Positively Public Fact-Sheet
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UNISON Fact-sheet on Healthcare Acquired Infections

How big is the problem?

A 2006 survey showed that 80% of the public are worried about going into hospital because of the risk of catching MRSA or another healthcare acquired infection (HAI).

There were more than 3,000 cases of MRSA bloodstream infection reported in April-September 2006 in England and the number of C difficile cases continues to rise with over 42,000 cases reported in patients aged 65+ in 2006. MRSA accounts for 40% of serious blood infections in the UK.

As many as 5,000 deaths each year may occur as a direct result of contracting an infection while in hospital, with MRSA mentioned on 1 in every 500 death certificates, and C Difficile on 1 in every 250. Community-acquired strains of MRSA that produce the PVL toxin are causing unexpected deaths among young and generally healthy people. More people die from infections than are killed on roads.

The UK is ranked towards the bottom of the European league where rates of MRSA are concerned.

Patients with an HAI are likely to stay in hospital longer (on average an extra 11 days) and the problem costs the NHS at least £1 billion each year.

Why are healthcare acquired infections so prevalent?

Whilst not the only factor in controlling HAIs, high quality cleaning can play a major part in reducing the spread of such infections. There is now a consensus that there is a definite link between HAIs and cleanliness.

The quality of hospital cleaning has declined since the decision was taken in 1983 to introduce compulsory competitive tendering of hospital cleaning and other “ancillary” services.

The fact that cleaning standards in hospitals have fallen as a result of contracting out is not disputed and led to the Government in 2001 ending the compulsory element of competitive tendering of cleaning services in the NHS.

Since the 1980s around a third of services have been contracted out to the private sector, with the remainder forced to match its costs. The number of

equivalent full-time cleaning posts has almost halved, from 100,000 in 1986 to 55,000 in 2004.

The regime of market testing brought in by competitive tendering is by its very nature a process of squeezing costs to gain “efficiencies.” In a labour intensive industry such as cleaning, where staffing accounts for up to 93% of the cost, such efficiencies are inevitably borne by the workforce, through cuts in numbers or wages and conditions.

Contract culture contributes to the breakdown of the team-based approach that unifies clinical and non-clinical staff, thereby damaging flexibility and overall effectiveness.

The value of a committed, integrated workforce should never be underestimated: hospital cleaners work best as part of a team dedicated to providing an overall service to patients and the public.

Short-term savings often mean that longer term priorities are jeopardised. The cost of HAIs could be reduced with higher quality cleaning to prevent patients becoming infected. Equally, low wages (another by-product of contracting culture) mean a greater turnover in staffing with the ensuing extra costs for training.

The case for ending the contracting-out of hospital cleaning is about more than a public-versus-private sector argument. The contracting regime has had a wholly detrimental effect on the performance of in-house teams as well, as they are forced to compete with the private sector.

What lessons need to be learnt?

Too many NHS authorities outsource cleaning contracts with levels of funding that mean cleaners will be employed on minimum wages and terms and conditions. This leads to low staff morale, poor productivity, high labour turnover and overall poor performance.

Cleaners want to be given the resources to do a better job of cleaning our hospitals. They want to regain their sense of pride in delivering high standards of cleanliness and to be involved in decisions about controlling the spread of HAIs.

Staff need real security and involvement, including the full implementation of Agenda for Change and fair employment guarantees. It is estimated that only about half of trusts have come good on their Agenda for Change payments despite the Government investing £75 million.

Contracting culture has led to the compartmentalisation of hospital cleaning. In many hospitals, cleaners are not treated as part of the NHS team – a feeling which emanates from boardroom level, where cleaning is not given the importance it needs. It is not just a matter of specific issues around cross-infection; cleanliness itself needs to become a priority at the highest levels.

Cleaning needs to be acknowledged as core to patient care and, as such, to be viewed as a clinical issue.

Providing staff with infection control training was a welcome move and the Knowledge and Skills Framework should boost training and development. But new initiatives will only have the desired effect if sufficient resources are available to give domestic staff the time to undertake training.

The Government's "Think Clean" campaign and Matron's Charter were steps in the right direction but there has been no recognition that the under-resourcing of cleaning staff is the main issue to be tackled. Similarly, Conservative policies proposing compulsory hospital changing and laundry facilities fail to recognise the fundamental importance of cleaning itself.

Health Minister Andy Burnham has acknowledged the distance between cleaners and the rest of the NHS family makes it hard to tackle hospital hygiene, and that progress could be made by encouraging trusts to bring services back in-house. He has also recognised the need to review how Agenda for Change benefits the lowest-paid workers in terms of pay and access to training.

These are welcome announcements but there is a need to go further and *ensure* cleaning services are brought back in-house as the best way of reducing HAIs. The Welsh Labour Party has proposed that all cleaners working in Welsh hospitals should be employed by the NHS. (Wales leads the UK with the lowest levels of MRSA, with all but one cleaning contract operated by the NHS.)

What is UNISON recommending?

1. Improve the quality of cleaning: this is likely to be a more effective way of tackling HAIs than specific virus-related control measures.
2. Increase the number of cleaning staff: all NHS organisations should set safe minimum staffing levels for their cleaning services.
3. End market testing and the tendering regime that puts cost ahead of quality, jobs and conditions.
4. Provide cleaning staff with the most up-to-date equipment and training.
5. Allow for greater involvement of all staff (cleaners, domestic supervisors, nurses and managers) in setting and monitoring cleaning standards.
6. Implement fully Agenda for Change: hospitals need cleaning staff who are valued and rewarded as an important part of the healthcare team by clinicians and health managers.
7. In line with Welsh Labour's proposals, guarantee that cleaners working in hospitals are employed by the NHS.
8. As a starting point, Strategic Health Authorities should insist on there being in-house bids where contract cleaning is concerned – this is not always the case.
9. The Government and the other political parties should note the experience of hospital cleaning as they consider extending market reforms further into the NHS and other public services.

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