



Royal United Hospitals Bath
NHS Foundation Trust

Royal United Hospitals Bath Infection Prevention and Control Annual Report 2025/26

Toni Lynch, Chief Nursing Officer and Director of Infection Prevention and Control

Lisa Hocking, Deputy Director of Infection Prevention and Control, Associate Chief Nurse

Julia Vasant and Sabrina Fudge, Consultant Microbiologist and Infection Control Doctors

Author: Lisa Hocking, Deputy Director of Infection, Prevention and Control - Document Approved by: Jason Lugg Chief Nursing Officer Chief Nursing Officer & Director of Infection, Prevention and Control Agenda Item:	Date: 28/05/2026 Version: 1 Page 1 of 68
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Contents

Infection Prevention and Control Annual Report 2025-2026	4
Purpose	4
Infection Prevention and Control Board Assurance Framework (BAF)	4
Background	4
Criterion 1	6
Infection Prevention and Control Staffing	6
Organisms subject to mandatory reporting	7
Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)	7
Methicillin-sensitive <i>Staphylococcus aureus</i> (MSSA) Bacteraemia	9
Gram Negative Bloodstream Infections	11
<i>Clostridioides difficile</i> (<i>C. difficile</i>)	21
Emerging strain of virulent CDI in UK	25
Criterion 2	29
Environmental IPC and Decontamination	29
Cleaning	29
Water Safety Group (WSG)	31
Ventilation Safety Group (VSG)	32
Decontamination of Medical Devices	33
Central Decontamination	33
Criterion 3	35
Antimicrobial stewardship (AMS)	35
Staff update	35
Antimicrobial Stewardship Activities	35
Antibiotic Consumption	37
Broad Spectrum Prescribing	39
Education and Training	40
Antimicrobial Stewardship Governance and Future Priorities	41
Criterion 4	42
Provision of Information	42
Criterion 5	43
Infection Prevention and Control Incidents and Learning	44
Norovirus Outbreaks	45
COVID-19	47
Influenza	48

Surgical Site Infection Surveillance (SSI)	52
Trauma and Orthopaedic SSI Surveillance	52
Colorectal SSI Data	54
Quarterly rates	54
National Benchmarking – UKHSA and GIRFT Comparison	55
Bundle Compliance – Current Performance	56
Modifiable Factors – Statistical Associations	56
Cost Analysis – Financial Impact of SSI Reduction	58
Variation Between Consultants	58
Future Priorities	58
Criterion 6	59
Mandatory IPC Training	60
Criterion 7	61
Building works	61
Criterion 8	63
Laboratory support	63
Criterion 9	64
Policies and Infections	64
Criterion 10	64
Staff Health and Wellbeing	64
Conclusion	66

Infection Prevention and Control Annual Report 2025-2026

Purpose

This report provides the Trust Board of Directors with an annual review of the mandatory reporting and activities undertaken by the Infection Prevention and Control Team between April 2025 and March 2026. The publication of the Infection Prevention and Control (IPC) Annual Report is a requirement to demonstrate good governance, adherence to Trust values and public accountability in line with the Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infection and related guidance.

This report follows the format of the Health and Social Act, reporting on each of the 10 criteria outlined in the Act.

Infection Prevention and Control Board Assurance Framework (BAF)

The adoption and implementation of the National Infection Prevention and Control Board Assurance Framework (2023) remains the responsibility of the organisation and all registered care providers must demonstrate compliance with the Health and Social Care Act 2008. This requires demonstration of compliance with the ten criteria outlined in the Act.

Across the ten IPC Key Lines of Enquiry (KLOEs), there are no areas assessed as non-compliant when results are considered in aggregate. Of the 54 individual elements reviewed, two have been identified as requiring further assurance (rated amber), where leads have reported partial compliance and have established action plans to strengthen performance. Importantly, there are no elements or KLOEs rated as non-compliant (red).

The areas of partial compliance relate to the identification of an antimicrobial clinical lead and ensuring sufficient numbers of staff are trained and competent in the use of personal protective equipment (PPE), including respiratory protective equipment and the correct procedures for donning and doffing. Targeted plans are in place to address both areas over the coming year and to support full compliance.

Background

The Director of Infection Prevention and Control (DIPC) Annual Report includes infection prevention and control activities within the Royal United Hospitals (RUH) Bath NHS Foundation Trust from April 2025 to March 2026. The report includes the Infection Prevention and Control (IPC) practice on the RUH Combe Park site, the NHS activity undertaken in the modular theatre and the Sulis Elective Orthopaedic Centre (SEOC), located at the Sulis Hospital Bath and any activity where services are run from community sites, such as midwifery services.

Author: Lisa Hocking, Deputy Director of Infection, Prevention and Control - Document Approved by: Jason Lugg Chief Nursing Officer Chief Nursing Officer & Director of Infection, Prevention and Control Agenda Item:	Date: 28/05/2026 Version: 1 Page 4 of 68
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The Trust maintains a zero-tolerance approach and has policies in place to ensure measures are taken to prevent avoidable Healthcare Associated Infections. We prioritise infection prevention and control, ensuring patients receive safe and effective healthcare when using RUH services. Consistent application of high-quality IPC practice protects everyone who uses the healthcare services effectively. Clinical staff members are trained annually to uphold an elevated level of infection prevention and control.

This report highlights the hard work and dedication of all staff, clinical and non-clinical, in improving the quality of patient care. Through open communication and collaboration, infection prevention and control measures effectively reduce risks for patients and stakeholders across the Trust and associated healthcare services. The Trust continues to work collaboratively with several stakeholders as part of the IPC governance arrangements including:

- NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)
- NHS Bath and North East Somerset Public Health team
- South West UK Health and Security Agency (UKHSA)
- South West NHSE IPC team

The Infection Prevention and Control Committee (IPCC) meets monthly and is chaired by the Chief Nursing Officer and DIPC. The IPCC reports to the Trust Insights and Improvement Committee (IIC) monthly and then the Quality Assurance Committee (QAC) quarterly.

Committees and services reporting to the IPCC are:

- Antimicrobial Stewardship (AMS)
- Clinical Divisions
- Decontamination Committee
- Estates and Facilities (estate, water and ventilation)
- Occupational Health & Wellbeing (OHWB)
- Soft Facilities Management
- Surgical Site Infection Surveillance

Criterion 1

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

Infection Prevention and Control Staffing

To ensure a safe service is delivered, we foster a strong collaborative working relationship among all teams within the Trust, including the Clinical Site Team, Ward leaders, Microbiology Laboratory services, the Estates and Facilities team, Health and Safety Team, Procurement, Occupational Health and Wellbeing and the Communications Team.

Table 1 shows the organisational chart for the IPC team and supporting teams as of the end of March 2026.

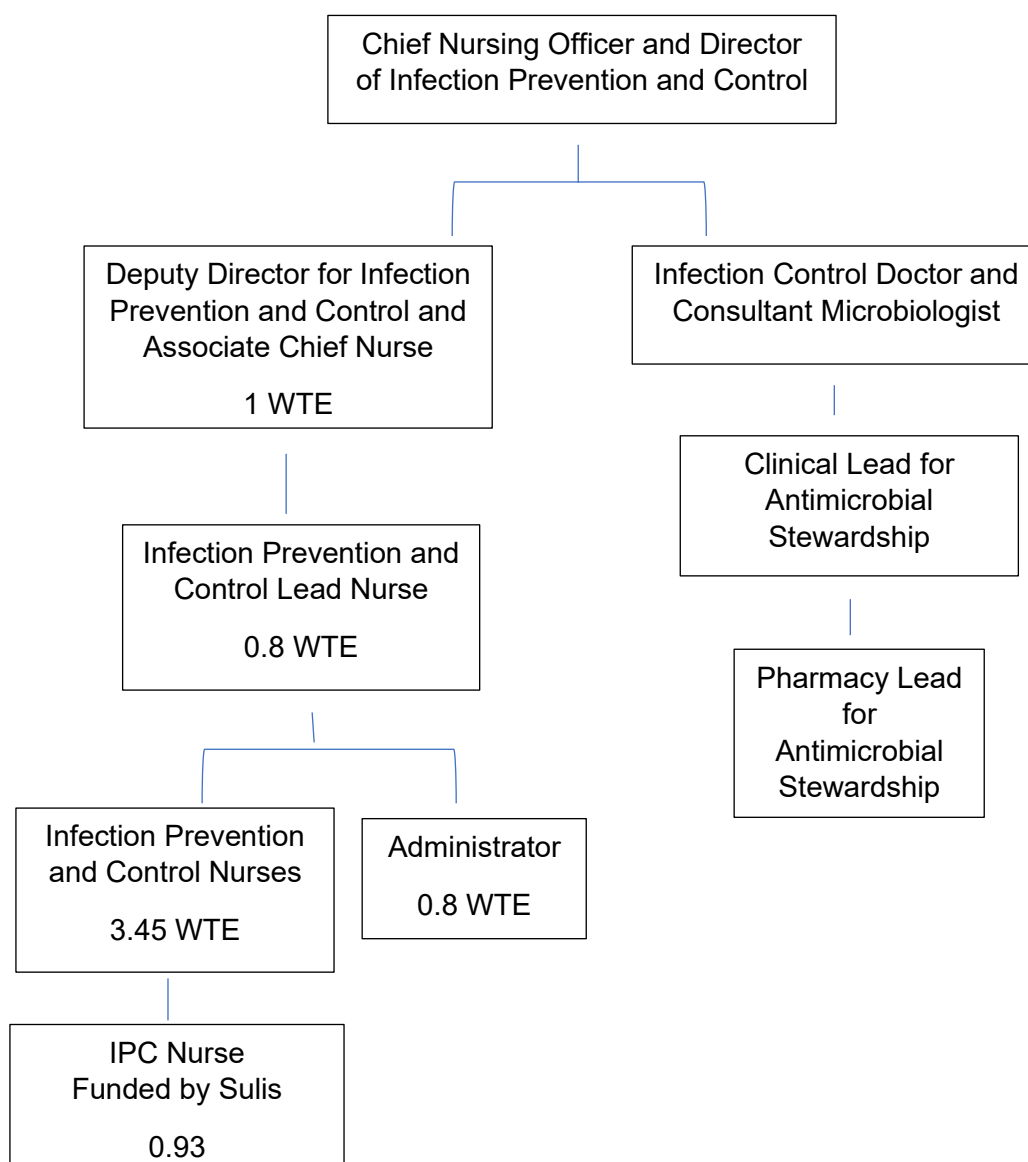


Table 1: Organisational Structure of Infection Prevention Service

Author: Lisa Hocking, Deputy Director of Infection, Prevention and Control - Document Approved by: Jason Lugg Chief Nursing Officer Chief Nursing Officer & Director of Infection, Prevention and Control Agenda Item:	Date: 28/05/2026 Version: 1 Page 6 of 68
---	--

Organisms subject to mandatory reporting

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

- Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- Methicillin-sensitive *Staphylococcus aureus* (MSSA) bloodstream infections
- Gram negative bloodstream infections - *E. coli*, *Klebsiella spp.* and *Pseudomonas Aeruginosa*
- *Clostridioides difficile* (*C. difficile*)

Bacteraemia Trust exposure categories (2020)

The two categories of reporting cover:

Hospital-Onset, Healthcare Associated (HOHA) Any NHS patient specimens taken on the third day of admission onwards (i.e., $\geq$ day 3 when day of admission is day 1) at an acute trust.

Community-Onset Healthcare-Associated (COHA)

Any case reported by an NHS acute trust not determined to be Hospital-Onset Healthcare Associated and where the patient was discharged within 28 days prior to the current specimen date (where date of discharge is day 1)

Reporting and Investigation

The IPC team reports all HOHA and COHA cases of reportable bacteraemias, as listed above and *Clostridioides difficile* (*C. difficile*) onto the Trust incident reporting system Datix. Upon identification, responsibility for completing the incident report sits with the division to investigate, in collaboration with the IPC team. Divisions report by exception to IPCC with any learning and improvement plans. The Patient Safety Incident Response Framework (PSIRF) principles were adopted during 2024, which is now being used to help identify any themes and trends related to these cases.

Methicillin-resistant *Staphylococcus aureus* (MRSA)

There were three cases of MRSA bacteraemia's reported during 2025-26, compared to one in 2024/25.

The common themes between these three cases are linked to the use of invasive cannula devices, history of MRSA colonisation and missed screening opportunities for high-risk patients on admission. The MRSA policy was revised to ensure the screening criteria was clear, spot check audits will take place to monitor compliance.

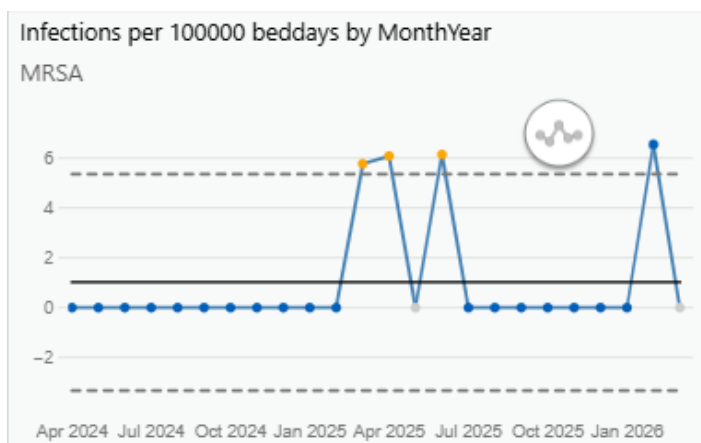


Figure 1. shows the MRSA bacteraemia rate for the Trusts; rate per 100,000 bed days.

Figure 2 shows the MRSA bacteraemia rates for the South West Trusts alongside the National rates per 100,000 bed days. The Trust ranked 6th best against other Trusts in the Southwest.

HCAI Data Tool 2025 / 2026													
Trust	April	May	June	July	August	September	October	November	December	January	February	March	YTD
RA7 - UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	3.33	0	6.66	9.93	0	3.42	3.26	3.37	0	3.26	7.22	3.26	3.6
RBD - DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	0	9.9	0	0	0	0	0	10.06	9.73	0	0	0	2.51
RN3 - GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	5.89	0	0	0	0	5.67	0	17	2.44
RH8 - ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	0	3.13	0	6.3	0	0	0	6.36	0	6.16	0	3.08	2.11
RH5 - SOMERSET NHS FOUNDATION TRUST	5.52	0	2.76	0	0	2.94	2.92	0	0	2.92	0	2.92	1.69
All SW Trusts	2.34	0.97	2.01	1.99	0.99	0.68	0.65	3.04	0.65	2.61	1.81	2.28	1.67
R0D - UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	3.32	0	0	0	3.3	0	0	6.64	0	6.43	0	0	1.65
REF - ROYAL CORNWALL HOSPITALS NHS TRUST	0	0	0	4.97	0	0	0	9.88	4.78	0	0	0	1.65
RD1 - ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	6.36	0	6.36	0	0	0	0	0	0	0	6.59	0	1.54
RK9 - UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	0	3.16	0	0	3.22	0	0	3.3	0	3.2	0	3.2	1.36
National Total	1.55	1.22	1.23	1.66	1.04	1.39	1.11	1.38	0.64	1.64	1.57	1.14	1.29
RTE - GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	3.98	0	3.98	0	0	0	0	0	0	0	4.33	0	0.99
RVJ - NORTH BRISTOL NHS TRUST	3.43	0	3.43	0	0	0	0	0	0	0	3.64	0	0.85
RA9 - TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	0
RNZ - SALISBURY NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0	0

Figure 2: UKHSA MRSA data plot 100,000 bed days 2025/26

Methicillin-sensitive *Staphylococcus aureus* (MSSA) Bacteraemia

The Trust reported 35 cases of methicillin-sensitive *Staphylococcus aureus* (MSSA) during 2025/26, representing a modest increase compared to 31 cases reported in 2024/25.

The distribution of primary recorded sources of infection is presented in Figure 3. The most frequently identified sources were unknown origin and skin and soft tissue infections, accounting for the largest proportion of cases. Device-related infections, including those associated with peripheral venous catheters, peripherally inserted central catheters (PICC), and portacaths, were also observed, alongside infections arising from respiratory, bone and joint, and urinary sources.

This distribution highlights the ongoing challenges associated with identifying definitive sources of MSSA bacteraemia and reinforces the continued importance of robust surveillance, line care practices, and early identification and management of skin and soft tissue infections.

Source	Number of cases
Bone and joint	3
Infected Portacath	2
Lower Respiratory Tract	4
Lower Urinary Tract & Catheter	1
Other	3
Peripheral Venous Catheter	3
PICC	1
Skin & Soft Tissue	7
Unknown	13

Table 2: MSSA Bacteraemia 2025-2026

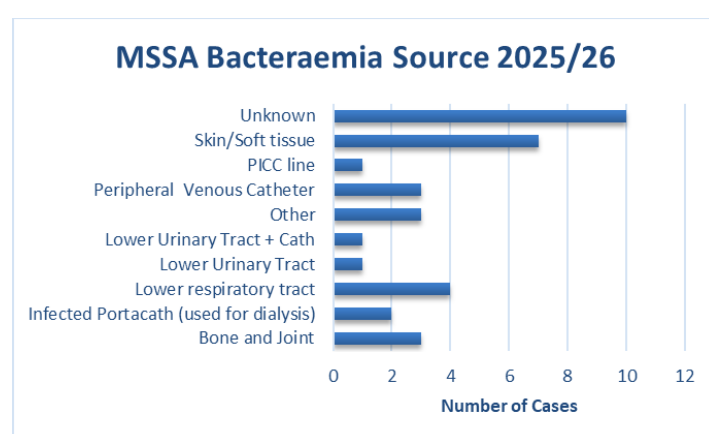


Figure 3: MSSA Bacteraemia Source 2025/26

During 2025–2026, MSSA infection rates show considerable month-to-month variability, with values fluctuating both above and below the benchmark. There is no sustained upward or downward trend, indicating instability rather than consistent

deterioration or improvement. This pattern indicates common-cause variation with intermittent special-cause signals, particularly during pronounced peaks and troughs. Interventions were put in place to address skin preparation and cannula care, this contributed the reduction in infection rates to zero in September, December 2025, February and March 2026.

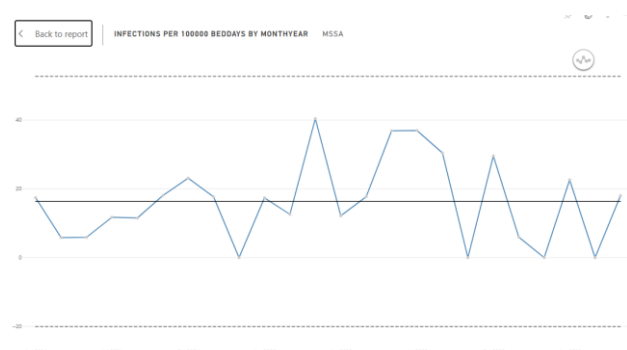


Figure 4: SPC Healthcare associated MSSA bacteraemia data 2024 – 2026 per 100,000 bed days

Although MSSA is reported, there is no threshold for this infection. The RUH benchmarked above the South West average throughout the year (worse than best performing Trusts).

The Trust had the 4th highest rate per 100,000 bed days across the South West for 2025/26.

HCAI Data Tool 2025 / 2026													
Trust	April	May	June	July	August	September	October	November	December	January	February	March	YTD
RA9 - TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	36.95	17.88	36.95	8.89	44.44	18.37	26.45	45.56	44.09	17.64	29.29	8.82	27.86
RK9 - UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	13.05	25.26	29.36	22.51	38.59	6.65	38.37	13.22	22.38	9.59	14.16	15.99	20.87
RH8 - ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	9.72	25.08	16.19	28.35	9.45	32.55	21.54	28.62	0	18.47	20.45	15.39	18.75
RD1 - ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	12.72	18.47	38.16	36.47	30.39	0	29.75	6.15	0	23.8	0	23.8	18.44
RA7 - UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	3.33	22.54	13.31	23.17	9.93	10.26	19.57	16.85	9.78	29.35	25.28	26.09	17.46
RVJ - NORTH BRISTOL NHS TRUST	20.6	16.62	13.74	23.6	13.49	27.88	6.58	10.2	19.75	16.45	25.5	13.16	17.2
RBD - DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	30.7	29.71	0	20	0	10.33	9.73	10.06	29.19	9.73	43.09	9.73	16.72
All SW Trusts	15.39	19.43	18.4	17.53	17.2	15.38	18.28	13.15	14.36	16.32	18.07	14.36	16.49
REF - ROYAL CORNWALL HOSPITALS NHS TRUST	25.12	19.45	25.12	19.9	4.97	20.56	14.35	14.82	4.78	9.56	21.18	19.13	16.47
RN3 - GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	11.9	23.04	5.95	29.45	11.78	12.17	0	5.85	28.33	11.33	18.82	17	14.64
RTE - GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	15.92	23.12	7.96	11.6	23.2	11.99	15.64	4.04	11.73	15.64	12.98	11.73	13.86
R0D - UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	16.6	16.07	19.92	6.59	16.49	17.04	16.07	9.96	12.86	12.86	17.79	3.21	13.74
National Total	12.89	14.04	13.1	13.97	13.19	13.6	13.68	12.16	12.43	13.66	13.21	11.88	13.15
RH5 - SOMERSET NHS FOUNDATION TRUST	19.34	8.02	22.1	0	17.08	14.71	14.6	9.05	17.52	11.68	12.93	8.76	13.01
RN2 - SALISBURY NHS FOUNDATION TRUST	0	14.11	7.29	0	0	0	21.93	0	7.31	29.24	0	14.62	8.03

Figure 5: UKHSA MSSA data plot 100,000 bed days 2025/26

Vascular Access Quality Improvement Programme

A dedicated Quality Improvement working group was established to review and strengthen cannula care practices across the organisation, including pathways for patients who are known to be difficult to cannulate.

Throughout the year, the group undertook a comprehensive programme of work comprising a point-prevalence survey, ward-based observations, patient interviews and surveys, and a review of electronic documentation. Early findings highlighted

inconsistencies in pre-cannulation skin preparation. Targeted actions were implemented, resulting in a demonstrable improvement in MSSA rates associated with cannulation.

This work also brought to light wider gaps in the standardisation of ongoing cannula care. In particular, the absence of a reliable pathway for patients with known cannulation difficulties and the lack of a formal extravasation protocol were identified as key risks. Addressing these gaps will form a central focus of the programme in the coming year, ensuring safer, more consistent care for all patients requiring intravenous access.

Gram Negative Bloodstream Infections

In 2019 the UK agencies published its 20-year vision for antimicrobial resistance (AMR). This set the ambitious goal of ensuring Antimicrobial Resistance (AMR) will be controlled and contained by 2040. To deliver on this vision, the government agencies committed to producing a series of 5-year national action plans across the United Kingdom.

The first 5-year national action plan for antimicrobial resistance, 'Tackling antimicrobial resistance 2019 to 2024', was a crucial step towards achieving this vision. The work conducted across government led to progressive action towards reducing the negative impact of AMR in the UK and globally. Successes of that plan included:

- further reductions in the use of antibiotics in food-producing animals
- the development of improved surveillance systems
- the piloting of new payment schemes for antibiotics on the NHS

These will provide sustained and ongoing progress towards achieving the vision's ambitions for change.

In 2024 'Confronting antimicrobial resistance 2024-2029' was introduced by the government, building on the achievements and lessons learnt in previous years. The work has been seen across the Integrated care board (ICB) and within the Trust highlighting the negative impact of AMR. This has continued to show how working as a multi-disciplinary team (MDT) can support the practice of increased switching from Intravenous antibiotics to oral antibiotics (IVOS) and improving knowledge surrounding AMR through the capability of teams to measure, predict resistance and recognise transmission. This will evidently lead to the empowerment of clinicians in the use of appropriate antimicrobials, strengthening surveillance to understand risk and support resilience against future organisms.



Table 3: summary of the 2024-2029 National Action Plan

There was an increase of four cases for *E.coli* to 104 for 2025-26. There has been a reduction in *Pseudomonas* of five cases staying within the threshold given by NHSE and an increase in *Klebsiella* of nine cases exceeding the NHSE threshold by six cases.

Infection	Threshold for 24/25	Final Numbers 24/25	Threshold for 25/26	Final Numbers 25/26	Difference in final Numbers 24/25 and 25/26
<i>E. coli</i>	82	100	77	104	+4
<i>Pseudomonas</i>	14	14	12	9	-5
<i>Klebsiella</i>	25	21	24	30	+9

Table 4: Thresholds for 2024/25 and 2025/2026

Escherichia coli Bacteraemia (*E. coli*)

The NHSE threshold of 77 was exceeded during 2025/26 by 27 cases. The RUH has continued to see an upward trend in *E. coli* bacteraemia infections which has positioned the Trust fourth from the top of the table for its rate of infection of 53.29 per 1000,000 bed days in the South West. There remains a noticeable trend involving a urinary source for *E. coli* infections within the Trust attributing 52% of the documented cases. A number of healthcare-associated cases have been attributed to the Trust, as these patients are currently receiving, or have previously received, care through the Hospital@Home service. This is a Trust-led service that typically manages up to 60 patients at any one time. Hospital@Home supports the Trust by enabling patients to receive hospital-level care in their own homes, thereby reducing the need for inpatient admissions and supporting earlier discharge. This model helps to optimise bed

capacity, alleviate pressure on acute services, and improve patient flow across the organisation.

Of this percentage these cases are associated to Upper urinary tract infection (6%) Lower urinary tract infection (28%). The percentage of patients with a urinary infection, upper and lower combined with a urinary catheter is 18%. This is the rationale for driving best prescribing practice and the promotion of hydration to prevent infection.

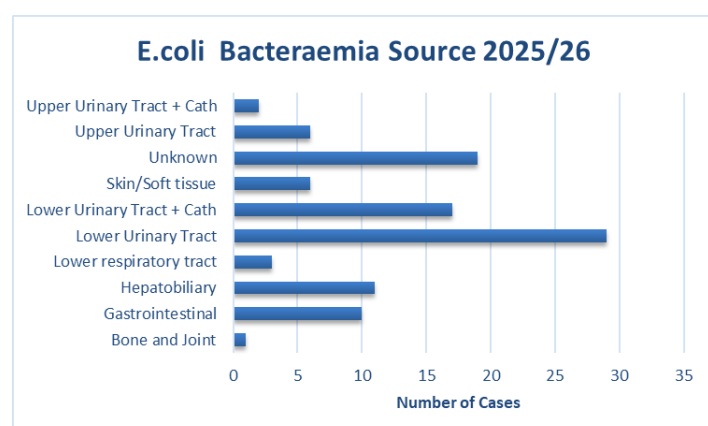


Figure 6: E.coli Bacteraemia Source 2025/26

The National Action Plan continues to emphasise the growing challenge of antimicrobial resistance (AMR) and the need to reduce unnecessary antimicrobial exposure. This includes raising awareness of the potential harms associated with antimicrobial use, the increasing prevalence of resistant organisms, and the escalating requirement for multiple antibiotics to treat infections that were previously straightforward to manage.

The Infection Prevention and Control team is actively engaged with the Integrated Care Board through a regional collaborative focused on improving urinary tract management and access within community settings. This work aims to better understand the wider system factors contributing to antimicrobial use and to support more effective, evidence-based approaches to infection prevention and stewardship across the local population.

As previously reported, the Trust continues to care for a growing and increasingly ageing population. The Office for National Statistics (ONS) projects that the UK population will reach 70 million by 2026, with the number of people aged over 65 rising to 12.7 million (19%). This represents a significant expansion of an age group that is inherently at higher risk of infection due to the greater likelihood of comorbidities, complex health needs, and the need for multiple treatments or medications.

This demographic shift is reflected in the Trust's infection profile, with patients over 65 contributing substantially to the number of Gram-Negative Bloodstream Infections (GNBSIs) identified.

All GNBSIs undergo a short case review completed jointly by the ward leader and the Infection Prevention and Control (IPC) team. These reviews assess the likely source of infection, associated risk factors, whether the case meets the definition of a healthcare-associated infection (HCAI), and any treatment or follow-up required. This structured approach supports focused learning, strengthens clinical practice, and promotes compassionate, meaningful engagement across surgical and medical divisions to drive continuous improvement.

Figure 7 demonstrates the Trust associated cases per month of each GNBSI, between April 2025 and March 2026. The cases are plotted against the annual threshold set by NHSE for 2025/26.

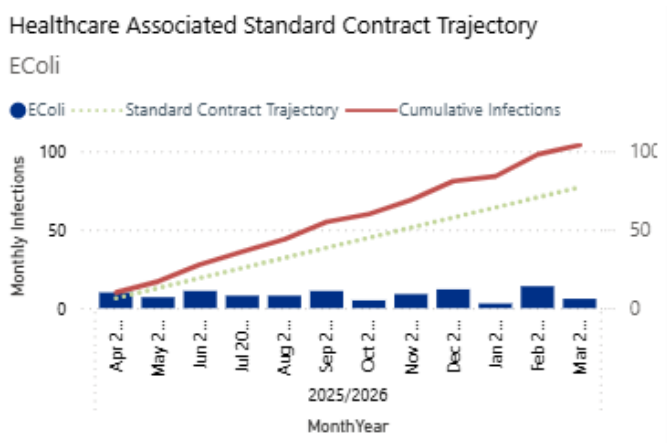


Figure 7: All *E. coli* infections against threshold for 2025/26

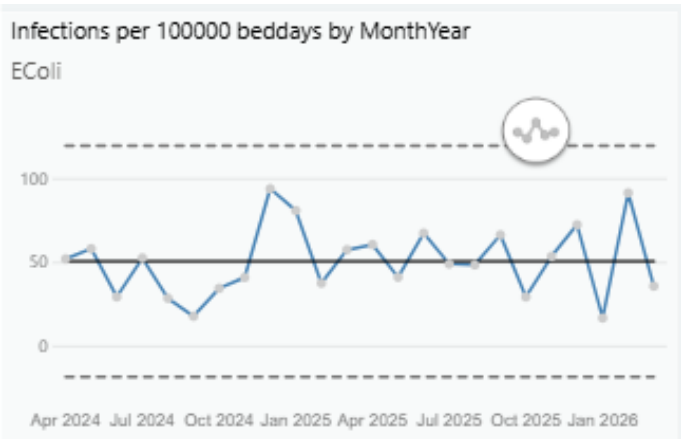


Figure 8: *E. coli* Bacteraemia rates per 100,000 bed days 2025/26

HCAI Data Tool 2025 / 2026													
Trust	April	May	June	July	August	September	October	November	December	January	February	March	YTD
RH8 - ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATI	74.5	78.36	35.63	91.35	59.85	55.33	52.32	60.43	61.56	49.25	78.37	49.25	62.07
RA9 - TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	46.19	44.7	73.9	71.1	88.87	18.37	79.36	27.34	70.55	52.91	78.1	52.91	58.73
RN3 - GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	59.51	51.83	53.56	47.11	53	42.6	62.32	40.98	56.66	56.66	56.45	62.32	53.66
RD1 - ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRU	63.61	43.09	69.97	48.63	48.63	69.09	35.7	55.34	71.41	17.85	85.64	35.7	53.29
RA7 - UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOU	23.29	28.98	46.59	49.66	43.04	51.31	94.58	60.66	29.35	45.66	54.16	61.96	49.05
RBD - DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	61.4	69.32	20.47	50	20	31	68.12	50.28	48.65	29.19	21.55	48.65	43.46
All SW Trusts	40.15	39.83	39.15	45.32	43.34	37.61	48.95	41.48	37.53	32.96	43	38.84	40.66
REF - ROYAL CORNWALL HOSPITALS NHS TRUST	35.17	53.49	35.17	44.77	84.57	10.28	57.38	24.71	28.69	14.35	26.47	43.04	38.3
ROD - UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRU	59.77	38.56	46.49	32.97	36.27	20.44	38.57	36.54	35.36	25.71	17.79	61.07	37.64
RK9 - UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	9.79	37.89	55.46	41.8	45.02	36.55	44.76	46.25	31.97	22.38	35.4	15.99	35.24
National Total	35.52	34.18	34.95	38.28	37.66	35.67	35.63	35.26	33.13	32.1	34.67	35.1	35.18
RH5 - SOMERSET NHS FOUNDATION TRUST	35.91	37.43	16.57	25.62	34.16	35.3	23.36	36.21	23.36	43.8	32.33	17.52	30.11
RVJ - NORTH BRISTOL NHS TRUST	24.04	16.62	30.91	33.72	33.72	45.3	42.78	20.4	13.16	32.91	40.08	19.75	29.32
RNZ - SALISBURY NHS FOUNDATION TRUST	43.73	21.16	21.86	52.03	14.87	30.72	21.93	22.66	29.24	14.62	8.09	36.55	26.57
RTE - GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	19.91	15.41	23.89	23.2	15.47	27.97	35.18	44.43	31.27	15.64	30.3	23.46	25.4

Figure 9: UKHSA *E. coli* data 100,000 bed days 2025/26

Figure 10 highlights the current age group and gender of patients who have been seen in RUH, totalling 376 cases of *E. coli* bacteraemia's that have been reported in the Trust, this includes 272 community onset community acquired cases.

% Infections by Age at Specimen Date (10 year bins) and Gender

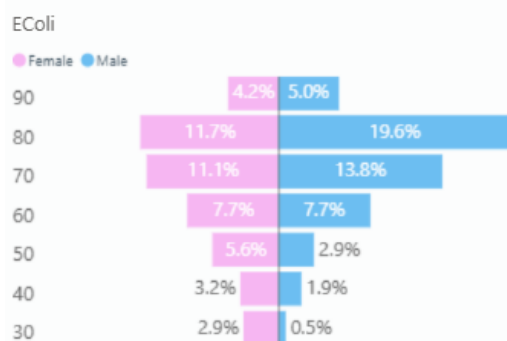


Figure 10: *E. coli* Infection % by age and gender for 2025/26

There is a gender split of 48% female and 52% males for *E. coli* infections. Further analysis has shown that 81% of the positive cases were over the age of 60. The most prevalent range is over 80 years of age relating to 15.9% female and 24.6% males. 0.01% of cases reported were under the age of 18.

Pseudomonas aeruginosa

Pseudomonas aeruginosa is a Gram-negative bacterium often found in soil and ground water. *P. aeruginosa* is an opportunistic pathogen and it rarely affects healthy individuals. It can cause a wide range of infections, particularly in those with a weakened immune system, for example cancer patients and newborns.

Pseudomonas aeruginosa infections are sometimes associated with contact with contaminated water. In hospitals, the organism can contaminate devices that are left inside the body, such as respiratory equipment and catheters. *Pseudomonas aeruginosa* is resistant to many commonly used antibiotics which is why it is closely monitored.

Overall, the Trust has stayed within the threshold set by the NHSE for 2025/26 reporting nine cases against a threshold of 12 (fig 11). The overall rate for the trust year was 4.61 per 100.000 bed days, positioning 3rd best in the South West (fig. 15). Of the nine cases identified there were five different sources attributed (fig 12). One ward has seen more than one case (n=2) in 2025/26. There are fluctuations in rates, per 100,000 beds days across all organisations throughout the year, and this can be a result of just one extra case (fig. 15).



Figure 11: All Pseudomonas infections against threshold for 2025/26

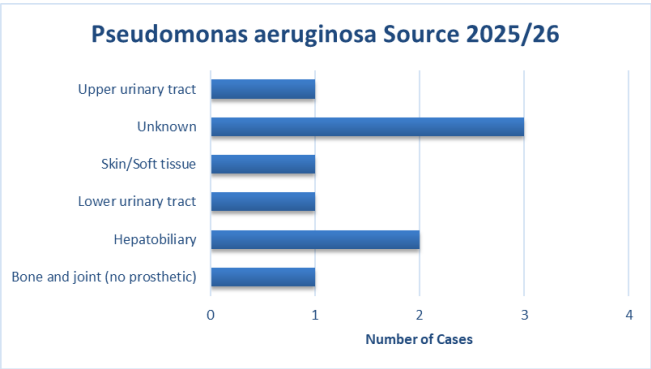


Figure 12: All Trust associated pseudomonas infection source 2025/26

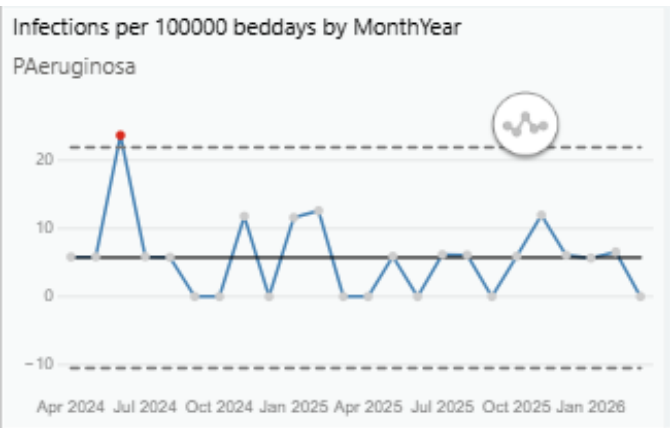


Figure 13: SPC Chart Pseudomonas Aeruginosa 100,000 bed days 2025/26

Figure 14 below highlights the current age group and gender of patients who have been seen in RUH, totalling 33 cases of *Pseudomonas Aeruginosa* bacteraemias that have been reported in the Trust, this includes 24 community onset community acquired cases.

The gender of *Pseudomonas* cases is shown to be predominantly 63% male and 36% female. 93% of the cases were over the age of 60.

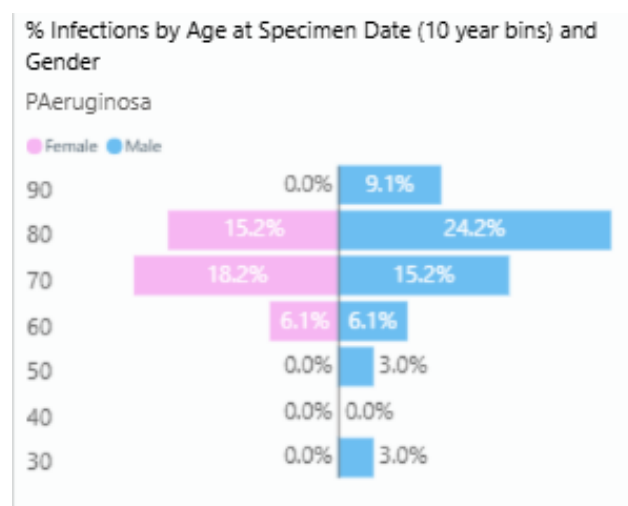


Figure 14: *Pseudomonas* bacteraemia by age and gender (total samples taken) 2025/26

HCAI Data Tool 2025 / 2026														
Trust	April	May	June	July	August	September	October	November	December	January	February	March	YTD	
RNZ - SALISBURY NHS FOUNDATION TRUST	14.58	0	7.29	14.87	29.73	15.36	7.31	7.55	7.31	7.31	8.09	0	9.89	
RN3 - GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	11.9	5.76	5.95	17.67	23.56	6.09	11.33	0	0	11.33	18.82	0	9.27	
RA7 - UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOUNDATION TRUST	9.98	6.44	0	3.31	16.55	13.68	9.78	6.74	19.57	3.26	18.05	3.26	9.15	
REF - ROYAL CORNWALL HOSPITALS NHS TRUST	10.05	0	0	4.97	14.92	10.28	4.78	9.88	9.56	14.35	10.59	9.56	8.24	
R0D - UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRUST	6.64	6.43	3.32	9.89	6.59	6.81	12.86	19.93	3.21	0	7.12	6.43	7.42	
RH8 - ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATION TRUST	0	6.27	9.72	12.6	9.45	6.51	9.23	9.54	9.23	6.16	0	9.23	7.4	
RH5 - SOMERSET NHS FOUNDATION TRUST	8.29	2.67	0	8.54	5.69	14.71	5.84	12.07	5.84	17.52	6.47	0	7.23	
All SW Trusts	7.03	5.83	3.68	8.6	9.93	7.18	6.85	7.08	7.18	7.18	7.95	3.59	6.83	
National Total	5.89	5.31	6	6.54	6.88	7.25	7.76	6.29	6.45	5.31	5.88	4.95	6.21	
RVJ - NORTH BRISTOL NHS TRUST	10.3	9.97	0	10.12	6.74	3.48	6.58	0	6.58	6.58	10.93	3.29	6.2	
RK9 - UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	6.52	3.16	13.05	9.65	0	3.32	6.39	3.3	3.2	12.79	0	3.2	5.42	
RTE - GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	7.96	19.26	3.98	3.87	7.73	0	0	0	3.91	0	4.33	3.91	4.62	
RD1 - ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRUST	0	6.16	0	6.08	6.08	0	5.95	12.3	5.95	5.95	6.59	0	4.61	
RBD - DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	0	0	0	10	10	10.33	0	0	0	0	21.55	0	4.18	
RA9 - TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	0	0	0	0	8.89	0	0	0	17.64	0	0	0	2.26	

Figure 15: UKHSA *Pseudomonas* data plot 100,000 bed days 2025/26

Klebsiella

Klebsiella species are commonly found in the environment and in the human intestinal tract and are frequently spread through contaminated hands.

Overall, the Trust exceeded the threshold set by the NHSE for 2025/26 reporting 30 cases against a threshold of 24 (fig 16).

Of the 30 Trust attributed cases identified, there were ten different sources attributed (fig 17). Two cases of *Klebsiella* were linked to the use of urinary catheters during

2025/26, the review of the catheter care pathway was completed in 2024/25, and whilst the discharge pathway had been strengthened there remains more work to be done to ensure there is a sustained change in practice across the Trust. 52% of the klebsiella infections were linked to urinary tract infections (fig 16). The nutrition and hydration group have driven the access to alternative beverages for patients including the access to caffeine-free drinks in all clinical areas. Wards are also testing coloured lids for patients who need more support with their hydration to increase awareness.

Quality Improvement work has been on going to support the hand hygiene of patients. Education has been given to staff around the importance of robust hand hygiene techniques within these areas.

The overall rate for the trust year was 15.37 per 100.000 bed days, positioning 4th highest in the South West (fig. 18 & 19).

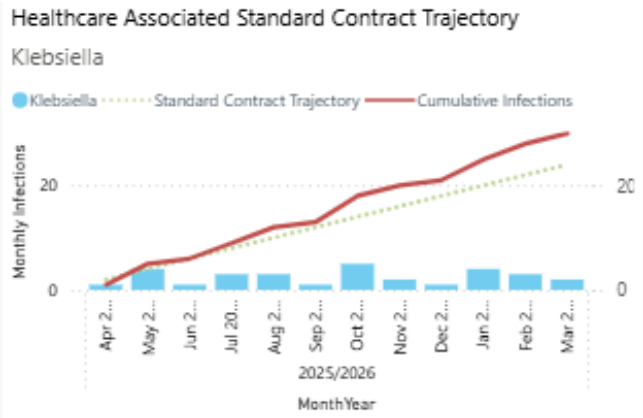


Figure 16: All Klebsiella infections against threshold for 2025/26

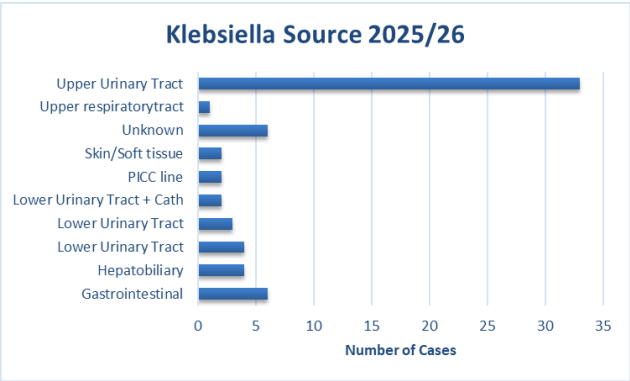


Figure 17: All Trust associated Klebsiella infection source 2025/26

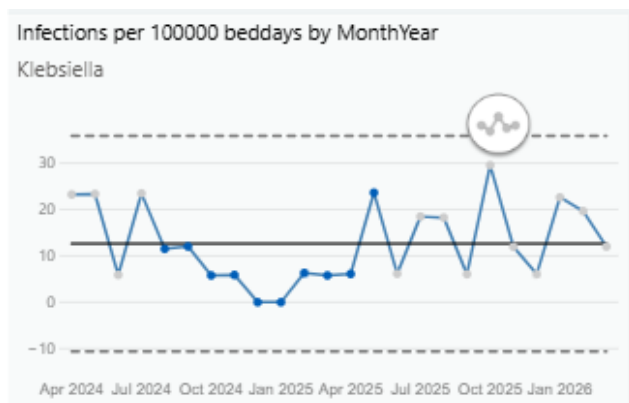


Figure 18: Klebsiella SPC chart 100,000 bed days for 2025/26

HCAI Data Tool 2025 / 2026													
Trust	April	May	June	July	August	September	October	November	December	January	February	March	YTD
RA7 - UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOU	16.64	16.1	13.31	19.86	33.1	30.79	35.87	23.59	13.05	16.31	21.66	32.61	22.73
RH8 - ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATI	6.48	18.81	12.96	18.9	22.05	26.04	9.23	31.8	21.54	21.54	17.04	15.39	18.49
REF - ROYAL CORNWALL HOSPITALS NHS TRUST	20.1	14.59	20.1	9.95	14.92	25.7	9.56	19.77	14.35	28.69	0	23.91	16.89
RD1 - ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRU	6.36	24.62	6.36	18.23	18.23	6.28	29.75	12.3	5.95	23.8	19.76	11.9	15.37
RN3 - GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	11.9	5.76	17.85	5.89	29.45	18.26	11.33	23.42	22.66	11.33	0	22.66	15.12
RK9 - UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	9.79	12.63	13.05	25.72	9.65	9.97	19.18	19.82	9.59	19.18	10.62	15.99	14.64
National Total	12.72	13.56	13.5	16.58	15.49	15.37	15.88	14.54	14.16	14.1	13.73	13.54	14.44
All SW Trusts	11.71	15.87	13.38	17.87	14.56	14.7	14.03	16.52	12.07	15.66	11.56	14.69	14.41
RA9 - TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	9.24	26.82	0	17.77	0	9.18	26.45	9.11	26.45	8.82	39.05	0	14.31
RBD - DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	20.47	29.71	10.23	40	10	10.33	19.46	0	9.73	9.73	0	9.73	14.21
RH5 - SOMERSET NHS FOUNDATION TRUST	11.05	13.37	11.05	25.62	11.39	11.77	8.76	18.1	5.84	8.76	3.23	14.6	12.04
RTE - GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	0	11.56	27.87	23.2	7.73	4	11.73	4.04	11.73	15.64	8.66	11.73	11.55
ROD - UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRU	9.96	19.28	13.28	13.19	13.19	13.63	6.43	6.64	9.64	12.86	10.68	9.64	11.54
RVJ - NORTH BRISTOL NHS TRUST	17.17	19.94	6.87	3.37	6.74	3.48	0	20.4	9.87	16.45	14.57	6.58	10.43
RNZ - SALISBURY NHS FOUNDATION TRUST	21.86	0	14.58	14.87	0	15.36	7.31	0	0	0	8.09	0	6.8

Figure 19: UKHSA Klebsiella data plot 100,000 bed days for 2025/26

There were predominantly more cases in men (60%) than in females (40%) with the overs 60s accounting for 86% of reported cases.

Figure 20 highlights the split of both gender and age across all Klebsiella cases reported from samples taken in the Trust including community onset cases (n-104) showing that the highest proportion of positive results occurring in patients aged over 60 years of age and predominantly male. Hydration programmes have been set up in the community to support this group of patients and to reduce the number of admissions to acute care, the impact of this work is yet to influence our data.

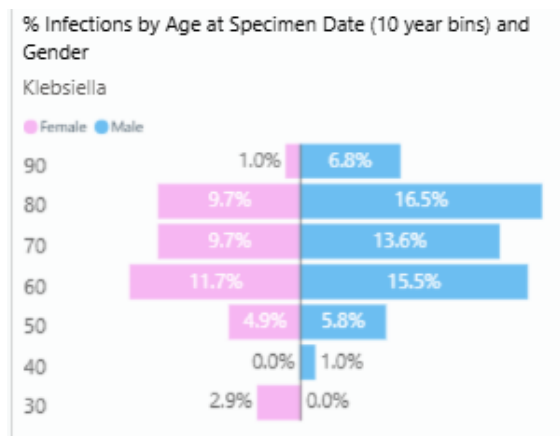


Figure 20: Klebsiella infection by age and gender 2025/26

Key improvements required for 2026/27

E. coli Infection Trends: Across the region, there has been a notable rise in E. coli infections, and despite the early progress made through several improvement collaboratives within the Trust, the number of cases recorded locally has continued to increase. The Trust reported 104 cases this year, compared with 100 cases in 2024/25.

The predominant contributing factor remains urinary tract infections in older adults who do not have a urinary catheter in place. This reflects the wider demographic pressures faced by the organisation and highlights the need for continued focus on prevention, early identification, and optimised management of urinary tract infections in this vulnerable population.

Fluid Management and Hydration Improvement Programme

Accurate monitoring of a patient's fluid intake and output remains a fundamental component of safe, high-quality care, particularly when managing patients who are acutely unwell or at risk of deterioration. The ability to reliably document this information on fluid balance charts is essential to support timely clinical decision making.

During 2025/26, clinical audits were undertaken to provide assurance that patients across the Trust are adequately hydrated throughout their stay. Maintaining optimal hydration plays a critical role in preventing urinary tract infections and constipation, supporting cognitive function, protecting skin integrity, promoting mobility, and reducing the risk of deconditioning.

Ongoing improvement work is being led by the Bowel and Bladder Matron in collaboration with Practice Educators, with a focus on reducing the risk of infection and improving continence care. This programme is strengthening the core skills of the workforce in continence promotion and safe catheter management, supporting a reduction in avoidable harm and contributing to improved patient outcomes.

***Clostridioides difficile* (C. difficile)**

Clostridioides difficile (also known as *Clostridium difficile*, *C. difficile* or *C. diff*) is a type of bacteria that can cause diarrhoea. It often affects people who have been taking antibiotics. *C. diff* bacteria usually live harmlessly in your bowel along with lots of other types of bacteria. Some of the known risk factors for *C. diff* infection is being over 65 years, taking, or have recently taken, antibiotics, staying in hospital or a care home for a long time.

A total of 75 cases of healthcare associated *Clostridioides difficile* were reported at the end of March 2026. The threshold for RUH apportioned cases was set at 75 cases of *C. difficile* for 2025/26 (fig 21). The NHSE threshold was not exceeded this year, the Trust reported 28 less cases than in 2024/25. The overall rate for the trust year was 38.43 per 100.000 bed days, positioning 3rd from the top in the South West (fig. 22 & 23).

Of the 75 cases, 45 were Hospital Onset Healthcare Associated (HOHA) cases and 30 Community Onset Healthcare Associated cases (COHA). Eleven of the 75 cases were repeat positive cases that met reporting criteria. There were an additional 70 cases of *C.diff* attributed to community onset, which aligns with the national picture of attribution.

The English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) report demonstrates an increase in overall antibiotic consumption in England in 2023. However, consumption remains below pre-pandemic levels, and significantly below the consumption peak seen in 2014. Use of broad-spectrum antibiotics is a recognised risk factor for CDI. Broad-spectrum antibiotics typically fall under the UK Access, Watch, Reserve, and Other (UK-AWaRe) classification Watch and Reserve categories. Since 2021, use of Access antibiotics as a proportion of total antimicrobial consumption has seen a gradual increase, beyond 2019 levels.

During 2025/26 the IPC teams, AMR Pharmacists and Microbiologists across the regions reviewed the impact of diabetes and obesity alongside the impact of medications that are used to treat depression and diabetes (GLP-2). It was concluded there was no correlation with the use of these medications and the likelihood of developing *Clostridioides difficile* Infection (CDI).

NHSE thresholds since 2024/25 – 2025/26

Infection	Threshold for 24/25	Final Numbers 24/25	Threshold for 25/26	Final Numbers 25/26	Difference in final Numbers 24/25 & 25/26
<i>C. difficile</i>	75	103	75	75	-28

Table 5: *C. difficile* Thresholds for 24/25 and 25/26 and final totals for RUH

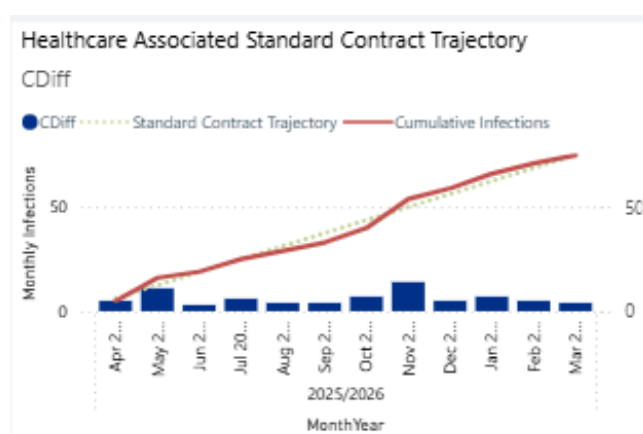


Figure 21: Total number of *C. difficile* cases 2025/26

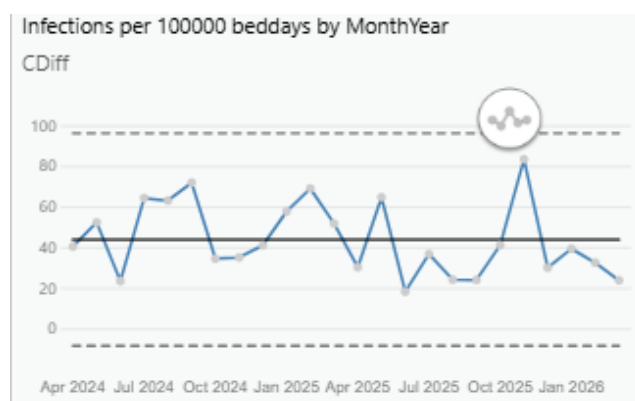


Figure 22: Trust SPC *C. difficile* data 100,000 bed days, by month 2025-2026

HCAI Data Tool 2025 / 2026													
Trust	April	May	June	July	August	September	October	November	December	January	February	March	YTD
RA9 - TORBAY AND SOUTH DEVON NHS FOUNDATION TRUST	92.38	62.58	18.48	26.66	106.65	36.73	70.55	36.45	44.09	52.91	29.29	52.91	52.71
RK9 - UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST	45.67	50.51	42.41	41.8	48.23	49.84	44.76	33.04	35.17	41.57	21.24	44.76	41.75
RD1 - ROYAL UNITED HOSPITALS BATH NHS FOUNDATION TRU	31.8	67.71	19.08	36.47	24.31	25.12	41.65	86.08	29.75	41.65	32.94	23.8	38.43
REF - ROYAL CORNWALL HOSPITALS NHS TRUST	30.15	43.76	55.27	74.62	34.82	35.98	23.91	44.47	19.13	33.47	15.88	47.82	38.3
RA7 - UNIVERSITY HOSPITALS BRISTOL AND WESTON NHS FOU	36.6	38.64	26.62	46.35	56.28	47.89	26.09	40.44	39.14	48.92	25.28	22.83	37.97
RBD - DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	40.93	39.61	20.47	60	30	31	58.39	0	29.19	19.46	43.09	48.65	35.1
All SW Trusts	35.8	34.97	30.11	35.07	37.38	32.82	31.66	29.34	25.13	30.68	25.65	29.37	31.53
RTE - GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	23.89	26.97	35.83	30.94	38.67	19.98	43	36.36	27.36	15.64	43.28	27.36	30.68
RN3 - GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	29.76	51.83	35.71	29.45	23.56	12.17	22.66	5.85	17	39.66	31.36	56.66	29.76
RVJ - NORTH BRISTOL NHS TRUST	24.04	26.59	41.21	33.72	30.35	41.81	32.91	27.21	16.45	23.04	25.5	26.33	29.04
ROD - UNIVERSITY HOSPITALS DORSET NHS FOUNDATION TRU	33.2	32.13	16.6	23.08	36.27	27.26	32.14	26.57	22.5	19.29	32.03	12.86	26.1
RH8 - ROYAL DEVON UNIVERSITY HEALTHCARE NHS FOUNDATI	32.39	28.21	38.87	3.15	18.9	35.8	18.47	19.08	24.62	27.7	17.04	33.86	24.83
National Total	24.81	23.79	26.65	26.46	27.33	25.89	26.31	22.79	20.64	22.7	23.34	23.95	24.56
RN2 - SALISBURY NHS FOUNDATION TRUST	51.01	14.11	21.86	44.6	14.87	7.68	29.24	7.55	14.62	21.93	16.19	21.93	22.24
RH5 - SOMERSET NHS FOUNDATION TRUST	33.15	10.69	11.05	34.16	37.01	29.42	11.68	15.09	14.6	23.36	16.16	2.92	19.99

Figure 23: UKHSA *C. difficile* picture data plot 2025/26

The gender of all reportable *Clostridioides difficile* cases is shown to be predominantly female (64%) with 36% being male. 86% of the cases were over the age of 60 with the remaining 12% being aged 18-29.

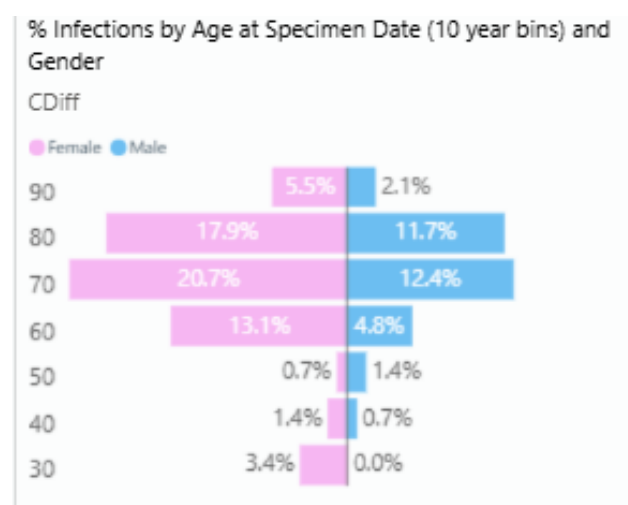


Figure 24 : C. difficile infection by age and gender 2025/26

Review of HOHA cases:

There were 45 HOHA CDI cases during 2025/26, this is a significant decrease from the year before, when there were 62 HOHA cases. 44 of the cases were analysed with the data available at the time. The average age of patients was 75.5 years (age range of 38 to 91 years), 54% of cases were female and 45% male. On average, the time to onset of CDI post admission was 12 days, although this ranged from as short as 3 days to as long as 44 days. 39% of patients developed CDI within the first week of admission.

68% of cases were deemed mild or moderate in severity. 27% of cases were classed as severe or complicated/life threatening. In two cases, severity could not be assessed, as the patient was at the end of life. Of the 44 HOHA cases reviewed, 11 patients sadly died within 28 days of the CDI diagnosis. All cases were reviewed by a microbiologist and treated appropriately with antibiotics active against *C. difficile* and where cases met the NICE criteria patients were also offered Faecal Microbiota Transplantation.

The *C. difficile* HOHA cases were reviewed in detail looking specifically at rates of recurrence, antibiotic usage and risk factors for diarrhoea, to identify learning themes.

Key findings from this analysis were:

- 20% of HOHA cases had prior *C. difficile* infection or carriage (down from 27% last year).

- 25% of HOHA were on laxatives at the time of sampling (much less than the figure of 42% last year).
- 73% of HOHA cases were on a proton pump inhibitor (PPI) (medications that have a known association with the development of CDI). This is a similar figure to last year. However, in all but 4 of these cases, the PPI was reviewed on the diagnosis of CDI.
- All except three cases of HOHA CDI had received antibiotics in the preceding 3 months before CDI diagnosis.
- In 14 cases (32%) antibiotics prescribing was not completely in concordance with guidance or otherwise a reasonable deviation from guidance. This was for a variety of reasons such as choice of antibiotic, duration or dose.
- In seven of the above cases, the deviation from optimal antibiotic prescribing increased the potential risk for CDI, and therefore these cases could not be deemed unpreventable.

Of the HOHA cases 36 (81%) were deemed to be unpreventable, with no lapses in care. As described above, in seven cases there was a deviation from optimal antibiotic prescribing, which may have increased the patient's overall risk of CDI. In all these cases however, there were other risk factors for CDI present, and antibiotics were still required, so we cannot conclude that CDI would not have developed even with improved prescribing. These cases were therefore deemed inconclusive. In one case, although CDI overall was likely to be unpreventable, a delay in sampling and therefore possibly diagnosis may have led to more severe CDI than would have otherwise developed. No HOHA CDI cases were deemed to be clearly avoidable.

Of the 29 CDI COHA cases reviewed, the average age of patients was 75.8 years with an age range of 17-98 years. 66% of cases were female and 34% male.

On average the time to onset of CDI post admission was 13 days. 82% of cases had had another previous admission with the prior 3 months.

3% of cases were deemed mild or moderate in severity. 6% of cases were classed as moderate/severe or severe. In the other cases severity could not be assessed. Of the 29 COHA cases 8 patients sadly died within 28 days of the CDI diagnosis. However in none of these patients was CDI thought to be the primary cause of death. All cases were treated appropriately with antibiotics active against *C. difficile*.

Two inconclusive cases were reviewed further, and the conclusion was made due to lack of full data as these patients had incomplete information which made it difficult to attribute the case as truly unpreventable. On further review, the balance would be that these cases were more on the unpreventable side.

The *C. difficile* COHA cases were reviewed in detail looking specifically at rates of recurrence, antibiotic usage and risk factors for diarrhoea, to identify learning themes.

Key findings from this analysis were:

- 34% of COHA cases had prior C. difficile infection or carriage.
- 24% of COHA were on laxatives at the time of sampling
- 72% of COHA cases were on a proton pump inhibitor (medications that have a known association with the development of CDI).
- 96% of COHA cases had received antibiotics in the past 3 months. Guidance/microbiology advice/ reasonable choice for the antibiotic prescribing occurred.

Overall, this data shows that there is no clear preventable cause to explain the majority of our COHA cases. Evidence for cross infection is minimal, where cases were reviewed further. The Trust is performing well in terms of antibiotic stewardship and adherence to guidance. However, there are areas of improvement identified regarding hand hygiene and cleaning, further investigation may be required into the high volume of prescription of PPIs. This pattern of increasing numbers of Trust associated CDI cases is not isolated to the RUH, and has also been reflected in increasing CDI rates regionally.

Emerging strain of virulent CDI in UK

Cases of CDI due to ribotype 955 (RT955) emerged in 2021 This emerging ribotype is closely related to the historic hypervirulent ribotype 027 (RT027). The new ribotype caused two large hospital outbreaks in the Midlands in 2023.

Since the emergence of RT955, the RUH has identified two cases which were detected on our Cepheid GeneXpert®, testing platform as an RT027. As required by UKHSA, these were sent for onward typing. One sample has returned as RT955, and this was reported during 2024/25.

The risk that has been on the risk register has now been closed, as we are not experiencing a high number of a new high virulent ribotype. All sample triggering as RT027 will continue to be sent to Leeds.

Period of Increased Incidence (PII)

As per the national *C. difficile* guidance (2013), periods of increased incidence (PII) are identified when two or more cases of *C. difficile* are reported on a ward within a 28-day period.

Review of CDI periods of increased incidence actions:

William Budd - 4 patients were included for review within this PII. Except for one, all investigations established that each infection outcome was unavoidable and no ribotypes matched.

One case was unable to be confirmed as unavoidable. It was noted that given the history of loose stool earlier in the admission, there may have been the opportunity to diagnose CDI earlier if present and treat more promptly. This may have prevented severe CDI. This patient died, with CDI a listed cause of death.

William Budd has an ongoing action plan because of this PII which is monitored closely by the division.

Pulteney ward - three patients were included for review. All investigations established that each infection outcome was unavoidable. Two samples went on for typing and did not match. The 3rd case included was that of a community patient and therefore unable to be processed for typing. It is worth noting though that this patient had recurring CDI and this was in fact their 3rd episode in recent months.

Charlotte ward - (first PII in July 2025) – two patients were included in this review, however as one sample was processed in North Bristol Trust (NBT), it was unable to be typed at the point the PII was triggered. Both investigations provided an unavoidable assessment for the infection outcome.

Charlotte Ward - (Second PII in October 2025), three patients were included in this review: all assessed as unavoidable infection outcomes. Ribotyping not completed.

Combe ward - two patients were included in this review; both infection outcomes unavoidable with differing ribotypes.

The Older Persons Assessment Unit (OPAU) - two patients were officially part of this PII (with a further two patients reviewed for assurance (these patients were not within the official 28-day window for consideration). All infection outcomes were assessed as unavoidable. Two ribotypes did match however, the latter positive patient was symptomatic prior to admission, with no recent Trust exposure.

There were three 005 ribotyping results; none of these patients had encounters that would connect them. Over the past three reporting years the table below clearly demonstrates 005 is becoming more common, alongside the variance in *C.diff* types over the years that we are seeing within our patient population.

Ribotyping results and evidence for cross-infection

The following areas have been identified as having two or more cases of *C. difficile* within 28 days throughout the year (Table 6):

Month of 25/26	Ward	Ribotype	Ribotype	Ribotype	Ribotype
April/May	William Budd	023	224	014	(GP)
April/May	Pulteney	005	018	(-)	
July	Charlotte	005	(-)		
October	Charlotte				
November	Combe	005	014		
November	OPAU	011	002	(127)	(002)

Table 6: Ribotyping results for Periods of Increased Incidence (PII) 2025/26

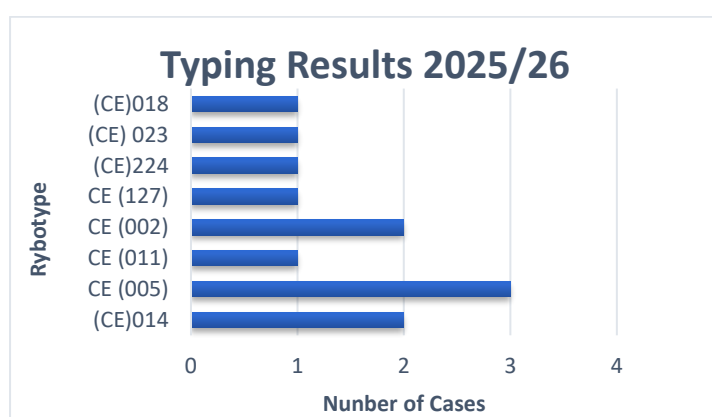


Table 7: RUH ribotyping 2025/26

Over the past three years, *C. difficile* ribotype 002 has been the predominant strain, demonstrating a sustained and increasing presence. Ribotypes 014 and 015 also recur across multiple years, consistent with endemic circulation (table 8).

The 2023/24 period showed the greatest ribotype diversity, with several single occurrences likely representing sporadic acquisition, while 2024/25 shows reduced diversity but increased clustering around established ribotypes. This could therefore suggest ongoing local transmission, rather than repeated new introductions and will be closely monitored going forward with the patient pathway reviews alongside the changes applied to cleaning.

Combined 3-year comparison (– = not detected that year)

Ribotype	2022/23	2023/24	2024/25	3 year total
002	2	4	5	11
014	2	–	3	5
015	–	4	2	6
023	1	2	1	4
05	3	1	1	5
011	1	1	2	4
054	1	1	1	3

018	1	1	–	2
106	–	1	2	3
207	–	1	–	1
430	–	1	–	1
871	–	1	–	1
029	–	1	–	1
271	–	1	–	1
062	–	1	–	1
202	–	1	–	1
046	–	1	1	2
064	–	1	1	2
181	–	1	1	2
126	–	–	1	1
050	–	–	1	1
107	–	–	1	1
021	–	–	1	1
955	–	–	1	1
127	1	–	–	1
224	1	–	–	1
076	–	–	1	1
Not grown / untyped	–	–	1	1

Table 8: RUH ribotyping 2023/26

Key improvements to implement during 26/27

- Embed revised cleaning standards throughout the Trust and the use of vapour cleaning to reduce the overall bioburden of infections
- Continue to embed cultural shift to support patient hand hygiene
- Continue to embed and promote gloves off where clinically appropriate
- Continue to closely monitor the Trusts usage of antimicrobials and ensure we are using them appropriately based on current best practice and guidelines
- Continue to work with partners regionally to better understand CDI risk factors locally and analyse data to determine current drivers causing increased rates of infection
- Continue the work around UTI prevention, catheter care and hydration
- Commence targeted work to improve peripheral cannula care

Criterion 2

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

Environmental IPC and Decontamination

The IPCC receives reports from the operational teams on cleaning, water, ventilation, and decontamination throughout the year. IPC are also active members of these operational meetings. A summary of each working group is detailed in this section.

Risk factors identified on the Trust risk register 2025/26 included:

- **Suboptimal ventilation in some of our clinical areas, including windows that open (with restrictors) or are unable to be opened for safety reasons.** This has been addressed during 25/26 with new window and openers fitted during 2026.
- **19% side room capacity across all adult services (excluding maternity services).** During 2025/26 five further side rooms have been designed all with ensuite toilet and shower facilities on B12. Two side rooms, with full ensuites have been built into the new Discharge Lounge and Medical Short Stay (MSS) have had two side rooms with full ensuite facilities added. Pulteney ward, three siderooms are being refurbished to include ensuite facilities, this will ensure all existing eight side rooms have suitable facilities to contain infections.
- **Limited bariatric side room capacity.** B12 has been redesigned to comprise of two bariatric side rooms, with full ensuites and one with bariatric hoist facilities. Further works needed in other areas to support need and demand.
- **Vacancies within the cleaning team, with challenges to deliver a full service to the organisation.** This has been addressed during 2025/26 and ongoing recruitment is being supported.
- **No access to hydrogen peroxide for deep cleaning services or any other enhanced cleaning services.** This has been addressed and the Trust are testing Hypochlorous acid (HOCl) vapour disinfection for post infection cleaning. There is a dedicated Rapid Cleaning team in place.

Cleaning

The Cleaning Standards Group (CSG) at the RUH was on hold for the majority of 2024 and early 2025 due to a restructuring of operational management. With the introduction of a senior cleaning lead and deputy manager completing the restructuring of the cleaning operational management the relaunch of the CSG took place in October 2025 to ensure compliance with the recently updated National Standards of Healthcare Cleanliness 2025.

This commitment aligns with Criterion 2 of the Health and Social Care Act, which emphasises the maintenance of a clean and suitable environment throughout the RUH premises. The CSG conducts meetings to evaluate cleaning standards, manage

action plans, and review cleanliness-related incidents. Operating under an approved terms of reference, the group reports to the Infection Prevention and Control Committee (IPCC) and the Safer Environment Group (SEG). These meetings involve participation from multidisciplinary stakeholders across the RUH.

Challenges

As with recent years the team continues to be met with considerable challenges. Staff absence rates and vacancy rates within the cleaning team, have hindered the team's ability to continually improve and build upon standards.

In the last few years, the scores from the technical auditing programme were inconsistent, indicating that the required cleanliness standards across the RUH were not consistently met. With the appointment of a senior cleaning lead in August 2024, it was quickly established that the rollout of the National Standards of Healthcare Cleanliness in late 2022 was not necessarily rolled out and implemented with the staff as effectively as it could have been.

Risk Management Measures

In response to these challenges, the team recorded this as a risk on Datix (the RUH risk register), scored at 16 - Datix ID 2398 – Cleaning standards in clinical and non-clinical areas – Infection Risk. This risk has an associated action plan that undergoes review at CSG meetings and the monthly Estates and Facilities (E&F) risk meeting to ensure it is kept current and progress is maintained. These challenges remain as a risk and therefore the existing Datix on the Trusts risk register remained and is scored at 16. A review of this risk took place in the spring of 2026 with most elements of the risk improving, although some remain a challenge, a new lower risk is due to be submitted in the summer of 2026

Following an external review of the Facilities Department. It was concluded in 2025 that an introduction of a new Facilities General Manager post and a new Associate Director of Facilities would improve on operational aspects of the division whilst improving the service of various departments.

Progress and Achievements

Despite the challenges, progress has been made in addressing these issues. Monthly staff meetings are now taking place across all shift patterns, some with 85% attendance rates. Recruitment has been ongoing throughout 2025 with over 40 new members of staff being recruited. Absence rates are being managed appropriately resulting in better engagement with HR, Unions, Occupational Health, and EAP. Cleaning Standards have been hugely improved due to the Audits being realigned into a blended approach, resulting in areas becoming more appropriate and allowing correct schedules and staffing levels matching an areas Cleanliness cleaning rating.

Author: Lisa Hocking, Deputy Director of Infection, Prevention and Control - Document Approved by: Jason Lugg Chief Nursing Officer Chief Nursing Officer & Director of Infection, Prevention and Control Agenda Item:	Date: 28/05/2026 Version: 1 Page 30 of 68
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Key improvements for 2025/26

Continual staff engagement was prioritised throughout 2025/26 with an electronic staff notice board being implemented within the department and monthly staff meetings for all shift patterns. The departments 2025 Staff Survey was a huge success with a record-breaking response rate of over 87%.

A realignment of the National Standards of Healthcare Cleanliness was introduced in summer 2025, which will moved away from the previous 'focused' approach to a 'blended' approach for the intention of improving the frequency of cleans in appropriate areas and allocating staff correctly in priority areas.

Driver measures for absences and vacancies remain in place whilst an on-going recruitment program to hire cleaners remain a high priority.

The primary goal for 2026/27 is to establish a workforce that meets the need of an ever-challenging service whilst maintaining a high level of staff engagement, improve cleanliness standards, and professionalise the service with operational standards being introduced.

Water Safety Group (WSG)

The Water Safety Group (WSG) of the Trust, which includes active participation from the Infection Prevention and Control (IPC) team, meets quarterly to discuss and manage water safety issues.

Over the past year, we have taken numerous proactive measures to ensure water safety. This includes conducting all necessary testing, monitoring, and remedials under Health Technical Memorandum (HTM) 04-01, Approved Code of Practice (ACoP) L8, and Health and Safety Guidance (HSG) 274, which have not highlighted any major concerns. We also reviewed the Trust's Water Sampling Plan and Legionella Risk Assessments to ensure their relevance and thoroughness. Staff training was implemented to reinforce aseptic sampling techniques and consider staff competency levels.

A challenge has been the ongoing positive *Pseudomonas aeruginosa* samples from Respiratory Ward; Estates commissioned an independent Environmental microbiologist to carry out a full *Pseudomonas aeruginosa* risk assessment of the ward from which a full action plan has been developed. This has included a recommendation to fully re-pipe the water system in the Respiratory Ward.

Improvements implemented

- Regular Estates IPC audits of areas to identify issue that could lead to Water safety issues, these are done on a weekly basis.
- Improvement in the Estates and IPC cooperation, completing the High-Count response documentation.
- All Estates staff working on the water system have had water awareness training.
- All records have been migrated on to the Trust Share point.
- The Trust water safety plan has been updated.
- Removal of little used sinks in NICU to proactively control the pseudomonas risk.

Ventilation Safety Group (VSG)

Throughout the past year, the Ventilation Safety Group (VSG) of the Trust, with active members from the Infection Prevention and Control (IPC) team, has completed all necessary monitoring, testing, verifications, and inspections. The Trust annual AE audit for Specialist Ventilation has been carried out, and the Trust continues to make improvements in regard to the management of specialist ventilation systems on site.

There is a risk associated with the age of the air handling units serving critical areas, such as the main theatres, which are approximately 40 years old and were deemed end-of-life 20 years ago. There were also key risks related to Magnetic Resonance Imaging (MRI) AHUs not being treated as critical systems, potentially leading to nosocomial transmission due to a lack of mechanical ventilation. The team also faced difficulties with new staff members becoming familiar with complex specialist ventilation systems and dealing with outdated systems that are not compliant with current Health Technical Memorandum (HTM) standards.

A challenge for the team has been getting contracts through the system this has resulted in a delay to some AHU's being verified, as a stop gap individual purchase orders to carry out works have been authorised.

Key improvements for 25/26

The Estates team plan to continue addressing actions from annual verifications of AHUs, to enhance resilience for ventilation systems through additional Competent Persons training and develop a user and operator list to ensure proper management of critical ventilation systems.

The Estates and IPC team have continued to use the Ventilation Verification Failure document this continues strengthen the process for failed verifications, ensuring users

Author: Lisa Hocking, Deputy Director of Infection, Prevention and Control - Document Approved by: Jason Lugg Chief Nursing Officer Chief Nursing Officer & Director of Infection, Prevention and Control	Date: 28/05/2026 Version: 1
Agenda Item:	Page 32 of 68

are immediately made aware of the reasons for failure so that a multi-disciplinary risk assessment can take place to determine if the system can continue being used.

Future recommended actions include addressing verification actions and AE Audit actions, training new starters, and updating Datix. This has improved the transparency to the Trust when a ventilation issue occurs.

The Magnetic Resonance Imaging (MRI) AHUs are now being treated as critical systems and are subject to annual verification.

Decontamination of Medical Devices

Central Decontamination

Sterile Services (SSD) is accredited to BS EN ISO 13485:2016 and registered with the Medicines and Healthcare products Regulatory Agency (MHRA) for the assembly, supply and distribution of sterile packs and instrument sets for hospitals and other health care related establishments. SSD re-manufactures procedure packs, single instruments and theatre sets using the items which are mutually compatible and used in accordance with manufacturer’s instructions and users requirements – to meet the provisions of Regulation 14, clause 1 (points a & b) of the Statutory Instrument 2002 No. 618, Medical Device Regulations 2002, as amended and are in conformity with the UK designated standards BS EN ISO 13485:2016, BS EN ISO 14971:2019, BS EN ISO 14644-1:2015. The items are thermally disinfected and will be sterilised in accordance with Health Technical Memorandum (HTM) 01-01 guidelines.

Currently SSD supplies to 73 locations – internal & external to RUH. During 2025-26 SSD process 276,489 items which includes 2,875,221 instruments.

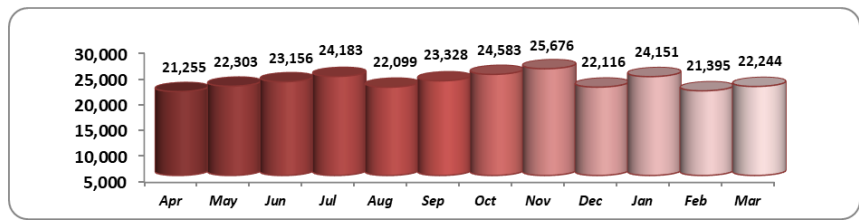


Figure 25: Surgical instrument sets processed per month 2025-26

SSD also provides a comprehensive decontamination services to various Service Users for re-useable heat sensitive flexible endoscopes. High level disinfection service for flexible endoscopes is managed by SSD in accordance with the BSG Guidelines for Gastrointestinal Endoscopy and HTM 01-06.

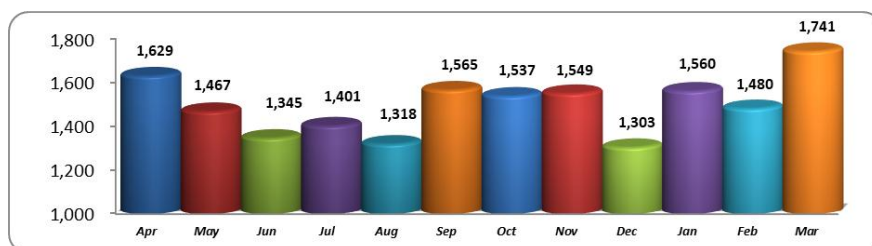


Figure 26: Endoscope processed per Month 2025-26

Trust Decontamination Manager attends and provides quarterly update reports to the IPCC regarding overall Trust compliance with decontamination requirements. The Decontamination Committee meets quarterly and provides assurance to the Health & Safety Committee and the IPCC and report key messages and risks.

Local Decontamination

SSD & IPC team are working with rest of the clinical colleagues to improve the local decontamination standards. Addressing pitfalls mainly on documentation (policies, SOPs, risk assessments & training records) is very important to give assurance on patient safety. ENT OPD is using Tristel Trio to disinfect non-lumened nasendoscopes between the procedures. Eye OPD is following Moorfields Eye Hospital NHS Foundation Trust's SOP to decontaminate contact lenses; as per the SOP, the lenses are being cleaned with detergent wipes. This is being done by the consultants after they have seen the patient in the individual clinic rooms. Transoesophageal Echocardiography Probes (TOE) are cleaned with Tristel Trio system and traceability records are in use, and stored in dedicated storage cabinets. Gynae OPD and Antenatal are using Tristel Duo to decontaminate their TV probes.

The Decontamination Committee meets quarterly and provides assurance to the Health & Safety Committee and the IPCC and report key messages and risks.

Criterion 3

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

Antimicrobial stewardship (AMS)

Antimicrobial resistance is a global public health threat. The UK has responded to this with a series of national action plans and by carrying out national surveillance of antimicrobial resistance. There are key aims around reduction of inappropriate antibiotic use, specifically broad-spectrum antibiotics. AMS activities within the trust are briefly outlined below.

Staff update

The trust has a clinical lead position for AMS which is currently held by one of the Trusts consultant microbiologists. There is also a trust lead antimicrobial pharmacist, who has support from a rotational clinical medicines' optimisation pharmacy technician 0.2 WTE.

Antimicrobial Stewardship Activities

AMS Activities	Description
Committee	Quarterly meetings, report to IPCC and Medicine Assurance Committee. Membership has been expanded to include representation from areas of high consumption including: • Respiratory • Acute medicine • General Surgery • OPU • Trauma and Orthopaedics There is a ratified antimicrobial stewardship policy in place which sets out the governance structure for AMS and defines roles and responsibilities. Standing items on the agenda discussed quarterly include Trust antimicrobial compliance audits, the Trust's consumption of antimicrobials, AMS e-learning compliance, patient safety incidents related to their use, quality improvement and research initiatives and new additions to the drug formulary. Issues The group has not had a consistent chairperson since the previous medical director left the trust. Going forward; Dr Alan Cordey will chair the meetings with senior support provided by the deputy medical director.
AMS Rounds	Microbiology rounds occur on a regular basis. These include: - ITU – daily visit weekdays

	Staphylococcus aureus bacteraemia weekly reviews Complex patient review – weekly OPAT virtual round – weekly Carbapenem reviews – weekly Monthly prosthetic joint infection meetings MAU MDT – weekly weekly MDT/AMS round on William-Budd AMS rounds on Parry and Pulteney ward based on antimicrobial compliance audit data and complexity of patients on these wards
<i>C. difficile</i>	Weekly reviews by Consultant Microbiologist. Contribution to RCAs, data on potential causative antibiotic trends, primary care feedback of non-guideline use of antibiotics.
Regional	BSW AMS network South West antimicrobial pharmacist network HCAI collaborative workshops BSW CDI task group
Training	Training is regularly delivered to relevant clinicians by either the microbiology consultants or the AMS pharmacist. Regular recipients of teaching include: Pharmacy team FY1 doctors FY2 doctors IMT doctors & medical registrars Surgical junior doctors Primary Care teaching Medical Nurse practitioner teaching MAU team
Audit	Trustwide compliance audit performed quarterly by AMS pharmacist and fed back to divisional and governance leads as well as antimicrobial stewardship group members. The data is also discussed quarterly at the IPCC meetings. Areas of good performance are ranked in top 3 and celebrated. Carbapenem review – 1x per week Antimicrobials missed doses audit now carried out quarterly.

	ED antibiotic use audit National Patient Safety Alert: Harm from incorrect recording of a penicillin allergy as a penicillamine allergy Antimicrobials IVOS/plastic waste audit carried out in December 2024 Datix review of antimicrobial incidents carried out quarterly
Guidelines	There are comprehensive antimicrobial guidelines available on the trust intranet and on Eolas. These are updated regularly to try and achieve the correct balance between offering appropriate treatment of infections and maintaining AMS goals. They are designed to ensure they are in line with new national guidance and take into consideration local <i>C. difficile</i> infections and resistance patterns. Within the past 2 years many of these guidelines have been updated to ensure they are current and offering the best guidance to our clinicians. Several other guidelines are also currently undergoing review and this is an ongoing process which will continue going forwards. Paediatric guidelines – for full review and update in 2026, including paediatric IVOS. Adult guidelines – updated throughout the year
Safety	Review of OPAT prescribing processes, clinical governance and structure ongoing.
Comms	World Antibiotic Awareness Week Nov 2026 Antimicrobial Stewardship Newsletter quarterly Updated guidelines highlighted on staff brief and emailed to AMS group members for dissemination to teams

Table 8: Activities of the Antibiotic Stewardship Team

Antibiotic Consumption

The Antimicrobial Stewardship (AMS) team continue to monitor antibiotic consumption across the trust using Defined Daily Doses (DDDs), an internationally recognised measure of antimicrobial use. A DDD represents the average daily maintenance dose of a drug used for its principal indication in adults.

Antibiotic consumption data are reported quarterly, reviewing both total antibiotic use and consumption within specific antimicrobial classes. An overall increase in antibiotic usage has been observed over recent years. This is likely related to changes in patient demographics, particularly an increase in the number of older patients, who often have multiple comorbidities and a higher clinical need for antibiotic treatment.

Despite increased overall consumption, the trust continues to demonstrate good antimicrobial stewardship practice in key areas. Use of narrow-spectrum ‘Access’ antibiotics remains appropriate, and carbapenem usage—a marker of broad-spectrum antibiotic exposure—remains below the national average for England. Carbapenem prescribing is closely monitored due to its association with antimicrobial resistance.

The AMS team will continue to monitor prescribing trends and provide regular feedback to clinical teams.

Antibiotic Prescribing Compliance

A quarterly antibiotic compliance audit is conducted by the AMS pharmacist and reviewed by the Antimicrobial Stewardship Group (ASG). This audit evaluates compliance with trust antimicrobial prescribing guidelines.

Audit outcomes are reported to the ASG and the Infection Prevention and Control (IPC) Committee. Results are shared with divisional and specialty clinical governance leads, who are responsible for cascading findings within their areas and supporting any required actions. Key themes, including areas of good practice and improvement opportunities, are reviewed at ASG meetings to drive continued improvement in antimicrobial prescribing.

	Q1 2024/25	Q2 2024/25	Q3 2024/25	Q4 2024/25	Q1 2025/26	Q2 2025/26	Q3 2025/26	In comparison to Q2:
Compliance with guidelines	94%	95%	92%	95%	96%	92%	97%	Compliance with guidelines has increased in Q3
% with ARK decision on initiation	87%	87%	84%	83%	83%	86%	86%	ARK decision on initiation has remained stable
% review by 72 hours	75%	82%	97%	95%	99%	97%	98%	Review by 72 hours has remained stable
Average compliance	85%	88%	91%	91%	93%	92%	93%	Average compliance has remained the same overall

Figure 27: quarterly antibiotic compliance audit results

(a) Total Antibiotic Consumption

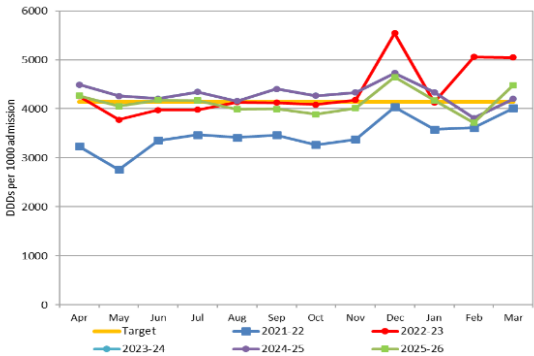


Figure 28: Total antibiotic consumption 2025/26

(b) Carbapenem Consumption

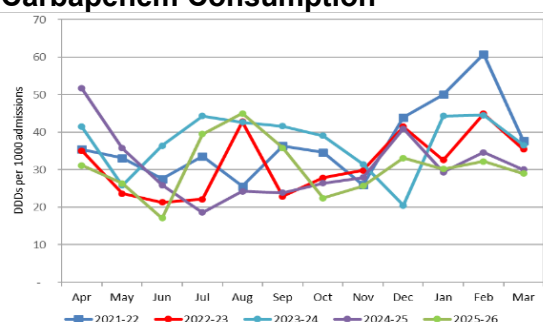


Figure 29: Total Carbapenem consumption 2025/26

(c) Access Group

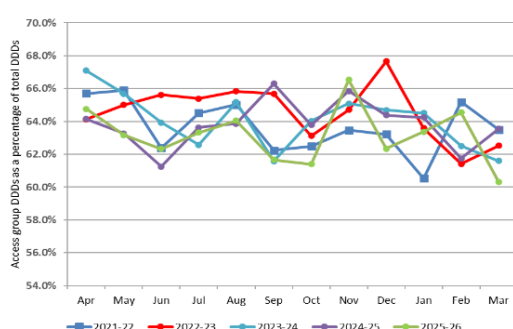


Figure 30: Access group antibiotic consumption 2025/26

(d) Broad Spectrum prescribing from Watch and Reserve

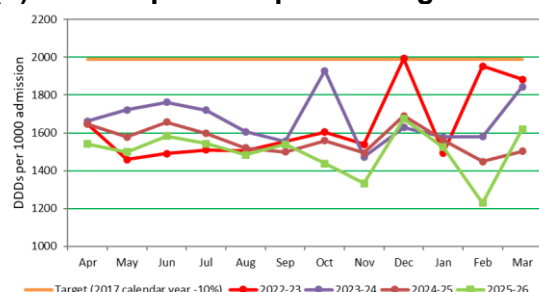


Figure 31: Watch and Reserve group antibiotic consumption 2025/26

Broad Spectrum Prescribing

Although there is no formal national target, a further reduction in broad-spectrum antibiotic prescribing has been achieved year on year.

Average broad-spectrum antibiotic consumption decreased from 1,575 DDDs per 1,000 admissions in 2024/25 to 1,501 DDDs per 1,000 admissions in 2025/26, demonstrating continued improvement in prescribing practice. The RUH remains the

lowest user of broad-spectrum antibiotics in the BSW region, reflecting the effectiveness of local antimicrobial stewardship interventions.

Broad-spectrum prescribing continues to be closely monitored. Ongoing education is provided to prescribers and pharmacists, and AMS ward rounds are undertaken to ensure antimicrobial choices are clinically appropriate and that course durations are minimised in line with best practice and trust guidance.

Education and Training

Antimicrobial stewardship education is embedded within the trust's mandatory training framework through completion of AMS Level 1 and Level 2 e-learning modules, including the ARK (Antibiotic Review Kit) toolkit. These modules support safe, evidence-based antimicrobial prescribing and review.

Training Compliance

- AMS Level 1: 99.3% (Target ≥85%)
- AMS Level 2: 79.16% (ARK completion is a prerequisite)

To address the lower compliance with AMS Level 2, a review of staff training allocations has been undertaken. A list of staff requiring access to the training has been requested, alongside identification of non-compliant staff. This information can be shared with divisional leads to support targeted follow-up and improved compliance.

In addition, the AMS pharmacist and microbiology consultants deliver regular face-to-face teaching sessions covering core AMS principles to a range of clinical staff groups across the Trust.

Specialist pharmacists and microbiology consultants also undertake regular stewardship ward rounds in areas with high antibiotic usage, including:

- Daily ward rounds in ITU
- Weekly rounds on Pulteney and Parry wards

They also contribute to:

- Weekly OPAT antimicrobial review meetings
- Monthly orthopaedic prosthetic joint infection MDT meetings

These activities provide clinicians with regular, direct specialist support to optimise antimicrobial decision-making.

Antimicrobial stewardship at the RUH is integral to improving prescribing quality, protecting individual patients and the wider population from harm associated with inappropriate antibiotic use (including healthcare-associated infections), and contributing to efforts to slow antimicrobial resistance.

Antimicrobial Stewardship Governance and Future Priorities

The Trust is committed to adhering to national AMS principles, including those outlined in the Department of Health guidance “Antimicrobial Stewardship: Start Smart – Then Focus”, alongside the requirements set out in NICE NG15 and the UK 5-year and 20-year action plans on antimicrobial resistance (AMR). The Trust will also align with any new national AMR action plans or guidance published in 2026 and beyond, ensuring local practice remains consistent with national expectations.

Microbiology consultants play a key role in delivering AMS on a daily basis by providing expert clinical advice on infection management for patients within the trust, as well as supporting primary care colleagues through telephone and email advice to local GPs. All advice provided incorporates core AMS principles, ensuring appropriate antimicrobial choice, dosing and duration. This stewardship approach is also embedded within microbiology reporting, where recommended antimicrobial treatments for positive clinical samples align with trust guidance and AMS standards.

Looking forward, the trust will continue to closely monitor antimicrobial usage and promote appropriate prescribing in line with current best practice and evidence-based guidelines. This will be supported through the ongoing stewardship activities described within this report, including surveillance, audit, education, ward-based review and multidisciplinary collaboration.

The principal risks to the continued effectiveness of AMS include workforce capacity and protected time, particularly ensuring that relevant clinical staff have sufficient opportunity to review antimicrobial prescribing, participate in stewardship ward rounds, and attend key governance meetings where AMS issues are discussed. These risks will continue to be monitored, with mitigation actions escalated through established governance routes as required.

Criterion 4

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

Provision of Information

The IPC team have continually reviewed and provided staff briefing alerts and standard operating procedure for staff to new and emerging infections, this year there has been a continued focus on our Measles preparedness and response alongside meningitis, due to the Kent outbreak in early 2026.

Staff have been supported by action response cards for new and emerging infections, including our response to a High Consequence Infectious Diseases (HCID) and Viral Haemorrhagic Fever (VHF). This has been a collaborative piece of work with Estates and Facilities alongside front door staff. As a result of this work, we have also been able to redesign a more suitable area to place patients and support staff safety.

The IPC team work closely with the three Divisions on visiting and supporting access to patients with infections or exposure with informed choice. This includes assessing the risk of potential nosocomial transmission with compassion and use of personal protective equipment (PPE) as appropriate.

There is a variety of patient information leaflets and links to website information on infections, including HCAs.

The IPC nurses provide patient-facing interactions with patients with infections especially *C.diff* and CPE to explain diagnosis and provide specialist support.

Criterion 5

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

IPC Policies

All Infection Prevention and Control (IPC) policies remain in place and continue to be reviewed in line with the Trust's policy review standards. During the year, significant updates were made to the Carbapenemase-Producing Enterobacterales (CPE) policy, ensuring that Trust practice is now fully aligned with UKHSA guidance. These changes are expected to enhance patient experience and improve operational efficiency by enabling side rooms to be released more quickly following completion of screening and receipt of results.

The Viral Haemorrhagic Fever (VHF) Policy was also updated, incorporating key learning identified during the management of a potential infectious patient earlier in the year. These revisions strengthen the Trust's preparedness and reinforce safe and effective practice.

Standard Operating procedure and Guidance :

- Eye Department Gonio Standard Operating procedure (SOP)
- Panton-Valentine Leukocidin (PVL) SOP
- COVID isolation flow chart
- Cold Sore SOP (New)
- Post infection cleaning requesting guidance

Policies:

- Management of diarrhoea and vomiting Trust Policy
- Meticillin Resistant Staphylococcus Aureus (MRSA) Policy (Screening and decolonisation)
- Standard Infection Control Precautions: National Hand Hygiene and Personal Protective Equipment Policy
- Clostridioides difficile Trust Policy
- Confirmed/suspected Influenza Policy
- Viral Haemorrhagic Fevers (VHF) Policy
- Carbapenemase-Producing Enterobacterales (CPE) Trust Policy
- Antibiotic Resistant Micro-organisms Trust Policy
- Animals and Working Dogs in the Healthcare Setting Trust Policy
- Trust Decontamination policy

Infection Prevention and Control Surveillance Software

The RUH continues to use ICNET, which is a specialised, real-time clinical surveillance software by Baxter Healthcare designed for infection prevention, control. The IPC team review the reports each day and add any alert flags to the electronic patient records (EPR). This allows for appropriate management of infectious or potentially infectious patients in real time. To reduce the risk to staff, patients and service users as part of the admission risk assessment.

There is a known gap with the current Millenium EPR package we have that does not interface with the CapMan system used for patient flow. This mean IPC alerts are not automatically transferred to the patient records. This is impacting how patients are identified as being at risk if staff miss the Millenium alert. The Shared EPR aims to resolve this gap, which the role out was delayed until 2027.

Gloves Off Campaign

In response to the ongoing increase in non-sterile glove use across the organisation, the *Gloves Off* quality improvement programme has been successfully implemented in thirteen areas of the Trust. Having now reached its initial improvement capacity, the programme will move into the next phase and be expanded using a structured spread methodology.

Excessive use of non-sterile nitrile gloves places significant pressure on environmental resources and contributes to avoidable waste. Some of this use is driven by concerns about infection risk and a perception that gloves offer a “safe default.” The campaign addresses these behaviours proactively by increasing staff knowledge, building confidence, and reinforcing evidence based decision making about when glove use is clinically necessary.

A clearer understanding of the environmental impact of glove production and disposal along with the social impact on the global workforce involved in their manufacture has further highlighted the importance of this initiative. The *Gloves Off* programme continues to support more sustainable, safe, and person-centred care across the Trust.

Infection Prevention and Control Incidents and Learning

The IPC estates work has continued to slowly increase the number of isolation facilities with ensuite services during 2025/26 and add ensuites within bays. Whilst his work has not increased the overall number of isolation rooms for use, this remains at 19%, the current facilities are much improved. 72% of our single rooms now have their own

toilet with 49% also having a shower. This reduces the risk of infection spread throughout the wards as infectious patients are not sharing toilet facilities with other patients.

Norovirus Outbreaks

Norovirus is a highly transmissible virus. Individuals are most infectious when symptomatic but remain infectious both before developing symptoms and after symptoms have stopped. Norovirus can be transmitted person-to-person and via contaminated surfaces, objects or food, especially within a healthcare environment. Diarrhoea, stomach pain and projectile vomiting typically begin 12-48 hours after exposure to the Norovirus infection and often comes with other common viral symptoms such as high-temperature and joint pain.

The RUH completes Norovirus testing on all stool samples taken from inpatients (in line with best practice), so there are consistent cases detected throughout the year. It should be noted that isolated cases do not necessarily develop into outbreaks of infection on our wards.

The rates of norovirus caused significant operational disruption this winter, particularly during the month of February. Norovirus was contained by closing bays and complete wards as and when required.

Ward Closures

During this reporting period, six ward closures were implemented to manage and reduce risks to patient safety. This is comparable to the previous reporting year (table 9). These ward closures resulted in 132 lost bed days, with bays closed for a total of 55 days, significantly impacting new admissions and overall patient flow.

The longest single ward closure lasted 20 consecutive days, during which the ward was designated as a cohort area to support ongoing community admissions and control transmission (table 10). This had a notable impact on both patient and staff experience, with a high number of patients requiring transfer or discharge to facilitate the admission of new infectious cases. The same ward required a subsequent closure of this area for a further 12 days for cohort reasons.

Norovirus continues to have its greatest impact on older persons' wards, highlighted in bold in table 10 below. The presence of mobile patients with infection who also have cognitive impairment presents a significant challenge to effective infection prevention and control. To protect this highly vulnerable patient group, the IPC and ward teams implement ward closures when two or more cases are identified. While this approach is necessary to limit transmission, it is recognised that such measures can lead to delays in discharge to care facilities for exposed patients, reflecting

ongoing concerns regarding the risk of onward spread and the varying capacity of receiving settings to maintain isolation precautions.

Reporting Year	2022/23	2023/24	2024/25	2025/26
Number of ward closures for Norovirus	4	5	6	6

Table 9: Ward closures due to Norovirus: 2022 - 2026

Month	Area	Days closed	Bed days lost
Jul-25	Pierce	2	11
Feb-26	ASU	8	13
Feb-26	Waterhouse	20	29
Feb-26	Combe	9	23
Feb-26	Cardiac	4	11
Mar-26	Waterhouse	12	45
		55	132

Table 10: Ward closures 2025/26

Outbreaks with bay closures

There were 15 bay closures due to Norovirus outbreaks during the year with a total of 226 lost bed days (empty beds within closed bays that could not be safely used).

There was an additional 36 bays closed due to exposure over 54 days (and the positive patient being isolated once the infection was identified), this resulted in a further 78 lost bed days to new admissions.

The Older Persons Unit, Short Stay (OPUSS), experienced seven episodes of outbreaks and bay closures. This is partly due to the type of patient this ward admits and the layout of the ward, which comprises of large open bays with nine beds in each bay, which impacts outbreak management, and lost bed days to be able to regain control and maintain patient safety.

Table 11 below outlines the impact of the number of days bays were closed and bed days lost as a total each month because of Norovirus.

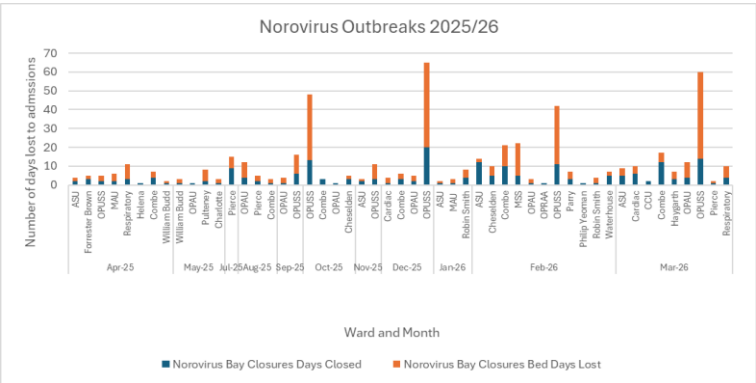


Table 11: Norovirus Outbreaks and Exposed bays during 2025/26

COVID-19

COVID-19 activity was broadly stable across 2025/26, and numbers were lower than similar times the year before but continued to place considerable pressure on the available isolation facilities during September and October particularly.

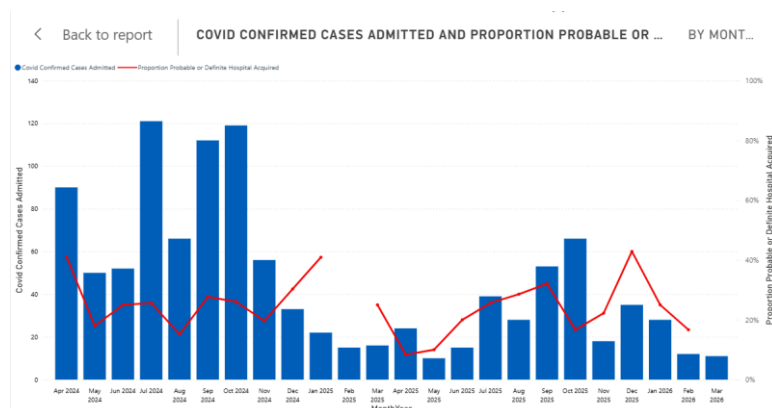


Figure 32: COVID-19 positive case numbers admitted to the RUH with an infection and positive cases identified while receiving healthcare 2024-2026

The vaccination programme continued to be provided in both spring and autumn for the elderly and vulnerable population, with healthcare workers were offered and boosters in the autumn of 2025. The Trust is commissioned to vaccinate inpatients, so that patients are not missing important vaccinations. This was provided by a small group of staff trained to vaccinate patients.

COVID Ward Closures and COVID-19 Outbreaks 2025/26

There were seven COVID Ward Closures during 2025/26, with a total of 50 lost bed days to new admissions.

Cheseldon ward, due to the ward layout has a low threshold for remaining open to new admissions when a patient develops COVID. This risk will be reduced as the ward refurbishments are fully completed.

Month	Area	Days Closed	Bed Days Lost
Apr-25	Cheselden	2	0
May-25	Cheselden	2	2
Jul-25	Cheselden	5	10
Jul-25	Combe	3	15
Sep-25	Cheselden	5	8
Dec-25	Waterhouse	4	10
Jan-26	Cheselden	3	5
		24	50

Table 11: COVID ward closures 2025/26

The impact of COVID across the Trust

There were 15 bays affected by COVID outbreaks, resulting in 86 days of closures and 67 lost bed days. There was a further 22 bays affected by exposures to COVID positive patients, over 41 days and 45 bed days lost.

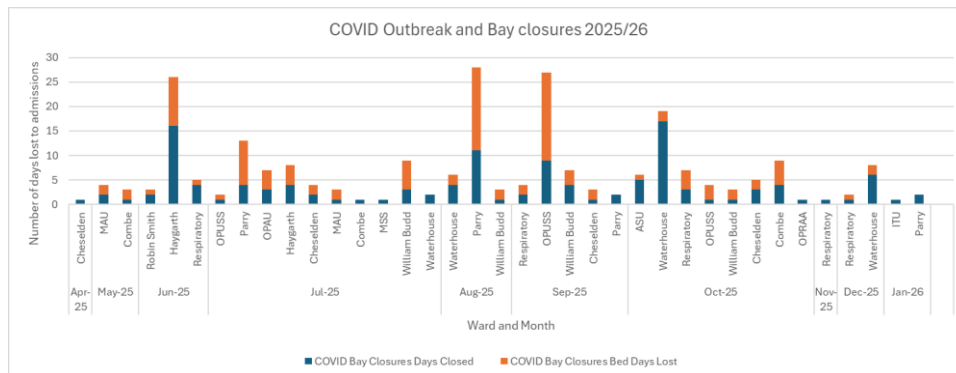


Table 12: COVID-19 bay and ward closures due to outbreaks 2025/26

Although the numbers above do not show levels of COVID that has been experienced over previous years, the pressures of bay closures have remained the same and have impacted as much as previous years, this is compounded by the low number of single rooms within the adult inpatient bed base, and the ability to segregate multiple infections at the same time.

Influenza

The RUH detected 686 cases of influenza (flu) during the year of 2025/26, 69 cases were 17 years old or under, compared to 730 cases in total and 87 children in the previous year (2024/25). There was a total of nine intensive care admissions due to influenza this reporting year, compared to five the previous reporting year.

At the beginning of November 2025, The UK Health Security Agency (UKHSA) alerted healthcare systems that influenza (flu) was already circulating and 2025 was going to be a particularly early flu season.

The first RUH bay and ward closures occurred in November, with Waterhouse ward being closed for five days initially, although the total flu numbers were still quite low at 74 cases. December 2025 saw a significant rise in influenza cases, when 248 cases of influenza A were detected.

January 2026 saw a further 167 detected cases (table 11) of Influenza A and 1 case of Influenza B. During this month, Waterhouse remained closed to non-flu admissions for an extended period as it was utilised as a cohort area, with only 12 lost bed days during this period.

During February there were 94 cases and 1 flu B. March saw the case rates rapidly decrease to 15, with little influenza B circulating all season.

FluType	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026	Mar 2026	Total
	0	0	0	0	0	0	0	0	0	0	0	0	0
Flu A	5	13	2	4	1	7	46	72	248	166	93	14	671
Flu B	8	1	0	1	0	0	0	2	0	1	1	1	15
Total	13	14	2	5	1	7	46	74	248	167	94	15	686

Table 13: Recorded Influenza numbers 2025/26

As in the previous year (2024/25), influenza transmission to exposed patients was generally slower than anticipated, with symptom onset typically expected within 3–4 days. However, during this period a proportion of patients became positive more than five days after exposure, and symptom duration frequently exceeded seven days. This extended incubation and recovery period resulted in delayed bay re-opening and necessitated changes in clinical practice to support effective infection prevention and control across the Trust.

The Trust continues to face challenges in identifying positive patients and implementing timely isolation on a 24-hour basis. Limitations in capacity restrict the rapid containment of communicable diseases, particularly during peak seasonal periods when respiratory viruses are more prevalent. Addressing these constraints remains a priority. Key initiatives include increasing the availability of single side rooms with en-suite facilities and extending laboratory testing capacity and operating hours, to strengthen infection prevention measures and maintain a safe environment for patients and staff.

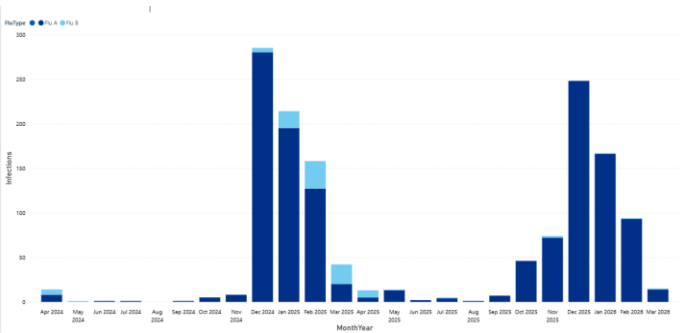


Figure 33: RUH Influenza positive case data 2024-26

The UKHSA data below shows the national overall influenza hospital admission rates per 100,000 trust catchment population, reported through SARI Watch sentinel surveillance, England. (figure 34).

This chart shows the early flu season commencing at the start of October which was out of character for previous seasons. The winter 2025 peak of influenza was during December. This data supports the activity that was seen in the Trust as our peak activity was during December with 248 cases.

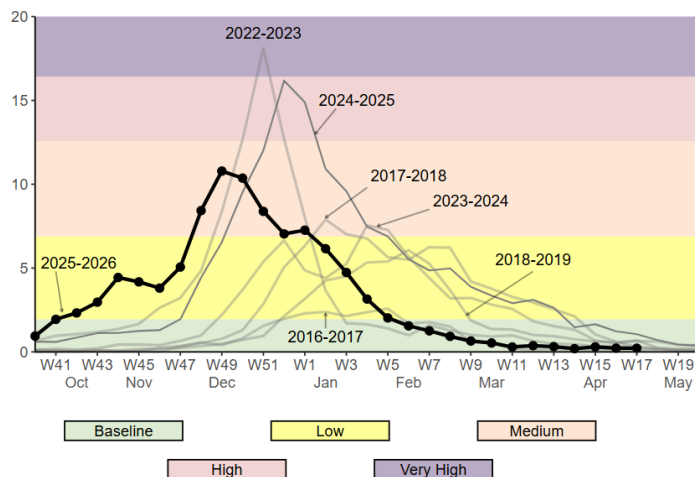


Figure 34: Hospital admission October 2025 - May 2026

Ward Closure impact for COVID, Norovirus and Flu (excluding bay closures)

Key: ☒ = infection present that month, — = no closures recorded

Month	COVID	Norovirus	Flu	Overlap Summary
Apr-25	☒	—	—	COVID only
May-25	☒	—	—	COVID only
Jul-25	☒	☒	—	COVID + Norovirus
Sep-25	☒	—	—	COVID only
Nov-25	—	—	☒	Flu only
Dec-25	☒	—	—	COVID only
Jan-26	☒	—	☒	COVID + Flu
Feb-26	—	☒	☒	Norovirus + Flu
Mar-26	—	☒	—	Norovirus only

Table 14: Ward closures and infection identified April 2025 - March 2026

Summary Insight

- COVID ward closures were spread across the year, peaking in July 2025.
- Norovirus showed a strong winter surge, particularly February 2026.
- Flu closures have overlapped the winter pressure months.
- January and February 2026 stands out as the most severe combined impact month, with multiple norovirus outbreaks and influenza activity.

NHSE Southwest Visit February 2026

During February 2026, the Trust was managing a significant and sustained outbreak of Norovirus and Influenza, prompting an Infection Prevention and Control (IPC) support visit from NHS England South West in February 2026. The visit focused on outbreak management, operational pressures, and estate related constraints that are limiting the Trust's ability to contain transmission effectively. The combined impact of these infections was placing considerable strain on patient flow, bed availability, and isolation capacity.

A major theme throughout the visit was the challenge posed by the hospital's estate. The Emergency Department (ED) has only one side room, and the wider hospital layout includes multiple entry points and Nightingale-style open wards with large bay's of 9–13 beds. These environments significantly limit the ability to isolate infectious patients and prevent cross-transmission. Additional issues include limited bariatric appropriate isolation rooms and delays in transferring patients to community hospitals, both of which contribute to prolonged bed closures and reduced flow.

Operational pressures were further intensified by unprecedented demand: approximately 100 ambulance arrivals and 300 emergency presentations per day. Corridor queueing of up to eight patients had become necessary: an approach not previously used by the Trust.

The IPC team were reported to be highly engaged, working closely with clinical site management, using electronic bed-flagging systems, isolation prioritisation tools, and daily outbreak monitoring. However, limitations in estate design, insufficient side rooms, and challenges in cohorting, particularly for patients with dual infections or those outside age-specific wards continue to restrict the Trust's ability to manage outbreaks efficiently.

Overall, the report concluded the Trust is demonstrating strong IPC leadership and operational commitment, but structural and capacity constraints are significantly impeding outbreak control and require strategic investment and system level support.

Surgical Site Infection Surveillance (SSI)

Trauma and Orthopaedic SSI Surveillance

At the RUH in terms of SSI surveillance we currently submit 3 categories to UKHSA. These being Total Hip replacement (THR), Total Knee Replacement (TKR), and Fractured Neck of Femur (NOF).

The number of operations being performed has fluctuated throughout the year. With both SOC and winter pressures having an impact. Due to medically suitable patients being diverted to Sulis Orthopaedic Centre (SOC) this has resulted in a consolidation of surgically and medically complex patients being operated on at the RUH. With 60% of our patients having an ASA score of 3, as opposed to the national average with only 20% having an ASA score of 3. Nearly 40% of patients between Jan-March 2025 were revisions as opposed to the national average of less than 4% in the same time period. These patients inherently carry more risk.

Our quarterly submission run as per the calendar year and are submitted three months in arrears. Our most serious infections, i.e. joint space and deep infections are generally reflected in the inpatient/readmission category of the report. The data presented is for the entirety of 2025.

Total Hip replacement

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2025 Q1	69	1	1.4%	1	1.4%	2	2.9%
2025 Q2	64	0	0.0%	0	0.0%	0	0.0%
2025 Q3	54	1	1.9%	0	0.0%	2	3.7%
2025 Q4	40	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 15: UKHSA SSI data for RUH Total Hip Replacement

In Q1 (Jan-March) and Q3 (July-September) we had one readmission due to infection. These were both classed as deep incisional infections. These patients were both revisions. The national average for readmission/inpatient is 0.2%-0.5% with an all SSI average of 0.7%. UKHSA class the RUH as being low sample size and therefore our results in terms of outlier are averaged over 4 quarters instead of a single quarter. This gives us a result of 0.8% for inpatient/readmissions. We are statistically very much affected by our low sample size and also the complexity of our case mix.

Total Knee replacement

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2025 Q1	30	0	0.0%	0	0.0%	1	3.3%
2025 Q2	25	0	0.0%	1	4.0%	1	4.0%
2025 Q3	28	0	0.0%	1	3.6%	1	3.6%
2025 Q4	35	0	0.0%	0	0.0%	0	0.0%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 16: UKHSA SSI data for RUH Total Knee Replacement

There have been no readmission/inpatient infections in 2025 following a TKR. The Trust have had some patient reported and superficial infections in this category, along with some slow healing and dressing adverse reactions. The Trust has an average of 2.7% in the All SSI category as opposed to the national average of 0.8%. However, this is again reflective of our very low sample size and complex case mix.

Fractured Neck of Femur

Table 3: Trends in rates of SSI by surveillance period at your hospital

Year and Period	No. operations	Surgical Site Infection					
		Inpatient & readmission		Post discharge confirmed		All SSI*	
		No.	%	No.	%	No.	%
2025 Q1	120	1	0.8%	0	0.0%	2	1.7%
2025 Q2	126	1	0.8%	0	0.0%	2	1.6%
2025 Q3	128	2	1.6%	0	0.0%	2	1.6%
2025 Q4	124	1	0.8%	0	0.0%	1	0.8%

*All SSI = Inpatient & readmission, post-discharge confirmed and patient reported

Table 17: UKHSA SSI data for RUH Fracture Neck of Femur

This category consists of our hemiarthroplasty, dynamic hip screw, and cannulated screw patients. It does not contain any patients having intramedullary (IM) nailing. These patients will be covered from 2026 in a new surveillance.

All four quarters of 2025 have had one joint space SSI reflected in inpatient/readmission. Q3 reflects two patients in terms of inpatient/readmission. There was one joint space SSI plus one superficial SSI occurring at the inpatient level in this quarter.

The Trust consistently (in terms of SSI) performs at the national average of 0.8%-1% with exception of Q3 as explained above. These patients are medically complex and are more likely to have an American Society of Anesthesiologists score (ASA) of 4 and 5. These patients are also covered by the orthogeriatric team and data is submitted not only to UKHSA but also the National Hip Fracture database (NHFU).

Changes and improvements

- Implementation of the standardised prophylactic antibiotic regime
- Use tranexamic acid during surgery
- Complex hip meetings

During 2026 the Trust shall be commencing a new surveillance including Periprosthetic hip/femoral fractures and intramedullary (IM) femoral nailing. This surveillance will not be submitted through UKHSA but will be structured following their guidelines. The SSI team is also keeping data on DVT occurring within these four categories of patients. As all these patients will all have implants/metalwork, they will be monitored for 12 months following surgery for infection and are eligible for submission at any point during that 12 month period.

Colorectal SSI Data

Since the introduction of the colorectal SSI improvement initiative at the RUH in 2019, there has been a substantial and sustained reduction of surgical site infections (SSI) in elective colorectal surgery. The baseline SSI rate of approximately 22% has reduced to consistently below 10% in recent years. This represents a significant improvement in patient outcomes and reflecting the impact of coordinated quality improvement interventions across the perioperative pathway.

This improvement has been achieved through a combination of standardisation of care, increased awareness, and implementation of evidence-based bundle interventions. Importantly, the reduction has been maintained over several years, indicating that this represents a genuine change in system performance rather than short-term variation.

Elective SSI Rates

Quarterly rates

Reporting year	Quarter	Months	Operations	SSI cases	SSI rate
2024/25	Q1	Apr-Jun 2024	84	8	9.5%
2024/25	Q2	Jul-Sep 2024	86	11	12.8%
2024/25	Q3	Oct-Dec 2024	79	7	8.9%
2024/25	Q4	Jan-Mar 2025	89	4	4.5%
2025/26	Q1	Apr-Jun 2025	74	6	8.1%
2025/26	Q2	Jul-Sep 2025	84	7	8.3%
2025/26	Q3	Oct-Dec 2025	79	3	3.8%
2025/26	Q4	Jan-Feb 2026 only	50	4	8.0%

Table 18: Colorectal quarterly SSI rates 2024 – 2026

Reporting year	Operations	SSI cases	SSI rate
2024/25	338	30	8.9%
2025/26 to date	287	20	7.0%

Note: 2025/26 Q4 includes January-February 2026 only as awaiting 30 day follow-up.

Table 19: Colorectal operation number and reported SSI numbers 2024 - 2026

Author: Lisa Hocking, Deputy Director of Infection, Prevention and Control - Document Approved by: Jason Lugg Chief Nursing Officer Chief Nursing Officer & Director of Infection, Prevention and Control Agenda Item:	Date: 28/05/2026 Version: 1 Page 54 of 68
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The observed variation is consistent with expected fluctuation at current case volumes rather than evidence of deterioration or sustained change. Notably, the most recent data lies at the lower end of the observed range, reinforcing that the system continues to deliver low SSI rates, albeit with some variability.

The run charts demonstrate the sustained SSI reduction elective colorectal surgery at the RUH (June 2020 – February 2026).

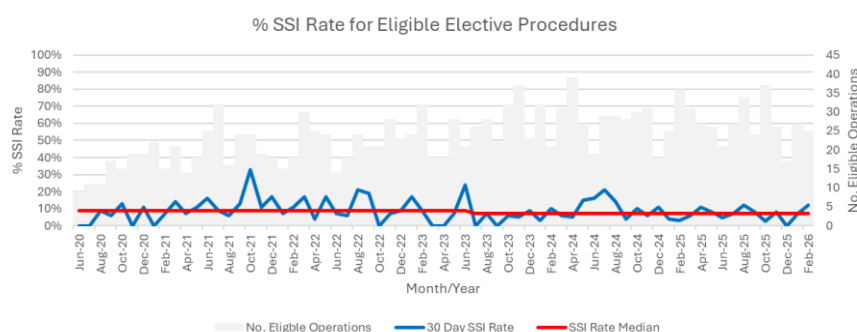


Figure 20: Percentage of infections for eligible elective procedures (low is good) 2020-26

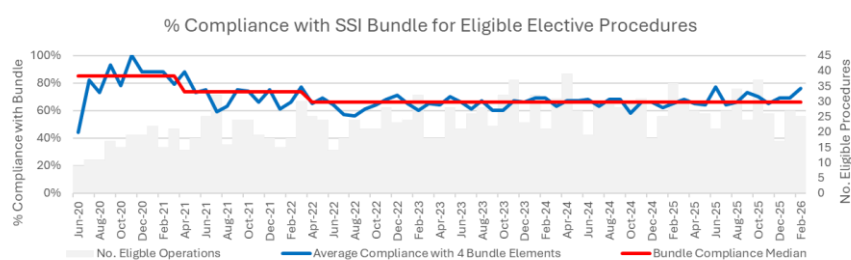


Figure 21: Percentage compliance with SSI bundle for eligible elective procedures 2020-26

National Benchmarking – UKHSA and GIRFT Comparison

- UK Health Security Agency surveillance data reports SSI rates of **8–11%** for elective colorectal surgery
- Getting It Right First Time (GIRFT) identifies a national mean of **11.7%**, with significant inter-hospital variation

In addition, several large, published datasets using 30-day SSI definitions, comparable to RUH methodology, report higher infection rates:

- American College of Surgeons National Surgical Quality Improvement Program: **15–20%** SSI rates for colorectal surgery
- European Society of Coloproctology international audits: **12–18%** SSI rates

These datasets include post-discharge surveillance and therefore capture a broader range of infections, making them directly comparable to RUH data.

The colorectal department at the RUH now consistently performs within or below UK national benchmarks and frequently below international published datasets. This supports the conclusion that the SSI reduction programme has not only improved outcomes locally but has achieved performance that is competitive at a national and international level.

Bundle Compliance – Current Performance

Compliance with the colorectal SSI bundle remains stable, with strong performance in key areas such as chlorhexidine skin preparation and appropriate timing of antibiotics.

However, variation persists in the uptake of certain bundle elements, and analysis suggests that **not all components contribute equally to outcome improvement**. This raises the possibility that further gains may be achieved by focusing on **high-impact interventions**, rather than attempting uniform optimisation of all elements.

Overall PreciSSIon bundle compliance - skin, antibiotics, sutures and wound protector

Bundle element	RUH compliance	GIRFT / best practice
Chlorhexidine skin prep	95%	≥90%
2nd antibiotic dose (>4hr procedures)	94%	≥95%
Documented wound protector use	54%	Routine use recommended. Likely underestimate, as wound protector use is now normal practice for specimen extraction.
Antibacterial sutures	76%	Precision bundle target ≥80%

Figure 36: Overall PreciSSIon bundle compliance

Modifiable Factors – Statistical Associations

Any antibacterial suture use

Period	Cases with	SSI rate with	Cases without	SSI rate without	p value
Apr 2024-Mar 2025	98	7.1%	240	10.0%	0.534
Apr 2025-Feb 2026	190	5.8%	95	11.6%	0.101
All data Apr 2024-Feb 2026	288	6.2%	335	10.4%	0.061

Figure 37: antibacterial suture use 2024-26

Monocryl superficial closure

Period	Cases with	SSI rate with	Cases without	SSI rate without	p value
Apr 2024-Mar 2025	264	7.6%	75	14.7%	0.070
Apr 2025-Feb 2026	211	5.7%	76	13.2%	0.045
All data Apr 2024-Feb 2026	475	6.7%	151	13.9%	0.011

Figure 38: Monocryl superficial closure 2024 - 26

Wound protector use

Period	Cases with	SSI rate with	Cases without	SSI rate without	p value
Apr 2024-Mar 2025	169	10.1%	170	8.2%	0.578
Apr 2025-Feb 2026	174	4.6%	111	12.6%	0.021
All data Apr 2024-Feb 2026	343	7.3%	281	10.0%	0.233

Figure 39: Wound protector use 2024 – 26

Antibiotic appropriateness

Period	Cases with	SSI rate with	Cases without	SSI rate without	p value
Apr 2024-Mar 2025	296	8.4%	40	15.0%	0.237
Apr 2025-Feb 2026	247	7.7%	37	8.1%	0.82
All data Apr 2024-Feb 2026	543	8.1%	77	11.7%	0.292

Note: Latest reporting period runs to February 2026 Monocryl analysis is based on free-text closure documentation.

Figure 40: Antibiotic appropriateness 2024 - 26

The key challenge is now not overall performance, but achieving consistent delivery of low SSI rates, particularly in higher-risk procedures.

Cost Analysis – Financial Impact of SSI Reduction

Surgical site infections are costly. NHS Improvement and GIRFT estimate that each colorectal SSI costs around £10,000–£15,000, due to extended hospital stays, readmissions, reoperations, and antibiotic use.

- 320 elective colorectal cases/year
- Initial SSI rate (2019): 22% → ~70 infections/year
- Current SSI rate (2024): 8% → ~26 infections/year
- Reduction: 44 fewer infections/year
- Estimated cost per SSI avoided: £12,500

Annual Cost Saving:

44 infections avoided × £12,500 = £550,000 saved per year. This does not include indirect savings such as bed capacity release, or improvements in patient experience.

Variation Between Consultants

Analysis of the last 12 months, restricted to colorectal consultants demonstrates meaningful variation in SSI rates between operators, with observed rates ranging from approximately ~3% to ~15%, a median of around ~7–8%, across consultants undertaking between 30 and 90 elective colorectal procedures per year.

At these volumes, a small number of additional SSI events (typically 2–4 cases) can materially influence percentage rates. However, the breadth of variation observed suggests that differences are unlikely to be explained by random fluctuation alone.

A substantial proportion of this variation is attributable to case-mix, particularly the proportion of higher-risk procedures such as anterior resection. Consultants undertaking a greater volume of pelvic surgery demonstrate higher overall SSI rates, consistent with procedure-specific risk (anterior resection ~12–13% vs right hemicolectomy ~6%).

Despite this, case-mix does not fully account for the observed spread, and residual variation likely reflects a combination of differences in operative technique adherence to key interventions (e.g. suture choice, antibiotic administration). There is no single consistent outlier across time, but variation across the consultant group remains evident.

Future Priorities

Future improvement should focus on:

- Reducing unwarranted variation in SSI rates
- Targeting high-risk procedures
- Increasing reliability of:

- Antibacterial suture use (Monocryl+)
 - Appropriate antibiotic administration
- Implementation of oral antibiotic bowel preparation (OABP + MBP) in line with national guidance – now approved.

Emergency Surgical SSI

Emergency SSI surveillance demonstrates a stable overall SSI rate of approximately 10% across the last two reporting periods. SSI was 9.8% in April 2024–March 2025 and 9.7% in April 2025–February 2026, with no clear year-on-year reduction.

Across the reporting period there were 275 assessable emergency bowel resection cases, with 32 SSIs, giving an SSI rate of 11.6%. Within this subgroup, SSI fell from 13.9% in 2024/25 to 9.2% in 2025/26 to date, suggesting a possible improvement although this was not statistically significant.

Benchmarking against emergency laparotomy literature. The SUNRRISE trial of 840 patients reported 30-day SSI rates of 27.4% with surgeon's preference dressing after emergency laparotomy. Against this benchmark, RUH emergency SSI outcomes appear favourable, with an overall emergency SSI rate of 9.8% and an emergency bowel resection SSI rate of 11.6%.

No individual modifiable factor demonstrated a statistically significant association with reduced SSI in this emergency dataset. This likely reflects smaller numbers, heterogeneous case mix and confounding by operative complexity.

Strategic priorities for 2025–26

1. Implementation of combined oral antibiotic and mechanical bowel preparation (OABP + MBP) in selected elective colorectal cases. Approved by DTC. - Now in place though limited uptake
2. Introduction of robotic intracorporeal colonic anastomosis. Risk: Lack of Robotic availability – Second robot now in place and disposables funded

Criterion 6

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

Mandatory IPC Training

All new staff to the Trust including contractors complete IPC induction. IPC eLearning meets the statutory and mandatory training requirements and learning outcomes for Infection Control Level 1 and 2 in the UK Core Skills Training Framework (UK CSFT). This is completed 3 yearly for level 1 and annually for level 2 which is designed to be completed by all healthcare staff groups involved in direct patient care or services.

All Trust job descriptions have IPC roles and responsibilities written into them. IPC team support clinical areas where practice needs to be improved on case-by-case basis. Bank staff training rates have been addressed, and a steady improvement is being made in the compliance rates.

Compliance is to be reported via Divisions to IPCC. The tables below demonstrate the Trust wide monthly compliance for both levels (1 & 2) of IPC mandatory training.

Division	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Bank [Division]	88.20%	90.07%	88.59%	90.32%	88.44%	89.12%	89.86%	90.51%	92.68%	84.03%	84.68%
Capital Summary [Division]	91.67%	91.67%	96.30%	88.89%	89.66%	89.66%	89.29%	89.29%	92.31%	92.86%	88.89%
Charity Summary [Division]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Corporate Division	92.02%	91.68%	92.67%	92.63%	92.68%	91.29%	90.93%	92.36%	92.52%	92.09%	92.18%
Estates and Facilities Division	93.51%	95.25%	94.20%	94.08%	94.16%	94.73%	95.01%	93.98%	92.56%	93.08%	93.07%
Family and Specialist Service Division	97.48%	96.47%	96.82%	96.76%	96.42%	96.04%	97.11%	95.59%	96.72%	93.58%	94.22%
Medical Division	97.31%	97.74%	97.76%	98.12%	97.63%	98.59%	95.91%	93.95%	96.31%	93.44%	94.64%
Research & Development [Division]	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.15%	97.01%	96.83%
Surgical Division	98.21%	97.64%	98.48%	97.54%	97.85%	97.55%	96.21%	95.77%	95.58%	95.03%	95.78%
Total	94.63%	94.95%	95.06%	94.89%	94.76%	94.64%	94.33%	93.96%	94.20%	92.86%	93.54%

Table 22: Divisional compliance IPC Level 1 Training 2025/26

Division	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Bank [Division]	71.13%	75.28%	76.35%	71.62%	69.85%	68.76%	71.21%	72.92%	73.20%	71.58%	72.08%
Capital Summary [Division]	75.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Corporate Division	84.97%	87.01%	85.16%	88.03%	85.06%	83.77%	84.87%	86.27%	83.55%	84.08%	83.22%
Estates and Facilities Division	89.47%	93.22%	89.47%	92.45%	96.49%	91.07%	98.21%	95.00%	98.36%	93.65%	91.94%
Family and Specialist Service Division	84.01%	86.10%	86.22%	85.97%	86.57%	85.70%	86.14%	85.44%	85.60%	86.53%	85.80%
Medical Division	83.77%	85.21%	83.91%	85.55%	84.24%	83.09%	83.74%	84.62%	84.41%	84.35%	85.31%
Research & Development [Division]	86.67%	90.91%	92.68%	87.50%	91.67%	86.84%	92.31%	92.31%	91.89%	92.68%	91.89%
Surgical Division	86.44%	88.59%	86.97%	87.36%	86.68%	86.77%	86.07%	85.08%	86.13%	86.41%	86.56%
Total	83.04%	85.33%	84.55%	84.41%	83.76%	82.95%	83.65%	83.88%	84.19%	84.30%	84.45%

Table 23: Divisional compliance IPC Level 2 Training 2025/26

Face Fit Testing

All identified staff are offered training in the selection and use of personal protective equipment. Face fit testing is carried out on site by a dedicated team of trained staff. The trust has also invested half face masks and air powered hoods to suit staff with facial hair. All training records are held centrally and are reported on monthly.

Currently there is a gap in the number of staff confident and competent to fulfil our need to be responsive to an infection outbreak requiring sustained use of this level of PPE.

Currently 14% of staff have been fit tested within past two years. This is a risk on the risk register and is being actively discussed at IPCC and with divisions to ensure key areas are adequately prepared. This includes front door assessment services, intensive care and theatre staff. This risk is being raised and actions being proposed.

Criterion 7

The provision or ability to secure adequate isolation facilities.

Building works

The RUH has continued to undertake extensive building works during 2025/2026.

The complete refurbishment of B12 from an open ward layout into a 16 bedded ward has commenced and due to open Spring 2026. The ward has been designed for Neurology patients, many of whom require a period of isolation when transferred to the RUH from a Tertiary centre. The ward will comprise of two bariatric side rooms, with full ensuite and one with bariatric hoist facilities. Five further side rooms have been designed all with ensuite toilet and shower facilities to enable effective isolation of patient as well as promoting privacy and dignity. Two bays (one with four beds and one with five beds) also have full ensuite facilities as well as a separate toilet.

C16 has been refurbished to support a new Discharge Lounge. Two side rooms (with full ensuites) have been added to ensure that patients who are being discharged with infections from wards can access the Discharge Lounge and release side rooms on the in-patient wards in a timelier manner. This will enable patients at the Front Door (ED or Assessment Areas), to be transferred to the in-patient wards earlier.

An extension to Medical Short Stay is nearly completed. Seven beds have been added to the Trust bed base, including two side rooms with full ensuite facilities. One of these side rooms has a separate exit directly into the ward corridor to allow separate doffing and donning areas if required.

Extensive works in The Emergency Department has removed hand wash basins from cubicles as these were too close to the patient care area. A single wash hand basin per quadrant has been installed. To date, three of the four “major’s quadrants” have works either completed or underway.

Phase 2 of the IPC works has commenced on Pulteney Ward, an acute surgical ward. All bays will have ensuites with toilet and showers. There are eight side rooms, three of which do not currently have ensuite facilities, and this is being addressed. Ensuite facilities with bays have been noted to reduce the risk of the spread of infections throughout wards. This programme is planned to continue, subject to funding, until all wards have ensuite facilities within bays and side rooms.

Isolation facilities and premises

The RUH is aware there are limited isolation facilities despite the investment in the past three years. The number of single rooms with ensuite capacity is significantly lower than the demand on the organisation. Phase 2 of the IPC works plans to continue to install en-suites on wards who lack facilities. This continues to be subject to funding and access and remains on the risk register.

For patients with known infections, alert flags are used to flag patients that require isolation or assessment. The clinical site team have a constant visual on all clinical flags to influence patient placement. Clinical handover processes are in place between clinical areas. Enhancement of the current process is being addressed in divisions to ensure patients safety is paramount during their admission.

Staff are encouraged to use Datix to report these delays or when and option to isolate is overridden by an alternative service. This will enable the Trust to understand the incidences that occur, that without completion of a Datix would not happen. Escalation plans are in place; this is led by the medical division for winter pressures, and staff are supported by the IPC team. These plans are there to ensure there are effective pathways in place in the event of increased influenza or COVID patients being

admitted through the front door. Two wards have been allocated that can be changed into cohort wards in light of increased pressure from respiratory like illness (RLI).

Criterion 8

The ability to secure adequate access to laboratory support as appropriate

Laboratory support

Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.

The RUH Laboratory operates within United Kingdom Accreditation Service (UKAS) accreditation covers all aspects of the laboratory service including standard operating procedures (SOP) and competencies as part of a yearly external assessment, as well as internal review through the Quality Management System. The RUH has access to an adequate repertoire of UKAS accredited microbiological diagnostic testing through a contract with the UKHSA Bristol Regional Laboratory (routine tests off-site, on-site 'hot lab' for time-critical testing).

The Trust pathology laboratory also provide on-site UKAS accredited testing for pathogens of IPC concern (e.g. Norovirus, C. difficile, COVID, Influenza). Laboratory performance is monitored through a Quality and Clinical Governance infrastructure. A clinical microbiology service is provided by Consultant Microbiologists for diagnostic support both in-hours, and out-of-hours through a collaborative service with University Hospitals Bristol and Weston. IPC monitor test results for patients awaiting screening results.

Point of care testing has been supported by the laboratory team for Influenza and COVID in the Emergency department, using the Abbott ID Now platform. Continuing to support out of hours testing all year round by lab trained ED staff, which has enabled 'informed' patient placement and flow.

Criterion 9

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

Policies and Infections

The National Infection Prevention Control (NIPC) manual is used by the Trust and the IPC team. The document is linked via the staff intranet. All IPC related policies are being reviewed within Trust time scales, and Standard Operating Procedures (SOP) are being introduced where considered necessary replacing some existing policies that were in place.

Outbreak meetings are held as necessary at times of significant ward and bay closures that are affecting site operations. These are supported throughout the day by the team and site managers via regular contact, with senior attendance at the morning site meeting and as deemed necessary across the day.

The continued collaboration with the Integrated Care Board and Public Health teams provided the IPC team insight into the local risks in relation to outbreaks, especially the impact of primary care that can restrict discharges from the Trust. Development of local protocols are in place to assist with deviation from current practice when the impact of outbreaks outweighs the service need. This enables the team to consider the need to bring certain patients out of isolation, when the balance of infections is significantly challenged.

Criterion 10

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

Staff Health and Wellbeing

The Chief Nursing Officer (DIPC) and Associate Chief Nurse (Deputy DIPC) work in collaboration with Occupational Health and specific questions/enquiries are responded to or advice given in a timely manner.

Occupational Health needs are managed by OPAS-G2 supplied by Civica. The system specifically designed for Occupational Health purposes, is on the framework, paperless, independent of other systems (for confidentiality), is easy to use and information is stored in a secure cloud hosted by Civica that meets all data protection requirements. G2 also interfaces with Trac our recruitment and on boarding system.

At the offer of employment, the recruitment Trac system will send a link to the appointed candidate to fill in a pre-placement questionnaire (PPQ) and this includes requirement from the candidate to upload any vaccination evidence as well as their exposure prone procedure (EPP) clearance evidence. This, along with other health questions is triaged by an experienced nurse and any issues identified are escalated to a more senior nurse. Skin assessments are also available through management referrals, at new starter or at any time via self-referral.

Any staff who are unable to provide evidence of their vaccination status (as required for their job role) are sent a link to self-book an appointment into the vaccination clinic OR to send in any evidence they may now have found. These clinics are available most days of the week excluding bank holidays. Staff who DNA their appointment are sent an email asking them to phone in to reschedule and their manager is also informed. Further DNA and the staff and their manager receive notification that they are now at risk and should complete a risk assessment or phone in and book an appointment.

Staff who move roles within the Trust must complete a new pre placement questionnaire which identifies the new role. This is triaged in the same way as a new starter and any change in category of role which requires further vaccinations the same process is repeated as for new starters e.g. staff nurse moving from a ward environment to Emergency Department will require further vaccination potentially or serology.

Staff who sustain a sharps injury follow the flow chart procedure which is available in every department and on the intranet. This includes calling in to the OH sharps line. Monday – Friday these calls are picked up by the electronic system and an experienced nurse will answer the call and take any necessary action. These staff are always prioritised for boosters/serology etc. Flow charts are provided to staff to follow.

Health surveillance for a range of tests is available for staff whose job roles require it. For example, plaster room staff will require annual spirometry and audiometry as well as hand/arm vibration tests. Currently our infection control health surveillance covers staff who live with 'blood borne virus' (BBV).

In the case of outbreak, the G2 system can report accurately both individually and Trust wide vaccination status as recorded within it. Annual flu vaccinations are provided in house via the occupational health team.

This last year (25/26) has seen the Flu campaign reported Trust wide via a dashboard accessible by all managers. Progress is charted weekly, and a separate bespoke system (Vaccination Trac) enables us to do this in a granular fashion in order that hot spot areas can be targeted using a different delivery model where necessary. The last campaign has recorded Flu vaccinations have increased by over 5% and RUH reported at 63.5% as 6th in the country of 205 acute Trusts.

RUH is currently aligned with GWH and SFT for OH, all using the same platform, with a view to being able to offer more choice of venue for staff during this financial year (26/27)

Trust vaccination status, in general, is an ongoing dynamic situation and currently it is necessary to build and run specific reports at time of request. However, we are constantly developing ways to get our system to work better for the Trust assurances whilst responding to the ever-changing infection status that is nationwide.

Conclusion

The Trust has demonstrated sustained commitment to infection prevention and control across 2025/26, with notable improvements in *Clostridioides difficile* reduction, strong antimicrobial stewardship performance, and continued progress in surgical site infection reduction programmes. However, key challenges remain, particularly in Gram-negative bloodstream infections, variability in MSSA rates, and the impact of estate limitations on effective isolation and outbreak management.

Rising demand, an ageing patient population, and increasing complexity of care continue to place pressure on existing systems. Despite these challenges, the organisation has maintained robust governance, strong multidisciplinary collaboration, and a proactive approach to quality improvement.

Future success will depend on translating identified learning into consistent practice, reducing variation, and strengthening the fundamental drivers of infection prevention particularly hydration, device care, antimicrobial optimisation, and environmental standards.

Key Actions to Improve Patient Outcomes for 2026/27

1. Reduce device-related infections to reduce MSSA bacteraemias and bloodstream infections overall

- Standardise cannula insertion and maintenance bundles
- Introduce daily device review and prompt removal
- Embed escalation for infiltration/extravasation

2. Strengthen UTI prevention in older adults to reduction E. coli & Klebsiella bacteraemia, admissions and length of stay

- System-wide hydration strategy (ward + community)
- Improve catheter decision-making and review
- Standardise UTI diagnostic stewardship

3. Address environmental and estate risks to reduce outbreak spread and risk of healthcare associated infections

- Continue side room and ensuite expansion
- Embed revised cleaning standards

4. Behavioural and cultural improvement to achieve a sustained reduction in multiple infection types

- Expand Gloves Off programme
- Improve patient hand hygiene engagement
- Reinforce the basics of IPC compliance

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Author: Lisa Hocking, Deputy Director of Infection, Prevention and Control - Document Approved by: Jason Lugg Chief Nursing Officer Chief Nursing Officer & Director of Infection, Prevention and Control Agenda Item:	Date: 28/05/2026 Version: 1 Page 67 of 68
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