

Infection prevention and control: lessons from acute care in England

Timeline of selected interventions to reduce health care associated infections and improve infection prevention and control, 2001-2014.

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Key	Launch of national campaigns	Recommendations	Mandatory
2001	First edition of epic published – <i>The epic project: developing national evidence-based guidelines for preventing health care associated infections</i> ⁱ Surveillance of MRSA BSI ⁱⁱ		
2003	Report of the Chief Medical Officer: <i>Winning ways: guidance to reduce hospital acquired infection in England</i> ⁱⁱⁱ Surveillance of Glycopeptide-Resistant Enterococci (GRE) ^{iv} (became voluntary in April 2013) ^v		
2004	cleanyourhands (England and Wales) funded by the Department of Health; coordinated by the National Patient Safety Agency ^{vi} Surveillance of <i>C. difficile</i> -associated diarrhoea in patients aged 65 and over ^{iv} Surveillance of orthopaedic surgical site infections ^{iv} Patient Safety Alert issued, mandating placement of bedside alcohol handrub ^{vii} All NHS trusts to appoint a director of infection prevention and control ⁱⁱⁱ		
2005	Saving Lives – including high impact interventions based on the care bundle principle ^{viii} National target reduction for the number of incidents of MRSA bloodstream infections by 50% over three-year period (April 2005 – March 2008) compared to the 2003/04 baseline data ^{ix}		
2006	Health Act 2006, requirement for provider registration with regulator, requirement for providers to ensure protection against HCAI, and new code of practice on infections ^x Visits by Department of Health improvement teams to acute hospitals ^{xi} Chief Medical Officer makes CEOs personally responsible for the accuracy of infection data submitted by their trusts ^{xii}		
2007	Introduction of bare below the elbows guidance ^{xiii} epic2: <i>National evidence-based guidelines for preventing health care associated infections in NHS hospitals in England</i> ^{xiv} Surveillance of <i>C. difficile</i> infection extended to all cases in patients aged two and over ^{xv}		
2008	Patient Safety First ^{xvi} Prime minister declared HCAs a ‘top priority’ and ordered a programme of deep cleaning DH issued Clean, safe care: reducing infections and Saving Lives ^{xvii} Health and Social Care Act 2008: required registration with the Care Quality Commission: duty to protect patients against HCAs. New code of practice ^{xviii,xix} National target to reduce <i>C. difficile</i> infection by at least 30% by March 2011, compared to the 2007/08 baseline data ^{xx}		
2009	Matching Michigan programme ^{xxi} Some NHS trusts participated in Commissioning for Quality and Innovation (CQUIN) schemes that made a percentage of their incomes dependent on demonstrating compliance ^{xxii}		
2010	Robert Francis Inquiry Report into Mid Staffordshire NHS Foundation Trust (January 2005 – March 2009) ^{xxiii}		
2011	Surveillance of <i>Methicillin sensitive S. aureus</i> (MSSA) BSI ^{xxiv} Surveillance of <i>Escherichia coli</i> (<i>E. coli</i>) BSI ^{xxv}		
2013	Robert Francis Report of the Mid Staffordshire NHS Foundation Trust public inquiry ^{xxvi} Post-infection reviews for all MRSA BSIs ^{xxvii}		
2014	epic3: <i>National evidence-based guidelines for preventing health care associated infections in NHS hospitals in England</i> ^{xxviii}		

Timeline references

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