Meeting Date	29 July 2025	**Agenda Item**	2.4
Report Title	**Infection Prevention and Control**		
Report Author	Joanne Walters, Deputy Head of Nursing, Infection Prevention & Control		
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Presented by	Joanne Walters, Deputy Head of Nursing, Infection Prevention & Control		
Freedom of Information	Open		
Purpose of the Report	This is an assurance report that provides an update on incidence, progress and actions relating to healthcare associated infections (HCAIs) within Swansea Bay University Health Board for the reporting period Quarter 1, 01 April 2025 to 30 June 2025.		
Key Issues	• Hospital onset case numbers for the four infections exceeded the Targeted Intervention de-escalation criteria during Quarter 1. • The health board continues to have the highest incidence of *C. difficile* in Wales. • The escalating number of *C. difficile* Periods of Increased Incidence (PII) and outbreaks is concerning. • Additional pre-empt patients on wards is a regular occurrence; this over-crowding increases the risk of infection transmission. • A lack of decant facility is impacting on the ability clean to the required health board standard the rooms where cases of *C. difficile* have been identified. This increases risks to patients subsequently admitted or transferred to these rooms. • The health board continues to face significant challenges relating to healthcare associated infection risks, which are recorded in the health board's Risk Register. • The health board has achieved compliance with mandatory Infection Prevention and Control training at Level 1 and 2.		
Specific Action Required *(please choose one only)*	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	The Infection Prevention & Control Strategic Group is asked to: • **ACKNOWLEDGE:** the health board's position in relation to the Targeted Interventions improvement goals. • **ACKNOWLEDGE:** the performance of the health board towards achieving internal and national infection improvement goals. • **ACKNOWLEDGE:** the health board has the highest incidence of *C. difficile* infection and *Pseudomonas aeruginosa* bacteraemia in Wales. • **ACKNOWLEDGE:** the continued increase in numbers of cases, and the numbers of periods of increased incidence, and outbreaks of *C. difficile* cases seen in Quarter 1, and the continuation of the Gold *C. difficile* High Incidence Management Group**.** • **ACKNOWLEDGE:** progress on Infection Prevention & Control Improvement Plan to 30th June 2025. • **ACKNOWLEDGE:** the IPC training compliance goal has been achieved (i.e. >80%). IPC Level 1 - 90.23%; Level 2 training - 82.34%. • **ACKNOWLEDGE:** the challenges and risks within the health board currently and mitigations recorded in the risks recorded in the health board's Risk Register.

INFECTION PREVENTION AND CONTROL

1. INTRODUCTION

This assurance report provides an overview of Swansea Bay University Health Board (SBUHB) progress against Welsh Government Targeted Intervention de-escalation criteria. Whilst awaiting the publication of Welsh Government's 2025/26 improvement goals, the health board set internal 2025/26 healthcare associated infection reduction goals in April 2025, which are based on the Welsh Health Circular (WHC/2024/038) Healthcare associated infections goals published in September 2024. Progress against these internal goals is included within this report. The reporting period is. 1st April 2025 – 30th June 2025.

The key HCAIs are:

a) *Clostridioides difficile* (*C. difficile*) infection
b) *Staphylococcus aureus* (*Staph. aureus*) bacteraemia
c) Gram negative bacteraemia *(Escherichia coli (E. coli), Klebsiella spp*., *Pseudomonas aeruginosa*).

A summary of infection-related incidents and outbreaks that occurred between 1st April and 30th June 2025 is provided also, along with a summary of the activities carried out across the health board in relation to the prevention, control, and management of infection.

The report also outlines the key risks, and recommendations to address areas requiring action or improvement.

2. Progress on key healthcare associated infections (HCAI)

2.1 Progress against Targeted Intervention

The health board's monthly progress against the Targeted Intervention de-escalation criteria for hospital onset, healthcare associated infections (HCAI) is presented in the table below.

During April, the target was achieved for *Klebsiella* spp. bacteraemia only. In May, the number of *C. difficile* cases did not exceed the target. By the end of Quarter 1, the targets for all the infections had been exceeded as shown in Table 1: Targeted Intervention progress.

Table 1	Targeted Intervention - De-escalation Criteria for Hospital Onset HCAIs		Q1 2025/26 Actual			
HCAI TI Criteria 2025/26	Av. Monthly HO TI Criteria (Max. av. monthly cases)	Q1 TI Criteria (Max. quarterly cases)	Apr-25 Hospital Onset Total cases (actual)	May-25 Hospital Onset Total cases (actual)	Jun-25 Hospital Onset Total cases (actual)	Q1 TI - HO Cases to 30.06.25
SBUHB HCAI *C. difficile* 2025/26 TI Criteria	6	18	11 (+5)	5 (-1)	11 (+5)	27 (+9)
SBUHB HCAI *Staph. aureus* bacteraemia 2025/26 TI Criteria	3	9	4 (+1)	6 (+3)	4 (+1)	14 (+5)
SBUHB HCAI *E. coli* bacteraemia 2025/26 TI Criteria	4	12	6 (+2)	5 (+1)	7 (+3)	18 (+6)
SBUHB HCAI *Klebsiella spp.* bacteraemia 2025/26 TI Criteria	4	12	4	7 (+3)*	7 (+3)	18 (+6)

(Hospital Onset (HO) infections are defined as a positive microbiology result for a sample collected on day 3 or more of a hospital admission with day 1 being the first day of the admission to an in-patient location).

Quality Improvement initiatives continue across primary and secondary care settings, which are monitored and reported within each of the service groups improvement plans and quarterly reports to the IPCSG.

2.2 Progress against internal health board reduction goals for key Healthcare Associated Infections (HCAIs): 1st April 2025 – 30th June 2025

Progress against the **internal health board HCAI reduction goals** (based on the Welsh Government 2024/25 improvement goals) is shown in Table 2. These continue to be monitored and reported within the health board, to maintain a focus on infection reduction for patients in primary care, community, and hospital settings. Table 2 also includes the summary cumulative position for service groups, with the annual increase or reduction shown in brackets.

Charts showing the position of the health board and service group progress against the infection improvement trajectories, up to 30th June 2025, are detailed in **Appendix 1**.

Table 2: Service Group Annual Comparison to end of June 2025

	CDI	SaBSI	EcBSI	KlBSI	PAER BSI
SBUHB - Total	53 (↓ 13%)	32 (↑ 19%)	65 (↑ 23%)	27 (↓ 21%)	9 (↑ 8 cases)
PCTSG - CAI	21 (↑ 5%)	14 (↑ 40%)	39 (↑ 56%)	9 (↓ 31%)	2 (=)
PCTSG - HAI	1 (=)	0 (=)	0 (=)	0 (=)	0 (=)
MH&LD – HAI	0 (=)	1 (↑ 1 case)	1 (=)	0 (=)	0 (=)
MORR – HAI	27 (↑ 4%)	15 (↑ 67%)	19 (↑ 36%)	15 (↑ 67%)	3 (↑ 2 cases)
NPTH - HAI	0 (=)	0 (=)	2 (↓ 33%)	1 (↓ 67%)	0 (=)
SH - HAI	4 (↓ 43%)	1 (↓ 86%)	4 (↓ 50%)	2 (↓ 60%)	4 (↑ 4 cases) target exceeded
Other HB Cases Identified in SBUHB	0 cases	1 case	0 cases	0 cases	0 cases

Appendix 2 provides a comparison with other acute health boards in Wales in relation to incidence of these infections per 100,000 population and per 1,000 admissions. Compared with other health boards in Wales, Swansea Bay has the highest incidence per 100,000 population for *C. difficile* infections and *Pseudomonas aeruginosa* bacteraemia.

a) Clostridioides difficile

The cumulative incidence (April to June 2025) was 54.56/100,000 population, which is lower than that for the same period in 2024 (62.97/100,000 population). However, the health board continues to have the highest incidence of *C. difficile* in NHS Wales. The health board and acute hospital comparisons can be seen in **Appendix 2**. This was a 13% decrease.

C. difficile toxin positive HCAI cases are reported in Datix and continue to be reviewed by the Service Group Director-led HCAI scrutiny panels to establish if the patient infection episodes were managed appropriately, and to determine if the infection episode could have been prevented.

The pilot of the HCAI *C. difficile* case review digital application commenced in Jun. It is currently in a user acceptability testing phase. The aims of the application are to standardise the case review process, to centralise the collation of information, improve thematic analysis, and identify opportunities where improvements can be made.

To address the rising burden and high prevalence rates of *C. difficile* in the health board, the ***Clostridioides difficile* (*C. difficile*) Standards: Risk Assessment and Governance Framework** has been developed and subsequently agreed for adoption following presentation to Management Board in May 2025. This framework will support compliance with national and best practice guidance and, promote robust oversight, reporting, and escalation in the management of *C. difficile* across the health board.

b) *Staph. aureus* bacteraemia

There has been a 19% increase in the case numbers reported across the health board compared to the same period in Quarter 1, 2024/25. All service groups need to maintain the focus on infection reduction strategies aimed at the reducing the infection risk associated to this skin bacterium. This includes appropriate, targeted screening for carriage and decolonisation of the organism, reducing the presence of invasive devices, strict adherence to aseptic technique and the provision of chlorhexidine gluconate, skin decolonisation personal hygiene wipes for inpatients.

c) Gram negative bacteraemia *(E. coli, Klebsiella spp., Pseudomonas aeruginosa)*

The internal infection target for *E. coli* bacteraemia has been exceeded by 9 cases during Quarter 1. This represents a 23% increase in case numbers across the health board when compared to the same period during 2024/25.

Most of the service groups achieved a reduction in the number of *Klebsiella spp*. bacteraemia cases reported during Quarter 1 this has achieved a 21% reduction in case numbers for the health board.

Although the total number of *Pseudomonas aeruginosa* bacteraemia cases reported are low, the nine cases reported during the reporting period represents a doubling of cases compared to the same reporting period in 2024/25.

2025/26 National infection improvement goals

The publication by Welsh Government of the healthcare associated infection goals for 2025 to 2026 is anticipated during the second quarter of the financial year. In the interim, the health board continues to report progress on the national goals established 2024/25.

3. Infection Prevention & Control Improvement Plan

3.1. Overarching 2025/26 Infection Prevention Improvement Plan

Progress to this year's Infection Improvement plan is shown in **Appendix 3**.

Forty-one percent of actions are currently achieved.

Forty-five percent are on track for achieving the agreed outcome.

The remainder of the actions are currently off-track and are impacted by current service pressures, for example, the ability to provide a dedicated decant facility.

4. Outbreaks and clusters, untoward incidents, Periods of Increased Incidence (PII), and ward/bay closures from diarrhoea and vomiting

4.1. Periods of Increased Incidence (PII) and outbreaks of *Clostridioides difficile (C. difficile).*

A period of increased incidence (PII) is when two hospital-acquired cases of *C. difficile* are attributed to the same ward location within a 28-day period. In Swansea Bay, the PII can include both toxin positive and toxin negative cases.

The National Anaerobic Reference Unit in Cardiff performs Whole Genome Sequencing (WGS) analysis on all *C. difficile* positive samples. If cases have the same genomic cluster code, they are genetically related. When the same WGS cluster code is identified for two or more cases, and epidemiological links are confirmed between them (i.e. linked in time and place), a transmission event (outbreak) is reported in Datix. **Charts 5 and 6** in **Appendix 4** includes the details of *C. difficile* PIIs and outbreaks reported in Datix since May 2022.

4.2. Incidents and outbreaks

Table 7 in **Appendix 5** provides a summary of the Datix reported infection-related incidents and outbreaks (not associated with *C. difficile*), where two or more confirmed cases were identified that were associated in time and place. Most of the outbreaks that occurred during the reporting period were associated with seasonal viral infections.

Insufficient single room accommodation across our acute inpatient settings may contribute to the outbreaks occurring. An inability to isolate all patients who require isolation (suspected and confirmed cases of infection) increases the risk of infection exposure for other patients. This can result in closure of bays, and in some instances, results in outbreaks occurring. The overcrowding caused by the regular use of pre-emptive beds (on-boarding) and the lack of mechanical ventilation also contributes to this risk. Daily Infection Control Safety Huddle meetings continue to be held at times of high incidence.

4.2.1. *Streptococcus pyogenes* and MRSA in Mental Health

During the reporting period, there was an outbreak of *Streptococcus pyogenes* in a mental health adult inpatient location. Eleven patients and four staff members who were screened were identified to be carrying the bacterium and received treatment. During the screening process, four patients were found to be colonised with MRSA, and were prescribed appropriate decolonisation treatment.

4.2.2. Varicella-zoster virus (Chickenpox) incident

In May/June, notification was received that a member staff was diagnosed with Chickenpox (Varicella-zoster virus), despite a childhood history of the disease. It was confirmed that, prior to the diagnosis by General Practitioner, this member of staff had been at work and would have been contagious during that time. Varicella is highly contagious (1 to 2 days before the rash appears until all blisters have crusted over).

The only known contact of infection for this member of staff was a patient who had Shingles, although the member of staff wore all appropriate personal protective equipment during contact with this patient. The member of staff could not identify any alternative community contact.

Contact tracing of patients and staff was undertaken on all the clinical areas that this staff member had worked over the three days whilst contagious. All patient contacts were confirmed as having had Chickenpox or had blood tests to confirm immunity. Staff contacts were referred to Occupational Health to check for disease history or immunity.

One of these staff contacts was diagnosed with Chickenpox by General Practitioner in early June. Although this member of staff did not recall having direct contact with the initial staff case, they had been working on the same ward

on the same day. The second member of staff also had a history of childhood Chickenpox. Patient and staff contacts were managed as previously. Only one staff contact was found to be non-immune and was excluded from work until 21 days post-exposure.

There have been no further cases identified.

5. Education & Training

Training compliance

The Infection Prevention and Control Team, along with local training practice leads, continues to deliver ad-hoc, non-mandatory infection prevention and control (IPC) related training and updates to both clinical and non-clinical staff employed by the health board. This is in addition to any online training undertaken by staff.

The tables in **Appendix 6** identify the percentage compliance with mandatory training and numbers of staff that have undertaken IPC-related training to 30th June 2025.

Level 1 and Level 2 Infection Prevention & Control Training (Table 8 and Table 9):

- The national minimum compliance target in ESR for both Level 1 and Level 2 IPC courses is 80%. Level 1 compliance across the health board was 90.23% and 82.34% for Level 2. Estates and Ancillary and the Medical and Dental staff groups are the only groups below the 80% target, but compliance has increased for both groups since the last reporting period.

Hand Hygiene Practice Assessment and Hand Hygiene Assessors (Table 10)

- Over the last rolling 12-month period (1st July 2024 to 30th June 2025), 2,972 staff have had a hand hygiene practice assessment, with the assessment undertaken by the department-based Hand Hygiene Assessors, or by the IPC team.
- ESR reports Hand Hygiene Competence compliance within the health board as 29.79% (Table 11). This information in ESR is considered unreliable if local records are not uploaded on ESR. To ensure appropriate compliance levels are recorded, Hand Hygiene Assessors must send records of staff who have been competence assessed to administrators within the service groups who can upload data onto ESR. Alternatively, records can be sent to IPC administration team to ensure competence compliance is recorded in ESR.
- Over the last three years (1st July 2022 to 30th June 2025), the IPCT has trained 627 Hand Hygiene Assessors within the service groups. Detailed information regarding Hand Hygiene Assessors is available for each service group.

Aseptic Non-Touch Technique (ANTT) (Table 12)

Compliance with ANTT training to 30th June 2025 is recorded in ESR as 31.64% for the ANTT e-learning course, and competence assessment compliance as 17.06%. Training reports from ESR uses **all** health board staff as the denominator for compliance. However, not all health board staff are required to undertake ANTT e-learning or competency assessment, therefore the compliance percentage is not a true representation of compliance. Service Groups may wish to consider alternative methods of recording compliance.

HCID PPE Training

Since October 2024, five staff have attended the accredited HCID PPE Train the Trainers course in Mexborough. Swansea Bay UHB now has four qualified HCID PPE Trainers; one has subsequently left the organisation. These staff are delivering training sessions across the health board, which also consists of a competency assessment for the attendees. ESR is being used to record the training and competence assessment. To date the HCID PPE training has been provided to more than 60 members of health board staff.

6. Assurance

Reporting

- The Quality & Safety Group receives quarterly assurance reports relating to infection prevention and control. In addition, any issues for escalation would be taken to the Quality & Safety Group outside of the quarterly reporting schedule.
- The assurance reports are formally presented to the Quality & Safety Committee quarterly.
- The performance tracker, showing performance against the Tier 1 infection reduction expectations, is circulated weekly to the Executive Team and Service Group Directors and is available on the IPC SharePoint site.
- The Targeted Intervention performance tracker is circulated to the Executive Leads for HCAI, and performance is reported formally at monthly Targeted Intervention and Integrated Quality, Planning and Delivery meetings with Welsh Government.
- Senior IP&C staff attend each Service Group Infection Control Group. The IP&C Matrons and the Matron, Decontamination Operational Lead, together with Band 7 Infection Control Nurses, ensure support is provided to the Service Group Triumvirates.

- The IPC team actively participates in healthcare associated infection review panels within Service Groups, liaising closely with service group IP&C leads and clinical staff from each ward/department.
- The senior members of the IPCN team, along with other Corporate Nurses, participate in Quality & Safety assurance visits across the health board to review Safe & Effective Care provision.
- *Clostridioides difficile (C. difficile*) Standards: Risk Assessment and Governance Framework has been developed and subsequently agreed by the Management Board in May 2025. This document has been presented at Nursing and Midwifery Group in June. The Head of Nursing, IPC will be attending senior team meetings in Service Groups to raise awareness of the Standards and framework and promote its adoption.

7. Infection Prevention Team Audit Programme

All acute inpatient settings are undertaking monthly audits using the IPC Standard Precautions in the Care Environment audit tool in the Audit Management and Tracking system (AMaT). Where noncompliance is recorded, service group staff are responsible for developing and monitoring improvement action plans within the system.

Out-Patient and Mental Health settings are still being introduced to the system currently.

The IPC programme of audit includes annual and biannual audits of Standard Precautions Practice. During Quarter 1, the infection control team has undertaken 98 audits in areas included in the audit programme: 78% of the biannual audits have been completed and 24% of the annual audits have been completed. The team is on track to complete the programme during the year. In addition, the team has undertaken 30 audits in response to outbreaks and PII. All areas audited were provided with immediate verbal feedback ahead of the audit report being available electronically.

- 23 audits (18%) were Red (<69%)
- 38 audits (30%) were Amber (70-84%)
- 67 audits (52%) were Green (≥85%)

The IPC team offers support, advice and training to help clinical staff achieve improvements. Where audits identify concerns relating to standards of cleanliness and infection control practice, these concerns are escalated to the Ward Manager and relevant Matron for the clinical area.

Please see **Appendix 7** for the updated Infection Prevention and Control Audit Programme for 2025/27.

8. Infection-related Incidents and Risks in DATIX

8.1. Infection-related incidents as reported in the RLDatix system 02nd July 2025

8.2. Risk Register

On the 8th of July 2025, there was one new infection-related risk reported (Datix ID 4180) relating to the impact of adopting the new National Cleaning Standards for Cleanliness which are due to be published imminently. There are currently 14 open and accepted infection-related risks on the Risk Register which are outlined in **Table 14** below.

Table 14: Open and Accepted infection-related risks on the Risk Register

Infection-related risks on the Risk Register	Total
Executive Director of Nursing	6
Chief Operating Officer	1
Morriston Hospital Service Delivery Unit	7
Total	**14**

Of the 14 open and accepted infection-related risks on the Risk Register, 6 had passed the review date. There has been email communication with all relevant Risk Handlers to request a review and update of overdue risks, the detail of which can be found in **Table 15**.

Table 15: Overdue review of infection-related risks, by Service Group	Overdue Review	Risk Register ID
Chief Operating Officer	**1**	3778
Morriston Hospital Service Delivery Unit	**1**	3678, 3515, 797, 35, 3011

Risk 2249 has been closed. This risk related to the visibility of Alert Organism flags within patient administration systems. All patients known to Swansea Bay, and who are known to have an alert organism, are currently flagged in Welsh Clinical Portal. This process will continue as new cases are identified to the IPCT.

9. CHALLENGES, RISKS AND MITIGATION: HEALTHCARE ASSOCIATED INFECTIONS

- Lack of a dedicated decant facility (**Datix Risk ID 2210**). There are still no permanent decant facilities available across the health board, which impacts on ability to decant bays and wards to undertake deep cleaning and high level disinfection following *C. difficile* cases, and for maintenance and refurbishment.
- Increased risk to patients for acquisition of *C. difficile* infection (**Datix Risk ID 2286**).

  Gold *C. difficile* High Incidence Management Group continues. The *C. difficile* Standards Framework was agreed at Management Board in May 2025.
- Service pressures across the acute sites, and in Morriston especially, preclude the ability to undertake a regular pro-active programme of 4D cleaning, and compromise the ability to undertake reactive 4D cleaning following episodes of infection such as *C. difficile*. Replacement parts for UV-C equipment high level disinfection equipment are now obsolete; consideration will need to be given to replace this equipment prior to them failing.
- The limited availability of single room isolation facilities continues to present a challenge to the appropriate management of patients with suspected or confirmed infections. This results in a risk of extended exposure of other patient contacts to the risk of transmissible infections, such as MRSA and other multi-drug-resistant organisms. Additionally, due to the competing demands for single rooms, there can be a delay in isolating patients while staff await confirmation of an infection prior to moving patients, which may add to the exposure risk for other patients and an extended period where organisms continue to contaminate the environment – **HBR 4 (Datix Risk ID – 739, 1750, 535, 797**).

- The high numbers of clinically optimised patients awaiting packages of care continues to put increased pressure on bed capacity in the acute sites. The additional patients "on-boarding" on most wards throughout Morriston continues. Surge beds are also in use in Gorseinon, staffed by bank and agency staff. Additional beds in existing multi-bedded rooms further reduces space between beds. These factors increase the risk of infection transmission due to non-compliance with bed spacing guidance (**Datix Risk ID – 2488**).
- Bed spacing and presence of limited natural ventilation within most inpatient wards poses an ongoing risk in relation to transmission of infections, including COVID-19 and other seasonal viral infections, including influenza, Respiratory Syncytial Virus, parainfluenza, and Norovirus (**Datix Risk ID 2488**).

10. GOVERNANCE AND RISK ISSUES

Healthcare associated infections are associated with poor patient outcomes and are significant quality and safety issues. Continuing failure to achieve the infection reduction improvements is an unacceptable position for our patients (**HBR 4**) and has resulted in an escalation from Enhanced Monitoring to Targeted Intervention.

11. 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 2024 to 30 June 2025, is as follows: *C. difficile* - £530,000; *Staph. aureus* bacteraemia - £224,000; *E. coli* bacteraemia - £76,600; therefore, a total cost of **£830,600**.

12. RECOMMENDATION

The Infection Prevention & Control Strategic Group is asked to:

- **ACKNOWLEDGE:** the health board's position in relation to the Targeted Interventions improvement goals.
- **ACKNOWLEDGE:** the performance of the health board towards achieving internal and national infection improvement goals.

- **ACKNOWLEDGE:** the health board has the highest incidence of *C. difficile* infection and *Pseudomonas aeruginosa* bacteraemia in Wales.
- **ACKNOWLEDGE:** the continued increase in numbers of cases, and the numbers of periods of increased incidence, and outbreaks of *C. difficile* cases seen in Quarter 1, and the continuation of the Gold *C. difficile* High Incidence Management Group**.**
- **ACKNOWLEDGE:** progress on Infection Prevention & Control Improvement Plan to 30th June 2025.
- **ACKNOWLEDGE:** the IPC training compliance goal has been achieved (i.e. >80%). IPC Level 1 - 90.23%; Level 2 training - 82.34%.
- **ACKNOWLEDGE:** the challenges and risks within the health board currently and mitigations recorded in the risks recorded in the health board's Risk Register.

Governance and Assurance		
Link to Enabling Objectives *(please choose)*	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High-Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	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

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. (*Trust and CCG level impact of E. coli BSIs* accessed online at: https://improvement.nhs.uk/resources/preventing-gram-negative-bloodstream-infections/).

Estimated costs related to healthcare associated infections, from 01 April 2024 to the end of June 2025 is as follows: *C. difficile* - £530,000; *Staph. aureus* bacteraemia - £224,000; *E. coli* bacteraemia - £76,600; therefore, a total cost of **£830,600**.

Legal Implications (including equality and diversity assessment)

Potential litigation in relation to avoidable healthcare associated infection.

Staffing Implications

None identified.	
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
A healthier Wales: preventing infections	
Report History	Previous meeting 29th April 2025
Appendices	**Appendix 1**. Tier 1 Progress. **Appendix 2**. All Wales comparison. **Appendix 3**. HB Improvement Plan 2025_26 to end Q1, 2025/26. **Appendix 4**. PII and WGS clusters for Quarter 1, 2025-26. **Appendix 5**. Incidents and outbreaks of infection, Quarter 1, 2025-26. **Appendix 6**. Infection Prevention & Control related education. **Appendix 7**. Infection Prevention & Control Audit Programme 2025 - 2027