Annual Infection Prevention & Control Report **1 January 2025 – 31 December 2025**

Executive Summary This report provides a detailed account of Infection Prevention and Control (IPC) activities across all services delivered by Here throughout 2025. The focus remains on safeguarding patient and staff health, ensuring compliance with legal and clinical standards, and promoting a culture of continuous improvement.

Service Structure Evolution IPC activity focused on the Memory Assessment Service and The Dementia Clinic Sussex throughout the year, and Additional Primary Care until closure in June 2025. Sussex Community Foundation Trust (SCFT) assumed CQC registration for Sussex MSK Health (SMSKH). Under this partnership arrangement, IPC incidents, risks, complaints, and audit data are reported through SCFT governance structures, with Here supporting delivery through compliance with SCFT reporting requirements.

Performance: The organisation maintained effective and proportionate IPC arrangements, providing clear assurance that statutory and regulatory requirements continue to be met. IPC governance remains well integrated within the organisational quality framework. Key achievements include:

- Residual IPC risks remained low to moderate across all services, with no reported IPC incidents. One informal complaint was received and effectively managed.
- Strong training compliance, with IPC Level 1 at 94% and Level 2 at 91%.
- Completion of annual IPC site assurance audits across all services, with improved audit capacity and consistency following staff training and strengthened oversight.
- Resolution of policy access issues through full migration to SharePoint, improving accessibility and reliability for staff.
- Quarterly IPC audits (e.g., hand hygiene) reported through SMSKH and MAS governance structures.

Areas for Improvement*:* Review of IPC assurance identified the following opportunities to shape the organisation's quality and improvement focus for 2026.

- Policy guidance and signposting
- Estates repairs
- Medical devices register management

Recommendations for 2026:

- Develop a dedicated chaperone policy and training offer aligned with national guidance.
- Signpost staff to approved policy matrix for SMSKH following organisational transition. Link with SMSKH partnership to support estates repairs, audits, site assurance actions through the year.
- Embed training opportunities to identify and log IPC incidents and near misses.
- Strengthen medical devices register processes and training.

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1 Introduction

This report provides assurance to the Board that Infection Prevention and Control (IPC) arrangements across the organisation remain compliant with statutory requirements and aligned with national best practice (see Appendix i). It outlines the structures, processes and activities in place to safeguard patients, staff and visitors from infection-related risks.

The report covers the period **1 January – 31 December 2025** and includes IPC performance, risks, incidents, and quality-improvement activity across all Here services.

2 Updates to Infection Prevention and Control

During 2025, our CQC-registered clinical portfolio included the Memory Assessment Service (MAS), The Dementia Clinic Sussex (TDC), and Additional Primary Care (APC) until its closure in June. In addition, we worked in partnership with Sussex Community Foundation Trust (SCFT) to deliver Sussex MSK Health (SMSKH), for which SCFT held the CQC registration. As part of this partnership, we were responsible for providing quality assurance to SCFT for relevant IPC governance.

The organisation's IPC Policy was comprehensively reviewed and updated in May 2025, ensuring that guidance reflects current national standards and operational needs. The next full review is scheduled for May 2027, or earlier if national or local recommendations change.

For SMSKH teams, a policy matrix was developed and approved through the SMSKH governance structure, providing clear policy guidance for the partnership.

3 Infection Prevention and Control Assurance Structure

3.1 IPC Structure and Responsibilities

In 2025, organisational responsibility for IPC was held by the Director of Operations**,** supported by the Contracts & Compliance Officer, clinical and operational service leads, and governance coordinators.

IPC forms a core component of our governance framework, with accountability through the Director of Operations to the Here Board. Oversight is supported by the Contracts & Compliance Officer, clinical and operational service leads, and governance coordinators who support incident management, site assurance processes and dissemination of learning. IPC is recognised as an organisational responsibility, not solely a clinical one.

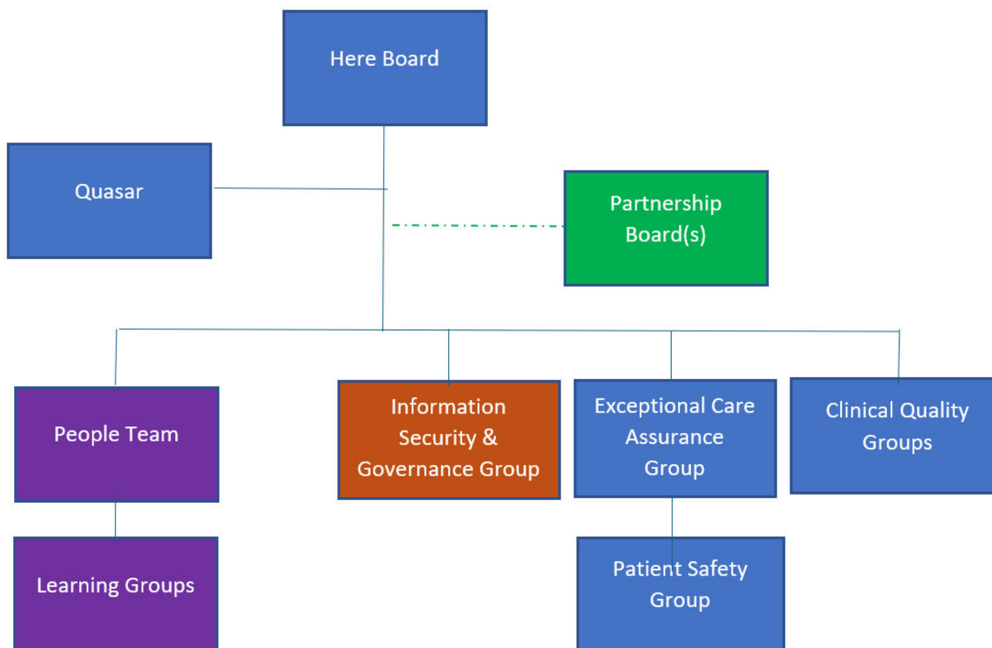
The IPC team maintains direct links with IPC specialists within SCFT and the Sussex Integrated Care Board (ICB)**.** These partnerships strengthen clinical oversight, shared learning and access to expert advice.

3.2 Monitoring

IPC incidents are monitored by service-level governance leads and reported to Clinical Quality Group (CQG) meetings and the Patient Safety Group (PSG). These forums review learning, oversee action plans and ensure risks are mitigated appropriately. SMSKH undertakes monthly reporting via their governance processes.

The Exceptional Care Assurance Group (ECAG) provides system-wide oversight of IPC compliance and organisational learning. Risks are reviewed, monitored and closed through CQG meetings on a monthly or bi-monthly basis, with escalation to Quasar or the MSK Partnership Board where necessary. Quarterly quality reports provide assurance to the Here Board.

Each service maintains a risk register. Any IPC risks assessed as moderate or high, or requiring organisational support, are escalated into Quasar monthly.



3.3 Additional Assurance Mechanisms

The following mechanisms support proactive IPC risk management and the prevention of healthcare-associated infections:

Policy Guidance: Staff have access to an up-to-date IPC Policy aligned with current NHS and national standards.

Training: Staff are required to have role appropriate immunisations (as per the Green Book), evidenced in staff files. Clinical staff complete **Level 1 and Level 2 IPC training** annually; non-clinical staff working in healthcare settings complete Level 1. Compliance is monitored closely to maintain a minimum **85% training completion rate**, supported through protected learning time.

Incident Reporting: Incidents and near misses are recorded via the Incident Reporting System in line with policy requirements. Incidents meeting the thresholds set out in the Patient Safety Incident Response Framework Policy are reported to NHS England.

Patient Information: Up to date patient information leaflets support infection prevention following invasive or higher risk procedures.

Site Assurance: Annual IPC site audits are undertaken for all clinical locations listed in the Site Assurance Matrix. Services ensure completion of site visits, action plans and local risk assessments in line with the IPC Policy.

IPC Audits & Risk Assessments: Routine and ad hoc audits and risk assessments are undertaken to test compliance and identify improvement actions. Risk registers are maintained in each service to grade, monitor and mitigate risks and to facilitate visibility to Quasar and Board. SMSKH maintains a separate risk register reported into SCFT quality team.

Staff Risk Assessments: Individual staff risk assessments are conducted where necessary to support safety, health and wellbeing.

Medical Devices Management: The Medical Devices Register records ownership, maintenance and decontamination responsibilities for all devices, including single-use equipment.
This register is cross-checked annually as part of IPC assurance processes.

3.4 Policies and Procedures

The IPC Policy sets out the organisation's approach to safeguarding patients and staff through evidence-based IPC best practice. Policy guidance aligns with Standard Infection Control Precautions (SICPs) as described in the National Infection Prevention and Control Manual. These precautions provide the essential measures required to minimise transmission from both known and unknown sources of infection.

4 Infection Prevention and Control Performance 2025

4.1 Service-Level Risk and Residual Risk

IPC risk profiles vary according to the nature of each service. In 2025, all services reviewed their IPC risk assessments and confirmed the following residual risks:

Service	Residual Risk	Rationale
MSK	Low to Moderate	SCFT now hold the CQC registration for MSK. Minor invasive procedures (e.g., injections), high patient throughput. Surgical activity under subcontracted providers is overseen by secondary care IPC governance. Podiatric surgery is delivered by SCFT under their governance arrangements. We are only responsible for the site assurance for Here 'owned' clinical sites (where we hold the lease). Under the new structure, SCFT hold overall responsibility for IPC. Here is responsible for supporting with SCFT's assurance process. All SMSKH IPC incidents, risks, complaints and audit data now report into SCFT board; Here supports where appropriate via internal SMSKH governance processes.
MAS	Low	No invasive procedures undertaken.
TDC	Low	No invasive procedures undertaken.
APC	Moderate	Physical examinations including rectal/vaginal assessments; sample collection; minor wound care.

4.2 Additional IPC Risks and Risk Assessments

APC documented a potential risk of exposure to high consequence infectious diseases arising from the national MPOX risk. Some clinicians were still pending respiratory mask fit testing at time of service closure; mitigations were in place and residual risk remained low.

Within MAS, an IPC audit requirement was identified in late 2025, and clinical leadership initiated the first audit cycle in early 2026.

4.3 Complaints

APC reported one informal IPC-related complaint concerning the cleanliness of a shared clinical environment. A review of cleaning protocols was undertaken and reinforced with staff. No further concerns were raised following this intervention.

4.4 Incidents

The IPC annual audit identified no reported IPC incidents during 2025.
While IPC incident rates have historically been low, there remains a recognised risk of under-reporting.

Continued emphasis on staff engagement, training, and awareness is recommended to embed a strong reporting culture and support shared learning.

4.5 IPC Audits

4.5.1 Hand hygiene

APC introduced hand hygiene audits in 2025, achieving a **92% compliance rate** prior to service closure. Quarterly hand hygiene audits in SMSKH now report into the partnership's governance structures.

4.5.2 Site Assurance

Annual site assurance visits were completed across APC, TDC, MAS and SMSKH by trained designated staff.

SCFT are now responsible for the site assurance for SMSKH. Here are supporting SCFT to ensure that sites are compliant where Here holds the service level agreement (SLA).

Current position
Over the last year ECAG has supported services to strengthen local assurance through site audits and training of governance coordinators (or nominated staff). This has increased capacity and brought greater consistency in identifying themes and sharing learning.

Progress since last cycle

- **Improved:** Site assurance capacity has increased, and consistent audit processes are now in place across services.
- **Superseded:** Since SCFT has now taken responsibility for site assurance and required displays, this work is no longer needed in its original form.

Procedures, Policies & Escalation Points

Current position
Last quarter, staff consistently demonstrated good awareness of procedures and escalation routes. However, during the most recent SMSKH visits, staff uncertainty increased regarding which organisational policies apply following the One Team transition. The SMSKH policy matrix was confirmed and shared with all teams to support clarity in which policy should be followed.

In MAS and TDC, awareness of emergency procedures remains strong: staff know who to contact in an emergency, how to access resuscitation equipment, and how to use emergency call functions.

Access to policies, previously impacted by MyCompliance, has now been resolved through full migration to SharePoint, which staff can access from any location including mobile devices. However, lack of clarity about when to follow Here vs. SCFT policies, and confusion around "The Pulse", appears to be contributing to lower scoring in this domain.

Progress since last cycle

- **Improved:** All policies are now reliably accessible via SharePoint, resolving previous access issues. The SMSKH policy matrix was confirmed and shared with all teams to support clarity.
- **Stable:** MAS/TDC continue to demonstrate strong awareness of emergency processes.
- **Opportunity:** Work in partnership with SMSKH to embed policy clarity across services following approval and sharing of policy matrix.

Repairs & Cleanliness

Current position
Across numerous sites—except recently refurbished ones—timely repairs are affecting overall assurance ratings.

SMSKH has established a consolidated action log capturing all repair issues across its sites. This will be shared with site owners and accountable teams.

Progress since last cycle

- **Improved:** SMSKH's new consolidated action log is a positive step in tracking and escalating repair issues.
- **No improvement:** Some repair delays remain unresolved and continue to impact audit scoring.
- **Opportunity:** For estates with Here SLAs, formalise escalation routes for site repairs involving external owners/landlords. Link with SMSKH partnership to support plan for estates repairs.

Disinfectant Availability

Current position
Earlier SCFT inspections of Legacy Central sites incorrectly downgraded compliance based on the absence of a specific brand of disinfectant wipes. SCFT has since confirmed that the green Clinell wipes used on these sites are fully IPC compliant.

Progress since last cycle

- **Resolved:** Previously incorrect scoring due to disinfectant-product assumptions has been corrected through updated SCFT policy guidance.

Chaperone Training & Policy

Current position

Across many sites, staff remain unclear about chaperone processes, relevant policies, and available training. This highlights an organisational gap in both policy and training provision.

Although historic chaperone policies existed, they were merged into wider documents over time, which inadvertently reduced clarity for staff. Given this, and the publication of new national guidance (NHS England, *Improving Chaperoning Practice in the NHS*, 5 December 2025), there is a clear case for a review of our organisational chaperone policy.

A simple training resource could be delivered in-house for frontline and reception staff, as no formal certification is required.

Progress since last cycle

- **Deteriorated / newly identified:** Persistent uncertainty about chaperone processes signals a widening gap without a dedicated policy within MAS.
- **Opportunity:** National guidance now provides a clear framework for updating and standardising local practice. Improve clarity around chaperone expectation via policy update and training.

4.6 Training

Threshold for compliance is 85%.

ALL HERE STAFF IPC Level 1					CLINICIANS IPC Level 2				
2021	2022	2023	2024	***2025***	2021	2022	2023	2024	***2025***
85%	**83%**	**85%**	***97%***	***94%***	**85%**	**82%**	**85%**	***91%***	***91%***

Training was carefully monitored and upheld across 2025 due to a sustained focus by the People Team to support training standards and performance.

4.7 Medical Devices Management

The medical devices policy was reviewed and updated in January 2025. The list of medical devices used by Here clinical services was also updated as part of an annual audit undertaken February 2025. Our audit identified an inconsistent approach to maintenance of the medical devices register. Improved processes are warranted for training and maintenance of the register.

5 Key Findings and Recommendations

Goals and progress from last IPC report can be found in Appendix ii. Objectives not fully met in 2025 have been carried forward into the 2026 improvement plan:

Action plan for 2026
• Review IPC audit requirements and site assurance documents for Here CQC registered services • Explore centralisation of audit results • Medical devices processes require refinement & training • Ensure any new services have named IPC / medical devices leads • Improve clarity around chaperone expectation via Here policy review and training • Continue to signpost staff to approved policy matrix for SMSKH following organisational transition. Link with SMSKH partnership to support estates repairs, audits, site assurance actions through the year. • For estates with Here SLAs, formalise escalation routes for site repairs involving external owners/landlords • Provide training and embed culture of reporting of IPC incidents

Appendix i: 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 2025:

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. Director of Operations responsible for IPC (Directorate) with clinical and operational leads holding IPC accountabilities within their services.
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:	Yes	Here produces an annual IPC report which is available publicly and is shared on our organisational website. We do not report on antimicrobial prescribing as we do not hold this function within our CQC registered services.

• 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 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 clinical sites will be checked annually for cleanliness and maintenance through the site assurance process, and each service will be responsible for ensuring sites remain fit for purpose as described in each services SLA.
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 is 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.	N/A	This does not relate to our current clinical portfolio.

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 relevant incident reporting system. Feedback regarding IPC concerns is 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.

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 incident reporting themes and individual cases resulting in harm. Following national and local IPC guidance and procedures identified within the organisational IPC policy.

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?**
	Yes	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') Access to an occupational health service should be available.	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 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.

Appendix ii: Review of Objectives from 2025

Objective	Status	Update
2025 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.	Completed	IPC reporting is fully enabled in Datix. SMSKH have since moved to InPhase to align to the SCFT incident reporting process. The system has pre-set categories used by the wider Trust. IPC incidents for SMSKH would now fall under the SCFT Infection Prevention Control Team.
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	Complete	See above section for the governance structure. Director of Operations responsible for IPC (Directorate) with clinical and operational leads holding IPC accountabilities within their services.
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.	Complete	SMSKH IPC structure now falls under SCFT. SCFT will now use their own site assurance frameworks and medical device frameworks, with Here offering any needed assurance for sites where we hold the lease/SLA.
Standardise agenda items for ECAG to provide needed assurance around IPC, most notably for timely site assurance completion and compliance between annual audits.	Complete	ECAG agenda is now standardised with site assurance and audit forming two of the standing agenda items.
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.	Complete	As part of mobilisation of TDC and the MAS review, we have decided that MAS would undertake a hand hygiene audit. This has now been started. As part of ECAG we have also embedded a process for escalating incidents and risks to ensure ongoing monitoring. This feeds into Quasar as part of a monthly reporting cycle to increase the visibility across the organisation of clinical risks.

Improve consistency and centralise storage of evidence for audits	In Progress	As part of CQC readiness plans we have been gathering evidence in central reference sheets for MAS. SMSKH are now storing evidence for audits in InPhase in line with the SCFT process.
Align annual risk assessment process in clinical services with insurance review to avoid duplication of tasks	Complete	Risk assessments developed as part of IPC policy and added as an appendix. This was used to 2025 for our CQC registered services for annual risk assessment of IPC activity.
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.	Complete	This is now added to the policy along with best practice for approach to PPE and patients who require isolation.
Review Site Assurance documentation considering changing service requirements and ensure it is fit for purpose, specifically alongside SCFT IPC inspections and changes in APC.	In Progress	We have reviewed site assurance prior to SCFT taking over the process. As part of ongoing CQC readiness action plan we are looking to review again as the current assurance document has many categories which are less relevant for MAS alone.