Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 10 September 2025

TB2025.76

Title:	**Infection Prevention and Control Annual Report 2024-25**

Status:	**For Information**
History:	**Annual report**

Board Lead:	**Chief Medical Officer**
Author:	**Prof Katie Jeffery, Director of Infection Prevention & Control**
Confidential:	**No**
Key Purpose:	**Assurance, Policy, Performance**

Executive Summary

1. The Infection Prevention and Control (IPC) Annual Report reports on infection prevention and control activities in the Oxford University Hospitals (OUH) NHS Foundation Trust between April 2024 and March 2025. The report covers IPC for the four main sites - John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre and Horton General Hospital - and sites across the region including satellite dialysis units, midwifery led units, radiotherapy and Katherine House Hospice.
2. The publication of the IPC Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability, in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.
3. The Trust Board received bi-monthly updates via the Integrated Assurance Committee. A monthly report is submitted to the Patient Safety and Effectiveness Committee (PSEC) which reports to Trust Clinical Governance Committee.
4. The following organisms are subject to NHSE mandatory reporting: Methicillin-resistant *Staphylococcus aureus* bacteraemia (MRSA), Methicillin-sensitive *Staphylococcus aureus* bacteraemia (MSSA), *Clostridioides difficile*, and Gram-negative bloodstream infections (*Escherichia coli,* Klebsiella species*,* and *Pseudomonas aeruginosa*). In 2024-25 OUH complied with all external reporting requirements.
5. **Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteraemia**

   The Trust reported 11 cases of healthcare associated MRSA bacteraemia. NHSE has a zero-tolerance policy for healthcare associated MRSA bacteraemia.
6. **Methicillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia**

   The Trust reported 66 cases of healthcare associated MSSA bacteraemia for 2024-25, which is a reduction of 4 cases from 2023-24. There is no threshold set by NHSE for MSSA.
7. **Clostridioides difficile (*C. difficile*)**

   The Trust reported a total of 164 cases in 2024-25 (130 in 2023-24). This was above the NHSE trajectory set at 123 cases.
8. **Gram negative blood stream Infections (GNBSI)**

   The Trust reported a total of 220 *E. coli*, 101 Klebsiella spp. and 63 *Pseudomonas aeruginosa* healthcare attributable blood stream infections in 2024-25, exceeding the trajectories set in the NHS Standard Contract.
9. **Central Line Associated Bloodstream Infections (CLABSI) surveillance**

   CLABSI surveillance is undertaken trust-wide by the IPC team.

10. Surgical Site Infection (SSI)

Information is submitted to the UK Health Security Agency (UKHSA) for the mandatory SSI surveillance of repair of fractured neck of femur procedures and voluntary surveillance relating to Coronary Artery Bypass Graft procedures and cardiac valve and transcatheter aortic valve implantation.

Following a review by the British Orthopaedic Association there has been a focus this year on infection in hip and knee replacement surgery, and a reduction in the SSI rate has been demonstrated.

11. COVID-19 & Respiratory Viruses

The IPC team continued to follow up COVID-19 and influenza positive patients. Operational pressures regularly impacted the Trust's ability to isolate all patients promptly.

12. The Built Environment and IPC

The IPC team has provided support in relation to both ongoing and new environmental concerns throughout 2024-25.

Water Safety at the Churchill Cancer and Haematology Hospital: Ongoing work to deliver an engineering solution to control the failings of the water system with respect to Legionella was completed in 2023-24 and remains in a period of surveillance. Point of use filters remain on all outlets within the building to maintain safe water at the point of use. The Extraordinary Water Safety Group continues to meet to ensure progress is being made. A number of key documents are yet to be provided by the subcontractor, G4S. As a result the SIRI called in 2019 has yet to have the actions closed (July 2025).

13. Infection Prevention and Control Surveillance Software

The company that supplied the surveillance system (ACMEipc) to the IPC team has ceased trading. In March 2025 the Microbiology laboratory team implemented a new Laboratory Information System (LIMS) and the LIMS now provides partial mitigation with daily reports for certain infections with some additional support from the EPR team. The OUH Digital Engineering Service is working on a web-based solution to provide an alert system for both pathogens (via LIMS) and patient factors (via EPR). Efforts are ongoing to identify funding to support the purchase of an IPC surveillance system with the required functionality (such as ICNET).

14. Investigation of Infection Prevention and Control Incidents and Outbreaks

The following outbreaks/incidents have been subject to investigation by the IPC team.

- ESBL in the neonatal unit
- Occupational exposure to TB and Meningococcus
- Measles

- Bedbugs
- Norovirus
- Influenza and COVID-19 outbreaks

15. Antimicrobial Stewardship (AMS)

AMS activity has included work in the following areas:

- Antibiotic consumption
- AMS ward rounds and 6 day AMS service
- *C. difficile* prevention

The team won the research category of the Antibiotic Guardian awards 2025 for their published work on the impact of AMS ward rounds.

16. Infection Prevention and Control staffing

The IPC Lead Nurse Manager was seconded into another role in the Trust in June 2024; together with difficulties recruiting experienced staff following the successful IPC business case, and a lack of surveillance software, 2024/25 has been a challenging year for the IPC team.

17. Recommendations

The Trust Board is asked to note the report.

1 Contents

1 Purpose

This report provides the Trust Board with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention and Control Team between April 2024 and March 2025. The publication of the Infection Prevention and Control (IPC) Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2028: Code of Practice on the Prevention and Control of Infection and related guidance (Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk). This report follows the format of the Health and Social Act, reporting on each of the 10 criteria outlined in the Act.

1.1 Infection Prevention and Control Board Assurance Framework (BAF)

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act (2008). This requires demonstration of compliance with the 10 criteria outlined in the Act.

The Board Assurance Framework is ordered by the 10 criteria of the Act and allows for evidence of compliance, gaps in compliance, mitigations, and comments to be recorded in a text format. This report is structured to report IPC activity and compliance against each of the 10 criteria.

The compliance ratings include the following categories: not applicable, non-compliant, partially compliant, compliant.

At the end of each section is OUH's compliance rating in line with the NHSE IPC BAF.

The Trust has more areas of compliance in 2024-25 than in 2023-24. There were no areas of non-compliance and no new areas of partial compliance in 2024-25. Areas of partial compliance are included in the IPC Strategic Plan.

1.2 Background

The Director of Infection Prevention and Control's (DIPC) Annual Report reports on IPC activities within the Oxford University Hospitals (OUH) NHS Foundation Trust for April 2024 to March 2025. The report covers IPC for

the four main sites - John Radcliffe Hospital, Churchill Hospital, Nuffield Orthopaedic Centre and Horton General Hospital - and several sites across the region, including satellite dialysis units, midwife led units and Katherine House Hospice.

A zero-tolerance approach continues to be taken by the Trust towards all avoidable Healthcare associated infections (HCAIs). We ensure that good IPC practices are applied consistently and are part of our everyday practice meaning that people who use OUH services receive safe and effective care.

This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical, who play a vital role in improving the quality of staff, patient and stakeholder experience as well as helping to reduce the risk of infections. Additionally, the Trust continues to work collaboratively with several outside agencies as part of its IPC and governance arrangements including:

- Integrated Care Board/System
- Oxford Health NHS Foundation Trust
- South Central Ambulance Service (SCAS)
- Thames Valley Health Protection Team/UKHSA
- NHSE

The Hospital Infection Prevention and Control Committee (HIPCC) meets monthly. HIPCC reports to the Patient Safety and Effectiveness Committee (PSEC) and the Deputy DIPC/Lead Nurse or deputy is a member of the Clinical Governance Committee.

Committees reporting to HIPCC are:

- Decontamination Committee

Regular reports to HIPCC include:

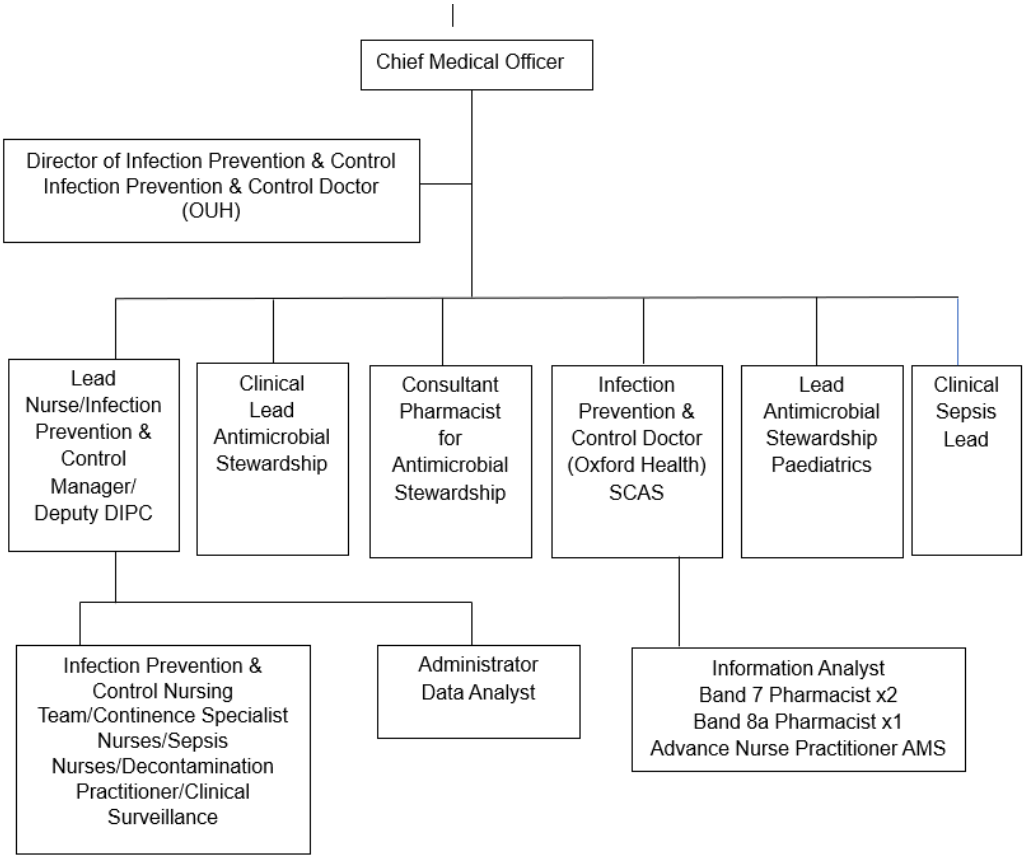
- Divisional IPC reports
- UKHSA/local Health Protection Team
- BOB ICS (Buckinghamshire, Oxfordshire and Berkshire West)
- Antimicrobial Stewardship (AMS) Team
- OUH Estates and Facilities
- Soft Facilities Management
- Centre for Occupational Health & Wellbeing (COHWB)
- Cardio-thoracic surgical site infection report
- IPC Risk Register

2 Criterion 1

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

Infection Prevention and Control Staffing

Table 1: Organisational chart for the IPC team at the end of March 2025



The IPC team commenced a 7-day on-site service in the Autumn of 2024 to provide IPC support to the wards and operational teams.

There is a close working relationship with all teams across the Trust, including the Microbiology Laboratory, Clinical Infection team, Estates and Facilities, Health and Safety team, Procurement, Centre for Occupational Health and Well-being (COHWB), Communications team, clinical and managerial staff, and across the PFI structure.

The Deputy DIPC/Lead Nurse was seconded to a Divisional Nurse role in the OUH in June 2024 and appointed to the permanent post in January 2025. An interim IPC Lead was appointed from November 2024.

The Deputy DIPC/Lead Nurse chairs the Water Safety Group and is a member of the Ventilation Safety Group. There have been several projects

throughout the year that have required the expertise of the IPC team on planning and opening of new or refurbished wards and clinical areas.

A new IPC administrator was appointed starting in February 2025 following the retirement of the previous post-holder in August 2024 after more than 40 years in the Trust.

Members of the wider microbiology/infectious diseases team provide support for specific workstreams.

2.1 **Organisms subject to mandatory reporting**

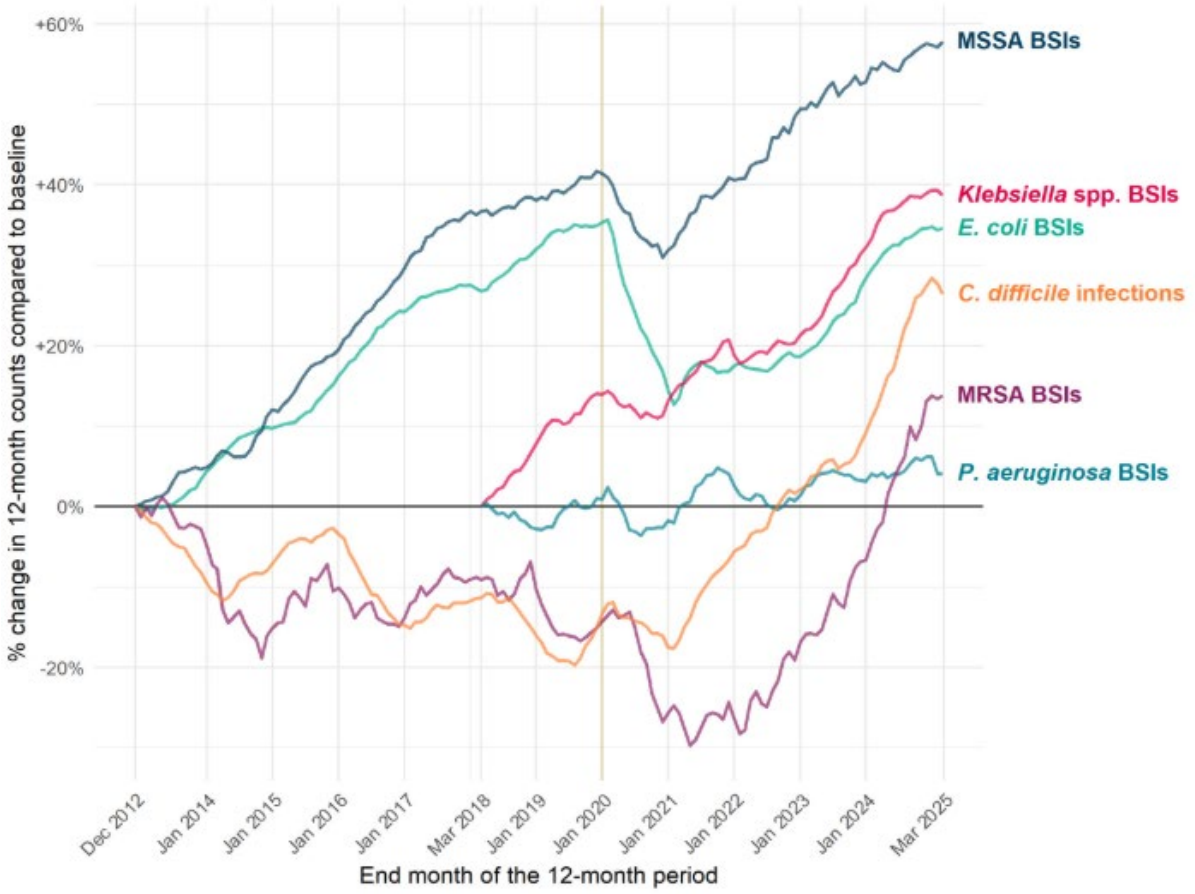
The OUH is required to report to UKHSA on the following organisms:

- Methicillin-resistant *Staphylococcus aureus* (MRSA)
- Methicillin-sensitive *Staphylococcus aureus* (MSSA)
- Gram negative Bloodstream Infections
- *Clostridioides difficile* (C. difficile)

2.2 **National overview of long-term trends in organisms subject to mandatory reporting**

National data presents a challenging picture for organisms subject to mandatory reporting. From 2021 until the latest quarter all six organisms surpass records of counts since their respective data collection began (Table 2). The increase in C. difficile infection is marked since 2023.

Table 2: National C. difficile and bloodstream infections, 12-month rolling percent change. Data shows a rise from 2012 baseline (2018 for Klebsiella spp. and Pseudomonas aeruginosa) of all organisms subject to mandatory reporting. Data to March 2025.



2.3 **Bacteraemia prior trust exposure categories**

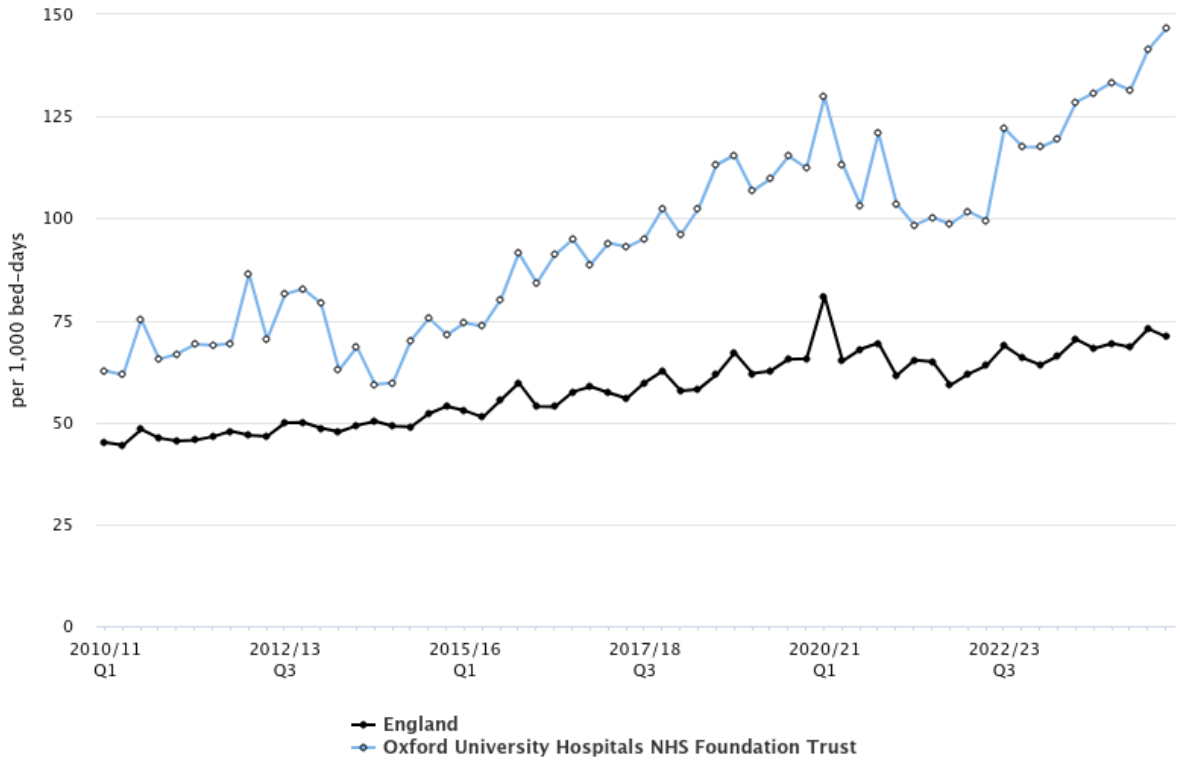
The two categories of reporting for healthcare-associated infection are:

- **Hospital-Onset, Healthcare Associated (HOHA)**: date of onset is greater than 2 days after admission (where day of admission is day 1)
- **Community-Onset Healthcare-Associated (COHA)**: is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

2.4 **Ascertainment of bacteraemia in the OUH**

The number of blood culture sets taken in the OUH per 1000 bed-days is almost twice the England acute Trust average (Table 3).

Table 3 Blood culture sets per 1,000 bed-days performed by reporting acute trust and financial quarter



2.5 **Reporting and Investigation**

HOHA and COHA cases of MRSA and MSSA bacteraemia are reported through the Trust incident reporting system Ulysses. A questionnaire is completed on Ulysses to identify any learning and the incident report is completed by the IPC team on identification of cases.

Divisions are asked to report by exception to HIPCC on action plans regarding MRSA and MSSA.

2.6 **Methicillin-resistant Staphylococcus aureus (MRSA)**

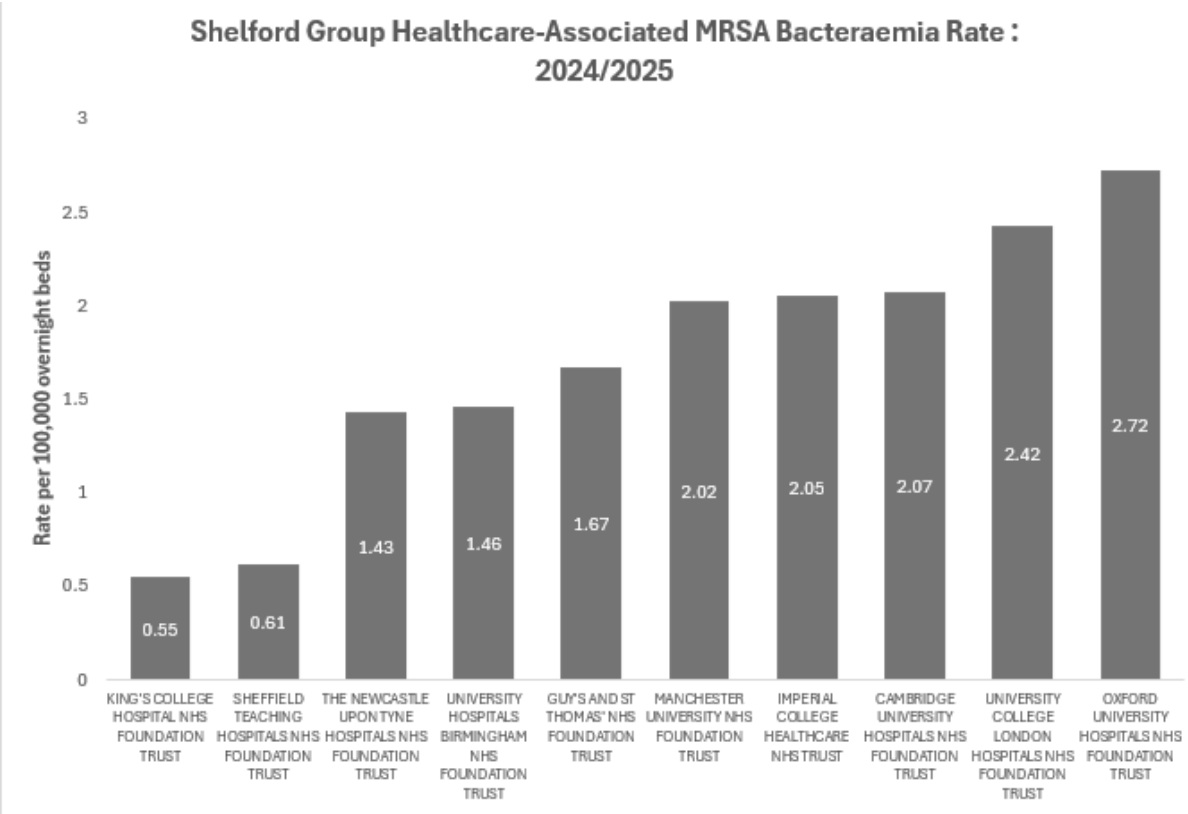
There were 8 HOHA and 3 COHA cases of MRSA bacteraemia in 2024-25. All cases have undergone a review to identify learning. Table 4 provides information on the source of infection. No learning was identified in the majority of cases. In one case there was a delay in sampling leading to a change in category from community to healthcare associated. Learning was identified in relation to line care, and cross-divisional work has been completed to ensure that decolonisation prior to line insertion is embedded in practice.

Table 4: MRSA: Breakdown of MRSA Infection Source

Recorded Source	No of HOHA	No of COHA
Lines (includes peripheral, Hickman, PICC, central and midlines)	4	1
Unknown / unclear	1	0
Other (Skin or soft tissue (includes surgical site infection), urinary)	3	2

Bar chart (Table 5) shows OUH MRSA bacteraemia rate in comparison with the Shelford group of Trusts. Our rate has deteriorated in comparison with our peer group.

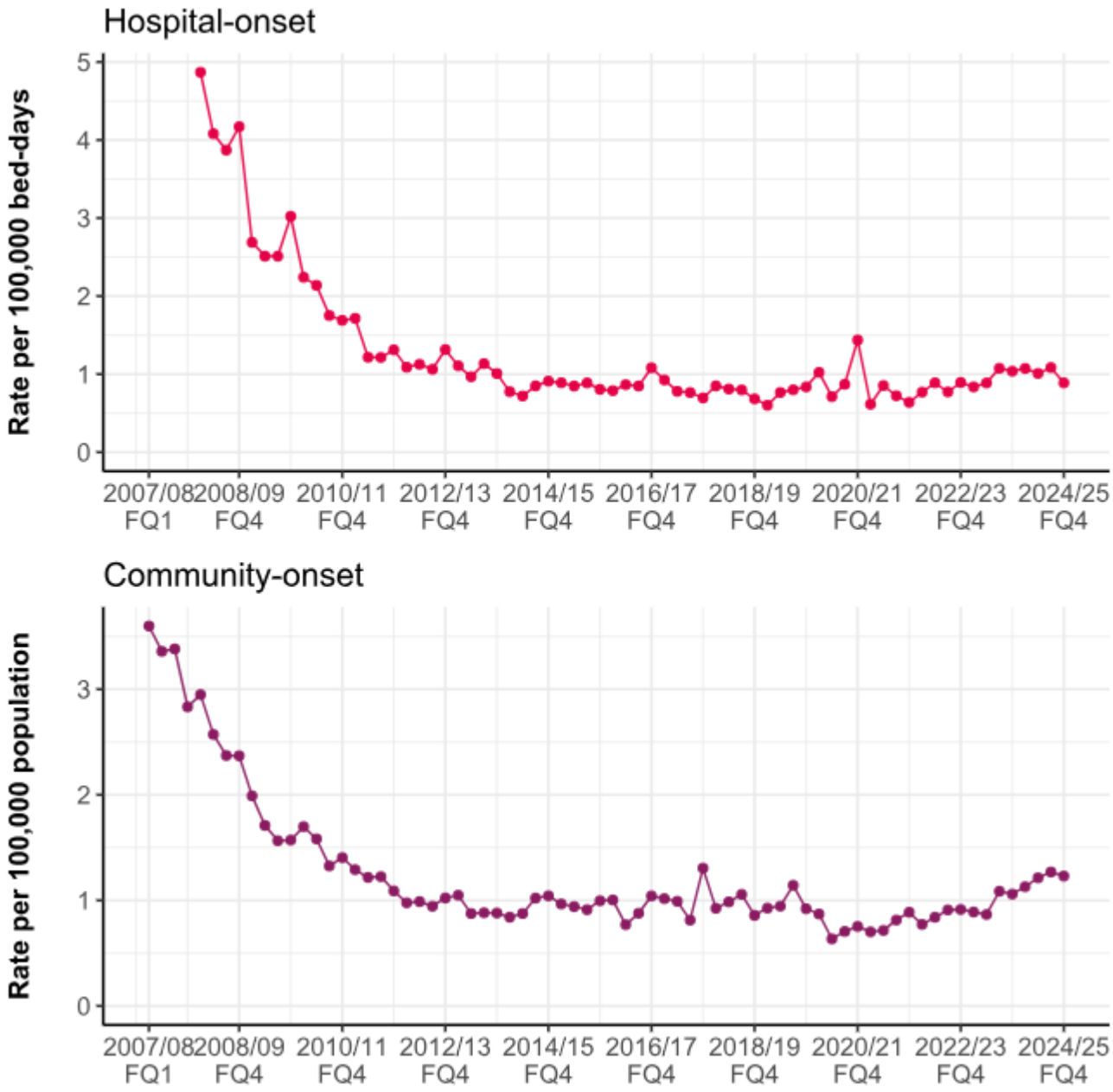
Table 5: Shelford Group Healthcare-Associated MRSA Rate 2024-25



National MRSA Picture

When comparing October to December 2024 with the equivalent pre-pandemic period (October to December 2019), there was a 21.5% increase in total cases. This increase appears more pronounced in community cases (Table 6) but as the overall numbers are small, this needs to be interpreted with caution.

Table 6: Quarterly rates of MRSA bacteraemia (April 2008 to March 2025) (National data)



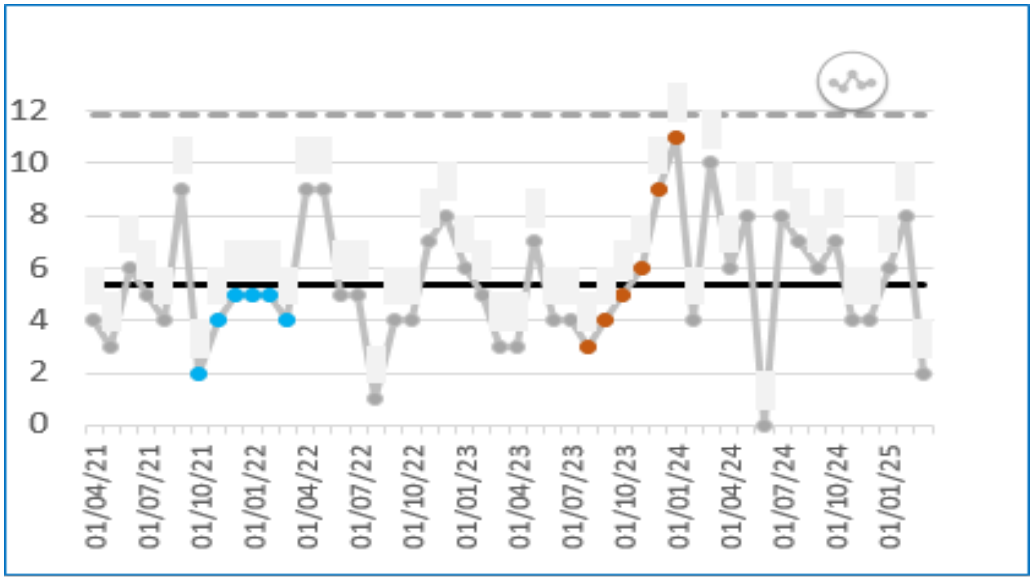
2.7 **Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia**

The Trust reported 46 (43 in 2023-24) HOHA cases and 19 (27 in 2023-24) COHA cases for 2024-25. The main recorded infection sources are documented below (Table 7) and remain the same as last year.

Table 7: MSSA: Breakdown of Top 3 Sources of Infection

Recorded Source	**No of HOHA**	**No of COHA**
Lines (includes peripheral, Hickman, PICC, central and midlines)	18	1
Unknown / unclear	8	3
Skin or soft tissue (includes surgical site infection)	3	5

Table 8: SPC HOHA and COHA associated MSSA bacteraemia (April 2021-March 2025)



Controlling the MSSA bacteraemia cases for discharges as a measure of activity shows a decline in attributable cases in 2024-25 (Table 9) to levels at their lowest for 5 years.

Table 9: OUH Healthcare associated MSSA bacteraemia cases controlled for activity (discharges)

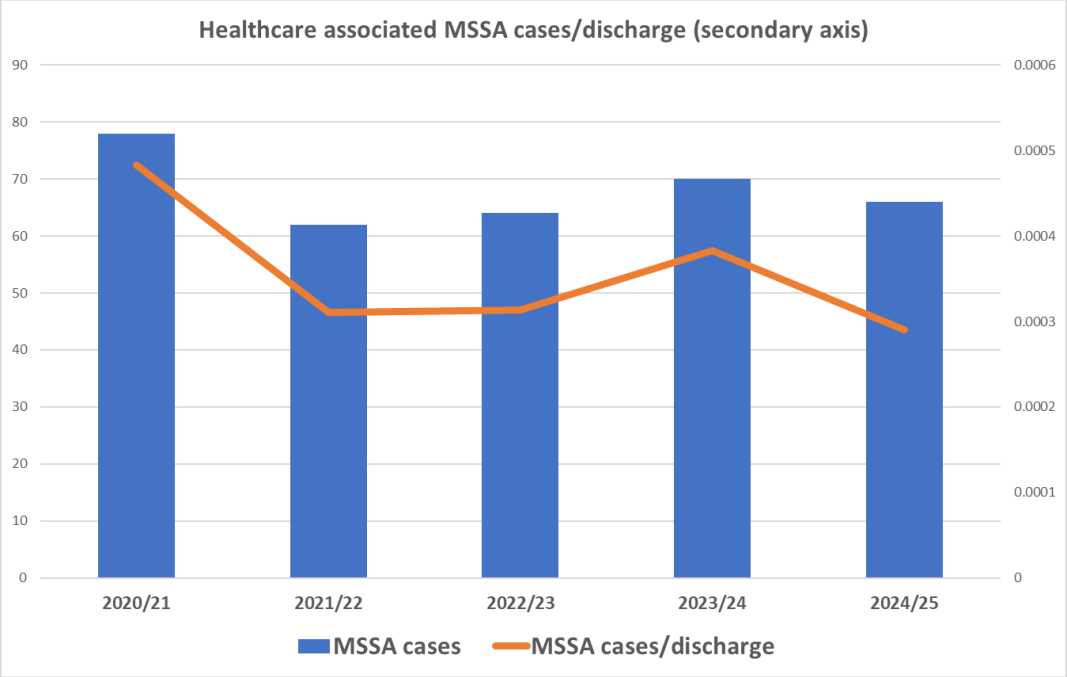
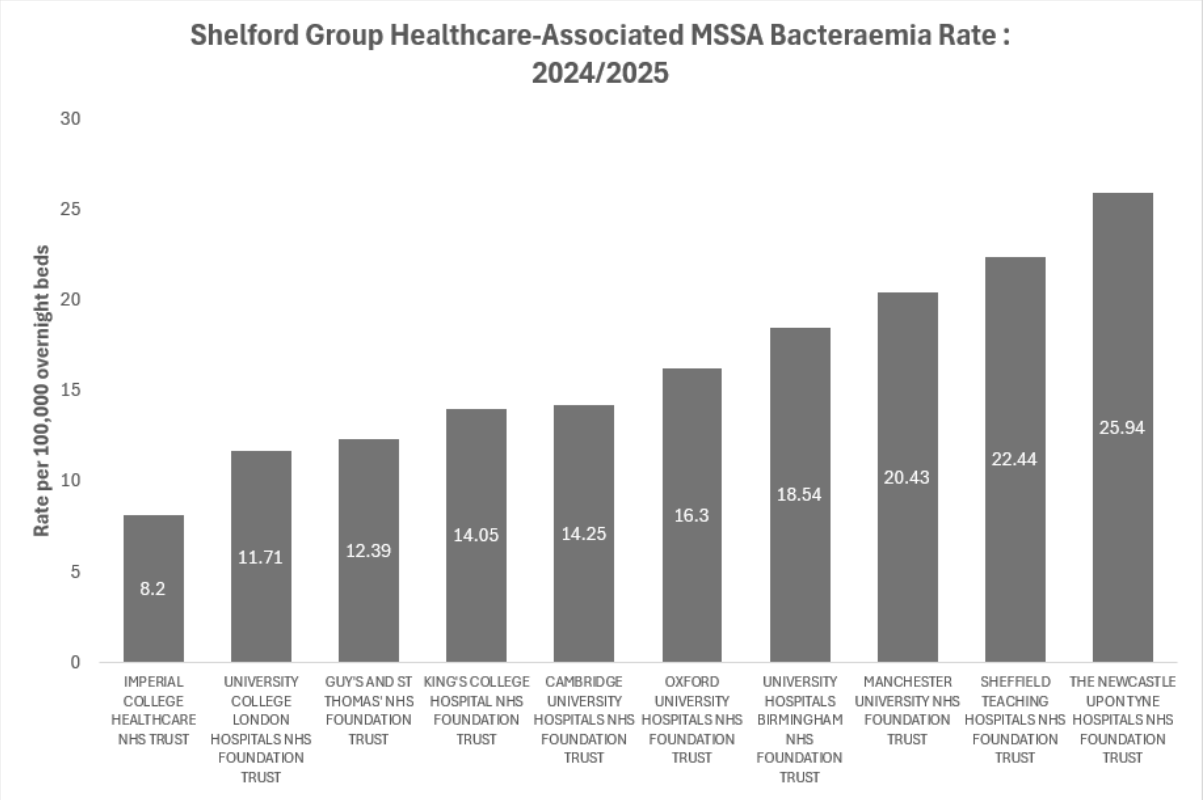


Table 10 shows OUH MSSA bacteraemia rate in comparison with the Shelford group of Trusts; our position has improved from 2023/24.

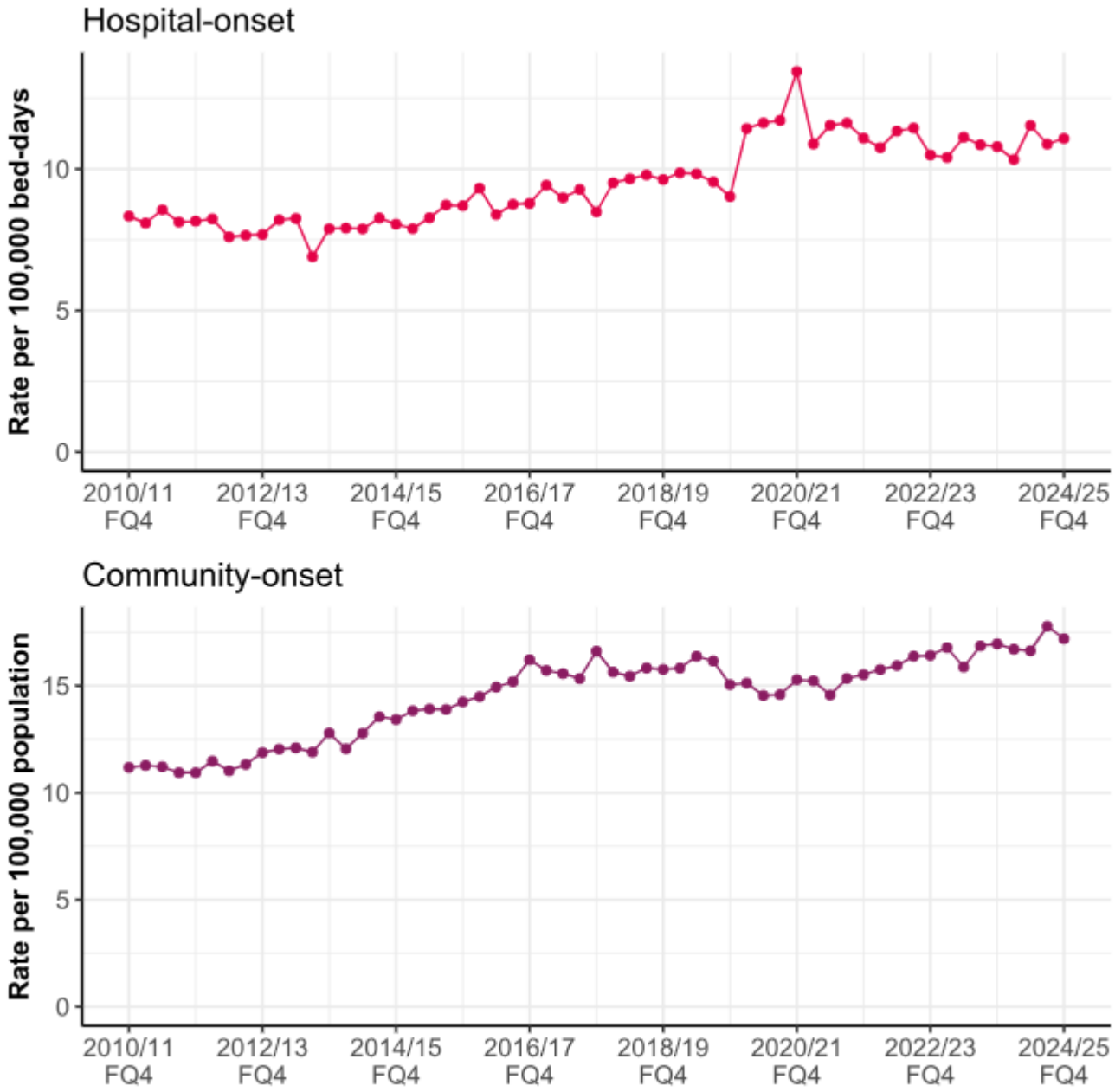
Table 10: Shelford Group Healthcare – Associated MSSA Rate 2024-25



National MSSA picture

Comparing the most recent quarter (October to December 2024) to the same period in the previous year (October to December 2023), hospital-onset MSSA bacteraemia cases increased by 1.0% and community-onset MSSA bacteraemia cases increased by 5.1% (Table 11).

Table 11: National MSSA picture Quarterly rates of hospital and community-onset MSSA bacteraemia cases, January 2011 to March 2025



2.8 **Gram Negative Bloodstream Infections**

The trajectories for Gram negative bloodstream infection were set in the NHS Standard Contract for 2024-25 at 5% less than the case count during the 12 months ending March 2024 (Table 12).

The OUH reported a total of 220 *E. coli*, 101 Klebsiella spp. and 63 *Pseudomonas aeruginosa* healthcare attributable blood stream infections in 2024-25, exceeding the trajectories set in the NHS Standard Contract.

There are no clear themes or interventions to reduce the rate of rise of healthcare associated Gram negative bloodstream infections. The changes

in patient demographics with an ageing population (18.6% of the total population were aged 65 years or older in the 2021 census compared with 16.4% at the time of the previous census in 2011) and more people at risk because of comorbidity or treatment such as immunosuppression are likely to contribute to an increase in cases. This has now been acknowledged in the National Antibiotic plan for 2024-29.

Table 12: Health care attributable Gram-negative blood stream infections for 2022-23,2023-24 and 2024-25

	Threshold 2024-25	Total Cases 2024-25	Total Cases 2023-24	Total Cases 2022-23
E. coli	165	220	173	208
Klebsiella	89	101	94	87
Pseudomonas	59	63	63	56

Table 13: SPC HOHA and COHA associated E. coli bacteraemia (April 2021-March 2025)

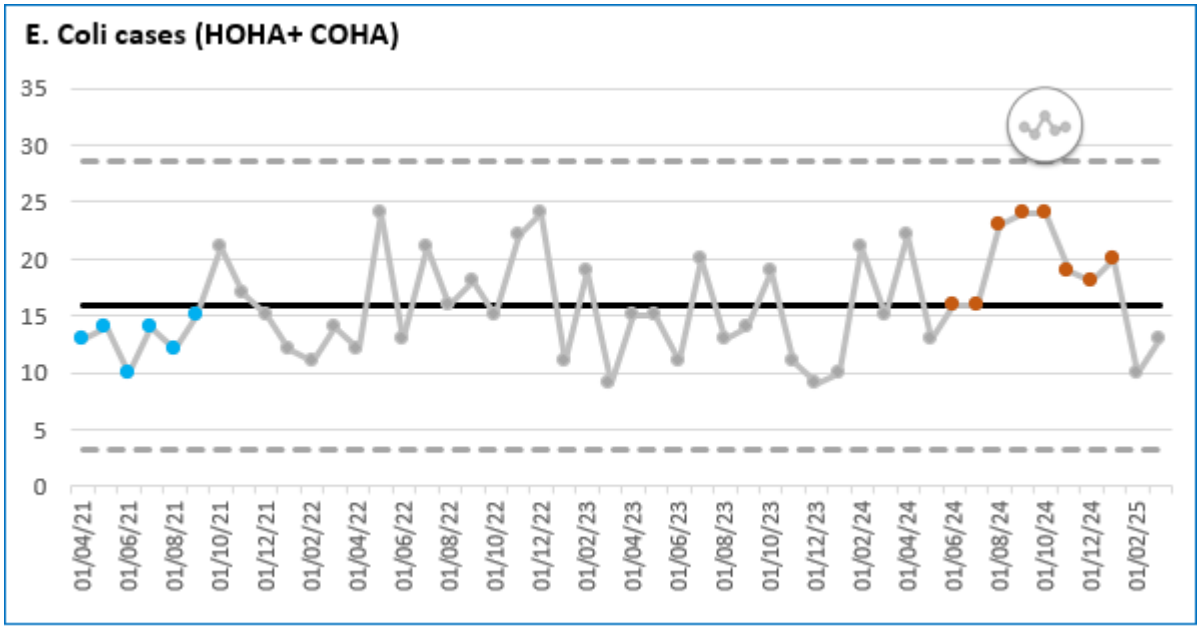


Table 14: SPC HOHA and COHA associated Klebsiella bacteraemia (April 2021-March 2025)

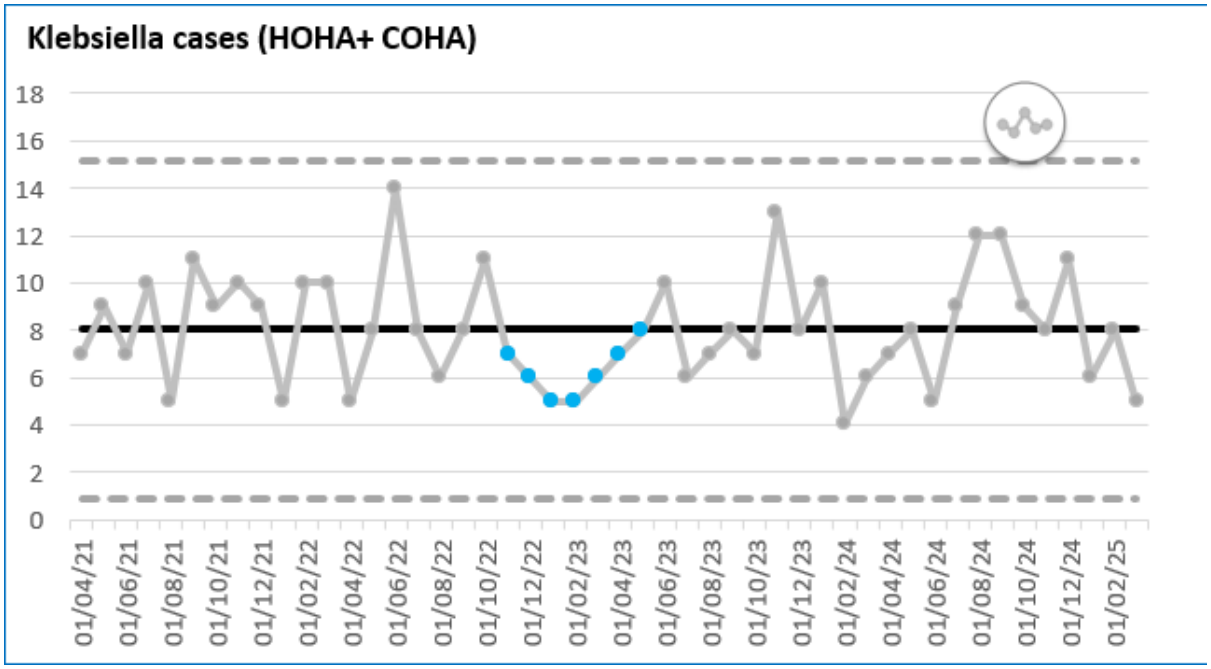


Table 15: SPC HOHA and COHA associated Pseudomonas bacteraemia (April 2021-March 2025)

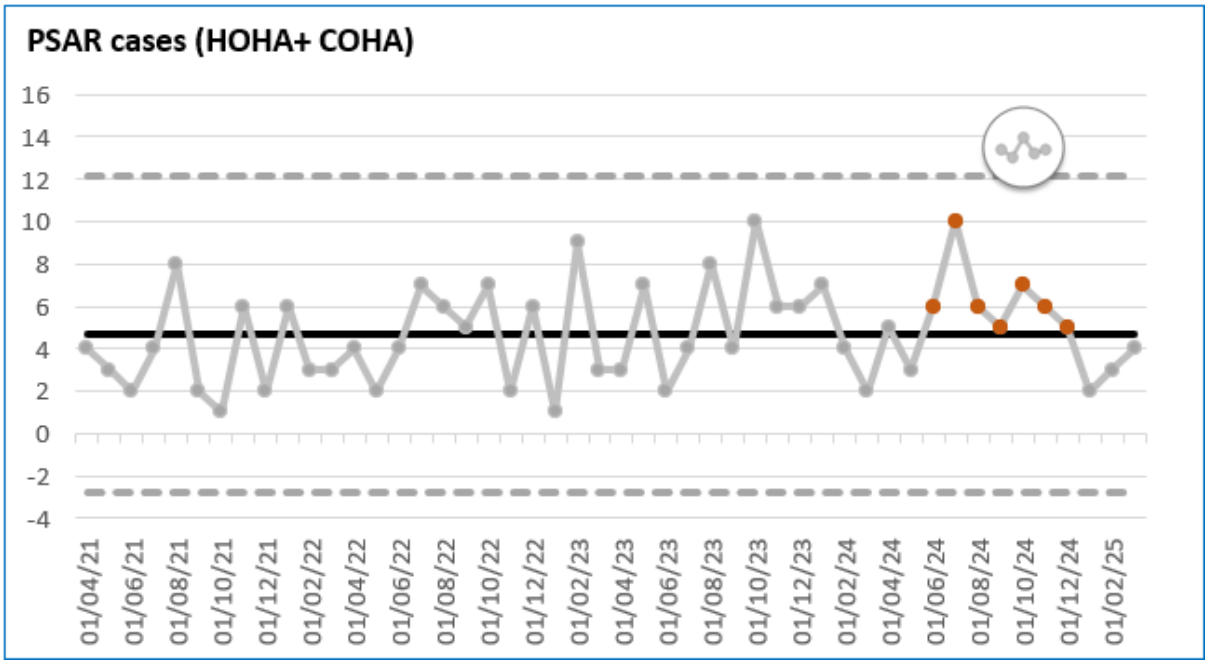


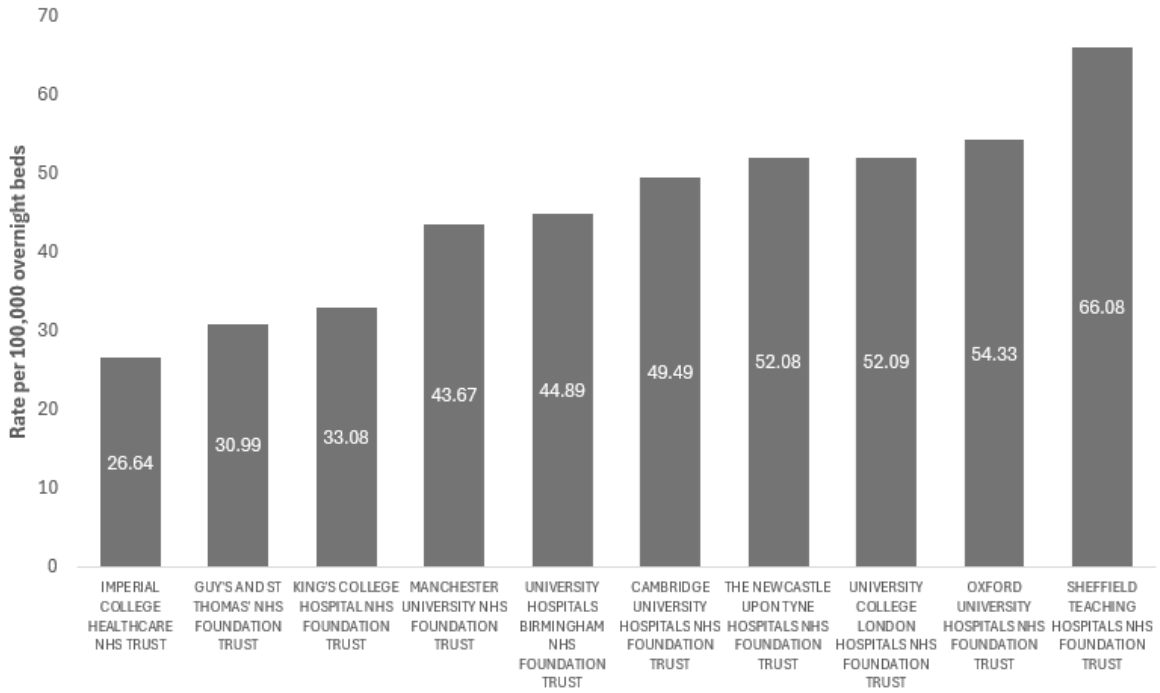
Table 16: Main Sources of Infection for Gram-negative Bloodstream Infections (HOHA)

	Unknown	Line / device	Gastro / Gut related	Other (eg chest)	Hepato-biliary	Urinary
Klebsiella	13	3	13	13	4	15
Pseudomonas	14	6	3	21	1	4
E.coli	19	6	22	18	18	34

Table 17: Main Sources of Infection for Gram-negative Bloodstream Infections (COHA)

	Unknown	Line / device	Gastro / Gut related	Other (eg chest)	Hepato-biliary	Urinary
Klebsiella	2	1	8	4	10	15
Pseudomonas	2	1	1	7	0	4
E.coli	20	2	7	16	12	46

Table 18: Shelford Group Healthcare–Associated E.coli Rate 2024-25. Oxford has the 9th highest rate out of 10 Trusts



2.9 *Clostridioides difficile* (C. difficile)

C. difficile review questionnaire is linked with Ulysses incident reporting. Community Onset Indeterminate Association (COIA) and Community Onset Community Associated (COCA) cases are reported on Ulysses in addition

to HOHA and COHA cases. COIA and COCA cases are investigated by the IPC team with contribution from clinical areas and the ICS as required.

C. difficile prior trust exposure categories:

hospital-onset healthcare-associated (HOHA): date of onset is greater than 2 days after admission (where day of admission is day 1)
community-onset healthcare-associated (COHA): is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the date of discharge)
community-onset indeterminate association (COIA): is not categorised HOHA and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date (where day 1 is the date of discharge)
community-onset community-associated (COCA): is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date (where day 1 is the date of discharge)

The trajectory for C. difficile infection in the NHS Standard Contract for 2024-25 was set at 5% less than the case count during the 12 months ending March 2024. The threshold for OUH apportioned cases of C. difficile for 2024-25 was set at 123 cases. OUH reported 164 cases (Table 19)

Table 19: Cumulative cases of OUH apportioned *C. difficile* (COHA and HOHA) per month (April 2024-March 2025)

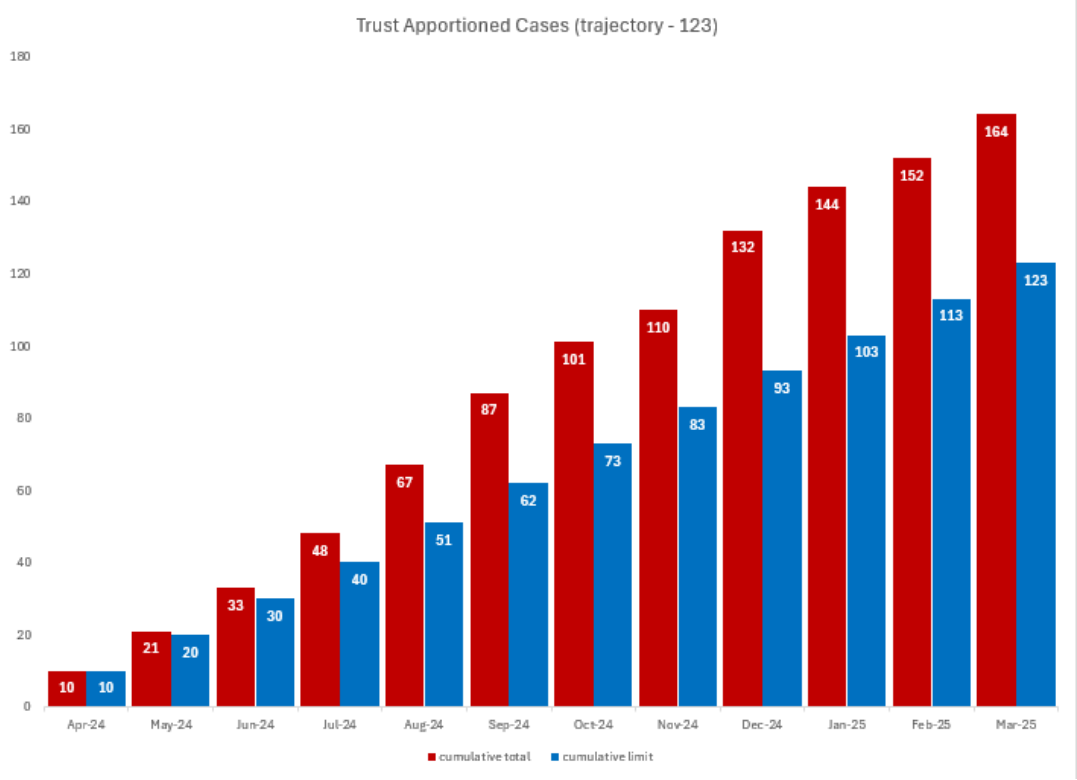


Table 20: Breakdown of C. difficile Healthcare associated cases by HOHA v COHA category (April 2024-March 2025)

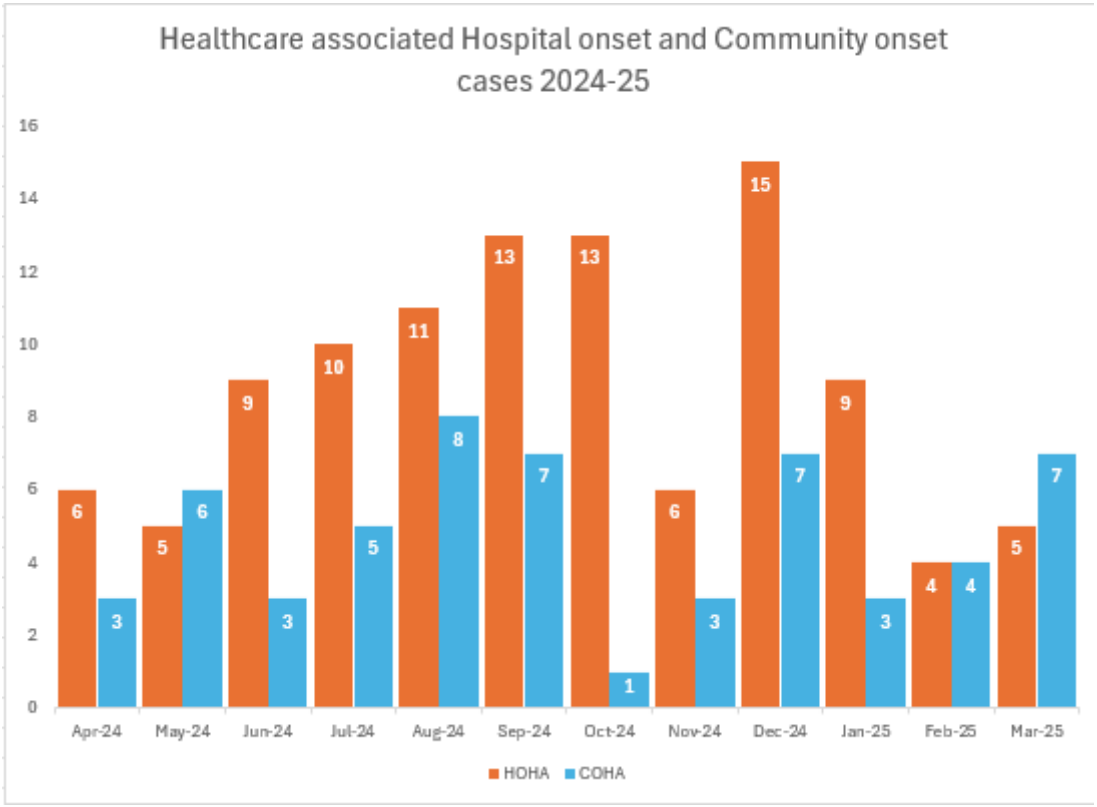
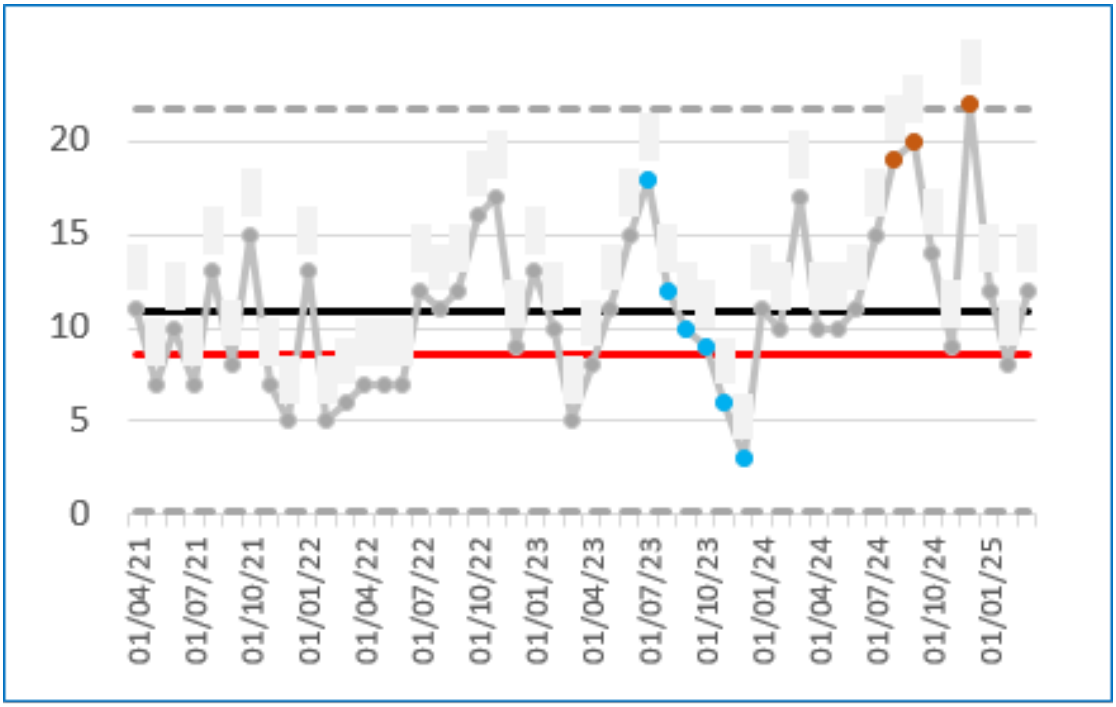


Table 21: Statistical Process Control (SPC) chart of HOHA and COHA C. *difficile* infection counts (April 2021-March 2025)



2.10 OUH compared to Shelford Hospitals

When comparing OUH to the Shelford groups, we are in the higher range of cases (Table 22).

Table 22: Shelford Group Healthcare–Associated C. difficile Rate 2024-25

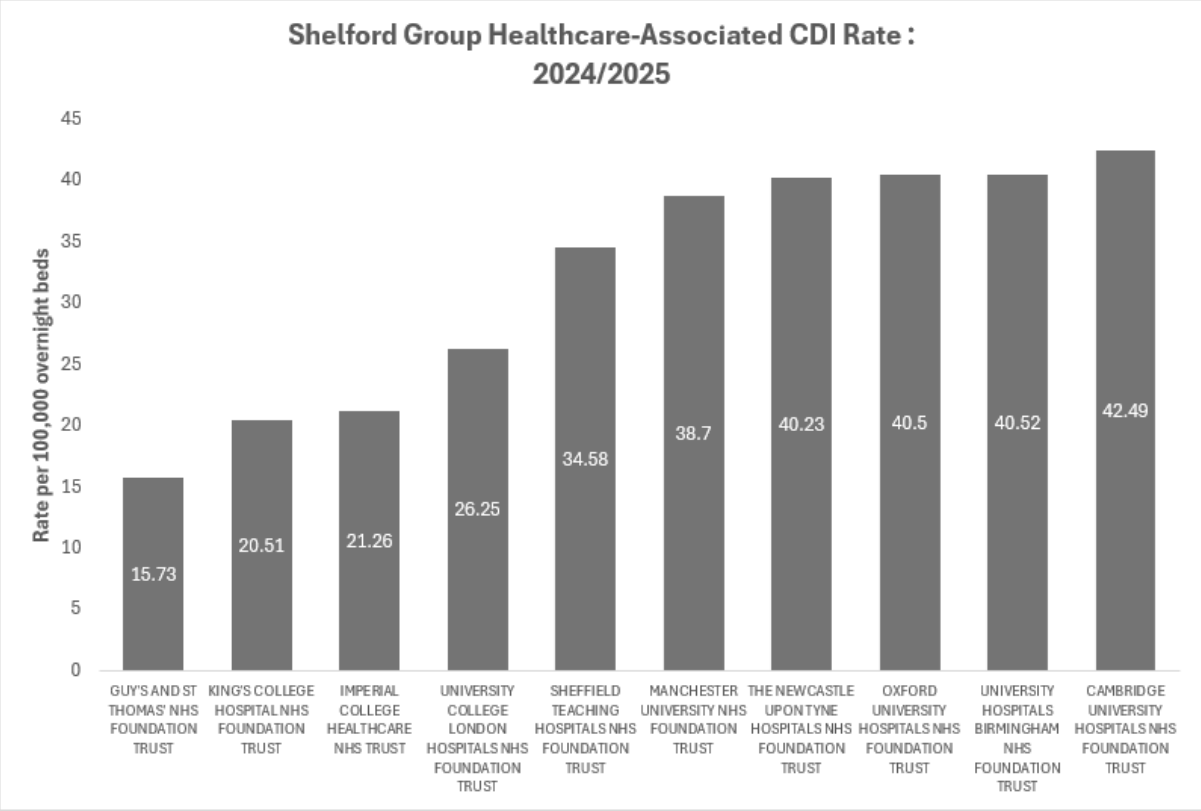


Table 23: Shelford Group Rates per 100,000 overnight beds 2021-25*. Eight out of 10 of the Shelford hospitals have seen a deterioration in the number of cases in 2024/25.

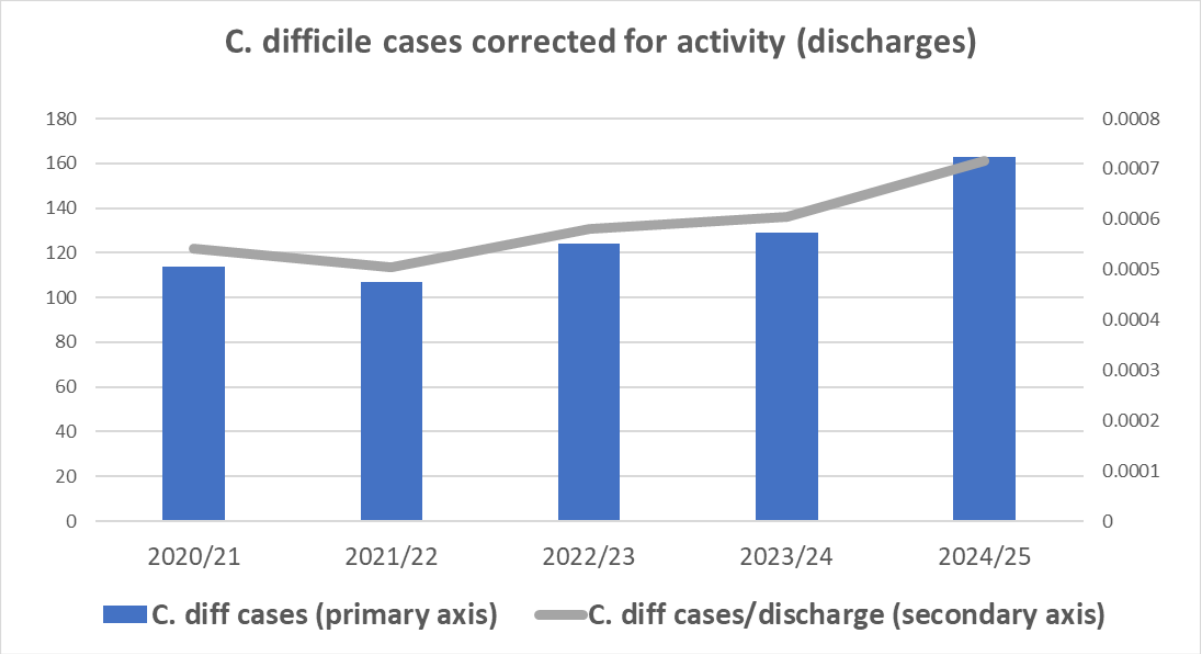
Organisation Name	2020/21	2021/22	2022/23	2023/24	2024/25
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	12.36	13.82	14.30	15.21	15.73
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	20.08	19.04	24.03	20.83	20.51
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	17.82	18.44	23.05	21.71	21.26
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	35.71	34.32	41.59	24.56	26.25
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	35.36	31.91	34.79	27.71	34.58
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	27.63	34.51	35.13	29.33	40.23
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	35.01	26.42	30.62	32.01	40.5
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	27.15	25.52	29.58	32.20	40.52

CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	21.99	31.61	33.42	36.69	42.49
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	30.31	27.55	27.14	36.85	38.7

*Green indicates improved performance and red worsening compared to previous year.

Table 24: OUH healthcare associated C. difficile cases corrected for activity (discharges)

Correcting the C. difficile data using discharges as a measure of OUH activity shows an increase in cases per episode of care in 2024/25.



C. difficile rates are rising nationally and the rate reported in England in March 2025 is the highest for 8 years (23.3 cases/100,000 bed days).

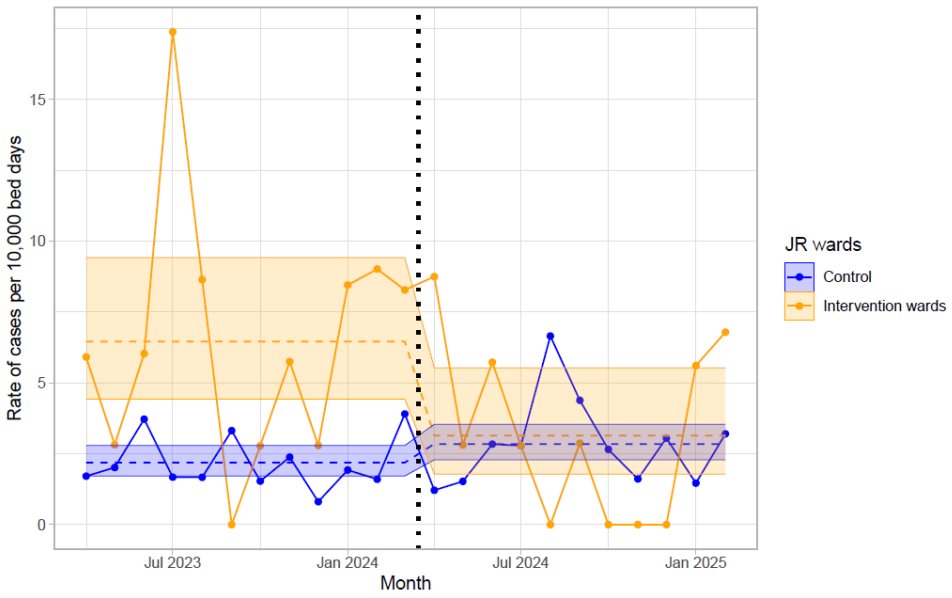
A C. difficile questionnaire is linked with Ulysses incident reporting. No major themes have been identified.

Proactive work continues in the OUH to minimise the occurrence of C. difficile infection including:

- Additional testing to identify those patients who are carriers of toxigenic strains but do not have C. difficile infection.
- Isolation of patients who are carriers of toxigenic strains as these patients can still transmit C. difficile.
- Pre-emptive treatment of patients who are carriers of toxigenic strains to reduce development of C. difficile infection and environmental contamination.

- Modification of antimicrobial guidelines to further reduce the empirical use of antibiotics such as Ciprofloxacin and Co-amoxiclav which have a stronger association with *C.difficile* infection.
- 7 day on-site infection prevention and control service, together with the 6 day antimicrobial stewardship (AMS) service which supports the microbiology team on a Saturday (see AMS section for further detail).
- Monitoring the use of antibiotics most likely to be associated with the development of *C. difficile* infection to support learning from C. *difficile* cases, and to guide which antibiotics to target on AMS rounds.
- Block booking of enhanced cleans to avoid missing enhanced cleans due to requesting.
- Questionnaire for C. difficile cases reviewed and updated to reduce time spent investigating and more on proactive work. A quarterly report from Ulysses is now available to identify themes more easily from completed questionnaires.
- A cleaning improvement project between the IPC team and medical wards at JR resulting in sustained improvement in cleaning scores. Data shows a reduction in C. difficile cases of 40% in intervention relative to control wards (p = 0.01) (Table 25). The intervention was in the wards with the highest rates of C. difficile - after the intervention rates of C. difficile in these wards went down to the lower rate usually seen in wards with lower risk patients. The IPC team plan to roll-out the intervention to other areas in the Trust 2025/26.

Table 25 Table shows the rate of C. difficile cases (y axis) per 10,000 bed days in the intervention and control wards.

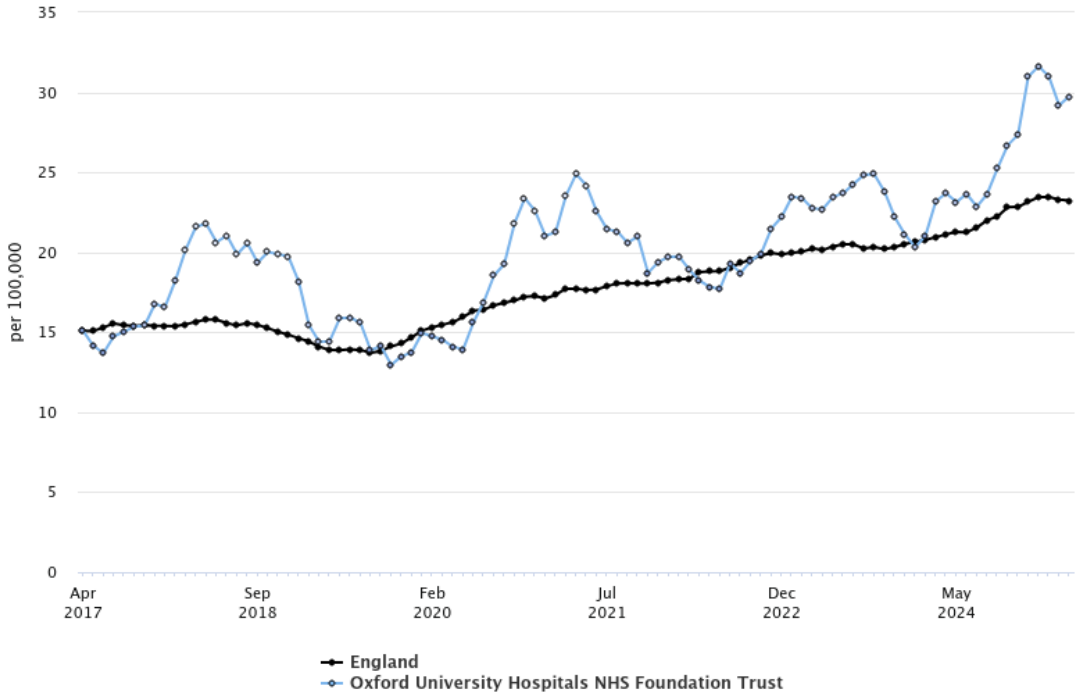


National C. difficile data

During the quarter October to December 2024 in England:

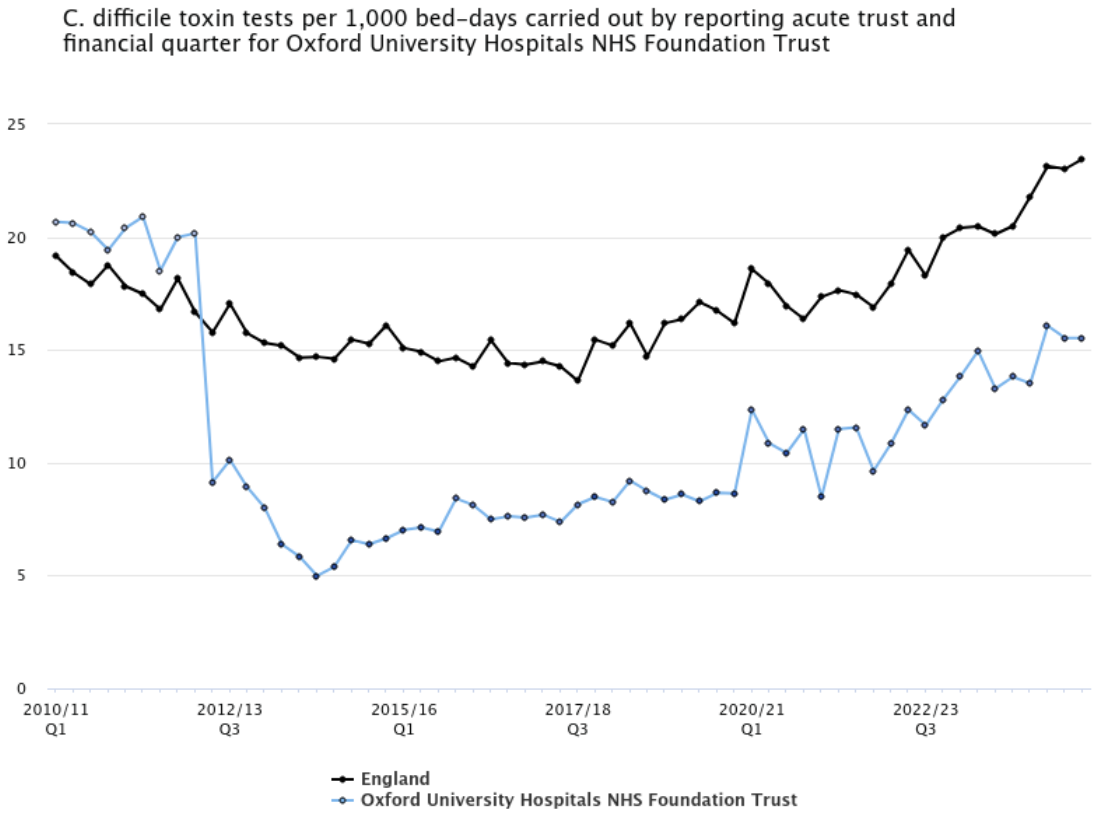
- there was a 13.7% increase compared with the same quarter last year and a 34.7% increase since the corresponding quarter in 2019
- both community- and hospital-onset rates have seen marked rises with community-onset rates increasing by 10.1% and hospital-onset rates rising by 17.7%.
- Table 26 shows the rising C. difficile rates in England as a baseline for the OUH data.

Table 26: C. difficile infection 12-month rolling counts and rates of hospital onset-healthcare associated cases for OUH



The number of stool samples processed in the OUH for C. difficile continues to increase in line with the national data over the last 4 years since the pandemic (Table 27). This includes samples from the community. This may be at least partly responsible for the local and national increase in cases (improved ascertainment).

Table 27: Number of stool samples processed for C. difficile by OUH Microbiology laboratory



2.11 Central Line Associated Bloodstream Infection (CLABSI) surveillance

Central Line Associated Bloodstream Infections (CLABSIs) are serious infections typically causing a prolongation of hospital stay, increased cost and risk of mortality. CLABSIs can be prevented through proper insertion techniques and management of the central line, using evidence based central venous line care bundles.

2.11.1 CLABSI surveillance in the Intensive Care Units

CLABSI surveillance is undertaken for all the intensive care areas by the IPC team. The CLABSI rate for all intensive care areas continues to be reviewed on a quarterly basis and results are fed-back to clinical units and Divisional governance leads.

In 2024-25 (Table 28):

- Rates in Neuro-ICU (NICU) Paediatric ICU (PICU), Cardiothoracic critical care (CTVCC) and Churchill ICU (CICU) have shown improvement.

- NICU had no episodes of CLABSIs for the last 3 quarters. Results are now well below the benchmark.
- An action plan has been implemented on newborn ICU (NBICU) in response to high CLABSI rates. Work has been done to re-establish line insertion and care bundles, and to discuss ANTT and audits.
- Churchill ICU (CICU) data continues to show the most variation due to lower patient numbers and line days than the other units.
- Cardiothoracic critical care (CTVCC) CLABSI rates continue to remain well below the benchmark.

Table 28: Annual CLABSI rates by ICU April 2018-March 2025, Rates are per 1000 line-days.

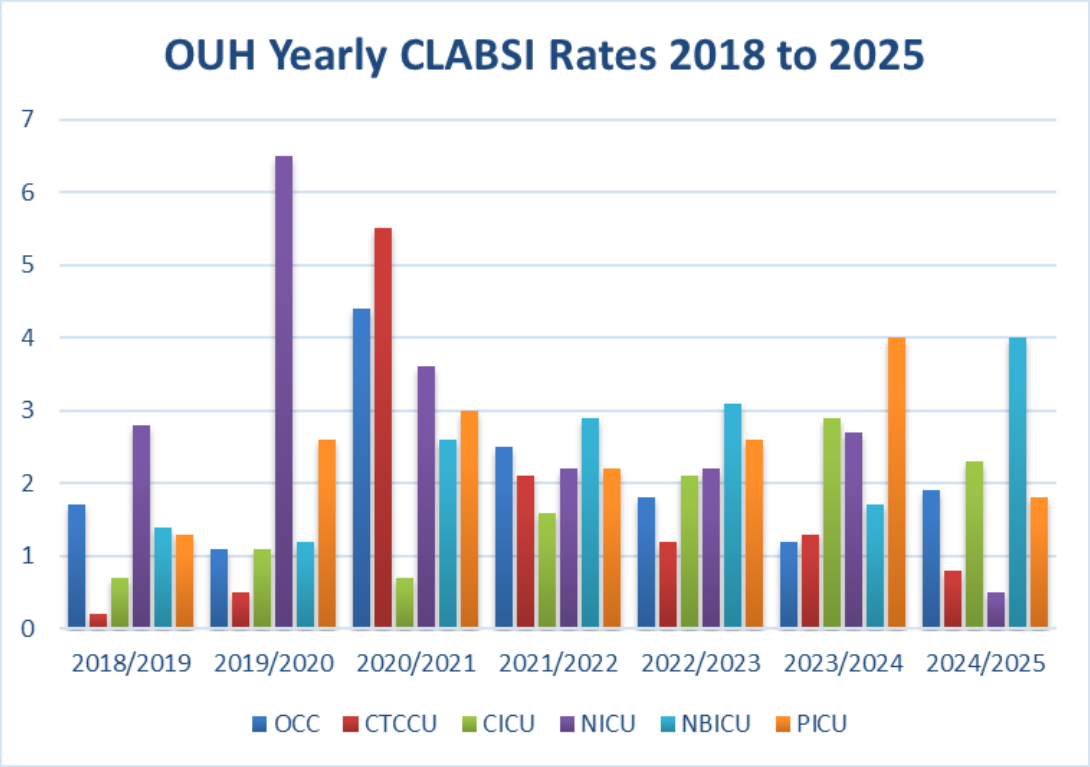


Table 29: Infection in Critical Care Quality Improvement Programme (ICCQIP) Benchmark for Intensive Care Areas

	OCC	CTCCU	CICU	NICU	NBICU	PITU/HDU
No of quarters in 2024/25 with data	4	4	4	4	4	4
Central line days	4265	3885	1745	1825	3961	2269
No of CLABSI	8	3	4	1	16	4
CLABSI/1000 central line days	1.9	0.8	2.3	0.5	4	1.8
Benchmark (ICCQIP) April 24 - Mar 25	1.3	1.3	1.3	1.3	1.5	0.5
Trend from 2023-2024	↑	↓	↓	↓	↑	↓

2.11.2 Trust wide non-ICU CLABSI surveillance

The IPC team continues to monitor Trust wide non-ICU Central line associated bloodstream infections (CLABSI) surveillance. This is a challenging dataset to maintain due to the large number of clinical departments using central venous access.

The definitions of HOHA and COHA as used for other healthcare-acquired infections reported in the Trust was not adopted for this surveillance as would exclude ambulatory encounters – many patients have long-term central venous access for dialysis or chemotherapy for example.

2.11.3 CLABSI prior Trust exposure categories for non ICU cases:

- Pre-48 hours: CLABSI identified within 28 hours of admission in a patient with a line already in situ and contact with OUH within last 28 days.
- Post-48 hours: CLABSI identified more than 48 hours after admission (NB line needs to have been in situ for > 48 hours).

The numbers of pre-48 hour cases remain fairly static, see table 30. Overall, during the financial year 2024-2025 in the OUH there have been 73 post-48 hour cases and 41 pre-48 hour cases. The areas of focus are the Haematology, Renal and Kamrans wards. This is in keeping with the high prevalence of central venous access, high complexity and clinical conditions cared for on these wards, which are associated with a higher risk of bacteraemia.

Data had not previously been reported in rates per 1000 line-days due to difficulty obtaining denominator data from the electronic patient record (EPR). We are now able to obtain denominator data and this has been utilised for the Haematology ward to present their CLABSI surveillance as a rate per 1000 line-days similarly to our ICU's, see Table 31. This shows that rates remain stable.

A QI project is underway on Kamrans ward to reduce incidence of CLABSI in collaboration with Paeds ID consultant and IPC team.

For the Renal ward, the Nephrology team with the IPC team identified areas for practice improvement. Dialysis line care and insertion protocols have been reviewed and protocols for skin decolonisation prior to line insertion have been developed for inpatients and outpatients.

Table 30 shows fluctuation over time for CLABSI rates on Haematology ward. The reduction in rates has not been sustained following the introduction of Biopatch in response to the spike in Q4 2022/23. A series of actions to improve practice on Haematology ward from Q1 2025, include awareness sessions for ANTT (aseptic non-touch technique), line

management, environment and hand hygiene and regular feedback to unit staff.

The IPC team will continue to monitor CLABSI trends to identify areas of concern and collaborate to reduce incidents of CLABSI.

Table 30: Trust-wide non-ICU CLABSI cases April 2024-March 2025

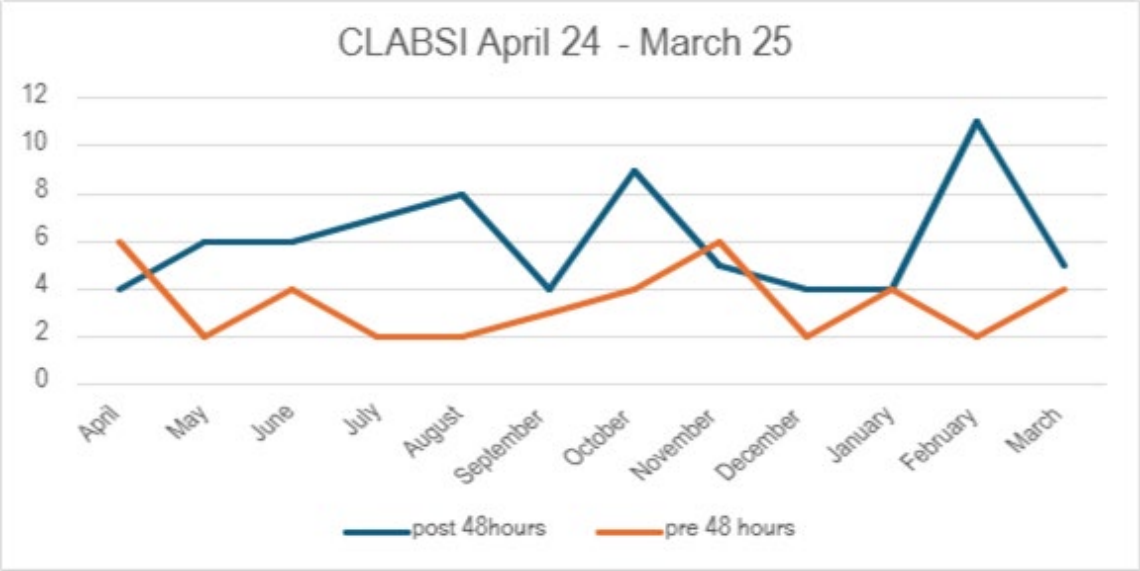
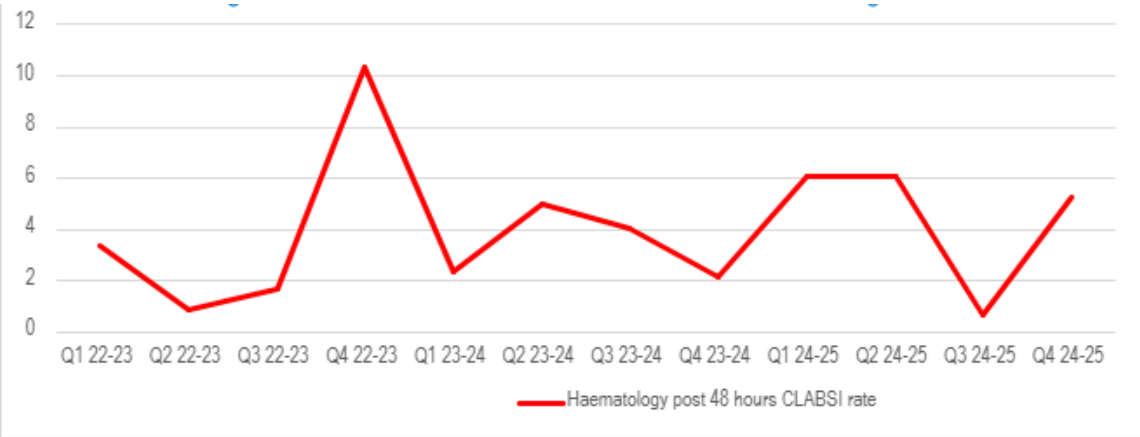


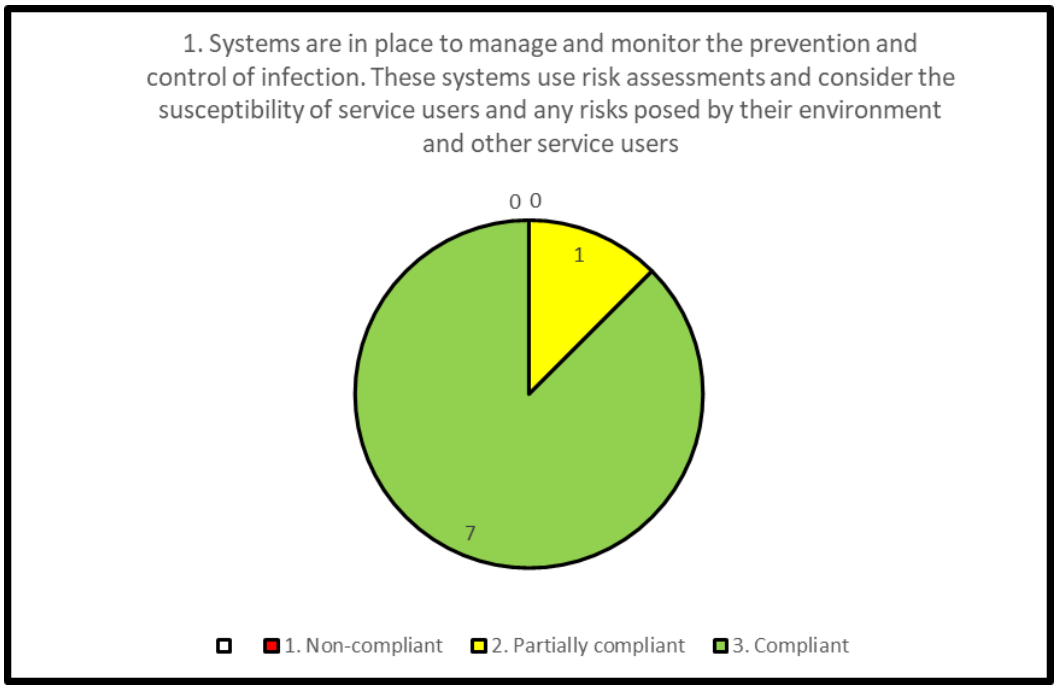
Table 31: Haematology CLABSI rates April 2022-March 2025 (rates per 1000 line days)



2.12 **IPC surveillance**

The company that supplied the surveillance system (ACMEipc) to the IPC team has ceased trading and the system is no longer available as the Microbiology laboratory has now switched to a new Laboratory Information Management system (LIMS) in March 2025, removing the interface. The Microbiology laboratory team are providing mitigation with daily reports for surveillance of organisms subject to mandatory reporting.

Figure 1: BAF Compliance to Criterion 1



Partial Compliant Elements of the BAF	Reason for Partial Compliance	Actions to Achieve Compliance
Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the National Infection Prevention and Control Manual.	The previous IPC surveillance system was withdrawn and now non-functional with the switch to a new LIMS removing the interface. The IPC team will therefore not be alerted to data for mandatory reporting or patients being admitted with infectious organisms or new results in real time. Some mitigation in place and others being developed. See Criterion 4.	Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support.

3 Criterion 2

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

3.1 Environmental IPC and decontamination

3.1.1 Water Safety Group (WSG) and Ventilation Safety Group (VSG)

The Trust's WSG and VSG meet quarterly. The IPC team are active members of both groups. Both safety groups are attended by the multidisciplinary team and our PFI colleagues. Compliance reports are produced by the Operational Estates team, and all the PFI partners. HIPCC receives reports from the Operational Estates team on water, ventilation, and environmental concerns. The Trust PFI office report on behalf of the PFI providers.

Churchill Cancer and Haematology Hospital

An ongoing issue with Legionella positive water samples at the PFI Cancer and Haematology Hospital on the Churchill site has been reported annually since 2018/9. This was first identified in 2015 when the Legionella risk assessment indicated hot water system circulation issues that are likely to date from construction (2009). It was recognised to be a systemic problem in September 2019 when increased surveillance showed continued presence of legionella widely within the water system. As a result, all water outlets in the Churchill PFI Cancer and Haematology hospital have had point of use filters (POUF) in place since 10 October 2019. POUFs ensure that water is safe at the point of use for both patients and staff. At the beginning of October 2019 prior to completion of POUF installation there was a single confirmed case of legionella infection in a patient who died. The timeline of events was consistent with a hospital acquired infection. Engineering works to manage this situation and provide a safe water supply have been ongoing since 2019 and have been managed via the Serious Incident Requiring Investigation (SIRI) process.

Water sampling continues to yield positive Legionella samples in the Churchill PFI building but counts are now falling; however the sampling schedule has not changed since prior to the engineering works. The root cause was thought to be a failure to maintain the flow of hot water, with cooler temperatures supporting growth of Legionella. The engineering solution has been completed this year with progress being monitored by the Extra-ordinary Water Safety Group. There is now a period of surveillance of hot water temperatures and continuing routine Legionella sampling. The POUFs remain in place.

The SIRI action plan has not yet been completed; at the beginning of April only 7 out of 21 actions have been signed off as complete by the Investigating Officer. A number of key documents are yet to be provided by the subcontractor, G4S, and then will need to be approved by the Trust Water Safety Group. At present, the WSG are unable to agree to the removal of the POUF. The Board are aware of the current lack of progress

in relation to the outstanding actions, and action has been taken to escalate the issue with the subcontractor.

Whitehouse Renal Dialysis Unit

Elevated levels of total viable counts (TVC) of organisms (not Legionella, Pseudomonas, E. coli or coliforms) are still present dating from the commissioning water testing for the new Whitehouse renal dialysis unit in Milton Keynes in 2023/24. POUFs remain in place on all outlets.

The Trust rent this building from Milton Keynes Council which adds a layer of complexity as there are also other tenants in the building. Temperature monitoring data showed that the cold-water supply is not in temperature range and this has been raised to Milton Keynes Council.

Engineering work has taken place to install Kemper valves to improve the turnover of the water and servicing of the taps has taken place. Further work is due to take place in 2025/26 and OUH are now undertaking the water sampling rather than Milton Keynes Council.

Ward 5C/5D

Since the commissioning of Wards 5C/5D at the JR, there has been an on-going issue with positive outlets for Pseudomonas. Pipework installation, observation of practice on the ward (cleaning, and use of sinks for water disposal) and maintenance standards have been reviewed.

Estates have conducted remedial work such as chlorination and changing taps and spouts. Additionally inline thermal disinfection units have been installation.

The number of outlets with high TVCs has reduced following the remedial work. POUFs remain in place on all positive outlets.

IPC and estates teams continue to meet with Ward 5C/D teams to raise awareness on the management of little used outlets.

3.1.2 Decontamination

The Decontamination Committee meets quarterly and covers decontamination in Sterile Services, endoscopy, decontamination of medical devices and patient equipment cleaning. This committee reports to HIPCC. There have been no major decontamination incidents to report this year.

An audit of semi-invasive and invasive ultrasound probes was carried out across the Trust between June 2023 and December 2024. In total 36 different departments were audited with the aim of verifying compliance with decontamination and assessing staff knowledge and competencies.

Following the audit an action plan was put in place to support creating and implementation of standard operating procedures for decontamination of ultrasound probes

The development of Trust wide ultrasound decontamination policy is in scope for 25/26.

3.1.3 Cleaning

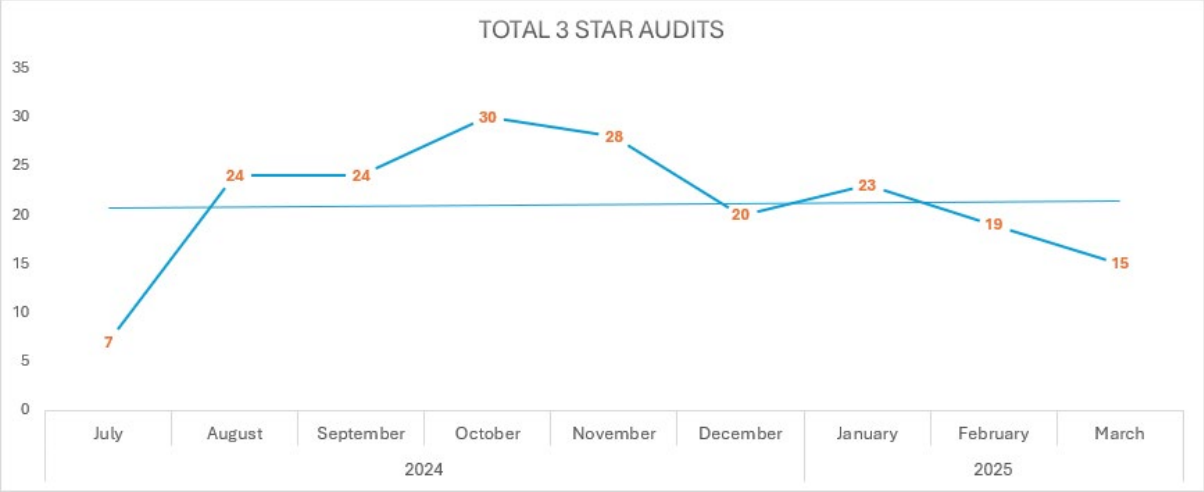
The National Standard of Cleaning has been implemented across the organisation. The IPC team, including the Clinical Decontamination Practitioner participate in cleaning audits as required. *My Audit* was introduced in July 2024 replacing the previously used Synbiotix platform for conducting cleaning audits. This new platform provides more reporting and analysis functionality and increases the coverage of rooms audited.

HIPCC receives a report from the Trust PFI office, reporting by exception those areas that have a low star rating and action plans to resolve concerns. IPC also receive an alert if an inpatient area has a 3-star rating or less. The top 7 areas with recurring 3-star rating are found in Table 32, Paediatric Critical Care (housed in Oxford Critical Care L3) and neonatal unit remain a concern. Of note using the My Audit platform data, the total number of 3-star or less audits is tracked and noted to be reducing, see Table 33.

Table 32: Locations with highest number of 3 Star or less audits, July 2024-March 2025

Row Labels	No of 3 Star or few audits
Blk 41 - PFI - Theatres (1 to 6)	17
Blk 244 Oxford Critical Care L3	10
Blk 41 - PFI - Theatre 7 and 8 (Mayfair Theatres - Ground Floor)	8
Blk 244 Oxford Critical Care L2	7
Blk 41 - PFI - Theatre Recovery Area	6
Blk 105 - PFI Transplant Ward	6
Blk 06 - Neonatal ICU	6

Table 33: Total number of 3 star or less audits, July 2024-March 2025

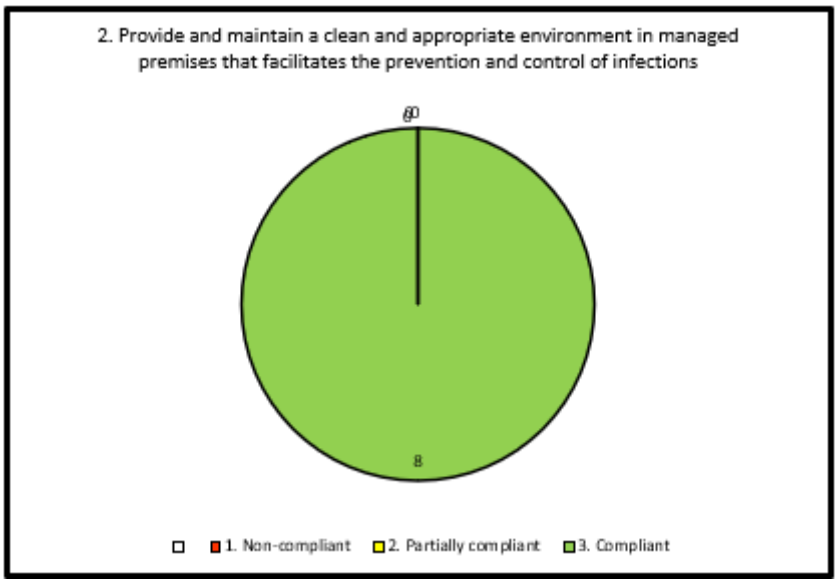


3.1.4 Neonatal Unit Estate

The neonatal unit has experienced intermittent outbreaks over the last three years including neonatal colonisation with extended-spectrum beta-lactamase (ESBL) producing Gram negative bacteria. Issues with the estate remain a particular concern. An action plan to facilitate an improvement in IPC on the unit is in place. A number of actions have been completed, including the purchase of new incubators, repair of the HDU flooring and creation of an incubator cleaning room. The more complex actions relating to the estate such as provision of a sluice and storage solutions, have yet to be undertaken. Work on creating an improved facility for decontamination of incubators will take place in May 2025.

The outbreak is discussed in more detail under Criterion 5.

Figure 2: BAF Compliance to Criterion 2



Partial Compliant Elements to the BAF	Reason for Partial Compliance
N/A	

4 Criterion 3

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

4.1 Antimicrobial Stewardship

In May 2024 a new National Action Plan (NAP) for Confronting Antimicrobial Resistance (AMR) was issued which will remain in place 2024-2029. The NAP has four themes, with themes 1 and 2 discussed in this section.

Theme 1 - 'Reducing the need for, and unintentional exposure to, antibiotics' includes IPC, public engagement and national surveillance of antimicrobial resistance patterns. The AMS team works closely with the IPC team to help reduce unnecessary exposure to antimicrobials. The AMS team also contributes to surveillance programs both locally and nationally.

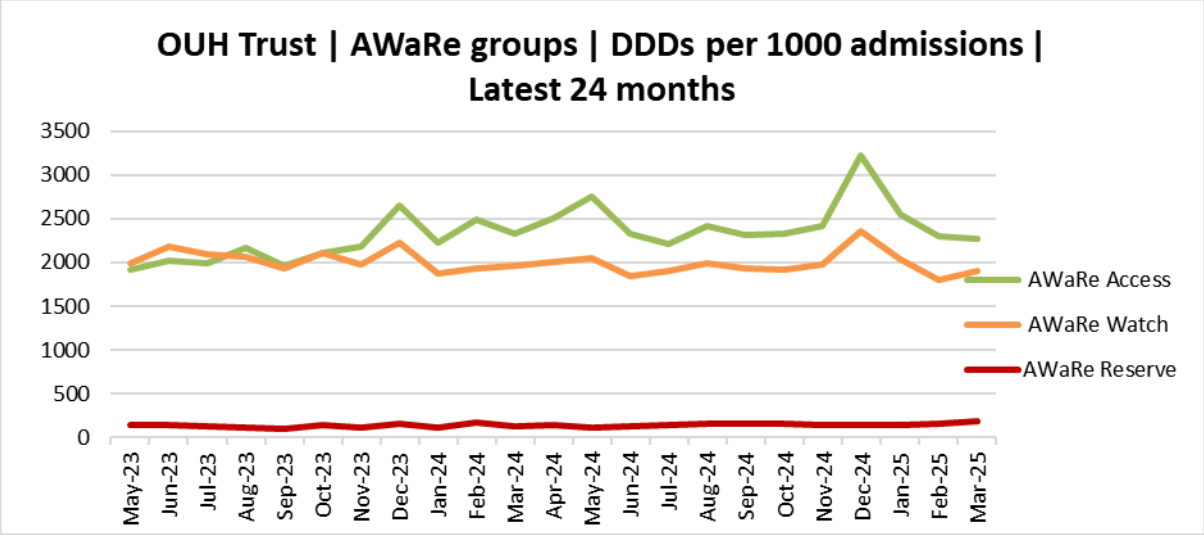
Theme 2- 'Optimising the use of antimicrobials' has an aim around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. This is one of the main objectives of the AMS team and the team are continuously introducing new initiatives to optimise antimicrobial use. Several of these initiatives are discussed below. No specific reduction has been set.

The World Health Organisation (WHO) uses the AWaRe (Access, Watch, Reserve) classification of antibiotics as a tool for monitoring antibiotic consumption. This classification categorises antibiotics into three groups - Access Watch and Reserve - based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare associated infection such as C. difficile Infection (CDI).

In 2023-24 the NHS National Contract in England specified a Trust target of a 10% reduction in consumption of antibiotics in the "Reserve" and "Watch" categories from the WHO AWaRE classification (adapted) against a 2017 (calendar year) baseline value. At the time of preparing this report, formal data from NHS England is only available up to the end of Q3 2024-25. The data showed that OUH has a 20% reduction in use of "Watch" and "Reserve" antibiotics against the 2017 baseline value. This shows that the Trust has made significant reductions in consumption of these antibiotic categories over the last financial year. For comparison the reduction reported at end of Q4 23-24 was 8.7%. The finalised data for 24-25 will be available later this year.

The consumption of antibiotic in the “Reserve, “Watch” and “Access” categories are monitored by the Antimicrobial Stewardship (AMS) Team and reported in their quarterly report to Hospital Infection Prevention and Control Committee (HIPCC). This is shown below in Table 34. Defined Daily Doses (DDDs) are used to measure consumption. The plot shows an increase in the use of “Access” antibiotics with a reduction in “Watch” but similar usage of “Reserve” antibiotics over time.

Table 34: Consumption of “Watch”, “Access” and “Reserve” antibiotics over time

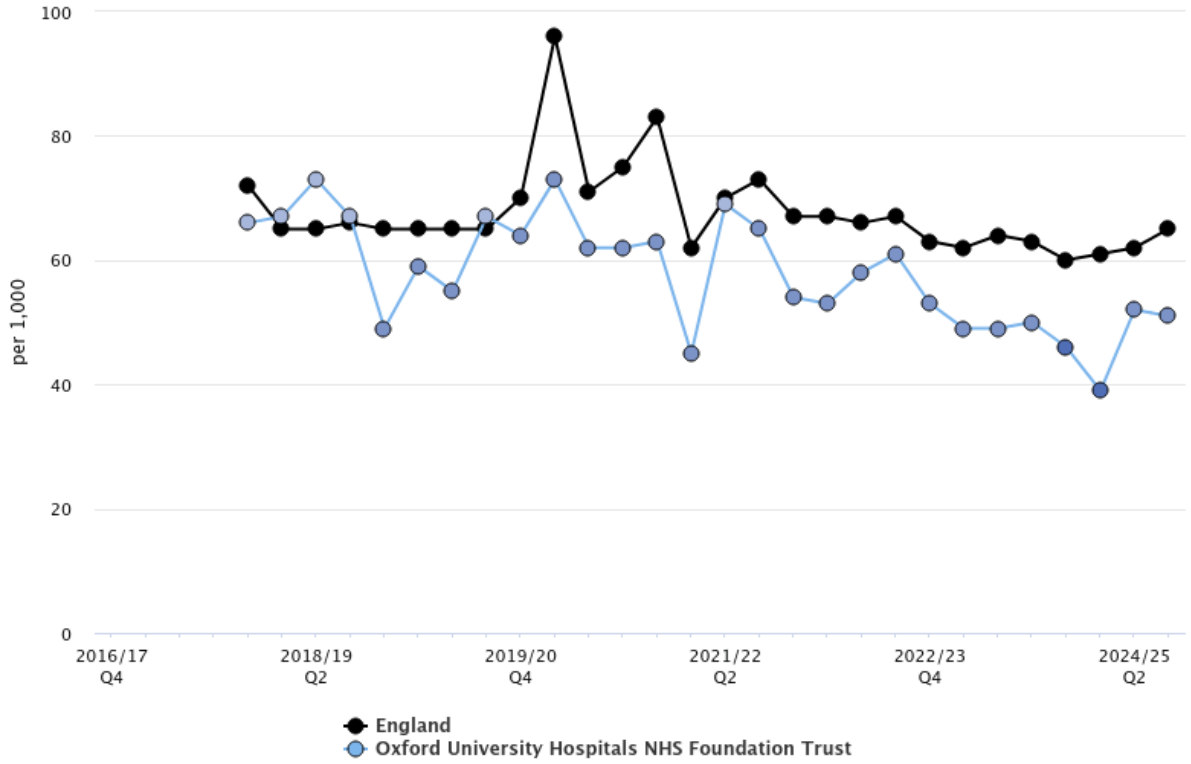


AMS activities during 2024-2025 which contributed to these changes in consumption were:

- Continued implementation of a 6 day AMS service (including adults, paediatrics and neonates) with positive feedback from clinical teams. The AMS team are recognised as part of the core weekend Micro service and support developing treatment plans for infection management, review antimicrobial TDM results and dosing, review broad spectrum antibiotic use, conduct a treatment review of patients with C. difficile and attend the microbiology ICU ward round.
- AMS ward rounds (discussed below).
- Use of data: the Orbit plus dashboard for AMS shows antimicrobial consumption at divisional, directorate and speciality levels as well as consultant level data. The dashboard has been refreshed and relaunched during 2024 and early 2025. Clinical teams are utilising this data to support their own AMS initiatives and identify areas for improvement.
- Providing AMS metrics for the monthly divisional reports to HIPCC which show the divisions consumption of antibiotic in the “Reserve, “Watch” and “Access”. These metrics have facilitated engagement from divisions with the AMS strategy for OUH.

- Education for clinical teams and divisions about their prescribing practice and consumption, including audit and individual feedback.
- Updating prescribing tools – Guidelines were reviewed and updated to reduce the use of ‘Watch’ and ‘Reserve’ antibiotics e.g. review of urology guidelines, urinary tract infection guidelines and skin and soft tissue infection guidelines.
- The AMS team support the IPC team in the Trust’s approach to preventing and managing C. difficile infection. Activities include monitoring use of antibiotics most likely to be associated with the development of C. difficile infection to support learning from C. difficile cases, including carbapenems (Table 35). The AMS team also conduct a review of medications within 24 hours of confirmation of a C. difficile infection to optimise the patient’s care.
- Carbapenems are “Reserve” broad spectrum antibiotics. Infections caused by organisms resistant to carbapenems have high mortality hence there is a global priority to reduce inappropriate exposure to carbapenems. Previously there have been CQUINs related to reducing the use of carbapenems and usage continues to be a key indicator monitored by UKHSA. The AMS team continue to undertake activities to optimise the use of carbapenems and Department of Health data (Table 35) shows that OUH use is falling and remains below the England average.

Table 35: Carbapenem prescribing DDs per 1000 admissions: by quarter and acute Trist for OUH. Graphs show that OUH prescribes carbapenems below the overall England rate.



The AMS team respond to MHRA Drug Safety Alerts. In January 2024 there was an alert regarding 'Fluoroquinolone antibiotics: must now only be prescribed when other commonly recommended antibiotics are inappropriate'. In 2024/25 the team completed work to create a position statement for the use of Fluoroquinolones in OUH, review antimicrobial guidelines (adults and paediatrics), review stock lists and ensured that there is access to Patient Information Leaflets when patients are prescribed fluoroquinolones. The team also implemented daily reviews (6 days a week) of fluoroquinolone use to ensure appropriate use of these antibiotics. This work was presented as two posters at the European Society of Clinical Microbiology and Infectious Diseases conference 2025.

4.1.1 Antimicrobial Stewardship Multidisciplinary Team ward rounds

Antimicrobial Stewardship (AMS) Multidisciplinary Team (MDT) ward rounds are conducted on a weekly basis. The rounds consist of pharmacists, nurses and infectious diseases clinicians who review patients on broad spectrum antibiotics. During the AMS MDT ward round interventions are made and the nature of which are recorded.

Currently AMS MDT ward rounds are carried out regularly in the following areas:

- Haematology-Oncology
- Churchill (excluding ITU and renal transplant, conducted separately)
- JR West Wing (excluding neuro-ITU, conducted separately)

- Horton (adults)
- Paediatrics at JR
- Neonatal unit
- Paediatric Intensive care
- Horton paediatrics
- Oxford Critical Care Unit conducted separately
- Cardio-thoracic Critical care conducted separately
- Pilots: Surgical admission unit at JR.

Table 36 shows the number of ward rounds, number of patients reviewed, number of interventions suggested during the ward rounds and percentage of those interventions that were actioned between April 2024 and March 2025.

	Number of ward rounds	Number of patients reviewed	Number of interventions	% of interventions actioned
Q1	88	1049	700	79.5
Q2	91	1193	813	76.6
Q3	85	1214	865	77.1
Q4	80	1270	906	75.1
Total	**344**	**4726**	**3284**	**77**

The AMS team had a paper published in the Journal of Infection (2025): “The impact of antimicrobial stewardship ward rounds on antimicrobial use and predictors of advice, uptake, and outcomes”. The conclusions were that multidisciplinary AMS ward rounds reduced antibiotic use and reduced length of hospital stay by 0.6 days if the suggested intervention is followed; senior clinician input and more AMS experience increased advice uptake. The team won the research category of the Antibiotic Guardian awards 2025 for the work that they have undertaken related to the AMS ward rounds.

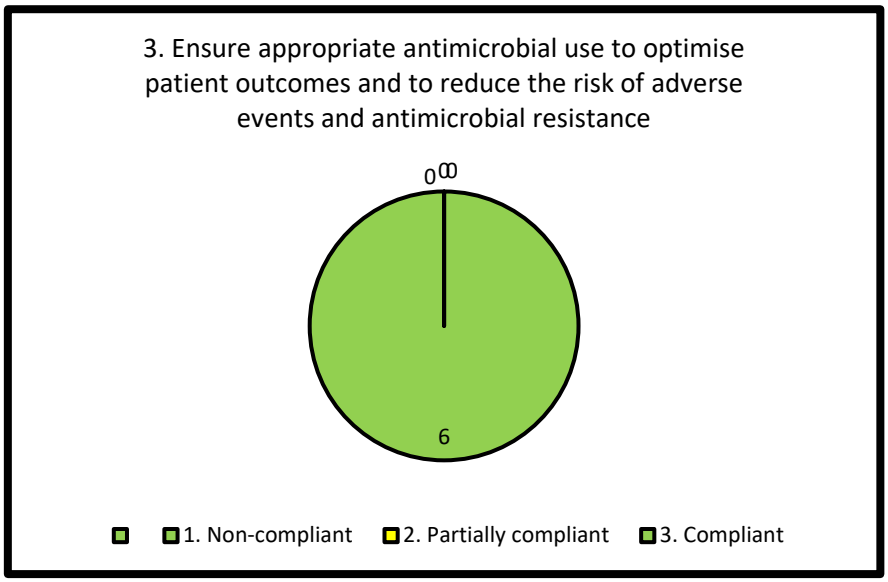
4.1.2 Penicillin de-labelling

The AMS team provide support for penicillin de-labelling, suggesting patients who may be suitable as part of their AMS ward rounds. Many people labelled as allergic to penicillin are not truly allergic, and being labelled can limit treatment options with potentially more effective or narrower spectrum antibiotics. The de-labelling is performed by the clinical staff on the ward. A protocol to support patient assessment and safe de-labelling is available nationally and in Trust antimicrobial guidelines. Data collection on de-labelling is complex; the figures below are for 2024-25, and are minimum figures with the margin for error in brackets.

280 de-labelling prescriptions on EPR (up to +77)

180 patients with associated de-labelling on EPR (up to +102)
110 patients successfully de-labelled (up to +70)

Figure 3: BAF Compliance to Criterion 3



Partial Compliant Elements to the BAF	Reason for Partial Compliance
N/A	

5 Criterion 4

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

5.1 Provision of Information

The IPC team take an active role in promoting patients, staff, and visitors' safety, for example, working with the communications and media team on visual material, and the procurement team on supplies of Personal Protective Equipment (PPE) where required.

We work closely with the Chief Nursing Officer's team on the visitor policy and assessing the risk of potential nosocomial transmission for all infections, keeping in mind national guidance, and being compassionate.

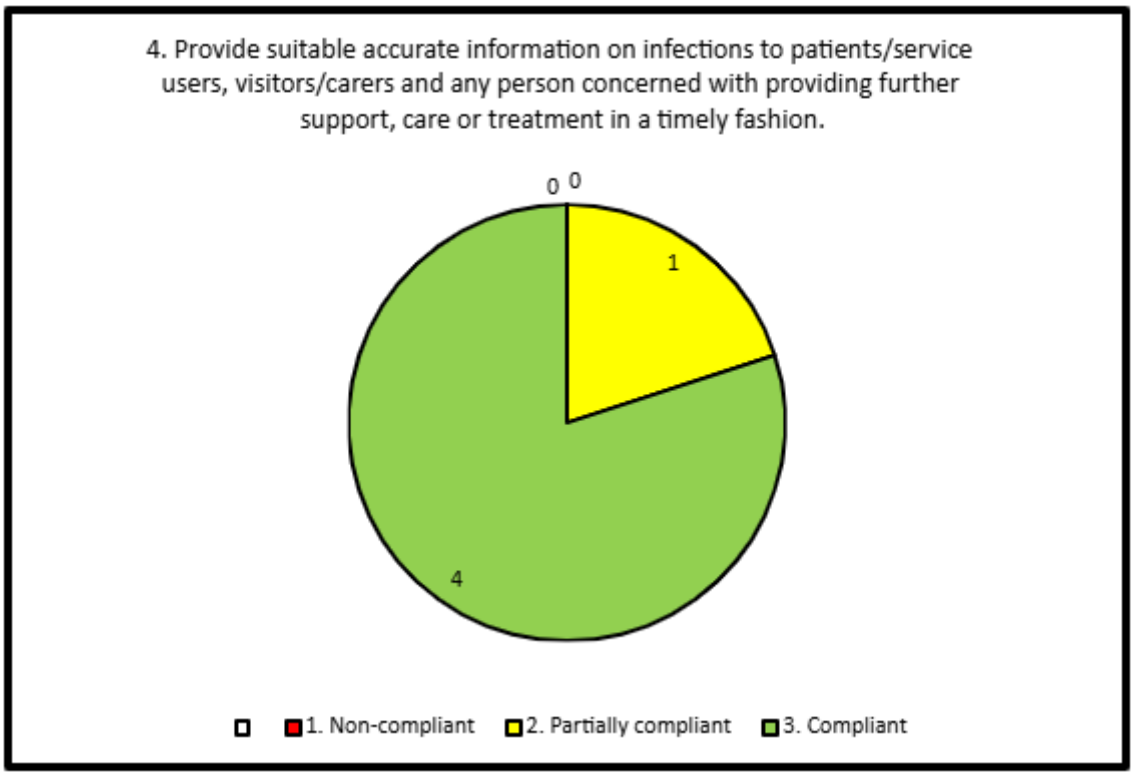
Clear signage is used in clinical areas to inform visitors, clinicians and other health care workers of infection prevention and control issues eg at entrance points to wards and side-rooms.

The Trust comms team use the external website (Home - Oxford University Hospitals) and social media (Facebook, X, Bluesky, Instagram and Threads) in the event of needing to provide urgent information on operational issues including IPC to service users/patients and visitors.

NHSE patient information leaflets and provision of links to 'NHS choices' are used for providing information to patients. The Buckinghamshire Oxfordshire and Berkshire (BOB) ICS IPC group have also produced patient information leaflets.

The Trust uses an Inter-Healthcare Infection Prevention & Control Transfer Form to provide information on infection risk to other providers.

Figure 4: BAF Compliance to Criterion 4



Partial Compliant Elements to the BAF	Reason for Partial Compliance	Actions to Achieve Compliance
Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	No IPC surveillance system in place. Previous system was shared with Oxford Health and will therefore not be able to share relevant information across organisational boundaries.	Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support.

6 Criterion 5

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

6.1 Infection Prevention and Control Surveillance Software

The company that supplied the IPC surveillance system (ACMEipc) to the infection prevention and control team (IPCT) has ceased trading. This system was also used by Oxford Health.

The risk of a lack of real-time IPC surveillance to support the minimisation of avoidable healthcare associated infection has been added to the risk register and escalated to relevant parties.

The Microbiology laboratory team have implemented the new Laboratory Information System (LIMS) which has provided mitigation with daily reports and alerts to certain infections have been set up with the help of the EPR team. Dialogue to support the implementation of an IPC surveillance system (such as ICNET) has taken place throughout 24-25 but no decision has been made.

6.2 Investigation of Infection Prevention and Control Incidents

6.2.1 IPC and the Neonatal unit

The neonatal unit has continued to be a cause for concern; this has been shared with the Chief Medical Officer and Chief Nursing Officer.

The incubator replacement programme was completed in May 2024 and an incubator cleaning room has since been created. Further work to provide a sluice area and improve storage is required.

Progress towards implementation of an electronic patient record system has been slow, and the unit is reliant on paper for all clinical and nursing notes. This creates clutter in the unit, and a risk of transmission from multi-use paperwork. Prescribing is now electronic (Sept 2024) which has removed multi-use paper drug charts and will facilitate antimicrobial audit.

Fortnightly MDT meetings to work through and complete actions on the IPC action plan have continued in addition to the regular IPC visits with a focus on reinforcing IPC practice in the unit and monitoring outstanding actions from the initial outbreak.

Weekly screening continues and cases of colonisation with ESBL have continued to be found; however no clinical or invasive isolates have been identified.

This year the unit has observed increased referral activity with admissions sometimes exceeding capacity. A shortage of support staff has also been reported.

6.2.2 Listeria monocytogenes

In 2024/25 there were 2 cases of Listeria monocytogenes bacteraemia. Immunocompromised patients, pregnant women, neonates, and adults over 65 are at the highest risk of contracting listeriosis and most at risk of severe infection.

An immunocompromised patient was admitted with Listeria monocytogenes bacteraemia. The patient had had a recent emergency (ED) encounter which was followed a week later by their hospital admission. Food consumed was investigated by Head of Soft FM Performance and Quality and our provider Mitie. No issues were identified associated with food at the time. The patient sadly died later in the month.

It was later identified that this case was linked through whole genome sequencing to a cluster of Listeria cases being investigated nationally, linked to a common food business operator providing sandwiches to NHS Trusts (including the OUH).

A sandwich had been consumed by the affected patient during the ED encounter. Food from the implicated supplier was removed from the Trust proactively as a precaution and alternative arrangements implemented. A national recall was subsequently implemented.

A second patient who had been receiving chemotherapy care in the cancer centre in the Churchill Hospital was admitted to another hospital with Listeria bacteraemia. UKHSA flagged up that the infection was potentially linked to the ingestion of contaminated food while at OUH.

The infection was not found to be linked to contaminated food served by the Trust but possibly linked to a sandwich from an external source.

These cases reinforced the importance of maintaining temperature control and the cold storage chain for food safety. IPC and Soft Facilities Management audited all Trust temperature-controlled fridges, and where required mitigation was put in place.

6.2.3 Bedbugs

There was an incidence of bed bug infestation in the Children’s hospital in November 2024, following a parent’s report of a rash which was suspected to be caused by bed bugs. IPC, estates PFI and pest control reviewed the ward and found a mattress which was contaminated with bed bugs. This was a designated mattress for parents/carers. The bay was closed with the temporary loss of 2 inpatient beds.

Following chemical treatment and the removal of 4 mattresses the bed bugs have been eradicated. The beds were re-opened for admissions

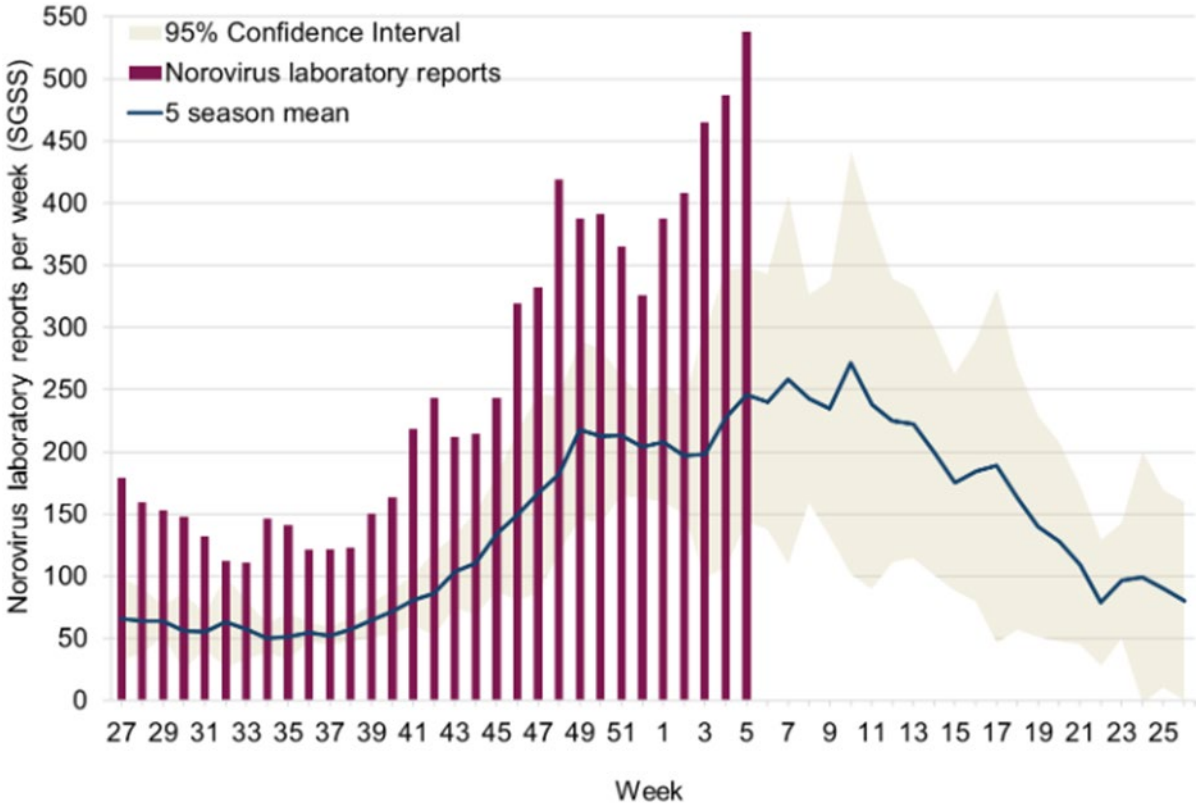
6.2.4 Norovirus Outbreaks

In April, May and June 2024 there were 4 outbreaks of norovirus all in acute medical wards affecting a total of 29 patients, 14 staff and 1 visitor.

The impact of norovirus on the Trust operational capacity is reduced as the IPC team are able to provide a physical presence 7 days a week, supporting and advising all affected wards, and thereby ensuring optimum patient placement and operational capacity. As a result lost bed-days have been minimised.

The incidence of norovirus in the Trust remained low in winter months. This is in contrast to the national experience (Table 37).

Table 37: Norovirus laboratory reports in England by week during the 2024/2025 season, compared with the 5 season average



6.2.5 Tuberculosis

Contact tracing was completed for an in-patient diagnosed with *Mycobacterium tuberculosis*. 6 patients were identified as contacts and warn and inform letters were sent to patients and GPs in line with guidance.

No staff were identified as contacts, but staff were given the opportunity to discuss any concerns with occupational health.

6.2.6 Salmonella

A long stay patient in Paediatric Critical Care (PCC) was found to have a bacteraemia with *Salmonella Montevideo*, an unusual organism to acquire as a nosocomial infection.

A second patient who had been on PCC but transferred to another intensive care facility then tested positive for *Salmonella Montevideo* the following day.

Investigation by the local health protection team revealed that the second patient was part of a known and long-standing outbreak of *Salmonella Montevideo* infection from a prior admission to the second facility.

Both patients were isolated appropriately and are likely to remain long-term carriers of *Salmonella Montevideo*.

No further cases of transmission were reported.

A review of IPC on the unit identified areas for improvement and an IPC/PICU task force was developed which met weekly to review IPC issues on the unit and to change practice.

The IPC team supported the unit to improve hand hygiene and cleaning scores through regular teaching and conducting weekly audits.

Lessons learnt were incorporated into the regular unit IPC meetings after 2 months and the taskforce was stood down.

6.2.7 Measles

There was a rapid increase in cases of measles in late 2023 driven by a large outbreak in Birmingham, with subsequent rises in London and small clusters in other regions in the first half of 2024.

A small number of cases have been manged in 2024/25 in the OUH:

In May 2024 a paediatric patient developed a fever and a rash and had a 90-minute wait in JR's Paediatric ED with other families. The clinical opinion was that this was a measles vaccine related response, as the child had been recently vaccinated, and not been in contact with anyone unwell. However UKHSA required the OUH to inform and warn contacts. This was undertaken using a text message. The reference laboratory failed to detect wild-type measles and the patient was deemed negative for measles.

Three proven measles cases and one probable case were seen in emergency settings in the OUH during 2024/25, 2 adults and 2 children.

Patients were managed with rapid isolation and appropriate precautions. All patient contacts identified were notified using text messaging (DrDoctor platform), and in the event of staff exposure occupational health assisted

with risk assessment. The Trust is not aware of any onward transmission from these cases.

Meningococcus

Staff exposure – see section Criterion 10.

6.3 Surgical Site Infection Surveillance (SSI)

6.3.1 Cardiac Surgery

Cardiac surgery continues to participate in voluntary surveillance and Surgical Site Infections (SSIs) information is reported to the UKHSA SSI surveillance service every quarter.

6.3.2 TAVI (Transcatheter Aortic Valve Implantation) surgical site surveillance

There have been no reported SSI cases for TAVI patients since surveillance commenced in 2019 (data to March 2025).

6.3.3 Cardiac artery bypass grafting (CABG) and non-CABG SSI surveillance

SSI data for non-CABG and CABG procedures is shown in tables 38 and 39 below. Both programmes have SSI rates well below national benchmarking (2% for non-CABG, and 4.8% for CABG).

Table 38: Non–CABG SSI RATES April 2024 to March 2025

Non-CABG Cardiac surgery Surgical site infections					
Period	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Reconciled
Quarter 1 Apr-Jun 2024	(0/107) = 0%	(0/107) = 0%	(0/107) = 0%	(0/107) = 0%	Yes
Quarter 2 Jul-Sep 2024	(1/109) =0.9%	(0/109) =0%	(0/109) =0%	(1/109) =0.9%	Yes
Quarter 3 Oct-Dec 2024	(0/101) = 0%	(0/101) = 0%	(0/101) = 0%	(0/101) = 0%	Yes
Quarter 4 Jan- Mar 2025	(0/101) = 0%	(0/101) = 0%	(0/101) = 0%	(0/101) = 0%	No
Running Total				(1/418) = **0.2%**	

Table 39: CABG SSI RATES April 2024 to March 2025

CABG Surgical site infections					
Period	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Reconciled
Quarter 1 Apr-Jun 2024	(1/88) = 1.1%	(1/88) = 1.1%	(0/88) = 0%	(2/88) = 2.2 %	Yes
Quarter 2 Jul-Sep 2024	(2/79) = 3.7%	(0/79) = 0%	(1/79) = 1.2%	(3/79) = 3.7%	Yes
Quarter 3 Oct-Dec 2024	(4/95) =4.2% (one donor site) (TBC)	(0/95) =0%	(0/95) =0%	(4/95) =4.2% (one donor site) (TBC)	Yes
Quarter 4 Jan-Mar 2025	(1/89) = 1.1 % (TBC)	(0/89) = 0%	(0/89) = 0%	(1/89) = 1.1% (TBC)	No
Running Total				(10/351) = 2.8%	

6.3.4 Trauma and Orthopaedic SSI Surveillance

Mandatory surveillance of infections in trauma and orthopaedics started in April 2004, specifying that each trust should conduct surveillance for at least one orthopaedic category for one period in the financial year.

OUH collects continuous data on repair of neck of femur at both the Horton and JR sites (Table 40).

Table 40: Fractured Neck of Femur SSI Rates – John Radcliffe and Horton sites

		JRH				HGH				National average 5 years to date		
		All #NOF Operations	No. SSI cases	JR SSI rate (%)	Outlier status	All #NOF Operations	No. SSI cases	HGH SSI rate (%)	Outlier status	All #NOF Operations	No. SSI cases	National SSI rate (%)
2024	Q1 Jan-Mar	83	1	1.2%		80	0	0.0%		97555	866	0.9%
	Q2 Apr-Jun	89	1	1.1%		79	0	0.0%		98874	877	0.9%
	Q3 Jul-Sep	79	0	0.0%		104	0	0.0%		99991	900	0.9%
	Q4 Oct-Dec	91	1	1.1%		92	0	0.0%		101820	923	0.9%
2025	Q1 Jan-Mar	93	1	1.1%		94	1	1.1%				

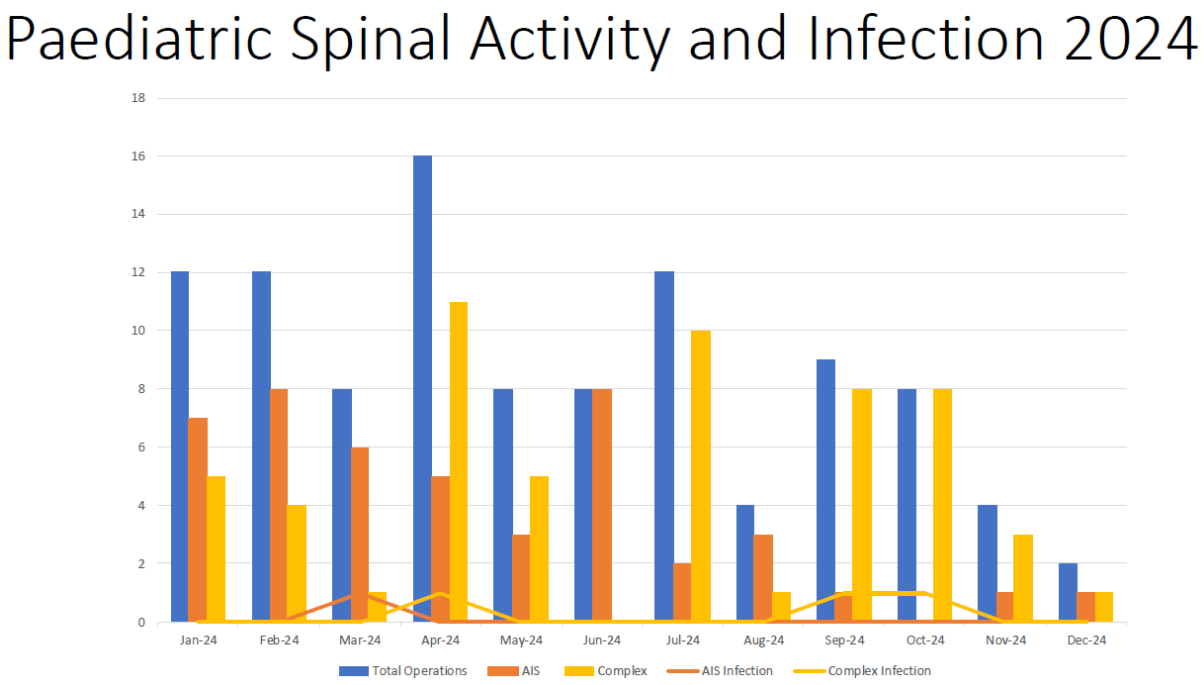
6.3.5 Spinal Service and Surgical Site Infection (SSI)

A review in 2023 by NHSE Specialist Commissioning of paediatric spinal surgery identified two serious concerns (a) the high rates of SSI and (b) extended waiting times for paediatric surgery. Quarterly review meetings with the Thames Valley and Wessex Surgery in Children Network were introduced. NHSE identified that the arrangement for monitoring progress would be to follow up through the contracting route as part of a Service Development Improvement Plan (SDIP). All actions have been progressed through 2024/25, and the quarterly meetings have now been stood down.

An overall reduction in spinal SSI from 9% to 2.2% (Table 41) has been achieved in 2024. The SSI prevention bundle is regularly audited with good compliance, with a weekly MDT to review patients with outcomes documented within patient record, data is collected prospectively and a discharge clinic established.

A business case was agreed for an SSI nurse to support the service at the NOC, but the funding was lost at financial out-turn and it has not been possible to recruit to the post due to the savings required in 2025/26.

Table 41: Paediatric Spinal Activity and Infections by procedure 2024



EOS Early Onset Scoliosis (Scoliosis in children under the age of 10 years)
AIS Adolescent idiopathic scoliosis
NM Neuromuscular

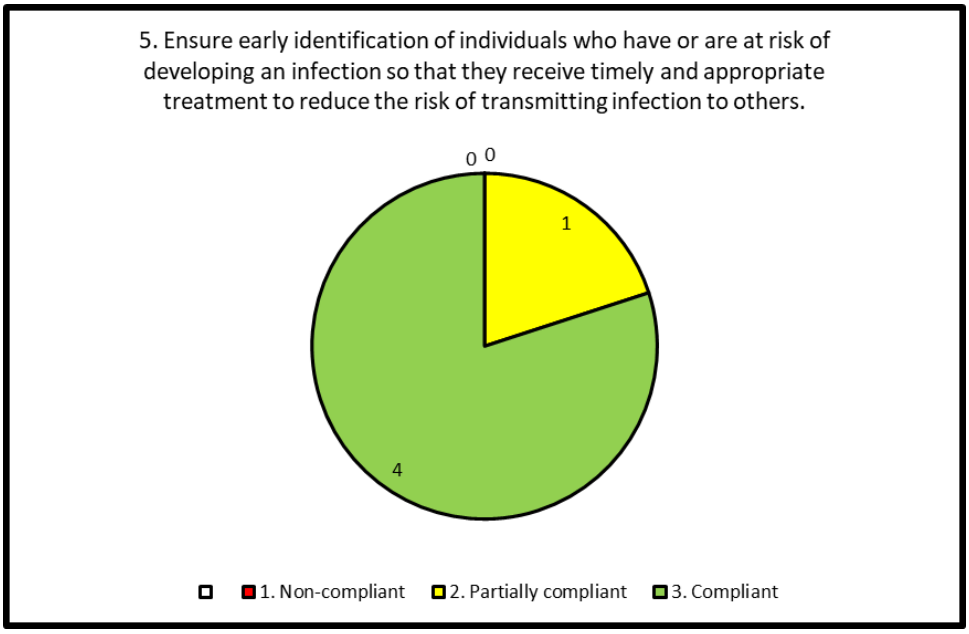
6.3.6 Trust wide SSI surveillance

A pilot of undertaking SSI surveillance digitally was successfully undertaken in caesarean sections and for emergency surgery patients. This will not be continued as the app has now been withdrawn by the company pending an upgrade.

Data is available at clinician and procedure level on the ORBIT surgical morbidity tracker on a number of parameters relevant to SSI such as returns to theatre.

Investment in SSI surveillance is required in order for the organisation to understand rates of SSI incidence in our patients, so patient experience and outcomes can be improved. Once SSI rates are known, interventions to reduce SSI can be monitored and evaluated, and specialities with rates outside expected norm can be supported to reduce rates.

Figure 5: BAF Compliance to Criterion 5



Partial Compliant Elements to the BAF	Reason for Partial Compliance	Actions to Achieve Compliance
All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receives timely and appropriate treatment to reduce the risk of infection transmission.	Loss of IPC surveillance system, with only partial mitigation. No replacement system confirmed.	Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support.

7 Criterion 6

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

7.1 Provision of information to staff

The OUH intranet hosts the IPC website which provides access to all IPC polices, guidelines and documents including a suite of ‘At A Glance’ quick reference guides.

7.2 IPC Training

There is an IPC eLearning package that meets the national requirements and is a Trust-wide requirement.

The IPC team offers bespoke training in a variety of ways and participates in training for medical students and doctors.

There is now a strong IPC Link Practitioner cohort of staff, who are attending IPC run workshops and completing competencies. Clinical areas have been supportive of the Links having time to attend sessions. These Link Practitioners could be an extremely useful resource should the pandemic resurface, or in the event of a new outbreak of infection.

7.2.1 Infection Prevention and Control Link Practitioner Workshop

In July 24 the IPC team held an IPC conference for link practitioners and staff members from the BOB network. 125 delegates attended the conference to discuss topics including C. diff, SSI and blood cultures. Feedback from delegates was universally positive.

The IPC team reached out to link practitioners to relaunch the link practitioner workshop in Q3 and Q4 of 24/25. A new curriculum has been put together following feedback from link workers and the workshops are planned to be relaunched in 2025.

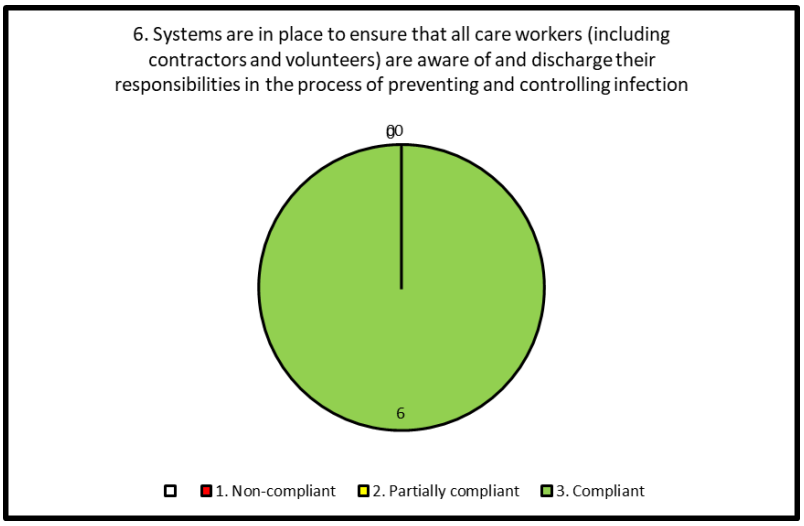
7.3 OUH IPC Team national positions of responsibility

The DIPC is a member of the New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) which advises the government on the threat posed by new and emerging respiratory viruses, Expert Advisor to the Infected Blood Inquiry, and a member of the Infectious Diseases Clinical Reference (commissioning) group.

New national roles taken on by the Consultant Pharmacist in 2024/25 include Chair of the Royal Pharmaceutical Society Antimicrobial Expert Advisory Group (AmEAG) and Membership Lead for the UKCPA.

The Senior AMS Pharmacist is Associate Members Secretary for the British Infection Association.

Figure 6: BAF Compliance to Criterion 6



8 Criterion 7

The provision or ability to secure adequate isolation facilities.

8.1 Isolation facilities

The John Warin Ward (JWW) provides isolation facilities with 4 isolation suites with positive pressure ventilated lobbies (PPVL). There is an isolation facility in the JR Emergency Department with direct access from the external environment. The critical care facility on the John Radcliffe site offers additional isolation facilities with 8 PPVL rooms.

8.2 High Consequence Infectious disease

The Trust made a successful application to become a centre for Airborne high consequence infectious disease (HCID) in 2023-24 and work has been undertaken this year to prepare the trust to receive patients. The Trust has an HCID group that meets monthly and maintains the HCID protocol. OUH has National HCID Airborne status which means that, following agreement with the HCID network, the unit (John Warin Ward and/or Oxford Critical Care) must be able to admit a patient (adult or child) and start treatment within six hours of a confirmed diagnosis; and to operate continuously for three weeks following unit activation with the admission of an HCID patient. The unit may be asked to take a family or up to three patients when fully operational.

The ‘go live’ date was in Q1 2025/26. to the Trust continues to receive and assess suspected cases of airborne or contact HCID.

Progress to date includes:

- Appointment of HCID clinical leads in paediatrics, paediatric critical care, infectious diseases, and adult critical care and an HCID Lead Nurse.
- Completion of enabling work on JWW to maximise storage and doors/security to separate the HCID facility from the main ward area has been completed with NHSE funding.
- 8 staff attended HCID PPE train the trainer day in June 2024 (Sheffield).
- 10 staff attended the HCID Network Day in May 2024.
- Revision of HCID plan to separate into suspected and confirmed cases.
- Review of ventilation by the Authorising Engineer for Ventilation wi the Head of Estates.
- A review visit from NHSE, the health and safety executive and EPRR (emergency preparedness, resilience and response) teams in June 2024.

8.3 Respiratory Viruses: Influenza, COVID-19 and RSV (Respiratory Syncytial Virus)

8.3.1 Influenza and COVID-19 Outbreaks

The Trust now manages patients with a positive diagnosis of COVID-19 through-out the year; this is often not the reason for admission.

There were a number of ward-based outbreaks of both COVID-19 and influenza in 2024/25. Sideroom availability for isolation of these patients on the John Radcliffe and Horton sites is limited.

IPC supported wards in cohorting of patients were possible and providing daily touch points to support enhanced cleaning, reinforce good hand hygiene practices and appropriate use of PPE.

Table 42 Graph of influenza cases by year and week number (fiscal week). Graph shows that influenza case numbers overall were high in 2024/25 over a number of weeks, but we did not experience the peak seen in 2022/23.

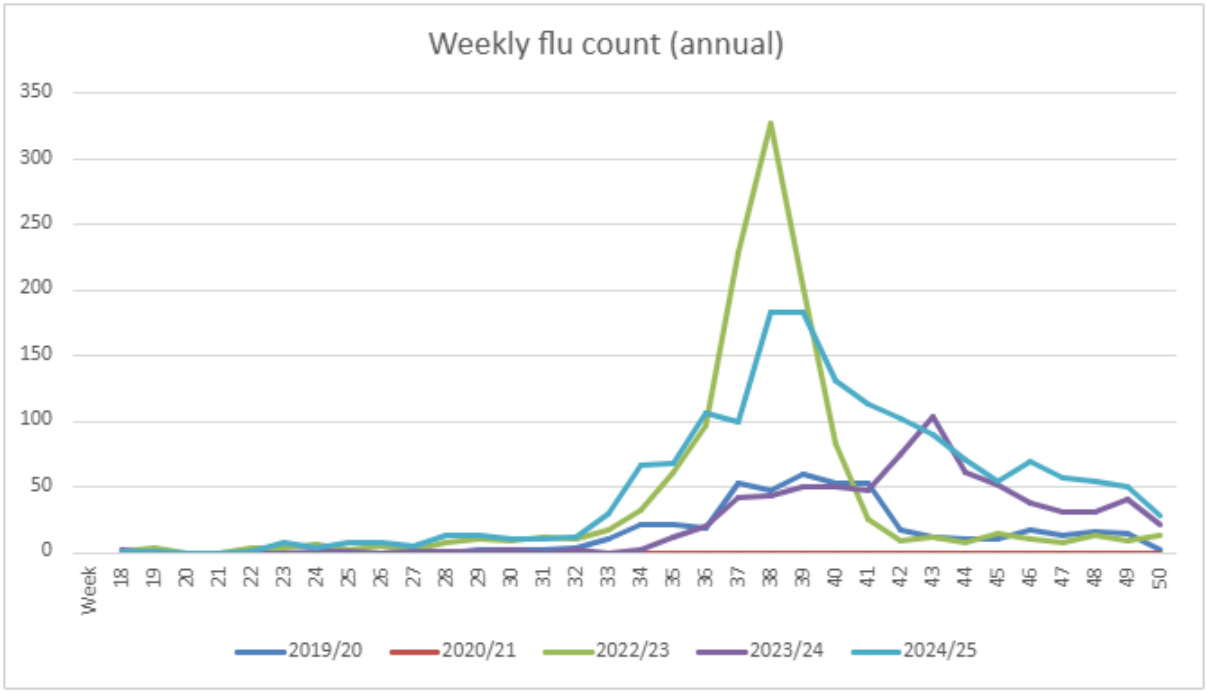


Table 43: Graph of RSV cases by year and week number (fiscal week)

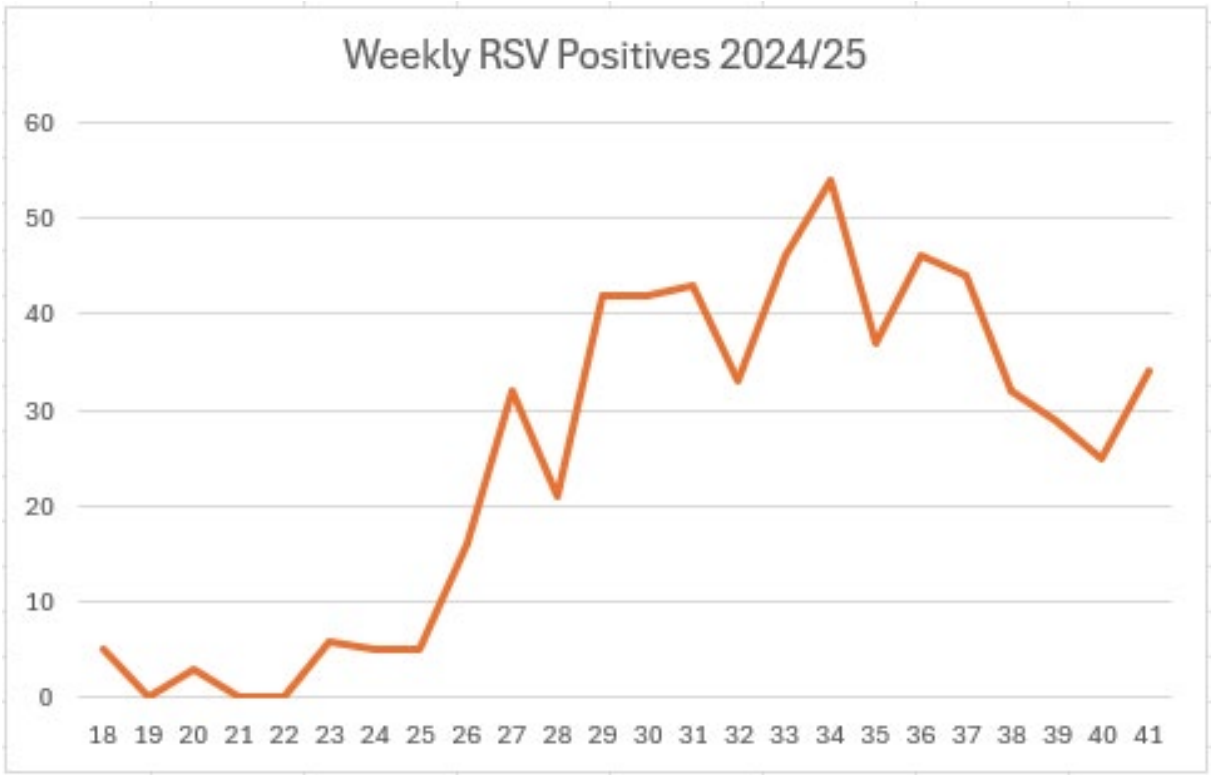
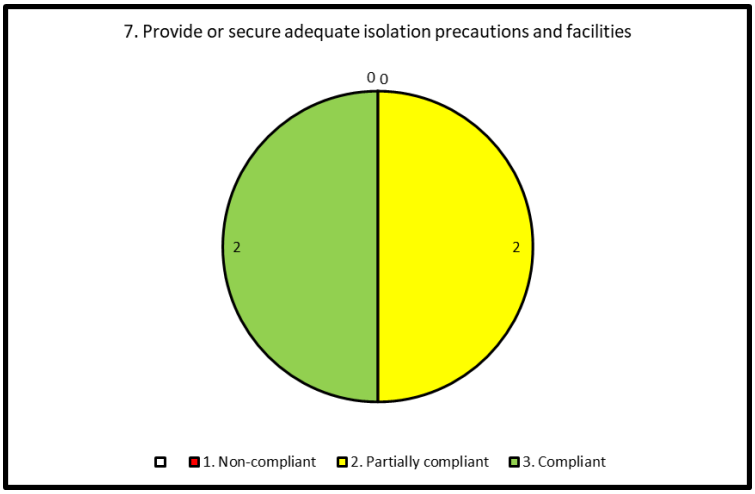


Figure 7: BAF Compliance to Criterion 7



Partial Compliant Elements to the BAF	Reason for Partial Compliance	Actions to Achieve Compliance
Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	Loss of IPC surveillance system, with only partial mitigation. IPC need access to patient level data on side-room availability and reason for isolation to ensure decisions about patient placement and prioritisation of patients for limited side rooms is optimally informed. No replacement system confirmed. Lack of recognition of biohazard flags.	Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with service continuity support.
Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and	Loss of IPC surveillance system, with only partial mitigation. IPC need access to patient level data on side-room availability and reason for isolation to ensure decisions about patient placement and prioritisation of patients for limited side rooms is optimally informed. No replacement system confirmed. Lack of recognition of biohazard flags. Work done with the EPR team for the IPC team to access sideroom information via Cerner capacity management module has not been able to supply the required information.	Procure and/or develop a suitable fit-for-purpose IPC alerting, surveillance and outbreak management system, with ward level data and service continuity support.

processes are in place to mitigate risk.		

9 Criterion 8

The ability to secure adequate access to laboratory support as appropriate.

9.1 Role of the Microbiology Laboratory

OUH has a dedicated in-house Microbiology Laboratory which provides a 24/7 service with United Kingdom Accreditation Service (UKAS) accreditation (ISO-15189). A Microbiology Consultant and SpR are available 7 days a week to provide IPC advice and support. The Microbiology clinical team also provide out of hours IPC support to Oxford Health as required. The IPC team attend the Microbiology 'plate' round daily, and present cases and issues for discussion.

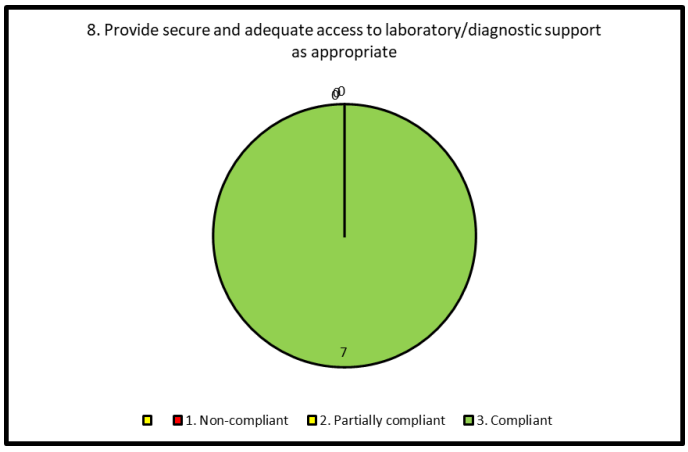
The Microbiology LIMS was replaced in March 2025, leading to the complete loss of functionality of the IPC surveillance system for real-time alert organism flagging. This has been partially mitigated by the production of daily organism reports by microbiology for IPC but with the loss of real-time reporting. EPR message box results have been set up for real-time reporting of respiratory pathogens of IPC interest. The OUH Digital Engineering Service is working on a web-based alerting system. A business case for a new surveillance system (eg ICNet) has not progressed.

The laboratory supports IPC investigations such as environmental swabbing as part of outbreak investigation.

During 2024/25 the microbiology point of care team supported by the IPC team implemented point of care respiratory virus testing in emergency admission areas (JR and Horton) to allow rapid patient diagnosis and appropriate triage, minimising operational pressures. Revised respiratory virus testing guidance was implemented to reduce the use of high-cost respiratory virus panel testing. Comparing Sept 23 -Mar 24 with Sept 24 - Mar 25, a total cost saving of £180K has been achieved by diverting tests to cheaper test panels and point of care testing without any identified negative clinical impact.

The Oxford University NIHR HPRU in Healthcare Associated Infections and Antimicrobial Resistance supports IPC Investigation with pathogen sequencing e.g. ESBL producing organisms on the neonatal unit, and 'big-data'.

Figure 8: BAF Compliance to Criterion 8



10 Criterion 9

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

10.1 Sepsis

The sepsis team have been working as an established team of 4 since implementation of the IPC business case in 2023 and have been undertaking cross site cover of the OUH including the Churchill and Horton General Hospital.

Paediatric Sepsis

In September 2024, the sepsis team successfully recruited a dedicated paediatric sepsis nurse on a fixed-term basis. This appointment followed a Serious Incident Requiring Investigation (SIRI), which identified significant gaps in paediatric sepsis training and education across the Trust.

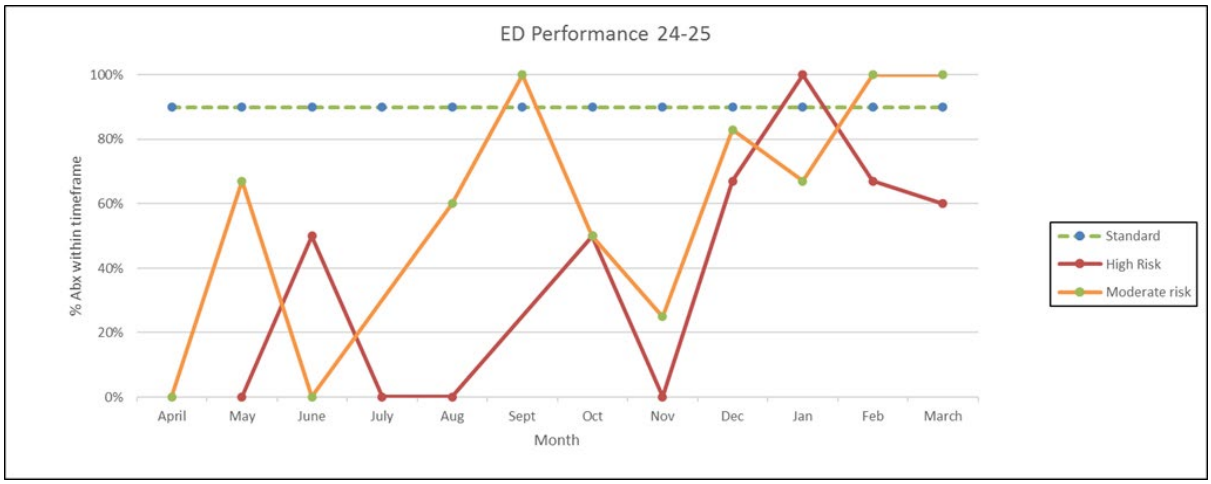
Various education and training initiatives have been developed by the sepsis team including:

- Delivery of sepsis education to the paediatric workforce, including sessions as part of the Level 2 Critical Care course and critical care teaching.
- Development of a paediatric sepsis e-learning package, which is currently under review by the lead paediatric infectious diseases consultant and the sepsis clinical lead.
- Delivery of several sepsis workshops across the Trust.

10.1.1 Quality Improvement

The sepsis team completed a retrospective 12-month (April 2024-March 2025) audit focusing on compliance with time to antibiotics in children presenting to the Emergency Department with suspected sepsis (Table 44).

Table 44. Paediatric Emergency Department performance against sepsis antibiotic time targets, April 2024–March 2025.

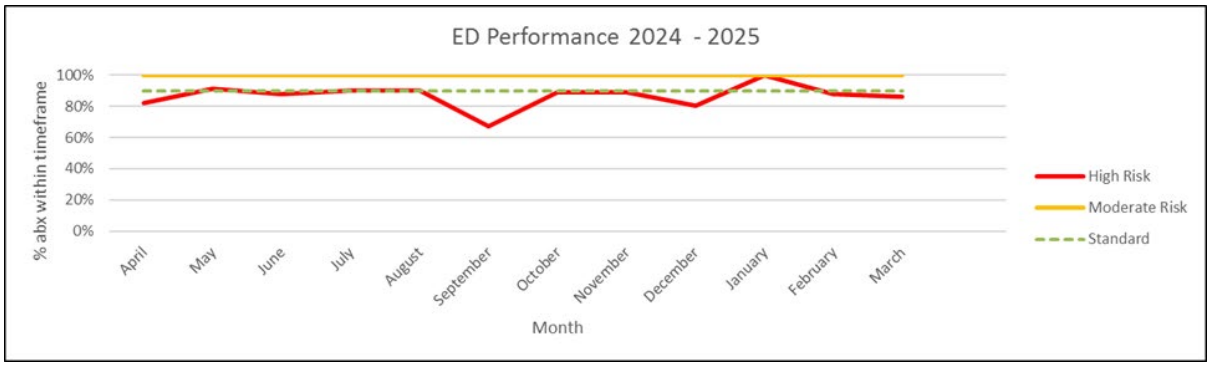


The introduction of a dedicated paediatric sepsis nurse at the end of September 2024 appears to correlate with a notable improvement in ED performance for both high- and moderate-risk sepsis patients:

10.1.2 Antibiotics Within One Hour of Sepsis Diagnosis

The sepsis team continues to support timely recognition and treatment of sepsis through active clinical involvement. Patients are flagged with a sepsis alert to ensure prompt assessment and timely administration of antibiotics, in accordance with NICE guidelines (Table 43)

Table 45. ED Sepsis performance – Antibiotics within 1 hour of a sepsis diagnosis in those who meet the high and moderate risk criteria for sepsis April 2024-March 2025.



OUH consistently achieved over 90% compliance with the 1-hour antibiotic target for high-risk sepsis patients in ED.

10.2 Ventilator Associated Pneumonia (VAP) Working Group

In 2024/25 the VAP group established an audit programme and re-introduced a VAP reduction bundle. A group has representatives from all adult and children's intensive care areas, IPC, Infectious Diseases and clinical risk practitioners.

The coding team provided the IPC team with numbers of patients coded for a VAP in 2023-24, which was 106 spells, and 53 spells in 2024/25, a 50% reduction.

Low VAP rates have been confirmed on audits of VAC (ventilator associated condition) and iVAC (infection related ventilator associated complication) Feb - July 2024 on OCC and CICU as defined by CDC criteria using automated surveillance tool.

Rates of compliance with the VAP prevention bundle are 85%-98% across 6 audits (3 per ICU (OCC and CICU).

10.3 Appropriate Glove Usage / Gloves Off Campaign

The IPC business case included recruitment of a decontamination practitioner. Implementation of findings from a recent decontamination audit in the endoscopy decontamination unit at the JR has resulted in cost savings of £10,000 in 2024/25 compared with 2023/24 through a reduction in the inappropriate use of sterile gloves.

10.4 Audits

10.4.1 Vascular device audit

The IPC team undertook a vascular device audit in May 2024. This took place during hand hygiene week 6th – 10th May. The team saw 679 patients and observed 356 peripheral cannulas. The results demonstrate a lower compliance in all key criteria than reported in the previous audit in November 2022.

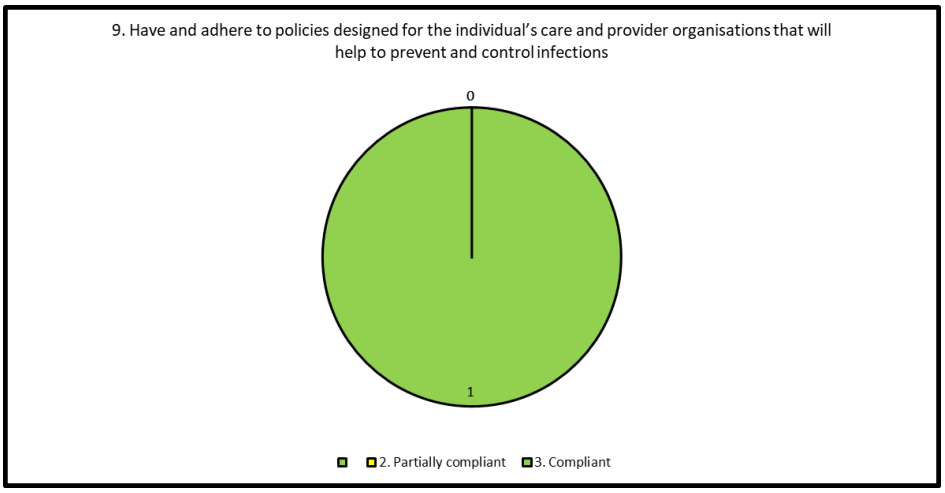
33% of peripheral cannulas were noted to be sited in the antecubital fossa (ACF). The ACF has been identified previously as a theme in association with MSSA bacteraemia, as well as peripheral cannulae inserted in emergency settings and those with prolonged dwell times (Ref: Trinh TT et al Infect Control Hosp Epidemiol. 2011).

Results have been shared at department level and areas requiring improvements advised to develop action plans. Other actions include continuing to work with education team around cannula site location, and work with the assurance team to be able to scrutinise quarterly audit results.

Table 46: Results of vascular device audit by question, comparing November 2022 and May 2024

	Nov 2022	May 2024
Areas audited	33	34
Patients	562	679
Peripheral cannulas	309	356
Documented on EPR	84% (261)	78% (276)
VIP score recorded once per shift	69% (212)	63% (223)
Still indicated for use	82% (252)	67% (239)
Dressing clean, dry and intact	91% (282)	87% (310)

Figure 9: BAF Compliance to Criterion 9



11 Criterion 10

That they have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

11.1 Staff Health

The Centre for Occupational Health and Wellbeing (COHWB) are members of HIPCC and present a twice-yearly report, including data on needlestick injuries. Support for staff sustaining a needlestick or sharps injury is available 24/7, supported out of hours by the Microbiology on-call team. No reported blood borne virus transmission to staff has been reported in 2024-25.

In 2024-25, Winter Staff Vaccination programme was delivered by 149 peer vaccinators delivering both Influenza and COVID-19 vaccination for OUH staff.

OUH Staff Influenza and COVID-19 vaccine rates 2024-25 season:

- Final percentage for influenza vaccination in front line HCW: 43%
- Final percentage for COVID-19 vaccination in front line HCW: 27.4%
- Total No. of HCW's involved with direct patient care: 10,688.

In addition to routine staff immunisation activities, in response to the 2022 outbreak of Mpox, COHWB have supported staff immunisation for staff at risk of MPox exposure.

Mpox Vaccine: A total of 49 out of 89 eligible staff members received the Mpox vaccine between 2024 and 2025, including those attending for their second dose. During the same period, 39 staff members declined vaccination.

Measles and hepatitis B vaccination status and varicella zoster immunity is assessed for all staff on pre-employment checks.

Staff measles vaccination data was reviewed as part of the response to the current national measles outbreak. Between 2024 and 2025, COHWB tested 499 OUH staff members for measles immunity. Of these, 409 had detectable antibodies, 72 had either an equivocal result or no antibodies, and for 17 individuals, no result has been recorded by clinicians.

During the same period, we administered 16 first doses and 21 second doses of the MMR vaccine, with no single measles-only vaccinations given.

This suggests that approximately 35 individuals may have either been missed, did not attend (DNA), or are still pending follow-up.

Communication about the importance of staff immunity to measles and access to immunisation has been sent to all staff via the corporate communications system.

Measles and Shingles: There were no cases of measles or shingles contact requiring contact tracing recorded between 2024 and 2025.

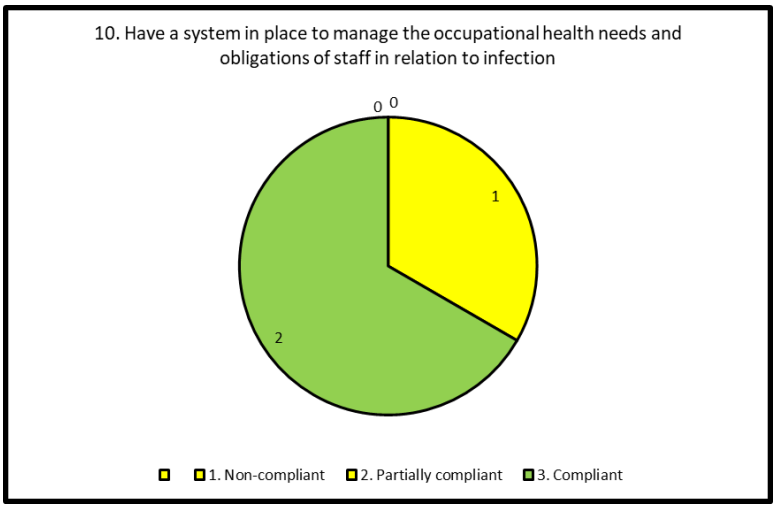
Pertussis exposure: One incident of pertussis exposure was recorded between 2024-2025. All individuals were assessed as having no significant exposure, and no further action was required.

Meningococcal exposure: Between 2024 and 2025, 4 potential incidents of staff meningococcal exposure were reported across the following departments: Theatre, Paediatric Intensive Care Unit (PICU), Emergency Department, and the Emergency Assessment Unit (EAU). Following a thorough risk assessment, it was determined that staff within the EAU did

not experience a significant exposure and therefore did not require further intervention. However, as a precautionary measure in alignment with public health guidelines, a total of 27 employees across the remaining departments received ciprofloxacin chemoprophylaxis. All appropriate protocols were followed to ensure the health and safety of staff, and there were no episodes of infection recorded.

Mycobacterium Tuberculosis exposure: Between 2024 and 2025, TB exposure was recorded among 14 staff members: 7 in the Mortuary Department and 7 within the Respiratory Medicine Unit. A recent IGRA test identified two staff members with positive results, though neither is currently experiencing symptoms of active TB. Investigations are ongoing.

Figure 10: BAF Compliance to Criterion 10



Partial Compliant Elements to the BAF	Reason for Partial Compliance	Actions to Achieve Compliance
Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	A system of health risk management is currently not in place for skin health (COSHH Regulations).	A system of organisational (regular) skin checks is required to ensure cases of occupational dermatitis are identified. Occupational Health are currently developing a guidance document outlining the system required for organisational legal compliance.

12 Conclusion

This report details the work of the IPC teams over 2024-25 and is set against the Health and Social Care Act (2015) criterion.

13 Recommendations

The Trust Board is asked to note the report.