



# INFECTION PREVENTION AND CONTROL

COMBATING A PROBLEM  
THAT HAS NOT GONE AWAY

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Sam Carter  
Peter Cuthbertson  
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Jennie Wilson

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Melissa Barnett  
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David Dawson  
Richard Devereaux-Phillips  
Jim Dobbin MP  
Steve Fearn  
Mike Fairbourn  
Deborah Fields  
Colin Hallmark  
Jayne Knowles-Smith  
Graziella Kontkowski  
Professor Heather Loveday  
Ros Meek  
Andrew Miller MP  
Nigel Mills MP  
Simon Noble-Clarke  
Jane Plumb  
Will Spiers  
Rod de St Croix

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## Executive Summary

Each healthcare acquired infection extends patients' hospital stay by an average of 10 days, and costs the NHS an extra £5,200. But Trusts are failing to measure how well they are tackling healthcare acquired infections, with the vast majority neglecting to track:

- the total number of extra nights each year that patients stay in hospital owing to a healthcare acquired infection
- the financial cost or operational impact of infections
- the total number of cases of sepsis, CAUTIs, catheter-related blood infections, ventilator-associated pneumonia and norovirus; or
- the total number of deaths from the above infections

This report also reveals:

- There is also no evidence of a substantial investment in Infection, Prevention and Control. This is in spite of growing anti-microbial resistance, with more and more resistance strains coming through. Experts fear an approaching "post-antibiotic age".<sup>1</sup>
- Some Trusts even received instructions to reduce expenditure on infection, prevention and control in the last five years. These are West Middlesex, University Hospital Southampton, Torbay & South Devon, Plymouth, Northumbria, Doncaster & Bassetlaw and Barnsley.
- Trusts do device surveillance on an average of 71% of wards. On average, each Trust neglects device surveillance in 9 wards. 7 Trusts neglect device surveillance on 100% of their wards.
- There is great variation in the number of times a member of a Trust's Board attends an infection prevention and control meeting - from 0 times a year to 24 times a year.
- There are an average of 104 hospital beds for every Infection Control staff member. These range from 161 beds for each IC staff members in the East Midlands to 71 in London.

## We recommend:

- 1 Trusts must be required to record the total number of cases and associated deaths from sepsis, catheter-associated urinary tract infections, catheter-related blood infections, ventilator-associated pneumonia and norovirus.
- 2 Trusts must be required to record the total number of nights patients stay longer in hospital each month owing to a healthcare acquired infection.
- 3 Trusts should receive no financial reimbursement for readmissions and bed days relating to a healthcare acquired infection that was acquired within the Trust itself. This will end the situation where Trusts actually financially benefit from healthcare acquired infections<sup>1</sup>, and better align financial incentives with the goal of lower infection rates.
- 4 Device surveillance should be mandatory for all hospital wards.
- 5 The Government should develop a strategy for using technology for infection prevention and control, and engage with industry on solutions for this.

<sup>1</sup> 'Prime Minister warns of global threat of antibiotic resistance', Department of Health and Prime Minister's Office, 10 Downing Street, 2 July 2014, at <https://www.gov.uk/government/news/prime-minister-warns-of-global-threat-of-antibiotic-resistance>

<sup>1</sup> Clinical and economic burden of surgical site infection (SSI) and predicted financial consequences of elimination of SSI from an English hospital, P.J. Jenks, M. Laurent, S. McQuarry, R. Watkins, *Journal of Hospital Infection*, 26 September 2013, at [http://www.journalofhospitalinfection.com/article/S0195-6701\(13\)00344-7/abstract](http://www.journalofhospitalinfection.com/article/S0195-6701(13)00344-7/abstract)

# Introduction

With MRSA and E.Coli rates having fallen dramatically in the last decade, there are two associated dangers:

1. Complacency about rates of other healthcare acquired infections, to which the same attention is not being paid
2. Failure to apply the successes of mandatory reporting to these other infections

Healthcare acquired infections remain a real problem. As the Prime Minister put it in July 2014: *“Resistance to antibiotics is now a very real and worrying threat, as bacteria mutate to become immune to their effects. With some 25,000 people a year already dying from infections resistant to antibiotic drugs in Europe alone, this is not some distant threat but something happening right now. If we fail to act, we are looking at an almost unthinkable scenario where antibiotics no longer work and we are cast back into the dark ages of medicine where treatable infections and injuries will kill once again.”*<sup>2</sup>

Dame Sally Davies, Chief Medical Officer for England, agrees: *“The soaring number of antibiotic-resistant infections poses such a great threat to society that in 20 years’ time we could be taken back to a 19th century environment where everyday infections kill us as a result of routine operations.”*<sup>2</sup>

Estimates of how much longer patients stay in hospital because of a surgical site infection range from 3.3 days for an abdominal hysterectomy to 21.0 days for a limb amputation.<sup>3</sup> Other studies found surgical site infections extended hospital stays by 10 days<sup>4</sup> and healthcare acquired infections generally extended hospital stays by 11.23 days<sup>5</sup>. One Trust we contacted estimated that a surgical site infection almost triples

the length of stay for a patient in primary admission – from 11 days to 31 days.

Healthcare-associated infections also impose great costs on the NHS. The cost of each surgical site infection has been estimated to vary from £959 for an abdominal hysterectomy to £6,103 for limb amputation.<sup>6</sup> Another study found the median additional cost attributable to each surgical site infection was £5,239.<sup>7</sup> Even as these avoidable costs are imposed on the NHS as a whole, there is also strong evidence that Trusts actually benefit financially from reimbursements when they treat patients who acquire an infection in that Trust’s hospital. Trusts are therefore put in the perverse position of being financially worse off if they eliminate surgical site infections.<sup>8</sup>

This report began as an effort to demonstrate the scale of the problem by tracking the number of infections and deaths caused by infections other than MRSA, MSSA, E.Coli and c difficile. As data from our Freedom of Information requests came in, we quickly discovered something more sinister. Most Trusts are failing even to measure the total number of cases of – and deaths from – sepsis, CAUTIs, catheter-related blood infections and ventilator-associated pneumonia. They have no idea of the total number of extra nights each year that patients stay in hospital owing to a healthcare acquired infection, or the total financial cost. This must change.

With so much variability by Trust and by region, there clearly needs to be a more effective national strategy to combat healthcare acquired infections. There is also no evidence of a substantial investment in Infection, Prevention and Control. The NHS is moving far too slowly. Starting from a very low base, budgets

2 'Prime Minister warns of global threat of antibiotic resistance', Department of Health and Prime Minister's Office, 10 Downing Street, 2 July 2014, at <https://www.gov.uk/government/news/prime-minister-warns-of-global-threat-of-antibiotic-resistance>

3 Adverse impact of surgical site infections in English hospitals, Coello R, Charlett A, Wilson J, Ward V, Pearson A, Borriello P, J Hosp Infect, 2005 Jun;60(2):93-103, at <http://www.ncbi.nlm.nih.gov/pubmed/15866006>

4 Clinical and economic burden of surgical site infection (SSI) and predicted financial consequences of elimination of SSI from an English hospital, P.J. Jenks, M. Laurent, S. McQuarry, R. Watkins, Journal of Hospital Infection, 26 September 2013, at [http://www.journalofhospitalinfection.com/article/S0195-6701\(13\)00344-7/abstract](http://www.journalofhospitalinfection.com/article/S0195-6701(13)00344-7/abstract)

5 The importance of good data, analysis, and interpretation for showing the economics of reducing healthcare-associated infection, Graves N, Barnett AG, Halton K, Crnich C, Cooper B, Beyersmann J, Wolkevit M, Samore M, Harbarth S, Infect Control Hosp Epidemiol. 2011 Sep;32(9):927-8, at <http://www.ncbi.nlm.nih.gov/pubmed/21828978>

6 Adverse impact of surgical site infections in English hospitals, Coello R, Charlett A, Wilson J, Ward V, Pearson A, Borriello P, J Hosp Infect, 2005 Jun;60(2):93-103, at <http://www.ncbi.nlm.nih.gov/pubmed/15866006>

7 Clinical and economic burden of surgical site infection (SSI) and predicted financial consequences of elimination of SSI from an English hospital, P.J. Jenks, M. Laurent, S. McQuarry, R. Watkins, Journal of Hospital Infection, 26 September 2013, at [http://www.journalofhospitalinfection.com/article/S0195-6701\(13\)00344-7/abstract](http://www.journalofhospitalinfection.com/article/S0195-6701(13)00344-7/abstract)

8 Clinical and economic burden of surgical site infection (SSI) and predicted financial consequences of elimination of SSI from an English hospital, P.J. Jenks, M. Laurent, S. McQuarry, R. Watkins, Journal of Hospital Infection, 26 September 2013, at [http://www.journalofhospitalinfection.com/article/S0195-6701\(13\)00344-7/abstract](http://www.journalofhospitalinfection.com/article/S0195-6701(13)00344-7/abstract)



increased by an average of only 8% a year before inflation in the period studied. This is in spite of growing anti-microbial resistance, with more and more resistance strains coming through. Rather than continue to overspend on the overuse of antibiotics, there must be a real investment in preventing infections in the first place.

Better measurement of and prevention of healthcare acquired infections is vital, and medical technology is key to this. We recommend that Trusts record cases and deaths from healthcare acquired infections. They should monitor the total number of nights patients stay

longer in hospital each month owing to a healthcare acquired infection. They should conduct device monitoring on all wards. They should receive no reimbursement for treating patients who acquire infections within the Trust.

# Recording

Among the more serious healthcare acquired infections are:

- **Sepsis:** Sepsis is a life threatening condition that arises when the body's response to an infection injures its own tissues and organs. Sepsis leads to shock, multiple organ failure and death especially if not recognized early and treated promptly.<sup>1</sup> The condition accounts for 100,000 hospital admissions.<sup>2</sup>
- **Catheter-associated urinary tract infections:** whereby urethral catheters introduce organisms into the bladder causing mucosal irritation. 25% of hospital patients have an in-dwelling urinary catheter fitted, of which 5% develop a urinary tract infection.<sup>3</sup> CAUTIs can develop into life threatening conditions and are significantly associated with 7-day mortality.<sup>4</sup> 1%-4% of patients with a CAUTI develop bacteraemia (the presence of bacteria in the blood). The mortality rate for bacteraemia is between 13% and 30%.<sup>5</sup>
- **Catheter-related blood infections:** bloodstream infection originating from an intravenous catheter. It is one of the most frequent, lethal and costly complications of central venous catheterisation. It has a mortality rate of up to 25% and significantly increases hospital length of stay and overall treatment costs. Presence, as opposed to absence, of CR-BSI is associated with higher mortality in critically ill adult patients.<sup>6</sup>
- **Ventilator-associated pneumonia:** a nosocomial infection resulting from microorganisms getting in to the lower respiratory tract and lung parenchyma. VAP may account for up to 60% of all Healthcare-Associated Infections.<sup>7</sup> Each incidence of VAP generates an increased cost of an estimated £6,000 - £22,000.<sup>8</sup>
- **Norovirus:** the most common stomach bug in the UK. It is highly contagious, can affect people of all ages and causes vomiting and diarrhoea. Seizures occasionally occur.<sup>9</sup> Two winters ago, the Health Protection Agency estimated there were more than 1 million cases in England and Wales - with only one in 288 recorded.<sup>10</sup>

Given the serious impact these conditions can have on patients and Trusts alike, it vital to tracking the number of cases and number of associated deaths. This is the beginning of the process of reducing the harm from these infections rather than the end.

Nonetheless, 58% of Trusts who responded to our Freedom of Information request said they do not collate the number of cases of any of these infections (a further 30% record some but not all of them). 76% of Trusts fail to collate the number of deaths (a further 18% record some but not all of them).

Only 12% of Trusts recorded the total number of cases of all these infections. Only 6% recorded the total number of associated deaths.

Similarly appalling reporting afflicts measurement of the financial costs. Of the 76 Trusts who responded to our inquiry about whether they measure the financial cost or operational impact of infections, only 9 (12%) confirmed that they did. Only 1 in 68 Trusts (1.5%) measured the total number of extra nights each year that patients stay in hospital owing to a healthcare acquired infection.

See the Appendix for a full list of these Trusts.

1 Info for the public', UK Sepsis Trust, at <http://sepsistrust.org/info-for-the-public/> (Accessed 11 September 2014)

2 'Sepsis lives can be saved, says ombudsman', BBC News, 12 September 2013, at <http://www.bbc.co.uk/news/health-24063623> (Accessed 2 September 2014)

3 'The efficacy of silver alloy-coated urinary catheters in preventing urinary tract infection: a meta-analysis', Saint S, Elmore JG, Sullivan SD, Emerson SS, Koepsell TD, Am J Med. 1998 Sep;105(3):236-41, at <http://www.ncbi.nlm.nih.gov/pubmed/9753027> (Accessed 2 September 2014)

4 'Outcomes in UK patients with hospital-acquired bacteraemia and the risk of catheter-associated urinary tract infections', Mark Melzer and Catherine Welch, Postgrad Med J 2013;89:329-334, at <http://pmj.bmj.com/content/89/1052/329.abstract> (Accessed 2 September 2014)

5 'Reducing the risk of catheter-related urinary tract infection', L Bisset, Nurs Times. 2005 Mar 22-28;101(12):64-5, 67, at <http://www.ncbi.nlm.nih.gov/pubmed/15822716> (Accessed 2 September 2014)

6 'Reducing the risk of catheter-related urinary tract infection', L Bisset, Nurs Times. 2005 Mar 22-28;101(12):64-5, 67, at <http://www.ncbi.nlm.nih.gov/pubmed/15822716> (Accessed 2 September 2014)

7 'Ventilator Associated Pneumonia - an Overview', Harshal Wagh and Devaraja Acharya, BJMP 2009;2(2) 16-19, at <http://www.bjmp.org/content/ventilator-associated-pneumonia-overview> (Accessed 2 September 2014)

8 'Ventilator Associated Pneumonia - an Overview', Harshal Wagh and Devaraja Acharya, BJMP 2009;2(2) 16-19, at <http://www.bjmp.org/content/ventilator-associated-pneumonia-overview> (Accessed 2 September 2014)

9 Norovirus, Patient.co.uk, at <http://www.patient.co.uk/doctor/Norovirus.htm> (Accessed 2 September 2014)

10 'Norovirus outbreak may have exceeded 1 million, says health agency', Shiv Malik and agencies, The Guardian, 28 December 2012, at <http://www.theguardian.com/society/2012/dec/28/norovirus-outbreak-exceeded-million> (Accessed 2 September 2014)



## How Infection Control Teams are Performing

### Infection Control staff numbers

107 Trusts responded to our query about the number of staff on their infection prevention and control teams.

Larger Trusts can be expected to have a larger absolute number of infection control staff – they have a larger

total number of staff. Arguably, a fairer measure is therefore the number of infection control staff for each bed within the Trust. On this measure, the North East and East Midlands are the two worst-performing regions, with London and the South West performing best. London has an Infection Control member of staff for every 71 beds. The East Midlands has one for every 161 beds (126% more beds per IC staff member).

Region	Number of IC staff	Number of beds	Number of beds per IC staff member	Difference from best-performing region
London	8.03	573	71	
South West	6.68	513	77	8%
Yorkshire & Humber	9.31	804	86	21%
West Midlands	6.82	643	94	32%
South East	7.72	838	108	52%
Eastern	4.95	560	113	59%
North West	6.92	830	120	68%
North East	13.39	1771	130	83%
East Midlands	10	1612	161	126%

### Infection Control business cases

One of the most encouraging results of our questionnaire was the degree to which Infection Control business cases succeed – an average of 86% of the time.

	2008/09	2009/10	2010/11	2011/12	2012/13
Success rate	82%	92%	85%	85%	87%



But there is great room for improvement in the actual number of cases submitted.

	2008/09	2009/10	2010/11	2011/12	2012/13
No. IC teams submitting no business cases	67 (74%)	77 (86%)	70 (78%)	75 (81%)	60 (64%)

In total only 175 business cases were submitted across all Trusts from 2008/09 to 2012/13. Encouragingly, this number rose dramatically between 2011/12 and 2012/13 without at all impacting on the success rate.

	2008/09	2009/10	2010/11	2011/12	2012/13
No. business cases submitted	39	25	29.5	26.5	55
No. successful	32 (82%)	23 (92%)	25 (85%)	22.5 (85%)	48 (87%)
No. IC teams submitting no business cases	67 (74%)	77 (86%)	70 (78%)	75 (81%)	60 (64%)

### Support for Infection Control from the Board

A key measure of how seriously Trusts are taking Infection Control is the number of infection prevention and control committee meetings the Board attends. The 86 Trusts who responded reported 1,983 occasions from 2008/09 to 2012/13 – giving an encouraging figure of 5.76 per Trust each year.

The variation by Trust was enormous, however. Torbay and Southern Devon Health and Care NHS Trust had board members attend 24 meetings a year in each of the five years surveyed. By contrast, the following Trusts had no board members attend an infection prevention and control committee meeting for at least one of the financial years covered:

- Calderdale and Huddersfield NHS Foundation Trust
- Sheffield Children's NHS Foundation Trust
- Airedale NHS Foundation Trust
- The Royal Wolverhampton NHS Trust
- Great Western Hospitals NHS Foundation Trust
- Plymouth Hospitals NHS Trust
- South Devon Healthcare NHS Foundation Trust

- Ashford and St Peter's Hospitals NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- South Tees Hospitals NHS Foundation Trust
- University College London Hospitals NHS Foundation Trust
- Great Ormond Street Hospital for Children NHS Foundation Trust
- Luton and Dunstable Hospital NHS Foundation Trust
- Mid Essex Hospital Services NHS Trust
- Hinchingsbrooke Health Care NHS Trust

### Device surveillance

Trusts do device surveillance on an average of 71% of wards. On average, each Trust neglects device surveillance in 9 wards, while completing it in 22. Seven Trusts neglect device surveillance on 100% of their wards. They are:

- Central Manchester University Hospitals NHS Foundation Trust
- Heart Of England NHS Foundation Trust



- Tameside Hospital NHS Foundation Trust
- Dorset County Hospital NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Walsall Healthcare NHS Trust
- Birmingham Women's NHS Foundation Trust

A further six Trusts had a very high number of wards without device surveillance:

- University Hospitals Of Leicester NHS Trust does not do device surveillance on 100 wards out of 101
- Leeds Teaching Hospitals NHS Trust does not do device surveillance on 107 wards out of 121
- Royal Marsden does not do device surveillance on 25 wards out of 47
- North Tees and Hartlepool NHS Foundation Trust does not do device surveillance on 25 wards out of 27
- Alder Hey Children's NHS Foundation Trust does not do device surveillance on 23 wards out of 24
- Great Western Hospitals NHS Foundation Trust does not do device surveillance on 24 wards out of 25

### Expenditure

There is no evidence of a substantial investment in Infection, Prevention and Control. The Trusts who responded to our Freedom of Information Requests indicated their budgets for infection prevention and control increased by only an average of 8% per annum from 2008/09 to 2012/13. This is very troubling in the context of increasing anti-microbial resistance.

Seven Trusts actually received instructions to *reduce* expenditure on infection, prevention and control in the last five years. They are:

- West Middlesex
- University Hospital Southampton
- Torbay & South Devon
- Plymouth
- Northumbria
- Doncaster & Bassetlaw
- Barnsley

## Recommendations

- 1 Trusts must be required to record the total number of cases and associated deaths from sepsis, catheter-associated urinary tract infections, catheter-related blood infections, ventilator-associated pneumonia and norovirus.
- 2 Trusts must be required to record the total number of nights patients stay longer in hospital each month owing to a healthcare acquired infection.
- 3 Trusts should receive no financial reimbursement for readmissions and bed days relating to a healthcare acquired infection that was acquired within the Trust itself. This will end the situation where Trusts actually financially benefit from healthcare acquired infections<sup>1</sup>, and better align financial incentives with the goal of lower infection rates.
- 4 Device surveillance should be mandatory for all hospital wards.
- 5 The Government should develop a strategy for using technology for infection prevention and control, and engage with industry on solutions for this.

<sup>1</sup> Clinical and economic burden of surgical site infection (SSI) and predicted financial consequences of elimination of SSI from an English hospital, P.J. Jenks, M. Laurent, S. McQuarry, R. Watkins, Journal of Hospital Infection, 26 September 2013, at [http://www.journalofhospitalinfection.com/article/S0195-6701\(13\)00344-7/abstract](http://www.journalofhospitalinfection.com/article/S0195-6701(13)00344-7/abstract)



# Appendix

Trust	Region	Do you measure the aggregate number of nights patients stayed in hospital longer owing to a healthcare acquired infection?	Do you collate the total number of cases of (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Do you collate the total number of deaths from (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Does the Trust carry out any financial analysis on the cost or operational impact of infections locally?
Kettering General Hospital NHS Foundation Trust	East Midlands	No	Some	No	No
Nottingham University Hospitals NHS Trust	East Midlands	No	No	No	No
United Lincolnshire Hospitals NHS Trust	East Midlands				No
University Hospitals Of Leicester NHS Trust	East Midlands	No	No	No	No
Bedford Hospital NHS Trust	Eastern	No	No	No	No
Cambridge University Hospitals NHS Foundation Trust	Eastern		No	No	
East and North Hertfordshire NHS Trust	Eastern	No	Yes	Yes	Yes
Mid Essex Hospital Services NHS Trust	Eastern	No	Some	Some	
Papworth Hospital NHS Foundation Trust	Eastern	No	Some	No	Yes
Southend University Hospital NHS Foundation Trust	Eastern				No
The Queen Elizabeth Hospital, King's Lynn. NHS Foundation Trust	Eastern	No	No	No	No
West Hertfordshire Hospitals NHS Trust	Eastern	No	No	No	No
Barnet and Chase Farm Hospitals NHS Trust	London	No	No	No	No
Chelsea and Westminster Hospital NHS Foundation Trust	London	No	No	No	No
Croydon Health Services NHS Trust	London	No	Yes	Yes	No
Epsom and St Helier University Hospitals NHS Trust	London	No	No	No	No
Great Ormond Street Hospital for Children NHS Foundation Trust	London	No	Some	No	No
Imperial College Healthcare NHS Trust	London	No			No
Moorfields Eye Hospital NHS Foundation Trust	London				No

Trust	Region	Do you measure the aggregate number of nights patients stayed in hospital longer owing to a healthcare acquired infection?	Do you collate the total number of cases of (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Do you collate the total number of deaths from (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Does the Trust carry out any financial analysis on the cost or operational impact of infections locally?
Royal Brompton and Harefield NHS Foundation Trust	London	Yes	Some	Some	Yes
Royal Free London NHS Foundation Trust	London	No	No	No	No
The Royal Marsden NHS Foundation Trust	London	No	Some	No	No
West Middlesex University Hospital NHS Trust	London	No	No	No	No
City Hospitals Sunderland NHS Foundation Trust	North East	No	Some	No	No
County Durham and Darlington NHS Foundation Trust	North East	No	No	No	No
North Tees and Hartlepool NHS Foundation Trust	North East	No	Some	No	No
Northumbria Healthcare NHS Foundation Trust	North East	No	No	No	No
South Tees Hospitals NHS Foundation Trust	North East	No	Some	No	Yes
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	North East	No	Some	No	No
Alder Hey Children's NHS Foundation Trust	North West	No	No	No	No
Central Manchester University Hospitals NHS Foundation Trust	North West	No	Some	Some	No
Countess Of Chester Hospital NHS Foundation Trust	North West	No	No	No	No
East Cheshire NHS Trust	North West	No	No	No	No
Lancashire Teaching Hospitals NHS Foundation Trust	North West	No	No	No	No
Pennine Acute Hospitals NHS Trust	North West	No		No	Yes
Royal Liverpool and Broadgreen University Hospitals NHS Trust	North West	No	Some	Some	No
Salford Royal NHS Foundation Trust	North West	No	Yes	No	No
Tameside Hospital NHS Foundation Trust	North West	No	Some	No	No
The Christie NHS Foundation Trust	North West	No	Yes	Yes	No
University Hospital Of South Manchester NHS Foundation Trust	North West	No	No	No	No



Trust	Region	Do you measure the aggregate number of nights patients stayed in hospital longer owing to a healthcare acquired infection?	Do you collate the total number of cases of (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Do you collate the total number of deaths from (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Does the Trust carry out any financial analysis on the cost or operational impact of infections locally?
Wirral University Teaching Hospital NHS Foundation Trust	North West	No	No	No	Yes
Wrightington, Wigan and Leigh NHS Foundation Trust	North West	No	No	Some	No
Ashford and St Peter's Hospitals NHS Foundation Trust	South East	No	No	No	No
Buckinghamshire Healthcare NHS Trust	South East				No
East Kent Hospitals University NHS Foundation Trust	South East	No	No	No	No
East Sussex Healthcare NHS Trust	South East	No	No	No	No
Heatherwood and Wexham Park Hospitals NHS Foundation Trust	South East	No	No	No	No
Medway NHS Foundation Trust	South East	No	Some	Some	No
Milton Keynes Hospital NHS Foundation Trust	South East	No	Some	No	
Oxford University Hospitals NHS Trust	South East	No	No	Some	No
Royal Berkshire NHS Foundation Trust	South East	No	No	No	No
Royal Surrey County NHS Foundation Trust	South East	No	No	No	
Surrey and Sussex Healthcare NHS Trust	South East	No	Some	No	No
University Hospital Southampton NHS Foundation Trust	South East	No	No		Yes
Western Sussex Hospitals NHS Trust	South East				No
Dorset County Hospital NHS Foundation Trust	South West	No	No	No	No
Great Western Hospitals NHS Foundation Trust	South West	No	Some	Some	No
Plymouth Hospitals NHS Trust	South West	No	Yes	No	Yes
Poole Hospital NHS Foundation Trust	South West				No
Royal Devon and Exeter NHS Foundation Trust	South West	No	Yes	Some	No
Royal United Hospital Bath NHS Trust	South West	No	Some	Some	

Trust	Region	Do you measure the aggregate number of nights patients stayed in hospital longer owing to a healthcare acquired infection?	Do you collate the total number of cases of (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Do you collate the total number of deaths from (i) sepsis, (ii) septicemia, (iii) a catheter-associated urinary tract infection, (iv) a catheter-related blood infection, (v) ventilator-associated pneumonia and (vi) norovirus?	Does the Trust carry out any financial analysis on the cost or operational impact of infections locally?
South Devon Healthcare NHS Foundation Trust	South West	No	No	No	No
Torbay and Southern Devon Health and Care NHS Trust	South West	No	Some	Some	Yes
University Hospitals Bristol NHS Foundation Trust	South West	No	No	No	No
Yeovil District Hospital NHS Foundation Trust	South West				No
Burton Hospitals NHS Foundation Trust	West Midlands				No
Heart Of England NHS Foundation Trust	West Midlands				No
Mid Staffordshire NHS Foundation Trust	West Midlands				No
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	West Midlands	No	No	No	No
Shrewsbury and Telford Hospital NHS Trust	West Midlands				No
South Warwickshire NHS Foundation Trust	West Midlands	No	No	No	
University Hospital Of North Staffordshire NHS Trust	West Midlands	No	Yes	No	No
Walsall Healthcare NHS Trust	West Midlands	No	Some	Some	No
Airedale NHS Foundation Trust	Yorkshire & Humber	No	No	No	No
Barnsley Hospital NHS Foundation Trust	Yorkshire & Humber				No
Calderdale and Huddersfield NHS Foundation Trust	Yorkshire & Humber				No
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	Yorkshire & Humber	No	No	No	No
Harrogate and District NHS Foundation Trust	Yorkshire & Humber	No	No		No
Hull and East Yorkshire Hospitals NHS Trust	Yorkshire & Humber	No	No	No	No
Leeds Teaching Hospitals NHS Trust	Yorkshire & Humber	No	No	No	No
The Rotherham NHS Foundation Trust	Yorkshire & Humber	No	Yes	Yes	No
York Teaching Hospital NHS Foundation Trust	Yorkshire & Humber	No	No	No	No



## The Medical Technology Group

The MTG is a coalition of patient groups, research charities and medical device manufacturers working to improve access to cost effective medical technologies for everyone who needs them. Our membership ranges from national charities such as the Juvenile Diabetes Research Foundation and the Patients Association, to international companies including Boston Scientific, Johnson & Johnson and Medtronic.

The common purpose of the MTG is to increase patient access to the best diagnostic, imaging, surgical and supported-living technologies on the NHS.

Appropriate use of medical technology provides value for money to the NHS, patients and taxpayers. It can improve clinical outcomes and experiences of patients and supports the wellbeing and personal development of individuals. It can also help to achieve savings to the NHS and other areas of public spending in a tight budgetary climate by improving independence, supporting care closer to home, and enabling faster rehabilitation after surgery as just a few examples.

Patient access to proven medical technology is not as good as it should be in the UK. For example, insulin pumps are NICE approved for the treatment of Type 1 diabetes but uptake stands at 4% compared to 35% in the USA.

Mainstreaming medical technology is an important part of the quality and efficiency agenda for today's NHS.

We need to foster a culture of improvement in the NHS so that:

- patients are empowered to access the technology that could help them to manage their condition and get on with their lives;
- commissioners are equipped to plan and deliver services that address growing patient need cost effectively;
- clinicians can harness technologies wherever it can best support the outcomes and experiences of the patient.

### MTG Membership

ABHI  
AdvaMed  
AntiCoagulation Europe  
ARMA  
Arrhythmia Alliance  
Arthritis Care  
Atrial Fibrillation Association  
BD  
Bladder and Bowel Foundation  
Boston Scientific  
British Cardiac Patients Association  
C R Bard  
Cardiomyopathy Association  
Diabetes UK  
Eucomed  
FABLE  
FEmISA  
Heart Research UK  
ICD Group  
INPUT  
International Alliance of Patients' Organizations  
JDRF  
Johnson & Johnson  
Lindsay Leg Club  
Medtronic  
National Rheumatoid Arthritis Society  
Pancreatic Cancer UK  
Pelvic Pain Support Network  
Pumping Marvellous  
Roche Diagnostics  
SADS UK  
St Jude Medical  
STARS  
Stryker  
The Circulation Foundation  
The Patients Association  
Transplant Support Network





The  
**Medical** Group  
**Technology**

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Improving patient access to medical technology

[www.mtg.org.uk](http://www.mtg.org.uk)