



**From the office of  
Dr Brian Iddon MP**

**Healthcare-Associated Infections:  
*Are we Doing Enough?***

**Chairs: Dr Brian Iddon MP  
Professor Nick Bosanquet**  
*Professor of Health Policy, Imperial College, London*

**House of Commons, 1<sup>st</sup> April 2009**

**The report from the meeting**

# Faculty

## Department of Health Policy and the Improvement Foundation

|                      |  |
|----------------------|--|
| <b>Ginny Edwards</b> | Head of Targeted Support Team, HCAI and Cleaner Hospitals Division, Department of Health |
| <b>Ruth Kennedy</b>  | Chief Executive of the Improvement Foundation  |

## Disease areas with a high risk of healthcare-associated infection

### Kidney Disease

|                                 |   |
|---------------------------------|---|
| <b>Dr Donal O'Donoghue</b>      | National Clinical Director for Renal Services (Renal Tsar)  |
| <b>Dr Roger Greenwood</b>       | Consultant Nephrologist, East and North Herts NHS Trust; and Chair, Patient Centred Service Group, East of England Renal Strategy |
| <b>Dr Richard Fluck</b>         | Consultant Nephrologist, Derby Hospitals NHS Foundation Trust   |
| <b>Mr Timothy F Statham OBE</b> | Chief Executive, National Kidney Federation   |
| <b>Fiona Loud</b>               | Chair, Kidney Alliance  |

### Diabetes

|                                 |  |
|---------------------------------|--|
| <b>Dr Jörg Huber</b>            | Principal Lecturer at Roehampton University  |
| <b>Professor Martin Stevens</b> | Professor of Medicine at University of Birmingham and Honorary Consultant Physician, Heart of England NHS Foundation Trust ( <i>unable to attend</i> ) |
| <b>Dr Prasad Yemparala</b>      | Consultant Physician in Diabetes and Endocrinology<br>Heart of England Foundation Trust Birmingham (Heartlands & Solihull Hospitals)                   |
| <b>Dr Reggie John</b>           | Associate Specialist in Diabetes and Endocrinology, Heart of England Foundation Trust Birmingham (Heartlands & Solihull hospital)                      |
| <b>Donna Castle</b>             | Campaigns Manager, Diabetes UK ( <i>unable to attend</i> )   |

### Musculoskeletal Conditions

|                          |  |
|--------------------------|--|
| <b>Ros Meek</b>          | Chief Executive, Arthritis and Musculoskeletal Alliance                      |
| <b>Dr Martin Duerden</b> | Medical Director, Bwrdd Lechyd Lleod, Colwyn Bay ( <i>unable to attend</i> ) |

### Cancer

|                                 |   |
|---------------------------------|---|
| <b>Ian Beaumont</b>             | Campaigns Director, Bowel Cancer UK                                   |
| <b>Ruth Liley</b>               | Assistant Director of Clinical Governance for Marie Curie Cancer Care |
| <b>Professor Nick Bosanquet</b> | Member of the DoH Advisory Panel on the Cancer Reform Strategy        |

### Infections, prevention and patient experience

|                         |  |
|-------------------------|--|
| <b>Dr David Jenkins</b> | Medical Microbiologist, University of Leicester and Lead Infection Control Doctor, University Hospitals of Leicester NHS Trust |
| <b>Martin Kiernan</b>   | President, Infection Prevention Society and Infection Nurse Consultant   |
| <b>Derek Butler</b>     | Chair, MRSA Action UK  |
| <b>Graham Tanner</b>    | Chair, National Concern for Healthcare Infection   |
| <b>Tony Field</b>       | Chair, MRSA Support  |
| <b>Graham Kendall</b>   | Freelance consultant, strategy and communications  |

### Policy implementation

|                      |                                       |
|----------------------|---------------------------------------|
| <b>Nigel Edwards</b> | Director of Policy, NHS Confederation |
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## Audience

**Baroness Masham of Ilton**

**Lynne Simpson** (DH Cleanliness Division)

**Robin Feline** (DH Cleanliness Division)

**Jane Heaton** (DH Renal Team)

**Patricia Johnson** (Improvement Foundation)

**Jean Smith** (Civil Service Pensioners Alliance and National Pensioners Convention)

**Juliette Millard** (Leonard Cheshire Disability)

**Graham Thompson** (Patient Governor, Sheffield)

**Arthur Newby** (Liverpool Patient and Public Health Reference Group)

**Diane Tolley** (Patient representative, Coventry)

**Maria Cann** (MRSA Action UK)

**Ruth Wollacott** (MRSA Support)

**Mike Barker MBE** (MRSA Support)

**Steve Ford** (Nursing Times)

**Heather Loveday** (Infection Prevention Society)

## Contributor unable to attend

**Stephen Bradshaw** (Public Affairs Consultant to the Spinal Injuries Association)

# Healthcare-Associated Infections: *Are we Doing Enough?*

**Chairs: Dr Brian Iddon MP**

**Professor Nick Bosanquet**

*Professor of Health Policy, Imperial College, London*

**House of Commons, 1<sup>st</sup> April 2009**

## Summary Overview

Dr Brian Iddon MP called the meeting to discuss progress being made towards meeting the objectives of the Government's "Clean Safe Care" policy in tackling healthcare-associated infections such as MRSA bacteraemias and *Clostridium difficile*, but not exclusively these, and to inform future developments.

The event was the first of its kind, bringing together expertise in healthcare-associated infections across policy-makers, clinicians and patient groups in major high-risk disease areas, researchers in microbiology, patient advocacy groups and the NHS. This report reflects the various views of this broad range of stakeholders.

A key aim of the meeting was to celebrate achievements in tackling healthcare-associated infections. A further aim was to highlight broad themes and identify fresh areas for further consideration, with the aim of informing future developments. Prominent among these was the importance of public and patient empowerment, and the vital role of the advocacy community in reaching millions of people with information and support, a critical factor in tackling healthcare-associated infections.

The key themes surrounding the goal of avoiding or reducing healthcare-associated infections were:

- **Considering the wider policy agenda, which is key to improvement**
- **Wide-ranging education is fundamental**
- **Engaged patients are partners in their own healthcare safety**
- **Disease-specific awareness is a top priority and patient groups have a major new role to play**
- **We need to maintain progress on reducing MRSA bacteraemias and *C. difficile* infections, while extending action against other and emerging pathogens**
- **Appropriate antibiotic prescribing and research on microbial resistance must be maintained**
- **All opportunities for preventing infection in hospitals should be identified and eliminated as far as practicable**
- **Improved hospital design will facilitate the avoidance of healthcare-associated infections**
- **Engaged NHS staff take pride and responsibility in making everything clean and 'ship-shape'**
- **Community-based care is in the spotlight**
- **Death certification is an issue.**

This report summarising the discussions will be widely circulated, including to patient groups across a range of therapy areas for whom the topic is new – but for whose members it may be highly relevant.

# Themes and ideas arising from the meeting

A key aim of the meeting was to celebrate achievements in tackling healthcare-associated infections. A further aim was to highlight broad themes and identify fresh ideas areas for consideration, with the aim of informing future developments. These broad themes and ideas were as follows:

## **Considering the wider policy agenda, which is key to improvement**

- A properly instituted root cause analysis programme should be instituted when outbreaks of infection occur in hospitals, to include investigation of patient's underlying illness to assess whether therapy and treatment could have contributed to bacterial infection.
- There is a science of how to run bed pools in hospitals, but it is not as widely used as many would want. There are some great examples where general medicine physicians have thought about the issue, but work on the systems of management and supporting middle managers in doing that is needed.
- The issue is not a regulatory one but one of local leadership, professionalism and responsibility from the ward right up to the board; understanding how we created the environment in which these things arose - to make sure that we did not do it again.
- There is an interesting question about what happened to professionalism and the role of front-line leadership. We should use the same kind of root-cause analysis that we use to understand how infections happen on how we got ourselves into a situation where patients were not the focus of attention, or people were not washing their hands.
- Multidisciplinary cross-clinical leadership and taking responsibility are key to achieving positive developments.

## **Wide-ranging education is fundamental**

- It is important to communicate widely that everyone should have a zero tolerance of avoidable healthcare-associated infections approach, and that everyone has a part to play in its achievement.
- Messages of good hand hygiene should be extended in the community as well as in hospital, using the full panoply of local media, TV and radio networks.
- Staff training, including postgraduate educational qualifications, together with best-practice sharing should continue to be implemented.
- General Practitioners need support in recognising healthcare-associated infections. Urgent expansion of the excellent workshops undertaken by the Improvement Foundation for GPs will enable care homes, residential homes, hospices and respite centres are to be able to meet the registration requirements of the Health & Social Act 2008.
- Simple ideas include: creating a "subjective norm" for hygiene ie "Yes to handwashing", or everyone entering a hospital carrying a clearly visible card saying, "*Don't touch me without washing your hands*".

### **Engaged patients are partners in their own healthcare safety**

- Patients need to know that it is acceptable to challenge staff when they do not comply with policies such as “Wash your hands”.
- Consistent and updated information on infection risks, the avoidance measures that patients and their families can take, and the guidelines about bringing personal items into the clinical setting from outside is needed, in language variants as necessary.
- Patient choice can be supported while maintaining health and safety standards.
- Early and open engagement should occur if there is a problem in a particular unit at a particular time, explaining to all involved that an infection has been detected and how it will be addressed.
- Healthcare professionals should have to disclose to patients whether they have a healthcare-associated infection.

### **Disease-specific awareness is a top priority and patient groups have a major new role to play**

- In disease areas where healthcare-associated infections have not historically been high on the policy agenda, they should be placed there, for example, inclusion in Dr Ian Gibson’s Annual Cancer Conference
- Educational outreach by patient groups is needed in the different disease areas; some conditions make patients more prone to healthcare-associated infection.
- The initiative to bring charities from different disease areas together could provide a good platform for mutual dissemination of information; the more patients and carers are informed of precautionary measures to prevent infection taking place the greater the reduction in costs in the longer term.
- An alliance of patient-groups working together in a positive advocacy campaign could significantly support the full implementation of the “Clean, Safe Care” policy.
- Where the disease burden is already heavy, it will be necessary to ensure that hygiene issues are sensitively discussed with patients.

### **We need to maintain progress on reducing MRSA bacteraemias and *C. difficile* infections while extending action against other and emerging pathogens**

- Full implementation of The Health and Social Care Act 2008 on specific alert organisms is needed, with the Care Quality Commission ensuring that policies are adhered to.
- Rigorous, reliable and comparable audits across all trusts will enable benchmarking and improvement plans to be constructed, with continuing inspections.
- It was suggested that a high level of surveillance be carried out, with all patients prospectively enrolled, monitored for the entirety of their inpatient stay and followed up in the community, to identify quickly any particular risk factors and incidence of healthcare-associated infections.
- Care should be taken to ensure that patients who may have a communicable healthcare-associated infection are not discharged from hospital early, posing a potential risk to the community.
- Clinical staff should be considered for screening, particularly where there are frequent occurrences of surgical site infections and bacteraemias that may have proved difficult to trace during root cause analysis, and appropriate measures taken to suppress the bacteria and protect patients.
- Research should be stepped up to identify a range of scientific interventions, and ineffective interventions avoided.

### **Appropriate antibiotic prescribing and research on microbial resistance must be maintained**

- Regular review of antibiotic prescribing and a high level of prescribing awareness among healthcare professionals in both hospitals and community are important.
- Antibiotic guidelines, prescribing of antibiotics supervised by senior staff, regular antibiotic ward rounds by a microbiologist, and antibiotic prescribing monitoring by a dedicated pharmacist is suggested.
- Additional research into microbial resistance, and new treatments, is suggested.

### **All opportunities for preventing infection in hospitals should be identified and eliminated as far as practicable**

- Earlier diagnosis allowing elective procedures, planned admissions, screening and decolonization should be the aim.
- Optimized timing of hospital admissions will mean that patients are not waiting in hospital unnecessarily for treatment.
- Bedspace management that restricts occupancy to planned, MRSA-screened admissions, with low transfer rates, should be the target.
- Units or beds could be ring-fenced for elective cases in general hospitals, with the goal of avoiding emergency patients being put into elective beds, to decrease the risk of infection.
- Less time-consuming surgical techniques eg laparoscopic surgery, and fistula surgery for dialysis lines will help to minimize the risk of infection.
- Patients should have adequate food intake to ensure that their immune system is not compromised.
- Staff should implement risk-reducing strategies, including use of facemasks, where these are appropriate and recommended by guidelines.

### **Improved hospital design will facilitate the avoidance of healthcare-associated infections**

- Sufficient numbers of single rooms and other flexible accommodation should be planned that will allow people to be nursed with better dignity and greater safety.
- The layout of facilities should encourage good hygiene practices.

### **Engaged NHS staff take pride and responsibility in making everything clean and 'ship-shape'**

- Engaging agency staff from a core group that is aware of hospital protocols, and involving housekeeping staff in developments around patient services, will encourage them to take pride and responsibility in making everything clean and "ship-shape".
- Non-compliance of staff with the "Clean Your Hands" policy, could be part of their contract of employment, and could result in disciplinary action.

### **Community-based care is in the spotlight**

- In order to reduce risks of infection in vulnerable patients, home care should be provided for patients as much as possible.
- Innovations such as training community nurses to undertake transfusion service in patients' homes, and greater use of oral medications, where these are available, should be supported.
- Good infection control prior to hospital admission should be ensured.
- Acute Trusts should pass information on to care homes and hospices with regard to a person's infection status.
- An augmented Care Homes strategy will be welcomed.

### **Death certification is an issue**

- The Coroner and Justice Bill proceeding through Parliament concerning the completion of Medical Certification on Cause of Death should provide for relatives or carers to express any concerns they may have, including healthcare-associated infections.

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# The presentations

## Introduction by Dr Brian Iddon MP

Tackling healthcare-associated infections is a huge and complex policy area of vital importance and is a top Government priority. Dr Iddon remarked that, because he speaks often with Alan Johnson, the Secretary of State for Health, he knows that Alan and the other Ministers in the Department of Health put this aspect of health policy at the top of their agenda.

The date of the meeting was auspicious, as April 1<sup>st</sup> marked the date that the Health and Social Care Act 2008 came into force. This was also the date by which all trusts would be offering MRSA screening for relevant elective admissions.

*“Because I speak often with the Secretary of State for health, I know Alan Johnson and the other Ministers put this aspect of health at the top of their agenda”.*  
Dr Brian Iddon MP

The Department of Health urges cross-community involvement. Everyone has a part to play, whether an official or elected representative, member of the public or patient, charity or healthcare professional. This being the case, the meeting brought together a wide range of disciplines and experience. In the first event of its kind, the event took a broad-brush view across the following aspects:

- Policy-making
- Disease areas with a high risk of healthcare-associated infections
- Scientific research
- Patient advocacy
- The NHS

The participants considered the level of public and patient awareness of healthcare associated infections, and the important role of patient groups at the “front end” of healthcare. Dr Iddon felt that everyone would possibly know of someone who had contracted one of these difficult infections. He had a friend who contracted MRSA and he had “a terrible time”. Dr Iddon had seen MRSA face to face, as many in the room also have done.

The meeting would aim to identify a number of fresh ideas on infection prevention and the delivery of sustainable reductions in infection rates, in line with the Department of Health policy, “Clean Safe Care”. It was hoped that these ideas would inform and support further achievement in tackling healthcare-associated infections wherever it was found.

## Department of Health Policy and the Improvement Foundation

### **Ginny Edwards**

#### **Head of the Targeted Support Team, Healthcare Associated Infections and Cleaner Hospitals Division, Department of Health**

Ginny Edwards said that she was delighted to have the opportunity to address what the Department of Health has been doing around reducing healthcare-associated infections.

The Department of Health has been very active in working to reduce healthcare-associated infections, and improvements have been made over the past four or five years.

Healthcare-acquired infections are so important for patients and of great concern to the healthcare profession. In 2004 the headlines around MRSA were about hospitals being in crisis: that infection rates were up; and that MRSA was a “super-bug/super- killer”. The Government was minded that this was an important issue for patients and the public and that it needed to have some attention focused on it.

***“We are delighted that the target set by Dr John Reid, to reduce MRSA by 50% was achieved last March and those numbers continue to decrease”.***  
**Ginny Edwards**

In 2004 the Department of Health set up a programme of work to see whether policies and improvement support could be given to the health service in helping it to reduce its infections. Ginny Edwards was appointed as the Head of Targeted Support, which means the heading up the Improvement Programme, to work with the NHS and help it reduce infections.

Up to today, the Targeted Support Team has been reviewing the policies that might help the NHS understand how it could work towards reducing infections. These include:

- The Hygiene Bill and the Code of Practice; with inspection powers given to the Healthcare Commission, that became the Care Quality Commission on 1<sup>st</sup> April.
- “Saving Lives” is a large campaign giving clinical and managerial people a spectrum of tools that help them to reduce healthcare-associated infections.
- Investment in new matrons.
- The deep cleaning programme.
- The “Clean Your Hands” campaign, carried out in co-operation and liaison with the National Patient Safety Agency.
- An extensive technology programme working in the health service seeking to obtain from frontline technicians the most important developments to reduce infections, and expediting the development of new products to get new offerings into use in the NHS.

As the above illustrates, there has been a great deal of work carried out on policy and guidance to give the NHS a focus on what it needs to do to reduce healthcare-associated infections. The programme of work called “Targeted Support” identified how the Department of Health could help with the implementation of best clinical practice, best policies and performance management with the health service in order that it would know what to do and how to do it.

An early decision was not to work with just “the worst organizations” in the country because that would only mean improvement for a few people. All Departmental services were offered to every single NHS acute trust in the country; the Department of Health has worked with 153 out of 170 organisations. The approach taken was for everyone to have an opportunity to improve, rather than going in and saying “You’re performing badly”. The Department wanted to be clear that it was there to help take improvement forward.

Ginny Edwards said she was delighted to report an excellent outcome, with great improvement having been made by the NHS in reducing MRSA bacteraemias. The target set by the then-Secretary of State, John Reid, to reduce MRSA by fifty per cent was achieved in March 2008. The figures continue to decrease and there is now a sixty two per cent improvement compared to the initial figure.

Not content with that or “sitting on its laurels” the Department of Health recognized that *Clostridium difficile* was also of enormous concern to patients and the public. Consequently, approximately two years ago, the Department began to focus its improvement efforts on this type of infection as well.

The hypothesis was that by obtaining good practice for reducing MRSA and *Clostridium difficile*, improved practice and reductions in other healthcare-associated infections would also result.

While national data is not available to prove this hypothesis (because data capture is not mandated for other infections) some hospitals are telling the Department of Health that many other hospital-associated infections are reducing in number, although there is a variable picture.

The Department of Health has been working with the Improvement Foundation, looking at the whole healthcare system, not just the acute hospital setting.

## **Ruth Kennedy** **Chief Executive of the Improvement Foundation**

Ruth Kennedy said that she was delighted to participate in the meeting. The Improvement Foundation, which began operation nine years ago as part of the NHS, is now a completely independent organization that supports improvement in public services.

The Improvement Foundation runs a programme entitled “Tackling Healthcare Associated Infections Outside of Hospital” which is focused around care homes, nursing homes, community nursing teams, GPs in general practice and hospitals. The aim is to engage the entire health community in what is a whole health community issue.

*“We are trying to engage the entire health community in what is a whole health community issue”.*  
**Ruth Kennedy**

The programme has been running for nine months. Work started with fifty care homes in the north east of England; work currently extends to one hundred and fifty six homes across England. The programme complements the work of the Department of Health. It engages care homes managers, relatives and others, using improvement techniques to address particular issues within care homes. The results to date on the programme are promising and further developments are awaited.

## **Disease areas with a high risk of healthcare-associated infection**

### **Introduction by Professor Nick Bosanquet** **Professor of Health Policy, Imperial College, London**

Professor Bosanquet welcomed the meeting as marking the beginning of a new kind of partnership involving the Department of Health, patient groups, clinicians and policy makers.

Risk factor evidence suggests that people who have continuing admissions, and treatment over long periods of time are at particular risk of acquiring a healthcare-associated infection. This is not a problem that can be solved all at once and then forgotten about. It was to be hoped that the problem could be managed and reduced.

*“This is the beginning of a new kind of partnership involving the DoH, patient groups and clinicians”.*  
**Professor Nick Bosanquet**

The presentations in the areas of renal disease, diabetes, musculoskeletal conditions and cancer aimed to consider: the particular risks associated with each disease; successes to date in tackling healthcare-associated infections; fresh ideas to further improvements; and how to involve patient groups more and to a greater degree.

## **Renal Services**

The renal services are a high-impact area from the perspective of healthcare-associated infection. Kidney disease has been a success story in terms of access to treatment, the development of local satellite units and quality of life for patients. However, there are a number of risks associated with hospital management of people with renal disease.

The National Clinical Director, Dr Donal O'Donoghue, and clinicians Dr Roger Greenwood and Dr Richard Fluck have been leading lights for a number of years in developing renal services and making huge strides in tackling healthcare-associated infections. The renal patient associations and advocacy groups have also been highly active and successful. Kidney Alliance was represented at the meeting by Fiona Loud, and The National Kidney Federation by Timothy Statham OBE.

### **Dr Donal O'Donoghue**

#### **National Clinical Director for Renal Services, leading the renal faculty**

Chronic kidney disease is common: about one in ten people have it. Advanced kidney disease only affects a minority of the five million people with chronic kidney disease but poses a massive risk of healthcare-associated infections, some of which is preventable. The main focus is on chronic kidney disease dialysis and the risks associated with people on the dialysis programme.

The "renal MRSA story" evolved particularly from the drive for improved vascular access. Work delivered by the renal community in the UK – led by people around the table – put vascular access on the map. This had benefits for its own sake, but also provided a better understanding of the nature of infections, and how to prevent or deal with them. The important link has been established between quality of dialysis and risk of infection, in particular, MRSA.

Acute kidney injury, formerly known as acute renal failure, is very important, affecting around one in twenty people admitted to hospital. If these individuals go on to require dialysis, they are at risk of healthcare-associated infection. While only about one in a thousand people are on renal replacement therapy, people with advanced kidney disease on renal replacement therapy used to make up eight per cent of all MRSA cases.

***"We have been privileged to work as members of a multi-professional team for nigh-on 30 years. It has to be a whole team effort if we are to address the safety issues".***  
**Dr Donal O'Donoghue**

The current major national focus is on MRSA which, together with *C. difficile*, provide the yardstick for measuring improvement in healthcare-associated infections. However, data capture in renal disease is progressing beyond simple MRSA reporting. Geographical variations are becoming more apparent. The National Renal Audit is about to begin reporting, which signifies a major, sophisticated advance. UK clinical leaders have also delivered a great deal of work and thinking around infection, notably by meta-analyses and randomised clinical trials.

A range of infections other than MRSA and *C. difficile* are with us, or around the corner; the Health and Social Care Act 2008 coming into effect on 1<sup>st</sup> April 2009 lists eight classes of specific alert organisms, together with the policies which should be adhered to in order to tackle outbreaks. The aim for the future is to maintain progress on MRSA and *C. difficile* while extending action against other pathogens. This will require a significant amount of training.

Kidney services are delivered through fifty two hospitals in England, and many more satellite units. It had been a useful learning exercise and a pleasure working with Ginny Edwards and her team at the Department of Health to address some of the issues and to get the improvements embedded into the services. But the risks are not going to go away. They are wider than MRSA and *C. difficile*, and include antibiotic prescribing and safety in general.

A systemic and quality improvement approach to kidney services have been developing for over a decade, measuring parameters using a renal registry and reporting on them in a public format. A multi-professional team approach has been operating for almost thirty years; it needs a whole team effort to address the safety issues.

There has been strong clinical leadership and the role of the national English renal Tsar adds to a kidney community across the whole of the UK. The renal community is a relatively small specialty, but it has had a great deal of visibility and has made significant progress in improving the outcomes for people with kidney disease, although there is still a lot to do to obtain the health gain that we need to see.

Renal patient's organizations have been strong and vigorous for over a quarter century. Patient choice has been raised up the agenda, with a rise in the level of home haemodialysis – and significant advances have been made in tackling the attendant risk of infections

In summary, the key messages are:

- The importance of patient choice linked to safety measures – essential parts of the quality agenda
- The need for honesty about the risks of infection
- That everyone has a part to play, with zero tolerance on healthcare-associated infections.

## **Dr Roger Greenwood**

### **Consultant Nephrologist, East and North Herts NHS Trust; and Chair, Patient Centred Service Group, East of England Renal Strategy**

The renal community has done well in tackling healthcare-acquired infections. This goes back more than forty years to when the first patients started to train for dialysis at the Royal Free Hospital. That was probably the first time that doctors and nurses worked shoulder to shoulder, and from that point a strong multi-disciplinary team ethos developed. That is relevant given the ability of nursing colleagues to drive through strict protocols, a feature of the renal specialty.

*“Renal had a special need and a special problem in the amount of MRSA being reported. I have been impressed by central direction and how multidisciplinary teams have picked it up. I have been amazed by the progress that has been made”.*

**Dr Roger Greenwood**

Approximately five years ago, the National Service Framework for Renal Disease was published and it was recognized that renal patients were extremely vulnerable to healthcare-associated infections. The main reason for that, apart from some depressed immunity in renal failure, is the captive nature of renal disease to the healthcare system. Patients have to attend hospital or clinic regularly and receive about three hundred connections and disconnections *per annum* to the central circulation, sometimes via an artificial plastic connection. Therein is the vulnerability.

Historically, there was a special problem in the amount of MRSA being reported from renal units. In response, Government direction was impressive and the multidisciplinary teams picked up on the issue very well. The progress that has been made has been excellent.

Dialysis is changing and it is necessary to move with the times and make NHS services more patient-centred. Patient-centredness is as much about service as it is about the built environment. Many kidney units are operated in congested environments. However, a new, modern renal unit is being opened in Stevenage which has ten square metres between each machine and a sink between each dialysis machine. It is necessary to keep up the pressure, never accepting the old environment as it stands; it has to move with the times. All future builds should take into account the importance of making it easier and automatic for staff, visitors and patients to adopt discipline and challenge culture.

Patient choice is often talked about. In renal services this is a huge challenge. We could do much better on offering patients independent self-care opportunities to take their own machines home; and there is new mobile technology on the way which is an exciting prospect to decongest the clinic.

In addition to the hospital environment, MRSA is out in the community and everyone must remain vigilant. The message is generally positive, but the challenges are:

- The environment and the discipline of working practice
- Keeping multidisciplinary teams together and ensuring good links with primary care
- Giving renal patients more choice, independence, self care and machines at home

## **Fiona Loud** **Chair of the Kidney Alliance**

Fiona Loud is Chair of The Kidney Alliance, which represents the main patient and professional charities in the UK. Fiona is also a kidney patient, having spent five years on dialysis and the past two years being transplanted, and brought to the discussion the perspective of a recipient of treatment.

In haemodialysis there is often a connection to the neck which makes the patient particularly vulnerable to infection. Many people are not aware of this; patients will come in to hospital not understanding that they are especially vulnerable and why. It is important to communicate clearly, being honest with patients that they are at further risk, but also that there are things that they can do about it. As guidance changes over time it should be reinforced and re-emphasised, and made in more than one language.

***“Trust can be built up between healthcare professionals and patients. Patients will be far more inclined to accept that they can control their part of it, and reduce their risk of infection, if they are told how to do so”.***

**Fiona Loud**

A fistula, another form of dialysis, is generally thought to be somewhat better for avoiding infection. However, there has historically been a lack of surgeons available to do the relatively minor but essential operation; this needs to be improved. People are being left vulnerable, dependant on dialysis through a neckline instead of being able to receive dialysis via a fistula.

Patients coming into clinics from other units or other countries may unwittingly be carriers of particular infections. Sometimes patients may not feel that they can challenge busy, overstretched staff to ask whether they can, or should, go to an isolation room and say where they have been. This is a message about the need for honesty in communication.

This leads on to partnership; a patient may feel that dialysis is something that has been done to them and they are suffering from it; but it is about the partnership. Trust can be built up between healthcare professionals and patients. Patients will be far more inclined to accept that they can control their part of it, and reduce their risk of infection, if they are told how to do so.

That will also encourage them to feel that they can challenge staff if they see that someone is not washing their hands - sometimes it is easy to forget.

There are some challenges, but things are improving:

- Patients may feel that their care might suffer if they challenge staff
- For access to safer vascular care, there should be more space for isolation in the units where people come in from other hospitals or other countries
- There should be consistency in guidance on infection risks associated with bringing personal items into the units from outside
- It is important to admit if there is a problem in a particular unit at a particular time, to explain to people that an infection has been detected and how it will be addressed.

## **Dr Richard Fluck**

### **Consultant Nephrologist, Derby Hospitals NHS Foundation Trust**

It has long been recognized that infection is a serious problem in renal disease. But we have moved culturally from a position where infection was accepted to one where it should be prevented. Over the past five years there has been a sea change on a national and local level.

***“A dialysis patient is 100 times more likely to get an MRSA bacteraemia than the general population. However, if they are dialyzing on a line, that figure becomes 800-fold higher.”***

**Dr Richard Fluck**

The renal community has had productive collaboration with the Health Protection Agency, designing a renal-specific data capture system for MRSA and tying that in to the patients' relative risk in respect of the type of treatment they are receiving.

A dialysis patient is one hundred times more likely to get an MRSA bacteraemia than the general population.

However, if they are dialyzing on a line, that figure becomes eight hundred-fold higher. We can move patients away from lines, but we have to accept that some may still need lines, which we need to deal with.

The Kidney Care Audit is coming through, which is part of the plan to broaden the scope to look at *C. difficile* diarrhoea, other infections and the relationship between infection, hospitalization and cardiovascular disease, which is the underlying cause of mortality within a dialysis population.

The United Kingdom has been one of the most active areas in research, moving from a position of acceptance through to prevention and how best to cut down on the rates of infection. This involves decreasing reliance on venous catheters with its associated high risk, as well as techniques to reduce the infection rate among those who need to have venous catheters. Work has addressed how the lines are looked after and the use of antibiotic locks to reduce infection. This has transformed care, with total rates of infection decreasing by ninety per cent over the past four years. That is a considerable change, going from a three-figure number of patients with bacteraemic episodes down to barely fifteen or sixteen per year. There has been no MRSA in the Derby renal unit for two and a half years.

This success is also happening in other units across the UK. Best practice is being shared through a policy of learning from the best, in conjunction with the Department of Health. While variation between centres continues, overall, the national picture is one of improvement. Considering MRSA, a sixty per cent reduction in MRSA bacteraemia has been achieved in just three years.

## **Timothy F Statham OBE**

### **Chief Executive of the National Kidney Federation**

The first message is that the problem is still here, varying between units, as reported by National Kidney Federation advocacy officers dealing with the aftermath of an infection. Issues are ongoing, with examples of disappointing standards of care. It is crucial that the public understand that infection is a real problem.

The National Kidney Federation is a campaigning body with thirty years' experience. What is needed is a campaign, public awareness, hospital awareness and a change of culture. Nothing is gained by starting a war and the charity does not believe in a name-and-shame type campaign. If the National Kidney Federation were to join together with the other therapy area groups that want to see a campaign to improve infection rates, the charity would not want a negative campaign, but a constructive campaign.

*"I would hope that the patient organizations could get together and decide on four or five simple messages that each of our organizations should start to bang on the table day after day, week after week, year after year."*  
Timothy Statham

The first thing to achieve is to simplify the message. For the public to understand that this is a real problem, three or four bullet points argued on each therapy area, would be much more valuable than everyone arguing their own corner. Patient organizations should get together and decide on simple messages that each organization should start to "bang on the table" day after day, week after week, year after year.

The problem for patients is that they are frightened of causing offence. They do not want to say to the doctor, *"Don't touch me now; I've been waiting for you all day, I know you want to touch me, but don't touch me until you've washed your hands"*. Patients should not have to have that conversation and nurses should not have to have it with the doctors.

One simple thing that would change the culture of the public, the staff and the patients is for everyone entering hospital to be given a little card that they could hang around their neck, pin on their lapel or put on the end of their bed. The card could say, *"Don't touch me without washing your hands"*.

If everyone had such a card, patients would not be fearful about talking to doctors. Doctors would have the message in front of them every second of the day because all their patients in the ward would be wearing the sign. That would change the culture without causing offence, and it would not cost anything.

## **Diabetes**

### **Introduction to the diabetes faculty by Professor Nick Bosanquet**

Diabetes is largely an uncharted area from point of view of hospital-acquired infections and community-acquired infections. Yet people with diabetes have an increased risk of contracting an infection in the course of their illness and its treatment, and awareness needs to be raised much higher, and at all levels.

Dr Jörg Huber, a psychologist, developed the first multi-national course for training specialist nurses, a joint effort between Roehampton University and Rhiner University in Germany.

Dr John and Dr Yemparala are clinicians specializing in diabetes. They work in an area of Birmingham that has a high prevalence of diabetes – one of the highest prevalences in Western Europe. Working with Professor Martin Stevens, they have been very active in developing leading-edge services for diabetes patients; in preventing and treating healthcare-associated infections in this high-risk group.

**Dr J3rg Huber**  
**Psychologist and Principal Lecturer, Roehampton University**

Dr Huber strongly endorsed what Timothy Statham said regarding the important role of patient groups in tackling healthcare-associated infections, working together right across high-risk conditions.

Speaking from the viewpoint of a psychologist, there are two key aspects relevant to people affected by diabetes and at risk of healthcare-associated infections. Firstly, the subjective perception of risk among staff and patients is particularly low in diabetes, possibly because diabetes is perceived primarily as a chronic disease with the risk of infection being considered an issue of secondary importance. We need to change that perception.

There also needs to be a change in the culture and what psychologists call “subjective norms”, which is a sense of obligation imposed by significant others. In other words, a patient or carer with a strong subjective norm will have a sense of duty eg *“I need to wash my hands”*. *“I need to wash my hands, and everyone should wash hands before entering or leaving a hospital, before and after medical examination and treatment”*. Just as society has introduced a “Say no to drugs” norm, we may need to create a similar norm for hygiene saying “Yes to handwashing”.

***“Depression not only lowers immune function, but also the motivation to look after myself properly and make an effort to wash hands”.***  
**J3rg Huber**

People with diabetes are frequently older, which places them at additional risk, partly due to lower immune function.

People with diabetes may be depressed or have emotional problems such as anxiety. About twice as

many people with diabetes are depressed compared with healthy individuals, although the numbers vary a great deal and there is a need for more research.

Depression lowers not only the immune function but also one’s motivation to make an effort, wash one’s hands and look after oneself. People with depression are known to have poorer self-care management and higher HB1c values, and the parameters are worse for those who are more depressed. There is also a chance that depression will affect hygiene behavior.

Diabetes is a demanding and complex disease. People who progress beyond the early stages of diabetes are usually confronted with a demanding regimen of medication and self-care. The disease burden may be further increased by requests, or what may be perceived as an additional demand, for handwashing and for greater vigilance in hygiene. This requires careful consideration because there may be a mood among people with diabetes that *“It is already all too much”*. The disease burden is high and hygiene issues may further increase it.

**Dr Prasad Yemparala**  
**Consultant Physician in Diabetes and Endocrinology, Heart of England Foundation Trust, Birmingham (Heartlands, Good Hope and Solihull Hospitals), in association with**

**Professor Martin Stevens, who was unable to attend in person**  
**Professor of Medicine at University of Birmingham and Honorary Consultant Physician at Heart of England NHS Foundation Trust**

Patients with diabetes have a higher chance of acquiring infections than those without diabetes. Infections including MRSA “superbugs” can be acquired in the community as well as in hospital. Patients with diabetes may be admitted to hospital with diabetes-related problems or other medical problems.

They may have a higher chance of acquiring infections from the hospital because of the age of the patient (diabetes is more common in older people), hyperglycaemia and possibly reduced immunity. In diabetes, the severity of infections can mean that antibiotics may be required for longer durations and at a higher strength than usual. Consequently, treatment regimens may be more prone to problems associated with antibiotics, such as *Clostridium difficile* infections which can cause life-threatening bowel complications.

Patients admitted for problems related to diabetes, for example, lower limb infections or diabetes complications such as ketoacidosis can be very sick and may need intravenous and central venous access for a longer duration, and so are susceptible to acquire bloodstream infections (septicemia).

***“Patients admitted for problems related to diabetes ...can be very sick and may need iv and central venous access for a longer duration, and so are susceptible to acquire bloodstream infection”.***

**Dr Prasad Yemparala**

Good progress has been made at the Heart of England Foundation Trust in dealing with these infections. Rates at the trust of dangerous infections have been significantly reduced, reflecting the implementation of a number of policies including:

- Treating people with antibiotics as outpatients whenever possible
- Screening and treating patients for MRSA on admission to hospital
- Prescribing carefully developed antibiotic guidelines, prescribing of antibiotics supervised by senior staff, regular antibiotic ward rounds by a microbiologist and antibiotic prescription monitoring by a dedicated pharmacist
- Careful isolation procedures for patients found to have an infection.

Infections in the community are another important problem. Patients with foot ulcers are prone to infections and septicaemia. Patient education, and education of foot health teams in the community regarding antibiotic guidelines, and policies for screening and isolation procedures for patients found to have an infection, have helped reduce infection rates in foot clinics at the trust clinics and in the community.

## **Dr Reggie John**

### **Associate Specialist in Diabetes and Endocrinology, Heart of England Foundation Trust Birmingham (Heartlands and Solihull hospital)**

Diabetic foot ulcers are the main cause of infection in diabetic patients. It is important to develop new prevention strategies.

- Roughly five per cent of the diabetic population will end up with foot ulcers or foot infections every year
- Overall, at least fifteen per cent of diabetic patients will end up with foot infections at some point in their life
- At least ten per cent will go on to have an amputation, the single largest cause of amputations, especially in the lower limb.

It is well known that people with diabetes are more prone to infections. They are also more prone to neuropathy, or nerve damage; meaning that they will be unaware of damage to their hands and feet. They have reduced blood supply, ischaemia, which can make them more prone to infections. People can have a combination of both and infections can become difficult to treat.

What can we do to reduce infection in people with foot infections? Firstly, good foot care is of paramount importance in diabetes. Information is being given out across the country that people with diabetes should have their feet examined by a professional healthcare specialist, a diabetologist or a podiatrist, at least on an annual basis.

People with diabetes should wash their feet at least once a day. They should examine their feet every day, preferably before they go to bed. If they cannot look at their feet themselves, they should make sure that someone else does examine them regularly. Even cracks, fissures, ulcers or swellings should not be ignored. First aid, can be administered if these appear in the middle of the night.

***“Diabetic foot ulcers are probably the main cause for diabetic infection. The majority of diabetic infections end up with foot infections”.***  
Dr Reggie John

However, the patient should contact their doctor or podiatrist the next working day, rather than try some over-the-counter preparation. Patients should be aware that the consequences could be severe if diabetic foot infections are not treated promptly.

Another very important fact is that the infections such as MRSA and *Clostridium difficile* are normally found safely in many people in the general population. Therefore, good hand hygiene is as important in the community as in the hospital to prevent spread to susceptible individuals.

Another hurdle faced in diabetic foot clinics is that patients with “diabetic foot” often need antibiotics, especially for deep infections or for infections going into the bone. This may put patients at higher risk of developing *C. difficile*, which is the infection that affects the stomach. To minimize this risk, it is important to try to limit the antibiotic usage based on the Culture Report to the shortest possible period to clear the wound.

We also try to avoid the use of multiple antibiotics, as this can increase the risk of *C. difficile* infection. However, none of the options are watertight or foolproof and they should be tailored to the needs of each individual patient.

Similarly, good hand hygiene, aseptic techniques, barrier nursing and decolonisation methods have helped Heartlands and Solihull Hospital to bring down considerably the number of MRSA cases to below the national target.

Everyone needs to join together in practicing good hand hygiene and strive to improve environmental cleanliness, which will give the health system a big boost in controlling these infections.

## **Musculoskeletal conditions**

### **Introduction by Professor Nick Bosanquet**

This is an opportunity to add to the healthcare-associated infection agenda the particular risks and needs of people affected by musculo-skeletal conditions. People requiring hip and knee surgery, and older people who are often affected, are at risk. This points to the need to identify people who are at particular risk, or who may have had healthcare-associated infections, to make sure that they do not acquire them again where they repeat admissions. This is a big agenda and it ought to be possible to achieve a great deal. Ros Meek brought the perspective of a trained nurse, patient and Director of a multi-disciplinary healthcare coalition.

#### **Ros Meek**

#### **Director of the Arthritis and Musculoskeletal Alliance**

Ros Meek recounted her experience of treatment in a Foundation Trust for a fractured tibia in 2008. Despite feeling vulnerable in raising the matter, Ros felt she needed to remind staff to wash their hands. There is a need to raise awareness, and one way of doing so may be to ask nurses and doctors to sit in the clinic or the environment in which they are working for fifteen minutes and to observe what goes on.

Not only will they pick up whether or not hands are being washed, but there will also be other benefits to their observation on the ward or the outpatients' department.

Arthritis and musculoskeletal conditions are long-term and affect a large number of people in the UK, requiring both GP and specialist care. Many people are at increased risk of needing surgery for joint replacement. Canvassing health professionals, patient organizations and researchers on key issues showed:

- Infection rates are higher in people with inflammatory arthritis, particularly with the new biologic drugs. Healthcare teams need to be vigilant, with experienced clinicians involved in assessing these cases, to pick up infections and treat them early. Otherwise infections can be devastating if they are missed and untreated.
- Joint replacement in inflammatory arthritis has a higher infection rate due both to the disease and the immunological suppressive agents used to treat the disease. There is a need to develop enhanced methods to avoid infection in high risk groups.
- Patients are often worried that they might need a blood transfusion when they go in for hip or knee surgery. GPs should routinely be assessing the patient's haemoglobin level as they refer them for surgery, intervening if necessary prior to surgery. This would reduce the need for blood and make that patient feel a little more secure.
- Orthopaedic Units need to protect their patients from infection. A solution may be standalone orthopaedic units or ring fenced units/beds for use only for elective surgical cases in general hospitals. A goal should be to avoid emergency patients (often medical with infections) being put into elective beds next to planned, clean orthopaedic surgical cases which might cause cross-infection.
- A lack of beds may be causing too high a bed occupancy ie greater than eighty-five percent, resulting in high rates of hospital-acquired infections. Patients are being screened for MRSA before elective admissions; however, emergency admissions will not be screened yet may be admitted to the same environment. The ability to have more single beds, or to be able to differentiate between those admissions and the planned admissions, is vital.
- Although arthritis is not strictly a disease of older people, nursing homes have higher rates of MRSA. It would be useful for people in those homes to understand more about MRSA and also to know the MRSA status of people who are living there. There is a need to ensure good infection control in these homes and to be careful if these patients are admitted for surgery as they may need treatment to eradicate infection before surgery.

***"Patients with rheumatoid arthritis are particularly vulnerable around surgery due to the increased risk of infection associated with the disease itself".***

**Ros Meek**

Patients with rheumatoid arthritis are particularly vulnerable around surgery due to the increased risk of infection associated with the disease itself. Therefore, for everyone contemplating surgery, hospital-acquired infections may be an issue of some concern. Patients going into an NHS hospital may wish to know what their record of hospital-acquired infections was. If this was not wonderful, patients might be concerned about the post-operative period. This could especially be the case on a general surgical ward, which is frequently where people with inflammatory arthritis are accommodated, many rheumatology wards having been removed.

Being on a general surgical ward, the healthcare professionals may be less knowledgeable about the needs of rheumatology arthritis patients, underestimating the difficulties these patients have in becoming mobilized due to the impact the surgery has on the rest of their body and joints. Developing an infection into a newly replaced joint can have very deleterious consequences .

Concern over healthcare-associated infections can sometimes mean that some rheumatoid patients leave hospital sooner than is desirable. They are at increased risk of infection due to their immuno-suppressed state. All hospitals should carry out pre-operative checks at least ten days before people are admitted for elective work; nose swabs, blood tests and tests for haemoglobin.

## **Cancer**

### **Introduction by Professor Nick Bosanquet**

There are a particular set of issues surrounding the risk and consequences of healthcare-associated infections in people with cancer. These were addressed by Ian Beaumont, from the leading cancer charity Bowel Cancer UK and Ruth Liley, from the leading end of life care organization, Marie Curie Cancer Care. Nick Bosanquet brought the perspective of working on an Advisory Group for the Cancer Reform Strategy and Chairmanship of the Costs and Benefits Sub-Committee.

Some of the issues include being immune-compromised and high-risk surgery eg of the large bowel. Community-based nursing and hospice care can provide tremendous insight of what works well. How can we energise more of the cancer charities to include this topic in their campaigning?

There is a big agenda for tackling healthcare-associated infections in cancer – needing new focus on education, measurements and service provision. Patient groups, clinicians; managers and network staff may need to start a much more active programme of focus, education, training, and research at the local level in this area. That would be a positive outcome from the meeting.

**Brian Iddon:** said that he would seek to get this onto the agenda for Ian Gibson’s annual cancer conference.

### **Ian Beaumont Campaigns Director at Bowel Cancer UK**

People working in the cancer field and other disease areas have been encouraged by the move towards more patient-centred care, considering the person rather than the disease, and being concerned with their quality of life. The co-morbidities that cancer patients face are as important as the cancer itself. In the specific area of healthcare-associated infections, the issues for cancer patients are the same as for many other patients.

*“It is possible that a number of cancer patients may have died prematurely as a result of not being able to have their drugs at the right time due to healthcare-associated infection”.*

**Ian Beaumont**

Cancer patients are particularly prone to hospital infections because they are in hospital a great deal. Their immune systems are weakened as a result of having cancer and being treated for cancer. Cancer patients may potentially be

undernourished, which increases their risk of infection. Intravenous treatment necessitating treatment with lines and tubes etc makes cancer patients more prone to infection.

A number of patients have called Bowel Cancer UK to say that they were not able to receive cancer treatment because they contracted MRSA or *C. difficile* and they had to wait to overcome the infection before they could have chemotherapy or biological agents to combat their cancer.

They felt that, by the time patients have recovered from the infection, the window of opportunity to achieve optimum benefit from their treatment has passed - and they would die much more quickly. It is possible that a number of cancer patients may have died prematurely as a result of not being able to have their drugs at the right time due to healthcare-associated infection.

A number of things can be done to improve the outcome of cancer patients who are prone to healthcare associated infections. These include:

- Optimizing the timing of hospital admissions so that patients are not routinely entered into a hospital on a Friday but not treated until Monday of the next week
- Using less time-consuming surgical techniques eg laparoscopic surgery
- Where appropriate, having treatment at home; this is becoming increasingly common, partly as a result of some of Professor Mike Richards' co-payments review and also through patients having oral treatment
- A positive agenda to ensure that fewer patients have to be treated as emergency admissions
- Earlier diagnosis for elective procedures and more controlled treatment
- Hospitals exercising their responsibility to keep hospitals clean and to reduce the risk of infections
- Patients should have adequate food intake to ensure that their immune system is not compromised
- Treating the person, considering patients and their families as partners

## Ruth Liley

### Assistant Director of Clinical Governance for Marie Curie Cancer Care

Marie Curie provides end of life care in patients' own homes through its nursing service and for inpatients, outpatients and through day care in its hospices. There are nine Marie Curie hospices throughout the UK. The organization faces different challenges in the environments in which it provides the treatment. In its hospices the charity has control over the environment and how hygienic it is; in patients' homes that is not always the case. However, the charity cares for patients in whatever conditions they are found.

*"In our hospices we have control over our environment and how hygienic it is. In patients' homes that is not always the case. We care for patients in whatever conditions we find them".*  
Ruth Liley

Marie Curie has contracts and agreements with local health boards and PCTs who provide gloves, aprons and all the rest of the equipment that would be expected to deliver care have in a patient's home. This has not been too much of an issue because traditionally the charity provided overnight care: one nurse to one patient for an eight-hour shift. There has not been a lot of interaction with numerous different health professionals coming and going.

However, the pattern in the way that Marie Curie provides care at home is changing. The charity is now being asked to carry out rapid-response type visits, and to visit more than one patient per shift. Hence, different challenges will need to be faced in the community than previously, needing careful thought about the right approach.

Within Marie Curie hospices there is a relatively low rate of infection. However, the care Marie Curie provides is only one small step in a patient care pathway. Patients may come to Marie Curie with the infection already identified or with the infection which has not been identified. Some patients come in for respite, some for end-of-life care and some for symptom control, so they are at different stages of their end-of-life pathway. The charity needs to be careful about how those patients are managed, because they are vulnerable. The challenges are different in as much as patients are being dealt with at the end of their lives; Marie Curie is dealing with a family at a difficult time.

Even if it was known that a patient had MRSA or *C. difficile* and they were dying, is it appropriate to ask the family to gown, glove and mask to be with them? There is always a balancing act between what is known to be appropriate from a healthcare infection point of view and what is right for that patient and that family at that time of their disease. It is always a balancing act for the clinicians.

Hence, when receiving guidance that says “must” or “should”, there is always that interpretation of what is right. A balance is needed to make sure that that patient is not endangering other patients coming into care. There are many issues that need to be considered with caring for patients in hospices.

What does Marie Curie do slightly differently in hospices compared to hospitals, to explain why the infection rate is not particularly high?

- Marie Curie housekeeping teams are directly employed by the charity and “part of the furniture” within the hospice. They are involved in every development around patient services. Taking great pride and responsibility in making everything clean and ship-shape. The charity considers itself fortunate with its housekeeping teams. This is not to say that by contracting out the benefits would be lost, but there is something about the ownership - of being part of a team caring for a patient - that makes a difference for staff. That is recognized by patients when they say how clean everything is, and that there is nothing that is too much trouble for the cleaning staff to come and mop up, which is important for the charity. [Many NHS trusts also have internal teams. DH advise that it is good management of the cleaning team - setting clear standards and monitoring - that is important, regardless of where the staff are drawn from].
- Marie Curie delivers a lot of one-to-one care within hospices and at home. There are a low number of patients per nurse and they are not moved much so there are few logistical problems. A patient comes into a bed and that is theirs and where they stay. While there are multi-bedded bays in all the hospices, it is bedspace management that seems to make a difference.

***“The main thing is about responsibility and the issue being everyone’s problem”.***  
Ruth Liley

- Marie Curie does not use many agency staff, and those who are used come from a core group of people. There are not many different staff coming in who do not know the charity’s procedures and protocols and the way that it works and cares for its patients. So staffing is consistent, which is another important factor for the charity.

- There is better control over admissions than hospitals have. Marie Curie does not have A&Es that have to admit patients; many of the admissions are planned although there are some emergencies as well.
- The charity is looking for ways to have patients cared for at home as much as possible. One example is taking the transfusion service into patients’ homes in Northern Ireland by training charity community staff to carry out the transfusions. Rather than bringing patients into the local acute trust or into the hospice where they had to be admitted, they were treated at home.
- Marie Curie is constantly looking at ways in which to reduce the risk to patients by keeping them away from those areas where they might be prone to picking up infection.

The main thing is about responsibility and the issue being everyone’s problem.

## Nick Bosanquet

### Professor of health Policy, Imperial College, London

The Advisory Group for the Cancer Reform Strategy had a number of meetings with many people from the cancer services, as did the Cost and Benefits Sub-Committee. There was no mention of hospital-associated infection in relation to cancer and The Cancer Strategy Report does not cover it in detail - if it is mentioned it is very much in passing. That was a jolt from the convening of this meeting: the issue has a low profile in the cancer world.

Cancer is way behind the awareness and action in kidney disease, where colleagues have pioneered on metrics and a coherent plan of approach across the renal units, using lots of comparative data.

There appears to be little research on hospital-associated infection problems in the cancer world, yet the risk factors are high: not only the more generic ones but also the effects of radiotherapy, which leads to a severe compromise in the immune system.

There are also the effects of multiple therapies, which are more common whether in sequence or concurrently; and with chemotherapy, radiotherapy and surgery all interacting.

It would be interesting to understand more about which groups of cancer patient are at risk of healthcare-associated infection; is it lung cancer, breast cancer, colorectal cancer, prostate cancer or what other types of cancer? Who acquires hospital-associated infection and what are the risk factors? How far have Cancer Networks been involved? Cancer is a big area; several hundred thousand people a year become new patients.

*In cancer, "we have a success story. But it could be undermined if people have a great fear and a real threat of obtaining an infection at some stage after they think they have recovered from cancer"*  
Nick Bosanquet

Patient groups, clinicians, managers and network staff could all have a part to play in education, training and research about healthcare-associated infections. This is a big agenda; we must not be complacent about healthcare-associated infections in the cancer area.

In cancer we are, rightly, getting more intensive treatment - there is a ninety per cent increase in radiotherapy fractions, for example. There are many more new drivers for patients with later stage cancer and many more cancer survivors out in the community, so we have a success story. However, that could be undermined if people have a great fear and feel a threat of obtaining an infection after they think they have recovered from cancer.

## Infections, prevention and patient experience

### Introduction by Professor Nick Bosanquet

Healthcare-associated infections are a moving problem; we are solving yesterday's problems but many new issues are emerging. What is the range of micro-organisms we should be concerned with going forward, and is enough research being done on avoiding them? How can prevention be supported by involvement of the advocacy community?

Dr Jenkins brought the perspective of a Medical Microbiologist and Clinician working as an Infection Control doctor. The patient experience was brought by people who have been patients and established education and campaigning groups on healthcare-associated infections.

## Dr David Jenkins

### Medical Microbiologist, University of Leicester and Lead Infection Control Doctor, University Hospitals of Leicester NHS Trust

The University Hospital of Leicester is a two thousand-bedded, three teaching hospital trust, with its share of infections. Many challenges have been faced over the past ten years. The discussion on healthcare-associated infections begs the question of what the NHS, and Leicester NHS Trust in particular, currently doing?

The answers to infection controls have been here all the time, there is nothing new, but the big question is, how do we get people to do it? Some key events and activities are as follows:

- There was public pressure in the early 2000s and the Secretary of State for Health, Dr John Reid, announced targets in December 2004 to reduce MRSA and bloodstream infections by the end of March 2008. Dr Reid is an “understated hero” in infection control, galvanizing trusts into action which has significantly and positively impacted infection control.
- The MRSA target was a particularly useful and valuable target; the NHS is collecting MRSA bloodstream infection data and *Clostridium difficile* infection data.
- There has been an impressive impact around targets. Reaching the fifty per cent target at Leicester NHS Trust was a credit to all the teams involved and to the Department of Health. A straightforward strategy was developed in 2004 to reduce the risk of bloodstream infections and the risk of MRSA acquisition and infection. This resulted in a ninety per cent reduction in MRSA bloodstream

infections. In February 2001 there were twenty one MRSA bacteraemias in the Trust; in February 2009 the figure was zero - the first time in over a decade that there were no MRSA bacteraemias in a month. “*We are getting there*”. However, while the reduction has occurred nationally, and well compared to European countries, not all trusts have reached the targets.

***“It is also important to bear in mind that screening in itself has no impact whatever on MRSA infections. It has an impact only if it causes an action of intervention”***  
David Jenkins

- The Health Act provides a major advance and the associated Code of Practice takes that forward. The Act is significantly backed by Healthcare Commission inspections - from 1<sup>st</sup> April, Care Quality Commission inspections.
- There have been a number of reports, for example into the outbreaks of *C. difficile* at Stoke Mandeville and Maidstone and Tunbridge Wells. The impact of those reports on stimulating senior management’s interest is noteworthy. It is important to ensure that the Chief Executive is really accountable, not just nominally, but in terms of his salary and job – that may be half the job done.

The Dutch are held up in infection control circles as the paradigm of how to do tackle infections. With the latest quarter rates at Leicester three times greater than the Dutch rate, “*We are within touching distance of the Dutch*”. There has been an international spread of a new strain of *C. difficile* over the past few years, creating possible outbreaks, including notably Holland, where it was found to be difficult to get rid of these infections. Leicester also, was badly affected and adopted a multifaceted approach, where hygiene and environmental hygiene were reinforced, with extra spending of millions of pounds on day-to-day and deep cleaning. The antibiotic policy was also dramatically reconfigured, removing high-risk antibiotics, abolishing some classes almost completely, resulting in an eighty per cent reduction in *C. difficile* within months. That success has been sustained, and interestingly, the winter peaks traditionally expected with *C. difficile* did not occur.

Are we doing enough? The NHS is starting compulsory MRSA screening for eligible elective admissions. MRSA screening has been going on for some time in Leicester, with currently five thousand screenings per month, at a cost of half a million pounds per year. A large fall in MRSA carriers has been identified by screening.

As the numbers of screenings, and implementation of suppression therapy treatment, have increased, and numbers of patients with MRSA have decreased, a massive and significant reduction in the proportion of positives has been observed. About eight years ago twenty per cent of Leicester screenings were finding new positive patients, now the figure is less than one per cent. Due to increasing numbers of screenings and decreasing numbers of positives, the laboratory costs of MRSA screenings to find one new positive patient have increased from about one hundred pounds to over eight hundred pounds. An exit strategy for screening may need to be considered, because once MRSA is got rid of, decisions will have to be taken on how much we want to spend on treating MRSA.

It is also important to bear in mind that that screening in itself has no impact whatever on MRSA infections. It has an impact only if it causes an action of intervention. The effective interventions are barrier nursing, which includes putting patients into single rooms, and suppression therapy.

There is some concern about the use of terms around “suppression therapy”. People talk about “eradication” or “decolonization”, but the evidence for using those two words in particular is weak. The term “suppression therapy” should be used as it is not possible to reliably or permanently get rid of MRSA.

Screening quickly by polymerase chain reaction (PCR) is possible but that is three times the cost of conventional screening, and would cost one and a half million pounds per year instead of half a million pounds in Leicester.

***“There are other antibiotic-resistant organisms and a ‘whole alphabet’ of these.  
David Jenkins***

Isolation should also be considered as a “not risk-free” intervention, with data to show some disadvantages of isolation. These include: receiving fewer doctors’ visits and depression; routine follow up is reduced with a long-term impact on their outcome.

MRSA screening, although appropriate in some circumstances, will not affect the rate of infection with any other organism, being an organism-specific intervention.

Many people believe that there is only MRSA and *C. difficile*, not appreciating that most healthcare-associated infections are not caused by MRSA or *C. difficile*. We have heard of MRSA meticillin resistance. Far more common is “meticillin-sensitive staph”, which is a conventional staphylococcus. People can carry MSSA without knowing about it. MSSA bloodstream infection rates locally in Leicester have hardly changed at all over the past ten years. That is very disappointing, because it had been hoped that by reducing the risks of infections MSSA bloodstream infections would reduce as well. Data from a range of sources suggests that the impact of MRSA control strategies has been minimal on MSSA infection rates.

There are other antibiotic-resistant organisms and a “whole alphabet” of these: VRE—vancomycin resistant enterococci, ESBLs—extended spectrum beta lactamase-producing Gram-negative bacilli and XDRKP—extremely or extensively drug-resistant *Klebsiella pneumoniae*. These infections are difficult to treat, in some cases there are only one or two active antibiotics left and patients suffer as a consequence. There is also a risk of new infections coming into hospitals. In the United States, MRSA bacteria called USA300, a form of MRSA which is community acquired, is now being seen in hospitals.

In summary, what can be done about tackling healthcare-associated infections?

- Rational scientific interventions should be developed
- Ineffective or damaging interventions should be avoided
- Education and postgraduate education qualifications should be carried out
- Rigorous, reliable and comparable audit should be carried out across all trusts, enabling benchmarking
- Continuing inspections are very important

- Improved or increased financial inducements to trusts are needed together with penalties for bad practice; payment by results is one measure, best practice is possibly another, concentrating the minds of senior management
- Research is vitally needed
- Infections need to be measured. An aspiration might be for all patients to be prospectively enrolled, monitoring the entirety of their inpatient's stay and followed up, to identify infections quickly
- Improved hospital design is required for it to become almost impossible not to do things improperly in terms of infection control and hygiene, with washes and single rooms that allow patients to be cared for without jeopardizing their care.

## **Martin Kiernan**

### **President, Infection Prevention Society and Infection Nurse Consultant**

The Infection Prevention Society was formed as the Infection Control Nurses Association in 1969, but changed two years ago to become the Infection Prevention Society. Prevention is everyone's business and any registered healthcare professional can join. Many years ago, people said that we could not always prevent, but we can do a great deal more prevention.

We are good at not following our own advice in England. The Dutch are successful because they implemented the advice the English gave them many years ago, but unfortunately did not implement themselves. John Reid does not have anything like the credit he deserves; his fifty per cent reduction target looked dramatic when it was introduced, but the reductions achieved should be celebrated - rates should never have become as high as they were. Many healthcare professionals recognize that good things can come out of it and infection is not inevitable.

***"We are treating an increasingly elderly population and advances in technology and medical practice means that more patients are able to be treated for conditions that were unmanageable even a few years ago. Thus the pool of patients susceptible to infection is ever-increasing and our challenge is to protect them in the most vulnerable moments".***

**Martin Kiernan**

Many more older people are being treated, with the average age of patients going into medical wards rising by a year and a half every year. More interventions are being carried out on them, and, therefore, they might increasingly open to the risk of an infection. That can now be "put to bed" with people much more confident that progress can be made. That has been a positive.

Places such as Michigan in the United States have reduced catheter-related bloodstream infections to zero. That is not done by luck but by good practice.

When Gary Player holed a bunker shot somebody said, *"Good shot"*, and he said, *"Actually, I find that the better I practice the luckier I get"*, which is exactly it! The better we do, the luckier we get!

The Infection Prevention Society is not a campaigning organization but provides education, an area in which the UK has been weak. Many years ago there were recognized infection prevention and control courses for practitioners in the field, but these days that has fallen off somewhat, and with a variability of different courses available.

There has been a huge influx of people into this specialty, but it is a small pool. A great deal of expertise is being lost from acute organizations into PCTs, as practitioners consider them a preferable place to work: there is much less pressure and the PCTs are offering better conditions and terms and conditions of service. Acute trusts have struggled because infection control has not been the most attractive job to go into, being seen as high pressure. That is regrettable, because it has been very rewarding, working in teams.

Better surveillance is needed; *"if you cannot measure it you cannot improve it"*. We have been excellent at measuring MRSA bloodstream infections and *C. difficile*; it has been possible to target them and targets have definitely worked.

We do not know the true burden of surgical site infections; surgeons may think they have a zero per cent infection rate because all the patients go home quickly after surgery and are often followed up by the GP. Post-discharge surveillance is often poor, so we have no real measure of the burden of infection.

Urinary catheter-related infections in the community are significant; many patients come to casualty with bloodstream infections related to urinary catheters, but sometimes they are non-antibiotic resistant organisms. A great deal of work is necessary on this burden because there is a high rate of associated morbidity and mortality.

Considerable work also needs to be carried out on chronic wound care, there being a larger problem with pressure ulcers, which are completely preventable. Most new cases of MRSA coming from the community are colonized pressure sores, where patients go on to develop bacteraemia.

In summary, a great deal of work needs to be carried out in the community, in surveillance and a better approach to education is necessary.

## **Derek Butler** **Chair of MRSA Action UK**

Derek Butler said that it was heartening that patient groups and advocacy groups were present in the meeting to discuss prevention and the patient experience of healthcare-associated infections. In answer to the question of whether we are doing enough, the answer was *"no"*, because as with learning - you can never do enough. The situation is continually improving all the time.

The first fifty per cent target reached for MRSA bacteraemia was the easy target. The second fifty per cent will be far harder to achieve, because the nearer we go towards zero, the more difficult it will be to retain that target. It is heartening that there is some good work going on in hospitals around the country; however, there is some bad work as well.

***"It was impressive that invasive devices where not being used unnecessarily; non-invasive devices such as external catheters were being used, which reduce infections".***  
**Derek Butler**

Watersheds like Maidstone and Tunbridge Wells, and Mid Staffs should be a learning point. In Scotland, following the Vale of Leven hospital experience, a fifteen-point plan was produced and there was All-Party agreement on tackling the problem. England may need to go down that road to put precise measures in place to prevent similar events happening again. There is the *"Clean, Safe Care"* policy and it is not acceptable for trusts to choose to put up barriers; the situation will grow tougher with time and the current financial climate. Money will have to be saved in trusts; and MRSA Action UK will be there to ensure that infection prevention and control is not the targeted area.

There is some good news, witnessed first-hand. One health trust visited by the charity at the end of March, the Royal Preston in Lancashire, was excellent; clean and well staffed. Hand hygiene was a top focus; there was a good display of posters encouraging the public to clean their hands and not to sit on the beds. The elderly were being helped; an elderly patient was being fed. Hand hygiene was excellent and there was a good safety technique. It was impressive that invasive devices were not being used unnecessarily; non-invasive devices such as external catheters were being used, which reduce infections. It was good to see the nursing staff, and even the tea lady, washing their hands between patients. However, a doctor was seen to not wash his hands in dealing with an unconscious patient. The charity said nothing, fearful that in making a fuss, the patient's care might have suffered.

The new regulator has the powers to ensure that those not meeting the targets within the Hygiene Code should be challenged and taken to task. At the launch of the “Clean Your Hands Campaign”, Sir Liam Donaldson said *“If staff in the hospitals cannot wash their hands they should find another profession. If they still refuse, they should be dismissed.”* MRSA Action UK endorsed that comment.

In summary, MRSA Action UK supports the following key actions:

- Accountability and better regulation; the Care Quality Commission has a key role in helping organisations achieve the goal of “no avoidable infections”. Without effective regulation and stiff action where organisations are not putting safety as the number one priority, this goal will fail to be reached by many and the great momentum we have gained in making hospitals a safer place to be could be lost
- The wider issue of healthcare-associated infections beyond hospital wards should be addressed. The work of the Improvement Foundation is to be applauded, staff in care homes are being empowered to deal with healthcare infections, but there is still a lot to do with Acute Trusts making sure they pass information on to care homes and hospices with regard to a person's infection status
- There is a need to consider screening for clinical staff, particularly where there are frequent occurrences of surgical site infections and bacteraemias that may have proved difficult to trace during root cause analysis, staff should be considered as a reservoir, and if they are colonised then appropriate measures should be taken to suppress the bacteria and protect patients
- Better measurement and publication of information on healthcare-associated infections is needed. There is a mandatory reporting system for surgical site infections; quarterly reporting we have seen for bacteraemias should be extended to the collection of this data
- The Department of Health will be embarking on a public information campaign which the charity welcomes. Furthermore, the charity would like to work with the Department of Health with this worthwhile campaign. More details around MRSA Action UK's calls for action are contained in Appendix 1.

## Graham Tanner

### Chair of the National Concern for Healthcare Infection

There is a need to move away from the blame culture and to work together on the issue of healthcare-acquired infection. Everyone is a potential patient for the NHS at some stage in their life. It will either be you, your parents, your grandparents or your children. It is in everyone's interest to try to improve patient safety across the board. Whatever disease or infection, we should be moving in that direction together.

The Department of Health and the National Patient Safety Agency should be praised for the policies that they have introduced. NHS staff are to be congratulated on the reduction in MRSA.

***“I encourage people to work with us and patient charities to improve matters. Compliance with hand hygiene is only 70%. If we can increase that figure, infections will fall still further”.***  
Graham Tanner

The World Alliance for Patient Safety is launching a “Save Lives: Clean Your Hands” campaign in Geneva on 5 May and hospitals and social care homes are invited to sign up. Materials can be downloaded free from the website (<http://www.who.int/gpsc/5may/form/en/index.html>) and it will be in the interest of all social care providers to go along this route.

When the Health and Social Care Act becomes completely into effect, possibly in April 2010, the provisions will apply to all health and social care providers. That will be difficult for some, and people are encouraged to work with the National Concern for Healthcare Infection and patient charities to improve matters. It is unfortunate that currently, despite all the campaigns, hand hygiene compliance in hospitals is only approximately seventy per cent. If we can increase that figure, infections will fall still further. Campaigning organizations wishing to link with National Concern for Healthcare Infections can contact the charity via [graham.tanner2@blueyonder.co.uk](mailto:graham.tanner2@blueyonder.co.uk)

Non-compliance of staff with the “Clean Your Hands” policy, could be part of their contract of employment, and result in disciplinary action.

The issue of extending mandatory reporting has been touched on and needs further attention. Over one thousand types of bacteria can cause infection, and the NHS measures two. Without identifying and measuring a problem, that problem cannot be addressed. Therefore, National Concern for Healthcare Infections calls on the Government to talk to the Health Protection Agency about extending mandatory surveillance. *Klebsiella* pneumonia has double the rate of infection from MRSA bacteraemia; mandatory reporting could help.

Some of the figures from the Health Protection Agency in relation to *Clostridium difficile* indicate a significant problem within the community. Nationally, the non-acute attributable figure is approaching fifty per cent and in some individual trust areas the figure can be in excess of sixty per cent attributable to non-acute trust contraction.

Healthcare professionals should have to disclose to patients what is wrong with them, and whether an infection is present. A family should not have to find out through reading medical notes that MRSA, *C. difficile* or *Klebsiella* etc was present and they were not told. That situation should be eradicated as quickly as possible.

The Coroner and Justice Bill now proceeding through Parliament contains reference to the completion of Medical Certification on Cause of Death (MCCD) and the creation of an independent medical examiner to investigate the compilation of a MCCD, and refer to a Senior Coroner where concerns exist. There appears to be no provision, despite the Shipman inquiry, for relatives or carers to express their concerns relating to the completion of a MCCD. That should be looked at to follow up in the issues that came out of the Shipman inquiry. More details around National Concern for Healthcare Infection’s calls for action are contained in Appendix 2.

## **Tony Field Chair, MRSA Support**

MRSA Support was established in 2003, seeking to address the issues that it considers to be most important, namely transmission of pathogens and handwashing. Handwashing is only one aspect of what should be done to combat healthcare-associated infections.

Infection may spread from the staff’s noses and throats, and is said to be transient. However, in that transient period, infections can be spread and staff are not being screened. Patients may be blamed for bringing infection into hospital, and may feel stigmatized in their notes even though they have been clear for some time.

***“Some hospital trusts may discharge patients prematurely, unaware that they have picked up an infection, only to be diagnosed on readmission from the community”.***  
**Tony Field**

Some hospital trusts may discharge patients prematurely, unaware that they have picked up an infection, only to be diagnosed on readmission from the community. In this way, reportable infection for the hospital may be missed.

From a personal perspective, Tony Field felt that more staff were needed on the ward, doing the job, with less management and more people to do the patient care.

Health Minister Ann Keen discussed the MRSA screening and decolonization programme on Radio 4, and the use of a nasal cream to screen eligible patients. This raised the question of whether there should also be a nasal cream for the staff. Guidelines state that staff colonization is transient, but they could potentially affect patients during this transient period; staff are guardians of the public's health.

Professor Voss and Professor Mark Enright are on public record for saying that masks are an effective intervention and the charity has evidence to suggest that the air in our hospitals is contaminated. The Department of Health has a duty to follow that up. [Government Scientific Advisers and the DH have reviewed the available evidence and taken international expert advice. They conclude that the evidence base does not support the routine use of facemasks for avoiding healthcare associated infections, but will consider any further new evidence if it becomes available. A copy of the report is given in Appendix 3]

## **Graham Kendall**

### **Freelance consultant on health policy strategy and communication**

Graham Kendall drew on his experiences over the past five months, having suffered a severe and complicated case of pneumonia, requiring six weeks in three different acute hospitals. Were it not for the care that he received he would not be here and healthy, so something went right!

***"The responsibility for cleanliness, not specifically hand hygiene, varied, with many people "absolutely on message" doing what they needed to do".***

**Graham Kendall**

But a few things also went wrong, including a lack of engagement on his patient requirements as his condition was changing dramatically from day to day. Graham felt his incapacity had a direct impact on his quality of care because care was structured around the ward rather than the patient. At a later stage in another hospital, where a nurse was allocated specifically to a small number of people, this was dramatically and positively transformed.

The responsibility for cleanliness, not specifically hand hygiene, varied, with many people "absolutely on message" doing what they needed to do. But there was a cultural issue with a significant proportion of people for whom it was "not my job". Other issues included being temporarily lost on patient records, variable maintenance of equipment and electric fans on all the time.

In summary, there is a cultural message around ownership and responsibility. Also, a number of structural messages on how staff are organized, and how people are processed through the system across the healthcare estate.

## **Nigel Edwards**

### **Director of Policy, NHS Confederation**

We have come a long way and there has been a lot of success. While the meeting brought up many interesting things, noticeably missing - and perhaps worthy of further investigation - would be to ask how we got into the original state. There is an interesting question about what happened to professionalism and the role of front-line leadership.

We should use the same kind of root-cause analysis that we use to understand how infections happen on how we got ourselves into a situation where patients were not the focus of attention, or people were not washing their hands.

The analysis from Tony Field does not work. We should properly and rigorously consider the matter. The big policy lessons that we might want to take are:

- Firstly, to look at the question of what has gone wrong in the context of the wider policy agenda, rather than in the silo of just infection. We talked a great deal about infection, but in fact more people die of preventable illness in hospital than infection. They would like a target too. If all the people who would like a target were put together we would be back where we were - with too many targets, without ever getting to the root cause of what is going on.
- Secondly, there is a huge panoply of machinery of regulators, improvement teams like Ginny Edward's, broad assurance measures, targets, monitors and arrangements for foundation trusts. The issue is not a regulatory one but one of local leadership and the responsibility from the ward right up to the board.

The comments that Dr Fluck and Dr Greenwood made were interesting; about the importance of multidisciplinary cross-clinical leadership and taking some responsibility, rather than saying *"We need better incentives to make the managers do what I want them to do"*.

People ask for a target. They are saying: *"I can't find my way round this system to create a case to get people to help me do the right thing"*. We need to understand why boards are not doing that. The matter needs to be dealt with.

***"We talked a great deal about infection, but in fact more people die of preventable illness in hospital than infection. They would like a target too"***

**Nigel Edwards**

There is an important point about leadership and professionalism: clinical leadership, middle management, responsibility of boards, and understanding how we created the environment in which these things were created - to make sure that we did not do it again.

The built environment is very important. We have missed a major trick in a number of the big PFI schemes over the past ten years, of not building nearly enough single rooms and other flexible accommodation that allow people to be nursed with better dignity and more safely, not needing more staff.

There is too much culture in many organizations where the response to being told that things are not right is, first, to challenge the data, and then to start thinking of excuses about why that is. Part of it is the cultural fear that we have created, because *"you get shopped"*. The route of action is, let us go and analyse the data to show why that cannot be true.

There are two or three points that are interesting, which may not be policy points but are big management challengers for clinical managers, ward managers and senior managers: the implications of the high throughput of our hospitals; the deleterious effect of mixing emergency and elected patients; and of moving patients frequently.

There is a science of how to run bed pools in hospitals, but it is not used. There are a few places that are using it. There are some great examples where general medicine physicians have thought about the issue, but some work on the systems of management and supporting middle managers in doing that is needed.

## **Summary of the meeting by Dr Brian Iddon MP**

Looking at the slogan, “Together Everyone Achieves More (TEAM) it is no good working up best practice in your own hospital or care setting; you have to spread that best practice and involve everyone who might benefit from it.

The meeting highlighted how important the subject of healthcare-associated infections is to the patient organizations and the volunteers who work with them. It is to be hoped that we will make a further big difference in this policy area. The themes that have been developed into this report are:

- Full implementation of “Clean, Safe Care”.
- Extended action beyond MRSA, especially to *C. difficile*, but not exclusively these; horizon scanning is needed, and we cannot be complacent. Horizon scanning is important because organisms mutate and change to make different species that are more potent than the old species.
- We cannot stop observing what is happening in the care setting, especially in our busy hospitals. This is one of the problems. There are patients being admitted and discharged faster than ever before, and it is obvious that this has caused its own difficulties.
- The meeting heard a great deal about hand washing and all the other clinical guidelines. People cannot ignore basic clinical practice. If people are ignoring them, it is necessary to speak up.
- There is a need for raising awareness and education, because there is probably little awareness in the community about healthcare-associated infections. More work has to be done through the local television and radio networks and the local media; the more publicity about everyone can do to avoid those infections the better.
- Patient groups need to keep raising their concerns, people are thick skinned enough to take the criticism.
- Local implementation of policies is needed; bridging the NHS with the public.
- Education needs to extend to people who care and clean for patients at home, mindful that they go from one household to another. Patients who have just come out of hospital may have been prematurely discharged and have become infected; care workers may pick up the infection and carry it to another fragile patient.
- Work is also needed in hospices, nursing homes and care homes.
- More research is needed about microbiology and associated issues, including transmission of disease.

Dr Iddon stressed the importance of people getting together across various disciplines and activities. It was important to break down silos.

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## **Contributions from people unable to attend the meeting, or submitted after the event (with the permission of Dr Iddon MP)**

**Stephen Bradshaw**

***Public Affairs Consultant to the Spinal Injuries Association***

The successful management of Spinal Cord Injury is deceptively difficult not least because people with complete lesions have no feeling or voluntary movement below the level of the neurological damage ie motor and sensory loss below the lesion, with bowel and bladder no longer function normally. Diagnosis of any problem is, therefore, complicated by the patient not being able to report pain or other indicators of damage or developing problems.

Also, healing and recovery from damage is slowed due to the impaired function of bodily systems, including blood flow. Additional complications commonly occur in Spinal Cord Injury patients when treated by non-specialist staff outside one of the eleven specialist Spinal Cord Injury Centres in the UK.

Thus, management of this multi-system physiological impairment and malfunction is complicated by the patients' susceptibility to infections such as MRSA and *C. difficile*, often contracted after acute admission to an A&E Department prior to transfer a Spinal Cord Injury Centre. Admission is often delayed or later in life after readmission to a local hospital with a pressure sore or other complication.

Unfortunately, general hospitals are usually unable to successfully heal a severe pressure sore, even in the absence of infection and patients are routinely admitted to the Spinal Cord Injury centres, where it can take months to repair the damage.

In general hospitals, it is often the inability to manage bowel and bladder function successfully that further impairs the paralysed bodies' ability to recover from infection.

Spinal Cord Injury people are amongst the most vulnerable to infection and are likely to have extra difficulty in throwing off such infections.

**Diane Tolley**

***Patient representative, Coventry***

We need to get people back to basics ie. Washing hands before and after meals and going to the bathroom. This should be emphasized in schools - that is where we can make the greatest impact. We must all remember that the Government wants the NHS to be PATIENT LED not just group led. Groups make a significant contribution but we all have a responsibility to give our views. We all have to re-educate ourselves to "Make a Difference".

**Arthur Newby**

***Patient representative, Liverpool Heart and Chest Hospital***

In any campaign it is vitally important that the organisers get the news media on their side. If the TV, radio and the press give a campaign wholehearted support without negativity, it will mean the difference between a failure and a resounding success.

All Hospital Trusts throughout the country should also be engaged to support the campaign as it affects every one of them. "No man or woman is an island". We all, individually and collectively, have an impact on society as a whole and on every person within it. Everyone has a duty of care and this message should be an important factor.

It is unlikely that we will ever totally eradicate healthcare-associated infections but that should not discourage us from doing everything we can think of to minimise it and its effects. It will not be sufficient just to purchase advertising space. We need to impress on the editorial departments that they have at least a moral duty to give support to what is a very important campaign to raise public awareness of healthcare-associated infections. We must use every tool at our disposal. The news media is probably the most powerful and influential weapon at our disposal in influencing public awareness. Let us make full use of it.

**Jean Smith**

***On behalf of The Civil Service Pensioners Alliance (circa 65,000 members) and the National Pensioners Convention (circa 1.5 million members)***

Older people, who may be admitted malnourished, are much more vulnerable to hospital-borne infections than younger people, therefore it is much more important for this age group that hygiene rules are followed, and that the NHS guidance on the minimum space between beds is adhered to.

When a ward has an outbreak of infection, it is especially crucial that the feeding needs of those people who are unable to feed themselves are fully met.

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# Appendices

## Appendix 1: Written submission by MRSA Action UK

The timing of the debate is apt, with the introduction of the Care Quality Commission on the 1 April 2009. We believe it's more a question of "what more can we do?" than "are we doing enough?"

### **Accountability and better regulation**

MRSA Action UK believes the Care Quality Commission have an absolutely key role to play in helping organisations achieve the goal of "no avoidable infections". Without effective regulation and stiff action where organisations are not putting safety as the number one priority we believe that this goal will fail to be reached by many and we could lose the great momentum we have gained in making hospitals a safer place to be.

Great strides have been made by many NHS Trusts, however there are still some that are not up to the job of shifting to a culture of "patient first". We have this week seen the Dr Foster report 10 hospital trusts have higher mortality rates than Mid Staffordshire Hospital Trust, and last week figures from the Health Protection Agency showed that some hospitals were still experiencing fluctuating performance with MRSA bacteraemias, one Trust has a rising trend and has only partially met registration criteria set out by the Care Quality Commission. What then is the Care Quality Commission going to do about it?

Leeds Teaching Hospitals NHS Trusts consistently say they do not meet the criteria set out in the Health Act 2006 - The Code of Practice for the Prevention and Control of Health Care Associated Infections. Yet despite Improvement Teams working with the Trust, it still isn't reducing its MRSA bacteraemias, which we know have a high mortality rate and costs a great deal more to treat, with often a poor prognosis for those who do survive.

It's not a question of naming and shaming, it's more about the fact that 48 people had a bacteraemia in this Hospital Trust in the space of three months, and that was double the number of the previous quarter. It's not luck when a hospital reports no bacteraemias; it's because of good practice. This Trust clearly needs assistance. If the management of the Trust cannot get the ethos right then there should be immediate intervention, bring in a management team that can turn the position around now.

One member of our charity whose family has been significantly affected by MRSA has reported that an NHS hospital gave absolutely exemplary care to her relative, there was a great focus on hand hygiene by everyone, posters and prominent gel stations, spotlessly clean wards, beds well spaced. Her relative she felt was in safe hands, invasive devices were checked daily and she saw these being inserted in A&E where everyone paid attention to aseptic procedures. She was however worried but felt unable to speak out when she went onto the ward. An unconscious patient in the bed opposite required IV lines, all the staff had so far followed assiduous hand hygiene, but the doctor treating this patient did not.

He was not bare below the elbows, he washed his hands at the sink and used the gloves designed for PPE (his protection), he did not use the surgical gloves that should be used for aseptic technique. Furthermore he did not follow the National Patient Safety Agency guidance on the five key moments of hand-hygiene, he handled curtains and other inanimate objects before inserting the IV line. He then handled key parts of equipment that go directly into the bloodstream. The working with him could have challenged this but didn't.

To the untrained eye this may seem a minor breach, but this patient could go on to develop a bacteraemia as a consequence. This demonstrates that no matter how good the organisation and its staff, there should be observational checks carried out, teams can observe and check that everyone is carrying out aseptic procedures as part of their everyday role, whilst giving care.

The Care Quality Commission must have a role to play in monitoring this practice. Organisations must have these checks in place and demonstrate that they are confident all of their staff are equipped with the necessary competencies required to give clean, safe care. Health professionals expect to be reminded, but it should be their peers that do the checks and reminders, not an onus placed on the patient. Yes, if a patient is not unconscious and they don't mind asking, that's fine, but it's not right to expect it.

### **Beyond hospital wards**

The wider issue of healthcare associated infections beyond hospital wards needs addressing. The work of the Improvement Foundation is to be applauded, staff in care homes are being empowered to deal with healthcare infections, but there is still a lot to do with Acute Trusts making sure they pass information on to care homes and hospices with regard to a person's infection status. This can be done discretely, as it is important to remember that people leave hospital and go back into their homes, whether this is in a care home or at home with relatives helping, they will have complex needs, they may have enteral feeding lines, catheters or other devices. Attention to dealing with these safely must be adhered to; carers will need proper help and guidance, and a good understanding of infection prevention and control. The Improvement Foundation are giving care home managers the tools to help them monitor people coming home from and going into hospital, everyone should have a care plan, and it should include details of the persons infection status. These are key measures and will bring about better outcomes for patients if everyone understands good infection prevention and control.

Also beyond the ward of course is the operating theatre. Patients that undergo lengthy surgery benefit from being warm, as a patient who is cold is at risk of the immune system not working efficiently and leaving the patient susceptible to a surgical site infection. Use of patient warming is sporadic despite this intervention being recommended by NICE.

Furthermore the method of patient warming is questionable, some techniques employ blowing warm air onto the patient, which is risky as airborne bacteria have the potential to get into patient wounds. Warming blankets, warmed operating tables or other methods should be employed to ensure the patient is not put at risk from airborne bacteria.

### **Screening staff**

Linked to theatre practice is the need to consider screening for clinical staff, particularly where there are frequent occurrences of surgical site infections and bacteraemias that may have proved difficult to trace during route cause analysis, staff should be considered as a reservoir and if they are colonised then appropriate measures taken to suppress the bacteria and protect patients.

### **Better measurement and publication of information**

Better measurement and publication of information on healthcare associated infections is essential. If you don't measure how many surgical site infections and how many urinary catheter infections you have then how will you know when things are improving? There is a mandatory reporting system for surgical site infections and we believe the quarterly reporting we have seen for bacteraemias should be extended to the collection of this data. This should be collected each quarter for improvement to be measured and this data should be in the public domain. The MRSA bacteraemia target focussed the mind, now its time to turn the focus on reducing mortality from surgical site wounds and mortality from infections in urinary catheters.

NHS Choices website only covers bacteraemias at a hospital trust level, not by individual hospital, the scorecard is still lacking fundamental information on infection rates. Dr Foster Health provides much more comprehensive information and should link directly to the NHS Choices scorecard for each hospital, the data is freely available and should be made more accessible through NHS Choices.

Hospitals should publish their infection rates at the door for people who do not have access to the Internet, and this information should be available on request.

The Department of Health will be embarking on a public information campaign which we welcome. Furthermore, we would like to work with the Department of Health with this worthwhile campaign. Our website has been designed in response to the questions we are frequently asked, including our tips for going into hospital, we are here as a resource to be used and hope the Department of Health will take advantage of our offer.

## Appendix 2: Written submission by National Concern for Healthcare Infection

NCHI recognises that reductions of incidence of infection have been achieved and that Department of Health and NHS Staff should be congratulated on their efforts.

There must, however, be a move away from the blame culture which tends to attempt to identify individuals (usually at the lowest level) when errors occur. This culture needs to be replaced by a properly instituted Root Cause Analysis programme when outbreaks of infection occur in hospitals. This analysis should include investigation of patient's underlying illness to assess whether therapy and treatment could have contributed to bacterial infection. In many instances procedures and systems failures contribute to deterioration in patient safety, including contraction of infection, and correct adoption of Root Cause Analysis tools should identify and such deficiencies and be capable of instituting recommendations for improvement.

There also needs to be a more holistic approach to the issue of infection. A patient's underlying condition needs to be included in any equation and therapy for life threatening conditions can compromise immune systems and increase susceptibility to infection. A patient's condition relating to nourishment also has to be assessed and included as a contributory factor to infection.

Statistics from the Health Protection Agency indicate that approx. 47% of *Clostridium difficile* infection is associated with the community. Surveys, however, tend to suggest that General Practitioners are vastly uninformed as to the recognition of healthcare associated infections. Some Primary Care Trusts have commissioned the Improvement Foundation to undertake training workshops within their catchment areas. Whilst the Improvement Foundation provides an excellent resource for information dissemination, these workshops are limited to particular areas. There needs to be an urgent expansion of the programme if Care Homes, Residential Homes, Hospices and Respite Centres are to be able to meet the registration requirements demanded by the Health & Social Act 2008.

The Department of Health provides significant resources for health research. Consideration needs to be given to the direction of some of this finance towards investigation into antimicrobial resistance. Some diseases and many infections are developing resistance to existing antimicrobials and a situation could develop where some diseases and infections become almost untreatable.

The initiative to bring charities from different disease areas together could provide a good platform for mutual dissemination of information which can only be of benefit to patients suffering from various diseases and the NHS itself. The more patients and carers are informed of precautionary measures to prevent infection taking place the greater the reduction in costs in the longer term.

NCHI looks forward to continuing to work in collaboration with the Department of Health both in terms of instituting measures to reduce infection and also the wider issues of improving patient safety in secondary, primary and social care.

### **Appendix 3: Written submission by MRSA Support to the meeting and response by Dr Brian Duerden (Inspector of Microbiology and Infection Control, Department of Health) sent to MRSA Support on 24<sup>th</sup> March 2009, in answer to the issues previously raised with the Department of Health by this group.**

#### **3.1: Written submission by MRSA Support**

##### **Review of HAI'S –Are we doing enough?**

No! The dept. is concerned only to head off the arguments and claim that they are in possession of all wisdom and knowledge on the issue while feigning to consult patients and the public, while they do not address the real issues.

The real issues are –

- transmission of pathogens through the air.
- transmission of pathogens by the staff from their noses and throats.
- blaming patients for bringing it in with them and then stigmatising them for evermore.
- discharging patients prematurely and then when readmitting finding an infection and then telling them they have caught it in the community, when in fact it was the hospital that gave them the infection. But this way the hospital is able to say they have no reportable infections.
- not enough nursing staff to do the job properly which forces them to cut corners and take risks. We want to see less management and more care for patients.

All CEO's should be made to work on a ward before they take up the post and any HAI should be regarded as failure and they should not be rewarded.

Ann Keen said this morning on the Today programme that all patients will be screened and decolonised with washes and a nasal wash. Consistently they (the DoH) have said that staff should not be screened for MRSA because the colonisation is transient on them and that if they become colonised it is only for a short period while they are working. (See the infection control guidelines.) In that short time while working they can pass on that colonisation to many patients from their normal respiration.

The dept. is in direct contradiction with Prof. Voss of the Netherlands and Prof Mark Enright who are both on public record as saying that masks are an effective intervention. We must demand that nurses and doctors dealing with open wounds canulae and catheters should use facemasks as a precaution.

There is much scientific evidence to suggest that the air in our hospitals is contaminated with many pathogens from MRSA to C-Difficile and efforts must be made to clear this. We have the technology but the Dept consistently deny it is a problem.

Until these points are made mandatory we say that the medical profession and the DoH is not doing everything it can to prevent the spread of MRSA and other infections.

#### **3.2: Response by Dr Brian Duerden (Inspector of Microbiology and Infection Control, Department of Health) sent to MRSA Support on 24<sup>th</sup> March 2009, in answer to the issues previously raised with the Department of Health by this group.**

##### **The prevention of MRSA healthcare-associated infection**

###### **Background**

During the early and mid twentieth century, the prevention of infection related to medical and surgical procedures (particularly wound infections following surgery) was recognised as an important part of hospital practice. In the pre-antibiotic era, the application of aseptic practices for a range of invasive clinical procedures was the major preventive measure.

Although antibiotics provided 'magic bullets' for treating infections, the emergence of antibiotic resistant bacteria has meant that prevention of infection by aseptic clinical procedures remains a key element in preventing healthcare associated infections in today's health service.

There is a firm evidence base for some of the elements of aseptic practice: the need for hand hygiene; the wearing of gloves for handling sterile equipment such as catheters; the use of sterile drapes; and the wearing of aprons by the staff conducting the procedures. Other parts of the aseptic procedure were part of a ritual 'package' rather than being evidence based in themselves.

The use of facemasks for performing aseptic procedures other than in operating theatres as in the 'ritual' category. As long ago as the 1940s and 1950s, questions were raised as to the value of masks and it was pointed out that they were unlikely to contribute to infection prevention because *Staphylococcus aureus* is not disseminated from the nose by normal breathing. Furthermore, wearing a mask could generate more skin scales (which act as 'rafts' for *S. aureus*) by rubbing against the skin, and putting masks on and off could also lead to greater hand or finger contamination. The lack of evidence for the value of face masks in preventing *S. aureus* infection led to the current recommendation that they are not necessary.

### **MRSA carriage and spread**

*S. aureus* is carried by around one third of the general healthy population (including an unknown number amongst these who will be carrying MRSA). The commonest carriage site is the nose, specifically the front the part or anterior nares, which is the part everyone tends to touch at frequent intervals. All carriers are probably nasal carriers. A proportion of carriers have *S. aureus* at other skin sites as well, particularly the moist areas of the axilla (armpit) and perineum (groin).

The main ways in which *S. aureus* including MRSA, is spread from carrier sites are:

1. Principally by contamination of fingers/hands and then touching other objects, clothing etc. Because everyone touches their nose frequently, a nasal carrier is likely to have *S. aureus* not only on their fingers but also on their clothes (jacket, shirt, tie, sweater etc), on their handkerchief, and particularly around pockets and other clothing areas frequently touched.
2. Secondly, by shedding skin scales that can act as 'rafts' carrying the staphylococci. These are more likely to come from those who are axilla or perineal skin carriers.

Nasal carriers do not shed *S. aureus* in their exhaled air in normal quiet breathing. Of course, the bacteria can be shed in droplets during sneezing, coughing, or nose-blowing.

### **Evidence for not recommending face masks routinely**

Current best practice guidelines for aseptic clinical procedures such as wound dressing, insertion of intravenous cannulae or catheters and urinary catheterisation are based upon evidence summarised as follows:

1. In a Q&A mini-review in 1980 (*Journal of Hospital Infection*, 1, 173-175), Lynda Taylor quoted studies by Duguid (1946), Gillespie *et al.* (1959), Ritter *et al.* (1975) and Ayliffe *et al.* (1979) showing that wearing masks did not reduce the number of airborne bacteria and did not reduce infections with, or acquisition of, *S. aureus* in patients.
2. The current guidelines for preventing healthcare associated infection were produced by the Department of Health funded *EPIC* project and published in 2001 (*Journal of Hospital Infection*, 47 supplement). The project team conducted a systematic review of the evidence for all aspects of prevention. This failed to reveal any robust experimental studies that suggested any clinical benefit from wearing surgical masks to protect patients during routine ward procedures such as wound dressing or invasive medical procedures.

They further commented that the studies they had reviewed concluded that the use of maximal/optimal aseptic technique for inserting central venous catheters significantly reduced the risk of infection. The *EPIC* team commentary was:

'maximal sterile barriered precautions involved wearing sterile gloves and gown, a cap, mask and using large sterile drape during insertion of the catheter as opposed to routine infection prevention procedures that involve wearing only sterile gloves and the use of a small drape.'

In these guidelines, we refer to this as optimum aseptic technique. However, there is no evidence that wearing a face mask or cap is important in preventing catheter-related bloodstream infection during catheter insertion.'

3. The *EPIC* project team at Thames Valley University conducted a further review in 2004 to update the 2001 guidelines. In relation to face masks and infection with epidemic MRSA strains, they identified one report in which wearing a mask reduced the acquisition of nasal, throat, and hand EMRSA in the healthcare staff; the significance was borderline.

No evidence was identified of face masks preventing transmission of infection from staff to patients and the project team did not recommend any change to the 2001 guidelines.

4. The study referred to above (3) examined the effect on staff acquisition of MRSA **from** MRSA-positive patients and concluded that the wearing of masks by healthcare workers performing certain activities for EMRSA positive patients may prevent transient colonisation and hence may be a useful intervention in the control of EMRSA in the hospital environment. However, numbers were small and this work needs further investigation to verify. The study did NOT support the routine use of face masks to prevent staff to patient transmission of MRSA.
5. In response to questions raised by the MRSA Support Group about the use of face masks, further details were sought from Professor Robert Pratt at the Richard Wells Research Centre, Thames Valley University. In relation to the above study (4) he states that it provides weak evidence from a small-scale observational study for a reduction in nasal, throat, and hand carriage of EMRSA in staff who wore face masks for certain activities (intensive care and contact with colonised sites) in a dedicated EMRSA unit.

He also points out that recent SHEA (USA) guidelines suggest that masks should be worn by healthcare staff as part of isolation precautions when entering the room of a patient colonised or infected with MRSA to decrease nasal acquisition by staff.

The SHEA paper also identified that wearing a simple surgical mask decreased shedding of MRSA by approximately 75% in an individual who had coryza from experimentally induced rhinitis infection. This would be relevant to MRSA shedding by a staff member who was a carrier and had an upper respiratory tract infection (e.g. common cold, influenza). However, staff with such infections should not be performing procedures on potentially vulnerable patients.

Professor Pratt concluded that his team 'had not identified any published evidence that indicates that wearing face masks as part of standard infection prevention and control precautions is effective in preventing healthcare associated infections. Nor did we identify any published evidence that wearing face masks is effective in preventing transmission of MRSA from a colonised member of healthcare staff to patients.'

6. The Chief Medical Officer contacted Professor Didier Pittet, WHO Advisory on healthcare associated infections, for specific advice on face masks. Professor Pittet confirmed that practice varies tremendously between countries but most does not have an evidence base. In his hospital in Geneva, masks are only worn when there is an issue of droplet spread. Although people with MRSA are colonised in the nose, he states that this is not a reason to wear a mask. If an MRSA patient has a condition where droplet transmission is likely (influenza, pneumonia), healthcare workers treating the patient should wear masks to protect themselves from acquisition.

## Appendix 4: Written submission by Arthur Newby, Patient representative, Liverpool Heart and Chest Hospital

### Promoting awareness of healthcare-associated infections. Thoughts from the “lower deck”. A layperson’s point of view.

At first this may appear not be relevant to the subject of HCAI but first I wish to establish a couple of benchmarks.

#### A. From the Oxford English dictionary

Lay Person: adj. (a) Non clerical (b) not ordained into the Clergy (3) not professionally qualified, especially in law or medicine

Apparently this was common usage in Victorian times to refer to Working Class or Labourers and its connotation still clings on to this day. People may not like being referred to as “Laypersons”.

Stakeholder: noun. An independent party with whom each of those who make a wager deposits the money

Stake: noun. A sum of money wagered on an event deposited with a stakeholder.

Modern day usage does have some relevance as someone having a “stake” in an organisation as a user of its services but this is not widely used in general life by the public. In my Hospital Volunteer role I am frequently asked to explain what a Stakeholder is.

Where is all this leading, you ask? In any communication with the public you need to carefully consider how one refers to them. “Layperson” could be considered to be somewhat officious and condescending, and “Stakeholder” may just confuse many people. Whichever is used may require some explanation in any literature directed at the public

#### B. Forming of public opinion

Recent events in the financial sector have instigated many reports in the media (TV, Radio, Press) alleging that the financial regulating authorities have, over the years, regarded and viewed the Financial Institutions and Banks as virtually “keepers of the financial world” in the belief that they knew what they were doing and were in full control of their respective duties with regard to the economy. Events have proved otherwise.

Whilst the public express anger at these Institutions for the situation they have reportedly landed them in, even greater resentment is felt about the alleged failure of the financial watchdogs including the FSA, the Treasury and the Government (i.e. Politicians). No matter what the truth may be and who are, or which institution is, to blame, the public can only form their opinions from what the News Media decide to tell them.

#### HOW DOES ALL THIS BECOME RELEVANT TO HCAI?

The most important factor here is **PUBLIC PERCEPTION**.

The news media always headline bad news because it sells newspapers and attracts advertising. Good news is always relegated to the inside pages of newspapers. For example, the Harold Shipman trial was headline news for weeks. Now we have the latest reported problems at Stafford Hospital.

Such reporting only serves to increase adverse public opinion regarding the system of health care from Hospital Trusts to the NHS as a whole.

Another matter which did not receive wide coverage is the subject of “ash cash” wherein doctors can charge/receive £71 for signing the certificate (two signatures required) to release a body for cremation. It has been reported that this has, on many occasions, led to delay in release and subsequent distress to the family. To those who had to deal with the loss of a loved one it becomes a very real problem that stays in their minds and also in the minds of those they relate it to.

People generally consider the NHS to be responsible for this little earner. Again... Public perception!

People also are generally suspicious of “official statistics”, believing that they can be made to prove anything according to how you manipulate them. This attitude tends to reinforce their reliance on the news media. Any campaign to raise awareness and get the message over to the general public should be careful not to overly rely on “statistics”

News Media reporting is very selective and frequently does the NHS a disservice. Very rarely do they report on the successful Trusts. All the good work being done in the background by the NHS and the DH does not meet their criteria for “newsworthiness”. (Or perhaps they are not aware of it?). The editorial departments need to be persuaded to reconsider their approach insofar as any campaign is concerned.

Could they be persuaded to see themselves as “Champions of the Campaign?” Such an approach could possibly encourage some competition between them to vie for this accolade.

#### **WHAT HAPPENS NOW?**

Following on from the Stakeholder Event on 30<sup>th</sup> July 2008, a further Event was held on 18<sup>th</sup> February 2009 at Inmarsat in London, I was privileged to be invited to both Events

At the latter Event we were told about a national campaign to raise awareness of HAI and prevention by such means as hand cleaning. This I understand is scheduled to take place late summer this year. It will be a perfect opportunity to get the message over to the public at large. One of those attending was the excellent campaigner Ashley Brooks, of MAX 4HEALTH, who immediately offered his experience, gleaned over the last 5 ½ years, in getting the message over. He should not be ignored as his input would be invaluable.

#### **IN CONCLUSION**

In any campaign it is vitally important that the organisers get the news media on their side. If we can get the TV, Radio and the Press to give it wholehearted support without negativity it will mean the difference between a failure and a resounding success.

All Hospital Trusts throughout the country should also be engaged to support the campaign as it affects every one of them.

No man or woman is an island. We all, individually and collectively, have an impact on society as a whole and on every person within it. Everyone has a duty of care and this message should be an important factor.

**ARE WE DOING ENOUGH?** It is unlikely that we will ever totally eradicate HCAI but that should not discourage us from doing everything we can think of to minimise it and its effects.

It will not be sufficient just to purchase advertising space. We need to impress on the editorial departments that they have at least a moral duty to give support to what is a very important campaign to raise public awareness of HCAI

We must use every tool at our disposal. The news media is probably the most powerful and influential weapon at our disposal in influencing public awareness. Let us make full use of it.

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