Making the connections

contract cleaning and infection control

UNISON
the public service union

A report for UNISON
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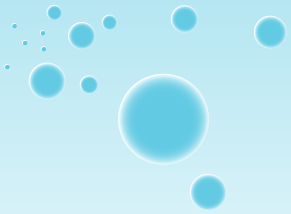

An independent report for UNISON by Steve Davies

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Executive summary

The debate about hospital infection control is essentially one about the connections and relationship between competitive tendering and contracting out of cleaning services, the quality of environmental cleanliness and the incidence of healthcare associated infections (HCAI). In part because of campaigns by UNISON, other unions, patients' organisations and the media, healthcare associated infections and hospital cleaning are now taken seriously by ministers. As a result, a higher priority has been given to environmental cleanliness and decontamination in recent years and ministers have changed their attitude about the link between cleanliness and infection control.

UNISON has neither claimed that a lack of cleanliness is the only factor behind the spread of infections nor that cleaning is the only solution. However, there is evidence of links between environmental contamination and infection outbreaks, and also evidence – both in the UK and abroad - of improved cleaning being a key part of controlling outbreaks of HCAI.

Increases in MRSA rates in UK hospitals coincided with the halving of the number of NHS cleaners and the impact of the introduction of competitive tendering and the contracting out of many hospital cleaning services to private sector providers.

The government claims that there is no direct relationship between contract cleaning and either the standard of cleanliness or the incidence of MRSA. However, it may be that the government is asking the wrong questions. What exactly constitutes 'clean', rather than just tidy is a key issue. The Patient Environment Action Teams (PEAT) scores that are used as a measure of cleanliness for both general statements about progress throughout the NHS or for analysis in specific outbreaks have serious weaknesses. These assessments rely on visual assessment, which is likely to be misleading, overestimating the cleanliness of a hospital unit and therefore potentially undermining infection control strategies.

The second question that the government needs to ask is about the tendering regime. We need to understand the relationship between quality of cleaning service and a tendering regime that focuses on price – *regardless* of whether or not the service is eventually outsourced.

There ***are*** particular problems associated with contracting out health care and particularly hospital cleaning to private contractors. But there are additional problems that a system of tendering imposes – ***regardless*** of whether the contract goes outside or not. In order to compete, public providers have had to join this race to the bottom. There is a great deal of research on the experience of contracting out – both of cleaning and other services – which suggests that outsourcing sets in train a set of impacts that are likely to damage teamworking and affect the quality of service provision.

These are systemic problems that arise from the nature of competitive tendering and contracting out of the cleaning service. Many of the recent initiatives by government are an acknowledgement of this and represent an attempt to overcome the limitations posed by contractual regimes.

A properly resourced, integrated, in-house cleaning service can make a real contribution to infection control because good quality cleaning is effective, achievable and is exceptionally good value for money.

Introduction

The debate about hospital infection control is essentially one about connections – those that are proven, those that are likely and those that are disputed. The relationships between the incidence of healthcare associated infections (HCAIs)[1] and a range of factors (including hand hygiene, environmental cleaning, antibiotic use, patient profile, hospital occupancy rates, patient mobility within hospitals) has generated a great deal of discussion among health professionals, in government circles, across several academic disciplines and throughout the media.

This report reviews some of the evidence for two sets of connections: that between environmental cleaning and HCAI incidence, and that between competitive tendering and contracting out and high quality cleaning. Drawing on government, parliamentary, academic and business literature and data as well as Freedom of Information requests, it updates a previous UNISON report on contract cleaning and infection control (Davies, 2005).

Before the breakthroughs in scientific understanding in the 19th century, fatal post-operative infection was common in British hospitals (Churchill, 1965). 'Ward fever' or 'hospitalism' was a notorious killer in the Crimean War until the reforms of military hospitals driven forward by Florence Nightingale. Further progress came with the widespread use of 'wonder drug' antibiotics (Bud, 2007) like penicillin from 1944 onwards which dramatically cut the rate of infections.

However, today we see the growth of strains of infection that are resistant to antibiotics and rising concern that we face the return of hospitals posing dangers to their patients. This is not just a problem in the UK: 'at any time over 1.4 million people worldwide are suffering from infections acquired in hospitals' (Pittet and Donaldson, 2006: 1246). Six years after the publication of Getting Ahead of the Curve - the Infectious Diseases Strategy for England (Chief Medical Officer, 2002), the secretary of state concedes: 'Healthcare associated infections still present us all with a great challenge' (Department of Health, 2008a: 1).

In part because of campaigns by UNISON, other unions, patients' organisations and the media, HCAIs and hospital cleaning are now taken seriously by ministers. Improving cleanliness and reducing HCAIs is listed as one of the government's priorities in the 2008-09 Operating Framework for the NHS in England (Department of Health, 2007a). Over the last six years, the government brought in a series of measures and initiatives, including the recent allocation of £57 million to fund a 'deep clean' of all hospitals in England which was supposed to be completed by the end of March 2008. NHS organisations were set a 2008 target of reducing the annual number of Meticillin-resistant Staphylococcus aureus (MRSA) bloodstream infections to less than half the number in 2003/04, and by 2011 a reduction of 30% nationally in C. difficile infections from 2007/08 (Department of Health, 2008a).

There has also been a shift in the government's tone in relation to the link between cleanliness and infection control. UNISON has neither claimed that a lack of cleanliness is

1 Defined as 'any infection by any infectious agent acquired as a consequence of a person's treatment by the NHS or which is acquired by a health care worker in the course of their NHS duties' (Department of Health, 2006a: 1).

the only factor behind the spread of infections nor that cleaning is the only solution. Nevertheless, it is important to recognise the key contribution that good quality cleaning can make to infection control. But as recently as 2004, with John Reid MP as secretary of state, the government was extremely reluctant to recognise any link, other than in the broadest sense (Department of Health, 2004a: 4). Today the government notes that healthcare associated infections and improving cleanliness in hospitals:

> **are often linked, and rightly so – cleanliness contributes to infection control, and a clean environment is the best platform from which to tackle HCAIs. Furthermore, clean environments are extremely important in their own right, and are central to patients receiving comfortable, reassuring and welcoming care.**
>
> *(Department of Health, 2008a: 3)*

Government-commissioned guidelines now note that there is:

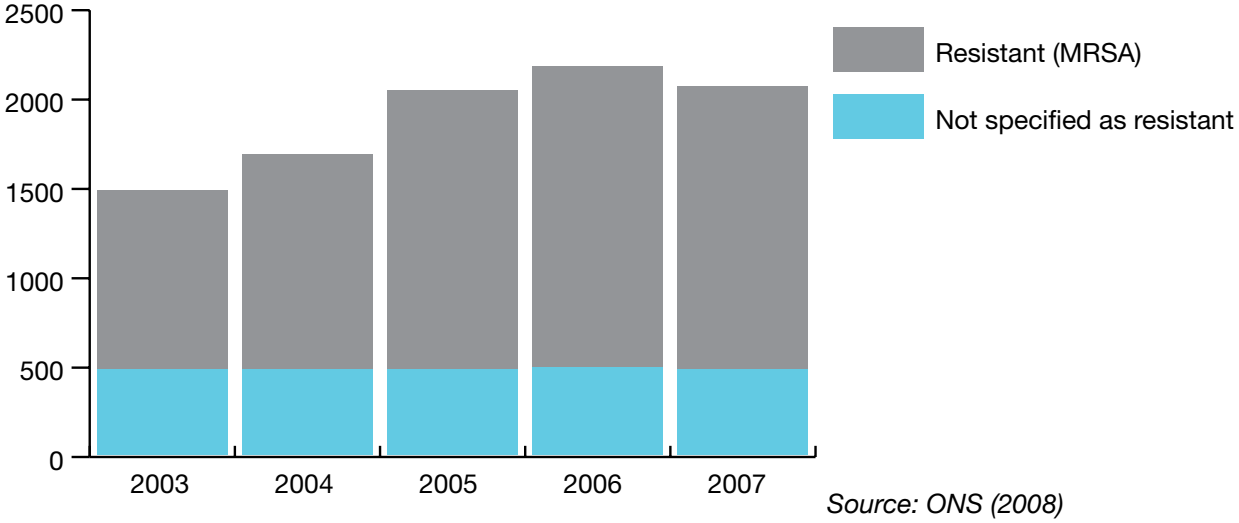
> **a body of clinical evidence, derived from case reports and outbreak investigations, which suggested an association between poor environmental hygiene and the transmission of microorganisms causing healthcare-associated infections in hospital.**
>
> *(Pratt et al, 2007: S13)*

UNISON's campaign has played a part in shifting the government's position.

The background

The UK 'has one of the highest rates of MRSA in the world' (The Lancet, 2005: 1203) and the number of death certificates in England and Wales mentioning MRSA (either as the underlying cause of death or a contributory factor) increased in every year from 1993, when records began, until 2007 when there was a slight decrease (ONS, 2008: 58). Deaths involving MRSA increased from 968 in 2003 to 1,652 in 2006 before falling to 1,593 in 2007 (ONS, 2008: 61).

Figure 1: Number of death certificates mentioning Staphylococcus aureus by meticillin resistance, 2003–07



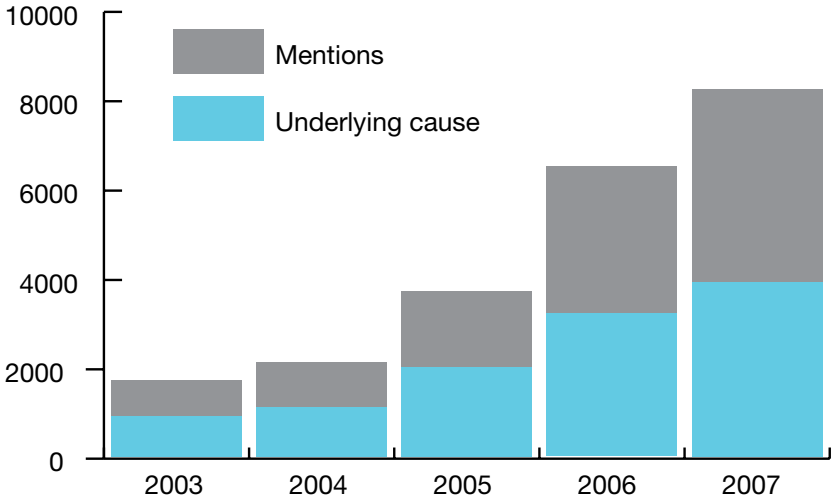
Source: ONS (2008)

At the time of writing, the latest data released by the Health Protection Agency (2008a) showed decreases in the number of reported MRSA bacteraemias in both the latest quarter and the financial year. In April to June 2008 there was a 14% decrease compared to the previous quarter (January to March 2008) and a 36% reduction compared to the corresponding quarter of 2007 (April to June). For the financial year 2007/08 there was a decrease in the rate from 1.67 to 1.16 cases per 10,000 bed days compared to financial year 2006/07. This represents a 30% decrease.

The figures for the other HCAI that has dominated the headlines – C.Difficile – show that the number of death certificates mentioning C.Difficile increased from 1,804 in 2003 to 8,324 in 2007. The number of certificates mentioning C.Difficile increased by 28% between 2006 and 2007 (ONS, 2008: 69-70).

Again, the Health Protection Agency (2008b) recently reported reductions in the latest quarter (April – June 2008) when compared to the previous quarter. For patients aged 65 years and over there was a reduction of 18% (a 38% and 41% reduction on the same quarters in 2007 and 2006, respectively) and for patients aged between two and 64 years of age there was a reduction of 7% (a 26% reduction on the same quarter in 2007).

Figure 2: Number of death certificates mentioning Clostridium difficile, by whether it was the underlying cause of death, 2003–07



Source: ONS (2008)

Although the problems relating to infection control in hospitals, and the spread of MRSA and C.Difficile in particular, are serious and have generated widespread public concern and media coverage (Washer and Joffe, 2006), the issue should be kept in perspective. As the then secretary of state explained, of the 12 million people admitted to hospital every year, there are fewer than two cases of MRSA bloodstream infection for every 10,000 hospital bed days (Hansard House of Commons, 2007a). However HCAIs are a growing problem and can result in patient discomfort, disability and sometimes death; distress to relatives; reputational damage to the NHS and loss of confidence among the public; as well as an increased financial burden on the health service and damage to the wider economy. In relation to the financial burden, it contributes to the soaring bill being paid out by the NHS in compensation cases – now running at £90 million a year in England (BBC, 2008a)[2]. From a different angle, a number of studies have shown that good quality cleaning and improved infection control is hugely cost effective with major potential savings (Rampling et al, 2001; Vonberg et al, 2008; Wilcox et al, 1996).

Before the widespread use of antibiotics in the 1940s, staphylococci accounted for most infections in hospitals. They were initially treated successfully with penicillin, which resulted in a dramatic fall in mortality from such infections. However, strains

2 A decrease in HCAIs would be likely to lead to reduced litigation and therefore reduced premiums for the Clinincal Negligence Scheme for Trusts (CNST). UCLH negotiated a cut of £75,000 in its annual CNST premium partly as a result of its impressive infection control programme. Across the whole of the NHS, reduced premiums could result in over £10m of annual savings (Department of Health, 2006b: 7)

of Staphylococcus aureus that were resistant to penicillin emerged in the 1950s, and in March 1960 a synthetic penicillin (Meticillin) was released to use to treat this. By the end of the decade, strains of Meticillin-resistant Staphylococcus aureus emerged and over the next 20 years spread throughout the world (Washer and Joffe, 2006).

In Britain, increases in MRSA rates coincided with a halving of the number of cleaners (BBC, 2005) and the impact of the introduction of competitive tendering and the contracting out of many hospital cleaning services to private sector providers. In their guidelines for preventing HCAIs (produced for the government) Pratt et al (2007: S13) point to the

> **perceived falling standards in the cleanliness of hospitals since the introduction of compulsory comprehensive tendering and the internal market.**

They note that this concern was addressed by the Infection Control Nurses Association (ICNA) and the Association of Domestic Managers (ADM) and resulted in the publication of new standards for hospital cleanliness by the Department of Health (ICNA and ADM, 1999; NHS Estates, 2000). This was followed by a series of regulations, advice and guidelines including the NHS Healthcare Cleaning Manual (NHS Estates, 2004) through to the Health Act 2006 Code of Practice (Department of Health, 2006a) as MRSA infection rates continued to climb and then gradually began to decline.

Patricia Hewitt MP (Hansard House of Commons, 2007a: col. 1303), then secretary of state told the Commons that:

> **from 1993 to 1996 MRSA rates were doubling, or nearly doubling, every year - an exponential growth in MRSA rates.**

In the same debate, Andy Burnham MP, then a health minister, reported that MRSA levels rose in every year between 1990 and 2004 and that 'between 1990 and 1997, MRSA increased by 3,332.4% in our national health service' (Hansard House of Commons, 2007a: col. 1342). The current Conservative shadow for health, Andrew Lansley MP concedes that the number of deaths associated with MRSA was just 49 in 1993, but 'began to rise sharply in 1995 and 1996, as the trend line shows. I do not dispute that' (Hansard House of Commons, 2007a: col. 1295).

Public concern about healthcare associated infections is reflected in media coverage, opinion polling and the public pronouncements of the main political parties. In the run-up to the general election of 2005, the manifestos of all three main parties made commitments to resolving the problem of HCAIs (Anseau et al, 2005). Just after the election, the British Medical Association (BMA) commissioned a YouGov Omnibus poll, in which members of the public were asked to prioritise where government NHS funding should be directed. 'Cleaner hospitals' came top out of a list of 10 options (British Medical Association, 2005).

How clean is clean?

The government claims that there is no direct relationship between contract cleaning and either the standard of cleanliness or the incidence of MRSA. However, it may be that the government is asking the wrong questions. What exactly constitutes 'clean', rather than just tidy is a key issue. As Collins (1988: 53) points out, cleaning has a dual role: non-microbiological, to sustain, improve or restore appearance; and microbiological, to assist infection control by reducing the presence of microbes and removing substances which support their growth: 'This dual role can cause some confusion when attempting to measure cleaning efficiency.' The following section reviews some of the evidence in relation to the measurement of cleanliness and its relationship with the incidence of infection.

The higher priority given to environmental cleanliness and decontamination in recent years is reflected in the publication of a series of resources (Department of Health, 2008c: 20) to help trusts. These include:

- guidance on contracting
- a matron's charter
- national specifications for cleanliness
- PL CNO(2007)6: Improving Cleanliness and Infection Control
- HFN 30 – Infection Control in the Built Environment.

In 2004 the government published Standards for Better Health (Department of Health, 2004c) which set out a series of standards for a new performance framework for the NHS in England. Several of these referred specifically to cleanliness and infection control. Core standard C4 requires trusts to keep patients, staff and visitors safe by having systems to ensure that:

- C4a) the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA
- C4c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed (Department of Health, 2004c: 10).

Core standard C21 requires that

> **healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises (Department of Health, 2004c: 16)**

The 2006 Health Act introduced a statutory duty on trusts to observe a Code of Practice for the Prevention and Control of Healthcare Associated Infection - the 'Hygiene Code' (Department of Health, 2006a), requiring them to 'to provide and maintain a clean and appropriate environment for healthcare' (Department of Health, 2006a: 5).

The standards will be replaced from April 2009 with the provisions of the Health and Social Care Act 2008. Under the Act, NHS bodies will be legally obliged to register with the Care Quality Commission and, 'as a legal requirement of their registration, must protect patients, workers and others who may be at risk, from

identifiable risks of acquiring an HCAI' (Department of Health, 2008b: 26). The Act's draft regulations set out that healthcare providers are required to:

> **ensure that patients, health care workers and others who may be at risk of acquiring a health care associated infection, are protected against identifiable risks of acquiring such an infection by means of —**
>
> **(a) the effective operation of systems designed to assess the risk of, prevent, detect, treat and control the spread of such an infection**
>
> **(b) the maintenance of appropriate standards of design, cleanliness and hygiene in relation to —**
>
> **(i) premises occupied for the purpose of carrying on a regulated activity; and**
>
> **(ii) equipment used in those premises.**

These will be judged against a set of published criteria (Department of Health, 2008b).

As well as new standards and legislation, more money is being spent: spending on cleaning in the NHS increased by £60m in real terms between 2000-01 and 2004-05. £481m was spent in 2000-01 and £542m is estimated to have been spent in 2004-05 (at 2004-05 prices) (Department of Health, 2006b). The need for additional investment in cleaning is underlined by evidence highlighting that the hospital environment can become contaminated with micro-organisms responsible for HCAI which can then contaminate healthcare staff's hands (for example, Halcomb et al, 2008; Barker et al, 2004; Bhalla et al, 2004; Boyce et al, 1997; Denton et al, 2004; French et al, 2004; Griffiths et al, 2002; Wilcox et al, 2003). As Dancer (2008: 104) notes:

> **Since there is plenty of evidence to show that MRSA can be found throughout the general environment, it is hardly surprising that it is also found on more tangible objects within clinical areas.**

The HCAI Guidelines for England (Pratt et al, 2007: S14) review the research evidence and report that MRSA (and other pathogens) have been recovered from all sorts of surfaces within hospitals, including door handles, computer keyboards, soap dispensers, sink taps and sites where dust is allowed to accumulate.

A recent systematic review of research literature on MRSA reservoirs in acute hospitals (Halcomb et al, 2008) concluded that MRSA strains within the environment often match those found in patients within that environment and there is a relationship between the environment and hospital equipment and the transmission of MRSA within the acute hospital setting. They point out that although the research suggests that there is often a link between MRSA found in the atmosphere and environment surfaces and that colonising and infecting patients in the clinical area, it is not clear which came first – the contamination of the environment or the colonisation/infection of the patient.

Nevertheless this connection provides evidence for the transmission of MRSA between patients and their environment. Furthermore they also noted that unless cleaning is of a high quality, uses the optimal methods, materials and equipment and appropriate frequency, it will not remove MRSA. In such circumstances MRSA can be picked up by staff on their hands, uniforms, gowns and gloves from the contaminated environment and passed on to other patients. The potential for

contamination of the hands or gloves of healthcare workers through touching contaminated environmental surfaces and consequent transmission of healthcare-associated pathogens to patients (or the direct contamination of patients from contaminated environmental surfaces) is not limited to MRSA but also applies to other pathogens including VRE and C. difficile (Boyce, 2007).

And such contamination can be easily repeatedly spread by hand. In a study of the impact of cleaning on Norovirus (NV) contamination - a major cause of gastroenteritis - Barker et al (2004: 46) found that 'contaminated fingers could sequentially transfer virus to up to seven clean surfaces'.

The conclusions of Halcomb et al (2008) concur with the views of Al-Hamad and Maxwell (2008: 4) who accept that there is (as yet) 'no direct proof that the environment acts as a secondary reservoir for the infection of patients with multidrug-resistant bacteria in epidemics or endemic situations', but point to the growing evidence (Boyce et al, 1997; Talon, 1999) that the environment of patients serves as a potential reservoir for cross-transmission and hence possible infection.

Just as there is evidence of environmental contamination, so too is there evidence – both in the UK and abroad - of improved cleaning being a key part of controlling outbreaks of HCAI (for example, Apisarnthanarak et al, 2008; Enoch et al, 2008; Biant, 2004; Denton et al, 2004; Roberts et al, 2001; de Lassence et al, 2006). In their study of an outbreak of an epidemic strain of MRSA, Rampling and colleagues (2001) linked the control of the outbreak to increased cleaning hours and an emphasis on the removal of dust. Similarly, Barker et al (2004: 48) found that

> **the key elements in the control of NV are a combination of decontamination of the environment (particularly contact surfaces) and implementation of a thorough handwashing technique. Handwashing alone is unlikely to be effective if recontamination occurs via environmental fomites[3].**

They did note however, that the right type of cleaning is also vitally important and recommended a combination of use of detergent and disinfectant, pointing out that detergent-based cleaning without adequate disinfection could actually increase the risk of infection transmission rather than reduce it. Others (eg Jeanes et al, 2005) have emphasised the need to deploy different forms of cleaning procedure in different circumstances. The investigation into the Stoke Mandeville outbreak of C. difficile (which resulted in the deaths of many patients[4]) concluded that

> **inadequate cleaning was the main factor that facilitated spread of the infection, since there was contamination of the ward by spores from infected patients.**
>
> *(Healthcare Commission, 2006: 78)*

3 A formite is a surface capable of carrying infectious organisms

4 There were two hospital-wide outbreaks of C.difficile: the first between October 2003 and June 2004 and the second between October 2004 and June 2005. In the first outbreak there were 174 cases and 19 deaths 'that were definitely or probably due to C. difficile', of which 16 almost certainly acquired the infection at Stoke Mandeville Hospital. In the second outbreak, there were 160 new cases and 19 further deaths that were definitely or probably due to C. difficile. Of these, 17 almost certainly acquired the infection in Stoke Mandeville Hospital (Healthcare Commission, 2006: 4).

Bhalla et al (2004: 166) highlighted the importance of environmental surfaces in several ways in terms of infection control (and by extension, also the importance of high quality cleaning):

- organisms such as VRE, MRSA, and C. difficile are able to survive for long periods on surfaces
- without routine surveillance, many patients colonized with important pathogens will not be identified and therefore will not be placed in isolation and thus are likely to contaminate the environment around them
- even with active surveillance, some colonized patients may not be identified or their identification may be delayed, and again are likely to contaminate their immediate environment.

A systematic review of interventions used to prevent and control MRSA (Loveday et al, 2006: S68) concluded that:

> **The effectiveness of environmental cleaning is an important factor in strategies to prevent the nosocomial transmission of MRSA.**

Baird (2006: 338) emphasised the importance of the fact that this was 'the only unequivocal conclusion' in the strategic review of interventions.

The government appears to accept a link between the spread of C. difficile and cleanliness but remains sceptical about a similar link for MRSA. The Healthcare Commission's investigation of the Stoke Mandeville C. difficile outbreaks (in which 38 people died) reported that

> **…we found significant relationships between scores from the PEAT inspection findings and CDAD [Clostridium difficile associated disease] infection rates. Better PEAT overall environment, specific cleanliness and toilet and bathroom cleanliness scores were associated with improved CDAD outcome measures for 2005 and 2006. A better PEAT general cleanliness score was associated with improved CDAD outcome measures for 2006.**
>
> *(Healthcare Commission, 2007: 66)*

Consequently, the investigation found that one of the key lessons for the NHS is that

> **hospitals need to be meticulous about cleanliness, hygiene and good practice in the control of infection.**
>
> *(Healthcare Commission, 2006: 89)*

More generally, the Department of Health claims that

> **…the standard of cleanliness in trusts has dramatically improved as measured by the cleanliness scores in the Patient Environment Action Teams (PEAT) monitoring system. In Autumn 2000, just over 20% of NHS trusts achieved a good standard of cleanliness in PEAT reports. By summer 2003 this had risen to just under 80%. In 2004, a revised scoring system was introduced and the two years of data available under this revised system shows continuous improvement, with an increase from 63% to 66% of trusts showing a good to excellent rating (Department of Health, 2006b: 10)**

The problem is that there are serious weaknesses with using the PEAT scores as a measure of cleanliness for either general statements about progress throughout the NHS or for analysis in specific outbreaks. The PEAT assessments rely on visual assessment, as do many of the other measures and standards in use. As Dancer remarks (2008: 101), these

may address the aesthetic demands from patients and their relatives about the superficial appearance of hospitals, but they are based on visual assessment and fail to recognise that microorganisms, including human pathogens, are invisible to the naked eye.

Reliance on visual assessment is likely to be misleading, overestimating the cleanliness of a hospital unit and therefore potentially undermining infection control strategies. Using it as a measure of cleanliness also invalidates any serious attempt to understand the relationship of cleanliness to the incidence of HCAI or to the type of cleaning provision. For example, the Healthcare Commission (2007) reports that its investigation into the Stoke Mandeville outbreak found that, although there was a significant correlation between PEAT scores for cleanliness and the incidence of CDAD, the association between PEAT scores and different rates of MRSA was much more uncertain. They note that this complements the findings of Green et al (2006). Perhaps not surprisingly – given its reliance on visual assessment – Green et al (2006: 185) found 'it was not possible to demonstrate a consistent relationship between hospital cleanliness, as measured by PEAT scores, and the incidence of MRSA bacteraemia'. The authors concede that

PEAT scores may not provide an accurate reflection of hospital environmental hygiene… PEAT scores can be criticised as being too subjective, and there is no evidence that they reflect microbiological cleanliness. Also, PEAT scores are only assigned once a year and thus may provide a poor reflection of hospital cleanliness for large parts of each year.

(Green et al, 2006: 186)

Despite this rather damaging admission, they then go on to assert:

The authors believe, and the data support this belief, that there is no direct link between hospital environmental cleanliness measured by PEAT scores and the risk of MRSA bacteraemia… A high standard of hospital cleanliness is certainly a goal worth achieving. However, it is not helpful for trusts, and specifically infection control teams, to repeatedly link MRSA control measures with improvements in cleanliness standards.

(Green et al, 2006: 186)

Given that any merit in the case rests entirely on whether or not PEAT scores are a reliable measure of cleanliness (and they admit there is no evidence that they reflect microbiological cleanliness), it was perhaps inevitable that this position would face severe criticism. Griffith (2007) demolishes the case made by Green et al by simply illustrating the glaring weaknesses of relying on the PEAT scores:

- the PEAT scores cover a much wider area than just cleanliness, incorporating access, safety and security, food, privacy and dignity
- the cleanliness section of the PEAT scores are unreliable as they are based on visual assessment, which is highly subjective.

As Griffith points out, it is perfectly possible for a surface to look clean while being microbiologically contaminated and as he says, surface contamination rates 'are central to any debate to prove or disprove a link between environmental cleanliness and infection rates' (Griffith, 2007: 276). Malik et al (2003: 182) observed:

Cleaning is a term that can be used and interpreted differently. Visibly clean surfaces are free

from obvious visual soil, but chemically clean surfaces are free from organic or inorganic residues, whereas microbiologically clean surfaces have a microbial load at an acceptable level.

Malik and colleagues (2003) conducted a study of the effectiveness of cleaning in two wards in four UK hospitals in which surface cleanliness was determined by three methods (visual, ATP bioluminescence, and microbiologic sampling) immediately after cleaning was done. The study showed that

…90% of ward sites were assessed as visually clean but 100% were considered as unacceptably clean with use of ATP bioluminescence and 90% were considered as unacceptably clean with use of microbiologic techniques.

(Malik et al, 2003: 184-185).

Others have expressed concern about the use of visual assessment to determine cleanliness or have shown the lack of correlation between it and microbiological surface counts, instead suggesting a new approach based on the experience of the food industry using ATP bioluminescence and microbiological analysis where necessary with visual assessment as a useful first stage of an integrated assessment strategy (Cooper et al, 2006; Dancer, 2004; Dancer et al, 2006; Griffith, 2006; Griffith et al, 2000; Lewis et al, 2006; Lipscomb et al, 2008; Malik et al, 2003).

Contracting out – an infection in the NHS

The second key connection is that between competitive tendering and the contracting out of hospital cleaning services and the quality of cleaning (and by extension with infection control). In 2005 the Commons Public Accounts Committee (2005: 16) noted:

> **The standard of cleanliness in hospitals remains a concern, with infection control teams, orthopaedic and vascular clinicians and patients reporting that cleanliness could be improved. Contracting out of cleaning appears to have made it more difficult for ward managers and matrons to control.**

Committee members asked the Department of Health whether there is a correlation between the contracting out of cleaning services and the number of deaths where MRSA is a contributory factor (2005: Ev 14). In response, the Department replied (Department of Health, 2004b, in House of Commons Public Accounts Committee, 2005: Ev 34-35) that data on MRSA-related deaths are unreliable at trust level, and that attributing deaths to MRSA is problematic. Instead, the Department believes that the incidence of MRSA bacteraemias (blood borne MRSA infections) is likely to be the best available proxy measure for variation between trusts in the number of deaths associated with MRSA. Analysis of this trust level data by the Department suggests that

> **there is no significant simple correlation (either positive or negative) between whether or not cleaning has been contracted out and the MRSA incidence rate (ibid)**

The Department reported that the question has been examined using a range of other control variables relating to the characteristics, operational performance, policy and casemix of the hospital and that 'tentative preliminary results from this ongoing work suggest that, after controlling for these other observable factors, there is no statistically significant relationship between the contracting out of cleaning services and the incidence of MRSA at trust level' (ibid). A similar answer was provided by Ivan Lewis MP, then a health minister in a Parliamentary Answer (Hansard House of Commons, 2007b: col. 967W). Later that year, the Department returned to the issue, reporting that there was no consistent relationship between the use of contract cleaners and MRSA rates (Department of Health, 2007b: 25).

Others are unconvinced. The Infection Control Nurses' Association and the Health Protection Agency noted that hospital cleanliness 'had not been helped by over-reliance on poorly paid contract cleaners with no allegiance to the NHS' (Health Service Journal, 2003, cited in Pollock, 2004: 49). Perhaps more significantly, the Healthcare Commission's review of facilities management services in acute hospitals (Healthcare Commission, 2005a) found widespread concerns about contract cleaning. Although outsourced cleaning services were 4% cheaper on average than services provided in-house, ward managers in every region, except Trent, considered outsourced cleaning services to be of poorer quality compared with in-house services.

The review compared trusts operating under the Private Finance Initiative (PFI) with trusts using in-house services and conventional outsourcing. Given the increased reliance on PFI for both new build

hospitals and the services within, this was of particular interest. The data gathered showed that PFI cleaning services provided no clear cost advantages over non-PFI cleaning services. In addition ward managers considered PFI cleaning services to be of a lower overall standard than non-PFI cleaning services, and staff employed by a PFI service to have poorer knowledge of hospital cleaning than those working for non-PFI services. Just four of the 23 PFI hospitals in the survey were rated above average in terms of their standard of cleaning compared with all hospitals in England and Wales. Given these results, the Healthcare Commission (2005a: 18) recommended that:

> **Facilities management departments in PFI hospitals also need to review their cleaning services urgently…**

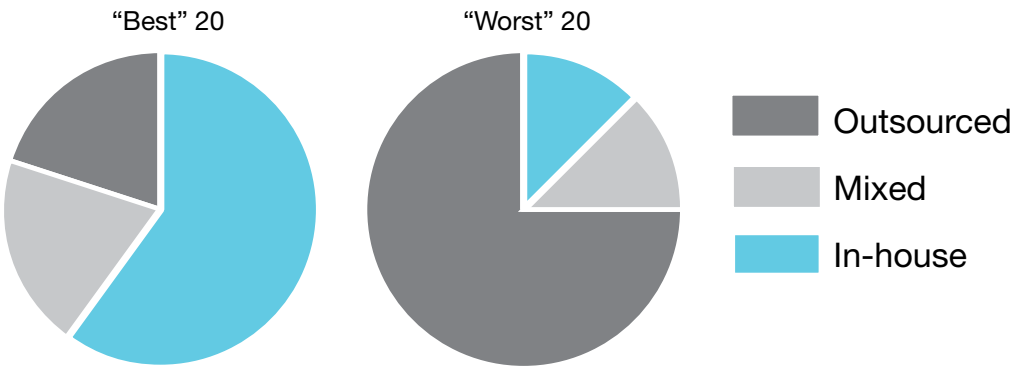
Two earlier pieces of research from 2001 also provide important data on the performance of contract cleaners. Although the data is a few years old, it is worth examining for two reasons: first until publication in this report it was not widely available; and second, it shows that the government has had indications of a problem with contract cleaning for several years – even while claiming that there was no link between contracting and poor quality cleaning. The first study was part of a wider internal NHS Estates discussion paper about hospital cleanliness (Department of Health, 2008d) and the second, a research project carried out by the Institute of Healthcare Management for NHS Estates (2001). The internal NHS Estates paper looked at the 20 'best' and the 20 'worst' trusts for cleanliness (from the National Inpatient Survey). The results are shown below in tabular and diagrammatic form.

Table 1: Service types of 'best' and 'worst' trusts for cleanliness (2001)

	"best" 20		"worst" 20	
Service type	No	%	No	%
In-house	13	65	2	10
Mixed	3	15	3	15
Outsourced	4	20	15	75

Source: Department of Health (2008d) Extract from NHS Estates Agency Internal Discussion Document 2001

Figure 3: Service types of 'best' and 'worst' trusts for cleanliness (2001)



Source: Department of Health (2008d) Extract from NHS Estates Agency Internal Discussion Document 2001

The paper very clearly shows the preponderance of outsourced providers in the 'worst' category and that of in-house providers in the 'best' category. The paper offers a series of possible explanations for this ranging from poor contract management by the NHS trust, to trusts attempting to offload an already existing problem, or contractors bidding too low in order to win the bid and then being unable to deliver at that price. The Department now describes the paper as a 'crude analysis' with statistical and analytical limitations (Department of Health, 2008d).

The aim of the Institute of Healthcare Management research was to:

> **produce evidence based understanding of the factors most closely associated with high standards of cleanliness and a quality ward environment in NHS hospitals.**
>
> *(Institute of Healthcare Management, 2001: 4)*

It compared those hospitals designated as 'exemplar' with those requiring special measures (RSM) by the NHS Estates Patient Environment Action Team process. Five of the seven exemplar hospitals and six of the ten RSMs were interviewed. Again the findings were stark:

> **The most striking difference between the exemplar and RSM sites lay in the chosen method for delivering domestic services. In all but one of the RSM sites, domestic services, along with other elements of facilities management and in some cases also estates, has been contracted out and are delivered by a private sector company. By contrast in all but one of the exemplar sites, domestic services are directly provided by staff employed and managed by the trust.**
>
> *(Institute of Healthcare Management, 2001: 7)*

The report noted that

> **Clean hospitals are more likely where domestic services are provided in-house by staff employed by the trust who are integrated and genuinely feel part of ward teams. Consequently, the cost of domestic services in terms of staff cost per m2 is likely to be higher in clean hospitals.**
>
> *(Institute of Healthcare Management, 2001: 20)*

Perhaps not surprisingly given its findings, the Department now also implies reservations about this report saying that it can 'best be summarised as an exploratory analysis using qualitative methods' (Department of Health, 2008d).

The Health Act 2006 Code of Practice (Department of Health, 2006a) came into effect in October 2006 and every NHS trust in England is now required to have proper systems in place to deliver effective infection control. If the Healthcare Commission believes that a trust has failed to take action to resolve infection control problems, it is able to issue an improvement notice requiring such improvements within a stipulated time.

In an interview with the Guardian (Carvel, 2008) Barbara Young, the head of the new Care Quality Commission (CQC), said the Healthcare Commission is about one-third of the way through its hygiene inspection programme, examining every acute hospital in England. At the time of writing, four were judged to be of such a low standard as to merit an improvement notice. The four were: Bromley Hospitals, Kent; Barnet and Chase Farm, north London; Ashford and St Peter's Hospitals, Middlesex and Surrey; and Ipswich Hospital, Suffolk. The interesting point about this is that three of the four have contracted out cleaning.

The inspections go much wider than cleaning standards: the hygiene code sets out 11 mandatory duties for NHS trusts to reduce and control healthcare-associated infections. Nevertheless, it will be of interest to see if there remains a preponderance of contract cleaning among others issued with improvement notices.

Table 2: Contract cleaning and improvement notices

Trust	Responsibility for cleaning	Date of Improvement Notice
Ashford and St Peter's Hospitals, Middlesex and Surrey	In-house, formerly Medirest	June 08
Bromley Hospitals, Kent	ISS	Jan 08
Ipswich Hospital, Suffolk	OCS	Feb 08
Barnet and Chase Farm, north London	Medirest and Ecovert	July 07

Source: Healthcare Commission

A tougher regime will come into being from April 2009. NHS bodies will be legally obliged to register with the Care Quality Commission under the Health and Social Care Act 2008 and, 'as a legal requirement of their registration, must protect patients, workers and others who may be at risk, from identifiable risks of acquiring an HCAI' (Department of Health, 2008b: 26). There will be a potential sanction of withdrawal of licences from hospitals that fail to meet their obligations.

While there may not be any clearcut evidence as yet that reveals a direct correlation between contracting out and competitive tendering with the incidence of HCAI, there is evidence that points in that direction. There is also a great deal of research on the experience of contracting out – both of cleaning and other services – which suggests that outsourcing sets in train a set of impacts that are likely to damage teamworking and affect the quality of service provision.

Part of the reason for the lack of hard data on connections is that cleaning itself has not been afforded scientific status (Dancer, 2008). The measurement of cleanliness is itself a contested area (as outlined in the previous section). But even if it was uncontroversial, it is difficult to isolate and measure the effectiveness of cleaning in preventing and controlling the incidence of HCAI, as infection control consists of a variety of different measures and policies running and applied concurrently (Healthcare Commission, 2005b). Finally, government may be asking the wrong questions. We need to understand the relationship between quality of cleaning service and a tendering regime that focuses on price – regardless of whether or not the service is eventually outsourced. The next two sections review some of the issues within the debate about competitive tendering, contracting out and hospital cleaning services.

Why are we still contracting out cleaning services in hospitals?

When the Conservatives first forced the contracting out of hospital cleaning (Department of Health and Social Security, 1983a; 1983b) they argued that it was cheaper and a more efficient use of resources. By ending in-house cleaning, they asserted that a redirection of funding would actually provide additional funds for patient care. Their 1983 manifesto proclaimed:

> **To release more money for looking after patients, we will reduce the costs of administering the Health Service. We are asking health authorities to make the maximum possible savings by putting services like laundry, catering and hospital cleaning out to competitive tender. We are tightening up, too, on management costs, and getting much firmer control of staff numbers**
>
> *(Conservative Party, 1983)*

Ironically, these days it is often the contractors or their representatives that berate Hospital Trusts for trying to get cleaning on the cheap. Norman Rose, then of the contractors' lobby group, the Business Services Association complained that

> **…in almost all contract renewals over the past two years, Trusts have requested that contractors do not quote on the basis of the 2004 Cleaning Standards as they cannot afford it… Does quality go out of the window, sacrificed on the altar of cost cutting?**
>
> *(Cleanzine, 2007)*

Unfortunately that is exactly what has happened with contract cleaning and the system of tendering. As the former Conservative Cabinet Minister, Michael Forsyth, conceded in a House of Lords debate:

> **…is it not obvious that competitive tendering for the cleaning of hospital services has been used exclusively to drive down costs and not improve quality?**
>
> *(Hansard, House of Lords, 2007)*

Despite widespread public disquiet in recent years over the perceived shortcomings in the quality of service provided by private sector contract cleaning companies, cleaning continues to be outsourced in many hospitals – particularly in England. Figures obtained from the Department of Health (2008e) (see Table 3 left) are incomplete but provide some indication of the large amounts of public money that continue to be spent on contract cleaning.

Table 3: Annual totals for the spend on outsourced domestic services 2002/03 – 2006/07

Year	Total Value £	Coverage (designation of data collection)
2002/03	160,505,785	Mandatory for all trusts
2003/04	188,009,294	Mandatory for all trusts
2004/05	115,136,152	Voluntary for all trusts
2005/06	92,667,181	Voluntary for all trusts
2006/07	174,531,317	Mandatory for all trusts except foundation trusts

Source: Department of Health (2008e) response to FoI request, 11 September 2008

NB: Data provided annually to the Department by the NHS via the Estates Returns Information Collection system (ERIC) on the outsourcing of estates & facilities related contracts for domestic services. As is clear from the table, the data is incomplete. In addition, the data has not been verified or amended centrally and its accuracy is therefore the responsibility of the individual organisation.

Data on the companies involved is also incomplete. However, even with this caveat, it is possible to see the dominance of a small group of companies from the data provided by the Department of Health (2008e). Just four firms have almost half of the contracts. Just two have almost a third. This is especially noteworthy as the total number of providers listed by the 122 trusts that responded to the ERIC returns is over 75.

Table 4: Leading contract cleaning companies 2006/07

Company	Number of contracts	% (n=178)
ISS	29	16.4
Initial	27	15.3
Medirest	14	8.0
Sodexho	10	5.6
Mitie	7	4.0
Carillion	6	3.4
OCS	5	2.8
Cannon Hygiene	3	1.7

Source: Department of Health (2008e) response to Freedom of Information request, 11 September 2008. 122 trusts reported the use of external providers in 177 cases (some trusts used different providers for different sites).

NB: The table reproduces data provided annually by the NHS via the Estates Returns Information Collection system (ERIC), on the outsourcing of estates & facilities related contracts for domestic services. The provision of this data is mandatory for NHS trusts but not for foundation trusts for whom it was voluntary. It is therefore unlikely to be complete. It lists those trusts that have reported that some element of the provision of domestic services has been outsourced and details the provider as identified by the trust. This data has not been verified or amended centrally, and its accuracy is therefore the responsibility of the individual organisation

Even health ministers have expressed concern about contracting out. In an interview with the Health Service Journal (Donnelly, 2007), then health minister, Andy Burnham MP said that he was struck by 'the distance between hospital cleaners and the rest of the NHS family', with potential problems for trusts to 'find the levers' to combat hospital infections. He accepted that it is difficult for trusts to be accountable for cleanliness if they do not have direct control of cleaning and commented that he would report to the Prime Minister that:

> **…we should be encouraging trusts to consider bringing their services back in-house. We won't be telling them that's what they have to do, but we will be encouraging them to look again at this, and to consider the whole picture.**
>
> *(Donnelly, 2007)*

In 2008 in discussions with the trade unions, led by UNISON, the Labour Party agreed to make it easier to terminate unsatisfactory contracted out cleaning services and committed the government to

> **maintaining and developing a central role for public provision and a directly employed workforce.**
>
> *(Evans, 2008)*

However, the UK government has stopped short of a full-scale move to bring NHS cleaning back in-house in England. Elsewhere the response has been different. In February 2007 in the run up to the 2007 election, the Welsh Assembly Government announced that trusts would not be obliged to go to tender again for cleaning services and this commitment has continued under the current coalition government (there are some obstacles to fully meeting this objective due to the

impact of existing long term Private Finance Initiative (PFI) contracts). Welsh Health Minister, Brian Gibbons said:

> **The Labour Assembly Government has acted to encourage health trusts to employ their own cleaning staff, so that cleaners working in our hospitals are employed by the NHS, not an outside agency.**
>
> **Wales already leads the UK in clean hospitals, with the lowest rates of MRSA. This is due to the professionalism and dedication of our NHS staff. Welsh Labour will not rest on its record and is committed to taking the next steps in eradicating hospital infections, protecting patients being treated in Welsh hospitals.**
>
> **After the next election, Welsh Labour wants all cleaners in every hospital in Wales to be employees of the NHS. Our cleaners provide a hugely important role in our public services. They work hard to make our hospitals fit for patients, staff and visitors. I see our cleaners as an important part of clinical teams across Wales. It is right that they should receive the same working terms and conditions as doctors and nurses.**
>
> *(Shipton, 2007)*

The Scottish Government has made a similar decision. Following the report into the outbreak of C.Difficile in the Vale of Leven hospital (which led to the deaths of 18 patients) Scotland's health secretary, Nicola Sturgeon called for the end of hospital contract cleaning:

> **I am keen to see the phasing out of existing contract cleaning in hospitals and I would want to see no more in the future, with cleaning kept in-house.**
>
> *(Foster, 2008)*

Accordingly, in October 2008 the Scottish Government issued guidance announcing that

> **all cleaning, catering and clinically related soft facilities management services in NHS Scotland clinical premises are to be exempt from contracting out in future schemes whether funded through Public Private Partnerships (PPPs) or not.**
>
> *(Health Finance Directorate, Scottish Government, 2008)*

At the 2008 Partnership in Power meeting in Warwick between affiliated trade unions and the Labour Party, the agreed health policy document carried the statement that:

> **The public must be able to trust the NHS to keep them safe from healthcare acquired infections such as MRSA and C. Difficile. And the cleanliness of hospitals is a key factor in whether patients have a positive or negative experience of using the NHS. All hospitals have a duty to employ enough cleaners to deliver the hygiene standards the public rightly demands and expects.**
>
> *(Labour Party, 2008: 20)*

There was even recognition that hospitals 'must give full consideration' to in-house options for cleaning in order to maintain and develop 'critical public sector capacity in the management of cleaning and hospital hygiene' (Labour Party, 2008: 21). But giving 'full consideration' to in-house options does not maintain and develop public sector capacity. In fact it is perfectly possible to adhere to the terms of this statement and still contract out the service. In any event, this is a long way from the necessary commitment to direct control of high quality in-house provision.

What about the workers? (and why it matters)

Cleaners are 'invisible workers' (Messing, 1998), noticed only when things go wrong or when their work is perceived to be below the standard expected. But in a hospital environment they are, or should be, a key part of the health care team. Contracting out the cleaning function undermines that in a number of different ways (identified in previous UNISON publications, for example Davies, 2005, and additional evidence for which is provided below). At the root of the problem is that the market approach poisons the values and norms that are the basis of the NHS public sector ethos. It replaces public service with private gain, introduces personal accountability instead of collegiate responsibility and discretionary, individual remuneration in place of uniform and transparent pay and promotion structures (Hebson, Grimshaw and Marchington, 2003).

There are a series of negative connections between low status, low pay, poor conditions and poor quality service that, although sometimes also present with in-house provision, are demonstrably more common if the service is provided by contract cleaners.

Low status

The low status of cleaners within hospitals is related to the low status of cleaning itself, and both have undoubtedly eased the path to the contracting out of cleaning services, and contributed to the present problems relating to HCAIs. In a study of Quebec hospitals, Messing (1998: 180) identified a hierarchy of status topped by personnel who cure (doctors and their assistants, who may be nurses or technicians), followed by personnel who care and heal (nurses, therapists, and attendants), and finally personnel responsible for hygiene (cleaners, sterilizers, and launderers) and for health maintenance (food services) at the bottom. She argues that the 'invisibility' and low status of cleaners is linked to: the perception of cleaning as peripheral to the mission of hospitals; the fact that it is overwhelmingly performed by working class women; and that it is even rated low in the hierarchy of women's tasks within a hospital (nursing being of much higher status) (Messing, 1998: 180).

Grimshaw and Rubery (2007: 58) noted that for cleaning contractors generally across the economy,

> **…reliance on a primarily female workforce may be related to undervaluation of the whole activity. In some cases, the opportunity to link pay to a disadvantaged group and thereby keep wage costs at a low average level may be associated with the formation of a separate sector.**

Thus a general problem may have additional factors specific to the hospital sector.

Low numbers

Hotel, property and estates staff account for 31% of all NHS infrastructure support staff. They include cleaners, laundry, catering and maintenance staff (others in the infrastructure category include senior managers, managers, HR, finance and IT staff). Since the Conservative push on contracting

out began in earnest in 1983, there has been a steady decline in the numbers of staff employed in this category of NHS staff. Figures issued by UNISON in 2005 suggested that there was a decline in the number of cleaners from 100,000 in 1984 to 55,000 in 2003-04. A spokesman for the secretary of state for health did not dispute the figures but pointed out that in 1986 there were 88,000 cleaners, and that the size of the NHS estate had shrunk since then (Revill, 2005).

Table 5: NHS hospital and community health services: NHS staff in the Hotel, property and estates area of work by level (as at 30 September each specified year) – Full time equivalent and head count

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total											
FTE	61,898	59,197	57,759	55,768	55,989	56,381	57,429	58,756	60,369	56,931	57,072
HC	80,174	76,981	75,209	72,809	72,898	73,306	74,365	76,132	77,640	72,768	73,089
Senior Manager											
FTE	395	462	487	469	445	463	454	427	421	428	389
HC	397	465	492	474	451	470	462	435	428	434	399
Manager											
FTE	1,943	1,812	1,769	1,469	1,508	1,536	1,652	1,736	1,747	1,529	1,552
HC	1,974	1,840	1,795	1,486	1,527	1,562	1,673	1,765	1,781	1,558	1,588
Clerical & administrative											
FTE	9,454	8,833	8,551	7,375	7,579	7,468	7,709	7,655	7,599	6,246	5,960
HC	10,782	10,025	9,630	8,341	8,516	8,392	8,688	8,627	8,553	7,107	6,831
Estates (maintenance & works)											
FTE	12,957	12,358	11,975	11,687	11,354	11,372	11,040	10,932	10,533	10,148	9,794
HC	13,231	12,717	12,313	12,050	11,674	11,694	11,456	11,324	10,954	10,556	10,194
Healthcare asst											
FTE	207	226	258	286	285	243	212	273	212	181	200
HC	286	308	389	431	426	355	300	391	291	244	271
Support worker											
FTE	36,943	35,506	34,718	34,481	34,818	35,299	36,362	37,734	39,857	38,400	39,178
HC	53,504	51,626	50,590	50,027	50,304	50,833	51,786	53,590	55,633	52,869	53,806

Source: NHS Information Centre (2008a).
NB the staffing figures do not include cleaner who work for non-NHS contractors

This decline has broadly continued under the Labour governments since 1997. Although there was an increase in every year between 2002 and 2005, the figures for full time equivalent and headcount are now both in decline again with the 2007 figures below those for 1997 (NHS Information Centre, 2008a). Despite the well-publicised public concern over outsourcing cleaning and other services, the 'overall fall is explained by contracting out of some services' (NHS Information Centre, 2008b: 4). The data for cleaners as a separate category is not available but there is no reason to believe that there is any major difference between the trend for cleaners and the hotel, property and estates category as a whole.

The effect on the workplace of cutbacks in staffing levels and hours can be sharp and damaging as illustrated by the following extract from a recent report of one of the patient and public involvement forums:

> **As a result of conversations with cleaning staff and housekeepers, there was evidence of demoralisation due to the reduction of personnel since Medirest took over the responsibility for contract cleaning from February 2007. There is concern that there are too many chiefs and not enough Indians – lots of supervisors going round checking, but reduced hours and personnel for actual cleaning. There was also mention of difficulties between cleaners and supervisors, when it was felt that supervisors had been confrontational in public when dealing with some issues. It was clear that a number of conscientious workers felt that they could not maintain standards in the number of cleaning hours available, and there have been resignations from erstwhile loyal and committed cleaning and housekeeping staff.**
>
> *(Addenbrooke Patient and Public Involvement Forum, 2007: 3)*

Low pay and poor conditions

Cleaning has never been a particularly well paid job, but at least in the public sector there are associated conditions and benefits, that are generally better than in the private sector. Martyn Vesey, director general of the Cleaning and Support Services Association (which represents many cleaning contractors) says that two thirds of cleaning jobs are part-time:

> **The average hours a week a cleaner works in the UK is only 15. And 15 times £5 doesn't make a living wage… A lot of people, who want to make a living from cleaning, might have as many as three jobs.**
>
> *(Cottell, 2005)*

Not only has competitive tendering reduced the number of cleaners, but workers' pay and conditions have also suffered for those now working for contractors. Even those remaining in direct employment have not escaped from the downward pressures. Grimshaw and Carroll (2008: 176) note that 'outsourcing has had a major adverse impact on employment conditions for cleaners in public sector hospitals'.

The Commons Health Committee commented:

> **We are aware that in many cases headline cost savings from contracting out for non-clinical services appear to have been associated with deterioration in the conditions of work for the staff involved and with a consequential negative effect on staff morale.**
>
> *(House of Commons Health Committee, 1999)*

That any 'savings' in contracting out public services in general and hospital cleaning in particular has usually been at the expense of the staff through job losses, cuts in pay and conditions, increased job insecurity and work intensification is well established by research and is not peculiar to the UK (Ascher, 1987; Marcy Cohen, 2006; Domberger et al., 2002; Escott and Whitfield, 1995; Grimshaw and Carroll, 2008; Quiggin, 2002; Walsh and O'Flynn, 2000). That this also often applies to tenders that remain in-house is sometimes overlooked:

> **The same savings are produced by the process of contracting out services no matter who wins, albeit by achieving those savings through the erosion of bonus schemes and conditions of employment.**
>
> *(Cumming, 1992: 22)*

UNISON's objectives in relation to wage bargaining for cleaners have included:

- to improve the position of directly employed cleaners
- to prevent the automatic transfer of ancillary workers to the private sector when a Private Finance Initiative (PFI) deal is signed
- to lock into the NHS agreements those cleaners employed by contractors, thus ending the 'two tier workforce'.

The signing of the Agenda for Change framework deal went some way to meeting the first objective by improving the relative position of cleaners - for instance, grade B cleaners with a basic hourly rate of £4.92 on the old pay scale transferred to the new Band 1 rate of £5.89, an increase of 20 per cent (Grimshaw et al, 2007). They should also benefit from the link between their pay band and that of nursing staff as well.

In March 2005 the government extended the remit of the Code of Practice on Workforce Matters (the 'Two Tier Code') from local government to all parts of the public sector including the NHS (Cabinet Office, 2005). David Miliband MP, then minister for the Cabinet Office, said:

> **… we are ensuring that all new entrants taken on by contractors in new or retendered service contracts will benefit from terms and conditions that are no less favourable than those of transferred public sector employees. They will also be offered a reasonable pension.**
>
> *(Cabinet Office, 2005)*

Unfortunately, not all contractors have been eager to implement these terms and UNISON has had to mount strong campaigns to force action with some contractors (for example, see UNISON, 2008: 3-4). Sometimes these campaigns have involved UNISON in broad community action such as at the Royal London Hospital (Sokol et al, 2006). In addition the union secured the agreement of the government that hospitals are no longer required to outsource all ancillary workers as part of PFI new builds.

High turnover

High staff turnover is a problem in any workplace where a premium is placed on creating teamwork and team spirit. Health care relies heavily on such a work ethic. In evidence on hospital cleaning to the Commons Public Accounts Committee, Sir Nigel Crisp (then Permanent Secretary at the Department of Health and NHS Chief Executive) conceded that

> **… it will be harder if you have a high turnover of staff whether they are employed or agency. This is just, if you like, common sense. And if you are in a situation like London where you will have, because the labour**

market is structured as it is, a higher level of agency staff, then you have to manage that divergently than if you have got a stable staff who have been in hospital perhaps in the north where people have been working together for a long time and standards are established. You have to keep reinforcing standards. So it does make it difficult.

(House of Commons Public Accounts Committee, 2005: Ev 4)

The Institute of Healthcare Management (2001) found that hospitals 'requiring special measures' (RSM), which mostly had contract cleaning were more likely to experience high vacancy and turnover rates among domestic staff than exemplar hospitals (mostly in-house provision). Although the latter experienced relatively high turnover rates, they generally managed to fill vacancies. Half of the RSM hospitals in the study considered that the contractors

had not put significant effort into recruitment and that by lowering terms and conditions for new staff (no sick pay, no pensions etc) they had failed to attract staff to the hospital.

(Institute of Healthcare Management, 2001: 10)

Grimshaw and Carroll (2008: 180) found that most hospitals in their study 'experienced significant problems recruiting and retaining cleaners'. Reasons provided for this included low pay, the level of hard work required and the discomfort of working in a hospital environment. However, there is some evidence that turnover problems are exacerbated where cleaning is contracted out (for example, Auditor General for Scotland, 2000).

Grimshaw and Carroll's study (2008: 181) also illustrated that there are problems of unreliable data, lack of managerial control and loss of flexibility with outsourcing and these have a relationship with staff turnover. In one of the hospitals, the private contractor reported that 'retention is very good for domestic staff'. However, the NHS hospital human resources manager said that, in fact, '[Sodexho] has a high turnover because we do their Criminal Records Bureau checking, and I know that there is a constant throughput'.

A frustrated HR director at another of the hospitals studied, complained that the contractor's 'ineffective personnel management' threatens the overall quality of service:

'If they don't recruit and retain, if they don't have an appropriate skill mix [and] don't pay the going rate, it affects our quality of services.'

(Grimshaw and Carroll, 2008: 182)

In another case, it was reported that cleaning contractor ISS Mediclean responded to uncertainty over future staffing requirements (because of planned new building space and closure of other buildings) by offering all new cleaner recruits fixed term contracts. Not surprisingly, this increased staff turnover. ISS Mediclean's HR manager said: 'they just walk' (Grimshaw and Carroll, 2008: 182).

In a separate study, contract staff interviewed at the Homerton Hospital in East London argued that every time the contract was retendered:

each contractor wanted to change their working arrangements, that each sought to intensify work, and that each suffered from the higher turnover of newer staff who were employed on inferior terms and conditions of work.

(Wills, 2006: 16)

The fact that newer staff were always offered lower wages and conditions increased the likelihood of vacancies as workers 'were more likely to move on in search of alternative and better paid work' (Wills, 2006: 17-18).

Undervalued skill set

There already existed a large building cleaning services market before hospital cleaning was opened up to the private sector. It was widely expected that these companies would expand into the hospital cleaning sector on the grounds that the same skills set was required. However, while many of the same companies did enthusiastically enter the hospital cleaning market (Milne, 1993), there is now research to show that

> **the work of support staff in health care is considerably more complex than is normally understood, and constitutes work that is substantially different from that undertaken within hotels.**
>
> *(Cohen, 2001: 6)*

Messing (1998: 174, 179) reports that far from being a simple and unskilled job, cleaning requires 'a number of skills in adapting chemicals, methods, and tools to different situations' and the capacity to deploy 'a considerable degree of planning in order to "work around" the demands of other staff, as well as a knowledge of cleaning products and procedures'.

In addition, there is a certain amount of job enlargement on the part of health support staff with the result that the distinction between their work and that of nursing staff is blurred at the edges. This has been recognised in research studies for some time. They provide social support to patients, by talking to them while on their rounds and assisting in various ways. This contact works both ways with patients able to influence the cleaning (Armstrong et al, 2006: 14). Attending to patients' needs is not part of a cleaner's job description, but Grimshaw and Carroll (2008: 198) found that 'it was considered by some as an inevitable part of the job'. In a study of three Scottish hospitals (Cumming, 1992: 23), ward domestics were second only to nurses in patient contact time:

> **Undeniably, the domestic has a very important (although not always formally recognised) role to play on the ward, perhaps more importantly where the patients are long-stay and overall team spirit on the ward is important.**

To be effective, support staff require and usually acquire considerable health care specific knowledge, skills and on-the-job experience and training (Cohen, 2001). The role of the cleaner (often stretching into the 'caring' area through patient contact); the standard of cleaning required; the health hazards faced by hospital cleaning workers; the level of responsibility, skills and training requirement, all differentiate them from general building cleaners.

An integrated team

Twenty years ago, Collins (1988: 55) observed that in the pre-contract era 'it was relatively easy' to get additional cleaning done during an infection outbreak but that contracts 'cannot readily be altered to respond to a change in infection hazard requirement, at least not until the task has been costed and allocated to a particular budget'.

An example of such inflexibility was provided by the Healthcare Commission, when its investigation into the outbreaks of C.difficile at Stoke Mandeville (in which 38 patients died) reported that cleaning of the side rooms by the external contractor was

> **sometimes delayed as the necessary cleaning equipment and domestic staff were not readily available out of hours. This in turn delayed the admission of other patients needing isolation.**
>
> *(Healthcare Commission, 2006: 37)*

The report also noted that some domestic staff were unable to understand English which meant that clinical staff found it difficult to communicate with them 'which affected both parties' ability to perform their tasks properly'. Although the report does not take this observation further, it may be that the pay and conditions offered by the contractor were so poor that only non-English speaking migrant workers were prepared to take the job. If so, this would illustrate another connection between pay and conditions and the ability to integrate cleaning staff into the wider team.

On a number of levels contracting out has a direct relevance to the need to integrate cleaners and other support staff within the healthcare team. Healthcare relies on teamwork and integration inevitably blurs some of the borders between the different specialisms and occupational groups (Armstrong et al, 2006: 15). McMaster (1995) argues that hospital cleaners see themselves differently to more general building cleaners. Their self-perception is as members of a larger team acting within the Hipppocratic ethos. This latter point was picked up by the House of Commons Health Committee (1999), which noted

> **The often spurious division of staff into clinical or non-clinical groups can create an institutional apartheid which might be detrimental to staff morale and to patients.**

As contracting out separates cleaners from the rest of the ward team, it is likely to damage the general commitment of all staff to the goals of the organisation (the hospital or the NHS), what McMaster (1995) calls the 'overall welfarist or Hippocratic objectives of the contracting authority'. Armstrong et al (2006) cite Canadian research which reports disruption of services and teams resulting in inefficiencies and poor quality care as a result of contracting out cleaning. As an example they illustrate the changes to routine reporting procedures that followed outsourcing:

> **The log book where cleaning requests were written by clinical staff, and then read by the cleaning staff on the floor, has been replaced by a call centre at the corporation. Clinical staff reported waiting on the line for requests that had to go through the call centre, rather than directly to the cleaners. The call centre would then page the cleaner, who disrupts their work to respond to the call. Indeed, clinical staff could no longer directly ask cleaners to do work that needed to be done as a result of changes caused by the regular irregularity of health care. Calling the call centres took clinical staff away from their caring work.**
>
> *(Armstrong et al, 2006: 87)*

A study (Liyanage and Egbu 2006: 251) comparing a contracted out cleaning service (part of a PFI project) with an in-house service found that the level of integration between domestic and clinical teams in the in-house case was 'fairly high' whereas 'there is a major rift between the domestic team and ICT [Infection Control Team] in the PFI case'. The 'clear rift between the ICT members and the domestic team in the PFI case was captured by a comment from a member of the ICT:

> **As far as the PFI contractor is concerned, we (the ICT**

> **members) are non-existent… the PFI contractor never comes to us seeking advice on infection control… let alone integration.**
>
> *(Liyanage and Egbu 2006: 249)*

ICT staff in the in-house case believed that domestic staff generally took the advice of nursing and ICT staff – 'the situation was completely the opposite in the PFI case' ((Liyanage and Egbu 2006: 250). An associated survey of ICT members and domestic managers in English and Scottish hospitals supported the findings of the case study with in-house provision exhibiting a high level of integration and that for PFI and conventionally contracted out services a low level of integration.

Grimshaw and Carroll (2008) note that outsourcing cleaning presents NHS managers with a challenge in creating a common approach to service delivery and maximising teamwork to meet quality of service standards. In a number of cases the conflict in human resource approach proved a 'significant obstacle' (Grimshaw and Carroll, 2008: 182). By contrast, among the three hospitals retaining in-house cleaning this was seen as a way of ensuring high quality service. One HR manager argued:

> **We have a duty to look [at outsourcing]. But there's a real issue that you should never compromise quality for what would be relatively marginal financial gain… Our chief executive is passionate about keeping [cleaning] in-house, and that's because there have been so many horror stories from different organisations.**
>
> *(Grimshaw and Carroll, 2008: 183)*

One of the claimed advantages of contracting out is that it is supposed to improve control and monitoring of the level and quality of service through the obligation to formally specify a contract for services (Domberger, 1998). However, the Health and Safety Executive's Stoke Mandeville investigation reported that witnesses stated that there were problems with the cleaning contractor as the contract was coming to an end and there 'were staff shortages and a reduction in the quality of management by the contractor' (Health and Safety Executive, 2006:9). The Healthcare Commission's investigation into the same incident noted that:

> **Most staff reported that the standard of cleanliness on the wards was largely dependent on the conscientiousness of the individual cleaning staff. This meant that there were variations between wards, and between weekdays and weekends.**
>
> *(Healthcare Commission, 2006: 37)*

The fracturing of the workforce makes across the board training initiatives difficult. In a Commons debate on health care-acquired infections, Conservative MP, Anne Main (Hansard House of Commons, 2007a: col 1326) drew attention to a report from the strategic health authority covering her constituency which pointed out one of the problems of using external contractors:

> **Mandatory staff training is included for staff at induction, but all staff groups are not always covered and training of doctors remains a challenge as does infection control standards in relation to outside contractors [my emphasis].**
>
> *(Woolaway, 2004: 3)*

In some cases it is clear that contractors do not have any desire to provide training to their domestic staff. The Institute of Healthcare Management (2001: 10) found that for RSM hospitals (mostly with

contracted out cleaning) the norm was not to provide anything more than a 'cursory induction for new domestic staff'.

> **By contrast, all of the exemplar sites gave evidence of a commitment to providing both in-house and external programmes for domestic staff. This included: H&S, manual handling, infection control and COSH; customer care; British Institute of Cleaning Standards and regular updates on the use of equipment and materials. In all of these hospitals domestic staff are encouraged and supported in undertaking relevant NVQs. Line managers and supervisory staff have also received on-going training and development.**
>
> *(Institute of Healthcare Management, 2001: 10)*

Career paths

There is another form of integration, related to the career paths of individual cleaners. In an integrated workplace, there are job ladders that are open to staff to move between different occupational groups. This allows both the employer and the individual employee to benefit. Despite claims by some of its advocates to the contrary (eg Smith, 1995) competitive tendering and contracting out works against attempts to create 'generic working' across support roles in ward teams around a 'patient-focussed care' approach as outsourcing tends to be on a functional basis (Bach, 1998). Contracting out ruptures any existing job ladder connecting skilled cleaners to the post of assistant nurse (Grimshaw and Carroll, 2008). With one employer, there is an overall gain. With a fractured workforce employed by several different employers, one can only gain at the expense of another. Consequently there is a disincentive for either the NHS or the contractor to encourage a situation in which either loses able staff.

Grimshaw and Carroll (2008: 204) found that some NHS managers 'expressed concern that fewer cleaners were applying for assistant nurse posts than previously when cleaning was managed in-house'. Not only was there a lack of information sharing between the hospital and the contractor and unwillingness of the contractor to see its best staff leave but there was also wariness among NHS managers about undermining relationships with the contractor. One HR director commented:

> **When we go over to the [contractor's] induction programme, we quite often get asked, "What are the opportunities to come and work in the NHS?"… We're sitting there with their manager saying, "We're not here to poach you!" But clearly we would welcome them if they take an interest in a particular area. So it's a bit sensitive really, because clearly [Sodexho] want to keep their best workers.**
>
> *(Grimshaw and Carroll, 2008: 204)*

The problem operates in the other direction as well when the 'retention of employment' model is in place (this is where supervisory staff move over to the contractor but 'soft services' ancillary staff like cleaners remain as NHS employees). In this case contracting out breaks the internal job ladder between cleaners and supervisor because a promotion to the latter means that the individual must transfer to the contractor with almost certainly a worse pension scheme.

Ironically, the 'retention of employment' model was introduced

in response to both the problems of a two tier workforce and

> **…concerns about the performance of contract cleaners in the NHS. There has been a perception that unified ward teams work more efficiently and that outsourcing can inhibit efficient management, with nurses finding themselves unable to direct private sector cleaners.**
>
> *(Maltby and Gosling, 2003: 16)*

Not only are cleaners directly employed by NHS trusts more likely to progress to clerical and healthcare assistant posts than contract cleaners, but the latter are also restricted by a more narrowly defined set of job tasks with less opportunity to combine tasks and learning (Grimshaw and Rubery, 2007).

Conclusion and discussion

The government claims that there is no evidence that contract cleaners have lower standards or a worse record than in-house cleaners. Yet such an approach asks the wrong question. Ministers should be asking what effect competitive tendering has on both in-house and contract services. There are particular problems associated with contracting out health care (Allen et al, 2002) and particularly hospital cleaning to private contractors. But there are additional problems that a system of tendering imposes – regardless of whether the contract goes outside or not. In order to compete, public providers have had to join this race to the bottom.

These are systemic problems that arise from the nature of competitive tendering and contracting out of the cleaning service. Many of the recent initiatives by government are an acknowledgement of this and represent an attempt to overcome the limitations posed by contractual regimes. Tendering faces hospitals with the dilemma of choosing quality or cost; HR managers know that the source of 'savings' is almost always staffing costs in one form or another and this has an impact on recruitment and retention, sickness absence and subsequently the quality of service provided. As Rampling and colleagues (2001: 115) warned: 'In the long term, cost-cutting on cleaning services is neither cost-effective nor common sense'. Despite this, over one third of respondents to a survey of English trusts reported experiencing difficulties in reconciling the management of HCAI with the fulfilment of financial targets (Healthcare Commission, 2007).

If the service is actually contracted out, these problems are exacerbated by the difficulties in drawing up contracts; the issue of commercially confidential information; the lack of flexibility available to NHS managers; the time and expense of monitoring and potential for lack of trust developing; the difficulties in imposing sanctions; the separation of the cleaning service from the rest of the ward team; the erosion of the public sector ethos and the danger of downgrading the importance of infection control.

There are three related elements to an effective hospital cleaning service:

- resources
- organisation
- quality.

Adequate resources means that staffing and hours of work must be set at a level to carry out the tasks assigned in recognition of the importance of cleaning in the overall infection control programme. Pay and conditions must reflect the need to ensure recruitment and retention of good quality staff; and the budget should be sufficient to ensure training and appropriate equipment for all staff. In terms of organisation, the cleaning service needs to be integrated into the ward team, so that it is both responsive and flexible. Finally, the service should be driven by high quality standards, drawn up with the participation of the staff themselves (both domestic and infection control). There is considerable emphasis on quality care in the NHS Next Stage Review Final Report (Department of Health, 2008f) but staff should be closely involved. It should be geared towards applying resources in the most effective way, which may mean targeted cleaning of high risk hand-touch sites (Dancer, 2008; Carling et

al, 2006a, 2006b) and monitored in a way that does not rely solely on visual assessment.

As Alastair Henderson of NHS Employers commented:

> **Tackling HCAIs is a key issue for NHS organisations. Experience shows that this will be best achieved when employers, staff and trades unions work in partnership to tackle the problem.**
>
> *(Social Partnership Forum, 2008: 6)*

Now is the time to make good on this. A properly resourced, integrated, in-house cleaning service can make a real contribution to infection control because good quality cleaning is effective, achievable and is exceptionally good value for money.

Annex: Outsourcing of estates and facilities related contracts for Domestic Services.

Trust	Provider
Avon And Wiltshire Mental Health Partnership NHS Trust	ISS
Barking And Dagenham PCT	Initial
Barnet PCT	ISS Ltd
Barnet, Enfield And Haringey Mental Health NHS Trust	SLA - 5A9 BPCT
Barnet, Enfield And Haringey Mental Health NHS Trust	Medirest Healthcare
Barnet, Enfield And Haringey Mental Health NHS Trust	Others
Barnet, Enfield And Haringey Mental Health NHS Trust	Prestige Services
Barts And The London NHS Trust	Carillion
Basingstoke And North Hampshire NHS Foundation Trust	ISS Deep cleaning
Birmingham East And North PCT	Mitie
Blackpool PCT	Blackpool Football Club
Blackpool PCT	Blackpool Council
Blackpool PCT	Initial
Blackpool, Fylde And Wyre Hospitals NHS Trust	ISS Mediclean
Blackpool, Fylde And Wyre Hospitals NHS Trust	Wrightcare Limited
Bolton Hospitals NHS Trust	ISS Mediclean
Bournemouth And Poole PCT	Regent Office Care
Bournemouth And Poole PCT	Mediclean
Bournemouth And Poole PCT	Other
Bradford And Airedale PCT	Operon/Kildwick
Bradford District Care Trust	Various
Bristol PCT	UBHT
Bromley Hospitals NHS Trust	ISS Mediclean / London Property Maintenance2010543
Cambridge University Hospitals NHS Foundation Trust	Medirest
Cambridgeshire PCT	Sodexho Healthcare Ltd
Central And North West London Mental Health NHS Trust	ISS, OCS
Central Manchester And Manchester Children's University Hospitals NHS Trust	MEDIREST
County Durham And Darlington NHS Foundation Trust	ISS Mediclean
County Durham And Darlington NHS Foundation Trust	Consort
County Durham And Darlington NHS Foundation Trust	Robertsons
Croydon PCT	ISS Mediclean
Dartford And Gravesham NHS Trust	Carillion Health

Trust	Provider
Derby City PCT	Rentokil Initial UK Cleaning
Derby City PCT	Elite Healthcare Services
Derby City PCT	Archgate Cleaning Services
Doncaster PCT	DMBC METROCLEAN
Doncaster PCT	DBH
Doncaster PCT	DASH
Dorset Healthcare NHS Trust	Mediclean
Dudley Group Of Hospitals NHS Trust	Summit Healthcare / Interserve fm
Ealing Hospital NHS Trust	Medirest
East Kent Hospitals NHS Trust	Medirest
East Sussex Hospitals NHS Trust	Shine window cleaning services
Enfield PCT	Barnet Enfield and Haringey Mental Health Trust
Epsom And St Helier University Hospitals NHS Trust	Sodexho
Essex Rivers Healthcare NHS Trust	Carillion
Great Ormond Street Hospital For Children NHS Trust	MITIE
Great Western Ambulance Service NHS Trust	various within Avon sector
Greenwich Teaching PCT	ISS Mediclean
Hammersmith Hospitals NHS Trust	Medirest
Haringey Teaching PCT	SLA - RRP BEHMHT
Hartlepool PCT	Able Clean and North Tees Trust
Hastings And Rother PCT	Sprint Cleaning
Hastings And Rother PCT	Shine Window cleaning services
Havering PCT	Initial Services
Heart Of Birmingham Teaching PCT	Mitie
Heart Of England NHS Foundation Trust	Initial Hospital Services
Herefordshire PCT	Sodhexo
Hertfordshire Partnership NHS Trust	Medirest
Hull And East Yorkshire Hospitals NHS Trust	MITIE
Humber Mental Health Teaching NHS Trust	OCS
Kettering General Hospital NHS Trust	Strand
King's College Hospital NHS Foundation Trust	HPC/Sodexho
Kingston Hospital NHS Trust	ISS Mediclean
Kingston PCT	Hi Spec
Kirklees PCT	Initial services
Lambeth PCT	Initial Hospital Services
Lancashire Care NHS Trust	ISS
Lancashire Teaching Hospitals NHS Foundation Trust	Window Cleaning

Trust	Provider
Lancashire Teaching Hospitals NHS Foundation Trust	Cannon Hygiene
Lancashire Teaching Hospitals NHS Foundation Trust	PHL Group
Lancashire Teaching Hospitals NHS Foundation Trust	D&I Cleaners
Lancashire Teaching Hospitals NHS Foundation Trust	Sodexho
Liverpool PCT	First Eclipse
Maidstone And Tunbridge Wells NHS Trust	City & Kent Cleaning
Manchester PCT	Initial Hospital Services
Mayday Healthcare NHS Trust	Initial Hospital Services
Middlesbrough PCT	Regency Cleaning
Middlesbrough PCT	Better Clean
Milton Keynes General Hospital NHS Trust	F & G Window Cleaners
Newham University Hospital NHS Trust	ISS Mediclean/Medirest
Norfolk PCT	ISS Mediclean
North East Ambulance Service NHS Trust	Newlife Cleaning Systems
North East Lincolnshire PCT	Carillion
North East London Mental Health NHS Trust	Initial Hospital Services
North Essex Mental Health Partnership NHS Trust	Initial Hygiene Services
North Staffordshire Combined Healthcare NHS Trust	Carillion
North Tees And Hartlepool NHS Trust	Sodexho
North Tees PCT	Sodhexo
North Tees PCT	GBL Valeting
North West London Hospitals NHS Trust	Sodexho/ISS
Northern Devon Healthcare NHS Trust	Sodexho
Nottingham University Hospitals NHS Trust	Ideal Cleaning Century Health (QMC)
Nottingham University Hospitals NHS Trust	Initial (QMC)
Nottinghamshire Healthcare NHS Trust	Medirest/Aramark
Oxleas NHS Foundation Trust	Initial Hospital Services
Oxleas NHS Foundation Trust	ISS
Pennine Care NHS Trust	Various providers
Peterborough And Stamford Hospitals NHS Foundation Trust	ISS Mediclean
Peterborough PCT	Sodexho Healthcare Ltd
Plymouth Hospitals NHS Trust	ISS Mediclean
Poole Hospital NHS Trust	ISS Mediclean
Portsmouth City Teaching PCT	Mclenan
Queen Elizabeth Hospital NHS Trust	ISS Mediclean
Redbridge PCT	Initial
Richmond And Twickenham PCT	Hi Spec
Royal Liverpool And Broadgreen University Hospitals NHS Trust	ISS Mediclean
Royal National Orthopaedic Hospital NHS Trust	Medirest
Sandwell Mental Health NHS And Social Care Trust	OCS

Trust	Provider
Sandwell Mental Health NHS And Social Care Trust	Medirest facilities
Sefton PCT	Initial Cleaning
Solihull Care Trust	Ideal
Solihull Care Trust	Regent
Solihull Care Trust	MITIE
Solihull Care Trust	Globe
Somerset Partnership NHS And Social Care Trust	OCS
Somerset Partnership NHS And Social Care Trust	AIS Contract Cleaners
Somerset Partnership NHS And Social Care Trust	ES Recruitment
Somerset Partnership NHS And Social Care Trust	Craftex
Somerset Partnership NHS And Social Care Trust	Other Suppliers
South Birmingham PCT	Mitie
South East Essex PCT	OCS
South Gloucestershire PCT	various
South London And Maudsley NHS Foundation Trust	Cleankill Environmental Services Ltd
South London And Maudsley NHS Foundation Trust	London Property Maintenance
South London And Maudsley NHS Foundation Trust	ISS Mediclean
South London And Maudsley NHS Foundation Trust	AMEC
South London And Maudsley NHS Foundation Trust	Other
South Tees Hospitals NHS Trust	Endeavour SCH PLC
South Warwickshire General Hospitals NHS Trust	ISS
South West Essex PCT	Initial hospital Services
South West London And St George's Mental Health NHS Trust	IHS
South West London And St George's Mental Health NHS Trust	OCS
South West Yorkshire Mental Health NHS Trust	Initial, Domestic Clean & Sunlight
Southwark PCT	Initial
St George's Healthcare NHS Trust	ISS Mediclean
St Helens And Knowsley Hospitals NHS Trust	Medirest
Stockport NHS Foundation Trust	Initial
Stockport PCT	Initial hospital services
Sussex Partnership NHS Trust	East Sussex Hospital Trust
Sussex Partnership NHS Trust	West Sussex PCT
Sussex Partnership NHS Trust	other
Sussex Partnership NHS Trust	Brighton and Sussex University Trust
Sussex Partnership NHS Trust	Proclean
Sutton And Merton PCT	Initial
Sutton And Merton PCT	Canon Hygiene
Sutton And Merton PCT	Atir

Trust	Provider
Swindon PCT	Blue Crest
Swindon PCT	SBC
Swindon PCT	Carillion
Swindon PCT	Classic
Swindon PCT	Marchants
Tameside And Glossop PCT	Pennine Care NHS Trust
Tees, Esk And Wear Valleys NHS Trust	Initial Hospital Services
The Hillingdon Hospital NHS Trust	Medirest
Trafford PCT	ISS Mediclean
United Bristol Healthcare NHS Trust	Initial Hospital Services
University Hospitals Of Leicester NHS Trust	Various
Wandsworth PCT	Cannon Hygiene
Warrington PCT	B&L Initial / Mitie / A & B contractors
West Essex PCT	Initial Cleaning Services
West Essex PCT	Other suppliers
West Hertfordshire Hospitals NHS Trust	Medirest
West London Mental Health NHS Trust	Brentford Lodge - Swift Office Cleaning
West London Mental Health NHS Trust	Cardinal Centre - Servicemaster
Whipps Cross University Hospital NHS Trust	Initial Hospital Services
Wiltshire PCT	Marchants
Wiltshire PCT	Blue Crest
Wiltshire PCT	David Wareham
Wiltshire PCT	Euroway contract cleaning
Worcestershire Mental Health Partnership NHS Trust	ISS Mediclean
Worcestershire Mental Health Partnership NHS Trust	Express Cleaning
Worcestershire Mental Health Partnership NHS Trust	Initial
Worcestershire PCT	ISS Mediclean
Worcestershire PCT	Express Cleaning
Worcestershire PCT	Initial
York Hospitals NHS Trust	MBD Window Cleaning

Source: Department of Health (2008e) response to Freedom of Information request, 11 September 2008.

NB: The table reproduces data provided annually by the NHS via the Estates Returns Information Collection system (ERIC), on the outsourcing of estates & facilities related contracts for Domestic Services. The provision of this data is mandatory for NHS Trusts but not for Foundation Trusts for whom it was voluntary. It is therefore unlikely to be complete. It lists those trusts that have reported that some element of the provision of domestic services has been outsourced and details the provider as identified by the trust. This data has not been verified or amended centrally, and its accuracy is therefore the responsibility of the individual organisation.

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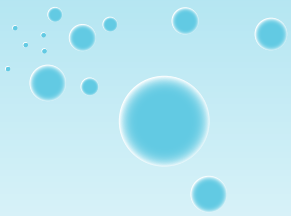

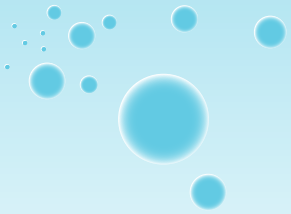

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