



Infection Prevention and Control Annual Report 2025-2026



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1. Executive Summary

Six [6] cases of Trust apportioned MRSA bacteraemia were reported against a trajectory of zero for the period of 2025/2026. This is an increase of 1 case compared to the 2025/26 period. Of the 6 cases, there 3 Hospital Onset Healthcare Associated (HOHA) and 3 Community Onset Hospital Associated (COHA) case. A targeted deep dive was undertaken [[Appendix 5: 2025/26 Healthcare Associated MRSA Bacteraemia Summary](#)].

There were 58 Trust apportioned *Clostridioides difficile* Infection (CDI) cases against a threshold of 33 for the 2025/26 financial year. Of the 58 cases, 47 were HOHAs and 11 were COHAs. This is a decrease of 5% in comparison to 61 Trust apportioned cases for the year 2024/25. This is against a background of a national increase in incidence. 3 lapses in care were identified, related to antibiotic choice and duration of dose. A deep dive was undertaken [[Appendix 3: Deep Dive of 2025/26 Trust Attributed *Clostridioides Difficile*](#)].

97 Trust attributed *E. coli* bacteraemias were reported from April 25 – March 26 against a threshold of 99. This is a decrease of 17% in Healthcare associated cases in comparison with the previous year's 117 cases and a 23% reduction when compared to 127 healthcare associated bacteraemias for 2025/26. There were 322 Community Associated *E. coli* bacteraemia, an increase of 21% in comparison with the previous year's 266 cases.

There were 31 cases of *Klebsiella spp.* Bacteraemias against an annual threshold of 47. This is a 38% reduction in comparison to the 50 healthcare associated cases that occurred the previous financial year and fell well below the target of 47.

26 Healthcare associated *Pseudomonas aeruginosa* bacteraemias were reported against an annual threshold of 20 cases. However, this was a decrease of 4% when compared with the 27 cases reported the previous financial year.

The Infection Prevention and Control Team continue to support the Trust in their response to rising Gram negative resistance, new and emerging infections such as *C. auris*, along with the national outbreak of measles and increased prevalence of Legionella and new and emerging viral haemorrhagic fevers.

Six [6] COVID-19 clusters were identified (two [2] at Chelsea, four [4] at West Middlesex); patient flow and business continuity were sustained through timely testing, isolation, and effective IPC and divisional oversight.

Three Norovirus outbreaks were identified (two [2] at Chelsea, one [1] at West Middlesex), resulting in full and partial ward closures; however, patient flow and business continuity were sustained through effective operational management and prioritisation by clinical and support teams.

The Trust's average hand hygiene compliance score was 98.67% compared to a target of 95.0% and an overall percentage completion of 99.4%.

Surveillance of surgical site infection (SSI) was undertaken for total hip replacement and knee surgery during this period across both sites; participation for 1 quarter of an orthopaedic module is mandated by the Department of Health. From April 2025 – March 2026, a total of 479 procedures were captured through surveillance (252 at Chelsea and Westminster Hospital; 227 at West Middlesex Hospital). Five confirmed SSIs



were identified overall (3 at Chelsea and Westminster Hospital; 2 at West Middlesex Hospital). Post-discharge surveillance (PDS) response rates remained consistently strong at >90% across completed quarters, demonstrating excellent patient engagement with follow-up processes

The Trust Antimicrobial Stewardship service continues to provide real-time feedback on all in-patients treated for bacterial or fungal infection at CWFT. The AMS pharmacy team have undertaken over 25,000 reviews of antimicrobials of admitted patients since April 2025 as part of the active antimicrobial stewardship program. This provides oversight on all in-patients managed for infection (bacterial, fungal and COVID-19) and supports the Trust in successfully achieving the national AMS targets, and NHSE contract requirements for reducing antimicrobial prescribing.

2. Introduction

This is the Chelsea and Westminster Hospital NHS Foundation Trust annual report of the Director of Infection Prevention and Control (DIPC) for the period 1 April 2025 to 31 March 2026. The report provides assurance to the Board, commissioners, regulators, and stakeholders that effective systems, processes, and leadership arrangements are in place to prevent and control infection, in line with the Health and Social Care Act 2008, the Code of Practice on the prevention and control of infections and related guidance (2022), and the National Infection Prevention and Control Manual for England.

The report outlines the work undertaken by the Infection Prevention and Control Team (IPCT) to identify, assess, and mitigate infection risks, ensure compliance with national standards, and promote a culture of safety, learning, and continuous improvement. It highlights the Trust's approach to leadership, assurance, and oversight of IPC activity, including the use of surveillance data, audits, and incident reviews to inform decision-making and drive improvement.

The report includes an overview of:

- The IPCT annual programme of work and its alignment with Trust priorities and regulatory requirements
- Mandatory surveillance and performance against national and local targets, providing assurance on patient safety
- Governance and management of incidents and outbreaks, including seasonal influenza
- Assurance from hand hygiene, personal protective equipment (PPE), and infection prevention and control high-impact intervention audits
- The Surgical Site Infection surveillance programme and associated improvement actions
- Education, training, and leadership development, including the role of IPC link professionals
- Antimicrobial stewardship arrangements supporting safe and effective care
- Management and learning from body fluid exposure incidents
- Decontamination and cleaning assurance arrangements
- Contributions from hard services in maintaining a safe care environment



3. Mandatory Reporting

Report written by Zara Tzouros, IPC Data Manager

The Trust is required to report the healthcare associated infections outline in Figure 1 (below) to UKHSA. Cases are apportioned into the following 3 categories based on data submitted.

- **Hospital-onset healthcare-associated (HOHA):** cases that are detected in the hospital two or more days after admission.
- **Community-onset healthcare-associated (COHA):** cases that occur in the community (or within two days of admission) when the patient has been a recent discharge from the reporting organisation with 28 days of their positive blood culture.
- **Community-Onset Community-associated (COCA):** cases that occur in the community with no patient history of a recent admission.

Analysis and review of all Trust attributed cases is conducted monthly.

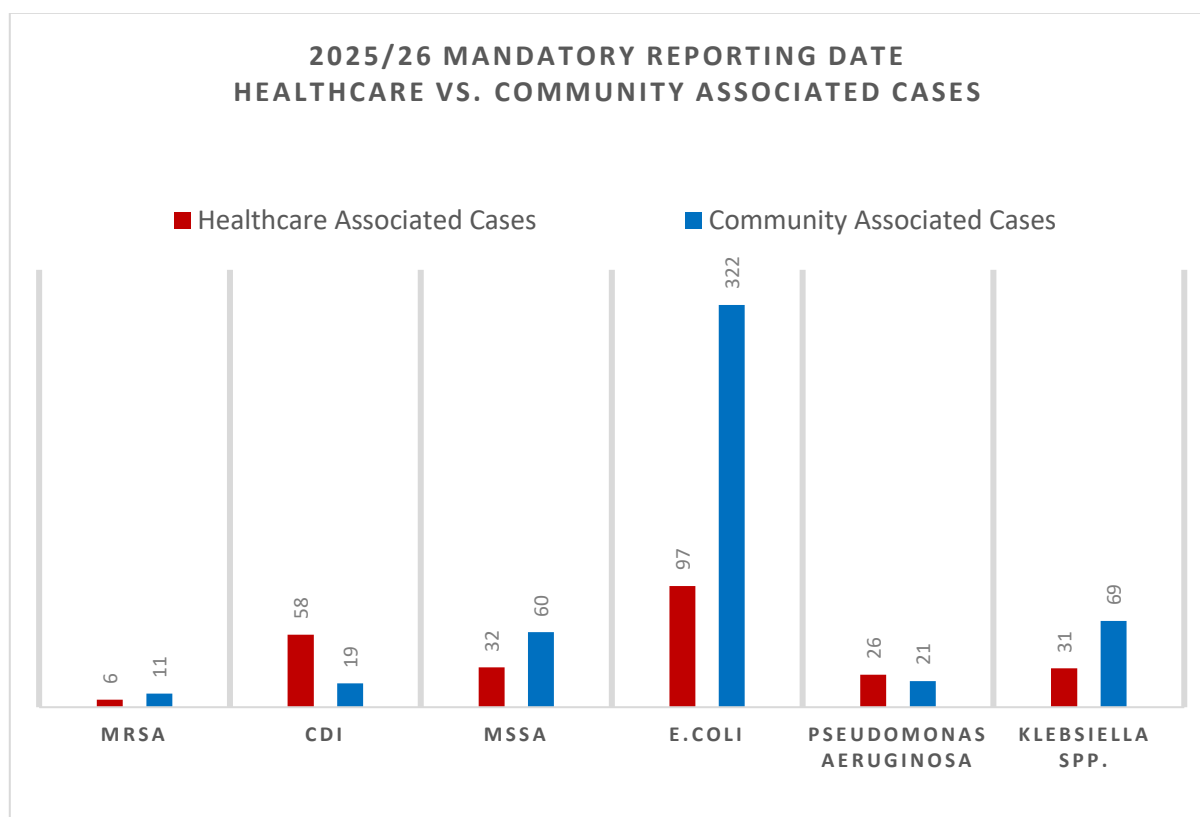


Figure 1: 2025/26 Mandatory Data Trust vs. Community Associated Cases

3.1. *Clostridioides difficile* Infection (CDI)

Trust apportioned *Clostridioides difficile* cases include:

- **Hospital-onset healthcare-associated (HOHA):** cases that are detected in the hospital two or more days after admission.



- **Community-onset healthcare-associated (COHA):** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks.

There were 58 Healthcare Associated CDI cases against a Target of 33. This is a decrease of 5% in comparison to 61 Trust apportioned cases for the year 2024/25. This is against a background of a national increase in incidence.

There were 19 cases of Community Associated CDI, a decrease of 44.1% decrease in comparison with the previous financial year, where 34 Community Associated cases were reported.

A PSIRF of each Trust apportioned case is initiated by the IPCT and senior medical and nursing staff caring for each patient. Action plans are subsequently developed to address lessons learnt which are monitored at Trust quality and risk meetings and learning highlighted at IPCG and the Patient Safety Committee.

A *Clostridioides difficile* Deep Dive was conducted for 2025/26 [[Appendix 3: Deep Dive of 2025/26 Trust Attributed *Clostridioides Difficile*](#)] which summarises learning.

3.2. **Meticillin Resistant *Staphylococcus Aureus* (MRSA) Bacteraemias**

There were a total of 6 Trust apportioned MRSA bacteraemias from April 2025 – March 2026 against a target of zero, an increase on 2024/25's 5 Healthcare Associated cases.

Of these six cases:

- 3 cases occurred at CWH and 3 at WMH.
- All cases occurred on different wards and were split across the divisions: 3 cases occurred in the Emergency and Integrated Care division (EIC), 1 in Planned Care (PC) and 2 in Specialist Care (SC) divisions.
- 3 cases were categorised as COHA, and 3 cases were categorised as HOHA.
- 3 of the cases were admitted with symptoms of bacteraemia and classified as healthcare associated due to a recent admission. PSIRF meetings concluded that the bacteraemias were unavoidable.
- 2 MRSA colonisations were Healthcare Associated acquisition occurring within a range of 25 – 37 days post admission.
- 1 patient was blood culture positive before the NAG result resulted and previously MRSA negative.
- 1 patient was deemed unsuitable for de-colonisation due to a large chronic leg wounds as per MRSA policy.
- 2 patients met the criteria for and received decolonisation.

There were 11 MRSA Community associated cases, a slight increase on the previous financial year's 10 cases. See [[Appendix 5: 2025/26 Healthcare Associated MRSA Bacteraemia Summary](#)] for a deep dive summary report of the MRSA bacteraemia cases.

3.3. **Meticillin Sensitive *Staphylococcus Aureus* (MSSA) Bacteraemias**

There were 32 cases of Healthcare Associated MSSA bacteraemia, an increase of 10% on last year's 29 cases and 60 community associated cases.



No upper limit has been currently set for this organism.

3.4. *E. coli* Bacteraemias

From April 2025 – March 2026, there were 97 cases of Healthcare associated *E. coli* bacteraemia against a target of 99. This is a decrease of 17% in Healthcare associated cases in comparison with the previous year's 117 cases (see [\[Appendix 2: IPC Data \(Figure 27- Figure 68\)\]](#)) for summary data.

There were 322 Community Associated *E. coli* bacteraemia, an increase of 21% in comparison with the previous year's 266 cases.

3.5. *Klebsiella* Spp. Bacteraemias

There were 31 cases of Healthcare associated *Klebsiella* spp. bacteraemia, this is a notable decrease of 38% in comparison to the 50 healthcare associated cases that occurred the previous financial year and fell well below the target of 47 Healthcare Associated cases set for the organisation.

From April 2025 – March 2026 there were 69 community associated cases (see [Appendix 2: IPC Data \(Figure 27- Figure 68\)](#) for summary data). A decrease of 12% in comparison to the previous year's 78 community associated cases.

3.6. *Pseudomonas aeruginosa* Bacteraemias

There were 26 cases of Healthcare associated *Pseudomonas aeruginosa* bacteraemia, against a target of 20. This was a decrease of 4% when compared with the 27 cases reported the previous financial year.

There were 21 community associated cases, an increase of 61% in comparison to the 13 cases the previous financial year.

3.7. Surgical Site Infection (SSI) Surveillance

Report written by Magno Castillo, IPC Surveillance Officer

Overview (April 2025 – March 2026)

In accordance with the UK Health Security Agency (UKHSA) SSI surveillance requirements, the Infection Prevention and Control (IPC) Surveillance Team participated in mandatory SSI surveillance for Total Hip Replacement (THR) and Total Knee Replacement (TKR) procedures across Chelsea and Westminster Hospital and West Middlesex Hospital during April 2025 to March 2026 (as at 31/03/26).

Across the reporting year, a total of 479 procedures were captured through surveillance (252 at Chelsea and Westminster Hospital; 227 at West Middlesex Hospital). Five confirmed SSIs were identified overall (3 at Chelsea and Westminster Hospital; 2 at West Middlesex Hospital). Post-discharge surveillance (PDS) response rates remained consistently strong at >90% across completed quarters, demonstrating excellent patient engagement with follow-up processes.

Detailed Summary



Chelsea and Westminster Hospital completed surveillance work for 252 elective orthopaedic procedures during 2025–2026 period, comprising of 124 hip and 128 knee replacements. Three confirmed surgical site infections were identified across the year—one in Q1 following a TKR procedure and two in Q2 following THR procedure wherein all required operative management and antibiotic therapy. The completed RCAs for both cases found no lapses in care.

No infections were reported in Q3 or Q4, reflecting a sustained period of stability. Surveillance processes remained strong, with >90% PDS response rates in Q1, Q2 and Q3 and timely submissions to UKHSA. Q4 data collection was completed as scheduled, with reconciliation and final submission progressing to plan.

Although there were several SSI incidents, the monitoring works remains up to standard, with high-quality data completeness, and effective governance oversight that supports continued assurance in the safety and reliability of orthopaedic surgical pathways.

The West Middlesex Hospital site recorded 227 orthopaedic procedures (88 hips, 139 knees) under the national SSI programme. Two SSIs were identified across the year.

The first infection occurred in Q1 following a total hip replacement and required surgical and antibiotic management. An RCA completed in October 2025 found no lapses in care. The second case, identified in Q3, followed a primary total knee replacement and was managed as a deep SSI. RCA is being arranged and will be done as soon as a schedule is finalised. No confirmed infections were reported in Q2 and Q4.

Due to an increase in infections, the IPC team and stakeholders, conducted a comprehensive deep-dive analysis to better understand the situation and potential for intervention. The review focused on identifying the root causes behind the increase, assessing operational and environmental factors that may have contributed, and evaluating the effectiveness of the current mitigation measures.

Through this process, data trends were examined with frontline feedback, and compliance levels reviewed across key areas. The IPC team also explored opportunities to strengthen the response, including reinforcing existing protocols, enhancing communication, and implementing targeted interventions where necessary.

The deep-dive provided clearer insights and more informed foundation for decision-making to support better practice and prevent further infections.

Data submission performance remained strong throughout the year. Q1, Q2, Q3 and Q4 datasets were fully collected, reconciled, and submitted within required deadlines, each with PDS response rates above 90%.

Overall, although an increase in infection rate was observed, the IPC team demonstrated timely data management, robust clinical engagement, and structured review processes, which continued to provide strong assurance and drive ongoing learning.

Table 1: CWFT Joint SSI Surveillance Data – Total Hip Replacement

Total Hip Replacement (THR)				
Surveillance Period	Number of Procedures	Number of Infections	Hospital % Infections	National Average
Apr – Jun 2025	42	2	5.0%	0.3%
Jul – Sep 2025	51	0	0.0%	
Oct – Dec 2025	72	0	0.0%	
Jan – Mar 2026	47	0	0.0%	

Total	212	2	0.95%	
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Table 2: CWFT Joint SSI Surveillance Data – Total Knee Replacement

Total Knee Replacement (TKR)				
Surveillance Period	Number of Procedures	Number of Infections	Infections rate %	National Average
Apr – Jun 2025	64	0	0.0%	0.2%
Jul – Sep 2025	69	2	2.9%	
Oct – Dec 2025	73	1	1.3%	
Jan – Mar 2026	61	0	0.0%	
Total	267	3	1.13%	

4. Hand Hygiene

Report written by Zara Tzouros, IPC Data Manager

Hand hygiene is a key priority within the organisation. Monthly audits of hand hygiene compliance are conducted and reported to the Infection Prevention and Control Group (IPCG).

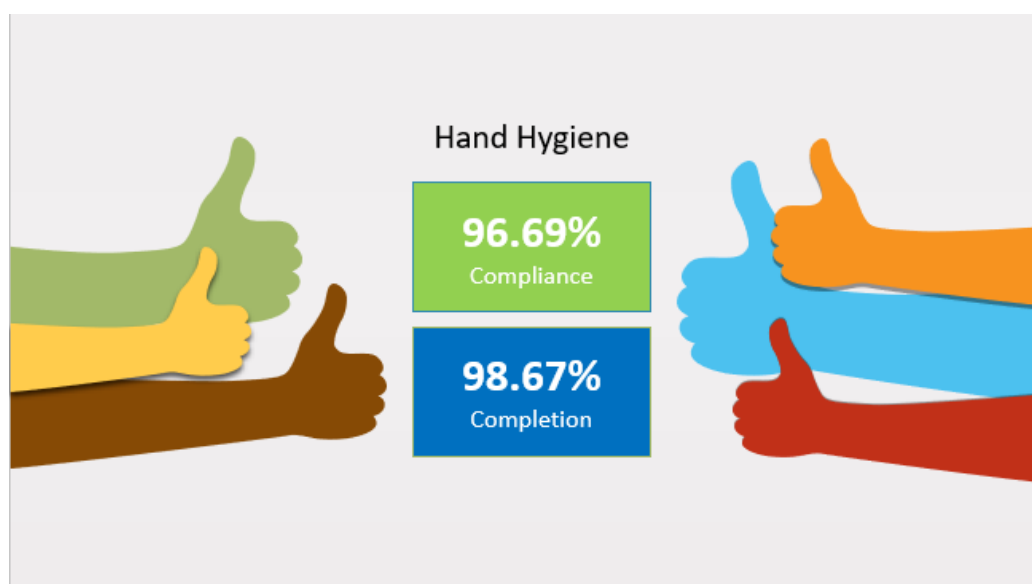


Figure 2: Hand hygiene audit completion and compliance (presentationgo.com)

From April 2025 – March 2026, 98.67% of hand hygiene audits were completed for the Trust and the mean hand hygiene compliance rate was 96.69% [2025 Hand Hygiene Audit Data].

5. Infection Prevention and Control Audits

Report written by Zara Tzouros, IPC Data Manager

Infection Control Link Professionals (ICLPS) continue to audit peripheral venous catheters (PVC), urinary catheters (UC) and central venous catheters (CVC) and Personal Protective Equipment (PPE) audits on a monthly basis, using a care bundle process. This process is an evidence-based approach to clinical interventions which when implemented consistently, reduces variation and the risk of infection.



Both sites audit electronically, via Survey Monkey.

Below are the average compliance scores for 2025/2026:

- PVC: 93.93%
- CVC: 98.20%
- Paediatrics CVC: 98.0%
- UC: 96.08%
- PPE: 95.51%

During April 2025 – March 2026, divisional triumvirates continued to receive a divisional dashboard, developed to allow them oversight of their audit data in order to improve on the IPC performance figures, with feedback received at the monthly IPCG [Divisional IPC Metrics]. Trust apportioned bacteraemias and CDI cases are also included to facilitate further monitoring, oversight and divisional review.

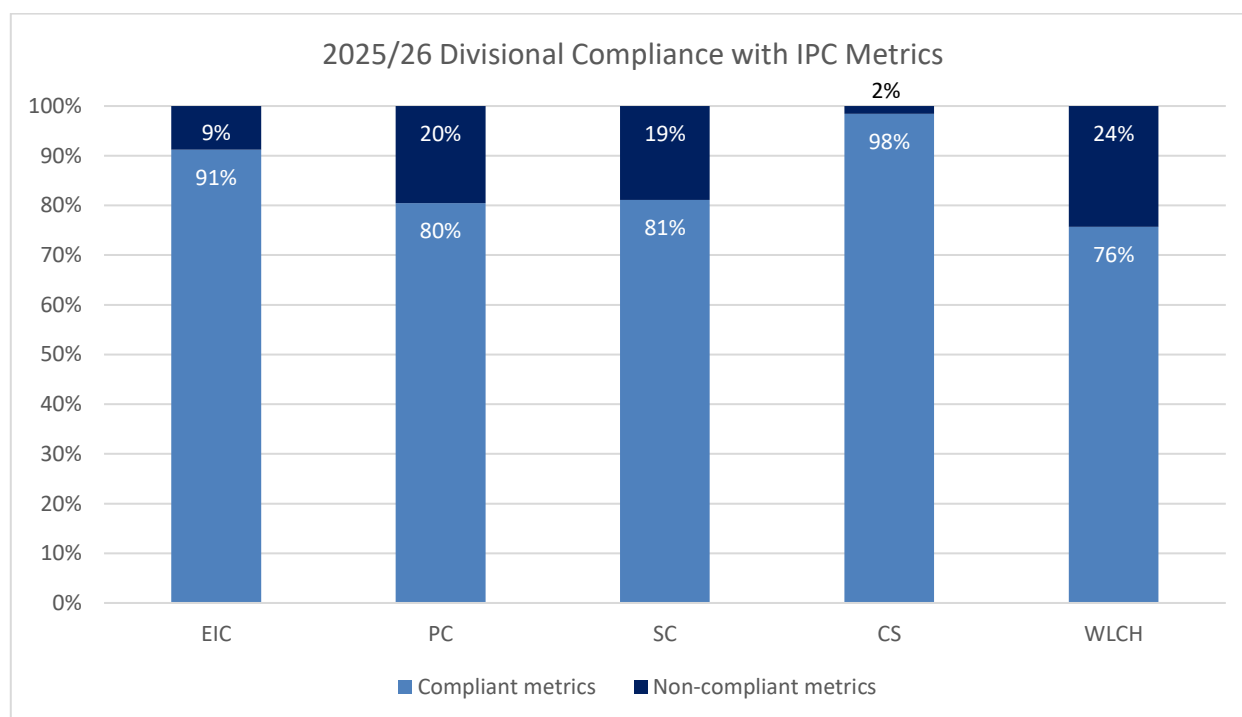


Figure 3: 2025/26 Compliant vs. Non-compliant IPC metrics per Division

Compliance with IPC metrics has improved in Emergency and Integrated Care and Clinical Support divisions by 3% and 1% respectively in comparison to the previous financial year.

Planned Care, Specialist Care and West London Children's healthcare saw notable declines in IPC compliance scoring 80%, 87% and 76% compliance respectively. Each division is held to account at the IPCG and data presented at the Patient Safety Meeting with action plans required for improvement.

5.1. IPCT Validation Audits

In September 2025, the Infection Prevention and Control Team (IPCT) introduced validation audits to provide additional assurance that ward-led hand hygiene and High Impact Intervention (HII) audits were being completed accurately and reflected actual practice. The validation process focused on clinical areas identified as higher risk due to recent infection prevention concerns or incidents. Targeted areas included



the Acute Assessment Unit (AAU) following increased rates of healthcare-associated *Clostridioides difficile* infection (CDI) identified in December 2025, Burns and Intensive Care Unit (ICU) areas in response to concerns regarding possible cross transmission of *Candidozyma auris* and Nell Gwynne Ward following an avoidable MRSA bacteraemia.

These validation audits aimed to strengthen audit reliability, identify any discrepancies between reported and observed compliance and support targeted improvement actions within high-risk clinical environments [Appendix 7: IPCT Validation Audits Jan – Mar 2026].

The audits remain ongoing as part of the Trust's assurance and quality improvement processes with an annual validation audit plan developed to ensure continued oversight of high-risk and priority clinical areas. Feedback is provided at ward level at the time of auditing, and a summary is emailed to the clinical areas, a summary is also provided at the monthly IPCG.

The IPCT supported ward accreditation audits across both sites, providing assurance of IPC compliance through assessment of key domains including staff practices, hand hygiene, patient screening, isolation precautions, environmental standards, equipment cleanliness, linen management, and supply availability. Findings demonstrated sustained compliance with IPC practices and appropriate infrastructure and resource provision to support safe care delivery.

A targeted environmental audit programme was conducted to provide assurance that key controls to minimise healthcare-associated infection (HCAI) risks are in place and consistently monitored. The programme supports proactive risk mitigation, strengthens compliance, and sustains safe, clean, and well-managed care environments through regular surveillance and monthly assessments across both sites, including oversight of infrastructure and adherence to core IPC practices.

6. Screening For Carbapenemase-Producing *Enterobacterales* (CPE)

Report written by Zara Tzouros, IPC Data Manager

A Carbapenem Resistant Organism (CRO) risk assessment is advised for all patients on admission to the Trust in line with national guidance; this identifies patients that require screening for CRO and that are at high risk of carrying carbapenemase producing *Enterobacterales* (CPE). Patients are also screened on admission to ITU and NICU and weekly during their augmented care stay.

From April 2025– March 2026 there were a total of 100 newly identified cases of CPE, 56 at the CWH and 41 cases at WMH (see [CPE Surveillance] for CPE matrix and Mechanism of resistance data), 3 cases were identified at other organisations and the IPC team notified of the case and tagged on Cerner/ICNet to ensure relevant precautions were utilised in future admissions. This is a decrease of 20% in comparison to the 2024/2025 FY total of 125 new cases of CPE.

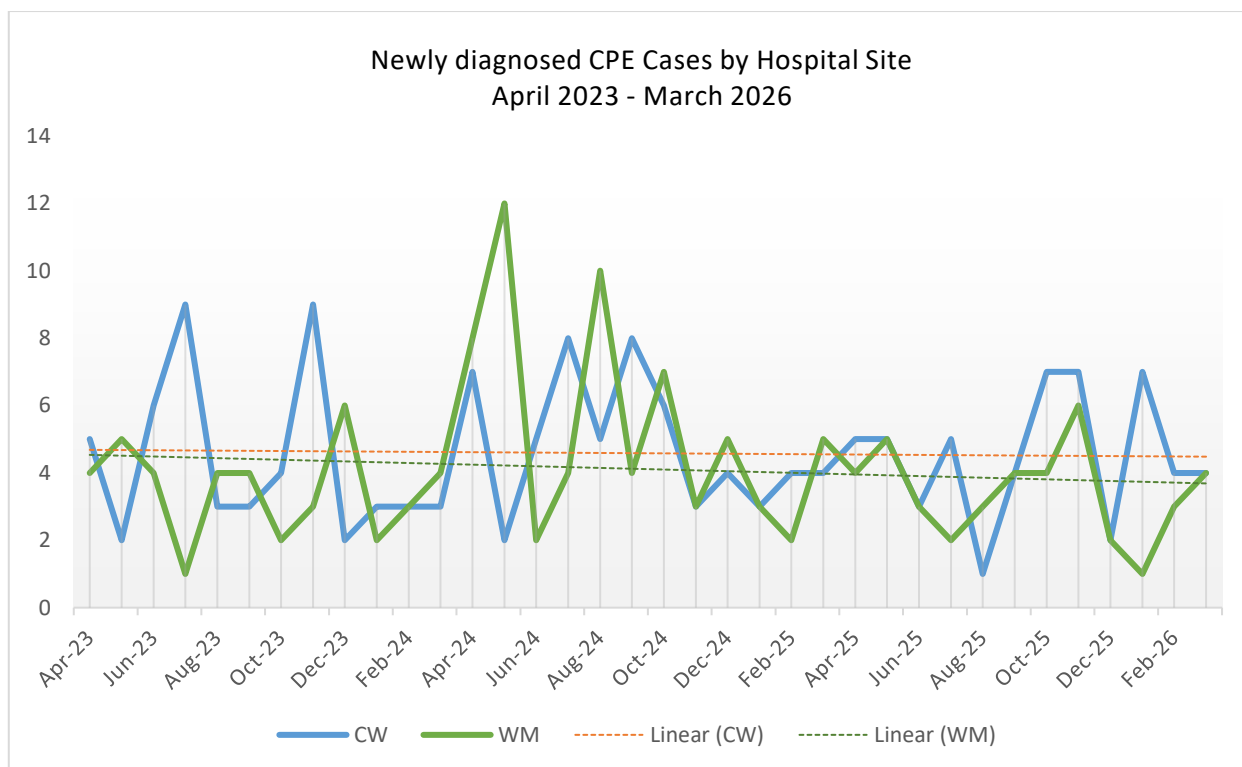


Figure 4: CWFT 2025/26 CPE Surveillance of New Cases

7. Emerging Infections / Horizon Scanning

Report written by Dr Nabeela Mughal, Director of IPC

The IPC team have been responsive and actively involved in implementing all UK Health Security Agency (UKHSA) guidance as published to keep patients, visitors and staff safe. This is delivered actively through review and update of existing guidelines and publishing new guidelines with emerging disease and threats, along with review of patient pathways, Trust wide communications/webinars, updated communication bulletins and updated training content.

The Trust managed and led a sector wide response to a national measles incident with exemplar contact tracing and management of cases supporting community and UKHSA teams. The learning was shared internationally at the Federation of Infection Conference in December 2025.

Significant updates to guidance published by UKHSA in 2025/26 have included new *C.auris* guidance for NHS Trusts- an emerging multi-drug resistant fungal pathogen with outbreak concern, updates secondary to a *Neisseria meningitidis* outbreak nationally, changes to Mpox guidance, alerts related to Marburg and other evolving Viral haemorrhagic fevers, Legionella outbreaks, Listeria and contaminated baby formula at national and international level, all of which have been cascaded to clinical colleagues, estates and pharmacy to ensure safety around use of the PPE, appropriate isolation, testing, clinical management and review and withdrawal of products.

The IPC team managed two *C. auris* incidents with containment of spread including in a tertiary burns' unit, with management complemented by UKHSA. The IPC team led on the introduction of a rapid *C. auris* PCR to expedite testing, isolation, management, prioritisation of side room resources and patient flow across the organisation.



Updates to the Trust respiratory pathways were made to reflect a change in diagnostic platform and implement targeted testing of patients presenting with or developing respiratory symptoms, moving away from universal testing, including in augmented care areas. Pathways also included updated guidance on isolation and patient management. The IPC team continued to manage clusters/outbreaks and to identify contacts of patients with influenza and COVID-19 in need of testing and monitoring as a precautionary measure to facilitate early identification, isolation and management.

The team has, and will continue to, promote standard infection control and transmission-based precautions, in line with national IPC guidance, to provide on-going safe care for patients, visitors and staff at all times.

Collaborative working across ICS and APC

The IPC team continue to work closely with Northwest London (NWL) Integrated Care System (ICS) AMS programme and the Acute Provider Collaborative (APC). CWFT actively contribute to the group and APC providers to improve IPC practice, share learning and improvements with the group led by the CWFT DiPC, standardising MRSA screening, leading on *C. auris* PCR introduction and sharing outbreak management to ensure safety across the sector and improving IPC audit practice.

8. Seasonal Influenza

Report written on behalf of influenza strategy group

Chelsea and Westminster Hospital NHS Foundation Trust commenced its seasonal influenza planning programme in July 2025, informed by learning from the 2024–25 flu campaign, including the benefits of early planning and timely provision of vaccines and educational resources. Oversight was provided through a multidisciplinary Strategic Flu Planning Group, chaired by the Director of Infection Prevention and Control (IPC), with representation from IPC, microbiology, nursing, clinical divisions, maternity, pharmacy, communications, and cross-site medical directors. Fortnightly governance meetings were established from September 2025 to support delivery, oversight, and assurance. Vaccination of maternity staff commenced on 1 September 2025, with formal campaign launch events delivered across both Trust sites on 6th October 2025.

The Trust achieved an overall influenza vaccination uptake of 44.97%, representing an 8.5% increase compared to the previous year and meeting the NHS England target for the 2025/26 season. This performance placed the Trust as the fourth-highest performing acute trust in London, behind:

Kingston & Richmond	46.4%
Kings	46.3%
Homerton	46.3%

Within Northwest London, CWHFT achieved the highest rate ahead of:

London Northwest	42.4%
Imperial College Healthcare	37.5%
Hillingdon	34.3%

Successful strategies included:

- Peer vaccinators were consistently identified as the most effective driver of vaccination uptake, particularly where staff were vaccinated by colleagues they knew and trusted.



- Vaccination clinics were initially delivered daily across both Trust sites before transitioning to more targeted and roving models, supported by clinical divisions, to maximise accessibility and uptake.
- High visibility of clinics within atriums and ward areas was highlighted by staff as having a positive impact on engagement.

The communications approach was also identified as a key success, with clear messaging focused solely on influenza (with no COVID-19 vaccination), increased use of video and social media, local staff featuring in London-wide campaigns, and targeted media engagement, including Radio Jackie. The publication and sharing of a comprehensive list of peer vaccinators with contact details was reported to further support accessibility and uptake.

Good practice examples included Paediatrics vaccinating newly qualified nurses and students on their first day of employment; targeted attendance at medical and surgical handovers to maximise staff reach; strong cross-divisional collaboration to support vaccine ordering and minimise wastage; and the delivery of high-profile “Big Bang” launch events at the start of the influenza season.

Whilst data demonstrated a significant improvement in influenza vaccination uptake, a number of areas for further improvement were identified. These included:

- the need for earlier and more robust engagement of peer vaccinators
- more varied messaging, including emphasis on protection of patients and family members
- greater involvement of influential consultants to support education and engagement
- increased availability of out-of-hours vaccination sessions
- clearer communication regarding vaccine effectiveness
- the use of staff flu experience stories to strengthen communications

In addition, timely testing of patients presenting with respiratory symptoms using rapid PCR was identified as an area for continued focus to reduce the risk of cross-transmission to patients and staff.

Table 3: Influenza staff vaccination rate for 2025-2026.

Divisional Metrics			
Division	Eligible Staff	Flu Immunised	Rate
Corporate	773	243	31.44%
Clinical Support	1400	483	24.50%
Emergency and Integrated Care	1775	770	43.38%
Planned Care	1386	515	37.16%
West London Childrens	459	177	38.56%
Specialist Care	1736	582	33.53%
Trust Total	7529	2770	36.79%
Site Based			
Site Based	Eligible Staff	Flu Immunised	Rate
Chelsea	4852	1790	36.89%
West Middlesex	2679	981	36.62%



National Metrics (Full Access to Health Records)			
Site Based	Eligible Staff	Flu Immunised	Rate
CWFT	4861	2186	44.97%
NWL Position	36046	14263	39.57%
London Position	191718	75377	39.32%

Figure 5: CWFT Seasonal Influenza Surveillance 2025/26Figure 5 below illustrates Influenza A and Influenza B positivity demonstrating a peak for Influenza A in December 2025 whilst Influenza B remains low throughout except in April 2025. These align with both regional data [Figure 6 and Figure 7] and national [Figure 8] below.

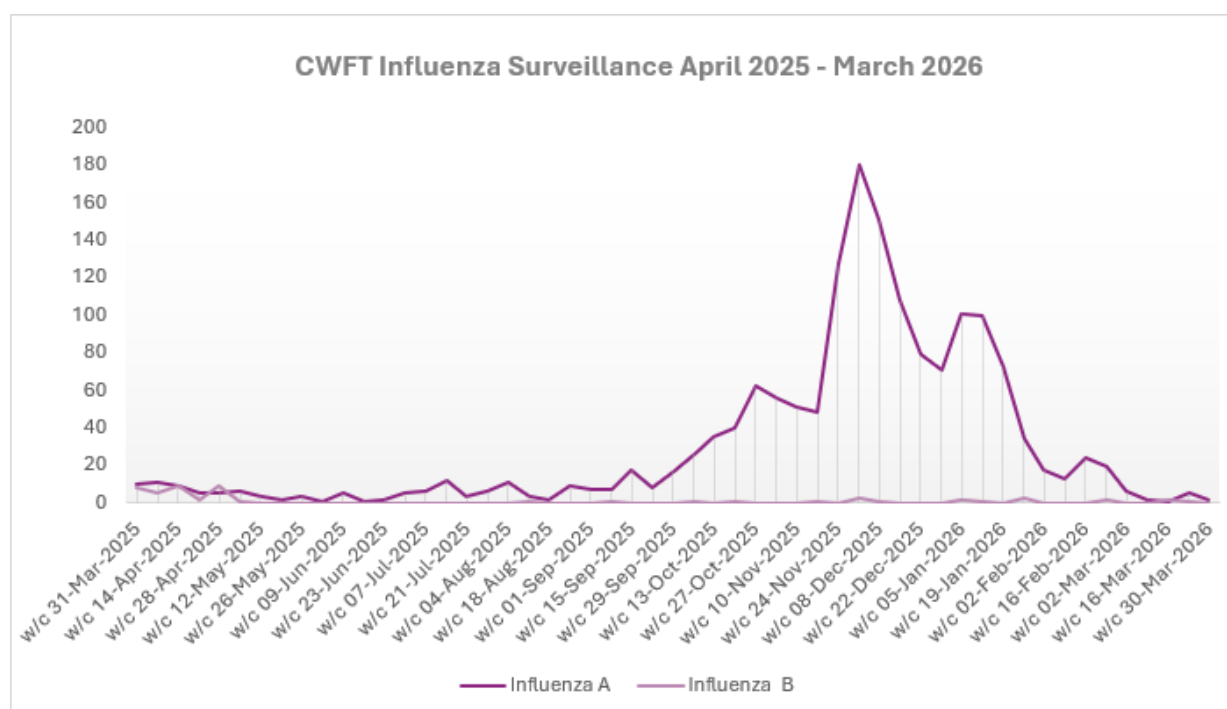


Figure 5: CWFT Seasonal Influenza Surveillance 2025/26

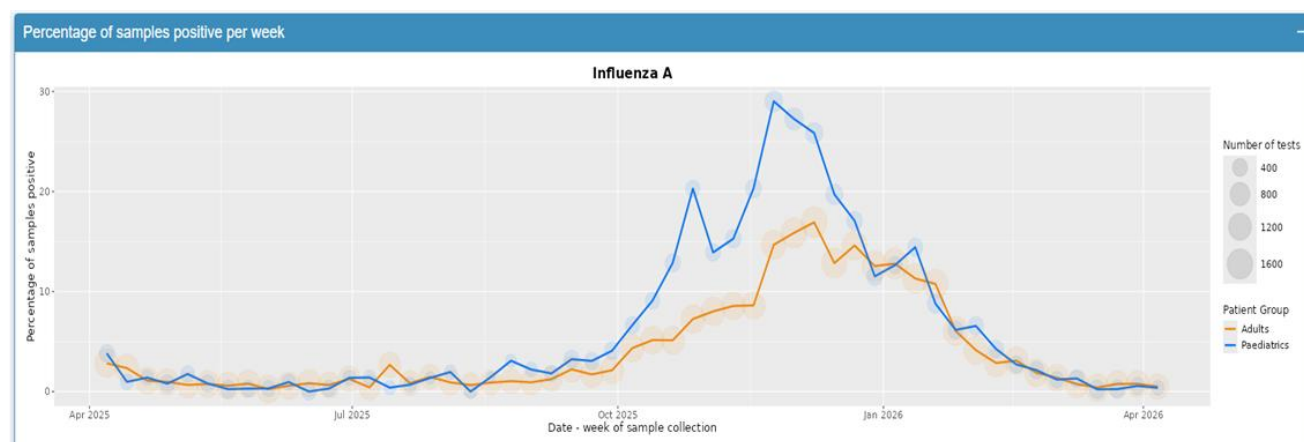


Figure 6: Northwest London pathology Influenza A Surveillance

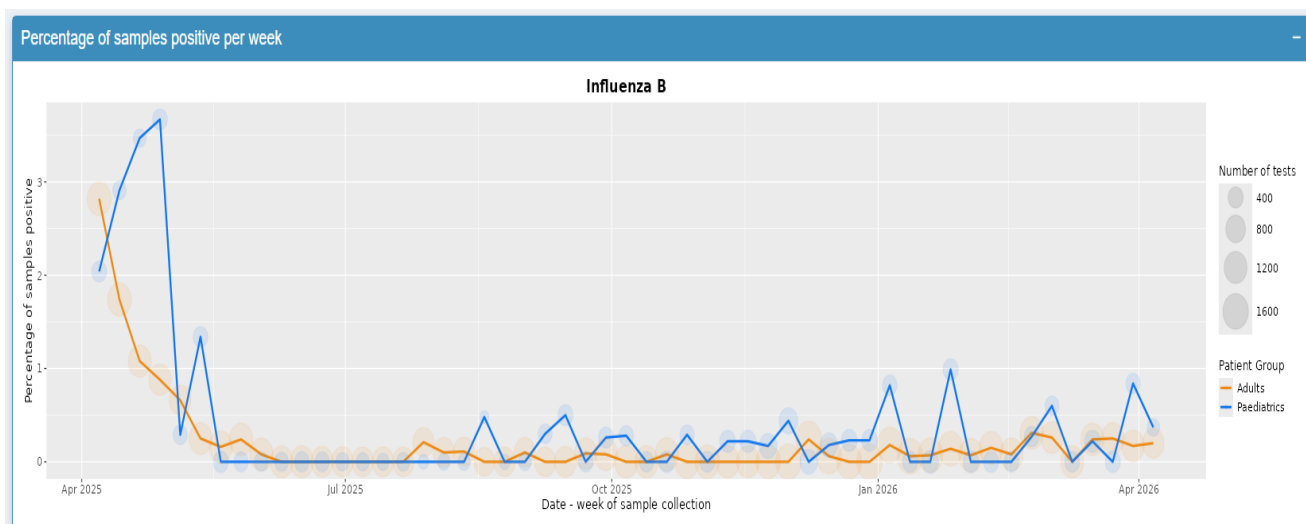


Figure 7: Northwest London pathology Influenza B Surveillance

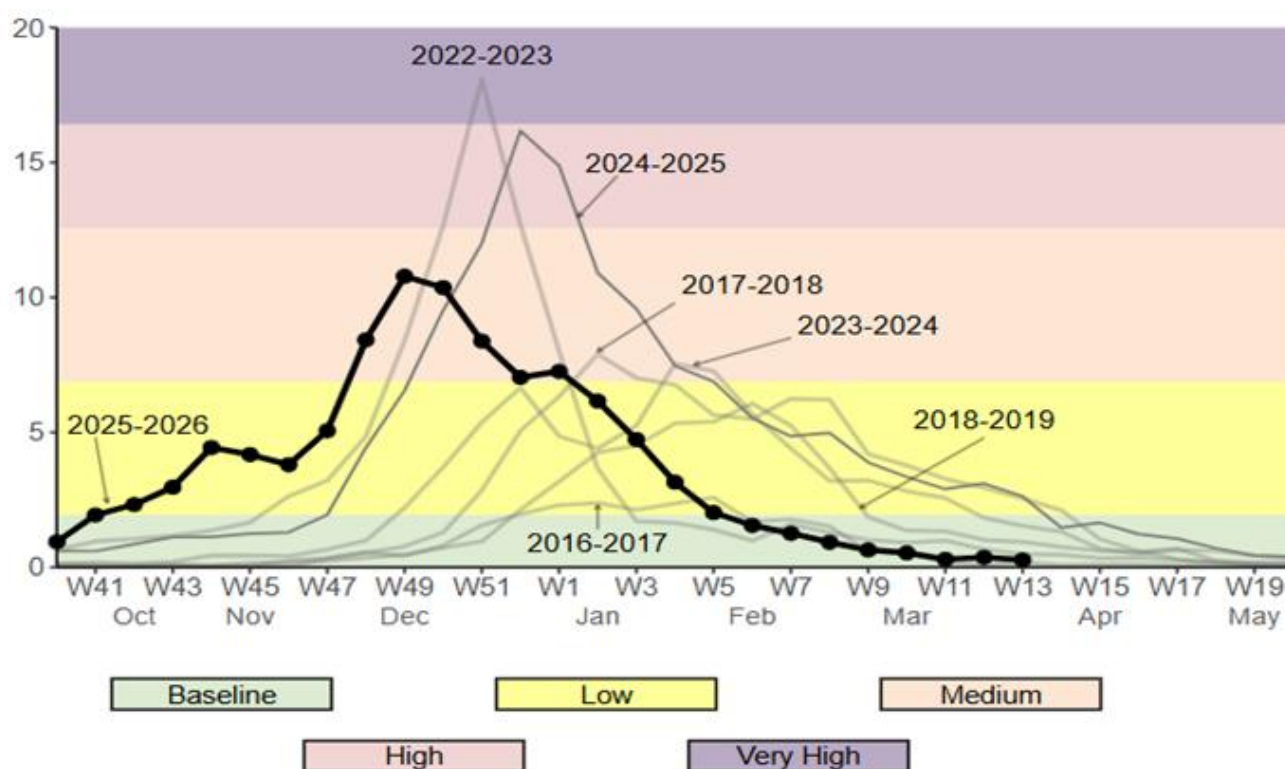


Figure 8: Weekly overall Influenza hospital admission rates per 100,000-trust catchment population with MEM (Moving Epidemic Method) thresholds, reported through SARI Watch sentinel surveillance, England.



9. Incidents, Outbreaks and Clusters

9.1. Chelsea and Westminster Hospital (CW)

Report written by Shebin Thomas and Alice Heath, IPC Nurse Specialists

Clostridioides difficile (C. difficile) Infections (CDI)

1. COHA CDI in Paediatric ED

3-year-old child with complex needs was initially admitted to CW on 03 March having been unwell for 6 days. A stool sample taken on admission tested *C. difficile* toxin positive. The child presented again on 01 April with cough, fever, vomiting and diarrhoea. A stool sample taken on 01/04/25 detected *C. difficile* toxin. PSIRF meeting held, no lapse in care identified. Lessons learned: discussion around the there is no value in sending a repeat *C. difficile* sample when the patient was already known to be positive as they are likely to be colonised for a prolonged period of time; reminder of the importance of documenting on the Cerner stool chart particularly when the patient is having diarrhoea and ensuring that other diagnosis are investigated.

2. HOHA CDI on SMA

61-year-old patient admitted on 20 March following a collapse at home and 4–5-day history of vomiting and diarrhoea with an upper GI bleed requiring ICU admission. The patient developed a new episode of diarrhoea on ward step down, a sample was sent on 04/04/25 was *C. difficile* PCR and toxin positive. The patient was treated with oral vancomycin for 10 days with good effect. PSIRF meeting was held which did not detect a lapse of care.

3. HOHA CDI on Rainsford Mowlem

96-year-old patient admitted to CW on 05 April following a fall at home. The patient began to develop diarrhoea on 15/04/25, laxatives were reviewed and stopped, however diarrhoea continued. A stool sample taken on 19/04/25 detected *C. difficile* toxin. PSIRF meeting held, no lapse in care identified. Issues recognised that did not contribute to the infection included a delay in isolating the patient and incorrect side room signage displayed. Good practice points: accurate stool chart documentation; good AMS prescribing and documentation; laxatives stopped in a timely manner.

4. HOHA CDI on AAU

On 28/04/25, a 73-year-old patient was admitted with bradycardia and atrial fibrillation. Prophylaxis was given for pacemaker insertion. The patient subsequently developed respiratory symptoms and was treated for hospital-acquired pneumonia. On 03/05/25, they developed diarrhoea; a stool sample tested positive for *C. difficile* by PCR and toxin assay. PSIRF meeting was held which did not detect a lapse of care.

5. HOHA CDI on Apollo

3-year-old patient was admitted to Apollo on 28/04/25 following step-down from PICU. With a complex medical history, they became septic and developed diarrhoea on 10/05/25. The patient had prior *C. difficile* toxin-positive stools in March and April 2025. A stool sample sent on 11/05/25 was PCR- and toxin-positive for *C. difficile*. PSIRF meeting held did not detect a lapse of care.

6. HOHA CDI on David Erskine

71-year-old patient transferred from St Mary's on 22/05/25 with spinal, sacral, and rib fractures and known PCR-positive for *C. difficile*. The patient developed diarrhoea; a sample sent on 29/05/25 was toxin positive. PSIRF meeting was held which did not detect a lapse of care.

7. HOHA CDI on Ron Johnson



71-year-old patient admitted with fever and confusion on 10/05/25. The patient had been recently discharged for a prolonged stay of sepsis secondary to sarcoma. The impression was sepsis secondary to sarcoma and the patient started on antibiotics. The patient deteriorated and a stool sample on 02/06/25 was *C. difficile* PCR and toxin positive. The patient was treated with IV metronidazole and oral vancomycin. A PSIRF meeting was held which did not detect a lapse of care.

8. COHA CDI on Rainsford Mowlem

37-year-old patient admitted on 06/06/25 with sepsis with a background of metastatic adenocarcinoma being treated at the Royal Marsden. The patient had increased inflammatory markers, and a stool sample sent on 10/06/25 was *C. difficile* PCR and toxin positive. The patient was successfully treated with fidaxomicin, however unfortunately later passed away from multi organ failure due to multiple co-morbidities. A PSIRF meeting was held and did not detect a lapse of care.

9. COHA CDI on SMA

The patient was admitted for acute cholecystitis and associated cholangitis and later re-presented to hospital with diarrhoea and vomiting on 23/06/25. A stool sample taken on 24/06/25 was *C. difficile* PCR and toxin positive. The patient was treated with IV metronidazole and oral vancomycin. A PSIRF meeting was held and did not detect a lapse of care.

10. HOHA CDI on Edgar Horne

75-year-old patient admitted on 17/04/25 with infected cholangitis and started on appropriate antibiotics. The patient deteriorated and was admitted to ICU where there was concern of untreated hepatic abscess. The patient developed diarrhoea and a stool sample sent on 29/05/25 was *C. difficile* PCR positive and toxin negative and the patient was successfully treated and recovered from *C. difficile*. The patient subsequently developed suspected aspiration pneumonia and was started on a short course of antibiotics. A stool sample sent on 02/07/25 was *C. difficile* PCR and toxin positive. The patient was initially treated with PO Vancomycin for 24 hours and then stopped as it was felt that the clinical impression was colonisation rather than an active infection. A PSIRF meeting was held no lapse in care was identified but learning included: to ensure an accurate stool chart as the on the whole the stool chart had been accurate there were days where it had not been filled in, the importance of comprehensive and accurate clinical notes and handovers where the patient's infectious history is noted.

11. COHA CDI on AAU

71-year-old patient admitted with a history of abdominal pain on 11/07/25 to AAU. The patient had a CT which detected colitis and given antibiotics. The patient was then discharged on 12/07/25. The patient re-presented later that day with abdominal pain and loose stool. A stool sample sent on 13/07/25 detected *C. difficile* PCR and toxin positive. The patient was discharged with AEC follow up. A sample sent in AEC on 14/07/25 detected *C. difficile* PCR positive and toxin negative. The patient was reviewed in AEC, where the result from 14/07/25 was known (PCR positive and toxin negative). At that time, the clinical impression was colonisation rather than an active infection. The patient was treated with PO vancomycin with good effect.

A PSIRF meeting was held and no lapse in care was identified but learning included: for documentation of stool chart as it had not been well filled out and escalation of side room requirements.

12. HOHA CDI on Ron Johnson

61-year-old patient was admitted to Ron Johnson from Gazzard Day Unit with neutropenic sepsis. The patient was treated with appropriate antibiotics. The patient developed diarrhoea and a stool sample sent on 19/07/25 was *C. difficile* PCR and toxin positive. The patient was known to be previously *C. difficile* PCR positive from a sample in May 2025. The patient was initially started on



oral vancomycin then switched to oral fidaxomicin with an extended course due to the patient being immunocompromised and due to the re-lapse of *C. difficile*. PSIRF meeting was held which did not detect a lapse of care.

13. HOHA CDI on Ron Johnson

45-year-old patient was admitted to Ron Johnson on 20/07/25 with abdominal pain, retching and diarrhoea. The patient had been recently diagnosed with throat cancer and had started chemotherapy. A stool sample sent on 23/07/25 was *C. difficile* PCR and toxin positive. The patient was started on oral vancomycin but then changed to oral fidaxomicin due to being immunocompromised. A PSIRF meeting was held and no lapse in care was identified but learning included: the accurate documentation of stool chart as there was a discrepancy between the nursing notes. The patient had reported diarrhoea in a ward round, and this was not then sampled until 3 days after initially noted that had diarrhoea. The learning was to ensure that if there are concerns of diarrhoea to ensure timely sampling of patients.

14. HOHA CDI on Apollo

4-year-old patient was admitted to Apollo following a step-down from St Mary's PICU on 30/05/25. The patient has a complex medical history and was known *C. difficile* PCR and toxin positive in March, April, and May 2025. The patient developed offensive diarrhoea, and a stool sample sent on 24/07/25 which was again *C. difficile* PCR and toxin positive. The patient was initially started on oral vancomycin but changed to oral fidaxomicin due to *C. difficile* relapse. PSIRF meeting was held which did not detect a lapse of care.

15. HOHA CDI on Lord Wigram

84-year-old patient admitted on 03/08/25 with left periorbital cellulitis following recent shingles where they had been admitted in hospital and treated with IV antivirals, antibiotics and topical treatment. The patient developed diarrhoea following discharge. A stool sample sent on 08/08/25 was *C. difficile* PCR and toxin positive. The patient was treated with oral vancomycin. A PSIRF meeting held on 29/09/25, during which a lapse in care was identified relating to inappropriate antibiotic stewardship.

16. HOHA CDI on Edgar Horne

70-year-old patient admitted with chronic diarrhoea, pancreatitis, fatigue, and leg pain. Stool sample sent on 07 August; confirmed *C. difficile* on 08 August; treated with oral vancomycin. Patient recovered from CDI but died in September from unrelated causes. A PSIRF meeting was held on 29/09/25 with no lapse in care identified.

17. HOHA CDI on SMA

80-year-old patient admitted on 09/08/25 following a fall at home with a long lie. The patient is under treatment for breast and lung cancer. The patient was started on IVABs due to sepsis concerns. A stool sample sent was *C. difficile* PCR and toxin positive. The patient was treated with 10-day course of oral vancomycin. A PSIRF was held on 14/10/25 with no lapse in care identified.

18. COHA CDI on Mars

3-year-old patient admitted to Mars on 15/08/25 with vomiting and temperature following a 1% TBSA contact burn to left palm. The impression was TSS and was started on IVABs. The patient was discharged home. The patient developed a fever, diarrhoea and vomiting and presented to West Middlesex on 29/08/25. A stool sample sent detected *C. difficile* PCR and toxin positive. The patient was started on oral vancomycin. PSIRF meeting was held which did not detect a lapse of care.

19. HOHA *C. difficile* attributed to Nell Gwynne

66-year-old patient transferred from Hammersmith hospital on 05/08/25 to Nell Gwynne ward. The patient had a prolonged course of antibiotics for aortic root abscess/prosthetic valve endocarditis



and whilst recovering also had a stroke. The patient developed diarrhoea and a stool sample sent detected *C. difficile* (PCR and toxin). The patient was treated with PO vancomycin with good effect. A PSIRF meeting was held which did not detect a lapse of care.

20. HOHA CDI on Ron Johnson

57-year-old patient admitted on 22/08/25 with fever, vomiting, and leg pain. Treated for suspected encephalitis and sepsis. Developed diarrhoea during admission and tested positive for *Clostridioides difficile* (PCR and toxin) on 08/09/25. Treated with 10 days of oral vancomycin. Antibiotics for suspected osteomyelitis were stopped following MRI and microbiology advice. Discharged on 16/09/25. A PSIRF was held on 23/10/25 with learning identified as no lapse in care contributed to the development of the infection.

21. COHA CDI on AAU

55-year-old patient female, a PSIRF review meeting held on 04/11/25 concluded there were no lapses in care related to the CDI. The patient, previously treated for *E. coli* bacteraemia, was re-admitted with diarrhoea and tested positive for *C. difficile*. Risk factors included recent antibiotic use, recurrent colchicine, and PPI therapy. Isolation and cleaning protocols were followed, and treatment with oral vancomycin was in line with guidelines. The learning point identified was the need for consistent stool chart documentation during all admissions, including for mobile and independent patients. Antimicrobial stewardship remains essential to reduce future risk.

22. HOHA CDI on Nell Gwynne

78-year-old patient presented to ED following a stroke and long lie. The patient was treated for a stroke and bilateral pulmonary emboli. Due to having a high WCC, the patient was started on IV antibiotics. The patient developed diarrhoea and a stool sample sent on 10/11/25 detected *C. difficile* PCR and toxin positive. The patient was treated with oral vancomycin with good effect. A PSIRF was held on 01/12/25 did not identify a lapse of care but identified learning: antimicrobial prescribing and reviewing, timely sampling of patients and to isolate patients and to document if unable to.

23. HOHA CDI on AAU

62-year-old patient admitted 16/11/25 with acute alcohol withdrawal following sudden cessation or alcohol intake 72hrs prior to admission. The patient was given antibiotics for aspiration pneumonia and antiviral treatment for potential encephalitis. Patient developed diarrhoea and a stool sample sent on 24/11/25 came back *C. difficile* PCR and Toxin positive and was treated with oral vancomycin. A PSIRF meeting held on 15/01/26 and no lapse in care identified.

24. HOHA CDI on AAU

82-year-old frail patient with multiple myeloma, readmitted with neutropenic sepsis. CDI confirmed promptly; early isolation maintained. Fidaxomicin used due to high relapse risk. A PSIRF meeting was held which did not detect a lapse of care. Learning points: improve stool chart documentation, communication, and antimicrobial review. Action: Reinforce documentation, enhance communication, and maintain isolation and cleaning compliance.

Increased Incidences of *C. difficile* - AAU

5x *C. difficile* cases in AAU in Dec 2025; ribotyping requested, 5x PSIRF completed with no lapse in care. IPC and AAU teams implementing enhanced measures: staff reminders on risk assessment, isolation, stool charting, sampling, and antimicrobial stewardship; regular IPC audits and ward visits; immediate escalation of issues; strict hand hygiene and PPE compliance; enhanced environmental cleaning (toilets, commodes, curtain changes); Chlor-clean availability verified; reusable equipment cleaned between use; early isolation of suspected cases; collaboration with medical team on antibiotic stewardship.



25. HOHA CDI AAU

62-year-old patient presented to ED, treated for influenza A with a bacterial super-infection. Background of metastatic breast cancer. The patient was being treated with IV antibiotics and developed diarrhoea. A stool sample was sent on 10/12/25 which detected *C. difficile* PCR and toxin positive. The patient was not treated as not symptomatic. A PSIRF was carried out, and which did not identify a lapse of care but identified learning. The learning included not sending a sample whilst on laxatives and the stool chart was not filled out accurately.

26. HOHA CDI-AAU

85-year-old female with multiple comorbidities admitted with urosepsis; *C. difficile* confirmed on 14 Dec. Treated with vancomycin, metronidazole, and then fidaxomicin; diarrhoea persisted at discharge. Initial meropenem appropriate, but repeated ciprofloxacin use despite resistance noted. No care lapses; learning points: Isolation delayed due to side room availability; stool chart documentation incomplete. Hand hygiene compliance 85%.

27. HOHA CDI-AAU

72-year-old patient admitted 14/12/25 following a fall from standing height, BIBA as a trauma call. Multiple (10x) left sided rib fractures, with small volume left haemo-pneumothorax and extensive surgical emphysema. Patient was given broad spectrum antibiotics for infection query source. Patient developed diarrhoea and a stool sample sent on 18/12/25 came back *C. difficile* PCR and Toxin positive. Treated with oral vancomycin. A PSIRF meeting was held on 15/01/26 and lapse in care identified as inappropriate use of piperacillin–tazobactam directly contributed as a lapse in antimicrobial stewardship.

28. HOHA CDI AAU

77-year-old patient admitted 10/12/25 with left flank pain and raised inflammatory markers. The patient had an *E. coli* bacteraemia. The patient was treated with IVABx. The patient developed diarrhoea and a stool sample sent on 22/12/25 detected *C. difficile* PCR and toxin positive. The patient was treated with PO Vancomycin and then escalated to an extended course of PO Fidaxomicin. A PSIRF meeting was held which did not detect a lapse of care.

29. HOHA CDI AAU

87-year-old patient admitted with a recurrent UTI on 20/12/25. Treated with IVABx. History of *C. difficile* detected in Nov 2025. A stool sample sent on 20/12/25 detected *C. difficile* PCR and toxin positive. The patient was treated with PO Fidaxomicin. A PSIRF meeting was held which did not detect a lapse of care.

30. HOHA CDI on Nightingale

67-year-old patient had recently been discharged following infected bilateral leg ulcers with concerns of possible osteomyelitis. The patient was given a 6-week course of ABx. The patient was re-admitted with fluid overload and suspected AKI and developed diarrhoea. A stool sample sent on 09/12/25 detected *C. difficile* PCR and toxin positive. The patient was treated with PO vancomycin and a PSIRF was held with no lapse of care, but learning included: documentation of isolation requirements, information given to patients re long term antimicrobials and reviewing course duration of IV antimicrobials.

31. COHA CDI on Ron Johnson

32-year-old patient admitted 09/12/25 with neutropenic sepsis. Treated with IV antimicrobials and discharged home. Reviewed as an outpatient where they disclosed they had developed diarrhoea. A



stool sample detected *C. difficile* PCR and toxin positive. The patient was treated with PO fidaxomicin due to an allergy to Vancomycin. A PSIRF was held on 17/02/26 and no lapse in care was identified.

32. HOHA CDI on SMA

80-year-old patient admitted on 21/12/25 with nausea, vomiting, and abdominal pain. A CTAP demonstrated small bowel obstruction. An NGT was inserted for drainage and had antibiotics for small bowel obstruction. Patient developed diarrhoea and a stool sample sent on 27/12/25 came back *C. difficile* PCR and Toxin positive. Currently treated with oral vancomycin. PSIRF pending due to consultant unavailability which was escalated to planned care.

33. HOHA CDI on AICU

65-year-old patient admitted on 20/12/25 with acute confusion in the context of being unwell for 2 weeks, reducing oral intake and significant weight loss in the preceding months. Transferred to AICU for renal replacement therapy and treated with antibiotics for urosepsis. Patient developed diarrhoea and a stool sample sent on 29/12/25 came back *C. difficile* PCR and Toxin positive and was treated with oral fidaxomicin. A PSIRF meeting was held on 15/01/26 with no lapse in care identified.

34. HOHA CDI on Rainsford Mowlem

88-year-old patient presented to ED following an unwitnessed fall on 26/11/25. The patient had an AKI due to the long lie, sepsis and dehydration and was treated with IV ABx. The patient had rising inflammatory markers and developed diarrhoea. A stool sample sent on 19/12/25 detected *C. difficile* PCR and toxin positive. Treated with PO Vancomycin with good effect. PSIRF meeting was held which did not detect a lapse of care.

35. HOHA CDI on SMA

82-year-old patient was admitted to CWH on 26/12/25 with left iliac fossa abdominal pain, vomiting, diarrhoea and acute kidney injury on a background of chronic kidney disease. *C. difficile*, confirmed on stool testing on 07/01/26 and the patient was treated oral vancomycin from 08/01/26 with good clinical response. PSIRF pending due to consultant unavailability which was escalated to planned care.

36. HOHA CDI on David Erskine

71-year-old patient admitted to CW following an unwitnessed fall following a recent discharge from hospital. The impression was fall due to infected leg ulcers and started on IV co-amoxiclav which was then changed to IV cefazolin. A stool sample was sent on 19/01/26 was *C. difficile* PCR and toxin positive. The patient was administered a 14-day course of oral fidaxomicin. A PSIRF meeting was held on 24/02/26 which did not identify a lapse in care but identified learning points of patient not being isolated at development of *C. difficile* symptoms and the stool charts not being accurately filled in.

37. COHA CDI on Rainsford Mowlem

93-year-old admitted following two recent admissions to CW for UTI and chronic ulcer. The patient had been re-admitted on 10/02/26 due to urinary retention secondary to UTI. A sample was sent on 10/02/26 which was *C. difficile* PCR and toxin positive. The patient was given a 10-day course of oral vancomycin with good effect. An internal PSIRF meeting identified no lapses in care. However, learning points included that the patient had received antibiotics in the care home prior to admission. In addition, during the penultimate admission, a broad-spectrum antibiotic was prescribed where a narrower-spectrum agent may have been more appropriate, highlighting the importance of antimicrobial stewardship.



38. COHA CDI on David Erskine

85-year-old has had multiple stool tests for *C. difficile* since January 2026, with two PCR-positive results and a recent toxin-positive sample confirming CDI. The patient had been receiving laxatives and enemas for faecal over-loading. CDI treatment was initiated with oral vancomycin. Due to recurrent infection and in line with guideline recommendations, treatment was switched to fidaxomicin. A PSIRF meeting was held on 17/03/26 and a lapse in care identified due to prolonged use of antibiotics for a prophylactic indication outside of local and international guidelines.

39. HOHA CDI on David Erskine

74-year-old admitted on 12/02/26 following an unwitnessed fall. The patient deteriorated and required to be intubated. The patient developed diarrhoea and the sample sent on 21/02/26 was *C. difficile* PCR and toxin positive. The patient was given a 10-day course of oral vancomycin. PSIRF pending.

40. HOHA CDI on Edgar Horne

75-year-old with advanced pancreatic cancer tested positive for *C. difficile* toxin on 27/02/26. CDI treatment was started with oral vancomycin. Broad-spectrum antibiotics and PPI were reviewed and advised to stop unless essential. Enteric isolation and stool monitoring were implemented. Following MDT review, CDI treatment was changed to fidaxomicin. A PSIRF meeting held on 20/03/26 and no lapse in care identified.

41. HOHA CDI on Lord Wigram

96-year-old male patient had been admitted following a fall and fracture of left neck of femur. The patient had a hemi arthroplasty and developed an aspiration pneumonia. The patient developed loose stool and a sample sent on 25/03/26 was *C. difficile* PCR and toxin positive. The patient was treated with fidaxomicin. A PSIRF was held which did not identify a lapse of care but learning identified. The importance of early isolation when an infectious cause of diarrhoea is suspected. Escalation and clear documentation of isolation decisions. Review of laxative use in patients with diarrhoeal symptoms. Timely review of antimicrobial therapy and appropriate liaison with relevant specialist teams.

42. COHA CDI on Lord Wigram

77-year-old patient was admitted to AAU with profuse brown watery diarrhoea following a recent discharge from Lord Wigram Ward. The patient was admitted to Chelsea and Westminster Hospital on 11/03/26 with a blocked nephrostomy and associated infection. The nephrostomy was unblocked, the infection treated with antibiotics, and a routine nephrostomy exchange was performed on 16/03/26. The patient was discharged with antibiotics to complete the course. PSIRF pending due to consultant unavailability which was escalated to planned care.

Key Learning.

- Early recognition of diarrhoea and prompt CDI testing is essential, even when confounding factors such as laxatives or comorbidities are present.
- Immediate isolation at first diarrhoeal episode should be prioritised and not delayed awaiting results or due to bed pressures.
- Consistent and complete stool chart documentation is required for all patients, including mobile and independent individuals.
- Accurate recording of stool type and frequency is necessary to support clinical assessment and decision making.
- Strict antimicrobial stewardship must be upheld, avoiding broad spectrum antibiotics without clear indication or unnecessary overlap.



- All antibiotic prescribing decisions should be clearly documented and regularly reviewed.
- CDI checklists should be completed accurately to ensure appropriate sampling and testing.
- Clear documentation is required to identify who authorised CDI testing.
- Effective communication and MDT handovers are vital, particularly for medical outliers and ward transfers.
- Duty of Candour should be completed and documented where appropriate, with rationale recorded when not possible.
- Ongoing staff education is needed on CDI recognition, testing, isolation, and documentation standards.
- Continued adherence to infection prevention, isolation, and cleaning protocols is essential to minimise environmental risk.

Non-C. *difficile* Incidents and Outbreaks

***Legionella* in AAU**

A patient was admitted on 13 April 2025 with a 10-day history of fatigue and lethargy following a recent course of chemotherapy. On 15 April 2025, the patient developed a cough and features of suspected sepsis while on Ron Johnson Ward and was subsequently transferred to the Acute Assessment Unit (AAU) for further management.

A urine sample sent on 16 April 2025 was positive for *Legionella* and pneumococcal antigen. A sputum sample was subsequently sent to the reference laboratory on 17 April 2025 for further testing; *Legionella* PCR was not detected.

The immediate actions taken were:

- A review of the patient's movements throughout their inpatient stay was undertaken.
- Estates, the authorised water engineer, and the UK Health Security Agency (UKHSA) were informed to advise on further risk mitigation measures.
- Temperature checks of cold water and hot water flow and return temperatures were completed.
- Assurance was sought regarding ward documentation for routine water outlet flushing.
- JCA was requested to share all *Legionella* water sampling and temperature monitoring results, and Estates and Facilities were asked to confirm that there were no concerns in other areas of the Trust.
- Clinical teams were reminded of the importance of using clinical hand wash basins exclusively for hand hygiene. It was reiterated that all water disposal activities must be carried out in the sluice room to reduce the risk of environmental contamination.
- A review of all aerosol-generating and water-associated equipment currently in use on the ward was completed, with confirmation that all equipment is cleaned in accordance with Trust policy.
- JCA was instructed to continue daily water flushing and temperature checks for all ward outlets until *Legionella* water sampling results were available and clearance confirmed.
- "Hand Washing Only" stickers were placed above clinical hand wash basins to reinforce that these sinks must be used solely for hand hygiene and not for any other purpose.
- Ward teams and ISS staff were asked to ensure that paper towels are promptly removed from hand hygiene sinks to maintain cleanliness and prevent outlet blockages.
- ISS supervisors and staff were reminded of the requirement to follow approved cleaning procedures consistently and thoroughly to reduce the risk of environmental contamination.



Lessons Learned:

- Shower heads are replaced every three months and should be uniform in colour to support compliance and ease of monitoring. All nursing teams and matrons should be informed of the designated colour for each replacement cycle. Any shower heads not matching the expected colour for the current cycle must be escalated to JCA or the Estates Team for investigation and resolution.
- All incidents involving water blockages or stagnant outlets should be documented in detail, including the nature of the issue and resolution times, to support proactive monitoring, timely intervention, and assurance of water safety standards.
- A broader review is required to assess and reposition paper hand towel dispensers currently located above hand wash basins. This will help prevent paper towels from falling into sinks and causing outlet blockages.
- Clinical teams should continue to reinforce the importance of using clinical hand wash basins exclusively for hand hygiene to all staff, patients, and visitors. All water disposal must be carried out in the sluice room to minimise the risk of environmental contamination.
- Staff should ensure regular review of all aerosol-generating and water-associated equipment in use on the ward and confirm that cleaning is carried out in line with Trust policy.

TB Exposure in the Urgent Care Centre (UCC)/ Emergency Department (ED).

On 17 April 2025, the Infection Prevention and Control (IPC) Team were notified of a patient who had been diagnosed with smear-positive pulmonary tuberculosis on 4 April 2025 at Imperial.

The patient initially presented to the Chelsea and Westminster Hospital Emergency Department (ED) on 26 March 2025 with acute psychosis. They were discharged the following day to St Charles Mental Health Unit and subsequently transferred to St Mary's Hospital (SMH) on 1 April 2025.

Exposure Assessment and Actions Taken:

- ED matrons identified six staff contacts who had greater than eight hours' cumulative exposure to the index case without appropriate personal protective equipment (PPE).
- These staff members were referred to Occupational Health for TB screening.
- In addition, all staff who had frequent contact with the index case, regardless of cumulative exposure time, were issued with a "warn and inform" letter outlining key TB symptoms and offering voluntary screening.
- No patient contacts were identified, as the patient remained isolated throughout their stay at Chelsea and Westminster Hospital.
- An incident review was undertaken by the CW TB team; however, the patient's ongoing care and management were overseen by the Imperial College Healthcare NHS Trust TB Team (ICHNT).

An incident meeting was convened on 16 May 2025. The key learning identified was the importance of early discussion with the TB team when chest X-ray findings are equivocal for tuberculosis. This learning has been taken forward by the TB service.

As part of the response:

- Targeted training has been delivered to ED medical staff by the TB consultant.
- The index case continues to be managed and treated by ICHNT.



Norovirus Incidents – Suspected and Confirmed Outbreaks

The norovirus incidents and outbreaks during the reporting period are outlined below.

A. Confirmed Outbreak – Rainsford Mowlem

Between 14 May 2025 and 9 June 2025, nine patients were confirmed positive for Norovirus genogroup II RNA. In addition, eight staff members reported symptoms of diarrhoea and vomiting. During the outbreak period, E-bay remained open, while the remaining four bays were closed at various points in response to case identification. Nine outbreak meetings were convened with UKHSA in attendance. The outbreak was declared over on 9 June 2025.

B. Suspected Outbreak – Nightingale

On 22 May 2025, a symptomatic patient was identified in C-bay on Nightingale ward. The patient was isolated and the bay closed. A second bay (A-bay) was closed on 23 May 2025 due to further concerns.

No specimens were collected from the index patient; therefore, laboratory confirmation of norovirus was not possible. Three outbreak meetings were convened with UKHSA involvement. The incident was declared over on 29 May 2025.

C. Confirmed Incident – Edgar Horne

One patient isolated in a side room tested positive for Norovirus genogroup II RNA from a stool sample sent on 01 June 2025. The remainder of the ward was monitored for gastrointestinal symptoms while the index patient remained symptomatic.

Following reports of gastrointestinal symptoms in C-bay, the bay was closed between 05 June 2025 and 6 June 2025 and subsequently reopened when no further cases were identified. One staff member developed gastrointestinal symptoms after providing 1:1 care to the index case.

D. Confirmed Incident – Acute Assessment Unit (AAU)

A suspected norovirus outbreak was identified in a community care home, affecting six residents. Two residents were admitted to AAU on 10 November 2025. One patient was isolated immediately, while the second patient had been isolated initially but was subsequently placed in the trolley bay prior to discharge.

One patient tested positive for Norovirus genogroup II RNA from a stool sample sent on 12 November 2025. The trolley bay was closed, and all contact patients were monitored for 72 hours. No further patients became symptomatic and the bay was reopened.

Two staff members reported symptoms of diarrhoea and vomiting. One incident meeting was held, and the incident was declared over on 14 November 2025.

E. Confirmed Incident – Neptune

7-year-old patient was admitted on 04 January 2026 with fever following recent travel to Pakistan. A stool sample sent on 07 January 2026 detected Norovirus genogroup II RNA. The patient's brother was admitted with similar symptoms.

Following discussion with the microbiology consultant and clinical team, the siblings were cohorted together in a double-bedded bay with enteric precautions in place. The remainder of the ward was monitored for gastrointestinal symptoms. No other patients or staff developed symptoms.

F. Confirmed Outbreak – Nightingale

Between 14 January 2026 and 25 January 2026, five patients tested positive for Norovirus genogroup II RNA (two from C-bay, one from B-bay, one from A-bay, and one from the day room). In addition, two staff members reported symptoms of diarrhoea and vomiting.



Initially, B-bay was closed to admissions. Due to concerns involving A-bay, C-bay, and D-bay, it was agreed at the incident meeting on 16 January 2026 that the entire ward should close to admissions. Bays were reopened on 23 January 2026.

Four outbreak meetings were held, and the outbreak was declared over on 26 January 2026.

G. Confirmed Incident – Nightingale

One patient tested positive for Norovirus genogroup II RNA from a stool sample sent on 20 February 2026. The patient had been an inpatient since 10 December 2025 and was initially located in D-bay. The patient was isolated in a side room on 22 February 2026.

D-bay and E-bay were closed on 22 February 2026 due to symptomatic patients, and all contacts were monitored. Following IPC review, beds were reopened on 26 February 2026. No staff members were affected.

Containment measures implemented across incidents included:

- Prompt isolation of symptomatic and confirmed cases
- Closure of affected bays and cohorting of contacts
- Application of enteric precautions
- Allocation of dedicated toilets and commodes
- Promotion of accurate stool chart documentation
- Ongoing review of laxative use
- Enhanced environmental cleaning, including steam cleaning of commodes
- Minimising clutter to facilitate effective cleaning
- Display of outbreak signage
- Strict adherence to hand hygiene using soap and water for staff and visitors
- Restricted visiting, including volunteers but ensuring that essential visiting to patients continued
- Reiteration of Trust sickness policy for staff
- Prohibition of food consumption on affected wards
- Incident meetings with UKHSA attendance
- Increased IPC presence on wards to provide education and support
- Reiterating support for patients to clean their hands

Lessons Learned:

- Accurate stool chart documentation is essential for early detection and monitoring of norovirus symptoms.
- Prompt specimen collection supports timely diagnosis and implementation of infection control measures.
- Consistent and correct use of PPE is critical to prevent transmission.
- Immediate isolation of symptomatic patients helps contain outbreaks.
- Effective cleaning of the environment and equipment reduces the risk of cross-contamination.
- Patient transfers from affected wards should be avoided unless clinically necessary.
- Allocation of dedicated staff and equipment to affected areas helps limit spread.
- Therapy staff cleaning competencies should be regularly assessed and updated.

COHA MRSA Bacteraemia – Ann Stewart / Neptune Ward

2-week-old infant presented to Chelsea and Westminster Hospital Emergency Department on 28 July 2025 and was diagnosed with MRSA bacteraemia. The patient was subsequently admitted to Neptune Ward.



The infant was born on 09 July 2025 via caesarean section at Chelsea and Westminster Hospital and was discharged on 12 July 2025 following routine postnatal care. The baby re-presented to the Emergency Department on 13 July 2025 following maternal concerns regarding reduced urine output; however, after assessment, the infant was found to be clinically well and was discharged home.

On 28 July 2025, the infant re-presented to the Paediatric Emergency Department with fever at home and poor feeding. A blood culture taken on the same day detected MRSA.

Following confirmation of MRSA bacteraemia, maternal screening was undertaken and returned positive for MRSA. The mother was subsequently commenced on suppression therapy. The infant's MRSA isolate was sent for typing and was identified as MLST:22 (allelic profile: 7,6,1,5,8,8,6) and PVL-positive MRSA.

To mitigate the risk of transmission to other vulnerable patients and staff, the following IPC measures were implemented:

- The infant was isolated in a single-occupancy room on admission, and contact precautions were initiated.
- Targeted education on PVL-MRSA was provided to staff, with emphasis on early recognition of skin and soft tissue infections and prompt escalation of concerns. This information was shared via staff handovers and the ward WhatsApp group.
- Cleaning protocols on the unit were reviewed to ensure compliance with IPC standards, and a deep clean of the ward was completed on 12 August 2025.

A PSIRF meeting was held on 13 August 2025. The source of the bacteraemia remained unclear, and no lapses in care or contributory factors were identified. All lines and devices had been managed appropriately in accordance with best practice guidelines, and no breaches of the MRSA screening policy were identified. The infant remained clinically well throughout admission.

An action from the investigation was for the PSIRF documentation to be shared with the Obstetrics Team for review and learning.

MRSA Bacteraemia – Adult Intensive Care Unit (AICU)

67-year-old patient presented to the Emergency Department on 29 June 2025 with reduced consciousness following a fall. The initial clinical impression was a urinary tract infection, and the patient was treated with intravenous antibiotics.

The patient subsequently deteriorated and was admitted to AICU on 13 July 2025 following intubation. The clinical picture was one of undifferentiated encephalopathy, and the patient received two courses of steroids. A tracheostomy was inserted on 04 August 2025.

MRSA was detected from a NAG screen on 04 August 2025, and a sputum sample taken on 5 August 2025 also grew MRSA. A blood culture taken on 9 August 2025 detected MRSA bacteraemia. Typing of the blood culture identified MLST ST97 (allelic profile: 3, 1,1,1,1,5,3).

A PSIRF review was conducted, and no lapses in care were identified.

The PSIRF review highlighted the following learning points:



- IPC teams to continue to ensure clear documentation of MRSA and ESBL status, along with related interventions, within patients' electronic records.
- Improved documentation on Cerner to clearly specify the source of blood cultures (e.g. peripheral or line-related).
- Review of the current tracheostomy protocol to consider incorporating routine skin swabbing 48–72 hours prior to insertion.
- Review and assurance of staff competency involved in tracheostomy procedures to ensure adherence to protocol and safe clinical practice.
- Timely review and initiation of MRSA decolonisation therapy where indicated.
- Verification that cleaning standards and single-use equipment protocols are consistently followed, particularly for ultrasound equipment and patient transfer devices used during procedures and imaging.

HOHA MRSA Bacteraemia on Nell Gwynne

73-year-old patient was admitted on 24/08/25 via the Emergency Department with progressive neurological symptoms following recent hospitalisation abroad. During admission, the patient developed cellulitis at a peripheral cannula site. Blood cultures taken on 17/09/25 confirmed MRSA bacteraemia, with the likely source identified as the peripheral intravenous cannula. The Nose and Groin screen which was positive for MRSA was sent for typing which was MLST ST97 (MLST allelic profile: 3,1,1,1,1,5,3). No typing result available. Transthoracic echocardiography demonstrated a mobile lesion on the mitral valve, consistent with probable native valve endocarditis. The patient was commenced on MRSA-active antimicrobial therapy and contact precautions were implemented. A PSIRF meeting was completed on 30/09/25.

Learning Identified

- Lapses in peripheral cannula documentation and inconsistent aseptic technique were identified as contributory factors.
- Reinforcement of the 72-hour cannula review and prompt removal policy is required to reduce the risk of device-related infection.
- Improved staff training on device care documentation and cannula management is necessary.
- Greater oversight of MRSA decolonisation processes is needed to ensure adherence, particularly in patients with complex care needs.

Varicella Zoster Virus (VZV)

The following summaries outline suspected and confirmed cases of shingles (VZV) and the actions taken.

- **Suspected Case – Nightingale Ward**

A patient admitted on 11/04/25 was noted on 14/04/25 to have new redness and swelling around the left eye and was commenced on IV ceftriaxone for suspected orbital cellulitis. The patient was reviewed in the Eye Unit on 15 April 2025 and diagnosed with early shingles involving the left trigeminal (V) nerve. Ceftriaxone was discontinued, acyclovir was commenced, and the patient was isolated.

Four patient contacts and seven staff contacts (six from Nightingale Ward and one from the Eye Clinic) were identified and assessed for chickenpox immunity.

- **Confirmed Case – Staff Member (Maternity)**



IPC was notified of a non-clinical staff member diagnosed with shingles. A risk assessment was completed. No patient contacts were identified, and two staff contacts were followed up by Occupational Health.

- **Confirmed Case – Edgar Horne Ward**

65-year-old patient admitted on 14 August 2025 with suspected aspiration pneumonia developed a rash on 18 August 2025, which was diagnosed as shingles. The patient was commenced on IV acyclovir and isolated. Five patient contacts were identified and risk assessed for prophylaxis. Two staff members were followed up by Occupational Health.

- **Suspected Case – Pre-Operative Assessment Unit**

61-year-old patient attended the Physiotherapy Unit on 6 October 2025 and the Pre-Operative Assessment Unit on 7 October 2025. During pre-operative assessment, the patient was found to have active shingles.

Two staff contacts were identified and followed up by Occupational Health. No patient contacts were identified.

- **Confirmed Case – Acute Assessment Unit (AAU) / Edgar Horne**

86-year-old patient was admitted to AAU on 28 September 2025 following a collapse at home. The patient developed a rash on 12 October 2025, which was diagnosed as shingles. Oral acyclovir was commenced, and the patient was isolated later the same day.

Four patient contacts were identified and risk assessed for prophylaxis. One staff contact was referred to Occupational Health for follow-up.

- **Suspected Case – Josephine Barnes Ward**

58-year-old patient admitted on 15 December 2025 was suspected to have shingles, with rash onset on 11 December 2025, extending from the scalp towards the eye. Acyclovir was commenced, and a swab was taken prior to treatment.

The patient was isolated on arrival; therefore, no patient contacts were identified. No staff contacts were identified.

- **Confirmed Case – Nell Gwynne Ward**

79-year-old patient admitted on 02 January 2026 developed a facial rash on 16 February 2026, later diagnosed as shingles and confirmed VZV-positive on 17 February 2026. Antiviral treatment was commenced on 18 February 2026, and the patient was moved from Bay C to a side room on 19 February 2026.

The infectious period was considered to have begun on 16 February 2026. Five patient contacts were identified and appropriately followed up. Staff contacts were referred to Occupational Health.

- **Confirmed Case – Antenatal Unit / Dermatology**

39-week pregnant patient attended Antenatal PMU on 6 March 2026 and Dermatology on 09 March 2026, where a skin swab confirmed VZV-positive shingles. The rash had begun on 1 March 2026, and lesions were covered and scabbing at the time of review.

As this represented localised shingles in an immunocompetent patient, the transmission risk was assessed as low, and post-exposure prophylaxis (PEP) was not indicated. No patient or staff contacts were identified.

- **Confirmed Case – Staff Member (Maternity)**

A healthcare worker was diagnosed with shingles, with rash onset on 7 March 2026. The staff member had worked on the unit on 09 March 2026 while the rash was active.

Nine maternity patients were identified as contacts; all were confirmed to have VZV immunity. No staff contacts required follow-up by Occupational Health.

- **Confirmed Case – Maternity Day Assessment Unit (MDAU) / Emergency Department**



38-year-old pregnant patient attended MDAU on 05 March 2026 and 07 March 2026. The patient had developed a rash on 04 March 2026 and subsequently attended the Emergency Department on 10 March 2026, where a swab detected VZV. The patient was commenced on acyclovir. No patient contacts were identified. Two staff contacts were identified and followed up by Occupational Health.

VZV (Chickenpox) Detected – Maternity Inpatients

A pregnant patient attended the Maternity Assessment Unit (MAU) on 22 November 2025 with a rash suspicious for chickenpox. The patient was isolated and discharged. She re-presented to MAU the following day with suspected sepsis, went into labour, and delivered. The mother and baby were transferred to a bay on the postnatal ward.

The patient was subsequently confirmed to have chickenpox. An incident meeting was convened, during which six maternity patients and five babies were identified as contacts. A further two maternity patients were identified as contacts from MAU.

All contacts were risk assessed for prophylaxis. Booking bloods were reviewed for VZV immunity, and one neonate was offered prophylaxis. Two staff members were identified and followed up by Occupational Health.

NICU – Suspected *Bordetella Pertussis* Exposure (Staff Member)

A staff member working on the Neonatal Intensive Care Unit (NICU) developed a cough while on duty, which subsequently worsened. The staff member's GP assessed the symptoms and raised concern for suspected *Bordetella pertussis*.

Following notification to Infection Prevention and Control, a risk assessment was undertaken. Six neonatal patient contacts and two staff contacts were identified. All patient contacts were followed up and assessed for the need for prophylaxis, and relevant staff contacts were referred to Occupational Health for further assessment and management.

Respiratory Clusters and Outbreaks

- **COVID-19 Cluster – Nightingale Ward**

Between 29 August 2025 and 9 September 2025, eight patients on Nightingale Ward tested positive for COVID-19. Cases were identified across three bays: three in C-bay, three in D-bay, and two in F-bay. Positive patients were cohorted in A-bay and F-bay, and identified contacts were isolated together. The cluster was declared over on 9 September 2025.

- **Influenza A Cluster – Lord Wigram Ward**

Between 4 January 2026 and 7 January 2026, three cases of Influenza A were identified in A-bay on Lord Wigram Ward. The bay was closed to admissions from 7 January 2026 to 10 January 2026 and reopened on 10 January 2026.

- **Influenza A Outbreak – Nell Gwynne Ward**

Between 5 January 2026 and 11 January 2026, seven confirmed cases of Influenza A were identified on Nell Gwynne Ward. Affected patients were isolated in Bay D, and the index case was transferred to AAU SR05. The ward fully reopened and returned to normal operations on 11 January 2026.

The following control measures were implemented across the respiratory clusters and outbreak:



- Respiratory precautions for confirmed cases and contacts
- Enhanced environmental cleaning, including daily steam cleaning of commodes and shared equipment
- Minimisation of clutter to facilitate effective cleaning
- One-off lateral flow testing for COVID-19 where advised by microbiology or IPC
- Reinforcement of correct PPE use, including changing PPE between patients
- Thorough cleaning of equipment before and after patient use

Good practice identified included the rapid establishment of a designated COVID-19 cohort bay to minimise cross-transmission and the responsiveness of the ISS team in managing infectious cleans during patient movements.

Learning identified included ensuring the correct respiratory swab is obtained and the prompt isolation of symptomatic patients.

2X MLST 152 PVL Producing MRSA on NICU

Two cases of PVL-producing MRSA (MLST 152) were identified on the Neonatal Intensive Care Unit (NICU). A hospital-acquired MRSA isolate was detected and sent to the reference laboratory for typing. The isolate was confirmed as PVL-producing MRSA, and samples were subsequently submitted for whole genome sequencing (WGS).

The MLST typing (MLST 152; allelic profile: 46, 75, 49, 44, 13, 68, 60) matched that of another infant who had recently been admitted to NICU. Notably, the two infants had no inpatient overlap or direct contact. An incident meeting was convened with UKHSA representation, during which the clinical care of both infants and potential opportunities for cross-transmission were reviewed.

The following actions were agreed at the incident meeting:

- Assurance regarding the decontamination of shared equipment, including audiology equipment, ultrasound machines, and biopsy kits
- UKHSA to provide advice on decolonisation for affected families
- Review of bed spacing within the SCBU
- Update of NICU MRSA guidance to explicitly include management of PVL-producing MRSA

Genomic Analysis Outcome

Whole genome sequencing demonstrated that single nucleotide polymorphism (SNP) analysis showed the two isolates differed by more than 25 SNPs. This degree of genetic difference indicates that the isolates are not closely related, making direct transmission unlikely.

Increased Incidence of Multi-Drug-Resistant *Acinetobacter Baumannii*

4 cases of MDR *Acinetobacter baumannii* (MDRAB) detected throughout the hospital

- **ICU / St Mary's Abbot Ward (SMA)**

36-year-old patient was admitted to AICU in a single room on 14 October 2025 following complications from plastic surgery performed in Egypt and subsequent hospital care in Uganda. The patient was isolated on admission due to a high risk of carbapenem-resistant organisms (CROs) and was known to be colonised with *Escherichia coli* (NDM and IMP).



A sputum sample taken on 18 October 2025 identified multidrug-resistant *Acinetobacter baumannii* (MDRAB). The patient was stepped down to St Mary's Abbot Ward (SMA) on 23 October 2025. No patient contacts were identified.

- **Chelsea Wing**

19-year-old patient was admitted to a single room following recent medical treatment in Kuwait. Admission CRO screening on 23 October 2025 detected *Acinetobacter baumannii* harbouring OXA-23, OXA-51, and OXA-58. No patient contacts were identified.

- **Adult Burns Unit (Two Cases)**

Two cases were identified on the Adult Burns Unit:

- One outpatient who sustained burns in Nigeria and received local hospital treatment; this patient was managed as high risk for CROs.
- One inpatient, identified on admission via wound swab as MDRAB, who did not have recognised risk factors for CRO acquisition.
- One patient contact was identified and screened (CRO result was negative).

Incident Management and Control Measures

Three incident meetings were convened, during which the following actions were implemented:

- All MDRAB isolates were sent to the reference laboratory for typing.
- CRO screening was completed for:
 - The entire SMA ward on 4 November 2025 and 11 November 2025
 - The Adult Burns Unit, initially for B-bay on 4 November 2025, followed by the entire unit on 12 November 2025
- Enhanced environmental cleaning was implemented in all affected areas for a minimum of one month and continued until patient discharge.
- Increased hand hygiene, PPE compliance, bare-below-the-elbows, and environmental audits were undertaken by the IPC team, with support from the wider senior leadership team.
- MDRAB awareness was raised through discussion at safety huddles across the hospital.
- Staff movement was reviewed to assess for potential cross-cover or transmission opportunities.

Typing results were returned for all four cases suggesting cross-transmission:

- The two Adult Burns Unit isolates were identical (ST1; allelic profile: 1, 1,1,1,5,1,1).
- The remaining two isolates were genetically distinct:
 - ST470 (allelic profile: 2,2,2,2,2,2,4)
 - ST2 (allelic profile: 2,2,2,2,2,2,2)

A further focused meeting was held for the Adult Burns Unit, during which:

- Laboratory processes were reviewed, including the timing of swab collection and plating. Both swabs were plated at similar times due to laboratory batching processes.
- The possibility of incorrect swab labelling was discussed. While no definitive evidence of mislabelling was identified, opportunities to strengthen swab collection and labelling processes were recognised.
- It was concluded that it was difficult to determine a clear route of direct patient-to-patient transmission.



Candidozyma auris (C. auris)

The following patients were identified as being colonised/ infected with *Candidozyma auris*.

- **2 Inpatient cases on Adult Intensive Care Unit and David Erskine:**
60-year-old patient presented to ED on 07/11/25 following recent travel from Kenya and with complaints of diarrhoea. The patient was seen as an outpatient on 11/11/25, 12/11/25, 13/11/25. The patient was then admitted on 14/11/25 to David Erskine following an ERCP. The patient was transferred to AAU on 16/11/25. The patient deteriorated and was transferred to AICU on 17/11/25. The patient was screened on 24/11/25 which detected *C. auris*.
A look back exercise was completed and 23 patients were identified as contacts from 3 different wards. All inpatient contacts were screened fully three times for *C. auris*.
A contact tested positive for *C. auris* from the contact screening. This in turn generated 10 contacts who were also screened 3 times for *C. auris*. All contacts who did not have 3 full screens prior to discharge were flagged for further admissions to ensure that all 3 screens were completed. One of the confirmed cases had been discharged home. They represented to hospital and was re-admitted into a bay on AAU. The patient was isolated. The bay was closed. There were 4 patient contacts identified. All 4 patient contacts had 3 full *C. auris* screens which all returned as negative.
- **An outpatient detected on Plastics Dressing Clinic:**
64yr-old patient had a wound culture collected on 09/01/26, which tested positive for MDRO– *Pseudomonas aeruginosa* and *C. auris*. The patient attended WM ED, CW ED, and the Plastics Dressing Clinic. UKHSA confirmed that contact tracing was not required for outpatient settings.
- ***C.auris* detected on adult burns:**
32-year-old admitted to the burns unit following a 40% TBSA flame burn. The patient had been hospitalised in Somalia for 45 days before flying back to the UK. On admission the patient was screened for CRO which detected a *MDR Acinetobacter baumannii*. The patient was screened for *C. auris* which was detected in the NTAG and wound swabs.

A look back exercise was completed which identified 7 inpatients contacts and 8 contacts who had been in operating theatre prior to the Hydrogen Peroxide vapour being completed. To date no onward transmission has been detected.

Immediate actions:

- Strict isolation of positive cases with enhanced contact precautions and dedicated equipment
- Enhanced environmental cleaning, including use of hydrogen peroxide vapour where feasible
- Weekly surveillance screening of affected areas for the duration of admission and for four weeks following patient transfer or discharge
- Operational meetings to review progress, address challenges, and update action plans
- Regular hand hygiene and PPE audits conducted by the IPC team and senior nursing leadership

This incident reinforced several important learning points for the early identification, containment, and management of *Candidozyma auris*, particularly in patients with recent overseas healthcare exposure.

- **Early risk identification remains critical.**
A detailed travel and healthcare exposure history at first presentation is essential to promptly identify patients at high risk of *C. auris* and other multidrug-resistant organisms. Early recognition supports timely screening, isolation, and implementation of enhanced infection prevention and control measures.



- **Rigorous screening and look-back exercises are effective in preventing onward transmission.**
The structured approach to contact tracing, including completion of three full screening swabs for all identified contacts and flagging incomplete screening at discharge, provided assurance that potential transmission was identified and managed appropriately.
- **Clear escalation pathways and multidisciplinary coordination are vital.**
Close collaboration between IPC, clinical teams, microbiology, operational leads, and UKHSA enabled timely decision-making, consistent messaging, and coordinated implementation of control measures across multiple clinical areas.
- **Environmental decontamination plays a key role in containment.**
The use of enhanced cleaning, including hydrogen peroxide vapour where feasible, alongside routine auditing, supported effective environmental control and reduced the risk of persistence or re-introduction of *C. auris* within affected areas.
- **Ongoing surveillance is essential even after initial containment.**
Continued weekly surveillance screening for four weeks following discharge or transfer provided additional assurance that the organism had not spread undetected and aligned with national guidance for *C. auris* management.
- **Clear documentation and electronic flagging improve patient safety across care episodes.**
Ensuring that patients and contacts were appropriately flagged within electronic systems supported continuity of precautions during re-admission and across different clinical areas.
- **Staff education and vigilance must be sustained.**
Regular reinforcement of hand hygiene, PPE compliance, and awareness of *C. auris* through audits, safety huddles, and leadership engagement remains essential to maintaining high standards of infection prevention.

Community-Acquired Infection (CAI) – *Neisseria Meningitidis*

ED / AEC / Nightingale Ward

63-year-old patient presented to the Emergency Department (ED) and Acute Emergency Care (AEC) on 13 October 2025 with back pain and cold/flu-like symptoms. A blood culture taken on 13 October 2025 initially showed no growth. The patient was admitted to a double-bedded bay on Nightingale Ward.

On 14 October 2025, the blood culture subsequently detected *Neisseria meningitidis*. The patient was treated with intravenous ceftriaxone.

Contact tracing was undertaken:

- ED: Four patient contacts were identified and discussed with UKHSA; no further action was required.
- AEC: No patient contacts were identified.
- Nightingale Ward: One patient contact was identified and risk assessed for prophylaxis.

ED, AEC, and Nightingale Ward were asked to identify staff contacts. Two staff contacts were identified and referred to Occupational Health for follow-up.

***Neisseria Meningitidis* Detected – Emergency Department**

19-year-old patient presented to the Emergency Department with myalgia, headache, and sore throat. The patient was known to be a contact of a confirmed Group A *Streptococcus* case. The patient was discharged with oral antibiotics and appropriate safety-netting advice.



A blood culture taken in the ED subsequently detected *Neisseria meningitidis*. The patient was followed up at their nearest Emergency Department.

There were no staff contacts identified. One patient contact was identified and risk assessed by the Infectious Diseases team.

Increased Incidence of MRSA on MARS

In May 2025, the MARS Paediatric Burns Unit recorded 13 MRSA-positive patients, compared with a baseline average of four cases per month. Most cases (85%) were MRSA-positive at first presentation, indicating community-acquired colonisation, while two cases met criteria for healthcare-associated infection (HAI). Molecular typing identified multiple unrelated MRSA strains with no dominant clone, suggesting no single outbreak or sustained in-unit transmission.

Despite the findings being largely community-driven, the review highlighted practice and environmental risks that could facilitate cross-transmission. Observations identified inconsistent application of aseptic non-touch technique (ANTT), hand hygiene lapses, shared or poorly labelled topical products, and issues with equipment and the clinical environment, including damaged dressing couches, worn flooring, and cluttered surfaces.

Agreed Actions

- Review and update dressing SOPs, including reinforcing hand hygiene for staff and parents.
- Strengthen and standardise training for dressing changes across adult and paediatric services.
- Ensure single-patient use and correct labelling of topical treatments and sterile water.
- Address equipment and environmental issues, including replacement of damaged furniture and decluttering of clinical areas.
- Conduct a joint IPC and ISS walk-through of the unit.
- Continue MRSA typing and surveillance, with review of any future clustering or HAIs.

Key Learning

- High levels of community-acquired MRSA require continued vigilance, even when in-unit transmission is not evident.
- Small lapses in aseptic practice and environmental standards can increase transmission risk in high acuity burn settings.
- Routine observation and rapid feedback are essential to maintain safe practice.

HOHA MSSA on NNU

A preterm infant (24+1 weeks, severe IUGR, birthweight 460g), was born in poor condition at QCCH on 12/01/26 by SVD and transferred to NNU for intensive care. During her early course, she experienced multiple complications related to extreme prematurity, including chronic lung disease, thrombocytopenia, metabolic acidosis, PDA, and feeding intolerance with several episodes of suspected septic ileus. A long line was inserted on 10/02 to commence TPN during periods of gut rest. The infant had previously tested positive for MRSA from a nasal swab on 19/01 but completed decolonisation successfully with three subsequent negative screens



A blood culture collected on 22/03/26 was positive for MSSA following swelling at the long line site, indicating a line-associated infection. The line was removed the following day, and an abscess later required drainage. The PSIRF has been completed, noting a possible lapse in care related to the delay in removing the line once swelling was first detected. Learning highlights include earlier consideration of infection when swelling occurs, clearer documentation, strengthened escalation for difficult access, enhanced line-care training, and awareness of virulence testing such as PVL.

9.2. West Middlesex Hospital (WM)

Report written by Sheeba Pothan and Jose Paulo Flor, IPC Nurse Specialists

Carbapenem Resistant Organism (CRO) Increased Incidence on Marble Hill 2 (MH2) – June

A total of two CRO patients, both *Escherichia coli* NDM, were identified from MH2 for the period 24/06/25 - 27/06/25. The index case was identified from a rectal screen performed whilst in a bay with a recent hospital admission abroad. Patient contacts were screened on 27/06/25, identifying a further positive case with the same organism and mechanism. VNTR typing for both isolates were different.

The following containment measures were performed: both patients were immediately isolated with enhanced contact precautions upon identification of results. Contacts screening was carried out. An enhanced infectious clean was performed in the bed space of both patients upon transfer and additional enhanced infectious clean was performed for the whole ward on 31/06/25. Dedicated equipment was used. IPC visits were conducted, and real-time feedback provided to the ward, with reminders to strictly adhere to enhanced contact precautions, appropriate hand hygiene, correct PPE donning and doffing, and cleaning of equipment after use.

Lessons learnt:

- Importance of maintaining and following transmission-based precaution, bare below the elbow and hand hygiene.
- Importance of strictly following the MDRO screening policy to ensure screening conducted.
- Importance of using dedicated equipment for CRO positive patients and disinfection of shared equipment between patients to mitigate cross-transmission risk.

MRSA Bacteraemia

A total of three MRSA bacteraemia patients were identified from Marble Hill 1, Labour ward and Kew respectively. 2x HOHA and 1x COHA. PSIRF meetings were conducted for all the three cases.

Lessons learnt:

- Importance of following aseptic technique steps during blood culture specimen collection and allowing alcohol to dry once disinfection of the skin has been performed.
- Importance of adhering to the screening schedule post-MRSA suppression therapy as outlined in the MRSA policy.
- Increasing Caesarean section rates highlight the need for a review of the MRSA screening policy, particularly for long-stay antenatal patients, those undergoing induction of labour, and healthcare worker risk stratification- under review by the IPC team.



- Clinical Documentation: Routine checking of the 'Problems and Diagnoses' section in Cerner is essential to ensure accurate organism flagging and application of appropriate risk assessments and transmission-based precautions.
- Follow strict ANTT technique during urinary catheter insertion.

MSSA Bacteraemia

A total of two MSSA bacteraemia patients were identified from Osterley 2 and SCBU. 2x HOHA. PSIRF meetings were conducted for SCBU case. A PSIRF meeting is pending from Osterley 2.

Lessons learnt:

- Reiterate to staff the importance of allowing alcohol to dry completely following cleaning of IV hubs and disinfection of skin
- Explore possibility of linking maternal flags to neonatal health record to improve care.

Measles Positive Therapy Staff

The Health Protection Team (HPT) notified IPC team regarding a physiotherapist who tested positive for measles. As the staff worked during their infectious period for 2 days, contact tracing was undertaken which identified 12 inpatient and 14 staff contacts. All patient contacts were assessed as immunocompetent and received warn and inform letters with the staff contacts risk assessed by Occupational Health.

Lessons Learnt:

- Importance to strictly follow the Trust sickness policy when unwell.
- Contact Occupational Health if unsure about your vaccination history.

Norovirus Redlees

Two Norovirus positive patients and 3x symptomatic staff were identified for the period 05/12/25 to 10/12/25. The first case was positive on 05/12/25 with diarrhoeal symptoms, result was identified after discharge to rehabilitation unit. They were informed about the diarrhoeal symptoms prior to discharge. The second case was positive on 10/12/25 with symptoms of nausea and vomiting. A symptomatic staff member reviewed the patient possibly resulting in the 2nd patient exhibiting symptoms. Subsequently, an HCA and a student nurse also became symptomatic. 10x total patient contacts were identified. The following IPC containment measures were initiated: The affected bays were closed, and patient contact were closely monitored. As they remained symptom free for 48 hours the bays were opened to admissions. A further infectious clean of the bay, including toilets, patient's gym room, and equipment were carried out with strict stool chart documentations.

Lessons Learnt:

- Symptomatic staff must strictly adhere with the Trust sickness policy to prevent cross- transmission.
 - Ensure strict documentations of stool chart as part of risk assessment for all patients.
 - Containment and isolation is imperative to control spread.
-



Chicken Pox on Marble Hill 2 (MH2)

The Chelwest Occupational Health Services informed the IPC team about a staff nurse in MH2 who was clinically diagnosed with Chickenpox. Staff presented to Occupational Health on 12/02/26 with rash behind the ear, history of fever and headache, although was reported to have received two doses of varicella vaccine in 2023. Subsequently, the staff member was seen in A&E from where the Chickenpox diagnosis was confirmed.

The staff worked during their infectious period on 12/02/26 in MH2, seven patient contacts were identified who were assessed by the clinical team, no prophylaxis was needed but symptom surveillance was performed. Two staff contacts were assessed by OH and were not considered to be at risk or immunocompromised.

Lessons Learnt: Staff to follow the Trust Sickness policy and ensure they are aware of their vaccination status.

TB Positive Patient on ED/AICU

The Health Protection Team (HPT) notified IPC team of an infectious pulmonary TB patient on 20/03/26. The patient was known to Ealing TB CNS and currently under their care. The HPT has informed that the patient's onset of symptoms was from March 2025 when they attended WMUH. The 31 years old patient admitted on 15/03/26 due to drug overdose and decreased GCS on 15/03/25. ACXR performed on 15/03/26 revealed a possible case of TB, however the patient self-discharged against medical advice a day after admission and was lost to follow up as they had no fixed abode or contact number. As the patient was possibly infectious during ED and AICU admission, contact tracing for patients and staff was carried out. Five patient contacts were identified and were managed by the WMUH TB CNS, 40 staff contacts were managed by OH.

Lessons Learnt: Staff to follow the Trust sickness policy if they are unwell with respiratory symptoms.

Water Incident on Queen Mary Maternity Unit (QMMU)

Two water tanks at QMMU were identified to be contaminated with *Enterococci*. The first tank had *Enterococci* results of 35 CFU/100ml and was immediately isolated while the 2nd tank with *Enterococci* results of 4 CFU/100ml supplied the building with mitigations in place such as point of use filters, alcohol hand gel after handwashing with soap and water and bottled water for drinking. The tanks underwent chlorination and flushing and the water was sent for sampling after 48 hours of chlorination. The post corrective water samples results returned back clear. Implemented the return of disinfected water fountains with new carbon filters. All mitigations were lifted and normal operations resumed.

***Clostridioides difficile* (*C. difficile*) Cases:**

Sixteen cases of *C. difficile* were identified which included x14 Hospital-Onset Healthcare-Associated (HOHA) x2 Community-Onset Healthcare-Associated (COHA)

1) *Clostridioides difficile* Infection (CDI) on AICU

Two cases were identified from AICU (x1 HOHA and x1 COHA)



Case 1

70-year-old patient was admitted on 08/04/25 due to acute kidney injury, metabolic acidosis and hyperkalaemia. History of decompensated liver disease and chronic diarrhoea prior to admission. The patient was transferred to AICU for renal replacement therapy.

Diarrhoea developed following admission and a sample tested positive for *C. difficile* PCR and toxin. The patient had a prior community-acquired CDI in February 2025. The patient sadly passed away on 23/04/25 due to multi-organ failure. A PSIRF meeting was conducted and no lapse in care was identified. Good practice was noted in documentation of stool chart and isolating patients with enteric precautions. However improved documentation about prior CDI was identified as this had not been highlighted in the *C. difficile* checklist completed for the patient.

Lessons learnt: The medical team should ensure that the *C. difficile* checklist is completed accurately, especially the section indicating whether the patient had previously had *C. difficile* infections.

Case 2

79-year-old patient presented to ED on 11/02/26 due to diarrhoea and vomiting. A stool sample was sent on admission came back *C. difficile* PCR and toxin positive. Patient was noted to have previous admission within the last 28 days and spent four days in WM AICU prior to discharge on 04/02/26. Treated with oral vancomycin. A PSIRF meeting was conducted and no lapse in care identified. Good practice identified – patient was immediately isolated with enteric contact precautions from admission. Issues identified: To improve clarity on antibiotic stop dates to minimise the risk of extending duration. Incomplete stool chart documentation.

Lessons learnt:

- For antibiotics prescription to clearly specify the review and stop dates to minimise the risk of unnecessarily extended treatment durations.
- Importance of stool charts documentation consistently and accurately every shift, including when bowels are not opened.

2) HOHA *Clostridioides difficile* Infection on Kew

A total of 2 cases of *C. difficile* (HOHA) were identified from Kew

Case 1

87-year-old patient admitted on 07/04/25 with dysuria, confusion and right knee pain with medical history of dementia, epilepsy, T2DM, CCF, CKD. The patient received antibiotic therapy for urinary tract infection and septic joint. On 13/04/25, the patient developed loose stool, and a stool sample tested positive for *C. difficile* PCR and Toxin. A PSIRF meeting was conducted and no lapse in care was identified. Good practise such as appropriate stool chart documentation and patient isolation while awaiting transfer to a side room were recorded. The following issues were identified: non-adherence to empiric antibiotic guidelines due to inappropriate use of ceftriaxone and low dose of cefalexin prescribed in the community.

Lessons learnt:

- Orthopaedic consultants to adhere to antibiotic guidelines when prescribing ceftriaxone.
- Inform community GPs to avoid Cefalexin under dosing.



Case 2

89-year-old patient presented to ED on 01/01/26 due to severe pain from a sacral pressure ulcer with malodorous discharge and was commenced on antibiotic treatment for an infected ulcer. Patient developed loose stools on 14/01/26 and the sample sent came back *C. difficile* PCR and toxin positive. Treated with oral Vancomycin. Patient treated with oral Vancomycin. A PSIRF was conducted with no lapse in care identified. Issues identified: Inaccurate completion of *C. difficile* checklist.

Lessons learnt: Importance of correctly filling up the checklist has been highlighted and dissemination and utilisation of risk assessment and management of diarrhoea and *C. difficile* posters has been carried out by The IPC team to ensure all staff specially the resident doctors and nurses are aware of and utilise these resources when filling up the checklist.

3) *Clostridioides difficile* Infection on Amu

A total of 4 cases of *C. difficile* (HOHA) were identified from AMU.

Case 1

77-year-old patient admitted on 30/04/25 due to abdominal pain, on and off diarrhoea & vomiting for 2/52 weeks with mild epigastric tenderness. On admission, the imaging showed duodenitis and colitis of unknown origin. Patient did not have diarrhoea on admission but developed diarrhoea on 07/05/25 for which a stool sample was sent and returned positive for *C. difficile* PCR and toxin. A PSIRF meeting was conducted, no lapse in care identified and no issues were identified.

Lessons learnt: The ward team promptly isolated the patient with enteric precautions after diarrhoea was identified, documented the isolation reason, maintained stool charts, and started treatment according to trust guidelines.

Case 2

17-year-old patient presented to ED on 15/10/2025 with a 6-week history of headache, nausea, and vomiting. CSF showed lymphocytosis and elevated protein for which neurology were investigating. The patient received antimicrobials and antivirals. Impression of Lyme disease. One episode of loose stool on 26/10/2025 prompted stool testing which came back *C. difficile* PCR and Toxin positive. Treatment held off as patient asymptomatic. A PSIRF meeting was conducted, and this was not considered a *C. difficile* infection. Issues identified: In appropriate sample sent for *C. difficile* testing. Stool chart documentation was incomplete.

Lessons learnt:

- Importance of completing stool chart documentation every shift.
- Importance of assessing the patients when diarrhoea is identified and use of posters for risk assessment posters for management of *C. difficile* and diarrhoea to avoid inappropriate samples being sent.

Case 3

24-year-old patient presented to ED on 07/01/26 due to reduced eating and drinking on a background of anorexia. Patient developed loose stool on 12/01/26 and a sample sent came back *C. difficile* PCR and toxin positive. Treated with oral Vancomycin. A PSIRF meeting was conducted and no lapse in care was identified. Issues identified: lack of documentation regarding the need for testing, side room escalation plan and



decision to manage in the bay with enteric contact precaution. Lack of awareness regarding the 'Risk assessment and management of *C. difficile* and diarrhoea' posters. Medical teams were unaware about the antibiotic history in the community prior to patients' admission.

Lessons learnt:

- The need for clear documentations on testing, side room escalation, and decision to manage with enteric contact precautions in a bay awaiting side room.
- Training for staff around the use of risk assessment tools using the poster on 'Risk assessment and management of *C. difficile* and diarrhoea'.
- Importance of utilising the medication history box by the medical team on Cerner and liaising with the antimicrobial pharmacist to obtain this information as part of patients' risk assessment.

Case 4

84-year-old patient presented to ED on 09/01/26 due to dizziness, cough, and fatigue, against a background of myasthenia gravis. The patient was treated with antibiotics for an exacerbation of myasthenia gravis secondary to community-acquired pneumonia (CAP). Patient developed loose stools on 15/01/26 sample sent on 16/01/26 came back *C. difficile* PCR and toxin positive. Treated with oral Vancomycin. A PSIRF meeting was conducted and no lapse in care was identified. Issues identified: the need for clear documentation of decisions regarding testing for *C. difficile*, isolation of diarrhoea patients in the bay and the lack of side rooms available.

Lessons learnt: The importance of clear documentations regarding sending sample for *C. difficile*, escalation for side room and decision to manage patients with enteric contact precautions in a bay while awaiting side room has been highlighted.

4) HOHA *Clostridioides difficile* Infection on Syon 1

76-year-old patient was admitted on 30/04/25 with fever, cough, and an unwitnessed fall. The patient was started on antibiotic therapy for suspected sepsis and pneumonia and subsequently developed diarrhoea, and a stool sample sent on 19/06/25 was positive for *C. difficile* PCR and toxin. A PSIRF meeting was conducted and no lapse in care was identified. Issues such as delay in sampling and isolating the patient were identified for improvement.

Lessons learnt:

- Improve communication strategy between the nursing and the medical team.
- Ensure if a paper *C. difficile* checklist version is used this information is widely disseminated to the clinical team to avoid delays in sending sample.
- Ensure diarrhoea patients are identified promptly, risk assessed and if infectious cause is identified, to isolate and screen immediately.

5) *Clostridioides difficile* Infection on Lampton

A total of 3 cases were identified from Lampton (x2 HOHA and X1 COHA)

Case 1

92-year-old patient tested positive for *C. difficile* PCR and toxin from a stool sample collected on 19/07/25. The patient was admitted to ED on 19/07/25 with several days of diarrhoea and green, malodorous loose stools prior to admission and was isolated in a side room under enteric contact precautions, and a stool



sample was obtained. The patient was then transferred to an acute medical unit (AMU) side room and subsequently to MH2 side room.

The PSIRF was attributed to Lampton ward as the patient was recently discharged from Lampton on 11/07/25 after treatment for falls, foot wounds, and right knee effusion. Good practice noted on the ward as the medical team reviewed and stopped the ceftriaxone promptly once the diagnosis was clear. Identified issues included the use of ceftriaxone in the ED to treat septic arthritis, which may increase the risk of *C. difficile* infection. Additionally, staff do not always highlight that the patient has diarrhoea, unless the patient is for discharge.

Lessons learnt:

- ED team to consider other alternatives to Ceftriaxone.
- Improve communication between the nursing and the medical team for prompt action and review of diarrhoea patients.

Case 2

73-year-old patient presented to ED on 14/08/25 due to physical deconditioning and acute constipation for which they were started on laxatives. Patient has been diagnosed with bladder cancer since 2021 with progressive osseous metastatic disease. Antibiotics were given due to query sepsis. The patient developed diarrhoea and a stool sample sent on 20/08/25 came back *C. difficile* PCR and Toxin positive. Discharged home on 21/08/25 with oral fidaxomicin following a palliative and physiotherapy input for continuing community therapy. PSIRF conducted on 16/09 with no lapse in care identified. Issues identified were for pharmacy team to review laxatives, PPI and help improve medication management and reduce recurrence risk. Improve communication for prompt review of diarrhoea, maintain up to date stool chart and importance of isolating patients with suspected diarrhoea.

Lessons learnt:

- Pharmacy team to review laxatives/PPI promptly when diarrhoea and *C. difficile* positive patient is identified.
- Clear and timely communication between nursing and medical teams for prompt clinical review of diarrhoea.
- Importance of accurate stool chart documentation.
- Importance of early isolation of patients with suspected infectious diarrhoea to minimise cross-transmission.

Case 3

76-year-old patient presented to ED on 16/09/25 due to fall, long lie and raised inflammatory markers. Antibiotics, laxatives and PPI were prescribed and given during their inpatient stay. Patient subsequently developed loose stools. A stool sample was sent on 22/09/25 which came back positive for *C. difficile* PCR and Toxin positive and the patient treated with oral vancomycin. A PSIRF was conducted and no lapse in care noted. Issues identified include a false positive blood culture result with skin contaminant was observed during the current admission which could lead to unnecessary treatment with antibiotics. Good practice was demonstrated, as antibiotics were avoided during the August admission and appropriately reviewed and discontinued in July when they were felt to be unnecessary.

Lessons learnt: Allow alcohol to dry on the skin before taking blood cultures



6) *Clostridioides difficile* Infection on Syon 2

A total of two cases of *C. difficile* was identified from Syon 2 x2 HOHA)

Case 1

90-year-old patient tested positive for *C. difficile* PCR and toxin positive from a stool sample taken on 25/07/25. The patient presented to ED on 25/05/25 due to unwitnessed fall, chest pain and shortness of breath. Diagnosis included pneumothorax and aspiration pneumonia, and treatment consisted of antimicrobials, laxatives, and proton pump inhibitors. On 25/07/25, the patient developed type 6 loose stools for which a *C. difficile* sample was sent. A PSIRF meeting was conducted on 04/09/25, identified issues included increased antibiotic exposure due to patient frailty; prescribing was appropriate and reviewed with the Microbiology team (good practice noted).

Incomplete documentation when transmission-based precautions were initiated while the patient was managed in a bay awaiting side-room availability. Inconsistent adherence to the Trust Bare Below the Elbow (BBE) policy by the medical team.

Lessons Learnt:

- Importance of accurate and timely documentation when transmission-based precautions are initiated in bays.
- Importance of adhering to the Trust Uniform and dress code policy is required to minimise the risk of cross-transmission.

Case 2

65-year-old patient has been identified to be positive for *C. difficile* from a stool sample sent on 09/03/26. Presented to ED with on 02/03/26 due to intermittent fever, difficulty in breathing, productive cough. Patient was transferred to Syon 2 on 04/03/26 and was treated for chest sepsis. Started having diarrhoea five days into their admission to the ward for which a sample was sent. The patient was initially treated with vancomycin, which was discontinued and started on fidaxomicin as the patient was deemed at risk of recurrent *C. difficile*. A PSIRF meeting was conducted and no lapse in care was identified. Issues identified - the need for clear documentation regarding isolation of diarrhoea patients in the bay and the lack of side rooms available. Incomplete stool chart documentation.

Lessons learnt:

- The importance of clear documentations regarding sending sample for *C. difficile*, escalation for side room and decision to manage patients with enteric contact precautions in a bay while awaiting side room has been highlighted
- Importance of stool charts documentation consistently and accurately every shift, including when bowels are not opened.

7) HOHA *Clostridioides difficile* Infection on Osterley 1

88-year-old patient presented to ED on 27/09/25 due to fall and underwent right hip arthroplasty on 28/09/25. The patient received antibiotics for *Klebsiella spp.* bacteraemia associated with hepatobiliary infection and bilateral pneumonia, suspected to be due to aspiration. The patient developed loose stools and persisted even after cessation of laxatives. A stool sample sent on 08/10/25 came back *C. difficile* PCR



and toxin positive and they were treated with Fidaxomicin. A PSIRF meeting was conducted and no lapse in care noted. Issues noted: Incomplete stool chart documentations and isolation of the patient occurred only after results were identified by the IPC team. Good practice was noted - ward pharmacist conducted review and recommended interventions in the management of the *C. difficile* case such as discontinuing laxatives, consulting with the microbiologist, and avoiding prokinetics unless indicated.

Lessons learnt:

- Importance of completing stool chart documentation every shift including instances where bowels are not opened.
- Importance of accurate and timely documentation when transmission-based precautions are initiated in bays.

8) HOHA *Clostridioides difficile* Infection on Osterley 2

73-year-old patient presented to ED on 14/02/26 due to abdominal pain and vomiting. Patient started to have episodes of diarrhoea while in ED and persisted whilst on Osterley 2. A stool sample sent on 22/02/26 returned *C. difficile* PCR and toxin positive. Patient was discharged after the result. The surgical team informed the patient about the result and treated with oral vancomycin. A PSIRF meeting is pending.

10. Education and Training

Report written by Mario Olivar, IPC Deputy Lead Nurse

The IPC team provides comprehensive training to staff across the organisation, offering both online and in-person formats. This includes mandatory programmes for all employees, as well as essential updates tailored for clinical personnel. A broad array of supplementary educational opportunities are available [[Appendix 5: 2025/26 Healthcare Associated MRSA Bacteraemia Summary](#)]

Report written by Zara Tzouros, IPC Data Manager

There were six Healthcare Associated MRSA bacteraemias from April 2025-March 2026, breaching the national target of zero cases of healthcare associated infections. This is an increase of one case on the previous financial year.

Three cases were categorised at Healthcare Onset, Healthcare Associated (HOHA) and three cases were categorised at Community Onset, Healthcare Associated (COHA); both categories are deemed as Healthcare Associated by UK HSA.

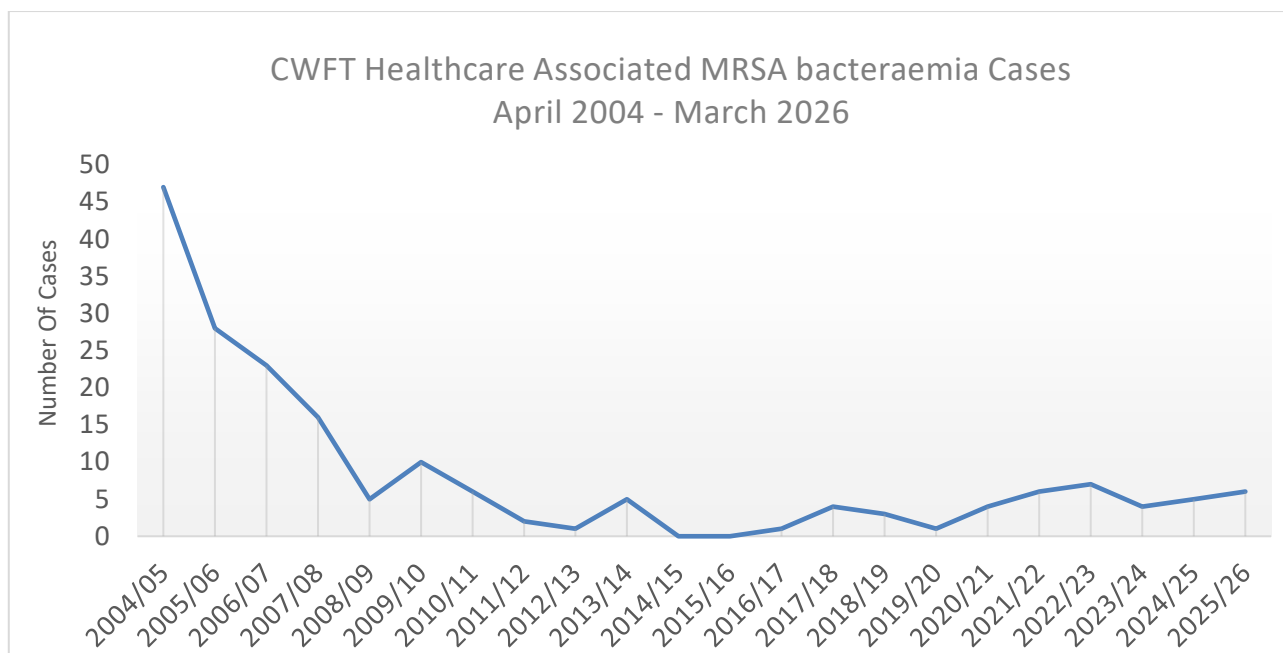


Figure 78: CWFT MRSA Bacteraemia Cases 2004 - 2026

Benchmarking

The Trust sits above the UK average rate of 1.64 with a 2025/26 average rate of 1.26 but falls below the London average rate of 1.75 per 100,000 bed days + day admissions.

Locally the trust has performed similarly to other organisations in the sector as evidenced by Figure 79 below.

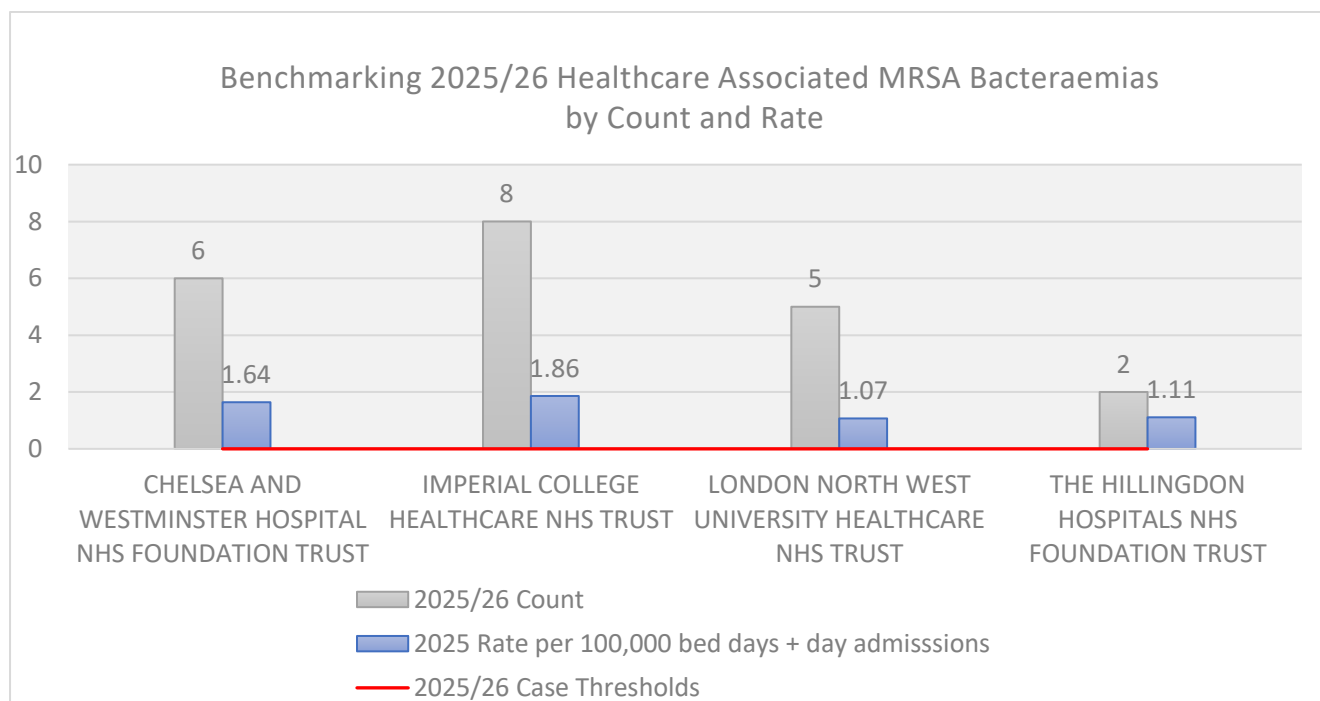


Figure 79: Trust attributed MRSA rates benchmarking against other organisations

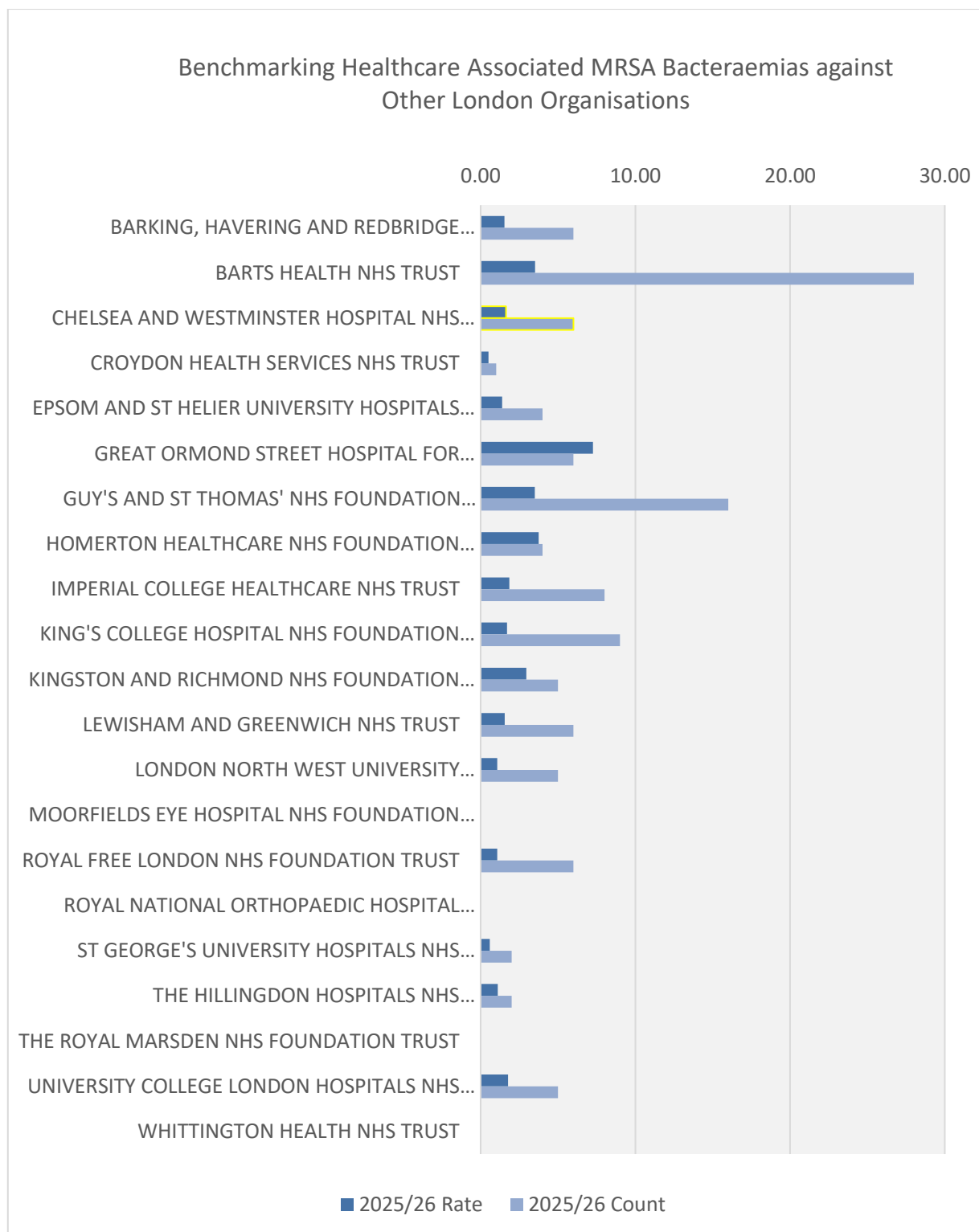


Figure 80: Trust attributed MRSA rates benchmarking against other London organisations

Ward And Divisional Distribution

Of the six cases that occurred, three were community derived with patients admitted with signs and symptoms of infection consistent with MRSA bacteraemia but due to the UK HSA criteria which includes previous admission within the past 28 days classified as a healthcare associated.



Three cases occurred at the WM site; and 3 cases occurred at the CW site, see Figure 81 for a breakdown of wards and divisions attributed.

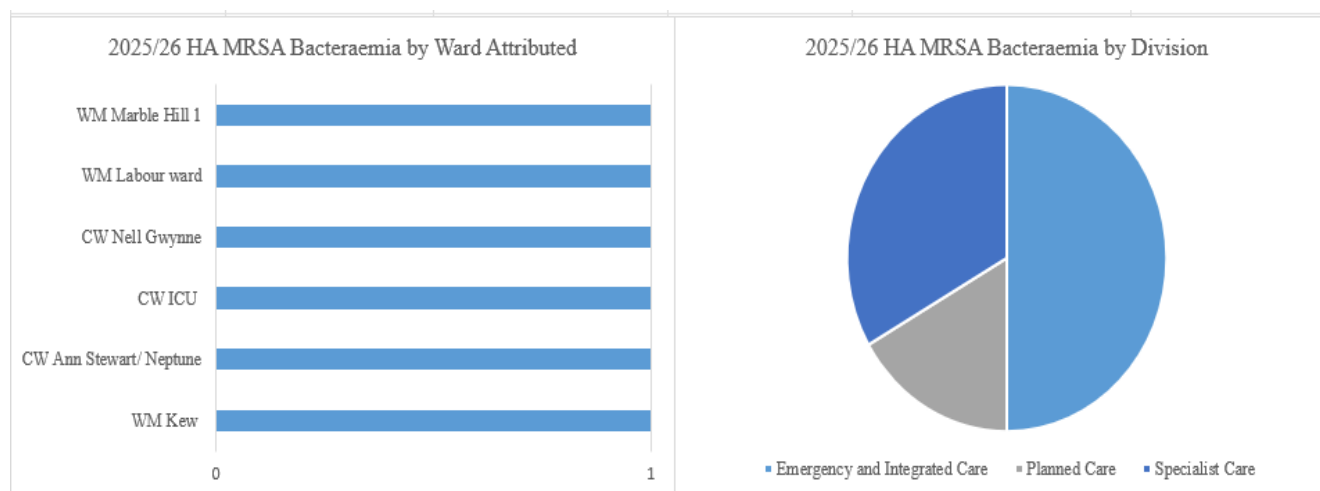


Figure 81: Healthcare Associated MRSA Bacteraemias by ward and division

All cases occurred on different wards and were split across the divisions: 3 cases occurred in the Emergency and Integrated Care division (EIC), 1 in Planned Care (PC) and 1 in Specialist Care (SC) divisions. Figure 82 below shows the distribution of cases throughout the year.

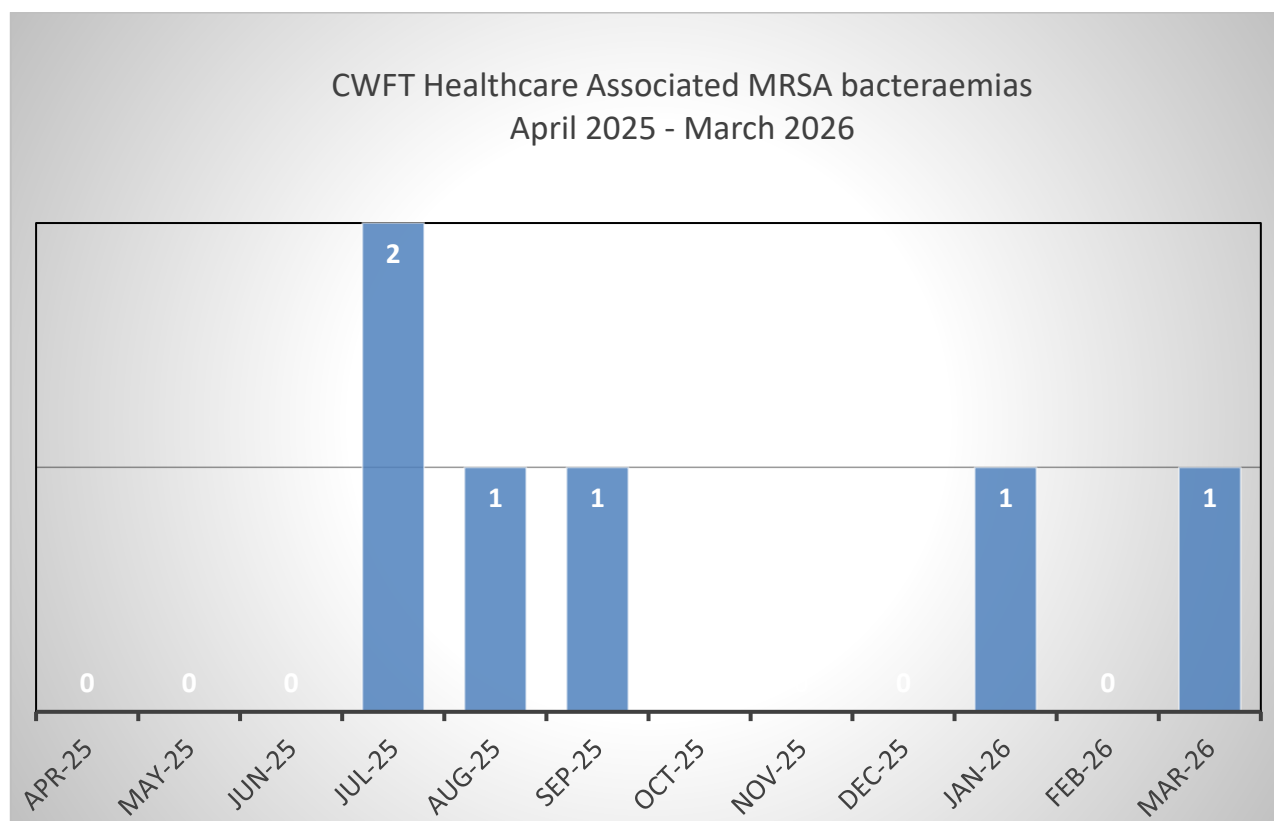


Figure 82: Healthcare Associated MRSA Bacteraemia by month positive



Blood Culture Data Analysis

From April 2025 – March 2026, and Westminster NHS Foundation Trust over 31,000 blood culture specimens were processed with a total six healthcare associated MRSA cases reported as detailed in figure 83 below.

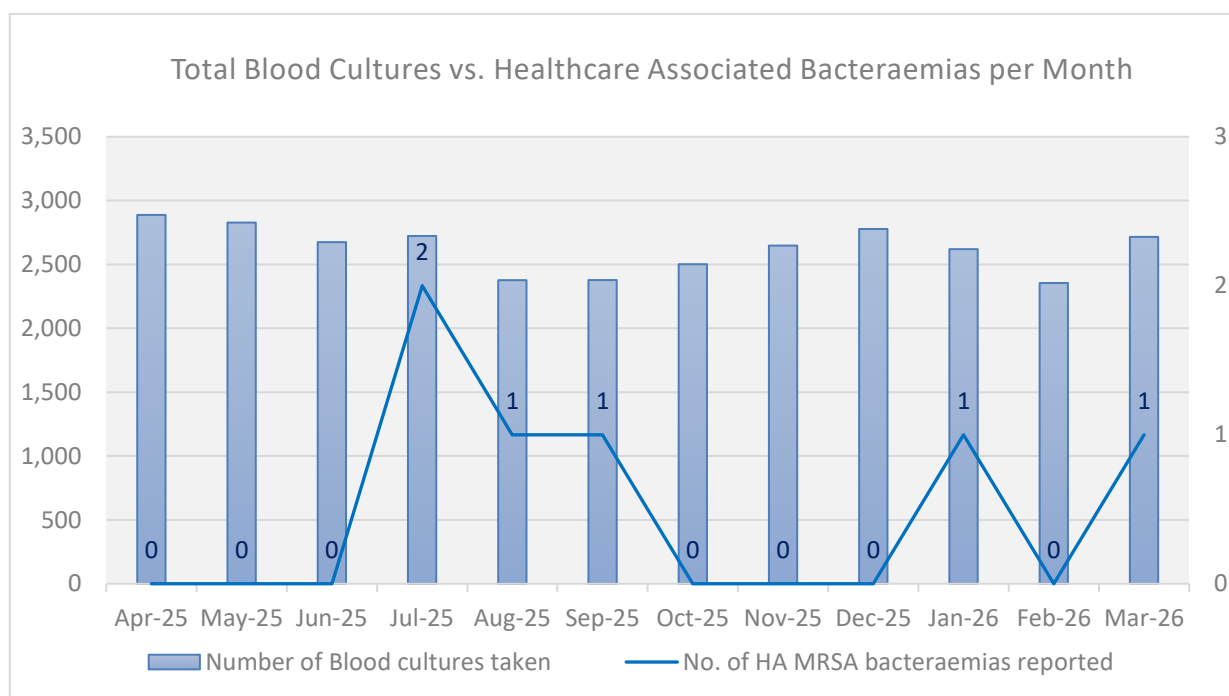


Figure 83: 2025/26 Number of Blood Cultures vs. MRSA Positive Blood Cultures

Time From Admission to Positive Result

Figure 84: Number of days from Admission to Positive Blood Culture. Figure 84 below shows the number of days from admission to positive blood culture (day 1 equals day of admission) per case which demonstrates a range of 1-45 days and an average of 12.17 days.

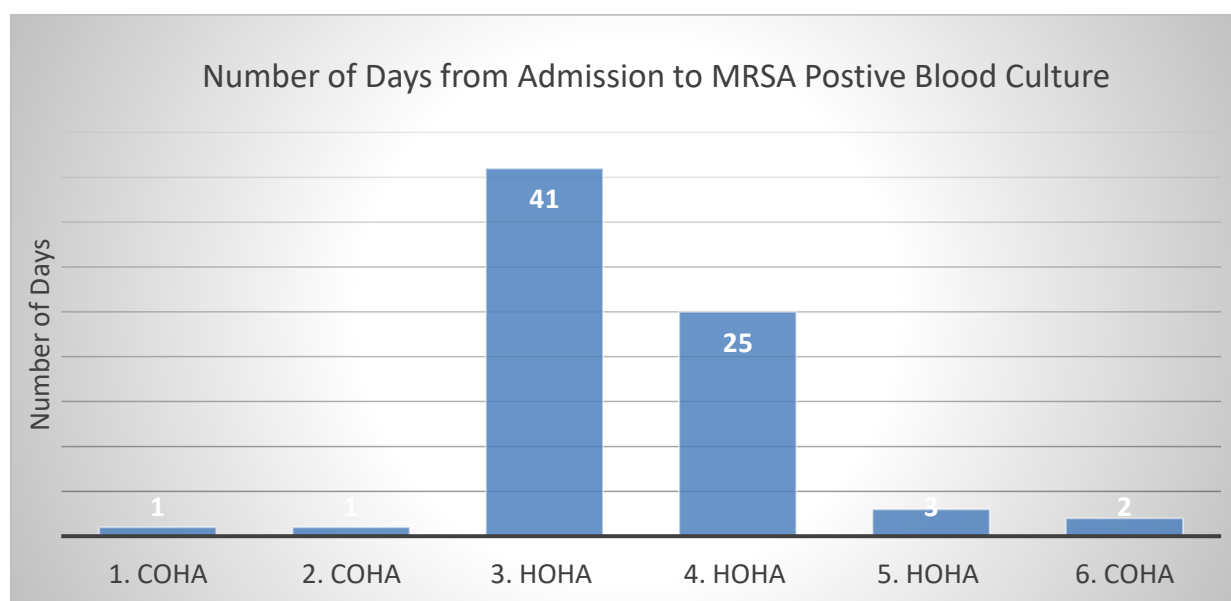


Figure 84: Number of days from Admission to Positive Blood Culture.



Summary of Cases

Of the six Healthcare Associated cases reported:

- 3 cases occurred at CWH and 3 at WMH.
- All cases occurred on different wards and were split across the divisions: 3 cases occurred in the Emergency and Integrated Care division (EIC), 1 in Planned Care (PC) and 2 in Specialist Care (SC) divisions.
- 3 cases were categorised as COHA and 3 cases were categorised as HOHA.
- 3 of the cases were admitted with symptoms of bacteraemia and classified as healthcare associated due to a recent admission. PSIRF meetings concluded these cases were unavoidable.
- 2 MRSA colonisations were Healthcare Associated acquisition occurring within a range of 25 – 41 days post admission.
- 1 patient was blood culture positive before the NAG result had resulted and previously MRSA negative.
- 1 patient was deemed unsuitable for de-colonisation due to a large chronic leg wounds as per MRSA policy.
- 2 patients met the criteria for and received decolonisation.

Sources of Infection

Sources of infections are identified at PSIRF meetings, Figure 85 below shows the sources of all 5 cases.

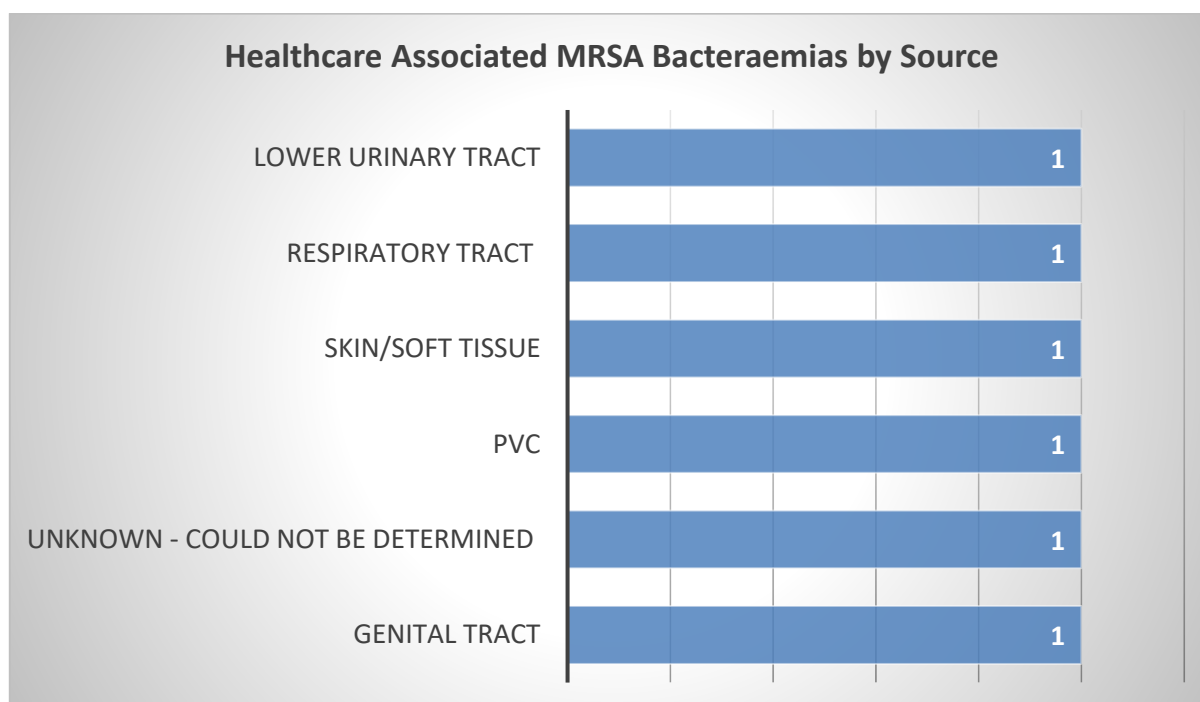


Figure 85: Source of Healthcare Associated MRSA bacteraemias

PSIRF Review

The Patient Safety Incident Review Framework (PSIRF) was utilised and MDT meetings held for all cases which identified/ confirmed:



- Compliance with the 5 moments of hand hygiene is imperative, hand hygiene compliance audits are conducted and submitted monthly and reviewed at IPCG. IPCT validation audits commenced in September 2025 to provide assurance of audit accuracy.
- Compliance with the bare below elbows policy in relation to hand hygiene continues to be challenging, this is being further supported by the executive nursing and clinical teams who have developed an escalation pathway for chronic offenders who do not follow policy.
- Reducing the inappropriate use of gloves is imperative to reducing cross-transmission of infections. This has been encouraged via the inclusion of the gloves off poster and glove usage risk assessment being uploaded as a digital screensaver to all Trust computers.
- Adherence to the MRSA screening policy is good, a point prevalence survey conducted by the team showed good compliance with screening.
- Prompt isolation of patients with MRSA (if possible) is ideal with staff encouraged to document on Cerner if there are no isolation facilities available.
- Prompt prescribing and appropriate administration of MRSA topical suppression therapy remains a priority with a QI project drafted for the upcoming financial year.
- Improve appropriate management of Intravenous devices – one of the MRSA bacteraemia reviews reached the conclusion that the bacteraemia was likely due to device management, though this was a highly complex patient and there was traumatic self-removal of device, a long-term alternative should have been discussed.
- Maintaining a high standard of environmental hygiene remains a priority.
- Prudent antibiotic stewardship remains important.
- Importance of following aseptic technique steps during blood culture specimen collection and allowing alcohol to dry once disinfection of the skin has been performed.
- Importance of adhering to the screening schedule post-MRSA suppression therapy as outlined in the MRSA policy.
- Increasing Caesarean section rates highlight the need for a review of the MRSA screening policy, particularly for long-stay antenatal patients, those undergoing induction of labour, and healthcare worker risk stratification- under review by the IPC team.
- Clinical Documentation: Routine checking of the 'Problems and Diagnoses' section in Cerner is essential to ensure accurate organism flagging and application of appropriate risk assessments and transmission-based precautions.
- Follow strict ANTT technique during urinary catheter insertion.

Individual Case Details

COHA MRSA Bacteraemia – Ann Stewart / Neptune Ward

2-week-old infant presented to Chelsea and Westminster Hospital Emergency Department on 28 July 2025 and was diagnosed with MRSA bacteraemia. The patient was subsequently admitted to Neptune Ward.

The infant was born on 09 July 2025 via caesarean section at Chelsea and Westminster Hospital and was discharged on 12 July 2025 following routine postnatal care. The baby re-presented to the Emergency Department on 13 July 2025 following maternal concerns regarding reduced urine output; however, after assessment, the infant was found to be clinically well and was discharged home.

On 28 July 2025, the infant re-presented to the Paediatric Emergency Department with fever at home and poor feeding. A blood culture taken on the same day detected MRSA.



Following confirmation of MRSA bacteraemia, maternal screening was undertaken and returned positive for MRSA. The mother was subsequently commenced on suppression therapy. The infant's MRSA isolate was sent for typing and was identified as MLST:22 (allelic profile: 7,6,1,5,8,8,6) and PVL-positive MRSA.

To mitigate the risk of transmission to other vulnerable patients and staff, the following IPC measures were implemented:

- The infant was isolated in a single-occupancy room on admission, and contact precautions were initiated.
- Targeted education on PVL-MRSA was provided to staff, with emphasis on early recognition of skin and soft tissue infections and prompt escalation of concerns. This information was shared via staff handovers and the ward WhatsApp group.
- Cleaning protocols on the unit were reviewed to ensure compliance with IPC standards, and a deep clean of the ward was completed on 12 August 2025.

A PSIRF meeting was held on 13 August 2025. The source of the bacteraemia remained unclear, and no lapses in care or contributory factors were identified. All lines and devices had been managed appropriately in accordance with best practice guidelines, and no breaches of the MRSA screening policy were identified. The infant remained clinically well throughout admission.

An action from the investigation was for the PSIRF documentation to be shared with the Obstetrics Team for review and learning.

MRSA Bacteraemia – Adult Intensive Care Unit (AICU)

67-year-old patient presented to the Emergency Department on 29 June 2025 with reduced consciousness following a fall. The initial clinical impression was a urinary tract infection, and the patient was treated with intravenous antibiotics.

The patient subsequently deteriorated and was admitted to AICU on 13 July 2025 following intubation. The clinical picture was one of undifferentiated encephalopathy, and the patient received two courses of steroids. A tracheostomy was inserted on 04 August 2025.

MRSA was detected from a NAG screen on 04 August 2025, and a sputum sample taken on 5 August 2025 also grew MRSA. A blood culture taken on 9 August 2025 detected MRSA bacteraemia. Typing of the blood culture identified MLST ST97 (allelic profile: 3, 1,1,1,1,5,3).

A PSIRF review was conducted, and no lapses in care were identified.

The PSIRF review highlighted the following learning points:

- IPC teams to continue to ensure clear documentation of MRSA and ESBL status, along with related interventions, within patients' electronic records.
- Improved documentation on Cerner to clearly specify the source of blood cultures (e.g. peripheral or line-related).
- Review of the current tracheostomy protocol to consider incorporating routine skin swabbing 48–72 hours prior to insertion.



- Review and assurance of staff competency involved in tracheostomy procedures to ensure adherence to protocol and safe clinical practice.
- Timely review and initiation of MRSA decolonisation therapy where indicated.
- Verification that cleaning standards and single-use equipment protocols are consistently followed, particularly for ultrasound equipment and patient transfer devices used during procedures and imaging.

HOHA MRSA Bacteraemia on Nell Gwynne

73-year-old patient was admitted on 24/08/25 via the Emergency Department with progressive neurological symptoms following recent hospitalisation abroad. During admission, the patient developed cellulitis at a peripheral cannula site. Blood cultures taken on 17/09/25 confirmed MRSA bacteraemia, with the likely source identified as the peripheral intravenous cannula. The Nose and Groin screen which was positive for MRSA was sent for typing which was MLST ST97 (MLST allelic profile: 3,1,1,1,1,5,3). No typing result available. Transthoracic echocardiography demonstrated a mobile lesion on the mitral valve, consistent with probable native valve endocarditis. The patient was commenced on MRSA-active antimicrobial therapy and contact precautions were implemented. A PSIRF meeting was completed on 30/09/25.

Learning Identified

- Lapses in peripheral cannula documentation and inconsistent aseptic technique were identified as contributory factors.
- Reinforcement of the 72-hour cannula review and prompt removal policy is required to reduce the risk of device-related infection.
- Improved staff training on device care documentation and cannula management is necessary.
- Greater oversight of MRSA decolonisation processes is needed to ensure adherence, particularly in patients with complex care needs.

COHA WM Marble Hill 1 MRSA Bacteraemia

81-year-old female presented to ED 04/07/25 with bilateral leg ulcers and social issues (non-engagement with QDS plan of care). Blood cultures on admission were MRSA positive. Admission NAG screen was negative but the right leg wound swab was MRSA positive. The patient was recently admitted to MH1 on 07/06/25 - 28/06/25 for a similar lower leg wound infection likely due to maggot infestation, then transferred to DRU after medical optimisation and subsequently discharged. Admission NAG screening on this visit detected MRSA and a positive MRSA culture from the left leg wound swab.

A PSIRF meeting conducted found no lapse in care. Summary of discussion: (1) probable skin contaminant, and (2) MRSA re-screening post suppression therapy performed on day 5 (right after suppression therapy) instead of the recommended day 8 (after 48hrs of suppression therapy).

Learning: (1) Ensure skin disinfectant has fully dried before collecting blood cultures. (2) Perform MRSA re-screening following suppression therapy on day 8 (after 48 hours of suppression therapy) as per protocol.

HOHA MWM Labour Ward MRSA Bacteraemia

29-year-old female admitted to QMMU for induction of labour on 20/01/26 and subsequently underwent an emergency caesarean section on 23/01/26 due to delayed labour progression. Patient developed pyrexia on 22/01/26, prompting a septic screen, which confirmed MRSA.



WM Kew (COHA) MRSA Bacteraemia

83-year-old male presented to ED on 04/03/26 due to fall and CAUTI. A blood culture sent on 05/03/26 came back MRSA bacteraemia treated with IV vancomycin. Previous admissions showed that the patient was known MRSA positive on 14/02/26 (Nose and groin), 20/02/26 (urine culture), 23/02/26 & 26/02/26 (penile swabs). Had suppression therapy on 09/03/26 to 14/03/26. Patient on long-term urinary catheter which was changed on 03/03/26 at the TWOC clinic, uneventful and there was an assurance that strict ANTT was followed. A PSIRF meeting was conducted and no lapse in care was identified. No issues directly identified.



Appendix 6: IPCT Training Conducted Apr 2026 – Mar 2026] to support the development of new clinical team members, such as resident doctors, medical students, internationally trained nurses, nursing students, healthcare support workers (via the Excellence in Care training), newly appointed ITU staff (through the Foundation of Critical Care course), participants in the Nurse Preceptorship Programme, and attendees of the IV Administration Study Day.

Additionally, one-day, in-person training sessions are organised for Infection Control Link Practitioners (ICLP) to provide key audit knowledge and empower them as IPC advocates. The team routinely engages with various stakeholders, delivering succinct teaching sessions during team away days and ward visits to address emerging learning needs, particularly in response to incidents and outbreaks. Provided below is the division-level mandatory compliance data for IPC Level 1 and Level 2 eLearning modules.

Table 4: Level 1 Mandatory Compliance by Division

Infection Control - Level 1	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Overall %	95%	94%	94%	95%	94%	94%	93%	93%	94%	93%	93%	93%
Change from previous month	↗	↘	↔	↗	↘	↔	↘	↔	↗	↘	↔	↔
Clinical Support Division	96%	96%	96%	96%	96%	96%	95%	96%	96%	95%	95%	94%
Corporate Division	95%	94%	93%	94%	94%	94%	90%	90%	92%	93%	93%	94%
Emergency & Integrated Care Division	86%	84%	81%	82%	83%	80%	89%	93%	89%	91%	89%	93%
Planned Care Division	95%	94%	96%	96%	94%	90%	93%	94%	92%	91%	85%	88%
Specialist Care Division	93%	93%	93%	93%	93%	92%	90%	91%	92%	92%	92%	92%
West London Childrens Healthcare	96%	96%	96%	93%	93%	96%	96%	96%	93%	93%	93%	93%

Table 5: Level 2 Mandatory Compliance by Division

Infection Control - Level 2	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Overall %	91%	92%	92%	91%	91%	89%	91%	92%	92%	92%	92%	93%
Change from previous month	↔	↗	↔	↘	↔	↘	↗	↗	↔	↔	↔	↗
Clinical Support Division	96%	96%	95%	95%	94%	93%	95%	95%	95%	95%	96%	97%
Corporate Division	91%	91%	93%	94%	93%	93%	95%	96%	97%	96%	95%	96%
Emergency & Integrated Care Division	92%	92%	92%	92%	91%	88%	91%	93%	93%	93%	93%	94%
Planned Care Division	89%	90%	90%	90%	89%	88%	89%	89%	89%	89%	90%	91%
Specialist Care Division	90%	91%	91%	91%	91%	90%	91%	92%	93%	93%	92%	92%
West London Childrens Healthcare	91%	91%	91%	91%	88%	84%	88%	90%	89%	89%	90%	91%

10.1. World Hand Hygiene Day 2025

The IPC team marked WHHD 2025 with the theme “It might be gloves. It’s always hand hygiene.” They set up stalls at both sites, visited clinical areas to promote the five moments of hand hygiene and PPE use, and used the Semmelweis scanner to demonstrate effective alcohol gel coverage. Staff and visitors actively participated in the activities.

CW WHHD Awareness Images – 13th May 2025



Figure 9: Chelsea & Westminster WHHD Photos

WM WHHD Awareness Images – 7th May 2025



Figure 10: West Middlesex WHHD Photos

10.2. International Infection Prevention and Control (IIPC) Week

The IPC team celebrated the IIPC Week in October 2025 with the theme: Stand UPPP (Unite, Prevent, Protect, Prevail) and stop the spread of infections. To reach a broader audience, message board and selfie frame were utilised, encouraging people to take photos and share them on social media. Roadshows were performed to increase staff awareness on the management of *Clostridioides difficile*, MRSA, line care management, and the gloves off campaign. The activity was highlighted during the Trust weekly safety huddle and well received by staff cross-site.

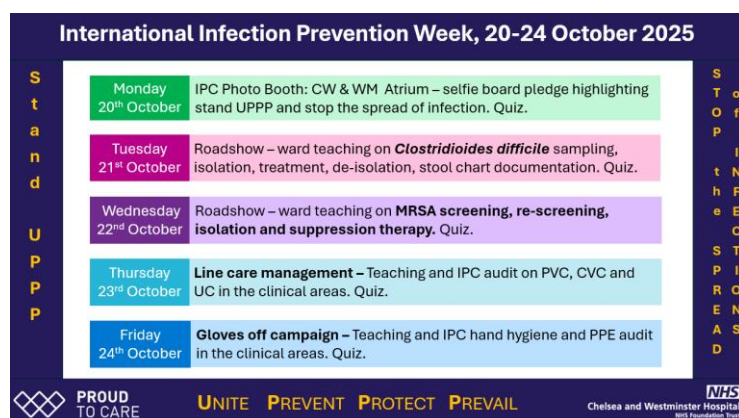


Figure 11: IIPC Week

11. Infection Control Link Professionals (ICLPS)

Report written by Alice Health and Jose Paulo Flor, IPC Nurse Specialists

The Infection Prevention and Control (IPC) team has a well-established network of Infection Control Link Professionals (ICLPs) across both hospital sites. While every employee within the Trust shares responsibility for preventing and managing infections, ICLPs provide additional local leadership and oversight to ensure effective infection prevention and control within their clinical areas. New cohorts of ICLPs are regularly designated and trained to support this role.

ICLPs promote and embed best IPC practice through staff education, implementation and reinforcement of Trust policies, collaboration with multidisciplinary teams, and engagement in ongoing professional development. They also undertake a programme of monthly audits, including hand hygiene, personal protective equipment (PPE), peripheral vascular devices, central venous catheters, and urinary catheters. Audit findings are reported to ward managers to support local governance, assurance, and continuous improvement.

In collaboration with the IPC team, ICLPs frequently lead or support targeted projects to address infection control challenges within their clinical environments, contributing to improvements in patient safety and standards of care. They act as IPC role models, respond to infection prevention and control queries from staff, and maintain regular communication with the IPC team for guidance and support when planning and implementing quality improvement initiatives. Examples of ICLP-led improvements include the replacement of bedside emergency kits at West Middlesex University Hospital (WMUH) Richmond and the Acute Medical Unit (AMU) to better meet IPC standards, improvements to sluice workflow within the Acute Assessment Unit at Chelsea and Westminster Hospital (CWH), implementation of the Gloves Off campaign, and the introduction of IPC information boards across wards at both CWH and WMUH.

During the year, the IPC team delivered seven ICLP study days, with a total of 76 attendees from across the Trust. Divisional attendance included 24 staff from Emergency and Integrated Care (EIC), 25 from Planned Care (PC), 16 from Specialist Care (SC), 6 from West London Children's Healthcare (WLCH), 3 from Clinical Support (CS), and 2 from Integrated Support Services (ISS).



The ICLP study days have consistently received positive feedback from attendees. The IPC team continues to review and enhance the training programme to improve the learning experience and incorporate effective strategies for knowledge sharing and skills development.

There are currently 335 trained ICLPs across the Trust (222 at Chelsea and 113 at West Middlesex).

Table 6: Average feedback scores for the study day (out of 10) and sample feedback comments

Date	Average Score	Samples of Comments Received
25.04.25	9.66	- Having attended ICLP course today, so refreshing, this should be continued for all of us, change habits, helping to spread good practices. Enhance understanding of ICLP and where we are in 2025 moving forward. These courses help to build motivation and willingness to give and receive feedback. - Good understanding on resistance of antibiotics and penicillin allergy. - Greater awareness and understanding of the importance of hand hygiene and PPE.
16.05.25	9.44	- I love that we did an interactive role play/audit. - Excellent course. Very informative. Well-explained. - Very interactive discussion from IPC team. Thank you.
22.08.25	9.61	- It was good to experience and learn from other colleagues. - General thank you! I learned a lot today. Learning to be taken home and shared with my colleagues. - Discussion is very interesting and lively.
05.09.25	9.34	- This was the most relevant to my clinical practice & I will regularly refer back to the slides. - Very useful to go and do audits on the day. Thanks for this good to see other areas. - Overall brilliant training session!
24.10.25	8.89	- Quite informative and a lot of changes will be implemented due to increase in knowledge. - It was great. Superb experience. Allowed me to see how our work looks from the other site. - Learned quite a bit about the different infections, differentiating it from bacteria, virus and fungi.
21.11.25	9.38	- Very knowledgeable facilitator and clear discussion. - Good opportunity to visit ward to do audit. - Very interesting subject well discussed. Very knowledgeable facilitator.
27.03.26	9.58	- Really good and very informative. Great course leaders and speakers. Only was a little more knowledge of dental just to tailor this training to our department. - Important to know as we cater to a lot of different kinds of patient conditions. - Good activity, nice to get first-hand experience in doing the audit. It was my first time.

12. Infection Prevention and Control Board Assurance Framework (BAF)



Report written by Mario Olivar, IPC Deputy Lead Nurse

The Infection Prevention and Control Board Assurance Framework (BAF) consolidate all relevant information and guidance required to assess organisational compliance with the National Infection Prevention and Control Manual (NIPCM) and associated infection prevention and control guidance. The framework supports systematic identification and management of risks associated with infectious agents, thereby providing enhanced assurance to the Trust Board.

The BAF was originally developed to support healthcare providers during the COVID-19 pandemic. Following the archiving of UKHSA COVID-19 guidance in April 2022, the BAF, used in conjunction with the NIPCM, continues to support this transition to business-as-usual arrangements for the management of infectious risks.

The application of the BAF ensures that Chelsea and Westminster Hospital NHS Foundation Trust (CWFT) maintain an evidence-based approach to protecting the safety of patients, service users, and staff. The framework is subject to regular review to ensure it remains current, identifies gaps in policy and practice implementation, and aligns with relevant legislation, including the Health and Social Care Act 2022. Risks and gaps identified through the BAF are documented, with clear actions and accountability assigned to relevant leads and divisions to support effective risk mitigation and patient safety.

Over the past year, several previously identified gaps have been addressed, including:

- IPC validation audits: IPC conducted hand hygiene and personal protective equipment (PPE) audit and feedback processes were re-established from Quarter 3, providing routine assurance and enabling targeted improvement actions.
- Environmental audits: Environmental assurance audits are prioritised in wards with increased infection incidence or identified risk, supporting targeted assurance and early identification of environmental issues.
- MRSA 'search and destroy' approach: A targeted audit of MRSA suppression therapy compliance has been implemented alongside screening, re-screening, and escalation processes. Planning commenced in January 2026. The programme aims to monitor compliance with the Trust MRSA policy, with outcomes fed back to clinical teams, divisions, and the Infection Prevention and Control Group (IPCG) to support continuous improvement.
- Antimicrobial Stewardship (AMS) oversight: While consistent executive engagement with the AMS group remains an identified gap, assurance is provided through reporting via the Director of Infection Prevention and Control (DIPC) and annual reports and a joint IPC and AMS priority to be set for 2026.
- IPC mandatory training compliance: IPC continues to work in partnership with the Learning and Development team to strengthen oversight of mandatory IPC training compliance, with performance monitored on a three-monthly basis.

13. IPC Annual Programme 2024-25

Report written by Mario Olivar, IPC Deputy Lead Nurse



During 2025–26, the Infection Prevention and Control (IPC) Team continued to deliver a comprehensive programme of both proactive and reactive activity, providing expert guidance to Trust staff and maintaining oversight of adherence to IPC policies. The programme aligned with the Trust’s strategic priorities, with a strong focus on patient safety, reduction of healthcare-associated infections (HCAIs), clinical effectiveness, staff education, and financial stewardship.

Table 7 Progress of IPC Annual Programme April 2025 - March 2026

Objectives	Current Progress
Back to Basics Campaign: Strengthened assurance across core IPC practice through education, audit and communication, focusing on hand hygiene, PPE use and the <i>Gloves Off</i> campaign to reduce HCAIs and improve patient outcomes, aligned to high-quality care and cost-effective delivery.	• Sustained delivery of the Trust-wide <i>Gloves Off</i> campaign using approved Trust communications materials. • Targeted promotion of glove reduction and hand hygiene, including focused activity during WHO World Hand Hygiene Day (May 2025), International Infection Prevention Week (October 2025) and reinforced messaging during IPC ward visits, particularly in areas of identified concern. • Ongoing ward-based education and mandatory training to support staff knowledge and compliance with appropriate use of personal protective equipment (PPE) and effective hand hygiene practices. • Hand hygiene and PPE audit and feedback processes, IPC independent audits implemented to provide routine assurance and targeted improvement actions. • Development of updated <i>Bare Below the Elbows</i> (BBE) communications in collaboration with the Communications Team and the Chief Nurse. • Senior nursing leadership oversight strengthened through implementation of structured reporting and feedback mechanisms to support BBE compliance. • IPC input supported evaluation of IPC-related products, ensuring cost-effectiveness and patient safety.
CDI Prevention and Management: Strengthened assurance across testing, isolation, case identification and risk-factor reduction through education, surveillance and governance review, ensuring learning is translated into improved patient outcomes and aligned to high-quality, cost-effective care.	• Patient Safety Incident Response Framework (PSIRF) reviews were undertaken for each <i>Clostridioides difficile</i> toxin-positive infection to identify contributory factors, actions and learning. Learning was cascaded for divisional review via the Infection Prevention and Control Group (IPCG), shared at Executive Management Board (EMB) and ICB IPC APC meetings for peer learning, and escalated quarterly to the Patient Safety Committee, providing multi-level governance oversight. • Monthly healthcare associated infection (HCAI) dashboards, including bloodstream infections and <i>C. difficile</i>, were routinely shared with Divisions to support transparency, scrutiny and ownership of performance for timely intervention. • Divisional action plans were reviewed and progressed locally, with accountability for completion embedded within divisional governance structures. • Targeted education was delivered to areas of concern, alongside proactive Trust-wide ward visits, to strengthen understanding of



	appropriate testing, isolation and management of patients with diarrhoea. This included active use of the <i>C. difficile</i> risk assessment and management poster to reinforce best practice. • Audits of transmission-based precaution signage were undertaken as part of the ward accreditation programme and during routine Infection Prevention and Control Nurse (IPCN) visits to provide ongoing assurance. • A rolling <i>C. difficile</i> awareness roadshow was delivered to reinforce key aspects of management, including timely sampling and isolation, hand hygiene, environmental decontamination, antimicrobial stewardship and appropriate use of PPE. • A learning and development tool in the form of a paper-based <i>C. difficile</i> sampling request tool was developed to support behavioural change, with pilot implementation planned. • Commode cleaning and availability checks were incorporated into routine IPC visits to reduce environmental transmission risk.
Digital IPC Communication: Strengthened delivery of key IPC messages through digital platforms, supporting clinical effectiveness, improved health outcomes and alignment of IPC education to the National IPC Education Framework.	• The IPC intranet was regularly updated to provide staff with easy access to current guidance, Trust clinical policies, and latest national updates from UKHSA, supporting timely and consistent application of best practice. • A digital hand hygiene monitoring device was utilised to improve staff awareness of hand hygiene technique. Through an associated Quality Improvement initiative, wards with identified concerns were supported using digitally generated images highlighting areas for improvement, enabling targeted feedback and education. • IPC and wider Trust staff education was formally mapped to the National IPC Education Framework, providing assurance that training delivery aligns with national standards and supports workforce competence. • Digital communication platforms, including the Trust social media account (Chelwest TikTok), were used to promote key IPC messages such as Bare Below the Elbows (BBE) and hand hygiene, supporting staff engagement and reinforcement of good practice with further plans to develop IPC digital dashboards in 2026/27.
Aligned to Trust Strategic Priorities: high-quality patient-centred care, employer of choice, and better care at lower cost.	• Active participation in the ward accreditation programme was maintained, with a primary focus on environmental audits to identify, mitigate and monitor infection risks associated with the care environment. • Targeted audits of invasive lines and devices are undertaken in wards with recurring low compliance against high-impact interventions to strengthen assurance and focus improvement activity to reduce HAI device related infections and a quality improvement project planned for improving line and device care



	• Ongoing joint cleaning reviews were carried out in collaboration with Infection Support Services (ISS) to support sustained environmental standards and address areas of concern. • IPC environmental audit was implemented, prioritising wards with increased infection incidence or identified risk, to provide targeted assurance and early identification of issues. • Teaching and education on equipment cleaning and audit processes were delivered to ensure staff competence in effective decontamination and safe equipment use. • Infection Control Link Professional training was provided to nursing staff to strengthen local IPC leadership, ownership and sustainability of good practice. • IPC support was provided during the seasonal influenza vaccination campaign to support staff uptake and protect workforce health during outbreak season. • Ongoing support for the education and professional development needs of IPC team members was maintained to ensure workforce capability and resilience.
Patient-Centred IPC Care: Strengthened patient information and engagement to support adherence to IPC practices, improve patient experience and reduce infection risk, aligned to high-quality, patient-centred care.	• The IPC Team reviewed and contributed to IPC information within the patient welcome pack to provide clear advice on hand hygiene, infection prevention expectations, and what patients can expect during their care. • During routine ward visits, the IPC Team actively supported patients to undertake effective hand hygiene, with ward staff encouraged to reinforce and support patient participation. • Patient-facing <i>Clostridioides difficile</i> information leaflets were reviewed and made accessible via the Trust intranet to support consistent patient education and understanding.

14. IPC Policies

Report written by Stacey Clarke, IPC Administrator

The IPC team has a comprehensive policy review programme to ensure that all policies and guidelines reflect the latest evidence-based practice. For the period 2025–2026, the following policies and guidelines outlined in

Table 1Table 8 have been reviewed and updated. All other policies and guidelines are currently in date.

Table 8: IPC Policies reviewed in the period 2025-2026.

Policy Title	Date of Approval
Infection Prevention and Control during Building Works - Prevention of nosocomial <i>Aspergillosis</i>	May 2025
Hand Hygiene	June 2025
Management of Outbreaks	September 2025



Decontamination Procedure for the high-level disinfection of Semi-critical Ultrasound Probes (Trans vaginal and Trans rectal): using a manual (chlorine dioxide) multi - wipe system.	October 2025
Infection Prevention and Control Overarching	September 2025
Investigation of Healthcare Associated Infections and Surveillance	September 2025
Isolation of Patients	September 2025
Linen	November 2025
Decontamination	November 2025
Group A <i>Streptococcus</i>	November 2025
Policy for the Prevention and Control of <i>Clostridioides difficile</i> Diarrhoea	January 2026
Panton-Valentine Leukocidin producing <i>Staphylococcus aureus</i>	February 2026
<i>Candidozyma auris</i>	February 2026
Policy for the Prevention of Iatrogenic CJD/ vCJD and other TSEs/Prion Diseases	March 2026

15. IPC Involvement in Building and Refurbishment Projects

Report written by Mario Olivar, IPC Deputy Lead Nurse

The Infection Prevention and Control (IPC) team has made a significant contribution to a wide range of building and refurbishment projects across both hospital sites, ensuring full compliance with all relevant IPC legislation, standards and guidance. This proactive and sustained involvement supports the reduction of healthcare-associated infection (HCAI) risk and associated costs. Through a strong emphasis on assurance and regulatory compliance, the team has helped to deliver safe clinical and non-clinical environments for patients, staff and visitors, while supporting improved patient outcomes.

Between April 2025 and March 2026, the Infection Prevention and Control (IPC) team provided sustained oversight of multiple building and refurbishment projects, as detailed in Table 9. This included comprehensive review of project plans, regular attendance at project meetings, and specialist advice on the selection of materials and furnishings in line with relevant Health Technical Memoranda (HTMs) and cleaning standards. This structured and consistent approach ensured compliance with IPC best practice and regulatory requirements, supporting the delivery of safe and well-designed clinical environments. Throughout the refurbishment lifecycle, the team worked collaboratively with key stakeholders to proactively identify, communicate and mitigate infection-related risks.

Table 9: Buildings and Refurbishments on which IPC have had input.

Site	Chelsea Site	West Middlesex site
Area	- A&E Paediatric Waiting Area - Clinical imaging - Treatment Centre - NICU/Maternity corridor - R&D OPD2	- Diagnostic, Treatment and Education Centre – New Build ongoing input - A&E and UCC Reception/ Waiting Area - A&E Paediatric Waiting Area/ Assessment - Syon 2 Treatment Room

16. IPC Risk Register

Report written by Mario Olivar, IPC Deputy Lead Nurse



The IPC risk register outlines the principal infection prevention and control risks to the Trust. In 2025–2026, four IPC risks were recorded on the register, all of which were rated as high risk [Figure 12: IPC Risk Register entries. Figure 12].

Approval status	ID	Site	Risk Handler	Division	Directorate	Speciality	Location (exact)	Risk Type	Risk Subtype	Title	Risk level (current)	Risk level (Target)	Date identified	Date reviewed	Date of next review
Live Risks	202	Cross site risk	Mario Olivar	Corporate functions	Medical Directorate	Infection Prevention And Control		Control of Infection	Control Of Infection: Risks from lack of infection control arrangements and practices	MRSA trajectory	High Risk	Moderate Risk	05/10/2016	27/04/2026	01/08/2026
Live Risks	209	Cross site risk	Mario Olivar	Corporate functions	Medical Directorate	Infection Prevention And Control		Control of Infection	Control Of Infection: Risks from lack of infection control arrangements and practices	Increase in cases of multi drug resistant organisms	High Risk	Moderate Risk	05/10/2016	27/04/2026	01/08/2026
Live Risks	208	Cross site risk	Mario Olivar	Corporate functions	Medical Directorate	Infection Prevention And Control		Control of Infection	Control Of Infection: Risks from lack of infection control arrangements and practices	Legionella in water outlets	High Risk	Moderate Risk	05/10/2016	27/04/2026	01/08/2026
Live Risks	207	Cross site risk	Mario Olivar	Corporate functions	Medical Directorate	Infection Prevention And Control		Control of Infection	Control Of Infection: Risks from lack of infection control arrangements and practices	Pseudomonas aeruginosa in tap water	High Risk	Moderate Risk	05/10/2016	27/04/2026	01/08/2026

Figure 12: IPC Risk Register entries.

There is a risk of breaching the MRSA trajectory arising from changes in screening policy, including the implementation of targeted screening rather than universal screening. This presents potential challenges relating to compliance and the timely identification of MRSA-colonised patients, thereby increasing the risk of MRSA bacteraemia. However, to mitigate this risk, the following controls have been implemented:

- Decolonisation and suppression therapy for all identified MRSA-positive patients if clinically applicable.
- PSIRF analysis undertaken for all MRSA bacteraemia cases with clinical and divisional teams and learning implemented by the division through their action plan.
- Ongoing review of mandatory MRSA reporting processes.
- Implementation and monitoring of the High Impact Intervention (HII) bundle.
- Point prevalence audits to assess MRSA screening compliance in selected areas.
- A sustained monthly focus on key aspects of MRSA management, including isolation practices, decolonisation, hand hygiene, aseptic non-touch technique (ANTT) equipment decontamination.

There is a risk of patients acquiring *Pseudomonas aeruginosa* from tap water in augmented care areas, which may pose a risk to patient safety if not effectively managed. To mitigate this risk, the following controls are in place:

- A regular programme of weekly flushing and six-monthly water sampling, with water results reviewed through the Trust Water Safety Group.
- Use of sterile water for the care and management of babies in the Neonatal Care Unit.
- Reinforcement of hand hygiene practices and the cleaning and decontamination of equipment.
- Inclusion of information relating to *Pseudomonas aeruginosa* within all IPC training programmes.

There is a risk of *Legionella* contamination associated with under-used water outlets or outlets where water temperatures are not maintained within recommended limits. *Legionnaires' disease* is a serious form of pneumonia caused by *Legionella* bacteria and poses a significant risk to patients, staff and visitors if exposure occurs. Current controls and mitigations in place include:

- Under-utilised water outlets are included within a weekly flushing programme to reduce the risk of stagnation and bacterial growth.
- Routine water temperature monitoring is in place to ensure compliance with required standards.
- Water temperatures are maintained in accordance with Health and Safety Executive (HSE) guidance, with corrective actions taken where deviations are identified.
- The Water Safety Group meets monthly, with identified risks, incidents, and mitigation actions reported to the Health, Safety and Environment Risk Group (HSERG).



- A formal Water Safety Report is presented to the Infection Prevention and Control Group (IPCG) and Health and Safety governance forums to provide oversight and assurance.
- Six-monthly *Legionella* water sampling is undertaken as part of the Trust's water safety management programme and additionally as instructed by the water group.
- Estates teams review pipework and dead-legs in affected areas and oversee changes in room function to ensure unused outlets are either removed or appropriately flushed.
- The IPC Team continues to work collaboratively with clinical teams to reinforce best practice and ensure local compliance with water safety and infection prevention standards.

There is an increase in cases of multi-drug resistant organisms (MDROs) in patients admitted to hospital due to rising international, national and local resistance patterns and clinical teams may not sufficiently conduct a robust risk assessment, screening and timely isolation on admission. In addition, inconsistent review of IPC alert flags and the movement of patients into open bays prior to completion of risk assessment, increases the risk of transmission and may potentially compromise patient safety. Current controls and mitigations in place include:

- Carbapenemase-resistant organism (CRO) status is automatically pulled through in Cerner and visible within nursing handover documentation to support early identification and appropriate placement of patients.
- The IPC risk assessment process as per the MDRO policy explicitly incorporates CRO and MDRO risk, ensuring screening, isolation, and escalation decisions are made promptly on admission.
- CRO and MDRO awareness is embedded within mandatory IPC training, reinforcing staff knowledge of risk factors, screening requirements, and isolation precautions.
- The Multi-Drug Resistant Organism Policy and Side Room Isolation Policy are readily accessible via the Trust intranet to support consistent clinical practice.
- Patients identified as high risk of MDRO colonisation should be screened on admission and isolated promptly in accordance with policy.

17. Health and Social Care Act

Report written by Mario Olivar, IPC Deputy Lead Nurse

The Health and Social Care Act 2008's (H&SCA) and Code of Practice for infection prevention and control requires all health and adult social care providers to have and maintain policies, procedures, and protocols to minimise the risk of infection. This includes ensuring a clean and appropriate environment, consistent application of Standard Infection Control Precautions (SICPs), along with adherence to the Code's ten criteria. The Act also emphasises the importance of a robust governance structure, clear accountability for IPC and adequate resources to support effective IPC practice.

Between April 2025 and March 2026, the Trust maintained and strengthened robust systems for the prevention and control of infection in line with the Health and Social Care Act 2008 (Code of Practice). This included ongoing surveillance and review of HCAI data, structured risk assessment of high-risk patients, and delivery of targeted action plans. A safe care environment was supported through routine IPC and Estates ward reviews, cleanliness and validity audits, and effective escalation for deep and outbreak cleaning. Antimicrobial stewardship was reinforced through weekly *C. difficile* and bacteraemia reviews and sustained education on antimicrobial resistance. Early identification and management of infection risks were ensured via screening programmes, updated respiratory pathways, prompt isolation, and clear outbreak escalation. Staff competence and accountability were supported through mandatory training, induction, link



practitioner programmes, and ward-based education, alongside regular audit and feedback on compliance with IPC policies and care bundles. Effective use of isolation facilities, timely access to laboratory and microbiology services, and comprehensive staff health and wellbeing support, including vaccination and occupational health services, underpinned the Trust's organisational approach to infection prevention and control.



18. Antimicrobial Stewardship

Report written by Stephen Hughes, Antimicrobial Pharmacist

18.1. Executive Summary

Antimicrobial resistance (AMR) represents one of the most significant patient safety threats facing acute healthcare. Antimicrobial stewardship (AMS) is a core Trust patient-safety and quality function, intersecting infection prevention, medicines safety, clinical outcomes, flow and financial sustainability. This report summarises AMS activity and impact at CWFT during 2025/26, covering both Chelsea and Westminster Hospital (CWH) and West Middlesex University Hospital (WMH).

The purpose is not only to describe activity, but to demonstrate:

- how stewardship interventions translate into measurable patient benefit
- where clinical complexity has created unavoidable cost pressures
- where governance gaps have been identified and mitigations proposed

Taken together, outcome data, safety metrics and national benchmarking support the conclusion that AMS activity at CWFT is safe, effective and delivering system value.

18.1.A. Headline Clinical Metrics

The following table summarises key performance indicators for 2025/26 against available comparators.

Table 10: Key Performance Indicators

Metric	CWFT	Context / comparator
30-day all-cause mortality, <i>E. coli</i> bacteraemia	10.8%	National average 15.9% 26% relative reduction (n=556 patient cases, Apr 2024–Nov 2025)
CDI rate (CO-HA and HO-HA)	Lowest national quintile (Q1) [Fingertips Feb 2026]	Rates have risen above historic CWFT baselines, consistent with trends across NWL and England
WHO Watch/Reserve antimicrobial use	24% reduction from 2019/20 baseline	NHSE target: 10% reduction. Significantly outperforms London peer median
Fluoroquinolone exposure	53% reduction from 2021/22 peak	Q2 in London; moved from high-use outlier following MHRA alert response
Piperacillin-tazobactam use	~50% reduction from peak	Q1 in London (lowest quintile)
Carbapenem use	~40% reduction from peak	Q1 in London (lowest quintile)
Total antibacterial use (adjusted)	26.8% reduction from 2019/20 baseline	Headline figure inflated by Doxy-PEP (sexual health programme); adjusted figure outperforms peer median reduction of 8.7%
IV antimicrobial use	Sustained reduction over time	Higher than NHS London peers, partly reflecting optimised dosing and local AMS priorities; see Section 2 for detail



OPAT clinical success rate	>90% across both sites	CWH 90%, WMH 93%
OPAT bed days saved	~17,000 per year	Equivalent to a continuously occupied 46-bed ward
Documented clinical reviews (AMS pharmacist team)	>25,000	Daily oversight of 150–250 inpatients (excluding NICU and Paediatrics)
<i>S. aureus</i> bacteraemia bundle compliance	>90% across all metrics	Standardised care bundle introduced 2025/26
SHMI index (Dec 2025)	Lowest 5% nationally (2025)	No signal of harm attributable to AMS interventions

18.1.B. Financial Summary

Total Trust antimicrobial spend (inclusive of antibacterials, antifungals, antiprotazoals, antimalarials and COVID-19 therapies) in FY 2025/26 was £2.96m, broadly consistent with the prior year.

Table 11: Total Trust antimicrobial spend

Financial year	In-tariff (£)	Out-of-tariff (£)	Total (£)
FY 2018/19	2,106,554	379,827	2,486,381
FY 2019/20	2,217,314	269,789	2,487,103
FY 2020/21	1,995,249	546,865	2,542,114
FY 2021/22	2,121,542	223,390	2,344,932
FY 2022/23	2,815,889	532,363	3,348,252
FY 2023/24	2,643,359	407,189	3,050,548
FY 2024/25	2,572,386	377,098	2,949,484
FY 2025/26	2,750,143	211,900	2,962,043

Key financial movements in 2025/26:

- Out-of-tariff (OOT) spend reduced by 45% (£226.8k) year-on-year, driven primarily by antifungal stewardship savings
- In-tariff spend increased by £177k, driven almost entirely by two cost pressures: cefiderocol use for MDR infections at Chelsea Adult ITU (+£180k), and IV artesunate for severe malaria (+£170k)
- £150k annual saving achieved through generic Ambisome substitution
- OPAT and AEC pathways delivered an estimated £254,340 in monthly cost avoidance (~£3m annually), based on avoided inpatient cost of £180/day as per NHSE calculation.

18.1.C. Governance Risks Requiring Executive Awareness

Risks for formal executive attention in 2026/27

These represent patient safety, financial and reputational risks if unaddressed. Each is described with a proposed mitigation in Section 2.

- *Ungoverned Complex Oral OPAT (COPAT)*: a significant volume of oral outpatient antimicrobial therapy currently operates without a formal governance framework, creating unquantified safety and financial risk



- *Escalating Reserve-agent use without MDT sign-off*: cefiderocol use increased by 220% in 2025/26; a formalised approval process is required

18.1.D. Priorities for 2026/27

- Formal TTO (discharge prescription) stewardship programme
- COPAT governance framework
- Reserve antimicrobial MDT approval process
- Pharmacy integration into the inpatient ID service
- Ceftriaxone reduction programme (highest use in England; driven by paediatrics and OPAT)
- Formalisation of TB pharmacy support role

NHS England Call to Action (awaiting approval)

In November 2025, NHS England issued a formal Call to Action on Antimicrobial Stewardship, requiring Trust Boards to provide formal assurance on executive AMS leadership, resource adequacy, and safety oversight of high-cost drug use and serious infection outcomes. The CWFT AMS team has completed a gap analysis and prepared a draft Trust response, which demonstrates strong performance overall while identifying key workforce and governance risks outlined in this report. Final Board feedback and approval are awaited; full details are provided in Section 3.

18.2. AMS Programme Report

This section describes the work undertaken within each strategic priority during 2025/26. Headline metrics are as reported in Section 1; this section focuses on how outcomes were achieved and the professional judgement underpinning each work stream.

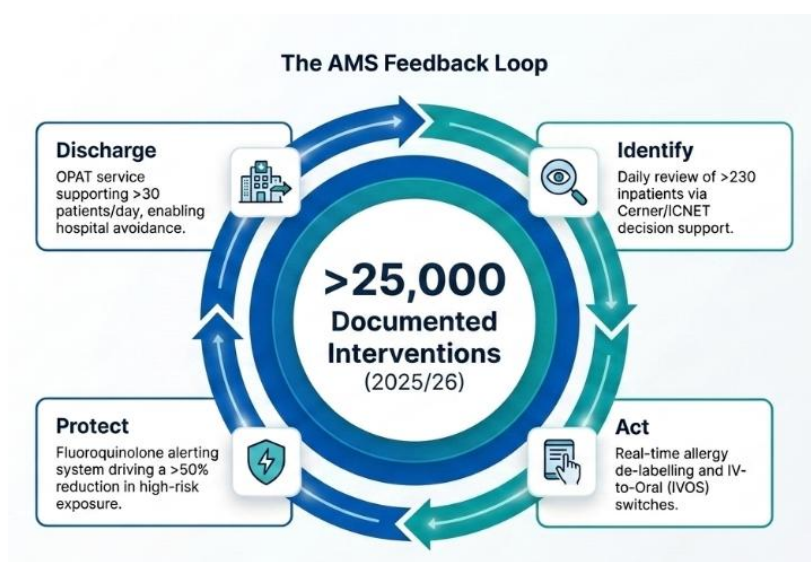


Figure 13: The AMS Feedback Loop



18.2.a. Strategic Priority 1: Effective And Safe Use of Antimicrobials

1A. Bacteraemia Outcomes and Clinical Review Activity

The AMS pharmacist team delivered over 25,000 documented clinical reviews in 2025/26, providing daily oversight for 150–250 inpatients across both sites (excluding NICU and Paediatrics). The team, working closely with microbiology, provides real-time advice, de-escalation, and direct prescribing for the most complex infective cases. This intensity of review underpins the outcome data presented in Section 1, including a 30-day all-cause mortality for *E. coli* bacteraemia of 10.8% against a national average of 15.9%. The Trust manages one of the highest burdens of resistant Gram-negative infection nationally (UKHSA 2025), making this outcome particularly significant. There is no signal of harm attributable to AMS interventions, including carbapenem-sparing regimens, early IV-to-oral switch, and shortened treatment courses.

1B. Standardised Care Bundles

Standardised treatment bundles were introduced in 2024/25 for high-risk invasive infections, including *Staphylococcus aureus* bacteraemia (SAB) and Candidaemia. Service evaluation confirms greater than 90% compliance across all SAB bundle metrics. Bundle adherence has directly supported the high rate of anti-staphylococcal beta-lactam prescribing described in section 1c below.

1C. Penicillin Allergy De-Labeling and Beta-Lactam Access

Approximately 12% of hospitalised patients carry a documented penicillin allergy, the majority of which are clinically inaccurate. In 2025/26 the AMS team expanded pharmacy-led allergy assessment and de-labelling and introduced the first facilitated beta-lactam prescribing policy for penicillin-allergic patients in England. This policy extends to patients with both low- and high-risk allergy histories, including those with a prior history of anaphylaxis, enabling access to narrow-spectrum first-line therapy for patients who would otherwise receive broader-spectrum, less effective, or more toxic alternatives.

Clinical impact: 97 of 98 patients with invasive methicillin-susceptible *Staphylococcus aureus* (MSSA) bacteraemia received an anti-staphylococcal beta-lactam (cefazolin or flucloxacillin) in 2024/25. This represents near-universal access to gold-standard therapy for high-risk bacteraemia. The policy was presented as a UK-first model at the Federation of Infection Societies (FIS) conference in November 2025 and has established a national blueprint for this approach.

1D. Fluoroquinolone Safety

Following MHRA safety alerts regarding fluoroquinolone-associated disability, the AMS team implemented bespoke electronic clinical decision support system (CDSS) alerts and real-time pharmacist review for high-risk prescribing patterns, specifically the concurrent use of fluoroquinolones and systemic corticosteroids. All such cases are reviewed individually, with a personalised risk assessment documented. In 2025/26, over 60% of high-risk inpatients were offered and accepted a safer alternative. Patient exposure to fluoroquinolones has reduced by 53% from the 2021/22 baseline, moving the Trust from a high-use outlier to a Q2 position (against London peers in 2025/26). This work was recognised as Highly Commended in the Antimicrobial Guardian Awards at the HSI Patient Safety Awards 2025 and presented at ESCMID 2025.



1E. *Clostridioides difficile* Infection (CDI)

In response to a rise in CDI incidence at CWFT, the AMS team support weekly multidisciplinary reviews of all active CDI cases jointly with Infection Prevention and Control (IPC). These reviews focus on antimicrobial de-escalation, optimisation, and real-time patient management. Broad-spectrum antimicrobial use — the principal modifiable risk factor for CDI — has reduced from baseline at CWFT. Although CO-HA and HO-HA CDI rates remain elevated compared with historic Trust baselines, similar increases have been observed across NWL and England without an identified precipitating cause. CWFT remains in the lowest (best-performing) national quintile for combined CO-HA and HO-HA CDI incidence.

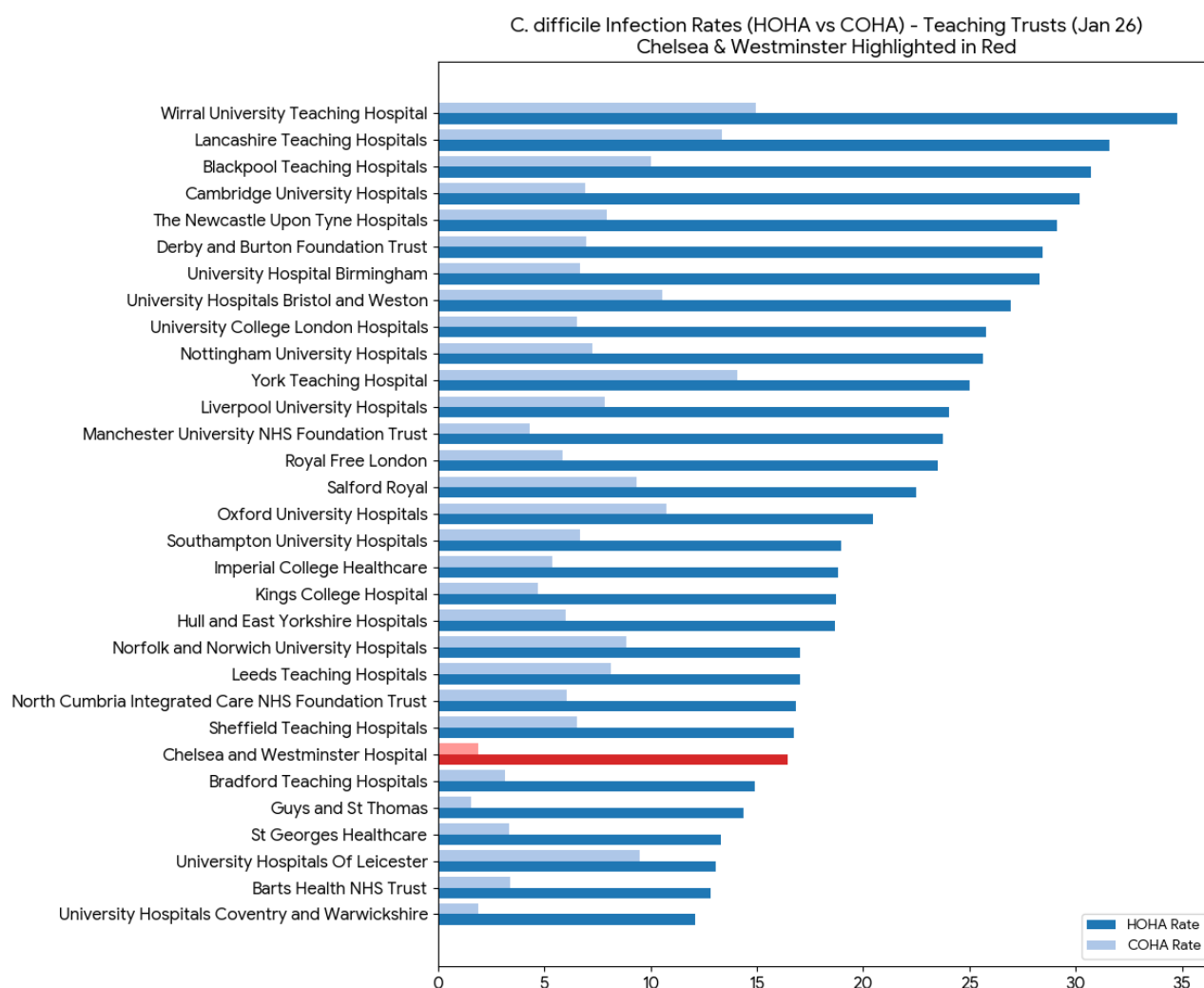


Figure 14: Rolling 12month CDI rates (HOHA & COHA) for CWFT against all NHS Teaching Hospitals, England (Jan 2026)

1F. Dynamic Guideline Oversight

In response to a rise in CDI incidence at CWFT, the AMS team instituted weekly multidisciplinary reviews of all active CDI cases jointly with Infection Prevention and Control (IPC). These reviews focus on antimicrobial de-escalation, optimisation, and real-time patient management. Broad-spectrum antimicrobial use — the principal modifiable risk factor for CDI — has reduced from baseline at CWFT. Although CO-HA and HO-HA CDI rates remain elevated compared with historic Trust baselines, similar increases have been observed



across NWL and England without an identified precipitating cause. CWFT remains in the lowest (best-performing) national quintile for combined CO-HA and HO-HA CDI incidence.

1G. Therapeutic Drug Monitoring (TDM) and The Tuck-Shop Study

The Trust AMS team led the TuCK-SHOP study — a major UK and Ireland multicentre improvement project to enhance safe prescribing of high-risk antimicrobials. The study was published in the Journal of Antimicrobial Chemotherapy (JAC) in 2026. This research directly informs the Trust's TDM service, ensuring personalised dosing that prevents drug-induced toxicity (including acute kidney injury) in the most complex patients.

1I. Prescribing Metrics and Benchmarking

Total antibacterial use: Total DDD/1,000 admissions increased by 57% from the 2019/20 baseline and is currently the highest in England. This figure is materially misleading without context. It is driven entirely by the introduction of doxycycline post-exposure prophylaxis (Doxy-PEP) via the Trust's sexual health service, a BASHH-mandated public health programme to reduce syphilis transmission that increases doxycycline prescribing by approximately 301%. When doxycycline is excluded, the underlying antibacterial usage trend shows a 26.8% reduction from baseline, significantly outperforming the peer median reduction of 8.7%. For governance and benchmarking purposes, doxycycline should be reported separately or excluded from core inpatient AMS metrics.

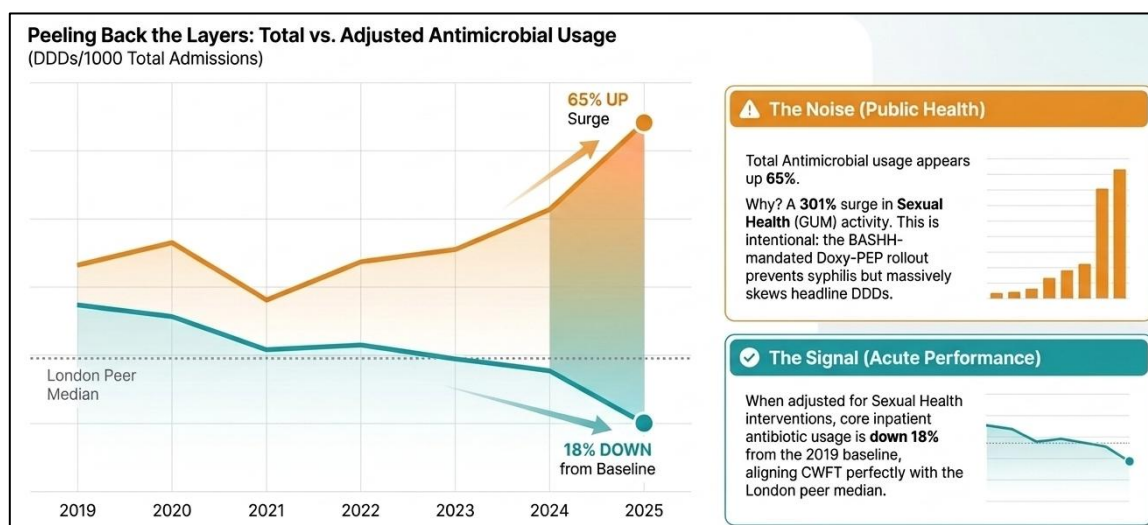


Figure 15: Total antibacterial usage at CWFT (with and without Doxycycline)

IV antimicrobial use: Total IV antimicrobial DDD/1,000 admissions has reduced over time reflecting expanded IV-to-oral switch activity and shorter treatment durations. CWFT usage remains higher than NHS London peers. This reflects two deliberate clinical decisions: the prioritisation of optimised (often higher dose) dosing regimens, which increase DDD without increasing days of therapy; and the focus on combination therapy to avoid use of last line broad spectrum antimicrobials (e.g. Meropenem). The AMS group continues to balance national KPI compliance against clinical outcome optimisation.

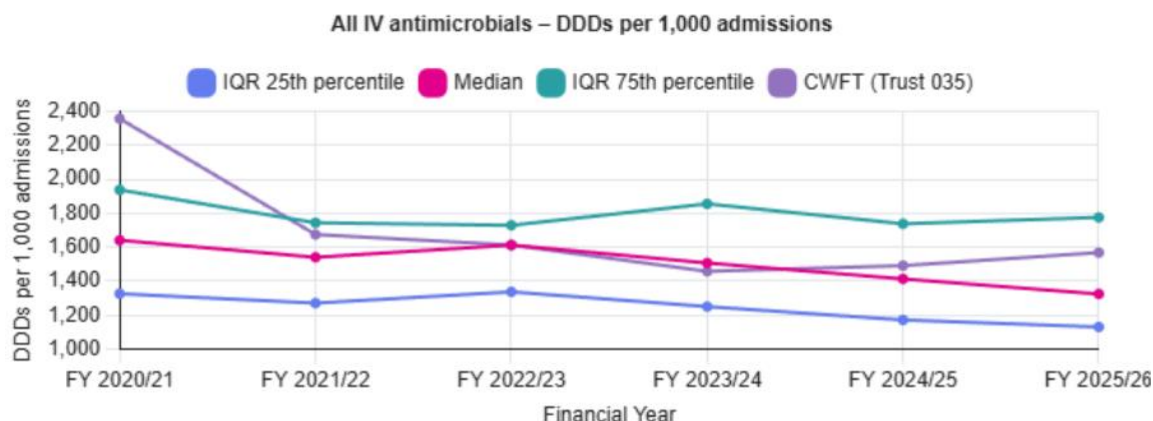


Figure 16: Ceftriaxone usage at CWFT compared to London peers

Broad-spectrum agents: CWFT has achieved nearly a 50% reduction in piperacillin-tazobactam and a 40% reduction in carbapenem use from baseline, placing the Trust in the lowest quintile (Q1) for these agents nationally. The use of broad-spectrum antimicrobial meets the current NHSE targets (<40% of total antimicrobial use). This represents a significant stewardship achievement given the Trust's high resistant infection burden.

Ceftriaxone — priority for 2026/27: Ceftriaxone use has increased by 78% from the 2020/21 baseline and the Trust is now the highest user in England. Use is driven principally by excess prescribing in paediatrics (highest paediatric use in England) and outpatient settings. Ceftriaxone is a broad-spectrum, once-daily intravenous cephalosporin; its overuse is a high-risk driver of future AMR and CDI. Clinical pathway optimisation in paediatrics and OPAT is a defined priority for 2026/27.

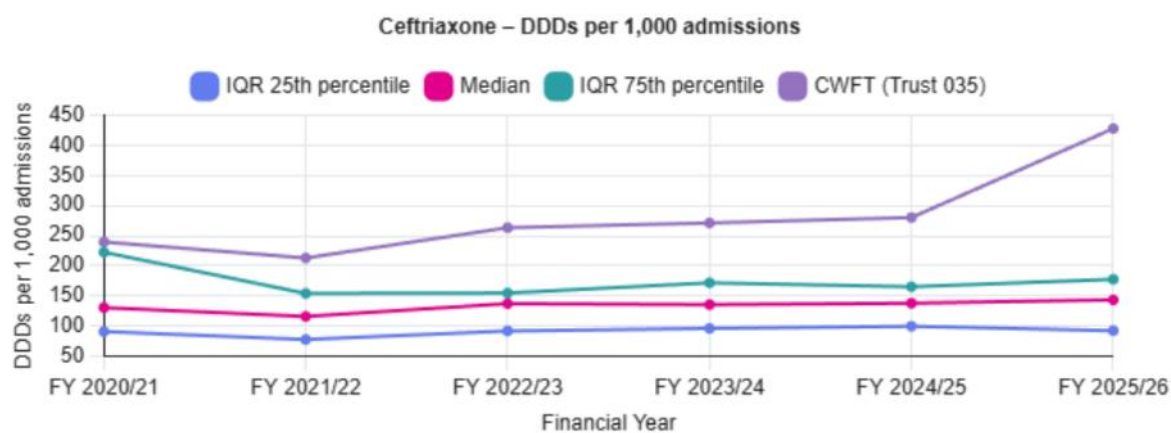


Figure 17: Ceftriaxone - DDDs per 1,000 admissions



18.2.b. Strategic Priority 2: Efficiency, Flow and Financial Value

2A. OPAT — Enabling Trust Flow

The adult OPAT service saved a mean of 1,413 bed-days per month in 2025/26 (approximately 17,000 annually), equivalent to a continuously occupied 46-bed ward. Clinical success (patient cured or clinically improved) exceeded 90% across both sites (CWH 90%, WMH 93%). The OPAT and Ambulatory Emergency Care (AEC) pathways together delivered an estimated £254,340 in monthly cost avoidance, approximately £3m annually, based on an avoided daily inpatient cost of £180 using NHSE calculation.

The AMS team has also worked to reduce inappropriate OPAT use: a 40% reduction in OPAT referrals at CWH has been achieved since summer 2025 through implementation of an IV-to-oral switch programme, reducing pressure on the AEC department and minimising unnecessary patient attendances. The team aims to replicate this at WMH in 2026/27.

2B. IV-To-Oral Switch and Treatment Duration

The AMS team has developed multiple improvement projects promoting early IV-to-oral switch and shorter, evidence-based treatment courses. Benefits include reduced line-related complications, shorter admissions, lower nursing and drug costs, and reduced selection pressure for resistance. Initial success has been demonstrated for community-acquired pneumonia and uncomplicated urinary tract infections in A&E, urgent care centres, and inpatient settings. The Trust has been shortlisted for two Antibiotic Guardian Awards in 2024/25 for digital stewardship and clinical safety and highly commended in the Improving Medicines Safety at the HSJ Patient Safety Awards 2025 based on this improvement work.

A significant residual risk has been identified at the point of discharge. AMS oversight of discharge prescriptions (TTOs) is currently minimal, and analysis indicates that prolonged and often inappropriate course lengths remain common in TTOs. This is further complicated by Trust's move to use of pre-packs (default 7-day courses) on through rapid discharge units, increasing overall antimicrobial use and patient exposure. This represents a patient safety risk and is a defined priority for 2026/27.

2C. Drug Expenditure and Demonstrable Savings

The primary driver of financial improvement in 2025/26 was a sustained reduction in out-of-tariff (OOT) spend, achieved through antifungal stewardship and early adoption of generic medications:

- Total OOT spend: £211,900 — a 45% reduction (£226.8k) year-on-year
- 50% reduction in high-cost antifungal spend (excluding fluconazole)
- Generic Ambisome substitution (Tillomed bioequivalent): 65.5% reduction in polyene spend, saving approximately £150,000 per year
- Echinocandin spend (anidulafungin): 51.5% reduction (£57,300) through rigorous clinical review
- Fidaxomicin spend: 28.1% reduction (£30,700) from previous year

Antifungals will move in-tariff from April 2026 and form a significant cost pressure for the Trust for 2026/27. However, the early work to minimise unnecessary use will benefit the Trust directly through reduced spend.



2D. In-Tariff Cost Pressures and Mitigations

Savings were partially offset by a 10% rise in in-tariff spend in 2025/26, driven by clinical complexity and regional resistance patterns rather than prescribing inefficiency. The following table summarises the main pressures and the stewardship response to each:

Table 12: Financial Impact

Category	Financial impact	Narrative and stewardship response
Severe malaria (IV artesunate)	£230k total (+£170k vs prior year)	Surge in severe cases plus rising acquisition costs (~£2,100/day). Mitigation: updated malaria guideline to enforce early IV-to-oral switch.
MDR infections (cefiderocol)	£250k total (+£180k)	Increased use for highly resistant organisms at Chelsea Adult ITU. Mitigation: addition to formulary of more cost-effective options. Governance: proposed formalised multidisciplinary sign-off to reduce clinical variation.
Supply chain pressures	£90k combined	Acyclovir IV (£40k): national contract issues. Valacyclovir PO (£50k): significant price-per-tablet increase.
Carbapenem-sparing agents (temocillin)	£170k total (+£70k)	Strategic shift toward carbapenem-sparing regimens to protect last-line antimicrobials. Mitigation: Restrict use to urinary tract infection only where greatest evidence base

High-cost novel beta-lactam use (cefiderocol, ceftazidime-avibactam) has increased beyond expected levels compared with London peers, increasing both cost and AMR pressure. Since restrictions for use from NHSE have been relaxed in June 2024 (removal of BlueTeq), there has been a usage creep. This is coupled with an ongoing outbreak of multi-drug-resistant *Pseudomonas* on Adult ITU wards. If use continues to rise above peers, it is recommended that usage is controlled to more formalised MDT approval process in line with NHS Peers; this would expect to reduce clinical variation and ensure cost capture.

2D. Formulary Expansion — Mitigating In-Tariff Cost Pressures

The AMS team has strategically expanded the Trust formulary to provide cost-effective alternatives to high-cost agents and to support earlier IV-to-oral switch. These additions directly address the in-tariff cost pressures identified in Section 1.2 and the cost pressure table above:

- **Ceftolozane/tazobactam (cefiderocol-sparing):** Added to the *formulary as a cost-effective alternative for specific resistant Gram-negative infections, particularly *Pseudomonas aeruginosa**, where cefiderocol would otherwise be required. Ceftolozane/tazobactam carries a lower unit cost than cefiderocol and is appropriate for a defined subset of resistant organisms; its introduction is expected to reduce reliance on cefiderocol and mitigate the £180k cost pressure identified at Chelsea Adult ITU.
- **Eurartesim (dihydroartemisinin-piperaquine) — oral antimalarial:** Added to the formulary to enable earlier step-down from intravenous artesunate in patients with severe malaria who are clinically improving. IV artesunate carries an acquisition cost of approximately £2,100 per day; Eurartesim provides a potent oral alternative that facilitates earlier discharge and substantially



reduces per-episode drug cost. This formulary addition is a direct response to the 145% rise in IV artesunate expenditure in 2025/26 and is incorporated into the updated malaria guideline.

- **Baloxavir — antiviral for influenza:** Introduced as a high-efficacy single-dose oral treatment for influenza in high-risk patients. Baloxavir offers a shorter treatment course and comparable efficacy to IV Zanamivir, with the potential to reduce hospitalisation duration and secondary complications during influenza season, contributing to improved flow and reduced bed utilisation at peak demand.

2E. COVID-19 Antiviral Stewardship

The AMS team provides formal stewardship oversight for all high-cost COVID-19 antivirals. Current annual expenditure is £66,818, which is successfully reimbursed through the Integrated Care System (ICS). This oversight ensures targeted use and protects reimbursement.

18.2.C. Strategic Priority 3: Organisational Capability, Research and Governance

3A. National Research and Academic Impact

CWFT AMS continues to lead nationally in antimicrobial stewardship research and innovation. Key outputs in 2025/26:

- TuCK-SHOP study (JAC 2026): the Trust led a UK and Ireland multicentre project to enhance safe prescribing of high-risk antimicrobials; published as lead author in the Journal of Antimicrobial Chemotherapy
- ESCMID 2025 international conference: Oral presentations on use of CDSS to improve patient outcomes across the Trust:
- FIS 2025 national presentation: a UK-first facilitated penicillin allergy de-labelling model was presented at the Federation of Infection Societies annual conference, establishing a national blueprint for this approach
- HSJ Patient Safety Awards 2025: Highly Commended in the Improving Medicines Safety category for use of clinical decision support to improve antimicrobial prescribing and outcomes
- Antibiotic Guardian Awards 2024/25: shortlisted for two awards confirming national recognition for shared learning and AMS innovation
- Multiple peer reviewed publications from AMS Pharmacy team

3B. Innovation — AMS Prescribing Dashboard

FY 2025/26 saw the launch of a bespoke AMS Prescribing Dashboard, providing divisional-level visibility of key prescribing metrics, including antimicrobial prescribing trends, IV-to-oral switch appropriateness, and appropriateness of ongoing review. The dashboard also provides educational content targeted on local QI projects or recent incident learning to improve feedback loop to prescribers and clinicians. A copy of the dashboard is appended to this report. The team welcomes the Board's review of this tool to further disseminate its reach.

3C. Education, Training and Multidisciplinary Programme

The clinical outcomes described throughout this report are underpinned by a sustained and systematic education programme, delivered across professional groups and both sites. In 2025/26 the AMS team delivered:



- Targeted prescribing training for junior doctors, covering antimicrobial selection, duration, escalation and de-escalation decision-making, and documentation standards
- AMS education sessions for nursing staff, focusing on IV-to-oral switch recognition, allergy documentation, and administration practice
- Pharmacy team training to support consistent application of formulary and guideline recommendations across dispensary and clinical pharmacy roles
- Emergency Department (ED) prescribing education, addressing high-volume infection presentations and appropriate empirical antibiotic selection
- Five cross-site Grand Rounds in 2025/26, facilitating peer-to-peer clinical discussion of complex infection cases between CWH and WMH and promoting standardised management of high-acuity infections across both sites

This breadth of educational activity directly supports culture change in prescribing practice and is a key mechanism through which AMS metrics improve. The team's ability to deliver this programme at scale — alongside over 25,000 clinical reviews — reflects the depth and stability of the specialist workforce.

3D. Workforce Development — CPHO Fellowship

In 2025/26 the Trust supported a Specialist AMS Pharmacist on secondment to the Chief Pharmaceutical Officer (CPHO) Fellowship programme. This competitive national fellowship embeds senior pharmacy practitioners in national NHS England and DHSC policy work, directly influencing antimicrobial stewardship strategy at a system level. The secondment benefits the Trust in two directions: CWFT expertise and operational experience inform national policy development, while the returning fellow brings advanced leadership skills, national networks, and policy insight back into the Trust's AMS programme. This investment signals the Trust's commitment to AMS as a professional development pathway and positions CWFT as a national talent incubator in the specialty.

3E. System Leadership — ICS and APC Collaboration

The AMS team plays an active leadership role beyond the Trust through formal collaboration with the Northwest London (NWL) Integrated Care System (ICS) AMS programme and the Acute Provider Collaborative (APC). This system-level engagement ensures that CWFT's local stewardship standards are aligned with NWL's strategic goals, particularly at the primary-secondary care interface where antimicrobial prescribing handoffs present the greatest risk.

3F. Governance Gaps and Proposed Mitigations

Complex Oral OPAT (COPAT): A significant volume of oral step-down therapy currently operates outside any formal governance framework. The cost avoidance attributable to COPAT is unquantified and unprotected. A formal COPAT governance pathway is proposed for 2026/27.

Reserve antimicrobial approval: The 220% increase in cefiderocol expenditure in 2025/26 confirms the need for formalised multidisciplinary approval for Reserve-category agents. A proposed framework would require documented consensus between the AMS team and Medical Microbiology before initiation.

Inpatient ID service: A new inpatient infectious diseases service is launching in 2026 without an embedded pharmacy role in its business case. The AMS team has the clinical expertise and established teaching capacity — demonstrated through the Grand Rounds programme and CPHO Fellowship — but lacks the contracted



WTE to cover a new inpatient ward. Complex ID inpatients require intensive pharmacist input for toxicity monitoring, TDM, and high-cost drug stewardship. A formal review of pharmacy resource within the ID service business case is advised.

TB service support: The AMS team has proactively extended specialist pharmacy support to the Tuberculosis service without a contracted requirement. This oversight mitigates the risk of treatment failure and drug-resistant TB emergence. Formalisation of this role is recommended.



18.3. AMS Newsletter and Dashboard (Spring 2026)

The 48-72 Hour Challenge: Intravenous to Oral Switch (IVOS)

A CWFT priority to improve patient flow, enhance safety, and reduce antimicrobial harm

The Trust Mandate: A formal review of all IV antimicrobials must occur within 48-72 hours of initiation

The Action: **STOP** or **IVOS**, or **DE-ESCALATE** (based on susceptibilities) or **ESCALATE** (where clinical failure)

The Reality: Approximately 20% of all patients at CWFT on IV antimicrobials for >72hours could have been switched to oral therapy earlier (Feb 2026)

The Goal: Get your patient home early. Every unnecessary day of IV therapy delays discharge

Antimicrobial Stewardship Update

Chelwest
AMS Group
April 2026

Why Route Matters: The Hidden Costs of Staying IV



The Risks of "Staying IV"

Patient Harm: Increase risk of line-associated infection, phlebitis and extravasation

Operational Drag: Significant nursing time (average 28min/day per patient) and prolonged admission

AMR burden: Prolonged broad-spectrum IV use drives antimicrobial resistance and *C. difficile* infection risk



The Benefits of "Going PO"

Patient Comfort: Eliminates cannula pain, improves mobility and facilitates early discharge

Equivalent Efficacy: Modern PO dosing offers comparable systemic exposure without vascular risk

Green NHS / Net Zero: Reduces plastic waste (bags, lines, syringes) and reduces drug therapy costs

Historical medical dogma suggests that IV antimicrobials are better – "stronger", more effective, safer – than oral antimicrobials for treatment of many infections. As a result, IV antimicrobials are often prescribed or prolonged in situations where oral antimicrobials would be appropriate. A growing body of high-quality evidence demonstrates that oral antimicrobials are non-inferior to IV antimicrobials in the settings of complicated urinary tract infections, respiratory infections, intra-abdominal infections, bone and joint infections, bacteraemia, and endocarditis.

*Has **your** patient been on IV Antimicrobials (ABX) for more than 48 hrs?*

IV to PO SWITCH OPTIONS – Get your patient HOME early

H <u>Haemodynamically stable</u> (BP / HR normalising), Apyrexial >24hrs	Does your patient meet the HOME criteria for IV-PO switch? YES: convert to appropriate PO ABX to reduce risk of CDI, AMR and line-related infection NO: review again in 24-48 hours
O <u>Oral (PO) route available</u> , eating/drinking, no malabsorption	
M <u>Markers improving</u> (CRP / WCC trending to normal)	
E <u>Exclude deep-seated infection source</u> (requires prolonged IV ABX e.g. meningitis, intravascular inf.)	

OPTIMISE YOUR PATIENT'S TREATMENT OPTIONS

STOP If no evidence of infections

SWITCH IV-to-ORAL

CHANGE To Narrow spectrum (targeted) antimicrobial

CONTINUE And review again in 24 – 48 hours

OPAT Out-patient Parenteral Antimicrobial Therapy for IV ABX at home

Figure 18: AMS Newsletter Part 1



AMS PRESCRIBING: EVIDENCE-BASED TARGETS

Identifying and closing the gaps in route, duration, and spectrum across CWFT

AUDIT & GUIDANCE

Oral antimicrobials should also be culture- and susceptibility-directed wherever possible, have high oral bioavailability, and be used at an optimal dosage for site of infection and patient demographics (e.g. age, weight, renal function) (Table 1)

Oral Antimicrobial Options for Transition from Intravenous

Oral ABX	Organisms Targeted*	Abs	Type of Infection	Oral Adult Dose**
Amoxicillin	Streptococcus spp, Enterococcus faecalis, E. coli	80%	Lower UTI Deep-seated infection Endocarditis	500mg TDS 1g TDS 1g QDS
Co-amoxiclav	Gram positive incl. Streptococcus spp, MSSA and Enterococcus faecalis, Gram-negatives, anaerobes	80%	Uncomplicated infection Complicated: H. Influenzae infection, Gram negative from non-urinary source (deep-seated)	625mg TDS 625mg TDS plus extra amoxicillin 500mg TDS (boosted co-amoxiclav)
Cephalexin	Streptococcus spp., MSSA, E. coli	90%	Lower UTI Upper UTI/Pyelonephritis S&STI / BJI	500mg TDS 1g TDS 1g QDS
Ciprofloxacin	Gram negatives, incl. Pseudomonas aeruginosa	70%	Enterobacterales (all) Pseudomonas spp. (all)	500mg BD 750mg BD
Clindamycin	Gram positive include some anaerobes	90%	Standard dose High dose obese	450mg QDS (600mg QDS if high TBW)
Flucloxacillin	Beta-haem strep, MSSA	55- 80%	Uncomplicated MSSA Complicated MSSA or GAS cover	500mg QDS 1g QDS
Linezolid	Gram positive, incl. MRSA and VRE	100%	Standard dose	600mg BD
Metronidazole	Anaerobes	100%	Standard dose Amoebic infection	400mg TDS 800mg TDS
Co-trimoxazole	Beta-haem strep, MSSA, MRSA, Gram negatives, PJP and Stenotrophomonas	85%	Standard dose Stenotrophomonas PJP	960mg BD 60mg/kg/day 60-120mg/kg/day
Levofloxacin	Gram negatives, incl. Pseudomonas aeruginosa	70%	Enterobacterales Gram positives or Pseudomonas	500mg OD 500mg BD

*General guide - should be confirmed with susceptibility results;

** Dose in non-obese adult patients with normal renal and hepatic function

The MDT Ward Round Prompt

**Does this patient still
need their cannula?**

Antimicrobial stewardship is everyone's responsibility.

Nurses:

You manage the lines.
If the patient is eating,
drinking and
improving, challenge
the need for IV

Pharmacists:

You are the drug
experts. Flag the
48-72h r/v and
advocate for the
PO switch

Doctors:

You lead the review.
Let's remove the
plastic, reduce risk
and get the patient
home

STOP • IVOS • DE-ESCALATE

Top Tips Prescribing

Double-dosing in 2025 @CWFT

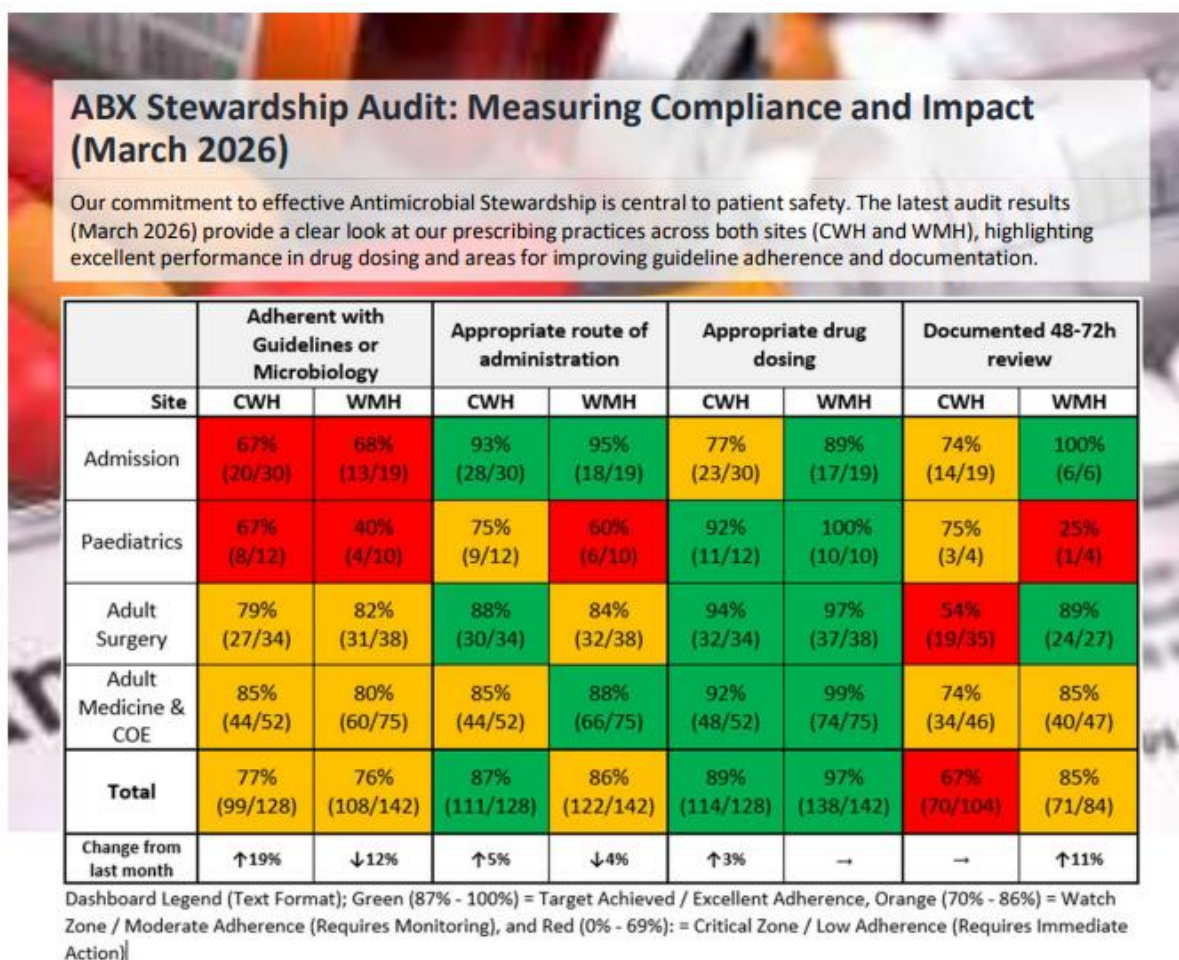


Top Tips for Aminoglycoside Prescribing: Watch for Unintended Double-Dosing

IV amikacin and gentamicin have a narrow therapeutic index. Inadvertent repeat dosing within 16 hours can cause acute kidney injury (AKI), particularly in patients with CKD stage 3 or above

CAUTION: Prescribers must check timing of
previous amikacin AND gentamicin doses to avoid
inadvertent double-dosing within 16 hours.

Figure 19: AMS Newsletter Part 2



Key Guideline Non-Adherence Points (Impacting CWH & WMH)

Area of Concern	Non-Adherent Practice Observed	Guideline-Compliant Action
Emergency Surgery (OOH)	Inappropriate escalation to piperacillin-tazobactam as empiric cover out-of-hours, despite high local resistance rates , making it an unreliable choice.	Use locally recommended empiric regimens aligned with resistance patterns; reserve piperacillin-tazobactam for suspected or proven <i>Pseudomonas</i> infection.
Skin & Soft Tissue Infection	Empiric clindamycin use despite MSSA resistance >25% , reducing likelihood of effective cover.	Avoid clindamycin as first-line empiric therapy; use beta-lactam-based regimens in line with local SSTI guidance unless contraindicated.
Medical Inpatients – CAP	Prolonged antibiotic courses for CAP: median inpatient duration 8 days , despite guideline recommendation of 5 days .	Review antibiotics at 48–72 hours ; limit course length to 5 days if clinically improving and no complications.
Surgical Prophylaxis	Extended post-operative prophylaxis beyond recommended duration, associated with hospital-acquired C. difficile infection.	Limit prophylaxis to single dose or <24 hours , as per surgical antimicrobial prophylaxis guidelines.
Trauma / Admission	Routine antibiotic prophylaxis for isolated rib fractures without specific infection risk factors.	Antibiotics not routinely indicated in isolated rib fractures unless clear infectious risk is present.

Non-adherence contributes to resistance, avoidable adverse events (including CDI), and unnecessary antimicrobial exposure.

Figure 20: AMS Dashboard



19. Body Fluid Exposure – Occupational Health (OH)

Report written by Pamela Duke, Service Director, and Anneliese Hayes, Senior OH Advisor

19.1. Executive Summary

19.1.A. Assurance

The Occupational Health Service has provided robust IPC assurance throughout 2025–2026, with all activity delivered in line with national guidance and Trust policy. There was 1 new UK Advisory Panel (UKAP) case identified during the year, and all existing cases continue to be monitored appropriately.

A high volume of blood and body fluid exposure incidents was managed (217), the majority assessed as low risk, with timely clinical assessment, source testing where indicated, vaccination, serum saves and follow-up completed. Where higher-risk exposures occurred, cases were escalated appropriately, including specialist referral and post-exposure prophylaxis.

The service delivered a substantial programme of immunity screening (4970) and vaccination (766), supporting workforce protection and patient safety. Access to daily Duty Nurse advice has remained a critical control, enabling rapid decision-making, staff reassurance, and consistent IPC application across the Trust.

19.1.B. Risk

Recurrent themes continue to be identified in relation to sharps injuries during or immediately after procedures, incomplete activation of safety devices, and mucocutaneous exposures where eye or face protection was not consistently used.

The scale and complexity of workforce movement, onboarding, and role change places ongoing demand on immunity screening and record assurance. While implementation of the new OH clinical system has strengthened data quality, reporting functionality and evidence availability remain areas requiring further development, particularly for high-risk clinical areas.

19.1.C. Forward Actions

Building on the digital transformation achieved in 2025–2026, the service will continue to review and refine IPC workflows to ensure they are user-friendly, equitable, and consistently applied. Subject to resourcing and enhanced reporting capability, high-risk areas will be prioritised for targeted review to strengthen assurance on immunity and exposure evidence.

During 2026–2027, the service will further develop more effective and responsive approaches to close-contact management for communicable diseases, alongside continued use of Duty Nurse intelligence to inform targeted communication, training, and prevention activity.

19.2. Statement on BBV

The Occupational Health Service confirms that there was 1 new UK Advisory Panel (UKAP) case identified during the reporting period 01 April 2025 to 31 March 2026. All previously known cases continue to be monitored in line with national guidance and Trust policy.



Occupational Health continues to provide expert clinical oversight, follow-up, and liaison with specialist services where required, ensuring robust governance and staff safety. Ongoing review of BBV management processes has been supported by the continued embedding of the new OH clinical system to improve data quality, consistency, and assurance reporting across the Trust.

19.3. Exposure To Blood / Body Fluids

Between 1 April 2025 and 31 March 2026, a total of 217 exposure incidents involving blood and body fluids were reported to Occupational Health and recorded on the OH clinical system. These incidents included percutaneous injuries, mucocutaneous exposures, instrument scratches, and human bites or scratches, occurring predominantly during clinical procedures or immediately before or after disposal of sharps.

Most exposures were assessed as low risk, with timely first aid, clinical risk assessment, source testing where appropriate, and follow-up undertaken in line with Trust policy. Where higher-risk exposures were identified, cases were escalated appropriately, including referral for specialist advice and consideration or initiation of post-exposure prophylaxis (PEP).

Recurring themes identified through incident review included incomplete activation of safety devices, disposal-related injuries, and splash exposures associated with inconsistent use of eye or face protection. These findings have been routinely shared with the IPC Committee and Safer Sharps Group to support targeted learning and prevention activity.

19.3.A. Post-Exposure Management and Assurance

All staff reporting exposure incidents were managed in accordance with CWFT policy and national guidance. Recipient hepatitis B immune status was assessed at the time of exposure, with hepatitis B boosters and serum save samples arranged where indicated.

Post-exposure prophylaxis (PEP) was offered and commenced where clinically appropriate following individual risk assessment, including for HIV exposures. Occupational Health ensured follow-up testing and clinical support, with clear documentation and case closure once safe to do so.

Occupational Health continues to provide assurance through regular reporting to Trust governance forums and maintains oversight of trends, escalation thresholds, and learning outcomes.

19.4. Immunity Screens

Throughout April 2025 to March 2026, Occupational Health delivered a high volume of immunity screening for new starters, existing staff, and role changes to ensure protection against communicable diseases.

Serology testing significantly exceeded vaccination activity, reflecting the scale of onboarding, internal movement, and ongoing workforce assurance requirements. The TB IGRA test remained one of the most frequently requested investigations, consistent with national guidance and the demographic profile of new starters.

19.4.A. Serology Screening



Screening covered a comprehensive range of infections including hepatitis B, hepatitis C, HIV, measles, rubella, varicella, and tuberculosis. Positive or equivocal results were managed in line with clinical protocols, with referral to specialist services where required.

Table 13: Staff Immunity Screening:

Serology Test Type	Number of events
ELISpot Blood test	15
TB IGRA test (inc. repeats)	695
Hepatitis B check e markers test	1
Hepatitis B core antibody test	65
Hepatitis B DNA genome level test (inc. repeats)	5
Hepatitis B surface Antibody test (inc. repeat)	766
Hepatitis B surface Antigen test (inc. repeat)	562
Hepatitis C antibody test	503
Hepatitis C RNA PCR test	55
HIV antibody test	544
HIV RNA PCR test	40
Measles antibody test	585
Mumps	1
Rubella antibody test	572
Varicella antibody test	561
Grand Total	4970

19.5. Immunisations

During the reporting period, Occupational Health delivered a substantial immunisation programme to address gaps in immunity identified through screening. Vaccinations administered included hepatitis B, MMR, varicella, pertussis, and BCG, supporting both patient safety and staff protection.

19.5.A. Vaccinations Administered

A continued requirement for MMR vaccination was noted, reinforcing the importance of sustained focus on measles prevention given national epidemiological trends. Immunisation activity reflects both new starter requirements and catch-up vaccination for existing staff where historic immunity evidence was incomplete or absent. Following the resumption of robust BCG vaccine supply we have relaunched regular BCG clinics.

Table 14: Staff Immunisation & Vaccinations

Vaccine Type	Number administered
BCG Vaccination	10
Hepatitis B	385
Measles, Mumps, Rubella	156
Pertussis (Combined dTaP)	149
Varicella	66
Grand Total	766

19.6. Outbreaks and Contact Events



Occupational Health supported the Trust in the management of multiple outbreak and contact events during 2025–2026.

Table 15: Types / Frequency outbreaks and contact events

Condition Type	Number of events
Igas	24
Measles	18
Meningitis	2
Mpox	2
Mumps	1
Norovirus	1
Pertussis	3
Tuberculosis	1
Varicella	30
Grand Total	81

In each instance, Occupational Health has assessed staff immunity status and provided risk-based advice / information e.g. warn and inform letters.

Line managers have been supported in ensuring safe staffing arrangements. This proactive approach we hope contributed to timely containment and minimised workforce impact.

19.7. Infection Control Related Projects

While there were no bespoke IPC projects delivered during 2025–2026, the year has marked a significant period of system and service transformation. As the new Occupational Health database continues to mature, a structured review of IPC-related workflows is underway to ensure processes are streamlined, user-friendly, and equitable, and that staff protection arrangements are consistently applied across the Trust.

Subject to available resourcing and the progressive enhancement of reporting functionality, across 2026–2027, high-risk clinical areas will be prioritised for review, with a focus on the availability and quality of immunity and exposure evidence to support assurance and compliance.

Again, looking ahead to 2026–2027, the service will build on this digital foundation to develop more effective and responsive approaches to the management of close contacts for communicable diseases, strengthening both operational efficiency and workforce protection.

19.8. Additional Support / Access to the Occupational Health Service

Staff and managers continue to access daily, timely IPC advice via the OH Shared Service Duty Nurse, which remains a key mechanism for rapid decision-making, reassurance, and consistent application of IPC guidance. Contacts received during 2025–2026 are being monitored to identify themes and inform targeted communication or training where required.

Access to Occupational Health is actively promoted, during onboarding contacts, ensuring staff understand how to self-refer and seek advice by telephone or email.



A Duty Nurse is available daily from 08:30 to 16:30 to provide immediate advice, supported by the service email CNWL.occupationalhealth@nhs.net. Staff may also request access to their immunisation and immunity screening records as required.

20. Decontamination

Report written by Tiziana Carta, Decontamination Manager

The service is audited for BS ES ISO 13485:2016 +A11:2021 and the relevant requirements of UK MDR 2002. The system covers all the activities undertaken by both the Sterile Services Department (SSD) and Endoscope Decontamination Unit (EDU) relevant to the quality of the products and services provided by the department. The department is audited by the External Approved Body SGS. The department successfully passed the annual 2-day External Audit in July 2025, confirmed compliance and accreditation was renewed.

The Trust has been registered with MHRA since October 2025 in order to be able to place products on the market and supply to other legal entities.

The new Quality Management System is under constant review with a full training programme to ensure compliance.

The EDU successfully passed the JAG (IHEEM) – Institute of Healthcare Engineering & Estate Management Audit in August.

This reflects strong compliance with operational, decontamination, and quality standards required for endoscopy reprocessing.

However, the audit identified an ongoing issue with ventilation. The current ventilation system in the dirty area does not comply with HTM 03-01:2001 requirements. This non-compliance has been formally reported to Estates for action and resolution.

A plan is required to ensure:

- Remedial works are scheduled,
- Timeframes for compliance are established, and
- Risks remain appropriately mitigated until full compliance is achieved.

Departmental Improvements

The current structure has strengthened significantly with the recruitment of three technicians, who now provide essential support for the EDU weekend lists as well as the expanded workload across SSD. Furthermore, the appointment of a Quality Manager enhances our capacity to maintain compliance, drive quality improvement initiatives, and ensure the service continues to meet operational and regulatory requirements

Sharps

There has been an improvement; however, we are still receiving sharps with the instruments, and these continue to be raised via DATIX.



- 2024: 19 sharps incidents
- 2025: 8 sharps incidents

This represents a 57.9% decrease in sharps incidents from 2024 to 2025

The Division Sharp Lead is providing training and support to various wards and also assessing wards procedures. The divisional sharp lead highlighted that these incidents happen mainly with new and bank staff whereby sufficient training has not been achieved.

Table 16: SSD Clinical User Error 2025

SSD CLINICAL USER ERROR 2025													none
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Total
Sharps/ Blades	1	1	3						0	2	0	1	8
Other item returned to SSD			1				1						2
Single use Items returned to SSD													0
Missing Items			2	5	1	4	6						18
Checklist not signed	1	1		1	1								4
Other								1					
Totals									0				32

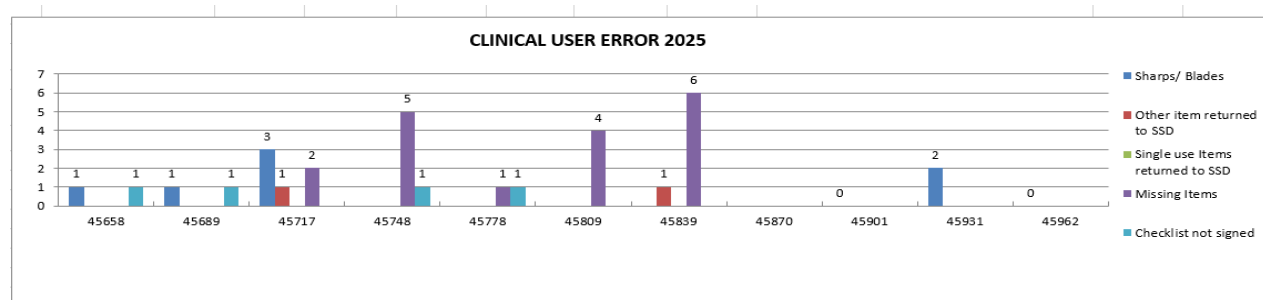


Figure 21: SSD Clinical User Error 2025

Table 17: SSD Clinical User Error 2024

SSD CLINICAL USER ERROR 2024													
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Total
Sharps/ Blades		3	2		1	1	4	2	2	2	1	1	19
Other item returned to SSD		1											1
Single use Items returned to SSD		1											1
Missing Items	2	2		5	3	4	4	2	3	3	5	2	35
Checklist not signed											1		1
Totals	2	7	2	5	4	5	8	4	5	5	7	3	57

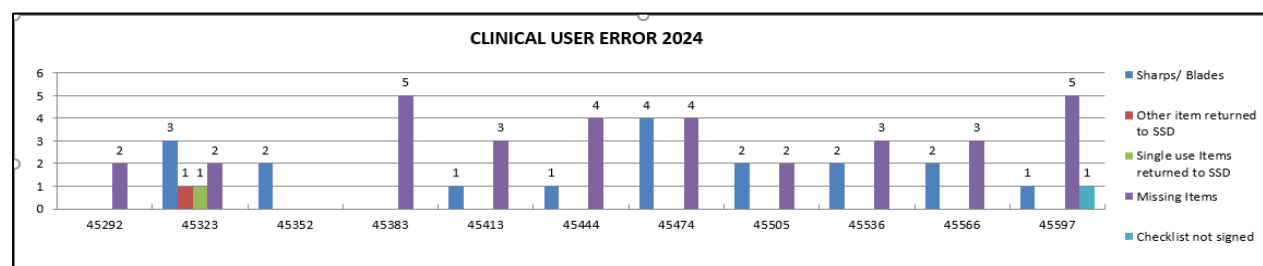


Figure 22: SSD Clinical User Error 2024



A reduction has also been observed in the number of missing items reported

- 2024: 35 missing-item DATIX reports
- 2025: 18 missing-item reports

This represents a 48.6% decrease in missing-item incidents.

Overall, both key risk areas — sharps and missing instruments — show substantial year-on-year reduction, indicating improvements in clinical practice, adherence to processes, and the effectiveness of recent staffing changes and monitoring measures. Continued vigilance, education, and quality assurance remain essential to maintaining and further improving performance.

Table 18: EDU Clinical User Error 2025

EDU CLINICAL USER ERROR 2025													Yearly total
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	total
Dirty Scopes (not flushed)											1		1
Other item returned to EDU													0
Missing Items													0
Scope not returned to EDU after procedure		1		2					1				4
													0
Totals	0	1	0	2	0	0	0	0	1	0	1	0	5

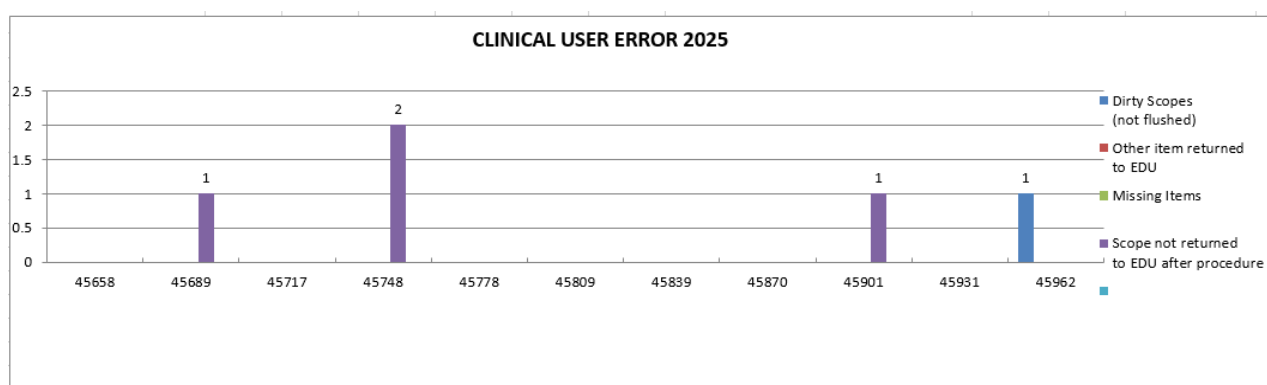


Figure 23: EDU Clinical User Error 2025

Table 19: EDU Clinical User Error 2024

EDU CLINICAL USER ERROR 2024													Yearly total
	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	total
Dirty Scopes (not flushed)		1								1	1		3
Other item returned to EDU													0
Missing Items													0
Scope not returned to EDU after procedure										1	1		2
													0
Totals	0	1	0	0	0	0	0	0	0	2	2	0	5

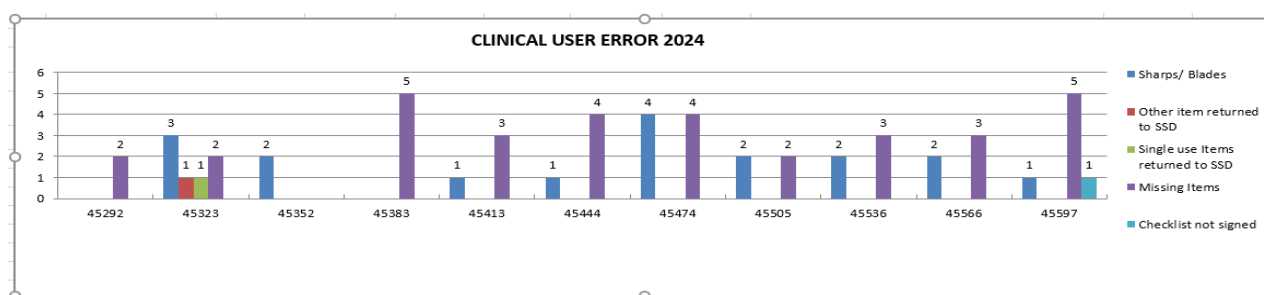


Figure 24: EDU Clinical User Error 2024

Although the overall number of incidents remained the same (5 in both years), there has been a significant improvement in the more critical area:

Scopes not flushed at point of use:

- 2024: 3 incidents (main theatre)
- 2025: 1 incident (main theatre)
- 67% reduction

This is a key improvement because failure to flush scopes immediately after procedures increases the risk of biofilm formation and compromises patient safety. The above incidents have been reported via DATIX and were discussed during the SSD/Theatre monthly meeting.

The Matron and Band 7 staff have been instructed to remind all team members to adhere to the correct procedures at all times.

Scopes not returned immediately after procedure:

- 2024: 2 incidents
- 2025: 4 incidents

Reports increased, but the above incidents are lower-risk compared to failure to flush. The Matron and Band 7 staff have been instructed to remind all team members to adhere to the correct procedures at all times.

Even though the total number of DATIX reports did not change between 2024 and 2025, there has been meaningful improvement because:

- The number of serious lapses (not flushing scopes) has significantly decreased.
- The remaining incidents relate to delayed returns, which, while important, carry lower decontamination risk.
- Staff adherence to flushing protocols has visibly strengthened.

21. Trust Estate's & Facilities Monitoring

Report written by Margaret Outaleb, Facilities Manager

Standards of cleaning in both Chelsea and West Middlesex Hospital sites are monitored through cleaning audits carried out jointly with a ward or department manager or their trained representative and Soft FM Contractor in all risk category areas with frequency stipulated in the National Standards of Healthcare Cleanliness (NSoHC 2021 updated NSoHC 2025).



In addition, daily ad hoc inspections are undertaken by the Facilities Manager and a monitoring officer in each respective site as a means of assurance that the quality and standards of cleaning is maintained at all times according

Efficacy audits are carried out by the Estates and Facilities team annually in every ward, department and ED to ascertain that correct cleaning processes are implemented while cleaning tasks are undertaken by the domestic team. 100% of efficacy audits were carried out in FR1 (Functional Risk 1) areas between April 2025 and March 2026.

On the Chelsea site, in November 2025 *C. auris*, was first identified in an index patient who had been treated previously abroad. The IPC team recommended that hydro peroxide vapour (HPV) be used as a way of controlling spread of *C. auris*. Cleaning in affected areas was undertaken by Ecolab, an expert cleaning company, using specialist equipment. Each of the HPV cleans was proceeded by an enhanced type of clean when steam cleaning of all equipment and surfaces was executed.

21.1. Chelsea and Westminster Hospital

During the year 2025/2026, a total of 1775 cleaning audits were undertaken in all functional risk (FR) category areas, from FR1 to FR6 in accordance with National Standards of Healthcare Cleanliness 2021 (NSoHC 2021 and 2025).

Within the FR1 category, all functional areas were inspected weekly with a ward representative, resulting in a total of 1208 audits. All audits achieved the minimum target score of 98%. The overall average score achieved for this category was 98.84% showing consistency with the previous year's score of 98.84%.

In the FR2 category, all functional areas were inspected monthly resulting in a total of 372 audits for the year. All audits achieved the minimum target score of 95%. The overall average score achieved for this category was 97.59%.

Functional areas within the FR3 category were audited bi-monthly making it a total of 48 audits for the year. The average score achieved for this risk category was 97.21% against a KPI target of 90%.

In the FR4 category, all functional areas were inspected quarterly resulting in a total of 114 audits for the year. All audits achieved the minimum target score of 85%. The overall average score achieved for this category was 96.49%.

Functional areas within the FR5 category were audited twice in the year making it a total of 12 audits for the year. The average score achieved for this risk category was 96.26% against a KPI target of 80%.

Finally, in the FR6 category, all functional areas were inspected once a year resulting in a total of 25 audits for the year. All audits achieved the minimum target score of 75%. The overall average score achieved for this category was 95.41%.

Compliance with cleaning audits being carried out jointly with a member of clinical staff was 100% in all risk categories reported above.

Deep Cleaning Programme was completed at 100% in FR1 areas between April 2025 and March 2026. As per the agreed process, each area that had been deep cleaned was inspected and signed off by the area's person



in charge and an Estates and Facilities representative. A full deep cleaning programme for 2025/6 was shared with Estates and Facilities

Departments: a list of areas deep cleaned in 2025 as part of the programme are as follows:

- Mars Ward
- Apollo Ward
- Birthing Centre
- ED OBS
- Intensive Care Unit & High Dependency Unit
- Burns Unit
- Burns Operating Theatre
- Ron Johnson Ward
- Labour Ward
- Labour Theatre
- Josephine Barnes Ward / HDU
- Neonatal Unit (NICU)
- Treatment Centre Day Surgery
- Operating Theatres (Main) & Recovery
- Children Theatres & Recovery
- Dermatology Theatre (Daniel Turner Theatre)
- ED Resus
- ED Paediatric
- ED Majors
- Gazzard Unit
- Endoscopy Unit/Theatres
- ECG/Cardiology & Lung Function

In addition to the standard discharge cleans carried out between April 2025 - March 2026, the cleaning teams completed 2872 infectious cleans as compared to the previous year of 3169 infectious cleans.

The graph below represents the number of discharges, infectious and enhanced type of cleans carried out in the hospital as logged through Helpdesk:

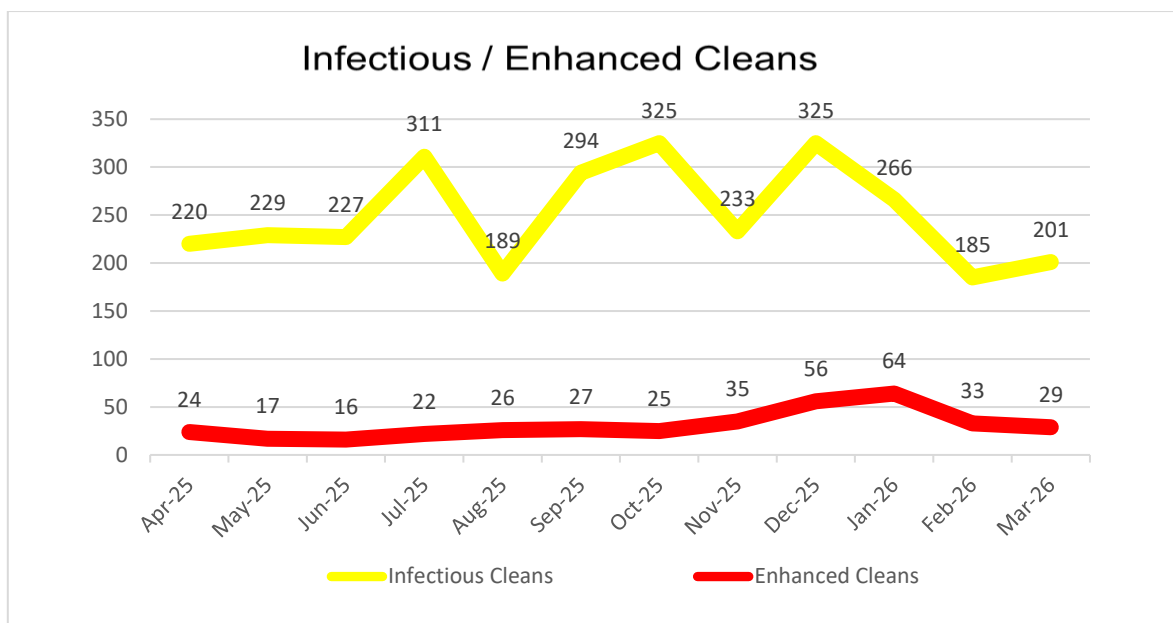


Figure 25: Cleans – Chelsea & Westminster Hospital.

Since late November 2025, Bioquell –using Hydro Peroxide Vapour (HPV) cleans were also carried out in various parts of wards/ Department on recommendation of the IPC management to control *C. auris*.

Below are the areas where the HPV clean took place since between November 2025 and March 2026.



Table 20: HPV Cleans

DATE	WARD/ DEPT	ROOM	INFECTION TYPE
28/11/2025	ICU	ROOM 11	<i>C.auris</i>
29/11/2025	ENDOSCOPY THEATRE	THEATRE 4	<i>C.auris</i>
12/12/2025	DAVID ERSKINE	A BAY	<i>C.auris</i>
12/12/2025	ICU	ROOMS 8,9,10,11,12	<i>C.auris</i>
22/12/2025	ICU	ROOM 20	<i>C.auris</i>
02/01/2026	ENDOSCOPY	THEATRE 4	<i>C.auris</i>
19/01/2026	RAINSFORD MOWLEM	SIDE ROOM 5	<i>C.auris</i>
19/01/2026	PLASTICS	CONSUL RM J.1.105	<i>C.auris</i>
27/01/2026	AAU	ROOM 4	<i>C.auris</i>
29/01/2026	IAVI	Room 15	<i>C.auris</i>
11/02/2026	Fracture Clinic	Room 5	<i>C.auris</i>
25/02/2026	Burns Unit	ITU1	<i>C.auris</i>
25/02/2026	Burns Unit	Theatre	<i>C.auris</i>
25/02/2026	Burns Unit	Theatre -Anaesthetics and Recovery room	<i>C.auris</i>
26/02/2026	Burns Unit	Side Room 1	<i>C.auris</i>
05/03/2026	Burns Unit	BICU2	<i>C.auris</i>
11/03/2026	Burns Unit	HDU 2	<i>C.auris</i>
12/03/2026	Burns Unit	HDU 2	<i>C.auris</i>
13/03/2026	Burns Unit	Side Room 1	<i>C.auris</i>
17/03/2026	Burns Unit	HDU2	<i>C.auris</i>
20/03/2026	Burns Unit	Shower Room	<i>C.auris</i>

21.2. West Middlesex Hospital

Between April 2025 and March 2026, 1,161 cleaning audits were undertaken in accordance with the National Standard of Cleanliness 2021 and according to the national standards updated in 2025.

Within the FR1 category, all functional areas were inspected weekly, for a total of 396 audits for the year from April 2025 to March 2026. All audits achieved the minimum target score of 98%. The overall average score achieved for this category was 99.18%.

In the FR2 category, all functional areas were inspected monthly, for a total of 336 audits from April 2025 to March 2026. All audits achieved the minimum target score of 95%, and the overall average score achieved for this category was 98.14%.

In the FR3 category, all functional areas were inspected monthly for a total of 49 audits from April 2025 to March 2026. All audits achieved the minimum target score of 90%. The overall average score achieved for this category was 97.85%.

Functional areas within the FR4 category, which include mainly OPD clinics, were all audited monthly rather than quarterly, for a total of 333 audits for the year. All audits achieved the minimum target score of 85%. The average score achieved for this risk category was 97.40%.

In the FR5 category, all functional areas were inspected monthly, for a total of 12 audits from April 2025 to March 2026. All audits achieved the minimum target score of 80%. The overall average score achieved for this category was 95.83%.



In the FR6 category, all functional areas were inspected monthly, for a total of 35 audits from April 2025 to March 2026. All audits achieved the minimum target score of 75%, and the overall average score achieved for this category was 94.85%.

Since April 2023, when the NSoC 2021 was introduced, all audits within all risk categories (FR1 to FR6) have been 100% undertaken jointly with a clinical member of Trust staff, including matrons, ward managers, sisters/charge nurses, theatres coordinators, and the E&F manager or monitoring officer.

Between April 2025 and March 2026, the ISS special projects team completed 261 deep cleans, including the annual deep clean of Main Theatres and the quarterly deep clean of the Aseptic Suite in Pharmacy.

In addition to the “standard” discharge cleans carried out between April 2025 and March 2026, the cleaning teams completed 3,658 “infectious” cleans, comparable to the previous year and representing a 7% increase in the total volume of discharge cleans.

Moreover, a total of 23 enhanced type of cleans were carried out when a CRO (Carbapenem Resistant Organism), an antibiotic-resistant bacteria, were detected.

The graph below represents the number of discharges, infectious and enhanced type of cleans carried out in the hospital as logged through Service desk:

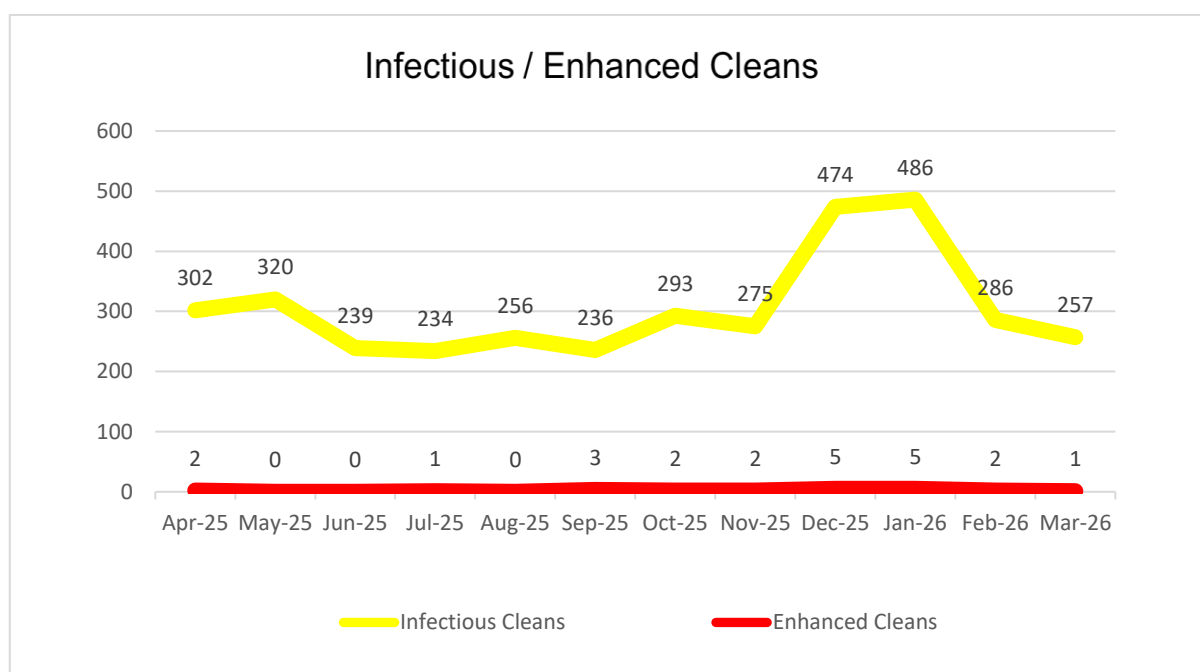


Figure 26: Cleans – West Middlesex Hospital



21.3. Estates – Chelsea and Westminster Hospital

Report written by Joao Silva, Head of Operational Estates

During 2025/2026, the Estates Department significantly strengthened its role within the Infection Prevention and Control Group (IPCG), improving governance, operational assurance, and the resilience of the Trust's water-safety systems. The transition to a fully in-house delivery model on 1 October 2025 marked a major shift in operational capability, enabling faster escalation, clearer accountability, and enhanced visibility over compliance activities.

Alongside the development of internal capacity, the Trust formally welcomed its new specialist partners in water safety and ventilation at the start of 2026, bolstering Estates' technical capability and strengthening the organisation's ability to respond to safety issues. Their expertise has supported a more robust approach to assurance, with improved collaboration across the Water Safety Group, Ventilation Safety Group, IPCG and clinical teams. This strengthened multidisciplinary structure ensures that Estates-related risks are consistently aligned with clinical priorities and escalated appropriately.

Monitoring and assurance processes have been stabilised following the introduction of calibrated Trust-owned temperature-monitoring equipment, enabling accurate and reliable data collection. Microbiological outcomes improved throughout the year, supported by targeted flushing, remedial works and enhanced surveillance in higher-risk areas, including NICU, Burns and the Ron Johnson Building. Continuous oversight of all thirty-four negative-pressure rooms has been maintained, with appropriate restrictions and review mechanisms in place for any rooms operating outside of expected parameters.

System maintenance also improved significantly over the year. Estates implemented a structured programme for thermostatic mixing valves and shower-head maintenance, introducing quarterly descaling cycles and upgraded shower heads in private-care settings. A Trust-wide asset-mapping exercise commenced, supporting long-term planning, lifecycle management and compliance with HTM guidance.

Looking ahead to 2026/2027, Estates will continue consolidating the water-safety programme by completing the asset-identification process and delivering a long-term tank-cleaning and maintenance schedule. Reporting dashboards will be standardised to improve trend analysis and strengthen governance. Estates will also enhance its collaboration with clinical teams, improving proactive risk planning and developing a shared IPCG–Estates water-safety risk register. Work to address remaining hot-water performance issues will continue, alongside broader resilience strategies for high-demand clinical areas. Workforce competency will be supported through additional technical training in water safety, Legionella management and ventilation monitoring.

In summary, the Estates Department has made substantial progress in water-safety governance, monitoring, microbiological assurance and system maintenance since transitioning to an in-house delivery model. With strengthened internal processes, improved data quality, and the added expertise of new water-safety and ventilation partners, the department is well positioned to deliver a resilient, data-driven and clinically focused service into 2026/2027.



21.4. Equans – West Middlesex Hospital

Report written by Paul Deavall, Equans Operations Manager

Water Safety and Infection Prevention Control Participation

EQUANS has representation on, and continued to support, the Water Safety Group (WSG) and the Infection Prevention Control Group (IPCG). EQUANS is also an active member of the Ventilation Safety Group (VSG). Training completed for both Responsible Person Ventilation (RP^v) and Competent Person Ventilation (CP^v). For Water one Responsible Person and one Deputy Responsible Person (DRP) are appointed, supported by 2 Water System Operatives (WSO's) Competent Persons.

Zetasafe System and Water Systems Operatives

EQUANS at West Middlesex Hospital continued the utilisation of the ZetaSafe digital compliance system as set out in the water safety plan (WSP). This database system gathers all live testing data from the Water Systems Operatives and engineers alike. The system support trend analysis and to enhance the identification of developing risks within the water network. Not all areas were currently incorporated into the ZetaSafe platform, and its scope is scheduled for re-evaluation in 2026 alongside the former internal compliance scheme. The Water Systems Operatives (WSO's) undertake all associated actions generated from ZetaSafe, including routine flushing tasks and the completion of site-wide water safety checks.

Flow Temperature Issues in Richmond Ward

The previously identified flow temperature issue affecting Richmond Ward had continued to be addressed throughout the reporting year. Replacement thermal balancing valves had been installed in place of flow-regulating valves on the First Floor. Further activities continued in Richmond Ward to improve hydraulic performance. The improvement of hydraulic performance was expected to deliver the inverse operational benefit, namely improved temperature delivery at outlets. A new return leg installed from Richmond Ward back to the main plant room is being fully utilized via a pump installed on the return to improve hydraulic performance. This matter continues and a biweekly call is used to update on progress. A control scheme remains in place, including daily flushing of impacted outlets and enhanced monthly microbiological testing alongside Point of Use (PoU) filtration.

Microbiological Testing Legionella and *Pseudomonas aeruginosa* Observed Trends

Microbiological testing undertaken by a United Kingdom Accreditation Service (UKAS) accredited laboratory. Positive results were generally associated with identifiable local causes, in the main we have several infrequently used outlets via worked practice and following the review of the Water Risk Assessment. These are communicated to IPC for evaluation and direction. The reporting year saw showers and utility areas being used for storage, which adversely affects water quality. EQUANS have communicated and worked with IPC over these matters which are continuing into 2026.

EQUANS observed good reduction in *Pseudomonas aeruginosa* levels, with a small number of anomalous positive results recorded over the previous 12 months. Conversely, increases in Legionella levels were noted in common areas. With agreement from IPC and Trust, selected low-use outlets are marked for removal where appropriate. All occurrences were investigated to identify root cause. Older parts of the estate had become increasingly vulnerable to microbiological issues due to age-related deterioration of pipework and fittings. To mitigate this, many outlets throughout the East Wing, Marjory Warren, and the Main Building



had been replaced to improve water safety and system resilience. QMMU being the latest building to be of focus for the Water safety group input.

Shower Head and Commercial Spray Tap Descaling

Showers are colour coded for removable shower heads and hoses and replaced on a quarterly change system to improve visual identification alongside fixed-head showers continued to undergo quarterly descaling. This alongside commercial spray taps in all kitchen areas.

Outlet Replacements Across the Estate

Significant outlet replacement works had been undertaken across older areas of the estate to address increased vulnerability to microbiological issues associated with ageing infrastructure. Deterioration of pipework and fittings in these locations had contributed to a higher likelihood of stagnation, sediment accumulation and reduced water turnover. In response, EQUANS replaced a substantial number of outlets throughout the East Wing, Marjory Warren and the Main Building. These replacement works formed part of a targeted risk-reduction strategy aimed at improving water system resilience, restoring correct outlet performance and supporting compliance with relevant Health Technical Memorandum requirements. The programme of outlet renewal was informed by trend data, microbiological sampling results and physical condition assessments undertaken by Water Systems Operatives.

Ventilation Compliance

Ventilation validation had been completed across all designated procedure rooms, theatres and recovery areas. Each report shows findings which are centralised on to an action plan and coordinated via the competent person ventilation (CPv) and managed via (RPv). There had been a specific focus on negative pressure environments, with improvement works undertaken in ITU Negative cascade rooms to better record pressure differentials and to bring in room 8 back into service. It was identified that there needed to be a more consistent operational approach regarding the closure of doors that formed part of the negative pressure envelope, including barrier rooms in Syon and the isolation rooms within Intensive Care Unit (ICU) and High Dependency Unit (HDU).

Legionella Water Risk Assessments (LRA) And *Pseudomonas Aeruginosa* Risk Assessments (PRA)

Comprehensive water risk assessments across all areas of the site had been completed in May 2025 and published in July LRA scheduled for renewal in 2026. The findings of which are being applied across the estate in all buildings. Both Estates and IPC are involved in essential parts of the requirements.

Forward Plan (SMART Goals Aligned with PSIRF)

1. Reduction of Legionella Positivity in Aged Estate Areas: Reduce positivity by Q4 2026 through enhanced monitoring, outlet replacement and flushing.
2. Improved Hydraulic Performance and Temperature Delivery in Richmond Ward: Achieve full compliance by September 2026 via hydraulic improvements and validation checks.
3. ZetaSafe System Review and Expansion: Complete re-evaluation and expansion plan by December 2026.
4. Elimination of Inappropriate Storage in Showers and Utility Rooms: Achieve 100% compliance by Q3 2026 via quarterly audits and staff engagement.
5. Water Risk Assessment Programme: Complete site-wide reassessment by May 2026.



6. Strengthening Negative Pressure Area Compliance: Achieve ≥95% door-closure compliance by August 2026 through monitoring and staff briefings.

21.5. Water Management

Report written by Ian Smith, Authorising Engineer (Water)

The Trust operates an established water management system in line with the requirements of HTM-00 and HTM-04-01. The Trust has in place the key elements of a Water Policy, Water Safety Group, the key appointments of Designated Person, and Authorising Engineer (Water), Water Safety Plan, Written Schemes of Control, *Legionella* risk assessments, *Pseudomonas aeruginosa* risk assessments to augmented care areas and a documented record system. At time of writing due to changes in personnel the formal appointments of the recently proposed Responsible Persons (Water) for both sites were in progress.

To the end of the year the maintenance service provision for the Chelsea site was brought in house and this caused an interruption to some of the service and monitoring activities, mainly the temperature checks. This has been resolved and during this time the reassurance water sampling for *Legionella* bacteria and *Pseudomonas aeruginosa* bacteria continued.

The estates service teams implement the required control measures identified in the written schemes of control and maintain the records. The control programme includes an element of investigative and reassurance sampling.

The status of the programme and any exceptions noted are reported by the maintenance service provider for West Middlesex and by the internal Estates Team for Chelsea to the Water Safety Group. For any out of specification results appropriate response actions are implemented as may be required.

From the *Legionella* risk assessment reports and other works it has been identified that the due primarily to the age of the systems there are items, such as cold-water tanks and pipework that will require investment over the coming years to assist in maintaining control.

The Authorising Engineer (Water) acts to provide external support and presents a summary overview of the status of the water management programme each quarter to the IPCG.

21.6. Ventilation Safety Assurance Report

Report written by Simon Bengé, Associate Director of Estates

During 2025/26, the Trust continued to strengthen its approach to ventilation safety following the transition of services to in-house Estates management on 1 October 2025. This shift has provided greater operational oversight, improved responsiveness, and clearer governance across all clinical and non-clinical ventilation systems.

See [\[Appendix 8: Ventilation Roles and Responsibilities Flow Chart\]](#) for ventilation Roles and Responsibilities flow chart.

Routine ventilation PPMs remained largely compliant throughout the year, with statutory checks completed as required and weekly operational monitoring stabilising as the Estates team embedded new workflows and CAFM-based scheduling. Estates also worked closely with the Water and Ventilation Safety Groups to ensure that risk-based prioritisation and escalation processes were consistently applied across critical areas.



A number of critical ventilation risks were identified across the estate, many relating to ageing or end-of-life AHUs, particularly within theatres, maternity, neonatal areas, dental surgery, and St Stephen's. Verification reports highlighted common issues including reduced air change rates, pressure imbalance, fabric deterioration, and limited access for maintenance. Estates and Capital Projects continue to develop a structured programme to manage these risks, supported by an updated AHU condition and compliance register.

To strengthen resilience and accelerate compliance recovery, the Trust formally on boarded specialist ventilation partners (MET Healthcare and Airisq) at the start of 2026. Their expertise is supporting Estates in re-establishing a structured verification programme, reviewing high-risk areas, and improving engineering assurance across the site.

In parallel, the Trust initiated a BMS upgrade to a modern, web-based platform, enabling improved monitoring, better fault diagnostics and more efficient control over ventilation systems. This work underpins long-term sustainability, energy optimisation, and more robust engineering governance.

Overall, ventilation safety assurance improved steadily throughout 2025/26. While several critical systems require significant refurbishment or replacement, the combined impact of in-house delivery, strengthened oversight, and the mobilisation of specialist partners has provided greater assurance and clearer direction for the Trust's long-term ventilation compliance strategy.

21.7. Water Safety Assurance Report

Report written by Simon Benge, Associate Director of Estates

During 2024/25, the Trust maintained a stable and comprehensive water safety management programme, supported by an established Water Safety Group, Water Safety Plan, and routine monitoring arrangements across all sites. The annual AE(W) review confirmed that core controls remained in place, though several areas required strengthened assurance as the estate continued to transition to an in-house service model.

At Chelsea and Westminster Hospital, water quality remained largely satisfactory, with microbiological results generally within expected limits. A small number of recurring issues, including persistent positive findings in M-Block Diagnostics/Endoscopy and isolated outlets such as those on Saturn Ward, required further investigation and remained active on the AE action tracker.

At West Middlesex University Hospital, the AE(W) highlighted a higher level of non-compliance, including an increased incidence of positive Legionella detections and delays in sampling and reporting. These were associated with known circulation and temperature control challenges in several buildings. Mitigation measures, including enhanced flushing, increased sampling frequency, and short-term use of point-of-use filtration, helped maintain patient safety while longer-term engineering works continued.

In late 2025, following the transition from JCA to an in-house Estates model, some planned preventative maintenance activities were affected, and ZetaSafe records were not consistently completed. To stabilise compliance, the Trust engaged H2O Water Specialists, who implemented an independent monitoring system and assumed responsibility for temperature checks and routine water quality tasks. This resulted in more consistent data capture and improved continuity of monitoring across the estate.



Microbiological sampling undertaken in early 2026 showed broadly reassuring results. Routine *Pseudomonas aeruginosa* sampling in augmented care areas was clear, and ongoing Legionella resampling continued as part of the Trust's strengthened programme of assurance.

The Water Safety Group also progressed work on the *Pseudomonas aeruginosa* risk assessment action plan, consolidating outstanding actions into the new CAFM system and prioritising issues related to drainage, plumbing configuration, and clinical-area hygiene practices. This work is being delivered collaboratively between Estates and IPC.

Training and competency arrangements were refreshed following staffing changes, with the AE remaining in post and a new Responsible Person identified, pending formal appointment. The Water Safety Group continues to oversee competency and governance requirements in line with HTM guidance.

A further area of focus was resolving intermittent hot-water circulation and temperature issues in specific clinical areas, supported by H2O's technical input and targeted remedial works, which remain ongoing.

The formal AE(W) audit for 2025/26 is pending. Overall, despite operational challenges during the service transition, the Trust maintained safe water systems, strengthened governance, and established a clearer path toward long-term compliance and resilience through specialist support and improved monitoring processes.



Appendix 1: Terms of Reference - Infection Prevention and Control Group

1. Constitution

The Infection Prevention and Control Group (IPCG) is a formal sub-committee of the Patient Safety Group, which reports directly to the Quality Committee, a formal Committee of the Trust Board. The IPCG has been established in line with the 'Health and Social Care Act 2008 – Code of Practice on the prevention and control of infections and related guidance updated December 2022. The IPCG will:

- Work to an annual plan.
- Investigate any activity within its terms of reference
- Monitor performance against targets/objectives and policy standards
- Report on the incidence & prevalence of 'alert organisms' and the nature of outbreaks of infection
- Monitor compliance with the Health & Social Care Act 2008, updated December 2022
- Report into & provide assurance to the Patient Safety Group on all aspects of IPC.

2. Authority

The Infection Prevention and Control Group (IPCG) is accountable to the Patient Safety Group and provides assurance through a quarterly summary report of its activities. Additional reporting is undertaken by exception or at the request of the Director of Infection Prevention and Control.

3. Purpose of the Committee:

The purpose of the IPCG is to ensure the Trust fulfils its duties listed in the Health and Social Care Act 2008, provide assurance & evidence via the IPCG to the Patient Safety Group with regards to prevention and control of infection issues, and to facilitate the governance of IPC within operational services.

Ensure that there are effective arrangements in place for IPC across the organisation, to achieve the best possible safety, experience, clinical effectiveness and outcomes for patients, their families/carers, visitors and staff, in accordance with the Health and Social Care Act 2008.

The IPCG will advise and assure the Board and the Trust accountable officers for infection prevention and control on whether effective arrangements are in place to monitor and review implementation of the Trust IPC policies, and other supporting policies.

This will be achieved by encouraging strong divisionally led leadership in infection prevention and implementation of infection control when incidents arise and action plan development and implementation to reduce the risk/ impact of reoccurrence.

4. Objectives:

The main objectives of the Trust IPCG are to:

- Approve and review progress against the IPC annual plan.
- Approve the annual report for IPC prior to presentation at the Patient Safety Group/Quality Committee and Executive Management Board.
- Advise the Chief Executive Officer (CEO) of serious problems or hazards relating to IPC.
- Monitor Trust performance against healthcare acquired infections outlined in the Health and Social Care Act 2008 including externally set objectives.



- Monitor performance against hand hygiene, use of personal protective equipment and the high impact intervention care bundles and associated internally set targets.
- Develop, review and approve IPC policies for which it has responsibility and monitor compliance.
- Advise on the planning and development of services and facilities in the Trust on issues relating to IPC.
- Monitor hard and soft facilities management, including water safety on a monthly basis.
- Monitor and report on Trust responsiveness to outbreaks of infection from ward to board executive level.
- Examine and provide feedback on IPC audits.
- The Group will consider any other reports relevant to IPC of staff working in the Trust.
- The Group will be kept up to date with new or revised international, national or local guidance and legislation.
- Deliver a robust action plan that holds divisions to account and provide feedback to the PSG and board.
- Quarterly reports will be received from the:
 - Decontamination lead
 - Head of occupational Health
 - United Kingdom Health and Security Agency (UKHSA)/ Health Protection units
 - Antimicrobial stewardship team
 - Surgical Site surveillance officers
- Receive annual reports on “sharps and inoculation incidents and audits”

5. Method of working:

Monthly standard agenda with additional quarterly and annual reports.

6. Membership:

The IPCG is chaired by the Director of Infection Prevention and Control or allocated deputy.

The core memberships shall comprise of:

- Director of Infection Prevention and Control
- Directors of Nursing
- Consultant Microbiologists
- Infection Prevention and Control Specialist Nurses
- Antimicrobial Pharmacists
- Consultant in Communicable Disease Control / Health Protection Team Nurse
- Health and Safety Manager
- Occupational Health Manager
- Trust Decontamination Lead
- Deputy Director for Facilities and Estates
- ISS Soft FM General Manager
- Bouygues Energies and Services General Manager
- JCA General Manager
- Divisional Senior Nurses including DDNs, Lead Nurses and Matrons
- Senior Divisional Doctors
- Divisional Directors



- Infection Prevention and Control Team Administrator

Meetings of the IPC Group shall not be held in public.

Only the Group Chair and members shall be entitled to be present. In addition, other members may be invited to attend some meetings depending on the agenda items to be discussed at the invitation of the Group.

7. Quorum:

The quorum necessary for business proceeding shall be 8 members (or appropriate deputies), of which must be the DIPC or nominated deputy and at least 1 representative from each division.

8. Frequency of Meetings and attendance:

The IPCG meetings will take place monthly using video/teleconferencing facilities to enable across site attendance.

Members are expected to attend a minimum of 80% of meetings per year. If a member cannot attend, a fully brief deputy must attend on their behalf.

9. Secretariat:

- The IPC Team will be responsible for circulating the agenda, action logs, meeting papers, and minutes prior to the IPCG meeting.
- The meeting slides will be uploaded onto the intranet up to 24-72 hours before the meeting.
- The minutes of the meeting will be uploaded onto the intranet once approved.
- The IPC team will store both copies of the minutes and meeting slides.

10. Review

The terms of reference will be reviewed yearly. Any changes to the terms of reference shall be presented to the Patient Safety Group for ratification.

Next review is July 2026.



Appendix 2: IPC Data (FIGURE 27- FIGURE 68)

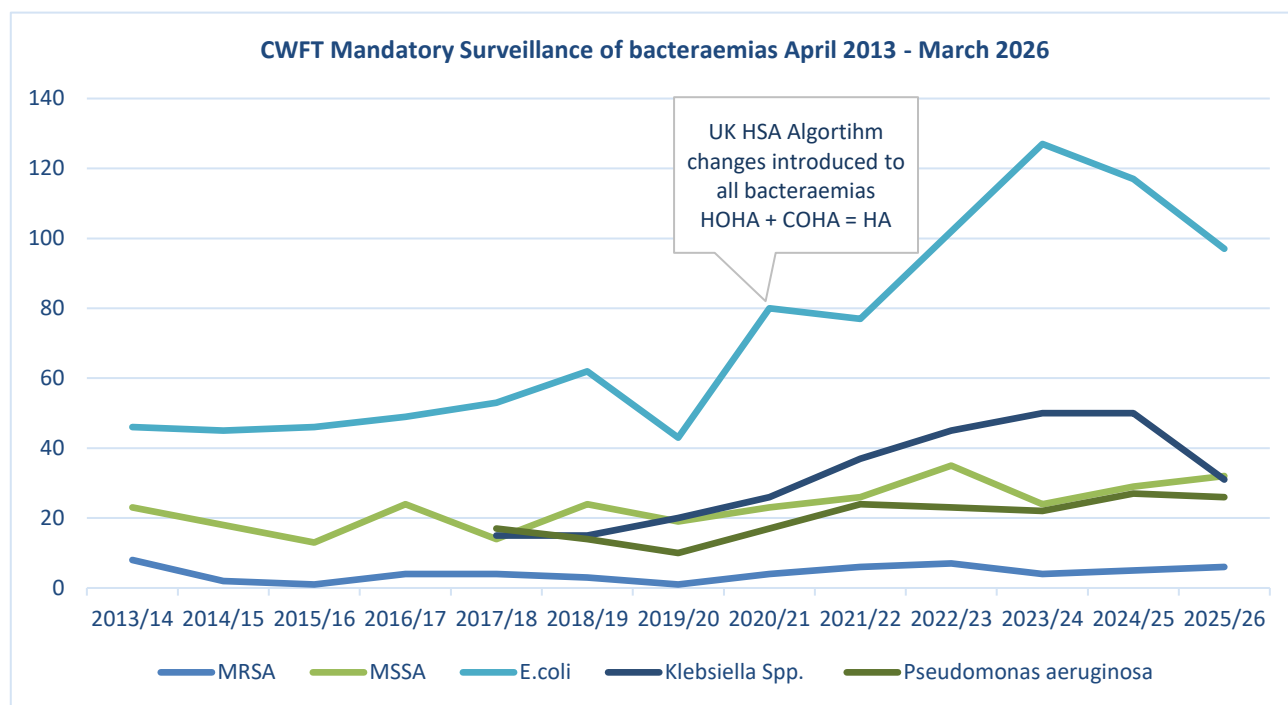


Figure 27: Mandatory Surveillance of bacteraemias 2013 – 2026

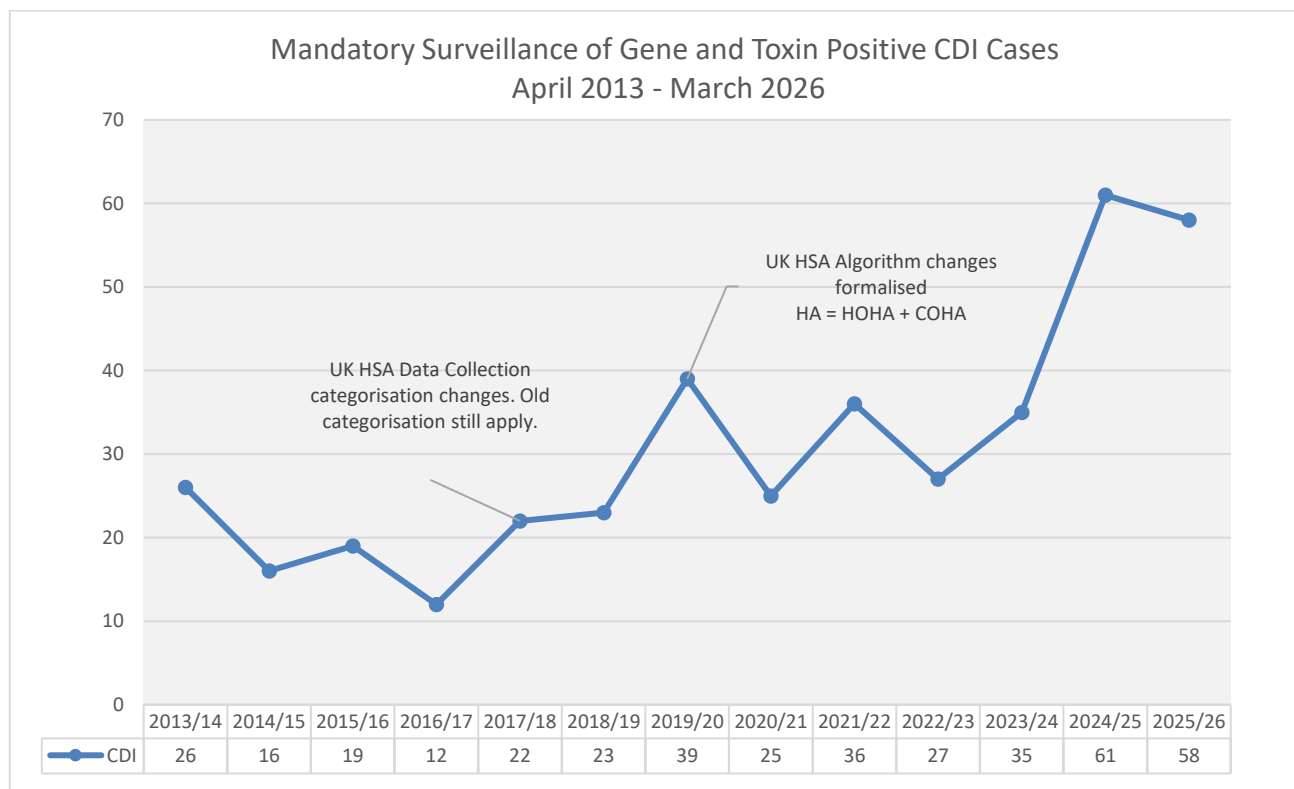


Figure 28: Mandatory CDI Surveillance of Trust attributed cases April 2013 – March 2026

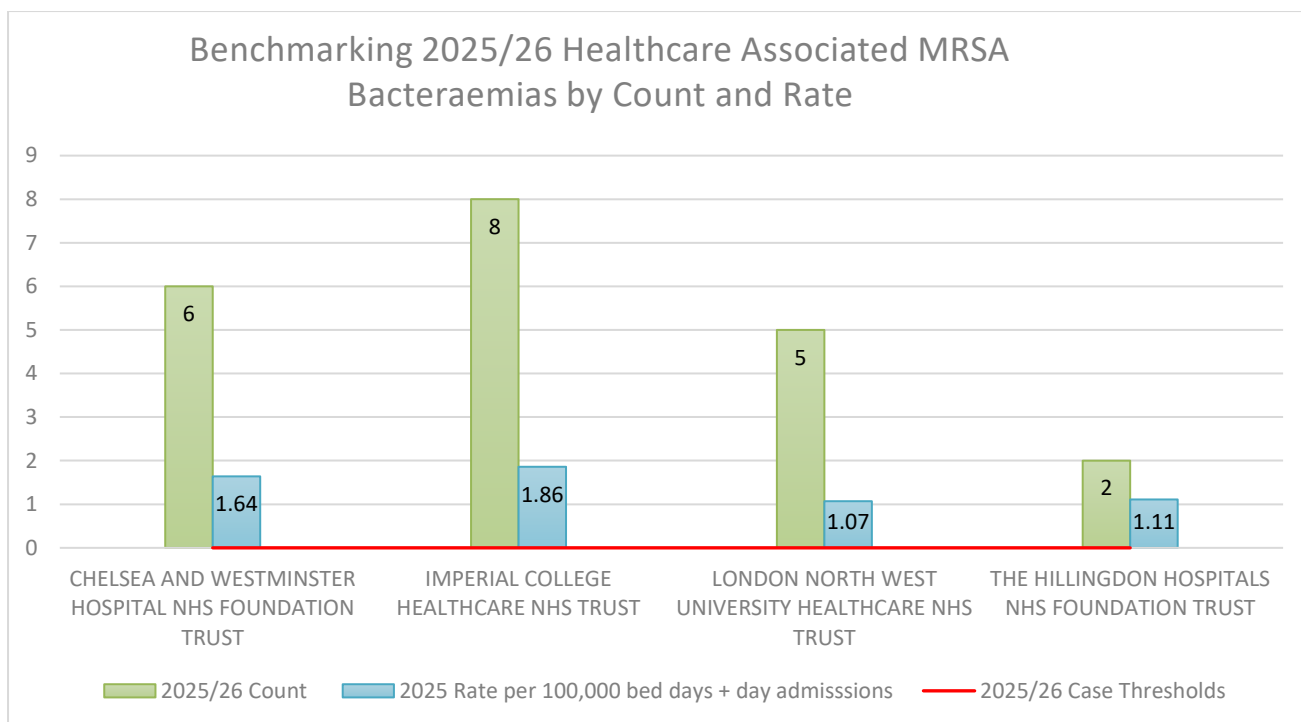


Figure 29: Benchmarking 2025/26 Trust Attributed MRSA bacteraemias by count and rate against local organisations

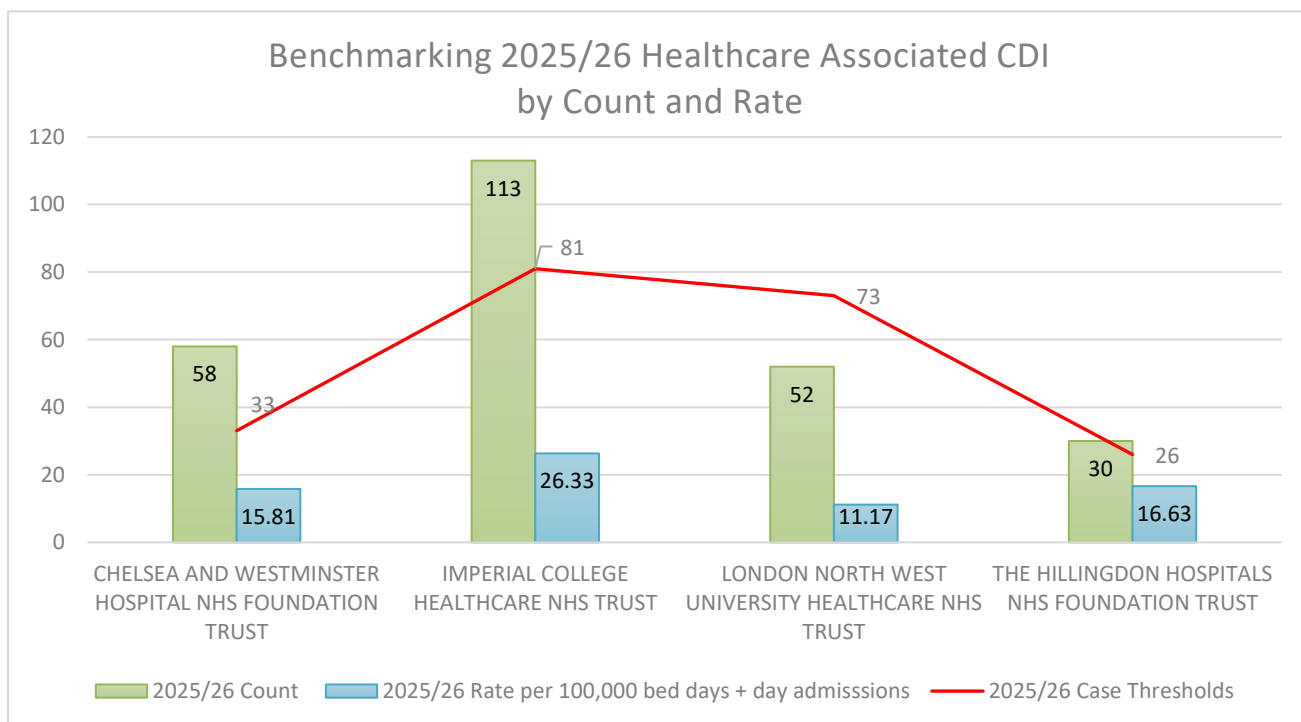


Figure 30: Benchmarking 2025/26 Trust Attributed CDI cases by count and rate against local organisations

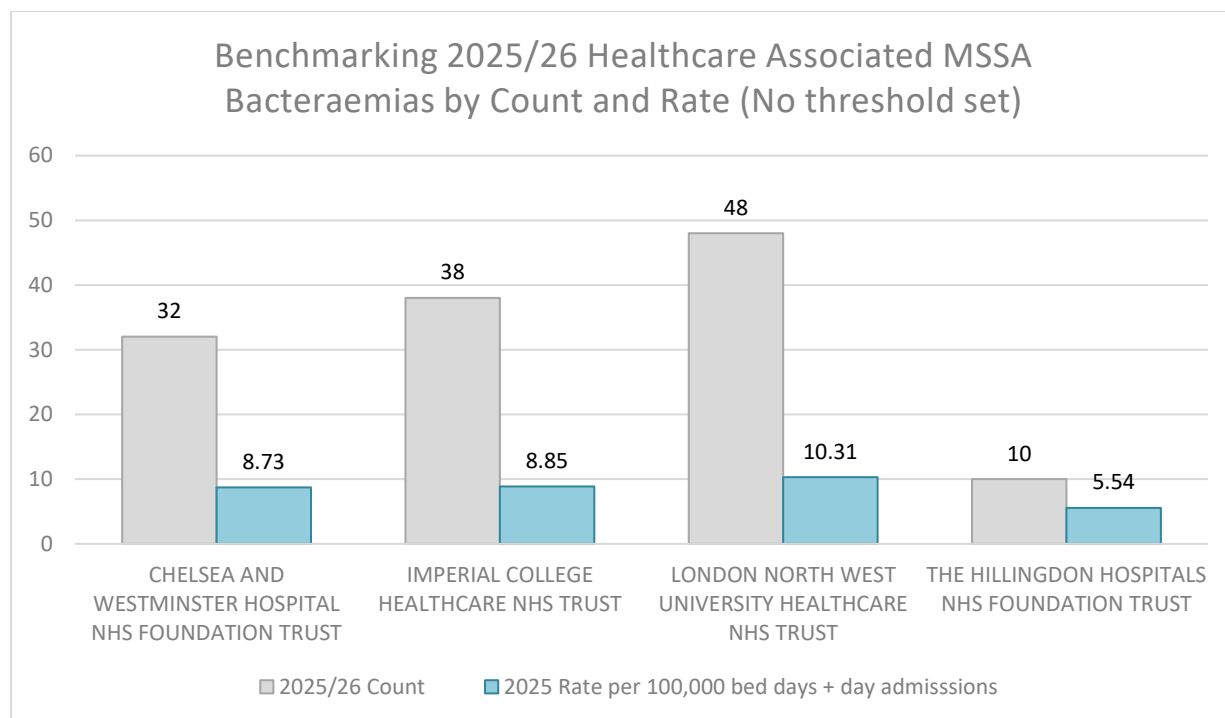


Figure 31: Benchmarking 2025/26 Trust Attributed MSSA bacteraemias against local organisations

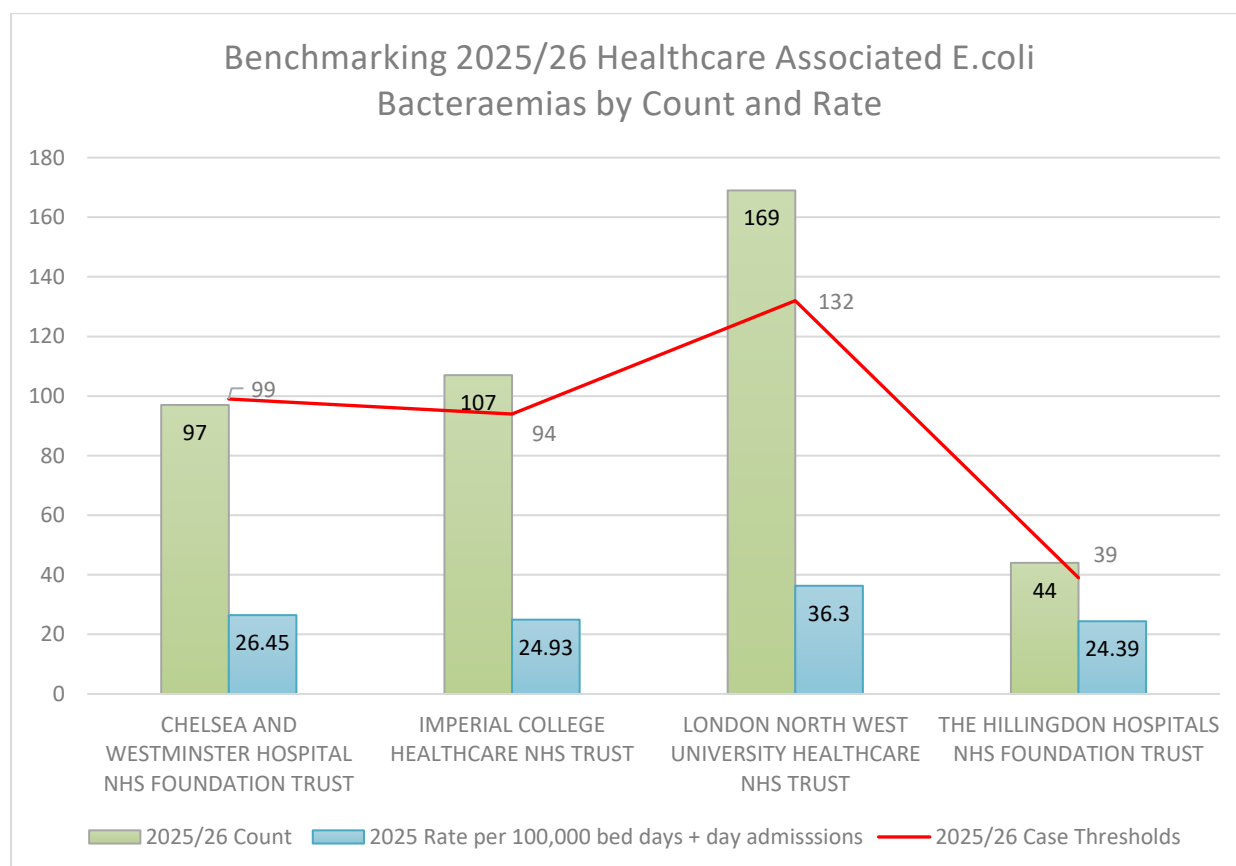


Figure 32: Benchmarking 2025/26 Trust Attributed *E. coli* bacteraemias against local organisations

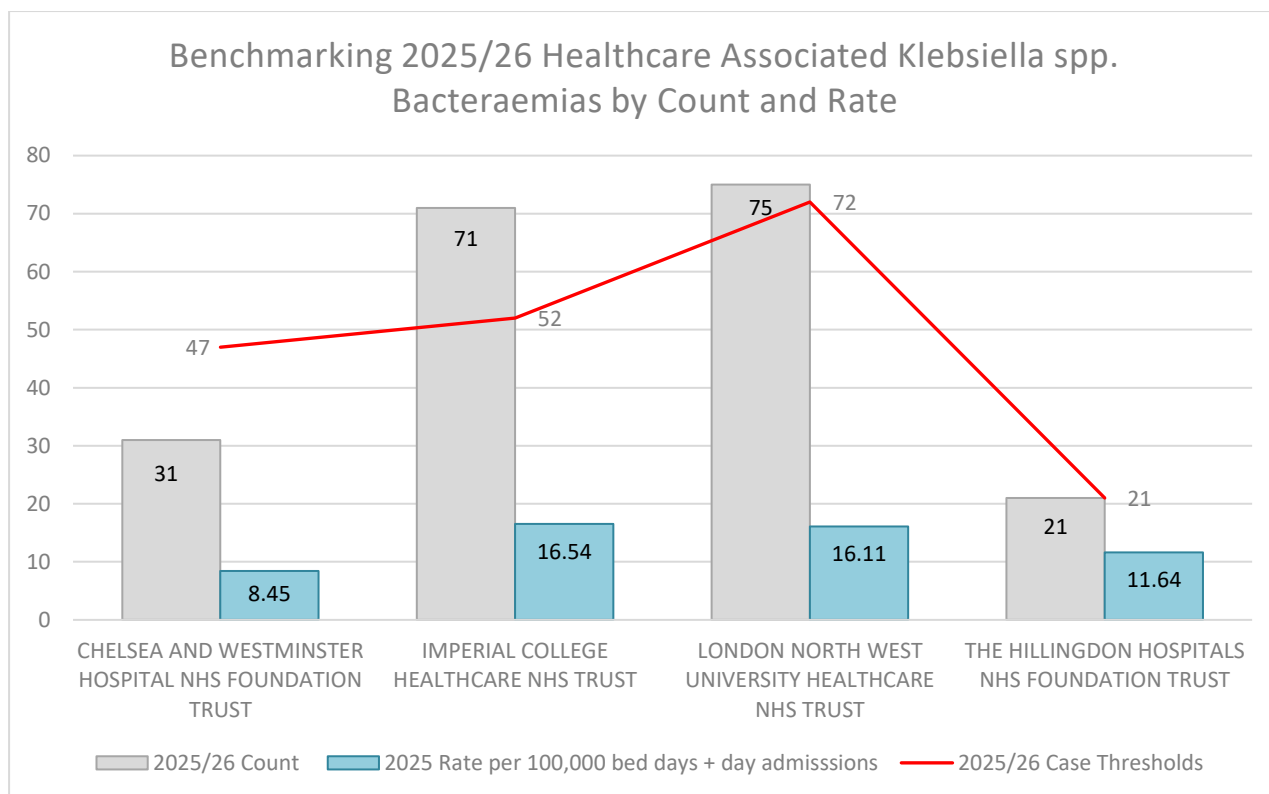


Figure 33: Benchmarking 2025/26 Trust Attributed *Klebsiella* Spp. bacteraemias against local organisations.

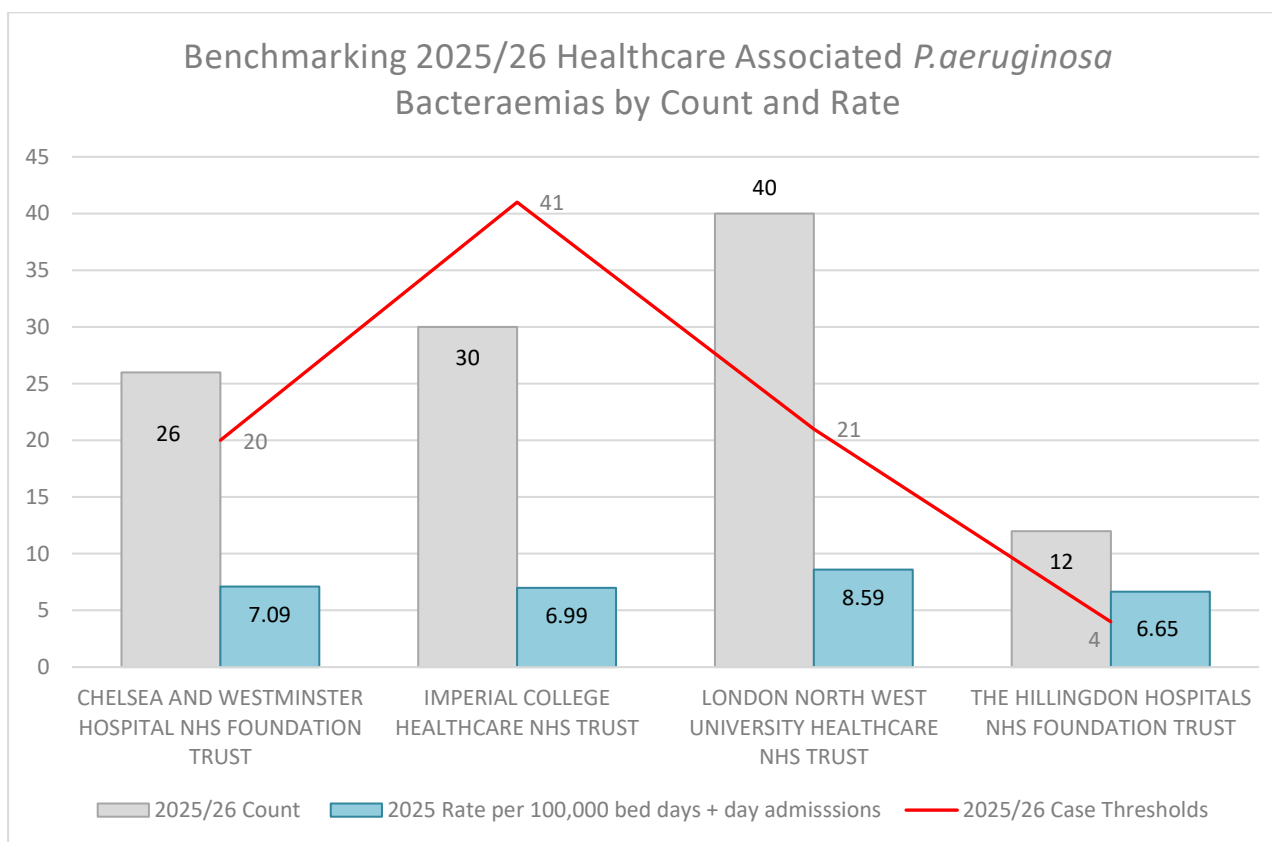


Figure 34: Benchmarking 2025/26 Trust Attributed *Pseudomonas aeruginosa* bacteraemias against local organisations.



2025 Hand Hygiene Audit Data

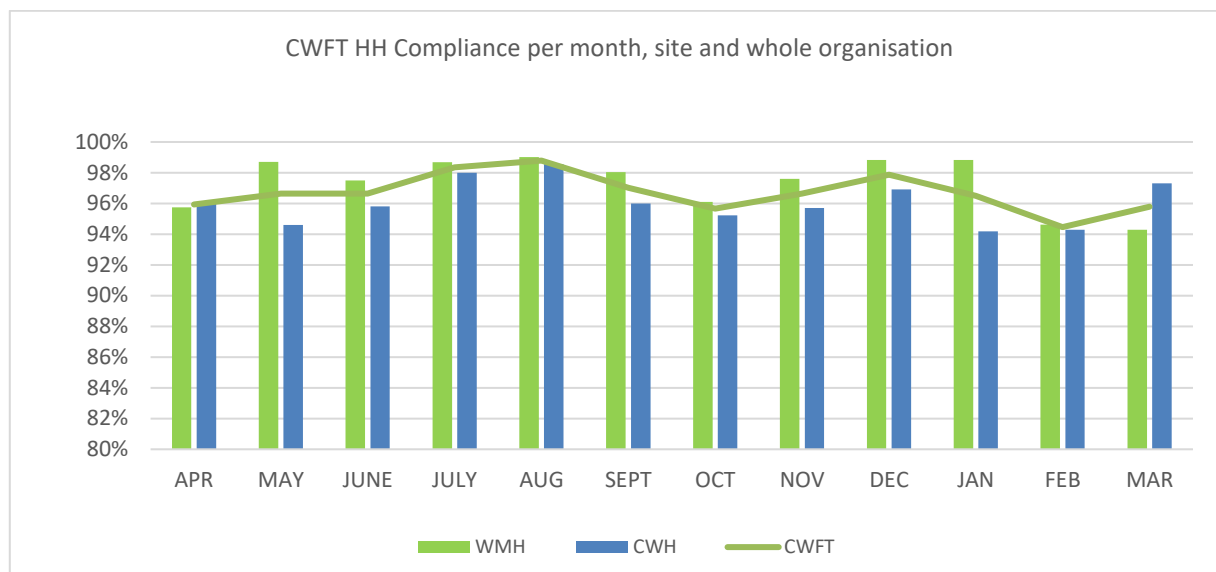


Figure 35: Hand Hygiene Audit Compliance by Month, Site and Organisation 2025/26

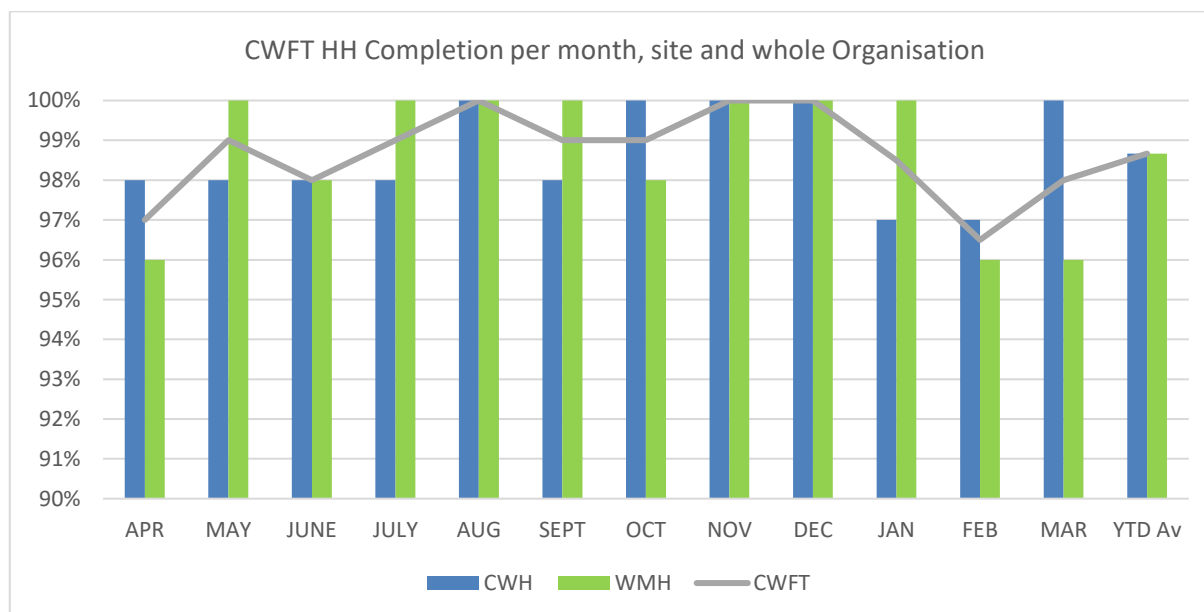


Figure 36: Hand Hygiene Audit Completion by Month, Site and Organisation 2025/26

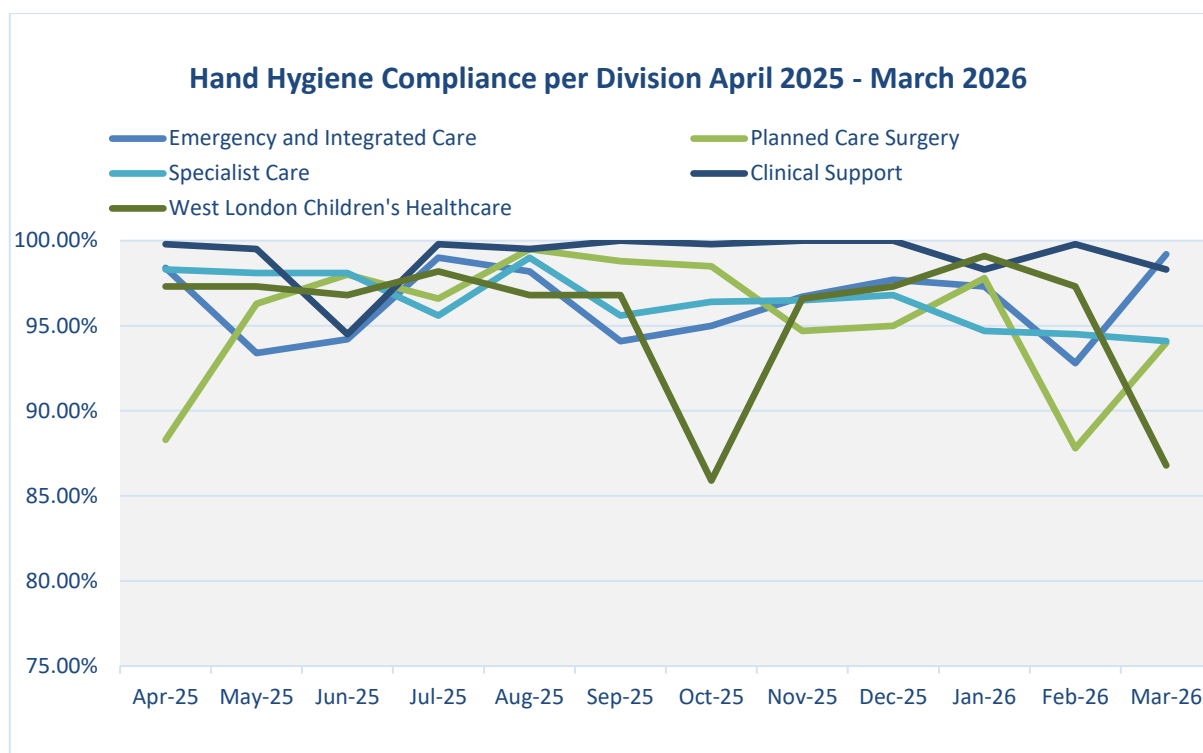


Figure 37: Hand hygiene monthly compliance per division 2025/26

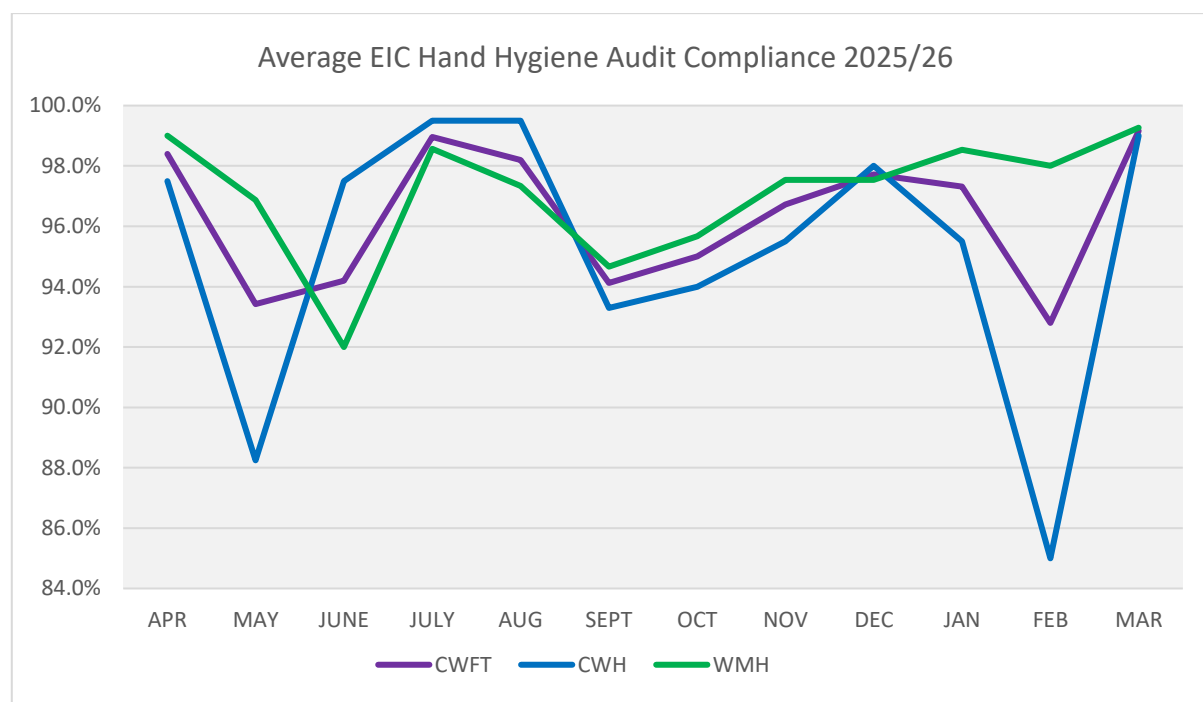


Figure 38: EIC Hand hygiene monthly compliance per site 2025/26

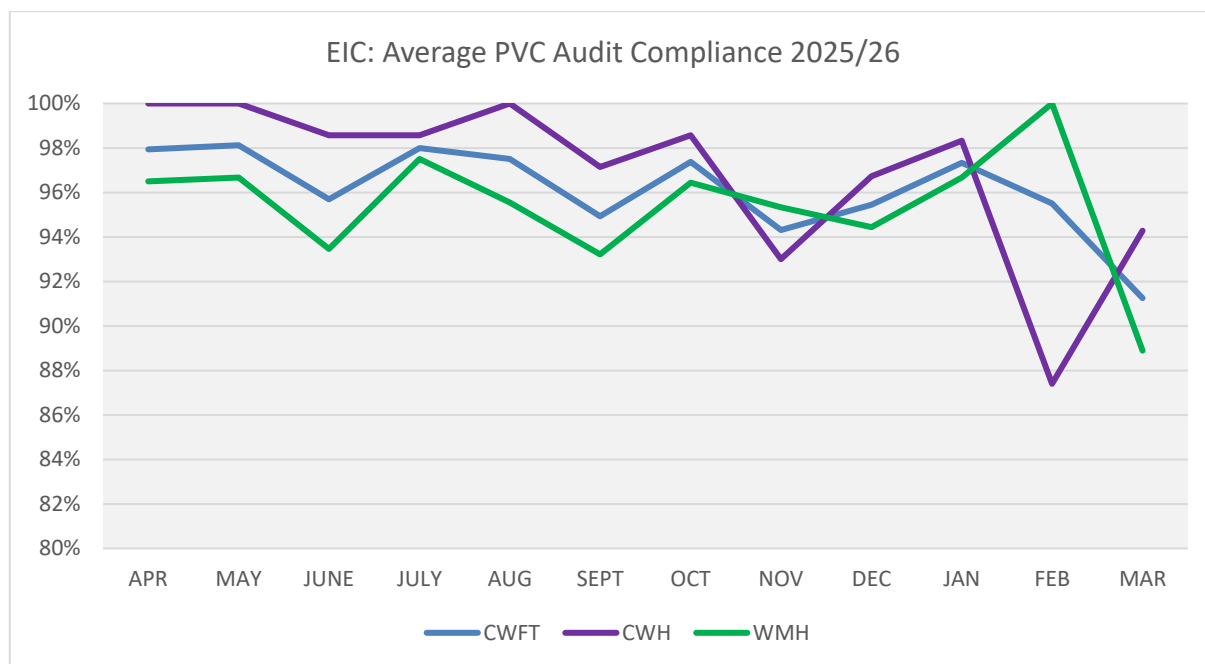


Figure 39: EIC PVC monthly compliance per site 2025/26

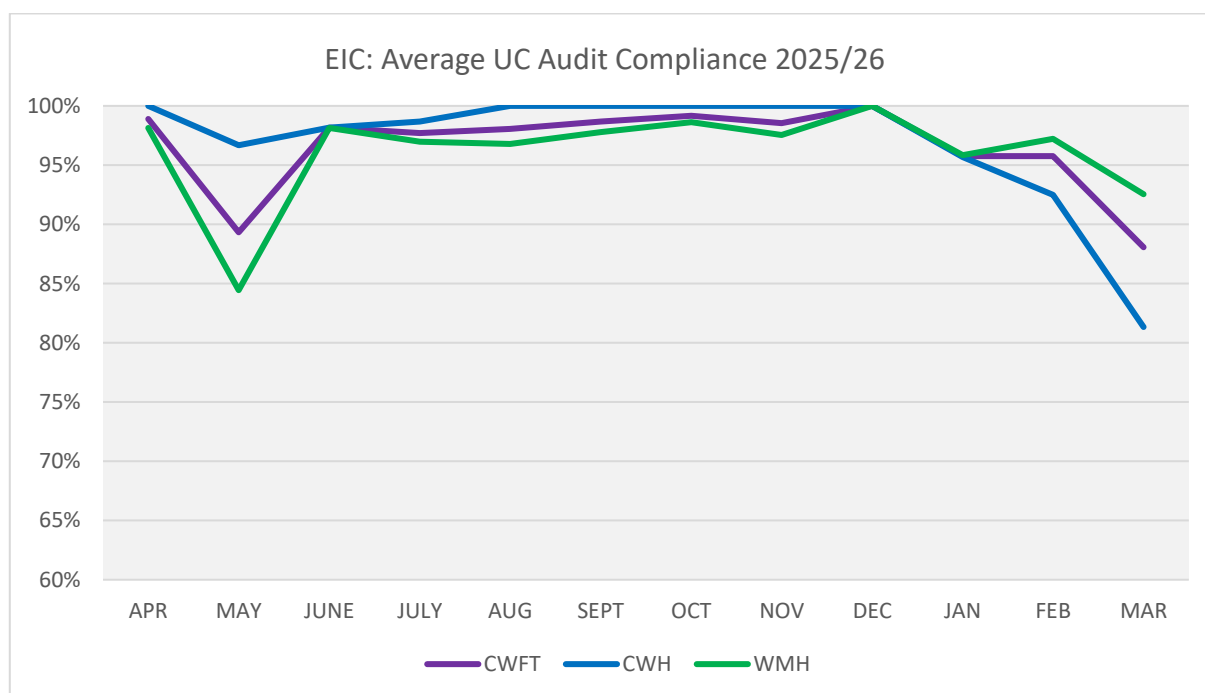


Figure 40: EIC UC monthly compliance per site 2025/26

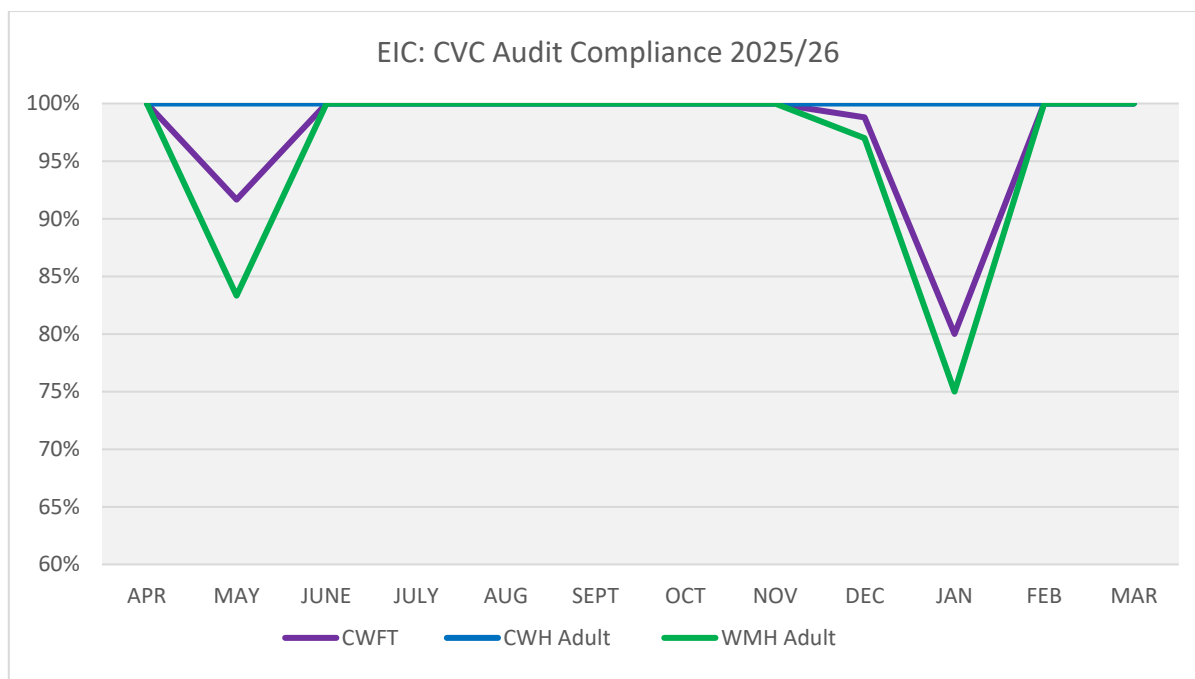


Figure 41: EIC CVC monthly compliance per site 2025/26

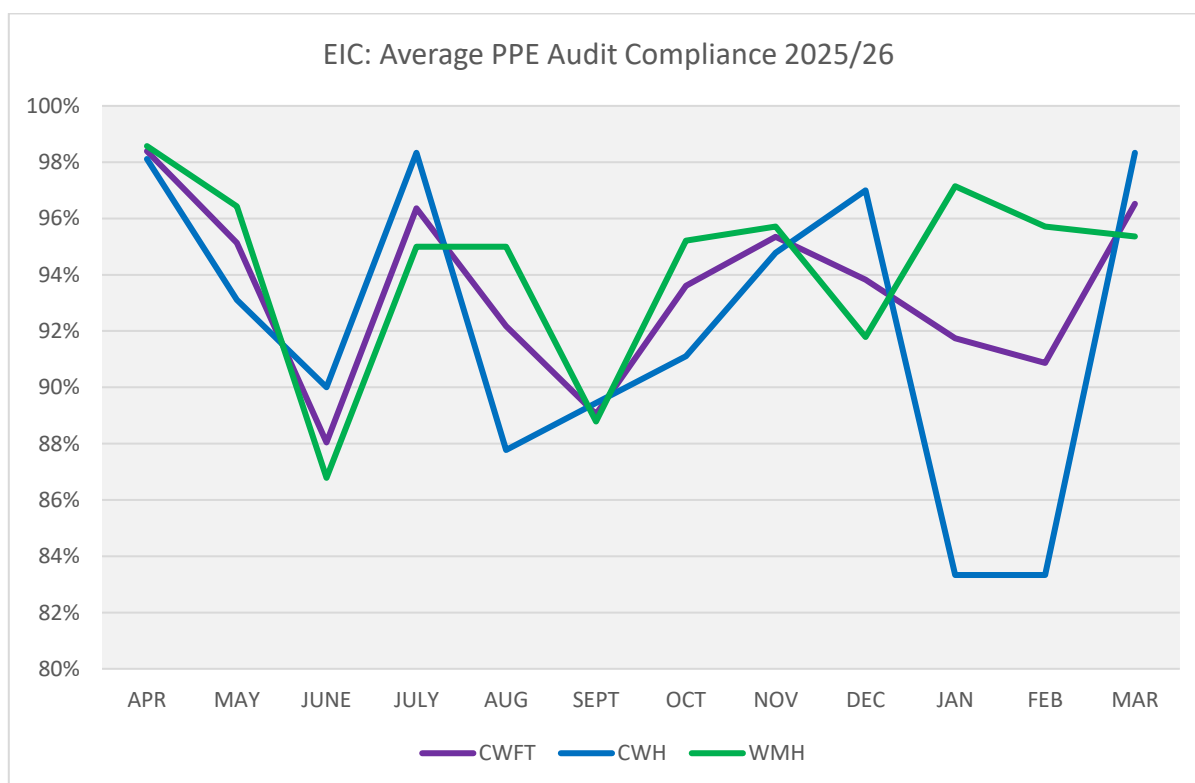


Figure 42: EIC PPE monthly compliance per site 2025/26

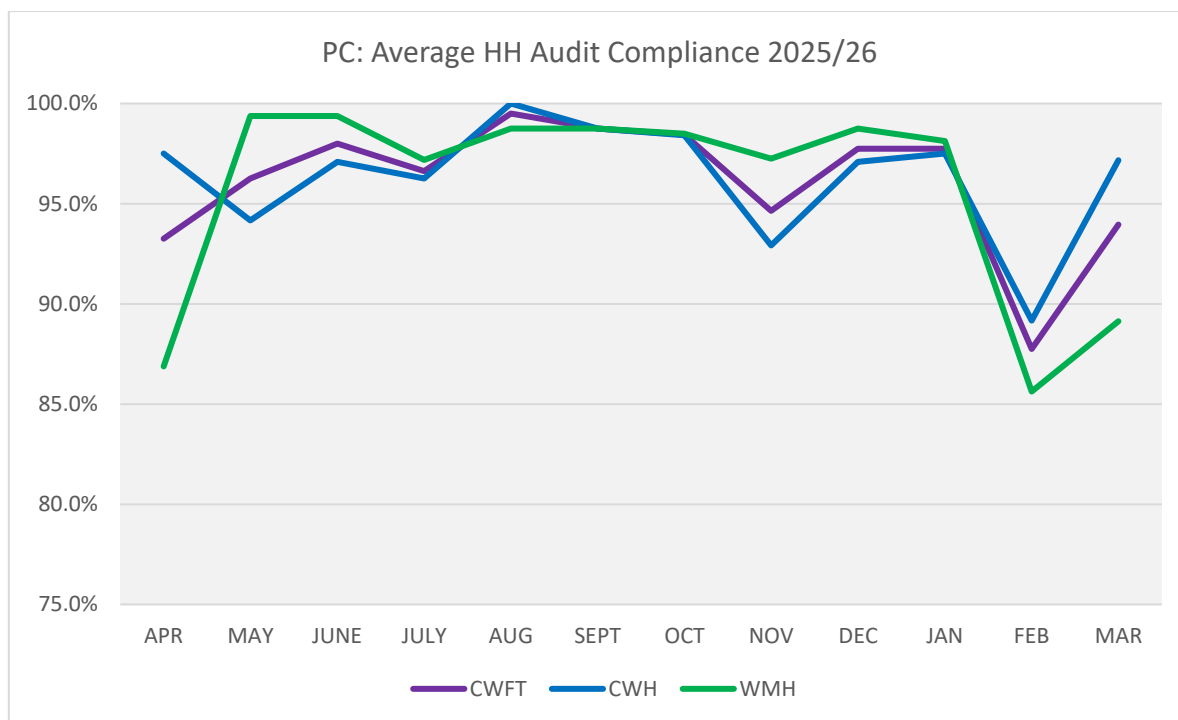


Figure 43: EPC HH monthly compliance per site 2025/26

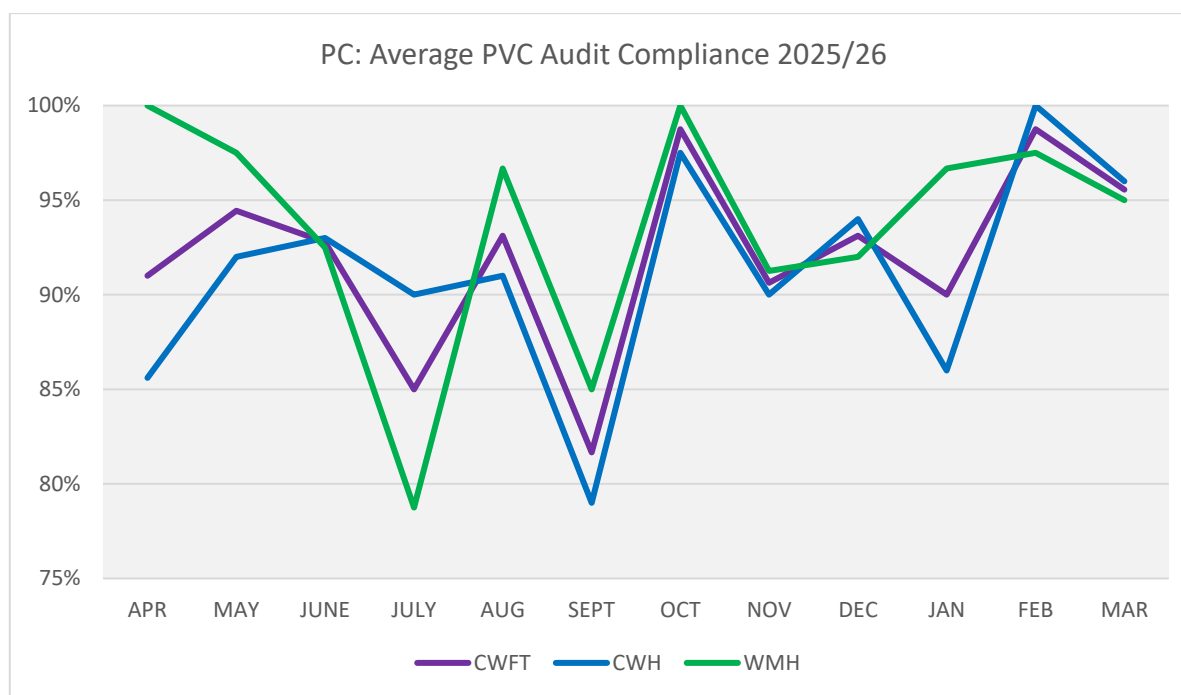


Figure 44: EPC PVC monthly compliance per site 2025/26

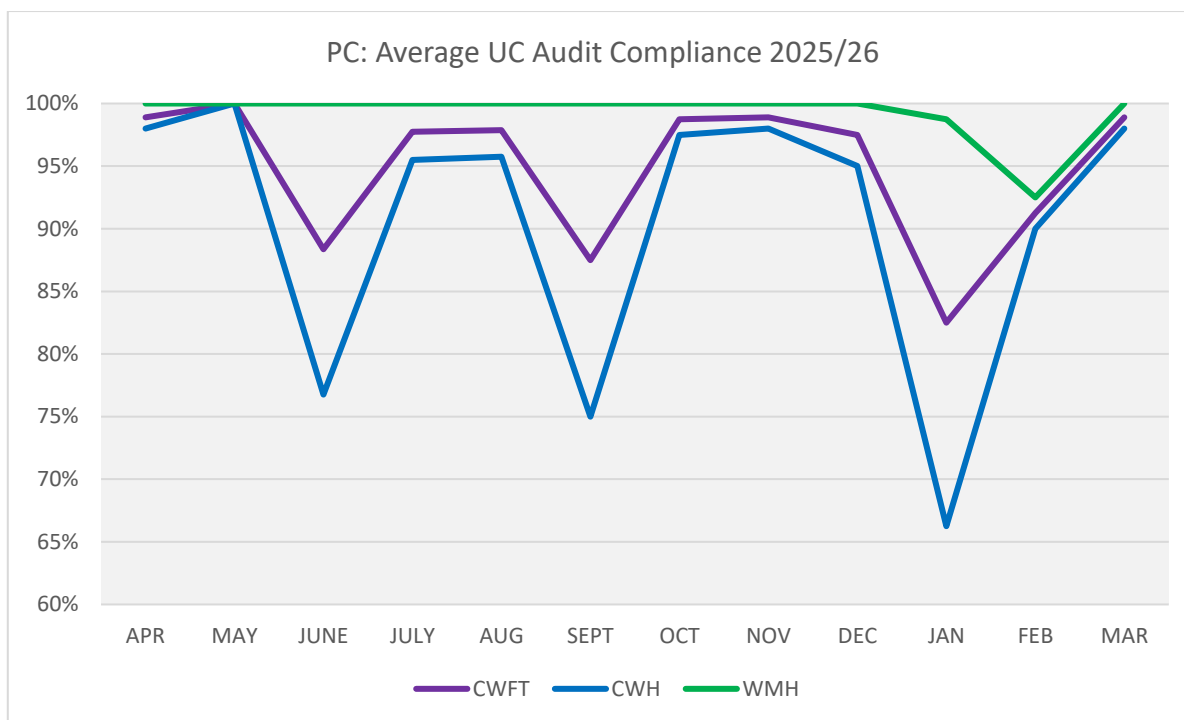


Figure 45: PC UC monthly compliance per site 2025/26

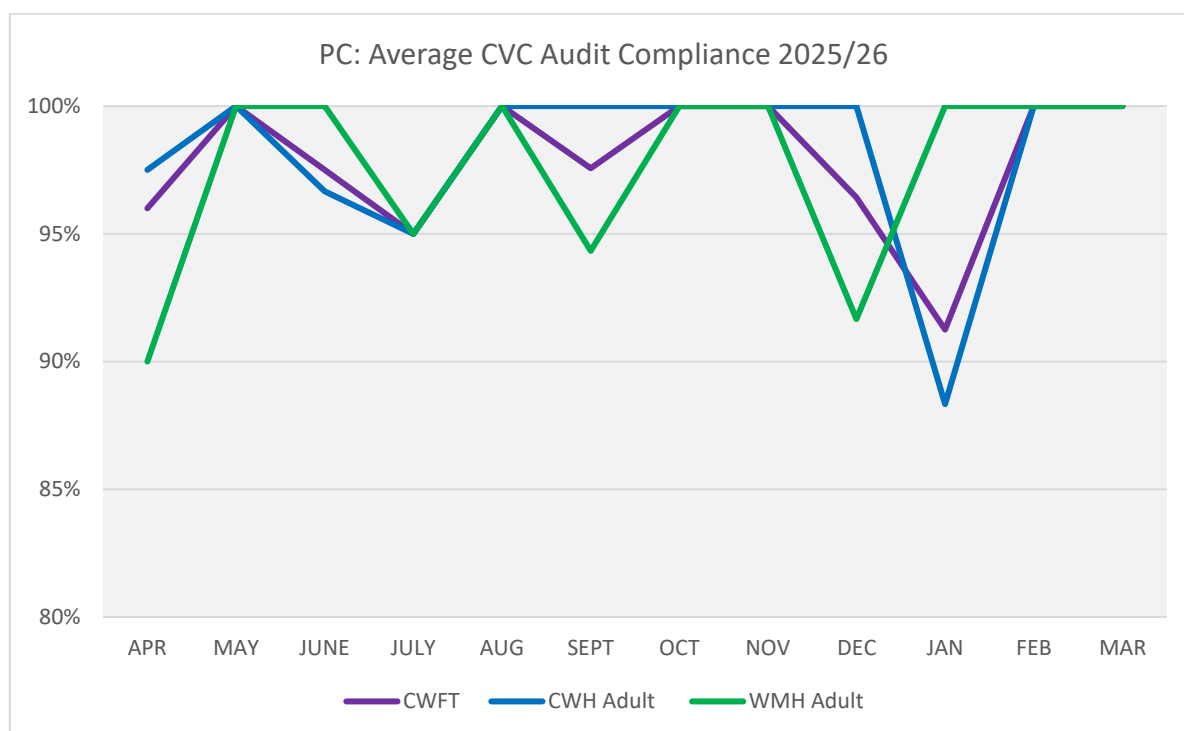


Figure 46: PC CVC monthly compliance per site 2025/26

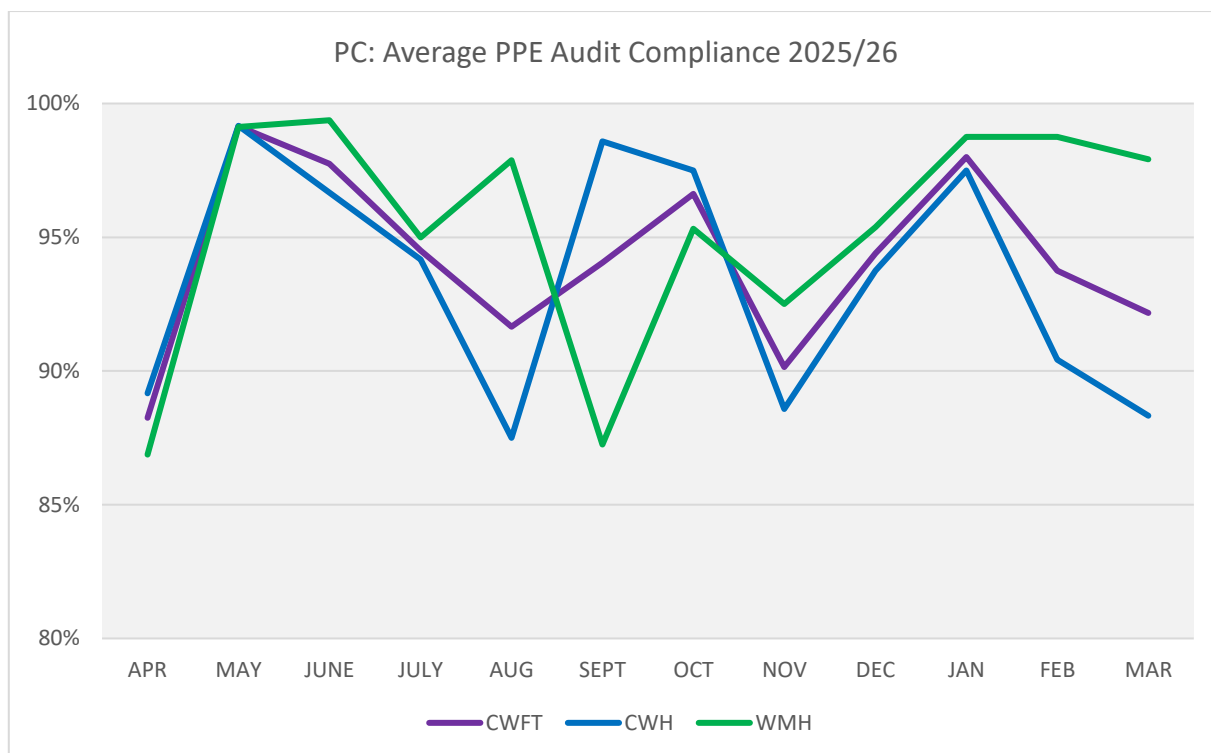


Figure 47: PC PPE monthly compliance per site 2025/26

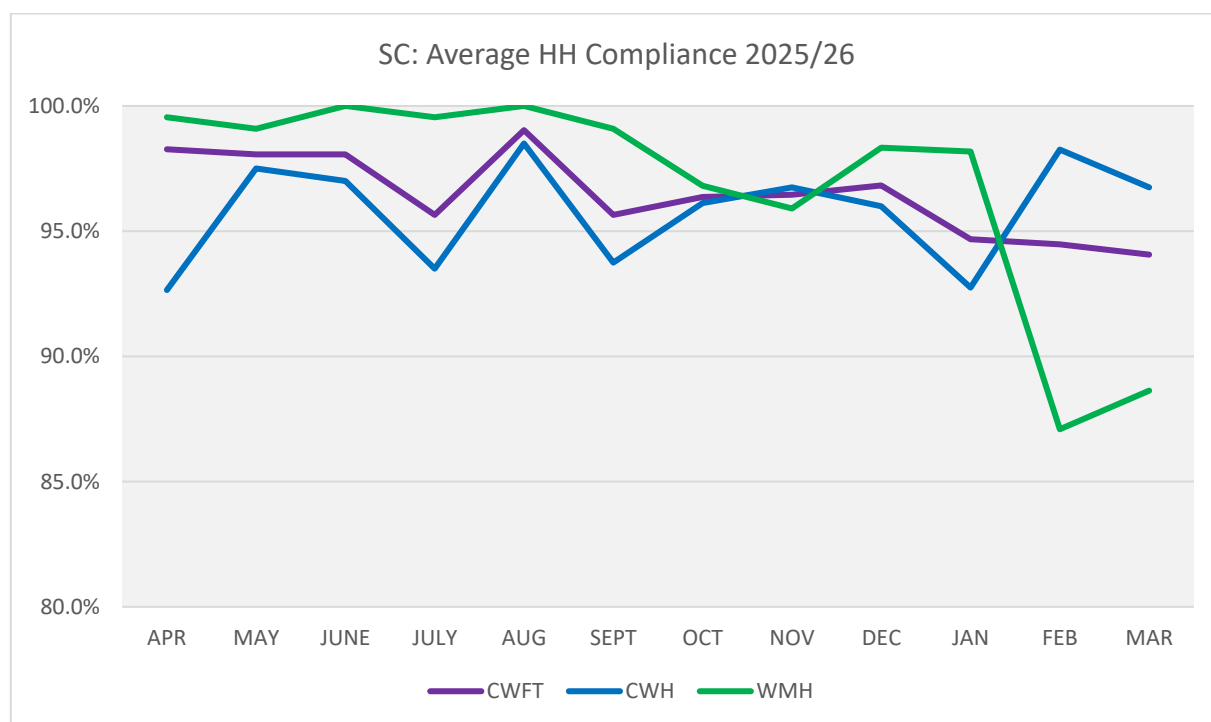


Figure 48: SC HH monthly compliance per site 2025/26

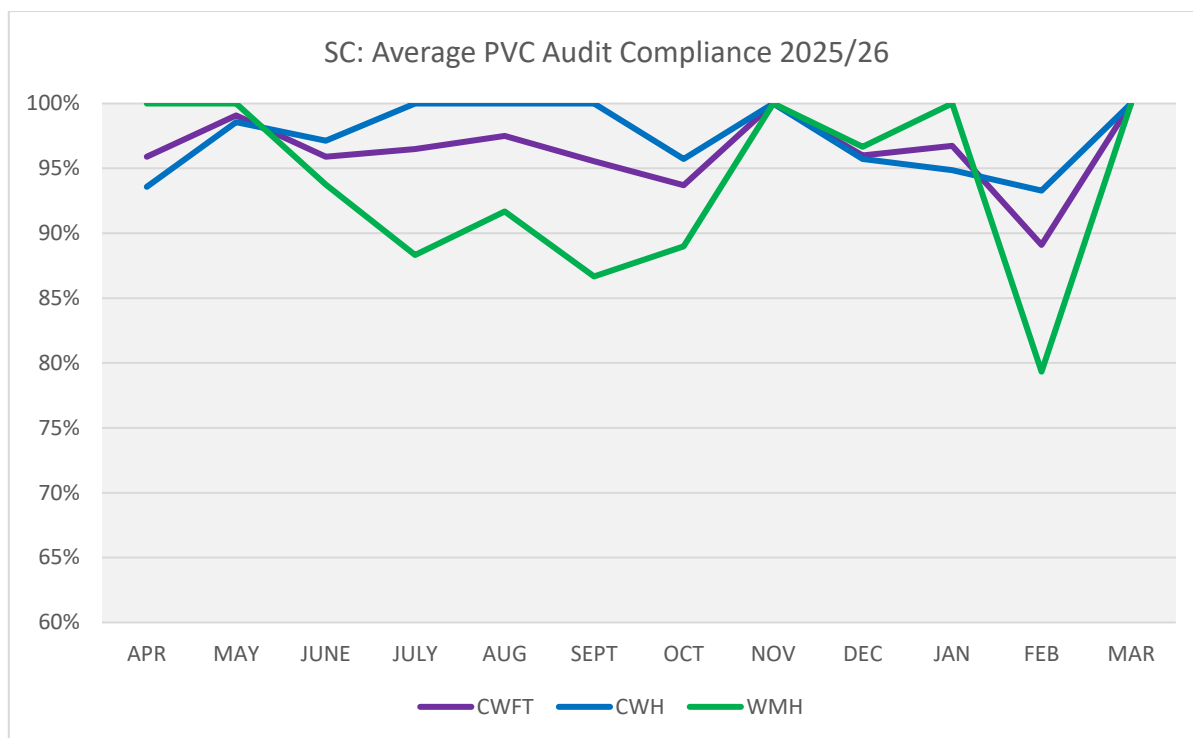


Figure 49: SC PVC monthly compliance per site 2025/26

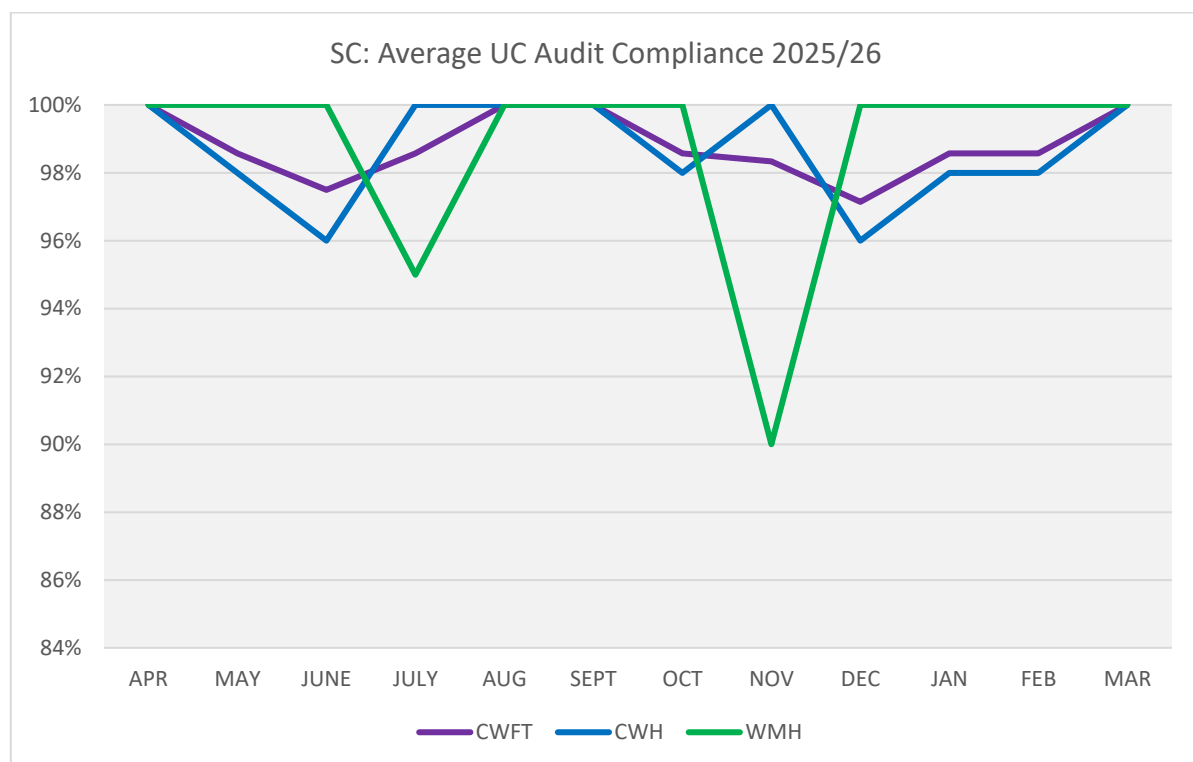


Figure 50: SC UC monthly compliance per site 2025/26

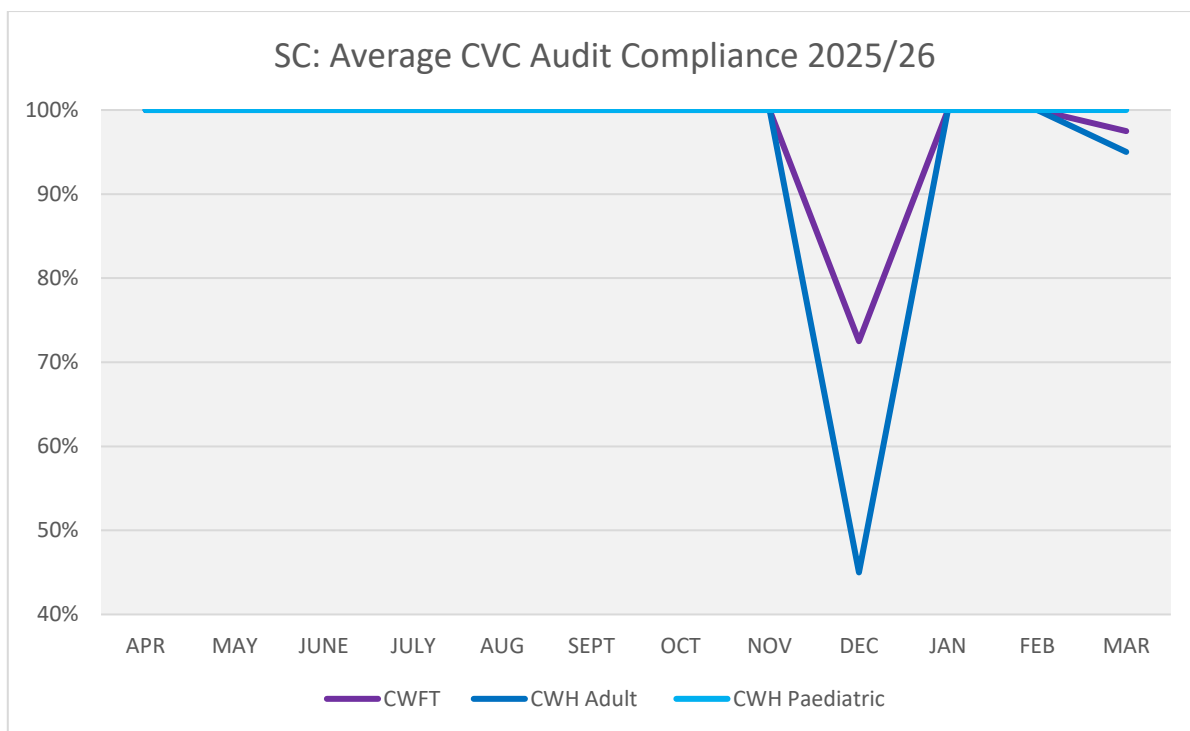


Figure 51: SC CVC monthly compliance per site 2025/26

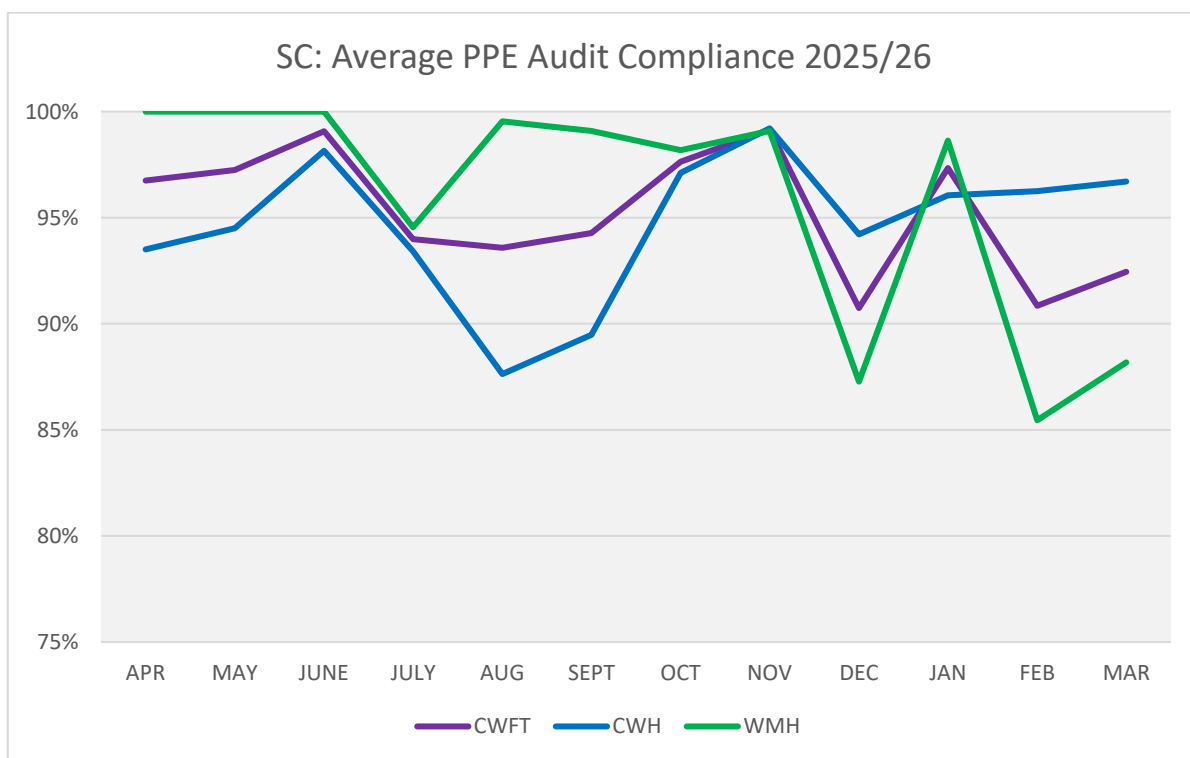


Figure 52: SC PPE monthly compliance per site 2025/26

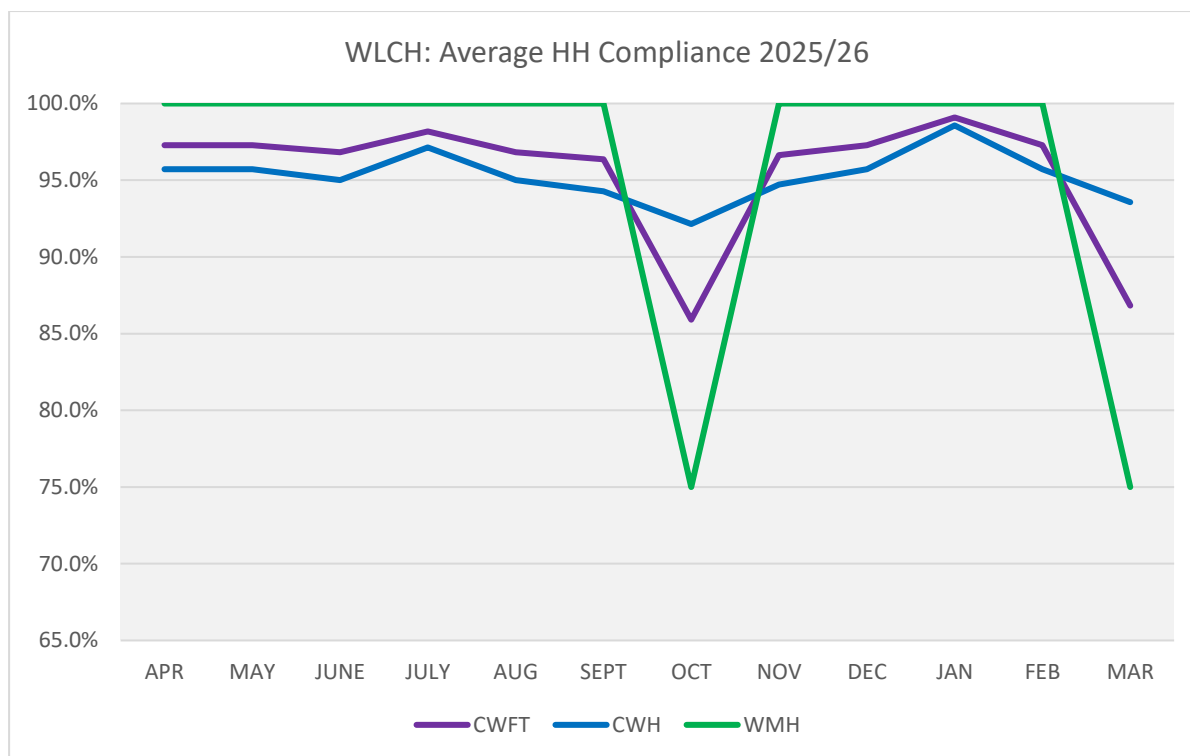


Figure 53: WLCH HH monthly compliance per site 2025/26

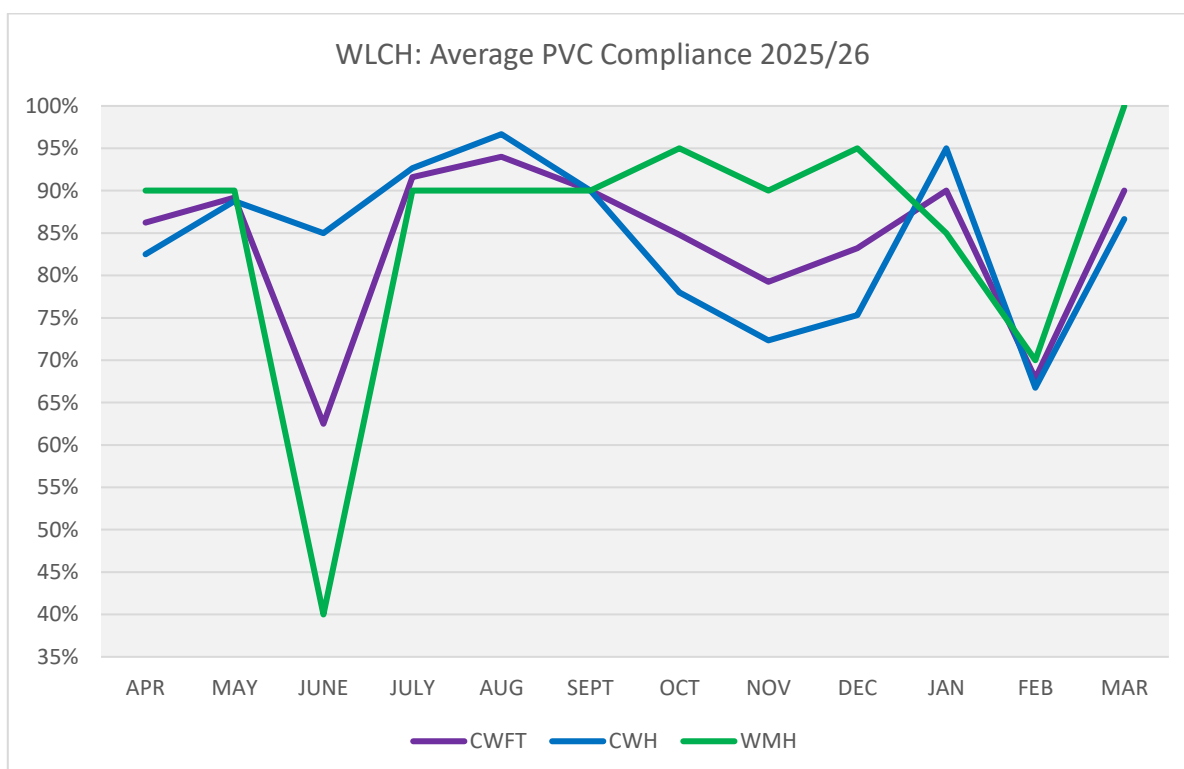


Figure 54: WLCH PVC monthly compliance per site 2025/26

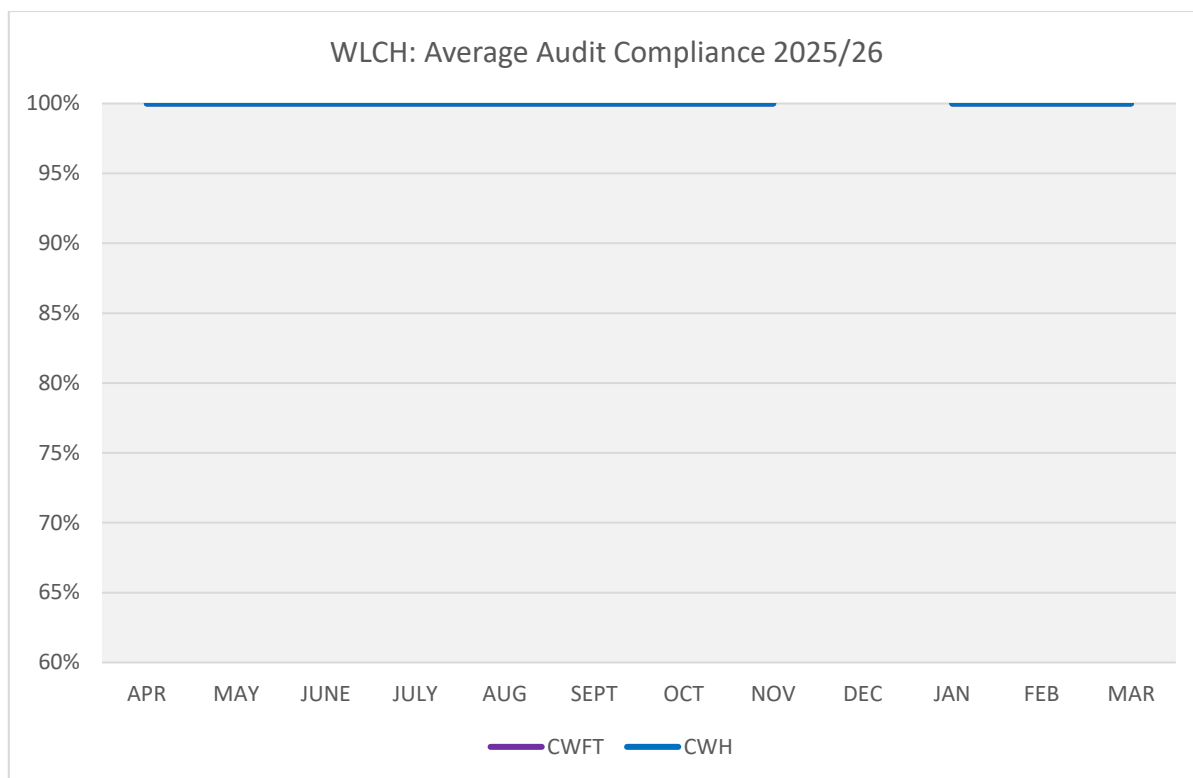


Figure 55: WLCH UC monthly compliance per site 2025/26

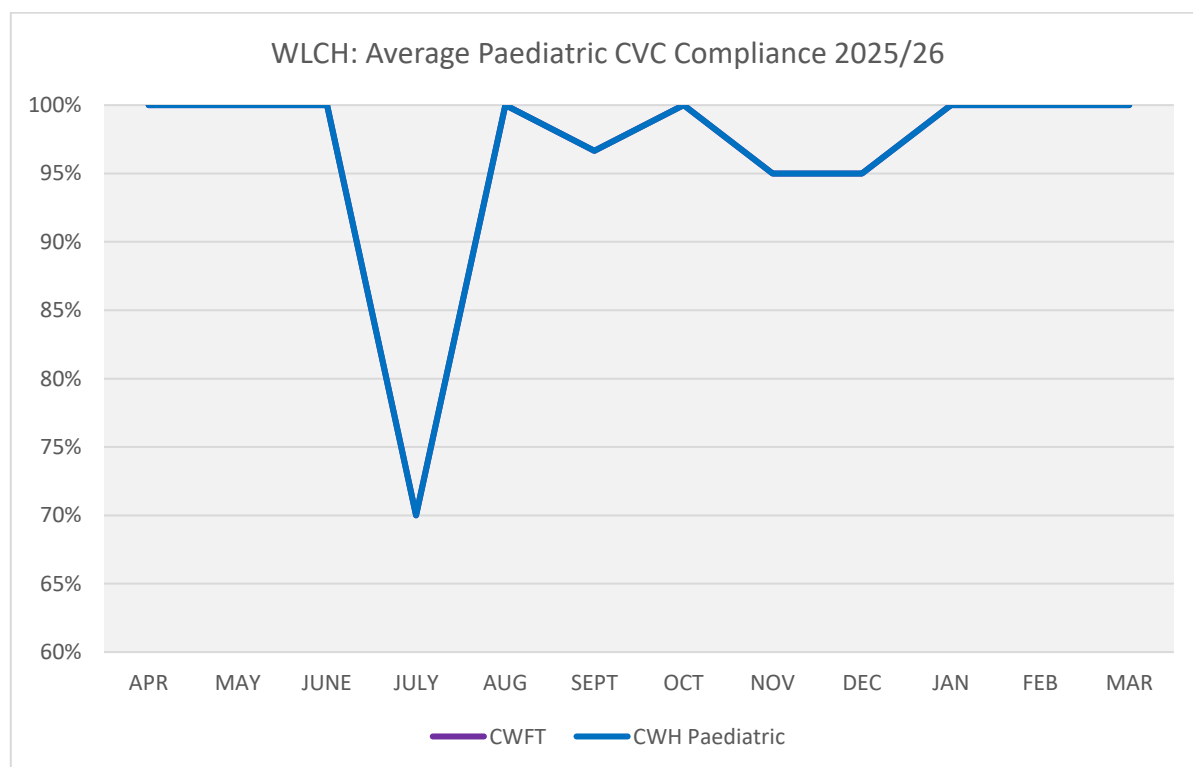


Figure 56: SC CVC monthly compliance per site 2025/26

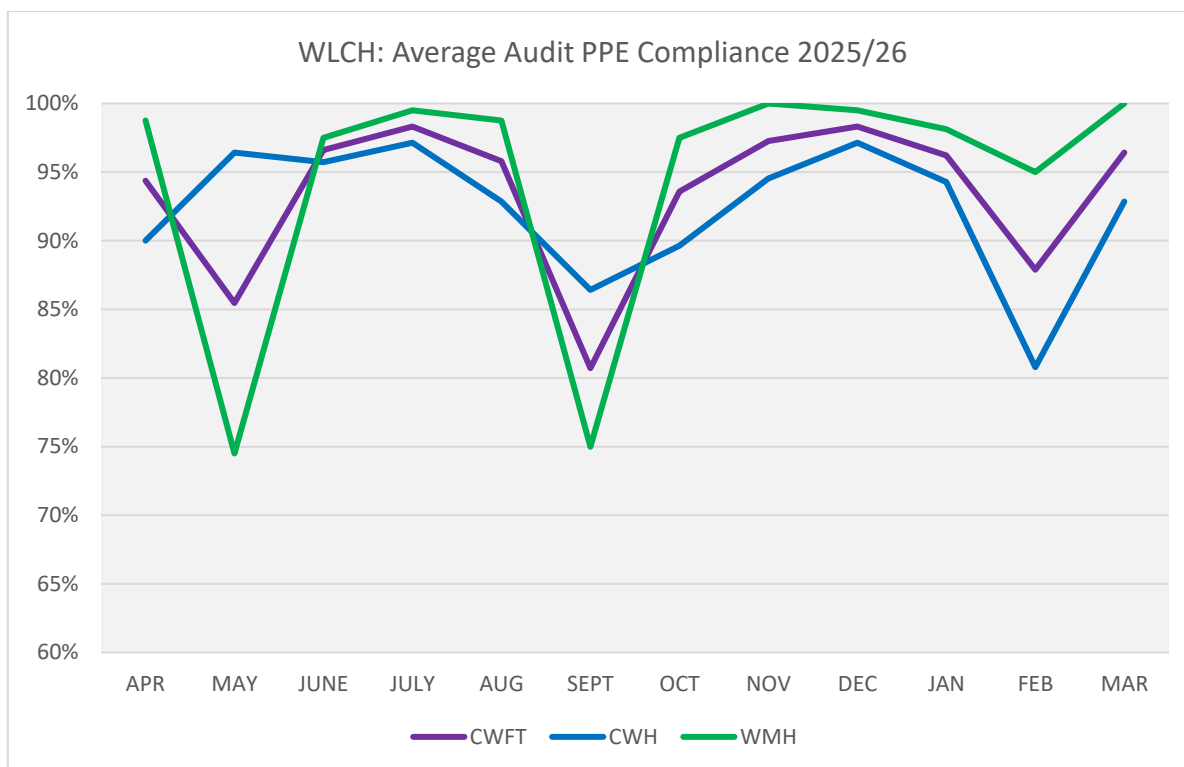


Figure 57: WLCH PPE monthly compliance per site 2025/26

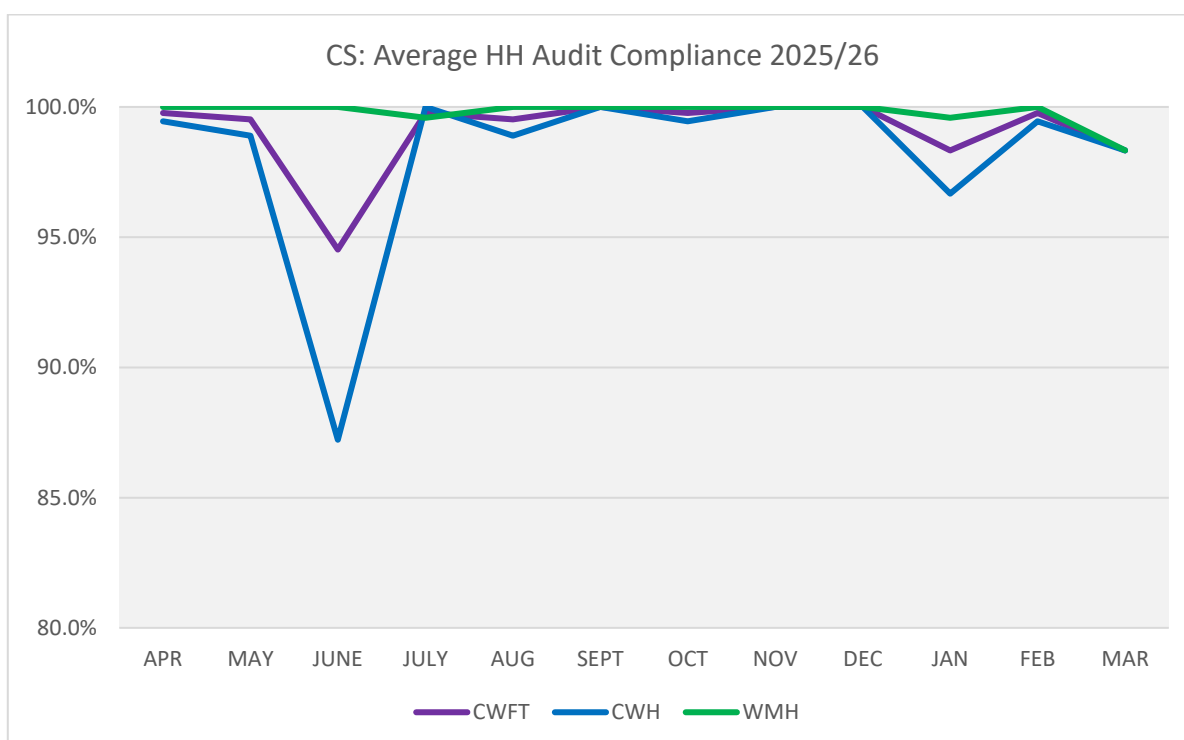


Figure 58: CS HH monthly compliance per site 2025/26

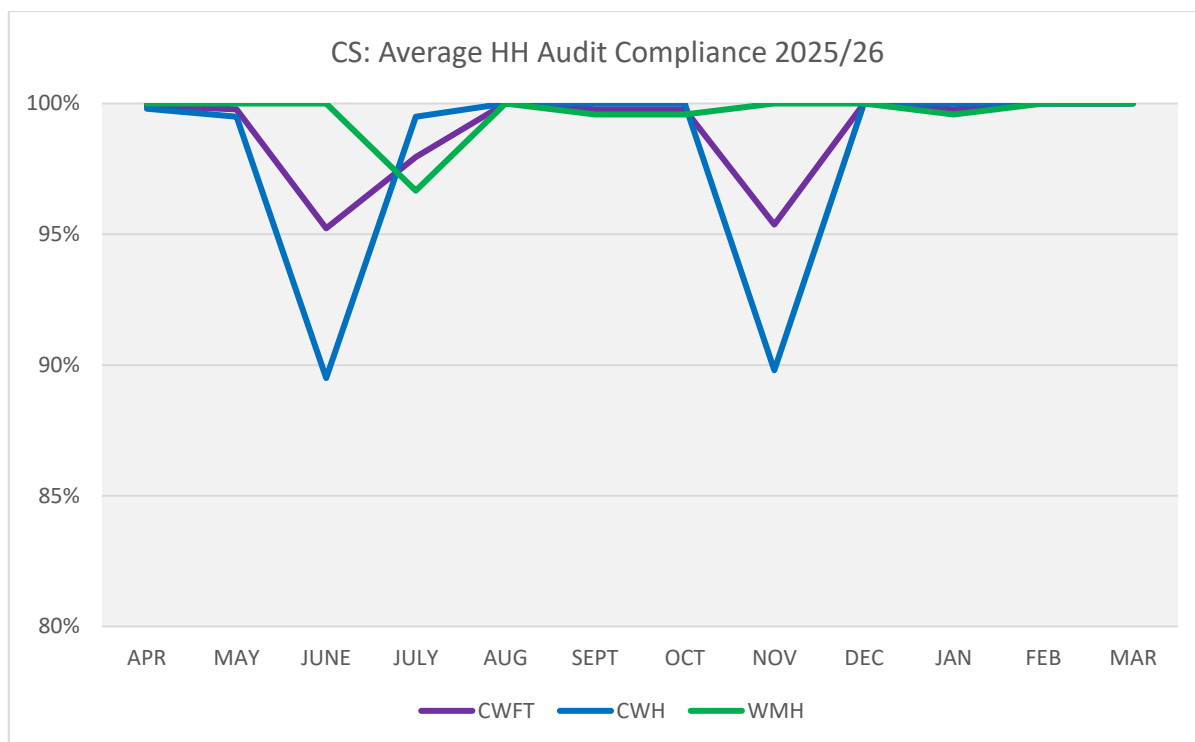


Figure 59: CS PPE monthly compliance per site 2025/26



Divisional IPC Metrics

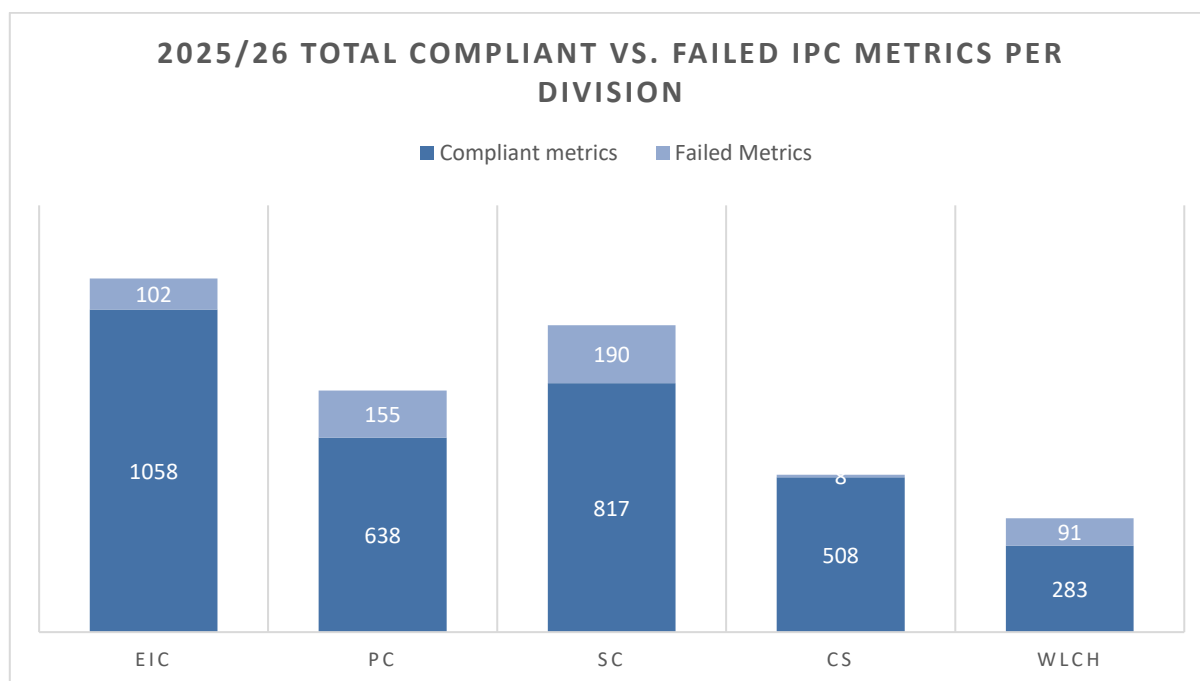


Figure 60: 2025/26 Total Compliant Metrics vs. Total Failed Metrics

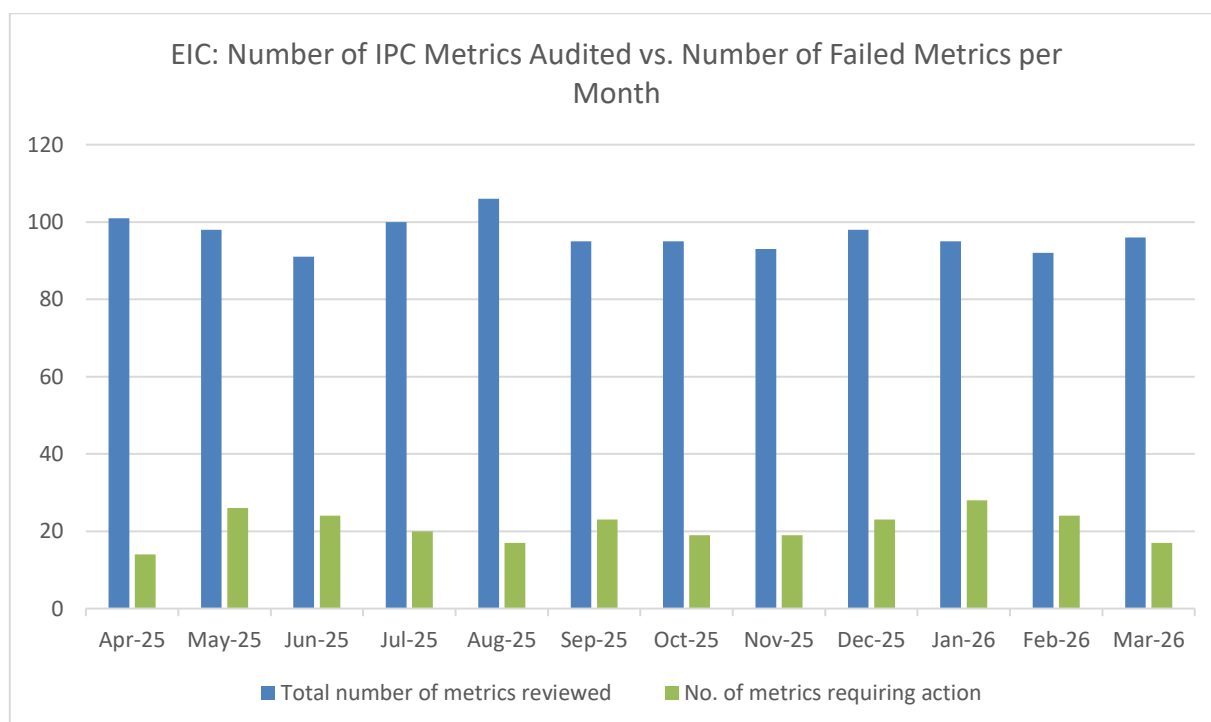


Figure 61: EIC 2025/26 Total Metrics Reviewed vs. Total Failed Metrics per Month

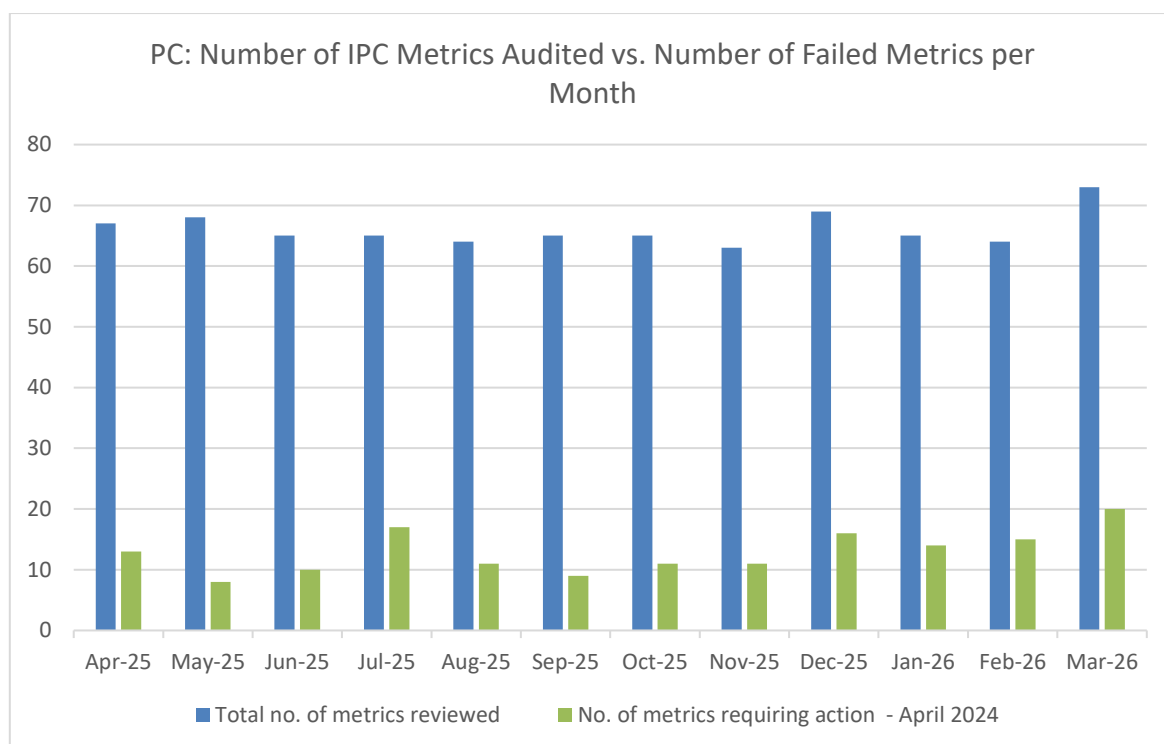


Figure 62: PC 2025/26 Total Metrics Reviewed vs. Total Failed Metrics per Month

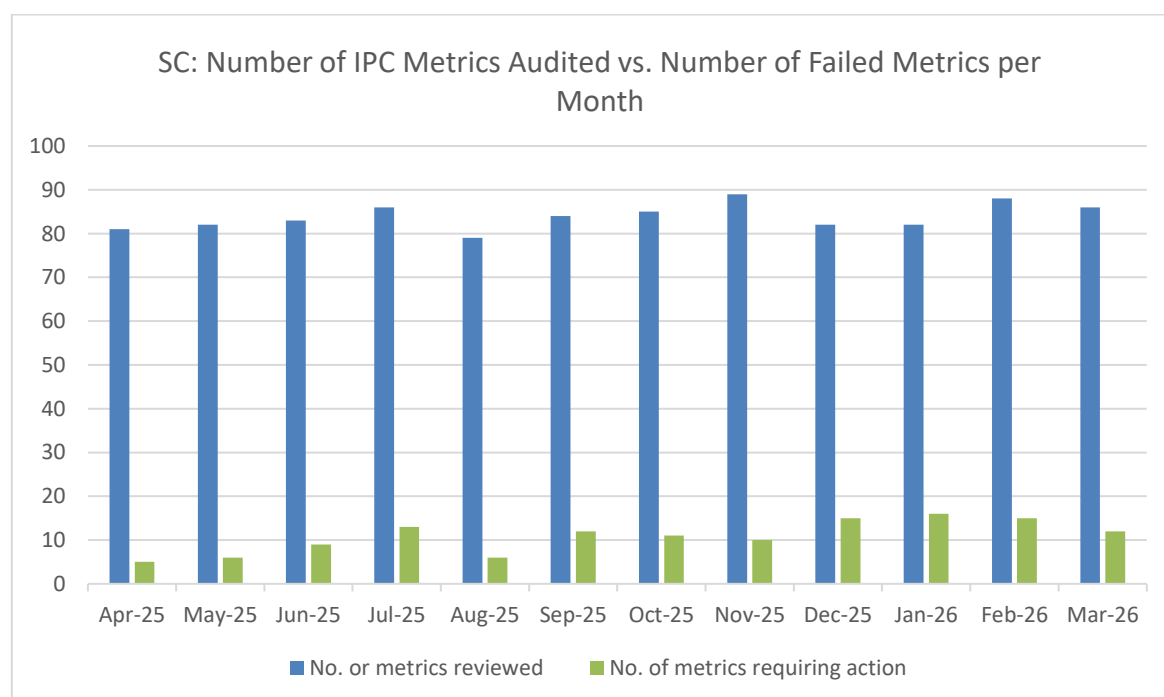


Figure 63: SC 2025/26 Total Metrics Reviewed vs. Total Failed Metrics per Month

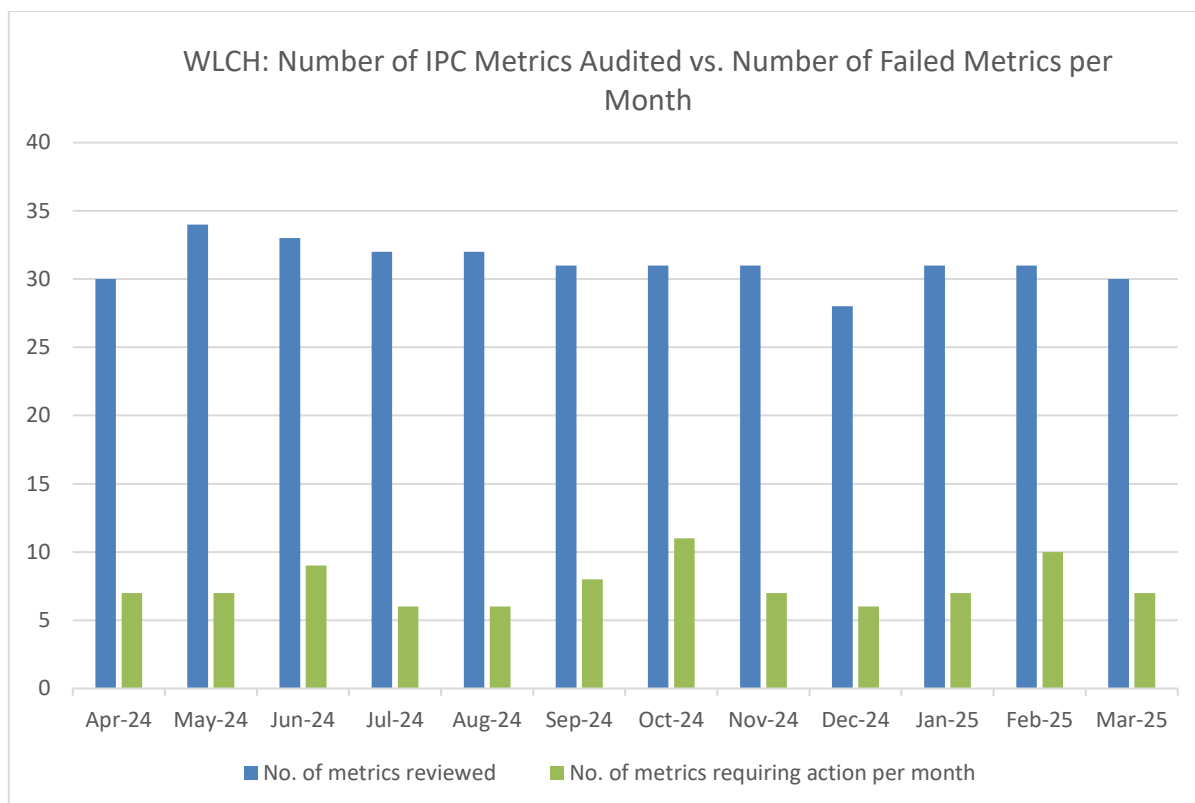


Figure 64: WLCH 2024/25 Total Metrics Reviewed vs. Total Failed Metrics per Month

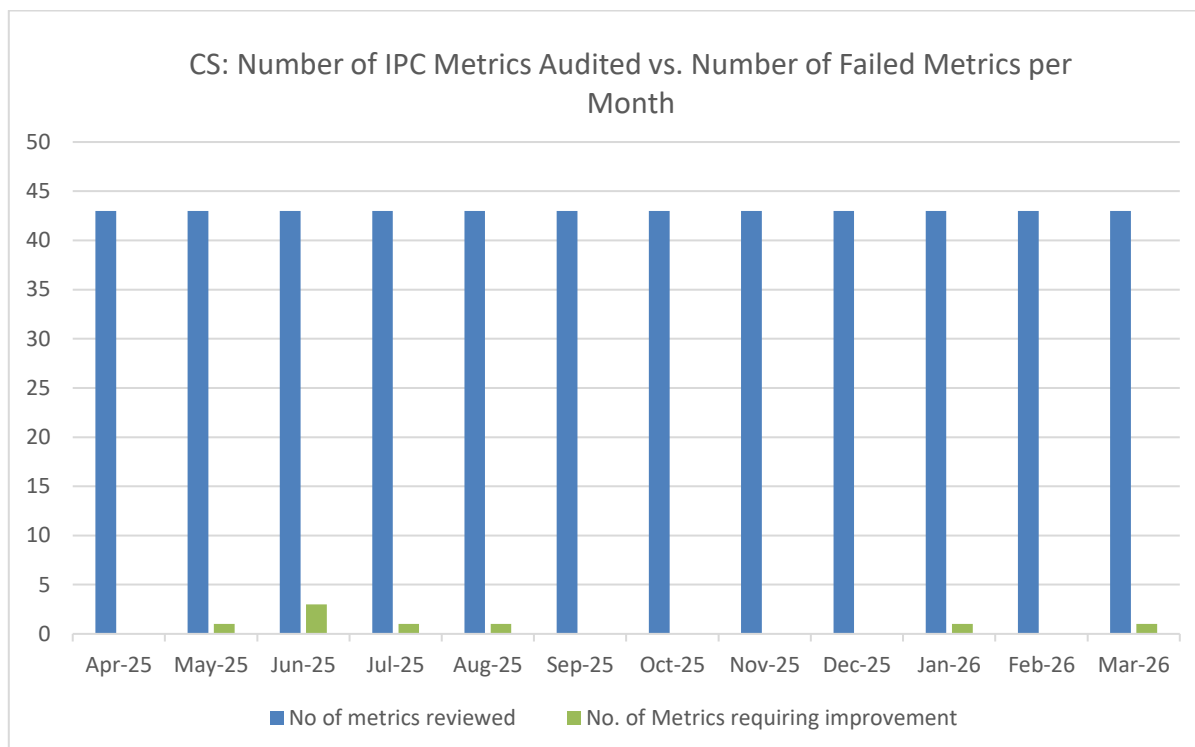


Figure 65: CS 2025/26 Total Metrics Reviewed vs. Total Failed Metrics per Month



CPE Surveillance

Table 21: 2025/26 CPE matrix by organism and mechanism of resistance.

CWFT	IMP	NDM	NDM + OXA 48	NDM + VIM	NDM + IMP	OXA 48	VIM	NDM + OXA 23	OXA 23 + 51	Not Specified	TOTAL
<i>Acinetobacter Spp.</i>		1						1	1	1	4
<i>Citrobacter freundii</i>	1	2				1					4
<i>Citrobacter Koseri</i>			1								1
<i>Citrobacter freundii</i> & <i>Klebsiella Pneumoniae</i> & <i>E.coli</i>		1									1
<i>E.coli</i>		22	1			28					51
<i>E.coli</i> & <i>Enterobacter spp.</i>						1					1
<i>E.coli</i> & <i>Klebsiella Pneumoniae</i>			1			1				2	4
<i>E.coli</i> & <i>Klebsiella Pneumoniae</i> & <i>Pseudomonas aeruginosa</i>					1						1
<i>Enterobacter Spp.</i>	2	5								1	8
<i>Klebsiella aerogenes</i>						2					2
<i>Klebsiella Pnuemoniae</i>	1	6	1			7	2				17
<i>Klebsiella</i> & <i>Pseudomonas aeruginosa</i>				1							1
<i>Klebsiella Pneumoniae</i> & <i>Enterobacter</i>			1								1
<i>Pseudomonas aeruginosa</i>		1					1				2
<i>Serratia Marcescens</i>		1									1
<i>Organism unknown</i>						1					1
Total	4	39	5	1	1	41	3	1	1	4	100

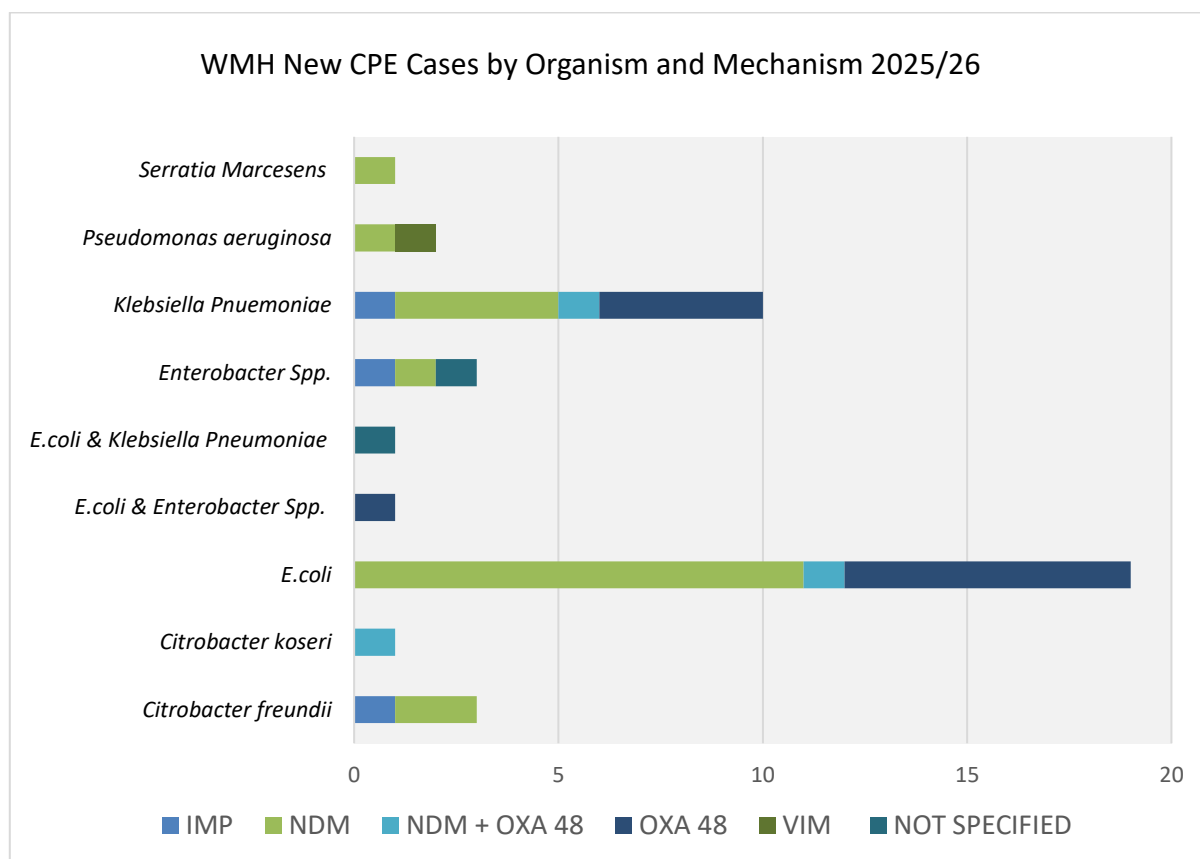


Figure 66: WMH Carbapenemase-Producing Enterobacterales (CPE) Surveillance 2025/26

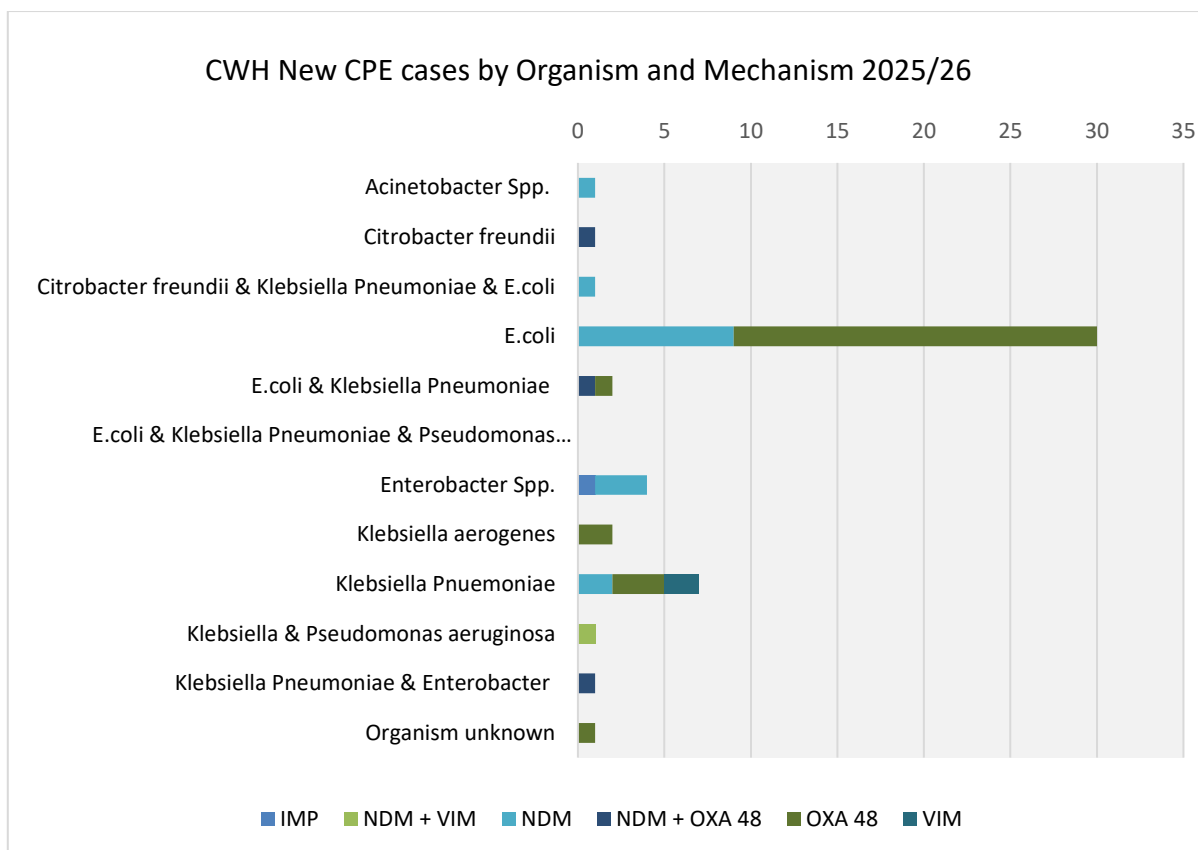


Figure 67: CWH Carbapenemase-Producing Enterobacterales (CPE) Surveillance 2025/26

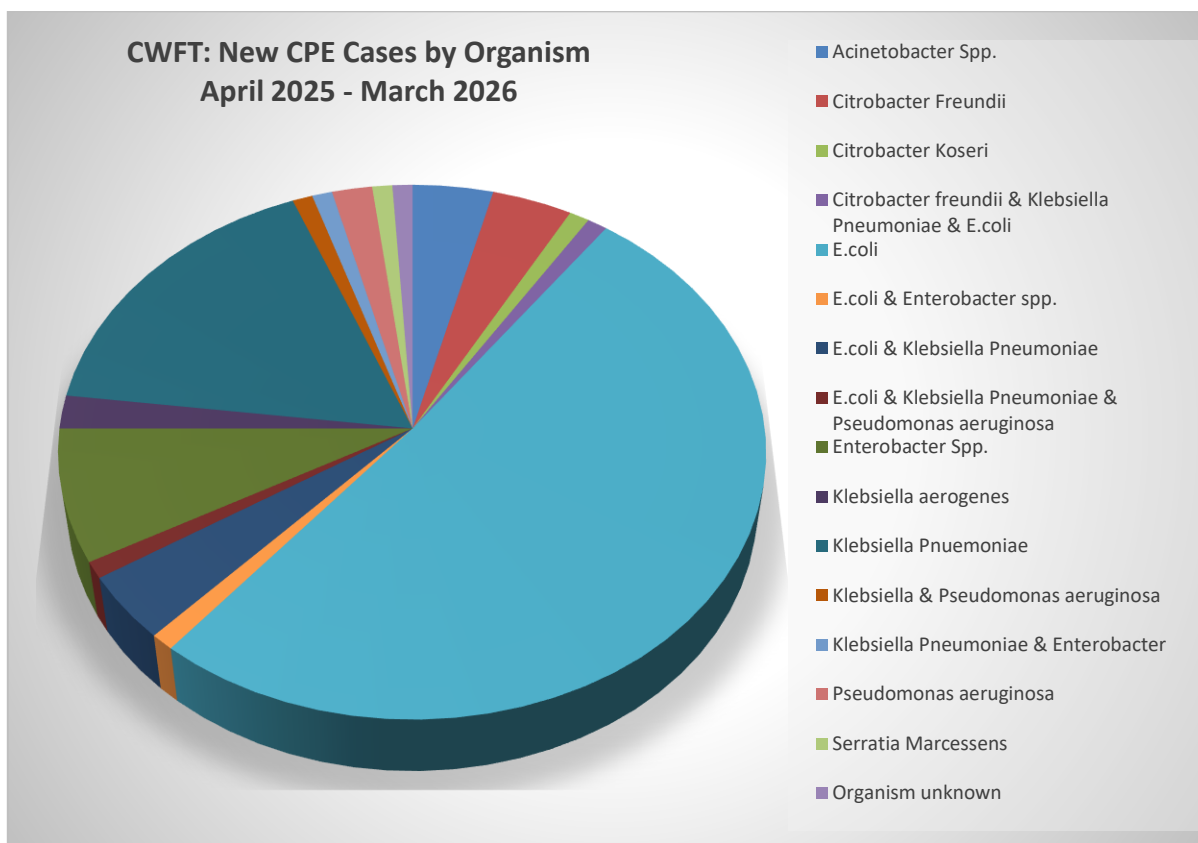


Figure 68: CWFT Carbapenemase-Producing Enterobacterales (CPE) Surveillance 2025/26



Appendix 3: Deep Dive of 2025/26 Trust Attributed *Clostridioides Difficile*

Clostridioides difficile infection (CDI) remains a significant healthcare-associated infection associated with increased patient morbidity, prolonged hospital admission and increased healthcare costs. CDI is recognised nationally as both a key patient safety indicator and an important measure of healthcare quality, with acute NHS organisations expected to maintain robust surveillance, prevention and reduction strategies.

Chelsea and Westminster Hospital NHS Foundation Trust has experienced sustained CDI activity across both Chelsea and Westminster Hospital (CWH) and West Middlesex Hospital (WMH), with cases occurring across multiple clinical specialties and inpatient areas. Review of current surveillance data demonstrates that CDI is not confined to isolated wards or individual outbreaks, but instead reflects a broader organisational challenge influenced by a range of complex and interrelated factors including antimicrobial exposure, prolonged inpatient stay, advanced patient age, recurrent gastrointestinal symptoms, proton pump inhibitor (PPI) use, laxative usage and variation in early recognition and management practices.

This report provides a detailed review of CDI cases identified across the Trust and explores key themes arising from surveillance data, case review findings and identified risk factors. In addition, the report summarises current Infection Prevention and Control Team (IPCT) interventions and outlines proposed actions required to support sustainable CDI reduction.

2025/26 Position

From 01 April 2025 to 31 March 2026, there were 58 Trust apportioned *Clostridioides difficile* infection (CDI) cases against a yearly target of 33, a decrease of 5% on the previous year's 61 cases.

Each case is subject to monthly mandatory reporting to UKHSA by the infection prevention and control team (IPCT) and is also presented at IPCG, the Trust Executive Board, Patient Safety Groups and divisional forums.

CDI data is presented on a monthly basis to the Infection Prevention and Control Group and information regarding lessons learnt is subsequently made available to clinical staff and divisions. Learning is also shared at ICS and ICB level and locally through the IPCG.

The graph below illustrates that the Trust continues to have low rates of trust attributed CDI in comparison to other London NHS Trusts with a rate of 15.81, which continues to fall below the London average rate of 19.01 and below the national average of 25.67.

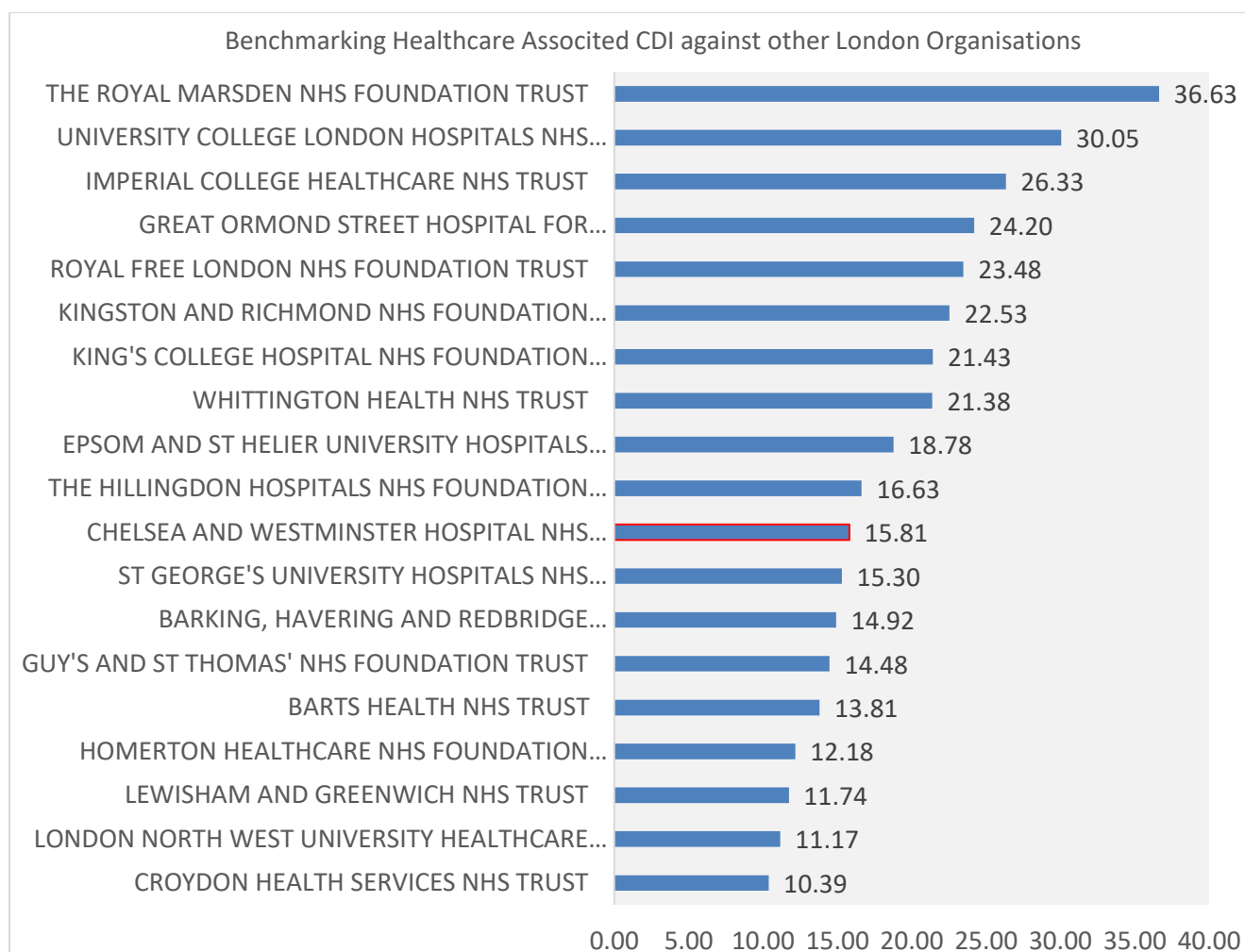


Figure 69: UK HSA CDI benchmarking graph

As predicted the Trust exceeded the target of 33 Trust attributed cases set in the NHS 2025/26 Standard Contact given both the low threshold set and rising national rates.

Whilst ambitious targets can help drive improvement, the reduction from 61 reported CDI cases in 2024/25 to a contractual target of 33 in 2025/26 represented a significant variance from the Trust's recent baseline activity. The IPC team have consistently raised concerns regarding the achievability of the target within the existing operational context.

The target-setting methodology used by UK HSA appeared insufficiently aligned to recent local epidemiology and historical CDI performance data at both local and national levels.

National UKHSA surveillance data demonstrates that CDI incidence has risen substantially (33%) across England in recent years, including increases in community-onset infection, indicating that current CDI pressures are not unique to individual organisations.

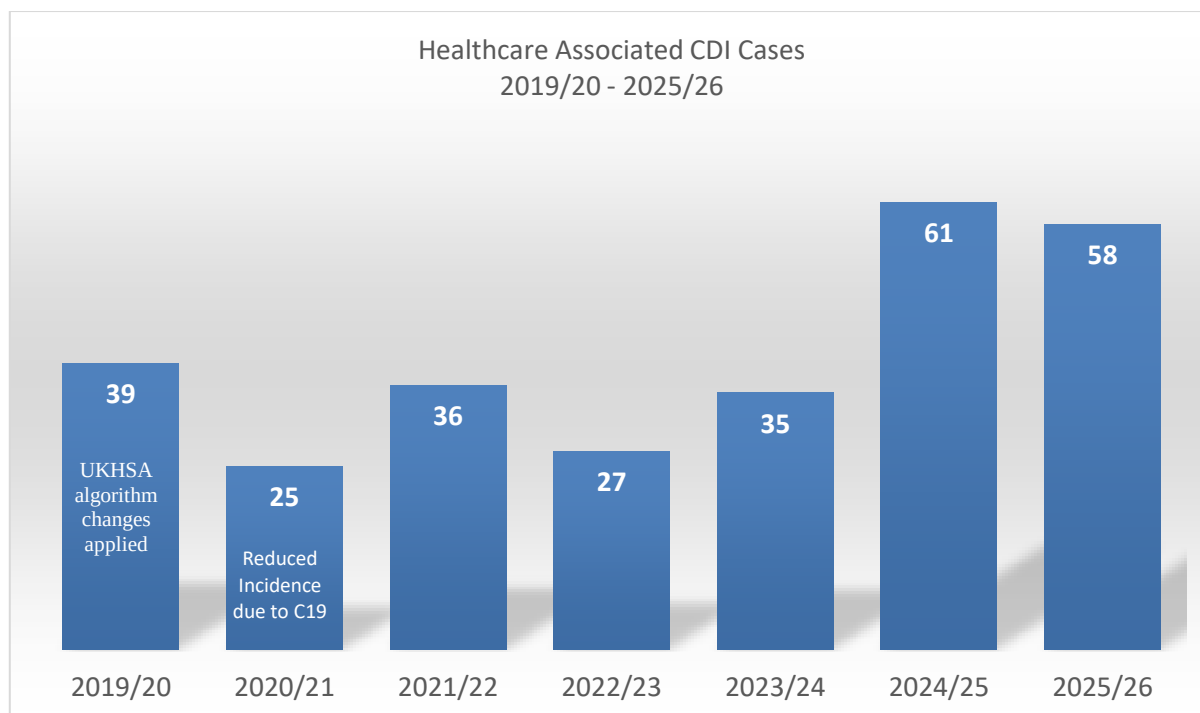


Figure 70: Trust attributed CDI total cases by financial year 2019-2025.

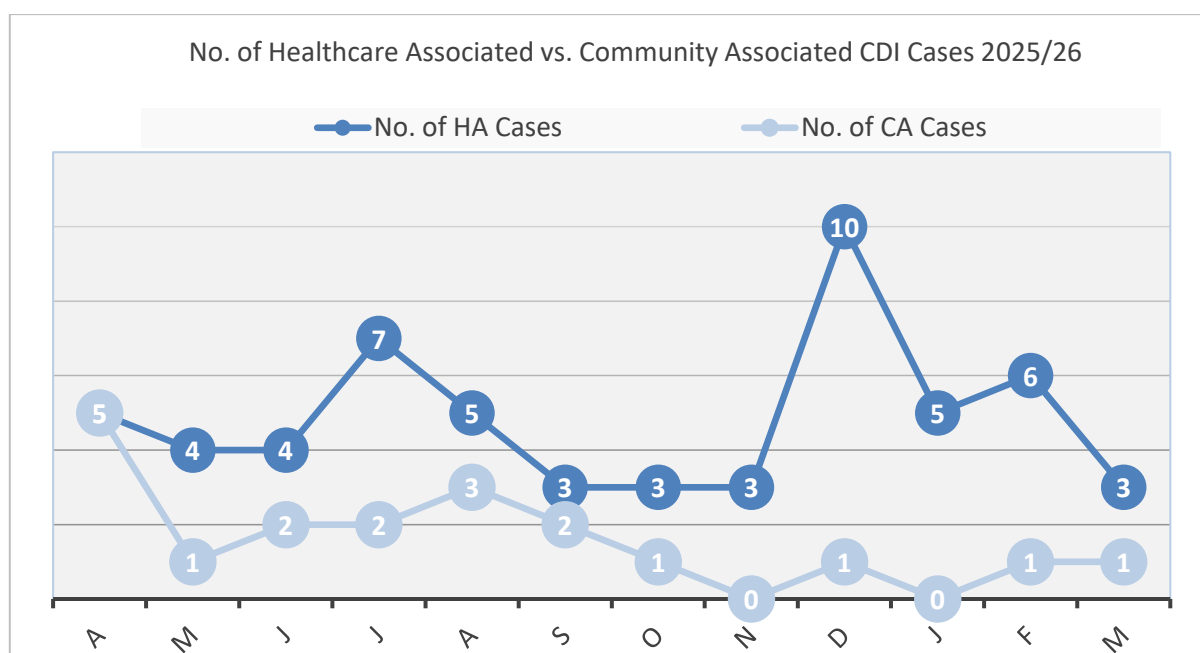


Figure 71: Trust attributed CDI vs. Community attributed Cases

Community attributed cases have decreased (n =19) in comparison to the previous financial yer.

Benchmarking

CWFT continues to perform well in comparison to local organisations within the sector, as detailed by the graph below.

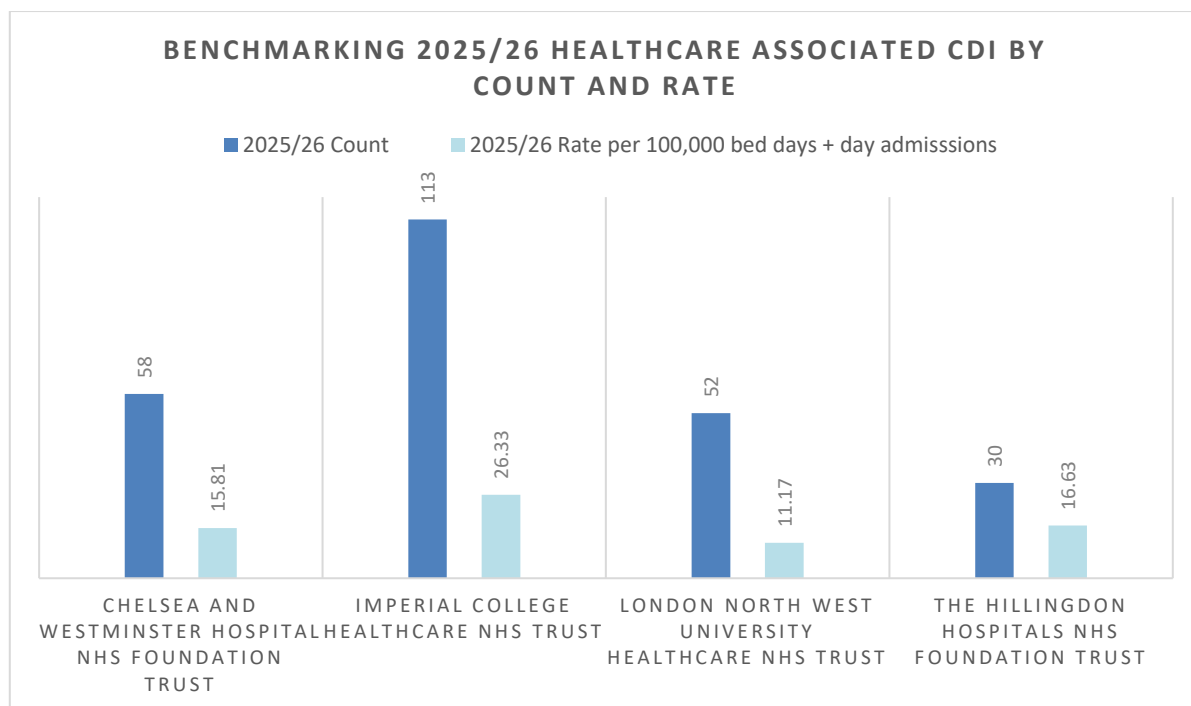


Figure 72: Benchmarking 2025/26 Trust attributed CDI cases by count and rate

The IPC team monitor all CDI cases in the organisation and offer timely advice, guidance and support to healthcare staff on the ongoing management of patients diagnosed with *C. difficile*.

In line with PSIRF principles, all healthcare-associated CDI cases are subject to multidisciplinary review meetings. Custom-designed review tools are utilised to systematically identify positive practice, gaps in care and recurrent themes, ensuring that learning is embedded within clinical governance and patient safety processes.

Ribotyping is performed on all cases and can help identify if cases are linked by time or location to assess for potential cross-transmission.

Arranging PSIRF review meetings for healthcare-associated CDI cases can be operationally challenging particularly at the CWH site, with delays often encountered in securing multidisciplinary attendance. Limited clinical engagement has impacted the timeliness of reviews and created a significant administrative burden for the IPC team. Plans to improve divisional engagement are underway.

Of the 58 cases attributed to the organisation in 2025/26, 54 PSIRF meetings were held and the 4 are pending, these cases occurred between December 2025 – March 2026 and further evidence the engagements issues highlighted above.



CDI Cases by Site

Of the 58 healthcare-associated CDI cases reported during the period, 42 occurred at the CWH site and 16 at the WMH site. Variation between sites is likely multifactorial and reflects differences in patient throughput, clinical complexity, antimicrobial exposure, and underlying patient risk profiles. Site-specific trends continue to be monitored through routine surveillance, PSIRF review processes, and targeted IPC interventions.

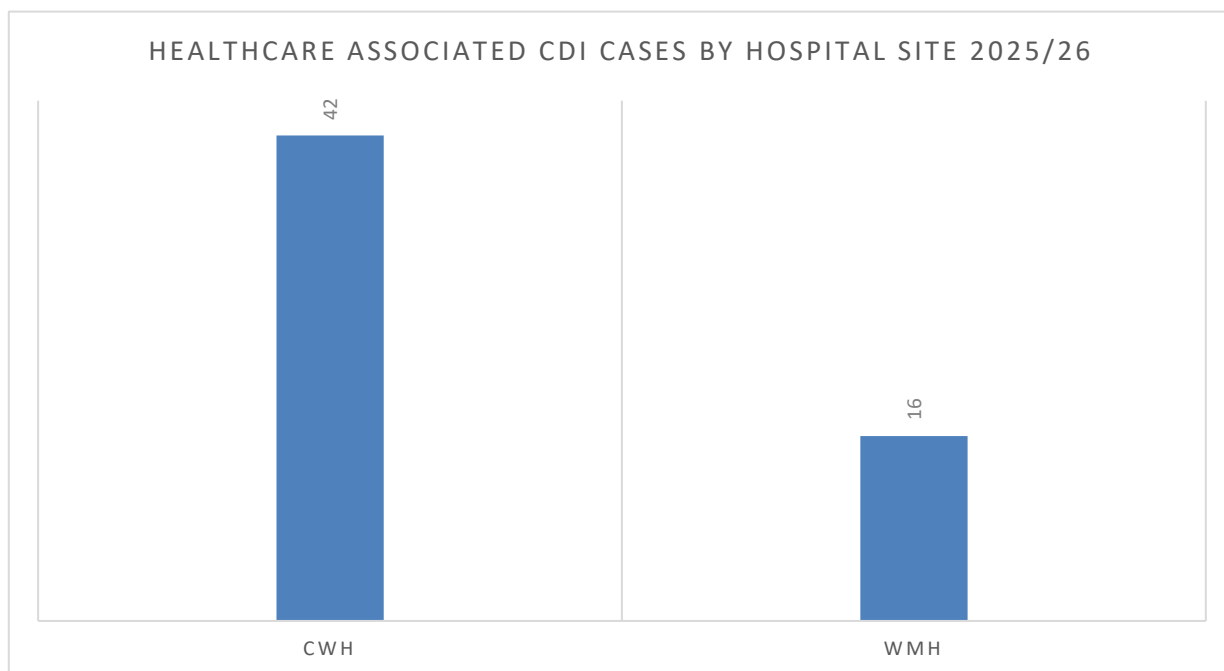


Figure 73: Healthcare Associated CDI Cases by Hospital site 2025/26

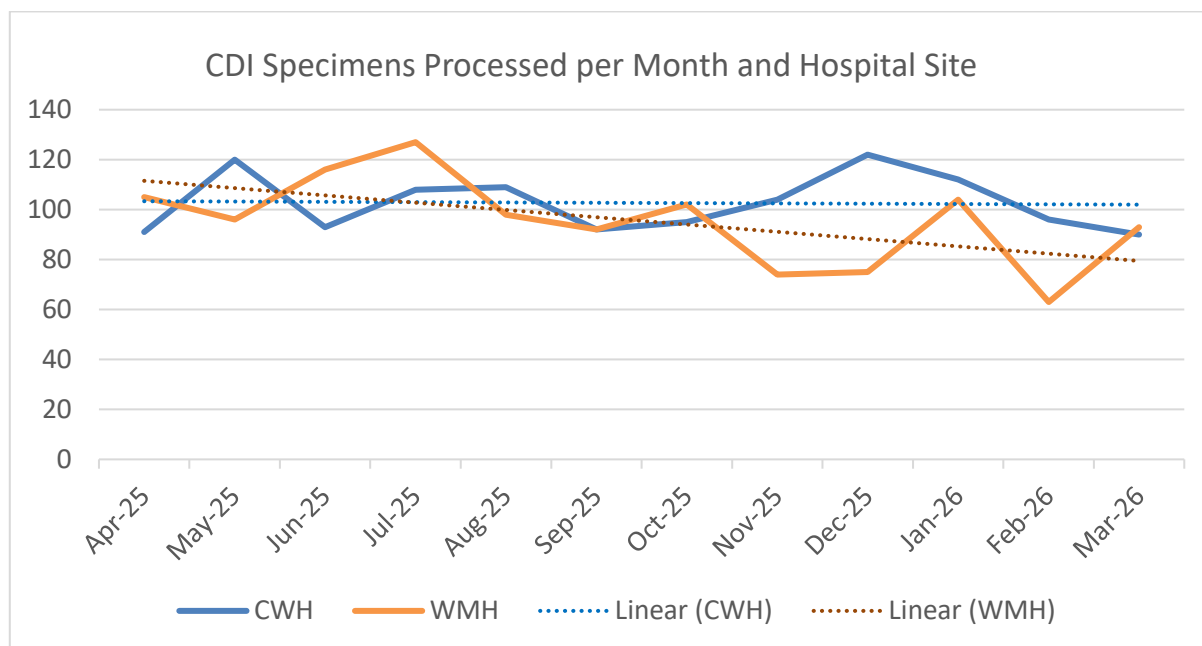


Figure 74: CDI Specimens Processed per Month and Hospital Site

Figure 74 above demonstrates monthly variation in the number of CDI specimens processed across both hospital sites between April 2025 and March 2026. Overall, CWH processed consistently higher specimen volumes than WMH for most months within the reporting period.



At the CWH site, specimen numbers remained relatively stable throughout the year, generally fluctuating between approximately 90 and 122 specimens sent per month. Peaks were observed in May 2025 and December 2025, suggesting periods of increased clinical testing activity or heightened suspicion of CDI. The linear trend line for CWH indicates a broadly stable trajectory across the year, with only a slight downward trend overall.

In contrast, the WMH site demonstrated greater month-to-month variation in specimen activity. Specimen numbers peaked during June and July 2025 before declining during the latter half of the year, with the lowest volume observed in February 2026. The WMH trend line demonstrates a clearer downward trajectory compared to CWH, indicating an overall reduction in specimens processed over time which requires further investigation and clinical correlation.

The differing trends between sites may reflect variation in patient activity, bed occupancy, clinical case mix, testing practices, seasonal pressures or underlying rates of diarrhoeal illness requiring investigation. Importantly, specimen processing activity does not necessarily correlate directly with confirmed CDI cases, but may indicate changing levels of clinical suspicion, screening activity or patient acuity across the organisation.

Overall, the data suggests that CWH maintained relatively sustained testing demand throughout the reporting period, whereas WMH experienced a gradual reduction in specimen submissions over time.

Trust Attributed CDI Cases by Division

As expected, and in line with previous trends, the majority of Trust attributed CDI cases occurred in the Emergency and Integrated Care Division with the second largest cohort occurring in the Planned Care division.

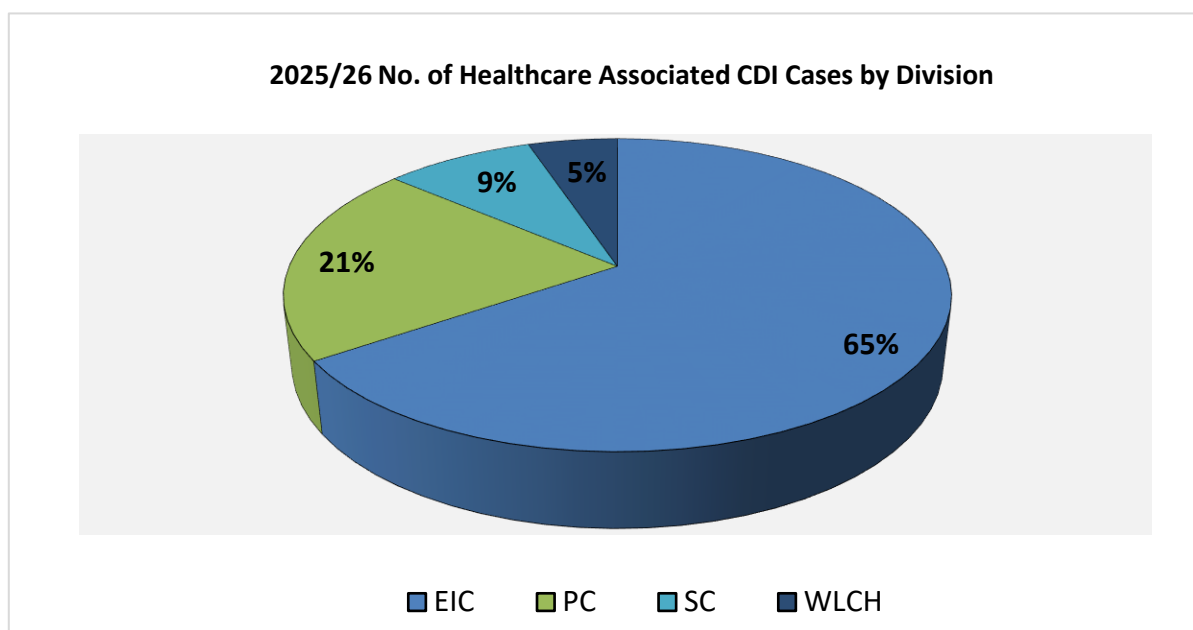


Figure 75: Trust Attributed CDI Cases by Division

The distribution of CDI cases aligns with established national epidemiology, whereby unscheduled and acute care environments typically demonstrate higher CDI burden due to increased antimicrobial prescribing,



complex inpatient management, recurrent healthcare exposure and the concentration of vulnerable patient groups.

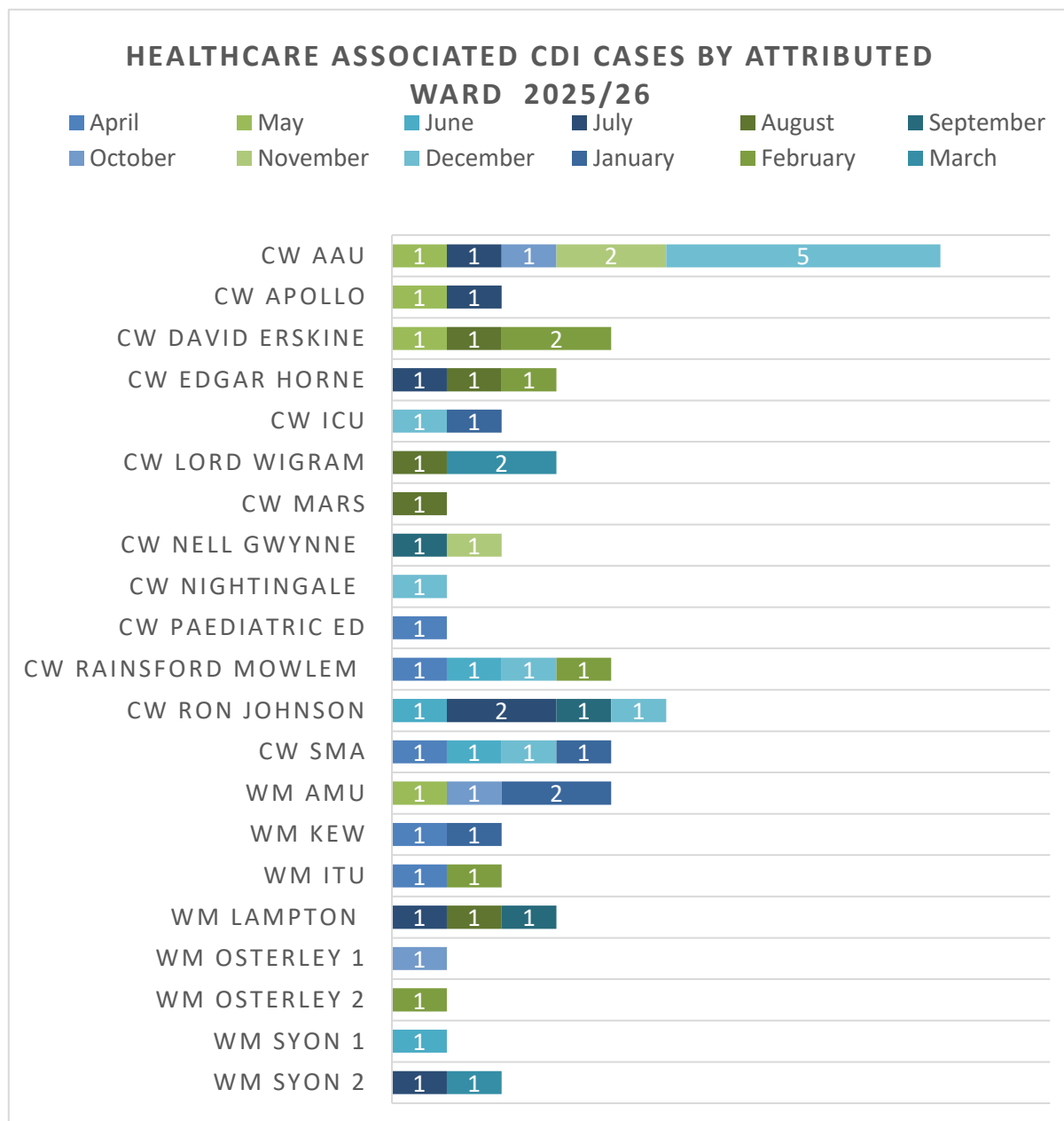


Figure 76: Healthcare Associated CDI Cases by Attributed Ward

Figure 76 above exhibits the distribution of healthcare-associated CDI cases across attributed wards during 2025/26, highlighting variation in case concentration between clinical areas over time.

At the CWH site, the highest number of attributed cases was identified within AAU, which reported a total of 10 cases across the reporting period, including a notable increase later in the year. CW Ron Johnson and CW SMA also demonstrated recurrent cases, reporting 5 and 4 cases respectively. Rainsford Mowlem reported 4 cases distributed across multiple months and several other wards, including Lord Wigram, David Erskine and Edgar Horne reported smaller numbers of cases.



At the WMH site, overall case numbers were lower and more dispersed across wards. AMU reported the highest number of cases at this site with 4 attributed cases during the year. Lampton and Syon 2 demonstrated smaller recurrent patterns, whilst several wards reported isolated single cases only.

The data suggests that CDI burden was not evenly distributed across the organisation, with a small number of wards accounting for a disproportionate number of healthcare-associated cases. However, areas such as acute assessment units and high-turnover wards may be more susceptible due to factors including increased patient throughput, higher antimicrobial exposure, patient acuity, bed pressures and complex comorbidity profiles.

Whilst some recurrent ward-level patterns are evident, the majority of wards reported relatively low case numbers, suggesting that widespread transmission across the organisation was not identified.

Ongoing surveillance, PSIRF review processes, environmental audits, antimicrobial stewardship measures and targeted IPC interventions remain in place to monitor recurrent themes and reduce future CDI risk within higher-incidence areas.

CDI by Specialty

The speciality distribution of the 58 healthcare-associated CDI cases was as follows:

- Acute Medicine – 13 cases
- Surgical specialities (including General Surgery and Trauma & Orthopaedics) – 9 cases
- Respiratory Medicine – 7 cases
- Elderly Care – 6 cases
- Haematology/Oncology – 5 cases
- Gastroenterology/Elderly Care combined services – 3 cases
- Intensive Care Medicine – 3 cases
- General Medicine – 4 cases
- Paediatric High Dependency – 2 cases
- Stroke services – 2 cases
- Paediatric Emergency Medicine (ED) – 1 case
- Cardiology – 1 case
- Gastroenterology – 1 case
- Paediatric Burns – 1 case

Overall, the highest burden of CDI was observed within Acute Medicine, Surgical, Respiratory and Elderly Care services. This is consistent with recognised CDI risk factors including increased antimicrobial exposure, older patient cohorts, prolonged admissions and higher levels of clinical complexity. It is worth noting that 3 of the four paediatric cases were samples sent from one patient.

Ribotyping

All cases that occur are reviewed for contact with other CDI positive cases and possible cross transmission and all specimens are sent for ribotyping.

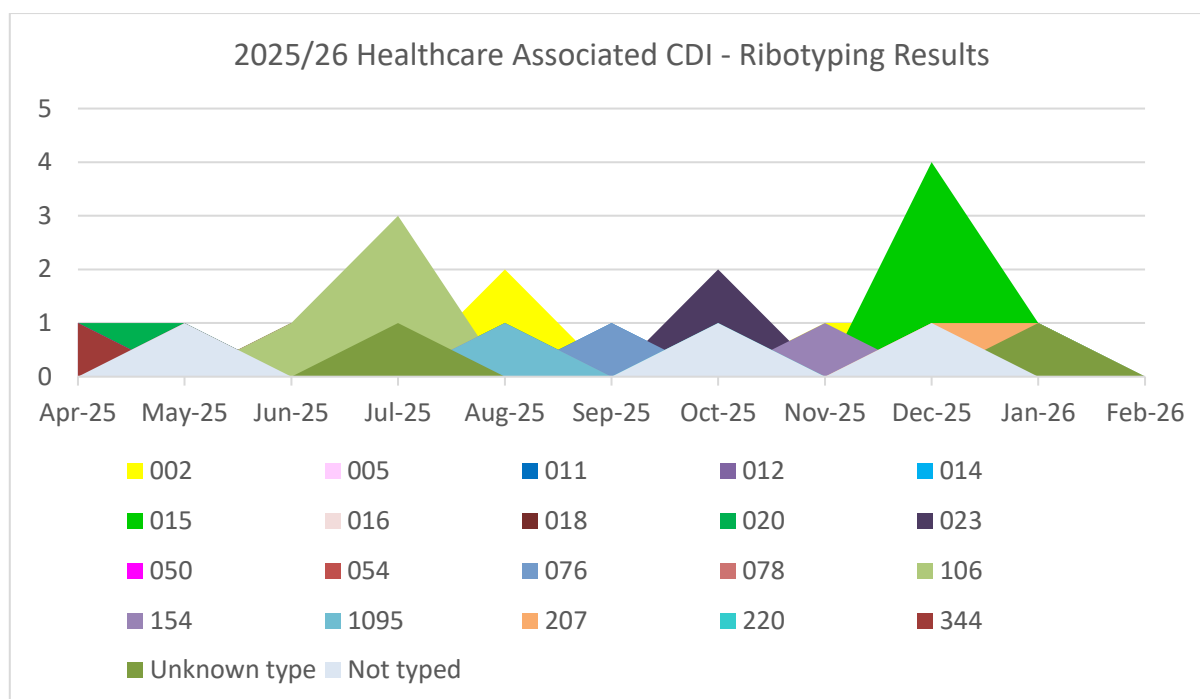


Figure 77: CDI Ribotyping Results

The ribotyping results for healthcare-associated CDI cases during 2025/26 demonstrate considerable strain diversity across the reporting period, with no single ribotype persistently dominating throughout the year. This diversity suggests that cases were likely unrelated and supports the absence of a sustained outbreak associated with a single circulating strain.

The most notable increase was observed in December 2025, where ribotype 015 demonstrated a temporary cluster of four cases and investigations conducted by the IPC team did not suggest cross transmission. This pattern was not sustained in subsequent months and therefore does not independently confirm ongoing transmission.

Importantly, several cases were classified as either “unknown type” or “not typed,” which may reflect limitations in specimen availability, laboratory processing or sequencing completion. As such, interpretation should be undertaken cautiously, as untyped isolates may potentially mask additional epidemiological links.

Overall, the ribotyping data does not demonstrate clear evidence of widespread cross-transmission associated with a single predominant ribotype across the organisation. Instead, findings are more suggestive of sporadic and heterogeneous CDI acquisition patterns, potentially influenced by antimicrobial exposure, patient susceptibility and community-associated disease pressures.

Recurrent or clustered ribotypes continue to be monitored closely through IPC surveillance and PSIRF review processes to identify any emerging transmission concerns at the earliest opportunity.

CDI and Bacteraemia

Review of healthcare-associated CDI cases identified that 9 of 58 patients (15.5%) had a documented positive bacteraemia prior to CDI development. This finding is clinically significant, as patients with bacteraemia frequently require prolonged or broad-spectrum antimicrobial therapy, which is a well-recognised risk factor for disruption of normal gut microbiota and subsequent CDI development. In addition,



patients with bloodstream infections are often clinically complex, have increased healthcare exposure, prolonged inpatient stays and higher levels of invasive intervention, all of which may further increase susceptibility/ risk.

Time from Admission to Positive Result

The time from admission to positive CDI result demonstrated considerable variation across cases, ranging from 1 to 77 days following admission. The median time to positive result was 8 days, with an average of approximately 11.6 days.

The majority of cases (45/57: 79%) developed within 14 days of admission, suggesting that most CDI cases occurred relatively early during the inpatient stay. A smaller number of patients developed CDI following prolonged admissions, including several outlier cases occurring after 24, 36 and 77 days in hospital.

At WMH, the time from admission to sampling ranged from 1 to 62 days, with an average of 11 days. Similarly, at CWH, the range was 1 to 76 days, with an average of 12 days. Despite the wide overall range, the mean duration is relatively similar across both sites, indicating a consistent pattern of CDI onset approximately 1–2 weeks into admission.

Prolonged hospitalisation is a recognised risk factor for CDI due to increased healthcare exposure, cumulative antimicrobial use, patient frailty and repeated contact with healthcare environments. Earlier-onset cases may reflect patients admitted with existing risk factors such as recent antibiotic exposure, recent healthcare contact, underlying comorbidities or potential community-associated acquisition prior to admission.

Analysis of time from admission to CDI sampling demonstrates a broad variation at both sites, suggesting that cases are occurring across both early and prolonged inpatient stays.

Risk Factor Analysis

Table 22: Risk Factor Analysis

Risk Factor	WMH	CWH
Laxative exposure	5/16 (31.2%)	13/42 (31.0%)
PPI exposure	10/16 (62.5%)	19/42 (45.2%)
Antimicrobial exposure	16/16 (100.0%)	29/42 (69.0%)
Previous positive within 3 months	0/16 (0.0%)	8/42 (19.0%)

Antimicrobial exposure remained one of the most prominent recurring themes across the reviewed CDI cases, supporting the continued importance of antimicrobial stewardship interventions. PPI exposure was also frequently identified, which is clinically significant given the established association between gastric acid suppression and increased susceptibility to CDI.

Laxative exposure was identified in a proportion of patients and may complicate recognition and assessment of infective diarrhoea. This highlights the importance of careful clinical assessment when interpreting diarrhoeal symptoms in inpatients.



The presence of previous positive CDI episodes at CWH may indicate a greater burden of recurrent CDI disease, repeat admissions, or patients with persistent underlying risk factors.

Actions Taken to Reduce Healthcare Associated CDI

The following Infection Prevention and Control Team (IPCT) actions have been undertaken/ strengthened to support reduction of *Clostridioides difficile* infection (CDI) across the organisation:

- Enhanced surveillance and case review processes, including routine review of all healthcare-associated CDI cases and identification of recurring themes, trends and learning opportunities.
- Daily monitoring of CDI cases through ICNet and laboratory surveillance systems to support rapid identification and escalation.
- Root Cause Analysis (RCA) / PSIRF reviews undertaken for healthcare-associated cases to identify contributory factors and improvement actions.
- Targeted ward support and increased IPCT visibility in high-incidence clinical areas.
- Promotion of prompt isolation and escalation of symptomatic patients in line with national infection prevention guidance.
- Ongoing review and challenge of isolation compliance, including escalation where delays or capacity issues are identified.
- Reinforcement of environmental cleanliness standards, including commode reviews and environmental review/ auditing.
- Continued auditing and validation of hand hygiene, PPE and High Impact Intervention (HII) compliance, including independent IPCT validation audits in high-risk areas.
- Collaboration with antimicrobial stewardship teams to review antimicrobial prescribing practices and promote reduction in unnecessary broad-spectrum antibiotic use.
- Collaboration with the Microbiology team to review all CDI cases weekly whilst in hospital.
- Review and challenge of proton pump inhibitor (PPI) prescribing where clinically appropriate.
- Review and challenge of laxative prescribing and administration where clinically appropriate.
- Education and awareness sessions delivered to ward teams regarding:
 - recognition of diarrhoeal symptoms
 - stool sampling requirements
 - isolation precautions
 - environmental decontamination
 - hand hygiene compliance
 - appropriate PPE usage
- Monitoring of recurrent CDI cases and previous CDI positive admissions via ICNet to ensure enhanced review and isolation requirements.
- Escalation of learning themes through IPCG, PSG, Acute Collaborative and Executive reporting processes.
- Development of targeted action plans for wards or specialties with recurrent CDI cases or identified lapses in care.
- Continued monitoring of turnaround times relating to stool sampling, isolation implementation and completion of case reviews to support timely organisational learning.

CDI incidence continues to represent a significant patient safety, quality and organisational performance concern across both hospital sites but particularly at CWH, with cases occurring across multiple specialties and clinical areas. Analysis of current surveillance data demonstrates that this is not isolated to a small



number of wards or individual clinical teams but instead reflects a wider Trust-wide challenge associated with complex patient pathways, prolonged admissions, antimicrobial exposure, recurrent gastrointestinal symptoms and variation in recognition and management practices.

Review of healthcare-associated CDI cases identified recurring contributory themes including delayed recognition of diarrhoeal symptoms, delays in stool sampling and isolation, antimicrobial exposure, proton pump inhibitor (PPI) use, recurrent admissions and variation in clinical documentation and escalation.

Whilst Infection Prevention and Control Team (IPCT) interventions remain ongoing; including enhanced surveillance, RCA/PSIRF review, targeted ward support, environmental monitoring, hand hygiene validation audits and antimicrobial stewardship collaboration — the scale and distribution of cases indicate that sustained reduction in CDI incidence will require a coordinated Trust-wide improvement programme rather than isolated localised interventions.

Actions Going Forward

The following priority actions are recommended:

- Development of a formal Trust-wide CDI Reduction Plan with clear executive oversight, accountability, trajectories and measurable improvement objectives.
- Strengthening of antimicrobial stewardship interventions, particularly relating to broad-spectrum antibiotic prescribing and duration review.
- Trust-wide review of proton pump inhibitor (PPI) prescribing practices and deprescribing opportunities where clinically appropriate.
- Reinforcement of early recognition, escalation, stool sampling and isolation requirements through targeted clinical education.
- Continued enhanced surveillance and thematic review of all healthcare-associated CDI cases to identify recurring system-wide risks.
- Continuation/ expansion of IPCT validation auditing in high-risk clinical areas to provide additional assurance around compliance with infection prevention standards.
- Targeted review of recurrent CDI cases and patients with repeated stool sampling to identify opportunities for earlier intervention and continuity of care improvements.
- Strengthening of environmental assurance processes, including monitoring of enhanced cleaning compliance and escalation of environmental risks.
- Improved divisional ownership and accountability for CDI reduction actions and demonstrating learning implementation.
- Continued reporting through EMB and governance structures to ensure organisational visibility and sustained oversight.

Conclusion

CDI reduction cannot be achieved through IPCT intervention alone. The current data demonstrates that CDI is a complex, multifactorial, Trust-wide issue requiring a coordinated organisational response involving operational teams, clinical divisions, antimicrobial stewardship, estates and facilities, nursing, medical staff and executive leadership.

Sustainable improvement is therefore likely to depend upon consistent Trust-wide ownership, standardisation of practice and delivery of a clearly defined organisational CDI reduction strategy.



Appendix 4: CDI Antimicrobial Exposure Analysis

Report provided by on behalf of Antimicrobial Stewardship Group

Clostridioides difficile infection (CDI) remains a key healthcare-associated infection monitored through the Trust Infection Prevention and Control (IPC) framework. Antimicrobial exposure is a well-recognised modifiable risk factor for CDI.

This analysis was undertaken to:

- Quantify cumulative antimicrobial exposure in the period preceding CDI diagnosis
- Compare exposure patterns between Chelsea and Westminster Hospital (CWH) and West Middlesex University Hospital (WMH)
- Identify stewardship-relevant drivers of exposure to inform targeted intervention

Methods

Study population

- All patients diagnosed with CDI over a one-year period (2025/26)
- Cases classified as:
 - Hospital-attributed CDI (HA-CDI) – case list as provided by the IPC team (M. Fontana)
 - Non-hospital-attributed CDI – all PCR-positive ($\pm$ toxin-positive) cases identified from ICNET
- Primary analysis focused on HA-CDI cases

Antimicrobial exposure definition

- Exposure window: 1–150 days prior to CDI diagnosis date
- Metric: total Days of Therapy (DOT) per patient, summed across all prescriptions within the exposure window
- The following agents were excluded from the primary exposure analysis:
 - Vancomycin, teicoplanin, metronidazole, gentamicin, amikacin

Table 23: Cases with in-patient antimicrobial prescriptions in the 150 days prior to CDI diagnosis

CDI Classification	CWH (n)	WMH (n)
HA-CDI	37	16
Non-HA-CDI (PCR +ve / non-HA toxin +ve)	23	36
Total	60	52

Note: a small number of cases had no identifiable in-patient antimicrobial prescribing within the exposure window and are excluded from the exposure analyses below.

Results

Table 24: Overall antimicrobial burden – HA-CDI

Site	Patients	Median DOT (days)	IQR
CWH	37	15.9	9.3 – 29.4



WMH	17*	4.0	2.3 – 10.4
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* WMH cohort n=17 after exclusion of cases with no in-patient prescriptions in the exposure window.

Patients with HA-CDI at CWH received substantially greater cumulative antimicrobial exposure prior to diagnosis than those at WMH. The median total DOT was approximately 16 days at CWH (IQR 9–29) compared with approximately 4 days at WMH (IQR 2–10) – a roughly four-fold difference in median exposure.

Table 25: Distribution of exposure by duration band

Exposure band	CWH HA-CDI (%)	WMH HA-CDI (%)
<3 days	8%	35%
3–7 days	17%	31%
7–14 days	21%	22%
>14 days	54%	12%

Over half of HA-CDI patients at CWH received more than 14 days of antimicrobial therapy prior to diagnosis. At WMH, the pattern is reversed: over a third of cases received fewer than 3 days of prior therapy, with only 12% exceeding 14 days. This contrast in duration distribution is the most striking feature of the inter-site comparison.

Table 26: Antimicrobial agent-level exposure – CWH HA-CDI (n=37)

Antimicrobial	Total DOT	Patients (n)	Median DOT
Co-amoxiclav	216.5	28	4.49
Ceftriaxone	91.6	17	4.89
Meropenem	70.3	7	8.23
Piperacillin/tazobactam	63.8	13	5.28

Table 27: Antimicrobial agent-level exposure – WMH HA-CDI (n=17)

Antimicrobial	Total DOT	Patients (n)	Median DOT
Co-amoxiclav	32.8	11	2.00
Ceftriaxone	20.9	9	2.33
Piperacillin/tazobactam	14.6	5	4.46
Cefuroxime	11.6	4	5.70
Meropenem	6.7	1	6.68

Table 28: Non-hospital-attributed CDI – antimicrobial exposure in 150 days prior to diagnosis

Site	Patients	Median DOT (days)	IQR
CWH	25	9.0	3.0 – 23.0
WMH	38	13.3	6.4 – 17.3



Non-hospital-attributed CDI cases also demonstrate substantial cumulative antimicrobial exposure prior to diagnosis. Unlike the HA-CDI comparison, median DOT is broadly similar between sites (9.0 days at CWH vs 13.3 days at WMH).

Limitations

- Small cohort size (n≈53 HA-CDI cases across both sites): findings should be treated as directional signals and hypothesis-generating rather than precise population estimates
- Prescribing location analysis reflects where DOT accumulates, not necessarily the clinical decision point for initiation or continuation
- This is an observational, descriptive analysis; no causal inference is made

Summary

Hospital-attributed CDI at CWFT is associated with substantially higher cumulative antimicrobial exposure, particularly at CWH, where over half of patients received more than 14 days of therapy prior to diagnosis. This is most commonly following exposure to broad spectrum antimicrobials (e.g. co-amoxiclav, ceftriaxone, Piperacillin/Tazobactam and Meropenem).

Non-hospital-attributed CDI cases also carry substantial prior antimicrobial exposure, with broadly similar burden across sites.

Observations For Non-Hospital Attributed CDI Cases

Table 29: CW – Antimicrobial exposure (non-HA CDI) n=25

Antimicrobial	Total DOT	Patients	Median DOT
Co-amoxiclav	187.9	18	7.07
Ceftriaxone	80.0	9	5.33
Meropenem	35.0	2	17.48
Doxycycline	24.6	3	7.06
Cefuroxime	17.7	2	8.85
Ciprofloxacin	13.8	2	6.90

Table 30: WM – Antibiotic exposure (non-HA CDI) n=38

Antimicrobial	Total DOT	Patients	Median DOT
Co-amoxiclav	164.9	28	5.43
Piperacillin/tazobactam	152.5	9	4.46
Cefuroxime	94.1	14	5.70
Ceftriaxone	62.5	15	2.00
Meropenem	57.0	6	7.96
Ceftazidime	40.3	4	9.28



Appendix 5: 2025/26 Healthcare Associated MRSA Bacteraemia Summary

Report written by Zara Tzouros, IPC Data Manager

There were six Healthcare Associated MRSA bacteraemias from April 2025-March 2026, breaching the national target of zero cases of healthcare associated infections. This is an increase of one case on the previous financial year.

Three cases were categorised at Healthcare Onset, Healthcare Associated (HOHA) and three cases were categorised at Community Onset, Healthcare Associated (COHA); both categories are deemed as Healthcare Associated by UK HSA.

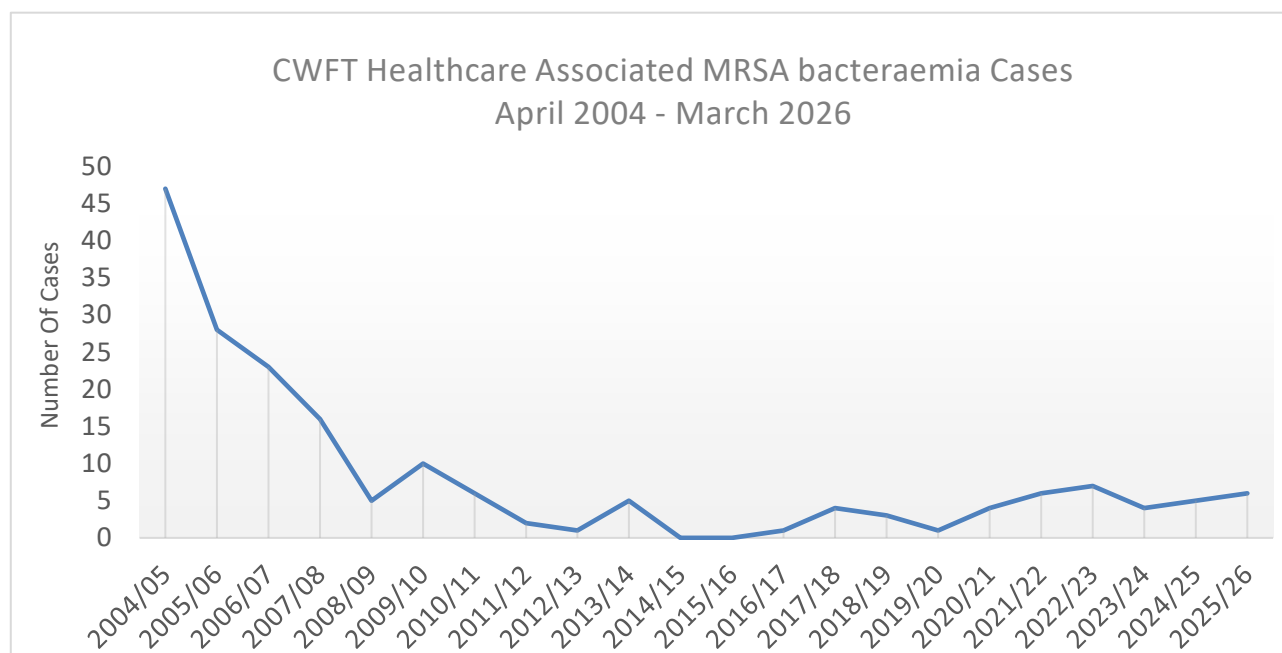


Figure 78: CWFT MRSA Bacteraemia Cases 2004 - 2026

Benchmarking

The Trust sits above the UK average rate of 1.64 with a 2025/26 average rate of 1.26 but falls below the London average rate of 1.75 per 100,000 bed days + day admissions.

Locally the trust has performed similarly to other organisations in the sector as evidenced by Figure 79 below.

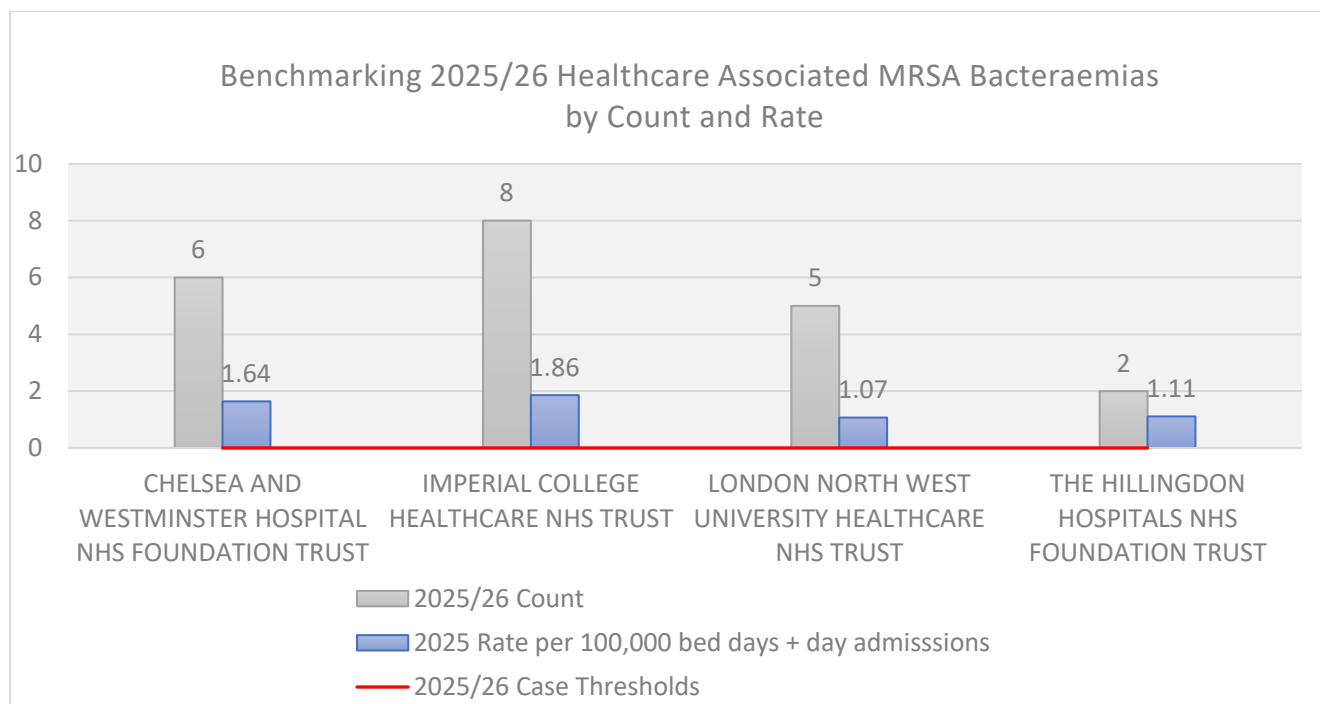


Figure 79: Trust attributed MRSA rates benchmarking against other organisations

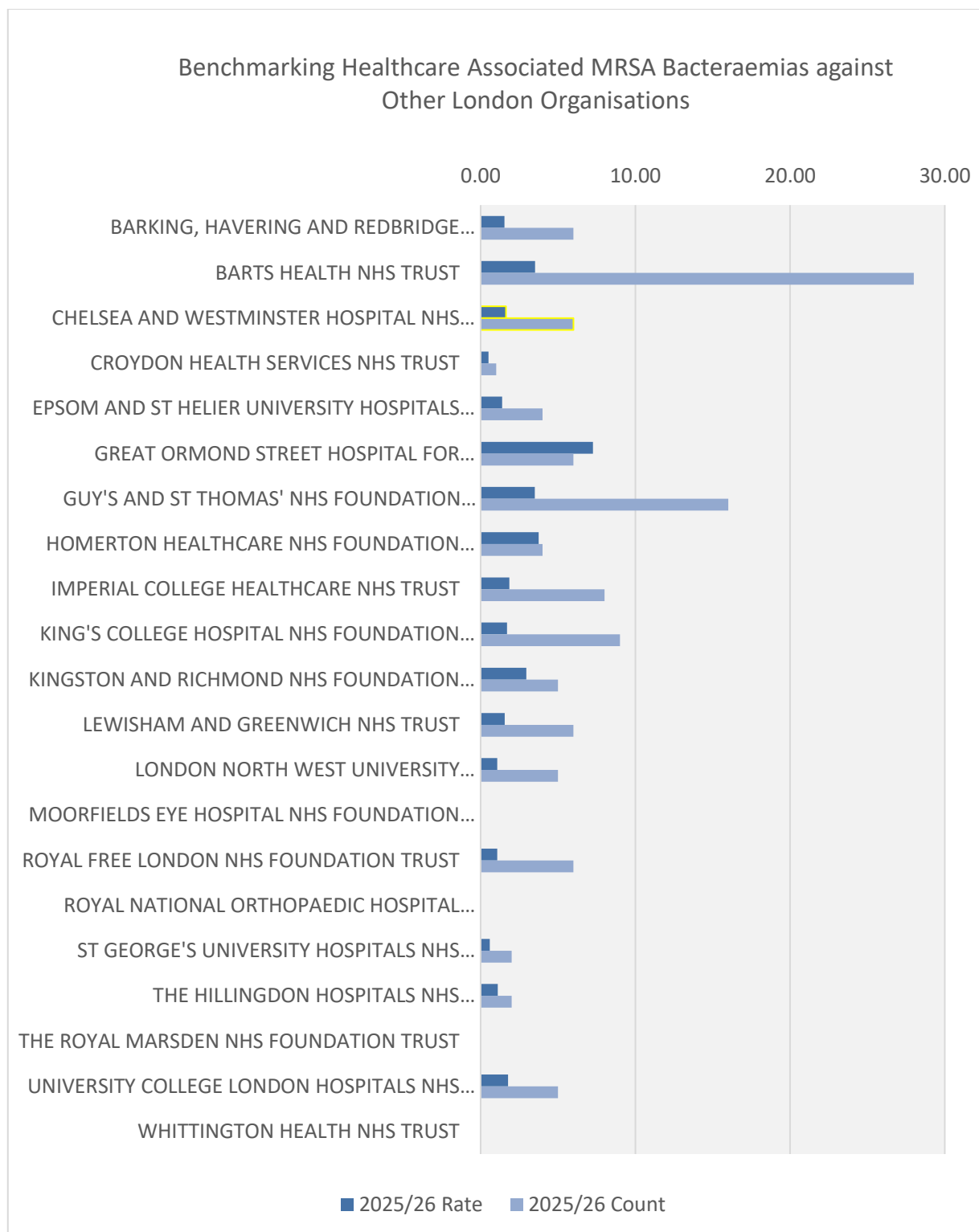


Figure 80: Trust attributed MRSA rates benchmarking against other London organisations

Ward And Divisional Distribution

Of the six cases that occurred, three were community derived with patients admitted with signs and symptoms of infection consistent with MRSA bacteraemia but due to the UK HSA criteria which includes previous admission within the past 28 days classified as a healthcare associated.



Three cases occurred at the WM site; and 3 cases occurred at the CW site, see Figure 81 for a breakdown of wards and divisions attributed.

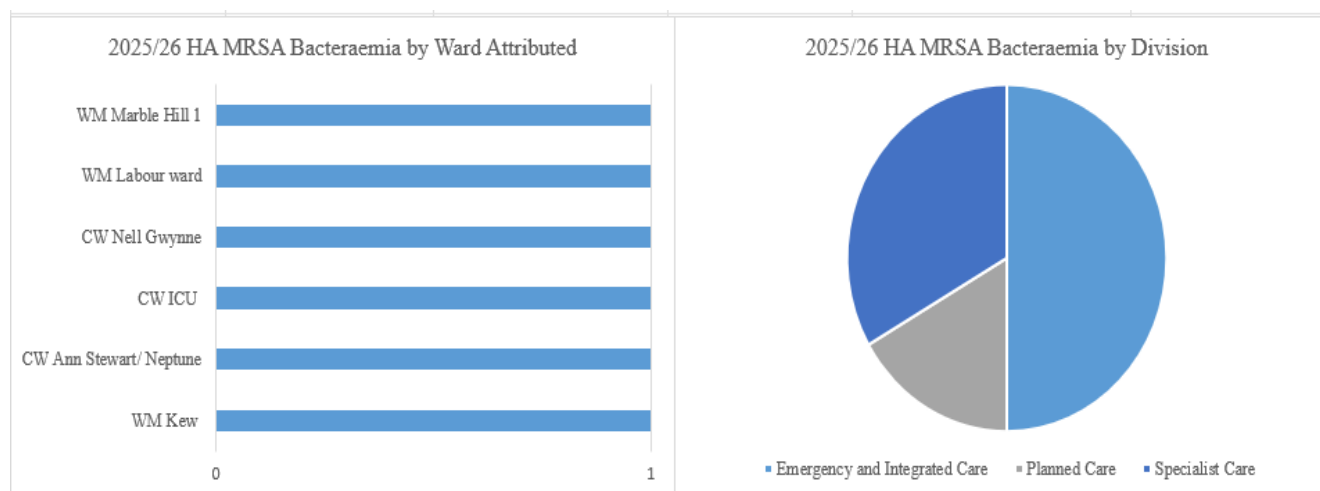


Figure 81: Healthcare Associated MRSA Bacteraemias by ward and division

All cases occurred on different wards and were split across the divisions: 3 cases occurred in the Emergency and Integrated Care division (EIC), 1 in Planned Care (PC) and 1 in Specialist Care (SC) divisions. Figure 82 below shows the distribution of cases throughout the year.

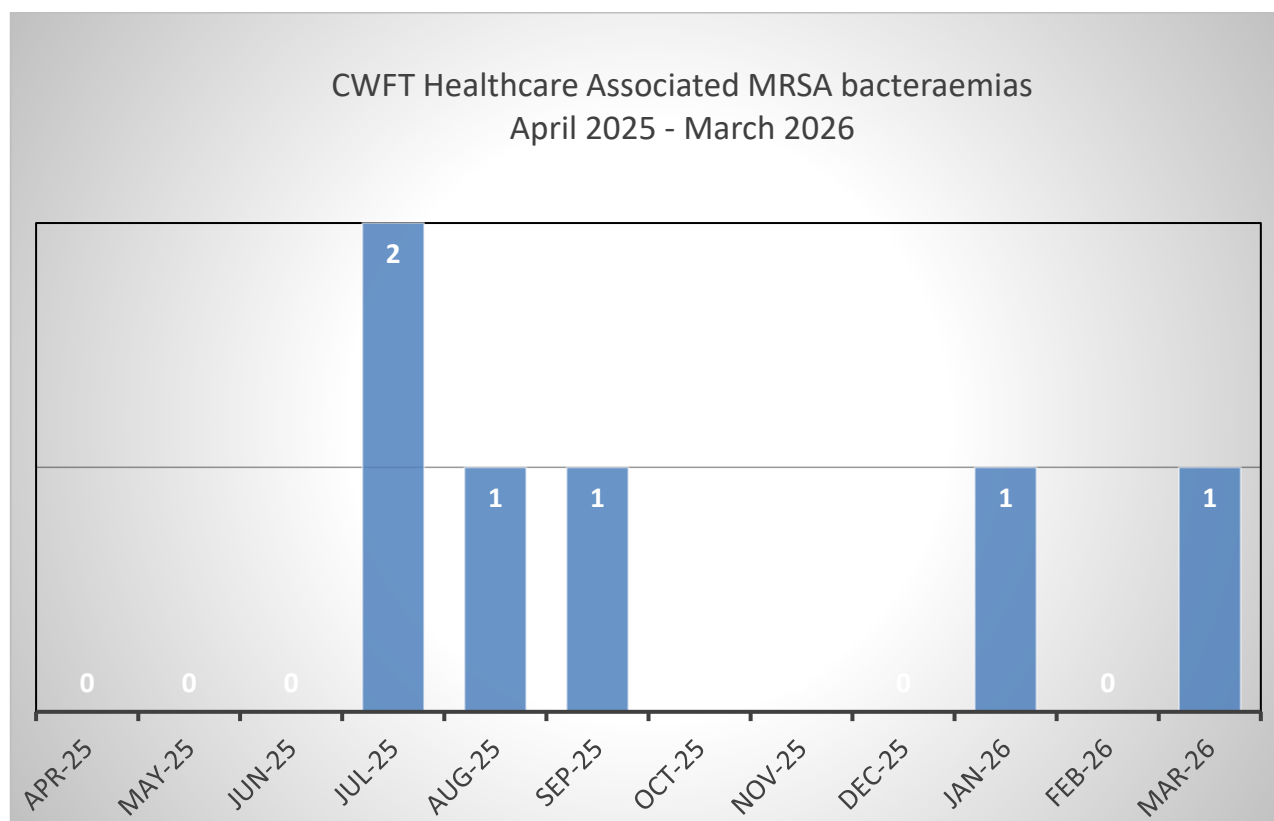


Figure 82: Healthcare Associated MRSA Bacteraemia by month positive



Blood Culture Data Analysis

From April 2025 – March 2026, and Westminster NHS Foundation Trust over 31,000 blood culture specimens were processed with a total six healthcare associated MRSA cases reported as detailed in figure 83 below.

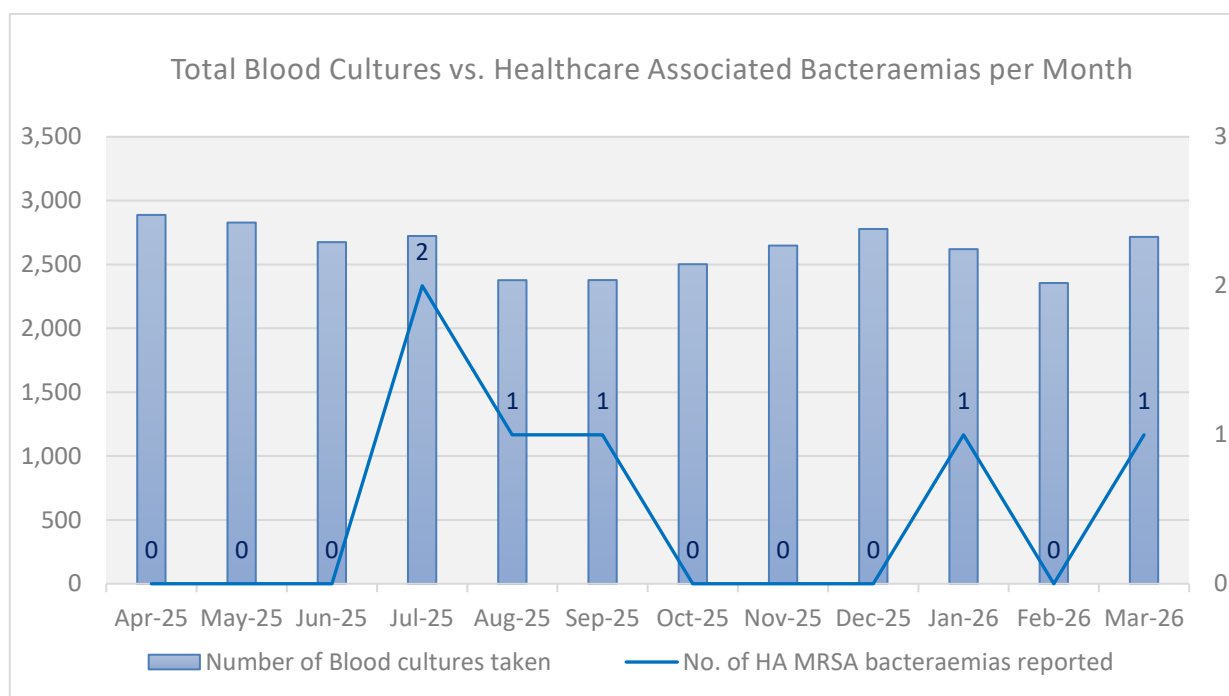


Figure 83: 2025/26 Number of Blood Cultures vs. MRSA Positive Blood Cultures

Time From Admission to Positive Result

Figure 84: Number of days from Admission to Positive Blood Culture. Figure 84 below shows the number of days from admission to positive blood culture (day 1 equals day of admission) per case which demonstrates a range of 1-45 days and an average of 12.17 days.

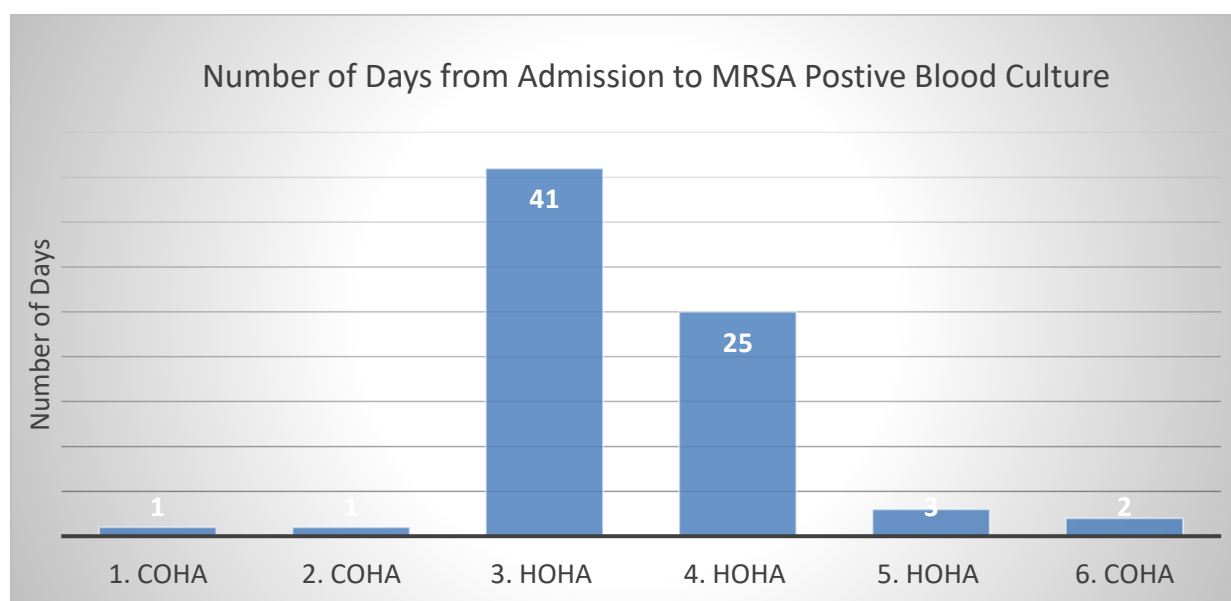


Figure 84: Number of days from Admission to Positive Blood Culture.



Summary of Cases

Of the six Healthcare Associated cases reported:

- 3 cases occurred at CWH and 3 at WMH.
- All cases occurred on different wards and were split across the divisions: 3 cases occurred in the Emergency and Integrated Care division (EIC), 1 in Planned Care (PC) and 2 in Specialist Care (SC) divisions.
- 3 cases were categorised as COHA and 3 cases were categorised as HOHA.
- 3 of the cases were admitted with symptoms of bacteraemia and classified as healthcare associated due to a recent admission. PSIRF meetings concluded these cases were unavoidable.
- 2 MRSA colonisations were Healthcare Associated acquisition occurring within a range of 25 – 41 days post admission.
- 1 patient was blood culture positive before the NAG result had resulted and previously MRSA negative.
- 1 patient was deemed unsuitable for de-colonisation due to a large chronic leg wounds as per MRSA policy.
- 2 patients met the criteria for and received decolonisation.

Sources of Infection

Sources of infections are identified at PSIRF meetings, Figure 85 below shows the sources of all 5 cases.

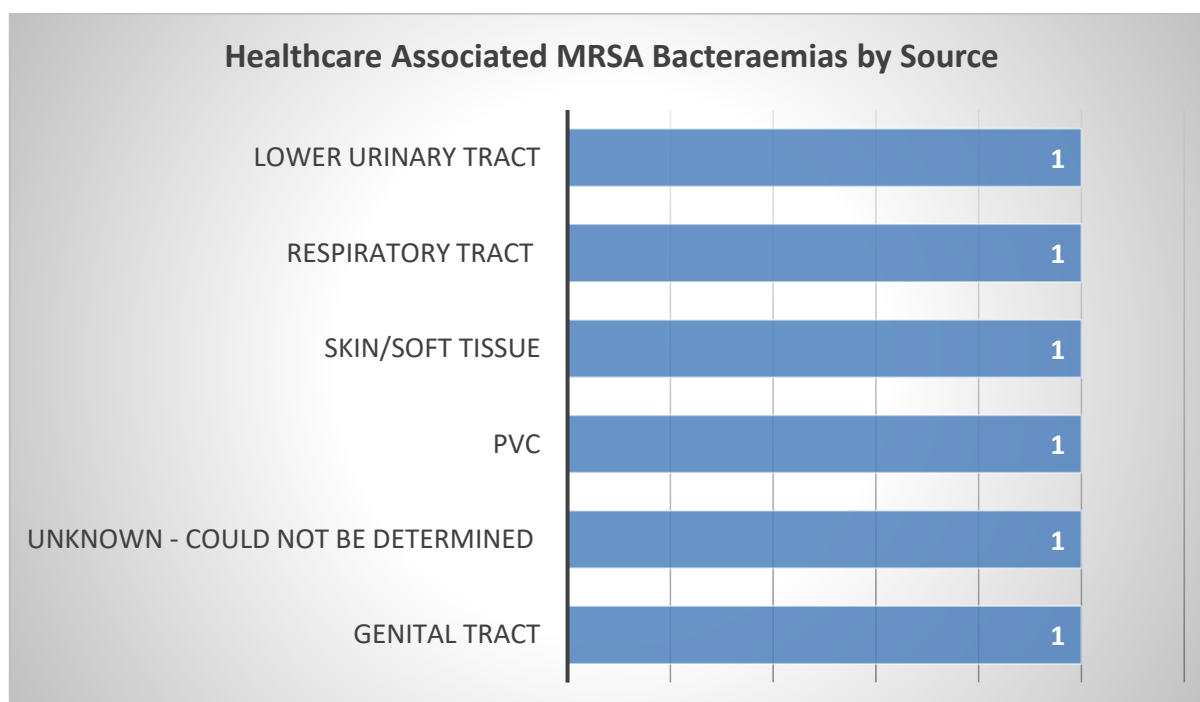


Figure 85: Source of Healthcare Associated MRSA bacteraemias

PSIRF Review

The Patient Safety Incident Review Framework (PSIRF) was utilised and MDT meetings held for all cases which identified/ confirmed:



- Compliance with the 5 moments of hand hygiene is imperative, hand hygiene compliance audits are conducted and submitted monthly and reviewed at IPCG. IPCT validation audits commenced in September 2025 to provide assurance of audit accuracy.
- Compliance with the bare below elbows policy in relation to hand hygiene continues to be challenging, this is being further supported by the executive nursing and clinical teams who have developed an escalation pathway for chronic offenders who do not follow policy.
- Reducing the inappropriate use of gloves is imperative to reducing cross-transmission of infections. This has been encouraged via the inclusion of the gloves off poster and glove usage risk assessment being uploaded as a digital screensaver to all Trust computers.
- Adherence to the MRSA screening policy is good, a point prevalence survey conducted by the team showed good compliance with screening.
- Prompt isolation of patients with MRSA (if possible) is ideal with staff encouraged to document on Cerner if there are no isolation facilities available.
- Prompt prescribing and appropriate administration of MRSA topical suppression therapy remains a priority with a QI project drafted for the upcoming financial year.
- Improve appropriate management of Intravenous devices – one of the MRSA bacteraemia reviews reached the conclusion that the bacteraemia was likely due to device management, though this was a highly complex patient and there was traumatic self-removal of device, a long-term alternative should have been discussed.
- Maintaining a high standard of environmental hygiene remains a priority.
- Prudent antibiotic stewardship remains important.
- Importance of following aseptic technique steps during blood culture specimen collection and allowing alcohol to dry once disinfection of the skin has been performed.
- Importance of adhering to the screening schedule post-MRSA suppression therapy as outlined in the MRSA policy.
- Increasing Caesarean section rates highlight the need for a review of the MRSA screening policy, particularly for long-stay antenatal patients, those undergoing induction of labour, and healthcare worker risk stratification- under review by the IPC team.
- Clinical Documentation: Routine checking of the 'Problems and Diagnoses' section in Cerner is essential to ensure accurate organism flagging and application of appropriate risk assessments and transmission-based precautions.
- Follow strict ANTT technique during urinary catheter insertion.

Individual Case Details

COHA MRSA Bacteraemia – Ann Stewart / Neptune Ward

2-week-old infant presented to Chelsea and Westminster Hospital Emergency Department on 28 July 2025 and was diagnosed with MRSA bacteraemia. The patient was subsequently admitted to Neptune Ward.

The infant was born on 09 July 2025 via caesarean section at Chelsea and Westminster Hospital and was discharged on 12 July 2025 following routine postnatal care. The baby re-presented to the Emergency Department on 13 July 2025 following maternal concerns regarding reduced urine output; however, after assessment, the infant was found to be clinically well and was discharged home.

On 28 July 2025, the infant re-presented to the Paediatric Emergency Department with fever at home and poor feeding. A blood culture taken on the same day detected MRSA.



Following confirmation of MRSA bacteraemia, maternal screening was undertaken and returned positive for MRSA. The mother was subsequently commenced on suppression therapy. The infant's MRSA isolate was sent for typing and was identified as MLST:22 (allelic profile: 7,6,1,5,8,8,6) and PVL-positive MRSA.

To mitigate the risk of transmission to other vulnerable patients and staff, the following IPC measures were implemented:

- The infant was isolated in a single-occupancy room on admission, and contact precautions were initiated.
- Targeted education on PVL-MRSA was provided to staff, with emphasis on early recognition of skin and soft tissue infections and prompt escalation of concerns. This information was shared via staff handovers and the ward WhatsApp group.
- Cleaning protocols on the unit were reviewed to ensure compliance with IPC standards, and a deep clean of the ward was completed on 12 August 2025.

A PSIRF meeting was held on 13 August 2025. The source of the bacteraemia remained unclear, and no lapses in care or contributory factors were identified. All lines and devices had been managed appropriately in accordance with best practice guidelines, and no breaches of the MRSA screening policy were identified. The infant remained clinically well throughout admission.

An action from the investigation was for the PSIRF documentation to be shared with the Obstetrics Team for review and learning.

MRSA Bacteraemia – Adult Intensive Care Unit (AICU)

67-year-old patient presented to the Emergency Department on 29 June 2025 with reduced consciousness following a fall. The initial clinical impression was a urinary tract infection, and the patient was treated with intravenous antibiotics.

The patient subsequently deteriorated and was admitted to AICU on 13 July 2025 following intubation. The clinical picture was one of undifferentiated encephalopathy, and the patient received two courses of steroids. A tracheostomy was inserted on 04 August 2025.

MRSA was detected from a NAG screen on 04 August 2025, and a sputum sample taken on 5 August 2025 also grew MRSA. A blood culture taken on 9 August 2025 detected MRSA bacteraemia. Typing of the blood culture identified MLST ST97 (allelic profile: 3, 1,1,1,1,5,3).

A PSIRF review was conducted, and no lapses in care were identified.

The PSIRF review highlighted the following learning points:

- IPC teams to continue to ensure clear documentation of MRSA and ESBL status, along with related interventions, within patients' electronic records.
- Improved documentation on Cerner to clearly specify the source of blood cultures (e.g. peripheral or line-related).
- Review of the current tracheostomy protocol to consider incorporating routine skin swabbing 48–72 hours prior to insertion.



- Review and assurance of staff competency involved in tracheostomy procedures to ensure adherence to protocol and safe clinical practice.
- Timely review and initiation of MRSA decolonisation therapy where indicated.
- Verification that cleaning standards and single-use equipment protocols are consistently followed, particularly for ultrasound equipment and patient transfer devices used during procedures and imaging.

HOHA MRSA Bacteraemia on Nell Gwynne

73-year-old patient was admitted on 24/08/25 via the Emergency Department with progressive neurological symptoms following recent hospitalisation abroad. During admission, the patient developed cellulitis at a peripheral cannula site. Blood cultures taken on 17/09/25 confirmed MRSA bacteraemia, with the likely source identified as the peripheral intravenous cannula. The Nose and Groin screen which was positive for MRSA was sent for typing which was MLST ST97 (MLST allelic profile: 3,1,1,1,1,5,3). No typing result available. Transthoracic echocardiography demonstrated a mobile lesion on the mitral valve, consistent with probable native valve endocarditis. The patient was commenced on MRSA-active antimicrobial therapy and contact precautions were implemented. A PSIRF meeting was completed on 30/09/25.

Learning Identified

- Lapses in peripheral cannula documentation and inconsistent aseptic technique were identified as contributory factors.
- Reinforcement of the 72-hour cannula review and prompt removal policy is required to reduce the risk of device-related infection.
- Improved staff training on device care documentation and cannula management is necessary.
- Greater oversight of MRSA decolonisation processes is needed to ensure adherence, particularly in patients with complex care needs.

COHA WM Marble Hill 1 MRSA Bacteraemia

81-year-old female presented to ED 04/07/25 with bilateral leg ulcers and social issues (non-engagement with QDS plan of care). Blood cultures on admission were MRSA positive. Admission NAG screen was negative but the right leg wound swab was MRSA positive. The patient was recently admitted to MH1 on 07/06/25 - 28/06/25 for a similar lower leg wound infection likely due to maggot infestation, then transferred to DRU after medical optimisation and subsequently discharged. Admission NAG screening on this visit detected MRSA and a positive MRSA culture from the left leg wound swab.

A PSIRF meeting conducted found no lapse in care. Summary of discussion: (1) probable skin contaminant, and (2) MRSA re-screening post suppression therapy performed on day 5 (right after suppression therapy) instead of the recommended day 8 (after 48hrs of suppression therapy).

Learning: (1) Ensure skin disinfectant has fully dried before collecting blood cultures. (2) Perform MRSA re-screening following suppression therapy on day 8 (after 48 hours of suppression therapy) as per protocol.

HOHA MWM Labour Ward MRSA Bacteraemia

29-year-old female admitted to QMMU for induction of labour on 20/01/26 and subsequently underwent an emergency caesarean section on 23/01/26 due to delayed labour progression. Patient developed pyrexia on 22/01/26, prompting a septic screen, which confirmed MRSA.



WM Kew (COHA) MRSA Bacteraemia

83-year-old male presented to ED on 04/03/26 due to fall and CAUTI. A blood culture sent on 05/03/26 came back MRSA bacteraemia treated with IV vancomycin. Previous admissions showed that the patient was known MRSA positive on 14/02/26 (Nose and groin), 20/02/26 (urine culture), 23/02/26 & 26/02/26 (penile swabs). Had suppression therapy on 09/03/26 to 14/03/26. Patient on long-term urinary catheter which was changed on 03/03/26 at the TWOC clinic, uneventful and there was an assurance that strict ANTT was followed. A PSIRF meeting was conducted and no lapse in care was identified. No issues directly identified.



Appendix 6: IPCT Training Conducted Apr 2026 – Mar 2026

Table 31: IPCT Training Delivered

	Date	Site	Teaching	Mode	Participants
Apr 2025	02-Apr	Cross	Doctors Induction	MST	Doctors
	03-Apr	WM	Excellence in care	F2F	HCSWs
	24-Apr	Cross	Corporate Induction	MST	New staff
	25-Apr	WM	ICLP	F2F	HCSWs
	28-Apr	CW	NICU mandatory update	F2F	Nurses/HCSWs
	29-Apr	CW	Saturn unit - organisms, PPE	F2F	Nurses/HCSWs
May 2025	01-May	CW	Dermatology	F2F	Nurses/HCSWs
	07-May	Cross	Doctors Induction	MST	Doctors
	07-May	WM	World Hand Hygiene Day 2025	F2F	Staff/visitors
	07-May	WM	Hand Hygiene Awareness Day	F2F	HCWs and Visitors
	08-May	CW	Rainsford Mowlem - <i>C. difficile</i>	F2F	Nurses/HCSWs
	08-May	Cross	Excellence in care	F2F	HCSWs
	09-May	WM	SCBU update	F2F	Nurses/HCSWs
	12-May	CW	Medical Students 1st year	F2F	Med students
	12-May	WM	IV Study Day	F2F	RNs
	12-May	WM	Medical Students 1st year	F2F	Med students
	13-May	CW	World Hand Hygiene Day 2025	F2F	Staff/visitors
	15-May	CW	Rainsford Mowlem - <i>C. difficile</i>	F2F	Nurses/HCSWs
	16-May	WM	ICLP	F2F	Staff
	19-May	WM	Student Nurses Induction	F2F	Student Nurses
	20-May	Cross	Corporate Induction	MST	New staff
Jun 2025	04-Jun	WM	IV Preceptorship	F2F	Nurses
	04-Jun	Cross	Doctors Induction	MST	Doctors
	13-Jun	CW	NICU mandatory update	F2F	Nurses
	13-Jun	WM	Excellence in care	F2F	HCSWs
	25-Jun	Cross	Corporate Induction	MST	New staff
Jul 2025	10-Jul	CW	Excellence in care	F2F	HCSWs
	02-Jul	Cross	Doctors Induction	MST	Doctors
	21-Jul	WM	IV Administration	F2F	Nurses
	22-Jul	WM	Corporate Induction	MST	New staff
	30-Jul	WM	Sonography dept. - obs /gyn	MST	Nurses/sonographers
	30-Jul	WM	F1 doctors' induction	F2F	Doctors
Aug 2025	08-Aug	WM	Syon 2 Team Away	F2F	Nurses/HCSWs
	06-Aug	Cross	Doctors Induction	MST	Doctors
	14-Aug	CW	NICU mandatory Training	F2F	Nurses
	18-Aug	CW	Student Nurses Induction	MST	Student Nurses
	18-Aug	WM	Foundation of Critical Care	F2F	ICU Nurses



	19-Aug	Cross	IV Preceptorship	F2F	Nurses
	22-Aug	Cross	ICLP	F2F	Staff
	28-Aug	Cross	Excellence in care	F2F	HCSWs
	28-Aug	Cross	Corporate Induction	MST	New staff
Sep 2025	01-Sep	Cross	Doctors Induction	MST	Doctors
	05-Sep	CW	ICLP	F2F	Nurses
	08-Sep	WM	MH1	MST	Nurses/HCSWs
	12-Sep	WM	Syon 2 Team Away	F2F	Nurses/HCSWs
	12-Sep	WM	IV Preceptorship	F2F	Nurses
	19-Sep	WM	Osterley 1 Team Away Day	F2F	Nurses
	19-Sep	WM	SCBU update	F2F	Nurses
	23-Sep	WM	Osterley 1 Team Away Day	F2F	Nurses
	30-Sep	CW	Student Nurse Induction	F2F	Student Nurses
	30-Sep	Cross	Corporate Welcome	MST	New Staff
Oct 2025	01-Oct	Cross	Doctors Induction	MST	Doctors
	02-Oct	WM	Medical Students Y3	F2F	Med students
	03-Oct	CW	Medical Students Y3	F2F	Med students
	03-Oct	WM	SCBU update	F2F	Nurses
	07-Oct	Cross	Excellence in care	F2F	HCSWs
	09-Oct	CW	Diagnostics clinical governance	F2F	Range
	09-Oct	CW	Dermatology	F2F	Nurses/HCSWs
	10-Oct	WM	Syon 2 Team Away	F2F	Nurses/HCSWs
	13-Oct	WM	Domestic Training Update	F2F	Domestic Supervisors
	17-Oct	WM	Osterley 1 Team Away Day	F2F	Nurses/HCSWs
	24-Oct	Cross	ICLP	F2F	Nurses/HCSWs
	29-Oct	WM	IV Study Day	F2F	Nurses
	30-Oct	CW	Fertility Unit IPC Updates	MST	Nurses/HCA
	30-Oct	Cross	Corporate Welcome	MST	New Staff
	31-Oct	WM	Osterley 1 Team Away Day	F2F	Nurses
Nov 2025	03-Nov	Cross	Student Nurse IPC placement (5-days)	F2F	Student Nurse
	03-Nov	WM	Student Midwives trust Induction	F2F	Student Midwives
	05-Nov	Cross	Doctors Induction	MST	Doctors
	18-Nov	Cross	Corporate Welcome	MST	New Staff
	21-Nov	Cross	HCSW Conference	F2F	HCSWs
	20-Nov	CW	NG Learning from incidences MRSA	MST	Nurses/HCA
	21-Nov	Cross	ICLP	F2F	Nurses
	26-Nov	CW	NG Learning from incidences MRSA	MST	Nurses/HCA
Dec 2025	01-Dec	WM	Imperial medical students Y2	F2F	Medical Students
	01-Dec	WM	Student Midwives trust Induction	F2F	Student Midwives
	03-Dec	Cross	Doctors Induction	MST	Doctors
	08-Dec	CW	Student Nurse Induction	F2F	Student Nurses



	17-Dec	Cross	Corporate Welcome	MST	New Staff
Jan 2026	05-Jan	WM	Adult Pre-reg Student Nurses Induction	F2F	Student Nurses
	05-Jan	WM	Imperial medical students Y3	F2F	Medical Students
	07-Jan	Cross	Doctors Induction	MST	Doctors
	19-Jan	WM	Student Nurses Induction	F2F	Student Nurses
	22-Jan	Cross	Foundation of Critical Care (FOCC)	F2F	ITU Nurses
	22-Jan	Cross	Excellence in Care	F2F	HCSWs
	26-Jan	Cross	Student Nurses Induction	F2F	Student Nurses
	27-Jan	Cross	Corporate Welcome	MST	New Staff
Feb 2026	02-Feb	WM	AMU Nurses	F2F	Nurses
	03-Feb	CW	Imaging IPC Training	F2F	Radiographers
	04-Feb	Cross	Doctors Induction	MST	Doctors
	13-Feb	WM	Haematology Nurses	F2F	Nurses
	17-Feb	Cross	Excellence in Care	F2F	HCSWs
	24-Feb	Cross	Corporate Welcome	MST	New Staff
Mar 2026	02-Mar	Cross	Doctors Induction	MST	Doctors
	02-Mar	Cross	Student Nurses	F2F	Student Nurses
	02-Mar	WM	Imperial Medical students Y2	F2F	Medical students
	04-Mar	Cross	Doctors Induction	MST	Doctors
	04-Mar	WM	Lampton <i>C. difficile</i>	MST	Nurses/HCA
	11-Mar	WM	Lampton <i>C. difficile</i>	MST	Nurses/HCA
	16-Mar	WM	Imperial Medical students Y3	F2F	Medical students
	17-Mar	Cross	EIC	F2F	HCA
	17-Mar	Cross	Excellence in Care	F2F	HCSWs
	18-Mar	CW	David Erskine away day	F2F	Nurses/HCA
	23-Mar	Cross	IV Administration	F2F	Nurses
	24-Mar	WM	Richmond lines and devices management	MST	Nurses
	27-Mar	Cross	ICLP	F2F	Nurses
	31-Mar	Cross	Corporate Welcome	MST	New staff

Key:

F2F = Face to Face

MST = Microsoft Teams

ICLP = Infection Control Link Professional

Obs / gyn = Obstetrics & Gynaecology

SCBU = Special Care Baby Unit

MH1 = Marble Hill 1



Appendix 7: IPCT Validation Audits Jan – Mar 2026

Table 32: Chelsea & Westminster Hospital

Month	Division	Location	HH Audit Date	HH IPC Result	HH Peer Audit	PPE Audit Date	PPE IPC Result	PPE Peer Audit
Jan	EIC	CW Nell Gwynne	05.01.26	70%	100%	05.01.26	0%	100%
Jan	EIC	CW Nell Gwynne	08.01.26	90%		08.01.26	100%	
Jan	EIC	CW Edgar Horne	08.01.26	75%	90%	08.01.26	80%	80%
Jan	EIC	CW Edgar Horne	23.01.26	80%		23.01.26	60%	
Jan	EIC	CW Nightingale	23.01.26	75%	100%	23.01.26	60%	100%
Jan	EIC	CW Nightingale	23.01.26	90%		23.01.26	40%	
Jan	EIC	CW Rainsford Mowlem	09.01.26	75%	90%	09.01.26	60%	85%
Jan	EIC	CW AAU	13.01.26	50%	95%	13.01.26	80%	90%
Jan	EIC	CW A&E	23.01.26	30%	85%	23.01.26	20%	95%
Jan	EIC	CW A&E	26.01.26	35%		-	-	
Feb	EIC	CW AAU	02.02.26	40%	95%	-	-	90%
Feb	EIC	CW AAU	17.02.26	60%		17.02.26	60%	
Feb	EIC	CW David Erskine	26.02.26	85%	95%	26.02.26	90%	90%
Feb	EIC	CW Nightingale	25.02.26	80%	Did not submit	25.02.26	80%	Did not submit
Feb	EIC	CW Nell Gwynne	26.02.26	80%	100%	26.02.26	85%	100%
Mar	WLCH	CW Mercury	03.03.26	90%	90%	03.03.26	90%	70%
Mar	EIC	CW AAU	10.03.26	50%	100%	10.03.26	80%	95%
Mar	EIC	CW A&E	12.03.26	55%	95%	12.03.26	40%	100%
Mar	EIC	CW AEC	17.03.26	35%	95%	17.03.26	80%	95%
Mar	EIC	CW Discharge Lounge	17.03.26	35%	100%	-	-	Does not participate
Mar	PC	CW Burns	20.03.26	90%	98%	20.03.26	100%	80%
Mar	PC	CW ICU/HDU Ward	30.03.26	90%	100%	30.03.26	100%	100%
Mar	SC	CW NICU	13.04.26	95%	100%	13.04.26	100%	95%
April	EIC	CW Edgar Horne	22.04.26	85%	100%	22.04.26	90%	100%
April	EIC	CW Nightingale	01.05.26	65%	95%	01.05.26	85%	95%
April	EIC	CW A&E	27.04.26	65%	95%	27.04.26	70%	100%
April	EIC	CW Paediatric ED	01.05.26	85%	100%	01.05.26	100%	100%
April	EIC	CW Rainsford Mowlem	22.04.26	80%	100%	01.05.26	95%	95%



Table 33: West Middlesex Hospital

Month	Division	Location	HH Audit Date	HH IPC Result	HH Peer Audit	PPE Audit Date	PPE IPC Result	PPE Peer Audit
Jan	EIC	WM Marble Hill 2	16.01.26	80%	100%	16.01.26	90%	90%
Jan	EIC	WM Marble Hill 1	16.01.26	55%	95%	19.01.26	60%	90%
Feb	EIC	WM Kew	09.02.26	50%	100%	09.02.26	40%	100%
Feb	EIC	WM Syon 1	10.02.26	80%	100%	10.02.26	70%	100%
Mar	EIC	WM AEC	16.03.26	50%	100%	16.03.26	70%	100%
Mar	EIC	WM Syon 1	16.03.26	30%	100%	16.03.26	90%	100%
Mar	PC	WM Cardiac Cath Lab	24.03.26	60%	100%	24.03.26	75%	100%
Mar	EIC	WM A&E	24.03.26	50%	90%	24.03.26	60%	50%
Mar	EIC	WM AMU	27.03.26	50%	100%	27.03.26	90%	100%
Mar	EIC	WM Discharge Lounge	27.03.26	75%	100%	24.03.26	100%	Does not participate
April	EIC	WM DRU	22.04.26	80%	100%	22.04.26	100%	100%
April	EIC	WM Marble Hill 1	24.04.26	69%	100%	-	-	95%
April	CS	WM Haematology / Oncology Unit	22.04.26	95%	100%	22.04.26	100%	100%
April	EIC	WM Lampton	15.04.26	90%	95%	15.04.26	90%	85%



Appendix 8: Ventilation Roles and Responsibilities Flow Chart

Provided by Joao Silva, Head of Operational Estates

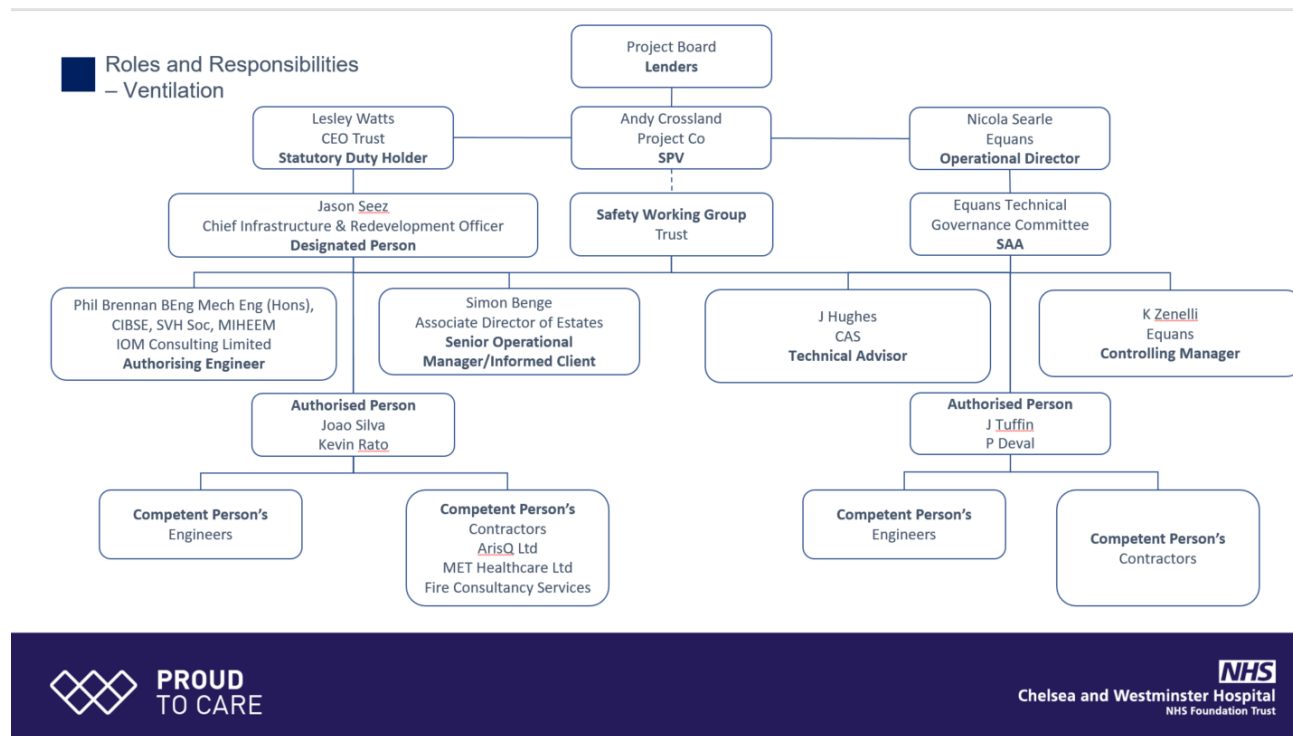


Figure 86: Ventilation Roles and Responsibilities



Appendix 9: Summary of UKHSA Alerts and Guidance

UKHSA published a number of alerts during this period which have been summarised below (newest – oldest). The IPC team cascade all updates to the clinical and executive teams for information and action, as well as through the monthly IPCG meetings. In addition, where indicated, updates are made to policies and the IPC intranet page, and the IPC team have ensured that clinical colleagues are aware of testing, PPE and management of conditions as required from the updates.

Briefing Note 2026/006: Increase in Mpox (clades Ib and IIb) in England_v01.00 (24th February 2026)

Mpox cases in England are increasing, particularly in London and the Northwest. Infections are predominantly occurring in known risk groups, notably gay, bisexual and other men who have sex with men (GBMSM). Most cases are clade IIb, however in the last 6 weeks there has also been an increase of clade Ib cases in London. Currently there do not appear to be differences between the clades in terms of severity.

In response to this, GUM, ED and clinical colleagues were updated.

UKHSA plans to reissue advice to communities most at risk, remind clinicians to remain vigilant, and improve coverage of two doses of vaccination for those eligible, who are predominantly GBMSM at higher risk of exposure.

Briefing Note 2026/004: Infant Formula and Follow-On Formula recall due to possible cereulide toxin contamination - Update 2 (12th February 2026)

This briefing note provides an update to the previous briefing notes BN 2026/001 and BN2026/002: Infant Formula and Follow-On Formula recall due to possible cereulide toxin contamination. This briefing note should be read in conjunction with the previous notes.

In response to this pharmacy, paediatric and ED teams were informed and stock reviewed. As this was not a product in stock, there was no clinical concern.

This was updated on the 09 January 2026 to include additional batch expiry dates. On 24 January 2026, Danone recalled a batch of Aptamil First Infant Formula following cereulide toxin detection in the product. On 06 February 2026, Danone further recalled 15 batches of Aptamil and Cow & Gate products (First infant, Anti-Reflux and Follow On Milk).

As of 09 February 2026, public health notifications have identified 44 probable cases from 8 regions in England (29), Scotland (10), Wales (3), Northern Ireland (1) and the UK Crown Dependencies (1). There are 9 possible cases reported in England (6), Scotland (2) and Wales (1). The median age of all cases was 5 months of age (range 6 weeks – 15 months). 23 cases were male and 20 female, 4 unknown. Cases have predominantly reported self-limiting diarrhoea and vomiting in the absence of fever. Co-infections with seasonal respiratory viruses have been noted in some cases.

Briefing Note 2026/002: Infant Formula and Follow-On Formula recall due to possible cereulide toxin contamination – Update 1 (27th January 2026)

This briefing note provides an update to the previous briefing note BN2026/001 Infant Formula and Follow-On Formula recall due to possible cereulide toxin contamination.

On 05 January the Food Standard Agency (FSA) issued a public product recall alert for Nestlé SMA (Synthetic Milk adaption) Infant Formula and Follow-On Formula, because of possible presence of cereulide. On 09



January, there was an update to the Nestlé UK recall with amendments to batch expiry dates. On 24 January, Danone recalled a batch of Aptamil First Infant Formula following cereulide toxin detection in the product.

The purpose of this briefing note is to ensure healthcare professionals are alert to the possibility of cases and are aware of the national level investigation and its association with certain formula milk products.

Briefing Note 2025/047: Increased case reporting of *Shigella sonnei*, following travel to Cape Verde (12th December 2025)

The UK Health Security Agency (UKHSA) together with partners in Wales, Scotland and Northern Ireland are investigating an increase in reports of *Shigella sonnei* across the UK, in travellers returning from Cape Verde. A total of 137 laboratory confirmed cases of *Shigella sonnei* have been reported since 1st October 2025. All isolates fall within a 10-SNP cluster [10-SNP address: 1.3.496.1102.2052.%].

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note 2025/045 MVD in Ethiopia (18th November 2025)

Marburg virus disease (MVD) is a viral haemorrhagic fever and classified as a high consequence infectious disease (HCID) in the UK. On 14 November 2025, an outbreak of MVD was confirmed in Ethiopia. MVD has not previously been reported from Ethiopia, and clinicians should now ensure that travellers from Ethiopia receive appropriate viral haemorrhagic fever (VHF) risk assessment and isolation as required.

In response to this briefing note, ED and clinical colleagues were updated and VHF PPE teaching and pathways reviewed.

Briefing Note 2025/042: Influenza A(H3N2) early season activity in England: implications for clinical practice and laboratory referral (5th November 2025)

Influenza is now circulating in the community with earlier than usual onset of activity in the 2025 to 2026 season, and with an A(H3N2) drifted strain (K, also known as J.2.4.1) predominating. A(H3N2) predominance is associated with higher morbidity and mortality, particularly in the elderly, than when A(H1N1) predominates. All eligible groups should be encouraged to get vaccinated with the 2025 to 2026 seasonal influenza vaccine as soon as possible.

Prompt antiviral post exposure prophylaxis and treatment for seasonal influenza should be offered to eligible groups. Antivirals guidance for treatment and prophylaxis of seasonal influenza has been updated – health professionals should familiarise themselves with the key updates which simplify first line recommendations, strengthen advice to support empirical treatment with neuraminidase inhibitors and diagnostic testing, and advise on the use of baloxavir marboxil.

In response to this briefing note, ED and clinical colleagues were updated, and pharmacy teams reviewed their guidelines to reflect the recommendations.

Briefing Note 2025/041: Clade Ib mpox – Community transmission in European countries and the USA (27th October 2025)

UKHSA has updated its clade I mpox risk assessment following reports of community transmission of clade Ib mpox in European countries (Spain, Portugal, the Netherlands, Italy) and the USA for the first time. This development differs from previously reported travel-associated clade Ib mpox cases between UKHSA Briefing Note: 2025/041 Issued: 27/10/2025 2



In response to this briefing note, GUM, ED and clinical colleagues were updated.

Briefing Note 2025/040: Removal of the restrictions on ordering BCG vaccine via ImmForm (27th October 2025)

Following on from previous briefing note (BN2025/038), the restrictions that were placed on ordering BCG vaccine have been lifted.

In response to this briefing note, TB, pharmacy and clinical colleagues were updated.

Briefing Note 2025/038 Delayed supply of BCG vaccine and temporary restriction of ordering via ImmForm (13th October 2025)

UKHSA has been informed by the sole supplier of BCG vaccine that is licenced for use in the UK that a delivery has been delayed for administrative reasons. This may lead to delay to the infant BCG programme, occupational health BCG vaccination and other indications for BCG as outlined in the Green Book should rescheduled deliveries not occur in time.

In response to this briefing note, TB, pharmacy and clinical colleagues were updated.

Briefing Note 2025/032: Cluster of Legionnaires' disease cases associated with Planet Hollywood in Cancun, Mexico (28th July 2025)

Cluster of Legionnaires' disease cases associated with Planet Hollywood in Cancun, Mexico.

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note 2025/031: National Standard Measles Incident: Measles epidemiology and recommended control measures (17th July 2025)

UKHSA declared a national standard incident response for measles on 10 July 2025 to oversee the risk assessment and public health response to the increase of measles cases in England and coordinate the multi-agency input to the response nationally with the aim of limiting further spread.

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note 2025/029: Iatrogenic botulism associated with cosmetic botulinum toxin injections v1.0 (18th July 2025)

UKHSA has been notified of several individuals with iatrogenic botulism linked with cosmetic procedures across England, including one large outbreak in the Northeast. The purpose of this communication is to ensure healthcare professionals are aware of the ongoing cases, the national level investigation and its association with certain brands of botulinum toxin.

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note 2025/028 Update on infection with non-toxigenic *C. diphtheriae* involving people experiencing homelessness and with substance use in England (21st July 2025)

In a briefing note, 10th February 2025 (BN2025/006), we reported five cases of non-toxigenic *C. diphtheriae* presenting with fulminant infective endocarditis (IE), with one fatality, in England between July 2024 and



January 2025. The cases were predominantly in people experiencing homelessness who were known to use drugs. The severity of clinical presentation and apparent clustering of cases was unusual.

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note 2025/027 Update on the epidemiology of toxigenic diphtheria in asylum seekers arriving to England 2025 v1.0 (17th July 2025)

This is an update to BN 2024/037.

An increase in cases of diphtheria caused by toxigenic *C. diphtheriae* among asylum seekers arriving by small boat to England was initially noted in the summer of 2022, mirroring a similar increase across a number of European countries.

Between 1st January 2022 and 30th June 2025, 87 confirmed cases and one probable case have been reported. Most cases were identified in 2022 (n=73), with 13 cases in 2023, no cases in 2024 and 2 cases reported in 2025 (to end June). Cases originate from diphtheria endemic countries but are considered likely to have acquired their infection during their long journeys to the UK.

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note 2025/022: Human rabies infection following animal exposure abroad (18th June 2025)

UKHSA has been notified of several individuals with iatrogenic botulism linked with cosmetic procedures across England, including one large outbreak in the Northeast. The purpose of this communication is to ensure healthcare professionals are aware of the ongoing cases, the national level investigation and its association with certain brands of botulinum toxin.

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note 2025/020: Cluster of Legionnaires' Disease cases associated with the Hotel Partner & Spa, Vlorë, Labëria region, Albania (10th June 2025)

Cluster of Legionnaires' Disease cases associated with the Hotel Partner & Spa, Vlorë, Labëria region, Albania.

In response to this briefing note, ED and clinical colleagues were updated.

Briefing Note - 2025/019 Pilgrims returning from the Hajj/Umrah: Middle East Respiratory Syndrome coronavirus (MERS-CoV) and invasive meningococcal disease (IMD) (2nd June 2025)

The Hajj is taking place in the Kingdom of Saudi Arabia (KSA) from 04 to 09 June 2025. This is the annual Islamic pilgrimage to Mecca and many pilgrims from around the world are expected to travel there, including from the UK. Millions also travel to KSA throughout the rest of the year to undertake Umrah pilgrimage. In response to this briefing note, ED and clinical colleagues were updated, and MERS policy recirculated.



Appendix 10: Publications 2025-26

Poster submitted to ECCMID April 2025

A qualitative review of infection prevention and control teaching in undergraduate medical students, perceptions, influences and behaviours

Nabeela Mughal (1, 2), Jo Horsburgh (2).

(1) Chelsea and Westminster NHS Foundation Trust - London (United Kingdom), (2) Imperial College London - London (United Kingdom) - London (United Kingdom)

Poster submitted to ECCMID April 2025

Optimising training and concordance to alcohol-based hand rub hand-hygiene using digital health technology image analysis.

Nabeela Mughal (1), Zara Tzouros (1), Magno Castillo (1), Alice Heath (1), Jose Paulo Flor (1), Joella Lucas (1), Stacey Clarke (1), Sheeba Pothen (1), Mario Olivar (1), Maia Dineen (1), Luke Moore (1, 2), Sarah Denny (1), Hugo Donaldson (1).

(1) Chelsea and Westminster NHS Foundation Trust - London (United Kingdom), (2) Imperial College - London (United Kingdom)

Poster submitted to FIS/HIS December 2025

Evaluating the role of a digital decision support system in managing clinical *Clostridioides difficile* infection (CDI) in acute hospitals.

A.E. Heath, J.P. Flor, M. Dineen, S. Pothen, J. Lucas, M. Olivar, Z. Tzouros, S. Clarke, M. Castillo, G. Agusiobo, L.S.P. Moore, S.J. Denny, H. Donaldson, N. Mughal
Chelsea and Westminster NHS Foundation Trust

JHI 2025

Travel-associated carbapenem-resistant organisms at a time of increasing geopolitical instability: a UK perspective

Captain Scott Pallett, Sara E Boyd, PhD; Aakash Khanijau, MRCP; Rishi Banerjee, MRCP; Nicola Reece, MRCP; Sarah Jawad, FRCPath; Victoria Daniel, MSc; Matthew Routledge, FRCPath; Harin Navalain, MRCP; Christopher Ward, FRCPath; Kordo Saeed, MD; Jonathan Lambourne, PhD; David A Enoch, FRCPath; Gabriella Shanks, MRCP; James Cai; Anna Wild, MRCP; Nikunj Mahida, FRCPath; Heather Hiles, MRCP; Helena Parsons, FRCPath; Maya Tickell-Painter; Robert Shorten, PhD; Vino Srirathan, FRCPath; Joe Suich; Deborah Wearmouth, FRCPath; Rishi Dhillon, FRCPath; **Nabeela Mughal**, FRCPath; Matthew K O'Shea, DPhil; Stephen D Woolley, MD; Luke SP Moore, PhD

Manuscript Number: JHI-D-25-00839R1

JAC-AMR-2025-327.R1

Exploring UK medical schools' perception and intent for teaching on antimicrobial resistance and stewardship

Author(s): Lambert, Zoe; Weeks, Simonne; Dissanayake, Oshani; Boyd, Sara; **Mughal, Nabeela**; Moore, Luke; Pallett, Scott

Paroikaki M*, Navalain H*, Pallett SJC, Mughal N, Davies F, Alqhatani SA, Moore LSP. Extended susceptibility testing for refractory *Helicobacter pylori* infection: regional testing should guide antimicrobial decision making. BMC Infect Dis. 2026; [InPress]



Lancet May 2024, Evolving antimicrobial resistance of extensively drug-resistant Gram-negative severe infections associated with conflict wounds: an observational study in Ukraine, 2024

Scott JC Pallett*,^{1,2} Anna Morkowska*,³ Stephen D Woolley,^{2,4,5} Viktoria V Potochilova,^{6,7} Kateryna L Rudnieva,^{6,8} Olga S lungin,^{6,9} Vincenzo Sgro,³ Sara E Boyd,^{10,11} Nicola Reece,² Zoe L Lambert,¹² Ngee Keong Tan,¹¹ **Nabeela Mughal**,^{1,3} Olena V Moshynets*,⁶ Luke SP Moore*,^{1,3,13}, Matthew K O'Shea*

Singhal A, Nurek M, Lau T, McEntee J, Moore LSP, **Mughal N**, Mason S, Vizcaychipi M, Singh S. Infection Point of Care Tests (POCT) in simulated vignettes can improve the education of Antibiotic Stewardship Programmes. An observational comparative study of Clinicians vs Medical Students. *J Antimicrob Chemother.* 2026; [InPress]

Wagner AP, Enne VI, Gant V, Stirling S, Barber JA, Livermore DM, Turner DA, **INHALE WP3 Study Group**. Cost-effectiveness of rapid, ICU-based, syndromic PCR in hospital-acquired pneumonia: analysis of the INHALE WP3 multi-centre RCT. *Critical Care.* 2025;29:352. PMID:40781331.

Enne VI, Stirling S, Barber JA, High J, Russell C, Brealey D, Dhesi Z, Colles A, Singh S, Parker R, Peters M, Cherian BP, Riley P, Dryden M, Simpson R, Patel N, Cassidy J, Martin D, Wlter ID, Page V, Kandil H, Tudtud E, Turner D, Horne R, O'Grady J, Swart AM, Livermore DM, Gant V, **INHALE WP3 Study Group**. A multicentre randomised controlled trial assessing the impact of rapid, ICU-based, syndromic PCR on antibiotic stewardship and clinical outcomes in hospital-acquired and ventilator-associated pneumonia. *Intensive Care Med.* 2025;51(2):272. PMID: 39961847