Meeting Date	**28 June 2022**	**Agenda Item**	**2.1 (i)**
Report Title	Healthcare Acquired Infections Update Report		
Report Author	Delyth Davies, Head of Nursing, Infection Prevention & Control		
Report Sponsor	Gareth Howells, Executive Director of Nursing & Patient Experience		
Presented by	Delyth Davies, Head of Nursing, Infection Prevention & Control		
Freedom of Information	Open		
Purpose of the Report	This paper provides the Committee with an update on progress against the Health Board's upcoming priorities and actions to prevent infection and avoid harm.		
Key Issues	• Service Groups will present their Improvement Plans to the Quality & Safety Committee in June 2022. • Service Groups made initial progress against their improvement plans, which will be discussed in their respective presentations to the Committee. • There have been year-on-year reductions in the following Tier 1 infections to the end of May 2022: *C. difficile* and *E. coli* bacteraemia. Further progress is required particularly in relation to hospital-acquired cases of *Staph. aureus* bacteraemia. • The following actions are proposed by the IP&C team for **June 2022**: – Identification of appropriate Clinical Codes and scoping feasibility of using these to identify target infections. – Delivery of ANTT Competence Assessor Training, and other IPC-related training to support Service Groups in achieving improved training compliance. Training dates circulated to all Service Groups. – Develop an educational package for optimal specimen collection, commencing with urine sampling (action by 31.07.22).		

Specific Action Required	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: Consider initial progress to the end of May 2022 against the Health Board's Infection Prevention Improvement Plan, and agree actions for May 2022.

Infection Prevention and Control Report

		Agenda Item	2.1 (i)
Freedom of Information Status		Open	
Performance Area	Healthcare Acquired Infections Update Report		
Author	Delyth Davies, Head of Nursing, Infection Prevention & Control		
Lead Executive Director	**Gareth Howells** **Executive Director of Nursing & Patient Experience**		
Reporting Period	31 May 2022	**Report prepared on**	8 June 2022

Summary of Current Position

Service Groups will present progress in relation to their infection improvement plans to the Quality & Safety Committee on June 28th. This paper will present a summary of the overarching position in relation to the number of cases of infection within the Health Board, and by Service Group, to the end of May 2022.

Health Board and Service Group progress against the Tier 1 infection reduction goals to the end of May 2022 is shown in Appendix 1.

A summary position for the Health Board is shown in the table below, identifying the cumulative position for the financial year 2022/23, the monthly case numbers, and the average monthly goal.

Table 1: Health Board Summary Position for May 2022

Infection	Cumulative Cases to end of May 2022	Monthly total: May 2022	Average monthly reduction goal (max.)
C. difficile (CDI)	**24**	11	<8 (annual maximum: <95 cases)
***Staph. aureus* bacteraemia (SABSI)**	**30**	17	<6 (annual maximum: <71 cases)
***E. coli* bacteraemia (EcBSI)**	**52**	21	<21 (annual maximum: <251 cases)
***Klebsiella spp.* bacteraemia (KI BSI)**	**14**	8	<6 (annual maximum: <71 cases)
Ps. aeruginosa bacteraemia (PAERBSI)	**4**	2	<2 (annual maximum: <21 cases)

A summary position for Service Groups is shown in the table below, identifying the reporting month's cases, with cumulative totals for the financial year to date shown in brackets.

Table 2: Service Group Summary Position for May 2022

	CDI	SABSI	EcBSI	KIBSI	PAERBSI
PCTSG - CAI	4 (6)	8 (15)	13 (31)	1 (3)	1 (2)
PCTSG - HAI	1 (1)	0 (0)	0 (1)	0 (0)	0 (0)
MH&LD – HAI	0 (0)	0 (0)	1 (1)	0 (0)	0 (0)
MORR – HAI	5 (13)	8 (11)	5 (12)	5 (7)	1 (2)
NPTH - HAI	1 (1)	0 (0)	0 (0)	0 (1)	0 (0)
SH - HAI	0 (3)	1 (4)	2 (7)	2 (3)	0 (0)

Each Service Group improvement plans were presented for final sign-off at Management Board on **18th May 2022.**

Progress against Infection Prevention Improvement Plan to 31.05.22

- To the end of May 2022, the Health Board was on trajectory in relation to the infection reduction profiles for *Klebsiella* bacteraemia and *Pseudomonas aeruginosa* bacteraemia.
- Whilst the Health Board had not achieved the reduction in infection in line with the proposed trajectory for *C. difficile*, *Staph. aureus* bacteraemia and *E. coli* bacteraemia by the end of May, there had been a year-on-year reduction in the number of cases of *C. difficile* (25% fewer cases) and *E. coli* bacteraemia (10% fewer cases).
- Service Groups provide monthly updates on progress at the Quality Management Board.
- Monthly scrutiny meetings have continued with the Executive Medical and Nursing Directors and Service Group Directors.
- Initial scoping meeting held with Clinical Coding to identify feasibility of obtaining baseline data on infections such as hospital acquired pneumonia, readmission for surgical site infection. Next stages will be to identify relevant Clinical Codes and scope with Digital Intelligence feasibility of extracting data for validation and for assessment as a tool for monitoring infections.

Service Group Reported Progress:

- Morriston Service Group – year-on-year reduction in *C. difficile* and *E. coli* bacteraemia; improved uptake of ANTT (Aseptic Non Touch Technique) training; establishment of a twice-weekly site-wide IP&C Safety Huddle, chaired by the Nurse Director; project leads aligned to delivery plan.
- Neath Port Talbot and Singleton Service Group – year-on-year reductions in *C. difficile* in Neath Port Talbot and Singleton Hospitals and in *Staph. aureus* bacteraemia in Singleton; multi-disciplinary workshops held to develop and agree infection improvement plan; 'hot debrief' tool established for review of key HCAI.
- Primary, Community & Therapies Service Group – year-on-year reductions in *C. difficile*, *Staph. aureus* bacteraemia, *E.coli* bacteraemia and *Klebsiella spp*. bacteraemia; reduction in 4C antimicrobial prescribing; key focus areas identified for improvement, with staged time frames, relating to *E. coli* and urinary tract infections; *C. difficile* and associated prescribing guidelines; *Staph. aureus* bacteraemia and community wound care; focussed collaboration with top three outlier GP practices for identified antibiotic prescribing.
- Mental Health & Learning Disabilities Service Group – zero cases to the end of May for *C. difficile,* and all bacteraemia with the exception of *E. coli* bacteraemia.

Challenges, Risks and Mitigation

- Current pressures on Health Board services, both in the community and in hospitals, is extreme, as are the pressures on providing social care packages. The results of these pressures are that numbers of medically fit for discharge patients have increased, which results in increased length of stay for many patients. The demand for unscheduled acute care remains, leading to increased demand for inpatient beds. Surge capacity is being utilised on all inpatient sites, leading to additional patients being on wards (over-occupancy) for periods of time. The increasing inpatient population occurs at a time of increased staff shortages, which an increasing patient-to-staff ratio.
- Historically, infection reduction initiatives have been compromised by the following: staffing vacancies, or shortages caused by sickness absence, with reliance on temporary staff; lack of isolation facilities; over-occupancy because of increased activity; use of pre-emptive beds; and increased activity such that it is not possible to decant bays to clean effectively patient areas where there have been infections.

Actions in progressing Infection Prevention Improvement Plan (what, by when, and by whom) – additional to those included within Service Group Presentations

Action: Identification of appropriate Clinical Codes and scoping feasibility of using these to identify target infections. **Target completion date**: 30.06.22. **Lead:** Head of Nursing IP&C, Clinical Coding Supervisor and Digital Intelligence.

Action: Delivery of ANTT Competence Assessor Training, and other IPC-related training to support Service Groups in achieving improved training compliance. Training dates circulated to all Service Groups. **Target completion date**: 30.06.22. **Lead:** Head of Nursing, IP&C.

Action: Develop an educational package for optimal specimen collection, commencing with urine sampling. **Target completion date**: 31.07.22. **Lead:** Head of Nursing, IP&C.

Financial Implications

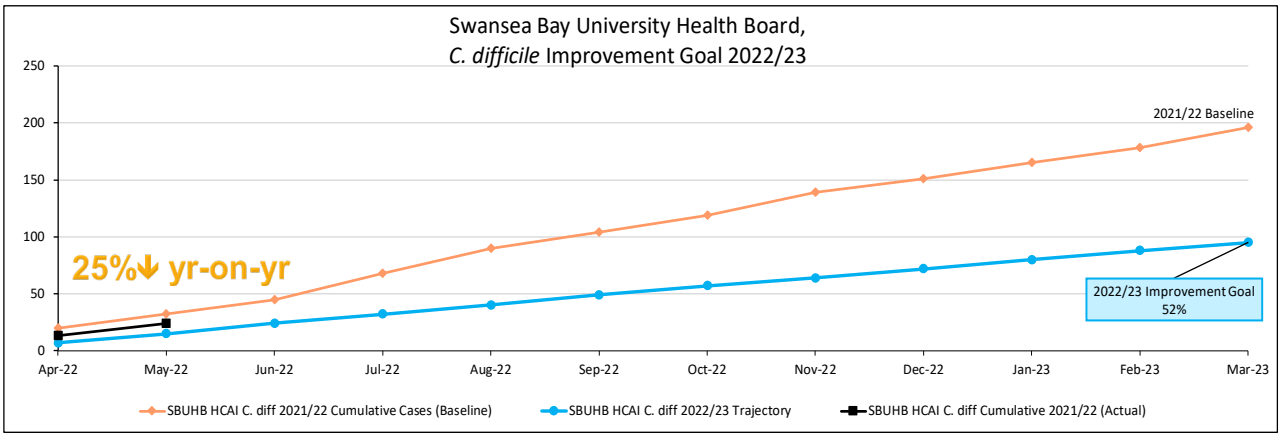
A Department of Health impact assessment report (IA No. 5014, 20/12/2010) stated that the best estimate of costs to the NHS associated with a case of *Clostridioides difficile* infection is approximately **£10,000**. The estimated cost to the NHS of treating an individual cost of MRSA bacteraemia is **£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, the estimated cost of an *E. coli* bacteraemia is between **£1,100** and **£1,400**, depending on whether the *E. coli* is antimicrobial resistant. Estimated costs related to healthcare associated infections, from 01 April 2022 to the end of May 2022 is as follows: *C. difficile* - £240,000; *Staph. aureus* bacteraemia - £210,000; *E. coli* bacteraemia - £58,700; therefore, a total cost of **£508,700**.

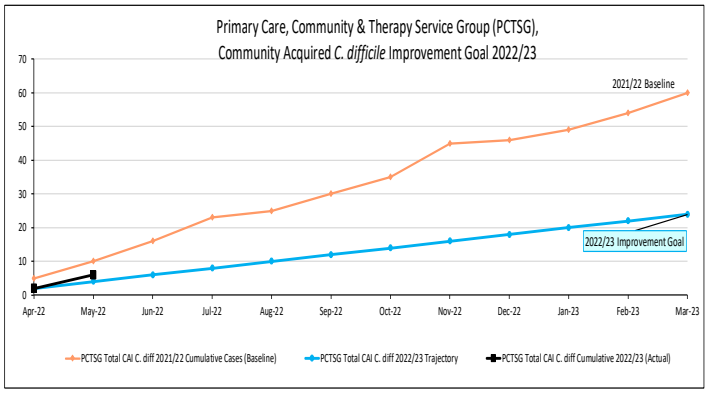
Recommendations

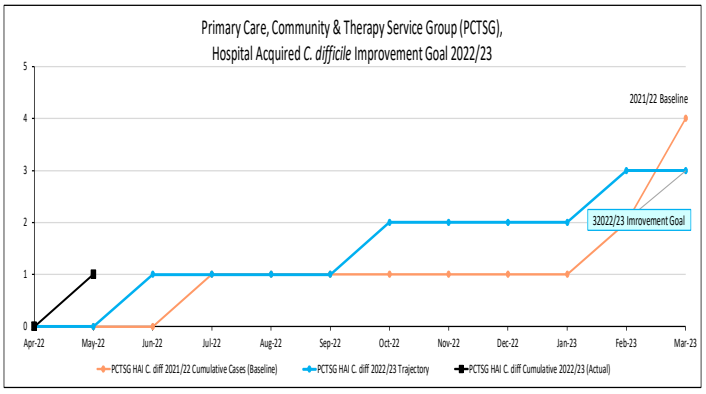
Members are asked to:

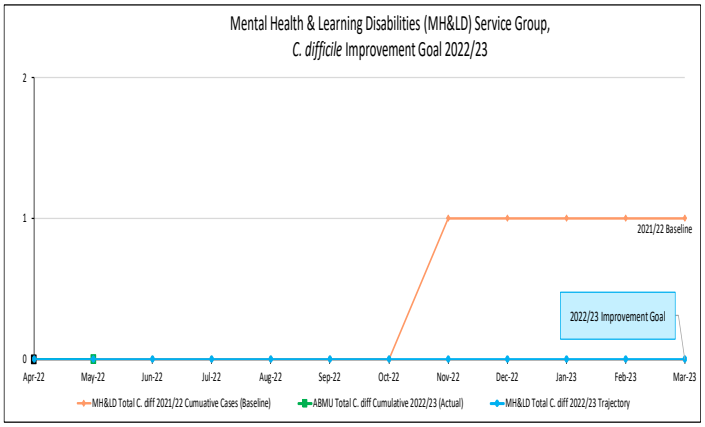
- Consider initial progress to the end of May 2022 against the Health Board's Infection Prevention Improvement Plan, and agree actions for June 2022.

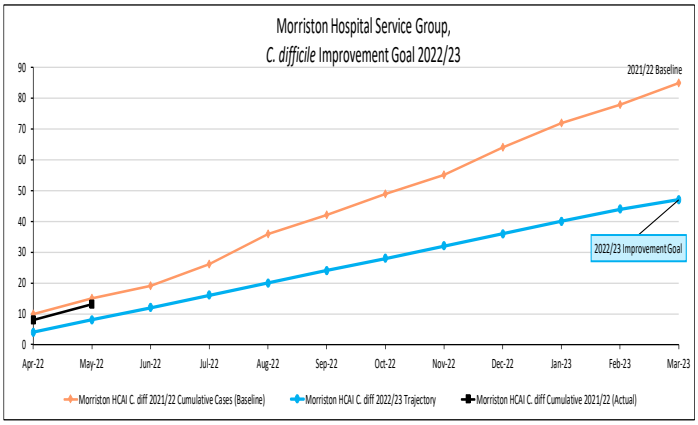
C. difficile

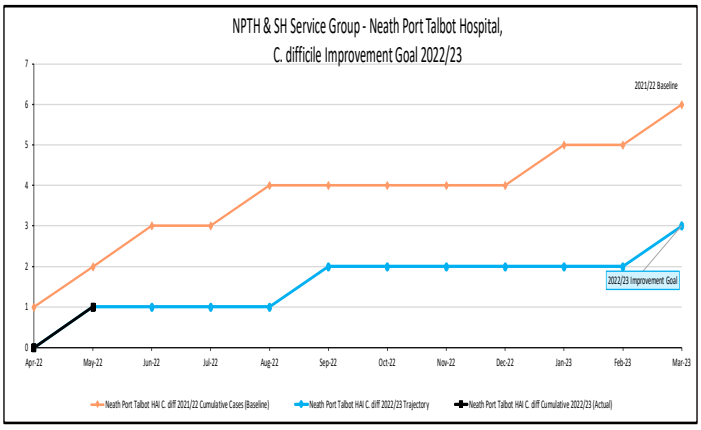

Swansea Bay University Health Board,
C. difficile Improvement Goal 2022/23
250
200
150
100
50
0
2021/22 Baseline
25%↓ yr-on-yr
2022/23 Improvement Goal
52%
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
SBUHB HCAI C. diff 2021/22 Cumulative Cases (Baseline)
SBUHB HCAI C. diff 2022/23 Trajectory
SBUHB HCAI C. diff Cumulative 2021/22 (Actual)

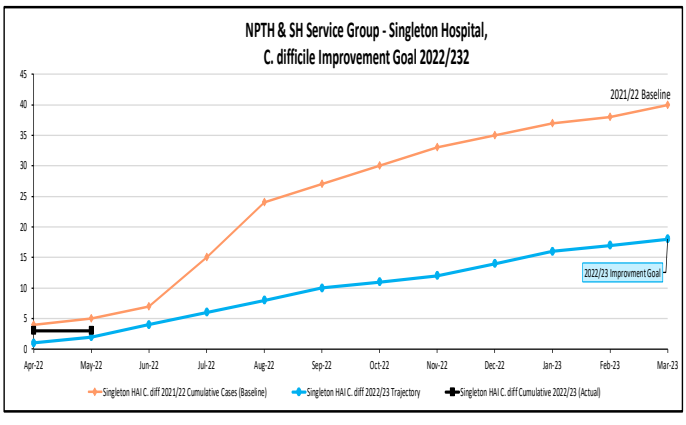

Primary Care, Community & Therapy Service Group (PCTSG),
Community Acquired C. difficile Improvement Goal 2022/23
2021/22 Baseline
2022/23 Improvement Goal
PCTSG Total CAI C. diff 2021/22 Cumulative Cases (Baseline)
PCTSG Total CAI C. diff 2022/23 Trajectory
PCTSG Total CAI C. diff Cumulative 2022/23 (Actual)


Primary Care, Community & Therapy Service Group (PCTSG),
Hospital Acquired C. difficile Improvement Goal 2022/23
2021/22 Baseline
32022/23 Improvement Goal
PCTSG HAI C. diff 2021/22 Cumulative Cases (Baseline)
PCTSG HAI C. diff 2022/23 Trajectory
PCTSG HAI C. diff Cumulative 2022/23 (Actual)

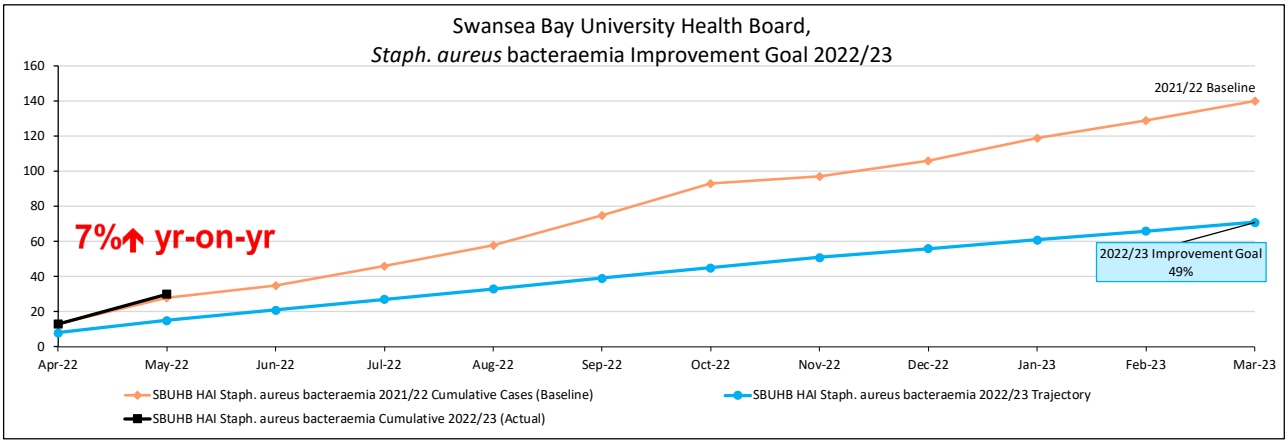

Mental Health & Learning Disabilities (MH&LD) Service Group,
C. difficile Improvement Goal 2022/23
2021/22 Baseline
2022/23 Improvement Goal
MH&LD Total C. diff 2021/22 Cumulative Cases (Baseline)
ABMU Total C. diff Cumulative 2022/23 (Actual)
MH&LD Total C. diff 2022/23 Trajectory

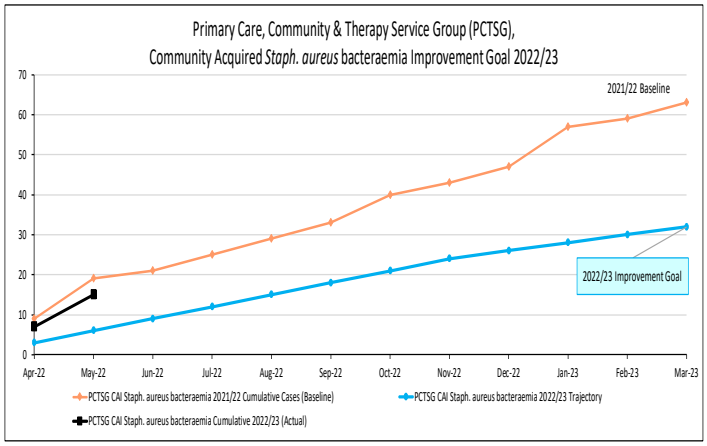

Morriston Hospital Service Group,
C. difficile Improvement Goal 2022/23
2021/22 Baseline
2022/23 Improvement Goal
Morriston HCAI C. diff 2021/22 Cumulative Cases (Baseline)
Morriston HCAI C. diff 2022/23 Trajectory
Morriston HCAI C. diff Cumulative 2021/22 (Actual)

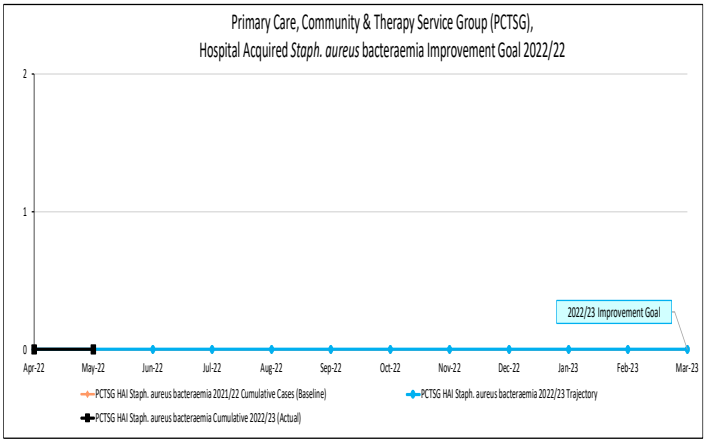

NPTH & SH Service Group - Neath Port Talbot Hospital,
C. difficile Improvement Goal 2022/23
2021/22 Baseline
2022/23 Improvement Goal
Neath Port Talbot HAI C. diff 2021/22 Cumulative Cases (Baseline)
Neath Port Talbot HAI C. diff 2022/23 Trajectory
Neath Port Talbot HAI C. diff Cumulative 2022/23 (Actual)

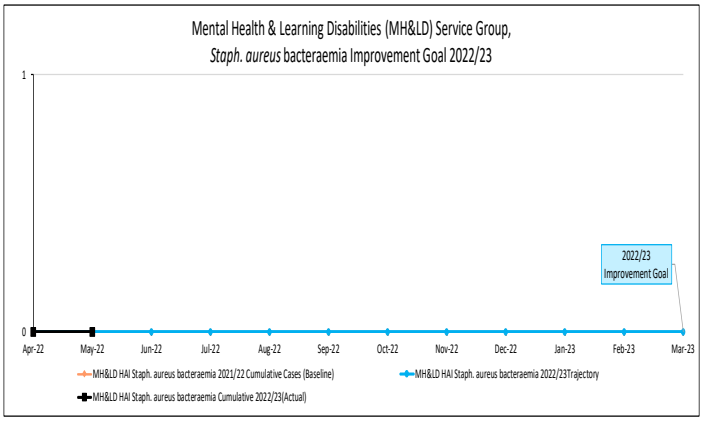

NPTH & SH Service Group - Singleton Hospital,
C. difficile Improvement Goal 2022/232
2021/22 Baseline
2022/23 Improvement Goal
Singleton HAI C. diff 2021/22 Cumulative Cases (Baseline)
Singleton HAI C. diff 2022/23 Trajectory
Singleton HAI C. diff Cumulative 2022/23 (Actual)

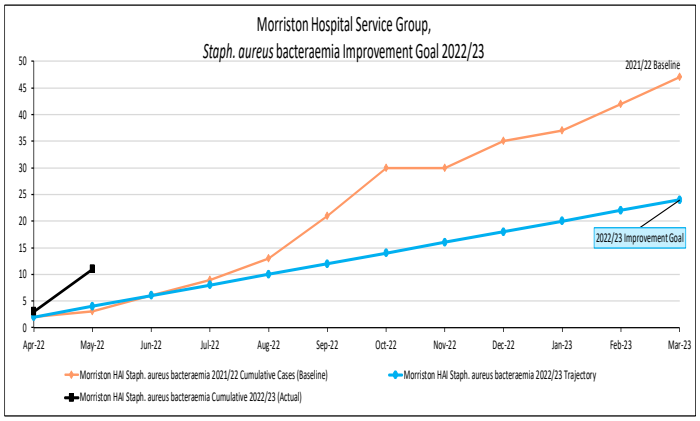
***Staph. aureus* bacteraemia**

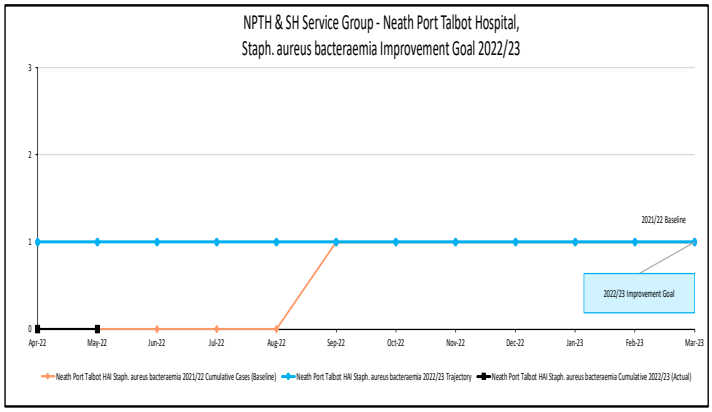


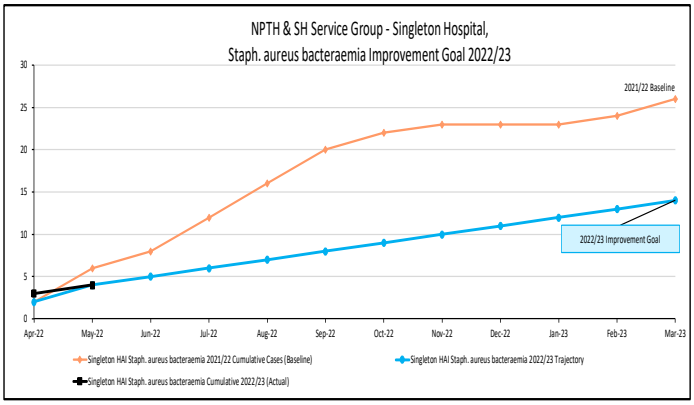




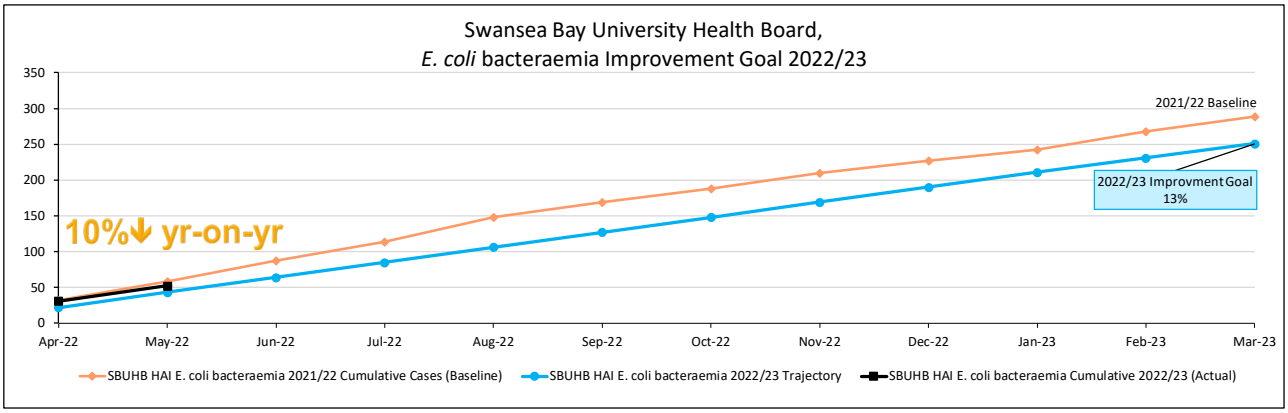


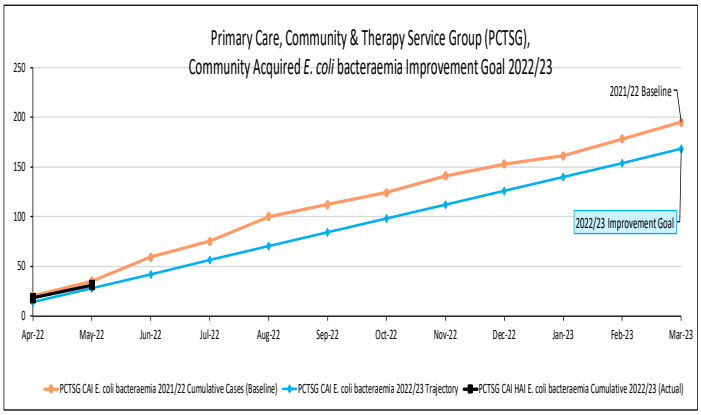


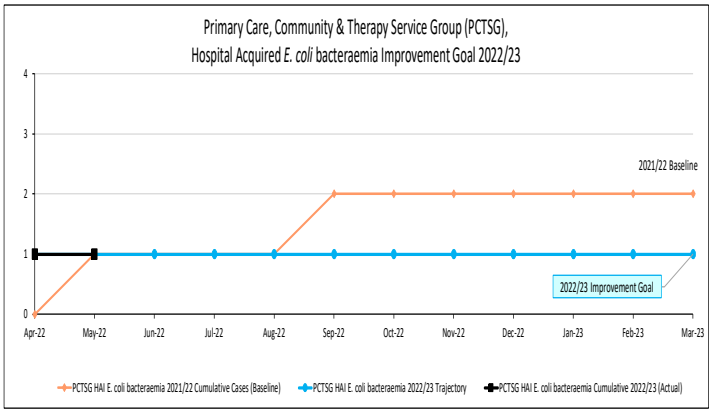


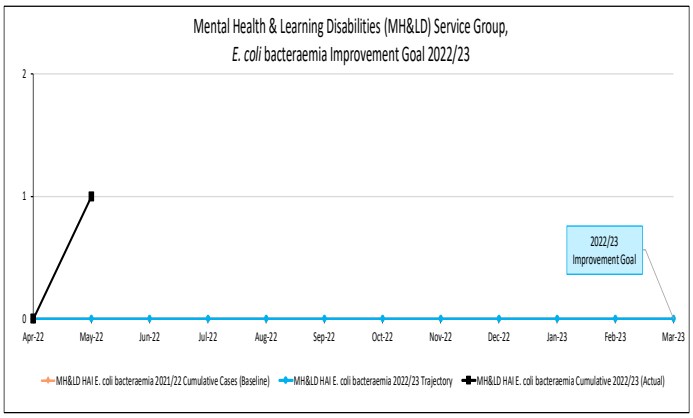


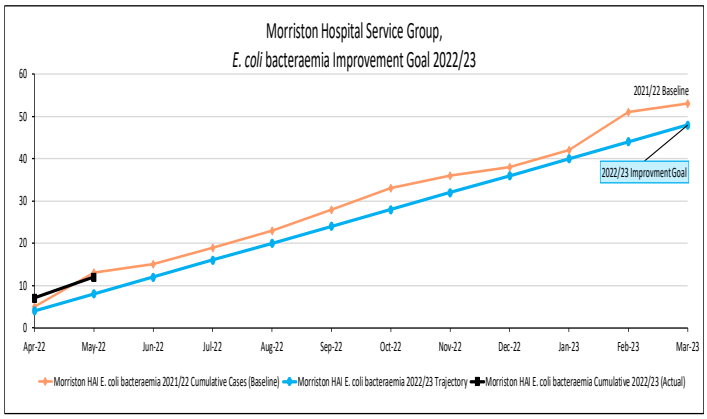
E. coli bacteraemia

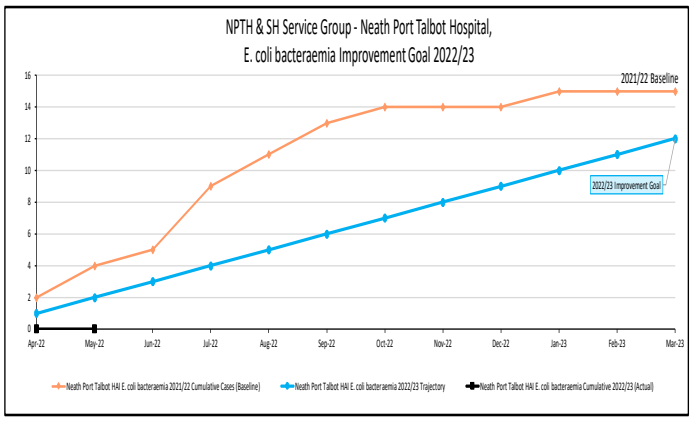


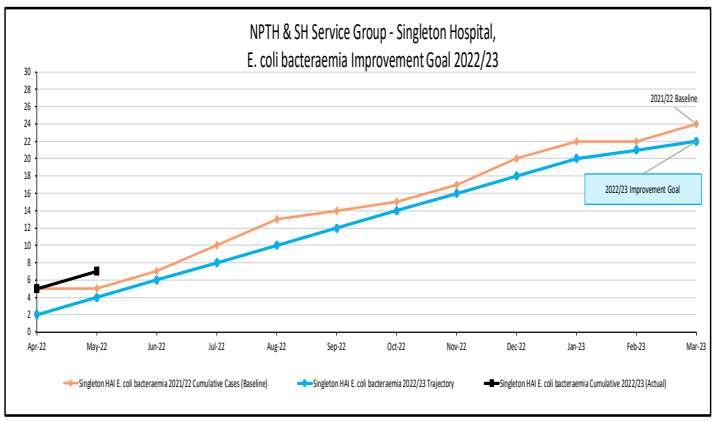




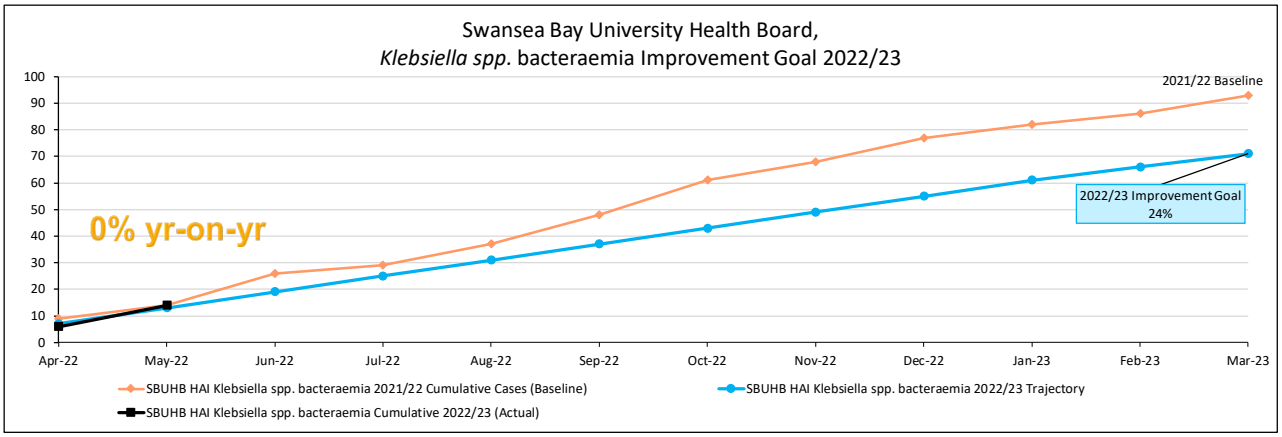


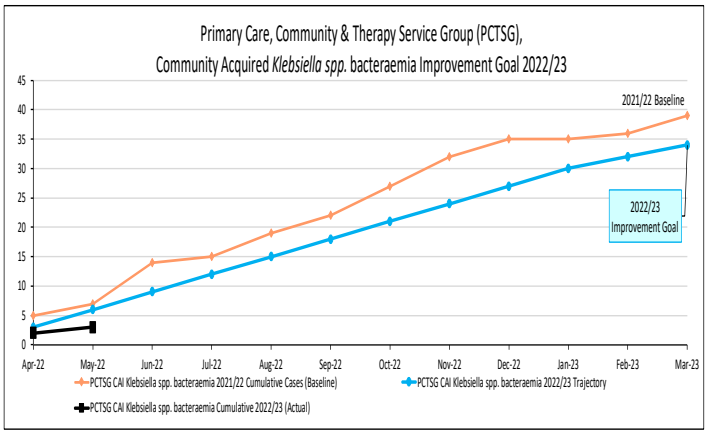


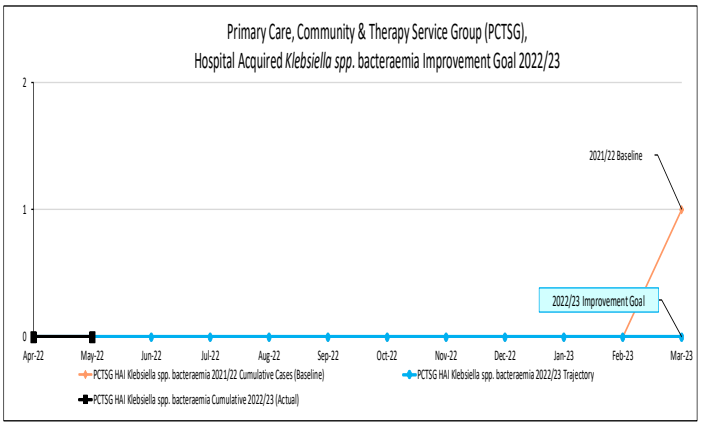


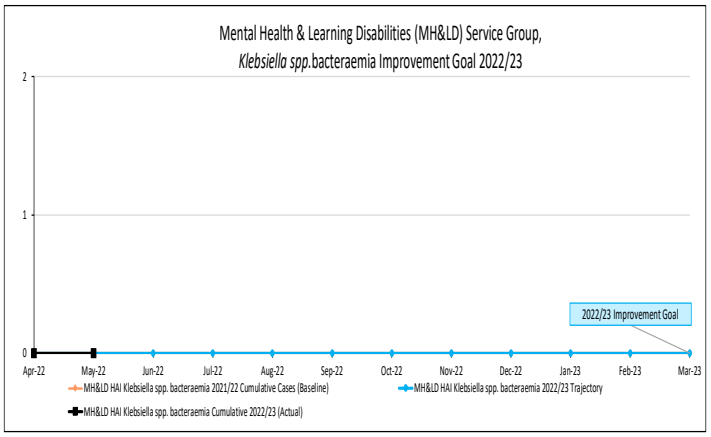


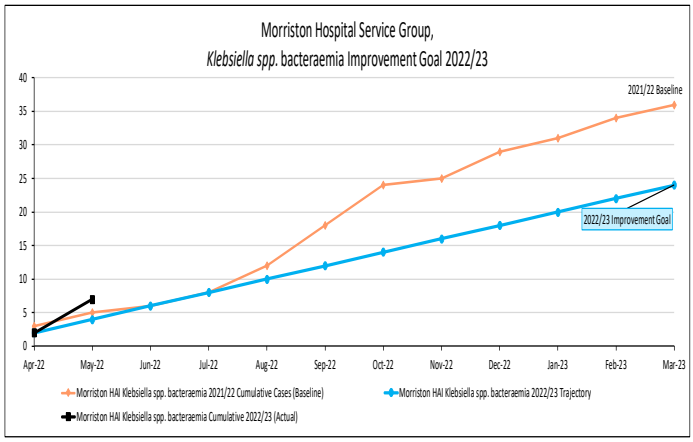
***Klebsiella spp.* bacteraemia**

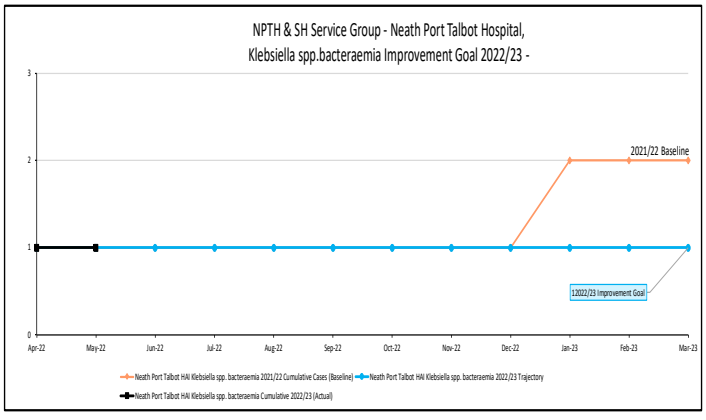


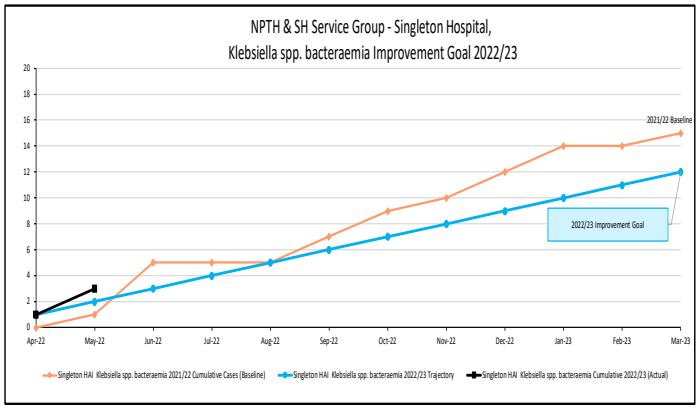




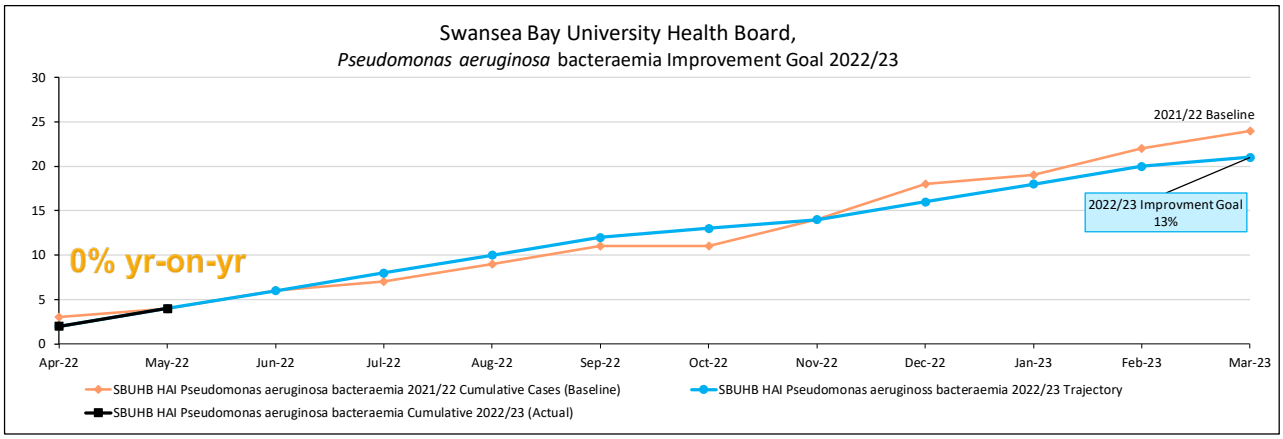


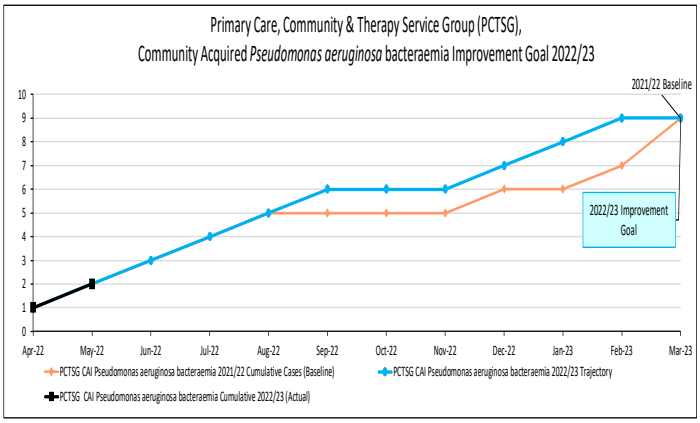


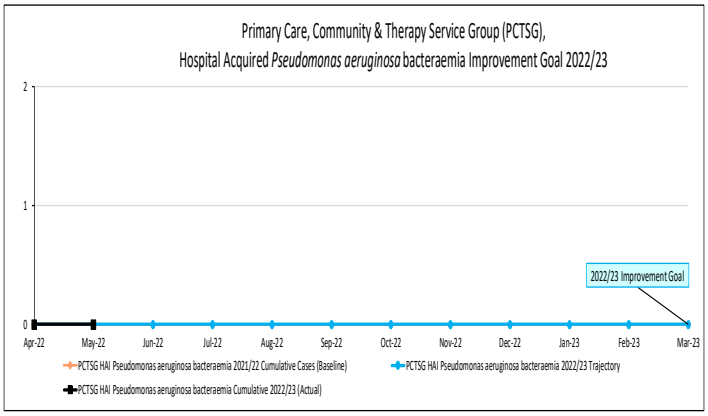


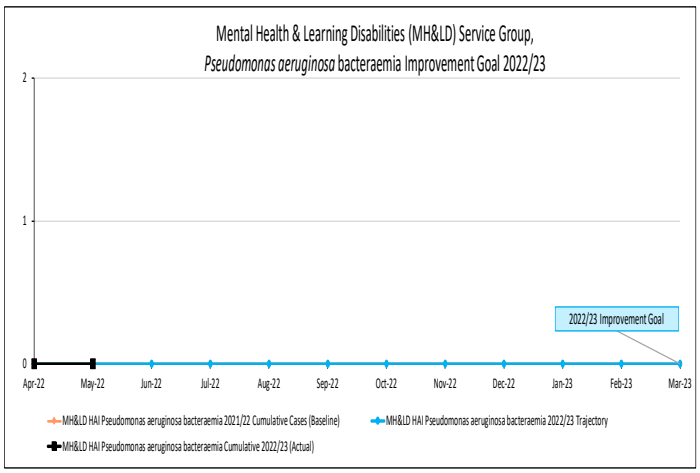


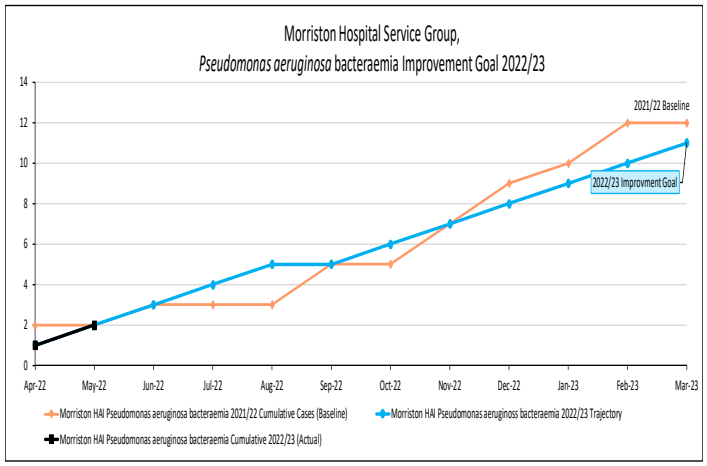
***Pseudomonas aeruginosa* bacteraemia**

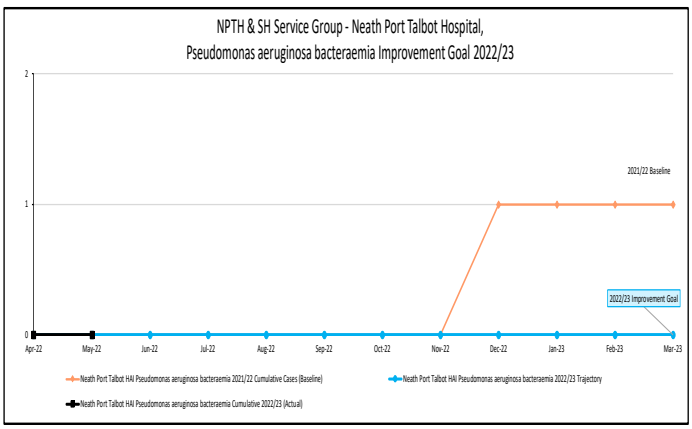


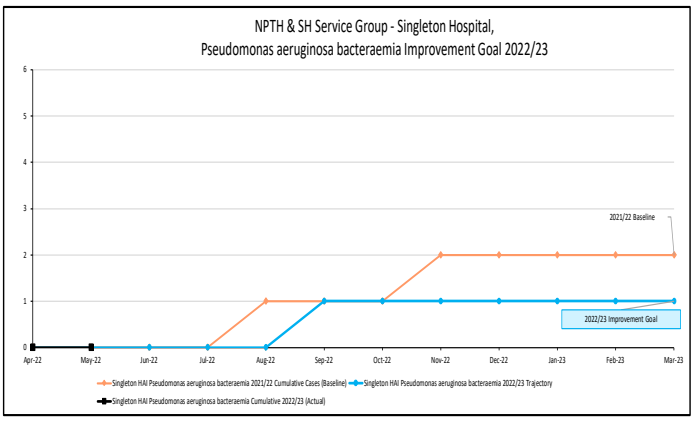












PCTSG IPC Update

Quarter 1

Current position: Tier 1 targets

	CAI cases April 22	CAI cases May 22	WG CAI monthly target rate	Total HB cases April 22	Total HB cases May 22	WG HB monthly target rate	SBUHB current rate per 100,000	WG HCAI reduction expectation per 100,000
E.Coli	18	12	<14	31	19	<21	74	67
C. Difficile	2	4	<2	13	8	<8	50	25
Staph. Aureus	7	9	<3	13	16	<6	36	20

	CAI cases April 22	CAI cases May 22	WG CAI monthly target rate	Total HB cases April 22	Total HB cases May 22	WG monthly target rate	Cumulative year-on-year % reduction	WG HCAI reduction expectation year-on-year
Klebsiella	2	1	<3	6	7	<6	-57	10%
P. aeruginosa	1	0	<2	2	1	<2	-50	10%

E-Coli

HCAI	Baseline	Qtr 1 target	Progress
E.coli	18% increase reported in year-on-year comparison data (20/21 – 21/22)	Establishment of UTI Campaign T&F group	Completed
	21/22 data reports current SBUHB infection rate of 74 per 100,000 population, above the all Wales average of 68 per 100,000	Engagement with General Practice, OOH and Care Homes sector	Ongoing. Initial engagement with General Practice regarding UTI prescribing and QAIF flexi scheme. Care Homes sector engagement via LTC and general IPC. Awaiting recruitment of link IPC Care Homes Lead Nurse role. Urgent Primary Care engagement yet to be initiated.

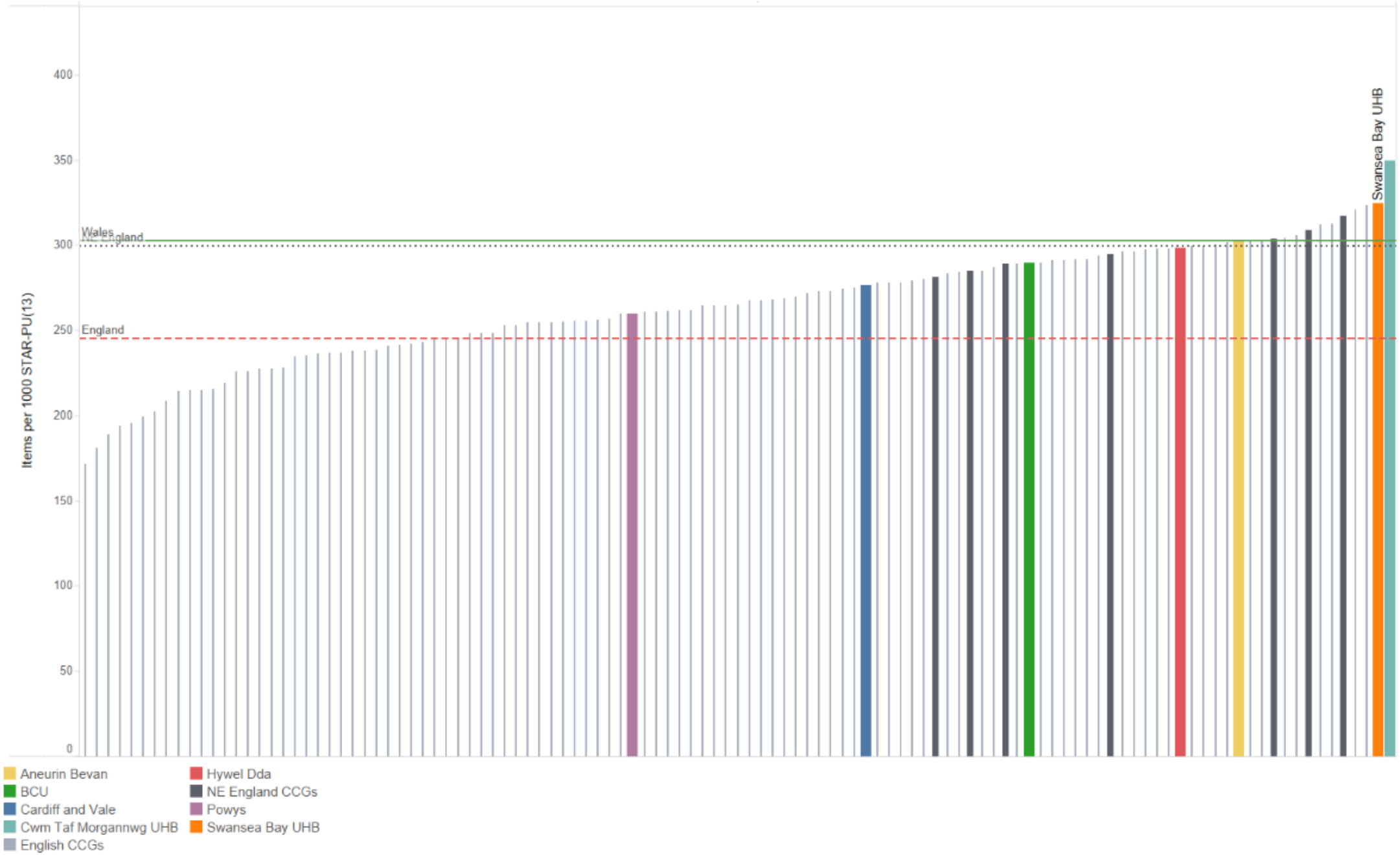
Clostridioides Difficile

HCAI	Baseline	Qtr 1 target	Progress
C. Difficile	6.3% increase reported in year-on-year comparison data (20/21 – 21/22)	Collaboration between IPC and PCTSG to establish a new SEA reporting pathway for Primary Care	Pathway agreed. Sign off and implementation expected by end of quarter 1.
	21/22 data reports current SBUHB infection rate of 50 per 100,000 population, above the all Wales average of 35 per 100,000	Introduction and promotion of new c.difficile prescribing guidelines across Primary Care, Community and Therapies services	Completed. Ongoing engagement with General Practice and UPC to ensure implementation and adherence to guidelines

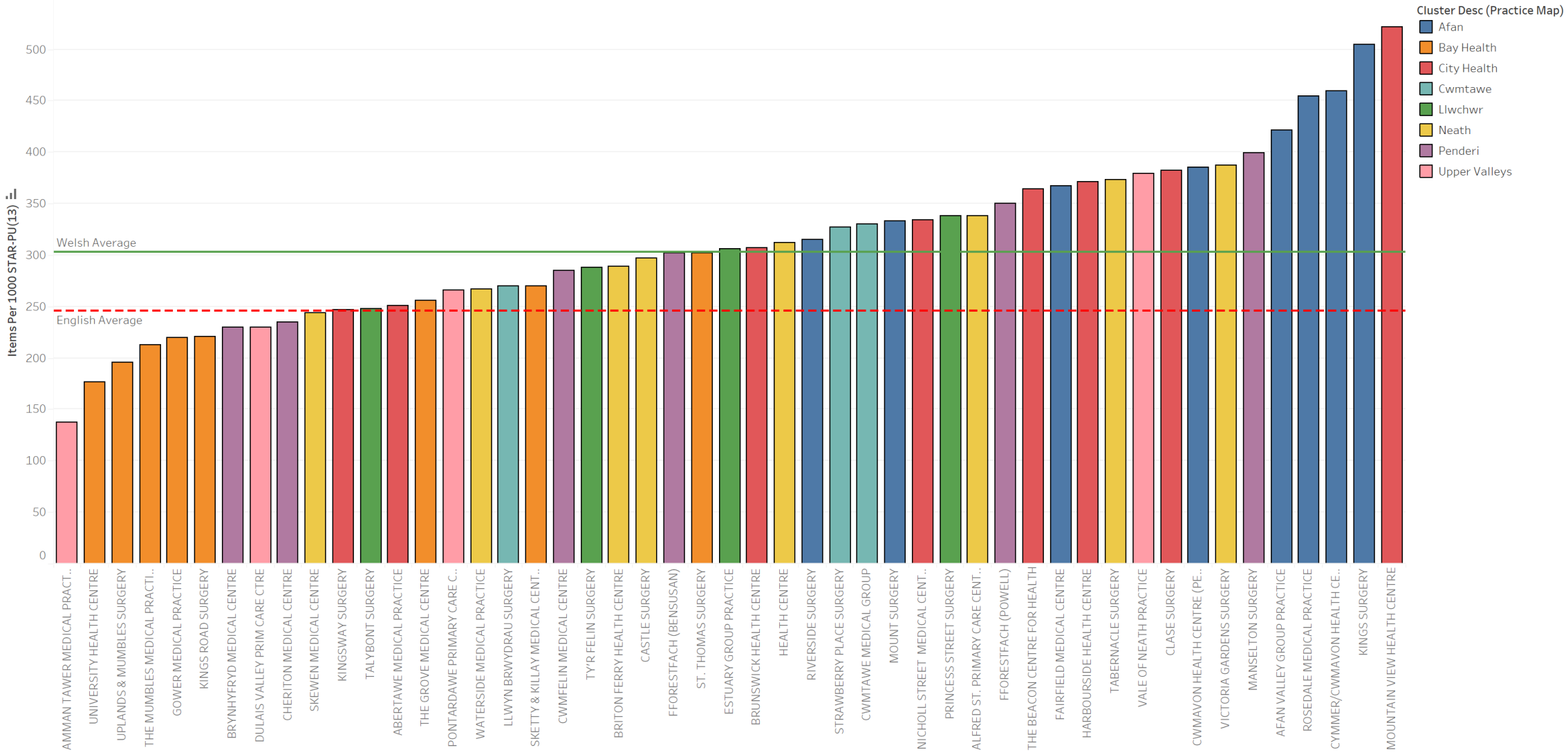
Staphylococcus Aureus

HCAI	Baseline	Qtr 1 target	Progress
Staph. Aureus	Static number cases reported in year-on-year comparison data (20/21 – 21/22)	Scrutiny of 2021/22 data. Discussion between PCTSG and IPC to agree a targeted approach to reduce Community associated staph aureus cases.	Completed
	21/22 data reports current SBUHB infection rate of 36 per 100,000 population, above the all Wales average of 26 per 100,000	Establish structure for Community wound care staph aureus prevention campaign. Engage with Community Wound Care team	Not commenced. Scheduled for end June 22.

AMS: Highest Prescribing Practices


Items per 1000 STAR-PU(13)
400
350
300
250
200
150
100
50
0
Wales
NE England
England
Swansea Bay UHB
Aneurin Bevan
BCU
Cardiff and Vale
Cwm Taf Morgannwg UHB
English CCGs
Hywel Dda
NE England CCGs
Powys
Swansea Bay UHB

Antibacterial Items Per 1000 STAR-PU(13)
December 2021



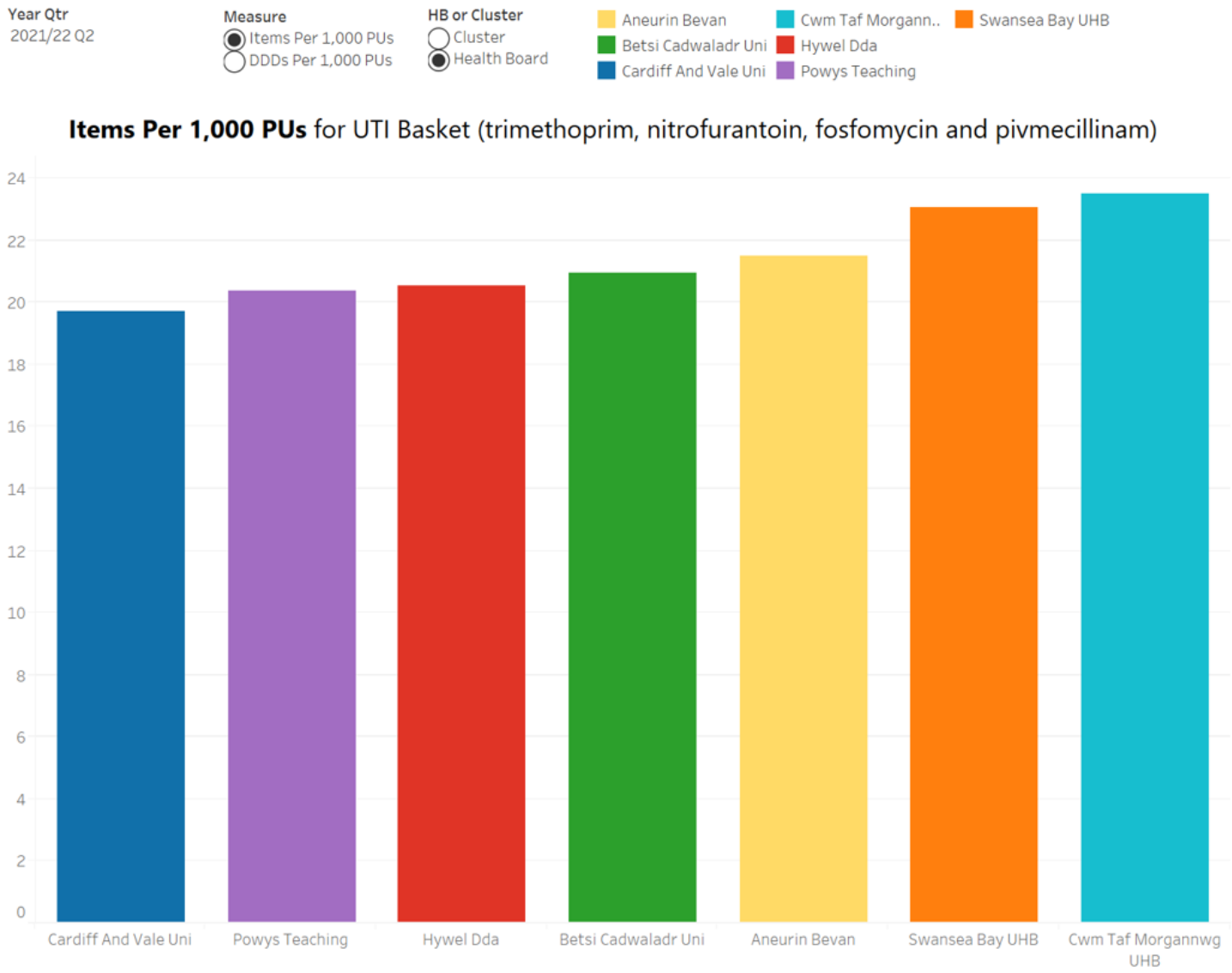
AMS

Highest Prescribers: Actions

- Top 3 outlier practices for antibiotic prescribing
- Collaboration with Antimicrobial Pharmacy team and PCTSG
- Afan and City Cluster Pilot
- Target areas: Long term abx and UTI associated prescribing
- Performance discussion: GMD/Governance CD to GPs

UTIs in Elderly Patients

- Urinary tract infections (UTIs) are one of the most commonly treated bacterial infections in primary care.
- There is concern that UTIs are misdiagnosed and inappropriately treated in elderly patients.
- SBUHB *E. coli* bacteraemia rates are above the national average



Method

- Prescribing of UTI antibiotics (nitrofurantoin, trimethoprim, fosfomycin and pivmecillinam) in patients over the age of 65 years were reviewed in:
  - **Cymmer/Cwmavon**
  - Afan valley
  - **Mountain View**
  - Greenhill
- Sample of prescriptions were audited more in-depth by AMP using the TARGET toolkit audit template

Areas Identified for Improvement

Choice of therapy

- Empirical trimethoprim use
- Nitrofurantoin use in impaired or unknown renal function

Duration

- All patients receiving 7 days

Diagnosis

- Dipstick use to guideline diagnosis
- Consistency of information from care homes

Education and training session conduction in surgery including GPs, nurses, PAs, reception staff

Posters of guidelines disseminated

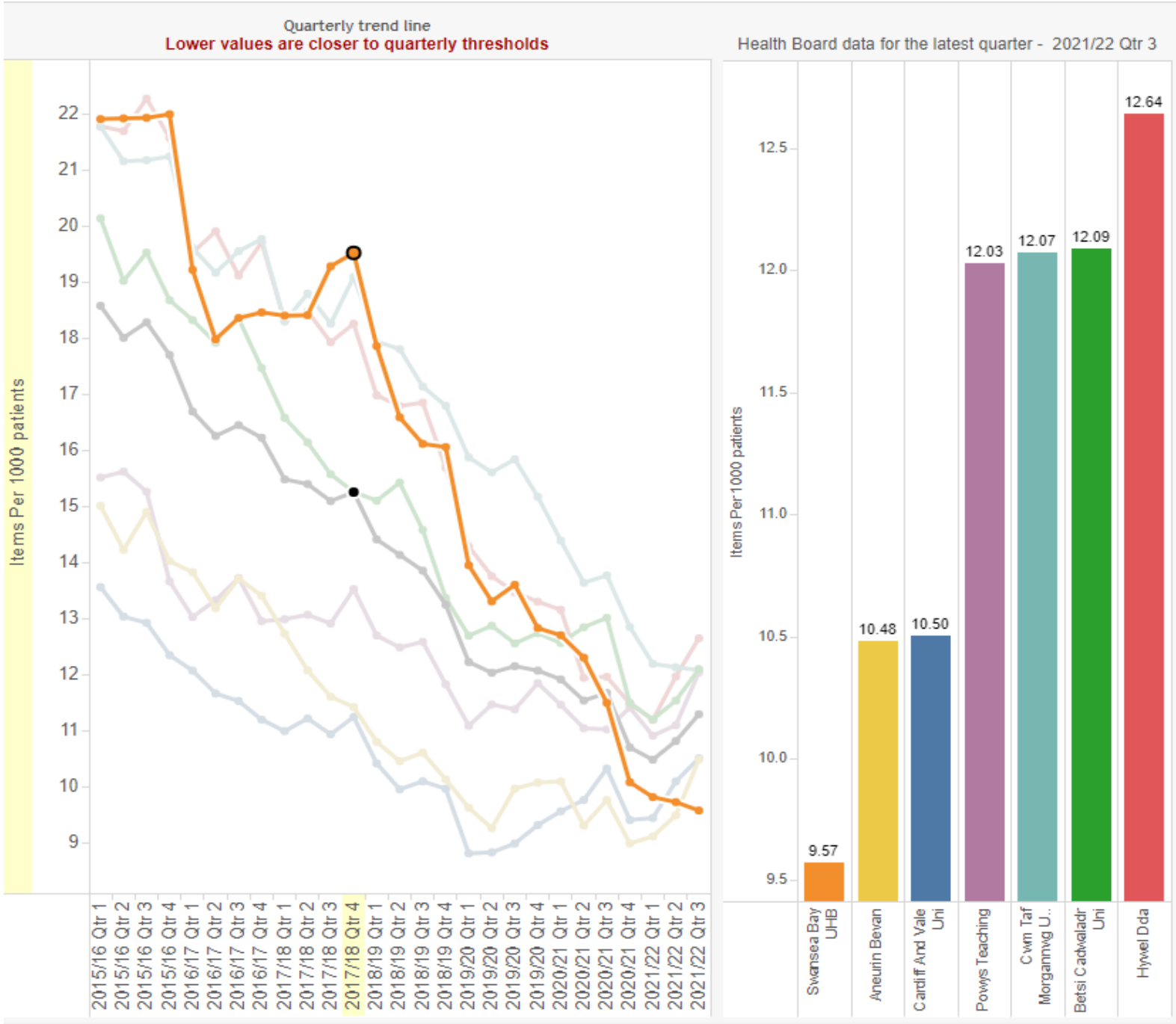
Quarter 1 Progress in UTI Prescribing: Pilot Data

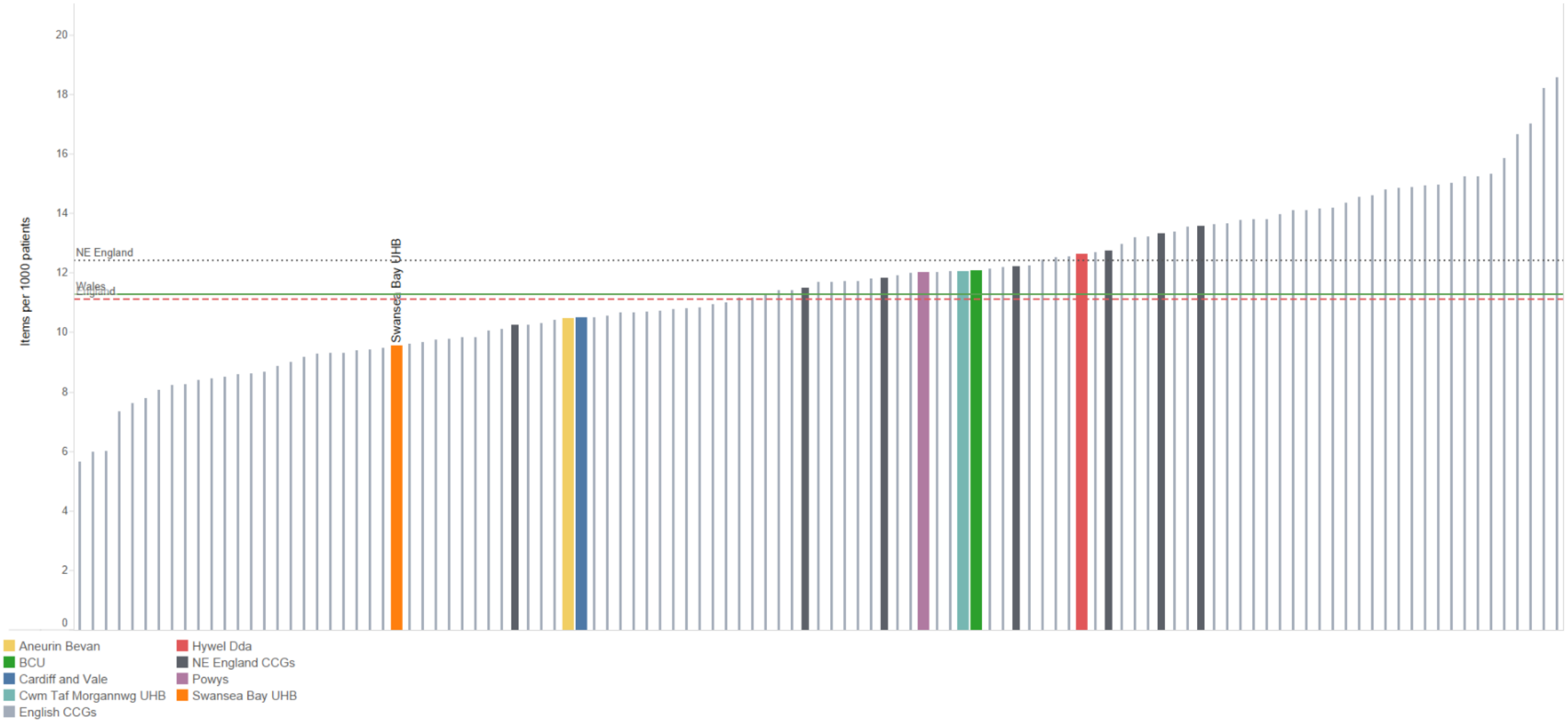
Antibiotic	Pre E&T session	Pre E&T session	% change
Trimethoprim	60	7	-88%
Nitrofurantoin	99	103	+4%
Pivmecillinam	9	21	+133%
Fosfomycin	34	18	-47%
Total	202	146	-28%

4C Prescribing

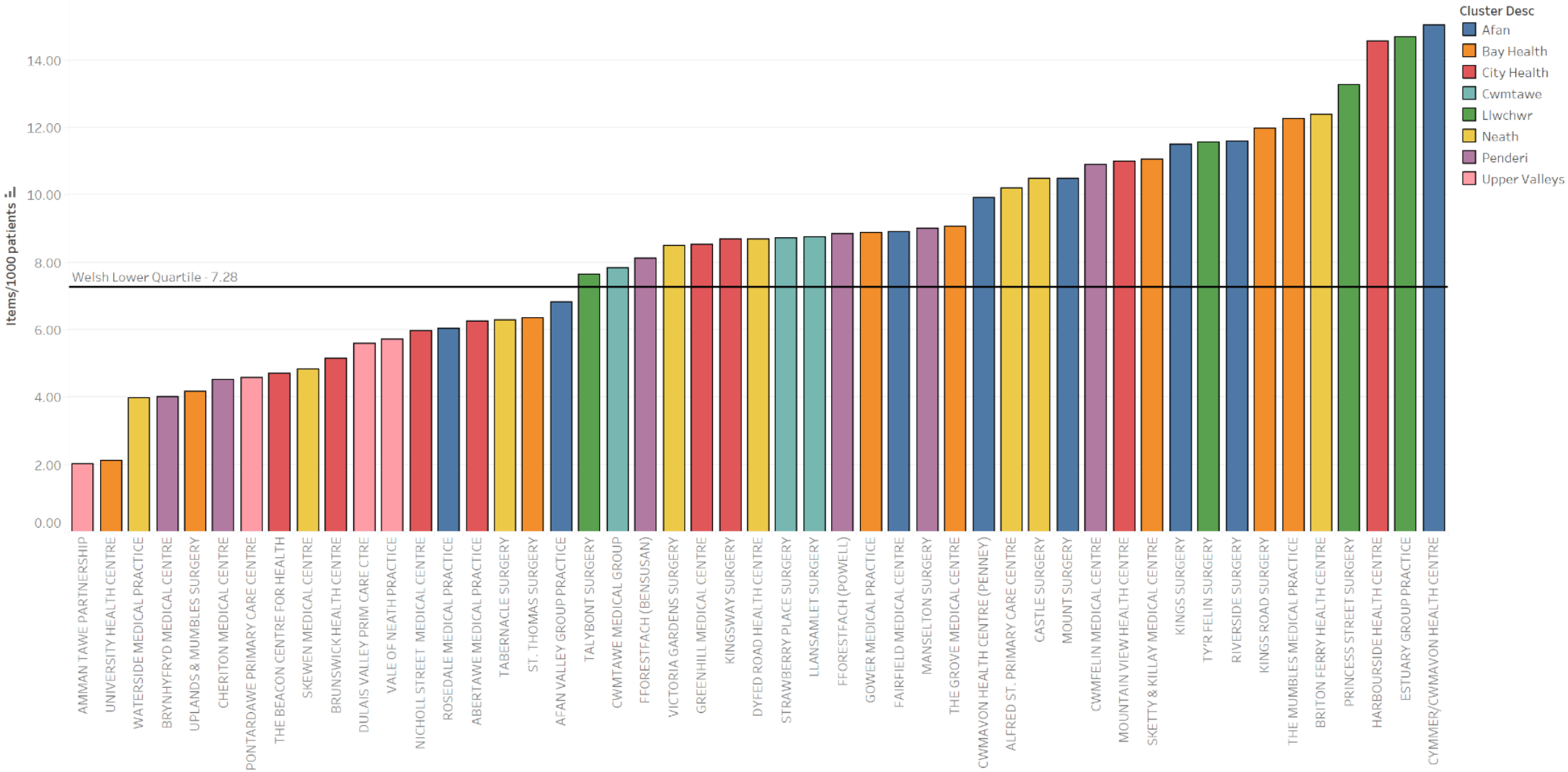
4Cs

- Broad-spectrum (4C) Prescribing in Primary Care by Health Board
- Data up to December 2021




Items per 1000 patients
20
18
16
14
12
10
8
6
4
2
0
NE England
Wales
England
Swansea Bay UHB
Aneurin Bevan
BCU
Cardiff and Vale
Cwm Taf Morgannwg UHB
English CCGs
Hywel Dda
NE England CCGs
Powys
Swansea Bay UHB

4C Antibacterials Items Per 1000 patients
December 2021



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

Quality & Safety Committee Health Care Acquired Infections Update

Neath Port Talbot & Singleton Service Group

July 2022

2021 / 2022 Position

Health Care Acquired Infections: 2021 – 2022

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Accum cases	Quality Priority Annual Goal
CDI	5	2	3	8	10	3	3	3	2	3	1	3	46	< 25
S Aureus	2	4	2	4	4	5	2	1	0	0	2	2	28	< 21
E. Coli	7	2	3	7	5	3	2	2	3	2	0	2	38	< 38
Klebsiella	1	1	4	0	0	2	2	1	2	3	0	1	17	< 15
Psudomonas	0	0	0	0	1	0	0	1	1	0	0	0	3	< 2

Clostridium Difficile
The SG exceeded it's Quality Priority reduction goal (<25) with a total of 46 cases reported (6 NPT and 46 Singleton)

There was a significant increase in cases during July and August 2021 (17 cases at Singleton and 1 at NPT)

Staph Aureus Bacteraemia

- The Group has exceeded its QP reduction goal (<21) with a total cases of 18 at year end

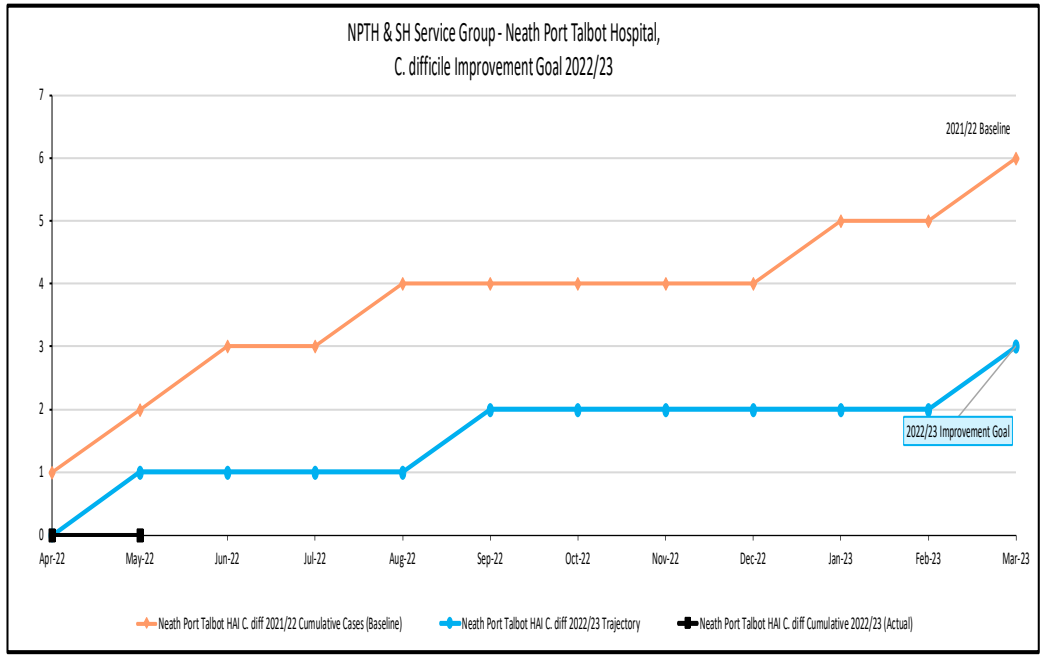
E Coli Bacteraemia

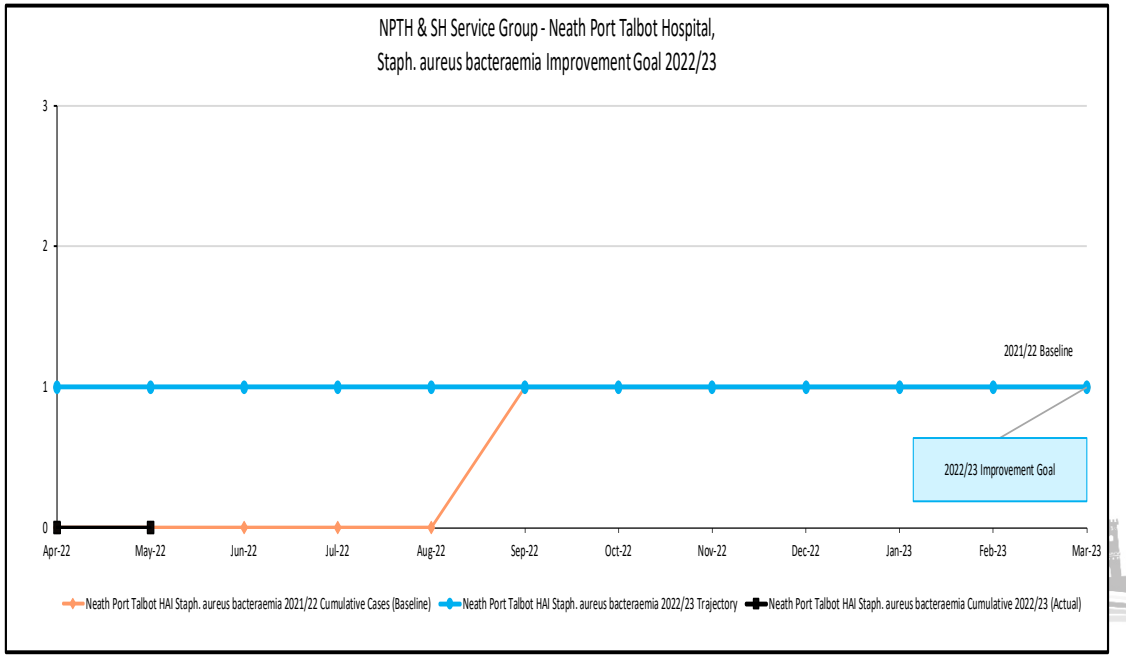
- The Group has achieved the QP annual goal (<38) for E-Coli

April / May 2022

Infection Prevention and Control – Current Position - NPTH

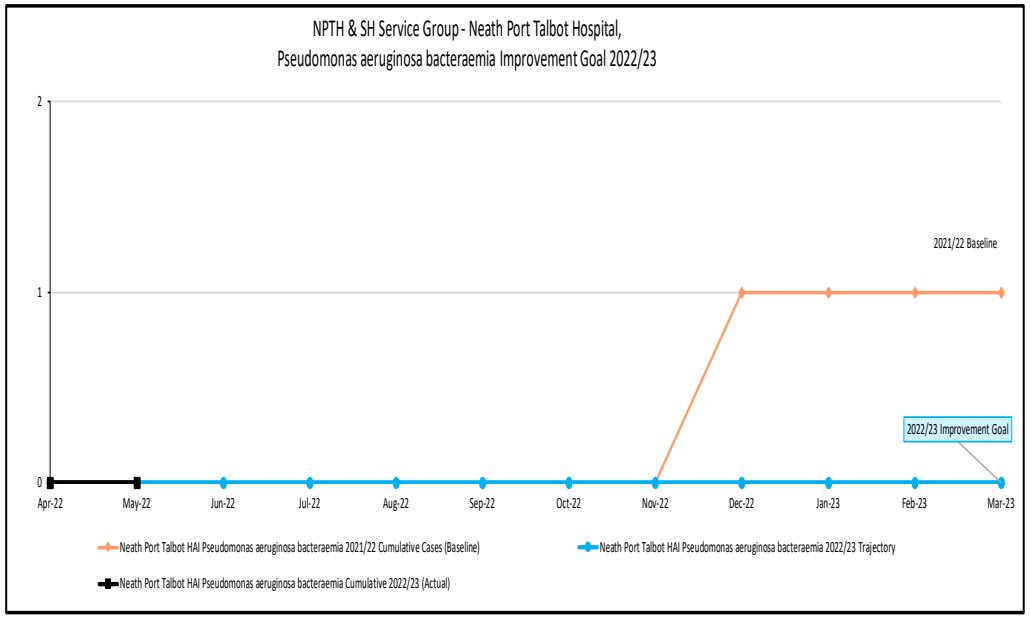
	April 21	May 21	Total 20/21	April 22	May 22 * Unverified figures	Total 2022	Improvement Goal	Performance against goal
C-Diff	1	1	1	0	0	0	1	-1
Staph Aureus	0	0	0	0	0	0	0	
E-Coli	2	2	2	0	0	0	1	-1
Klebsiella	1	0	1	1	0	1	0	+1
Pseudomonas	1	0	1	0	0	0	0	

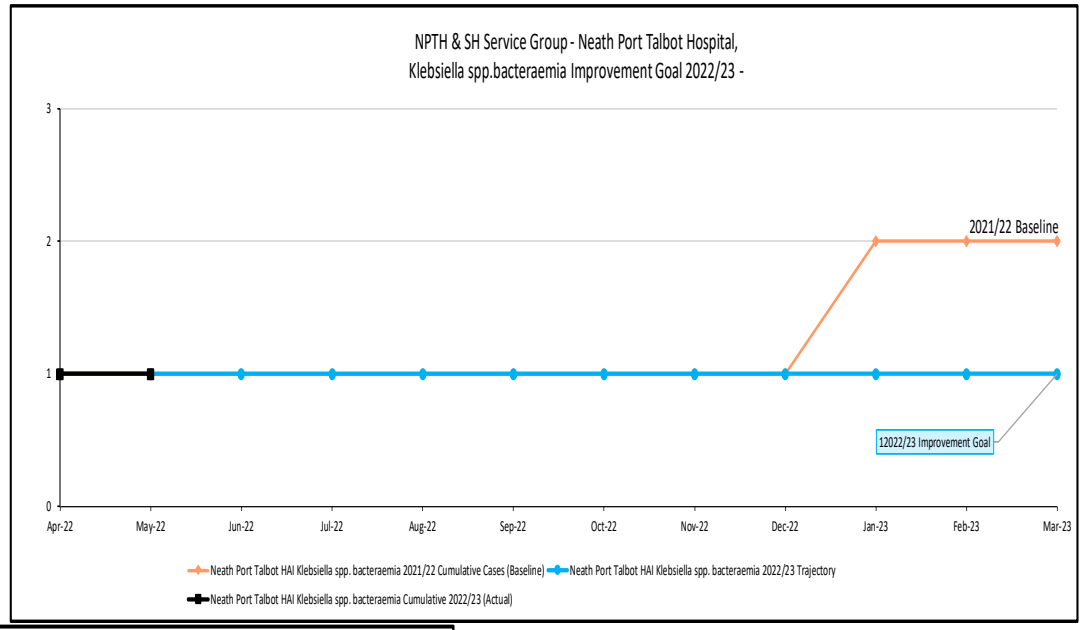


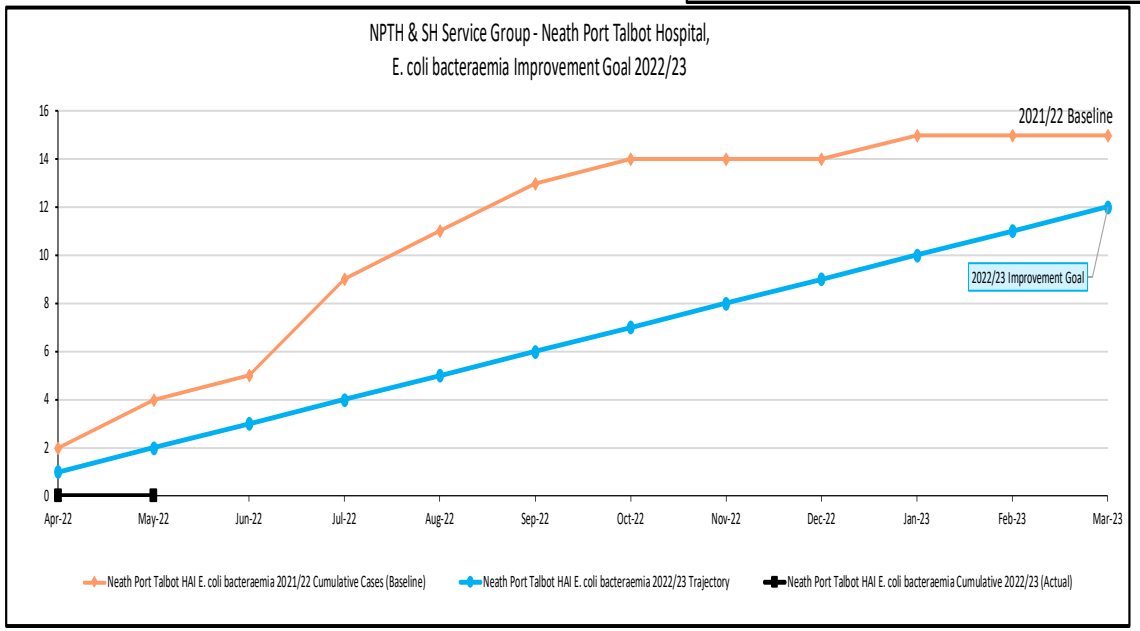


April / May 2022

Infection Prevention and Control – Current Position - NPTH



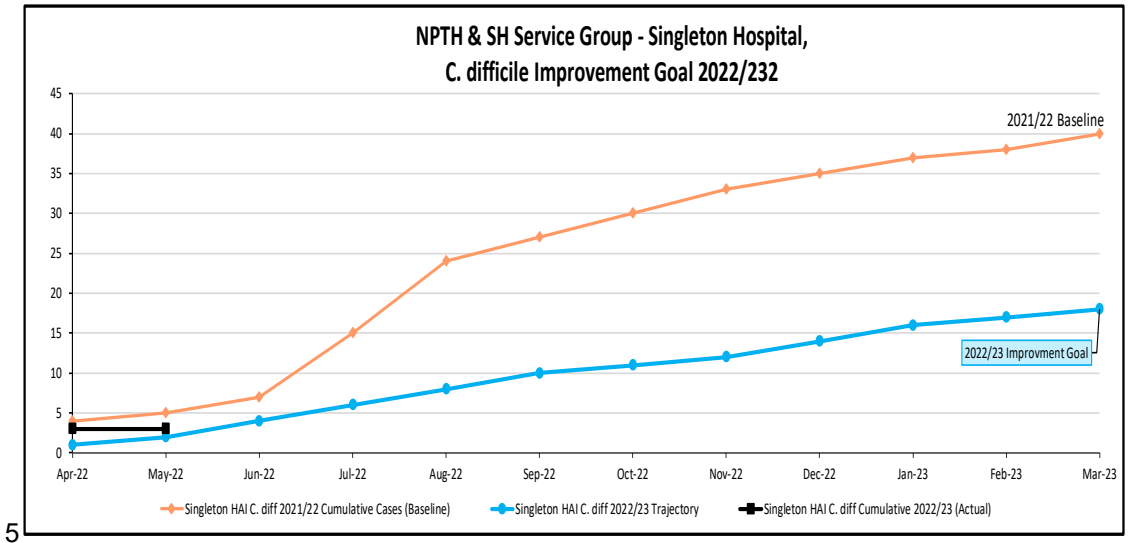


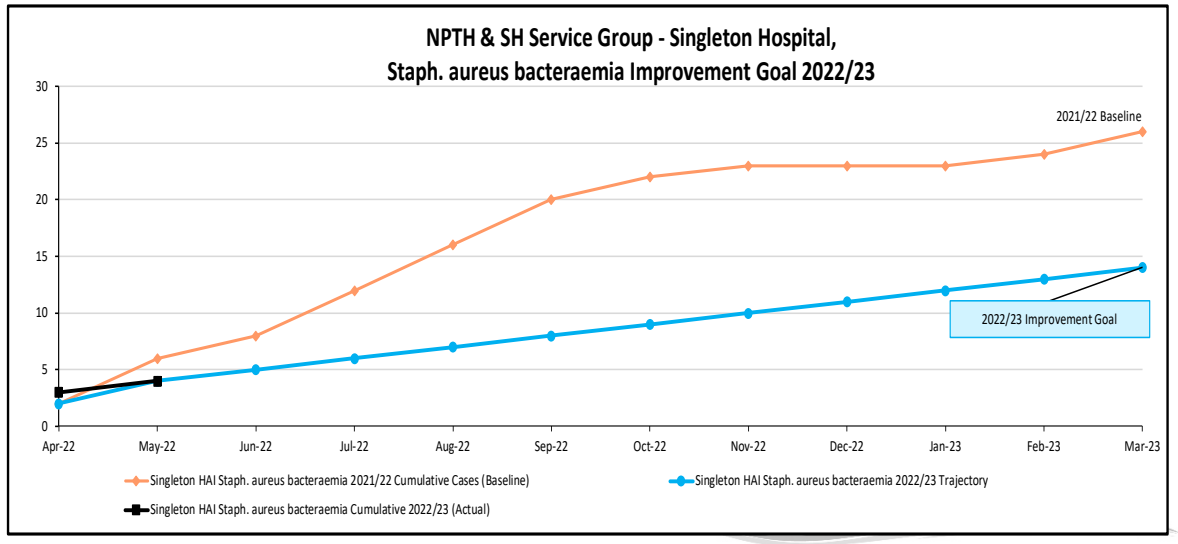


April / May 2022

Infection Prevention and Control – Current Position – Singleton Hospital

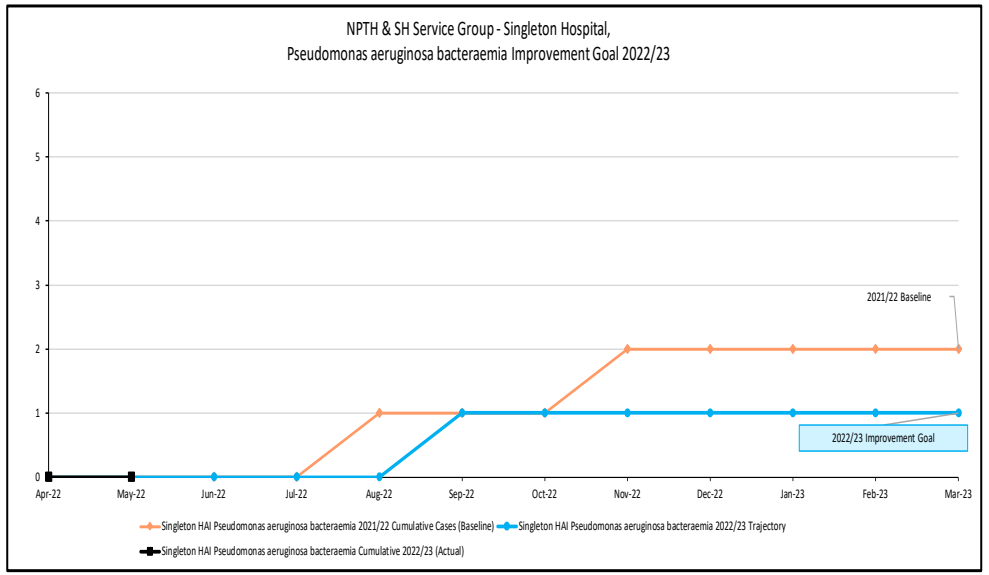
	April 21	May 21	Total 21/22	April 22	May 22 * Unverified figures	Total 2022	Improvement Goal	Performance against goal
C-Diff	4	2	6	3	1	↓ 4	1	↑ +3
Staph Aureus	2	4	6	3	1	↓ 4	2	↑ +2
E-Coli	5	0	5	5	2	↑ 7	2	↑ +5
Klebsiella	0	1	1	1	2	↑ 3	1	↑ +2
Pseudomonas	0	0	0	0	0	0	0	→

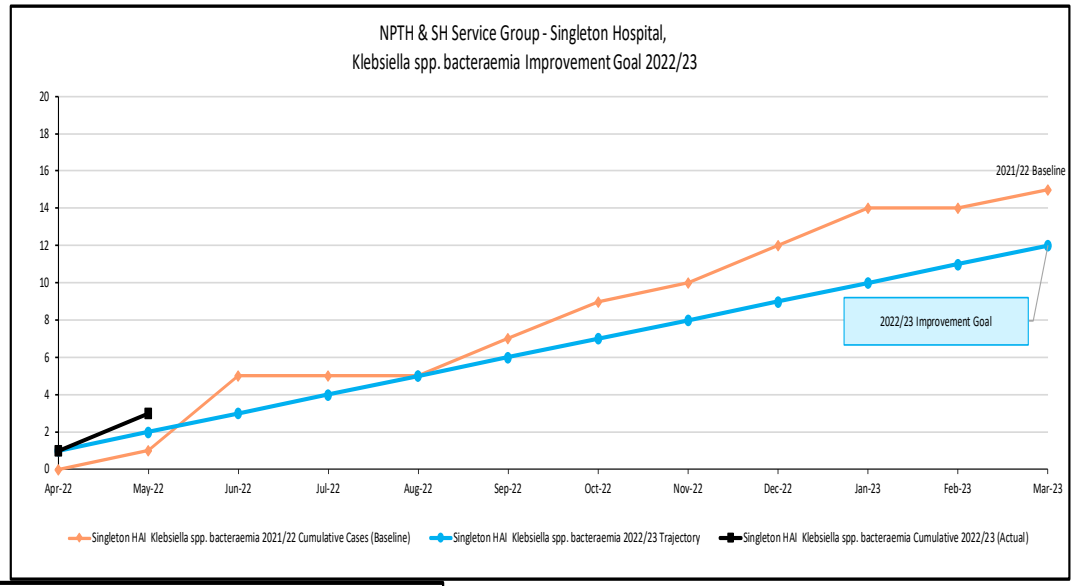


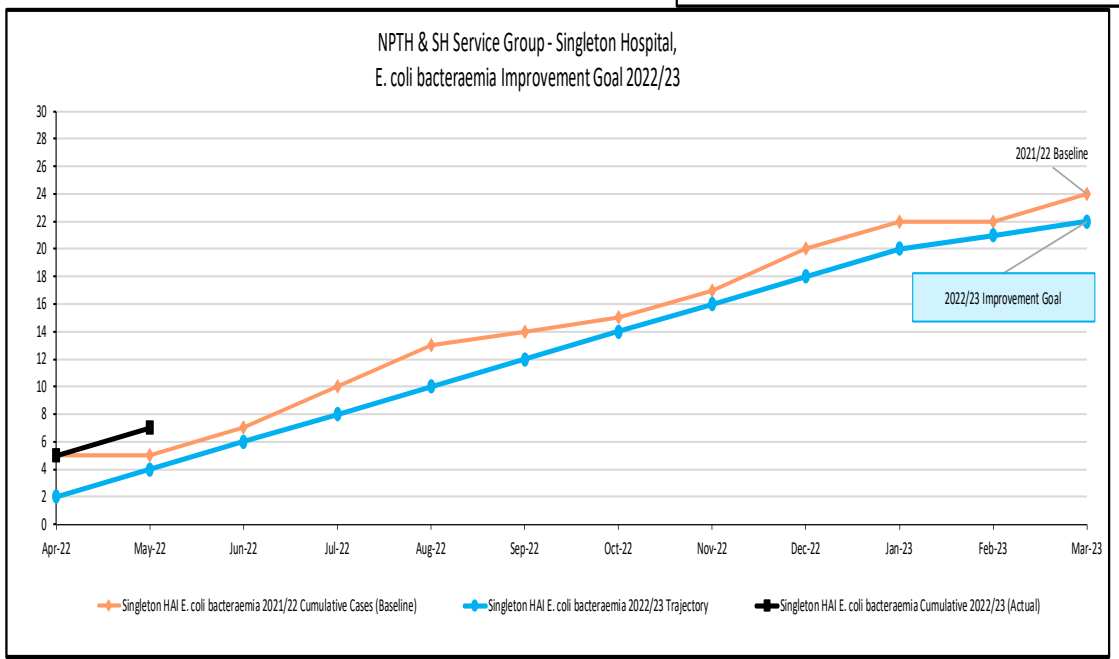


April / May 2022

Infection Prevention and Control – Current Position – Singleton Hospital







Progress against Infection Control Plan

Goal - To provide divisional assurance of IPC governance structures and arrangements
Method - Launch of Service Group Infection Improvement Plan
Plan launched on 24th May 2022
Scheduled to attend NPT & Singleton Physicians meeting (10th June 2022) to ensure maximum medical engagement
Method - Establish a process for high level scrutiny and learning for Staph. Aureus bacteraemia and C. Difficile infection.
Director-led scrutiny meetings scheduled weekly from 21stJune 2022 for DHoN and Clinical Lead to present findings
Method - HCAI objectives are visible and understood by the ward MDT and teams are aware of patient outcomes at ward level
Division of Medicine tackling MDT engagement by the introduction of monthly 'Appraise Support and Guidance' meetings at ward level led by Lead Consultant and Ward Manager

Progress against Infection Control Plan

Goal - Reduce incidence of key infections

Method - Clinical staff will be compliant with mandatory ANTT training and will be ANTT competence assessed, All staff to be compliant with appropriate levels of IPC training, Clinical staff to be compliant with Level 2, Hand Hygiene

Org L5	Performance March 2022	Performance May 2022	% increase / decrease
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	86.17%	84.16%	↓
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	37.18%	28.25%	↓
NHS|MAND|Aseptic Non Touch Technique - 3 Years|	20.57%	22.58%	↓
NHS|MAND|Hand Hygiene - 1 Year|	9.36%	15.29%	↑

Performance with mandatory training has dropped in all areas since the last reporting period.

Level 1 training across most ward areas is in excess of 90%, there have been some reduction in performance on Ward 4, 8 and 3 at Singleton Hospital.

However, this data is for all staff groups, further work to be completed to establish true baseline of relevant staff compliance for each training module.

Thank you

Infection Prevention & Control Quality Improvement Plan 2022/2023

Morriston Service Group

June 2022

Qtr1 Successes

- Group IP&C Governance structure established and feeding into HB Committee
- Agreed Service Group overarching Quality Improvement Plan
- ANTT register of trainers across site - 20 ANTT trained staff in one week in ISSG with ongoing training underway across site.
- Sustained reduction in Antimicrobial prescribing in line with improvement targets
- Rapid response domestic bed space cleaning service established
- All wards populating visual boards with current IPC position.
- Scheduling and rollout of IPC safety huddle twice weekly.
- Aligned Project leads to the project delivery plan/quadrants; Training & Development, Environment & Decontamination, Patient Experience/ Governance reporting/ Engagement & Communications, Scrutiny & Audit
- Start roll-out of Mealtime Hand-washing initiative

Priorities for Q2

- Agree details of Hospital wide Declutter Amnesty – June 2022
- Each QI Quadrant Lead to develop dedicated smart actions and feedback using the simple reporting templates – August 2022 meeting
- Develop local Business Case for a dedicated IPC Quality Improvement Programme Lead – June 2022
- Develop SOP to support the process of Case Review – August 2022
- Agree trajectory for improvement at next MSG IPC group meeting – June 2022
- Agree and sign-off Staff Hand-washing compliance plan, to include non-clinical and volunteer staff visiting clinical areas as part of their role – July 2022
- Engage with Health Records to develop and implement a IPC training plan for staff based at Morriston Hospital – July 2022
- In conjunction with IPC Team build observations of patient hand washing in to the QA audit – August 2022
- Undertake Mattress audit across hospital site – August 2022
- Refresh education of staff to understand when to sample for CDiff, in conjunction with IPC Team – August 2022
- Complete Tazocin audit – August 2022
- Access Junior Doctor Induction Programme to reinforce IPC Principles – August 2022

Opportunities

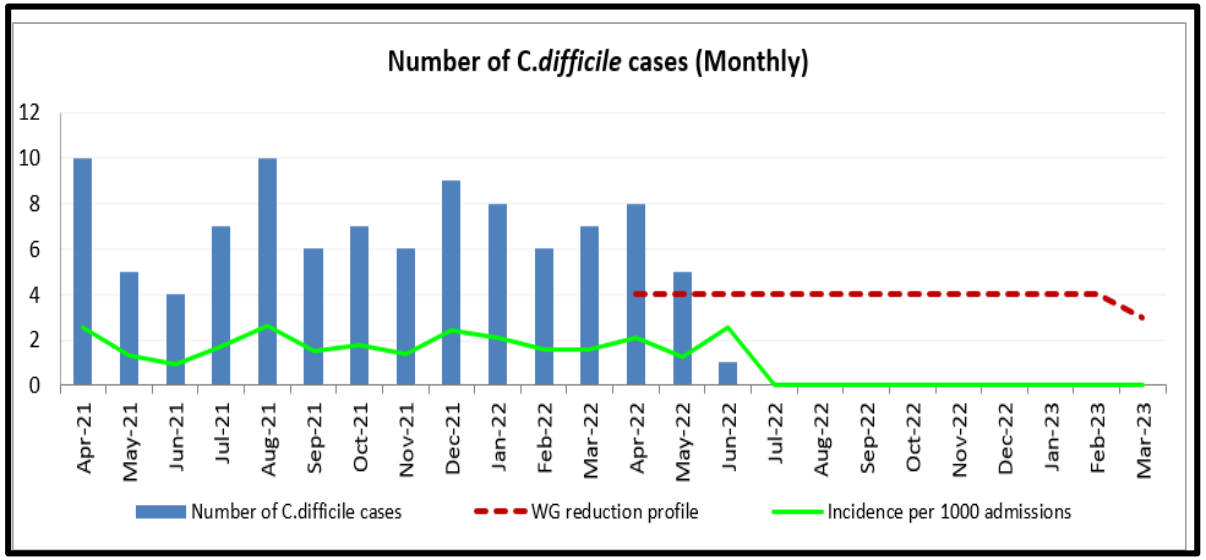
- Explore opportunities for greater MDT engagement, across clinical staff, non-clinical staff and volunteers.
- Extend the use of "How we are doing!" visual boards to support staff, patients and visitors.
- Development of multi-professional training programme to reflect expected minimum standards
- Regenerate Link Champions – as a defined role with responsibilities.
- Engagement & peer review via executive teams through planned site visits.
- Promote MDT Hot debriefing across all inpatients areas.
- Development of local Surgical Site Surveillance monitoring
- Annual relaunch of Hospital Flu Vaccination Programme

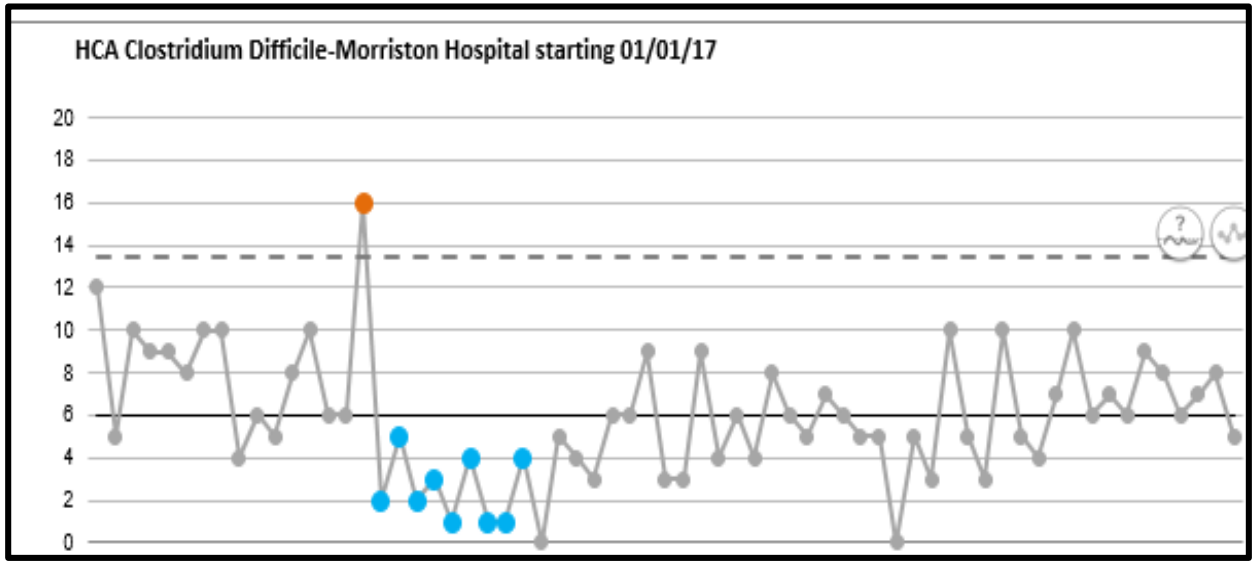
Risks

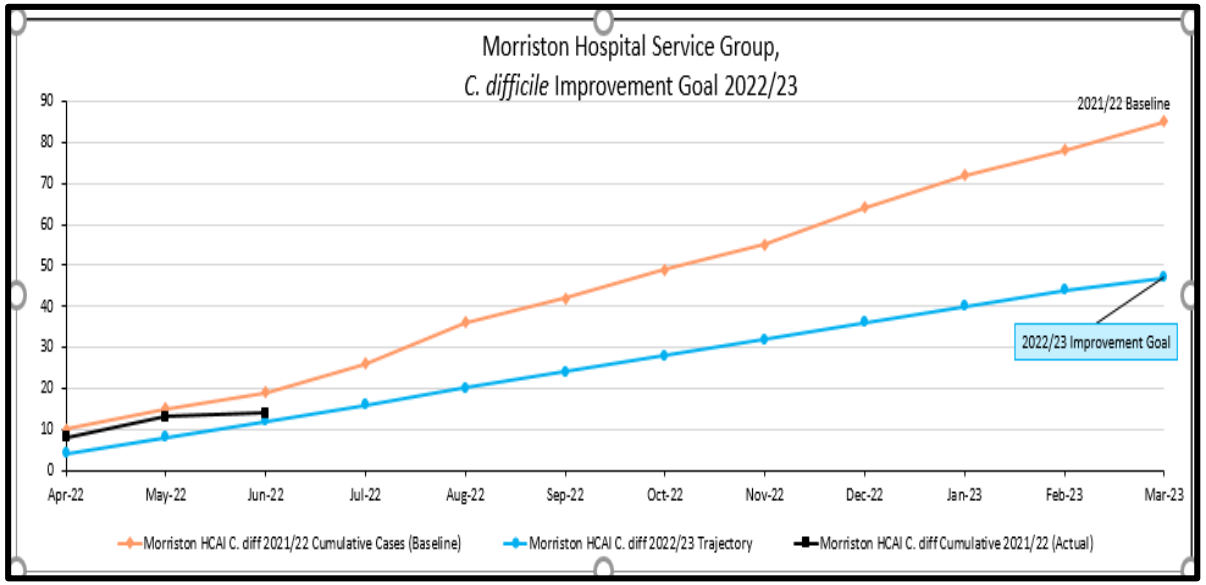
- Reintroduction of Hospital Visiting and need to reinforce IPC messaging
- Lack of isolation facilities
- Delayed solution for decant area to support cleaning and refurbishment plans
- Long term implication of CV19 waves/ seasonal IPC pressures
- Failure to secure QI Improvement IPC Programme Lead.
- Delays in consumable replacement – mattresses and other equipment
- On Site storage
- Ongoing building works on site
- Extended length of stays impacting on increased exposure.

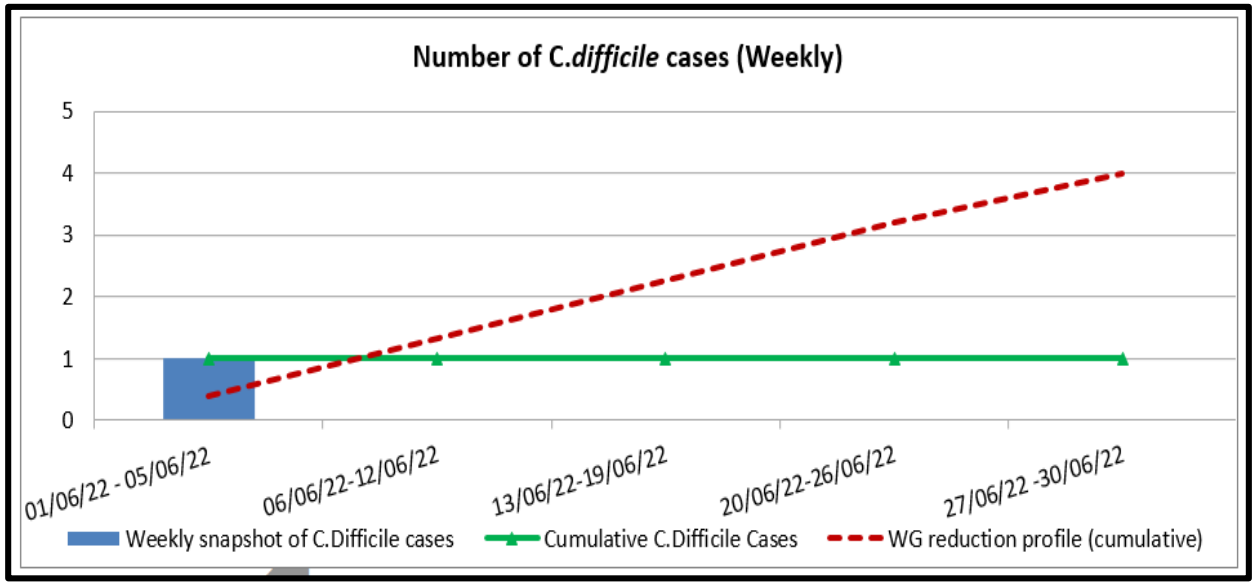
C. difficile

	Cumulative Target End of May22	Actual 07/06/2022
Clostridium Difficile Infection (CDI)	8	14



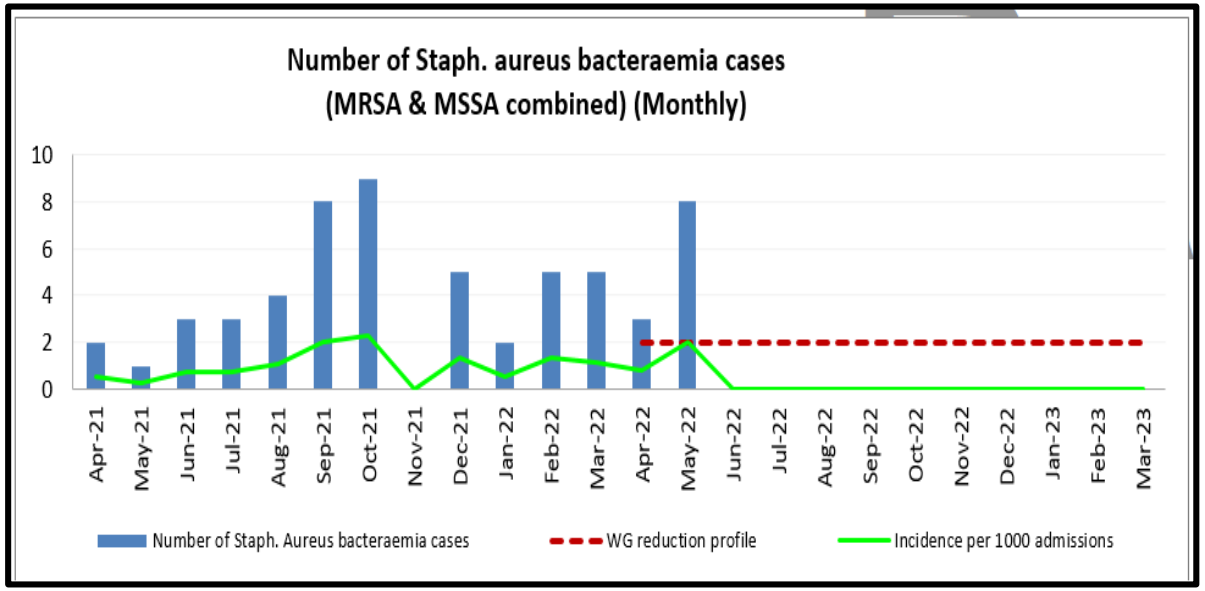


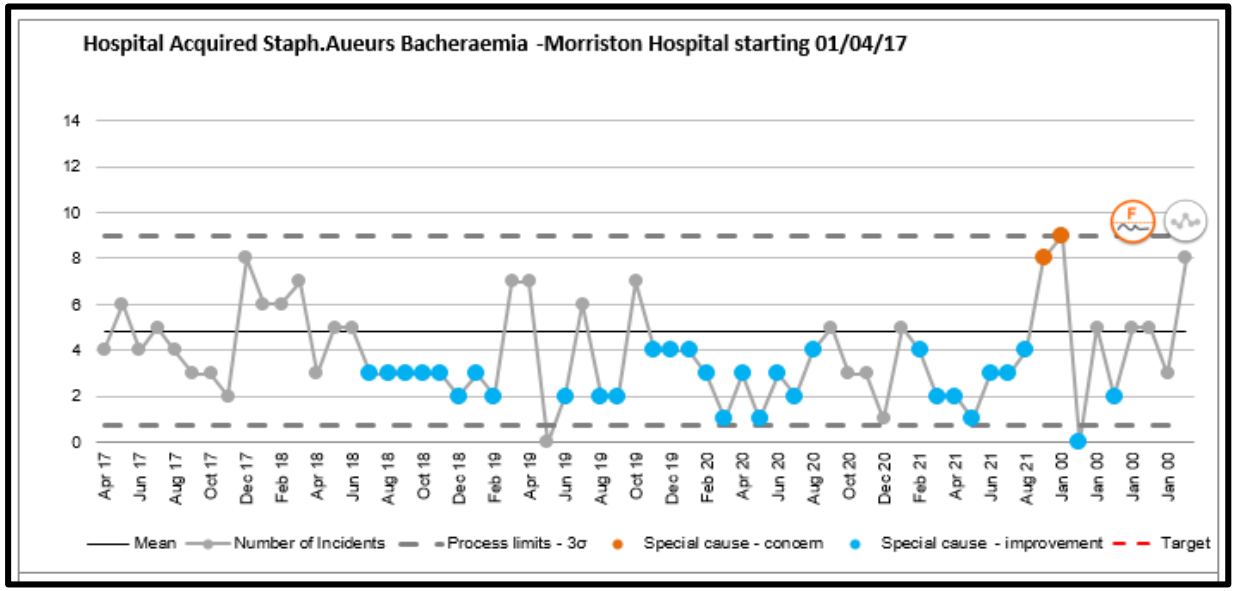


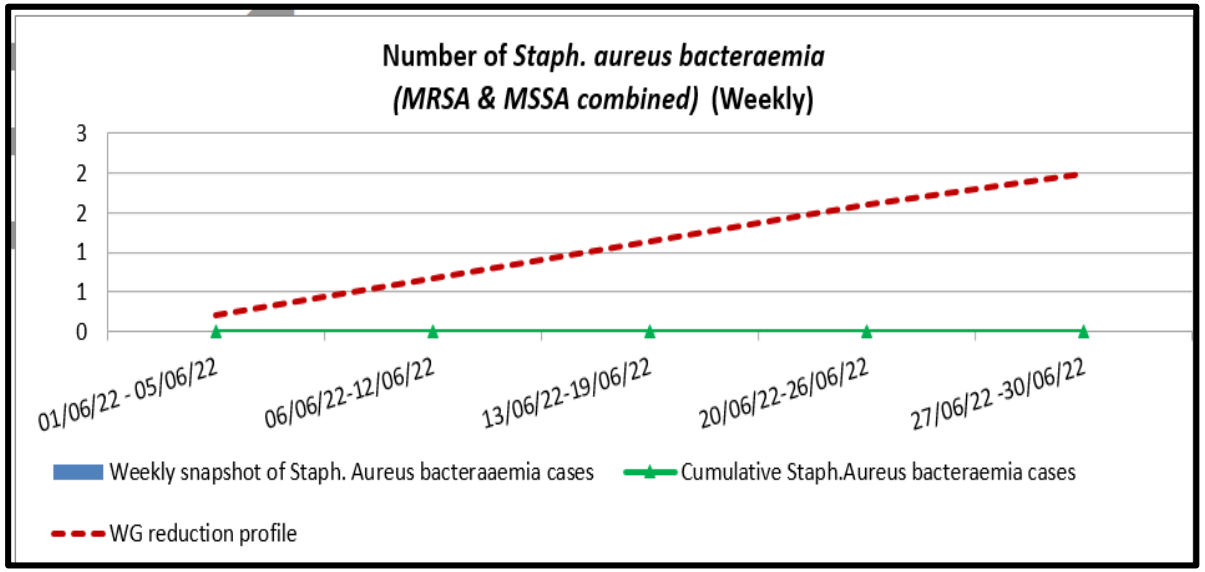


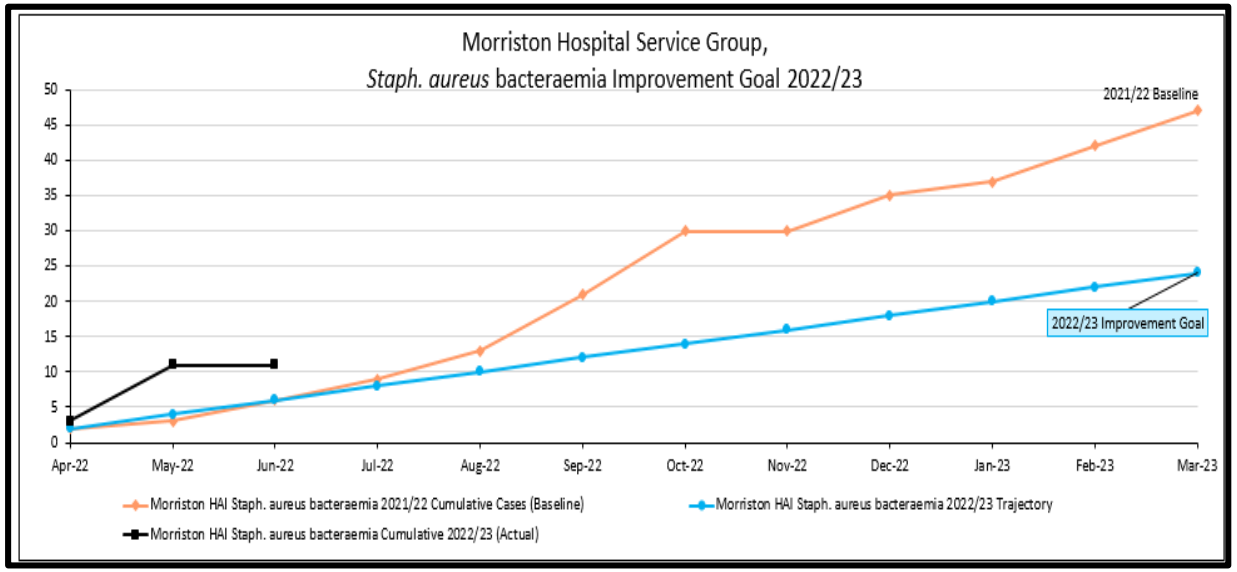
Staph. aureus bacteraemia

	Cumulative Target End of May 2022	Actual 07/06/2022
Staph.Auerus Bacteraemia	4	11



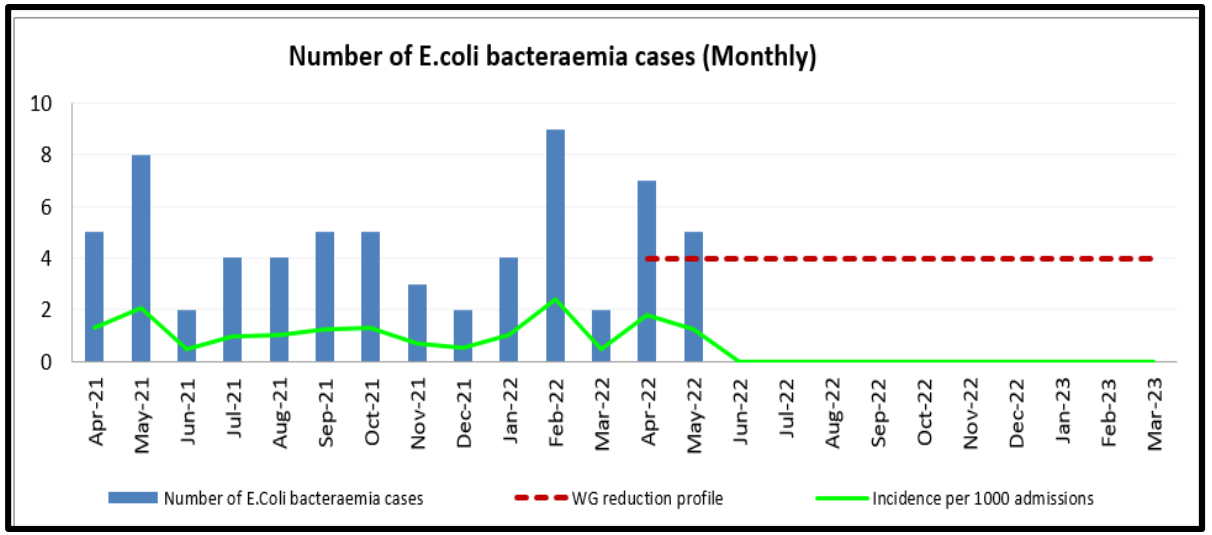


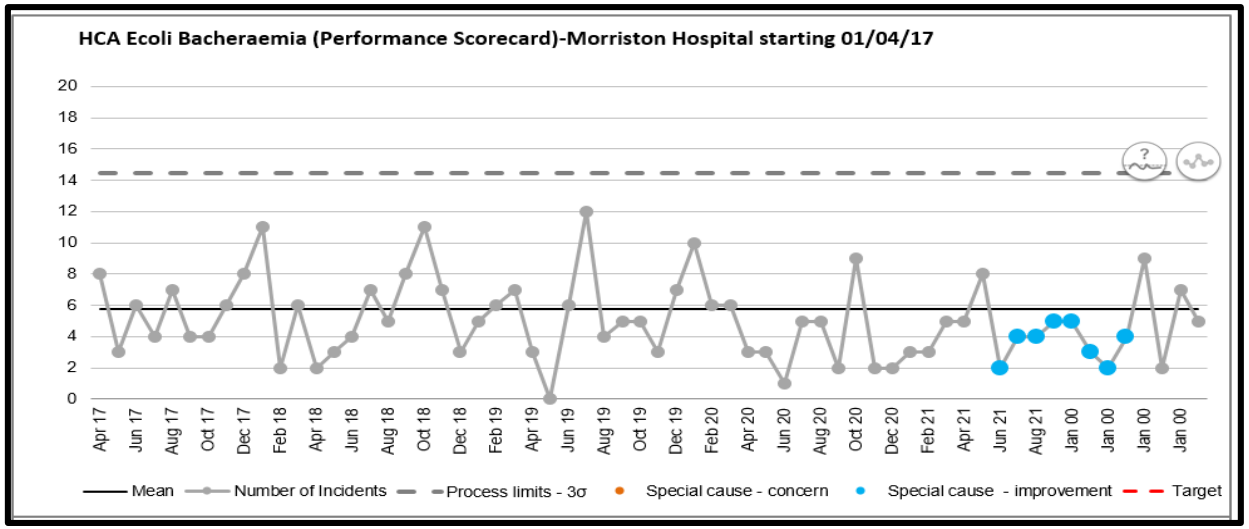


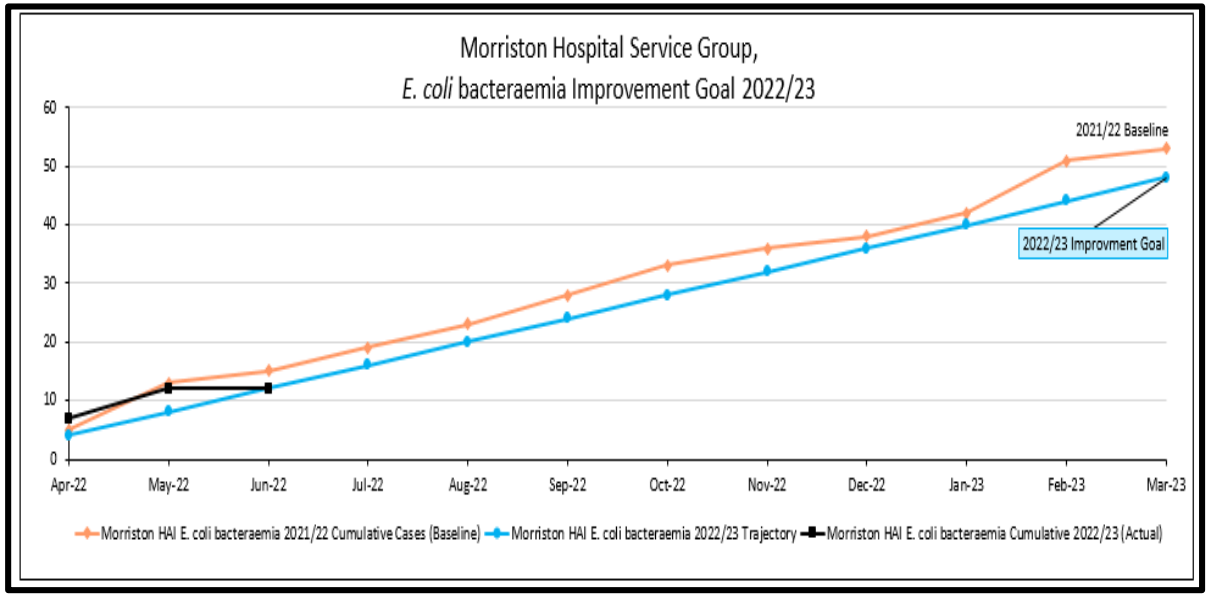


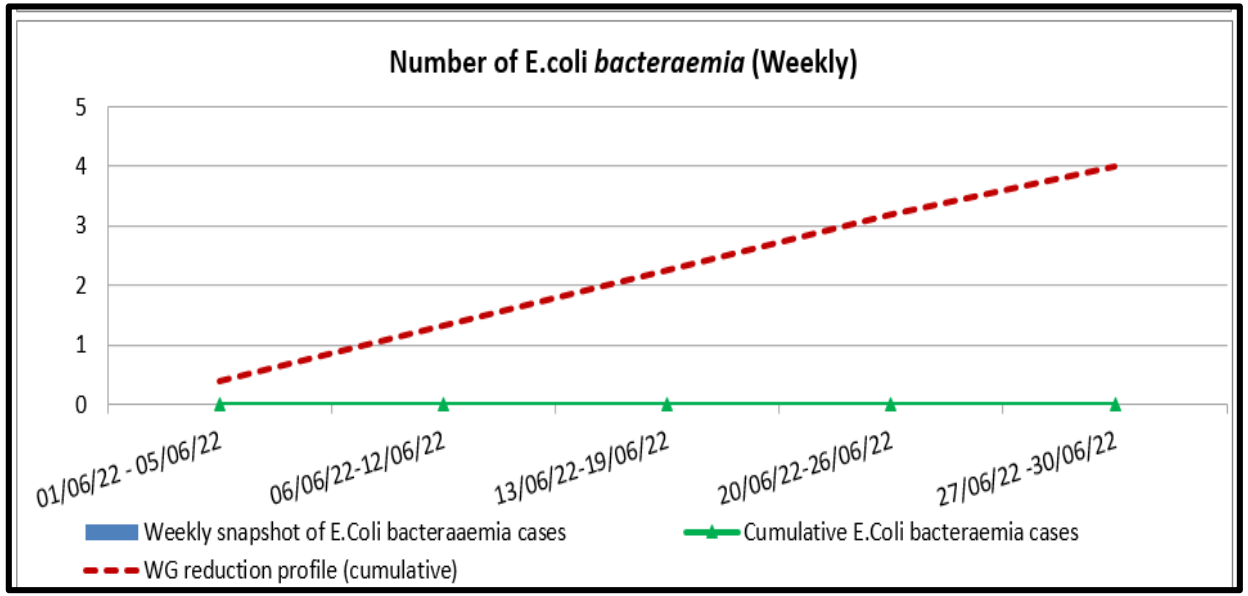
E. coli bacteraemia

	Cumulative Target As at End of May22	Actual 07/06/2022
E. coli.	12	8



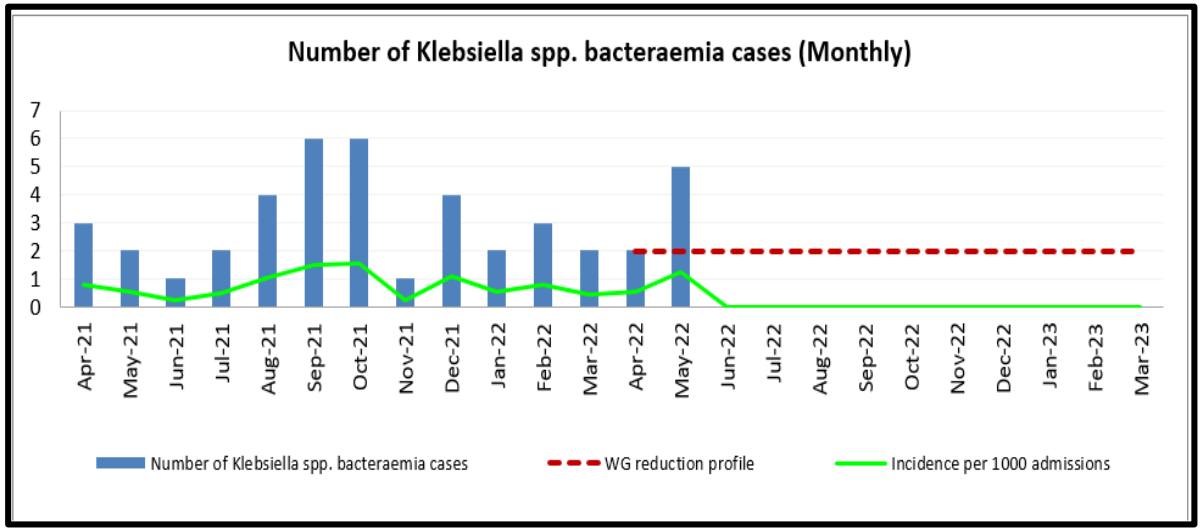


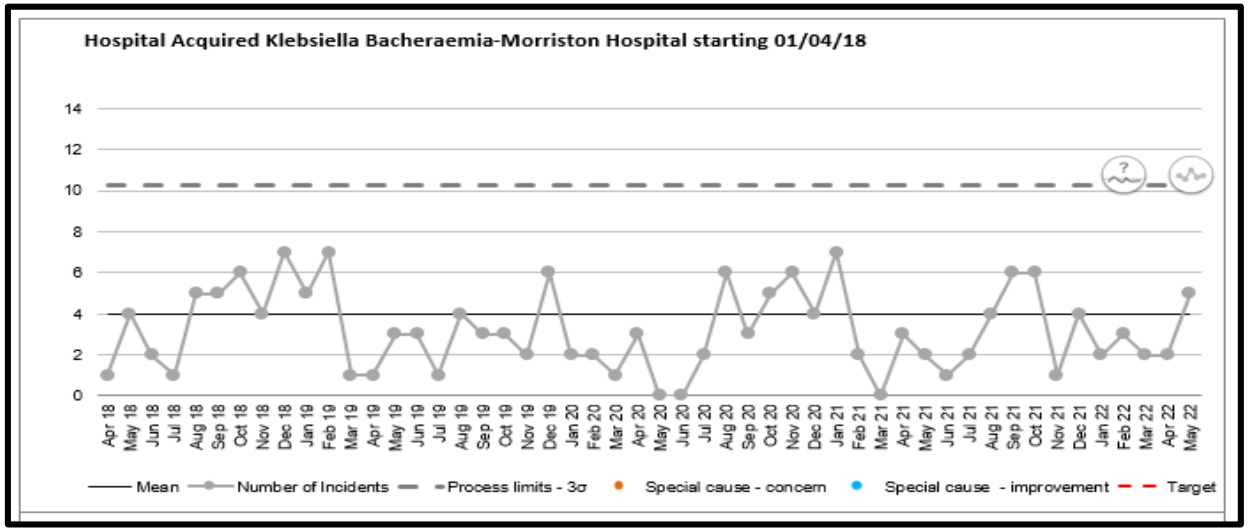


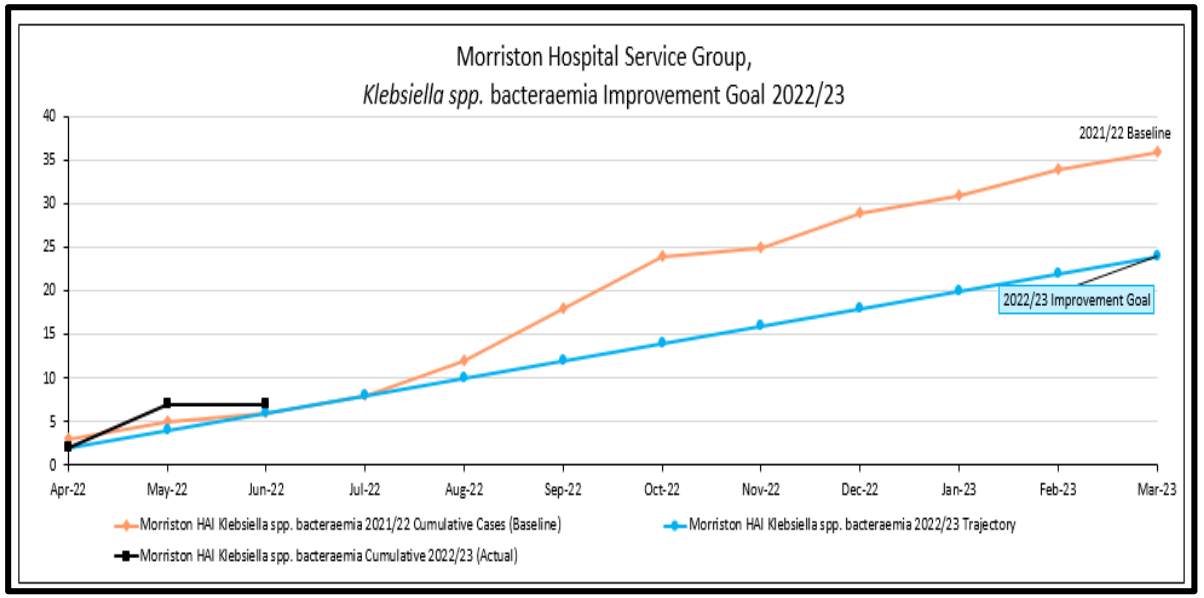


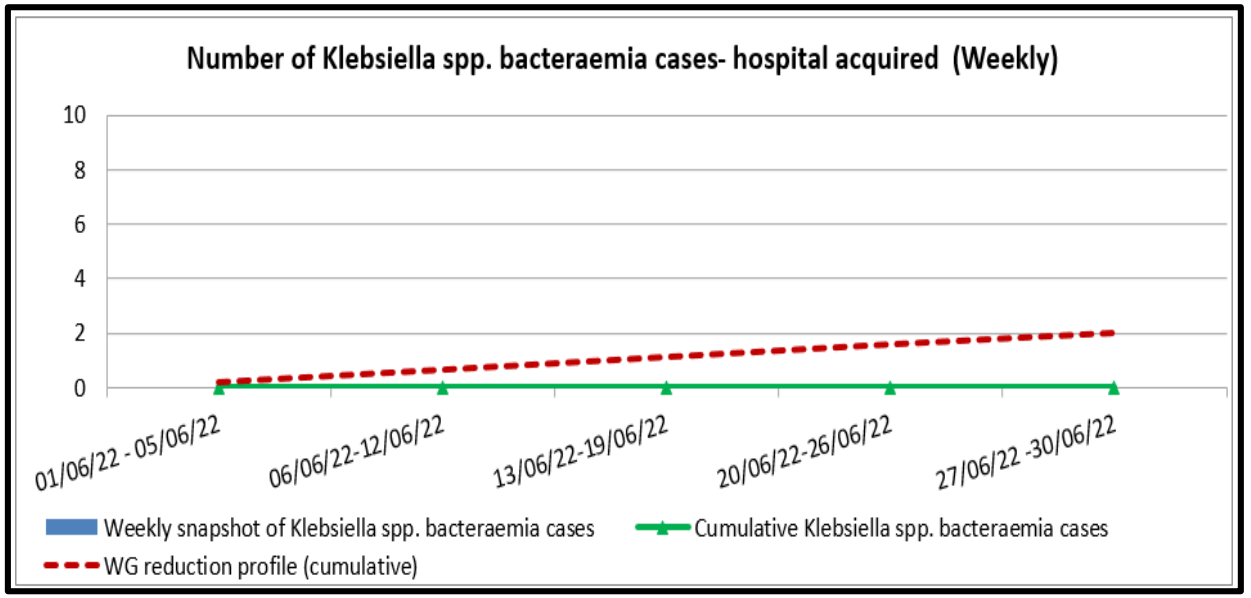
Klebsiella spp. bacteraemia

	Cumulative Target As at End of May22	Actual 07/06/2022
Klebsiella	7	4



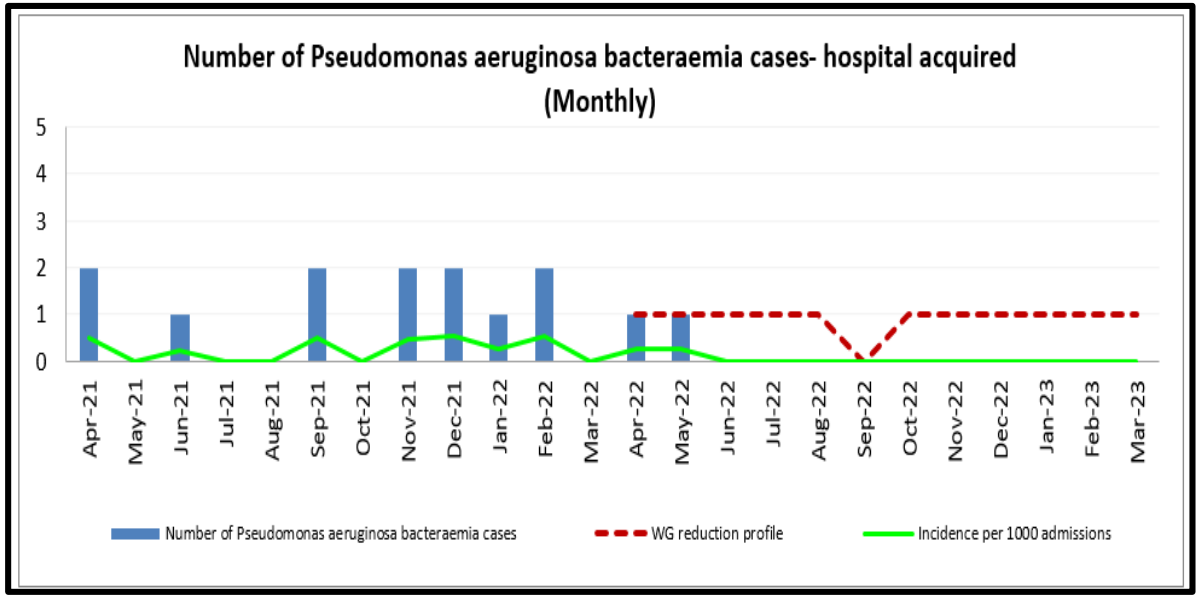


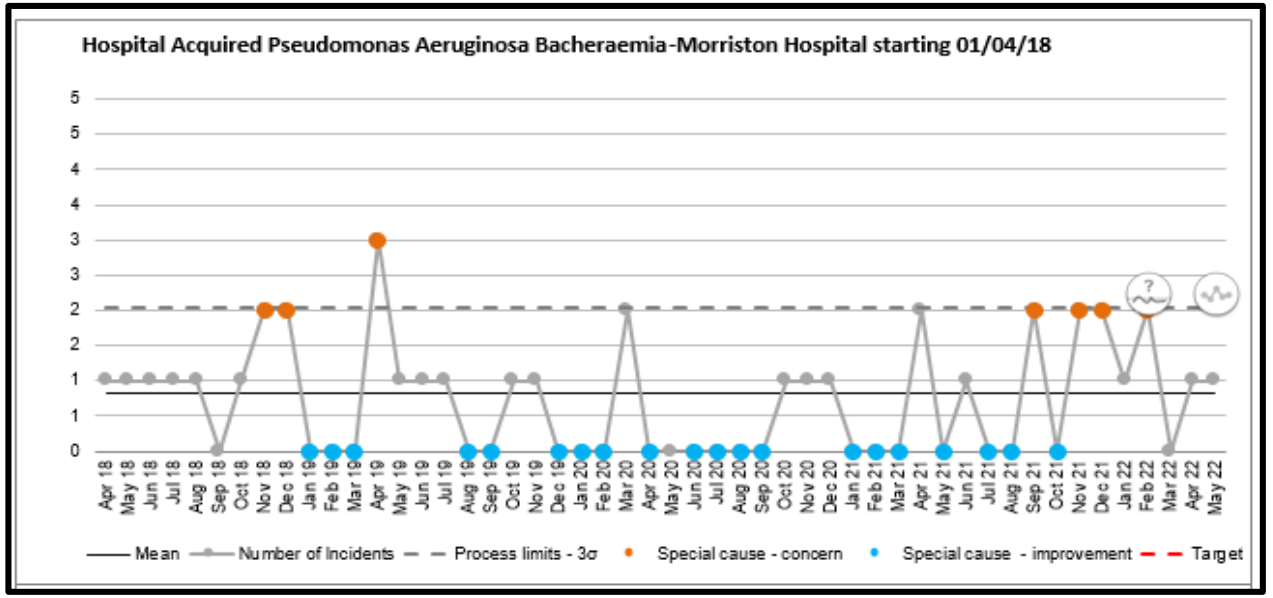


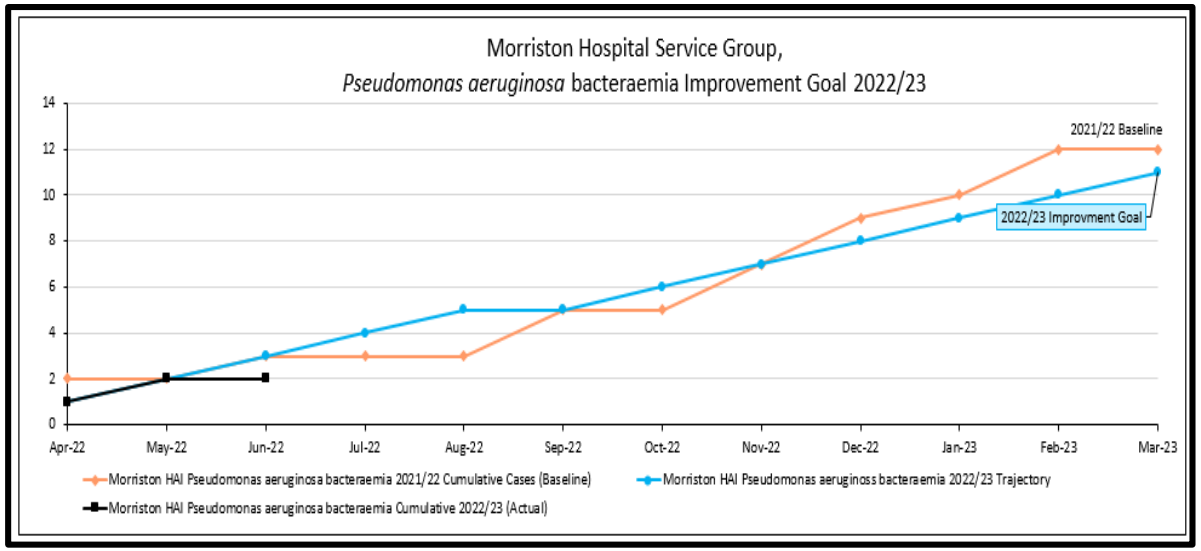


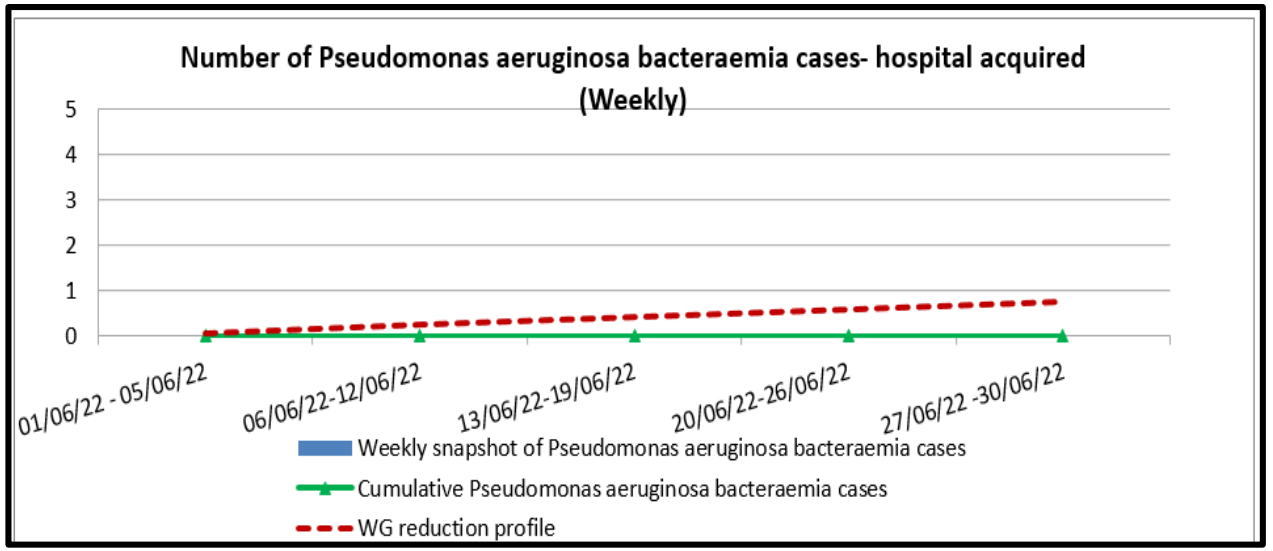
Pseudomonas bacteraemia

	Cumulative Target As at End of May22	Actual 07/06/2022
Pseudomonas	2	2









In Summary:

- Despite early signs of improvement within the trajectory templates Morriston continues to experience periods of increase incidence for Cdiff which are managed against the Health board guidance and policy. These can be delayed due to the availability of MDT members and the service group are currently looking at alternative ways in which early hot debriefs can be used to prevent further transmission in the possible likelihood of delayed deep dive reviews.
- IPC safety huddles twice weekly are adding a layer of support to the ward areas and supporting site matrons decision making with regards to patient placement.
- The value of surgical site surveillance is being realised in Cardiac surgery and they have progressed their process to a point where this is naturally maturing in the service. With the benefit of than overarching Head of nursing now leading Quality and safety the Divison is now extending best practice in to T&O and the surveillance tools are being adopted for use.
- Surface decontamination of patients using chlorhexidine wash is routinely being used for all T&O patients and therefore consideration for continued routine VRE screening as a result of this practice needs to be concluded.
- Project governance and programme management plan is in place in readiness for the soon to be appointed programme lead to own.
- We are working closely with corporate colleagues to reintroduce Hospital visiting cautiously. In addition to this, arrangements for ongoing management of CV19 continues to be debated. Arrangements to support staff & patients presenting with Monkeypox are in place and progressing.

Morriston Service Group: Infection Prevention & Control 12 Month Plan

Goal	Action	Lead	Target	Status	Progress 2022/2023				Evidence
					3 month	6 month	9 month	12 month	
Service Groups to review IPC governance arrangements & structures and submit to Health Board Infection Control Committee.	**Governance Arrangements**								
	Review and establish a robust IP&C Improvement Group within Morriston Service Group - ensuring repesentation from IP&C, Estates and Support Services	Group Nurse Director	By 01/04/2022	COMPLETED	First meeting held 19/02/2022, with quarterly meetings	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	
	Nominate Group Lead Roles for both Medical and Nursing professions	Group Nurse Director	By 01/04/2022	COMPLETED	First meeting held 19/02/2022, with quarterly meetings	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	
	Establishment of IP&C Work Programme - clearly identifying improvement workstreams with explicit routine monitoring and outcome reporting	Group Nurse Director / Group Head of QS&PE	By 31/05/2022	Outcome from Morriston Improvement Group Meeting 26/04/2022	To be completed by end of May 2022	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	
	Development of comprehensive set of Standard Operating Procedures to support a process for high level scrutiny and learning from nosocomial Staph. aureus bacteraemia and C. difficile infection.	Group Nurse Director / Group Head of QS&PE	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022	To be operational within clinical services pending approval by Morriston Improvement Group	To be operational within clinical services following approval by Morriston Improvement Group	Clear evidence of improvement strategies.	Clear evidence of improvement strategies.	
	Review and identify ALL risks in relation to Infection Control & Prevention and update the Morriston Risk Register with outcomes - to include both and process and environment risks	Group Nurse Director / Group Head of QS&PE	By 30/06/2023	For Approval at Morriston IP&C Improvement Group - 28/06/2022	Assess risks and ensure that resolution/mitigation is built into IP&C Improvement workstreams - escalate via Health Board Risk Excpetion Reporting if required	Risks to be monitored quarterly	Risks to be monitored quarterly	Risks to be monitored quarterly	
Reduce incidence of the following key infections: Staph. aureus and Gram negative bacteraemias, and C. difficile infection.	**Infection Prevention**								
	Operational Divisions to set out service led process for the rapid review of nosocomial infection cases - ensuring that they are multi-disciplinary and that there is a clear process for learning lessons to reduce future prevalence	Divisional Head of Nursing/ Divisional Clinical Leads	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022	Presentation from each division on plan for rapid review process and dessemination of lessons learnt - at Morriston IP&C Improvement Group	All inpatient cases will have rapid MDT review undertaken. Lessons identified will be shared and improvement actions implemented using Quality Improvement methodologies.	All inpatient cases will have rapid MDT review undertaken. Lessons identified will be shared and improvement actions implemented using Quality Improvement methodologies.	All inpatient cases will have rapid MDT review undertaken. Lessons identified will be shared and improvement actions implemented using Quality Improvement methodologies.	
	Improve compliance with **'Start Smart Then Focus' (SSTF)** antimicrobial stewardship programme, with timely feedback of results to Service Groups	Group Medical Director / Nominated Medial Lead	By 01/04/2022	COMPLETED	Continue with quarterly audits. Complete scoping and draft version of dashboard available.	Continue with quarterly audits. Testing and refinement of dashboard, with Go Live date agreed.	Continue with quarterly audits (Links to HEPMA roll-out)	Continue with quarterly audits (Links to HEPMA roll-out)	
	Develop a Service Improvement Workstream for the reduction of the use of **unnecessary peripheral vascular cannulae (PVC)**, and **urinary catheters**, utilising **STOP** protocol or from the point of assessment and admission	Nominated Nursing Lead/ Nominated Medical Lead	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022	Scoping completed, with proposals for methodology for obtaining baseline and agree how data will be presented. If a digital solution is not available, a manual point prevalence survey will need to be undertaken in Service Groups.	Data on incidence of presence of PVC and urinary catheters by ward, specialty and site available on Ward to Board dashboard. Utilise baseline data on PVC and urinary catheter incidence to agree improvement goal.	Incidence of PVC and urinary catheter use is routinely monitored and scrutinised at ward and divisional/specialty group. Service Group Infection Control Committees (ICC) to monitor progress against improvement goals.	Incidence of PVC use is routinely monitored and scrutinised at ward and divisional/specialty group. Service Group Infection Control Committees (ICC) to monitor progress against PVC incidence improvement goal.	
	Development a Service Improvement Workstream to provide assurance in relation to compliance against the PVC insertation and urinary catheter bundles	Nominated Nursing Lead/ Nominated Medical Lead	By 30/06/2023	For Approval at Morriston IP&C Improvement Group - 28/06/2022	Scoping completed, with proposals for methodology for obtaining baseline and agree how data will be presented. If a digital solution is not available, a manual point prevalence survey will need to be undertaken in Service Groups.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	Clear progress on Improved compliance reported quarterly with clear plan to deliver on 100% compliance. Service Group ICC to review progress against improvement goals.	
	Review the pathway and interactions to aid reduction of incidence of **catheter associated urinary tract infection (CAUTI)**.	Nominated Nursing Lead/ Nominated Medical Lead	By 31/08/2022	For Approval at Morriston IP&C Improvement Group - 23/08/2022	Pending	Scope with Digital Intelligence ability to identify CAUTI utilising existing DI systems, e.g. WNCR, HEPMA, or LIMS (using positive urine cultures from catheter samples of urine).	Cases of CAUTI are reported on Ward to Board dashboard.	Cases of CAUTI are reported on Ward to Board dashboard.	
	Reduce **hepatobiliary-related E.coli and Klebsiella spp. bacteraemia** cases.	Nominated Nursing Lead/ Nominated Medical Lead	By 31/08/2022	For Approval at Morriston IP&C Improvement Group - 23/08/2022	Pending	Undertake risk based review of patients awaiting surgery or procedures related to hepatobiliary disease. Service Groups to link review to IMTP and Surgical Services plans.	Monitored through IMTP process.	Monitored through IMTP process.	
	Reduce incidence **of hospital acquired pneumonia (HAP)**	Nominated Nursing Lead/ Nominated Medical Lead	By 31/08/2022	For Approval at Morriston IP&C Improvement Group - 23/08/2022	Pending	Agree methodology for obtaining baseline, or for undertaking point prevalence survey to obtain baseline prevalence.	Validation of data and review of cases to identify contributory factors & causes. Agree quality improvement initiatives.	Implement agreed methodology. Service Groups monitor infection data, and review progress against improvement actions at Service Group Infection Control Committee.	
	Reduce the incidence of **surgical site infection (SSI).**	Nominated Nursing Lead/ Nominated Medical Lead	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022	Develop a risk based approach process for surveillance of surgical site infection (SSI) - with a focus on high consequence SSI (those involving a readmission or a return to theatre as a consequence of infection). Agree methodology for obtaining baseline, or for undertaking point prevalence survey to obtain baseline prevalence.	Validation of data and review of cases to identify contributory factors & causes. Agree quality improvement initiatives and methodology. Initial cut of data to review and validate	Monitor infection data, and review progress against improvement actions at Service Group Infection Control Committee.	Service Groups continue to monitor infection data, and look for outcomes including reduce LOS and antibiotic use.	
Improve safety of patient care environment	**Environment & Estates**								
	Develop Service Improvement Workstream to clearly identify and prioritise in Capital Investimant Priorities to suport the prevention of infection and reduce the risk of nosocomial harm as a result of a poor clinical environment. To include refurbishment, repair, improvements to compliance with required mechanical ventilation standards, increasing single room capacity and maintenance - ensring that risks are clearly identified both by Estates and in relation to service sustainability.	Group Nurse Director / Group Head of QS&PE	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022 (LINKED TO RISK REGISTER)	Assess risks and ensure that resolution/mitigation is built into IP&C Improvement workstreams - escalate via Health Board Risk Excpetion Reporting if required	Risks to be monitored quarterly	Risks to be monitored quarterly	Risks to be monitored quarterly	
	Robust programme of **Planned Preventive (PPM)** and monitoring to maintain the integrity and functioning of engineering aspects of infection prevention, e.g. water safety, mechanical ventilation, etc.	Hospital Site Estates Lead/ Group Service Director/Group Nurse Director/Group Medical Director	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022 (LINKED TO RISK REGISTER)	Estate representation at Morriston IP&C Improvement Group - PPM for Morriston Hospital Site to be shared	Assess risks and ensure that resolution/mitigation is built into IP&C Improvement workstreams - escalate via Health Board Risk Excpetion Reporting if required	Risks to be monitored quarterly	Risks to be monitored quarterly	
	Quarterly cleaning of ceiling-mounted ventilation grilles	Hospital Site Support Services Lead/ Group Service Director/Group Nurse Director/Group Medical Director	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022 (LINKED TO RISK REGISTER)	Support Services representation at Morriston IP&C Improvement Group - Annual Cleaning Plan for Morriston Hospital Site to be shared	Assess risks and ensure that resolution/mitigation is built into IP&C Improvement workstreams - escalate via Health Board Risk Excpetion Reporting if required	Risks to be monitored quarterly	Risks to be monitored quarterly	

Goal	Action	Lead	Target	Status	3 month	6 month	9 month	12 month	Evidence
	Attain and sustain **minimum standards of cleanliness including the ability to develop an electronic system to request "4D" cleaning**	Hospital Site Support Services Lead/ Group Service Director/Group Nurse Director/Group Medical Director	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022 (LINKED TO RISK REGISTER)	Support Services representation at Morriston IP&C Improvement Group - Annual Cleaning Plan for Morriston Hospital Site to be shared	Scoping with Digital Intelligence the development of an electronic requesting system and feasibility of utilising existing systems, such as SIGNAL. Audit Compliance to be monitored on a quarterly basis	Audit Compliance to be monitored on a quarterly basis	Audit Compliance to be monitored on a quarterly basis	
	Establish funding a **Discharge/Transfer Response Team** in Morriston Hospital, to undertake all patient care equipment and environment cleaning & disinfection.	Hospital Site Support Services Lead/ Group Service Director/Group Nurse Director/Group Medical Director	By 31/08/2022	For Approval at Morriston IP&C Improvement Group - 23/08/2022 (LINKED TO RISK REGISTER)	In line with AMSR Redesign - Scoping to identify required resource. Second/recruit support service staff to response team.	Audit Compliance to be monitored on a quarterly basis	Audit Compliance to be monitored on a quarterly basis	Audit Compliance to be monitored on a quarterly basis	
	Decontamination & Medical Equipment								
	Produce a Position Statement of Decontamination for Morriston Service Group to ensure that there is a clear understanding of decontamination services managed by the Group and Health Board wide decontamination services which are hosted by Morriston Service Group - with explicit lines of accountability, monitoring and reporting	Group Nurse Director / Group Head of QS&PE	By 31/05/2022	Outcome from Morriston Improvement Group Meeting 26/04/2022	To be completed by end of May 2022	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	Operational sense check to ensure relevance and inclusion of all parameters	
	Each patient will have a single patient use patient medical devices, e.g. BP cuffs, oxygen saturation probes, glide sheets, hoist slings, cardiac monitoring leads , pressure bags, for the duration of the inpatient episode.	Nominated Nursing Lead / HSDU Lead / HB Decontamination Lead Nurse/ HB Lead Nurse for Clinical Procurement	By 31/08/2022	For Approval at Morriston IP&C Improvement Group - 23/08/2022 (LINKED TO RISK REGISTER)	Identification of RISK to patients and staff in relation to the use/incorrect use of existing equipment Scoping of availability of disposable alternatives, which would be allocated to a patient for the duration of their inpatient episode. Estimation of numbers of items required and associated revenue costs. Review learning from previous outbreaks regarding disposable alternatives.	Where inline with evidence based infection prevention and reduction outcomes - Development of a business case for funding for consideration by the Health Board.	If business case supported, implementation of single patient use devices.	If business case supported, implementation of single patient use devices.	
Effective communication strategy making IPC everyone's business	**IP&C Training**								
	Develop a robust Staff Training Plan with clear parameters by staffing group against; mandatory training, decontamination training, ANTT mandatory training	Group Nurse Director/ Group Medical Director/ Group IP&C Lead	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022 (LINKED TO RISK REGISTER)	With support from IP&C a robust training plan to be developed (against all professional criteria) to improvement staff understanding of the requriements of infecion control.	Monitoring against standards to be part of routine Disional monitoring on a quaterly basis	Monitoring against standards to be part of routine Disional monitoring on a quaterly basis	Monitoring against standards to be part of routine Disional monitoring on a quaterly basis	
	Local promotion of IP&C Improvement Needs & Action; regular review at management board and key COMMS strategy to in reach all staff within the HB	Group Directors	By 01/04/2022	COMPLETED	Outline strategy to facilitate go live in April 22 All key stakeholders including WG, CHC , Local Authorities to be advised	Review through Service Groups and up via new governance structures to Board. Revise plan if required and monitor success of commas strategy and engagement	Continue process to monitor and establish success and awards to maintain positive approach	Build in likely approach for 23-24	
	Communication and Patient Engagement								
	Key information on infection reduction performance will be published and available at the entrances to wards and units.	Group Nurse Director / Group IP&C Lead	By 30/06/2022	For Approval at Morriston IP&C Improvement Group - 28/06/2022 (LINKED TO RISK REGISTER)	Agreement on a standardised approach to publishing infection information at ward/unit entrances.	Infection performance, which is timely and current, is displayed at the entrances to wards & units.	Infection performance, which is timely and current, is displayed at the entrances to wards & units.	Infection performance, which is timely and current, is displayed at the entrances to wards & units.	
	Excellence will be recognised within Service Groups and through Director led walkabouts.	Group Directors	By 01/04/2022	COMPLETED	Group Nurse Director - weekly "walkabout" established	Recognition of excellence and processes established to provide support in the quality improvement journey to excellence.	Recognition of excellence and processes established to provide support in the quality improvement journey to excellence.	Recognition of excellence and processes established to provide support in the quality improvement journey to excellence.	