Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

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Title:	**Infection Prevention and Control Annual Report 2025-26**

Status:	**For Information**
History:	**Annual Report**
	Trust Management Executive, 10 September 2026

Board Lead:	**Chief Medical Officer**
Author:	**Katie Jeffery, Director of Infection Prevention and Control**
Confidential:	**No**
Strategic Pillar:	**Patients, 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 2025 and March 2026. 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 Katharine 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 receives IPC updates via the monthly Integrated Performance Report (IPR) to Trust Management Executive and Integrated Assurance Committee/Board. This report has been updated to include a routine section for key IPC updates and exception reports. In this way IPC issues are escalated by exception in a timely way each month through the IPR and the Chief Medical Officer as required. 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 2025-26 OUH complied with all external reporting requirements.

Methicillin-resistant Staphylococcus aureus (MRSA) Bacteraemia

5. The Trust reported 6 cases of healthcare associated MRSA bacteraemia which is a reduction of 3 cases from 2024/25. NHSE has a zero-tolerance policy for healthcare associated MRSA bacteraemia.
6. A new MRSA screening method (multi-site swabbing) was introduced in February 2026 which has increased the percentage of positive MRSA screens, providing an opportunity for intervention to reduce the risk of MRSA bacteraemia.

Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia

7. The Trust reported 75 cases of healthcare associated MSSA bacteraemia for 2024-25, which is an increase of 9 cases from 2024-25. There is no threshold set by NHSE for MSSA.

Clostridioides difficile (C. difficile)

8. The Trust reported a total of 109 cases of C. difficile in 2025-26 (163 in 2024-25). This was below the NHSE trajectory set at 123 cases. The number of C. difficile cases assigned to OUH for 2025/26 gave the Trust a score of 1.00 in the NHS Oversight Framework (NOF) Acute Trust league table (the lowest possible score) as we met our threshold for 2025/6.

Gram negative blood stream Infections (GNBSI) (last year's data in brackets)

9. The Trust reported a total of 220 (220) E. coli, 86 (101) Klebsiella spp. and 46 (63) Pseudomonas aeruginosa healthcare-associated blood stream infections in 2025-26, exceeding the trajectory set in the NHS Standard Contract for E. coli (target 165), but meeting the trajectories for Klebsiella sp. (target 89) and Pseudomonas aeruginosa (target 59).

Central Line Associated Bloodstream Infections (CLABSI) surveillance

10. CLABSI surveillance is undertaken trust-wide by the IPC team. The CLABSI rate on the neonatal unit remains an area of concern and an action plan is in place.

Surgical Site Infection (SSI)

11. Information is submitted to the UK Health Security Agency (UKHSA) for the mandatory SSI surveillance of fractured neck of femur surgery and voluntary surveillance relating to Coronary Artery Bypass Graft procedures, cardiac valve and transcatheter aortic valve implantation and hip and knee surgery. No concerns have been raised regarding high or low rates in 2025/26.

Respiratory Viruses

12. The IPC team continued to follow up COVID-19, Influenza and RSV (Respiratory Syncytial Virus) positive patients. Operational pressures regularly impacted the Trust's ability to isolate all patients promptly.

The Built Environment and IPC

13. The IPC team has provided support in relation to both ongoing and new build environmental concerns throughout 2025-26.

14. Water Safety at the Churchill Cancer and Haematology Hospital: Work in 2023/24 to deliver an engineering solution to control the failings of the water system with respect to Legionella (SIRI, 2019) has been augmented in 2025/26 with the

installation of upgraded thermal balancing valves. Good progress has been made through the SIRI process during 2025/26, but the required actions have not yet all been closed. Point of use filters remain on all outlets within the building to maintain safe water at the point of use.

Infection Prevention and Control Surveillance Software

15. The absence of a unified IPC surveillance system remains the most significant organisational IPC risk. By year end, funding had been secured for an IPC surveillance system with the required functionality (ICNET) and implementation is planned through 2026/27. A number of different surveillance systems providing partial mitigation remain in place.

Investigation of Infection Prevention and Control Incidents and Outbreaks

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

- Occupational exposure to TB and Meningococcus
- Measles
- Bedbugs
- Norovirus
- Influenza and COVID-19 outbreaks
- *Burkholderia stabilis* infections

Antimicrobial Stewardship (AMS)

17. AMS activity has included work in the following areas:

- Antibiotic consumption and working towards the UK 5-year action plan for antimicrobial resistance 2024 to 2029
- AMS ward rounds and 6 day AMS service
- *C. difficile* prevention

18. National targets were met, with measurable improvements in prescribing contributing to reduced infection rates.

Infection Prevention and Control staffing

19. Staffing stabilised during the year following recruitment of a substantive IPC Lead Nurse Manager in-post by October 2025.

High Consequence Infectious Diseases (HCID)

20. The Trust successfully became a designated airborne HCID centre with capability to receive and care for adult and paediatric patients in ward and intensive care setting with confirmed airborne HCID. This ability significantly enhances preparedness to manage suspected HCID cases.

Summary

21. Key Achievements

- Achievement of C. difficile, Klebsiella spp. and Pseudomonas aeruginosa trajectories
- Sustained reduction in MRSA bacteraemia
- Airborne HCID centre designation
- Progress towards surveillance system implementation
- Appointment of IPC Lead Nurse/Manager

22. Key Priorities for 2026–2027

- Implement IPC surveillance system
- Reduce E. coli bacteraemia
- Address MSSA line infections
- Support projects/estates risk actions
- Maintain workforce stability

Conclusion

23. 2025–2026 has been a year of progress in key infection control indicators, but important systemic challenges remain. Continued focus on surveillance, environmental risks, and device-related infections will be critical.

Recommendations

24. The Trust Board is asked to:

- Receive this report for information.

Contents

Infection Prevention and Control Annual Report 2025-26

1. Purpose

1.1. 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 2025 and March 2026. 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 2008: 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.

Infection Prevention and Control Board Assurance Framework (BAF)

1.2. 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.

1.3. 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.

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

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

1.6. There were no areas of non-compliance and no new areas of partial compliance in 2025-26. Areas of partial compliance are included in the IPC Strategic Plan.

2. Background

2.1. 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 2025 to March 2026. 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 Katharine House Hospice.

2.2. 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.

2.3. 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

2.4. 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.

2.5. Committees reporting to HIPCC are:

- Decontamination Committee

2.6. Regular reports to HIPCC include:

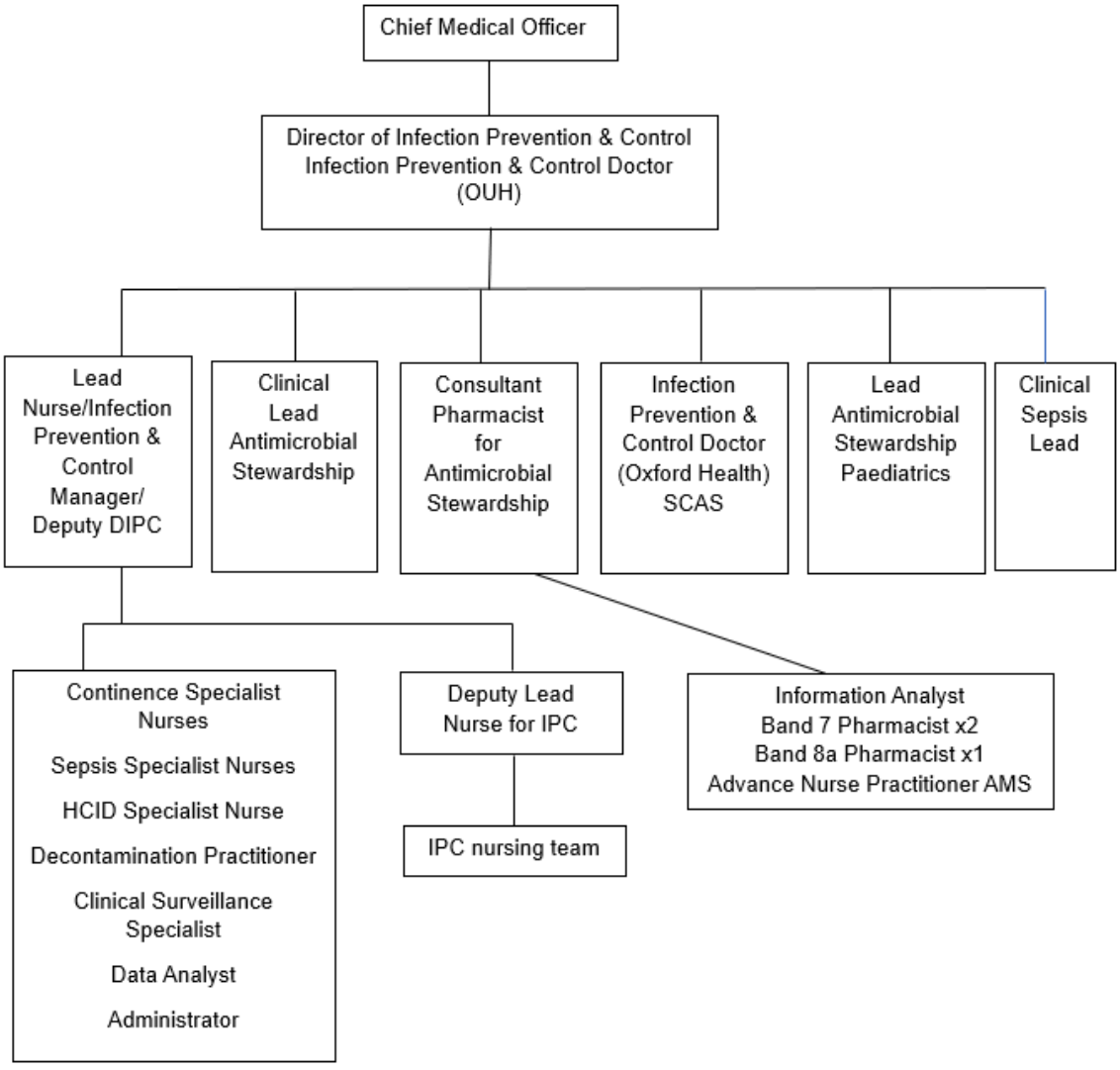
- Divisional IPC reports
- UKHSA/local Health Protection Team
- BOB ICS (Buckinghamshire, Oxfordshire and Berkshire West) (Thames Valley ICS 2026)
- Antimicrobial Stewardship (AMS) Team
- OUH Estates and Facilities
- Soft Facilities Management
- Centre for Occupational Health & Wellbeing (COHWB)
- Cardio-thoracic surgical site infection report
- IPC Risk Register

3. Criterion 1

3.1. 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.

3.2. Infection Prevention and Control Staffing.

Table 1: Organisational chart for the IPC team at the end of March 2026



3.3. The IPC team provides a 7-day on-site service to give IPC support to the wards and operational teams.

3.4. 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.

3.5. Following the secondment of the Deputy DIPC/Lead Nurse to a Divisional Nurse role in the OUH in June 2024, an interim manager was in post from November 2024 to July 2025. A new Deputy DIPC/Lead Nurse has been appointed and in post from October 2025.

3.6. The Water Safety Group was Chaired by the previous Deputy DIPC/Lead Nurse throughout 2025/26 as part of their Divisional Lead role with a transfer to the current Deputy DIPC/Lead Nurse planned for Summer 2026.

3.7. There have been several large projects throughout the year that have required the expertise of the IPC team on planning (Surgical Elective (SEC) and Urgent and Emergency (UEC) care centres) and opening of new or refurbished wards and clinical areas.

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

Organisms subject to mandatory reporting

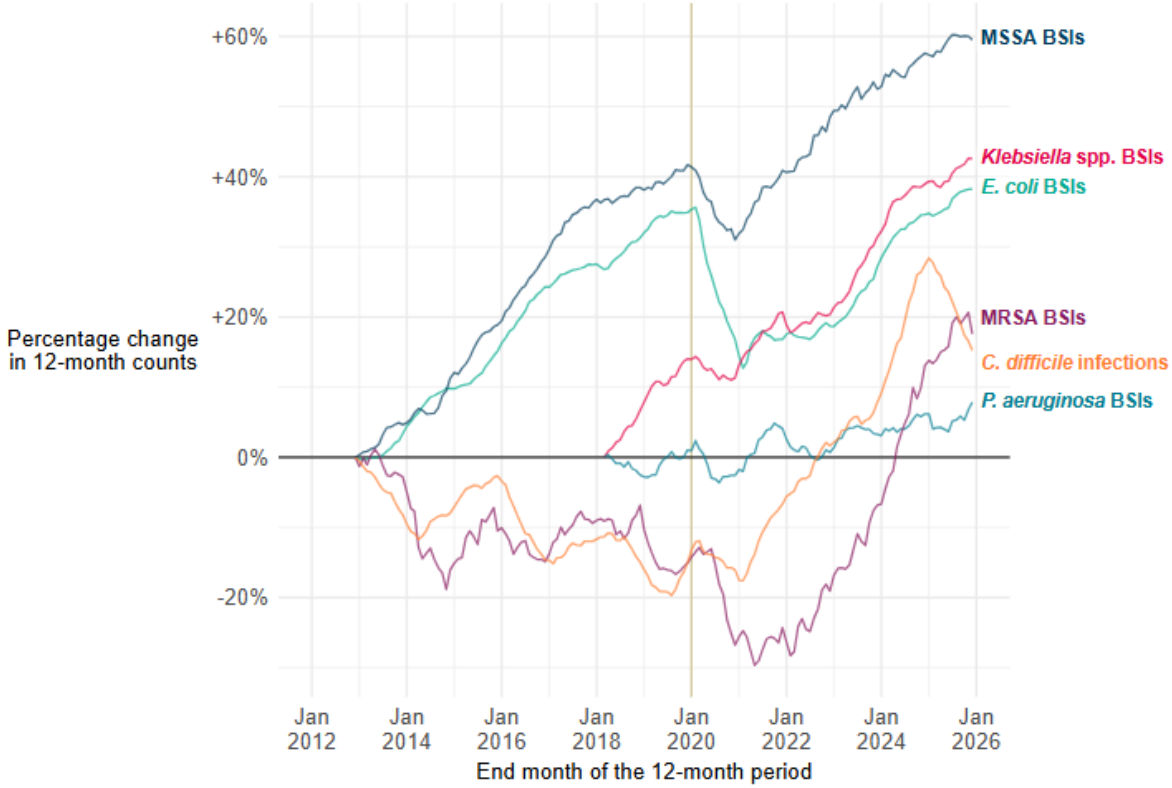
3.1. The OUH is required to report to UKHSA on the following organisms:

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

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

3.1. 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 highest percentage increases in 12-month rolling case counts have been observed for MSSA bacteraemia, which continued to increase in 2025. The start of 2025 saw a flattening of trends in E. coli and Klebsiella spp. bacteraemia, with a recent return to increasing case counts. There has been a sustained decrease in C. difficile rolling case counts in 2025, reversing the upward trend that began in January 2021. MRSA may also be turning a corner, with a decrease in rolling case counts from last quarter.

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 December 2025.



Bacteraemia prior trust exposure categories

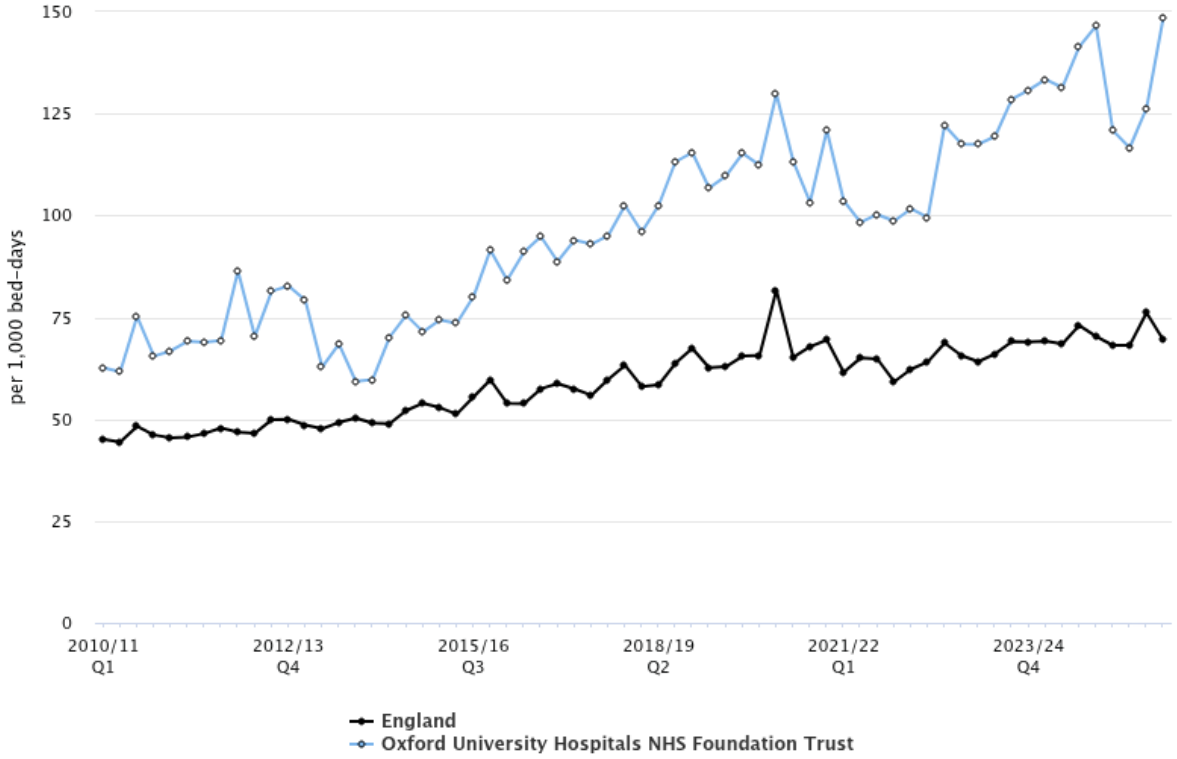
3.1. The two categories of reporting for healthcare-associated infection are:

- **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)

Ascertainment of bacteraemia in the OUH

3.1. The number of blood culture sets taken in the OUH per 1000 bed-days is almost twice the England acute Trust average (Table 3). This is likely to be associated with improved ascertainment of bacteraemia relative to Trusts with lower testing rates.

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



3.2. 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.

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

Methicillin-resistant Staphylococcus aureus (MRSA)

3.1. There were 3 HOHA and 3 COHA cases of MRSA bacteraemia in 2025-26. All cases have undergone a review to identify learning. Table 4 provides information on the source of infection. The majority of cases were found not to be preventable. In one case there was learning identified in relation to line care; an action plan was created and implemented in the speciality to address this.

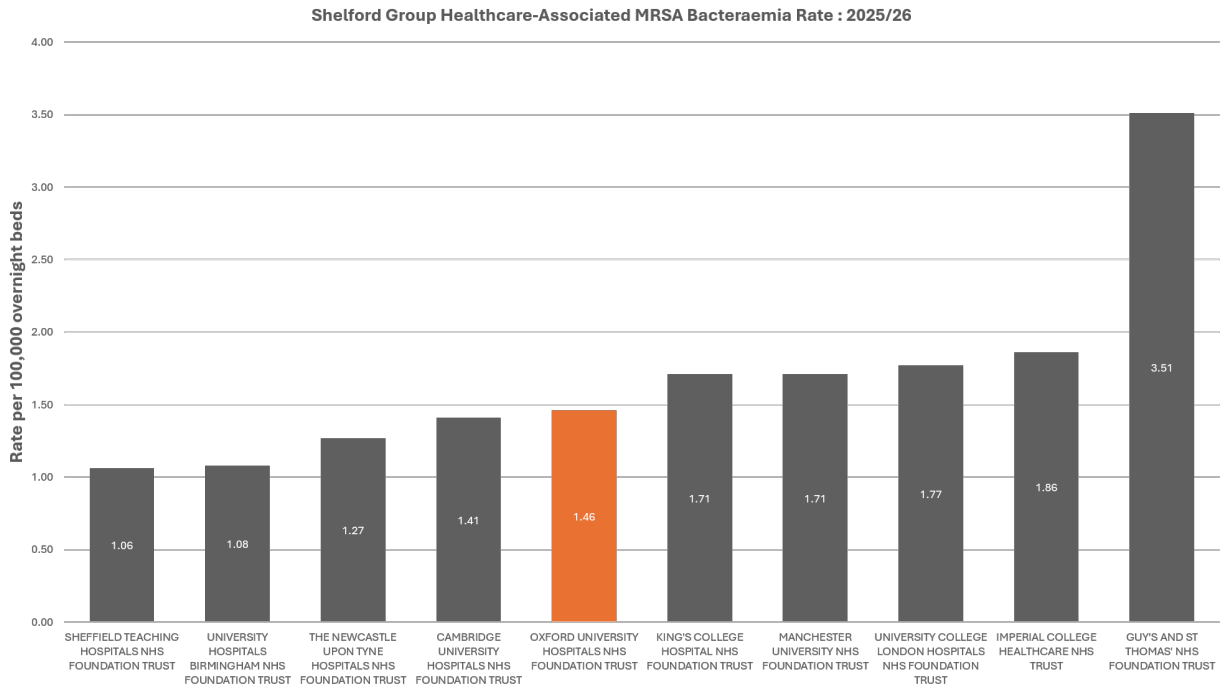
Table 4: MRSA: Breakdown of MRSA Infection Source

Recorded Source	No of HOHA	No of COHA
Endocarditis		1
Skin/soft tissue	1	
Urinary tract	1	1
Unknown / unclear	1	1

3.2. The number of MRSA bacteraemia cases assigned to OUH between April 2025 and March 2026 (six cases) gave the Trust a score of 3.32 in the NHS Oversight (NOF) Framework Acute Trust league table, demonstrating an improvement from 2024/25. A score of 1.00 would indicate zero cases. All Trusts with cases are given scores between 2.00 and 4.00 based on the absolute number of cases. This methodology is skewed against larger organisations with a more complex case mix, which might be expected to have a larger number of cases.

3.3. The bar chart (Table 5) shows OUH MRSA bacteraemia rate in comparison with the Shelford group of Trusts. Last year we were the worst performing Trust in the group so our position has improved. This metric is based on small numbers of cases and is therefore subject to stochastic variation.

Table 5: Shelford Group Healthcare-Associated MRSA Rate 2025-26



Quality Improvement project to increase the sensitivity of MRSA screening

3.4. For many years in the OUH, MRSA screening has been performed using a nose swab alone. National guidance recommends at least 2 sites to be screened. A literature review was performed to understand the sensitivity

of MRSA screening according to the number of swabs taken. It was estimated that by increasing the number of screening sites from a single site (nose) to multi-site (nose/throat, axilla/groin) the sensitivity of the screen could be increased from around 50% to 90%.

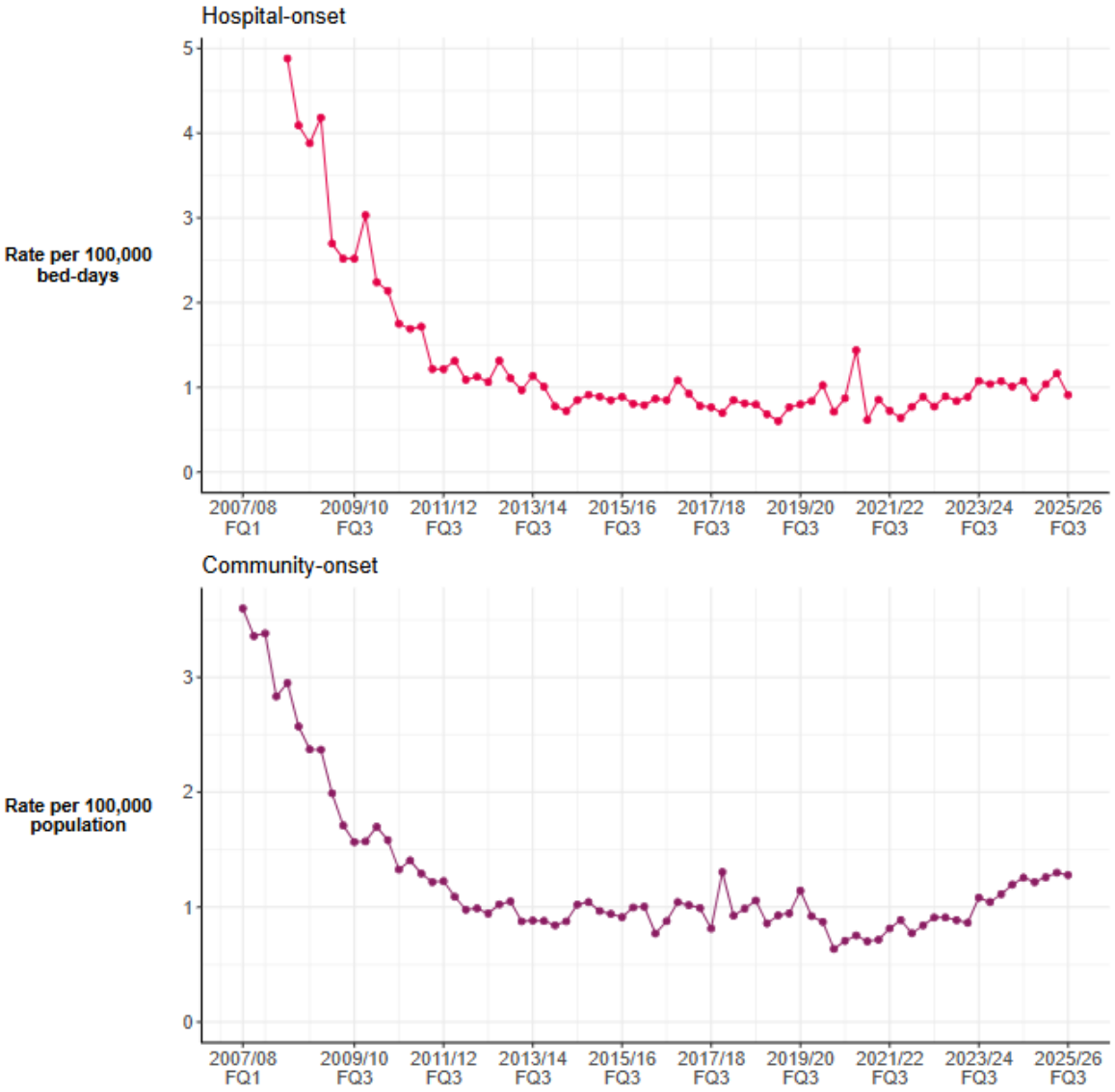
3.5. A quality improvement project was undertaken led by the IPC team to introduce a multi-site swab for MRSA screening across the Trust. This entailed procurement of a different swab specifically for MRSA (2 swabs and 1 specimen pot). All the screening sites are then processed as a single screen in microbiology. The screen request for MRSA in EPR was updated with the multi specimen site information. A collaborative pilot was undertaken on ward 6A, vascular triage and pre-operative departments for 4 weeks December to January. Feedback was collected from the microbiology laboratory and clinical staff in these departments on the acceptability of the new swab type, the screening process and the guidance resources which enabled implementation of lessons learnt before the wider roll out. Further learning was identified post roll out and iteratively shared and implemented across the Trust.

3.6. The project has led to a statistically significant increase in MRSA screen positive rate (1.02% positive with a single site screen, 1.35% positive with a multi-site screen, $p < 0.01$). This increased detection ensures that more patients can be decolonised reducing the risk of MRSA infection and bacteraemia, and more patients can be appropriately isolated reducing the risk of onward transmission.

National MRSA Picture

3.7. When comparing October to December 2025 with the equivalent pre-COVID-19 pandemic period (October to December 2019), there was an increase of 11.6% in the incidence rate from 1.6 to 1.8 cases per 100,000 population. 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 December 2026) (National data)



Methicillin-sensitive Staphylococcus aureus (MSSA) Bacteraemia

3.1. MSSA cases are reported externally but no threshold is set by NHS England. There were 75 cases in 2025/6, nine more than in the previous year.

3.2. The Trust reported 51 (47 in 2024-25) HOHA cases and 24 (19 in 2024-25) COHA cases for 2025-26. The main recorded infection sources are documented below (Table 7) and remain the same as last year. An increase in cases associated with peripheral lines inserted in the antecubital fossa was noted, and minimising use of this insertion site became a focus of messaging from the IPC team, including the issuing of a Trust-wide patient safety message. Numbers fell following this focus.

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)	23	4
Unknown / unclear	8	2
Skin or soft tissue (includes surgical site infection)	9	9

Table 8: Statistical Process Control (SPC) chart for HOHA and COHA associated MSSA bacteraemia (April 2024-March 2026)

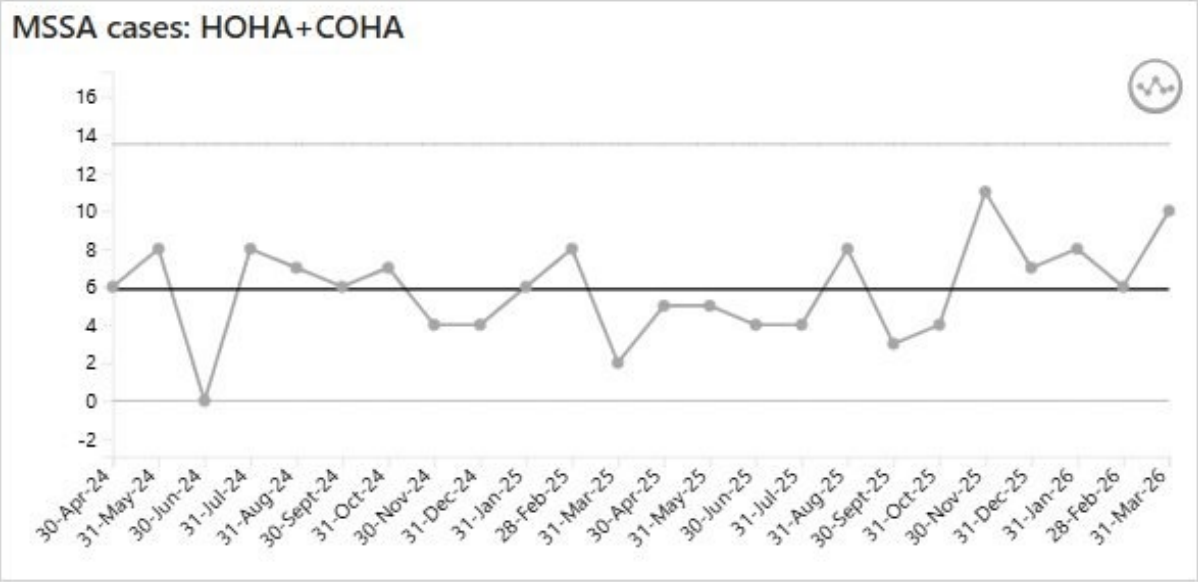
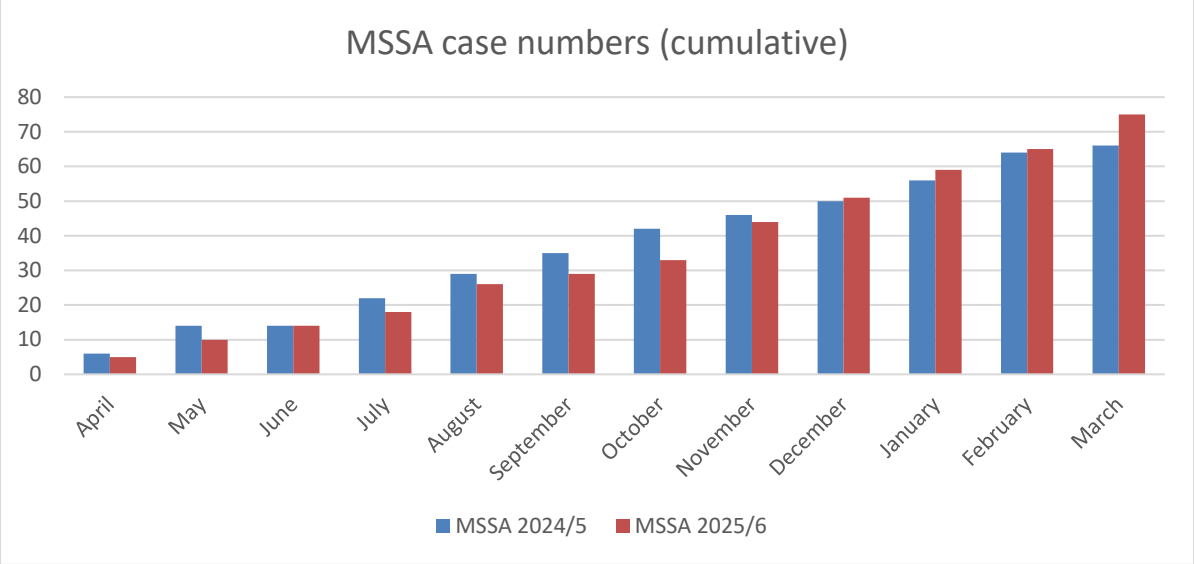
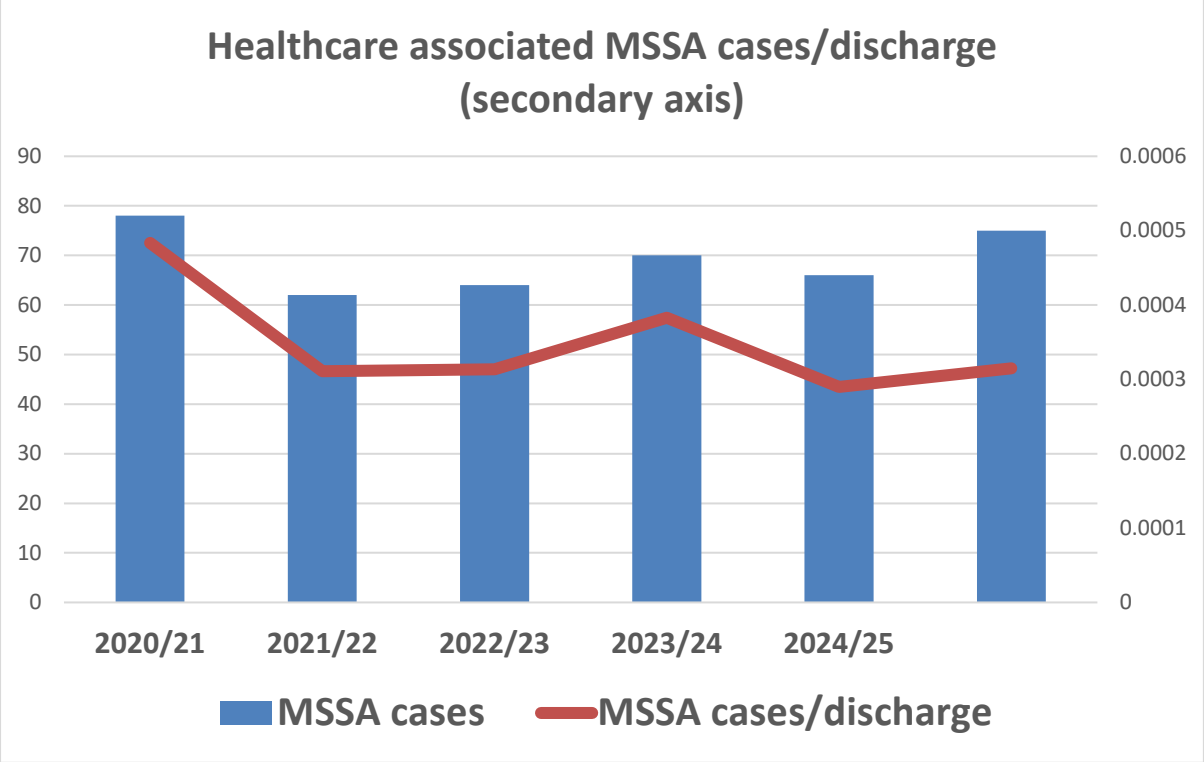


Table 9: Comparison of 2024/5 and 2025/6 MSSA case numbers.



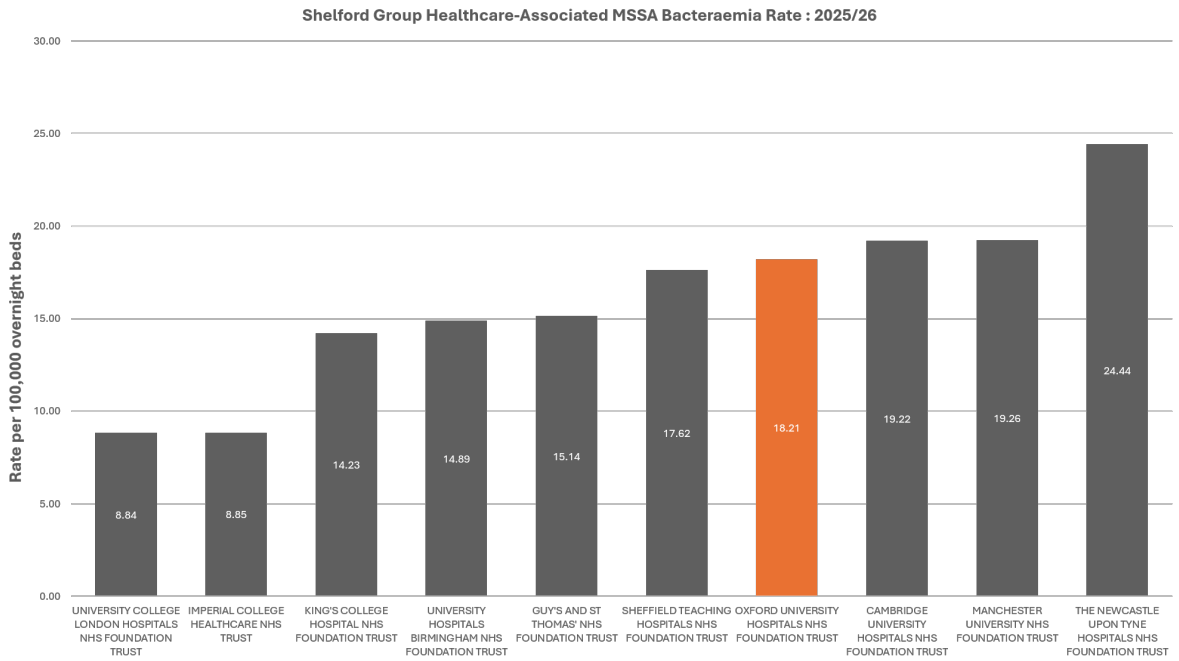
3.3. Controlling the MSSA bacteraemia cases for discharges as a measure of activity shows a relatively stable rate of healthcare attributable cases.

Table 10: OUH healthcare associated MSSA bacteraemia cases corrected for activity (discharges)



3.4. Table 11 shows OUH MSSA bacteraemia rate in comparison with the Shelford group of Trusts; our position has deteriorated from 6th to 7th highest in 2025/26.

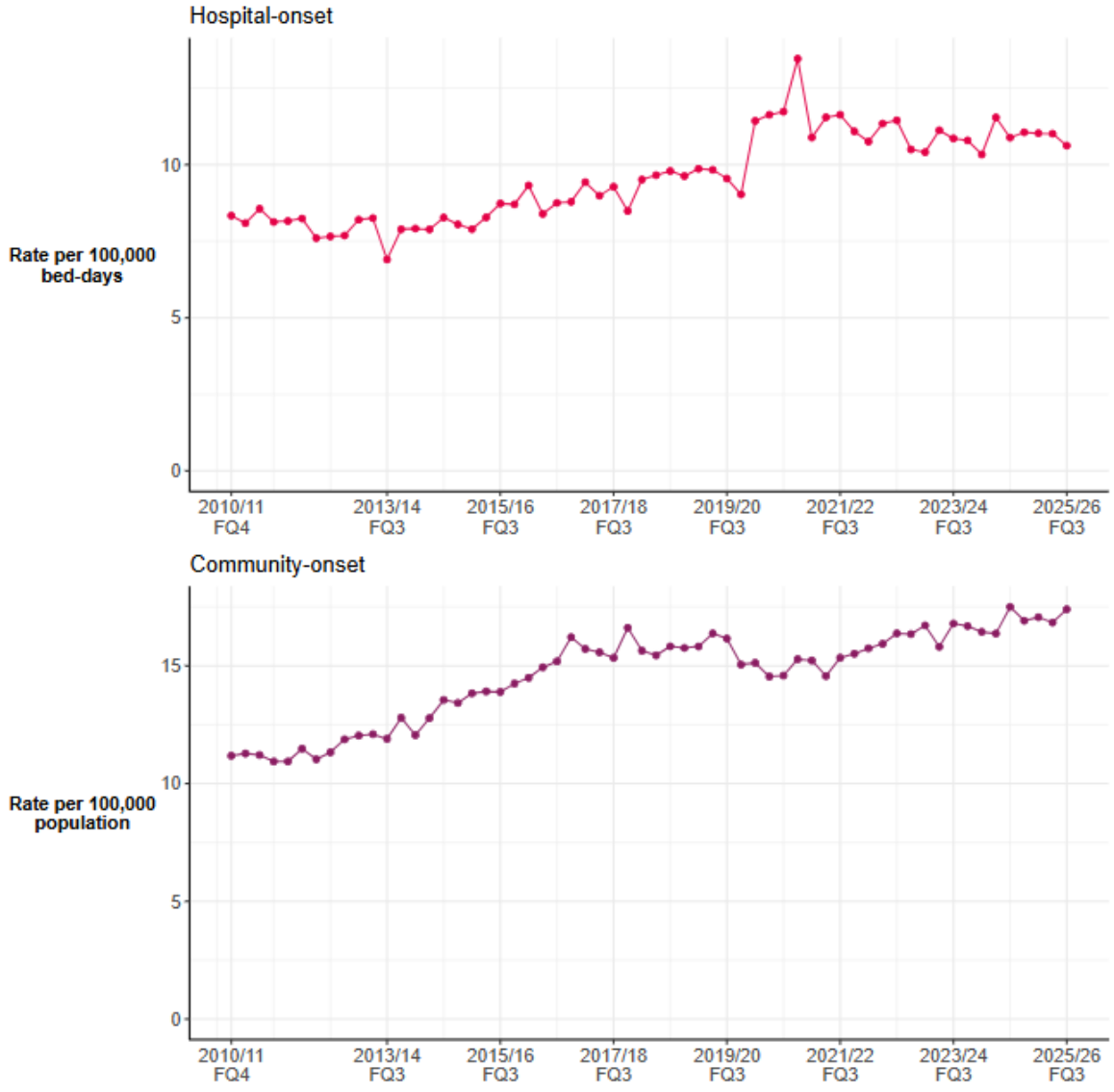
Table 11: Shelford Group Healthcare – Associated MSSA Rate 2025-26



National MSSA picture

3.5. When comparing October to December 2025 with the equivalent pre-COVID-19 pandemic period (October to December 2019), there was an increase of 7.9% in the incidence rate from 22.1 to 23.9 cases per 100,000 population. The incidence rate of community-onset cases increased by 7.7% from 16.2 to 17.4 cases per 100,000 population. (Table 12).

Table 12: National MSSA picture Quarterly rates of hospital and community-onset MSSA bacteraemia cases, January 2011 to December 2026



Gram Negative Bloodstream Infections

3.1. Due to the increasing trends nationally, the trajectories for Gram negative bloodstream infection were set in the NHS Standard Contract for 2025-26 at the lower of their 2024/25 thresholds **or** 10% decrease on 2024

calendar year cases (Table 13). For OUH as our trajectories were not met last year our thresholds were unchanged.

3.2. The OUH reported a total of 220 E. coli, 86 Klebsiella spp. and 46 Pseudomonas aeruginosa healthcare attributable blood stream infections in 2025-26, exceeding the trajectories set in the NHS Standard Contract for E. coli but well within our trajectories set for Klebsiella spp. and Pseudomonas aeruginosa.

3.3. 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.

3.4. The majority of E. coli bacteraemia cases seen in the Trust are community onset. The number of E. coli bacteraemia cases assigned to OUH between April 2025 and March 2026 gave the Trust a score of 3.42 in the NOF Acute Trust league table, which represents a slight deterioration.

3.5. It is not clear why the number of Klebsiella spp. and Pseudomonas aeruginosa healthcare associated bloodstream infections have reduced so significantly without the same reduction in E. coli. However, there are a number of programmes in place, including in relation to central-line associated bloodstream infection (CLABSI) reduction, water management, urinary catheter management, antimicrobial stewardship (AMS) and cleaning, all of which could have had an impact, in addition to any differences due to random chance.

Table 13: Health care attributable Gram-negative blood stream infections for 2022-23 to 2025-26

	Total Cases 2022-23	**Total Cases 2023-24**	**Total Cases 2024-25**	**Total Cases 2025-26**	**Trajectory 2024-25 and 2025-26**
E. coli	208	173	220	220	165
Klebsiella	87	94	101	86	89
Pseudomonas	56	63	63	46	59

3.6. Tables 14, 15 and 16 show the SPC charts for the Gram negative blood stream infections for the last 2 financial years. The black line represents the average number of cases by month over the 2 years, and the dotted orange line represents the NHSE trajectory.

Table 14: SPC HOHA and COHA associated E. coli bacteraemia (April 2024-March 2026)

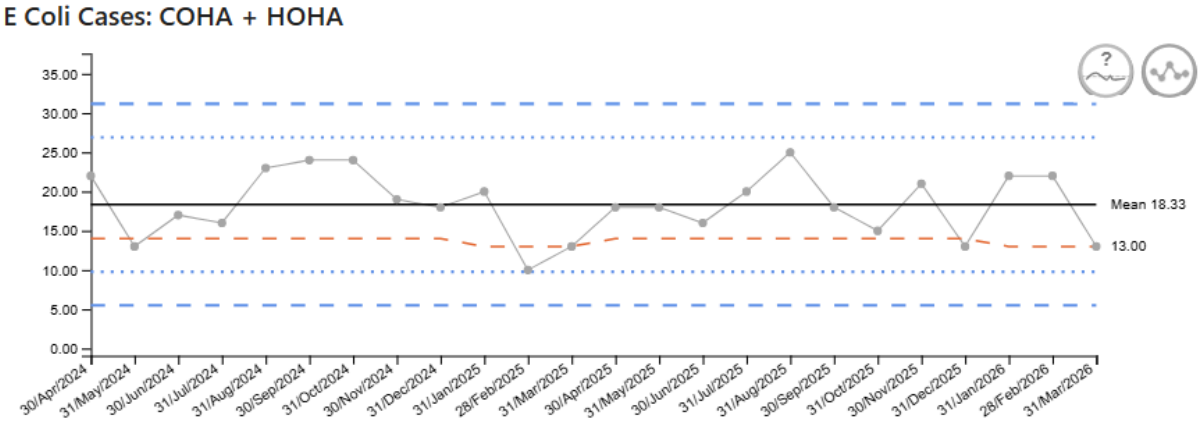


Table 15: SPC HOHA and COHA associated Klebsiella bacteraemia (April 2024-March 2026)

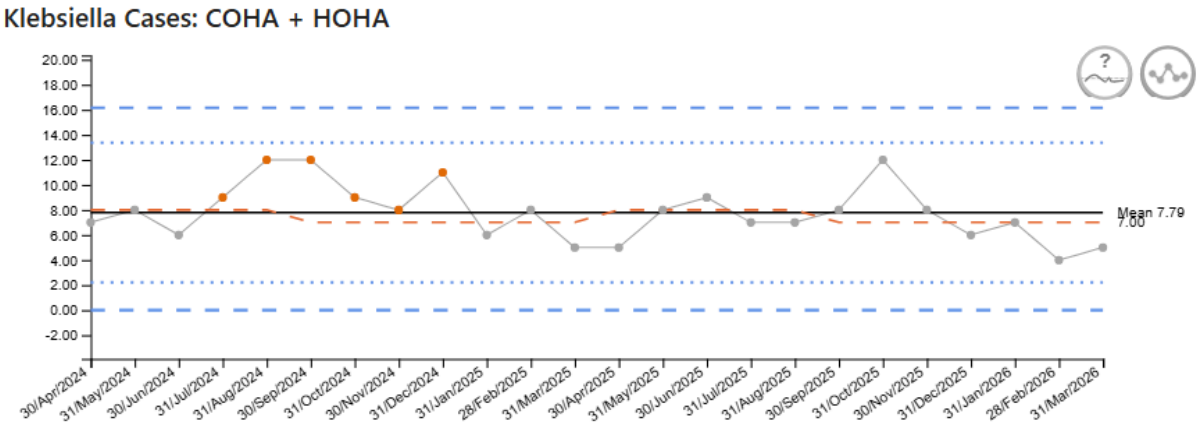
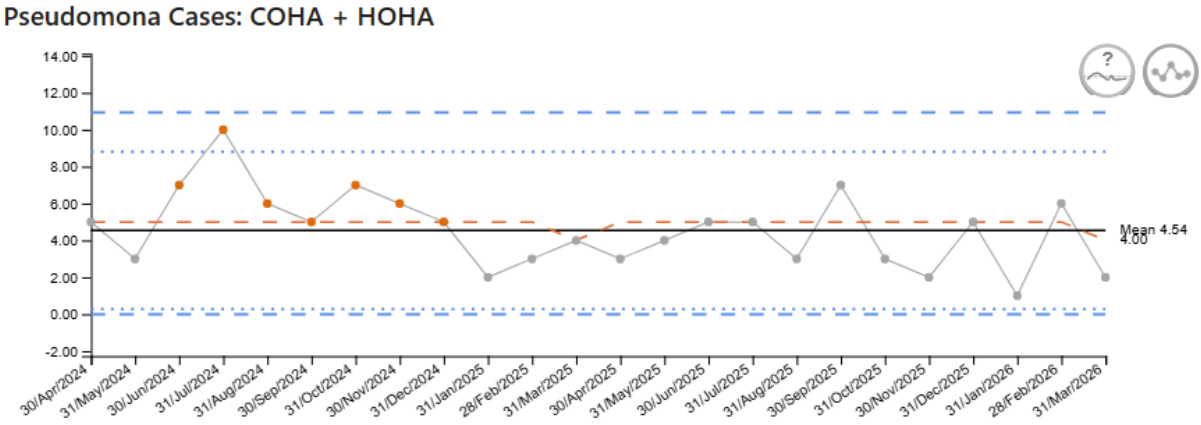


Table 16: SPC HOHA and COHA associated Pseudomonas bacteraemia (April 2024-March 2026)



3.7. Tables 17 and 18 show the most likely source of infection for the healthcare associated Gram negative blood stream infections divided by hospital and community onset. The number of patients with a

hepatobiliary or urinary focus presenting back to the Trust after a hospital discharge provides a potential focus for intervention.

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

	Unknown	Line / device	Gastro / Gut related	Other (eg chest)	Hepato-biliary	Urinary
Klebsiella	9	6	7	6	4	8
Pseudomonas	8	7	4	5	3	4
E. coli	32	3	20	9	23	31

Table 18: Main Sources of Infection for Gram-negative Bloodstream Infections (COHA)

	Unknown	Line / device	Gastro / Gut related	Other (eg chest)	Hepato-biliary	Urinary
Klebsiella	3	1	1	2	6	9
Pseudomonas	10	1	0	1	0	3
E. coli	22	3	5	4	22	45

Table 19: Shelford Group healthcare associated E.coli Rate 2025-26. Oxford has the highest rate out of 10 Trusts, although a slightly lower rate than we had last year.

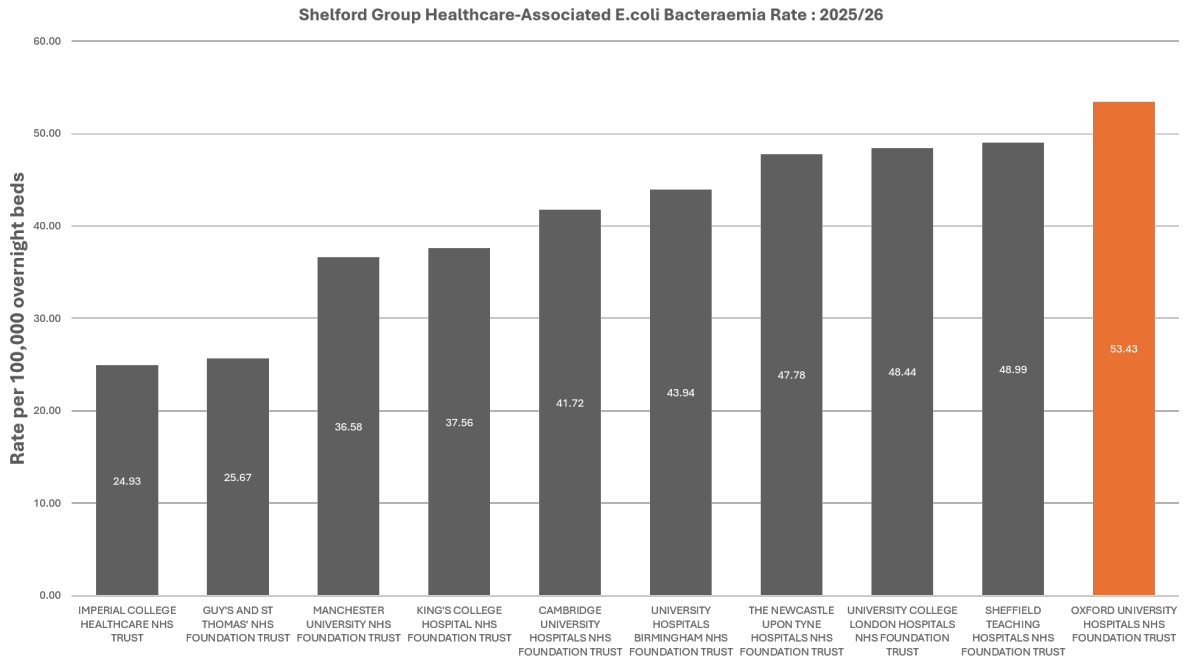


Table 20: Shelford Group Healthcare–Associated Klebsiella spp. Rate 2025-26

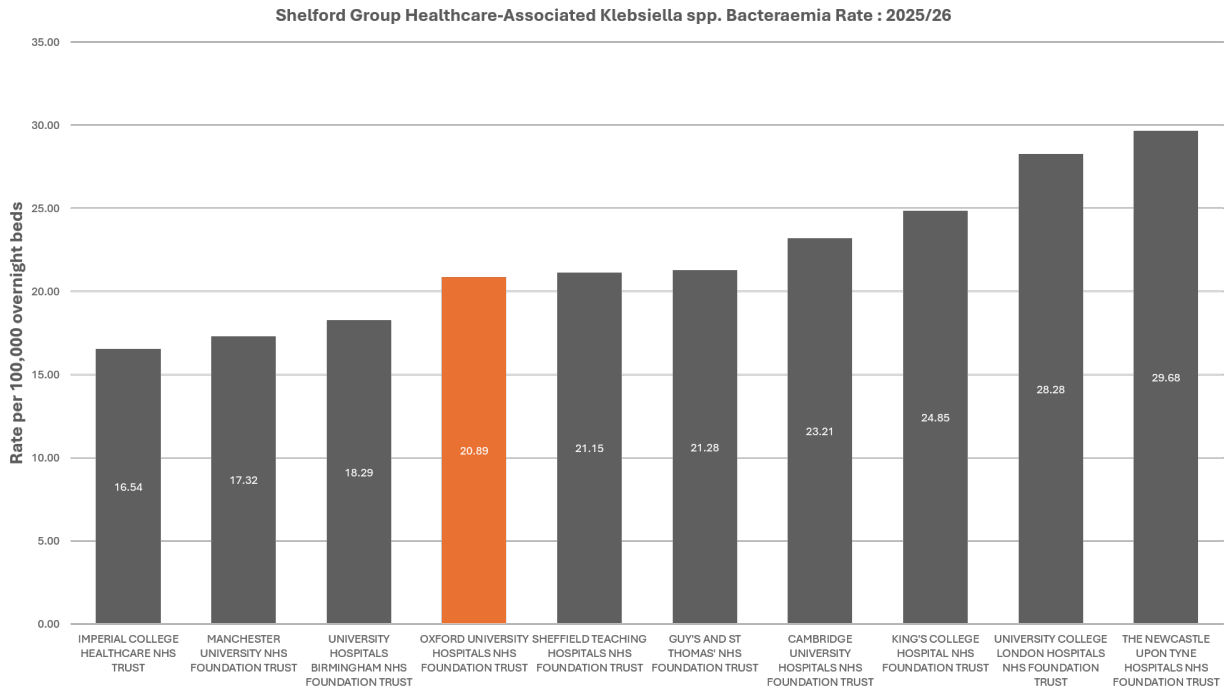
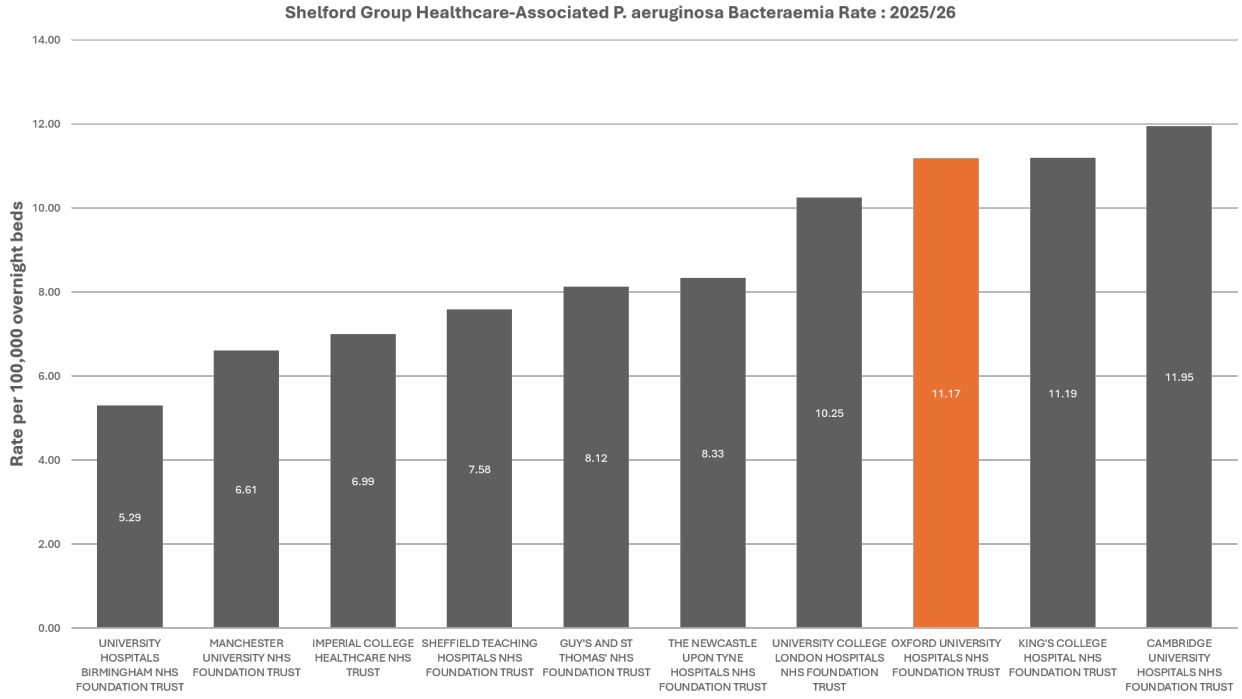


Table 21: Shelford Group Healthcare–Associated *P. aeruginosa* Rate 2025-26



Clostridioides difficile (C. difficile)

Reporting and investigation of C. difficile

3.1. A *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)

3.2. The trajectory for C. difficile infection in the NHS Standard Contract for 2024-25 was set at the lower of the 2024/25 thresholds **or** 10% decrease on 2024 calendar year cases. The threshold for OUH apportioned cases of C. difficile for 2025-26 was unchanged at 123 cases. OUH reported 109 cases (Table 22), an improvement of 55 cases, and 14 cases below NHS trajectory. This represents a 33% reduction on the incidence in 2024/25.

3.3. The number of *C. difficile* cases assigned to OUH between January and December 2025 gave the Trust a score of 2.14 in the NOF Acute Trust league table, which placed us 54th out of 134 Trusts – this was a further improvement on the previous quarter (2.38, 61/134). We further improved on this position in the final quarter of 2025/26 with a score of 1.00 (the lowest possible score), due to meeting our threshold for 2025/6.

Table 22: Cumulative cases of OUH apportioned *C. difficile* (COHA plus HOHA) in 2024/5 and 2025/6 compared to the threshold set by NHS England

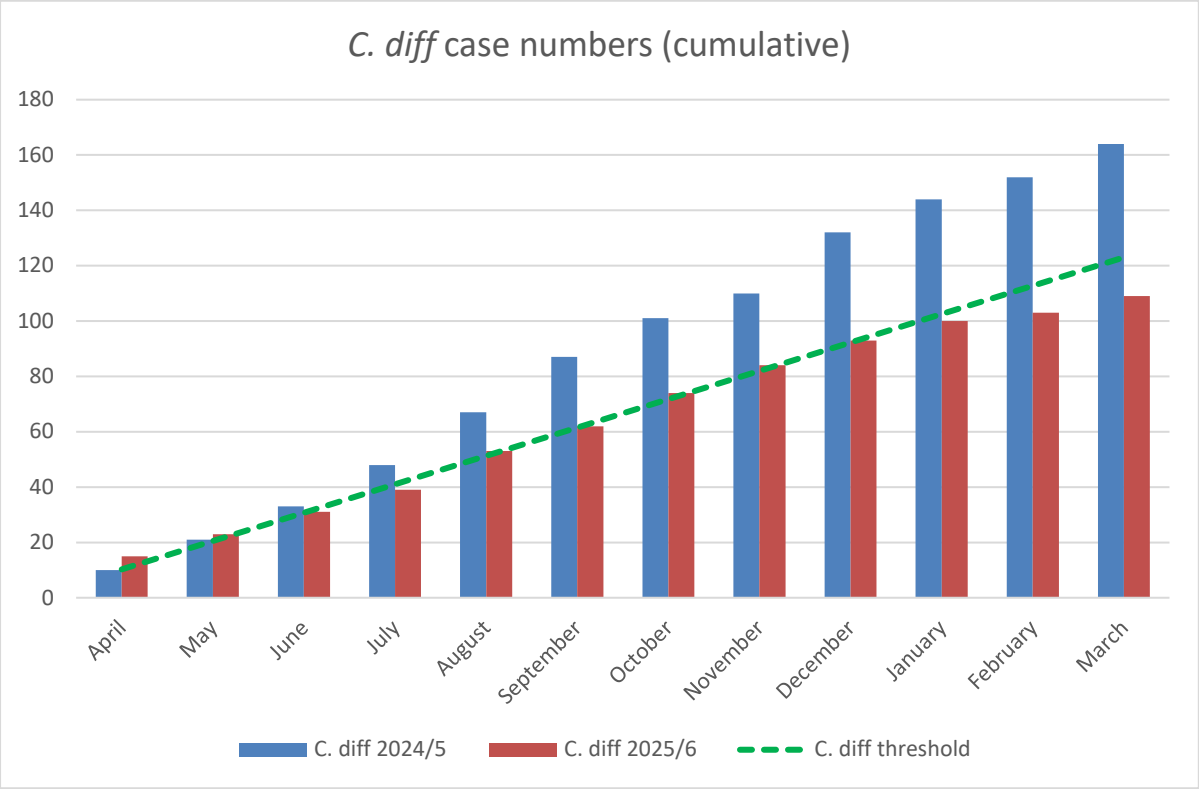
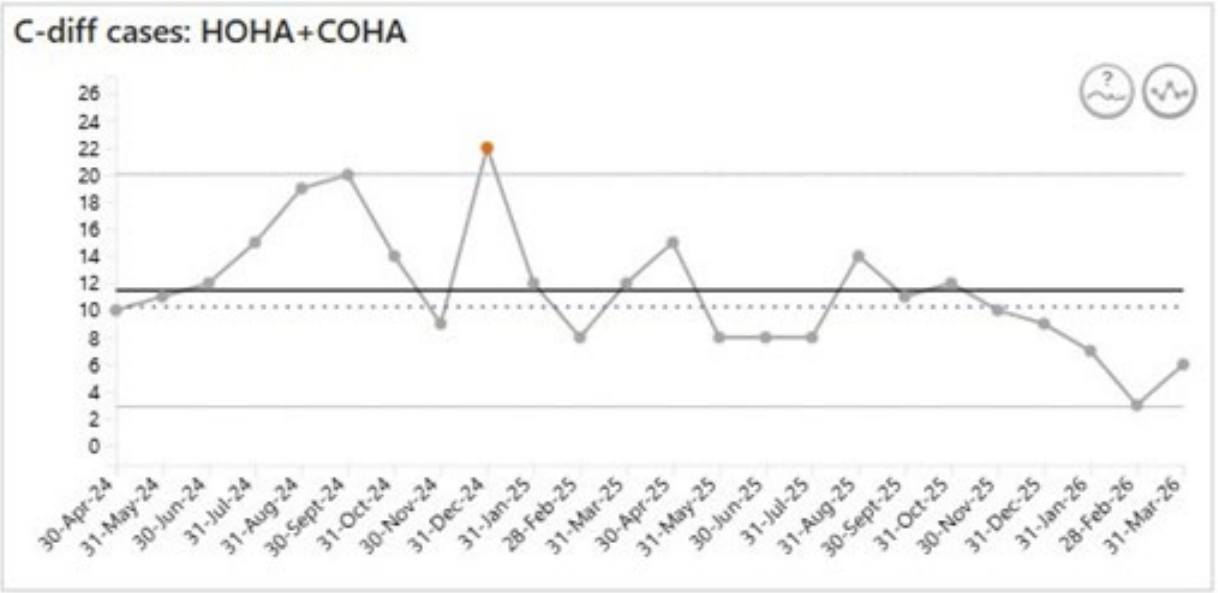
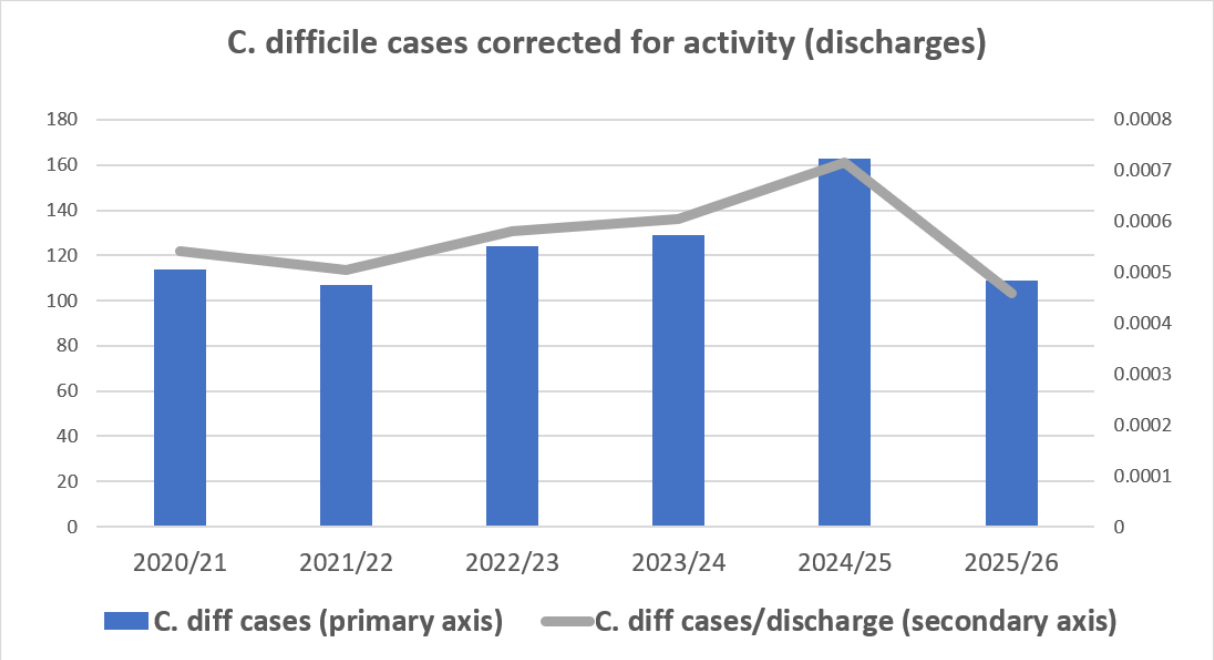


Table 23: SPC chart of HOHA and COHA C. *difficile* infection counts (April 2024-March 2026)



3.4. Correcting the C. difficile data using discharges as a measure of OUH activity supports our improved trajectory with a significant decrease in cases per episode of care in 2025/26 (Table 24).

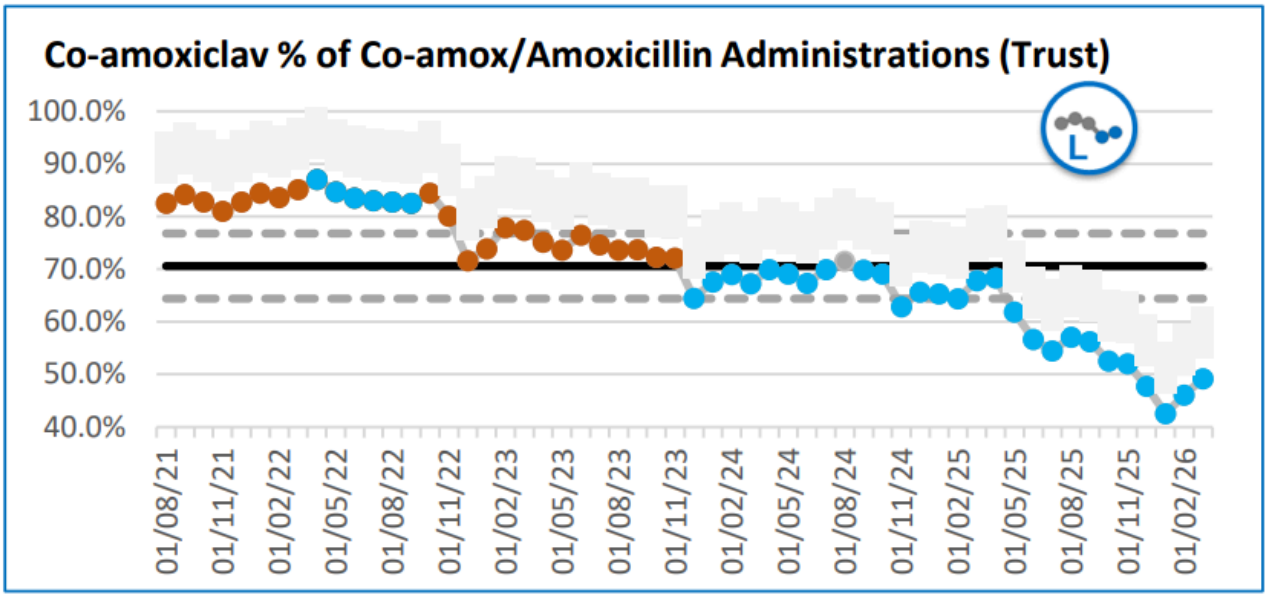
Table 24: OUH healthcare associated C. difficile cases corrected for activity (discharges)



3.5. A significant amount of proactive work has taken place over the last few years in the OUH to minimise the occurrence of C. difficile infection including:

- Additional testing to identify and isolate those patients who are carriers of toxigenic strains but do not have *C. difficile* infection, since 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 significant association with *C. difficile* infection. This is likely to be the intervention with the most impact; the reduction in *C. difficile* cases is seen in conjunction with a significant decrease in the use of co-amoxiclav across the Trust, and improvements in prescription of antibiotics from the Access category, relative to the Watch and Reserve categories. Table 25 shows the reduction in co-amoxiclav as a percentage of Co-amoxiclav and Amoxicillin prescriptions, driven by antimicrobial guidance and other AMS activities.

Table 25: Co-amoxiclav as a percentage of Co-amoxiclav and Amoxicillin prescriptions



3.6. 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).

3.7. 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.

3.8. Block booking of enhanced cleans to avoid missing enhanced cleans due to requesting.

3.9. 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.

3.10. Cleaning improvement interventions last year have been followed with a review of cleaning products this year. Following a review of published evidence, a trial was undertaken on Level 7 of the main JR building, using a combined detergent and disinfectant for all environmental cleaning. The disinfectant uses peracetic acid, which has been shown to have a number of efficacy and safety benefits over chlorine. The trial saw a reduction in healthcare-associated infections across the wards taking part which, although small, was greater than the reduction seen in other areas. Following this and good feedback from users, it was agreed to roll the product out across the rest of the JR site in 2026/7.

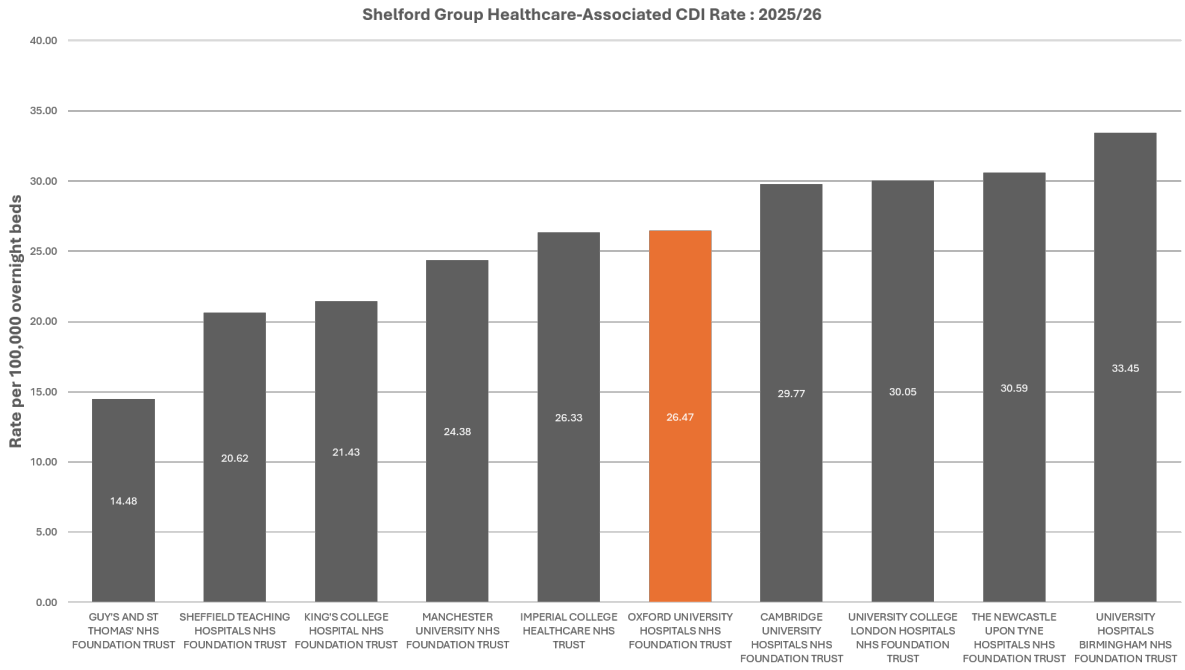
C. difficile ribotyping network (CDRN)

3.11. The OUH was selected as a sentinel site for national whole genome sequencing (WGS) surveillance as part of the *C. difficile* ribotyping network (CDRN). Starting from April 2025, the first 10 samples from the hospital and community each month were submitted to the CDRN for ribotyping and WGS. Ribotyping results are reported monthly and WGS is reported quarterly. The data from the CDRN are used to support OUH investigation into rates of *C. difficile.* WGS reports for Q1 and Q2 have been received and together with the monthly ribotyping results have not identified any strong epidemiological links to inform IPC interventions. Q1 and Q2 each found a pair of cases with a close genetic link, however no epidemiological links were found in GP or OUH location history between each pair which may suggest an unknown community reservoir. Further results from the ongoing surveillance may shed additional light on this.

OUH compared to Shelford Hospital Group

3.12. When comparing OUH to the Shelford groups, our position has improved significantly from our rate in 2024/25 (40.5) and our position relative to other Shelford Trusts (8th to 6th) (Table 26).

Table 26: Shelford Group Healthcare–Associated C. difficile Rate 2025/26



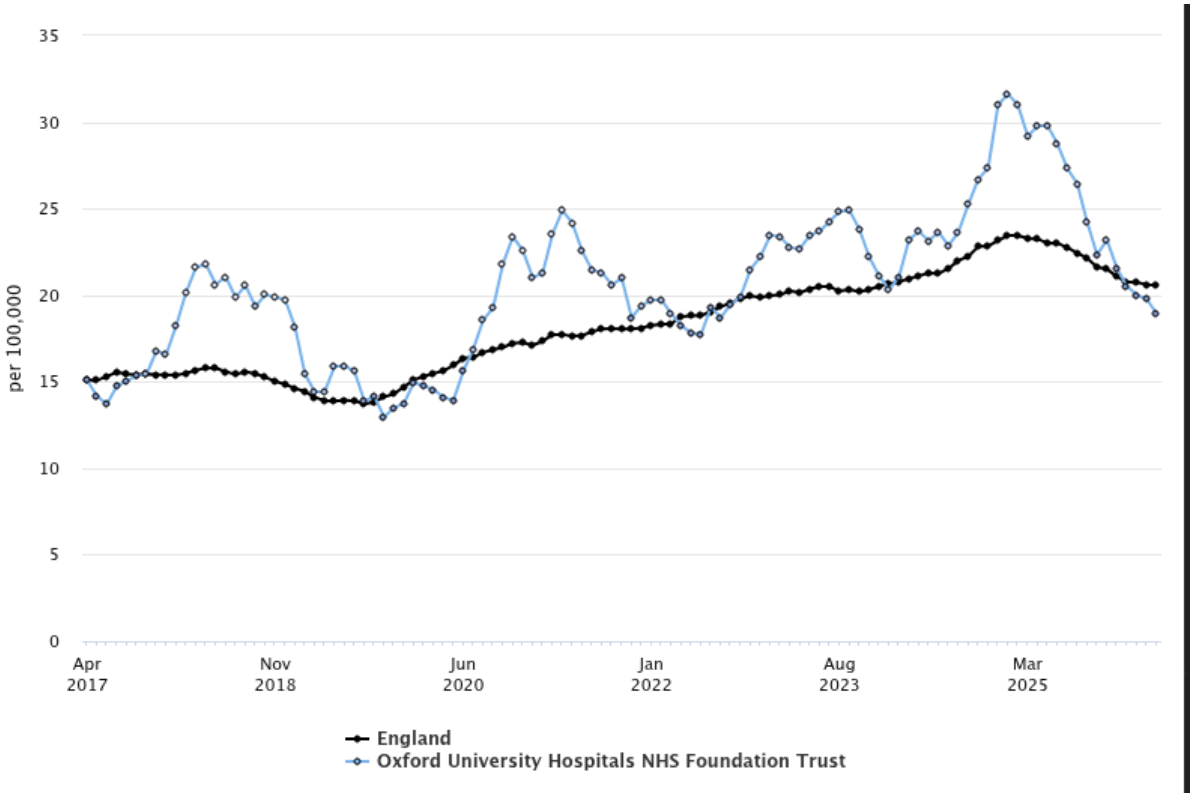
National C. difficile data

3.13. During the quarter October to December 2025 in England:

- there was a 17.6% decrease in incidence rate from 23.7 to 19.6 per 100,000 bed-days compared with the same quarter last year in hospital onset cases

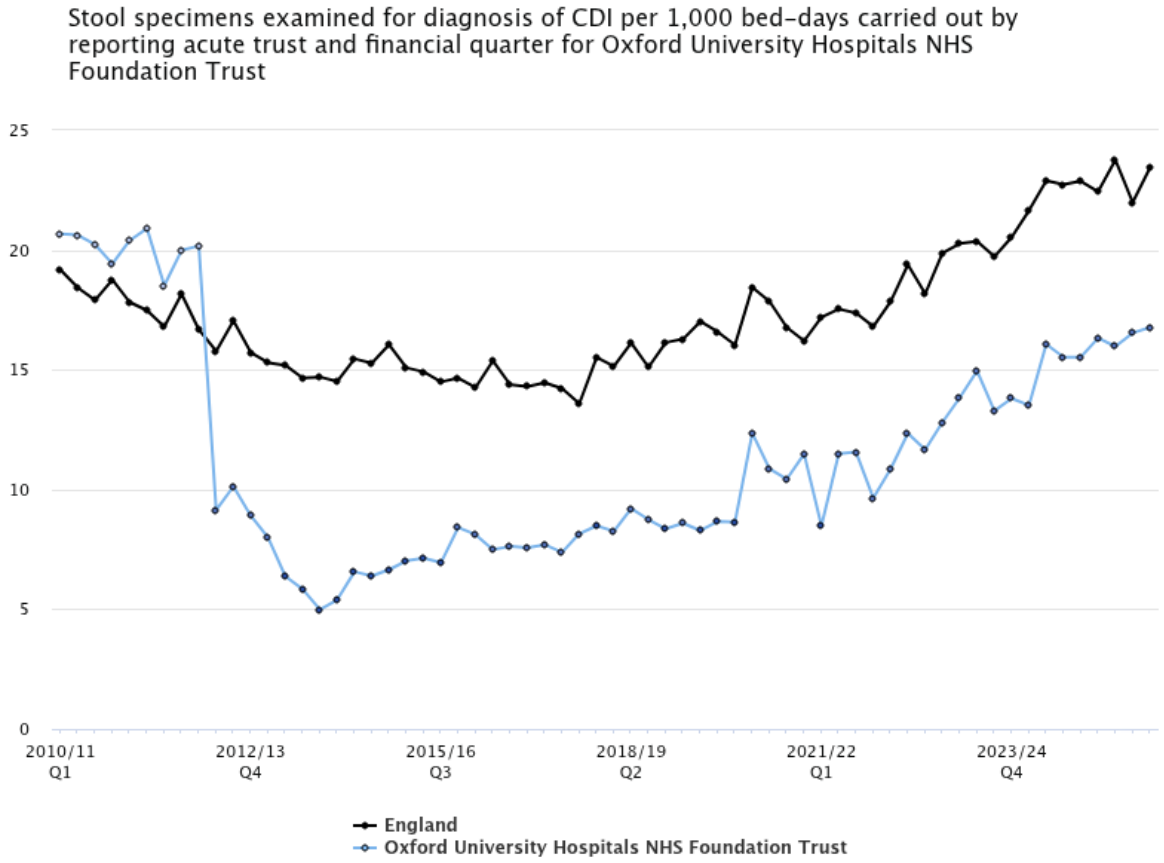
- Table 27 shows the *C. difficile* rates for the OUH baselined against the England data

Table 27: C. difficile infection 12-month rolling counts and rates of hospital onset-healthcare associated cases for OUH to March 2026 graphed against England rate



3.14. The number of stool samples processed in the OUH for C. difficile continues to increase (Table 28). This includes samples from the community. It is pleasing that C. difficile infection rates in the OUH have reduced against a continued increase in testing across the Trust. It is likely that testing rates will be included as part of the NOF Acute Trust League tables in 2026-27.

Table 28: Number of stool samples processed for C. difficile by OUH Microbiology laboratory (data to March 2026)



Central Line Associated Bloodstream Infection (CLABSI) surveillance

3.1. 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.

CLABSI surveillance in the Intensive Care Units

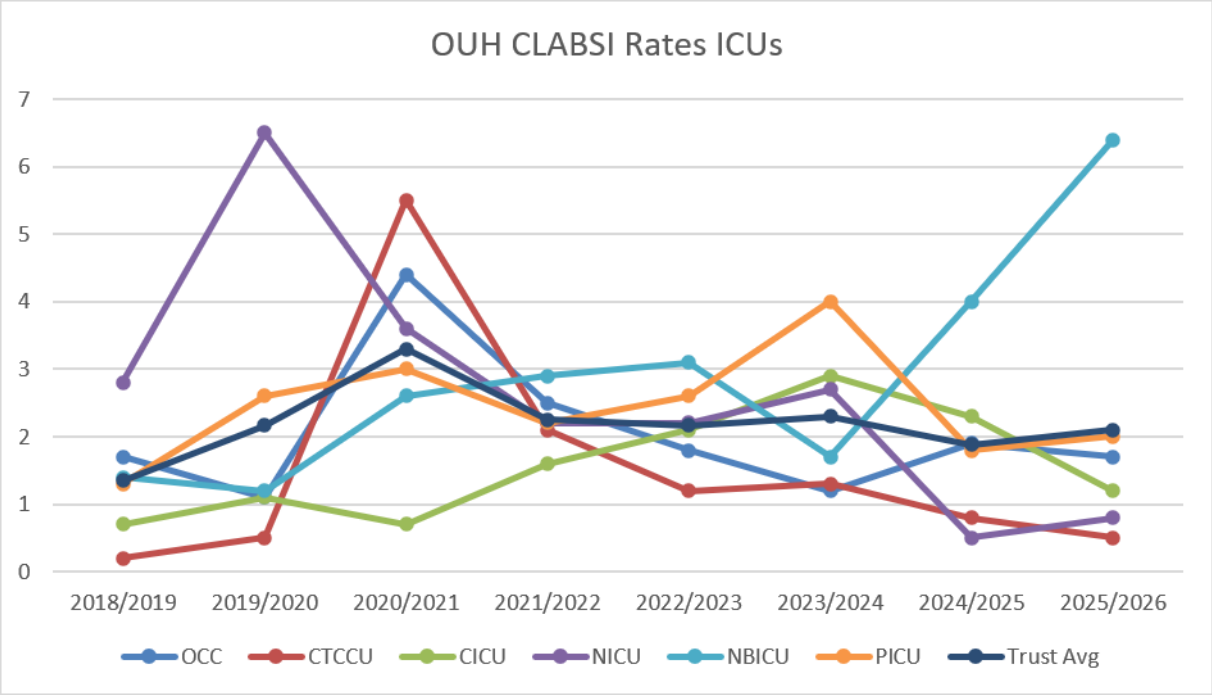
3.2. CLABSI surveillance is undertaken for all the intensive care areas by the IPC team. The CLABSI rate for all intensive care areas continues to be reviewed on a quarterly basis and results are fed-back to clinical units and Divisional governance leads.

3.3. In 2025-26 (Table 29):

- Rates in all ICUs with the exception of neonatal ICU remain close to or well below the national benchmark (1.7 per 1000 catheter days in 2023/24).

- In 2025/26 Neuro-ICU had only one CLABSI episode, and Cardiothoracic critical care (CTVCC) had only 2 episodes. 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. The results of aseptic non-touch technique (ANTT) and hand hygiene audits are reviewed at regular monthly meetings with the IPC and multi-disciplinary teams.

Table 29: Annual CLABSI rates by ICU April 2018-March 2026, Rates are per 1000 line-days



Trust wide non-ICU CLABSI surveillance

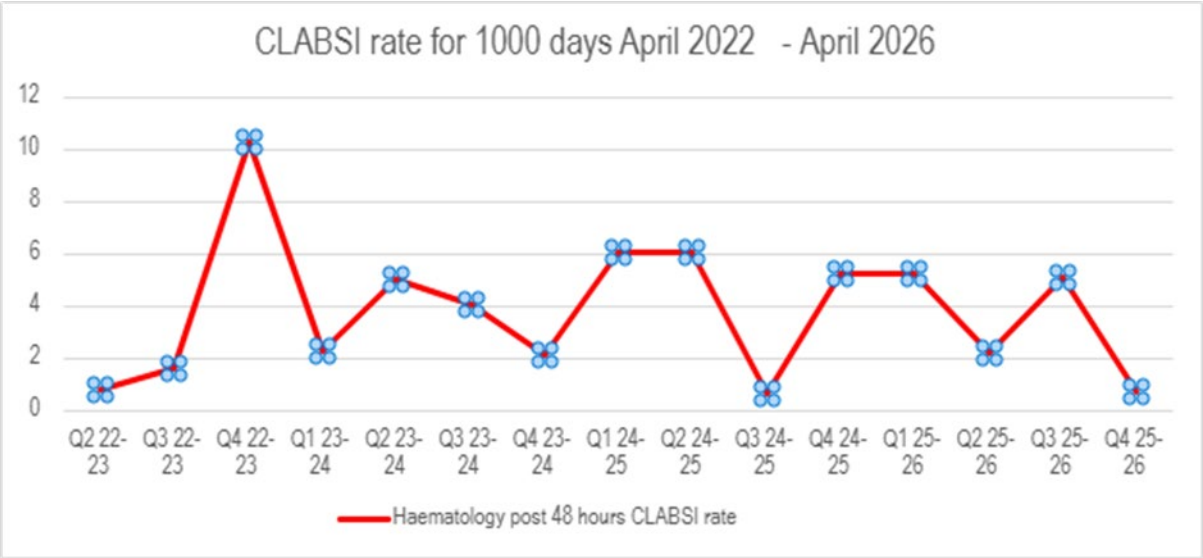
3.4. The IPC team continues to undertake Trust-wide surveillance of non-ICU Central Line Associated Bloodstream Infections (CLABSI). During the reporting period, 541 bloodstream infection episodes were reviewed, of which 109 were identified as line-associated bloodstream infections (CLABSIs) and 434 were classified as non-line-related infections.

3.5. Within the non-ICU CLABSI surveillance programme, longer-term lines are frequently used in a number of units for parenteral nutrition, and for vascular access including renal dialysis and chemotherapy in an ambulatory setting. These areas include adult and paediatric haematology and oncology, renal and gastroenterology. 65 CLABSI cases were reported during 2025/26 within the units under surveillance. Data

collection, especially for line-days, is challenging in the absence of surveillance software currently.

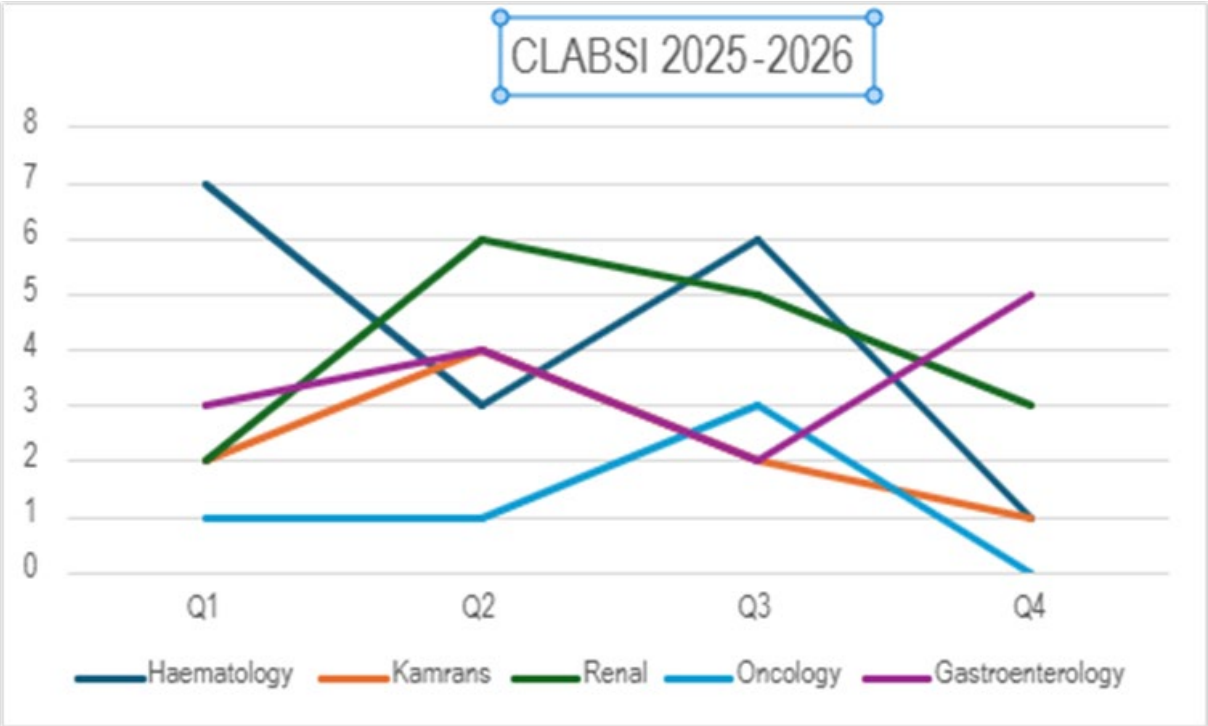
3.6. Adult haematology historically has the highest levels of CLABSI in this surveillance group, but recent data is more encouraging (Table 30).

Table 30: Annual CLABSI rate (per 1000 line days) for adult Haematology



3.7. Quarterly totals across all monitored units remained relatively stable, with 17 cases in Q1, 18 cases in Q2, 18 cases in Q3, and a reduction to 12 cases in Q4, which represented the lowest quarterly total of the year (Table 31).

Table 31: Annual CLABSI counts by unit for all monitored non-ICU settings

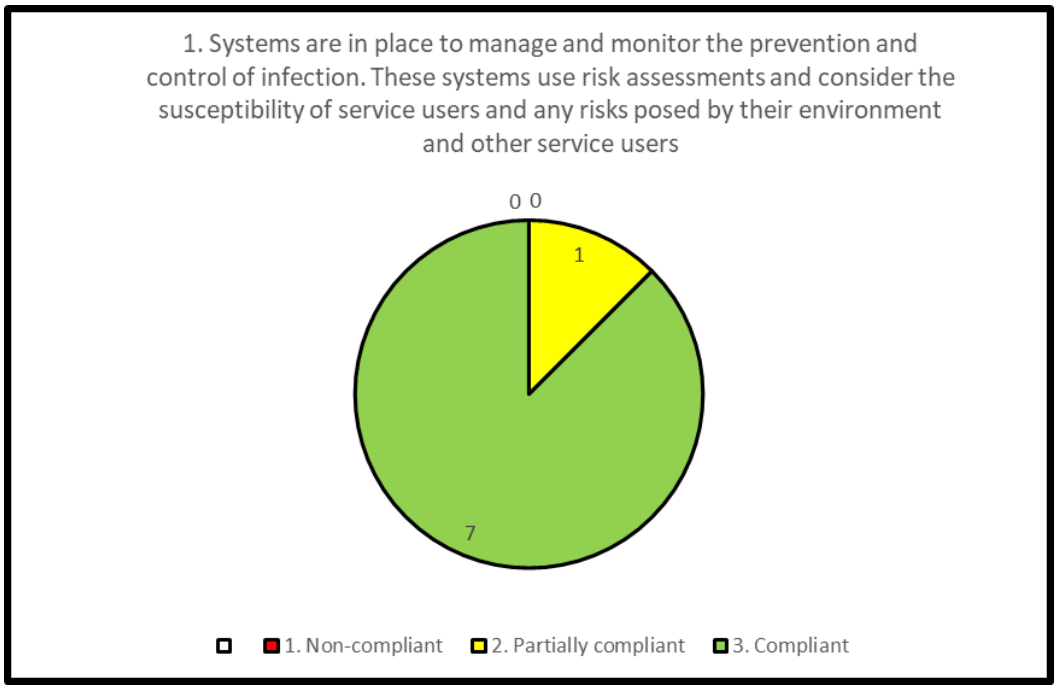


3.8. The number of cases observed highlights the importance of continued focus on line insertion standards, maintenance practices, timely line review, and ongoing surveillance within high-risk patient groups.

IPC surveillance

3.9. The company that supplied the Trust's previous electronic IPC surveillance system (ACMEipc) has ceased trading and the system is no longer available following the switch in Microbiology to a new Laboratory Information Management system (LIMS) in March 2025, removing the interface. The absence of a unified IPC surveillance system remains the most significant organisational risk. By year end, funding had been secured for an IPC surveillance system with the required functionality (ICNET) and implementation is planned through 2026/27. A number of different surveillance systems providing partial mitigation remain in place.

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	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	Procurement of a suitable surveillance package (ICNet) is complete and implementation in progress – this is expected to be in place in Q4 2026/27. Current partial

Prevention and Control Manual.	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.	mitigation strategies remain in place.

4. Criterion 2

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

Environmental IPC and decontamination
Water Safety Group (WSG) and Ventilation Safety Group (VSG)

4.1. 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 including Estates and PFI colleagues. Compliance reports are produced by the Operational Estates team and all the PFI partners, with the exception that the NOC and Churchill PFI provider has not been providing ventilation compliance reports to the VSG. This assurance gap is being addressed by the PFI Contracts team. 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.

Water safety
Churchill Hospital

4.2. 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, though the ongoing maintenance and cleaning of them brings additional challenges, and the filters themselves can present infection risks if not managed correctly.

4.3. 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.

4.4. The root cause was thought to be a failure to maintain the flow of hot water, with cooler temperatures supporting growth of Legionella. An engineering solution in 2023/4 and upgrading of several thermal balancing valves in 2025/26 has been followed by eight months of consistently compliant temperature readings. If this continues, all SIRI actions are planned to be complete by October 2026. Discussions in the fortnightly SIRI review meetings are now focused on plans to enable the POUFs to be removed following a period of sampling.

Whitehouse Renal Dialysis Unit

4.5. 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 2023/4.

4.6. The Trust rents 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 escalated to Milton Keynes Council.

4.7. Engineering work took place in 2024/5 to install valves to improve the turnover of the water and servicing of the taps has taken place. Further work was due to take place in 2025/6 however there have been challenges in identifying contractors able to undertake the work. POUFs remain in place on all outlets to ensure a safe water supply.

Ward 5C/5D

4.8. Since the commissioning of Wards 5C/5D at the JR following refurbishment work, there had been an issue with positive outlets for Pseudomonas spp.

4.9. Pipework installation, observation of practice on the ward (cleaning, and use of sinks for water disposal) and maintenance standards were reviewed. Estates conducted remedial work including chlorination and changing taps and spouts. Inline thermal disinfection units were installed.

4.10. Repeat testing showed a gradual improvement over time and all outlets are now testing negative, so are expected to return to business-as-usual management imminently.

Decontamination

4.11. 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.

4.12. Significant progress has been made in strengthening decontamination standards across the Trust.

4.13. A Trust-wide ultrasound probe decontamination audit completed during 2023-24 identified opportunities for improvement, and a report summarising the findings and recommendations was produced to support service improvement and compliance through 2025/26.

4.14. Specialist decontamination advice and training have been provided to departments using reusable endoscopes, supporting patient safety and compliance with national standards. Support has been provided for the development of a business case for a new John Radcliffe Endoscopy Decontamination Unit, ensuring infection prevention, decontamination, sustainability, and NHS England Design for Life principles are incorporated from the outset. Input has been provided into design of the new Churchill Endoscopy Decontamination Unit and advising on the future of the West Wing decontamination facility following the loss of service due to biofilm contamination within washer-disinfectors, identifying opportunities to reduce costs whilst maintaining service resilience.

4.15. Decontamination support has been provided to other Trust services during the year, including:

- advice on decontamination requirements and environmental controls for the neonatal incubator decontamination area.
- supporting equipment procurement and service design for the Surgical Elective Centre.

4.16. Collaborative work with Theatre Services, Sterile Services, the Renal Dialysis Team, and Optometry has reviewed decontamination processes, identifying opportunities to improve efficiency, reduce costs and maintain compliance.

Cleaning

4.17. The National Standard of Cleaning was updated in 2025, and the changes were implemented across the organisation. The IPC team and Clinical Decontamination Practitioner participate in cleaning audits as required. MyAudit software continues to provide the data used to improve cleaning across the Trust.

4.18. HIPCC receives a report from the Trust PFI office, reporting by exception those areas with cleaning audits with 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.

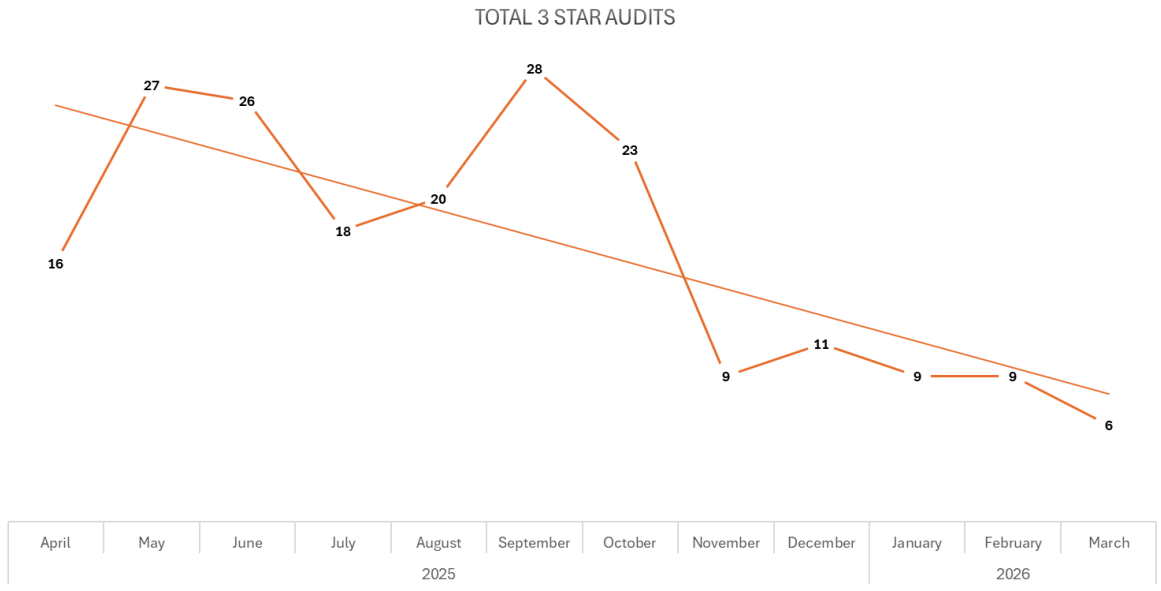
4.19. For context the PFI team perform over 4800 cleaning audits each year in total. The majority of audits are 5* (70%).

4.20. The top 7 areas with recurring 3-star rating in 2025/26 are found in Table 32. The total number of 3-star or less audits is tracked and noted to be reducing, see Table 33. In 2025 the percentage of audits at 3* or less was 5%; in 2026 (to September) the percentage at 3* or less was 2.6%, providing appropriate assurance that the issues are being addressed. As an example, in the Emergency Department, low scores were seen in autumn 2025. This was discussed at HIPCC and a suggestion was made of investigating whether volunteers could help with equipment cleaning, to assist the busy clinical teams there. This was instigated and a significant improvement in scores was seen.

Table 32: Locations with highest number of 3 Star or less audits, April 2025-March 2026

Row Labels	3 stars or fewer
Blk 09 - ORU - Observation and Review Unit	13
Blk 09 - ED Majors	11
Blk 09 - ED Resus	11
Blk 09 - JR 2 Theatres	7
Blk 09 - EAU	7
Blk 105 - PFI Theatres	6
Blk 06 - Delivery & Observation Suite	6

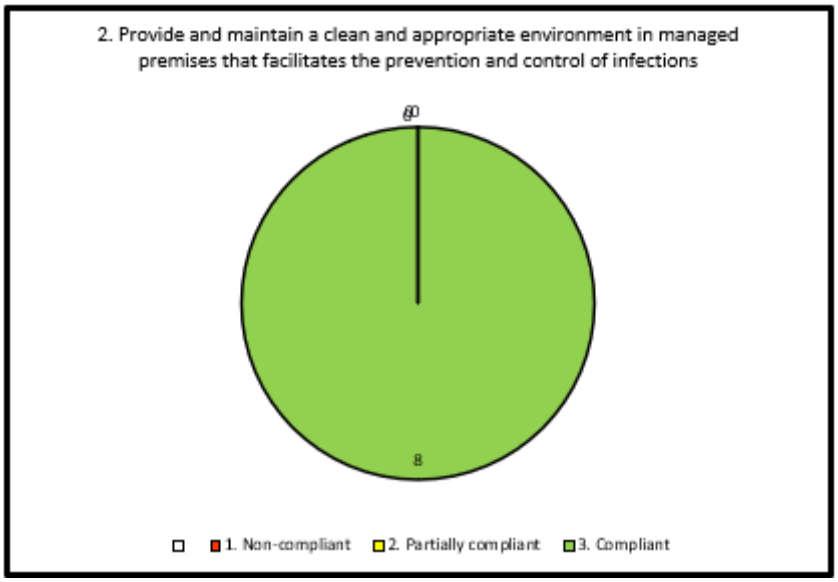
Table 33: Total number of 3 star or less audits, April 2025-March 2026



Neonatal Unit Estate

4.21. A number of actions have been completed on the action plan to facilitate an improvement in IPC on the unit, including the purchase of new incubators and ventilators, 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.

Figure 2: BAF Compliance to Criterion 2



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

5. Criterion 3

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

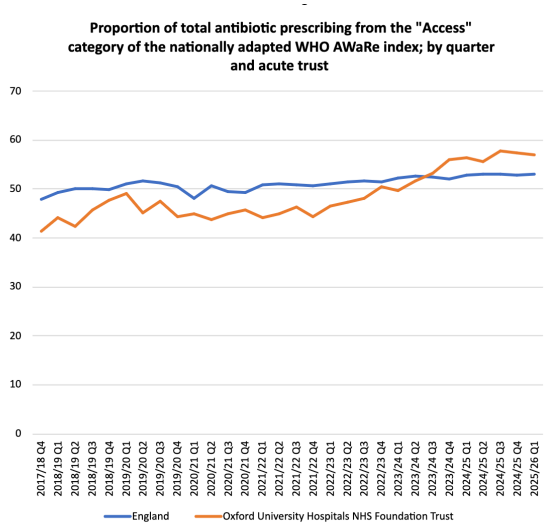
Antimicrobial Stewardship (AMS)

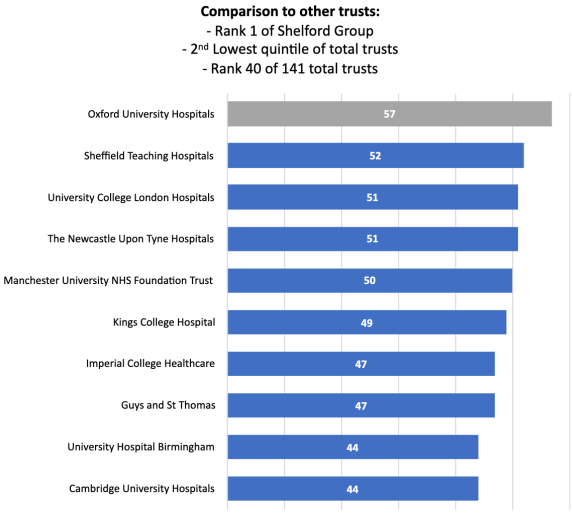
5.1. In May 2024 a new National Action Plan (NAP) for Confronting Antimicrobial Resistance (AMR) was issued which will remain in place 2024-2029. The NAP has four themes. Theme 2 is ‘Optimising the use of antimicrobials’ and has an aim around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. This is one of the main objectives of the AMS team and the team are continuously introducing new initiatives to optimise antimicrobial use.

5.2. The World Health Organisation (WHO) uses the AWaRe classification of antibiotics as a tool for monitoring antibiotic consumption. This classification categorises antibiotics into ‘Access’, ‘Watch’ and ‘Reserve’ groups based on their spectrum, anticipated risk of resistance development, risk of toxicity, and risk of causing healthcare associated infection such as C. difficile infection. The UK uses a modified version of the classifications. Target 4b of the NAP aims to achieve 70% of total use of antibiotics from the ‘Access’ category across the human healthcare system, based on the UK-AWaRE categories.

5.3. The consumption of antibiotics in the ‘Reserve’, ‘Watch’ and ‘Access’ categories for the Trust and for the individual divisions are monitored by the AMS Team and reported quarterly to HIPCC. Table 34 shows an increase in the proportion of antibiotics from the ‘Access’ category used in OUH, crossing the line from below to above average for acute Trusts in England. Trust data also shows a reduction in ‘Watch’ but similar usage of ‘Reserve’ antibiotics over time. OUH are ranked first within the Shelford group for the proportion of antibiotic prescribing from the ‘Access’ category.

Table 34: Consumption of ‘Access’ antibiotics in DDD (defined daily dose) over time for OUH compared to the average for England and comparison with Shelford Group Trusts (higher use better)





Source: Fingertips data to December 2025

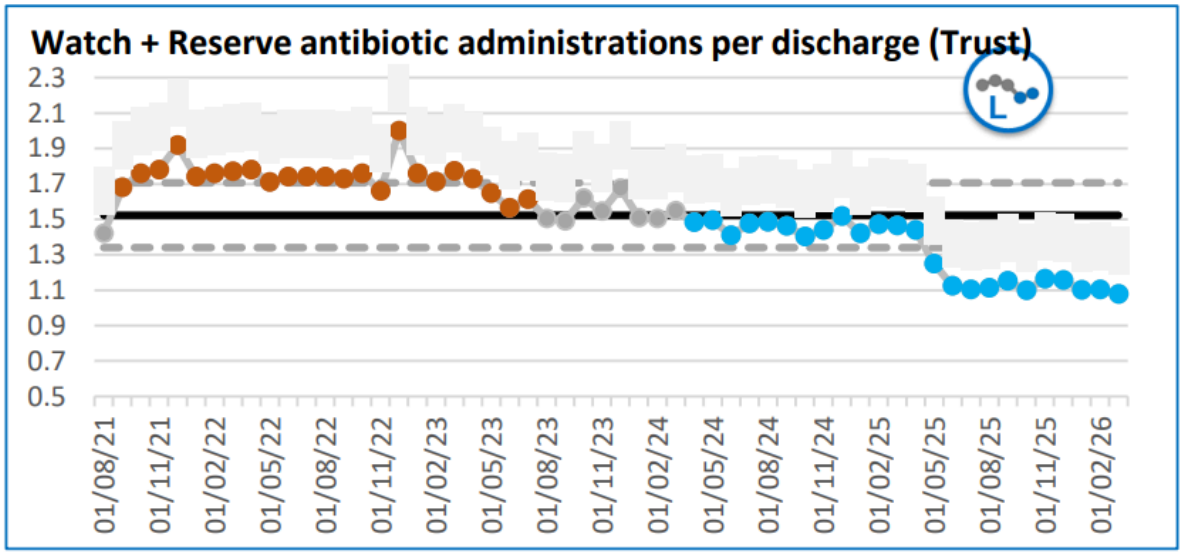
5.4. AMS activities during 2025-2026 which contributed to these changes in consumption were:

- AMS ward rounds (discussed below).
- 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

Microbiology 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.

- 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. Table 35 shows a reduction in the average number of antibiotics from the 'Watch' and 'Reserve' categories from 1.7 per patient in 2021 to 1.1 in 2026.

Table 35: 'Watch' and 'Reserve' antibiotic prescriptions per patient discharge (lower use better)

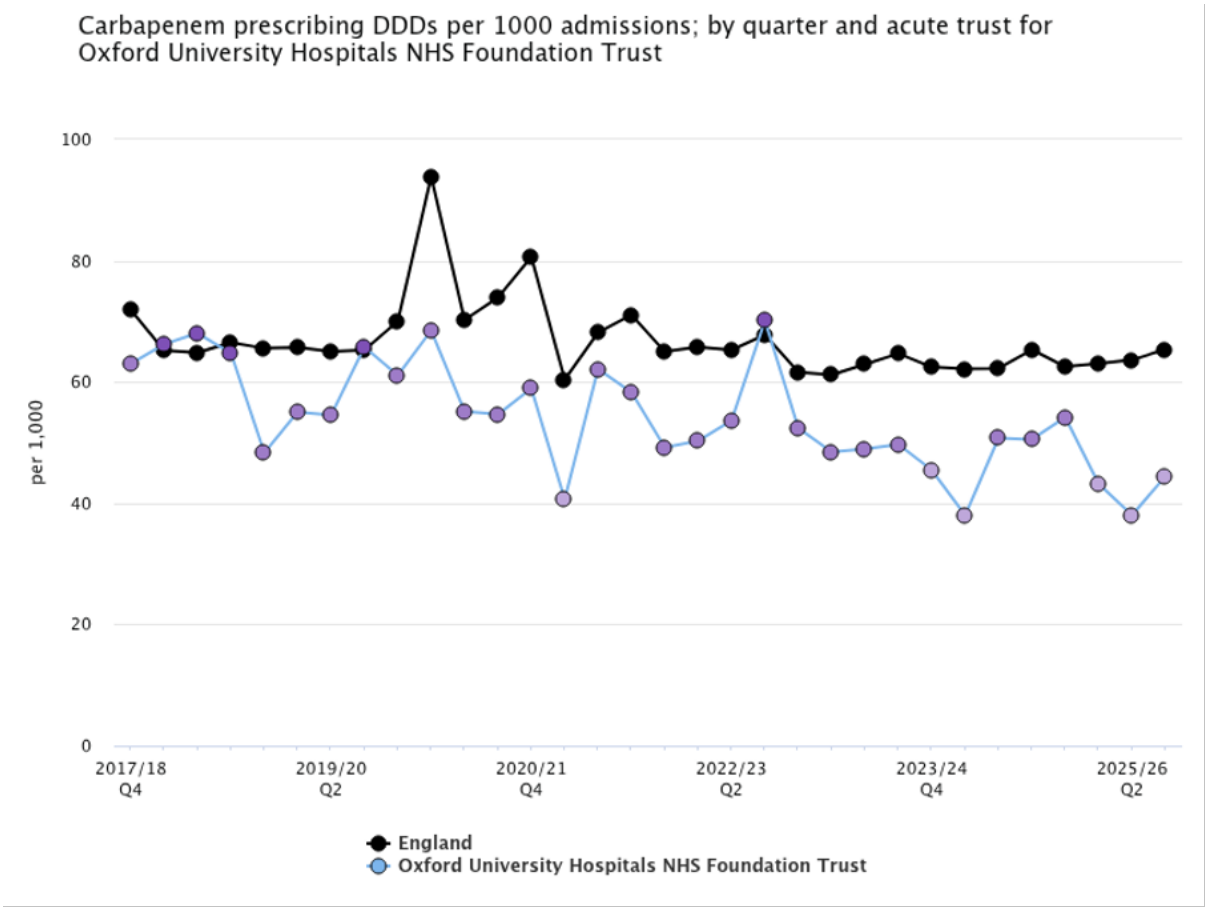


5.5. Education for clinical teams and divisions about their prescribing practice and consumption, including audit and individual feedback.

5.6. Updating prescribing tools – Guidelines were reviewed and updated to reduce the use of 'Watch' and 'Reserve' antibiotics e.g. review of sepsis guidelines.

5.7. Reviewing use of broad spectrum antibiotics, including carbapenems, and optimising their use. Carbapenems are 'Reserve' broad spectrum antibiotics. Infections caused by organisms resistant to carbapenems have high mortality hence the global priority to reduce inappropriate exposure to carbapenems. The AMS team undertake activities to optimise the use of carbapenems and Department of Health data (Table 36) shows that OUH use is falling and remains below the England average.

Table 36: Carbapenem prescribing DDDs (defined daily dosage) per 1000 admissions: by quarter and acute Trust for OUH (lower use better)



Antimicrobial Stewardship Multidisciplinary Team (MDT) ward rounds

5.8. AMS MDT ward rounds are conducted on a weekly basis for adults, paediatrics and neonates. The rounds consist of pharmacists, an advanced clinical practitioner 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.

5.9. 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

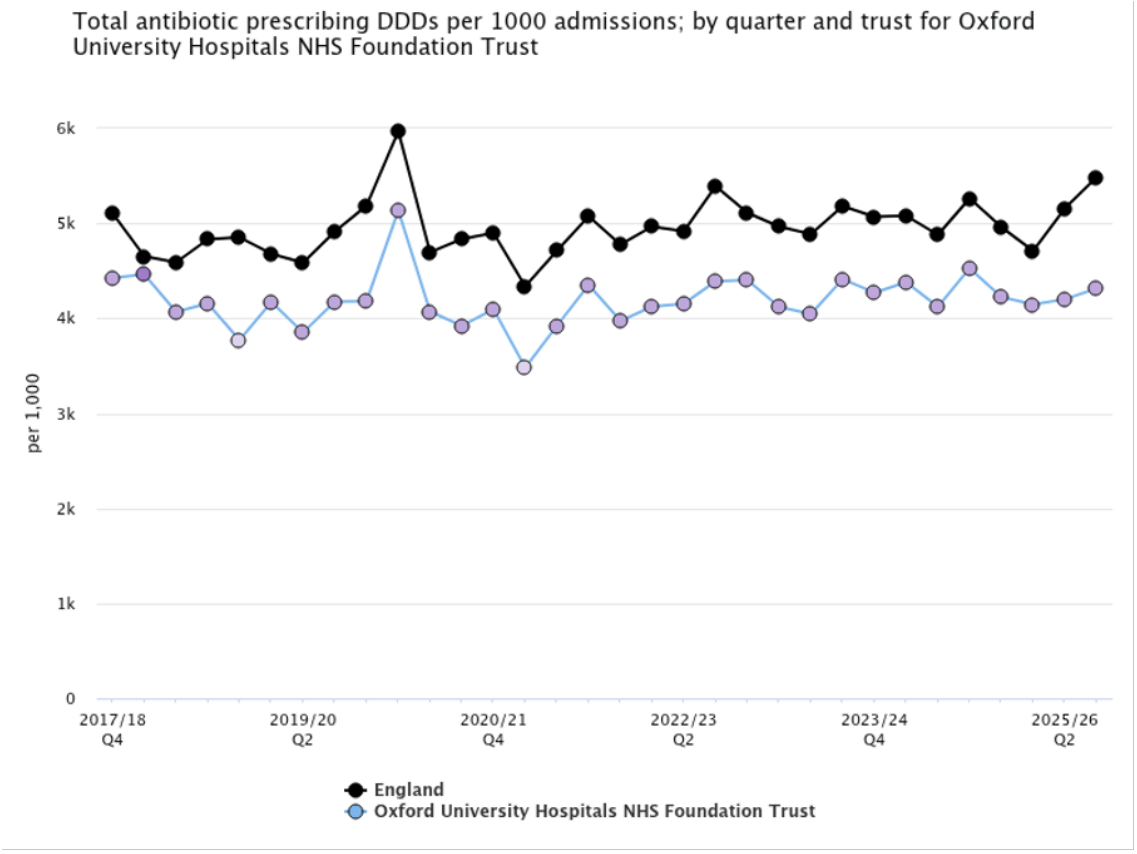
Table 37: number of ward rounds, number of patients reviewed, number of interventions suggested during the ward rounds and percentage of those interventions that were actioned between April 2025 and March 2026

	Number of ward rounds	Number of patients reviewed	Number of interventions	% of interventions actioned
Q1	91	1124	829	78
Q2	90	1156	799	78.7
Q3	90	1040	765	82.3
Q4	87	1158	846	81.5
Total	**358**	**4478**	**3439**	**80.1**

5.10. The AMS team have shown that multidisciplinary AMS ward rounds reduce antibiotic use (DDDs) and reduce length of hospital stay if the suggested intervention is followed. The team are looking to introduce more ward rounds within Acute General Medicine during 2026-2027.

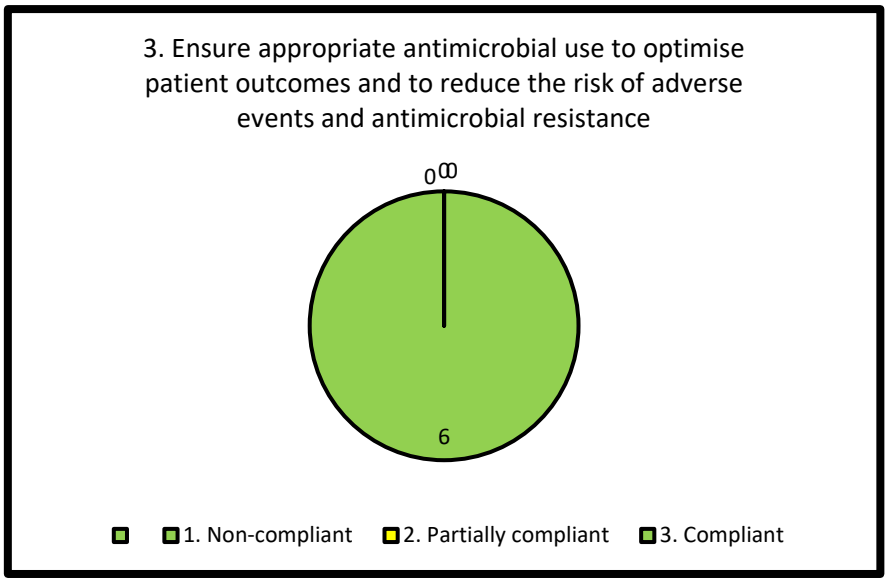
5.11. OUH are making progress with reducing total antibiotic use (DDD) and are ranked second lowest in the Shelford Group for total consumption. Table 38 shows that OUH prescribes antibiotics below the overall England rate.

Table 38: total antibiotic consumption expressed as DDDs per 1000 admissions: by quarter and acute Trust



5.12. The AMS team are committed to sharing learning with colleagues to support the AMS agenda and have had posters at infection international and national conferences over the last year as well as delivering AMS teaching to undergraduate and postgraduate doctors, nurses, pharmacists and physician associates.

Figure 3: BAF Compliance to Criterion 3



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

6. Criterion 4

6.1. 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.

Provision of Information

6.1. 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.

6.2. 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.

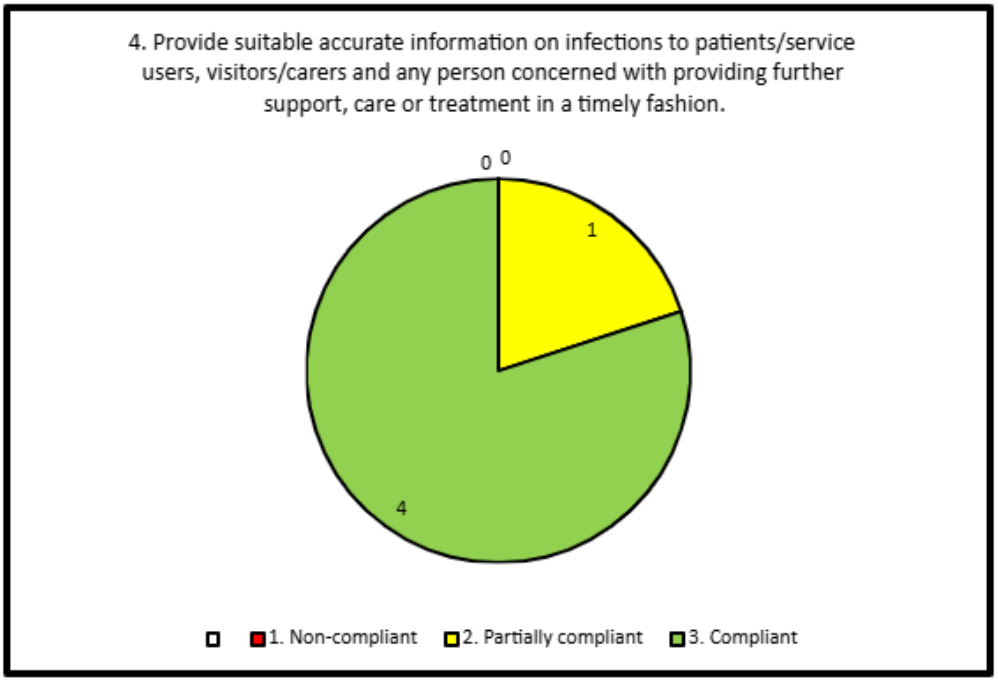
6.3. Clear signage is used in clinical areas to inform visitors, clinicians and other health care workers of infection prevention and control issues eg at entrance points to wards and side-rooms.

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

6.5. 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.

6.6. 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. In the absence of a shared surveillance system not able automatically to share relevant information across organisational boundaries electronically.	Implement ICNet as an IPC alerting, surveillance and outbreak management system, with service continuity support. This will not share data with Oxford Health but partial mitigation is already in place.

7. Criterion 5

7.1. 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.

Infection Prevention and Control Surveillance Software

7.1. The company that supplied the IPC surveillance system (ACMEipc) to the infection prevention and control team (IPCT) ceased trading in 2024. This system was also used by Oxford Health.

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

7.3. In terms of current mitigation, the Microbiology laboratory team have a new Laboratory Information System (LIMS) and provide daily alert organism reports. Some EPR message box alerts for respiratory viral infections have been set up with the help of the EPR team. The Trust Digital Engineering service is developing a web-based system to provide a real-time alerting capability. The IPC team no longer receive any EPR based alerts eg admission of patients with multi-drug resistant organisms and other biohazard flags.

7.4. At the end of 2025/26 the Trust purchased ICNet to provide a comprehensive IPC surveillance package – this will be implemented in 2026/27.

Investigation of Infection Prevention and Control Incidents
IPC and the Neonatal unit

7.1. The neonatal unit has continued to be a cause for concern especially in terms of CLABSI rates secondary to coagulase negative Staphylococci. A bundle of care is being rolled out to include increasing staff education in relation to line care

7.2. Monthly MDT meetings continue to work through and complete actions on the IPC action plan. Regular IPC visits take place with a focus on reinforcing IPC practice in the unit with a focus on hand hygiene, ventilator associated pneumonia, cleaning, ANTT and CLABSI rate reduction including improvement in decontamination prior to line insertion and cleaning of bung prior to line access.

Bedbugs

7.3. There have continued to be sporadic presentations of patients who live in accommodation infested with bedbugs. These presentations can cause anxiety amongst clinical staff and there is an associated risk of patients feeling embarrassed or stigmatised. An at-a-glance document giving easy to follow guidance for these situations was created by the IPC team, accessible via the team's intranet site.

Respiratory virus outbreaks

7.4. A number of outbreaks or periods of increased incidence of COVID-19 (5 outbreaks) or Influenza (4 outbreaks) were identified and managed during the year. The majority of these outbreaks occurred in ward areas with limited numbers of single rooms. The 7-day presence of the IPC team,

supporting and advising all affected wards helped to ensure optimum patient placement and bed capacity (see below).

Norovirus Outbreaks

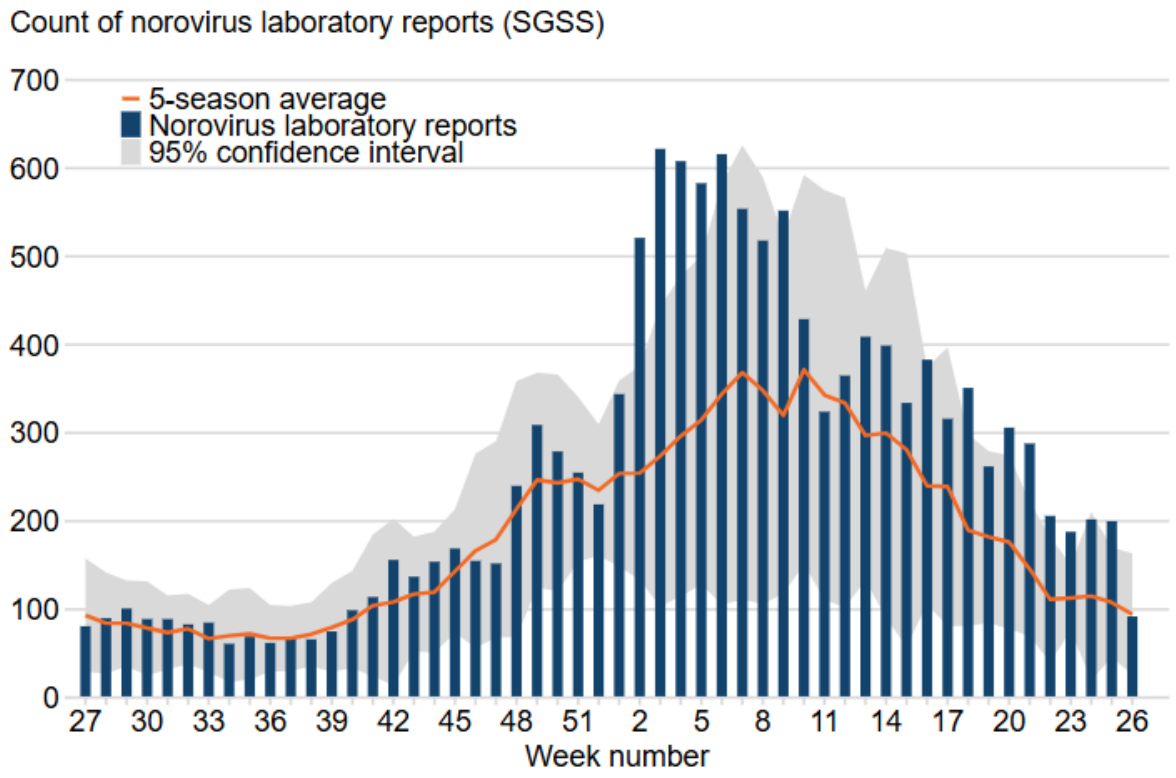
7.5. There were 11 outbreaks of norovirus in 2025/6, compared to only 4 in the previous year, with January being a particularly challenging month. This increase reflected national trends and has been attributed to the co-circulation of two norovirus genotypes (GII.4 and GII.17), as infection by one genotype does not provide protection from the other.

- Six of the 11 outbreaks were in the complex medical unit wards (CMU A-D), which have small numbers of single rooms, reducing the ability to promptly isolate suspected cases before transmission occurs. None of the single rooms across CMU have en-suite facilities.
- Two outbreaks were in Paediatric wards which is relatively unusual and presented a particular challenge with significant numbers of staff affected.

7.6. The impact of norovirus on Trust operational capacity was mitigated significantly by the 7-day presence of the IPC team, supporting and advising all affected wards, and thereby ensuring optimum patient placement and bed capacity. As a result, lost bed-days were minimised.

7.7. Table 39 shows the national norovirus picture with the number of norovirus reports through the winter period above the 5-season average.

Table 39: Norovirus laboratory reports in England by week during the 2025/2026 season, compared with the 5 season average



Note 1: the grey shading represents 95% confidence intervals for the 5-season average.

Tuberculosis (TB)

7.8. See section under Criterion 10 for staff exposures. No patients met the requirement for contact tracing for a TB exposure within the hospital in 2025/26.

Measles

7.9. A small number of measles cases continue to present at the OUH.

7.10. In May and August 2025, two individual children who attended the JR Children's ED were identified to have measles. Contacts were sent 'warn and inform' information and some children required post-exposure prophylaxis (4 in May and 2 in August).

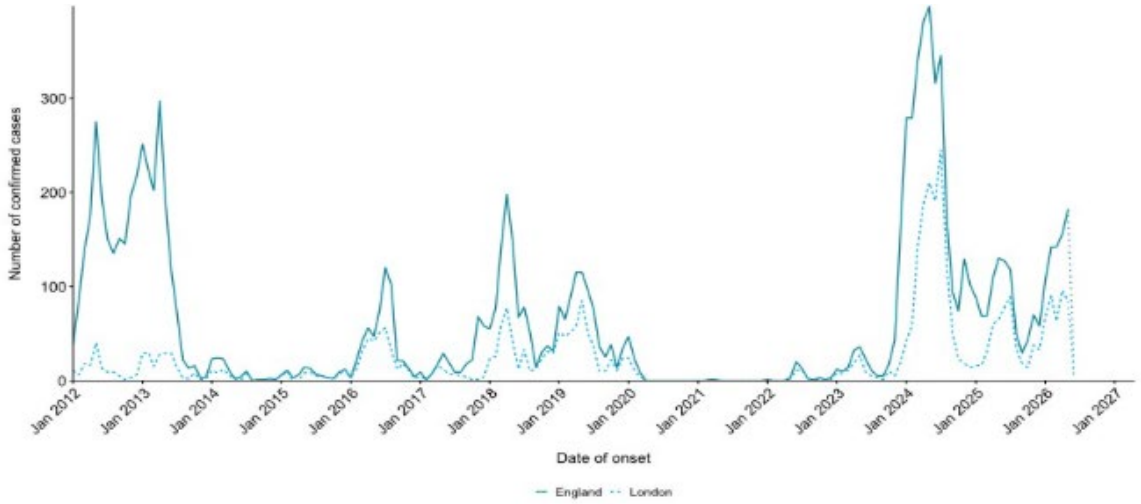
7.11. Once identified, patients were managed with rapid isolation and appropriate precautions. All patient contacts identified were notified using text messaging (DrDoctor platform), and in the event of staff exposure occupational health assisted with risk assessment. The Trust is not aware of any onward transmission from these cases.

National measles picture

7.12. Measles activity increased again in early 2026, mainly due to outbreaks in London and the West Midlands, with the majority of cases in unvaccinated children aged 10 years and under.

7.13. To date, two measles related deaths have been reported nationally in 2026: one was an acute measles death in a child, and another is a death in a child due to late effects of measles.

Table 40: Laboratory confirmed cases of measles by month of onset of rash or symptoms reported, London and England: 1 January 2012 to 8 June 2026



Meningococcus

7.14. Staff exposure – see section under Criterion 10.

Burkholderia stabilis

7.15. In November 2021, a cluster of 18 cases of an uncommon sequence type of B. stabilis was identified by the UKHSA Antimicrobial Resistance and Healthcare Associated Infections (AMRHAI) reference unit. These cases were geographically disseminated with specimens submitted from acute hospital settings. An investigation was initiated, suspecting a common source product exposure.

7.16. Following a local case in 2025/26, products were submitted to UKHSA for microbiological testing by the OUH IPC team. In June 2025, Burkholderia stabilis was recovered from a non-sterile, alcohol-free skin cleansing wipe intended for first aid. This product had been purchased by the patient for home use. Further unopened stock of the same wipe and other similar wipe brands were tested by UKHSA. Burkholderia stabilis contamination was identified in four product brands.

7.17. UKHSA has advised the public and healthcare providers to stop using and safely dispose of these specific non-sterile, alcohol-free wipes. There have now been 59 confirmed cases in the UK 2018-2026. The diligence of the OUH IPC Team in collecting all possible products that could be implicated in this outbreak was key to terminating a national outbreak. Burkholderia stabilis infections associated with non-sterile alcohol-free wipes: ongoing risk to patients - GOV.UK

Surgical Site Infection Surveillance (SSI)
Cardiac Surgery

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

TAVI (Transcatheter Aortic Valve Implantation) surgical site surveillance

7.2. There have been no reported SSI cases for TAVI patients since surveillance commenced in 2019 (data to March 2026).

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

7.3. SSI data for non-CABG and CABG procedures is shown in tables 41 and 42 below. Both programmes have SSI rates well below national benchmarking (1.9% for non-CABG, and 5% for CABG).

Table 41: Non–CABG SSI RATES April 2025 to March 2026

Non-CABG Cardiac surgery Surgical site infections					
Period	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Reconciled
Quarter 1 Apr-Jun 2025	(0/123) = 0%	(0/123) = 0%	(0/123) = 0%	(0/123) = 0%	Yes
Quarter 2 Jul-Sep 2025	(0/118) = 0%	(0/118) = 0%	(0/118) = 0%	(0/118) = 0%	Yes
Quarter 3 Oct-Dec 2025	(0/112) = 0%	(0/112) = 0%	(0/112) = 0%	(0/112) = 0%	Yes
Quarter 4 Jan- Mar 2026	(0/110) = 0%	(0/110) = 0%	(0/110) = 0%	(0/110) = 0%	No
Running Total				(0/463) = 0.0%	

Table 42: CABG SSI RATES April 2025 to March 2026

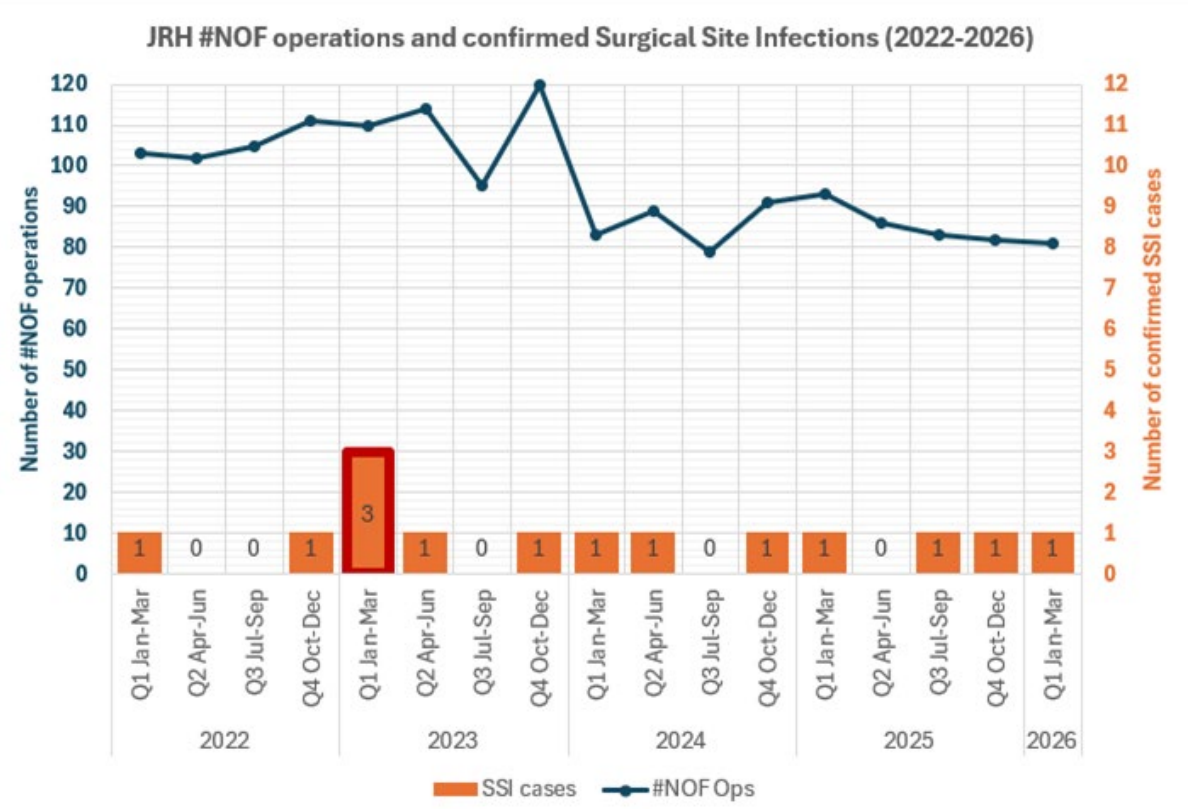
CABG Surgical site infections					
Period	Superficial wound infections	Deep incisional wound infections	Organ / Space infections	Total	Reconciled
Quarter 1 Apr-Jun 2025	(1/84) = 1.1%	(0/84) = 0 %	(1/84) = 1.1%	(2/84) = 2.3 %	Yes
Quarter 2 July – Sept 2025	(2/86) = 2.3% (one donor site)	(1/86) =1.1%	(1/86) = 1.1%	(4/86) =4.6 %	Yes
Quarter 3 Oct-Dec 2025	(3/89) = 3.3%	(1/89) =1.1%	(0/89) =0%	(4/89) = 4.4%	Yes
Quarter 4 Jan-Mar 2026	(4/100) = 4% (TBC with case reviews)	(0/100) = 0%	(0/100) =0%	(4/100) = 4%	No
Running Total				(14/359) = 3.8%	

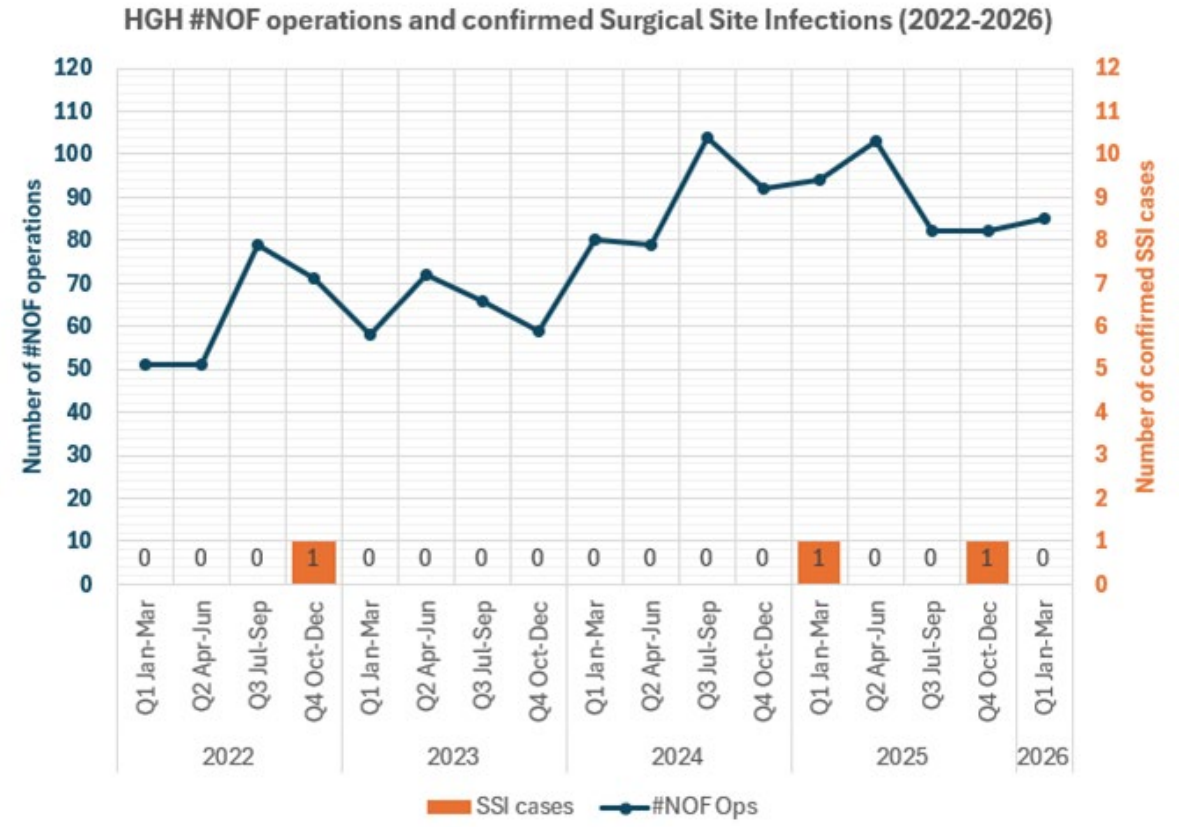
Trauma and Orthopaedic SSI Surveillance

7.4. 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.

7.5. OUH collects continuous data on repair of neck of femur at both the Horton and JR sites (Table 43). In 2024/25 111 hospitals participated in repair of neck of femur infection surveillance: there were 103,329 operations with an SSI risk of 0.8%. Our rates for 2025/26 at the JR were 0.9% and 0.3% at the Horton. Nationally the data for 2025/26 is not yet available.

Table 43: Fractured Neck of Femur SSI Rates – John Radcliffe and Horton sites





SSI in Orthopaedic hip and knee replacement surgery

7.6. Following a review by the British Orthopaedic Association in 2024 initiated because of being a high outlier for infection, an action plan was developed and a reduction in the hip and knee prothesis SSI rate was demonstrated. The unit also commenced data submission to the national surveillance team. In 2024/25 the unit reported a count of 2 SSI infections in knee prosthesis procedures (0.3% (England rate 0.4%)) and for hip prostheses a count of 3 SSIs (0.5% (0.5%)).

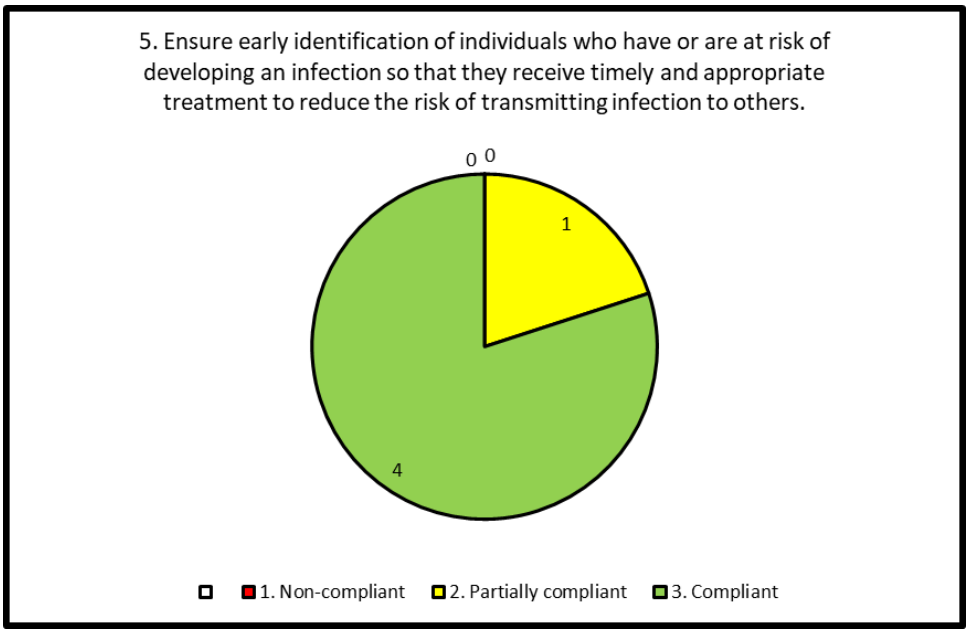
7.7. In 2025/26 the unit reported a count of 5 SSI infections (3 deep and 2 superficial in knee prosthesis procedures (0.73% (England rate TBC)) and for hip prostheses a count of 6 (4 deep and 2 superficial) SSIs (0.83% (TBC)), maintaining a low rate of SSI despite the surgical complexity of patients managed in our specialist centre.

Trust wide SSI surveillance

7.8. Data on a number of parameters relevant to SSI such as returns to theatre were previously available at clinician and procedure level for all surgical specialties on the ORBIT surgical morbidity tracker. The surgical morbidity dashboard is currently no longer available following the transition from the previous Tableau platform to Power BI. Discussions are ongoing to scope a new surgical morbidity dashboard.

7.9. It is anticipated that with full implementation of the ICNet surveillance package by the beginning of 2027/28 the Trust will provide improved oversight of SSI incidence. 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 so patient experience and outcomes can be improved.

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 receive timely and appropriate treatment to reduce the risk of infection transmission.	Loss of IPC surveillance system, with only partial mitigation.	Procurement of a suitable surveillance package (ICNet) is complete and implementation in progress – this is expected to be in place in Q4 2026/27. Current partial mitigation strategies remain in place.

8. Criterion 6

8.1. 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.

Provision of information to staff

8.1. 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.

IPC Training

8.1. There is an IPC eLearning package that meets the national requirements and is a Trust-wide requirement; this was refreshed in 2025/26.

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

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

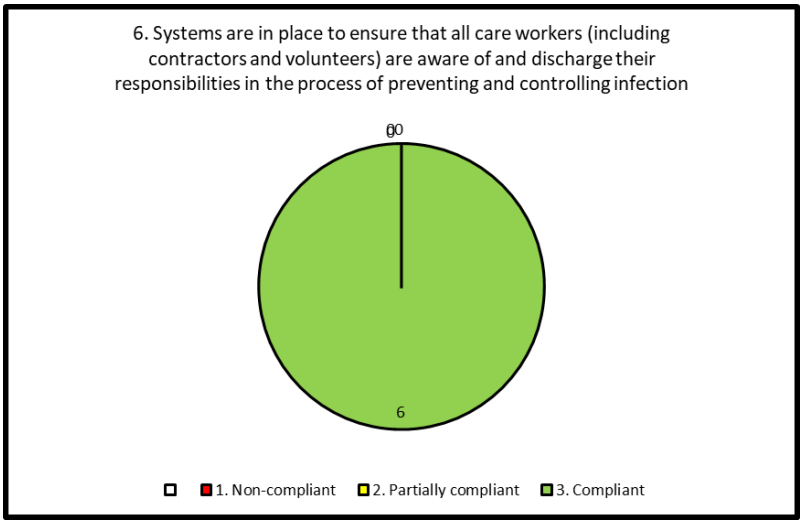
OUH IPC Team national positions of responsibility

8.1. 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.

8.2. The Deputy DIPC is coordinator of the Infection Prevention Society's (IPS) sustainability special interest group, and represents the IPS in the Circular Economy Healthcare Alliance, the Infection Societies Sustainability Forum and the UK Health Alliance on Climate Change. He is a member of a short-life working group on sustainability in IPC convened by NHS England, and is being consulted by the National IPC team on the development of a chapter on this topic in the National IPC Manual.

8.3. National roles taken on by the Consultant Pharmacist include being Chair of the Royal Pharmaceutical Society Antimicrobial Expert Advisory Group (AmEAG) and UKCPA membership secretary.

Figure 6: BAF Compliance to Criterion 6



9. Criterion 7

9.1. The provision or ability to secure adequate isolation facilities.

Isolation facilities

9.1. 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.

High Consequence Infectious disease

9.1. The Trust made a successful application to become a centre for Airborne high consequence infectious disease (HCID) in 2023-24 and went 'live' in 2025/26 as a member of the active airborne HCID network. This 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.

9.2. The Trust has an HCID group that meets monthly and maintains the HCID protocol.

9.3. There were no network requirements to admit an HCID patient following our go-live in 2025/26. The Trust continues to receive and assess suspected cases of airborne or contact HCID.

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

Influenza, RSV and COVID-19

9.4. Sideroom availability for isolation of patients with respiratory viral infections on the John Radcliffe and Horton sites is limited (see above).

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

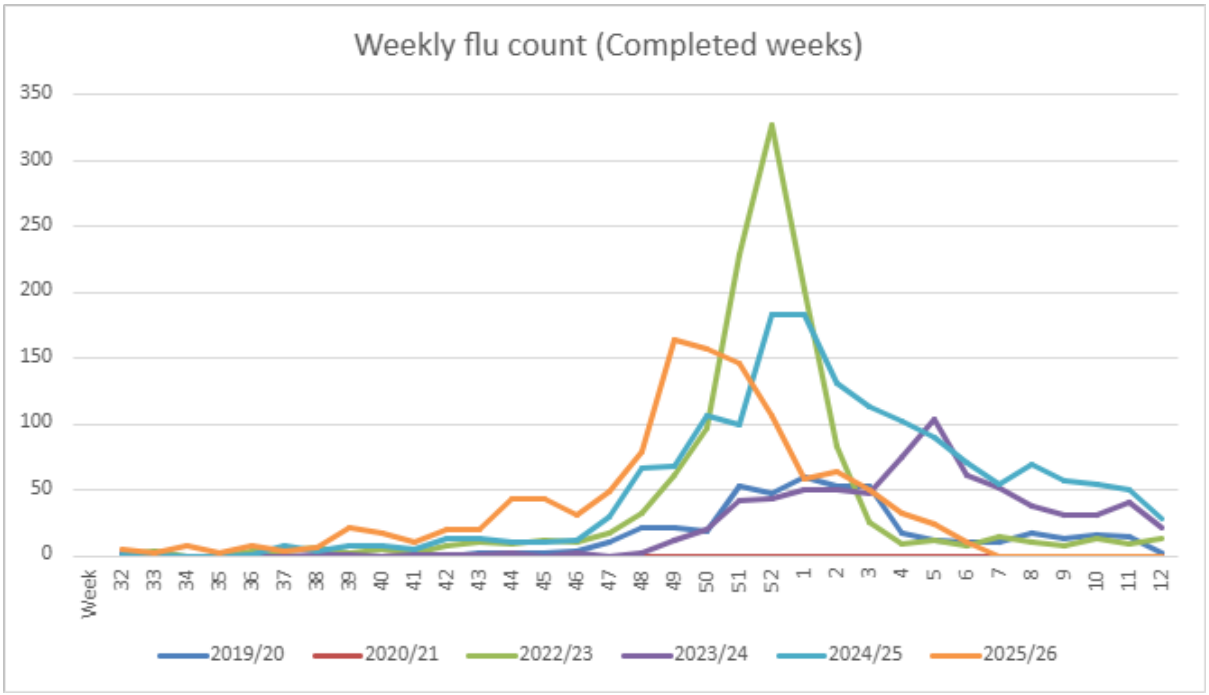
COVID-19

9.6. The 2025–2026 COVID-19 season in the UK saw stable, baseline-level virus activity overall, following an early autumn rise in hospital admissions. Nationally this was managed via targeted seasonal vaccinations for high-risk adults and vulnerable individuals.

Influenza

9.7. Table 44 shows that influenza case numbers overall were moderate in 2025/26 with a relatively early peak, but despite concerns regarding a vaccine mismatch, cases declined quickly and we did not experience the peak seen in 2022/23.

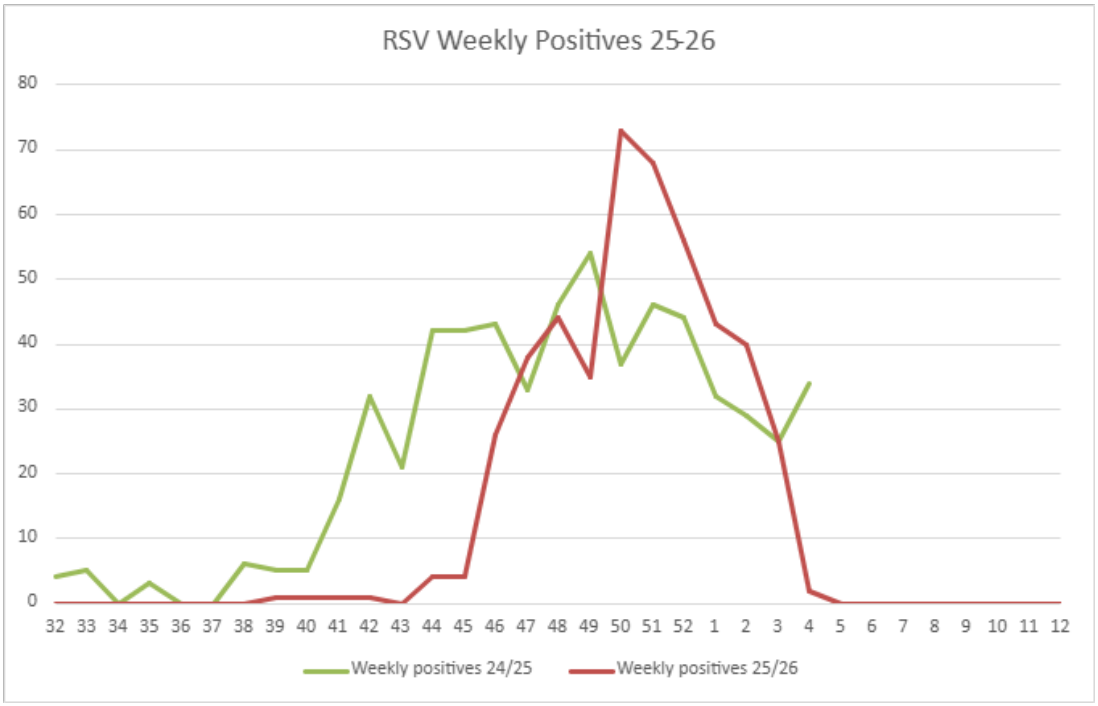
Table 44: Graph of influenza cases by year and week number (fiscal week)



RSV

9.8. RSV circulation began climbing in October 2025, peaked during the mid-winter months (late November through January), and declined to baseline low levels by the end of January 2026. The season was marked by the successful continuation of the primary infant and older adult immunisation strategies, alongside substantial policy expansions enacted by the Joint Committee on Vaccination and Immunisation (JCVI) to protect wider vulnerable cohorts

Table 45: Graph of RSV cases by year and week number (fiscal week) compared with 2024-25



9.9. The majority of cases were seen in children under 5, with a slightly later peak seen in older adults (Table 46).

Table 46: RSV weekly positive rates in adults and children 2025-26

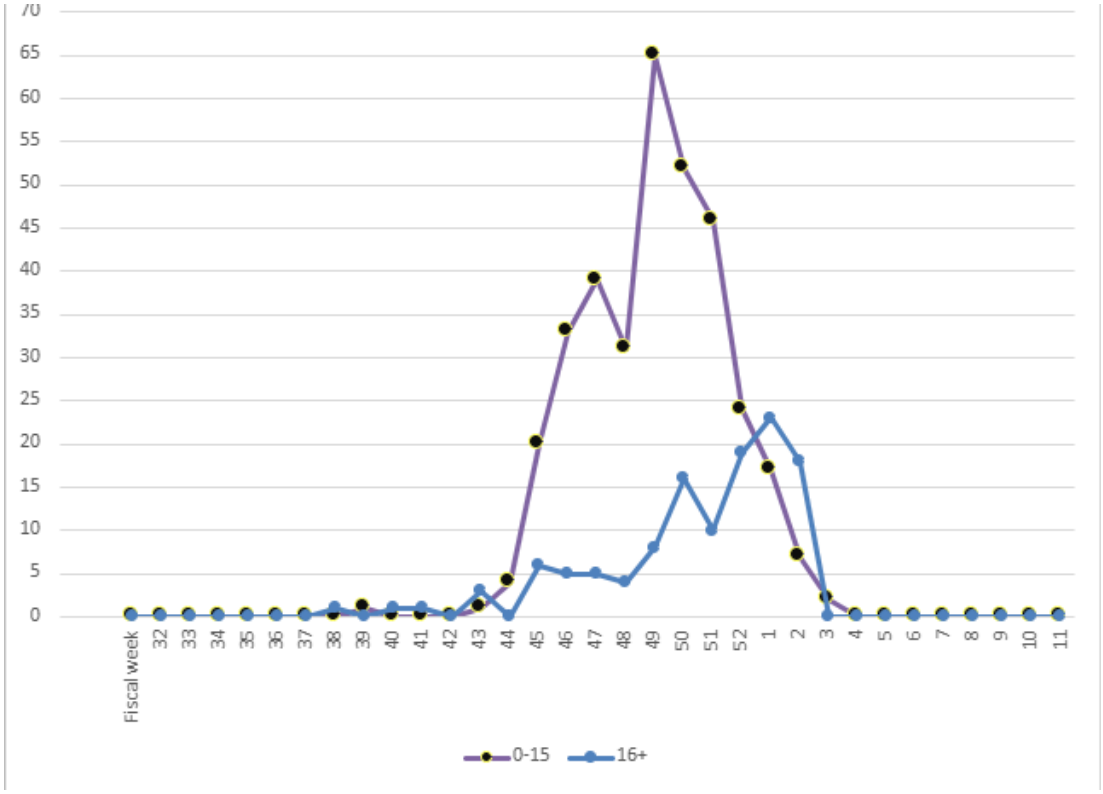
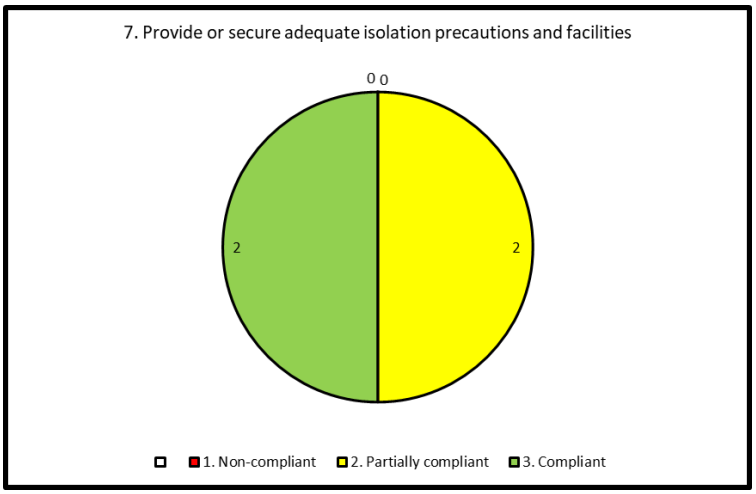


Figure 7: BAF Compliance to Criterion 7



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. Lack of recognition of biohazard flags.	Procurement of a suitable surveillance package (ICNet) is complete and implementation in progress – this is expected to be in place in Q4 2026/27. Current partial mitigation strategies remain in place.
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. 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.	Procurement of a suitable surveillance package (ICNet) is complete and implementation in progress – this is expected to be in place in Q4 2026/27. Current partial mitigation strategies remain in place.

processes are in place to mitigate risk.		

10. Criterion 8

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

Role of the Microbiology Laboratory

10.1. 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.

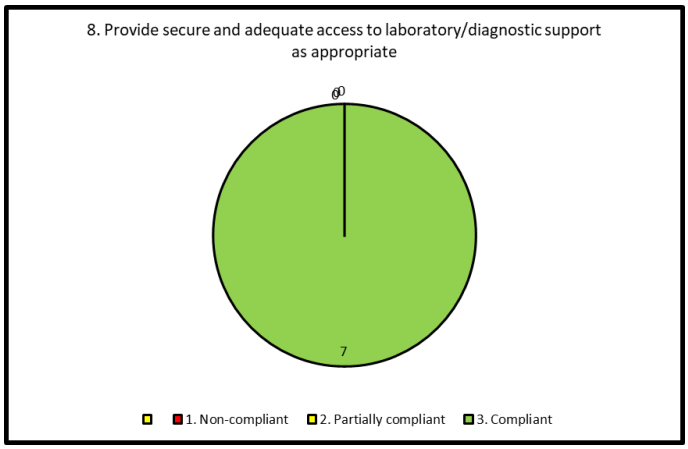
10.2. The Microbiology LIMS was replaced in March 2025, leading to the loss of functionality of the IPC surveillance system for real-time alert organism flagging. This has been partially mitigated by the production of daily organism reports by microbiology for IPC but with the loss of real-time reporting. EPR message box results have been set up for real-time reporting of respiratory pathogens of IPC interest. The OUH Digital Engineering Service continues to work on a web-based alerting system. Funding for a new surveillance system (ICNet) was obtained at the end of 2025/26, and implementation is expected to be complete by the end of the next financial year (2026/27)

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

10.4. During 2025/26 the microbiology point of care team supported by the IPC team implemented further changes in our point of care (POC) respiratory virus testing in emergency admission areas (JR and Horton) to allow rapid patient diagnosis and appropriate triage, minimising operational pressures. The IPC team are alerted to POC results in real time via EPR.

10.5. 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.

Figure 8: BAF Compliance to Criterion 8



11. Criterion 9

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

Sepsis Service Overview

11.1. The Sepsis Team consists of three adult sepsis nurses. The team provides cross-site cover, with a focus on the JR and Horton sites, and remote review support for the Churchill and NOC. The Sepsis Team continues to support and audit timely recognition and treatment of sepsis through active clinical involvement in adults.

11.2. Patients are identified via the electronic sepsis alert system ("Sepsis Agent"), supporting timely assessment and antibiotic administration in line with NICE guidance where appropriate. Audit work is ongoing to refine the sepsis alert and the coding of sepsis within the trust.

11.3. Following the departure of the paediatric sepsis nurse in August 2025, the Sepsis Team has continued audit of paediatric patients, focusing on time to antibiotics in those meeting high-risk sepsis criteria.

11.4. The Sepsis Team supports maternity services through the mandatory PROMPT (Practical Obstetric Multi-Professional Training) course, providing education and debrief on maternal sepsis, including antimicrobial guidelines, the Sepsis Six bundle, and blood culture practice in line with Trust standards. The team's contribution to maternity education has been formally acknowledged by the Consultant Obstetrician leading the PROMPT programme. In feedback to the faculty, she highlighted the valuable input of the specialist sepsis nurses, noting that their involvement has enhanced multidisciplinary learning and contributed positively to programme delivery.

Ventilator Associated Pneumonia (VAP) Prevention Working Group

11.5. The multidisciplinary VAP Prevention Working Group, established during 2024–2025, has continued to meet on a quarterly basis throughout 2025–2026. Membership includes representatives from adult, paediatric and neonatal critical care services, medical and nursing leadership, Infectious Diseases, the Infection Prevention and Control Team, and Clinical Governance and Risk Practitioners (CGRPs).

11.6. Significant progress has been made in standardising preventative practice across critical care services. The adult and paediatric VAP prevention bundles, together with mouth care products, have been standardised across all relevant intensive care units. In addition, a bespoke Neonatal Intensive Care Unit (NBICU) VAP prevention bundle was developed and successfully introduced in December 2025 to reflect the specific needs of the neonatal population.

11.7. Work was also commenced to align clinically coded VAP cases with ventilator associated events (VAE) surveillance data through use of the Electronic Patient Record (EPR) and data science methodologies. This project has been paused until implementation of the new ICNet infection prevention and surveillance system.

VAP Prevention Care Bundle Compliance

11.8. Compliance with the VAP prevention bundle continued to be monitored through regular audits across critical care areas during 2025–2026. Overall compliance varied between 79% and 99% across the six intensive care units (Table 48). Cardiothoracic Critical Care Unit (CTCCU) demonstrated excellent sustained compliance (99%), while Churchill ICU (CICU), Oxford Critical Care (OCC) and Neonatal ICU achieved compliance between 83% and 90%. Paediatric ICU recorded the lowest compliance (79%) and least number of audits completed, highlighting an area for continued support, education and quality improvement to strengthen adherence to the VAP prevention bundle.

Table 47. Percentage compliance with VAP **Prevention Care Bundle by ICU**

Unit/Speciality	Overall annual Compliance	No. of Audits	No of observations
Churchill ICU	83%	6	41
Oxford Critical Care	84%	6	49
CTCCU	99%	6	68
Neuro ICU	86%	5	39
Paediatric ICU	79%	3	19
Neonatal ICU	90%	6	14

VAP Activity

11.9. Clinical coding data provided to the Infection Prevention and Control Team identified:

- 2024–2025: 53 clinically coded VAP spells.
- 2025–2026: 61 clinically coded VAP spells.

11.10. Greater awareness of the CDC Ventilator-Associated Event (VAE) surveillance algorithm across adult, paediatric and neonatal intensive care units may have contributed to improved case identification, surveillance and reporting. Further validation work is required to determine the extent to which the observed increase reflects improved surveillance and case definition rather than a true increase in possible VAP incidence.

VAP/VAE Priorities for 2026–2027

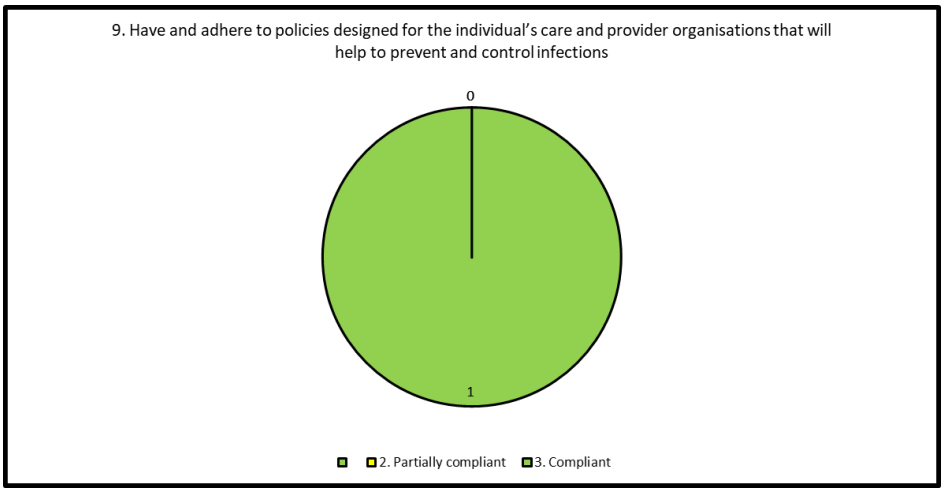
11.11. Key priorities for the coming year include:

- Improving compliance with the VAP prevention bundle in lower-performing clinical areas.
- Strengthening engagement and attendance at the multidisciplinary VAP Working Group.
- Embedding the neonatal VAP prevention bundle and monitoring its effectiveness.
- Resuming work to align clinically coded VAP cases with VAE surveillance following implementation of ICNet.
- Enhancing surveillance processes to improve the accuracy and consistency of VAP case identification and reporting.
- Continuing education and awareness initiatives to support consistent implementation of evidence-based VAP prevention practices across all critical care areas.

Audits

11.1. IPC audits are conducted using the Trust Ulysses platform. This includes hand hygiene, aseptic non-touch technique, equipment cleaning, intravascular device, sharps safety audits and ventilator associated pneumonia prevention audits. Clinical teams complete these audits on a monthly, bimonthly and quarterly audit frequency which are presented to hospital infection prevention and control committee HIPCC by divisions. The IPC team complete observations within these for locations of concern and also conduct environmental audits on Ulysses of clinical departments across the organisation. Actions can then be generated within Ulysses where improvements are required.

Figure 9: BAF Compliance to Criterion 9



12. Criterion 10

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

Staff Health
Sharps/needlestick injury support

12.1. The Centre for Occupational Health and Wellbeing (COHWB), as HIPCC members, report twice yearly on needlestick, sharps, scratch, or splash injuries. Staff can access support 24/7, including out-of-hours assistance from the Microbiology on-call team. In 2025–26, no blood-borne virus transmission events to staff were reported.

Staff vaccination

12.2. All new starters in the OUH complete pre-employment checks and assessment of immunity; any additional vaccinations required such as hepatitis B or VZV are provided.

12.3. In 2025–26, the Winter Staff Vaccination Programme was delivered by the Winter Vaccination Team and peer vaccinators. A total of 6,342 frontline healthcare workers received influenza vaccination, achieving an uptake rate of 52.5%.

12.4. A targeted meningococcal vaccination programme for high-risk staff groups within Microbiology was also undertaken and remains ongoing, with most eligible staff having received their first and second doses

Staff infectious disease exposure events

12.5. During 2025–26, Occupational Health managed several infectious disease exposure incidents.

12.6. **Tuberculosis (TB)** contact tracing for staff meeting the criteria for exposure was undertaken following:

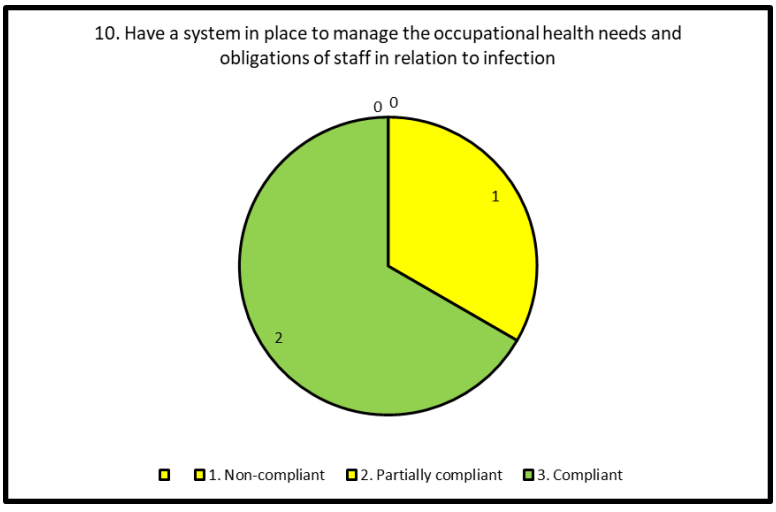
- a TB exposure incident in Bronchoscopy in May 2025, with 5 staff contacts requiring follow-up from Occupational Health.
- identification in June 2025 that the air-handling unit supplying the mortuary was recirculating air, which led to concern about cumulative TB exposure from the post-mortem room. All mortuary staff members were followed up by Occupational Health, and estates staff managed the ventilation issue to ensure air could no longer re-circulate.
- an exposure incident in Theatres in March 2026, with two staff identified as contacts requiring follow-up.

12.7. Risk assessments, screening and follow-up was arranged where required. No staff were found to have acquired TB as a result of these incidents.

12.8. Two ***Neisseria meningitidis*** exposure incidents involving staff from Neuro ITU, CTCCU and the Emergency Department were also investigated, with prophylactic treatment provided in accordance with UKHSA advice and guidance. A further review of a potential meningococcal disease exposure in the Paediatric Critical Care Unit identified no significant occupational exposure.

12.9. There were no staff contacts of **measles, varicella, shingles or pertussis** requiring Occupational Health contact tracing or intervention during the reporting period.

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	A system of health risk management is currently not in place for	A system of organisational (regular) skin checks is required

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.	skin health (COSHH Regulations).	to ensure cases of occupational dermatitis are identified. Occupational Health are currently developing a guidance document outlining the system required for organisational legal compliance.

13. Conclusion

13.1. This report details the work of the IPC teams over 2025-26 and is set against the Health and Social Care Act (2015) criterion.

14. Recommendations

14.1. The Trust Board is asked to:

- Receive this report for information.