

Combined Infection Prevention Control, Antimicrobial Resistance and Health Care Associated Infection Improvement Programme Report

2025/2026

1. Executive Summary

This report combines infection prevention and control (IPC) performance, antimicrobial resistance (AMR) and IPC patient safety improvement programme work.

The North East and North Cumbria (NENC) system follows the well-established national standards and has provider governance and surveillance arrangements for infection prevention and control (IPC), health care associated infections (HACIs) and antimicrobial resistance (AMR).

Currently there is clear evidence of monitoring and oversight, however assurance on improvement is limited. NENC has worked with providers on an IPC improvement programme to understand the barriers to good IPC and reducing HACIs.

Further work is needed to improve intelligence around primary and community care, the impact of inequalities and evidence that interventions are consistently delivering sustained outcomes.

2. Introduction

Infection prevention and control (IPC), at its simplest, is stopping patients from picking up avoidable infections while they are being diagnosed and treated and is one of the most fundamental measures of whether a hospital or other health settings is safe. The evidence on how to achieve this is well understood and universally accepted; the challenge, however, is doing this consistently and reliably, day in and day out, everywhere, and whilst health care settings are under operational pressure.

Infection prevention and control (IPC) is a core strategic commissioning responsibility of the ICB and is fundamental to ensuring safe, effective and sustainable care. The ICB must be assured that the services its commissions meet the IPC regulatory requirements, prevent healthcare-associated infections (HCAIs), manage antimicrobial resistance (AMR), respond effectively to infection outbreaks and demonstrate continuous improvement. This assurance should be aligned to the Health and Social Care Act 2008 Code of Practice, the NHS England National Infection Prevention and Control Manual, the national IPC Board Assurance Framework, and alongside the UK AMR National Action Plan 2024–2029.

A healthcare-associated infection can harm patients directly, lengthen hospital stays, drive the use of antibiotics and impact on antimicrobial resistance. It disproportionately affects the frail, the elderly and the most deprived communities, of which our system has many. Furthermore, IPC is our front-line defence against the next pandemic. In

short, the quality of infection prevention and control is a reliable indicator of the overall standard of clinical care.

As a Board we should care about IPC because it is fundamental to patient safety and to reducing avoidable harm and preventing deaths.

The ICB is well placed to influence IPC through our strategic commissioning role, in terms of monitoring, assurance and oversight.

3. Improvement Programme (HCAIs): Improving and standardising infection prevention and control across NHS Trusts in NENC

Earlier this year the ICB began a NENC wide initiative, led by the ICB Chair and the Chief Nurse to raise standards and improve consistency in IPC. The improvement approach focused initially on NHS trusts through a system-wide approach to improving patient safety and reducing unwarranted variation.

The NENC wide improvement work started as an exploration of understanding the reality and lived experience of ways of working in NHS trusts in relation to IPC. Two independent experts, both senior infection-control specialists, who had worked with the World Health Organisation's global programme were commissioned to support this work.

The programme had three stages:

1. A diagnostic review of three volunteer trusts: Gateshead Health, County Durham and Darlington, and University Hospitals Tees. The purpose was to look beyond formal assurance paperwork and focus on leadership, culture and the working environment that influences good practice.
2. A detailed report, followed by an informal debrief with each volunteer trust to understand its perspective and confirm the practical implications of the findings.
3. A system learning event held in June 2026, chaired by Sir Liam Donaldson, and attended by senior clinical leaders from trusts and the ICB met to share findings and good practice, agree the next phase of work and strengthen shared ownership of improvement.

3.1 Emerging findings

The findings indicated that, although staff commitment and examples of excellent practice are evident, sustained improvement is dependent on leadership, culture and reliable operational delivery as well as policy and guidance.

Four themes emerged, and these were triangulated by the experts' review, the trusts' own accounts and the rich discussion at the learning event.

Culture and leadership matter most. The single biggest factor is not the quality of guidance available, which is good, but whether leaders, from the board to the ward, visibly own infection control and treat it as everyone's business. Where executive ownership is genuine and visible, IPC culture is markedly stronger.

Infection prevention and control can be treated as a specialist addition. In some organisations IPC has drifted away from mainstream patient safety and is perceived as a service that can be a barrier, rather than a partner in safe care. Reconnecting the two is central to improvement.

Operational pressure impacts on best practice. The ongoing tension between moving patients through a busy system (“patient flow”) and keeping them safe can work against infection prevention and control measures. A particular concern is the continued practice, originating during the pandemic, of setting aside infection prevention and control precautions when services are under pressure, despite a lack of evidence to support this approach. Notably, one volunteer trust has shown this was reversed by clear board-level expectations.

The buildings and the environment. Hospitals ageing estates, too few single rooms, a lack of proper isolation facilities and limited space for deep cleaning are a major practical constraint. This is beyond any single trust’s short-term control given the time and capital availability limitations.

The learning event also brought three further issues into focus:

- the community, where many infections originate and where prevention could have the greatest impact, but where our analysis is minimum.
- the national measurement system, currently counting infections that are easy to measure. There are other indicators that could be used to measure good or poor practice; and
- the reduction in IPC training in medical and nursing education.

Encouragingly, the diagnostic also identified genuinely impressive innovation in the participating trusts, including new digital tools to flag infection risks in real time and well-led, relationship-based improvement projects owned and delivered by frontline teams.

3.2 Next Steps

This work will be taken forward as a sustained programme of change, with the explicit ambition of becoming the best-performing and most consistent area in the country.

The next steps are:

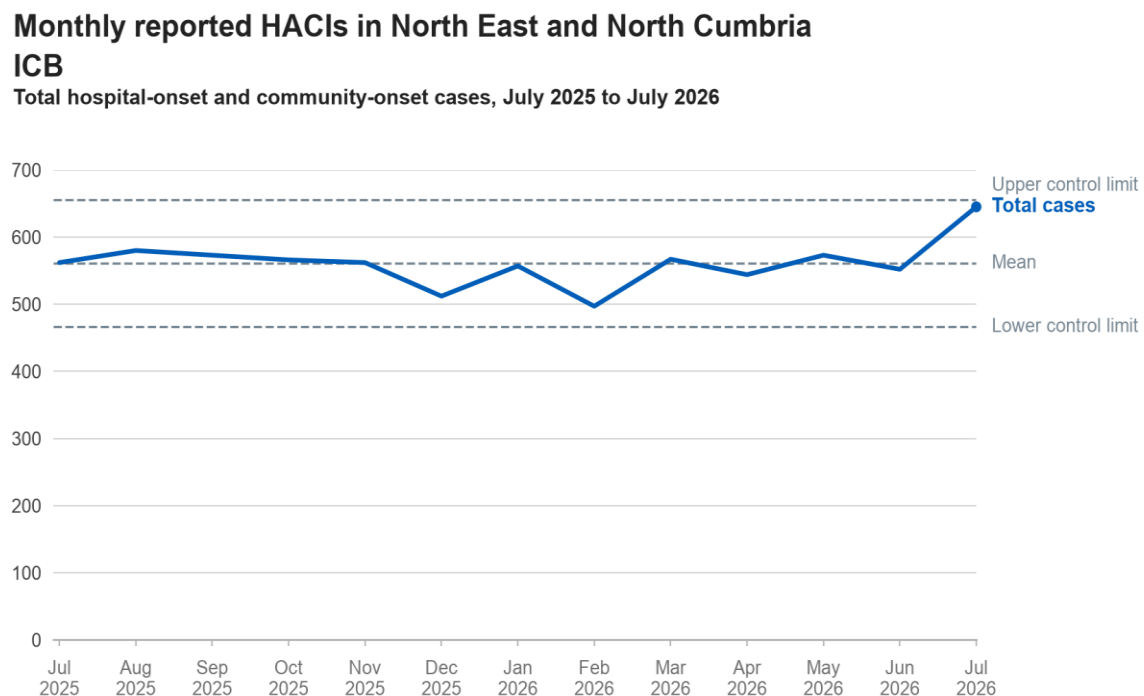
1. Share the learning across all NENC trusts, with a simple self-assessment tool so they can gauge their own maturity.
2. Reinvigorate the system wide AMR/ HCAI working group as an improvement collaborative, which is multiprofessional and focused on actions rather than networking alone.
3. Strengthen board-level ownership and embedding infection prevention and control as a standing line of inquiry in the ICB’s routine quality and contractual meetings with providers.
4. Convene a further system-wide meeting in late 2026 devoted to the community and the “left shift” of care.
5. Consider more meaningful measurement; counting and attributing infections in ways that drive genuine improvement.

4. Health Care Associated Infections (HACIs) - Performance

Reported healthcare-associated infections across North East and North Cumbria have been broadly stable over the last 12 months (2025-26), and they have consistently performed poorly against national trajectories. There is a notable increase in July 26 despite remaining within the overall ICB control limits. Figure 1 provides provisional data from July to July 25-26 for all HACIs across NENC ICB.

Appendix One provides more detailed data by organisation on total HACIs.

Figure 1



July 2026 recorded the highest monthly ICB total in the last 12 months, with 645 reported cases. The increase followed several months of fluctuation rather than a sustained upward trend. On further investigation this was because of an increase in infection rates of E Coli and C Diff at two of the provider Trusts. Both providers are reporting a return to usual rates of HACIs for August.

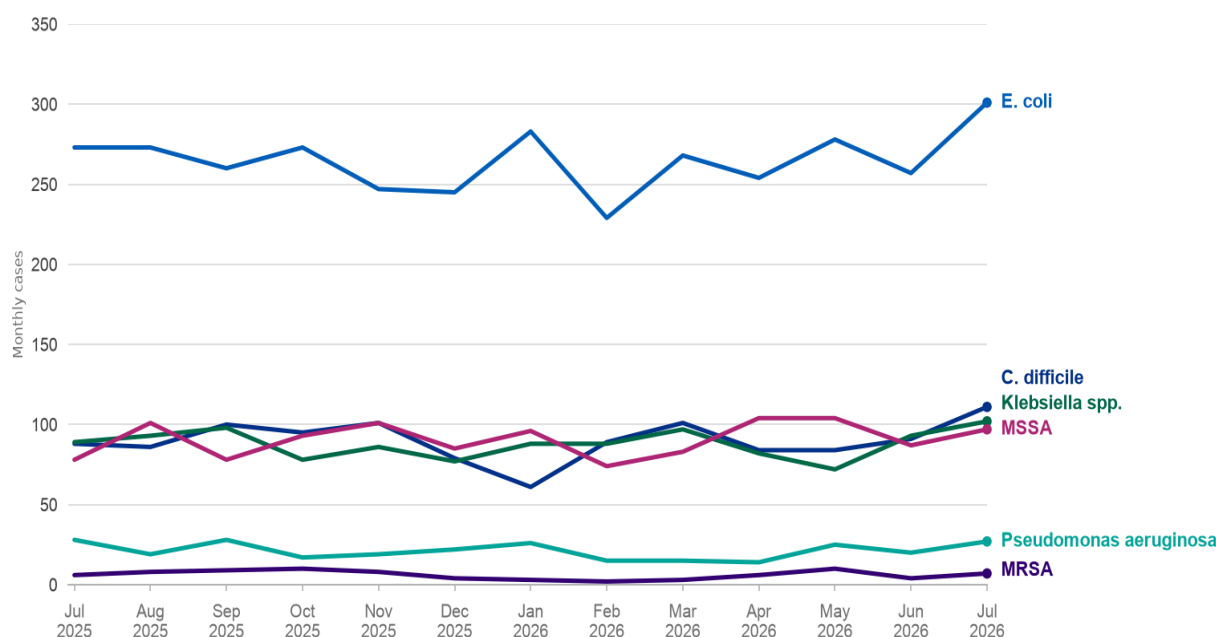
A more detailed breakdown of provisional data on 6 nationally reportable infections across the ICB is detailed in Figure 2, these are a combination of both hospital and community onset reported cases. The nationally reported organisms are MRSA, C, difficile, MSSA, E. coli, Pseudomonas aeruginosa and Klebsiella. Each of these infections have different tolerances (e.g. MRSA has a zero tolerance) as well as different presentations and routes for infection (e.g. blood stream infection (MSSA); bowel infection (C. difficile)).

Appendix Two provides more detailed provisional data of reportable HACIs by acute provider organisation.

Figure 2

Monthly reported HACIs by disease

North East and North Cumbria ICB. Total hospital-onset and community-onset cases, July 2025 to July 2026



Escherichia coli (*E. coli*) remains the highest of the reported infections and contributed almost half of the increase from July. *Clostridioides difficile* (*C. difficile*) was the next-largest infection rate.

Monthly cases of *E. coli*, *C. difficile* and *Klebsiella* each reached their highest monthly count in the period shown. All six reported infection categories are higher than anticipated, suggesting a wider rise in infections rather than an increase in just one type.

Whilst these observations do not establish why the increased occurred, these findings highlight areas there is a need for further review to assist in identifying priorities for provider monitoring and system triangulation. Further work is needed to review the outcome of provider investigations, contributory factors, actions and expected timescales for improvement.

5. Antimicrobial Resistance (AMR)

Antimicrobial resistance (AMR) is the existence of infections that are resistant to common antibiotics, they pose a significant risk across the ICB to clinical outcomes, financial sustainability, and operational resilience. Addressing AMR is essential to maintaining patient safety and safeguarding routine healthcare delivery across the system.

5.1 Key Themes and System Position

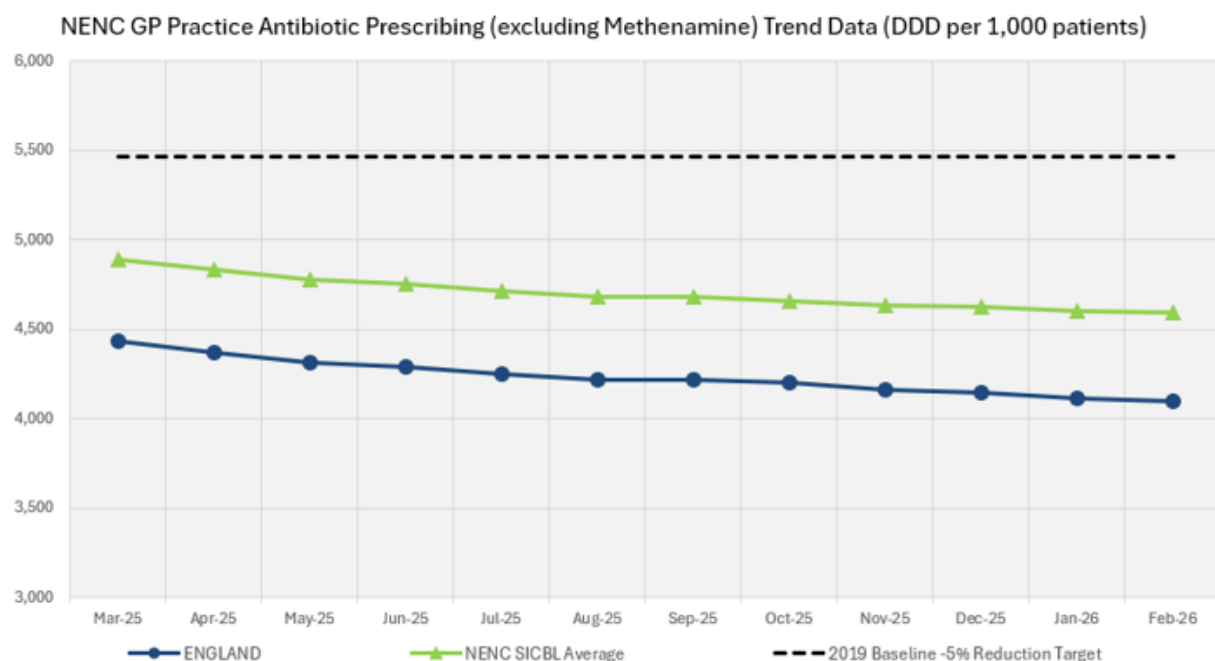
Antimicrobial resistance (AMR) remains one of the most significant long-term threats to patient safety and healthcare sustainability. Resistant infections are associated with increased morbidity and mortality; prolonged hospital stays and rising healthcare costs. The UK National Action Plan (NAP) 2024-2029 identifies four key ambitions for health systems: reducing antibiotic use, increasing use of lower-risk "Access" antibiotics, preventing increases in bloodstream and drug-resistant infections, and improving public and professional knowledge of AMR.

Within North East and North Cumbria (NENC), antimicrobial stewardship continues to be recognised as both a quality and patient safety priority. Significant progress has been made across several areas, although performance remains variable and further improvement is required if national ambitions are to be achieved by 2029.

5.2 System Performance

Antibiotic prescribing in primary care has continued to improve, with prescribing now below the 2019 baseline. This represents a positive trajectory and reflects sustained work through prescribing optimisation programmes, practice engagement and quality improvement activity. Prescribing rates remain above the England average and NENC continues to face greater challenges than many systems due to its population health profile.

Figure 3



Progress has also been made in increasing the proportion of prescribing from the Access category of antibiotics. Access antibiotics are recommended first-line treatments and are less likely to drive antimicrobial resistance. Current system performance stands at approximately 64%, which is an improvement but remains

below the national ambition of 70%. Performance is strongest in primary care, whilst considerable variation exists between provider organisations.

5.3 Key Improvement Activity

The Medicines Optimisation Annual Quality Report highlights positive progress during 2025/26, including reductions in overall antibiotic prescribing, improved adherence to recommended antibiotic course lengths and continuing movement towards greater use of Access category antibiotics. Prescribing in children has also reduced compared with previous years.

A range of actions are already underway across the system to strengthen antimicrobial stewardship and reduce antimicrobial resistance.

In primary care, the Prescribing Outcomes Scheme (POS) incentivises practices to reduce avoidable antibiotic prescribing, while quality and variation processes provide oversight of higher-prescribing practices. New digital clinical consultation templates are being developed to support evidence-based antibiotic prescribing decisions and reduce unwarranted variation in practice.

In secondary care, antimicrobial stewardship improvement targets have been incorporated into provider contracts. Work is also underway through antimicrobial stewardship networks to increase Access-category prescribing, harmonise clinical guidance and implement initiatives such as penicillin allergy de-labelling programmes to improve antibiotic choice and reduce unnecessary use of broader-spectrum agents.

Public-facing antimicrobial stewardship initiatives have also contributed to improvement. The Little Bug Busters campaign has sought to improve understanding of common childhood infections, self-care and appropriate antibiotic use, supporting reductions in antibiotic prescribing for children across the system.



5.4 Challenges and Future Priorities

Despite progress, significant challenges remain, such as high levels of deprivation, poor housing quality, fuel poverty, an older population and a greater prevalence of chronic respiratory disease. These factors increase infection rates, antibiotic demand and susceptibility to healthcare-associated infections and antimicrobial resistance.

Variation between providers remains evident, particularly in antibiotic prescribing patterns and progress towards Access antibiotic targets. Hospital antibiotic use continues to increase overall and further work is required. Strengthening surveillance, data sharing and executive accountability will therefore remain important priorities. Our focus is on three overarching priorities:

1. Strengthening executive oversight and accountability for AMR and healthcare-associated infection performance.
2. Enhancing assurance and stewardship arrangements across primary and secondary care, supported by contractual, quality and performance mechanisms.
3. Supporting wider population health programmes that address deprivation, housing, fuel poverty and other upstream determinants that contribute to infection risk and demand for antibiotics.

Overall, while progress is evident across many indicators, antimicrobial resistance continues to represent a significant strategic risk. Sustained system-wide action will be required to ensure the effectiveness of antibiotics is preserved for future generations and that NENC can achieve the ambitions set out within the UK National Action Plan.

6. Principal Risks and Assurance Gaps

The principal risks and assurance gaps as presented to the ICB Quality and Safety Committee.

Risk	Current control and assurance	Gap and required action
Provider variation and adverse infection signals	Routine surveillance, provider governance and targeted review are in place.	Introduce defined trigger thresholds, provider recovery plans, named executive ownership and time-bound escalation.
Fragmented system intelligence	Multiple HCAI, outbreak and prescribing datasets are available.	Create one validated dashboard with common definitions, denominators, benchmarks, inequalities views and exception reporting.
Incomplete primary and community care assurance	Some prescribing and incident intelligence is available.	Establish proportionate minimum assurance requirements across primary, community and independent sector services.
Workforce and estate constraints	Local risk assessments and mitigation are undertaken by providers.	Triangulate training, specialist capacity, isolation facilities, cleanliness and estate risks, escalating material constraints through planning routes.

AMR and antimicrobial stewardship delivery	Improvement programmes and prescribing surveillance are established.	Set measurable provider trajectories for antibiotic consumption, Access prescribing, resistance and priority infections, with evidence of clinical impact.
Outbreak and emerging-threat resilience	Incident response arrangements exist across partners.	Test preparedness, clarify cross-system command and reporting, and capture learning and inequalities impacts after incidents.

7. Key Priorities and Plans

The proposed next steps are to bring the existing IPC and AMR activity into a single, outcome-focused improvement programme. Delivery will be phased, with clear executive ownership, agreed measures and proportionate escalation, to ensure the Board receives consistent evidence of compliance, emerging risk, provider performance and sustained improvement across all commissioned services. We will

- Establish an IPC assurance framework by adopting a common evidence-based framework aligned to national IPC standards, covering acute, community, mental health, primary care and independent sector provision.
- Implement an integrated dashboard by establishing a core minimum dataset covering HCAI counts and rates, statistical variation, outbreaks and response, antimicrobial consumption, Access/Watch/Reserve prescribing, resistance profiles, stewardship compliance and health inequalities.
- Strengthen provider monitoring and surveillance by embedding IPC and antimicrobial stewardship within routine quality and contractual oversight.
- Deliver a system-wide IPC improvement plan as detailed in section 3.

8. Conclusion

There is some assurance that national standards and provider arrangements for IPC and AMR are in place. Provider monitoring and surveillance of infection data is in place, and improvement work is under way. However, assurance is limited because infection rates are over trajectory, oversight of primary and community care is incomplete, health inequalities need further consideration and there is little evidence measurable improvement across organisations.

The improvement programme is encouraging with staff deeply committed to patient safety and evidence of pockets of excellent practice, however the findings indicated improvement depends on leadership, culture and how organisations behave more than on the need for new policies or guidance. There is an ambition to roll out this work to make sustainable change.

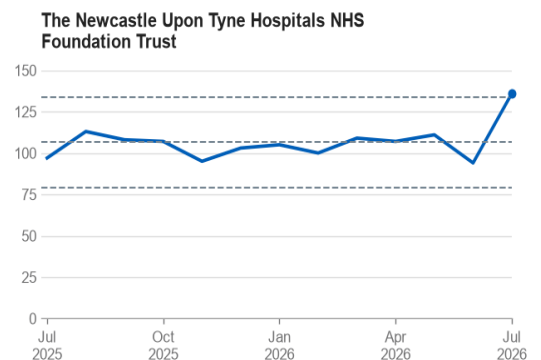
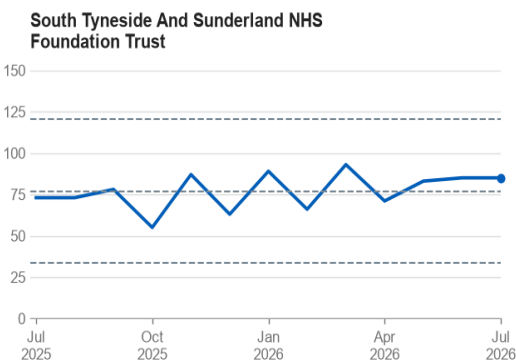
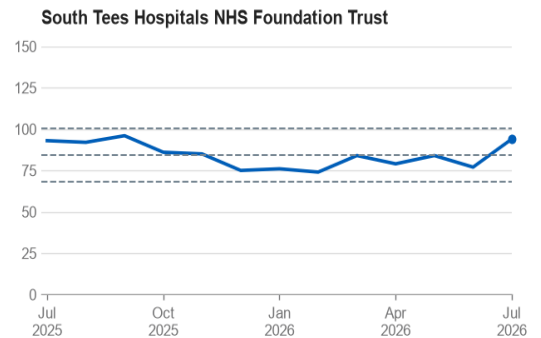
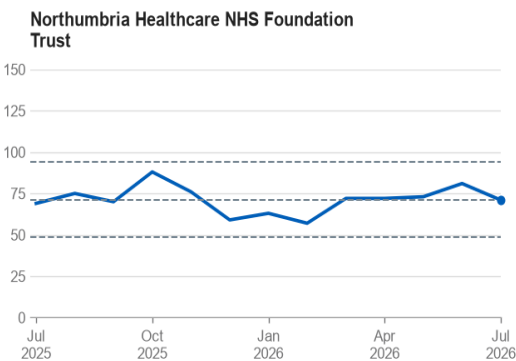
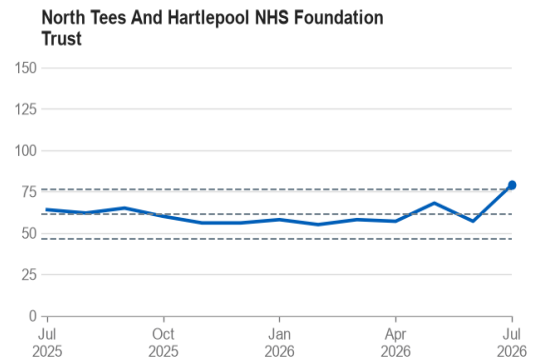
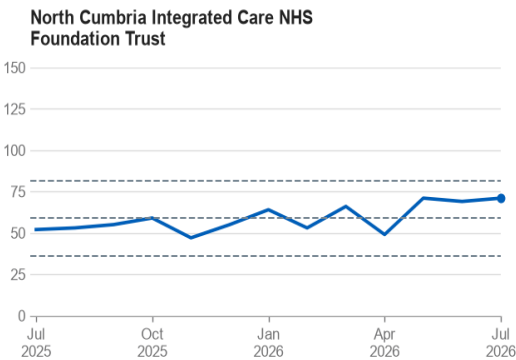
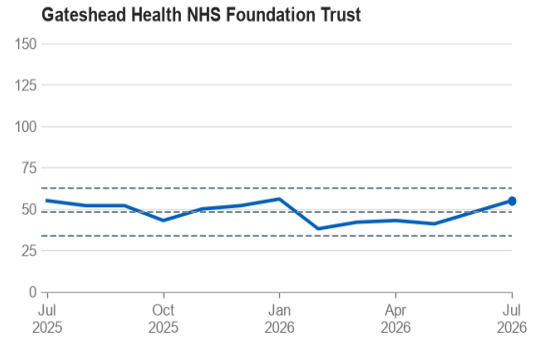
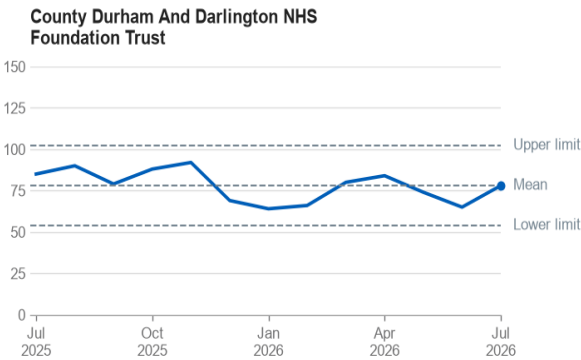
9. Recommendation

The Board is asked to note the progress made, to recognise infection prevention and control as a core patient safety priority for the system, and to endorse the key priorities and next steps set out above.

Appendix One: total monthly reported HCAIs by provider

Monthly reported HACIs by trust

Total hospital-onset and community-onset cases, July 2025 to July 2026
Monthly cases



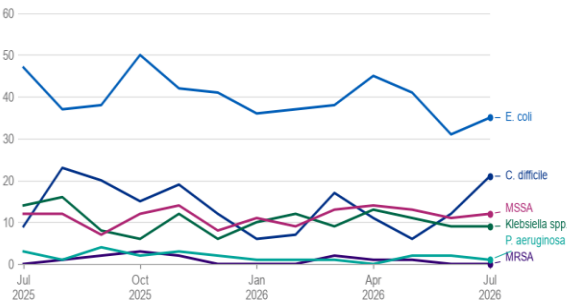
Appendix Two: Monthly reported HCAs by infection category and provider

Monthly reported HACIs by disease and trust

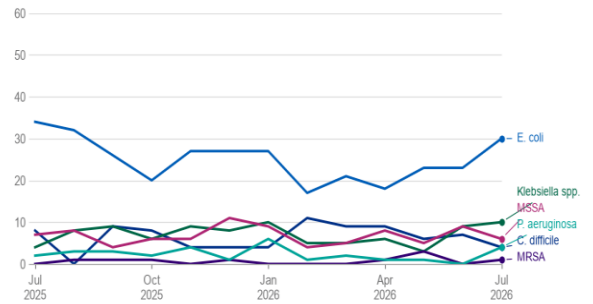
Total hospital-onset and community-onset cases, July 2025 to July 2026

Monthly cases • P. aeruginosa = Pseudomonas aeruginosa

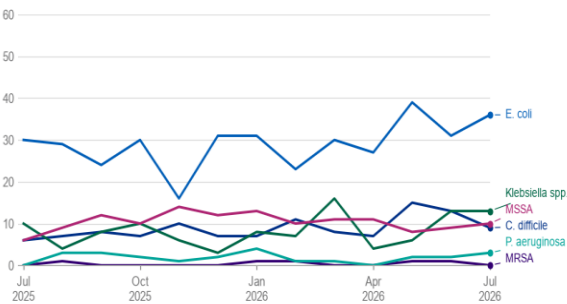
County Durham and Darlington NHS Foundation Trust



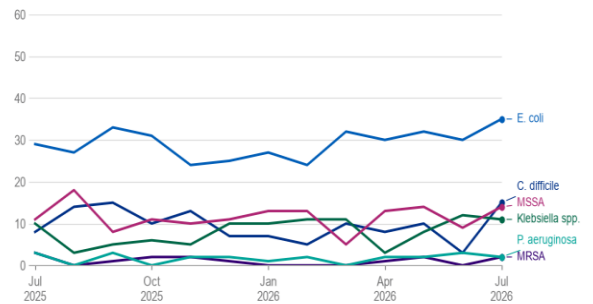
Gateshead Health NHS Foundation Trust



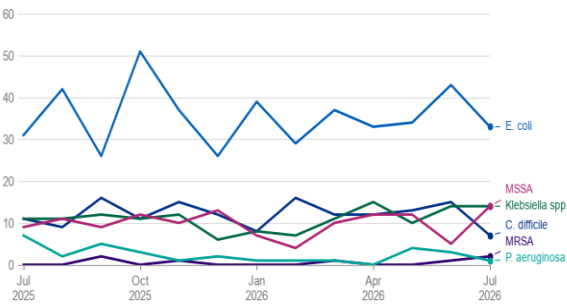
North Cumbria Integrated Care NHS Foundation Trust



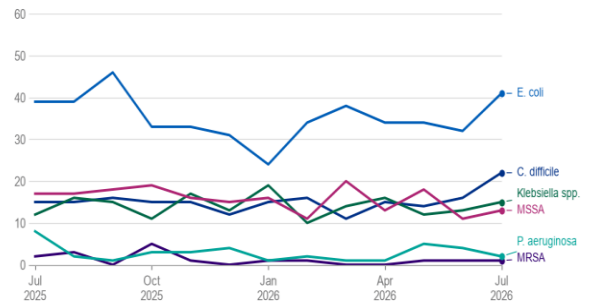
North Tees and Hartlepool NHS Foundation Trust



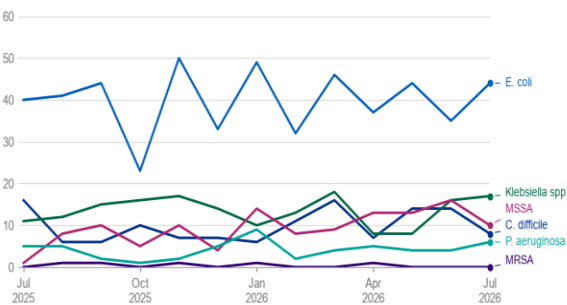
Northumbria Healthcare NHS Foundation Trust



South Tees Hospitals NHS Foundation Trust



South Tyneside and Sunderland NHS Foundation Trust



The Newcastle upon Tyne Hospitals NHS Foundation Trust

