NHS

The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Infection Prevention & Control and Cleanliness

Annual Report 2025–2026

Reporting period: April 2025 to March 2026

Safe care • Clean environments • Continuous improvement • Shared responsibility

Forward by the Director of Infection Prevention and Control

As the Interim Chief Nurse and Director of Infection Prevention and Control (DIPC), it gives me great pleasure to introduce the Trust's Infection Prevention and Control annual report for the year 2025/26. It describes the achievements of the Trust under the specialist advice, guidance and support of our Infection Prevention and Control (IPC) Team.

The Robert Jones and Agnes Hunt (RJAH) faced profound loss this year with the passing of Interim Chief Nurse and Director for IPC, Sam Young.

The sudden passing of Sam in June 2025 was a profound loss to our organisation and particularly the IPC Team, who she worked closely with to oversee the IPC programme. Her professionalism, kindness and compassionate leadership leave a lasting legacy, and she is deeply missed by her colleagues.

This year we have continued to focus on sustaining high levels of IPC compliance across the Trust. The Trust continues to build on the significant improvements made in relation to Infection Prevention and Control, to ensure that providing quality care remains at the heart of everything we do, every day.

This report highlights our journey through 2025-26, and the key achievements that have been made in infection prevention and control at RJAH and shows that we are committed to providing excellent and innovative care in a safe and clean environment. The detail within clearly demonstrates the dedication, expertise and collaborative approach from our IPC Team and wider teams.

I extend my thanks to all colleagues who have been part of making this a successful year including our IPC Team, operational and clinical colleagues, Pharmacy and our Estates and Facilities departments.

Clair Hobbs

Interim Chief Nurse and Director of Infection Prevention & Control

Glossary of terms

Bacteraemia	The presence of bacteria in the blood without clinical signs or symptoms of infection
CDI	Clostridioides difficile infection. It is a bacterium found in the intestines of around 1 in 30 adults, and usually causes no harm. An overgrowth of this bacteria can produce toxins which cause inflammation and can be difficult to treat.
E. coli	Escherichia Coli is a bacterium found in the intestines. It can cause infections and can prove difficult to treat.
HAI	Healthcare Associated Infection. An infection either as a direct result of healthcare intervention such as medical or surgical treatment, or from being in contact with a healthcare setting.
MRSA	Methicillin Resistant Staphylococcus Aureus is a highly resistant strain of the common bacteria
MSSA	Methicillin Sensitive Staphylococcus Aureus is the more common sensitive strain of Staphylococcus Aureus.

Acronyms

AE (D)	Authorised Engineer (D)
AMS	Antimicrobial Stewardship
ANTT	Aseptic Non-Touch Technique
CAUTI	Catheter-Associated Urinary Tract Infection
CQC	Care Quality Commission
DIPC	Director of Infection Prevention & Control
E. coli	Escherichia coli
HAI	Healthcare Associated Infection
HPV	Hydrogen Peroxide Vapour
HTM	Health Technical Memorandum
IPC	Infection Prevention & Control
IPCM	Infection Prevention & Control Meeting
IPCT	Infection Prevention & Control Team
ICD	Infection Control Doctor
ICS	Integrated Care System
KPIs	Key Performance Indicators
MDT	Multi-Disciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
PIR	Post Infection Review
PLACE	Patient Led Assessment of the Care Environment
SATH	Shrewsbury and Telford Hospitals
SSI	Surgical Site Surveillance
SNAHP	Senior Nurse and Allied Health Professionals
SOP	Standard Operating Procedure

STW	Shropshire, Telford and Wrekin
TSSU	Theatre Sterile Services Unit
UKHSA	UK Health Security Agency
WTE	Whole Time Equivalent

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Introduction

The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH) is a specialist orthopaedic centre. We provide specialist and routine orthopaedic care to our local catchment area, as well as specialist services both regionally and nationally.

Our organisation is a single site hospital based in Oswestry, Shropshire, close to the border with Wales. We serve the people of England and Wales, as well as acting as a national healthcare provider. We also host some local services which support the communities in and around Oswestry. The hospital is a specialist centre for the treatment of spinal injuries and disorders and provides specialist treatment for children with musculoskeletal disorders. Additionally, the Trust works with partner organisations to provide specialist treatment for bone tumours and community-based rheumatology services.

The Trust is part of the National Orthopaedic Alliance (NOA), an acute care collaboration vanguard designed to improve orthopaedic care quality across England.

We are proud to be a Veteran Aware hospital aiming to provide the best care for veterans in the NHS. Veteran Aware hospitals are leading the way in improving veterans' care within the NHS.

We are part of the Veterans Covenant Hospital Alliance (VCHA) which means we share and drive best practice in NHS care for people who serve or have served in the UK Armed Forces in line with the Armed Forces Covenant.

We support the health commitments of the Armed Forces Covenant and are committed to ensuring no disadvantage and giving special consideration where appropriate.

As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to deliver world class care by working in partnership to continuously improve and meet the needs of those we serve.

This annual report outlines the activities of RJAH relating to Infection Prevention & Control for the year April 2025 to March 2026, showing the arrangements RJAH has in place to reduce the spread of infections. The report fulfils its statutory requirements under the Health and Social Care Act 2008: code of practice on the prevention and control of infections. The prevention and management of infection is the responsibility of all staff employed by RJAH and is integral to patient safety.

Health and Social Care Act 2008: code of practice on the prevention and control of infections

The Health and Social Care Act (revised 2022), sets out the code of practice on the prevention and control of infections and applies to registered providers of all health and adult social care in England. This act sets out the overall framework for the regulation of health and adult social care activities by the Care Quality Commission (CQC).

	What providers will need to show evidence of
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Criterion 5	Ensure that people who have or at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
Criterion 7	Provide or secure adequate isolation facilities.
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key Achievements 2025/26

- We created a 2-year IPC Ambitions programme of works under the following primary categories
    - Education
    - Collaboration
    - Integration & Innovation
    - Digital Technology

One year into this programme, we are proud of the achievements we have made so far:

Ambition - Education	
We will introduce diverse ways to learn which adapts to staff needs	• The IPC Team have delivered over 100 education sessions for staff this year, ranging from bitesize sessions within clinical areas, lectures to delegates of the Orthopaedic/Spinal Injuries course, refresher training for Cleanliness Technicians, Trust inductions, Student Nurse/AHP shadowing, Pharmacy Student sessions and many more. • The IPC Team have supported shadow experiences for Student Nurses, and Pharmacy students
We will develop the IPC Team knowledge by keeping up-to-date with evidence-based practice and attending IPC related courses and events	• The IPC Clinical Lead Nurse completed a Water Safety Responsible Person Accreditation course this year, refreshing knowledge around water safety risks, and empowering ideas to improve the awareness of water safety risks to clinical staff. • IPCN started IPC course as part of professional development as an IPC subject matter expert. • The IPC Team attending an annual IPC Conference • An IPC Team member enrolled into an accredited IPC course
We will align IPC education to the National IPC Education Framework	• We developed education materials for students and Allied Healthcare Professionals in line with the National IPC Education Framework to support those on placement within the Trust.
We will ensure staff have access to IPC support	• We introduced an IPC Buddy system to support staff with all aspects of IPC. This system has helped provide consistency across the Trust, with all areas having a direct point of contact during weekdays. • The IPC intranet pages have been redesigned to ensure that information is relevant, current and easy to understand. The pages have links to key documents to support clinical staff. The IPC team are monitoring the usage of the pages and have seen a notable rise in staff accessing the page, giving staff more access to IPC advice when they need it.

We will provide a yearly IPC Fayre to promote best IPC practice in collaboration with key stakeholders	• The annual IPC fayre was held on 17th September in collaboration with Estates and Facilities colleagues. The fayre provided staff with opportunities to learn about the chain of infection, HAIs and how to prevent them, CDI, AMS, and involved interactive games which staff enjoyed. The IPC Team were particularly impressed by the engagement of the Cleanliness Technician teams who showed good understanding around different infections and how they would enhance cleaning to prevent infections from spreading.  *IPC Team with CEO Stacey Keegan*  *Estates & Facilities Team supporting the IPC Fayre*  *Cleanliness Technicians learning about IPC*

Ambition – Collaboration	
We will share our learning from the IPC journey with other Trusts to support improvements	• In September, the Facilities Compliance Manager and IPC Clinical Lead delivered a presentation entitled '*Collaborative leadership and culture change in delivering a clean safe environment'* at the Healthcare Facilities Management conference in Birmingham. The presentation summarised the key learning points from the RJAH journey through from being escalated on the National Oversight Framework, to achieving Exemplar status for cleanliness, and shared and honest reflection of difficulties that were faced. This promoted excellent networking opportunities with other providers, who were keen to visit RJAH and learn about the collaboration between IPC Teams and Estates & Facilities, which we believe is the key to the sustained improvements seen across the Trust.

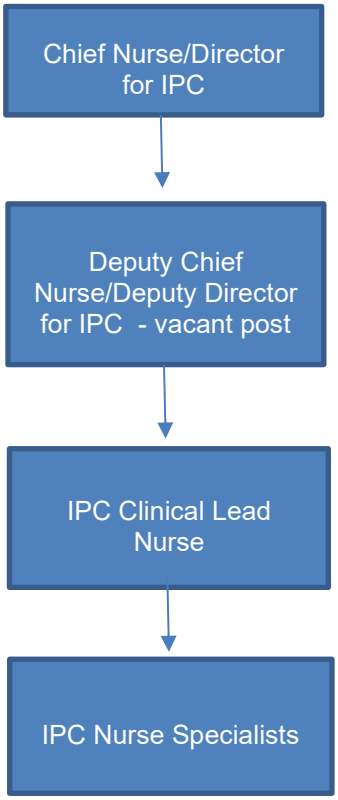
	 *Facilities Manager and IPC Lead Nurse presenting at conference*
We will represent RJAH on regional collaboratives	• We worked in collaboration with NHS England to develop an IPC competency booklet to support staff in practice which will be implemented in 2026-27.
We will work in partnership with the ROH in Birmingham to share infection data, benchmark, and work on improvement projects	• We share quarterly infection data with the Royal Orthopaedic Hospital (ROH) and have developed key working relationships with their IPC Team to share learning
We will work with the Lead Antimicrobial Steward to support initiatives to reduce antimicrobial resistance in line with the National Action Plan	• The IPC Team supported the Antimicrobial Pharmacist during World Antimicrobial Awareness Week in November. A board was created and placed in the hospital restaurant to raise the profile of the importance around appropriate antimicrobial usage.

Ambition - Integration & Innovation	
Use evidence-based practice to support optimisation of patients before surgery to reduce risk of SSI	• We extended the MSSA decolonisation programme this year to include all elective patients undergoing joint replacement surgery. These patients are provided with a 5-day course of MSSA decolonisation therapy before their procedure to reduce skin colonisation with Staphylococcus aureus and lower the risk of surgical site infection. This proactive approach forms an important part of the wider surgical infection prevention pathway, helping to optimise patients before surgery, reduce avoidable harm, and support safer postoperative outcomes.
We will integrate with teams to provide IPC support for off-site services	• We have provided IPC advice and guidance to Orthotics this year to support improvements to IPC compliance on off-site services.
We will report key themes from HAIs and work with wards and departments on quality improvement projects	• We are delighted that the Trust has maintained under the national thresholds set by NHS England for healthcare associated infections this year. • We conduct reviews into all reportable Healthcare Associated Infections to learn about good practice and IPC improvements. We share this learning throughout the Trust.

Ambition - Digital Technology	
We will use the new electronic patient record to ensure that patient alerts are identified in a timely manner to ensure that precautions can be put in place to prevent spreading infections	• A new function was introduced this year which includes an ‘alert’ on the electronic patient record to enable the correct patient placement across the Trust.
We will provide a central space for IPC data	• We have made improvements to the Quality Management System to ensure that the data is presented concisely.

Criterion 1: Systems to manage and monitor the prevention and control of infection.

Team Structure



Chief Executive Officer (CEO)

The CEO has overall responsibility to ensure that systems and resources are available to implement and monitor compliance with infection prevention and control at RJAH.

Director of Infection Prevention & Control (DIPC)

The DIPC is the Executive Lead for IPC and oversees the implementation of the IPC programme of work through their role as Chair of the Trust Infection Prevention and Control and Cleanliness Meeting (IPCCM). The DIPC delegates the responsibility and management of IPC for the Trust to the IPC Clinical Lead.

Infection Control Doctor

The Trust utilises an Infection Control Doctor who is employed by Shrewsbury and Telford Hospitals (SaTH) and has a contract to deliver services for RJAH in the in and out of hours period. This includes clinical microbiology advice and reporting, virtual, microbiology ward rounds, antimicrobial stewardship and infection prevention and control advice.

The Infection Prevention and Control Team (IPCT)

The Infection Prevention and Control Team (IPCT) are the nursing infection prevention and control specialists responsible for providing a proactive IPC service to the Trust aligned to the National Infection Prevention and Control Manual, the IPC Strategy, and their programme of works.

RJAH Orthopaedic Hospital NHS Foundation Trust (RJAH) IPCT currently consists of:

- Director of IPC (also Chief Nurse and Patient Safety Officer) (1.0 WTE)
- Infection Prevention and Control Lead Nurse (1.0 WTE)
- Infection Prevention & Control Nurse Specialists (2.0 WTE)

The Antimicrobial Pharmacist

The Trust has a designated Antimicrobial Pharmacist. The role of the Antimicrobial Pharmacist includes:

- Supporting antimicrobial stewardship initiatives
- Lead for the Trust antimicrobial CQUINs
- Maintaining a programme of audits in line with national guidance

The IPC Programme of Work/Workplan

The IPC Programme of Work 2025-27 was designed to focus on achieving full compliance with the standards identified in the Health and Social Care Act, and to monitor compliance with national and local infection related thresholds. To ensure consistent momentum with improvements, the team adopted an annual workplan to meet deadlines assigned to works sited on the IPC Quality Improvement plan.

Quality Management System

We continue to use a quality management system to capture all data in relation to IPC. The system holds a data warehouse that consolidates all IPC related data and provides a central space for correlation of themes and trends. The system incorporates a dashboard providing a live position for IPC governance position.

This year, the system continues provide the following:

- Live Unit level dashboards for real-time data
- Policy matrix and review tracker
- IPC unit reports linked to the system for auto-population of data. Unit reports are presented at Infection Control & Cleanliness Meeting.
- Reports to monitor and track actions relating to IPC generated from many sources.
- Rolling audit plan to include IPC Assurance audits
- Live reporting to surgical site infections and statistical process charts.

Infection Prevention Control & Cleanliness Meeting

The purpose of the Infection Prevention and Control & Cleanliness Meeting (IPCCM) is to ensure compliance with the requirements of the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, and to ensure that the Trust has safe and effective IPC practice and processes embedded across the organisation, within an environment that has consistently high levels of cleanliness.

The IPCCM is held monthly and chaired by the DIPC with Multi-disciplinary representation across Nursing, AHPs, and Estates & Facilities teams. A monthly Chair report is provided to the Quality & Safety committee for oversight, which in turn, reports to the Trust Board.

Infection Prevention and Control Working Group

The purpose of the Infection Prevention and Control, and Cleanliness Working Group (IPCCWG) this group is to ensure that the Trust is fully engaged and proactive in delivering the IPC agenda aligned to the statutory requirements of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections (Revised December 2022) Care Quality Commission Standards and other national, regional or professional bodies. This involves oversight of leadership and ownership of IPC and cleanliness at a service and operational level.

The group provides a forum for discussion, review and approval of IPC, cleanliness, and estates related activity, policy, procedure and guidance, and monitors the progress of actions against the Infection Prevention and Control Quality Improvement Plan and IPC Quality Management System.

The IPCCWG met monthly throughout 2025/26. The meetings were well attended with the IPC Quality Improvement plan as a standing item on the agenda to maintain oversight of actions. This group reports to the Infection Prevention

& Control and Cleanliness Meeting. The Group provides effective communication between the IPC team, operational areas, and Estates & Facilities by identifying and resolving issues in line with Trust priorities.

Our continued collaboration through the IPCCWG has been the driving force behind this year's improvements to the estate, including replacement floor coverings in several ward and clinic areas, sluice replacement, Theatre operating lights replacement, and staff rest room refurbishments.

IPC Link Staff System

The IPC Link Staff system enables the IPC Team to deliver key information, education, and advice that is shared to the wards and departments in a cascade system. IPC Link Staff form part of a group that meets bi-monthly. The IPC Team and the link staff ward/department managers agree to roles and responsibilities which clearly define the expectations of the link staff role. Attendance at meetings has been mixed this year given some changes to the way that Link meetings are held across the Trust. The IPC team have provided a central hub of information for link staff to ensure that up to date information is shared.

Health & Social Care Act 2008 (HSCA) & Board Assurance Framework IPC BAF

Annual Statement – HSCA and IPC Board Assurance Framework Compliance

Throughout the year, compliance with the Health and Social Care Act and the IPC Board Assurance Framework (BAF) has been closely monitored via the monthly IPC&C Meeting and reported through the Quality Management System's Assurance Dashboard.

The Trust achieved a 99% regulatory compliance rate this year, with continued efforts to strengthen performance against Criteria 3.

We close the year reporting 1 open action related to antimicrobial stewardship which is in progress.

Compliance to both frameworks is monitored by the IPC Team and reported through the IPC&C Meeting for oversight.

Mandatory Surveillance

All organisms of significance are monitored by the IPC team via a database supported by the SaTH laboratory so that timely action can be taken to support the clinical teams in the management of patients, including safe patient placement and advice on isolation requirements to prevent cross infection risks. The introduction of the new electronic patient record Apollo now gives the function for the IPC Team to add alerts directly to the patient's notes; allowing for patients to be placed accordingly to their infection status on future admissions.

Healthcare Associated Infections (HAIs)

HAIs can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being on contact with a healthcare setting. There is overwhelming evidence that the implementation of IPC best practices leads to significant reductions in HAIs and patient harm. All healthcare workers are responsible for the prevention of HAIs by ensuring they practice standard infection control precautions at every patient interaction.

Reportable infections are categorised either as avoidable or unavoidable:

An **avoidable** HAI is an infection that could have been prevented by following correct IPC precautions. For example, a patient could develop a urinary tract infection from a catheterisation performed in a healthcare setting where the practitioner did not follow correct precautions.

An **unavoidable** HAI is an infection that could not have been prevented, despite following best practice. For example, a patient with a history of CDI who has had a prolonged stay in hospital, and receives antibiotics to treat an infection, which disrupts the microbiome of the intestines and allows CD to germinate and produce toxins that can cause watery diarrhoea.

The IPC Team follow a post-infection review process for every RJAH acquired reportable infection. This system allows the organisation to identify how the case occurred and identify how the Trust can learn and improve.

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Reducing healthcare associated infections (HAIs) remains high priority. Challenges in the management of infections have been experienced nationally with not only an increase in resistant micro-organisms, but also the number of patients experiencing infections. We are delighted that the Trust has maintained under the national thresholds set by NHS England for healthcare associated infections this year. This is an improvement from last year and shows the increased engagement and ownership of IPC practice across all staff groups. The chart below shows the distribution of 6 HAIs across this year, compared to 14 last year:

Organism	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	RJAH Total	Threshold
MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	1	1	0	0	2	N/A
C Diff	0	0	0	0	1	0	0	0	0	0	0	0	1	2
E.coli	0	0	0	0	0	0	0	1	0	0	0	1	2	9
Klebsiella	0	0	0	0	1	0	0	0	0	0	0	0	1	1
Pseudomonas	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A

Clostridioidies Difficile infection (CDI)

Clostridioidies Difficile is a type of bacteria that can cause diarrhoea and other symptoms. It is found in peoples' intestines and affects around 3% of the population where is causes no symptoms. If Clostridioidies Difficile is present in the bowel, it can grow to unusually high levels (usually after taking antibiotics for another infection) and can produce toxins that attack the intestines and cause mild to severe infection.

The Trust reported 1 RJAH acquired, unavoidable case of CDI this year; improving on last year's total of 3 cases.

Multi-drug resistant organisms (MSSA, E.Coli, Klebsiella)

There were 2 cases of MSSA, 3 cases of E.Coli, and 1 case of Klebsiella bloodstream infections this year. Bloodstream infections occur when microorganisms enter the bloodstream, sometimes through medical devices such as urinary catheters and cannulas. All of the cases were reviewed as part of the hospital's Patient Safety Incident Response Framework, and all of the cases were unavoidable due to various risk factors.

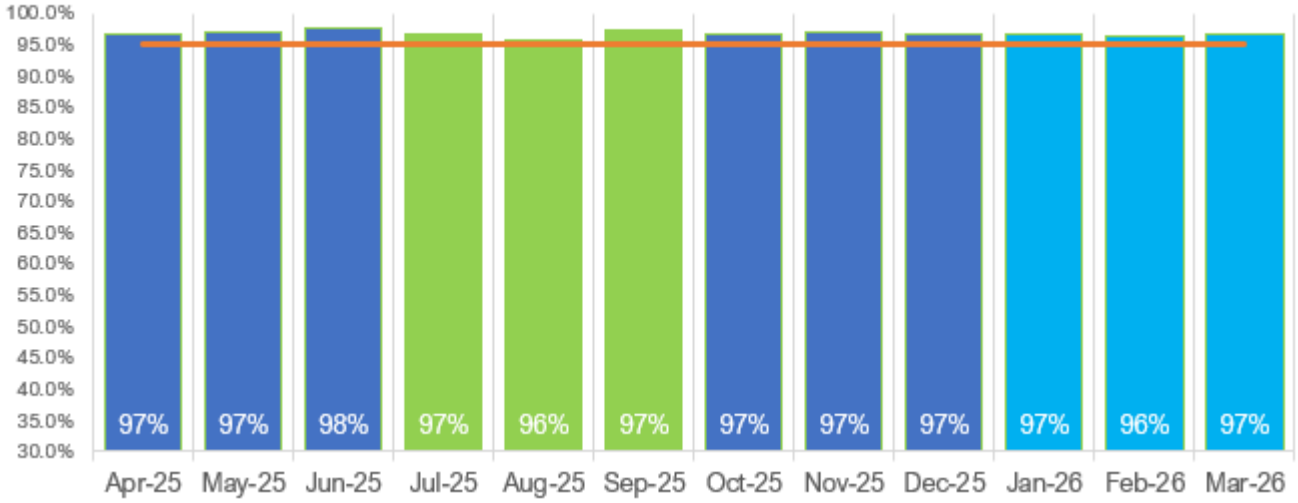
All learning from case reviews is shared through the Trust's governance groups to ensure that key themes, contributory factors and examples of good practice are identified and acted upon. This shared learning supports continuous improvement, strengthens accountability, and helps teams apply lessons more widely across services, reducing the risk of similar incidents recurring and improving patient safety outcomes.

Infection Prevention & Control Ward/Department Audits

All wards and departments are responsible for completing IPC audits as part of routine clinical practice. These audits are essential in providing assurance that infection prevention standards are being consistently applied, identifying areas of good practice, and highlighting where further support or improvement is needed. By monitoring compliance with key IPC measures, audits help teams to reduce variation in practice, strengthen accountability, and take timely action to address risks, ultimately supporting safer care for patients, staff, and visitors.

The graph below shows Trust-wide audit scores and frequency compliance from April 2025. Overall, scores consistently met or exceeded the 95% target.

IPC Audit Perfomance



Any gaps in audit frequency are addressed at working group meetings, with ongoing support to strengthen assurance.

Real-time tracking via the IPC QMS Unit Dashboard allows teams to monitor compliance and provide feedback.

For system issues, paper audits and a scoring toolkit are available on the IPC intranet to maintain continuity.

IPC Quality Assurance Walks

The IPC Team continued to undertake Quality Assurance Walks (QA Walks) across the Trust to seek assurance on standards of infection prevention across the Trust, in line with national standards of infection prevention.

The schedule is aligned to audit frequencies with Functional Risk (FR) categories, ensuring a targeted and risk-based approach, as outlined below:

FR1: Monthly (Theatres, Recovery, HDU and TSSU)

FR2: Bi Monthly (Wards)

FR4: Quarterly (Outpatient areas, Radiology and Therapies)

RED	Below 90%
AMBER	90% - 94%
GREEN	95% And Over

QA Walks continue to be scored using a RAG (Red, Amber, Green) rating.

This year the IPC Team undertook 178 QA walks that identified common themes such as condition of walls and floors in clinical areas. Quality assurance walks are documented using an electronic programme that enables actions to be identified to the responsible ward/dept manager straight away. Actions are monitored through the Infection Prevention and Control & Cleanliness Working Group to ensure that actions are dealt with in a timely manner.

The table below shows the overall compliance related to the scoring thresholds based on 178 completed QA Walks:

Scoring Threshold	Number of QA Walks
RED Below 90%	11
AMBER 90%-94%	47
GREEN 95% and over	120

Results show that most areas achieved over the Trust target. For areas that fell below the Trust target, the IPC Team performed spot checks to support timely action around IPC noncompliance and to aid assurance. Matrons, Ward and Department Managers are responsible for ensuring that all actions related to IPC noncompliance are completed to ensure that standards of IPC remain high across the Trust.

Areas scoring RED relate to mostly to wards with long-term patients, where volume of equipment and patient belongings is high, resulting in challenges in maintaining clear spaces, due the nature of the patient needs. Other challenges related to accessibility for the Estates Team to rectify

The IPC Team continue to support clinical areas to improve IPC compliance by adopting an 'IPC Buddy' system. This means that all wards and departments have a named IPC Team member as their point of contact, providing timely advice, practical support and guidance tailored to the needs of each area. The system helps to strengthen relationships between clinical teams and the IPC Team, promotes consistency in practice, and enables issues to be identified and addressed promptly. It also supports staff confidence, encourages shared ownership of IPC standards, and helps wards and departments to sustain improvements in patient safety and quality of care.

Criterion 2: Provide and maintain a clean and appropriate environment.

The Trust understands the importance of a clean, appropriate environment and focuses on providing excellent outcomes.

Cleanliness

Environmental cleaning was provided by the Trust's in-house team of cleaners and deep cleaners; the internal team was supported by external window cleaners and pest control operatives. Cleaning staff are allocated to their own area, giving them ownership of the standard; the number of hours for each area is determined by the Credits for Cleaning information system, with further input from local stakeholders, on a risk adjusted basis.

Cleaning responsibilities are defined, reviewed annually and displayed prominently across clinical departments, promoting accountability regardless of the staff group responsible for cleaning.

Outcomes for cleaning continued to be monitored internally throughout the year. External and patient led monitoring, including PLACE assessment were completed in line with our workplan.

Cleanliness – Enhanced Cleaning

Whilst routine cleaning is completed in all areas daily, staff in high-risk areas are supported with extra staff to complete an enhanced clean on a weekly basis. In the very high-risk area of theatres there is a rolling deep clean programme that runs alongside the routine clean; cleaning in these areas is completed over night, when the theatres are not in use, to provide the most effective service.

The Trust recognises the potential need to employ the use of technologies such as hydrogen peroxide vapour for the fogging of facilities and equipment in certain circumstances, as specified by the Cleaning Policy, room cleaning is completed as below:

- Green – Standard daily clean using detergent.
- Amber – Terminal clean using 1000 ppm Chlorine Based Agent
- Red – Terminal clean using 1000 ppm Chlorine Based Agent followed by HPV fogging.

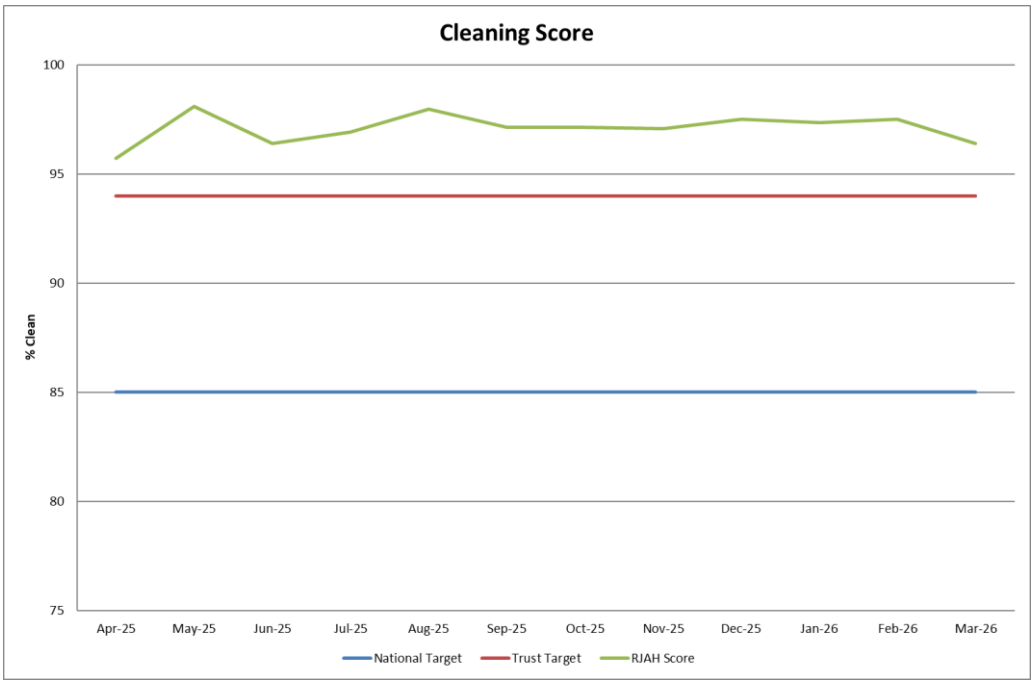
This protocol has ensured that there are no delays in the provision of enhanced cleaning whilst clinical sign off is sought.

The Trust employed an external contractor to complete HPV fogging; responses to date have been quick, effective, and professional.

33 individual rooms and 2 complete bays have required a red terminal clean in 2025/26; in each case a stringent process of isolation is undertaken by the estates team alongside a physical clean of the environment and equipment prior to completion.

Cleanliness – Internal Monitoring

The Housekeeping Department has devised an effective sign-off sheet that allows staff to easily demonstrate the work they have completed and alert the next person on shift to any outstanding requirements. Evidence of cleaning is retained by the department and is validated by supervisor monitoring and managerial spot checks. The department has continued to work collaboratively with clinical teams to share expertise in robust cleaning documentation, focused this year on theatres and therapies departments.



Internal monitoring is carried out every day, visiting all areas on a rolling programme according to their risk. All cleanliness matters are issued within 24 hours to the relevant team; assurance is provided in relation to resolution through signed off completion. All required improvements identified by the audits are acted upon by the internal team and the results are reported to the Infection Prevention, Control & Cleanliness Meeting on a quarterly basis, with specific action plans or failure themes managed through the Infection Prevention, Control & Cleanliness Working Group.

The Trust has a risk based national cleanliness target of 85%, internally the Trust has set a 94% target, for the year 2025/26 the Trust achieved an average score of 97.10%.

National Standards of Cleanliness

The Trust fully complies with the requirements of The National Standards of Healthcare Cleanliness. In 2024, the Trust successfully gained NHS England Exemplar Site Status, following a robust accreditation process which included evidence package submission and review, and an on-site visit, with a focus on demonstrating full compliance with the National Standards, an innovative approach to delivering cleaning services, and collaboration and ownership of cleaning across the multi-disciplinary team. The Trust will reapply for Exemplar Status in 2026, following the same process aligned to the updated 2025 National Standards of Cleanliness.

Infection Prevention & Control and Cleanliness - Collaborative Working

The Estates, Facilities and Infection Prevention and Control teams work collaboratively throughout the year, formally through the Infection Prevention, Control and Cleanliness Working group, documented sign off following refurbishment works and quarterly reports. Again, this year, the team has joined to facilitate an IPC fayre, where awareness and education relating to waste segregation, cleaning standards and cleaning techniques were shared.

Cleanliness and Environment - Kitchen

The Trust kitchen retained its 5-star food hygiene rating at last inspection in February 2026, which in particular, highlighted the high standards of cleanliness within the Trust kitchens and maintenance of assurance records in line with Hazard Analysis Critical Control Point (HACCP) principles.

The Inspector noted that refurbishment works within the kitchen have been completed to a high standard and supported the plans for works to ventilation systems later in 2026.

The onsite Nursery is registered with Shropshire Council environmental health and retained its 5-star food hygiene rating in August 2025.

Compliance with the National Standards for Healthcare Food and Drink, published in 2022 and requiring specific standards for food safety within a healthcare setting, is monitored by the Nutrition & Hydration Steering Group, with Food Safety also specifically discussed through Health and Safety Working Group. The Trust maintains the services of an external Food Safety Specialist, who along with completing biannual audits, supports with specialist advice, including review of relevant food safety policies and standard operating procedures specific to catering.

CQC Inpatient Survey

The CQC Inpatient Survey 2024 results were published in September 2025, with the Trust scoring top in the country under the metric 'how clean was the hospital room or ward that you were in' with an average score of 9.90. The consistently excellent results achieved through this survey are a testament to the dedication and exacting standards maintained by the entire Housekeeping team.

PLACE – Patient Led Assessment of the Care Environment

The National PLACE assessment was completed and submitted in October 2025.

PLACE captures responses to questions on cleanliness; food; privacy, dignity and wellbeing; condition, appearance and maintenance; dementia and disability. Each year questions are updated/added to reflect what is deemed as best practice – therefore careful consideration must be given when making any comparison to previous years responses, however this patient led assessment provides vital insight into the patient's perspective of the environment.

This year, we welcomed students from Shropshire Community Health Trust to take part in the assessment, gaining valuable insight from their perspective alongside Healthwatch patient panel and volunteer representation.

Domain	2025 score
Cleanliness	99.93%
Food	93.22%
Privacy, Dignity & Wellbeing	92.23%
Condition, Appearance & Maintenance	98.76%
Dementia	87.98%
Disability	88.35%

Actions arising from the PLACE assessment, along with commentary and feedback outside of the scoring criteria, are collated to form an action plan overseen by the Patient Experience Meeting. Where appropriate, actions are linked to and inform development of the Patient Experience Strategy.

Linen

Quarterly review meetings were held to ensure standards relating to the provision of linen were monitored.

Linen services are provided by an alternative external supplier, who continues to provide assurance to the infection control working group through monthly compliance reporting against National Guidance standards (HTM 01 04).

Clinical Waste

Quarterly review meetings continued to ensure standards relating to the provision of clinical waste were monitored.

Clinical waste services are provided by an alternative external supplier. Assurance this waste is being managed, both at Trust level and by the external contractor, in line with National Guidance is provided to the infection control working group though annual pre acceptance audits.

The NHS England Clinical Waste strategy, alongside relevant guidance (HTM 07 01) sets out a clear direction of travel for the management of clinical waste, including a waste segregation target of 20% incineration (yellow bag) waste, 20% infectious (orange bag) and 60% offensive waste. The strategy further advocates the use of reusable sharps containers, which have been in place at the Trust since February 2025. Compliance with this guidance is monitored through the Health and Safety working Group, in close the collaboration with Infection Prevention and Control team. The Trust continues to report segregation metrics above those specified by the strategy.

Estates Department Contribution to the Clean and Appropriate Work Environment

Estates department activity is essential in delivering the IPC agenda, it is delivered under the principles outlined in National Guidance, which covers the importance of a clean, safe environment for all aspects of healthcare.

Matters of Estate that impact the clean environment are escalated through the IPC working group for prioritisation and oversight. This year, projects have included:

- Refurbishment of Hydrotherapy Pool
- Refurbishment of Kenyon Ward
- Toilet refurbishment scheme across site
- Flooring replacement scheme across site

Water

The control of water is a legal requirement; the Estates Department work to National Guidance to mitigate risks from exposure to Waterborne Pathogens

The Estates Department continues to employ a third-party contractor to provide technical advice for water services and undertake water risk assessments on Trust properties every two years or where required following incidents or significant infrastructure changes.

There is a written site-specific scheme of control within the Water Safety Plan. Eurofins provide the Trust an internet-based water testing database storage and reporting for statutory test results. There is also a three-monthly review of test results, control measures and procedures at the Water Safety Group to ensure compliance with current legislation and these results are published at the Infection Prevention Control & Cleanliness Meeting.

In line with National Guidance. The Trust has an Authorising Engineer for Water AE (W), appointed in writing. The AE(W) is a 'independent advisor,' who offers technical advice to the Estates Engineers, auditing the management of water safety and increasing the Trust's resilience and bolsters the management of water hygiene.

The Estates Department continually undertake water tests throughout the Trust estate. This water testing is carried out in line with legislation and guidance. Testing is standard practice at RJAH to ensure robust control of waterborne infections such as legionellosis; it is a method of using qualitative data to measure that our planned maintenance is successfully controlling growth of microorganisms in the potable water supply. The Trust conducts Water sample tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

In response to out of parameter results, the Mechanical Team within the Estates Department continue to employ an effective method of disinfection, including thermal and chemical. This process increases efficacy and reduces costs because of the in-house delivery of such works. Disinfection is often employed to manage domestic water hygiene. All positive samples have a microbiological filter fitted. The Water Safety Group discusses positive results, control measures and any actions required. An independent Water Authorising Engineer is an active member of the group.

The Trust is therefore assured that the Water Safety of the site is compliant in-line with current Legislations and guidance.

Ventilation

It is a legal requirement to provide adequate Ventilation in enclosed areas of a workplace.

Ventilation is led and monitored by the Estates Department, supported by an Authorising Engineer for Ventilation AE(V), appointed in writing. The AE(V) is a 'independent advisor,' a requirement of National Guidance and offers technical advice to the Trust, auditing the Specialised Ventilation and increasing the Trust's resilience.

The Trust conducts monthly air velocity tests, at a greater frequency than required by guidance; the purpose of which is to identify potential issues sooner so that corrective actions can be implemented at the earliest possible time.

The Trust has a mixed Estate in relation to facilities that situate air handling units. Re-verification is done in line with current guidance and enhanced mitigations are put in place for aging parts of the estate where design specification differs from guidance,

The RJAH Estates Team conduct Quarterly PPMs on all Air Handling units (AHU's) to ensure they are clean, fully functional, and proactively manage any issues that should arise.

Accredited third party contractors revalidate Specialised Ventilation Units on an annual basis, including Theatres, Critical Care and Laboratories, providing an inspection and reverification report. These reports are then reviewed by the Trusts Authorising Person (AP(V) and the AE(V)

Decontamination Group

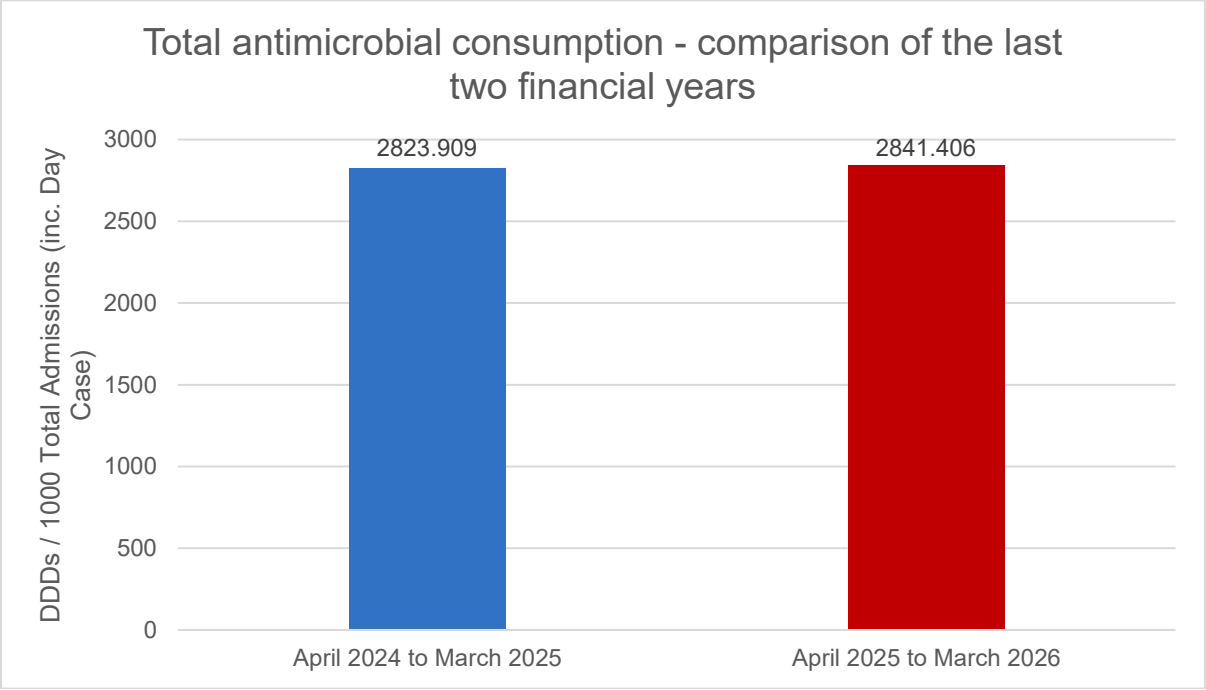
Decontamination, which covers the Theatre and Sterile Services environment, is led and monitored by the Estates Department supported by their third party accredited Authorising Engineer for Decontamination AE(D), who is appointed in writing. The AE(D) is a 'independent advisor,' a requirement of National Guidance who offers technical advice to the Trust, auditing the Decontamination equipment and increasing the Trust's resilience.

The RJAH Estates Team maintain a local testing regime of Decontamination equipment on a weekly basis and proactively manage any issues that should arise. Reports are produced for Quarterly and Annual Testing. These reports are then reviewed by the Trusts Authorising Person (AP(D) and the AE(D)

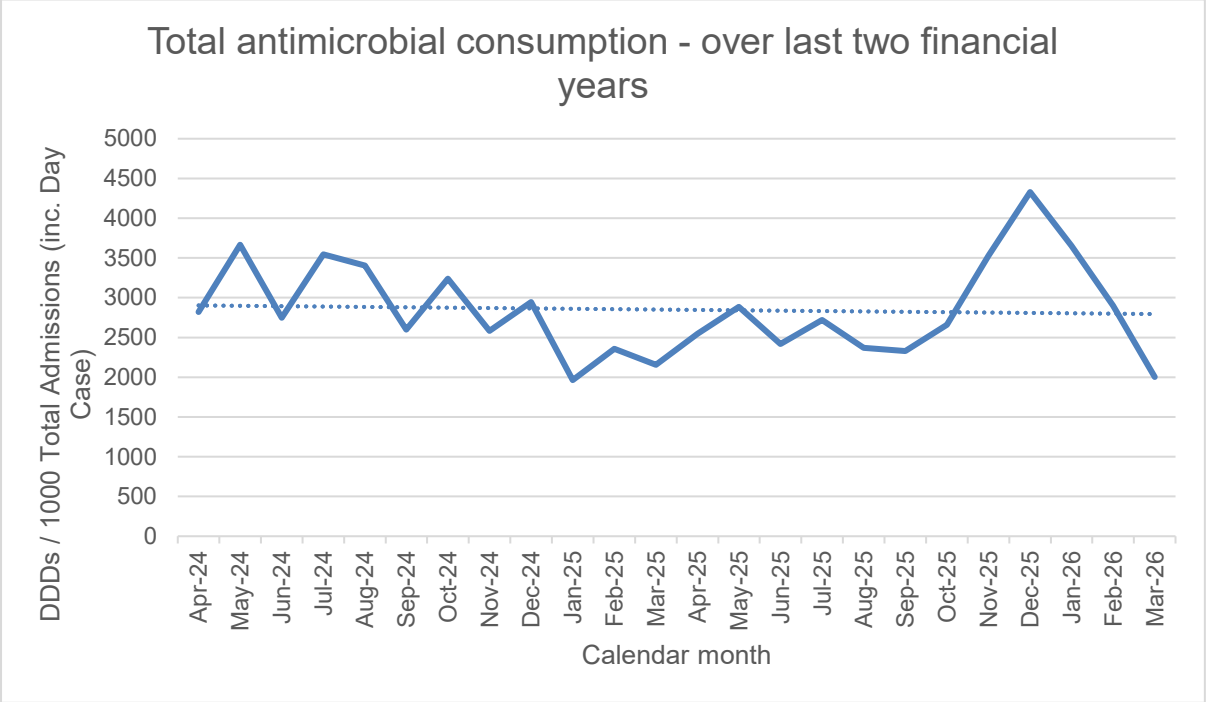
The Trust is therefore assured that the Decontamination of Theatre Surgical equipment is compliant in-line with current Legislations and guidance.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

The graph below shows that when comparing the total antimicrobial consumption between April 2024 to March 2025 and April 2025 to March 2026 there is not much difference in the usage. However, the second graph displays that overall, there has been a downward trend which contradicts the first graph. There are peaks and troughs in usage throughout the last two financial years, but this variability occurs due to the type of patients admitted e.g. spinal patients admitted for pressure ulcer management who have osteomyelitis, surgical patient with infected joint replacements – these patient groups require antimicrobials for a longer period. This is when looking at DDDs/1000 total admissions.



DDD (Defined Daily Dose) – 'The assumed average maintenance dose per day for a drug used for its main indication in adults'. It is defined by the World Health Organisation (WHO).

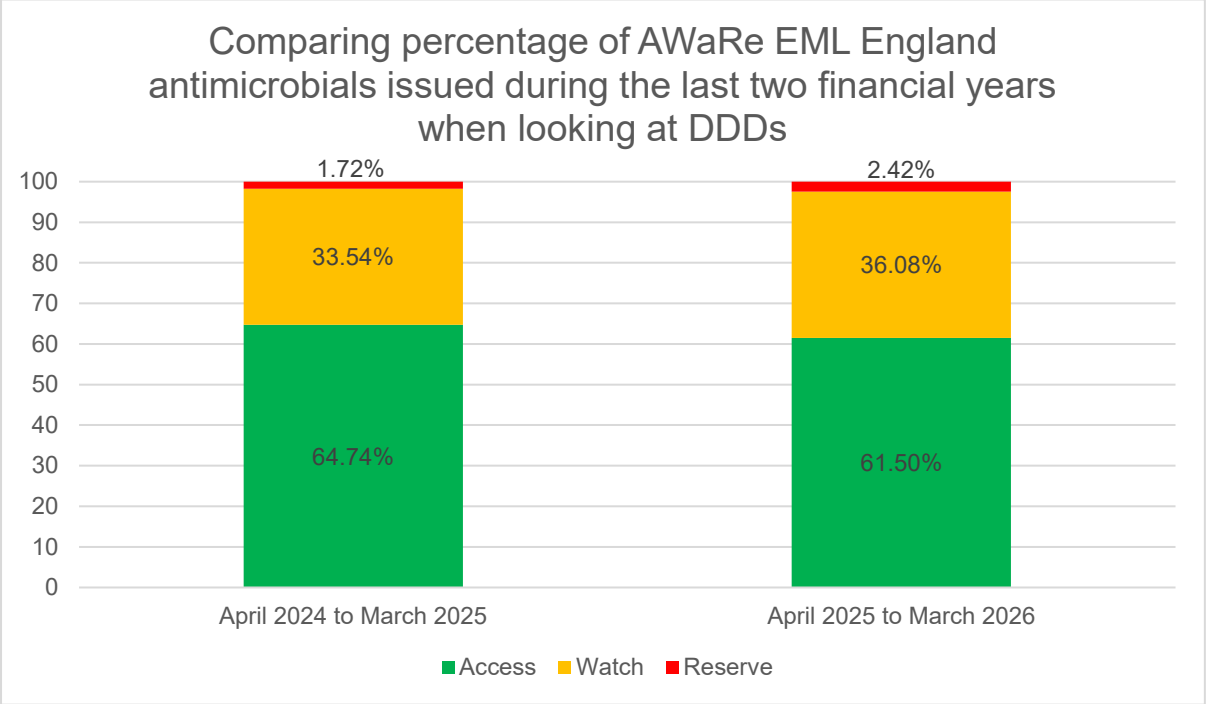


AWaRe antimicrobials review

The graph below shows the percentage of access, watch and reserve antibiotics that have been issued over the last 24 months when looking at DDDs. In the last financial year 2025/26 there has been an increase in the percentage of watch and reserve antimicrobials and a decrease in access antimicrobials issued compared to 2024/25. 'The UK revised its AWaRe classification in 2024, aiming for 70% of antibiotic use to come from the 'Access' category'[11] but our Trust falls below this target. Ideally the use of watch and reserve antibiotics should be kept to a minimum as these are preserved for more serious infections and those microorganisms that have multiple resistances. Clear documentation about why an antimicrobial has been started and who has recommended it is sometimes lacking. Since the implementation of electronic prescribing (EPMA), an indication must be selected before an antibiotic can be prescribed. Although this is an essential and useful prompt, there is not always an appropriate indication to choose meaning that it doesn't always match what is documented in the notes.

Dalbavancin is a reserve antimicrobial as well as a high-cost drug. It should only be used in patients who have grown a gram-positive organism, undergone a DAIR procedure or single stage revision and are ready for discharge and must be recommended by microbiology. If a patient is prescribed dalbavancin it should be administered on the day that it is prescribed. This has been monitored and, more often than not, the patient is discharged on the same day.

[1] *ESPAUR report 2024 to 2025: extended summary - GOV.UK (accessed 20/05/2026).*



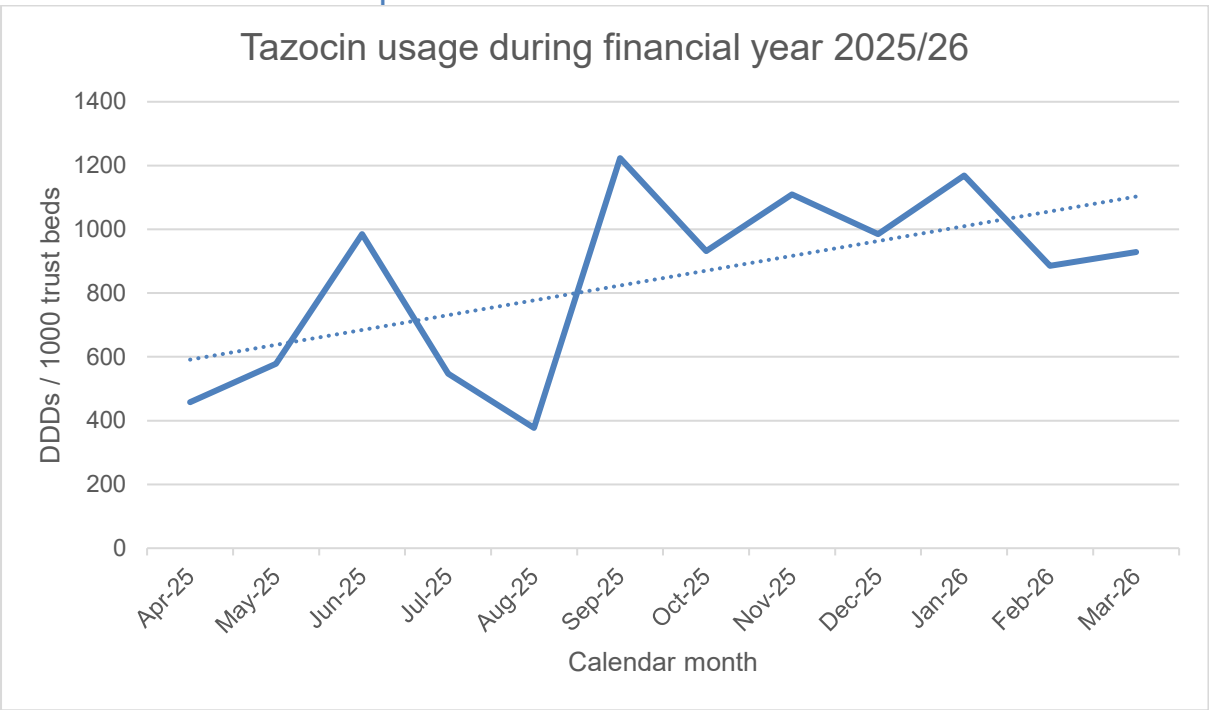
EML – List of Essential Medicines

AWaRe – This is a WHO classification for antimicrobials which is split into Access, Watch and Reserve:

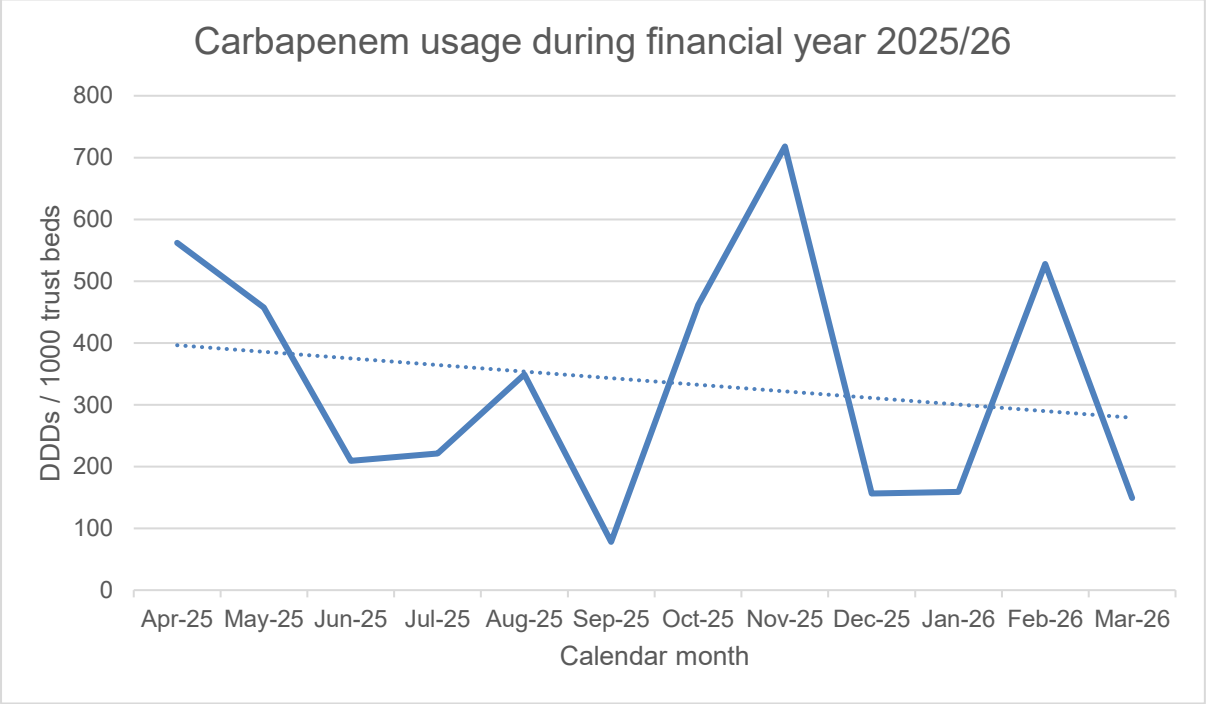
- Access antibiotics e.g. Amoxicillin – first or second choice antibiotics which are used empirically for common infections while minimising the potential for resistance. They usually have a narrow spectrum of activity, fewer side effects and are lower cost.
- Watch antibiotics e.g. Meropenem – first or second choice antibiotics which are used for more specific limited number of infections. They need to be closely monitored to avoid overuse as they are more prone to be a target of antibiotic resistance.
- Reserve antibiotics e.g. Linezolid – these are 'last resort' antibiotics used for severe infections usually associated with multi-drug-resistant bacteria. They need to be closely monitored to ensure their continued effectiveness.

When looking at the WHO AWaRe classification, carbapenems and Tazocin are 'watch' antibiotics, however, according to the modified England AWaRe index carbapenems are 'reserve' antibiotics. The updated list was published in 2019, and the changes were made due to several factors such as recommendations in national guidelines, to reduce the risk of C. difficile infection, due to AMR and the need to preserve some antibiotics for multi-drug-resistant infections. The graphs below indicate the usage of both during the last financial year as they are often prescribed within the Trust.

This graph shows the overall usage of Tazocin during the last financial year 2025/26 when looking at DDDs/1000 Trust beds. Overall, there is an upward trend with usage peaking in September 2025. Every quarter those patients prescribed Tazocin are reviewed to check for appropriateness. Tazocin is often prescribed in surgical patients for e.g. revision arthroplasties, infected arthroplasties according to the Sheffield guidelines. However, when looking at patients with more medical related issues, microbiology advice is very rarely sought when Tazocin is prescribed - Tazocin often appears to be the go-to antibiotic when a patient spikes a temperature/is unwell or if the patient deteriorates whilst already on treatment for an infection. It is essential that the antimicrobial guidelines are being followed, recent cultures and sensitivities are reviewed and acted upon and that Microbiology involvement is sought when necessary. It is also vital that an indication or suspected diagnosis is specified as documentation is often lacking regarding this. Tazocin usage should be kept to a minimum where possible especially with the rising rate of antimicrobial resistance.



This graph shows the overall usage of carbapenems (Ertapenem and Meropenem) during the last financial year 2025/26 when looking at DDDs/1000 trust beds. There are peaks and troughs in usage although the overall trend is downward. Most patients prescribed carbapenems during the financial year were appropriate and prescribed according to sensitivities, guidelines or as per microbiology advice. Occasionally documentation is lacking meaning that it is difficult to determine appropriateness.



Future actions

- Implement a weekly antimicrobial ward round with the antimicrobial pharmacist and IPC lead when EPMA is in place. This will provide greater insight into the use of antimicrobials within the Trust.
- Incorporating the Sheffield antimicrobial guidelines with the current antimicrobial guidelines will help to improve antimicrobial stewardship and the awareness of guidelines among prescribers.
- Once published on EOLAS a QR code will be available in Theatres for easy access to the most up-to-date version of the guidelines.

Criterion 4: Provide suitable accurate information on infections to service users.

Patients who are identified to be carrying (colonised) or infected with alert organisms are visited by the IPC Team to ensure that patients are well informed about their condition and how they will be managed during their admission. This is a fundamental element of the role of the IPC team. During the visit, patients and families can discuss any queries or concerns, and the IPC Team take opportunities to educate patients on how they can manage infections once they are discharged.

Patient Information

All patient information leaflets are stored on the Trust website and in paper format.

Patient leaflets are reviewed every year, with improvements made to align the content with current guidance, to enhance accessibility of information for patients, and to avoid information overload.

In addition to the Trust website, the IPC team have an intranet page which is managed locally by the IPC Team. This page has proven to be an effective information hub for staff and serves as a central source for all IPC related information.

Medical Illustration Team

The IPC team maintains strong collaboration with the Medical Illustration team, who have continued to offer invaluable support throughout the year, helping us deliver key information to both staff and patients. Examples of their contributions include:

- Posters for IPC Fayres and exhibitions
- Patient Information Leaflets

The Team continues to benefit from their prompt and efficient service, which allows us to communicate information in a professional and timely manner.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection.

The IPC team perform several activities that minimise the risk of infection to patients, staff and visitors including advice on all aspects of infection prevention and control; education and training; audit; formulating policies and procedures; interpreting and implementing national guidance at a local level; alert organism surveillance and managing outbreaks of infection.

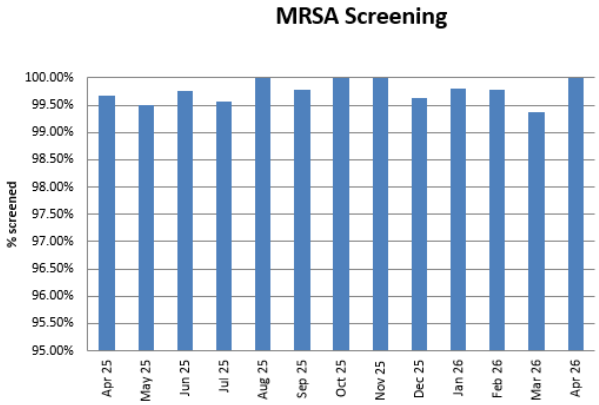
Oswestry Infection Control (OIC)

The IPC Team receive a daily report (between Mon-Fri) which identifies all positive samples sent to the laboratory as part of the OIC reporting system. This system enables the IPC team to advise and support on the management of patients' infections, including patient placement, to reduce risk of cross-infection.

MRSA screening

Meticillin-Resistant Staphylococcus Aureus (MRSA) is a type of bacteria that has become resistant to many of the antibiotics used in hospitals. It usually lives harmlessly on the skin, but if it enters the body, it can cause serious infection.

All elective surgical patients undergo screening for MRSA, and positive results are alerted to the IPC Team daily as part of the OIC reporting system. This enables prompt recognition of MRSA so that decolonisation treatment can be offered to the patient, preventing potential delays or complications of surgery.



The graph and table below demonstrate the MRSA screening compliance, which is consistently above 99%.

	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Apr 26
Eligible patients	935	810	834	902	838	953	1027	981	799	1010	911	960	980
Screened for MRSA	932	806	832	898	838	951	1027	981	796	1008	909	954	980
% achieved	99.68%	99.51%	99.76%	99.56%	100.00%	99.79%	100.00%	100.00%	99.62%	99.80%	99.78%	99.38%	100.00%
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Surgical Site Infection Surveillance Service (SSISS)

Surgical site infection (SSI) is a type of healthcare associated infection in which a surgical incision site becomes infected after a surgical procedure. SSI are associated with increased morbidity and mortality in surgical patients and risk can be minimised with appropriate care before, during and after surgery. The management of an SSI can involve

prolonged hospitalisation, readmission, and reoperation, can be associated with increased diagnostic and treatment costs affecting patient safety and care.

Surveillance of SSI with appropriate and timely feedback of data to clinicians is crucial in supporting strategies to reduce the burden of infection within the health system. The importance of monitoring and reducing rates of surgical site infection is widely acknowledged and the IPC Team at RJAH follow policy and process to support early SSI recognition and actions to minimise risk and preserve patient safety.

Pathogens that cause SSI may originate from:

- the patient's own microbial flora presents on skin and in the body
- the skin or mucous membranes of operating personnel
- the operating room environment
- instruments and equipment used during the procedure

There are several activities undertaken at the Trust to prevent SSIs from occurring:

- Minimising the number of microorganisms introduced into the incision site, for example removing microorganisms that normally colonise the skin of patient, maintaining asepsis and managing air quality.
- Enhancing the patients' defences against infection, for example by minimising tissue damage and maintaining normal body temperature during the procedure.
- Preventing the multiplication of microorganisms at the incision site, for example using prophylactic antibiotics.
- Preventing access of microorganisms into the incision site, for example postoperatively by use of a wound dressing.
- The Trust extended the MSSA decolonisation programme this year to include all elective patients undergoing joint replacement surgery. These patients are provided with a 5-day course of MSSA decolonisation therapy before their procedure to reduce skin colonisation with Staphylococcus aureus and lower the risk of surgical site infection. This proactive approach forms an important part of the wider surgical infection prevention pathway, helping to optimise patients before surgery, reduce avoidable harm, and support safer postoperative outcomes.

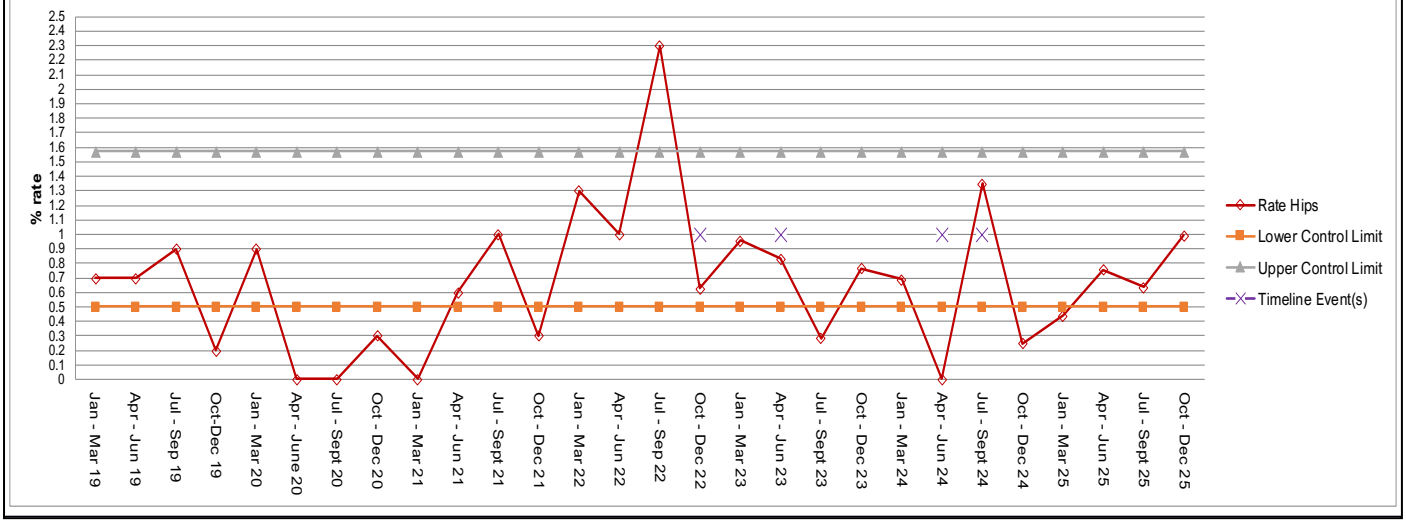
In April 2004, surveillance of surgical site infections (SSIs) in orthopaedic surgery became mandatory for all English NHS Trusts. RJAH submits surgical site infection data to the UK Health Security Agency (UKHSA) database on a quarterly basis.

The UK Health Security Agency (UKHSA) analyses the submitted data at quarterly intervals to identify hospitals whose SSI incidence may be high or low, enabling the Trust to benchmark against the national rate of infection.

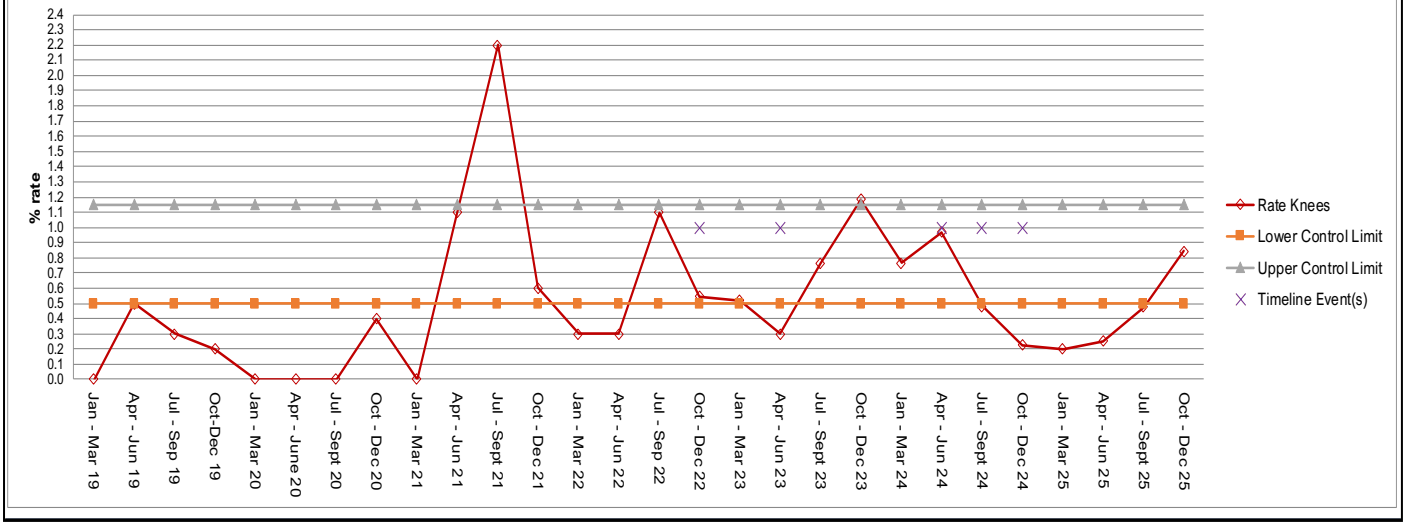
From April 2025 – December 2025, RJAH submitted data to SSISS on total of 3306 operations – 1371 Total Hip Replacements (THR), 1288 Total Knee Replacements (TKR) and 647 Spinal surgeries was collected by the RJAH surgical site surveillance team. During this period, there have been a total of 24 reported, with 11 THR, 7 TKR, and 6 spinal surgeries.

The following graphs show the breakdown in RJAH rate of surgical site infections reported to UKHSA between April 2025 and December 2025. At the time of writing this report, UKHSA have not yet reconciled SSI data for Jan-March 2026, as it is reported one quarter behind to allow time for any infections to present, which is why it is not shown below.

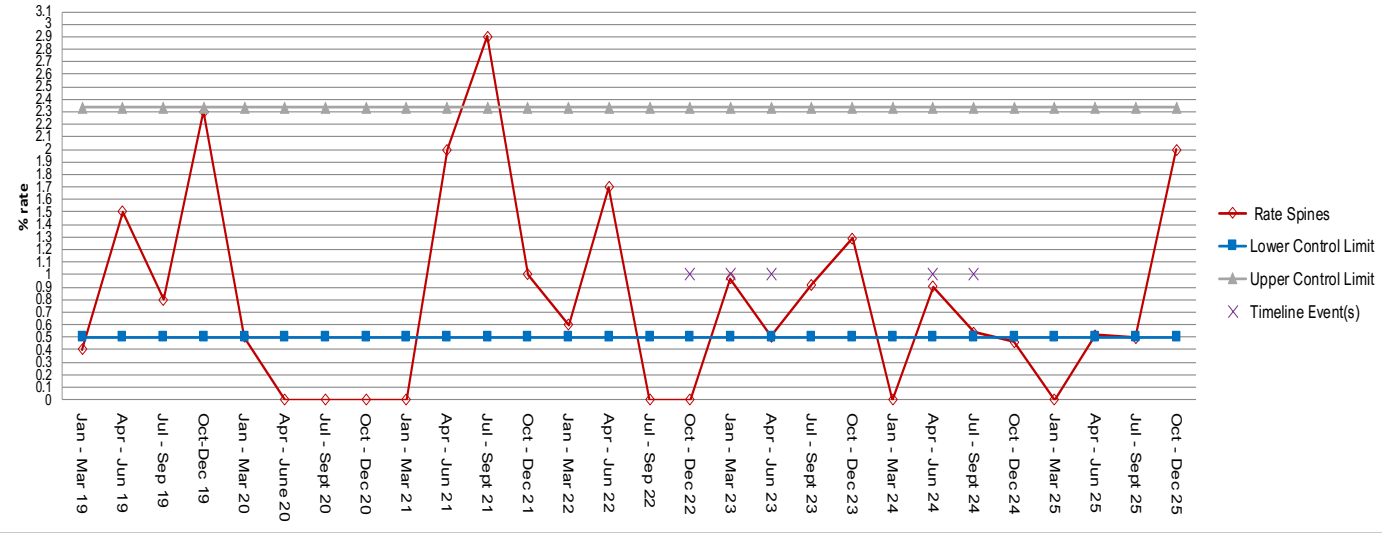
Rates of RJAH Total Hip Replacement Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



Rates of RJAH Total Knee Replacement Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



Rates of RJAH Spinal Surgery SSIs Reported on the Surgical Site Infections Surveillance Service per Qtr



The Trust continues to assess standards across the surgical pathway using the OneTogether assessment toolkit. This toolkit is an important quality improvement resource because it provides a structured framework for monitoring key elements of SSI prevention across the patient journey, including skin preparation, prophylactic antibiotics, patient warming, maintaining asepsis, the surgical environment, wound management and surveillance. By using the toolkit, the Trust can identify variation in practice, provide assurance that evidence-based standards are being followed, and highlight areas where further action or improvement is needed. This supports a consistent approach to safer surgical care and helps reduce the risk of surgical site infection by strengthening oversight of the whole pathway.

A review into a spike in SSIs from Oct-Dec 2025 was undertaken finding no single attributable cause but identified several relevant themes, including patient co-morbidities, uncertainty regarding completion of MSSA decolonisation, post-operative wound issues, Staphylococcus Aureus as the most common organism, and possible associations with timing of surgery. A wider analysis of cases from 2018 to 2025 also suggested small associations with outside temperature, number of ward moves, weekend surgery and post-operative HDU admission, reinforcing the multifactorial nature of SSI risk.

Infection Multi-Disciplinary Team (MDT)

The Infection MDT meet weekly to discuss infections and make recommendations for treatment. The Infection MDT is attended by Consultant Surgeons, a Consultant Microbiologist, an antimicrobial Pharmacist, the Infection Prevention & Control Team, and a Consultant Radiologist.

UKHSA Surgical Site Surveillance System requirements are to report hip, knee, and spinal surgery, however the Infection MDT reviews patients from all orthopaedic specialities, including upper limb, lower limb, sports & spinal injuries.

Outbreaks

An outbreak of infection is described as two or more people (this could be patients and staff) with the same disease or symptoms or the same organism and are linked through a common exposure, personal characteristics, time, or location. The Trust follows Infection Event and Outbreak Management Policy to ensure a standardised response to outbreak management that includes external reporting.

The Table below summarises the outbreaks declared in RJAH during 2025/26:

Area	Date	Causative Organism
Sheldon Ward	26/06/2025	COVID-19
Ludlow Ward	25/10/2025	Diarrhoea and vomiting (no microorganism identified)
Kenyon	09/02/2026	Diarrhoea and Vomiting (no microorganism identified)
Ludlow	09/02/2026	Diarrhoea and Vomiting (no microorganism identified)

Serious Incidents

There were no serious incidents related to IPC to report in 2025/26.

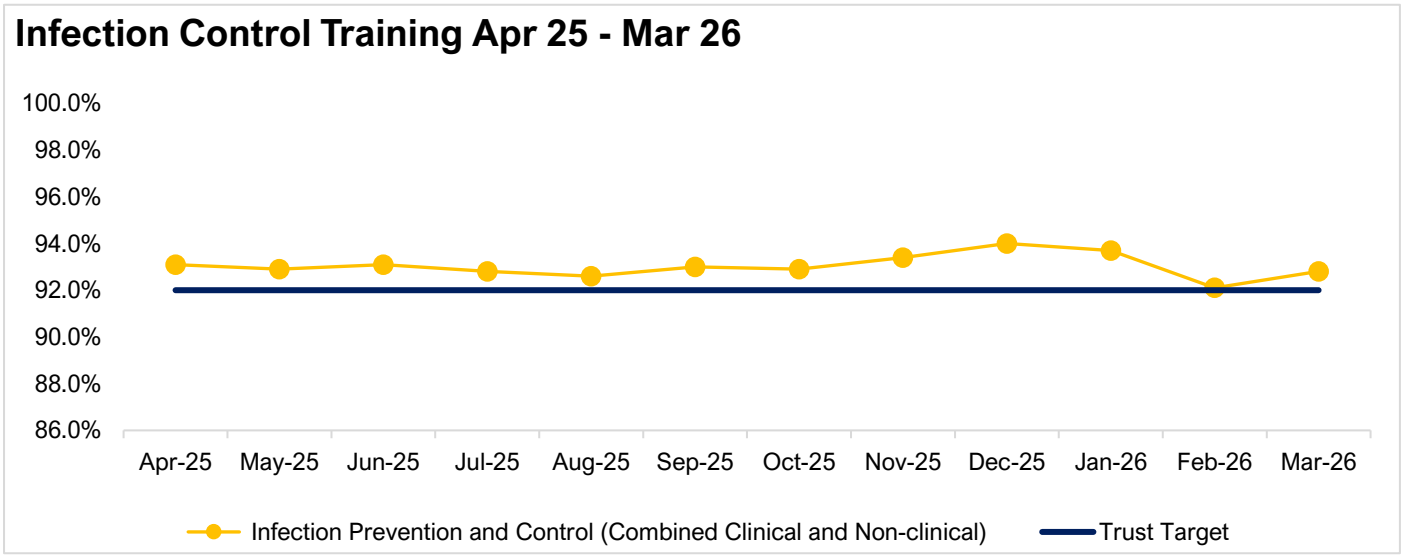
Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

Our IPC Arrangements and Responsibilities policy reflects the management and reporting structure of RJAH outlining its collective responsibility for IPC from Board to floor, demonstrating that responsibility is disseminated to all staff in the organisation.

The following IPC modules are monitored via ESR and mandatory for staff to completed:

- Infection Prevention & Control Training Clinical & Non-Clinical
- Aseptic Non-Touch Technique

The chart below shows that the Trust has maintained good compliance to infection prevention and control training and has met the required Trust target of 92%:



Additional to the mandatory suite of IPC modules managed via ESR, the following training is delivered by the IPC Team:

- Induction training for all clinical and non-clinical staff and rotational doctors
- Hand washing assessments to clinical staff to ensure staff obtain full hand hygiene competency.
- All volunteers receive a training presentation and hand hygiene education.
- Cleanliness Technicians receive a yearly IPC refresher session

The IPC Team have provided over 100 education sessions throughout the year as part of the IPC strategy, including:

- MRSA Decolonisation
- Handwashing
- Donning and doffing
- Standard IPC precautions
- Transmission-based precautions
- Surgical site infection prevention
- Ad-hoc sessions in ward/departmental areas
- Student shadowing
- IPC in relation to patients with spinal injuries

Criterion 7: Provide or secure adequate isolation facilities.

The Trust has isolation policies in place and has single side room accommodation with en-suite facilities to isolate patients when required.

The Trust Isolation Policy includes an updated risk assessment tool which allows staff to consider individual requirements for isolation to ensure patients are managed on a case-by-case basis. In rare cases where there has been no side room available; the IPC team have assisted the ward area with mitigations dependent upon the organism – this is documented in a risk assessment template and kept in the patient's notes.

Cleaning and management of our isolation facilities is conducted by our facilities team in accordance with our policy, the National Cleaning Standards, and the National IPC Manual.

Criterion 8: Secure adequate access to laboratory support as appropriate.

The contract for laboratory services is with Shropshire and Telford Hospitals NHS Trust (SaTH) which is fully UKAS (United Kingdom Accreditation Service) compliant under ISO 15189. The ICD is a Consultant Microbiologist at SaTH who is contracted to work at RJAH as a specialist. Medical microbiology support is provided 24 hours a day, 365 days a year. In addition, we have a service level agreement with Sheffield laboratory who provide advice and guidance specific to samples from theatres and radiology.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

Following the introduction of the National IPC Manual in early 2023, the IPC Team initiated a review of all policies and procedures to ensure full alignment with its requirements. This work continued into 2024/25 and was completed by the end of March 2025. Since then, a policy tracker has been maintained including review dates, to ensure that policies are updated in a timely way. The IPC Team provide assurance that policies are maintained through the IPC Quality Management System. The IPC Team maintain 100% compliance to IPC policies.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Optima Health Occupational Health

Occupational health work collaboratively with the Trust in enabling the Trust to meet the occupational requirements for their workforce. General work health assessments standards are based on NHS Employer recommendations. The immunity and immunisation standards are based on the Department of Health and Social Care guidance, the Department of Health (DOH) Green Book *Immunisation against infectious disease* and the UK Health Security Agency (UKHSA).

The day-to-day service provision include:

Pre-employment/pre-placement screening

New starters or those who are changing role within the Trust are required to complete a health questionnaire in determining medical fitness to undertake the position which they are applying for. This is referred to as pre-employment questionnaire (PPQ) screening which provides the Trust with assurance that the candidate has satisfactory health clearance prior to the offer of a job role. PPQ screening also assists the Trust in determining whether reasonable adjustments need to be considered for a potential recruit who has a long-term condition; this aligns with the disability provisions of the Equality Act (2010).

For those candidates whose job role may expose them to substances hazardous to health, in line with Health and Safety Legislation, they will be enrolled onto the health surveillance (HS) and/or the immunisation programmes. For candidates who are in exposure prone procedure (EPP) roles and, they are living with a blood borne virus (BBV) they are enrolled in the close monitoring programme in line with the UK Advisory Panel (UKAP) for healthcare workers living with a BBV.

Body Fluid Exposure (BFE) incidents

A dedicated clinician is assigned daily during business hours to handle enquires related to BFEs in line with Optima policy; which is underpinned by government guidance and BASHH guidelines. The initial call involves undertaking a risk assessment and organizing follow-up attendance for a blood test or vaccination plus setting out a timetable for follow-up surveillance bloods. The Trust will be informed of BBV exposure incidents that may be reportable under RIDDOR (2013) Regulations.

For incidents occurring out of hours, emergency departments provide initial treatment, with Optima Health completing all required follow-up assessments and blood tests.

Management Referrals

This is a pathway for the Trust to seek advice about fitness for work once a member of staff has employee status. Changes in health or circumstances can occur during the period of employment with the organization. If there are concerns about the impact of work upon health or vice versa, referring an employee to occupational health can yield benefit in terms of an earlier return to work if sickness absence is a feature or, advice in terms of preventative measures with regards to sickness absence.

Case Conferences

For complex health and employment situations, a virtual meeting for all relevant parties can be helping in terms of finding appropriate solutions in moving forwards.

Data Requests and Reports

Reporting into the IPC and H&S committees provides an opportunity to inform the Trust of concerns or trends related to IPC and H&S. Optima work with the Trust in terms of projects related to vaccine compliance for assurance purposes.

Safer sharps

Following a HSE inspection in July 2025, the Trust was served an Improvement Notice which required changes in practice in relation to the use of insulin needles. A further Notice of Contravention required that improvements be made to the management of medical sharps across the site. All requirements were met within deadlines, and no further enforcement action was taken.

It should be noted that sharps (including needlestick) injuries remained at a low level with 15 ‘dirty’ and 6 ‘clean’ incidents reported. No incident meeting the criteria for reporting to the HSE under RIDDOR. Safer sharps are the default devices of choice for all procedures wherever clinically practicable. The use of standard sharps is by exception and supported by robust risk assessments

Conclusion

Overall, this report demonstrates that infection prevention and control remains firmly embedded across RJAH, supported by strong leadership, collaborative working and a clear commitment from staff at every level. During

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2025/26 the Trust has sustained high standards of practice, strengthened systems for assurance and surveillance, and continued to make measurable progress in reducing healthcare-associated infections. While national challenges remain, the achievements outlined in this report reflect a positive culture of continuous improvement and shared ownership, providing a strong foundation for the year ahead as we continue to deliver safe, clean and effective care for our patients.

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