# THE NATIONAL ASSEMBLY FOR WALES:

# AUDIT COMMITTEE

**Report 06-03 presented to the National Assembly for Wales on 18 December 2003 in accordance with section 102 (1) of the Government of Wales Act 1998**

# The Management and Delivery of Hospital Cleaning Services in Wales

## Introduction

1. In this report we assess the effectiveness of the management and delivery of domestic cleaning services in the seventeen major acute NHS hospitals in Wales. A clean hospital environment is essential for the health and well being of patients, staff and visitors. Effective cleaning is vital in maintaining a healthy and safe hospital environment, and contributes significantly to the quality of patient care. However, following recent research, there has been increasing concern that standards of cleanliness have been falling across the NHS in Wales, especially in major acute hospitals.

2. On the basis of a report produced by the National Audit Office Wales on behalf of the Auditor General for Wales[1], we took evidence from Ann Lloyd, Director of NHS Wales; Stuart Fletcher, Acting Head of Estates Services, NHS Wales Department; and Dr Anthony Howard, Director for Infection and Communicable Diseases, National Public Health Service for Wales. This report considers the links between cleaning and infection control, the problems experienced on the ground in cleaning hospitals, and the work of the NHS Wales Department in addressing some of the issues with hospital cleaning.

## Cleaning and infection control

3. It has proved difficult to establish a definite link between levels of cleanliness and outbreaks of infection. However, the House of Lords Select Committee on Science and Technology in March 1998 stated that basic hygiene should be at the heart of good hospital management and practice. Their report also observed that "poor hygiene has been definitely implicated in some outbreaks of hospital infection".[2] And the National Audit Office found in February 2000 that poor basic hygiene could lead to prolonged patient stays in hospital due to acquiring infections, in particular, *Methicillin Resistant Staphylococcus aureus* (MRSA), and therefore cost the NHS in England as much as £1,000 million each year.[3]

4. The Director for Infection and Communicable Diseases, National Public Health Service from Wales told the Committee that whereas there was obviously a link between cleaning and the external perception of the environment by patients and visitors to hospital, the relationship between cleaning and infection control was complex. It was quite possible to

[1] Report by the Auditor General for Wales, *The Management and Delivery of Hospital Cleaning in Wales*, presented to the National Assembly 23 May 2003

[2] House of Lords Select Committee on Science and Technology, seventh report of 1997-98 *Resistance to antibiotics and other antimicrobial agents*, HL81, April 1998

[3] Report by the Comptroller and Auditor General, *The Management and Control of Hospital Acquired Infection in Acute NHS trusts in England*, HC 230, February 2000

have an apparently clean environment with a huge microbial contamination. In one case, for example, contaminated cleaning equipment actually spread bacteria in wards. However, any breakdown of normal cleaning practices would expose people to risk, such as the failure to deal promptly with a spill of infective bodily fluids into the environment. What was uncertain from research is the variation in infection rates that relate to variations in cleaning. From an infection control viewpoint, therefore, the areas to concentrate on were those of major risk to patients - where they are most likely to be exposed to environmental contamination, such as shared equipment.[4]

5. Against this background, the Auditor General found evidence of poor links between hospital cleaning teams and infection control teams. Only three hospitals involved infection control teams in the development of their cleaning standards. There is also a great variation in the number of infection control audits carried out by hospitals varying from four times a year at the Royal Gwent to no infection control audit for five years at Llandough Hospital.[5] We view this as unsatisfactory and a matter for concern. We were informed that, within six months of our hearing on the topic, the NHS should have carried out a full review of cleaning services and should have a definitive picture of the level of infection control involvement in the development of cleaning standards with the aim of ensuring full involvement.[6]

6. We recognise the difficulties involved in proving an exact link between outbreaks of infections and levels of cleanliness; however, we believe that there is sufficient evidence to conclude that the likelihood of such a link cannot be ignored. We therefore find it unacceptable that some hospitals do not carry out infection control audits and that infection control teams are currently not involved in the development of hospital cleaning standards. **We recommend that, without further delay, NHS trusts involve infection control teams in the development of cleaning standards and ensure regular infection control audits are carried out.**

## Factors affecting cleaning in hospitals

7. There are a number of serious problems in the hospital cleaning arrangements. There are issues, for example, over costs, staffing, minimum cleaning standards, specifications, monitoring and with regards to hospitals having a “clean culture”. Furthermore, the Director of NHS Wales told us that support services such as cleaning have traditionally

[4] Q51

[5] AGW Report, paragraphs 1.2, 2.4 and Case Study F

[6] Qs 52 - 55

been those areas where efficiencies have been sought and that there has not in the past been any definitive information on what constitutes a clean hospital.[7] This part of the report considers each of the factors affecting cleaning in hospitals.

## The cost of hospital cleaning

8. In 2000-01, over 2,000 cleaning staff worked to clean some 800,000 square metres of hospital space in the 17 major acute NHS hospitals in Wales, at a cost of more than £18 million. Staff costs contribute 93 per cent of the cost of cleaning; the remaining seven per cent being for the purchase of cleaning equipment, materials and consumables. The Auditor General's report highlights the large variations between hospitals in the cost of cleaning, from £14.43 to £46.61 per square metre with an average cost of £25.23 per square metre. These variations in cost do not appear to be simply related to the age of the hospital, which could make cleaning more difficult, as the report showed that the most recently built of the hospitals surveyed - the Royal Glamorgan - had the second highest cleaning costs.[8]

9. Witnesses told us that this difference in cost was attributable to a number of factors: the priority that trust management has given to cleaning within the organisations, how old the buildings are, how well they have been maintained and the sorts of materials being used.[9] We also heard that the Royal Glamorgan Hospital, the second most expensive hospital to clean, may have paid more attention to maintaining a clean environment than other hospitals.[10]

10. We were interested to discover the relationship between contracting out cleaning services and cost. Of the four hospitals that contract out cleaning, three had lower than average cleaning costs. Witnesses explained that the decision to keep cleaning contracts in house requires trusts to go through the process of competitive tendering to ensure they were achieving best value for money. However, we were told that there was currently no information on the relative quality of cleaning at hospitals and whether that had a bearing on cost.[11]

11. We accept that there will always be variations in hospitals' average cleaning costs - because of the age of the buildings, maintenance issues and the materials being used. But

[7] Q4

[8] AGW Report, paragraphs 1.8 - 1.10 and Figure 1

[9] Q15

[10] Q16

we are not at all convinced that the variations evidenced in the Auditor General's report are justified. We consider that the NHS Wales Department should have an overview of not only the standard of hospital cleanliness across Wales but also the cost of cleaning and the reason why such variances occur. In particular, we view it as important that the relationship between the cost and quality of cleaning be examined. We are aware that the NHS Wales Department is about to conduct a thorough review of hospital cleaning, and we therefore **recommend that the differences in the cost of cleaning form part of the NHS Wales Department's review.**

12. Another issue concerning the cost of cleaning stems from the fact that most hospital cleaning budgets were set a long time ago and have largely seen only inflationary increases in recent years, regardless of the increase in hospital size or activity. There has been a significant increase in hospital activity throughout Wales in recent years: patient numbers have increased by more than 14 per cent in the last ten years, with an associated increase in patient turnover and extended visiting hours. There has also been an increase in patient movement - each time a patient is moved, the vacated area must be cleaned before a new patient arrives.[12] **We recommend that cleaning budgets be determined by cleaning needs and not by previous budgets.**

13. Physically, too, the size and structure of Welsh hospitals has changed considerably and presents problems for cleaning. Nearly all hospitals have expanded and many have reorganised existing work areas, such as turning office space into wards. The backlog of building maintenance experienced by the majority of major acute hospitals in Wales impacts upon the efficiency of cleaning hospitals. Damaged and poorly maintained surfaces or inappropriate fabrics and furnishings can be difficult and time consuming to clean.[13]

14. These factors will inevitably put more pressure on cleaning costs. We note that one hospital - the Princess of Wales - alone has a cleaning budget deficit of £650,000.[14] We heard evidence of best practice in the case of patient movement where some trusts have set up bed teams to ensure each bed is thoroughly cleaned before being re-used.[15] We were told about both good and bad practice in terms of the fabric of the building and were

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[11] Qs 25 - 30

[12] AGW Report, paragraphs 3.5 - 3.6

[13] AGW Report, paragraphs 3.7 – 3.14 and Photographs 1 & 2

[14] AGW Report Case Study H

[15] AGW Report paragraph 3.6; Qs 35 and 100 - 102

given assurances that hospital cleaning teams would in future be consulted prior to the purchase of fabric and fittings. We were also told that the good practice found identified by the Auditor General would be disseminated across the NHS in Wales.[16]

15. However, we remain concerned about the level of extra funding that may be required for hospitals to cope with the additional cleaning that now needs to be done. In our view it is imperative that communications between procurement officers and cleaners improve to avoid purchasing the wrong fabrics and fittings. Moreover, the impact of building defects on cleaning costs should in future directly influence the prioritisation of backlog maintenance. **We recommend that hospitals ensure that communication between the maintenance and cleaning departments is effective, and that, where necessary, a member of the maintenance department is present on the regular cleaning monitoring rounds in order to develop a better understanding of the issues affecting cleaning. We also recommend that trusts ensure the cost of ongoing cleaning services is factored into any new procurement, taking into account the whole life cost, and that cleaning services are consulted whenever furnishings and fabrics are procured.**

## Staffing

16. The Auditor General's report highlights a number of issues concerning the recruitment and retention of domestic cleaning staff, including high turnover, low wages, sickness absence, high vacancies and insufficient staff. Recruitment and retention is clearly a major factor hindering cleaning services in Welsh hospitals today, with one hospital having an astonishing turnover rate for its cleaning staff of 82 per cent in the nine months prior to the National Audit Office Wales visit. Of the 2,000 domestic cleaners in major acute hospitals across Wales, almost one quarter had been in post for less than six months. This is putting immense pressure on an already stretched service. The Auditor General's report does set out a number of positive attempts by hospital cleaning teams to overcome some of these problems, such as the University of Wales' teamwork pilot.[17]

17. Witnesses added their own example of good practice - from the Princess of Wales Trust - which has employed bed teams with the dual purpose of easing the pressures on ward based staff and introducing better checks on the cleanliness of beds as patients are discharged.[18] More generally, witnesses explained that there is an awareness of the issues

[16] AGW Report Case Studies A and I; Qs 34 - 35; Qs 120 – 125 and 129

[17] AGW Report, paragraphs 1.14 – 1.17 and Case Study A

[18] Q35

surrounding staffing issues and that these issues need to be addressed before we will see evidence of an improved quality of service. A new Wales recruitment strategy and a structured career path is being developed for domestic cleaning staff in order to raise the profile of working within hospital domestic services. This is aiming to integrate staff into the ward team and encourage vocational training, which will broaden the skill base and motivate staff.[19]

18. The Committee recognises the difficulties surrounding the staffing of domestic cleaning but is concerned by the lack of concrete progress in addressing these issues. We accept that it is the responsibility of individual trusts to ensure its hospitals employ sufficient cleaning staff but consider that this should be within a national framework to ensure that the public receive a standard level of service across all hospitals in Wales. We consider that the new Trust Facilities Forum - the successor to the All-Wales Facilities Group[20] - has a role to play in this regard. **We recommend that the Trust Facilities Forum for Wales evaluates the pilot schemes for overcoming staffing issues and, if they are successful, promulgate details of those schemes across the NHS in Wales.**

## Cleaning standards

19. The NHS Wales Department has recently issued a set of minimum national cleaning standards (see paragraph 29). However, at the time of the Auditor General's examination, cleaning standards varied greatly between trusts and often within trusts. The last set of national standards was issued in 1979.[21] The Auditor General's report detailed the array of cleaning standards subsequently made available to hospitals over the past 25 years and he expressed concern that, at the time of his audit, there were no compulsory minimum standards of hospital cleanliness in the NHS in Wales. NHS trusts and hospitals have been free to decide which cleaning standards they use. Moreover, few hospitals benchmark their cleaning services to provide information on whether they are appropriately cleaned. Despite the fact that hospitals have been free to choose their own cleaning standards the Auditor General's report showed that eight of the eleven hospitals visited were failing to meet these standards.

## Cleaning specifications

20. Cleaning specifications are detailed, documented instructions for cleaners. Domestic cleaners are required to clean to the specifications, which outline the minimum

[19] Qs 18 - 20 and 132 - 134

[20] Q13

requirements needed to ensure that all areas of a hospital are "clean". Cleaning specifications can be formulated in various ways:

- input driven, eg clean carpet twice daily;
- output driven, eg carpet must be free of dust and impacted dirt; or
- process driven, eg use a suction cleaner to pick up dust and dirt from the floor.

21. There were a number of problems with hospitals' current cleaning specifications. Twelve of the 17 major acute hospitals had specifications that were only input based and do not, therefore, outline how a ward should be cleaned or what standards it should meet. Another problem with existing cleaning specifications was that they did not include all the areas and items that needed to be cleaned, such as drip stands, hoists and commodes, and there was confusion at ward level about who was responsible for their cleaning.[22] It was precisely such items which we were told were those where patients are most likely to be exposed to environmental contamination and should therefore be of the most concern.[23] The majority of hospital cleaning specifications were out of date and had not been amended to reflect changes in hospital activity. Seven of the 17 acute hospitals had not re-written their cleaning specifications for over a decade, despite increases in hospitals' activity levels which generally meant that higher levels of cleaning were required.[24] Lastly, the ability of staff to meet hospital cleaning specifications was further stretched when unplanned cleaning had to be carried out. A major concern in hospitals was that unforeseen spillages were often being left unattended due to staff shortages.[25]

22. The Auditor General's report does also highlight some examples of good practice where trusts have re-written their cleaning specifications room by room and have made good use of IT solutions in the process to ensure that any changes in hospital size or use is reflected in updated specification.[26] But this good practice is more than outweighed by the problems with specifications above.

23. Witnesses confirmed that the specifications used by some hospitals did have some major gaps. We also heard of the confusion surrounding the responsibilities for cleaning certain

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[21] AGW Report, paragraphs 2.2 – 2.4

[22] AGW Report, paragraphs 2.6 – 2.9

[23] Q51

[24] AGW Report, paragraph 3.3

[25] AGW Report, paragraph 2.13

[26] AGW Report, paragraph 2.9 and Case Study B

areas and equipment and the "grey areas" in cleaning specifications that have developed over the years. We were told about many high risk shared areas, such as bathrooms, being inadequately cleaned. The witnesses reiterated to the Committee the importance of a single point of responsibility for the cleanliness of a ward and that the new national minimum cleaning standards (paragraph 29) would be used to ensure that it once again receives the attention it needs. The Committee was especially pleased to hear that ***every*** hospital that has not done so already would have to rewrite their cleaning specifications and that this data would be available after the first six monthly review.[27] However, we do have some concern over the ability of hospitals to allocate resources to re-specify their cleaning requirements for entire hospitals when it is clear that they currently do not have the staff to carry out the actual cleaning. **We recommend that the new cleaning specifications that have been developed by trusts should detail the entire hospital area, room by room, specifying the frequency that the area needs to be cleaned and what the area should look like after it has been cleaned – the specifications should be input and output driven. We also recommend that the accountability for the cleaning of ward equipment and carrying it out be more clearly defined and monitored.**

## Monitoring and the development of a "clean culture"

24. The Auditor General reported that there were three key elements to hospital monitoring of cleanliness: day to day ongoing supervision; regular formal monitoring; and infection control audits. He concluded, though, that trusts' compliance with these three elements was very patchy, so that even where there was regular monitoring of cleaning, and this showed that standards were not being met, the results were not being reported to senior management or being acted upon.[28]

25. Like the Director of NHS Wales, we see this issue as being linked to the lack of a "clean culture" within the NHS in Wales, whereby keeping a clean hospital is seen as purely the work of the domestic cleaning staff. This is partly why cleaning reports and problems picked up by monitoring are not high on the management agenda. In many hospitals there is poor communication between the domestic cleaning teams and ward management. Very often there is little senior management involvement or influence in hospital cleaning.[29]

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[27] Qs 58 - 60

[28] AGW Report, paragraphs 2.14 - 2.15

[29] AGW Report, paragraphs 2.16 – 2.20

26. Witnesses told us that the culture of the past decade had seen the priority of hospital cleaning services slip and that cleaning had not been high on the agenda of many trust boards. We were assured that each trust board now has an executive board member who is designated as responsible for the ultimate ownership of this issue, and who has to report on this area within the board itself. This should help ensure that any cleaning monitoring results that give cause for concern are reviewed and fully actioned at the appropriate level. In order to highlight the importance of day to day monitoring of hospital cleanliness by all staff, not just cleaners, there are plans to ensure that staff induction training works closely with infection control and ensures that the importance of cleanliness and personal hygiene is highlighted for everybody within the hospital community. We were also pleased to hear that the results of hospital monitoring would reach the Director of NHS Wales as part of the performance management system.[30]

27. We were encouraged to learn that there are firm plans to introduce a clean culture from the top down and bottom up within hospitals. This should help to ensure that the results of monitoring cleaning activity will get the attention they need. We are also pleased that the monitoring results that show poor cleaning standards will in future be reviewed and tackled at the very top of the NHS in Wales. However, we note that the NHS Wales' strategy, *Improving Health in Wales – A Plan for the NHS with its Partners*, also sought to address such issues as training and executive board representation; we are not clear whether the recommendations of that report have yet been implemented. **We recommend that the NHS Wales Department works with the individual NHS trusts to ensure that monitoring of cleaning is consistent across Wales and that trusts consider making the best use of IT to ensure consistency. We recommend that the results of cleaning monitoring are reported monthly to the management of cleaning services within each trust, with any reports that show wards failing to achieve acceptable standards being discussed at Board level and referred to the infection control team. Lastly, we consider it imperative that the importance of cleaning and the level of cleaning services being provided is clearly communicated and understood by all hospital staff and that all hospital staff have an introduction to the importance of cleaning during their induction.**

## The role of the NHS Wales Department

28. The Director of NHS Wales told us that since she had taken up post issues around accountability within the NHS in Wales had been clarified. Although responsibility for

[30] Qs 89 - 95

cleaning hospitals lies with the individual trusts in the first instance, chains of accountability within the NHS mean that the NHS Wales Department retains ultimate responsibility.[31] This means that the NHS Wales Department has a clear duty to work with individual trusts to improve the cleanliness of hospitals.

29. We therefore welcome the fact that the NHS Wales Department, through the All Wales Facilities Group, has worked closely with all key interested parties in hospital cleaning and with the National Audit Office Wales in the development of a set of national cleaning standards and that these standards have now been issued to the NHS together with a copy of the Auditor General's report.[32] We were encouraged to learn that the standards took full account of all the previous guidance, both domestic and international, that has been issued over the past 25 years.[33] The standards are very comprehensive and cover: the management of environmental cleanliness; local cleanliness strategies; involving and listening to patients; education and development; risk-based analysis for service provision; facilities management and the monitoring of cleaning outcomes.

30. Together with the cleaning standards, the NHS Wales Department has issued a performance assessment toolkit which enables trusts to audit these standards to a consistent standard across Wales. We were especially pleased to see the enlarged role of the Community Health Councils who were due to carry out their first audit of these standards throughout September and October 2003.[34]

31. The new standards should help hospitals address some of the other problems considered in this report. For example, as part of the implementation of the standards, all hospitals will have to re-specify their cleaning requirements in order to ensure all changes in activity and size of the hospital have been taken into account. There is a pro forma in the standards that requires hospitals to detail all the items and areas contained in every room in the hospital.[35] This will not only ensure that the right amount of cleaning is taken place at each hospital, but also that hospital cleaning budgets can be set according to cleaning needs rather than on an inflationary basis and that accurate cleaning costs can be compared across trusts.

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[31] Qs 77 – 83, 110 – 118 and Annex C

[32] AGW Report, paragraph 1.7 and Annex C, Qs 6 – 13, 40 – 46, 58, 90 – 98 and 135

[33] Q40

[34] Q6

[35] National Standards of Cleanliness for NHS Trusts in Wales, Annex D

32. The NHS Wales Department is also taking steps to ensure that infection control teams are involved in the implementation of these cleaning standards; that trusts are aware that best practice demands this; and that minimum frequency for infection control audits will be re-enforced in the standards. It is also encouraging to have reassurances that evidence of hospitals achieving a compulsory minimum cleaning standard will be part of the NHS performance management system and that the results will be used for benchmarking and published, in order that the community at large can be reassured that their hospitals are cleaned to a satisfactory standard.[36]

33. The All Wales Facilities Group has been wound up after the successful development of the national cleaning standards but it has been replaced by the Trust Facilities Forum. This forum will be tasked with monitoring the implementation of the standards and in the dissemination of the numerous good practices that have emerged from this report.[37] We view this as very important work.

34. We commend the NHS Wales Department on the development and issuing of a set of national minimum cleaning standards, but we do have strong reservations about the ability of trusts to meet these standards. We have had evidence to show us that hospitals are failing to meet standards that they themselves have set and have seen little evidence to convince us that they will be able to meet a far more demanding set of standards. There is therefore an ongoing role for the NHS Wales Department in ensuring that its new cleaning standards are achieved. **We recommend that, in addition to the monitoring of the national standards recently issued, the NHS Wales Department produces not only a report on the results but a detailed action plan for any hospital that fails to meet the standards.**

## Summary of recommendations

35. In light of these findings and conclusions we recommend that:

i. **without further delay, NHS trusts involve infection control teams in the development of cleaning standards and ensure regular infection control audits are carried out;**

ii. **given the wide variations in the hospitals' average cleaning costs, these differences form part of the NHS Wales Department's review of cleaning;**

[36] Qs 42 – 45, 47 – 55, 71 - 73

[37] Qs 12 - 13

iii. **cleaning budgets be determined by cleaning needs and not be previous budgets;**

iv. **hospitals ensure communication between the maintenance and cleaning departments is effective and that, where necessary, a member of the maintenance department is present on the regular cleaning monitoring rounds;**

v. **trusts should ensure the cost of ongoing cleaning services is factored into any new procurement, taking into account the whole life cost, and that cleaning services are consulted whenever furnishings and fabrics are procured;**

vi. **the Trust Facilities Forum for Wales evaluates the pilot schemes for overcoming staffing issues and, if they are successful, promulgates details of those schemes across the NHS in Wales;**

vii. **the new cleaning specifications that have been developed by trusts should detail the entire hospital area, room by room, specifying the frequency that the area needs to be cleaned and what the area should look like after it has been cleaned – the specifications should be input and output driven;**

viii. **the accountability for the cleaning of ward equipment and carrying it out should be more clearly defined and monitored;**

ix. **the NHS Wales Department works with individual NHS trusts to ensure that monitoring of cleaning is consistent across Wales and that trusts consider making the best use of IT to ensure consistency;**

x. **results of monitoring cleaning services are reported monthly to the management of cleaning services at each Trust, with any reports that show wards failing to achieve acceptable standards be discussed at Board level and referred to the infection control team;**

xi. **the importance of cleaning and the level of cleaning services being provided is clearly communicated and understood by all hospital staff, and that all hospital staff have an introduction to the importance of cleaning during their induction; and**

xii. **in addition to the monitoring of the national standards recently issued, the NHS Wales Department produces not only a report on the results but a detailed action plan for any hospital that fails to meet the standards.**

## Concluding comments

36. We have seen and heard evidence on the importance of a clean hospital to patients, visitors and staff, and on widespread shortcomings across the NHS in Wales in relation to cleaning. It has long been recognised that cleaning, among other hospital services, has not been a priority over the past decade. We have seen patient numbers increase and hospitals expand in size, yet hospital cleaning specifications have not adjusted to reflect this. There are significant variations in the cost of cleaning throughout Wales and numerous personnel issues around the recruitment and retention of staff. Our hospitals have not been working to a common set of national standards and have been continually failing to meet their own cleaning standards. There has been insufficient senior management involvement in the monitoring of cleanliness, which is core business. There is some evidence of the links between cleanliness and infections; yet there are still hospitals that do not involve infection control teams in the development and management of hospital cleaning standards. It is clear to the Committee that there is a lack of a clean culture throughout the NHS in Wales and not all hospital staff see cleanliness as a key issue for them. Taken overall, the management of hospital cleaning has been and remains unsatisfactory.

37. However, we are pleased to see that that many of these problems are in the process of being addressed and improvements, hopefully, are in prospect. One of the key building blocks for developing a clean culture, a set of national cleaning standards, has recently been issued to the NHS in Wales. We are pleased that, prior to the Committee hearing, the NHS Wales Department has been working on areas of particular weakness, drawing on the work of the Auditor General and the National Audit Office Wales. The All Wales Facilities Group has used the best guidance available to produce what appears to be a robust set of standards and this work will be continued under the auspices of the Trust Facilities Forum. The Auditor General's work shows that pockets of good practice are already out there. We therefore encourage both local health boards and trusts, with the support of the NHS Wales Department, to identify and adopt best practice where it exists elsewhere.

38. Whilst we are pleased with the progress now being made and the improvements that should result from these new standards, we still have reservations over the ability of trusts to achieve them. We have seen that trusts have not in the past been able to meet the cleaning standards they had set for themselves, and some have significant cleaning budget deficits. It is imperative that the new standards do not sit on the shelf to be admired but are achieved. We are still looking forward to the results of the first audit of the new

standards - which we expect to be made available to us - and hopes that this will mark a significant upward move in hospital cleanliness.

# Cynulliad Cenedlaethol Cymru
## Pwyllgor Archwilio

# The National Assembly for Wales
## Audit Committee

**Rheoli a Darparu Gwasanaethau Glanhau Ysbytai yng Nghymru**
**The Management and Delivery of Hospital Cleaning Services in Wales**

**Cwestiynau 1-136**
**Questions 1-136**

**Dydd Iau 17 Gorffennaf 2003**
**Thursday 17 July 2003**

*Aelodau o'r Cynulliad yn bresennol: Janet Davies (Cadeirydd), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Christine Gwyther, Mark Isherwood, Denise Idris Jones, Val Lloyd.*

*Swyddogion yn bresennol: Syr John Bourn, Archwilydd Cyffredinol Cymru; Gillian Body, Swyddfa Archwilio Genedlaethol Cymru; Frank Grogan, Swyddfa Archwilio Genedlaethol Cymru; David Powell, Swyddog Cydymffurfio Cynulliad Cenedlaethol Cymru.*

*Tystion: Ann Lloyd, Cyfarwyddwr GIG Cymru; Stuart Fletcher, Pennaeth Dros Dro, Gwasanaethau Ystadau GIG Cymru; Dr Anthony Howard, Cyfarwyddwr Heintiadau a Chlefydau Trosglwyddadwy, Gwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru.*

*Assembly Members present: Janet Davies (Chair), Leighton Andrews, Mick Bates, Alun Cairns, Jocelyn Davies, Christine Gwyther, Mark Isherwood, Denise Idris Jones, Val Lloyd.*

*Officials present: Sir John Bourn, Auditor General for Wales; Gillian Body, National Audit Office Wales; Frank Grogan, National Audit Office Wales; David Powell, National Assembly for Wales Compliance Officer.*

*Witnesses: Ann Lloyd, Director of NHS Wales; Stuart Fletcher, Acting Head of Estates Services, NHS Wales; Dr Anthony Howard, Director for Infection and Communicable Diseases, National Public Health Service for Wales.*

*Dechreuodd y cyfarfod am 9.30 a.m.*
*The meeting began at 9.30 a.m.*

[1] **Janet Davies:** Good morning. I welcome everyone to the second meeting of the Audit Committee in the second Assembly. An apology has been received from Carl Sargeant, and I understand that Val will be asking his allocated questions on the report. Do any Members need to make declarations of interest? I see that they do not. I will need to declare an interest when we reach the item on draft Committee reports, but I will leave that until later.

[1] **Janet Davies:** Bore da. Croesawaf bawb i ail gyfarfod y Pwyllgor Archwilio yn yr ail Gynulliad. Derbyniwyd ymddiheuriad gan Carl Sargeant, a deallaf y bydd Val yn gofyn ei gwestiynau penodol ar yr adroddiad. A oes gan unrhyw Aelodau ddatganiadau o fudd i'w gwneud? Gwelaf nad oes. Bydd angen imi ddatgelu budd pan fyddwn yn cyrraedd yr eitem ar adroddiadau drafft y Pwyllgor, ond yr wyf am adael hynny tan yn ddiweddarach.

The Committee operates bilingually, so if anyone wishes to speak in Welsh, they are welcome to do so. Headsets are provided for the translation, and they are also helpful if people have difficulty in hearing, as the acoustics are not good at times. I ask everyone to ensure that they have switched off their mobile phones, pagers and other electronic devices. Not only do they cause an interruption, but also even text messages can cause difficulties for those using headsets.

Mae'r Pwyllgor yn gweithredu'n ddwyieithog, felly os oes unrhyw un am siarad yn Gymraeg, mae croeso iddynt wneud hynny. Darperir clustffonau ar gyfer y cyfieithiad, ac maent hefyd yn ddefnyddiol os ydych yn drwm eich clyw, gan nad yw'r acwsteg yn dda yma o bryd i'w gilydd. Yr wyf yn gofyn i bawb ddiffodd eu ffonau symudol, galwyr ac unrhyw ddyfeisiau electronig eraill. Maent nid yn unig yn tarfu ar y drafodaeth, ond gall hyd yn oed negeseuon testun beri anawsterau i'r rhai sy'n defnyddio clustffonau.

The second item on today's agenda is an evidence session on the management and

Sesiwn dystiolaeth ar reoli a darparu gwasanaethau glanhau ysbytai yw'r ail eitem

delivery of hospital cleaning services. This is in connection with the report by the Auditor General for Wales, which was published on 23 May. I welcome the three witnesses and ask them to introduce themselves.

ar yr agenda heddiw. Mae hyn yn gysylltiedig â'r adroddiad gan Archwilydd Cyffredinol Cymru, a gyhoeddwyd ar 23 Mai. Croesawaf y tri thyst a gofynnaf iddynt gyflwyno eu hunain.

**Ms Lloyd:** I am Ann Lloyd, the director of NHS Wales.

**Ms Lloyd:** Fi yw Ann Lloyd, cyfarwyddwr GIG Cymru.

**Mr Fletcher:** I am Stuart Fletcher, acting head of the NHS estates and facilities branch.

**Mr Fletcher:** Fi yw Stuart Fletcher, pennaeth dros dro gwasanaethau ystadau a chyfleusterau'r GIG.

**Dr Howard:** I am Tony Howard, director for infection and communicable diseases in the National Public Health Service for Wales. I also chair the Assembly's healthcare associated infection sub-group. [*Interruption.*]

**Dr Howard:** Fi yw Tony Howard, cyfarwyddwr heintiau a chlefydau trosglwyddadwy yng Ngwasanaeth Iechyd Cyhoeddus Cenedlaethol Cymru. Yr wyf hefyd yn cadeirio is-grŵp heintiau cysylltiedig gofal iechyd y Cynulliad. [*Torri ar draws*.]

[2] **Janet Davies:** I ask everyone again to switch off their mobile phones.

[2] **Janet Davies:** Gofynnaf eto i bawb ddiffodd eu ffonau symudol.

[3] **Christine Gwyther:** I apologise, Chair.

[3] **Christine Gwyther:** Ymddiheuraf, Gadeirydd.

[4] **Janet Davies:** That is okay. I will start with the first question. I am very pleased that we are considering this report, because I think that it is a very important report for hospitals in Wales. Ms Lloyd, it does seem from the report that hospital cleanliness has not been particularly high on the NHS agenda. How do you intend to instil a clean culture in the health service in Wales?

[4] **Janet Davies:** Mae hynny'n iawn. Yr wyf am ddechrau gyda'r cwestiwn cyntaf. Yr wyf yn falch iawn ein bod yn ystyried yr adroddiad hwn, oherwydd credaf ei fod yn adroddiad pwysig iawn i ysbytai yng Nghymru. Ms Lloyd, ymddengys o'r adroddiad nad yw glanweithdra ysbytai wedi bod yn uchel iawn ar agenda'r GIG. Sut yr ydych yn bwriadu sefydlu diwylliant glân yn y gwasanaeth iechyd yng Nghymru?

**Ms Lloyd:** I think that support services in hospitals have traditionally been those areas where we have always looked for efficiencies. It has been very much an issue of direct management control by trust chief executives. The Assembly itself had little influence over it. That changed when the 'Plan for Wales 2001' was produced, and we set up, as part of the implementation teams that would look at those recommendations and how they could be taken forward, a facilities sub-group. From that, the standards that will be produced in the next 10 days have been established. I think that people tend to be oblivious about the state of cleanliness in hospitals. If you walk through the corridors and wards in hospitals, you will

**Ms Lloyd:** Credaf fod gwasanaethau cymorth mewn ysbytai yn draddodiadol wedi bod yn feysydd lle'r ydym wastad wedi ceisio bod yn effeithlon. Mae wedi bod yn fater o fesurau rheoli uniongyrchol gan brif weithredwyr yr ymddiriedolaethau. Nid oedd gan y Cynulliad ei hun lawer o reolaeth dros hyn. Newidiodd hynny pan gynhyrchwyd y 'Cynllun i Gymru 2001', a bu i ni sefydlu, fel rhan o'r timau gweithredu a fyddai'n edrych ar yr argymhellion hynny a sut y gellid eu datblygu, is-grŵp cyfleusterau. O hynny, sefydlwyd y safonau a fydd yn cael eu cynhyrchu yn y 10 diwrnod nesaf. Credaf fod pobl yn tueddu i anghofio am gyflwr glanweithdra ysbytai. Wrth gerdded drwy goridorau a wardiau ysbytai, byddwch yn

see many examples of where, if it was your own home, you would not have it like that. It seems that, with the rush and the hurly-burly and the concentration, quite rightly, on clinical care, cleaning and the cleanliness of hospitals has been overlooked in some instances. Also, we have not in the past produced definitive information on what constitutes a clean hospital and, more importantly, on what we should be doing about hand hygiene, which is one of the major causes of the spread of infection in hospitals, rather than on whether or not the floors are clean—although, aesthetically, one does not like a dirty environment. So I think that, with the establishment of these standards and with the establishment of a trust facilities forum for Wales, which will be charged with auditing good practice and making sure that good practice is spread throughout Wales, and with this being performance managed now as well so that we get a better understanding of the variations in performance throughout Wales, and also with the requirement that infection control teams play a much greater part in heightening awareness in terms of hygiene and cleanliness in hospitals, then we will be monitoring very carefully how a clean culture is developing within those hospitals.

gweld sawl enghraifft lle, pe bai'n gartref i chi, na fyddech yn ei adael fel hynny. Ymddengys, gyda'r bwrlwm a'r cynnwrf a'r canolbwyntio, a hynny'n iawn, ar ofal clinigol, bod glanhau a glanweithdra mewn ysbytai wedi'u hesgeuluso mewn ambell achos. Yn ogystal, nid ydym yn y gorffennol wedi cynhyrchu gwybodaeth bendant am yr hyn sy'n gwneud ysbyty glân ac, yn bwysicach, beth y dylem ei wneud o ran hylendid dwylo, sef un o brif achosion lledaenu heintiau mewn ysbytai, yn hytrach nag a yw'r lloriau'n lân ai peidio—er, yn esthetaidd, nid yw pobl yn hoffi amgylchedd budr. Felly credaf, ar ôl sefydlu'r safonau hyn a sefydlu fforwm cyfleusterau ymddiriedolaeth i Gymru, a fydd yn gyfrifol am archwilio arferion da a sicrhau bod arferion da yn cael eu lledaenu ledled Cymru, gyda pherfformiad yn cael ei reoli hefyd er mwyn i ni gael gwell dealltwriaeth o'r amrywiaethau o ran perfformiad ledled Cymru, a hefyd gyda'r gofyniad i dimau rheoli heintiau chwarae rhan gynyddol i hybu ymwybyddiaeth o ran hylendid a glanweithdra mewn ysbytai, byddwn yn monitro datblygiad diwylliant glân yn ofalus iawn yn yr ysbytai hynny.

[5] **Janet Davies:** Thank you, Ms Lloyd. You are talking, then, about a clean culture being developed. You mentioned a whole list of procedures and systems that are being put into place. Do you think that these will be successful in instilling in everyone, from porters to visitors to consultants, that it is not only cleaners' responsibility to keep a hospital clean, but the responsibility of everyone?

[5] **Janet Davies:** Diolch, Ms Lloyd. Yr ydych yn siarad, felly, am ddatblygu diwylliant glân. Bu i chi grybwyll rhestr gyflawn o weithdrefnau a systemau sy'n cael eu rhoi ar waith. A ydych yn credu y bydd y rhain yn llwyddo i drosglwyddo'r neges i bawb, o borthorion i ymwelwyr i ymgynghorwyr, nad cyfrifoldeb y glanhawyr yn unig yw cadw ysbyty yn lân, ond cyfrifoldeb pawb?

**Ms Lloyd:** Yes, I sincerely hope so. However, I think that we have a lot of work to do because, certainly in terms of the junior staff and the staff who work on the wards, we really have to ensure that hand hygiene and other hygiene processes are followed absolutely, because it is really essential. As part of the induction programmes now, within each of the organisations, we include this very important area of hand hygiene and the spread of infection and the fragility of the patients—the patients who are coming into our hospitals are much more ill and

**Ms Lloyd:** Ydw, yr wyf yn mawr obeithio hynny. Fodd bynnag, credaf fod gennym lawer o waith i'w wneud oherwydd, yn sicr o ran y staff iau a'r staff sy'n gweithio ar y wardiau, mae'n rhaid i ni sicrhau bod pobl yn dilyn prosesau hylendid dwylo a phrosesau hylendid eraill, oherwydd mae hynny'n wirioneddol hanfodol. Fel rhan o'r rhaglenni sefydlu yn awr, ym mhob sefydliad, yr ydym yn cynnwys y maes pwysig iawn hwn o hylendid dwylo a lledaenu heintiau ac eiddilwch cleifion—mae'r cleifion sy'n dod i'n hysbytai yn llawer mwy sâl a bregus nag

vulnerable than they used to be—and it is really important that all the staff understand that.

yn y gorffennol—ac mae'n bwysig iawn bod yr holl staff yn deall hynny.

In terms of visitors and other people who attend hospitals, I think that we just have to have a vigilant attitude and point out quite calmly to people that dropping stuff all over the place is not acceptable. Hospitals are places of care and they are not to be abused. It used to thoroughly irritate me when I went down my hospital corridors and saw people dropping stuff all over the place. We have to be able to challenge that in a constructive way. It cannot add to the confidence that patients or visitors have in the care that we are able to provide if they come into an environment which to their mind looks uncared-for and not clean.

O ran ymwelwyr a phobl eraill sy'n ymweld ag ysbytai, credaf fod yn rhaid i ni feithrin agwedd wyliadwrus a dweud wrth bobl yn bwyllog nad yw gollwng eitemau ymhob man yn dderbyniol. Mae ysbytai yn lleoedd sy'n rhoi gofal ac ni ddylid eu camddefnyddio. Yr oedd yn arfer fy ngwylltio'n gacwn pan fyddwn yn cerdded i lawr coridorau ysbytai a gweld pobl yn gollwng eitemau ar y llawr. Mae'n rhaid i ni allu herio hynny mewn ffordd adeiladol. Ni all hyn ychwanegu at hyder cleifion neu ymwelwyr yn y gofal y gallwn ei ddarparu os ydynt yn dod i mewn i amgylchedd sy'n ymddangos yn ddiofal ac yn fudr iddynt.

[6] **Janet Davies:** When I hear you coughing as you just did, Mrs Lloyd, I sometimes think that you should be in hospital. [*Laughter*.]

[6] **Janet Davies:** Pan fyddaf yn eich clywed yn tagu fel y gwnaethoch yn awr, Mrs Lloyd, credaf weithiau y dylech fod yn yr ysbyty. [*Chwerthin*.]

The NHS in England has set up independent patient environment action teams to assess the quality of the hospital environment, including the cleanliness. Could you explain why there has not been any systematic review to assess the standards of cleanliness in hospitals in Wales? Maybe you are going to say that there has been now, but perhaps you could explain what the situation is.

Mae'r GIG yn Lloegr wedi sefydlu timau gweithredu amgylchedd y claf annibynnol i asesu ansawdd amgylchedd ysbytai, gan gynnwys glanweithdra. A allwch egluro pam nad oes adolygiad systematig wedi'i gynnal i asesu safonau glanweithdra mewn ysbytai yng Nghymru? Efallai eich bod am ddweud bod un ar waith yn awr, ond efallai y gallwch egluro'r sefyllfa i ni.

**Ms Lloyd:** The concept of the patient environment action teams in England was established as part of the NHS plan that it produced in June 2000. We did not adopt that immediately, as the Assembly Government was preparing its own plan for Wales. The importance of cleanliness and standards was highlighted in that report. That is why we have now produced our standards but, additionally, our community health councils were at the time engaged in some really valuable work in looking at the hospital environment. That has now been implemented. The baseline self-assessment of each trust was completed in May and our CHC colleagues will be inspecting each of the environments in September and October. So, we have done it slightly differently but in a parallel way in Wales, so that highlights how important cleanliness within an

**Ms Lloyd:** Sefydlwyd cysyniad y timau gweithredu amgylchedd y claf yn Lloegr yn rhan o'r cynllun GIG a luniwyd ganddo ym Mehefin 2000. Ni wnaethom fabwysiadu hwnnw'n syth, gan fod Llywodraeth y Cynulliad yn paratoi ei gynllun ei hun ar gyfer Cymru. Rhoddwyd sylw i bwysigrwydd glanweithdra a safonau yn yr adroddiad hwnnw. Dyna pam ein bod bellach wedi cynhyrchu ein safonau ond, hefyd, yr oedd ein cynghorau iechyd cymuned ar y pryd yn cyflawni gwaith gwerthfawr iawn yn edrych ar amgylchedd ysbytai. Mae hwnnw ar waith bellach. Cwblhawyd hunan-asesiad llinell sylfaen pob ymddiriedolaeth ym mis Mai a bydd ein cydweithwyr CIC yn archwilio pob amgylchedd ym mis Medi a Hydref. Felly, yr ydym wedi'i wneud ychydig yn wahanol ond mewn ffordd gyffelyb yng Nghymru, ac mae hynny'n

environment is to us all. So we have done it slightly differently.

pwysleisio pa mor bwysig yw glanweithdra mewn amgylchedd i ni i gyd. Felly yr ydym wedi gwneud hyn ychydig yn wahanol.

[7] **Janet Davies:** Right, thank you. Val, you have some questions to ask?

[7] **Janet Davies:** Iawn, diolch. Val, mae gennych gwestiynau i'w gofyn?

[8] **Val Lloyd:** Ms Lloyd, you mentioned 'Improving Health in Wales' and the aim to introduce a number of specific measures, and you told us about the trust facilities forum. However, the Auditor General's report shows that progress has not been made on all aspects of the strategy. Could you tell us why progress has been so slow, considering that you yourself talked about the importance that we should place on hospital cleaning?

[8] **Val Lloyd:** Ms Lloyd, crybwyllasoch 'Gwella Iechyd yng Nghymru' a'r nod o gyflwyno nifer o fesurau penodol, a dywedasoch wrthym am fforwm cyfleusterau'r ymddiriedolaethau. Fodd bynnag, mae adroddiad yr Archwilydd Cyffredinol yn dangos na chafwyd cynnydd ar bob agwedd ar y strategaeth. A allwch ddweud wrthym pam fod y cynnydd wedi bod mor araf, o ystyried eich bod chi eich hun wedi siarad am bwysigrwydd glanhau ysbytai?

**Ms Lloyd:** I think that the standards have been delayed beyond that which we expected, and I think that this was largely because this was a highly complex area and we really needed to get them right. We also took the opportunity to engage properly with the service itself and to gain its commitment. Therefore the consultation period was extended to make sure that everyone had the opportunity to comment on these standards, and to comment on how applicable they would be and how they could be measured. Although I would have preferred to have done this a year ago, I think that it was really important that we gained a commitment from the service, and its views on how it could manage the establishment of standards and being measured against them. Also, we took the time to engage the CHCs fully because their patient environment teams and hospital inspection teams, and our work on the national standards, have to correlate and work together.

**Ms Lloyd:** Credaf fod y safonau wedi'u hoedi y tu hwnt i'r hyn yr oeddem yn ei ddisgwyl, a chredaf fod hyn yn bennaf oherwydd bod hwn yn faes cymhleth iawn a bod angen cyflawni'r gwaith yn iawn. Manteisiwyd ar y cyfle hefyd i gydweithio'n agos â'r gwasanaeth ei hun ac i sicrhau ei ymrwymiad. Felly ehangwyd y cyfnod ymgynghori i sicrhau bod gan bawb y cyfle i roi sylwadau ar y safonau hyn, ac i roi sylwadau ar ba mor gymwys fyddent a sut y gellid eu mesur. Er y byddwn wedi dewis gwneud hyn flwyddyn yn ôl, credaf ei bod yn bwysig iawn ein bod wedi sicrhau ymrwymiad y gwasanaeth, a'i safbwyntiau ar sut y gallai reoli'r gwaith o sefydlu safonau a chael ei fesur yn eu herbyn. Hefyd, cymerwyd yr amser i gynnwys y CIC yn llawn oherwydd bod yn rhaid i'w timau sy'n ymdrin ag amgylchedd y claf a'u timau archwilio ysbytai, a'n gwaith ar y safonau cenedlaethol, gydberthyn a gweithio gyda'i gilydd.

So I apologise for the slowness in getting there, but I think that the finished product and the outcome should be more sustainable within the service.

Felly ymddiheuraf ein bod wedi cymryd ein hamser, ond credaf y bydd y cynnyrch gorffenedig a'r canlyniad yn fwy cynaliadwy o fewn y gwasanaeth.

[9] **Val Lloyd:** Thank you. Could I ask a follow-up question? You have given some indication of the steps that are being taken to ensure that the cleanliness strategy will be implemented. Are there any more steps, and could you tell us when you expect full

[9] **Val Lloyd:** Diolch. A gaf fi ofyn cwestiwn dilynol? Yr ydych wedi rhoi awgrymiadau am y camau sy'n cael eu cymryd i sicrhau y caiff y strategaeth lanweithdra ei gweithredu. A oes unrhyw gamau eraill, ac a allwch ddweud wrthym

compliance?

pryd yr ydych yn disgwyl cydymffurfio'n llawn?

**Ms Lloyd:** I am sorry, but I did not hear that. I got the 'full compliance', but missed the bit before it.

**Ms Lloyd:** Mae'n ddrwg gennyf, ond ni chlywais hynny. Fe glywais y 'cydymffurfio'n llawn', ond collais y rhan cyn hynny.

[10] **Val Lloyd:** You have given an outline of the steps that you took to ensure that the strategy would be implemented, but what other steps have been taken to ensure that it will be fully implemented?

[10] **Val Lloyd:** Yr ydych wedi rhoi amlinelliad o'r camau a gymerwyd gennych i sicrhau y byddai'r strategaeth yn cael ei gweithredu, ond pa gamau eraill sydd wedi'u cymryd i sicrhau y bydd yn cael ei gweithredu'n llawn?

**Ms Lloyd:** Well, it is now a statutory requirement and you will see on the balanced scorecards that we will be producing—giving the overarching performance of each organisation—that the environment is an important part of those. First, we must get a baseline survey. From that we will be able to work with each organisation over time to ensure full compliance and also an extension of the standards. It is important that we do not just adopt one set of standards forever because, as you know, the workload in hospitals is changing all the time. One of the problems has been that our cleaning standards and cleaning guidance have not kept up with that changing workload. So, we will have an agreement with each organisation about the progress that it can make—it is one of our continuous improvement targets—and we will also monitor whether or not it is complying with best practice and really spreading some of the good practice to ensure that cleaning standards can be improved.

**Ms Lloyd:** Wel, mae'n amod statudol bellach a byddwch yn gweld ar yr adroddiadau mesur perfformiad y byddwn yn eu cynhyrchu—o ystyried perfformiad cyffredin pob sefydliad—bod yr amgylchedd yn rhan bwysig o'r rheini. Yn gyntaf, mae'n rhaid i ni gael arolwg llinell sylfaen. O hwnnw byddwn yn gallu gweithio gyda phob sefydliad dros amser i sicrhau cydymffurfiaeth lawn ac ehangu'r safonau. Mae'n bwysig nad ydym yn mabwysiadu un gyfres o safonau'n unig am byth oherwydd, fel y gwyddoch, mae'r llwyth gwaith yn newid drwy'r amser mewn ysbytai. Un o'r problemau yw nad yw ein safonau glanhau a'n canllawiau glanhau wedi cadw i fyny â'r llwyth gwaith newidiol hwnnw. Felly, byddwn yn cytuno â phob sefydliad ar y cynnydd y gall ei wneud—mae'n un o'n targedau gwella parhaus—a byddwn hefyd yn monitro a yw'n cydymffurfio â'r arferion gorau ai peidio ac a yw'n lledaenu rhywfaint o'r arferion da i sicrhau y gellir gwella safonau glanhau.

[11] **Janet Davies:** Okay. Denise, you have some questions to ask?

[11] **Janet Davies:** Iawn. Denise, mae gennych gwestiynau i'w gofyn?

[12] **Denise Idris Jones:** The all-Wales facilities group has three objectives: developing definitions of environmental cleanliness, determining the interface between environmental cleanliness and infection control and developing national cleaning standards. What progress has been made on all three of the all-Wales facilities group's objectives?

[12] **Denise Idris Jones:** Mae gan y grŵp cyfleusterau Cymru gyfan dri amcan: datblygu diffiniadau o lanweithdra amgylcheddol, pennu'r berthynas rhwng glanweithdra amgylcheddol a rheoli heintiau a datblygu safonau glanhau cenedlaethol. Pa gynnydd sydd wedi'i wneud gyda thri amcan y grŵp cyfleusterau Cymru gyfan?

**Ms Lloyd:** Well, on the cleaning standards, they will be produced in 10 days' time. So, I

**Ms Lloyd:** Wel, o ran y safonau glanhau, byddant yn cael eu cynhyrchu ymhen 10

think that that will be an important landmark for that. In terms of infection control, the facilities group has on it, and on all its subsequent sub-groups, infection control people, and they have outlined the ways in which infection control teams should be engaged more purposefully in cleaning standards: in overseeing cleaning standards, in looking at the equipment that is purchased to ensure that it can be cleaned, the frequency of cleaning and what should be done when equipment is moved around hospitals. It also recommends that the outcomes of the cleaning standards assessment is sent to the infection control committees so that they can give additional guidance. I think that the role of infection control teams, and the importance of that role, has been highlighted by the work that the trust facilities group has done so far. However, we expect the work of that group to be expanded further so that it encompasses portering, linen services and security, so that it wraps up the whole support teams that are contained within each of our organisations to ensure that really good practice is spread throughout those teams. So it has made a good start, but its work is by no means finished.

diwrnod. Felly, credaf y bydd hynny'n garreg filltir ar gyfer hynny. O ran rheoli heintiau, mae swyddogion rheoli heintiau ar y grŵp cyfleusterau, ac ar ei holl is-grwpiau dilynol, ac maent wedi amlinellu'r ffyrdd y dylai timau rheoli heintiau gyfrannu'n fwy penderfynol at safonau glanhau: drwy oruchwylio safonau glanhau, edrych ar y cyfarpar a brynir i sicrhau y gellir ei lanhau, pa mor aml y glanheir a beth ddylai gael ei wneud wrth symud cyfarpar o gwmpas ysbytai. Mae hefyd yn argymell bod canlyniadau'r asesiad safonau glanhau yn cael eu hanfon i'r pwyllgorau rheoli heintiau fel y gallant roi canllawiau ychwanegol. Credaf fod rôl timau rheoli heintiau, a phwysigrwydd y rôl honno, wedi'i hamlygu gan y gwaith y mae'r grŵp cyfleusterau ymddiriedolaethau wedi'i wneud hyd yma. Fodd bynnag, yr ydym yn disgwyl i waith y grŵp hwnnw gael ei ehangu ymhellach fel ei fod yn cynnwys dyletswyddau porthorion, gwasanaethau dillad gwely a diogelwch, er mwyn iddo gwmpasu'r holl dimau cymorth sydd wedi'u cynnwys ym mhob un o'n sefydliadau i sicrhau bod arferion da iawn yn cael eu lledaenu ledled y timau hynny. Felly mae wedi dechrau'n dda, ond nid yw ei waith wedi'i orffen ar unrhyw gyfrif.

[13] **Denise Idris Jones:** I have a follow-up question. You have said that this report will come out in 10 days' time and so you might have answered this. When will the work of the all-Wales facilities group be completed and introduced to the trusts?

[13] **Denise Idris Jones:** Mae gennyf gwestiwn dilynol. Yr ydych wedi dweud y bydd yr adroddiad hwn yn cael ei gyhoeddi ymhen 10 diwrnod felly efallai eich bod wedi ateb hyn. Pryd fydd gwaith y grŵp cyfleusterau Cymru gyfan yn cael ei gyflawni a'i gyflwyno i'r ymddiriedolaethau?

**Ms Lloyd:** Well, as soon as the patient environment standards are produced, we will start to monitor them in our next round of quarterly reviews, performance reviews with trusts, so we will start that then. The facilities group will be wound up, but transmogrified into a facilities forum and it will start to take on this additional work to look at the other support services that underpin clinical care. So its work is by no means finished yet.

**Ms Lloyd:** Wel, cyn gynted ag y bydd safonau amgylchedd y claf yn cael eu cynhyrchu, byddwn yn dechrau eu monitro yn ein cylch nesaf o adolygiadau chwarterol, adolygiadau perfformio gydag ymddiriedolaethau, felly byddwn yn cychwyn ar hynny bryd hynny. Bydd y grŵp cyfleusterau'n dod i ben, a'i weddnewid yn fforwm cyfleusterau a bydd yn dechrau ymgymryd â'r gwaith ychwanegol hwn i edrych ar y gwasanaethau cymorth eraill sy'n ategu gofal clinigol. Felly nid yw ei waith wedi'i orffen eto ar unrhyw gyfrif.

[14] **Janet Davies:** Leighton, you have some questions to ask?

[14] **Janet Davies:** Leighton, mae gennych gwestiynau i'w gofyn?

[15] **Leighton Andrews:** Ms Lloyd, can I refer you to figure 1 on page 8 of the Auditor General's report? It sets out the cleaning costs per square metre in each hospital. There seems to be an extraordinary range of variations in the cost of cleaning per square metre between, for example, Neath General Hospital, at £46, and the University Hospital of Wales, at £14. Obviously, there is a balance between efficiency and assurance about standards in this, but could you give us your observations on why there are such wide variations?

[15] **Leighton Andrews:** Ms Lloyd, a gaf fi dynnu eich sylw at ffigur 1 ar dudalen 8 adroddiad yr Archwilydd Cyffredinol? Mae'n nodi costau glanhau fesul metr sgwâr ym mhob ysbyty. Ymddengys bod amrywiaeth anhygoel rhwng costau glanhau fesul metr sgwâr rhwng, er enghraifft, Ysbyty Cyffredinol Castell-nedd, sef £46, ac Ysbyty Athrofaol Cymru, sef £14. Yn amlwg, mae cydbwysedd rhwng effeithlonrwydd a sicrwydd am safonau yn hyn, ond a allwch roi eich sylwadau ar y rhesymau dros amrywiaethau mor eang?

**Ms Lloyd:** Well, I think that there are a variety of reasons. Unfortunately, Neath General Hospital is now closed. I think that some of the factors include the priority that trust management has given to cleaning within the organisations, how old the buildings are—as we all know, the older the building, the more difficult they usually are to clean—how well they have been maintained and what sort of materials are being used. We have found in the past that there was a great surge in favour of having a more homely environment in many hospitals, and you found carpets being laid in acute general wards. They cost a great deal of money to clean, and they were not always satisfactorily cleaned. In fact, most of them were taken up. Therefore, I think that the equipment, the way in which the hospital is designed and the priority given by the management to the importance of maintaining that clean environment have all been factors in this variation. However, when we have undertaken our first round of environmental assessment reviews, then we might be able to unpick some of this in a more constructive way because we have not routinely monitored things such as the costs in the past.

**Ms Lloyd:** Wel, credaf fod pob math o resymau. Yn anffodus, mae Ysbyty Cyffredinol Castell-nedd wedi cau bellach. Credaf fod rhai o'r ffactorau'n cynnwys y flaenoriaeth y mae rheolwyr yr ymddiriedolaeth wedi'i rhoi i lanhau o fewn y sefydliadau, pa mor hen yw'r adeiladau—fel y gwyddom i gyd, po hynaf yw'r adeilad, yr anoddaf oll ydynt i'w glanhau fel arfer—pa mor dda y maent wedi'u cynnal a'u cadw a pha fath o ddeunyddiau sy'n cael eu defnyddio. Yr ydym wedi canfod yn y gorffennol bod cynnydd mawr o blaid sicrhau amgylchedd mwy cartrefol mewn sawl ysbyty, a gwelwyd carpedi'n cael eu gosod mewn wardiau cyffredinol aciwt. Maent yn ddrud iawn i'w glanhau, ac nid oeddent wastad yn cael eu glanhau'n foddhaol. Yn wir, yr oedd y mwyafrif ohonynt yn cael eu codi. Felly, credaf fod y cyfarpar, y ffordd y mae'r ysbyty'n cael ei gynllunio a'r flaenoriaeth a roddir gan y rheolwyr i bwysigrwydd cynnal a chadw'r amgylchedd glân hwnnw i gyd wedi bod yn ffactorau yn yr amrywiaeth hwn. Fodd bynnag, ar ôl i ni gyflawni'r cylch cyntaf o adolygiadau asesu amgylcheddol, efallai y byddwn yn gallu mynd i'r afael ag agweddau ar hyn yn fwy adeiladol oherwydd nad ydym wedi monitro pethau megis costau yn rheolaidd yn y gorffennol.

[16] **Leighton Andrews:** You made the point that a hospital's age is a factor. However, in looking at the table, Royal Glamorgan Hospital, which is a very new hospital, is in fact the most expensive after the now-closed Neath General Hospital. Many of my constituents use this hospital regularly—at least, when the buses are

[16] **Leighton Andrews:** Gwnaethoch y pwynt bod oed ysbyty yn ffactor. Fodd bynnag, wrth edrych ar y tabl, Ysbyty Brenhinol Morgannwg, sy'n ysbyty newydd sbon, yw'r drutaf ar ôl Ysbyty Cyffredinol Castell-nedd, sydd wedi cau bellach. Mae nifer o'm hetholwyr yn defnyddio'r ysbyty hwn yn rheolaidd—o leiaf, pan fydd y

running. Is it possible that the reason why, its being a new hospital, it is so much more expensive is that—are you going to tell us that it is because the management has looked more closely at the costs? Is it because it has more recently looked at the costs? Do you have views on that?

bysiau'n rhedeg. A oes posibilrwydd mai'r rheswm pam, ac yntau'n ysbyty newydd, ei fod cymaint drutach yw—a ydych yn mynd i ddweud wrthym bod hyn oherwydd bod y rheolwyr wedi edrych ar y costau'n fwy manwl? A yw hyn oherwydd ei fod wedi edrych yn ddiweddar ar y costau? A oes gennych farn ar hynny?

**Ms Lloyd:** It is possible that the management places a high importance on maintaining a clean environment. However, until we undertake our review, I cannot assure you of an answer.

**Ms Lloyd:** Mae'n bosibl bod y rheolwyr yn rhoi'r pwys mwyaf ar gynnal a chadw amgylchedd glân. Fodd bynnag, tan i ni gyflawni ein hadolygiad, ni allaf roi ateb sicr i chi.

[17] **Leighton Andrews:** Okay. I think that we would want to see the results of that review, because the Royal Glamorgan figure is quite striking and that raises quite a lot of issues such as whether, because it is a new hospital, it has simply struck new contracts that have gone into the whole issue in more detail. That might be rather worrying in terms of the other hospitals. Would you accept that?

[17] **Leighton Andrews:** Iawn. Credaf y byddem am gael gweld canlyniadau'r adolygiad hwnnw, oherwydd bod ffigur Ysbyty Brenhinol Morgannwg yn eithaf trawiadol ac mae hynny'n codi nifer o gwestiynau megis a yw wedi ymrwymo i nifer o gontractau newydd sydd wedi mynd i'r afael yn fwy trylwyr â'r mater yn ei gyfanrwydd oherwydd ei fod yn ysbyty newydd. Gallai hynny fod yn achos pryder o ran yr ysbytai eraill. A fyddech yn derbyn hynny?

**Ms Lloyd:** Yes. That is absolutely true. It has reduced its costs to £30 per square metre now. Nevertheless, that is one of the issues that we will take up with it and other hospitals.

**Ms Lloyd:** Byddwn. Mae hynny'n hollol wir. Mae wedi gostwng ei gostau i £30 fesul metr sgwâr bellach. Fodd bynnag, dyna un o'r materion y byddwn yn ei drafod gydag ef ac ysbytai eraill.

[18] **Leighton Andrews:** Obviously, a large proportion of the costs—over 90 per cent of the cleaning costs—are staff costs. Another factor in the report that is signalled to us is that there are clearly high staff vacancies, high staff turnover and high levels of sickness among staff. That cannot be doing much for the costs of the service. Do you think that it is possible to improve the cleanliness of hospitals without tackling some of those issues?

[18] **Leighton Andrews:** Yn amlwg, mae cyfran fawr o'r costau—dros 90 y cant o'r costau glanhau—yn gostau staff. Ffactor arall yn yr adroddiad sy'n dod i'n sylw yw bod llawer o swyddi gweigion, trosiant staff uchel a lefelau uchel o salwch ymhlith staff. Ni all hynny wneud llawer i gostau'r gwasanaeth. A ydych yn meddwl bod modd gwella glanweithdra ysbytai heb fynd i'r afael â rhai o'r materion hynny?

**Ms Lloyd:** No, we cannot. You will see in this report areas where trusts have looked very carefully at how they might maintain their cleaning staff. Traditionally, cleaning staff in both the private and the public sectors have had high turnover rates. However, some people—and this is mentioned later in the report—including me, are advocates of providing a sort of career path or multi-

**Ms Lloyd:** Na, ni allwn. Byddwch yn gweld yn yr adroddiad hwn feysydd lle y mae ymddiriedolaethau wedi edrych yn agos iawn ar sut y gallant gadw eu staff glanhau. Yn draddodiadol, bu cyfraddau trosiant uchel ymhlith staff glanhau yn y sector preifat a chyhoeddus. Fodd bynnag, mae rhai—ac mae hyn yn cael ei grybwyll yn ddiweddarach yn yr adroddiad—gan

skilling of the support-worker teams. There is certainly evidence that, if you do that, then you do have a workforce that is more stable, where recruitment can improve and retention is also improved. However, basically, until recruitment and retention are managed very effectively, and the absence through sickness that goes with that, then we are never going to improve the quality of this service.

gynnwys minnau, o blaid darparu rhyw fath o lwybr gyrfa neu gyfle aml-sgiliau i'r timau gweithwyr cymorth. Os ydych yn gwneud hynny mae tystiolaeth sicr bod gennych weithlu sy'n fwy sefydlog, lle gall recriwtio yn ogystal â chadw staff wella. Fodd bynnag, yn y bôn, tan y rheolir recriwtio a chadw staff yn effeithiol iawn, ynghyd â'r absenoldeb oherwydd salwch sy'n mynd law yn llaw â hynny, ni fyddwn byth yn gwella ansawdd y gwasanaeth hwn.

[19] **Leighton Andrews:** The figures do show that, I think, a quarter of the cleaning staff in Wales have been in post for less than six months. Now, it might be that if you improve the career structure, as you suggest, you might be able to improve retention, but do you not think that there is also a problem with recruitment? How can you attract and recruit domestic cleaning staff to the NHS in Wales?

[19] **Leighton Andrews:** Credaf fod y ffigurau'n dangos bod chwarter y staff glanhau yng Nghymru wedi bod yn eu swyddi am lai na chwe mis. Nawr, efallai pe baech yn gwella'r sdrwythur gyrfaoedd, fel yr awgrymasoch, efallai y byddai modd gwella'r cyfraddau cadw staff, ond onid ydych yn meddwl bod problem recriwtio hefyd? Sut y gallwch ddenu a recriwtio staff glanhau domestig i'r GIG yng Nghymru?

**Ms Lloyd:** I think that one of the issues is the importance that you place on having a clean environment. If individuals believe that they are doing a valuable job, then that increases the status of what they are doing and the importance of what they are doing for the whole after-clinical care of a patient. I think that it has been important that ward managers, ward sisters, and charge nurses are seen to be responsible for the whole of the clinical environment in which patients are cared for, and that the cleaning and domestic staff and other staff or support workers are really part of that team. In those hospitals where that has happened, you find that people really do want to come to work in such an environment and stay there. So I think that there are good examples that can be used throughout Wales to look at how we do retain and encourage people to come to work for us. I think that, generally in Wales, we have to become much more creative about ensuring that people understand that, within the health service, there is a vast variety of work that needs to be done to support patient care, and we in Wales, as part of our new recruitment strategy, which I am developing at the moment, have to look at how we actually get to the communities within which these units are placed, to encourage people who would not normally have put an NHS career—and in that I

**Ms Lloyd:** Credaf mai un o'r materion yw'r pwyslais yr ydych yn ei roi ar gael amgylchedd glân. Os yw unigolion yn credu eu bod yn gwneud gwaith a werthfawrogir, yna bydd hynny'n cynyddu statws yr hyn y maent yn ei wneud a phwysigrwydd yr hyn y maent yn ei wneud i holl ofal ôl-glinigol y claf. Credaf ei bod wedi bod yn bwysig dangos mai rheolwyr ward, prif nyrsys ward, a phrif weinyddwyr nyrsio sy'n gyfrifol am yr holl amgylchedd clinigol lle mae cleifion yn derbyn gofal, a bod y staff glanhau a domestig a staff eraill neu weithwyr cymorth yn rhan wirioneddol o'r tîm hwnnw. Yn yr ysbytai hynny lle mae hynny wedi digwydd, gwelwch fod pobl yn ysu am gael dod i weithio mewn amgylchedd o'r fath ac aros yno. Felly credaf fod enghreifftiau da y gellir eu defnyddio ledled Cymru i edrych ar sut yr ydym yn dal ein gafael ar bobl ac yn eu hannog i ddod i weithio i ni. Credaf, yn gyffredinol yng Nghymru, bod yn rhaid i ni fod yn llawer mwy creadigol ynghylch sicrhau bod pobl yn deall bod amrywiaeth helaeth o waith sydd angen ei wneud i gynnal gofal cleifion yn y gwasanaeth iechyd, a bod yn rhaid i ni yng Nghymru, fel rhan o'n strategaeth recriwtio newydd, yr wyf yn ei datblygu ar hyn o bryd, edrych ar sut yr ydym mewn gwirionedd yn cyrraedd y cymunedau lle mae'r unedau hyn wedi'u lleoli, i annog pobl na fyddai wedi dewis

include the cleaning staff—as a first priority, to come to work for us. The old methods have only worked spasmodically. I think that we have to look at very different ways of encouraging people to work for the health service.

gyrfa yn y GIG fel arfer—ac yr wyf yn cynnwys y staff glanhau—fel blaenoriaeth, i ddod i weithio i ni. Mae'r hen ddulliau wedi gweithio'n achlysurol yn unig. Credaf fod yn rhaid i ni edrych ar ffyrdd gwahanol iawn o annog pobl i weithio i'r gwasanaeth iechyd.

[20] **Leighton Andrews:** I am glad to see that you are developing a recruitment strategy in this, but are you confident that the measures that you are advocating are being properly received by the hospital trusts and taken seriously?

[20] **Leighton Andrews:** Yr wyf yn falch o weld eich bod yn datblygu strategaeth recriwtio ar gyfer hyn, ond a ydych yn hyderus bod y mesurau yr ydych yn eu hargymell yn cael eu croesawu'n iawn gan ymddiriedolaethau'r ysbytai ac yn cael eu hystyried o ddifrif?

**Ms Lloyd:** That is what we are discussing with the trusts at the moment. As the areas of good practice have been clearly outlined in this report, as the facilities forum will take those forward with a view to spreading that good practice, and as the trusts will be monitored against their adoption of good practice, then, hopefully, there will be more enlightenment among some of the trusts' management about the ways in which others, who have major problems like they have, have overcome those problems.

**Ms Lloyd:** Dyna'r hyn yr ydym yn ei drafod gyda'r ymddiriedolaethau ar hyn o bryd. Gan fod y meysydd arferion da wedi'u hamlinellu'n glir yn yr adroddiad hwn, wrth i'r fforwm cyfleusterau ddatblygu'r rhain gyda golwg ar ledaenu'r arferion da hynny, ac wrth i'r ymddiriedolaethau gael eu monitro yn ôl a ydynt wedi mabwysiadu arferion da, yna, gobeithio, y bydd gan rai o reolwyr yr ymddiriedolaethau ragor o wybodaeth am y ffyrdd y mae eraill, sydd â phroblemau difrifol hefyd, wedi goresgyn y problemau hynny.

[21] **Janet Davies:** Do you want to keep going, Leighton?

[21] **Janet Davies:** A ydych am barhau, Leighton?

[22] **Leighton Andrews:** I have one more question. You say that you hope that there will be more enlightenment, Ms Lloyd. That did not sound too confident to me.

[22] **Leighton Andrews:** Mae gennyf un cwestiwn arall. Yr ydych yn dweud eich bod yn gobeithio y bydd esboniad pellach, Ms Lloyd. Nid oedd hynny'n swnio'n rhy hyderus imi.

**Ms Lloyd:** Well, I am hopeful about most things, but if people are being performance managed against standards and against the adoption of best practice, it usually concentrates the mind a bit more, and we will be able to chart a map on how that good practice is really being implemented throughout Wales.

**Ms Lloyd:** Wel, yr wyf yn obeithiol am y rhan fwyaf o bethau, ond os y rheolir perfformiad pobl yn ôl safonau ac yn ôl mabwysiadu arferion gorau, mae'n hogi'r meddwl ychydig yn fwy nag arfer, a byddwn yn gallu llunio map i ddangos sut mae'r arferion gorau hyn yn cael eu gweithredu mewn gwirionedd ledled Cymru.

[23] **Janet Davies:** I will bring Alun in in a moment, but may I follow this up? I noticed in the report that there are relatively few hospitals with outside contractors doing the cleaning, contrary to what may be the general perception. Do you think that it would be more difficult to get a career path for support staff with outside contractors than it would

[23] **Janet Davies:** Caiff Alun gyfrannu yn y man, ond a gaf fi ddilyn y trywydd hwn? Sylwais yn yr adroddiad nad oes llawer o ysbytai yn defnyddio contractwyr allanol i wneud y gwaith glanhau, yn groes i'r gred gyffredinol. A ydych yn meddwl y byddai'n anoddach creu llwybr gyrfa i staff cymorth gyda chontractwyr allanol nag y byddai gyda

be with in-house cleaning?

**Ms Lloyd:** That would depend on how you contract for the work. If we were to specify that that was the sort of career path and that that was the sort of multi-skilling support worker that we required, then the standard requirement, whether or not it was provided in-house or externally, would be the standard requirement. I think that it is in our specification that we can sort that out.

[24] **Janet Davies:** Thank you. Alun, you have some questions to ask?

[25] **Alun Cairns:** My line of questioning follows the same sort of issue that the Cadeirydd has raised, Ms Lloyd. I was surprised that only four of the 17 hospitals that were investigated had used private sector contractors for their cleaning services. Are you able to tell us which ones they are?

**Ms Lloyd:** Yes, there is Ysbyty Gwynedd, Llandough Hospital, Singleton Hospital and Morriston Hospital.

[26] **Alun Cairns:** Sorry, that was Singleton and—?

**Ms Lloyd:** Morriston.

[27] **Alun Cairns:** Okay. What analysis have you made of the value for money that might or might not be drawn from private sector contractors in comparison to NHS-employed cleaners?

**Ms Lloyd:** The trust management has been charged with that matter over the past 20 years. As you will recall, the requirement to competitively test these sorts of services was introduced in around 1985. All trusts have been required to test competitively their cleaning, porter service and other support worker services since then. That requirement was loosened slightly in the 1990s, but nevertheless, every three to four years, they had to ensure that they were competitive. Therefore, the way in which some people have an in-house service and others have external contractors would have been scrutinised through a proper process. Sometimes, contracts were extended because

staff glanhau mewnol?

**Ms Lloyd:** Byddai hynny'n dibynnu ar sut y byddech yn contractio'r gwaith. Pe baem yn pennu mai dyna'r math o lwybr gyrfa ac mai dyna'r math o weithwyr cymorth aml-sgiliau yr oedd eu hangen arnom, yna'r gofyniad safonol, waeth a oedd yn cael ei ddarparu'n fewnol neu'n allanol, fyddai'r gofyniad safonol. Credaf fod ein manyleb yn nodi y gallwn drefnu hynny.

[24] **Janet Davies:** Diolch. Alun, mae gennych gwestiynau i'w gofyn?

[25] **Alun Cairns:** Mae fy nghwestiynau i'n mynd i'r afael â'r un math o faterion ag y mae'r Cadeirydd wedi'u trafod, Ms Lloyd. Fe'm synnwyd mai pedwar ysbyty'n unig o'r 17 a archwiliwyd a oedd wedi defnyddio contractwyr sector preifat ar gyfer y gwasanaethau glanhau. A allwch ddweud wrthym pa ysbytai ydynt?

**Ms Lloyd:** Gallaf, mae Ysbyty Gwynedd, Ysbyty Llandoche, Ysbyty Singleton ac Ysbyty Treforys.

[26] **Alun Cairns:** Mae'n ddrwg gennyf, dywedasoch Singleton a—?

**Ms Lloyd:** Treforys.

[27] **Alun Cairns:** Iawn. Sut yr ydych wedi dadansoddi'r gwerth am arian a allai neu na allai fod wedi deillio yn sgîl defnyddio contractwyr sector preifat o'i gymharu â glanhawyr a gyflogir gan y GIG?

**Ms Lloyd:** Rheolwyr yr ymddiriedolaeth sydd wedi bod yn gyfrifol am hynny ers 20 mlynedd bellach. Fel y cofiwch, cyflwynwyd y gofyniad i brofi'r mathau hyn o wasanaethau'n gystadleuol tua 1985. Mae'n ofynnol i bob ymddiriedolaeth brofi'n gystadleuol ei gwasanaethau glanhau a phorthor a'i gwasanaethau gweithwyr cymorth eraill ers hynny. Llaciwyd y gofyniad hwn ychydig yn y 1990au, ond er hynny, pob tair i bedair blynedd, yr oedd yn rhaid iddynt sicrhau eu bod yn gystadleuol. Felly, byddai'r ffordd y mae gan rai wasanaeth mewnol ac eraill gontractwyr allanol wedi cael ei harchwilio drwy broses briodol. O bryd i'w gilydd, cafodd contractau

either there would be a change in the configuration of a hospital's services, or there would be a move to new premises. However, even when contracts were extended by, say, one to two years, as an expedient move, they still had to prove that they had been through that rigorous test.

eu hestyn oherwydd naill ai byddai gwasanaethau ysbyty yn cael eu hailwampio, neu byddai'n rhaid symud i adeiladau newydd. Fodd bynnag, hyd yn oed pan estynnwyd contractau o, dyweder, flwyddyn neu ddwy, fel cam priodol, yr oedd yn rhaid iddynt brofi eu bod wedi cyflawni'r prawf manwl hwnnw.

[28] **Alun Cairns:** Three of the four hospitals that you highlighted are below the average cost of cleaning as shown in the table in figure 1. What analysis has been made of the quality of cleaning at those three hospitals, or even at the four private sector hospitals, in comparison to the other 13, or 17—no, sorry, 13?

[28] **Alun Cairns:** Mae tri o'r pedwar ysbyty a amlygwyd gennych yn is na chyfartaledd y costau glanhau a nodir yn y tabl yn ffigur 1. Pa ddadansoddiad a wnaed o ansawdd glanhau y tri ysbyty hynny, neu hyd yn oed y pedwar ysbyty sector preifat, o'i gymharu â'r 13 arall, neu 17—na, mae'n ddrwg gennyf, 13?

**Ms Lloyd:** I cannot give you that information at the moment because that is very much total accountability for an operational issue within a trust.

**Ms Lloyd:** Ni allaf roi'r wybodaeth honno i chi ar hyn o bryd oherwydd bod ymddiriedolaethau'n gwbl atebol am faterion gweithredol.

[29] **Alun Cairns:** But do you not think—

[29] **Alun Cairns:** Ond onid ydych yn meddwl—

**Ms Lloyd:** They will have to have satisfied the test of competitive tendering, they will have had to have been satisfied that they were getting value for money and they will have had to have been satisfied that their hospitals were meeting the standards.

**Ms Lloyd:** Bydd yn rhaid iddynt fod wedi bodloni'r prawf tendro cystadleuol, bydd yn rhaid iddynt fod yn fodlon eu bod yn cael gwerth am arian a bydd yn rhaid iddynt fod yn fodlon bod eu hysbytai yn bodloni'r safonau.

[30] **Alun Cairns:** Bearing in mind the differences in cost that have been highlighted in those four, if the quality of cleaning by private sector contractors is as good as that of NHS employees, do you not think that a best practice analysis could be made in terms of disseminating either the value or the poor value that might be provided from those private sector contractors?

[30] **Alun Cairns:** O gofio'r gwahaniaethau mewn costau sydd wedi'u hamlygu yn y pedwar hynny, os yw ansawdd glanhau contractwyr sector preifat cystal ag ansawdd glanhau gweithwyr y GIG, onid ydych yn meddwl y gellid cynnal dadansoddiad o arferion gorau o ran dosbarthu naill ai'r gwerth neu'r diffyg gwerth y gellid ei ddarparu gan y contractwyr sector preifat hynny?

**Ms Lloyd:** Indeed. That is what we expect the forum to take forward for us. I would not differentiate between the private sector and the in-house service. It is the value for money of the whole of this system that is important.

**Ms Lloyd:** Digon gwir. Dyna'r hyn yr ydym yn ei ddisgwyl i'r fforwm ei ddatblygu i ni. Ni fyddwn yn gwahaniaethu rhwng y sector preifat a'r gwasanaeth mewnol. Gwerth am arian y system gyfan hon sy'n bwysig.

[31] **Alun Cairns:** My final question on this relates to paragraph 1.15, which mentions that one hospital had a turnover of 82 per cent in the nine months prior to the National

[31] **Alun Cairns:** Mae fy nghwestiwn olaf am hyn yn ymwneud â pharagraff 1.15, sy'n crybwyll bod gan un ysbyty drosiant o 82 y cant yn y naw mis cyn ymweliad ac

Audit Office visit and investigation. That is a staggering level of staff turnover. Has any analysis been made of whether that level is higher among private sector contractors than among in-house cleaners?

archwiliad y Swyddfa Archwilio Genedlaethol. Mae'r lefel hwnnw o drosiant staff yn anhygoel. A wnaed unrhyw ddadansoddiad i weld a yw'r lefel honno yn uwch ymhlith contractwyr sector preifat nag ymhlith glanhawyr mewnol?

**Ms Lloyd:** No. Again, that is something that the forum will take on board. It will be looking at the whole of the recruitment, retention and sickness levels in all of these services.

**Ms Lloyd:** Na. Eto, mae hynny'n rhywbeth y bydd y fforwm yn ei ystyried. Bydd yn edrych ar yr holl lefelau recriwtio, cadw staff a salwch yn yr holl wasanaethau hyn.

[32] **Janet Davies:** Thank you. Denise, you have some questions to ask?

[32] **Janet Davies:** Diolch. Denise, mae gennych gwestiynau i'w gofyn?

[33] **Denise Idris Jones:** Can you hear me, Ms Lloyd?

[33] **Denise Idris Jones:** A ydych yn gallu fy nghlywed, Ms Lloyd?

**Ms Lloyd:** Yes.

**Ms Lloyd:** Ydw.

[34] **Denise Idris Jones:** Good. If you turn to page 11 of the Auditor General's report, case study A shows an example of good practice from the University Hospital of Wales. To me, as a layperson, reading through this, it seems that this is quite achievable. If you look at the first example, which says that

[34] **Denise Idris Jones:** Da iawn. Pe baech yn troi i dudalen 11 adroddiad yr Archwilydd Cyffredinol, mae astudiaeth achos A yn dangos enghraifft o arferion da gan Ysbyty Athrofaol Cymru. I mi, fel person lleyg, wrth ddarllen drwy hwn, ymddengys bod hyn yn dra phosibl. Os edrychwch ar yr enghraifft gyntaf, sy'n dweud

'sickness cover is more manageable—a team of six can more easily and quickly cover the absence of one person'

'mae'n haws sicrhau bod gweithwyr ar gael pan fydd rhywun yn sâl—gall tîm o chwech wneud gwaith rhywun sy'n sâl yn haws ac yn gynt'

that obviously makes complete sense. Do you not think that we could carry out this good example in the other hospitals?

mae'n amlwg bod hynny'n gwneud synnwyr llwyr. Onid ydych yn meddwl y gallem weithredu'r enghraifft dda hon mewn ysbytai eraill?

**Ms Lloyd:** I do, yes.

**Ms Lloyd:** Ydw.

[35] **Denise Idris Jones:** Good. Top marks. Let us hope that we do so as soon as possible. Are there any further examples of good practice? I hope that there are in my constituency, but I do not know. Can you tell me that?

[35] **Denise Idris Jones:** Da iawn. Marciau llawn. Gobeithio y byddwn yn gwneud hynny cyn gynted â phosibl. A oes unrhyw enghreifftiau eraill o arferion da? Gobeithio bod rhai yn fy etholaeth i, ond nid wyf yn gwybod. A allwch ddweud hynny wrthyf?

**Ms Lloyd:** Well, the Princess of Wales Hospital has looked at a broader support-worker system. There are some hospitals that employ bed teams so that nurses do not have to clean the beds and so that there is a team responsible for the management of a bed,

**Ms Lloyd:** Wel, mae Ysbyty Tywysoges Cymru wedi edrych ar system gweithwyr cymorth ehangach. Mae rhai ysbytai yn defnyddio timau gwlâu fel nad yw nyrsys yn gorfod glanhau gwlâu ac fel bod tîm yn gyfrifol am reoli gwely, sydd wedi

which has released the nursing staff and also meant that there was a sort of better check on the cleanliness of beds as patients are discharged. However, the forum is collecting together all these areas of good practice to disseminate them. The Auditor General has helpfully highlighted many of them in the report. As part of the performance management first round, we will be looking to see how far these have been adopted throughout Wales. One of the things that we are not tremendously great at is ensuring that good practice is known from place to place. That is why I have put a high emphasis and high importance on ensuring that we do monitor good practice and make sure that everybody knows about it and is able to test and consider it.

rhyddhau'r staff nyrsio ac sydd hefyd yn golygu bod glanweithdra gwlâu yn cael ei wirio'n well pan fydd cleifion yn gadael yr ysbyty. Fodd bynnag, mae'r fforwm yn casglu'r holl feysydd hyn o arferion da at ei gilydd i'w lledaenu. Mae'r Archwilydd Cyffredinol wedi amlygu llawer ohonynt yn yr adroddiad sy'n ddefnyddiol. Fel rhan o gylch cyntaf rheoli perfformiad, byddwn yn edrych i weld pa mor bell y mabwysiadwyd y rhain ledled Cymru. Mae sicrhau bod arferion da yn cael eu hadnabod o le i le yn un o'r pethau nad ydym yn eu gwneud yn dda iawn. Dyna pam fy mod wedi rhoi'r pwys mwyaf ar sicrhau ein bod yn monitro arferion da a sicrhau bod pawb yn gwybod am hynny ac yn gallu ei brofi a'i ystyried.

[36] **Janet Davies:** We will move on to paragraphs 2.2 to 2.4, which talk about there being no compulsory national minimum standards of hospital cleanliness. Figure 5 on page 14 shows a number of different cleaning standards across Wales. I do realise that you have not been in post for 25 years—

[36] **Janet Davies:** Symudwn ymlaen at baragraffau 2.2 i 2.4, sy'n trafod y ffaith nad oes safonau gofynnol cenedlaethol ar gyfer glanweithdra ysbytai. Mae ffigur 5 ar dudalen 14 yn dangos nifer o safonau glanhau gwahanol ledled Cymru. Sylweddolaf nad ydych wedi bod yn eich swydd ers 25 mlynedd—

[37] **Alun Cairns:** It may feel like it.

[37] **Alun Cairns:** Efallai ei fod yn teimlo felly.

**Ms Lloyd:** Sometimes. [*Laughter*.]

**Ms Lloyd:** Weithiau. [*Chwerthin*.]

[38] **Janet Davies:** Do you think that it was acceptable during all those years that there were no national minimum standards for cleaning? It was a long time to go without.

[38] **Janet Davies:** A ydych yn credu ei bod yn dderbyniol nad oedd safonau gofynnol cenedlaethol ar gyfer glanhau yn ystod yr holl flynyddoedd hynny? Yr oedd yn gyfnod hir i fod hebddynt.

**Ms Lloyd:** Well, there was guidance and there were standards. When I cast my mind back 25 years when I was setting some of these standards, there were minimum standards, which were known to people who were managing hospitals or clinics, against which they asked their cleaning staff to perform. However, I believe that the science and the research have become more stark and helpful about the types of cleaning service that you need. The numbers and the vulnerability of patients have increased and the whole work pace has increased within hospitals. They are dealing with a very different case mix of patients now than they were 20 years ago. I think that with

**Ms Lloyd:** Wel, yr oedd canllawiau ac yr oedd safonau. Wrth imi feddwl yn ôl 25 mlynedd pan oeddwn yn pennu rhai o'r safonau hyn, yr oedd safonau gofynnol, a oedd yn hysbys i bobl a oedd yn rheoli ysbytai neu glinigau, ac yr oedd yn rhaid i'w staff glanhau berfformio'n ôl y rhain. Fodd bynnag, credaf fod y wyddoniaeth a'r ymchwil wedi dod yn fwy amlwg a defnyddiol ynglŷn â'r mathau o wasanaethau glanhau sydd eu hangen arnoch. Mae niferoedd a gwendidau cleifion wedi cynyddu ac mae'r holl lwyth gwaith wedi cynyddu o fewn ysbytai. Maent yn delio â chymysgedd gwahanol iawn o gleifion yn awr o'i gymharu ag 20 mlynedd yn ôl.

everything—with the advent of more auditing of practice and the importance of a clean environment and very good hygiene—it has really come rightly to the fore now that we do have standards that will be adhered to and which we will be ensuring each of the organisations is adopting.

Credaf fod hynny â ynghyd â phopeth arall—gyda dyfodiad rhagor o archwilio arferion a phwysigrwydd amgylchedd glân a hylendid da iawn—mae'n hanfodol bwysig bellach bod gennym safonau i gadw atynt, y byddwn yn sicrhau bod yr holl sefydliadau yn eu mabwysiadu.

[39] **Janet Davies:** Right. When I look back rather more than 25 years, in the very old days, you had a situation whereby the ward sister was totally in control and the matron was coming around twice a day to make sure that everything was okay in every ward. To a large extent, that worked. It does seem to me that there was a gap in the middle where quite a lot of the organisation changed and it did not actually take on board the need for cleanliness in that change. I do not know whether you would agree; it looks to me as though perhaps you do agree with me on that. However, at the end of the day, the issue is what it is actually like on the wards, in the corridors and in the other departments. So, do you feel confident that the systems that are now being put into place are really going to make sure that hospitals are clean? I take on board your point about patients being much more fragile and much more ill when they are in hospital now than perhaps patients were 30 or 40 years ago.

[39] **Janet Davies:** Iawn. Wrth imi edrych yn ôl ymhellach na 25 mlynedd, ymhell i'r dyddiau a fu, yr hyn a oedd gennych oedd prif nyrs y ward â rheolaeth lwyr a'r metron yn ymweld ddwywaith y dydd i sicrhau bod popeth yn iawn ym mhob ward. I raddau helaeth, yr oedd hynny'n gweithio. Ymddengys i mi fod bwlch yn y canol lle y newidiodd llawer o'r sefydliad ac ni ystyriodd yr angen am lanweithdra yn y newid hwnnw mewn gwirionedd. Nid wyf yn gwybod a fyddech yn cytuno; ymddengys i mi eich bod efallai yn cytuno gyda mi ar hynny. Fodd bynnag, yn y pen draw, yr hyn sy'n bwysig yw'r sefyllfa wirioneddol ar y wardiau, yn y coridorau ac yn yr adrannau eraill. Felly, a ydych yn teimlo'n hyderus y bydd y systemau a weithredir ar hyn o bryd yn sicrhau bod yr ysbytai'n lân mewn gwirionedd? Yr wyf yn derbyn eich pwynt bod cleifion yn llawer mwy bregus ac yn llawer salach pan eu bod yn yr ysbyty bellach nag oedd cleifion 30 i 40 blynedd yn ôl efallai.

**Ms Lloyd:** Yes, I think that the prevalence of infection has really reached the top of the agenda for trust management now, because we know that it hardly increase patients' confidence when coming into hospitals, it certainly costs us more and patients have to stay in hospital longer. In a pressurised system, we want patients who are confident and who get better quickly so that we can release some of the capacity within the hospital. So with us all having infection control teams now, which are extremely good at advising us on best practice and how areas should be cleaned and what should happen with equipment, and with the audits that come through—because it might have looked clean 30 years ago but we did not audit it so we do not have the evidence—and also with the reinstitution, I think, of a ward-based culture where the ward manager has that renewed responsibility for the total environment in which patients are cared for,

**Ms Lloyd:** Ie, credaf fod cyffredinrwydd heintiau wedi cyrraedd brig agenda rheolwyr yr ymddiriedolaethau bellach, oherwydd ein bod yn gwybod nad yw dod i'r ysbyty yn cynyddu hyder cleifion, mae'r costau'n uwch i ni heb os ac mae'n rhaid i gleifion aros yn yr ysbyty am gyfnodau hirach. Mewn system dan bwysau, yr ydym eisiau cleifion sy'n hyderus ac sy'n gwella'n gyflym er mwyn i ni allu rhyddhau rhywfaint o gapasiti'r ysbyty. Felly gyda phawb â thimau rheoli heintiau erbyn hyn, sy'n hynod effeithiol o ran rhoi gwybod i ni am arferion da a sut y dylid glanhau gwahanol rannau a beth ddylai ddigwydd i'r cyfarpar, a chyda'r archwiliadau a gynhelir—oherwydd efallai eu bod wedi ymddangos yn lân 30 mlynedd yn ôl ond nid oeddynt yn cael eu harchwilio felly nid oes gennym y dystiolaeth—a hefyd, yn fy marn i, drwy ailsefydlu diwylliant sy'n seiliedig ar wardiau lle mae gan y rheolwr ward y cyfrifoldeb newydd hwnnw am yr

there should be a great improvement: there has to be a great improvement.

holl amgylchedd lle mae cleifion yn derbyn gofal, dylid gweld cynnydd sylweddol: mae'n rhaid bod cynnydd sylweddol.

[40] **Janet Davies:** Thank you. I have one last question before Val continues the questioning. In developing the single set of national minimum standards, will you be taking into account all the existing standards and taking the best from each of them?

[40] **Janet Davies:** Diolch. Mae gennyf un cwestiwn terfynol cyn i Val barhau â'r cwestiynau. Wrth ddatblygu'r gyfres unigol o safonau gofynnol cenedlaethol, a fyddwch yn ystyried yr holl safonau presennol a defnyddio'r gorau o bob un ohonynt?

**Ms Lloyd:** Yes. That is what we have done and that is why it has taken quite a long time to produce these standards, because we have been looking right across the UK and to some parts of Europe—some of the cleaning standards in Europe are very helpful—to bring together the very best. However, as I said, on the standards as they stand now, we will see how they fare in the first round of performance management. If they need adaptation, if they need improvement, they will be improved, and they will be updated regularly.

**Ms Lloyd:** Byddwn. Yr ydym wedi gwneud hynny a dyna pam ei bod wedi cymryd cryn amser i gynhyrchu'r safonau hyn, oherwydd ein bod wedi bod yn edrych ar y DU gyfan a rhannau o Ewrop—mae rhai o'r safonau glanhau yn Ewrop yn ddefnyddiol iawn—i ddod â'r safonau gorau ynghyd. Fodd bynnag, fel y dywedais, o ran y safonau ar eu ffurf bresennol, byddwn yn gweld sut y byddant yn llwyddo yn y cylch rheoli perfformiad cyntaf. Os oes angen eu haddasu, os oes angen eu gwella, byddant yn cael eu gwella, a'u diweddaru'n gyson.

[41] **Janet Davies:** Thank you. Val, you have some questions to ask?

[41] **Janet Davies:** Diolch. Val, mae gennych gwestiynau i'w gofyn?

[42] **Val Lloyd:** Yes, thank you, Chair. Mrs Lloyd, I know that the situation is going to change, but hospitals are currently free to choose their own minimum standards. However, when the National Audit Office visited 11 hospitals, it found that eight of the hospitals, by their own admission, were not achieving their own targets. Could you explain that, please?

[42] **Val Lloyd:** Oes, diolch, Gadeirydd. Mrs Lloyd, yr wyf yn gwybod y bydd y sefyllfa'n newid, ond mae gan ysbytai'r rhyddid i ddewis eu safonau gofynnol eu hunain ar hyn o bryd. Fodd bynnag, pan ymwelodd y Swyddfa Archwilio Genedlaethol ag 11 ysbyty, canfyddodd nad oedd wyth o'r ysbytai, yn ôl eu cyfaddefiad eu hunain, yn bodloni eu targedau eu hunain. A allwch egluro hynny, os gwelwch yn dda?

**Ms Lloyd:** That, again, is a matter for the trust. If, whatever service it is, the trust management believes it is not meeting its standards, it is for the trust management to do something about it. Again, I think that that is down to the priority that is given to this area.

**Ms Lloyd:** Mae hynny, eto, yn fater i'r ymddiriedolaeth. Os yw rheolwyr yr ymddiriedolaeth, pa bynnag wasanaeth ydyw, yn credu nad yw'n bodloni ei safonau, cyfrifoldeb rheolwyr yr ymddiriedolaeth yw gwneud rhywbeth yn ei gylch. Eto, credaf mai'r flaenoriaeth a roddir i'r maes hwn sy'n gyfrifol am hynny.

[43] **Val Lloyd:** Yes, you made that clear earlier. So if hospitals are not reaching their own targets now, and bearing in mind your answer regarding the trusts, what guarantee can we have that they will meet the proposed national standards? How will you deal with trusts that continually fail to meet those

[43] **Val Lloyd:** Do, bu i chi bwysleisio'r pwynt hwnnw'n glir yn gynharach. Felly os nad yw ysbytai yn bodloni eu targedau eu hunain yn awr, ac o gofio eich ateb ynglŷn â'r ymddiriedolaethau, pa sicrwydd y gallwn ei gael y byddant yn bodloni'r safonau cenedlaethol arfaethedig? Sut y byddwch yn

standards, should they do so—although I hope they will not?

delio ag ymddiriedolaethau sy'n methu'n barhaus â bodloni'r safonau hynny, os mai dyna maent yn ei wneud—er fy mod yn gobeithio nad dyna sy'n digwydd?

**Ms Lloyd:** That will be part of the performance management. The regional offices that we have established will have the overall responsibility of ensuring that trusts are making continuous progress towards all the targets in the balanced scorecard. They will be working, and we will be working, with those organisations to overcome any barriers to improvement. Some places will be further away from the targets than others, but we will know exactly where they are and what their plans for improvement will be, and will help and encourage them to do that. Those who are incorrigible will be dealt with under the performance management system.

**Ms Lloyd:** Bydd hynny'n rhan o'r system rheoli perfformiad. Y swyddfeydd rhanbarthol a sefydlwyd gennym fydd â'r cyfrifoldeb cyffredinol dros sicrhau bod ymddiriedolaethau yn gwneud cynnydd parhaus i fodloni'r holl dargedau ar yr adroddiad mesur perfformiad. Byddant hwy yn gweithio, a byddwn ni yn gweithio, gyda'r sefydliadau hynny i oresgyn unrhyw rwystrau i wella. Bydd rhai lleoedd yn bellach o'r targedau nag eraill, ond byddwn yn gwybod yr union sefyllfa a beth fydd eu cynlluniau ar gyfer gwella, a byddwn yn eu cynorthwyo a'u hannog i wneud hynny. Byddwn yn delio â'r rhai hynny nad ydynt wedi gwella dan y system rheoli perfformiad.

[44] **Val Lloyd:** Do you envisage that the national cleaning standards will allow for hospitals and trusts to benchmark their cleaning services?

[44] **Val Lloyd:** A ydych yn rhagweld y bydd y safonau glanhau cenedlaethol yn galluogi i ysbytai ac ymddiriedolaethau feincnodi eu gwasanaethau glanhau?

**Ms Lloyd:** Yes, and that is a very important thing. I have noticed in Wales that the chief executives are very proud of where they stand against the benchmark, and I think that that is a very helpful tool to ensure progress.

**Ms Lloyd:** Ydw, ac mae hynny'n rhywbeth pwysig iawn. Yr wyf wedi sylwi yng Nghymru bod y prif weithredwyr yn falch iawn o sut y maent yn cymharu â'r meincnod, a chredaf fod hwnnw'n ddull defnyddiol iawn i sicrhau cynnydd.

[45] **Val Lloyd:** So would you then consider that it would be beneficial to publish the results of the benchmarking?

[45] **Val Lloyd:** Felly a fyddech yn ystyried y byddai'n fuddiol cyhoeddi canlyniadau'r meincnodi?

**Ms Lloyd:** We expect to publish the whole of the balanced scorecard, which will include the benchmarking results, so that it will be clear to the community the standards that are being achieved by their organisations.

**Ms Lloyd:** Yr ydym yn disgwyl cyhoeddi'r adroddiad mesur perfformiad i gyd, a fydd yn cynnwys canlyniadau'r meincnodi, er mwyn sicrhau bod y safonau a fodlonir gan eu sefydliadau'n glir i'r gymuned.

[46] **Janet Davies:** Okay, thank you. Mick, you have some questions to ask.

[46] **Janet Davies:** Iawn, diolch. Mick, mae gennych gwestiynau i'w gofyn.

[47] **Mick Bates:** I would like to refer you to paragraph 2.4 on page 14. It is interesting to note that only three hospitals involve their infection control teams in devising their own cleaning standards. Is this not putting patient health and wellbeing at risk?

[47] **Mick Bates:** Hoffwn dynnu eich sylw at baragraff 2.4 ar dudalen 14. Mae'n ddiddorol gweld mai tri ysbyty'n unig sy'n cynnwys eu timau rheoli heintiau yn y broses o lunio eu safonau glanhau eu hunain. Onid yw hyn yn peryglu iechyd a lles cleifion?

**Ms Lloyd:** I do not think that it is adopting

**Ms Lloyd:** Nid wyf yn credu ei fod yn

the best practice that one possibly could have done, and, certainly, within the guidance that has been given to trusts, the importance of involving infection control teams is really highlighted. They can help in a number of ways because they, after all, have the bed of research and will be able to advise on best practice. All trusts will be monitored on the extent to which they involve infection control because, if they do not, they are not adopting best practice.

mabwysiadu'r arferion gorau y gallai fod wedi'i wneud, ac, yn sicr, o fewn y canllawiau sydd wedi'u rhoi i ymddiriedolaethau, mae pwysigrwydd cynnwys timau rheoli heintiau wedi'i amlygu'n glir. Gallant gynorthwyo mewn sawl ffordd oherwydd bod ganddynt, wedi'r cwbl, yr ymchwil sylfaenol a byddant yn gallu cynghori ar arferion gorau. Bydd yr holl ymddiriedolaethau'n cael eu monitro ar i ba raddau y maent yn cynnwys timau rheoli heintiau oherwydd, os nad ydynt, nid ydynt yn mabwysiadu arferion gorau.

[48] **Mick Bates:** You said earlier that one of the reasons for cleaning was for aesthetic purposes. We appreciate that as we like places to be tidy. What I find absolutely amazing is that, after all these years of knowing about the connection between cleanliness and infection—several paragraphs in the report say that there is a link—infection control teams are not part of the cleaning process in checking and swabbing areas as a matter of routine. Why has that not happened? I know that history is a dangerous thing, but why has this not taken place?

[48] **Mick Bates:** Dywedasoch yn gynharach bod estheteg yn un o'r rhesymau dros lanhau. Yr ydym yn gwerthfawrogi hynny am ein bod yn hoffi i leoedd fod yn daclus. Yr hyn sy'n hollol syfrdanol i mi, ar ôl gwybod am y cysylltiad rhwng glanweithdra a heintiau am yr holl flynyddoedd hyn—mae sawl paragraff yn yr adroddiad yn dweud bod cysylltiad—yw nad yw timau rheoli heintiau yn rhan o'r broses lanhau wrth archwilio a mopio mannau fel mater o arfer. Pam nad yw hynny wedi digwydd? Gwn fod hanes yn beth peryglus, ond pam nad yw hyn wedi digwydd?

**Ms Lloyd:** I think it was because the importance of cleaning and the correlation between hygiene—which is different from cleaning—and infection had not been made. Would it be helpful, Chair, if Dr Howard gave the Committee some information about the correlation between cleaning and infection? Would that be helpful?

**Ms Lloyd:** Credaf fod hyn oherwydd nad oedd pwysigrwydd glanhau a'r gydberthynas rhwng hylendid—sy'n wahanol i lanhau—a heintiau wedi'i wneud. A fyddai'n ddefnyddiol, Gadeirydd, pe bai Dr Howard yn rhoi peth gwybodaeth i'r Pwyllgor am y gydberthynas rhwng glanhau a heintiau? A fyddai hynny'n ddefnyddiol?

[49] **Janet Davies:** I think that it would be, yes.

[49] **Janet Davies:** Credaf y byddai.

[50] **Mick Bates:** Especially if only three hospitals actually understand it.

[50] **Mick Bates:** Yn arbennig os mai tri ysbyty yn unig sy'n ei ddeall.

**Dr Howard:** I hope that that is not the case.

**Dr Howard:** Gobeithiaf nad yw hynny'n wir.

[51] **Mick Bates:** Only three actually involved their infection control teams in setting cleaning standards.

[51] **Mick Bates:** Dim ond tri oedd wedi cynnwys eu timau rheoli heintiau yn y broses o bennu safonau glanhau.

**Dr Howard:** Okay. May I first say that, as a professional who has a mission to try to improve the situation in relation to infection control in Wales, I very much welcome this

**Dr Howard:** Iawn. A gaf ddweud yn gyntaf, fel gweithiwr proffesiynol sydd â thasg i geisio gwella'r sefyllfa o ran rheoli heintiau yng Nghymru, fy mod yn croesawu'r

report. It is a very helpful contribution. As people have pointed out, and as Ms Lloyd pointed out earlier, the report is really about two things. First, it is about cleaning in relation to the external perception of the environment by patients and visitors to hospitals, as an indicator of, or shop window on, the professional competence of the management of the place. The second issue is the importance of cleaning in relation to infection control.

adroddiad hwn yn fawr iawn. Mae'n gyfraniad defnyddiol iawn. Fel y mae pobl wedi ei nodi, ac fel y nododd Ms Lloyd yn gynharach, mae'r adroddiad yn ymwneud â dau beth mewn gwirionedd. Yn gyntaf, mae'n ymwneud â glanhau o ran sut y mae'r amgylchedd yn cael ei amgyffred yn allanol gan gleifion ac ymwelwyr â'r ysbytai, fel dangosydd, neu i arddangos, cymhwysedd proffesiynol rheolwyr y lle. Yr ail fater yw pwysigrwydd glanhau i reoli heintiau.

The problem with the second issue is that it is actually quite a complex relationship. I will talk this through. The problem in terms of the threat of the environment to patients in relation to infection depends on two issues. It depends on the load of pathogenic micro-organisms—the numbers of bacteria or viruses—and on the capacity of micro-organisms in the environment to get into patients and to then infect them. We are using the concept of a clean environment as a proxy, if you like, for a low content of contamination. Of course, the two things do not fully correlate. It is quite possible to have an apparently clean environment with a huge microbial contamination, because micro-organisms are very small and you cannot see them. That has been demonstrated very well by some published research in Wales that looked at the cleanliness of environments and at microbial load, and has shown not a tremendously strong correlation. I will give another example of that: I once dealt with an outbreak in a Welsh hospital that affected quite a lot of patients, where we ultimately identified that the cause of the outbreak was contamination that was affecting the cleaning cloths. So actually, in that environment, the cleaner the hospital, the more dangerous it was. The more people were actually cleaning it, the more patients were being exposed to risk. The reason that I just labour that point is that, in terms of infection control, the important issues to consider are actually the potential risks in given situations.

Y broblem gyda'r ail fater yw ei fod yn gydberthynas eithaf cymhleth mewn gwirionedd. Yr wyf am egluro hyn. Mae'r broblem o ran bygythiad yr amgylchedd i gleifion mewn perthynas â heintiau'n dibynnu ar ddau fater. Mae'n dibynnu ar lwyth y micro-organebau pathogenaidd—nifer y bacteria neu firysau—ac ar allu micro-organebau yn yr amgylchedd i gyrraedd y cleifion a'u heintio. Yr ydym yn defnyddio'r cysyniad o amgylchedd glân yn lle halogiad isel, os hoffwch chi. Wrth gwrs, nid yw'r ddau beth yn cydberthyn yn llawn. Mae'n dra phosibl cael amgylchedd sy'n ymddangos yn lân sydd â halogiad microbaidd enfawr, oherwydd bod micro-organebau yn fach iawn ac na ellir eu gweld. Dangoswyd hynny'n dda iawn gan rywfaint o'r gwaith ymchwil sydd wedi'i gyhoeddi yng Nghymru a fu'n edrych ar lanweithdra amgylcheddau ac ar lwyth microbaidd, ac mae wedi dangos nad oes cydberthynas gryf iawn. Yr wyf am roi enghraifft arall o hynny: bum yn delio unwaith ag achos mewn ysbyty yng Nghymru a oedd yn effeithio ar lawer iawn o gleifion, ac yn y pen draw nodwyd gennym mai achos yr argyfwng oedd halogiad a oedd yn effeithio ar y clytiau glanhau. Felly mewn gwirionedd, yn yr amgylchedd hwnnw, po lanaf oedd yr ysbyty, po fwyaf y perygl. Po fwyaf o bobl a oedd yn ei lanhau, po fwyaf y cleifion a oedd yn agored i berygl. Y rheswm yr wyf yn llafurio dros y pwynt hwnnw, o ran rheoli heintiau, yw mai'r materion pwysig i'w hystyried mewn gwirionedd yw'r risgiau posibl mewn sefyllfaoedd penodol.

We know, for example, that major breakdowns of normal practice will expose people to risk. If there is a large spill of infective bodily fluids into the environment then that is clearly a risk. From a cleaning

Gwyddom, er enghraifft, y bydd diffygion sylweddol mewn arferion cyffredin yn peryglu pobl. Os oes swm enfawr o hylifau corfforol heintus yn cael eu gollwng i'r amgylchedd yna mae'n amlwg bod hynny'n

point of view, it is essential to ensure that that is dealt with as soon as possible and that you have staff available to deal with it quickly. We know that, in certain outbreak situations, the environment is important and that has been well demonstrated in relation to staphylococcal infections and gastro-intestinal infections. The problem with many of those investigations is that outbreaks are often multi-factorial in that, whenever you get a large outbreak in a hospital, there is usually a breakdown in practice at a variety of levels. It is quite difficult to pull the cleaning issue out. The difficult area to correlate, where there is not such a strong association is, if you like, the association between cleaning, in relation to infection control in the way that it is routinely undertaken, and baseline infection rates.

risg. O safbwynt glanhau, mae'n hanfodol mynd i'r afael â hynny cyn gynted â phosibl a bod gennych staff ar gael i ddelio â hynny'n gyflym. Gwyddom, mewn sefyllfaoedd o argyfwng penodol, bod yr amgylchedd yn bwysig ac mae hynny wedi'i ddangos yn glir mewn perthynas â heintiau staffylococol a heintiau perfeddol. Y broblem gyda nifer o'r archwiliadau hynny yw bod argyfyngau yn aml yn rhai amlffactoraidd o ran, pa bryd bynnag y byddwch yn cael achos mawr mewn ysbyty, mae fel arfer arferion sy'n methu ar amrywiaeth o lefelau. Mae'n eithaf anodd rhoi sylw penodol i'r mater glanhau. Y maes lle mae'n anodd creu cysylltiad, lle nad oes cysylltiad mor gryf, os hoffwch chi, yw'r cysylltiad rhwng glanhau, o ran rheoli heintiau yn y ffordd a ddefnyddir yn rheolaidd, a chyfraddau heintiau sylfaenol.

So, one assumes, we talk about levels of cleaning in Welsh hospitals, but everybody has a baseline level of cleaning; what is uncertain from research is the variation in infection rates that relate to variations in cleaning above that baseline level. So, from an infection control point of view, the areas that are really important to concentrate on are the ones of major risk to patients. Those are the ones where patients are most likely to be exposed to environmental contamination. So, the areas that we would be most concerned about are things like the contamination of equipment that is shared between patients, because any contamination has ready access to patients. That point is helpfully highlighted in the report in relation to the multiple use of beds. I mean, clearly, there is a capacity for intimate contact and spread of contamination between patients. So, those are the areas that, from an infection control standpoint, we will want to focus on.

Felly, mae rhywun yn rhagdybio, yr ydym yn trafod lefelau glanhau mewn ysbytai yng Nghymru, ond mae gan bawb lefel glanhau sylfaenol; yr hyn sy'n ansicr o'r ymchwil yw'r amrywiadau mewn cyfraddau heintiau sy'n perthyn i'r amrywiadau mewn glanhau uwchlaw'r lefel sylfaenol hynny. Felly, o safbwynt rheoli heintiau, y meysydd y mae'n wirioneddol bwysig canolbwyntio arnynt yw'r rhai sy'n fwyaf peryglus i gleifion. Dyna'r rhai lle mae cleifion yn fwyaf tebygol o fod yn agored i halogiad amgylcheddol. Felly, y meysydd y byddem yn fwyaf pryderus ynglŷn â hwy yw rhai megis halogi cyfarpar a rennir rhwng cleifion, oherwydd bod gan unrhyw halogiad fynediad parod i gleifion. Mae'r pwynt hwnnw'n cael ei amlygu'n ddefnyddiol yn yr adroddiad o ran defnyddio'r un gwlâu drosodd a throsodd. Yn amlwg, mae posibilrwydd o gysylltiad agos a lledaenu halogiad rhwng cleifion. Felly, dyna'r meysydd y byddwn, o safbwynt rheoli heintiau, am ganolbwyntio arnynt.

What I do not know, when we talk about just three hospitals with an infection control specialist being involved in the cleanliness standards—is the context of this in relation to other infection control activities. However, I would find it surprising if infection control specialists were not more widely involved in infection control practice, particularly in terms of being devoted to risk activities. You see, a lot of the cleanliness standards, which

Yr hyn nad wyf yn ei wybod, wrth drafod mai tri ysbyty yn unig yng Nghymru sydd ag arbenigwr rheoli heintiau yn cyfrannu at lunio'r safonau glanweithdra—yw cyd-destun hyn o ran gweithgareddau rheoli heintiau eraill. Fodd bynnag, byddai'n syndod i mi pe na bai arbenigwyr rheoli heintiau'n cyfrannu'n ehangach at arferion rheoli heintiau, yn arbennig o ran canolbwyntio ar weithgareddau peryglus.

are very important, will be some way down the list of potential risk factors in relation to acquisition of infection. So, the infection control teams may actually, in those hospitals, be involved in quite important areas in relation to the hospital hygiene. I mean, the general principle is obviously right, in that, obviously, the infection control specialists should be involved at all levels in the construction of the cleaning programme.

Bydd llawer o'r safonau glanweithdra, sy'n bwysig iawn, yn eithaf isel ar restr y ffactorau risg posibl o ran dal heintiau. Felly, efallai fod y timau rheoli heintiau mewn gwirionedd, yn yr ysbytai hynny, yn cyfrannu at feysydd eithaf pwysig o ran hylendid yr ysbyty. Credaf fod yr egwyddor gyffredinol yn amlwg yn iawn, o ran y dylai'r arbenigwyr rheoli heintiau, mae'n amlwg, gymryd rhan wrth lunio'r rhaglen lanhau ar bob lefel.

[52] **Mick Bates:** We can only go on the evidence found in this report and it clearly states that only in three hospitals were they directly involved. You are making the assumption that they might be involved in the other hospitals. I accept that they might be involved, but we need evidence. We are here trying to improve the standards, and I am still not convinced, from what you have told me, that these infection control teams in the other hospitals will actually become involved in setting these minimum standards. Is that going to be the case?

[52] **Mick Bates:** Gallwn ond bwyso ar y dystiolaeth yn yr adroddiad hwn ac mae'n nodi'n glir mai dim ond mewn tri ysbyty yr oeddent yn cymryd rhan uniongyrchol. Yr ydych yn rhagdybio eu bod efallai'n cymryd rhan mewn ysbytai eraill. Yr wyf yn derbyn eu bod yn cymryd rhan o bosibl, ond mae angen tystiolaeth arnom. Yr ydym yma i geisio gwella'r safonau, ac nid wyf wedi fy argyhoeddi eto, o'r hyn yr ydych wedi'i ddweud wrthyf, y bydd y timau rheoli heintiau hyn yn yr ysbytai eraill yn cyfrannu mewn gwirionedd at bennu'r safonau gofynnol hyn. A fydd hynny'n digwydd?

**Ms Lloyd:** That is part of the standard that has been set.

**Ms Lloyd:** Mae hynny'n rhan o'r safon sydd wedi'i phennu.

[53] **Mick Bates:** So it will be the case?

[53] **Mick Bates:** Felly bydd hynny'n digwydd?

**Ms Lloyd:** They will be. However, as Dr Howard said, it is not just about the cleaning standards, it is about the management of equipment and so on, which is really important.

**Ms Lloyd:** Bydd. Fodd bynnag, fel y dywedodd Dr Howard, mae mwy i hyn na'r safonau glanhau'n unig, mae'n ymwneud hefyd â rheoli cyfarpar ac ati, sy'n hynod bwysig.

[54] **Mick Bates:** I think that I accept that but, of course, we have MRSA and all the concerns that the public has about standards. I accept that it is a cultural thing, and not just one specific aspect. When will you check up that the infection control team is part of the cleaning team?

[54] **Mick Bates:** Credaf fy mod yn derbyn hynny ond, wrth gwrs, mae gennym MRSA a'r holl bryderon sydd gan y cyhoedd ynghylch safonau. Yr wyf yn derbyn mai rhywbeth diwylliannol yw hyn, ac nid un agwedd benodol yn unig. Pryd y byddwch yn sicrhau bod y tîm rheoli heintiau yn rhan o'r tîm glanhau?

**Ms Lloyd:** In the first round of reviews in six months' time.

**Ms Lloyd:** Yn y cylch adolygiadau cyntaf mewn chwe mis.

[55] **Mick Bates:** So, in six months' time, will I be able to look at a report that states that all the infection teams are involved in these cleanliness standards?

[55] **Mick Bates:** Felly, mewn chwe mis, a fyddaf yn gallu edrych ar adroddiad sy'n nodi bod yr holl dimau heintiau yn cymryd rhan yn y safonau glanweithdra hyn?

**Ms Lloyd:** You will be able to look at a report that will tell us to what extent exactly the infection control teams were involved in these important areas and what the places are going to do about that.

**Ms Lloyd:** Byddwch yn gallu edrych ar adroddiad a fydd yn dweud wrthym i ba raddau'n union y bu'r timau rheoli heintiau'n cyfrannu at y meysydd pwysig hyn a beth y mae'r lleoedd yn mynd i'w wneud am hynny.

[56] **Mick Bates:** Thank you.

[56] **Mick Bates:** Diolch.

[57] **Janet Davies:** Jocelyn, you have questions to ask.

[57] **Janet Davies:** Jocelyn, mae gennych gwestiynau i'w gofyn.

[58] **Jocelyn Davies:** We see in the report that some equipment such as drip stands, hoists and commodes are not covered by a hospital's cleaning standards, specifications or the monitoring arrangements. Has the all-Wales facilities group taken these items into account when looking at the national cleaning standards or are those standards just specifically for domestic cleaning? How and why are you making the distinction between domestic cleaning and all other cleaning?

[58] **Jocelyn Davies:** Yr ydym yn gweld yn yr adroddiad nad yw peth o'r cyfarpar megis standiau diferwyr, peiriannau codi a chomodau yn cael eu cynnwys yn safonau glanhau, manylebau na threfniadau monitro ysbytai. A yw'r grŵp cyfleusterau Cymru gyfan wedi ystyried yr eitemau hyn wrth edrych ar y safonau glanhau cenedlaethol neu a yw'r safonau hynny'n benodol ar gyfer glanhau domestig yn unig? Sut a pham yr ydych yn gwahaniaethu rhwng glanhau domestig a'r holl feysydd glanhau eraill?

**Ms Lloyd:** The standards do include those items because that was a considerable gap, we believed, in the cleaning standards and in the infection control standards. I think that, when you look at this—and there is a great example in here of who does what in a hospital—you really have to unpick to what extent does this make any sense to anybody. When you look at it you think, 'goodness me, there's a bit of a haphazard approach here'. Therefore, as part of the cleaning standards, the other important thing that they do is to highlight to the trust management the variable practice within their own organisations so that they can assure themselves that the right people are doing the right sort of cleaning. It is very much from a practical point of view and how their support-worker teams are constructed. It is really important that they think very carefully about the practicalities of cleaning, who manages spillages, what they do about equipment that might go with a patient from one ward to another and how they will ensure that it is not infected so that it does not cross-infect in another area. I think that the standards will serve the purpose of highlighting these grey areas within the cleaning specifications within organisations.

**Ms Lloyd:** Mae'r safonau'n cynnwys yr eitemau hynny oherwydd bod hwnnw'n fwlch sylweddol, yn ein barn ni, yn y safonau glanhau ac yn y safonau rheoli heintiau. Credaf, wrth edrych ar hyn—ac mae enghraifft wych yma o bwy sy'n gwneud beth mewn ysbyty—bod yn rhaid i chi bennu i ba raddau y mae hyn yn gwneud synnwyr i unrhyw un. Wrth edrych arno yr ydych yn meddwl, 'bobl bach, mae elfen o agwedd rywsut-rywsut yma'. Felly, fel rhan o'r safonau glanhau, y peth pwysig arall y maent yn ei wneud yw amlygu i reolwyr yr ymddiriedolaethau yr amrywiaeth o arferion o fewn eu sefydliadau eu hunain fel y gallant sicrhau eu hunain bod y bobl iawn yn gwneud y math iawn o lanhau. Mae hyn o safbwynt ymarferol a sut y ffurfir eu timau gweithwyr cymorth. Mae'n bwysig iawn eu bod yn meddwl yn ofalus iawn am ymarferoldebau glanhau, pwy sy'n rheoli gollyngiadau, beth y maent yn ei wneud â chyfarpar a gludir o bosibl gyda chlaf o un ward i un arall a sut y byddant yn sicrhau nad yw wedi'i heintio fel nad yw'n traws-heintio mewn lleoliad arall. Credaf y bydd y safonau yn cyflawni'r nod o amlygu'r meysydd anelwig hyn ym manylebau glanhau sefydliadau.

[59] **Jocelyn Davies:** The report states in paragraph 2.11 that the National Audit Office noted during visits to hospitals that, for example, bathrooms were clean but contained equipment such as hoists and commodes that were not clean. Dr Howard just told us that shared equipment presents a major risk of infection. I understand that the domestic cleaners are not trained to clean those items. It is nurses, who would have enough other things to do, who are expected to clean those pieces of equipment—and they are not cleaned. They then present a major risk of infection to patients.

[59] **Jocelyn Davies:** Mae'r adroddiad yn nodi ym mharagraff 2.11 bod y Swyddfa Archwilio Genedlaethol wedi sylwi'n ystod ymweliadau ag ysbytai bod, er enghraifft, ystafelloedd ymolchi yn lân ond yn cynnwys cyfarpar megis peiriannau codi a chomodau nad oeddynt yn lân. Mae Dr Howard newydd ddweud wrthym bod cyfarpar a gaiff ei rannu yn achosi perygl difrifol o heintiau. Deallaf nad yw'r glanhawyr domestig wedi'u hyfforddi i lanhau'r eitemau hynny. Mae disgwyl i nyrsys, sydd â mwy na digon o bethau eraill i'w gwneud, lanhau'r darnau hynny o gyfarpar—ac nid ydynt yn cael eu glanhau. Yna mae perygl difrifol iddynt heintio cleifion.

**Ms Lloyd:** Yes. As I said, I think that there needs to be a rethinking within organisations about how the whole environment is maintained in a clean state that will minimise the risk of infection, and who should do that is the second point that they need to consider.

**Ms Lloyd:** Ie. Fel y dywedais, credaf fod angen i sefydliadau ailfeddwl am y ffordd y dylai'r holl amgylchedd gael ei gynnal a'i gadw mewn cyflwr glân a fydd yn lleihau'r risg o heintiau, a phwy ddylai wneud hynny yw'r ail bwynt y mae angen iddynt ei ystyried.

[60] **Jocelyn Davies:** You mentioned earlier, when we were discussing recruitment, the advantages of the whole clinical environment coming under the direction of the ward sister. You also mentioned the advantage of having a ward-based culture. Are you saying that there perhaps should be plans to introduce the equivalent of the matron, or a single person with ultimate responsibility for all aspects of cleanliness in a ward?

[60] **Jocelyn Davies:** Bu i chi grybwyll yn gynharach, pan yr oeddem yn trafod recriwtio, y manteision i'r holl amgylchedd clinigol o fod dan adain prif nyrs y ward. Bu i chi grybwyll hefyd y fantais o gael diwylliant yn seiliedig ar y ward. A ydych yn dweud y dylid cael cynlluniau efallai i gyflwyno gweithiwr sy'n cyfateb i'r metron, neu unigolyn gyda'r prif gyfrifoldeb am yr holl agweddau ar lanweithdra mewn ward?

**Ms Lloyd:** I think that the ward manager already has that role. There needs to be much more discussion between the supervisors who look after cleaning and those ward managers about best practice and the involvement of the infection control teams. I think that the concept of a matron is a difficult one because it is somewhat stylised and possibly does not reflect actually what a clinical ward manager would be required to do for the future. However, it is a commonly held concept among the public—people like matrons. Basically, whatever we call them, it is really important that one individual has the responsibility for the whole of the ward environment and the clinical care of the patient, and cleaning, and the total environment in which patients are managed,

**Ms Lloyd:** Credaf fod rheolwr y ward yn ymgymryd â'r rôl honno eisoes. Mae angen i oruchwylwyr sy'n gofalu am lanhau'r wardiau a'r rheolwyr wardiau hynny gynnal llawer mwy o drafodaethau am arferion gorau a chyfraniad timau rheoli heintiau. Credaf fod y cysyniad o fetron yn un anodd oherwydd bod ganddo'i ddelwedd i ryw raddau ac nid yw o bosibl yn adlewyrchu'n union yr hyn fyddai'n ofynnol i reolwr ward clinigol ei wneud yn y dyfodol. Fodd bynnag, mae'n gysyniad cyffredin ymhlith y cyhoedd—pobl fel metronau. Yn y bôn, beth bynnag yr ydym yn eu galw, mae'n bwysig iawn bod gan un unigolyn gyfrifoldeb dros holl amgylchedd y ward ac mae gofal clinigol y claf, a glanhau, a'r holl amgylchedd y caiff cleifion eu trin ynddo, yn

is vital to that.

hanfodol i hynny.

[61] **Jocelyn Davies:** Maybe we could change the stereotype from Hattie Jacques to something a bit more modern. Could that be achieved when a hospital is using the private sector? Can you have someone who is absolutely in charge?

[61] **Jocelyn Davies:** Efallai y byddem yn gallu newid y stereoteip o Hattie Jacques i rywbeth ychydig yn fwy modern. A ellid cyflawni hynny pan fo ysbyty'n defnyddio'r sector preifat? A oes modd cael rhywun sydd wirioneddol wrth y llyw?

**Ms Lloyd:** Yes, because as I said to the Chair, it is the specification that you give and the way in which you expect that team to work that is important, not who actually provides it at the end of the day.

**Ms Lloyd:** Oes, oherwydd fel y dywedais wrth y Cadeirydd, y fanyleb a roddir gennych a'r ffordd yr ydych yn disgwyl i'r tîm hwnnw weithio sy'n bwysig, nid pwy yn union sy'n darparu'r gwasanaeth yn y pen draw.

[62] **Janet Davies:** Thank you. We will now break for coffee.

[62] **Janet Davies:** Diolch. Fe gawn egwyl am goffi yn awr.

*Gohiriwyd y cyfarfod rhwng 10.29 a.m. a 10.48 a.m.*
*The meeting was adjourned between 10.29 a.m. a 10.48 a.m.*

[63] **Janet Davies:** Right, if we could start again, I think that you wish to take up the issue of infection control, Mick, and pursue that further.

[63] **Janet Davies:** Iawn, os cawn ail-ddechrau, credaf eich bod am drafod y mater o reoli heintiau, Mick, a thrafod y mater hwnnw ymhellach.

[64] **Mick Bates:** Yes, I do. Thank you, Chair. On infection control again, and referring to paragraph 2.14, some very interesting information emerges. For example, how do you account for the fact that the Royal Gwent Hospital carries out an infection control audit four times a year in each ward, while Llandough Hospital has not carried out an infection control audit for more than five years?

[64] **Mick Bates:** Ydw, yr wyf am wneud hynny. Diolch, Gadeirydd. I fynd yn ôl at reoli heintiau, a chan gyfeirio at baragraff 2.14, mae gwybodaeth ddiddorol iawn yn codi'i phen. Er enghraifft, sut yr ydych yn egluro'r ffaith bod Ysbyty Brenhinol Gwent yn cynnal archwiliad rheoli heintiau bedair gwaith y flwyddyn ym mhob ward, tra nad yw Ysbyty Llandoche wedi cynnal archwiliad rheoli heintiau ers dros bum mlynedd?

**Ms Lloyd:** There again, I think that it is down to the trust management and the importance that it is placing on this.

**Ms Lloyd:** Eto, credaf mai cyfrifoldeb rheolwyr yr ymddiriedolaeth yw hynny a'r pwys y mae'n ei roi ar hyn.

[65] **Mick Bates:** That is an obvious point. However, where is the responsibility—?

[65] **Mick Bates:** Mae hynny'n bwynt amlwg. Fodd bynnag, pwy sydd â'r cyfrifoldeb—?

**Ms Lloyd:** With the trust management.

**Ms Lloyd:** Rheolwyr yr ymddiriedolaeth.

[66] **Mick Bates:** It is with the trust management?

[66] **Mick Bate** Rheolwyr yr ymddiriedolaeth?

**Ms Lloyd:** Yes. It is totally accountable.

**Ms Lloyd:** Ie. Maent yn hollol atebol.

[67] **Mick Bates:** It is totally accountable.

[67] **Mick Bates:** Maent yn hollol atebol.

But, is there not a further layer of management that overlooks it and asks where the standards are? I refer to the point that I made earlier that, throughout all this time, there have been no minimum standards to ensure that infection control teams, for example, as I said before, were involved in setting the standards.

Ond, onid oes lefel uwch o reolwyr sy'n goruchwylio hyn ac yn gofyn ymhle mae'r safonau? Cyfeiriaf at y pwynt a godais yn gynharach, na fu safonau gofynnol drwy gydol y cyfnod hwn, i sicrhau bod timau rheoli heintiau, er enghraifft, fel y dywedais yn gynharach, yn cyfrannu at bennu'r safonau.

**Ms Lloyd:** Until very recently, the Assembly had no powers or accountability in this area. That has now been put right. I think that that is very important. Standards might be one thing, but it is really important that the management itself applies those standards. You can have the best standards in the world, but if they are not applied well, then we are not going to see improvement. Dr Howard tells me that there is good infection control surveillance at Llandough Hospital, so I am not quite sure how that came about.

**Ms Lloyd:** Tan yn ddiweddar iawn, nid oedd gan y Cynulliad bwerau nac atebolrwydd yn y maes hwn. Mae hynny wedi ei gywiro bellach. Credaf fod hynny'n bwysig iawn. Efallai fod safonau'n un peth, ond mae'n bwysig iawn bod y rheolwyr eu hunain yn cymhwyso'r safonau hynny. Gallwch gael y safonau gorau'n y byd, ond os nad ydynt yn cael eu cymhwyso'n dda, yna welwn ni ddim gwelliant. Mae Dr Howard yn dweud wrthyf bod rhaglen oruchwylio rheoli heintiau dda yn Ysbyty Llandoche, felly nid wyf yn siŵr sut y digwyddodd hynny.

**Dr Howard:** I am not sure about the arrangements in relation to audit, but what one would say is that Llandough Hospital has good infection control surveillance programmes in place. So one would hope that it would have a parallel system that would highlight problem areas in relation to changing rates of infection.

**Dr Howard:** Nid wyf yn siŵr am y trefniadau o ran archwilio, ond byddai dyn yn dweud bod gan Ysbyty Llandoche raglenni goruchwylio rheoli heintiau da ar waith. Felly byddai rhywun yn gobeithio y byddai system gyffelyb ganddo a fyddai'n amlygu meysydd lle ceir problemau o ran cyfraddau newidiol heintiau.

[68] **Mick Bates:** I see. So you are saying that it carries out what you would view as a high standard of infection surveillance?

[68] **Mick Bates:** Gwelaf fi. Felly yr ydych yn dweud ei fod yn cynnal yr hyn y byddech yn ei alw'n safon uchel o oruchwylio heintiau?

**Dr Howard:** Yes.

**Dr Howard:** Byddwn.

[69] **Mick Bates:** But it is not manifest in this report?

[69] **Mick Bates:** Ond nid yw wedi'i amlygu yn yr adroddiad hwn?

**Dr Howard:** Yes, that is right.

**Dr Howard:** Ydyw, mae hynny'n gywir.

[70] **Mick Bates:** Okay. Do you see the point that, as the general public, we need to know that?

[70] **Mick Bates:** Iawn. A ydych yn deall y pwynt ein bod, fel y cyhoedd, angen gwybod hynny?

**Ms Lloyd:** Of course.

**Ms Lloyd:** Wrth gwrs.

[71] **Mick Bates:** Finally, I will return to the new standards. Will these new standards include minimum frequencies for the carrying out of infection control audits?

[71] **Mick Bates:** Yn olaf, yr wyf am ddychwelyd at y safonau newydd. A fydd y safonau newydd hyn yn cynnwys cyfnodau gofynnol ar gyfer cynnal archwiliadau rheoli heintiau?

**Ms Lloyd:** Yes.

[72] **Mick Bates:** Can you tell me what they will be?

**Ms Lloyd:** Can I look it up, please? Can I give you a note on that?

[73] **Mick Bates:** Okay, fine.

**Ms Lloyd:** You will get the standards anyway at the end of this month, so if you would like me to circulate the standards to you, would that be helpful?

[74] **Janet Davies:** Yes, I think that it would.

[75] **Mick Bates:** Thank you, Chair.

[76] **Janet Davies:** Leighton, did you want to come in on this?

[77] **Leighton Andrews:** I did, really. You say that the trusts are totally accountable, Ms Lloyd, for infection control audits. However, it is hard to understand how that accountability is held to in a situation where one has not had an audit for five years.

**Ms Lloyd:** Yes, I would quite agree.

[78] **Leighton Andrews:** But then how are they accountable in practice? The management is accountable to the trust, and, ultimately, you, presumably, and we, have sanctions over that, but what do you regard as being appropriate?

**Ms Lloyd:** The trust management will be accountable to its board, which is accountable to its community for the standards of care. That is why we have said in our new standards and in our new guidance that there has to be a greater ownership of this important area at the trust board. It is only really in the last 15 months that the accountability between trust chief executives and myself has been clarified and extended. That is why we have been putting into place under the plan issues such as facilities management and the standards that we expect to see. That accountability has only recently been reasserted.

**Ms Lloyd:** Byddant.

[72] **Mick Bates:** A allwch ddweud wrthyf beth fydd y rhain?

**Ms Lloyd:** A gaf wirio hynny, os gwelwch yn dda? A gaf roi nodyn i chi ar hynny?

[73] **Mick Bates:** Ie, iawn.

**Ms Lloyd:** Byddwch yn cael y safonau beth bynnag ddiwedd y mis hwn, felly os ydych am imi ddosbarthu'r safonau i chi, a fyddai hynny'n ddefnyddiol?

[74] **Janet Davies:** Byddai, credaf y byddai.

[75] **Mick Bates:** Diolch, Gadeirydd.

[76] **Janet Davies:** Leighton, a oeddech am gyfrannu yma?

[77] **Leighton Andrews:** Oeddwn, a dweud y gwir. Yr ydych yn dweud bod yr ymddiriedolaethau'n hollol atebol, Ms Lloyd, am archwiliadau rheoli heintiau. Fodd bynnag, mae'n anodd deall sut y glynir at yr atebolrwydd hwnnw mewn sefyllfa lle na chynhaliwyd archwiliad am bum mlynedd.

**Ms Lloyd:** Ie, byddwn yn cytuno'n llwyr.

[78] **Leighton Andrews:** Ond sut felly y maent yn atebol yn ymarferol? Mae'r rheolwyr yn atebol i'r ymddiriedolaeth, ac, yn y pen draw, mae gennych chi, mae'n debyg, a ni, sancsiynau dros hynny, ond beth sy'n briodol yn eich tyb chi?

**Ms Lloyd:** Bydd rheolwyr yr ymddiriedolaeth yn atebol i'w bwrdd, sy'n atebol i'w gymuned am y safonau gofal. Dyna pam ein bod wedi dweud yn ein safonau newydd ac yn ein canllawiau newydd bod yn rhaid i fwrdd yr ymddiriedolaeth gymryd mwy o gyfrifoldeb am y maes pwysig hwn. Yn y 15 mis diwethaf yn unig, mewn gwirionedd, y mae'r atebolrwydd rhwng prif weithredwyr yr ymddiriedolaethau a minnau wedi'u hegluro a'u hesbonio. Dyna pam ein bod wedi bod yn rhoi materion, megis rheoli cyfleusterau a'r safonau yr ydym yn disgwyl eu gweld, ar waith drwy'r cynllun. Yn ddiweddar yn unig

yr ailsefydlwyd yr atebolrwydd hwnnw.

[79] **Leighton Andrews:** Okay. You say that the trust board is ultimately accountable to its community. The ways in which communities can exercise accountability over their trust boards are not necessarily obvious to the community at large, unless, to be honest with you, probably the media or elected representatives call the community's attention to issues that may arise. That may not be, actually, the most helpful way in which to have accountability in this area, because it means that you simply get a cycle of negative coverage and perhaps an over-fixation on certain points. So in terms of your processes, it seems to me that your processes have to provide an additional layer of accountability so that the operating process itself addresses the kinds of concerns that might arise if people felt that these inspections were not happening on a regular enough basis.

[79] **Leighton Andrews:** Iawn. Yr ydych yn dweud mai bwrdd yr ymddiriedolaeth sy'n atebol yn y pen draw i'w gymuned. Nid yw'r ffyrdd y gall cymunedau ofyn am atebolrwydd gan fyrddau eu hymddiriedolaeth yn eglur i drwch y gymuned o reidrwydd, os nad, i fod yn onest â chi, yw'r cyfryngau neu gynrychiolwyr etholedig efallai yn tynnu sylw'r gymuned at faterion a allai godi. Efallai nad hynny, mewn gwirionedd, fyddai'r ffordd fwyaf defnyddiol o sicrhau atebolrwydd yn y maes hwn, oherwydd ei fod yn golygu eich bod yn y bôn yn cael cylch o sylw negyddol a gorbwysleisio pwyntiau penodol o bosibl. Felly o ran eich prosesau, ymddengys i mi fod yn rhaid i'ch prosesau ddarparu lefel ychwanegol o atebolrwydd er mwyn i'r broses weithredu ei hun fynd i'r afael â'r mathau o bryderon a allai godi pe bai pobl yn teimlo nad oedd yr archwiliadau hyn yn digwydd yn ddigon rheolaidd.

**Ms Lloyd:** That is precisely why, in the past year, I have been developing the performance management structure. That will highlight all these areas and will include any additional guidance and standards that we wish to set. That will be published, so that the community, as well as the Assembly, can see quite well the sorts of standards and performance that are available within each of the organisations. There was not a performance management culture before; there is now.

**Ms Lloyd:** Dyna'n union pam, yn y flwyddyn ddiwethaf, fy mod wedi bod yn datblygu'r sdrwythur rheoli perfformiad. Bydd hwnnw'n amlygu'r holl feysydd hyn ac yn cynnwys unrhyw ganllawiau a safonau ychwanegol yr ydym am eu pennu. Bydd hynny'n cael ei gyhoeddi, er mwyn i'r gymuned, yn ogystal â'r Cynulliad, allu gweld yn eithaf clir y mathau o safonau a pherfformiad sydd ar gael ymhob sefydliad. Nid oedd diwylliant rheoli perfformiad yn y gorffennol; mae un ar gael bellach.

[80] **Janet Davies:** Thank you, Leighton. Alun, would you like to continue with the questions?

[80] **Janet Davies:** Diolch, Leighton. Alun, a ydych am barhau â'r cwestiynau?

[81] **Alun Cairns:** Thank you, Cadeirydd. I would like to pursue this a bit further, because I am interested in the responses that you gave to Leighton, Mrs Lloyd. I accept that the first level of accountability is to the trust management, and then, obviously, to the board, and then to the community. However, where do you see that your role lies in this? What responsibility or accountability do you, and then, ultimately, the Minister have?

[81] **Alun Cairns:** Diolch, Gadeirydd. Hoffwn fynd ar drywydd y mater hwn ymhellach, oherwydd mae gennyf ddiddordeb yn yr ymatebion yr ydych wedi'u rhoi i Leighton, Ms Lloyd. Yr wyf yn derbyn mai i reolwyr yr ymddiriedolaeth y mae'r lefel gyntaf o atebolrwydd, ac yna, yn amlwg, i'r bwrdd, ac yna i'r gymuned. Fodd bynnag, lle yr ydych yn ystyried eich rôl chi yn hyn i gyd? Pa gyfrifoldeb neu atebolrwydd sydd gennych chi, ac yna, yn y pen draw, y Gweinidog?

**Ms Lloyd:** Well I now have the ultimate accountability to the Minister for the management and the standards of the NHS right throughout Wales. However, when I was appointed two years ago, that accountability was not stated like that; on the requirement of the Minister, this has been clarified over the last 18 months. You will know that, in the recent Wanless report, this issue of accountability has again been highlighted. Derek Wanless has recommended that it be strengthened further.

**Ms Lloyd:** Wel mae gennyf yn awr yr atebolrwydd pennaf i'r Gweinidog am reolaeth a safonau'r GIG ledled Cymru. Fodd bynnag, ar ôl fy mhenodi ddwy flynedd yn ôl, ni nodwyd yr atebolrwydd hwnnw fel hynny; ar gais y Gweinidog, mae hyn wedi'i egluro'n ystod y 18 mis diwethaf. Byddwch yn gwybod, yn adroddiad diweddar Wanless, bod yr achos hwn o atebolrwydd wedi'i amlygu eto. Mae Derek Wanless wedi argymell ei fod yn cael ei atgyfnerthu ymhellach.

[82] **Alun Cairns:** Okay. So, going back to your first answer when you said that accountability is with the trust manager and the board, do you accept that that could suggest an abdication of the responsibility of the Assembly in the process?

[82] **Alun Cairns:** Iawn. Felly, gan fynd yn ôl at eich ateb cyntaf pan y bu i chi ddweud mai rheolwr yr ymddiriedolaeth a'r bwrdd sydd â'r atebolrwydd, a ydych yn derbyn y gallai hynny awgrymu bod cyfrifoldeb y Cynulliad yn y broses yn cael ei ymwrthod?

**Ms Lloyd:** No, because we cannot do everything ourselves—otherwise, why appoint trust boards; we might as well manage the lot. It is really important that trusts take care of their own responsibilities. They are charged with that responsibility, for which I hold them to account, for the management and organisation of clinical and support care within their organisations, within guidelines set by the Assembly to which, now, the Assembly holds them to account.

**Ms Lloyd:** Na, oherwydd na allwn wneud popeth ein hunain—fel arall, pam penodi byrddau ymddiriedolaeth; man a man i ni reoli'r cwbl. Mae'n bwysig iawn bod ymddiriedolaethau'n gofalu am eu cyfrifoldebau eu hunain. Eu cyfrifoldeb hwy yw hynny, ac maent yn atebol imi, am reoli a threfnu gofal clinigol a chymorth yn eu sefydliadau, o fewn canllawiau a osodir gan y Cynulliad ac sy'n golygu, bellach, eu bod yn atebol i'r Cynulliad.

[83] **Jocelyn Davies:** So it is the Assembly and yourself, as well as the community, that will hold them to account?

[83] **Jocelyn Davies:** Felly i chi a'r Cynulliad, ynghyd â'r gymuned, y byddant yn atebol?

**Ms Lloyd:** Yes.

**Ms Lloyd:** Ie.

[84] **Janet Davies:** Thank you. Mark, do you have a question?

[84] **Janet Davies:** Diolch. Mark, a oes gennych chi gwestiwn?

[85] **Mark Isherwood:** May I ask a supplementary question prior to my allocated questions? It is in relation to this matter.

[85] **Mark Isherwood:** A gaf ofyn cwestiwn ychwanegol cyn fy nghwestiynau penodol? Mae'n ymwneud â'r mater hwn.

[86] **Janet Davies:** Yes, okay.

[86] **Janet Davies:** Ie, iawn.

[87] **Mark Isherwood:** You have referred many times to performance management, Ms Lloyd. I would be interested to hear your understanding of performance management, because on one occasion you actually said that you could use performance management to deal with failure to deliver. My

[87] **Mark Isherwood:** Yr ydych wedi cyfeirio sawl gwaith at reoli perfformiad, Ms Lloyd. Byddwn â diddordeb i glywed beth yw ystyr rheoli perfformiad i chi, oherwydd ar un achlysur bu i chi ddweud y gallech ddefnyddio'r broses o reoli perfformiad i ddelio â methu â darparu. Yr oeddwn i ar

understanding of performance management is that it is about coaching, development, agreeing action plans with individuals, and then reviewing that on a systematic basis, whereas failure to deliver and failure to co-operate becomes more of a disciplinary issue. Do you agree, or does your performance management system incorporate the disciplinary aspects as well?

ddeall bod rheoli perfformiad yn ymwneud â hyfforddi, datblygu, cytuno ar gynlluniau gweithredu gydag unigolion, ac yna adolygu hynny'n systematig, a bod methu â darparu a methu â chydweithredu yn fwy o fater disgyblu. A ydych yn cytuno, neu a yw eich system rheoli perfformiad yn cynnwys agweddau disgyblu hefyd?

**Ms Lloyd:** The regions and we are monitoring all the trusts against all the targets and standards that have been set. We have just finished the first round of that, and are now into the first quarterly reviews of how the organisations are performing against the standards set by the Assembly and its Government. What is also contained within that, and that has been something that we have been discussing in the last six months, is the issue of what are the incentives and sanctions that you place within a performance management system. The sanctions obviously follow the line that, if there is a failure to act against an agreed action plan over a reasonable period of time—that is, reasonable in our view—then, obviously, there has to be a withdrawal of executive authority. That is what you will see. As accounting officer, I already have the responsibility for the governance of the organisations, and I can issue letters of censure to chief executives who fail to operate their accountability effectively. This is not a disciplinary issue; this is a performance management issue. This is something that I do very infrequently, I have to say. However, the whole of the performance management system, which has been developed in Wales, is all about continuous improvement, and a continuing striving towards increased accountability, increased responsibility and an increase in standards and delivery. However, if there is a failure that is continuous, then executive power has to be removed.

**Ms Lloyd:** Mae'r rhanbarthau a ninnau yn monitro pob ymddiriedolaeth yn ôl y targedau a'r safonau a osodwyd. Yr ydym newydd orffen y cam cyntaf o hynny, a bellach yr ydym yn cynnal yr adolygiadau chwarterol cyntaf o sut y mae'r sefydliadau'n perfformio yn ôl y safonau a osodwyd gan y Cynulliad a'i Lywodraeth. Yr hyn sydd hefyd wedi'i gynnwys yn hwnnw, ac mae hynny'n rhywbeth yr ydym wedi bod yn ei drafod yn ystod y chwe mis diwethaf, yw beth yw'r cymhellion a'r sancsiynau a roddir gennych o fewn system rheoli perfformiad. Mae'r sancsiynau'n amlwg yn dilyn y feddylfryd, sef os methir â gweithredu'n erbyn cynllun gweithredu y cytunwyd arno dros gyfnod rhesymol o amser—hynny yw, rhesymol yn ein barn ni—yna, yn amlwg, mae'n rhaid dirymu'r awdurdod gweithredol. Dyna beth y byddwch yn ei weld. Fel swyddog cyfrifo, mae gennyf y cyfrifoldeb yn barod dros reoli'r sefydliadau, a gallaf anfon llythyrau cerydd at brif weithredwyr nad ydynt yn gweithredu eu hatebolrwydd yn effeithiol. Nid mater o ddisgyblu yw hyn; mae'n fater o reoli perfformiad. Anaml iawn y byddaf yn gwneud hyn, mae'n rhaid i mi ddweud. Fodd bynnag, mae'r holl system rheoli perfformiad, sydd wedi'i datblygu yng Nghymru, yn ymwneud â chynnydd parhaus, ac ymdrech barhaus tuag at atebolrwydd cynyddol, cyfrifoldeb cynyddol a chynnydd mewn safonau a darpariaeth. Fodd bynnag, os ceir methiant parhaus, mae'n rhaid dirymu'r pwerau gweithredol.

[88] **Mark Isherwood:** There are checks and balances therefore in place?

[88] **Mark Isherwood:** Mae rhwystrau a gwrthbwysau ar waith felly?

**Ms Lloyd:** Yes.

**Ms Lloyd:** Oes.

[89] **Mark Isherwood:** To return to my allocated questions therefore, I draw attention to paragraph 2.15 of the report,

[89] **Mark Isherwood:** I ddychwelyd at fy nghwestiynau penodol felly, tynnaf eich sylw at baragraff 2.15 yr adroddiad, sy'n nodi bod

which notes that many hospitals have monitoring checks in place. However, the results of the monitoring checks were, apparently, rarely reported to senior management or discussed at board level. Why should this be the case, when the NHS plan for Wales clearly aims to ensure that trust boards are accountable for overseeing all aspects of hygiene?

nifer o ysbytai yn gweithredu gwiriadau monitro. Fodd bynnag, anaml yr oedd canlyniadau'r gwiriadau monitro, yn ôl pob sôn, yn cael eu hadrodd i uwch reolwyr na'u trafod ar lefel y bwrdd. Pam fod hyn yn digwydd, pan fo cynllun GIG i Gymru yn amlwg am sicrhau bod byrddau'r ymddiriedolaethau'n gyfrifol am oruchwylio pob agwedd ar hylendid?

**Ms Lloyd:** I think that that again is an issue of culture, and of the priority given by organisations to this area. That is why we now have an executive board member on each board who is designated as responsible for the ultimate ownership of this issue, and who has to report on this area within the board itself. We felt that it was important that the boards did start to grapple with this.

**Ms Lloyd:** Credaf fod hynny eto'n fater o ddiwylliant, ac o'r flaenoriaeth a roddir gan sefydliadau i'r maes hwn. Dyna pam bod gennym aelod bwrdd gweithredol ar bob bwrdd sy'n gyfrifol am berchnogaeth y mater yn y pen draw, ac sy'n gorfod adrodd ar y maes hwn o fewn y bwrdd ei hun. Yr oeddem yn teimlo ei bod yn bwysig bod y byrddau yn dechrau mynd i'r afael â hyn.

[90] **Mark Isherwood:** Thank you. Referring again to case study D on page 19, which highlights best practice in the Singleton and Morriston hospitals in Swansea NHS Trust, it showed that some hospitals have introduced strict lines of communication—monthly monitoring checks in this case. How could you make such a system compulsory across the whole of Wales, and when could this become the case?

[90] **Mark Isherwood:** Diolch. Gan gyfeirio eto at astudiaeth achos D ar dudalen 19, sy'n amlygu arferion gorau yn ysbytai Singleton a Threforys yn Ymddiriedolaeth GIG Abertawe, yr oedd yn dangos bod rhai ysbytai wedi cyflwyno sianeli cyfathrebu llym—gwiriadau monitro misol yn yr achos hwn. Sut allech chi wneud system fel hyn yn orfodol ledled Cymru gyfan, a phryd ellid gwneud hyn?

**Ms Lloyd:** This is again part of the standards. These are the good practice issues that have been picked up by the forum as it developed these standards. Again, I will be able to advise you on how prevalent this system is throughout Wales once we have finished our first six-monthly check. However, we will agree with each organisation, if it does not already do this, by what time it will be doing it. I think that there is an important issue to remember here. About 20 years ago, in terms of domestic services, there was a national domestic services manager training programme, which lapsed right throughout the UK. Given the importance of cleaning, and the development of support services, this is a time when we need to reconsider how we really get good supervisors, good managers of these services, back into the system. The supervision of cleaning makes a great deal of difference to a hospital. Again, we need to provide and reinstate a proper career structure, with proper training and development, so that,

**Ms Lloyd:** Mae hyn eto'n rhan o'r safonau. Y rhain yw'r materion arferion gorau sydd wedi'u dethol gan y fforwm wrth iddo ddatblygu'r safonau hyn. Eto, byddaf yn gallu eich cynghori ar ba mor gyffredin yw'r system hon ledled Cymru ar ôl i ni orffen ein gwiriad chwemisol cyntaf. Fodd bynnag, byddwn yn cytuno â phob sefydliad, os nad yw'n gwneud hyn yn barod, erbyn pryd y bydd yn ei wneud. Credaf fod mater pwysig i'w gofio yma. Tua 20 mlynedd yn ôl, o ran gwasanaethau domestig, yr oedd rhaglen hyfforddi rheolwyr gwasanaethau domestig cenedlaethol, a ddaeth i ben ledled y DU. O ystyried pwysigrwydd glanhau, a datblygiad gwasanaethau cymorth, dyma gyfnod lle mae angen i ni ailystyried sut y gallwn gael goruchwylwyr gwirioneddol dda, rheolwyr da ar gyfer y gwasanaethau hyn, yn ôl i'r system. Mae goruchwylio glanhau yn gwneud cryn wahaniaeth i ysbyty. Eto, mae angen i ni ddarparu ac ailsefydlu sdrwythur gyrfa iawn, gyda hyfforddi a datblygu iawn, er mwyn i'r bobl hynny, drwy weithio â'r

working with the infection control teams, those people can ensure that induction for all staff is right, and that the importance of cleanliness and personal hygiene is highlighted for everybody within the hospital community.

timau rheoli heintiau, sicrhau bod eu rhaglenni sefydlu ar gyfer yr holl staff yn iawn, a bod pwysigrwydd glanweithdra a hylendid personol yn cael ei amlygu i bawb yng nghymuned yr ysbyty.

[91] **Mark Isherwood:** Thank you. Leading on from that, I refer you to paragraph 2.18, which highlights the issues of poor communication to hospital staff in this area. Case study G on page 20, which again highlights good practice—[*Interruption*.]

[91] **Mark Isherwood:** Diolch. Gan ddilyn y trywydd hwnnw, cyfeiriaf at baragraff 2.18, sy'n amlygu materion cyfathrebu gwael i staff ysbyty yn y maes hwn. Mae astudiaeth achos G ar dudalen 20, sydd eto'n amlygu arferion da—[*Torri ar draws*.]

**Ms Lloyd:** Excuse me, I have a cough.

**Ms Lloyd:** Esgusodwch fi, yr wyf yn pesychu.

[92] **Mark Isherwood:** Are you all right? Good. Case study G on page 20 again highlights best practice in Swansea NHS Trust. What plans do you have to ensure that such a system is used across all hospitals in Wales, and how can outcomes then be systematically monitored?

[92] **Mark Isherwood:** A ydych yn iawn? Da iawn. Mae astudiaeth achos G ar dudalen 20 eto'n amlygu arferion gorau yn Ymddiriedolaeth GIG Abertawe. Pa gynlluniau sydd gennych i sicrhau bod system o'r fath yn cael ei defnyddio ym mhob ysbyty yng Nghymru, a sut y gellir monitro canlyniadau'n systematig wedi hynny?

**Ms Lloyd:** Well, in the same way, this is also part of the standards and will also be available.

**Ms Lloyd:** Wel, yn yr un modd, mae hyn hefyd yn rhan o'r safonau a bydd hefyd ar gael.

[93] **Mark Isherwood:** I am sure, from what you have already told us, that you agree that ownership of delivery should be cascaded top-down to everybody in the organisation, on a collective team basis?

[93] **Mark Isherwood:** Yr wyf yn siŵr, o'r hyn yr ydych wedi'i ddweud wrthym yn barod, eich bod yn cytuno y dylai'r cyfrifoldeb am ddarpariaeth gael ei ffrydio o'r brig i'r bôn i bawb yn y sefydliad, ar sail tîm cyfunol?

**Ms Lloyd:** Yes.

**Ms Lloyd:** Ydw.

[94] **Mark Isherwood:** As part of that, do you believe that you yourself should have sight of the hospitals that are continually failing to keep the wards clean?

[94] **Mark Isherwood:** Fel rhan o hynny, a ydych yn credu y dylech chi eich hun weld yr ysbytai sy'n methu byth a hefyd â chadw'r wardiau'n lân?

**Ms Lloyd:** As part of my performance management, I make regular visits, with my regional directors, to organisations, good and improving. I will be taking up the results of the performance management outcomes with them to address personally how the trust management is going to take forward any improvements that are needed, or how the trust management is going to spread the good practice that has been found in the trust.

**Ms Lloyd:** Fel rhan o'm system rheoli perfformiad, ymwelaf yn rheolaidd, gyda'm cyfarwyddwyr rhanbarthol, â sefydliadau, rhai da a rhai sy'n gwella. Byddaf yn trafod canlyniadau'r rheoli perfformiad gyda hwy er mwyn mynd i'r afael yn bersonol â sut y bydd rheolwyr yr ymddiriedolaeth yn cyflawni unrhyw welliannau sydd eu hangen, neu sut y bydd rheolwyr yr ymddiriedolaeth yn lledaenu'r arferion da sydd wedi'u canfod

yn yr ymddiriedolaeth.

[95] **Mark Isherwood:** I think that your visible involvement will give a powerful message to all the staff involved in these improvement projects, certainly.

[95] **Mark Isherwood:** Credaf y bydd eich gweld yn cyfrannu yn rhoi neges bwerus i'r holl staff sy'n cyfrannu at y prosiectau gwella hyn, yn sicr.

**Ms Lloyd:** Yes. Well, I hope so.

**Ms Lloyd:** Bydd. Wel, yr wyf yn gobeithio hynny.

[96] **Mark Isherwood:** Okay, thank you.

[96] **Mark Isherwood:** Iawn, diolch.

[97] **Janet Davies:** Moving on to page 22, I want to look at figure 8, which shows the number of cleaning specifications that have been rewritten recently. Clearly, we are hearing this morning about all the new systems that are being put into place, and, in a way, this whole situation is moving. So, perhaps, on some of the things that we are looking at in the report, there may have been changes by the time we get to them but, obviously, it is the report that we are talking about. So, could I ask you about the fact that only two of the 17 acute hospitals in Wales have updated their cleaning specifications, according to the report, within the last three years, and that seven of them have not rewritten them for more than 10 years. I do not know if you can give any more up-to-date information than that but, if not, how would you explain that situation?

[97] **Janet Davies:** Gan symud ymlaen at dudalen 22, yr wyf am edrych ar ffigur 8, sy'n dangos nifer y manylebau glanhau sydd wedi'u hailysgrifennu'n ddiweddar. Yn amlwg, yr ydym yn clywed y bore yma am yr holl systemau newydd sy'n cael eu rhoi ar waith, ac, mewn ffordd, mae'r holl sefyllfa hon yn symud. Felly, efallai, gyda rhai o'r pethau yr ydym yn edrych arnynt yn yr adroddiad hwn, efallai y bu newidiadau erbyn i ni eu trafod ond, yn amlwg, yr ydym yn trafod yr adroddiad. Felly, a gaf ofyn i chi am y ffaith mai dau ysbyty'n unig o'r 17 ysbyty aciwt yng Nghymru sydd wedi diweddaru eu manylebau glanhau, yn ôl yr adroddiad, o fewn y tair blynedd diwethaf, ac nid yw saith ohonynt wedi'u hailysgrifennu ers dros 10 mlynedd. Nid wyf yn gwybod a allwch roi gwybodaeth fwy diweddar na hynny ond, os na allwch, sut y byddech yn egluro'r sefyllfa honno?

**Ms Lloyd:** I am advised by my colleague that these specifications will obviously be rewritten as part of the standards that have to be complied with. In terms of why they have not been rewritten so far, there have always been basic standards against which trusts commission their cleaning services, and again, I think that this is very much a matter of trust priority—what priority did the management give to rewriting specifications. For many of them, their hospitals will have remained unchanged for some considerable time. Obviously, when you have new areas, you rewrite specifications, so some might have been luckier than others. However, with the increase in infection, and with the spotlight that has been highlighted there, then obviously all of them will be rewritten within the next year, unless they are very, very new and comply with the best practice.

**Ms Lloyd:** Fe'm cynghorir gan fy nghydweithiwr y bydd y manylebau hyn yn amlwg yn cael eu hailysgrifennu fel rhan o'r safonau y mae'n rhaid cydymffurfio â hwy. O ran pam nad ydynt wedi'u hailysgrifennu hyd yma, bu safonau sylfaenol gydol yr amser fel sail i'r ymddiriedolaethau gomisiynu eu gwasanaethau glanhau, ac eto, credaf fod hwn yn fater y dylai'r ymddiriedolaethau roi blaenoriaeth iddo—pa flaenoriaeth a roddodd yr ymddiriedolaethau i ailysgrifennu manylebau. I nifer ohonynt, ni fydd eu hysbytai wedi newid ers cryn amser. Yn amlwg, pan geir meysydd newydd, bydd yn rhaid ailysgrifennu manylebau, felly efallai fod rhai wedi bod yn fwy ffodus nag eraill. Fodd bynnag, gyda'r cynnydd mewn heintiau, a chyda'r sylw sydd wedi'i roi ar y maes, byddant i gyd yn amlwg yn cael eu hailysgrifennu yn ystod y flwyddyn nesaf, os nad ydynt yn newydd sbon ac yn

cydymffurfio â'r arferion gorau.

[98] **Janet Davies:** Yes, because the report does talk about changes to the soft furnishings or the floor coverings and so on, and it seems to me that most hospitals will have changed those within 10 years. I am also very concerned that, over the years, and after taking evidence on different issues within the NHS, we have been told quite a number of times that various issues have not been seen as a priority. I think that I may have raised that issue before, namely what are the priorities in the health service, over and above day-to-day crisis management. It is something that I get quite concerned about. I think that that is more of a statement than a question possibly. How are you going to ensure that these hospitals update their cleaning specifications regularly? Will you be going back to them now to ensure that this is happening?

[98] **Janet Davies:** Ie, oherwydd mae'r adroddiad yn sôn am newidiadau i'r dodrefn meddal neu'r gorchuddion llawr ac ati, ac ymddengys i mi y bydd y mwyafrif o ysbytai wedi newid y rheini o fewn 10 mlynedd. Yr wyf hefyd yn bryderus iawn, dros y blynyddoedd, ac ar ôl cymryd tystiolaeth ar wahanol faterion o fewn y GIG, ein bod wedi clywed sawl gwaith nad yw materion amrywiol wedi'u hystyried fel blaenoriaeth. Credaf fy mod wedi trafod y mater hwnnw o'r blaen, sef yn bennaf beth yw'r blaenoriaethau yn y gwasanaeth iechyd, ar wahân i reoli argyfwng o ddydd i ddydd. Mae'n rhywbeth yr wyf yn eithaf pryderus yn ei gylch. Credaf ei fod yn fwy o ddatganiad na chwestiwn o bosibl. Sut yr ydych am sicrhau bod yr ysbytai hyn yn diweddaru eu manylebau glanhau yn rheolaidd? A fyddwch yn mynd yn ôl atynt yn awr i sicrhau bod hyn yn digwydd?

**Ms Lloyd:** Yes. With the standards being rolled out, and with the six-month review, we will be very clear about what specifications really need to be uprated first because they will have to risk-assess their environment.

**Ms Lloyd:** Byddaf. Gyda'r safonau'n cael eu cyflwyno, a chyda'r adolygiad chwe mis, byddwn yn glir iawn ynglŷn â pha fanylebau sydd wir angen eu diweddaru gyntaf oherwydd y bydd yn rhaid iddynt asesu risg eu hamgylchedd.

[99] **Janet Davies:** Right, thank you. Alun, you have some questions?

[99] **Janet Davies:** Iawn, diolch. Alun, mae gennych gwestiynau?

[100] **Alun Cairns:** Thank you, Cadeirydd. My questions build on those that you have just asked and I will refer specifically to the budgets that are built on the specifications. Eleven out of the 17 acute hospitals calculate their cleaning service budget from out-of-date specifications. Are you satisfied that sufficient resources are being invested in hospital cleanliness?

[100] **Alun Cairns:** Diolch, Gadeirydd. Mae fy nghwestiynau'n ychwanegu at y rheini yr ydych newydd eu gofyn a byddaf yn cyfeirio'n benodol at y cyllidebau sy'n seiliedig ar y manylebau. Mae 11 o'r 17 ysbyty aciwt yn cyfrifo eu cyllideb gwasanaeth glanhau o fanylebau sydd wedi dyddio. A ydych yn fodlon bod adnoddau digonol yn cael eu buddsoddi yng nglanweithdra ysbytai?

**Ms Lloyd:** Until I have those updated specifications, which are costed, I cannot give you an answer to that. What we have got to do is to review very carefully the funding available to them once those specifications have been costed.

**Ms Lloyd:** Tan imi weld y manylebau diweddaraf hynny, gyda'u prisiau wedi'u pennu, ni allaf roi ateb i chi ar hynny. Yr hyn sydd yn rhaid i ni ei wneud yw adolygu'r cyllid sydd ar gael iddynt yn ofalus iawn ar ôl pennu prisiau'r manylebau hynny.

[101] **Alun Cairns:** Can I then refer you to case study H on page 23, which shows a hospital that has recently reviewed its

[101] **Alun Cairns:** A gaf fi felly eich cyfeirio at astudiaeth achos H ar dudalen 23, sy'n dangos ysbyty a adolygodd ei

specifications? When it then analysed the costing of that, it came up with a shortfall of £650,000 in the cleaning budget. How should the hospital reconcile that?

fanylebau'n ddiweddar? Pan ddadansoddodd gostau hynny yn ddiweddarach, dangosodd ddiffyg ariannol o £650,000 yn y gyllideb lanhau. Sut y dylai'r ysbyty gysoni hynny?

**Ms Lloyd:** I think that that is very much an issue of the cleaning culture. The LHBs will be commissioning care from hospitals like the Princess of Wales Hospital in the future. They will know what environmental standards will need to be attained in the hospitals. It will be a discussion between them and those hospitals about the priority that they accord to an improvement in a specification if it is not being met at the moment.

**Ms Lloyd:** Credaf fod hynny'n fater o ddiwylliant glanhau. Bydd y byrddau iechyd lleol yn comisiynu gofal o ysbytai fel Ysbyty Tywysoges Cymru yn y dyfodol. Byddant yn gwybod pa safonau amgylcheddol fydd angen eu bodloni yn yr ysbytai. Trafodaeth rhyngddynt a'r ysbytai hynny fydd hon am y flaenoriaeth y byddant yn ei rhoi i wella manyleb os nad yw'n cael ei bodloni ar hyn o bryd.

[102] **Alun Cairns:** So how are you providing the resources, or what resources are being provided? If, after the review of the specifications comes out, the example in case study H of the Princess of Wales Hospital is typical everywhere else, the need for additional resources will be massive when you multiply that 17 times, or at least the potential is that it will be 17 times greater. From where should they fund the increased requirement in funding?

[102] **Alun Cairns:** Felly sut yr ydych yn darparu'r adnoddau, neu pa adnoddau a ddarperir? Os, ar ôl cyhoeddi adolygiad y manylebau, yw'r enghraifft yn astudiaeth achos H o Ysbyty Tywysoges Cymru yn nodweddiadol o bob man arall, bydd angen dybryd am adnoddau ychwanegol ar ôl lluosi hynny 17 o weithiau, neu o leiaf mae posibilrwydd y bydd 17 gwaith yn fwy. O ble y dylent gyllido'r gofynion cyllid cynyddol?

**Ms Lloyd:** That is a discussion that I and my regional directors will have with the local health boards in terms of the priorities that need to be met within the NHS in Wales because they do get an uplift every year and it is a question of how that is applied.

**Ms Lloyd:** Mae honno'n drafodaeth y byddaf i a'm cyfarwyddwyr rhanbarthol yn ei chynnal gyda'r byrddau iechyd lleol am y blaenoriaethau sydd angen eu bodloni o fewn y GIG yng Nghymru oherwydd eu bod yn cael cynnydd bob blwyddyn ac mae'n fater o sut y byddant yn defnyddio hwnnw.

[103] **Alun Cairns:** Okay. Thank you.

[103] **Alun Cairns:** Iawn. Diolch.

[104] **Janet Davies:** Christine, you have some questions?

[104] **Janet Davies:** Christine, mae gennych gwestiynau?

[105] **Christine Gwyther:** Yes. I would like to try, if possible, to tease out to what extent our trusts are anticipating the unexpected. I will take you back to paragraph 3.2 in the document, which states that many hospitals cannot meet their own minimum standards of cleanliness. I think that it states that eight out of the 11 acute hospitals that were visited stated that they were not meeting their own standards. So that I can be clear, could you tell me whether the three hospitals that are meeting the standards are those where infection control teams are working in

[105] **Christine Gwyther:** Oes. Hoffwn geisio, os yw hynny'n bosibl, weld i ba raddau y mae ein hymddiriedolaethau yn rhagweld yr annisgwyl. Yr wyf am eich cyfeirio'n ôl at baragraff 3.2 yn y ddogfen, sy'n nodi na all nifer o ysbytai fodloni eu safonau glanweithdra gofynnol eu hunain. Credaf ei fod yn nodi bod wyth o'r 11 ysbyty aciwt yr ymwelwyd â hwy yn datgan nad oeddent yn bodloni eu safonau eu hunain. Er mwyn imi allu bod yn glir, a allwch ddweud wrthyf ai'r tri ysbyty sy'n bodloni eu safonau yw'r rhai hynny sydd â thimau rheoli

collaboration with cleaning services? I think that that would help me to understand where the problem might lie. Could you tell me how they tackle the problems of unforeseen cleaning such as spillages or emergency barrier rooms; that relates to the infection control question that was asked by Mick Bates.

heintiau yn cydweithio gyda'r gwasanaethau glanhau? Credaf y byddai hynny o bosibl yn fy helpu i ddeall ble mae gwreiddyn y broblem. A allwch ddweud wrthyf sut y maent yn mynd i'r afael â'r problemau glanhau annisgwyl megis gollyngiadau neu ystafelloedd rhwystr argyfwng; mae hynny'n gysylltiedig â'r cwestiwn ar reoli heintiau a ofynnwyd gan Mick Bates.

**Ms Lloyd:** I do not know which three are not complying with this. I will not know that until we place these standards and they report back formally.

**Ms Lloyd:** Nid wyf yn gwybod pa dri a fethodd â chydymffurfio â hyn. Ni fyddaf yn gwybod hynny tan i ni roi'r safonau hyn ar waith a'u bod yn adrodd yn ôl yn ffurfiol.

[106] **Christine Gwyther:** I think that there are three that are meeting the standards, and eight that are not.

[106] **Christine Gwyther:** Credaf fod tri sydd yn bodloni'r safonau, ac wyth sydd yn methu.

**Ms Lloyd:** Three that are? I do not know which ones they are. In terms of people continually failing to meet the standards, it depends to what extent that is and how they have risk-assessed the consequences of failing to meet the standards. I have to re-stress that this is an issue for trust management. I am not directly operationally managing the NHS trusts in Wales on a day-to-day basis. The trusts' management are charged with doing that on behalf of their communities. I would expect them to properly risk assess any failure to meet their standards whether cleaning or any other clinical standards. They will then be held to account for their risk assessment, whether it is wrong or right.

**Ms Lloyd:** Tri sydd yn eu bodloni? Nid wyf yn gwybod pa rai ydynt. O ran pobl yn methu'n barhaus â bodloni'r safonau, mae'n dibynnu i ba raddau y mae hynny'n digwydd a sut y maent wedi asesu'r risg yn sgîl methu â bodloni'r safonau. Mae'n rhaid imi ailbwysleisio bod hyn yn fater i reolwyr ymddiriedolaethau. Nid wyf yn rheoli gwaith ymddiriedolaethau'r GIG yng Nghymru'n uniongyrchol o ddydd i ddydd. Cyfrifoldeb rheolwyr yr ymddiriedolaeth yw hynny ar ran eu cymunedau. Byddwn yn disgwyl iddynt asesu risg unrhyw achos o fethu â bodloni eu safonau boed yn safonau glanhau neu unrhyw safonau clinigol eraill. Byddant wedyn yn atebol am eu hasesiad risg, boed yn anghywir neu'n gywir.

In terms of spillages, this is one of the things that causes me the greatest concern because too often we get so much feedback from the general public and staff that areas appear unwholesome because there is dried blood on the floor or patients will say that there has been a spillage for the last three hours and nobody has come to clean it up. Personally, this is one of the areas that I will be chasing up with the greatest diligence with the trust staff management because it cannot give confidence to patients and it can be a hazard as well, and a difficult hazard to deal with. Some places have managed very well in dealing with spillages, in that they have proper processes in place. However, that good practice must be spread out, because I think that it is one of the more disturbing

O ran gollyngiadau, dyma un o'r pethau sy'n achosi'r pryder mwyaf imi oherwydd yn rhy aml yr ydym yn derbyn cymaint o ymateb gan y cyhoedd a staff bod mannau yn ymddangos yn afiach oherwydd bod gwaed wedi sychu ar lawr neu bydd cleifion yn dweud bod rhyw hylif wedi'i ollwng ers tair awr ac nad oes neb wedi dod i'w lanhau. Yn bersonol, dyma un o'r meysydd y byddaf yn mynd i'r afael ag ef gyda'r diwydrwydd mwyaf gyda staff rheoli'r ymddiriedolaethau oherwydd na all roi hyder i gleifion a gall fod yn beryglus hefyd, ac yn berygl anodd i fynd i'r afael ag ef. Mae rhai lleoedd wedi ymdopi'n dda iawn wrth ddelio â gollyngiadau, oherwydd fod ganddynt brosesau iawn ar waith. Fodd bynnag, mae'n rhaid lledaenu'r arferion da hynny, oherwydd

parts of a failure to address cleaning standards.

fy mod yn credu ei fod yn un o'r elfennau sy'n peri'r pryder mwyaf o ran methu â bodloni safonau glanhau.

[107] **Christine Gwyther:** Coming back to the emergency barrier rooms issue, would you say that there should be flexibility built into the cleaning specifications as part of that risk assessment and should rapid response cleaning teams be introduced, perhaps?

[107] **Christine Gwyther:** Gan ddychwelyd at ystafelloedd rhwystr argyfwng, a fyddech yn dweud bod angen hyblygrwydd yn y manylebau glanhau fel rhan o'r asesiadau risg hynny ac a ddylid cyflwyno timau glanhau ymateb brys, o bosibl?

**Ms Lloyd:** Yes. In terms of the specifications, that flexibility is built in and we do have to ensure that emergency barrier rooms can be thoroughly cleaned before any other patient goes in them or they cease to be a requirement for barrier nursing. Some of these rapid response teams have been very effective at doing that. However, again, it is an issue of ward management. There has to be control over that environment so that risk is absolutely minimised.

**Ms Lloyd:** Dylid. O ran y manylebau, mae'r hyblygrwydd hwnnw yn rhan ohonynt ac mae'n rhaid i ni sicrhau y gellir glanhau ystafelloedd rhwystr argyfwng yn drylwyr cyn i unrhyw gleifion eraill fynd i mewn iddynt neu ni fyddant yn un o ofynion nyrsio rhwystr. Bu rhai o'r timau ymateb brys hyn yn effeithiol iawn wrth wneud hynny. Fodd bynnag, eto, mae'n fater o reoli wardiau. Mae'n rhaid rheoli'r amgylchedd hwnnw er mwyn lleihau'r risg yn llwyr.

[108] **Christine Gwyther:** Finally, will those risk assessment reviews, when they are carried out, be part of your performance management systems?

[108] **Christine Gwyther:** Yn olaf, a fydd yr adolygiadau asesu risg hynny, pan fyddant ar y gweill, yn rhan o'ch system reoli perfformiad?

**Ms Lloyd:** Yes.

**Ms Lloyd:** Byddant.

[109] **Janet Davies:** Alun, you have some questions?

[109] **Janet Davies:** Alun, mae gennych gwestiynau?

[110] **Alun Cairns:** Yes, thank you, Chair. Before I move forward to page 25, I was a bit troubled again by one of your responses to Christine Gwyther, Ms Lloyd, in relation to repeating the point that you made earlier about responsibility lying with the trust management. Again, if the trust management fails to meet its obligations in terms of the specifications, setting the right priorities and so on, someone needs to act. Do you think that there needs to be clarification, even if it is only for me personally, as to where the accountability lines are, because I am still not clear from the answers that you have given?

[110] **Alun Cairns:** Oes, diolch, Gadeirydd. Cyn imi symud ymlaen at dudalen 25, yr oeddwn yn eithaf pryderus eto gydag un o'ch ymatebion i Christine Gwyther, Ms Lloyd, o ran ailbwysleisio'r pwynt y gwnaethoch yn gynharach bod y cyfrifoldeb yn nwylo rheolwyr yr ymddiriedolaeth. Eto, os yw rheolwyr yr ymddiriedolaeth yn methu â bodloni'r gofynion o ran y manylebau, pennu'r blaenoriaethau cywir ac ati, mae'n rhaid i rywun weithredu. A ydych yn credu bod angen eglurhad, hyd yn oed os yw imi yn unig, ynglŷn â'r drefn gyfrifoldeb, oherwydd nid wyf yn glir o hyd o'r atebion yr ydych wedi'u rhoi?

**Ms Lloyd:** Trust management is now accountable to me. It was not in the past.

**Ms Lloyd:** Mae rheolwyr yr ymddiriedolaethau bellach yn atebol i mi. Nid oeddent yn y gorffennol.

[111] **Alun Cairns:** That is the answer that you gave earlier. However, you still come

[111] **Alun Cairns:** Dyna'r ateb y bu i chi ei roi yn gynharach. Fodd bynnag, yr ydych yn

back to say that the responsibility lies with the trust management. In reality, the ultimate responsibility really lies with you and then the Minister, surely?

dal i ddod yn ôl i ddweud mai rheolwyr yr ymddiriedolaethau sy'n gyfrifol. Mewn gwirionedd, eich cyfrifoldeb chi yw hynny yn y pen draw ac yna'r Gweinidog, does bosibl?

**Ms Lloyd:** Yes, that is how it is. However, the day-to-day management responsibility has to be vested in trust management. That is what it is charged to do. Ultimately, it will be my responsibility, but I have delegated day-to-day management to the trusts.

**Ms Lloyd:** Ie, fel yna y mae hi. Fodd bynnag, mae'n rhaid rhoi'r cyfrifoldeb o reoli o ddydd i ddydd yn nwylo rheolwyr yr ymddiriedolaethau. Dyna eu cyfrifoldeb. Yn y pen draw, fy nghyfrifoldeb i ydyw, ond yr wyf wedi dirprwyo'r cyfrifoldeb rheoli o ddydd i ddydd i'r ymddiriedolaethau.

[112] **Alun Cairns:** Fine, I accept that.

[112] **Alun Cairns:** Iawn, yr wyf yn derbyn hynny.

[113] **Leighton Andrews:** May I come in here?

[113] **Leighton Andrews:** A gaf fi gyfrannu yma?

[114] **Janet Davies:** Yes.

[114] **Janet Davies:** Cewch.

[115] **Leighton Andrews:** It is confusing at one level, though. Trying to understand the difference in the level of accountability from the trust management to you and the trust management to its own board is one of the areas here, I think. As you rightly said earlier, the trust management is accountable to its board and it is accountable theoretically—I think that it is sometimes a theoretical accountability—to its community. One of you might say that your role perhaps, and the Minister's role, is to lay down national standards and to ensure that they are being adhered to. However, there is a level at which the board has to ensure locally that the trust is also doing that. To what extent are you, therefore, involved in ensuring that board members themselves understand their own responsibilities in this area?

[115] **Leighton Andrews:** Fodd bynnag, mae'n ddryslyd ar un lefel. Ceisio deall lefelau gwahanol yr atebolrwydd o reolwyr yr ymddiriedolaethau i chi a rheolwyr yr ymddiriedolaethau i'w bwrddau eu hunain yw un o'r meysydd yma, yn fy marn i. Yr oeddech yn llygad eich lle pan y bu i chi ddweud yn gynharach bod rheolwyr yr ymddiriedolaeth yn atebol i'w bwrdd a'r bwrdd yn atebol yn ddamcaniaethol—credaf mai atebolrwydd damcaniaethol yw hyn ar brydiau—i'w gymuned. Efallai y gallai un ohonoch ddweud mai eich rôl o bosibl, a rôl y Gweinidog, yw pennu safonau cenedlaethol a sicrhau eu bod yn cael eu cadw. Fodd bynnag, mae lefel lle mae'r bwrdd yn gorfod sicrhau'n lleol bod yr ymddiriedolaeth yn gwneud hynny. I ba raddau yr ydych, felly, yn cyfrannu at sicrhau bod aelodau'r bwrdd eu hunain yn deall eu cyfrifoldebau eu hunain yn y maes hwn?

**Ms Lloyd:** In terms of cleaning, or generally?

**Ms Lloyd:** O ran glanhau, neu yn gyffredinol?

[116] **Leighton Andrews:** Cleaning particularly.

[116] **Leighton Andrews:** Glanhau'n benodol.

**Ms Lloyd:** To step back, generally, there is an induction programme anyway for all board members so that they can understand their responsibilities well. The trust chair is held to account in a performance review held

**Ms Lloyd:** I gamu'n ôl, yn gyffredinol, mae rhaglen gyflwyno beth bynnag ar gyfer pob aelod o'r bwrdd er mwyn iddynt allu deall eu cyfrifoldebau'n well. Cadeirydd yr ymddiriedolaeth sy'n atebol mewn adolygiad

by the Minister on an annual basis anyway, as is now the chief executive whom I hold to account. So, that covers that dual accountability. In terms of the cleaning specifications, we have required trust boards to ensure that one of their executive directors holds a portfolio for this area and that there are regular reports provided to the trust boards on the standards that are being achieved. That will be underpinned by these new standards, where reports on that which is to be included in the results of the balanced scorecards are regularly provided to the trust boards. As the regional offices are monitoring trusts on a quarterly basis now with this new performance management system, then, on a quarterly basis, the results will be published and will go to the trust boards.

o berfformiad a gynhelir gan y Gweinidog yn flynyddol beth bynnag, a'r prif weithredwr sy'n atebol i mi. Felly, mae hynny'n delio â'r atebolrwydd deublyg hwnnw. O ran y manylebau glanhau, yr ydym wedi gofyn i fyrddau ymddiriedolaethau sicrhau bod gan un o'u cyfarwyddwyr gweithredol bortffolio ar gyfer y maes hwn a bod adroddiadau rheolaidd yn cael eu darparu i fyrddau'r ymddiriedolaethau ar y safonau sy'n cael eu bodloni. Bydd hynny'n cael ei ategu gan y safonau newydd hyn, lle bydd adroddiadau ar hynny'n cael eu cynnwys yng nghanlyniadau'r adroddiadau mesur perfformiad a'u darparu'n rheolaidd i fyrddau'r ymddiriedolaethau. Gan fod y swyddfeydd rhanbarthol yn monitro ymddiriedolaethau bob tri mis bellach gyda'r system rheoli perfformiad newydd hon, yna, bob tri mis, bydd y canlyniadau'n cael eu cyhoeddi ac yn mynd i fyrddau'r ymddiriedolaethau.

[117] **Janet Davies:** Alun, do you want to continue with your questions?

[117] **Janet Davies:** Alun, a ydych am barhau gyda'ch cwestiynau?

[118] **Alun Cairns:** Thank you, Cadeirydd. Mrs Lloyd, I do not want to labour the point, but is there any way in which you can provide a paper to the Committee, with the Cadeirydd's permission obviously, to explain where the accountability line falls? The reason for my asking this is that we get requests from constituents asking who is responsible when standards have not been met. Therefore, we need to be quite clear in responding to those constituents on where the responsibility lies and, where there has been a failure, whether it is within the Assembly or at trust management level.

[118] **Alun Cairns:** Diolch, Gadeirydd. Mrs Lloyd, nid wyf am rygnu ar y pwynt, ond a oes unrhyw ffordd y gallwch ddarparu papur i'r Pwyllgor, gyda chaniatâd y Cadeirydd yn amlwg, i egluro pwy yn union sy'n atebol? Y rheswm fy mod yn gofyn hyn yw ein bod yn cael ceisiadau gan etholwyr yn gofyn pwy sy'n gyfrifol pan nad yw safonau wedi'u bodloni. Felly, rhaid inni fod yn hollol glir wrth ymateb i'r etholwyr hynny ynghylch pwy sy'n gyfrifol ac, mewn achosion o fethu â bodloni'r safonau, ai'r Cynulliad neu reolwyr yr ymddiriedolaethau oedd ar fai.

**Ms Lloyd:** I would be very happy to provide that. As a consequence of the action plan that the Minister has asked me to prepare for the implementation of Wanless—which, again, underlines the importance of strengthening accountability—I will be able to give you an update on the recommendations arising from that report.

**Ms Lloyd:** Byddwn yn falch iawn o ddarparu hynny. O ganlyniad i'r cynllun gweithredu y mae'r Gweinidog wedi gofyn imi ei baratoi ar gyfer gweithredu Wanless—sydd, eto, yn ategu pwysigrwydd cryfhau atebolrwydd—byddaf yn gallu rhoi'r newyddion diweddaraf i chi ar yr argymhellion sy'n deillio o'r adroddiad hwnnw.

[119] **Janet Davies:** Thank you, Ms Lloyd.

[119] **Janet Davies:** Diolch, Ms Lloyd.

[120] **Alun Cairns:** I am sure that you will be glad to hear that these are my final

[120] **Alun Cairns:** Yr wyf yn siŵr y byddwch yn falch o glywed mai dyma fy

questions. Page 25 of the report shows some pretty worrying photographs of the condition of the building fabric and how it hinders the cleaning services. However, case study I on the same page details the relationship between the maintenance department and the cleaning staff in terms of how some of these issues have been overcome at the University Hospital of Wales. Are there any plans to promote this good practice?

nghwestiynau olaf. Mae tudalen 25 yr adroddiad yn dangos ffotograffau o gyflwr ffabrig yr adeilad sy'n peri tipyn o ofid a sut y mae'n rhwystro'r gwasanaethau glanhau. Fodd bynnag, mae astudiaeth achos I ar yr un dudalen yn manylu ar y berthynas rhwng yr adran gynnal a chadw a'r staff glanhau o ran sut y mae rhai o'r materion hyn wedi'u goresgyn yn Ysbyty Athrofaol Cymru. A oes unrhyw gynlluniau i hyrwyddo'r arfer da hwn?

**Ms Lloyd:** Yes, indeed. As part of the estates management standards that are also produced now, the first round of reviews of which will be in January 2004, this good practice from the University Hospital of Wales is being highlighted. It is really important that there is correlation between the cleaning services and maintenance. Trusts in Wales are provided with £52 million a year to maintain their buildings and to undertake small improvement schemes. Pictures such as these are unacceptable.

**Ms Lloyd:** Oes, yn wir. Fel rhan o'r safonau rheoli ystadau sydd hefyd yn cael eu cynhyrchu'n awr, a bydd y cylch cyntaf o adolygiadau ym mis Ionawr 2004, mae'r arfer da hwn gan Ysbyty Athrofaol Cymru yn cael ei amlygu. Mae'n hynod bwysig bod cydberthynas rhwng y gwasanaethau glanhau a'r adran gynnal a chadw. Darperir £52 miliwn y flwyddyn i'r ymddiriedolaethau yng Nghymru i gynnal a chadw eu hadeiladau ac i gyflawni cynlluniau gwella bach. Mae lluniau fel y rhain yn annerbyniol.

[121] **Alun Cairns:** The reality is that, irrespective of the increased investment that has gone into the health service, such conditions still exist in hospitals, and the photographs are evidence of that. Can you tell me whether, if patients find themselves in a hospital or a ward area where there are such conditions, they are more susceptible to germ infection?

[121] **Alun Cairns:** Y gwirionedd yw bod amodau fel hyn, er gwaethaf y buddsoddiad cynyddol yn y gwasanaeth iechyd, yn bodoli o hyd mewn ysbytai, ac mae'r lluniau'n dystiolaeth o hynny. A allwch ddweud wrthyf a yw cleifion, os ydynt yn canfod eu hunain mewn ysbyty neu ward yn y fath gyflwr, yn fwy agored i heintiau germau?

**Ms Lloyd:** I do not know whether I can answer that question. Can you answer it, Dr Howard?

**Ms Lloyd:** Nid wyf yn gwybod a allaf ateb y cwestiwn hwnnw. A allwch chi ei ateb, Dr Howard?

**Dr Howard:** Sorry, can you repeat the question?

**Dr Howard:** Mae'n ddrwg gennyf, a allwch ailofyn y cwestiwn?

[122] **Alun Cairns:** Yes. Bearing in mind the photographs on page 25, which highlight the state of disrepair in some hospitals, if patients finds themselves in a ward where there are such conditions, are they more susceptible to germ infection? Is there an increased risk of that?

[122] **Alun Cairns:** Gallaf. O gofio'r lluniau ar dudalen 25, sy'n amlygu cyflwr gwael rhai ysbytai, os yw cleifion yn cael eu rhoi ar ward yn y cyfryw gyflwr, a ydynt yn fwy agored i heintiau germau? A oes risg gynyddol o hynny?

**Dr Howard:** In themselves, fabric problems such as those would provide a low risk of infection. If they are reflective of a wider systems failure, then there may be other reasons for an association with increased

**Dr Howard**: Ohonynt eu hunain, byddai problemau ffabrig fel y rheini yn peri risg isel o heintiau. Os ydynt yn adlewyrchu methiant system ehangach, yna efallai fod rhesymau eraill dros gysylltiad â rhagor o

infection, but, in themselves, no.

[123] **Janet Davies:** Thank you. Christine, you have some questions to ask?

[124] **Christine Gwyther:** Thank you, Chair. To the casual observer—and that is what we are; we are lay people—that sort of imperfection in the infrastructure makes us less confident in the overall management. I want to talk about new furnishings and fabrics. There is a case study on page 26 of the report that talks about Llandough Hospital and a fancy new carpet that was installed there, which has been difficult and costly to clean, and must be cleaned three times a day, or something like that. I wanted to ask you—and this is a subjective question, but I am interested in hearing your answer—whether you think it is the case that hospital management is becoming more concerned with the aesthetic appearance of their hospitals rather than with the cleanliness.

**Ms Lloyd:** I think that the hospital management would wish the environment to look as welcoming as possible. I think that the issue with this was that it probably did not ask its cleaning experts first before laying the carpet, and that, I think, is highlighted here. If we are trying to make hospitals more friendly appearing places and more welcoming to people—and, of course, there has been a lot of talk and fashion in the last six years in terms of trying to make them look more like hotels than hospitals because it was felt that, psychologically, that was better for patients and visitors. Then we saw a great prevalence of laying carpets which was followed by everyone taking them up again because they did not prove to be satisfactory given the environment in which they were laid. I think that, basically, the lesson to be learnt from this is, if you are going to make hospitals more aesthetically pleasing, for goodness' sake ensure that the furnishings can be cleaned and that they are robust enough to stand the wear and tear to which they are to be subjected.

[125] **Christine Gwyther:** How can we ensure that hospitals only buy fabrics and furnishings that can be effectively cleaned, and using the cleaning equipment already available, because, again, they should not be

heintiau, ond, ohonynt eu hunain, na.

[123] **Janet Davies:** Diolch. Christine, mae gennych gwestiynau i'w gofyn?

[124] **Christine Gwyther:** Diolch, Gadeirydd. I'r llygaid cyffredin—a dyna beth ydym; yr ydym yn bobl leyg—mae'r math hwnnw o amherffeithrwydd yn y seilwaith yn ein gwneud yn llai hyderus yn y rheolaeth gyffredinol. Yr wyf am drafod dodrefn a ffabrigau newydd. Mae astudiaeth achos ar dudalen 26 yr adroddiad sy'n trafod Ysbyty Llandoche a charped newydd ffansi a osodwyd yno, sydd wedi bod yn anodd a chostus i'w lanhau, ac mae'n rhaid ei lanhau dair gwaith y diwrnod, neu rywbeth tebyg. Yr oeddwn am ofyn i chi—ac mae hwn yn gwestiwn goddrychol, ond mae gennyf ddiddordeb i glywed eich ateb—a ydych yn credu fod rheolwyr ysbyty yn fwy pryderus am ymddangosiad esthetaidd eu hysbytai na chyda'r glanweithdra.

**Ms Lloyd:** Credaf y byddai rheolwyr yr ysbyty am i'r amgylchedd edrych mor groesawgar â phosibl. Credaf mai'r broblem yma oedd nad oedd y rheolwyr yn debygol o fod wedi gofyn i'w arbenigwyr glanhau cyn gosod y carped, ac mae hynny, yn fy marn i, yn cael ei amlygu yma. Os ydym yn ceisio gwneud ysbytai yn lleoedd sy'n ymddangos yn fwy cyfeillgar a chroesawgar i bobl—ac, wrth gwrs, mae llawer o siarad a thrafod wedi bod dros y chwe blynedd diwethaf am geisio gwneud iddynt edrych yn fwy fel gwestai nag ysbytai oherwydd y gred bod hynny'n well, yn seicolegol, i gleifion ac ymwelwyr. Yna gwelwyd tuedd gyffredin gennym i osod carpedi cyn i bawb eu codi eto oherwydd nad oeddent yn foddhaol o ystyried yr amgylchedd lle cawsant eu gosod. Credaf, yn y bôn, mai'r wers i'w dysgu o hyn yw, os ydych am wneud ysbytai'n fwy pleserus yn esthetaidd, gwnewch yn siŵr er mwyn y nefoedd y gellir golchi'r carpedi a'u bod yn ddigon cryf i wrthsefyll y traul a'r gwisgo sy'n dod i'w rhan.

[125] **Christine Gwyther:** Sut y gallwn sicrhau bod ysbytai ond yn prynu ffabrigau a dodrefn y gellir eu glanhau'n effeithiol, a chan ddefnyddio'r cyfarpar glanhau sydd ar gael yn barod, oherwydd, eto, ni ddylent fod

spending large amounts of cash not just on the products themselves, but on the cleaning equipment that is needed to keep them in good condition? How do we do that?

yn gwario llawer o arian ar y cynhyrchion eu hunain, ac ar y cyfarpar glanhau sydd eu hangen i'w cadw mewn cyflwr da? Sut y gallwn wneud hynny?

**Ms Lloyd:** I think that examples such as this help us enormously because that sort of example, having been publicised by the NAO as it has, will highlight to any trust management that these things must be considered and that one might want the environment to look much more domestic but that there are consequences to that decision. It must either be prepared to accept the consequences or not do it, and be warned by it.

**Ms Lloyd:** Credaf fod enghreifftiau fel hyn yn ein cynorthwyo'n fawr oherwydd y bydd enghraifft fel honno, ar ôl i'r SAG dynnu sylw ati fel y gwnaeth, yn pwysleisio i reolwyr unrhyw ymddiriedolaeth bod yn rhaid ystyried y pethau hyn ac y gallai amgylchedd sy'n ymddangos yn llawer mwy domestig fod yn ddymunol ond bod gan y penderfyniad hwnnw oblygiadau. Bydd yn rhaid iddynt naill ai fod yn barod i dderbyn y canlyniadau neu beidio â gwneud hyn, a'i ddefnyddio fel rhybudd.

[126] **Christine Gwyther:** How can you guarantee that hotel services teams and, more specifically, infection control teams are consulted when new fabrics and furnishings are bought? Will that be put into a strict service conduct standard?

[126] **Christine Gwyther:** Sut y gallwch sicrhau yr ymgynghorir â thimau gwasanaethau gwesty ac, yn fwy penodol, timau rheoli heintiau, wrth brynu ffabrigau a dodrefn newydd? A fydd hynny'n cael ei gynnwys mewn safon ymddygiad gwasanaeth llym?

**Ms Lloyd:** That is part of the environment standards that have been set now. It is again an excellent check to ensure that trust management, right throughout, is aware of the importance of these issues and the fact that the teams must work together.

**Ms Lloyd:** Mae hynny'n rhan o'r safonau amgylchedd sydd wedi'u pennu bellach. Mae hyn eto'n ddull rhagorol o wirio i sicrhau bod rheolwyr ymddiriedolaethau, drwy'r ymddiriedolaeth i gyd, yn ymwybodol o bwysigrwydd y materion hyn a'r ffaith bod yn rhaid i'r timau gydweithio.

[127] **Christine Gwyther:** How will that be put into operation when, for instance, friends of the hospital, or other organisations, want to purchase items for their local hospital?

[127] **Christine Gwyther:** Sut y bydd hynny'n cael ei roi ar waith pan fydd, er enghraifft, cyfeillion yr ysbyty, neu sefydliadau eraill, am brynu eitemau ar gyfer eu hysbyty lleol?

**Ms Lloyd:** Trust managers usually attend leagues of friends meetings and other fundraising enterprises, and I would expect them to operate in no different a way than if they were buying it themselves. It is only fair that leagues of friends are properly advised on these matters.

**Ms Lloyd:** Fel arfer, mae rheolwyr ymddiriedolaeth yn mynychu cyfarfodydd cymdeithasau cyfeillion a mentrau codi arian eraill, ac ni fyddwn yn disgwyl iddynt weithredu mewn ffordd wahanol na phe baent yn prynu eu hunain. Mae ond yn deg rhoi cyngor priodol i gymdeithasau cyfeillion ar y materion hyn.

[128] **Janet Davies:** Before I bring Val in, I have a closely related question on the type of cleaning equipment used—the state-of-the-art equipment. Perhaps I could give you an example. Using vacuum cleaners on carpets to move the dust and make them look nice

[128] **Janet Davies:** Cyn i Val gyfrannu, mae gennyf gwestiwn cysylltiedig ar y math o gyfarpar glanhau a ddefnyddir—y cyfarpar diweddaraf. Efallai y gallaf roi enghraifft i chi. Nid yw defnyddio sugnwyr llwch ar garpedi i symud y llwch a gwneud iddynt

while blowing bugs out of the back of the cleaner is not particularly helpful. Is there any guidance for trusts on the type of cleaning equipment that they should use?

edrych yn ddymunol tra'n chwythu bygiau o gefn y sugnwr yn arbennig o ddefnyddiol. A oes unrhyw ganllawiau i ymddiriedolaethau ar y math o gyfarpar glanhau y dylent ei ddefnyddio?

**Ms Lloyd:** Yes, a huge amount of research has been undertaken into the type of cleaning equipment that is required. That is part of the specifications, which is why it is important that these specifications are updated and that the evidence available on what is most effective to clean modern surfaces, or even old ones, is disseminated widely. There are cleaning supervisors who will be well-versed in what is the best method of cleaning certain surfaces and fabrics.

**Ms Lloyd:** Oes, mae ymchwil di-ri wedi'i gynnal ar y math o gyfarpar glanhau sydd angen ei ddefnyddio. Mae hynny'n rhan o'r manylebau, a dyna pam ei bod yn bwysig diweddaru'r manylebau hyn a bod y dystiolaeth sydd ar gael ar yr hyn sy'n effeithiol i lanhau arwynebau modern, neu hyd yn oed hen arwynebau, yn cael ei dosbarthu'n eang. Mae goruchwylwyr glanhau sydd â gwybodaeth eang am y dulliau gorau o lanhau arwynebau a ffabrigau penodol.

[129] **Val Lloyd:** In an earlier question asked by my colleague, Denise, relating to case study A, which refers to the spend-to-save scheme, you made your views known in relation to the positive effects such schemes could have on staffing issues. However, that case study also shows what can be done when money is invested in buying new equipment. It was a very good case study in that it highlighted a number of issues. Are there any plans to investigate the impact that such schemes could have on the rest of the NHS in Wales?

[129] **Val Lloyd:** Mewn cwestiwn cynharach a ofynnwyd gan fy nghydweithiwr, Denise, ynglŷn ag astudiaeth achos A, sy'n cyfeirio at y cynllun gwario i gynilo, bu i chi roi eich barn ar yr effeithiau cadarnhaol y gallai cynlluniau fel hyn eu cael ar faterion staffio. Fodd bynnag, mae'r astudiaeth achos honno hefyd yn dangos yr hyn y gellir ei wneud pan fuddsoddir arian mewn prynu cyfarpar newydd. Yr oedd yn astudiaeth achos dda iawn oherwydd ei bod yn amlygu sawl mater. A oes unrhyw gynlluniau i ymchwilio i'r effaith y gall y fath gynlluniau ei chael ar weddill y GIG yng Nghymru?

**Ms Lloyd:** Yes, the trust facilities forum will be taking those schemes forward and disseminating them throughout the NHS. We will ask it to evaluate the consequences of that particular scheme.

**Ms Lloyd:** Oes, bydd fforwm cyfleusterau'r ymddiriedolaeth yn datblygu'r cynlluniau hynny ac yn eu dosbarthu ledled y GIG. Byddwn yn gofyn iddo werthuso canlyniadau'r cynllun penodol hwnnw.

[130] **Val Lloyd:** Throughout the document, there are instances of equipment—in more than one hospital—being out of date and not really fit for purpose. How do you reconcile the fact that that seems to be a Wales-wide problem and yet, in case study J, we have what seems to be inappropriate expenditure, or not properly thought through expenditure, on a new carpet?

[130] **Val Lloyd:** Gydol y ddogfen, mae enghreifftiau o gyfarpar—mewn mwy nag un ysbyty—wedi dyddio ac yn anaddas i'r pwrpas. Sut yr ydych yn cysoni'r ffaith bod hon yn broblem ledled Cymru ond eto, yn astudiaeth achos J, bod gennym enghraifft o'r hyn sy'n ymddangos fel gwariant amhriodol, neu wariant na chafodd ei gynllunio'n fanwl, ar garped newydd?

**Ms Lloyd:** All trusts have equipment budgets and it is for them to decide what their priorities for expenditure are. Much of it goes on medical equipment, which is quite appropriate, but I think that they have to give

**Ms Lloyd:** Mae gan bob ymddiriedolaeth gyllidebau cyfarpar a'u cyfrifoldeb hwy yw penderfynu ar eu blaenoriaethau gwario. Mae llawer o hwn yn mynd ar gyfarpar meddygol, sy'n eithaf priodol, ond credaf fod yn rhaid

a bit more thought as to whether or not the rest of the equipment, which patients rely on for their care, is appropriate any longer. I think that case study J shows a well-intentioned effort by an organisation to try to improve its environment that, unfortunately, did not work. I think that these two things have to be balanced. The importance of being able to clean an environment is being highlighted and we have all laid carpets that we have had to pull up, I am afraid.

iddynt feddwl mwy ynglŷn ag a yw gweddill y cyfarpar, y mae cleifion yn dibynnu arno am eu gofal, yn briodol bellach ai peidio. Credaf fod astudiaeth achos J yn dangos ymdrech ddidwyll gan sefydliad i geisio gwella ei amgylchedd ond, yn anffodus, ni weithiodd. Credaf fod angen cydbwysedd rhwng y ddau beth hyn. Mae pwysigrwydd gallu glanhau amgylchedd yn cael ei bwysleisio ac yr ydym oll wedi gosod carpedi y bu'n rhaid i ni eu codi, yn anffodus.

[131] **Janet Davies:** Okay. Thank you. Mark, you have some questions to ask?

[131] **Janet Davies:** Iawn. Diolch. Mark, mae gennych gwestiynau i'w gofyn?

[132] **Mark Isherwood:** Paragraphs 3.15 to 3.16 note that domestic staff combine cleaning duties with other activities, such as serving food. What are your personal views on this?

[132] **Mark Isherwood:** Mae paragraffau 3.15 i 3.16 yn nodi bod staff domestig yn cyfuno eu dyletswyddau glanhau gyda gweithgareddau eraill, fel gweini bwyd. Beth yw eich barn bersonol ar hyn?

**Ms Lloyd:** I have very particular personal views on this, as it happens. Objectively, I have no real view on the appropriateness of either nursing auxiliaries or domestic cleaners, or any support staff, serving food as long as proper hygiene procedures are followed and as long as the ward manager believes that that is the most appropriate individual or team to undertake that job. Personally, I believe that one of the responsibilities of the nursing staff is the whole care of a patient, which will include their diet, which is really very important to the health and wellbeing and the recovery rates of patients. Therefore, I think that the nursing staff must accept a responsibility for ensuring that the right quality and quantity of food is served to patients, that they actually eat it and that it is suitable for them. So, my personal view is probably a harder-line view than my more objective professional view, I am afraid.

**Ms Lloyd:** Mae gennyf farn bersonol gref iawn ar hyn, fel mae'n digwydd. Yn wrthrychol, nid oes gennyf farn bendant ar briodolrwydd cynorthwywyr nyrsio na glanhawyr domestig, nac unrhyw staff cymorth, yn gweini bwyd cyhyd â bod gweithdrefnau hylendid manwl yn cael eu dilyn a chyhyd â bod rheolwr y ward yn credu mai dyna'r unigolyn neu'r tîm mwyaf priodol i wneud y gwaith hwnnw. Yn bersonol, credaf mai un o gyfrifoldebau'r staff nyrsio yw gofal llwyr am y claf, a fydd yn cynnwys eu deiet, sy'n bwysig iawn i iechyd a lles a chyfraddau gwella cleifion. Felly, credaf fod yn rhaid i'r staff nyrsio dderbyn cyfrifoldeb dros sicrhau bod digon o fwyd o ansawdd yn cael ei weini i gleifion, eu bod yn ei fwyta a'i fod yn addas ar eu cyfer. Felly, mae'n debyg fod fy marn bersonol i yn farn fwy digyfaddawd na fy marn broffesiynol fwy gwrthrychol, yn anffodus.

[133] **Mark Isherwood:** Perhaps you are more objective professionally than you would be—

[133] **Mark Isherwood:** Efallai eich bod yn fwy gwrthrychol yn broffesiynol nag y byddech—

**Ms Lloyd:** Well, it does not matter who serves the food as long as the right procedures are followed and as long as the nurses ensure that the patients have eaten it and that it has been suitable for them. I

**Ms Lloyd:** Wel, nid yw'n bwysig pwy sy'n gweini'r bwyd cyhyd â bod y gweithdrefnau cywir yn cael eu dilyn a chyhyd â bod y nyrsys yn sicrhau bod y cleifion wedi'i fwyta a'i fod yn addas ar eu cyfer. Byddwn yn

would really expect a team approach to this. It matters not who serves it, but I do believe that the nursing staff, in terms of their care for the patient, which includes diet and nutrition, have an essential role to play.

disgwyl i dîm wneud hyn. Nid yw'n bwysig pwy sy'n ei weini, ond credaf fod gan staff nyrsio, o ran eu gofal am y claf, sy'n cynnwys deiet a maethiad, rôl hanfodol i'w chwarae.

[134] **Mark Isherwood:** Career development is clearly vital for the retention and motivation of all staff, including cleaning staff. So, in terms of having sufficient cleaning staff and retaining them, how can you do that while meeting their career objectives and giving them clear career paths?

[134] **Mark Isherwood:** Mae'n amlwg bod datblygu gyrfa yn hanfodol i gadw ac ysgogi'r holl staff, gan gynnwys staff glanhau. Felly, o ran bod â digon o staff glanhau a'u cadw, sut y gallwch wneud hynny tra'n parhau i fodloni eu hamcanion gyrfa a rhoi llwybrau gyrfa clir iddynt?

**Ms Lloyd:** I ran a scheme once that looked at how you could have layers of support care workers, who would encompass whole housekeeping roles and who were really integral to that ward team and not regarded as different from it. I think that that is the only way to get people very motivated, that they are part of a whole clinically orientated team. Many of the housekeeping schemes have been very successful because they will do the portering roles, they will do the cleaning roles, they will serve meals, but they will be working as a whole team and as part of that clinical team on the ward. I believe that that is the best way to motivate people and give them a career path because they can then progress from junior to senior staff where they are given more training and they can also incorporate more tasks. We found that nursing auxiliaries, when national vocational qualifications came in, could start to move up through the ranks to be higher-graded nursing auxiliaries, taking over many of the roles that the professionally qualified nurses used to undertake. It really acted as a motivation for them. I am a great believer in teamwork and in ensuring that people have the proper training to do the job.

**Ms Lloyd:** Bu imi gynnal cynllun unwaith a oedd yn edrych ar sut y gellid cael gwahanol lefelau o weithwyr gofal cymorth, a fyddai'n cwmpasu'r holl swyddogaethau cadw tŷ ac a oedd yn wirioneddol ganolog i'r tîm ward hwnnw ac nid yn cael ei ystyried i fod yn wahanol iddo. Credaf mai dyna'r unig ffordd o wir ysgogi pobl, eu bod yn rhan o dîm clinigol cyfan. Mae llawer o'r cynlluniau cadw tŷ wedi bod yn llwyddiannus iawn oherwydd byddant yn cyflawni swyddogaethau'r porthorion, byddant yn cyflawni'r swyddogaethau glanhau, byddant yn gweini prydau, ond byddant hefyd yn gweithio fel tîm cyfan ac fel rhan o'r tîm clinigol hwnnw ar y ward. Credaf mai honno yw'r ffordd orau o ysgogi pobl a rhoi llwybr gyrfa iddynt, oherwydd gallant ddatblygu wedi hynny o fod yn staff iau i fod yn staff uwch pan fyddant yn derbyn rhagor o hyfforddiant ac yn cyflawni mwy o dasgau. Yr ydym wedi gweld bod cynorthwywyr nyrsio, ar ôl cyflwyno cymwysterau galwedigaethol cenedlaethol, yn gallu dechrau dringo'r ysgol i fod yn gynorthwywyr nyrsio â graddau uwch, gan ymgymryd â nifer o'r swyddogaethau yr oedd nyrsys cymwys proffesiynol yn arfer eu cyflawni. Cafodd effaith fawr wrth eu hysgogi. Yr wyf yn credu'n gryf mewn gwaith tîm a sicrhau bod pobl yn derbyn yr hyfforddiant iawn i wneud y gwaith.

[135] **Janet Davies:** To sum up, there have been a number of quite worrying aspects of the management and delivery of hospital cleaning services. Could I ask you, Ms Lloyd, what are your key priorities to improve matters quickly?

[135] **Janet Davies:** I gloi, cafwyd nifer o agweddau ar reoli a darparu gwasanaethau glanhau ysbytai sy'n peru pryder mawr. A allaf ofyn i chi, Ms Lloyd, beth yw eich blaenoriaethau allweddol i wella'r sefyllfa'n gyflym?

**Ms Lloyd:** I think that the thing that will improve matters quickly is the swift dissemination of these standards and training and development to underpin them in each of the organisations. I think that it will be a good learning experience that will highlight the issues that trust management needs to grapple with when we undertake the first six-monthly review and have an action plan from each of the organisations.

**Ms Lloyd:** Credaf mai'r ffordd o wella'r sefyllfa'n gyflym yw lledaenu'r safonau hyn yn gyflym a darparu hyfforddiant a datblygiad i'w hategu ym mhob un o'r sefydliadau. Credaf y bydd yn brofiad addysgol da a fydd yn amlygu'r materion y mae angen i reolwyr ymddiriedolaethau fynd i'r afael â hwy pan fyddwn yn cynnal yr adolygiad chwemisol cyntaf a chael cynllun gweithredu gan bob sefydliad.

[136] **Janet Davies:** Thank you. We look forward to seeing that come back to the Committee at the appropriate time. I thank the three of you for your answers, which were, as always, very helpful and informative. You will be aware that a draft transcript of the proceedings will be sent to you for you to check its factual accuracy before it is published as part of the minutes. When the Committee publishes its report, the transcript will be included as an annex. Thank you very much indeed.

[136] **Janet Davies:** Diolch. Edrychwn ymlaen at weld hynny'n dod yn ôl at y Pwyllgor ar yr adeg priodol. Diolchaf i'r tri ohonoch am eich atebion, a oedd, fel bob amser, yn ddefnyddiol iawn ac yn llawn gwybodaeth. Byddwch yn ymwybodol yr anfonir trawsgrifiad drafft o'r trafodion atoch i chi gael archwilio ei gywirdeb ffeithiol cyn ei gyhoeddi fel rhan o'r cofnodion. Pan fydd y Pwyllgor yn cyhoeddi ei adroddiad, caiff y trawsgrifiad ei gynnwys fel atodiad. Diolch yn fawr iawn.

*Daeth y sesiwn cymryd tystiolaeth i ben am 11.35 a.m.*
*The evidence-taking session ended at 11.35 a.m.*

**Annex B**

## THE AUDIT COMMITTEE

The National Assembly's Audit Committee ensures that proper and thorough scrutiny is given to the Assembly's expenditure. In broad terms, its role is to examine the reports on the accounts of the Assembly and other public bodies prepared by the Auditor General for Wales; and to consider reports by the Auditor General for Wales on examinations into the economy, efficiency and effectiveness with which the Assembly has used its resources in discharging its functions**.** The responsibilities of the Audit Committee are set out in detail in Standing Order 12.

The membership of the Committee as appointed on 3 June 2003:

Janet Davies (Plaid Cymru) - Chair
Leighton Andrews (Labour)
Mick Bates (Liberal Democrat)
Alan Cairns (Conservative)
Jocelyn Davies (Plaid Cymru)
Christine Gwyther (Labour)
Denise Idris-Jones (Labour)
Mark Isherwood (Conservative)
Val Lloyd (Labour)
Carl Sargeant (Labour)

Further information about the Committee can be obtained from:

Adrian Crompton
Clerk to the Audit Committee
National Assembly for Wales
Cardiff Bay
CF99 1NA
Tel: 02920 898264
Email: Audit.comm@wales.gsi.gov.uk

**Annex C**

# ACCOUNTABILITY IN THE NHS IN WALES

1. During discussion at the Audit Committee meeting on 17 July 2003 on the National Audit Office report "The Management and Delivery of Hospital Cleaning Services in Wales", the committee requested a paper setting out the accountability arrangements that apply to the NHS in Wales. This paper summarises the lines of accountability of individuals and organisations within NHS Wales. It is intended as a general guideline only and is not intended to supplant the more detailed information provided in the documents such as the Code of Conduct and Accountability which is currently being rewritten to reflect the recent changes to the structure of the NHS in Wales.

2. The National Assembly for Wales has statutory responsibility, set out in section 1 of the National Health Service Act 1977, to promote a comprehensive health service designed to secure improvement of the health of the people of Wales and to improve the prevention, diagnosis and treatment of illness. All of the Assembly's functions, other than those it cannot delegate, have been delegated to the First Minister. In turn, the First Minister has delegated functions to the respective Assembly Ministers. Functions concerning the NHS in Wales have been delegated to the Minister for Health and Social Services. Therefore, all NHS statutory organisations in Wales are ultimately accountable to the Minister for Health and Social Services and the Welsh Assembly Government for the performance of their functions and for meeting statutory financial duties.

3. However, this is just a starting point. There are many different layers of accountability. NHS trusts and local health boards are established under statute as bodies corporate and so have their own legal personality. Statute and regulations are used to delegate functions to trusts and local health boards and account must also be taken of the role of the Accounting Officer.

4. The Treasury appoints the Principal Accounting Officer and any Additional Accounting Officers of the National Assembly for Wales in accordance with section 98 of the Government of Wales Act 1998. The Director of NHS Wales is one of the Additional Accounting Officers so appointed. She is responsible for the propriety and regularity of the public finances for the NHS in Wales; for the keeping of proper accounts; for prudent and economical administration; for the avoidance of waste and extravagance; and for the effective and efficient use of all resources. The Director of the NHS in Wales is accountable to the Assembly and to Parliament and can be called as a witness before the Audit Committee of the Assembly or the Committee of Public Accounts.

5. The Director of the NHS in Wales appoints chief executives of trusts and chief officers of local health boards to serve as accountable officers. An Accountable Officer Memorandum sets out the functions of the body and describes the relationship between the Director, as Accounting Officer, and the accountable officer and sets out the duties of the accountable officer. Chief executives have the same responsibilities for their organisation as the Director has for the NHS in Wales.

6. Therefore, statutory NHS bodies, ie trusts and LHBs, are directly accountable to the Director and ultimately to the Assembly and, where financial stewardship is concerned, also to Parliament. Regional Directors act as agents of the Director on a day to day basis in holding to account the Chief Executives of the 36 statutory NHS bodies and managing the performance of these bodies. They are directly accountable to the Director. Day to day monitoring is supplemented through an annual review process led by the Director and supported by the Regional Directors.

7. In respect of NHS trusts, the chair and non-executive directors are appointed by the Assembly, or rather the Minister for Health and Social Services to

whom the function has been delegated. Executive directors, including the chief executive, are appointed by a "relevant committee". The NHS Trust (Membership and Procedure) Regulations 1990 govern the appointment, and removal, of Board members.

8. In the case of local health boards, the chair and, if she thinks fit, the vice-chairman, is appointed by the Minister for Health and Social Services. All other members are appointed by the Board, subject to the approval of the Minister. Co-opted members are appointed by the Board but Ministerial approval is not required although account must be taken of guidance on appointments issued by the Assembly. The Local Health Boards (Constitution, Membership and Procedures) (Wales) Regulations 2003 govern the appointment, and removal, of Board members.

9. NHS Boards share corporate responsibility for all decisions of the Board. The chief executive is directly accountable to the chairman and non-executive or non-officer members of the Board for the operation of the organisation and for implementing Board decisions. Boards are required to meet regularly and to retain full and effective control over the organisation. The chairman and non-executive or non-officer members are responsible for monitoring the executive management of the organisation and are responsible to the Assembly for the discharge for these responsibilities. Chairmen are responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the organisation as a whole.

10. All Board members of trusts and local health boards are bound by the Code of Conduct and Accountability. This provides that breaches of the code by the chairman or any of the non-executive directors or non-officer members should be brought to the attention of the Board and thereafter to the attention of the Director of NHS Wales. Breaches of the Code by co-opted members of local health boards should be dealt with by the Board. Chairman and non-

executive directors or non-officer members are responsible for taking firm, prompt and fair disciplinary action against any officer members in breach of the code.

IMPROVING HEALTH IN WALES

NHS WALES GIG CYMRU

# National Standards of Cleanliness for NHS Trusts in Wales

produced in association with
the All Wales Facilities Group

July 2003

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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# National Standards of Cleanliness for NHS Trusts in Wales

## produced in association with the All Wales Facilities Group

## JULY 2003

The Welsh Assembly Government would like to thank the Department of Human Services, State Government of Victoria, Australia for its kind permission to reproduce parts of the Australian publication 'Cleaning Standards for Victorian Public Hospitals'.

This publication in based on the current NHS Estates documents entitled 'National standards of cleanliness for the NHS' published in April 2001, and it's 'Implementation Guidance (Toolkit)' published November 2001, published by the Department of Health for England.

# Contents

# Foreword

Improving Health in Wales outlined a number of issues related to the cleaning of healthcare facilities. A quality environment for health care is not a luxury – it is essential and needs to be underpinned with the appropriate standards. The National Standards of Cleanliness are to be applied in all NHS Trust premises in which patient services are delivered.

The All Wales Facility Group (Annex A) which was set up to produce these standards took account of recent work undertaken by the National Audit Office in its "Report on the Management and Delivery of Hospital Cleaning Services". This gives an illuminating insight into environmental cleanliness in the major hospitals across Wales and it is strongly recommended that Trusts refer to this report which complements these standards.

The Standards of Cleanliness are presented in two parts, the first laying out the standards themselves and the second part addressing performance assessment. Trusts are required to ensure that there is sustained improvement in cleanliness standards and that related areas of hygiene and infection control are appropriately linked to this work.

The Standards recognise that cleaning services may be provided in a number of ways and that Trusts require this operational flexibility. It is also vital that common standards are applied across all NHS Trust facilities and that performance is regularly assessed and year on year improvement made. Progress will be monitored by a number of organisations, some may be chosen by Trusts with others such as the National Audit Office, Association of Community Health Councils and the Audit Commission fulfilling a national/external audit role.

**Ann Lloyd**
**Director, NHS Wales**

# Executive summary

Patients expect wards to be clean and furnishings to be tidy. They have a right to expect a welcoming environment at all times, particularly when they might be in pain and feel threatened by unfamiliar surroundings.

Healthcare buildings are the 'shop window' of the NHS. People may judge the quality of the service by the way it presents itself at first glance. A healthcare facility that appears dirty, untidy and uncared for may lead patients to believe that the care it offers is also poor. Staff, too, may feel demoralised and may not give of their best.

**Improving Health in Wales identified a need for Trusts to participate in national audits for standards of environmental cleanliness.**

This document sets out the National Standards for Cleanliness that will apply to all NHS Trust facilities in Wales where patient services are delivered. The nature of health facilities varies widely according to local circumstances (patient mix, age and design of buildings) and each has different needs.

The Standards provide a framework that NHS Trusts can adapt to meet local requirements regardless of whether the cleanliness service is performed in-house or contracted out. These requirements will include the development of cleaning plans, training programmes and decisions about staffing, including who is accountable and takes responsibility for cleaning.

**The NHS Wales Performance Management Framework will include cleanliness issues in the performance improvement arrangements.**

To allow NHS Trusts to measure the efficacy of the cleaning service they administer against the National Standards there is an accompanying document (toolkit) on performance assessment. This includes an Audit Tool for the on-going monitoring of cleaning outcomes that may be applied to all NHS Trust healthcare facilities.

From April 2004, it will be a requirement for the results of an external audit of cleaning outcomes for hospitals using the Audit Tool results for hospitals to feed into the Estates and Facilities Performance Management System (EFPMS) and ultimately form a part of the patient experience quality monitoring aspects of the Performance Management Framework.

## WHO SHOULD APPLY THE STANDARDS?

A clean healthcare environment is of paramount importance to patients and staff; and this document describes the Standards, the rationale for their introduction, and guidance on how to use them, and in general all staff and users of the service should be made aware of them.

Where necessary, staff should familiarise themselves with relevant components, and in particular the following staff should ensure they are familiar with the Standards:

- Trust procurement manager;
- Local Health Board;
- clinical staff;
- supervisors;
- cleaning staff;
- the responsible cleaning manager;
- infection control staff;
- central sterile supply staff;
- works and estates staff;
- ward managers; and
- departmental managers.

In addition, the accompanying document on performance assessment of healthcare facilities in terms of cleaning outcomes, incorporates a set of tools that should be used by ward and departmental managers, and by both in-house and contracted service providers, to monitor and improve their cleaning services.

# 1 – Introduction

## IMPROVING HEALTH IN WALES – INVESTMENT IN INFRASTRUCTURE

**1.1** 'Improving Health in Wales – A Plan for the NHS and its partners', identified Clean Hospitals as a key component of health provision and that hygiene and infection control issues should become embedded as a core item of the management agenda and a key management responsibility.

**1.2** It directed that an Executive Board member must be given responsibility for overseeing all aspects of healthcare facility hygiene, and that a review should be carried out of the management structure at ward level.

**1.3** The plan also stated that similar processes would need to be introduced in all other appropriate areas and health facilities outside the confines of hospitals, and recognized the requirement for NHS Trusts to participate in national audits of the standards of environmental cleanliness in these facilities.

**1.4** It follows that the Standards of Cleanliness set out specific requirements for healthcare facilities. These will ensure that a consistently high level of service will apply to all NHS Trust facilities that deliver patient services.

**1.5** This document sets out:

- the principles of Cleanliness to be applied by NHS Trusts in Wales;
- the Standards and their requirements;
- guidance on meeting the requirements of certain Standards; and
- the application of outcome and risk-based analysis.

**1.6** The accompanying document on performance assessment sets out:

- measures for performance evaluation for NHS Trusts to monitor cleaning outcomes and improve their cleaning services; and
- an Audit Tool to use to monitor cleaning outcomes that can be used for all Trust healthcare facilities.

## NATIONAL FRAMEWORK FOR STANDARDS OF CLEANLINESS

1.7 The National Standards set out a framework of organisational and managerial standards for cleaning activites along with cleaning outcome requirements based on risk-assessments.

These have been designed to be used as:

- the basis for specifications for all service-level agreements and contracts;
- standards against which the service provider can be benchmarked as part of an ongoing management process; and
- the basis for the auditing of cleanliness services and scoring required as part of the Estates and Facilities Performance Management System (EFPMS) and ultimately the Performance Management Framework (PMF).

### *Why do we need National Standards?*

1.8 Cleanliness services in NHS Trusts are being performed and managed in ways more varied than ever before. In the past, cleaning services have often been targeted as an area of potential efficiencies, tested on the open market, and fragmented as a result. Some people believe this has been done at the expense of maintaining a quality service for patients.

### *Will the providers of the service change?*

1.9 There is now a range of cleaning service delivery models. These include:

- services fully provided and managed in-house by NHS staff;
- services completely purchased from an external provider; and
- hybrid models somewhere between these two models.

**These Standards aim to improve the quality of health service provision by ensuring that all risks involving cleaning are identified and managed in an appropriate manner, irrespective of cleaning service provider arrangements.**

### *Who are the stakeholders?*

**1.10** Within every healthcare environment there are many interested stakeholders. As well as staff, these will include:

- patients;
- service providers;
- the public;
- the media;
- Government; and
- Community Health Councils.

**1.11** All have an interest in clean healthcare facilities. However, without National Standards of Cleanliness and identified cleaning outcomes to measure performance against, it has been difficult for people to set common goals.

**The Standards aim to provide stakeholders with a common understanding of the question 'Is this facility clean?'**

### *What will change?*

**1.12** To encourage innovative and efficient cleaning practices, these Standards provide for a focus on outcomes, not methods. This will mean that the suitability of different methods can be demonstrated by assessing the outcomes of their use.

**The Standards are designed to focus users' attention on the outcome or output sought, rather than the method by which it is achieved.**

**1.13** When the required outcomes are achieved, other stakeholders such as patients and visitors will see the results of the Standards being used.

### *What are the benefits of National Standards for Cleanliness?*

**1.14** Cleanliness outcomes can be achieved in different ways. The cleaning outcome standards do not prescribe inputs such as frequencies, techniques, equipment or processes. Certain inputs feature as part of the Estates and Facilities Performance Management System (EFPMS) and are measured separately. However, year-on-year improvements in patient satisfaction with cleanliness will be a requirement of the Performance Management Framework (PMF).

**Using outcome measures allows different healthcare facilities to use different methods, yet still be assessed in the same way**

## *How are the outcome standards applied?*

**1.15** Assessment of risk – Throughout the Standards, the concept of 'risk' is applied. This helps identify the variety of problems that poor cleanliness can cause in a facility. Risks include:

- the risk of infection for patients;
- the risk of a poor public image for the facility / Trust / NHS;
- a health and safety risk for the public and staff; and
- the risk of a service providing poor value for money.

## *What are the key components?*

**1.16** Functional areas – A 'functional area' is the area in which the cleaning occurs (for example, a ward or operating theatre). This document groups functional areas according to risk, so that appropriate cleaning processes can be applied. For instance, Intensive Care Units (ICUs) and operating theatres are viewed as higher risk than plant rooms and medical record stores. (See Annex C for more on functional areas.)

**1.17** Elements – The 'element' is the surface, article or fixture being cleaned (for example, 'windows'). Items to be cleaned in a healthcare building have been broken down into fifteen generic elements. Particular outcome standards apply to these groups of elements. (See Annex D for more on elements.)

**1.18** Inputs – The resources used at appropriate frequencies to produce and deliver outputs. Inputs may include staff, equipment and materials. (See Annex B and Annex E for more on Inputs and Cleaning Frequencies.)

**1.19** Outputs – The actual product or service, for example cleaning.

**1.20** Processes – The procedures, methods and activities that turn the inputs into outputs, for example, mopping a floor.

**1.21** Outcomes – The effect or consequence of the output, for example, cleaning (output) produces a clean and safe environment (outcome) for patient care. (See Annex B for outcome requirements and the accompanying document on performance assessment for details of the Audit Tool).

## DEFINITIONS OF TERMS USED

**1.22** A range of terms is used in this document, and these often have special relevance to the way cleaning services are provided. A list of such terms is provided in the 'Glossary' .

# 2 – Principles

## *Clear outcome statements*

**2.1** The Standards reflect the outcomes required of the cleaning service, and keep the focus on the need to have a clean and safe environment. The outcome-based standards focus on:

- The patient and customer;
- Clarity for cleaners and service providers;
- Effective aid to contract management;
- Consistency with infection control standards and requirements; and
- Clear outcome statements, which can be used as benchmarks and output indicators.

## *The patient and customer*

**2.2** Everyone who enters a healthcare facility, whether as a patient, visitor or member of staff, is a customer of the cleaning service. The Standards have to focus clearly on their expectations. Although the main users of these Standards will be the service providers, they must be easy for everyone to understand.

In order to undertake work on public and patient involvement, it is important that NHS Trusts have a common understanding of what the term means and take a consistent approach.

Public and patient involvement needs to be carried out across two levels:

- the individual – the involvement of patients in discussions and decisions concerning their own individual care and treatment. It is closely linked to the overall care experience for individual patients.
- the collective – the involvement of patients and the wider public in decisions concerning the delivery and planning of services.

**2.3** Standards are set for both patients and other stakeholders. The patient's perspective will feature in the Hospital Patient Environment (HPE) assessments which assess a range of environment issues, one of which is cleanliness. Cleanliness data will also contribute to the Trust Performance Management Framework.

**2.4** Patient Representatives will report patient observations to a Board member who has been nominated to take personal responsibility for cleanliness. In this way, patients will directly influence the quality of their healthcare environment.

**2.5** NHS Trusts must ensure that patients are made aware of internal systems for expressing their views.

### *Clarity for cleaners and service providers*

**2.6** The clarity of standards for cleaning outcomes is of paramount importance. All staff involved in cleaning procedures need to have the same understanding of the standards and task requirements to ensure that they are working towards and assessing the same cleanliness outcomes.

**2.7** It is essential that clinical staff be involved in the provision of cleaning and ensuring that their wards and departments are kept clean. Where a ward or departmental manager is unable to resolve problems directly with cleaning service providers, there should be a clear mechanism that is agreed locally and well documented for resolving them, and if necessary to provide alternative arrangements for continuity of service in the interim.

# 3 – The Standards

## I Management of environmental cleanliness

NHS Trusts are able to demonstrate clear management arrangements for environmental cleanliness, linked to corporate and clinical governance.

## II Local cleanliness strategies

A consistently high standard of environmental cleanliness is delivered in all Trust healthcare facilities

## III Involving and listening to patients

Patient views on cleanliness are integrated into the planning, implementation and monitoring process

## IV Education and development

Staff are trained to undertake their duties in ensuring that the cleanliness standards are met

## V Risk-based analysis for service provision

The most appropriate cleaning methods and frequencies are applied to specific functional areas within healthcare facilities

## VI Facility management

Trust buildings and fixtures are maintained to an acceptable condition and enable the effective and safe cleaning of the patient environment

## VII Monitoring of cleaning outcomes

The state of cleanliness of the healthcare environment is assessed by both internal and external audit.

# Standard I – Management of environmental cleanliness

**NHS Trusts are able to demonstrate clear management arrangements for environmental cleanliness, linked to corporate and clinical governance.**

**The standard requires that:**

1.1 Overall accountability for all aspects of cleanliness and cleaning staff rests with the Trust Chief Executive and the Board.

1.2 Each NHS Trust has an Executive Board member who takes personal responsibility for environmental cleanliness.

1.3 The Standards of Cleanliness Group, or similar multi-disciplinary group set up to take responsibility for implementing the Standards, will report to the Executive Board member on progress made against the objectives at least twice a year, and an annual report submitted to the Executive Board.

1.4 Targets for environmental cleanliness will be set as part of the Trusts Corporate Plan.

1.5 The role of staff with responsibility for cleanliness is clearly set out in their job description.

1.6 The lines of accountability for all managers and supervisors with a responsibility for cleanliness are clearly set out.

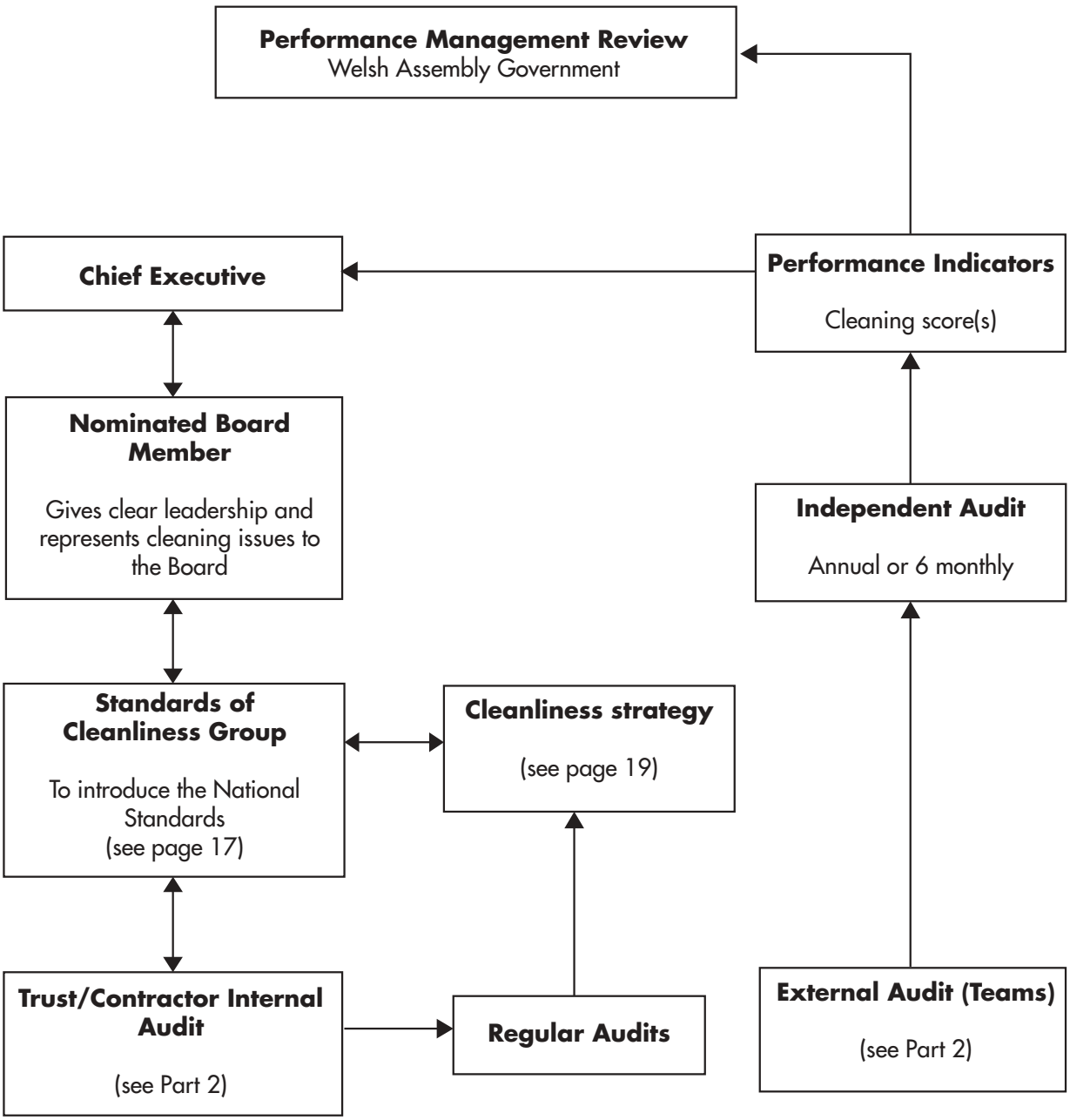
1.7 Where the Trust purchases some or all of it's cleaning service from an external provider, the roles and responsibilities between the purchaser and the provider are defined at the start of the commercial relationship and written into the contract.

1.8 While a contractor may be responsible for service provision, the accountability relating to that service remains with the Chief Executive and the Trust Board.

1.9 The ward or departmental manager has a key role in monitoring standards, effectively acting as the arbiter of local standards, and that cleaning service managers work closely with their nursing and departmental colleagues to make sure the standards are met.

**1.10** The Trust will be able to demonstrate linkages with the standards of environmental cleanliness to corporate and clinical governance, along with risk and performance management systems.

**Schema for Groups and Reporting**



# Standard II – Local cleanliness strategies

**A consistently high standard of environmental cleanliness is delivered in all Trust healthcare facilities.**

**The standard requires that:**

2.1 Each Trust produces a cleanliness strategy that sets out the internal structure and processes of how they tackle the introduction and development of the National Standards.

2.2 Each Trust has implementation plans covering one, three and five-year periods, that includes clear, consistent contracts or service level agreements between service providers and users.

2.3 Implementation plans set out the range and scope of the work to be undertaken and identify the process by which they are continuously monitored and updated.

2.4 The Trust's implementation plan forms part of their estates strategy to ensure that the physical environment experienced by the patient supports their expectations.

2.5 All managers, including infection control, are fully consulted regarding the content of service specifications and have a key role in ensuring that standards are met.

2.6 Each Trust develops detailed operational policies and procedures for environmental cleanliness, including those relating to equipment used in the cleaning process, linen/laundry services and patient's own clothing.

2.7 An annual report is presented to the Trust Board on the progress made with implementation of the cleanliness strategy and the improvements made to the patient environment, a copy of which is sent to the Infection Control Committee.

## Guidance

### *Standards of Cleanliness Group*

To focus on the delivery of the National Standards of Cleanliness, it is anticipated that a multidisciplinary group is set up to take responsibility for their implementation.

The group will be responsible for the following:

- Ownership of the National Standards of Cleanliness for the NHS;
- Development of a Cleaning Plan;
- Implementation of the Standards;
- Responsibility for maintaining acceptable Standards;
- Advising the Board on performance against Standards;
- Development of a Communications plan for Standards (as and when necessary);
- Continuous, review, feedback and improvement of the above; and
- To receive 'exception' reports that directly impact the capability within the Trust to clean to the Standards, and where necessary advise the Board on any remedial action.

It is anticipated that members of the group be drawn from the following areas:

- CHC Representative;
- Contractor (where relevant);
- Domestic Management;
- Hotel Services;
- Estates Department;
- Infection Control Nursing;
- Patient Representative;
- Staff Representative and /or Union Representative; and
- Ward/Departmental Representative.

### *Cleanliness strategy*

All Trusts will develop a strategy for cleaning in order to provide focus for this initiative. The agreed cleanliness strategy will be presented to the Board, and clearly set out the current situation, the desired future position and the actions necessary to move from the current to future positions.

The content of the document should be concise and cover the following with respect to the Standards:

a) Where you should be;
b) Where you are;
c) What needs to be done;
d) Who will be doing it; and
e) When it will be done by.

It would be appropriate for the document to contain the following as a minimum:

- Introduction;
- Baseline audit (more details can be found in accompanying document on performance assessment);
- SWOT report;
- GAP analysis;
- Implementation Plan giving short term (1yr), medium term (2yr), and long term (5yr) objectives; and
- Cleaning plan.

## *Cleaning plan*

The cleaning plan should include the following as a minimum:

- The requirements of the standard;
- An audit of compliance with the standard covering:
  - all existing work schedules;
  - all existing service level agreements;
  - all existing service specifications.
- A detailed plan for any changes required in (a) to (c) above; and
- A briefing paper for feedback into the strategy document

## *Communications*

Communication is vitally important in raising both the importance and awareness of the National Standards. The Trusts Standards and Cleanliness Group will send out the cleanliness strategy to all of the Trust's Board members.

For other groups who need to be aware of what action is being taken, but do not have any direct involvement in the actual implementation, a shortened form of the full cleanliness strategy might be considered. The target audience for this will be:

- Finance Department
- Procurement Section
- Communications and PR
- Patient Groups
- Risk Management
- Community Health Council
- Other stakeholders

For notice boards, and the wider health community a shortened version of the document may be released once approved by the Trust.

### *External contractors*

There is a percentage of NHS Trusts where the cleaning service is delivered by external contractors.

The National Standards of Cleanliness will apply to all NHS Trusts, irrespective of whether cleaning is provided in-house, or by an external contractor.

# Standard III – Involving and listening to patients

**Patient's views on cleanliness are integrated into the planning, implementation and monitoring process.**

**The standard requires that**:

3.1 The nominated executive Trust Board member is responsible for ensuring patient participation in the development of the cleanliness strategy and the cleaning plan.

3.2 Trends in patient compliments and complaints are made available to the Board and used to evaluate, and where necessary amend, the cleanliness strategy and cleaning plans.

3.3 Information obtained from the Local Community Health Council's 'Quality Monitoring Visit' Reports is utilised to evaluate and where necessary amend the cleanliness strategy and implementation plan.

3.4 The Board nominee meets regularly with the Patient Representatives and CHC's, and ensures that the patient's views are reported to the Trust Board.

## Guidance

The patient's voice is of key importance in the drive for service improvement. The involvement of patients and their representatives will underpin the process of continuous service improvement. This will allow patients to have a direct impact on the health care environment.

**It is an important part of the nominated Executive Board member's role to ensure that patient's views are central to the monitoring process and that patient views are made available to the Trust Board for action.**

Patient's views will be reported to the Trust Board member who has been nominated to take personal responsibility for cleanliness in the healthcare facility. In this way, patients will directly influence the quality of the health care environment. Cleanliness is an integral part of patient satisfaction surveys. However, NHS Trusts will ensure a more extensive feedback of patient views.

The views of patients and their representatives will be obtained by:

- Local patient surveys. Patients will be asked their views about their satisfaction with the patient environment and issues regarding cleanliness;
- Trends from patient complaints and compliments regarding cleanliness; and
- Community Health Council 'monitoring visit' reports.

NHS Trusts should have a form of 'Patient Involvement Group' that will be involved in the implementation of the National Standards. In support of this Group the statutory role of the Community Health Council in monitoring NHS services and representing the patient will be recognised and CHCs actively engaged in the process. When more than one CHC has an interest and responsibility for any Trust site each CHC should be included in the process to ensure a more equitable representation for patients.

# Standard IV – Education and development

**Staff are trained to undertake duties in ensuring that the cleanliness standards are met.**

**The standard requires that:**

4.1 The nominated Executive Board member will ensure that all staff are aware of the cleanliness standards.

4.2 The service provider is responsible for training staff adequately to meet the Standards of Cleanliness.

4.3 All staff who undertake cleaning duties must be trained to an appropriate level in the following:

- customer service;
- health and safety issues;
- control of substances hazardous to health;
- relevant infection control principles and procedures;
- manual handling; and
- basic cleaning techniques.

4.4 There is a planned and documented training programme and updating to ensure that all staff are competent to carry out the tasks required of them.

## Guidance

Where appropriate and practicable, staff should have access to accredited training.

# Standard V - Risk-based analysis for service provision

**The most appropriate cleaning methods and frequencies are applied to specific functional areas within healthcare facilities.**

**The standard requires that:**

**5.1** Areas to be cleaned in a Trust healthcare facility are broken down into functional areas as stated in Annex C.

**5.2** Items to be cleaned in a healthcare facility are accounted for in terms of the fifteen generic elements set out in the schedule in Annex D.

**5.3** The relative risks posed by the functional areas of a healthcare facility, and the likelihood of their occurrence, are identified, assessed and taken into account when determining cleaning frequencies, as set out in Annex E.

**5.4** The required cleaning outcome for an element of a functional area is achieved in accordance with schedule set out in Annex D, irrespective of where it is located within a healthcare facility.

**5.5** Each Trust develops detailed operational policies and procedures to achieve the required cleaning outcomes for each functional area.

# Standard VI - Facilities management

**Trust buildings and fixtures are maintained to an acceptable condition and enable the effective and safe cleaning of the patient environment.**

**The standard requires that:**

6.1 Financial and management responsibility for utilities, consumables, waste disposal and other facilities-related issues associated with the core cleaning functions are defined, and included as part of the service specification.

6.2 The service provider and the purchaser's representative carry out a baseline audit of facilities to document problems that may make it difficult, or impossible, to meet the Standards of Cleanliness.

6.3 The Trust should take action to rectify any problems with a facility that make it impossible to achieve the standards of cleanliness, within a timeframe commensurate with risk.

6.4 All procurement of new equipment and/or new or upgraded buildings should take into consideration the ability of service providers to clean properly when installed and review the implications, with advice sought from infection control teams where appropriate.

## Guidance

Operational policies should set out the range and scope of the work to be undertaken, including:

- the standards to be achieved;
- clear and measurable outcomes, including response time to clean spills or body fluids;
- systems that routinely measure these outcomes and report the results;
- working methods, including equipment, materials and frequencies that are to be applied; and
- contingencies in the event of major incidents, potential and actual outbreaks of infection, and decontamination e.g. chemicals.

An example of where new equipment and/or new or upgraded buildings can affect the ability of service providers to clean properly may be the purchase of

equipment with porous surfaces or which needs special cleaning techniques, as this may lead to increased costs or risk of infection. (N.B. – The Infection Control Team must always be consulted on such matters in keeping with Welsh Risk Management Standard 14: Infection Control.)

### *Infrastructure maintenance and facility management*

As buildings and fixtures become old they become more difficult to clean and maintain in an acceptable condition. Providers of cleaning services are not generally expected to contribute to infrastructure maintenance or capital expenditure, or undertake painting/refurbishment programmes.

### *The line between cleaning and maintenance*

The most common point of dispute in this context is exactly where cleaning ends and maintenance or engineering work begins. The specification must be clear at this point.

To prevent disputes, it may help if the service provider and the purchaser's representative carry out a baseline audit of the facilities to document problems that may make it difficult, or impossible, to meet the Standards of Cleanliness. The audit should note, for example, any floor surfaces that need repair and walls or ceilings that require painting. Other areas might include significant staining of the carpets, curtains etc., and the condition of the air ducting. The NHS Trust should take action to rectify any problems that make it impossible to achieve good standards of cleanliness.

Where problems cannot be resolved directly with cleaners, their supervisors or the cleaning service manager, ward and departmental managers should be aware of the mechanisms at their disposal to resolve such problems and this may extend to instruct that payment be withheld. Where necessary, an arbitration process may be initiated and, should a breach of contract have occurred, alternative arrangements put in place as required.

# Standard VII – Monitoring of cleaning outcomes

**The state of cleanliness of the healthcare environment is assessed by both internal and external audit.**

**The standard requires that:**

**7.1** Three levels of audit are undertaken:

- cleaning service provider audits;
- internal audits; and
- external audits.

**7.2** All cleaning service providers for Trust healthcare facilities undertake regular internal audits of cleanliness, including where there may be joint facility/provider arrangements. This process will highlight areas that fall short of the expected standards and provide an opportunity to negotiate targets for improvement over a period of time.

**7.3** Regular comprehensive internal audits that cover multiple elements and functional areas are scored.

**7.4** Along with auditing cleanliness outcomes, NHS Trusts will undertake wider performance management audits. This will include monitoring costs, activity (such as input hours, patient days etc.), absence and turnover, and setting targets for cost and quality.

**7.5** NHS Trusts establish formal systems to accurately reflect cost and activity, and benchmark these against other service providers to demonstrate best value.

**7.6** All managers, supervisors and infection control teams:

- have a key role in monitoring compliance with agreed policies and procedures in relation to issues such as poor cleanliness, that directly affect the patient environment;
- are fully consulted on the development of service specifications for cleaning services, whether provided by in-house or external contractors; and
- have a key role in monitoring cleanliness standards at ward and departmental level, and in ensuring that corrective action is taken where standards fall short of what is expected.

**7.7** The assessments collected in any audit are acted upon as part of the process of continuous improvement.

## Guidance

Guidance on the audits and performance assessments generally, and in particular the audit requirements for NHS Trusts hospitals that feature in the EFPMS, are contained in the accompanying document on performance assessment against the National Standards of Cleanliness.

# Annex A

## All Wales Facilities Group

| | |
|---|---|
| Ms Cathy O'Sullivan | Association of Welsh Community Health Councils (Chair) |
| Ms Pauline Richards | Association of Domestic Management |
| Mr Gary Rix | Chief Executives of NHS Trusts |
| Ms Jayne Cutter | Communicable Disease Committee - Healthcare Associated Infection |
| Dr Mac Walapu | Consultants in Communicable Diseases Committee |
| Mr Keith Jones | Directors of Finance NHS Trusts |
| Ms Sheelagh Lloyd Jones | Directors of Personnel/Human Resources NHS Trusts |
| Mr David Hawes | Information Managers NHS Trusts |
| Mr Peter Leonard | Nurse Executives Wales |
| Dr Nicholas Looker | Public Health Laboratory Service |
| Mr Brian Owen | Society of Hospital Linen Service and Laundry Manager |
| Mr David Wells | Society of Hospital Linen Service and Laundry Manager |
| Mr Glyn Jones | Unison |
| Ms Lorna Tinsley | Welsh Board Royal College of Midwives |
| Mr Colin Pike | Welsh Board Royal College of Nursing |
| Ms Delyth Davies | Welsh Region Infection Control Nurses Association |
| Mr Sid Johnson | Welsh Health Estates |
| Ms Bethan Jenkins | Welsh Health Supplies |
| Mr John Bowles | Welsh Risk Pool |
| Ms Maggie Parker | Welsh Assembly Government |
| Ms Tracey Gauci | Welsh Assembly Government |
| Dr Mike Simmons | Welsh Assembly Government |
| Co-opted Member | |
| Ms Claire Birchall | Welsh Board Royal College of Nursing |

# Annex B

# Applying outcome and risk-based analysis

The frequency of cleaning is dependent upon:

- the room or area in which the cleaning is occurring (the functional area);
- the surface, article or fixture being cleaned (the element); and
- any exceptional activity performed in the functional area (the activity).

## *Functional areas*

Areas to be cleaned in a healthcare facility have been broken down into functional areas – see Annex C. Maintaining the required Standard of Cleanliness is more important in some functional areas than others. They are therefore grouped into five levels of cleaning intensity, based on the risks associated with inadequate cleaning in that functional area:

1. Very high risk
2. High risk
3. Moderate risk
4. Low risk
5. Minimal risk

For example, 'very high risk' functional areas in hospitals include operating theatres and the Intensive Care Unit ( ICU).

## *Elements*

Items to be cleaned in a healthcare facility have been broken down into fifteen generic elements. The cleaning outcome requirement applicable to each of these groups of elements are stated in Annex D. The element should be cleaned to the stated outcome requirement irrespective of where it is located within the healthcare facility.

### *Activities*

The frequency and type of cleaning may need to reflect a change in activity e.g. Isolation Nursing, whereby the risks would alter from the 'normal' requirements for the elements and the functional area where they were located.

# Annex C

# Identifying risk associated with functional area

## VERY HIGH RISK FUNCTIONAL AREAS

**In the functional area designated 'very high risk', the required cleaning standards are of critical importance to patient care. The outcomes must be achieved through the highest level of intensity and frequency of cleaning.**

Patients are at very high risk of infection, and a frequent and responsive cleaning service is essential. Defined protocols and processes in addition to the outcomes need strict adherence.

### *Functional areas*

- Operating theatres: this may include procedure areas in other departments where significant invasive procedures are performed and patients are at high risk of infection;
- Intensive Care Unit (ICU)/ITU;
- Neonatal ICU/HDU and Special Care Baby Unit; and
- Special needs areas: areas with patients in isolation or who are immunosuppressed, such as the burns unit, the oncology unit and the infectious diseases unit.

### *Additional internal areas*

It is essential that areas adjoining very high risk functional areas also receive a risk based assessment of the level of cleaning required.

## HIGH RISK FUNCTIONAL AREAS

**In the functional areas designated 'high risk', the required Standards are of high importance. The outcomes must be maintained by frequent scheduled cleaning, with a capacity to spot clean.**

### *Functional areas*

- CSSD
- Sterile supplies
- Accident and Emergency (A&E) Department
- Pharmacy – sterile production areas

### *Additional internal areas*

It is essential that areas adjoining high risk functional areas also receive a risk based assessment of the level of cleaning required.

## MODERATE RISK FUNCTIONAL AREAS

**In the functional areas designated 'moderate risk', the required Standards are important for both hygiene and aesthetic reasons. The outcomes should be maintained through regular cleaning on a scheduled basis, with some capacity to spot clean in between.**

### *Functional areas*

- General wards, maternity and CCU
- Day activity area
- Rehabilitation areas
- Residential accommodation
- Pathology
- General pharmacy
- Kitchens
- Laboratories
- Mortuary
- Medical imaging
- Outpatient clinics
- Treatment and procedure rooms
- Waiting rooms
- Cafeteria
- Public thoroughfares

### *Additional internal areas*

It is essential that areas adjoining moderate risk functional areas also receive a risk based assessment of the level of cleaning required.

## LOW RISK FUNCTIONAL AREAS

**In the functional areas designated 'low risk', Standards are important for aesthetic, and to a lesser extent, hygiene reasons. The outcomes should be achieved through regular cleaning on a scheduled basis, with a capacity to spot clean in between.**

### *Functional areas*

- Administrative areas
- Non-sterile supply areas

### *Additional internal areas*

It is essential that areas adjoining low risk functional areas also receive a risk based assessment of the level of cleaning required.

## MINIMAL RISK FUNCTIONAL AREAS

**In the functional areas designated 'minimal risk', the required Standards can be met in these areas through infrequent cleans on a scheduled or project basis.**

### *Functional areas*

- Record storage and archives
- Engineering workshops
- Plant rooms
- External surrounds

### *Additional internal areas*

It is essential that areas adjoining minimal risk functional areas also receive a risk based assessment of the level of cleaning required.

# Annex D

## Elements

| **BUILDING**<br><br>Element | Cleaning outcome requirement |
|---|---|
| External features, fire exits and stairwells | • Landings, ramps, stairwells, fire exits, steps, entrances, porches, patios, balconies, eaves, external light fittings are free of dust, grit, dirt, chewing gum, leaves, cobwebs, rubbish, cigarette butts and bird excreta.<br>• Handrails are clean and free of stains.<br>• Garden furniture is clean and operational. |
| Walls, skirting and ceilings | • Internal and external walls and ceilings are free of dust, grit, lint, soil, film and cobwebs.<br>• Walls and ceilings are free of marks caused by furniture, equipment or staff.<br>• Light switches are free of fingerprints, scuffs and any other marks.<br>• Light fittings are free of dust, grit, lint and cobwebs.<br>• Polished surfaces are of a uniform lustre. |
| Windows | • External and internal surfaces of glass are clear of all streaks, chewing gum, spots and marks, including fingerprints and smudges.<br>• Window frames, tracks and ledges are clear and free of dust, grit, marks and spots. |
| Doors | • Internal and external doors and doorframes are free of dust, grit, lint, chewing gum, soil, film, fingerprints and cobwebs.<br>• Doors and doorframes are free of marks caused by furniture, equipment or staff.<br>• Air vents, grilles and other ventilation outlets are kept unblocked and free of dust, grit, soil, film, cobwebs, scuffs and any other marks.<br>• Door tracks and doorjambs are free of grit and other debris.<br>• Polished surfaces are of a uniform lustre. |

| **BUILDING**<br><br>Element | Cleaning outcome requirement |
|---|---|
| Hard floors | • The floor is free of dust, grit, litter, chewing gum, marks and spots, water or other liquids.<br>• The floor is free of polish or other build-up at the edges and corners or in traffic lanes.<br>• The floor is free of spots, scuffs or scratches on traffic lanes, around furniture and at pivot points.<br>• Inaccessible areas (edges, corners and around furniture) are free of dust, grit, lint and spots.<br>• Polished or buffed floors are of a uniform lustre.<br>• Appropriate signage and precautions are taken regarding pedestrian safety on newly cleaned or wet floors. |
| Soft floors | • The floor is free of dust, grit, litter, chewing gum, marks and spots, water or other liquids.<br>• The floor is free of stains, spots, scuffs or scratches on traffic lanes, around furniture and at pivot points.<br>• Inaccessible areas (edges, corners and around furniture) are free of dust, grit, lint and spots<br>• Carpets are of an even appearance without flattened pile. After deep cleaning, there is no shrinkage, colour loss or embrittlement of fibres. |
| Ducts, grills and vents | • All ventilation outlets are kept unblocked and free of dust, grit, chewing gum, soil, film, cobwebs, scuffs and any other marks.<br>• All ventilation outlets are kept clear and uncluttered following cleaning. |

| **FIXTURES**<br><br>Element | Cleaning outcome requirement |
|---|---|
| Electrical fixtures and appliances | • Electrical fixtures and appliances are free of grease, dirt, dust, deposits, marks, stains and cobwebs.<br>• Electrical fixtures and appliances are kept free from signs of use or non-use.<br>• Hygiene Standards are satisfied where the fixture or appliance is used in food preparation.<br>• Motor vents, etc., are clean and free of dust and lint.<br>• Drinking fountains are clean and free of stains, mineral build-up and litter.<br>• Insect-killing devices are free of dead insects, and are clean and functional. |
| Furnishings and fixtures | • Hard surface furniture is free of spots, soil, film, dust, fingerprints and spillage.<br>• Soft furnishings are free from stains, soil, film and dust.<br>• Furniture legs, wheels and castors are free from mop strings, soil, film, dust and cobwebs.<br>• Inaccessible areas (edges, corners, folds and crevices) are free of dust, grit, lint and spots.<br>• All high surfaces are free from dust and cobwebs.<br>• Curtains, blinds and drapes are free from stains, dust, cobwebs, lint and signs of use or non-use.<br>• Equipment is free of tapes/plastic, etc., which may compromise cleaning.<br>• Furniture has no unpleasant or distasteful odour.<br>• Shelves, bench tops, cupboards and wardrobes/lockers are clean inside and out and free of dust, litter or stains.<br>• Internal plants are free of dust and litter.<br>• Waste/rubbish bins or containers are clean inside and out, free of stains and mechanically intact.<br>• Fire extinguishers and fire alarms are free of dust, grit, dirt and cobwebs, and mechanically intact.<br>• All decorative plants are free of dust and debris. |

| **FIXTURES**<br><br>Element | Cleaning outcome requirement |
|---|---|
| Kitchen fixtures and appliances | • Fixtures, surfaces and appliances are free of grease, dirt, dust, deposits, marks, stains and cobwebs.<br>• Electrical and cooking fixtures and appliances are kept free from signs of use or non-use.<br>• Cooker hoods (interior and exterior) and filters are free of grease and dirt on inner and outer surfaces.<br>• When cleaning food preparation areas, fixtures or appliances, the requirements of the Chartered Institute of Environmental Health or the Royal Institute of Public Health and Hygiene, as appropriate, must be satisfied.<br>• Motor vents, etc., are clean and free of dust and lint.<br>• Refrigerators/freezers are clean and free of ice build-up. |
| Toilets and bathroom fixtures | • Porcelain, cubicle rails and plastic surfaces are free from smudges, smears, body fluids, soap build-up and mineral deposits.<br>• Metal surfaces, shower screens and mirrors are free from streaks, soil, smudges, soap build-up and oxide deposits.<br>• Wall tiles and wall fixtures (including soap dispensers and towel holders) are free of dust, grit, smudges/streaks, mould, soap build-up and mineral deposits.<br>• Shower curtains and bath mats are free from stains, smudges, smears, odours, mould and body fluids.<br>• Plumbing fixtures are free of smudges, dust, soap build-up and mineral deposits.<br>• Bathroom fixtures are free from unpleasant or distasteful odours.<br>• Polished surfaces are of a uniform lustre.<br>• Sanitary disposal units are clean and functional.<br>• Consumable items are in sufficient supply. |

| **EQUIPMENT**<br><br>Element | <br><br>Cleaning outcome requirement |
|---|---|
| Patient equipment* | • Equipment is free from soil, smudges, dust, fingerprints, grease and spillages.<br>• Equipment is free of tapes/plastic, etc., which may compromise cleaning.<br>• Equipment legs, wheels and castors are free from mop strings, soil, film, dust and cobwebs.<br>• Equipment has no unpleasant or distasteful odour. |
| Cleaning equipment | • After use, equipment is left in a clean and functional condition.<br>• After use, equipment is appropriately stored in accordance with Trust policy |
| **ENVIRONMENT**<br><br>Element | <br><br>Cleaning outcome requirement |
| Overall appearance | • The area appears tidy and uncluttered.<br>• Floor space is clear, only occupied by furniture and fittings designed to sit on the floor.<br>• Furniture is maintained in a fashion which allows for cleaning.<br>• Fire access and exit doors are left clear and unhindered. |
| Odour control | • The area smells fresh.<br>• There is no unpleasant or distasteful odour.<br>• Room deodorisers are clean and functional. |
| * Local policies and procedures must make clear who has responsibility for cleaning the environment when contaminated with blood and/or body fluids (see guidance for Standard VI). | |

# Annex E

## Cleaning frequencies

The service provider is required to provide the cleaning service at whatever frequencies are deemed necessary in order to meet the required Standards of Cleanliness.

The table below is an example of a cleaning frequency chart for a functional area. This chart could be adapted and/or expanded to the individual healthcare facility's requirements. It is thereby possible to specify cleaning frequencies for each functional area.

### *Cleaning frequency chart*

| Location and tasks | Daily | Weekly | Monthly | Other |
|---|---|---|---|---|
| FUNCTIONAL AREA eg Ward 1A | | | | |
| Entrance and corridors | | | | |
| Thoroughly clean glass or other doors, surrounds,<br>Window ledges, partitions, visible glass and approaches.<br>Spot clean glass. | | | | |
| Waste collection/recycling of waste | | | | |
| Empty all waste containers, wipe clean and replace liners.<br>Wash bin with neutral detergent. | | | | |
| Toilet/bathroom/shower | | | | |
| Thoroughly clean all basins, toilets, fittings and all vertical,<br>horizontal surfaces below 1.8m with an approved detergent.<br>Mop floor with neutral detergent.<br>Supply/replenish consumables.<br>Scrub toilet floor (machine scrub and manually).<br>Wash all tiled surfaces below 1.8m.<br>Wipe surfaces above 1.8m with detergent cloth.<br>Thoroughly clean exhaust fans and vents.<br>Spot clean and hot rinse showers.<br>Thoroughly clean showers, screens/curtains and bathroom<br>furniture including chairs and commodes. | | | | |

| Location and tasks | Daily | Weekly | Monthly | Other |
|---|---|---|---|---|
| Basins, sinks, benches, surrounds (areas other than toilets/bathrooms). | | | | |
| Thoroughly clean all hand basins, sinks, associated fittings and fixtures.<br>Supply and replenish consumables. | | | | |
| Fixtures, fittings and furniture (all areas including offices and nurses' station). | | | | |
| Wipe with neutral detergent cloth and spot clean (desks should be clear). | | | | |
| Ledges | | | | |
| Wipe all surfaces with a neutral detergent and cloth, spot clean and remove all obvious stains. All should be free from dust and stains. | | | | |
| High level surfaces (above 1.8m) | | | | |
| Wipe all surfaces with neutral detergent cloth, spot clean and remove any obvious stains.<br>Remove cobwebs as they appear. | | | | |
| Walls | | | | |
| Wash with a neutral detergent. | | | | |
| Hard floors (non-carpeted) | | | | |
| Thoroughly sweep with an electric dust mop.<br>Spot wet mop.<br>Wet mop with a neutral detergent, removing all marks, stains.<br>Buff with a filtered suction polisher.<br>Vacuum sliding door tracks.<br>Strip and resurface (excluding low-maintenance flooring) as required.<br>Radiology dry mop Room 1, processing room and Radiology-Emergency Department corridor on Sunday mornings. | | | | |

| Location and tasks | Daily | Weekly | Monthly | Other |
|---|---|---|---|---|
| Soft floors | | | | |
| Thoroughly vacuum with a filtered machine, detail corners, edges and sliding door tracks.<br>Spot vacuum, remove stains, spillages etc.<br>Thoroughly shampoo and pile lift as necessary. | | | | |
| Air-conditioner vents/fans (internal and external) | | | | |
| Thoroughly wipe with an appropriate detergent and cloth and keep vents free from dust, also wipe area surrounding the vent/fan. | | | | |
| Doors/frames/surrounds | | | | |
| Spot clean and remove obvious marks.<br>Thoroughly clean all doors, including fire doors. | | | | |
| Internal glass in doors and partitions | | | | |
| Thoroughly clean both sides of glass including frames and sills.<br>Spot clean glass. | | | | |
| Special requirements for wards | | | | |
| Spot clean all walls, floors and ceilings to remove deposits, such as sputum and enteral feeds.<br>Spot clean beds daily.<br>Thoroughly clean bed fittings on patient discharge.<br>Spot clean bed accessories (such as lockers, chairs, over-bed tables, call buttons) and ledges and wardrobes daily, and thoroughly on patient discharge.<br>Thoroughly clean beds with a neutral detergent on patient discharge.<br>Clean all negatively ventilated rooms in accordance with the infection control manual/guidelines.<br>Pantry areas-thoroughly clean all benches, floors and surfaces daily, and spot clean as required.<br>Treatment room-thoroughly clean all benches, surfaces and floor.<br>Patient water jugs and beakers-thoroughly clean and replenish water. | | | | |

# Glossary

| | |
|---|---|
| Audit | An examination or inspection. A procedure for investigating accounts and other measurements. |
| Auditor | A trained person who undertakes audits. |
| CCU | Coronary Care Unit. |
| CHC | Community Health Councils are statutory organisations set up to monitor the NHS and to be the Patients Voice within the Health Care system. They are independent of NHS management, answerable to the secretary of State for Health and their work is governed by statutory instrument. The main role of CHCs is to advise Trusts and Local Health Boards on the views and concerns of patients and the public. A key function of the CHC is to undertake monitoring visits of health care premises. |
| Clean | Free from dirt, impurities, marks, stains, blemishes, odours and contamination. To clean: to make clean by removing dirt, filth or unwanted substances from an object or area. |
| Contract manager | The person(s) handling the contract between the NHS Trust and the service provider. The 'contract manager' may also be known as the 'purchaser'. |
| Contracted provider | The team or group which provides the cleaning service to the healthcare facility. The contracted provider is contracted by the NHS Trust to provide the service; its employees are not employed directly by the NHS Trust. Contracted providers have responsibility for their cleaning staff and the service provision. |
| CSSD (or similar) | Central Sterile Supply Department. |
| Element | Items to be cleaned in a healthcare facility have been broken down into fifteen generic elements. Standards apply to each group of elements, for example, 'windows'. |

| | |
|---|---|
| EFPMS | Estates and Facilities Performance Management System whereby Welsh Health Estates annually collects and reports on data provided by NHS Trusts. |
| Functional area | The functional area is the area in which cleaning occurs (for example, a ward or operating theatre). This guide groups functional areas according to risk, so that appropriate cleaning processes can be applied. For instance, Intensive Care Units (ICUs) and operating theatres are viewed as higher risk than plant rooms and medical record stores. |
| HDU | High Dependency Unit |
| High risk | In the functional area designated 'high risk', the required Standards are of high importance and must be maintained by frequent scheduled cleaning, and a capacity to spot clean. |
| ICU/ITU | Intensive Care Unit./Intensive Therapy Unit |
| In-house provider | The team or group of staff which provides the cleaning service to the NHS Trust and which is employed directly by the NHS Trust. In-house services and employees are the responsibility of the NHS Trust. |
| Intensity | The level of cleaning required for a certain element and/or functional area. |
| Low risk | In the functional areas designated 'low risk', the required Standards are important for aesthetic, and to a lesser extent hygiene reasons. The outcomes should be achieved through regular cleaning on a scheduled basis, with a capacity to spot clean in between. |
| Minimal risk | In the functional areas designated 'minimal risk', the required Standards can be met in these areas through infrequent cleans on a scheduled or project basis. |

| | |
|---|---|
| Moderate risk | In the functional areas designated 'moderate risk', the required standards are important for both hygiene and aesthetic reasons. The outcomes should be maintained through regular cleaning on a scheduled basis, with some capacity to spot clean in between. |
| Outcomes | The effect or consequence of the output; for example, cleaning produces a clean and safe environment for patient care. |
| Outputs | The actual product or service; for example, cleaning. |
| PMF | Performance Management Framework for the NHS in Wales |
| Processes | The procedures, methods and activities that turn the inputs into outputs; for example, mopping a floor. |
| Quality systems | The organisational structure, procedures, resources and responsibilities required to implement quality management. |
| Risk | Throughout this guide, 'risk' can mean: hazard, danger, peril, exposure to loss, injury, or destruction, and in particular the risk of infection to patients. This approach has been chosen because of the variety of problems that poor levels of cleanliness can cause within different areas of a healthcare facility. Different types of risk include:<br>• The risk of infection for patients;<br>• The risk of a poor public image for the NHS Trust;<br>• An occupational health and safety risk for healthcare facilities staff and the public; and<br>• The risk of a service providing poor value for money. |

| | |
|---|---|
| Service provider | The organisation or group which supplies the service to the healthcare facility and employs staff and cleaners, whether that be in-house or contracted out. |
| Very high risk | In the functional area designated 'very high risk', the required Standards of Cleanliness are of critical importance. The outcomes must be achieved through the highest level of intensity and frequency of cleaning. |
| WRP | Welsh Risk Pool |

# References

Improving Health in Wales: A Plan for the NHS and its partners, January 2001.

Well Being in Wales: a consultation document - Public Health Strategy Division, Office of the Chief Medical Officer, Welsh Assembly Government, 2002

Signposts: A practical guide to public and patient involvement in Wales, National Assembly for Wales, 2001.

Performance Management Framework for the NHS in Wales – A Summary, National Assembly for Wales, Nov 2000.

Standards for environmental cleanliness in hospitals. NHS Estates, with the Infection Control Nurse Association and the Association of Domestic Management, The Stationery Office, 2000.

A first class service: quality in the NHS. Department of Health, 1998.

Cleaning standards for Victorian public hospitals. Acute Health Division, Department of Human Services, Victorian Government Publishing Services, 2000.

Developing an estate strategy: modernising the NHS. NHS Estates, The Stationery Office, 1999.

Welsh Risk Management Standard 14: Infection Control, Welsh Risk Pool.

The management and control of hospital infection: action for the NHS for the management and control of infection in hospitals in England (HSC 2000/002). Department of Health, 2000.

Annex D

IMPROVING HEALTH IN WALES

NHS WALES GIG CYMRU

# National Standards of Cleanliness for NHS Trusts in Wales

# PERFORMANCE ASSESSMENT (TOOLKIT)

produced in association with
the All Wales Facilities Group

July 2003

Llywodraeth Cynulliad Cymru
Welsh Assembly Government

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# National Standards of Cleanliness for NHS Trusts in Wales

## PERFORMANCE ASSESSMENT (TOOLKIT)

produced in association with the All Wales Facilities Group

JULY 2003

The Welsh Assembly Government would like to thank the Department of Human Services, State Government of Victoria, Australia for its kind permission to reproduce parts of the Australian publication 'Cleaning Standards for Victorian Public Hospitals'.

This publication in based on the current NHS Estates documents entitled 'National standards of cleanliness for the NHS' published in April 2001, and it's 'Implementation Guidance (Toolkit)' published November 2001, published by the Department of Health for England.

# Contents

# 1 - Introduction

The Welsh Assembly Government has issued the National Standards of Cleanliness for NHS Trusts in Wales, and they provide the framework around which NHS Trusts can tailor their cleaning services to meet accurately identified requirements. The Standards will also assist Trusts to ensure that the expectations of patients and their visitors are fully taken into account, and it is vital that Control of Infection staff, the respective CHC, and service providers, whether internal or external contractors, are fully involved in this process.

There will be the need to demonstrate that cleanliness in NHS Trust health care facilities in Wales is being maintained to consistent standards that meet the expectations of all stakeholders, and in turn, this document now identifies the Welsh Assembly Government's performance assessment requirements for the National Standards. This 'toolkit' sets out the manner in which cleaning outcomes should be assessed and provides guidance on audit requirements and the application of an Audit Tool for this purpose. The Audit Tool is suitable for monitoring all NHS Trust facilities, and its application will be mandatory for an externally audited score to be submitted for the hospitals included in the Estates and Facilities Performance Management System (EFPMS) returns for April 2003 to March 2004.

This measure of performance in hospitals against the standards will feature in the EFPMS reports, and the results will ultimately feed into the Performance Management Framework (PMF). In addition to the year-on-year performance of hospitals measured from the Audit Tool results for the EFPMS, the PMF will also take into consideration an external assessment of the patients' perspective of environmental cleanliness provided by Hospital Patient Environment (HPE) assessments conducted by Community Health Councils (CHCs).

Progress with HPE issues will be monitored by Assembly Regional Offices. Progress with meeting the National Standards of Cleanliness will complement this as part of the purview for monitoring corporate and clinical governance in the hospitals concerned.

# 2 – Cleaning Outcome Requirements

As indicated in the National Standards of Cleanliness for NHS Trusts in Wales, the standards do not prescribe inputs such as specified cleaning frequencies, techniques, equipment or processes. These will be determined by the Trust managing the healthcare facility according to risk-based analysis, and the resultant cleaning outcomes used as a measure of performance against the requirements set out in the Standards for the functional area and element concerned.

**Using outcome measures allows different healthcare facilities to use different methods, yet still be assessed in the same way.**

To recap on this principle the concept of 'risk' helps identify the variety of problems that poor cleanliness can cause in a facility.

Risks include:

- the risk of infection for patients;
- the risk of a poor public image for the facility/Trust/NHS;
- a health and safety risk for the public and staff; and
- the risk of a service providing poor value for money.

With the key components of the analysis being:

- Functional areas – A 'functional area' is the area in which the cleaning occurs (for example, a ward or operating theatre). The standards document grouped functional areas according to risk, so that appropriate cleaning processes can be applied.
- Elements – An 'element' is the surface, article or fixture being cleaned (for example, 'windows'). Items to be cleaned in a healthcare building are broken down into fifteen generic elements. Particular outcome standards apply to these groups of elements.
- Inputs – The resources used at appropriate frequencies to produce and deliver outputs. Inputs may include staff, equipment and materials.
- Outputs – The actual product or service, for example cleaning.
- Processes – The procedures, methods and activities that turn the inputs into outputs, for example, mopping a floor
- Outcomes – The effect or consequence of the output, for example, cleaning (output) produces a clean and safe environment (outcome) for patient care.

The following tables of cleaning output requirements for building elements have been reproduced from the National Standards of Cleanliness for the NHS in Wales below:

| **BUILDING**<br><br>Element | Cleaning outcome requirement |
|---|---|
| External features, fire exits and stairwells | • Landings, ramps, stairwells, fire exits,steps, entrances, porches,patios, balconies, eaves, external ight fittings are free of dust,grit,dirt, chewing gum, leaves,cobwebs, rubbish, cigarette butts and bird excreta.<br>• Handrails are clean and free of stains.<br>• Garden furniture is clean and operational. |
| Walls, skirting ands ceiling | • Internal and external walls and ceilings are free of dust, grit, lint, soil, film and cobwebs.<br>• Walls and ceilings are free of marks caused by furniture, equipment or staff.<br>• Light switches are free of fingerprints, scuffs and any other marks.<br>• Light fittings are free of dust, grit, lint and cobwebs.<br>• Polished surfaces are of a uniform lustre. |
| Windows | • External and internal surfaces of glass are clear of all streaks, chewing gum,spots and marks, including fingerprints and smudges.<br>• Window frames, tracks and ledges are clear and free of dust, grit, marks and spots. |
| Doors | • Internal and external doors and doorframes are free of dust, grit, lint, chewing gum, soil, film, fingerprints and cobwebs.<br>• Doors and doorframes are free of marks caused by furniture, equipment or staff.<br>• Air vents, grilles and other ventilation outlets are kept unblocked and free of dust, grit, soil, film, cobwebs, scuffs and any other marks.<br>• Door tracks and doorjambs are free of grit and other debris.<br>• Polished surfaces are of a uniform lustre. |

| **BUILDING**<br><br>Element | Cleaning outcome requirement |
|---|---|
| Hard floors | • The floor is free of dust, grit, litter, chewing gum, marks and spots, water or other liquids.<br>• The floor is free of polish or other build-up at the edges and corners or in traffic lanes.<br>• The floor is free of spots, scuffs or scratches on traffic lanes, around furniture and at pivot points.<br>• Inaccessible areas (edges, corners and around furniture) are free of dust, grit, lint and spots.<br>• Polished or buffed floors are of a uniform lustre.<br>• Appropriate signage and precautions are taken regarding pedestrian safety on newly cleaned or wet floors. |
| Soft floors | • The floor is free of dust, grit, litter, chewing gum, marks and spots, water or other liquids.<br>• The floor is free of stains, spots, scuffs or scratches on traffic lanes, around furniture and at pivot points.<br>• Inaccessible areas (edges, corners and around furniture) are free of dust, grit, lint and spots.<br>• Carpets are of an even appearance without flattened pile. After deep cleaning, there is no shrinkage, colour loss or embrittlement of fibres. |
| Ducts, grills and vents | • All ventilation outlets are kept unblocked and free of dust, grit, chewing gum, soil, film, cobwebs, scuffs and any other marks.<br>• All ventilation outlets are kept clear and uncluttered following cleaning. |

| **FIXTURES**<br><br>Element | Cleaning outcome requirement |
|---|---|
| Electrical fixtures and appliances | • Electrical fixtures and appliances are free of grease, dirt, dust, deposits, marks, stains and cobwebs.<br>• Electrical fixtures and appliances are kept free from signs of use or non-use.<br>• Hygiene Standards are satisfied where the fixture or appliance is used in food preparation.<br>• Motor vents, etc., are clean and free of dust and lint.<br>• Drinking fountains are clean and free of stains, mineral build-up and litter.<br>• Insect-killing devices are free of dead insects, and are clean and functional. |
| Furnishings and fixtures | • Hard surface furniture is free of spots, soil, film, dust, fingerprints and spillage.<br>• Soft furnishings are free from stains, soil, film and dust.<br>• Furniture legs, wheels and castors are free from mop strings, soil, film, dust and cobwebs.<br>• Inaccessible areas (edges, corners, folds and crevices) are free of dust, grit, lint and spots.<br>• All high surfaces are free from dust and cobwebs.<br>• Curtains, blinds and drapes are free from stains, dust, cobwebs, lint and signs of use or non-use.<br>• Equipment is free of tapes/plastic, etc., which may compromise cleaning.<br>• Furniture has no unpleasant or distasteful odour.<br>• Shelves, bench tops, cupboards and wardrobes/lockers are clean inside and out and free of dust, litter or stains.<br>• Internal plants are free of dust and litter.<br>• Waste/rubbish bins or containers are clean inside and out, free of stains and mechanically intact.<br>• Fire extinguishers and fire alarms are free of dust, grit, dirt and cobwebs, and mechanically intact.<br>• All decorative plants are free of dust and debris. |

| **FIXTURES**<br><br>Element | Cleaning outcome requirement |
|---|---|
| Kitchen fixtures and appliances | • Fixtures, surfaces and appliances are free of grease, dirt, dust, deposits, marks, stains and cobwebs<br>• Electrical and cooking fixtures and appliances are kept free from signs of use or non-use.<br>• Cooker hoods (interior and exterior) and filters are free of grease and dirt on inner and outer surfaces.<br>• When cleaning food preparation areas, fixtures or appliances, the requirements of the Chartered Institute of Environmental Health or the Royal Institute of Public Health and Hygiene, as appropriate, must be satisfied.<br>• Motor vents, etc., are clean and free of dust and lint<br>• Refrigerators/freezers are clean and free of ice build-up. |
| Toilets and bathroom fixtures | • Porcelain, cubicle rails and plastic surfaces are free from smudges, smears, body fluids, soap build-up and mineral deposits.<br>• Metal surfaces, shower screens and mirrors are free from streaks, soil,smudges, soap build-up and oxide deposits.<br>• Wall tiles and wall fixtures (including soap dispensers and towel holders) are free of dust, grit, smudges/streaks, mould, soap build-up and mineral deposits.<br>• Shower curtains and bath mats are free from stains, smudges, smears, odours, mould and body fluids.<br>• Plumbing fixtures are free of smudges, dust, soap build-up and mineral deposits.<br>• Bathroom fixtures are free from unpleasant or distasteful odours.<br>• Polished surfaces are of a uniform lustre.<br>• Sanitary disposal units are clean and functional.<br>• Consumable items are in sufficient supply. |

| **EQUIPMENT**<br><br>Element | <br><br>Cleaning outcome requirement |
|---|---|
| Patient equipment* | • Equipment is free from soil, smudges, dust, fingerprints, grease and spillages.<br>• Equipment is free of tapes/plastic, etc., which may compromise cleaning.<br>• Equipment legs, wheels and castors are free from mop strings, soil, film, dust and cobwebs.<br>• Equipment has no unpleasant or distasteful odour. |
| Cleaning equipment | • After use, equipment is left in a clean and functional condition.<br>• After use, equipment is appropriately stored in accordance with Trust policy. |
| **ENVIRONMENT**<br><br>Element | <br><br>Cleaning outcome requirement |
| Overall appearance | • The area appears tidy and uncluttered.<br>• Floor space is clear, only occupied by furniture and fittings designed to sit on the floor.<br>• Furniture is maintained in a fashion which allows for cleaning.<br>• Fire access and exit doors are left clear and unhindered. |
| Odour control | • The area smells fresh.<br>• There is no unpleasant or distasteful odour.<br>• Room deodorisers are clean and functional. |
| * Local policies and procedures must make clear who has responsibility for cleaning the environment when contaminated with blood and/or body fluids (see guidance for Standard VI). | |

# 3 – Performance Assessment

Baseline audits and on-going audits against the cleaning outcome requirements will provide Trusts with the basis on which progress with meeting the organisational and management requirements of the National Standards of Cleanliness will be progressed.

Major factors in making progress may include:

- Having clear lines of accountability up to Board level;
- Establishing a Standards of Cleanliness Group;
- Confirming a Cleanliness strategy;
- Establishing a mechanism for Patient Involvement;
- Devising a Cleaning Plan;
- Communicating all activities with all departments and patient groups
- Delivering appropriate training to staff at all levels;
- Clear policies on Building Infrastructure/Maintenance with respect to cleaning; and
- On-going auditing of performance in terms of cleaning outcomes.

## Providing an external audit score of cleaning outcomes

The following checklist of activities is suggested as a guide to ensure the provision of a timely score from the Audit Tool for the hospitals featuring in the Estates & Facilities Performance Management System (EFPMS). The timing of activities may vary for particular Trusts but will need to provide the externally audited scores for EFPMS returns required for April 2003 to March 2004.

### *Activities*

- Establish Standards of Cleanliness Group
- Confirm Cleanliness Strategy
- Devise Cleaning Plan
- Prepare baseline audit of cleaning outcomes and calculate score
- Submit exception report to board nominee and relevant departments
- Communicate all activities with all departments and patient groups
- External audit of Audit Tool score
- Prepare board report
- Provide score to Welsh Health Estates for EFPMS

# 4 - Baseline Audit

The baseline audit is considered to be a fundamental prerequisite of implementing the National Standards of Cleanliness for the NHS. The baseline audit of cleaning outcomes will provide a detailed report on the current state of cleanliness within the healthcare environment. The audit will highlight any issues which impact directly on cleanliness or the capability to effectively clean any area, room or element.

It is anticipated that the baseline audit, should be fully documented and submitted to the Standards of Cleanliness Group. If there are major issues which affect capability to clean, these may need to be reported to the board.

- The audit should clearly identify anything that impacts on the capability to clean.
- The audit should clearly identify tidiness issues that impact on the capability to clean.
- Your audit should identify any areas/items/elements that are not within the remit of the cleaning team.
- The audit should clearly highlight the distance between current cleanliness levels and the standard levels of cleanliness.
- The audit will be an integral part of the strategic cleaning plan, and the operational cleaning plan.
- The audit should clearly highlight the gap between current levels of cleanliness and the outcome requirements laid down in the National Standards.
- All issues/items identified as part of the audit will generate exception reports*.

* A report giving detail of failures or defects that require immediate inspection as they impact the capability to clean. Such reports would be escalated to the relevant professional lead and the Standards of Cleanliness Group.

A typical problem for a baseline audit to note may be, for example, any floor surfaces that need repair and walls or ceilings that require painting. Other areas might include significant staining of the carpets, curtains etc., and the condition of the air ducting.

# 5 - Ongoing Audits

## Internal audits

**Purpose: To verify cleanliness outcomes for a particular healthcare facility and identify areas for improvement. These comprehensive audits are generally scored.**

Internal audits form part of the quality programme. They should be followed up according to the magnitude and location of any problems identified, and lead-times identified for corrections specified. For example, a problem in the operating theatres will need to be resolved immediately, while one in a stationery storeroom may require checking within a week or during the next scheduled audit.

## External audits

**Purpose: To provide an objective view of the cleaning service, and the basis for agreement on contractual issues.**

External audits generally occur less frequently but should occur at least once a year to inform the Estates and Facilities Performance Management System. The past performance of the service provider and the results of the internal audits will also affect the frequency of these audits. Where a service provider has consistently performed well, and no significant problems are being detected in internal audits, then the interval between the comprehensive/external audits can be extended significantly (for example, yearly). On the other hand, where significant problems are being detected it is recommended that external audits be conducted more frequently.

## Cleaning service provider audits

**Purpose: As an important element of their ongoing and continuous internal quality programme.**

# 6 - The Audit Process

## ISSUES FOR CONSIDERATION

Important issues when designing and implementing an audit of cleaning outcomes include:

- frequency;
- personnel;
- sampling;
- scoring;
- reporting; and
- action.

## Frequency

The following table seeks to give guidance based on the audit requirements.

| | Recommended frequency |
|---|---|
| 1. Patient High Risk | Weekly |
| 2. Patient Moderate Risk | Monthly |
| 3. Patient Low Risk | Monthly |
| 4. Other Areas | Quarterly |
| 5. Whole Healthcare Facility | Quarterly |

They are all scored audits.

By following this guideline, a full score for a healthcare facility will be achieved each quarter.

## Personnel

### *General*

All audit staff are expected to have substantial knowledge of healthcare facilities and their procedures, and be able to make discriminating judgements on risk in relation to the areas being cleaned.

Only experienced auditors should undertake the independent audits. Contract managers should be knowledgeable about, or must undertake training in, auditing techniques.

### *Internal*

The composition of the internal audit team is very important. The overriding factor is to ensure that audits and monitoring are (as far as possible) undertaken by first line supervisory staff. The following staff/groups should be included in some/all stages of the audit process:

1. Supervisor – domestic;
2. Manager – domestic;
3. Housekeeper or similar;
4. Ward/departmental manager or a nominated deputy;
5. Estates;
6. Patient Representative (periodic attendance); and
7. CHC's (as part of an agreed programme of attendance).

Where an external contractor delivers the cleaning service, the contractor will carry out this internal audit with input from the NHS Trust.

### *External*

1 It is proposed that NHS Trusts work together to provide an external audit score.

2 Personnel involved in this process are likely to include a number of representatives from the following:

- domestic manager;
- hotel services manager;
- facilities manager;
- senior nurse/infection control nurse;
- patient representative; and
- CHC representative.

Other personnel can be included in the audit process for example:

- Nominated Executive Board member;
- Monitoring officer; and
- Risk Manager.

## Sampling

Audits may only address a small sample of the healthcare facility and may be element-based (for example, all floor surfaces are audited) or based on functional areas (for example, a number of rooms in several wards are reviewed). However, where there are particular problems, the sample size should be increased to better inform the audit process.

Random sampling in a range of areas will ensure that areas are more uniformly cleaned. There should be different sampling cycles for different areas: high-risk areas should be audited more frequently than low-risk areas.

## Scoring

1. The scoring system has to mirror the standard.
2. The standard is **acceptable** or **unacceptable** - Therefore acceptable is clean and unacceptable is dirty. The only other category is **acceptable between cleans** in which case the area is accepted, and scored as clean.
3. The standard system based on pass or fail satisfies the criteria in (1) and (2) above.
4. This concept needs to be introduced very carefully to ensure focus on a systematic, honest and consistent approach.

Scoring of audits provides an objective relative assessment of the cleanliness of the healthcare facility. However, in some circumstances purchasers may decide not to score daily or weekly internal audits. Nonetheless, the outcomes should be retained and used as a reference for future audits that cover the same area or element.

The internal auditor (for example, the contract manager) should undertake regular comprehensive audits on a quarterly basis, and these should be scored. Audits will need to be regularly discussed with ward and departmental managers and reviewed as required. They should cover a variety of areas within the facility and cover all functional areas. The scoring of these audits provides the baseline data and an ongoing measurement of the effectiveness of the cleaning process.

Scoring must be done in the independent audit. A suggested scoring system is included with a sample audit and measurement tool, in Chapter 7. The score will be reported to the Board through the Standards of Cleanliness Group and recorded as part of the EFPMS/PMF and will contribute to the overall assessment of the Trust's performance.

## Reporting

Departmental level

- Departmental Scores & Exception Reports
- Standard of Cleanliness Group:
- Quarterly Area Scores plus whole healthcare facility scores
- Exception Reports

Infection Control Committee

- Quarterly Area Scores plus whole healthcare facility scores
- Exception Reports

## Action

The assessments collected in any audit must be acted upon as part of the process of continuous improvement.

## STEPS OF THE AUDIT PROCESS

1 At the Baseline Audit Stage for Cleaning Outcomes, a full review must be made of the elements list to agree exactly what elements will be included in the local model – this may involve the addition of new elements or the exclusion of certain elements that are not the responsibility of the cleaning personnel.

2 Items should only be scored if they are within the responsibility and control of the cleaning team.

3 Any items which directly impact the capability to clean should be documented on an exception report for remedial action by the responsible party.

4 The Standards of Cleanliness Group must ensure that there is clear definition of the responsibilities and accountabilities of the cleaning team– some aspects will be general nursing responsibilities.

5 The sampling pattern must be random to ensure that there is no predictable pattern.

6 The audit can be conducted on a 'room' or 'element' basis. It is for the Standards of Cleanliness Group in each Trust to determine this at the start of the process, providing the basic process for auditing and scoring are followed.

7 NHS Trusts may wish to reproduce the list of elements in a different order to suit their site/s better. Some elements will be n/a – this should not present a problem, but to reach an accurate score it is important to retain the method of scoring.

8 Where maintenance issues impact on the audit process, or poor maintenance is seen to contribute to a low score, this must be recorded in the audit comment sheet, and in an exception report for the Standards Group, and the Board Nominee.

# 7 - Audit Tool

The following audit tool is written with reference to hospitals but the principles should be adopted as appropriate for all healthcare facilities. Audits are for quality improvement purposes and should not be punitive. This approach is consistent with the outcome focus of the National Standards.

Information collected during the audit should be made available to the service provider as soon as possible after the audit is completed. Agreement should be reached on the corrective action which needs to be taken by the service provider.

## Internal Audit

Internal audit will be a continuous process as part of the management of the service-level agreement. It should be conducted as a joint exercise between the NHS Trust and the service provider.

The audit should be conducted on a number of discrete functional areas by random sampling (see page 19).

A separate audit sheet should be used for each functional area – see proposed audit sheet below.

The audit will be evidence-based. If an element is not acceptable, then the auditor must make a comment as to why it is not acceptable and indicate the corrective action needed. A timescale for corrective action should be recorded on the reverse of the audit form.

The auditor should also take the opportunity to comment where the service provider has achieved a particularly good result.

## How to score a functional area

There is a maximum of fifteen elements that can apply to any one functional area. The audit sheet should record how many of the fifteen elements apply to the functional area being audited.

For each element, the auditor should deem it to be 'acceptable' or 'acceptable between cleans' (score 1), or 'not acceptable' (score 0).

This scoring is subjective and the auditor should exercise some discretion in judging the acceptability of an element. For example, one or two scuffmarks on a floor or an isolated smudge on a window does not indicate that the element should necessarily score as unacceptable.

The auditor should also take into account the physical condition of the infrastructure when making the assessment. For example, it may be impossible to obtain a uniform lustre on a damaged floor surface.

Once all elements have been scored, the total number of 'acceptable' scores should be expressed as a percentage of the total possible number of 'acceptable' scores in that functional area. For example, if the operating theatres had a maximum of 12 elements, and 10 were acceptable, the overall percentage would be calculated as 10/12 or 83%.

## External Audit

External auditing will need to be done at least once a year to produce a score for the hospitals featured in the EFPMS/PMF.

This audit should be conducted objectively, perhaps by a multi-disciplinary team from another NHS Trust, or a CHC. Such a team should include a Patients Representative.

The external audit brings together the work done for the internal audit and incorporates a weighting factor to distinguish between the risk of different functional areas.

Suggested weightings for the functional areas described in Annex C of the National Standards are as follows:

| | |
|---|---|
| Very high risk | 7 |
| High risk | 6 |
| Moderate risk | 4 |
| Low risk | 2 |
| Minimal risk | 1 |

Applying the weighting to the functional areas will give a weighted average score for the whole healthcare facility.

Healthcare facilities may increase the weightings applied to a particular functional area if the patients in that area are considered to be at increased risk. No area listed in the National Standards of Cleanliness for the NHS Trusts in Wales should have its weighting reduced.

## Scoring the hospital

Once audit scores have been calculated by the assessment team for all functional areas, the following formula is applied to calculate a weighted average:

$$\frac{(a \times \alpha) + (b \times \beta) + (c \times \gamma)}{\alpha + \beta + \gamma}$$

Where

a, b, c, etc is the score achieved for each functional area included in the audit, and

$\alpha$, $\beta$, $\gamma$, etc is the weighting for each area that has been audited.

### *Example*

A hospital has three functional areas. The introduction of a weighting factor reflects the importance that each functional area makes to the overall score for the hospital. The weightings of each functional area and the corresponding scores were as follows:

| **Functional area** | **Weighting** | **Score** |
|---|---|---|
| Theatre | 7 | 83% |
| Ward | 6 | 86% |
| Workshop | 2 | 90% |

The overall hospital score is

$$\frac{(83 \times 7) + (86 \times 6) + (90 \times 2)}{7 + 6 + 2} =$$

$$\frac{581 + 516 + 180}{15} =$$

$$\frac{1277}{15} = \quad 85\%$$

It is this overall percentage that is reported to the Board for the EFPMS.

**SCORE SHEET**

| | | | |
|---|---|---|---|
| Functional area | | Weighting | |
| Auditor(s) | | Audit date | |
| Locations/sub-areas audited: | | | |
| Acceptable =1. Unacceptable = 0, not applicable = n/a | | | |

| Element | Acceptable/ unacceptable | Comments | Action Time frame | Action taken Y/N |
|---|---|---|---|---|
| External features, fire exits, stairwells | | | | |
| Walls, skirting and ceilings | | | | |
| Windows | | | | |
| Doors | | | | |
| Hard floors | | | | |
| Soft floors | | | | |
| Ducts, grills and vents | | | | |
| Electrical fixtures and appliances | | | | |
| Kitchen fixtures and appliances | | | | |
| Toilets and bathroom fixtures | | | | |
| Furnishings and fixtures | | | | |
| Patient equipment | | | | |
| Odour control | | | | |
| General tidiness | | | | |
| TOTAL SCORE | | | | |
| SCORE expressed as a % | | | | |

Signature.....

(See over for audit comment sheet)

**AUDIT COMMENT SHEET**

| Area | Comments |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
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| | |
| Notes | |

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