NHS
The Royal Wolverhampton
NHS Trust

Infection Prevention Annual Report 2024/25

Care Colleagues
Collaboration Communities

Executive Summary

The Infection Prevention (IP) Team has seen another busy year, with challenges in the form of increases in the number of *Clostridioides difficile* (*C diff*), Gram negative bacteraemia and Carbapenemase Producing Enterbacteriaceae (CPE) cases, Mpox and high consequence infectious disease (HCID) preparedness activity, continued COVID-19 cases, an increase in number of cases and outbreaks of influenza and norovirus.

Despite this, The Royal Wolverhampton NHS Trust has maintained compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of Health, 2015). This report takes the opportunity to celebrate the successes and highlights the increasing challenges going forward.

Increased risk factors for healthcare acquired infections (HCAIs) are recognised in the ageing population, complexity and level of illness or disease, alongside changes in use of health services, and the expanding threat of highly resistant organisms. These are all considered when drawing up our local strategy for preventing HCAI. The work of the IP Team includes education, research and development, standard and policy setting, establishing assurance processes and, most importantly, ensuring patient safety in the prevention of spread and acquisition of new infections across RWT and the city. During 2024/25 the IP Team has continued to ensure that both staff and patients are updated with national guidance and appropriate PPE recommendations, particularly regarding *C diff*, Mpox and HCID, CPE, COVID-19, and influenza. The IP team has strived to undertake proactive work, for example taking opportunities for staff education, involvement in regional and national initiatives and audits.

In late 2023 the IP Team participated in the national point prevalence survey on healthcare associated infections (HCAIs), antimicrobial use (AMU) and antimicrobial stewardship (AMS) in England (2023). RWT results were communicated within the organisation and there was a high incidence of healthcare acquired pneumonia (HAP) noted. As a result, a multidisciplinary HAP group has been formed.

There were four RWT-attributable MRSA bloodstream infections during 2024/25 (target of zero).

NHS England sets annual thresholds for NHS Trusts for *Clostridioides difficile* and specific Gram-negative bacteraemia (*Escherichia coli, Klebsiella and Pseudomonas aeruginosa*). *Clostridioides difficile* was over trajectory this year with 126 RWT-attributable cases during the year, against a threshold of 81. The thresholds for *Escherichia coli, Klebsiella and Pseudomonas aeruginosa* were exceeded with 135/107, 36/32 and 28/15, respectively.

Unfortunately, RWT recorded 64 device-related hospital-acquired bacteraemias (DRHABs) during 2024/25 against an internal trajectory of 48. This was an increase on last year where 54 were reported (and from 58 in the prior year).

There was an increase in patients identified with CPE. This year 117 were identified compared with 98 (2023/24), 53 (2022/23), 27 (2021/22) and 18 (2020/21) and a significant increase to pre-pandemic case numbers (56 in 2019/20). Patients are still risk assessed as previously.

Education and awareness have been one of the top priorities in supporting the endeavour of a well-informed workforce in relation to infection prevention and control, from fundamental IP practices to more specialist areas. This approach has been complemented by use of manned stands in high footfall areas, screen savers and regular publication of IP newsletters.

Environmental controls continue to play an important role in our approach to tackling HCAI. An annual deep clean programme of wards was completed, although the ability to undertake routine full ward deep cleans has been limited by the inconsistent availability of a decant ward.

A permanent Patient Equipment Cleaning Centre (PECC) was opened in 2024, which provides support to clinical areas with cleaning of equipment particularly commodes, beds and patient bedside equipment.

The Intravenous Resource Team continues to deliver a high standard of intravenous line care with many lines being inserted by the skilled team, and patients have continued to be discharged on Outpatient Parenteral Antibiotic Therapy (OPAT) where appropriate.

Surgical Site Infection (SSI) Surveillance continues across all specialities with data shared with Consultant Surgeons via a monthly dashboard.

Influenza preparedness and prevention for patients and staff was a key activity within the Trust. In line with national increase in numbers of cases, RWT has seen several influenza cases during this season. The uptake of influenza vaccine among front-line staff was 24% which was a decrease from uptake in 2023/24 (40%), 2022/23 (41%) and 2021/22 (58%).

There has continued to be proactive engagement and partnership working with our Public Health colleagues. Outbreak management support to care homes and very sheltered housing establishments across the Wolverhampton health economy was maintained, ensuring a seamless service across healthcare facilities throughout the city. During periods of reduced outbreak activity, infection prevention audits and education took place in care homes.

The IP team has undertaken collaborative working with regional IP colleagues, NHSE, UKHSA and ICS/ICB colleagues and more locally it has continued to strengthen relationships and partnership working with Walsall Healthcare NHS Trust IP colleagues and wider.

There have been three directorate risks managed by the IP Team during 2024/25, discussed at the Infection Prevention and Control Group (IPCG) meeting.

Neonatal Unit (NNU) MRSA outbreak – NHS England and Black Country ICB visit

The NNU saw clusters of acquisitions, with three separate clusters in 2024/25 with typing demonstrating similarity between isolates suggesting transmission. PII meetings were arranged, with actions including staff education on hand hygiene and the decontamination of equipment, and actions to improve the environment.

Supportive visits were carried out by the Black Country ICB on 16 May 2024 and a collaborative visit from NHS England and Black Country ICB on 24 January 2025. Both visits were positive, and the Trust received good feedback with evidence of compliance with infection prevention practices.

Introduction

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (also referred to as The Hygiene Code) was last updated in December 2022:

Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK (www.gov.uk)

The Code of Practice document reflects changes to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and the role of Infection Prevention and Control (IPC) (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance. The Code of Practice was revised in 2015 to make it clear to non-specialists that cleanliness is an integral part of IPC. The document takes account of changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic. The law states that the Code must be considered by the CQC when it makes decisions about registration. The regulations also state that providers must have regard to the Code when deciding how they will comply with registration requirements. By following the Code, registered providers can demonstrate that they meet the requirements set out in the regulations. The Code aims to exemplify what providers need to do to comply with the regulations.

CQC reviews the code requirements in relation to Fundamental Standard Regulation 12 – Safe care and treatment and Fundamental Standard Regulation 15 - Premises and equipment. The Trust is declaring full compliance with the Code.

The National Infection Prevention and Control Board Assurance Framework (IP BAF) is issued by NHS England for use by organisations to enable them to respond using an evidence-based approach to maintain the safety of patients, services users, staff and others. The framework is for use by all those involved in care provision in England and can be used to provide assurance in NHS settings or settings where NHS services are delivered. This framework is not compulsory but should be used by organisations to ensure compliance with Infection Prevention and Control (IPC) standards. The RWT IP BAF is presented for assurance at Infection Prevention and Control Group (IPCG) monthly.

The purpose of the framework is to provide an assurance structure for boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA).

Infection Prevention Reporting Structure

Infection Prevention and Control Group (IPCG)

The IPCG continued to meet monthly during 2024/25, with meetings chaired by the Chief Medical Officer. Monthly reports are received by IPCG from the operational teams and supporting departments which demonstrate and assure compliance; this includes dashboards from the Divisions and reports from Hotel Services, Pharmacy, Estates, TB service, Intravenous Resource Team, the Decontamination Lead and Occupational Health and Wellbeing. Performance data, the IP BAF document and the IP risk register was also discussed. These meetings took place on Microsoft Teams.

The Head of Nursing for Corporate Support Services sits on the Trust's Nursing, Midwifery, Health Visiting and AHP Leaders Group and the Senior Matron Infection Prevention is Deputy Chair of the Environment Group, IP Matrons attend the Matrons, Ward Managers, Senior Nurses, Midwives, Health Visitors and Allied Health Professionals Group.

These forums offer an additional opportunity to feedback information to the wards and departments and receive information to inform the priorities and actions of the Infection Prevention Team.

Infection Prevention continues to report to the Integrated Care Board (ICB) as part of the commissioned services. A Consultant Microbiologist sits on the Medicines Management Group. The Microbiologists continue to work with the Antimicrobial Pharmacist in monitoring, auditing, and education on the use of antimicrobials, and an Antimicrobial Stewardship Group meets regularly. The Ward Pharmacists monitor antimicrobial use around the hospital. An antimicrobial ward round has been in place since July 2021 which includes Consultant Microbiologist, Antimicrobial Pharmacist, and an Infection Prevention Practitioner.

The Infection Prevention Team holds a Surveillance meeting twice a month with a Microbiologist to review infection-related surveillance data and to collate themes and trends following incidents. An IP Governance meeting is held to discuss governance data which include policies, patient literature, audit and effectiveness, NICE guidance compliance, investigations including root cause analyses (RCA) completed and lessons learnt, compliments and complaints, internal and external visits and reviews, Freedom of Information requests, action plan monitoring and Health and Safety compliance.

Reports to the Trust Board

At every Trust Board the Chief Nursing Officer (CNO) presents the CNO Report for the organisation, which includes the most recent infection prevention performance data. Bi-monthly IP reports are presented to Trust Board, therefore, ensuring full sight and access to all information concerning the Trust's performance against the external and internal infection prevention targets and other infection-related issues. Infection Prevention Board Assurance Framework document was presented at Trust Management Committee, Trust Board and Quality Governance Assurance Committee (QGAC). The Consultant Microbiologist delivers an IP report to the Quality & Safety Assurance Group (QSAG) twice yearly.

The Infection Prevention Team (IPT) comprises of the following individuals:

Sessional Commitment to Infection Prevention:

Name	Title	Sessional Commitment to Infection Prevention
Dr J Macve	Consultant Microbiologist, Infection Control Doctor	5.0 PA
Dr D K Dobie	Consultant Microbiologist, RWT Head of Microbiology Department, Infection Control Doctor Wolverhampton Service specification - Primary care, Pandemic Influenza lead	2.0 PA
Dr H E Jones	Consultant Microbiologist	0.5 PA
Dr K French	Consultant Microbiologist, Antimicrobial Stewardship lead started in post March 2021	0.5 PA

Pharmacy Staff

Name	Title	Sessional Commitment to Infection Prevention
Miss L Hodgins	Principal Pharmacist Antimicrobial Stewardship Pharmacist	1.0 WTE – 8B Pharmacist. Post commenced June 2024.
Miss D Kalliopi	Antimicrobial Stewardship Pharmacist and Clinical Practitioner at University of Birmingham	0.6 WTE AMS Pharmacist 0.4 WTE Clinical practitioner. Post commenced October 2024.

Infection Prevention Risks

Risk	Open / closed	Current grade	Key points of update
6405 - Ability of response to HCID cases/s attending RWT	Open Risk added March 2025	6 Yellow	Awaiting confirmation that NHSE will be facilitating regional PPE training for the HCID PPE ensemble. National course at Sheffield places are unavailable until March 2026.
5648 – If CPE screening is not undertaken according to updated guidance RWT will not identify positive patients and will increase the risk of nosocomial transmission and outbreaks	Open	6 Yellow	Patients are risk assessed on admission, but this only includes if they have travelled abroad or been an inpatient in another healthcare setting not including RWT.
5682 - The Trust is at risk of increased incidence of Healthcare Acquired Infections (HCAI) as there are a limited number of side rooms and a limited number of side rooms with en suite facilities There is a risk of inability to accommodate patients with suspected / laboratory confirmed specific infections due to a limited number of negative pressure isolation rooms available for use at RWT	Open	9 Amber	Trust-wide isolation audit to be completed in 2025/26 by Infection Prevention Team.

Infection Prevention and Control Budget 2024/25

A service provision continued to the Black Country ICB providing advice, quality assurance and education to independent contractors in Wolverhampton including contracted GPs and dentists and care homes.

Through a contract with Wolverhampton City Council Public Health, the IP Team provides outbreak management to all Wolverhampton care homes and very sheltered housing.

All individuals in the Team are encouraged to be members of the Infection Prevention Society (IPS) and to consider roles within the IPS committee structure. This gives them the opportunity to attend conferences, courses, and study days to network with IP colleagues in other organisations and maintain up to date knowledge within the speciality. The IP Team contributed to NHS England / Improvement (NHSEI) facilitated collaborative groups to share experience and knowledge of Neonatal Unit outbreak considerations and review of surveillance data for gram negative bacteraemia. Collaborative work with Walsall Healthcare NHS Trust IP Team continues to share learning and resources.

The team successfully provided support and leadership for sheltered housing and care home facilities, successfully working alongside the Community Rapid Intervention Team (RIT) to greatly enhance provision for COVID-19, Norovirus and Flu outbreak management and prevention of admission to acute services. Regular meetings were held with Black Country ICB, local authority, and Public Health to ensure that the care homes, predominantly, were supported appropriately.

Research, development, and innovation

The IP team continued to participate in a research project to support data collection, implementation, and evaluation of the Catheter Care Behavioural Insights Research Programme, led by the HIN and Revealing Reality, using a grant provided by the Health Foundation. Work also continues to develop an IP app to support staff with up to date information and guidance.

Performance

Summary of 2024/25 performance

- Four Trust-attributable MRSA bacteraemias (external definition) against a target of zero
- Thirty six Trust-attributable MSSA bacteraemias (internal definition) against an internal target of 24
- Sixty six MRSA acquisitions, more than doubt the number in 2023/24
- A total of 126 Trust-attributable toxin positive *C. difficile* cases against an external target of 81
- Sixty four device-related healthcare associated bacteraemias (DRHABs) against an internal target of 48
- Highest number of new Carbapenemase-producing Enterobacteriaceae (CPE) colonised patients detected in one year (117)
- First case of Candidozyma auris detected at RWT

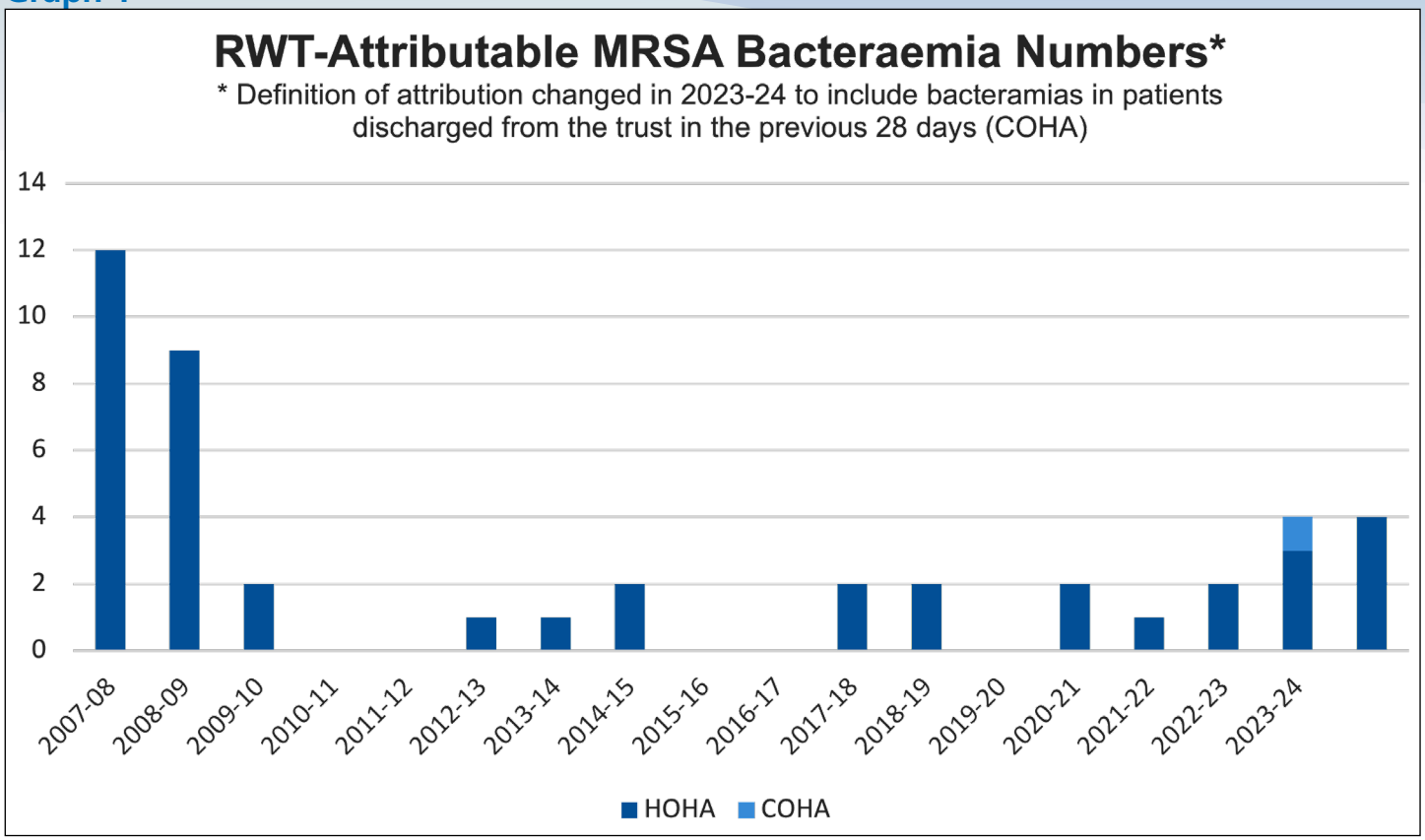
a. Meticillin Resistant *Staph. aureus* (MRSA) Bacteraemias

The targets for the acute Trust and Wolverhampton CCG for MRSA bacteraemia are zero each year. The way that UKHSA is determining Trust-attributable MRSA bacteraemias has changed, although there has been no formal communication regarding this. Previously, only bacteraemias occurring post 48 hours were attributable, however, new categorisation is now being used.

Bacteraemias are either Hospital Onset Healthcare Associated (HOHA, occurring ≥two days after admission), Community Onset Healthcare Associated (COHA, occurring ≤28days after discharge) or Community Onset Community Associated (COCA). Bacteraemias that fall under the first two categories (HOHA and COHA) are Trust-attributable. RWT had four HOHA MRSA bacteraemias attributed during 2024/25 (and no COHA); the number of post 48 hour bacteraemias has been increasing year on year for the past four years. The first HOHA episode was in April 2024, and was thought to be related to an infected heel ulcer. Two further HOHA episodes occurred in June 2024; one arose from a surgical site infection, while the source of the other could not be determined. The fourth HOHA bacteraemia occurred in December 2024 and the source was again unclear. Graph 1 shows the number of RWT-attributable MRSA bacteraemias for each year since 2007/08.

Three patients who had not had any recent contact with RWT were found to have an MRSA bacteraemia on admission to New Cross Hospital. Of these, one was due to foot osteomyelitis in a diabetic patient, one was a post-operative infection following surgery at another hospital, and the third was an infected dialysis line following dialysis abroad. All Trust-attributed cases had RCAs carried out and Post-Infection Review (PIR) meetings, in conjunction with the ICB. The overall combined number of MRSA bacteraemias (Trust and Community) was therefore seven, which is one fewer than 2024/25.

Graph 1



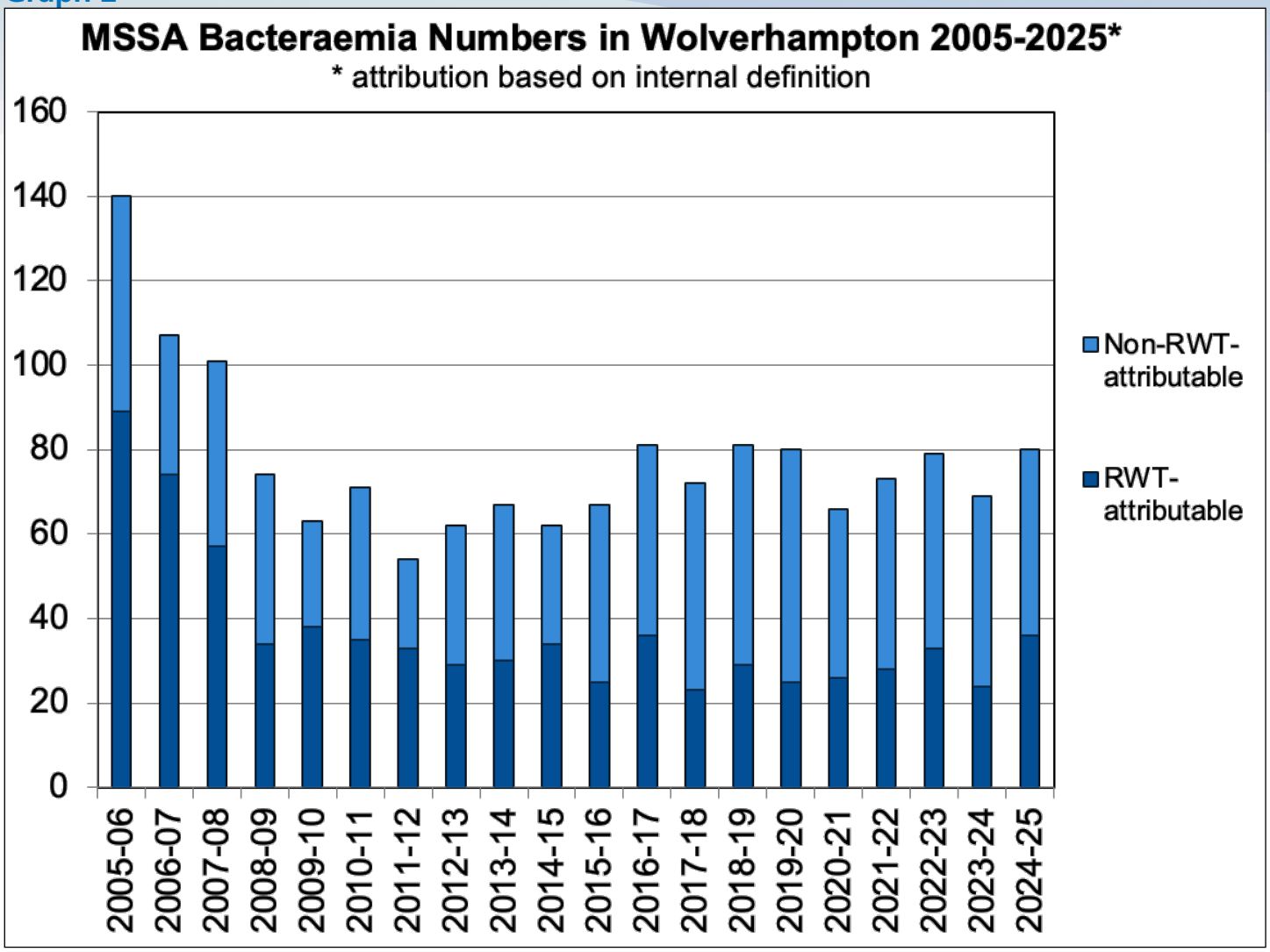
b. Meticillin Sensitive *Staph. aureus* (MSSA) Bacteraemias

National mandatory surveillance of MSSA bacteraemia began in January 2011, but locally we have undertaken surveillance of these infections for much longer than this, with this information used as a Key Performance Indicator (KPI) across the organisation. Graph 2 shows the annual total number of MSSA bacteraemia diagnosed in Wolverhampton since 2005/06, split according to whether these infections were attributable to RWT or not using our in-house definition of attribution (which includes patients who have been discharged from our hospital in the previous 14 days, or are regular or day-case attenders as being RWT-attributable).

It can be seen that the total number of cases is higher than the previous year's total, and that this is due to an increase in the number of RWT-attributable cases, with a total of 36 cases against an internal target of 24. The external definition was again changed last year to include those that occur within 28 days of discharge – the total for this in 2023/24 therefore was 25 HOHA and 17 COHA (vs 26 HOHA and 16 COHA in 2023/24).

A Root Cause Analysis is carried out on all RWT-attributable MSSA bacteraemias. These revealed: 12 were related to intravenous lines including five due to peripheral cannulae, four were related to skin infection including three infected pressure ulcers, three were related to surgical site infections, three were thought be from a chest infection, three were from discitis, one was from septic arthritis, one was from osteomyelitis, one was from a dental abscess, one from epistaxis, one was thought to have an abdominal source, one was due to a UTI , one was deemed a contaminant and the source was uncertain for four cases.

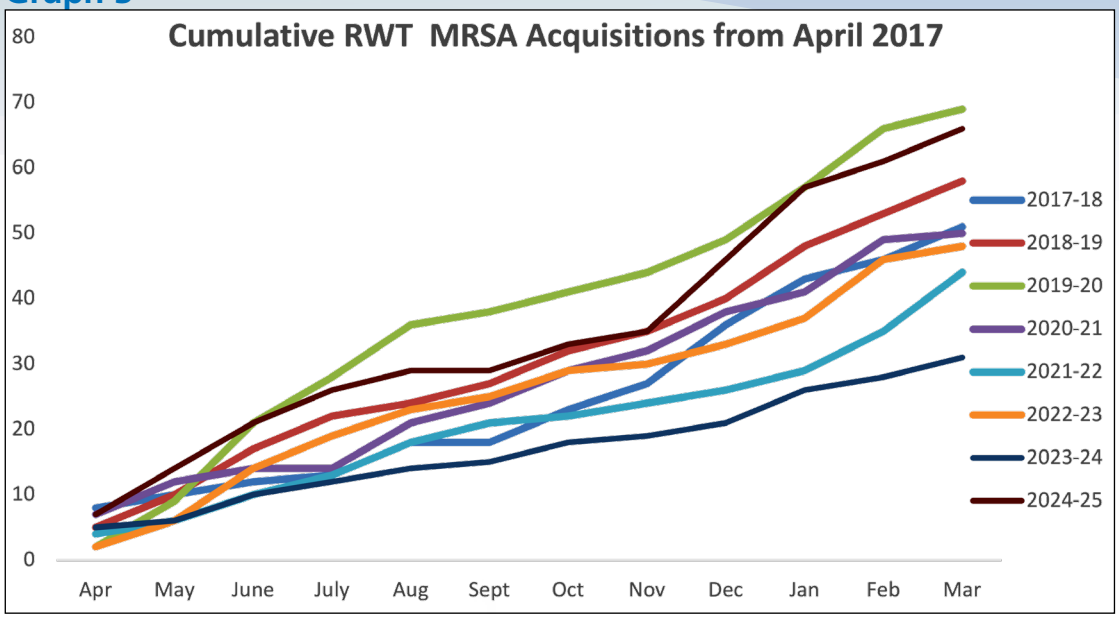
Graph 2



c. MRSA Acquisitions

Universal admission screening for MRSA has enabled us to monitor the acquisition of MRSA in RWT and use this as another KPI for the organisation. Graph 3 shows the number of MRSA acquisitions across RWT over the past seven years. It can be seen that there in 2024/25 there were 66 acquisitions, which is more than double the previous year. This demonstrates the importance of ensuring that appropriate decontamination of hands and equipment is consistently applied. The ward with the highest number of acquisitions saw 16 new cases in one year, with the next two highest areas seeing five cases each. Where clusters of acquisitions were seen the appropriate actions were taken in response to these.

Graph 3



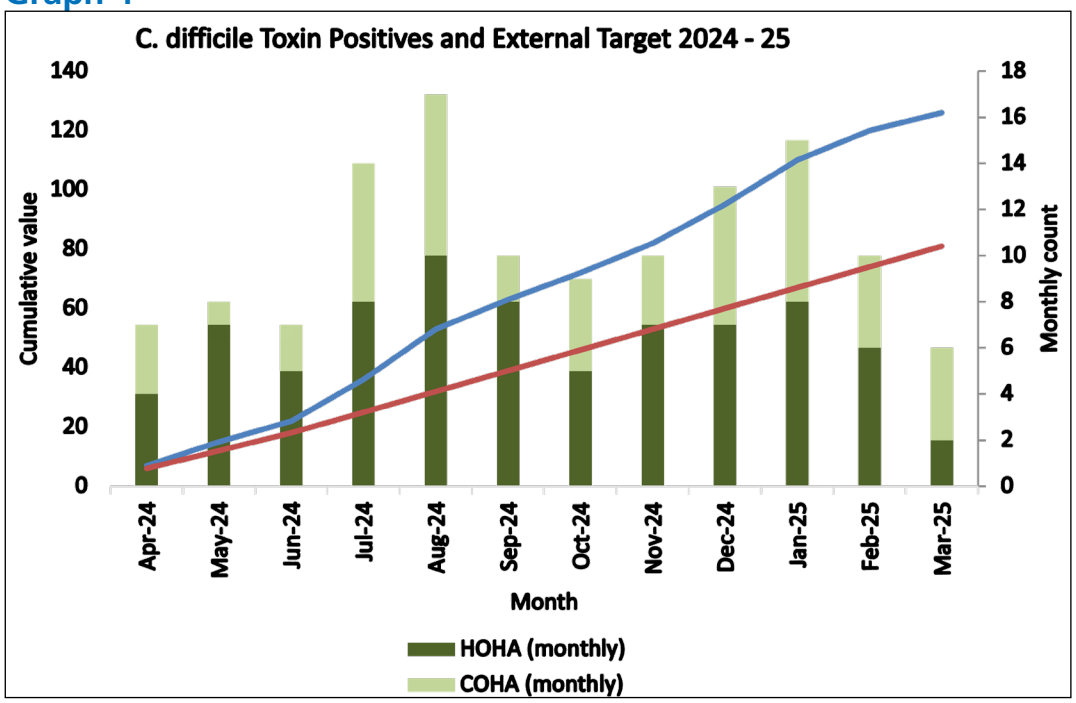
d. Glycopeptide Resistant Enterococci (GRE) Bacteraemias

During the year there were nine GRE bacteraemias in RWT inpatients. This compares with four cases last year, and between two and nine cases per year during each of the preceding twelve years. The cases this year included four across the Haematology-Oncology ward areas.

e. *Clostridioides difficile*

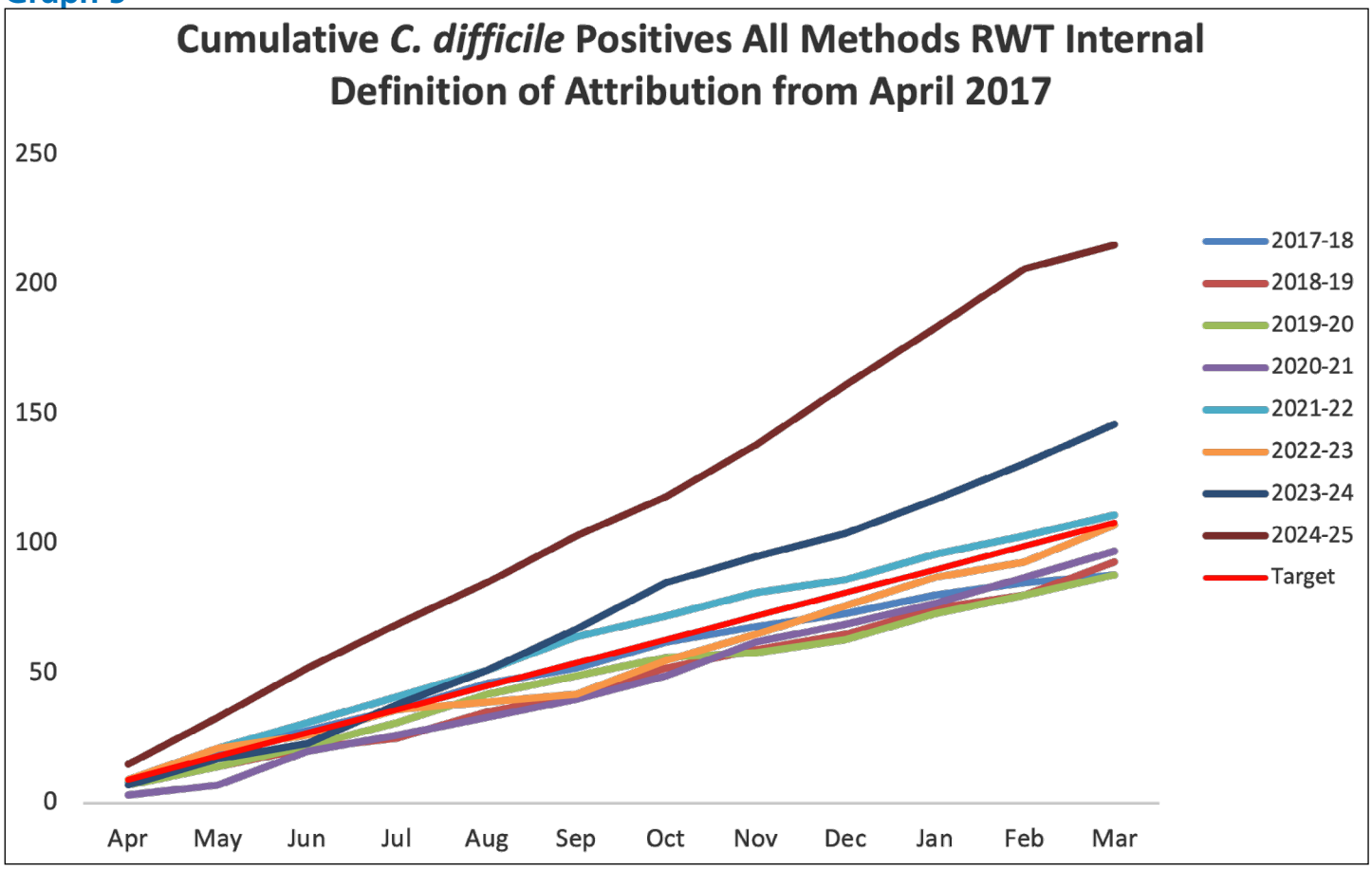
Objectives for the number of *C. difficile* infections for Acute Trusts and CCGs were set for the year 2024/25 by the DH based on nationally set target rates. The external objective for the number of *C. difficile* infections for RWT was 81 cases, increased from 53 the previous year. At the end of the year, RWT had had 126 cases, so had exceeded the trajectory. The definition of an acute Trust-attributable case was changed in the year 2019/20, to include patients who had been discharged within 28 days of the positive sample (COHA), and also samples taken more than two rather than three days following admission. In 2024/25 the definition of the admission date for patients admitted via the emergency department was changed to the 'decision to admit' date. Wolverhampton CCG is now included in Birmingham and Black Country ICB therefore the number of community Wolverhampton cases is no longer easily monitored. Graph 4 shows the cumulative monthly performance against target for RWT.

Graph 4



The objectives are based on DH's definitions of attribution of infections, which only takes into account discharge from hospital within the last 28 days and only records those cases that give a *C. difficile* toxin positive result. Internally, we set another target that includes cases diagnosed three days into admission or within six weeks of discharge, unless the patient had been housed in another healthcare institution since discharge. This internal definition of infection includes all cases diagnosed with either a positive *C. difficile* PCR or toxin result. The PCR test is a measure of colonisation with strains of *C. difficile* capable of causing disease and allows us to better monitor the spread of *C. difficile*. It enables us to take appropriate barrier precautions with such patients to prevent spread or contamination of the environment, and to pre-emptively treat such patients if they develop symptoms. This year there were 215 cases diagnosed against the internal definition of attribution. This is significantly above our annual target of 108, and our highest number of cases since PCR testing for *C. difficile* was introduced.

Graph 5



If there are possible linked cases on a ward or clinical area, the isolates are sent for ribotyping to determine if the same strain of *C. difficile* has spread. Those that are the same ribotype then undergo further sub-type analysis. Usually, ribotyping demonstrates that there are different strains involved, and therefore that transmission has not occurred. Ribotyping indicated spread between two patients on an orthopaedic ward in April 2024, and between two patients on a medical ward in August 2024. Due to the relative infrequency of the identified strain, and the clear epidemiological link between the two cases, sub-type analysis was not deemed necessary to assume transmission had occurred. Sub-type analysis of the strain isolated from two patients on a surgical ward in January 2025 indicated that transmission had occurred.

Extra cleaning including hydrogen peroxide environmental decontamination, is carried out on all wards where apparent spread has occurred, while audits of the environment, practices on the ward and antimicrobial use are also undertaken. The ability to undertake routine full ward deep cleans has been limited by the inconsistent availability of a decant ward. Regular hydrogen peroxide decontamination of side rooms in which *C difficile* infected patients are located has not consistently occurred due to pressures on the limited isolation facilities available in the Trust.

f. Hospital Acquired Bacteraemia (HABs) and Device-Related Hospital Acquired Bacteraemia's (DRHABs)

Device-Related Hospital Acquired Bacteraemia's (DRHABs) are used as another KPI for the Trust. All positive blood cultures are designated as being either significant or a contaminant by a Consultant Microbiologist, and the source of all significant positive blood cultures is determined. If the source is an implanted medical device and the patient has been in hospital for more than 48 hours when the blood culture was taken, or is within two weeks of discharge, or is a regular day-case attender, then it is designated as a DRHAB. Graph 6 shows how the Trust's performance has improved over the years that this data has been collected, although in 2020/21 the numbers went up. The DRHAB target for this year was 48 and there were 64 DRHABs, which the highest since 2020/21. No target is set for HABs, however in 2024/25 there was a total of 279 HAB, the highest since 2012/13.

Graph 6

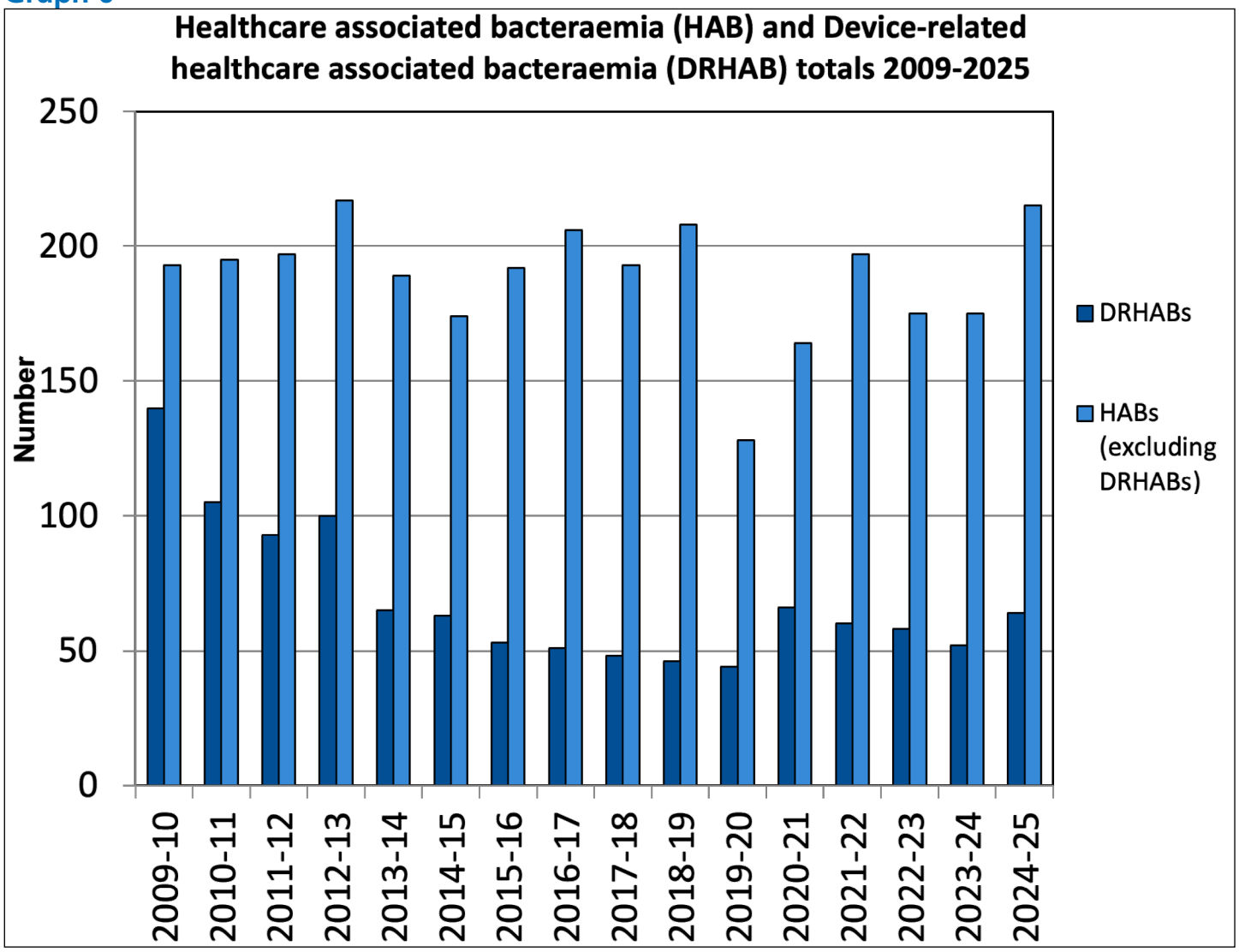


Table 1 shows the blood culture data, with sources of DRHABs over the course of the year and data from the previous two years and from the first year this data was collected, for comparison. Regarding DRHABs, it can be seen that there was an increase in 2024/25, with increased numbers of urinary catheter-related infections compared to previous years. Table 2 shows that line infections increased slightly year (this includes five cannula-related infections)

Table 1

	2009-10	2021-22	2022-23	2023-24	2024-25
Blood Cultures taken	**10,943**	**15,990**	**19,076**	**19,825**	**19,395**
Blood Culture positives	**1,113**	**1, 127**	**1,150**	**1,152**	**1,283**
Blood Culture significant	**824**	**835**	**782**	**834**	**880**
Blood Culture contaminants	**299**	**292**	**368**	**318**	**403**
Hospital Acquired Bacteraemia (HAB)	**333**	**257**	**233**	**227**	**279**
Device-Related HABs:	**140**	**60**	**58**	**53**	**63**
Lines	91	39	36	33	33
Urinary Catheters	15	18	20	16	26
VAP	14	0	0	0	0
?VAP/?Line	7	0	0	0	0
Nephrostomy	4	1	2	3	4
Pacemaker	4	1	0	0	0

Table 2

Ward / Area	2009-10	2021-22	2022-23	2023-24	2024-25
Clinical Haematology Unit	35	5	7	4	4
Durnall / Chemotherapy	7	0	8	3	5
Deanesly Ward	6	2	0	3	3
Neonatal Unit	26	11	3	8	5
RDU (including satellite units)	19	10	10	2	7
Critical Care Unit	8	1	1	2	1
Cardiac (excluding CCU)	3	1	2	1	4
Surgical Wards	21	8	10	10	8
Medical Wards	12	16	12	10	16
West Park and Cannock Chase Hospitals	0	3	2	3	5
Other wards	3	3	3	4	6

g. Gram negative Bacteraemias

In August 2021, objectives were issued for the first time to Trusts by NHS England for the numbers of bacteraemias caused by the Gram negative organisms Escherichia coli, Klebsiella species and Pseudomonas aeruginosa. These Gram negative organisms are found in the gastrointestinal tract, and most commonly are associated with infections of the urinary tract or biliary tree. Trust-attributable bacteraemias are those that occur on day two or more of admission (HOHA), or within 28 days of discharge from any inpatient admission, including day case admissions (COHA). Last year the Trust was above all three objectives and so the objectives for 2024/25 were increased or maintained (the previous year's objectives are shown in brackets). Table 3 shows that in 2024/25 RWT was above the objected for all three Gram negatives that re monitored. For comparison the numbers from the previous years are also shown in the table Of particular note is the 28 P. aeruginosa bacteraemia; this is the highest number we have seen in recent years. Of these, six were in Haematology patients, compared with a maximum of two in the years prior to 2023.

Other than targeting the small number of these infections that are related to devices (device-related RWT-attributable E. coli bacteraemia fell from more than 11% in 2010/11 to just under 4% of the total in 2020/21), the ubiquity of these organisms in the gastrointestinal tract and the nature of the infections that they cause mean that other targets for intervention are not clear cut. P. aeruginosa is found in water and there is routine testing of water from outlets in high-risk areas.

Table 3

	Escherichia coli	Klebsiella spp	Pseudomonas aeruginosa
Target 2024-25 (Target 2023-24)	**107 (94)**	**32 (29)**	**15 (15)**
Number 2024-25	**135**	**36**	**28**
Number 2023-24	113	35	16
Number 2022-23	95	32	17
Number 2021-22	103	36	16
Number 2020	81	22	18
Number 2019	97	20	14
Number 2018	122	43	18

h. Carbapenemase-Producing Enterobacteriaceae (CPEs)

The carbapenem group of antibiotics is regarded as the antibiotic of last resort in many situations in which they are used. CPEs are organisms that produce enzymes (the common enzymes being NDM, KPC, and OXA-48) that destroy these antibiotics. The main takeaway from this section of the report is that number of patients colonised with these, often untreatable organisms, is increasing year on year. Hospitals within the West Midlands have seen sizeable and ongoing outbreaks with these organisms, with associated bacteraemias. It is well recognised that infections with these highly resistant organisms carry significant mortality, particularly in high-risk groups such as those undergoing treatment for cancer, likely related to the fact that some of these bacteria are resistant to all antibiotics. To reduce the risk of this occurring at RWT, it is vital that we have sufficient and appropriate isolation facilities, alongside a comprehensive screening strategy.

RWT has had a screening strategy for a number of years to try to control the spread of these organisms. New guidance regarding screening was issued in 2020 by Public Health England, however, which recommended rectal screening of all patients admitted to high-risk areas including critical care and oncology units, and also all patients who have been admitted to hospital in the last year. Currently RWT still uses a risk-based screening strategy to include all patients who have travelled abroad or had healthcare in a hospital other than RWT in the last year. We remain unable to implement the new guidance so far, because the need to agree a screening method across the four Black Country Pathology Services Trusts, alongside the necessary funding, has prevented progress with this.

Table 4 shows that up until the end of 2017/18 the number of patients in Wolverhampton found to be carrying these organisms was rising annually, but in 2018/19 this rise appears to have stalled. This may be related to introduction of the CPE policy including improved detection of carriers, reducing incidences of spread. In the spring of 2019/20, however, molecular testing was introduced as the first-line screening method. This is far more sensitive and is capable of detecting multiple resistance mechanisms. Prior to the introduction of this method it was very difficult to detect OXA-48 producing organisms.

In 2020/21 there was a marked decrease in the number of new patients identified carrying CPE. This most likely reflects the reduction in overseas travel due to the COVID-19 pandemic, with perhaps a contribution also from reduced screening due to reduced elective activity. In the year 2024/25 we have seen the highest number of new CPE patients to date.

The majority of CPEs continue to be detected from screening samples rather than from clinical isolates, which shows the screening strategy is working (Table 5). There were nine patients identified as positive from clinical samples, however. Seven of these patients were from the community with little information available as to their risk factors. Of the two patients who had samples taken in the Trust, both had been admitted three weeks prior to the positive sample. The first patient had a sputum sample that grew KPC, and no identifiable risk factors.

No further cases were found on contact screening. The second patient, who has been admitted to a respiratory ward from a care home, grew an OXA-48 producing organism from a catheter urine sample. Screening of contacts found a further positive case, suggesting transmission had occurred. Two patients who were on the ENT ward were found to be carrying the same enzyme (Oxa-48) indicating possible transmission; extended screening found no further cases on that ward.

Typing in this context is limited because only the organisms and not the resistance genes can be typed currently, and the genes can spread readily between different bacteria in the gastrointestinal tract.

Table 4

	NDM	OXA-48	KPC	Others	Total
2012-13	2	0	0	0	**2**
2013-14	5	1	2	0	**8**
2014-15	2	0	6	0	**8**
2015-16	4	1	7	0	**12**
2016-17	7	2	10	0	**19**
2017-18	19	6	9	2	**34***
2018-19	15	3	2	0	**20**
2019-20	26	34	5	2	**56***
2020-21	6	12	4	0	**18***
2021-22	10	14	4	0	**27***
2022-23	22	32	7	0	**53***
2023-24	44	57	9	1	**98***
2024-25	42	77	11	3	**117***

*The number of patients is fewer than the combined number of resistance mechanisms because some patients carried more than one resistance mechanism.

Table 5

	Detected from screens	Detected from clinical samples	Total
2012-13	0	2	2
2013-14	2	6	8
2014-15	1	6	7
2015-16	4	7	11
2016-17	13	5	18
2017-18	31	3	34
2018-19	20	0	20
2019-20	48	8	56
2020-21	13	5	18
2021-22	25	2	27
2022-23	43	10	53
2023-24	91	7	98
2024-25	108	9	117

i. *Candidozyma auris*

Candidozyma auris is a rapidly emerging fungal pathogen which is now endemic in healthcare institutions worldwide. It can cause a wide variety of infections and has developed resistance to many available antifungals. Large outbreaks have occurred in hospitals in southeast England. The UKHSA released updated guidance in March 2025 for screening and management of this organism. The first known case at RWT of *C. auris* was detected March 2025 in a patient repatriated form a hospital abroad. A business case is in development for the introduction of screening to reduce the risk posed by this organism.

Outbreaks and incidents

The Trust has an Outbreak / Incident Policy and incidents are reported and managed in line with this policy. Outbreaks / incidents are managed by Post Incident Review meetings (PIR) held within seven working days, wherever practicable, and chaired by an Executive Director / Head of Corporate Services or Senior Matron supported by key healthcare professionals. A 48-hour report is completed by the Infection Prevention Team to outline the suspected outbreak or incident, and this is submitted to the area concerned. Frequent meetings are held to manage and monitor the outbreak / incident to discuss individual cases and arrange appropriate sampling or screening, support patient experience and care, inform, arrange appropriate decontamination of the affected areas, and reduce the risk of spread to other areas whilst maintaining the operational function of the hospital and patient flow. Different outbreaks / incidents demand different responses but are managed with precision and collaborative working between the multi-disciplinary teams across the health economy.

COVID-19

There were 36 outbreaks across the organisation which were investigated and managed as per local outbreak management processes. An assurance report was completed by the affected area to ensure compliance with infection prevention practices to prevent the spread of infection. Outbreak meetings were arranged if there were any areas of concern that required escalation, there was an impact on a service, a ward closure or moderate / severe harm was identified.

Healthcare associated infections were identified following NHSE guidance. Cases that were identified eight to 14 days post admission are classed as probable and over 14 days definite were all investigated through the Datix process. There was a total of 182 HCAI in 2024/25

- Quarter 1 April – June – 40
- Quarter 2 July – September – 62
- Quarter 3 October – December – 57
- Quarter 4 January – March - 23

COVID-19 numbers and outbreaks have continued to decrease since the height of the pandemic and the Trust has returned to business as usual as per national guidance. COVID-19 is now managed like other respiratory illnesses and preventing the spread of infection. A joint RWT and Walsall Healthcare executive approved respiratory risk assessment is in place to help support with managing respiratory outbreaks across the organisation to prevent the spread of infection and maintain operational function.

Norovirus or Suspected Norovirus

Norovirus is a self-limiting diarrhoea and vomiting bug that usually lasts 48 – 72 hours and is usually more prevalent in the winter months earning it the nickname "Winter Vomiting Bug". There was a national increase of norovirus cases reported during 2024/25, which impacted significantly on the Trust, affecting activity. There were 18 outbreaks of confirmed Norovirus, 11 resulting in ward closures.

Influenza

This is a respiratory virus. There were 15 Influenza outbreaks detected in 2024/25. Incident meetings were held for both outbreaks. Like COVID-19 an assurance report was completed by the affected area to ensure compliance with infection prevention practices to prevent the spread of infection. Outbreak meetings were arranged if there were any areas of concern that required escalation, there was an impact on a service, a ward closure or moderate / severe harm was identified.

Clostridioides difficile related incidents and outbreaks

All patients identified with *C. difficile* are reviewed following the sample result by the IPT / Microbiologist / Antimicrobial Pharmacist and as part of a weekly multidisciplinary ward round. Increased incidence of *C. difficile* is managed and monitored in line with IP06 Policy. A period of increase incidence (PII) within a 28-day period triggers a Post Incident Review (PIR). Any actions from the review meetings are implemented at ward level.

There were 23 PIIs reported in 2024/25 involving *C. difficile*. In 3 incidents there was proven onward transmission between patients as the same ribotypes were detected. Robust actions were identified following each PIR to include increased environmental cleaning using HPV, hand hygiene assessments for all staff in the areas and reinforcement of infection prevention principles including timely sampling and isolation at onset of symptoms.

Due to bed capacity side rooms were not always available, so moving patients every seven days to a clean side room was not always feasible.

A permanent Patient Equipment Cleaning Centre (PECC) was opened in 2024, which provides support to clinical areas with cleaning of equipment - particularly commodes, beds and patient bedside equipment. An annual deep clean programme of wards was completed along with support from Hotel Services to deep clean additional areas that are unable to relocate to a decant ward facility e.g. AMU, theatres and maternity. A Trust *C. diff* action plan is in place with compliance monitored at IPCG.

Carbapenemase-Producing Enterbacteriales (CPE)

Enterobacteriaceae is a large family of bacteria that usually live harmlessly in the gut of all humans and animals. These organisms are also some of the most common causes of urinary tract, intra-abdominal and bloodstream infections. They include species such as *Escherichia coli, Klebsiella* spp and *Enterobacter* spp.

The carbapenems are a family of antibiotics including meropenem and ertapenem that are usually reserved for serious infections caused by drug-resistant Gram-negative bacteria (including *Enterobacteriaceae*).

Carbapenemases are enzymes that destroy carbapenem antibiotics, conferring resistance. There are several different types of Carbapenemases, of which KPC, OXA-48, NDM and VIM enzymes are currently the most common. In the UK over recent years, there has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant Carbapenemase-producing organisms. Several clusters and outbreaks have been reported in England, some of which have been contained, providing evidence that, when appropriate control measures are implemented, these clusters and outbreaks can be managed effectively.

There has been an increase in CPE cases detected in 2024/25 as rates of international travel increased. Most identified cases were detected on screens following risk assessment on admission and were isolated prior to the result. There was one outbreak of CPE during the year, one patient was identified as CPE positive from a clinical sample taken 22 days after admission. One further patient was identified as CPE positive from rectal screen following contact tracing and cloud screening of the ward. An incident meeting was held, and all actions were implemented at ward level including weekly CPE screening for all patients. No further cases were identified.

Neonatal Unit (NNU) MRSA outbreak – NHSE and ICB assurance visit

NNU saw clusters of acquisitions, with three separate clusters in 2024/25. Typing demonstrated similarity between the isolates suggesting transmission. PII meetings were arranged, with actions including staff education on hand hygiene and the decontamination of equipment, and actions to improve the environment.

Supportive visits were carried out by the Black Country ICB on 16th May 2024 and a collaborative visit from NHS England and Black Country ICB on 24th January 2025. Both visits were positive, and the Trust received good feedback with evidence of compliance with infection prevention practices. The IP Team was involved in a Midlands IPC regional task and finish group to review the learning from outbreaks on neonatal units across the region. As a result, an aide memoir "Management of Outbreaks in a Neonatal Unit" has been produced to support decision making and sharing of practices that have impacted on the management of outbreaks.

Mpox (MPXV) is a virus from the same family as smallpox, that presents with a rash illness which may be mild and localised, or severe and disseminated. There are two major genetic groups (clades) of MPXV, Clade I (formerly known as Central African or Congo basin clade) and Clade II (formerly known as West African clade). Clade II MPXV is responsible for the global outbreak that began in 2022. Clade I MPXV is currently considered more severe than Clade II MPXV.

UKHSA issued guidance that Clade I MPXV appeared to be spreading more rapidly across central Africa with potentially greater pathogenicity. WHO announced Clade I mpox should be considered a public health emergency of international concern; in the UK it is considered a high-consequence infectious disease (HCID).

Hotel services and deep clean programme

The Trust's Housekeeping Services are managed in-house.

The Housekeeping Services are split into three sections for the different sites covered: New Cross Hospital and West Park Hospital, Cannock Chase Hospital and Community premises. The table below details who is responsible for which area:

Area	Manager	Deputy
New Cross Hospital	Amy Hill	Tina Tipton
Cannock Chase Hospital	Damian Jones	Paul Warrilow
West Park and Community premises	Brendan Houston	Julie Burgess

The management structure for each of the three areas is supported by a well-trained team of Day and Evening Supervisors.

The Community premises include the following sites:

Castlecroft Medical Centre, Coalway Road, Lea Road Medical Practice, Oxley Practice, Pendeford Health Centre, Penn Manor, Primrose Lane Health Centre, Maltings, Warstones, Maurice Jackson Renal Unit, Thornley Street Surgery and West Park GP Surgery.

The Housekeeping Services Managers and Head of Facilities meet monthly with the Head of Nursing for Corporate Support Services (to include Infection Prevention) at the Environment Group. This meeting is chaired by the Head of Facilities, who presents a report from the Environment Group to the IPCG.

Training

During the year, priority has been given to ensure that all Hotel Services staff, Housekeeping, Catering and Portering completed their annual mandatory hand hygiene and IP Level 1 training.

Monitoring

The cleanliness technical audits are conducted by the Hotel Services Monitoring Officer and the Domestic Supervisors in accordance with the "National Standards of Healthcare Cleanliness, 2021". This document assigns areas within hospitals a 'functional risk', and this informs the frequency of the audit:

- FR1 areas are audited weekly
- FR2 areas are audited monthly
- FR3 areas are audited bi-monthly
- FR4 areas are audited quarterly
- FR5 areas are audited six-monthly
- FR6 areas are audited annually

In the main, the audits are carried out electronically, using a bespoke monitoring system.

Budget Allocation

The pay budget for the whole of Housekeeping Services for the year 2024/25 was £11,777,082; the non-pay budget was £1,460,700.

Clinical Responsibility / Access

The Domestic staff play a pivotal role in ensuring the hospital is a safe environment for patients, visitors and staff. The Domestic Services Department is very receptive to clinical need and responds to emergency and urgent situations rapidly and fully whenever possible 24 hours a day.

Deep Clean

This team has been in place since October 2008 and is required to deep clean all areas at least annually.

To support the Deep Clean Programme, the Housekeeping Department also operates its own in-house HPV system (Hydrogen Peroxide Vapour). This is used, in both the annual scheduled programme and also used throughout the year, to support the eradication of Norovirus and *C. difficile*. We currently are without a decant facility which means not all the wards were able to be fully proactively deep cleaned this year. We have concentrated on Theatres throughout the year, and we have deep cleaned wards bay by bay.

Ultra Violet Light Decontamination

The Domestic Service trialled the use of UV-C light decontamination throughout 2019/20 on AMU. This has resulted in the Trust approving a business case that has allowed the Housekeeping Service at New Cross Hospital to proactively decontaminate areas on AMU, the Emergency Department, and Renal treatment area with a timely turn around since 2020/21 and has carried on throughout the following years.

Patient Equipment Cleaning Centre (PEC Centre)

In 2022/23 the Patient Equipment Cleaning Centre was reintroduced. This service manually cleans patient beds, mattresses, over bed tables, and patient chairs after green and amber discharges with a chlorine and detergent solution. The equipment is then steam cleaned followed by HPV decontamination before being placed, covered, in clean storage.

These clean equipment sets are dispatched to discharges where the domestic cleans the rest of the room and the dirty equipment taken away to the dirty storage area of the PEC Centre awaiting decontamination.

The service is currently only able to be used to assist push discharge areas as well as assisting wards that require a deep clean but are unable to decant.

A purpose built PEC facility has recently opened on the New Cross site.

Antimicrobial Stewardship

- Antimicrobial use
- AMR CQUIN
- Antimicrobial resistance data
- AMS team activities

National Action Plan Policy Paper 2024/29: Confronting antimicrobial resistance

- Prevent any increase in a specified set of drug-resistance in humans from the 2019/20 financial year baseline
- Prevent any increase in gram-negative blood stream infections from the FY 2019/20 baseline
- Aim to increase UK public and healthcare professionals knowledge on AMR by 10% using 2018 and 2019 baselines
- Reduce total antibiotic use in human populations by 5% from the 2019 baseline
- Achieve 70% of total use of antibiotics from the access category (new UK category) across the healthcare system (N.B it is acknowledged with the community that 70% in hospital might not be achievable due to the complexity of infections. The figures is a combination of primary and secondary care)

Standard contract for 2024-25

- "For 2024/25, given that the detailed requirements of the new national action plan have not yet been confirmed, we therefore propose to amend the Contract wording to require each Trust to use all reasonable endeavours, consistent with good practice, to minimise its broad-spectrum antibiotic usage, in accordance with the requirements of the new national action plan when published. We will then consider re-introducing specific percentage targets for annual reductions into the Contract for 2025/26 onwards
- In primary care, the NHS Oversight Framework (NOF) targets have been rolled over for 2024/25
    - Items / STAR-PU <0.871 and broad spectrum proportion ≤10%

Antimicrobial Use

We report on the following markers of antibiotic use:

1. Total antibiotic usage (for both inpatients and outpatients) per 1,000 admissions.
2. Total usage (for both inpatients and outpatients) of carbapenems per 1,000 admissions.
3. The proportion of antibiotic usage (for both inpatients and outpatients) within the Access group of the AWaRe category.
4. Percentage reduction in prescribing from the 'Watch' and 'Reserve' groups of antibiotics.

- Access group of antibiotics includes: phenoxymethylpenicillin, nitrofurantoin, metronidazole, gentamicin, flucloxacillin, doxycycline, co-trimoxazole, amoxicillin, ampicillin, benzylpenicillin, benzathine benzylpenicillin, procaine benzylpenicillin, oral fosfomycin, fusidic acid, pivmecillinam, tetracycline and trimethoprim

Total Antimicrobial Consumption

- At the time of writing, data is available up to the end of quarter one for 2024/25.
- This data is in the public domain, accessible through UKHSA's 'Fingertips' Website:

  https://fingertips.phe.org.uk/profile/amr-local-indicators
- RWT continues to use less antibiotics per 1,000 Trust Beds than the National average
- RWT sits in the best quintile for total antimicrobial consumption

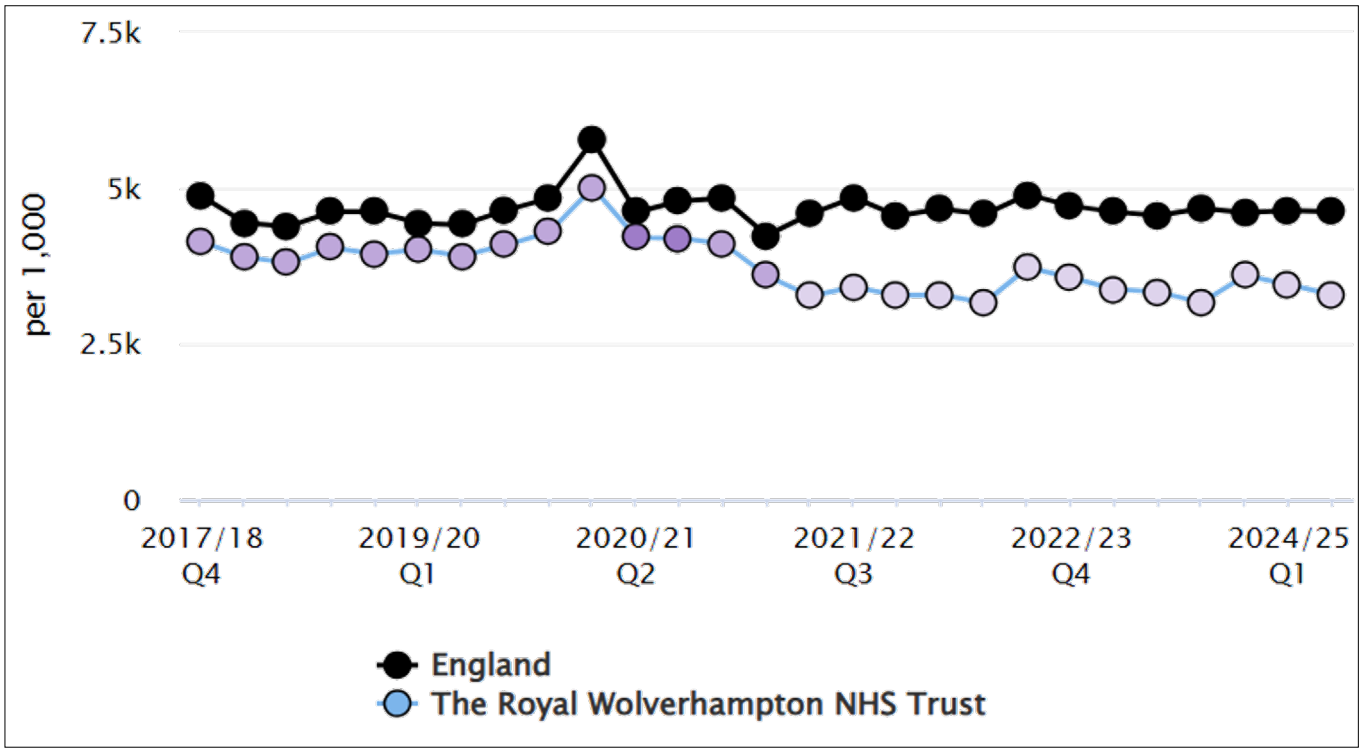


Figure 1 - shows the total consumption of antimicrobials compared to the National average adjusted per 1000 Trust Beds from Q4 2017- Q1 2024 in RWT

Carbapenem use

- Carbapenems are very broad-spectrum antibiotics, often an agent of last resort
- RWT has, in the past, prescribed more carbapenems than the average for England with a spike seen in quarter one 2020/21, coinciding with the first wave of COVID-19
- Up until Q1 24/25 carbapenem prescribing in RWT was just above the National average in England

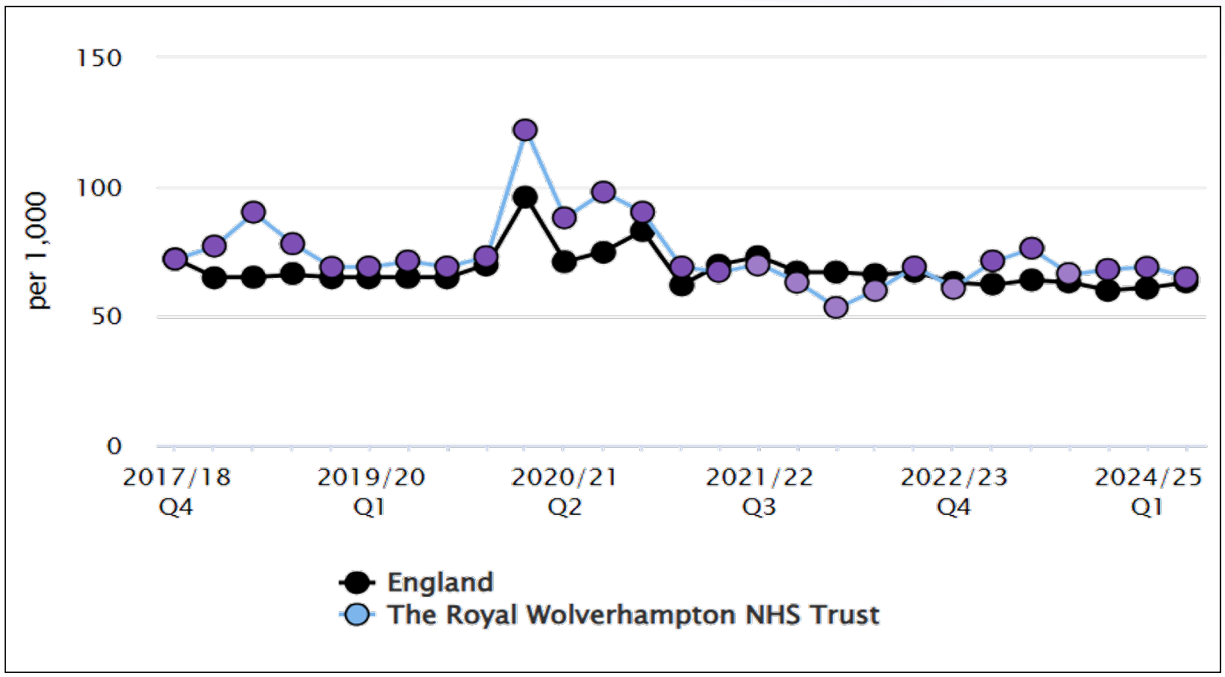


Figure 2 - Shows the consumption of carbapenems compared to the National average adjusted per 1000 Trust Beds from Q4 2017 - Q1 2024

- Fingertips data at the time of writing is only available up to Q1 for Q1 2024/25
- Some interventions have been made by the AMS team in relation to carbapenem prescribing since June 2024
- More up to date data (show in figure 3) has been pulled from refine and define which shows a reduction and downward trend
- Strategies to reduce carbapenems could include use of newer agents such a temocillin which the AMS team will explore. There is an increased cost associated with using these agents however

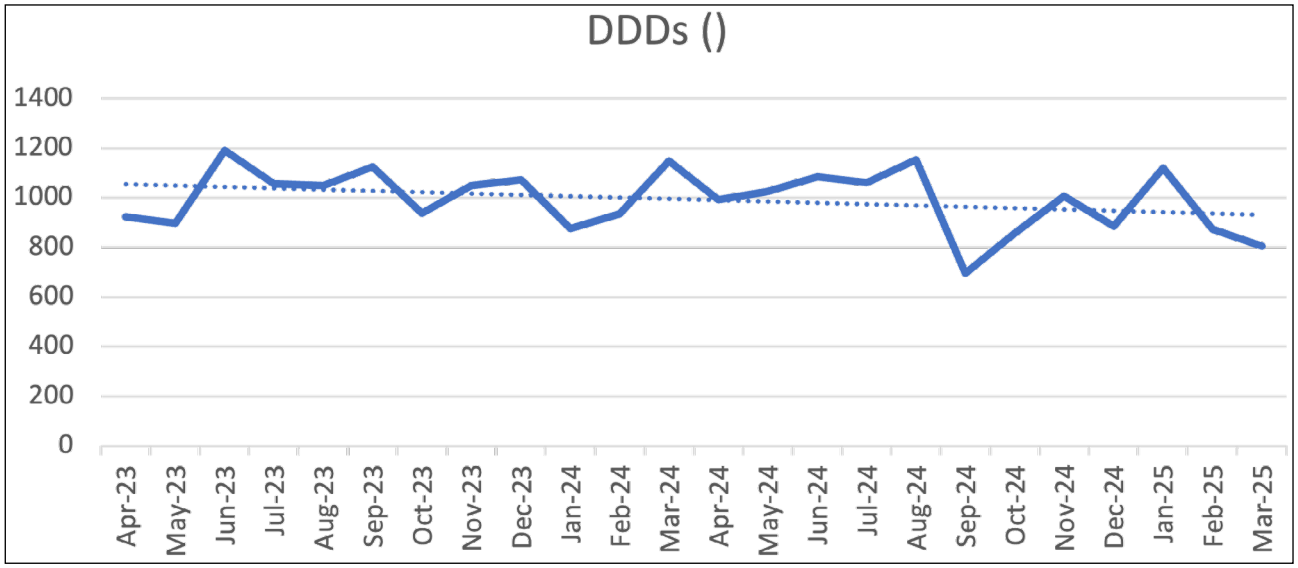


Figure 3 - Shows the consumption of carbapenems in RWT adjusted for 1000 admissions from April 2023 - March 2025

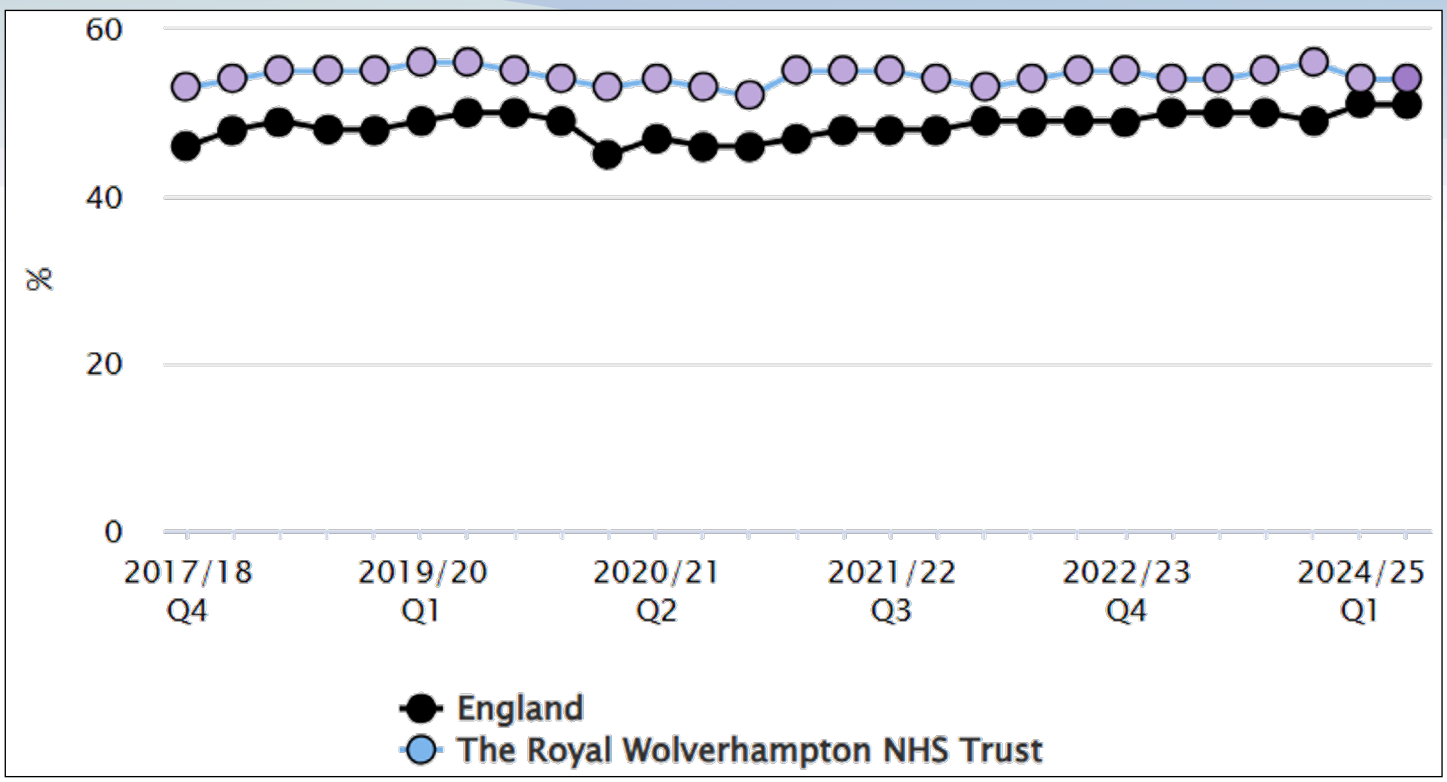


Figure 4 - Shows the percentage of access antibiotics compared to the National average used from Q4 2017 - Q1 - 2024

Access Antibiotics

- We aim to use a greater proportion of antibiotics from the WHO 'Access' group of antibiotics and a lower proportion from the 'Watch' and 'Reserve' groups in line with National Action Plan targets
- RWT is performing above average for England. At present RWT remains in the second-best quintile in England for this
- Due to National targets aimed at increasing prescribing within the Access group, England is now closing the gap
- Prescribing from the access group at RWT can be challenging due to higher-than-average resistance rates for certain infections

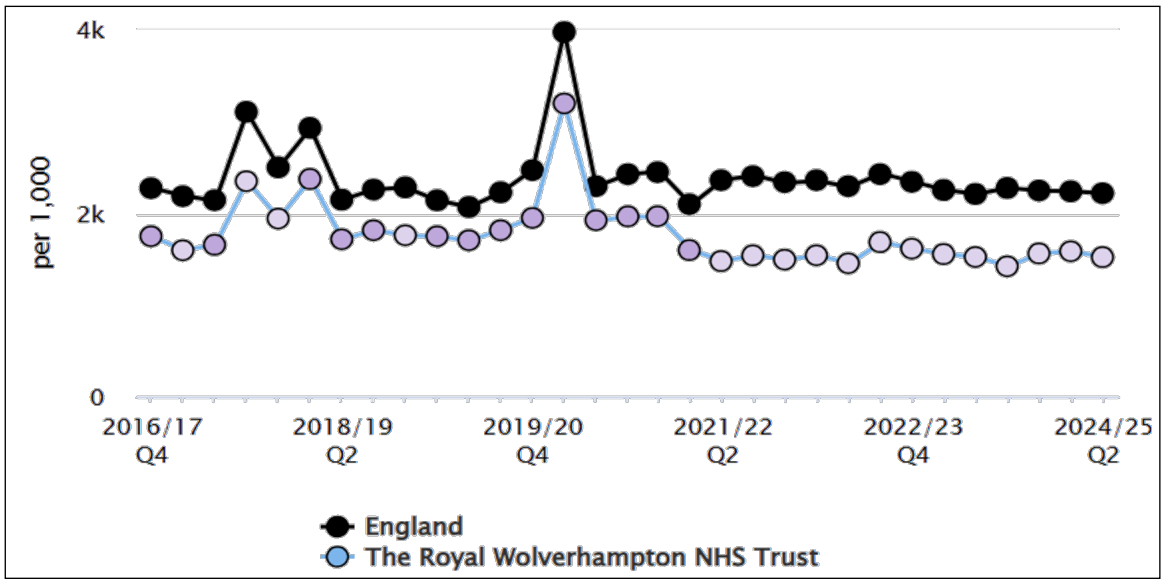


Figure 5 - Shows the consumption of watch and reserve antibiotics compared to the National average adjusted per 1000 Trust Beds from Q4 2016 - Q2 2024

- National target is to increase prescribing from the access group to 70% (across primary and secondary care) and reduce prescribing from the watch / reserve group
- Improvements have been made to the usage of watch and reserve antibiotics since 2019
- RWT still uses significantly less watch and reserve antibiotics compared to the national average and sits in the best quintile for England
- Increasing usage from the access group in Secondary Care can be challenging due to the complexity of infections being treated
- The AMS Team feels that most of the gains could be made from unnecessary usage
- The team will focus on ensuring that durations are appropriate, and that patients are stepped down to oral as early as possible
- Quality improvement work will be undertaken to ensure patients have their allergy statuses recorded appropriately which may encourage use from the access group as it broadens the options for antimicrobial treatment

Antimicrobial Stewardship CQUIN

The 2024/25 CQUIN required 100 adult patients on IV antibiotics to be audited every quarter and assessed for suitability for oral antibiotics.

- The CQUIN this year was non-mandatory but the AMS Team chose to participate due to purported benefits of stepping patients down from IV to oral
- Weekly antimicrobial stewardship rounds were conducted to carry out this audit
- After Q2 the AMS Team put interventions into place such as teaching for all Healthcare professional groups, distribution of resources to all wards, support for areas who were finding it more challenging
- Q4 13.08% of patients were receiving antibiotics past the point which they could have switched – therefore RWT achieved this target
- This has correlated with a reduction in IV antibiotic consumptions outlined in Figure 7

Prompt switching of intravenous to oral antibiotic

Description	Achieving 15% (or fewer) patients still receiving IV antibiotics past the point at which the meet switching criteria.	
Numerator	Of the denominator those who at the point of audit, have already met the criteria for switching from IV to oral administration of antibiotics according to adult (16+ years of age) or paediatric (under 16 years of age) criteria as appropriate.	
Denominator	Total number of adult and paediatric inpatients with active prescriptions for IV antibiotics at the point of audit (sample size 100 patients per quarter, aim to cover all included wards / specialities.	
Exclusions	Patients in HOU and ICU. Patients treated with intravenous antifungals or antivirals.	
Data reporting and performance	For local agreement between provider and commissioner - the UKHSA portal will continue to take submissions where providers and commissioners wish to use this route. Details can be found in the AMR Programme FutureNHS Workspace link below.	
Scope	Acute	Period: All quarters
Suggested thresholds	Minimum: 25% Maximum: 15% **Please note that for this indicator, a LOWER % = better Performance**	Whole period %
Lead contact	england.amrprescribingworksteam@nhs.net	

Figure 6 - Shows the details for the non-mandatory CQUIN 24/25

Table 1: Sows the results for 24/25 CQUIN

Quarter	Number of patients audited	Result
Q1	50	20%
Q2	101	22.77
Q3	100	13%
Q4	107	13.08%

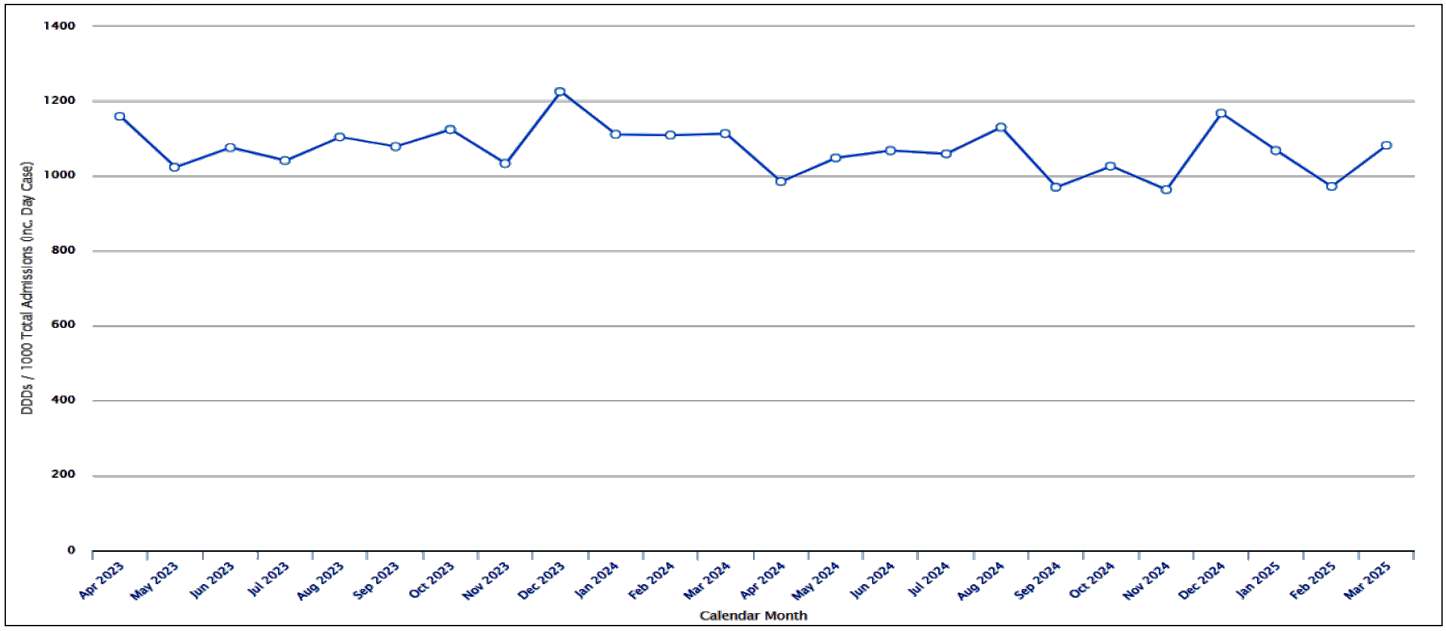


Figure 7 - Shows the total consumption of IV antibitoics adjusted per a 1000 total admissions from April 2023 - March 2025

Antimicrobial Resistance

- Resistance data is currently drawn from the UKHSA fingertips website
- Resistance in E. coli is used to give an impression of resistance rates in Gram-negative enteric pathogens
- In the past, RWT has had higher rates of resistance than the national average for gentamicin, cephalosporins and ciprofloxacin
- Our Tazocin resistance rates have been lower than average
- Most recent data shows a worsening of Gram negative resistance rates across the board. This is likely to be contributing to our increasing use of carbapenems to adequately treat patients with infections caused by multi-drug resistant pathogens

Table 2: E.coli resistance data by antibiotic from 2021/24 compared to the National Average for England

% *E. coli* bacteraemia isolates resistant to antibiotic					
Antibiotic	**RWT 2021**	**RWT 2022**	**RWT 2023**	**RWT 2024**	**Average for England 2024**
Tazocin	11	10	12.0	11	12
Ciprofloxacin	34	21	38.0	36	21
Cephalosporins	19.0	15.0	24.0	26	18
Gentamicin	15.0	8.0	19.0	18	12

Antimicrobial Stewardship Team Activities

AMS Ward Rounds

- The AMS Team conducst AMS ward rounds reviewing antibiotic prescriptions on a weekly basis
- Due to the CQUIN every ward in the Trust received at least one AMS ward round at least once a quarter Q2-Q4
- From September 2024 the AMS Team started to collect data on ward round activity to allow us to identify areas requiring further attention or support
- A total of 177 patients were reviewed from September 2024 – March 2025
- A total of 201 interventions were made by the AMS Team for the patients reviewed relating to antibiotic, dose, duration, IVOS switch, monitoring, further investigations, de-labelling penicillin allergies, recommendation for OPAT and cultures / sensitivity

AMS teaching

- **Resident Doctors:** Two sessions delivered to each new cohort (one delivered by a Microbiologist and one delivered by the Antimicrobial Stewardship Pharmacist)
- **Physicians Associates:** Annual session delivered by Antimicrobial Stewardship Pharmacist
- **Nurses:** Teaching delivered on an annual basis as part of bite-sized training
- **Pharmacists:** Six monthly teaching delivered by Antimicrobial Pharmacist and training packaged delivered for newly qualified Pharmacists
- **Pharmacy Technicians:** six monthly teaching delivered by Antimicrobial Pharmacist
- **Consultants:** Grand Round booked for 2025 during World Antimicrobial Awareness Week
- Additional AMS session delivered via Teams which was open to all staff during World Antimicrobial Awareness Week
- Knowledge café hosted during World Antimicrobial Awareness Week

Other activities over the last 12 months:

- Attended governance meetings to support areas and address specific issues relating to antimicrobial stewardship
- Successfully supported a Trust-wide change in the platform hosting the antimicrobial guidelines from Microguide to Eolas
- Additional antimicrobial stewardship ward rounds were undertaken with the microbiology clinical fellow whilst they were in post
- Antimicrobial stewardship group re-established
- World Antimicrobial Stewardship Week activities: Infection prevention stand, penicillin de-labelling quiz, antimicrobial stewardship teaching session, knowledge café with micro and attendance to wards to provide AMS resources
- Elastomeric Devices: Supported the introduction of Flucloxacillin and Piperacillin / Tazobactam 24 hour infusion to allow patients to go home on OPAT
- Tobramycin therapeutic drug monitoring guideline produced
- Supported with the administration of tobramycin for OPAT
- Guidelines reviewed to reduce use to quinolones in response to the MHRA alert published January 2024
- Supported with a Trust-wide risk assessment supporting areas to continue to use Ecovidene as multiuse vials safely
- Cost improvement projects: Switch of Ambisome to amphotericin B liposomal generic solution. Estimated saving £142,632 per annum. Switch of ertapenem to meropenem. Estimated saving £24,675 per annum
- Links made with Walsall Healthcare to share best practice

- Band 8A Pharmacist to support principal antimicrobial stewardship recruited and established in post
- Presented CQUIN quality improvement at the QSIR Roadshow
- Engaged with ICB AMS regional work streams
- Baseline service evaluation undertaken by Trainee Pharmacist assessing the quality of documentation surrounding penicillin labels
- Baseline service evaluation undertaken by Trainee Pharmacist assessing compliance to community acquired pneumonia guidelines in acute medical areas

AMS Team aims for the coming year:

- Review Trust mandatory AMS training modules.
- Review and update the following antibiotic guidelines:
  - Intra-abdominal infection
  - Sepsis of unknown source
  - Hospital Acquired Pneumonia
  - Aspiration pneumonia
  - Community acquired pneumonia
  - Clostridioides Difficile Treatment
- Aim for twice weekly antimicrobial stewardship ward rounds
- Continue to deliver teaching plan as outlined earlier
- Continue to attend governance meeting to support areas and address specific issues
- Review OPAT service and work towards a COPAT service (Complex Outpatient Antimicrobial Therapy) which includes complicated oral regimens
- Pilot new ways of collecting snapshot data to obtain a deeper level of data
- Quality improvement project to be undertaken to improve the quality of documentation in relation to penicillin allergies
- Quality Improvement project to be undertaken to improve compliance with community acquired pneumonia guidelines
- Participation in the Hospital Acquired Pneumonia working group to improve mortality and patient management
- Review capabilities of ePMA to see whether this can support with Stewardship

Audit

Primary Care - GP Practices and Health Centres

Audits have taken place in Primary Care General Practices and RWT Health Centres in Wolverhampton. There are a total of 56 GP practices, inclusive of nine practices under RWT. A specific audit tool for RWT practices has been developed. This tool ensures that risks continue to be managed in line with RWT processes and policies.

To date the following practices to have integrated with RWT are as follows:

1. Alfred Squire Road,
2. Coalway Road Surgery
3. Lea Road Surgery
4. Oxley Surgery
5. Penn Manor Medical Practice
6. Thornley Street Surgery
7. Warstones Surgery
8. West Park Surgery
9. Tettenhall Road Medical Practice

There are a total of 10 RWT Health Centres. A specific audit tool has been developed. The tool again has been designed to ensure that risks are managed in line with RWT processes and policies. The 10 health centres are as follows:-

1. Lower Green
2. Pendeford
3. Warstones
4. Whitmore Reans
5. Ashmore Park
6. Mayfields
7. Alfred Squire
8. Bilston
9. Phoenix
10. Primrose Lane

There has been continued engagement with all service providers, GP practices and health centres. Infection prevention standards are monitored and reviewed through the audit process. Any issues that are highlighted from the audit are fed back to the practice manager and an action plan requested. Audit feedback is also shared with ICB colleagues.

Policies and Audit

Infection Prevention policies have been reviewed accordingly during the year to ensure they reflect national guidance. There has also been a programme of policy audits undertaken to assure the Trust of compliance and to identify learning needs and actions required.

The current policy suite includes the following policies:

Policy number	Policy title	Policy reviewed	Policy audited
IP01	Hand Hygiene	x	x
IP02	Preventing Infection associated with the Built Environment	x	x
IP03	Prevention and Control of MRSA, VRE and other Antibiotic Resistant Organism		x
IP04	Transportation of clean and contaminated instruments, equipment and specimens		
IP05	Linen		x
IP06	*Clostridioides difficile*	x	x
IP07	High Consequence Infectious Disease policy (HCID) revised to replace IP07 Viral Haemorrhagic fever policy	x	
IP08	IP Operational Policy		
IP09	Glove Policy	x	
IP10	Isolation Policy for infectious diseases		x
IP11	IP Management of patients affected by common UK Parasites	x	
IP12	Standard Precautions		
IP13	Outbreaks of Communicable Infection / Infection Prevention Serious Untoward Incidents	Review due, extension granted	
IP18	Norovirus		
IP19	Blood and Body fluid spillage Management	x	
IP20	Urinary Catheter Policy		
IP21	Control and Management of TSE including CJD		

Compliance

Guidance released throughout the year has been appraised and incorporated into policy / process where appropriate:

Significant Guidance / Report / Alert	Recommendation / Action taken
TASK55010 FOR URGENT ACTION / CASCADE: Administration of GOJO Industries Europe Ltd Trust letter	The company GOJO went into administration, GOJO had 80% of the regional market share. A Trust meeting was held to discuss the next steps to secure a new soap and gel product supplier for the Trust and to discuss how to maintain current stock and supplies. S C Johnson was selected as the new supplier
15/08/2024 UKHSA Briefing Note Serial number: 2024/032 Event: Pertussis standard incident response – updates to national guidance	Amendments to guidance on occupational vaccination for healthcare workers
14/08/2024 UKHSA Briefing note Serial number 2024/033 Event: Outbreak of Clade I mpox in the African Region: update to high consequence infectious disease case definition	Clinicians were asked to: 1. Be alert to the possibility of clade I mpox in all patients with suspected mpox if there is a link to the specified countries in the African region (as listed above) 2. Have a low threshold for testing for mpox in patients with clinically compatible presentations with a travel history irrespective of sexual history 3. Isolate patients meeting the following criteria as a high consequence infectious disease and contact the Imported Fever Service to discuss urgent testing and typing
28/11/2024 UKHSA Serial number 2024/051 Event: Increased norovirus activity and emergence of GII.17 noroviruses in England during 2024	Frontline clinicians are advised to continue to confirm suspected cases / outbreaks with testing as per local procedures and provide advice for norovirus prevention to patients and visitors in hospitals, especially those in vulnerable groups such as elderly people, infants and anyone who is immunocompromised.
10/02/2025 UKHSA Serial number: 2025/007 (updated version) Publication of guidance for the management of persons exposed to animals, including birds infected with Avian Influenza A(H5)	To update UKHSA Health Protection Teams and partners to a guidance update relating to the public health response and management of persons exposed to animals, including birds, infected with Avian Influenza A(H5).
05/03/2025 Point prevalence survey on HCAI, AMU and AMS in England 2023: report. Point prevalence survey on HCAI, AMU and AMS in England 2023: report - GOV.UK	This report described the main results of the point prevalence survey (PPS) on healthcare-associated infections (HCAIs), antimicrobial use (AMU) and antimicrobial stewardship (AMS) which was conducted in England in 2023.
19/03/2025 UKHSA Serial Number: 2025/012 Event: Derogation of clade I mpox	The Advisory Committee on Dangerous Pathogens (ACDP) assessed evidence gathered by UKHSA for clade I mpox advised that it no longer met the criteria of a high consequence infectious disease (HCID). Therefore, the Chief Medical Officers (CMOs) of the four nations have agreed that mpox will no longer be managed as an HCID within healthcare settings.
19/03/2025 UKHSA Serial number: 2025/009 Event: Candidozyma auris (Candida auris) – updated	Guidance has been updated and is available on the GOV.UK website

Environment Audits

The Environment Audits of inpatient areas are conducted on a monthly basis by the clinical team and annually they are accompanied by IP, Estates and Hotel Service Supervisors. The audits are reviewed by the Clinical Leads, Infection Prevention and Hotel Services at the monthly Environment Group. Environmental audits (expert) are completed by the IP Team as a minimum twice yearly and at additional times if there are any concerns.

Infection Prevention Annual audits

The IP Team completes an annual audit (expert) for inpatient, clinical areas including Theatres and Primary Care. The tool is now completed on Inphase to support electronic reports and gives visual access to ward and department managers.

Estates Programmes

It is recognised that buildings must be safe to reduce the risk of infection through design and building works. The IP Team has worked collaboratively with Estates (Capital and Maintenance) this year on a range of both small and large building projects to ensure patient safety is always maintained. The Environment Group receives a report from Estates on planned developments which ensures the IP Team is informed of future projects.

Infection Prevention Representation at Key Meetings

The IP Team has maintained representation on numerous working groups this year as a method of ensuring appropriate IP advice is communicated and to ensure that infection prevention is considered as part of the design, policy and decision making processes across the organisation.

These groups include:

- Capacity / bed meetings
- Clinical Practices Working Group
- Clinical Practices Ratification Group
- Environment Group
- Health and Safety Operational Group
- Health and Safety Steering Group
- Sharps Safety Group
- Water Safety Group
- Ventilation Safety Group
- Medical Devices Group
- Clinical Procurement Equipment Group (CPEG)
- Theatre Procurement Equipment Group (TPEG)
- Quality and Safety Action Group (QSAG)
- Quality Governance Assurance Group (QGAC)
- Matrons, Senior Nurses, Midwives and Health Visitors Group
- COVID-19 and Influenza Vaccination Operational Group
- COVID-19 and Influenza Vaccination Oversight Group
- Infection Prevention and Control Group
- Trust Management Committee
- Trust Board
- Decontamination Group
- Fire Safety Group

- Tenanted Buildings Working Group
- Antimicrobial Stewardship Group
- *C. diff* Task and Finish Group
- Catheter and Continence Group
- Sustainability
- Measles Oversight Group
- Trust Healthcare Acquired Pneumonia (HAP) Intervention Group
- Clade 1 Mpox Preparedness Task and Finish Group

Intravenous Resource Team (IVRT)

The IVRT is a clinically active Nurse-led team which provides ultrasound guided long term and complex vascular access device insertion for patients across the adult inpatient and outpatient services of RWT

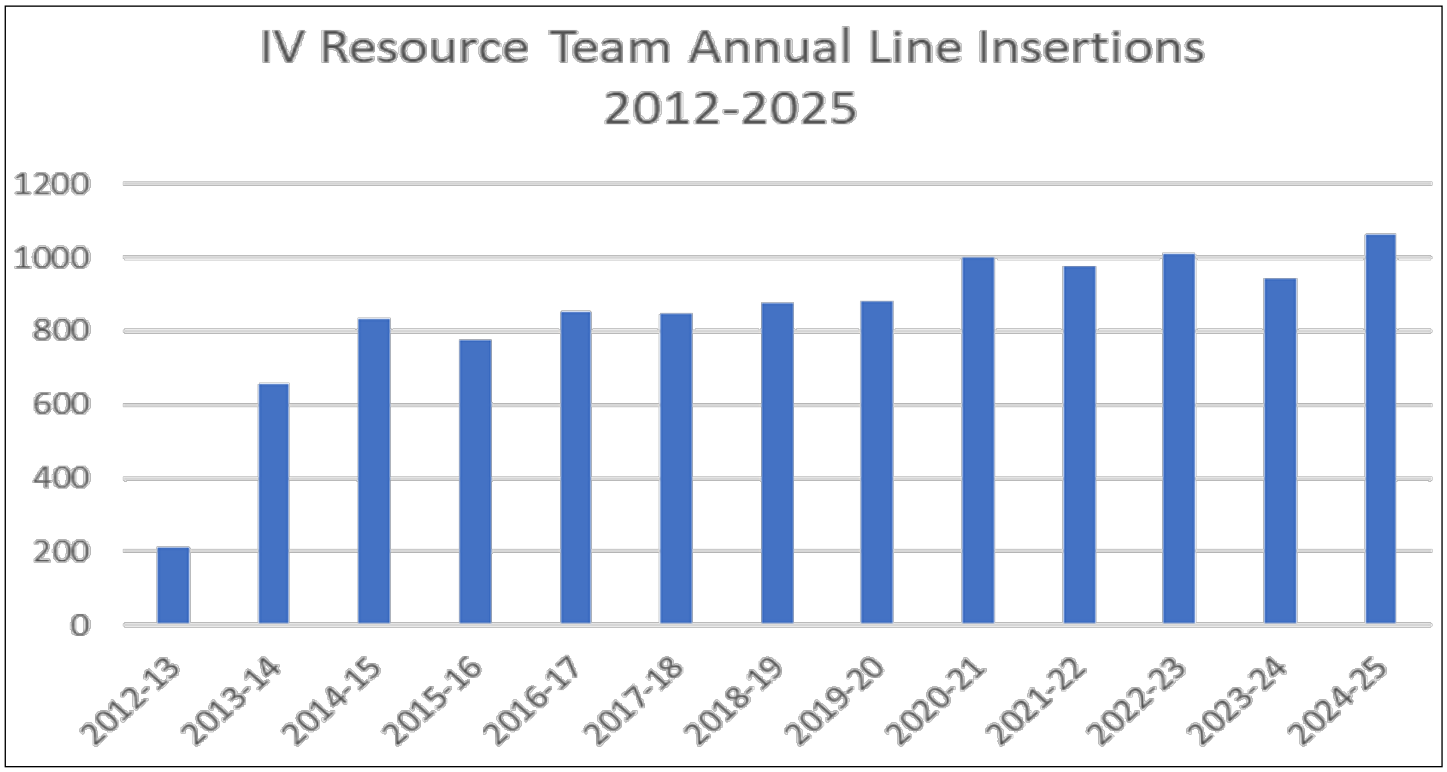
The team facilitates the discharge and ongoing monitoring of patients via the Outpatient Parenteral Antimicrobial Therapy (OPAT) service, which involves a large amount of clinical communication between a variety of differing community teams and Trust-based Consultants.

Alongside these two workstreams, the IVRT is also responsible for working with Microbiology to identify and report device related bacteraemias (DRHABs). This work aims to improve patient safety by identifying associated key issues and themes attached to these events, thereby enabling the implementation of actions to prevent future recurrence.

Long line insertion and maintenance

The insertion of peripherally inserted long intravenous lines under ultrasound guidance has continued, with the past year showing the highest annual number of successful procedures since the team was created in 2012, a total of 10,927 lines having now been inserted.

The graph below demonstrates the number of lines inserted on an annual basis.



Note: line insertions in 2024/25 were the highest they've been since recorded (2012) at 1060 (49 more / 4.8% higher than the last highest, 1011 in 2022/23 and 116 more / 12% higher than last year, 944 in 2023/24).

To support the increased demand on Haematology Oncology Services, the dedicated number of line insertions per week day was increased to two per day two years ago, and these numbers have continued to be maintained despite intermittent challenges to staffing levels within the team.

The team also continues to support the maintenance of all inpatient lines within the Trust by monitoring them daily, and the provision of support to ward teams by troubleshooting any issues they encounter. Dressing changes and the routine weekly replacement of add on devices (for example needle free access devices) are reliably ensured by the team as a result.

Requests for line insertions or issues requiring support are now made to the team via the Care Flow Connect system which the team was one of the first services to trial and implement last year. This has now been fully adopted as a referral pathway – improving the speed and accuracy of communication between ward areas and the team with resulting benefits to patient safety.

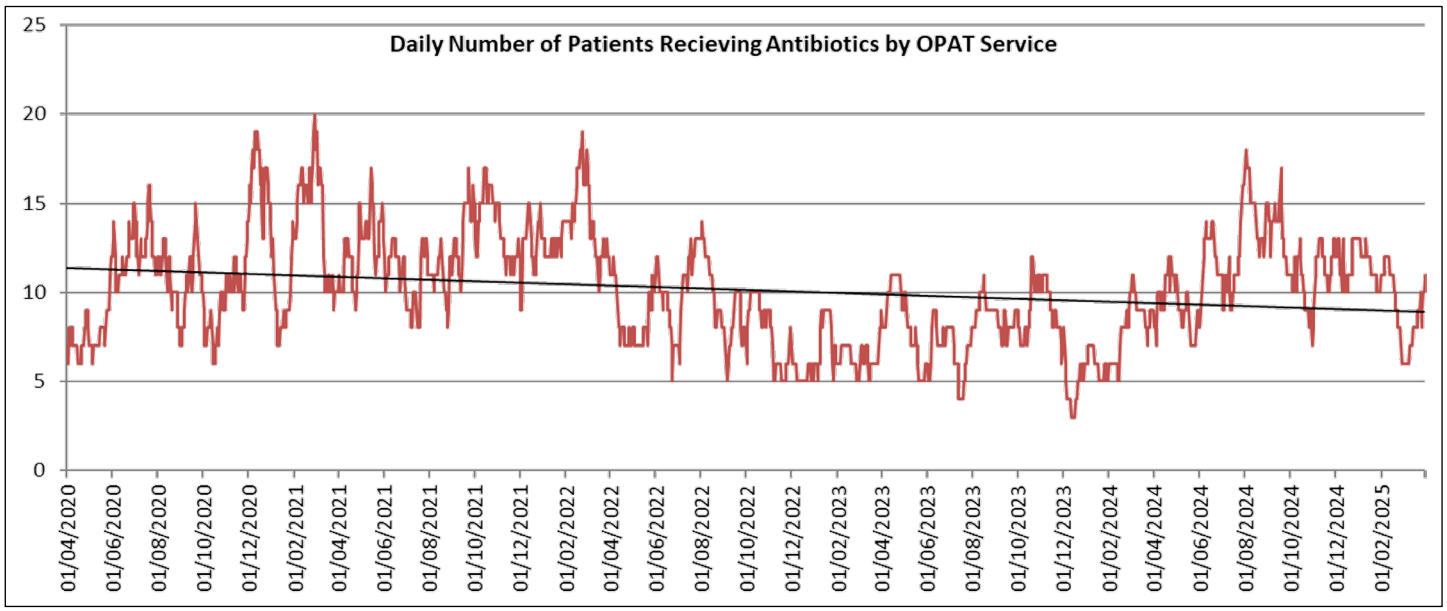
Outpatients Parenteral Antibiotic Therapy (OPAT) service

The OPAT service continues to discharge appropriate patients to their home environment whilst receiving intravenous antibiotics and is crucial to assist with the efficient and safe discharge of this patient group. Peripheral long-term IV lines are inserted according to patient need and patients referred to OPAT are then assessed prior to contacting relevant community teams to confirm their capacity before discharge.

The last financial year has shown 132 patients discharged via the service with a total combined bed day saving of 3649. The graph below indicates the ongoing numbers of patients benefiting from this service since 2020.

To ensure that the maximum number of patients possible are discharged via this route, obstructions to discharge are being analysed and consequent new pathways considered, for example a fast-track service for short term treatment courses where formal long line insertion may be avoided.

Other options in the initial stages of consideration include the administration of complex oral antimicrobial therapy regimes with the option of rapid IV switch where required, however these workstreams are, as yet, in the early stages of consultation.



A revised trial of the use of elastomeric administration devices has started again this year with the advent of increased levels of available support from Pharmacy. These devices allow the administration of antimicrobials that would otherwise require multiple daily dose administration by community teams, to be delivered slowly over 24 hours. Additional benefits to this approach include ability to ensure stable blood antimicrobial levels with obvious benefit to patient recovery. New pathways involving increased collaboration with the Hospital In reach Team and Virtual Ward have been created, and alternative device suppliers procured with reduced delivery timeframes further speeding up the discharge process.

Device-Related Hospital Acquired Bacteraemias (DRHABs)

Alongside many other Infection Prevention performance markers, these have sadly increased over the past 12 months, with the summer months showing the highest numbers. Bacteraemia rates have been equally spread across vascular access devices and urinary catheters / nephrostomies.

As a result, large numbers of teaching sessions have been provided for qualified nursing staff with ongoing sessions for parenteral nutrition bag changes also being held by the IV Team Lead. Going forward, additional education will be planned for non-qualified nursing staff based in clinical areas.

The identification and reporting process has been streamlined, with a Microbiology lead weekly ward round now taking place to enable a succinct process within ward areas.

As a result, immediate feedback is provided to clinical teams which join discussions regarding causative issues and factors behind the event, and the consequent identification of recurrent themes. These can then be fed back more effectively across the organisation, enabling widespread implementation of required actions to prevent recurrence.

External opportunities

Work continues with the Infection Prevention Society (IPS) and Device-Related Infection Prevention Practice (DRIPP) collaborative to create a surveillance tool for the monitoring and reporting of line related and associated bacteraemias between NHS organisations. A prototype has been trialled for two years and data submitted by five Trusts. This is to be analysed and a resulting article planned to be published to support bids for financial funding for the creation of a robust electronic app for widespread use. Central data collection already exists for central line bacteraemias, but the ability to achieve this in a standardised fashion for a wide variety of vascular access devices has not previously been achieved making this a very exciting project, hopefully of large significance to future improvements to patient safety.

The Trust is closely involved with the implementation of a trial of a similarly accessible system for urinary catheters, currently being developed alongside the vascular access tool, with supporting funding already identified from the IPS.

Tuberculosis Service

Tuberculosis (TB) is an infectious disease that is treatable and curable but continues to be a major public health issue. It is a serious, potentially fatal, disease that requires prolonged and complex treatment and is also an infection risk to close contacts, posing a significant burden on the patient, family and NHS. Those in under served populations (which include migrants, refugees, asylum seekers and those with social risk factors - homelessness, imprisonment, and drug and alcohol misuse) are at higher risk of acquiring TB. The incidence of TB in England is higher than most other Western European countries. Nationally, the highest rates of TB are seen in London, with the West Midlands having the highest rates outside of London.

The activity of the TB service ensures that TB cases in Wolverhampton are well managed according to NICE guidance and reduce the threat of spread in the city. Where active (infectious) cases are identified there is a swift response to contact tracing with appropriate education (e.g. to workplaces and family members) to reduce anxiety.

Persons with latent TB infection are not infectious and cannot spread TB infection to others; however, it is known that approximately 10% of latent cases can progress to active TB disease which is transmissible. New entrants screening was introduced in 2020. Information of new entrants is provided from Flag 4 data. TB Services continue to use the data to offer screening by sending letters and use of text messaging to invite new entrants for screening which are held in two locations. If a positive T-SPOT diagnostic test result is confirmed treatment is offered.

The TB Service supports three 3 local prisons - Oakwood is the second largest prison in Europe and operated by G4S, Featherstone is a Category C men's prison and Brinsford is a youth offenders' centre operated by HM Prison Service. The TB Team supports with TB cases and contact tracing. Each prison has identified link Nurses to enable a good working relationship and the team supports when there is a possible TB case and guidance is given. There is no initial screening programme in place at present, however any prisoner that presents with a cough and any signs and symptoms is isolated and screened. Continued educational sessions are provided to healthcare staff.

The BCG immunisation programme is a risk-based programme. The vaccine is recommended for individuals at higher risk of exposure to TB, particularly to protect against serious forms of disease in infants. Local pathways are agreed in the Trust for delivery of BCG vaccinations by Maternity from birth to the age of one by the Newborn Screening Team. All targeted children from birth will have a severe combined immunodeficiency (SCID) blood spot test. The TB Team has worked with local commissioners to facilitate BCG vaccination required for eligible children over one year old up to <18 years old.

The TB service delivers TB education sessions to statutory and non-statutory sectors across Wolverhampton, South Staffordshire, Cannock and surrounding areas.

Educational sessions will include Epidemiology of TB, local incidence, high risk groups and settings, the signs and symptoms of Active TB and Latent TB and treatments. They raise awareness of TB and provide a local service overview which will include pathway and referral process to the TB service. The training sessions can be delivered face-to-face or online via teams.

Surgical Site Infection Surveillance (SSIS)

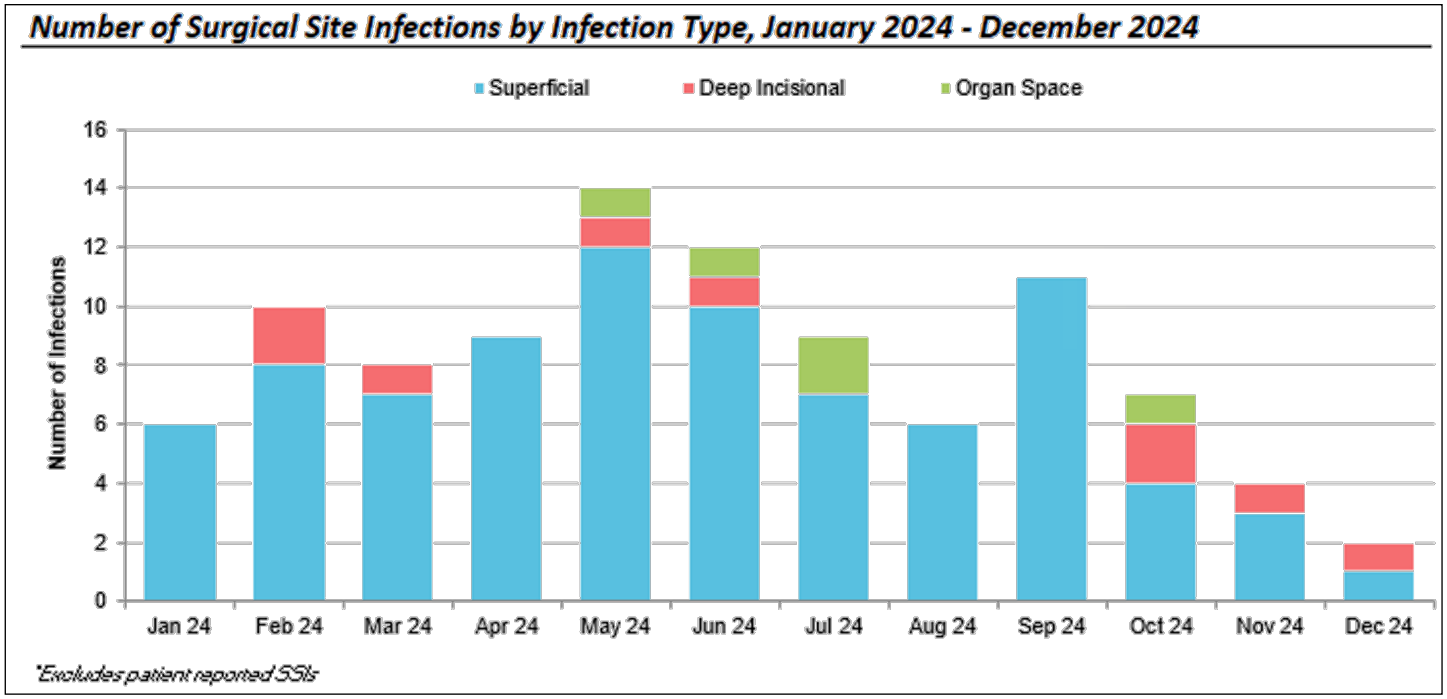
The SSIS Team consists of:

- 1.0 WTE Band 6 SSIS Nurse
- 2.5 WTE Band 3 SSIS Co-ordinators
- 1.0 WTE Administrative Support

The Trust has continued to collect and report on data around SSIS since 2012. It currently undertakes data collection for all knife to skin procedures 365 days a year and has a standardised approach using methodology set by UKHSA to collect data across inpatient facilities. This amounts to surveillance of more than 1,000 procedures each month from both New Cross and Cannock Chase Hospitals during a normal year.

The criteria for diagnoses of infections is set by UKHSA and differentiates between superficial, deep and organ / space infections.

The service currently follows up all patients at 30 days post operatively using telephone surveillance. All patients who have had surgery where an implant has been inserted are monitored for SSI for 12 months.



An electronic based surveillance system is used by the SSIS Team which ensures environmental friendliness and compliance with data protection legislation. The surveillance system used has an interface with Silverlink Theatre system currently used however this is due to be updated in the near future) allowing for accurate surgical data to be transferred. This system also allows for the SSIS team to complete and upload data to UKHSA for the mandatory reporting of hip and knee replacements and surgery for fractured neck of femur. Data is also submitted for Coronary Artery Bypass Graft (CABG) and valve replacement, totalling around 3,000 procedures per annum.

This data is used to compare local rates of SSI over time and against a benchmark rate obtained from data published by all Trusts. This enables Trusts to inform and guide the review or change of local practice to improve the quality of care.

All other surgery data is collated for internal quality reporting. In total, surveillance was performed for almost 9,000 inpatient and more than 3,500 day case procedures in 2024.

A local report is published and this data is shared with the Divisional Surgical Director on a monthly basis. Consultants have their own personal code which allows them to identify their own rates and comparisons can be made within their speciality, it also means that the data is anonymised. This is used to drive further improvement.

Total Number of Surgical Site Infections and Rate (%), January 2024 - December 2024

Month	No. Procedures	Surgical Site Infections				SSI Rate (%)			
		Inpatient	Readmission	Post Discharge	Patient Reported	Inpatient	Inpatient & Readmission	All (excluding patient reported)	All
January 2024	693	0	4	2	11	0.2%	0.8%	1.1%	2.5%
February 2024	717	2	5	3	11	0.0%	0.6%	0.9%	2.5%
March 2024	736	0	4	4	3	0.3%	1.0%	1.4%	2.9%
April 2024	766	1	4	4	6	0.0%	0.5%	1.1%	1.5%
May 2024	737	1	2	11	6	0.1%	0.7%	1.2%	2.0%
June 2024	724	1	3	8	5	0.1%	0.4%	1.9%	2.7%
July 2024	774	2	6	1	6	0.1%	0.6%	1.7%	2.3%
August 2024	726	0	0	6	12	0.3%	1.0%	1.2%	1.9%
September 2024	732	2	1	8	8	0.3%	0.4%	1.5%	2.6%
October 2024	816	0	5	2	12	0.0%	0.6%	0.9%	2.3%
November 2024	772	1	1	2	2	0.1%	0.3%	0.5%	0.8%
December 2024	688	1	0	1	5	0.1%	0.1%	0.3%	1.0%

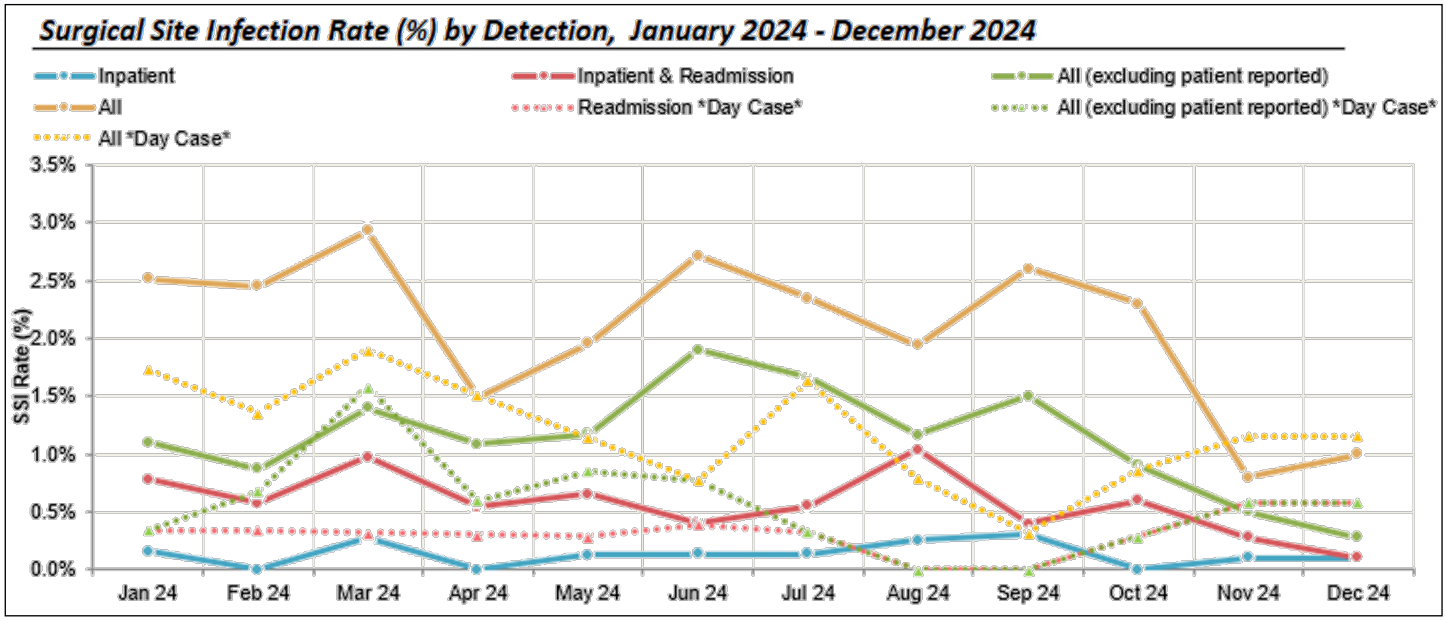
When the table above is compared to the report for 2013 below we can see that SSI rates have improved considerably since the service began.

Total Number of Surgical Site Infections and Rate, October 2012 - December 2013.

Month	No. Procedures	Infections				SSI Rate			
		Inpatient	Readmission	Post Discharge	Patient Reported	Inpatient	Inpatient & Readmission	All (excluding patient reported)	All
Sep 2012	510	13	17	21	15	2.5%	5.9%	10.0%	12.9%
Oct 2012	613	12	13	28	18	2.0%	4.1%	8.6%	11.6%
Nov 2012	536	5	11	18	5	0.9%	3.0%	6.3%	7.3%
Dec 2012	466	9	11	15	11	1.9%	4.3%	7.5%	9.9%
Jan 2013	494	2	10	12	12	0.4%	2.4%	4.9%	7.3%
Feb 2013	455	6	3	10	1	1.3%	2.0%	4.2%	4.4%
Mar 2013	458	4	10	11	2	0.9%	3.1%	5.5%	5.9%
Apr 2013	508	7	7	8	14	1.4%	2.8%	4.3%	7.1%
May 2013	546	10	5	12	11	1.8%	2.7%	4.9%	7.0%
Jun 2013	512	5	10	11	12	1.0%	2.9%	5.1%	7.4%
Jul 2013	563	2	14	8	10	0.4%	2.8%	4.3%	6.0%
Aug 2013	485	10	7	13	17	2.1%	3.5%	6.2%	9.7%
Sep 2013	554	3	8	16	8	0.5%	2.0%	4.9%	6.3%
Oct 2013	566	6	13	7	10	1.1%	3.4%	4.6%	6.4%
Nov 2013	536	11	5	8	9	2.1%	3.0%	4.5%	6.2%
Dec 2013	489	6	8	4	4	1.2%	2.9%	3.7%	4.5%

Data is reviewed at the Infection Prevention and Control Group (IPCG) and the Infection Prevention Team surveillance meetings where new initiatives and directives are discussed by the team, such as new NICE guidance NG125 and antimicrobial dissolvable sutures, which have been incorporated into practice.

The data set and system we use is highly commended by other organisations and we continue to host visits from other Trusts, to review our methods of data collection and reporting to see if it can be replicated to assist them in their service delivery.



A large scale audit involving pre-operative clinics, Theatres and wards is undertaken annually, using a toolkit devised by 'One Together' which is a collaboration of The Infection Prevention Society, The Association for Perioperative Practice, The College of Operating Department Practitioners, The Royal College of Nursing, The Central Sterilising Club and 3M. The tool is designed to demonstrate compliance with infection prevention practices across the surgical pathway. This has been launched for 2025 to be completed by the end of May.

A working party has been set up by the Cardiothoracic directorate to investigate an increase in post op wound complications. The team will include cardiothoracic surgeons, Theatre staff and specialist Nurses including the SSI Nurse for the Trust.

The Continence Care Service (CCS)

The Continence Care Service (CCS) has continued to demonstrate unwavering dedication to enhancing continence care standards across community healthcare settings throughout a particularly challenging year. The 2024/25 period has been marked by significant staffing and funding pressures affecting the entire NHS, including our own service. Despite these difficulties, the CCS has remained resilient, prioritising patient care and continuing to deliver high-quality, evidence-based support.

Staffing challenges, particularly those arising from sickness absence, have made it difficult at times to maintain service delivery and overall wellbeing. Nevertheless, the team has worked with determination and adaptability to ensure continuity of care and uphold our service values. Our ability to meet activity targets during this period stands as a testament to the team's commitment and perseverance under pressure.

Throughout the year, the CCS has provided vital health promotion, training, and shadowing opportunities to staff members both within the Trust and across care home settings. We also extended our training and support to the acute hospital, reinforcing collaborative efforts and shared learning across the care pathway. These initiatives have ensured that professionals remain equipped with the knowledge and confidence to deliver effective, person-centred continence care.

Our ongoing partnership with Ontex has continued to support product knowledge and training delivery in care settings, further contributing to improvements in continence management and dignity for residents. Meanwhile, the Continence Hub at our health centre remains a cornerstone of our community service—providing access to specialist advice, concurrent clinics, and a welcoming space that promotes holistic care through engaging health promotion displays.

The CCS has continued to address the impact of the cost-of-living crisis and rising incontinence poverty. Working in partnership with service users, carers, and professionals, we have supported individuals facing hardship and ensured continued access to essential continence care and supplies.

Despite financial constraints exacerbated by rising fuel and raw material costs, we have maintained our focus on rehabilitation, cost-effective product provision, and patient-centred care. Our use of digital platforms, such as the CCS Facebook group, has also remained a vital tool in raising awareness, sharing resources, and helping to reduce stigma around bladder and bowel issues.

Operationally, we maintained our commitment to staff support and communication, though the pressures of the year made this more challenging than before. We are proud to have continued with daily team communications, peer support, and training where possible, reinforcing our strong team ethos.

In summary, despite facing one of our most difficult years to date, the Continence Care Service has upheld its mission of delivering dignified, person-centred care. Through resilience, innovation, and strong collaboration with our RWT colleagues, we remain committed to excellence and to supporting the health and wellbeing of our community.

IP future plans for 2025/26

We will continue to focus on the Infection Prevention and Control (IPC) joint organisation Delivery plan 2023/26, prioritising key elements of the fundamentals of infection prevention to ensure safe effective, high quality care as outlined in the Trust Quality framework 2025/28. The focus will be maintaining hand hygiene, appropriate use of personal protective equipment, environmental and equipment cleanliness and safe device management when clinically indicated. We will support and empower staff to apply these fundamental elements consistently as part of everyday practice and celebrate sustained improvements.

We need to be resilient and adaptable to enable us to plan and manage future global and local health threats such as High Consequence Infectious Diseases (HCID) and emerging pathogens - for example Candidiozyma auris - ensuring that we have an agreed Trust plan and local pathways in place.

The IP Team will continue with the ongoing work the organisation is undertaking to support and encourage environmental sustainability, exploring new products and innovations, considering cost benefit analysis whilst prioritising quality and safety.

PSIRF review processes will be embedded into Infection Prevention and learning from themes and trends captured with achievable action plans developed by clinical teams supported the IP Team.

The IP Team will continue to work collaboratively with colleagues and partners towards our collective vision, as defined in our joint Trust Strategy “To deliver exceptional care together to improve the health and wellbeing of our communities”.

Designed and produced by The Department of Clinical Illustration and Graphic Design, RWT

MI_15856614_14.10.25_V_1