

Now wash your hands 2

An investigation into progress on
Infection Control in the NHS



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1. Main Findings

1.1 1 in 10 hospital patients has a hospital acquired infection at any one time. This is equivalent to at least 100,000 infections a year¹. 'Now Wash Your Hands 2' examines what the Government has been doing to tackle the superbugs. The main findings are:

- Since the publication of *Now Wash Your Hands*, in 2002, rates of MRSA have hit record levels. MRSA rates have increased from just over 1000 in 1996 to over 7000 last year, under the new mandatory collection scheme.
- It is currently impossible to tell how many deaths are caused by superbugs every year. Official statistics are simply the tip of the iceberg. Parliamentary answers show that **despite reforms to the death certification process, there is still no way of finding out the true number of deaths caused by these bugs.**
- Hospitals only scored themselves 6 out of 10 last year for implementing infection control standards.
- There has been no national audit of compliance with infection control standards in NHS hospitals. The Government have stated: "*We have no plans to publish such a national audit*".
- There are over 3000 fewer hospital beds now than when Labour came to power. This has led to high levels of bed occupancy and a higher risk of infections.
- Despite Government guidance saying that staff should not wear uniforms home, Ministers have no idea which hospitals have laundry facilities. The Government has no plans to improve this situation.
- Government documents admit that the provision of isolation facilities and single rooms in NHS hospitals is sadly lacking. The Government required hospitals to review their isolation facilities, but completely failed to collect the information themselves. **If Ministers are completely in the dark about the level of frontline preparedness to deal with hospital infections in general how can they hope to deal with serious diseases like SARS?**
- Staff in many hospitals are struggling with inadequate washing facilities, which makes hand hygiene more difficult to enforce. The Government is monitoring new hospitals to make sure they have enough wash-hand basins. But Ministers do not monitor or collect information on the number of basins in existing hospitals.

¹ National Audit Office, The Management and Control of Hospital-Acquired Infection in Acute NHS Trusts in England, London: The Stationery Office, 2000, www.nao.gov.uk/publications/nao_reports/9900230.pdf

2. Introduction

2.1. In February 2000, the National Audit Office published a highly critical report on the control of infection in acute hospitals in England. The NAO found that healthcare acquired infections (HAIs) cause more than 5,000 deaths per year and cost the NHS £1 billion².

2.2. Prompted by the NAO report I began asking Health Ministers questions about how the Department of Health and the NHS were responding to its findings and recommendations. The answers I received shed little light and gave the clear impression that control of infection was not a high priority. Most of the information I sought was not collected by the Department of Health. This led me to conduct my own survey of hospital infection control teams, and publish my findings in *Now Wash Your Hands* in 2002.

2.3. The main findings were:

- Rates of MRSA in 2001 were nearly 50 times higher than in 1992.
- The Government's 'Clean Hospitals Campaign', which Ministers used to defend their record on infections³, was shown to be a sham. The campaign sent teams of inspectors into hospitals to monitor cleanliness. *Now Wash Your Hands* revealed that out of 19 inspection categories, **only one related to ward cleanliness**, and none to infection control. Categories included CCTV in car parks, new signage and redecorated reception areas.
- 61% of respondents felt they did not have adequate resources to carry out their role effectively – “*we are severely under-resourced*”, and two thirds of those who felt this way explained that lack of staff was a major problem.
- Almost a third of respondents were either “quite” or “very” unsatisfied that staff were washing their hands as often as was recommended.
- 6 out of 10 trusts responding to the survey admitted that their staff wore uniforms to and from work, thus increasing the risk of infection.
- I found anecdotal evidence that MRSA patients are often treated on wards because of lack of isolation facilities and staff as one respondent said, “*Like most trusts, we do not have enough isolation rooms for all infected patients of all kinds, and even if we did, we probably would not have enough nurses to staff them*”.

² Ibid

³ 3 December 2002, column 738 Mr. Hutton: I certainly agree with the hon. Gentleman that that (infections) is a serious problem. We should tackle it on three different levels. First, it is important that we start to monitor the rates of MRSA and other hospital-acquired infections; we are doing that for the first time this year. No previous Health Minister—Tory or Labour—has been able to tell the House what the rates of such infections are. That is our first port of call. Secondly, we need to get in additional resources to improve standards of cleanliness and hygiene in our hospitals. We are doing that: **there will be £62 million for the clean hospital programme** and a £200 million additional investment to improve sterilisation.

- 2.4. Further research since the publication of *Now Wash Your Hands* found that the Government's Clean Hospital Programme had no relation at all to MRSA rates. Out of the 40 hospitals with the most MRSA or Superbug cases, not one of the hospitals was classed as a dirty hospital under the Government's Clean Hospital Programme

3. The Government Response to Now Wash Your Hands

- 3.1. The Government's response to the publication of my original report was complacent in the extreme. They pointed out that hospital cleanliness is not the main factor in combating MRSA:

"There's no scientific evidence to link dirty hospitals with increasing rates of MRSA,' a spokesman said. It's to do with increasing antibiotic resistance, what sort of operations people have and many other factors. National guidelines are now in place. These spell out standard principles for preventing such infections, including detailed guidance on issues such as hand hygiene"⁴.

That was exactly the point of my report! It was the Government who proposed the Clean Hospital Programme as their solution to the problem. Also the national guidelines were already in place – *Now Wash Your Hands* was raising the issue of whether they were being implemented on the frontline.

- 3.2. *Now Wash Your Hands* made six recommendations for action by Government. Since that time progress has been at best patchy and at worst unacceptably slow. The table on the next page sets out the recommendations made in the original report and progress on each of these is documented in the following paragraphs.

⁴ Quoted in Daily Mail, 17 October 2002

Table: Recommendations from Now Wash Your Hands

1. Infection control must remain high on the Government's agenda. There must be a sustained effort to maintain cleanliness standards, not just a one-off, gimmicky "clean-up drive".
2. Staff shortages lead to low morale and overworked doctors and nurses. This leads to infection control policies being, of necessity, ignored. Staff shortages must be tackled as a matter of urgency. This is not just about recruiting new staff, but retaining old staff with better pay and more flexible working conditions.
3. Proper changing facilities and enough uniforms should be provided so that staff do not have to wear uniforms out of the hospital. Strict protocols should be introduced to enforce this.
4. Infection control teams must be given the resources and the authority to undertake their jobs effectively. One doctor or nurse for over a thousand beds is just impractical.
5. There should be an independent, scientific inspection of hospital cleanliness and infection control, perhaps by the new Commission for Healthcare Audit and Inspection (as long as it is truly independent) giving a national picture of the cleanliness of England's hospitals, so that patients can be sure that everything that can be done is being done to keep hospitals clean, and to control the spread of healthcare acquired infections.
6. The problem must be tackled at its source. The growth of antibiotic resistant infections is partly due to our overuse of antibiotics. There should be a visible and sustained campaign to educate GPs and the public against the overuse or inappropriate use of antibiotics. There should be strict regulations against the overuse of antibiotics in agriculture.

3.3. **Recommendation 1:** The Government has made some progress since the publication of Now Wash Your Hands. Last year, the Chief Medical Officer Sir Liam Donaldson, published a strategy to combat infections⁵. At the time, he admitted that “ **healthcare associated infection has in the past not been as high a priority for action as some other aspects of healthcare**”

This lack of urgency on infections has resulted in almost no improvement. The strategy goes on to state that “**Despite the extent of the guidance issued to the NHS, such data as are available show that the degree of improvement has been small.**”

The strategy noted that key factors in the spread of infections are inadequate facilities, lack of time and a paucity of hand hygiene agents. This is consistent with the findings of our survey. John Reid admitted after the publication of this strategy, that it “did not announce any new policy”⁶.

3.4. **Recommendation 2:** The Government has made progress on increasing staff numbers, although hospitals are still very reliant on temporary staff. It is

⁵ *Winning Ways* :Working together to reduce Healthcare Associated Infection in England, Report from the Chief Medical Officer, Dec 2003. <http://www.publications.doh.gov.uk/cmo/hai/winningways.pdf>

⁶ Letter to Peter Lilley MP, quoted in The Times, December 12, 2003.

essential that these doctors and nurses are given proper training on infection control practices if they are new to the hospital.

- 3.5. **Recommendation 3:** There is not much evidence of improvement. Recent parliamentary questions uncovered that⁷:

“No information is held centrally on the number of hospitals with on-site laundry facilities. There is no intention to require all hospitals to have laundries on site. The management and control of hospital linen is administered at local level. National health service trusts are required to have risk management protocols with regard to effective laundry practice.

Provision and laundering of staff uniforms is a matter for individual trusts to determine. There are no proposals to require staff to leave uniforms at work for trusts to launder.”

The Government have guidelines on the use of laundry facilities and these highlight the need for proper laundering of uniforms⁸: *“Washers and dryers of an industrial standard must be purchased (domestic washing machines have a very small rinse cycle)....“Changing facilities should be provided for staff, to encourage them to change out of their uniform, in the workplace.”*

However, it is clear that this guidance is being ignored. A recent MORI survey⁹ found that 95% of nurses said they used their own domestic washing machines to clean dirty uniforms. Sixty-eight per cent of nurses questioned by MORI said their trusts did not have facilities to wash their uniforms.

- 3.6. **Recommendation 4:** The Government’s new strategy will mean every NHS trust will get a Director of Infection Control. It is difficult to see how these directors will improve the situation. Hospitals already have heads of infection control teams who can report to the Chief Executive who has ultimate responsibility. Many also now have ‘modern matrons’ who are meant to hold responsibility for infections on the wards. The Government risks created many different new managers all focused on the same issue, with conflicting chains of command.

I asked which hospitals did not already have a director of infection control before the strategy was announced. Health Minister Melanie Johnson replied: *“No National Health Service organisation had a director of infection prevention and control (DIPC) in place last year as this new responsibility and its associated duties were only announced in December. Information on the heads of infection control teams is not collected centrally but the DIPC’s remit extends beyond the infection control team”*

In other words it is very likely that every hospital already had an infection control team, headed by a lead person on infection control. It is unclear what real difference this new role will make on the wards. The problem

⁷ 8 September 2003, Official Report column reference 6W.

⁸ Infection Control in the built environment – NHS Estates, second edition 2002

⁹ Sunday Express, August 10, 2003

outlined by the National Audit Office was that infection control was not high enough on the agenda of trust chief executives. It is this ordering of priorities which must change. Chief Executives must not become complacent, believing that all infections are inevitable and that nothing can be done to improve the situation.

- 3.7. **Recommendation 5:** The Chief Medical Officer's Strategy stated that the new watchdog, the Healthcare Commission "*will be asked to make infection control a key priority when assessing hospital performance*". However, this does not mean that the Commission will publish a national report on infection control and hospital infections. There has still been no national audit of compliance with infection control standards in NHS hospitals, and the Government have no plans to publish one. Health Minister Hazel Blears wrote to me saying that:¹⁰ "*We have no plans to publish such a national audit [of compliance with infection control guidelines]*."

In order to get a national picture of hospitals' compliance with infection control standards, I asked some parliamentary questions on central monitoring of the 'controls assurance standards' used in the star ratings. The information I was given was less than encouraging. **Hospitals assessed themselves on how well they were implementing infection control procedures. On average, they gave themselves 6 out of 10¹¹.** The Government have now reneged responsibility for measuring infection control standards. I was told¹²: "*Under Shifting the Balance of Power, strategic health authorities assumed responsibility for monitoring national health service trusts' compliance with the controls assurance standard on infection control*"

Ministers plan to allow strategic health authorities to monitor the implementation of their infection control strategy. The new Healthcare Commission will include this implementation in the star ratings. The Government's mandatory reporting scheme for MRSA has also been included in these ratings, which at least provides some incentive for hospitals to target infection control.

- 3.8. **Recommendation 6:** Very little progress has been made on this point. The Government's claims in their strategy are aspirational to say the least. The claim that "*Antibiotics will only be taken by patients over the prescribed period at the correct dose*" will be impossible to monitor. It is clear that much of this strategy is an exercise in good publicity for the Government, with not much substance underneath. The Government should do more to encourage companies to invest in developing new antibiotics. When asked about this, Health Minister Melanie Johnson simply said: "*Our policy concentrates on supporting appropriate prescribing rather than influencing industry's research programmes*"¹³.

¹⁰ Letter 13 Nov 2002 to Paul Burstow MP

¹¹ Written answer 23 April 2004, column reference 705W. See Appendix A

¹² Written answer 12 March 2004, column reference 1822W

¹³ Written answer to Paul Burstow MP, 20 April 2004, Official Report, column reference 426W

4. Clean Hospitals Programme – The Sham Continues

- 4.1. Despite the discrediting of the Clean Hospital Programme inspections in *Now Wash Your Hands*, the latest strategy still boasts of this as a way to tackle hospital infections, even though the programme covers many different things other than cleanliness and infection control. In a recent parliamentary answer to Liberal Democrat MP Mike Hancock¹⁴, Health Minister John Hutton stated that *“there are no plans to change the system”*. *These scores will be fed into hospitals ‘star ratings’ for 2004/5*¹⁵.
- 4.2. There is obviously a strong incentive for Ministers not to scrap the scheme – as the parliamentary answer stated, no hospitals are now assessed as ‘red’. This shows that the clean hospitals traffic light system is nothing more than a PR exercise. If no hospital is ‘red’, it is impossible to compare which hospitals are doing better than others, or any measure of how hospitals are improving over time. It is like measuring the height of men in England starting with a category of 2 to 3 foot. Of course no one will be in the lowest category.

5. Where are the ward housekeepers?

- 5.1. Another key element of the Government’s strategy to combat infections is the introduction of ward housekeepers to clean up the wards¹⁶. But progress on this has been astonishingly slow.
- 5.2. The Government set a target in the NHS Plan¹⁷ half of all hospitals to have ward housekeepers by 2004. In September 2003 only 2 in 5 hospitals had introduced them¹⁸. In June 2000 72 hospital trusts had already ‘begun to develop services in this area’. This is the same as 41% of all hospital trusts¹⁹. This does not look like much progress.

6. Bed shortages

- 6.1. A key issue in combating the spread of infection is the sheer number of patients needing to be admitted to hospitals. This combined with the fall in the number of hospital beds, means that there is less time to clean beds between patients.

¹⁴ Written answer 8 September 2003, Official report column reference 6W.

¹⁵ http://www.chi.nhs.uk/eng/ratings/2005/2005acute_KT.pdf

¹⁶ The Government’s patients ‘czar’, Harry Cayton has said that a key role of ward housekeepers is to combat hospital acquired infection:

http://www.nhsestates.gov.uk/download/ward_housekeeping/Contributing.pdf

¹⁷ July 2000, Dept of Health

¹⁸ Written answer, 8 April 2004 (CHECK COLUMN REF)

¹⁹ <http://hcl1.hclibrary.parliament.uk/notes/sgss/snsg-02217.pdf> According to the House of Commons library, there are 154 acute trusts and 22 trusts which offer acute and community services – that equals 176 hospital trusts.

- 6.2. The table on the next page shows the number of hospital beds has dropped under Labour. Even though there has been a small rise over the last two years, there are still fewer beds now than when Labour came to power. Bed occupancy has risen dramatically in that time to dangerous levels. A bed occupancy of over 85% leads to many problems including with infection control²⁰.

Average daily number of general and acute beds open overnight (England)		
Year	Number of Beds	Bed Occupancy (%)
1996-97	140,515	80.8
1997-98	138,047	80.5
1998-99	136,426	82.5
1999-00	135,080	83.1
2000-01	135,794	84.7
2001-02	136,583	86%
2002-03	136,679	86.5%

Source: Department of Health Hospital Activity Statistics

7. Isolation facilities

- 7.1 *Now Wash Your Hands* found anecdotal evidence that MRSA patients are often treated on wards because of a lack of isolation facilities and staff. Government guidelines on the management of patients with infections recommend the use of isolation facilities for certain infections²¹:

“With an increase in antibiotic-resistant bacteria and immunocompromised in-patients, there is an increasing need for en-suite single rooms and negative or positive pressure isolation rooms. Provision of isolation/single rooms will help prevent the spread of organisms, especially those transferred by the airborne route or those easily disseminated into the immediate patient environment.”

However, the same guidance admitted that the provision of isolation facilities and single rooms in NHS hospitals is sadly lacking:

“Experience has shown that many hospitals find the present allocation of isolation/single rooms inadequate to deal with the increasing numbers of infected and immunocompromised patients (Langley et al, 1994; Wiggam and Hayward 2000).

“Hospitals with 10% of their bed contingent as single rooms often find that this number is inadequate to cope with every infectious patient. Where this is the case, risk assessment is used to inform decisions regarding which patients to nurse in single rooms.”

²⁰ The Government’s Emergency Services Action Team (ESAT) report in 1997 included analyses showing that in acute hospitals average bed occupancy rates over 85% are associated with rapidly growing problems in handling emergency admissions.

²¹ Infection Control in the built environment – NHS Estates, second edition 2002

- 7.2 Parliamentary questions were asked to ascertain whether the Government is monitoring compliance with these guidelines. Ministers have stated that NHS trusts are individually responsible for “*determining the level of provision of isolation and single rooms*”²². Health Minister Melanie Johnson stated that²³:

“Health Service Circular 2000/002 on the “Management and control of hospital infection” required trusts to undertake a risk assessment to determine appropriate provision of isolation facilities within each trust but these data were not collected centrally.”

If Ministers are completely in the dark about the level of frontline preparedness to deal with hospital infections in general how can they hope to deal with serious diseases like SARS?

- 7.3 The Chief Medical Officer’s strategy for combating infections stated that: “*NHS Trust Chief Executives will ensure that, over time, there is appropriate provision of isolation facilities within their healthcare facilities*”.

I asked a parliamentary question to obtain more details. The reply was not informative. Health Ministers have no sense of urgency on this issue:

*“As the creation of new isolation facilities is generally linked to local plans for rebuilding and refurbishment it is not feasible to set a national timetable. Over-time is not specifically defined but provides flexibility for chief executives to implement realistic, timed work programmes for isolation facilities”*²⁴

This response is a worrying sign that the Government’s new ‘strategy’ is little more than a paper exercise. It compares unfavourably to the Government’s ability to set a central timetable for the removal of mixed sex wards. At the very least the Department of Health should undertake an audit of local timetables for introduction of isolation facilities.

8. Hand Basins

- 8.1 *Now Wash Your Hands* found that almost a third of respondents were either “quite” or “very” unsatisfied that staff were washing their hands as often as was recommended. Hand hygiene is a major factor in the prevention of infections in hospital, as the Chief Medical Officer accepted in his strategy. The National Patient Safety Agency in their hand hygiene campaign found that, on average, only 40% of necessary hand hygiene procedures were carried out”²⁵.

²² Written answer to Sandra Gidley MP 19 Sept 2002, column 407W

²³ 2 February 2004, column 687W

²⁴ Written answer to Paul Burstow MP 12 March 2004, column 1819W

²⁵ Source: Nursing Standard April 14/vol18/no31/2004

8.2 One of the major factors as to whether people wash their hands is the availability of hand basins. Government guidance²⁶ states:

“A minimum of one hand-wash sink in each single room is required.

- Ideally in intensive care and high dependency units, consideration should be given to providing one hand-wash basin at the front of each bed space
- In acute, elderly and long-term care settings, consideration should be given to providing one sink between four patients”

According to a written parliamentary answer²⁷, any new facilities being built are monitored by NHS Estates, including on how they comply with recommendations on the number of wash-hand basins. However, existing facilities are the responsibility of individual hospitals. The Government does not collect information on the availability of wash-hand basins in NHS hospitals.

9. MRSA

9.1 Since the publication of Now Wash Your Hands, in 2002, rates of MRSA have hit record levels. The Government’s mandatory scheme of reporting MRSA rates is now in its second year. The table in Annex 1 of this report illustrates the scale of the problem and the extent to which the voluntary reporting system failed to demonstrate this²⁸.

9.2 The number of MRSA infections has increased from just over 1000 in 1996 to over 7000 last year. In 1996 there were 3 recorded infections per 100,000 people in England. Last year, under the mandatory scheme this was 15 (see Appendix A). We know that the figures for 1996-2002 under the voluntary scheme were incomplete, and the huge rise in infections reported to the mandatory scheme shows how far the problem has previously been hidden. Highest rates of infections are found in London.

9.3 Worryingly, in America there have already been three cases of vancomycin-resistant MRSA. This means that the bacteria has got stronger and has developed resistance to ‘vancomycin’, a very strong antibiotic used to treat MRSA. Although there are still some drugs available which could treat VRSA it is a worrying sign of the ability of these drugs to develop resistance to even the strongest antibiotics.

10. Death Certificates

10.1 While statistics are now available on the numbers of MRSA infections, it is still very difficult to gauge the number of deaths caused by this bug. The problem is that it cannot be separately coded as a cause of death on death

²⁶ Infection Control in the built environment – NHS Estates, second edition 2002

²⁷ Written answer to Paul Burstow MP 28 January 2003, column 808W

²⁸ Figures obtained from a Parliamentary answer 12 March 2004, Official report column reference 1822/3W.

certificates. Often a code for another disease will be used, for example “carrier of unspecified infection”. People who catch MRSA are often already very sick, and their original condition is listed as the cause of death. Death certificates are notoriously incomplete and inaccurate. In one study only around half (55%) of certificates were completed to an acceptable minimum standard²⁹.

- 10.2 Some limited research has been undertaken by the Health Protection Agency and the Office of National Statistics, involving a manual examination of death certificates. The number of certificates where MRSA was mentioned as either a direct or an underlying cause of death has increased over 15 fold between 1993 and 2002³⁰. Death certificates showing MRSA as the underlying cause of death increased from 15 in 1993, to 248 in 2002.
- 10.3 The Government gave reassurances in Parliament that the issue of the recording of MRSA on death certificates would be covered in a consultation on the certification process³¹. A World Health Organisation review of disease codes is currently looking at using additional codes to identify resistant bacteria and that process is ongoing. The codes may be used from 2006³².
- 10.4 The difficulty stems from the fact that death certificates identify the cause of death as the condition which ‘began the sequence leading to death’. This is then seen as the underlying cause of death. As people who catch MRSA are usually sick with another disease in hospital, according to the National Statistician Len Cook: *“It is up to the doctor how many conditions in the sequence, other than the underlying cause, he thinks should be recorded. MRSA may contribute to death, but it is unlikely to be the first event in the sequence”*³³.
- 10.5 This, coupled with the fact that there is no identifying code for MRSA means that even when MRSA is recorded on the certificate, it is rarely identified as a cause of death. Routine mortality statistics can therefore not measure the number of deaths caused by the superbug.
- 10.6 According to the National Statistician to really know the extent of the role of MRSA in deaths in hospital would require³⁴: *“special epidemiological research studies which compared the outcome in patients who were otherwise equally ill and had similar treatment, but who did or did not contract MRSA.”*

²⁹ Swift B, West K. Death certification: an audit of practice entering the 21st century. J Clin Pathol 2002; 55: 275-79

³⁰ Trends in MRSA in England and Wales: analysis of morbidity and mortality data for 1993 - 2002, completed in collaboration with the Office of National Statistics is published in Health Statistics Quarterly 21 - Spring 2004 <http://www.statistics.gov.uk/STATBASE/Product.asp?vlnk=6725>

³¹ House of Commons Hansard: 10 July 2003, column 1356

³² Letter from National Statistician Len Cook to Paul Burstow MP, 27 October 2003

³³ Ibid

³⁴ Letter from the National Statistician and Registrar General, Len Cook, dated 9 December 2003:

- 10.7 A parliamentary answer to a question I tabled showed that even the Government's proposed solution, the review of the death certification process, will not solve this problem³⁵:

"The proposal to reform the coroner and death certification service is likely to improve information about MRSA infection at or shortly before death in a number of ways:

The emphasis on improved training for doctors in how to complete death certificates and the scrutiny of all certificates by specially trained medical examiners will improve the quality and completeness of information collected.

The ability to link fact and cause of death to laboratory or patient records of infection will make it possible to determine how many people die following a diagnosis of invasive MRSA infection.

Specific research studies would still be needed to determine how much MRSA, or other health care associated infections, contribute to the likelihood of dying amongst patients with the same underlying illness and treatment."

Therefore it will continue to be impossible to assess the scale of the problem. Official statistics on the number of superbug deaths are simply the tip of the iceberg. The Government should undertake the research studies needed to ascertain how serious the situation really is.

11. Community infection

- 11.1. Healthcare associated infections are not confined to hospitals. The increase of infections in hospitals has been mirrored by more reports of infections in the community – in GP surgeries and in care homes. The Department of Health has issued guidance to primary care trusts about infection control, but there is little monitoring or awareness of the problem. Infections in people who have not had contact with healthcare are also becoming more resistant to antibiotics.
- 11.2. Recently, there have also been cases of MRSA being found in animals, including pets. This is worrying as it may make it harder to limit the spread of these bacteria and the threat of MRSA becoming more resistant to strong antibiotics. It is unknown whether animals have acquired the infections from humans or vice versa.
- 11.3. The use of antibiotics in the community is contributing to this greater resistance, and this means in future GPs will have fewer antibiotics to use to treat infections. Awareness needs to be raised amongst GPs and patients of the danger of over-prescribing of antibiotics.

³⁵ Written answer 22 March 2004 , column 648W

11.4. Despite the Chief Medical Officer's strategy to tackle infections, the Government are dangerously complacent on infections in the community. In a written parliamentary answer, Health Minister Melanie Johnson said³⁶: *"Central monitoring of compliance with infection control in community settings is not undertaken"*. This means the Government has no idea how big the problem of community infection is, or how well local health services are tackling infection control.

12. Infection Control in Care Homes

12.1. Of particular concern are infections occurring in care homes. Patients who would previously have been treated in long stay beds in hospital are now being treated in care homes and so people in these homes are often sicker, and therefore more at risk from infections than they used to be. Research from Nottingham found more than half the nursing homes in Nottingham were affected³⁷. Some care homes have chosen to prevent any resident who has caught MRSA in hospital from being returned to the home, despite reassurances from the hospital that the return is safe.

12.2. The Government's guidelines on infections in care homes³⁸ state that: *"Infection is a major cause of illness among nursing home residents and may result in avoidable admissions to hospital....Increasingly, people are being discharged into the community having acquired MRSA in hospital."*

There appears to be no obligation from these guidelines for infection control staff from the NHS to visit private care homes. The guidelines assume that each home will have a person in charge of infection control, but this is not obligatory, and the person does not have to have specific infection control qualifications or training.

12.3. Research has shown that an average 36 bed nursing home in the UK might have 50-80 infections a year, with around five or six residents affected at any one time. An audit of infection control in UK nursing homes found that there was still much room for improvement on handwashing, isolating patients, and cleaning. Standards for caring for residents with MRSA were met in only 19% of cases³⁹.

12.4. The Commission for Social Care Inspection does check up on care homes to ensure they are meeting minimum standards on infection control. However, they do not collect and publish information specifically about MRSA⁴⁰. There is very little evidence that the Government are monitoring this issue, in the same way that they are in hospitals. Despite the

³⁶ Written answer 14 October 2003, column 44W

³⁷ Sunday Express, September 21, 2003, Dr Richard Slack, consultant for communicable diseases at Nottingham Health Protection Unit

³⁸ 1996 Guidelines on the Control of Infection in Residential and Nursing Homes, Public Health Medicines Environmental Group.

³⁹ Ibid

⁴⁰ Written answer 6 May 2004, column 1799W

importance of infection control in care homes, a written answer⁴¹ stated that: “*There are no centrally held statistics on care homes and the admission of patients with MRSA or other hospital acquired infections.*”

13. Conclusion

- 13.1. Since the publication of *Now Wash Your Hands*, the Government have admitted that infection control has not been a priority. They have set out a new strategy and it remains to be seen if these measures will prove to be effective. This report has highlighted the gaps in Government monitoring of the situation and in hospitals’ ability to tackle the superbugs. Not all infections can be prevented. It is essential, however, that the Government makes infection control a top priority to minimise the risk of healthcare associated infections.

14. Recommendations

1. The strategy introduced by the Chief Medical Officer must be introduced urgently, to an agreed timetable (para 4.2)
2. The Healthcare Commission should undertake a national review of the state of infection control in the NHS in England, including community services – working together with the Commission for Social Care Inspection (see para 3.7)
3. The Government should undertake the research studies needed to ascertain the number of deaths caused by MRSA each year (section 7)
4. The Government have introduced a confusing number of new job titles to deal with the problem, like modern matrons, ward housekeepers and directors of infection control, Further guidance is needed on the relative roles of clinical and management staff in infection control and lines of accountability. Guidance is required on the clinical competence and the authority a director of infection control should have. (para 3.6)
5. Urgent guidance is needed on the appropriate level of infection control staffing. No guidance exists on numbers of infection control nurses and there is a wide disparity between trusts, as evidenced in the previous report, *Now Wash Your Hands*. (para 2.4)
6. Primary Care Trusts must either have infection control staff or there must be a dedicated member of staff from the local acute trust to handle the problem of healthcare associated infections and antibiotic resistance in the community (section 8)
7. Education and training in infection control should be mandatory, in the same way that health and safety and fire regulations are mandatory. Training on infection control should also be a part of pre-registration programmes for all health care staff, not just doctors and nurses. (para 2.4)
8. The number of single room facilities is drastically lacking. The Government should immediately commission a review into provision of single room facilities and isolation rooms with specialist ventilation and produce a timetable for providing appropriate isolation facilities in every NHS hospital

⁴¹ Written answer 28 February 2003, column 769W

9. An audit of the provision of wash-hand basin facilities and alcohol hand rubs should be undertaken in existing hospitals, to ensure that hand hygiene protocols are more likely to be adhered to (section 5)
10. The Government should produce a template guide for patients to raise awareness of what can be done to prevent unnecessary infections based on best practice of existing guides produced by hospitals or patient organisations
11. The Healthcare Commission should coordinate all the bodies charged with monitoring and implementing infection control guidance – at present roles are split between the Health Protection Agency, The National Patient Safety Agency, the Healthcare Commission, and other bodies.
12. The Government should evaluate existing schemes to raise awareness of inappropriate use of antibiotics including in animal husbandry and continue the emphasis on this element of the solution (para 3.8)
13. The Government should undertake a thorough evaluation of the need to roll-out the mandatory surveillance schemes to cover other healthcare associated infections, so that it is possible to assess the scale of the problem (para 3.7)

Appendix A: MRSA Rates

Number of MRSA bacteraemia lab reports and rate per 100,000 population—voluntary lab surveillance	1996		1997		1998		1999	
	Region	Number of MRSA	Rate	Number of MRSA	Rate	Number of MRSA	Rate	Number of MRSA
North East	10	0.39	46	1.78	138	5.35	143	5.55
Yorkshire and Humberside	50	0.73	130	1.89	197	2.86	181	2.63
East Midlands	40	0.79	130	2.57	143	2.83	215	4.25
Eastern	159	3.78	271	6.44	364	8.65	442	10.50
London	327	6.13	447	8.38	422	7.91	458	8.58
South East	228	4.18	321	5.88	375	6.87	404	7.40
South West	87	1.18	191	2.59	191	2.59	305	4.14
West Midlands	267	3.29	336	4.14	396	4.88	498	6.14
North West	105	2.11	173	3.48	295	5.93	367	7.38
England	1,273	2.55	2,045	4.09	2,521	5.04	3,013	6.03

Number of MRSA bacteraemia lab reports and rate per 100,000 population—voluntary laboratory surveillance	2000		2001		2002	
	Region	Number of MRSA	Rate	Number of MRSA	Rate	Number of MRSA
North East	185	7.18	179	6.95	236	9.390
Yorkshire and Humberside	314	4.55	378	5.48	496	9.955
East Midlands	331	6.54	404	7.99	441	10.461
Eastern	477	11.34	604	14.35	620	11.438
London	549	10.29	525	9.84	691	9.395
South East	564	10.33	724	13.26	745	9.269
South West	373	5.06	479	6.49	541	10.908
West Midlands	771	9.50	817	10.07	768	14.479
North West	365	7.34	453	9.11	477	7.068
England	3,929	7.86	4,563	9.13	5,015	10.12383

Number of MRSA lab	2001-2	2002-3
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reports—and rate per 100,000 population—mandatory surveillance				
Region	Number MRSA	Rate	Number MRSA	Rate
North East	363	14.42	380	15.12
Yorkshire and Humberside	714	14.37	671	13.47
East Midlands	543	13.01	494	11.72
Eastern	744	13.79	710	13.10
London	1,571	21.86	1,655	22.50
South East ⁽¹⁹⁾	967	12.08	936	11.65
South West	696	14.11	738	14.88
West Midlands	761	14.45	812	15.31
North West	867	12.88	934	13.84
England	7,226	14.69	7,330	14.80

⁽¹⁹⁾ Analysis based on 24/25 trusts in this region, due to late submission of data from one trust

MRSA

Mr. Burstow: To ask the Secretary of State for Health pursuant to the answer of 12 March 2004, *Official Report*, columns 1822–23W, on MRSA, what the assurance scores on infection control are for NHS trusts in England. [167533]

Miss Melanie Johnson: The infection control self-assessment scores are collected annually and will not be available until June 2004. National average scores for the past three years for national health service trusts and primary care trusts are shown in the table.

	Score (percentage)
2001	63.2
2002	63.6
2003	64.3