The Christie NHS
NHS Foundation Trust

Title: Annual report of the infection prevention and control team April 2016-17

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Approved by: The Infection Prevention and Control Committee

Date: 26th April 2017

Contents

Executive Summary

This report details the activities of the Infection Prevention and Control Team (IPCT) to ensure that The Christie Hospital NHS Foundation Trust is compliant with the The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (updated 2015) and associated Care Quality Commission (CQC) guidance.

Infection Prevention and Control at The Christie Hospital NHS Foundation Trust has benefited from the establishment of a new team at the end of February 2016 with both a new Lead Infection Prevention and Control Nurse and Band 7 Infection Prevention and Control Nurse specialist coming into position as well as new microbiology cover from Salford Royal Hospital.

The year 2016-2017 has seen challenges with an increase in post-72 hour *Clostriduim difficile* Toxin positive (CDT) cases and an MRSA bacteremia which was associated with the hospital.

All cases of CDT post-72 hours go through a rigorous root cause analysis (RCA) process and the MRSA bloodstream infection was also subjected to an extensive post-infection review with actions being identified such as the transmission-based precautions training being carried out again across the Trust.

Methicillin-resistant staph aureus (MRSA) colonisation and Vancomycin-resistant enterococci (VRE) colonisation have decreased, while *Escherichia coli* bacteremia numbers have remained similar to the previous year and MSSA bacteremia cases have increased slightly.

Quality improvements have been a key feature of the year with a focus on educating the staff of The Christie (via the Infection Control Champion programme) and enabling them to tackle infection prevention and control issues in their own clinical areas (via the Hand Hygiene taskforces) as well as raising the profile of and the accessibility of the IPCT.

The Director of Infection Prevention (DIPC) set up a quality improvement collaborative project to trial small tests of change in December 2016 which has seen successes with such projects as a new style stool chart. This will continue into 2017-2018 as a new Healthcare-associated infection reduction collaborative.

1. Current staffing levels

The IPCT consists of 1 WTE band 8A lead nurse and 1 WTE band 7 infection prevention and control nurse specialist and 1 WTE Band 6 infection control nurse. The team is supported by 1 WTE band 4 PA/administrator.

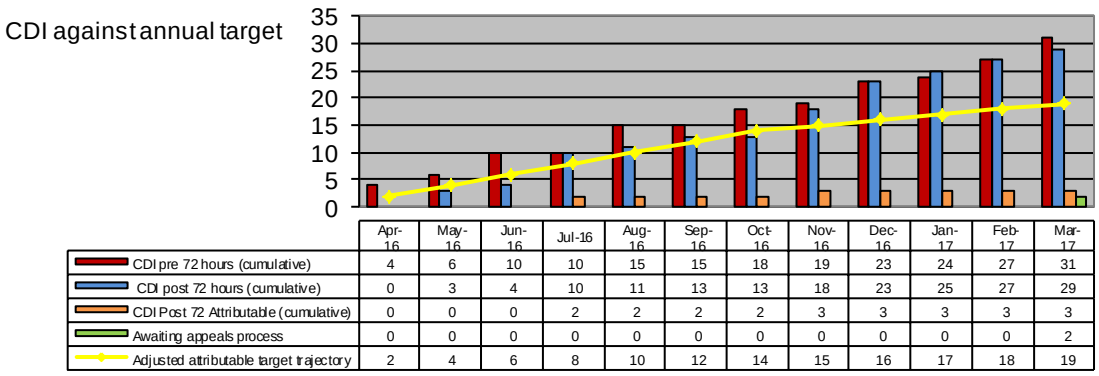
A nurse educator (Band 7) was seconded to the team for one day a week January-March 2017 to assist with the introduction of surgical site surveillance.

Microbiology cover is provided by Salford Royal NHS Foundation Hospital and there are medical staff on site 5 days a week attending rounds and antibiotic ward rounds. Dr Paul Chadwick is the designated Infection Control Doctor for the Christie Hospital.

2. Surveillance

2.1 Clostridium difficile infection

Figure 1: All cases of *Clostridium difficile* infection (CDI) against yearly target



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
CDI pre 72 hours (cumulative)	4	6	10	10	15	15	18	19	23	24	27	31
CDI post 72 hours (cumulative)	0	3	4	10	11	13	13	18	23	25	27	29
CDI Post 72 Attributable (cumulative)	0	0	0	2	2	2	2	3	3	3	3	3
Awaiting appeals process	0	0	0	0	0	0	0	0	0	0	0	2
Adjusted attributable target trajectory	2	4	6	8	10	12	14	15	16	17	18	19

The *Clostridium difficile* infection (CDI) trajectory for 2016/17 was set by NHS England at 19 cases

All cases of CDI have a surveillance definition applied to them and are identified as being pre and post 72 hours of admission. Any cases that meet the definition as being 72-hours post-admission are assessed by a member of the staff and a root cause analysis (RCA) is initiated. Cases that are categorized as being pre-72 hours are referred to the relevant community team for RCA.

Cases are discussed at the monthly Nosocomial Infection Performance Review (NIPR) meeting chaired by the DIPC and attended by the infection control doctor, relevant pharmacist, the infection prevention and control nurses, a member of NHSE Specialised Commissioning team and nursing and medical staff that cared for the patient.

Figure two below shows the pre and post-72 hour cases by month. Periods of increased incidence (PII) were declared when there were two or more cases in a ward within 28 days. When a PII has been declared this activates a number of measures including enhanced environmental cleaning, increased antimicrobial surveillance and daily auditing. PIIs were declared in April, July and December/January. The Trust had a total of 60 cases of CDI all of which underwent a root cause analysis. 31 were identified pre 72 hours and 29 were post 72 hours of their admission. Following rigorous assessment of each case using the attribution process as agreed with our commissioners, three cases were deemed to be attributable to the Trust. All cases were reported on the Public Health England (PHE) Healthcare-associated infection data capture system

Figure: 2 Pre and Post-72 hours CDT cases in The Christie Hospital 2016/17 showing lapses in care

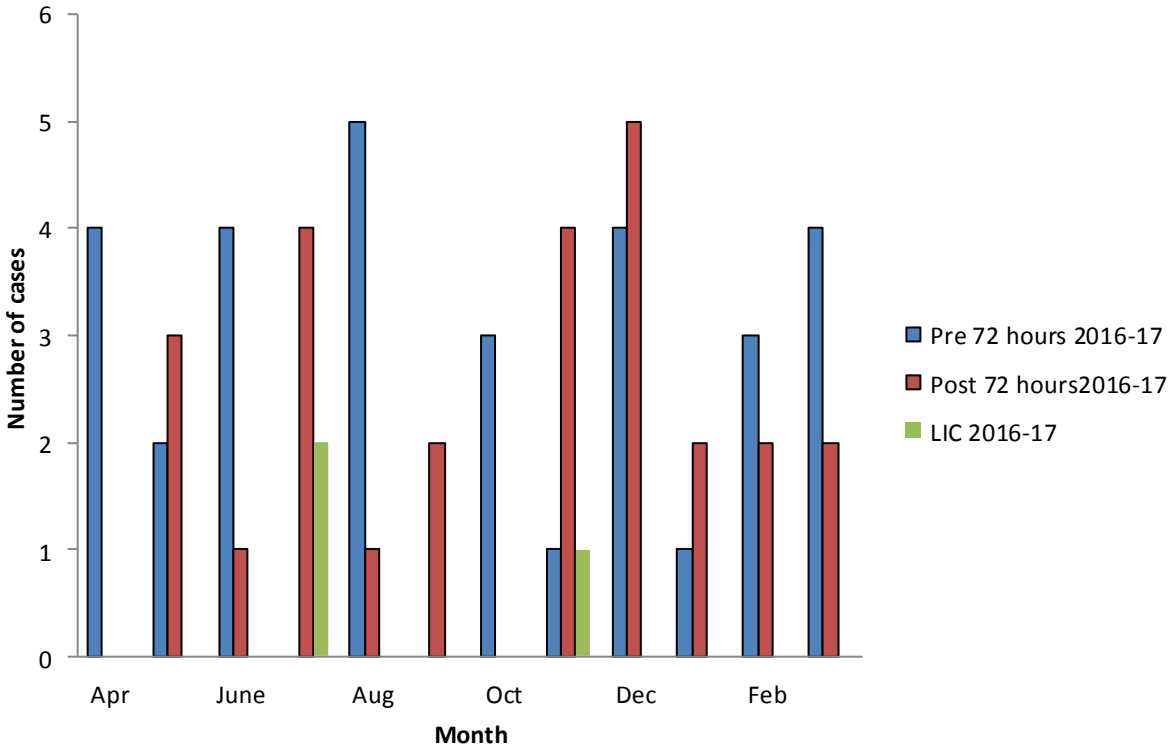
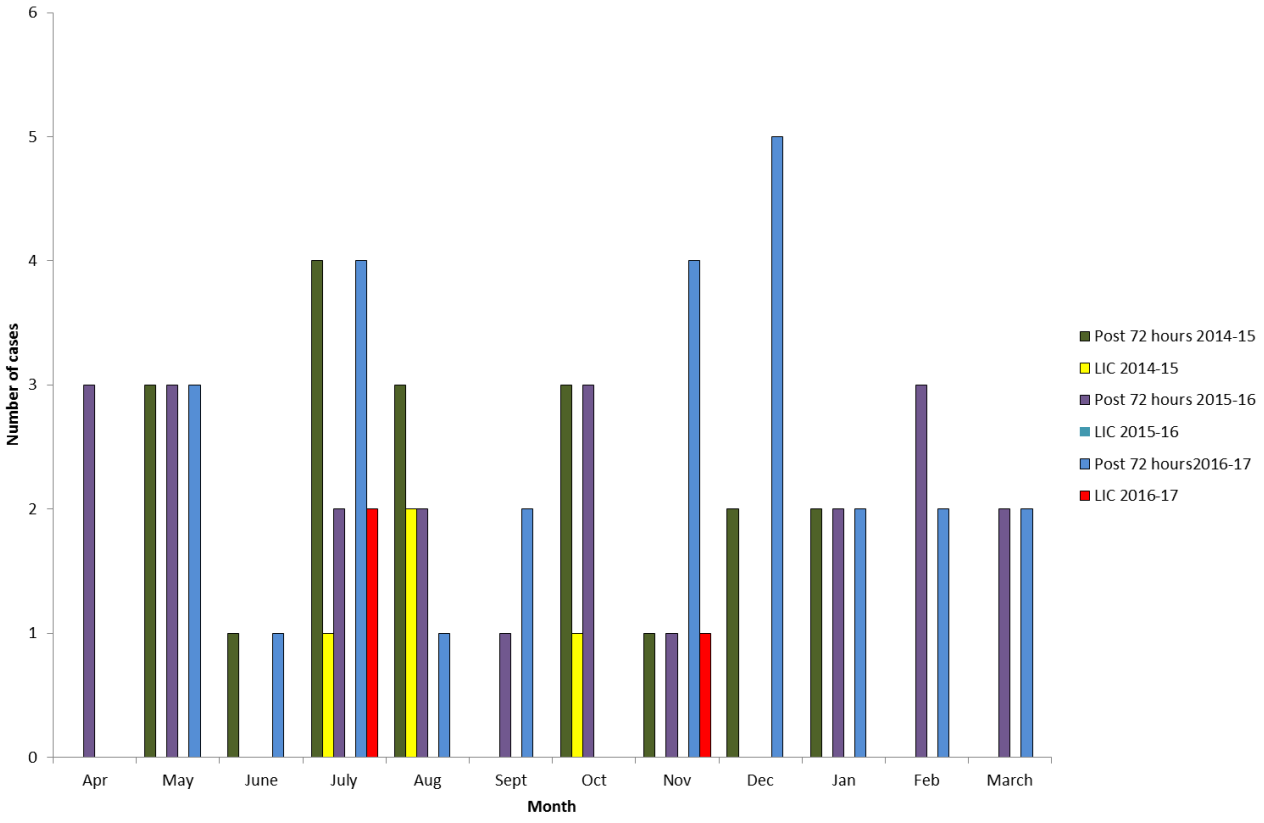


Figure 3 below shows that the number of post-72 hour cases of CDT increased in 2016-7 from the previous two years, although the number of cases considered lapses in care in 2016-2017 were less than in 2014-2015:

Figure: 3 Comparison of post-72 hour CDT cases in The Christie Hospital 2014/17



As part of addressing this increase in CDT, the Director of Infection Prevention and Control (DIPC) convened a quality improvement collaborative group with senior nursing staff, allied health professionals (AHPs) and other stakeholders to create and test changes in practice to reduce healthcare-associated infections (HCAI). These have included a new stool chart and wards carrying out their own hand hygiene audits and feeding them back.

As part of this work an analysis of all CDT cases to date was undertaken by the Infection Prevention and control team (IPCT) and a report produced for the Infection Prevention and Control Committee. (IPCC). This showed that the median time to CDT acquisition was nine days with a range of three to 63 days. Only 18% (4) of the cases reviewed were symptomatic on admission and we could only ascertain a delay in sampling on two occasions. The audit also demonstrated that many of the areas affected by PII had bed occupancy rates of over 90% when 82% is considered by the Trust as the efficiency benchmark. There were only two cases in which there was a delay of over twenty-four cases in isolating a patient with suspected CDT due to availability of side rooms and a risk assessment of each case.

2.2 Meticillin resistant staphylococcus aureus (MRSA)

A total of 49 new cases of MRSA colonisations/infections were identified during the financial year. The majority of patients identified as MRSA positive are colonised and not infected with the organism and found on admission. The Trust screens all patients for MRSA as follows:

- Elective admissions to the trust
- Admitted patients
- Day cases-including procedures
- Inter-hospital transfers
- Emergency admissions
- All patients admitted to Palatine ward and/or the Oncology Critical Care Unit (OCCU) will be screened on admission and weekly thereafter.
- All patients admitted to the Young Oncology Unit(YOU)

The Trust trajectory for MRSA bacteremia was 0 for the period 2016/17.The Trust has had one MRSA bacteremia which was associated with the community and one which after a Post Infection Review (PIR) led by the Director of Infection Prevention and Control was accepted as being attributable to the Trust. This is the first MRSA bacteremia that has been attributable to the Trust since 2013.

The results of the PIR were distributed to relevant stakeholders in the Trust and actions from the PIR included the distribution of a transmission-based precautions training package.

There were 20 MSSA bacteremia in the Trust during this financial year, all of which had a root cause analysis (RCA) completed by the Infection Prevention and control team (IPCT) and relevant ward manager.

Figure 4: MRSA cases 2016-2017 (including MSSA bacteremia)

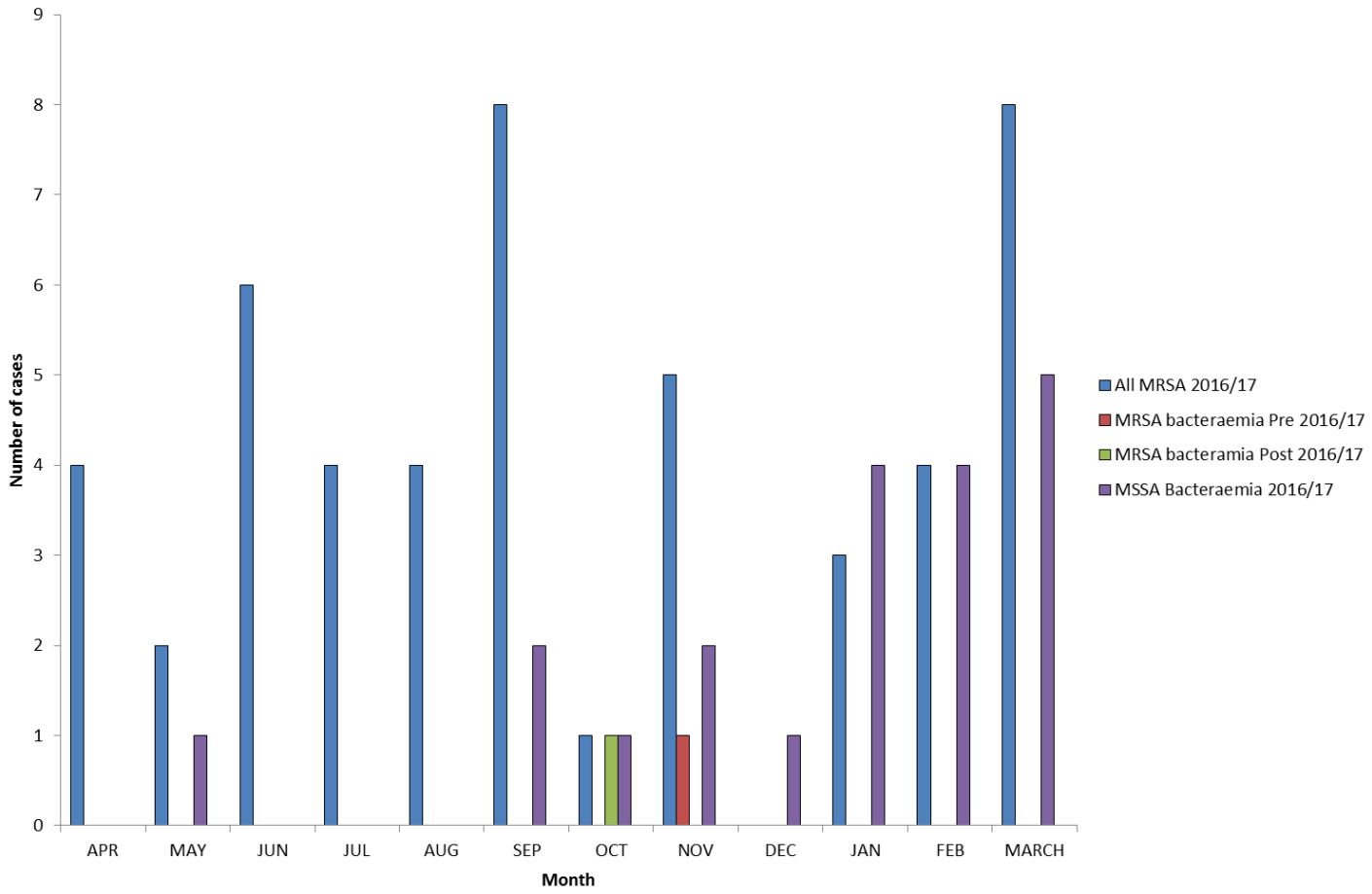


Figure 5 below represents all MRSA cases (including colonised and infected patients) in the financial years 2015-2017. This shows that there has been a reduction in all MRSA cases of about 28% from 2015/6 to 2016/7.

Figure 5: MRSA cases 2015-2017

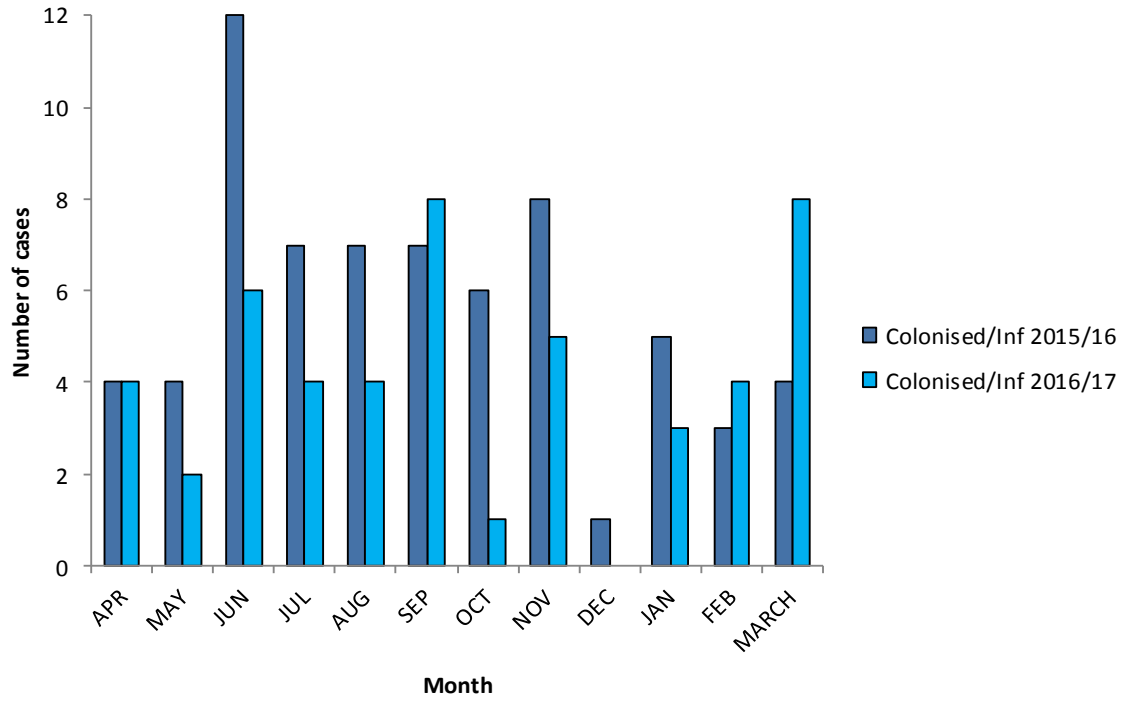
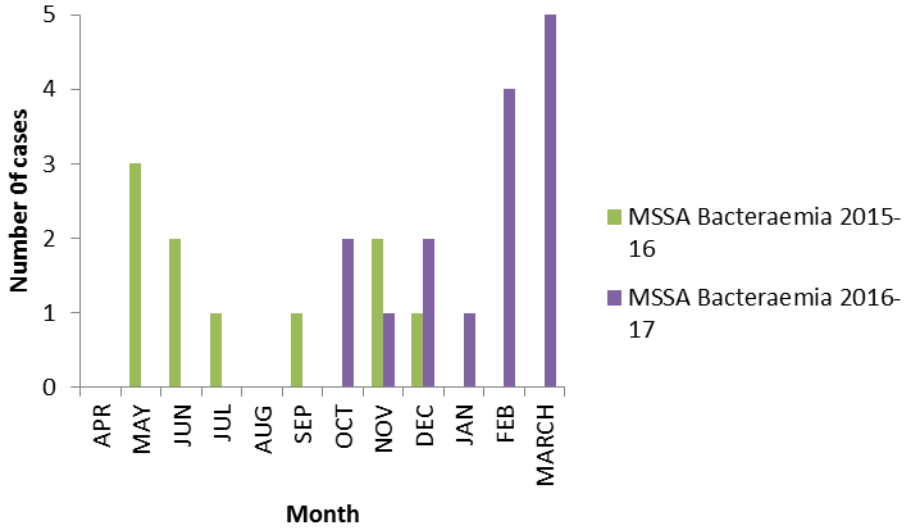


Figure 6 below represents MSSA bacteremia cases 2015-2017 and shows a small increase of 5 cases between the two financial years. MSSA bacteremia will be included in the new quality improvement collaborative to reduce key healthcare-associated infections at The Christie Hospital in 2017-2018:

Figure 6: MSSA bacteremia cases 2015-2017



Glycopeptide resistant enterococci (GRE)

There have been ninety two (92) colonisations with Vancomycin-resistant enterococcus (VRE) and twelve (12) VRE bacteremia during this financial year

The majority of the colonisations were identified on Palatine Ward (33) and Ward 12 (34), with 25 cases across the rest of the Trust.

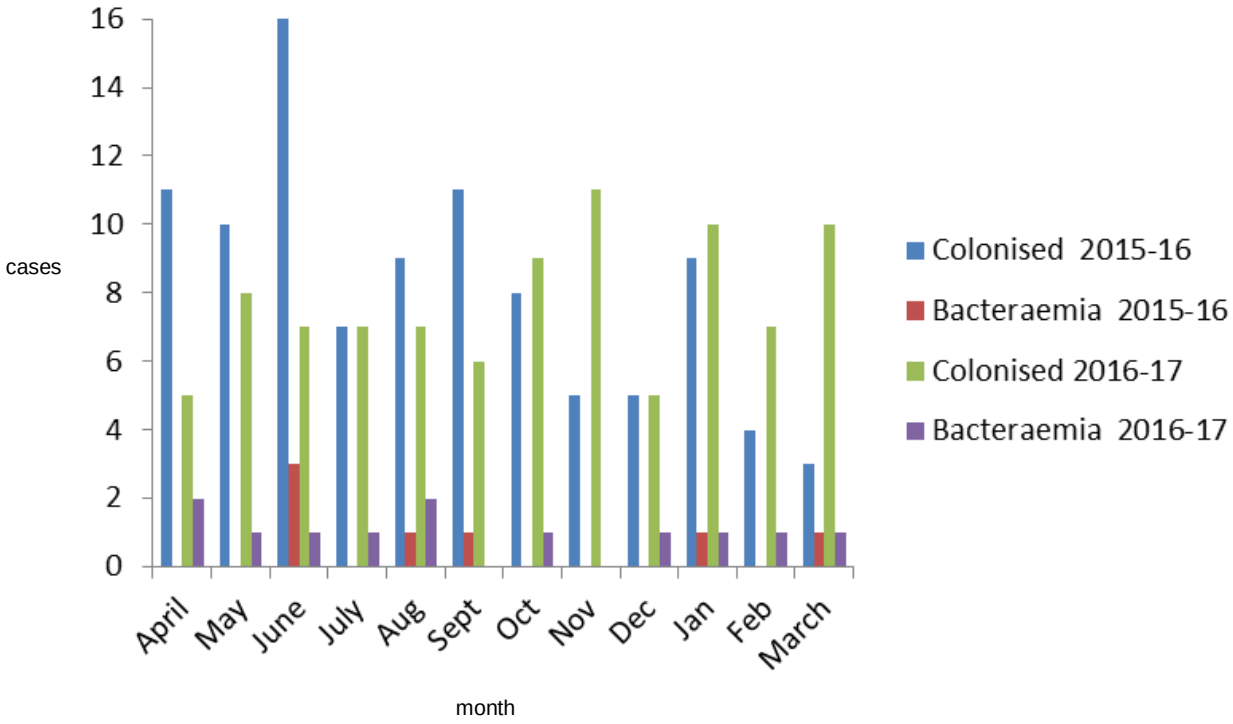
The VRE bacteremia cases are distributed as follows:

- 8 cases on Palatine Ward
- 3 cases on Ward 11
- 1 case Ward 4

Figure 7 below shows that there has been a 5% reduction in VRE colonisations between 2015/6 and 2016/7.

VRE bacteremia have risen 28% from ten to fourteen cases in the same time period.

Figure 7: VRE in the trust 2015/17

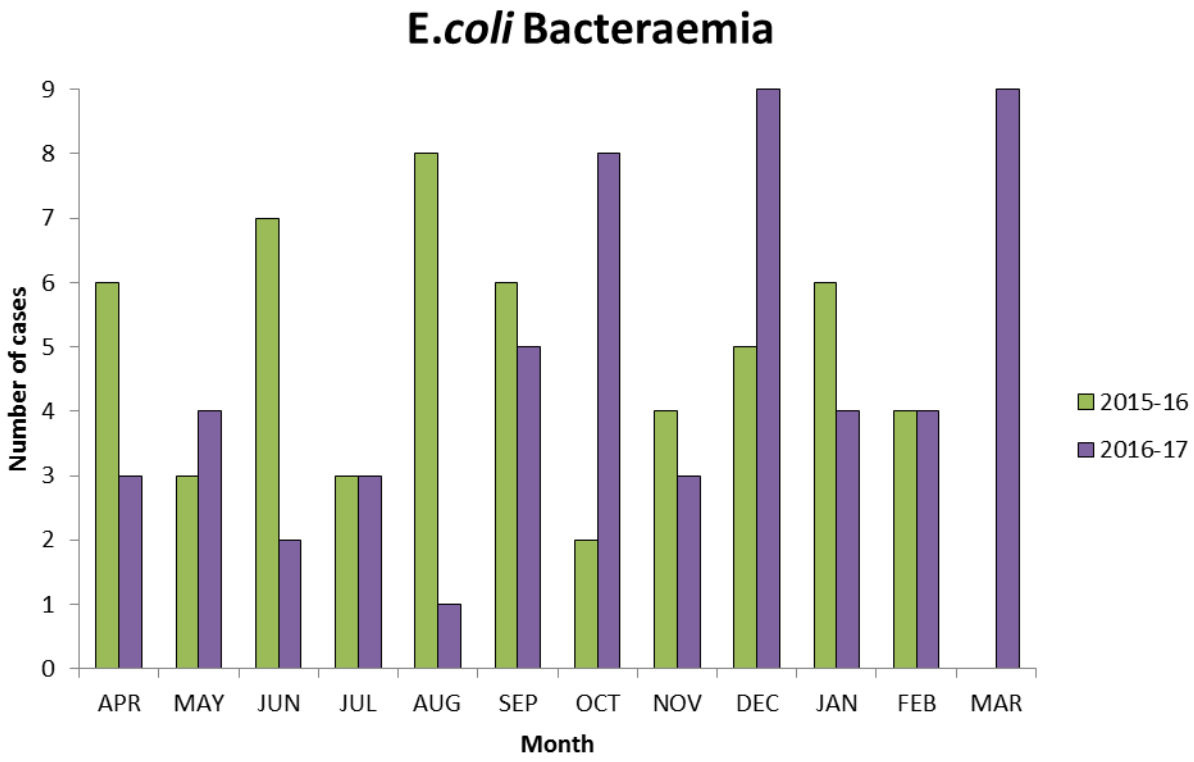


2.4 *Escherichia coli* bacteremia 2015/17

Figure 8 below shows the *E.coli* bacteremias recorded in the Trust for 2015-2017. There have been 54 cases in 2015/6 and 55 cases 2016/7.

E.coli bacteremias will be included in the trust healthcare-associated infection reduction targets for 2017-2018 and will form part of a Department of Health (DH) reduction programme with an expected reduction of 20% by 2020.

Figure 8: *E. coli* bacteremias at the Christie Hospital 2015-17

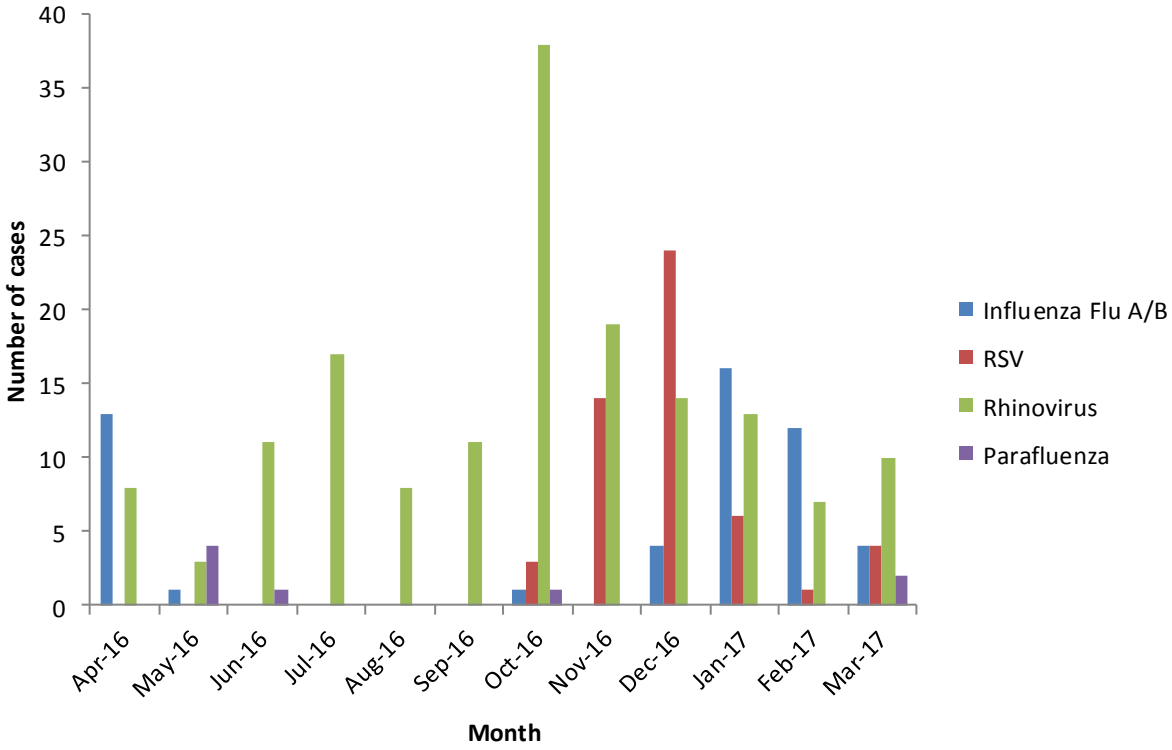


2.5 Respiratory virus surveillance

The majority of respiratory viruses are found in outpatients in particular the Haematology Day Unit (HTDU). Seasonal spikes occur during the influenza season and the number of cases reduces during the summer months.

During 2016-2017 the IPCT worked with the team on the HTDU to introduce the concept of a respiratory hygiene station where patients with a symptomatic respiratory virus are segregated from other patients.

Figure 9: Numbers of respiratory viruses at the Christie Hospital 2016-2017



2.6 Other alert organism surveillance.

In addition to the organisms above, surveillance is undertaken on other organisms as they arise including:

- Tuberculosis
- Haemolytic streptococci
- Varicella zoster virus
- G-I viruses
- Multi-drug resistant organisms (e.g. AmpC producing organisms, CPEs, ESBLs)

Four organisms are reported via the mandatory surveillance system:

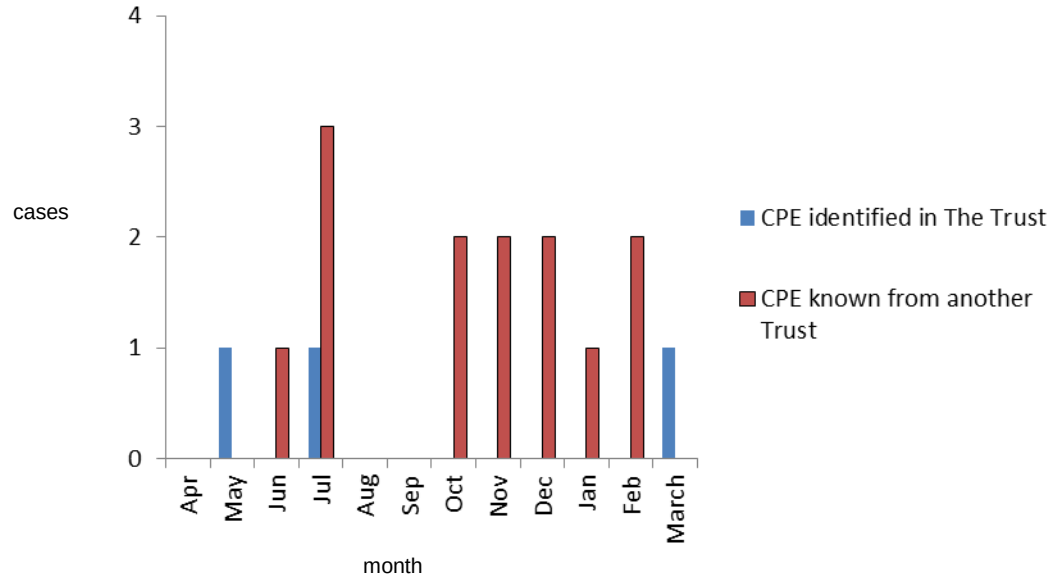
- CDI
- MRSA bacteraemia
- MSSA bacteraemia
- E coli bacteraemia

2.7 Carbapenemase-producing enterobacteriaceae (CPE)

During 2016-2017, the majority of patients identified with CPE in the trust have come from other hospitals and specifically Manchester Royal Infirmary (MRI) and Wythenshawe hospital.

Only three CPE cases have been identified for the first time in the hospital during this period.

Figure 10: CPE in the Christie Hospital 2016-2017



During 2016-2017 all patients admitted to Palatine ward were screened for CPE. In line with Public Health England (PHE) recommendations in 2016-2017 a plan was formulated and agreed to screen all patients being admitted on the basis of a risk assessment to ascertain if they had been in a high risk hospital in the United Kingdom or in a hospital abroad.

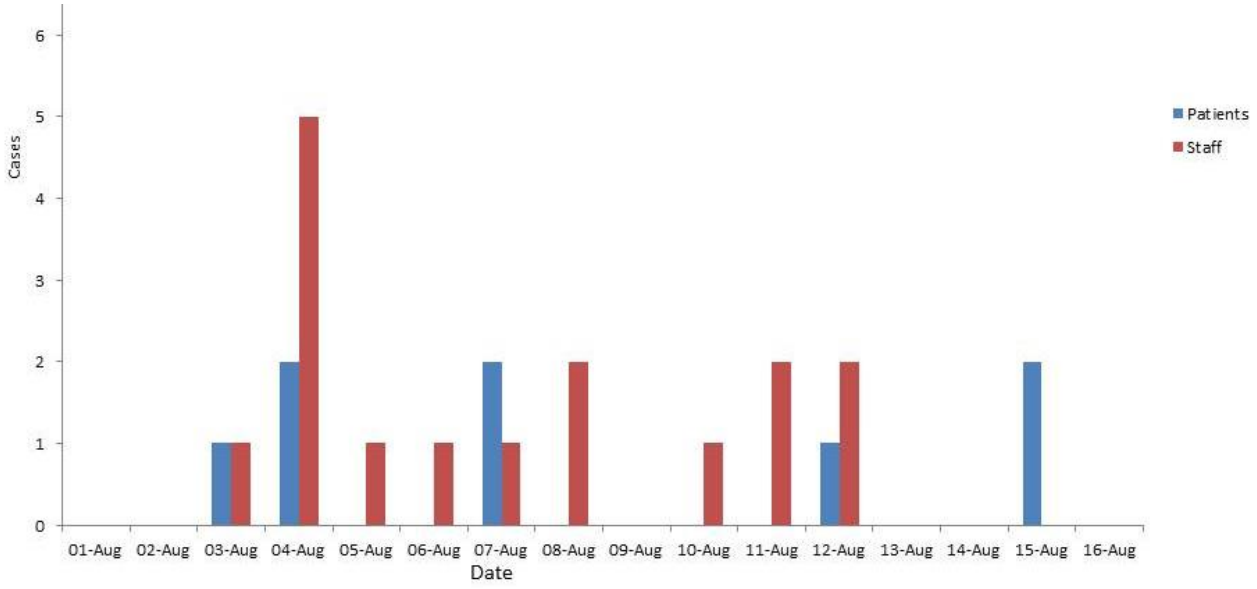
This will be introduced in April 2017 after training for staff from the Infection Prevention and Control Team (IPCT)

2.8 Outbreaks

In August 2016, a gastrointestinal outbreak was declared on ward 12.This is the first outbreak that the Trust has recorded. From patient samples norovirus was isolated. The outbreak affected 8 patients and 16 members of staff and was finally declared over on the 16th August 2017 when the ward was declared open after a deep clean.

Figure 11 below represents the epicurve of the outbreak and shows both patient and staff cases.

Figure 11: Epicurve for the norovirus outbreak on ward 12 in August 2016



A post-outbreak group was convened to look at what had been done well and what could be improved. As a result of this group outbreak tools to help identify an outbreak situation were added to the Duty Manager folder and were widely distributed in the hospital.

2.9 Other surveillance systems

2.9.1 Catheter-associated urinary tract infection (CAUTI) surveillance
Surveillance of catheter associated urinary tract infections is monitored weekly through a point prevalence audit undertaken by the IPCT. The Trust has very small numbers of CAUTI's and none were identified as being attributable to the Trust

2.9.2 Surgical Site Surveillance (SSI)
In January 2017 a trial of surgical site surveillance was introduced on the surgical wards at the Trust. This included data collected by ward staff as well as data being collected by the Infection Prevention and Control team.

This has concentrated on Cyto-HIPEC surgeries and a procedure involving the breast. It is anticipated that data from this programme will be fed back in May 2017.

2.10 Antimicrobial Resistance and Invasive Isolates

2.10.1 Blood culture isolates (bacteraemias) 2016

Blood culture is one of the most important investigations undertaken by the microbiology laboratory as positive results typically represent invasive infections. It is important to monitor resistance in these isolates.

7972 blood culture examinations were undertaken, producing 631 positive sets in 355 patients: an overall positivity rate of 7.9%. (These figures include Christie Clinic locations). Table 1 shows the frequency of isolation of the 10 most common organisms in patients with positive cultures and includes both community-acquired and hospital-acquired infections. The largest number of blood cultures was collected from Palatine Ward (2478) and the Oncology Assessment Unit (1464), with 194 and 90 positive sets respectively. National data shows that the number of Gram negative blood stream infections continues to increase (English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) 2016). Between 2014 and 2015, bacteraemias due to *Escherichia coli* and *Klebsiella pneumoniae* rose by 4.6% and 9% respectively. There was a 23% reduction in *S. pneumoniae* bloodstream infections between 2010 and 2014.

Table 1. Most common isolates in bacteraemia (all patients & locations) 2016

Organism	**No. of isolates (patients) 2016**
Coagulase negative staphylococci	**183 (115)**
*Escherichia coli**	**97 (65)**
Enterococcus faecium	**65 (33)**
Klebsiella pneumoniae	**45 (30)**
Pseudomonas aeruginosa	**22 (15)**
Enterococcus faecalis	**15 (12)**
Candida albicans	**14 (7)**
Enterobacter cloacae	**14 (8)**
*Staphylococcus aureus**	**17 (14)**
MRSA	**3 (3)**
MSSA	**14 (11)**
Klebsiella oxytoca	**13 (6)**

** Results are not deduplicated as per national Mandatory HCAI data, so figures will not correspond with MRSA/MSSA bacteraemia figures and trajectories reported elsewhere.*

Table 2. Most common isolates in bacteraemia (Haematology patients) 2016

Organism	**No. of isolates (patients) 2016**
Coagulase negative staphylococci	**103 (52)**
*Escherichia coli**	**33 (18)**
Enterococcus faecium	**42 (17)**
Klebsiella pneumoniae	**17 (9)**
Streptococcus mitis	**10 (6)**
Pseudomonas aeruginosa	**7 (5)**
Streptococcus pneumoniae	**5 (5)**
Rothia mucilaginosa	**5 (4)**
Enterobacter cloacae	**5 (3)**
*Staphylococcus aureus**	**6 (3)**
MRSA	**1 (1)**
MSSA	**5 (2)**
Leptotrichia trevisanii	**4 (3)**

** Results are not deduplicated as per national Mandatory HCAI data, so figures will not correspond with MRSA/MSSA bacteraemia figures and trajectories reported elsewhere.*

2.10.2 Resistance in blood culture isolates 2016

Across England and Wales between 2014 and 2015, antibiotic use reduced significantly across the whole healthcare system (by 4.3%) for the first time (ESPAUR 2016). Antimicrobial resistance is stable in pneumococcal and *Pseudomonas* bloodstream infections. However, vancomycin resistance in bloodstream infections caused by *Enterococcus* spp. rose from 10% to 16% between 2011 and 2015. There were 27 isolates of glycopeptide-resistant enterococci from blood from 11 patients at the Christie in 2016, of which 16 isolates in 5 patients were from Palatine ward.

The proportion of bloodstream infections resistant to piperacillin-tazobactam (the most frequently used antibiotic for the treatment of sepsis) rose dramatically between 2011 and 2015, from 8.5% to 11.7%

for those caused by *E. coli* and from 12.6% to 18.5% for *K. pneumoniae.* This highlights the importance of reducing the use of piperacillin-tazobactam, as well as carbapenems, to reduce the emergence and subsequent spread of resistance. Carbapenem resistance remains low in bloodstream infections in England (*E. coli* 0.2% and *K. pneumoniae* 1.1%).

Christie hospital susceptibility patterns in Gram negative organisms (*E. coli, K. pneumoniae* and *P. aeruginosa*) are shown in table 3. These patterns are broadly similar to national figures (see below), except that we have higher rates of resistance in commonly used broad-spectrum oral agents, co-amoxiclav and ciprofloxacin. Nationally, the proportions of *E. coli* isolates that were non-susceptible in 2015 were 19% for ciprofloxacin, 12% for third-generation cephalosporins, 9% for gentamicin, 19% for piperacillin-tazobactam, 42% for co-amoxiclav and 0.2% for meropenem. For *K. pneumoniae*, non-susceptibility figures were 11% for ciprofloxacin, 11% for third-generation cephalosporins, 10% for gentamicin, 12% for piperacillin-tazobactam, 28% for co-amoxiclav and 1.1% for meropenem. It is important that we also avoid inappropriate use of oral antimicrobial agents.

Table 3. Gram negative resistance in blood isolates at The Christie, 2016

Organism	Antibiotic	Susceptibility in Christie isolates 2016 (%)
E. coli (97 isolates)	Amoxicillin	**34**
	Co-amoxiclav	**58**
	Gentamicin	**91**
	Ciprofloxacin	**73**
	Piperacillin-tazobactam	**91**
	Meropenem	**100**
	ESBL positive	**2**
K. pneumoniae (45 isolates)	Co-amoxiclav	**60**
	Gentamicin	**87**
	Ciprofloxacin	**87**
	Piperacillin-tazobactam	**91**
	Meropenem	**100**
	ESBL positive	**16**
P. aeruginosa (22 isolates)	Ceftazidime	**95**
	Gentamicin	**100**
	Ciprofloxacin	**86**
	Piperacillin-tazobactam	**95**
	Meropenem	**91**

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3 Environmental Audits

3.1 Infection Prevention and Control Team Environmental Audits

Infection Prevention and Control environmental audits are a requirement of the *Code of Practice for the prevention of healthcare-associated infection (*Health and Social Care Act 2008-updated 2015).

The standards used in the audit use the most up to date guidance and incorporate the latest standards and guidelines as well as incorporating the Infection Prevention Society's Quality Improvement Tools.(2015)

Scoring

In line with Department of Health (DH) initiatives, compliance categorisation has been incorporated into the scoring system to provide a clear indicator of compliance. The allocation of compliance levels is based on the scores obtained. The scoring system is worked out using the DH formula:

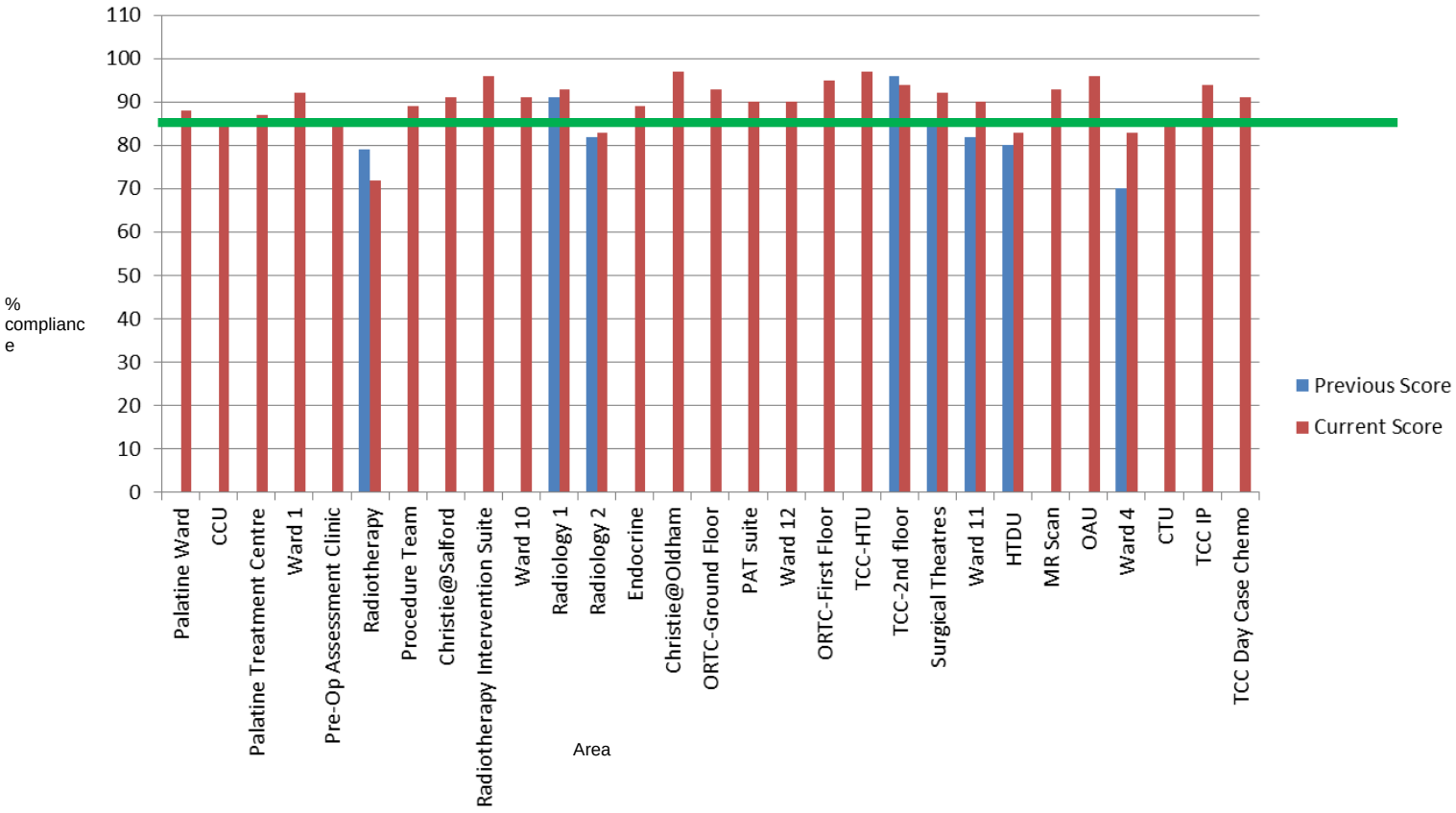
$$\frac{\text{Total Number of yes answers}}{\text{Total number of yes and no answers}} \times 100$$

The score is then categorized into a compliance level against infection control standards:

Full Compliance	85%+	Audit again within one year
Partial Compliance	76 – 84%	Audit again within 6 months
Minimal Compliance	75% or less	Audit again within 3 months

After every audit an action plan is issued and the area has three months to return it to the IPCT. Poorly performing areas are re-audited again according to the matrix above and are assisted to complete as much as their action plan including mitigating interventions if something cannot be achieved.

Figure 12: IPCT annual audit programme



85% indicates FULL compliance

3.2 Frontline Ownership (FLO) Audits

In September 2016, the IPCT introduced the FLO audit.The aim of the FLO audit is to provide ward managers and matrons/senior managers that staff are adhering to the best possible infection prevention and control practices.

The audit covers ten areas crucial for infection prevention and control and based on best available evidence and policy, as well as hand hygiene audits.

The FLO audit tool is completed monthly and results are feedback to the ward/department team to action any non-compliant issues. A whole hospital document is also produced by the IPCT for senior nurses which looks at common themes for improvement purposes.

Themes identified during the year have highlighted among others sharps safety, storage issues and patient hand hygiene which have been addressed at a ward level.

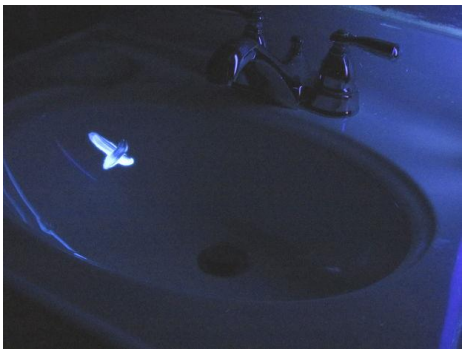
For 2017-2018 we are anticipating that these audits will be completed electronically in the new IC Net surveillance system.

3.3 Ultraviolet (UV) Marking Audits

In May 2016, the Infection Prevention and Control Team launched a programme of UV marking for dirty utility rooms in all areas of the trust. At least two wards a week are marked including commodes as well as other high touch areas in the room. These are then being fed back to ward managers and the cleaning supervisors.

Ultra violet marking (UVM) refers to the application of an ultraviolet marker on a surface in a hospital ward which fluoresces under black light and verifies the compliance of domestic staff with cleaning protocols by confirming whether or not a surface has been cleaned.

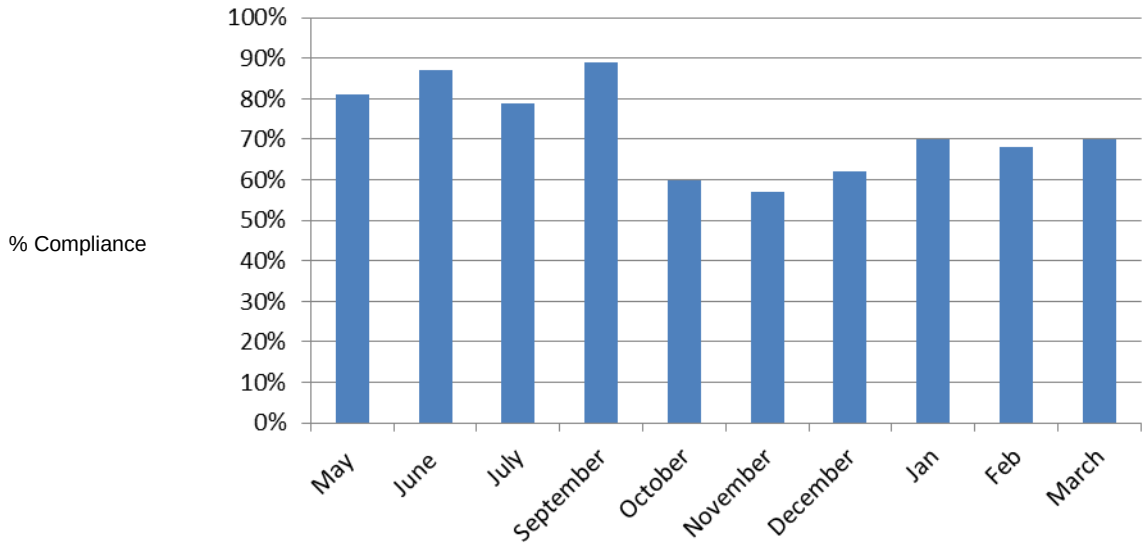
Generally a UV marker is placed on various locations in a clinical area which are considered high use- they are then reviewed 24-48 hours later to see if they have been effectively cleaned and scored to produce an audit result. See below for an example of a UV marker and the equipment required to apply it:



(Photos from http://www.instructables.com/id/How-to-Conduct-a-Cleaning-Audit-Environmental-Ser/?ALLSTEPS)

These techniques are generally used in conjunction with traditional methods of auditing cleanliness which rely on visual checks to provide reliable data on the effectiveness of cleaning in clinical areas. Results are given to cleaning supervisors and ward managers so that remedial action can be taken and used for education purposes

Figure 13 Percentage Compliance results by month from UV Marking audits 2016-2017



4. Education

4.1 Infection Control Champions

The Infection Control Link Worker programme was rebranded as the Infection Control Champion programme with new resources (including an educational folder and a monthly newsletter) and study days replacing the quarterly 1 hour sessions.

Two study days have been held in 2016-2017 with a total of 64 Champions attending. These sessions have been undertaken with the Tissue Viability Nurse and the Diabetes specialist nurse with sessions about audit and quality improvement being held in common. The study days have been very well received and there are future plans for study days with the Manchester community infection control team.

Recruitment to the programme is ongoing and we currently have fifty five members of staff signed up as Champions including allied health professionals and Champions from new areas like the bed management team.

The Champions have been linked with the Infection Prevention and Control Nurse (IPCN) for their particular area to provide coaching and ongoing support. IPCNs have also assisted Champions by providing feedback for their Nursing and Midwifery Council (NMC) revalidation where appropriate

4.2 Mandatory and other training

The IPCT provides education on the combined essential training day for all staff and volunteers. During 2016-2017, the IPCT also provided tailored training to an additional 49 members of staff from Estates and Facilities, Portering, the Outreach team, dieticians, Outreach Homecare and Outpatient Health Care Assistants (OPD-HCAs).

The Infection Prevention and Control Team (IPCT) also introduced a self-directed learning package with a competency framework which could be used by all members of staff. This was trailed successfully on Ward 4 with the competency framework being signed off by Band 6 ward sisters for

junior staff. This package went to medical staff, allied health professionals, and nursing as part of the response to the increase in CDT cases.

5. Quality Improvement

5.1 Quality Improvement Projects

6. Trial of digital assurance framework on ward 11 for hand hygiene. This involved use of the Sure Wash hand hygiene technique training machine, automated sensors for alcohol-based hand rub (ABHR) containers, IPCT hand hygiene auditing and a website that the ward manager could access to see how the ward was performing. Article to be submitted to an appropriate journal.
7. Isolation Priority Matrix developed for bed and duty managers. Daily ward rounds from IPCT to advise on patients in side rooms.
8. Development of IPCT mission statement and allocation of individual IPCNS to wards/departments.
9. 'Good job' cards-staff engagement project to engage staff when good practice is seen. These can be used for feedback for NMC revalidation and are entered into a monthly competition.
10. Personal protective equipment (PPE) card-development of a card which is designed to go with staff ID cards which gives basic information about alert organisms, how they are transmitted, and what PPE to wear when looking after patients with these organisms.
11. Review of deep cleaning procedures on Palatine ward and creation of a Red Amber Green (RAG) matrix to decide what type of clean a room requires. This has freed up the Deep Clean team to enable them to clean all rooms which have had a patient with *Clostriduim Difficile* Toxin (CDT).
12. Creation of respiratory hygiene station for patients attending the Haemotology Day Unit(HTDU) to reduce the risk of transmission of respiratory viruses in the HTDU reception area.
13. Antibiotic ward rounds with microbiology and pharamacy
14. CDT collaborative has produced the following quality improvement interventions:
    1. Hand Hygiene taskforces-led by staff on the ward to carry out hand hygiene auditing and feedback to colleagues
    2. Improved stool chart and assessment form for patients with diarrhoea.
    3. 'It's okay to ask' poster campaign

5.2 Awareness Campaigns

- World Hand Hygiene Day May
- Infection Prevention and Control Week September
- Antimicrobial awareness day November
- Diarrhoea awareness week March
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The team has run competitions, provided prizes and campaign materials to all areas in the hospital during these campaigns.

6. Facilities

The IPCT continues to provide advice and monitor construction and maintenance work across the Trust. The risk of aspergillus infection to immunocompromised patients is assessed prior to the start of any works with regular assessments being conducted throughout.

The IPCT provide specialist advice at the start of any schemes to estates, the architects, the builders and contractors.

During the past year the IPCT have been extensively involved in providing advice and monitoring of:

- Proton Beam
- Ward 4

- MR scanners
- IPU

7. Committees

The Infection Prevention and control Team send representatives to the following meetings:

- Health and Safety Committee
- Medical Devices and Procurement Committee
- Infection Prevention and Control Committee
- GM Safety Committee
- Pathology Lab Safety Committee
- Drugs and Therapeutics Committee
- Water Safety Committee
- HTU Quality Meetings
- Nosocomial Infection Performance Review meetings
- Cleaning Operational Group
- Cdiff collaborative meetings

8. Management of water systems

The water safety committee meets quarterly and reports to the infection prevention and control committee. Infection Prevention and control also meets monthly with the Estates and Facilities supervisor for water management to look at water sampling issues and remedial actions being taken.

9. Conclusion

2016-2017 has had its challenges for infection prevention and control at the Christie Hospital with rises in CD and MSSA bacteremia, although we have seen reductions in MRSA and VRE colonisation. The team has shown a strong commitment to quality improvement and this will continue into 2017-2018.