas, which are also considered when cleaning assignments are submitted. The point was made, however, that key to a clean and effective hospital was encouraging a culture whereby every member of staff takes responsibility and does not 'just call Sovereign'. The Panel was told that the Modern Matron body would not support Trust staff leaving things. Whilst the Trust was reasonably happy with the progress on this front, it was noted that improvements can always be made and staff should be continually reminded that they should not abdicate their responsibility and rely solely on cleaning staff.

51. It was noted, however, that there are still cleaning problems facing such wards and Matrons, which are not solved by cleaning services per se. The example was given of a lack of storage space on wards, which meant that areas of wards were cluttered. Consequently, as things are stored not all areas can be cleaned properly.

52. The Panel made enquires in relation to the management of the cleaning services on behalf of the Trust. Within the Trust, the responsibility of ensuring the delivery of the contract falls to the Directorate of Operational Services, which the Panel was told was one of the first example of a Trust giving such responsibility at Board level.

53. It was confirmed that two trust managers are responsible for ensuring that services are delivered and according to the contract. Built into this regime are variation agreements, whereby contractual arrangements can be altered if the nature of hospital business is altered (which may result in an additional cost). It was noted, however, that at present it was felt the South Tees Trust was getting the service it was paying for. There are monthly meetings with the service providers regarding operational issues and monthly reports are produced on how the contract is performing, together with Key Performance Indicators (KPIs), which are built into the contract.

54. It was stated that nominated officers (and not clinical staff) raise service variations when the needs of clinical areas change, to ensure that clinical staff are not distracted from the provision of care.

55. At this juncture, the Panel spent some time hearing about the role of modern matrons. There are 27 Matrons in total at JCUH, who strive to introduce themselves and make themselves known on the ward. Matrons have a special responsibility in relation to ward standards. The example of Intensive Care Unit was given, to illustrate the type of role a modern matron carries out.

56. In that ward, two cleaning staff concentrate on the clinical areas as the priorities and also handle corridors and such areas. The Matron carries out a weekly check with the senior housekeeper, sometimes with infection control personnel present and reports her findings. The cleaning staff work to a specification which is signed off, or not as the case may be, by the Matron.

The feeling of the Matron present at the Panel meeting was that the arrangement worked well. Regular PEAT inspections indicated that there were no serious areas of concern and if there were problems, the fact that PEAT inspections took place increased the chances of such problems being identified and rectified.

57. It was confirmed at the meeting that Modern Matrons have an important responsibility in relation to reacting to Healthcare Associated Infections, if and when an instance arises 'on their patch'. It is the responsibility of the Matron to ensure that the infectious patient is isolated, should there be room to do so. The Panel noted that this was a key point, people affected would be isolated *if* there was room. The Panel noted, however, that in a health system funded by taxation, such as the NHS, the ability to fund individual rooms was always going to be limited. This is especially so given that many hospitals would have to be rebuilt to meet this standard. Consequently, the system is left hoping that if and when there is an infection (which is a rare occurrence in itself) there will be facilities available to isolate the infected and prevent its propagation.

58. It was also said that having regular staff doing the cleaning would improve matters, as knowledge of what was required would develop and a rapport has a better chance of developing between those working regularly on the ward. The Panel considered that cleaning staff feeling like part of a team, as opposed to 'hired help', would be of benefit to the workings of a ward team and ultimately, therefore, the patient environment.

59. The Panel made enquiries as to the cleaning arrangements in relation to communal/general areas of the Hospital such as receptions, waiting rooms and corridors.

60. The Panel heard from the Matron present that such areas are, to some extent, "no man's land". It was confirmed that clinical staffs were responsible for clinical areas and understandably, should not be pulled away from the ward environment to maintain cleanliness standards. Whilst the Panel acknowledged that the Trust was encouraging a culture of 'not walking past', it was concerned that areas of a hospital were viewed as "no man's land" in relation to cleanliness.

61. It was confirmed by the Trust that general areas in the hospital are subject to the control of Estates staff and are inspected on a rota basis. It was acknowledged that Estates staff are not able to be 'everywhere all of the time'. This supported the point that it is crucially important for everyone to respect the integrity of the hospital, including the general public who are encouraged to report areas or incidents of concern.

62. The Panel also heard that receptionists also had the ability to report matters of concern in their areas and could use their position to inspect communal areas.

63. On this point, the Panel felt it was a bridge too far to expect receptionists to inspect or monitor the condition of communal areas near to their location. The

Panel felt that such staff would have their work cut out simply performing their contractual duties at such a busy hospital as JCUH. Consequently, whilst reception staff are well placed in advising members of the public of who to report problem spots to or to relay those concerns, the Panel feels it is not practical to expect receptions to proactively monitor communal areas.

64. It was confirmed to the Panel that the helpdesk relating to cleaning services gets around 7500 calls/jobs per month, which are signed off when completed.

65. Members of the Panel were also interested to hear that no clinical staff should travelling to and/or from work in uniforms, for the sake of infection control and associated cleanliness.

66. The Panel was interested to hear about the management arrangements in relation to the service provider. Teams are divided up into the Domestic Services and Housekeeping sections, consisting of a variety of posts including Hotel Service Managers, Patient Service Managers, Senior Housekeepers, Help Desks and Performance Managers. The JCUH is divided up into six zones and there is a senior housekeeper for each zone.

67. It was emphasised to the Panel that Patient & Public Involvement is absolutely vital, if Healthcare Associated Infections are going to decrease in rates of incidence.

68. The Panel heard that there is Patient & Public Involvement at the Trust Board, the Governance Committee and the Hospital Infection Control Committee. The Trust has also engaged with the Patient & Public Involvement Forum attached to the trust, who have conducted a MRSA workstream. The Trust has been active in promoting the (national) *Clean Your Hands* campaign and has installed alcohol gel dispensers at every hospital bedside, of which there are in excess of 1000.

69. The Trust also sponsored a Public Forum in November 2005, which it was hoped would act as a debating forum and raise the local profile of such an important issue, whilst dealing in the facts relating to the area. The Panel heard that the event was extremely poorly attended by the public, despite it being advertised. The Panel felt that this was unfortunate and symptomatic of a wider problem. There are often very high profile stories relating to infections in hospitals and the affects they are having on the people involved. When an opportunity to hear about the status of the issue locally and what the public can do to assist in tacking the problem is presented, the opportunity was spurned. The Health Scrutiny Panel thought this was very disappointing.

70. On the subject of MRSA specifically, it was confirmed that at present, JCUH is not meeting its MRSA target. The Panel felt it was important to note, however, that the Trust has previously reduced the rate by 40% from a higher baseline. It was acknowledged, however, that once incidence rates reach a certain level, it becomes much more difficult to continue their downward trend.

71. The Panel heard that there was high compliance of hand washing practices across the Trust, which included patients and visitors. Nonetheless, where there were examples of poor handing hygiene amongst staff, it was established as an “identified training need”, which is duly addressed.

72. The Panel heard that if members of staff were persistently not meeting the necessary standards in relation to hand hygiene, there would be disciplinary consequences, as it is endangering health and safety. Nonetheless, it was confirmed that at present, there have been no disciplinary proceedings in relation to this matter. Further to this point, it was confirmed that the Trust operates a uniform policy, which states that no clinical staff should travel to and from work in their uniform in an effort to promote cleanliness. The Panel though that this matter was vital to press home amongst clinical staff and encouraged the Trust to proactively enforce the policy. The notion of legal action against the Trust by patients in times of infection was raised. It was stated that this would be a predictable outcome of any type of outbreak and the Trust would find it very difficult to win defend such proceedings if its own hygiene related policies had not been followed by its own staff.

73. The Panel also made additional enquiries with reference to the PEAT visits and reports. The Panel heard that the outcome of PEAT visits is the direct responsibility of the Trust Chief Executive and flows down the organisation, such is its level of importance. Board Members are also part of PEAT teams. It was confirmed that a quarterly report is presented to the Trust Board on current standards, identifying any areas requiring action to the Board. The Panel enquired as to ramifications of poor cleanliness/high HCAI rates, other than the patient safety risks.

74. The Panel heard that poor performance in this field is likely to impact upon the Trust rating as published by the Healthcare Commission. This in turn will impact on the Trust’s ability to apply and gain Foundation Trust status, which brings about a greater deal of autonomy for the Trust from central control.

EVIDENCE FROM MIDDLESBROUGH PRIMARY CARE TRUST

75. Whilst the Panel is mindful that HCAI are more associated with the acute sector and therefore hospital trusts, the Panel was very keen to discuss the matter with Middlesbrough Primary Care Trust (PCTs). PCTs have a very important role in commissioning and providing some services for the communities they serve. Collectively, PCTs hold around 75% of the total NHS budget. With that in mind, the Panel felt it very important that it sought the views of Middlesbrough PCT about an important topic impacting upon the local health economy and the population it serves.

76. The Panel heard that the three main functions of a Primary Care Trust were re-iterated in national guidance published in May 2006. These are

76.1 Engaging with its local population to improve health and well being

76.2 Commissioning a comprehensive and equitable range of high quality, responsive and efficient services, within allocated resources, across all service sectors.

76.3 Directly providing high quality responsive and efficient services where this gives best value.

77. Middlesbrough PCT, therefore, has a dual role, in that it provides services and also commissions services.

78. The Panel heard that HCAIs are infections as a result of the healthcare system in its widest sense. That is, from care provided in the home, to primary care, nursing home care and acute care in hospitals. Accordingly, HCAIs include both hospital-acquired infections where an infection develops in a patient 48 hours or more after admission and community acquired infections where an infection is identified within the first 48 hours of admission to a hospital.

79. In its evidence relating to how it has reacted to HCAI in the local health economy, the PCT made the distinction between the steps it has taken as a service provider and as a Commissioner.

Service Provider Approach

80. The Panel heard that in August 2005 the PCT invested resources to establish its own Infection Prevention and Control Team. Prior to this, the service had been provided by the South Tees Hospitals NHS Trust via a Service Level Agreement. In relation to this, the Panel heard that the South Tees Trust had difficulty in staffing their own team and meeting their own requirements, so the PCT took the decision to establish its own team. The Panel noted that a PCT having its own dedicated team is by no means uniform and is quite unique in the Tees Valley.

81. The Panel heard that the PCT's Infection Prevention & Control Team has been very successful in implementing an 'everyone's business' approach within the provider services of the PCT. The Panel was provided with an information pack, which detailed the achievements of the PCT. In summary, those achievements included the re-drafting and distribution of policies, a hand hygiene audit, two thirds of PCT staff having received appropriate training, the PCT scoring a 90% compliance rate according to the Healthcare Commission and an 'excellent[6]' rating from a PEAT visit to Carter Bequest Community Hospital.

82. The Panel heard that further work is taking place in accordance with the PCT's annual plan for the Prevention and Control of Infection. It was confirmed that to date, there have been no MRSA bactaraemia occurrences at Carter Bequest Hospital.

[6] See Press Release of PCT, 26 September 2006. "Community Hospital Achieves Top Rating"

Commissioning & Performance

83. The Panel heard that the PCT monitors the performance of providers in relation to HCAIs on a monthly basis and this activity is reported at Board Level. The South Tees Trust has produced an action plan with regard to their MRSA position, which is monitored by the North East Strategic Health Authority in conjunction with the PCT on a monthly basis.

84. The Panel heard that following a visit to South Tees Hospitals Trust by the Department of Health, a steering group has been established to monitor the delivery of the action plan formulated in response to the visit. The PCT is represented on the group both from a commissioner and provider perspective. The Panel heard that the PCT feels that this approach enhances the ability for whole systems working and raises awareness of the need for different approaches to commissioning.

85. The Panel also learnt that a Teeswide MRSA steering group has been established to take forward the strategic issues associated with Healthcare Associated Infections. The group is sponsored by the Chief Executives of all organisations across the Tees Valley. It was confirmed to the Panel that Middlesbrough PCT is leading the delivery of the action plan associated with community issues.

86. Following the consideration of the paper submitted by the PCT, the Panel debated with the PCT a number of issues.

87. Whilst the Panel was mindful that the PCT does not control James Cook University Hospital , it was interested to hear about the HCAI are Carter Bequest Community Hospital. It was confirmed that there was no record of MRSA bacterium at Carter Bequest, although there was a history of one patient testing positive for Clostridium Difficile(C-Diff)[7].

88. The Panel heard that the main symptom of C-Diff is diarrhoea. If patients display such a symptom, a sample of faeces is always taken and checked for C-Diff. In such an instance of a positive test, the patient would be isolated if the facilities allowed. Th Panel noted that C-Diff would have precedence over MRSA in terms of isolating patients.

89. The Panel made enquiries as to who is responsible for standards at Carter Bequest Hospital. The Panel heard that there is a non-clinical general manager, although the clinical lead has responsibility for clinical standards. It was noted and welcomed by the Panel, however, that the PCT tried to foster an environment where everyone should accept a degree of responsibility for

[7] *Clostridium difficile* infection is the most important cause of hospital-acquired diarrhoea. *Clostridium difficile* is an anaerobic bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants. However, *Clostridium difficile* rarely causes problems in children or healthy adults, as it is kept in check by the normal bacterial population of the intestine. When certain antibiotics disturb the balance of bacteria in the gut, *Clostridium difficile* can multiply rapidly and produce toxins which cause illness. See www.hpa.org.uk

standards, where it should be everyone's problem and staff are encouraged to challenge.

90. Again, the Panel was interested to hear as to whether there have been any disciplinary proceedings in relation to breaching clinical standards in relation to HCAIs. Whilst the Panel heard that such outcomes were perfectly feasible, the PCT always attempted to give the benefit of the doubt and provide people with every opportunity to understand the impacts of such breaches.

91. The Panel enquired as to what would happen in the case of an infection if a single room was not available. It was stated that dual bedded areas could be commandeered in such an instance. The Panel heard that in terms of isolating infectious patients, the most critical element is when patients have explosive diarrhoea, as the germs can be airborne, although they are not able to travel long distances.

92. On that point, it was stated that individual rooms across the NHS would be the ideal scenario, although the NHS is unable to fund this, given its status as a service funded by general taxation and not a privately funded service.

93. The Panel discussed the concept of screening incoming patients for HCAIs. The Panel heard that unless patients were being transferred from an acute setting, it was not normal practice to screen patients for HCAIs. The point was made that often Carter Bequest Hospital deals with emergencies and it would not be good for the patient or the best use of time to immediately screen patients, when in need of urgent/emergency care. It was raised that Cleveland Nuffield Hospital, a small independent sector hospital, does run such checks on all admissions.

94. The Panel heard that this was not a fair comparison, for a number of reasons. Firstly, the Nuffield Hospital only deals with elective patients and on a much smaller scale than the local District General Hospital. Staff at such a facility therefore have more time and opportunity to perform such checks on all patients. Secondly, private hospitals such as the Nuffield are able to pick and choose which patients they take on and treat. NHS hospitals do not have that privilege.

95. In relation to the NHS, it was stated that, in the view of the witnesses, it would not be good practice to screen universally at such facilities at Carter Bequest Hospital. Evidence thus far indicated that HCAI were not enough of a risk to warrant such a measure and it would probably not be the best use of resources.

96. It would, however, be a much more sensible use of screening to concentrate on those patients in environments where multiple invasions were necessary. These would be areas such as Intensive Treatment Units (ITU), Cardiothoracic and Renal. By virtue of the services mentioned it would follow that most screening would be done at JCUH.

97. The Panel was interested to hear the PCT's views on screening as a commissioner of services. The Panel heard that the PCT's thinking is in line with recent Department of Health policy guidance on screening practice. It was stated that the PCT would always consider advocating wider screening if it was felt there was a clinical need for such action, although would be duty bound to consider the costs attached to a widening of screening practices and whether this would be money well spent.

98. It was noted that screening is done by the South Tees Trust where there was felt to be a clinical need, although the PCT may not always share the same view as to what constitutes clinical need, which would have to be worked out between the two organisations.

99. The Panel heard that on the subject of cost, it was very difficult to put a cost on the practice of screening. One could work how much each instance of screening costs, although when one starts to consider the costs and savings of preventing potential outbreaks it becomes hazier. Indeed, if a screening programme has no positive screenings for a year, is that money well spent? The Panel thought that it was, although could see the complexity of the issues which the local NHS is faced with in considering what to do.

100. The Panel was aware that it had spent a lot of time discussing what the NHS does and could do to tackle HCAIs, although understands that patients and visitors also have a critical role to play in fighting HCAIs.

101. On this point, the Panel enquired with the PCT over what it had done or felt it could do to publicise the importance of patients and visitors playing their part in fighting HCAIs. The Panel was rather surprised to hear that in the view of the PCT, there was uncertainty over the value of promoting appropriate messages, doubts over whether anyone would pay any notice and doubts over whether it is the role of the PCT to do so. Further, in an increasingly finance conscious NHS, the PCT may have difficulty in demonstrating an impact and therefore whether it was money well spent. The Panel heard the view that such public awareness campaigns were the responsibility of central government.

102. It was, however, agreed that the members of the public also have a responsibility to take action to prevent infection spreads, which was emphasised by the national '*Wash your hands'* campaign. It was agreed that to some extent, what was needed was a change in personal habits and a realisation from the wider public that to tackle the matter of HCAIs also required their action.

103. At this juncture, it was brought to the Panel's attention that when people speak of various infections and bacterium, there is a huge difference between colonisation and infection. The Panel was reminded that many people in the general population have certain bacterium living on within their normal skin flora and therefore could be described as having being colonised, whilst also being perfectly healthy. That is rather different to someone who is infected,

say when such bacteria have entered the body via a wound or other intervention.

104. The PCT, as a commissioner of services, was asked about its views on the current HCAI rate at JCUH. The point was made that JCUH is always going to have a degree of HCAIs, as the services it provides brings it into contact with the sickest patients, who are most likely to contract such infections. This group would include people requiring Intensive Treatment, multiple invasion points and chemotherapy as an example. To confirm, the Panel heard that JCUH does not have a big problem as such, although it is the nature of the facility's business to treat the sickest people.

105. The Panel heard that to a large extent, JCUH had all implemented pertinent HCAI policy guidance and taken all other steps requested of it. Consequently, the Panel heard that it might now have reached the stage where more responsibility is placed on the general public to fight HCAIs. The example was given that the JCUH could spend £1million on one ward and it would not be guaranteed to be infection free.

106. Given that backdrop, the Panel enquired as to what the PCT could do if felt that infections rate were not at a suitable rate. It heard that, at this stage, the PCT cannot *not* use JCUH due to the services that are required by the population and the capacity that JCUH can offer. It was confirmed to the Panel that the PCT would only consider decommissioning a service is feedback from patients and GPs indicated that confidence in a service was lost. The Panel heard that no such feedback has been received. Whilst there are instances of HCAIs at all hospitals dealing with seriously ill people, the Panel heard that at times the media can propagate scare stories which do not, actually, convey the reality. As a result of this, there can be patient groups who are rather fearful of attending a service which may be completely different to that which has had instances of HCAIs, although all the public hears is the name of a certain facility.

107. The Panel explored further the nature of the relationship between the PCT and the South Tees Trust in relation to the rate of HCAIs at JCUH. Specifically, what the PCT would do if rates got too high and what course of action would be taken.

108. On this point, the PCT stressed that it did not see its role as the Commissioning body to "bang the South Tees Trust over the head" over HCAIs and that it was much more productive to work with the Trust to tackle the matter. The Panel heard that it was crucial to prevent people choosing to not use JCUH.

109. It was accepted that as a commissioner, the ultimate act is to decommission, although the Panel heard that the PCT would never want to be in that situation as ultimately, local people want local services, which JCUH represents.

110. The Panel also had the benefit of an interesting observation from the PCT in relation to the changing landscape of the NHS. If the South Tees Trust was a Foundation Trust, which it is working towards, the Trust would be at liberty to choose which services they wanted to run and which they didn't. Such a scenario could leave people in Middlesbrough with a journey to Newcastle to access services, which they presently access at JCUH. Consequently, the Panel saw the rationale behind a collaborative approach towards HCAIs, as opposed to an approach that may lead South Tees to think that it could do without the controversy that certain services bring. The Panel heard that the attitude of the PCT is very much focussing on collaboration and rewarding good results as opposed to being punitive over bad results.

111. It was confirmed to the Panel by the PCT that MRSA rates at JCUH are currently around 70 per annum, which when compared to the facility's throughput, represents a very low percentage, certainly less than 1%.

112. The Panel was interested to hear the PCT's views on the chances of an outbreak of HCAIs at JCUH. The Panel heard that an outbreak could also happen, given the correct circumstances. Given that fact, the PCT advised that it was happy that the South Tees Trust was not being negligent and was doing all it can to tackle HCAIs. The Panel heard it needed to be said that HCAI are never going to be prevented per se, although you can attempt to keep them to a minimum. It was confirmed that the PCT's facilities met targets set by the Healthcare Commission in respect of HCAIs.

FURTHER EVIDENCE FROM THE SOUTH TEES TRUST

113. During this review, the Panel became aware of a visit to South Tees Hospitals NHS Trust by a Department of Health (DH) team in late August/early September 2006. The purpose of that team's visit was to perform a MRSA improvement review. The Panel was very keen to hear the outcome of that visit and the associated action plans that it produced. Consequently, the purpose of the Panel's meeting on 8 January 2007 was to gather than information.

114. The Panel heard that the DH team has offered to visit a number of Trusts around the country to work with the trusts on their plans to reduce MRSA. The Panel was pleased to hear that the DH team had actually visited on the strength of an invite from the South Tees Trust, with the support of the North East Strategic Health Authority, to review plans in place and to consider what else could be done. The Panel thought that this reflected well on the Trust and illustrated a very senior commitment to tackle the problem.

115. The Panel heard that following the visit, the DH team reported on a number of encouraging signs.

116. Firstly, there is robust corporate governance framework, which insures that information regularly goes from "ward to board" on HCAI matters and it is considered in the public domain. The Panel heard that there is a clear and demonstrable willingness amongst staff to improve and there are effective

medical champions in many specialities. The Panel was also interested to hear that a four-day training programme is in place which was drafted in collaboration with the University of Teesside. The course has had 100% attendance of the Trust's clinical matrons and was actually taken away by the DH, to be considered for a national roll out. Again, the Panel thought this reflected well on the Trust.

117. The Panel also heard that the General ICU and Renal departments have embraced their challenges with MRSA bacteraemias, which has resulted in a positive outcome. There is good, visible infection control information available on the intranet for staff and three Patient & Public Involvement Forum Members are now present on the Hospital Infection Control Committee.

118. The Panel heard that South Tees, according to previously plotted trajectories, should have had 55 instances of MRSA is 2005/6, although finished the year with 76. It is, however, very important to note that the Trust saw a 7% increase in the numbers of patients coming through its doors, so it would probably be fair to surmise that the proportionate number of MRSA cases did not increase.

119. The DH team identified that the Trust could improve the root cause analysis that it does on each confirmed MRSA case, although it was accepted that finding a root cause of a bacteraemias is a very difficult thing to do. The DH had advised the South Tees Trust that compliance with providing regular and timely information for divisions and front line staff and robust root cause analysis processes are key to achieving the MRSA target. On this point, it was confirmed that every instance of MRSA is the subject of a thorough root cause analysis, by an infection control specialist, the outcome of which is shared with the SHA as a clinical incident.

120. The Panel was briefed upon the findings of the DH team in relation to practices within the Trust. The perception amongst staff is that hand hygiene is good and the practice is improving across the Trust. High Impact Interventions are well established in some clinical areas, although they should be rolled out across all clinical areas. It was also confirmed that the Trust practices screening for high-risk patient groups, on which guidance is available in the infection control policy. The Trust has an antibiotic policy, compliance with which was felt to be good and MRSA status is alerted on the PAS system for designated staff.

121. The DH team was also very complimentary about the senior leadership within the Trust in combating HCAIs, with the Trust's Chair and Chief Executive 'leading from the front'. The Panel was pleased to hear of such senior leadership and the Panel's own experiences with the Trust in this review supported the DH team's view. The Panel was mindful that this is not always the case with Trusts, as the recent report into Stoke Mandeville Hospital's fatal outbreak of C-Diff, was very critical of senior management of the Trusts[8].

[8] Please see http://news.bbc.co.uk/1/hi/health/5209330.stm for further information

122. The DH team felt the senior management's attitude towards combating HCAIs filtered down to the wider staff cohort, who see it as a priority and are committed to addressing the matter.

123. The Panel heard that attendance at the Trust's mandatory training has improved from 59% to 69%. Given that this is mandatory training, the Panel though that whilst the improvement was to be welcomed, 69% at mandatory training is still not particularly impressive. The Panel also heard that the Trust's infection control team has developed a four day infection control course which all matron and ward managers will be attending, in addition to an e-learning package which some clinical staff have undertaken and found very useful. The Panel also noted that infection control duties and responsibilities are now expressly referred to in the job descriptions of many staff.

124. The Panel heard that whilst the DH team had identified many positive aspects of the Trusts work in relation to tackling HCAIs, it also made a series of recommendations.

125. The Panel heard that it was recommended that the Trust work closely with partner organisations to reduce the amount of people being diagnosed with pre-48 hour MRSA bacteremias. To clarify, that is when it is felt that MRSA has actually been contracted or has developed external to JCUH, although has been diagnosed in JCUH. The partners that the recommendation refers to are those facilities in primary care, as well as residential homes for the elderly.

126. In relation to such pre-48 hour MRSA bacteraemias, it was also recommended that the Trust engages with partner organisations to conduct joint Root Cause Analysis exercises, so expertise may be pooled and as much information is gathered as possible to assist in the prevention of further instances. It was also recommended that discharge information to GPs be reviewed.

127. The Trust was also invited to consider widening the screening programme to include more high risk groups and hopefully catch any other instances of HCAIs before they became bigger problems. The DH team also stressed the importance of the Trust monitoring compliance against the existing screening policy.

128. In so far as the management of the organisation is concerned, there were also recommendations around the MRSA being a standing item on divisional meeting agendas and ensuring that infection control measures are inserted into all job descriptions. The Panel noted that this would be quite a task, given that the Trust employs around 7,500 people.

129. Following the presentation of information from the DH visit, the meeting opened up into an 'around the table' debate, with the Panel asking a series of questions and points of clarification on what they had heard.

130. The Panel was mindful that whilst JCUH staff obviously have a huge role to play in the fight against HCAI, the role of patients and visitors cannot be underestimated. The Panel was interested to hear what was being done (or could be done) to educate the public further on what it could do to help.

131. The Panel heard that staff at the Trust felt that the message was, slowly but surely, getting through to patients and visitors about the importance of cleanliness in medical facilities. Nonetheless, the point was made that there was still a lot more to do. Reference was made to the patient handbook/leaflet which was distributed which contained a lot of pertinent information in this regard.

132. It was also confirmed that it is the responsibility of clinical matrons to regularly circulate on their areas of influence, ensuring that ctandards are met and liasing with patients and visitors on what can be expected of the hospital and what is expected of the public. It was also confirmed that the Trust will be launching a media campaign in the spring, which will provide another opportunity to get appropriate messages across on cleanliness and associated standards. The Panel welcomed this development and was of the view that such messages can never be publicised too much, as with every campaign the message will seep through that little bit further.

133. The Panel made further enquiries into the background of the DH team's visit and their findings. The Panel heard that the bottom line message following the visit was that the Trust is making significant inroads and improvements on the matter, although there are still things to be done. It was noted that the DH team had come following an invite from the Trust and had not taken it upon itself to arrange a visit. Further to that, it was noted that the DH team had only felt it necessary to attend for 3 days, rather than the usual 2 weeks, in recognition of the amount of work already being done by the Trust.

134. It was confirmed that the DH team had visited both various members of staff and various departments within the Trust, as the DH team had wanted to ensure that **all** departments were taking the necessary action and not most. It was also noted that in the view of the DH team, the Trust was very well evolved when compared nationally in relation to steps taken to combat the incidence of C-Diff specifically.

135. Discussion ensued about the Trust's MRSA target. The point was made by the Trust that hardly any Trust in the country was actually on course to hit its MRSA targets. It was explained that the Department of Health had set a 60% reduction target on all Trusts, irrespective of what their statistics where at the given point. It was explained to the Panel that the impact of this was that where Trusts had already reduced MRSA significantly, they were required to find another 60% reduction, whereas Trusts that hitherto had not been particularly active in combating MRSA could actually hit the target easier. The Panel felt that establishing a national target in such a way is rather perverse and does not necessarily inform the public which are the 'best performing' hospitals.

136. The point was illustrated by saying that if the South Tees Trust was to hit its MRSA target, it would mean it having a lower incidence of MRSA than Harrogate Hospital. When it was explained that Harrogate Hospital is around a quarter of JCUH's size and has none of the complex services areas it struck the Panel as a nonsense that such a target can be imposed. This is especially so given that JCUH tends to run at around 90%. As evidence has previously indicated, JCUH's business mix means that a certain number of MRSA cases are always going to present themselves, as it deals with the sickest patients. When JCUH is considered alongside comparable facilities such as those in Leeds, Newcastle, Sunderland and Hull, it ranks at "about mid table" in MRSA statistics.

137. In an associated point in relation to MRSA rates, the Panel heard that as the necessary laboratory services were housed at JCUH, all positive identifications of HCAIs contribute to JCUH's figures. To give an example, if a man presents at JCUH's A&E section and is tested for, say, MRSA and he returns a positive result he contributes to JCUH's figures. That man may never have been an inpatient at JCUH or even been there before, although nonetheless he contributes to those figures. This concept also extends to the laboratory services which are provided at JCUH for General Practice. That is, if a blood test is ordered by a GP and analysed at JCUH laboratory services, if a HCAI is diagnosed it is marked up against the JCUH's figures. The Panel found if to be bizarre and rather unfair that someone may never have been to JCUH and yet their infection is logged against JCUH.

138. On this point, the Panel heard from the Trust and the SHA representative that root cause analyses were so important whenever there was an incidence of an HCAI. The point was made that the community sector needs to become more engaged with such root cause analysis exercises as infections often occur in the community although are invariably picked up in hospitals, which can give the misleading notion that there are exclusively hospital problems.

139. The Panel explained that its evidence to date had indicated that C-Diff would be the next high profile HCAI and is considered more of a danger than MRSA in some quarters. The Trust agreed that C-Diff was increasing in profile and impact and would hope that the Department of Health would look to set a more meaningful target in relation to C-Diff prevalence.

140. Whilst accepting the points made in relation to targets, the Panel enquired as to why targets were needed on such an important topic and queried whether infection control should just be part of the Hospital Trust's core business. That point was accepted, although nonetheless the Panel heard that although the culture of targets in the NHS may be criticised, it has been needed by the NHS and has focussed minds on matters, which required attention.

141. The Panel made enquiries as to what could be done to further tackle the incidence of HCAIs, as infections are becoming increasingly virulent. The Panel heard that with the exception of thorough, regular handwashing there are no other 'magic bullets' to tackle the problem.

142. The Panel heard that consideration was being given to American style Scrubs (types of uniform), which are easier to launder at higher temperatures but even then, one could only say that it might work.

143. The concept of expanding the screening was also discussed. The Panel heard that at present, in line with national guidance, only cohorts of high-risk patients are screened. It was said that if screening practices were extended, there is no evidence that it would have a decreasing effect on the rates of HCAIs. It would however, bring about major considerations around the capacity of the Trusts laboratory services to cope with the amount of screenings necessary and PCTs would have to pay for them, which would mean funds could not be spent on other things.

144. The Panel also made enquiries as to how clinical standards in relation to HCAIs are upheld. It was said that the NHS, on this matter, initially started down a road of learning and wanting to improve staff practices and services. It was stated, however, that if Members of staff consistently acted outside of agreed policy, they would be subject to disciplinary action. It was noted that there had not been any disciplinary action to date with reference to HCAIs.

145. The Trust was asked about the issue of performance in relation to the relationships with commissioners. Specifically, the concept of a commissioner applying financial penalties, in connection to the rate of HCAIs at a facility used by that commissioner was raised. It was felt that such a relationship would not be helpful to a commissioner, the provider trust or the patients. It was felt that a recognition was needed that HCAI will occur, especially in facilities such as JCUH, although what was key was the attitude of the Trust in question to tackle the rate of incidence.

146. On the question of HCAI, the Panel heard that the important figure to consider is the rate of infections not the total number. To support this point, it was said that JCUH had around 75 cases of infection in the last year, which may sound quite a daunting number. When one considers that against the total throughput of the facility, it actually equates to less than 1%. The Panel heard that whilst the Trust was strongly committed to reducing the rate further, the fact that instances were less than 1% should be noted. It was agreed however, that a relatively low rate on infection in the facility was absolutely no consolation to those who were affected. On that point, the Trust felt it was important to note that MRSA is not fatal and can be treated if diagnosed promptly, there was a misconception that it was fatal that needed to be challenged. On this point, it was also felt that media coverage can sometimes be unhelpful, as it sometimes seems to sensationalise the subject when the reality is that different to what is presented.

147. It was emphasised at this point that when considering rates of infection statistics, it was so crucial that people compare like with like. It was also necessary to acknowledge that a tertiary hospital such as JCUH was also going to be one of the highest rate groups, due to the nature of its business. As an aside, the Panel noted that JCUH actually has one the best rates for infections in postoperative orthopaedics.

148. The Panel enquired as to what other aspects of the local health economy could assist the South Tees Trust in combating HCAIs. The Trust told the Panel that the relationship with care homes was critical. The Panel heard that it was absolutely vital that care homes work to the same standards as hospitals, otherwise hospitals can become the backstop for problems elsewhere in the system and notably those figures present on hospital figures.

149. The Panel agreed that there might be a role for local government and specifically Social Care Commissioning in assessing the conditions and standards of care homes and making a judgement on their suitability for the populations they serve.

150. In previous meetings the Panel had heard from a Clinical Matron that non-clinical areas, such as corridors and reception areas, were “no man’s land” in relation to cleaning standards. There seemed to be an element of doubt as to who was actually responsible for cleanliness standards in these areas. The Panel has been rather concerned at hearing such a message and pursued the matter at this final meeting.

151. The Panel was reassured to hear that the above situation has actually changed somewhat and been addressed. It was said that every clinical matron has an area of influence, where they have overall responsibility for standards of cleanliness. As a result, the Panel heard, every square foot of the JCUH premises has a clinical matron responsible for its cleanliness. It was said that this development had occurred following a review of the Clinical Matron job descriptions, which rectified a previous position which the South Tees Trust accepted needed to change.

152. In conclusion to the evidence collected from the South Tees Hospitals NHS Trust, the Panel heard that the Trust is attempting to bring about a cultural change. Patients are encouraged to see themselves as partners in their care and should feel able to speak up if they see something they are not satisfied with, especially in relation to cleanliness and hygiene standards. Further, it is absolutely critical that patients and visitors are aware of the responsibilities they have in relation to facility cleanliness and hygiene and further all efforts to promote that message should be explored. Combating HCAIs is not a losing battle, but an ongoing one.

CONCLUSIONS

153. The Panel is invited to consider the conclusions it wishes to draw from the evidence received.

RECOMMENDATIONS

154. The Panel is invited to consider whether it wishes to make any recommendations.

BACKGROUND PAPERS

Prevention of hospital-acquired infections, a practical guide, 2nd edition. World Health Organization. www.who.int/emc

"General Information – Healthcare-associated infections"
www.hpa.org.uk/infections/topics_az/hai/gen_inf.htm

www.dh.gov.uk/reducingmrsa

http://news.bbc.co.uk/go/pr/fr/-/1/hi/england/leicestershire/5396800.stm

http://news.bbc.co.uk/go/pr/fr/-/1/hi/health/5209330.stm

See *The Times* Newspaper, 25 July 2006.

See Press Release of PCT, 26 September 2006. "Community Hospital Achieves Top Rating"

www.hpa.org.uk

http://news.bbc.co.uk/1/hi/health/5209330.stm for further information

Fundamental Values And Behaviours For Nursing And Midwifery Care Within South Tees Hospitals Nhs Trust – Document

Visiting Policy – South Tees Hospitals NHS Trust

South Tees Hospitals NHS Trust Fact Sheet

Methicillin Resistant Staphylococcus Aureus – MRSA General Information for Patients and Visitors

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