

Healthcare Associated Infections – litigation and reputation

A MindMetre research note on the reputational risk to healthcare institutions of litigation by patients suing as a result of an HCAI

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Management Summary

Health economics studies of return on investment from screening for Healthcare Associated Infections (HCAIs) have tended to focus only on the consequent reduction in patient treatment costs. A few studies have also looked at the direct impact of patient lawsuits resulting from HCAIs, but here only in terms of the cost of damages and legal fees. This short research note suggests that, in the newly structured NHS, where groups of GPs - Clinical Commissioning Groups (CCGs) - are now commissioning acute services, where competition for service provision between trusts is overtly encouraged, and where there is a clear mandate to 'improve patient outcomes', HCAI rates are likely to play an increasing role in the ability of a trust to attract patients and the funds that come with them.

HCAI-related lawsuit volumes have been shown to be directly linked to HCAI incidence. Since these lawsuits are widely reported in the press, and therefore clearly affect a trust's reputation, this paper has researched the likelihood of UK citizens to sue following a serious HCAI, and compared with other countries. The high likelihood of suing (64%) in the UK provides evidence which suggests investment in methods and processes to rapidly detect and reduce HCAI rates produces valuable reputational returns that go beyond simply reducing treatment costs and avoiding damages. Being able to promote low HCAI rates may well influence the longer-term ability of a trust to attract CCG funds.

Infection Rates – MRSA is not the only enemy

According to a report published by the UK's Health Protection Agency (HPA) in 2012¹, rates of infection with the best-known antibiotic-resistant 'superbug', MRSA, in British hospitals have fallen significantly in recent years. However, the same report warned that over 6% of English hospital patients still acquire some form of infection during their stay. This is echoed across Europe in a report from the European Centre for Disease Prevention and Control, which finds that, on any given day, almost one in every eighteen patients has a Healthcare Associated Infection (HCAI). The UK authorities' decision to specifically target MRSA and *C. difficile* reduction has undoubtedly been successful in the country; but it would appear that a broader set of initiatives directed at HCAs, and measures to prevent them, is required.

According to the HPA report, new types of infections have emerged over the last five years, as MRSA has been brought more under control. A class of organisms called enterobacteriaceae were most frequently reported, with an almost 1% infection rate amongst the English hospital patients surveyed. Enterobacteriaceae include bacteria that are normally found in the human intestine, such as *E. coli* and salmonella, along with a range of newly identified strains. Of concern is the finding that around 15% of the enterobacteriaceae infections reported in the HPA survey appear not only to be antibiotic-resistant, but also resistant to some newer antibiotics.

Reduction Methods

The success of the UK campaign to reduce MRSA infection rates clearly shows that HCAs are to a significant extent preventable. The UK Department of Health advocates the adoption of "high-impact interventions" - evidence-based techniques to reduce the risk of HCAI. The HPA advocates a handful of critical disciplines in this regard:-

- Hand-washing, either with soap & water or alcohol hand gel
- Use of protective clothing, e.g. disposable gloves
- Regular and thorough cleaning of premises and equipment
- Rapid identification and isolation of patients with antibiotic or antimicrobial-resistant infections, to prevent wider infection spread
- More appropriate and effective use of antibiotics, e.g. only use the most effective antibiotic at the right dose, and only then when judged medically necessary

¹ HPA, *English National Point Prevalence Survey on Healthcare-associated Infections and Antimicrobial Use, 2011: preliminary data*

Identification and Appropriate Use of Antibiotics

In terms of ‘identification’, the effective policies of recent years to reduce MRSA infection have focused on active screening of admissions. There is a commitment in the Department of Health Operating Framework to active screening (“The zero tolerance approach to all avoidable HCAs will continue”), and the process has been mandatory in England and Wales since 2010. Around this time, some pioneering Trusts also introduced rapid screening for other associated infections².

Additionally, rapid identification of a strain’s particular antibiotic-resistance reduces the level of ‘trial and error’ in treating dangerously infected patients, consistent with the discipline noted above about “more appropriate and effective use of antibiotics.” However, the technology and techniques used to actively screen and rapidly identify the most appropriate antibiotic may need to be applied to a wider range of potential infections, given the rise reported by the HPA in infections that are neither MRSA nor *C. diff*³.

Justifying the Cost of Prevention

However, any screening programme costs money – a real issue in an atmosphere where (although ‘ring-fenced’) NHS spending remains under pressure. Pressure is on to achieve £20bn of efficiency savings by 2015, making the availability of funds for new initiatives especially tight, especially where it involves expenditure on capital equipment.

Investment initiatives to extend active detection to the wider range of HCAs identified by the HPA therefore require clear economic and patient-outcome return on investment. Most studies of the parameters of screening programmes (the point at which they become ‘cost-effective’) have focused only on the reduction in infections rates and consequent reduction in treatment costs. A few have embraced the additional risk factor of claims and litigation by patients infected with an HCAI⁴. However, the direct financial consequences of a legal action need to be combined with a factor that has become extremely topical recently – reputational risk.

What is the impact of reputational risk, and how is that tied to litigation volumes related to HCAs?

² See, for instance, *Blackpool, Fylde and Wyre Hospitals, Blackpool Hospitals first in the UK to screen for superbug MSSA, 30 Jul 2010*

³ *European Centre for Disease Prevention and Control, Surveillance Report 2012*

⁴ See, for instance:- Goldenberg SD, Volpé H, French GL *Clinical negligence, litigation and healthcare-associated infections, J Hosp Infect. 2012 Jul;81(3):156-62. Epub 2012 Jun 1; Julie V Robotham, Nicholas Graves, Barry D Cookson, Adrian G Barnett, Jennie A Wilson, Jonathan D Edgeworth, Rahul Batra, Brian H Cuthbertson, Ben S Cooper, Screening, isolation, and decolonisation strategies in the control of meticillin resistant Staphylococcus aureus in intensive care units: cost effectiveness evaluation, 9 Aug 2011*

The Rise of Reputational Risk and its Impact on Revenue

In recent years the NHS has witnessed a radical new approach to healthcare management, with poor standards of patient care having led to NHS acute trusts being taken over or being (partially) closed. Hinchingsbrooke Hospital in Cambridgeshire and Stafford Hospital are the two most widely reported examples, but more are expected to follow⁵, now that the Government has introduced a more stringent inspection regime.

At the same time, the structure of the NHS has been radically changed under the Health and Social Care Act 2012, with Primary Care Trusts and Strategic Health Authorities abolished, and commissioning for most acute treatment being put in the hands of Clinical Commissioning Groups run by groups of GPs (commissioning treatment of a few conditions remains in the hands of supra-body NHS England). This infrastructural change is considered the fundamental reform that will enable patient choice, force competition between acute Trusts encourage funds to truly ‘follow the patient’⁶, all with the aim of improving clinical and care standards in the UK.

The changing shape of the UK hospital network has been underlined by the Royal College of Surgeons, which noted “the reshaping of hospital services and a move towards greater centralisation.... There is an undeniable clinical case for change as concentrating specialist services into fewer, larger centres of excellence can improve patient outcomes and make services more sustainable⁷.”

Therefore, reform of UK acute trusts is in progress, and competition between acute trusts has been enabled. This makes the control of HCAs all the more urgent. The Health and Social Care Act 2012 requires Clinical Commissioning Groups to ensure good practice, to promote and protect patient choice, and to improve services for patients. A hospital that is not seen to be striving to reduce HCAs, or is showing a rate above that of peer institutions (especially those within a sensible travelling distance from the patient’s home) is likely to see reduced commissioning from CCGs over time. Sending patients to an acute care institution with a high HCAI count can hardly be seen as consonant with the CCG’s, and the individual GP’s, statutory duties.

⁵ BBC News, *More failing hospital ‘likely to be found’*, 30 Sep 2013

⁶ NHS England, *Choice and Competition*, <http://www.england.nhs.uk/ourwork/gov/choiceandcompetition/>

⁷ Royal College of Surgeons, *Comment on the Report from the Future Hospital Commission*, 12 Sep 2013

Lawsuits and Reputation

Studies into MRSA rates have found that lawsuit volumes follow the same trajectory as infection rate volumes. Reduce the former, and the latter will follow. ‘Superbug’ lawsuits are very widely reported in the press (as a quick Google search will show), having therefore a direct impact on hospital reputation. Moreover, the accumulated reporting over the last ten years may well have encouraged more HCAI victims to sue.

This research study conducted research fieldwork amongst a nationally representative sample of the populations in the UK, Germany, France, the Netherlands and the US, from September to December 2013 (sample size, 3,000+ per country; margin of error +/- 1.78%). Most likely to sue following a serious HCAI were French patients, followed by those in Germany, and then the UK. Interestingly, in the US, propensity to sue is much lower than in the UK and Europe, possibly because state support for plaintiffs is less, and only a quarter of cases end up in the plaintiff’s favour⁸.

Q: If I picked up a serious infection while being treated in hospital, and I believed that this was the result of negligent or poor standards of hygiene and/or care in the institution, I would definitely take the hospital in question to court and sue them for damages.	UK	DE	FR	NL	US
Agree %	64	66	70	61	52
Disagree %	36	34	30	39	48

The new structure of the NHS encourages competition between acute trusts. No CCG, or individual GP, will be inclined to send patients to an acute hospital known to have high HCAI rates. HCAI-related lawsuits rise and fall in direct correlation to HCAI incidence. These cases are widely reported in the press, and patient and GP perceptions of substandard infection control will therefore be (in part) influenced by the volume of media reporting on HCAI rates.

Conclusion

Further work needs to be done on the issue of reputational impact of HCAI rates. However, this short research note, and its underlying data, suggests that reputational and litigation risk should form a part of the economic justification for further HCAI reduction initiatives in a newly competitive NHS.

⁸ U.S. Bureau of Justice, Medical Malpractice Trials, <http://www.bjs.gov/index.cfm?ty=tp&tid=4511>

Research Methodology

Fieldwork was conducted by MindMetre Research during September-December 2013, via online questionnaires, amongst a nationally representative sample of 3,000+ per country, in the UK, Germany, France, the Netherlands and the United States. Margin of error: - +/- 1.78%.

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