

IPC Performance and Assurance Report July/August 2025

Public Board

25th September 2025

Presented for:	Position Statement, Information.
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Previous Committees:	Quality Assurance Committee, 21 August 2025.

Our Annual Commitments for 2025/26 are:	
Recognise and act upon moments that matter to our patients	✓
Support our patients to get home a day sooner	
Be in the top 25% for patient experience and efficiency in outpatients	
Support each other to act with kindness and compassion	
Reduce our carbon footprint by creating greener patient pathways	
Support our staff to manage every £ wisely	
Make best use of our estate, equipment and digital assets	

Risk Appetite Framework				
Level 1 Risk	(✓)	Level 2 Risks	(Risk Appetite Scale)	Impact
Workforce Risk		Workforce Retention Risk - We will deliver safe and effective patient care, through providing a supportive culture, training, development and H&WB to our staff to retain the appropriate level to continue to meet the patient demand for our clinical services	Cautious	Moving Away
Operational Risk		Choose an item.	Choose an item	Choose an item.
Clinical Risk		Infection Prevention & Control Risk - We will manage the risks related to infection prevention and control to reduce the transmission of infection in our hospitals.	Minimal	Moving Away
Financial Risk		Choose an item.	Choose an item	Choose an item.
External Risk		Choose an item.	Choose an item	Choose an item.

Key points	
1. This paper provides an update on the current escalating HCAI position	Information
2. Review and note the additional actions that are being requested to bring the HCAI position back under control	Discussion

1. Summary

The purpose of this paper is to provide an update on the current escalating HCAI position, noting the previous paper (agenda item 5.4(i) detailing the HCAI Q1 position and to provide oversight and monitoring of actions taken during July and August. This paper provides additional actions that are being requested to bring the HCAI position back under control. The escalating position and proposed additional actions have been presented to the executive team 26 July by the Director of Infection Prevention and Control and on the Infection Prevention and Control Sub Committee agenda 20 August 2025.

2. Introduction

NHS England set a 10% reduction target for healthcare-associated infection (HCAI) for the period 2025-26. Unfortunately, the rates of HCAI at LTHT have increased in the first quarter of 2025-26 for all nationally reportable infections, this follows a period of improvement in HCAI over the past 24 months. We know that HCAs have a significant negative impact on patient experience of healthcare and are associated with prolonged admission, increased risk of readmission, increased antibiotic use and a case-related mortality rate of 15 - 25%¹. This impacts on our ability to provide safe care, optimise our service delivery and negatively influences our ability to deliver this year's annual commitments to their full potential.

3. Background

Nationally reportable HCAs include *C. difficile* infection and bacteraemia caused by MRSA/E coli and *Klebsiella* sp. The trust also monitors MSSA bacteraemia rates, this is not reportable. Infection prevention and control (IPC) was delivered through a 'command and control' model during the pandemic response between 2020 and 2022. At the end of this period, it was recognised that LTHT had high rates of HCAI compared to peer organisations (e.g. the Shelford group) and high HCAI rates per overnight stay compared to NHS trusts in the Yorkshire and Humber region.²

From April 2023 to March 2025, a trust-wide annual commitment promoted improvement in infection prevention, engaging all clinical and non-clinical teams in LTHT from board to ward. During the two years of the annual commitment, improvements were seen in infection rates, especially in *C. difficile* infection and MRSA/MSSA bacteraemia. The commitment was delivered by refreshing the 'Essentials' of IPC and developing detailed HCAI data on CSU level infection risks and introducing local clinically-led responses to these risks.

In addition to the HCAI annual commitment, the IPC improvement model 2023-2025 included other aspects:

- Development of a 'Dyad model' of IPC promoting equal accountability for HCAI between medical and nursing team members. This was in recognition of data analysis highlighting key HCAI risk factors that do not sit in individual

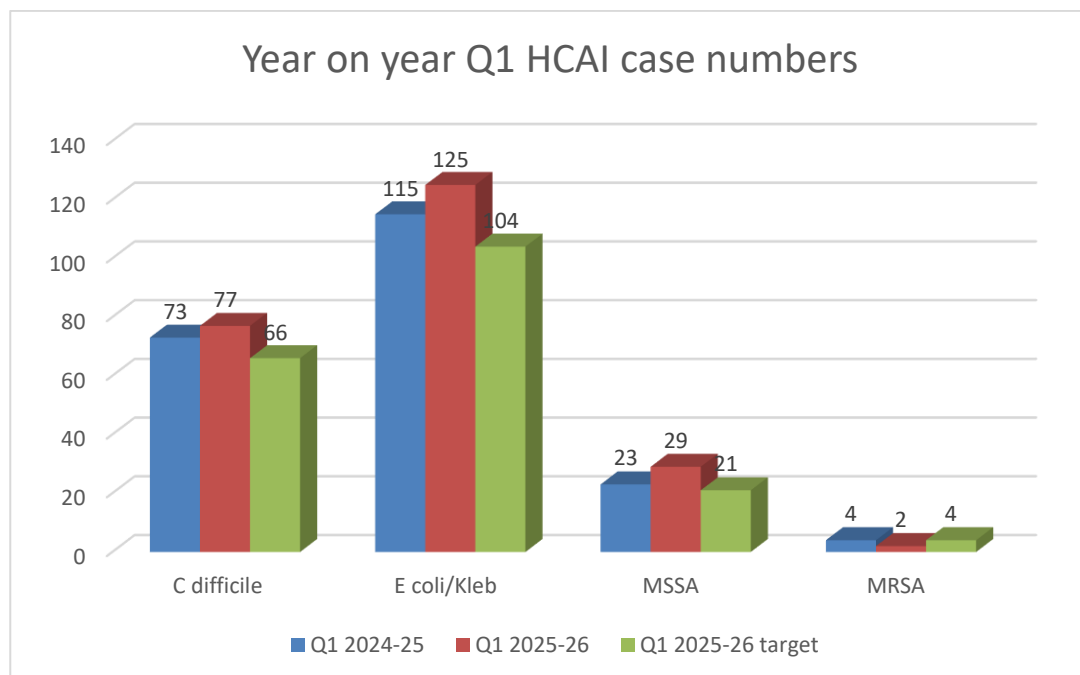
professional teams, for example, central venous access devices and post-operative infections.

- Introduction of the National Patient Safety Incident Response framework (PSIRF), which is built around a multi-disciplinary team using lean working, and Leeds Way values, to create rapid and far-reaching meaningful action to prevent infection
- Use of the Leeds Improvement Method to translate learning from HCAI reviews into safer clinical practices in a patient-centred and collaborative model
- Introduction of water safe care in ward areas with highly vulnerable patients, again using all professionals working in the area, both clinical and non-clinical

By March 2025, the total number of annual HCAIs at LTHT had reduced by 8.3% compared the year to March 2023, in the context of national increased incidence in all HCAIs. Since April 2025, the IPC team have developed an annual plan, however, this is unlikely to bridge the gap that has developed in essential IPC practices, governance and PSIRF.

4. Current Situation

A number of LTHT CSUs are tracking in excess of their 2025-26 HCAI trajectories, and it is likely that the overall trust HCAI thresholds will be exceeded if current infection rates persist. The graph below shows our current progress (orange) compared to expected HCAI incidence (grey). To note, Spring/Summer is not usually a peak period for HCAI.



Aside from IPC, a trust-wide model has been introduced for nursing and allied health profession (AHP) teams to deliver 'harm free care'. The Harm Free Care Improvement Group (HFCIG) begins on the 13th August and will absorb WARM and oversight of the 'report outs' of pressure ulcers and falls. The dashboard currently includes other harm free

care subjects' data, including sepsis screening tool compliance, alongside incidence of HCAI's.

5. Proposal

Sustain Integration of IPC within the organisation

The reduced rates of HCAI during 2023-25 followed a trust-wide strategic response to improve IPC practices including hand hygiene, cleaning, decolonisation, prescribing, peri-operative care. Getting the basics right every day across multiple teams, including those without high HCAI rates, was required to reduce overall trust rates of HCAI. It has been recognised at the Quality Assurance Committee that infection prevention requires trust-wide strategic action and the IPC team cannot be effective if working independently of other teams, leaders and governance structures. Given the annual HCAI commitment followed the national pandemic response, a new strategic approach for trust-wide IPC delivery to all staff is required for the first time since 2020.

Provide a structure to support the dyad model of IPC

The Dyad model of IPC is developing well at LTHT, with greatly improved attendance of medical staff at IPC meetings at all levels, and consultants from across many teams contributing to infection prevention work. Further leadership is required to build a system of standard IPC work shared by medical staff and nursing staff at CSU-level, and embed the Leeds Way values, especially accountability and patient-centred approaches.

Ensure the HCAI PSIRF framework is integrated into quality reporting

PSIRF is currently not well embedded in some CSUs, with delays in completion of HCAI reviews, and weak or ineffective governance and poor meeting organisation. The PSIRF process and supplementary data from IPC provides CSU teams with themes on HCAI, but teams are not always able to develop or deliver proportionate action plans. Time has been saved by shortening the administrative and review process of HCAI, and the ambition of PSIRF is that this time is reinvested into improvement work. Assurance processes do not currently include data on essential IPC, and teams are not always providing CSU leadership, or an improvement plan, in response to increased infection rates.

CSU's to monitor compliance with 'Essential IPC'

The work to embed 'Essential IPC' from the commitment has not been sustained in all CSUs, with recent data analysis showing missed opportunities to get the basic practices right. For instance, decolonisation was missed in 25% of eligible MSSA bacteraemia cases, hand hygiene scores were 45% on wards with increased incidence of C difficile. Cleaning metrics remain high across the trust from a facilities team point of view, some gaps exist in other areas such as appropriate use of single-use items and lapses in the correct decontamination of multi-use items.

6. Financial Implications

There are no new financial implications within this paper

7. Risk

The IPCT provides assurance to the IPC Sub-Committee which reports to the Quality and Safety Assurance Group and Quality Assurance Committee. There was no material change to the risk appetite statement related to the level 2 risk category (Healthcare Associated

Infection) and the Trust continues to operate within the risk appetite for the level 1 risk category (clinical risk) set by the Board.

The LIMS transition continues from Telepath to WinPath. The electronic surveillance system ICNET user acceptance testing phase was initially scheduled for two weeks, however this was extended and a formal sign off occurred on 17 June 2025. During the user acceptance phase, a WinPath exported list was provided to the IPC team and this underwent an internal QA process. A paper describing the associated risk was presented at the OIPC meeting on 25 June 2025. The Virology service is still completing transition to the new LIM system.

8. Communication and Involvement

The IPCT feeds into the internal LTHT communications team, the IPC Sub-Committee and the OIPC. This report is developed by the Infection Prevention and Control Team. Review, assurance, and actions where agreed are undertaken at Trust and CSU level and where required and monitored through the various boards and committees outlined above.

9. Improving Health Equity

HCAI does not affect patients equally, some patients have demographic and/or clinical risks which predispose them to infection. Local and national data on health inequalities provide information allowing teams to identify HCAI risk in the early stages of hospital admission. As part of the patient safety incident response framework (PSIRF), there is an ambition to respond to patient risk factors for HCAI at the point of hospital admission in order to highlight vulnerable patients to teams and to provide interventions to reduce risk of infection in vulnerable individuals. This is new work, and the team is not aware of other NHS organisations using this approach. A quality improvement project is planned in 2025-26 to start to identify HCAI risk on admission and seek interventions to prevent patient harm from infection.

10. Equality Analysis

The Leeds Teaching Hospitals NHS Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflects individual needs, promotes equality and does not discriminate unfairly against any particular individual or group.

11. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000

12. Recommendation

- QAC are asked to acknowledge the current high rates of HCAI at LTHT, and recognise the risk that national infection trajectories could be exceeded in 2025-2026
- It is recommended that a strategic multi-disciplinary HCAI model is developed to provide the architecture for teams to deliver the essentials of IPC and provide focus, oversight and assurance of HCAI through local governance structures, with clarity on the relationship between HCAI and the harm free care LTHT programme.

- Further development of the Dyad model of IPC leadership at CSU level by introducing 'standard work' for medical and nursing IPC leads in each area with greater accountability
- It is recommended that PSIRF is rapidly and comprehensively implemented in all CSUs, following the same dyad medical nursing/AHP leadership model, so that HCAI reviews are rapid and meaningful, and there is co-production of CSU-level action plans to prevent the next infection case. It is recommended that CSUs are held accountable for PSIRF including timely completion of investigations, identification of HCAI themes and derived actions plans to ensure safe patient care.
- A relaunch of the Essentials of IPC with oversight and monitoring through the Trust quality processes incorporating Harm Free Care dashboard and RISE ward accreditation process.

13.Supporting Information

References

1. Annual epidemiological commentary: Gram-negative, MRSA, MSSA bacteraemia and C. difficile infections, up to and including financial year 2023 to 2024 - GOV.UK
2. AMR local indicators - produced by the UKHSA | Fingertips | Department of Health and Social Care

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