UHL response to the cluster of cases of Listeriosis associated with sandwich products supplied to NHS organisations

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Trust Board paper F

Executive Summary

Context

This report provides a summary of UHL's response to the nationally reported issues related to Listeriosis associated with sandwich products supplied to NHS organisations. The cases of infection to date have been confirmed in 9 seriously ill hospital patients across England. 5 patients have sadly died. One of these patients received treatment at UHL.

Questions

1. How has the University Hospitals of Leicester responded to the reported issues?
2. What actions have been put into place to ensure that our sandwiches are safe?

Conclusion

Public Health England informed the Trust of their concerns on Saturday 25th May 2019 via on-call routes in respect of a risk of Listeriosis in vulnerable patients from sandwiches supplied by the Good Food Chain Company to NHS Trusts, including UHL. UHL immediately responded to the alert and took all necessary steps to remove sandwiches as advised. We changed suppliers as quickly as possible to ensure continuity of supply for patients in our care. Subsequently it was identified that a patient who had received care within UHL was part of the national outbreak.

UHL have reviewed all aspects of its cold chain for this food from the receipt of supply to the point of service to the patient. This has been supported by inspections from the Leicester City Council's Environmental Health Officer to investigate listeria controls on site for patient and retail catering.

The Trust has robust food safety management systems in place which were scrutinised as part of the inspections and found to be satisfactory.

Input Sought

The Trust Board is asked to note the content of this report.

For Reference

Edit as appropriate:

1. The following objectives were considered when preparing this report:

Safe, high quality, patient centred healthcare	[Yes /~~No /Not applicable~~]
Effective, integrated emergency care	[~~Yes /No~~ /Not applicable]
Consistently meeting national access standards	[~~Yes /No~~ /Not applicable]
Integrated care in partnership with others	[~~Yes /No~~ /Not applicable]
Enhanced delivery in research, innovation & education	[~~Yes /No~~ /Not applicable]
A caring, professional, engaged workforce	[Yes /~~No /Not applicable~~]
Clinically sustainable services with excellent facilities	[Yes /~~No /Not applicable~~]
Financially sustainable NHS organisation	[Yes /~~No /Not applicable~~]
Enabled by excellent IM&T	[Yes /~~No /Not applicable~~]

2. This matter relates to the following governance initiatives:

Organisational Risk Register	[Yes /~~No /Not applicable~~]
Board Assurance Framework	[Yes /~~No /Not applicable~~]

3. Related Patient and Public Involvement actions taken, or to be taken: N/A

4. Results of any Equality Impact Assessment, relating to this matter: N/A

5. Scheduled date for the next paper on this topic: N/A

6. Executive Summaries should not exceed 1 page. [My paper does comply]

7. Papers should not exceed 7 pages. [My paper does comply]

1.0 **Introduction**

1.1. We were first notified of concerns in respect of a risk of Listeriosis in vulnerable patients from sandwiches supplied by the Good Food Chain company (GFC) to NHS Trusts on Saturday 25th May 2019 via on-call routes. We subsequently received a letter from Public Health England (PHE) dated the 26th May 2019 which referred to investigated cases of Listeriosis in the North West of England with infection likely to have been acquired in hospital. It made a number of recommendations including not serving sandwiches supplied by GFC to patients in vulnerable groups, such as those with significant immunosuppression until further investigations ruled out the risk.

1.2. We were one of nine Trusts across the Midlands identified by the national team as being in receipt of products from the identified supplier.

2. Immediate actions taken by UHL

2.1. Upon notification of concerns from PHE our catering department immediately removed all patient sandwiches supplied by GFC. We sourced an accredited alternative supplier as quickly as possible. During this transitional period we supplemented food for patients with additional product lines, more snack boxes etc.

2.2. Subsequently, PHE requested all NHS Trusts that had taken delivery of sandwiches from GFC submit any isolates of *Listeria monocytogenes* obtained over a specified period to their reference laboratory for analysis. Leicester's laboratory submitted one sample on 6 June 2019.

3. UHL Identified Patient

3.1. UHL received a PHE report on 15 June 2019 that the isolate sent to the laboratory confirmed that a previous UHL patient was part of the national outbreak.

3.2. A comprehensive patient review was commenced.

3.3. The patient was admitted into UHL during April, suffering from multiple co-morbidities and generally unwell. During this time it has been identified that on one occasion sandwiches from the identified company were served within the bay where the patient was being cared for. As the patient was not neutropenic (suffering from a low white blood count, the white blood cells being the mechanism that fights infection) there would have been no reason to advise that a sandwich was not appropriate, indeed sandwiches form an important part of our patients dietary intake.

3.4. The patient returned to UHL towards the end of April where blood cultures were taken on admission. This was the sample that subsequently identified *Listeria monocytogenes.*

3.5. The patient and family were advised of the diagnosis (although not known at that time that this was linked to the outbreak strain) and treatment commenced.

3.6. The patient was discharged home on an End of Life Pathway not connected to Listeriosis. The patient passed away at home as per the family's wishes.

3.7. The patient's family has been contacted by the UHL Patient Safety Lead (PSL) and a meeting with the family, UHL PSL, Consultant Medical Microbiologist/Lead Infection Prevention Dr and Communicable Disease Consultant from PHE is being arranged.

4. Food Safety Assurance

4.1. UHL serve approximately 1.5 million meals per year to our patients including approximately 650,000 pre-packaged sandwiches. Sandwiches are a common menu option in hospital and Trusts.

4.2. Our patient sandwiches are procured off the NHS Supply Chain (NHSSC) by Foodbuy which requires all suppliers to have STS (Support, Training & Services Ltd) approval in accordance with the Code of Practice and Technical Food Safety Standard for Food Suppliers and Distributors which is developed at national level. This scheme requires the supplier to submit to unannounced food safety audits. The supplier is assessed against strict criteria which includes reviewing microbiological sampling results and Listeria swabbing test results.

4.3. UHL engage the services of a Chartered Environmental Officer to carry out both routine and unannounced food safety inspections. He is a recognised expert in his field, a lead assessor for food safety management systems and a founder member and external examiner for qualifications relating to food premises inspections.

4.4. All managers, supervisors and food handlers working in our patient and retail undergo food hygiene training in accordance with the Trust's Food Safety Policy. This includes specialist sessions on Listeria.

4.5. Our premises are also subject to unannounced inspections by the local authority Environmental Health Officer.

5. Recent Actions

5.1. We changed sandwich supplier via the NHSSC to "On The Roll" (OTR) with effect from the 28th May 2019. OTR has recently been re-audited by STS and maintained its accreditation.

5.2. UHL have reviewed all aspects of its cold chain for this food from the receipt of supply to the point of service to the patient. This has been complimented by a number of inspections from the Leicester City Council's Environmental Health Officer over the past 2 weeks to include a full inspection and to investigate listeria controls on site for patient and retail catering.

5.3. The Trust has robust food safety management systems in place which were scrutinised as part of the inspections and found to be satisfactory.

5.4. The EHO inspections determined that overall the findings were a combination of very good and satisfactory but there were some shortcomings relating to food storage, temperature monitoring and environment issues which required rectification. These have now been fully actioned.

6. Communications and Media Interest

6.1. Communications handling has been managed at a national level by PHE with support from NHS England.

6.2. The Trust Board has been briefed regularly by the Deputy Director of Communications on media interest and response.

7. Further Actions

7.1. To further enhance our food safety across the Trust, a number of additional actions have or are in the process of being completed including:

- A review of the catering management structure including the appointment of a Food Safety Manager working across both retail and patient catering who will work within the Estates and Facilities Governance and Assurance structure to ensure an impartial assessment of our catering and will provide an audit, report and advice function to continue the improvements within our patient and retail catering services. To be actioned immediately with substantive appointment by the end of September 2019.
- Reviewing the need and practicability of installing temperature data loggers on all of our ward refrigeration to ensure additional monitoring by end of August 2019.
- Change of responsibility for recording ward fridge temperatures from Ward staff to catering staff at the LRI to bring in line with the Glenfield and General sites. Completed.
- Additional training sessions supporting the need to reaffirm key customs and practice around our Patient Catering services. On-going.
- A focus on any minor repairs and refurbishment works across catering areas including Ward kitchens and a revue of any longer term capital works. On-going.
- Increase of audits involving Infection Control, Facilities and our consultant EHO to further enhance our existing food safety assurance systems and processes. On-going.

7.2. Throughout July we are undertaking comprehensive post incident analysis which will include a review of the future provision of food services, both patient and retail, across all sites. A multi-disciplinary task and finish team involving external experts and the LCC EHO inspector will review our existing policies, controls and principals of food provisions for all patient groups with findings reported to our Quality and Outcomes Committee of the Trust Board along with regular updates. We are arranging the first meeting for early August 2019.

The Trust Board is asked to note the contents of this report.