

## Director of Infection Prevention and Control Annual Report 2024/2025



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## EXECUTIVE SUMMARY

The purpose of this report is to inform patients, public, staff, the Board of Directors and Governors of the infection prevention and control (IPC) work undertaken in 2023/24 and provide assurance on Trust compliance with the [Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance \(National infection prevention and control manual for England 2022\)](#). This report covers the management arrangements, the position of infection prevention and control within the Royal Devon University Healthcare NHS Foundation Trust (hereafter referred to as 'RDUH'), outcomes and progress against performance targets.

The publication of the Director of IPC (DIPC) annual report is a requirement to demonstrate good governance, adherence to Trust values and public accountability (Dept. of Health, 2004) and reports on IPC activities within the RDUH for the period covering April 2024 to March 2025.

All NHS organisations must ensure that they have effective systems in place to control healthcare associated infections in accordance with the Health and Social Care Act 2008. The RDUH has a pro-active IPC team that is very clear on the actions necessary to deliver and maintain patient safety. Equally, it is recognised that IPC is the responsibility of every member of staff and must remain a high priority for all to ensure the best outcome for patients.

The annual DIPC report is mapped to the ten compliance criteria outlined in the Code and takes the opportunity to celebrate successes and highlight the increasing challenges going forward in 2025/26. The following are highlights from 2024/25:

1. The Trust maintains a comprehensive and robust framework for Infection Prevention and Control (IPC), underpinned by strong governance structures, risk management processes and evidence-based surveillance programmes. The Infection Prevention and Decontamination Assurance Group (IPDAG), chaired by the Chief Nursing Officer and DIPC for Northern services, oversees all IPC activities, with direct reporting to the Board via the Patient Safety Committee. This ensures transparency, accountability and rapid escalation of infection-related risks.
2. In 2024/25, the Trust's IPC systems were independently audited by ASW Assurance, confirming the effectiveness of IPC governance and proactive alignment of policies following organisational integration. Despite delays in unifying DIPC responsibilities across Northern and Eastern services, a transition is planned for 2025/26, supported by clear operational and strategic intent.
3. Risk management is deeply embedded, with IPC-related risks monitored via the Corporate and Care Group Risk Registers and reviewed quarterly. A strong incident reporting system enables the IPC team to swiftly address Healthcare Associated Infections (HCAI) events and inform learning across clinical groups. Active support from IPC nurses and Microbiologists further strengthens the Trust's response to infection-related challenges. The Trust faces several IPC-related risks linked to backlog maintenance issues. While these risks are well-documented and understood by the Estates team, limited capital investment poses a challenge to fully addressing them. Key concerns include persistent water safety and drainage issues, as well as the overall condition of parts of the Eastern estate.
4. Surveillance plays a critical role in informing practice and supporting national reporting obligations. The Trust conducts both mandatory and voluntary surveillance of bloodstream infections and surgical site infections. Although thresholds for certain infections (e.g. *Clostridioides difficile*, Klebsiella, *Pseudomonas aeruginosa*) were exceeded, rates remain broadly aligned with or below regional and national averages. A

notable concern is the higher rate of E. coli bloodstream infections, although there has been a year-on-year reduction.

5. Encouragingly, there has been a significant reduction, nearly 20%, in healthcare-associated bloodstream infections overall, with targeted interventions yielding measurable outcomes. The Trust's MSSA bloodstream infection rate has notably declined, especially intravascular catheter-related cases, indicating progress from Trust-wide quality improvement efforts.
6. Surgical site infection rates within the hip category remain exemplary, with the Trust highlighted as a national low outlier in hip replacement infections. Surveillance practices exceed mandatory requirements, demonstrating a proactive culture of safety and continuous improvement.
7. A rise in outbreaks was noted during periods of operational strain, with COVID-19 remaining the most frequently reported infection. Influenza and Norovirus outbreaks also impacted services, particularly in winter months. A Group A Streptococcus outbreak resulted in two patient deaths, triggering a detailed investigation and response in collaboration with UKHSA.
8. The Trust is seeing a growing number of Carbapenemase-producing resistant Gram-negative bacteria. While still a low-incidence region, trends highlight the need for continued vigilance.
9. Audit data suggests high reported compliance with hand hygiene protocols, though observational validation indicates challenges, particularly with glove overuse and workload pressures. A "gloves off" initiative was launched to reinforce best practice. Community audits and a smooth transition from Gojo to Ecolab hand hygiene products maintained standards amid supply disruption.
10. Domestic Services in both Eastern and Northern sites adapted effectively to staffing pressures and increased cleaning demand. In the Eastern services, the specialist cleaning team operated 24/7 during peak periods. While the annual deep clean programme has not been formally delivered since 2018/19, an opportunistic cleaning model has continued. Northern services introduced UV-based Black Light technology to enhance cleaning effectiveness and performance monitoring.
11. Regular IPC spot checks and technical audits are embedded in practice, with findings directly shared with teams for immediate feedback and improvement. The Trust scored 97.82% in the national PLACE cleanliness assessment
12. Legionella and *Pseudomonas aeruginosa* remain primary waterborne pathogens of concern. The Trust maintains control through thermal regulation, regular flushing, and supplementary copper/silver ionisation systems. Ageing infrastructure, especially within the Wonford estate, has compromised thermal control in some areas, increasing colonisation risk. Mitigation includes engineering works, enhanced monitoring, and regular risk assessments. IPC controls are in place in high-risk areas, such as the Paediatric Assessment Unit.
13. Ventilation systems are managed through routine cleaning of Air Handling Units and ducting. Portable and wall-mounted units are maintained despite not being HTM 03-01 preferred options. Specific issues, such as odours and fly ingress in theatres due to seasonal conditions and construction, were effectively addressed. Continued investment will be needed to sustain compliance as systems age.

14. Both Eastern and Northern services received 5-star hygiene ratings from local authorities. Regular audits, staff training, and allergen awareness remain priorities. Electronic meal ordering (via the Saffron system) has improved efficiency and allergen management in Eastern services. Northern services received an amber assurance rating due to labelling issues, with improvement actions ongoing.
15. The 2024/25 NHS Premises Assurance Model assessment showed improvement over the previous year and did not identify any critical IPC-related risks.
16. In 2024/25, the Trust significantly strengthened its Antimicrobial Stewardship (AMS) programme to improve patient outcomes and mitigate the risks of antimicrobial resistance (AMR) and other adverse effects. Aligned with national priorities and the UK 2024–2029 AMR action plan, AMS was embedded into wider IPC strategies across Trust sites.
17. The Trust remains committed to high standards of IPC through robust systems that ensure timely and accurate information sharing, effective risk identification and comprehensive staff training and support. Information on infections is disseminated to patients, carers and providers via multiple channels including the website, outpatient letters and the Community Infection Management Service, which continues to provide valued education and coordination for primary and social care.
18. Patients are routinely assessed on admission for infection risks, with policies in place to guide isolation, placement and movement to minimise transmission. IPC responsibilities are clearly defined in staff roles, supported by mandatory training programmes, including e-learning and specialist sessions for frontline staff. The Trust has acknowledged limitations in isolation infrastructure and continues to use cohorting and portable isolation units as interim measures.
19. UKAS-accredited laboratories provide 24/7 support, and microbiology teams work closely with IPC teams to manage emerging risks. All IPC policies are subject to regular review, with substantial progress made in aligning documentation across sites. The Occupational Health Service plays a key role in infection prevention through vaccination, screening and outbreak response. While immunisation activity dipped slightly in 2024/25 due to staffing limitations, capacity improved later in the year and proactive steps are being taken to address lower flu vaccine uptake.

## **INTRODUCTION**

The publication of the Director of Infection Prevention and Control (DIPC) Annual Report is essential for demonstrating robust governance, alignment with Trust values, and public accountability. Its primary purpose is to assure that the Trust maintains high standards of compliance with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance, last updated in December 2022. Accordingly, this annual report is structured around the ten compliance criteria outlined in the Code of Practice (refer to Table 1).

Healthcare-associated infections (HCAs) pose significant risks to patient safety, potentially leading to harm, prolonged hospital stays, and a diminished patient experience. Minimising HCAI rates remains central to the Trust's commitment to delivering safe, high-quality care across all services. This report acknowledges the dedication and diligence of staff at all levels, both clinical and non-clinical, whose efforts are vital in enhancing patient outcomes and reducing infection risks. Furthermore, the Trust continues to collaborate with various external partners as part of its Infection Prevention and Control (IPC) and broader governance frameworks.

The authors extend their sincere gratitude to everyone who supported the Trust over the past year and to those whose contributions were instrumental in the development of this report.

**Table 1. The Hygiene Code Compliance Criteria and Trust compliance summary**

	Fully compliant	Partial compliance	Non-compliant (NC)
No	Criterion		
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them		
2	The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections (known risk)  <i>Non-compliant with 1 of 11 elements related to 'all parts of the premises from which it provides care are suitable for the purpose, kept clean and <b>maintained in good physical repair and condition</b>'.</i>		
3	Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance		
4	The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion		
5	That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people		
6	Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.		
7	The provision or ability to secure adequate isolation facilities due to limited side room capacity (known risk)  <i>Achievement of this criterion is reliant on future substantial capital estates work / redesign across both Trust sites and through the New Hospital Programme (Northern)</i>		
8	The ability to secure adequate access to laboratory support as appropriate.		
9	Registered provider has and adhere to policies designed for the individual's care, and provider organisations that will help to prevent and control infection.		
10	Service providers will have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.		

## 1. Systems to manage and monitor the prevention and control of infection.

### 1.1 Governance arrangements

1.1.1 The Trust-wide Infection Prevention and Decontamination Assurance Group (IPDAG) is chaired by the Executive Lead for Healthcare-Associated Infections/DIPC for Northern services, who is also the Trust's Chief Nursing Officer (CNO). The group convenes quarterly and reports to the Board of Directors through the Quality Committee (Board Committee), via the Patient Safety Committee sub-group report. This reporting structure ensures that concerns, risks, and gaps in assurance are escalated appropriately.

1.1.2 Currently, the Trust operates with separate arrangements for the DIPC role across its Northern and Eastern services. A transition to a single, unified arrangement was planned for implementation in 2024, however, this was delayed and now planned for 2025.

1.1.3 The Trust utilises NHS England's Infection Prevention and Control (IPC) Board Assurance Framework, alongside Care Quality Commission (CQC) regulatory standards, to conduct self-assessments. These tools provide internal assurance that the Trust is meeting expected quality and compliance standards in relation to infection prevention and control.

1.1.4 In line with the 2024/25 Audit and Assurance Plan, ASW Assurance reviewed the Trust's IPC arrangements. The review assessed:

- The robustness of the IPC governance structure, including the Directors of Infection Prevention and Control (DIPC) roles.
- The strength of the Trust's main IPC policies and progress in aligning Eastern and Northern policies.
- The monitoring and reporting arrangements for compliance with policies and the IPC Code of Practice, including audits and remedial actions.
- Effective management and escalation of IPC-related risks and incidents.
- Progress on addressing partial compliance with NHSE's IPC Board Assurance Framework (BAF) key lines of enquiry (KLOE), as reported to IPDAG in April 2024.

1.1.5 The audit concluded that the Trust's IPC arrangements are effective, with significant work done by the IPC team to align procedures and policies post-integration. The overall conclusion of the audit was a **satisfactory** rating. A clear IPC governance structure is in place, and IPDAG provides assurance to the Board on the effectiveness of IPC arrangements, compliance with the IPC Code of Practice, and risk management. The IPC team is proactive in ensuring compliance and improving IPC practices.

### 1.2 Risk Management

1.2.1 The Trust undertakes comprehensive and systematic assessments of risks associated with healthcare-associated infections (HCAIs), ensuring they are suitable and sufficient to protect patients. These assessments are benchmarked against national best practice, clinical expertise, and local risk intelligence. Risk is monitored through a combination of data collection, audits, and analysis of clinical incident reports. The outcomes of these activities, along with updates to existing risk assessments, are reported to the IPDAG, where they are used to shape strategic planning and future interventions.

1.2.2 Corporate and service-level HCAI risk assessments are documented within the Trust's Corporate Risk Register (CRR). High-risk ratings are reviewed quarterly by the Patient Safety Committee. Both existing controls and proposed preventative actions are identified and tracked through divisional governance structures. As of the reporting

period, there are no IPC related risks on the CRR. There are two care group-level risks recorded, relating to the renal template environment and rebuild (medicine care group) and Legionella Safety – Eastern (estates and facilities). Both risks are scored at 12 and have been recently reviewed.

- 1.2.3 The Trust maintains a robust incident reporting system that allows staff to report adverse events, including deviations from clinical guidelines or poor practice that may compromise patient safety. The IPC team oversees all IPC related incidents, offering expert advice and support to mitigate further risks and prevent harm. While ownership of clinical incidents remains with the care groups in which they occurred, care groups are expected to provide assurance to IPDAG regarding any significant investigations and to share key learning outcomes.
- 1.2.4 All outbreaks, bay and ward closures are logged via the incident reporting system. While not all outbreaks are preventable, they are reported due to their operational impact, particularly regarding bed capacity and patient flow. A summary of outbreaks recorded during 2024/25 is provided in Section 1.9 of this report.

### **1.3 Infection Prevention and Control (IPC) Teams**

- 1.3.1 The specialist IPC nursing teams provide education, support, and expert advice to staff across the Trust, as well as communication and reassurance to patients and families regarding infection concerns. Although the teams have collaborated since integration, progress towards a unified team structure has been delayed but remains a key priority for 2025/26 with the clinical integration processes commencing in May 2025.
- 1.3.2 Through commissioned arrangements and service level agreements, the IPC teams deliver services to Devon Partnership Trust and through a variation to contract with the Devon Integrated Care Board (ICB) to provide the Community Infection Management Service (CIMS) to care homes and primary care services. The IPC teams also provide advice and guidance to the NHS Nightingale Hospital Exeter, Sexual Health and Assault Services and Vaccination Centres.
- 1.3.3 Two of the medical microbiologists work collaboratively to fulfil the role of Infection Control Doctors (ICD) with one based at the Northern site and one at the Eastern site who also provides an ICD role under the service level agreement with DPT.
- 1.3.4 The antimicrobial stewardship team is led by a Consultant Medical Microbiologist with PAs identified for antimicrobial stewardship activities. Working collaboratively, the Consultant Medical Microbiologist and Antimicrobial Pharmacists provide leadership to influence and promote the safe and effective use of antimicrobials across the Trust, in accordance with local and national guidelines.
- 1.3.5 The Antimicrobial Stewardship Group (ASG) is tasked with ensuring that antimicrobial drugs are utilised throughout the Trust in a way which results in optimal treatment of infections while minimising the risk of adverse effects, including healthcare associated infections. The group is chaired by a Consultant Medical Microbiologist and reports to IPDAG.
- 1.3.6 An annual programme of work for 2024/25 was prepared and ratified by IPDAG. The programme of work is mapped to the duties of the Code of Practice thus demonstrating the Trust's continued work to maintain compliance with the Code.

## 1.4 Surveillance of Healthcare Associated Infections

1.4.1 Surveillance and clinical audit are key tools in identifying good practice and areas for improvement in IPC. Some data is used internally, while other data supports external mandatory or voluntary reporting and benchmarking. Mandatory surveillance is reported via IPDAG to the Patient Safety Committee and the Board through the Integrated Performance Report. Most importantly, surveillance informs and engages frontline teams, driving learning, reflection and continuous improvement.

## 1.5 Mandatory Surveillance of Bloodstream infections and Clostridioides difficile

1.5.1 Mandatory reports are submitted to the UK Health Security Agency (UKHSA) via online systems, covering:

- Resistant and sensitive Staphylococcus aureus bloodstream infections (MRSA and MSSA)
- Gram-negative bloodstream infections (GNBSIs): E. coli, Klebsiella, Pseudomonas
- Clostridioides difficile infections

1.5.2 Infections are classified as healthcare-associated or community-associated:

- HOHA (Hospital Onset Healthcare Associated): Identified on/after day 3 of admission
- COHA (Community Onset Healthcare Associated): Identified within 2 days of admission, with prior discharge within 28 days
- COCA (Community Onset Healthcare Associated)

1.5.3 NHS Standard Contract sets infection thresholds (not rates) for C. difficile and GNBSIs. Table 2 below outlines Trust-level thresholds, actual case counts and infection rates per 100,000 occupied bed days, with regional and national comparisons for benchmarking.

**Table 2: Summary of Trust, South West & National cumulative GNBSI and C. difficile data**

	<b>NHS Standard Contract Trust threshold</b>	<b>No. of reported HOHA + COHA</b>	<b>Royal Devon rate</b>	<b>South West rate</b>	<b>National rate</b>
Clostridioides difficile	72	86	22.54	34.40	27.48
Escherichia coli	210	203	53.83	38.38	34.39
Klebsiella spp.	57	68	18.03	13.58	14.49
Pseudomonas aeruginosa	18	24	6.36	5.35	5.88

*Source: UK Health Security Agency Field Epidemiology Service South West HCAI Data Tool – Final Year 2024-2025 (June 2025)*

1.5.4 Although above the threshold count, the rate of Pseudomonas aeruginosa is on a par with, and Clostridioides difficile is below, the regional and national rates. Of concern, is the high rate of E. coli bloodstream infection. The Trust did meet the threshold count set for the year, however, and despite being higher than desired, there has been a small decrease in the rate compared with the prior year. An investigation into a spike in

multidrug resistant Klebsiella bloodstream infections at the end of Q3 into January yielded no link between episodes nor learning to have prevented the infections.

- 1.5.5 There has been a national rise in incidence of Clostridiodes difficile, not driven by a single ribotype, for which no explanation has yet been found. The Trust is working closely with UKHSA and NHS Devon to establish, guide and support national infection prevention initiatives.
- 1.5.6 Trust wide mandatory enhanced surveillance (MES) organism reduction initiatives are ongoing and continue to inform a large body of the IPC annual programme of work. The focus remains a back-to-basics approach across the whole healthcare economy to increase communication of healthcare associated infection, improve patient education and staff training whilst promoting multidisciplinary engagement with a range of infection reduction initiatives.

**Table 3: Summary of Trust and South West Staphylococcus aureus data**

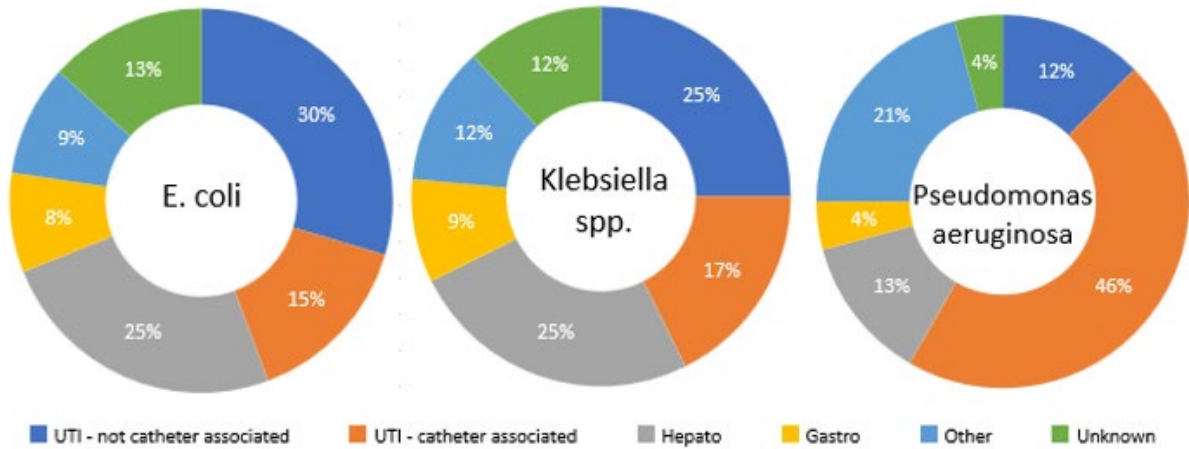
	2024/25 Threshold	No. of reported cases HOHA + COHA	Royal Devon rate	South West rate	National rate
MRSA	Zero	4	1.06	1.54	1.16
MSSA	101	86	22.80	17.17	13.33

*Source: UK Health Security Agency Field Epidemiology Service South West HCAI Data Tool – Final Year 2024-2025 (June 2025)*

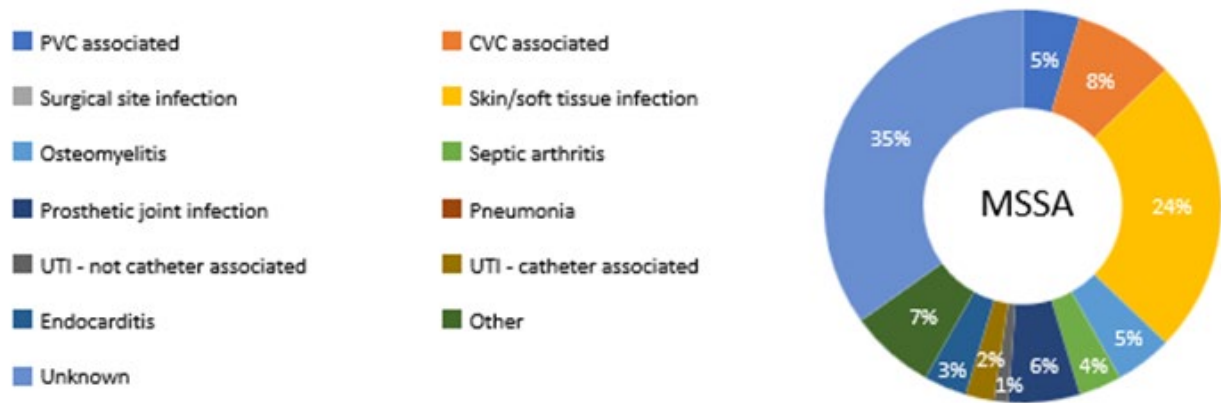
- 1.5.7 Whilst MSSA surveillance is mandatory, threshold levels are not pre-set by NHS England via the NHS Standard Contract therefore local thresholds have been calculated using the same methodology. Performance and comparison with regional and national rates are shown in Table 3 above.
- 1.5.8 A zero-tolerance approach to MRSA bloodstream infection is sustained in the NHS Standard Contract quality requirement. There were four healthcare associated MRSA bloodstream infections in 2024/25. Following newly revised, multidisciplinary after-action review, all four incidences were deemed to be unavoidable. The review incorporates both Patient Safety Incident Investigation Response Framework (PSIRF) principles whilst balancing those requirements mandated by UKHSA via the mandatory enhanced surveillance programme. The response to common IPC incidents were also reviewed last year in collaboration with clinical, governance and patient safety teams and have been published in the Trust’s Patient Safety Incident Reponse Plan for 2025 for wider clarity and ease of use.
- 1.5.9 Incidental findings from MRSA bloodstream infection after action reviews, alongside clinical teams have flagged several areas through which proactive measures have been implemented to further facilitate staff with the early recognition of IPC alerts thus prompting best practice pathways. These measures are ongoing and will inform the annual programme of work for 2025/26. Further review of Trust MRSA screening criteria within the One Devon programme alongside reinforcing good communication of care inside a patient’s electronic record are also key. Trust rates for MRSA are below the regional and national averages.

1.5.10 Figures 1 and 2 show the source split for healthcare associated gram negative and MSSA blood stream infection.

**Figure 1: Source data spilt for GNBSI HOHA + COHA bloodstream infections 2024/25**



**Figure 2: Source data spilt for MSSA HOHA + COHA bloodstream infections 2024/25**



1.5.11 Improvement drives, largely focused on the daily review and prompt removal of indwelling devices commenced in the latter half of 2023/24. These initiatives often take time to show impact. Although rates are still higher than desired, 18 months later, we are now witnessing the impact of those interventions with notable reductions in the rate of MSSA and an overall fall in the incidence of healthcare associated bloodstream infection for all reportable organisms of almost 20% compared to the prior year.

1.5.12 The source data distribution depicted above, in Figure 2, is in keeping with that seen nationally. For gram negative bacteraemia urinary infection is the largest contributor, followed by intra-abdominal foci which are split into hepatobiliary and gastrointestinal subsections albeit often linked. An action group of infection control doctors and lead IPC nurses has met at least monthly to specifically review the Trust's position with MES organisms, benchmarking against local trends alongside the regional and national picture. Prior attempts to reduce bacteraemia both locally and nationally, despite best direction over the years, have been largely unsuccessful. The exact cause for the high rates is unclear and likely to be a complex combination of factors.

- 1.5.13 The MES organism reduction group oversees the implementation of targeted actions throughout the Trust to tackle key source areas identified through continuous voluntary enhanced surveillance. It provides both project support and specialist infection prevention expertise to produce strategies to try to combat the issue. Actions include reducing overall urinary catheter usage within the Trust, linking with broader IPC initiatives targeting a 'back to basics' drive to ensure adherence to best practice and promoting the review and safe removal of indwelling devices at the earliest opportunity. Following an IPC team cultural survey of urinary catheter usage on the Healthcare for Older People wards, a new dashboard has been created within the electronic patient record for clinical staff to easily identify those patients with indwelling urinary catheters within their area of work for ease of review and communication of care at any given time.
- 1.5.14 The proportion of E.coli bacteraemia with a urinary source and an indwelling catheter has fallen from 23% of healthcare associated cases in 2023/24 to 15% in this last year. There is now consultant urology and microbiology representation at Trust wide catheter group meetings, with active ownership of the higher than desired rates of E.coli bacteraemia communicated via multiple channels. These include wider Trust communications, doctors' Grand Rounds, senior nurse meetings, governance routes, staff induction and all avenues available to the IPC team both within more formal teaching sessions and those spontaneous face to face and ward-based interactions with clinical teams. As a result of this, and multiple audit and point prevalence studies, the IPC team will now attend ward board round huddles to provide specialist input with regard to the review of urinary catheters, intravascular devices, multidrug resistant organism identification, screening, hydration and fluid management, alongside patient placement for optimal infection prevention.
- 1.5.15 There have been multiple deep dive reviews of bacteraemia to identify trends throughout the year, and a thorough review of the existing evidence base to understand which interventions have worked and those which have not despite best efforts, as published in local projects, national guidance and international literature. As a result, pre-cystoscopy prophylaxis has been reviewed, and there has been an exploration into mismatch with UTI treatment and bacteraemia resistance resulting in a prompt with guidance on urinary specimen results for clinicians and GPs going forward. There has also been engagement with hepatobiliary teams to utilise MES surveillance findings as a mechanism to reconsider 'hot' gallbladder pathways with data shared directly with the relevant specialities. The Trust also participated in a national improvement drive to improve the intravenous to oral switch for antimicrobial therapies thus reduce vascular access device usage where no longer required.
- 1.5.16 The importance of good quality IPC surveillance data to inform quality improvement, increase communication and direct strategy to reduce infection has played a key role in the acquisition of funding to join One Devon in improving the infection surveillance capability of the electronic patient record. This is a large collaborative project throughout Devon with the aim of providing greater ability to collate local and system wide risk factor data through an electronic surveillance mechanism at the point of identification of a bacteraemia or via monthly prevalence surveys. This will enable greater communication of the Trust's MES position in real time and allow for detailed analysis of those risk factors with increased ease in communication of such in order to identify areas for improvement and facilitate the removal of any barriers to care. This work will continue into 2026/27.
- 1.5.17 MSSA remains the most common organism identified via intravascular device associated blood stream infection surveillance (see section 1.8). Whilst the overall rate remains higher than regional and national rates, it is encouraging to see the proportion attributable

to central or venous catheters reduce from 27% to 13% as these are the most preventable hospital acquired cases. The cause of the higher overall rates is unclear but the Trust source split is in line with national data suggesting there is not a single explanation or particular type of infection which accounts for the high rate.

## **1.6 Orthopaedic Surgical Site Infection (SSI)**

1.6.1 It is a mandatory requirement to conduct surveillance of orthopaedic SSI, utilising the UKHSA Surgical Site Infection Surveillance Service (SSISS). Surveillance data submitted to SSISS for analysis and reporting is validated against a strict protocol to facilitate meaningful comparison between centres within England. Surveillance of implant surgeries requires follow-up of patients for 12 months post-procedure.

1.6.2 The mandatory minimum requirement is to report one quarter of orthopaedic surveillance from one of the following categories:

- Reduction of long bone fracture
- Repair of neck of femur
- Hip replacement
- Knee replacement

1.6.3 The minimum mandatory requirement is exceeded with continuous voluntary surveillance in both the hip and knee categories at the Princess Elizabeth Orthopaedic Centre, Royal Devon & Exeter Hospital (PEOC) and the South West Ambulatory Orthopaedic Centre (SWAOC), Nightingale Hospital. One quarter of surveillance is also submitted in the knee category for North Devon District Hospital (NDDH).

1.6.4 Alongside dilution in volume of surgery across the three orthopaedic sites, case mix for both PEOC and NDDH has changed to involve more complex cases. This can result in a higher than anticipated risk of infection in those acute hospital settings when an infection is detected. Despite this, the Trust was one of just two Trusts that were highlighted as low outliers for total hip replacement surgery in the 'UKHSA Surveillance of Surgical Site Infections in NHS Hospitals in England: April 2023 to March 2024' annual report which was published in December 2024 and continues to have exemplary rates of infection in the hip category.

1.6.5 The SWAOC site, within the Nightingale Hospital, is utilised by orthopaedic surgeons from other hospitals across the Integrated Care System as well as from the Royal Devon. The IPC team work collaboratively with hospital teams throughout the South West region to share improvements and ensure strict readmission surveillance protocol is maintained for the full 12 months post procedure in keeping with the UKHSA SSI Surveillance Service requirement.

## **1.7 Voluntary Surveillance**

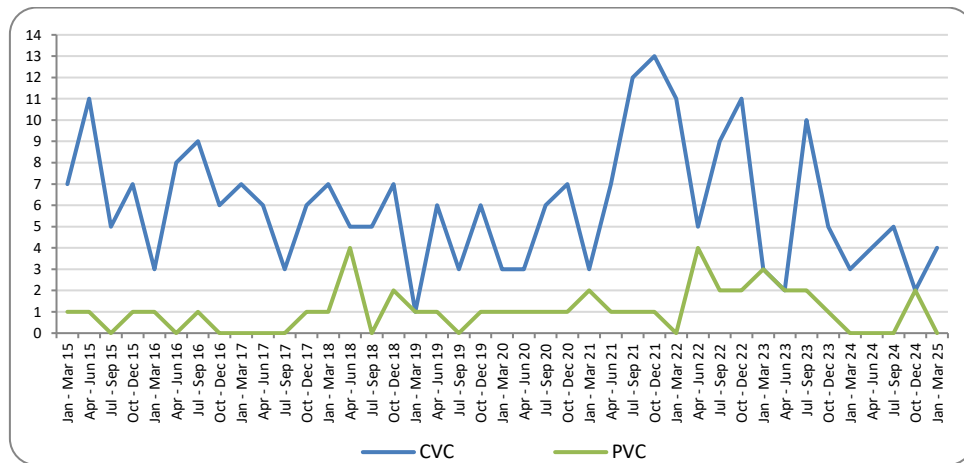
1.7.1 In addition to mandatory enhanced surveillance, the IPC team conducts voluntary surveillance to monitor hospital infections. This includes the following:

## **1.8 Intravascular device associated blood stream infection surveillance**

1.8.1 All central venous catheter (CVC) and peripheral venous catheter (PVC) associated bacteraemia, deemed attributable to the Trust per Nosocomial Infection National Surveillance Scheme (NINSS) definitions in Eastern services, are reported via Datix with shared learning fed back to clinical teams. From this, local and whole Trust action and improvement planning can occur in order to prevent further infection incidence, with wider

communication of successes in infection prevention and lessons learnt shared throughout the whole Trust.

**Figure 3: Intravascular device associated blood stream infection (Eastern)**



1.8.2 The graph in Figure 3 above demonstrates how IPC focus specifically targeted at indwelling device associated infection has had a sustained impact on the incidence of intravascular device associated infection since 2024. CVC and PVC device associated blood stream infections have decreased considerably since that time with just two PVC associated blood stream infections in the last twelve months (both within the same quarter but unrelated).

1.8.3 Continuous line bacteraemia surveillance has been undertaken in Eastern services for over 20 years. Although this is voluntary surveillance, it has always been a valuable and very popular data resource utilised for infection prevention and improvement work with the wider clinical teams. Production of the quarterly report, ensuring the accuracy required with surveillance specific infection criteria, remains resource heavy.

It is the future intention that this data set will be expanded to include those blood cultures processed in the Northern laboratory to enable Trust wide line bacteraemia surveillance. This aspiration is pending an EPIC system upgrade to include Buggy, the IPC module within EPIC which should enable smarter, faster and more widely accessible infection surveillance capability alongside an increase in resource availability. The Eastern team have used ICNet – an IT surveillance system for many years which enables automated data capture, but the Northern team do not have this.

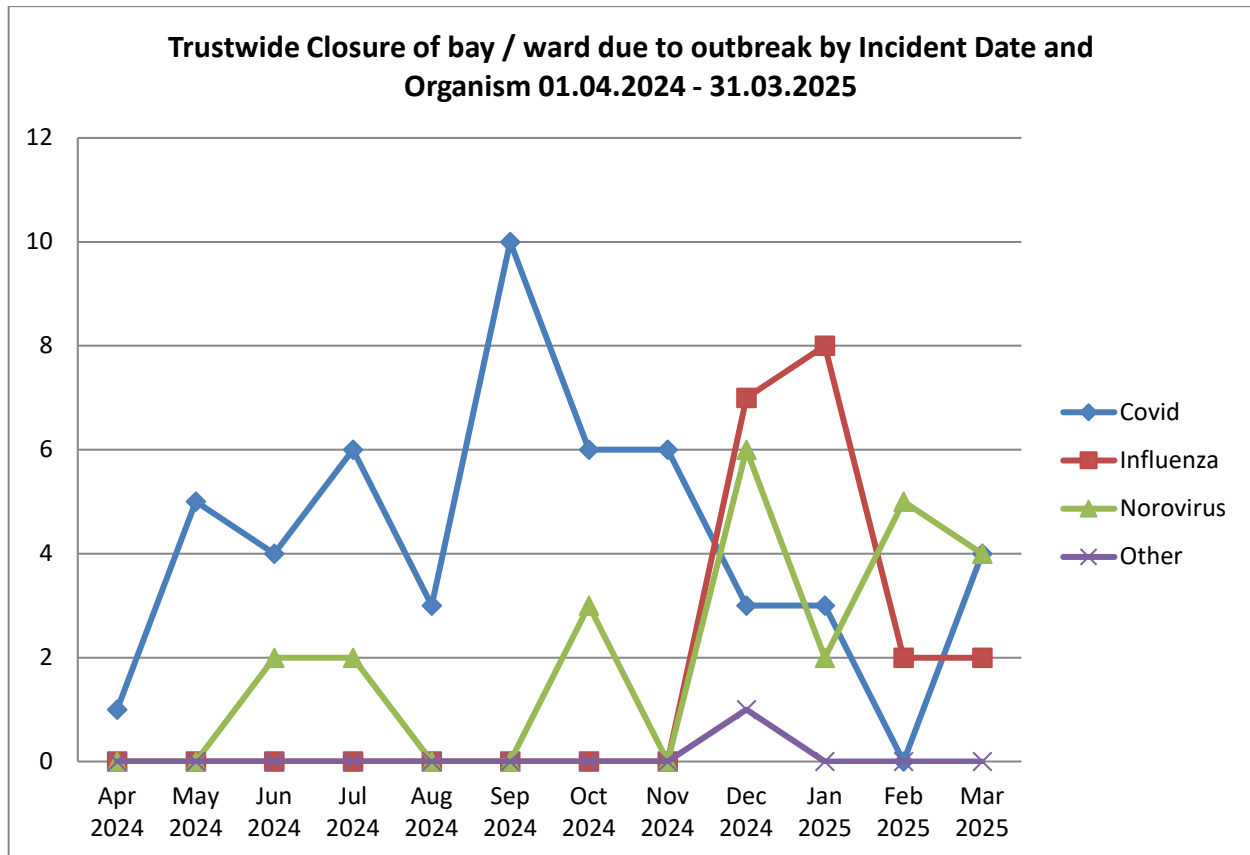
1.8.4 In addition to continuous voluntary surveillance in Eastern services, the annual PVC point prevalence survey was held. This provides a realistic gauge of current practice and intravascular device care within a given timeframe throughout the service which is fed back to each of the Care Groups in order to identify any barriers that may be able to be resolved in order to promote adherence to best practice and ensure good clinical practice. This mini prevalence survey, plus the voluntary all organism central venous and peripheral venous device associated blood stream infection surveillance will be extended Trust wide in 2025/26.

## 1.9 Outbreaks and Incidents

1.9.1 Prompt identification of actual or potential outbreaks is essential to reducing unnecessary risk to patients, staff, and visitors. An outbreak is generally defined as two or more cases of the same infection occurring within a defined timeframe and location. However, if the

infection is widespread in the community, two cases in the same healthcare facility may not be epidemiologically linked, and investigations may not yield conclusive results.

1.9.2 The graph below illustrates infection outbreaks reported over the past 12 months. There was a noticeable rise in outbreaks during periods when the hospitals experienced increased strain due to high admission volumes and delays in patient discharge.



1.9.3 Outbreak control measures were carried out in accordance with established protocols. These included restricting new admissions to affected wards or bays until the outbreak was contained. While this approach effectively reduces exposure and shortens outbreak duration, it also adds pressure to hospital operations, especially in managing emergency admissions and sustaining elective care services.

1.9.4 To limit bed closures where possible, patients with the same infection or those recently recovered were cohorted into designated areas. Although this strategy helps maintain overall bed capacity, it can extend ward closures and delay transfers to external care providers, such as nursing homes.

## 1.10 COVID-19 outbreaks

1.10.1 All COVID-19 outbreaks are reported internally via Datix.

1.10.2 Most patients were identified on admission and isolated in single rooms or in COVID-19 cohort bays depending on prevalence. Some patients admitted to hospital for other reasons developed symptoms of COVID-19 whilst in hospital, however, for the majority of patients, infections remained mild.

1.10.3 In Eastern services, there were 16 outbreaks resulting in whole ward closures and 38 bay closures (not all were associated with an outbreak i.e. bay closed to admissions as unable to isolate an infectious patient). In Northern services, there were 23 outbreaks.

### **1.11 Influenza outbreaks**

1.11.1 In Eastern services, there were no outbreaks resulting in whole ward closures but bay closures were reported on 14 occasions. In Northern services, there were 8 influenza outbreaks.

### **1.12 Norovirus outbreaks**

1.12.1 Norovirus is predominantly a winter pathogen but can also cause outbreaks in summer months. Norovirus is easily transmitted between people even with excellent infection prevention and control practice. Outbreaks are often seen in semi-closed settings such as hospitals, schools, cruise ships, care homes and hotels.

1.12.2 In Eastern services, there were 14 outbreaks resulting in whole ward closures and bay closures on 13 occasions. In Northern services, there were 6 outbreaks.

### **1.13 Other Outbreaks and Incidents**

1.13.1 An outbreak of Group A Streptococcus occurred, centred on Ashburn ward (c/o elderly ward) which resulted in 6 cases of Group A strep infection. Five of these were classified as invasive and 2 patient deaths occurred as a consequence. Once identified, the outbreak was managed in conjunction with UKHSA with numerous mitigation measures in place from the end of February until the mid-April 2025. Molecular typing of the outbreak strain revealed a likely introduction into the hospital by a patient from the community in January with subsequent spread within the hospital. Widespread staff screening did not reveal any cases of the outbreak strain. The outbreak has been reported through the Emerging Patient Safety Event Panel. After Action Reviews have taken place for each of the patient deaths and a review of the infection prevention control practices on the associated wards has occurred.

1.13.2 The trust continues to see a rise in the number of resistant gram negative carrying Carbapenemase genes rendering them resistant to commonly used antibiotics. Devon is historically a low incidence region and while this remains true the numbers are increasing noticeably. The trust has an active screening and isolation policy in place.

1.13.3 All babies on the Neonatal Unit are screened from MRSA and pseudomonas weekly, in line with national guidance. Three cases of the same strain of MRSA were identified on the unit in March 2025, indicative of spread within the unit. No infections occurred as a result and following an outbreak meeting in March 2025, infection prevention practices were reviewed and reinforced. There have been no further cases, but this highlights the ability of organisms to spread within the hospital environment and the need for a continual focus on infection prevention and control.

### **1.14 Hospital and Community Hand Hygiene Audits**

1.14.1 Monthly audits assess compliance with WHO's 5 Moments for Hand Hygiene. While reported compliance is generally high, IPCT validation audits and informal observations suggest actual performance is lower, largely due to overuse of gloves, staffing challenges, and workload pressures. Data is reviewed at IPDAG and Care Group Governance Meetings. A focus on a "gloves off" approach was delivered in 2024/25 with ongoing education throughout 2025/26.

1.14.2 Hand hygiene audits conducted by trained practitioners working in the community continue providing data collected in patients' homes, community clinics and other settings.

### **1.15 Transition of Hand Hygiene Products Following Gojo Administration**

1.15.1 In April 2024, Gojo Industries Europe Ltd entered administration, disrupting the supply of Purell hand wash, hand sanitiser and dispensers widely used across the RDUH eastern sites. With no access to Gojo products following this announcement, an immediate switch to an alternative was required. The transition to Ecolab products was smoothly managed, thanks to the collaborative efforts of all teams involved. Staff played key roles in trialling and installing the new products, ensuring minimal disruption and maintaining high standards of hand hygiene across the Trust.

### **1.16 Spot Check Audits**

1.16.1 Each month, IPCNs conduct spot check audits across inpatient, outpatient, and off-site areas. Using a nationally based audit tool, the checks focus on infection prevention practices, cleanliness standards, and common themes.

1.16.2 Non-compliance or examples of good practice are discussed with staff on the spot. Results are shared with ward managers, senior nurses, and relevant departments (Sodexo, Estates, Facilities) with a summary email highlighting key issues or positives.

1.16.3 The audits cover a range of IPC practices, including:

- Hand hygiene, Bare Below Elbows (BBE) compliance, and availability of alcohol hand gel and sinks
- Care of peripheral IV cannulas and urinary catheters
- Communication about resistant organisms and MRSA suppression treatment
- Isolation practices for infection control
- Sharps bin storage and management
- Cleanliness of patient equipment (e.g., hoists, tourniquets, trolleys, commodes)
- Linen and waste management
- Food hygiene and management of patient-use water coolers

## **2 Provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infection**

### **2.1 Domestic Services (Eastern)**

2.1.1 The Domestic Services Department continues to collaborate closely with Ward Housekeepers, who transferred to the Facilities team in December 2024 after previously being managed by clinical nurse managers. The zonal system overseen by Supervisors is working effectively, with regular visits to wards and public areas ensuring cleanliness, tidiness, and minimal clutter. Numerous tickets have been raised with the Estates team to report any identified damage.

2.1.2 The most pressing challenge for the Domestic Services team in 2024/25 remains staff vacancies and the ongoing difficulty in recruitment. During periods of high demand, it is still necessary to redeploy domestic staff from non-clinical to clinical areas to maintain patient care standards. Encouragingly, recruitment has improved, and the department anticipates reaching full staffing capacity within the next six months.

- 2.1.3 Recruitment is currently underway to expand the specialist cleaning team in response to increased demand. This enhancement will support patient flow in key areas, including the Acute Medical Unit and Emergency Department.
- 2.1.4 With the reduction in viral outbreaks, all domestic assistants have resumed their regular duties. When there are no active deep or outbreak cleans, the Specialist Cleaning Team is assigned to non-clinical areas.
- 2.1.5 The Audit Team continues to perform and record weekly technical monitoring, supplemented by Quarterly Management Audits to ensure standards are maintained.
- 2.1.6 Due to the volume of deep and specialist cleans required overnight, the Specialist Cleaning Team was temporarily expanded to operate 24/7. As demand decreases, this is gradually being scaled back to two night-shift team members. Coordination between the Site Management Team and the overnight Supervisor remains a strong example of effective collaboration.



2.1.7 The annual deep clean programme, a Department of Health initiative, was last fully completed on the Eastern site in 2018/19. Since then, a more opportunistic, ad hoc approach has been adopted, using periods of reduced clinical activity or lower bed occupancy to undertake deep cleaning. This method continued through 2024/25, although it remains difficult to coordinate due to the short notice required and the limited availability of appropriate teams and external contractors. Recommendations have been submitted to the Infection Prevention and Decontamination Action Group (IPDAG) and the Safety and Risk Committee, suggesting the protection and use of vacant space within acute and community hospitals to enable consistent annual deep cleaning. Discussions are ongoing to identify viable solutions.

## 2.2 Domestic Services (Northern)

2.2.1 Sodexo continues to provide high-quality domestic services at the Northern site, consistently seeking improvements and innovation within the contract. One such development is the implementation of Black Light technology, a training tool that enhances cleaning effectiveness. The UV marking system highlights high-touch surfaces, allowing cleaners to visually assess the success of their cleaning and engage in constructive feedback with supervisors. This approach not only strengthens cleaning standards but also supports staff development and reduces the risk of healthcare-associated infections (HCAIs).

- 2.2.2 Unlike the Eastern site, the Northern site does not carry out an annual deep clean. Instead, thorough weekly cleans and dedicated bed washing routines are maintained to ensure a high level of hygiene across all wards and departments, in addition to regular daily cleaning.
- 2.2.3 Cleaning performance is monitored by site monitoring officers and further audited by the Facilities Department. In 2024, monitoring expanded to cover both nursing and estates elements in line with the National Standards of Cleanliness. Each area receives a star rating based on its risk category and the percentage of cleaning achieved. An average cleanliness score of 98.5% was recorded across acute and community sites.
- 2.2.4 Health and safety compliance audits are conducted throughout the year using a four-tier system:
- T1 and T2 audits are completed by site supervision and management teams.
  - T3 audits are annual and conducted by Sodexo’s Health, Safety, Environment and Quality (HSEQ) team (formerly Safeguard).
  - T4 audits are external accreditations such as ISO.
- 2.2.5 A quarterly “aesthetics” monitoring programme continued in 2024 to identify environmental issues such as damaged flooring, peeling paint, or broken furniture. All findings are reported to the Estates team, though resolution has been difficult due to resource limitations.

## 2.3 Patient Led Assessment of the Care Environment (PLACE)

- 2.3.1 The Patient-Led Assessments of the Care Environment (PLACE) offer insights into how the Trust is performing in various non-clinical areas that influence patients’ overall care experience. While the criteria used in PLACE are not formal standards, they reflect priorities identified by patients and the public. Assessments are conducted by teams that include both staff and local volunteers, known as Patient Assessors, who must make up at least 50% of each team. These assessors evaluate how well the environment supports the delivery of clinical care from a patient perspective.

In 2024/25, the Trust achieved a cleanliness score of 97.82%, representing a slight decrease of 0.08% from the previous year. Site-specific results are as follows:

Victoria Hospital (Sidmouth)	93.72%
Tiverton & District Hospital	100.00%
North Devon District Hospital	98.26%
Royal Devon & Exeter Hospital (Wonford)	97.74%
South Molton Hospital	94.89%

## 2.4 Hospital Sterilisation and Decontamination Unit (HSDU)

- 2.4.1 The Trust maintains robust systems for the effective decontamination of surgical instruments and other reusable medical devices. It is fully compliant with Health Building Note (HBN) 13 – Sterile Services Department, and operates under a certified quality management system aligned with ISO 13485:2016. Additionally, the Trust is registered under the UK Medical Devices Regulation 2002 (as amended). All decontamination procedures are conducted in accordance with Health Technical Memorandum (HTM) 01-01—which governs the decontamination of surgical instruments—and integrates the relevant standards, including ISO 15883, ISO 17665, and ISO 22441. The Trust also adheres to the Advisory Committee on Dangerous Pathogens (ACDP) guidance on

Transmissible Spongiform Encephalopathies (TSE), in line with NICE Interventional Procedures Guidance IPG666.

- 2.4.2 In 2024, the Trust appointed a new Decontamination Lead responsible for overseeing services across both the Eastern and Northern sites. This role ensures that the Trust-wide decontamination policy is implemented in accordance with national standards and best practice. Quarterly review meetings are held with the Decontamination Lead and key stakeholders from both locations, reporting to the Decontamination Safety Group and the Medical Devices Steering Group.
- 2.4.3 With the Trust continuing to drive down patient waiting times, the volume of surgical and clinical procedures has surpassed previous records, exceeding levels last seen in 2019. Between January and December 2024, the Hospital Sterile Services Department (HSDU) successfully decontaminated, inspected, packaged, and sterilised 4,032,882 surgical instruments—marking the first time the four-million milestone has been achieved. To support this sustained growth, recruitment and retention efforts have been strong, and the department will increase its HSDU Technician workforce by 4.0 whole-time equivalent (WTE) positions starting April 2025.
- 2.4.4 The Trust has effective arrangements for the appropriate decontamination of surgical instruments and other reusable medical devices. The Trust is fully compliant with *Health Building Note, HBN/13 – Sterile Services Department*; operates a quality management system in accordance with *ISO 13485:2016* and has registration under the *UK Medical Devices Regulation 2002 (as amended)*. Decontamination processes are undertaken in line with *Health Technical Memorandum HTM 01-01 – Decontamination of Surgical Instruments* guidance, incorporating *ISO 15883*, *ISO 17665* & *ISO 22441* standards as appropriate. The *Advisory Committee on Dangerous Pathogens (ACDP)* guidance on Transmissible Spongiform Encephalopathy (TSE) is followed in accordance with *National Institute for Health & Care Excellence (NICE) Interventional procedures guidance, IPG666*.
- 2.4.5 The Trust follows rigorous procedures for the acquisition and maintenance of decontamination equipment. This includes obtaining specialist advice from the appointed Authorised Engineer (Decontamination) [AE(D)] and involving suitably qualified Authorised Persons (Decontamination) [AP(D)], both designated by the Trust to ensure compliance with relevant standards and best practice.
- 2.4.6 The Trust continues to expand its surgical capabilities and invest in advanced technologies. Building on the established use of the Intuitive Xi 'Da Vinci' robotic system for Urology, Colorectal, Prostate, ENT (Head & Neck), and Gynaecological surgeries, the Trust has recently introduced Aquablation techniques for prostate removal. Minimally invasive procedures are also being extended into community settings, such as laparoscopic and endoscopic surgeries now underway in Tiverton. These minimally invasive approaches offer significant benefits, including reduced hospital stays, faster recovery, and improved outcomes compared to traditional open surgeries.

The reprocessing of specialist instruments used in the above procedures is more complex and time-consuming than that of general surgical tools. It involves additional steps and requires a higher level of skill and technical expertise from decontamination staff to ensure that all instruments meet the strictest standards of cleanliness and sterilisation.

- 2.4.7 The specialised knowledge and skills required for decontamination work are gaining formal recognition through the Institute of Decontamination Sciences (IDSC), the professional body for the field. Decontamination staff are increasingly recognised as Healthcare Scientists and may be eligible for registration under the Academy for

Healthcare Science, provided they meet the relevant criteria and maintain professional development through CPD accreditation.

2.4.8 A comprehensive monitoring system is in place to ensure decontamination processes remain effective, compliant and aligned with all relevant standards. Key components include:

- **Divisional and Departmental Risk Assessments:** Incorporating full COSHH reviews to identify and mitigate risks associated with substances and processes used in decontamination.
- **Instrument Tracking:** A robust 'Track & Trace' system is implemented for all surgical instrument trays and supplementary devices across both hospital and community settings, ensuring full traceability.
- **Enhanced Traceability Technology:** The introduction of a NuTrace Laser Instrument Marker has improved the traceability of reusable medical devices. This upgrade supports continued use of unique identifier markings, future-proofs traceability capabilities, and broadens the range of materials that can be reliably marked.
- **NICE Compliance:** Ongoing review of compliance with *NICE Interventional Procedure Guidance (IPG666)*, which addresses the reduction of Creutzfeldt–Jakob disease (CJD) transmission risk via surgical instruments used on high-risk tissues.
- **Environmental Monitoring:** Clean Room environments and associated processes undergo quarterly bioburden testing and staff fingertip sampling ('finger dabs'), in accordance with *ISO 14644* and *BS EN 17141* standards.
- **Water Testing:** Weekly water quality testing is conducted, with prompt review and response to results.
- **Equipment Validation and Testing:** Routine daily, weekly, quarterly, and annual checks of all decontamination machinery are performed, along with revalidation as required to maintain assurance.
- **Maintenance and Record Keeping:** A structured maintenance programme is in place, with complete records available for audit and review.
- **Residual Protein Testing:** The use of ProReveal technology enables highly sensitive detection of residual proteins post-decontamination, supporting assurance to micro-level precision.
- **Independent Monitoring and Parametric Release:** Independent systems validate the safe and effective release of sterilised loads based on monitored parameters, rather than solely biological indicators.
- **External Auditing:** Regular audits are carried out by accredited external bodies, covering equipment performance, validation testing, staff competencies, and procedural compliance.

## 2.5 Linen Decontamination Unit (LDU)

2.5.1 The Linen Decontamination Unit (LDU), located on the Eastern services site, is one of the largest NHS healthcare laundries in the UK, equipped with the latest technology and efficient monitoring systems.

2.5.2 The LDU consistently exceeds customer expectations for quality, as confirmed by positive feedback during quarterly contract reviews.

2.5.3 The LDU operates under HTM 01-04 'Decontamination of Linen for Health and Social Care' regulations.

- 2.5.4 The Health and Social Care Act requires compliance with linen handling standards, either the Essential Quality Requirement (EQR) minimum or the preferred Best Practice (BP). Acute Trusts and healthcare providers now favour BP when procuring laundering services.
- 2.5.5 The LDU achieved BP certification in October 2017 via external audit to BS EN 14065:2016, assuring safe, decontaminated linen for NHS, public, and private sectors. Registration lasts three years with annual surveillance audits. The LDU also adopts progressive measures to enhance textile safety regarding infections.
- 2.5.6 To maintain certification, the LDU uses a Risk Analysis Biocontamination Control (RABC) Management System that assesses and manages hazards throughout laundering to prevent contamination, with ongoing internal monitoring and audits.
- 2.5.7 The RABC system and BS EN 14065:2016 certification is accredited by Atlas Certification Limited, recognized by UKAS and the International Accreditation Forum (IAF).
- 2.5.8 The LDU prioritises the highest safety and quality standards, employing advanced decontamination and biocontamination controls to ensure safe linen for patients and staff while committing to continual service improvement.
- 2.5.9 Linen decontamination follows Critical Control Points (CCPs) in the wash stage, meeting HTM 01-04's time and temperature standards to achieve 99.99% biocontaminant kill.
- 2.5.10 HTM 01-04 specifies thermal disinfection at 65°C for 10 minutes or 71°C for 3 minutes; the LDU uses the 65°C/10 minutes criterion.
- 2.5.11 CCPs are monitored in real time, with processes halted if critical temperatures are not met.
- 2.5.12 Monitoring is validated using data loggers inside wash machines, with additional monthly audits by detergent suppliers covering temperatures, water quality, and chemical dosing.
- 2.5.13 Beyond standards, the LDU conducts biannual independent tests to scientifically verify germ kill levels during washing.
- 2.5.14 The first test, Precision Analysis, sends laundered linen samples to an independent lab to assess contamination (including *S. aureus*, *Pseudomonas*, *B. cereus*, *Listeria*, *Salmonella*). Results consistently fall below recommended bacterial detection limits.
- 2.5.15 The second test, the DES-infection Controller, measures microbiological reduction by passing fabric swatches containing *Enterococcus faecium* through the LDU's decontamination process. Swatches, enclosed in semi-permeable membranes that allow water and chemicals but prevent rinsing off bacteria, start with microbial loads of  $10^5$ ,  $10^6$ , and  $10^7$  cfu/cm<sup>2</sup>. After processing, swatches are tested independently to assess bacteria killed. The industry standard for germ reduction is a  $10^6$  kill log; the LDU consistently achieves a minimum  $10^7$  kill log or higher.
- 2.5.16 The RABC system is verified at multiple Control Points (CPs) within the LDU to minimize re-contamination. These controls are audited using evidence-based systems and documentation, including hygiene protocols, protective footwear, KanBan linen handling at Washer Extractors, dip slide testing, cleaning schedules, cage sanitisation records, and test results.

- 2.5.17 The RABC system relies on a pre-requisite programme that ensures foundational controls are in place – such as appropriate building design, physical barriers between clean and used linen, ventilation, handwashing facilities, and cleaning regimes. Together with the biocontamination Risk Plan, these measures support effective contamination control.
- 2.5.18 The RABC system complements the LDU's quality management, incorporating quality checks throughout finishing. Detailed Standard Operating Procedures (SOPs) guide staff training and processes, including linen inspection, safe packing, loading, and secure cage covering before transit.
- 2.5.19 Annually, the LDU processes around 16 million items for the Trust – including Nightingale Hospital Exeter – along with other Acute NHS Trusts, Community Trusts, and healthcare and non-healthcare clients across the Southwest Peninsula.

## 2.6 Water Safety

- 2.6.1 *Legionella* spp. and *Pseudomonas aeruginosa* (*Pa*) are the two primary bacteria that are capable of living in hospital water systems and indeed can be found in almost any water course or feature as they can be found commonly in the environment around us. They have the potential to cause clinically significant infections in patients, especially those with underlying health conditions or immune suppression.
- 2.6.2 The Water and Ventilation Safety Group (WVSG) meets monthly on a departmental (Estates) level, twice per year on Trust level and as further required if an issue or risk with water or ventilation is identified. Among the attendees is an appointed external specialist, known as an Authorising Engineer (AE W) who offers advice on how to ensure that the Trust is able to follow best practice to ensure continued control of *Legionella* spp. and *Pseudomonas aeruginosa*.
- 2.6.3 The primary Microbiological control of *Legionella* and *Pseudomonas aeruginosa* is achieved by:
- Thermal Regimen; the Trust employs temperature control as the primary method of *Legionella* and *Pa* control within the domestic water systems
  - This is achieved by maintaining temperatures of:
    - Cold water at temperatures of < 20°C
    - Stored hot water at >60°C
    - Distributed water at >55°C
  - The avoidance of stagnation by:
    - Removing any blind or dead ends on distribution pipework as far back to the origin of supply as possible
    - Ensure all Dead-Legs e.g. low use taps, are either flushed twice weekly or removed including any associated pipework
    - Minimising stored water volumes where possible
    - Ensuring that both existing and new systems have a good turnover of any water stored within them, e.g. appropriate tank sizing
    - Maintain cleanliness at outlets and follow prescribed cleaning routines to minimise cross contamination from plug holes etc.
    - Cold water storage tanks are inspected annually and cleaned as required by specialist contractors

- 2.6.4 A secondary form of bacterial control is provided by the use of a Copper/Silver (Cu/Ag) ionisation unit. There are currently five units fitted as below, and each is carefully monitored and regular samples taken to prove its efficacy:
1. Centre for Women's Health (Ag+ only)
  2. Modular Wards Ashburn and Yealm (Ag+ only)
  3. Heavitree Hospital (Ag+ only)
  4. RDE Energy Centre (Ag+ only)
  5. North Devon District Hospital
- 2.6.5 Historically *Legionella* bacterium have been found in low numbers in water samples taken from outlets within the Trust. This is not entirely unexpected as the organisms can be found readily in most water supplies, and does clearly illustrate the need to effectively control the environment.
- 2.6.6 More recently, due to the age of the Wonford Hospital's main building pipework system, scale and corrosion has impacted the available water flow resulting in the loss of thermal control in some secondary and tertiary loops (loops that feed floors and/or one or two outlets). This has led to bacterial colonisation within the water supply system and an increased risk of legionella related infection. This has been appropriately managed through extraordinary water safety groups and there is a risk on the Estates risk register to reflect ongoing concerns, controls and mitigations.
- 2.6.7 Engineering works to replace major pipework and pumps on the hot-water system have commenced, along with installation of a supplementary and enhanced site wide temperature monitoring system. A number of corroded and failed isolation valves have been replaced in preparation for the replacement circulation pumps which are currently on order and awaiting delivery.
- 2.6.8 Along with engineering works to replace ageing infrastructure and permit a rebalance the water system to regain thermal control, a secondary biocide system in the form of a copper/silver (Cu/Ag) ionisation unit has been installed in the Energy Centre. The unit has been in operation for c12 months and is being monitored monthly with additional bacterial sampling.
- 2.6.9 *Pseudomonas aeruginosa* sampling takes place as per HTM 04-01 recommendations; in Augmented Care areas (ICU, HDU, NNU etc.), on a 6 monthly rolling program. Historically positive results have been recorded from both Yarty and Yeo Wards.
- 2.6.10 Remedial action for any outlet testing positive includes immediate isolation of the outlet and removal from use, an urgent review of cleaning processes, the implementation of a regular flushing and sampling regime; engineering works and chemical cleans as required and regular discussion with the WVSG and DIPC, followed by a prescribed sampling regime, which only allows the outlet to be put back into use after 3 consecutive sample results indicate the outlet is clear, as prescribed in HTM 04-01.
- 2.6.11 Works to remove plastic flow straighteners, flexible hoses and corroded pipework or valves also reduces risk, and is undertaken as soon as is practicable.
- 2.6.12 Some parts of the sewerage system at the Eastern site are working at capacity, however improvement works including descaling, relining and water level (blockage) alarm sensors have been fitted in a bid to monitor and minimise the impact of blockages. The biggest issue currently is the disposal of non-flushable hygienic wipes and incontinence pads, directly via sluices and indirectly via macerators. This is being

managed by the estates team and affected Care Groups, with a risk on the Medicine Care Group risk register.

- 2.6.13 The Trust has a number of IPC risks associated with backlog maintenance. These are well-understood and documented by the IPC team and Estates. However, a lack of capital investment means there is a risk of these not all being mitigated in their entirety. This specifically relates to ongoing water safety, drainage, ventilation and the general condition of parts of the Eastern estate and therefore, the Trust is partially compliant with this criterion.
- 2.6.14 An external specialist company undertakes a Water Safety Risk Assessment (WSRA) of all distinct water systems managed by the Trust. This makes recommendations based on associated risk and provides a basis for water hygiene activity. These are then reviewed every two years for all clinical locations and every three years for non-clinical locations, as advised by the AE (W). A new WSRA is provided for any new installation or significant alteration to an existing system.
- 2.6.15 Due to the water flow issues across the wider Wonford estate, the newly opened paediatric assessment unit was opened with suboptimal water flow rates, posing a potential risk of bacterial colonisation, pending effective remedial works on the older part of the estate. This is mitigated by secondary biocidal measures and regular use or flushing of outlets. This was known about before opening the unit and derogated due to the urgent need for a more suitable paediatric assessment area.

## **2.7 Ventilation**

- 2.7.1 Risks from ventilation are minimised by the use of contractors to clean the inside of each Air Handling Unit (AHU) on a 3 or 4-month rolling program. This includes disinfection of areas subject to moisture, such as cooling coils and fins, as well as regular filter changes.
- 2.7.2 Wall or ceiling mounted cooling units are also subject to regular maintenance and cleans by a specialist contractor, as are portable equipment. Whilst the current HTM 03-01 recommends against this type of unit, the risks are theoretical and they have never been associated with a reported healthcare outbreak, and are ubiquitous in the built environment outside of healthcare with no evidence of harm. They do provide essential heating and cooling in areas that otherwise would pose a health risk to staff and patients due to adverse temperatures.
- 2.7.3 Other safety precautions include cleaning of ducting and ventilation grills as required and for key areas on a regular PPM program generated by MICAD, the computer aided facility management system.
- 2.7.4 It is likely that as the ventilation systems continue to age, various aspects will require financial investment to ensure continued compliance. This may include replacement AHUs and duct cleaning programs.
- 2.7.5 The building of the paediatric assessment unit has altered the flow of rainwater and roof detritus from the main theatre roof area. This led to a very significant build-up of seagull guano. As the weather warmed in Spring this generated a considerable stench that was sucked in through the ventilation system for theatres. The systems operated correctly – filtering out pathogens – but they are not designed to filter out volatile organic chemicals. Remedial action was taken to remove the guano and there is a plan to net the roof area from gulls once the breeding season is over.

2.7.6 Around the same time as we had issues with unpleasant odours we also had building works ongoing within the theatre complex. Again, with the warmer weather the building contractors left windows open that allowed the ingress of flies into the theatre area. This was remedied by encouraging the closing of windows and doors to prevent fly ingress.

## **2.8 Food Hygiene Eastern**

2.8.1 Exeter City Council Environmental Health Officers inspect all Trust-run catering outlets, Patient Meal Service, and three Community hospitals at least every 18 months to ensure compliance with Food Safety regulations. Inspections cover cleanliness, temperature monitoring, stock rotation, and adherence to hazard analysis plans. The Trust has earned full 5-star ratings for all Eastern catering areas.

2.8.2 All catering staff in the East complete Level 2 online food safety training to maintain hygiene standards. Plans are underway to extend this training to ward housekeepers.

2.8.3 Team leaders conduct weekly and monthly food safety and cleaning audits to ensure regulatory compliance, identify improvements, and maintain consistent cleaning standards.

2.8.4 In February 2025, electronic meal ordering via the Saffron system was introduced across Eastern wards. This system, shared with Northern Services, improves efficiency by enabling allergen filtering, reducing food waste, and eliminating paper menus.

## **2.9 Food Hygiene Northern**

2.9.1 Environmental Health Officers from North Devon Council inspect all Northern Services catering areas every 18 months to ensure compliance with Food Safety regulations, including cleanliness, temperature monitoring, stock rotation, and hazard analysis. The last inspection on 5th February 2024 awarded a 5-star rating for NDDH's main kitchen, restaurant, and café.

2.9.2 An annual health and safety assurance review, conducted by Sodexo's HSEQ Team over two days in August 2024, covers food safety and overall site compliance. The Northern site received an amber score due to food labelling and allergen management issues. Monthly audits by the site team address food safety, allergens, and calorie display.

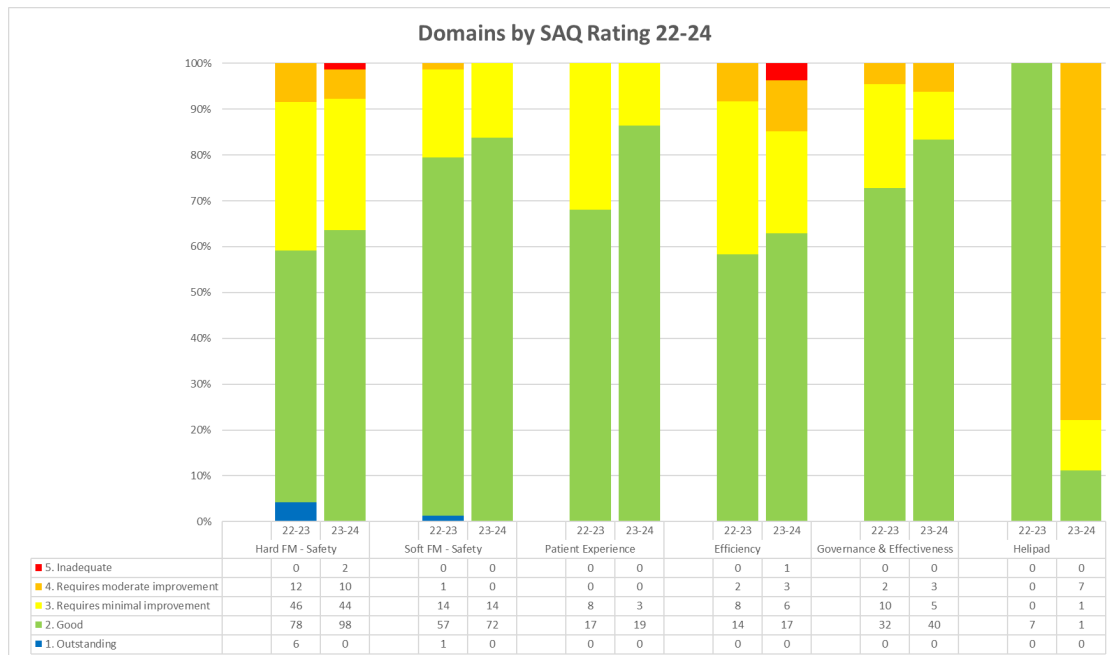
2.9.3 All Sodexo and Trust food handlers complete annual food safety training, including allergen awareness, now delivered via Sodexo's new online platform, ACCESS.

2.9.4 New patient menus have been introduced, expanding plant-based options and switching the supplier to Apetito for Acute and community hospitals. The menu complies fully with BDA standards.

## **2.10 NHS Premises Assurance Model (NHS PAM)**

2.10.1 The NHS PAM is a management tool that provides NHS organisations with a way of assessing how safely and efficiently they run their estates and facilities services. The assessment covers the period 1st September 2023 to 31st August 2024. Completion of the PAM assessment, reporting to the Trust Board and online submission is a requirement of the NHS Standard contract.

2.10.2 The assessments are rated on a 5-point scale from Inadequate through Moderate or Minimal improvement to Good or Outstanding. From the applicable assessment criteria, the Trust rated:



2.10.3 The PAM assessment has not identified any serious concerns or risks.

2.10.4 The main criteria for Infection Prevention & Control are within the Hard and Soft FM assessments. The areas assessed as inadequate relate to the management of ligature risks and financial pressures affecting sustainability objectives.

2.10.5 Overall the assessment has shown an improvement on the previous year.

2.10.6 Areas for improvement identified through the PAM Assessment are recorded and reviewed through the Estates and Facilities Governance Groups in order to demonstrate continuing and targeted improvement.

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

3.1 Antimicrobial stewardship (AMS) optimises infection treatment while minimizing risks like resistant organisms and *Clostridioides difficile* infection. It's a core part of infection prevention and control (IPC) and a national priority, supported by the 2024-2029 UK action plan and NHS contract targets to reduce antimicrobial use.

3.2 AMS activities expanded significantly in 2024/25:

- **Eastern sites:**

- Stewardship ward rounds thrice weekly with a multidisciplinary team (microbiologists, clinicians, IPC nurses, antimicrobial and clinical pharmacists).
- Weekly virtual reviews for vascular patients; in-person rounds added for renal and Healthcare for Older People specialties.
- Weekly CDI review MDT for inpatients and community cases.

- **Northern sites:**

- Remote stewardship rounds via optimized MyCare reporting for UTI and IV antimicrobial patients.
- Weekly CDI review MDT as above.

- **Trust-wide:**

- Weekly antimicrobial reviews for paediatric and neonatal unit patients with a multidisciplinary team including liaison and transition nurses.
- Educational sessions for junior medical staff, non-medical prescribers, physician associates, IPC link nurses, and pharmacists.
- No antimicrobial CQUINs for 2024/25.
- Antimicrobial usage monitored from April 2024 to March 2025 using Rx Info©, now merging Northern and Eastern data:

Antimicrobial Agent	Joint Trust usage
Carbapenem	Reduce by 12.8%
Tazocin	Reduce by 12.2%
AwaRe Category Usage (target = 70% Access)	70% Access 29% Watch 1% Reserve
Total Antimicrobial Usage	Reduce by 0.3%

- The Trust is merging its Antimicrobial Treatment Guidelines; completed topics include Maternity, ENT, Brain Abscess, and Ophthalmology, with others like aspiration pneumonia, neutropenic sepsis, paediatrics, and community-acquired pneumonia under review.
- Devon Trusts are collaborating on a unified MRSA decolonisation protocol for orthopaedic pre-operative care. The Antimicrobial Resistant Microorganism (ARM) policy and related patient group directives (PGDs) have been updated accordingly.
- The Outpatient Parenteral Antimicrobial Therapy (OPAT) service has expanded to Northern sites, with a weekly virtual MDT reviewing active and potential patients.
- The Antimicrobial Stewardship Group (ASG), overseeing the Trust's AMS program, met four times in the year with full quorum and now includes representatives from both Northern and Eastern services.
- The Trust joined the UK Antimicrobial Registry (UKAR) study late last year, collecting real-time data on antimicrobials for multidrug-resistant pathogens; five patients have been recruited so far.
- At the Eastern site, an antimicrobial pharmacist is participating in a PhD ethnography project in general surgery, with a follow-up quality improvement project planned.

### 3.3 Key challenges to be addressed in the IPC and ASG 2025/26 workplan include:

- Developing Epic reports to track antimicrobial stewardship KPIs, with AMS and business intelligence teams collaborating.

- Implementing the IPC/AMS module within Epic as part of the One Devon rollout, including exploring Buggy resources and engaging Devon secondary care partners to enhance infection and prescribing data analysis.
- Harmonising Epic AMS stewardship tools across Devon, aligning with current use at RDUH.
- Completing the review and consolidation of antimicrobial guidelines across Eastern and Northern Trust sites.
- Ensuring all antimicrobial guidelines on the Trust Hub meet governance standards.

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

- 4.1 Information is provided in a variety of ways for patients, visitors and carers: Available on the Trust website and in outpatient letters. During outbreaks, telephone systems provide a pre-recorded message on visiting restrictions. Patient information leaflets are available for specific infectious conditions. Annual reports are published on the Trust website and presented to the Public Board of Directors.
- 4.2 Information is shared through the same channels, plus the CIMS, which supports care homes and primary care. This service, funded by the ICB, fosters communication and collaboration between providers.
- 4.3 A variety of educational sessions were offered to other providers by the CIMS during the year including:
- Quarterly updates for Primary Care Infection Control Link Practitioners.
  - Sessions concerning antimicrobial stewardship and antimicrobial resistance for adult social care providers and settings delivered via MS Teams.
  - 'Gloves off' educational sessions for adult social care providers and settings delivered to small groups.
  - Support was given to engagement events organised by the Community Education and Assurance Team (CEAT).
- 4.4 The CIMS continues to receive positive feedback for its work in social and primary care sectors, with quarterly activity reports to IPDAG and the Care Group Governance Meeting.

**5. Ensure that people who have or are at risk of developing an infection are identified properly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.**

- 5.1 Patients are assessed on admission for infection risk factors, including signs, symptoms, and travel history, with prompts in the electronic patient record.
- 5.2 The Trust-wide Source Isolation policy guides the prioritisation of patient placement in single rooms for their own or others' protection. The Patient Placement and Movement Policy further ensures appropriate placement to minimize infection risks.
- 5.3 Patient movement within the Trust is managed through policies on admission, discharge, and transfer. The IPC team collaborates with site management, estates, and facilities to coordinate patient movements between departments and healthcare facilities.

5.4 Infection control information is shared with other institutions prior to patient transfers. The IPC team works with the discharge planning team to ensure infection control details are included in all relevant documentation.

**6. Systems are in place to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection**

6.1 IPC responsibilities are outlined in job descriptions for all Trust staff.

6.2 The Trust has adopted National Health Education e-learning programs: Level 1 for non-patient-facing staff and Level 2 for patient-facing staff, aligned with the UK Core Skills Training Framework.

6.3 Patient-facing staff in key roles attend face-to-face or virtual IPC training, approved by the Operational Training and People Development Groups.

6.4 IPC is incorporated into clinical skills training, including venepuncture, cannulation, drug/nutrition administration, and IPC link practitioner courses.

6.5 Fit testing and training for FFP3 respiratory protective equipment are provided to all staff who need it by the fit testing team, however, work continues to improve compliance rates in patient facing roles.

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

7.1 The Trust acknowledges the need to expand isolation facilities for infectious patients, while also ensuring privacy for other patients. However, many single rooms lack en-suite facilities, and some isolation room lobbies are too small for proper PPE donning and doffing. As a result, the Trust is partially compliant with this criterion.

7.2 The Trust has isolation and patient placement policies, with IPCTs advising on prioritisation for single room use.

7.3 To address the shortage of single rooms, cohort bays are used for patients with the same infection when necessary.

7.4 A limited number of portable isolation rooms, known as Redirooms, are used in settings like ITU and Respiratory HDU for patients who cannot be placed in a cohort.

**8. Secure adequate access to laboratory support as appropriate**

8.1 Laboratory services at both acute sites are UKAS accredited, with established protocols and standard operating procedures.

8.2 Laboratory services operate seven days a week, with 24-hour access to medical microbiology advice.

8.3 Microbiology Consultants collaborate closely with the IPCTs, attending weekly meetings with the virology and microbiology teams to address ongoing and emerging issues.

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

- 9.1 Infection control policies, procedures and guidance documents are available on the Trust's intranet. The IPCT is responsible for maintaining and updating these, with approval via IPDAG and ratification by the Patient Safety Committee. Many documents align with national guidance.
- 9.2 Significant progress has been made to align all IPC policies, with a total of 18 completed in 2024/25 and 1 outstanding for 2025/26.
- 9.3 The antimicrobial prescribing policy, co-managed by the Consultant Microbiologist and antibiotic pharmacist, is approved by the Antimicrobial Stewardship Group, which reports to IPDAG.
- 9.4 Decontamination policies are overseen by the decontamination lead.
- 9.5 IPC policies undergo reviews every three to five years or sooner based on new evidence. The review schedule is part of the annual infection control programme, and compliance is audited as planned.

**10. Have a system or process in place to manage staff health and wellbeing and organisational obligation to manage infection, prevention and control**

- 10.1 The Occupational Health Service is SEQOHS (Safe Effective Quality Occupational Health Service) accredited. It has been accredited since 2012 and was last reaccredited in December 2024.
- 10.2 The SEQOHS standards are the benchmarks that occupational health services are required to demonstrate they meet to be awarded accreditation and to retain accreditation. Accreditation is a robust process involving self-assessment and external peer assessment against accreditation standards, to establish and promote a culture of continual improvement. The service takes part in Mohawk national OH benchmarking twice a year since 2012.
- 10.3 Particularly in a healthcare setting, the occupational health services play a significant role in infection prevention and control. Some of the work they have undertaken in 2024/25 to support the protection of staff is identified in the table below:
- 10.4 Occupational Health continue to undertake vaccination and blood screening where indicated to reduce the risk of infection in staff at high volumes to tackle the backlog caused by the pandemic and higher levels of recruitment. Table 4 summarises the work carried out in 2024/2025 in comparison to 2023/24.

**Table 4: Vaccinations/Bloods**

	Jan - Mar 25	Total Apr - Mar 25	Total Apr - Mar 24	Comparison
<b>Type of Service</b>				
<b>Immunisations</b>				
TB Screening	29	283	425	-33%
Hep B	380	1278	1834	-30%
MMR	241	935	1315	-29%
Varicella	31	154	242	-36%
Other vaccinations	51	253	339	-25%
<b>Sub Totals</b>	<b>732</b>	<b>2903</b>	<b>4155</b>	<b>-30%</b>
<b>Blood Test Screening</b>				
Quantiferon	74	290	421	-31%
Varicella	79	302	503	-40%
Hep B	301	1221	1670	-27%
MMR	82	191	442	-57%
Hep C	89	330	427	-23%
Other screening	550	1259	1187	6%
<b>Sub Totals</b>	<b>1175</b>	<b>3593</b>	<b>4650</b>	<b>-23%</b>
<b>Vaccination Assessment</b>	<b>368</b>	1758	1953	-10%
<b>EPPs</b>	<b>102</b>	533	565	-6%
<b>Total</b>	<b>2377</b>	<b>8787</b>	<b>11323</b>	<b>-22%</b>

10.5 Immunisation and blood tests activity is 22% lower than last year. Every category within this section is less than the same timeframe last year with the exception of 'Other Screening'. This included a large amount of Step A screening this quarter following an outbreak. Recruitment of 2 new OHPNs from September onwards increased capacity in the latter part of the year. The reduction in vaccinations/blood test activity over the year was in part due occupational health capacity.

**Table 5: COVID-19 Activity**

	Jan - Mar 25	Total Apr - Mar 25	Total Apr - Mar 24	Comparison
Type of Service				
Coronavirus advice	12	399	1073	-63%
Coronavirus risk assessment		0	154	-100%
Coronavirus medical assessment		0	7	-100%
Coronavirus contact tracing		0	0	
<b>Total</b>	<b>12</b>	<b>399</b>	<b>1234</b>	<b>-68%</b>

10.6 Table 5 captures the additional coronavirus activity logged onto the OH database. Each category is lower than last year. There were 9 positive cases reported this quarter.

10.7 In keeping with other NHS Trusts, flu vaccination uptake for frontline staff is lower than in previous years at 49% against a target of 75%. This is 5,111 vaccinations administered to frontline staff.

ROYAL DEVON						
Employment code	A. Medical and Dental	B. Nursing and Midwifery Registered	C. All other professional clinical staff	D. Support to Clinical Staff	E. No direct patient care	TOTAL
ROYAL DEVON Headcount	1678	3042	1682	4022	2394	12818
						0
FLU TOTAL - GIVEN	912	1502	864	1833	1227	6338
						0
COVID TOTAL - GIVEN	767	978	668	1232	983	4628
FLU % of staff group	54%	49%	51%	46%	51%	49%
COVID % of staff group	46%	32%	40%	31%	41%	36%

## 11. Conclusion

- 11.1 Eliminating avoidable healthcare-associated infections remains a priority for RDUH to protect patients, staff, and the public. We continue to thank the IPC team for their dedication and hard work throughout the year.
- 11.2 The Trust is fully compliant with 8 out of 10 criteria of the Health and Social Care Act 2008: Code of Practice on infection prevention and control, with partial compliance in two criteria.
- 11.3 The 2025/26 IPC annual programme was approved by IPDAG in May 2025 which focuses on monitoring, support, education and intervention to promote IPC and ensure full compliance with the Code of Practice, along with NICE Quality Standards, CQC Guidance, NHSE Board Assurance Framework for IPC and internal audit recommendations. Progress will be monitored by IPDAG and the Patient Safety Committee.
- 11.4 The RDUH remains committed to reducing HCAs and will continue to collaborate with staff, patients and carers to develop and implement IPC strategies for delivering safe, clean care and aiming for no avoidable infections.

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