The Royal Wolverhampton NHS
NHS Trust

CHIEF EXECUTIVE's SUMMARY REPORT

This summary sheet is for completion by the Chair of any committee/group to accompany the minutes required by a trust level committee

Name of Committee/Group	Infection Prevention and Control Committee (IPCC) held on 22 March 2013 and 26 April 2013
Report from:	Chief Nursing Officer
Date:	Minutes dated 22.03.13 and 26.04.13 to Trust Board 20.05.13

Action required by receiving committee/group:	☑ For information ☐ Decision ☐ Other

Aims of Committee: Bullet point aims of the reporting committee (from Terms of Reference)	To provide strategic direction and decision-making for IPCC. To review the Trust and operational performance against IPCC targets.

Drivers: Are there any links with Care Quality Commission/Health and Safety/NHSLA/Trust Policy/Patient Experience etc.	• Care Quality Commission (CQC) compliance • NHSLA • NICE guidance

Main Discussion/Action Points	**22 March 2013** • Draft minutes approved at IPCC on 26 April 2013 – no significant amendments • Points of note as reported to Trust Board on 22 April 2013 **26 April 2013 – draft minutes** • IPCC observed by visitors from North Cumbria PCT • Medical staff will not be eligible to apply for CEA awards if mandatory training has not been completed • CJD policy approved • Terms of Reference reviewed (TMT approval, May 2013) • Weekly meetings held by Public Health to monitor measles vaccinations across the city (RWT – 5,394 staff vaccinated, 600 outstanding) • Final flu vaccinations rate - 53% (West Midlands average 42%) • Haematology/Oncology directorate presented approach to reducing DRHABs to assure IPCC • New CDI target 2013/14. RWT – 39 cases, Wolverhampton – 65 cases • PLACE assessment due week commencing 29 April 2013 • IV Team/OPAT presentation on impact to date

Risks Identified:	Compliance with C.Difficile target

DRAFT

Minutes of Infection Prevention and Control Committee

Date **26th April 2013**

Venue **Board Room, Clinical Skills Building**

Time **10am – 12noon**

Present:	David Loughton (Chair)	**(DL)**	Chief Executive Officer
	Cheryl Etches	**(CE)**	Chief Nursing Officer
	Jonathan Odum	**(JO)**	Medical Director
	Ian Badger	**(IB)**	Medical Director – Division 1
	Dr Suneil Kapadia	**(SK)**	Medical Director – Division 2
	Katie Spence	**(KS)**	Consultant in Public Health
	Vanessa Whatley	**(VW)**	Infection Prevention Lead Nurse
	Sandra Roberts	**(SR)**	Head of Hotel Services
	Professor Ray Fitzpatrick	**(RF)**	Director of Pharmacy
	Dr Mike Cooper	**(MC)**	DIPC/Consultant Microbiologist
	Tom Butler	**(TB)**	Action Head of Estates
In Attendance	Julie Sharp	**(JS)**	Nurse Manager OHWB
	Kerry Anelli	**(KA)**	Matron Surgery Urology
	Rose Baker	**(RB)**	Head of Nursing – Division 2
	Jonathan Swindells	**(JS)**	Microbiology SPR
	Maurice Hakkak	**(MH)**	Group Manager Cancer Services
	Amanda Watts	**(AW)**	Matron
	Dr A Jacobs	**(AJ)**	Consultant Haematologist
Apologies	Dr Janet Anderson	**(JA)**	Non-Executive Director

Item No		Action
1.	**Welcomes and Apologies**	
	IPCC welcomed visitors from North Cumbria PCT who joined the committee to observe. Apologies were received from Dr Janet Anderson	
2.	**Minutes and Actions of meeting 22nd March 2013**	
	Were agreed with one amendment on page 5 of 8 last paragraph should read as follows: **PT** asked if there was any reason why staff could not purchase left over food, **SR** replied that this was not feasible due to staff not being able to reheat, reheated food, which means the food would need to be consumed immediately and would lead to various issues.	

3.	**Matters Arising**	
	3.1 Medical staff not completing their mandatory training will no longer be eligible for CAA awards. Concerns were raised by the committee that this did not give enough assurance that full compliance on mandatory training is being carried out. The committee agreed that two written warnings should be given followed by a disciplinary process. **MC** has agreed to take this forward.	
	3.2 CJD Policy This has been forwarded to TMT and discussed with Divisions and theatres. **VW** is awaiting feedback from Marion Washer on how to implement the CJD policy in the most efficient way. A small implementation group including endoscopy and cardiac is to be arranged to take this forward.	**MC**
	3.3 Hand Hygiene Performance Report – Vanessa Whatley A new way of collecting data has been implemented across the Trust. Synbiotix commenced January 2013, in which data is being inputted on a monthly basis of 20 observations. The overall compliance with hand hygiene has been 95% but requires further motivation from medical staff, porters, therapists and patient areas to improve specific compliance. A hand hygiene campaign is being carried out by Infection Prevention to raise awareness. Community have been the least likely areas in returning data, this has been particularly challenging with the use of Synbiotix, but is being addressed. **PT** asked how porters are observed and monitored; **VW** replied that this is usually carried out within the ward environment. **SR** commented that further work was needed with porters to raise awareness in hand hygiene. **SR** to arrange meeting with porters and liaise with **VW** to organise training and feedback to IPCC within 2 months. **CE** commented that whilst overall the report looked a reassuring picture, it is expected that once safe hands is in place data should be expected to be considerably lower.	**SR/VW**
	3.4 IPCC Terms of Reference These have been revised with the addition of a general practitioner from the CCG to be included in the membership and also for reporting to be exception based. **DL** requested that a GP representative from South Staffs and Cannock areas should also be included into the IPCC TOR membership. ***Dr Jonathon Odum joined the meeting at this point.*** **RB** pointed out in the TOR membership that matron representation was for division 2 only. **VW** to amend to include division 1. **DL/CE/VW** to meet and discuss Care Homes in South Staffs areas and Infection Prevention Team across Stafford.	**VW** **VW** **DL/CE/VW**

4.	**Occupation Health & Well Being Report – Reported by Julie Sharp** Quarter 4 Sharps Injuries • 38 reported – 3 unknown sources/35 known sources • 2 doses were given to high risk patients for post exposure of HIV – upon testing results were negative. • 38 reported – 7 have not completed DATIX incident reports, 6 of which were Doctors. Work is being carried out to improve DATIX compliance. **CE** enquired on cost pressure with regard syringes and if had gone into this year's budget. **JS** to check with Procurement and draft e-mail for **DL** to send to consortium enquiring on purchase of syringes across the patch. ***Maurice Hakkak, Amanda Watts, Dr Jacob from CHU joined the meeting at this point.*** Measles Status **CE** enquired with regard to measles status what was happening with the 600 staff that remain outstanding for immunisation. There are currently 5,394 staff immunised, with combinations of blood test results or MMR vaccines. From results received back there are 154 Acute/23 community were negative, in which the majority have been or are in the process of being vaccinated. Occupation Health are currently in the process of ensuring that staff are not DNA their appointments. The 600 existing staff outstanding across community, lists have gone out to managers with information for drop in centres and visits with appointments also going to staff. The majority of staff are in low risk areas, but there are 6 outstanding in paediatrics and 3 neonatal.in which message have out to their managers to inform them that these staff need to go to Occupational Health for screening ASAP. There are also 5 on AMU, 2 CCU, 2 in emergency department in which Occupation Health will be following up. **CE** asked if these had been escalated to division level, **RB** responded that staff have been informed that if they do not attend there next appointment then they would not be allowed back into work. Public Health are currently organising meetings on a weekly basis to discuss measles across Wolverhampton City which is being led by Katie Spence. A September deadline has been implemented for vaccination within the community. **VW** suggested that maybe this deadline should be implemented for staff within the Trust. **JS** agreed. Bank staff have also been identified for screening and have been written to restricting them from high risk areas, **DL** commented that these staff should be excluded from working. Flu Vaccination Uptake The final percentage uptake for the 2012/13 campaign stood at **53%**, the West Midlands achieved **42%** and the national average was **49%**. We will be using the same approach for the 2013/14 campaign supported by lessons learned in 2012/13. ***Julie Sharp left the meeting at this point.***	**JS** **JS**

	Haematology/Oncology DRHABs - Report 2012/13 – Reported by Maurice Hakkak, Amanda Watts, Dr Jacobs **MH** thanked the committee for being invited to the meeting to discuss, what is currently being done across the directorate to reduce the number of DRHAB's in patients. The ultimate way to reduce DRHABs in patients is looking at hand hygiene and managing lines. A joint presentation was given by **MH, AW** and **Dr Jacobs** Work demonstrated within the presentation is being carried out with the consultation of both Infection Prevention and Microbiologists. Copy of the presentation to be distributed with the minutes. **MC** enquired how much had the work increased on haematology/oncology within the last 2/3 years. **AW** replied that haematology alone had increased by 24% within the last 2 years. **MH** commented that there were 50% more lines being inputted than 2 years ago. **MC** said a key point was that currently this is being recorded as straight numbers, rather than rates, but are now looking at to record this as a rate. So although numbers have increased the rates in terms of infections per 1000 line days might have actually decreased. This group of patients are inherently at high risk of getting infections and also have high risk procedures. **DL** said that after listening to the comments regarding the report it was highly unacceptable. Leadership was a key issue and he had already spoken to the Clinical Director from CHU. **DL** was not happy with the situation and said that this was causing harm to patients and that there were no excuses and performance needed to be changed. **DL** enquired how this compared to Christie or Homerton and that benchmarking in the report was inappropriate. **CE** enquired what risk register this was on, **MH** replied that this was part of infection generally to investigate this group of patients and went onto the risk register over 2 years ago. **CE** commented that mandatory training showed significant improvement in performance but asked what had made the change. **CE** asked in terms of clinical practice who assessed trained nurses on CHU in line care. **AW** replied this was carried out by the practice development nurse and nurse specialist. **CE** enquired where did the band 7's role fit into this on improvement of practice. **AW** replied that band 7's were going out onto the wards and spot checking daily and involving the patients to make them fully aware of the situation. **CE** asked how assured are CHU as a directorate that actions are taking place. **AW** said she was confident and has observed practices taking place and actions on the risk register are updated on quarterly basis, which is now due. **CE** stated although the directorate had reported this as a problem 2 years ago there does not seem to be any significant improvement and she is not assured that this has been a high priority for the directorate. **DL** asked if **MH/ AW/AJ** accepted that patients were being harmed and wanted substantial improvement within 2 months reporting back to IPCC. ***Maurice Hakkak, Amanda Watts and Dr Jacobs left the meeting at this point.***	**MH/AW/AJ**

5.	**Divisional Performance Reports**	
	5a Reported by Ian Badger • CDI – shows a good month within the report and is encouraging • Divisional performance demonstrates too much red within the report but most of the directorates have shown improvement in March. • Antimicrobial prescribing 57% head & neck is significantly different to their performance in other parameters, According to the data base this is not consultants, it is due to the new intake of junior doctors being unregistered and is being addressed. • DRHABs – there have been 2 general surgical patients both involving lines.	
	5b Reported by Suneil Kapadia • DRHABs X 4 relating to Renal Directorate - overall numbers have decreased over the year • Mandatory training – IP level 1 has significantly dipped over the last 3 months. The report shows numerous red areas and e-mails have gone out to the Clinical Directors requesting actions plans for proposals of current data. The IPCC date has also been circulated to them with a view to one be selected to attend the next meeting to provide an explanation. The committee agreed that this was the way forward and that accountability should be held at Directorate level. **VW** enquired what was being done to rectify DRHABs in renal. **RB** replied that and RCA investigation has been completed on one of the DRHABs but could not find anything that could be done differently on any of the others, but are investigating into this further. **JO** commented that with there being 4 within one month this did need to be investigated further to see if there is a common denominator. **CE** asked how assured was the Directorate that standards are being maintained and are we confident that there is good leadership. **RB** answered that Directorate were not confident, but action is underway.	
6.	**Action on Cd*ifficile* - Reported by Vanessa Whatley**	
	• Dashboard has been updated with the strategic objectives target being to reduce CDI cases with the requirement for 2014/15 is for RWT – 39 cases and across Wolverhampton 65 cases. • CDI cases have levelled from November 2012 since the Norovirus outbreak, which was probably due to the vast amount of hydrogen peroxide vapour being in constant use. • Time to isolate from symptoms and results has vastly improved; identifying 90% of patients within 2 hours, with the current pressures is a positive outcome. • HPV 8 days and on discharge has continued to improve and is very positive. • Improvement on relapse patient's needs to be addressed which are now higher in proportion of low quarterly numbers. This has been discussed with the CCG with a view to putting a business case together to look at the	

	business element and review of changing therapy given to patients for CDI. • CDI remains below regional target • CDI in accordance with the algorithm 95% - an improvement but requires further work. • Antibiotic prescribing according to Trust policy – 97% • Clinical Cases according to Algorithm – 66% **CE** commented that information within the report was very well presented. • Two companies supplying probiotic yogurts have presented in the Trust. The aim is to reduce antibiotic associated diarrhoea and subsequently some cases of *C. difficile*. Further information is being gathered to see if a trial is feasible in the Trust is in progress. • **JO** commented that it would be interesting to see a publication on this.	
7.	**Estates Report – Reported by Tom Butler**	
	<u>Water Safety Group</u> • Current temporary and fixed Chlorine Dioxide plants are producing good reserves of Chlorine Dioxide. • Installation of centralised Chlorine Dioxide system is partially installed, awaiting delivery of sampling equipment from Siemens. • Hydrop Legionella Consultants have started a site wide Legionella risk assessment including our community properties. This will take approximately 2 months to complete. • The previously reported low positive Legionella Pneumophila type one at OPD 2 room 004 Ground Floor Disabled Toilet is now clear. However following wider sampling of the area we found a subsequent Legionella Pneumophila type one at 400cfu/l from the sink located in Staff Kitchen / rest area. As a precaution the block was correlated and are awaiting the results. <u>Water Outlet Management</u> • Compass flushing system has been rolled out to the existing 102 nominated persons, some nominations are changing as people start using the systems and areas of responsibility become defined. • One to one user training is being provided where required. • Users have welcomed the system seeing it as a vast improvement on existing arrangements. • This month's report is based on the existing paper system but some areas have transferred to the compass which will be presented at the next meeting: **VW** asked if **TB** could clarify e-mailing out to staff that guidance on flushing systems has not changed only the reporting structure. **<u>Clinical Waste Incineration</u>** • Providing high temperature waste disposal for the sites clinical waste. • One week's loss of production due to serious failure of the bin lift mechanism. Incinerator remains operational throughput and waste being managed to maintain operational of plant.	**TB**

	Pseudomonas Aeruginosa (PA) • Estates and Infection Prevention are currently working on a risk assessment for water safety plan. The final draft document will be approved by the Water Safety Group before it is added to policy. • Infection Prevention arranging a trial in CHU with the use of high concentrate chlorine wipes to disinfect the environment surrounding outlets before re-sampling outlets in the area for Pseudomonas Aeruginosa. **KPI's** 96.4% complete **VW** enquired on risk assessment on water plan if this was going onto the Estates register for monitoring. **TB** replied that according to guidance this was an Infection Prevention risk assessment, but could go onto Estates as this was a shared responsibility, as the bulk of the actions are with Estates, **VW/TB** to review. **MC** asked for confirmation in regard to Legionella in outpatients and asked if there were any engineering issues with pipe work. **TB** replied no there were no pipe work issues and are just waiting for results of sampling. **DL** enquired what was the current status of the incinerator. **TB** to discuss with Mike Godwin and feedback to **DL.**	**TB/VW** **TB**
8.	**Environment Report – Reported by Sandra Roberts**	
	Deep Clean Programme The programme of work is 99% completed with all areas being deep cleaned and if appropriate using HPV by March 2013. The exception to this is the Cath Labs where we have been unable to access due to capacity. The programme at the beginning of the year was assisted by the use of decant wards. Concern needs to be highlighted with regard to limited decant facilities from April 2013. On-going capacity could also be an issue. The department also completed over 700 unplanned deep cleans in bays and side rooms in response to Norovirus and C Diff. **DL** enquired if the HPV machine could be tagged by using the safe hands system, to record the areas where the machine had been used. **SR** to liaise with Claire Nash to review. PLACE Assessment Being held at West Park week commencing 29/4/13 – actual date cannot be identified. Bed Space Cleaning Protocol This procedure has now been agreed at the Senior Nurse Operational Group and approved at the Environment Group. The Protocol is to be disseminated via Divisional Nurse Managers. Technical Audit Report This identifies a monthly average summary taken from the Credits for Cleaning Audits for Nursing, Estates and Housekeeping Cleaning for March 2013 for Very	**SR**

	High Risk and High Risk Ward Areas.: **CE** highlighted that there has been a review on reporting structures, moving to exception reports, giving evidence of assurance. **CE** asked if HPV in ITU discussed in previous IPCC meeting had been resolved. **SR** commented that this was something that was still being looked into whether this can be done internally to save cost. A meeting is scheduled for beginning of May 2013, relevant people have been invited. Discussions took place with regard to food wastage and how it was bench marked. This is difficult because other organisations operate different systems and nationally 10% for a bulk service is acceptable. **SR** to discuss with dieticians organising a snap shot audit on medical and orthopaedic wards to calculate what actual waste is left on patients on plates.	**SR**
9.	**LNIP Report – Reported by Vanessa Whatley**	
	<u>Outbreak</u> It has been 14 days since last Norovirus positive patient was reported, a RCA is underway, with a meeting arranged 9/5/13 for post outbreak discussion. The outbreak was at its highest peak during November/December 2012 and then on-going with a lot of sporadic cases affecting numerous wards. Lessons have been learnt from this outbreak and high capacity has been a contributing factor. Care homes outbreaks have been low during winter months, but have increased during the last couple months. Rotavirus outbreak discovered in one care home has been discussed in detail with the home and a root-cause analysis is underway. Initial learning from this unusual outbreak includes requirements to improve standard precautions and communication of cases. <u>Annual Programme of Work</u> • 2012/13 is completed and has been closed off. • 2013/14 is on-going, in which DRHABs feature largely with the IV Team – 4 years data collection demonstrated within the report. • Catheter Safety CQUIN - completed with requirements being delivered. • Catheter prevalence study held May 2012 has been repeated with a full reported to be completed, highlights being 15.4% increase of urinary and long term catheters within Wolverhampton. A survey of catheters is now underway within community through WUCTAS following patient discharge from the Acute with a view to reducing long term catheters. The Continence Team will be managed under the Infection Prevention Team from 1/5/2013. Short term catheters within the Acute reduced 33% Use of catheters in care homes have increased • DRHABs data – distributed and attached to the report – Renal Unit/NNU needs to be addressed (as discussed above).	
10.	**IV Resource Team/OPAT Business Case – Reported by Vanessa Whatley**	
	Presentation by Vanessa Whatley- copy to be distributed with minutes.	

	JO enquired how savings on bed days was calculated; **JS** replied bed days are calculated on day to discharge to the date that outpatient antibiotics are stopped. **CE** asked what were the annual cost savings, **VW** answered the 6 months data demonstrated within the reported would need to doubled. **SK** disputed the figure of cost saving following discussions with finance. **CE** reminded the committee that this was still a business case and would be going back to TMT in May 2013 to be evaluated. This still needs further discussion in the way forward and has to cost effective.	
11.	**Pharmacy Report – Reported by Professor Ray Fitzpatrick**	
	<u>Monitored Antibiotics</u> • Division 1 – fluctuation during the quarter, but no trends • Division 2 – gradual increase in use of carbapenems and is being monitored agaisnt antibitic guidelines. <u>Antibiotic Interventions March 2012</u> The majority of interventions involved: dose/frequency (23%), incomplete/incorrect drug histories (17%), choice of drug/indication (14%) and antimicrobial course lengths (14%). <u>Allergy Box Interventions</u> There were 6 allergy box interventions in March. <u>DATIX Incidents</u> In March there were 2 Datix incidents, relating to allergy box non-completion. Datix Incident Reports are completed when allergy boxes on treatment sheets have no statement and or signature. Both incidents were from the Haematology Day Case Unit. **RF** to check if both members of staff have been disciplined. <u>Antimicrobial Prescribing Key Performance Indicators for March 2013</u> The results are a 'snap shot' of prescribing per quarter, during a week, across all the wards – details in report circulated. <u>Allergy box completion</u> The Trust have again scored 100% across the board, which is a great achievement**.** <u>Antimicrobial Sticker Completion</u> Performance is still poor across the Trust, but the Antimicrobial Stewardship Committee are looking at various ways to improve this. <u>Documenting the indication</u> The Department of Health advise documenting the indication on the treatment sheets and in the notes. This is something new for our Trust, as our guidelines have always said to document in the notes only; the guidelines are being updated to include documenting the indication in both places. The draft Antimicrobial Prescribing Policy is due to be reviewed in May, it details exactly how and where prescribing information is to be documented. Once it has been approved, it is hoped that documentation will improve significantly. The new Antimicrobial Prescribing Policy will be launched at Grand Round, along with the revised treatment chart.	**RF**

	VW enquired what was being done to encourage use of antibiotic prescribing stickers in patient notes. **RF** replied that this already in progress, with stickers being on trolleys along with notices on the wards and also printed onto medical clerking sheets. **CE** asked who is accountable for making this happen. The CEO from North Cumbria commented that in they involved the Deanery and education secondment was not signed off until correct procedures had taken place. The committee agreed that this was a good suggestion **SK/IB** to discuss further with Louise Nickell.	**SK/IB**
12.	**Performance Report – Presented by Dr Mike Cooper**	
	• MRSA Bacteraemia – PCT target hit, Acute over target with one case • MSSA Bacteraemia – within target • MRSA colonised patients – record low • MRSA Acquisitions – low within target • CDI PCR Positives - increased during March– no clusters. A PII meeting was held with C18 to discuss 2 cases reported during February, only 1 of which was toxin positive. • CDI toxin positives – 13 PCR positives, 5 of which were toxin positive, 2 attributable to the Acute and 1 WPH. • Blood culture contamination - 50% of which are from A&E, which is possibly due to increased pressures. **DL c**ommented that with 10 new bays going into to A&E further resources will be required.	
13.	**Any Other Business**	
	13.1 **VW** highlighted that there had been a TB incident within the Trust and that generally been an increase across Wolverhampton with contact chasing taking place. A process for this is being added as an appendix to the TB Policy and will be reporting back at next month's IPCC.	
	13.2 **MC** enquired what was happening with regard to measles within the Wolverhampton community. **KS** replied that weekly meeting were taking place within Local Authority with local partners, but were still waiting for the national plan. Public Health are focusing currently at identifying unimmunised 10-16 year olds, but will be looking at 5-18 year olds and adults if requested. There have been no confirmed cases within Wolverhampton, but there are low rates of MMR 2 doses which has improved 70%. Quite a lot of work is being carried out to developing plans should an outbreak occur. Should any hot spots be identified within certain areas, schools may be used for vaccinations. Target nationally for 10-16 years olds to be completed by September 2013, a 12 month programme for catch up will be required locally.	
	13.3 Anne Farrow acting CEO from North Cumbria thanked the committee and commented that the committee had clearly strong leadership with CEO chairing the IPCC. **AM** also commented on the respect that was given on discussion of reports, support and standards within the organisation.	
14.	**Date of Next Meeting**	
	Friday 31st May 2013, 10am – 12noon Board Room, Clinical Skills Building	

The Royal Wolverhampton NHS Trust
ACTION LOG
Infection Prevention Team Meeting
26th May 2013

ACTION NO	ACTION	LEAD	COMMENTS
1.	Implementation Group meeting to be arranged to discuss how to take forward CJD Policy.	**Dr Mike Cooper**	
2.	Meeting and training for hand hygiene to be organised for porters.	**Sandra Roberts** **Vanessa Whatley**	Feedback to IPCC June 2013.
3.	Terms of Reference to be amended to include, GP representation from South Staffs Cannock areas and Division 1 Matron.	**Vanessa Whatley**	
4.	**DL/CE/VW** to meet and discuss Care Homes in South Staffs areas and Infection Prevention Team across Stafford.	**David Loughton** **Cheryl Etches** **Vanessa Whatley**	
5.	DRHABs renal to be discussed at May IPCC.		Agenda items May 2013 IPCC.
6.	**JS** to check with Procurement on cost for syringes and draft e-mail for **DL** to send to Consortium.	**Julie Sharp**	
7.	**JS** to implement September deadline for measles immunisation for staff within the Trust.	**Julie Sharp**	
8.	Feedback on DRHABS Haematology/Oncology at IPCC June 2013	**Maurice Hakkak** **Amanda Watts** **Dr A Jacobs**	Agenda item IPCC June 2013.
9.	**TB** to e-mail guidance on water flushing system.	**Tom Butler**	
10.	Risk Assessment on water plan to be reviewed.	**Tom Butler** **Vanessa Whatley**	
11.	**TB** to discuss with Mike Godwin status on incinerator and feedback to **DL.**	**Tom Butler**	
12.	**SR** to liaise with Claire Nash on tagging HPV machines, using safe hands system.	**Sandra Roberts**	
13.	**SR** to discuss with dieticians organising a snap shot audit on medical and orthopaedic wards	**Sandra Roberts**	

	to calculate what actual waste is left on patients on plates.		
14.	**RF** to check if 2 members of staff from Haematology Day Case Unit have been disciplined with regard to DATIX incidents non-completion of allergy boxes.	**Professor Ray Fitzpatrick**	
15.	**SK/IB** to discuss with Louise Nickell, involvement with Deanery to withdraw education secondment for non-completion antibiotic prescribing stickers.	**Suneil Kapadia Ian Badger**	
16.	Appendix to be added to TB Policy for process chasing.	**Vanessa Whatley**	Agenda item IPCC May 2013.