Annual Infection Prevention & Control Report

1 January 2024 – 31 December 2024

Executive Summary This report provides a detailed account of Infection Prevention and Control activities across all services delivered by Here throughout 2024. The focus remains on safeguarding patient and staff health, ensuring compliance with legal and clinical standards, and promoting a culture of continuous improvement.

Key Highlights:

- *Service Structure Evolution:* With the closure of the Vaccination Service in 2023, IPC efforts were concentrated on the Sussex MSK Partnership (MSK), Memory Assessment Service (MAS), and Additional Primary Care (APC).
- *Governance Transition:* Responsibility for IPC leadership shifted towards improved integration within clinical services, ensuring broader ownership and continuity. This will continue in 2025, with further assurances and improvements.
- *Performance:* IPC training compliance exceeded targets. IPC policies remained current. A proactive response was conducted in relation to the emergence of MPXV clade 1, including PPE training and fit testing. Audit schedules and documentation consistency require enhancement. All 17 clinical sites completed IPC site assurance by early 2025. Areas for improvement were identified in audit, signage, cleanliness, stock control, and sharps management. Action plans were created for focused IPC improvements in 2025. Adherence to Health and Social Care Act 2008 Code of Practice was confirmed across applicable criteria.

Recommendations and Next Steps:

- **Approve and publish** the 2024 IPC report.
- **Support proposed improvements** for 2025, including standardising audit practices, refining site assurance processes, confirming new IPC leads per service, and enhancing visibility of IPC risks and responses.

Purpose: To provide the Board with:

- An overview of the Infection Prevention and Control arrangements within the organisation during 2024
- An update on the agreed improvements from the previous annual report 2023
- A summary of the successes and highlights over the last year
- A summary of what we are looking to improve upon over the next 12 months
- Assurance that the infection control arrangements effectively protect patients from healthcare acquired infections and staff from workplace infection hazards
- Assurance on compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance

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For Board May 2025

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1 Introduction

The aim of this report is to provide information and assurance to the board that the Infection Prevention and Control (IPC) measures and structures in place are compliant with current legislation and align with best practice to protect patients and staff from the risk of infection.

The report covers the period 1st January– 31st December 2024 and specifically provides IPC activity information in relation to the services delivered by Here.

2 Updates to Infection Prevention and Control

In 2024, our clinical services included Sussex MSK Partnership (MSK), MAS (Memory Assessment Service) and APC (Additional Primary Care). Our vaccination service ended in November of 2023; thus is therefore no longer captured in this report.

Here's IPC policy remained in date throughout this reporting period, providing clear IPC guidance to our services.

We moved towards a more integrated structure of governance and reporting in 2024, with reduced reliance on a single IPC lead moving towards greater accountability within respective services.

3 Infection Prevention and Control Assurance Structure

3.1 IPC Structure and Responsibilities

In 2024, our IPC lead role was held by our ANP Clinical Lead with the support of service clinical leads.

IPC reports into our wider governance structure, accountable to the Director of Primary Care and the Here Board. IPC incidents and site assurance audits are supported by governance coordinators or quality improvement officers within each service.

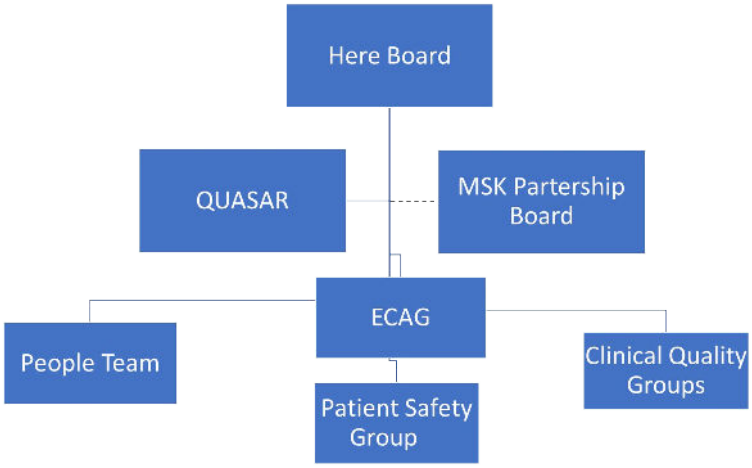
All service managers and clinical leads within each service have a responsibility to raise IPC concerns and to support others in the teams to raise concerns, log incidents and escalate appropriately. Individual service leads and governance coordinators ensure that learning is shared effectively within the teams and shared as appropriate.

It is important to note that IPC is not just a clinical concern but is relevant to all services provided by Here and requires us all to take action as needed.

Here IPC team links directly with IPC colleagues in both Sussex Community NHS Foundation Trust (SCFT) and the Sussex Integrated Care Board (ICB) as appropriate. The team provides advice and support across the organisation, taking a proactive approach to communications and shared learning and encouraging all staff to raise concerns as they arise.

3.2 Monitoring

Infection Prevention and Control incidents are monitored internally by the individual service governance leads and reported within service CQG meetings and Patient Safety Group (PSG) to take learning, generate action plans and reduce risk. The Exceptional Care Assurance Group (ECAG) holds oversight for compliance and learning. All risks are closed via the appropriate CQG on a monthly or bi-monthly basis and are outlined in individual service quality reports. Anything requiring further escalation is taken to Quasar and MSK Partnership Board for visibility and support. Quality reporting is undertaken quarterly to the Here Board.



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Each service maintains a risk register which is monitored by service leads. Risks that have moderate to high ratings, are ongoing or require support are escalated into Quasar monthly for visibility and assurance.

3.3 Additional Assurance Mechanisms

Here uses the following mechanisms to prevent against health care acquired infections, and to identify and address any issues that may arise:

- ***Policy Guidance*** Aligning to an up-to-date infection control policy which is accessible to all staff (see section 5.2)
- ***Training*** All staff are required to have relevant immunisations prior to starting work with Here relevant to their role and in line with the guidance as cited in the Green Book. This is recorded within staff files and is up to date for all staff.

  Providing annual training relevant to role is essential. All clinical staff are required to undertake level 1 and level 2 annual infection control training, which is nationally approved and designed for community-based health settings. Non-clinical staff who regularly work in health care settings are required to undertake level 1 infection control training

  We monitor training closely to ensure that at least 85% of our staff are up to date with their infection prevention training. Staff are supported with protected time to complete this training, and progress is reviewed regularly to make sure standards remain high.

- ***Reporting*** All IPC incidents and near misses are reported using Datix and follow the procedure as outlined in the current policy. All staff should be aware of the incident process and the need to escalate and log incidents relating to IPC.

  Following transition to PSIRF, incidents that result in a patient safety incident as defined in our Patient Safety Incident Response Plan (PSIRP) are reportable to NHS England via our incident reporting system.

- ***Patient information*** Providing up-to-date information for service users to reduce risk of infection following invasive procedures carried out as part of an agreed treatment plan

- ***Site Assurance*** Completing annual site assurance audits and action plans. Here has a centralised Site Assurance Matrix which lists all sites that are used for the delivery of its services. The Site Assurance Matrix is monitored centrally and overseen by the individual services whose responsibility it is to ensure visits and actions plans are completed in a timely fashion. All clinical services have completed an infection control risk assessment for each site and measures taken to reduce the risks as described in the Infection Control Policy.

- ***IPC Audit & Risk Assessment*** Completing appropriate IPC audits and ad hoc IPC risk assessments to ensure safety and compliance and generate action plan

- ***Staff Risk Assessment*** Carrying out individual staff risk assessments as needed to support staff health and wellbeing. These risk assessments are used to recommend reasonable adjustments to the work environments and work patterns on a short- or long-term basis

- ***Medical Devices Management*** Managing the Medical Devices Matrix, which lists all devices used within each service. The matrix clearly details who owns/is responsible for the device and therefore responsible for maintenance and cleaning or decontamination in order to control the risk of infection. The matrix also lists all single use medical devices used by the service so that any relevant alerts related to such equipment can be addressed promptly.

3.4 Policies and Procedures

The Infection Prevention and Control Policy supports staff in adopting best practice and outlines the arrangements in place to support this for the protection of both patients and staff.

Our policy guidance is aligned with standard infection control precautions (SICPs).These precautions ensure the safety of those being cared for, including staff and visitors. SICPs represent the basic IPC measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. There are 10 SICPs outlined in the National Infection Prevention and Control Manual: NHS England » Chapter 1: Standard infection control precautions (SICPs)

4 Infection and Prevention Performance Data 2024

4.1 Service Level risk assessment and residual risk

IPC is important in all healthcare services, and we recognise that the level of potential exposure and risk varies considerably.

Each Here service reviewed their infection control risk assessment in 2023 and identified the residual risk relating to the activities undertaken. No changes to delivery or risk were escalated in 2024. For 2025, it would be prudent to align the annual review of IPC activity and risks with our insurance reporting to avoid duplication of work.

The residual risk is the likelihood of potential harm as a result of infection after all mitigations in the infection control procedures have been put in place.

Service	Residual risk	Rationale
MSK	Low to Moderate	Procedures: some minor invasive procedures, mainly injections which could lead to needle stick injuries or injection site infections. High volume of patients. Whilst the Partnership is responsible for the MSK programme budget including invasive surgery, Here is not responsible as a health care provider for surgical activity in secondary care. Health care acquired infections associated with surgery are monitored as part of subcontracts with secondary care providers. Sussex MSK Partnership is responsible for podiatric surgery, which is carried out in the community, but the governance sits with Sussex Community NHS Foundation Trust. ***Note: from December 2024, MSK entered a new contract that necessitates a new risk assessment as level of activity will change post-mobilisation (in 2025). This will be captured in action log.***
MAS	Very Low	No invasive procedures
APC	Moderate	Procedures: Physical assessment including rectal and vaginal exams. Pathology investigations including urine samples, faeces samples and swabs. Minor wound care.

4.2 Complaints

There were no IPC complaints raised in 2024.

4.3 Incidents

Our incident reporting system is configured to enable reporting for IPC incidents. The annual audit identified **no** infection control incidents over this period.

Historically, our IPC incident rate has been low proportionate to the size of our services. However, there is a risk that the lack of incidents identified in our system is related to underreporting.

Internal training delivered in 2023 demonstrated a positive impact on awareness and reporting rates for 2024. It is advisable to engage with a re-training program in our services about reporting of IPC incidents.

4.4 Ad hoc Risk Assessment(s)

Here undertook an IPC risk assessment in October 2024 related to the emergence of MPXV clade 1 in England as per issued guidance. This allowed us to improve our preparedness in APC, an unscheduled care environment, to better understand national and regional guidance, assess our current mitigation and residual risks and carry out an action plan.

To ensure staff were able to safely use PPE, our Contract and Compliance Officer completed respirator fit training, and we offered FFP3 fitting (and issuing of masks) for APC team as well as our wider organisation. This training also included learning around compliance of PPE and donning and doffing coaching for staff. All GP's working in APC were offered fit tests and coaching, and staff from other teams were able to self-identify if they were at risk

4.5 Site Assurance Audits

Annual site assurance visits were undertaken by a trained designated person in MAS and MSK. Our APC service reported annual site assurance was delayed from September 2024 to January 2025 due to absence within the team. This was added to the risk register, re-delegated and ultimately completed in January 2025.

Of our 17 clinical sites, 9 were completed in 2024 with the remaining 8 delayed either due to issues with capacity or training needs. All sites are now complete and in date.

Our site assurance audits identified that most of our staff have a good awareness of procedures and policies. There was also a high level of awareness of who to speak to in an emergency.

Opportunities for improvements were also identified:

Quality of Assurance and update of actions between routine inspections We have a robust template for annual site assurance that identifies strengths and areas for improvement. However, action planning and audit should be embedded between annual cycles.

Over the next 6 months ECAG will explore how we can follow the thread of site assurance throughout the year. Having built the service capacity to complete site assurance, our aim is to achieve a more consistent approach and support services to make issues raised in site assurance documents more visible. We will do this by:

- Having a standing agenda item at ECAG to look at the quality of reporting and common themes

- Having a clear benchmark of what is exceptional in terms of site compliance and what to do when something requires improvement
- Reporting to Quasar and service managers when sites fail inspection and the reasons why
- Creating clearer action plans around areas of improvements with timeframes proportional to the level of risk an issue creates
- Creating clear lines of escalation when issues are not able to be resolved
- Supporting services to log risks raised by site assurance on service risk registers to keep them visible within service BAU
- Creating a site pack with information and posters commonly needed in a clinical environment and sharing this information via comms, SharePoint and Teams policy channel Procedures, policies and escalation points.

Signage and posters Signage and access to standard IPC information could be more consistent. For clinical sites, the following information is recommended to be displayed in appropriate areas:

- Handwashing procedure and reminder
- Clinical waste procedure
- Sharps and stick injury advice as well as information about when a sharps bin was installed and when it should be disposed of

Over the next 6 months we will be looking to collate and review the most recent versions of the above information into a ‘site information’ pack. These can be shared with staff digitally as well as printed and laminated and placed in clinic rooms.

Repairs and cleanliness Levels of maintenance and cleanliness reported across sites should be more consistent, with clear action planning where concerns arise.

In cases where there is visible dirt and contamination, a site cannot be considered to have passed inspection. Feedback must be given on the day of the visit with a request that IPC concerns are rectified with timely attention.

We recommend sites should then be given an agreed period to resolve the issue before the site assurance is repeated. In these instances, it would only be the areas of concern which would need to be re-checked. Individual instances will be raised with service managers, within service governance forums such as ECAG and Quasar.

Stock control and medicine checks Improved processes and oversight of stock control would be beneficial. ECAG will be raising this as a standing agenda item, along with FP10 storage and audit. We will also be asking services to clearly identify who is responsible on site for stock control and working with services to explore how we may do this better through ECAG.

Sharps Information about sharps procedures should be consistently available.

This information will be included in the 'site pack' of posters, and where it cannot be placed on walls, it will be sorted with sharps bins or in injection kits.

ECAG will be looking to follow up with services to engage with colleagues around whether further training or reminders are needed for sharps management. We will also be supporting services to have conversations with site contacts about ensuring correct usage and disposal of sharps bins is followed in areas where this has been raised.

4.6 Additional IPC Audits

Service leads in MAS and APC reported no additional IPC audits undertaken in 2024. APC identified a need for hand hygiene assurance and launched an in May of 2025.

MSK reported no IPC audits for which Here holds responsibility; however, it is reported that hand hygiene audits are undertaken across some aspects of the service and by our partner organisation. Podiatric surgery also collect data for MRSA screening and antibiotic prescribing.

Pathways to ensure audit consistency, collation and storage, would benefit from dedicated improvement in 2025. An action to address this has been noted.

4.7 Training

Threshold for compliance is 85%.

	ALL HERE STAFF IPC Level 1				CLINICIANS IPC Level 2			
	2021	2022	2023	***2024***	2021	2022	2023	***2024***
	85%	**83%**	**85%**	***97%***	**85%**	**82%**	**85%**	***91%***

Training was carefully monitored and upheld across 2024 owing to an increased focus organisationally by the People team to support training standards and performance.

4.8 Medical Devices Management

The medical devices policy was reviewed and updated in 2024. The list of medical devices used by Here clinical services was also updated as part of this work.

5 IPC Compliance Standards Assurance

As a registered provider of healthcare, Here is required to align to the code of practice for the prevention of infection which sets out the 10 criteria against which all providers are monitored. It is accepted that not all criteria will apply to every regulated activity. Health and Social Care Act 2008: code of practice on the prevention and control of infections - GOV.UK

The 10 criteria which organisations such as Here must adhere to are detailed below and has been reviewed for 2023/2024:

1. Systems to manage and monitor IPC. These use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them		
Criteria	**Met?**	**How do we meet this criterion?**
The provider has a clear governance structure and accountability that identifies a lead for IPC	Yes	See above section for the governance structure. The IPC named lead will change to the from ANP following role holder's departure in early 2025.
There is an IPC programme in place which should say as a minimum what: • IPC measures are needed • Policies, procedures and guidance are needed and how they will be kept up to date and monitored for compliance • Initial and ongoing training staff will receive, where appropriate	Yes	IPC measures are identified within the organisational policy and is reviewed every 2 years or where there is a change to national guidance which has been overseen by the IPC Lead. Here has an up-to-date IPC policy. The IPC measures required are identified in the IPC policy. Here disseminates all new policies via the sharepoint platform which enables Here to monitor when a new policy has been viewed by individual staff members. Whilst the platform cannot monitor whether a policy has been fully read, the critical information is that staff are aware that it has been updated and know where to find it for reference as needed. All staff are expected to complete level 1 infection control training with clinicians completing level 2 on an annual basis with new starters completing training within the first 6 weeks.
An annual report is provided for anyone who wishes to see it, including service users and regulatory authorities which should be prepared by the designated IPC Lead or delegate. This should provide a short review of any: • IPC incidents and actions as a result • Audits undertaken, as part of a quality improvement programme, and subsequent actions implemented • Risk assessments undertaken and any actions taken and	Yes	Here produces an annual IPC report which is available publicly and is shared on our organisational website.

recorded for prevention and control of infection • Education and training received by staff • Review and update of policies, procedures and guidance • Antimicrobial prescribing and stewardship		
2. Provide and maintain a clean and appropriate environment in managed premises to facilitate the prevention and control of infections		
Criteria	**Met?**	**How do we meet this criterion?**
That providers have a designated individual responsible for the oversight and management of cleaning on Here sites.	Yes	This is held by the People Team and Facilities Team with oversight reporting into Quasar
All parts of the premises from which the organisation provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition.	Yes	All sites that Here operates out of are subject to annual site assurance visits appropriate to the level of infection risk with action plans resulting. IPC risk assessments are undertaken for all new sites or where a new service is being delivered from an existing site. Any IPC concerns identified during the site assurance process is escalated to either the service Clinical Quality Group (CQG) and/or IPC Lead. Where risks are considered significant a specific risk assessment in undertaken with an action plan to address the concern. All sites have adequate provision of suitable hand-washing facilities and products. Cleaning schedules are in place at all sites and align to Control of Substances Hazardous to Health (COSHH).
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance		
Criteria	**Met?**	**How do we meet this criterion?**
Providers should be able to demonstrate that prescribing clinicians are able to diagnose and treat effectively common infections and document allergy status, reason for antimicrobial prescription, dose, route and duration of treatment.	Yes	This relates to our primary care services only and is monitored through supervision and documentation audits which are completed routinely in APC.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion		
Criteria	**Met?**	**How do we meet this criterion?**
Providers should make information available about their approach to prevention and control of infection, staff roles and responsibilities, and who people should contact where there are concerns about prevention and control of infection.	Yes	**Services users are able to raise concerns via our website or directly via telephone, email or letter. All feedback from services users is managed internally by the individual teams and recorded either as feedback, concerns/complaints or incidents using the Datix system.** Staff are able to raise IPC concerns directly through their line management or to any member of the leadership team. Staff raise and log IPC incidents using the Datix system. Feedback regarding IPC concerns are generally completed through staff 1:1s and where shared learning is considered appropriate, via Clinical Quality Meetings, Operational Service Meetings and ECAG. IPC risks are also identified through the annual site assurance process. *Improvements in maintaining assurance throughout the year are needed and will form part of action plan for coming year.*
5. Ensure that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people		
Criteria	**Met?**	**How do we meet this criterion?**
The primary medical care practitioner will provide initial advice and treatment when a service user under their care develops an infection, and will assess any potential communicable disease control issues.	Yes	Assessed through Datix incident reporting themes and individual cases resulting in harm. Following national and local IPC guidance and procedures identified within the organisational IPC policy. *Note* *Our Infection Prevention and Control policy is being updated in 2025 to ensure it reflects the latest guidance and changes in our services*
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and		

controlling infection		
Criteria	**Met?**	**How do we meet this criterion?**
The registered provider must ensure that every person working in the practice, including agency staff, locum staff, support staff, external contractors and volunteers, understand and comply with the need to prevent and control infections, including those associated with invasive devices.	Yes	Our training matrix identifies the need for all staff to complete level 1 IPC training as part of their onboarding – the guidance specifically refers to contractors and agency staff whose responsibility it is to complete the training ahead of starting in post or soon after starting. Here accepts IPC training completed at other healthcare organisations. Where this is not possible, service managers are asked to complete a risk assessment.
7. Provide or secure adequate isolation facilities. See note.		
Criteria	**Met?**	**How do we meet this criterion?**
Primary medical care facilities do not require dedicated isolation treatment rooms but are expected to implement reasonable precautions when a service user is suspected or known to have a transmissible infection.	Yes	Staff are expected to follow the procedure as outlined in the IPC policy
8. Secure adequate access to laboratory support as appropriate. See note.		
Criteria	**Met?**	**How do we meet this criterion?**
Primary care services should have access to a diagnostic microbiology and virology laboratory service.	N/A	This is provided via the practices/sites directly and is the responsibility of the practices/sites to maintain adequate access.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections		
Criteria	**Met?**	**How do we meet this criterion?**
See assurances and points in annual reporting in relation to policies, risk assessment and training.		
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection		
Criteria	**Met?**	**How do we meet this criterion?**
Risk assessments of need should be carried out for immunisation as described in 'Immunisation against infectious disease' (the 'Green Book')	Yes	All new staff are required to provide evidence of sufficient immunisations relevant to their role and in line with the recommendations laid out in the Green Book ahead of starting in post. All new staff undergo an occupational health

Access to an occupational health service should be available.		screen prior to starting.
Providers should hold an up-to-date record of relevant immunisation status.	Yes	Here staff files contain confidential information relating to immunisation status of all staff. Where this has been waivered, a completed risk assessment is also held on file.

6 Key Findings and Recommendations

Objectives set for 2023 have been outlined below with commentary regarding the status of progress in completing each objective. Any objectives not met have been carried forward into our 2024 improvement plan and are noted below.

6.1 Review of Objectives for previous period

Objective	Status	Update
2023 findings and action plan		
Create standardisation within the incident reporting process in terms of use of categories to enable more efficient visibility of IPC incidents across the organisation.	In progress	IPC reporting is fully enabled in Datix. Datix is in final stages for aligning with PSIRF reporting; however, we were able to manage this with a mitigation in 2024 whilst awaiting full functionality of Datix, which is scheduled to be complete by end of Q1 2025.
Review of the medical devices policy and update of medical devices list used by Here clinical services.	Completed	The medical devices policy and inventory was updated in 2024.
Maintain 2023 IPC training compliance levels		

6.2 Findings and Recommendations from this report

Objective	Status	Update
2024 findings and action plan		
Identify and/or confirm IPC lead organisationally and within each service to provide required ongoing assurance about our sites, escalate any changes in activity and act as a point of contact for clinical IPC and quality issues such		

as needlestick injuries, risk assessments etc		
Understand new MSK IPC structure congruent to new contract from Dec 2024. Here and SCFT both have various visits and site assurance frameworks. Need confirmation of IPC accountabilities and functions.		
Standardise agenda items for ECAG to provide needed assurance around IPC, most notably for timely site assurance completion and compliance between annual audits.		
Review IPC audit requirements and schedules in clinical services. Spot and interim audits may be required to provide needed assurance around cleanliness, sharps, stock management and signage/posters.		
Improve consistency and centralise storage of evidence for audits		
Align annual risk assessment process in clinical services with insurance review to avoid duplication of tasks		
Cross check IPC policy guidance to ensure that people who have or are at risk of developing an infection are identified promptly and receive		

the appropriate treatment and care to reduce the risk of transmission of infection to other people, in line with local and national guidance.		
Review Site Assurance documentation considering changing service requirements and ensure it is fit for purpose, specifically alongside SCFT IPC inspections and changes in APC.		