Developing the annual health check in 2008/2009 - Have your say

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1. Comments are sought on our proposals for national reviews and studies in 2008/2009, focusing on the themes set out in section three of the consultation document.

	We are fully supportive of the national reviews on commissioning of services for people with learning disabilities; end-of-life-care and medicines management in primary care. We believe that there should also be a national review on the implementation of the Hygiene Code. The principles in pathways of care are the same for healthcare associated infections. There are increasing concerns and considerable anecdotal evidence from patients and carers that healthcare associated infections are moving between healthcare providers. A national review is needed so that the position on healthcare associated infections in the wider healthcare community can be fully assessed and safeguards such as planned care pathways can be put into place for all aspects of the patients' health and social care. This also links with end-of-life-care, so many patients contract infections during end-of-life-care, and we as a patient group have anecdotal evidence to show that care of patients with infections is not always as it should be at this difficult time. This is distressing for the patient and the carers, and caring for a patient who is receiving end-of-life-care should include ensuring that if they have an infection appropriate treatment is provided to make the patient comfortable and that dignity is maintained.

2. Please comment on whether our plans for PCTs in the annual health check in 2008/2009 are reasonable in the current context and how they could be improved (in particular our proposal to have a separate score for the provider and commissioning functions of PCTs)

	We welcome the approach on looking at the provider role and commissioning role as two areas that receive a separate score. As outlined in "Developing the Annual Healthcheck" there is an increasing recognition on the emphasis of commissioning as a main driver for improving healthcare provision. Lord Darzi's Review includes an independent review of the NHS, one of the areas assessed included commissioning. The Review identified that there were areas of improvement needed with too much of a focus on getting the highest volume of work for the least money, with much less concern about value and quality. The Review also identified that there appeared to be a lack of clarity on the clinician's role in the commissioning process, with some clinicians believing that they were providers and therefore this was a conflict in the commissioning process. We believe it is absolutely vital that clinicians are

	involved in the design, planning and commissioning of services. Involvement in delivering safe, quality care should not just be about budgets and PCTs must be able to demonstrate that they are taking the role of the clinician into consideration in the commissioning process. This is a measure of good clinical governance.

3. Please comment on our proposed indicators for primary care trusts, which are set out in appendix A (in particular whether they provide sufficient coverage of key health and healthcare priorities to inform local communities and sufficiently recognise the move to localism).

	We welcome the use of the incidence of MRSA and C difficile as performance indicators to show outcomes of measures to prevent infections. We also welcome the measure to ensure that admissions are screened, although we believe this does not go far enough. We would also like to see patients screened on discharge from the Acute setting when they are carrying on in their patient journey within the primary care setting. We would like to see evidence of staff training in respect to infection prevention measures within the Hygiene Code. Staff surveys are one way of measuring this, but we would like to see this backed up during inspection for quality assurance. This may be carried out in assessment of staff training plans.

4. Please comment on whether our plans for acute trusts in the annual health check in 2008/2009 are reasonable in the current context and how they could be improved.

	We are pleased to see that Acute Trusts will continue to be assessed on their compliance with the Hygiene Code. Whilst we welcome the new inspection regime where all Trusts will receive a visit to provide quality assurance, we would hope that resources for inspection will also be sufficient to ensure that Acute Trusts who are not performing as well will be able to be prioritised so that patient safety is not compromised.

5. Please comment on our proposed indicators for acute trusts, which are set out in appendix A.

	Incidence of Clostridium difficile and Incidence of MRSA We welcome these measures as these can assess outcomes of infection prevention and control. If acute trusts are using the *Saving Lives* toolkit effectively to ensure compliance with the Hygiene Code then incidence of avoidable healthcare infections should drop significantly. The Government target of a 50% reduction since 2003/04 is not challenging enough when you look at the measures that are in place and working in acute trusts that have fully implemented controls. As this is a national target and the Government plan to maintain this level we believe the target itself is flawed. Nonetheless if the *Saving Lives* toolkit is used effectively we believe that this will significantly reduce the risks to patients from contracting a healthcare infection and wish to see this used in the monitoring and compliance of the Hygiene Code within the Annual Healthcheck. The mandatory reporting of bloodstream infections should continue. We would also like to see mandatory reporting on wound infections, IV lines

	and catheters. These would be good outcome measures for the High Impact Interventions in *Saving Lives* which are designed to reduce the incidence of these infections. There are mandatory data collections of orthopaedic infections that should also be used to assess care and these should be published and used in the Annual Healthcheck. Another area where we believe performance indicators should be used relate to complaints from patients / carers. NHS trusts have complaints managers, and PALS and there should be an indicator showing how many complaints involving healthcare infections were resolved at a local level and what proportion are passed on for review by the Healthcare Commission, and at Ombudsman stage. A good investigation of a complaint involving poor infection prevention and control measures would need a response from the Infection Prevention and Control nursing staff – and these should be reported through the DIPC at Board level. Complaints about cleanliness should also be included. Whilst we appreciate that complaints from patients and carers can be wide ranging if they are treated seriously, as all trusts tend to say when patients complain, then this information would be measurable if there is good governance within the trust. There are proposals to remove indicators from the Annual Healthcheck which we believe should remain. This is data that is readily available and should continue to be used: Patient Environment Action Team (PEAT) score for cleanliness Indicators from staff survey re cleanliness These are important indicators to patients and the public and if it is collected then it should be included as this is valuable information. Including data from PEAT scoring is seen as an independent assessment and should be used. This will help to improve patient confidence. Central line infections – your rationale for deletion "Lack of available data" – We believe this should be measured. Trusts are now undertaking Route Cause Analysis as part of infection prevention and control and this data should therefore become more readily available. If it is not this is an indication that Trusts are not undertaking sufficient Route Cause Analysis of infections. There is anecdotal evidence to suggest many patients have central line infections from accounts we receive from patients.

6. Please comment on whether our plans for mental health trusts in the annual health check in 2008/2009 are reasonable in the current context and how they could be improved.

	We are pleased to see that there will be partnership working with other regulators to include the NHSLA in extending risk assessments to mental health trusts, and the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission (MHAC).

7. Please comment on our proposed indicators for mental health trusts, which are set out in appendix A.

	We welcome the indicators proposed for mental health trusts under the four themes of: • health and wellbeing • clinical effectiveness • safety • patient focus and access We also welcome the use of indicators from the NHS staff survey. Feedback from staff is particularly important in specialist areas. We are particularly keen to see that staff are receiving the correct training and welcome the proposal to collect this data from the staff survey to measure this outcome: "*Clinical staff should receive sufficient training to support policy implementation. From 2007 onwards the annual staff survey for mental health trusts collects recent training data specifically for mental health trust clinical staff on CPA, medicines management, suicide risk, carer support, dual diagnosis and psychological therapies."* Quality assurance can be provided by follow-up during the Annual Health Check by assessing training plans. We wish to comment on the proposal to delete performance indicators: Rate of C.difficile Rate of MRSA Your rationale for deletion - Difficulties around variations in reporting. Dependent upon data collection and reporting systems being in place via HPA. All mental health trusts providing long term care should have arrangements in place for these indicators. If they do not, then recommendations should be made to ensure that this is put in place. This should form part of the Annual Health Check. PEAT score for cleanliness Indicators from staff survey re cleanliness These are important indicators to patients and the public and if it is collected then it should be included as this is valuable information. Including data from PEAT scoring is seen as an independent assessment and should be used. This will help to improve patient confidence.

8. Please comment on whether our plans for ambulance trusts in the annual health check in 2008/2009 are reasonable in the current context and how they could be improved.

	We welcome partnership working with other regulators, particularly in relation to a risk based approach. We welcome the extension of the NHSLA assessment being used in acute trusts and the extension of its risk assessments to ambulance trusts.

9. Please comment on our proposed indicators for ambulance trusts, which are set out in appendix A.

	We welcome the performance indicators for Ambulance Trusts particularly those on clinical quality. In terms of the availability of hand washing facilities we would like to see the availability of disposable personal protective equipment added to this indicator. Disposable gloves, aprons and masks to mitigate cross transmission of infection where treatment is necessary at the scene. We believe the data in staff surveys is a valuable source of information and that measures will be taken to ensure the maximum response rate to the surveys. We wish to comment on the proposal to delete performance indicators. Composite indicator on percentage of staff who received relevant training, learning and development in previous 12 months – your rationale for deletion - duplication with NHSLA assessments. We believe if this data is already published and available is should be included in the Annual Health Check. Training, learning and development is essential for staff to ensure patient safety, and forms an essential element of meeting the Hygiene Code, whilst we welcome the use of data in the staff surveys to assess training, if the NHSLA assessments aid in validation and quality assurance of the information then it should be used. Frequency of deep cleaning of ambulances – your rationale for non inclusion - In ambulance data set for urgent care review, but awaiting first cut off data (21/11/07) to determine usefulness. Difficult to score as there are no national standards on frequency, but could potentially be in benchmark set. Unlikely to be scored in urgent care review. We believe ambulances should be thoroughly cleaned at the end of each shift. Ambulances should be equipped with cleaning materials and spare blankets to ensure any patient who is known to have a healthcare associated infection who is being transported will not present a risk to the next patient. Handwashing facilities and personal protective equipment should be available for ambulance crews at all times.

10. Please comment on whether our plans for trusts with learning disability services in the annual health check in 2008/2009 are reasonable in the current context and how they could be improved.

	We are pleased to see that there will be joint assessments of the commissioning of services for people with learning disabilities, and plans to develop a joint assessment for the small number of care trusts that provide or commission both health and social care services.

11. Please comment on whether you think our proposals for the annual health check 2008/2009 will provide an appropriate assessment of the safety of care provided by NHS organisations and on how they could be improved.

	We are pleased to see that Acute Trusts will continue to be assessed on their compliance with the Hygiene Code. Whilst we welcome the new inspection regime where all Trusts will receive a visit to provide quality assurance, we would hope that resources for inspection will also be sufficient to ensure that Acute Trusts who are not performing as well will be able to be prioritised so that patient safety is not compromised. We believe there should be a strong emphasis on care pathways to ensure that safe care is continued throughout the patient journey. Documenting treatment for infections is as important as documenting and setting out the care pathway for someone who has cancer or who has had a stroke, and this needs to be carried out in all healthcare settings. The Annual Health Check should look for this evidence when assessing compliance with the Hygiene Code.

12. Please comment on whether you think our proposals for the annual health check 2008/2009 will provide an appropriate assessment of the quality of clinical care provided by NHS organisations and on how they could be improved either for 2008/2009 or in the medium to long-term.

	We would like to see evidence that clinicians participate in regular clinical audits and reviews of clinical services. It is important that clinicians are involved about decisions in the design and planning of services and that quality is the driver for the best clinical care, not budgets.

13. Please comment on whether you think our proposals for the annual health check 2008/2009 will take sufficient account of patient views.

	We welcome involving patient groups, not only in the consultation process but in the design and planning of services. It is important however that individual patients have the opportunity to be heard about the quality of the care they are receiving. This is why we believe better use of complaints and feedback should be used in improving services. We would like to see performance indicators on complaints handling. We have referred to this in our response to question 5.

14. Please comment on our risk-based approach. Does it strike the right balance between using information to scan performance across the range of healthcare and more detailed scrutiny through inspection? Does it take account of the right issues? Are there areas that are unsuitable for such an approach?

	It is important that inspections are tailored to protect patients who are potentially at the highest risk. Whilst we welcome the full inspection of acute trusts to assess compliance with the Hygiene Code, adequate resources must be put into place to enable this to happen. Where you have trusts where infection rates are not reducing as quickly as you would expect, then these should be prioritised. We would expect trusts to be using their own audit tools to ensure compliance with the Hygiene Code and this should be borne in mind when looking at statements of compliance. We also would expect trusts to be passing information on to patients and carers beyond the acute setting, therefore a strong focus on Duty 5 of the Hygiene Code is needed.

To ensure we are reaching as many people as possible with information about our work, we would like to ask you a few questions to help us monitor who has provided us with comments. The answers you provide will be completely confidential. You do not have to answer any of the questions in order to submit the questionnaire.

Would you like us to keep you informed of the Healthcare Commission's work:

	Yes
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Please select appropriate options:

Are you responding as an individual or on behalf of an organisation?

	organisation
Please name your organisation	MRSA Action UK

If you are responding on behalf of an organisation, what sector do you work in?

	voluntary