KENT COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

MINUTES of a meeting of the Health Overview and Scrutiny Committee held in the Council Chamber, Sessions House, County Hall, Maidstone on Friday, 9 January 2009.

PRESENT: Mr M J Fittock (Vice-Chairman), Mrs C Angell, Mr A R Chell, Mr A D Crowther, Mr J Curwood, Mr D S Daley, Mr C G Findlay, Ms A Harrison, Mr M J Northey, Mr R J Parry, Dr T R Robinson, Mrs E D Rowbotham, Ms B J Simpson, Mrs P A V Stockell (Substitute for Mr B R Cope), Mr R Tolputt, Cllr Ms A Blackmore, Cllr J Cunningham (Substitute for Cllr Mrs M Peters), Cllr R Davison and Cllr M Lyons.

ALSO PRESENT: Mr R Kenworthy, LINk Member, Mr M Cayzer, Wateringbury Parish Council, Mrs A Burnand, Performance Management Officer, KCC, Ms K Barkway, West Kent PCT and Ms G Alexander, Eastern & Coastal Kent PCT.

IN ATTENDANCE: Mr P D Wickenden (Overview, Scrutiny and Localism Manager) and Mr T Godfrey (Research Officer to Health Overview Scrutiny Committee).

Mr Fittock presiding as Chairman

UNRESTRICTED ITEMS

1. Membership

The Overview, Scrutiny and Localism Manager reported that Mr C G Findlay had replaced Mrs E M Tweed on the Committee.

2. Minutes - 17 October 2008

(Item 3)

RESOLVED that the Minutes of the meeting held on 17 October 2008 are correctly recorded and that they be signed by the Chairman.

3. Matters Arising

A Picture of Health for Outer South East London

(1) The Overview, Scrutiny and Localism Manager reported that since the last meeting of the Committee the Joint Committee of London Boroughs and the County Council had referred the reconfiguration proposals for a Picture of Health for Outer South East London to the Secretary of State for Health as had the London Borough of Bexley separately.

(2) Notification had been received from the Secretary of State for Health that this matter had been referred to the Independent Reconfiguration Panel for consideration.

Accessing Healthcare – Transport

(3) The Overview, Scrutiny and Localism Manager reported that a commitment had now been received from the two Primary Care Trusts in the administrative county of Kent, the acute Hospital Trusts, Social Services and transport planners to this piece of work. A half day workshop to identify clearer service delivery objectives was being prepared for early February.

(4) In the spring it was hoped that an initial action plan for taking this work forward would be reported to the Committee.

Annual Health Check

(1) The Committee had before them a briefing note prepared by the Research Officer to the Health Overview and Scrutiny Committee which set out the key points for the Annual Health Check and the Committee's interest in looking at three core standards in detail relating to the Hygiene Code which included:-

- C4a – Infection Control;
- C4c – Decontamination; and
- C21 – Clean, well designed environment.

(2) The Committee noted that assessment of the Core Standards forms part of the "Quality of Services" score in the Annual Health Check. Any commentary from a Health Overview and Scrutiny Committee will form part of the evidence the Care Quality Commission (CQC) uses to cross reference the declarations made by each individual Health Trust. In the early part of 2009 NHS Trusts will have to register with the CQC. Registration is contingent on compliance with the Hygiene Code. There will be a separate assessment of Primary Care Trusts as providers of services and commissioners for 2008/2009. Between 15 April and 1 May 2009 Trusts will be asked to submit self declarations on how compliant they are against the Core Standards, including the three relating to the Hygiene Code.

(3) These Core Standards were derived from the 2004 Department of Health publication "Standards for Better Health" which set down 24 core standards and described the minimum level of service all Health Trusts were meant to provide. In October 2009 the CQC will publish the results of the Annual Health Check for 2008/2009.

4. Dartford & Gravesham NHS Trust

(Item 4)

Mr M Devlin, Chief Executive and Mrs I Smith, Director of Infection Prevention and Control were in attendance for this item.

(1) Mr Devlin and Mrs Smith made it clear that they did not want to say much in the way of introduction but leave the majority of the time for questions from those Members present. However, by way of introduction the Chief Executive indicated he had struggled with a low tolerance for infection control and in particular MRSA. The Trust allowed for 12 cases of MRSA per year and that included community acquired infections detected at hospital. However, the numbers of MRSA cases to date were

30% lower than the previous year. The Trust had taken a much higher profile with regard to prevention in terms of hand hygiene and alcohol gels.

(2) A programme of deep cleaning had been undertaken and was a continuous, on-going programme.

(3) In answer to a question about the risks associated with infection control in an emergency or for elective surgery. Colleagues from the Trust responded and talked about the processes that they had in place at the Dartford & Gravesham NHS Trust which included the pre-assessment clinics for elective surgery. Since July 2007, screening had taken place for all routine admissions of all adults. This had resulted in the reduction of post operative ward infections, e.g. levels of MRSA and had therefore been a successful strategy.

(4) The Committee were informed by Trust colleagues that screening would be extended to include emergency screening in accordance with the Department of Health advice by 2011.

(5) The Trust informed the Committee that by the end of March 2009 screening of all elective cases would begin. Guidance was still being issued and work was also be undertaken to assess the amount of inpatient days patients stayed which gave a measure of success for the pre-assessment.

(6) In answer to a question about the amount of time that it took to do the screening, Mrs Smith informed the Committee that with pre-assessments there was enough time to have the swab analysed. This generally took 2 days. However, there was provision, which was very expensive, to analyse a swab within 4 hours. This was particularly important in higher risk areas such as the Intensive Care Unit (ICU). The Trust continued to look at the use of new technology to assist in this process.

(7) The Committee noted that within the document that the Trust had prepared in advance for the Health Overview and Scrutiny Committee one of the sections related to success and challenges. The Trust had identified that the success of the IP Management pathway had been extended to urinary catheters as they were recognised as being a source of hospital acquired infection (HAI).

(8) Mrs Smith responded that the IV lines Management pathway had been a great success. She spoke about the importance of education and training, recognising new diseases and auditing what was going on. She said that there had been one incident of canula infection during the past year but this was one too many. The Trust had learnt an awful lot from the IV Management pathway and they were extending this to other parts of the organisation. Canulas and catheters presented a greater risk for infection.

(9) In answer to a question relating to the Trust's policy of "bare below the elbows" uniform policy, adopted by clinical staff thereby facilitating hand hygiene practice the Committee were informed that policy being adopted by the Trust of "bare below the elbows" was being dealt with where there were issues on an individual basis.

(10) The Committee were advised that this policy was not confined purely to the hospital and some colleagues were challenging this policy. Mr Devlin added that he did feel that the message was getting through to the staff concerned and this was a

consistent message from himself as Chief Executive, Iris Smith as the Director of Infection Prevention and Control (DIPC) and the Trust' Medical Director. Those members of staff who were not complying with this policy he did not feel were doing this wilfully. He said they were not covered by the evidence.

(11) The elective cases not screened were the day cases. The trust needed to look at elective day cases.

(12) In answer to a question as to whether children were screened Mrs Smith answered that they were not routinely screened, which was in line with the Department of Health Guidance.

(13) Asked about the challenges surrounding a patient's length of stay and the impact in terms of infection control Mrs Smith responded that the longer a patient stayed in hospital the more likelihood was that the general condition and not if infection would be increased, i.e. because of being in a shared environment and the immobility of a patient made them at a higher level of risk for hospital acquired infection and the spread of that infection. Mr Devlin informed the Committee that the Trust were undertaking a significant piece of work to achieve the outcome of reducing the length of stay of patients.

(14) One of the difficulties referred to was that many of the patients, before they even present to the hospital have a community acquired infection. What the public did not appreciate is that a percentage of the population already have MRSA and C Difficile but do not appreciate that they have it. What concerned the Member is where was the public awareness campaign, and what was happening in the community in terms of presentation and raising the awareness of community acquired infections. It was not joined up with the PCTs.

(15) Mr Devlin acknowledged that the statement made by the Member was very true and that this was another very important strand that the Trust would be tackling as part of the 'whole system's' approach with its Primary Care Trust colleagues.

(16) He added that Primary Care Trusts were building up their expertises in the area of community acquired infections. 50% of all infections were community acquired. Mr Devlin reaffirmed that it was important that the Strategic Health Authority, Primary Care Trusts, the community and the Department of Health were all working together and it was important that the education and public relations exercise was undertaken.

(17) Asked the question about whether it would be appropriate not to take in patients who had the infection because ultimately that costs the National Health Service more Mr Devlin responded that that clearly would not be appropriate. In an emergency urgent situation patients could not be turned away. For elective surgery the pre-assessment for infection was reducing the risk.

(18) However, he said that this continued to be a challenge for hospitals such as the Darent Valley Hospital because it was very different to somewhere like the Queen Victoria Hospital in East Grinstead which had no Accident & Emergency Unit – they run on elective services.

(19) In response to a series of questions about hospital cleanliness including what is a deep clean, how is cleaning physically undertaken, especially around the beds,

what was the Trust's advice relating to visitors and what physically happens on the ward.

(20) Mrs Smith responded that there were three cleaning processes that she wished to describe. The first was day to day cleaning, the second was cleaning of areas around patients with infection and the third was the deep cleaning process.

Day to day cleaning – with regard to the day to day cleaning each ward had a dedicated cleaner employed by Carillion, the external cleaning provider for the Dartford & Gravesham NHS Trust. The cleaning schedule was designed in consultation with the Matron and ward sister. There were also domestic supervisors who had a role of checking quality standards.

This was followed up by monthly monitoring which was normally unannounced and a number of unannounced meetings.

Deep cleaning – the challenge here was to initially empty an entire ward to thoroughly clean the ward bay by bay and room by room and then to carry out this process systematically throughout the hospital. The Trust had purchased six steam machines.

(21) The Committee noted the challenges associated with the deep cleaning process.

(22) Pushed further about the part of the question which had not been responded to on infection control Mrs Smith said that she was an advocate for soap and water as being one of the best preventions for infection. Alcohol does have its benefits (particular for visitors) and she reminded the Committee of the huge push that had been undertaken by the Department of Health. However, alcohol gel was not effective in terms of C Difficile.

(23) She added that education was key to prevention. With a regard to a patient who already had C Difficile then the process would be that that person would be isolated to a single room and Trust staff would talk to the patient and their visitors in terms of infection control management.

(24) In response to a Member's question relating to the role of nurses and how they are trained before they start work on the ward Mrs Smith stated that she too had been a nurse at the same time as the Member asking the question and the role had changed dramatically since she was nursing.

(25) The induction process for new nurses was fairly broad but it was important that part of this training was going "back to basics" in terms of hygiene.

(26) Mrs Smith advised the Committee of the processes student nurses go through. She explained that the Trust had set aside an area where there was a bed where nursing assistants and student nurses were trained on how to strip the bed and clean it. With regard to agency staff Mrs Smith informed the Committee that the number of agency staff within the Dartford & Gravesham NHS Trust had significantly dropped. However, agency staff had their own set standards but it was fair to say that those standards matched those standards that would be required by the Dartford &

Gravesham NHS Trust. Increasingly, as opposed to using agency staff, the Trust were relying on their own 'bank staff'.

(27) In answer to a question about the screening process Mrs Smith informed the Committee that with regard to MRSA screening there were three sites on the body where swabs for MRSA were taken. These sites were; underneath the arm; in the groin and nasal swabs. These swabs were generally taken by a nurse based on the ward and were then sent to the laboratory. If the results were negative this would be known within 24 hours but if the results showed that it was positive further tests would be undertaken and these would be known within about 48 hours. This was the general standard but there was a four hour rapid testing system available.

(28) In terms of an urgent admission or emergency, the process also involved an assessment of risk and in appropriate cases antibiotic cover would be provided.

(29) Mrs Smith was unable to answer directly the cost associated with these tests in terms of the swab and consumables.

(30) One Member spoke of recent visits to hospitals where innumerable people did not use the alcohol gels and parents not asking children who were visitors to the hospital to undertake the required level of hygiene.

(31) Mr Devlin responded to the Committee that the issue of hand hygiene needed to have a much higher profile. Engagement with the public was key. It was a case of continually refreshing and changing the message. He spoke of work that the Trust had undertaken within the hospital to insure that whilst the message was the same it was dealt with in a different way so always had an impact. Mrs Smith added that there was a need for a huge public campaign on hand hygiene and infection control.

(32) In answer to a question relating to infection control for community hospitals Mrs Smith said that community hospitals were managed by colleagues in the Primary Care Trusts.

(33) In response to a question relating to infection control in nursing and residential homes she said that this was an issue for the Health Protection Unit. The Committee noted that the registration process for nursing and residential homes for the new CQC was due to start next week. The CQC would have the right to make spot check inspections of these establishments.

(34) In answer to a question about the provision of domestic services the response from the Trust was that this was in-house.

(35) Asked whether staff were screened for infections Mrs Smith responded that the screening of staff would increase the cost to the Trust considerably. The Patients Association were advocating that staff should be screened but Mrs Smith said that she was not sure how that could be achieved, what the benefits were and how often it should be done.

(36) Mrs Smith responded to a question relating to the budget for infection control that initial screening was in excess of £30-50,000 per year on the initial part of the screening, but she could not give the exact cost at the meeting. What was important was to identify those areas of greater risk, e.g. orthopaedics. Ongoing training for all

staff was very important. Mrs Smith informed the Committee of the ongoing training programme which took place in the wards within the hospital rather than a thorough traditional tutorial approach. There was much more informal and ward based training.

(37) In answer to a question about the re-testing for infections for long stay patients Mrs Smith advised the Committee that this took place every 14 days if a patient remained in hospital.

(38) In conclusion, as a local Member, Mrs Angell said that she had recently been a 'mystery' shopper and she wanted to congratulate the professionalism of the staff and the services provided at a very good hospital.

5. Maidstone & Tunbridge Wells NHS Trust
(Item 5)

Sara Mumford, Director of Infection Prevention and Control, Flo Panel-Coates, Director of Nursing and Claire Roberts, Head of Quality and Governance were in attendance for this item.

(1) Attached as an appendix to these Minutes is a copy of the presentation that the Trust had prepared but was not delivered to the Committee and a Healthcare Commission press release which was positive for the Maidstone & Tunbridge Wells NHS Trust.

(2) All those Members who asked questions of colleagues from the Maidstone & Tunbridge Wells NHS Trust were very pleased to acknowledge the hard work of the Trust which had resulted in the Healthcare Commission press release and they hoped that this was reflected in the local community and by the local press.

(3) In answer to a number of specific questions the Trust were invited to explain to the Committee the development of the C Difficile Integrated Care pathway.

(4) In answer to a question about the screening processes within the Trust and the different processes in terms of those patients who present in an emergency situation at Accident & Emergency and elective care Ms Mumford answered in terms of the two organisms of major concern. Turning first to MRSA Ms Mumford advised the Committee that patients that were attending the hospital for elective treatment were screened and pre-assessed. For those patients presenting in an emergency setting not all of them were screened. Then it was an issue of identifying those areas of greater risk, i.e. orthopaedics, surgery patients, those that require coronary care, intensive care, whether the patients were at risk of bringing in a community acquired infection, for example from a nursing home setting or whether they had any chronic wounds that made them of higher risk, such as ulcers.

(5) Mrs Stockell said that the Trust must not become complacent. She had certainly noticed people within the Hospital that were not using the alcohol gels or hand washing and she asked how working together there could be a campaign for the public on the importance of using the facilities provided in a hospital to avoid infection as well as working with schools to change the culture and educate young people. Ms Mumford responded that it was important that the public were constantly

reminded of the importance of using the facilities to avoid infection as a means of infection control within the hospitals.

(6) The Trust had recently introduced new signage which was much more noticeable but she said they could not force the public to use the facilities available but they could be encouraged.

(7) Staff had spent time, sometimes up to an hour at a time, welcoming and greeting members of the public to advise them of the importance of using the gels or hand washing but it was not an optimum use of time to do this all the time.

(8) In answer to questions about staff walking from one ward to another and not using the facilities and the new culture that had been explained to the Committee of continuous development Ms Mumford responded that the importance of staff having it emphasised to them the importance of using the gels and appropriate hand washing. All wards now had dedicated domestics and they were part of the ward team.

(9) Members of the cleaning team management hierarchy also took part in the nursing and infection control meetings.

(10) In response to a question about deep cleaning Ms Mumford informed the Committee of the process within the Trust. She said that there was often pressure on beds but what they did in the case of a deep clean was to empty a ward where possible or if not possible then to systematically bay by bay thoroughly clean with steam and chemicals so that every 'nook and cranny' is cleaned.

(11) In answer to a question about spot checks Ms Mumford responded that these were periodically undertaken and of course the Trust was open to external scrutiny. Internal inspection, the cleaning of hospital wards, did take place on a fairly regular basis. As part of this deep cleaning disposable curtains around the bed were replaced annually.

(12) Mr Fittock then asked the question about how the deep cleaning was undertaken in public areas and also reminded the Trust that bed spaces had been an issue for the Trust before. The response was that there was a programme of deep cleaning and the first task was to identify those areas of high risk and these areas are prioritised. The Trust had pulled together various strands of evidence to produce one audit standard and spot checks were undertaken by Matrons against this standard.

(13) The issue of space between the beds had been addressed at both sites.

(14) Ms Mumford said that everything to do with the Hygiene Code was discussed at a monthly meeting which included the Director of Nursing, the Medical Officer, the Chief Operating Officer and the Director of Infection Prevention and Control and regular reports were made by the Trust Board.

(15) In response to a question and where children are playing with toys as to how often the toys are cleaned the answer was that the toys were cleaned on a regular basis.

(16) In answer to a question about how often the trolleys in Accident & Emergency were cleaned Ms Mumford said that this happened every morning. The incidents of infection arising from this area had reduced significantly.

(17) Asked about community acquired infection and what activities the Trust were undertaking to ensure that the public were aware of preventative measures the Trust said representatives they were putting a strategy in place, it was about the Trust being excellent at being proactive and trying to change the public's behaviour.

(18) In answer to why Trusts tended to only screen for MRSA and C Difficile Ms Mumford responded that there were other infections which would require other facilities and equipment to screen.

(19) The Committee noted that the Trust would not routinely screen for C Difficile as there was no reliable method for doing so.

(20) In answer to a question about the screening which takes place in London Ms Mumford responded that the challenges for London hospitals were very different to those such as the Maidstone & Tunbridge Wells NHS Trust.

(21) Asked about the separate treatment centre at the Maidstone Hospital site and whether they were compliant to infection control Ms Mumford responded that whilst they were a separate body she could confirm that the policies they had for infection control were compliant with the Trust's standards. Ms Mumford said that the treatment centre did not have the same issues with C Difficile or MRSA.

(22) In answer to a question about transferring patients from the Kent & Sussex Hospital, Tunbridge Wells to Maidstone or by ambulance from London patients to the Trust's hospitals and whether there would be additional resources for infection control made available by the Government to Trusts Ms Mumford responded that the funding for infection control was an ongoing funding stream.

(23) The current funds which had been made available by the PCT were for the Trust's recovery period following the Healthcare Commission's reports into the outbreaks of C Difficile which had contributed to the death of a number of patients. Pushed for an answer relating to whether patients from the Kent & Sussex had to be transferred to Maidstone because the Kent & Sussex Hospital, Tunbridge Wells did not have the facilities for treating a person with C Difficile Ms Mumford confirmed that there were facilities at the Kent & Sussex Hospital. However, the isolation ward had recently had to be closed in Tunbridge Wells which necessitated a patient being transferred to Maidstone.

(24) A Member asked whether, because of the pressure on beds, the opportunity to use these was reduced. Ms Mumford replied that this had been an issue the week before but it was an ongoing issue that she discussed with the Trust's Operational Director.

(25) In conclusion the Trust welcomed the opportunity for the discussion with the Health Overview and Scrutiny Committee and recognised that the Committee saw the positive contribution and continuous improvement the Trust had made since the outbreak of C Difficile.

6. Eastern & Coastal Kent Primary Care Trust

(Item 6)

Sarah Andrews, Director of Nursing and Infection Prevention & Control, Karen Benbow, Deputy Director of Provider Development and Assurance Carol Cassam, Head of Infection Control from Eastern & Coastal Kent PCT and Philip Greenhill, Chief Operating Officer, Sue Baldwin, Assistant Director of Adult Clinical Services and Joan Maudsley, Head of Infection Prevention from Eastern & Coastal Kent Community Services were in attendance for this item.

(1) Ms Andrews introduced the team attending the meeting and explained that they represented the two arms of the Primary Care Trust as commissioners through the Eastern & Coastal Kent Primary Care Trust and as a provider through the Eastern & Coastal Kent Community Services.

(2) Mr Greenhill informed the Committee that they, Eastern & Coastal Kent Community Services, were a separate organisation and employed some 3,500 people. They were largely a home based service. The Community Services organisation had their own management and governance arrangements.

(3) In answer to a Member question about screening Ms Andrews said that it was appropriate that screening took place in context. As a commissioner it was about having clear standards in place and looking at all opportunities to increase screening. She added that the Eastern & Coastal Kent PCT were on track for universal screening.

(4) Ms Maudsley referred the Committee to a letter which set out new guidelines for screening. She said that screening is not a control mechanism. She added that there were no cases of MRSA in the community hospitals. 80% of MRSA is transferred into the community hospitals from the Acute Trusts and others come straight from the community.

(5) In answer to a question about C Difficile the Committee were informed that within the Eastern & Coastal Kent PCT boundaries there were six community hospitals and there had been 18 cases of C Difficile in two years, seven last year and this year five cases. Asked by a Member how many of those five patients were out of a total the Committee were informed that that information was not readily available at this meeting. The Member was keen to explore the incidents of cases of infection within Eastern & Coastal Kent PCT area community hospitals with the community hospitals in other parts of the county.

(6) In answer to a series of questions about prevention and how the Trusts could be more proactive in training staff about good practice in terms of hygiene and hand washing Ms Andrews answered that there was very little extra funding available for this activity. However, the Trust were working with the care home sector and recognised that education and training on the Hygiene Code were key. Ms Andrews referred the Committee to the establishment of the Care Quality Commission as from 1 April 2009 which would have clear standards set out for providers. She added that patient through-put through hospitals was quicker than it had been in the past and the length of stay briefer. The challenge was to undertake the best of the modern world and some of the better aspects of the past. There was a correlation between modern

nursing methods and some of the old disciplines from nursing which she had been brought up with.

(7) With regard to the Community Services operation Mr Greenhill informed the Committee that within his service there was dedicated nurses' team and a dedicated community matron team. Ms Baldwin informed the Committee of the key relationship between students and support to ensure that there were standards of quality care. She informed the Committee of how the students acquired the skills within a competency framework. Ms Maudsley said that training was mandatory and she talked about the methods of training for hand hygiene and the Infection Control module taken by Matrons through the University of Greenwich.

(8) Asked about the morale of staff Ms Baldwin said that when there were incidences of C Difficile morale was very low because staff felt they had failed but now they take pride in what they do.

(9) Finally in answer to some questions about how GPs and staff within nursing homes are trained Ms Andrews responded that it was difficult to have any impact on the independent sector.

7. Plenary session
(Item 7)

Comments in the plenary session included:-

- The role of Public Health in running a campaign about the importance of hygiene in terms of infection control.

- Promoting hand hygiene in schools.

- It was refreshing to hear how nurses were being trained, particularly by Eastern & Coastal Kent Primary Care Trust, and that ignorance was not an excuse.

- The Committee recognised the importance of undertaking a root/cause analysis when outbreaks of infection occurred was reiterated.

- It was unclear what Primary Care Trusts responsibilities were when an outbreak of infection occurred and when patients needed to be isolated as to what the policy was in standards across Kent.

- The need to understand the relationship between Adult Social Services and nursing homes in terms of infection control

8. Date of next programmed meeting – Friday 6 February 2009 at 10.00 am
(Item 8)

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Compliance with the Hygiene Code, Core Standards C4a, C4c & C21

Flo Panel-Coates, Director of Nursing
Sara Mumford, Director of Infection Prevention & Control
Claire Roberts, Head of Quality & Governance

9th January 2009

Governance arrangements:

- New governance structure
- New governance committee structure
- DIPC appointed
- Increased resource within infection control team
- Revised policies, procedures and audits

Scrutiny:

- External scrutiny:
  - Department of Health
  - Strategic Health Authority
  - PCT
  - Specialists – e.g. Alan Bedford (most recent visit = 7th Jan 09)
  - Healthcare Commission – Hygiene Code Team
  - Healthcare Commission – Investigation Team
  - Health And Safety Executive
  - Health Protection agency HCAI mandatory surveillance
  - Joint Advisory Group on Gastrointestinal Endoscopy (JAG)
  - OSC

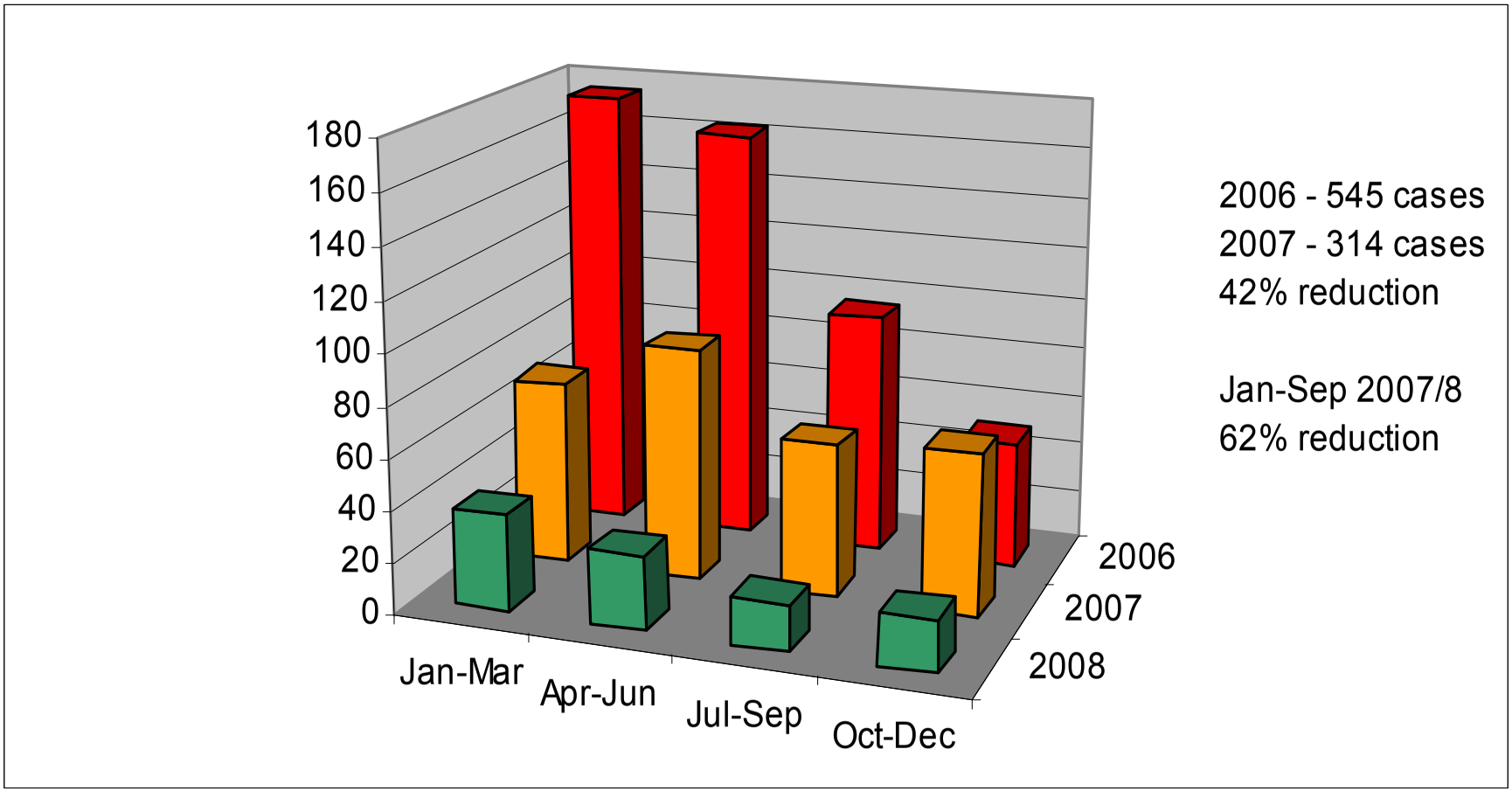
Scrutiny contd:

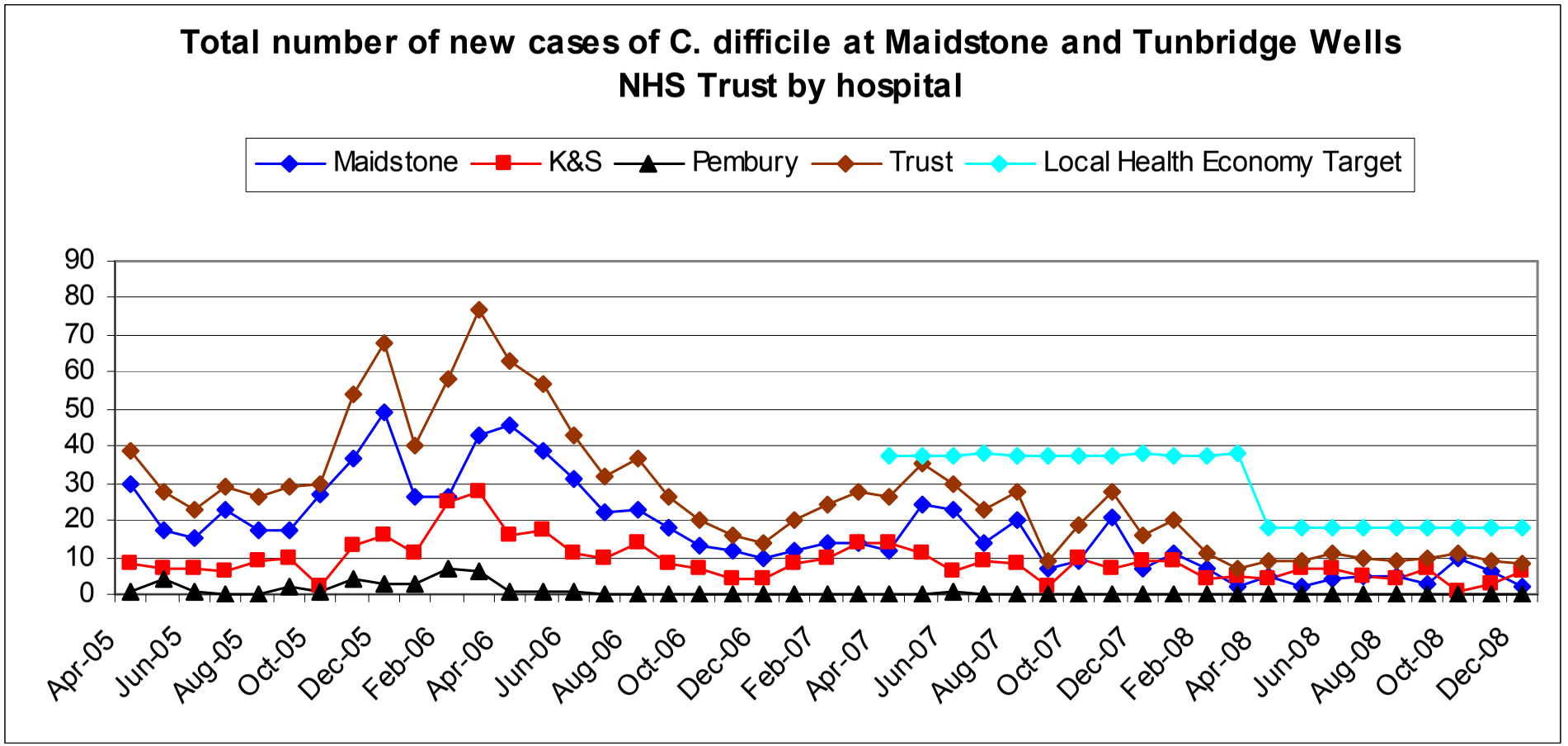
- Internal Scrutiny
  - DIPC reports weekly to Executive Team
  - DIPC reports monthly to the Trust Board
  - DIPC reports monthly to the Quality and Safety Committee
  - Q&S Committee reports monthly to the Trust Board
  - NED representation on Trust Board and sub committees
  - Audit programme e.g.PEAT, hand hygiene, “saving lives” actions, compliance with antibiotic policy
  - Root cause analysis of all C diff cases and MRSA bacteraemias
  - Weekly then monthly review of the action plan resulting from the investigation – SHA and PCT involved

C4a – Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in MRSA

- Clear areas of responsibility and lines of accountability
- Weekly reporting of infection control rates to execs
- Monthly reporting to Trust Board
- Healthcare Commission and Hygiene code action plans monitored by IPCC and reported to Quality and Safety Committee (sub-committee of Board)
- Saving Lives Audit programme – daily audits - reviewed weekly
- “Bare below elbows” campaign
- Staff training programmes
- Root cause analysis of MRSA bacteraemias and C diff – learning cascaded stat and via IPCC

Quarterly C. difficile infections 2006-8




Total number of new cases of C. difficile at Maidstone and Tunbridge Wells NHS Trust by hospital
Maidstone
K&S
Pembury
Trust
Local Health Economy Target
90
80
70
60
50
40
30
20
10
0
Apr-05
Jun-05
Aug-05
Oct-05
Dec-05
Feb-06
Apr-06
Jun-06
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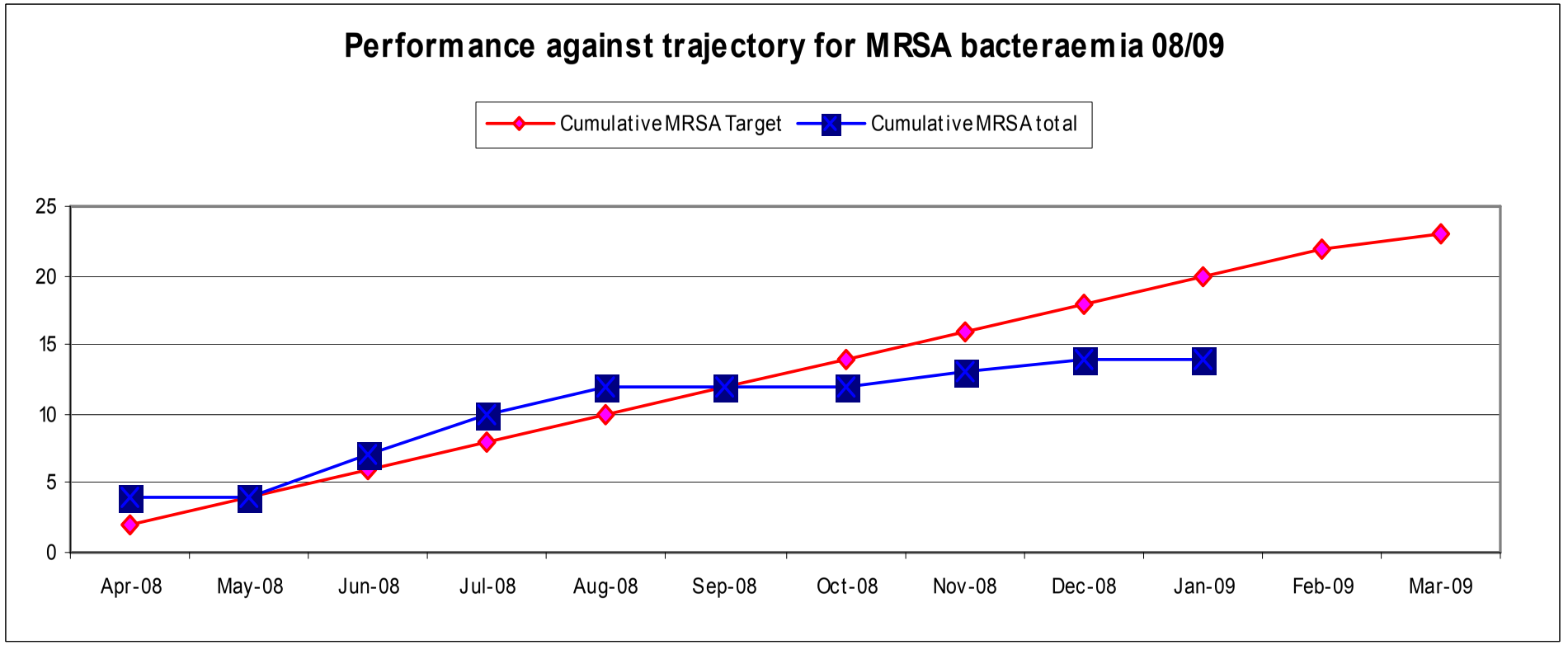
MTW MRSA bacteraemia against Target



C4c - Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

- JAG accreditation
- HC visit – recommendations made and being addressed
- Kent wide decontamination service by IHSS
- Medical devices library being set up

C 21 - Healthcare services are provided in environments, which promote effective care and optimise health outcomes by being well designed and well maintained, with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

- Bed spacing – remains an issues within the estate – reviewed and improved following investigation – estates strategy to improve existing estate and new hospital build
- DDA audits
- Isolation wards at Kent and Sussex and Maidstone Hospitals
- Cleaning Quality audits are completed using the NHS 'Cleaning for Credits' system
- 24 hour cleaning
- PEAT assessments
- Quality monitors
- Training and development for all staff groups

Healthcare Commission finds substantial improvement in infection control at Maidstone and Tunbridge Wells NHS trust

Published: 09 January 2009

Trust must maintain momentum and make further improvements

The Healthcare Commission today (Friday) welcomed substantial improvements in infection control at Maidstone and Tunbridge Wells NHS Trust since an investigation by the watchdog in 2007 identified serious failings.

An estimated 90 people definitely or probably died as a result of *Clostridium difficile*, during two outbreaks of the infection at the trust in 2005 and 2006. It is estimated that a further 30 patients definitely or probably died of *C. difficile* between April 2004 and September 2005.

Immediately following its investigation, the Commission called for a range of changes to the way the trust cares for patients with infections and to its wider systems of prevention and control.

Today, in line with its normal practice after an investigation, the Commission published a follow-up report detailing the trust's progress in implementing the recommendations. It also published a report outlining findings from a routine spot check made in October 2008 to assess compliance with the hygiene code.

The Commission says the trust has made "huge strides" putting considerable effort and resource into improving infection control. It commends the trust for reporting its lowest rate of *C. difficile* infection in three years, for the period January to March 2008.

However the Commission has highlighted some areas that still require further work such as recruiting more nursing staff and learning from complaints and incidents.

The spot check in October found a number of breaches of the hygiene code. The most serious breach related to decontamination of equipment in the endoscopy unit. This had been addressed by the time the Commission made its final investigation follow-up visit to the trust in November.

Key improvements identified in the investigation follow-up report include:

- A re-structured board with new non-executive directors and many new directors. This new structure has clear lines of reporting and processes for escalating issues up to the board. Infection control is a consistent item at the top of the board's agenda.
- New clinical governance and risk reporting structures which allow the trust to address key risks. A new head of governance and quality has been appointed who has revised the governance committee structure, creating four clinical governance directorates within the trust.
- Increased leadership, size and effectiveness of the infection control team led by a new director of infection prevention and control. There are two additional senior infection control nurses and a new microbiologist.

- *C. difficile* is now recognised as a serious diagnosis in its own right, and a ‘care pathway' has been designed and implemented for patients with the infection, ensuring they receive timely and appropriate care.
- Specific wards have been allocated for the isolation of infected patients.
- Better standards of cleaning and improvements to the hospital environment. Extra cleaning staff have been appointed, new audit systems implemented, and nurses find urgent cleaning needs are more rapidly addressed.
- The removal of beds and the installation of new wash basins to ensure appropriate spacing between beds and improved levels of cleanliness.
- An ongoing process for infection control training has been implemented, including areas such as hand hygiene techniques and sharps handling. The infection control team also runs an extensive training programme for other members of staff.

Areas requiring further work include:

- The recruitment of further nursing staff and continued work to ensure good basic nursing care.
- Improvements to how the trust learns from complaints, incidents and serious untoward incidents (SUIs). The system for responding to complaints also needs to be reviewed.
- The trust is currently in the process of appointing a new medical director to the board. It must ensure this happens as soon as possible.
- The trust must embed the new clinical governance structure in day-to-day practice, ensuring that staff at all levels understand and follow the new ways of reviewing clinical care.

Healthcare Commission head of investigations Nigel Ellis said: "This is a very different trust to the one we investigated in 2007. It was never going to be easy to turn things around in just 12 months and indeed, there is still some way to go. But the substantial progress the trust has made to improve the prevention and control of infection is commendable.

"Staff at every level have put in considerable effort to make these improvements and should be recognised for their hard work. Senior staff have demonstrated strong leadership and it is clear that infection control is now a top priority at the trust.

"However now is not the time for the trust to relax. The trust's infection control systems still need further improvement. More nurses are needed and the trust must make sure it learns from complaints and serious incidents. Above all, it must make sure the changes they have made are embedded in day-to-day practice and that improvements are sustained.

"The trust must also address the remaining breaches of the hygiene code. Although these breaches are not considered to be an immediate threat to the safety of patients, they must be dealt with in order to ensure all necessary systems and processes are in place.

"What happened to patients at Maidstone and Tunbridge Wells NHS Trust was a tragedy. We have been working to make sure those lessons are learnt throughout the entire NHS so this is never allowed to happen again.

"Along with the South East Coast Strategic Health Authority, we will continue to monitor progress at the trust and we look forward to seeing further improvements in the future."

Throughout last year, the Commission made a number of announced and unannounced visits to the trust to check on progress in implementing the recommendations from the investigation.

In October, it also conducted a spot check to assess compliance with the hygiene code, as part of the Commission's ongoing programme of visits to every acute NHS trust in England.

On this inspection, the Commission found that the trust had invested in adequate isolation facilities, including a new *C. Difficile* ward. It also found that proper processes were in place to keep the board informed of issues relating to infection control and that the board demonstrated responsibility for infection control.

However, the Commission found the trust breached parts of Duty 2 relating to infection control audits not being reflected in all trust policies, low compliance with some audits and recommendations from audits not being followed through.

The trust also breached several areas relating to Duty 4 including having inaccessible hand wash basins in one ward and inconsistencies in the preparation of cleaning solutions.

More seriously, in an endoscopy suite on the Kent and Sussex site the Commission found unclear manual cleaning processes, inappropriate movement of equipment to and through the room and a hand wash basin which was not easy to access and had inappropriate taps.

Immediately following this inspection the Commission asked the trust to urgently conduct a risk assessment of all of the decontamination facilities in the endoscopy suite, identifying actions to be carried out.

The Commission checked the trust had addressed the issues in the endoscopy suite when it visited the trust a month later as part of its review of progress in November.

It found the trust had reviewed and revised protocols, training and the movement of equipment in and to the suite. The hand wash basin taps had been replaced and a double sink for manual washing and rinsing of endoscopes had been ordered.

The Commission will check with the trust in six months to ensure the remaining breaches identified in the hygiene code spot check have been addressed.

Information on the Healthcare Commission

The Healthcare Commission is the health watchdog in England. It keeps check on health services to ensure that they are meeting standards in a range of areas. The Commission also promotes improvements in the quality of healthcare and public health in England through independent, authoritative, patient-centred assessments of those who provide services.

Responsibility for inspection and investigation of NHS bodies and the independent sector in Wales rests with Healthcare Inspectorate Wales (HIW). The Healthcare Commission has certain statutory functions in Wales which include producing an annual report on the state of healthcare in England and Wales, national improvement reviews in England and Wales, and working with HIW to ensure that relevant cross-border issues are managed effectively.

The Healthcare Commission does not cover Scotland as it has its own body, NHS Quality Improvement Scotland. The Regulation and Quality Improvement Authority (RQIA) undertakes regular reviews of the quality of services in Northern Ireland.

For further information contact the press office on 0207 448 9401, or on 07917 232 143 after hours

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