University Hospitals of North Midlands NHS Trust

Infection Prevention, Vaccination and Sepsis Team

Annual Report 2025/26

The best joined-up care for *all*

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Foreword by Chief Nurse/Director of Infection Prevention & Control (DIPC)

Infection Prevention and Control Annual Report 2025-26

I am pleased to introduce our Annual Infection Prevention Report for 2025-26.

Infection Prevention (IP) continue to be a core component of our statutory responsibilities and a critical determinant of the safety and quality of the services we provide. Throughout the reporting period, our Infection Prevention team have maintained a rigorous and systematic approach to preventing and managing infection risks, ensuring alignment with national legislation, regulatory standards, and evidence-based best practice.

This Annual report covers the period 1st April 2025 to 31st March 2026 and has been written in line with the ten criteria as outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2022). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation

This year's work has focused on sustaining high levels of compliance across all clinical and non-clinical areas, strengthening organisational resilience, and ensuring that robust governance arrangements remain firmly embedded. Surveillance, audit, and incident management processes have been consistently applied to support early identification of risks, promote timely intervention, and minimise the potential for healthcare-associated infections.

Significant emphasis has been placed on maintaining strong hand hygiene performance, ensuring environmental cleanliness, supporting prudent antimicrobial stewardship, and enhancing staff competence through targeted education and training.

We have both refreshed and maintained reporting of our Infection Prevention Board Assurance Framework and welcomed the focus on this. We are clear where we need to drive continual improvement and will continue to promote good infection prevention practices as part of everything we do across the organisation.

I am incredibly proud of the professionalism, expertise, and commitment of the Infection Prevention team throughout another challenging year. Their leadership has had a direct and positive impact on the safety and wellbeing of patients, service users, staff, and visitors.

We have some exciting initiatives planned for 2026-2027 to support our continual improvement work and support deliver against our Strategic Objectives for 2025-2026

Ann Marie Riley OBE
Chief Nurse and Director of Infection Prevention and Control

Abbreviations

AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
C *difficile*	Clostridioides *difficile*
CDI	Clostridioides *difficile* infection
CQC	Care Quality Commission
COHA	Community onset Hospital Associated
CQRM	Clinical Quality Review Meeting
CQUIN	Commissioning for Quality and Innovation Payment Framework
CWCSS	Children's, Women's and Clinical Support Services
DH	Department of Health
DIPC	Director of Infection Prevention & Control
E coli	Escherichia coli
ESR	Electronic Staff Record
ESBL	Extended Spectrum Beta Lactamase
FFP3	Filter Face Piece (with an assigned protection of 20)
GDH Ag	Glutamate dehydrogenase antigen of *C. difficile*
GRE	Glycopeptide Resistant Enterococcus
HCAI	Health Care Associated Infection
HOHA	Hospital onset Hospital Associated
ICB	Integrated Care Board
ICD	Infection Control Doctor
iGAS	Invasive Group A Streptococcal Infection
IM&T	Information & Technology
IP	Infection Prevention
IP BAF	Infection Prevention Board Assurance Framework
IPCC	Infection Prevention and Control Committee
IPN	Infection Prevention Nurse
IPT	Infection Prevention Team
IVAB	Intravenous antibiotics
MDT	Multi-Disciplinary Team
MGNB	Multi resistant Gram-negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *staphylococcus aureus*
MSSA	Meticillin Susceptible *staphylococcus aureus*
NHSE	National Health Service England
OH	Optima Health
OPAT	Outpatient Parenteral Antibiotic Therapy
PCR	Polymerase Chain Reaction
FDP	Federated Data Platform
PFI	Private Fund Initiative
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, amber, green
PSIRF	Patient Safety Incident Response Framework
RCA	Root Cause Analysis
RSUH	Royal Stoke University Hospital
SOP	Standard Operating Procedure
SSI	Surgical Site Infection
UHNM	University Hospitals of North Midlands
UKHSA	UK Health Security Agency
VNTR	Variable-number tandem-repeat

Introduction

This report summarises the combined activities of the Infection Prevention, Vaccination & Sepsis Team (IPT), other senior colleagues, and staff at University Hospitals of North Midlands (UHNM) in relation to the prevention of healthcare associated infections (HCAIs).

The Trust recognises that the effective prevention of HCAIs is essential to ensure that patients using our services receive safe, effective and quality care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety and delivery of quality care to our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place, for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this law there are two key principles:

- to deliver continuous improvements of care
- it meets the need of the patient.

This report includes a summary of the annual plan for the IPT for 2026/27.

Compliance Criteria 1:

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

Infection Prevention Team

At UHNM the Director of Infection Prevention and Control (DIPC) is the Chief Nurse who has overall responsibility for the IPT. The Associate Chief Nurse (Infection Prevention) at UHNM also has the role of Deputy DIPC.

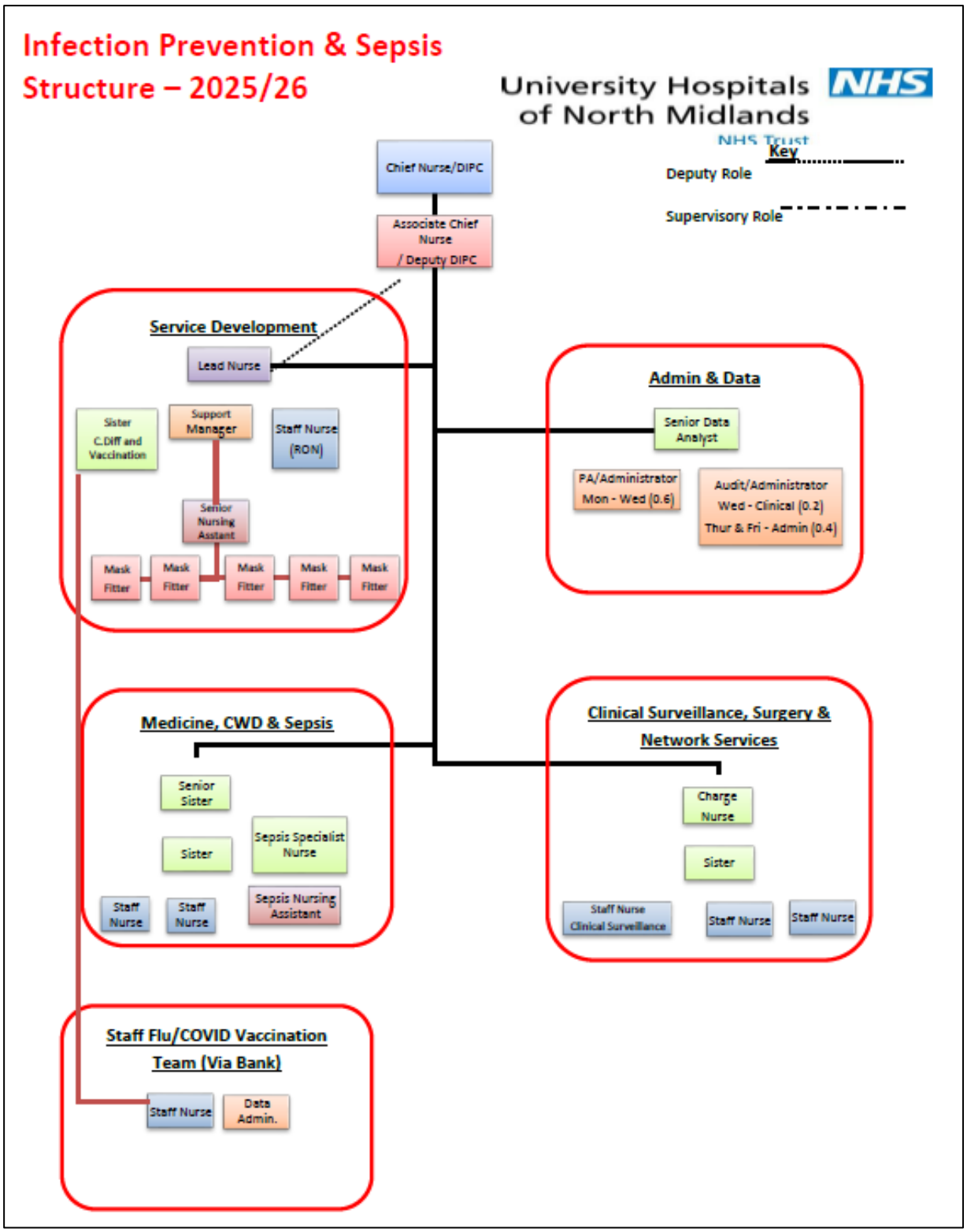
The IPT work collaboratively alongside front-line clinical leaders, supporting proactivity with improved clarity and defined alignment to clinical services. The introduction of new technologies allows the IPT to be present within the clinical settings for most of their time.

The Infection Prevention Team experienced staff vacancies in previous years which is now gradually being filled in with the capacity to deliver IP proactive and collaborative work. Whilst most vacancies have been filled the new team are learning about IP roles and responsibilities to support clinical areas. Our focus will remain back to basics and delivering education to front line clinical and medical staff.

Quality Nurses and clinical educators remain an integral part of service delivery at UHNM. Nurses have a significant role in patient safety explicit within their responsibilities. This provides

a key lynchpin, and an ideal opportunity for the IPT to meet the challenges and significantly change the method of service delivery to front-line colleagues.

The infection prevention service is provided through a structured annual programme of works which includes expert advice, education, audit, campaign & awareness initiatives, policy and service development. The Trust has 24-hour access to expert advice and support.



Committee Structures and Assurance Processes

Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for infection prevention and control. The Chief Executive has overall responsibility for the control of infection at UHNM. The Chief Nurse is the Trust designated Director of Infection Prevention and Control (DIPC). The DIPC attends Trust Board meetings with detailed updates on infection prevention and control matters. The DIPC also meets regularly with the Chief Executive.

Quality Access Outcome Committee

The Quality Access Outcome Committee is a non-executive committee of the Trust Board.
The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality and research objectives. This assurance is secured through the Assurance Framework, the Corporate Risk Register and the audit plans, which focus on the quality and research objectives of the Trust.
The Infection Prevention Team provides a quarterly report on surveillance and outbreaks. The Infection Prevention Board Assurance Framework (IP BAF) is also submitted to the committee quarterly.

Executive Quality Outcome Group

The Executive Quality Outcome Group has been formed as an Executive Group to support assurance through the Quality Governance Committee to the Trust Board on quality and safety.

The Executive Quality Outcome Group serves a dual purpose within the Trust's governance, assurance and performance arrangements:

- Accountable to the Quality Access Outcome Committee, through its executive membership it will provide assurance across the key areas set out within the Board Assurance Framework
- It will receive and consider any concerns or issues escalated from Care Groups and sub-groups and provide advice, guidance and support.

The Executive Quality Outcome Group is the forum at which the Trust focuses on its delivery of patient centred care and services in accordance with the Trust's Strategic Objectives. The Group is responsible for developing, implementing, monitoring and evidencing actions which improve the quality and safety of care and services provided to patients and service users.

The Infection Prevention Team provides a monthly report on surveillance and outbreaks.

Care Groups Infection Prevention Groups

These groups are responsible for monitoring local performance in relation to infection prevention. Assurance is provided by Care Groups and Infection Prevention meetings. Groups provide assurance to the Trust IPCC that adequate systems and processes are in place within wards and departments and that performance and risks are being monitored.

Antimicrobial Stewardship Group

The Antimicrobial Stewardship Group (ASG) is a multidisciplinary group responsible for the monitoring and review of good antimicrobial stewardship within the Trust. The ASG reports directly to the IPCC and meets on a bi-monthly basis. The group drives forward local activities to support the implementation of international and national initiatives on antimicrobial

stewardship including ‘Start Smart then Focus’ and the ‘European Antibiotic Awareness Campaign’. The ASG produces and updates local antimicrobial guidelines which considers local antibiotic resistance patterns; regular auditing of the guidelines; antimicrobial stewardship practice and quality assurance measures; and identifying actions to address poor compliance with guidelines. Antimicrobial audit results are reported widely throughout the organisation, for example at Care Groups Clinical Governance and Speciality Morbidity and Mortality meetings. There are robust processes in place to support clinical areas that require additional support or oversight to achieve continual improvement.

There is a separate Health Economy Antimicrobial Group, chaired by a Consultant Microbiologist, which meets quarterly and has representation from all key stakeholders, including General Practitioners. A regular report is submitted to IPCC.

Decontamination Safety Meetings
The Trust Decontamination Lead is a joint lead between the Director of Estates Facilities and PFI and the Chief Nurse/DIPC.

The management of decontamination and compliance falls into three distinct areas: Estates, IPT and the Equipment User, details are outlined later in the report.

The Decontamination Safety Group and Operational WSG is a subgroup of IPCC and meets quarterly. It is chaired by the Deputy DIPC with multi-disciplinary representation.

Water Safety Group and Operational WSG
The Water Safety Group and Operational WSG is a subgroup of IPCC and meets quarterly. It is chaired by the Deputy DIPC with multi-disciplinary representation.

Ventilation Safety Group
The Trust Ventilation Safety group is in place and meets quarterly, and is chaired by the Associate Director of Estates & Facilities..

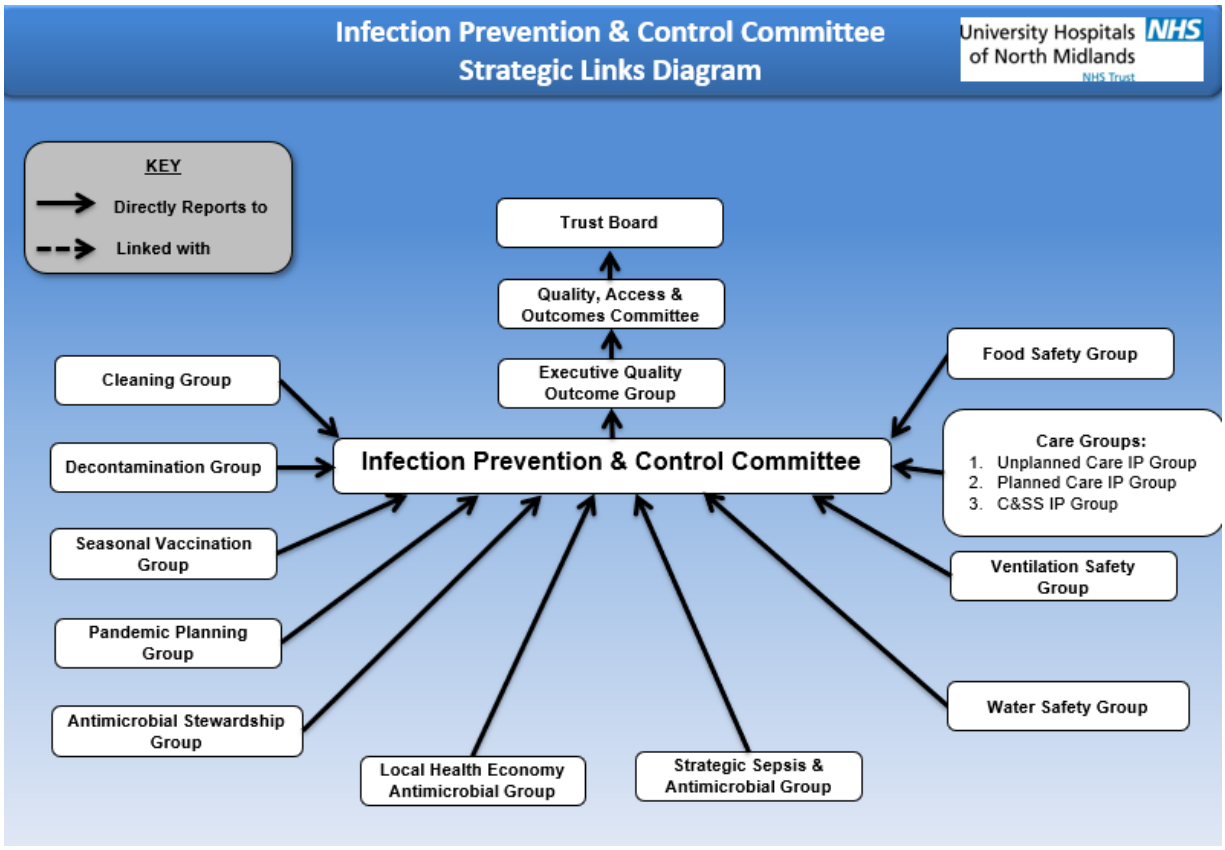
Mortality Review Group
The Trust Mortality Review Group meets monthly and the Chair for the group is the Deputy Medical Director (Patient Safety). This group reports directly to the Executive Quality Outcome Group providing an understanding of the interpretation and application from mortality data. The group has initiated a proactive approach to reviewing mortality alerts and providing prompt assurances to both the Trust and its external stakeholders in relation to any potential alerts relating to mortality. The mortality information and analysis are also reported to the Quality Access Outcome Committee to allow for non-executive review and challenge around the robustness of the data and the processes in place for reviewing mortality and providing assurances to the Trust Board.

The corporate structure for reporting and monitoring on mortality issues is outlined below:

Clostridioides *difficile* 30-day all-cause mortality information is included in the Infection prevention reports to IPCC.

The IPT complete a Board Assurance Framework self-assessment which is reported into IPCC.

Infection Prevention and Control Committee (IPCC) Strategic Links



Reports/Papers Received by IPCC

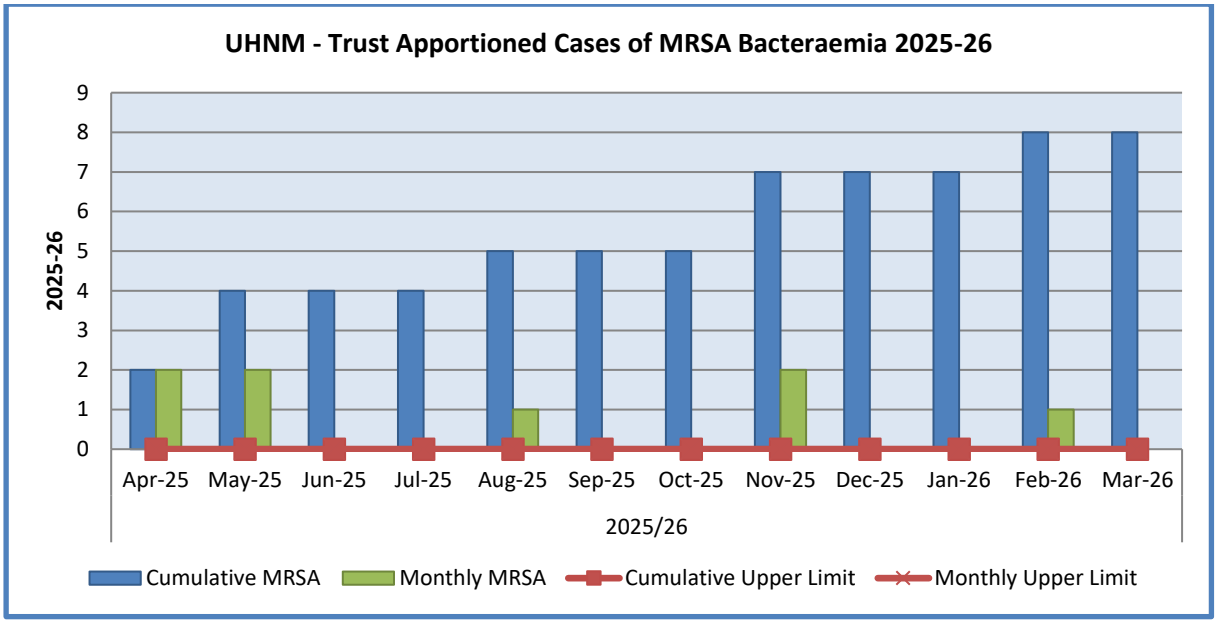
Policy/Procedure Updates and Standard Operating Procedures (SOP) updates	Rotational Report: Water Safety
UHNM HCAI Surveillance & Performance Reports	Rotational Report: Occupational Health
Outbreaks & Incidents	Rotational Report: Decontamination
Care Group Reports	Rotational ventilation
Environment Report	Pandemic/ HCID Update
UHNM Antimicrobial Group Update	Annual Report
Antimicrobial CQUIN Update	Sepsis Report
Local Health Economy Antimicrobial Group Update	Annual Manual Decontamination Audit
Documents Received from other Committees, Regional & National	Annual Mattress Audit Report
HCAI Monthly Bulletin	Annual IP Link Practitioner Report
Compliance report for IPCC (Governance)	IP Risk Register
Review & Update Committee Terms of Reference	IP Stat & Mandatory figures (Quarterly)
IP Board Assurance Framework (BAF)	Food Safety Group Update
SSI Report	Antimicrobial Stewardship Group

Blood Culture Contamination Rates Report	Decontamination Safety Group
BSI Report /Gram negative Report	IP Risk Register
Hand Hygiene Audits	Water Safety Group Minutes
ANTT Update	Sharps Report
CDI Plan Update	Health Economy Committee
UKHSA Update	3T Heater Cooler Update
Annual IP Code of Practice Self -Assessment Tool	Vaccination Update
IP Manual guidelines update & approval	NHSE & UKHSA briefing update

Groups/Meetings Infection Prevention Team Attend

Weekly Clinical Advisory Group	Health Economy Antimicrobial Group
Weekly IP Systems Meeting	Midlands Infection Prevention Meetings
Antimicrobial Stewardship Group	Theatre Product Evaluation Group (TPEG) Group
Clinical Equipment Product Evaluation Group (CEPEG)	Executive Quality Outcome Group
Quality, Access & Outcomes Committee	Health Economy IP Group
Flu Vaccination Steering Group	Infection Prevention Meetings, Care Groups
Clostridioides *difficile* Multi- Disciplinary Meetings	Infection Prevention Group Meeting, Estates, Facilities and PFI Division
Winter Planning Group	Mortality Review Group
Clostridioides *difficile* period of increased incidence meetings (PII)	Pneumatic Tube Meetings
Bed and Mattress Meetings	Decontamination Group
Estates refurbishments and new development projects	Ventilation Safety Group
UHNM Clinical Quality Review Meeting (CQRM)	Strategic Sepsis and antimicrobial Group
Trust Health and Safety Committee	Tissue Viability
Health and Safety Imaging	Teaching and Educational Meetings
Fire Enforcement	Water Safety Group (WSG)
Nursing and Midwifery and APH Advisory Forum	Weekend Planning Meeting
Catheter Strategic Group/ Pathway project	County Working Group Meeting
National Standards for Cleanliness	Medical Device Strategy Committee
Care Excellence Framework (CEF)	Executive Health & Safety Group

MRSA Bacteraemia (Blood stream infection)



8 patients developed a MRSA bacteraemia, out of the 8 cases 6 were deemed unavoidable and 2 avoidable, action plans instigated, learning alerts were circulated Trust wide with the lessons learnt.

***Clostridioides difficile* Infection (CDI)**

Clostridioides *difficile* is a bacterium that can cause colitis. Symptoms range from mild diarrhoea to a life-threatening disease. Infections are often associated with healthcare, particularly the use of antibiotics which can upset the bacterial balance in the bowel that normally protect against CDI. Infection may be acquired in the community or hospital, but symptomatic patients in hospital may be a source of infection to others. A proportion of the healthy population have Clostridioides *difficile* normally residing in their gut without causing any illness.

In March 2012 the Department of Health (DH) issued revised guidance on how to test, report and manage CDI. The new guidance aimed to provide more effective and consistent diagnosis, testing and treatment of CDI. It provided the ability to categorise patients into one of three groups:

- CDI likely
- Potential Clostridioides *difficile* excretors (carriers)
- CDI unlikely

Identification of potential Clostridioides *difficile* excretors may aid infection prevention measures.
UHNM is compliant with DH testing guidance for CDI.

All patients with a toxin A/B positive or a toxin B gene PCR test positive report are isolated until at least 72hrs free of symptoms and a formed stool has been achieved.

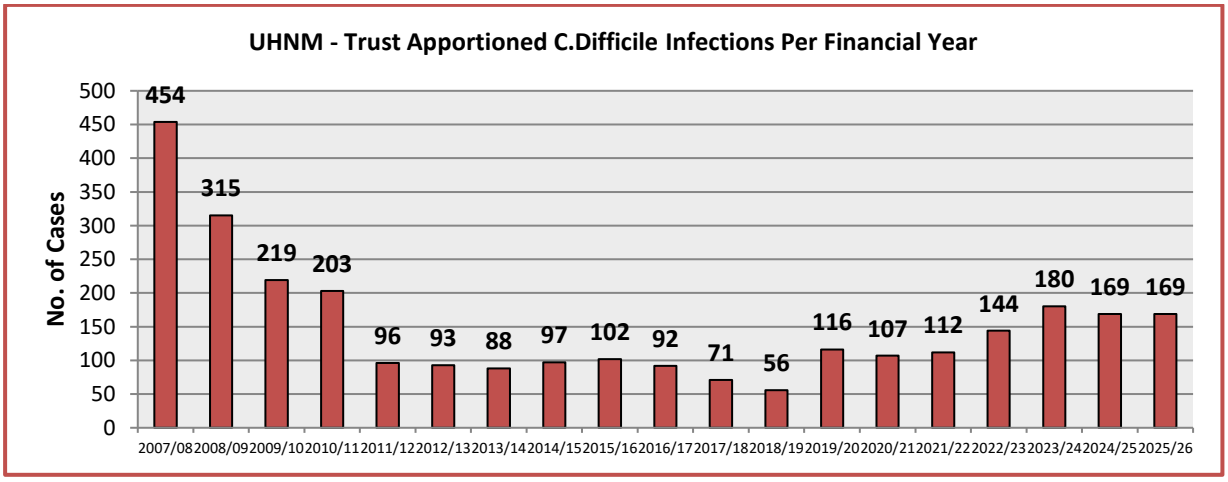
Reporting of Clostridioides *difficile* toxin cases UK Health Security Agency

Healthcare associated infection (HAI) cases are Clostridioides *difficile* toxin positive specimens taken on or after day 3 of a hospital admitted spell where day 1 is the day of admission.

Community onset hospital associated (COHA**)** cases that occur in the community (or within two days of admission) when the patient had been an in-patient in the trust reporting the case in the previous four weeks.

From April 2019 onwards the performance of each Trust in relation to their annual target (as set out by NHSE in their CDI Objectives for NHS organisations) regarding trust apportioned cases is the total of HAI cases plus COHA cases.

The upper limits set by NHSE for Trust acquired cases at UHNM 2025-26 was 144. UHNM reported a total of 169 cases which is the same as the previous year (2024/25) and was well above the upper limit.

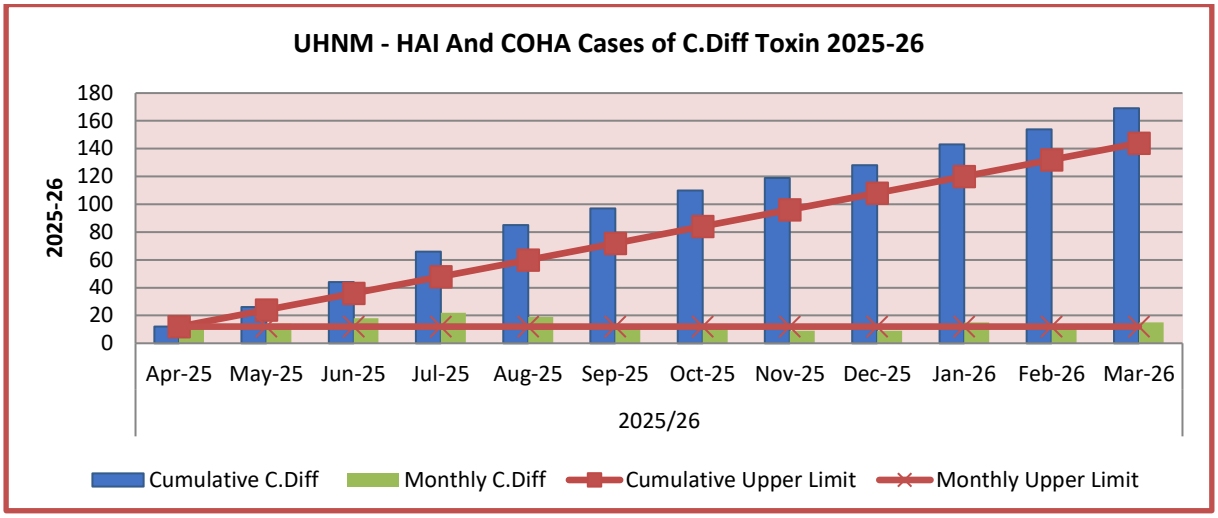


The University Hospitals of North Midlands NHS Trust (UHNM) was selected as one of the designated sentinel surveillance sites by the UK Health Security Agency (UKHSA) amongst other large hospital Trusts in England.

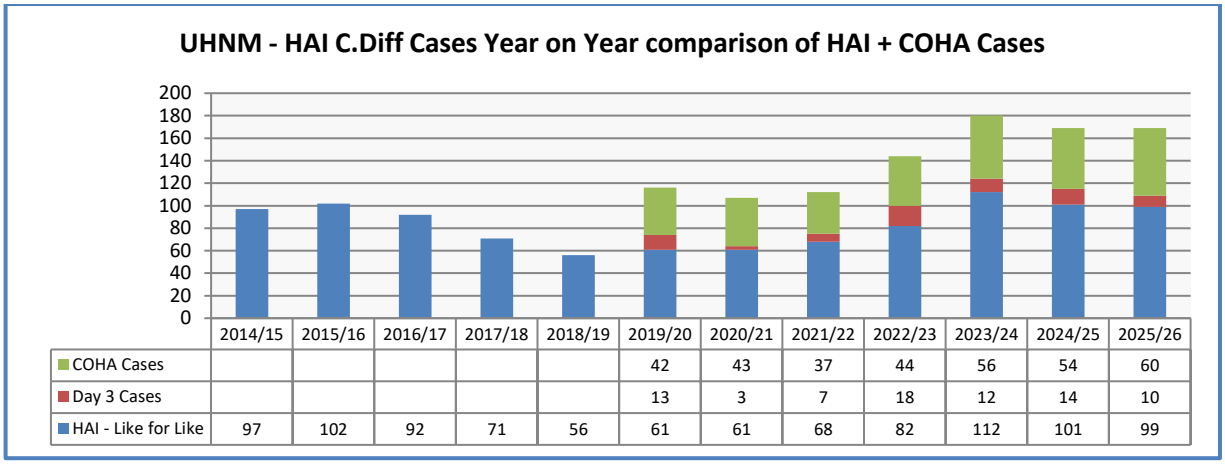
The national *Clostridioides difficile* Ribotyping Network **(**CDRN) service, based at the UKHSA Laboratory in Leeds, supports hospitals across England by investigating clusters of *Clostridioides difficile* infection (CDI) and providing timely data using PCR ribotyping, with MLVA (Multilocus Variable-number tandem-repeat Analysis) available for more detailed outbreak analysis when needed. The aims are to strengthen early detection of emerging *C. difficile* strains, track antimicrobial resistance, and inform national infection prevention policies.

From April 1st, 2025, and up to present, the sentinel surveillance seeks to obtain a representative sampling of *C. difficile* ribotypes from trusts with high levels of patient transfers. To obtain the representative sampling the first 10 *C. difficile*-positive de-duplicated specimens per month are sent to the CDRN reference laboratory.

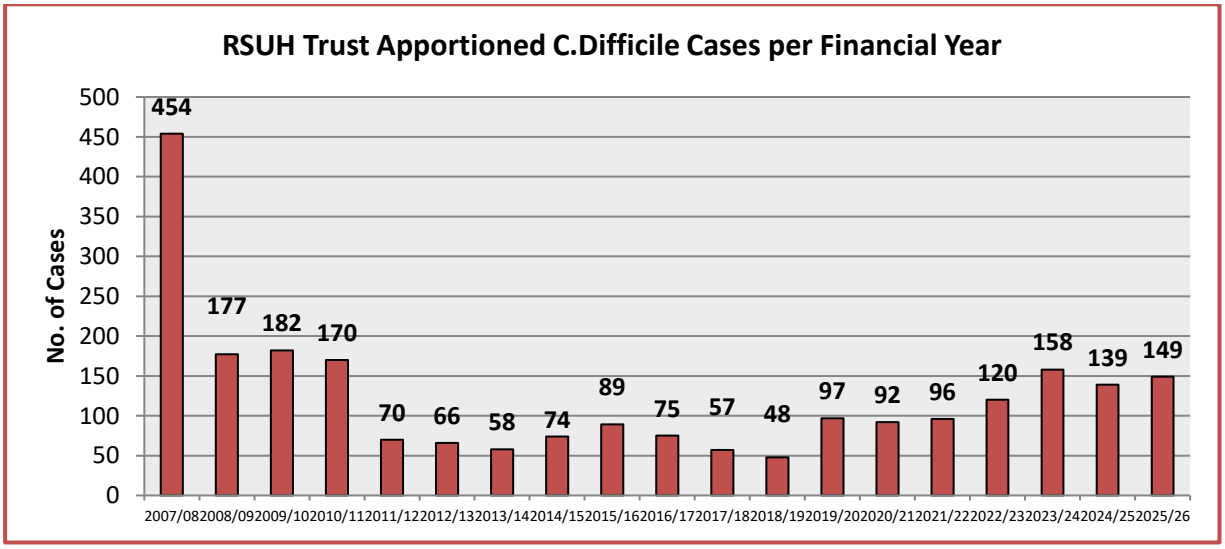
UHNM's selection is a significant marker of the Trust's leadership in infection prevention. It recognises the high quality of local diagnostics, data governance, and clinical care. As a sentinel site, UHNM will contribute representative case data and clinical isolates for advanced ribotyping and genomic surveillance, enabling real-time national responses to CDI trends.

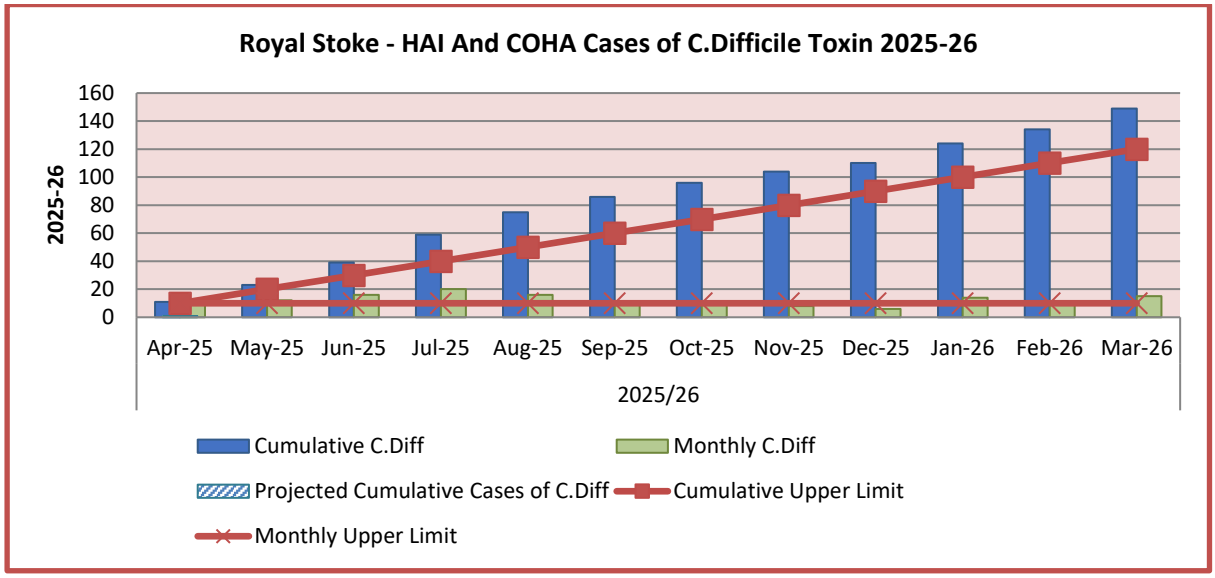


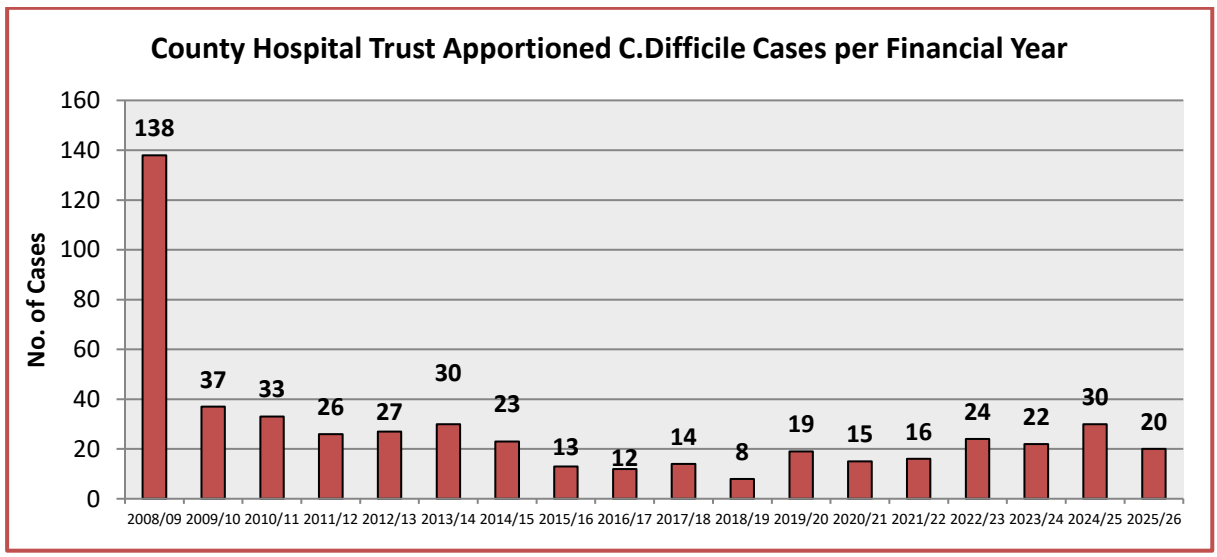
The following chart shows the impact that the change in Trust apportionment rules have had on the total number of cases attributed to UHNM for each completed fiscal year.

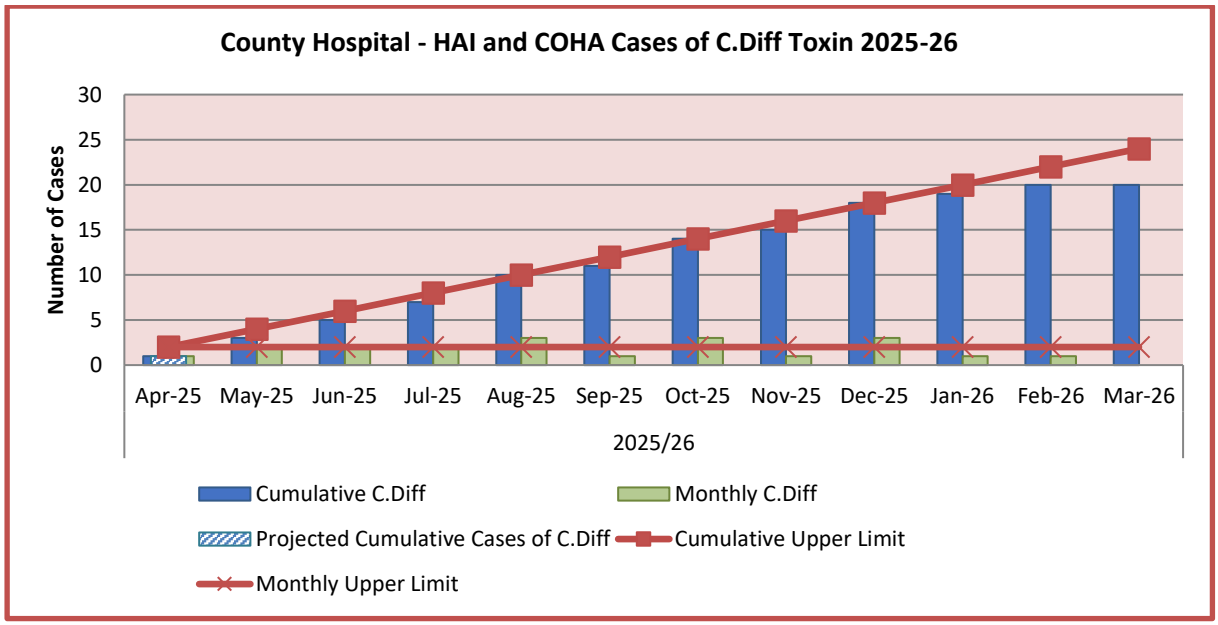


	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
COHA Cases						42	43	37	44	56	54	60
Day 3 Cases						13	3	7	18	12	14	10
HAI - Like for Like	97	102	92	71	56	61	61	68	82	112	101	99




Royal Stoke - HAI And COHA Cases of C.Difficile Toxin 2025-26
2025-26
160
140
120
100
80
60
40
20
0
Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26
2025/26
Cumulative C.Diff
Monthly C.Diff
Projected Cumulative Cases of C.Diff
Cumulative Upper Limit
Monthly Upper Limit


County Hospital Trust Apportioned C.Difficile Cases per Financial Year
No. of Cases
160
140
120
100
80
60
40
20
0
138
37
33
26
27
30
23
13
12
14
8
19
15
16
24
22
30
20
2008/09 2009/10 2010/11 2011/12 2012/13 2013/14 2014/15 2015/16 2016/17 2017/18 2018/19 2019/20 2020/21 2021/22 2022/23 2023/24 2024/25 2025/26


County Hospital - HAI and COHA Cases of C.Diff Toxin 2025-26
Number of Cases
30
25
20
15
10
5
0
Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25 Oct-25 Nov-25 Dec-25 Jan-26 Feb-26 Mar-26
2025/26
Cumulative C.Diff
Monthly C.Diff
Projected Cumulative Cases of C.Diff
Cumulative Upper Limit
Monthly Upper Limit

Clostridioides *difficile* Action Plan

Preventing and controlling the spread of Clostridioides *difficile* is a vital part of the Trust's quality and safety agenda utilising a multifaceted approach and the proactive element of early recognition and isolation of Clostridioides *difficile* toxin positive cases, and of those cases that are Clostridioides *difficile* carriers (PCR positive).

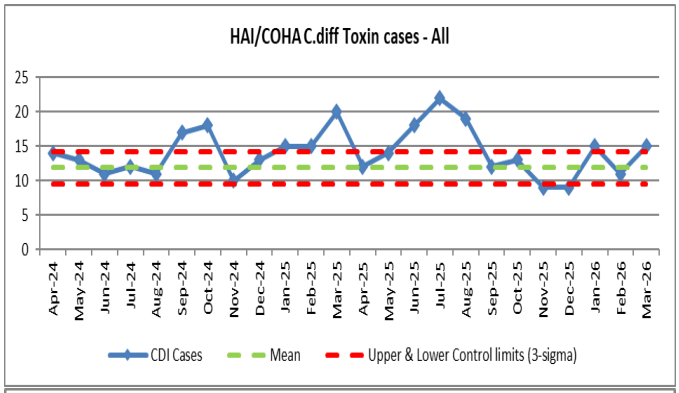
All hospital acquired Clostridioides *difficile* positive samples or cases where the patient has had a recent hospital stay at UHNM were previously submitted for ribotyping.

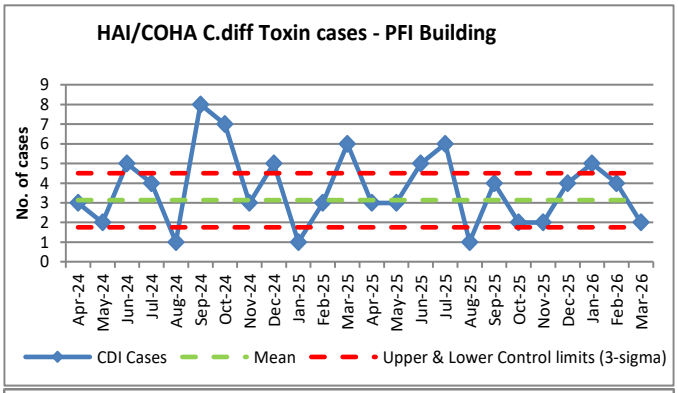
On 7th July 2023 all NHS Trusts were notified by UKHSA about the introduction of a charge per test for the typing of C diff toxin positive stool samples. This testing was previously done by UKHSA for free, the new charge will be **£60.08** per test requested.

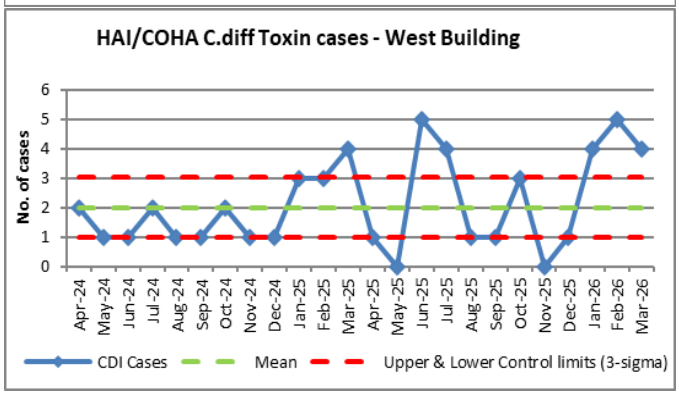
UKHSA will no longer test PCR-positive samples with Clostridioides *difficile* toxin below detection level, since they consider the probability of being able to culture and type the organism from such samples too low. This change will approximately half the number of positive samples that may be submitted for ribotyping.

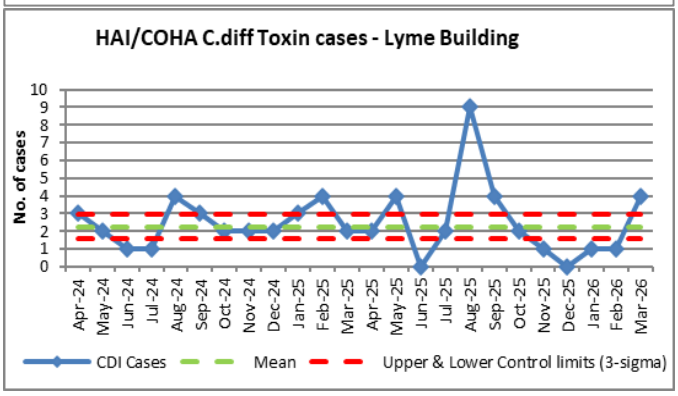
The Executive Team have agreed funding to continue to send C *difficile* toxin samples for ribotyping for periods of increased incidents (n=~8 per month) to determine whether any person-to-person transmission or environment to person transmission has occurred.

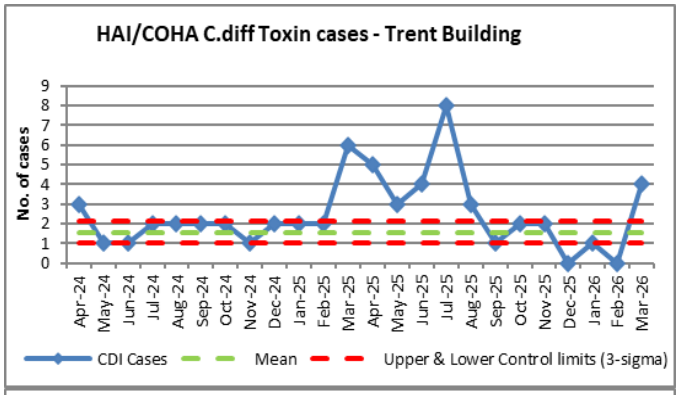
Statistical Process Control charts – Trends since April 2023

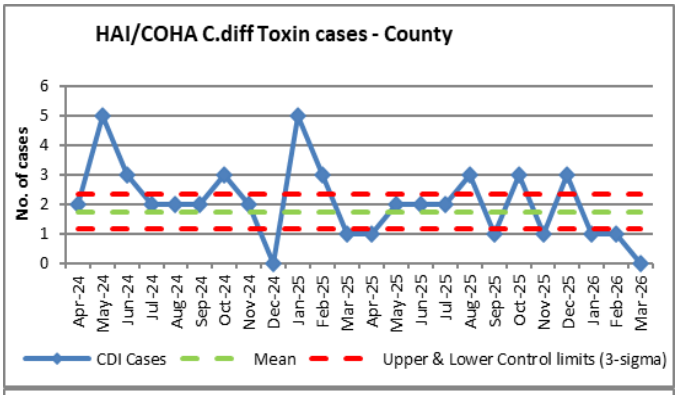


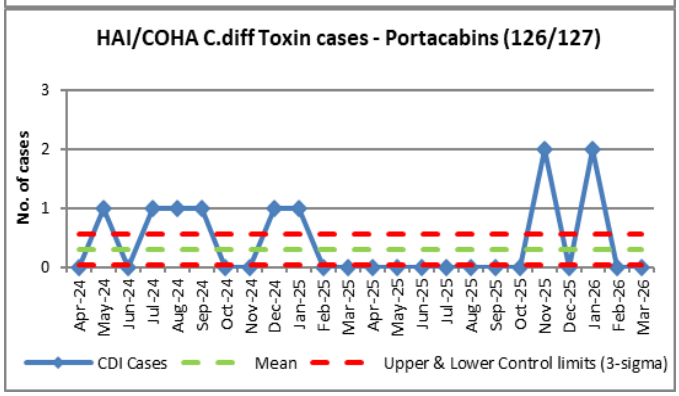


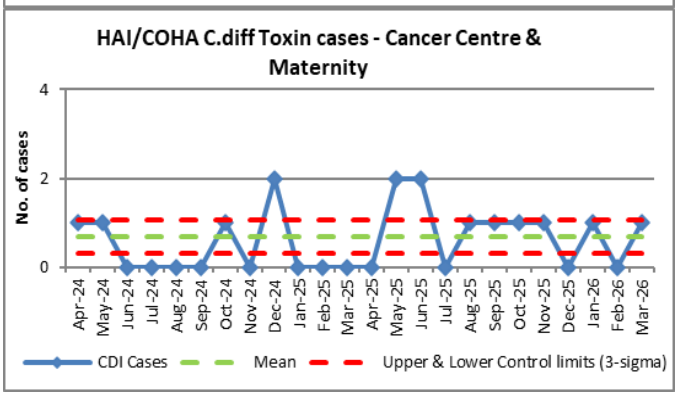












In all cases control measures are instigated immediately, and PSIRF methodology is adopted to identify themes and any lessons to be learned. Each inpatient is reviewed by the Clostridioides *difficile* Nurse, and forms part of a bi-weekly multi-disciplinary review where the patients' case is discussed, including antibiotics and where necessary feedback is given to Ward Doctors and Clinical Teams.

UHNM closely monitor Periods of Increased Incidence (PII) of patients with evidence of toxigenic Clostridioides *difficile* in any ward or area. The definition of a PII is two or more patients identified with evidence of toxigenic Clostridioides *difficile* within a period of 28 days and associated with a stay in the same ward or area or outbreak if proven to be the same strain of Clostridioides *difficile* by variable number tandem repeat analysis VNTR (DNA sequence).

In the past, samples with the same ribotype were then examined further by way of variable-number tandem repeat (VNTR). This provides further analysis to establish if the same ribotypes match, indicating transmission between patients.

Leeds perform VNTR, since the COVID 19 pandemic pressures VNTR has not been possible; however, all Infection Prevention measures were instigated. This has changed recently and with laboratory support Leeds Hospital had started accepting VNTR requests for areas with PII.

Wards with HCAI CDI are placed on barrier cleans for a total of 28 days provided no further HCAI cases are reported from the area, in addition wards with a PII undergo a full terminal clean and stringent IP measures in place.

Sporicidal disinfectant is used routinely across UHNM for cleaning of the general environment and non-invasive equipment used in wards/departments e.g. commodes. Emergency portals are on a routine six monthly deep clean programme in addition to all other cleans.

In addition, the Trust held a Big Bed and Commode Cull Clean day and will continue bi-yearly as part of the initiative to reduce risk of contamination and outbreaks.

The above approach has assisted greatly in the early identification and termination of any outbreaks of CDI.

Faecal microbiota transplant (FMT) involves the infusion of healthy human donor flora bacteria into the bowel of the affected patient. The indications for the treatment were either recurrent diarrhoea or no response to aggressive Clostridioides *difficile* management.

Education is a key aspect of helping to promote the prevention of Clostridioides *difficile* within the Trust. Assisting with staff knowledge of stool sampling practices and Clostridioides *difficile* risks factors.

A programme of Clostridioides *difficile* education is in place for all clinical and medical staff. The Clostridioides *difficile* Nurse role is 50% patient reviews and 50% education.

Sessions are extended to include non-clinical staff such as Domestic Staff, plus Clostridioides *difficile presentation* is available online.

As part of the Clostridioides *difficile* work a Task and Finish Group was set up previously for the West Buildings with good outcomes.

The biweekly Clostridioides *difficile* MDT meeting continues.

A top tips cards for staff are issued to staff during the education sessions, again promoting sampling practices and the 'Pooh' help line.

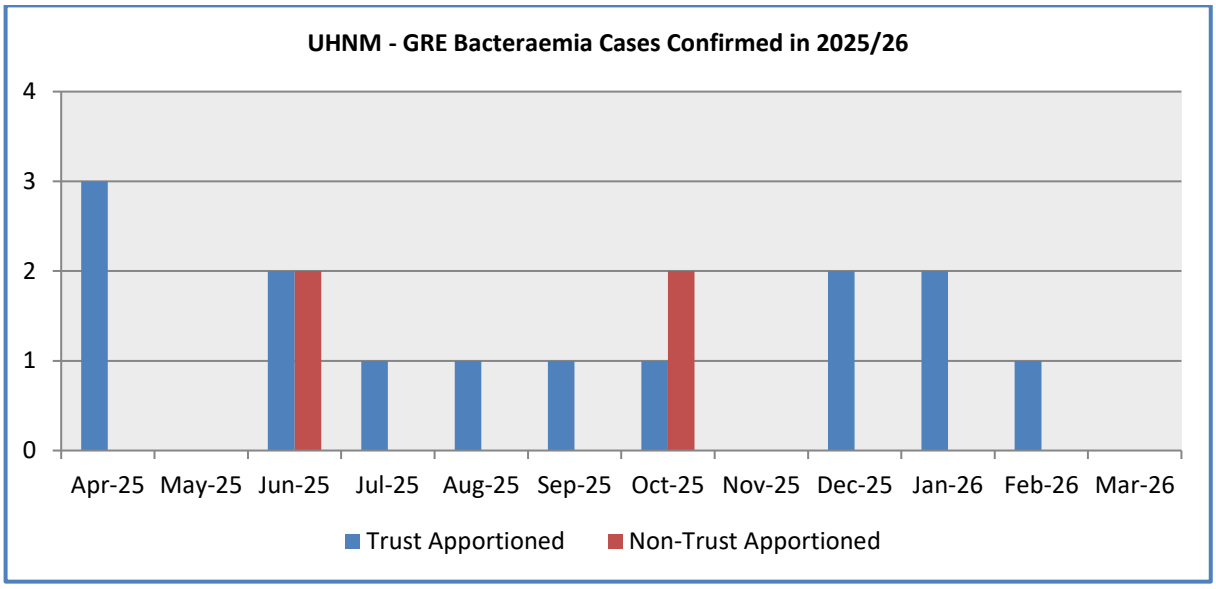
The 'Pooh' help line has been relaunched during the year. A Trust wide learning alert was also issued around timely sending of stool samples. Further plan of C diff initiatives and awareness will continue throughout the year.

All patients with Clostridioides *difficile* infection are provided with an information leaflet which contains the Clostridioides *difficile* passport (green card), this card is for the patient to keep and then show to any doctor, pharmacist, dentist or healthcare provider.

Glycopeptide Resistant Enterococcus (GRE) Bacteraemia

Enterococci are bacteria commonly found in the bowel and GRE are enterococci that have become resistant to glycopeptides (for example vancomycin). Reporting of bacteraemia caused by GRE has been mandatory for NHS acute Trust in England since September 2003.

During 2025-26 the Trust reported 18 of this type of blood stream infection (see chart below), with 28 cases recorded at UHNM in 2024-25.



Carbapenemase – Producing Enterobacteriaceae (CPE)

Public Health England (PHE) published a toolkit for the early detection, management and control of CPE in December 2013. The toolkit provides expert advice on the management of CPE to prevent or reduce the spread of these bacteria into (and within) health care settings, and between health and residential care settings.

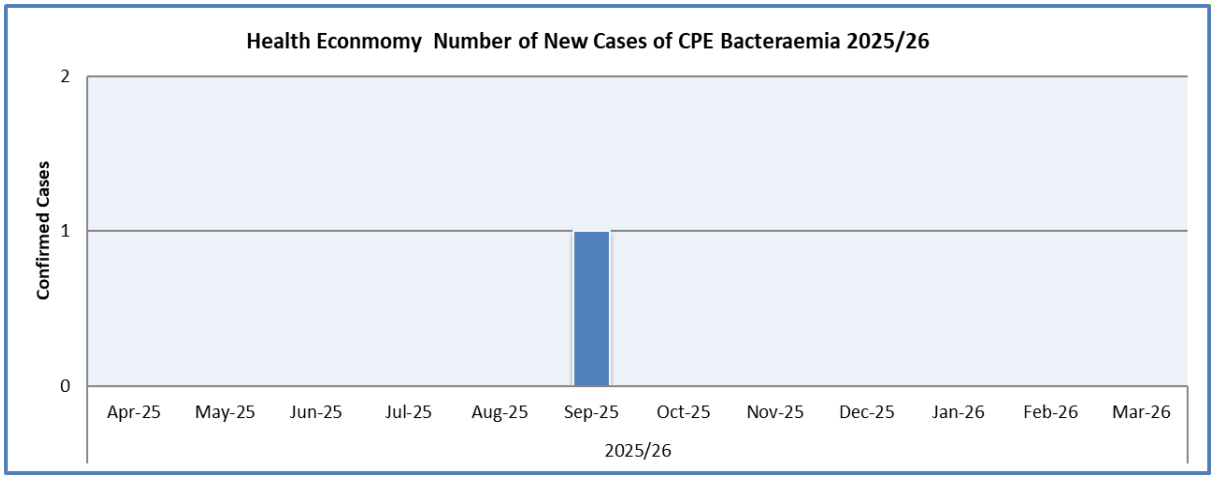
A Trust CPE policy has been in place for some time; this reflects screening guidance recommended by Public Health England.

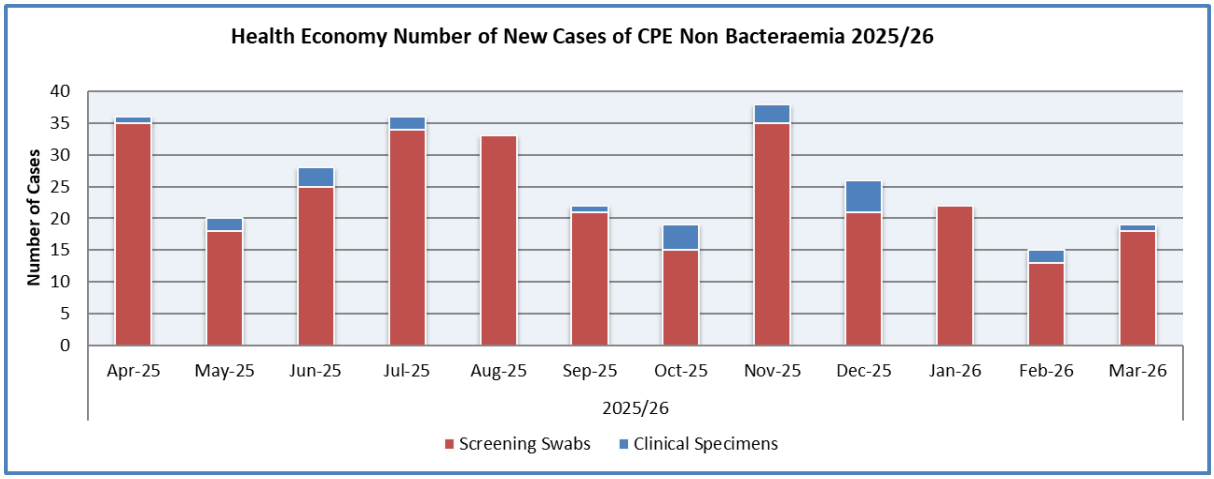
In addition to national guidance UHNM perform routine admission and weekly screening on the following wards: Adult Intensive Care Unit, Renal Ward, Oncology and Haematology Ward, Infectious Diseases Ward, all Elderly Care Wards and other high risks areas.

A screening close contact flow chart remains in place to assist staff in the clinical areas where contact screening of patients is required.

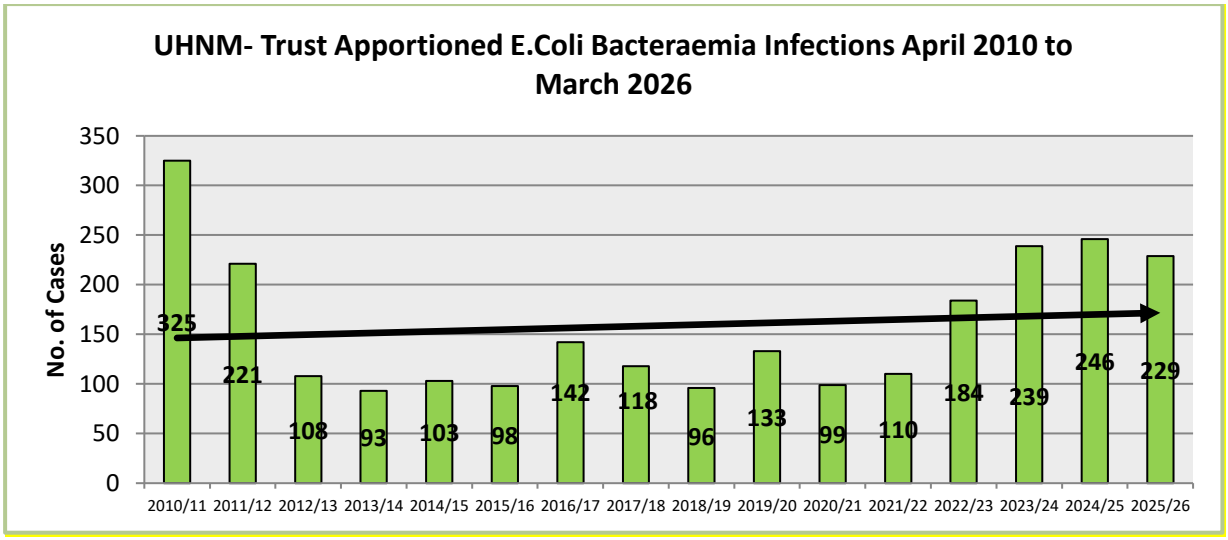
UHNM screening method (for rectal swab & catheter sample urines) uses culture plates that can detect both extended spectrum beta-lactamase (ESBL) and CPE.

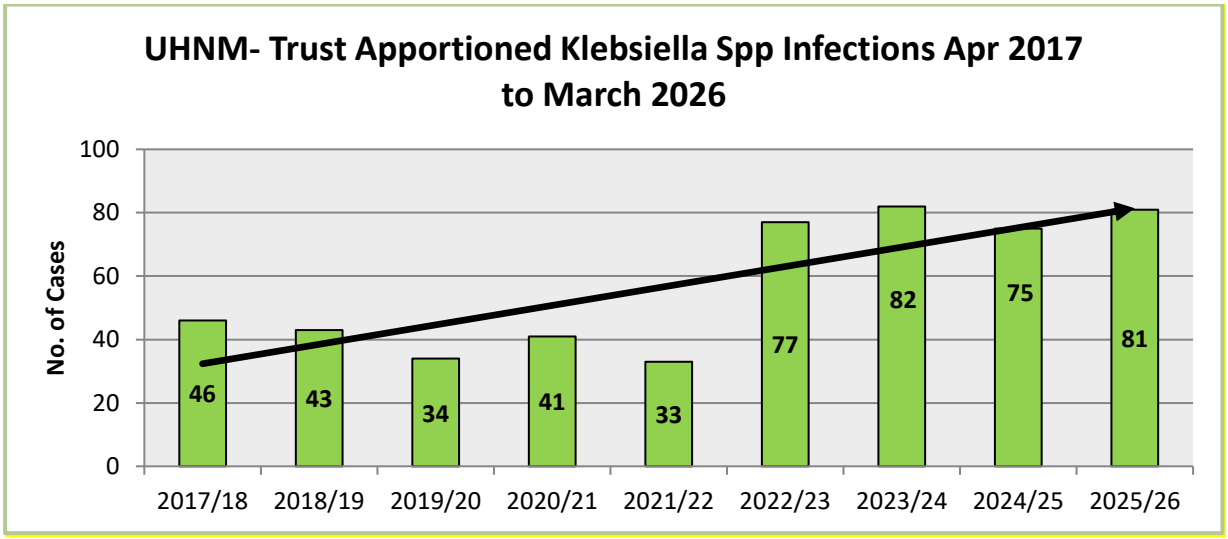
For identified hospitalised close contacts of confirmed CPE UHNM PCR tests are performed on rectal swabs to enable rapid results and subsequent actions.

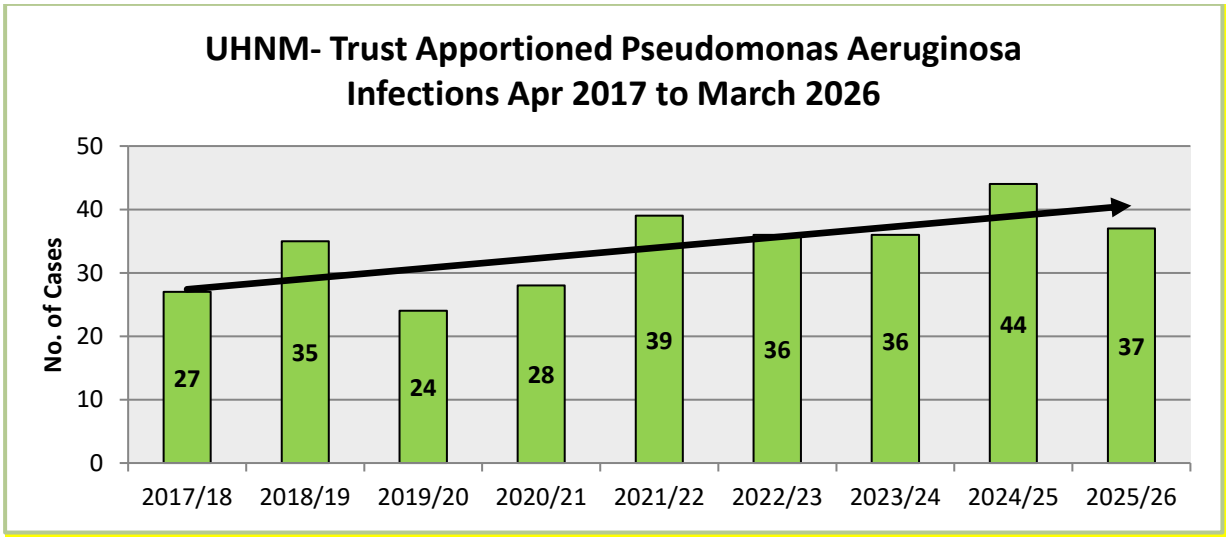




Gram- negative Bacteraemia Trust Apportioned







Pseudomonas aeruginosa is a Gram-negative bacterium often found in soil and ground water. It is an opportunistic pathogen which rarely affects healthy individuals. It can however cause a wide range of infections, particularly in those with a weakened immune system e.g. cancer patients, new-borns, people with severe burns and diabetes mellitus or cystic fibrosis.

To reduce the risk of water borne infections, clinical areas have an on-going responsibility to identify any unused or infrequently used water outlets and to implement flushing regimes as specified in the Water Safety SOP, available via the Trust Infection Prevention intranet page.

There is also a process in place and SOP to follow when there is a positive result from the routine outlets testing in high-risk areas. Immediate measures commence as soon as notification received by the IPT from the Estates Team.

Candida auris

In 2017, UKHSA produced a document - Guidance for the laboratory investigation, management and infection prevention and control for cases of *Candida auris (C. auris),* which is a yeast species.

C. auris is a *Candida* species that has been associated with infection and outbreaks in healthcare settings on five continents including the UK. It has been isolated from a range of body sites, including skin (very common), urogenital tract (common), and respiratory tract (occasional), and resulted in invasive infections, such as Candidaemia, pericarditis, urinary tract infections and pneumonia.

C. auris affects both paediatric and the adult population and has predominantly been identified in critically unwell patients in high dependency settings and patient repatriated from foreign hospital.

As with other organisms associated with nosocomial outbreaks, it appears to be highly transmissible between patients and from contaminated environments, highlighting the importance of instituting effective infection prevention practices and stringent screening.

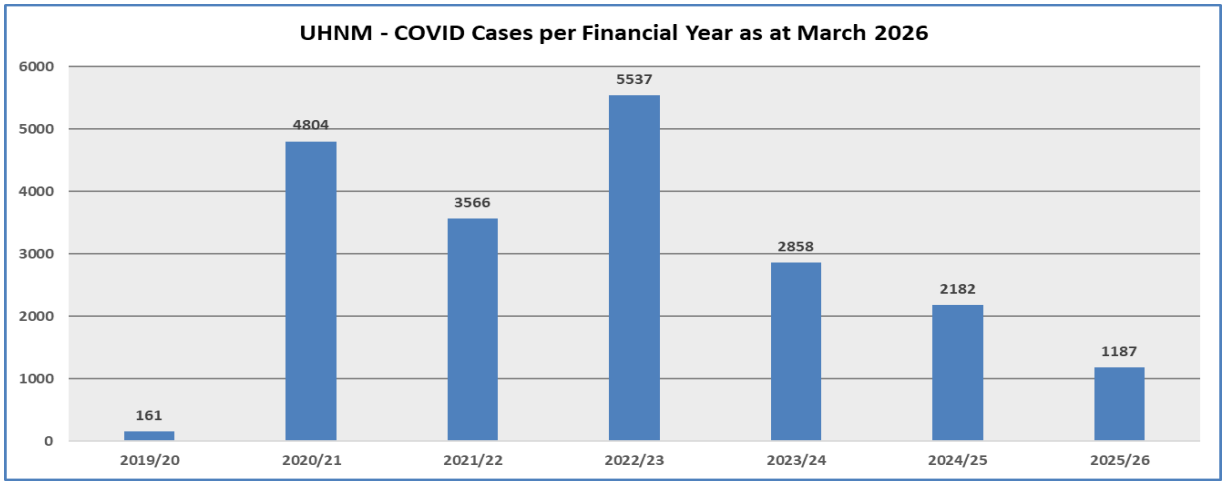
C. auris became a Notifiable organism since April 2025.

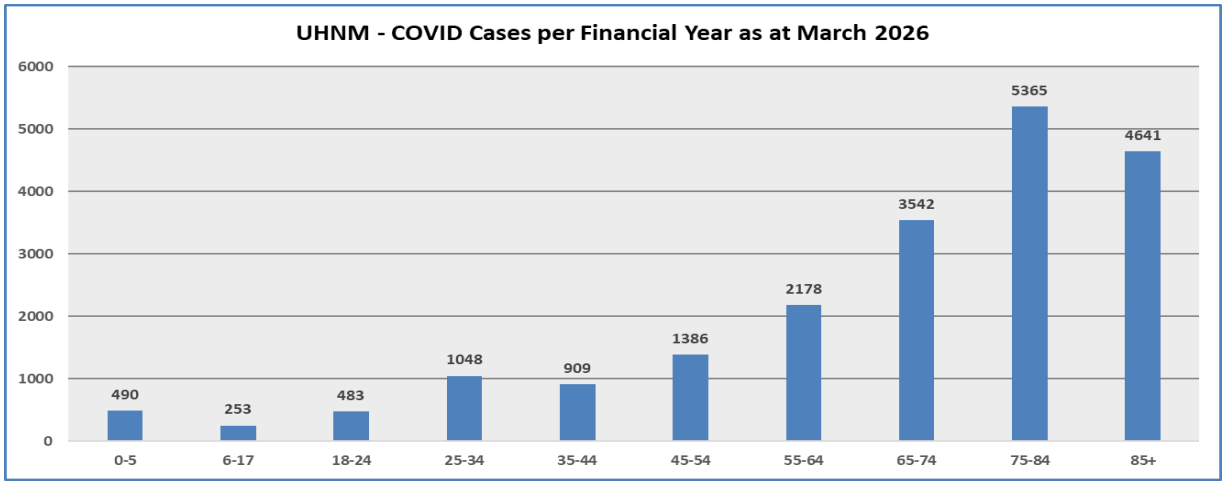
A screening policy, guidance on treatment and infection prevention precautions, is included in the Infection Prevention Questions and Answers Manual.

COVID-19

The Infection Prevention Team has been, and continues to be, fundamental to this collaborative Trust wide work.

During March 2020 UHNM started to see their first COVID-19 cases. As of March 31st 2026, laboratory confirmed cases since the start of the pandemic totalled 20,295. The following charts show the yearly numbers of new cases confirmed and the age groups of the patients who tested positive this includes both primary cause for admission and incidental finding.



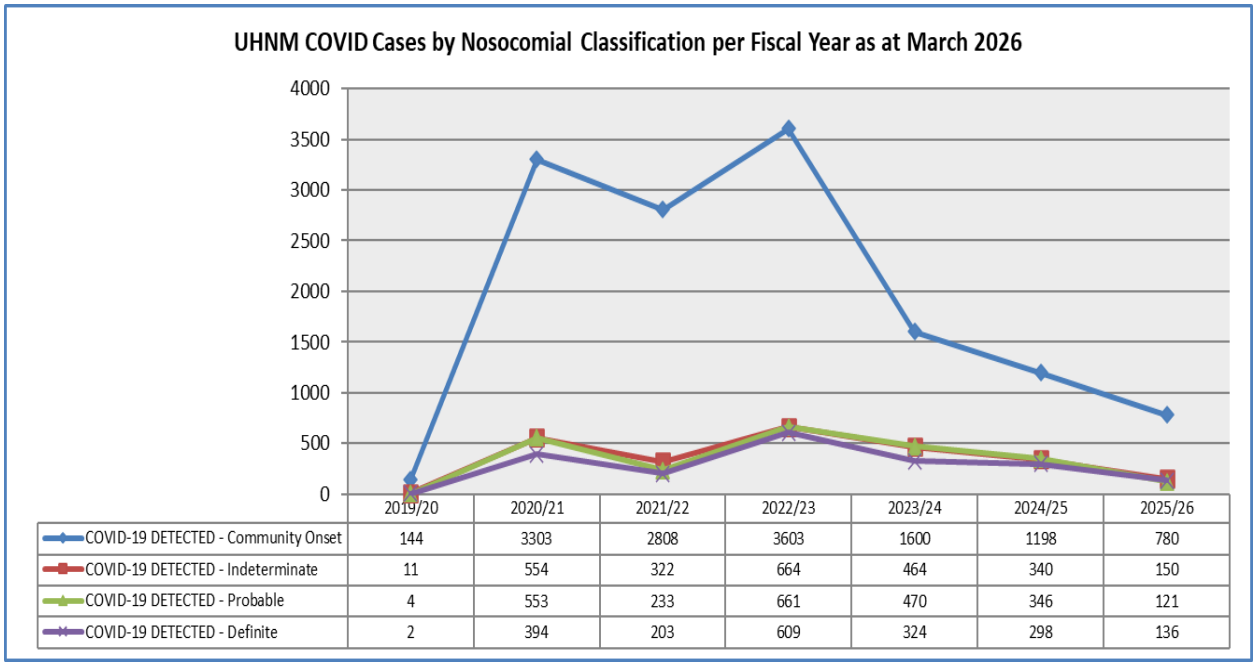


In June 2020 NHS England issued instructions to all NHS Trusts to submit data relating to their nosocomial infection levels of COVID-19.

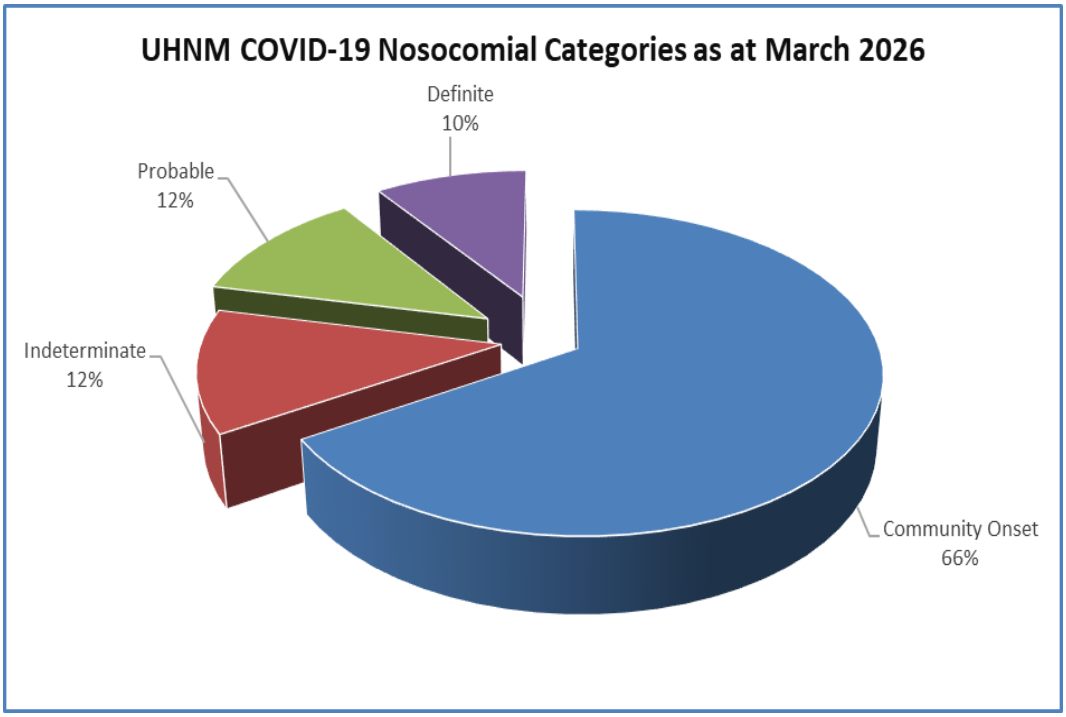
The 4 categories of apportionment of cases for determining the probability of a case being hospital acquired or not are as follows (N.B: the first day of admission counts as day 1 of the admission spell):

- **Community-Onset** – First positive specimen date <=2 days after admission to trust
- Hospital-Onset **Indeterminate** Healthcare-Associated – First positive specimen date 3-7 days after admission to trust
- Hospital-Onset **Probable** Healthcare-Associated – First positive specimen date 8-14 days after admission to trust
- Hospital-Onset **Definite** Healthcare-Associated – First positive specimen date 15 or more days after admission to trust.

The following chart shows the monthly trend within each category of apportionment since March 2020, whereas the second chart shows the overall percentage split of cases within each category for all patients who became hospitalized at the point of confirming being COVID-19 positive.



	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26
COVID-19 DETECTED - Community Onset	144	3303	2808	3603	1600	1198	780
COVID-19 DETECTED - Indeterminate	11	554	322	664	464	340	150
COVID-19 DETECTED - Probable	4	553	233	661	470	346	121
COVID-19 DETECTED - Definite	2	394	203	609	324	298	136



UHNM has guidance on screening, testing and repeat testing for Covid-19 and interpretation of test results in relation to lifting Infection Prevention (IP) in place. A COVID 19 resource page on the Trust intranet was developed which is updated on a regular basis in line with new or changing guidance from NHSE and UKHSA.

COVID-19 Outbreaks

At UHNM as soon as a suspected outbreak is triggered an immediate virtual meeting is held with the Chief Nurse/DIPC, Infection Prevention Doctor, Deputy Chief Nurse, Deputy Medical Director and Deputy DIPC who decide the immediate actions required, including whether to close the affected area to new admissions.

These control measures include:

- Isolation of positive patient(s)
- Symptomatic staff cases would be self-isolating, as per policy.
- Terminal clean and barrier cleans.
- Screening of contacts using ILOG number; any discharged patient deemed as a contact is contacted.
- Unannounced IP team visits and refresher training
- Staff screening may be instigated using a separate ILOG and swabbing team with strict staff lists, including medical, nursing, AHP, pharmacy, cleaning and dietetic teams during the pandemic. However, this has recently ease and covid-19 guideline has been updated accordingly.
- At least twice daily support visits to the outbreak area to provide support.
- Regular updates to the Chief Nurse/DIPC
- Reactive media statement prepared.
- Surveillance continues for 28 days after the last case before the outbreak is closed.

Outbreak meetings are convened with invitations to external colleagues in UKHSA, NHSE, local authority public health and ICB. These meetings are minuted with actions undertaken reviewed and any additional measures agreed. However, there has been no outbreak seen in the last year/ months.

UHNM has a weekly clinical advisory group where any new COVID19 guidance is discussed.

A COVID-19 swabbing training video is in place to help ensure false negative results are minimised as far as possible due to technique.

Infection Prevention Board Assurance (BAF)

The new IP BAF published 13th September 2023 replaced the original respiratory BAF. This has been aligned with the refreshed Health and Social Care Act 2008: code of practice on the prevention and control of infections and the National Infection Prevention and Control Manual NIPCM.

This continuous self-assessment process ensures organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

On 8th April 2025, there has been some minor amendments made however, the 10 assurance criteria remain the same.

The BAF is a standing agenda item at IPCC and presented to Executive Quality Outcome Group, Quality Access Outcome Committee and Trust Board.

Audit Programme to Ensure Key Policies are Implemented

UHNM has a programme of audits in place, undertaken by both clinical areas and the IPT to provide assurance around practice and to ensure that areas are consistently complying with evidence-based practice and policies. Action plans are devised where issues are highlighted and fed back to the IPCC via the Matron for the area.

Routine audits undertaken by the IPT were initially reduced due to team vacancies, however now we have recruited to the vacancies, and the audits are now in progress.

The audit tools for general ward areas are designed to ensure relevance to that Clinical Area. In addition, the IPT completed additional audits where infection numbers are highest or where there appears to be an identified risk concern, so improvements in the care process can be identified quickly and put into action.

The hand hygiene audit is now available on the Tendable (or Genome) audit system.

Hand Hygiene

SCJohnson hand hygiene training

In November and December SCJohnson visited a number Inpatient areas, across both sites (The Royal and The County) with the inclusion of ED, promoting good hand hygiene.

Hand Washing Technique: This was undertaken with the aid of a UV Glow Torch and Glow Cream, enabling SCJohnson to point out to participants which areas of their hands they need to spend particular attention to when washing them, whilst highlighting the five moments of hand hygiene.

Skin Hydration: A Corneometer (a device that measures the hydration levels in a person's hands) was used, raising awareness with staff around the importance of applying moisturising cream and the correct application of it.

Audits of Hand Hygiene Practice

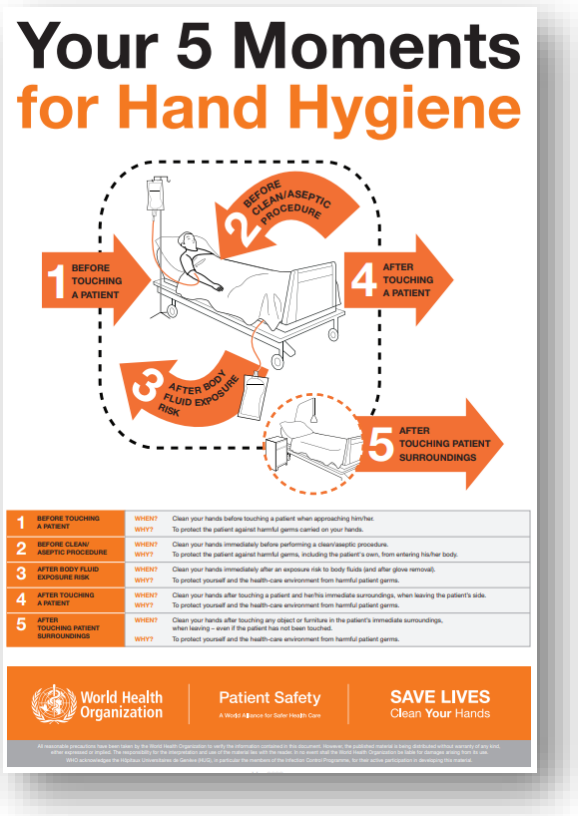
Hand hygiene remains central to the audit programme.

The Trust continues to focus on:

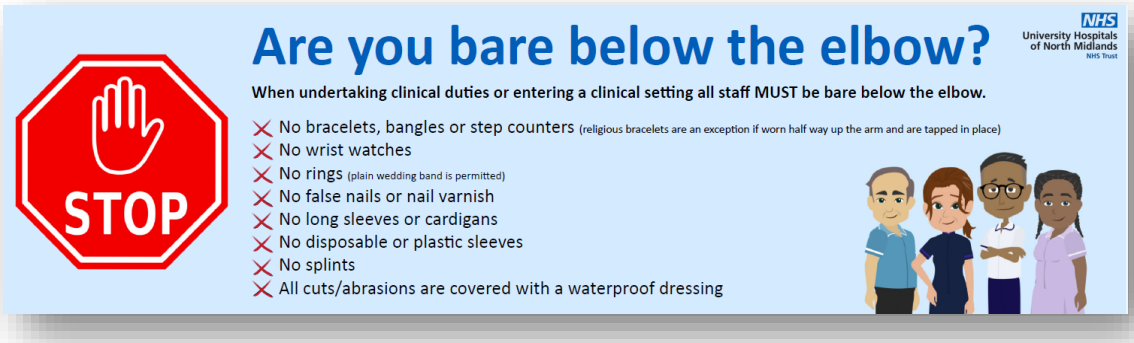
- Alcohol hand rubs at the point of care, prominently positioned near each patient or staff carriage so that hands can be cleaned before and after care within the patient's view.
- Audit of hand washing – Peer review hygiene audits are undertaken with the aim that all clinical areas are audited at least once at The Royal and quarterly at The County.

The hand hygiene tool used is the World Health Organisation "five moments for hand hygiene", with 10 consecutive opportunities for hand hygiene observations with a pass rate set at 95%.

Any area that doesn't achieve 95% is reaudited, with hand hygiene training offered by the Trust's Hand Hygiene Trainer.



In addition, compliance around bare below the elbow and hand gel available at the point of care is also observed.



Overall, the Trust average for hand hygiene was

Hand Hygiene – 92%
Bare Below the Elbow – 93%
Hand Gel available at the point of care – 93%

- Patients are encouraged to prompt staff if they have any doubts about hand hygiene and in cases of repeated non-compliance, escalation of concerns.

Gloves off Campaign

Following the relaunch of the gloves off campaign in 2023 the Trust continues to highlight to staff the need to only wear gloves when appropriate, not only due to the cross-contamination risk but also the sustainability aspect and the impact that the overuse of gloves has on the environment.

<u>Mask Fit Training</u>

The Health & Safety Executive (HSE) requirements and NHS England guidance state that it is a requirement that all staff who require to wear an FFP3 mask to protect them from transmission of infection must be fit tested by a competent Fit Tester on at least two different masks.

To meet this requirement the Trust has an established Team of five dedicated Fit2Fit trained Mask Fit Testers.

Between April 2025 – April 2026 the Mask Fit Testers fit tested over 2,000 members of staff and students.

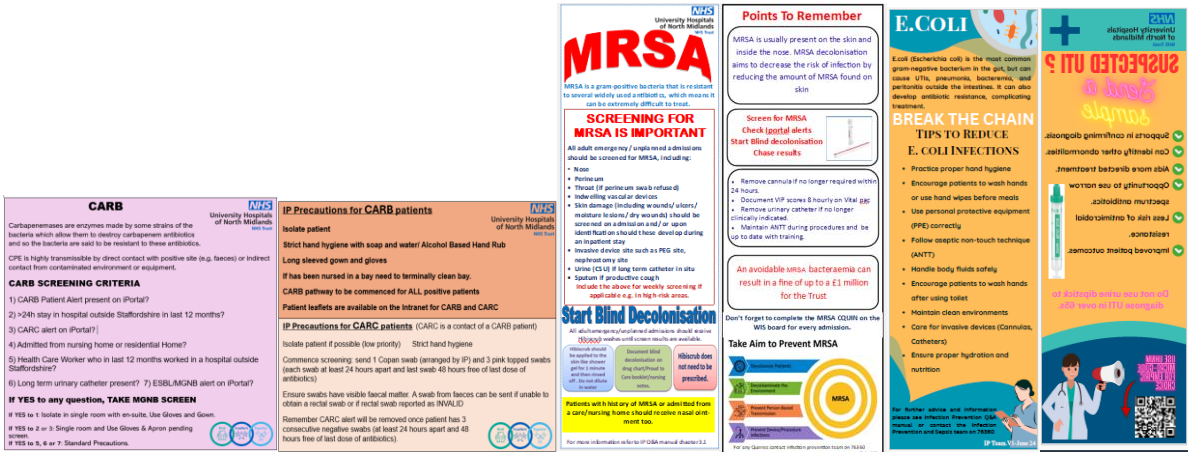
In addition to mask fit testing, the Team carry our adhoc IP audits and undertake training on hand hygiene and PPE.

Staff Information

- COVID 19 intranet page which includes PPE information, posters, guidelines and questions and answers.
- Alert organism surveillance is reported to the organisation by the Infection Prevention Nurses daily.
- Monthly ward based/Care Group surveillance data is produced, including surveillance, information on MRSA, Clostridioides *difficile*, ESBL, MGNB and antimicrobial. This information is used to update ward dashboards which are on display on the wards; this informs the public on ward performance.
- IP promotional activities have been held throughout the year promoting infection prevention with good practice being targeted at both staff and visitors to the Trust.
- Intranet: IP continues to make use of the intranet for providing staff with an easy access portal for information, policy guidance and IPT contact details. This information is regularly updated.
- Norovirus, Flu and other toolkits are available for all ward areas. The toolkits include everything that staff require to help manage infections, including posters and information for relatives/visitors.
- Posters and information leaflets are displayed throughout the Trust. These provide key infection prevention messages and actions for staff, public and visitors.

Staff Training

The IP Team continue to have a role within the UHNM, educational sessions have been delivered throughout the year. These have included: ANTT, Sepsis, MSSA/MRSA, ESBL/CPE, MRSA screening and MRSA decolonisation, influenza, flu and COVID 19 vaccination, norovirus, Clostridioides *difficile,* Measles, winter planning, water safety/flushing, personal protective equipment (donning and doffing).



Several Infection Prevention educational sessions are also available via the Trusts online system and via Microsoft Teams.

IP Links regular meeting and training also re launch and managed by the IP Service Development and Operational Team. This is to give opportunity to our clinical link workers to work closely with the IPT and hopefully will achieve significant impact to patient care as well as reducing our HCAIs.

Staff Supervision

Infection Prevention Team are allocated their own areas of responsibility for wards/departments/Matrons. This enables IP nurses to link in with ward staff to provide relevant training and expert advice to staff, as well as monitoring compliance in those areas. In this way, the work of staff in the Trust was subject to scrutiny and supervision, but more importantly clinical staff felt supported and knew who their point of contact was.

Bed Management and Movement of Patients

The IPNs work closely with the Clinical Site Team especially during the winter period, providing timely and expert advice on the management and movement of potentially infected patients. There is a RAG rating system for the use of side room/isolation facilities available for staff to use to ensure that as far as possible informed decisions are made when considering patient placement.

Furthermore, as part of the new initiative, there is now a specific direct phone line communication channel between IP outbreak nurse and emergency portals/ site team to ensure quick call response and advice during winter and capacity pressure.

Seasonal Staff Influenza and COVID 19 Vaccination Campaign

The 2025–2026 seasonal flu and Covid -19 vaccination programme commenced on October 1st, 2025, at the University Hospitals of the North Midlands (UHNM). The COVID-19 vaccination programme concluded on January 31st, 2026, with the influenza campaign continuing through to March 31st, 2026, in line with national guidance.

- Staff were offered influenza vaccination only per national guidance
- Eligible patients received both influenza and COVID-19 vaccinations concurrently
- COVID-19 eligibility was limited to:
    - Individuals aged ≥75 years
    - Immunosuppressed patients

Delivery Model

Vaccination delivery used a flexible, multi-channel approach to maximise uptake:

Appointment Access

- Bookable appointments via Patient Connect (7 days per week)
- Walk-in availability across clinic locations

Roving commenced at the start of the campaign to support busy clinical staff; it was deployed across clinical areas to maximise accessibility for both staff and patients.

Pop-up clinics:

- Critical Care
- Pathology Laboratories
- NICU
- Emergency Department
- Haemodialysis units
- IT department
- Maternity
- Pharmacy
- Restaurant mezzanine area

Additional outreach included:

- Night-shift access: Vaccination clinics were delivered seven days a week with extended operating hours, including early starts 07:15, late finishes: 20:30 at Royal Stoke and 08:30 – 17:00 at County, and night shifts up to midnight or as operationally required were also offered.
- Targeted deployment to outbreak areas
- Focused delivery in historically low-uptake departments
- Visibility clinics in high-footfall locations improved engagement among both staff and patients.

Key Achievements

- Staff influenza uptake reached 7499, compared to 6010 in the previous year (+24.8% increase)
- Second highest uptake in the past five years
- Exceeded NHS England target, achieving an 8.7 percentage point increase (target: 5%)
- Ranked among highest-performing large Trusts in the Midlands
- Successful implementation of pre-discharge vaccination pathways for care home patients
- Expanded vaccination offers to long-term inpatients (21+ days) from admission however, this was extended to all eligible patients towards the end of the campaign as well as all eligible outpatient cohorts
- A total of 255 doses of influenza vaccine were administered **opportunistically** by 31st March, with the following figures of flu doses administered for each site:
- County 56
- Royal Stoke 199

Summary for patients' vaccination figures:

Vaccinations doses administered	Covid Vaccinations	Influenza Vaccinations
Opportunistic	124	255
In-patients	137	358
Total patients' vaccinations	261	613

Patient Safety and Quality Improvement

In response to NHS England priorities, the Trust strengthened its approach to vaccinating patients prior to discharge, particularly those transferring to care homes with the following key interventions:

- Clinical eligibility flowchart to support decision-making
- Education programme for elderly care medicine teams
- Development of a Careflow Order Comms vaccination pathway
- Weekly identification of eligible patients via the Integrated Discharge Hub
- Daily ward-based vaccination reviews

These measures improved vaccination uptake among vulnerable patients and supported safer transitions of care, reducing the risk of respiratory infection outbreaks in care settings.

Digital Innovation and Data Quality

The programme leveraged digital systems to improve uptake and reporting:

- Continued use of the online Patient Connect booking system.
- Introduction of personalised staff invitation emails with automated reminders until a response has been submitted (whether I have had my vaccination including elsewhere or wish to decline).
- Integration of the Federated Data Platform (FDP) with ESR, enabling capture of vaccinations delivered externally. This resulted in improved data accuracy, reduced reliance on manual reporting, and better visibility of uptake.

Workforce and Training

All vaccinators completed mandatory training, including:

- National flu and COVID-19 e-learning
- Face-to-face anaphylaxis training (five sessions delivered pre-campaign)

Updated Patient Group Directions (PGDs) and clinical protocols were implemented ahead of campaign launch to ensure safe and compliant practice.

Governance and System Working

The Vaccine Steering Group provided oversight throughout the campaign, meeting regularly and maintaining strong multidisciplinary engagement across:

- Infection Prevention Team
- Communications &strategy teams
- IT and Digital
- Nursing Directorate
- Pharmacy
- Integrated Care Boards (ICB) colleagues

A structured communications strategy, including intranet updates and social media messaging, supported elevated levels of staff engagement and addressed vaccine hesitancy through targeted myth-busting.

All vaccination activity was recorded via the national RAVS system, ensuring compliance with national reporting requirements.

Staff Engagement and Culture

Staff engagement initiatives included:

- Personalised communication and reminder system
- Visual campaign materials and recognition (e.g. “I Have Had My Vaccine” stickers)
- Support from Infection Prevention Link Practitioners to promote best practice locally
- Faith-sensitive communications were developed for our Muslim staff confirming that injectable influenza vaccines do not contain porcine gelatine.
- Materials were shared in prayer spaces and supported by engagement with Mosque leadership to reinforce accurate information during Friday prayers.

These approaches contributed to a positive vaccination culture and sustained engagement across the organisation.

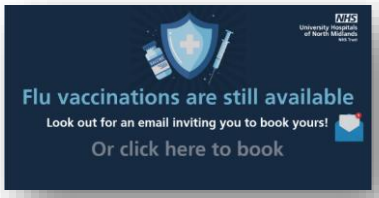
Conclusion

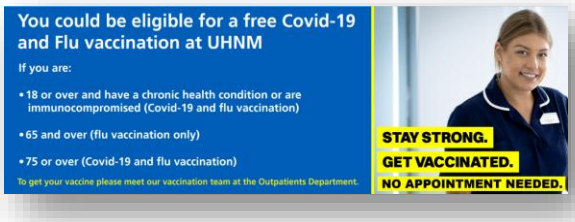
The 2025–2026 vaccination programme delivered strong performance against national objectives, with notable improvements in staff uptake and significant progress in patient vaccination pathways. The Trust has demonstrated:

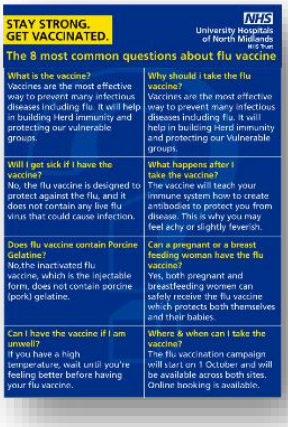
- Effective system-wide collaboration
- Strong governance and assurance
- A proactive approach to patient safety and infection prevention

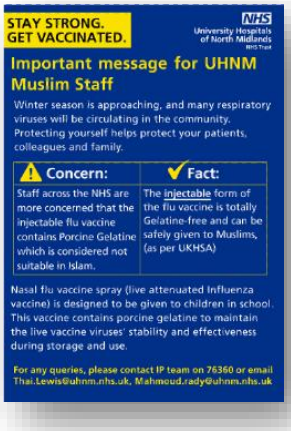
These foundations position the organisation well for continued improvement in future vaccination campaigns.

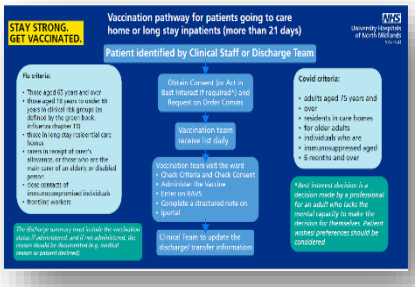
Initiatives











Aseptic Non-Touch Technique (ANTT)

Healthcare-associated infections (HCAIs) can be significantly reduced through the consistent application of effective aseptic technique. University Hospitals of North Midlands (UHNM) adopted Aseptic Non-Touch Technique (ANTT) in 2015 as the standard approach for all relevant clinical procedures.

The Infection Prevention Clinical Surveillance Team (CST) provides support to clinical teams to ensure ANTT principles are embedded within policies, protocols, guidelines, and training programmes, upon request. Supporting ANTT resources are readily accessible via the Infection Prevention section of the Trust intranet.

Trust documentation outlines the ANTT Cascade Trainer training process, along with the defined roles and responsibilities. This provides clarity regarding expectations and supports managers in identifying appropriate staff members for the role. ANTT Cascade Trainer theory sessions are delivered monthly via Microsoft Teams and are accessible to staff across both hospital sites. Practical competency assessments are arranged with the Infection Prevention team at mutually agreed times. Targeted ANTT update sessions continue to be delivered to individual clinical areas as required, subject to staffing capacity. The Trust expectation is that each clinical area/ward has at least one ANTT Cascade Trainer. During 2025, a total of 47 staff members from a range of clinical areas and departments were trained and accredited as ANTT Cascade Trainers.

The Trust's Electronic Staff Record (ESR) ANTT theory package, launched in August 2018, is required to be completed annually by all clinical staff. This requirement became mandatory from November 2024. Compliance data is reported to clinical divisions via the Infection Prevention and Control Committee (IPCC). Annual ANTT practical assessments, undertaken with Cascade Trainers, can be recorded on Health Roster as a clinical competency by departmental managers.

Compliance Criteria 2:

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Monitoring Processes

Royal Stoke

The cleaning provided at the Royal Stoke Hospital site for all clinical and non-clinical areas are split between an in-house cleaning team as well as an external cleaning contractor (Sodexo).

Monitoring Processes for In-house Retained Estate Cleaning/Domestic Services

The Retained Estate Team is responsible for cleaning approximately 21% of areas at the Royal Stoke site and provides a comprehensive 24/7 scheduled and ad-hoc cleaning service.

The Contract Performance Management (CPM) team complete environmental audits for all wards and departments within the retained estate cleaned areas at a frequency dictated by the National Cleaning Standards 2025 which is determined by the functional risk rating of each area. All audits are completely unannounced to ensure that cleanliness standards found are reflective of those found by our patients and visitors and is carried out with representatives from the Retained Cleaning, Clinical and Estates Teams.

Self-monitoring is completed by the Retained Supervisory Team on a weekly basis, to ensure standards are maintained throughout all the retained areas. If there are areas of concern, the monitoring is increased until the Team are satisfied that the standards are being met. Spot checks and unannounced ad-hoc audit inspections are also carried out by the Management Team, the frequency of these is determined on a week-to-week basis.

The Retained Team are committed to providing an outstanding service which is reflected in the Environmental Audit scores and our Patient-Led assessments of the care environment (PLACE) results.

Representatives from the Retained Management Team also participate in any outbreak or periods of increased incidents (PII) meetings when issues are identified on site.

Scheduled and ad-hoc meetings with Infection Prevention, Matron's, and Clinical colleagues to regularly monitor, review progress and address/resolve any issues are held to ensure that standards and performance target and compliance is met.

Monitoring Processes for Sodexo Cleaning Services

Sodexo is responsible for cleaning approximately 79% of areas at the Royal Stoke site and provides a comprehensive 24/7 ad hoc and scheduled cleaning service via a helpdesk on site. The contract in place has been amended so that all areas are cleaned by Sodexo are delivered to the 2025 National standards of Healthcare Cleanliness, as well as a contractual requirement that Sodexo complete self-monitoring of all rooms every 10 weeks. The Trust has a Contract Performance Management (CPM) Team in place to ensure that standards on site are maintained for Sodexo areas. The CPM Team work closely with Sodexo to drive and sustain improvements, concerns regarding cleanliness can be raised by all staff via the helpdesk route, and an escalation process exists should users feel that their concerns have not been addressed satisfactorily.

The Contract Performance Management (CPM) team complete environmental audits for all wards and departments within the Sodexo cleaned areas at a frequency dictated by the 2025 National standards of Healthcare Cleanliness which is determined by the functional risk rating of each area. All audits are completely unannounced to ensure that cleanliness standards found are reflective of those found by our patients and visitors and is carried out with representatives from Sodexo Cleaning, Clinical and Estates Teams.

In addition to this the CPM Team also provides representation for the Water Safety Group, Operational Water Group, RSUH FM & PFI Infection Prevention meetings, IPCC, Clinical Excellence Framework Group (CEF), clinical divisions Infection Prevention meetings and participate in any outbreak or periods of increased incidents (PII) meetings when issues are identified on site.

The CPM team continue to work closely with Sodexo on-site representatives, their national senior management team, Matron's, and clinical colleagues to regularly monitor, review progress and address/resolve any issues or concerns promptly:

- Regular meetings between Sodexo management representatives and Trust clinical teams to review cleaning performance and ensure that improved performance is sustained and confidence in the service is maintained.
- Frequency of joint spot-checks, and unannounced cleanliness audit inspections continue at an increased level.
- CPM and FM Team's will continue to work closely with the IP team to trial innovation on site to help deliver the cleaning standards more efficiently and effectively.

RSUH FM & PFI Infection Prevention Meetings

RSUH FM & PFI Infection Prevention meetings are held monthly to review infection surveillance data, environmental cleaning scores, provide updates from the statutory and mandatory maintenance programme and discuss any areas of concern. This meeting has representatives from Infection Prevention, PCo, Retained Estate cleaning, EFP Matron, Sodexo cleaning and CPM allowing a multidisciplinary approach to work through infection concerns raised for the RSUH site.

Assurance to the Trust Executive board for 2025 National standards of Healthcare Cleanliness

A representative from EFP attends the Infection Prevention and Control Committee (IPCC) meetings, and submits an assurance report for both RSUH and County of cleaning challenges, innovation and developments on site along with a summary report to provide Environmental Audit score analysis for the previous 2 months that demonstrate not only are 2025 National standards of Healthcare Cleanliness being delivered across both sites, but provide assurance where poor scores have been found , what actions have been taken to improve and sustain the cleaning delivery to the identified areas.

County Hospital

Monitoring Processes for Cleaning/Housekeeping Services

The County cleaning service is delivered via an in house retained team and is responsible for cleaning all areas (which from April 2026, now includes Theatres 1-7) on site and provides a comprehensive scheduled and ad-hoc cleaning service from 6am – 10pm, seven days a week.

The County Monitoring Team completes environmental audits in line with The National Standards of Cleaning 2025; all audits are carried out dependent on the dictated frequency ratings for each area. All audits are unannounced with only 20 minutes notice being given to other trust representatives from the Retained Cleaning, Clinical and Estates Teams to attend with the Monitoring Officers, this approach ensures a true reflection of the cleaning standards being provided.

Self-monitoring is completed by the Housekeeping Supervisory Team on a weekly basis to ensure standards are maintained throughout all the retained areas. If there are areas of concern, the monitoring is increased until the Team are satisfied that the standards are being met. Spot checks and unannounced ad-hoc audit inspections are also carried out by the Management Team in addition.

Representatives from the County Management Team also participate in any outbreak or periods of increased incidents (PII) meetings, when issues are identified on site, additional measures are agreed and put in place until improvement is achieved and becomes an embedded standard.

Scheduled and ad-hoc meetings with Infection Prevention, Matron's and Clinical colleagues to regularly monitor, review progress and address/resolve any issues are held to ensure that standards and performance target and compliance are met.

PLACE Inspection

The annual PLACE inspection took place in Sept/Oct 2025 with results published in February 2026 for all Trusts. Our patient assessors were welcomed back to our County and Royal Stoke sites over a series of inspection dates during October and November 2025 to visually inspect our hospital environment. The inspection team assessed how the environment supports the provision of clinical care, inspecting things such as cleanliness, food, general building maintenance, privacy and dignity and the specific needs of our patients with dementia, or with a disability.

UHNM have achieved excellent scores that are above the national average across all domains. These scores recognise that good environments and services that respond to the needs of our patients really do matter.

The table below outlines the site scores for Royal Stoke University Hospital and County Hospital plus the overall UHNM Trust organisation score alongside the national average for 2025.

UHNM achieved above the national average for all domains.

PLACE Scores 2025: -

Site Name	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity & Wellbeing	Condition, Maintenance & Appearance	Dementia	Disability
Royal Stoke University Hospital	99.84%	96.43%	94.27%	96.99%	90.98%	99.23%	88.00%	91.47%
County Hospital	99.87%	95.51%	90.60%	97.92%	95.08%	99.27%	93.89%	94.01%
UHNM Trust Score 2025	99.85%	96.36%	93.99%	97.06%	91.29%	99.24%	88.45%	91.66%
National Average	98.55%	92.13%	N/A	N/A	89.37%	97.00%	85.68%	87.12%

Where improvement has been identified through the inspection, an action plan has been compiled and will be worked through by a multidisciplinary group linking into the Trusts Values, Safe, Improving and Together.

Terminal Cleans

All emergency portals undergo a deep clean on a six-monthly basis in addition to their annual scheduled cleans, with terminal cleans being requested as required within the scheduled periods.

All terminal clean requests required within working hours, are requested via the Trust Infection Prevention team. Requests for terminal cleans outside of these hours are requested via the Site Matron, with some emergency portals able to request and authorise their own terminal cleans to ensure patient flow is not impacted with delays to getting cleans authorised. During busy times, priority for terminal cleans are decided by the site teams, to ensure that resources are directed to the area needed most urgently again to ensure patient flow at RSUH and County sites are maintained.

Radiator Cleaning

RSUH & County have a planned programme of radiator cover removal in some of the older estate where wall mounted radiators are still used to allow for removal of any dust which may accumulate behind these covers.

Food Safety

The CPM, Sodexo and Retained Estates teams continue to complete regular kitchen inspections on the Royal Stoke site and ensure that any issues highlighted are addressed quickly. Environmental/IP ward audits are also reviewed by the CPM team and the appropriate actions taken to rectify and monitor any food safety issues raised. Regular meal monitoring sessions are completed by Sodexo/CPM and Retained Estates teams where all aspects of the patient meal service are observed to ensure that all food service standards/guidelines are being adhered too.

Any emerging issues are discussed at the fortnightly Sodexo Operational Meetings the monthly Performance Meetings, the monthly Dieticians Meeting and with the Food Standards Group.

The Food Standards group are currently working on the implementation of the National Healthcare Standards for Food and Drink and have completed a GAP analysis exercise, along with a Food and Drink Matrix Score Sheet. The new standards relate to all aspects of healthcare food and drink including the provision of patient food and drink as well as retail and staff and visitor requirements. Sustainability, procurement and food waste is also featured in the new standards.

Food Hygiene Inspection Royal Stoke University Hospital Food hygiene inspections at RSUH were carried out by Stoke on Trent City Council Environmental Health Officer, Public Protection Division in January and March 2025 in the Sodexo main kitchen the ED Costa and

all Retained Estates areas which resulted in the Royal Stoke Hospital Site being awarded five stars for all areas reviewed under the national food hygiene rating scheme.

Food Safety Training

All Retained Estates staff that handle food receive level 2 Food Safety training every 3 years, which is arranged by the Facilities Management team. Level 3 Food Safety is also obtained and renewed every 3 years for all staff from Supervisory level to and including the Facilities Manager.

Food Hygiene Inspection County Hospital

County Hospital kitchens underwent a routine Environmental Health Officer (EHO) inspection conducted by Stafford Borough Council on 31st March 2026. We are pleased to report that the department successfully retained its five-star food hygiene rating for the eighth consecutive year. The inspection report highlighted the excellent standards maintained across the department, recognising the continued commitment to high standards of food safety, hygiene, and operational compliance within the catering service.

These inspection outcomes provide strong positive assurance to patients, staff, visitors, and regulatory bodies that robust food safety management systems, effective monitoring processes, and high standards of operational practice continue to be embedded across both County Hospital and the retained estate at Royal Stoke. The results reflect the ongoing dedication of catering teams across both sites to maintaining safe, compliant, and high-quality food services within a healthcare environment.

Food businesses are required by law to comply with food hygiene regulations as outlined by the Food Standards Agency. Members of the public can find how compliant a food business is with legislation through the following link University Hospitals of North Midlands NHS Trust | Rating Business Details | Food Standards Agency . On the website, food businesses are rated through a star award system with five stars being the maximum achievement. On the link provided above, the following three core subjects have been assessed through the inspection process. The outline below includes the narrative and overall standards found within each field:

Area inspected by food safety officer	Standards found
Hygienic food handling Hygienic handling of food including preparation, cooking, re-heating, cooling and storage	Very good
Cleanliness and condition of facilities and building Cleanliness and condition of facilities and building (including having appropriate layout, ventilation, hand washing facilities and pest control) to enable good food hygiene	Very good
Management of food safety System or checks in place to ensure that food sold or served is safe to eat, evidence that staff know about food	Very good

Management of Decontamination

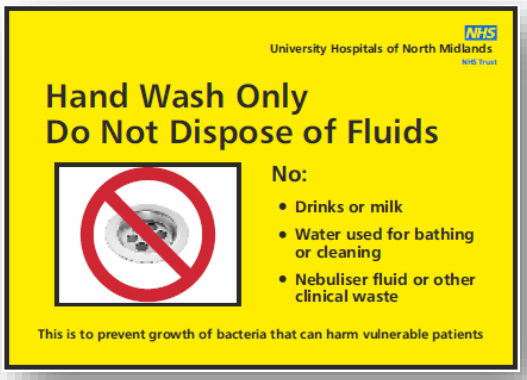
Management and compliance currently fall into three distinct areas i.e.

- Estates – for medical device reprocessing equipment. UHNM provides Estates Services and those provided by Sodexo as part of their estates (hard FM) management responsibilities within the PFI contract.
- Infection Prevention – for monitoring/audit of compliance of medical devices with Trust Policies and advise with pre purchase questionnaire (PPQ)
- User – to comply with Trust Policies and to ensure all decontamination equipment within their area is fit for use and subject to periodic testing and maintenance.

The Decontamination Safety Group is a subgroup of IPCC and meets quarterly, reporting directly to IPCC.

Sinks and Drains

The IPT continued to work closely with Estates and Facilities to ensure hand wash sinks are cleaned appropriately and ensuring no other fluids were disposed down them by the continued roll out of the hand wash only signs in all areas.



In addition, a learning alert was created and communicated across the Trust, emphasizing the correct use of hand wash sinks and the importance of not disposing of any inappropriate items down the toilets, drains and prompt reporting of slow draining sinks.

Cardiac Surgery Bypass Machine

In June 2015 MHRA issued a Medical Devices Alert concerning all heater-cooler machines used for cardiac surgery. This is part of a pan European issue following a case of post-operative wound infection from mycobacterium reported in Switzerland. A European wide surveillance programme has been established, led by UKHSA in England.

UHNM, as are all cardiac surgery centres, continue to work closely with the UKHSA and the MHRA on the initiative with regular updates provided at the IPCC. All required control measures were instigated following the initial MDA alert in 2015 and continue in place together with surveillance for any potential infections. Regular updates are presented at the IPCC and Water Safety Group around the regular decontamination and sampling processes for the machines, as per manufacturer's instruction. Currently, no Mycobacterium chimaera has been identified with the machines at UHNM.

Refurbishment and new Build Projects

The IPT worked closely with the Capital Team and Estates providing advice on number of planned programmes of maintenance, refurbishment and new build projects throughout the Trust, including – at the Royal: Urgent Treatment Care (UTC) – at the County: New Day Case Unit and Breast Care Unit. As part of the UHNM initiative, refurbishment of Community Diagnostic Centre (CDC) commenced in 2025, is now open and aim to be fully operational in July 2026. Some new building projects will continue into 26/27 financial year. Advice was also given on the reconfiguration of a few clinical and non-clinical areas.

Compliance Criteria 3:

Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Sepsis is defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection. It is a syndrome of physiological, pathological, and biological abnormalities induced by infection. It is now a major public health concern (NICE UK Sepsis guidelines 2017).

There are 250,000 cases of sepsis in the UK each year resulting in between 52,000 and 68,000 deaths. That is more than breast cancer, bowel and prostate cancer combined. With effective screening and early treatment, we can save 14,000 lives across the UK. The UK mortality rate for patients admitted to hospital with red flag sepsis can be up to 30%.

The Sepsis Team was established and has been in place from October 2016, comprising of a Sepsis Clinical Lead, Sepsis Fellow, Senior Sister, Sepsis Specialist Nurse. Previously there was a Senior Nursing Assistant but as of 2026 this role was replaced with a Sepsis Nurse. The main aim of the team is to achieve the sepsis CQUIN compliance target, by ensuring that our patients are always safe, as well as reducing the mortality rate and morbidity. However, for 2019/2020 and up to present, the Sepsis CQUIN will be incorporated into the Trust contract, with stringent requirements and penalties remaining.

The Sepsis Team are working optimally and collaboratively with our AMR colleagues and front-line clinical colleagues to continue to raise awareness and propagate education and training in sepsis, which has clearly had a demonstrable effect. Sepsis training is now an integral part of the newly qualified nurses', Band 4, and Medical Staff. Working with our AMR colleagues ensures that there is an equal emphasis on sepsis screening, treatment, and antibiotic stewardship.

National Sepsis CQUIN

National Sepsis CQUIN: There are three elements needed to be achieved and will remain into the contract: However, some elements will change significantly once our trust is ready to implement the new NICE sepsis guidelines.

- All patients with a National Early Warning Score (NEWS2) of five or greater (or three in a single parameter) and when patient looks unwell or when there's a clinical concern, need to be screened for sepsis.
- All patients that have red flag sepsis need to receive IVAB within one hour.
- All IVAB for sepsis patients must be reviewed within 24 to 72 hours.

Training

Training sessions, Kiosks, and online training

On-going training plan to identify Sepsis Champions (staff nurses/nursing assistant/ in house doctors/ANP) in each clinical area/ Care Group. Also, planning for a Sepsis Champion Day (5 hours CPD) training that includes workshops & simulation learning for 2026/2027.

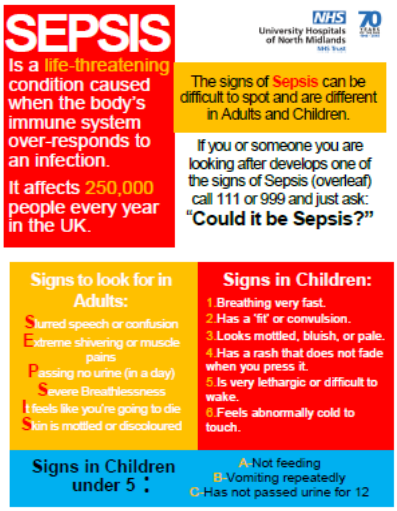
-Supporting and delivering sepsis sessions as part of Induction programme for Nursing assistants, new nursing staff and doctors in the trust.

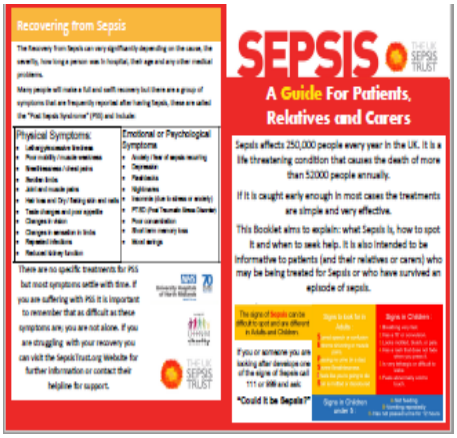
-Sepsis kiosks, sepsis reinforcement and face to face and adhoc training provided to all clinical areas when required.

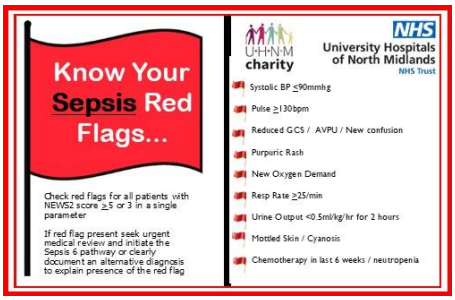
-Online training resource via ESR for staff nurses/doctors and other clinical staff is available, this will be updated once the new NICE sepsis guidelines is adopted.

-Recognition of significant contributions and improvements in sepsis management by rewarding specific clinical areas and individual staff with certificates.

Awareness & Initiatives

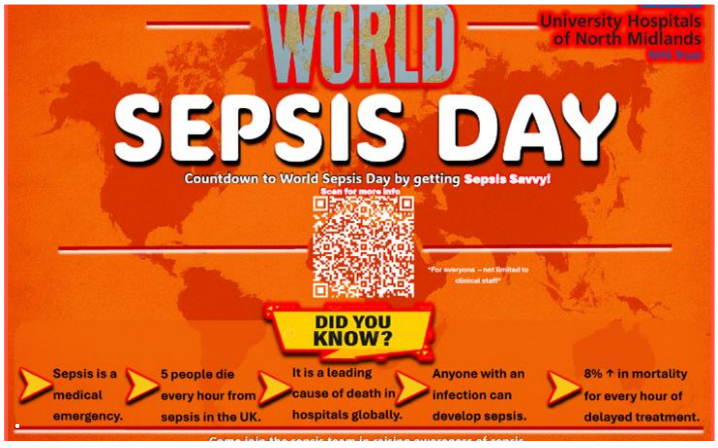






Educational Resources

- Trust wide awareness to include sepsis awareness notice boards, sepsis symptom cards, flyers, sepsis red flags cards, patient leaflets, and sepsis screening/IVAB compliance reminder cards.
- Our own sepsis pen as an additional visual awareness aid.
- Community awareness and on-going collaborative work with UHNM charity by organising a sepsis fundraising event each year.



Word Sepsis Day

The Sepsis Team continued their annual Sepsis Awareness Campaign, held each year on World Sepsis Day on September 13th, a tradition they have maintained since 2017. As part of the campaign, the team engaged with both staff and the public by handing out flyers and posters, sharing key information about recognising sepsis, and speaking directly with patients and relatives to raise awareness and encourage early recognition.

Sepsis Day Awards

As part of World Sepsis Day, we recognised and celebrated several wards across the trust for their outstanding commitment to improving sepsis care. Awards were presented to the areas that demonstrated the highest levels of sepsis screening compliance, the fastest and most consistent administration of antibiotics within the first hour, and the wards that showed the greatest improvement over the past year. These achievements reflect the hard work, dedication, and collaborative effort of staff who continue to prioritise early recognition and timely treatment, ultimately helping to improve patient outcomes and strengthen sepsis safety across the trust.

World Sepsis Day Sepsis Stars

On World Sepsis Day, the sepsis team recognised and celebrated staff from across the trust for the actions they had taken to promote better and safer sepsis care. These staff members were acknowledged for organising sepsis training within their divisions, working closely with the sepsis team to strengthen colleagues' confidence in sepsis management, and ensuring thorough investigations of any DATIX reports so that lessons were learned and future incidents could be prevented.

For developing and delivering innovative sepsis training within her division.

For her contribution to improving patient care in ED.

For her commitment to educating her division.

Introducing The Sepsis Star Badge

The Sepsis Team introduced a new Sepsis Star Badge in 2026. The badge is about recognising the staff who make a difference in sepsis care every day. Whether they are a doctor, midwife, nurses, nursing associate, or nursing assistant - this badge is celebrating those day-to-day actions and those often-unseen efforts of staff whose awareness and quick actions around sepsis play a big part in keeping patients safe and ensuring they get the right care at the right time.

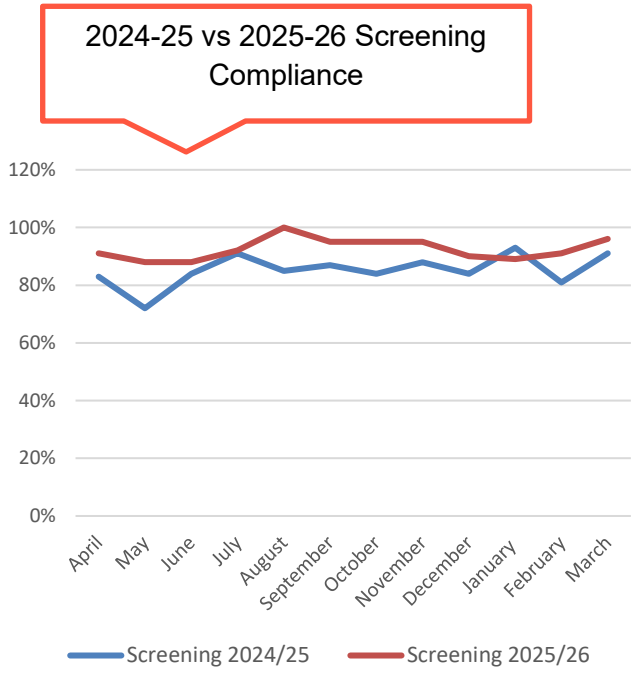
- Regular Strategic Sepsis & Antimicrobial Group meetings, Deteriorating Patient Steering Group and Sepsis Team meetings put in place, to work optimally and collaboratively.
- Contributing to Trust Divisional IP meetings, supporting, and providing regular sepsis compliance update to be able to help drive for compliance.
- The Sepsis Team has put robust actions in place and is working closely with frontline staff, multi-disciplinary & senior teams, and medical staff to have a maximum effect on the achievement of the Trust's sepsis contract.

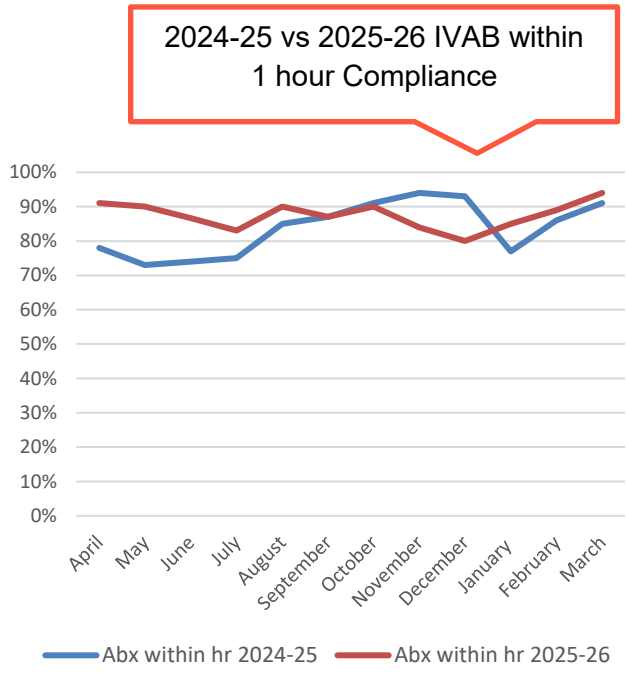
Sepsis Team Achievements

Sepsis Team Achievements

The Sepsis CQUIN/ Contract compliance achievement throughout the year of 2025 to 2026 in our emergency department has proved to be a challenged. However, the Sepsis Team remain optimistic that our objective to maintain, sustain and embed best practice will continue. Our priority will remain to focus on providing education, promote sepsis awareness and campaign across the trust. The sepsis team will continue to work closely with frontline staff, multi-disciplinary, senior teams, and medical staff to have a maximum effect on the achievement of the Trust's sepsis CQUIN/ contract. The support and hard work of all the front-line staff/senior team/divisions in the Trust is vital to protect patients from deadly conditions and ensure that they are always safe.

Emergency Portals Sepsis Screening Compliance





For contracted areas, inpatient services have consistently maintained screening and antibiotic compliance above 90% throughout 2025–2026. Emergency portals, however, have historically found it more challenging to sustain compliance for both screening and administering antibiotics within the one-hour target. In 2025/2026, emergency portals demonstrated a notable improvement in sepsis screening, achieving the 90% target in more months than not. Although IV antibiotic administration within one hour has also improved, it still falls short of the 90% compliance benchmark. Significant training has been delivered within ED, with mandatory sepsis training for all new staff and refresher sessions available for existing staff.

Antimicrobial Stewardship (AMS)

The Trust has an Antimicrobial Stewardship team (AMS) that supports the work of the Trust Antimicrobial Stewardship Group (ASG). The AMS team consists of:

- Lead Consultant Microbiologist,
- 0.8 FTE Advanced Pharmacist Practitioner (APP),
- 0.6 FTE Antimicrobial Nurse (AMN),
- 2 x 0.8 FTE Advanced Specialist Pharmacist (ASP)
- 0.5 FTE Rotational Pharmacist (RP)
- 1 FTE Lead Pharmacy Technician for AMS and Outpatient Parenteral Antibiotic Service (OPAT).

The pharmacists and technician provide clinical support to the infectious diseases ward as well as supporting the Trust AMS agenda through CQUIN and Core Contract AMR work streams and attendance at the ASG. The team is also supported on an ad hoc basis by a Pharmacy data analyst and clinical information technician as required to support the compiling of reports for submission to UKHSA and NHSEI, and the compilation of other antimicrobial data on a regular basis.

In 2023 the team expanded with an additional ASP – AMS and Crit care joining. The team have contributed to a business case for OPAT expansion to support pharmacy input into this key MDT. A final decision is still awaited re: funding for the OPAT service. To date, Pharmacy input into the OPAT service **remains unfunded** despite the increasing workload for the AMS team especially around stock management of antibiotic infusion devices and participation in MDT decisions around optimising therapy.

The expanded team brings clinical experience and expertise in all aspects of antimicrobial stewardship and, on behalf of the ASG, is supported in escalating prescribing or clinical issues relating to antimicrobials to the appropriate forum. The AMS team has developed initiatives and relationships with key stakeholders to drive forward good antimicrobial stewardship and promote awareness of the global rise in antibiotic resistance. The team work closely with regional colleagues and regularly participate in national AMR initiatives.

The AMS team at UHNM has continued to build on the foundations put in place over the last few years. The core functions which are routinely undertaken include:

- A regular review of the ASG membership to include representatives from both hospital sites so that local champions will support engagement with good antimicrobial stewardship. The Terms of Reference have recently been reviewed and new members recruited to reflect diversity e.g. non-medical prescribers and junior medical representation.
- A regular update of the Trust Antimicrobial Stewardship Policy. Regular audits measure compliance with this policy, with an escalation process in place for clinical specialities that require support to achieve compliance.
- Regular ward rounds and audits in line with ‘Start Smart then Focus’ have been in place across the Trust for several years. The results are shared via the bi-monthly ‘AMS Newsletter’ which is available on the Trust Intranet. Antimicrobial consumption and prescribing trends can be reviewed by specialities and their peers. The ASG review and support the development of action plans in areas of poor compliance and, going forward, specialities will be required to report progress against action plans to the ASG. This has been particularly important in supporting the achievement of the AMR CQUIN antibiotic consumption targets over the past few years.

- The Trust's Antimicrobial Treatment and Prophylaxis Guidelines are regularly reviewed in response to global and national shortages of certain key antibiotics: alternative antibiotics are procured, and temporary alternative guidance issued where necessary.
- Successful collaboration with specialities is important in the development of a number of new guidelines to rationalise antibiotic prescribing in line with good antimicrobial stewardship. The team are currently reviewing all antimicrobial guidelines, and proposed changes are discussed at ASG meetings for ratification.
- The Antimicrobial Guideline App (Eolas) for mobile devices and a web version for Trust PCs has been successfully rolled out following acquisition by the company of the previous MicroGuide software. The new platform supports prescribers by facilitating easy access of antimicrobial guidelines at the point of prescribing. The web-based app allows more efficient updating of guidelines following review by ASG members. An increasing number of links to national guidelines are embedded to facilitate timely access by prescribers to evidence-based resources.

 Eolas App and QR-code 

- There is an Antimicrobial Education and Training Strategy. All antimicrobial stewardship-related presentations are available on the Trust Intranet.
- Antimicrobial stewardship educational sessions for Pharmacy staff across both sites continue to be undertaken to support a uniform approach to antimicrobial stewardship and the quarterly antibiotic audit process. Sessions continue to be delivered on the increase in Gram negative infections and Carbapenemase resistance, as well as key messages and supporting materials to support the aims of the NHSE AMR 5-year National Action Plan.
- Workshops on the prescribing, dosing and monitoring of two high risk drugs, gentamicin and vancomycin, are delivered as part of the antimicrobial stewardship induction programme to familiarise newly appointed pharmacists with the vancomycin and gentamicin dosing calculators and associated guidelines in place at UHNM, so that consistent advice and information is provided to prescribers and nursing staff.
- A session covering therapeutic drug monitoring for high-risk antimicrobials is provided by the APP to year 5 Keele medical students.
- In addition to pharmacist awareness sessions, ad hoc sessions on AMS, gentamicin and vancomycin are provided for nursing staff, advertised via Trust Comms
- The team regularly review topics for educations and produce sets of aide-memoires to support nursing staff in practice where appropriate.
- The AMS team provides training to each intake of overseas nurses recruited to UHNM as well as the preceptorship nurse scheme. This is important to align practice amongst colleagues who may have worked in different Trusts (and countries) with different approaches to antimicrobial stewardship.

The following initiatives have continued throughout the year despite significant operational and capacity challenges at time:

- A rolling programme of antimicrobial sessions for newly qualified nursing staff.

- Targeted ad hoc sessions for Specialities/Wards. These are routinely based on analysis of local monthly antimicrobial consumption data to support antimicrobial review and optimising prescribing.
- The development of gentamicin/vancomycin workshops for nurses on doses, monitoring and side effects of these high-risk antibiotics.
- Antimicrobial stewardship and antimicrobial resistance awareness sessions for Laboratory and Infection Prevention staff.
- Engagement sessions with prescribers, nurses and pharmacists in relation to the updated UHNM Adult Antimicrobial Treatment and Prophylaxis Guidelines.
- Support for all Infection Prevention, Periods if increased incidence or outbreak review meetings and attendance at (and provision of data & advice to) any other ad hoc meetings requiring ASG input.

There are 5 Consultant Microbiologists (one post is covered by a locum) and 4 Consultant Physicians in Infectious Diseases, who provide antimicrobial stewardship support by telephone and face-to-face on ward rounds and during teaching sessions in addition to their substantive posts. Antimicrobial stewardship ward rounds continue to be undertaken on targeted wards daily which provide opportunities for the AMS team to raise awareness and make timely AM interventions.
Antimicrobial consumption by Specialities and Wards is analysed monthly throughout the year to allow flexible targeted stewardship/antimicrobial review ward rounds for those areas requiring additional support to promote good antimicrobial stewardship and reduce antibiotic consumption.
The AMS team also provides input into the OPAT, *Clostridioides difficile*, Infective Endocarditis, Sacral ulcer / TV MDT, Bone infection and Spinal MDTs. Attendance by the antifungal stewardship pharmacist will be re-introduced for the haematology / oncology MDT to support stewardship.
The ASG, Microbiology and Pharmacy Departments work collaboratively to ensure that alternative agents are available for patients if first line antimicrobials become unobtainable.
Collaboration with colleagues across the health system locally (Stoke and Staffordshire ICS) continues and the APP chairs the monthly AMR working group. The group recently reviewed the primary care antimicrobial guidelines for adults and is currently working on the equivalent for paediatric patients in primary care.
The APP is a committee member of the UKCPA Pharmacist Infection Network and is active in providing education, chairing symposium sessions and online learning through UKCPA webinars. This helps raise the profile of the UHNM AMS team activities at a national level.

In Year Initiatives:

Antimicrobial Stewardship ward rounds at County and Stoke (with a microbiologist where available) continue alongside AMN/specialist pharmacist ward rounds in high consumption areas where capacity allows. Links with specialist ward teams have increased pro-stewardship activity.

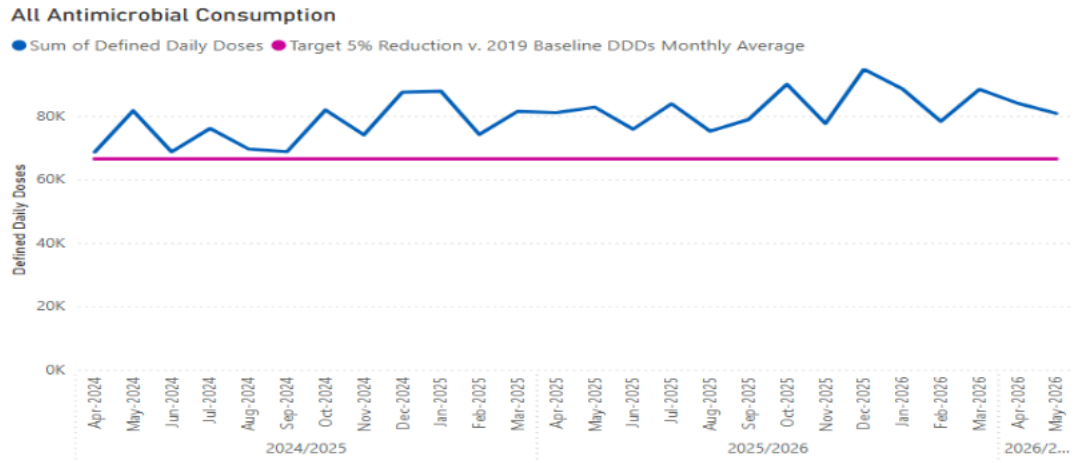
Support for European Antimicrobial Awareness Day was provided virtually and with the support of the Trust social media team. The UHNM AMS mascot, Bugsy McBugface, visited ward areas as part of a Twitter campaign and distributed lanyard AMS reminder cards to ward teams.

In line with National aspirations to increase the number of Consultant Pharmacist posts in acute Trusts, the UHNM AMS team are currently reviewing the credentialing process for post approval with the Royal Pharmaceutical Society, and the APP is similarly undertaking credentialing as a Consultant Pharmacist in Antimicrobial Stewardship.

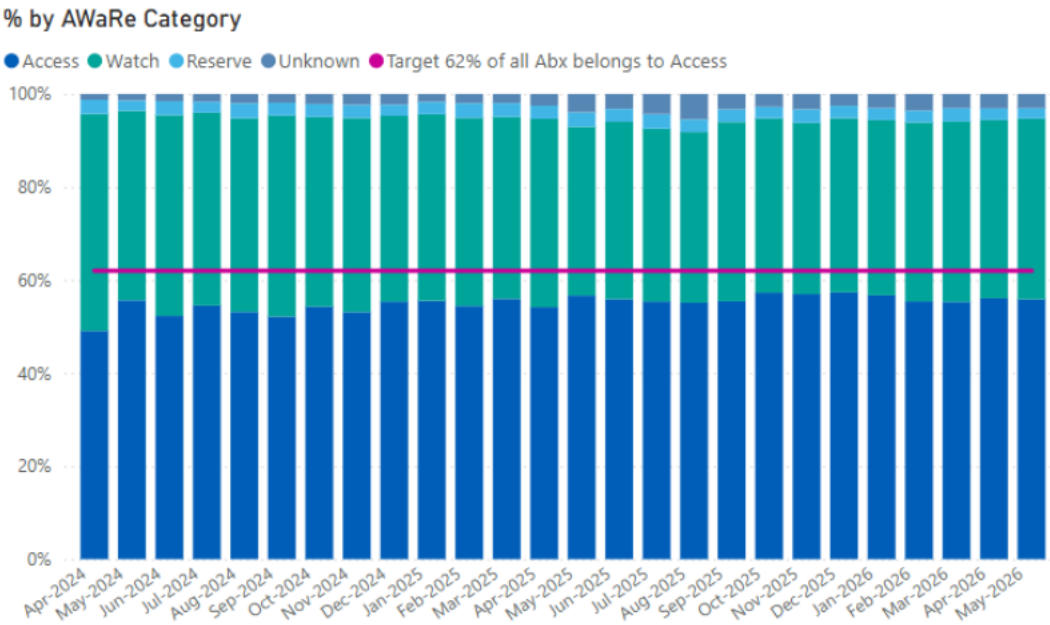
The APP and AMN prepare updates for the bi-monthly IPCC meetings, and these form the basis for a similar submission as part of the IPC annual report to the Trust board.
This report outlines progress against NHSE and UKHSA targets such as Core Contract elements and the 5 yr NAP targets relating to AMS activities. The report also details supporting activities around AMS such as monitoring antimicrobial consumption, changes to AM guidelines, support for external events such as WAAW and EAAD and other themes relating to the UK AMR National Action Plan such as % of Abx prescribed from the 'Access' group of the AWaRe classification.

UHNM Antimicrobial Consumption

The graph below shows the total consumption of antimicrobials at UHNM. The recent upturn in consumption reflects the winter pressures experienced by the Trust with increased prescribing of antimicrobials in the context of fewer admissions. The AMS team are able to 'drill down' into the data to specialty level and act on any unusual consumption seen.



The table below summarises the % proportion of Abx from the 'Access' group of the NHSE AWaRe categories. The 5-year NAP sets a target of 62% of Abx to come from the Access group by Mar 2029.

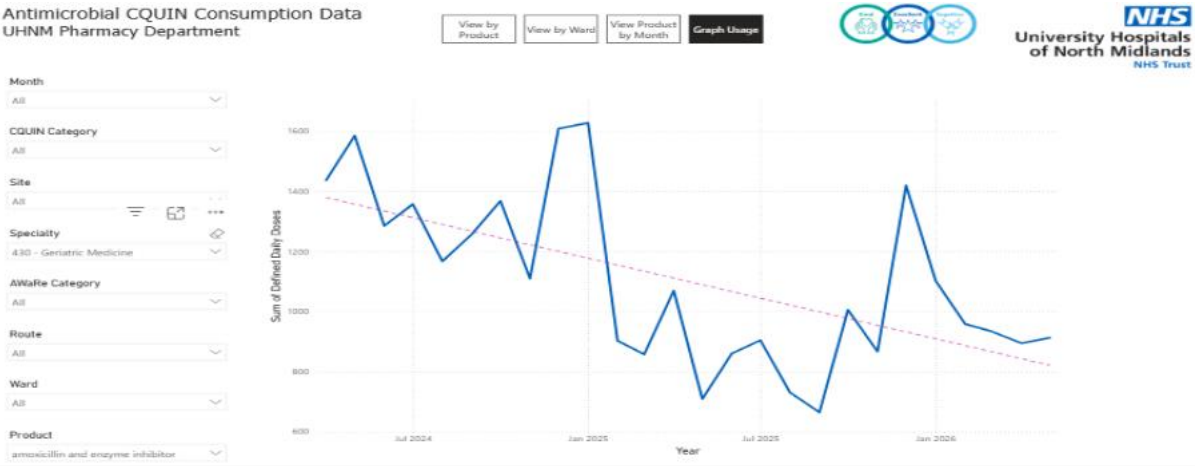


NHS E Antimicrobial CQUINs 2026/27

There is no AMR-related CQUIN for 26/27, but we continue to apply the principles of optimising IVPO switch as well as maximising opportunities to further reduce broad-spectrum antimicrobial consumption.
The two targets for the Trust as part of the 5-year NAP are detailed above.

ePMA at UHNM

The AMS team have supported the roll-out of ePMA across inpatient areas at UHNM with the design of 'AMS protocols' for the empiric treatment of common infections in line with Eolas App content.
Typical ePMA reports include carbapenem prescribing, IV Abx > 72 hours and focus on specific antimicrobial choice and duration. The graph below shows the decrease in co-amoxiclav prescribing across Older Adults over the last 2 years:



Compliance Criteria 4:

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

Communication Programme

The Trust has a dedicated Communication Team. Outbreaks where there may be interest from the media, the Communications Team are invited to meetings and their support and guidance on preparing Press statements is invaluable. The IP Team ensures that the Communications Team are involved in the following:

- Advertising infection prevention events.
- Communication campaign to inform GPs and the public around management of Measles, Influenza and Norovirus.
- Updating the Trust website.
- Press statements during outbreaks.
- Sepsis education
- Flu vaccination campaign.
- HCID information
- COVID-19 intranet and internet information.
- FFP3 mask and PPE information.
- Infection Prevention campaigns
- Bed and Commode Cull Cleaning
- Gloves off Campaign
- Any relevant outbreak meetings

Trust Website and Information Leaflets

The Trust website promotes infection prevention issues and to guide people to performance information on COVID 19, CPE, MRSA, Clostridioides *difficile* and other organisms.

These leaflets have been refreshed.

The IPT have produced a range of information flyers and leaflets on various organisms.

UHNM subscribe to ICNet surveillance system which enables information to be shared with colleagues in the Health Economy.

The Trust has a policy on the transfer of patients between wards and departments.

Compliance Criteria 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Infection Prevention Nurses (IPNs) receive daily laboratory reports detailing microbiology results. Based on these results, IPNs provide timely and appropriate infection prevention and control advice to clinical areas. In addition, the Infection Prevention team receives alerts from ICNET (software used by IP team), which further supports the identification of cases and enables the team to deliver prompt and targeted guidance to clinical teams.

The Trust has a policy for screening both elective and emergency patients for MRSA and MGNB. A system is in place for monitoring compliance.

iPortal System

The Lead Consultant Microbiologist/Infection Control Doctor works closely with IM&T Team regarding patient alerts. This system provides clinical staff with real time alerts and access to information from other hospital systems. Infection Control real-time alerts on the iPortal system includes Red and Amber alerts for patients with a very recent and relatively recent history, respectively, of MRSA, CDI, PVL-toxin producing *S. aureus*, and ESBL or Carbapenemase producing multi-resistant Gram-negative Bacilli. These alerts enable staff on wards and departments to promptly identify patients who have recently had an alert organism identified, allowing wards/departments to timely isolate and follow-up patients appropriately and to prescribe appropriate empiric antibiotics if antibiotic treatment is indicated.

COVID 19 alert

The IP team continue to apply COVID19 contact tags in Careflow/iPortal as required and in ICNet. There is also an iPortal clinical note that can be added by Preams for patients assessed to have been COVID19 positive in the community in the 90 days prior to planned admission. This facilitates early identification and placement of contacts who are re admitted to the Trust. However, there are some changes to this process from May 2026.

Surgical Site Infection Surveillance (SSIS)

UHNM participates in the UKHSA National Surgical Site Infection Surveillance Programme and remains compliant with both national and local commissioning requirements across both sites. The aim of SSIS is to enhance the quality of patient care by enabling hospitals to use surveillance data to monitor SSI rates over time and benchmark against national standards. These findings inform and guide improvements in clinical practice.

Hospitals may undertake surveillance across one or more of 17 defined surgical categories. Orthopaedic SSIS for one quarter has been mandatory since April 2004. The duration of surveillance depends on the type of surgery:

- Non-implant surgery: surveillance is completed at 30 days post-operation
- Implant surgery: surveillance continues for 1-year post-operation

ICNet alerts are applied by the Infection Prevention Clinical Surveillance Team (CST) to identify readmissions and relevant microbiology results throughout the surveillance period.

Methodology for Surveillance

The surveillance is undertaken by the Clinical Surveillance Team (CST). All eligible patients are reviewed using ICNET and IPortal. Electronic tags are added to eligible patient records in ICNet to provide alerts to notify when a patient was readmitted or had a wound swab sent, for the duration of the surveillance period (30 days or 365 days, depending on if implant is inserted at the time of surgery).

The plan for SSIS schedule for the year 2025-2026 is as below:

SSI SURVEILLANCE 2025-26		
QUARTER	PERIOD	SURVEILLANCE
		Royal/County
1	Qtr 1 - Apr – Jun	Hip replacement
2	Qtr 2 - Jul – Sep	Cardiac Surgery (non-CABG)
3	Qtr 3 - Oct – Dec	(Breast Surgery) Changed to Spinal Surgery
4	Qtr 4 - Jan – Mar	(Spinal Surgery) Changed to Cranial Surgery

Note: As Qtr 4 (2024-25) surveillance on Cranial Surgeries identified 6 SSI cases, a decision was made to alter SSI Surveillance plan to include Cranial Surgeries.

Qtr.1 Surveillance on Hip replacement Surgeries had 64 cases at Royal Stoke and 83 cases at County Hospital. No SSI cases were identified.
SSI surveillance for Qtr 2 on Cardiac Surgeries (non-CABG) had 64 cases at Royal Stoke and no cases at County Hospital. No SSI cases were identified.
Qtr.3 Surveillance on Spinal Surgeries had 136 cases at Royal Stoke and 43 cases at county. 4 cases of SSI were identified. An outlier letter from UKHSA was received and investigation into these cases have begun.
Qtr.4 Surveillance on Cranial Surgeries has ended in March 2026 and have 116 cases included in the surveillance. Data is under reconciliation

Future Developments

The Trust has agreed to establish a Surgical Site Infection Sub-Group reporting to the Infection Prevention and Control Committee (IPCC). This group will provide dedicated oversight of SSI surveillance, trends, and improvement actions. Formal establishment is currently in progress.

Managing Outbreaks of Infection - Responses to Incidents and Outbreaks

The IPT are involved in the management of outbreaks, periods of increased incidence and incidents.

CPE Outbreak

On March 2024, RSUH saw the beginning of an increase in IMP Enterobacter CPE cases linked to one of the cardiac wards.

October 2024 there were 17 cases spread throughout all the buildings on the Royal Stoke site but none at the County site.

Actions initiated by our Estates colleagues identified some blocked/slow draining drains as a coincidental finding and an alert was issued reminding staff regarding early reporting of slow draining sinks.

November 2024, we had received typing back from most of the isolates and 2 distinct outbreaks were identified – STOKPEB 50 and STOKPEB 51. An external meeting was held and attended by ICB, NHSe and UKHSA. There have been no further cases of IMP Klebsiella anywhere in the Trust until late of April 2025.

There had been several IMP CPE cases with different strains and clusters from previous were further identified through IP surveillance, another external meeting was held in Feb 2026. Most of the cases were spread through all the buildings on the Royal Stoke site and again none at County site.

IP immediate strict measures were instigated; independent unannounced audits undertaken and completed a good terminal cleans to all areas affected. Environmental swabs were also completed in few different areas; all samples came back negative.

CPE IMP cases monitoring and surveillance will continue throughout clinical areas.

iGAS outbreak

The UKHSA continues to monitor raise iGAS cases across the region and no recent incidence or outbreak that could be linked to UHNM.

Norovirus

It was reported that there were high levels of norovirus circulating in the community at the beginning of winter period.

There were several ward areas closed in UHNM during winter period of 2025/2026.

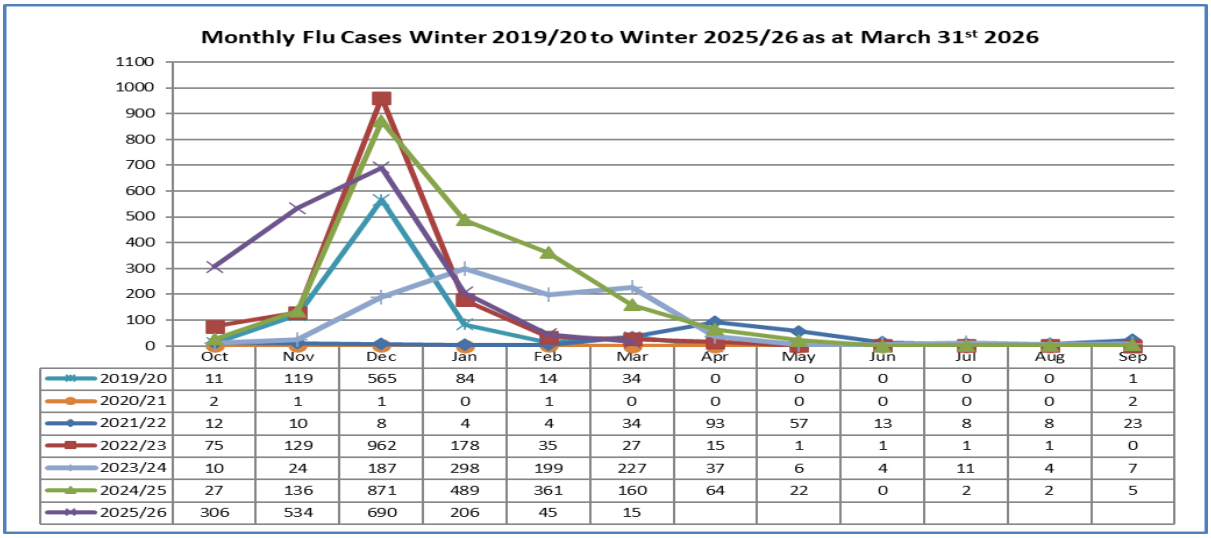
Spring-Summer 2026, we are still seeing low numbers of Norovirus circulating in the community and admitted to UHNM which is unusual according to NHSE.

Seasonal Influenza

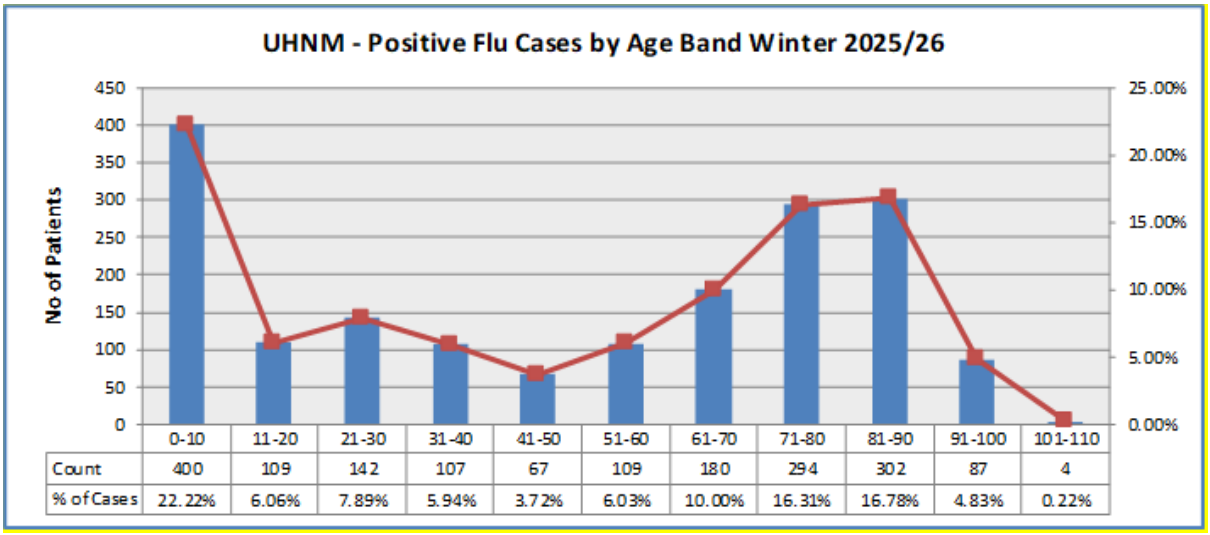
As will be seen from the graphs below UHNM have seen a major increase in patients compared to previous years with confirmed influenza, mainly Influenza A. with 690 cases reported in December alone.

For each case immediate control measures were instituted, following the latest UKHSA guidance, including the use of antivirals. UHNM instigated mandatory wearing of surgical mask to all staff in emergency portals and high-risk areas during influx of flu cases.

There were no whole ward closures due to influenza.



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
2019/20	11	119	565	84	14	34	0	0	0	0	0	1
2020/21	2	1	1	0	1	0	0	0	0	0	0	2
2021/22	12	10	8	4	4	34	93	57	13	8	8	23
2022/23	75	129	962	178	35	27	15	1	1	1	1	0
2023/24	10	24	187	298	199	227	37	6	4	11	4	7
2024/25	27	136	871	489	361	160	64	22	0	2	2	5
2025/26	306	534	690	206	45	15						



	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	101-110
Count	400	109	142	107	67	109	180	294	302	87	4
% of Cases	22.22%	6.06%	7.89%	5.94%	3.72%	6.03%	10.00%	16.31%	16.78%	4.83%	0.22%

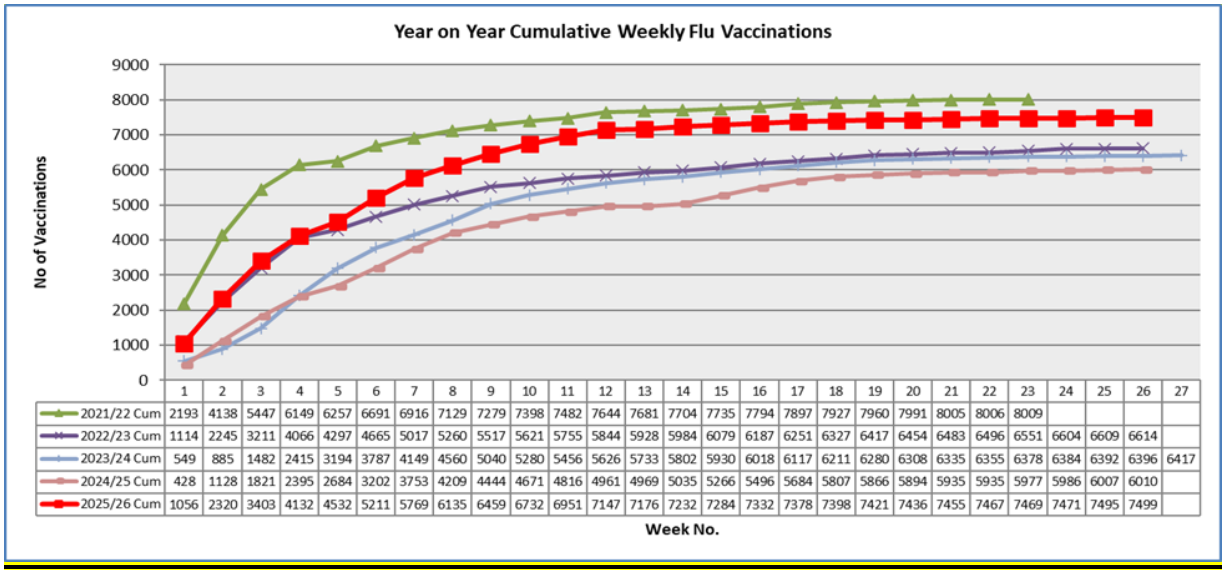
Compliance Criteria 6:

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

At the UHNM infection prevention is included in all job descriptions. All clinical staff receive training and education in optimum infection prevention practices.

Occupational Health services are provided by Optima Health.

Seasonal Staff Influenza Vaccination Campaign
Refer to page 29-32 of this report.



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
2021/22 Cum	2193	4138	5447	6149	6257	6691	6916	7129	7279	7398	7482	7644	7681	7704	7735	7794	7897	7927	7960	7991	8005	8006	8009				
2022/23 Cum	1114	2245	3211	4066	4297	4665	5017	5260	5517	5621	5755	5844	5928	5984	6079	6187	6251	6327	6417	6454	6483	6496	6551	6604	6609	6614	
2023/24 Cum	549	885	1482	2415	3194	3787	4149	4560	5040	5280	5456	5626	5733	5802	5930	6018	6117	6211	6280	6308	6335	6355	6378	6384	6392	6396	6417
2024/25 Cum	428	1128	1821	2395	2684	3202	3753	4209	4444	4671	4816	4961	4969	5035	5266	5496	5684	5807	5866	5894	5935	5935	5977	5986	6007	6010	
2025/26 Cum	1056	2320	3403	4132	4532	5211	5769	6135	6459	6732	6951	7147	7176	7232	7284	7332	7378	7398	7421	7436	7455	7467	7469	7471	7495	7499	

Compliance Criteria 7:

Provide or secure adequate isolation facilities.

Royal Stoke Hospital

Single Bedrooms & En Suites

Trent Building

	No. of Single Rooms	No. of En Suites
Ward 120 Medicine	3	0
Ward 121 Diabetes & Endocrinology	3	0
Ward 122 General Medicine	3	0
Ward 123 Elderly Care	3	0
Ward 124 Renal unit	16	16
Ward 126 Neurology	6 Pods / 1 Side Room	0
Ward 127 Acute Stroke Unit	8 Pods	0
Ward 128 Respiratory	14	14

Lyme Building

	No. of Single Rooms	No. of En Suites
SSCU	2	0
Ward 104/105	7	3
Ward 102/103 Emergency Surgery	Ward 102: 4 Ward 103: 4	Ward 102: 2 Ward 103: 2
Ward 100 SSDEC	4 Clinical Room	0
Ward 101 SAU	3	1
Ward 106/107 Urology & Gynaecology	3	2
Ward 108/109 Surgical Elective Unit.	Ward 108: 4 Ward 109: 4	Ward 108: 2 Ward 109: 2
Ward 110 Vascular	12	12
Ward 111 Specialised Surgery	12	12
Ward 112 Elective Orthopaedics	11	11
Ward 113 Respiratory	11	11

Maternity Centre

	No. of Single Rooms	No. of En Suites
Delivery Suite	17	16
Neonatal Unit	6(Parents overnight stay)	6
Ward 205	12	12
Ward 206	12	12
Midwifery Birthing Centre	12	12

Cancer Centre

	No. of Single Rooms	No. of En Suites
Oncology Day Unit	8	2
Ward 201 Haematology & Oncology Inpatients	20 3 Assessment Bed	20 3

West Building

	No. of Single Rooms	No. of En Suites
Ward 78/79 Older Adults Unit	Ward 78: 4 Ward 79: 4	Ward 78: 1 Ward 79: 1
Ward 80/81 Elderly Care	Ward 80: 2 Ward 81: 2	Ward 80: 0 Ward 81: 0
Ward 76a Elderly Care	3	1
Ward 76b Elderly Care	3 4 Pods	1 0

Main Building

	No. of Single Rooms	No. of En Suites
AMRAU	8	8
CDU	NA	NA
215 A High Independency Unit	6	6
216 Children Assessment Unit	8	8
217 Children's Surgery	13	13
217B Oncology Day Care	4	4
218 Children Medicine	12	11
CCU Cardiology	3	0
220 Cardiology	14	13
221 Cardiology	10	9
222 Respiratory NIV	10	10
223 Cardio Thoracic Surgery	16	15

225 Specialised #NOF	16	15
226 Trauma Orthopaedics	11	10
227 ARTU	10	9
228 Neurosurgery	15	15
230 Gastroenterology	17	16
231 AMU	11	10
232 AMU	11	10
233 SSU	17	16

Isolation Rooms	
PICU	2 Single rooms (3&4) with positive pressure gowning lobby
Emergency Department	1 Treatment room (2) with balanced pressure gowning lobby
Infectious diseases (Ward 117)	4 Negative pressure isolation rooms with lobbies

Side rooms within Critical Care	
Standard Side Room (No gowning lobby, neutral air pressure)	
Pod 1	Side room 8
Pod 2	Side room 16
Pod 3	Side room 24
Pod 5	Side room 33
Pod 6	Side room 4

Side rooms within Critical Care	
Isolation Side room (Gowning lobby, side room neutral pressure)	
Pod 1	Side room 1
Pod 2	Side room 15
Pod 3	Side room 17

Side rooms within Critical Care	
Isolation Side room (side room negative pressure)	
Pod 2	Side room15
Pod 4	Side room 32 (has lobby) and side room 25
Pod 6	Side room 3 (has lobby)
Pod 1	Side room 1

Side rooms within Critical Care	
Protective isolation room (with gowning lobby, side room. Positive pressure turned off)	
Pod 5	Side room 34

County Hospital

Ward	No. of Single Rooms	Toilet	Shower
Elective Trauma and Orthopaedic Ward	13	13	13
Ward 12 Respiratory	12	12	12
Ward 14 Diabetes & Endocrinology	12	12	12
Ward 15 Elderly Care	12	12	12
Day Case Unit	4	4	1
AAU	4	1	1
AMU	3	3	0
Critical Care Unit	0	0	0
ED Major	6	1	0
ED Resus	3	0	0
ED Ambulance Triage Corridor	5	0	0
ED Ambulatory/ ED Ambulance Triage	4	3	0
Medical Same Day Emergency Care	3	3	0
Chemotherapy Unit	6	3	0
Ward 1 (ward 7) General Medicine	4	3	0
Medical Receiving Unit	4	0	0
Frailty Assessment Unit (FAU)	4	1	0
Ward 8 Choices (Closed)	N/A	N/A	N/A

Compliance Criteria 8:

Secure adequate access to laboratory support as appropriate

Laboratory services for UHNM are located in the purpose-built Pathology Laboratory on-site at RSUH. The Infection Science Department is United Kingdom Accreditation Service (UKAS) accredited.

The Infection Prevention Nurses work closely with the Biomedical Scientists and Lead Infection Prevention Consultant Microbiologist. The IP nurses have access to the laboratory and liaise with Biomedical Scientists on a daily basis. There are systems in place for the laboratory staff to contact the IP team directly if required for notification of alert organisms. The IP team can contact the laboratory staff directly if organisms need further work for IP requirements and to raise ILOG numbers for outbreaks. The Biomedical Scientists are available 24/7 if urgent testing is required and the consultant microbiologists are contactable 24/7 if urgent advice is required. The IP team and laboratory leads have bi-monthly meetings to review processes and discuss issues.

The laboratory LIMS system is set up to generate IP alert flags in downstream systems to identify patients with e.g. methicillin resistant Staphylococcus aureus, Carbapenemase producing Gram negative bacilli, vancomycin resistant enterococci etc.

Compliance Criteria 9:

Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections.

An Infection Prevention Questions and Answers Manual, with an overarching policy is in place at UHNM this significantly enhances the quick location of key infection prevention guidance by our front-line staff.

The overarching policy is written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Both policy and manual are available for staff to view on the Trust intranet.

Clinical Governance has produced a directory of policies alerting when policies are due for update, policies are also updated prior to review date if guidance is updated.

The COVID 19 Trust guidance was regularly updated in line with UKHSA COVID 19 guidance.

Compliance Criteria 10:

Providers have a system in place to manage the occupational health needs of staff in relation to infection.

All job descriptions include infection prevention responsibility, and this message is reiterated during mandatory training. The IPT participate in mandatory updates for all staff groups (clinical and non-clinical). The IPT regularly meet with representatives of the Occupational Health Service to ensure compliance with Criteria 10.

Staff Training
This has been documented earlier in this report.

IPN/Team Development

Numerous Webinars and external conferences were held throughout the year which IP Team attended.
IP Senior Teams attended IPC Acute trusts Leads Forum held by NSHEI.
Various water safety, ventilation and mask fit, and decontamination webinars were attended throughout the year.

All new Nursing staff to the Infection Prevention Team undergoes a two-week supernumerary induction programme on Infection Prevention, as well as being issued with a personal copy of a relevant textbook.

Conclusion

Infection prevention is a key marker of patient safety within UHNM, as it encompasses a broad range of factors, from the state of the environment through to the effect of antibiotic use on the selection of organisms such as Clostridioides *difficile,* MRSA and Gram-negative Bacteria. This requires the involvement of all grades of staff, on an on-going basis, and the IPT are central to this.

At UHNM we acknowledge that the Trust has several challenges:

- Continuing threat of respiratory viruses such as Avian influenza
- National rise in measles cases and outbreaks
- Pertussis cases
- Sustaining FFP3 mask resiliency.
- Reduction of Gram-negative blood stream infections
- Continuing threat from CPE.
- Reducing the incidence of CDI.
- Reducing the incidence of MRSA bacteraemia.
- Below 90% sepsis IVAB compliance in A&E Royal site due to high acuity, capacity pressure and ambulance hold.
- Sustainability of Infection Prevention practices across the Trust.
- Monitoring of pharmacy/prescribing data
- Threat and incidence of AMR nationally/globally
- Monitoring of Surgical Site infections.
- National/international threats, e.g. multi-resistant Gram-negative Bacilli; emerging respiratory viruses, childhood diseases such as measles and working closely with the Emergency Planning Team.
- Mpox virus, new Ebola threat and other HCIDs

Appendix 1 Annual Programme of Works 2026-2027

Infection Prevention Programme of Works for the period April 2026 March 2027
The Trusts aim is to care for patients in a safe environment protecting them from harm with a zero tolerance to avoidable hospital attributable infections. The document sets out the Trust's objective and priorities risk of infection for the period 1 April 2026 – 31 March 2027. The intentions detailed below aim to sustain and strengthen the Trust's position in achieving compliance with The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and Related Guidance (updated 2022) and other key national documents. The programme details the essential components of the infection prevention service including- • Surveillance • Policy development and review • Outbreak prevention and management. • Quality improvement and audit • Education and training • Specialist advice including promoting compliance with regulation, legislation, guidance and evidence-based practice. The following abbreviations are used throughout the document: DIPC – Director of Infection Prevention and Control IPN – Infection Prevention Nurse IPT – Infection Prevention Team ICD – Infection Control Doctor ICB – Integrated Care Board NHSI – National Health Service Improvement PLACE – Patient Led Assessment of the Care Environment RON – Resistant Micro-organism Nurse

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 1 Systems to manage and monitor the prevention and control of infection	**Assurance Framework**		
	Key committees including Quality and Safety Committee and the Trust Board will receive reports and presentations, monthly as a minimum for the former and quarterly for the latter from the DIPC.	DIPC	Quarters 1-4
	The DIPC will ensure the Trust Board agree and approve the:		
	• Annual Programme of Works	DIPC	Quarter 1
	• Annual report	DIPC	Quarter 1
	• Policy, procedure and guidance documents	DIPC	Quarters 1-4
	• Cleanliness and Patient Led Assessment of the Care Environment (PLACE) scores.	Support Services	Annually
	The DIPC will ensure that the Trust Board is made aware of:		
	• Emerging issues with the potential to impact upon patient safety and the delivery of clinical services.	DIPC	Quarter 1-4
	• Unforeseen issues impacting upon progress of the annual programme.	Deputy DIPC	Bi-monthly
	• Ensure the progress of the annual programme is monitored by the IPT and any identified or emerging issues affecting the programme are reported to members of the group and where necessary escalated to the Trust Board.	DIPC	Quarter 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	• Ensure that the Infection Prevention Control Committee meet bi-monthly and is chaired by the DIPC.	Deputy DIPC	Bi-monthly
	IPT to attend Health Economy Antimicrobial Meetings	Deputy DIPC	Quarterly
	IP Deputy DIPC any Health Economy meeting organised by the ICB	Deputy DIPC	As required
	Infection Prevention Nurse to attend Trust Antimicrobial Stewardship Group	Lead Nurse Infection Prevention	Bi-monthly
	Performance Management Ensure that the Quality, Safety and Compliance Team receive appropriate information to support on-going registration with the Care Quality Commission	Governance	As required.
	Report on progress against the HCAI assurance framework. strategy including emergency and elective screening compliance.	Deputy DIPC	Monthly
	Quarterly report and IP BAF to Quality Access Outcome Committee (QAOC) and Trust Board	Deputy DIPC	Quarterly/Monthly
	Ensure that monthly data summaries, incidents and outbreaks are included in the Quality and Safety reports.	Deputy DIPC	Monthly
	Update any Infection Prevention risks on risk register	Deputy DIPC	Bi-monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Make a suitable and sufficient assessment of the risks of infection and take actions to minimise the risk	IPT / ICD/ Consultant Microbiologist	Daily
	Using ICNet, review laboratory reports during periods of duty and provide specialist advice to clinical teams on the management of individual patients.	IPT	Daily
	Undertake alert organisms' surveillance report to IPCC.	ICD and Senior Data Analyst	As required but at least bimonthly
	Outbreaks		
	Respond to and advise on the management of outbreaks of infection.	IPT	Within 24 hours
	Where required report outbreaks of infection through Trust reporting systems. Inform the DIPC, senior management, Heads of Services, Performance Management and key individuals of outbreaks.	IPT	No later than 48 hours after incident or lapse in care is identified.
	Initiate the investigation process.	IPT	Within 24 hours
	Prepare outbreak summary reports and submit to IPCC, Quality Access Outcome Committee and the Board.	IPT	At next IPCC
	PSIRF/ Themes reviewed for hospital attributable clostridium *difficile* cases. • Learning and actions owned and received at divisional IP meetings and summary to IPCC.	Associate Chief Nurse/ Matron/ Ward Sister/ Ward Charge Nurse for the Care Group/ IPT	As required

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Post infection review for all MRSA bacteraemia. • Learning and actions owned and received at divisional meetings and summary to IPCC	Associate Chief Nurse/Matron/Ward Sister/Ward Charge Nurse for the care Group/ IPT	As required
	Facilitate Screening of alert organisms e.g. MRSA, Multi drug resistant organisms admitted or transferred to UHNM in accordance with National guidance and evidence-based practice.	IPT/Senior Data Analysis	Quarter 1-4
	Participate in multi- disciplinary review of Clostridium difficile toxin positive patients.	Infection Prevention Nurse/ Microbiologist/Dietician/ Pharmacist/Gastroenterologist/ Surgeon	Weekly/ Quarterly
	Maintain and review Clostridium difficile action plan and Submit to Executive Quality Outcome Group (EQOG).	Deputy DIPC	Bi-monthly
	Monthly Clostridium difficile 30-day all-cause mortality report	Deputy DIPC	Bi-monthly to IPCC
	Surgical Site Surveillance Infection Surveillance programme in place. Feedback to Directorate Meetings. SSI subgroup will be established in Q3.	Clinical Surveillance Team IP	Quarters 1-4
	Review and update Gram negative action plan and submit to the Executive Quality Outcome Group bimonthly.	Clinical Surveillance Team IP	Bi-Monthly
	IPT to attend and provide specialist advice: • Infection Prevention Care Groups meetings	IPN and IP Sister	Bi -Monthly
	• Vaccination planning group	Deputy DIPC	Three times per year
	• Sepsis planning meetings Strategic and antimicrobial group	Deputy DIPC	Bi-monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	• Trust Antimicrobial Group	IP Lead Nurse	Bi-monthly
	• Executive Quality Outcome Group	Deputy DIPC/ Lead	Bi-monthly
	• Quality Access & Outcome Committee	Deputy DIPC/ Lead	Quarterly
	• CQRM	Deputy DIPC	Monthly report
	• Health & Safety Committee	IP Lead Nurse	Bi-monthly
	• ICB Infection Prevention Group	Deputy DIPC /Lead	As Required
	• Ventilation group	IP Decontamination Lead	Quarterly
	• Water Safety Group and Operational WSG	Deputy DIPC	Quarterly
	• Health Economy Antimicrobial Group	Deputy DIPC	Quarterly
	• IP Care Group Meetings	IPT	Monthly
	• Mortality review meetings	IP Lead Nurse	Monthly
	• Decontamination Safety Group	IP Decontamination Lead	Monthly
	• Clostridioides *difficile* Task and Finish Group	IP Lead Nurse	As required
	• Stoke on Trent Health Protection Board	Deputy DIPC	

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 2 Provide and maintain a clean and appropriate environment in managed premises that facilities the prevention and control of infections	IPT to attend and provide specialist advice:		
	• Multi- Disciplinary Environmental Strategy Group	IPT	Monthly
	• Water Safety Group and Operational WSG	Deputy DIPC/ IP Decontamination	Quarterly
	• Environmental Health Food Hygiene Inspections	IPT	Annually
	• Refurbishment and Building Meetings	IPT/Service Development Team	As required
	• Infection Prevention Cleaning Services (Soft FM)	IPT/Service Development Team	Monthly
	• Decontamination Safety Group	IPT/Service Development Team	Monthly
	• Clinical Equipment Product Evaluation Group (CEPEG) and TPEG	IPT/Service Development Team	Monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Re refresh Pooh help line sampling CDI training video and sessions	IP C. *difficile* Nurse IP C. *difficile* Nurse	Ongoing Ongoing
	Quality Improvement Audits IPN to conduct period of increased incidence (PII) audits when PII is identified. Feedback to ward, Matron and Care Groups. IPN to conduct Clostridium *difficile* audit following each hospital acquired case IPN's will undertake a programme of unannounced audits in clinical areas, including hand hygiene audits/ATP/ spot checks Audit tools and programme in place for Care Groups/areas to monitor environment. IPN's to support service leads, Matron and Ward Sisters/Charge Nurse National Cleaning Standards audit programme in place - feedback bi -monthly at IPCC	 IPN IPN IPN/Hand Hygiene Trainer Associate Chief Nurses/Matrons/ Ward Sister/Charge Nurse Facilities Manager	 As required As required As required Weekly/Monthly/ Quarterly Bi-monthly

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	Prompt to protect audits	IP Team	Weekly
	IPCC to receive summary progress and action plans for Care Groups	Nurse Director/Matron	Bi-monthly
	Building works and refurbishments IPT to advise on building and refurbishments.	IPT/Service Development Team	As Required
	IP Team to advise on new cleaning products and deep clean programmes	Deputy DIPC/IPT	As Required
Criteria 3 Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	Work with partner organisations to ensure that the Trust has systems and procedures which minimise the risk from emerging and resistant organisms	Advance Specialist Pharmacist Antimicrobials/Microbiologist/ ICD/ ID Team DIPC	Quarters 1-4
	Representation at Local Health Economy Antimicrobial Group Meeting	Deputy DIPC/Microbiologist	Quarterly
	Antimicrobial pharmacist to report antibiotic audits to IPCC	Advance Specialist Pharmacist Antimicrobials	Bi-monthly
		Microbiologist	Quarters 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
	The IP and Antimicrobial Team work closely together re CQUIN	Microbiologist/Advanced Specialist Pharmacist Antimicrobials Deputy DIPC/IP Team	Quarters 1-4
	Access to Microbiologist to advise on appropriate choice of antimicrobial therapy.	ICD/Microbiology Manager	Quarters 1-4
	Access to microbiology diagnosis, susceptibility testing and reporting of results.	ICD/Microbiology Manager	Quarters 1-4
	Sepsis Audit Compliance as part of Trust contract	Deputy DIPC/ Sepsis IP Team	Quarters 1-4
	Strengthening of Sepsis champions and sepsis screening	Deputy DIPC/ Sepsis IP Team	Quarters 1-4
	Sepsis training video and educational material	Deputy DIPC/Sepsis IP Team	Quarters 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 4 Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.	DIPC to liaise with Communications Team to deliver public messages in times of outbreaks.	DIPC	As required
	Patient information leaflets available for the public. IPT to actively participate in promotional activities across the Trust, raising awareness of good practice e.g. visitor's stands / Infection Prevention Awareness Week/ Hand Hygiene World Health Organisation Day	IPT/Service Development Team	Quarters 2-4
	Review public internet page	IPT	Quarter 1-4
	All Clostridioides *difficile* given a "green alert card" to be presented when receiving future healthcare.	Service Development Team/IPT	As required.
	Hand hygiene education for patients	Hand hygiene Technician	Quarters 1- 4
	Ensure IP annual report available externally on UHNM site	IP Lead Nurse	Yearly
	Review IP contents of Intranet and Internet	IPT	As Required
Criteria 5 Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Alert tag system place at Royal Stoke to allow staff to check for current and previous alert organisms to enable proactive approach to IP.	IPT	As required.
	Norovirus/winter signage displayed throughout the Trust.	IPT	Quarter 3-4
	Outbreak daily allocated Nurse within the IP Team as necessary.	Deputy DIPC/ Lead Nurse	Quarter 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.	**Education and Training** Liaise with the Education and Learning Team, Service Leads and Business Managers to ensure all staff are suitably educated in the prevention and control of infection.		Time scale in accordance with documented programmes
	IPT to attend. • Teaching and Education	IPT	Quarters 1-4
	• Corporate induction	IPT	Quarters 1-4
	• Mandatory training days	IPT	Quarters 1-4
	• Scheduled programme of updates	IPT	Quarters 1-4
	• Infection Prevention Link Practitioners study days	IPT	Quarters 2-4
	Supporting Spoke Placement for Student Nurses to shadow the IPT.	IPT	Quarters 34
	Contribution for the continuous personal development programme for medical and other staff.	IPT/ICD	Quarters 1-4
	Provide cascade training for volunteers/porters/catering assistants/domestics about the importance of complying with good practice.	IPT	Quarters 1-4
	Use variety of educational approaches to engage staff e.g. ATP monitoring, PowerPoint, shadowing, online learning, Teams	IPT	Quarters 1-4
	Hand Hygiene and Mask Fit Testing. Trust Mask fit team in place. PPE donning and doffing, gloves off campaign	Deputy DIPC /IPT	Quarters 1-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 7 Provide and secure adequate isolation facilities	To advise/make recommendations on isolation facilities during refurbishment programmes. Inform DIPC where there is lack of isolation rooms of when requirements change e.g. threat of alert organism	IPT Deputy DIPC	As required As required
Criteria 8 Secure adequate access to laboratory support as appropriate	Ensure CPA accreditation of laboratories is current Daily laboratory bench round with “on call” microbiologist	ICD/Lab Manager IPT	Annually Daily
Criteria 9 Have and adhere to policies, designed for the individuals care and provider organisation that will help to prevent and control infections	Amend polices or guidance and any related documents in response to legislation, regulations and evidence-based practice. Ensure that existing policies with a review date falling within this period are revised and comply with legislation, regulations, current guidance and evidence-based practice: Infection prevention Question and Answer manual in place	IPT Service Development Team	As required Quarter 3-4

Objective	Actions	Person(s) Responsible	Time Scale & Priority
Criteria 10 Providers have a system in place to manage the occupational health needs of staff in relation to infection	Liaise and support the Optima Health in protecting healthcare workers from infections through: The review and follow up of inoculation and/or splash injury. Work with partner organisation to ensure that the Trust has systems and procedure in place which reduces the risk from emerging and resistant organisms. Lead the planning and delivery of the staff influenza programme. Review of staff pre-employment immunisation matrix Optima Health to report to IPCC	Optima Health ICD IPT Health and Safety Department ICD IPT Deputy DIPC Optima Health/ Health & Safety Department/ Microbiologist ICD Optima Health	Quarters 1-4 Quarter 3 Quarters 1-4 Quarters 1-4 Quarters 1-4 Quarters 1-4

References

Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Infection Prevention Society Audit tools. http://www.ips.uk.net/professional-practice/quality-improvement-tools/quality-improvement-tools/