

Britain: rise in “superbug” cases linked to decrease in hospital cleaning staff

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Britain’s largest union, UNISON, has drawn attention to the dramatic decrease in the numbers of cleaning staff in the country’s hospitals and the corresponding rise in the incidence of the so-called “superbug,” MRSA.

In a report issued this month, UNISON notes that the size of the cleaning staff working in National Health Service (NHS) facilities has fallen from about 100,000 in 1984 to about 55,000 today. The decrease in staff numbers is due to the contracting out of cleaning jobs, which began under the previous Conservative government. It has led to poor training, low retention levels due to pitiful wages and dirty hospitals, which in turn have directly contributed to the rise of MRSA.

The British government admits that the number of cleaners in the NHS has played a part in the spread of MRSA, but Health Secretary John Reid denied a direct correlation. He also quibbled about the numbers, saying that in 1986 there were 86,000 cleaners, and that the size of the NHS estate had decreased by 20 percent over the period, so therefore, there is less physical space to clean.

MRSA is the acronym of the disease Methicillin-resistant *Staphylococcus aureus* (commonly called “staph”). *Staph* are bacteria often carried on the skin or in the nose of healthy people. They are a common cause of minor skin infections—such as pimples and boils—but can also cause serious infections such as surgical wound infections, bone infections and pneumonia. Approximately 25-30 percent of the population is colonised with *staph* bacteria at any one time—i.e., have the bacteria on or in their bodies without it causing illness. At the point where it begins to cause them illness, it is referred to as infection rather than colonisation.

Methicillin is a form of the antibiotic penicillin that has historically been used to treat *staph*. However, over the past 50 years, *staph* has increasingly become resistant to antibiotics, which has led to the use of the nickname “superbug.” New strains of MRSA are constantly emerging, and there are deep concerns that it is becoming increasingly resistant to the last-resort antibiotic Vancomycin.

The first report of a penicillin resistant strain of *staph* was in 1945. MRSA was first reported in Europe in the 1960s, and in the US in 1968.

MRSA is usually contracted in hospital but can occur in the wider community, where it is closely linked to recent antibiotic use, sharing contaminated items, having active skin diseases or living in crowded settings. Within hospitals, post-op patients are

most at risk, particularly the elderly and those with chronic illnesses. The working class and poor are generally more at risk, since they tend to live in more crowded surroundings and are more likely to visit hospital with chronic illnesses.

It is estimated that one in ten patients acquire the infection during their hospital stay, and with approximately 100,000 hospital-acquired infections per annum, this costs the NHS an estimated £1 billion a year.

During the last decade, deaths from hospital-acquired MRSA have increased more than 15-fold, and infection rates 24-fold, according to the UK’s Office of National Statistics. Fifty-one deaths were reported from 210 infections in 1993, compared to 800 deaths from 5,309 infections in 2002. MRSA cases as a proportion of all *staph* cases have risen from 2 percent in 1994 to more than 40 percent in 2004.

The figures are extracted from death certificates, and Tony Field from the national MRSA support group believes that the real figure is much higher, since doctors are not obliged to put MRSA on the death certificate as a secondary cause of death. The group’s analysis suggests that the true figure for *staph* deaths is closer to 20,000, with around half of these from MRSA. Field also believes that the government’s widely used figure of 5,000 deaths is outdated and drawn from statistics compiled in 1994.

The Department of Health has said that it did not have a clear idea what the death rate was, and added cynically that the people who die from hospital-acquired infections are already very ill, which is why their immune systems cannot fight the bacteria.

A number of health care professionals have raised the alarm at the level of infections in Britain’s hospitals. One of these is Dr. Chris Malyszewicz, who has pioneered research into testing for levels of MRSA and other bacteria in hospitals, and reports that he has been harassed by the government since speaking out.

Malyszewicz claims that two senior government health advisors visited him at home just hours after meeting with the Health Secretary. During a “tense” and “aggressive” three-hour meeting, they sought to discredit his work. “It was clear they were trying to shut me up,” he said. “Publicity about my research into MRSA levels in NHS hospitals has obviously caused problems.”

The reasons for the spread of MRSA are complex and involve a number of different factors, such as the inappropriate use of antibiotics in agriculture and the over-prescription of antibiotics in society. Most experts also consider ineffective hygiene control and the connected inability to provide clean hospitals as key factors in

the recent upsurge in the incidence of MRSA.

Britain is ranked second-worst of the European Union countries for the rate of MRSA as a proportion of all diseases in its hospitals, which runs at 44 percent. This compares to rates of 1 percent in the Netherlands, 19 percent in Germany, and 33 percent in France. A quarter of Britain's dirtiest hospitals are in London, according to government figures, including some of the most prestigious specialist hospitals.

The Netherlands attributes its success at tackling the infection to its policy of Search and Destroy—i.e., the screening of patients for MRSA and the isolation of those found to be infected. It has also set aside a number of single rooms in hospitals for the treatment of those with MRSA. In addition, the Netherlands has a much higher proportion of healthcare workers per patient than the UK.

The isolation of those with MRSA in private rooms is recommended by many experts, though a study in the medical journal *The Lancet* has cast doubt on the use of isolation as a means of curbing the spread of MRSA, at least in regard to intensive care patients. It points to the need to comply with other means of curbing disease in conjunction with isolation—e.g., hand washing and the use of protective clothing.

Hand hygiene is by far the most important strategy in controlling MRSA, though there are a number of contact precautions that experts also suggest. These include the use of gowns, gloves and dedicated equipment, as well as the transportation of patients only when absolutely essential.

Bed making in hospitals is also thought to be a factor in the spread of infection, as it releases large quantities of microorganisms. Studies have shown that vigorous bed making can lead to in excess of 6,000 colony-forming units per cubic metre of air in the ward.

“The problem is that as one patient leaves a bed another is just about to occupy it, which means you do not have time to clean the beds,” believes Michael Summer of the Patients Association. “In other countries they actually rotate the beds so that the infection is carefully monitored.”

MRSA takes up to 48 hours to grow and is often not picked up until the patient has been in hospital for several days.

Dr. Clive Beggs of Leeds University explains how sneezing can also cause infection to spread. When a patient sneezes, droplets are expelled at around 100 metres per second. These are largely made up of droplets between 10 and 100 *micro* metres in diameter. The larger droplets fall to the ground, but the smaller droplets can evaporate and shrink to droplet nuclei that settle slowly. For example, droplet nuclei of 2 *micro* metres in diameter can take more than four hours to fall 2 metres in a calm room. Convection currents could therefore carry particles long distances dependent on ventilation conditions, thereby distributing them widely throughout the hospital.

The Thatcher government's privatisation strategy in the 1980s—the introduction of competitive tendering and the contracting-out of services—led directly to an escalation in MRSA rates. Over the next decade, “efficiency drives” saw the almost total destruction of the NHS culture, with nursing staff forced onto short-term contracts and cut to inappropriate and dangerous levels.

Prior to this, in the 1970s, cleaners were employed directly by

the hospital. Each ward had its own cleaners who were part of the ward team. Porters, maintenance staff and cleaners had pride in their wards, and many worked for most of their careers in the same place.

The NHS Trust hospitals that emerged from the creeping privatisation process are under enormous pressure to cut costs, and will invariably pick the cheapest option in choosing their contracted-out services. This almost necessarily leads to contractors cutting corners and subsequently to a less efficient or thorough job being undertaken. The cleaning companies operate on tightly drawn contracts, where every task is listed and timed, which leaves no place for anything not on the list, including accidents. An attitude of apathy and disregard for cleanliness pervades.

The pressure on hospitals to cut costs has also led to other factors that help spread infections. For example, in the past, hospital workers were issued uniforms for use only on the premises, and these were laundered on site—often boil-washed. Nowadays, staff are responsible for their own uniforms, which they wear to and from work, via public transport, etc. Uniforms, therefore, gather many germs from the environment en-route, and are then probably often washed at home on normal domestic low-temperature washes, which do not kill many germs.

A journalist from the *Daily Mail* who worked undercover for Rentokil Initial, one of the firms with contracts to clean hospitals, revealed that he received only a 90-minute induction course and had no relevant experience. He reported finding bags of blooded bandages and plaster casts left overnight in the fracture clinic. He also found 2-inch (5-cm) insects, and heard of cleaners failing to clean areas properly because of their workload. The areas he was allocated were to be checked just once a month by the hospital trust and once a week by his Rentokil Initial supervisor, if she had time.



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