Dealing with clinical waste in a more efficient and cost effective way

A guide for local authorities

Staffordshire County Council

Newcastle under Lyme Borough Council

Staffordshire Moorlands District Council
Achieving Excellence

"Helping you to reduce cost of clinical waste collections."

Purpose

The purpose of this information pack is to provide local authorities which currently collect clinical waste, with a methodology and guidance to correctly identify the waste types and provide the service in a more efficient and cost effective way. Correctly identifying the waste will ensure the most appropriate disposal method is used, the requirements of duty of care are satisfied and collections are carried out in the most efficient manner. Significant savings and operational efficiencies can also be made.

The folder contains information and advice on how to implement such changes, using the Staffordshire project as an example. Sample letters and forms are also provided within the pocket of the folder and as MS Office files on the resources CD.

Contents

Enclosures

- Sample letters
- Clinical Waste Questionnaire

Resources CD

- Sample letters
- Clinical Waste Questionnaire

Further information

Further information on the process can be obtained from:

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Improvement and Efficiency West Midlands

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"Simple unobtrusive changes reduced the number of truly clinical collections dramatically"

Background

A review of local authority clinical waste collection and disposal arrangements in Staffordshire was undertaken in March 2011 to establish the types of waste collected across a number of WCA Clinical Waste Collection Services and identify the most appropriate collection methods and disposal routes. This was carried out with the aim of achieving a more efficient and cost effective service. At that point four of the eight Waste Collection Authorities (WCAs) in Staffordshire, collected clinical waste:

- Staffordshire Moorlands District Council;
- Newcastle under Lyme Borough Council;
- Stafford Borough Council; and
- South Staffordshire Council.

The first phase of the review, undertaken in 2011, considered collections from two WCAs in the North of Staffordshire: Staffordshire Moorlands District Council and Newcastle under Lyme Borough Council. Both Councils offered in-house collections of clinical waste to their residents. The waste collected was disposed of via a combination of autoclaving and high temperature incineration.

Staffordshire County Council, as the Waste Disposal Authority (WDA) for these areas, has responsibility for treatment and disposal of household waste. In addition, the local NHS Primary Care Trust (PCT) had their own arrangements in place for collecting and disposing of clinical waste.

A project team, consisting of a representative from each of the two WCAs, the WDA and two representatives from the local NHS Primary Care Trust (PCT) was established.

While the initial project was delivered in conjunction with the PCT, recent changes have seen the introduction of Clinical Commissioning Groups (CCGs) replace PCTs. Therefore, any future assessments of clinical waste services should be done in conjunction with CCGs*.

The PCTs/CCGs have a responsibility for the safe management of healthcare wastes from within their area.

*or their equivalent

The project team agreed at an early stage that they would work together to identify the waste types currently being collected as clinical waste to determine the most appropriate treatment or disposal routes. It became clear that much of the waste collected as clinical waste in both districts was being incorrectly categorised and therefore being disposed of in an inefficient and unnecessarily costly manner. Most of the material was identified as offensive waste, which could easily be disposed of much more economically, through normal household waste collections.

A full, systematic audit of collections was developed and undertaken by both WCAs. The audit included identifying collections, establishing what material residents were producing and working alongside the PCT to identify and introduce new referral processes within the healthcare profession and agree a system whereby truly clinical collections are made via their service provider. A review of the current legislative guidance was also carried out at the same time.

Working together with the PCT the correct routes for the very small proportion of clinical waste that remained was established. This involved considering the referral system, joint visits to some of the referral units and discussions with the Ambulance service as collection service provider who undertake collections of clinical waste on behalf of the PCT. The audit reduced the need for collections of truly clinical waste significantly, eliminating completely the need for any such collections in Newcastle Under Lyme BC and leaving only a handful in Staffordshire Moorlands DC remaining to be collected by the PCT/via their service provider.

Through the implementation of simple, unobtrusive changes to the way in which residents were asked to present their waste the number of "truly clinical collections" reduced dramatically.

The process stipulated within this toolkit is an example of how to deal with clinical waste in a more efficient and cost effective way in Staffordshire and should therefore be used as a guide by WCAs and WDAs alike to formulate their own strategies that are tailored to their services, specifically in relation to the provision of additional capacity for offensive wastes.

Clinical Waste Legislation Guidance

Alongside regulations about containment and transportation, definitions of 'household', 'clinical' and 'offensive waste' are key to establishing what should be collected. For clarity, the legal definitions have been interpreted and simplified as follows.

Household Waste

Waste generated by a property used for domestic purposes: house, caravan, vessel, etc. No charge can be made for collection or disposal unless the collection costs from the property are unreasonably high and the collection authority is satisfied that the householder has made adequate alternative disposal arrangements. (Defined through Controlled Waste Regulations 2012, Schedule 1)

Offensive Waste

Household waste containing bodily fluids, secretions, or excretions, which are not infectious. Examples include: dressings, gloves, nappies, incontinence pads and sanitary products. This waste can be collected via tiger sacks if the end disposal point is landfill, or through the normal domestic bin collection if incineration is the end disposal point. A charge can be levied for collection but not disposal. (Legal definition can be found in the Controlled Waste Regulations 2012, Schedule 1, Section 1).

Clinical Waste

Waste containing infectious material, such as something for which antibiotics may be prescribed, produced by a healthcare activity. The material must be secured in bags, which are yellow or orange and marked for incineration. Sharps are clinical waste, but should be returned to designated health centres/ GP surgeries. Containment and transport are closely regulated. A charge can be levied for collection but not disposal. (Defined through Controlled Waste Regulations 2012, Schedule 1; Section 1)

Detailed information, legal definitions, technical information and recommended further reading can be found in

- The Environmental Protection Act 1990 (Section 45; Paragraph 1 – Collection of Controlled Wastes) Defines the duties of a Waste Collection Authority.
- Controlled Waste Regulations 2012 (Schedule 1; Paragraph 1, 3, and 4) Differentiates household waste from industrial waste and commercial waste, and categorises household waste.
- Hazardous Waste Regulations 2005 (Schedule 1 (Annex 1), Paragraph 18 and Paragraph 19) Defines hazardous wastes and stipulates limits on transportation, mixing and treating hazardous waste.
- Carriage Regulations 2009 (European Agreement concerning the International Carriage of Dangerous Goods by Road) (ADR) 2011 Stipulates the parameters for transporting Clinical Waste, and recommended training for drivers. Annex 1, Part 4 and Chapter 1.3; Annex A.
- List of Wastes Regulations 2005 – Defines/ classifies the waste into categories. Section 18 Wastes from Human or Animal Health Care and/or Related Research. (Previously the European Waste Catalogue Codes) available from the Environment Agency

It is recommended that any WCA, WDA and CCG* familiarise themselves fully with the appropriate regulations prior to reviewing their clinical waste collections.

*or their equivalent

Frequently asked questions

Q Why undertake the project?

There are potential significant financial savings to be made. The cost of making separate collections is substantial, and disposal costs associated with clinical waste are many times those for mixed municipal waste. The WCA needs to ensure that the right waste stream is being collected with the right collection service.

Typically waste generated by householders and collected via clinical collections is often only offensive waste, which can be disposed of via the normal collection routes. By correctly identifying the waste this ensures the most appropriate disposal point is used, thereby satisfying the requirements of duty of care and ensuring that collections are carried out in the most cost effective efficient manner. This often reduces the need for a separate collection.

Q Who do I need to involve?

There are various stakeholders involved in the process, below are a list of key ones. This list is in no way exhaustive and depending specific internal processes may or may not include all of these stakeholders:

Internally – Portfolio Holder, Cabinet/other elected Members, Contact Centre staff, operational collection staff, staff in Waste Strategy Team

Externally – CCG* staff, disposal authority staff, future contractor, residents

It is essential that a Project Team is established consisting of representatives from the waste collection service, waste disposal authority and CCG*. It is also crucial to have a project lead to drive the project forward.

Q Who are the key contacts that need to be involved in the project team?

The key contacts that should be included in your project team are:

- Waste management staff – Disposal Authority
- Waste management staff – Collection Authority (Head of Service and officers)
- CCG* management staff
- CCG* Clinal Collection Service provider

Q Is there a good time to start?

As soon as possible! However, it is a good idea to ensure timing takes account of restrictions such as PURDAH. The project will take time to complete and if not managed appropriately may be perceived by some stakeholders as a 'withdrawal' of service.

*or their equivalent

Q How long will it take?

The time it takes to complete the review will very much depend on each Local Authority. A review of the service will be the starting point; in particular, information relating to service users. If you know names of the people receiving the service, other contact names/information if appropriate, exactly what the waste type is etc then the project length can be considerably shortened. Timescales will also depend upon what new collection arrangements are proposed – the same provider, or a new one (such as the CCG*).

It will also depend on how proactive and engaged your local CCG* is, as it will need to agree to the procedures to be put into place.

Having all your partners signed up to the changes will ensure effective delivery of the project.

Q Will there be bad press about the changes?

It is important that the process is managed appropriately to minimise any potential for negative press. It might be worth briefing your Media team, but the need for this will depend very much on local circumstances and previous history. If you have everything in place – partner buy-in, training for Contact Centre staff, alternative collection arrangements, extra capacity for those users switching onto a standard refuse collection service, fully briefed elected members, etc – and you focus on the need to collect the right materials in the right collection stream and deliver value for money services, then negative press coverage can be minimised or avoided.

Q Who will collect the waste if the WCA doesn't?

Discussions with the CCG* need to take place at the very start of the process in order to ensure their buy in. The success of the project will very much be dependant on this, as they will need to work with the Local Authority to ensure that suitable arrangements are in place for the collection of clinical waste. The CCG* will have their own arrangements in place for collection and disposal of clinical waste across their own services. Using these arrangements will become key to the delivery of the efficiencies.

Q What provisions should the WCA make for additional capacity?

It is important that the WCA has the appropriate policies in place to allow customers effected by the changes to access additional residual waste capacity. Similarly considerations have been given to any associated resource implications, for example, bin supplies/sacks etc.

*or their equivalent

The Process for WCAs

The process can be broken down into a number of key steps.

1. Collate current lists of addresses receiving clinical waste collections from databases. (Consideration should also be given to including current collection arrangements for nursing/care homes and how this process can also benefit the management of their offensive and clinical waste.)
2. Populate your records with as much information as you have – names (referrer or entitled resident, contact details, nature of waste being collected, etc.)
3. Set in place a procedure whereby requests for clinical waste collections are authorised in your team, rather than going straight from the contact centre to the collection staff.
4. Brief contact centre staff fully – what you're doing and why, as well as empower them to solve capacity issues by linking them direct to additional capacity resourses.
5. Contact residents effected by changes by phone – demonstrating a personal, sensitive and diplomatic attitude – ascertaining the type of waste and making appropriate arrangements, e.g. extra capacity if needed. Record the outcomes – waste types, additional capacity required, additional recycling capacity etc.
6. Where residents cannot be contacted by phone a simple letter can be provided – advising what is and isn't clinical waste and offering solutions.
7. Brief Contact Centre staff again, advising that letters are going out to residents.
8. After a month, send a further letter to those who don't make contact advising that their collections will stop in a further month unless they do make contact.
9. Brief Contact Centre staff again, advising that letters are going out to residents.
10. After another month stop the collections for all except those that you have identified and confirmed to be producing clinical waste. Advise contact centre staff that this is happening, so they can provide services as necessary, such as extra containment or advice for CCG* staff to refer in to provider of clinical waste collections.

The Process for WDAs

1. Work closely with the WCA and other parties in the Project Team throughout the process.
2. Engage with your residual waste treatment/ processing contractor early on, making them aware of the increase in household waste and negotiating any impacts on maximum tonnage inputs
3. Engage with any clinical waste disposal contractors early on. Consideration must be given to potential impacts on contractual obligations and meeting tonnage inputs, negotiations may be required.
4. Brief Elected Members fully so they are aware of the project and potential savings that can be made.

*or their equivalent

Waste Assessment for Referrers

The chart below shows how waste can be assessed to see if it should be classed as clinical waste and therefore require specialist disposal or treatment. It's primary use is for medical/CCG* staff, at the point of referral, to establish if the waste produced is clinical and requires special collections by their collection service provider or whether it is simply offensive waste which can be disposed of through household waste collections. When advising residents of the arrangements for additional capacity, it is important to emphasise and provide assurance that this process is about enhancing and providing the right services for residents and is therefore not the removal of a service.

Waste Assessment Chart

What is the composition of the waste?

Is the waste 'sharps'?

Advise the patient to take the waste to healthcare centre. They must be sealed correctly, have the patients name on them and the date this was returned, they are then signed for and collected for disposal. There is a special container in the health centre receptions for this.

Is the waste offensive? e.g. dressings, human faeces, incontinence pads, catheter and stoma bags, nappies, sanitary waste, nasal secretions, sputum, urine, vomit or soiled human bedding from a patient with no infection?

The WCA will collect this waste because it is classified as 'household waste'. Advise the patient to contact their local council to discuss what arrangements are in place for additional capacity.

Is the waste from a patient with an infection (for which they are being treated – e.g. with antibiotics)?

This is 'clinical waste' and you should send the referral form to the Primary Care Centre - see flow chart on next page

*or their equivalent

This flow chart shows the process which could be used by a CCG or equivalent to start/ stop collections of clinical waste from a particular patient or address.

Hazardous Waste Collection Referral Flow Chart

Referrer

Paper referral form sent to the Primary Care Centre to

Commence / Continue / Cease the service

Primary Care Centre instruct the CCG collection service provider to commence collections

If commencing service

Review date established

Email reminder sent to referrer

If stopping service

Cease date established

Email reminder sent to referrer

NHS

Primary Care Centre

Referrer contacts Primary Care Centre to cease or continue collection service with new review date