“I thank the Patients Association for the pressure they put on us to keep improving standards. Long may they continue.”
Sir Ian Carruthers, when Acting Chief Executive of the NHS

PREVENTING INFECTION ON THE FRONTLINE

A Survey of NHS Staff

Supported by an educational grant from enturia

May 2008
The Government must require Trust Boards to:

- End the culture of ignoring infection control guidance. It is their duty to ensure implementation of Department of Health guidance issued to staff. Failure to do so endangers their patients and wastes public money. (Sections 1, 2)

- Reduce the danger to their patients by breaking the vicious circle of high bed occupancy rates = increased infection = increased bed occupancy. (Section 1)

- Comply with its new top priority for infection control and accelerate reductions in MRSA, Clostridium Difficile and other avoidable infections revealed in this report. (Section 1)

- Simplify the number of NHS staff titles. Not only are they confusing to patients, but we believe this unnecessary complexity is contributing to the failure of guidance to reach the appropriate staff members. (Section 1)

- Require all hospital PFI contracts to include adequate numbers of isolation rooms. (Section 1)

- Make compliance with guidance part of all staff appraisals and thus end the ‘silo’ mentality of those NHS staff who regard infection control as “Not My Problem”. (Sections 1, 2)

In addition the Patients Association calls on the Government to

- Ensure Strategic Health Authorities (SHAs) offer full value for money by ensuring best practice is implemented by every Trust in their area.

- Examine the role of its targets on bed occupancy levels and on healthcare acquired infection levels, and so ensure future patient safety.
Foreword by Claire Rayner
President of the Patients Association

Those of us who have been hospital patients – and I have had more than my fair share of being one – know the importance of being in safe surroundings. The best clinical care in the world can be worthless if patients pick up other infections while they are in hospital. Regardless of where the infection originates, it is surely the first duty of every member of staff in a hospital to do everything they can to make sure their patients are cared for, and returned to health, as quickly as possible and as free from Healthcare Associated Infections as possible. The Hippocratic Oath includes the vital words “Do no harm”.

For nearly 10 years, the Patients Association has campaigned for the NHS to get to grips with infections acquired in healthcare settings. During that time the equivalent of a full jumbo jet a month has become ill or died from HAIs. Targets have come and gone. So too have personnel. Even the name has subtly altered, but the infections themselves have stayed throughout, together with the undeniable fear of them that we all now have.

In 2007 the Government gave £50m to Strategic Health Authorities for them to distribute to trusts in their areas, specifically to combat healthcare acquired infections. As with our previous surveys, we have asked questions designed to sift the facts on the frontline from the political rhetoric. We have tracked where the money has gone and how it has been spent. Our survey of SHAs is complementary to this survey of infection control frontline staff.

The results should be compulsory reading for Ministers and NHS senior management. The fault line between rhetoric at the top and reality on the frontline has never been starker.

We thank all those on the NHS frontline who kindly made time to answer our questions. We are also grateful to Enturia for their educational grant which has made possible the production of this report. Our campaign on HAIs will go on until patients receive the safe health service they deserve - and pay for.

Claire Rayner
Never be afraid to ask questions, especially about your own condition or to make valid complaints. It may be easiest to speak to whoever is in charge of the ward. Your awareness of your own condition will help you to recover more quickly and your complaints or comments on what happens in the ward could be of great value.

1. **Do your homework:** Check your Trust’s Annual Health check ratings. Log on to www.healthcarecommission.org.uk and follow the appropriate links. The ratings are made up of a number of performance indicators and show how Trusts are doing in relation to some of the main targets set by the Government for the NHS. Ask your GP what they know about local hospital infection rates.

2. **Take avoiding action:** Before a planned admission, take a long warm soapy bath or shower, without using heavily scented brands, and have an all-over scrub with a soft gentle brush or loofah. Clip your toe and finger nails (removing all nail polish) and wash your hair. Put on freshly laundered underwear. All this helps prevent unwanted bacteria coming into hospital with you and complicating your care.

3. **Be prepared:** When preparing the items you are taking with you, such as newly-washed nightwear, dressing gown, slippers and so on, add packs of antiseptic hand-wipes together with a couple of bulldog clips and some small bags for refuse. Use the wipes every time you go to the toilet, and also before and after meals. Use a bulldog clip to clip an open bag to the edge of the bottom sheet and use it for your own rubbish. Give full bags to the ward cleaner for disposal.

4. **Take the lead:** When you arrive take a note of areas that are messy or dirty and point them out to staff. A clean and tidy environment not only keeps infection at bay, it looks better, makes all patients feel better and can get you out of hospital faster. Do not be afraid to ask anyone – doctor, nurse, cleaner or visitor - who comes to your bed to visit or examine you whether they have washed their hands, or used the antiseptic gel.

**And for Visitors . . .**
Make sure your visitors do their bit for your safety:

5. **Ensure they themselves are as clean as possible** when they visit. They should not come straight from work, but have a shower or bath and wear clean clothes. It all helps to reduce the risk of bringing infection in from outside.

6. **Co-ordinate their visits** so there are only two people at the bedside at any time. The more visitors a patient has the higher the risk of bringing in an infection from outside.

7. **Try not to let any children be brought in as visitors.** However much you want to see them, you don’t want their coughs and colds and it is better not to expose them to hospital infections.

8. **Arrange a “phone tree”** with family and friends. Ask one of them to be the person who phones the ward staff for information on how you’re getting on, and then to pass the news on to everyone else (e-mail is good for this!). This will obviously save time when staff are busy.

9. **Tell visitors not to sit on your bed.** Not only is it uncomfortable for you, but it is another way to prevent infection reaching you. Remember even healthy people carry bacteria on their skin; indeed, we all do! And if they have even the slightest snuffle or cough ask them nicely not to come and see you.

10. **If your visitors are taking a course of antibiotics themselves**, they should not visit you. They may be putting themselves at risk of infection if their immune systems are weakened by the antibiotics.

CHECK OUT THE PATIENTS ASSOCIATION’S WEBSITE FOR FURTHER UPDATES TO THIS INFORMATION: [www.patients-association.com](http://www.patients-association.com)
PREVENTING INFECTION ON THE FRONTLINE
A SURVEY OF NHS STAFF

Introduction

Our previous work

From the private concerns of a few, came the public flood of worry from many.

The Patients Association has been leading the campaign against Healthcare Associated Infections (HAIs) since 2000 with a series of reports highlighting the true scale and nature of the fight to ensure patient safety. This rolling programme to date has seen the publication of 7 major reports looking at all aspects of infection control and patient safety dating back to 2000.

Following widespread press coverage our first report, “Hospital Acquired Infection and the Re-use of Medical Devices” in 2000 the Department of Health responded with significant investment and new policy. This success was followed in 2001 with our staff survey looking at decontamination within hospitals “The Decontamination of Surgical Instruments: A Survey of Hospital Staff in the UK” and was designed to assess the progress of the Health Service Circular 2000/032.

Our programme continued in 2002 with a survey of the new Strategic Health Authorities. “Infection Control and Medical Device Decontamination – A survey of Strategic Health Authorities” assessed the extent to which Strategic Health Authorities would be following the decontamination and medical device issue under the new local agenda and “Shifting the Balance of Power” (October 2002). The report was the collaborated work of the Patients Association, Infection Control Nurses Association (ICNA), the Institute of Sterile Services Management (ISSM) and the National Association of Theatre Nurses (NATN) and looked at the monitoring of decontamination within Trusts.

The Patients Association has long believed that the involvement of healthcare professionals is crucial to an understanding of frontline infection control. Building on this belief and previous reports, our next survey in October 2004 was directed at staff, examining the realities of infection control and prevention. It revealed worrying levels of sterilisation and decontamination hygiene, and the report was also the first examination of patient involvement in infection control measures. “Infection Control and Medical Devices” surveyed a wide range of staff to gain a clear understanding on infection control across entire Trusts, considering the views of, amongst others, infection control staff, consultant microbiologists and senior clinical nurses.

We returned to the issue of decontamination in March 2005 when we published our report “Tracking Medical Devices and the Implications for Patient Safety- A survey of hospital practices and opinions” in collaboration with the Institute of Decontamination Sciences (IDSc), the Infection Control Nurses Association (ICNA) and the National Association of Theatre Nurses (NATN). This, survey, timed to coincide with decisions on the future management of medical devices revealed that many staff did not feel confident in the level of decontamination in their trust.
With growing media coverage and public concern about infection control the Patients Association expanded its campaign with the April 2005 *Clean Hospitals Summit*. With delegates and speakers from government, clinical staff, NHS providers and of course patients, the Summit not only addressed the reality of healthcare associated infections but it also offered solutions to those present via an exhibition of more than 50 suppliers of all types of infection control equipment.

The Summit concluded with a commitment by all participants to work towards reducing infections acquired by patients in hospital by signing up to the “100 Day Challenge Report”. Together with mandatory reporting of some infections and published standards by statutory organisations, such as the Healthcare Commission, this report aimed to inform patients and patient organisations of the measures taken by hospitals to protect patients from infections.

The highly successful summit was followed in 2006 by the “*Cleaner Hospitals, Safer Healthcare*” event together with the first Patients Association Awards recognising the best in healthcare practice, innovation and personal commitment to patients.

The Patients Association report “*Infection Control – Is it only skin deep?*” in November 2006, revealed a shocking picture of infection control and prevention across the country. The survey revealed a picture of insufficient staff training, budget cuts, lack of knowledge as to best practice and the fact that over 90% of staff had to spend clinical time reassuring patients about the risks of acquiring an infection.

**For more than 7 years the Patients Association has been leading the campaign against infection control on behalf of all patients. In that time, patients, the public and the media have gone from a situation where healthcare associated infection was something people read about to something of which most of us have a direct experience.**

**This report represents our research into the everyday consequences and demands of infection control and we are pleased to present this latest addition to our continuing campaign.**

**The Current Situation: Why we undertook this survey**

It is, surely, a basic requirement of any patient that they be cared for in a clean, safe environment. Cost dictates many areas of healthcare, but infection control is all about its priority within the NHS. The cost to individual patients and the public purse, when it goes wrong, is vast. Funding that should be put towards other improvements and advances in healthcare are wasted in a cycle of weak control and dangerous practice. In spite of increased public awareness, media coverage and government targets, the Patients Association remains concerned at the current situation surrounding healthcare associated infections.

The Patients Association will continue to campaign for healthcare associated infections to be the highest Government priority. We welcomed the additional funding promised to Strategic Health Authorities by the new Secretary of State, Alan Johnson, in July 2007 for dispersal to frontline infection control staff. This is the subject of an additional survey of SHAs which we include in this report. However we remain concerned by the rates of infection. We continue to receive regular calls to our Helpline which confirm that the prevalence of such infections continues to be a major concern for many patients. Media coverage also continues to publicise individual cases.
In 2007 the Health Protection Agency reported that the rates of MRSA bloodstream infections were gradually being reduced, although it is clear the Government target of halving number of infections by April 2008 has not been met. Whilst the Patients Association welcomes any reduction in the rate of infection it must be remembered behind each of the 1,087 MRSA bloodstream cases (reported between October and December 2007) is a person who was already sick, who trusted the NHS to make them better and who was let down.

In contrast to the decreasing MRSA figures, *Clostridium Difficile* continues to rise with more than 12,000 reported cases between October and December 2007. Despite government focus on slowing of the rate of increase, rates are rising and more and more patients are being affected each year.

Figures show that where trusts make reducing infection everyone’s priority, the number of patients contracting healthcare associated infections falls. The Patients Association believes Trust board-level accountability is essential and that significant reductions in infection rates will only be achieved when NHS managers take infection control seriously.

With the official Health Protection Agency figures and the general trends in infection rates in mind, the Patients Association undertook this survey in November/December 2007 to gain a better understanding of the current situation behind the statistics. We believe that in order to reduce rates of infection it is important to look at all aspects of care, both patient-focussed and organisational. This survey covered current procedures, guidelines and training for staff.

We know that the vast majority of healthcare professionals want to provide high quality safe care for their patients and we have consulted a range of staff for their perspective on infection control and where they feel improvements can be made.

This survey was designed to provide a unique insight into the frontline situations facing staff and allow them to tell us their experience of infection control and prevention. We call on the Government, Strategic Health Authorities in England and NHS trusts across the UK to consider our results carefully and improve patient safety by making healthcare associated infections THE top priority.

**Research Methodology**

The questionnaire from which the following results are taken was sent via post and email to a wide and random sample of NHS personnel throughout the UK, with a level of involvement in infection control practice.

This report is based on the 511 full responses received from frontline staff.

Statistical analysis of quantitative results was achieved through the use of data analysis software with answers to open-ended questions subjected to corresponding qualitative study. Respondents were also prompted to provide any additional comments they felt were relevant to infection control generally.
Research Responses

Among the 511 respondents, 25% were Theatre Nurses, 21.4% were Clinical Directors and 11.7% were Senior Nurses. Infection Control Nurses were 7.6%. As illustrated by the graph below, we received responses from throughout the United Kingdom, with the greatest response from the South West (14.9%) and London (13.2%).
Executive Summary

The Healthcare Commission report in July 2007 stated that 36% of trusts had experienced difficulties reconciling the management of HAIs and cleanliness against their financial targets.

Our survey finds:

- Information is not reaching the right staff. In common with our previous reports, this report confirms that many frontline staff are still unaware of the guidance being issued from the Department of Health.

- New money is not universally available for infection control. Many departments still have to fund improvements from within their department.

- A wide range of staff post titles, which may contribute to the difficulty in information reaching the appropriate staff member.

- A wide range of priority and attitude within individual trusts. Ending the postcode infection control should be a priority.

- ‘NMP’ – there are too many staff members taking the view that Infection Control (IC) and HAIs are ‘Not My Problem’. The silo mentality that is allowed to flourish is dangerous to patients.

- There are many scathing comments about the usefulness of SHAs in ensuring best practice nationwide against healthcare acquired infections. Trusts should be able to point to the added value of SHAs.

- The number of ‘Don’t Knows’ in answer to some of our questions is worrying.

BUT

- There was an encouraging and very wide range of projects reflecting different stages of development within individual trusts and their varying priorities. Details are available and the Patients Association will be pleased to provide them. They were not included in this report for reasons of space.
Question 1:
Which best describes your role?

As with our previous report, ‘Infection Control – Is it only skin deep?’ this survey was designed to be completed by a wide cross-section of NHS staff. This allows a clearer picture of infection control throughout the health service to be built up. Whilst infection control specialists provide an excellent indication of the situation they face it is also vital to get an understanding of infection control practice and priority throughout a department, acute hospital or Primary Care Trust.

Comment:
‘Other’ (20.5%) included over 50 different named posts/roles. While the Patients Association believes infection control should be everyone’s priority, we are nevertheless surprised at this number. We believe this must contribute to the failures in dissemination of information / guidance from the Department of Health.
Question 2:
Mandatory Surveillance

Mandatory surveillance for *Staphylococcus Aureus* (including *Methicillin Resistant Staphylococcus Aureus*, MRSA) bacteraemia was introduced in April 2001, having been recognised as the key to controlling and preventing infections. Following increasing incidences of infection this mandatory surveillance was extended to *C. Difficile* associated disease in patients aged 65 and over, in January 2004. In April 2007 surveillance of *C. Difficile* infections was extended to all patients over the age of 2 years. Mandatory surveillance was designed to provide healthcare staff with a means to measure the impact of their actions on the rates of infection. This information has become particularly relevant with the introduction of targets for reducing HAIs in all NHS organisations.

Rather than focusing on the raw statistics for the number of infections in a particular department or Trust, this survey looked at the trend in infection rates. This provides a more general overview of the situation and allows those non-specialists in infection control to comment on their direct experience.

**In your area of hospital care have MRSA bloodstream, Clostridium Difficile and other hospital associated infections increased or decreased in 2007?**

(a) MRSA

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<th>Increase</th>
<th>Decrease</th>
<th>Same Level</th>
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<td>MRSA</td>
<td>15.8 %</td>
<td>49.5 %</td>
<td>34.7 %</td>
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(b) Clostridium Difficile

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<th>Decrease</th>
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<tr>
<td>Clostridium Difficile</td>
<td>27.5 %</td>
<td>39.4 %</td>
<td>33.1 %</td>
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(c) Other infections – The list of responses may be found at Appendix A.

While media attention has focussed on the high profile MRSA and *C. Difficile* it is also important to consider other HAIs that may be prevalent in the health service. These infections may have much lower incidence rates but by including other infections within the survey it provides information for future analysis.

Comment:
After additional money was put in via Strategic Health Authorities in 2007 and despite continuing assurances that infection control is a priority and numbers are falling, these graphs reveal a continuing disgraceful situation on infection control. A 15.8% increase in MRSA, 27.5% increase in *C. Difficile*, and 10.2% increase in other infections should not be tolerated by NHS Trusts or the Government.

Question 3: Finance for infection control

In July 2007 the Secretary of State for Health, Alan Johnson, announced an additional £50 million in funding for infection control. Strategic Health Authority Directors of Nursing each received £5 million to distribute to Primary Care Trusts to ensure that “frontline clinicians are supported in the work they do to reduce infection and to provide a clean, safe environment”. This question was designed to ensure that this funding has reached the front line staff as intended and to look at the ways in which it had been used.

See also our survey of the Strategic Health Authorities’ role at Appendix B for a more comprehensive overview of the Department of Health’s funding for HAIs.
(a) Have you received more resources for infection control since the start of 2007?

- Yes 60.2 %
- No 24.9 %
- Unknown 14.9 %

(b) If yes, where did you get the money from?

- Strategic Health Authority 40.1 %
- Department of Health 34.4 %
- Other 32.8 %

“Other”: Of the replies received, 66.7% had increased resources from internal budgets, 18.5% from external sources such as PCT or league of friends. 6.2% did not know where the money had come from.

“CEO & Chairman sacked. New CEO & Chairman came with money.”
(c) If yes, how has this been used?

Of the 25.5 % ‘Other’: the replies gave a wide range of responses from new commodes, mattresses and curtains, to upgrade of the laundry for microfibre cleaning and the opening of a dedicated *C. Difficile* isolation ward. Within ‘Other’ 41.6 % had funded new training, 20.8 % had acquired new equipment, 16.1 % had spent money on wider estate works, 5.2 % had recruited new staff with the funding and 3.9 % had spent on additional screening.

(d) Is the Trust’s infection control budget ring-fenced?

Unknown 65 %

Yes 24.3 %

No 10.7 %
(e) If not, why not?

Of the replies, 15.9% did not know, and a further 15.9% either had no ring-fenced budget or no budget at all. Individual responses ranged as follows:

“The priority is a safe environment and if there is evidence that more can be done it is. It is not “raided” by other users – but has no specific upper limit.”

“The entire trust is currently undergoing a reorganisation which requires 25% reduction in administration staff and 12% reduction in professional management. This affects all aspects of care.

“Ask Matron!”

“That is how it is when you are broke and non-clinicians make decisions.”

“Lack of communication in department”

“We get little response from the infection control team.”

Comment:
Nearly a quarter of respondents said new money had not reached them. This was either because funding did not reach the trust – and our SHA report shows that not all trusts received a share of the £5 million – or did not reach their department within the trust. In either case, given that these are frontline staff answering for their trusts, the answers are a matter of concern.
Those who ‘do not know’ are as worrying (nearly 15%).
Our previous report’s call for action included the ring-fencing of infection control budgets. Nearly three quarters of trusts still do not have ring-fenced budgets or ‘do not know’.

Question 4: Some of the comments we received about the availability of alcohol gels and/or alcohol free gels -

“They are present in most but not all areas but are not regularly checked and run out for protracted periods”

“Patients and visitors steal and drink them if outside wards/A&E”

“Everyone too busy; who is responsible?”

“We do not have alcohol free gels in the trust – all gels contain alcohol as recommended by NPSA”

“Lack of good leadership in this area”

“Everyone too busy despite domestic staff asking for replenishing”
Question 5: Information

The Patients Association’s previous report on HAIs in 2006 reinforced the view that patients and the public are extremely concerned about the risks of acquiring infections following admission to hospital. More than 93% of our respondents said their patients experienced anxiety due to the possibility of catching HAIs. At the same time a 2007 Healthcare Commission report stated “thirty per cent of trusts did not have a protocol for discussing the risk of infection with patients or their relatives on admission to hospital or before they undergo a procedure”.

It is therefore crucial that clear written information is made available to outpatients, inpatients and visitors. This aims not only to ease anxiety and fears but to inform them of preventative and precautionary actions they can take to reduce the risk of infection. From January 2008, the Code of Practice of the Health Act (*Duty 5a*) requires NHS bodies to ensure they make suitable and sufficient information available “to patients and the public about the organisation’s general systems and arrangements for preventing and controlling HAI”.

Does your Trust offer specific written information on infection control to:
(a) Outpatients?

![Outpatients Pie Chart]

(b) Inpatients?

![Inpatients Pie Chart]

(c) All patients?

![All patients Pie Chart]

No 3.1 %
Unknown 17.2 %
Yes 79.6 %

No 7.6 %
Unknown 27.8 %
Yes 64.6 %

No 6.6 %
Unknown 20 %
Yes 73.4 %
Comment:
Between 20% and 35% of respondents were either not offering information or did not know. If the infection control priority for trusts is as claimed, it is extraordinary that information for patients is not guaranteed and known about among NHS staff.

Question 6: Isolation Facilities

The *Health Act 2006, Code of Practice, N° 8* lists a “duty to provide adequate isolation facilities” and goes on to state that an “NHS body providing in-patient care must ensure that it is able to provide or secure the provision of adequate isolation facilities for patients sufficient to prevent or minimise the spread of HAI”. There is no specified number of isolation facilities as “sufficient” obviously will depend on local need.

The Healthcare Commission report *Healthcare associated infection: what else can the NHS do?* In 2007 found trusts with a higher proportion of single rooms were more likely to be reducing their rates of MRSA in line with national targets. The question of sufficient isolation is clearly crucial in infection prevention and control.

(a) Does your department / Trust have sufficient isolation facilities for effective infection control practices?

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<th>Yes</th>
<th>57 %</th>
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<tr>
<td>No</td>
<td>43 %</td>
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(b) If not, why not?

Responses revealed the following:

38.4% said not enough single rooms were available. High bed occupancy of 95+% made this worse. In addition 24.7% pointed to the age and old-fashioned layout of their hospital buildings. Lack of funding was blamed by 7%. Some respondents (4.5%) did not think this question was applicable to their department (especially theatres) and others assured us the situation was about to change for the better.
“Two hospitals – less than 15 beds are single rooms – one is PFI – very difficult to provide isolation – other is old building with limited single rooms.”

“We have about 20%, the need is 50% - this means the building we have built is already out of date for our needs.”

“Very old hospital in poor state of repair. Single isolation room on same ward of 20 beds.”

“Mental health trusts have historically been under resourced in relation to this area.”

“Not enough side rooms therefore where possible patients are cohorted or at very least moved to a bed by a sink and toilet if possible.”

“They were considered unnecessary by the Trust Board.”

“We only have one cubicle in ICU & few single rooms are available – This is a new PFI hospital with insufficient isolation facilities.”

“Because the hospital was built to be as small as they could possibly get away with – which leaves us with little or no room for manoeuvre.”

“We need more single rooms, then we wouldn’t have the infection rates in the first place.”

“ Took an MRSA to ward and was told only place was middle of ward.”

“Money, dumbass. What do you think?”

“Drive to maximise bed usage has meant that majority of isolation beds that were lost approx 10 years ago are still not functioning again.”

“In my opinion infection control protocols are ineffective and not enforced.”

“Age of infrastructure plus new PFI build means space very limited and theatres not actually custom designed for my speciality.”

“One new hospital in the region I know has several single rooms that look like they have single and negative pressure controls, but in actual fact no system was actually installed to allow this to happen.”

Comment: These remarks make depressing reading. To have even a single PFI (Private Finance Initiative) development building insufficient isolation facilities means an inferior service for patients has been approved. PFI is specifically designed to provide state of the art facilities. Trusts should not be allowed to waste public money in this way. Lord Warner, Chairman of the NHS Provider Development Agency in London, and a former Health Minister, has said new builds should be single rooms only (30.1.08 interview with Evening Standard).
Question 7: Antibiotics

In the Chief Medical Officer’s 2003 *Winning Ways* report, the “prudent use of antibiotics” is required by Action Area Five. This states that the “indiscriminate and inappropriate use of antibiotics to treat infection within a clinical service promotes the emergence of antibiotic resistant and the ‘super-bug’ strains”. Action Area Five therefore recommends prescribing in hospitals to be supported by clinical pharmacists, medical microbiologists and infectious diseases physicians on the staff.

In addition, NHS bodies are required to have in place core policies in relation to preventing and controlling the risks of HAI, laid out in the 2006 *Code of Practice*. Amongst these policies is antimicrobial prescribing, which includes the putting in place of procedures to ensure prudent prescribing.

(a) Are your antibiotics practices monitored by the pharmacist?

![Pie chart showing 93.1% Yes and 6.9% No]

(b) If not, why not?

There were 2 main reasons: other staff were monitoring or no pharmacists were available.

“We have 0.2 whole time equivalent pharmacy input for the whole directorate”

“...not yet funded”

“Pharmacists have inferior training.”

“The pharmacy department is off site”

Comment: It is good news that most trusts are complying with Winning Ways but, even here, 6.9% are not, and the quotes above give examples of reasons for this.
Question 8: Bed Occupancy

The National Audit Office’s 2000 report *The Management and Control of Hospital Acquired Infection in NHS Acute Trusts in England* highlighted the issue of bed occupancy in relation to infection control. At a subsequent Public Accounts Committee meeting the NHS Executive recognised that “more effective bed management can help reduce hospital acquired infection.”¹

Higher bed occupancy is considered inconsistent with good infection control practice. However government priorities to reduce waiting times have seen bed occupancy rates rise. In 2006 the Department of Health reported bed occupancy rates of 84.6%, far above the 75% rate which is internationally considered the ideal rate to effectively control infection.

This question seeks to build on the information given in the National Audit Office’s 2004 report, *Improving patient care by reducing the risk of hospital acquired infection: A progress report* which stated more than 71% of trusts were operating bed occupancy rates higher than the 82% target the Department of Health has previously hoped to achieve. It has been specifically phrased to ensure that the response is not reliant on the simple statistical evidence of bed occupancy rates but looks wider and considers the impact of current rates, regardless of their exact value.

Do you believe your bed occupancy rates are compromising good infection prevention and control practices?

![Pie chart showing responses: Yes 54.5%, No 30.5%, Unknown 14.9%]

Comment:
Patients should be alarmed that 54.5% of respondents confirmed that bed occupancy rates were compromising good infection prevention and control practices. Government policy must guarantee patients’ safety instead of putting it at risk by setting targets to be achieved without consideration for infection control and prevention. Bed occupancy problems faced by the majority of NHS trusts are longstanding. Specific solutions need to be developed urgently to resolve this issue. It is intolerable that the basic HAI prevention requirement of a 75% bed occupancy rate remains a distant target in almost all NHS hospitals. There is a continuing failure to act on this vicious circle in which HAIs lengthen stays, thereby increasing pressure on beds, thus reducing availability.

Question 9: Department of Health Programmes and Government Legislation

Saving Lives
Launched in June 2005 and updated in August 2007 Saving Lives is a delivery programme to reduce Healthcare Associated Infections in line with the NHS aim to halve MRSA bacteraemia by March 2008. The programme uses evidence-based good practice and clinical information to provide the tools and resources for NHS organisations to reduce the risk of HAI and improve patient safety.

The Saving Lives programme includes assessment and action plan tools based on the Duties of the Health Act Code of Practice 2006 as well as High Impact Interventions (HIIs) which allow staff compliance to clinical procedures to be measured.

Saving Lives is designed as a “framework for organisation-wide improvement on infection rates” (Introductory letter from the Chief Nursing Officer and the Chief Medical Officer, Saving Lives, 2007) and provide practical assistance to Chief Executives and Trust Boards in implementing current legislation and best practice on infection control.

The programme does not itself have any specific requirements but instead is designed to be used in the implementation and evaluation of existing legislation. Participation in the programme is helpful in demonstrating compliance with the Health Act Code of Practice.

Epic2
The Epic guidelines were commissioned in 1999-2000 by the Department of Health to develop standard principles for the prevention of HAI. They also made specific recommendations to reduce infection “associated with the use of short-term indwelling urethral catheters . . . and with central venous catheters in acute care” (Journal of Hospital Infection (2001) 47(Supplement): S5–S9).

The guidelines were subsequently reviewed and updated in line with new research evidence and in February 2007 the updated Epic 2 guidelines were issued. These provide “comprehensive recommendations for preventing HAI in hospitals and other acute care settings based on the best currently available evidence”.

The guidelines are divided into four distinct interventions, with all recommendations considered essential and are designed to be incorporated into local guidelines.
The areas covered are:
1. Hospital environment hygiene;
2. Hand hygiene;
3. The use of personal protective equipment;
4. The safe use and disposal of sharps.
Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections

The Code of Practice is designed to help NHS bodies plan and implement how they can prevent and control HAI. **Compliance with the Code is a legal requirement** and failure to observe it can result in Improvement Notices being issued by the Healthcare Commission, or in an organisation being reported for significant failings and placed on “special measures”.

Each provision of the basic Code applies to Acute Trusts and is constituted by three sections:
1. Management, organisation and the environment
2. Clinical care protocols
3. Health care workers

Other specified provisions apply to other NHS bodies, including any NHS Trust established as a mental health trust, ambulance service, blood authority or any Primary Care Trust.

Question 9
Are you familiar with the following Department of Health programmes and Government legislation?

(a) Saving Lives

No 18.2 %
Yes 81.8 %

(b) Epic 2

No 59.8 %
Yes 40.2 %
Comment:
Patients will be deeply concerned that more than half of their frontline healthcare professionals are unaware of the guidelines of *Epic 2*. There are serious faults in a health system where such large percentages of frontline staff are unaware of these 3 central pieces of guidance on infection control. The *Health Act 2006* placed a legal duty on NHS staff to comply with best practice. Those of our respondents who say there is a culture of ignoring guidance are correct.
The Patients Association expects the Healthcare Commission and its successor from 2009 to continue its work to ensure compliance and issue improvement notices where necessary.

Question 10:
Do you know the level of compliance within your department/Trust?

(a) Saving Lives
(b) Epic2

(c) Health Act 2006 – with specific emphasis on management, organisation and the environment

Comment:
Once again, patients should be aghast at the lack of such basic knowledge about compliance in some trusts. It should also be a matter of deep concern to those issuing guidance at the Department of Health. Individual Members of Parliament at Westminster or Holyrood, and Assembly Members in Wales and Northern Ireland, as well as local councillors should take
urgent action to ensure compliance within their locality. Ignorance of the law is no defence in the NHS as well as elsewhere.

Question 11:
On a scale of 1-5 (1=great impact, 5=no impact at all), to what extent do the following impact on your and colleagues’ daily activities?

(a) Saving Lives
Average= 2.6

(b) Epic2
Average= 3.2
Comment:
Patients can see from these charts that for substantial numbers of frontline infection control staff the guidelines issued by the Department of Health and legislation enacted in 2006 have “no impact at all” on their work. It is good that more than half of respondents reported significant impact of the three main guidelines on infection control but clearly there is something wrong with methods of dissemination and compliance. Healthcare professionals need concise and very practical information on infection control; information that doesn’t add to their workload but helps them manage it while respecting good practice.

Question 12:
If your answers to Q.10 above are not “full compliance” in each case, what is preventing this?
Answers were ranked as follows:

- **Board Leadership**: 2.8
- **Lack of manpower to implement changes**: 1.8
- **Lack of clinical evidence**: 3.1
- **Insufficient Funding**: 2.2
- **Other**: 2.14
- **Lack of management support**: 2.7

“Most difficult issue is getting staff to change behaviour.”

“Insufficient funding/Board leadership/lack of manpower/lack of management support”

“Infection control is very important in the trust. I cannot indicate “full compliance” when the documents you refer to are just 3 of the hundreds (literally) which shower down on us each year. I can’t remember them all.”

“Have not heard of these documents”

“In some areas . . . clinicians see some IC measures as part of management . . . and lacking evidence. The BMA do not help in this.”

Comment:
Funding is usually blamed for failings in the NHS. These findings reveal, however, that the failing here is not financial but managerial. The top management responsibility in each Trust lies with the Board. Implementation of guidance is their responsibility. 1 in 5 Trusts Boards are failing in their leadership role, while continuing to be remunerated from public funds. They serve patients in their area, and patients are entitled to a better service from some of them than this. The role of SHAs in this regard also requires scrutiny.
Question 13: Responsibility & Leadership

“The chief executive carries ultimate responsibility for assuring the quality of services provided by the trust. The chief executive should therefore ensure that prevention and control of infection is a part of the trust’s programmes for clinical governance and the safety of patients”

“The trust’s board must assure itself that the trust has arrangements in place to prevent and control infection”.


The Health Act Code of Practice Duty 2 requires NHS bodies to “have in place appropriate management systems for infection prevention and control” with specific mention of allocating responsibility, although, it does not stipulate where this responsibility must lie. However, it is clear that reducing HAI can not be achieved solely by clinical staff. Senior management, especially the chief executive and board must be involved in shaping and leading infection control and prevention.

The Healthcare Commission’s 2007 report highlights “the importance of the visibility of senior managers in their advocacy of good practice in relation to the prevention and control of infection” and suggests that boards of trusts could emphasise infection control through its inclusion in other aspects of strategic planning.

Who is responsible for implementation of or compliance with national infection control guidelines and legislation within your trust?

<table>
<thead>
<tr>
<th>Role</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Executive</td>
<td>42.1%</td>
</tr>
<tr>
<td>IC Team</td>
<td>42.3%</td>
</tr>
<tr>
<td>Clinical Director</td>
<td>32.3%</td>
</tr>
<tr>
<td>IC Link Nurse</td>
<td>38.5%</td>
</tr>
<tr>
<td>Director of IPC</td>
<td>27.8%</td>
</tr>
<tr>
<td>Modern Matron</td>
<td>47.7%</td>
</tr>
<tr>
<td>Everyone</td>
<td></td>
</tr>
</tbody>
</table>
Answers were ranked as follows:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Chief Executive</th>
<th>IC Team</th>
<th>Clinical Director</th>
<th>IC Link Nurse</th>
<th>Director of IPC</th>
<th>Modern Matron</th>
<th>Everyone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.9%</td>
<td>2.2%</td>
<td>3.3%</td>
<td>2.8%</td>
<td>2%</td>
<td>3.2%</td>
<td>2.3%</td>
<td></td>
</tr>
</tbody>
</table>

Comment:
It is welcome that frontline staff share the Patients Association view that “everyone” is responsible. However, for this to become a reality it is essential that there are improvements to the overall results of question 12. Good intentions are worthless without robust cascading of the information to “everyone”.

Question 14:
(a) On a scale of 1-6 (1=greatly supportive, 6=not supportive at all), to what extent is your trust supportive towards individual staff members identifying and promoting best practice in infection control?
Comment:
These responses are shaming to Trust leadership. There is an identified problem with ensuring top-down information reaches everyone (Questions 10-12 above). These results compound the problem by revealing that less than 20% of Trusts (2 out of 10) support “everyone” in promoting best practice. This is not the standard of leadership required to improve the infection control standards in the NHS.

(b) If you rated your Trust between 1 and 3 (included), please give us specific examples of such individual staff-led best practice:

“Supervision of handwashing by everyone”

“Department rewarded at annual trust awards for cutting HA-MRSA to zero”

“Trust has adopted zero tolerance approach.”

“Specific ward leads enforcing hand washing – regular audits Saving Lives initiatives.”

“Good visiting guidelines – bedside cleaning check list – junior doctor training programme”

“Ward sisters, infection control team & artist-in-residence working with staff & patients to design information . . .”

“. . .Glow boxes in all community hospital settings ... “

“Rolling up shirt sleeves – continuous regular audit of handwashing/gel application”

“Installation of extra sinks to promote handwashing. Research into insertion of catheters”

“On-call availability of infection control team”

“Consultants and senior nurses conducting handwashing audits and revealing outcomes ‘name and shame’”

“Every 2 weeks a Trust member chairs the strategic infection control group.”

“Screened ward for elective orthopaedics”

“Wash the Doc competition staff given prize for . . . getting people to demonstrate washing their hands”

“Prizes for innovations in infection control. Very supportive infection control nurse. Posters around hospital”

“All staff take great pride in the fact that we are an MRSA-free hospital and are working together to keep it that way.”
“Getting the curtains . . . changed on a regular basis. It took 4 months of constant arguing with the . . . contractors to organise curtain changes every 2 weeks with special arrangements for soiled curtains. Previous to this no one could remember them ever being changed!”

“...Spot checks”

“In mental health/LD trust, infection control has not always appeared to be a part of core business. This has changed in the past 12 months, with huge emphasis on our partnership with other NHS providers ... dedicated infection control nurse. Generally we have low numbers of infections, usually as a result of frail elderly or disabled individuals being discharged to us from acute trusts. Our skill is in managing this.”

“Team Nurses were supported to carry out audit of infection control rates, change practice and teach other nursing staff best practice.”

c) If you rated your trust between 4 and 6 (included), please elaborate:

“...Targets are constantly mentioned but ‘patients’ are not.”

“Depends which member of staff is asked. Very senior support is good, the rest is appallingly bad.”

“Clinical governance within the trust has been destroyed by management activity. All statutory groups have been disbanded and staff ‘let go’. “

“They admit acute patients to MRSA-controlled orthopaedic joint replacement bays during bed crisis...”

“Resistance to change”

“Targets dictate that we are only to have 6 minutes between each case. This is not achievable with only 2 staff, and all the other tasks, e.g. clear up from the last case and set up for the next.”

“The trust is reactive rather than proactive to infection control – they do not listen until an incident occurs.”

“They don’t support staff who wish to change and improve practice, they don’t allocate resources to improve standards, they don’t allow staff to attend infection control meetings, etc.”

“I’m annoyed by this survey. Why are you asking these questions to people like me who have our faces against the coalface and no awareness of broader issues? In military terms I’m a foot soldier, my line manager might be a NCO and these questions are for the generals.”

“Greater input and commitment required from senior clinical staff and managers.”

“Reluctance to invest in new technology”
Question 15: Compliance

NHS bodies are required under the Code of Practice to have in place a programme of audit to ensure that key policies and practices are being implemented appropriately. This section examines where in the department or trust, responsibility for auditing compliance with guidelines lies and whether frontline staff are confident that this compliance is being achieved.

Within your trust who has responsibility for monitoring/auditing compliance with Department of Health guidelines for infection control?

“Other”:

“Infection control champions and audit nurse”

“Matrons”

“Board takes collective responsibility at the end of the day.”

“No idea”
Question 16:
On a scale of 1-6 (1=not at all confident, 6=fully confident) how confident are you that your Trust’s staff practice on infection control complies with current guidelines?

Average= 4.3

Comment:
These confidence levels are encouraging by themselves. However in view of the answers to Questions 10-14 above, it is not easy to work out what the basis for this confidence is. The Department of Health’s visits to determine compliance would appear to offer confirmation or lack of it in individual Trusts.
The *Health Act 2006 Hygiene Code* Duty 11 requires that in all NHS trusts staff are “suitably educated in the prevention and control of HAI”. In particular it stipulates infection control and prevention be part of induction programmes for all new staff alongside a programme of ongoing education for existing staff.

This requirement is also included under Duty 2(d) which states that all NHS bodies must ensure “that relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection” and included in the *Healthcare Commission Core Standards* (standard C11).

Infection Control evaluation in staff performance assessments

“Infection control should be considered as part of the personal development plans for all healthcare staff.”

Action Area Four, *Winning Ways Report* from the Chief Medical Officer, December 2003

It is recognised that whilst infection control and prevention training and evaluation are common amongst nursing staff other clinical staff, in particular medical staff are generally far less likely to have these training and assessment requirements. The Healthcare Commission found in 2007 that 34% of trusts did not include objectives for the prevention and control of infection in Personal Development Plans (PDPs) for medical staff. More worryingly, in 12% of trusts no staff working in clinical areas had infection control and prevention included in their annual appraisals.

The importance of including infection control in appraisals was clearly demonstrated in the same report which showed lower rates of MRSA in trusts that had done so for both nursing staff and other clinical healthcare workers (besides medical staff).

**Question 17:**
(a) Do your staff performance assessments include evaluation of compliance in infection control?
(c) If no, why not?

“We are looking into introducing.”

“Hadn’t thought of it!”

“The only staff I can comment on are doctors and I recently asked them if they were aware of our infection control policy – none were.”

“Even mandatory training (including infection control) has been sidelined in an effort to meet waiting list targets.”

“It is not seen as an important enough issue to spend time on staff training.”

“It has been two years since I had a performance review and I am still waiting.”

“I can only speculate, but I doubt very much whether any of our managers have noticed which staff lay up carelessly for cases or behave sloppily during operations.”

Comment:
To be certain “everyone” takes responsibility for infection control, trust boards must ensure that compliance is part of all staff appraisals. These answers are unhelpful to that process if over one third of respondents either do not know or do not have such an assessment.

Question 18: Frequency of Infection Control training

The National Audit Office 2004 report recommended that infection control training be made mandatory for all staff. However, in the latest Healthcare Commission report only 11% of trusts had ongoing programmes of training for medical staff or for non-clinical staff working in clinical areas. Whilst all trusts had training programmes for nursing staff, this worrying statistic was something this survey aimed to explore further.

When was the last time you received training specifically related to infection control?

Training in infection control and prevention is vital to reduce the risk of infection for patients. The Patients Association also recognises that many NHS staff work long hours in challenging environments. It is important therefore that staff have training as part of the working hours rather than an out-of-hours requirement. Making training part of the working day also reinforces that it is a central element of posts, not merely a desirable skill.
Question 19:

(a) Is training offered to you during normal work hours?

(b) If no, why not?

“Internet based – available any time”

“Don’t have time and my colleagues wouldn’t support me in taking ‘time out’ of clinical duties. Instead I did training online in my own time.”

“No time/no staff”

“Financial constraints within trust has limited training.”

“Theatre lists are continually over-filled to ensure compliance with Waiting Times Guarantee.”

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can’t remember</td>
<td>5.4%</td>
</tr>
<tr>
<td>Last Month</td>
<td>31.8%</td>
</tr>
<tr>
<td>Last quarter</td>
<td>24.3%</td>
</tr>
<tr>
<td>Last 6 months</td>
<td>14.5%</td>
</tr>
<tr>
<td>More than 6 months</td>
<td>19.5%</td>
</tr>
<tr>
<td>Never</td>
<td>4.6%</td>
</tr>
</tbody>
</table>
“Theatre staff are never included in meetings/training, etc. We have to gatecrash.”

“Any time I get offered training it gets cancelled on the day because of staff shortages.”

**Question 20: Access to Training**

In 2007 it was shown that only 54% of trusts provided protected time for training for all staff working in clinical areas and 20% did not provide protected time for any staff. With this in mind the Patients Association was keen to explore whether time restriction was the only factor limiting staff access to training. We were also interested in how staff ideally would want to access this training and whether they feel they are supported currently to do so.

By gathering information on the current situation with regards to access for infection control individual training, departments and trusts can address training issues and ensure sufficient quality and frequency of training.

**What most limits your access to appropriate infection prevention and control training?**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>29.2%</td>
</tr>
<tr>
<td>Not a Trust priority</td>
<td>3.2%</td>
</tr>
<tr>
<td>Lack of Management support</td>
<td>6.3%</td>
</tr>
<tr>
<td>Other</td>
<td>5.9%</td>
</tr>
<tr>
<td>Not relevant to my job</td>
<td>4.1%</td>
</tr>
<tr>
<td>Lack of resource to cover your absence</td>
<td>34.7%</td>
</tr>
<tr>
<td>Lack of resource to carry out training</td>
<td>12.1%</td>
</tr>
</tbody>
</table>

“Other” included these comments:

“Nothing gets in the way – it is mandatory”

“Trust infection control team needs expanding to provide increased educational role.”
“Not an issue”
“Most study that I need can be attended and I have support time/finance to attend.”

“There is only me in post at the moment.”

“All the other training that I have to attend. I also have to work.”

“Huge problems in getting management support in rolling out mandatory training to medical staff”

“Too much else to do”

Question 21:
What is your preferred method of receiving or accessing training?

![Bar chart showing preferences for training methods]

- Web based: 47.6%
- Distance Learning pack: 5.1%
- On the job training: 24.1%
- Other: 3.1%
- Offsite training course / workshop: 20.7%
- None: 0.8%
- Non-Applicable: 5.2%

Question 22:
Are you aware of any such training programmes that are available to you?

![Pie chart showing awareness of training programmes]

- Yes: 72%
- No: 22.8%
- Non-Applicable: 5.2%
Question 23:
(a) Are you supported by your employer in accessing such training?

(b) If no, why not?

“Priority is to meet targets.”

“No time for CPD in working week. I have to do it in my free time. My medical colleagues would probably criticise me for not doing ‘clinical work’ and my senior consultant is likely to take the attitude that this is ‘nurses’ work’.”

“Waiting list targets again!”

“Management do not support staff training.”

“All training/education had been suspended to save money. Now quality is supposed to be the priority – but never seems appropriate to theatres, therefore we set out own training and protocols.”

“Having staff on maternity leave for 1 year and not being able to replace them impacts on the service. When a person is having a baby they can be off sick for months and it is not classed as being sick because it is related to being pregnant.”

Comment:
The preferred access to training is matched with the ability to do so for 72% which is good news for those staff. However staff who are not supported by their employer (13.5%) or do not know how to access training by their preferred method (22.8%) are being put at a disadvantage which may render the trust liable under the Health Act 2006.

Question 24: Leadership in Infection Control

NHS trusts are responsible for ensuring their compliance with infection control and prevention legislation in order to provide the safest possible environment for patients. However, the role and
duty of Strategic Health Authorities in relation to disseminating best practice to assist trusts in achieving this aim is often overlooked. As a key link between the Department of Health and the local NHS they are designed to ensure local health services offer a high quality whilst developing plans for future improvement. As a national and local concern infection control is an area in which Strategic Health Authorities should ensure best practice in trusts is disseminated to all trusts within its SHA area.

(a) Is your SHA taking the lead in the dissemination of best practice around infection control and patient safety issues?

(b) If no, why not?

“Other”: Almost universal attack on SHAs:

“Very poor leadership by SHA. Lots of targets but poor understanding of real issues”

“We have not received any specific assistance from our SHA on tackling HAI.”

“Don’t know – please ask them”

“SHA not evident. All initiatives appear to have come from within the Trust.”

“SHA is a remote body unconcerned in best practice.”

“Information on best practice is better obtained through other networks.”

“Do not know of any SHA initiated programmes – all Trust based.”

“(They) leave things to last minute, e.g. send email and expect response next day.”

“Who are they?”

“What is an SHA?”

“Communication from SHA is poor unless finance is involved.”

“Too busy closing services”
“Don’t know exactly what they are doing.”

“What SHA? All but invisible to clinical staff.”

Comment:
The annual budget for SHAs in 2008 is £6.9bn.

If nearly one third are not taking the lead, in the view of our respondents, the Patients Association queries:
   a) Value for money of SHAs;
   b) Their role in effecting improvement in their local NHS.
The comments we received from front line staff are listed above but it is a cause for concern that some of the views are expressed in such terms. It must be a barrier to good service for patients that such views exist within one NHS.

Question 25: Disciplinary Procedures
(a) Has the Health Act 2006 resulted in change to disciplinary procedures for staff?

(b) If not, why not?

“No reason why this should. Failure to follow trust policy has always been a disciplinary issue.”

“Unaware of Act”

“Procedures already in place. Job descriptions are being continuously upgraded to reflect infection control responsibilities fully.”

“Not thought to be an appropriate means to change behaviour.”

“Management don’t want to know.”

“Strict procedures in place before Health Act 2006.”
“Certain grades of staff will be challenged but others not – political!”

**Question 26: Annual Report**

Under Duty 5 of the *Health Act 2006 Hygiene Code* NHS bodies are required to make “suitable and sufficient information available” both to patients regarding the risk of HAI and any preventative measures that ought to be taken, but also to the public about the organisation’s general systems and arrangements for preventing and controlling HAI. Trusts must ensure that this information is both easily accessible and meets the needs of its local community.

**Do you produce and publish an Annual Infection Control Report to the Board?**
“Major staff cuts in cleaning and nursing staff as a result of need to break even financially ...”

“The majority of staff are very willing to comply but there are a few die-hards who refuse (mainly medical consultants). Disciplinary action seems the only way ... as peer pressure doesn’t seem to help.”

“We have zero rates of MRSA and C. Difficile for 4 years and are active in maintaining these excellent results.”

“There are issues with infection control that need to be accepted; infection control was a Cinderella service and will take many years to change this...cleanliness is intrinsically linked to infection control but cleaners need to be paid more to do their jobs.”

“The problem dates to the compulsory move from in-house services . . . extending visitor hours has had some effect in increasing HAIs.”

“Why doesn’t the DH manage its instructions better? Why do I learn about DH initiatives via BBC website?”

“Many problems would resolve if we had a hierarchical structure for doctors and nurses that was meaningful and effective.”

“Failure to isolate a patient is reported as a serious untoward incident. Such incidents are rare.”

“... No question included as to the role played by patients and visitors in compliance.”

“We get a lot of guidance, best practice, toolkits and monitoring but some of the basic questions remain without clear central policy, e.g. what should MRSA screening policy be?”

“Looking further afield, community usage of antibiotics needs to be addressed.”

“All areas are working ...in a way that is identical to Maidstone. It is only a matter of time before a similar event unless the imposed management team start to accept they are responsible for the clinical care offered.”

“Beds don’t get cold between patients, let alone cleaned.”

“It is the top priority of the Trust Board, CEO and all modern matrons to get our rates down to nil. Patients are choosing to come to our hospital because infection rates are the lowest in (the region).”

“Every single patient’s positive MRSA or C. Difficile is discussed at the bed meeting everyday so positive patients are quickly isolated in a side room.”

“Allocating a defined amount of money is not the answer. This money must be recurring to enable Trusts to raise and maintain standards.”
“Junior staff are not assertive enough to challenge surgeons and anaesthetists...”

“As long as trusts attempt to meet the 18 week target we will never have enough beds and resources to cope efficiently. No down time to do deep cleans, etc. and staff are chasing around trying to meet the extra demands.”

“We have diminishing numbers of staff to do more work in order to meet targets. Morale is very low.”

“Surgical dressings must be fit for purpose. Screening patients prior to surgery again must be a priority (and) would reduce HAI in surgical site infections and catheter associated infection which stands at 80%.”

“As a theatre sister it really makes me sad to see bad practice and negligence when it comes to infection control. I find it extremely stressful, as the patients’ advocate, in my daily job.”

“Better patient education on MRSA – they are not aware it is part of the natural flora on the skin of many people.”

“Cleaning should come fully back to the supervision of senior nurses as it was before all the changes in the 80s.”

“Our theatre manager and directorate managers are not ‘clinical’ and cannot be persuaded how important this issue is.”

“I have friends in other trusts and we all say that top priority should be given to teaching junior registrants and consultants about proper infection control in operating theatres with frequent reminders!”

“One HAI is one too many”
Question 2 (c):
Which Other HAIs?

The individual responses received are listed below:

- ESBL
- VRE
- PS
- RSV
- ESBL Bacteraemia – UII
- MSSA, CNS Line inf, Norovirus, ESBL, E. Coli
- Rotavirus DSV
- Norovirus
- Norovirus and acinetobacter
- ESBC – Acinetobacter
- Non resistant staph. Aureus
- E-coli, TB, HEp B & C
- ESBL
- ESBL
- Norovirus - more outbreaks in last quarter 2007 & ESBL strain of Klebsiella - mainly UTIs greater than 2006
- ESBLs / VRE
- Unable to access exact percentages as they are collated by the local acute trust
- Staph Aureus
- ESBL / Norovirus
- VRE / Orthopaedic site infections - data not complete to date
- Catheter Acquired Infections
- ESBL
- Norovirus
- vancomycin resistant enterococci (2) other gram primitive cocci
- Extended spectrum beta-lactamase producing organisms (ESBLS)
- ESBLS - Surveillance organisms
- Acinetobacter
- VRE, Acinetobacter (very low levels)
- ESBLS
- VRE
- Acinetobacter
- None apart from Norovirus
- ESBL - VRE - MSSA
- ESBL, MSSA bacteraemia
- Acinetobacter, ESBL
- ICU: multiple HAIs relation to lung
- ESBL
- Others are not formally monitored
- VRE
- All
- Not such a problem with kids!
Urinary tract infection, surgical site infection, hospital-acquired pneumonia, skin and staff tissue infection
ESBL is rising
VRE
Acinetobacter
ESBLs
ESBLs
We have calculated our decreases on a comparative period over 2 years
VRE
Very low level
Norwalk Virus
VRE
Acinetobacter
None recorded in 2007. No cases found
Acinetobacter
GRE
VRE - Septicaemia
Can’t remember organisms names but 4 dramatic rise
None
RSV Bronchitis
ESBL
None
This is a dental hospital
We have no case
VRE/GRE
VRE
Don't know for Other HAI: I don't do useful surveillance routinely (yet) on other HCAI -
Everything: surgical wards infection, UTI, IV line infection
VRE
REPORT OF STRATEGIC HEALTH AUTHORITY
INFECTION CONTROL QUESTIONNAIRE

EXECUTIVE SUMMARY

There are 10 Strategic Health Authorities: London, South West, North East, Yorkshire and The Humber, East Midlands, East of England, South East Coast, South Central and North West Midlands. North West SHA’s response was promised late, but did not arrive.

In general, the money has been allocated as intended with minimal sums retained by SHAs for SHA-wide projects or contingency.

The nursing directorate has taken the lead on distribution.

Audit is in place with monthly monitoring by SHAs.

QUESTIONNAIRE

Q.1. Has your SHA received £5 million?

8 had received the funding; 2 did not answer, but 1 answered additional questions so presumably received money.

Q.2. How many trusts have applied for some or all of £5 million?

5 said all trusts had applied; 4 gave numbers – 48, 39, 20, 16 in each case more than half.

Q.3. Who has responsibility for allocation?

Strong Nursing directorate bias: either alone or in collaboration with other SHA performance managers. One SHA allocated to PCTs for distribution and monitoring.

“Turnaround Director HAI”

“Programme Manager for £5m HAI reduction”
Q.4. How were the funds allocated by %?

Most failed to answer in this way but gave us lists by
a) Allocation –
   b) Activity, e.g. cleaning, hand hygiene training
   c) Bed/per capita basis of allocation between Trusts

“The largest proportion of our budget £1,588,000 will be spent on creating or enhancing isolation facilities.”

“£16k on communications campaigns.”

“£1,005,000 will be spent on staff. The vast majority of this money is destined for additional clinical staff including pharmacists, doctors and nurses.”

Q.5. Projects allocated?

We received hundreds of individual examples of projects including:
local intensive support team inspecting highest risk trusts, MRSA rapid detection screening, line care, probiotics use pilots, new handwashing facilities, isolation wards conversions, antimicrobial cleaning products.

Q.6. Is there a formal audit process?

8 responses – 7 confirmed monitoring schemes in place. 1 said it was impossible to do this in isolation. 4 described monthly monitoring. 3 described different monitoring schemes.

Q.7. Who is responsible for audit?

6 monitor at SHA level. 2 DIPC monitors – at which level is not stated but presumably Trust. 1 PCT monitor and report to SHA subsequently

Q.8. Timetable within which SHA expects to see impact of allocation?

1 said no (as for Q.6). 4 = March 2008. 1 = immediate results expected. 2 = agreed implementation timetables. Interestingly, 1 (East of England) said it would provide its own additional funding equal to the first grant for a second agreed action plan, thereby providing longer term funding.

Q.9. Are there any time constraints on delivery of improvements?

5 answered yes. 1 answered no. Of those saying yes, 3 cited the March 2008 timeframe, 2 gave the difficulties of recruiting staff.
At the conclusion of our work, and in further response to Question 26 of our main survey, we decided to contact 20 trusts websites, chosen at random, to see how easy it would be for a patient to access the mandatory Trust Board’s Annual Infection Control Report. Our results are listed below. “Click” refers to the number required to get to the appropriate site on the individual website. The relevant websites are also listed, and it is possible subsequent improvements have been made.

<table>
<thead>
<tr>
<th>Name of Trust</th>
<th>How long it took</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea and Westminster Hospital NHS Foundation Trust</td>
<td>4 clicks</td>
<td><a href="http://www.chelwest.nhs.uk/documents/about/documents/board_meetings/may06/4.2.1%20Staff%20Survey%2004.05.06.pdf">www.chelwest.nhs.uk/documents/about/documents/board_meetings/may06/4.2.1%20Staff%20Survey%2004.05.06.pdf</a></td>
</tr>
<tr>
<td>Barnsley Hospital NHS Foundation Trust</td>
<td>1 click</td>
<td><a href="http://www.bhnft.nhs.uk/">http://www.bhnft.nhs.uk/</a></td>
</tr>
<tr>
<td>Bolton Hospitals NHS Trust</td>
<td>NO FIGURES</td>
<td></td>
</tr>
<tr>
<td>Trust Name</td>
<td>Clicks</td>
<td>Link</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>NO FIGURES</td>
<td><a href="http://www.leedsth.nhs.uk/cgi-bin/search.cgi?wm=sub&amp;q=figures&amp;ul=">http://www.leedsth.nhs.uk/cgi-bin/search.cgi?wm=sub&amp;q=figures&amp;ul=</a></td>
</tr>
<tr>
<td>Royal Liverpool Children’s NHS Trust</td>
<td>4</td>
<td><a href="http://www.alderhey.com/RLCH/assets/Accounts%202006-07.pdf">http://www.alderhey.com/RLCH/assets/Accounts%202006-07.pdf</a></td>
</tr>
<tr>
<td>County Durham and Darlington Acute Hospitals NHS Trust</td>
<td>2</td>
<td><a href="http://www.cddft.nhs.uk/NR/rdonlyres/DC7A0515-F8D7-45A4-8A38-F0335D2D2E59/0/AnnualReport1Apr06to31Jan07.pdf">http://www.cddft.nhs.uk/NR/rdonlyres/DC7A0515-F8D7-45A4-8A38-F0335D2D2E59/0/AnnualReport1Apr06to31Jan07.pdf</a></td>
</tr>
<tr>
<td>Birmingham Children's Hospital NHS Foundation Trust</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Brighton and Sussex University Hospitals NHS Trust</td>
<td>NO FIGURES</td>
<td></td>
</tr>
</tbody>
</table>
The Patients Association is an advocacy group that highlights the concerns of patients. The Patients Association works with government and a broad range of individuals and organisations involved in healthcare to develop better and more responsive health services.

The Patients Association advocates for greater and equitable access to high quality, accurate and independent information for patients, for greater and equitable access to high quality care and for involvement in decision making as a right.

After 40 years The Patients Association still has a vital role to play. Our role is to help provide patients with the information that is difficult to access, often hidden away by vested interests. Our range of booklets help and so does our Helpline, but this is not enough. Over the coming months and years we aim to increase the amount of information for patients so when we are offered a choice we know what we are choosing and why we are choosing it. The Patients Association is well placed as a platform to facilitate a dialogue between all the stakeholders in a patient’s care, from the NHS itself to companies that produce the medical devices across to medical insurance companies and the pharmaceutical industry. The Patients Association is in a unique position, always challenging, always independent and always there for patients.

The Patients Association Helpline 0845 608 44 55 is there to help patients. It is a lo-call rate telephone number to help inform patients and gather their views.

We also have a range of booklets available for patients, including Living Wills – a guide for patients, How to make a complaint, You and your doctor, You and your dentist, How to access your medical records.

We have also produced a number of reports, including Infection Control & Medical Decontamination – a Survey of Strategic Health Authorities: Infection Control & Medical Devices and Tracking Medical Devices & the Implication for Patient Safety.

Booklets, reports and a lot more are available on our website www.patients-association.com