

Trust Board paper F1

Meeting title:	Trust Board
Date of the meeting:	8 October 2026
Title:	Escalation Report from the Quality Committee (QC): 24 September 2026
Report presented by:	Jill Houghton, Non-Executive Director QC Chair
Report written by:	Jill Houghton, Non-Executive Director QC Chair

Action – this paper is for:	Decision/Approval		Assurance	x	Update	
Where this report has been discussed previously	Not applicable					
To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which						
BAF risk 01 (Quality)						
Impact assessment						
N/A						

Purpose of the Report

To provide assurance to the Trust Board on the work of the Trust's Quality Committee (QC).

Summary

QC met on 24 September 2026 and was quorate. The attached escalation report identifies any issues which the Committee either needs to recommend, or wishes to highlight, to the Trust Board, and sets out QC's level of assurance.

There are no items requiring formal recommendation to the Trust Board from the September 2026 QC meeting.

This escalation report follows a quadrant template, focusing on assurance levels and aiming to provide an 'at a glance' report from the Board Committees. The template covers: **key escalations**; **actions to take outside the Committee**; **positive assurances**, and **decisions taken**.

The escalation report also sets out any items recommended for Trust Board approval, and any items referred to other Committees.

The report is not intended to be a narrative account of all issues discussed at the meeting.

scores. However, there is still work to be done to further improve patient experience in this area. (Moderate assurance) BAF Quality 01 Update Report from the Safeguarding Assurance Committee The Quality Committee noted the work completed in response to the High Court Judgement in relation to Deprivation of Liberty Safeguard criteria, the required work to meet the NHS England specification for the Child Protection Information Sharing System with NerveCentre and the progress in transitioning to the new approach to safeguarding training as directed by NHS England (Moderate Assurance) BAF 01 Quality 1 and 2 UHL Perinatal Report The Quality Committee was pleased to note that the July data from perinatal services and intelligence gained from the Perinatal Assurance Committee on 2 September 2026 demonstrated that perinatal safety, quality, workforce, experience, equity and improvement remained broadly stable despite sustained operational performance. The report also reflected the UHL’s Board’s approval of the NHS England’s 10 Point Plan baseline assessment and ongoing work, the refreshed UHL Perinatal Assurance and Accountability Framework. Gap analysis against the recent Thirlwall Report has been circulated to board members and will be further discussed in the October Board meeting. (Moderate Assurance) BAF 01 Any Other Business The Committee received a verbal update on the NUH Paediatric Scoliosis Service. Oversight of the review of patient impact associated	sampling of patients could be better deployed in relation to ethnicity and deprivation. The ICB Lead present at the Quality Committee agreed to continue to work with UHL on system wide safeguarding issues. The Chief Operating Officer will provide a further update to the next Board.
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with the waiting list backlog will continue through the Trust's governance processes.	
Positive Assurance taken	Decisions taken
Reports reviewed: Quality and Safety Performance Report Patient Safety Quarterly Report Q1 2026/2027 Update report from the Safeguarding Assurance Committee Patient Safety Committee Assurance Summary (Moderate Assurance)	
Items recommended for Board approval:	
None.	
The Patient Experience Annual Report 2025/26 and the Infection Prevention Annual Report 2025/26 from the July and August 2026 QC meetings respectively are attached for the Board's interest.	
Items referred to other committees:	
None	

SIGNIFICANT ASSURANCE	Clear understanding of the issues with a robust, deliverable plan which will achieve the required outcomes. Only insignificant residual risk. There may be external evidence to corroborate this view
MODERATE ASSURANCE	Good understanding of the issues, a clear plan with timescales that are credible and deliverable but some action still required. The residual risk is more than insignificant
LIMITED ASSURANCE	Recognised material weaknesses which may be incomplete understanding of the issues or an action plan which is not comprehensive, credible or deliverable. A significant amount of residual risk remains
NO ASSURANCE	A fundamental failure to understand the issues. An action plan is inadequate with fundamental gaps, weaknesses or breakdown in compliance. A significant of residual risk remains and immediate action is required

Patient Experience Annual Report 2025-26

Board-quality thematic analysis: complaints, PALS, FFT, surveys and Patient Experience programmes

Meeting title:	Quality Committee
Date of the meeting:	30 July 2026
Title:	Patient Experience Annual Report 2025-26
Report presented by:	Sue McLeod, Head of Patient Experience
Report written by:	Sue McLeod, Head of Patient Experience, Maya Farmer, Complaints & PALS Lead / Patient Experience Team, Sharon Wilkinson Senior Nurse for Patient Experience, Mike Burgess, Share Your Experience Lead

Action – this paper is for:	Decision/Approval		Assurance	x	Update	x
Where this report has been discussed previously	PIPEAC, Quality Committee quarterly Patient Experience updates, CMG governance routes					

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Yes. BAF risk within the remit of QC is listed below: - delete as appropriate Board Assurance Framework (BAF) Quality Risks (BAF reference: 01-Quality) 3)There is a risk that patients, families, and carers are not fully engaged in service development and feedback, due to limited access to and responsiveness of engagement mechanisms, leading to unmet needs, dissatisfaction, and increased complaints

5,451	1,478	115	18
PALS concerns	Formal complaints	Reopened complaints	PHSO contacts
Annual contacts	Annual complaints	Further responses	New contacts

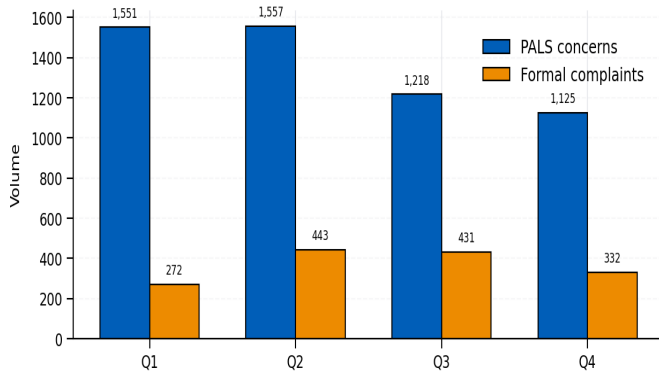
Purpose of the Report

- To provide the Quality Committee with a Board-level annual thematic analysis of patient experience across 2025-26, integrating complaints, PALS, Friends and Family Test feedback, patient surveys, Healthwatch intelligence, VALE, volunteer services, Chaplaincy activity and wider patient experience improvement programmes.
- Receive the annual patient experience thematic analysis for 2025-26.
- Take assurance that patient feedback is being triangulated across multiple routes and used to inform learning and service improvement.
- Support the proposed patient experience priorities for 2026-27: access, communication, continuity of care, compassionate care, patient moves, inclusion and strengthening the patient voice.

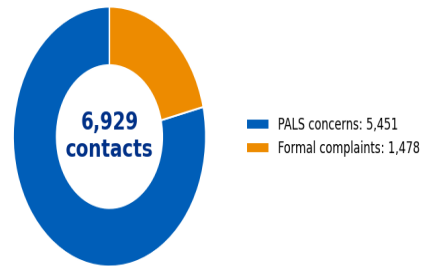
Patients value the compassion and commitment shown by staff, but want services that are easier to access, communicate more clearly, and provide better continuity through care pathways.

Section 2: Patient Experience Dashboard

Patient Experience Activity by Quarter, 2025-26



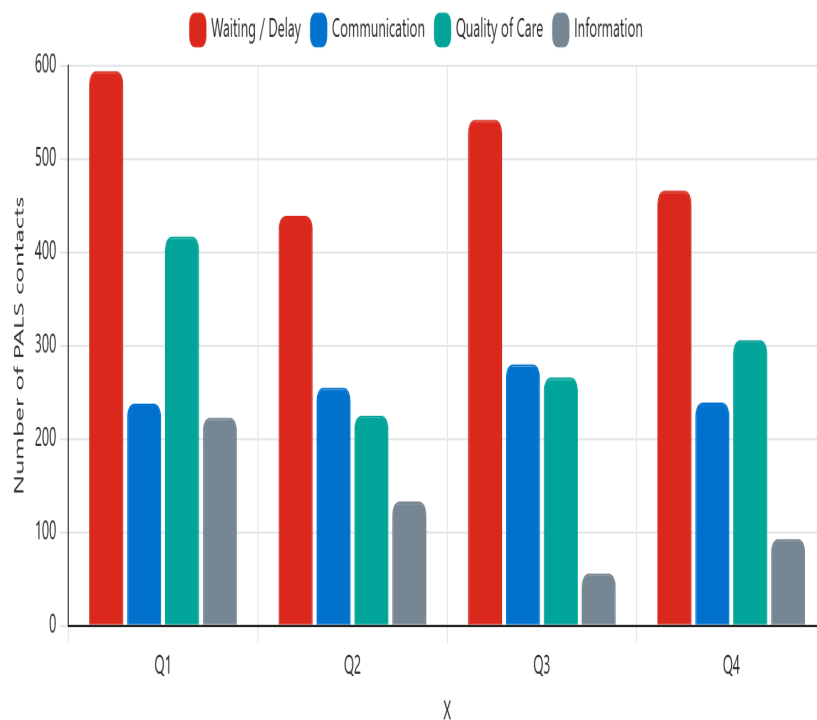
Complaints and PALS Activity



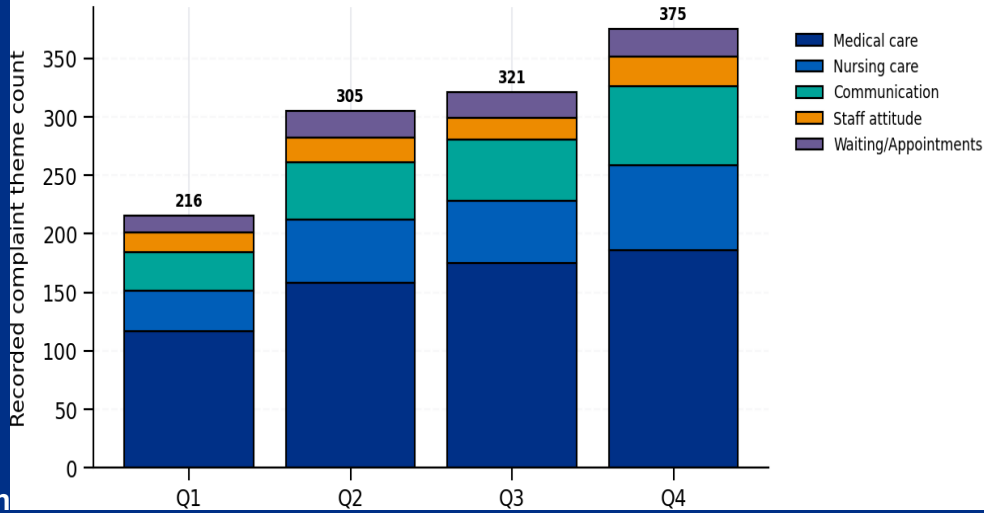
The dashboard shows high levels of patient contact through both PALS and the formal complaints process. PALS concerns were highest in Q2 and reduced in Q3 and Q4. Formal complaints increased sharply in Q2 and remained high in Q3 before reducing in Q4.

Measure	Q1	Q2	Q3	Q4
PALS concerns	1,551	1,557	1,218	1,125
Formal complaints	272	443	431	332
Reopened complaints	25	26	32	32
PHSO contacts	0	5	6	7

Key PALS Themes by Quarter (2025-26)



Top Complaint Themes by Quarter



Section
Themes

3: Eight Strategic

#	Theme	Evidence-based summary
1	Access and waiting times	Dominant PALS theme; outpatient access, telephones, appointments and delays were repeatedly raised.
2	Communication and information	Recurring across PALS, complaints, Healthwatch, maternity and survey intelligence.
3	Medical care	Largest formal complaint theme in every quarter.
4	Nursing care	Second largest complaint theme; includes basic care, pain, dignity, hydration and escalation.
5	Compassion and dignity	Experience is strongly influenced by whether patients and families feel listened to and respected.
6	Women's health and gynaecology	Persistent access, communication and compassion themes; also evidence of improvement.
7	Inclusion and inequalities	Feedback highlights engagement gaps for younger people and some communities, and specific needs for carers, LD and accessible information.
8	Patient Experience improvement programmes	Sleep, nutrition, carers, patient moves, surveys, VALE, volunteers and Chaplaincy strengthened the portfolio.

Theme Detail and Narrative

Access and Waiting Times

Access and waiting times were the strongest recurring theme. Patients most often raised concerns about delays to appointments and treatment, difficulty contacting services, long clinic waits, appointment changes and uncertainty about next steps. Hotspot locations included LGH OP1, Balmoral Eye Clinic, Sleep Services, ENT outpatients, Gynaecology and LRI OP3.

Communication and Information

Communication concerns appeared in every feedback route. Patients and families described not feeling listened to, receiving inconsistent information, delays in updates and poor information about waiting or care plans. The data suggests that dissatisfaction is amplified when delays are not accompanied by clear, timely explanations.

Medical and Nursing Care

Medical care remained the largest complaint theme throughout the year, with nursing care the second largest. The thematic picture includes clinical decision-making, treatment planning, continuity, hydration, nutrition, pain management, dignity, call bell response and escalation of concerns. This is particularly important for frail, elderly and vulnerable patients.

Compassion and Dignity

Patients often judged experience through the human aspects of care: whether staff listened, spoke with kindness, involved them in decisions and made families feel supported. Positive feedback frequently praised individual members of staff who went above and beyond.

Women's Health and Gynaecology

Women's Health and Gynaecology remained a visible theme in feedback, with concerns around access, waiting times, communication, compassion and bereavement support. Positive assurance includes reduction in maternity complaints, new maternity surveys, enhanced bereavement work, patient information improvements and Call for Concern developments.

Inclusion and Health Inequalities

The Trust strengthened focus on carers, learning disability, translation, health literacy and demographic reach. FFT analysis highlighted opportunities to improve participation from younger people and some minority ethnic and faith communities. Healthwatch feedback reinforced the importance of carer communication, overnight support and appropriate communication tools.

Patient Experience Improvement Programmes

In response to feedback, coordinated work has been undertaken over the past two years to align Patient Experience and Fundamentals of Care to improve the empathy of our staff across Clinical Management Groups and roles.

Furthermore, the Patient Experience portfolio expanded beyond complaints and PALS through sleep improvement, nutrition and hydration, carers passport rollout, patient moves work, survey expansion, VALE, volunteers and Chaplaincy. This provides a broader, more rounded understanding of experience of care.

Complaint distribution by clinical CMG's

CMG	Complaints
CMG 3 – Emergency & Specialist Medicine (ESM)	352
CMG 7 – Women's & Children's (W&C)	306
CMG 5 – Musculoskeletal & Specialist Surgery (MSK & SS)	225
CMG 1 – CHUGGS	201
CMG 2 – RRCV	112
CMG 6 (CSI + UHL in the Community)	111
CMG 4 – ITAPS	49

Key Themes Across the CMGs

• Urgent and Emergency Care Continues to Generate the Highest Volume of Complaints

CMG 3 receives the greatest number of complaints, with Emergency Department activity representing the single largest specialty area.

This suggests that access, patient flow, waiting times, communication and patient experience within urgent care pathways remain significant areas of concern.

• Women's Health Services Are a Major Source of Feedback

Women's & Children's services represent the second highest complaint volume.

Maternity and Gynaecology services are among the most frequently complained-about specialties, indicating the importance of continued focus on communication, involvement in decision-making, continuity of care and patient experience.

• Surgical Services Account for a Significant Proportion of Complaints

Across CHUGGS and MSS, complaints are concentrated within General Surgery, Trauma & Orthopaedics, ENT, Ophthalmology and Urology.

This suggests recurring themes associated with elective pathways, treatment expectations, communication and co-ordination of care.

• Complex Long-Term Conditions and Older People's Care Remain Important Themes

RRCV and CHUGGS include services caring for patients with complex medical needs and multiple co-morbidities.

Complaint activity within Cardiology, Oncology, Neurology, General Medicine and Geriatric Services highlights the challenges associated with complex care journeys and communication across multiple teams.

• Complaints Are Concentrated Within High-Volume Patient Pathways

The services generating the greatest number of complaints are among the busiest services across UHL, including:

Emergency Department

Maternity

General Surgery

Gynaecology

Trauma & Orthopaedics

This indicates that complaint volumes are largely driven by areas with high patient activity and complex pathways.

Id Us

VALE end-of-life support

"The VALE Team in attendance were wonderfully empathetic and their offer of support was much appreciated at such a sad time."

Chaplaincy

"The way she spoke to us and listened gives us great comfort. Thank you."

Family experience

"The support offered by VALE is fantastic and very much appreciated. Your volunteer staff are amazing and really lifted our spirits."

VALE continuity and presence

"It was comforting knowing in between our visits she was being supported."

Section 5: How We Responded

- Expanded patient surveys, including Family, Carers and Friends, Virtual Ward, Same Day Emergency Care, Maternity, Elective Waiting List and Catering surveys.
- Strengthened complaint governance through Independent Complaints Review Group activity and Non-Executive Director thematic scrutiny.
- Expanded VALE and volunteer services, with 15 VALE volunteers active across LRI and GH and 372 active volunteers in Trust roles by Q4.
- Progressed patient moves and outliers work, including outlying assessments, Nervecentre documentation and dashboard development.
- Continued 15 Steps assessments, Sleep Charter implementation, nutrition and hydration monitoring and carers passport rollout.

Trust wider programmer being delivered for Fundamentals of care

- Further developed accessible information, alternative language survey options, health literacy awareness and engagement with community representatives.

Section 6: Impact and Improvement Achieved

Area	What changed	Patient experience impact
End-of-life care	Improved documentation, handover and	Supports more reliable follow-through on

	escalation following complaint learning.	management plans and family concerns.
Maternity	Improved digital records, referral pathways and communication standards.	Reduces risk of missed follow-up and inconsistent advice.
Children's services	Reinforced treatment-site verification and documentation following complaint learning.	Improves confidence in basic safety checks and parental communication.
Gynaecology	Wayfinding, escalation, environmental and bereavement support work progressed.	Addresses access, communication, dignity and emotional support themes.
Patient moves	Outlying policy, assessment and dashboard work progressed.	Focuses on reducing disruptive moves, particularly for vulnerable patients and those living with dementia.

Section 7: Priorities for 2026-27

Priority	What this means in practice
Improve access and waiting experience	Focus on outpatient hotspots, telephone access, appointment information and waiting list communication.
Strengthen communication	Improve responsiveness, updates and plain-English information for patients and families.
Improve continuity of care	Strengthen transitions across teams, wards, specialties and sites.
Embed compassionate care	Continue focus on staff attitude, dignity, kindness, listening and support for families.
Reduce avoidable patient moves	Prioritise patients living with dementia, end-of-life patients and other vulnerable groups.
Improve inclusion and accessibility	Increase participation from under-represented groups and improve accessible information and reasonable adjustments.
Strengthen the patient voice	Further develop triangulated intelligence across complaints, PALS, FFT, surveys, Healthwatch and improvement programmes.

Board Assurance Statement

The Patient Experience Programme demonstrates that UHL continues to listen to, learn from and act on patient, family and carer feedback. The intelligence gathered throughout 2025-26 provides a comprehensive view of patient experience and supports targeted improvement across services. Access, communication and continuity of care remain the most significant opportunities for improvement, but there is clear evidence of organisational learning, service improvement and compassionate care delivery across the Trust.

Acronyms Used

Acronym	Meaning
BAF	Board Assurance Framework

CMG	Clinical Management Group
FFT	Friends and Family Test
PALS	Patient Advice and Liaison Service
PHSO	Parliamentary and Health Service Ombudsman
VALE	Volunteering at Life's End

Meeting title:	Quality Committee
Date of the meeting:	27 August 2026
Title:	Infection Prevention Annual Report 2025/26
Report presented by:	Julie Hogg Group Chief Nurse
Report written by:	Elizabeth Collins Head and Deputy Director of Infection Prevention

Action – this paper is for:	Decision/Approval		Assurance	x	Update	X
Where this report has been discussed previously						

To your knowledge, does the report provide assurance or mitigate any significant risks? If yes, please detail which
Provide assurance

Impact assessment
None to date

Acronyms used: TIPAC Trust Infection Prevention Assurance Committee UHL IP BAF Infection Prevention Board Assurance Framework UKHSA United Kingdom Health Security Agency IPT Infection Prevention Team IP Infection Prevention CQC Care Quality Commission NHSE National Health Service England NCS National Cleaning Standards CMG Clinical Management Groups MRSA Meticillin Staphylococcus Aureus CDT Clostridioides difficile toxin E.coli Escherichia coli HOHA Hospital onset hospital associated COHA Community onset hospital associated COIA Community onset indeterminate association COCA Community onset community associated PPE Personal Protective Equipment FFP3 Face filtering Piece PLACE Patient Led Assessment of the Care Environment WSG The Water Safety Group AE Authorising Engineer
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Purpose of the Report

Present the 2025/26 Infection Prevention Annual Report

Recommendation

The committee is asked to receive this report and to note the work load and effort of the Infection Prevention Team during the past year.

Summary

The Committee is asked to note in particular the work load and efforts of the Infection Prevention Team during the past year which includes continuing to implement a Board Assurance Framework which has been

recognised as an exemplar by NHSE.

The Mask Fit Testing Team continues to provide a valuable to clinical service to our staff. This is a cost effective service to the organisation which is a mandatory requirement for UHL.

The continued development of the UHL Surgical Site Infection Surveillance Programme which has been recognised as an exemplar and continues to develop

The team continues to respond to all actions that have been required of it, and proactively supports all CMGs and UHL teams in managing healthcare associated infections and on-going respiratory infections.

Main report detail



University Hospitals
of Leicester
NHS Trust

Infection Prevention Annual Report

2025-2026



Infection Prevention Annual Report

April 2025 - March 2026

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1. **Executive Summary**

This Report reviews the 2025/26 Infection Prevention successes and challenges for UHL.

The Trust continues to be licensed to practice healthcare with the Care Quality Commission (CQC).

Quarterly reporting to the Trust Infection Prevention Assurance Committee throughout 25/26 used a slide deck presentation. This was in order to accommodate a large amount of information in an easier to read format. This Annual Report however continues to use a narrative presentation to further support effective governance and assurance with regard to Infection Prevention management within UHL and to ensure that the report remains accessible and readable for the public.

UHL Infection Prevention Board Assurance Framework (IPBAF) continues to be strengthened in content. As it has developed, it has proved to be an effective tool for data capture at ward and department level, indeed it has been recognised by NHSE as an effective tool for IP management and we have been commended for this.

UHL is required to report onto the United Kingdom Health Security Agency data capture system the following organisms:

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

This data reporting has continued throughout the year. This is subject to a strict quality checking process.

The growth of the Surgical Site Infection Surveillance (SSI) programme continues at pace now and regular reports are presented to the UHL Quality Committee. The Trust continues to develop this vital quality system.

For the surveillance undertaken UHL has moved into a position of being an exemplar in this field and most importantly directly supports the provision of a quality and safer service for our patients. There is further detail later in this document

Mandatory Mask Fit Testing for the protection of our staff continues and after significant work by the UHL Fit Testing Team, the Trust again is in the best position it has ever been in with regard to being able to understand compliance with this directive and importantly offer protection to our staff.

2. Introduction

This report provides the Trust Board with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention Team between April 2025 and March 2026. The publication of the Infection Prevention (IP) 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.

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

This report acknowledges the hard work and diligence of all grades of staff, clinical and non-clinical, which play a vital role in improving the quality of patients' and stakeholders' experience as well as helping to reduce the risk of infections.

Defects in the structure and function of buildings across the NHS now pose a real challenge for Infection Prevention. Lack of adequate numbers of single en-suite facilities within the acute Trust and social care facilities within the LLR community has led to more patients remaining in acute sector hospitals for much longer than is required, therefore exposing them to the risk of Hospital/ Healthcare Associated Infection (HCAI)

The UHL Infection Prevention Team (IPT) is committed to identifying and highlighting these weaknesses, redoubling efforts to work with colleagues at every level to improve the quality of NHS estate, resources and practice locally and nationally.

The IPT is dedicated to providing a service that treats all patients equitably, making sure that patients from frequently underserved communities and backgrounds receive high quality care. Working with all colleagues across the organisation has ensured that there has been ongoing emphasis given to the implementation of National directives, guidance documents and the Prevention of Healthcare Associated Infection.

I would like to thank the Infection Prevention Team for being truly reactive and responsive to challenges presented to them on an almost daily basis and for their unswerving support.

**Elizabeth Collins, Head and Deputy Director of Infection
Prevention University Hospitals of Leicester**

3. UHL Governance and Assurance Framework

The Board of Directors has collective responsibility for keeping to a minimum the risk of infection and recognises its responsibility for overseeing Infection Prevention arrangements in the Trust.

The Trust Infection Prevention Assurance Committee (TIPAC) continued during 2025/26 and received reports and updates from the Infection Prevention Team and wider allied groups within UHL.

The TIPAC is chaired by the Chief Nurse, who is also the Director of Infection Prevention and Control (DIPC). UHL TIPAC receives assurance of the Clinical Management Group (CMG) Infection Prevention Programme implementation and monitors compliance with Trust policies.

Adherence to National policy and guidelines continued to be implemented through a dedicated Infection Prevention multi-disciplinary Trust Infection Prevention Operational Group (TIPOG) with fortnightly meetings and has been formally adopted as a subgroup of the Trust Infection Prevention Assurance Committee.

This meeting is used to communicate operational guidance and issues relating to Infection Prevention, including cleaning and decontamination, Personal Protective Equipment, Vaccination, staff and patient testing, and Occupational Health. It is also useful as a forum for staff to be able to express concerns and provide opinion on local guidance. Information shared is taken forward into staff safety huddles for onward communication.

The Trust CMGs are comprised of different clinical specialties – their management structures are bespoke around these and the IP management arrangements may vary between them. They continue strengthening the assurance and monitoring processes into their committees and structures for the reporting and monitoring of Infection Prevention related activities.

A comprehensive assurance reporting framework remained in place.

The Infection Prevention arrangements within the CMGs are reported and confirmed at the CMG Quality and Performance Management Committees and ultimately by exception to the Trust Infection Prevention Assurance Committee and then into the Quality Committee.

An annual Infection Prevention programme is prepared by the IPT, which is agreed, each year, by the TIPAC and approved by the Executive Team and Trust Board. The annual programme runs from April to March. Progress against the Annual Programme is monitored by the TIPAC.

The programme of work is mapped to the duties of The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (2022) and incorporates elements of the Trust Commissioning Quality Schedule (where applicable) UHL Quality Commitment, National Institute for Clinical Excellence (NICE) guidelines and any relevant recently produced national guidance documents.

Throughout 2025-2026 the IPT continued to engage in the Monthly Integrated Performance Reviews on HCAI performance (including MRSA and *C.difficile* rates). These are produced and presented to the Quality Committee and quarterly Infection Prevention reports are produced by all CMGs which are presented to TIPAC.

The Director of Infection Prevention and Control provided the direct link to the Trust Leadership Team with issues, by exception.

3.1 Infection Prevention Board Assurance Framework

During 2025/26 the Infection Prevention Team concentrated on implementing the National Infection Prevention and Control Board Assurance Framework, published by NHSE. This framework enables organisations to use an evidence based approach to maintain the safety of

patients, service users, staff, and others.

It is used by all those involved in care provisions in England and can be used to provide assurance in NHS settings.

[National-infection-prevention-and-control-board-assurance-framework.xlsx \(live.com\)](#)

UHL has adapted this framework and renamed it the UHL Infection Prevention Board Assurance Framework (UHL IP BAF) in order to provide an assurance structure for the Trust Board.

It has been devised to enable transparency from ward to board in regards to the level of compliance against the Health and Social Care Act 2008: Code of practice for health and adult social care on the prevention and control of infections and related guidance (2022). All Ward/Department Leaders across all services delivered at UHL are engaged in the UHL IP BAF and are accountable for their documented level of compliance.

The level of compliance at Ward/Department or service through to CMG and department is monitored robustly through the TIPOG meetings with exceptions escalated to TIPAC accordingly.

This assurance process has gone from strength to strength throughout the year of 2025- 2026 with more areas and services coming on board with the UHL IP BAF, to gain a better understanding of the Health and Social Care Act and code of practice but to also assess their level of Infection Prevention compliance and how they can address those areas of concerns.

The UHL Infection Prevention Board Assurance Framework (IP BAF) supports effective financial management by enabling targeted prioritisation of infection prevention measures at ward and departmental level.

Across 2025/26, the IP BAF programme has transitioned from a high-performing but self-reported assurance model to a more robust, evidence-based system.

Quarters 1 and 2 demonstrated strong compliance scores, but validation activities in Q3 identified significant discrepancies between reported and actual practice, particularly in governance processes such as incident discussion and risk escalation.

This led to a redesign of the BAF and implementation of binary scoring in Q4, providing a more transparent and accountable view of performance. While this resulted in a reduction in reported compliance scores, it reflects improved standards rather than deterioration.

Key challenges have remained consistent throughout the year, including mask fit testing, workforce training, PPE availability, and governance oversight. Action plans are in place, with over half currently in progress, though delivery remains variable across CMGs.

Overall, the programme has made significant progress in strengthening assurance, but further work is required to embed consistent governance, improve compliance in key operational areas, and complete the transition to a fully integrated digital reporting model.

The exceptions from the continued development of the BAF are indicated for each quarter below:

Q1: “High performance but immature assurance”

- Strong headline scores (~90–96%)
- Known areas for focus (mask fit, training)
- Heavy reliance on self-reported compliance
- Overall there was a risk of false assurance

Q2: “Plateau and system alignment”

- Performance stabilises, not improving significantly
- Persistent operational challenges (training, PPE, cleaning)

- Progression begins toward:
 - CQC domain alignment
 - Better structure
 - Early triangulation
- Overall theme was continued building of the framework but not yet slow progression of improving outcomes

Q3: “Insight and challenge”

- Key discovery:
 - During a collaborative validation check a discrepancy between reported vs verified performance identified
- Governance weaknesses identified:
 - Staff engagement in meetings
 - Incident learning processes
- Action taken:
 - Redesign of BAF to strengthen ward level responses
 - Removal of subjective reporting
 - Move to evidence-based assessment
- Overall progression of moving from assurance to reassurance

Q4: “Reset to higher standard”

- Scores drop due to:
 - Binary scoring (stricter process)
 - Better visibility of non-compliance
- Real issues now clearly quantified:
 - PPE systems (fit testing + availability)
 - Workforce training compliance
 - Governance (IPOG, ICCQIP)
 - Documentation and outbreak management
- Action delivery:
 - Majority underway but not yet embedded
- Overall trend is transparency and accountability increase, but system maturity still developing

Overarching Key Themes across the Year

1. Persistent Operational challenges

- Mask fit testing (consistent RED throughout)
- Training compliance (Hand Hygiene, ANTT, IP link staff)
- Cleaning processes & visibility

2. Governance Weakness

- Poor meeting attendance / discussion culture

- Limited oversight of key data (ICCQIP)
- Criterion 3 gap throughout year

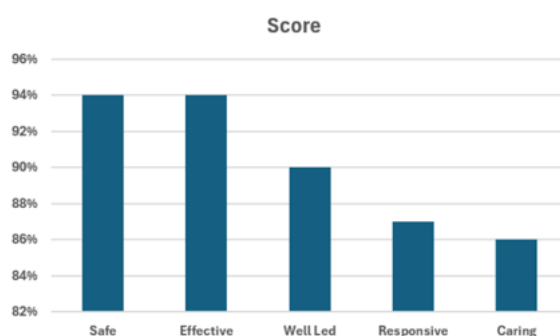
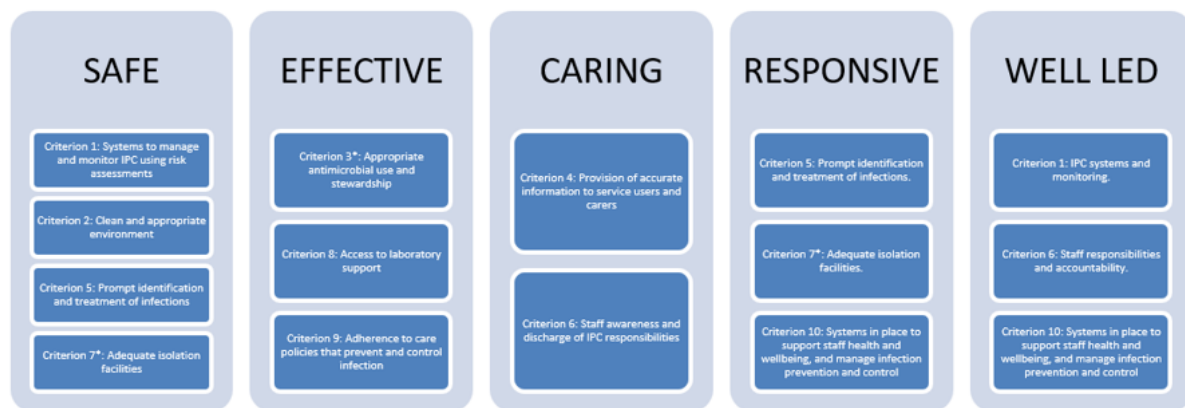
3. Assurance Transformation

- Q1–Q2: self-reported compliance
- Q3: validation exposes gaps
- Q4: robust, binary, evidence-based model

4. Data & Digital Immaturity

- Dashboard instability (Qlik → Power BI transition)
- Data ambiguity (HELM mask fit data)
- Missing datasets

UHL IPC BAF – Overall CQC Compliance based on the 10 Criteria (Q2 – Q4 2025-2026)



- Strong overall compliance across Safe, Effective and Well-led domains
- Greater variability observed in Caring and Responsive domains with Q4 decline reflecting strengthened assessment standards rather than reduced performance

Chart 1: UHL IPC BAF: Overall CQC Compliance Q2 – Q4 2025/26

4. Leicester, Leicestershire and Rutland (LLR) Monitoring Framework

NHS Commissioning of services for Leicester, Leicestershire and Rutland is undertaken through an Integrated Care System (ICS). All parts of the NHS, as well as other partners such as local authorities and the voluntary and community sector, take on greater responsibility for working together and collectively managing resources. They aim to improve the health of residents by preventing illness, tackling inequalities and unwarranted variation in care, whilst delivering seamless services.

During 2025/26 Infection Prevention advice to the ICS was provided by 2 IPNs employed directly by them.

The ICS IPN participates in the post infection reviews for all patients who develop MRSA bacteraemia in line with the NHS England guidelines for the management of cases. They also receive an overview of the cases of UHL CDI.

As part of the Government review of Healthcare provision, NHSE and the local ICBs have been the subject of reorganising and restructuring during the year. At the time of writing this continues and we await a final outcome of consultation processes. Clarification of how Infection Prevention will be managed is yet to be announced.

5. Care Quality Commission Regulation

The Code of Practice: *The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance* applies to NHS bodies and providers of independent healthcare and adult social care in England, including primary dental care, independent sector ambulance providers and primary medical care providers. The code of practice document was updated on 13 December 2022 to reflect changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the role of Infection Prevention and Control (IPC) to include cleanliness and optimising antimicrobial use and reducing antimicrobial resistance. The new document takes account of changes to the IP landscape and nomenclature that have occurred since the COVID-19 pandemic.

The law states that the Code must be taken into account by the CQC when it makes decisions about registration against the Infection Prevention requirements. The regulations also say that providers must have regard to the Code when deciding how they will comply with registration requirements. So, by following the Code, registered providers will be able to show that they meet the requirement set out in the regulations.

The Code of Practice sets out criteria for the prevention and control of infections associated with healthcare delivery.

Compliance Criterion	What the registered provider will need to demonstrate
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	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems 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	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Table 1: Compliance Criterion

A copy of the CQC compliance reports for Leicester Hospitals is available on the UHL public and CQC websites.

There were no national reports published for UHL in 2025-2026

The CQC did inspect Surgery at GH in June 2025, the Emergency Department on the 17th and 18th of February 2026 and Medicine at the GH was completed on the 2nd and 3rd of March 2026

The final inspection in 2025-26 was Medicine as part of winter pressures on 30th and 31st March 2026.

There was nothing IP related in the feedback letter from the March inspection; however, the ageing estate and infrastructure challenges were noted.

Observations of missed hand hygiene opportunities, management of cleaning fluid and the use of face masks were noted. Actions to address the noted observations were and are being taken. Reports are through the UHL IP governance route previously described.

6. Infection Prevention Within UHL

University Hospitals of Leicester has a specialised IPT that work across the three main acute hospital city sites and also across the UHL Alliance (Community hospitals and Day Surgical units) 7 Renal Dialysis sites across the East of England and the St Marys Birthing Centre at Melton Mowbray.

6.1 Infection Prevention Team – Whole Time Equivalent Posts

Head and Deputy Director of Infection Prevention (HDDIP).	X1
Deputy Lead Infection Prevention Nurse (DLIPN)	x1
Senior IPNs	x 2
Specialist IPNs	x 7.2
IPN	x 3
CDI Specialist Nurse	x1
Surveillance Assistants MSS and Maternity employ their own SSI colleagues x1 per CMG managed within the IPT	X2
Senior Information Analyst	X1
Data Information Analyst	x1
MFT Manager and Personal Assistant to HDDIP	x1
Mask Fit Testers	x6

Table 2: Infection Prevention Team (IPT)

IPN qualifications range from Diploma, BSc to MA level and the team work to a set of core competencies developed by the Infection Prevention Society.

One of the Senior IPN works specifically within the Estates and Facilities Team providing specialist IP advice and support. We feel this is particularly important as the Trust embarks on an ambitious reconfiguration and transformation programme.

National standards and guidance with regard to Water Management, Ventilation system provision, aspects of Decontamination, New Build and refurbishment of existing estate both exist and continue to be developed. Providing guidance and working with both estate colleagues and external contractors ensures UHL works towards meeting these important standards designed to provide a safe environment for our patients.

The IPT coordinates and contributes to the Trust's priority to minimise the risk of infection to our patients, visitors and staff by:

- Providing advice on all aspects of Infection Prevention ensuring that UHL meets the requirements of The Health and Social Care Act (2008) Code of Practice for the Prevention of Healthcare Associated Infections
- Closely monitoring Microbiology results via the electronic reporting system to enable robust and timely patient management

- Managing outbreaks of infection
- Managing incidents that relate to Infection Prevention
- Improving Infection Prevention capability and capacity within Clinical Management Groups
- Developing and facilitating programmes of education and training
- Undertaking audit and developing a targeted surveillance programme where possible
- Formulating policies and procedures
- Interpreting and implementing national guidance at a local level
- Involvement with new building and equipment projects

There is an ever-diminishing pool of Infection Prevention Specialists nationally, for which all organisations now compete.

Infection Prevention is a specialism which requires study as described previously at not only a basic level, but has the opportunity to follow an extensive educational career pathway in both the practical application of this subject and also research. Specialist Infection Prevention courses are best taken after staff have 'hands on experience' of at least a year. Education and training of our new Infection Prevention staff is ongoing as we develop our own Specialist Nurses. Within UHL we then encourage our colleagues to undertake further academic training courses offered by various Universities in England.

One of the Senior Infection Prevention Matrons has developed a program of learning for the differing staff groups amongst the team as well as ensuring collective learning for the team as a whole. The IP matron has regular one-to-one reviews with our new starters to support their integration into the team and into UHL as well as their health and wellbeing. Feedback from our new team members is extremely positive with regard to the support, education and training they have been given by the whole team and we are delighted to welcome them and look forward to supporting their career development

6.2 Education and Quality Improvement

The IPT provide an extensive multi-modal programme of Infection Prevention education across the Trust to support compliance with mandatory training and national guidance

In addition to this IP education is provided in response to data collection, identified need or upon request.

During 2025/26 167 'face to face' taught training sessions were delivered. The IPT have also continued to deliver Infection Prevention training to International Nurses, Trainee Nursing Associates, Medical Students, Health Care Assistants, Midwifery Care Assistants, Theatre Support, Doctors local inductions, Surgical Practice Course, High Consequence Infectious Disease Buddy Training, Hand hygiene and PPE audit training. These taught sessions vary in length of delivery from 20 minutes to 4 hours.

These training sessions have been well received and the feedback is positive for content, style and pace of delivery. Activity has been driven by:

- Sustained outbreak management requirements
- Increasing complexity from organisms of significance (TB, measles, MRSA)
- Ongoing challenges relating to patient flow and limited isolation capacity

These pressures continue to present a significant organisational risk, impacting patient placement, flow, and the ability to consistently maintain optimal infection prevention standards.

Of the 167 taught training sessions the IPT has also delivered approximately 99 CMG based

training sessions in the clinical areas which all vary in length of time and topic but included: Viral Hemorrhagic Fever training, link staff training and decontamination training.

During 2025/26 the Infection Prevention intranet pages were also completely reviewed to ensure information and guidance on the new Trust 'Connect' pages is correct and up to date

These figures do not include locally delivered education by individual IP nurses who have provided a blend of in situ and virtual Infection Prevention training within their own CMG.

Quality Improvement is an integral part of the Infection Prevention role and whilst there is always competing priorities for the whole team, a collaborative effort by the IPT has again determined that, the lack of face to face Infection Prevention education contributes to the incorrect use of PPE and a reduction in compliance with hand hygiene.

The Compliance with the 5 moments of hand hygiene is always variable for many different reasons within any healthcare facility and UHL is no different, during 2025/26 this simple practice continues to present as a challenge from an educational perspective.

6.3 Infection Prevention Link Staff (IPLS)

There is a robust IPLS training programme that can be successfully delivered by the IPT, which normally includes quarterly training days as well as individual support and workplace advice. The content of the programme is continually reviewed to ensure that it is reflective of current practice and supports the Link Staff to remain current and up to date.

The team have also explored other multi-model methods of delivery to maintain engagement and enthusiasm of the Link Staff, acknowledging other competing training programmes and service delivery challenges.

Link Staff Role

- Infection prevention practice
- Local education and awareness
- Communication between wards and IP team

Variation observed in:

- Engagement and participation
- Training delivery and uptake
- Clarity of role and expectations

Key Risks

- Inconsistent utilisation of link staff impacting local leadership of IP standards
- Limited assurance around training compliance and competency

- Variation reducing effectiveness of programme as a sustainable improvement model

Strategic Aim; established across CMGs to support: development of a consistent, high-impact Link Staff model that strengthens ward-level leadership, improves compliance, and supports sustained infection prevention improvement across UHL. Further revision of this role will take place during 2026/27

7. Mask Fit Testing Service

The Mask Fit Testing (MFT) Service manages and oversees the FFP3 (Filtering Face Piece) mask fit testing programme across University Hospitals of Leicester NHS Trust (UHL). The service sits within the Infection Prevention Team and ensures compliance with Health and Safety Executive (HSE) requirements for respiratory protective equipment.

The MFT Service continues to provide a responsive and accessible service for staff, supporting compliance with mandatory mask fit testing requirements. Sessions are available to book via HELM and are delivered across all three UHL hospital sites. The team works proactively to identify gaps in compliance and ensure appropriate actions are taken to support staff requiring testing.

A roving mask fit testing service is available to Clinical Management Groups (CMGs) and is provided following a risk-based assessment. This service can be booked directly with the MFT Team.

The service was implemented in 2023, with FFP3 fit tests valid for a period of two years. During 2025/26, a significant number of staff reached their renewal date, requiring retesting. This has contributed to a temporary reduction in overall compliance levels while the service works through increased demand.

Key developments during the reporting period include:

- Successful implementation of the Mask Fit Testing Service: How to Use a Powered Air Purifying Respirator (PAPR) e-learning package via HELM.
- Return of one member of staff following a period of long-term sickness absence.
- Departure of one member of staff from the service, with recruitment underway.

7.1 Challenges

The service continues to face a number of challenges, including:

- Staff attending fit testing sessions with facial hair, or attending clean-shaven despite routinely maintaining facial hair, resulting in invalid test outcomes.
- Non-attendance at booked sessions.
- Ongoing difficulties with the release of staff from clinical areas to attend appointments.
- A temporary dip in Trust-wide compliance rates due to the first cohort of staff reaching the two-year retesting requirement following implementation of the service.
- Limited engagement from medical staff in the mask fit testing programme.
- Variable engagement from CMGs with the roving service.

7.2 Compliance

Trust-wide respiratory protection compliance for 2025/26, including both FFP3 masks and Powered Air Purifying Respirators (PAPR), is 72.16%.

This comprises:

- **FFP3 Compliance:** 62.68%
- **PAPR Compliance:** 9.48%

The table below outlines the total number of Mask Fit Testing sessions provided during 2025/26, including the number of staff successfully fitted with an FFP3 mask and those requiring a Powered Air Purifying Respirator (PAPR).

Quarter	Number of Session Offered on HELM	Attendance				FFP3 & Respirator Hood Compliance		
		Total number of sessions booked on HELM	Number of People Attended session	Number of People Did Not Attend session	Sessions Available but Not Booked	No of Staff passed on FFP3	Staff require hood due to non compliant with FFP3	Staff require Hood due to facial hair
Q1	1794	1051	778	273	743	719	59	63
Q2	1550	1382	1063	319	168	905	158	0
Q3	1962	1912	1521	391	50	1306	215	0
Q4	1547	1467	1220	247	80	827	393	0
Total	6853	5812	4582	1230	1041	3757	825	63

Table 3: FFP3 attendance tracking for 2025/26

7.3 Next steps for 2026/27

The following priorities have been identified for 2026/27 to support service resilience, improve compliance, and meet increasing demand for mask fit testing renewals:

- Recruitment is underway to replace one substantive post within the Mask Fit Testing Team, with the successful candidate expected to be in post during Quarter 1 (Q1) 2026/27.
- The additional workforce capacity will support increased service delivery and help address demand associated with on-going fit test renewals.
- Continued engagement with Clinical Management Groups (CMGs) will focus on improving staff attendance at booked appointments, facilitating the release of staff for testing, and improving the quality and accuracy of compliance data.
- Delivery of a targeted programme of fit test renewals for staff reaching the two-year expiry date, with priority given to patient-facing staff and those working in higher risk clinical environments.
- Further promotion and development of the roving mask fit testing service to improve accessibility and increase uptake across clinical areas.
- Continued monitoring of Trust-wide compliance rates, with targeted interventions implemented where compliance falls below expected standards.
- On-going promotion of the PAPR e-learning package and respiratory protective equipment guidance to support staff knowledge and compliance with respiratory protection requirements.

These actions are intended to support recovery and improvement of Trust-wide mask fit testing compliance during 2026/27 while maintaining a responsive and sustainable service.

8. Healthcare Associated Infection Surveillance

The Infection Prevention Team (IPT) undertakes continuous surveillance of alert organisms and alert conditions using Nervecentre (our next generation electronic system partners). This system has been developed within UHL in collaboration with our IT System partners and we continue to

work with them to further develop the programme.

8.1 Alert Organisms¹

- MRSA
- Clostridium difficile
- Group A Streptococcus
- Salmonella spp.
- Campylobacter spp.
- Mycobacterium tuberculosis
- Glycopeptide resistant Enterococci
- Multi-resistant Gram-negative bacilli e.g. extended spectrum beta-lactamase (ESBL) producers
- Carbapenemase-producing Enterobacterales (CPE)
- Influenza
- Neisseria meningitidis
- Aspergillus
- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV

8.2 Alert Conditions

- Scabies
- Chickenpox and shingles
- Measles
- Two or more possibly related cases of acute infection e.g. gastroenteritis
- Surgical site infections

Since 2001 reporting of the numbers of significant organisms related to Healthcare Associated Infection (HCAI) has been mandatory. These are reported to the United Kingdom Health Security Agency (UKHSA) data capture system.

This began with Staphylococcus Bloodstream infection including resistant strains (MRSA), later extending to Clostridium difficile and subsequently E coli, Klebsiella, Pseudomonas Bloodstream infections.

¹ Alert organisms are organisms identified as important due to the potential seriousness of the infection they cause, antibiotic resistance or other public health concerns. This is a nationally recognised term; these organisms may be part of mandatory or voluntary surveillance systems and are used as indicators of general Infection Prevention and Control performance.

During the past year we have continued to implement an analysis process for MRSA, MSSA bacteraemia, *C.difficile* deaths and increased incidence of cases of *C.difficile*. This ensures we comply with the required external reporting arrangements, and provides us with a way of learning lessons from each case, enabling us to develop and change practice, all with the aim of leading to further reduction in infections and bacteraemias within UHL. MRSA bacteraemia and *C.difficile* are two of the performance management indicators used by the DH.

8.3 Mandatory Surveillance of Surgical Site Infections (SSI)

UHL participates in the UKHSA mandatory hip and knee surveillance programme. Orthopaedic data is submitted by hospitals following the mandatory surveillance requirement introduced by the Department of Health in April 2004 [1]. This requires all NHS Trusts undertaking orthopaedic surgical procedures to carry out a minimum of 3 months' surveillance in each financial year in at least one of four categories (hip prosthesis, knee prosthesis, repair of neck of femur or reduction of long bone fracture). The Orthopaedic Team manage and submit data with support and advice from IPT, when required.

In 2025/26, UHL submitted data for knee replacement surgery for quarters 1, 2, 3 and for hip surgery during quarter 4.

8.4 Surgical Site Infection Surveillance Programme

During 2025/26, the Surgical Site Infection (SSI) surveillance and reduction programme at University Hospitals of Leicester (UHL) has undergone a significant transformation. Following a period of workforce disruption in 2023, which necessitated a focus on team rebuilding, the programme has re-established itself and evolved into a comprehensive, Trust-wide patient safety and quality improvement initiative.

Initially focused on a small number of high-risk surgical specialties, the programme has now expanded to include a broad range of services including cardiac, spinal, HPB, breast, bowel, obstetric (C-section), and gynaecological surgery. This expansion reflects a deliberate shift from isolated specialty reviews toward a unified and systematic approach to SSI prevention and reduction across the organisation.

By the end of the reporting period, the programme is characterised by a robust surveillance structure, increasing clinical engagement, and a growing emphasis on translating data into actionable learning and improvement.

8.5 Activity and Programme Delivery

Over the course of the year, SSI surveillance has matured into a data-driven, clinically validated process. Up to the 9th June 2025, a total of 2,635 surgical cases were reviewed, with structured 30-day follow-up embedded into routine practice. This includes not only hospital-based activity but also integration with community data through the LLR Care Record system, allowing for more comprehensive detection of infections occurring post-discharge.

This approach has enhanced the reliability and completeness of surveillance, particularly in identifying infections that manifest outside the acute setting.

In parallel, the programme has significantly increased its audit and observational capability. The use of the One Together Toolkit enabled 65 structured theatre observations, providing direct insight into perioperative behaviours and adherence to infection prevention standards.

Targeted audits were also undertaken in key areas, including:

- Skin preparation practices
- Pre-operative warming
- Hair removal techniques

- Dressing application and management

These audits have been critical in moving beyond outcome measurement to understanding variation in process and practice.

Engagement and education is central to deliver key messages and recommendations for practice. In collaboration with our external providers the Infection Prevention Team have commenced training sessions, CPD activity, and “time to train” events, with over 30 staff receiving formal education on SSI prevention.

At a system level, governance has strengthened through the establishment of quarterly reporting which includes activity against the Trust Level Surgical Site Infection Prevention Reduction plan to the Trust Infection Prevention Operational Group and Trust Infection Prevention Assurance Committee meetings. The Infection Prevention Team has delivered presentations and updates on the work activity in a number of CMG-led Multidisciplinary/Consultant/Infection Prevention meetings, supporting ownership of data and improvement at a clinical level.

8.6 Outcomes and Impact

Across the surveillance cohort up to the 9th June 2025, 205 SSIs were identified, representing roughly 7–8% of monitored cases.

While this provides a clear baseline, it also highlights significant variation between specialties. Certain areas, including cardiac, spinal, bowel, and breast surgery, report infection rates that exceed national benchmarks, indicating opportunities for targeted improvement.

Conversely, some specialties such as HPB and Orthopaedics demonstrate comparatively lower or improving rates, suggesting pockets of good practice that can be leveraged more widely.

8.7 Detection across the patient pathway

One of the most important findings this year is that a substantial proportion of SSIs are identified after discharge, via:

- GP consultations
- Community nursing
- Outpatient/Triage or Wound Clinics follow-up

This reflects the success of enhanced surveillance but also reinforces the need for strong community–secondary care integration, particularly in early recognition and management of infection.

8.8 Patient and system impact

The consequences of SSI remain significant. Patients who develop infections experience:

- Prolonged recovery
- Increased complications
- Greater psychological and physical burden

From a system perspective, the impact is substantial. SSIs are associated with:

- Markedly increased length of stay (often doubled or more)
- Increased demand for diagnostic imaging and interventions
- Additional outpatient and community activity

This translates into a high cost burden, with cumulative financial impact estimated at over £500k annually when considering bed days, investigations, and service utilisation.

8.9 Risk factors and patient profile

Analysis confirms that SSIs are strongly associated with known risk factors, including:

- Poor baseline health (ASA ≥ 3)
- Emergency surgery
- Diabetes
- Obesity

These findings reinforce that patient optimisation prior to surgery remains a critical area for improvement and requires alignment with wider system partners beyond the acute Trust.

8.10 Compliance with infection prevention standards

While several aspects of practice demonstrate consistently high compliance (e.g. skin preparation, draping), the programme has identified key areas where reliability remains poor:

- Antibiotic prophylaxis timing remains suboptimal
- Temperature monitoring and maintenance is inconsistent
- MRSA screening and management, particularly in emergency pathways, is significantly below expected standards

These gaps are particularly important as they represent high-impact, evidence-based interventions known to reduce SSI risk.

8.11 Theatre practice and behavioural insights

Observational audits have provided critical insight into how care is actually delivered in theatre settings.

Key recurring themes include:

- Variation in adherence to infection prevention standards
- Inconsistent use of PPE and theatre discipline
- Environmental factors such as unnecessary traffic and door usage
- Poor standardisation of skin preparation technique

These findings highlight that SSI risk is not solely a clinical issue, but also influenced by culture, behaviour, and system reliability.

Improvement activity and early impact

Targeted interventions within the HPB specialty demonstrated that improvement is achievable.

During quarter 3 2025/2026 a product evaluation was undertaken to review the efficacy of a waterproof dressing. The outcome identified;

- A 1% reduction in SSI rates
- Improvements in:
 - Antibiotic timing
 - Normothermia
 - Glycaemic control

However, these gains were offset by:

- Declining MRSA compliance

- Persistent gaps in temperature monitoring
- Increase in organ/space infections
- Significant differences in wound dressing management practices

This demonstrates that partial improvement is insufficient, sustainable reduction requires consistency across all elements of care.

8.12 Key Themes from the Year

Across all quarters, several consistent themes have emerged:

- **Variation in practice**

There is significant unwarranted variation in how infection prevention standards are applied across teams and sites.

- **Reliability gap**

Key safety processes (antibiotics, normothermia, MRSA) are not reliably delivered.

- **Behaviour and culture**

Theatre discipline, staff behaviour, and ownership play a significant role in infection risk.

- **Post-operative care**

Wound management and dressing practices represent an under-recognised contributor to SSI risk.

- **System rather than individual factors**

Findings support a shift toward system-level improvement, rather than focusing solely on individual performance.

8.13 Priorities and Next Steps for 2026/27

The focus for the coming year will be to move from data collection to reliable system delivery of safe and improved practices.

Improve reliability of high-impact interventions

- Antibiotic prophylaxis (timing and selection)
- Normothermia monitoring and maintenance
- MRSA screening and decolonisation pathway

- **Standardise practice**

Develop and implement Trust-wide SSI policy that introduces prevention across the patient pathway from pre-operative, intra operative and post-operative care bundles of practice.

- **Strengthen workforce capability**

- Consider competency-based training
- Deliver structured education programmes across theatres and wards

- **Enhance perioperative optimisation**

Consider through the UHL Prevention Strategy how pathways can be develop to optimise:

- Diabetes control
- BMI and nutrition
- Smoking cessation

- **Expand digital capability**

- Scale digital wound surveillance (ISLA)
- Enhance real-time dashboards and data visibility

- **Strengthen governance**

- Enhance the Trust-wide SSI oversight
- Increase CMG accountability for outcomes

- **Continue innovation and evaluation**

- Evaluate adjunct technologies (dressings, sutures, temperature monitoring and hair removal)
- Focus on practice improvement alongside product use

- **Conclusion**

The SSI programme at UHL has made substantial progress during 2025/26, successfully establishing a strong surveillance foundation, expanding its scope, and identifying key drivers of infection.

However, the findings clearly demonstrate that further reduction in SSI rates will depend on improving the reliability and consistency of care delivery, alongside strengthening system-wide ownership and capability.

The next phase of the programme will focus on embedding these improvements into routine practice, with the aim of delivering measurable improvements in patient outcomes, experience, and system efficiency.

8.14 MRSA and MSSA Prevention and Reduction Strategies

Staphylococcus aureus is a bacterium commonly found colonising humans. Although most people carry this organism harmlessly, it is capable of causing a wide range of infections from minor boils to serious wound infections and from food poisoning to toxic shock syndrome. In hospitals it can cause surgical wound infections and bloodstream infections. When *Staphylococcus aureus* is found in the bloodstream it is referred to as a *Staphylococcus aureus* bacteraemia.

The UHL threshold for MRSA bloodstream infections for 2025/26 was 0 avoidable cases. The Trust recorded 8 Hospital onset Healthcare Associated (HOHA), 0 Community onset, Healthcare Associated (COHA) case for 2025/26.

The implementation of measures, in recent years, designed to further reduce the number of cases of MRSA bacteraemia within UHL has continued during 2025/26. However given the number of cases that have been identified a review of the MRSA policy and all actions pertaining to the prevention of infection with this organism will be reviewed during 2025/26

There is absolutely no room for complacency with regard to our drive to prevent acquisition of infection within the hospitals. As these numbers become smaller, there will inevitably be a threshold beyond which a continued reduction will not be possible. Sustained management of systems and processes instigated in previous years will be crucial to our continued success and our teams work hard to maintain these low infection numbers.

8.15 Clostridioides difficile Prevention and Reduction Strategies

Colleagues should note the nomenclature change of *Clostridium difficile* to *Clostridioides difficile*, based on adoption by the Clinical Laboratories and Standard Institute, (CLSI) and the following publication: Lawson P. A., Citron D. M., Tyrrell K. L., Finegold S. M. (2016).

Reclassification of *Clostridium difficile* as *Clostridioides difficile* (Hall and O'Toole 1935) Prevot 1938. Anaerobe 40, 95–99.

We will therefore see this change in subsequent papers and readers should note you may/will see this terminology used going forward

Those dated before January 1, 2019 will retain the former organism name; those dated on or after January 1, 2019 may/will incorporate the new name

Please note that the abbreviations CDI, CDIFF, and *C. difficile* remain appropriate abbreviations after the change and will not be modified within UHL.

Mandatory surveillance for CDI in over 65 year olds has been undertaken since 2004. Since 2007 episodes of CDI in patients between the ages of 2 and 65 have also been reported.

For mandatory reporting purposes, all diarrhoeal stools submitted to the microbiology laboratory are examined for the presence of *C.difficile* toxin (it is the toxin released by the *C.difficile* bacterium that causes damage to the bowel).

Episodes are reported via the UKHSA mandatory enhanced surveillance system.

From 2019/20 cases reported to the healthcare associated infection data capture system will be assigned as follows:

- **Hospital onset healthcare associated (HOHA):** cases that are detected in the hospital two or more days after admission
- **Community onset healthcare associated (COHA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks
- **Community onset indeterminate association (COIA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous 12 weeks but not the most recent four weeks
- **Community onset community associated (COCA):** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the Trust reporting the case in the previous 12 weeks.

Acute provider objectives are set using these two categories:

- Hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

Reference: Clostridium difficile infection objectives for NHS organisations in 2023/24 and guidance on the intention to review financial sanctions and sampling rates from 2023/24.

CDIFF NHSE Threshold 25/26	13	14	14	14	14	14	14	14	14	14	14	14	167
* Actual Infections (HOHA) 25/26	4	6	10	10	10	7	7	5	6	7	9	11	92
* Actual Infections (COHA) 25/26	4	3	7	4	7	6	6	4	4	3	0	7	55
* Actual Infections Total (HOHA & COHA) 25/26	8	9	17	14	17	13	13	9	10	10	9	18	147

Table 4: The monthly number of Clostridium difficile reportable infections 2025-2026

Isolating each patient with *C.difficile* diarrhoea continues to be a priority, to prevent cross contamination. Patients with *C.difficile* are cared for in single rooms. Where patients were not isolated it was for over-riding clinical reasons in the vast majority of cases (e.g. on an Intensive Care Unit).

It is recognised that it is important to continually monitor and reinforce the messages to staff with regard to HCAI's. The Department of Health published guidance entitled '*Clostridium difficile* - How to deal with the problem' in early 2009. UHL has implemented this guidance across the Trust and a dedicated CD Liaison Nurse works across the three sites and continues to work with the Infection Prevention Team to ensure appropriate management of these patients and to provide specialist support to nursing and medical colleagues.

A weekly Multi-Disciplinary Team meeting takes place where there is a review of patients within UHL that are both positive and symptomatic with this infection.

Any Periods of Increased Incidence (two or more cases of *Clostridium difficile* infection within 28 days in the same clinical setting) automatically triggers a multi-disciplinary review of the patients and their environment to ensure that there are rigorous processes in place and policy is being adhered to, to prevent cross infection with this organism.

The Infection Prevention Team and the Antimicrobial Pharmacist continued to support Trust colleagues with:

- Increasing hand hygiene awareness among staff, patients and visitors: using soap and water where *C.difficile* is present (as alcohol rub used on its own is ineffective against *C.difficile*). The roll out of the World Health Organisation '5 moments of Hand Hygiene'
- Continuing to improve antimicrobial prescribing, notably more regular recording of the reasons for antibiotics and stopping them as soon as the patient has completed the required course
- Reinforce the required use of hydrogen peroxide decontamination to clean isolation rooms and other clinical areas post identified infection.
- Weekly data reporting to identify problem areas
- Attendance at the period of Increased Incidence meetings with colleagues supporting these areas with audit, inspections and helping staff to problems solve where necessary.
- Reinforcement of the use of the Care Pathway for *Clostridium difficile*
- Reinforcement of the message of the vital importance of a clean, clutter free environment for patients.
- Reinforcement of the use of source Isolation precautions when caring for patients with infections

A review of all actions in relation to CDI will be undertaken in 25/26 to ensure everything that should be being undertaken within UHL to prevent this infection is being carried out.

Clostridium difficile infections rate 2025/26

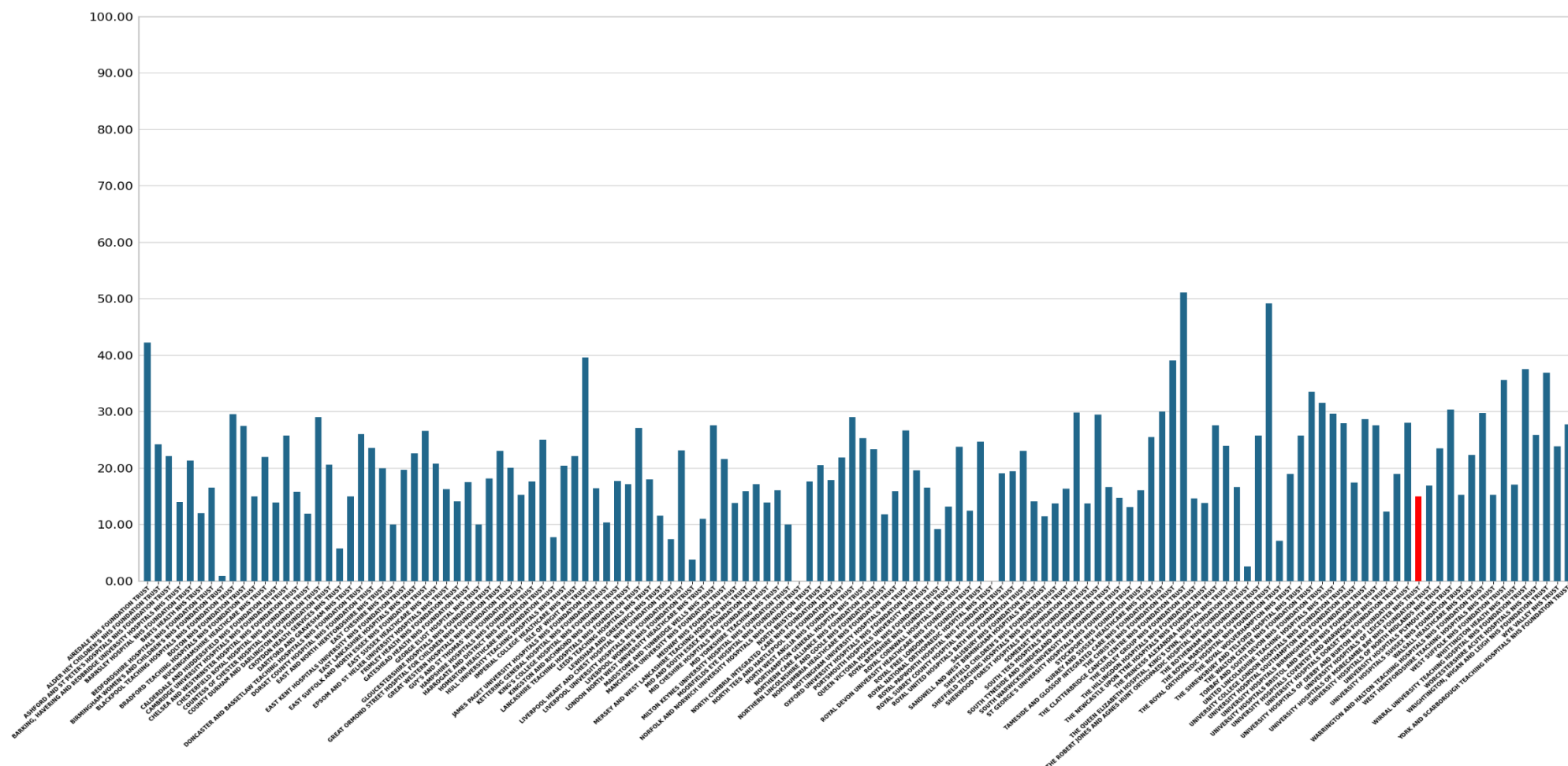


Table 5: Hospital onset- hospital associated Clostridium difficile infections rate by financial year per occupied overnight beds (per 100,000). (source UKHSA). UHL highlighted in red.

8.16 Gram-Negative Bloodstream Infections

There was a National ambition to reduce healthcare associated Gram-negative Bloodstream infections (healthcare associated GNBSIs) by 50% by March 2024. There was no forthcoming guidance as to how this might be achieved or supported by organisations or any funding forthcoming for this. As previously indicated we continued to collect the alert organism data and report this to the Data Capture System (DCS) at United Kingdom Health Security Agency (UKHSA).

These can be serious infections and often result in admission to critical care and in some cases mortality. We know GNBSI cases can occur in hospitals however, half of all community onset cases have had some healthcare interventions either from acute, primary or community care. Therefore, we can only achieve the reductions by working together across the whole health and social care sector.

As part of the UHL Patient Safety Incident Response Framework (PSIRF) the IPT have been reviewing our approach to Infection Prevention reviews and incidents. This has enabled us to begin the review of all identified bloodstream infections in collaboration with ward based colleagues, with the aim of understanding acquisition of these organisms and what actions may be taken to prevent this in our healthcare setting

The Head and Deputy Director of Infection Prevention and Lead Infection Prevention Dr have written an Infection Management Strategy for the ICB and across LLR.

This seeks to support understanding of the development of these infections and actions required to mitigate, reduce, and prevent these where possible

Work has now commenced to implement this strategy

8.17 E coli (*Escherichia coli*) Bacteraemia

E coli is the leading cause of Gram-Negative Bloodstream Infections (GNBSIs) and in accordance with the Department of Health (DH) Guidelines the IPCT undertakes mandatory reporting of identified cases.

E-Coli NHSE Threshold 25/26	14	14	14	14	14	14	14	14	15	15	15	15	172
* Actual Infections (HOHA) 25/26	5	5	12	13	17	5	2	4	5	7	8	14	97
* Actual Infections (COHA) 25/26	3	12	8	9	8	15	7	9	13	6	7	8	105
* Actual Infections Total (HOHA & COHA) 25/26	8	17	20	22	25	20	9	13	18	13	15	22	202

Table 6: The monthly number of E.Coli reportable infections 2025-2026.

8.18 Pseudomonas BSI

Pseudomonas NHSE Threshold 25/26	2	3	3	3	3	3	3	3	3	3	3	3	35
* Actual Infections (HOHA) 25/26	1	1	2	0	2	0	0	1	2	2	3	3	17
* Actual Infections (COHA) 25/26	2	2	0	1	2	3	1	2	2	1	0	1	17
* Actual Infections Total (HOHA & COHA) 25/26	3	3	2	1	4	3	1	3	4	3	3	4	34

Table 7: The monthly number of Pseudomonas reportable infections 2025-2026.

8.19 Klebsiella sp. BSI

Klebsiella NHSE Threshold 25/26	6	7	7	7	7	7	6	6	7	7	7	7	81
* Actual Infections (HOHA) 25/26	3	7	3	2	3	4	7	6	3	4	2	8	52
* Actual Infections (COHA) 25/26	3	4	1	3	1	4	2	4	2	4	4	1	33
* Actual Infections Total (HOHA & COHA) 25/26	6	11	4	5	4	8	9	10	5	8	6	9	85

Table 8: The monthly number of Klebsiella reportable infections 2025-2026.

Escherichia coli bacteraemia rate 2025/26

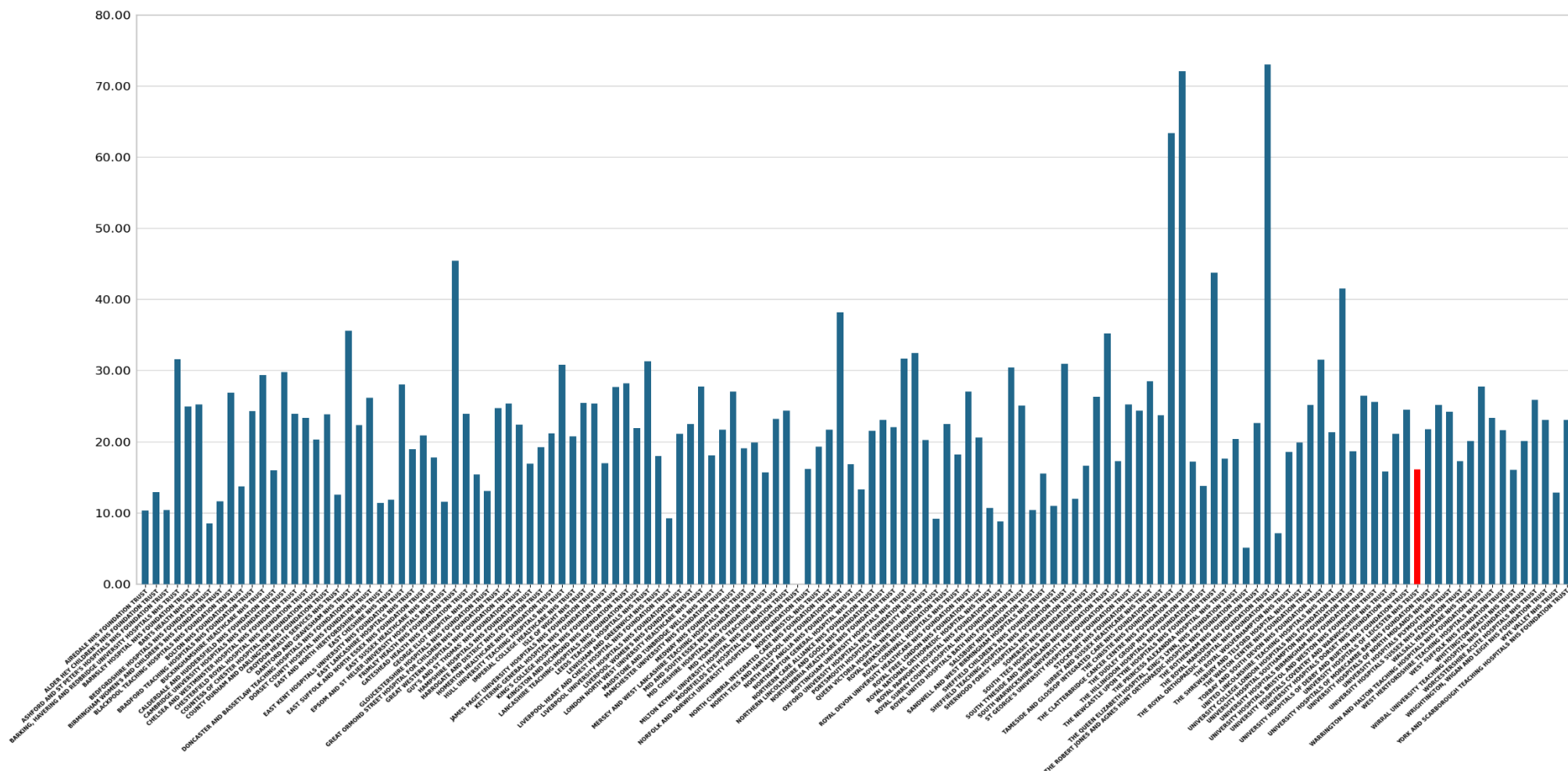


Table 9: Hospital onset - hospital acquired apportioned E coli infections by financial year (2025/26) per occupied overnight beds (per 100,000). (source UKHSA). UHL highlighted in red.

8.20 Carbapenem Resistant Enterobacterales/Extensive Drug Resistance

Guidance by the United Kingdom Health Security Agency (UKHSA) for the above predominantly concentrates on prevention: isolation of high-risk individuals with screening being of particular importance. The UHL focus is to identify, isolate, investigate, inform and initiate (the i5's of Infection Prevention) management of these patients and all patients that fit specific screening criteria are screened for these organisms. This enables identification and management of these patients to prevent further transmission.

Carbapenem Resistant Enterobacterales (CRE) typically colonises well patients but can present a threat when they become a systemic infection. They are clinically important because they are resistant to most antibiotics and so exceedingly difficult to treat. In addition, while some antibiotics remain effective treatment, these are very expensive drugs, costing up to £450 per patient per day. CRE are a global phenomenon for which there is a policy and management protocol well established within UHL.

Historically Environmental sampling has provided evidence of the potential for environmental transmission within wards. The importance of a robust cleaning standard and a reactive maintenance process are extremely important in the prevention of spread of these organisms.

9. Outbreaks of Infection and Incident Reports

UHL continued to instigate formal outbreak management processes where outbreaks of Infections were identified throughout 2025-26.

In accordance with UKHSA Guidance an outbreak or incident may be defined as:

- an incident in which 2 or more people experiencing a similar illness are linked in time or place
- a greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred
- a single case for certain rare or high-consequence diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio
- a suspected, anticipated or actual event involving microbial contamination of food or water

These events are recognised through surveillance, reporting or routine IP activities and are by definition unpredictable. UHL have the support of the informatics team whereby there is an automated process by which patient infection numbers are reviewed and analysed on a daily basis according to the nationally defined criteria and apportionment of the onset model.

Infection Prevention incidents may not always relate directly to infection but be the consequence, where further investigation is required. If this has an operational impact then this in itself can be enough to trigger an incident response requiring a multi-disciplinary focus.

Every year the Infection Prevention Team recognises and responds to many incidents and potential outbreaks. Some are of significance. However others turn out to be

chance clusters not caused by cross infection. The Infection Prevention Team has to be alerted to all potential outbreaks.

For each outbreak an 'outbreak/incident control team' is required key colleagues from the relevant CMG, laboratory, estates and facilities, as well as colleagues from NHSE, UKHSA and the ICB are considered to attend a meeting to which all minutes and action logs were kept. Senior Leadership at all outbreak/incident meetings was provided by the Chief Nurse/Deputy Chief Nurse or the Lead Infection Prevention Nurse

Outbreaks and Incidents may be recorded in several different ways. UHL use a DATIX incident reporting mechanism and a monthly report is produced from this system to enable the Infection Prevention Nurses to feedback to the Clinical Management Teams at their Infection Prevention Group meetings.

Where an outbreak or incident is considered to be particularly significant because of its size or the lessons learnt, this is managed as a Patient Safety Incident Investigation (PSII) and reported in line with the NHS Patient Safety Incident Response Framework (PSIRF)

During an outbreak/incident, the IPT provides a higher than usual level of support, information and training to the area affected, and works in close partnership with the clinical staff to try to prevent further spread of the infection, and to minimise service disruption.

After an outbreak/incident, the IPT support the development of a report which is presented to the CMG IP groups and TIPAC.

At a Leicester, Leicestershire and Rutland (LLR) level all organisations providing NHS services meet on a weekly basis to discuss the local infection status.

During 2025-26 52 outbreaks of Respiratory Virus/CRO/Norovirus, have been managed by the IPT in line with the UKHSA Communicable disease outbreak management: operational guidance.

During 2025/26 an IP Matron Led initiative was introduced

Service Improvement: Introduction of Initial Outbreak Assessment Model:

- Capture outbreaks not previously recorded
- Improve visibility of infection prevention workload
- Identify early lapses in care

Matron-Led Improvement

- Successfully introduced a standardised triage approach to outbreak management
- Enabled earlier identification of risks requiring escalation
- Improved consistency of outbreak documentation

Process Overview

All outbreaks now assessed using standard form

Escalation pathway determines need for full outbreak management

Lapses in care identified and fed into learning systems

Impact

Improved visibility of IP workload

Strengthened governance and assurance processes

Reduced risk of unrecorded outbreak activity

Initial Assessment Compliance and Opportunities

- 33 of 52 outbreaks had documented initial assessments
- Variation highlights need for improved compliance and process embedding

Matron Response

- Identified gaps in documentation and reporting consistency
- Initiating actions to:
 - Improve process compliance
 - Reinforce accountability across teams
 - Ensure a true reflection of IP workload

Key Issue

Primary theme remains limited isolation facilities impacting practice

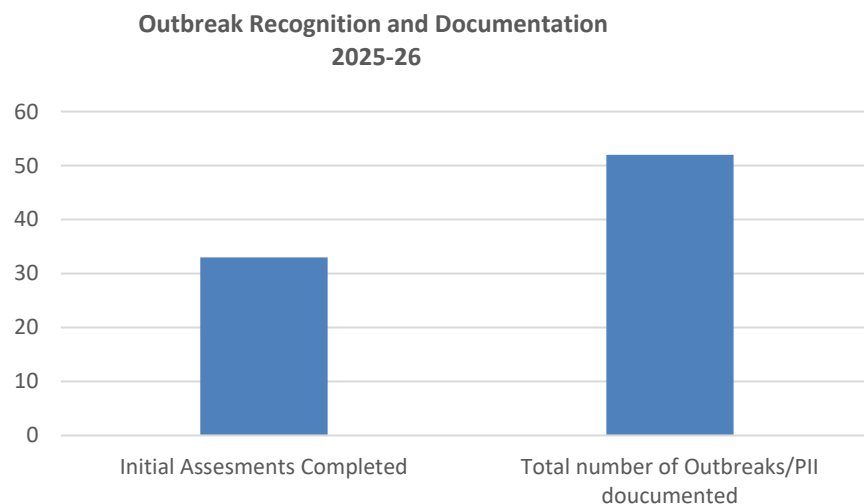


Chart 2: Outbreak recognition and documentation

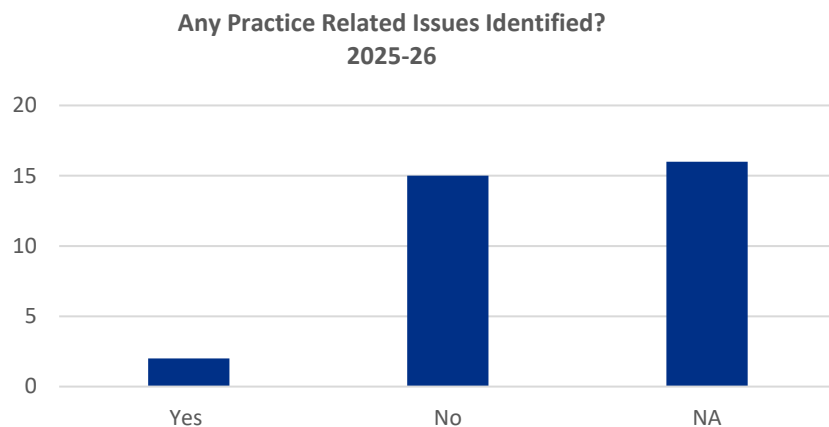


Chart 3: Outbreak: Practice related issues

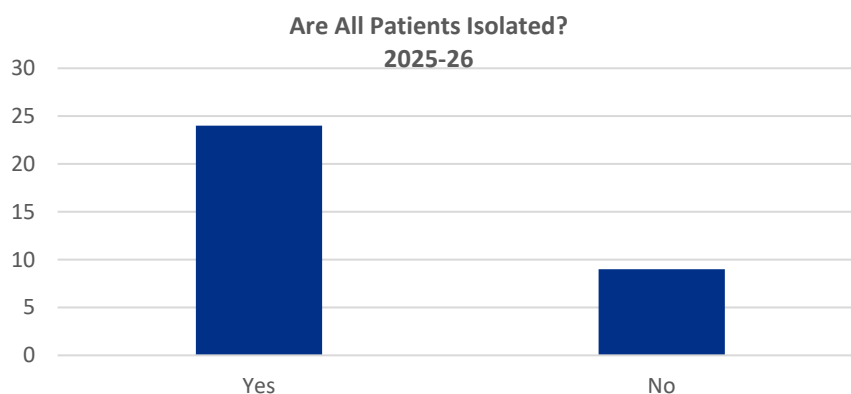


Chart 4: Outbreak: Patient Isolation

Initial Assessment Compliance and Opportunities

- 33 of 52 outbreaks had documented initial assessments
- Variation highlights need for improved compliance and process embedding

Matron Response

- Identified gaps in documentation and reporting consistency
- Initiating actions to:
 - Improve process compliance
 - Reinforce accountability across teams
 - Ensure a true reflection of IP workload

Key Issue

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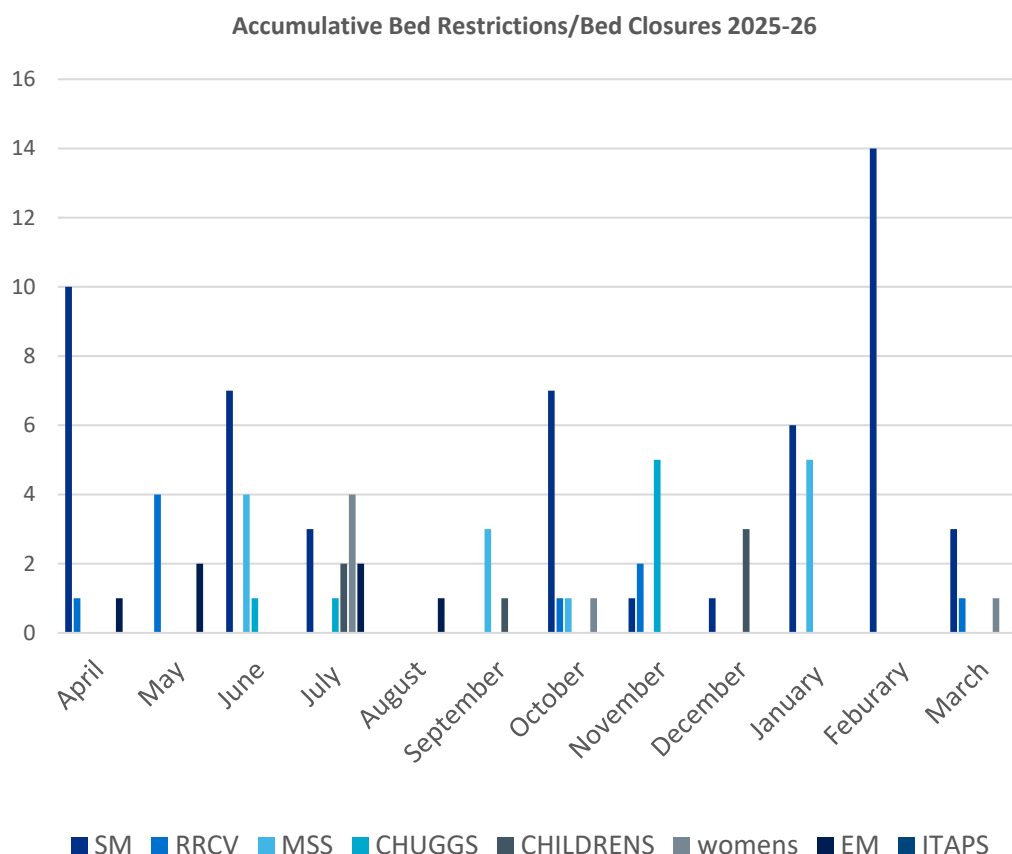


Chart 5: Outbreak: Accumulative bed restrictions and bed closures

During 2025–26, outbreaks resulted in 99 temporary bed closures/restrictions which is equivalent to 1 in every 20 beds unavailable due to infection prevention measures (based on 2000 inpatient beds). This creates:

- Reduced flow through emergency pathways
- Increased pressure on elective recovery
- Ongoing challenges in maintaining safe cohorting environments

IP Matron Leadership & Influence

- Escalated the impact of bed closures to Tactical command and operational leadership
- Advised on risk-balanced decisions between patient safety and flow
- Supported wards in minimising closures where clinically appropriate
- Contributed to long-term discussions regarding estate and isolation capacity

Key Message

Sustained bed losses due to infection risk require system-wide solutions, not ward-level mitigation alone.

10. Norovirus

The winter season of 2025/26 saw a reduction in the number of cases and outbreaks of Norovirus.

Management of Norovirus within UHL follows the national guidance within the 'Guidelines for the Management of Norovirus outbreaks in Acute and Community Health and Social Care settings'

The CMG IP groups, relevant UHL CMG Boards, NHS Midlands and East are all part of the reporting mechanism to ensure due process with regard to the management of Governance and Assurance.

The LLR ICS are copied into a daily increased incidence/outbreak e-mail that is widely circulated across UHL and also sent to external partners to ensure that they are fully sighted to what is happening within the Trust. This e-mail identifies restricted areas and details actions required.

11. Influenza and Respiratory Syncytial Virus (RSV)

During 2025/26 winter season there were cases of Influenza and RSV patients that required timely placement and management. The Specialist Infection Prevention Nurses supported those areas most affected by cases by assisting with the review and management of the side room capacity to support patient placement.

Respiratory testing arrangements are in place to ensure that patients across the main sites were supported with rapid testing to facilitate timely identification and isolation of infectious cases. The ability to isolate into side room continues to present as a challenge due to lack of side room facilities over the winter period.

12. Measles

Measles is a viral infection that causes a variety of symptoms, with more serious complications that occur, especially in children less than 5 years of age, adults older than 20 years, pregnant women, and people with compromised immune systems.

Measles is highly contagious. It is spread by contaminated airborne aerosols and droplets, infecting up to 90% of non-immune individuals in the same room. Contaminated air remains infectious for up to two hours after the patient has left the room.

Before 1970, virtually all UK children contracted measles. An effective vaccine was introduced into the UK immunisation schedule in 1968 and this was responsible for the gradual decline in cases and temporary elimination of measles in 2016 and 2017. However, at least 95% of the population needs to be immune in order to prevent transmission and incomplete coverage, exacerbated by the measles vaccine autism scare in the late 1990s, means that measles re-emerged as a National public health concern during the year 2023/24 and this has continued during 2024/25

The IPT continue to support the implementation of a pathway across UHL that focusses on early identification, isolation, contact tracing to be able to offer timely post exposure prophylaxis and or treatment, communication including public facing messages, staff personal protective equipment and vaccine availability.

UHL Measles 25-26	Q1	Q2	Q3	Q4	Totals
Confirmed	30	2	1	2	35
Suspected	34	9	10	1	54
Contact	111	13	4	15	143

Table 9: shows the number of confirmed, suspected and contact Measles cases 2025/26

13 Tuberculosis

Across LLR there has been a significant increase in confirmed cases of Tuberculosis

Number of TB Cases requiring Infection Prevention Review and Action

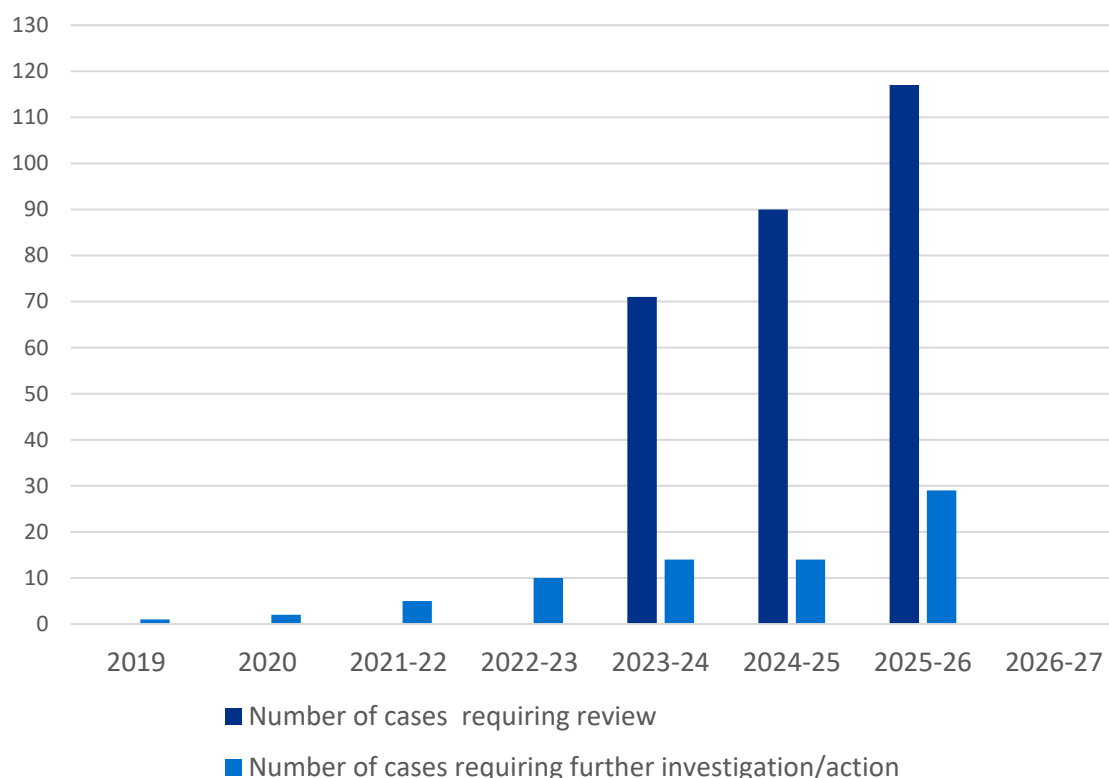


Table 11: Shows the number of Pulmonary TB cases Review by IPT per Year

Leicester City has the highest incidence of TB in the UK. The work involved with contact tracing patients and staff is growing rapidly

There are a growing number of patients whose first diagnosis is as an in-patient and this has created a growing amount of work for the IPT and TB service. This has reached a point where the impact of this and the resources required have to be reviewed. This is exacerbated by the inadequate number of single rooms within UHL, the proximity of

beds within bays and the lack of adequate ward mechanical ventilation.

This first annual audit of TB-related IPC activity at UHL identifies a clear increase in demand, complexity and operational burden. Cases requiring further investigation/action increased from 71 in 2023/24 to 117 in 2025/26, alongside sustained month-to-month variation. The audit found recurring delays in recognising and acting on possible TB, particularly across admission and transfer points such as ED, CDU, inpatient wards and boarding arrangements. In many reviewed cases, TB had been documented as a possible diagnosis, or symptoms and risk factors were present, but prompt TB-specific action was not consistently taken.

Overall, the report answers the audit questions by showing that TB-related IPC activity has increased, cases are not always managed consistently against expected standards, delays cluster around key pathway points, and the consequences include additional IPC, OH, TB nursing, screening and governance activity. The recommended response is targeted quality improvement in the highest-risk areas, using COM-B-informed staff engagement, practical education, visible “Think TB” prompts, clearer escalation and transfer processes, improved monitoring and stronger data-sharing arrangements.

UHL has a robust process for the management of TB cases once identified and there will be a focus on the response to this infection and the systems and processes in place for the further management of this during 2026/27

14 Risk Register and Datix Themes 2025/26

The Datix system is web-based software used primarily in healthcare settings, particularly within the NHS, for incident reporting and risk management. It allows staff to report incidents, near misses, and other safety concerns, which are then logged and analysed to identify potential risks and improve patient safety.

There is one Infection Prevention risk cited on the Trust Risk Register and this relates to bed spacing and is kept under regular review

The slide below indicates the themes that have been identified from a review of the UHL Datix submissions. System pressures relating to patient flow, capacity and lack of isolation facilities remain the key issues identified

Top IP datix by Year

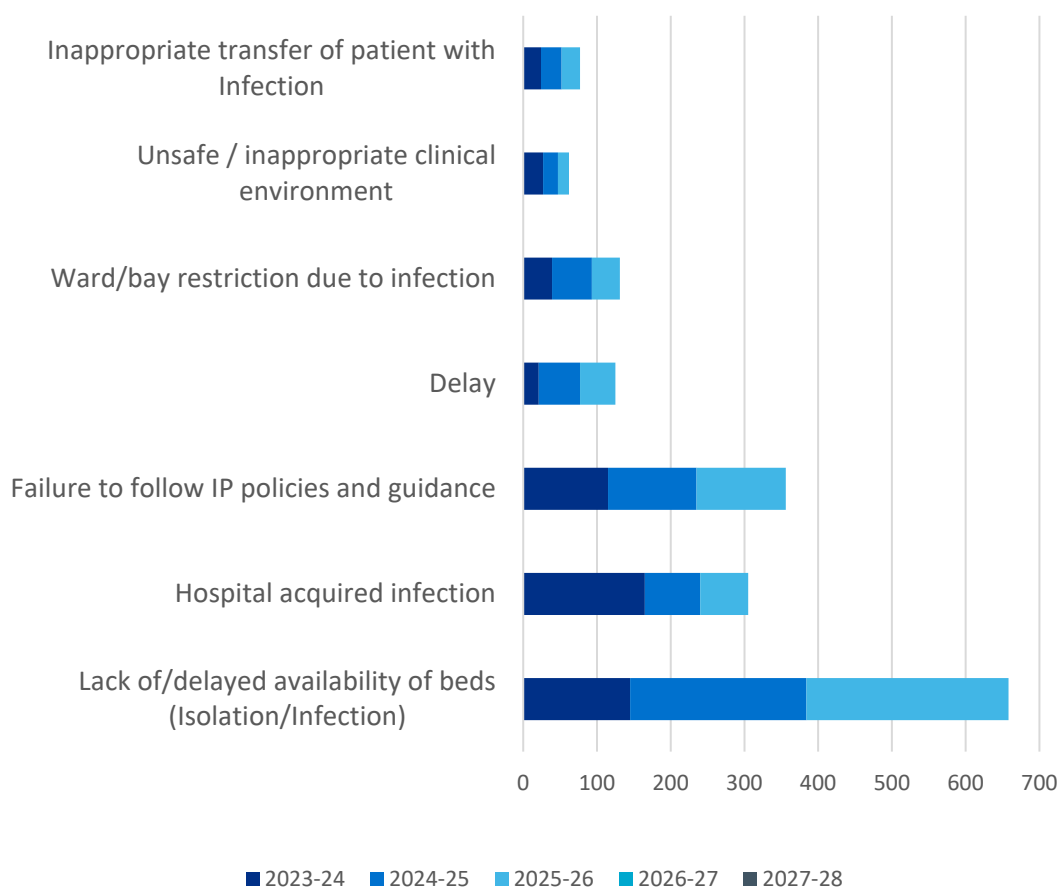


Table 12: Shows the number and themes of IP Datix by year

Actions required from the review will be incorporated into the IP programme for 2026/27 to seek improvement in some of these issues.

15 Infection Prevention in the Built Environment

Infection Prevention provides on-going support and advice around all aspects of Infection Prevention in the built environment with a full time senior Infection Prevention nurse embedded within estates and facilities.

There are a number of elements of Infection Prevention in the built environment. These are:

- New builds and refurbishments
- Water
- Ventilation
- Cleaning
- Food safety
- Linen
- Waste and sustainability

16 New builds and refurbishments

There have been a number of new builds and refurbishments during the past year that Infection Prevention have been involved with, providing advice and support to ensure compliance with regulations such as health building notes and health technical memoranda as well as support during commissioning and opening processes.

These schemes include the new endoscopy unit Leicester General Hospital, Leicester Royal Infirmary Maternity theatre refurbishment, Windsor extension, Urgent Treatment Centre planning as well as some other minor refurbishments

17 Food Safety

The Infection Prevention team work closely with the estates and facilities team to ensure that food that is consumed by patients is safe.

Formal inspection is carried out by the Local authority environmental health officer but on going inspection of ward and department kitchens occurs throughout the year to ensure standards are being met.

18 Contracts supported by Infection Prevention

In addition to day to day support there are a number of contracts that require Infection Prevention input. These include standardising curtains as well as the bed and equipment contract that provides and maintains beds, trolleys, couches and patient bed side chairs across the Trust. The team have also provided support to procurement teams on review of products to achieve cost improvements across the Trust

Duty of care visits have been conducted to suppliers this year and Infection Prevention have been part of the team carrying out these visits. These ensure that suppliers maintain hygiene standards and store products that are to be consumed in the Trust appropriately.

19 Waste and sustainability

Work continues to support wards and departments with compliance with the waste policy with sustainability, continuing to provide behavioural change support through education and audit.

Contracts for the different waste streams have been reviewed and are in place to ensure that there is appropriate segregation of the different types of waste. This ensures that the different streams are taken for appropriate reprocessing.

Linen

Linen such as sheets, pillowcases, blankets and nightwear are provided via a third party provider Elis who both provide the linen and launder the products. Infection Prevention are members of the linen contract review team and have participated in site visits to the laundry to carry out a duty of care visit in order to ensure standards are being met.

20 Bed and Mattress Contract

Senior Infection Prevention input has been provided to the Bed and Mattress third party contract review process.

IP input is extremely important in this process as the surfaces and integrity of the beds, chairs and equipment on which we place patients is known to be a source of acquisition of micro-organisms and subsequent infection for patients. Ensuring these surfaces are intact and fit for purpose is a vital element of Infection Prevention.

21 Policies Procedures and Guidelines

UHL recognises the importance for staff to have ready access to a full range of Infection Prevention and Control policies, procedures and guidelines. Through 2025/26 we have continued to revise Trust policies and guidelines and have included Infection Prevention Pathways to help staff quickly and safely manage patients with infections.

22 Infection Prevention Clinical Audit Programme

The IP audit programme is compliant with The Health and Social Care Act: Code of Practice on the prevention and control of infections and related guidance (2022). The audits include evidence based interventions to reduce the risk of infection to provide education and feedback to clinical staff.

The audit programme is part of the Annual Infection Prevention programme the results are presented to the CMG through the Infection Prevention Dashboard. The dashboard and Action Trackers are reviewed as part of the CMG IP groups and discussed at the TIPOG with escalations and exceptions raised at the TIPAC accordingly.

23 Sharps Audit

An audit of sharps containers is conducted by Mauser TA/Daniels Healthcare, the provider of our sharps bins. Formal audits were undertaken during the year 2025/26 and the results were shared with the CMGs, for any remedial actions.

24 Decontamination

Endoscopy decontamination is conducted within a purpose-built facility, this opened in January 2023. These are operated to HTM 01-06 standards and all staff are trained to this level. Clinical areas are responsible for the bedside clean (in line with the Endoscopy policy) and the dedicated specially trained decontamination staff are responsible for the pre-clean (manual wash) and using the automated decontamination machines. This facility also low-temperature sterilises all cystoscopes and associated accessories. All staff have specific Decontamination training in Isopharm and are assessed for competence every six months.

The team are currently working through a Quality Management system to be able to apply for ISO 13485 accreditation

Sterilisation of surgical instruments is conducted by our third-party partners (Steris) and a yearly external audit ensures they are compliant to HTM 01-01. As part of the yearly audit the decontamination lead attends the unit and conducts an inspection to give the Trust assurance of the external findings. There is also a monthly Joint Business Meeting

where new equipment is discussed and any non-compliances are discussed and documented. This has both clinical and managerial representation for UHL.

The cleaning and decontamination audit described within the Infection Prevention UHL policy (B5/2006) includes guidelines for all staff in the correct cleaning of medical devices. The decontamination lead has now included the questions from the yearly audit within the Board assurance framework, this is reported by the Heads of Nursing at the Trust Infection Prevention Assurance board works closely with the procurement team to ensure compliance to the cleaning products listed within the policy for the use on medical equipment.

The Trust decontamination lead sits on the Medical Equipment Executive and can give assurance that any medical equipment brought into the Trust has been through an assurance process to ensure the equipment can be decontaminated appropriately and all staff are aware of the correct decontamination requirement. When the item is subsequently delivered to the organisation the staff are aware of the requirements.

25 Estates and Facilities Management

25.1 Water

Water provided for drinking and bathing naturally contains small amounts of bacteria, including *Legionella* species and *Pseudomonas aeruginosa* that can cause infection if allowed to build up into large numbers. This is a particular concern in hospitals because of the vulnerability of patients. Consequently, the Trust has established strategic and operational arrangements aimed at minimising infection risk from water. Both strategic and operational water groups remained in place and meet regularly

The Water Safety Group (WSG) chaired by the Consultant Microbiologist with representation from Estate, Capital, IP, CMG and the Authorising Engineer convenes quarterly and reports to TIPAC

The Operational Water Task Group convene monthly with multidisciplinary members including contractors to progress issues as they arise and report upwards to the WSG.

The incumbent Authorising Engineer (AE) Water contract has been extended to support the Trust in monitoring compliance in line with HTM, including the biannual compliance audits. Additional services have also been procured via the AE service to provide a more proactive and technical approach in supporting the Trust's water management agenda.

The Water Management UHL Policy (A1/2004) reviewed April 2024 with a planned review due 2027. The supporting Water Safety Plans due for review in Q2 2025.

The revised and extended water sampling programme across the Trust has run to schedule with all adverse results reviewed and actioned on a fortnightly basis by Estates, Compliance and Infection Prevention colleagues. The output from the enhanced management and flushing protocols has been a significant reduction in overall positive samples for *Legionella* and *Pseudomonas* across the Trust and a declining trend in Long Term Positives

Flushing compliance reports continue to be issued to the Heads and Deputy Heads of Nursing to review and onward cascade to CMG level on a monthly basis.

Duty of Care (DOC) audits continue for community locations, including Renal Services, and provide assurance around water management provided by third parties.

25.2 Ventilation

Ventilation provided for all areas inclusive of both Critical and Non-critical classed systems, if not maintained and operated correctly can cause to an infection, risk to health and a poor facility / environment conditions too hot or cold patients, staff and visitors. This is a particular concern in hospitals because of the vulnerability of patients. Consequently, the Trust has established Ventilation Safety Group to oversee the strategic and operational arrangements aimed at minimising issues relating to the ventilation systems.

The Ventilation Safety Group (VSG) chair is currently vacant due to personal changes but is envisaged to be chaired by the Consultant Microbiologist with representation from Estates operational and Authorised Persons Ventilation (APv), Capital Project Team, Infection Prevention Team, Clinical Representation and the Authorising Engineer Ventilation (AEv). The meeting will convene quarterly and reports to TIPAC.

A separate Operational Ventilation Task Group will be formulated to convene monthly with multidisciplinary members including contractors to progress issues as they arise and report upwards to the VSG.

Risks related to ventilation safety and compliance are currently reviewed at the VSG as to reviewing, updating, and identify risks that require to be placed on the Trust risk register.

The incumbent AEv contract is in-place to support the Trust in monitoring compliance in line with HTM 03-01 Parts A & B, including the annual compliance audits. Additional services have been commissioned via the AE service to provide a more proactive and technical approach in supporting the Trust's ventilation management protocols.

The Ventilation Systems Management Policy (B1/2022) was reviewed March 2025 with a planned review due 2030.

The current schedule of "Critical Ventilation Verification Reports" continues and is reviewed by the newly appointed Specialist Engineering Team at the Glenfield Hospital (GH) and Leicester General Hospital (LGH) with the remedial actions implemented or escalated for additional support. Due to the success of the new workforce structure the same is to be implemented at the Leicester Royal Infirmary (LRI) to support the current APv set up.

The successful appointment of the Specialist Engineering Team has enhanced the level of governance and assurance, with the format being adopted at the LRI as the relevant personnel are recruited.

The output from the enhanced management and additional resources has given rise to a more proactive approach with elevated operational awareness to ventilation systems that issues are highlighted sooner with the relevant remedials implemented quicker.

The "Critical Ventilation Verification Reports" continue to be reviewed by the Specialist Engineering Teams and APs with onward communication to the users and senior management to maintain operational use of the ventilation systems.

As UHL has invested in many capital projects with various elements of ventilation within them but highlighting the large projects as being at the LGH a new Maternity Theatre, Lithotripter procedure room, Leicester Diabetes Centre, Endoscopy Centre and three new Air Handling units for the whole of maternity building, LRI major refurbishment

being two Maternity theatres, Ward 39 and the Maxillofacial department and at the GH the Mortuary also the development and design of the Windsor Extension, Decant Theatres and an Aseptic Suite.

Duty of Care (DOC) audits continue for community locations, including Renal Services, Endoscopy, Clinical Outpatients and diagnostic Imaging, as provide assurance around ventilation management provided by third parties where UHL provide patient services.

25.3 Soft Services

As part of the transition of Estates and Facilities (E&F), Soft Services has commenced a comprehensive programme of improvement to support compliance with the National Standards of Healthcare Cleanliness and to strengthen assurance regarding environmental standards across the Trust. This work has focused on enhancing the quality of the patient environment and maintaining confidence amongst patients, staff and visitors.

A detailed review of cleaning services and audit processes identified opportunities to improve consistency, transparency and the accuracy of performance reporting. As part of this review, it was recognised that some historical reporting arrangements did not always reflect the standards observed within clinical areas, highlighting the need for a more robust approach to assurance and governance.

In response, revised reporting arrangements were introduced, including the implementation of fortnightly performance reviews and increased engagement with clinical teams. These changes have supported greater visibility of cleaning performance and reinforced the shared responsibility for maintaining high standards of environmental cleanliness. Encouraging improvements have been seen across a number of high-risk clinical areas, including the Emergency Department and Theatres, although further improvement remains a priority.

The service has also increased operational oversight, with greater emphasis placed on direct observation and monitoring of cleaning activities to improve consistency and effectiveness. Alongside this, staff are undertaking British Institute of Cleaning Science (BICSc) training to further develop their knowledge and understanding of the contribution that environmental cleanliness makes to infection prevention and patient safety.

To strengthen assurance processes, a dedicated team of independent auditors has been established. The auditors have no direct operational responsibility for the areas they assess, providing an objective and impartial approach to auditing and reporting. This has enhanced confidence in the accuracy and reliability of audit outcomes.

These improvements have contributed to positive outcomes within the Patient-Led Assessments of the Care Environment (PLACE), with ward cleanliness scores consistently reported at between 85% and 90%. Work continues across the service to build upon this progress and further improve environmental standards during 2026.

26 Vascular Access Committee

A Vascular Access Committee within UHL previously reported to the Trust Infection Prevention Committee on any matters that related to Infection Prevention within medical devices that enter the sterile circulatory system. The Chair of this Committee is now one of the Deputy Medical Directors and reporting is through the Quality and Safety Committee via the Medical Director.

A Transformation Team led review of the service was undertaken during 2025/26. The terms of reference and clinical representation for this group, workplans and priorities to ensure it is fit for purpose formed part of this review and the final report findings will be published during Quarter 2 2026/27

27 Occupational Health

Our Occupational Health (OH) Service remains an integral component of the Trust's infection prevention and staff safety arrangements and continues to provide specialist advice and support to staff, managers and organisational leaders on matters relating to health, work and the prevention of infectious disease transmission. The service works closely with Infection Prevention colleagues, People Services, Clinical Management Groups and corporate teams to ensure that staff health risks are appropriately managed, thereby contributing to the delivery of safe patient care. The Occupational Health Service continues to play a key role in supporting compliance with the Health and Social Care Act 2008 Code of Practice requirement that organisations maintain effective systems to manage the occupational health needs of staff in relation to Infection Prevention and Control.

The service continues to deliver a comprehensive programme of immunisation, screening and health surveillance for staff across the organisation. This includes routine occupational vaccinations such as Hepatitis B, seasonal influenza and other vaccines indicated by role-specific risk assessments. The service also undertakes pre-placement screening and clearance processes for new starters, ensuring that staff are appropriately protected against occupationally relevant infectious diseases before commencing work where required. Existing staff continue to be recalled for review, vaccination or testing where indicated by national guidance, occupational risk assessment or local outbreak management arrangements.

During 2025/26 the Occupational Health Service continued to provide significant support to the Trust's response to communicable disease risks affecting healthcare workers. Particular areas of activity this year again included measles and tuberculosis. The service worked closely with Infection Prevention colleagues to support risk assessment of staff, immunity assessment where indicated, management of occupational exposures and implementation of appropriate work restrictions or exclusion periods where required. Occupational Health also contributed specialist advice to organisational discussions concerning the protection of vulnerable staff and the management of infectious exposures within clinical environments. The continued close working relationship between Occupational Health and Infection Prevention has supported a coordinated and proportionate response to these issues across the Trust.

The service continues to provide the Trust's specialist clinical assessment and follow-up arrangements for occupational sharps injuries and blood or body fluid exposures. Robust systems remain in place to ensure prompt assessment of exposed workers, timely access to specialist treatment where indicated and appropriate follow-up testing and support. Occupational Health continues to contribute to organisational monitoring and reporting processes relating to these incidents and works collaboratively with other stakeholders to identify opportunities for prevention, learning and quality improvement. Occupational Health also maintains arrangements for the management of healthcare workers undertaking exposure-prone procedures, including the monitoring and assessment requirements associated with blood-borne virus guidance. This work remains an important component of the wider Trust infection prevention framework.

Occupational Health has continued to support wider Trust initiatives relating to workforce wellbeing and resilience. Work has progressed to strengthen the alignment of Occupational Health, psychological support services and staff wellbeing initiatives, with

the aim of improving accessibility, enhancing staff experience and ensuring that support is delivered through an increasingly coordinated and user-focused model. The service has also continued to provide specialist advice in relation to reasonable adjustments, fitness for work and rehabilitation following illness, supporting both employee wellbeing and sustainable attendance at work.

The Occupational Health Service successfully maintained its accreditation as a Safe Effective Quality Occupational Health Service (SEQOHS), providing independent external assurance regarding the quality and governance of the service. The department also continues to contribute to the development of the future occupational health workforce through its recognised role in postgraduate training in Occupational Medicine and multidisciplinary professional development. The service remains committed to supporting evidence-based practice, clinical governance and continuous quality improvement across all aspects of its work.

Looking ahead, Occupational Health will continue to strengthen its contribution to infection prevention, staff safety and workforce wellbeing. Priority areas for the coming year include continued support for vaccination and immunity programmes, further development of collaborative working with Infection Prevention and Wellbeing services, enhancement of digital systems and processes, ongoing support for the management of communicable disease risks within the workforce and maintenance of high-quality training and accreditation standards. Through these activities the service will continue to support both staff health and the delivery of safe, effective care for patients across University Hospitals of Leicester.

28 Next Steps

We will continue to strengthen the work streams identified during 2025/26 for 2026/27

We continue to refine the Infection Prevention reviews using the Patient Safety Incident Response Framework [NHS England » Patient Safety Incident Response Framework](#) and system based approaches.

In turn this above approach will help to further develop our HCAI and Gram Negative Bacteraemia Reduction Programme key elements of this being

- Reduce bacteraemia through membership of the Vascular Access Committee. A Transformation Whole Service Review was requested for 2025/26
- Continued support of The Harm Free Care agenda whereby it supports HCAIs including the reduction of urinary tract infections
- Support the development of any Trust initiatives of which one objective is reduction of fungal infections

Actions from the Datix system review will be taken forward during 2026/27

To further develop the digital platform that underpins the UHL IP BAF.

Fully embed the revised evidence-based Infection Prevention Board Assurance Framework across all CMGs and services, including completion of the digital reporting solution and continued validation of reported compliance to reduce the risk of false assurance.

Continue to support Trust and Group estate redevelopment programmes to increase isolation capacity, improve ward bed spacing, optimise ventilation systems and reduce the infection prevention risks associated with aging infrastructure.

Implement the recommendations from the Tuberculosis IPC Audit, including staff

education, "Think TB" awareness campaigns, strengthened admission and transfer processes, enhanced contact tracing pathways and improved monitoring arrangements.

Improve Trust-wide compliance with respiratory protective equipment requirements through enhanced mask fit testing uptake, targeted medical engagement, strengthened compliance monitoring and full implementation of the PAPR management programme.

Develop a sustainable Infection Prevention workforce strategy, including succession planning, specialist nurse development, competency frameworks and advanced practice opportunities.

Develop and implement a Trust-wide Surgical Site Infection Prevention Strategy incorporating standardised peri-operative care bundles, digital wound surveillance, and specialty benchmarking and strengthened clinical accountability for outcomes.

Continue the development of collaborative infection prevention governance and assurance arrangements across the wider UHL/UHN Group and Leicester, Leicestershire and Rutland system to support consistency of standards, surveillance and improvement activity.

To explore multi-model methods of delivery to support the ongoing training and education programme to ensure we remain current and up to date with learning requirements

Support the establishment of the Antimicrobial Stewardship Programme delivered through a revised committee within the Trust

To further develop IP data collection systems within Nervecentre

To support the enhancement of the ICCQIP quality improvement programme across our Critical Care Units

To strengthen our response to any query or identified High Consequence Infectious Disease across UHL

To work collaboratively with our Sepsis Team to understand harm outcomes and how this relates to Infection Prevention

To fully support the embedding of the National Standards for Cleanliness Programme across the Trust to include the review of the disinfectant cleaner used Trust-wide.

Horizon scan for future improvements or innovations across the Infection Prevention pathway

Have an ambition to host a Midlands Region Surgical Site Infection Surveillance Conference and Infection Prevention Conference 2026/27