AUDITOR GENERAL

PERFORMANCE AUDIT

Hospital cleaning

PREPARED BY AUDIT SCOTLAND

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Hospital cleaning

A report to the Scottish Parliament by the Auditor General for Scotland

Auditor General for Scotland

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Tricia Meldrum and John Simmons managed the review under the general direction of Barbara Hurst, Director of Performance Audit.

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Contents

Summary

Introduction

Audit Scotland published '*A clean bill of health*', a baseline review of hospital cleaning services, in April 2000. This made a number of recommendations aimed at improving the quality and effectiveness of hospital cleaning. This follow-up review assesses progress against a number of these recommendations. It also includes a review of the level of cleanliness observed in hospitals, providing the first national snapshot. The report investigates the reasons for variations in the levels of cleanliness, looking at issues identified in '*A clean bill of health*'. It considers frequency of cleaning tasks, staff inputs to cleaning and monitoring, recruitment and retention of staff, management arrangements and the application of policies and procedures. The review also incorporates a baseline assessment of compliance with standards for cleaning services issued by the Clinical Standards Board for Scotland (CSBS) in January 2002.

Level of cleanliness

Local auditors, together with domestic services managers acting as peer reviewers, visited 74 hospitals throughout Scotland between March and May 2002. They reviewed the level of cleanliness in a sample of wards and public areas against a number of specified criteria. Each area reviewed was rated as one of four categories: very good, acceptable, need for improvement or concern. This provided a snapshot of the levels of cleanliness in hospitals in Scotland (Appendix 2).

We found a very good or acceptable level of cleanliness in over 70% of wards and 80% of public areas reviewed. Almost half of the hospitals had a very good or acceptable level of cleanliness in all areas reviewed. However, over 20% of hospitals show a clear need for improvement, with the remainder in need of some minor improvement. We recommend that a rolling programme of peer review visits is introduced to assess and improve the level of cleanliness in hospitals.

Responsibilities for cleaning clinical equipment[1] are not clearly specified in some hospitals, and the level of cleanliness of some items was found to be unacceptable in 10% of wards reviewed. This

[1] Items such as hoists, drip stands and commodes.

requires co-ordination between domestic services and nursing staff and the development of operational policies with explicit responsibilities.

The appearance of wards and public areas varies, and this is not always related to level of cleanliness. Poor maintenance of buildings and fabric, the need for redecoration and dirty windows all contribute to a public perception that standards of cleanliness are poor. In some cases, poor maintenance and decoration can make it more difficult for areas to be cleaned effectively. There is a need for better co-ordination of domestic services and estates management to identify and manage areas of risk.

Ward staff interviewed as part of the review were generally aware of areas of concern about levels of cleanliness and felt these were mostly related to insufficient staff hours or cleaning frequencies.

In addition to presenting a snapshot indication of the level of cleanliness in hospitals throughout Scotland, this review investigates the reasons for the variation observed. It considers a number of factors that may relate to level of cleanliness:

- the staff time available for cleaning, supervision and monitoring
- staff training
- management arrangements – does management provide knowledge and leadership, ensure accountability, manage and minimise risks?
- the application of comprehensive policies and procedures, developed in collaboration by providers and users.

Inputs to cleaning, supervision and monitoring

One key risk to the quality of cleaning is the staff time available. This review examines how often a task should be carried out (cleaning frequency) and how many staff hours are spent on cleaning tasks and monitoring. It also looks at risks to maintaining the required level of staffing, particularly staff turnover, sickness absence and recruitment difficulties.

The majority of hospitals have put in place planned cleaning frequencies that are in line with national guidance. In most wards actual frequencies are in line with planned. However, we found shortfalls in the staff hours spent on cleaning, supervising and monitoring. The staff time available for cleaning fell below planned levels in a quarter of wards and the time for monitoring was below planned levels in a third of wards (Exhibit 1).

Exhibit 1: Variation between planned and actual input hours (weekdays)

	Cleaning	Supervising	Monitoring
Actual equal to planned	184 (66%)	207 (81%)	140 (61%)
Actual less than planned	71 (25%)	35 (14%)	77 (33%)
Actual more than planned	26 (9%)	13 (5%)	15 (6%)

Source: Audit Scotland

This means that tasks are carried out as often as planned but with less staff time. The quality of cleaning may be compromised because of a lack of time, cover provided by relief staff unfamiliar with the area or supervisors undertaking cleaning tasks at the expense of supervising and monitoring. Almost a quarter of hospitals reported that staff shortages meant that monitoring was not taking place either as often or in as much detail as planned.

Rates of staff turnover and sickness absence continue to be a problem in many hospitals. Almost half reported difficulties attracting and retaining staff, due to the availability of other job opportunities offering higher rates of pay. Basic hourly rates of pay in hospitals ranged from £4.10 to £4.86, with an average of £4.25. There was little difference between rates paid by in-house providers or external contractors. Rates at all hospitals are below the basic hourly rate of £5.02[2] offered by local authorities, one of the main competitors for staff.

Given the risks to levels of cleanliness of under-staffing, '*A clean bill of health*' recommended that trusts should agree performance indicators and targets for staffing indicators such as sickness absence, turnover and vacancies. However, half of the trusts did not have these in place.

Compliance with CSBS standards for cleaning services

CSBS issued standards for cleaning services in pre-publication form in January 2002. The standards relate to 14 elements covering policies and procedures for managing cleaning services. Many of the standards focus on the processes in place to manage risk. We carried out a baseline indication of compliance with the standards.

[2] Personal communication. Convention of Scottish Local Authorities (COSLA). Rate at 1 April 2002.

Significant work to implement the standards is taking place in many trusts. The elements of the standards that are most developed are management structures and cleaning services specifications, while risk management structures, quality control systems and putting in place locally agreed performance targets are least developed (see Appendix 5).

As part of the reports produced by local auditors, each trust has received a detailed breakdown on its compliance with the standards, and has agreed an action plan to work towards full implementation.

Management of cleaning services

Both the CSBS standards and '*A clean bill of health*' identify the importance of good management arrangements, clear service specifications, and adequate monitoring to achieve clean hospitals. We followed up these issues in more depth.

Management arrangements are well developed in most trusts and hospitals, with domestic services managers generally working closely with Infection Control Teams (ICTs). However, some trusts do not yet have these links in place and we found the cleaning specification had still not been approved by the ICT in one in six hospitals, in spite of this being a recommendation in '*A clean bill of health*'. Infection control training is provided to domestic staff in almost all hospitals, albeit with further development required in some hospitals. A number of hospitals have put in place formal and comprehensive training programmes for staff, in some cases working with local colleges to develop formal courses and qualifications. Infection control training for domestic staff is included in the training programme in two-thirds of trusts.

External contractors provided cleaning services in one in five hospitals at the time of the review. While many hospitals reported no difficulties with the terms of external contracts, some hospitals identified particular problems. Contracts with external providers are not always specific enough to ensure acceptable levels of cleanliness and may allow for repeated non-compliance with targets for levels of cleanliness.

Specifications for cleaning services are mostly based on recognised national guidance for minimum cleaning frequencies, with adjustment for local needs. In our previous report we identified the importance of reviewing the specification on a regular basis to ensure that it is kept up to date with national best practice guidance and local needs, based on a risk assessment. Over half of hospitals have

reviewed their specification recently, but over a quarter have not undertaken a formal review since the publication of '*A clean bill of health*'.

Whilst almost 80% of trusts have a formal policy for monitoring levels of cleanliness, we found that actual monitoring arrangements are insufficient in just over 40% of hospitals. A number of hospitals with appropriate monitoring policies and procedures are not always able to put these into practice because of staff shortages and workload pressures. Ward and departmental staff are often not involved in monitoring, and staff do not always have information on the inputs and level of cleanliness that should be achieved in their areas.

Conclusions

There is no clear association between the level of cleanliness and any one of the factors investigated. However, we have identified a number of factors that make it more difficult for hospitals to achieve high standards:

- staff vacancies and absence
- high staff turnover
- lack of co-ordination between cleaning and other services
- poorly defined or managed contracts
- inadequate monitoring arrangements.

Levels of cleanliness are variable and improvement is required in over 20% of hospitals. We have made a number of recommendations to improve the management and operation of cleaning services, including an ongoing programme of peer reviews to improve and maintain levels of cleanliness (see page 50).

Introduction

Background

In April 2000, Audit Scotland published a baseline report entitled '*A clean bill of health*'. The main conclusions of this report were that:

- some hospitals were not meeting national minimum standards for frequency of cleaning
- the quality of cleaning in a great number of hospitals was being compromised by high staff absence and turnover, lack of input from infection control teams to domestic services, and a lack of emphasis on cleaning inputs (actual hours and processes) and minimum frequencies
- hospitals could not demonstrate that their cleaning services were effective and achieving value for money because of the lack of comparative information on the quality of cleaning
- there was a wide variation in the costs of cleaning, attributable not only to differences in size, but also to differences in the role of domestic staff, and the level of cleaning.

This follow-up review assesses progress against a number of the issues raised in the original report, but also investigates two areas in more detail:

- the actual time spent on cleaning and monitoring
- a review of levels of cleanliness against specified criteria.

The review also incorporates a baseline assessment of compliance with the Clinical Standards Board for Scotland (CSBS) standards for cleaning services which were issued in pre-publication form in January 2002.

The CSBS was established as a special health board in April 1999. It was established to develop and run a national system of quality assurance of clinical services, with the aim of promoting public confidence in NHSScotland. The CSBS established a Healthcare Associated Infection (HAI) Reference Group in June 2001, with a sub-group involving representatives of hospital domestic services involved in producing hospital cleaning standards. The CSBS has recently undertaken a detailed review of compliance with standards for the management of HAI.

Events since the publication of the baseline report

"High standards of cleanliness are particularly important. There is a perception that standards of cleanliness in hospitals have deteriorated over the years. This must be addressed. The NHS must achieve best value in cleaning services… The key is to ensure that the highest possible standards of cleanliness are achieved and to satisfy patients that hospitals are clean."

Source: Our National Health: A plan for action, a plan for change (December 2000)

Since the publication of the baseline report hospital cleaning has been highlighted as an area of continuing concern to the Scottish Executive. Progress against the Auditor General's baseline report was reviewed through a self-assessment issued by the Scottish Executive Health Department in July 2001. This showed progress had been made, but there remained some areas for further improvement. Areas where further development was required included:

1 **assuring quality** – less than a third of trusts had fully assessed the potential costs and benefits of using generic support staff to increase flexibility.
2 **infection control** – only half of trusts had fully reviewed their practice against '*Standards for environmental cleanliness in hospitals*'[3]; almost half needed to further develop control of infection policies to cover cleaning and descriptions of tasks.
3 **supervision and monitoring** – significant developments had taken place in supervision and monitoring arrangements, but a number of trusts had still to fully develop formal policies for monitoring domestic services and for joint supervision and monitoring by domestic services and ward managers.
4 **staff turnover and absence** – many trusts had still to put in place a programme to reduce sickness absence to the national target of 3% and to identify the main causes of staff absence and turnover; less than half compared performance against other hospitals and set realistic targets.
5 **reviewing and comparing domestic services** – while many trusts had some involvement in benchmarking, further development was required for this to be more useful in identifying how services can improve quality and value.

[3] '*Standards for environmental cleanliness in hospitals*', Infection Control Nurses' Association and Association of Domestic Management Standards Working Group, 2000.

In October 2002, the Scottish Executive published the HAI action plan[4]. This takes forward both discussions at the HAI Convention held in Glasgow in June 2002[5] and the recommendations of the Watt Report into the management of a salmonella outbreak in the Victoria Infirmary, South Glasgow Trust[6]. Action will be taken forward through an HAI Taskforce headed by the Chief Medical Officer. Key actions relating to hospital cleaning are:

- the development of an NHSScotland Code of Practice for the local management of hygiene in hospitals, including appropriate standards and cleaning schedules for wards and equipment
- the development of standard education packages for NHS staff groups on risk assessment and risk management in relation to HAI
- setting national requirements for the frequency of cleaning and technical requirements for cleaning processes which should be used by trusts in their service specifications for cleaning.

Trusts have also been requested to take action on a number of specific recommendations in the Watt Report. These recommendations include putting in place better arrangements for cleaning and infection control.

Study objectives and methods

Objectives

The audit addressed the following issues.

- Are hospitals achieving an appropriate level of cleanliness?
  - If not, what are the reasons and what is being done about it?
  - If so, how is this being achieved and is it likely to be sustainable?
- Are cleaning frequencies and staffing inputs appropriate?
- How well are trusts meeting the CSBS cleaning services standards?
- Are management arrangements appropriate?
- Have trusts implemented the recommendations of '*A clean bill of health*'?

Methods

This is the first time that Audit Scotland and CSBS have worked together on a study. Given that both organisations planned to review different aspects of cleaning services during 2002, a single, integrated approach was considered most appropriate in order to reduce workload for trusts and avoid duplication. Local auditors undertook all aspects of the external review and this report both incorporates

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4 '*HAI action plan – preventing infections acquired while receiving healthcare'*, Scottish Executive Health Department, 23 October 2002.

5 HAI Convention, June 2002.

6 '*A review of the outbreak of salmonella at the Victoria Infirmary',* The Watt Group Report, October 2002.

the issues arising from the follow-up of '*A clean bill of health*' and provides a baseline review of trusts' compliance with the CSBS cleaning services standards.

The audit involved several components.

- A review of the level of cleanliness against specified criteria in a sample of ward and public areas in 74 hospitals. Reviews were undertaken by local auditors accompanied by peer reviewers from domestic services.
- A review of hospital and ward questionnaires returned by each trust. These include information on planned and actual frequency of cleaning tasks, and planned and actual input hours.
- An assessment of trusts' compliance with the 14 cleaning services standards published by CSBS.
- Interviews with domestic services managers, ward staff and infection control staff, and a review of documentary evidence.

This report initially outlines our findings from the review of levels of cleanliness in hospitals. In subsequent sections it goes on to comment on factors that may be associated with the variations in the level of cleanliness, particularly:

- inputs to cleaning, supervision and monitoring
- compliance with CSBS standards and the management of risks
- organisation and management processes.

Audit Scotland has a local presence in all NHS trusts. This means that every trust has received a local audit report outlining detailed actions which they need to take against the findings of the national review. Local reports were agreed with trusts in autumn 2002 and action plans have been put in place.

Level of cleanliness

Introduction

Since the publication of '*A clean bill of health*', there has been continuing public concern about cleanliness of hospitals. This report therefore looks directly at the level of cleanliness, offering a snapshot of the situation in a sample of hospital areas at a point in time.

This chapter reports on:

- the level of cleanliness found in wards and public areas, against specified criteria
- the relationship between levels of cleanliness and the appearance of wards and public areas
- cleanliness of items outside the remit of cleaning staff
- the views of hospital staff.

Our approach

We carried out reviews at all larger hospitals throughout Scotland (mostly hospitals with at least 70 beds), with the exception of Edinburgh Royal Infirmary which was at the beginning of an 18-month process of relocating services to a new build site at the time of the review. In total, 74 hospitals were included, with 283 wards and 436 public areas reviewed.

Local auditors and peer reviewers (domestic services managers from trusts throughout Scotland) undertook reviews of wards and public areas in hospitals between March and May 2002. They carried out checks in four wards in each hospital (less if the hospital had less than four wards in total). A cross-section of wards was chosen, including a mix of medical, surgical, long stay and other wards in a mixture of older and newer buildings. High-risk areas such as theatres, high dependency units (HDUs) and intensive therapy units (ITUs) were excluded from the review.

Checks included bed areas, sanitary areas, ward kitchens, sitting-rooms and corridors. Checks were also made of the main reception area, public toilets, corridors and stairways. Auditors and peer reviewers were accompanied by representatives of the hospital and/or the external contractor providing domestic services. The purpose of this part of the review was to assess levels of cleanliness and not to assess the performance of domestic services staff. Reviewers therefore reported on the level achieved regardless of whether particular

cleaning tasks were the responsibility of domestic services. Hospitals were given advance notice of the date of the review but not of the wards and public areas that would be assessed.

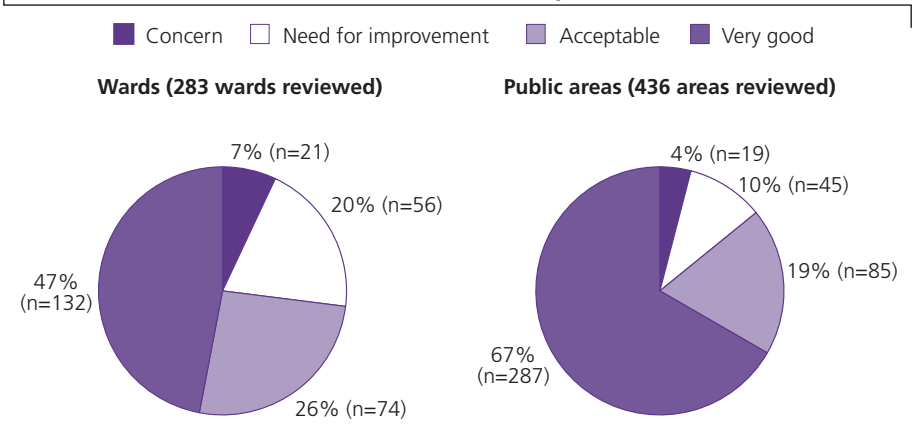
Auditors scored areas against seven criteria relating to floors, internal glass, fixtures and fittings, sanitary ware, walls, curtains and screens and waste bins. A total score was calculated for each ward and public area reviewed and each area was classified into one of four categories: very good, acceptable, need for improvement and concern. The criteria and scoring system are shown in Appendix 1.

In addition to assessing levels of cleanliness, auditors looked at cleaning inputs immediately prior to the review and at an earlier date, to consider whether the hospital was specially cleaned for the review. They also discussed with the hospital domestic services managers and ward staff their views on standards of cleanliness more generally.

Level of cleanliness

Over 70% of wards and 80% of public areas are classified as very good or acceptable (Exhibit 2). Seven per cent of wards and 4% of public areas are classified as being of concern, while a further 20% of wards and 10% of public areas show a need for improvement.

Exhibit 2: Level of cleanliness in wards and public areas

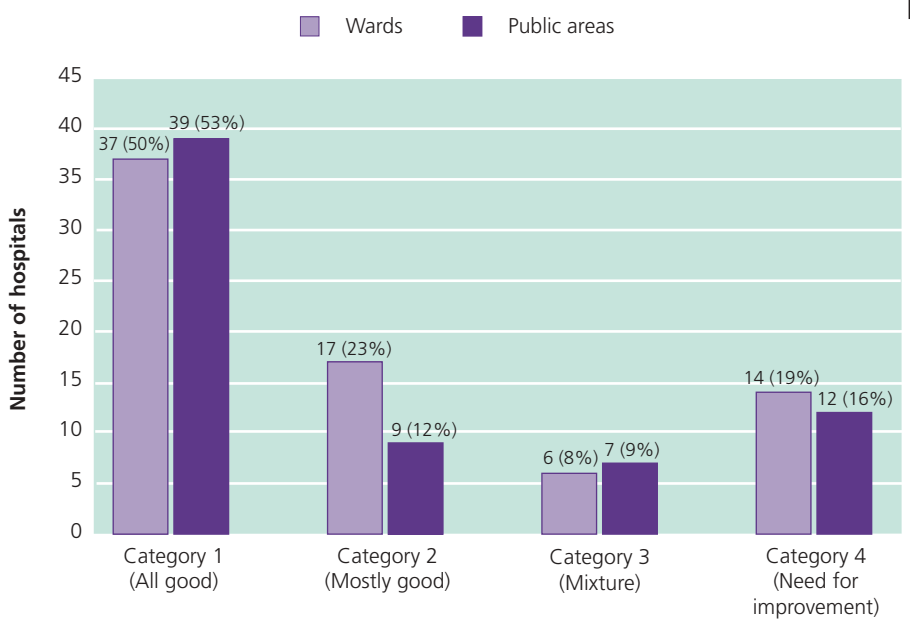


Source: Audit Scotland snapshot review

Aggregating the results from wards and public areas, we looked at the level of cleanliness at a hospital level. Hospitals have been split into four categories ranging from category 1, where all wards or public areas reviewed are rated as very good or acceptable, through to category 4 where at least one ward or public area is classified as being of concern or all wards/public areas show a need for improvement.

Half of the hospitals reviewed fall into category 1, whilst almost one in five hospitals show a need for improvement (Exhibit 3).

Exhibit 3: Level of cleanliness in hospitals reviewed



Source: Audit Scotland snapshot review

Appendix 2 provides more results of our snapshot review of hospital cleanliness. The tables name the hospitals in each category for the wards and public areas reviewed.

In most hospitals there was no evidence that additional cleaning had taken place prior to the review, either in the cleaning schedules or in comments made by staff. The only hospital where staff reported a significant change was Royal Victoria Hospital, Lothian University Trust. Management responsibility at Royal Victoria and Western General Hospital had recently passed from clinical directorate level to the domestic services manager and a number of steps had been taken as part of an overall strategy to improve standards of cleanliness.

The review considered a number of other criteria that were assessed but not scored. These included:

- the general appearance of wards and public areas which can influence public perceptions of the cleanliness of the hospital
- items outwith the remit of domestic services staff.

Appearance of wards and public areas

The general appearance of wards and public areas varied between hospitals but was not always related to the level of cleanliness. Some areas, such as new facilities at Hairmyres and New Craigs Hospitals, appeared clean but on inspection did not meet the acceptable level. Other areas, such as older parts of Western General Hospital, appeared poor because of shabby decoration and poor fabric but were found to achieve acceptable levels of cleanliness. In some cases the two issues were related. At Dunoon General Hospital, for example, it was observed that the poor state of repair of the building and equipment makes it difficult to maintain levels of cleanliness. Some areas, such as psychiatric and learning disabilities wards, looked untidy due to behavioural difficulties of particular patient groups but were felt to achieve acceptable levels of cleanliness.

Cleanliness of items outwith the remit of cleaning staff

We examined the cleanliness of certain items outwith the remit of domestic services staff, particularly clinical equipment and external windows.

The cleanliness of clinical equipment[7] failed to reach acceptable standards in 10% of wards[8]. While the cleanliness of equipment was found to be acceptable on the day of the review, domestic services managers in a number of other hospitals identified this as a concern and felt that responsibility for cleaning this equipment is not always clearly specified. This is a similar finding to the Watt Report which recommended that: "*Trusts should develop policies which clearly identify the accountabilities of nursing and domestic staff...*".

The external windows at many hospitals were not clean. This is mainly the responsibility of external contractors. The frequency of window washing programmes varies from three-monthly through to annually and some hospitals do not have a programme in place. While this is not an infection control issue, the poor appearance of external windows contributes to a poor public perception of levels of cleanliness. Local reports include comment and recommendations on these issues as they impact on the public perception of whether hospitals are clean.

One of the problems associated with the public areas is that some corridors and stairways are inaccessible for cleaning by domestic staff.

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7 Items such as hoists, drip stands and commodes.

8 This was a concern in all or most wards at Inverclyde Royal, Royal Alexandra Hospital, City Hospital (Aberdeen), Ladysbridge Hospital and Monklands.

In these circumstances, domestic services staff need to work with estates departments to ensure that cleaning takes place.

Staff views

Ward staff generally expressed views that were in line with the reviewers' observations, identifying staff shortages and lack of inputs as problems in a number of the wards that did not achieve acceptable levels of cleanliness. At some hospitals a number of ward staff felt that cleaning frequencies and staff hours are insufficient for the volume of patient activity, particularly the frequency of cleaning toilets. In some wards these frequencies are already above SCOTMEG recommendations. Lack of staff on late afternoon shifts was an issue raised by staff in some hospitals, as this means areas may be left in unacceptable states for long periods.

Staff in many wards commented positively on the work done by domestic staff and appreciated having regular domestic staff working as part of the ward team. Some concerns were expressed in hospitals where domestic staff are rotated on a six-monthly basis, both because this may reduce the pride in doing a good job that comes from being part of a team and because it can be unsettling for long stay patients.

Conclusions

We found that levels of cleanliness were very good or acceptable in all wards reviewed in 50% of hospitals and in all public areas reviewed in 53% of hospitals. However, over 20% of hospitals show a clear need for improvement in either wards or public areas, with the remainder acceptable or in need of minor improvements. This shows that further improvements are required and we recommend that levels are reviewed on a ongoing basis, through a rolling programme of peer review visits.

The cleanliness of clinical equipment failed to reach an acceptable level in 10% of wards. The respective responsibilities of nursing and domestic staff are not always explicit.

The appearance of wards is not always in line with the findings against specific criteria for levels of cleanliness. Poor maintenance of buildings and fabric, the need for redecoration and dirty windows all contribute to the public perception that levels of cleanliness are poor.

Ward staff were generally aware of areas of concern which they felt mostly related to insufficient staff hours or cleaning frequencies.

The main purpose of this review is to understand why there is variation in the levels of cleanliness identified in hospitals throughout Scotland. We investigated a number of factors:

- the staff time available for cleaning, supervision and monitoring
- staff training
- management arrangements – does management provide knowledge and leadership, ensure accountability, manage and minimise risks?
- the application of comprehensive policies and procedures, developed in collaboration by providers and users.

In the next sections we consider each of these factors and how they relate to the levels of cleanliness found in hospitals.

Recommendations

- *Trusts should ensure that operational policies specify responsibility for cleaning clinical equipment and that all staff are made aware of their responsibilities. The cleanliness of clinical equipment should be included in routine monitoring.*
- *Domestic services management should work with estates to agree a cleaning programme for areas inaccessible to domestic staff. Trusts should ensure that regular maintenance and redecoration programmes are in place.*
- *An ongoing programme of peer review of levels of cleanliness or similar quality assurance mechanism should be introduced.*

Inputs to cleaning, supervision and monitoring

Introduction

One key risk to the quality of cleaning is the level of staffing inputs. This is recorded in terms of both how often a cleaning task should be undertaken ie, cleaning frequencies, and how many staff hours are spent on cleaning tasks ie, input hours.

This chapter reports on:

- whether cleaning frequencies meet minimum recommendations
- whether hospitals are able to allocate staff input hours as planned to meet those frequencies
- the reasons for shortfalls against planned input levels, specifically rates of sickness absence, vacancies and staff turnover
- the factors that may influence these staffing indicators, such as pay rates.

Our approach

Hospitals returned questionnaires reporting the planned and actual frequencies and cleaning inputs for a sample of wards for the week beginning 4 February 2002. Planned cleaning frequencies were compared against national minimum recommendations and actual frequencies were compared to planned. Actual inputs in terms of number of hours spent on cleaning, supervision and monitoring were also compared to planned inputs. Data were returned for 287 wards at 76 hospitals. Appendix 3 shows the types of wards included in the review.

Frequencies and input hours

Almost all wards are cleaned to frequencies that are in line with or above minimum national recommendations. However, actual staffing hours spent on cleaning fell below planned levels in a quarter of wards, and actual monitoring hours fell below planned in a third of wards. This means that while cleaning tasks took place as often as planned, the quality may be reduced and this may not be rectified through monitoring.

Most wards reported planned cleaning frequencies in line with or above SCOTMEG[9] or the more recent Association of Domestic Managers (ADM)[10] recommendations for the sample of tasks identified. The exception is cleaning hard floors in ward offices where

[9] Domestic Services Part 1, Scottish Health Management Efficiency Group, August 1987.

[10] '*Recommended minimum cleaning frequencies – a best practice document 2*', Association of Domestic Management, 2002.

almost 42% of wards have a planned frequency below the recommended full clean five times per week. This is a similar finding to the initial review and reflects the fact that hospitals prioritise the cleaning of clinical areas. A small number of hospitals have planned frequencies below SCOTMEG for a number of the other tasks identified, with under-cleaning mostly occurring at weekends for tasks where the recommendation is for a full clean on seven days of the week. In almost all cases the actual cleaning frequency was the same as planned (Appendix 4).

In addition to the particular tasks specified, just over a third of hospitals reported that they have some cleaning frequencies below SCOTMEG recommendations. In most cases the reasons for this are documented and justified. At four hospitals (State Hospital, Vale of Leven, Glasgow Victoria and Mansionhouse Unit) it was reported that funding is being sought to increase frequencies, whilst at another hospital (Campbeltown) increases were being implemented at the time of the review. All four hospitals at Lothian University Hospitals Trust included in the review currently have a local specification which has a lower frequency of floor scrubbing, but had allocated funding to increase this to meet SCOTMEG requirements.

While cleaning tasks took place as often as planned in almost all wards, the staff time available for cleaning and monitoring was often less than planned. There was a shortfall against planned staff hours on cleaning in a quarter of wards on weekdays, and a shortfall on monitoring hours in a third of wards (Exhibit 4). In many cases these shortfalls were significant. Actual monitoring hours were less than 75% of planned in over half of the wards with a shortfall. These shortfalls raise concerns that staff may not be able to perform cleaning tasks to the required quality. This concern is exacerbated by the shortfalls in supervision and monitoring which are important in ensuring high quality.

Exhibit 4: Variation between planned and actual input hours (weekdays)

	Cleaning	Supervising	Monitoring*
Actual equal to planned	184 (66%)	207 (81%)	140 (61%)
Actual less than planned	71 (25%)	35 (14%)	77 (33%)
Actual more than planned	26 (9%)	13 (5%)	15 (6%)

* Data are missing for 55 wards at 21 hospitals, mainly because monitoring is not planned in terms of input hours at ward level. Percentages are based on 232 wards with valid data.

Source: Audit Scotland

Almost a quarter of hospitals reported that, on occasion, monitoring has to be reduced to cover domestic staff shortfalls, with supervisors having to cover cleaning tasks or spend time arranging cover. This was the case in two hospitals where the snapshot review of levels of cleanliness identified some areas of concern. Glasgow Victoria Infirmary and Caithness General Hospital stated that monitoring had not been taking place as planned at the time of the review as a result of staff shortages and workload pressures. At Dykebar (Renfrewshire and Inverclyde PCT), monitoring hours were less than planned in half of the wards included in the survey, and it was reported that additional domestic hours are required to meet minimum frequencies.

This is obviously a concern and hospitals should take steps to ensure that dedicated resources are available to cover monitoring, with alternative arrangements to cover cleaning shortfalls. However, the key objective is to reduce shortfalls to a minimum to ensure that there is continuity of input, rather than having to allocate staff from other areas. This is discussed further in later sections, which look at examples of good practice in attracting and retaining staff. Trusts should also review arrangements for covering staffing shortfalls and ensure that resources are available to put in place contingency arrangements such as 'bank staff'.

Staff turnover, absences and recruitment

Staff turnover and recruitment continues to be a problem for a number of hospitals. This is a particular problem facing hospitals in areas where other job opportunities are available to domestic staff, as basic rates of pay remain low compared to other employers. Sickness absence rates also continue to be high in many hospitals.

High levels of sickness absence and staff turnover and recruitment difficulties can impact on a hospital's ability to provide input hours as planned in three ways:

- insufficient resources are available to cover for absences and vacancies and so cleaning hours are less than planned
- cleaning is provided by relief or temporary staff who may not achieve the same standards as regular staff who are familiar with the areas they are cleaning and the cleaning methods required
- supervisors have to undertake cleaning duties or spend additional time arranging cover, to the detriment of supervision and monitoring.

Staff turnover

The average turnover rate of domestic staff for the three months prior to February 2002 was 10%. When extrapolated over a year, this is higher than the finding in the baseline report, which showed an annual rate of approximately 25%. There is wide variation between hospitals. At the upper end, five hospitals had turnover rates above 20%[11] in the three-month period. In four of these hospitals our snapshot review identified no concerns about levels of cleanliness, but this is a risk if turnover remains high.

High turnover rates may be related to terms and conditions of working, including shift patterns, flexible working arrangements and rates of pay. These issues are discussed further in relation to policies for attracting and retaining staff. One of the main reasons cited for difficulties with staff recruitment and retention is higher rates of pay offered by other local employers. This means that hospitals in areas with a number of alternative employment opportunities are most at risk of recruitment and retention difficulties. Differences in turnover rates, even within the same trusts, highlight the variation (Exhibit 5). We found no direct association between pay rates and turnover rates, but managers reported an apparent association with alternative employment opportunities offering higher rates of pay.

Exhibit 5: Variation in turnover rates by alternative employment opportunities

	Areas with less alternative opportunities			Areas with alternative opportunities		
Trust	**Hospital**	**Turnover**	**Location**	**Hospital**	**Turnover**	**Location**
Lanarkshire Acute	Wishaw General	12%	Wishaw	Hairmyres	31%	East Kilbride
Grampian PCT	Ladysbridge	7%	Banff	City Hospital	33%	Aberdeen
Fife Acute	Victoria	9%	Kirkcaldy	Queen Margaret	25%	Dunfermline

Source: Audit Scotland

[11] Astley Ainslie, Lothian PCT; Liberton, Lothian University; Hairmyres, Lanarkshire Acute; Queen Margaret Hospital, Fife Acute; City Hospital (Aberdeen), Grampian PCT.

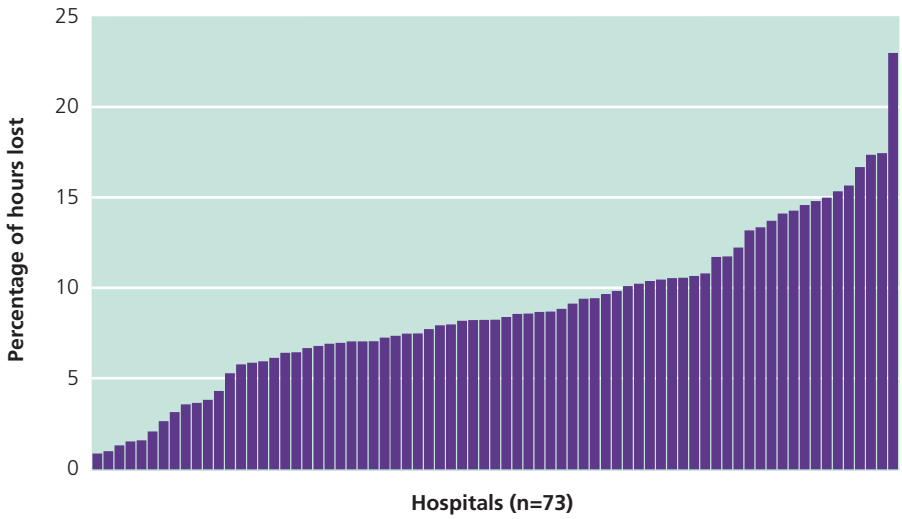
In spite of the high turnover rates, 80% of wards reported no vacant hours in the week of 4th February. However, in discussions, many hospital managers said they have problems with vacancies and difficulty filling posts. Vacant posts were identified as a particular problem at Gartnavel General Hospital, and actual cleaning and monitoring hours fell far below planned levels in a number of wards. In addition, the minimum recommended frequency of cleaning sanitary areas was not achieved at this hospital.

Sickness absence

Sickness absence rates for domestic staff remain above the national target of 3% in many hospitals, with an average sickness absence rate in the three months prior to February 2002 of 9% (Exhibit 6). Whilst a number of hospitals are working towards the national target, it is felt to be very difficult to achieve. Only seven hospitals, all smaller hospitals in primary care trusts (PCTs) and an island board, had rates below 3%[12]. As in the baseline survey, there is wide variation between hospitals. Comparison with the baseline data shows no clear pattern, with rates decreasing in some hospitals and increasing in others.

Exhibit 6: Sickness absence rates – domestic staff

Rates of sickness absence varied from 0.8% to 23%



Source: Audit Scotland

[12] City Hospital & Royal Cornhill Hospital, Grampian PCT; Bonnybridge, Forth Valley PCT; Crichton Royal, Dumfries & Galloway PCT; Dunoon General, Lomond & Argyll PCT; Gilbert Bain, Shetland; Sunnyside Royal, Tayside PCT.

Impact of vacancies, absences and high turnover

Our analysis shows no clear association between staffing indicators and levels of cleanliness found in the snapshot review. Many hospitals achieved high standards of cleaning while suffering from high levels of turnover and sickness absence. However, there is a risk that if these difficulties remain in the longer term, it will put more pressure on the service and levels of cleanliness may be adversely affected. In some hospitals we found that these difficulties could not be managed and there is an issue about the staff available to cover shortfalls, particularly if hospitals are not resourced for this or are not able to attract sufficient staff. In others, such as Hairmyres, it appears that appropriate cover is in place through a pool of relief staff, but the cleanliness review identified areas of concern.

A number of hospitals, such as Yorkhill, Queen Margaret (Dunfermline), Royal Edinburgh and Belford (Fort William) achieved generally high levels of cleanliness while having high levels of sickness absence and staff turnover. At present, these hospitals are able to put in place contingency plans and achieve high standards, but are obviously at risk should their staffing situations worsen.

We also found examples of hospitals which appeared to have no particular difficulties with staffing inputs, absences and turnover but failed to achieve acceptable levels of cleanliness. These include Bonnybridge, Falkirk Royal, Inverclyde Royal and Whyteman's Brae.

There was no direct relationship between these staffing indicators and some basic conditions of employment, namely rates of pay and whether staff have a wider remit.

Policies for attracting and retaining staff

A number of hospitals have put in place policies aimed at improving working conditions. These include developing working policies and shift patterns that are more flexible and family-friendly, with examples of good practice at North Glasgow Trust, Southern General Hospital and Monklands. Other initiatives in place at Southern General include exit interviews and providing staff with advice on available tax credits and benefits. Staff turnover and absence are very low at State Hospital where it was noted that domestic staff have a housekeeper role, with enhanced rates in addition to the forensic allowance. Also, staff are not required to work shifts.

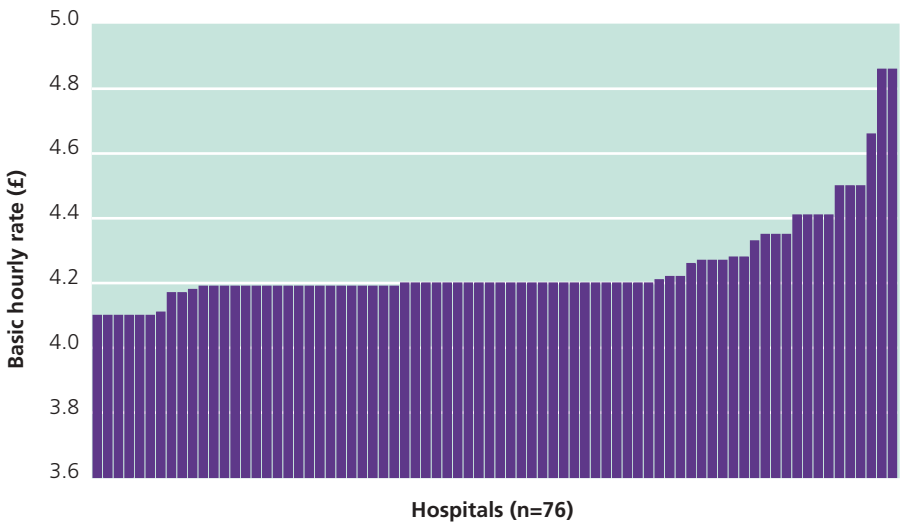
Payments to staff

As at the time of the baseline study, there is variation in the basic hourly rates of pay offered to domestic staff and supervisors. At an average of £4.25 an hour, basic rates of pay for domestic staff are low when compared with competitors.

Rates for domestic staff vary from £4.10 to £4.86. This variation is wider than at the time of the baseline study. Rates for domestic supervisors vary from £4.55 to £7.90, with an average of £4.92 (Exhibit 7). It should be noted that the hospital with a rate of £7.90 pays no enhancements to supervisors. There is little difference between the average basic hourly rates reported by in-house providers and external contractors. However, there is less variation in the rates paid by external contractors, with no contractors reporting payments above £4.35 to domestic staff and £5.39 to domestic supervisors.

Exhibit 7: Basic hourly rates of pay for domestic staff

Hourly rates of pay ranged from £4.10 to £4.86, with an average of £4.25.



Source: Audit Scotland

A number of hospitals cited local authorities and supermarkets as main competitors for staff. The average hourly rate of £4.25 for domestic staff compares with a basic hourly rate of £5.02 paid by local authorities[13].

[13] Personal communication. Convention of Scottish Local Authorities (COSLA). Rate of pay as at 1 April 2002.

Monitoring staffing indicators

Half of the trusts did not have agreed performance indicators and targets in place for staffing indicators and so had limited information for managing the cleaning plan. Given the risk to levels of cleanliness of low levels of staffing inputs, '*A clean bill of health*' recommended that hospitals should monitor sickness absence, turnover and retention levels, set realistic targets and compare performance with other hospitals.

Almost all wards in the survey reported that there is a policy for deciding what not to clean when shifts are under-staffed. However, documented policies are available in just over half the wards. While levels of under-cleaning are recorded and monitored in most wards, with levels mostly monitored by domestic supervisors, under-cleaning due to staff absences is not recorded and/or monitored in approximately a fifth of wards, making it difficult to manage absences appropriately.

Conclusions

The majority of hospitals have put in place planned cleaning frequencies that are in line with national guidance. In most wards actual frequencies are in line with planned. However, we found shortfalls in the staff hours spent on cleaning, supervising and monitoring. Cleaning hours were less than planned in a quarter of wards and monitoring hours were less than planned in a third of wards. These shortfalls were often substantial. This shows that while wards and public areas are being cleaned as often as planned, this is often with less staff time, raising concerns about the ability of staff to clean to the same quality. Standards are further compromised by the shortfall in monitoring hours, with supervisors often having to undertake cleaning duties to make up for staff shortfalls, foregoing planned monitoring.

Rates of staff turnover and sickness absence remain high in many hospitals and many also reported difficulties recruiting staff. A key difficulty identified in attracting and retaining staff is the availability of alternative local job opportunities offering higher rates of pay. Basic rates of pay for domestic staff and supervisors remain low, with the average hourly rate for domestic staff of £4.25. In all hospitals the basic rate is below the rate paid by local authorities, cited by many hospitals as a major competitor for staff.

Some hospitals have put in place systems to attract and retain staff, such as more flexible shifts and other family-friendly measures. A number of steps have also been taken to reduce sickness absence rates. These have had some limited success. The hospitals with the least difficulties reported the importance of factors such as a tight-knit workforce and strong loyalty to the local hospital in attracting and retaining staff.

Recommendations

- *Trusts should identify and agree key performance indicators and targets for staffing, and share best practice through involvement in benchmarking.*
- *Trusts should ensure that they have in place, and have appropriately resourced, contingency plans to deal with significant vacancies or sickness absence.*
- *Trusts should ensure that they have a clear policy for managing and monitoring under-staffed shifts.*
- *Trusts should investigate the reasons for high levels of absence, turnover and vacancies and consider what action needs to be taken to improve these indicators. This may include reviewing rates of pay and other working conditions, such as flexible hours and family-friendly policies.*

Compliance with CSBS standards for cleaning services

Introduction

The CSBS standards issued in pre-publication form in January 2002 relate to 14 elements covering policies and procedures for cleaning services. Many of the standards focus on the processes in place to manage risk. The overall standard statement is that:

"Healthcare facilities are managed in order to provide safe, efficient, effective and clean physical environments."

CSBS aims to set standards that are 'achievable but stretching' and trusts are expected to work towards complying with all elements of the standards. We reviewed trusts against these standards to give a baseline assessment of compliance.

This chapter reports on compliance with the standards against the following topics:

- management arrangements and lines of accountability
- processes in place, particularly policies and procedures and risk management arrangements relating to cleaning services
- capability in terms of access to information and the availability of staff training
- outcome measures in place for assessing performance
- policies and procedures for monitoring and review
- internal audit of arrangements for managing cleaning services.

Our approach

Trusts completed and returned a self-assessment form and supporting evidence was submitted when they stated that they complied with a standard. The central project team at Audit Scotland and secondees from CSBS reviewed this evidence to establish if it was sufficient to confirm that the trust complied with the standard. Where the evidence was insufficient, or the trust had misinterpreted a standard, local auditors followed this up with the trust. Auditors reviewed any further evidence provided and indicated if they were satisfied that the standard was met. Amended assessment forms were completed by the auditors and confirmed with the trust. These were returned to the central project team for further review to ensure that there was consistency in the assessments.

Two members of the central project team went through each assessment form independently, rating the extent to which the trust complied with each standard. Ratings were compared, areas of disagreement discussed and a final rating agreed. Compliance with the standards was rated from 'complies fully', where there was evidence that all components of the standard were met, through to 'does not comply at all', where there was no evidence that any components of the standard were met. In a number of trusts there was variation between the different hospitals, for example, if hospitals had different service providers with different policies and procedures. The rating reflects the overall position of the trust eg, if two hospitals complied mostly and two hospitals did not comply mostly, the overall trust rating is 'complies partially'.

Given the time constraints on this review, Trusts were asked to report against the standards within a very short time-scale and so had less time to move towards implementing the CSBS standards than is usual practice. However, it was felt that the benefits to trusts of having a single review rather than separate Audit Scotland and CSBS reviews offset this disadvantage.

Findings

Accountability (Standard 1)

All trusts were able to demonstrate that they have a senior manager designated as having overall responsibility for cleaning services, although there is variability in whether that is a direct responsibility or more distant through a reporting chain. Most, but not all, trusts were able to demonstrate that the senior manager also has overall responsibility for risk assessment and risk management processes relating to cleaning services, as specified in HDL(2001)10[14]. Almost all trusts have organisation charts outlining lines of accountability from cleaning staff ultimately through to the Trust Management Team. Many of these charts do not specify links with wider functions, such as infection control, health and safety, nursing and clinical staff.

Most trusts which either buy in from, or sell cleaning services to, other organisations were able to demonstrate, mostly in contracts or service level agreements, that the scope of responsibility specifies professional liability. All trusts with services provided by external providers were able to show this, with the exception of Lanarkshire Acute Trust where relevant documents were not made available because of commercial confidentiality.

[14] '*Decontamination of Medical Devices'*, NHS HDL(2001)10, Scottish Executive.

Processes (Standards 2, 3, 4, 5, 6, 7, 8)

Almost all trusts have cleaning services managers with appropriate qualifications and experience and close links with the ICT and other specialist staff.

Policies and procedures

All but two trusts have documented policies and procedures for cleaning services. These were under development at Lomond and Argyll PCT at the time of the review. NHS Orkney does not have detailed policies and procedures and stated that this was mainly due to the small size of the organisation. It is not always clear if these policies have been approved by the trust management team. All policies specify minimum frequencies and/or output measures, but many do not specify audit requirements or the procedures for addressing deficiencies identified through audit and monitoring. Whilst it is clear that monitoring and audit is taking place at most trusts, there is often no policy providing details such as how often audits should take place, who should be involved, the standards to be audited against and how results should be reported and acted on.

Many policies detail working relationships with ICTs, but not with departmental staff and patients. Lack of clarity on relationships with departmental staff can lead to confusion as to the cleaning responsibilities of ward staff and domestic staff, and some tasks not being covered appropriately. The review of levels of cleanliness identifies this as a particular issue in relation to responsibility for cleaning clinical equipment.

Operational policies are in place in all trusts and most include the range of guidance specified in the standards. Operational policies often take the form of a range of documents, including infection control manuals, risk management policies and guidance on control of hazardous substances (COSHH[15]), in addition to cleaning specifications. Trusts should ensure that all these documents are easily accessible to staff and, ideally, that all relevant sections are included in one policy. In line with best practice, most trusts date new policies and procedural guidance and mark them with a review date, but older policies that have not been reviewed recently are often not dated.

Cleaning plans are in place in almost all trusts, although not always in one single document. Again, this is not ideal as it means that essential information may be less accessible to staff. Most trusts monitor compliance with the cleaning plan.

[15] Control of Substances Hazardous to Health (COSHH).

Trusts have evidence that they obtain feedback from users, mainly through user surveys, patient council visits, comments forms and complaints. While there are opportunities for patients, visitors and staff to comment on standards of cleaning at all trusts, only half actively seek patient views. Further development is required in the way that user feedback and monitoring information is used in trusts, with many having no clear mechanism for using this information to support continuous improvement.

Risk management

There has been significant focus on the systematic identification and management of clinical and non-clinical risks in the NHS in recent years. Best practice includes the use of risk registers to record and prioritise risks and comprehensive processes for managing and minimising risks. A number of the CSBS standards relate to systems for managing risk.

The standards require trusts to review the cleaning services specification on an annual basis, particularly to ensure that it appropriately manages risks. Many trusts do not have an annual programme of formal reviews of the specification. Of those that undertake formal reviews, a number do not have a documented risk register and risk management process to be used in the review process and so fail to meet the criteria of the standard. However, there is evidence that while these formal systems are not always in place, some trusts review the cleaning specification on an ongoing basis, amending it as required to deal with changes such as additions or alterations to the properties to be cleaned or the frequency of cleaning required.

All trusts have some aspects of a risk management process in place. However, only two trusts meet all components of the CSBS standard. All trusts but one have some record of risks related to cleaning services. Ten trusts have documented risk registers and these are under development at a further 11 trusts. The remaining trusts either have only high-level risk registers, risk registers for some hospitals within the trust or risk registers held by external contractors, or they have documented and assessed cleaning risks but not in a formal risk register. Only NHS Orkney did not have any register of risks in place or under development.

We are concerned to note that, in a number of trusts, risk management processes, and the identification of risks, is limited to health and safety risks. It is important that risk management processes include all risks, particularly infection control.

Many trusts have a process for informing senior management of significant risks and risk management plans, but few were able to show that they monitor and review risk and the effectiveness of risk management on a continuous basis.

Capability (Standards 9, 10, 11)

All trusts reported that staff have access to up-to-date guidance and legislation relating to cleaning services, mainly through the internet and libraries. This means staff can access information relevant to ensuring that the cleaning specification and operational policies are up to date.

Less than half of trusts have undertaken an analysis to identify the skills and training required to meet statutory and mandatory requirements. Many trusts have training programmes, but few are based on a formal skills needs analysis. A small number of trusts review staff training needs in the light of the findings from routine or ad hoc monitoring of standards of cleanliness and environmental audits by ICTs, providing refresher training or amending training programmes as required.

Trusts generally provide training in most topics identified in the standards, although not always as part of a formal training programme. Infection control training is provided to staff in most trusts, although in some cases this needs to be developed further. This is discussed further in the next chapter. The topic covered by least trusts is risk assessment. All trusts provide training in the management of specific risks eg, approved codes of practice, but few provide training in risk assessment. This should be developed as part of risk management to ensure that staff are able to identify risks and draw these to the attention of managers. Almost a third of trusts have a formal training programme for domestic services managers, and most others noted that training opportunities are available. Almost all trusts maintained training records for all staff, in line with best practice.

Outcome measures (Standard 12)

Most trusts have some agreed performance indicators in place and monitor performance against these indicators. However, few have agreed performance targets and only a small number of those with targets publicise the targets and performance to staff. Similarly, most trusts have some involvement in benchmarking groups, but few reported being able to make best use of key indicators as part of benchmarking mainly because of concerns about the lack of comparability of the data.

Monitoring and review (Standard 13)

Most trusts have systems in place for monitoring and reviewing cleaning services, although, as noted earlier, lack of staff time means they are not always fully operational. Arrangements varied from comprehensive quality control systems, with full supporting documentation and systems for corrective action, through to less formal systems. Slightly more than half the trusts have formal systems in place for review, adjustment and corrective action. Few trusts have policies in place to consider the views of a wide range of internal and external stakeholders, although a number have systems for considering the views of patients and staff.

Audit (Standard 14)

At the time of the review only three trusts (Borders Acute, Borders PCT and NHS Orkney) had involved the internal audit department in reviewing the management of cleaning services, other than the management of the contracts with external providers. However, a number of trusts have included cleaning services in the future work programme.

Appendix 5 shows the number of trusts who fell into each of the five categories of compliance against each standard. Exhibit 8 summarises some of the areas that have been developed in most trusts and some areas where further development is required.

Exhibit 8: Summary of compliance with CSBS standards

Areas most developed	Areas where more development required
Management structures	Annual review of cleaning specification and risks
Lines of accountability	Comprehensive risk management structures
Appropriate cleaning plans in place and managed systematically	Agreed performance indicators and targets
Comprehensive and up-to-date cleaning services specifications	Formal quality control/monitoring and review system
Access to up-to-date legislation and guidance	Periodic independent review of management of cleaning services

Source: Audit Scotland/CSBS review

A number of trusts have put significant work into developing comprehensive policies and procedures in line with the standards, while many others have developed action plans to bring them in line with the requirements. Ayrshire & Arran PCT, Greater Glasgow PCT, Dumfries & Galloway Acute Trust and Grampian University Hospitals Trust are particularly far advanced in having the appropriate policies, procedures and management arrangements in place. Others, such as Fife Acute Trust, were undertaking significant development work at the time of the review. In this case, a significant driver to these developments is the change from an external to an internal provider, involving joint working with the PCT, and the need to revise management arrangements, policies and procedures accordingly.

Conclusions

Many elements of the CSBS standards are in place in a number of trusts and significant work is taking place to take them forward. Management structures and cleaning services specifications are most developed, while risk management structures and formal quality control systems are areas where further work is required in many trusts.

It is important to note that the self-assessment and follow-up review took place very soon after the pre-publication standards were issued to trusts and this review forms a baseline indication of compliance.

Any further follow-up of compliance with the standards will be determined by NHS Quality Improvement Scotland, the new national quality assurance body which incorporates CSBS.

Recommendation

- *Trusts should work towards full compliance with all cleaning services standards.*

Management of cleaning services

Introduction

The CSBS standards identify the need to have policies and procedures for cleaning services. This section of our report focuses on the practical application of these policies and procedures. Specifically, we focus on:

- links with ICTs
- terms of contracts with external providers of cleaning services
- cleaning services specifications
- monitoring arrangements
- changes in cleaning budgets in recent years.

A number of the recommendations in '*A clean bill of health*' focused on the management and organisation of cleaning services, identifying areas that would improve practice and outcomes. In this section we also highlight the extent to which trusts have implemented these recommendations.

Links with infection control teams (ICTs)

There is evidence of regular communications between the Cleaning Services Manager and the ICT in almost all trusts. This is through domestic services and infection control staff serving as members of Infection Control Committees and other groups, regular meetings and joint monitoring arrangements. Lomond & Argyll PCT has infection control link nurses in each locality, providing a local source of advice and support over the wide geographic spread of the trust.

Good practice example: Ayrshire & Arran Primary Care Trust

There are a number of examples of close working between domestic services and infection control at the trust. During 2002, the trust introduced joint inspection audits of standards of cleanliness. They involve the Infection Control Nurse Specialist Adviser and the Assistant Hotel Service Manager. The trust undertakes an annual review of the cleaning specification. This is carried out jointly by the Hotel Services Manager and the Infection Control Nurse Specialist Adviser.

Infection control is part of the training programme in 22 trusts, while limited training is available at a further two trusts and funding has been sought to develop this further. At one trust training is provided to domestic supervisors only and there is an expectation that this training will be cascaded to domestic staff. This is insufficient and exposes trusts to risk. Domestic staff should receive this training directly, with appropriate records maintained.

Forth Valley Acute Trust provides only written information to staff, while Fife PCT and NHS Shetland only provide formal training as part of the general induction. While formal training is not provided at State Hospital, it was reported that training from the ICT is regular and informal. NHS Orkney was unable to provide any training as it does not yet have an Infection Control Nurse in post. While the external contractor provides infection control training at Glasgow Royal and Princess Royal Maternity, there is no formal programme of infection control training at Western Infirmary and Gartnavel General, hospitals within the same trust which have internal providers. It was also noted that there is no formal process for involving the ICT in developing cleaning policies or work schedules at these two hospitals. At Royal Alexandra Hospital, infection control training is provided by the contractor, but the hospital has no input to assess its adequacy or appropriateness.

Contracts with external providers

Four in five hospitals provide domestic services in-house. We found high levels of cleanliness at many hospitals with external providers. In particular, we found no areas of concern or need for improvement at Ladysbridge, City Hospital and Royal Cornhill (all Grampian PCT), Princess Royal Maternity (North Glasgow Trust) or Queen Margaret Hospital (Fife Acute). However, a number of other hospitals had problems associated with poorly defined or managed contracts.

Four hospitals, Victoria Infirmary and Mansionhouse Unit at South Glasgow Trust, Stobhill and Royal Alexandra Hospital, reported difficulties with the terms of the external contract. With the exception of the Mansionhouse Unit, the review of levels of cleanliness identified areas of concern at these hospitals. Management and staff at South Glasgow Trust reported that there were a number of difficulties with the contract for cleaning services including a lack of:

- clarity in the terms of the contract and the standards expected
- responsiveness to issues arising
- legal recourse in the event of failure or substandard quality and minimal penalties for breaches; and
- a failure to specify the information that should be made available to the trust on a monthly basis.

These issues are also identified as concerns in the Watt Report[16]. Since the time of the review, South Glasgow Trust has announced plans to change to in-house provision of services.

At Hairmyres Hospital the contract is based on an output specification, with comprehensive monitoring and reporting arrangements. However, our snapshot review identified that levels of cleanliness fell below acceptable levels and a review of monitoring reports showed repeated non-compliance with targets. Under the terms of the contract, the financial penalties enacted were negligible because the provider was able to rectify problems highlighted within agreed time-scales. These rectification times are based on the level of priority detailed in the specification. We are concerned that the trust reported that the external contractor at Hairmyres did not give them details on why cleanliness at Hairmyres failed to reach acceptable levels or of measures to prevent future failings. The trust reported that under the terms of the contract, they could do nothing to obtain this information. Wishaw Hospital, part of the same trust, has a similar contract with an external provider, but our review found no areas of concern about levels of cleanliness.

While the contract at New Craigs Hospital, Highland PCT, includes comprehensive monitoring arrangements, local management were concerned that there is a tendency to award higher scores resulting in the acceptable levels at New Craigs being lower than those at other hospitals within the Trust. This is a hospital where our snapshot identified that cleanliness was below acceptable levels. There is no evidence that the Domestic Services Manager and ICT were formally involved in agreeing the cleaning specification.

A higher proportion of hospitals with in-house providers fell into category 1 for the wards reviewed – category 1 indicates that all wards were very good or acceptable (Exhibit 9). However, this difference is not statistically significant. The review of public areas showed a similar finding, but, again, did not show a significant difference.

[16] '*A review of the outbreak of salmonella at the Victoria Infirmary*', The Watt Group Report, October 2002.

Exhibit 9: Results of snapshot review of wards by provider

Snapshot provider	Category 1	Category 2	Category 3	Category 4	Total
In-house	31 (53%)	14 (24%)	5 (9%)	8 (14%)	58
External	5 (31%)	4 (25%)	1 (6%)	6 (38%)	16
Total	36 (49%)	18 (24%)	6 (8%)	14 (19%)	74

Pearson $\chi 2 = 5.09$, 3 df; p=0.166.

Source: Audit Scotland snapshot survey

Cleaning specifications

In '*A clean bill of health*' we highlighted the importance of specifying the required level of cleaning in ways that could be monitored. We recommended that cleaning specifications should ideally specify both minimum frequencies of tasks and the outcomes, in terms of level of cleanliness, that are expected.

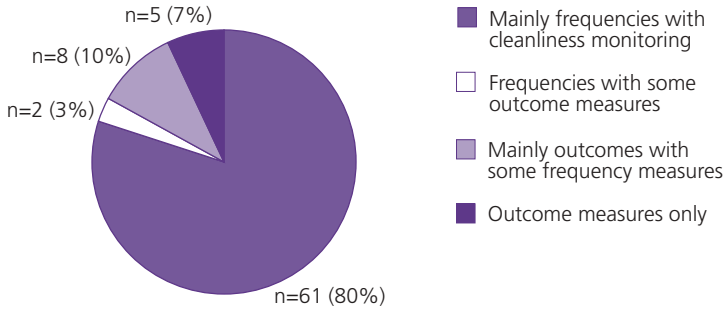
Cleaning frequencies are included in 93% of the specifications (Exhibit 10). This is in line with the baseline review. Cleaning specifications are mostly based on SCOTMEG or ADM frequencies, with adjustment for local needs. However, in most cases this adjustment is not based on a formal risk analysis.

Five hospitals across three trusts have output-based specifications and do not specify minimum frequencies. However, in three of these hospitals[17], minimum cleaning frequencies are included in operational policies. The only hospitals which reported that minimum frequencies are not specified in the specification or operational policy are Hairmyres and Wishaw General.

[17] Victoria Infirmary and Mansionhouse Unit, South Glasgow Trust; New Craigs, Highland PCT.

Exhibit 10: Type of specification

Most cleaning specifications are based on frequency of cleaning.



Source: Audit Scotland

Involving ward staff

'*A clean bill of health*' recommended that cleaning priorities and expected levels of cleanliness for wards and departments should be agreed with and jointly monitored by ward/departmental staff. We found that while local cleaning priorities are available in 23 trusts, these had been formally agreed with departmental managers in only eight trusts and informally or verbally agreed in a further six.

The baseline report also made a number of recommendations concerning information that should be agreed and made available at ward level. Frequencies are written into the work schedules of each ward at almost all of the 71 hospitals with specifications that include frequencies. Hospitals reported a number of ways that ward/department staff are made aware of the levels of cleanliness to expect in their own areas, mainly through work schedules, cleaning specifications and regular contact with the cleaning services manager. At a third of hospitals it was explicitly stated that this information is available in wards or domestic services rooms (DSRs) attached to wards. This is good practice as it ensures this information is easily accessible to ward staff, who can then contact domestic services if levels of cleanliness are not being achieved as planned. In a number of hospitals where we reviewed levels of cleanliness, staff raised concerns about the lack of cleaning schedules in their wards. Hospitals should ensure that this information is available to ward staff.

Good practice example: Highland Primary Care Trust

Hospitals at Highland PCT make use of a ward duty/communication book which is held in the DSR. Domestic staff use this book to note any tasks which they could not complete and the reason it could not be completed. The book is then updated by the member of staff who does complete the task. All entries are signed and dated and are reviewed by the supervisor on a daily basis. This communication system means that staff on different shifts, and supervisors, are aware of any tasks outstanding, and ward staff have access to this information.

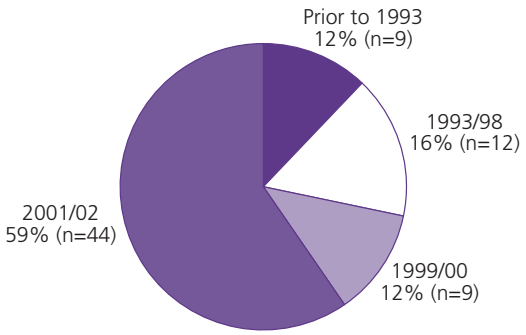
Involving ICTs in approving specifications

It is good practice for the cleaning frequencies and specification to be approved by the ICT. The specification had been approved by ICTs in 84% of hospitals, compared to 81% at the time of the baseline review. However, the specification has still not been approved by the ICT in 12 hospitals, leading to a risk that the specification may be inappropriate to meet local infection control needs. The snapshot review of levels of cleanliness found areas of concern in wards at four of these 12 hospitals and in public areas at five of the hospitals. The proportion of hospitals with an area of concern is higher in hospitals where the specification has not been approved by the ICT, although this difference is not statistically significant.

Reviewing specifications

Regular reviews of the cleaning specification and frequencies should be conducted to ensure that it is updated to reflect changing needs, such as changes in the physical elements to be cleaned and revised risk management arrangements. Specifications in three-fifths of hospitals had either been reviewed within the last 18 months, were in the process of being reviewed or had a review planned for 2002 (Exhibit 11). This is an improvement from the baseline report which showed that only a third of frequencies had been reviewed in the last 18 months. However, 28% of hospitals have not reviewed their specification since the publication of '*A clean bill of health*'. At Falkirk Royal, a hospital where the snapshot review identified areas of concern, the specification has not been reviewed since 1988, and it was reported that there is a concern that the clinical areas defined do not include all patient contact areas. As noted previously, many hospitals do not have comprehensive risk registers and risk management processes in place for reviewing the cleaning specification.

Exhibit 11: Year specification was last reviewed



Source: Audit Scotland

Monitoring and audit

Monitoring is vital to ensure that appropriate levels of cleanliness and infection control are achieved. We found that cleaning services are monitored in a number of different ways. Over half the hospitals monitor cleanliness/outcomes only, including the five hospitals with specifications based on outcome measures only. Many hospitals with specifications that are mainly frequencies with some outcome measures monitor cleanliness/outcomes only and do not monitor frequencies.

Monitoring arrangements

Domestic supervisors and domestic services managers typically carry out monitoring of levels of cleanliness. Joint monitoring with ward/department staff takes place in just under half the trusts, although only 13 trusts have formal joint monitoring arrangements. While not involved in monitoring, ward staff at a further four trusts have the opportunity to comment when signing off monitoring forms. In hospitals where ward staff have no opportunity to be involved in monitoring or formal opportunity to comment on cleaning inputs and outputs, staff concerns may not be identified and addressed.

Good practice example: Glasgow Primary Care Trust

The trust has a formal ISO Quality Plan covering domestic services. Quality procedures are still being developed further towards the new quality standard due in 2004. Monitoring forms have been updated to allow joint completion of a self-assessment form by ward managers and domestic services managers on a monthly basis. In addition, new procedures formalise the Assistant Hotel Services Manager as having responsibility for inviting an area/ward representative to accompany support services supervisors on their self-assessment visits.

There is variation in what is monitored at hospitals, the staff groups involved, the frequency of monitoring, reporting and rectification arrangements and the level of documentation. There is also variation between trusts having formal, documented procedures and ad hoc arrangements. A formal monitoring policy is in place in 78% of trusts, an increase from 65% in the baseline review. While this is a considerable improvement, all trusts should put in place formal monitoring procedures, including relevant documentation and reporting arrangements. This will ensure that the process is transparent and consistent, that monitoring takes place as planned and that arrangements are in place for acting on monitoring results, both at ward level and in terms of organisational or training needs identified.

A lack of a formal monitoring system can lead to ad hoc arrangements, leading to risks such as incomplete coverage, variation in standards and results not being collated, reviewed and acted on. If hospitals do not monitor both inputs and outputs, they will not have the information to amend cleaning plans as required to deal with lower inputs or poor outcomes.

We found shortfalls in the monitoring arrangements in place in eight of the hospitals where standards of cleanliness fell below acceptable levels[18]. At seven hospitals no specific monitoring hours were planned for the wards included in our questionnaire survey. This includes Stirling Royal Infirmary, where cleanliness failed to reach acceptable levels.

Good practice example: Dumfries & Galloway Acute Trust

Formal monitoring is carried out by domestic supervisors on a weekly basis. A sample of 92 rooms within wards and departments is selected at random by computer. This equates to 11.3% of the total areas cleaned by domestic services being formally monitored each week.

Domestic supervisors are issued with both a list of the areas to be monitored and scoring sheets. Monitoring is completed over a period of a week in order that access can be gained to all areas selected and to tie in with the worksheets for the areas selected. Formal feedback on the results of the monitoring exercise is provided to staff. The Hotel Services Manager receives summary monitoring information each month and this is then reported at the Trust Management Team.

[18] Bonnybridge, Dunoon General, Dykebar, Falkirk Royal, Inverclyde Royal, New Craigs, Ravenscraig, State Hospital, Stirling Royal.

The monitoring information is transferred onto a central computer database and summary results generated. Any area failing to meet the pass mark is automatically selected again for monitoring the following week, in addition to the normal random sample generated.

An annual audit of standards of cleaning is carried out by the Hotel Services Manager and reported to the Trust Management Team. This highlights particular problem areas and improvements planned to address identified weaknesses. The Assistant Hotel Services Manager represents the department on the Area Control of Infection Committee, and highlights concerns identified through monitoring processes to infection control officers as appropriate.

Environmental audit

In addition to monitoring by supervisors, environmental audits take place at most hospitals. These mostly involve the ICN. In a number of hospitals other staff are involved, such as domestic/hotel services managers (at six hospitals[19]) or ward nurses (hospitals in Lanarkshire PCT only). These audits take place less frequently, typically every year, and are often part of a formal environmental audit programme. At Lanarkshire PCT, it was reported that the regular programme of visits maintains contact between infection control staff and domestic staff, and supports a good working relationship.

External contractors

Monitoring arrangements are more formalised at a number of hospitals where external contractors provide cleaning services. Contractors generally work to detailed monitoring, time-specific rectification and reporting policies. '*A clean bill of health*' recommended that monitoring should be conducted by hospitals in addition to the monitoring undertaken by the external provider. We found that this happens routinely in 12 of the 16 hospitals with external providers[20]. While we found no link between observed levels of cleanliness and trusts undertaking their own monitoring, this is recommended as good practice as it ensures that trusts are not solely reliant on information produced by the external provider. However, as noted earlier, comprehensive monitoring and reporting arrangements may not always be followed up with quality improvement.

[19] Ailsa, Borders General, Hay Lodge, Kelso, Monklands, Leverndale.

[20] Ward staff are invited to participate in joint monitoring at New Craigs, but it was reported that they usually decline. Trust staff receive monitoring reports but do not conduct their own regular monitoring. Grampian PCT reported that it has decreased its monitoring of the three hospitals included in the review in recent years as confidence in the provider has increased.

Case study: Lanarkshire Acute Trust, Wishaw General Hospital

The trust employs a Support Services Manager at each hospital site. These managers are responsible for monitoring levels of cleanliness provided by the external providers and are the main point of contact between the providers and the trust. The managers report directly to the trust's Head of Property and Support Services who, in turn, reports directly to the Director of Strategic Planning and Development.

The Support Service Managers conduct random quality audits using detailed checklists, and findings are reported to the external providers.

A full-time Customer Liaison Manager is employed by the provider at Wishaw to audit outcomes at wards throughout the hospital. A monthly quality report is produced for the Trust and this details performance failures. The report also analyses calls made to the helpdesk facility provided at the hospital by the external provider.

Supervisors monitor levels of cleanliness on a more regular basis. The external provider also conducts quality checks on a random sample of areas throughout the hospital using the computerised PMS audit system. Four standards are assessed during these quality checks, and each standard has 12 indicators of quality.

The PMS system recorded that 98.83% of areas reviewed were satisfactory in the month prior to our review. Customer liaison forms completed by ward staff at Wishaw also support these findings.

Ward staff have the opportunity to comment on levels of cleanliness during monitoring checks. They can also phone the helpdesk to report any concerns. The hospital Support Services Manager occasionally attends meetings of ward managers and senior nurses to discuss cleaning services and standards.

Training

All trusts provide some training for domestic staff, although there is variation between hospitals with formal and informal training programmes and some variation in range of topics covered. Three trusts[21] have put in place or are in the process of developing Scottish Vocational Qualifications (SVQ) accredited training programmes.

[21] Ayrshire & Arran PCT, Fife PCT, Glasgow PCT.

Good practice example: Fife Primary Care Trust

The General Services Manager has worked with a local college to develop an SVQ in Cleaning Building Interiors. This provides training in an appropriate range of skills and all domestic staff are encouraged to attend this training. The trust is one of only a few in Scotland that routinely offers this training to all domestic staff.

Budgets

It is difficult to look at trends in budgets and expenditure given the variation in what is included in total budget figures across hospitals. A number of trusts reported that budgets had risen only in line with inflation in recent years, while some, such as Yorkhill, reported that budgets had increased to bring about a partial return to Whitley Council terms and conditions.

At Lothian University Hospitals Trust it was noted that the Trust had recently agreed additional funding to allow frequencies in patient areas to be increased to SCOTMEG recommendations. All trusts in Lothian have agreed to implement a recruitment and retention plan as per Lothian Health Plan, and it is hoped these new arrangements will assist in maintaining a skilled staff group within domestic services and other ancillary staff groups.

Conclusions

Management arrangements are well developed in most trusts and hospitals, with domestic services managers generally working closely with ICTs. However, some trusts do not yet have these links in place and we found the cleaning specification had still not been approved by the ICT in 12 hospitals, in spite of this being a recommendation in '*A clean bill of health*'. Infection control training is provided to domestic staff in almost all hospitals, albeit with further development required in some hospitals. A number of hospitals have put in place formal and comprehensive training programmes for staff, in some cases working with local colleges to develop formal courses and qualifications.

The majority of hospitals provide services in-house. We found a number of concerns about the terms of contracts in some hospitals with external providers. These concerns included non-specific terms of contracts and repeated non-compliance with targets for levels of cleanliness. However, we also found a number of examples of external contracts that are working well and where hospitals showed high levels of cleanliness.

Specifications for cleaning services are mostly based on recognised national guidance for minimum cleaning frequencies, with adjustment for local needs. In our previous report we identified the importance of reviewing the specification on a regular basis to ensure that it is kept up to date with national best practice guidance and local needs, based on a risk assessment. Whilst over half of hospitals have reviewed their specification recently, over a quarter have not reviewed it since the publication of '*A clean bill of health*', and over 10% last reviewed it prior to 1993.

There are variations in the monitoring and audit arrangements in place in hospitals, from formal monitoring arrangements and quality assurance systems through to more ad hoc arrangements. We found a need for improvement in the monitoring arrangements in many of the hospitals where concerns were identified in the snapshot review of levels of cleanliness.

Recommendations

Management arrangements

- *Trusts should support opportunities for close working between domestic services and ICTs.*
- *Risk registers and risk management processes should include all risks associated with cleaning rather than health and safety risks only.*

External contracts

- *Trusts should ensure clarity in the terms of contract, standards expected, monitoring arrangements, information to be reported and the trust's right of access to information to investigate deficiencies.*

Cleaning specification

- *Cleaning specifications should specify both minimum frequencies of tasks and expected outcomes in terms of levels of cleanliness.*
- *Cleaning specifications should be based on SCOTMEG or ADM frequencies, adjusted for local needs.*
- *Adjustment should be based on a formal risk assessment with reasons for variation documented.*
- *Cleaning specifications should be reviewed annually, in line with CSBS standards.*
- *Cleaning specifications should be approved by the ICT.*

Monitoring

- *Trusts should monitor both cleaning inputs and outputs.*
- *Ward staff should either be involved in joint monitoring arrangements or have a formal opportunity to comment on cleaning inputs and outputs.*
- *Ward staff should have explicit information on the level of cleanliness to expect in their wards.*
- *All trusts should put in place formal monitoring procedures, including relevant documentation and reporting arrangements.*
- *In addition to monitoring by external providers, all trusts should undertake monitoring using NHS staff.*
- *When monitoring identifies poor performance, the reasons should be established and remedial action taken. If monitoring repeatedly highlights similar failings, this should be reported to the board.*

Training

- *Infection control should be part of the training programme for domestic staff.*

Conclusions

A snapshot review found very good or acceptable levels of cleanliness in over 70% of wards and 80% of public areas reviewed at hospitals throughout Scotland. At hospital level, half of the hospitals were very good or acceptable in all areas reviewed, over 20% showed a need for improvement in either some of the wards or public areas, and the remainder were considered to be in need of some minor improvement.

This review aimed to investigate the reasons for the variation in levels of cleanliness. It considered cleaning frequencies, staff inputs to cleaning and monitoring, recruitment and retention of staff, management arrangements and the application of policies and procedures. While we found no clear association between levels of cleanliness and any of these factors individually, a number of themes emerged as to factors that appear to make it more difficult for hospitals to achieve acceptable levels of cleanliness. These are summarised below:

- Hospitals mainly work to and achieve cleaning frequencies that are in line with or above national minimum recommendations. However, staff inputs to cleaning are often below planned levels, meaning that tasks are carried out as often as planned but with less staff time. As a result, quality of cleaning may be compromised due to lack of time, cover may be provided by relief staff unfamiliar with the wards/public areas, or supervisors may have to undertake cleaning tasks at the expense of supervising and monitoring.

- Rates of staff turnover and sickness absence remain high in many hospitals. Many hospitals report difficulties attracting and retaining staff, particularly as a result of the availability of alternative employment opportunities offering higher rates of pay. Basic rates of pay in all hospitals are below the hourly rate offered by local authorities, one of the main competitors for staff.

- Terms of contracts with external providers are not always specific enough to ensure acceptable levels of cleanliness. Terms of contracts may also allow for repeated non-compliance with achieving targets for levels of cleanliness.

- Links with ICTs are in place in most trusts. However, some cleaning specifications have not been approved by the ICT and may be insufficient to ensure appropriate levels of cleanliness and infection control.

- Monitoring arrangements are insufficient in some hospitals, particularly hospitals with ad hoc arrangements and a lack of detailed monitoring and audit policies. In some instances, appropriate monitoring policies are in place but are not always put into practice because of staff shortages and workload pressures. Ward and departmental staff are often not involved in monitoring, and in a number of hospitals these staff do not have information on the inputs and levels of cleanliness that should be achieved in their areas.

The review also incorporates a baseline indication of compliance with the CSBS standards for cleaning services which were issued to trusts in pre-publication form in January 2002. We found that significant work to implement the standards is taking place in many trusts. The elements of the standards that are most developed are management structures and cleaning services specifications, while risk management structures and quality control systems are least developed. All trusts have received a detailed report on their compliance with the standards and are expected to work towards full implementation.

Our review also assessed the extent to which trusts had implemented a number of the recommendations in '*A clean bill of health*'. We found considerable progress against a number of the recommendations and some further development since the review undertaken by Scottish Executive Health Department (SEHD). Exhibit 12 identifies the areas that have been progressed in most trusts and the areas where most development is required. These are mainly the same areas as identified in the SEHD review.

Exhibit 12: Progress against recommendations in *'A clean bill of health'*

Most developed	More development required
Effective links with ICTs	Proactively seeking patients' views on levels of cleanliness
Minimum frequencies specified in specifications and at ward level	Agreeing and monitoring staffing indicators
Widening remit of domestic staff	Joint monitoring by domestic services and ward staff
Levels of cleaning to be expected are communicated to ward staff	Documented policies for covering under-staffed shifts
Infection control training provided to domestic staff	Monitoring results reported to management

Source: Audit Scotland

In the next section we outline our recommendations. In some cases they re-state recommendations from '*A clean bill of health*', and in others they focus on issues identified through this follow-up review.

Summary of recommendations

Standards of cleanliness

- Trusts should ensure that operational policies specify responsibility for cleaning clinical equipment and that all staff are made aware of their responsibilities. The cleanliness of clinical equipment should be included in routine monitoring.
- Domestic services management should work with estates to agree a cleaning programme for areas inaccessible to domestic staff. Trusts should ensure that regular maintenance and redecoration programmes are in place.
- An ongoing programme of peer review of levels of cleanliness or similar quality assurance mechanism should be introduced.

Staffing inputs

- Trusts should identify and agree key performance indicators and targets for staffing, and share best practice through involvement in benchmarking.
- Trusts should ensure that they have in place and have appropriately resourced contingency plans to deal with significant vacancies or sickness absence.
- Trusts should ensure that they have a clear policy for managing and monitoring under-staffed shifts.
- Trusts should investigate the reasons for high levels of absence, turnover and vacancies, and consider what action needs to be taken to improve these indicators. This may include reviewing rates of pay and other working conditions, such as flexible hours and family-friendly policies.

Clinical Standards Board standards

- Trusts should work towards full compliance with all cleaning services standards.

Management arrangements

- Trusts should support opportunities for close working between domestic services and infection control teams (ICTs).
- Risk registers and risk management processes should include all risks associated with cleaning rather than health and safety risks only.

External contracts

- Trusts should ensure clarity in the terms of contract, standards expected, monitoring arrangements, information to be reported to the trust and the trust's right of access to information to investigate deficiencies.

Specification

- Cleaning specifications should specify both minimum frequencies of tasks and expected outcomes in terms of levels of cleanliness.
- Cleaning frequencies should be based on SCOTMEG or ADM recommendations, adjusted for local needs.
- Adjustment to the frequencies should be based on a formal risk assessment with reasons for variation documented.
- Cleaning specifications should be reviewed annually, in line with CSBS standards.
- Cleaning specifications should be approved by the ICT.

Monitoring

- Trusts should monitor both cleaning inputs and outputs.
- Ward staff should either be involved in joint monitoring arrangements or have a formal opportunity to comment on cleaning inputs and outputs.
- Ward staff should have explicit information on the level of cleanliness to expect in their wards.
- All trusts should put in place formal monitoring procedures, including relevant documentation and reporting arrangements.
- In addition to monitoring by external providers, all trusts should undertake monitoring using NHS staff.
- When monitoring identifies poor performance, the reasons should be established and remedial action taken. If monitoring repeatedly highlights similar failings, this should be reported to the board.

Training

- Infection control should be part of the training programme for domestic staff.

Appendix 1: Cleanliness review methods

Checklist for scoring levels of cleanliness

Criteria	
1	Floors will be left dry and without dirt, dust, marks, film or reasonable streaks. There will be no obvious signs of soiling or spillage.
2	Glass (excluding external windows) will be cleaned on both sides and free from smears, film streaks or marks. Corners and edges will be free from build up of dirt and cleaning materials.
3	Fixtures and fittings (including vacated patient lockers, patient beds and over-bed trolleys) shall be free from smears and marks. All debris will be removed from the lockers and the wheels and castors shall be free from dirt and grime.
4	All sanitary ware, including toilets and urinals, will be clear of debris, built-up films and smears, and soap dispensers, taps, basins, overflow traps and drainage will also be free from soap deposits and build up. All consumables eg, soap, paper towels, toilet tissue will be replenished to maintain constant availability.
5	Walls, to include doors, door frames and window frames will be visibly clean and free from dust, smears and spillage.
6	All cubicle curtains, window curtains and blinds (vertical, horizontal and roller) shall be free from dust, dirt and smears.
7	All domestic and clinical waste bins are regularly emptied and free from odours and dirt inside and out, and the exterior of the waste bin will be clean.

Criteria reviewed but not included in score

Appearance
Floors will have a uniform appearance.
Areas will be neat and tidy.
External windows will be cleaned on both sides and, as far as is reasonable, free from smears, film streaks or marks. Corners and edges will be free from build up of dirt and cleaning materials.
Clinical equipment, including clinical trolleys, drip stands etc. shall be free from dust, dirt and smears.
The area will be in good decorative order.

Scoring method

Each functional area reviewed eg, a ward, corridor, reception area, was assessed using the list of seven criteria. They were scored against each criteria to reflect the extent to which they complied. Scores are shown below. A total score was then calculated for each ward and public area reviewed, and this was used to classify the ward or public area as shown below (bottom). A number of the criteria did not apply to public areas and classifications for total scores for the different numbers of criteria against which an area was reviewed are shown below (bottom).

Scoring system for reviewing wards and public areas

Classification	Score
Complies completely	0.01
Complies in most areas	0.1
Complies partially	1
Does not comply in most areas	10
Does not comply at all	100

Classifications applied to areas reviewed on basis of total points scored

	Number of criteria that applied					
	7	**6**	**5**	**4**	**3**	**2**
Classification	**Total score**					
Very good	0.7 or below	0.6 or below	0.5 or below	0.4 or below	0.3 or below	0.2 or below
Acceptable	1.06 - 2.5	1.05 - 2.4	1.04 - 2.3	1.03 - 1.3	1.02 - 1.2	1.01
Need for improvement	3.04 - 30.4	3.03 - 24	3.02 - 14	2.02 - 4	2.01 - 3	1.1 - 2
Concern	31 or above	30 or above	20 or above	10 or above	10 or above	10 or above

Appendix 2: Levels of cleanliness in hospitals

The following tables show the profile of hospitals in terms of the wards and public areas reviewed. Hospitals are split into four groups: those where all wards reviewed were rated as either very good or acceptable; hospitals where at least one ward had a major or significant concern or where all wards were rated as 'need for improvement'; the remaining hospitals fell into two middle categories on the basis of the number of wards rated as 'need for improvement'. Hospitals are listed alphabetically.

Profile of hospitals by levels of cleanliness in wards reviewed

Category 1	Category 2	Category 3	Category 4
All wards very good or acceptable (n=37)	**Wards mostly very good or acceptable with one need for improvement (n=17)**	**Wards a mix of very good, acceptable and more than one need for improvement (n=6)**	**At least one ward of concern or all wards need improvement (n=14)**
Aberdeen Children's	Ashludie Hospital	Coathill/Alexander	Bonnybridge
Aberdeen Maternity	Belford, Fort William	Kirklands Hospital	Caithness General
Aberdeen Royal	Gartnavel General	Ninewells	Dunoon General
Ailsa Hospital	Gilbert Bain	Victoria, Fife	Dykebar
Astley Ainslie	Hawkhead	Western Infirmary, Glasgow	Falkirk Royal
Ayr Hospital	Kelso Hospital	Whyteman's Brae	Glasgow Royal
Ayrshire Central	Leverndale		Hairmyres
Balfour Hospital	Mansionhouse Unit		Inverclyde Royal
Biggart	Merchiston		Monklands
Borders General	Perth Royal Infirmary		New Craigs, Inverness
Cameron Hospital	Raigmore		Ravenscraig
Campbeltown	Royal Edinburgh		Royal Alexandra
City Hospital, Aberdeen	Western General, Edinburgh		Stirling Royal
Crichton Royal	St John's Hospital		Victoria Infirmary, Glasgow
Crosshouse	Stobhill		
Dr Gray's, Elgin	Vale of Leven		
D&G Royal Infirmary	Wishaw General		
Edenhall			
Hartwoodhill Hospital			
Hay Lodge Hospital			
Ladysbridge			
Liberton Hospital			
Murray Royal			
Princess Royal Maternity			
Queen Margaret			
Royal Cornhill			
Royal Dundee Liff			
RHSC, Yorkhill			
RHSC, Edinburgh			
Royal Victoria, Lothian			
Royal Victoria, Tayside			
Southern General			
State Hospital			
Stracathro			
Strathmartine			
Sunnyside Royal			
Western Isles			

Profile of hospitals by levels of cleanliness in public areas reviewed

Category 1	Category 2	Category 3	Category 4
All areas very good or acceptable (n=39)	**Areas mostly very good or acceptable with no more than 25% of areas need for improvement (n=9)**	**Areas a mix of very good, acceptable and more than 25% of areas need for improvement (n=7)**	**At least one area of concern or all areas need improvement (n=12)**
Aberdeen Children's	Astley Ainslie	Bonnybridge	Aberdeen Royal
Aberdeen Maternity	Cameron Hospital	Borders General	Falkirk Royal
Ailsa Hospital	Kelso Hospital	Caithness General	Gartnavel General
Ashludie	Mansionhouse Unit	Inverclyde Royal	Hairmyres
Ayr Hospital	Ravenscraig	Liberton Hospital	Monklands
Ayrshire Central	Royal Edinburgh	Stirling Royal	New Craigs, Inverness
Balfour Hospital	Stracathro	Victoria, Fife	Southern General
Biggart	Western General, Edinburgh		State Hospital
Campbeltown	Wishaw General		Stobhill
Crichton Royal			Victoria Infirmary, Glasgow
Crosshouse			Western Infirmary, Glasgow
Dr Gray's, Elgin			Whyteman's Brae
D&G Royal Infirmary			
Dunoon General			
Dykebar			
Gilbert Bain			
Glasgow Royal Infirmary			
Hay Lodge Hospital			
Hawkhead			
Leverndale			
Merchiston			
Murray Royal			
Ninewells			
Perth Royal Infirmary			
Princess Royal Maternity			
Queen Margaret			
Raigmore			
Royal Alexandra			
Royal Cornhill			
Royal Dundee Liff			
RHSC, Edinburgh			
RHSC, Yorkhill			
Royal Victoria, Lothian			
Royal Victoria, Tayside			
St John's Hospital			
Strathmartine			
Sunnyside Royal			
Vale of Leven			
Western Isles			

Note: This table excludes four hospitals in three PCTs where a small number of public areas were reviewed. All public areas were scored as very good or acceptable in three of these hospitals, and in the other hospital one area was scored as need for improvement. In three hospitals no public areas were reviewed.

Appendix 3: Wards included in the questionnaire survey

Type of ward	Number	Per cent
Medical assessment/admission	52	18
Acute psychiatric	35	12
Long stay (care of the elderly)	31	11
Orthopaedic	28	10
Maternity	20	7
Care of elderly	22	8
Care of elderly (assessment/rehab)	16	6
Other surgical	14	5
Learning disability	13	4
Other continuing care	13	4
Old age psychiatric	10	4
Stroke	6	2
HDU/ITU etc.	5	2
Other	22	8
Total	287	

Appendix 4: Planned and acutal cleaning frequencies

Difference between planned and actual frequency of cleaning tasks (number of wards and per cent of valid responses)

Task	No difference		Actual < planned		Actual > planned	
	Weekdays	Weekend	Weekdays	Weekend	Weekdays	Weekend
Clean hard floors in bed area	259 (98.5%)	262 (99.6%)	2 (0.8%)	0	2 (0.8%)	1 (0.4%)
Clean soft floors in bed area	181 (100%)	179 (100%)	0	0	0	0
Damp clean furniture and fittings in bed area	276 (96.2%)	283 (99.6%)	8 (2.8%)	0	3 (1%)	1 (0.4%)
Clean basin, taps & surrounds in bed areas	280 (98.2%)	283 (99.6%)	2 (0.7%)	0	3 (1.1%)	1 (0.4%)
Clean hard floors in sanitary areas	281 (97.9%)	280 (98.2%)	1 (0.3%)	1 (0.4%)	5 (1.7%)	4 (1.4%)
Clean basins, WC, baths etc. in sanitary areas	280 (97.9%)	278 (98.2%)	1 (0.3%)	1 (0.4%)	5 (1.7%)	4 (1.4%)
Clean dispensers & holders in sanitary areas	275 (97.5%)	272 (99.6%)	5 (1.8%)	1 (0.4%)	2 (0.7%)	0
Clean hard floors in ward offices	207 (95%)	197 (98%)	7 (3.2%)	1 (0.5%)	4 (1.8%)	3 (1.5%)
Clean basins, taps & surrounds in ward utility areas	282 (98.9%)	284 (99.6%)	2 (0.7%)	0	1 (0.4%)	1 (0.4%)

Appendix 5: Compliance with CSBS standards (number of trusts in each category)

Standard	Complies fully	Complies mostly	Complies partially	Mostly does not comply	Does not comply at all
1 Responsibility for cleanliness in healthcare premises is clearly defined and there are clear lines of accountability throughout the organisation, leading to the trust management team.	14	10	6	2	0
2 A suitably qualified person has been designated to manage the cleanliness of the healthcare facility.	19	7	3	3	0
3 The trust management team endorses the specification for the provision of cleaning services throughout the organisation.	3	13	13	3	0
4 Operational elements of the cleaning services specifications are in place and up-to-date.	2	16	10	4	0
5 An annual review is undertaken to assess whether the service specification is being achieved and reflects current requirements.	4	3	9	14	2
6 The cleaning plan and associated risk is managed systematically.	10	13	7	1	1
7 All cleaning management issues are evaluated, considered, and dealt with to achieve optimum user satisfaction.	12	6	8	4	2
8 A risk management process is applied to healthcare cleaning services.	4	8	7	13	0
9 The organisation has access to up-to-date legislation and guidance relating to healthcare cleaning services.	32	0	0	0	0
10 The competency and performance of cleaning personnel are monitored and evaluated to ensure standards are maintained.	12	7	8	4	1
11 Cleaning services staff receive training and instruction on the safe operating practices and cleaning of healthcare facilities.	4	12	13	3	0
12 Key indicators are a component of the performance assessment of cleaning services.	2	8	9	6	7
13 The system in place for healthcare facilities cleaning services is monitored and reviewed by management in order to make improvements to the system.	4	10	7	7	4
14 The trust internal auditor carries out periodic audits to provide assurance that a system of managing healthcare facilities cleaning services is in place that conforms to the requirements of these standards.	3	0	5	2	22

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