

31st December 2008

Gateway reference number 11123

**To: SHA Chief Executives
SHA Directors of Finance
SHA Directors of Medicine
SHA Directors of Nursing
SHA Directors of Performance**

**Cc: PCT Chief Executives
NHS Trust Chief Executives
NHS Trust Directors of Infection Prevention and Control
NHS Trust Directors of Medicine
NHS Trust Directors of Nursing
NHS Foundation Trust Chief Executives
NHS Foundation Trust Directors of Medicine
NHS Foundation Trust Directors of Infection Prevention and Control
NHS Foundation Trust Directors of Nursing
Regional Directors of Public Health
Independent Sector Treatment Centre Chief Executives
Monitor**

Dear Colleague

MRSA SCREENING – OPERATIONAL GUIDANCE 2

This guidance is aimed primarily at Chief Executives and Directors of Performance. It will be of interest to Finance Directors, Directors of Nursing and Medicine, Directors of Infection Prevention and Control and their teams, medical microbiologists, laboratory managers, bed managers and those running pre-admission clinics and admission units.

Aim

This guidance is to support NHS trusts, (including Primary Care Trusts and NHS Foundation Trusts) in introducing MRSA screening for all elective patients by the end of March 2009. It is intended to clarify expectations around the roles of the Department of Health, acute, primary care, other NHS Trusts, NHS foundation trusts, Monitor and Strategic Health Authorities over the next 3 months in ensuring the commitment is achieved. A timeline of key actions is included in Annex A.

Monitor is currently consulting on the inclusion of the requirement to introduce elective screening for all elective patients with its Compliance Framework from 1 April 2009.

It builds on previous guidance “Screening for MRSA colonisation – a strategy for NHS Trusts: a summary of best practice”¹ and “MRSA Screening – Operational Guidance”² issued on 31 July 2008, Gateway reference 10324, both available on the Department of Health website.

This document clarifies:

- The planning requirements to support MRSA screening for all relevant patients from April 2009;
- The assurances needed by trusts to provide evidence of MRSA screening;
- The roles of SHAs, PCTs, Monitor and DH in assuring and supporting the delivery of MRSA screening.

The guidance updates the existing guidance but does **not** replace it. It does not prescribe how the NHS should deliver the commitment. This is a matter for local determination.

2008/09 and 2009/10 Operating Framework Requirements

There is a commitment in the 2008/09 Operating Framework to introduce MRSA screening.

“Meeting the challenge of HCAI will require additional actions across the system for 2008/09, including: introducing MRSA screening for all elective admissions from 2008/09 and for all emergency admissions as soon as practicable within the next three years.”

This is reiterated in the 2009/10 Operating Framework:

“From April 2009, all elective admissions must be screened for MSRA in line with Department of Health guidance. This should be extended to cover emergency admissions as soon as possible and definitely no later than 2011.”

Context

Following the previous guidance, (see links under ‘aims’ above), all trusts which have relevant elective admissions³ should have firm plans in place to introduce MRSA screening for all of the relevant patients, including milestones and systems for assurance, and be implementing those plans and systems.

¹ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063188

² http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_086687

³ Relevant elective admissions are all elective admissions which are not exempt. The list of exemptions is at Annex C.

While it is clear that some organisations are well advanced in implementing their plans, it is also clear that others have a considerable amount of work to do before end March 2009 to ensure the MRSA screening commitment is delivered on time.

A good practice checklist of the elements of an effective screening plan is attached as Annex B.

Which patients in which locations need to be screened by March 2009?

It is important to note that the MRSA screening commitment includes all relevant elective admissions, including patients treated in non-acute provider units such as community hospitals and NHS patients treated by the independent sector. PCTs will want to assure themselves that they have identified all elective patients in non-acute provider units and that they are assuring themselves that these patients are being screened in line with DH guidance.

A small number of patient groups are exempt from the screening requirement. This was set out in the previous operational guidance and the list is attached again here as Annex B for ease of reference. There are no other exemptions so any local **plans which exempt other groups, such as all day cases, will not be compliant** with the screening requirement in the Operating Frameworks for 2008/09 and 2009/10 and will need to be revised.

Decolonisation

We expect all patients who test positive for MRSA on screening prior to admission to be effectively decolonised, as indicated in previous guidance.

Role of NHS Trusts and other organisations admitting relevant elective patients - Planning and Assurance

In addition to effective plans for MRSA screening, organisations undertaking screening will need to have clear assurance processes in place to provide evidence that they will be/are screening all relevant elective patients. Good practice guidance on an effective screening assurance process is attached as Annexes D and E and is also available on the *Clean, Safe Care* website at:

<http://www.clean-safe-care.nhs.uk/public/default.aspx?level=1&load=ArticleViewer&ArticleID=461#mrsascreen>

Fuller guidance will follow shortly and will be made available on the *Clean, Safe Care* website.

By 31 March 2009 every organisation which admits relevant elective patients will need to publish its MRSA screening policy along with a statement that it is compliant with that policy. Chief Executives of those organisations should sign off with the appropriate body that they are complying with their local MRSA screening policy and that they have evidence to demonstrate that they are screening all relevant elective patients. (This will be SHAs/PCTs for non-foundation trusts, and Monitor/PCTs for Foundation Trusts).

Monitor will hold NHS foundation trust Boards to account for compliance with their trust's MRSA screening policy.

Role of SHAs and PCTs and Monitor – Planning

SHAs and PCTs will want to build assurances, into their operational plans, initial plans due on 30th January for tier 1 Vital Signs, that all organisations admitting relevant elective patients have effective implementation plans in place outlining how they will get to full compliance with the commitment by 31 March 2009.

Where SHAs and PCTs have reason to be concerned they should monitor progress to compliance with the commitment on a monthly basis using the implementation plans they receive (i.e. against key milestones), the monthly national data collection and soft intelligence, or in the case of NHS foundation trusts, inform Monitor as to any concerns.

Role of SHAs and PCTs and Monitor – Assurance

Every organisation which admits relevant elective patients is being asked to publish its MRSA screening policy and a statement of compliance. SHAs, working with their PCTs, will want to ensure that Chief Executives of those organisations sign off that they are complying with their local MRSA screening policy and that they have appropriate evidence to demonstrate that they are screening all relevant elective patients. They should also regularly monitor Trusts' compliance with this commitment. In the case of NHS foundation trusts, Monitor will ensure compliance and will hold Boards to account.

DH will seek assurance from SHAs/Monitor that the required policies, sign-offs, assurances and evidence are in place.

PCTs may wish to include locally agreed healthcare associated infection improvement plans in their contracts with organisations, which could include MRSA screening sanctions and incentives.

Role of SHAs and PCTs – Data

SHAs, with their PCTs, should now be reviewing the current screening data returns for their area to identify those trusts which appear to be at risk of failing to deliver the commitment by 31 March 2009, feeding back any concerns to organisations on their patch. SHAs may want to compare organisations' figures on relevant elective admissions with Health Episodes Statistics data to assure themselves that Trusts are identifying approximately the right number of relevant elective admissions as well as reporting an appropriate number of screening tests.

Data collection

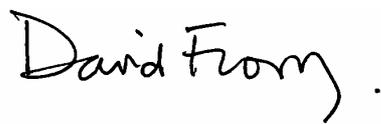
The current national data collection provides a broad indication of the numbers of relevant elective admissions and gives an overview of the existing

screening activity. This data return will be discontinued once more comprehensive assurance processes are in place at a local and Regional level. We will notify you when this data return is no longer required.

Role of DH and further guidance

DH will continue collating and sharing good practice through the *Clean, Safe Care* website to support learning.

We will also be discussing with the Care Quality Commission how they will be monitoring compliance with the screening commitment (which is part of the Hygiene Code⁴) in the future.



Director General of NHS Finance,
Performance and Operations



Chief Nursing Officer

⁴ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081927

Annex A - Timeline to Commitment

31 December 2008	Publication of this guidance.
By 30 January 2009	SHAs with PCTs ensure all organisations with relevant elective admissions have effective screening implementation plans in place to achieve end March compliance
February & March 2009	SHAs, PCTs & Monitor to monitor screening data and progress against plans.
By 31 March 2009	Publication of MRSA screening policy by all organisations with relevant elective admissions. Locally, Chief Executive agreed, arrangements that show organisational compliance with the policy and that evidence confirms it is being followed.
1 April 2009 onwards	All relevant elective NHS patients screened for MRSA.

Annex B

GOOD PRACTICE CHECKLIST OF THE ELEMENTS OF AN EFFECTIVE MRSA SCREENING PLAN

Effective plans should cover as a minimum:

- policy on compliance with MRSA screening
- how screening and effective decolonisation is being rolled out across the organisation
- impact on key resources including isolation facilities and capacity / staffing in microbiology
- staff training on swabbing and decolonisation where necessary
- an understanding of manufacturers' ability to provide key supplies
- how compliance with the policy will be assured, monitored and reported
- how MRSA screening policy will be communicated to patients and positive results reported.

Annex C – Which patient groups should be screened by March 2009?

All elective admissions should be routinely screened. We have identified within elective admissions and attendances, the following patient groups who should not be routinely screened:

- Day case ophthalmology
- Day case dental
- Day case endoscopy
- Minor dermatology procedures, eg, warts or other liquid nitrogen applications
- Children/paediatrics unless already in a high risk group
- Maternity/obstetrics except for elective caesareans and any high risk cases, i.e. high risk of complications in the mother and/or potential complications in the baby, (e.g. likely to need SCBU, NICU because of size or known complications or risk factors.)
- Mental Health Patients. Please see specific guidance on screening for mental health patients on the Clean Safe Care web site at:

<http://www.clean-safe-care.nhs.uk/public/default.aspx?level=1&load=ArticleViewer&ArticleID=461#mrsascreen>

In addition, it is important that trusts continue locally to assess all their patient admission groups for screening according to risk – as advised in the existing guidance.

Annex D – ASSURANCE FRAMEWORK CHECKLIST

This summary enables you to assess quickly which parts of the assurance framework you have in place and which you might need to focus on in order to gauge your current baseline against the Prime Minister's MRSA screening commitment and to assist you in mapping your journey to ensure delivery. This can form part of a trust's ongoing assurance framework rather than being a stand alone element. A more detailed example can be found on the clean safe care website at the end of January 2009.

1. Are your principal objectives defined? Yes No

Principal objectives are the strategic goals within an organisation. These will drive the response to why screening is so important within your Trust.

2. Are your principal risks identified? Yes No

Principal risks will highlight any obstacles to achieving your principal objectives as well as the associated consequences. They may include, for instance, gaps in staff training, policy shortfalls, patient group directives (PGD) to ensure timely decolonisation, or inability to undertake data collection with appropriately trained staff to understand percentage compliance.

3. Do you have key controls in place to manage risks? Yes No

Are key controls in place to manage the principal risks? Controls should relate directly to the principal risks and should be practical. Each risk may need more than one control, and the same control may address more than one risk. Is current good practice in screening in place and adopted by the whole organisation, is screening taking place at the right point in the patient pathway so patients' treatment is not delayed for any reason?

4. Are assurances provided on the effectiveness of controls? Yes No

This element is about gathering the evidence about the effectiveness of the key controls. Observation and recording of patients screened can show where improvement action is required ultimately to achieve 100% compliance every time, without which the control is not as effective as it could be. Examples of evidence gathering could include random point prevalence surveys asking patients if they had been screened and subsequently decolonised, or direct patient to screen matching as a continuous audit of compliance.

5. Putting it all together.

Yes No

All of the stages of the assurance framework should work together as a continuous process of identifying objectives, assessing risks, introducing controls and assessing whether these controls have been effective.

6. Trust board papers include all the above elements?

Yes No

Trusts should ensure all the above elements are incorporated into their routine board reports.

7. Effective delivery plans are in place?

Yes No

Having assessed the current position, boards should have an action/delivery plan which is outcome focused, owned and measurable to improve its key controls to manage its principal risks and gain assurance that the screening commitment is being met.

Annex E – Example Screening Assurance Framework

Corporate Objective	Local Sub Objective	Current State	Future State	Executive Lead	Operational Lead and involved individuals	Risk	Measure of Success	Evidence
Delivery of clean safe care to all our patients	<i>From April 2009, all elective admissions must be screened for MRSA in line with Department of Health guidance. This should be extended to cover emergency admissions as soon as possible and definitely no later than 2011.</i>	Unknown, anecdotally wards are saying they are screening high risk and elective patients. However, we know from the MRSA RCA, and screening audits that this is not case	Full assurance that all patients are given the choice of being screened and all patients are appropriately managed if declined Full decolonisation of appropriate patients, in line with current best practice, (bactroban and mupirocin)	Director of Operations (name)	General Managers (names) Matrons (names) Clinical Leads (names)	25	All patients in point prevalence surveys indicate they have been offered an MRSA screen upon or before admission, it had not delayed their pathway of care for subsequent treatment Direct patient to screen match	Policy has been agreed awaiting approval by board Point prevalence survey results to be part of board KPIs for the next 6 months or until assurance is gained that the process is compliant and sustainable. Exception reporting after full assurance gained Divisional KPIs reported monthly both internally and to commissioners

	Full elective screening by March 2009 Full emergency screening by April 2010 (begin roll out April 2009 starting with high risk groups)						Ongoing audit of elective screening for all relevant electives at point of screen Pre-procedure checklist	Briefings at ward level by General Managers Briefings to clinicians by clinical leads and general managers Full audit annually to ensure sustainability of policy
Action Plan								
Local Sub Objective	Current State	Future State	Executive Lead	Operational Lead and involved individuals	Date of Completion	Risk	Measure of Success	Evidence