# The current state of play on healthcare infections

In my role as Chairman of MRSA Action UK I have been working closely with patients and those in the health and social care profession, and looking back at recent events I am of the opinion that the next few months will be a defining time for infection prevention and control, why?

Five years ago healthcare associated infections were endemic across our healthcare system, and there was a perception that in many cases getting an infection was almost inevitable if a patient was immune suppressed and vulnerable. Many hospitals were unclean and newspaper headlines featured stories of superbugs that were killing patients in dirty hospitals, the principal one at the time being MRSA. John Reid responded to pressure from patients, the media and politicians and set what was thought to be an unachievable target to reduce the numbers of people contracting an MRSA bloodstream infection by half within five years. The reason many people believed this was unachievable was because of the poor state of our hospitals and the lack of resources diverted into infection prevention, a culture of relying on antibiotics to treat infections rather than a culture of doing everything we could to prevent infections was as endemic as MRSA.

There have been some significant achievements since that time, with a lot of Hospital Trusts achieving the fifty percent reduction, the trend continues in the right direction despite the fact that success is not uniform across all Acute Trusts. During this recent period *Clostridium difficile* has become endemic in hospitals and in the community, and there are still many other healthcare associated infections that are not reported in the same way as MRSA bacteraemia or *Clostridium difficile* disease.

The target to reduce the MRSA bacteraemia by half, and then a target to reduce *Clostridium difficile* galvanised everyone into action and resources had to be directed into preventing infections. We are now in a position in many Trusts where it is possible that the bloodstream infections have reached an irreducible minimum, to us as patients an irreducible minimum means that any infection acquired is not avoidable, that may seem difficult to define, however we know that the body can produce toxins and cause infections without being introduced by receiving healthcare, I have experienced this within my own family. There does need to be a focus for every Trust to meet an irreducible minimum and achieve an ethos of zero tolerance to avoidable infections.

We need to consider that over the last few years we have concentrated our efforts on MRSA bacteraemias whilst doing very little on the majority of other MRSA infections, such as surgical site, catheter and urinary infections. These amount to around ninety four percent of the total of MRSA infections in our care settings; these will need to be focussed on if we are to reduce the burden of MRSA. The National Audit Office have repeatedly raised this in their assessment of the progress in reducing healthcare associated infections, and have raised the issue of other micro-organisms on the horizon that do not appear on the radar.

*Clostridium difficile* became a huge problem leading up to the year 2008, with some 65,000 cases in that particular year, this was a huge embarrassment not only to the NHS, but for the government when you consider that only as far back as the mid 1990s there were as few as twelve cases a year.

The government set the NHS a target of reducing the number *Clostridium difficile* cases by thirty percent before 2011, whilst this seemed a large reduction, there would still be over forty thousand cases a year when this target was met. It would seem that although this target has already been achieved well in advance of the target date we will still see some one hundred cases per day in our healthcare settings.

Once again we have concentrated on the Acute setting, and there have been insufficient initiatives to control Clostridium difficile in the community. We are seeing numbers in hospital reducing whilst numbers are increasing in the community setting.

So what does this mean for the state of play now with healthcare associated infections, and with the current climate of budget cuts, what are the prospects for the future?

The new MRSA Objective sets out targets for individual hospitals, and it is planned to set out a similar stall for hospitals to conquer Clostridium difficile.

Whilst all the current reductions in healthcare associated infections has been achieved under record funding for the NHS over the past few years, we are moving into new territory because of the current economic situation facing the country. We believe our Health Ministers, the Prime Minister and those shadow ministers are being disingenuous with their promises of protected funding for the NHS which in our opinion cannot be met and is already being cut.

Real spending on the NHS will fall in the years ahead despite all the assurances being made by those elected officials in the run up to the general election. We are already aware that funding for the NHS is already being cut by stealth. Primary Care Trusts are being asked to make efficiency savings that amount to tens of millions of pounds for the year 2010/2011. My own local Primary Care Trust are having to make savings of some £30 million for this financial year. We are aware that the Department of Health has slashed budgets for microbiology and the centre for infections and asks for efficiency savings that equate to £14 million in real terms across the Health Protection Agency.

The Improvement Foundation worked with care homes educating staff and help to implement action plans and performance measures to bring about significant reductions in healthcare associated infections in the care home setting. They have now ceased to operate, we believe, because of cuts in funding to Primary Care Trusts. We are of the opinion that lack of attention to improvement programmes like this one will influence the number of healthcare associated infections in the community which will turn full circle and go back into the Acute Hospital setting.

In helping the Acute Hospitals to achieve the reductions in healthcare associated infections, those hospitals that struggled to achieve the required reductions were supported by Improvement Teams and the Department of Health. From April 2011 the funding for the Improvement Teams ceases. This, in our opinion, is a retrograde step because we believe that they should be incorporated in helping not only Acute Trusts, but the social sector too.

The National Patient Safety Agency Cleanyourhands campaign has also played a critical role in improving hand hygiene, yet central support is being removed from this vital programme.

The next few years are going to be tough on the healthcare sector and the momentum achieved in reducing healthcare associated infections has to be maintained and whilst cuts are inevitable in health funding we believe it is critical to ring fence infection prevention and control budgets. There is a false economy in cutting this budget, we must invest or maintain funding because we know that each case saves the NHS thousands and alleviates pain and suffering for patients and families.

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