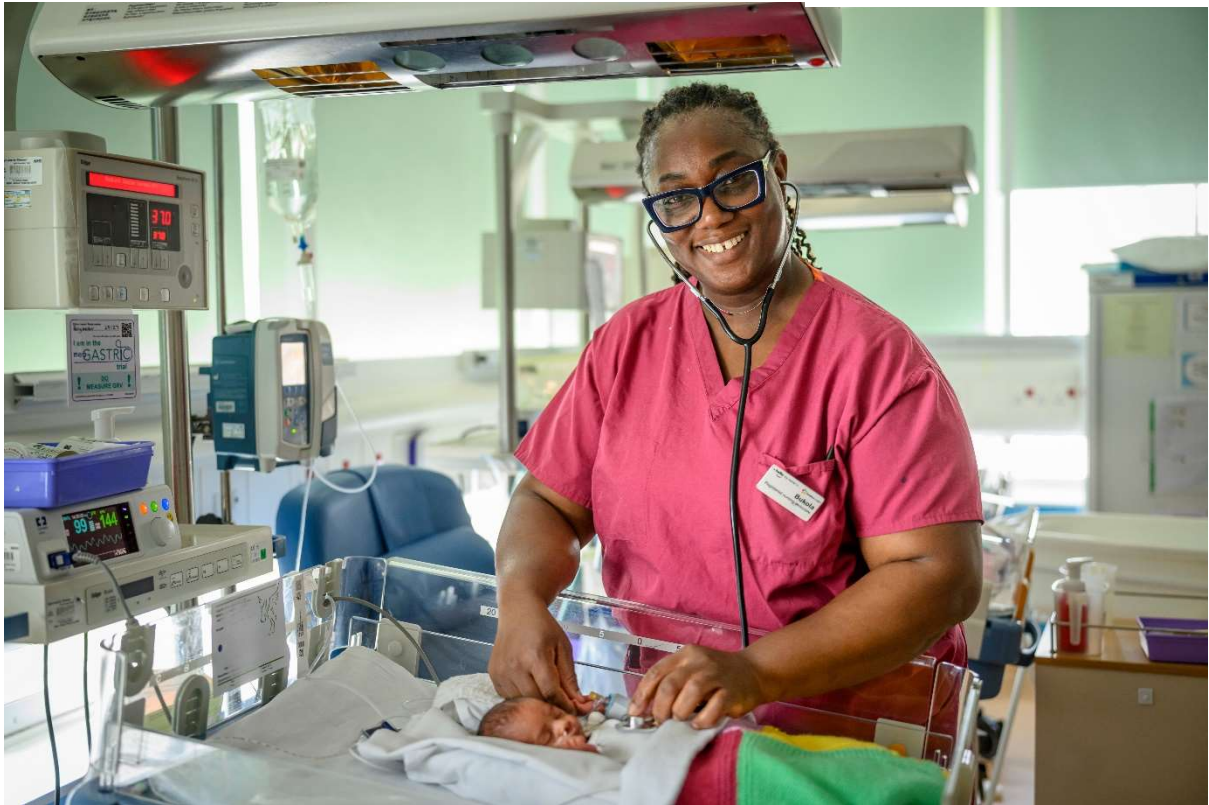




Infection Prevention and Control Annual Report 2025/26

1 Foreword

It is our pleasure to introduce the Infection Prevention and Control (IPC) Annual Report for 2025/26 for Guy's and St Thomas' NHS Foundation Trust. This report reflects the continued dedication, expertise and resilience of our staff, and demonstrates our unwavering commitment to delivering safe, high-quality care for our patients across all our services.

This year has been characterised by both challenge and progress. While we have continued to see pressures associated with healthcare-associated infections (HCAIs), including performance above threshold for some key organisms, it is equally important to recognise areas of significant achievement. Notably, our rates of *Clostridioides difficile* remain among the lowest when benchmarked against peer organisations, our intensive care services have achieved rates of central line-associated bloodstream infection below national benchmarks across all units, and our rate of surgical site infections has improved in recent years. These outcomes reflect sustained effort from clinical teams, supported by high-quality surveillance, audit, and improvement work.

We have also responded proactively to areas of concern. Elevated rates of MRSA bloodstream infection have driven a comprehensive Trust-wide action plan focused on strengthening screening, improving device-related care, and enhancing learning and accountability systems. Learning from post-infection reviews continue to be shared widely, reinforcing a culture of continuous improvement and openness.

The management of outbreaks remains a central focus for the Trust. During 2025/26, we have managed several complex and sustained incidents, including *Candidozyma auris* and vancomycin-resistant enterococci (VRE). These outbreaks have highlighted the importance of early diagnosis, robust screening programmes, environmental control, antimicrobial stewardship and multidisciplinary collaboration. They have also provided valuable learning to strengthen our systems and resilience for the future.

Innovation continues to be a defining strength of our IPC service. The development of digital surveillance tools, dashboards, and the integration of IPC systems within Epic are enhancing our ability to use data in real time to support clinical decision-making and improvement. Our applied research programme remains a cornerstone of our work, contributing nationally and internationally to the evidence base on infection prevention, antimicrobial resistance, and digital health.

A key area of focus has been the prevention of device-related infections, supported by the *Every Device Journey Matters* campaign and the work of our Vascular Access Service. These programmes exemplify our emphasis on practical, patient-centred interventions that reduce infection risk while improving clinical care. Similarly, our antimicrobial stewardship programme continues to demonstrate strong prescribing quality, while addressing the ongoing challenge of reducing overall antimicrobial consumption.

We also recognise that effective infection prevention requires strong infrastructure and organisational systems. This report highlights important work in environmental IPC, including water safety, ventilation, decontamination and cleaning. While these areas present ongoing risks, they are subject to robust governance, investment and improvement programmes to ensure patient safety.

Above all, we recognise that IPC is everyone's responsibility. The commitment of our workforce, from ward staff and clinical teams to estates, facilities and support services, is fundamental to our success. High levels of training compliance, active engagement in audit and improvement, and a strong organisational culture underpin our ability to deliver safe care.

Looking ahead, our strategic objectives reinforce our ambition to be a national leader in infection prevention, embedding data-driven approaches, strengthening prevention across pathways, and translating research into practice. We remain committed to continuous improvement, collaboration, and innovation in the service of our patients. We would like to thank all our colleagues and partners for their ongoing commitment and contribution to infection prevention and control across the Trust.

Professor Avey Bhatia OBE, Chief Nurse

Dr Jon Otter and Dr Nick Price, Joint Directors of Infection Prevention and Control

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2 Glossary

A&E	Accident & Emergency
AMS	Antimicrobial Stewardship
BAF	Board Assurance Framework
BSIs	Bloodstream infections
CABG	Coronary artery bypass graft
CATS	Cardio Adjustable Thoracic Support
CCQIP	Critical Care Quality Improvement Programme
CITI	Centre for Innovation Transformation and Improvement
CQUIN	Commissioning for Quality and Innovation
DoI	Directorate of Infection
HCAI	Healthcare Associated Infection
HCAI DCS	Healthcare associated infections data capture system
HCID-A	High Consequence Infectious Disease – Airborne
HDU	High Dependency Unit
HEPA	High Efficiency Particulate Air
ICB	Integrated Care Board
IPC	Infection Prevention and Control
ICU	Intensive care unit
iGAS	invasive Group A Streptococcus
IPC	Infection Prevention and Control
LTV	Long Term Ventilation
MDR	Multidrug Resistant
MRSA	Methicillin-resistant <i>Staphylococcus aureus</i>
MSSA	Methicillin-susceptible <i>Staphylococcus aureus</i>
NIPCM	National Infection Prevention & Control Manual
PPE	Personal protective equipment
RMch	Ronald MacDonald House
RSV	Respiratory Syncytial Virus
SEL	South East London
SI	Serious Incident
SIAP	Serious Incident Assurance Panel
SIU	Surveillance and Innovation Unit
SSI	Surgical site infection
UKHSA	UK Health Security Agency
UTI	Urinary tract infections
VAD	Vascular Access Device
VRE	Vancomycin-resistant enterococci

3 Executive summary

This report summarises infection prevention and control (IPC) performance, activity, and strategic priorities at Guy's and St Thomas' NHS Foundation Trust during 2025/26. It highlights sustained strengths in several areas of infection prevention, alongside important challenges relating to healthcare-associated infections (HCAIs), antimicrobial stewardship, environmental risks, and digital infrastructure.

Performance against mandatory HCAI surveillance indicators was mixed. The Trust exceeded NHS thresholds for *Clostridioides difficile* infection and bloodstream infections (BSIs) due to *Klebsiella* species and *Pseudomonas aeruginosa*, while remaining at or below threshold for *Escherichia coli* BSI. Despite these challenges, comparative benchmarking demonstrates strong relative performance in key areas, including one of the lowest *C. difficile* rates and a low rate of *E. coli* BSI within the Shelford Group, although MRSA BSI rates remain comparatively high. Robust post-infection review processes continue to identify learning, with particular emphasis on device-related risks and vascular access practices.

Significant progress has been achieved in targeted areas of IPC. Intensive care unit catheter-associated BSI rates are now below national benchmarks across all units, reflecting sustained improvement in line-related care. Surgical site infection (SSI) surveillance demonstrates a marked reduction in infection rates and associated bed utilisation, supported by innovative digital pathways and high levels of patient engagement. The vascular access service continues to deliver high-quality, responsive care with low complication rates, supported by strong audit and education programmes.

However, several ongoing risks require continued focus. Complex and prolonged outbreaks including *Candidozyma auris*, VRE, and MRSA highlight persistent challenges related to environmental contamination, screening compliance, and system factors such as laboratory turnaround times. Water hygiene remains a significant organisational risk, with elevated *Legionella* positivity across sites and a small number of healthcare-associated cases, necessitating sustained mitigation and strategic infrastructure interventions. Cleaning and disinfection performance is generally strong in audit data but variable in practice, prompting strengthened governance arrangements and targeted improvement programmes.

The antimicrobial stewardship (AMS) programme demonstrates strong prescribing quality and governance processes, with high compliance to prescribing standards and reductions in broad-spectrum antibiotic use. Nevertheless, overall antibiotic consumption continues to rise and remains high compared to peers, posing a risk to national antimicrobial resistance (AMR) targets. Limitations in data granularity and digital infrastructure constrain the ability to deliver targeted interventions and fully understand prescribing patterns.

Digital transformation and innovation remain central to IPC strategy. The Surveillance and Innovation Unit continues to expand data dashboards and applied epidemiology capability, although implementation challenges associated with Epic and the Buggy IPC module have introduced operational risks. The Trust continues to lead in applied research, particularly in SSI, AMR, and emerging pathogens, with a strong focus on translating evidence into practice.

Staff engagement, training, and governance arrangements remain strong, with high compliance for mandatory IPC training and well-established committee structures providing assurance to the Trust Board. However, some gaps remain in Level 2 training compliance and workforce capacity in key areas.

Key priorities for 2026/27 include reducing MRSA BSI, strengthening device-related infection prevention, improving antimicrobial consumption, addressing water hygiene risks, and enhancing digital surveillance capability. These priorities align with the Trust's broader strategic ambition to deliver world-class IPC outcomes through innovation, prevention, and system-wide improvement.

4 Infographic summary



5 About Guy's and St Thomas' NHS Foundation Trust

- From our [five main hospitals](#), and in the [community](#), we provide a full range of lifelong, general and specialist care, as well as [clinical research](#), innovation, [education and training](#).
- We are a diverse and welcoming organisation and are incredibly proud of our around 25,000 staff and the dedication they show to our patients and each other.
- We aim to be outstanding in everything we do and to provide high quality and compassionate care and experience to all of our patients and families.
- As a leading centre of clinical research with a long history of innovation and medical firsts, we are able to provide the latest and most advanced treatments. We're [ranked top in England](#) for the number of trials open to patients and in the top 10 for the number of patients recruited to help us in our research.
- Together with our partners in [King's Health Partners](#), we form one of the UK's eight Academic Health Science Centres.
- Our world-famous teaching hospitals train the doctors, nurses and healthcare professionals of the future. [GKT School of Medical Education](#) is our medical school, run jointly with [King's College London](#) and [King's College Hospital](#).
- We are guided by [our values](#) in everything we do and, as one of the largest employers in London, we reflect the diversity, opportunity and ambition of our communities and the people we serve.

6 Healthcare-associated infection (HCAI) surveillance

The Surveillance and Innovation Unit (SIU) continues to provide improved insight into the epidemiology of infections to inform IPC activity. Since its inception, there has been increased accessibility of mandatory reportable organism surveillance data and tools to support improvement within and outside the IPC team.

6.1 Summary of mandatory organism surveillance

- As part of the NHS Standard contract 2025/26, thresholds for healthcare-associated infections are published and used to benchmark our performance.
- We ended the financial year above threshold for *C. difficile* infection, and healthcare-associated BSIs due to *Klebsiella* species and *Pseudomonas aeruginosa*; we are below threshold for healthcare-associated *E. coli* BSIs (Figure 2).
- A comparison with the Shelford Group of hospitals provides a different picture of performance around mandatory organism surveillance (Figure 3). For example, in the case of *C. difficile* infection, we have the lowest rate in the Shelford group by some margin despite breaching our local threshold. However, the rate of healthcare-associated MRSA BSI is the highest in the Shelford group.

6.1.1 *Clostridioides difficile* infection

- In 2025/26, there were 67 healthcare-associated *Clostridioides difficile* (*C. difficile* toxin-positive (reportable) cases, against the NHS threshold of 60.
- We have the lowest rate of *C. difficile* infection in the Shelford group.
- There has been a small year-on-year increase in the number of healthcare-associated *C. difficile* infection over the last five financial years.
- We have not identified any lapses in care due to cross-transmission or antibiotic choices during 2025/26.

6.1.2 MRSA bloodstream infections

- There have been a total of 14 healthcare-associated MRSA BSIs this financial year.
- We have the highest rate of healthcare-associated MRSA BSIs in the Shelford group.
- There is a 15th healthcare-associated MRSA BSI that occurred during 2025/26. This patient was transferred with an MRSA BSI from another NHS hospital. UKHSA surveillance definitions, which are based only on specimen timelines and not case review, have incorrectly attributed this case to GSTT. Since GSTT was not responsible for the development of this BSI, and hence there is no

preventative learning associated with the case, we believe that a total of 14 healthcare-associated MRSA BSIs for 2025/26 is the most meaningful total.

- Each case receives a post-infection review (PIR) in order to identify learning that is shared with clinical teams.
- Given the elevated rate of MRSA BSI this financial year, in Q3 we launched an MRSA BSI action plan to reduce the risk of further cases. The action plan was built around the learning that had been identified from the review of MRSA BSIs that occurred during the financial year.
- The plan includes the following key elements:
 - Strengthen prevention through improved screening, documentation, and data use: increase MRSA admission screening compliance, enhance EPIC documentation (including vascular access and catheters), and use ward-level data and audits to drive local improvement.
 - Reduce device-related risk and optimise clinical care: improve vascular access practices (documentation, Biopatch use, timely removal of devices) and reinforce adherence to key clinical processes such as blood culture collection and MRSA rounds.
 - Improve management and learning systems for MRSA patients: enhance MRSA suppression therapy (timeliness, adherence, tailored approaches), strengthen the post-infection review (PIR) process, and establish clearer clinical leadership and accountability for MRSA BSI prevention.

6.1.3 MSSA bloodstream infections

- In 2025/26, there were 76 healthcare-associated MSSA BSIs; no national threshold is provided.
- The number of MSSA BSIs has fluctuated over the past five financial years, reaching a high point in 2023/24.
- We rank sixth out of the 10 Shelford Group hospitals for our rate of MRSA BSI.
- Investigations of these cases continue to identify recurring themes related to peripheral line care practices and record keeping. Key messages to promote best practice have been shared with clinical leaders in the organisation and frontline clinical teams.

6.1.4 Gram-negative bloodstream infections

- Each Gram-negative BSI is clinically reviewed to identify sources, risk factors and determine which cases were potentially avoidable.

6.1.4.1 *Escherichia coli* bloodstream infections

- In 2025/26, there were 120 healthcare-associated *E. coli* BSIs, against the NHS threshold of 120.
- There has been a year-on-year decrease in the number of *E. coli* BSIs reported over the past three financial years.
- When compared with the Shelford Group, we report the second lowest rate of *E. coli* BSI.

6.1.4.2 *Klebsiella sp.* bloodstream infections

- In 2025/26, there were 100 healthcare-associated *Klebsiella sp.* BSIs, against the NHS threshold of 90.
- There has been a year-on-year decrease in the number of *K. pneumoniae* BSIs reported over the past three financial years.
- When compared with the Shelford Group, we had the fifth highest rate of *Klebsiella sp.* BSI.

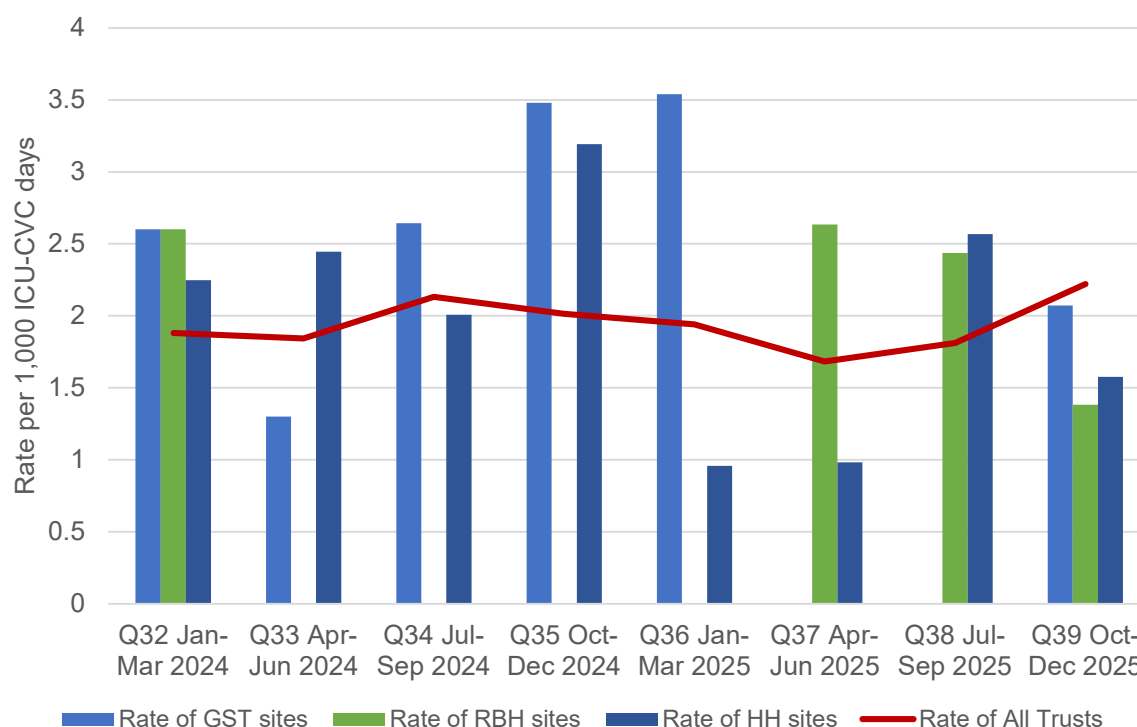
6.1.4.3 *Pseudomonas aeruginosa* bloodstream infections

- In 2025/26, there were 37 healthcare-associated *Pseudomonas aeruginosa* BSIs, against the NHS threshold of 35. For comparison, the NHS threshold for the previous financial year was 51.
- The number of *P. aeruginosa* BSIs in 2025/26 was the same as in 2024/25, and lower than the prior three financial years.
- When compared with the Shelford Group, we had the fifth highest rate of *P. aeruginosa* BSI.

6.2 ICU-associated central venous catheter-associated bloodstream infections

The UKHSA Infection in Critical Care Quality Improvement Programme (ICCQIP) surveillance programme provides data on the rate of BSI and central-venous catheter-associated BSIs in participating adult ICUs. For 2025/26, for the first time since reporting began, all of our ICUs fell below the national rate derived from participating units (Figure 1). This is a substantial achievement, because the national rate that we are using to benchmark is not adjusted for complexity, and we care for patients with highly complex needs who are at a higher risk of BSI and other infections.

Figure 1: ICU-associated central venous catheter (CVC) BSI data from ICCQIP (January 2024 – December 2025, the latest available data)



6.3 Respiratory virus infections

The respiratory infections dashboard tracks the number of respiratory viral infection cases Trust-wide. Mirroring national trends, COVID-19, Influenza A, and RSV prevalence rose and fell seasonally throughout the year (Figure 4). We identified and managed several outbreaks of these viral infections throughout the year.

6.4 Digital and epidemiological development in the Surveillance and Innovation Unit

- As part of a programme of local digital transformation, the SIU has continued to develop our systems to support the IPC team to reduce the risk of HCAI and address AMR.
- A new IPC section has been launched on MIDAS, the Trust digital information platform, which hosts interactive dashboards, one of which being the current position in terms of reportable HCAI Trustwide.
- A new tool has been developed to track compliance with MRSA admission screening.
- An interactive dashboard has been created to support the *Every Device Journey Matters* improvement programme, including key metrics around the use of vascular access devices.
- The SIU is a centre of expertise to use applied epidemiology to support and extend clinical teams within the Directorate of Infection. Analysis on the ongoing *Candidozyma auris* outbreak has been published.
- The SIU has continued to work closely with the Epic teams to tailor the Buggy (IPC) application within Epic for best IPC utilisation.

Figure 2: Trust-wide mandatory healthcare-associated HCAI surveillance case numbers over the last five financial years

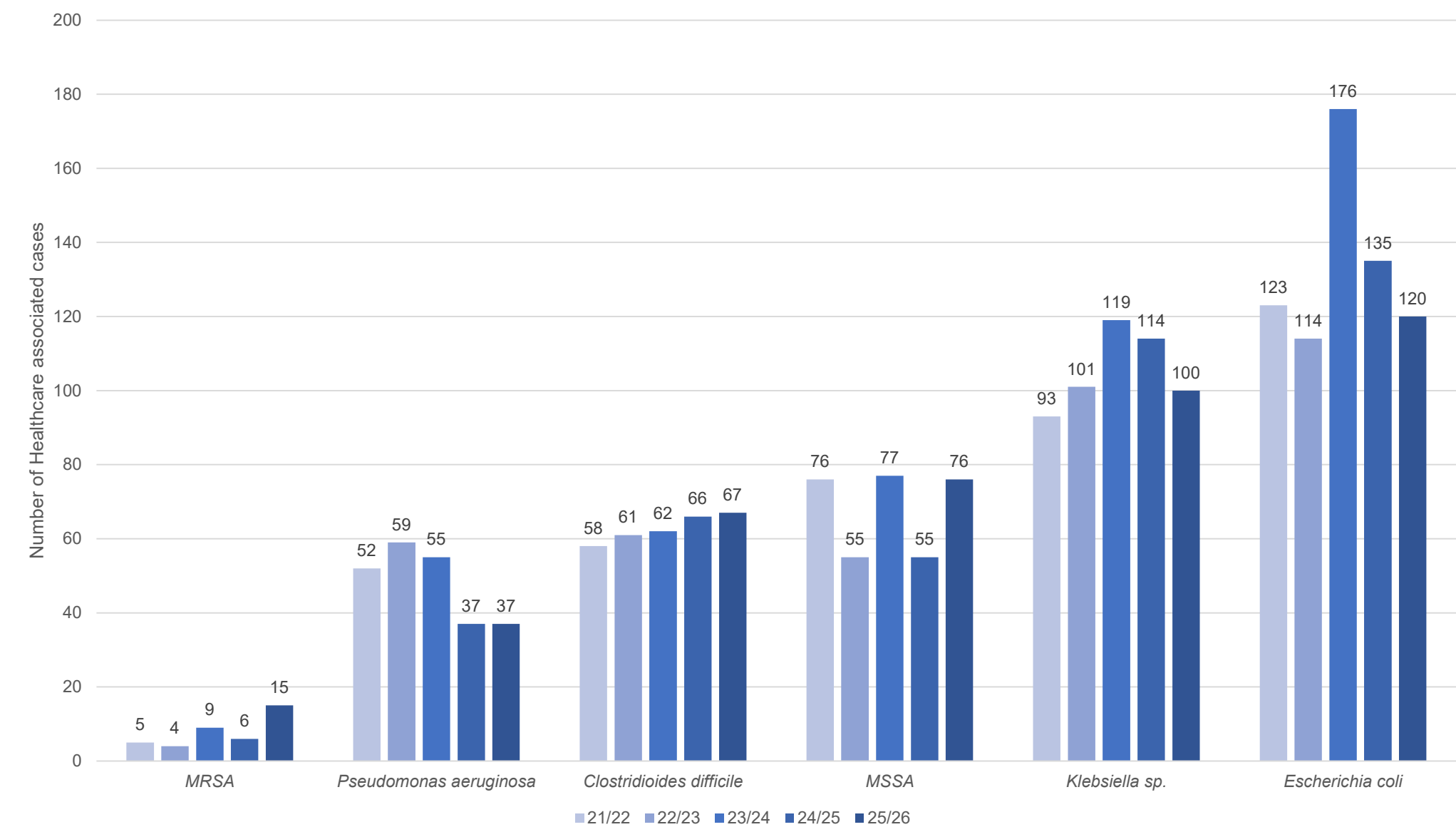


Figure 3: Healthcare-associated HCAI surveillance rates in the Shelford Group (April 2025–March 2026)

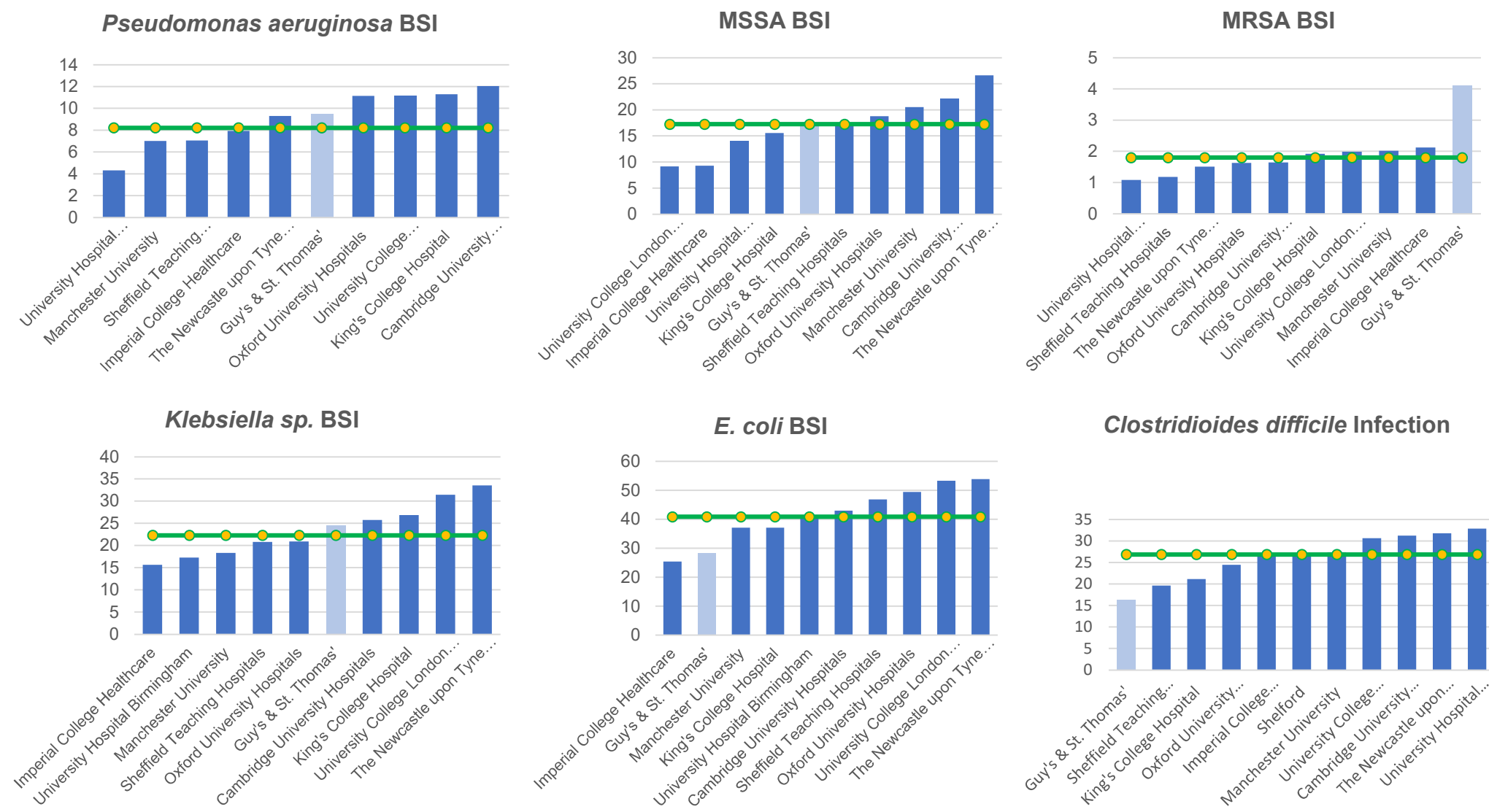
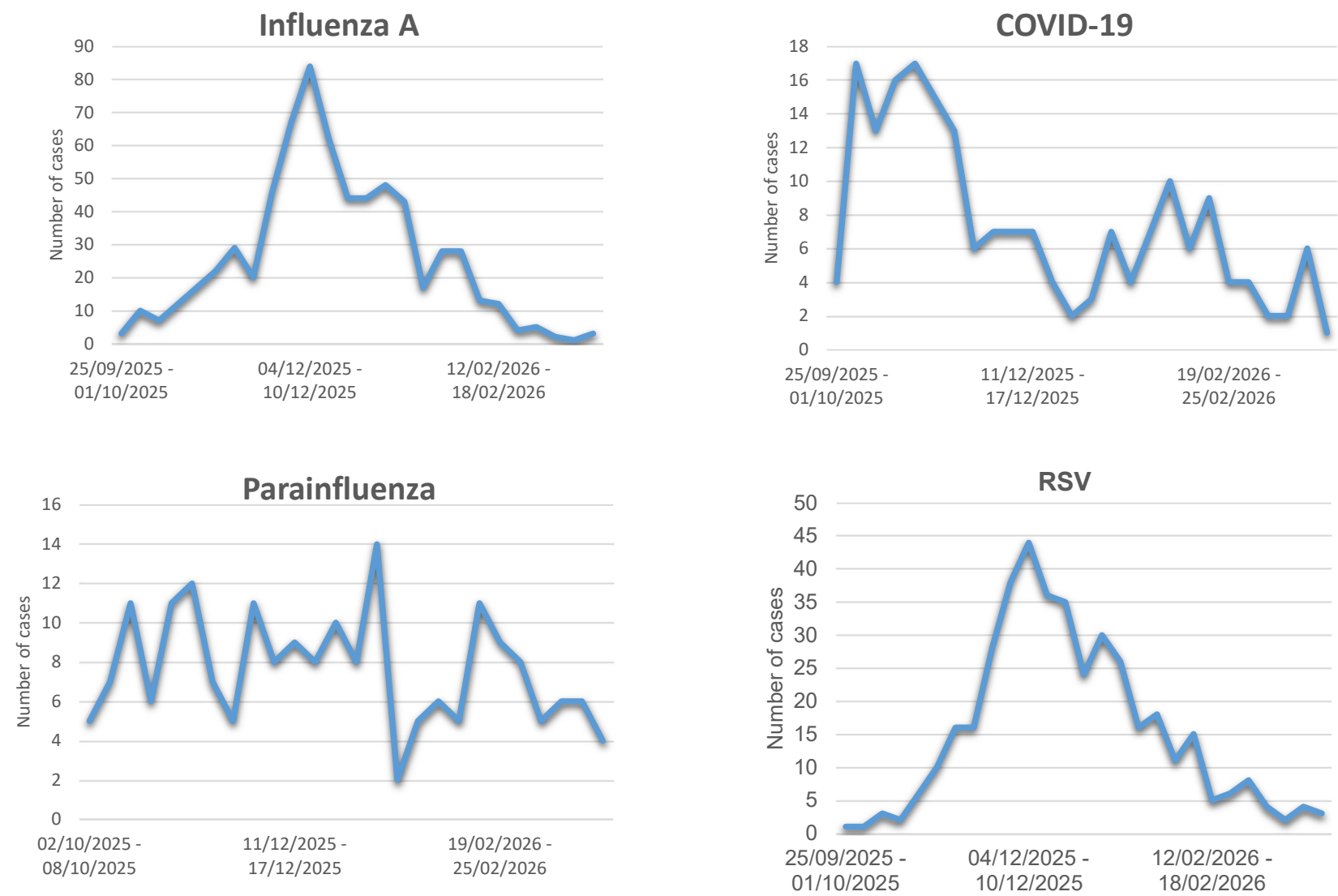


Figure 4: Respiratory virus trends (October 2025–March 2026)



6.5 Surgical site infection

6.5.1 SSI rates, impact and prevention

- The overall inpatient/readmission rate for SSI fell from 3.1% (303/9,901; November 2022–December 2023) to 1.0% (98/9,988; May 2025–April 2026), representing a 68% relative reduction. The greatest improvements were seen in vascular surgery, coronary artery bypass graft (CABG) surgery, and orthopaedics (hip and knee replacement surgery).
- During the same period, recorded bed days associated with SSI management fell from 1,213 to 1,133. Although additional specialties were included in the later reporting period, comparison of like-for-like specialties suggests that SSI-related bed utilisation reduced by approximately 60%, driven largely by improvements in CABG surgery, orthopaedics, and vascular surgery.
- Submission of hip and knee replacement surveillance data to UKHSA resumed for the January–March 2026 reporting period. Further automation of UKHSA reporting through EPIC is currently being developed.
- The Trust's digital SSI surveillance programme, delivered through Isla and now integrated with EPIC, has secured ongoing funding. While the service will move from a seven-day to a five-day operating model, it continues to support almost 10,000 GSTT patients annually across vascular, thoracic, breast, cardiac (adult and paediatric), general surgery, obstetric, and upper gastrointestinal services.
- Patient engagement remains high, with an 86% response rate. Hip and knee replacement patients will be added to the programme from July 2026.

6.5.2 SSI team applied innovation and research

- The SSI team have developed several revenue generating innovations including the CATS Vest, BHIS bra, Isla SSI digital pathway, and service level agreements for digital SSI surveillance. The team have worked closely with CITI (the Trust's innovation and commercialisation team) to develop and realise these opportunities.
- **WISDOM** The [WISDOM](#) study, funded through the NIHR Invention for Innovation (i4i) programme, was completed in December 2025. The study developed and clinically evaluated an artificial intelligence (AI)-enabled model to support remote wound assessment through a feasibility randomised controlled trial (RCT). Building on the success of WISDOM, the team secured additional funding through WISDOM 1.1 (NIHR Connect) to further refine and evaluate the AI-enabled wound assessment model, with a particular focus on improving performance across darker skin tones. The study was completed in May 2026, and the findings have been submitted for publication. The team has also submitted an application for WISDOM 2, a definitive real-world evaluation of AI-assisted surgical site infection (SSI) surveillance.



- The [TREASURE](#) study, funded through the NIHR Research for Patient Benefit (RfPB) programme, was successfully completed in June 2026. The study evaluated the feasibility and acceptability of patient self-swabbing of surgical wounds at home using a co-designed surveillance kit. The study protocol has recently been published, and final data analysis is underway. The findings are expected to inform future approaches to remote wound monitoring and infection detection. The team have submitted an application to NIHR for a 'randomised feasibility study of self-management SSI prevention kits after caesarean section (SOSSSI)'.



- The GSTT SSI team was selected to provide centralised SSI surveillance for the national [ROSSINI-Platform](#) study, the largest surgical wound research programmes undertaken in the UK. Through the Central Digital Wound Hub, the team delivers remote postoperative wound monitoring and specialist SSI assessment for participants across multiple NHS organisations, supporting high-quality outcome ascertainment and patient follow-up at scale. The study commenced in 2026 and is expected to recruit up to 26,000 participants across approximately

100 NHS hospitals. Participation in the programme further strengthens the GSTT's position as a national leader in digital SSI surveillance and remote postoperative care.

7 Antimicrobial stewardship programme

- The Trust's AMS programme continues to deliver active stewardship interventions and innovation in digital optimisation; however, overall antibacterial consumption has increased across 2025/26, and challenges in data infrastructure and workforce capacity limit the ability to fully understand and control prescribing patterns.

7.1 Antimicrobial consumption trends

- Total antibacterial use has increased over recent years, a +24.3% rise vs 2019 baseline (Figure 5).
- The increase is primarily driven by Access antibiotics, particularly doxycycline linked to prophylaxis programmes.
- Watch & Reserve agents fell overall by 3.4% during 2025–26, reflecting stewardship impact.
- However, reserve antibiotic use increased by 12.3%, largely due to rising colistin use.
- Carbapenem use continues a downward trend, suggesting effectiveness of targeted interventions (Figure 6).
- Compared with peer (Shelford) organisations, the Trust continues to have the highest overall antibacterial consumption.
- The Trust is improving antimicrobial selection (shift away from broad-spectrum agents), but this is offset by rising total volume, posing a risk to national AMR targets.

7.2 Stewardship activity and impact

- Multidisciplinary review rounds have been undertaken at Guy's, St Thomas', and Evelina) showing high compliance with prescribing standards (~90–95%), indicating good quality prescribing for Reserve agents.
- Point Prevalence Surveys have been undertaken quarterly, showing a continued reduction in patients receiving antimicrobials (~35.8% in April 2026).
- Improved Access vs Watch/Reserve balance has been achieved at most sites, though variation persists with Royal Brompton and Harefield showing a higher usage of Watch and Reserve agents.
- Targeted audits and reviews have demonstrated reductions in selected agents (e.g. piperacillin–tazobactam when review rounds active).
- Ongoing guideline optimisation and engagement, including work in respiratory infections and specialty-specific prescribing.
- The programme demonstrates strong stewardship processes and prescribing quality, but system-level impact on total consumption remains limited.

7.3 Digital systems and data limitations (Epic)

- The lack of granular antimicrobial consumption data remains a key constraint.
- Reporting largely limited to Trust-level data, with little reliable breakdown by site or specialty.
- Up to ~45% of antimicrobial use (ambulatory) is not captured in Epic DDD data.
- Progress to address these issues includes:
 - Development of DDD reporting within Epic (inpatient only).
 - Workstreams on indication-based prescribing, ARK toolkit, IV-to-oral switch, and duration optimisation.
- Digital infrastructure is improving but currently limits surveillance, benchmarking, and targeted intervention.

7.4 External performance and national targets

- I go National policy requires reduction in broad-spectrum antibiotic use and overall consumption.

- Our performance shows a reduction in Watch/Reserve use since Epic implementation, aligning with policy direction.
- However, overall consumption remains high and rising, meaning that we are off target to achieve a 5% reduction in total antibiotic use vs a 2019 baseline.
- We continue to work towards the national target of 70% Access use by 2029.

7.5 Key risks and priorities

- Key risks:
 - Continued increase in total antibiotic consumption.
 - Lack of data granularity to identify high-use areas.
 - Rising Reserve agent use (colistin) without clear drivers.
 - Staffing shortages at our Royal Brompton and Harefield sites continue to constrain AMS delivery and outbreak response.
 - Programme alignment challenges also exist across our sites.
- Strategic priorities:
 - Strengthen Epic-based analytics and dashboards to enable actionable insight.
 - Scale stewardship interventions (e.g. review rounds, IV-PO switch, duration optimisation).
 - Address workforce gaps, especially at Royal Brompton and Harefield.
 - Deliver measurable reductions in total consumption aligned with National AMR Action Plan.
 - Enhance ICS-wide coordination on antimicrobial reduction.

Figure 5. Antibacterial DDDs per 1000 Admissions for GSTT for April 2021 to March 2026: Total Consumption – taken from Rx-Info Define.

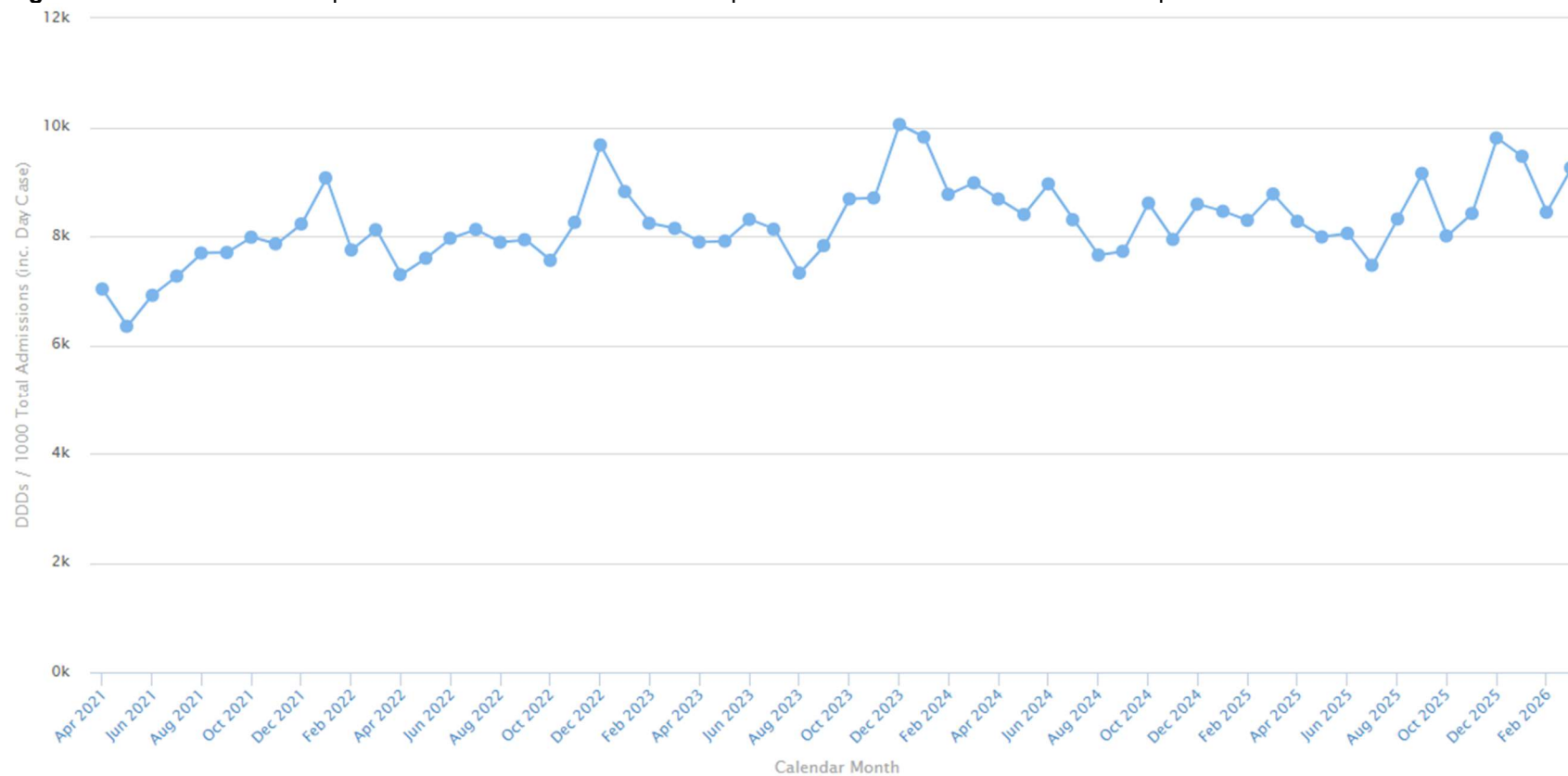
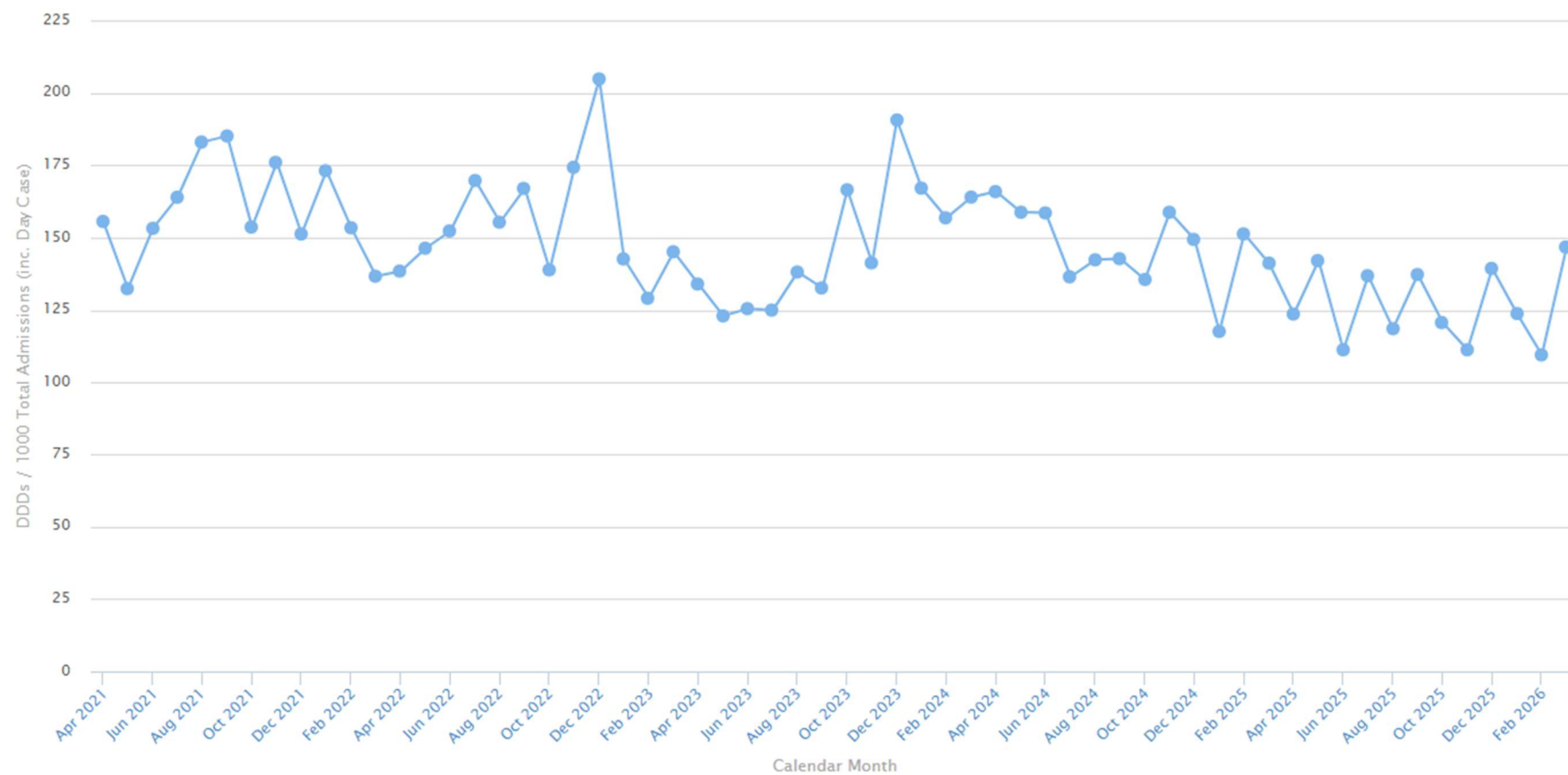


Figure 6: Antibacterial DDDs per 1000 Admissions for GSTT for April 2021 to March 2026: Carbapenems - taken from Rx-Info Define.



8 Vascular access team

The Vascular Access Service (VAS) continued to deliver a high-volume, responsive, and clinically effective service across Guy's, St Thomas', and Evelina, maintaining low complication rates and high procedural success, while strengthening infection prevention practices through audit, education, and targeted interventions. There is currently no nurse-led VAS for our Royal Brompton and Harefield sites.

8.1 Activity and service delivery

- The service delivered consistently high activity throughout the year inserting 473 midlines, 659 PICC lines, 1989 ultrasound-guided peripheral lines (EDPVC), and 3088 difficult cannulation/phlebotomy procedures.
- The service has delivered 1219 line management interventions.
- The service is highly responsive, with the majority of referrals seen within 24 hours (~91%).
- Complication rates for PICCs and midlines remain very low, supporting safe practice.
- PICC outcomes demonstrate the majority appropriately removed at end of treatment, low rates of infection (~1%), malposition (~1%), and thrombosis (~1%).
- Midline outcomes similarly show most removed at end of treatment, low infection (~2–4%) and complication rates.
- Patient feedback consistently improved comfort compared to previous attempts, clear communication and patient reassurance, and high confidence in procedural care. This is illustrated by this feedback from our patients:
 - *"Everything was so clearly explained and the nurses totally put me at ease. They made sure I was comfortable at every stage and were just generally nice and friendly to be around."*
 - *"After previous painful attempts, the team made me feel at ease and the procedure was no longer painful."*

8.2 Audit for improvement, and education

- Monthly point-prevalence audits of vascular access devices were sustained across the year. Overall audit compliance was ~85%, with 99% of devices free from signs of infection.
- Improvements implemented in response to the audit findings include strengthened documentation of insertion and ongoing care, standardisation of audit processes across the Trust, expansion of CHG-based interventions including improving compliance with CHG dressings by ~33%) and CHG washes before and during central line use.
- The VAS launched a targeted response to the MRSA BSI increase, including: 3x weekly audits of MRSA-positive patients with vascular access devices, and an increased focus on antimicrobial dressings and best practice.
- Ongoing education programme across clinical areas, includes regular teaching sessions, Quarterly Vascular Access Masterclasses, and training in ultrasound-guided cannulation.
- The team has an active involvement in BSI investigations, particularly when catheter-related.
- Partnership working with industry has continue to improve device care practices.
- The team have supported the continued delivery of the *Every Device Journey Matters* campaign to promote optimal device care and documentation.

8.3 Key risks and priorities:

- Key risks
 - Ageing equipment (ultrasound and ECG guidance systems) now out of warranty, posing risks to service continuity.
 - Continued need to improve documentation compliance, maintain gains in CHG-related infection prevention practices, and focus on MRSA BSI prevention in patients known to be colonised.
 - Lack of nurse-led VAS at our Royal Brompton and Harefield sites.
- Strategic priorities:

- The Trust Operations Board reviewed a business case to expand the VAS to cover our Royal Brompton and Harefield sites. This case was deferred and will be resubmitted during 2026/27.
- Sustain and expand audit and IPC interventions, particularly for high-risk groups (e.g. MRSA patients).
- Implement and evaluate antimicrobial locking solutions to reduce catheter-related bloodstream infection.
- Strengthen device selection and appropriateness (vessel health preservation).
- Expand training and co-audit programmes across clinical groups and community settings.
- Support Trustwide implementation of CHG-based prevention measures.

9 Environmental IPC

9.1 Decontamination

- The Trust continues to deliver a high-quality decontamination service, with Sterile Services maintaining strong performance despite increasing demand. Activity levels remain above pre-pandemic baselines, with significant year-on-year increases in instruments processed, placing pressure on capacity and workforce.
- Quality indicators remain robust, with very low non-conformity rates (0.035%) and turnaround times well within the Trust standard, providing assurance that reusable medical devices are being safely reprocessed.
- Infrastructure improvements have supported compliance, including replacement and upgrade of air handling units (AHUs) in Sterile Services, ensuring alignment with HTM requirements. However, system integration challenges between Epic and decontamination tracking systems remain unresolved, limiting full traceability and digital optimisation.
- The Trust is progressing an options appraisal for future decontamination provision, including potential insourcing of services currently delivered via external contractors.

9.2 Water Hygiene

- Water safety remains a high-risk area for the Trust, with ongoing challenges in *Legionella* and *Pseudomonas* control requiring sustained organisational focus.
- Across the estate, *Legionella* positivity rates remain elevated, including 20% at Guy's, 13% at St Thomas', and ~12% across RBH, Harefield and Wimpole Street.
- *Pseudomonas* results are variable, with low rates at Guy's but higher levels at St Thomas' and some persistent issues at Royal Brompton and Harefield.
- In response, a range of mitigation measures have been implemented including appointment of a new Water Authorising Engineer, reorganisation of compliance and assurance teams, increased use of point-of-use filters and enhanced flushing regimes, delivery of planned preventative maintenance (PPM) and remediation programmes.
- A key strategic intervention is the "Water-Lite" programme, piloted in Guy's Borough Wing following links to hospital-acquired *Legionella* cases. This involves deactivation/removal of underused outlets to improve system performance, alongside temperature optimisation and system rebalancing.
- External assurance has confirmed effective control of cooling tower systems following regional concerns about *Legionella* outbreaks.

9.3 Ventilation

- Ventilation systems across the Trust continue to provide core assurance for safe clinical environments, with all critical plant verification in date (100%), demonstrating regulatory compliance.
- Consolidated action plans are in place to address identified risks across sites.
- Targeted issues have been identified, including suboptimal air change rates in specific clinical areas (e.g. Guy's Critical Care Unit bed bays) due to legacy system design.
- There is also an ongoing need for system upgrades and optimisation as part of refurbishment programmes.

- Significant progress has been made in infrastructure improvement, including AHU upgrades within Sterile Services, improving air change rates and pressure differentials.
- Governance and control frameworks have also been strengthened through the introduction of a standardised permit system for ventilation isolation works. Trustwide action plans and verification oversight processes have been developed.

9.4 Cleaning and disinfection

- Cleaning and disinfection performance across the Trust presents a mixed picture over 2025/26, with strong measured audit performance alongside recognised operational and assurance challenges.
- Routine assurance data indicates that cleaning standards are consistently high, with audit scores exceeding Trust and national targets across most sites (typically $\geq 95\%$, with Trust-wide performance $\sim 97\text{--}98\%$).
- However, throughout 2025/26 there were significant concerns regarding consistency, assurance, and service delivery, identified through IPC reviews, outbreak investigations, and frontline feedback. These concerns included variability in cleaning and disinfection practices, reduced assurance in some areas, and specific risks relating to disinfectant use (e.g. dilution practices).
- In response, the Trust implemented a range of strengthened governance and improvement measures, including:
 - Establishment of Trustwide strategic and operational cleaning groups, providing oversight and coordination of improvement work.
 - Identification and active management of six priority areas for improvement (training, workforce, resources & equipment, six specific priority areas (sinks / taps, beds/ cots, high dusting, low dusting, drains, shared medical equipment), audit, and roles & responsibilities).

10 High consequence infectious diseases – airborne (HCID-A) centre

- We continue to provide training to ensure preparedness for HCID. This is supported by a comprehensive programme including in situ simulation, simulation centre training, AI-based training, and table-top exercises. Training and preparedness have been continually refined in response to emerging global threats, including activation of the HCID unit following a suspected Andes hantavirus exposure and updated frontline guidance during the Ebola outbreak in West Africa.
- Details of our training programme was presented at ECCMID 2025.
- We launched a new suspected PPE ensemble for suspected HCID, which was communicated to frontline teams.
- Our HCID clinical lead sits on the steering committee for the UKHSA Avian Influenza research project, ensuring alignment between national research priorities and operational practice.

11 Hand hygiene and PPE auditing

Almost 50,000 hand hygiene observations were recorded by ward-based link practitioners, and 13,000 by the IPC team. Compliance is recorded in terms of 'action compliance', which refers to the WHO's 5 moments of hand hygiene and 'barrier compliance', which refers to observation of being bare below the elbow to ensure that there are no wrist watches, rings, or long sleeves while decontaminating hands. Action compliance from hand hygiene auditing was 82% (46,878 observations). Audits undertaken by infection prevention nurses showed a lower level of action compliance with a rate at 67% (12,914 observations), while barrier compliance rate was 96%. The difference between action compliance figures by ward-based link practitioners vs. the IPC team suggests that link practitioners are over estimating compliance. This gap is being addressed via monthly MEG audit training, increased infection prevention nurses' hand hygiene validation observations, and escalations via the monthly Infection Control Committee. Overall compliance rate from PPE audits undertaken by both infection prevention nurses and link practitioners was 90% (8,104 observations). The overall figure was also adapted and now includes donning and doffing. The PPE audit form was adapted to take into consideration isolation compliance. Isolation compliance is 94.9% (4013 observations) and non-isolation compliance e.g., PPE use in non-infected patients, is 88.2% (8104 observations).

12 Clinical activity, incidents, and IPC team activity

12.1 *Candidozyma auris* outbreak

The *Candidozyma auris* outbreak remained our highest priority outbreak throughout the financial year. The total number of patients affected reached 259 by the end of the financial year. Whilst there was an ongoing reduction in the number of new cases detected, transmission persisted.

Key developments and learning:

- The outbreak was linked to ongoing challenges with environmental persistence and challenges with cleaning and disinfection.
- Implementation of rapid PCR testing on East Wing wards.
- Identification of missed screening opportunities contributing to transmission.
- Incident involving laboratory transcription error, demonstrating system vulnerability and operational impact.
- Laboratory challenges resulted in extended turnaround times for our *C. auris* screening programme.

12.2 VRE outbreak (Harefield site)

The VRE outbreak was another sustained incident, with 145 patients affected by the end of the financial year. Ongoing transmission involved both cross-infection and new introductions.

Key developments and learning:

- Antimicrobial stewardship challenges were a central driver.
- Contributory environmental factors included drainage, equipment cleaning, and environmental contamination.
- Control measures included enhanced surveillance, environmental interventions, and prescribing review, but the outbreak persisted throughout the year.

12.3 MRSA outbreak (Neonatal Unit)

The neonatal MRSA outbreak continued throughout the reporting period, with a total of 16 patients affected between December 2024 and early 2026.

Key learning:

- Importance of consistent screening and surveillance.
- Focus on environmental and equipment cleaning.
- Investigation of staff colonisation as a transmission source.
- The outbreak reinforced the complexity of managing transmission in neonatal settings.

12.4 Healthcare-associated *Legionella*

A case of probable healthcare-associated *Legionella pneumonia* related to the Borough Wing at Guy's. The patient required critical care but survived and has been discharged. Issues with the operational management of water hygiene have been identified, which may have contributed to this case. The Trust has now experienced 7 cases of healthcare-associated *Legionella pneumonia* in the past 5 years, more than any Trust in the country.

12.5 Other outbreaks

Other outbreaks that were identified and managed include:

- COVID-19 – 20 ward-based outbreaks with varying transmission patterns.
- Influenza A / Influenza B – 10 seasonal outbreaks across multiple specialties.
- Norovirus (including suspected D&V outbreaks) – six outbreaks affecting both patients and staff.
- Parainfluenza (Parainfluenza III) – one outbreak in a haemato-oncology setting.
- CPE / CPO / CRE (e.g. *K. pneumoniae* OXA-48/NDM; *E. coli* NDM) – two outbreaks linked to ward-based transmission and delayed diagnostics.

Key shared learning includes:

- Delays in diagnosis and laboratory processes increase transmission risk.
- Early isolation and cohorting remain pivotal – but delays to isolation are a common theme of outbreak investigations.
- Staff may play a key role in transmission dynamics, particularly for viral pathogens such as the SARS-CoV-2 virus that causes COVID-19 and norovirus.
- Transmission frequently but not always occurs within bays – sometimes ‘ward-level’ interventions (such as patient screening and cleaning and disinfection) are necessary for control.
- Environmental and operational factors are recurrent contributors, such as ward design and sub-optimal patient movement.
- Screening strategies are essential to identify patients with infection risks, but compliance with screening policies require focus.
- Antimicrobial resistance outbreaks require system-level responses to reduce drivers for AMR.
- Outbreaks often have operational impacts, but remain manageable, including bay closures and much less commonly ward closures.

12.6 Other

- Trust-wide improvement programmes. Two major improvement programmes were central across the year:
 - *Every Device Journey Matters* campaign. Launched in Q1 to improve vascular access device and urinary catheter care, with focus on reducing unnecessary device use, improving documentation via Epic, and embedding review via ward and clinical processes. We used the London Tube Map to illustrate the improvement programme and grab the attention of busy staff (Figure 7). Throughout the financial year, metrics to evaluate the impact of the campaign have been developed.
 - *Gloves Off* campaign. Our ongoing Gloves Off continued throughout the year, aligned with sustainability and IPC goals.
- Staff engagement through awareness events (such as to promote World Hand Hygiene Day in May and IPC week in October).
- Service development and organisational change. Several service and structural developments were progressed:
 - Development of a proposal for vascular access service expansion, including our Royal Brompton and Harefield sites.
 - Launch of the strategic cleaning group in Q3.
 - Secured internal investment for the continuation of the Central Digital Wound Hub.
- Laboratory and diagnostic capacity. Delays in turnaround time linked to our laboratory provider, Synnovis, transitioning to a central hub resulted in increased transmission risk.

Figure 7. Illustration of the *Every Device Journey Matters* improvement programme.

We used a familiar image to our workforce, the London Tube Map, to illustrate the infection prevention interventions (i.e. the stations) that occur for a journey of a vascular access device or a urinary catheter. The stations on the blue 'central line' are relevant to both types of device.



13 Training and education

- Core mandatory IPC training is delivered to all staff, clinical and non-clinical, and has historically combined online and face-to-face formats.
 - Overall compliance remains strong for IPC Level 1 training (for all staff), with 97% of staff meeting the Trust target. However, compliance for IPC Level 2 training (for clinical staff) is 80.85%, below the 95% target. Plans are in place to address this gap.
 - Since December 2025, delivery has transitioned fully to e-learning using the updated national IPC package aligned with the Core Skills Training Framework (CSTF). This sets training frequency at every three years for Level 1 and annually for Level 2.
 - Implementation is being finalised following presentation to the Nursing and Midwifery Workforce Council, with full rollout expected within the year.
- IPC nursing teams continue to provide targeted, role-specific training across all sites, including sessions for Site Nurse Practitioners, medical staff inductions, Essentia staff, and Allied Health Professionals. The team also supports wider Trust initiatives such as World Hand Hygiene Day and professional development events to reinforce best practice and strengthen IPC culture.
- The IPC team contributes actively to student education programmes led by the Chief Nursing Office, hosting nursing students to provide insight into IPC practice and promote early adoption of infection prevention principles.
- The IPC Link Practitioner Programme supports local ownership of IPC through a structured foundation course, regular updates, and networking opportunities, promoting consistent standards and audit compliance.
- The annual IPC conference, held in August 2025, focused on vascular access best practice and recognised excellence through the IPC Star Award.
- During 2025/26 and in response to our staff survey results, we have delivered a programme of Civility Training for all staff and ensured that all those in our team with management responsibility have completed the People Manager Programme.

14 Governance, policy, and risk

14.1 Team structure

The IPC team is a multi-professional team comprising nurses, doctors, scientists, pharmacists, and others to support the Trust in meeting its obligations under the *Health and Social Care Act 2008 code of practice for prevention and control of infections* and other relevant legislation and guidance from, for example, the Department of Health and Social Care, UKHSA, and the Care Quality Commission. The service is led by two Joint Directors of Infection Prevention and Control, with the Chief Nurse as executive lead.

14.2 Governance and assurance arrangements

- A quarterly Trust Infection Control Assurance Committee is chaired by the Chief Nurse and reports to the Trust board.
- It receives regular reports and updates from each Clinical Group and the following various sub-committees:
 - Trust Infection Control Committee
 - Clinical Group specific Infection Control Committees
 - Surgical Site Infection (SSI) Committee
 - Water and Ventilation Safety Committee
 - Decontamination Committee
 - Antimicrobial Stewardship Committee
 - Intravenous Line Governance Committee
- The Trust Infection Control Assurance Committee also receives reports or updates from our UKHSA Consultant in Communicable Disease Control, Integrated Care Board, Essentia (estates and facilities), Occupational Health, and Health and Safety.
- IPC also publishes quarterly reports and an annual report. Any interim exceptional reporting to the Trust board is undertaken via existing reports from the Chief Nurse's Office.
- Occupational Health continue to record information on infectious diseases in staff, occupational exposure of staff to body fluids (including sharps injuries), fit testing for respiratory PPE, and any issues with processes for occupational healthcare work clearance related to infectious diseases.
- The Trust Infection Control Assurance Committee includes a representative from the pathology laboratory, to ensure that appropriate laboratory support is in place for our services.
- IPC policies are agreed via either the quarterly Trust Infection Control and Decontamination Assurance Committee or the monthly Infection Control Committee. During 2025/26, key policies were merged to cover all sites.

14.3 Risk management

- IPC risks are included on a risk register, which is reviewed quarterly at the Trust Infection Control Assurance Committee.
- New risks for 2025/26 include:
 - Vascular access and line care at Royal Brompton and Harefield: Suboptimal line management (training, supervision, delays, and troubleshooting) contributing to a high proportion of BSIs (~60%) and avoidable device-related harm.
 - Business support capacity. Staffing shortages and delays in recruitment limit the ability of support functions to meet service demands.
 - *Mycobacterium tuberculosis* (TB) service provision at Royal Brompton and Harefield. Limited or absent TB service leading to delays in diagnosis and management, increasing patient and transmission risk.
- Key risks reflected on the IPC risk register include:
 - Water hygiene. Ongoing inability to provide full Board assurance, with associated clinical risk (e.g. Legionella).
 - Major outbreaks. Persistent and complex outbreaks of *C. auris*, VRE and MRSA, with ongoing transmission and operational impact.
 - MRSA BSI performance. Rates above trajectory and high relative to peers, linked to recurring issues in screening, vascular access device care, and suppression therapy.
 - Cleaning and disinfection. Limited assurance, variable standards across sites, and risks linked to transmission of environmental pathogens.

- Diagnostics and laboratory capacity. Delays and occasional errors impacting timely isolation and outbreak control.
- Digital and surveillance systems. Ongoing Epic/Bugsy limitations affecting surveillance, reporting and workflow efficiency.
- Operational pressures and capacity. Workforce behaviours, bed pressures and loss of isolation capacity affecting timely implementation of IPC measures.
- The IPC Board Assurance Framework (BAF) has been updated quarterly throughout 2025/26. Actions arising from the BAF are being monitored via the Infection Control Committee.

15 Applied research

The IPC team is committed to the goals of the Trust as an Academic Health Science Centre in undertaking and implementing the findings of applied research. The Department of Infection hosts the Kings College London Centre for Clinical Infection and Diagnostics Research, which is focussed on applied research in HCAI and AMR, with a focus on implementing respiratory metagenomics. Recently completed, presented or published applied research projects for 2025/26 include:

- Surgical site infections (SSI) and wound care
 - Home-based self-swabbing after surgery is feasible and supports remote infection surveillance.
 - Smartphone-based wound monitoring reduces healthcare visits while maintaining safe SSI management.
 - Digital wound monitoring provides an effective model for remote SSI surveillance.
 - Patients and carers broadly support remote wound monitoring, with some variation in preferences.
 - Multiple patient, procedural and system factors influence SSI risk after cardiac surgery.
 - International guidance highlights priorities for improving surgical wound complication management.
 - Rapid-response approaches (e.g. SWIFT models) can improve post-operative wound care delivery.
- *Candidozyma auris* and emerging pathogens
 - Key risk factors and transmission dynamics for *C. auris* are identified in acute hospital settings.
 - Wastewater surveillance can detect *C. auris* during outbreaks, complementing clinical screening.
- Diagnostics, AMR and bloodstream infection prevention
 - Blood culture diversion devices reduce contamination and improve patient safety, but face implementation barriers.
 - Carbapenem-resistant Enterobacterales remain present across UK healthcare and community settings.
 - Current AMR diagnostic approaches have important limitations, with new technologies offering future improvements.
- Environmental IPC and water safety
 - Remote water temperature monitoring supports safer water system management and ICU sink provision.
 - Environmental sampling shows air and surface contamination with monkeypox virus, reinforcing IPC precautions.
- Faecal microbiota transplantation (FMT) and gastrointestinal health
 - Global FMT use varies widely, highlighting the need for greater standardisation in practice and regulation.
 - The gut microbiome is central to MDRO colonisation and infection, offering potential targets for prevention.
 - Standardising donor screening is essential to improve safety and consistency in FMT programmes.
 - Screening FMT donors for *C. auris* should be considered given its emerging global importance.
 - FMT is feasible for reducing gastrointestinal carriage of antibiotic-resistant organisms, supporting further trials.
 - Lyophilised FMT capsules maintain microbial diversity and viability, supporting clinical use.

16 Annual plan

16.1 Objectives for 2025/26

Table 1. Objectives for 2025/26

Objective	Lead team
Delivering healthcare excellence	
Submit updated business case for a vascular access service for our Royal Brompton and Harfield sites.	VAS Lead
Review and update our Post Infection Review processes for HCAs across our sites in line with the new PSIRF framework.	IPN Team
Evaluate the impact of our “Every Device Journey Matters” campaign.	All
Evaluate the impact of our ‘Gloves Off’ campaign	All
Improving the health of our populations	
Continue to support sustainability initiatives.	All
Implement systematic measurement of compliance with our admission screening programme (e.g. for MRSA, <i>C. auris</i> , CPO) and improve compliance.	SIU
Continue to reduce prevalence of key antimicrobial-resistant microbes such as CPE, <i>C. auris</i> , and VRE.	IPN Team
Continue to embed equality and diversity monitoring in our SSI service and deliver solutions to improve health equity and fairness.	SSI
Focus on prevention of MRSA BSI, especially in patients known to be colonised, supported by the Trustwide MRSA BSI action plan.	All
Valuing all of our people	
Ensure that training and development opportunities are available and integrated into PDRs, including developing applied research skills.	All Managers
Continue with a programme of team development to address the feedback from the 2025 NHS staff survey.	All
Innovating for a better future	
Develop the functionality of Epic to implement semi-automated surveillance for HCAI.	SIU
Continue to undertake an epidemiological evaluation of the ongoing <i>C. auris</i> .	SIU
Strengthen links with the ACORN programme to provide applied research opportunities for the team.	All
Expand on the successful commercialisation of the Central Wound Hub model, establishing service level agreements with additional partner organisations.	SSI
Promote revenue-generating innovations developed by the SSI team, including the BHIS bra, the Isla SSI pathway, and CATS vests.	SSI
Deliver the ambitious SSI national research programme, which includes remote wound swabbing, interventions to reduce SSI, antibiotic-sparing innovations, and applications of AI.	SSI
Review new auditing platform for IPC	IPN Team
Begin to implement AI-enabled solutions to improve our surveillance systems for SSI and other HCAI.	SIU Lead
Modernising our infrastructure	
Support Estates to expand the provision of “Water-lite” care to improve our water hygiene risk management.	IPN Team

16.2 Updates on objectives from 2024/25

Table 2. Updates on IPC team objectives for 2024/25.

Objective	Update
Delivering healthcare excellence	
Finalise business case for a vascular access service for our Royal Brompton and Harfield sites.	Business case was finalised and submitted for consideration by the Trust Board.
Review and update our Post Infection Review process across our sites in line with the new PSIRF framework.	Initial scoping was undertaken, including comparison with approaches in different organisations; the MRSA BSI and <i>C. difficile</i> infection review processes were modified to meet current needs.
Complete the alignment of our policies and clinical procedures across our sites.	Completed
Implement a Trust wide improvement project, “Every Device Journey Matters”, to improve our care of vascular access devices and urinary catheters to reduce the risk of infection and other complications.	Completed
Actively promote our remote wound service which supports earlier discharges, optimised bed use, and reduced demand on clinical teams, to improve elective throughput.	Completed – a business case to support the continuation of the central digital wound hub was approved by the Trust Board.
Improving the health of our populations	
Continue to support sustainability initiatives (including the “Gloves Off” campaign, a transition to reusable sharps bins, and remote wound monitoring to reduce patient travel).	The IPC team has continued to support sustainability initiatives.
Implement systematic measurement of compliance with our admission screening programme (e.g. for MRSA, <i>C. auris</i> , CPO), and improve compliance.	A tool to monitor compliance with MRSA admission screening has been prioritised, developed, and tested and is awaiting implementation.
Bring ongoing outbreaks of <i>C. auris</i> , MRSA, and VRE under control.	Whilst the <i>C. auris</i> and VRE outbreaks continue, the number of new cases detected has reduced, and the MRSA outbreak in paediatrics has come to an end.
Continue to embed equality and diversity monitoring in our SSI service and deliver solutions to improve health equity and fairness.	Work has continued to ensure equality and diversity in the patients that we serve are reflected in solutions.
Valuing all of our people	
Ensure that training and development opportunities are available and integrated into PDRs, including developing applied research skills.	All staff have been encouraged to include their training and development needs into their PDRs.
Embed the learning from our civility training, the People Manager Programme, and discussions on anti-racism to improve our team performance.	We have continued to underline the importance of civility for all, and all managers have completed the People Manager Programme.
Implement a regular education session aimed at our clinical teams.	We have integrated our academic session into the wider Directorate of Infection academic session.
Innovating for a better future	
Develop the functionality of Epic to report on antimicrobial stewardship indicators.	Substantial development work has gone into improving the access to antimicrobial prescribing and stewardship data via Epic.
Undertake an epidemiological evaluation of the ongoing <i>C. auris</i> and CPE outbreaks.	An epidemiological evaluation of the <i>C. auris</i> and CPE outbreaks have been undertaken and published.

Review and evaluated innovate training support systems (e.g. virtual reality).	Several different innovative training approaches have been reviewed but none implemented.
Strength links with the ACORN programme to provide applied research opportunities for the team.	We continue to support staff to develop their research skills and seek research opportunities.
Review opportunities for income generation from the services we provide.	The clinical digital wound hub has continued to go through a process of commercialisation.
Expand on the successful commercialisation of the Central Wound Hub model, establishing service level agreements with additional partner organisations.	Completed
Promote revenue-generating innovations developed by the SSI team, including the BHIS bra, the Isla SSI pathway, and CATS vests.	This work has continued
Deliver the ambitious SSI national research programme, which includes remote wound swabbing, interventions to reduce SSI, antibiotic-sparing innovations, and applications of AI.	The SSI national research programme has continued to deliver.
Modernising our infrastructure	
Ensure that Buggy, the IPC module in Epic, is optimised and its use is standardised across our sites.	Buggy is now stabilised and supporting our clinical activities across the Trust.
Begin to implement AI-enabled solutions to improve our surveillance systems for SSI and other HCAI.	Several different novel tools to maximise our use of data to support clinical services have been implemented.

16.3 GSTT IPC Strategic Objectives (2026–2030)

1. Deliver world-class infection prevention outcomes

Mapped to: Delivering healthcare excellence

Strategic alignment: Supports the Trust ambition to deliver safe, effective, high-quality care and continuous improvement in clinical outcomes.

Objective: Position GSTT as one of the safest NHS organisations for healthcare-associated infections through sustained reduction in HCAs and consistent excellence across all sites.

Key focus areas:

- Achieve and sustain low rates of MRSA BSI and further reduce *C. difficile* and Gram-negative BSI below national thresholds.
- Deliver speciality-specific improvement programmes (e.g. SSI reduction in orthopaedics, cardiac, vascular).
- Embed continuous quality improvement using data-driven IPC dashboards and surveillance systems.
- Strengthen outbreak prevention and response capability, building on learning from large-scale events (e.g. *C. auris*).

2. Shift IPC from reactive control to preventive population health

Mapped to: Improving the health of our populations

Strategic alignment: Aligns with the Trust's shift towards prevention, population health, and reducing health inequalities.

Objective: Extend IPC impact beyond hospital settings to reduce infection risk across pathways, populations, and communities.

Key focus areas:

- Target high-risk pathways (e.g. device-related infections, antimicrobial exposure, vulnerable populations).
- Partner with ICS and community services to reduce HCAI risk across care interfaces.
- Use surveillance data to identify inequalities in infection risk and target interventions accordingly.
- Support prevention through “Every Contact Counts” type approaches (e.g. vaccination, device stewardship).

3. Build a high-performing, embedded IPC workforce and culture

Mapped to: Valuing all of our people

Strategic alignment: Supports the Trust priority of developing, supporting and retaining a skilled, engaged workforce.

Objective: Develop an organisation-wide IPC culture where safe practice is owned by all staff and supported by a skilled, modern IPC workforce.

Key focus areas:

- Strengthen and modernise the IPC link practitioner network.
- Improve training quality and impact beyond compliance metrics (currently high completion rates at 96%).
- Embed human factors and behavioural approaches to improve reliability in IPC practices.
- Support workforce development in digital, data science, and advanced IPC roles.

- Continue to attract the best to join the IPC team.

4. Lead innovation in digital, data-driven IPC

Mapped to: Innovating for a better future

Objective: Establish GSTT as a national leader in digitally enabled IPC, using Epic and advanced analytics to transform surveillance, prediction, and response.

Strategic alignment: Directly supports the Trust ambition to harness technology, data and AI to improve care and drive innovation.

Key focus areas:

- Stabilise and optimise IPC functionality within Epic (addressing current limitations such as Buggy).
- Develop real-time, automated surveillance and alerting systems.
- Expand use of AI and advanced analytics to predict outbreaks and guide interventions.
- Use integrated data to support research, innovation, and system-wide learning.

5. Ensure safe, sustainable environments and infrastructure

Mapped to: Modernising our infrastructure

Strategic alignment: Supports Trust priorities to modernise infrastructure, reduce risk, and improve environmental sustainability and resilience.

Objective: Deliver resilient, safe, and sustainable healthcare environments that minimise infection risk across all estates and infrastructure.

Key focus areas:

- Strengthen assurance and operational delivery of water safety (identified as a key risk).
- Embed infection prevention into estate redevelopment, ventilation upgrades, and capital programmes.
- Support sustainable IPC approaches aligned with net zero ambitions.
- Improve reliability of decontamination, sterile services, and environmental hygiene systems.

6. Lead applied IPC research and translation into practice

Mapped to: Innovating for a better future

Strategic alignment: Supports the Trust ambition to be a world-leading academic health science centre delivering translational research, innovation, and data-driven improvement in care.

Objective: Position GSTT as a leading centre for applied IPC research, rapidly translating evidence into practice to improve patient outcomes locally and nationally.

Key focus areas:

- Deliver high-impact applied research programmes (e.g. CPE, *C. auris*, SSI, environmental microbiology, digital IPC, AMR), building on current NIHR and other academic partnerships.
- Embed “research to practice” pipelines so that new evidence is rapidly implemented through improvement programmes and clinical pathways.
- Expand use of routinely collected data (Epic, surveillance systems) to support real-world evidence generation and evaluation.
- Strengthen multi-professional research engagement across IPC, nursing, medical and AHP teams.
- Scale innovation through partnerships with academia, industry and ICS networks to influence practice beyond GSTT.