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Bwrdd Iechyd Prifysgol
Abertawe Bro Morgannwg
University Health Board



Meeting Date	Quality & Safety Committee, 7th June 2018	Agenda Item	4d
Report Title	Infection Prevention & Control Report for Quality & Safety Committee		
Report Author	Delyth Davies, Head of Nursing, Infection Prevention & Control		
Report Sponsor	Cathy Dowling, Deputy Director of Nursing & Patient Experience		
Presented by	Angela Hopkins, Interim Director of Nursing & Patient Experience		
Freedom of Information	Open		
Purpose of the Report	This report provides the Quality & Safety Committee with an assurance report on the Health Board's overall performance since March 2018, and that of the Service Delivery Units, in relation to <i>Clostridium difficile</i> infection, <i>Staphylococcus aureus</i> bacteraemia, and <i>Escherichia coli</i> (<i>E. coli</i>) bacteraemia.		
Key Issues	<p>The key points within the report are:</p> <ul style="list-style-type: none"> - the Health Board failed to achieve a reduction in the target HCAs in 2017/18. - the Health Board set the following infection reduction improvement goals by March 2019: <ul style="list-style-type: none"> • A 15% reduction in <i>Clostridium difficile</i> infection; • A 10% reduction in <i>Staph. aureus</i> bacteraemia; • A 5% reduction in <i>E. coli</i> bacteraemia. - Monthly profiles have been calculated within the IMTP. In April, the number of <i>C. difficile</i> cases was 5 higher than the profile (due to the impact of the influenza activity); the number of <i>Staph. aureus</i> bacteraemia cases was one above the profile; the number of <i>E. coli</i> bacteraemia cases was 3 below the monthly profile. - Delivery Units must focus on key Quality Improvement actions to achieve infection reduction improvement goals. 		
Specific Action Required (please ✓ one only)	Information	Discussion	Assurance
			✓
Recommendations	<p>Members are asked to:</p> <ul style="list-style-type: none"> • Note the contents of this assurance report. 		

INFECTION PREVENTION & CONTROL REPORT

1. INTRODUCTION

This report provides the Quality & Safety Committee with an assurance report on the Health Board's overall performance since March 2018, and that of the Service Delivery Units, in relation to the following Healthcare Associated Infections:

- *Clostridium difficile* infection,
- *Staphylococcus aureus* bacteraemia,
- *Escherichia coli* (*E. coli*) bacteraemia.

The paper will outline actions implemented and monitored to achieve improvements in reducing preventable healthcare associated infections. The paper will outline risk issues that impact on the Health Board's ability to deliver on its infection reduction improvement goals. The report will reflect also key actions that reflect the standards established by Welsh Government in the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* (2014), and which are aligned to the Infection Prevention & Control elements (Standard 2.4) of the Health and Care Standards (2015).

2. BACKGROUND

Healthcare Associated Infections (HCAs) impact on the Health Board's performance and reputation in relation to the provision of safe, quality healthcare. Eliminating avoidable infections and reducing harm and variation are of key quality measures to the Health Board, its staff and the population it serves.

In the financial year, 2017/18, the Health Board failed to achieve a reduction in the target HCAs. For each of the target infections, *Clostridium difficile*, *Staph. aureus* bacteraemia, and *E. coli* bacteraemia, the number of infections had increased by 23%, 10% and 12% respectively, compared with 2016/17. ABM University Health Board had the highest incidence of *Clostridium difficile* infection and *Staph. aureus* bacteraemia in NHS Wales, and the second highest incidence of *E.coli* bacteraemia. This is an unacceptable position for the Health Board.

In WHC/2018/020 (*AMR Improvement Goals & HCAI Reduction Expectations by March 2019: Primary & Secondary Care Antimicrobial Prescribing Goals; C. difficile, S. aureus bacteraemias and Gram Negative bacteraemias*), Welsh Government set out its expectations for improvement. University Health Boards are expected to achieve the following:

- **C. difficile**: no more than 26 cases per 100,000 population (maximum of 136 cases for ABMU), and should work towards an additional 10% reduction in rate. For ABMU, this would mean a 57% reduction in cases within one year, which would not be achievable.
- **Staph. aureus bacteraemia**: no more than 20 cases per 100,000 population (maximum of 105 cases for ABMU). For ABMU, this would mean a 47% reduction in cases within one year, which would not be achievable.

- ***E. coli* bacteraemia:** no more than 67 cases per 100,000 population (maximum of 352 cases for ABMU). For ABMU, this would mean a 33% reduction in cases, which would not be achievable within one year. In addition, Welsh Government has set a new reduction expectation for other Gram negative bacteraemias: a 10% reduction in both *Klebsiella* spp. bacteraemia and *Pseudomonas aeruginosa* bacteraemia. These have not been included in national or local surveillance programmes previously.

Within the 2018/19 Annual Plan submitted to Welsh Government, the Health Board set the following infection reduction improvement goals by March 2019:

- A 15% reduction in *Clostridium difficile* infection;
- A 10% reduction in *Staph. aureus* bacteraemia;
- A 5% reduction in *E. coli* bacteraemia.

Using these reduction goals, infection reduction monthly trajectories for the Health Board as a whole have been calculated for each of the infections above. Monthly trajectories have been calculated for each of the Service Delivery Units also; these are shown in the tables in [Appendix 1](#).

How are we doing?

In April 2018, the Health Board's performance in relation to these key healthcare

Measures	WG Target	IMTP Profile	April-18 Profile	April-18 Actual
<i>C. difficile</i>	136 cases (max.) 26/100,000 pop.	239	21	26 (+5)
<i>Staph. aureus</i> bacteraemia	105 cases (max.) 20/100,000 pop.	182	13	14 (+1)
<i>E. coli</i> bacteraemia	352 cases (max.) 67/100,000 pop.	504	45	42 (-3)

associated infections is shown below:

At the time the Health Board set the IMTP profile, the full impact of the 2017/18 seasonal influenza activity was unknown. In January 2018, the number of influenza cases presenting within the Health Board was approximately four times higher than the number of cases since in January 2017. Studies^{1, 2} have identified a correlation between peak incidence for Influenza and pneumonia and a subsequent peak in *C. difficile* incidence, approximately 9 weeks later, or with a 1-2 month lag (respectively). The influenza season lasted approximately 14 weeks, and the number of cases significantly exceeded those seen in the previous year. As such, the Health Board may see increased numbers of *C. difficile* infection between March and May 2018.

The Health Board's performance in relation to each of the three key healthcare associated infections for April, and up to 20th May 2018, is shown in [Appendix 2](#). The performance of each Service Delivery Unit for April, and up to 20th May 2018, is shown in [Appendix 3](#).

Local surveillance, utilising the newly implemented electronic surveillance system ICNet, it has been possible to identify "hotspot" wards. These are the wards that have had the highest incidence of hospital acquired infections. For 2018, these "hot spot" wards are identified in [Appendix 4](#).

Using the results of local surveillance in this way provides key information for the Delivery Units, enabling them to focus Quality Improvement activities, and direct appropriate resources, in these "hot spot" areas. Specialist teams, such as Consultant Microbiologists, the Infection Prevention & Control Team, and Antimicrobial Pharmacists, provide support, guidance and advice to the Delivery Units Directors, Delivery Unit Quality Improvement Leads for Infection (once appointed), and relevant clinical teams, as they progress their annual infection reduction improvement plans. Local surveillance will provide information that will help Delivery Units to demonstrate improvement outcomes.

Key healthcare associated infection reduction priorities for each of the Delivery Units include:

1. Reduction in use of Co-amoxiclav (broad-spectrum antibiotic) by March 2019. Implement restrictive antimicrobial policy (restricting use of Co-Amoxiclav) – Implementation date **12th June 2018**.
2. Reduction in overall antibiotic usage volumes – **by March 2019**.
3. Improvement in reactive High Level bed and room decontamination for each incident of *C. difficile*, together with the development and delivery of a proactive High Level decontamination of high incidence wards/units **during Quarter 2 and 3**.
4. Reduce the unnecessary use of invasive devices such as urinary catheters and peripheral vascular catheters. When use is necessary, improve compliance with best practice guidelines for insertion, maintenance and removal of invasive devices. Continue with PDSA style Quality Improvement programmes commenced in Singleton and Murrumbidgee to reduce prevalence of invasive devices and improve management of invasive devices across Health Board - extend to key **wards in POW and Neath Port Hospital by 30 June 2018**.
5. Increase the numbers of staff who perform aseptic clinical procedures that will have completed the required Aseptic Non-Touch Technique (ANTT®) training and that will have been competency assessed. ANTT training is currently recorded on ESR; to identify a means of recording ANTT competence assessments on ESR also – proposal to be presented to Nursing and Midwifery Board by **30 June 2018**.
6. Sustain improvements in hand hygiene compliance.

Key to successful delivery

This Plan focusses on a system wide approach embedding quality improvement methodologies that focus on prevention, risk reduction and changing behaviours to lead to a step change in performance. It is recognised that this will take time, but the Board believes that it is the only approach that will lead to sustainable improvement and is in line with the Welsh Health Circular 2018/020.

The Health Board has invested resources to bolster the expert teams in place, including funding sessional time to enable a QI Infection Prevention and Control (IPC) lead clinician in each Delivery Unit and will shortly be recruiting a Lead Nurse, Head of Nursing, Head of HSDU and Lead for Decontamination. The 'whole system QI plan' relies on a broader team being available which would include a Consultant Antimicrobial Pharmacist working across primary and acute care; together with additional sessions for an Infectious Diseases and IPC Doctor; a Data Analyst, and surveillance support staff.

CODE OF PRACTICE REQUIREMENTS

Additional improvement actions, aligned to the Code Practice for the Prevention & Control of HCAI, and Health and Care Standard 2.4) are detailed in [Appendix 5](#).

A summary of key progress includes:

- Significant improvement in reviewing Infection Prevention & Control Policies, with approximately **90% having been reviewed**. The publication of national guidance is awaited, at which point the outstanding policy will be reviewed to reflect this national guidance.
- Assistant Director of Nursing, Infection Prevention & Control (IPC) post will be advertised **by end of May 2018**.
- Succession planning support arrangements, the temporary establishment of an action 8A Matron for IPC, to commence on **4 June 2018**.
- Agreed senior support from Public Health Wales Healthcare Associated Infection and Antimicrobial Resistance Programme Team from **mid-June 2018** for 3 months, whilst the recruitment process for the 8D post progresses.

3. GOVERNANCE AND RISK ISSUES

Issues that may impact on the Health Board's ability to deliver the infection reduction improvement goals within the IMTP include:

- Bed occupancy, which frequently is close to, or exceeds, 90%. Analysis by the Department of Health, reported in [Tackling healthcare associated infections through effective policy action](#)³ (BMA, June 2009), suggested that when all other variables are constant, an NHS organisation with an occupancy rate above 90 per cent could expect a 10.3% higher MRSA rate compared with an organisation with an occupancy levels below 85%.
- High bed turnover. In the same BMA report, the impact on MRSA rates of turnover intervals were suggested to have a greater impact on MRSA rates than bed occupancy levels.

- High acuity, and caring for an ageing population with more complex needs and co-morbidities, which increases their susceptibility to infection.
- Increased length of stay, which is influenced by economic challenges and limitations in social care.
- Increasingly frequent use of pre-emptive beds (e.g. adding a 7th bed to a 6-bedded bay; or placing beds into non-clinical areas that do not have hand washing facilities);
- Aging estate, and deteriorating condition of the fabric of the buildings, which impacts significantly on the ability of housekeeping teams to clean effectively.
- Staff shortages, with a reliance on temporary staffing.
- In addition, it is acknowledged that there would be a risk in the Health Board being able to achieve the infection improvement goals for 2018/19 if there is a decision not to invest in a comprehensive new approach to the prevention of HCAI.

4. FINANCIAL IMPLICATIONS

Within the proposal for a broader HCAI Collaborative team to strengthen the existing investments made by the Health Board, the year 1 cost has been estimated as £254,000.

However, there are costs associated with healthcare associated infections. A Department of Health impact assessment report (IA No. 5014, 20/12/2010) stated that the best estimate of costs to the NHS associated with a case of *Clostridium difficile* infection is approximately **£10,000**. The estimated cost to the NHS of treating an individual cost of MRSA bacteraemia is **£7,000** (the cost of MSSA bacteraemia could be less due to the availability of a wider choice of antibiotics). In an NHS Improvement indicative tool ⁴, the estimated cost of an *E. coli* bacteraemia is between **£1,100** and **£1,400**, depending on whether the *E. coli* is antimicrobial resistant.

5. RECOMMENDATION

The Quality and Safety Committee is asked to note the contents of the report.

References:

¹ Brown KA, et al *Am J Epidemiology*. 2013 Jul 1; 178(1):118-25.

² Polgreen, P., et al (2010). *Infection Control & Hospital Epidemiology*, 31(4), 382-387.

³ British Medical Association (June 2009) *Tackling healthcare associated infections through effective policy action*.

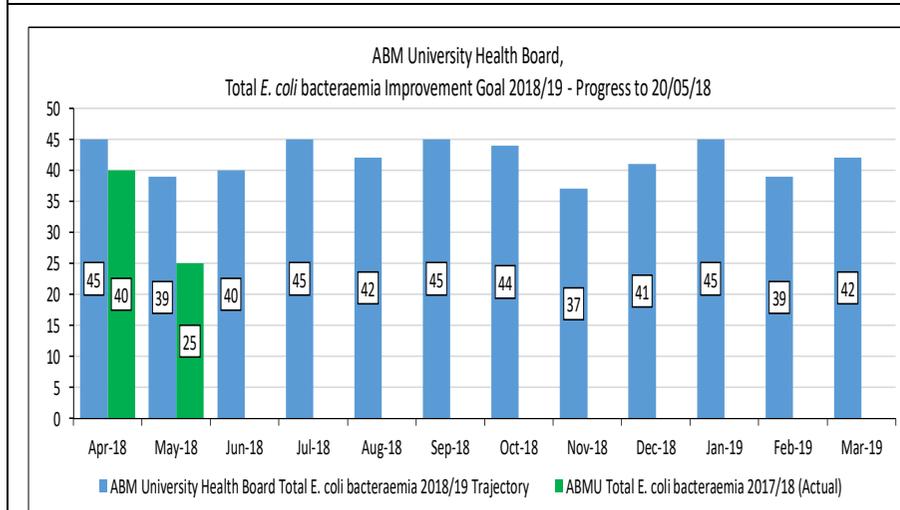
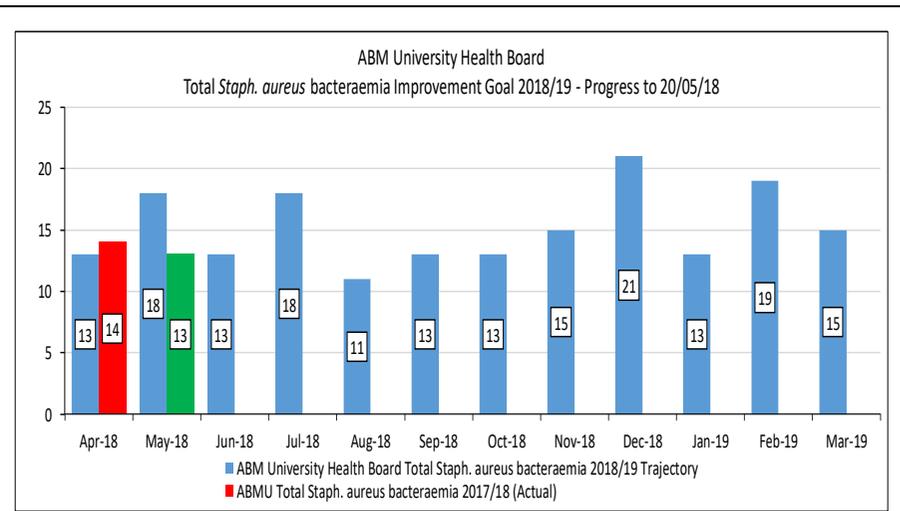
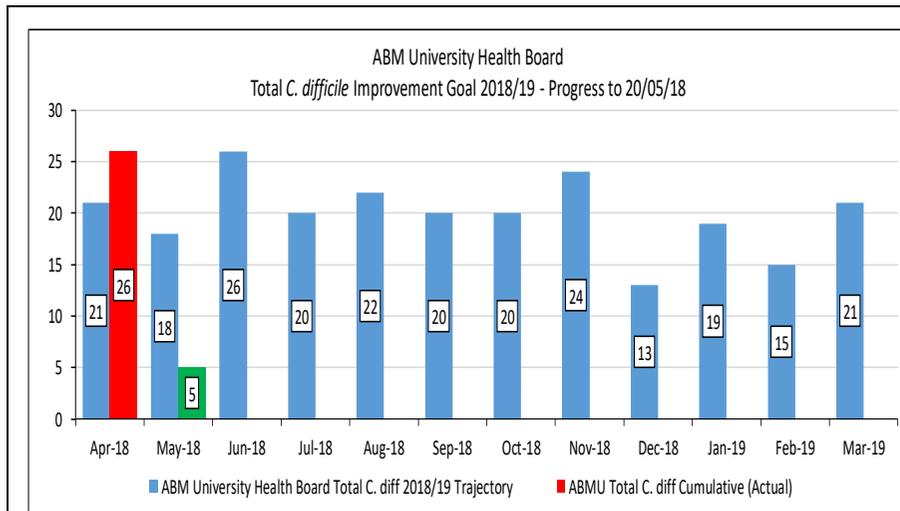
⁴ NHS Improvement *Trust and CCG level impact of E.coli BSIs* accessed online at <https://improvement.nhs.uk/resources/preventing-gram-negative-bloodstream-infections/>

Governance and Assurance							
Link to corporate objectives (please ✓)	Promoting and enabling healthier communities		Delivering excellent patient outcomes, experience and access	Demonstrating value and sustainability	Securing a fully engaged skilled workforce	Embedding effective governance and partnerships	
			✓				
Link to Health and Care Standards (please ✓)	Staying Healthy	Safe Care	Effective Care	Dignified Care	Timely Care	Individual Care	Staff and Resources
		✓					
Quality, Safety and Patient Experience							
Effective infection prevention and control needs to be everybody's business and must be part of everyday healthcare practice and be based on the best available evidence so that people are protected from preventable healthcare associated infections.							
Financial Implications							
<p>The Health Board has invested resources to bolster the specialist teams team in place, including funding sessional time to enable a Quality Improvement Infection Prevention and Control (IPC) lead clinician in each Delivery Unit and will shortly be recruiting a Lead Nurse, Head of Nursing, Head of HSDU and Lead for Decontamination. In addition to that, and reflecting the Health Board's Annual Plan, there is a proposal for a broader HCAI Collaborative team to strengthen the existing investments made by the Health Board, the year 1 cost has been estimated as £254,000.</p> <p>Estimated financial impact of these HCAs as cost per case is: <i>Clostridium difficile</i> infection - approximately £10,000; <i>Staph. aureus</i> bacteraemia - up to £10,000; <i>E. coli</i> bacteraemia – between £1,100 and £1,400.</p>							
Legal Implications (including equality and diversity assessment)							
None identified.							
Staffing Implications							
The current resource within the specialist Infection Prevention & Control (IPC) team is significantly reduce, with a shortfall in senior level strategic lead roles. There is a shortfall also in the Public Health Wales resource for Consultant Microbiologists. The implications of this are an increased workload for an already stretched service.							
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)							
A healthier Wales: preventing infections							
Report History	Infection Prevention & Control Report presented to Quality & Safety Committee, 5 th April 2018.						
Appendices	Appendix 1: IMTP HCAI Monthly Profiles for 2018/19 Appendix 2: Health Board Monthly Performance to 20/05/18 Appendix 3: Service Delivery Unit Monthly Performance to 20/05/18 Appendix 4: HCAI "Hot spot" Wards Appendix 5: Code of Practice/Health & Care Standard 2.4 Actions						

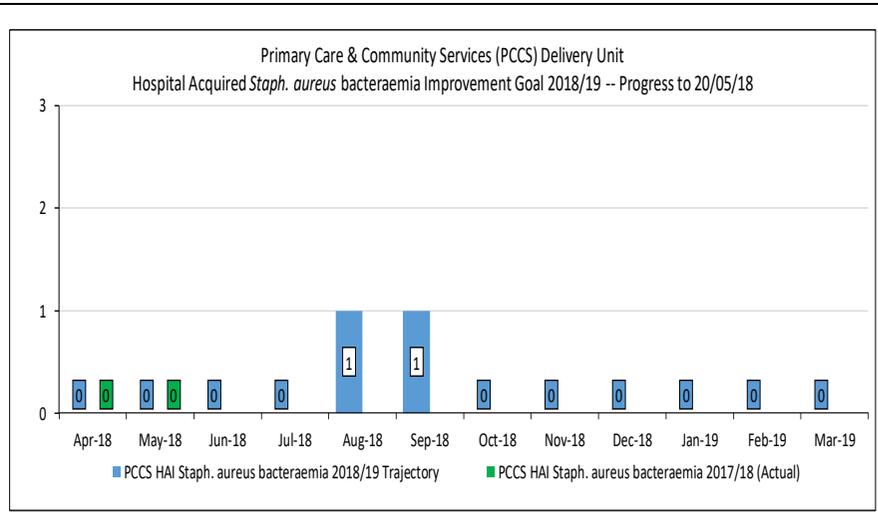
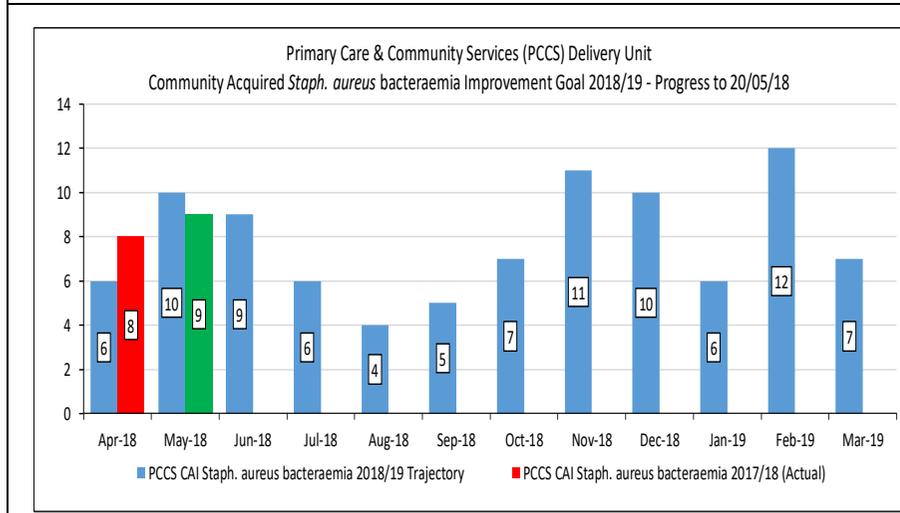
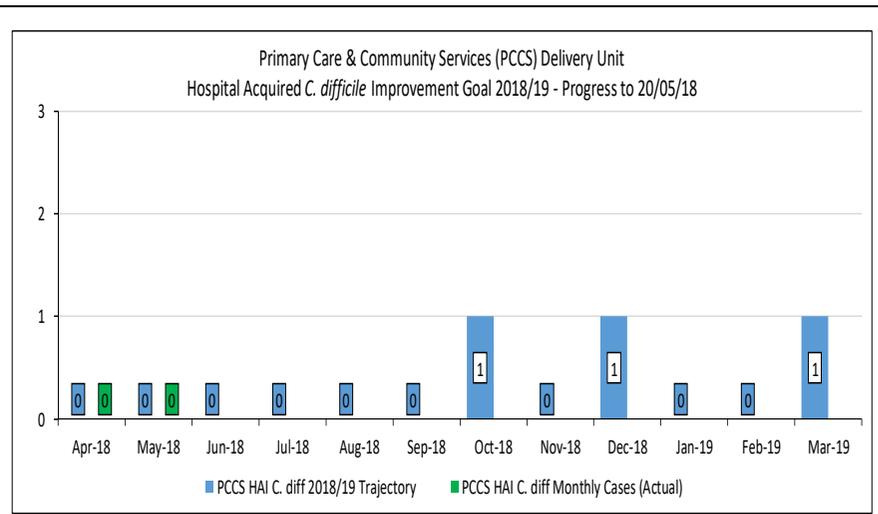
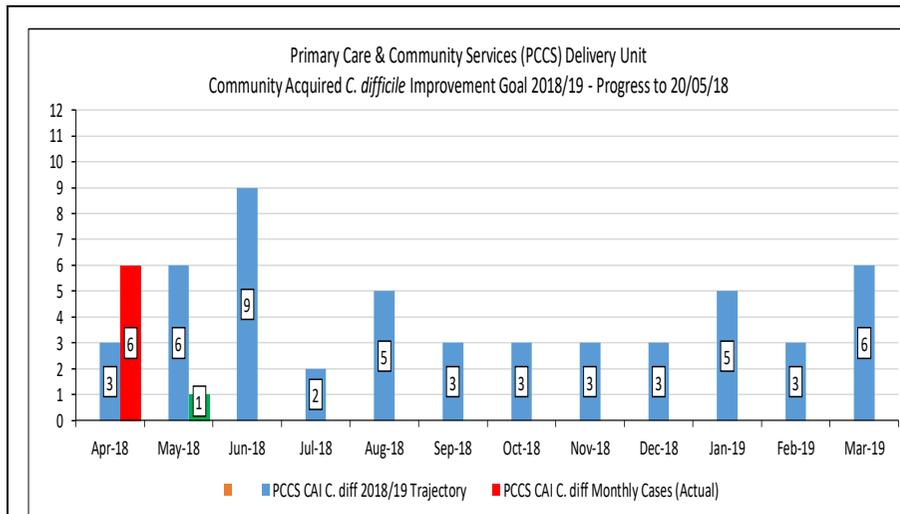
Appendix 1: IMTP HCAI Monthly Profiles for 2018/19

Measure Profiles	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
Total Number of Cases of C. difficile													
PCCS Community Acquired Infections	3	6	9	2	5	3	3	3	3	5	3	6	51
PCCS Hospital Acquired Infections	0	0	0	0	0	0	1	0	1	0	0	1	3
MH&LD Hospital Acquired Infections	0	1	0	0	0	0	0	0	0	0	0	0	1
Morrison Hospital Acquired Infections	9	5	9	7	7	7	8	9	4	5	4	7	81
NPTH Hospital Acquired Infections	0	1	0	0	1	1	1	0	0	2	2	1	9
POWH Hospital Acquired Infections	6	5	4	8	6	6	5	4	2	4	3	3	56
Singleton Hospital Acquired Infections	3	0	4	3	3	3	2	8	3	3	3	3	38
Sub-total Hospital Acquired Infections	18	12	17	18	17	17	17	21	10	14	12	15	
HB Total	21	18	26	20	22	20	20	24	13	19	15	21	
Cumulative Cases Profiles	21	39	65	85	107	127	147	171	184	203	218	239	
Total Number of cases of S. aureus bacteraemia													
PCCS Community Acquired Infections	6	10	9	6	4	5	7	11	10	6	12	7	93
PCCS Hospital Acquired Infections	0	0	0	0	1	1	0	0	0	0	0	0	2
MH&LD Hospital Acquired Infections	0	0	0	1	0	0	0	0	0	0	0	0	1
Morrison Hospital Acquired Infections	4	5	3	5	4	3	3	2	6	5	5	6	51
NPTH Hospital Acquired Infections	0	0	0	1	1	0	1	0	1	1	0	0	5
POWH Hospital Acquired Infections	1	3	0	2	0	1	1	1	2	1	1	1	14
Singleton Hospital Acquired Infections	2	0	1	3	1	3	1	1	2	0	1	1	16
Sub-total Hospital Acquired Infections	7	8	4	12	7	8	6	4	11	7	7	8	
HB Total	13	18	13	18	11	13	13	15	21	13	19	15	
Cumulative Cases	13	31	44	62	73	86	99	114	135	148	167	182	
Total Number of cases of E. coli bacteraemia													
PCCS Community Acquired Infections	30	28	27	31	28	33	30	23	25	31	32	34	352
PCCS Hospital Acquired Infections	0	0	0	0	0	0	0	0	0	0	0	0	-
MH&LD Hospital Acquired Infections	0	0	0	1	0	0	0	1	0	0	0	0	2
Morrison Hospital Acquired Infections	8	3	6	4	6	4	4	6	7	9	4	5	66
NPTH Hospital Acquired Infections	0	2	1	2	1	1	3	1	3	2	1	0	17
POWH Hospital Acquired Infections	1	2	2	3	2	3	3	4	4	2	1	1	28
Singleton Hospital Acquired Infections	6	4	4	4	5	4	4	2	2	1	1	2	39
Sub-total Hospital Acquired Infections	15	11	13	14	14	12	14	14	16	14	7	8	
HB Total	45	39	40	45	42	45	44	37	41	45	39	42	
Cumulative Cases	45	84	124	169	211	256	300	337	378	423	462	504	

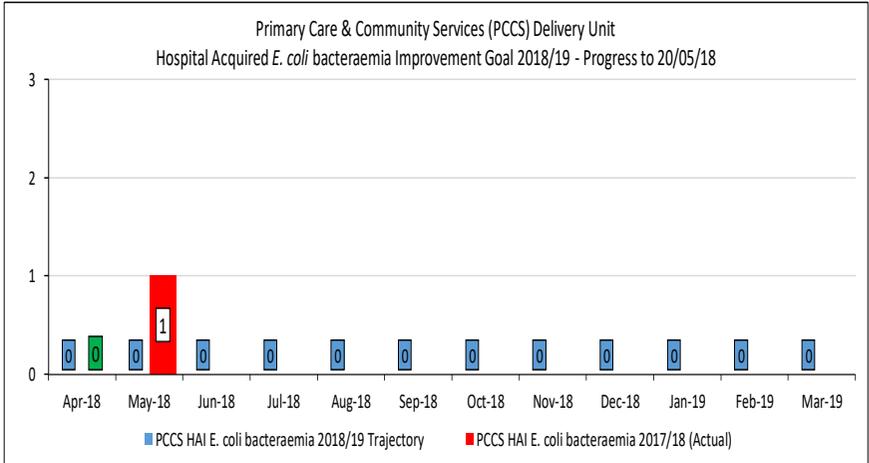
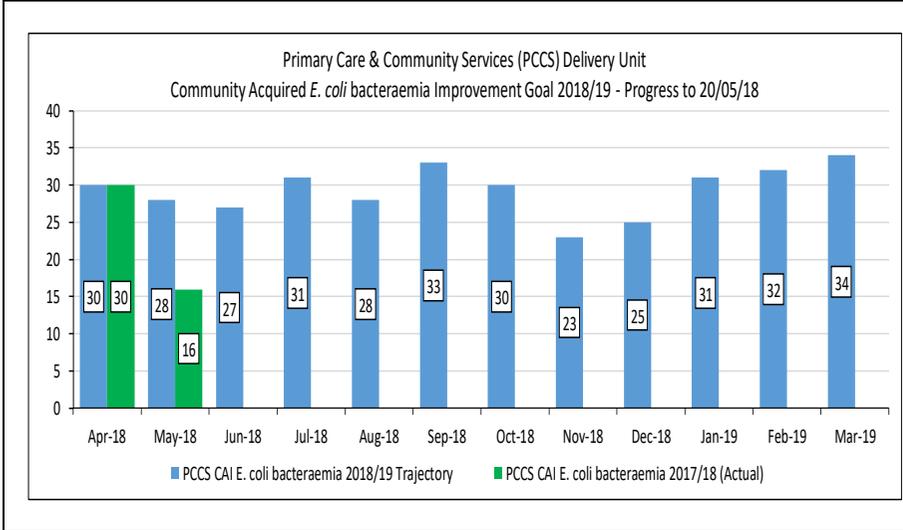
Appendix 2: Health Board Monthly Performance to 20/05/2018



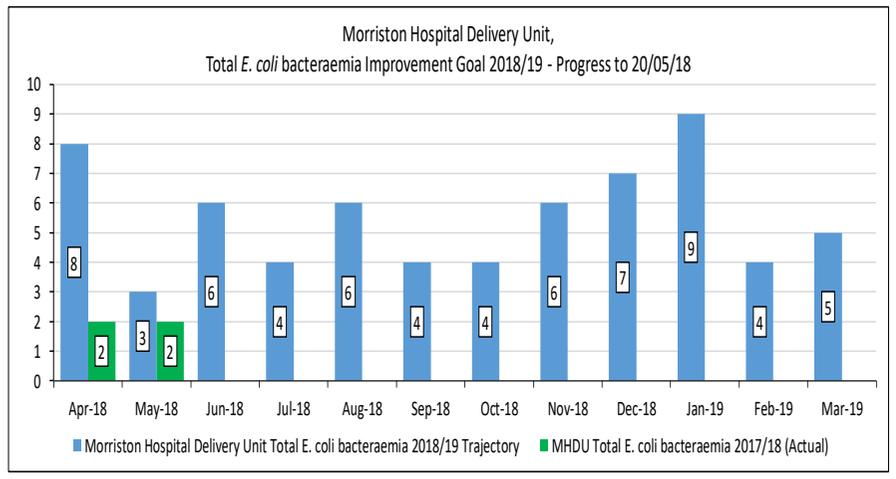
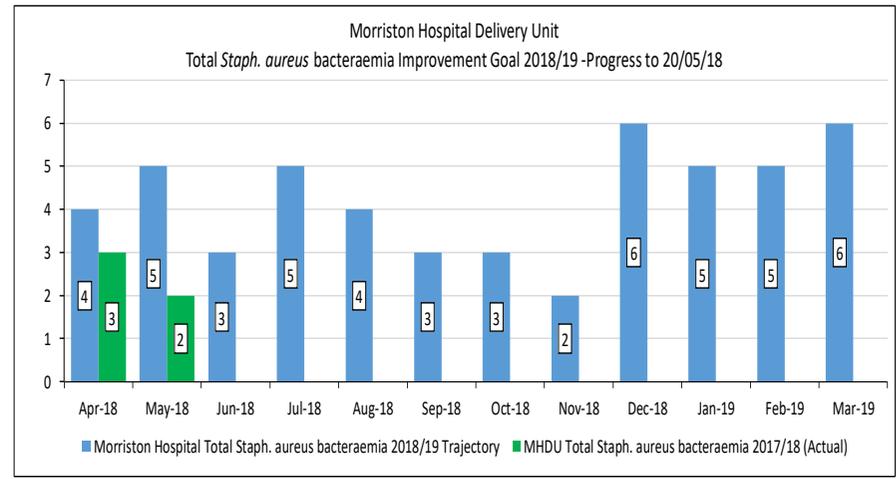
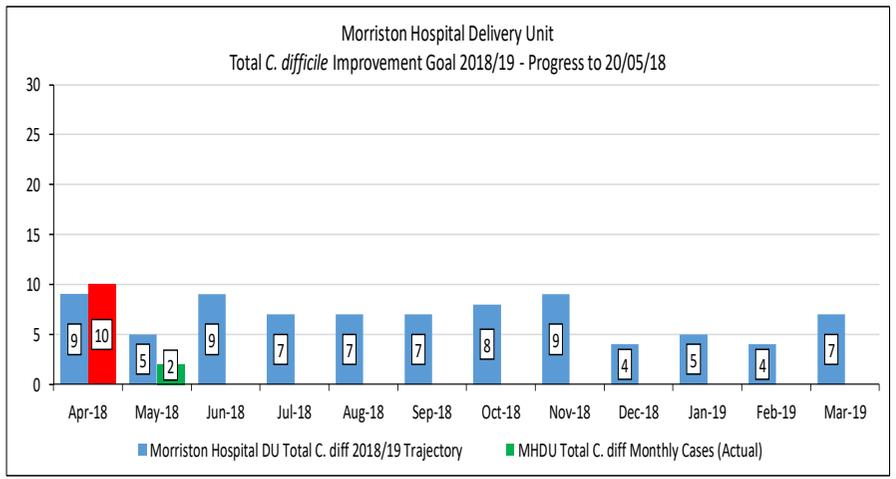
Appendix 3: Service Delivery Unit Monthly Performance to 20/05/2018



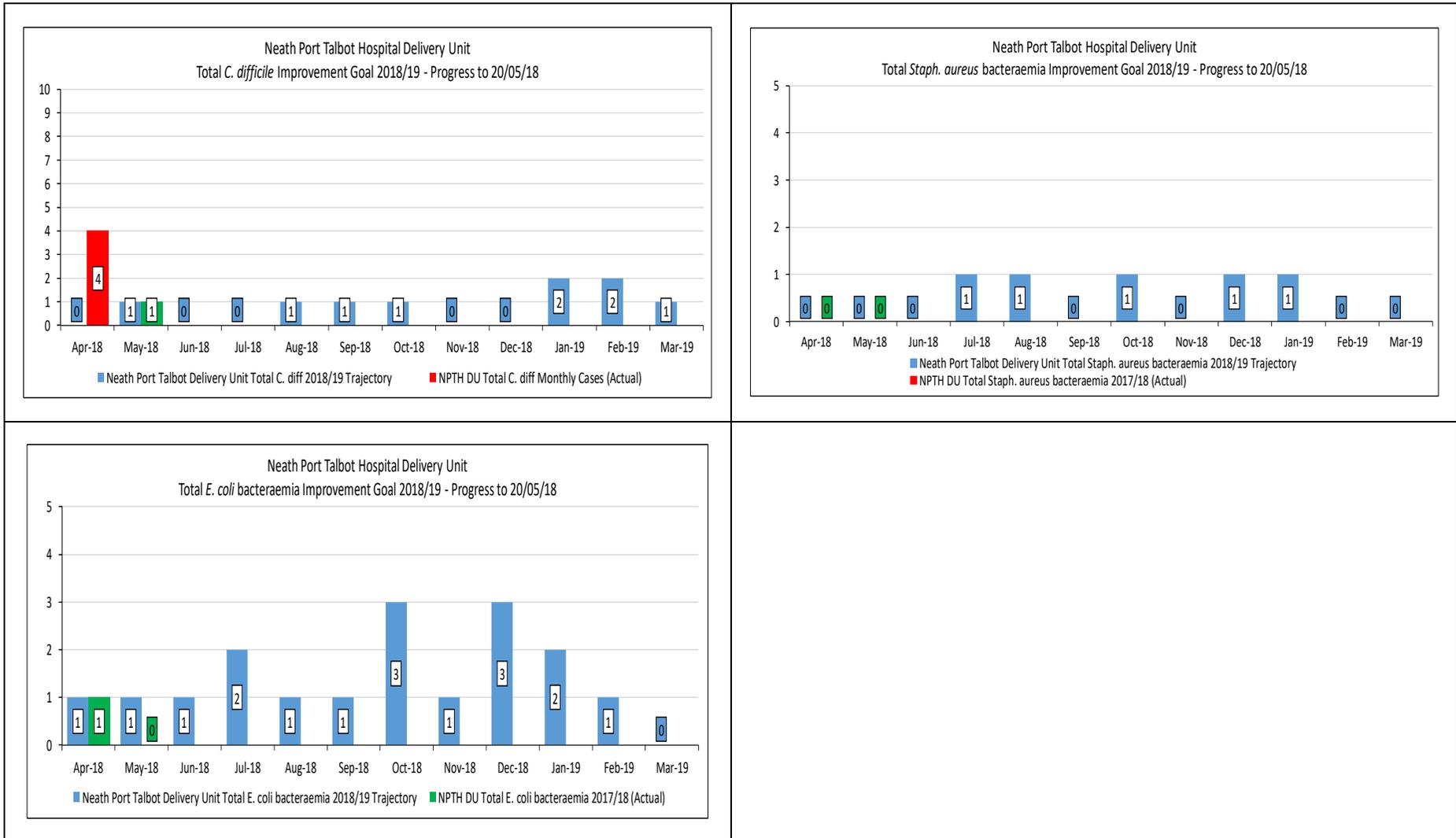
Appendix 3: Service Delivery Unit Monthly Performance to 20/05/2018



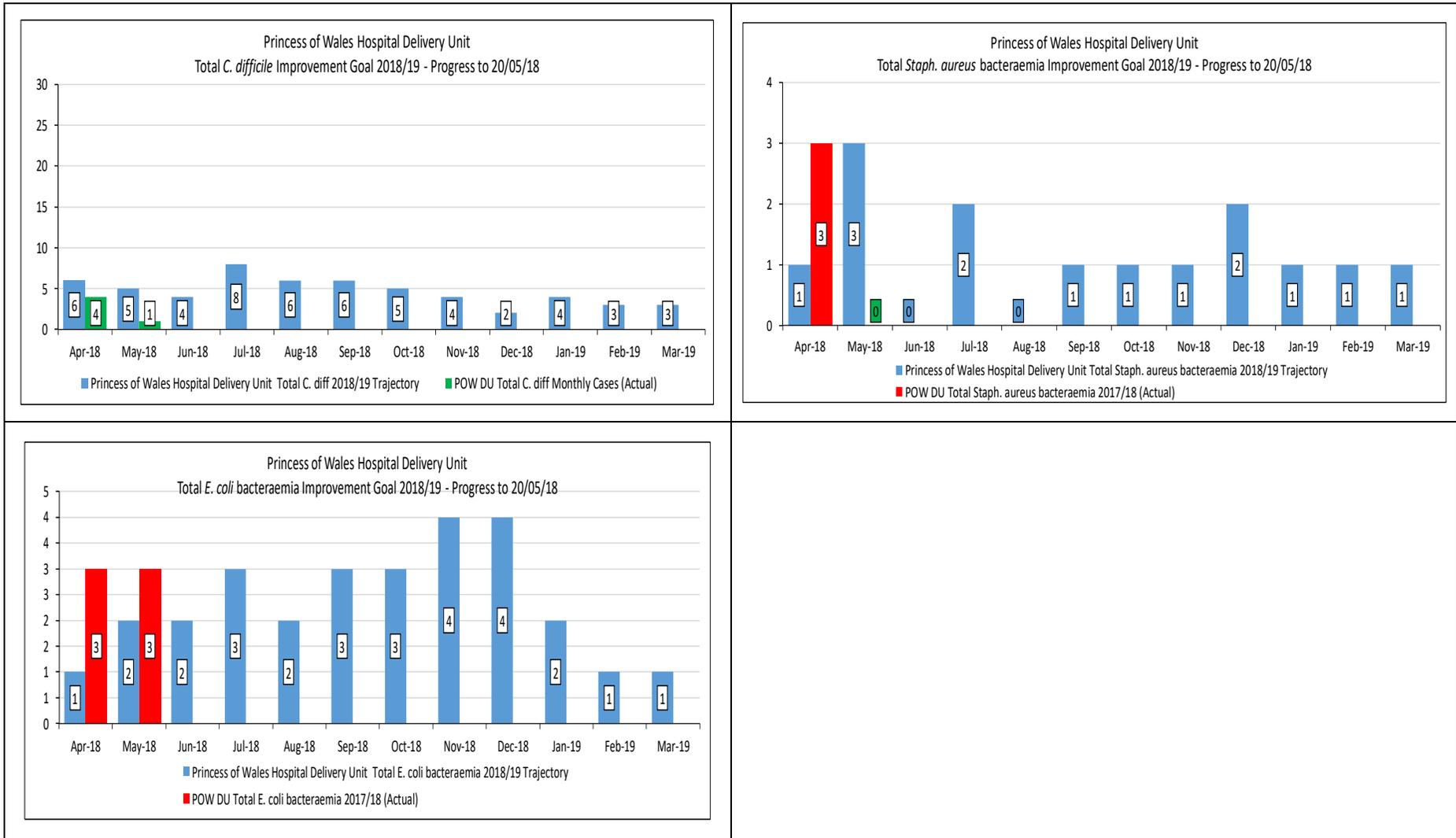
Appendix 3: Service Delivery Unit Monthly Performance to 20/05/2018



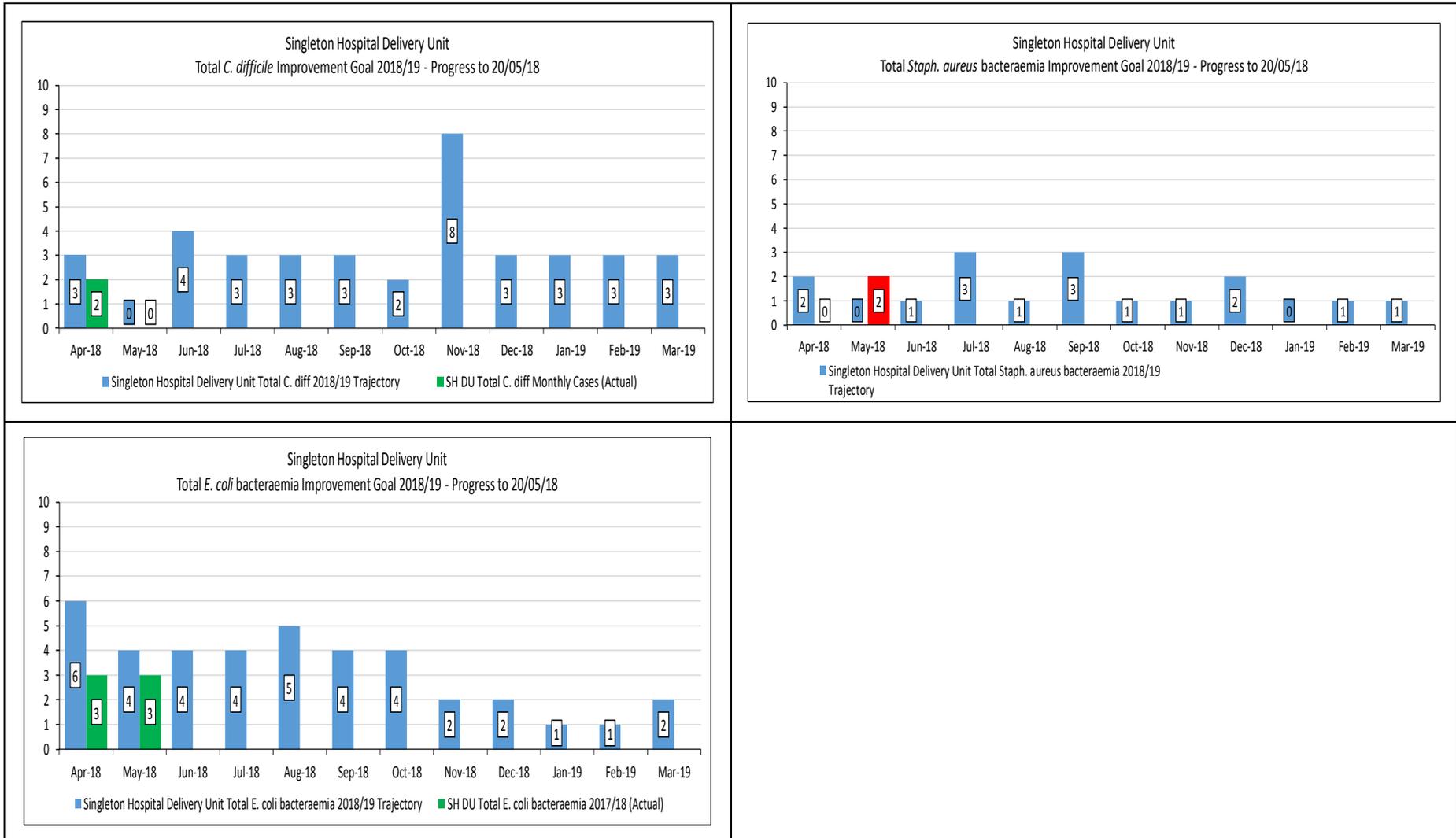
Appendix 3: Service Delivery Unit Monthly Performance to 20/05/2018



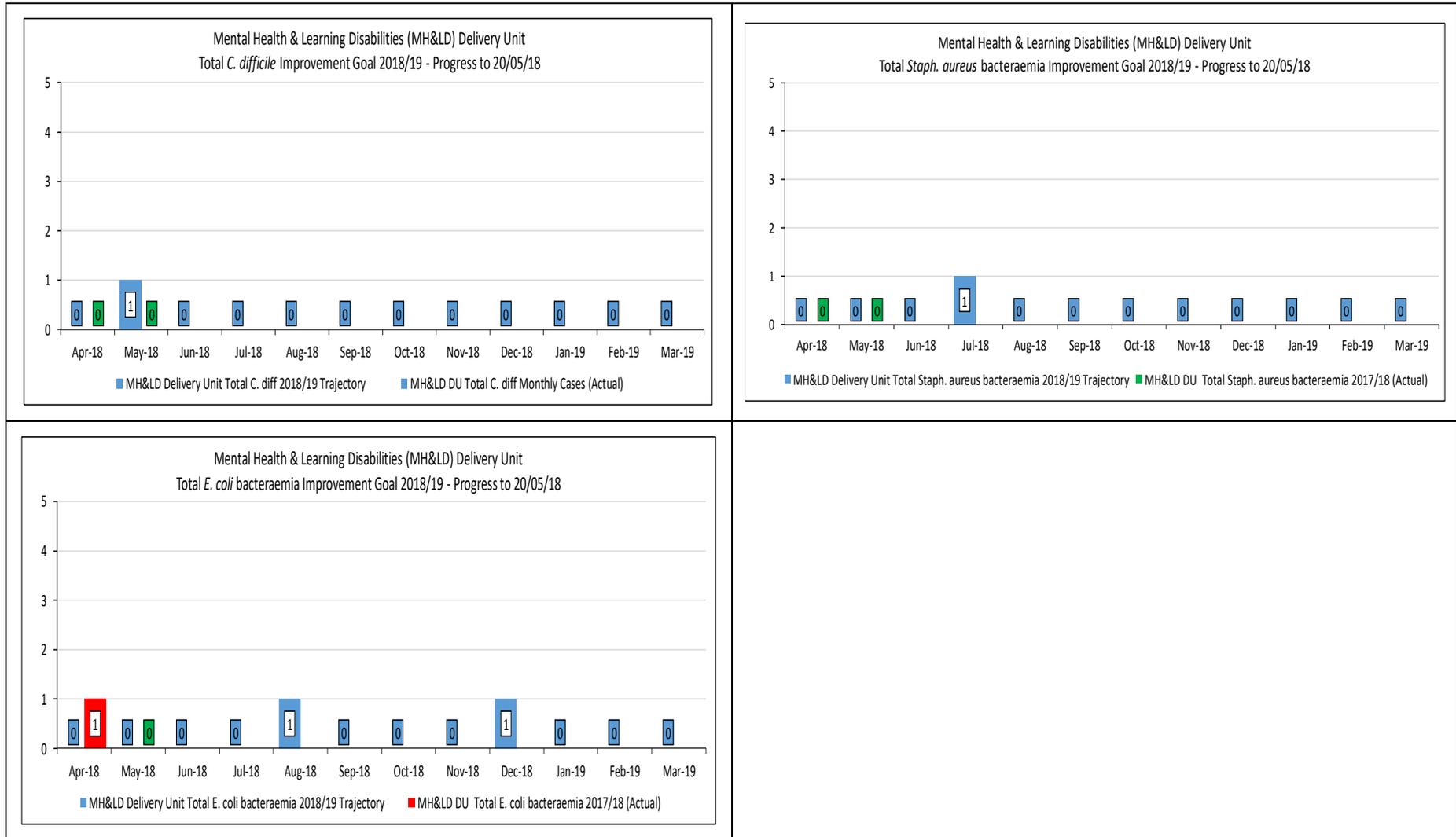
Appendix 3: Service Delivery Unit Monthly Performance to 20/05/2018

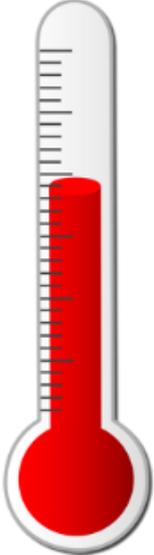


Appendix 3: Service Delivery Unit Monthly Performance to 20/05/2018



Appendix 3: Service Delivery Unit Monthly Performance to 20/05/2018



“Hot Spot” Wards (January – May 2018) - in descending order			
	<i>C. difficile</i>	<i>Staph. aureus</i> bacteraemia	<i>E. coli</i> bacteraemia
	<ul style="list-style-type: none"> • MH Gowers • SH Ward 3 • MH Ward B • POW Ward 7 • NPTH Ward B2 • MH ITU • MH Ward D • MH Ward S • POW Ward 10 • NPTH Ward E • MH Ward R • MH Ward A • SH Ward 6 • POW Ward 9 • POW AMU • NPTH Ward C 	<ul style="list-style-type: none"> • MH RDU • MH ITU • MH Cardigan • MH Ward D • MH Ward H • MH Ward J 	<ul style="list-style-type: none"> • MH Ward V • MH Ward D • MH RDU • MH Cardigan • MH Powys • MH Anglesey • POW Ward 10 • POW Ward 8 • POW Ward 6 • SH Ward 12 • SH Ward 8

Wards highlighted in bold font, appear within the “hot spot” wards for more than one infection.

Appendix 5: Code of Practice/Health & Care Standard 2.4 Actions

The following existing improvement actions will be strengthened and additional focussed actions will be implemented (these actions are grouped to reflect the Code of Practice for the Prevention & Control of HCAI, and Health and Care Standard 2.4).

Organisational and management systems for infection prevention and control

- In addition to the vacancy for the Assistant Director of Nursing Infection Prevention & Control, the Assistant Head of Nursing IP&C retired on 31st March 2018 (returning to 0.5 WTE post on 15th April 2018), and the Head of Nursing IP&C will retire on 30th June 2018. This will lead to a 66% reduction in senior expertise and experience in IP&C within the corporate IP&C team. During July 2018, there will be only 17% availability of the senior strategic team establishment. Whilst it has been agreed that both the Head and Assistant Head IP&C will return on a part-time basis, it is proposed that a temporary arrangement for an additional Band 8a post is established to supplement the strategic element of the service at this critical time where improvement in infection reduction is imperative. This has been actioned and the will **commence on 4th June 2018**.
- The post for the Assistant Director of Nursing Infection Prevention & Control will be advertised **by end of May 2018**.
- Agreed senior support from Public Health Wales Healthcare Associated Infection and Antimicrobial Resistance Programme Team from **mid-June 2018** for 3 months, whilst the recruitment process for the 8D post progresses.
- The Health Board has developed a plan which focusses on a system wide approach embedding quality improvement methodologies that focus on prevention, risk reduction and changing behaviours to lead to a step change in performance. It is recognised that this will take time, but it is considered that it is the only approach that will lead to sustainable improvement and is in line with the Welsh Health Circular 2018/020, released in May 2018. The Health Board has invested resources already, including funding sessional time to enable a QI Infection Prevention and Control (IPC) lead clinician in each Delivery Unit, and will shortly be recruiting a Lead Nurse, Head of Nursing, Head of HSDU and Lead for Decontamination. The 'whole system QI plan' relies on a broader team being available which would include:
 - a Consultant Antimicrobial Pharmacist working across primary and acute care;
 - additional sessions for an Infectious Diseases and IPC Doctor.
 - analytical support to ensure timely information, making best use of the ICNet system to develop performance trajectories, local improvement plans and to provide both local and strategic data that can be used in a collaborative methodology to drive improvement and a critical role will be a data analyst.
 - surveillance officers working at a Band 3 level, taking a new approach to surveillance. The surveillance officers will provide better intelligence, taking information from ICNet. ICNet currently collates numbers of laboratory confirmed isolates of bacteria only; there is no intelligence behind this and it is not possible to determine whether the organisms have resulted in clinical signs and symptoms of infection. Minimum data sets are essential for better analysis.
 - utilising the proposed broader team to train and develop our future workforce (growing our own) in specialties where recruitment is challenging.

Appendix 5: Code of Practice/Health & Care Standard 2.4 Actions

The intention is to package these new posts as a big service recruitment through a big bang recruitment offering by utilising the concept of a HCAI collaborative as an attractive option.

- This could be seen as a 'pathfinder' development of NHS Wales in terms of the approach and methodology for reducing HCAI in Wales and the Health Board would be keen to share learning with other organisations. A bid for additional funding for this "pathfinder" development is to be submitted to Welsh Government for consideration – **May 2018**.

Clean Physical Environment

- Sustain the increased scrutiny of cleaning compliance, including the environmental hygiene services provided by Hotel Services, the maintenance of the estate, and the cleanliness of patient care equipment by nursing staff. These will be monitored through Credits for Cleaning and by validation audits undertaken by Delivery Unit staff and the Infection Prevention & Control Team.
- Cost benefit review of the structure and roles of the Rapid Response service, to ensure that it is appropriately funded to meet the requirements of cleaning and decontamination, from a patient safety perspective, as well as maintaining patient flow on acute sites. This work is to be progressed within the Recovery & Sustainability work streams, guided by the Programme Manager – Procurement, Recovery and Sustainability Programme, **to commence in June 2018**.
- In addition to the above, there will be a Recovery & Sustainability work stream to standardise environmental clean products and disinfectants across the Health Board, **to commence in June 2018**.
- The use of environmental decontamination technologies, such as Hydrogen Peroxide Vapour and Ultraviolet C radiation, remains suspended. There has been good progress made in the review and strengthening of Risk Assessment and Safe Systems of Work for Ultraviolet C (UVC), which have been accepted by the Health & Safety Executive. However, staff side representatives continue to raise their concern about the re-introduction of UVC. This is being addressed with support from Human Resources, with a view to proceed with reintroduction in **June 2018**.

Suitable and accurate information

- Monthly data on the healthcare associated infections included in the reduction expectations is available to the Executive Team and Service Delivery Units as statistical process control charts.
- Localised surveillance is used to identify those wards in Morriston, Princess of Wales, Singleton and Neath Port Talbot with the highest incidence of hospital acquired *C. difficile*, *Staph. aureus* bacteraemia, and *E. coli* bacteraemia
- Localised surveillance data for 2017/18 was used to calculate infection improvement profiles and trajectories for each Service Delivery Unit for 2018/19. These were shared with the Delivery Units at the beginning of **April 2018**.

Staff engagement

- Following participation in the Public Health Wales / NHS Quality Improvement Healthcare Associated Infection & Antimicrobial Resistance Collaborative Launch

Appendix 5: Code of Practice/Health & Care Standard 2.4 Actions

event, a local collaborative has been established. The future appointments to the Clinical HCAI Quality Improvement Leads will be critical to establishing the Expert Group of the ABU Collaborative – the appointment process in each of the Delivery Units anticipated to be completed **by end of June 2018**.

Adequate isolation facilities

- Work has progressed on the provision of a negative pressure isolation room in Morriston Hospital. The major building work was completed in March 2018. Commissioning and validation tests are being undertaken in April and May 2018 by the Specialist engineering systems and services of NHS Wales Shared Services Partnership. Once these validation checks are approved, the room will be available for use – anticipated by end of **Quarter 1, 2018**.

IPC Policies

- Significant progress has been made in reviewing outstanding IPC policies – with **90% of all policies reviewed**. The outstanding policy on Carbapenemase-producing *Enterobacteriaceae* has been delayed whilst awaiting review and publication of the corresponding national policy by Public Health Wales. In the interim, the Infection Prevention & Control Committee in April 2018 agreed that the existing policy remained extant.

Staff health

- The updated position by 27th March 2018 was as shown below:

Total Vaccinations Given	Front Line Staff	Non-Front Line Staff
Update to 21/02/2018	6950	2603
Staff Number excluded	436	57
	6514	2547
Updated Totals	58.54%	51.96%
	9553 (Total Vaccinated)	

- A number of neighbouring Health Boards have included nurse bank and new starters in their immunization reports. If ABMU had used the same reporting criteria, ABMU could have reported achieving the immunization target set by Welsh Government. The different reporting criteria used by various Health Boards has been highlighted to the National Immunisation Advisory Group.

Staff training

- The Standard Infection Control Precautions (SICP) training has been refreshed. Face to face SICP training has been temporarily suspended, with staff being directed to the e-learning programme to comply with mandatory training requirements. The IPC team resource will be focussed on training to support the implementation of amended IPC policies, and to support QI projects. This will be **reviewed and evaluated by 30 September 2018**.
- The Hand Hygiene Coach training has been refreshed and training has been resumed at **the end of March 2018**.

Appendix 5: Code of Practice/Health & Care Standard 2.4 Actions