University Hospitals Sussex
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report

April 2024- March 2025

1. Executive Summary

University Hospitals Sussex NHS Foundation Trust (UH Sussex) continues to meet its statutory obligations under the Health and Social Care Act 2008 (the Hygiene Code). The Trust's annual Infection Prevention and Control (IPC) Board Assurance Framework assessment confirms broad compliance, with 41 of 54 standards fully achieved, 11 partially compliant, and only two non-compliant (fit testing). Plans are in place to address these areas, supported by recruitment and oversight through the Trust IPC Committee (TIPC), and Quality Governance Steering Group (QGSG), achieving full compliance in 2025/26.

All improvement actions identified following the 2023 Care Quality Commission (CQC) inspection have been delivered and are now embedded as part of "business as usual." The Trust is fully compliant with the National Infection Prevention and Control Manual (NIPCM).

1.1 Performance and Surveillance

- Infection rates per 100,000 bed days remain comparable or better than regional Trusts for most metrics, despite absolute numbers being high due to size and activity. Power BI dashboards have enhanced monitoring and divisional analysis.
- Mandatory surveillance trajectories were not fully met, but benchmarked well against other organisations. There was particular learning around line-associated infections and antimicrobial stewardship.

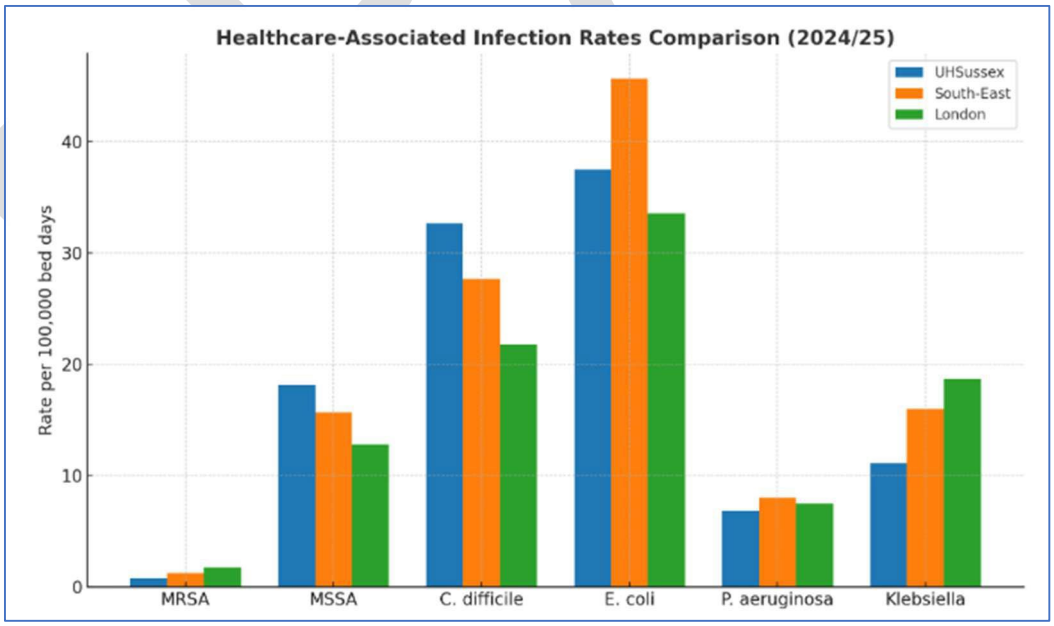

Table 1, UH Sussex Mandatory surveillance data benchmark per 100,000 bed days.

- Trust-wide programmes have been launched to strengthen vascular access device management, commode cleaning standards, and antimicrobial prescribing practices.
- Outbreak management was robust across the year, including respiratory viruses (influenza, COVID-19, RSV), and norovirus. A significant case of pan-resistant *Acinetobacter baumannii* with *Candidoyzma auris*, was safely contained.

1.2 Governance and Assurance

- Estates and Facilities, including water, and ventilation safety remain critical areas of focus. The Trust has progressed a 10-year ventilation replacement plan, strengthened the Water Safety Group, and influenced national design guidance to reduce risks associated with waterborne pathogens.
- Surgical site infection (SSI) surveillance is in place across cardiac, orthopaedic and breast surgery, with improvements seen in SSI rates.
- Decontamination services continue to be strengthened with central oversight, audits, and incident investigation.
- Antimicrobial stewardship has seen gradual improvement, although national consumption targets remain challenging due to workforce pressures in pharmacy and microbiology.

1.3 Workforce, Education, and Research

- IPC training compliance remains high at 92.3%, with strong engagement through IPC Link Champions and participation in national campaigns such as “Gloves Off.”
- Fit testing capacity is being expanded through dedicated recruitment.
- Staff vaccination uptake was lower than desired (31% influenza, 26% COVID-19), contributing to staff absence during outbreaks.
- Recruitment of a dedicated fit testing team is underway.
- The IPC team continues to grow as a research-active department, with contributions to national guidelines, national and international networks, and sustainability-focused projects such as safe reuse of medical equipment.

1.4 Priorities for 2025/26

- **Achieve full compliance:** Ensure full compliance with the IPC Board Assurance Framework, including antimicrobial stewardship and provision of a fit testing service at all main Trust sites.
- **Strengthen surveillance:** Expand surgical site surveillance (including additional categories), improve line-associated bloodstream infection prevention, and increase IPC reviews and visits across all Trust sites.
- **Embed audit and accountability:** Deliver robust audit feedback, ensure divisional accountability, and integrate PSIRF methodology into infection investigations for efficient capture and learning.
- **Assure environmental safety:** Support Facilities and Estates to maintain water and ventilation standards across the Trust.
- **Grow engagement:** Expand the IPC Link Champion programme and clinical engagement across all departments and sites.
- **Broaden research and innovation:** Enhance research skills and initiatives within IPC, promote sustainability projects (including hydration and mouth care), and increase regional and national impact through conferences and collaborations.

1.5 List of Abbreviations used in the document

No.	Abbreviation	Full Text	No.	Abbreviation	Full Text
1	3Ts	Teaching Tertiary and Trauma	34	IPOG	Infection Prevention Operational Group
2	AMP	Anti-microbial pharmacist	35	IV	Intravenous
3	BAF	Board Assurance Framework	36	*K. pneumoniae, K. oxytoca,* Klebsiella spp.	*Klebsiella pneumoniae, Klebsiella oxyto*ca and Klebsiella species
4	BSI	Blood stream infection (bacteraemia)	37	LIMS	Laboratory information management system
5	CAG	Clinical Advisory Group	38	LMB	Louisa Martindale building
6	cDIPC	Corporate Director Infection Prevention Control	39	MDRO	Multi drug resistant organisms
7	CDT	*Clostridioides difficile* toxin	40	MPV	MPox virus (previously Monkeypox)
8	CEO	Chief Executive Officer	41	MRSA	Meticillin Resistant *Staphylococcus aureus*
9	CMO	Chief Medical Officer	42	MSM	Men who have Sex with Men
10	CNO	Chief Nursing Officer	43	MSSA	Meticillin Sensitive *Staphylococcus aureus*
11	COCA	Community-onset community-associated	44	NHSE	National Health Service England
12	COHA	Community-onset healthcare-associated	45	PLACE	Patient Led Assessment of the Care Environment
13	COIA	Community-onset indeterminate-associated	46	PPE	Personal protective equipment
14	COVID-19	Coronavirus disease of 2019	47	PRH	Princess Royal Hospital
15	CPA	Clinical Pathology Accreditation	48	PSIRF	Patient Safety Incident Response Framework
16	CPE	Carbapenemase-producing Enterobacterales	49	QGSG	Quality Governance Steering Group
17	CQC	Care Quality Commission	50	QSIP	Quality Safety Improvement Programme

18	CSSD	Central sterile services departments
19	DCS	Data Capture System
20	DDD	Defined Daily Dose
21	DIPC	Director of Infection Prevention Control
22	EDU	Endoscopy decontamination units
23	EPRR	Emergency preparedness resilience and response
24	EUCAST	European Committee on Antimicrobial Susceptibility Testing
25	FFP	Filtering Face Piece
26	HCAI	Healthcare-associated Infection
27	HOHA	Hospital-onset healthcare-associated
28	HPV	Hydrogen Peroxide Vapour
29	HTM	Health Technical Memorandum
30	ICB	Integrated Care Board
31	iGAS	Invasive Group A Streptococcus
32	IPC	Infection Prevention & control
33	IPCT	Infection Prevention & control Team

51	RACH	Royal Alexandra County Hospital
52	RSCH	Royal Sussex County Hospital
53	SCFT	Sussex Community Foundation Trust
54	SRH	St Richards Hospital
55	SRO	Senior Responsible Officer
56	SSD	Sterile Service Department
57	SSI	Surgical Site Infection
58	SSISS	Surgical Site Infection Surveillance Scheme
59	STAM	Statutory and mandatory training
60	THR	Total hip replacement
61	TIPC	Trust Infection Prevention Committee
62	TKR	Total Knee replacement
63	UHSussex	University Hospitals Sussex NHS Foundation Trust
64	UKHSA	UK Health Security Agency
65	VIP	Visual infusion phlebitis
66	WGS	Whole-genome sequencing
67	WH	Worthing Hospital
68	WSP	Water Safety Plan

2. Introduction

Welcome to the annual Director of Infection Prevention and Control (DIPC) report for University Hospitals Sussex (UHSussex) for the year 2024-25. UHSussex serves a community of 1.9 million people and employs nearly 20,000 staff across seven main hospital sites and several smaller locations.

2.1 What This Report Covers

This report summarises our infection prevention and control (IPC) and antimicrobial stewardship efforts from April 1, 2024, to March 31, 2025. It includes all UHSussex sites.

- Royal Sussex County Hospital (RSCH)
- Royal Alexandra Children's Hospital (RACH)
- Sussex Eye Hospital (SEH)
- Princess Royal Hospital (PRH, Haywards Heath)
- Worthing Hospital (WH)
- Southlands Hospital (SH, Shoreham)
- St Richard's Hospital (SRH, Chichester

Additionally, it covers services at Crawley & Worthing Sexual Health Service, Brighton General Hospital, Hove Polyclinic, Newhaven Hospital, and Park Centre for Breast Care. We also have IPC service contracts with three hospices in West Sussex.

2.2 Compliance and Assurance

We are pleased to report that UHSussex meets requirements of the CQC under the Health and Social Care Act 2008 regulations (the Hygiene Code). Our IPC Board Assurance Framework assessment confirms our broad compliance with these regulations. We are fully compliant in 4 domains, partially compliant in 6 domains with 1 area of concern which is not compliant in some parts of the trust (table 2 below) related to backlog estates maintenance of critical ventilation. The trust is sighted on areas where we need to make improvement. Any areas of concern identified by the CQC in August 2023 have been addressed. We are compliant with the National Infection Prevention and Control Manual (NIPCM).

2.3 Our Commitment to Safety

This report is based on the Hygiene Code framework and outlines our IPC arrangements. It highlights the projects and initiatives we have implemented over the past year to protect our patients from healthcare-associated infections (HCAIs). This ensures that our patients, staff,

and the public can trust that we are meeting our obligations for patient safety and clinical governance.

3. Organisation and Governance of IPC Service

Criteria 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.

3.1 Governance framework

Every Trust must have a Director of Infection Prevention and Control (DIPC). At UHSussex, the Chief Nurse, Maggie Davies, is the Executive DIPC, with Pat Cattini as the Corporate Director handling daily responsibilities, and Sharon Reed as the operational lead nurse and Deputy DIPC.

The Trust's Infection Prevention and Control Committee (TIPC) oversees all IPC activities and meets quarterly. The TIPC receives assurance reports from the water Safety Group, Ventilation Safety Group, Decontamination Group, Antimicrobial Pharmacy, Surgical Site Surveillance, Estates and Facilities, Capital development and Property, and Occupational Health.

TIPC reports to the Quality Governance Steering Group (QGSG), which then reports to the Patient and Quality Committee, a sub-committee of the Executive Board.

Monthly IPC Operational Group (IPOG) meetings, chaired by the Deputy DIPC, monitor progress on the IPC work plan. These meetings help address operational issues and escalate them to TIPC if needed. IPOG reports contribute to the quarterly TIPC report, summarizing IPC activities.

The statutory DIPC Annual Report and the Board Assurance Framework (IPC-BAF) are presented through TIPC.

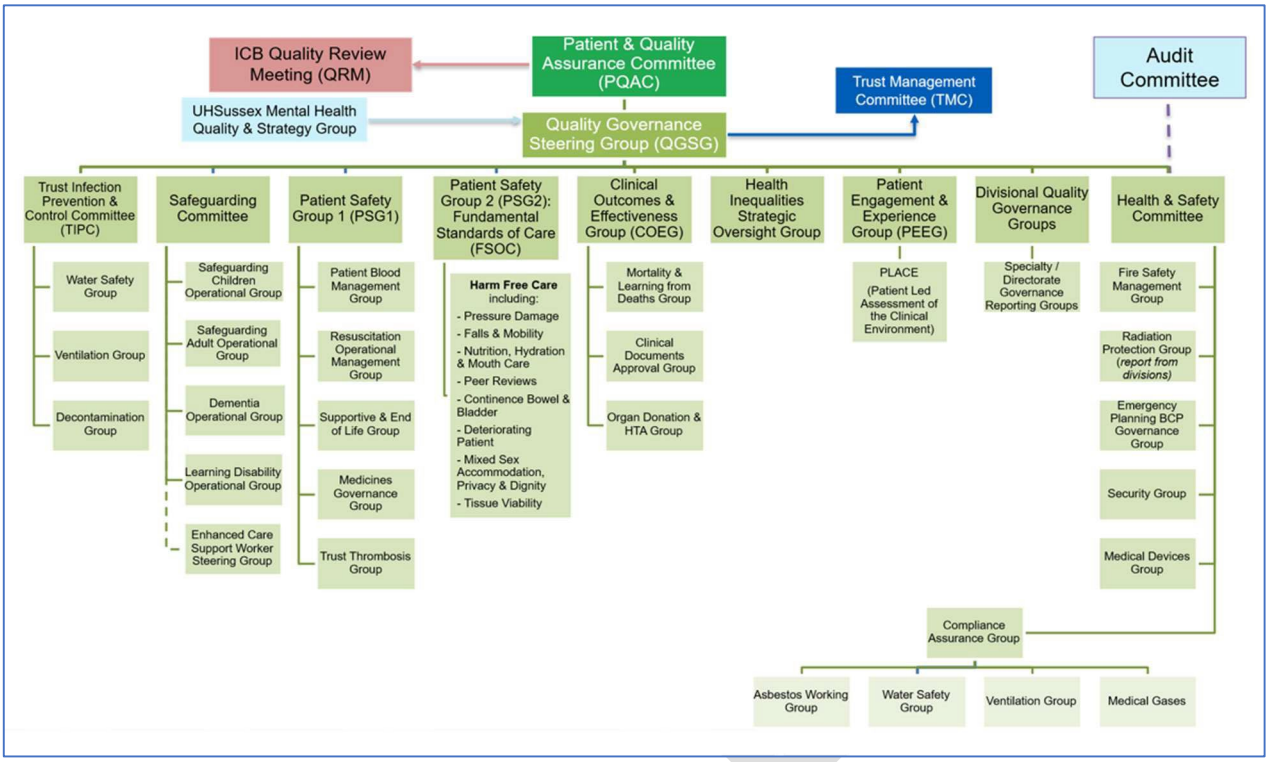

Table 2 Trust Governance structure

3.2 Infection Prevention and Control Team (IPCT)

Infection prevention is part of every role at UHSussex. The Infection Prevention and Control Team (IPCT) provides expert guidance and supports staff in maintaining high IPC standards. They ensure guidelines, policies, and protocols are up-to-date and effectively implemented to reduce HCAI. The IPCT focuses on educating staff, promoting proper antimicrobial use, advising on personal protective equipment (PPE), and managing infection outbreaks.

The IPCT works closely with site and clinical teams to ensure safe patient placement and risk reduction. They are supported by Consultant Microbiologists and Virologists, and a part-time Infection Prevention and Control Doctor (ICD) Dr James Price (4 PA's).

The team is structured to recruit and develop practitioners at various levels, ensuring sustainability and succession planning. Team members receive ongoing training and attend relevant conferences to stay current. The IPCT has a presence on each of the four main sites, providing consistent advice across the organisation.

To address antimicrobial resistance, the IPCT works with the Trust's Antimicrobial Pharmacists to promote safe antimicrobial use. The clinical lead Antimicrobial Pharmacist is Joanne Munns.

IPC also work closely with the Estates and Facilities teams on environmental hygiene, decontamination, new builds, refurbishments, ventilation, and water safety.

3.3 Key roles and responsibilities

The IPCT is responsible for all aspects of infection control across all staff groups. This includes managing outbreaks, alert organism management, environmental management, antimicrobial stewardship, education, and epidemiology. Their duties include:

- Providing expert advice to staff, patients, and visitors.
- Participating in surveillance, investigation, and management of HCAI and infectious diseases.
- Ensuring compliance with current legislation and guidance.
- Advising the Trust board on IPC legislation and compliance.
- Planning and implementing strategies to reduce HCAI, including mandatory training.
- Ensuring policies and procedures are in place for safe and effective care, such as hand hygiene.

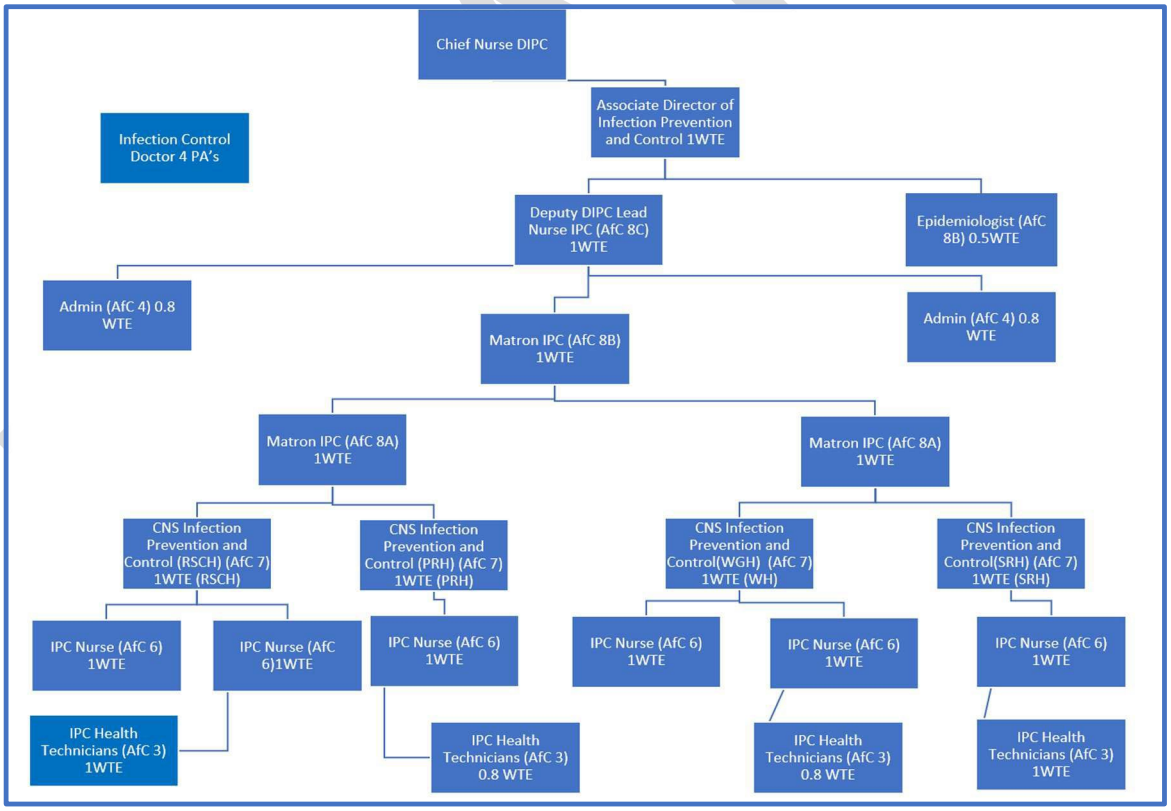

Table 3 Infection Prevention and Control Team structure at UHSussex

3.4 TIPC membership

The TIPC has a broad membership with representation from divisions and our partner organisations (see Appendix 1). TIPC terms of reference are reviewed and agreed annually.

3.5 IPC Board Assurance Framework (BAF)

The IPC BAF is updated annually to assure the Trust Board that IPC arrangements align with the National Infection Prevention and Control Manual (NIPCM) and the Health and Social Care Act 2008 (Hygiene Code).

Hygiene Code Criteria	Description	See Report Section	BAF Section
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of the service users and any risks that their environment and other users may pose to them.	3	1
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	6	2
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.	7	3
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.	5 & 8	4
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.	4 & 9	5
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	10	6
7	The provision or ability to secure adequate isolation facilities.	11	7
8	The ability to secure adequate access to laboratory support as appropriate.	12	8
9	That they have and adhere to policies designed or the individual's care, and provider organisations that will help prevent and control infections.	13	9
10	That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage infection, prevention and control.	14	10

Table 4 Health and Social Care Act 2008: Code of Practice on the prevention and control of infection (Hygiene Code).

The BAF includes 54 key lines of enquiry over the 10 domains of the Hygiene Code. The annual BAF assessment found that six domains are fully compliant and four partially compliant. Of the 54 elements, the trust is fully compliant against 41, partially compliant against 11 and non-compliant against 2.

The two areas of non-compliance are around fit testing (criteria 6), however there is a plan in place and recruitment will begin shortly. The work plan will go to TIPC to provide delivery oversight. This will enable the Trust to be compliant in this area next year.

The areas of partial compliance are around antimicrobial stewardship (criteria 3) and OH support (criteria 10). This is due to the shortages of pharmacists and lack of access to data to identify trends. Funding allocated for a pharmacist recruitment drive in 2025 will bring further support.

The framework report acts as a gap analysis and allows us to prioritise areas for improvement going forward. Incomplete domains and elements are escalated through the QGSG for risk oversight. Key areas for improvement and actions are documented and a summary with associated actions is documented in Table 5a.

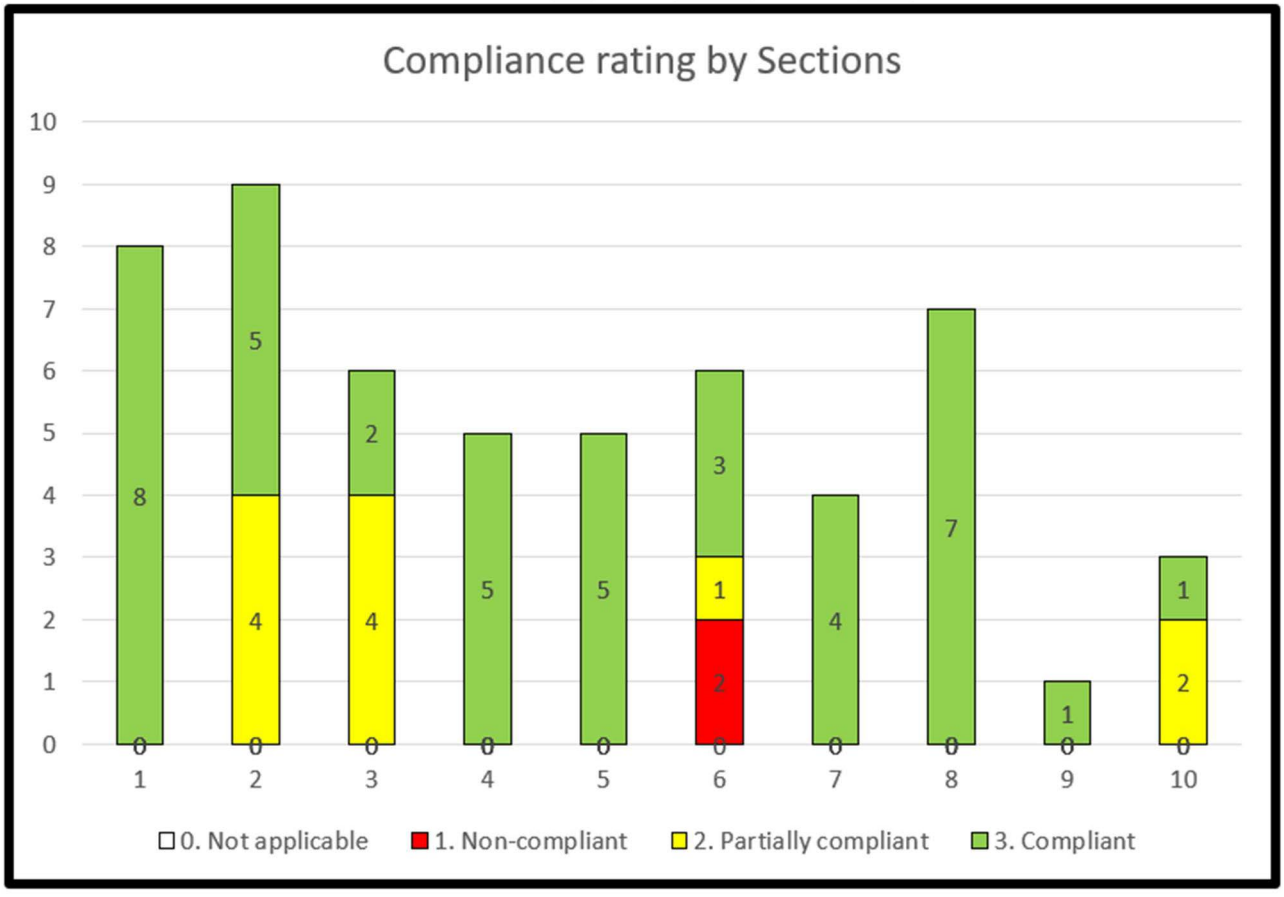

Table 5 Summary 2024 BAF assessment of each section of the Hygiene Code (see table 2)

3.6 Risk assessment

The IPC risk register is updated at least quarterly. Two significant risks (score over 12) are detailed on the IPC risk register: inadequate staff FFP3 respirator fit testing and failures in critical ventilation across UHSussex. These risks are also identified in the BAF with associated mitigations.

Risk Identified	Actions
Imperfect ventilation strategy and delivery	Physical mitigations are in place in non-critically ventilated areas (HEPA filtered air scrubbers, open windows/natural ventilation). Trust wide plans for improvement of critical ventilation have been drawn up. Significant remedial work will be undertaken over the next 10 years.
Lack of planned preventative maintenance in some areas inhibiting environmental cleaning.	Estates working with IPC and hospital leadership teams to effect repairs in prioritised areas. An Estates Improvement Group has been set up for next year and strategic plans are in place for significant capital investment to improve the Estate.
Need to improve waste handling	Local audits are showing some non-compliance with incorrect segregation at source. There is a limited team offering waste support and education across the Trust.
Non-compliance with segregation of laundry at source	Issues with segregation of laundry at ward level leading to excess red bag laundry is being addressed by direct intervention from IPC team.
Limited antimicrobial stewardship service across UHSussex	Development of ward specialist pharmacists to support within clinical areas and business plans for increasing pharmacy workforce. Need to improve EPMA and digitisation of pathology to understand prescribing data, trends and antimicrobial resistance patterns.
Sub-optimal fit-testing for staff	Effort to prioritise high risk staff for fit testing. Recruitment underway for substantive fit testers with aim this will be green next year.
Occupational Health service provision at UHSussex sites	Planning for enhanced availability and service for screening; staff vaccination support. Plans in place for UHSussex to consider a single trust wide service.

Table 6 Themes identified in 2025 BAF assessment

3.7 CQC Action Plan

Following the CQC inspection in August 2023, the trust completed the required actions which include aspects of infection prevention and control. There were 7 identified areas for improvement. Evidence of compliance was collated and monitored by the CQC steering group. This work needs is now ‘business as usual and thus monitored through TIPC on a quarterly basis.

Regulation 12: Safe Care and Treatment - IPC Audit, monitoring and ventilation	Target completion action owner	Trust Target Completion	RAG
1.Update annual audit programme for coming year and publish in the annual report.	31/03/2024	N/A	Completed
2. IPC healthcare assistants to work on wards 2 hours a week to develop consistent audit practice.	30/04/2024	30/09/2024	Completed
3. Introduce IPC champions to provide a conduit between IPC and clinical departments.	31/03/2024	30/09/2024	Completed
4.Introduce divisional IPC 'Deep Dives' to pull together data for each division to be shared at Governance meetings.	31/12/2024	31/12/2024	Completed
5. Continue to refine SSI data collection and expand service offer.	31/12/2024	31/12/2024	Completed
6. Formalise IPOG audit reporting template for all divisions with training.	31/03/2024	N/A	Completed
7. Second annual IPC Team away day April 24	09/04/2024	30/09/2024	Completed

Table 7 IPC CQC actions

4. Healthcare-associated Infection surveillance Mandatory Reporting

Criteria 5: There is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

All Trusts in England must submit monthly data on key healthcare-associated infections to the UK Health Security Agency (UKHSA) Data Collection Scheme (DCS).

4.1 Key Infection Categories:

- **Hospital Onset Healthcare Associated (HOHA):** Infections detected in the hospital two or more days after admission.
- **Community Onset Healthcare Associated (COHA):** Infections occurring in the community or within two days of admission, if the patient was an inpatient in the reporting Trust within the previous four weeks.
- **Community Onset Indeterminate Association (COIA)**
- **Community Onset Community Associated (COCA)**

HOHA and COHA cases are considered attributable to the Trust.

4.2 Performance Summary:

- The UH Sussex infection rates for all five mandatory surveillance metrics exceeded national thresholds (where available).
- When compared to other Trusts in the South-East, our infection rates per 100,000 bed days are comparable to or better than those of other hospitals.
- This highlights the importance of measuring infection rates rather than absolute numbers to understand our performance in infection prevention and control (IPC) over the past year.
- IPC implemented Microsoft Power BI tools to optimise mandatory national infection surveillance reporting, including risk factor collation and analysis. IPC have undertaken a Divisional level analysis, looking at trends in key reportable healthcare-associated infections, summary on which is provided alongside each 'key organism'.

Mandatory reportable infections	**Q1**	**Q2**	**Q3**	**Q 4**	**Year to date case s**	**UKHSA Q1 threshold 25/26**	**UKHSA Annual threshol d F25/26**
Meticillin-resistant *Staphylococcus aureus* (MRSA) BSI	1	-	-	-	1	0	0
Meticillin-sensitive *Staphylococcus aureus* (MSSA) BSI	18	-	-	-	18	No threshold	No threshold
Escherichia coli (E.coli) BSI	55	-	-	-	55	43	208
Klebsiella *species* BSI	18	-	-	-	18	12	67
Pseudomonas aeruginosa (P.aeruginosa) BSI	15	-	-	-	15	6	36
Clostridioides difficile (C.difficile) infection	45	-	-	-	45	30	152

Table 8: Summary of mandatory reportable healthcare-associated infections at UHSussex by quarter. Results are RAG rated against national quarterly threshold (red = above threshold, orange = meets threshold, green = below threshold, grey = no national threshold provided). Hospital onset healthcare associated (HOHA): cases that are detected in the hospital two or more days after admission. Community onset healthcare associated (COHA): cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks. DCS = UKHSA data capture system. YTD = year to date. Key: NA = no national ceiling available, MSSA = Meticillin resistant S. aureus, MRSA = Meticillin resistant S. aureus.

4.3 Healthcare-associated *Staphylococcus aureus* (MSSA and MRSA) bloodstream Infections

Healthcare-associated *S. aureus* bloodstream infections, including both Meticillin-sensitive (MSSA) and Meticillin-resistant (MRSA) strains, are significant due to their high morbidity and mortality rates, especially in vulnerable patients. These infections often result from invasive procedures and prolonged hospital stays. MRSA is particularly challenging due to its resistance to many first-line antibiotics. While MSSA can be treated with a broader range of antibiotics, prompt and effective management is crucial to prevent severe complications. Both MSSA and MRSA infections underscore the need for stringent IPC measures to prevent transmission and outbreaks. Early detection and targeted antimicrobial therapy are essential for improving patient outcomes and reducing the healthcare burden.

4.4 MRSA

- **Reported Cases:** In 2024/25, there were five healthcare-associated MRSA BSI HOHA and/or COHA), against a UKHSA ceiling of zero cases (Figure 1).
- **Infection Rates:** The cross-Trust rate was 0.78 per 100,000 bed days, a decrease from 1.08 per 100,000 bed days in FY 23/24 and lower compared to a South-East rate of 1.23 and the London rate of 1.73 (figure 2).
- **Hospital-Onset Cases:** Four out of the five cases (80%) were hospital-onset.
- **Investigations and Actions:** Risk factor analysis noted 19% of all MRSA BSI's during a 10-month period attributable to vascular access devices or line-associated, with Medicine and Surgery Divisions sharing the majority of case incidence, which is expected owing to them being the largest Divisions.
    - As part of the after-action review (AAR), which is within the PSIRF methodology, for all MRSA BSIs, we identified the following themes, 1) Delay of prescribing suppression therapy, 2) Suppression therapy not administered correctly (diluted rather than using neat), and 3) lack of IV-line care and phlebitis awareness.
    - In response, we reviewed our suppression therapy guidance, focused on optimising approaches around intra-venous placement times and worked with the antimicrobial stewardship group to harmonise suppression therapy. Specifically, consideration being given to IPC being able to prescribe

suppression therapy under a Patient Group Directive (PGD). Further work needed to ensure governance supports this method.

- IPC's annual programme of work will include line-associated BSI surveillance as a top priority for FY 2025/26.

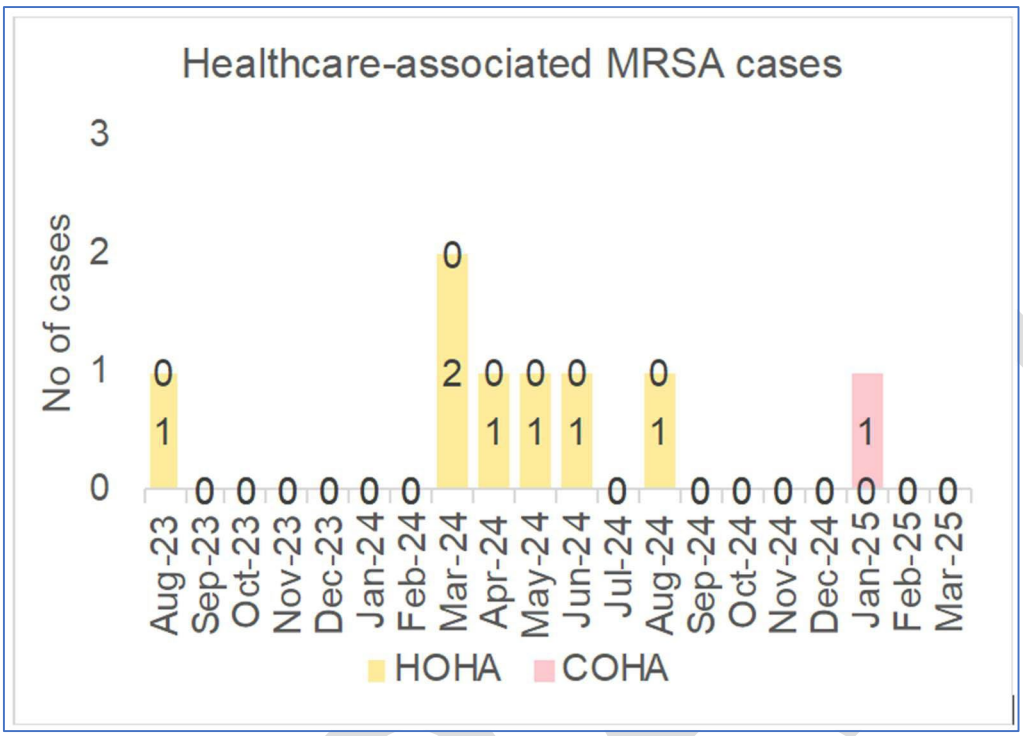

Figure 1: Healthcare-associated MRSA BSIs at UHSussex by month.

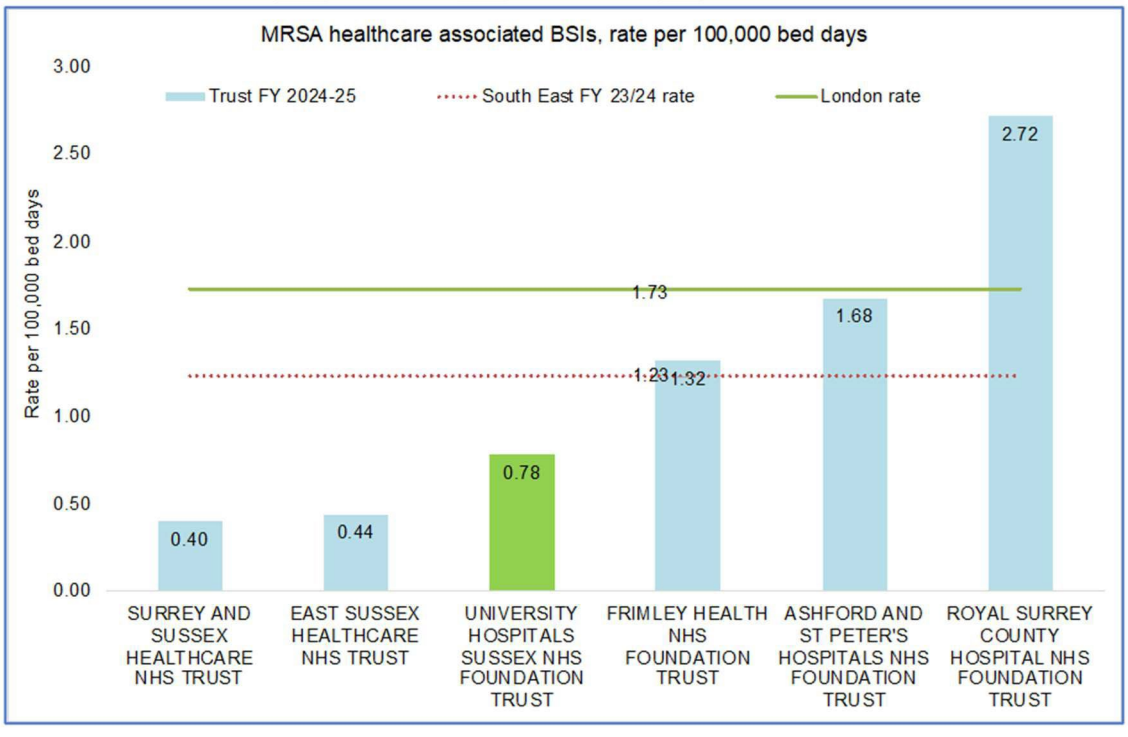

Figure 2: MRSA healthcare associated BSI rate comparison – South-East region and London.

- **Screening Policy:** In line with national guidance, the Trust introduced a new MRSA screening policy in October 2022 and consequently no longer routinely screen all patients on admission. Three of the MRSA BSI cases occurred in patients who were not screened as they did not meet the risk factor threshold.

4.5 MSSA

- **Reported cases:** In 2024/25, there were 116 cases of MSSA BSI reported (figure 3). There is no national target for these cases.
- **Infection rates: The** UH Sussex rate (18.13) sits above both the London and South-East rate, 12.8 and 15,7 respectively. UHSussex sits second highest amongst SE Trusts (figure 4).
- **Investigations and Actions:** Risk factor analysis (Figure 5) noted almost 11% of all BSI during a 10-month period attributable to vascular access devices, with the divisions of Medicine and Surgery claiming the vast majority, followed by Women's and Children and Specialist.
    - In recognition of line-associated infections making up the top source for both MRSA and MSSA BSI, IPC will lead of a surveillance programme in FY 25/26, focusing on key specialities including renal and haematology.

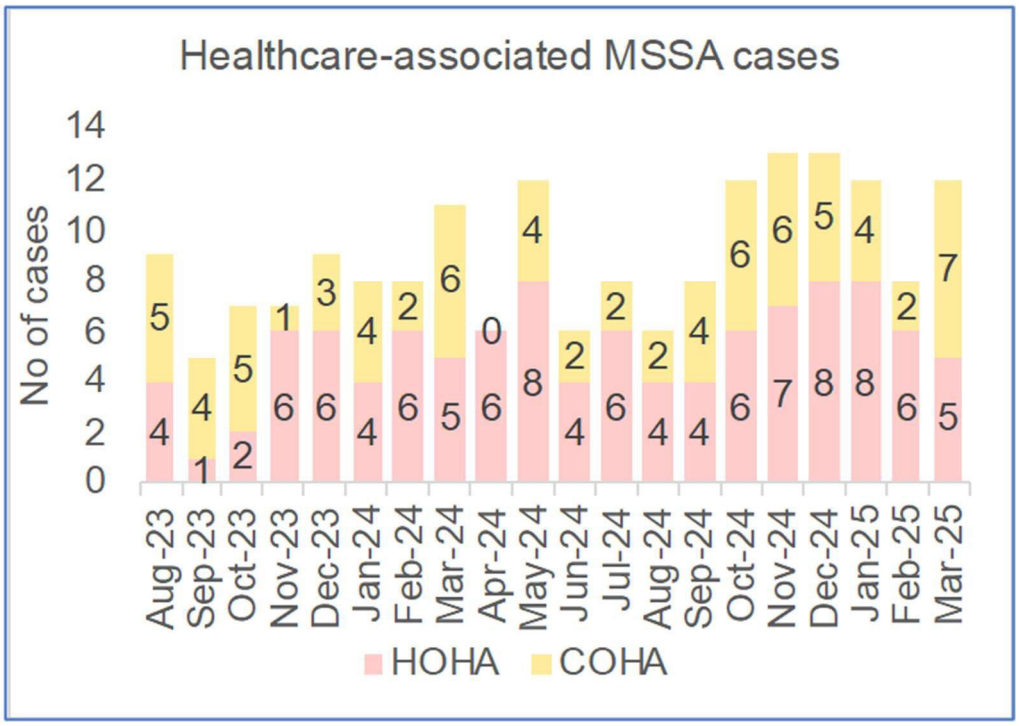

Figure 3: Healthcare-associated MSSA BSIs at UHSussex by month.

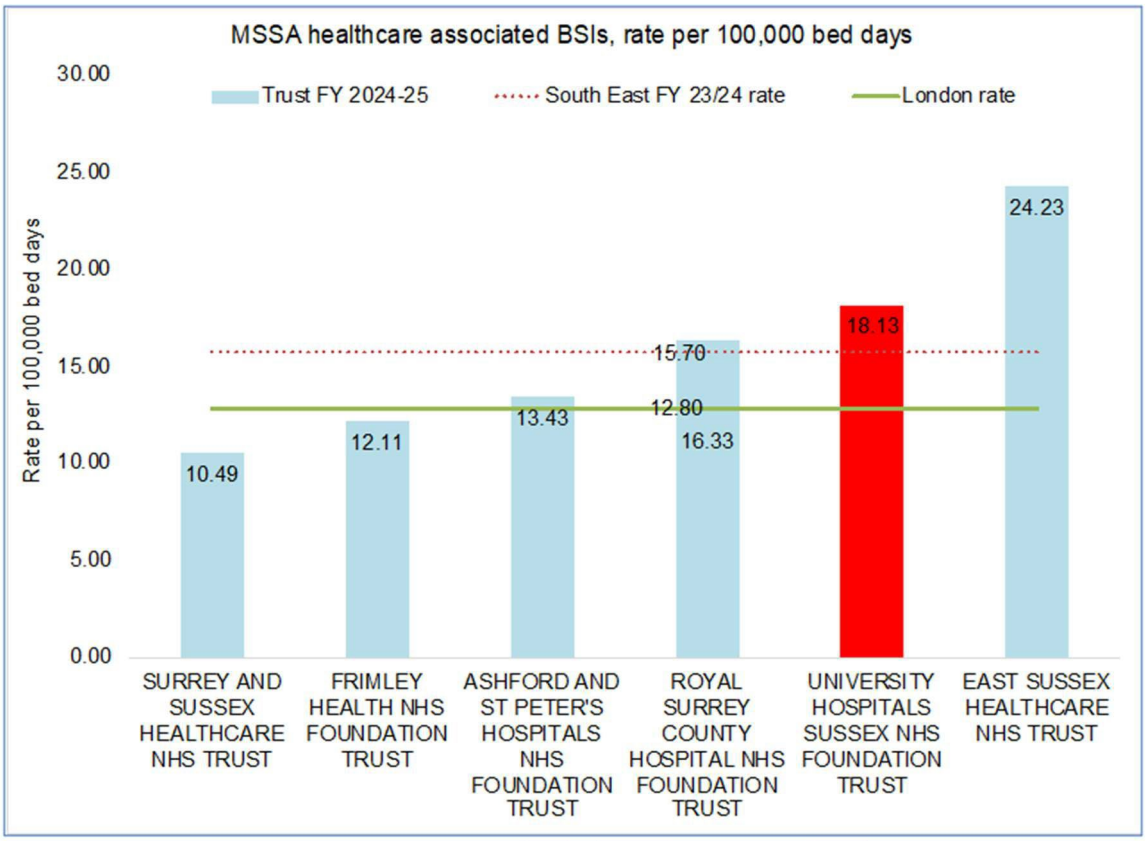

Figure 4: MSSA healthcare associated BSI rate comparison – South-East region and London.

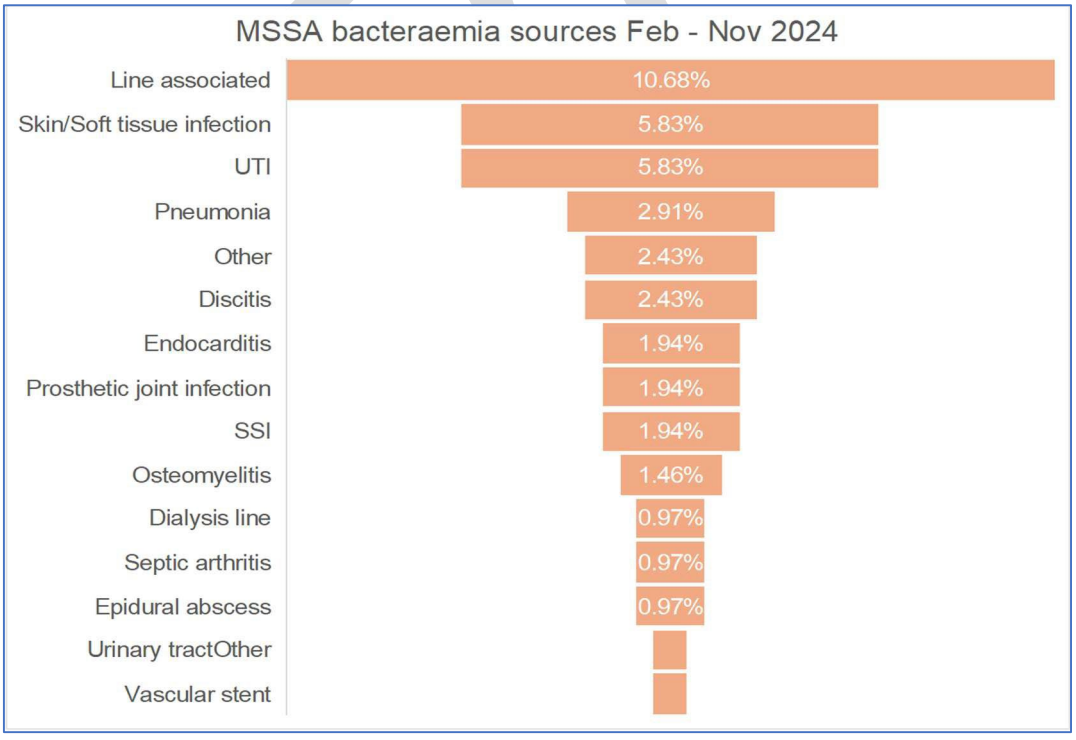

Figure 5 Analysis of MSSA Bacteraemia source Feb-Nov 2024

4.6 *C. difficile* infections

C. difficile infections (CDI) are a major concern due to their high morbidity, mortality, and healthcare costs, especially among elderly and immunocompromised patients. These infections often occur after antibiotic use, which disrupts normal gut bacteria, leading to severe diarrhoea and potentially life-threatening complications like toxic megacolon and sepsis. The recurrent nature of these infections makes treatment challenging and increases the risk of long-term health issues. As with other infections monitored as part of the DCS, CDI has shown a rise nationally since the COVID-19 pandemic (figure 6).

- **Reported cases:** In 2024/25, there were 209 cases of *C. difficile* infections reported, within the context of a UKHSA threshold of 152 (figure 7).
- **Infection rates: The** UH Sussex rate (32.67) sits above the London and the South-East rate, 21.8 and 27.7 respectively. UHSussex sits second highest across the South-East (figure 8).
- **Prevention and Management:**
    - **Stringent IPC Measures:** Hand hygiene, environmental cleaning, and careful antibiotic use are crucial to prevent the spread within healthcare facilities.
    - **Early Diagnosis and Management:** Prompt diagnosis and targeted antimicrobial therapy are essential to improve patient outcomes.

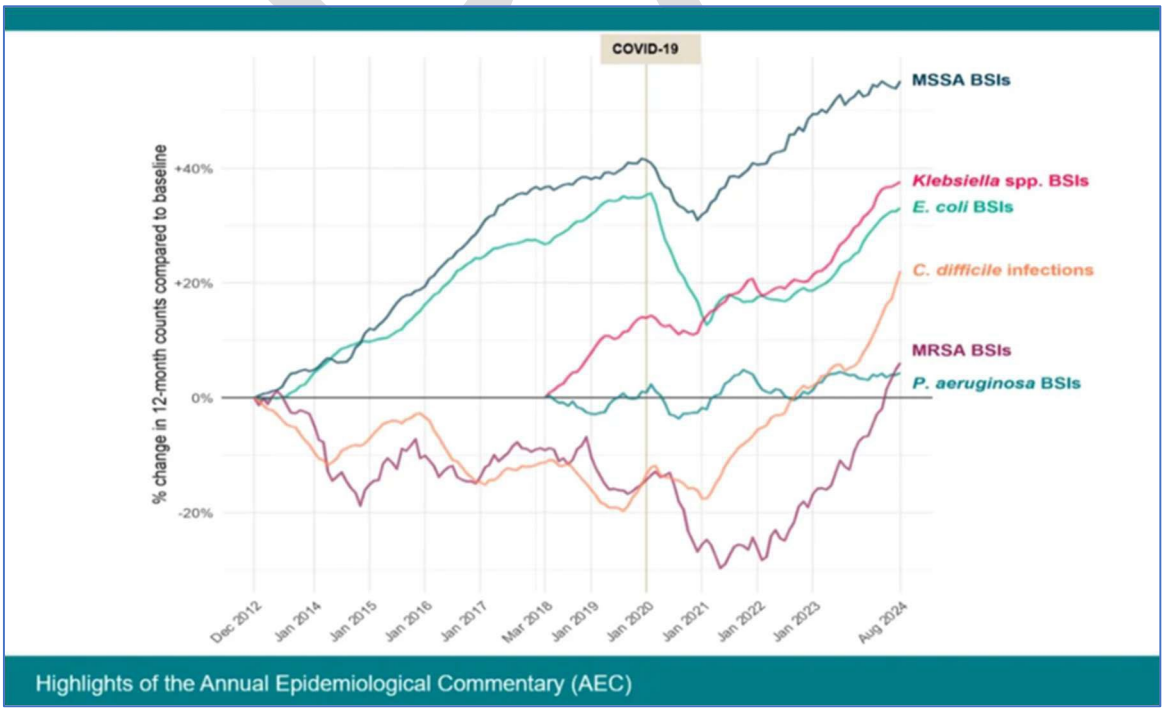

Figure 6 English national data for healthcare associated infections since 2012.

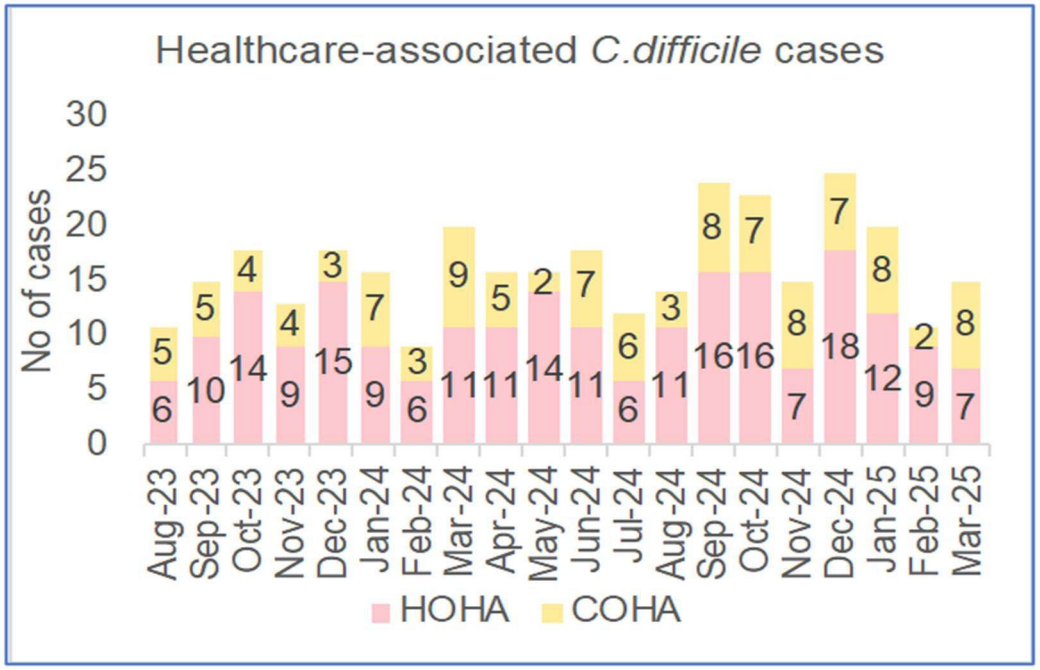

Figure 7: Trend in healthcare-associated C.difficile infections, FY 2024/25

- **Ribotyping** helps identify specific strains of *C. difficile* that are hard to control during outbreaks or may lead to poor clinical outcomes. This method is used when there is an increase in cases or suspected transmission within the same area and time frame.
- In response to the year on year rise in *C. difficile* cases, IPC formulated a Trust-wide action plan, outlining key interventions – a) establishment of a monthly MDT meeting to discuss key themes driving *C. difficile* cases, b) develop and deploy *C. difficile* specific Patient Safety Incident Response Framework (PSIRF) alongside the DATIX system, to drive our understanding of risk factor data and direct learnings, which will go live in mid-May 2025, c) provide targeted training at ward level, d) drive *C. difficile* agenda via the monthly Antimicrobial Stewardship Group (ASG) – looking at prescribing among other factors, and e) promoting audit and peer-reviews to drive Trust wide learning and consistency of clinical approach. The Trust-wide action plan came into effect in mid-Feb 2025. In Q4 we noted a drop in *C. difficile* numbers, with the final figure for the quarter standing lower than the previous three quarters (n=46). We will continue to monitor progress against the plan in the coming FY 2025/26.
- Current thematic analysis of these cases highlights sub-optimal IPC practices, particularly in relation to commode audits, which assesses the cleanliness of bedpans, shower chairs, toilet seats, commodes, and the accuracy of labelling. The most common reasons for audit failures include inadequate cleaning of toilet seats and commodes, as well as incorrect or missing labelling.

- The incidence spread is across the divisions of Medicine and Surgery claiming the vast majority, followed by Specialist and the division of Women's and Children.

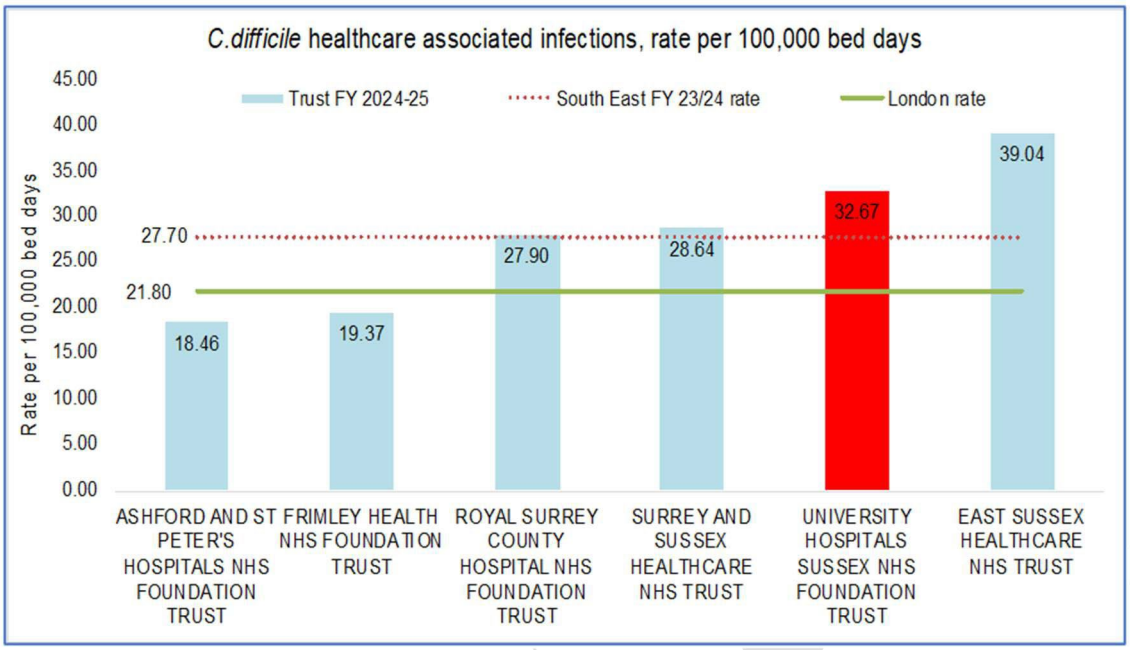

Figure 8: C.difficile healthcare associated infection rate comparison – South-East

Figure 8b below shows the Statistical Process Chart (SPC) for *C.difficile*. There is a spike in Dec-24 standing out as the only point passing the upper control limit. To date this calendar year has not yet seen a datapoint exceeding the upper control limit. Over the period Apr-2020 to June-2025, we see a steady rise in the number of data points over the mean, suggesting an upward trend in infection incidence, which chimes with the National and internal picture

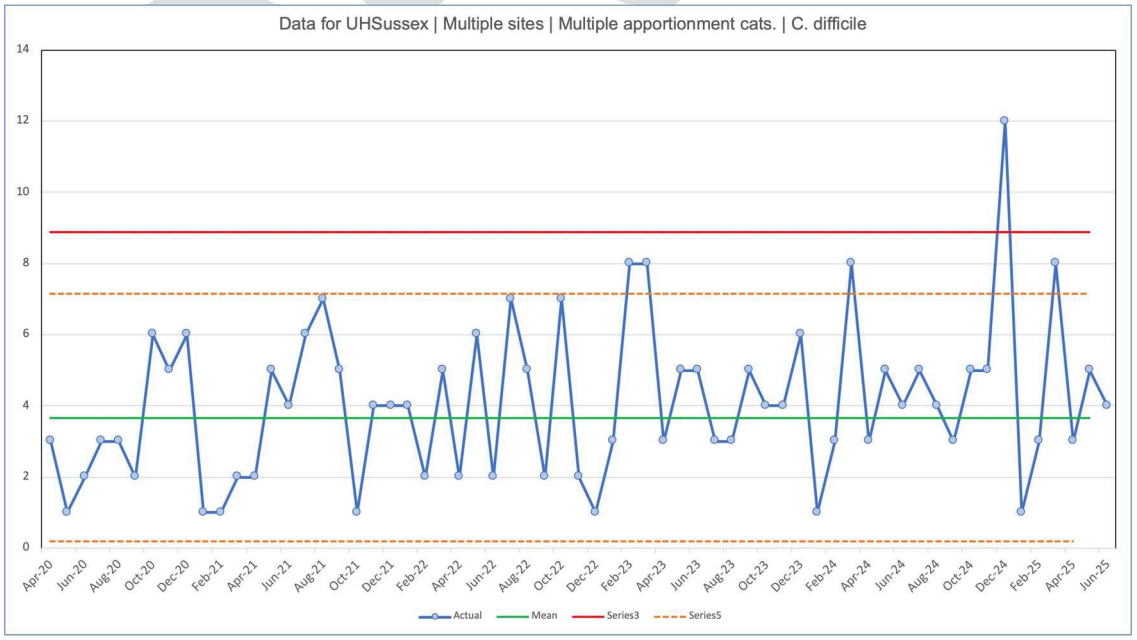

Figure 8b: C.difficile healthcare associated infection rate – Statistical Process Chart.

4.7 Gram-negative blood stream infections

Infections caused by Gram-negative bacteria like *E. coli*, *Pseudomonas aeruginosa*, and Klebsiella species are serious due to their high morbidity, mortality, and increasing antibiotic resistance. These infections often occur in patients with long hospital stays, invasive devices, or underlying health conditions, leading to severe complications such as septic shock and organ failure.

- ***E. coli*:** Commonly originates from urinary or gastrointestinal sources.
- ***P. aeruginosa* and Klebsiella species:** Notable for their ability to develop resistance to multiple antibiotics.
- **Multidrug-Resistant Strains:** The rise of strains like Carbapenem-Resistant Enterobacterales (CRE) complicates treatment, requiring more toxic and less effective therapies.
- **Effective IPC Measures:** Crucial to prevent the spread of these infections.
- **Prompt Diagnosis and Targeted Therapy:** Essential to manage infections and improve patient outcomes.

4.8 *E. coli* Infections

- **Reported Cases:** There were 240 healthcare-associated *E. coli* BSI's, exceeding the UKHSA threshold of 219 cases (figure 9).
- **Infection Rate:** The UH Sussex rate (37.5) sits above the London rate (33.6) and below the South-East rate of 45.7. UHSussex sits lowest across the South-East Trusts (figure 10).
- **Investigations and Actions**
  - Risk factor analysis (Figure 11) showed that 23% of BSIs over a 10-month period were attributable to urinary tract infection with a further 12% linked to a hepatobiliary source, with the divisions of Medicine and Surgery claiming the vast majority, followed by Women's and Children and Specialist.
  - Hydration is increasingly recognized as a crucial factor in reducing Gram-negative BSI. The Trust is part of a Sussex-wide project led by the ICB to explore how promoting hydration can help reduce these infections. This two-year collaborative project focuses on improving the hydration status of people over 65 living in their own

homes. It involves using a hydration plan and addressing educational barriers to proper hydration. Additionally, we aim to better understand the origin and specialty of *E. coli* bacteraemia, starting with healthcare-associated infections, to develop a targeted strategy for reducing their incidence.

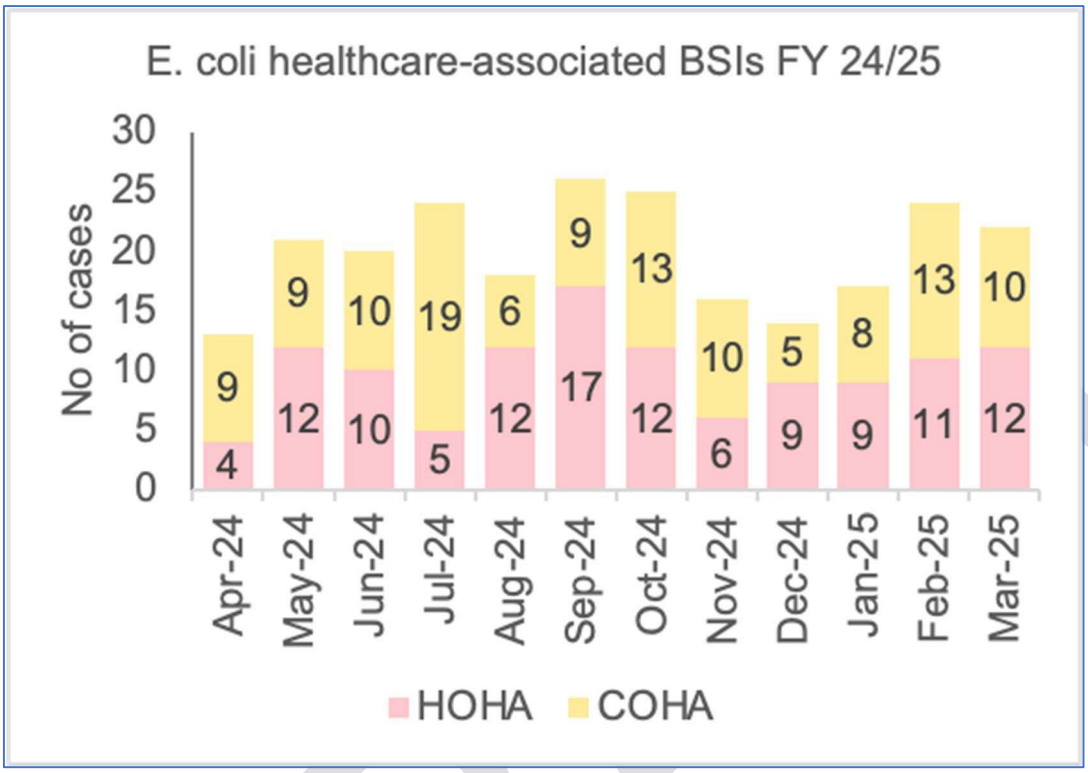

Figure 9: Healthcare-associated E. coli BSIs at UHSussex by month.

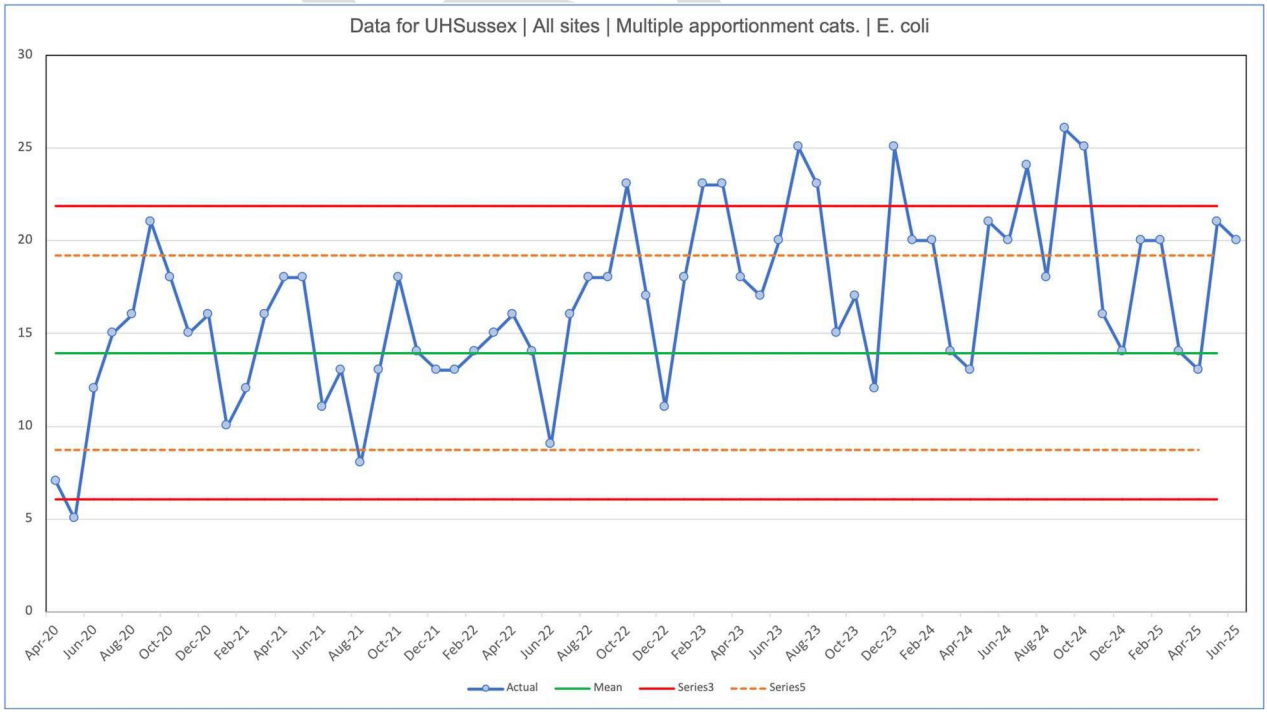

Figure 9b: Healthcare-associated E. coli BSIs at UHSussex by month – Statistical Process Chart

Figure 9b shows the Statistical Process Chart (SPC) for E. coli. There is a spike in Q3 2024 where two data points were above the upper control limit, post which all subsequent data point have sat lower than the upper control limit. Over the period Apr-2020 to June-2025, we see a steady rise in the number of data points over the mean, suggesting an upward trend in infection incidence, which corelates with the National and internal picture.

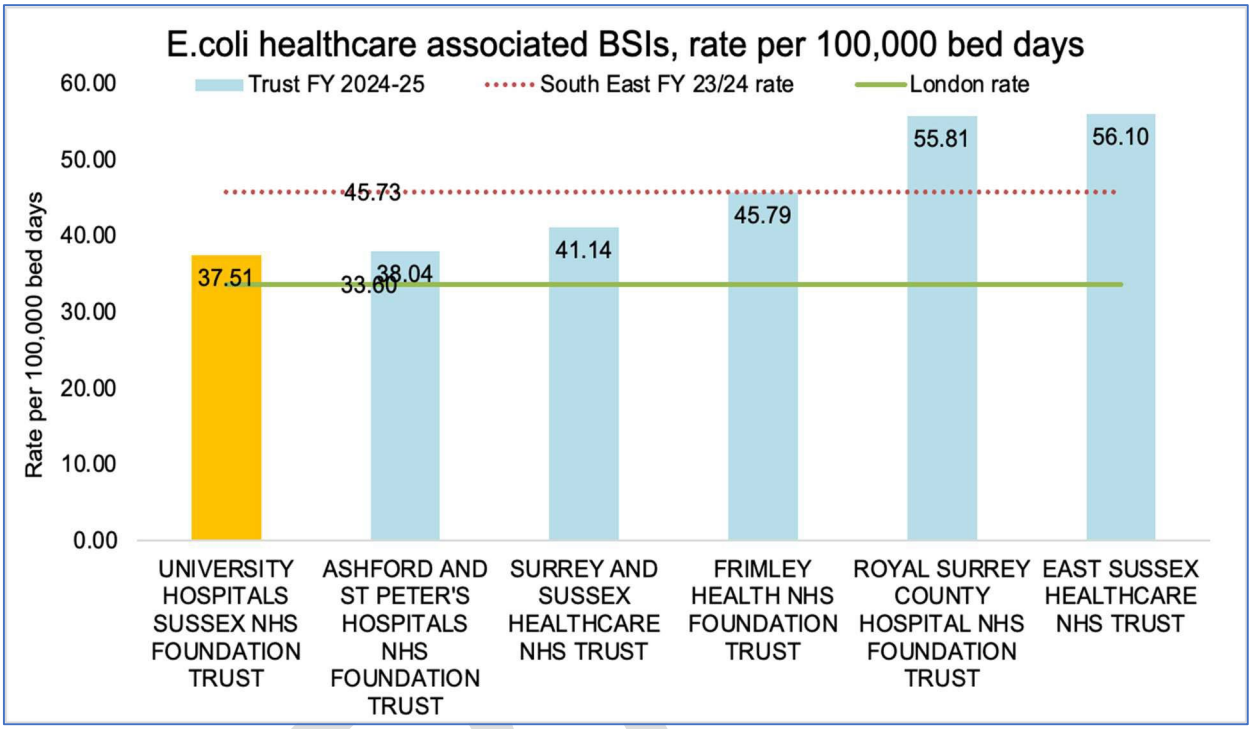

Figure 10: E. coli healthcare associated infection rate comparison – South-East region and London.

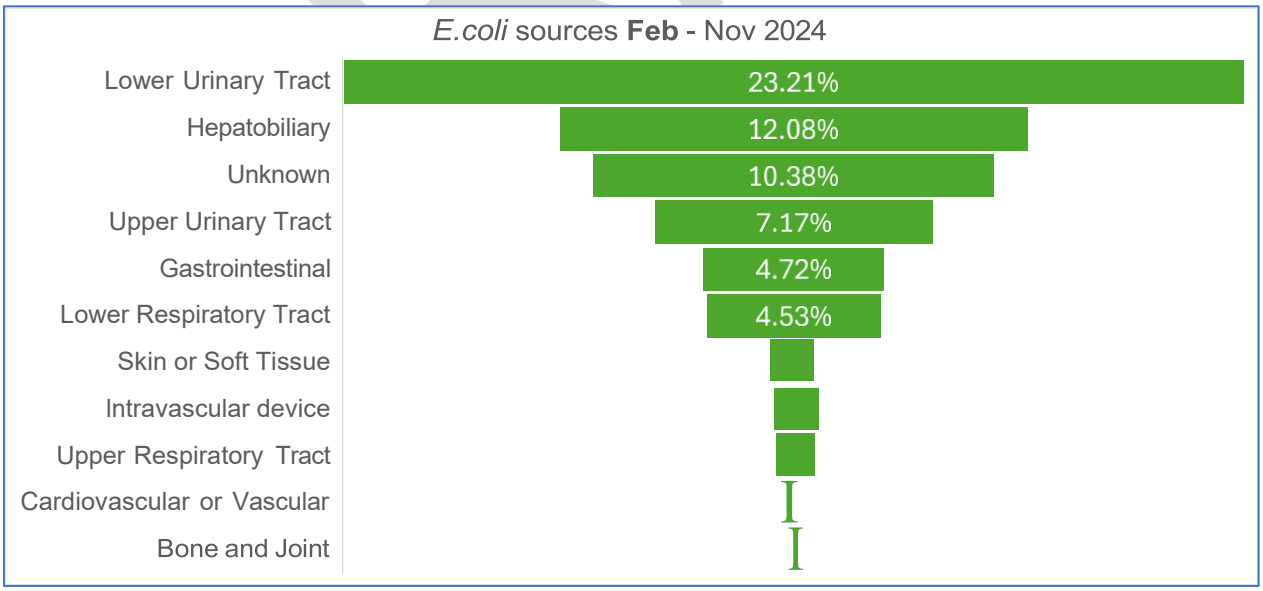

Figure 11 E. coli risk factor analysis

4.9 *Pseudomonas aeruginosa*

- **Reported cases:** There were 44 healthcare-associated BSI's reported, exceeding the UKHSA ceiling of 39 (figure 12).
- **Infection rates: The** UHSussex rate (6.8) sits below both the London and the South-East rate (figure 13).
- **Investigations and actions**
  - Risk factor analysis showed that 20% of all BSIs over a 10-month period were attributable to urinary tract infections, with the division of Medicine claiming the vast majority, followed by Surgery and Specialist.

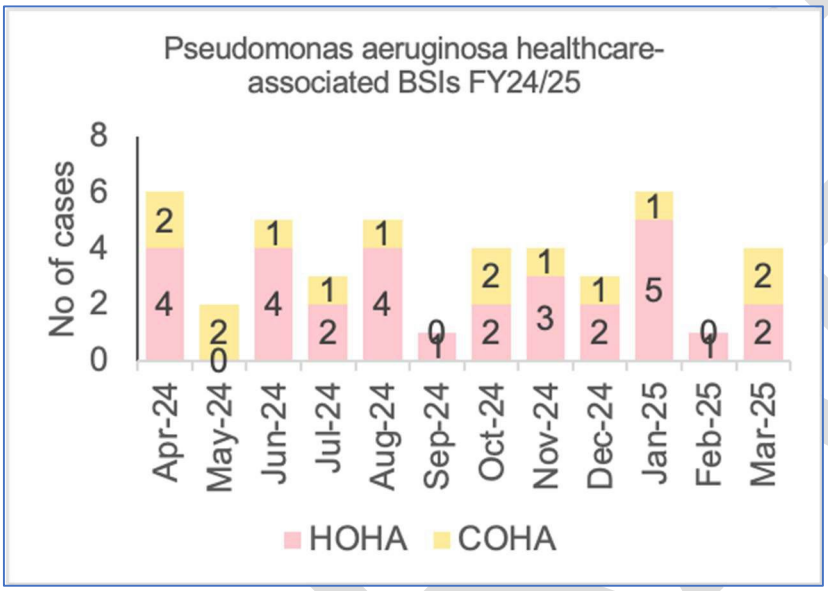

Figure 12: Healthcare-associated P. aeruginosa BSIs at UHSussex by month.

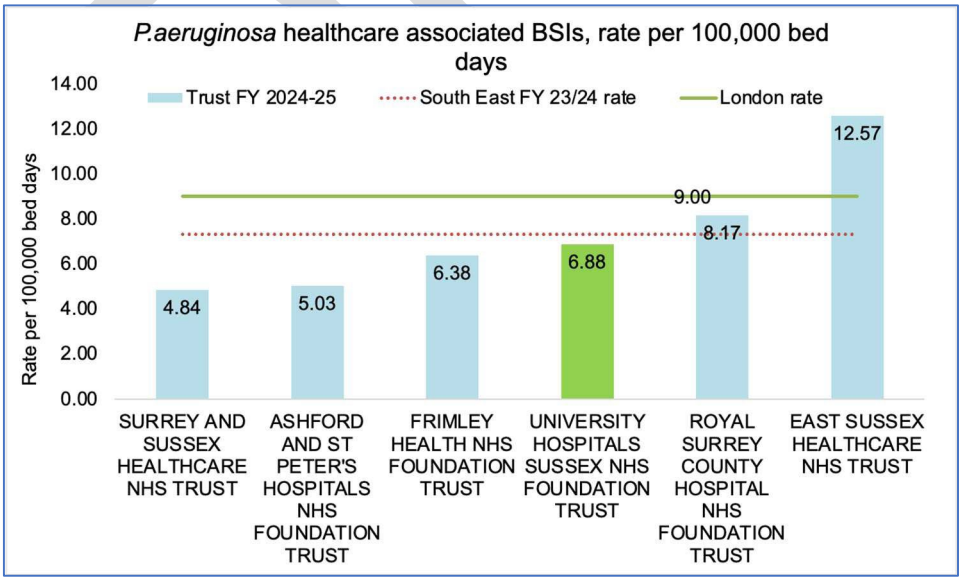

Figure 13: P. aeruginosa healthcare associated BSI rate comparison – South-East region and London.

4.10 Klebsiella species

Klebsiella pneumoniae, *Klebsiella oxytoca*, and other species are reportable to the UKHSA.

- **Reported cases:** There were 71 cases of *Klebsiella* spp. BSI below the UKHSA threshold of 89. Nationally, healthcare-associated *K. pneumoniae* bloodstream infections have been consistently rising (figure 14).
- **Infection rates: The** UH Sussex rate (11.1) sits lowest amongst the South-East NHS Trusts, and lower than the London and South-East rate, 18.7 and 16.0 respectively (figure 15).
- **Investigations and actions:**
  - Risk factor analysis showed 23.4% of all *Klebsiella* spp. BSI are associated with urinary tract infections**,** with Medicine claiming the majority, followed by Surgery, and Women's and Children.
  - As part of our response to understand trends in Gram-negative BSI, and with access to whole-genome sequencing as part of IPC research, the IPC team are leading further investigation to identify any environmental links with patient cases.

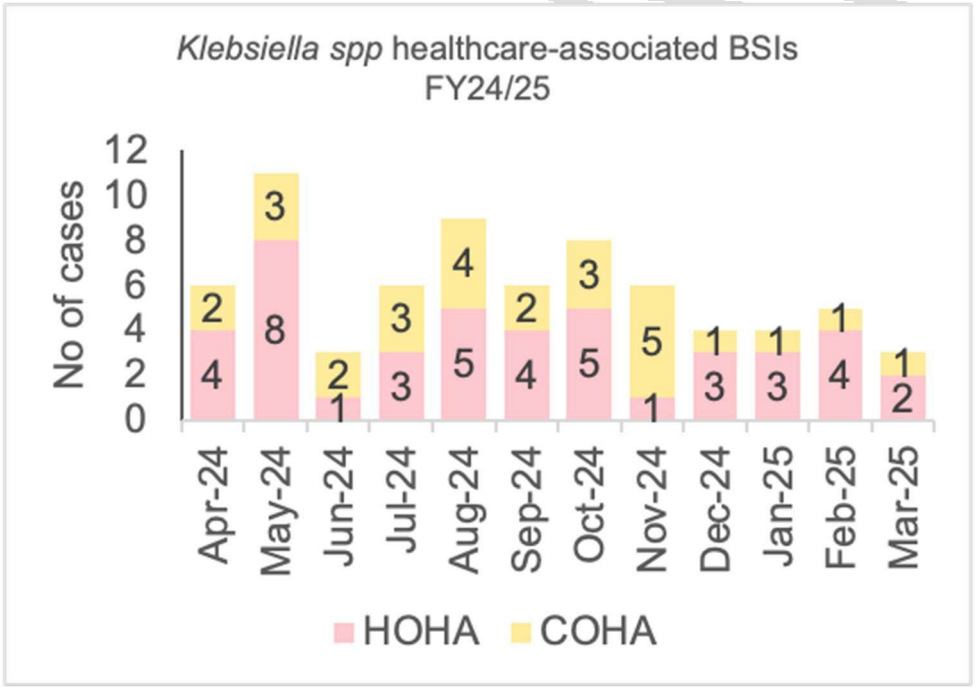

Figure 14: Healthcare-associated Klebsiella. spp BSIs at UHSussex by month.

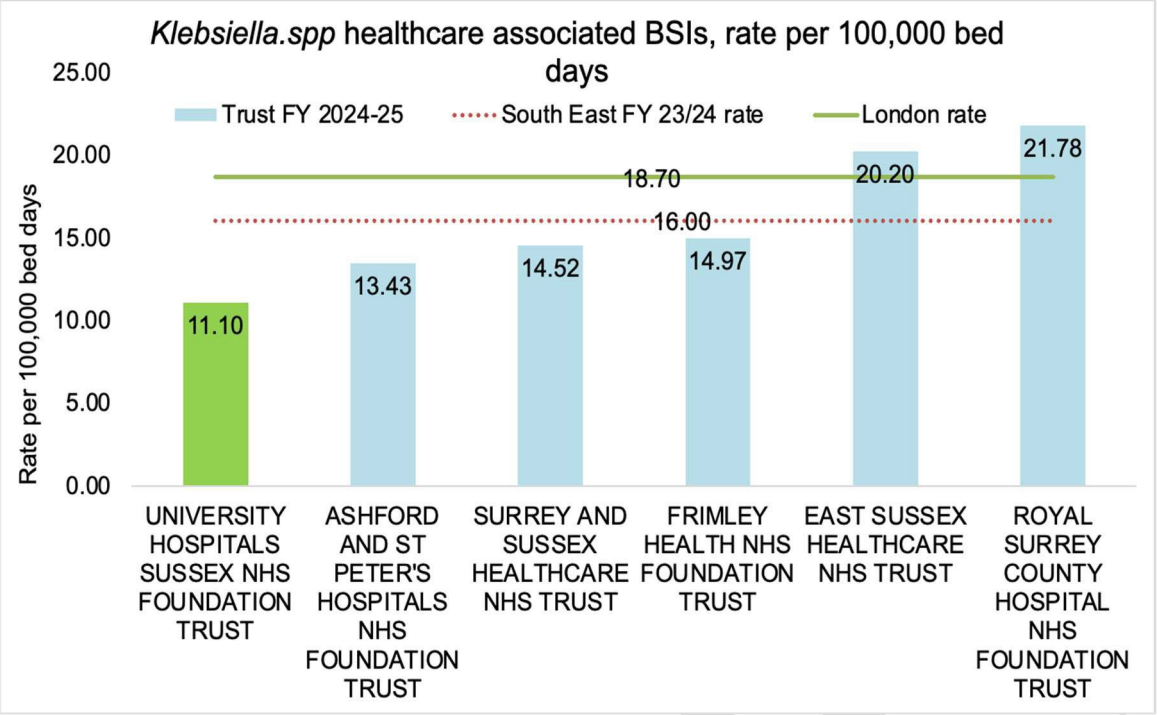

Figure 15: Klebsiella species healthcare associated BSI rate comparison – South-East region and London.

4.11 Multi-Drug Resistant Organisms (MDROs)

MDROs are bacteria resistant to multiple antibiotics, making infections difficult to treat. At UHSussex, MDROs are not endemic, and cases remain sporadic. We have a screening programme for high-risk individuals, to enable early detection and appropriate management. There were no significant outbreaks in 2024/25.

In late July a patient was admitted to Princess Royal with a pan-resistant *Acinetobacter baumanii* (resistant to all antibiotics) and *Candidoyzma auris.* The patient had returned from Greece (on a commercial flight) after spending time in ICUs in Crete and Rhodes.

They presented at PRH via ED and were admitted to a ward. Following deterioration they were admitted to ICU. A CPE screen identified the multi-drug-resistant *A. baumannii*, which was also found to be resistant to colistin (a final line antibiotic used to treat MDRO infections). Despite extensive searching and collaboration with national experts, there were no antibiotics the organism was susceptible to – so combination therapy of sub-optimal antibiotics was used to treat this infection. The patient died.

A total of 33 other patients required contact screening with no further transmission was identified.

The presence of a patient with such a resistant organism resulted in the ITU being closed other than for urgent treat and transfer.

A number of IPC issues were raised, including prompt identification and screening, safe isolation, environmental decontamination, equipment decontamination, environmental surfaces such as wood, water safety and compliance of outlets, human waste disposal, and last offices.

As a result of the incident (it was not an outbreak as the patient was admitted from Greece with the organism, there were no further cases); the ICU at PRH was given an extensive refurbishment to improve the fabric of the environment. There remains a need to undertake work on the dated and failing ventilation system, and we have also recommended updating the medical gas 'bollards' to improve space and efficiency and enable cleaning and maintenance.

Learning was shared in well received sessions at the Infection Prevention Society annual conference and at the Healthcare Infection Society/Federation of Infection Society Conference. Raising awareness of this incident helped identify further cases in other parts of the country and enabled UKHSA to undertake proactive surveillance. At the request of colleagues from the New Hospitals Programme a video was recorded of the 'story' to press home the need for a safe environment in a world where we are seeing such significant resistant infection.

Pat Cattini, Dr Jo Peters and Dr James Price discussing the Pan Resistant Acinetobacter case at FIS/HIS24 in Liverpool.

4.12 Respiratory viruses

4.12.1 Influenza A and B: The 2024/25 influenza season was worse than in recent years; with cases occurring earlier in the season and continuing for longer than expected, well into the spring. December 2024 was particularly challenging with a rise in patients presenting with influenza, a reflection of high community prevalence. The 2024 staff influenza and COVID-19 vaccination campaign ran from October to January delivering nearly 10,000 vaccinations (5,000 of each type) to staff across the Trust. Despite this overall uptake was poor, averaging 31% for influenza and 26% for COVID-19, and this was reflected in multiple ward outbreaks which included staff sickness. A set of 'IPC Winter Action Cards', which summarise key management aspects for confirmed or suspected respiratory tract infections was launched across the trust. Outbreak control meetings were held daily to review cases and management and affected wards received daily support from the IPC team.

4.12.2 COVID-19: Symptomatic COVID-19 patients were seen throughout the year, with a peak in winter. This led to bay closures but few full ward closures. Continuous education and training on IPC precautions were promoted.

4.12.3 RSV: The RSV season was consistent with national rates, with no healthcare-associated outbreaks.

4.12.4 Testing for Respiratory Viruses

The IPC team recommended implementation of a new lateral flow test that detects influenza, RSV and COVID-19. The use of LFD is about 1/10th of the cost of a PCR test, and the result is available in 10 minutes (as opposed to 6–12 hour turnaround time offered by laboratory-based PCR testing). Unfortunately, the LFT was identified and introduced relatively late in the season and did not fully embed, however further work has been undertaken to ensure we are ready for the 2025/26 season.

4.13 Norovirus

Throughout the year, there were intermittent cases of Norovirus, mirroring national trends. Several small ward outbreaks occurred particularly in Q3 and Q4. There were larger outbreaks in February (WH) and March (SRH). The SRH outbreak led to significant bed losses, prompting the Trust to declare a critical incident and activate business continuity plans. Daily outbreak meetings were held, and the IPC team provided intensive support to the affected wards. Risk factors identified on the wards included poor cleaning of tables and lockers, as the work had been assigned to kitchen staff, poor commode cleaning and hand

hygiene practices. The outbreak was controlled by early April. Key learnings included ensuring full attendance at outbreak control meetings for comprehensive situational reports, improving communication and coordination during incidents, and enhancing education for all staff on outbreak recognition and management.

4.14 MPox

UHSussex successfully managed a suspected, then confirmed patient with a High Consequence Infectious Diseases (HCID) via the Infectious Diseases (ID) Unit based at RSCH. The patient was admitted overnight on ID ward prior to a nationally coordinated HCID transfer to St Thomas's hospital in London.

The IPC and ID Teams participated in the national incident call, and the handling of the case at RSCH was commended and the patient was allowed to remain overnight on the ward as they had been securely isolated and managed.

Mpox Clade 1b was derogated by UKHSA in March 2025 as no longer a HCID.

To ensure that the trust is prepared for any HCID the IPC Team have ensured that the multi-disciplinary teams on each site have discussed the safest and least risk averse admission pathways for patients suspected or confirmed with a HCID. Safe assessment, testing and admission pathways for all HCID, are now in place for emergency departments across UHSussex. 'Live' action cards have been developed and are available on the intranet.

A HCID PPE ensemble training course is now available on the IRIS platform to relevant staff. In addition to which bespoke face-to-face PPE ensemble training is being delivered by IPC.

The finance and storage facilities for the vast HCID PPE ensemble was clarified during and the HCID PPE kit is available, with cascade training for safe donning and doffing procedures.

An IPC Training session on correct donning and doffing of HCID PPE

5. Surgical Site Infection surveillance

Criteria 4: The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The National Surgical Site Infection Surveillance (SSIS) programme in England, established in 1999 and run by the UKHSA, monitors patient outcomes post-surgery to track and reduce the risk of surgical site infections (SSI). This programme helps healthcare providers to collect and compare data, identify infection causes, and promote improvements. Providers receive quarterly reports comparing their data with others, and an annual report is published. Monitoring for orthopaedic surgeries (total hip and knee replacements) is mandatory for at least three months each year, with surveillance of SSIs in other surgical specialties remaining optional, albeit recommended. The UKSA quarters run per calendar year rather than financial year.

5.1 SSIS at UHSussex

SSI are a common cause of HCAIs. Whilst most SSI are localised to the incision site they can develop in deeper tissues. Rates of SSI vary between specialities, with higher rates associated with operations undertaken on parts of the body that harbour a higher burden of micro-organisms.

At UHSussex, the SSIS program is well-established across both the Specialist and Surgical divisions.

Unfortunately, the SSI nurses for both surgical divisions left their posts in December leaving a gap in provision over Q1 (Jan to March 2025). These posts were recruited with the new post holders starting in April 2025.

Over the year SSI surveillance was carried out to review primary (elective) hip and knee replacements, fractured neck of femur surgery, breast surgery, and coronary artery bypass graft (CABG) surgery.

Table 9 below provides a quarterly view of SSI rates by operation and hospital site. SSI data is reported by calendar year quarters. The most recent data is up to end of UKHSA Q1 2025 (January to March). Please note that the UKHSA reporting system excludes patient-reported infections, as it focuses on infections detected by hospital clinicians or during readmissions, not via optional patient reports unless they are confirmed by a clinician. This data is not included in national benchmarks or outlier assessments because the patient-reported data

method is optional and inconsistent across hospitals. Data may change from that previously published if further cases are added due to late diagnosis.

Operation	2023 Q1 (Jan-Mar)	2023 Q2 (Apr-Jun)	2023 Q3 (Jul-Sept)	2023 Q4 (Oct-Dec)	2024 Q1 (Jan-Mar)	2024 Q2 Apr-Jun	2024 Q3 July - September	2024 Q4 (Oct-Dec)	2025 Q1 (Jan-Mar)	National (5 year rolling average)
TKR SRH	0.0%	1.5%	0.0%	0.0%	0.8%	0.9%	0.0%	0.0%	0.0%	0.4%
THR SRH	2.2%	0.0%	0.0%	0.0%	0.8%	1.8%	1.7%	0.0%	0.0%	0.6%
THR PRH	0.0%	2.2%	0.0%	2.0%	0.0%	0.0%	0.0%	0.8%	-	0.6%
TKR PRH	0.0%	2.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%	-	0.4%
#NoF WGH	–	–	–	–	2.6%	–	-	-	-	0.9%
Breast SRH	0.0%	0.0%	0.0%	1.4%	0.0%	0.0%	1.4%	0.0%	1.8%	0.6%
Breast WGH	1.2%	0.0%	1.1%	1.0%	0.0%	1.9%	0.8%	0.0%	3.3%	0.6%
Large Bowel RSCH	–	–	–	–	2.2%	2.0%	-	-	-	8.0%
CABG RSCH	2.0%	12.3%	9.0%	13.3%	1.3%	0.0%	3.5%	6.5%	2.2%	2.7%
Other Cardiac								4.6%	1.6%	3.0%

Table 9: *Summary of latest Trust verified SSI rates by procedure and site August 2025. Unavailable data is marked by a dash (-). Key: Total knee replacement (TKR), total hip replacement (THR), fractured neck of femur (#NOF).*

There is ongoing work using the One-Together gap analysis framework to review and refine clinical pathways. Senior multidisciplinary groups led by the Chiefs in both surgical and the specialist divisions, meet to review all identified SSI cases, and determine learning and areas for improvement.

Pat Cattini gave presentations about the work and outputs from the One Together framework used by the trust at the annual Association for Perioperative Practitioners conference in August, and at the One Together expert conference in March. Dr Sam Machen, Associate Director of Patient Safety also gave a presentation at the One Together Conference on the use of patient safety incident response framework has been used to investigate and manage SSI risks in cardiac surgery.

Pat Cattini Presenting UH Sussex work at the OneTogether Expert Conference

5.2 Orthopaedics

The surgical divisions continue to hold quarterly multi-disciplinary meetings using the 'OneTogether' framework to review and improve the orthopaedic surgical pathway. This framework provides a comprehensive, evidence-based approach to prevent SSI and improve patient outcomes through standardized best practices and collaboration among healthcare professionals.

From these meetings, new improvement actions are trialled to see if they can enhance patient safety. Quarterly multi-disciplinary team (MDT) meetings, led by the Chiefs of Surgery, review all SSI cases to identify learning opportunities. Efforts are ongoing to identify high-risk patients early and implement targeted preventative measures, such as using negative pressure dressings.

5.3 Cardiac

The IPC team have continued to provide support to the cardiac surgery team in reducing SSI among patients undergoing CABG and other cardiac surgeries. This has included support to the weekly surveillance monitoring meeting and the quarterly review panels. The support for early recognition and intervention to prevent infection developing has resulted in improvements in infection rates in CANG and other cardiac surgeries.

All cardiac theatres have been reviewed and meet required ventilation standards, although some improvements have been identified. These are planned for funding in 2025-26. Some environmental improvements have been achieved, and the cardiac ICU will be fully refurbished when an agreed move takes place to the ITU in the LMB in 2025.

Infection rates significantly improved to below the national benchmark from January to March, and support is ongoing.

5.4 Breast

The IPC team continues to support the development of SSI surveillance following breast surgery. Formal UKHSA SSI surveillance for breast surgery is conducted at SRH and WH. Work is needed to establish similar surveillance at PRH.

5.5 Blood culture contamination

In response to a concern regarding the incidence of blood culture contamination, a 6-month analysis of all blood cultures cultured at RSCH, Royal Alex, and PRH was undertaken, with

an average contamination rate of 3.6% (of all cultures taken). Contaminated cultures from Accident and Emergency units were overrepresented in the results. Scientific consensus is that a contamination rate more than 2-3% is a trigger for epidemiological investigation. In response the IPC team have encouraged a renewed focus on aseptic-non-touch-technique (ANTT) and teaching on blood culture contamination as part of the junior doctor induction, across the Trust.

6. IPC in built environment

Criteria 2: The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

6.1 Facilities

The Trust manages its facilities contract in-house. Ward sisters conduct weekly checks of clinical areas against The Hygiene Code, with monthly validation by matrons. Results are recorded on the Tendable system.

The IPC team have a weekly meeting with Facilities to discuss any operational issues identified in the week and agree rectifications and solutions.

All NHS Trusts must conduct an annual PLACE assessment, which evaluates non-clinical aspects impacting patient care, such as cleanliness, maintenance, privacy, food quality, and dementia-friendly facilities. At UHSussex, PLACE assessments are part of weekly routines, conducted by patient assessors and staff teams, including facilities, estates, and infection prevention and control. These assessments cover all clinical departments and some non-clinical areas like main receptions and gardens. Outcomes from weekly inspections lead to both immediate and future improvements in patient environments. Results are discussed at bi-monthly PLACE review meetings, and a quarterly report with an action plan is provided to the Patient Engagement and Experience Committee.

6.1.1 Environmental Cleanliness

The Facilities and Estates Division ensures a safe, clean environment for patients, staff, and visitors. The Domestic department uses both manual and automated cleaning methods. Technical audits of all hospital areas are conducted, categorized into four risk levels, with very high-risk areas being the top priority. Audit results are reviewed monthly at IPOG meetings, with multi-disciplinary discussions to drive continuous improvements.

Where issues with the cleaning standards are identified these are discussed with Facilities for prompt rectification.

Work is in progress to improve clarity on cleaning responsibilities to ensure all necessary equipment receives adequate decontamination.

The F&E team have a comprehensive list of the areas which need improvement, particularly for the Estates team. This is managed on a weekly basis through the weekly PLACE inspections, work tickets for repairs. Larger pieces of work that need to be completed by the Estates or Capital Projects teams are listed and discussed with Hospital Directors and priority-rated in preparation for any minor works monies that become available.

The National Patient Led Assessment of the Clinical Environment (PLACE) is undertaken in the autumn every year. Figure 16 shows how UH Sussex compares with the national average score.

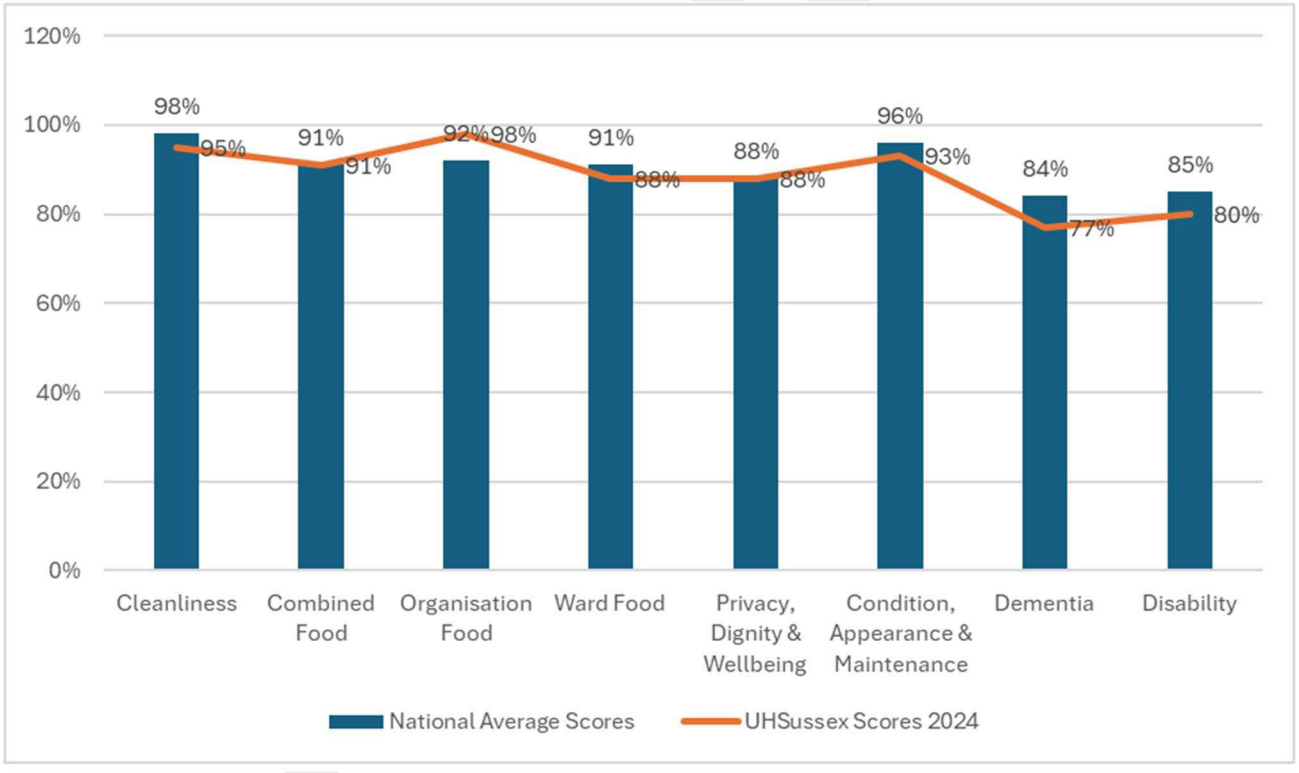

Figure 16; National PLACE inspection scores UH Sussex 2024

6.1.2 Automated Room Disinfection

Effective room decontamination is crucial to prevent cross-infection, especially for pathogens like C. difficile and multi drug-resistant organisms. Automated systems, such as Hydrogen Peroxide Vapour (HPV), are used for enhanced disinfection. HPV is available at SRH and WH. A planned trial and purchase of Ultraviolet-c (UVC) light technology for RSCH/ PRH has

not been possible. UVC and HPV were used successfully at PRH when we cared for the patient with the pan-resistant *Acinetobacter baumannii.* UVC was used to decontaminate portable equipment including beds in an empty side room. After the patient died, the whole unit was decontaminated using HPV.

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6.2 Capital Projects

The IPC team collaborates with the Estates and Capital Project Teams to ensure facilities meet IPC standards.

Work has been undertaken to standardise equipment used in new builds such as basins and taps, floor and wall finishes etc.

IPC have been involved in all the major capital builds including RSCH ED redevelopment, Theatre 6 Bi Plane and the Sussex Cancer Centre and the new UTCs at WH and SRH

6.3 Planned Preventative Maintenance

Maintaining buildings and equipment is crucial for safe patient care. The Trust has a significant backlog of maintenance work, but progress has been made in replacing flooring in many areas. The Estates team conducts weekly and quarterly maintenance, servicing, and filter changes for ventilation systems.

6.4 Ventilation

Proper ventilation is essential in healthcare settings to provide a safe environment and control odours. Specialised ventilation reduces airborne infection risks in areas like operating rooms and critical care. The Estates department manages ventilation systems, following HTM 03-01 guidelines. The Trust wide Ventilation Safety Group (VSG), a multidisciplinary team, oversees ventilation, monitors reports, and recommends improvements. The VSG met

quarterly. Reports are taken at the TIPC meeting, and the Director of Estates and Facilities now also reports into QGSG.

Many theatre air handling units are nearing the end of their lifespan, causing frequent breakdowns and operational disruptions. A 10-year capital plan has been developed with funding for replacement of units according to priority. There has been engagement with clinical teams and agreement for annual operating theatre shutdowns to enable the annual validation and any planned preventative maintenance, though this is sometimes difficult to achieve due to the competing priority to reduce waiting lists and thus not take the theatre out of service. The VSG have requested robust logs be kept of each system, any failings and remedial works needed to ensure that the systems remain safe to use.

The VSG maintains logs of system performance and updates the trust risk register as required.

6.5 Water

Water is essential in healthcare settings for keeping patients clean and hydrated, and for running equipment. Common water outlets include handwash basins, showers, toilets, hydrotherapy facilities, ice machines, and drinking fountains. However, these outlets can pose risks to patient safety by exposing them to waterborne pathogens like *P. aeruginosa* and *Legionella pneumophila*.

The Trust follows national guidance (HTM 04-01: Safe water in healthcare premises), monitored by the Trust wide Water Safety Group (WSG). This multidisciplinary group is responsible for developing and managing the water safety plan (WSP). They also advise on remedial actions when water systems or outlets are contaminated, increasing risks to vulnerable patients. The WSG meet quarterly during the year. The WSG is working to further develop process and governance. The WSG reports to TIPC and escalates identified risks to QGSG for mitigation.

The Trust continuously monitors for signs of *Legionella pneumophila* across all services and *P. aeruginosa* in augmented care areas, which provide advanced medical support and continuous monitoring for patients with critical or complex health conditions.

Work was progressed on the new Sussex Cancer Centre at RSCH. The Water Safety Group, led by the IPCT at UHSussex sought and obtained approval for a reduction in clinical handwash basins. Water outlets in healthcare premises are now widely recognised as risk to patient safety. The body of scientific literature indicates that reduced exposure to water

outlets is associated with a reduction in healthcare associated infection. The push to increase access to hand hygiene needs to be balanced against the risk of water borne infection by gram negative organisms such as *P. aeruginosa*. To mitigate this risk we proposed reducing the number of water outlets in key areas including the clean utility/drug prep rooms and single patient bedrooms. This approach was approved by colleagues at the 'New Hospitals Programme' and later endorsed following publication of the NHS Estates Technical Bulletin 2024/3 Designing safe spaces for patients at high risk of infection from nontuberculous mycobacteria and other waterborne pathogens. This approach was shared at the IPS Conference in Sept 2024.

An audit of facilities at the Park Centre for Breast Care in Brighton revealed several maintenance issues including problems with hand wash basins. Many did not work and had not been serviced. There was no water testing in place. IPC worked with lead nurse Lynette Awdry and Estates colleagues, and all the clinical handwash basins were either replaced or fixed. Other remedial work was also undertaken to improve the environment.

Plans to move the haematology-oncology unit at RSCH into the Courtyard building were significantly delayed due to ongoing contamination of the water supply. Extensive work was undertaken to make the building safe for use including regimented flushing of water, temperature monitoring, Authorised Engineer for Water (AE (W)) assessments and installation of Omnia-Klenz (non-invasive monitoring and analytical system). As per HTM 04-01, water sampling and testing continues to be monitored as per guidance for an augmented care area. The Oncology team took occupancy in February 25.

The Estates team at PRH were extremely helpful in replacing some non-compliant handwash basins in the ITU when we cared for the patient with the Pan-Resistant *Acinetobacter baumannii*. This was an important improvement as resistant Gram-negative organisms are known to inhabit drains and spread may be exacerbated by no compliant basins such as the one shown in the picture below. This was an important improvement as resistant Gram-negative organisms are known to inhabit drains and spread may be exacerbated by no compliant basins.

IPC highlighted concern over the temporary use of 'Water Leek Diverters, which are used when there is a roof or pipework leak. A drain outlet hose is put into a WHB for water discharge. IPC recommended the use of a self-contained system sue to concern that it will lead to drain contamination.

6.6 Decontamination of medical devices

The Trust-wide Decontamination Committee has met quarterly, and the terms of reference were updated.

UHSussex operates four Central Sterile Services Departments (CSSD), one at each main site. These departments are responsible for reprocessing instruments used in surgeries and other procedures that require sterile equipment. The performance of CSSDs is benchmarked against national regulations to ensure high standards.

The endoscopy unit at WH/SRH hold Joint Advisory Group on Gastrointestinal Endoscopy (JAG) Accreditation. The unit at RSCH does not hold JAG accreditation currently.

Local decontamination audits were completed at SRH, WH and PRH and are in progress at RSCH.

There were 2 endoscopy incidents that were investigated. The first involved an external provider (18-week support) who used an endoscope that had been washed but had not been through the appropriate automated process on a second patient at RSCH. After assessment the incident was considered low risk to the patient with the patient being informed at the time. The external company investigated the incident and have highlighted training requirements, and the surgical division presented the incident to the patient safety incident group.

The second involved use of a previously condemned TOE (Trans-oesophageal endoscope) probe that was put into used in an emergency. The staff member unfortunately overlooked the prepared trolley and instead took another scope out of a case on a high shelf, despite it being labelled condemned. The scope had been cleaned before being stored and the learning was to move condemned scopes to another area to avoid mix up.

7. Antimicrobial stewardship

Criteria 3: Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial resistance (AMR) is one of the biggest challenges in modern healthcare, with significant social and economic impacts. The UK Government's 20-year vision includes national objectives to manage antimicrobial resistance, emphasizing the appropriate use of antimicrobials. An updated 5-year action plan was launched in May 2024 adopts a "One Health" approach across humans, animals, food, and the environment—focusing on reducing unnecessary antimicrobial exposure, optimising use, strengthening surveillance, investing in

innovation, and maintaining global collaboration to advance the UK's 20-year vision to contain, control, and mitigate AMR by 2040.

The Trust employs three Antimicrobial Pharmacists (plus one rotational post at RSCH) to oversee stewardship and guide appropriate prescribing practices. The two pharmacists based at RSCH also support the infectious diseases ward with clinical pharmacy cover.
Specialist pharmacists support Infection Consultants in managing infections in patients, including those who may acquire infections during their stay or as a side effect of other treatments. This includes cancer patients needing antibiotics to prevent infections during immunosuppressant therapies and intensive care patients with multiple invasive devices.

National workforce challenges, including a shortage of trained Pharmacists and Consultant Microbiologists, have impacted stewardship activities. This has reduced the number of general ward Pharmacists and pulled Antimicrobial Specialist Pharmacists into core pharmacy services.

7.1 Antibiotic consumption

Antibiotic consumption is tracked using data from a system called 'RxInfo'. There was no national target for reduction of antimicrobial use for secondary care in 2024-25 due to the new 5-year action plan being published after the date of the national contract for commissioning. However, the ASG continued to monitor the use of WHO watch and reserve classification antimicrobials with the historical contract measure of reduction of 10% from use in 2019. The Trust did not meet the target, which was challenging based on use growth in the years post COVID-19, but we have seen continued reductions in use over the last 2 financial years which is gratifying. The ASG plan to continue to monitor use of broad-spectrum use going forward and focus on clinical areas of high use for stewardship interventions.

7.2 CQUINS

There were no national mandatory CQUINs in 2024-25. However, the national AMR team supported a continuation of the intravenous to oral switch CQUIN for the year. UHSussex agreed with our local commissioners to continue with the CQUIN as a quality measure of good care within our local contract.

Data was collected across the 4 hospital sites and submitted every quarter by the antimicrobial pharmacists. 100 patients on IV antibiotics per quarter were reviewed using the Antimicrobial Intravenous to Oral switch Decision Aid developed by the UKSHA and assessed

as either appropriate to remain on IV or would be eligible for switch. The minimum target set was less than 25% not switched at the point of review and the maximum target less than 15%. The ASG set the target to meet as the stretch less than 15% target. The cumulative end of year result was 15.87% (within minimum target (25%) but just above maximum target (15%))

The trust met the lower target but missed the higher local target by a small percentage. Reasons for this were assessed to be multifactorial including higher patient numbers and the use of temporary escalation spaces, reduced nurse/doctor/patient ratios, low numbers of pharmacist staff on ward areas due to vacancies and a lack of Consultant Microbiologists at Worthing/SRH due to vacancies. The ASG plan to continue this as an area of focus with a review of the last 2 years data to look for trends and develop an action plan for further improvements in this area.

The results can be seen in table below

Quarter	% of prescriptions not appropriately switched at time of audit	Target	Comment
Q1 - April – June 24	9%	Less than 15%	Target met
Q2 Jul – Sept	13.4%	Less than 15%	Target met
Q3 – Oct – Dec	18%	Less than 15%	Over target.
Q4 – Jan – March 25	23%	Less than 15%	Over target.

Figure 17 IV Oral Switch target data 24/25

7.3 ASG meetings & Guidelines

Cross-site ASG meetings have continued, despite significant challenges in staffing both within pharmacy and in microbiology. Work to unify the empiric antimicrobial guidelines across the organisation has continued this year and an ongoing workplan of outstanding guidelines to unify has been put in place. ASG work has been impacted by the staffing challenges in pharmacy. The previous shortages in Microbiology staffing have been mitigated with new appointments at RSCH, but are still an issue at St Richards where we rely on locum cover.

Pharmacy shortages will improve in 2025 with an over recruitment of newly qualified Pharmacists following a successful business case by the Interim Chief Pharmacist.

8. Information on infections

Criteria 4: The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.

The IPCT is dedicated to supporting public health by effectively managing and communicating important IPC results to both internal and external stakeholders. Our IPC epidemiologist has enabled us to use data more effectively to identify trends and improve patient safety and quality outcomes. The procurement of the new pan Sussex Laboratory Information Management System (LIMS) will improve data management but has unfortunately been delayed.

8.1 Patient and Staff Communication

Information leaflets are available for staff to discuss with patients, and the IPCT provides additional support as needed. The IPCT also collaborates with the communications team to ensure important information is effectively communicated to staff and patients, promoting safe care and compliance with national guidelines. An example of this collaboration is the HCID and the Respiratory virus action cards.

9. Infection Management

Criteria 5: That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.

At UHSussex, we continuously monitor for infections to ensure early detection and effective management. During working hours, the IPCT visits clinical areas daily, attends operational site meetings, and reviews microbiology and virology results throughout the day. Outside of these hours, site teams continue to monitor and manage patients with suspected or known infections, passing this information to the IPCT as soon as possible. The Microbiology team communicates any key infection indicators or early warnings to the IPCT and is available on call for urgent specialist advice outside of regular hours.

10. Health care worker responsibilities

Criteria 6: Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

During 2023-24 the IPCT have supported a series of initiatives aimed at enhancing healthcare workers engagement, awareness, and involvement in IPC.

10.1 Link Champions

IPC Link Champion meetings are held every other month. Sessions covered a variety of topics to promote and embed good practices across the Trust. IPC team members liaise with the Link Champions as a conduit to effective communication among clinical teams.

10.2 Education and training

All staff members, both clinical and non-clinical, receive IPC training during their induction. Clinical staff also complete annual virtual IPC training through the Health Education England e-learning tool. Currently, overall IPC training compliance is 92.3%. To improve uptake, we plan to reintroduce face-to-face training sessions over the coming year, based on feedback.

New resident doctors attend face to face sessions where they have the opportunity to meet with IPC, the antimicrobial pharmacy team and the IV team.

IPC Team members also provide ward based teaching sessions as requested.

The IPC team also use other opportunities such as the Annual General Meeting to showcase work and key messaging.

IPC Team members in the 'art space' at the 2024 Trust AGM

10.3 IPC Audit and monitoring

10.3.1 IPC Environmental spot check

The rolling programme of quarterly IPC environmental audits in clinical areas has continued via the Tendable programme in conjunction with the Matron and a member of the domestic team where possible. Feedback is given to ward and departmental staff, including domestics, to enable rectifications and communicate learnings. In addition, an IPC spot check audit is completed and available for the clinical teams to share and discuss during their patient safety huddles.

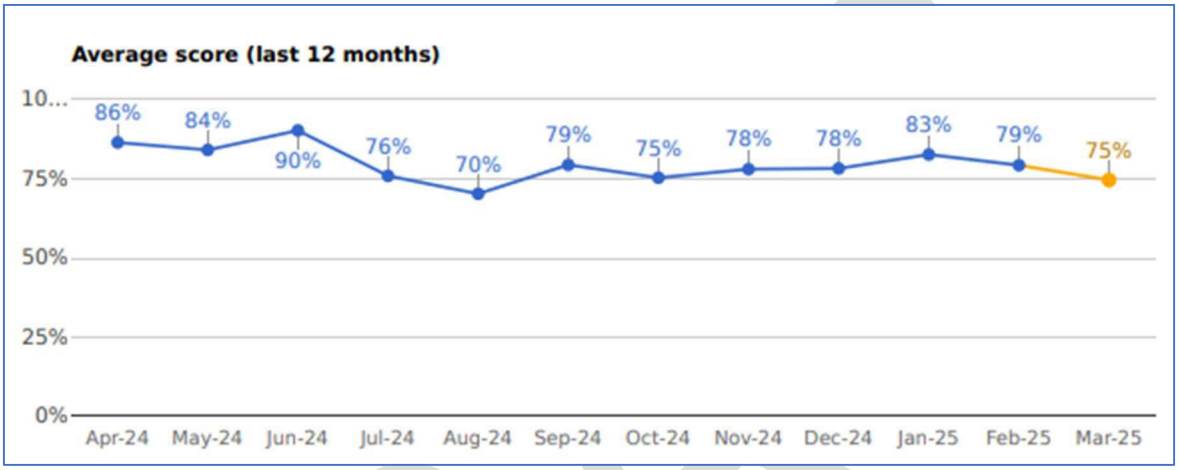

Figure 18 Trend analysis of environmental spot check audit data over 1 year.

10.3.2 IPC Weekly assurance audits

IPC Weekly Assurance audits are conducted using Tendable across the Trust and undertaken by the senior departmental nursing team.

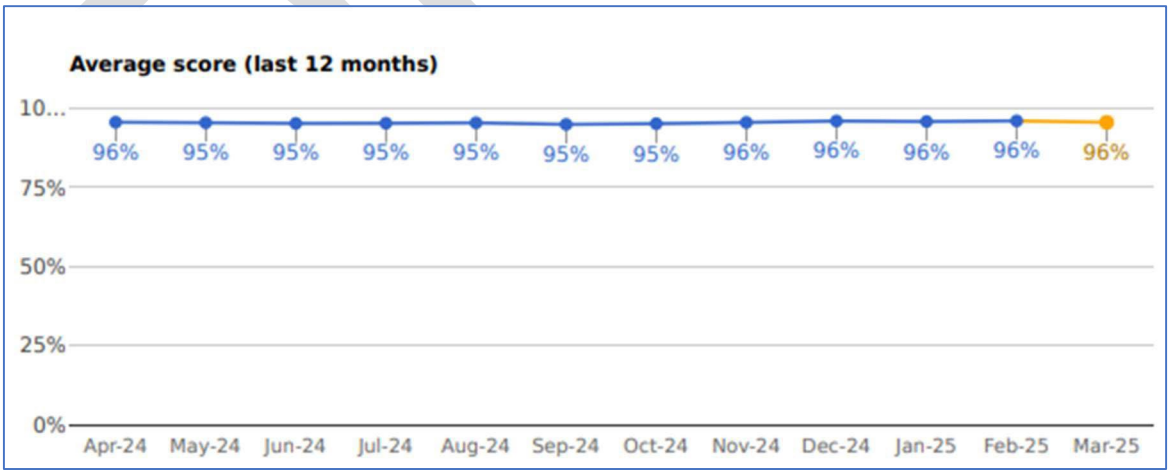

Figure 19: Trend analysis of weekly cleaning assurance audit data over 1 year.

The IPC weekly assurance audit allows clinical leads to directly review key aspects of IPC and action any issues identified.

10.3.3 Hand Hygiene Compliance audits

The rolling programme of monthly IPC Hand Hygiene compliance audits in clinical areas continues conducted by clinical staff on the Tendable programme.

The average hand hygiene compliance score recorded on the wards for Q4 was 93%.

Hand Hygiene audit scores inform the IPC team of areas that require additional support with hand hygiene compliance through targeted education sessions.

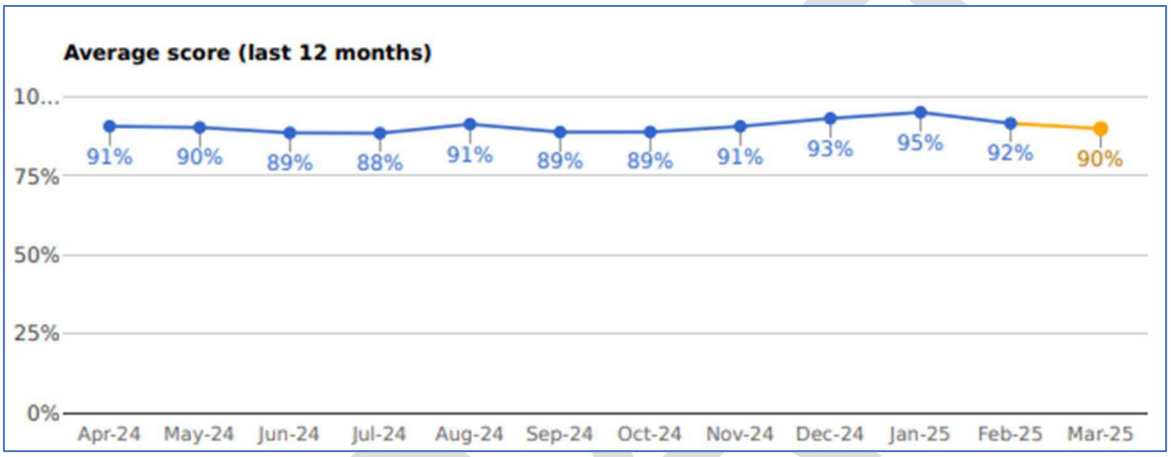

Figure 20: Trend analysis of hand-hygiene audit data over 1 year, available on Tendable.

10.3.4 IPC Commode Audits

The IPCT aim to complete monthly commode cleaning validation audits across all sites. These reviews include commodes, shower chairs, raised toilet seats and bed pans. The IPC team continue to work with clinical teams to promote the importance of commode hygiene in line with the 'Get It Right First Time (GIRFT) ethos.

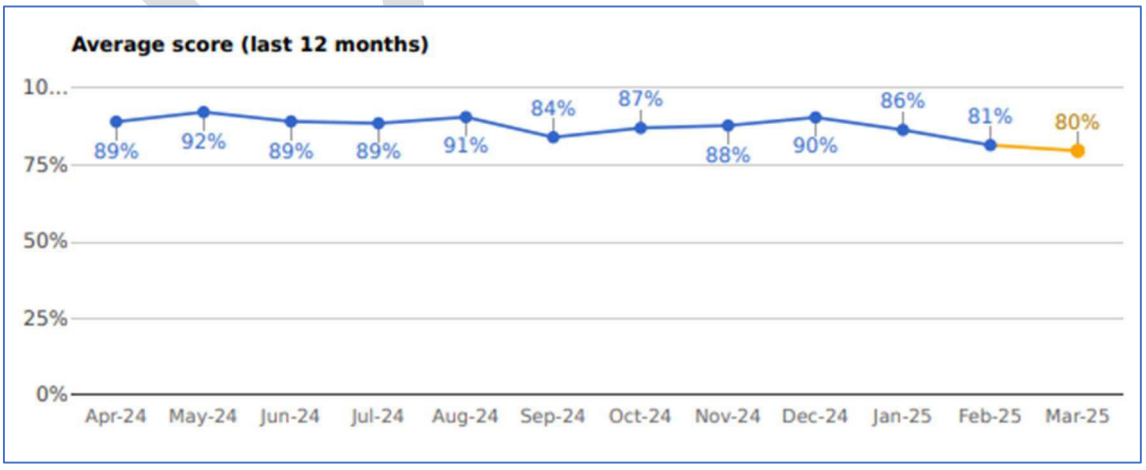

Figure 21 Trend analysis of commode audit data over 1 year, available on Tendable.

10.4 IPC supporting decarbonising healthcare

The IPC Team continue to support the national 'Gloves Off' campaign to reduce unnecessary use of gloves in healthcare.

Other areas where work is being carried out includes looking at re-processing of some low-risk medical equipment and reusable fabrics in theatre.

11. Isolation facilities

***Criteria* 7:** The provision or ability to secure adequate isolation facilities.

UHSussex currently has a reasonable proportion of single rooms, although many lack *en suite* facilities. Isolation rooms are in the minority, and most do not have the appropriate mechanical ventilation to support negative or positive pressure ventilation. Additionally, the distribution of isolation rooms is uneven, with the majority located at RSCH. The Louisa Martindale Building at RSCH is equipped with 60% single rooms, including 10 isolation rooms in the new infectious diseases' unit and ICU. Where there are difficulties in locating a single room, risk assessments are used to determine priority.

12. Laboratory support

Criteria 8: The ability to secure adequate access to laboratory support as appropriate.

Having reliable laboratory support is essential for effective infection prevention and control. Our Trust operates two Clinical Pathology Accreditation accredited microbiology laboratories at RSCH and SRH. These labs are working to harmonize their approaches following the merger and are working towards a new Sussex wide LIMS.

13. Policy

Criteria 9: That they have and adhere to policies designed or the individual's care, and provider organisations that will help prevent and control infections.

13.1 Guidelines and Policies

All IPC policies are up to date as per Appendix 2

UHSussex follows the National Infection Prevention and Control Manual (NIPCM) for England, which is referenced in our IPC policies. Additionally, we use EOLAS an IT system that provides clear (MS principles to support the prescribing of targeted antimicrobial therapies. The IPCT have been working on adding additional IPC key advice to support the guidelines.

14. Staff Health

Criteria 10: That they have a system or process in place to manage staff health and wellbeing, and organisation obligation to manage IPC.

14.1 Staff Winter Vaccination Programme

Vaccination uptake fell as compared to previous years with 31% of staff receiving influenza vaccine and 26% receiving a COVID-19 vaccine. These figures are in line with national uptake figures indicating a degree of vaccine apathy. IPCT continues to work with divisions, occupational health, communications team and pharmacy to optimise uptake through information giving and ease of access to the vaccine.

14.2 FFP3 Respiratory Fit testing

Filtering Face Piece 3 (FFP3) respirators provide the highest level of protection against airborne particles, including viruses and bacteria, filtering at least 99% of airborne particles. They are commonly used in healthcare settings to protect against highly infectious diseases.

FFP3 respirator fit testing is mandated for patient-facing staff every two years, in line with NHS England resilience principles. During 2024/25, this service was provided by bank staff, leading to inconsistent availability across Trust sites. When staff pass a fit test, the mask type is recorded in their Health Roster profile.

The Trust has been challenged with improving fit testing numbers and a new team of Fit testers is being actively recruited to ensure a more robust offering going forward.

15. Research and scholarship

Over the last year the IPC department made substantial progress in developing its research and academic activities under the leadership of Dr James Price. The team has grown

significantly, with several new academic colleagues undertaking research that spans infection genomics, AMR), environmental hygiene, healthcare sustainability, and global health.

15.1 New team members and their projects include:

- Dr Maria Krutikov (NIHR Clinical Lecturer) – researching AMR in wastewater and the implications for environmental and healthcare transmission routes.
- Dr Simon Stoneham (NIHR Clinical Lecturer) – exploring host–pathogen interactions underpinning MRSA infections, with a focus on host susceptibility and bacterial virulence.
- Dr Lizzie Cross (NIHR Clinical Lecturer) – leading clinical trials for novel diagnostics and therapeutics in the management of skin and soft tissue infections.
- Dr Opeyemi Makanjuola (NIHR Academic Clinical Fellow) – evaluating safe reuse of surgical instruments using novel disinfection technologies to support healthcare decarbonisation.
- Ida Sey (PhD student) – investigating the role of whole-genome sequencing (WGS) in outbreak detection and IPC decision-making within hospital settings.
- Dr Lauren Hookham (Wellcome Trust CREATE PhD Fellow) – assessing transmission pathways of multidrug-resistant organisms in maternal and neonatal care settings in Uganda using WGS.
- Dr Jack Leach (Academic Foundation Doctor) – analysing local epidemiological trends in healthcare-associated infections using routine microbiological and clinical surveillance data.
- Dr Lena Al-Hasan (Research Fellow) – studying environmental sources of gram-negative bloodstream infections in hospital settings, including sink and surface contamination.
- Sid Mookerjee, (Academic Epidemiologist) - support applied epidemiology and modelling across IPC and global health themes.

15.2 Key departmental achievements include:

- **Academic Leadership**: Dr Price was appointed Director of the Centre of Infection and Antimicrobial Research (CINAMR) at Brighton and Sussex Medical School. CINAMR brings together clinicians and academics across Sussex, Surrey and Kent to advance translational research on infection and AMR. In addition, Dr Price led the inaugural GENOTIPE (Genomics to Optimise Infection Prevention) Network meeting. The

event, funded through Higher Education Innovation Funding (HEIF), convened over 40 stakeholders from across the NHS, academia, UKHSA, professional societies and industry to define research priorities and implementation challenges for WGS in IPC practice.

- **Research Capacity Building**: IPC Matron Andrew Davies was appointed to the Chief Nurse Fellowship Programme, developing artificial intelligence tools to predict and prevent healthcare-associated infections. In addition, the department supported four NIHR academic training applications (three ACFs, one CL) across infection-related specialties including GUM/HIV, orthopaedics, and healthcare sustainability.
- **Strategic Appointments**: Dr Price was appointed Research Lead for the Department of Global Health and Infection at BSMS, Research Lead for the Department of Infection at University Hospitals Sussex, and NIHR Regional Delivery Network Specialty Co-Lead.
- **Sustainable IPC**: The IPC team is a key partner in the new Green Healthcare Hub at BSMS, leading research on safe, evidence-based reuse of medical equipment to reduce environmental impact.

15.3 Research income and outputs:

- The IPC team supported successful research grants totalling £3.5 million
- Research was presented at major conferences, including the European Society of Clinical Microbiology and Infectious Diseases (ESCMID Global) 2024 and the Federation of Infection Societies (FIS) Conference 2024, Infection Prevention Society and OneTogether. Dr Price served as conference chair the FIS Conference 2024.

15.4 Selected publications:

- Osborne-Grinter M, Cousins S, Ramirez J, Price JR, et al. Delivering surgery outside operating theatres: scoping review. BJS Open. 2024. DOI: 10.1093/bjsopen/zrae104
- Shutt AE, Ashiru-Oredope D, Price JR, et al. The intersection of the social determinants of health and antimicrobial resistance in human populations: a systematic review. BMJ Global Health. 2025. DOI: 10.1136/bmjgh-2024-017389
- Leiser R, Shutt AE, Price JR, et al. Insights into the implementation of a whole genome sequencing report form (SRF) to reduce nosocomial SARS-CoV-2 in UK hospitals: a qualitative evaluation. PLoS One. 2025. DOI: 10.1371/journal.pone.0321534

This growing research programme exemplifies the department's commitment to innovation, real-world evidence generation, and building capacity in applied IPC research to improve patient safety and health system resilience.

16. External work with national IPC groups

James Price (i) Healthcare Infection Society Secretary, (previously chair of Professional Development Committee), (iv) UK representative for the European Committee for Infection Control (EUCIC), (v) expert panellist on national guidelines committees including surgical site infections, *S. aureus* panton valentine leucocidin, and epic-4

Pat Cattini, is (i) Member of the expert advisor group to New Hospitals Programme, (ii) member of the Healthcare Infection Society Professional Development Committee, (iii) Infection Prevention Society (IPS) Scientific Programme Committee member, (iv) Member of the OneTogether Board, (v) Member of Central Sterilising Club Board.

Sid Mookerjee is Member of the Healthcare Infection Society Professional Development Committee

Sharon Reed, Deputy DIPC Incoming IPS Wessex Branch Deputy Coordinator

17. Other External Work

We have extended our contract to provide IPC cover and support to the local hospices across Sussex. This includes undertaking IPC audits and giving clinical support.

An audit of IPC provision was undertaken for Pioneer Healthcare, an independent provider of wound care services in Sussex and other parts of the country.

Engagement and leadership within the Sussex IPC cell which includes representatives from all acute, community and local authority providers.

Engagement with NHSE South East IPC cell. Contributor to several projects including *C difficile* and *E. coli* working groups.

The IPC team is a key partner in the new Green Healthcare Hub at BSMS, leading research on safe, evidence-based reuse of medical equipment to reduce environmental impact.

18. Achievements

We would like to congratulate Sharon Reed our Deputy DIPC, who was awarded Bronze in the British Journal of Nursing Infection Prevention Nurse of the Year 2025 award in March.

Karen Wares (IPS Board) with Sharon Reed Deputy DIPC at the BJN Award ceremony

19. Priorities for 2024-25

Our IPC annual programme of work is shown in appendix 3.

Our priorities focus on achieving full compliance with the IPC Board Assurance Framework, including antimicrobial stewardship and a robust fit testing service. We will strengthen surveillance of surgical site and line-associated bloodstream infections, extend IPC reviews across all Trust sites, and embed PSIRF methodology to ensure effective learning from investigations. Robust audit feedback and divisional accountability will remain central to our assurance processes. Alongside this, we will support Facilities and Estates in maintaining water and ventilation safety, while expanding engagement through the IPC Link Champion programme and wider clinical networks. Finally, we will broaden our research, innovation, and sustainability agenda—enhancing team capability, advancing projects such as hydration and mouth care, and increasing regional and national impact to support safer, greener healthcare.

20. Conclusion

The Trust demonstrates compliance with the Hygiene Code across all its sites, as outlined in the Board Assurance Framework.

The IPCT works collaboratively with staff across UHSussex to ensure that infection prevention is fully integrated into all activities. This helps protect both patients and staff from avoidable infections.

For the year ahead, there is a comprehensive IPC programme that incorporates learning opportunities, experience, and empirical research. This programme aims to improve patient safety and experience while reducing infection rates.

21. References

English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report 2023 to 2023 (publishing.service.gov.uk)

NHS England » National infection prevention and control manual (NIPCM) for England

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

22. Appendices

Appendix 1 TIPC Membership

Appendix 2 IPC Policies

Appendix 3 - Summary of IPC Annual Programme of work 2025/26

Appendix 1 TIPC Membership

TIPC membership includes:

- Chief Nurse /DIPC (Chair)
- Corporate DIPC (Co chair)
- Medical Director
- Infection Prevention & Control Doctor / Consultant Microbiologist
- Deputy DIPC
- Infection Prevention Matron(s)
- Surgical Site Surveillance Lead Nurses
- Antimicrobial Pharmacist(s)
- Decontamination Lead(s)
- Divisional Director of Nursing (DDoN) /Head of Nursing (HoN) - Medicine
- DDoN/ HoN Surgery
- DDoN/ HoN Women & Children
- DDoN/ HoN Cancer
- DDoN/ HoN Women and Children
- Director of Estates & Facilities/ Associate Director of Estates & Facilities
- Health and Safety Lead(s)
- Occupational Health Manager(s)
- UKHSA representative
- NHS Sussex Integrated Care Board (ICB) Infection Prevention Lead Nurse(s)

Appendix 2 List of IPC Policies

Policy Title
UHSIC001 Infection Prevention and Control Organisational and Assurance Framework Policy
UHSIC002 Standard and Transmission Based Precautions Policy
UHSIC004 Isolation of Patients Policy
UHSIC006 Decontamination Policy
UHSIC007 Prevention and Control of Meticillin Resistant Staphylococcus Aureus (MRSA) Policy
UHSIC008 Clostridioides difficile Infection Policy
UHSIC009 Norovirus (Viral gastro-enteritis) Policy
UHSIC010 Blood Borne Virus Policy (Including Management of Sharps Exposure Incidents and HIV Post Exposure Prophylaxis)
UHSIC0011 Infection Control and Prevention Management of Tuberculosis Policy
UHSIC0012 Aseptic Non-Touch Technique Policy
UHSIC013 Respiratory Viruses Policy
UHSIC014 Creutzfeld Jacob Disease (CJD) and variant CJD (vCJD) Policy
UHSIC015 Policy for the prevention of surgical site infection
UHSIC017 Prevention of Apergillosis and infection from other fungi during demolition/construction and renovation activities Policy
UHSIC018 Infestation Policy
UHSIC020 Control of Multi Drug Resistant Organisms (MDRO) (including glycopeptide-resistant enterococci (GRE) and multidrug resistant Gram negative bacilli Policy
UHSIC026 Management of a Patient's Body Following Death with an Infection Policy
UHSIC027 Surgical Instrument Loan Policy
UHSC049 Viral Haemorrhagic Fevers: Management and Control Policy
UHSC059 Blood Culture Collection Technique Policy
UHSTW014 Animals and Pets in Hospital Policy
UHSTW015 Outbreak Management of Healthcare Associated Infection Policy

Appendix 3 Summary of IPC Annual Programme 2025/26

Summary

The Infection Prevention and Control (IPC) Annual Plan 2025/26 sets out the proposed activities for the IPC service at University Hospitals Sussex NHS Foundation Trust. This plan will ensure that the Trust continues to meet the requirements of the Department of Health and Social Care, the Care Quality Commission, and other requirements such as alert organism reductions. The plan specifying Trust agreed actions as well as internal programmes of work that IPC will endeavour to support/deliver on.

The Trust has a series of policies and expert committees, along with strong engagement with the clinical divisions, to prevent and manage healthcare-associated infections (HCAI) and optimise antimicrobial usage. Actions arising from these committees underpin the programmes of work referenced in this plan.

This plan will be reviewed annually, with progress and evidence of completing actions will be regularly reviewed at the Trust Infection Prevention and Control Committee. Progress on actions will also be followed up through Infection Prevention Operational Group (IPOG).

Quarterly review RAG rating	
	Action complete
	Action on track
	Action underway
	Action not on track

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
Criterion 1 - Systems to manage and monitor the prevention and control of infection.	1.1 To fully implement, manage and upload all alert organisms to UKHSA DCS via Power Apps (Power BI).	Optimise power BI tool, educate users, validate data entries and include thematic data analysis.	IPC team including Epidemiologist, Power BI team				
	1.2 Recognise set NHSE alert organism thresholds for 2025/26. 5% reduction target set in healthcare associated infections.	Review and analyse HOHA/COHA attributed HCAI	IPC team, Divisional leads, PSIRF team				
		Standardise IPOG divisional template to ensure hand hygiene, environmental audits, commode audits, indwelling insertion and on-going management is monitored consistently.	DDIPC, Divisional leads.				
		Alert surveillance, thematic reviews, trend analysis for discussion at IPOG/TIPC and antimicrobial stewardship group meetings.	IPC team including Epidemiologist, Divisional leads.				
	1.3 Develop new approaches to investigate HOHA/COHA HCAIs, hospital outbreaks, to seek learning	Following training, introduce PSIRF methodology into IPC service.	IPC team (band 8's), Epidemiologist, Patient safety team,				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	opportunities to change future practice.		Datix team.				
		Transfer remaining alert organism RCA templates onto a PSIRF template.	Patient safety team				
		Undertake thematic analysis using Datix and Power BI platforms.	Epidemiologist, Datix team.				
	1.4 The surgical site surveillance team will establish the burden of SSI in key surgical settings through optimisation of surveillance.	Undertake mandatory SSI surveillance in line with national recommendations.	SSI teams, IPC support				
		Undertake voluntary SSI surveillance in key surgical areas and reactionary SSI surveillance in areas of increased infection rates.	Surgical site surveillance team. Divisions with IPC support.				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	1.5 Implement the IPC audit programme for 2025/26.	All audits to be carried out as detailed in the approved audit programme and action plans automatically sent via Tendable. Divisions to report at IPOG any delayed actions that require IPC support to escalate.	IPC team, Divisions				
		IPC team to liaise with clinical teams post audit to offer face to face/interactive education and support completion of recommendations.	IPC team				
	1.6 Support relevant Trust auditing including National PLACE, PLACE lite and peer reviews.	IPC CNS to manage relevant audit requests by site.	IPC CNSs				
Criterion 2 - The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the	2.2 IPC will work with Estates to effect improvements across the trust (inclusive of water, ventilation, capital builds) throughout the year.	Specialist (W/V) group members to receive all commissioning, validation, interim/full reports for water and ventilation results, ensuring AE (W/V) is involved at every opportunity.	IPC team, Estates team, Capital team				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
prevention and control of infections.		IPC to attend all capital project meetings to ensure HTM/HBN standards are delivered for every new build or refurbishment.	IPC team, Capital team				
Criterion 3 - Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.	3.1 There will be appropriate antimicrobial use and stewardship across UHSussex, that is reviewed at each AMR meeting.	IPC to be an integral stakeholder on AMSG meetings and provide quarterly infection data.	AMSG, IPC team				
		Gain an understanding of Trust antimicrobial resistance rates (Blood cultures, urine positive for gram negative infections) using PPS and thematic analysis.	Epidemiologist, ICD				
Criterion 5 - That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the	5.1 The IPC and micro teams will liaise closely for early identification and IPC measures to be initiated daily (working days).	Microbiology/Virology team to attend Clinical IPC weekly meeting.	Microbiologist, Virologists, IPC team ICD				
		IPC to send updates to micro team in preparation for weekend work if appropriate.	IPC CNS				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
risk of transmission of infection to other people.	5.2 Pathology and IT will collaborate databases to ensure all patient results reach the IPC team for action as soon as the result becomes available.	IPC team to participate with Southeast LIMs project to align lab data feeds.	IPC team & Epidemiologist				
	5.3 IPC team to visit and support patients/NOK with education	IPC team to visit patients/ NOK and offer advice and support	IPC team				
Criterion 6 - Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	6.1 The IPC team with support of the Divisions will strengthen and expand the IPC link champion scheme during the year.	IPC CNS to lead link champion programme. Bimonthly meetings to include appropriate use of PPE/gloves, standard precautions, staff health and hand hygiene initiatives (involve patients either at ward level or part of a group).	IPC CNS IPC Matrons for oversight.				
	6.2 The IPC team will support with Sustainability and Net Zero Target over the coming fiscal year:	IPC designated green ambassador(s).	IPC 8's to discuss and assign.				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	6.3 The IPC team will establish & review current education being delivered by IPC team in line with national IPC framework.	Collect data on current education delivered by IPC and develop a strategy to expand educational opportunities to support staff.	Senior IPC Matron, IPC team				
		Develop a ten-week IPC educational program for IPC link practitioners.	Senior IPC Matron				
	6.4 Develop and provide further education, learning opportunities for the IPC Team over the coming year.	Identify what education IPC team members wish to undertake in 2025/26 and formalise within a training need analysis document. Team being active members of the IPS and join relevant branch meetings	IPC Matrons/ Senior Matron				
	6.5 The IPC team will continue expanding, engaging and supporting research (local and national) relevant to IPC throughout the year and beyond.	ICD to highlight research opportunities.	ICD & Epidemiologist				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
		IPC team members to attend and engage with CINAMR.	IPC Matrons/ Senior Matron				
Criterion 7 – The provision or ability to secure adequate isolation facilities.	7.1 Capital/ minor works will involve IPC in the plans for new builds throughout 2025/26 and beyond as standard collaboration.	Review plans for refurbishment and new builds to ensure the scheme includes adequate and appropriate isolation facilities.	IPC team Capital Team				
Criterion 8 – The ability to secure adequate access to laboratory support as appropriate.	8.1 IPC will further strengthen relationships with the wider infection department at UHSussex.	IPC team to explore visits/placements within the microbiology laboratories. In addition to exploring the development of an IPC rotation for infection trainees.	IPC team, ICD, Lab leads				
		IPC team to join clinical infection ward rounds at all sites.	Micro leads, IPC team				
Criterion 9 -Adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infections.	9.1 IPC will review, and update IPC polices as they approach expiry or when new information is published.	Policy updates and reviews will follow the Trust governance pathway and be uploaded to IPC policy page on SharePoint.	DDIPC, Senior IPC Matron, IPC secretaries				

10 criteria of the Hygiene Code (2008)	Objectives	What steps need to be taken?	Who is responsible?	Q1 review (Apr-Jun 25)	Q2 review (July-Sept 25)	Q3 review (Oct-Dec 25)	Q4 review (Jan-March 26)
	9.2 IPC will ensure audit processes are in place for policy compliance over the year 2025/26	Disseminate policies as per local governance processes and support education as per criterion 6.	IPC team				
Criterion 10 – That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.	10.1 Substantive Trust Fit testing team to be recruited and trained to provide the service across all sites. Support the People Directorate in shaping the Occupational Health offer as relates to IPC	Job descriptions to be approved by Executive Team (band 4/band 3). Followed by advertising and recruiting to the substantive positions. Advise People Directorate re IPC staff screening, occupational exposure assessments, inoculation injuries and vaccination.	DDIPC, Band 8's, IPC secretary, cDIPC, People Directorate leads and OH leads				

References

Department of Health & Social Care (updated 13th December 2022) *Guidance: Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance* [online] available from: Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK (www.gov.uk) [Accessed 03.04.2025]