

FOI REF: 26/296

21st May 2026

Eastbourne District General Hospital

Kings Drive
Eastbourne
East Sussex
BN21 2UD

Tel: 0300 131 4500
Website: www.esht.nhs.uk

Further to your recent request for information made under the Freedom of Information Act (FOIA) 2000, I now set out our answers to your specific questions, and any clarifications sought and provided, as follows:

I would be grateful if you could provide the following information regarding the Infection Prevention & Control (IPC) leadership and IPC nursing team at East Sussex Healthcare NHS Trust, covering:

- **Conquest Hospital**
- **Eastbourne District General Hospital**
- **Bexhill Hospital**
- **Rye, Winchelsea & District Memorial Hospital**
- **All associated community services within the Trust footprint**

1) IPC Leadership – Names, Roles, and Contact Details:

Please provide the name, job title, and NHS email address (where publicly releasable) for the following positions:

Please see below for the name and job titles, as requested, and note that we are applying Section 44 to the email addresses.

East Sussex Healthcare NHS Trust (ESHT) are unable to provide the contact details of staff as we consider this information to be exempt from release in accordance with section 44 of the Freedom of Information Act (Prohibition on disclosure) and would refer to the Privacy and Electronic Communications EC Directive Regulations 2003 which provide specific rules on electronic communication services, including marketing (by phone, fax, email or text) and keeping communications services secure. We will not provide any information that could result in the transmission of unsolicited communications which may place an unacceptable risk to our email network and could also have a detrimental impact on patient care and treatment.

The contact number for the Trust is accessible on the Trust website <http://www.esht.nhs.uk>.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

a) Director of Infection Prevention & Control (DIPC).

Vikki Carruth
Chief Nurse and Director of Infection Prevention and Control

b) Deputy DIPC.

Lisa Redmond
Head of Infection Prevention and Control

c) Lead Nurse for Infection Prevention & Control.

Lisa Redmond
Head of Infection Prevention and Control

d) IPC Matron / IPC Manager.

Helen Tingley
Senior Infection Prevention Control Nurse

Florence Mpofo
Senior Infection Prevention Control Nurse

e) Infection Prevention & Control Doctor (IPCD).

Dr Lasantha Rajakaruna
Consultant Microbiologist and Infection Prevention Control Doctor

f) Any Consultant Microbiologists with designated IPC responsibility.

Dr Diana Amoiridou
Consultant Microbiologist

Dr John Koroneos
Consultant Microbiologist

Dr Dushani Mudalige
Consultant Microbiologist

2) IPC Nursing Team:

For all IPC nursing staff employed by the Trust, please provide:

- a) Names.**
- b) Job titles and bandings.**
- c) NHS email addresses (where publicly releasable).**
- d) The clinical areas or sites they cover.**

According to ESHT's Freedom of Information Policy we only release the names of staff on Grade 8a and above. The IPC nursing staff are below a Grade 8a and therefore the details requested cannot be provided.

3) IPC Organisational Structure:

Please provide:

- a) The most recent IPC organisational structure chart, including reporting lines.**

Please see attached a copy of ESHT's IPC structure chart.

- b) Any documentation describing how IPC services are structured across the Trust.**

Please refer to the 'Who's who' on ESHT Website via the following link:

<https://www.esht.nhs.uk/wp-content/uploads/2025/05/Whos-who-at-East-Sussex-Healthcare-NHS-Trust.pdf>

4) IPC Contact Information:

Please provide:

- a) Any generic IPC team email addresses.**

Not applicable.

- b) Any team telephone numbers used for clinical enquiries or staff contact.**

Telephone: 0300 131 4500.

- c) Any site-specific IPC contact details, if applicable.**

Section 44 applied, please refer to question 1.

5) Additional IPC Documentation:

If available, please provide:

a) The most recent IPC Annual Report.

Please see attached ESHT's 'Infection Prevention & Control Annual Report - 2024-2025'.

Please also note that we have redacted the names of the Trust's IT Systems and are applying Section 31(1)(a) respectively, please see below:

Under Section 31(1)(a) of the Freedom of Information Act (FOIA), the Trust can confirm that it holds information relevant to your request, however, we are unable to disclose it for the reasons explained below.

Historically, we would disclose information relevant to the Trust's IT systems, infrastructure and software as part of our transparency agenda under the terms of the Freedom of Information Act (FOIA). However, in light of the recent cyber-attacks on NHS hospitals and the serious impact these have had on patient services and the loss of patient data, we are having to reconsider this approach. Please see several links to news articles about these recent cyber incidents provided below for your information.

- [NHS England — London » Synnovis Ransomware Cyber-Attack](#)
- [NHS England confirm patient data stolen in cyber attack - BBC News](#)
- [Merseyside: Three more hospitals hit by cyber attack - BBC News](#)

As a result of these attacks, thousands of hospital and GP appointments were disrupted, operations were cancelled, and confidential patient data was stolen which included patient names, dates of birth, NHS numbers and descriptions of blood tests.

When we respond to a Freedom of Information request, we are unable to establish the intent behind the request. Disclosure under the FOIA involves the release of information to the world at large, free from any duty of confidence. Providing information about our systems or security measures to one person is the same as publishing it for everyone. While most people are honest and have no intention of misusing information to cause damage, there are criminals who look for opportunities to exploit system weaknesses for financial gain or to cause disruption.

In the context of the FOIA, the term "public interest" does not refer to the private or commercial interests of a requestor; its meaning is for the "public good". The Trust receives a significant number of requests each year regarding our IT systems, infrastructure and cyber security measures. Most of these requests are commercially driven and serve no direct public interest. Information relevant to our IT portfolio is often requested by consultancy companies who then pass on this information to their client base. Many of these requests are submitted through the

FOI portal whatdotheyknow.com who publish our responses, making this information available to an even wider audience.

As a large NHS Trust we hold extensive personal data relevant to our patients and staff, much of which is considered very sensitive. A lot of this information is held electronically on various administration and clinical systems. We have a duty under the Data Protection Act 2018 and the UK GDPR to protect this personal information and take all necessary steps to ensure this data is kept safe. This means not disclosing information that could allow criminals to gain unlawful access to our systems and infrastructure. The Trust can be heavily fined should it be found to have acted in a negligent way which results in a personal data breach. We need to demonstrate that we comply with our legal obligations under data protection and freedom of information legislation, but we must be careful that too much transparency does not result in harm to our patients or staff, or cause disruption to our services.

Moreover, under the Network and Information Systems (NIS) Regulations Act 2018, operators of essential services such as NHS organisations like ours have a legal obligation to protect the security of our networks and information systems in order to safeguard our essential services. By releasing information that could increase the likelihood or severity of a cyber-attack, the Trust would fail to meet its security duties as stated in Section 10 of the Network and Information Systems Regulations 2018. Should we not comply with these requirements regulatory action can be taken against the Trust. Further information about the [Network and Information Systems \(NIS\) Regulations Act 2018](#) can be found here – [The Network and Information Systems Regulations 2018: guide for the health sector in England - GOV.UK](#)

Your request asks for policy documents which unfortunately mention specific details regarding our IT Systems which, for the reasons explained above, would be inappropriate to release into the public domain. If disclosed, it is possible that patient data as well as other confidential information would be put at risk. Such disclosure could also impact on the security of our systems and result in serious disruption to the health services we deliver to the local community. Section 31(1)(a) of FOIA provides that information is exempt if its disclosure would, or would be likely to, prejudice (a) the prevention or detection of crime. In this case, disclosure would be likely to prejudice the prevention of crime by enabling or encouraging malicious acts which could compromise the Trust's IT systems and infrastructure. The Trust's capacity to defend itself from such acts relates to the purposes of crime prevention and therefore Section 31(a) exemption is applicable in these circumstances. For these reasons, the Trust considers disclosure of the information you are seeking to be exempt under Section 31(1)(a) [*law enforcement*] of the FOIA and the names of the IT systems within the annual report is being withheld. The full wording of Section 31 can be found here: [Freedom of Information Act 2000](#)

Section 31 is a *qualified* exemption and therefore we must consider the prejudice or harm that may be caused by disclosure of the information you have requested, as well as apply a public interest test that weighs up the factors in maintaining the exemption against those in favour of disclosure.

In considering the prejudice or harm that disclosure may cause, as explained should the Trust release information into the public domain which draws attention

to any weaknesses relevant to the security of our systems or those of a supplier, this information could be exploited by individuals with criminal intent. Increasing the likelihood of criminal activity in this way would be irresponsible and could encourage malicious acts which could compromise our IT systems or infrastructure, result in the loss of personal data and/or impact on the delivery of our patient services. We consider these concerns particularly relevant and valid considering the increasing number of cyber incidents affecting NHS systems in recent years and the view by government, the ICO and NHS leaders that the threat of cyber incidents to the public sector is real and increasing.

- [Organisations must do more to combat the growing threat of cyber attacks | ICO](#)

In the Government's Cyber Security Strategy 2022-2030, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office states on page 7:

“Government organisations - and the functions and services they deliver - are the cornerstone of our society. It is their significance, however, that makes them an attractive target for an ever-expanding army of adversaries, often with the kind of powerful cyber capabilities which, not so long ago, would have been the sole preserve of nation states. Whether in the pursuit of government data for strategic advantage or in seeking the disruption of public services for financial or political gain, the threat faced by government is very real and present.

Government organisations are routinely and relentlessly targeted: of the 777 incidents managed by the National Cyber Security Centre between September 2020 and August 2021, around 40% were aimed at the public sector. This upward trend shows no signs of abating.”

With this in mind, we then considered the public interest test for and against disclosure. It should be noted that the public interest in this context refers to the public good, not what is 'of interest' to the public or the private or commercial interests of the requester. In this case we consider the public interest factors in favour of disclosure are:

- Evidences the Trust's transparency and accountability
- Provides information relevant to the IT systems and applications the Trust uses
- Reassures the public and partners that the Trust procures these systems in line with Procurement legislation
- Reassures the public and partners that the Trust's IT infrastructure and systems are secure

Factors in favour of withholding this information are:

- Public interest in crime prevention
- Public interest in avoiding disruption to our health services

- Public interest in maintaining the integrity and security of the Trust's systems
- Public interest in the Trust avoiding the costs associated with any malicious acts (e.g. recovery, revenue, regulatory fines)
- Public interest in complying with our legal obligations to safeguard the sensitive confidential information we hold

In considering all of these factors, we have concluded that the balance of public interest lies in upholding the exemption and not releasing the information requested. Although disclosure would provide transparency about our software systems and IT infrastructure, this is outweighed by the harm that could be caused by people who wish to use this information to assess any vulnerabilities in our security measures and consequently use this information for unlawful purposes. Cybercrime can not only lead to major service disruption but can also result in significant financial losses. As a publicly funded organisation, we have a duty for ensuring our public funding is protected and spent responsibly. Moreover, as a public body the Trust must demonstrate that it keeps its confidential data and IT infrastructure safe and complies with relevant legislation, but at the same time we must be vigilant that transparency does not provide an opportunity for individuals to act against the Trust. In considering the impact that recent cyber-attacks have had on NHS services, including the cancellation of thousands of patient appointments and procedures as well as the loss of confidential patient data, we consider the overriding public interest lies in withholding this information. The private or commercial interests of a requester should not outweigh the public interest in protecting the integrity of our systems and continuity of our essential patient services. Although we appreciate there may be legitimate intentions behind requesting this information, we must take a cautious approach to requests of this nature and appreciate your understanding in this matter.

b) Any IPC governance documents or summaries produced within the last 12 months.

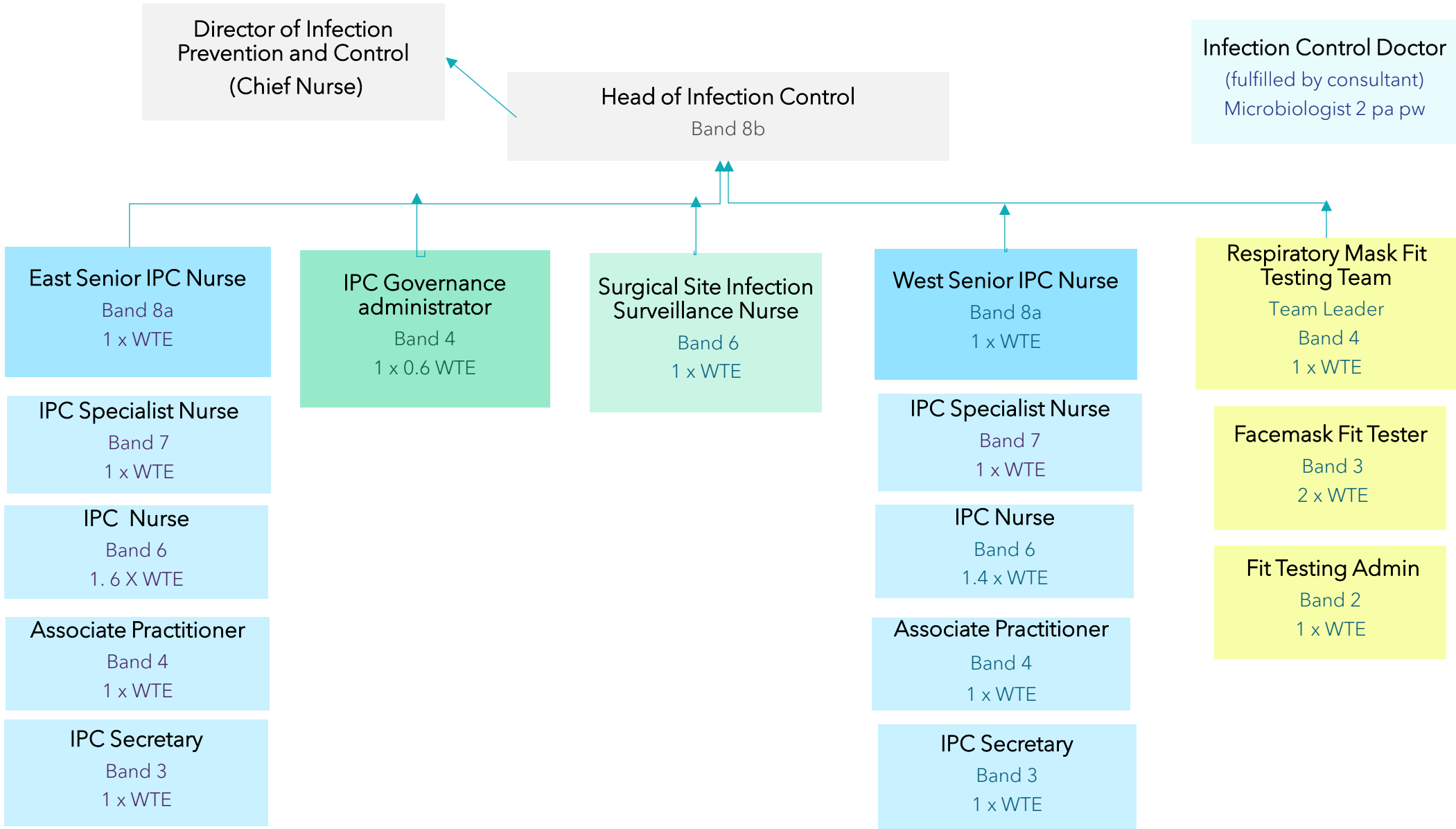
Included in the attached annual report.

I trust this information is helpful in its detail or explanation however, if you are dissatisfied with the response, then you have the right to request an internal review. If you wish to seek an internal review, please write to the Freedom of Information Team at esh-tr.foi@nhs.net quoting the above FOI reference number, within 40 working days. Please note the Trust is not obliged to accept a request for an internal review after this time period.

Yours faithfully

Freedom of Information (FOI) Team
East Sussex Healthcare NHS Trust
0300 131 4716
Core Hours of Business: Monday to Friday 9.00am to 4.00pm

Infection Prevention and Control Team



Infection Prevention & Control

Annual Report 2024 - 2025

No patient will be harmed by an avoidable Healthcare Associated Infection

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1. Executive Summary

This report outlines the infection prevention and control (IPC) activities of East Sussex Healthcare NHS Trust (ESHT) for the financial year 2024/25. Arrangements made by ESHT to allow the early identification of patients with infections, measures taken to reduce the spread of infections to others, audit, surveillance, achievements, and challenges are presented.

The prevention of avoidable infections is fundamental to safe patient care. ESHT employs a team of specialist nurses and support staff to advise and co-ordinate activities to prevent and control infection, but it is the responsibility of all staff in the organisation to comply with Trust policies and implement these.

Key points during 2024/25:

All mandatory reporting was fully compliant. ESHT was one of only four trusts in the region to submit the full dataset to the mandatory surveillance scheme.

The threshold for healthcare associated *Clostridium difficile* was exceeded. An outbreak of CDI at EDGH significantly contributed and was associated with movement of patients and inability to undertake enhanced environmental cleaning during periods of operational escalation and high bed occupancy. Renewed focus on HPV and antimicrobial prescribing for older patients and intravenous to oral switch in the coming year is intended to realise reductions in CDI going forward.

The increased incidence of mandatory reportable MSSA and Gram negative infections is reflective of the national increased prevalence post pandemic. Post infection review of MSSA bacteraemias is required to understand contributing factors.

High numbers of flu, COVID and respiratory syncytial virus (RSV) and Norovirus were managed in line with best practice and agreed Sussex IPC winter surge plan, during a challenging winter period.

A new high consequence infectious disease was identified requiring additional HCID preparedness actions.

There are robust processes for maintaining a safe environment and reporting to the Trust Infection Prevention Control Group.

The aging estate is negatively impacting on the national specification of cleanliness and is challenging for infection prevention and control. There is robust collaborative working between estates and facilities, clinical and IPC teams to try to mitigate the risk.

Compliance with the IPC BAF and clinical engagement with IPC initiatives and training demonstrates ongoing support and commitment to infection prevention and control.

2. Structure

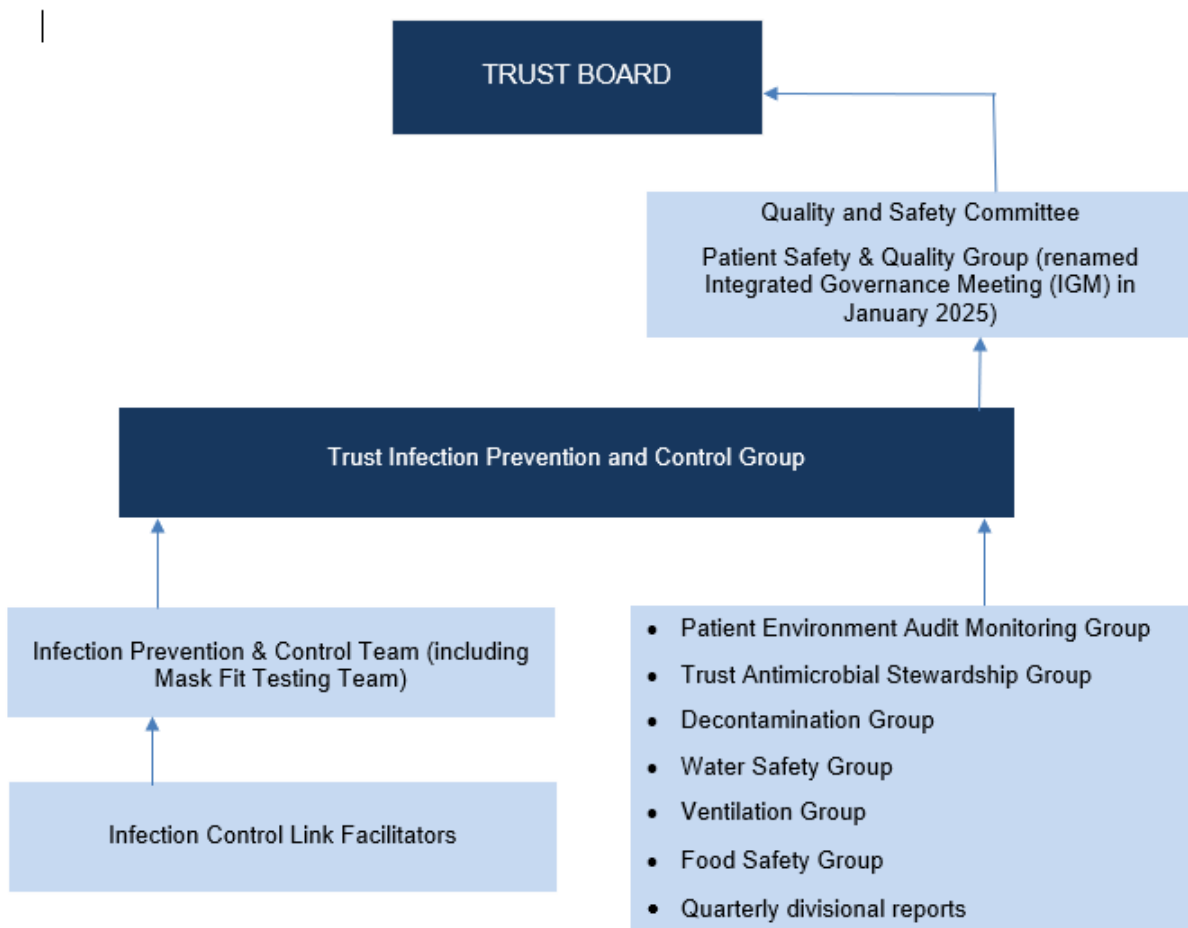
The Chief Nurse is the Executive Lead and Director of Infection Prevention and Control (DIPC), within the Trust and sits on the Trust Board.

2.1 Infection Prevention & Control Team Structure

The IPCT comprises of specialist Infection Prevention and Control nurses and administrative staff. Two area teams (East and West) based in each of the acute hospital sites provide Infection Prevention and Control support to all ESHT services in their local area (acute, community, inpatient and domiciliary). There is also a dedicated Surgical Site Infection Surveillance Nurse to undertake mandatory surveillance of orthopaedic surgery. The mask fit testing team also forms part of the IPC service.

In addition to the IPCT, the Trust also funds four (WTE) Consultant Microbiologist posts (2 on each acute site) based within the Core Services Division who work with the IPCT, one of whom undertakes the role of Infection Prevention and Control Doctor.

2.2 Infection Prevention & Control Internal Reporting Arrangements



The Trust Infection Prevention and Control Group (TIPCG) is chaired by the DIPC/ Chief Nurse. The Group meets monthly and has wide representation from throughout the Trust including from Divisions, Occupational Health, Pharmacy, Integrated Care Board, and external membership from the local department of UK Health and Security Agency (UKHSA). The TIPCG reports quarterly to the Safety and Quality Committee regarding performance and operational issues and compliance against the Infection Prevention and Control Board Assurance Framework (BAF).

Each of the Divisions report directly to the TIPCG on compliance with regulatory standards for IPC. Matrons and Managers have the responsibility for the prevention and control of infection in their local area in line with national and local policies and guidelines. Each clinical department has appointed an Infection Control Link Facilitator (ICLF) who, with educational support and guidance from the IPCT, is responsible for cascading and monitoring compliance with Infection Prevention and Control practices at local level.

2.3 Infection Prevention & Control External Reporting Arrangements

The Department of Health (DoH) requires NHS Trusts to take part in a national mandatory and voluntary surveillance programme. The mandatory HCAI Data Capture System is a web-based data collection system managed by UKHSA for specific infections (*Escherichia coli*, *Klebsiella* spp., *Pseudomonas aeruginosa*, *Staphylococcus aureus* (MRSA and MSSA) and *Clostridioides difficile*).

A weekly status report of mandatory reportable infections at ESHT is shared with IPC colleagues at NHS Sussex and ESCC. The DIPC and Head of IPC discuss any significant IPC issues with the ICB, UKHSA and ESCC as required. ESHT reports outbreaks and seasonal flu data via data capture systems as required. Significant outbreaks and incidents are escalated to NHS Sussex Head of Quality and Nursing and the Southeast Lead for NHS England as required. ESHT has been compliant with reporting requirements throughout the year.

2.4 Infection Control Link Facilitators

There are approximately 80 Link Facilitators across the Trust. Each new ICLF is provided with an induction programme provided by the IPCT. With the educational support and guidance from the IPCT, they are responsible for cascading and monitoring compliance with infection prevention and control practices at clinical level. The IPCT hold bi-monthly ICLF meetings on each acute site or online.

2.5 Joint Working across the Local System

The Trust IPCT continues to work with the Integrated Care Board (ICB), Public Health at East Sussex County Council, United Kingdom Health and Security Agency (UKHSA) and NHSE colleagues towards joint strategies for the reduction of healthcare associated infections which can lead to hospital admission.

The IPC specialist nurses are members of the Infection Prevention Society and the senior ICNs participate in the Sussex IPC cell which aims to share and discuss local initiatives and work towards common goals across Sussex. The Head of IPC represents the Trust in the NHSE IPC Network, interpreting local application of national guidelines, IPC related safety briefings and regional best practice.

Mandatory surveillance of community acquired *Clostridioides difficile* infections and Gram-negative bacteraemias and *Staphylococcus aureus* has continued to be undertaken by the ESHT IPC team on behalf of the local ICB.

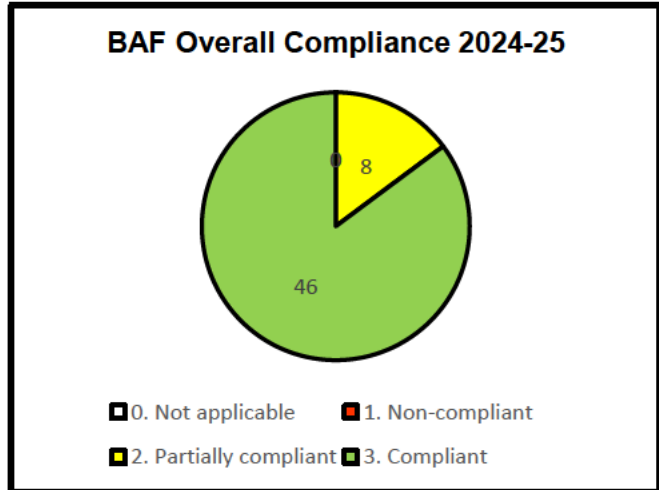
3. Compliance with Outcome 8 Regulation 12 “Cleanliness and Infection Control” Health & Social Care Act 2008 and the new NHS IPC Board Assurance Framework.

The Infection Control Board Assurance Framework is structured around the 10 criteria set out in the Code of Practice on the Prevention and Control of Infection linked to Regulation 12 of the Health and Social Care Act 2008.

The aim of the framework is to identify risk associated with infectious agents and outline a corresponding systematic framework of mitigation measures. It should be noted that the IPC BAF is iterative and has changed over time.

The Trust performance against framework standards is discussed at the Trust Infection Prevention and Control Group (TICPG) which also receives reports from Divisions as evidence of local compliance and assurance.

Overall, in March 2025 there was evidence of compliance with 46 of the 54 key lines of enquiry, which is an improved position on last year.



BAF - Key Lines of Enquiry Criteria	
<p>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 their environment and other users may pose to them</p> <p>Partial compliance 6/8. Further assurance required for compliance with IPC policies, post infection review shows delays in specimen collection and some areas have low compliance with hand hygiene. Attendance at mandatory training is compliant at 90% but junior doctor compliance is at 76%.</p>	
<p>2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections</p> <p>Fully Compliant 9/9</p>	
<p>3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance</p> <p>Partial compliance 2/6 This is currently the most challenging criteria for ESHT. Antimicrobial stewardship has been escalated via the TICPG and Medicine Optimisation Group and IGM. AMS ward rounds have realised real improvements in prescribing and lower CDI but are difficult to sustain due to staffing. Overall antibiotic use is stable but use of antimicrobials from watch and reserve category is high as is prescribing of antibiotics that are higher risk for CDI.</p>	
<p>4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion</p> <p>Fully Compliant 5/5</p>	

<p>5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others</p> <p>Fully Compliant 5/5</p>
<p>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</p> <p>Partial compliance 5/6</p> <p>There is a need to re-embed standard and transmission based precautions. There is a revised standard for management of high consequence infectious diseases which requires significant additional training resource. The education team, vascular access and IPC working towards competency assessment with IPC as part fundamental skills training and a review of how we can provide cost effective training on aseptic non touch technique is being considered by the education team.</p>
<p>7. Provide or secure adequate isolation precautions and facilities</p> <p>Fully Compliant 4/4</p> <p>ESHT is compliant, however this requires considerable resource to maintain compliance and manage risk.</p>
<p>8. Provide secure and adequate access to laboratory/diagnostic support as appropriate</p> <p>Fully Compliant 7/7</p>
<p>9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections</p> <p>Partial compliance 0/1</p> <p>Several IPC policies are overdue for review. Solutions are being sought to support audit of compliance.</p>
<p>10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection</p> <p>Fully Compliant 3/3</p>

Compliance with the IPC BAF is reported to the Quality Safety Committee on a quarterly basis.

4. Epidemiological Commentary

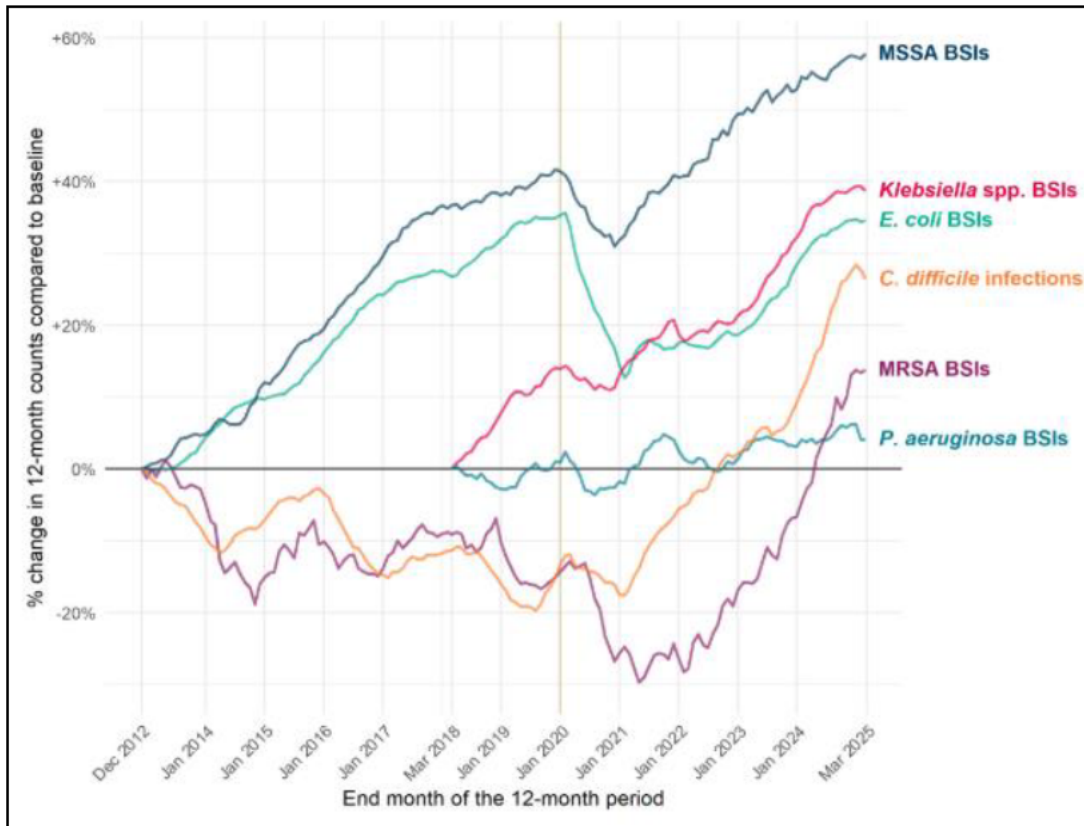
The criteria for attributing healthcare associated infections via the mandatory HCAI Data Capture System changed on 1st of April 2024. Admission date is now calculated from the time of a decision to admit rather than actual admission to a ward. Patients receiving treatment in the virtual ward are now considered the same as inpatients and treatment on the virtual ward counts as a healthcare admission when considering prior healthcare exposure in patients with a community onset bacteraemia.

Standard contract limits set for 2024/25. Overall expectation is to achieve a 5% reduction this year. The limits set for ESHT are:

<i>C. difficile</i>	67
<i>E. coli</i>	109
<i>P. aeruginosa</i>	19
<i>Klebsiella spp.</i>	47

There have been no limits set for MSSA and the expectation for MRSA remains as zero avoidable infections.

The annual epidemiology shows that since the onset of the pandemic reportable HCAIs have increased with most significant increase in MRSA bacteraemia from the previously very low baseline. The reasons for this national increase is not yet fully understood but is thought to be a consequence of the pandemic.



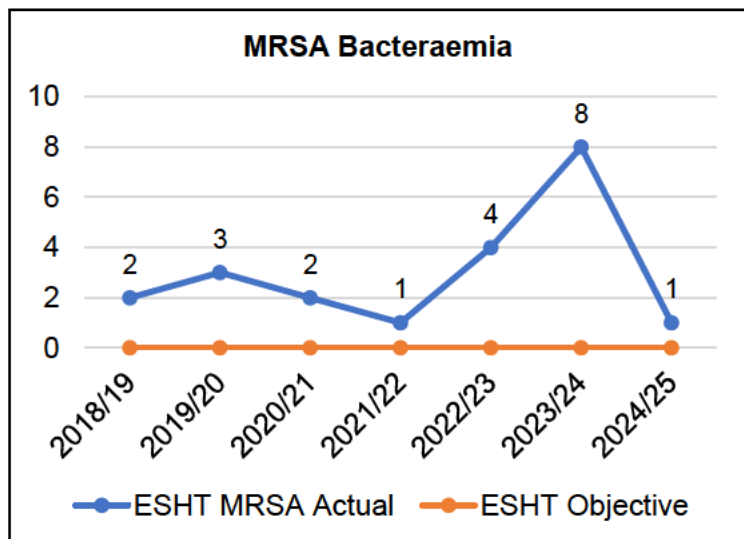
Each Trust is set an annual objective. Not all cases of CDI or bacteraemias are avoidable or due to lapses and therefore the focus is on preventing avoidable harm.

4.1 MRSA bacteraemia

ESHT continues to have a zero tolerance to cases of MRSA bacteraemia that could potentially be avoidable. ESHT reported 1 case of healthcare associated MRSA bacteraemia in April of 2024/25 compared to 8 cases in 2023/24.

The community onset infection occurred in a 71 year old male who was admitted with a history of MRSA from a wound swab sample taken on a previous admission. Patient was being treated for diabetic foot sores. Routine MRSA screen was negative. Pus swab from wound and blood culture isolated MRSA.

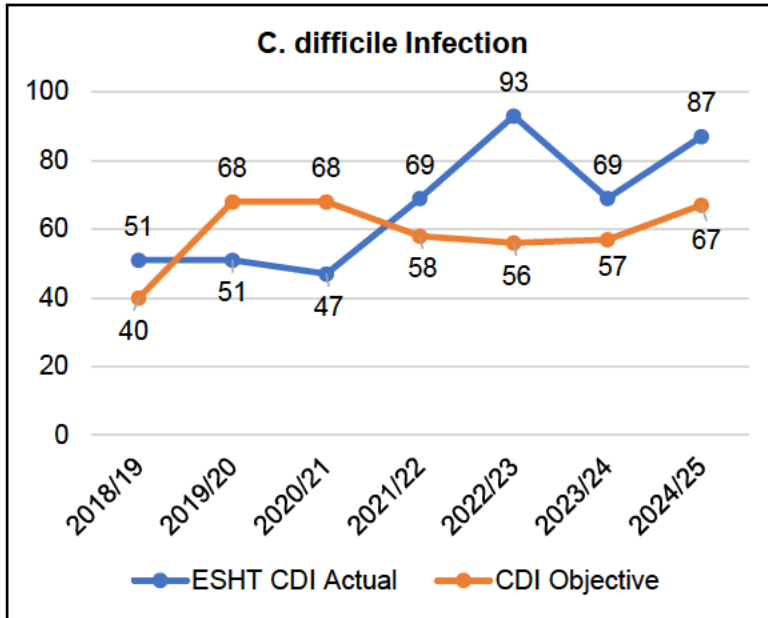
Post infection review concluded that the MRSA BSI was unavoidable as the wound was already known to be colonised with MRSA prior to admission and was treated appropriately at ESHT.



In 2024/25 as a result of this improved performance, ESHT was ranked 6 of 134 (was 124 in 2023/24) for in MRSA in England and regionally in the Southeast at 2 of 18 (was 17 in 2023/24).

4.2 C. difficile Infection (CDI)

The annual limit set for 2024/25 was 67 cases for ESHT to take account of prior healthcare exposure within 28 days.



In total 87 cases were attributed to ESHT for 2024/25 and occurred in 81 patients.

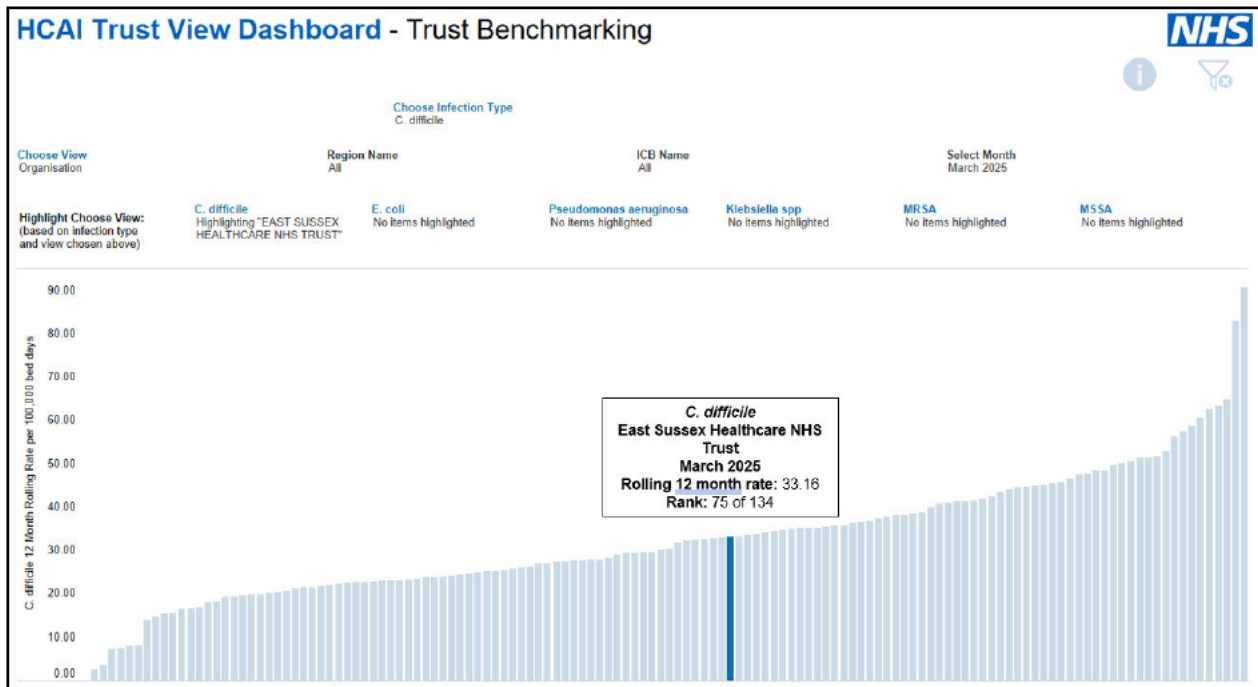
28 cases (32%) were Community Onset Healthcare Associated (COHA) because the CDI diagnosis was made within 28 days of a patient's previous treatment in hospital rather than related to a current admission.

The number of *C. difficile* infections reported annually within ESHT is shown in the table below.

C. difficile toxin Infection 2024/25 – limit 67						
Quarter	Limit	ESHT			ICB Actual	Combined Total
		HOHA	COHA	TOTAL		
Q1	17	18	10	28	14	42
Q2	17	18	8	26	16	42
Q3	16	15	7	22	7	29
Q4	17	8	3	11	12	23
TOTAL	67	59	28	87	49	136

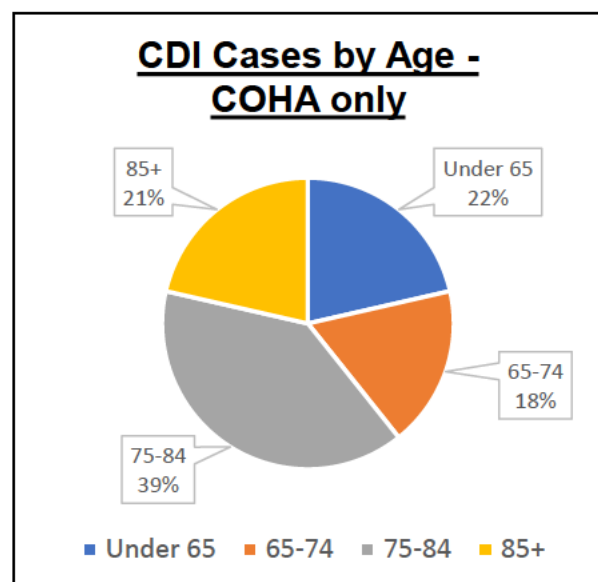
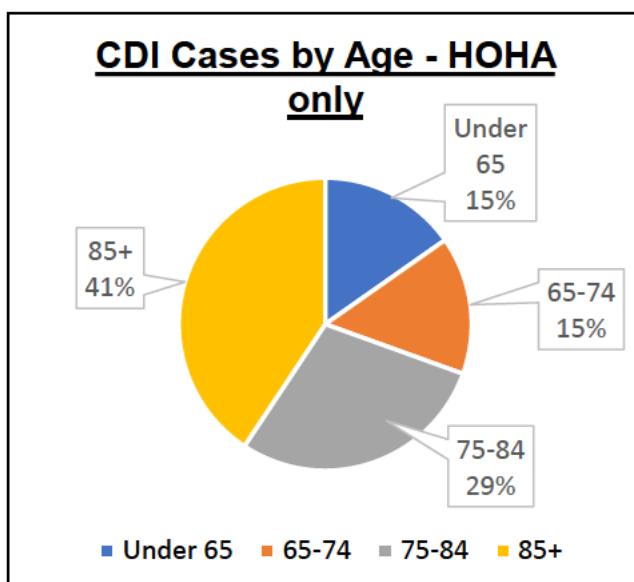
There is no significant difference in the number of infections diagnosed on each acute site, Conquest 43 and EDGH 44, with EDGH having one more hospital onset infection, but equal numbers of COHA infections.

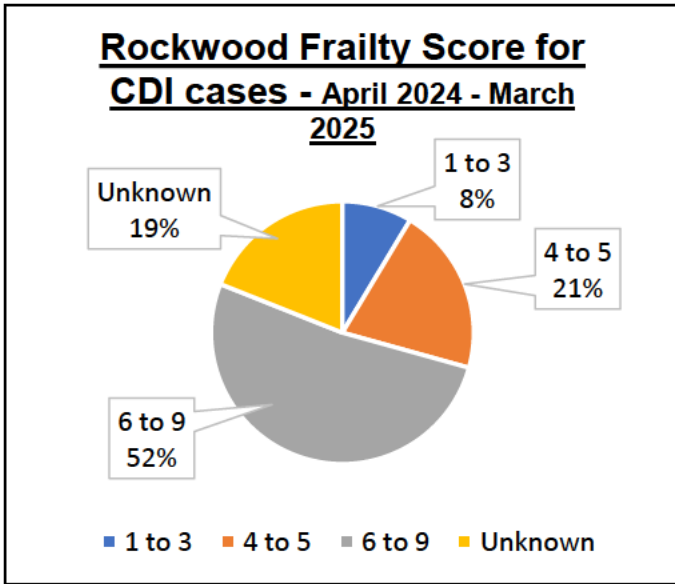
18% of community onset infections had not had an overnight stay for treatment but still met the criteria for attributing to ESHT because they were coded as admissions (this is the same as 2023/24).



In 2024/25 we ranked 75 of 135 (was 67 in 2023/24) for *C. difficile* in England and regionally in the Southeast at 14 of 18 (was 12 in 2023/24). It is likely that our integrated Trust function contributes to the number of COHA infections that we report as both patients acute and community care is attributed to ESHT. Trusts do not code patients in the same way, therefore it can be difficult to directly compare Trusts in relation to COHA infections.

The risk of CDI increases exponentially with age which also means we are more likely to have cases than organisations treating a younger population.





70% of hospital onset infection and 60% of community onset infection, occurred in patients aged 75 or over. In addition to advancing age, 52% of patients were very frail (with a Rockwood score of 6 or more).

The antimicrobial steering group (ASG) is reviewing prescribing policies aiming to provide guidance on prescribing in older people to minimise the risk of CDI.

All Hospital Onset Healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) CDI cases have had a multidisciplinary post infection review (PIR) where the patient risk factors, cleanliness, antimicrobial

prescribing, and adherence to policy is assessed. The outcome is either No lapse in Care (Green), Lapse in Care that is unlikely to have contributed to the CDI (amber) and Lapse in Care that is likely to have contributed to the CDI (red).

PIRs	2024/25
No Lapse in Care	50 (57.5%)
Lapse in Care likely to have contributed to outcome	10 (11.5%)
Lapse in Care unlikely to have contributed to outcome	27 (31%)
TOTAL cases	87

Lapses in Care

The year ended with 10 cases thought to have been lapses in care. 8 cases were assessed as lapses due to evidence of cross infection as supported by ribotyping and subtyping by the *C. difficile* reference laboratory. A further red case was the index case of the outbreak as it was felt this patients treatment was not escalated in line with Trust policy. There was one lapse not related to the outbreak, a patient at Bexhill Irvine Unit did not have their ongoing CDI notified to the Consultant microbiologists for escalation of treatment. Lessons learnt have been widely shared at Trust and divisional governance, patient safety and matrons groups.

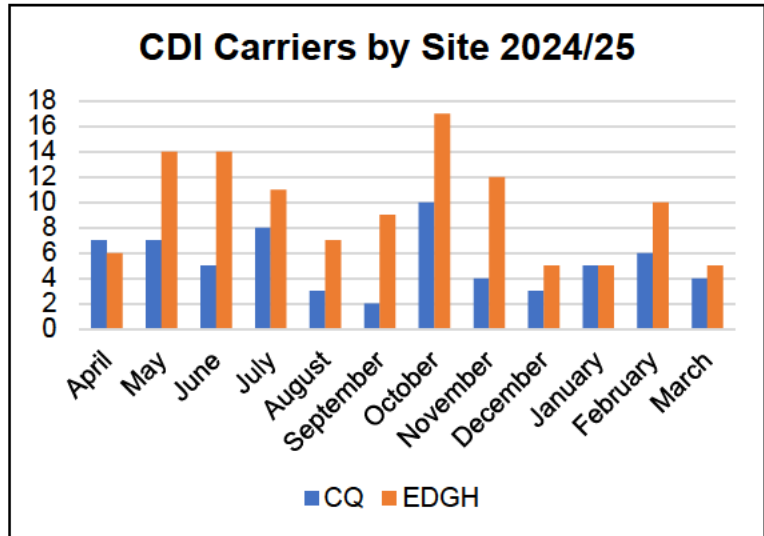
Outbreaks and Periods of Increased Incidence (PIIs)

The 002 *C. difficile* ribotype was dominant since April with 18 cases identified, of which 14 have occurred at EDGH. This ribotype is among the five most commonly reported in England but has not been previously dominate locally. All cases were sent to the CDI reference laboratory for subtyping. Cases with an epidemiological link to Littlington, Frailty and Stroke were shown to be indistinguishable. The outbreak was managed in line with trust policy and duty of candour was undertaken. Patient movement and an inability to undertake enhanced environmental decontamination after each case due to high bed occupancy and operational escalation, was identified as contributory. Wards have since been treated with HPV when emptied as part of remedial fire safety work. As a result of learning, the need for HPV decontamination is escalated via clinical site meetings to gain support for this process.

C. difficile carriers

179 tests identified a CDI carrier (115 at EDGH and 64 at Conquest). 136 (76%) were in hospital or admitted to hospital when identified as carrier. Of these 49 were at Conquest and 87 at EDGH. The 179 tests equated to 148 patients.

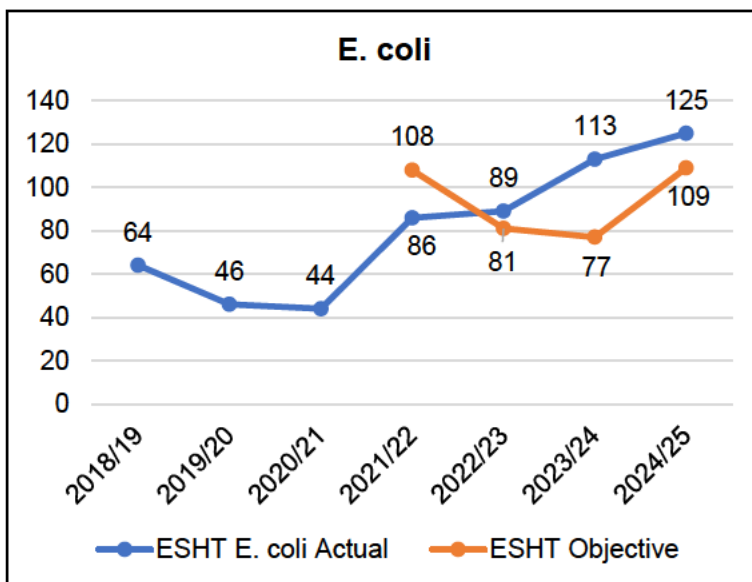
C. difficile carriage increases the risk of infection and also increases transmission burden of *C. difficile* as carriers shed the bacteria. Symptomatic carriers receive antimicrobial treatment. Nine carriers went on to become CDI toxin positive.



4.3 Gram-negative Bacteraemias

4.3.1 E. Coli

E. coli 2024/25 – limit 109					
Month	ESHT			ICB Actual	Combined Total
	HOHA	COHA	TOTAL		
Q1	19	18	37	62	99
Q2	17	16	33	62	95
Q3	13	14	27	70	97
Q4	15	13	28	73	101
TOTAL	64	61	125	267	392

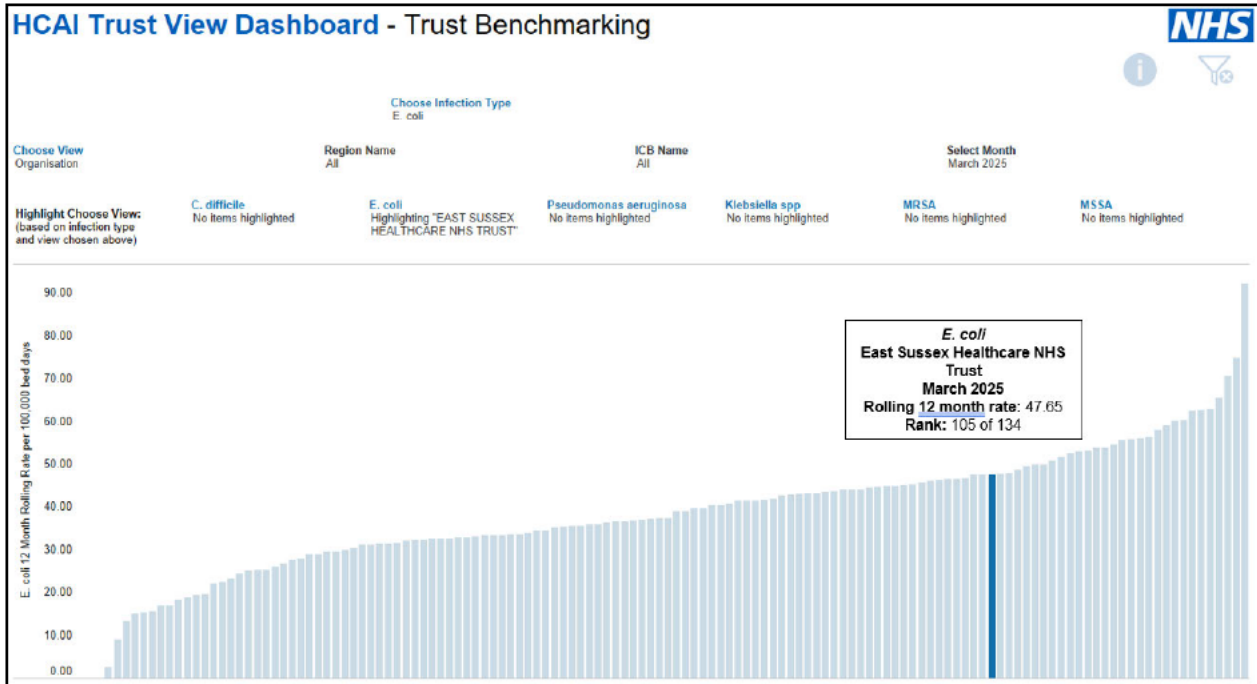


We have reported 125 cases of *E. coli* bacteraemia, against a limit of 109. There were 64 cases of Hospital Onset Healthcare Associated (HOHA) *E. coli* bacteraemia.

The most common source was urinary tract infection (34 cases), followed by hepatobiliary (22 cases).

A further 61 cases were Community Onset infection where the patient had prior healthcare within 28 days. It is very difficult to influence community onset cases with patients in their own homes.

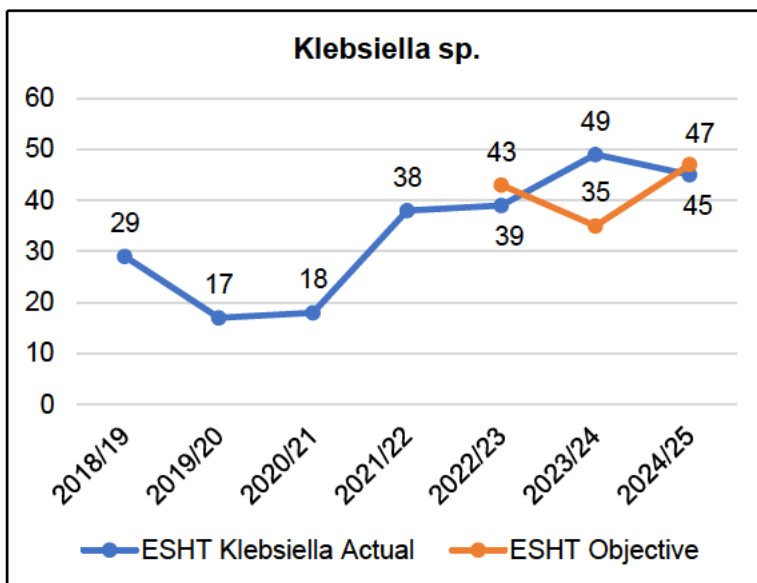
Deconditioning, dehydration, poor mobility and subsequent urinary tract infection can all increase the risk of *E. coli* bacteraemia.



In 2024/25 we were ranked 105 of 134 (was 102 in 2023/24) for *E. coli* in England and regionally in the Southeast at 13 of 18 (was 11 in 2023/24).

4.3.2 *Klebsiella* sp.

Klebsiella sp. 2024/25 – limit 47					
Month	ESHT			ICB Actual	Combined Total
	HOHA	COHA	TOTAL		
Q1	9	6	15	18	33
Q2	7	4	11	16	27
Q3	9	4	13	10	23
Q4	3	3	6	15	21
TOTAL	28	17	45	59	104



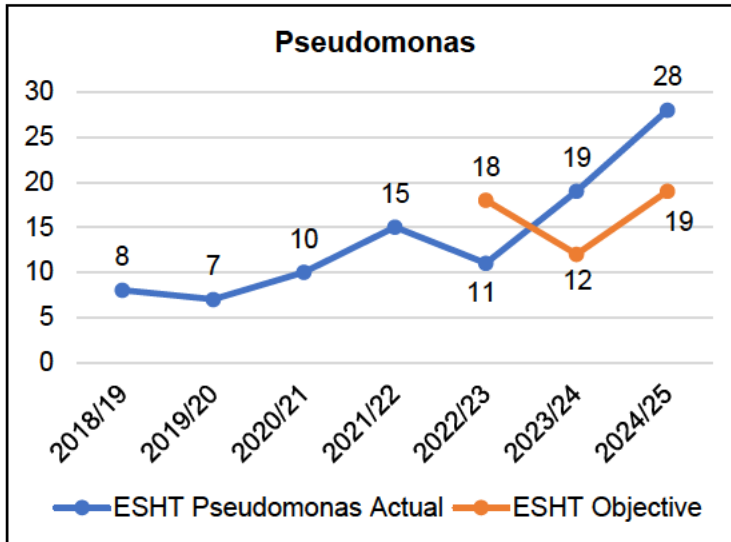
ESHT reported 45 cases of *Klebsiella* bloodstream infection against a limit of 47.

The most common source was urinary tract infection (10 cases), followed by hepatobiliary (9 cases).

In 2024/25 ESHT was ranked 88 of 134 (was 105 in 2023/24) for in *Klebsiella* spp. in England and regionally in the Southeast at 11 of 18 (was 15 in 2023/24).

4.3.3 Pseudomonas

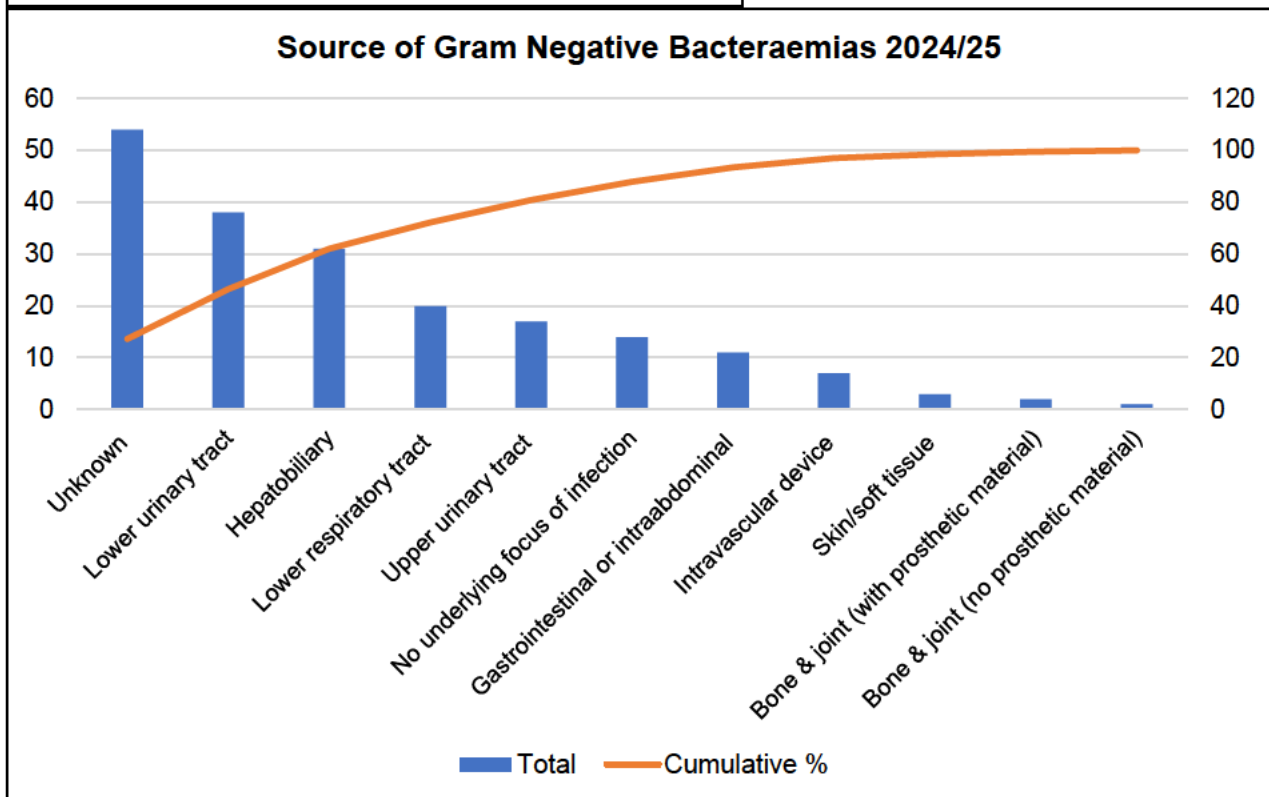
Pseudomonas 2024/25 – limit 19					
Month	ESHT			ICB	Combined
	HOHA	COHA	TOTAL	Actual	Total
Q1	6	2	8	4	12
Q2	4	2	6	7	13
Q3	3	6	9	2	11
Q4	1	4	5	4	9
TOTAL	14	14	28	17	45



ESHT reported 28 cases of *Pseudomonas* bloodstream infection against a limit of 19.

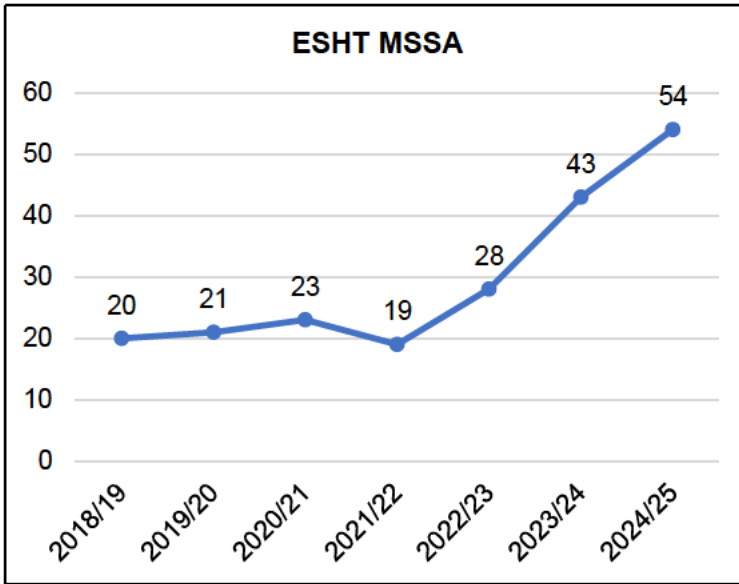
The most common source of *Pseudomonas* bacteraemia was urinary tract infection (11 cases).

In 2024/25 we were ranked 116 of 134 (was 94 in 2023/24) for in *Pseudomonas* in England and regionally in the Southeast at 15 of 18 (was 11 in 2023/24).



4.4 Methicillin Sensitive *Staphylococcus Aureus* (MSSA)

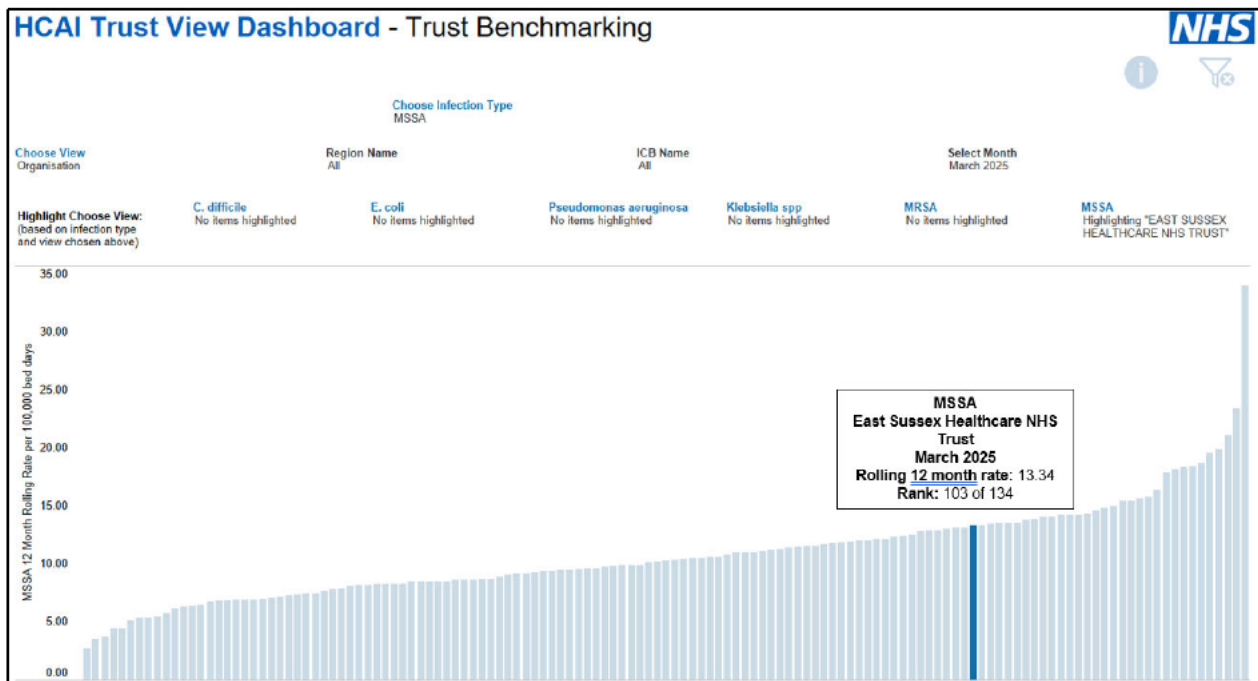
MSSA 2024/25					
Month	ESHT			ICB	Combined
	HOHA	COHA	TOTAL	Actual	Total
Q1	16	5	21	14	35
Q2	6	4	10	15	25
Q3	9	5	14	16	30
Q4	4	5	9	15	24
TOTAL	35	19	54	60	114



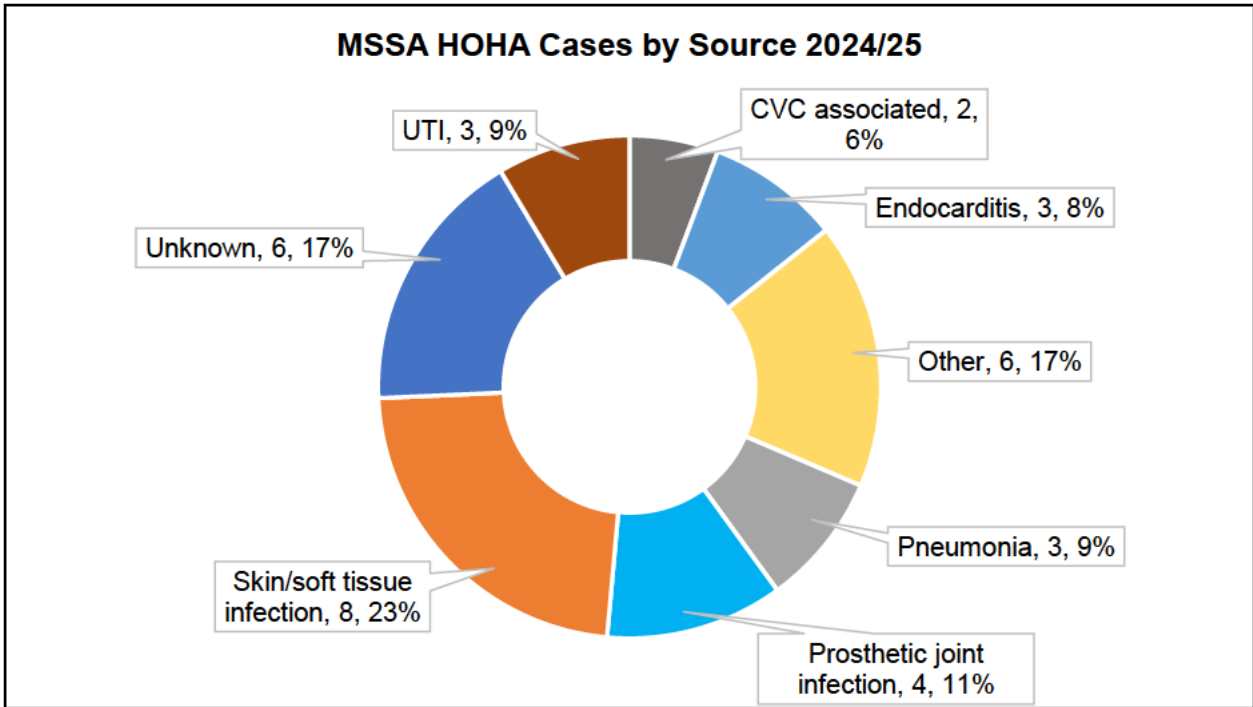
No limit has been set for MSSA blood stream infections for Trusts. The bacterium is commonly found on the skin of >20% of the general population.

54 MSSA bacteraemia were reported for 2024/25.

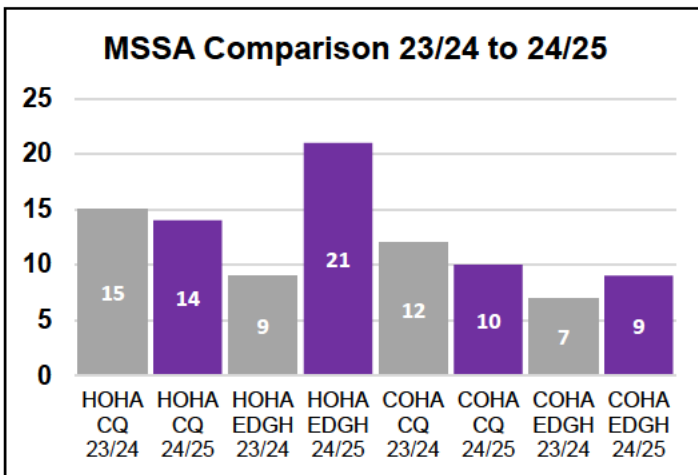
The reason for increases in MSSA bacteraemia post pandemic is not fully understood. IPC have commenced PIR on all hospital onset MSSA bacteraemia to try to understand what is driving the local increase.



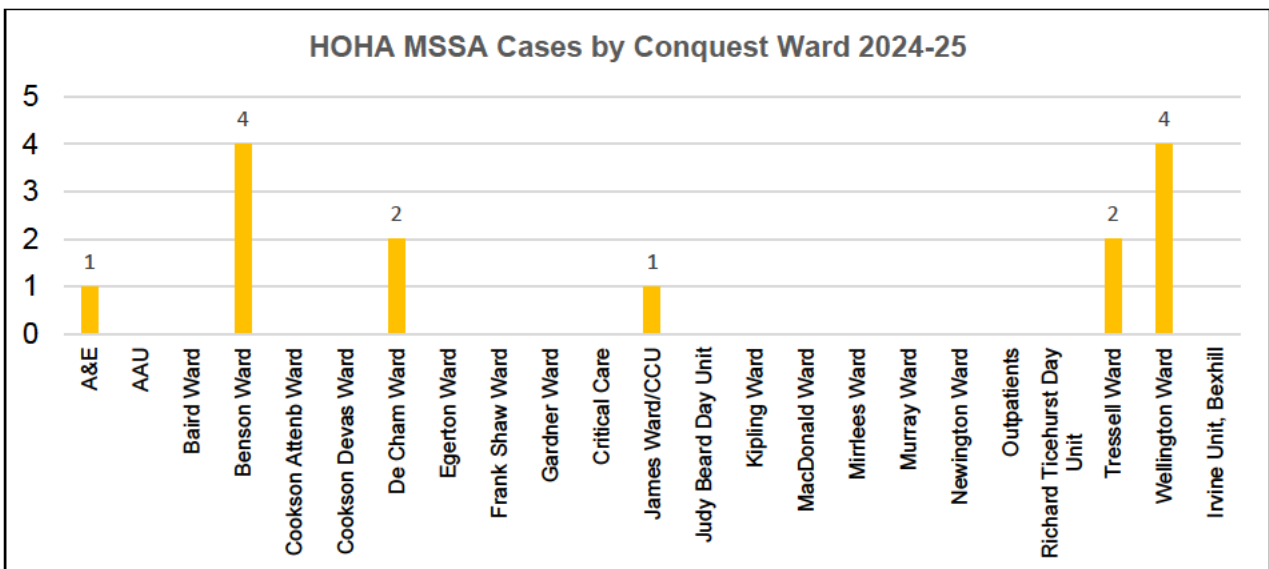
In 2024/25 we were ranked 103 of 134 (was 61 in 2023/24) for MSSA in England and regionally in the Southeast at 15 of 18 (was 8 in 2023/24).

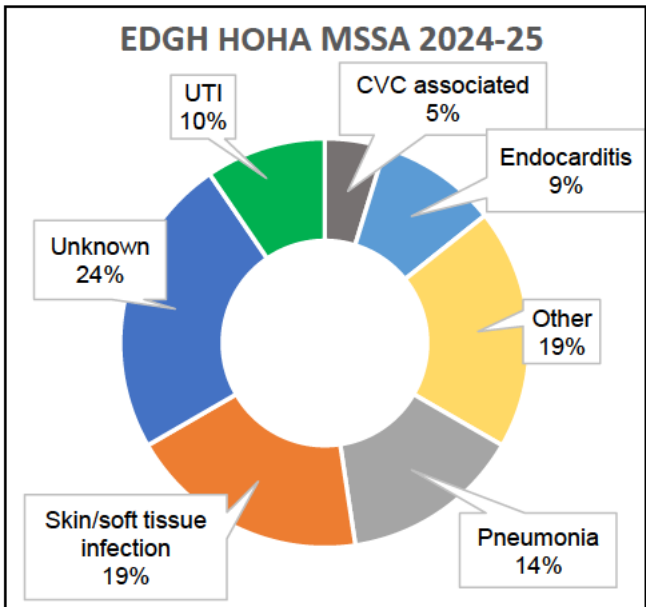
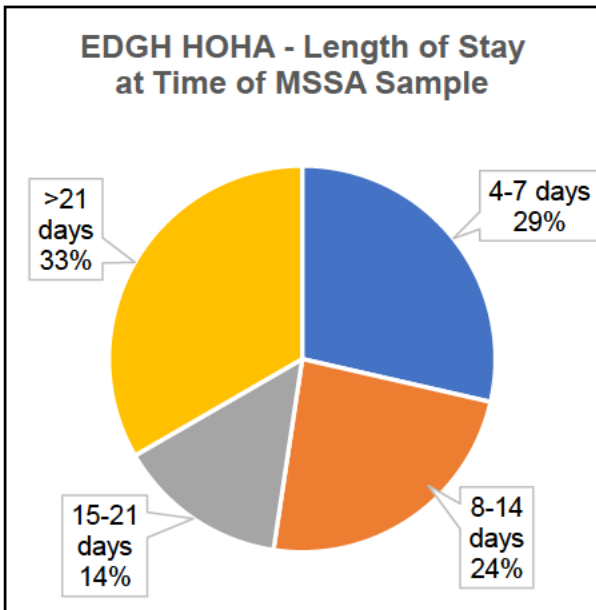
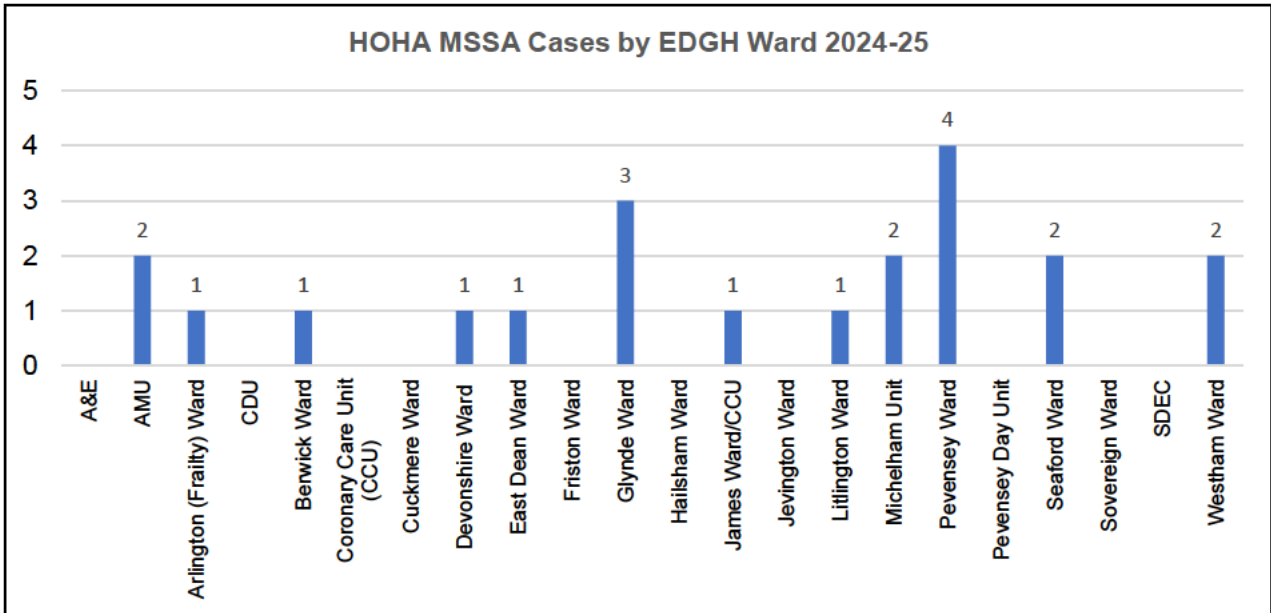


Skin/soft tissue was the most common source of infection.



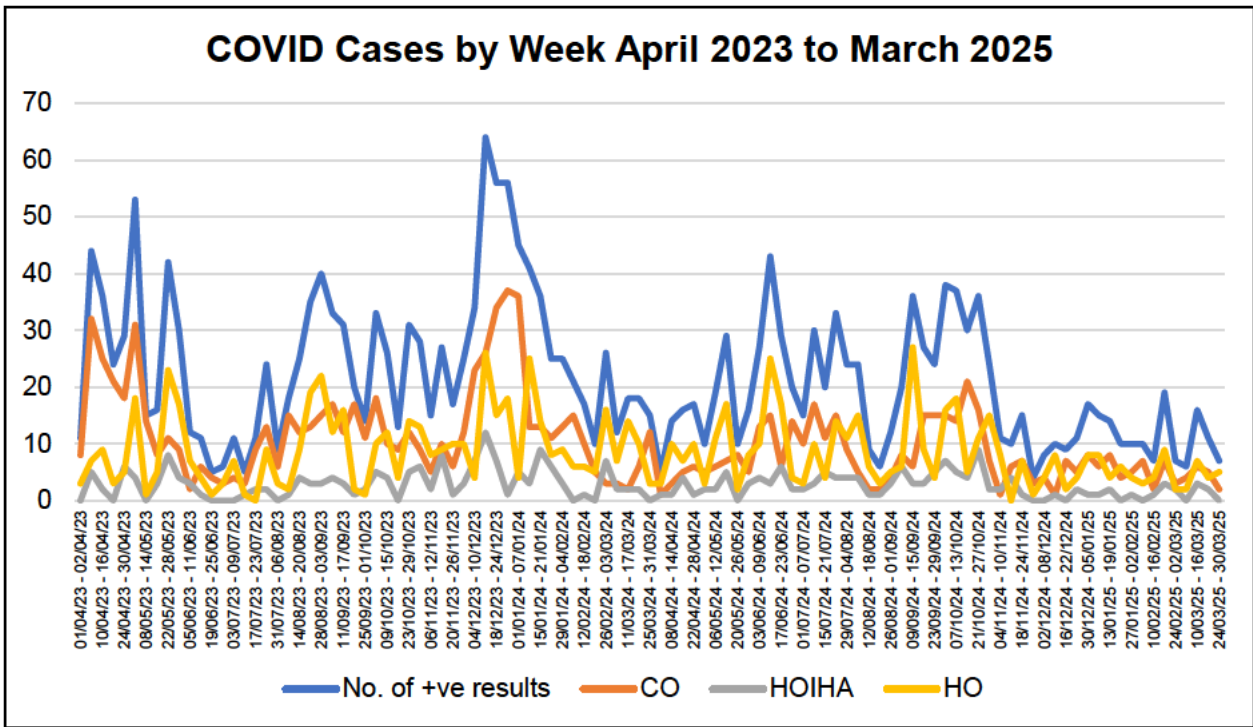
The bar chart (left) shows that in 2024/25 the number of MSSA infections reduced at Conquest (from 27 in 2023/24 to 24 in 2024/25), but increased at EDGH from 16 in 2023/24 to 30 cases in 2024/25.





4.5 SARS-CoV-2, COVID-19

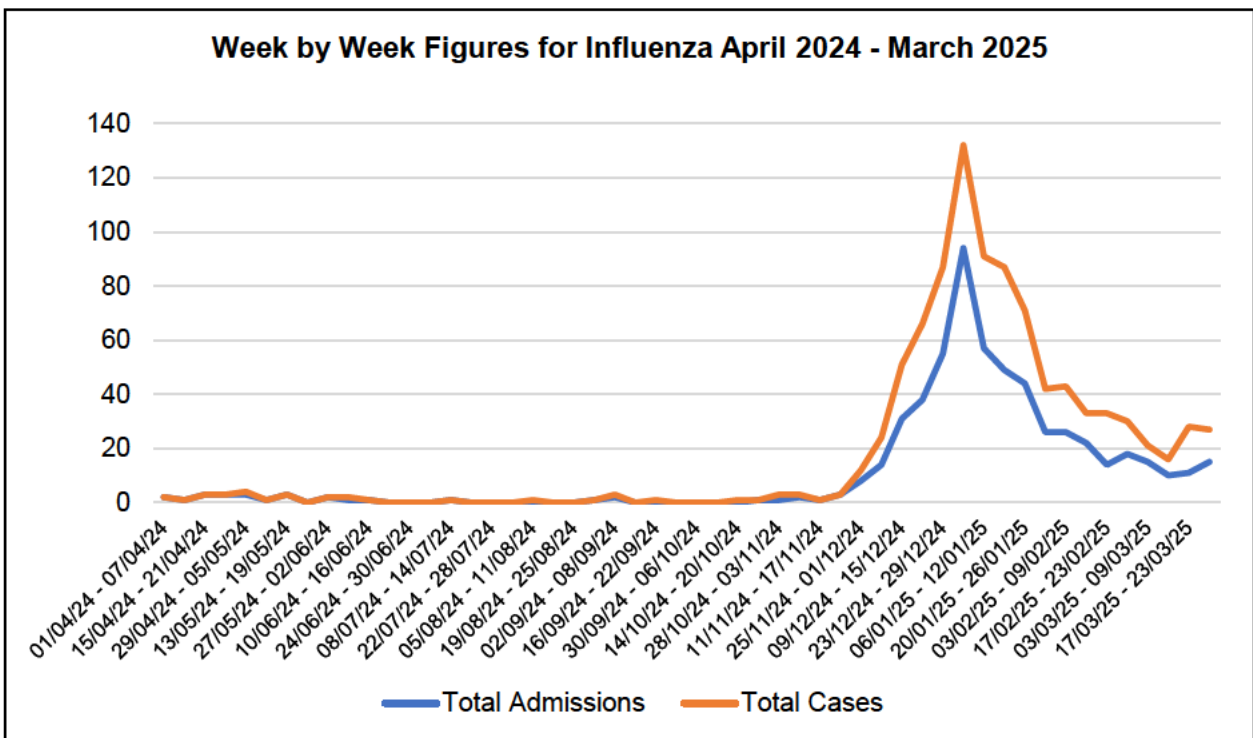
933 cases of covid were identified. Testing remains focused on symptomatic patients and those exposed in outbreaks. The Trust continued to experience COVID outbreaks with prevalence increasing and declining in a wave like pattern. Most patients did not require significant additional treatment.

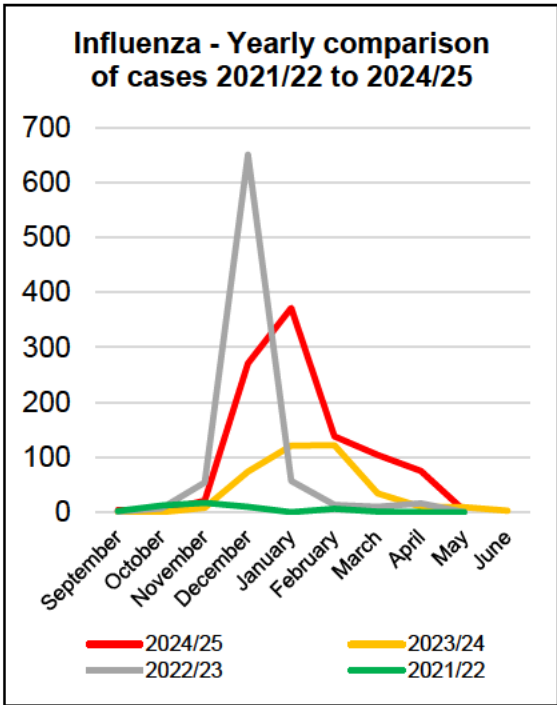


There have been multiple COVID outbreaks requiring ward closure to non-covid admissions. Wards without air changes in bays at EDGH have higher hospital onset cases, this has been escalated to the ventilation safety group and mobile Hepa-filters deployed to support air quality during periods of high prevalence. IPC work closely with the operational site team to minimise void beds due to COVID, using Nervecentre liveflo data to map appropriate admissions to available beds.

4.6 Influenza

All acute trusts are required to report (on a weekly basis during the Influenza season) the number of cases of Influenza requiring admission and additionally the number of cases admitted to intensive care to determine the national “burden” on critical care units.





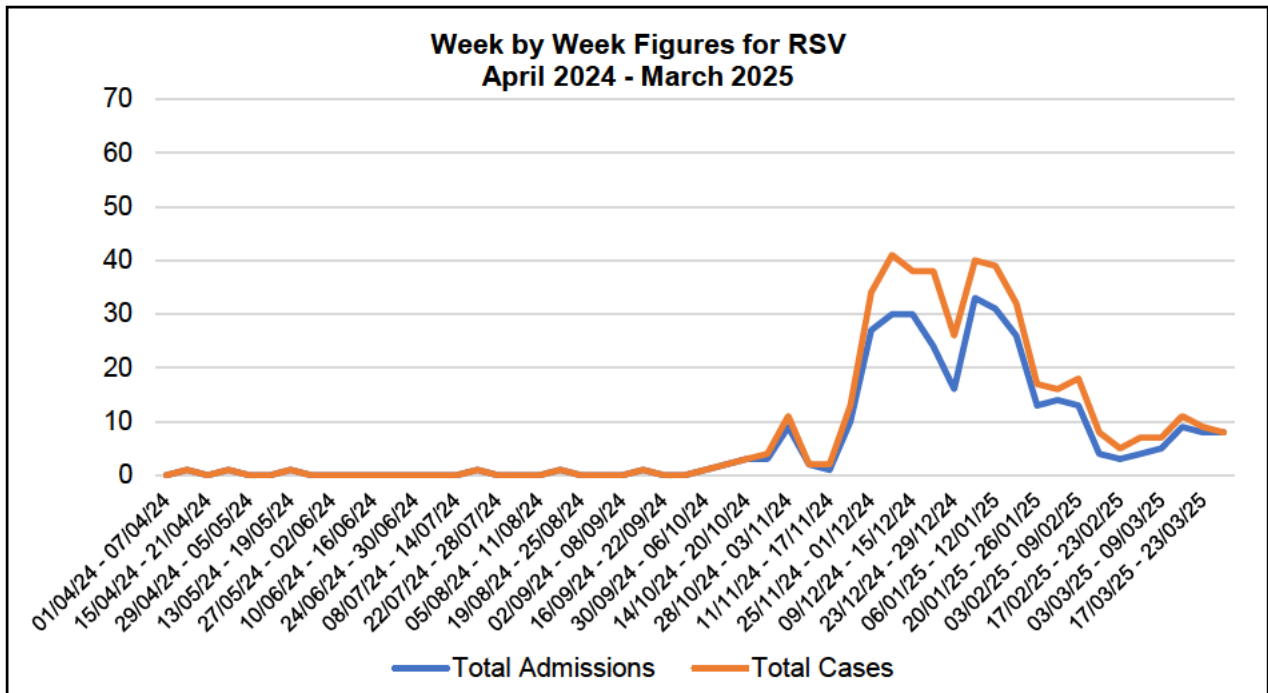
There was a lengthy flu season during the year commencing in late November with patients diagnosed until April. Overall, 939 cases of infection were diagnosed of which 579 (62%) were admitted to hospital. 366 (63%) were admitted at Conquest and 213 at EDGH.

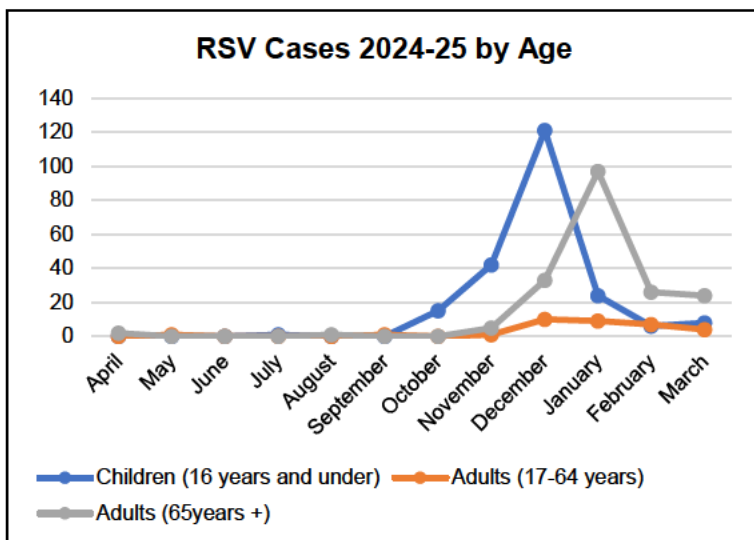
Ninety five infections were assessed as hospital onset (17% of those admitted), with outbreaks mainly confined to bays that were well managed in line with the winter IPC plan.

Vaccination of ESHT frontline clinical staff for flu was managed by Occupational Health.

4.7 RSV

438 cases of infection were diagnosed, of which 335 (76%) were admitted. 216 (64%) were admitted to Conquest and 119 to EDGH.





Seventy cases were assessed as hospital onset (16%), 94% of which occurred in adults aged 65 years or over. Patients were isolated for 5 days while symptomatic, to try to minimise the negative impact on deconditioning that can occur in isolated older patients.

4.8 Norovirus

In February 2025 we were notified by UKHSA that Norovirus was circulating at the highest level recorded since 2014 and that multiple genotypes were involved which could result in patients being infected more than once in the season. At ESHT confirmed cases occurred on Arlington, Benson Egerton Trauma Unit, Newington, Littleington, Devonshire, East Dean, CCU(E) and Irvine Unit. Cases were confined to bays on most wards apart from BETU where several bays were closed. Norovirus remained prevalent in March with less impact. Hepa-filters were deployed during outbreaks and seemed to reduce the extent of transmission.

4.9 Mandatory Surgical Site Infection Surveillance Scheme

Surgical site surveillance is conducted prospectively and submitted quarterly. However, as results are influenced by infections that develop 365 days after surgery results are published 12 months retrospectively. Finalised results are available up to 31st March 2024 (see table below). ESHT has completed surveillance for 3 quarters for knees and hips.

Category of Surgery	Number of Procedures	Number of Infections	Infection Rate	Mean Infection Rate for all participating Trusts
Total knee replacement	234	1	0.4 %	0.4
Total hip replacement	305	3	1.0 %	0.5

There has been an increase in the infection rates for both categories since April 2022- 2023. Two of the three infections in the total hip replacements were in one patient who had 2 separate infections with different microorganisms. The patient was identified as high risk prior to surgery due to impaired immune system and latent TB. The other total hip replacement and the total knee replacement identified MSSA as the causative microorganism. The trust is currently reviewing the MRSA/MSSA policy.

5. Emerging Threats and Operational Preparedness

5.1 High consequence infectious disease (HCID) and mPox

MPXV is a virus from the same family as smallpox, which presents with a rash illness which may be mild and localised, or severe and disseminated. There are 2 distinct clades of the virus: Clade I and Clade II.

Clade II MPXV is responsible for the global outbreak that began in 2022. There have been many cases locally since and numbers are reducing. This is not classed as high consequence infectious disease.

Clade I MPXV was considered more severe than Clade II MPXV, leading to its classification as a high consequence infectious disease (HCID). This is associated with travel to Central and East Africa or contact with a person who has acquired the infection in Central or East Africa. The World Health Organisation (WHO) declared a global emergency on 14/08/24 in concern for increased spread of this type of Mpox. In August 2024, UKHSA issued a CAS alert requiring healthcare providers to prepare for possible case(s) although the risk in the UK was assessed as low.

Providers were instructed to ensure that relevant clinical services considered a differential diagnosis of Clade I mpox virus (MPXV) infection in any patient who meets the operational case definition. Adequate stocks of appropriate personal protective equipment (PPE), staff are training and a clear clinical pathway was implemented.

HCID preparedness tabletop event had been undertaken at ESHT earlier in August and formed the foundation for planning preparedness actions for Mpox and other high consequence infectious diseases. While MPXV has now been downgraded from a HCID, the learning and actions have improved local HCID preparedness.

The new level of HCID PPE has been procured. HCID preparedness boxes have been delivered to all gateway areas and a surplus stock added to the EPRR store. EPRR has agreed to support initial PPE training via the existing CBRN training days. Significant further work is required with clinical education to agree on how we can access and disseminate new training required for managing PPE for High Consequence infectious diseases. The risk is registered with EPRR.

5.2 Respiratory Mask Fit testing

Anyone wearing an FFP3 mask is legally required by the H&S executive, to be fit tested by an accredited mask fitter. It remains mandatory for all patient facing staff at ESHT to be fitted to a minimum of two FFP3 masks so that there is low reliance on a specific product. Staff need to be retested as part of the requirement and to be retested within two years.

A mask fit testing service is provided at both acute sites and offers appointments between 6am and 10pm on specific weekdays. Saturday morning appointments are provided monthly and fit testing of teams at other locations can be accommodated on request. The fit testing team is managed by the Head of IPC.

Appointment activity has risen from 4497 in 2023/24 to 4658 in 2024/25. There are over 1700 staff fitted to two masks (gold standard) and over 1500 staff fitted to one mask or allocated a powered hood. Non-attendance at booked appointments remains unchanged at 25%.

Compliance is monitored at divisional performance review and presented quarterly for assurance to TICPG.

6. Incidents related to Infection

6.1 Serious Incidents (SIs) and Risks Managed by the IPC Team

ESHT reports outbreaks of infection as possible serious incidents to the Weekly Patient Safety Summit (WPSS) who discuss and agree the approach required. These include incidents where there has been a significant impact on the running of the Trust's services (ward closures for example), or where there has been a severe impact on patient outcome. In addition to this, the team undertake risk assessments in response to organisms that could pose a risk to patients and/or staff to ensure they were safely managed. The PIR/RCA investigations and subsequent recommendations and completion of actions are monitored by the TICPG.

An outbreak of MRSA on Frailty ward identified two patients who probably acquired MRSA in their wounds as a result of an MRSA carrier being cared for in the same bay. Outbreak investigation identified that some staff were not aware of the patients MRSA status, the patient had been assessed to remain in the bay on decolonisation as no isolation available at the time, however the patient was not compliant with decolonisation (to reduce risk of transmission) and in such cases we should raise the requirement for isolation. The two patients with wounds developed these during their stay, one related to an underlying skin condition so not preventable and this patient remains in hospital due to other reasons. The other patients wound was possibly due to pressure injury from their catheter, the patient was discharged.

Three cases of *Stenotrophomonas* on Critical Care at EDGH were investigated. Testing of water outlets was undertaken and did not isolate *Stenotrophomonas sp.* The reference laboratory reported that the samples were not the same and therefore the outbreak has been closed.

An increase in MRSA and MSSA c-section wound infections was noted in August 2024. Screening and decolonisation of elective patients has been strengthened and additional requirements for screening and decolonisation of emergency cases has been introduced to reduce the risk of post operative wound infections.

An investigation into two patients on Gardner ward and one on Devas with Glycopeptide resistant enterococcus (GRE) in November, indicated that cases were related. Outbreak control group was convened and environmental swabbing and further high level decontamination to be undertaken on critical care and Gardner B bay. Another cluster of GRE related to De Cham was identified during February. Outbreak meetings were convened with clinical teams. IPC supported additional environmental decontamination and training on GRE and hand hygiene.

7. Promoting Standard Infection Prevention Precautions

7.1 Hand Hygiene Promotion

A comprehensive, week-long campaign was launched to celebrate World Hand Hygiene Week in May 2024, emphasizing the critical importance of clean hands across all healthcare settings. Multiple wards and departments produced imaginative displays to engage staff. The use of glowbox hand hygiene toolkit continues to be popular with both acute and non-acute infection control link facilitators providing team hand hygiene training updates.

7.2 Hand Hygiene Compliance

For the 2024-2025 period, the Trust demonstrated high overall hand hygiene compliance, achieving 98% in inpatient areas and 99% in non-inpatient areas. This strong performance was supported by significant engagement initiatives, most notably a comprehensive, week-long campaign for World Hand Hygiene Week in May 2024. The campaign featured widespread communications, promotional kiosks, a staff newsletter competition, and a dedicated focus on patient hand hygiene, successfully reinforcing the critical importance of clean hands across all healthcare settings. IPC undertake triangulation audits to further support assessment of compliance.

Despite the high overall scores, there are several areas that did not submit the Hand Hygiene Audits as required monthly. Even though there was a total of 1905 audits submitted for the non-inpatient areas, only an average of 26 out of 65 areas had submitted their audits throughout the year. Following guidance from the TIPCG meeting, the triangulation audit tool was updated to align with the standard monthly audit, ensuring data consistency. There was also inaccurate data in EDGH due to closure of wards and movement of services to support essential estates and fire compartmentation work.

In-Patient Areas

2024 - 2025	Total Number of Audits Submitted	Hand Hygiene Before Patient Contact	Hand Hygiene After Patient Contact	Bare Below Elbows	Hand Hygiene Technique	Overall Compliance	IPCT Triangulation Audit
Quarter 1	1672	98%	99%	99%	99%	99%	83%
Quarter 2	1493	97%	99%	99%	98%	98%	82%
Quarter 3	1382	97%	99%	98%	98%	98%	60%
Quarter 4	1368	98%	99%	98%	98%	98%	86%
ANNUAL TOTAL	5915	98%	99%	99%	98%	98%	77%

Non In-Patient Areas

2024 - 2025	Total Number of Audits Submitted	Bare Below Elbows	5 Moments of Hand Hygiene	Hand Hygiene Technique	Overall Compliance	Glow Box Hand Hygiene Training
Quarter 1	424	99%	99%	99%	99%	83%
Quarter 2	354	100%	99%	100%	99%	82%
Quarter 3	495	100%	99%	100%	99%	60%
Quarter 4	632	100%	99%	100%	99%	86%
ANNUAL TOTAL	1905	100%	99%	99%	99%	77%

7.3 Infection Prevention & Control Compliance Monitoring Programme

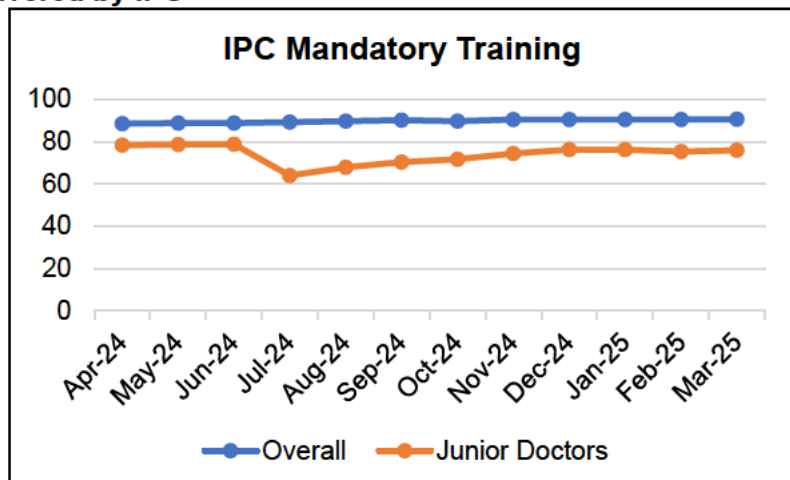
The Infection Control Associate Practitioners undertake compliance monitoring and with the ICNs they support those services where compliance is found to be reduced.

During 2024/25 compliance with MRSA screening, triangulation of hand hygiene audits, sharps safety, universal precautions, PPE, Commode cleanliness and safe food storage was assessed and results fed back to clinical teams to effect timely action.

Audit of Pseudomonas risk at clinical handwash basins was undertaken in augmented care as part of the water safety programme.

7.4 Training and Education delivered by IPC

The IPC specialist nurses provide a comprehensive training and education programme for all Trust staff and volunteers related to all aspects of infection prevention and control, both planned and as required. Infection Prevention and Control is part of mandatory induction and update. Compliance with mandatory IPC training remained around 90% overall for ESHT, though is lower for Junior Doctors.



Face to face training has recommenced and updates are provided at divisional matrons meetings and governance meetings on request.

Over 70 staff attended the annual IPC study day. National CDI lead Professor Mark Wilcox delivered an update on best practices in managing CDI and workshops relating to preventing urinary catheter infection in acute and community setting, bed bugs, MPXV/HCID preparedness, ANTT and management of vascular access devices were also included.

7.5 Professional Development

Specialist nurses within the team maintain professional competence and attend relevant study and training. Networking with other clinical specialists is supported through attendance at regional meetings which have taken place at national conference centres and online in the past year. The team is represented at the monthly NHSE IPC network events and has participated in national CDI collaborative and sustainability events.

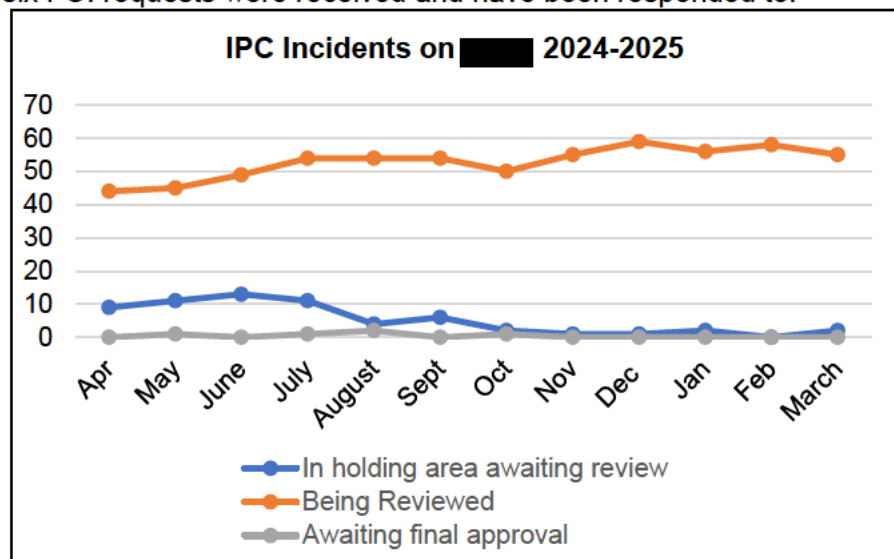
The team have presented at the Sussex wide IPC link conference and the ESCC IPC champions event. Another member of the team has successfully completed an IPC leadership course under the auspices of the Florence Nightingale Foundation.

7.6 IPC Governance

Key Achievements for 2024-25:

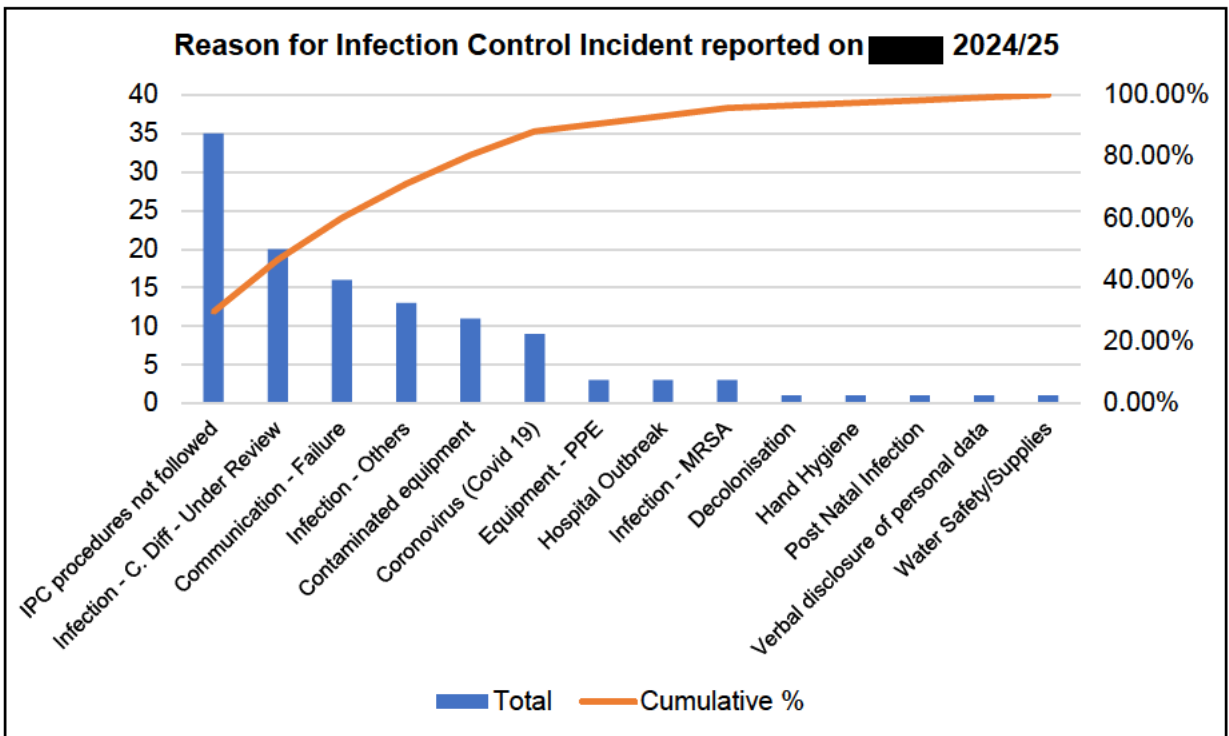
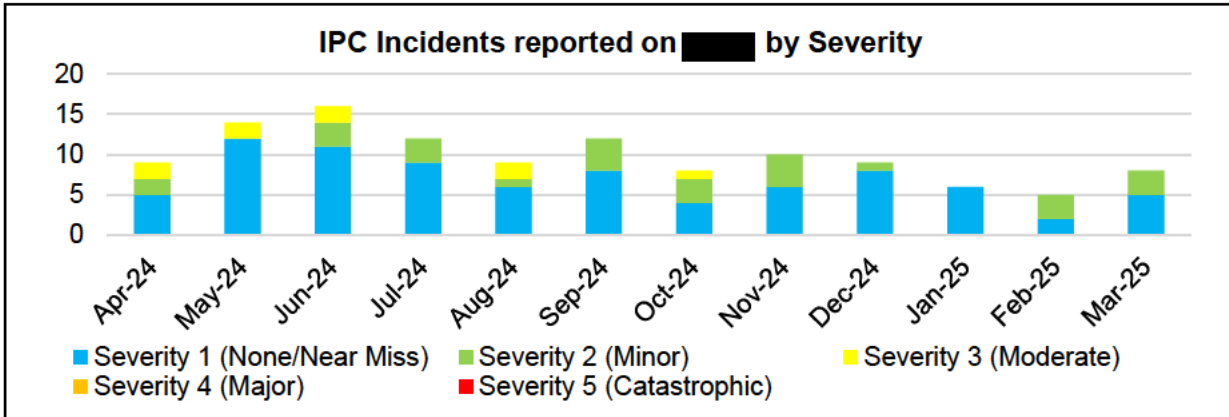
- We were compliant with reporting our monthly HCAI data by the deadline to UKHSA via the DCS, apart from June 2024 when a change in Executive Assistant resulted in the CEO completing the sign-off late. The Quarterly Mandatory Laboratory Returns were completed by the deadline to UKHSA via the DCS.
- The number of policies in date increased from 59% to 81% and five new policies are currently being written.
- Patient Information Leaflets – the number in date decreased slightly from 50% to 44%.
- Two audits were completed and presented at TIPCG (Audit 1586: Sharps Safety Re-audit and Audit 1793: Risk of *pseudomonas aeruginosa* and Legionella contamination in augmented care). A joint audit with microbiology is at report writing stage (Audit 1752: Outcome of *Staphylococcus aureus* bacteraemia in ESHT).
- IPC team mandatory training compliance was above the ESHT target of 90% for 11 of 12 months, with an average of 94.5% and ended the year at 95.9%.
- Appraisals averaged 79.4% across the year and ended the year at 94.7%. This is due to one member of staff who has been long term sick.
- One complaint and six FOI requests were received and have been responded to.

118 IPC related incidents were reported on █████ during 2024/25. Fourteen of these were reported as Severity 3. Seven Severity 3 incidents remain open (the majority relate to the C. difficile outbreak at EDGH), two have been closed and remained at Severity 3 (INC3347: MRSA on Frailty ward and INC4842: *Stenotrophomonas maltophilia* on ITU at EDGH), three



have been closed and downgraded to severity 2. The remaining two remain open, but have been downgraded to severity 1 and severity 2 respectively.

- The number of IPC related incidents open on [redacted] ended the year at 57. 69% were reported at severity 1, 23% at severity 2 and 8% at severity 3.
- The reasons for infection control incidents being reported on [redacted] can be seen in the chart below:



The high number of reports at severity 1 is indicative of a good safety culture that supports action at the earliest opportunity to avoid harm.

8. Maintaining a Clean Environment that Facilitates the Prevention and Control of Infection

The National Specification of Cleanliness (NSC) audits continue to be monitored via the Patient Environmental Action Meeting (PEAM) and the Trust Infection Prevention Control group (TIPCG) and the Divisional Integrated Performance Reviews.

The Trust NSC target score for Clinical, Housekeeping and Estates was assessed as 95.96%, overall, this was achieved. Where an area has consistently scored low, they are asked to attend the Patient Environmental Audit Meeting (PEAM) and provide an Action Plan to address the low compliance, and this is discussed at the TIPCG which is chaired by the DIPC.

	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
House Keeping	97.86%	97.55%	97.61%	97.57%	97.64%	97.21%	97.08%	97.55%	97.10%	97.44%	96.77%	97.24%
Clinical Staffing	98.60%	98.49%	98.42%	98.11%	98.61%	97.97%	98.01%	98.44%	98.02%	98.16%	97.2%	97.82%
Estates	97.48%	95.18%	95.32%	94.64%	94.68%	94.59%	94.80%	94.89%	95.04%	95.44%	94.49%	94.15%

The Estates challenges are considered as a cleanliness concern. Cleanliness is reported and discussed at PEAM. Maintenance issues are directed straight to the Estates department. The “Building for Our Future” project work has commenced and will make a significant improvement to the standards of the estate and will be ongoing.

8.1 Housekeeping

The Housekeeping services for ESHT continue to be provided by the in-house team within Facilities. Housekeeping resources are matched to each area in line with the National Specification for Cleanliness (NSC 2021). We continue to clean with bleach-based products. Both acute sites have invested in new equipment to provide a more productive cleaning service.

8.2 Deep Clean Programme

The Rapid Response team continue to provide cover 24/7 and are an integral part of the housekeeping team. We have seen a rise in deep clean requests.

Year	22/23	23/24	24/25
Average no. of deep cleans per month carried out on the Acute Sites	977	1164	841

The highest month this year was January 2025 with 1215 cleans and the lowest month was November 2024 with 665 cleans.

It has been challenging to undertake hydrogen peroxide vaporisation treatment of clinical environments due to the lack of decant facilities while there is increased bed occupancy. This has been mitigated by ensuring that deep cleaning is undertaken by the rapid response team of housekeepers who have dedicated resource for this environmental decontamination.

Significant fire compartmentation work has required movement of services particularly at EDGH, but has enabled enhanced decontamination of each area and treatment with hydrogen peroxide vapour prior to reopening the areas.

9. Antimicrobial Stewardship Activities and Innovation

The Trust Antimicrobial Stewardship Group (ASG) core membership consists of a consultant medical microbiologist, antimicrobial pharmacist, and a ICB representative. The purpose of the ASG is to support the prudent use of antimicrobials to reduce the development and spread of antimicrobial resistance. This is achieved by:

- Developing and maintaining evidence based antimicrobial policies and guidelines for use in secondary and primary care
- Developing a strategic plan with the aim to continuously improve antimicrobial prescribing practice
- Ensuring safe and cost-effective antimicrobial use.
- Monitoring antimicrobial expenditure data and addressing identified issues
- Undertaking audit on antimicrobial prescribing practice and providing feedback to TIPCG, ASG and MOG
- Providing advice to other specialist groups/committees on antimicrobial use
- Providing education to staff on all matters relating to antimicrobials.
- Educating patients and members of the public on antimicrobial stewardship

-
- The lead antimicrobial pharmacist providing feedback from lesson learnt, following a Post Infection Reviews to the pharmacy team.

The Adult and Paediatric antimicrobial guidelines are reviewed, on a regular basis, by the Antimicrobial Stewardship Group (ASG). The guidance is evidence based and Consultants and/or Allied Health Professional (AHP) are consulted. Any major change to the Trust antimicrobial guidance must be submitted to the Medicines Optimisation Group (MOG) for consideration.

To improve ASG attendance by the medical and surgical teams, the ASG has scheduled a rolling review of clinical specialities, with the aim of reviewing each speciality at least every 2 years or earlier if needed.

9.1 Multi-disciplinary team (MDT) Ward Rounds

The aim of MDT ward rounds provides specialist advice on antimicrobials. The ward round should reduce the inappropriate prescribing of antibiotics, treatment failure rate and the development of antimicrobial resistance. Regular AMS MDT ward rounds are undertaken in the following areas:

- Diabetic Foot Management
- Orthopaedics
- Acute medical units
- Wards highlighted by Infection control team e.g., CDI rate
- Intensive Care Units

AMS wards rounds are targeted to a ward or area with a concern, for example a ward with an unexpected high use of broad-spectrum antibiotics. In addition, the ward round provides support to the prescribing team with specialist input into the highest risk and/ or most critical patients in the hospitals.

The review of antimicrobial prescribing follows standards outlined in the PHE “Start Smart then Focus” document (September 2023).

The AMS ward round has made several interventions that include.

- Stopping treatment.
- Escalating / de-escalating treatment.
- Switching administration route from an intravenous to oral treatment.
- Continuing current treatment and providing advice on duration/review date.
- Providing advice to the medical or surgical team on the prescribing of antibiotics for a CDI antigen or toxin positive patient.

9.2 Training

An in-house on-line module is used for induction and the 3 yearly assessment.

An antibiotic training pack is available to help support the development of rotational pharmacists in antimicrobial use and prescribing. The training pack is based on the Royal Pharmaceutical Society antimicrobial training guidance.

As part of the FY1/FY2 induction pharmacy provides an overview on antimicrobial prescribing and what support is available. Also, there may be a microbiologist training session on antimicrobial use.

9.3 Antibiotic Incident Reports

The lead antimicrobial pharmacist is involved in reviewing incidents reported on [REDACTED] involving antimicrobials. An Antimicrobial and Ward Pharmacist should attend Post Infection Reviews (for example CDI) and provide feedback to the pharmacy team. In addition, the lead antimicrobial

pharmacist may be asked to provide detail to a Freedom of Information request, and any investigations.

9.4 Audit of Antimicrobial Usage

Improving Antimicrobial Stewardship standards at ESHT forms part of the quality improvement strategy for patient safety, to help to reduce inappropriate prescribing and optimise antibiotic use. The Trust total antimicrobial consumption rate is monitored by a review of pharmacy and admission data (via Define), Public Health England (PHE) fingertip and NHS Future reports.

To help provide assurance on AMS practice, pharmacy undertakes a monthly antimicrobial stewardship audit. The audit should identify AMS issues and highlight areas for improvement. If warranted, the concern will be escalated to the Antimicrobial Stewardship and Infection Prevention and Control Groups.

The reasonable endeavours undertaken by the AMS team to reduce inappropriate antimicrobial prescribing, and to offer clinical and pharmacy support to help maximise patient outcomes from antimicrobial use. The AMS ward rounds have included reviewing broad-spectrum antibiotic prescribing e.g., Meropenem, recommending WHO AWaRe Available category antimicrobials where clinically appropriate, and to rationalise antimicrobial treatment.

9.5 Innovation

The electronic prescribing and medication administration system (ePMA) has been rolled out across the Trust, except for paediatric and ITU and used to audit antimicrobial prescribing practice and use. The ePMA system enables pharmacy to identify antimicrobials prescribed per Trust guidance, and to challenge inappropriate prescribing.

In addition, when cross referenced with Nervecentre and e-searcher, pharmacy can identify patients with a positive *Clostridium difficile* (CD) toxin / antigen (within the previous 12 months) that may need prophylactic CD cover and/or a consultant medical microbiologist referral. This was started in November 2024, and pharmacy will be assessing the possible impact in CD numbers – feedback to the Infection Control and Antimicrobial Stewardship Groups.

10. Water Safety

The well-established Trust Water Safety Group, in line with the Health Technical Memorandum (HTM) 04, meet 3-times per year. It aims to ensure Strategic Water Safety Management for patients, visitors and staff. Reporting to the Trust's Infection Prevention and Control Group (TIPCG). The Trust has in place a Water Safety Policy to confirm responsibilities and arrangement for Water Safety Management. The Policy has been approved by TIPCG and was ratified by the Trust Policy Group in November 2023: a revision was conducted regarding "Governance Arrangements" in December 2024, approved by TIPCG in April 2025.

Water Safety Plan (WSP) and Legionella Written Schemes of Control (WSoc)

The Legionella Written Schemes for Eastbourne, Conquest and Bexhill have been updated as a Water Safety Plan (WSP).

Water Safety Risk Assessment

The Trust is required to undertake Risk Assessments to identify the potential hazards which may be present from water systems and their use; and to identify the control measures to eliminate or reduce the risks of ill health. Hospital Risk Reassessments are due to be undertaken in 2025 with Conquest Hospital commencing in July and Eastbourne Hospital to follow.

Schedules of the remedial works, from the Risk Assessments, have been compiled and several maintenance tasks have been completed in-house. More complicated and labour-intensive works have been contracted out over a two-year period for completion. All redundant pipework

that was identified at EDGH via risk assessment has now been removed with work ongoing for more complicated removals across Bexhill Hospital Campus and Egerton Park Paediatric Clinic.

Pseudomonas Risk Assessments

Pseudomonas Risk Assessments have been completed by external consultants and an action plan prepared. Elevated counts in Pevensey Ward at Eastbourne are yet to be resolved. Temporary Point of User (POU) are in place.

Maintenance of water systems

The Estates Department has in place a comprehensive Computer Aided Facilities Management (CAFM) system which is used to plan and monitor maintenance issues.

Planned Maintenance, Year-to-Date: 79%

Follow-up Maintenance, Year-to-Date: 94%

Legionella & Pseudomonas Sampling

Legionella sampling is carried out each month for the Trust Healthcare Facilities. The results are reviewed, and corrective measures taken or escalated. Samples of water for *Pseudomonas Aeruginosa* testing are carried out every 6 months. The results are reviewed and corrective measures taken.

11. Ventilation Group

The Trust attaches the greatest importance to the health, safety and welfare of staff, patients and visitors. It is accepted that it is for management and staff to do all that is reasonably practicable to achieve compliance with the HSE, NHS and other guidance regarding ensuring the safe management, design, installation, operation and maintenance of the Trust's Specialist Ventilation systems.

Trust Ventilation Safety Group (VSG)

The Trust Ventilation Safety Group, in line with the Health Technical Memorandum (HTM) 03-01, meets 4 times per year. It aims to ensure Strategic Ventilation Safety Management for patients, visitors, and staff. Reporting to the Trust's Infection Prevention and Control Group. The Trust VSG is supported by the Estates and Facilities Ventilation Safety Sub-group (VSSG).

Trust Policy

The Trust has in place a Ventilation Safety Policy to confirm responsibilities and arrangements for Ventilation Systems Management. The updated Policy has been approved by the VSSG and is being submitted to the next VSG meeting for approval followed by TIPCG for approval.

Risk Assessment

Condition Surveys are carried out by the Independent Authorising Engineer to arrive at Risk Assessments for each system. The Trust continues to upgrade ventilation systems where achievable during major refurbishment projects. New builds are designed and commissioned to meet the requirements HTM 04-01.

Maintenance of ventilation systems

The Estates department has in place a comprehensive Computer Aided Facilities Management (CAFM) System which used to plan and monitor maintenance issues.

Planned Maintenance Rolling Year (last 12 months) : 80%

Follow Up Maintenance Rolling Year (last 12 months) : 80%

Microbiological Sampling

Microbiological sampling is carried out regularly for the Critical Ventilation Systems. The results are reviewed, and corrective measures taken, or escalated.

Management

The Ventilation Authorised Person (AP) for each site have commenced closer working relationships with the Ventilation AE and IPC representatives to improve joint working and develop a new monthly report content and format that meet all parties' requirements. The AP's have been provided additional time to undertake their AP duties which is already improving the ventilation management and service delivery to patients and clinical operations.

12. Food Safety Group

The Food Safety Group continues to uphold high standards in food safety, aligning with the National Healthcare Food and Drink Standards. Reporting to the Trust's Infection Prevention and Control Group, the group meets regularly to address and act upon food safety concerns, ensuring best practices in food handling, preparation, and storage.

Key Achievements for 2024/25:

- The Trust continues to hold 5* Food Hygiene ratings across all sites
- Our Independent Food safety Advisor has conducted comprehensive reviews of the Trust's Food Safety Management System and Policy documents. Further updates will follow her scheduled visit in June 2025.
- Critical food safety audits have been completed across main kitchens and ward areas. Targeted action plans have been developed and implemented and are being closely monitored.
- New refrigeration equipment was installed in the Emergency Department at Conquest Hospital to improve storage capabilities.
- Actions from PLACE inspections are in motion, with specific attention to improving patient access to hand hygiene before meals—echoing IPC priorities, particularly during World Hygiene Week in May.

The Food Safety Group remains a vital forum for ensuring compliance, driving improvements, and reacting swiftly to new food safety alerts via their link with the Food Standards Agency.

13. Decontamination Group

The Decontamination Group continues to demonstrate a strong commitment to maintaining safe and effective decontamination practices across the Trust. Operating under the governance of the Trust Infection Prevention and Control Group (TIPCG), the group plays a key role in monitoring compliance, supporting capital developments, and driving standardisation across departments.

Key Achievements for 2024/25:

- The full installation of six new sterilisers in the HSDU and Pathology departments has been completed. These units feature integrated steam generators, reducing reliance on the hospital's central steam supply and improving operational resilience.
- Ventilation improvements have been completed in the Conquest Endoscopy Decontamination Unit, addressing key recommendations from the IHEEM audit and supporting improved environmental safety.
- Following successful trials, peracetic acid monitoring systems have now been fully implemented, enhancing quality assurance across decontamination processes.
- Policy development remains a priority, with the Flexible Endoscope Decontamination Policy formally ratified and now accessible via the Trust's intranet.
- The HSDU has successfully retained its +ETS UKMDR medical devices certification, as well as compliance with ISO 13485:2016, reflecting continued adherence to high regulatory standards.

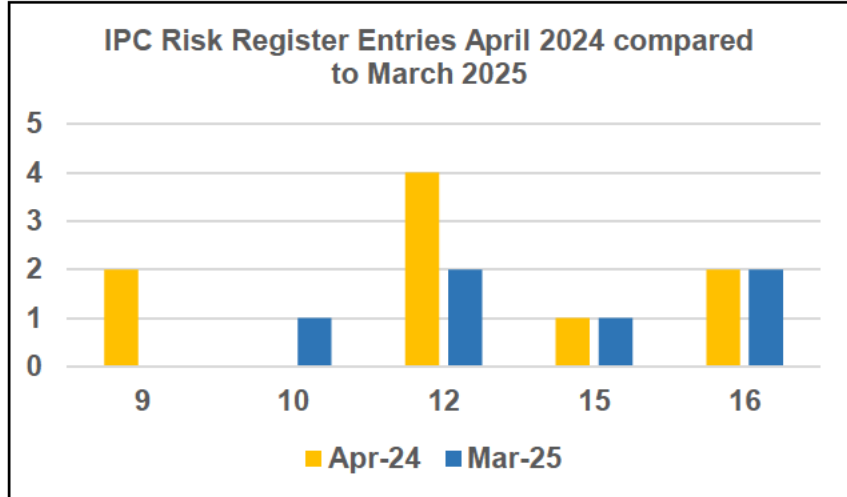
The group continues to provide oversight and support to operational teams across theatres and community dental services, with no major concerns reported. Planning for additional

instrumentation to support the Sussex Surgical Centre is underway, forming part of broader service development discussions.

The Decontamination Group’s collaborative approach, alongside ongoing investment in infrastructure, policy, and assurance processes, continues to underpin the delivery of safe, compliant, and efficient decontamination services across the organisation.

14. Risk Register

At April 2024 there were nine infection control items that were on the risk register. Three were classed as extreme risks (15 or above) and six were below 15. This risk register is reviewed monthly for extreme risks and quarterly for all risks at the TIPCG.



At the end of March 2025, the three extreme risks remained on the risk register (insufficient ward decant

facilities to support deep cleaning, insufficient isolation facilities to meet demand and clinical environment maintenance and refurbishment). Two risks below 15 remained on the risk register (low compliance with cleanliness of patient/nursing equipment in Urgent Care and patient rooms in Sussex Premier Health) and one was added in March 2025 relating to water safety. Risks around the reception area at Sussex Premier Health, replacement compressor for main air conditioning unit in HSDU, lack of spare parts for Conquest storage unit in HSDU and the autoclave at EDGH have all been removed from the risk register.

Acknowledgements

The report includes contributions from the Antimicrobial Lead Pharmacist and Directors of Estates and Facilities. Data presented and prepared by the IPC governance facilitator.

Appendix 1 – TIPCG Reporting Schedule for 2024-25

Reporting Item	Apr 24	May 24	June 24	July 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
HCAI Update Report including BAF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hand Hygiene Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
NSC Audit Report & PEAM Minutes	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Antimicrobial Stewardship Group/Pharmacy Report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DAS Report	✓			✓			✓			✓		
Medicine Report	✓			✓			✓			✓		
WC&SH Report	✓			✓			✓			✓		
Maternity Report	✓			✓				✓		✓		
Urgent Care Report	✓			✓				✓		✓		
CHIC Report	✓			✓			✓			✓		
Core Services Report	✓			✓			✓			✓		
Sussex Premier Health Report	✓			✓			✓			✓		
Estates & Facilities Report Quarterly Report		✓			✓			✓			✓	
Ventilation Group Report		✓			✓						✓	
Water Safety Group Report		✓				✓			✓			✓
Decontamination Group Progress Report			✓				✓			✓		
Food Safety Group Report		✓			✓			✓			✓	
CEF Report			✓			✓			✓			
SSISS Quarterly Report			✓			✓			✓			✓
Risk Register (all Trust risks linked to IPC)			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mask Fit Report			✓			✓			✓			✓
IPC Governance Report			✓			✓			✓			✓
Flu Planning									✓			
Infection Prevention & Control Annual Report						✓	✓					
Audits									✓		✓	
Policies	✓	✓	✓	✓		✓				✓	✓	