Central Sterilising Club
The Original Decontamination Forum

Newsletter, Summer/Winter 2016

From the Editor

Well, it's been a bit of a year hasn't it! That's probably a massive understatement but it has. For many the stability and predictability of their worlds has been challenged and that can leave us feeling a bit out of sorts. Looking forward to 2017 we can expect more change and unpredictability but at the centre of all this healthcare will continue. It's been a really busy year – another massive understatement, but it has. Having drafted numerous versions of my Editors section, during which being bust scuppered all efforts to complete I think I'd like to keep this combined 2016 Newsletter simple, and take the opportunity to thank everyone for their hard work during 2016. CSC members are at the heart of healthcare delivery and are central to its success. The contribution of the science of decontamination is immense so everyone from the scientists, to the manufacturers to the staff who work in SSD's make it happen and should feel proud that they are part of this.

2017 will no doubt bring more changes and challenges, some welcome some perhaps not so. Some of it though might be very exciting! Personally, I am excited about the current procurement work, early in its development but with huge potential. Friday saw the launch of the NHS Clinical Evaluation Team first set of clinical reviews. This work, and the first four recommendations is the

beginning of something quite unique. For the first time, we are starting to articulate what quality looks like, and set some requirements for commonly used products and consumables used by nurses to deliver care. These are the result of clinical reviews, working with staff to identify key elements needed to allow us to use the product safely and effectively – check it out at **http://tinyurl.com/jyf77ou**

The aim at this stage is not to produce a list of manufacturer's products that fit the criteria but to outline the core elements that need to be included - and surprisingly these are not always present. It's not deliberate – it's just never been raised, and it's fair to say that this has caused some concern – the predictability of the procurement world is being challenged, and for the first time the conversation is about 'what do we need and want' rather than what products do we have to choose from. The good news is its impact is already being felt, and for example changes to packaging and labelling are already moving ahead making it safer for nurses to use. Defining the essential criteria however is just the first step – there will be technical criteria needed for some products and design changes needed – but all of that is for the future – and decontamination will be in there at some point. So if like me you have a long wish list of products I would like to see change – keep it close, the future is not that far away! 2017 is almost here.

So on behalf of the Committee we wish all our members a restful Christmas and a prosperous 2017.

We are particularly looking forward to seeing everyone at the Annual Scientific meeting which will be held in Leicester – a brand new venue, on **3rd and 4th April**. So hold the dates, more information will be out in the New Year.

Rose Gallagher, Editor

From the Chair

Welcome to the CSC Summer/Winter newsletter 2016.

Well, the 2016 Annual Scientific Meeting has been and gone and now we are looking forward to the Autumn Study Day. The Annual Meeting, in my opinion, was well attended and the feedback from delegates was overall very positive. Val O'Brien has provided a summary of the meeting as an "aide memoire" to those that were there and which also shows those that couldn't attend what they missed.

A few guidance documents have been published since the last newsletter
HTM 01-01 Management and decontamination of surgical instruments (medical devices) used in acute care;
HTM 01-06 Decontamination of flexible endoscopes
HTM 04-01 Safe water in healthcare premises

All of these are free to download from www.gov.uk. The theme of the Autumn Study Day was based on changes to decontamination guidance and I hope that many of you were able to attend – we are including a write up early in 2017 for those who were unable to make it.

The CSC continues to be a member of the Professional Experts Communication Forum: Decontamination of Medical Devices (PECF) which has met twice this year. Discussion topics have included changing chemistries for washer disinfectors, education of decontamination staff and decontamination audits to name but a few.

The CSC Working Group on endoscope storage drying cabinets is currently reviewing the draft document which will hopefully be published in the near future.

The CSC was invited to arrange a session at the FIS/HIS Conference

in November 2016 in Edinburgh. The theme of the session was "Changes to Guidance" and the presenters were Jimmy Walker, David Perrett and Karen Tweed. It was another fantastic opportunity to showcase the CSC at an infection prevention and control/microbiology meeting.

The CSC finances are good which has enabled us to again offer free places for members at the study day. We also offer members the opportunity to apply for the Hurrell Simpson training grant, details of which can be found on our website.

There were a few committee changes at the last AGM. After 11 years of committee membership, the last 5 as Treasurer, Jim Reid stepped down. On behalf of the committee and CSC members I would like to extend a huge thank you to Jim for his service to the CSC and for managing the Club finances so well. John Prendergast is now the CSC Treasurer and I would like to thank him for taking on this role. Olga Sleigh also stepped down from the committee and a call for nominations was put out as there were 2 vacancies on the committee. Andrew Birch put his name forward and was appointed. There was also a decision taken to co-opt Karen Tweed to join the committee. The membership secretary, Paul McAdams, is currently trying to evaluate our membership numbers against their professional groups. One thing that is clear is that the number of members who are clinical microbiologists or infection prevention control nurses has declined over the years. Please may I ask all members to continue to promote the CSC, but in particular to these disciplines?

Please continue to support the CSC. It is your Club and we welcome any ideas or comments you may have. You can contact the Committee through the website.

Tina Bradley

Reflections on the 2016 CSC Scientific meeting

Tina Bradley the CSC Chairman welcomed everyone to the conference with a reflection on past CSC conferences in Leeds and the people who were members in 1974 when the conference was last held there.

Darryn Kerr - Director of Estates and Facilities Leicester NHS Trust and previous Director Estates and Facilities and National Decontamination Program Director, delivered the keynote address to officially open the conference.

He provided reflections back to 1999/2000 and quoted this as a milestone year for Decontamination and the start of the decontamination program. This was the era of the "Snapshot survey" and where all of the Department of Health guidance was issued to NHS organisations free of charge where previously they were only available for purchase.

NHS Estates was officially wound up and transferred into the main Estates and Facilities within the Department of Health in 2005. He visited the offices and found many items of historical interest and in particular an original copy of a document entitled - *Studies in sterile supply – arrangements in Hospitals – Present Sterilization Practices in 6 hospitals (1958).* This copy of the original document (often referred to as the "Yellow Peril") has very kindly donated to the CSC for our archives.

The decontamination life cycle diagram was created at this time, the logic being that all aspects of instrument processing needed to be taken into consideration not just one element which used to be sterilization! Darryn gave an overview of the program and the tools provided to the NHS to improve services including PAT (process assessment tool) DORIS – Decontamination Organisational Review Information System and guidance documents which were created to support a better

understanding of standards required. He paid tribute to David Hurrell and Rosemary Simpson for their dedication to Decontamination Sciences and posed the question – "where will the next generation of experts come from?" He suggested that the CSC should be looking to ensure it was one of the main organisations to work on new guidance and that it was our choice if the future of the business is in our hands!

The 30th Kelsey Lecture was given by Dr Dominque Goullet - "The Myths of Sterilization" - he provided an overview of the health system in Lyon where he lives as background to his presentation and then posed many questions!.

In April 2011 the largest CSSD 2500 square meters was opened to service Lyon which he is involved in managing. He spoke of the recommendations for categories of decontamination based on the level of evidentiary proof available. He posed a question – "would conductance of surgery with non-sterile devices necessarily produce infection?"

What statistics are currently available to provide the relationship between non sterile or inadequately sterilized medical instruments and nosocomial infections? Mortality due to lack of sterility of medical devices used is an extremely rare event. He suggested that some of Spalding classifications are not supported in France. High Level Disinfection (HLD) is for critical and not semi critical based on the fact that many biopsies are taken during scoping of patients – questioning – "is this not a critical activity?"

Resistance testing all sterilization methods? The answer – overkill parameters should be used as a standard approach. Spores do not necessarily present the highest risk to patients. Food preservation companies test using *Geobacillus stearothermophillus* but they require an assurance level of 10^{-9} compared to the sterilization of surgical instruments where an assurance level of 10^{-6} is considered sufficient! So why less of a sterility assurance in medical device decontamination and food canning?

Prion protein question: is the prion protein not destroyed after 17.5 minutes instead of the fateful 18 mins at 134 ºC? France use 18 minutes as standard hold time for steam sterilization.

Should the water for sterilization and cleaning be pure? There is good logic to use the highest quality water for both purposes. You can achieve sterility of devices with poor water quality however highest standards are necessary and this is why good quality is required. It is not just sterility that is needed but water without endotoxins too!

He referred to the packing of peel packs and folding the inner bag – there is no evidence to confirm this does not produce a sterile device. Is this purely aesthetics?

Does it matter if there is a small amount of water in the base of a container? French reference suggests that each case requires a risk assessment and this is the responsibility of the surgeon.

Why is the packaging not reused? Using packaging (paper and linen) once or twice has no effect on the product. Testing has shown that products stay within the standards parameters so why not reuse?

We still use containers although the American Journal of Infection control Sterility maintenance study concluded that the contamination of the contents increased with the usage of the containers. So why are they still used? In a study where 257 containers were tested in a number of establishments it was proved that 30% are not waterproof and even after maintenance there was still a high percentage of containers that leaked.

If the outside packaging is damaged then what? Many variables exist.

What happens at midnight of the expiry date? What does clean mean – no definition exists.

What is the purpose of disinfection during cleaning? In France they disinfect using chemicals immediately after use, and yet in the UK it is thought that disinfection in the AWD is sufficient??

He questioned the sterilization hold time of 3 mins and yet have the BDT operating at 3.5 minutes?

How many countries practice validation of equipment? How many do not and yet still produce sterilized devices?

Loading sterilizers – we still say that peel packs should be paper against paper - there is no evidence to support this practice.

Queried the environment needing to be controlled? Class 8 has not been justified – none founded recommendation!

Standards committees are generally made up of industry and not users – often in faraway countries and where it is expensive to travel – this needs addressing! There should be greater opportunity for users to provide opinion and not just industry.

We are obliged to blindly continue to apply a certain number of these dogmas which should be challenged but need more research.

Hand Hygiene: Why is it so difficult? Shaun Bay Surewash

The most dangerous person in the hospital is the person who THINKS their hands are clean!

Hand hygiene products in hospitals can give a false sense of security. 1 in 14 patients get an HAI with 50% of these associated with a lack of hand hygiene. Patients are clearly at risk and in a location where infections are rife.

Considerations need to include the right product, the right timing (when to use) when to be applied, the right technique.

Hand hygiene is like learning to tie shoe laces – it's something we learn early on in life and should also be something we also learn about early in our jobs/routines Technique is the key not just checking people have dirty hands. Training needs to take place when time allows and with immediate feedback. Technology allows this to happen now but is not routinely available or used.

Microbial contamination cannot be seen (unlike smears and streaks on a poorly washed car). UV boxes can be used to visualise florescent markers which are applied to skin, as a marker for residual contamination after hand washing.

Hand hygiene is only part of the solution to tackle HCAI's – we need to take other issues into account – surface cleaning, disinfection, advanced chemicals, antibiotic stewardship, education program, dedicated staff. By applying the bundled approach a hospital can reduce HAI by 46%

Should we be testing endoscopes? – Thomas Vanzieleghem

One Life Specialist medical cleaning company – Enzymatic chemistries

There is a risk of residual contamination posed by not following procedures. Human factors play a significant part in this area. Biofilms favour bacterial tolerance towards disinfectants.

ERCP scope cleaning – high level of cleaning required. These scopes have been associated with infection and death in some patients. Thomas spoke about testing of scopes and the inconsistent approach worldwide.

Details were given on microbiological testing of a series of scopes which were designated as patient ready. 4 scopes were tested in France, and 3 of the 4 were contaminated – this was consistent across the board in France, UK and Belgium. In all cases at least one scope was found to be contaminated. Different types of scopes were tested including

Gastroscope, Duodenoscopes, Colonoscopes, Bronchoscope and Ureterscopes.

Some were found to be contaminated before AER cleaning others after which suggested the machine was the source. He concluded there needs to be a standard approach to testing the cleanliness of scopes however many factors affect the outcome of processing.

Debate of the day – This house believes that decontamination of surgical instruments should start in the theatre suite - Sue Lord & Paul Jenkins.

Once again the debate proved to be lively and informative. Despite Sue's determined effort it's perhaps not surprising that delegates at the CSC conference found in favour of Paul and his baked beans analogy.

Ginny Moore – Heater Cooler units – what are the microbial risks?

Ginny highlighted complications associated with water coolers including cardiac issues i.e. prosthetic valve endocarditis. Coolers do not come into contact with the patient but aerosols can be generated within the theatre during surgery.

In February 2015 a retrospective investigation was were launched by PHE which identified 9 deaths out of 18 cases of infection following cardiac surgery.

45 heater cooler units across 12 different Trusts were sampled, and tested for *M chimeraera* and other water borne organisms. *M chimeraera* was found in all water samples which were tested. Air sampling was also undertaken to investigate aerosol release.

A laboratory study of a heater-cooler was undertaken and sampling taken at rest and when the unit was switched on with the water circulating. A smoke pen was able to show the flow of the aerosol.

In June 2015 manufacturers issued a Field Safety Notices (FSN) recommending decontamination regimes and more frequent water changes. The risk of biofilm build up over time can only be minimised by replacing selected internal parts and through regular chemical disinfection but despite evidence of extensive contamination these heater coolers remain in use because infection rates are very low and there is no safe alternative to provide life-saving by-pass surgery.

Legionella in your water system: how vulnerable are you and your patients? -Dr Susanne Lee Director Owner Legionella Ltd

Suzanne introduced the subject by stating how many cases of Legionella – 2014 6941 cases reported most of which are community acquired 18% travel related. Men are more susceptible than women and risk increase with age – older than 50 accounted for 80% of all cases. It is now 40 years since the first outbreak.

How is this contracted? Inhalation is the primary route and large outbreaks are commonly associated with cooling towers. Spa pools are the third most common source of legionella.

Legionella can travel in humid conditions and distances of up to 6 kilometres have been identified. No recorded person to person transmission is known although mother of a son who was infection died without being in the same area as the son when he was infected.

Outbreaks can last years – some hospitals in the US are particularly problematic. Poor system design can support legionella growth – hot and cold together, dead legs, poor flows and no return, lack of monitoring etc. poor planning of new units is also an issue. Ice making machines are also a risk.

Audit results performed in the last few months (notes taken April) incorrect temp of water; strainers before the TMS blocking; pipework behind panelling not insulated;

lack of training and contractor induction; no procedures for separating of clean and dirty plumbing jobs.

Not documented procedures for checking or risk assessments for location of TMVs. (Thermostatic mixer valve)

Contractors must be managed and scope of work clearly defined. Regular meetings and communications; competency of staff carrying out work needs to be verified.

Tuesday 12th April

Why you should consider alternative chemistries - Matthew Peskett

Matthew approached a Trust to undertake a trial of endoscope chemistries.

Amity provided a compatibility guarantee for all flexible endoscopes before the trial started

Amity also tested the water quality for compatibility. The EWD manufacturer offered their own chemical however many only offer one and customers feel tied in to. Machines were flushed to ensure old chemistry had been removed before the new offering was attached. A risk assessment was carried out according to ISO 14971.

Type testing is carried out by the manufacturer of the EWD however only test compatibility of their own chemistry and not third parties. Some EWD manufacturers test in the country of origin and not in the country in which it is to be operated.

Trust needed to confirm compatibility with the chemistry to the scopes in use – PENTAX was contacted and asked for comment on the trial.

The trial used Ruhof Liquidclean S and was checked against the process parameters i.e. operating temp etc

Audere Medical Services Ltd used a UKAS accredited laboratory for the EWD validation and undertook a full annual validation of the machine; which passed.

The EWD chemistry was based on paracetic acid however Audere found that the O rings in the machine were not compatible with paracetic acid. Audere replaced the O rings which appeared to improve the operation of the machine. Training was given to staff in handling the new chemicals and documentation was provided (Safety Data Sheet)

The Results – over 2 years the EWD and endoscopes were checked for damage. Annual saving of 56k was achieved. The trial was written up in a journal.

Scope Control: A breakthrough in rigid endoscope quality assurance and service optimisation – Bert Dommerholt

Designed in the Netherlands after a query by the operating theatres to help determine the condition of the scopes they used. The machine is designed to check and predict failures of performance.

How long does an endoscope last? Anything between 10 seconds and 10 years depending on how it is handled! Real time testing of scopes before each use is advocated. Key benefits to the organisation includes patient safety, surgeon support, quality management, legal logistics, repair provider, medical engineering, SSD. Testing may also be used to check repairs and guarantee.

What does it measure? The tests include viewing angle, sharpness of focus, lens light transmission, colour balance; (light dark). It is possible to identify dust particles, lens slipping and contamination within the devices, water etc.

Clinical validation – what values should be expected from new scopes? This is felt to be important in order to determine the minimum values for each scope so that they could be taken out of use for repair at a given agreed time. A number of hospitals have tested the scope control (over 7,000 scopes) and applied the values, this led to creation of a 'Utrecht norm' based on discussions with clinical users for each scope.

The machine has a simple touch screen clear green and red indicators for pass and fail. Measurements take 1-3 minutes and training time for operators is less than 15 minutes. A web based application allows access to device specific values. Comparisons can be made between scope types and manufacturers.

New developments – A data matrix scanner is available to work with Scope control and also storage of information on the Cloud. A matrix can be created to show the exact condition of all scopes – identifying how many are in use, how many undergoing repair and how many require repair. It also shows how many uses each scope has had before repairs are required however handling plays a large part in the repair rates. Warning note – it won't work on Da Vinci at the moment!

Provision of sterilised medical devices - Matthew LeMasonry

Matthew gave an overview of how Zimmer Biomet provides patient ready instrument and implant sets from a facility in south wales. They work with surgeons to determine the exact surgical equipment and implants including sizes to eliminate waste both in the number of instruments provided but also in the size ranges of implants.

The instruments and implants are delivered to the theatre (sterile and ready-for-use on a named patient). After use they are returned directly to Zimmer Biomet where they are stripped down, thermally disinfected and autoclaved prior to being re-allocated to a new set, which will be sterilised for a new named patient.

Individual instruments carry unique identifiers, which ensure that tracking and traceability can be maintained for every individual instrument level rather than simply for whole trays.

Ethics and governance of reprocessing animal and human surgical instruments – Mike Simmons

An excellent presentation covering many aspects of instrument processing. Single use versus reusable; single use have their place in patient care but only with the high levels of controls assurance to ensure functionality and conformity to prescribed standards.

MHRA position and response to local RA - Andrew Bent Senior Product Specialist MHRA

Andrew confirmed the role of the MHRA and that of the notified body. Facts – there are approximately 90,000 medical devices on the market, the annual spend on medical devices is £11.2 billion

18,000 patients experience adverse events due to devices and 50% of these are preventable. 33% lead to severe disability or death. Issues – manufacturer's decontamination instructions or lack of them; misuse of devices (inappropriate use)

Suggest that the risk assessment ISO 14971 closely matches the MDD clauses and can be used in conjunction with each other.

Health and safety perspective, Paul McDermott

Risk assessment is an ongoing process and should not be seen as a one off event.

Biological agents and the law.

The overarching legislation is the Health and Safety at work Act 1974 – the regulations are COSHH and Management of Health and Safety at work 1999 (MHSWR)

Approved code of practice (ACoP) practical advices on specific topics

Guidance e.g. HTM series which provide detailed advice.

Risk assessments must be carried out according to regulations COSHH Reg 7 and MHSWR Reg 5. Both say that risk assessment has to be "suitable and sufficient" – a term which is quoted and must be justifiable if challenged.

HSG 65 Managing for health and safety – published guidance – PLAN-DO-CHECK-ACT

Local factors should be taken into account when performing risk assessment for example water quality if working on water coolers.

Carry out risk assessment – apply control measures – monitor the outcome and check effectiveness

Rapid Review Panel – overview and update - James Vaudrey

James explained the role of the RRP. Started in 2004 and assesses innovative infection prevention and control products, equipment and materials for potential use in the NHS. Part of public health England now, created as a result of Winning Ways CMO report. RRP works towards cleaner hospitals and lower rates of infection.

Its membership is multidisciplinary including NHS Civil Servants and Private Sector contributors. Does not do any cost benefit analysis but looks at products for improved efficacy over current products used, innovation and efficacy.

If the product obtains a 1 or 2 rating out of 1-6 then its accepted however outside of this range 3-6 will have outcome published on line and that it's been reviewed.

Constructive feedback is returned to applicants confidentially; companies have 24 hours to review and respond to these outputs. Only 12% of all applicants are approved at level 1-2. Quite a few of those accepted have been through the process more than once.

The Panel has indemnity and disclaimers relating to the reviews and to protect the panel members. Restrictions apply on the use of the RRP rating as an endorsement!

Negatives include government versus industry – manufacturer and distributors and differences in international approaches and working. MUST be based on scientific evidence and not marketing materials and in English. Current reviews include ultrasonic cleaners and prion detergents.

Number of applications has dropped since 2004 to current date. Guidance on RRP has been updated to encourage more applications.

HCAI@phe.gov.uk for questions on RRP and more information

Risk Management: patient safety versus cost or how to get your organisation to buy stuff! – Alison Gee

Risk assessment should cover all aspects of patient safety. The outcomes of risk assessment can be used as powerful tools to help overcome shortages, deal with risks in practice etc.

Make sure everyone is familiar with their own organisations policy. Use the risk management system to its full advantage e.g. Datix. Upload documentation as quickly as possible and keep it up to date by dating the actions undertaken to mitigate the risks identified. Use sections to demonstrate each risks and include consequences including scores for each. Tips include, always include the words – there is a risk of …… Plan the escalation strategy; know who the key stakeholders are in the organisations persons who can support your proposals.

Get it on the agenda for the various committees and lobby members. Try to perform risk assessments as part of a group or committee – it adds weight to the argument. Try to get a doctor or senior manager involved. Try to anticipate the need for change before replacements are needed – identify data to support the request for action. Undertake a risk assessment even if risk is managed immediately – always document the incident. Be accurate in the scores you give the risks. Be prepared to challenge scores that other people use in risk assessments they may over egg their case!

Alison.gee@nuh.nhs.uk – any questions please use this email

Val O'Brien

Annual Scientific Meeting 2017 – hold the date!

Next year's annual scientific meeting will be held on **3rd and 4th April** at the Marriott Hotel in Leicester. Further information will be sent out via email and will be placed on the CSC website when available. We look forward to seeing you there!

All Wales Endoscope Decontamination Survey - 2016

Welsh Government has commissioned a survey to be carried out in 2016 to review standards of decontamination for flexible endoscopes and ultrasound probes within NHS Wales facilities. The survey is a follow up to the 2014 exercise that will provide a measure of reassurance that all the processes involved in decontamination of such devices now complies with regulatory requirements and accords with guidance developed to help ensure patient safety. It should identify continual improvement that has been implemented and identify areas of weakness that maybe the result of environmental, financial or organisational restrictions.

The objectives of this survey are to:

Identify areas where continual improvements have been instigated to raise the standards of decontamination.

- Identify if a clear decontamination reporting/structure to the Executive Board is in place in accordance with national guidance

- assess the effectiveness of local arrangements for endoscope re-processing against standards, national policy and best practice (e.g. Welsh Health Technical Memorandum 01/06,BS EN documents and British Society of Gastroenterology guidelines);

- identify and urgently escalate inadequate re-processing practices and advise the Health Board/Trust of remedial actions needed immediately to ensure compliance and protect patients;

- Identify any variation in re-processing practices within the Health Board/Trust to ensure standardisation of approach and equity in patient care.

    - ensure/facilitate a standardised approach to processing throughout Wales; and to

    - Provide the findings and evidence to advise Welsh Government about the continued level of compliance and identify where the risks of inadequate re-processing remain across Wales.

It is aimed that a report will feedback to Welsh Government that will include:

- feedback of all endoscope decontamination practices, procedures and facilities in the NHS in Wales;

- an up to date assessment of current practices and procedures for re-processing at each location with each Health Board/Trust;

- An analysis of findings, to include identification of key risks and themes across Wales whilst acknowledging improved and best practises.

A multi-disciplinary team will undertake a review of each identified endoscope decontamination department. The team will be made up of a combination of at least a decontamination engineer, a sterile service's manager, a clinical representative (infection control and/or endoscopy nurse) and an operational lead that are collated from the Health boards within Wales.

The survey team shall work closely with each HB to assess the individual Development plans produced in response to the 2014 findings.

A formal summary report will be produced post survey of each Health Board. That will identify findings, to include continuous improvements/future development Plans/training initiatives and negative feedback that documents poor practices.

NHS Wales Shared Services Partnership/Specialist Estates Services are acting as the facilitators for the survey and will work closely with both Government and NHS Wales to complete the survey.

From our membership secretary

Membership Subscriptions

Dear Members,

If you are not already aware the CSC has been using a club membership software called Paysubsonline , PSO for short.

It allows us to more efficiently manage members information and payments, combined with notification of CSC events (event payments, is in the process of being set up) and newsletters.

By now you should have has a few emails via the system to update you on your membership status, giving you details for direct access to your own membership details (after setting up a password) and allows checking of payments and payment online if you have not already set up a standing order or direct debit.

To help us reduce running costs and collection time required. Can I urge all those who pay by cash or cheque to please use the system for setting up automatic annual payments?

If you already pay by standing order or direct debit you do not have to do anything regarding membership payments.

PSO allows you to directly check and change your contact details if you situation changes, without contacting any of the committee members.

Link to member's area on PSO **http://tinyurl.com/jydvw6y**

The system is only as good as the accuracy of the information, especially your up to date email address. So if you have changed this in the last year or so please update via the system log on or contact me if any problems.

If you have not received this information from CSC regarding PSO, it could be because your contact details have not been updated.
Please email me directly with changes and your membership number if you have it, so I can link you into the PSO system.

Many thanks for you co operation

Paul McAdams

Updating the CSC website

As you will be aware we have been working to update the new website however we have run into a number of technical issues that have taken longer to resolve than we had hoped. Work is continuing to resolve these so please bear with us.

Rose Gallagher

Event Payments

The new CSC website will eventually include the facility to book and pay for the Conference and Study Day through the website.

We will be able to facilitate payment in any of three ways:

- Print a Booking Form and send a cheque
- Book using a Purchase Order number
- Book using Credit Card payment (through Paypal)

Work is progressing and we hope the facility should be available shortly. We will initially retain the option to send a "traditional" Booking Form by post or email. These will be available to download via the website Booking Form and we will include draft programmes in newsletters and by email to maximise members' notice of these.

John Prendergast

Stay in touch between newsletters

Please do take the time to go to the CSC Facebook page and Twitter site.

The Facebook page is an informal way to keep in-touch with goings on at CSC, so if you use Facebook to keep in touch with friends and family just 'like' our page and we can reach you that way too. It can be located through the CSC website homepage or Google (if you don't have a Facebook account) or by searching Central Sterilising Club on Facebook. We have put some photos up for people to enjoy as well as messages and updates to keep people in touch with latest news.

Rose Gallagher