

Meeting Date	30 January 2026	Agenda Item	3.1	
Report Title	Infection Prevention and 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 3, 01 April 2025 to 31 December 2025.			
Key Issues	• De-escalation criteria have not been met for Hospital onset case numbers during Quarter 3. • The health board continues to have the highest incidence of <i>C. difficile</i> in Wales. • <i>C. difficile</i> Periods of Increased Incidence (PII) and outbreaks continue to be of concern. • Additional pre-empt patients on wards are a regular occurrence; this over-crowding increases the risk of infection transmission. • A lack of decant facility is impacting on the ability to clean to the required health board standard, the rooms where cases of <i>C. difficile</i> 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.			
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* infections and *Staphylococcus aureus*, and *Pseudomonas aeruginosa* bacteraemia in Wales,
- **ACKNOWLEDGE:** the number of periods of increased incidence, and outbreaks of *C. difficile* cases seen in Quarter 3.
- **ACKNOWLEDGE:** progress on Infection Prevention & Control Improvement Plan to 31st December 2025.
- **ACKNOWLEDGE:** the IPC training compliance goal has been achieved (i.e. >80%). IPC Level 1 – 90.08%; Level 2 training – 84.92%.
- **ACKNOWLEDGE:** the challenges and risks within the health board currently and mitigations recorded in the risks recorded in the health board's Risk Register.



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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. The health board set the internal 2025/26 healthcare associated infection reduction goals in April 2025, based on the Welsh Health Circular (WHC/2024/038) Healthcare associated infections goals that were published in September 2024. Progress against these internal goals is included within this report. The reporting period is 1st April 2025 – 31st December 2025.

The key HCAs 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*).

This report also presents a summary of infection-related incidents and outbreaks that occurred between 1st April and 31st December 2025, along with a summary of the activities conducted across the health board in relation to the prevention, control, and management of infections.

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 Table 1. It will not be possible to achieve the targets set for *C. difficile*, *Staph aureus*, and *E coli* as the maximum number of HO cases has been exceeded.

Table 1. Targeted Intervention progress

Targeted Intervention - De-escalation Criteria for Hospital Onset HCAs			Q1 2025/26 Actual	Q2 2025/26 Actual	Q3 2025/26 Actual			
HCAI TI Criteria 2025/26	Av. Monthly HO TI Criteria (Max. av. monthly cases)	TI Criteria (Max. quarterly cases)	Q1 TI - HO Cases to 30.06.25	Q2 TI - HO Cases to 30.09.25	Oct-25 Hospital Onset Total cases (actual)	Nov-25 Hospital Onset Total cases (actual)	Dec-25 Hospital Onset Total cases (actual)	Q3 TI - HO Cases to 31.12.25
SBUHB HCAI <i>C. difficile</i> 2025/26 TI Criteria	6	18	27 (+9)	40 (+22)	5 (-1)	10 (+4)	9 (+3)	24 (+6)
SBUHB HCAI <i>Staph. aureus</i> bacteraemia 2025/26 TI Criteria	3	9	14 (+5)	16 (+6)	4 (+1)	4 (+1)	3	11 (+2)
SBUHB HCAI <i>E. coli</i> bacteraemia 2025/26 TI Criteria	4	12	18 (+6)	20 (+8)	5 (+1)	5 (+1)	4	14 (+2)
SBUHB HCAI <i>Klebsiella</i> spp. bacteraemia 2025/26 TI Criteria	4	12	18 (+6)	12	4	3 (-1)	7 (+3)	14 (+2)

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

2.2 Progress against internal health board reduction goals for key Healthcare Associated Infections (HCAIs): 1st April 2025 – 31st December 2025.

Progress against the **internal health board HCAI reduction goals** is shown in [Table 2](#). These continue to be monitored and reported to maintain a focus on infection reduction for patients in primary care, community, and hospital settings. Reductions have been achieved in relation to the number of cases of *C. difficile*, *Staphylococcus aureus*, and *Klebsiella* spp. bacteraemias. Table 2 also includes the summarised cumulative position for the service groups, with the annual increase or reduction shown in brackets.

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

	CDI	SaBSI	EcBSI	KIBSI	PAER BSI
SBUHB - Total	170 (↓ 17%)	97 (↓ 1%)	214 (↑ 26%)	88 (↓ 2%)	19 (↑ 6 cases)
PCTSG - CAI	56 (↑ 4%)	42 (↑ 8%)	135 (↑ 47%)	35 (↑ 30%)	4 (↑ 33%)
PCTSG - HAI	3 (↓ 40%)	0 (=)	0 (=)	0 (=)	1 (↑ 1 case)
MH&LD – HAI	3 (↑ 2 cases)	1 (↑ 1 case)	1 (↓ 50%)	0 (=)	0 (=)
MORR – HAI	88 (↓ 18%)	41 (↑ 5%)	55 (↑ 25%)	36 (↓ 8%)	5 (↓ 29%)
NPTH - HAI	5 (↓ 55%)	2 (↑ 2 cases)	6 (↓ 25%)	5 (↑ 1 case)	1 (=)
SH – HAI	13 (↓ 48%)	9 (↓ 47%)	14 (↓ 18%)	11 (↓ 27%)	7 (↑ 5 cases) target exceeded
Other HB Cases Identified in SBUHB	2 cases	2 cases	3 cases	1 case	1 case

Charts showing the position of the health board and service group progress against the infection improvement trajectories, up to 31st December 2025, are detailed in **Appendix 1**. In October, Gorseinon hospital temporarily moved its inpatient services to Singleton Ward 3. Any positive samples for inpatients on ward three have subsequently been included in the Singleton data.

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 *Staphylococcus aureus*, and *Pseudomonas aeruginosa* bacteraemias.

HCAI cases are reported by the infection control team in Datix, they continue to be reviewed by the Service Group Director-led HCAI scrutiny panels. These groups are multi-disciplinary and include the SG chair/deputy, a consultant microbiologist, the clinicians responsible for the patients care, a member of the Infection Control Team, and an antimicrobial pharmacist. The review panel aims to establish if the patient infection episodes were managed appropriately, and to determine if the infection episode could have been prevented. The outcome around the number of preventable HCAI's and lessons learned are reported by each service group individually.

a) *Clostridioides difficile*

The health board still has the highest incidence of *C. difficile* in NHS Wales with the cumulative incidence rate reported as 57.57/100,000 population; this is lower than the same period in 2024/25. There has been a 17% annual decrease in overall case numbers compared to the same reporting period in 2024/25 and the internal infection reduction target has been exceeded by two cases.

Each of the acute hospital sites achieved a reduction in overall case numbers, with Mental Health and Primary Care service groups seeing increases. Inpatients with a new diagnosis of *C. difficile* with a notification card that can be presented to health care settings to raise awareness of the Cdi history. A similar process will be rolled out for non-inpatients when the Community Infection Control Nurse team are fully inducted.

The operational challenges of over occupancy in clinical areas and the high number of clinically optimised inpatients awaiting appropriate discharge arrangements, insufficient single room capacity, challenges in undertaking effective cleaning and the condition of the environment continue to present challenges in adhering to the *Clostridioides difficile* (*C. difficile*) Standards: Risk Assessment and Governance Framework.

***Staph. aureus* bacteraemia**

There has been a slight (1%) reduction in case numbers reported across the health board compared to the same period in Quarter 3, 2024/25, and the cumulative position to date is on trajectory to achieve the internal improvement goal. Singleton continues to be the only health board site that has achieved a reduction in case numbers (47%) and are on target to achieve their internal improvement goal.

During the reporting period, skin and soft tissue infections were the most frequently recorded as the source for all diagnosed bacteraemias (36%). In hospital acquired cases, respiratory infection was reported as the source in 31% of cases and line associated infections were the source in 19% of the HAIs.

There were two MRSA bacteraemias identified during the reporting period. Case reviews have been undertaken; both were deemed unlikely to have been preventable. Neither case had a prior history of MRSA; case one was detected on admission to hospital (reported as a CAI) there were no risk factors that would have triggered the need for MRSA screening. The second case was recorded as health care associated, and during the case review it was highlighted that the admitting ward had taken an MRSA screen on admission (reported as MRSA Not isolated), but the screen had not included the multiple skin abrasions sustained prior to the admission.

All service groups must maintain their focus on interventions aimed at reducing infections associated to this skin colonising bacterium. These include screening patients on admission if they have risk factors for MRSA carriage, participation in targeted surveillance programmes for high-risk populations such as dialysis patients, administering decolonisation treatments when required, reducing the presence of invasive devices, and adherence to ANTT during procedures and care interventions.

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

It will not be possible to achieve the improvement goal; there has been a 26% increase in case numbers compared to the same reporting period Q3, 2024/25 and the internal infection target for *E. coli* bacteraemia has been exceeded by thirteen cases.

A higher proportion of cases were community acquired infections. The urinary tract continues to be the most common source for all the bacteraemia cases (47%).

Whilst there has been a 2% reduction in the number of *Klebsiella* bacteraemia cases compared to the same reporting period in Q3 2024/25, it is unlikely that the improvement goal will be achieved this year as the current cumulative

position is equal to the improvement goal of eighty-eight cases. The most common sources for these infection episodes were found to be associated to urinary tract infections, hepatobiliary disease, and respiratory tract infections.

The overall number of *Pseudomonas* cases reported are low compared to the other Tier One organisms, but there has been a 46% increase reported compared to the same reporting period in 2024/25. Of all the cases diagnosed during Q3, 50% were considered to have a line associated infections as the source. Cases considered to be Hospital acquired infections had urinary and line associated sources.

2025/26 National infection improvement goals

The health board continues to report progress on the national goals established 2024/25. [WHC 2025_036- AMR & HCAI Improvement Goals 2025-2027](#) has been published. The reduction targets outlined in the WHC which are below. The health board improvement targets for the next financial year are being calculated based on the following:

- *C.difficile* Improvement Goals – to reduce the overall burden by at least 25% against the 2024/25 counts.
- *E. coli* bloodstream infections Improvement Goal: A reduction of at least 10% in cases of hospital onset *E. coli* BSI is expected vs the cases in 2024-2025.
- *Klebsiella spp.* Bloodstream infections a reduction of at least 20% is required due to the increases seen in 2024-25.
- *Pseudomonas aeruginosa* bloodstream infections. A reduction of at least 10% in cases of hospital onset *Pseudomonas aeruginosa* BSI vs the cases in 2024-2025.

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-five 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 resolute decant facility.

The 2026-2027 Infection Prevention Improvement Plan is in development and will incorporate the AMR & HCAI Improvement Goals For 2025-2027 outlined in WHC/2025/039 and the Welsh Government Quality Statement – Infection Prevention & Control that was issued in January.

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 (i.e. linked in time and place), a transmission event is reported in Datix (i.e. outbreak).

Charts 5 and 6 in **Appendix 4** includes the details of the *C. difficile* PIIs and outbreaks reported in Datix since May 2022. The number of PII and genomically linked clusters has reduced during the reporting period. During the last quarter there were eleven PII detected involving between two and eleven patients. There were four genomically linked outbreaks, each involving two patients.

4.2. Incidents and outbreaks

Norovirus, Influenza, and other respiratory viral infections continued to circulate in the community and admissions to hospital created significant pressure across the health board, predominantly in Morriston.

Operational pressures continue to exist, with overcrowding and pre-emptive beds (your next patient) being present across Morriston wards. The additional beds further reduce the spacing between patients. Movement of inpatients within and across hospital sites, who had been exposed to infectious cases, can contribute to outbreaks occurring in multiple locations. The increased activity and capacity increase the risk of transmission of infections and can impact on the ability to effectively clean the environment and patient equipment.

Table 7 in Appendix 5 provides the number 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. There were twenty-five outbreaks reported during Q3.

A retrospective review of the pathways of ninety patients who had a Norovirus positive sample (from Dec 13th) has been undertaken. It is likely that an outbreak

resulted in AMU; a cohort of patients had been created due to insufficient single rooms to meet the demand; these patients had been admitted with community acquired norovirus. Eighteen patients had a positive sample during their admission and had been admitted to AMU in the five days before testing positive (possible exposure), thirteen tested positive in AMU and four patients tested positive in other locations where outbreaks had been reported.

Due to limited single room accommodation, it was not possible to isolate all the patients with infectious symptoms that presented to the emergency and assessment units. This increased the likelihood of transmission to other patients receiving care in these locations which is likely to have resulted in small outbreaks occurring across inpatient locations.

CPO *Klebsiella pneumoniae* Oxa-181 outbreak Surgery Morriston

During November, clinical samples from two patients sharing the same admission pathway were diagnosed with an extensively antibiotic-resistant strain of carbapenemase producing *Klebsiella Pneumoniae*. These have been typed by UKHSA labs and indicate both cases have the same resistance mechanism OXA_181, this is a unique new strain. Contact tracing identified over 100 other patients who shared the same admission pathway, screening of those who were inpatients identified three additional patients colonised with the outbreak strain. All five of the patients had been admitted to Ward V Morriston during October. During contact screening several other patients with other CPO's (unrelated) were identified, carrying other organisms and resistance mechanisms that are not related to the outbreak strain. Not all the contacts have been screened for CPO to date; this will be undertaken if they are readmitted to hospital.

Concerns regarding cleaning standards on Ward V were identified and addressed during the outbreak. Also, insufficient functioning shower and toilet facilities for inpatients were highlighted including blocked drainage outlets and a toilet out of use. Surveys have been undertaken to assess the extent of the drainage problems and quotations are being progressed by the estates department to rectify the problem. Environmental sampling was undertaken and although pathogens were detected, the outbreak strain was not identified.

Pulmonary TB Gwelfor.

In December, following a bronchoscopy a diagnosis of Pulmonary TB was made for a patient who had been an inpatient across several SBUHB locations since July 2023. An Incident Management Group was convened, the ward closed to

admissions and the respiratory team and occupation health team have undertaken a co-ordinated contact tracing exercise. To date this has identified for follow up screening: close family members (3), staff (30) and inpatients (17). An escalation model of contact tracing is being undertaken with wider screening, outside of this cohort, only if indicated from these results. The patient experienced some deterioration in his mental health during the TB treatment phase as there were contraindications and interactions with anti-psychotic medication. The initial two-week treatment regime to reduce infectivity has now been administered, and isolation precautions are no longer required. During the incident, the ward overcame the challenge to maintain patient compliance with isolation precautions, the need to FFP3 fit test train the ward staff was supported by the HB respiratory protection co-ordinator.

5. Education & Training

Training compliance

The Infection Prevention and Control Team, along with local practice facilitators and clinical educators, continue 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 31st December 2025.

To ensure appropriate compliance levels are recorded in ESR competency assessment training records for ANTT, Hand Hygiene, and HCID PPE, the assessors must send records of staff who have received their annual update 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.

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 is 90.08%.
- Level 2 compliance is 84.92%.

Estates and Ancillary, and the Medical and Dental staff groups, continue to be 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)

All health board staff are required to have an annual assessment of hand hygiene competence.

The Infection Prevention and Control Team (IPCT) deliver assessor training sessions across each of the service groups so that all departments have an assessor to deliver annual competency assessment of all staff. Practice evaluation sessions are also undertaken in response to infection incidents, outbreaks, and PII, the IPCT visit affected areas and offer hand hygiene practice assessment to staff on duty.

Between 1st January 2023 to 31st December 2025,

- 893 Hand Hygiene Assessors have been trained by the IPCT within the service groups.

In the last 12 month rolling period,

- ESR reports Hand Hygiene Competence compliance as 30.06% (Table 11).
- 3,223 staff have had a hand hygiene practice assessment with the assessment undertaken by the department-based Hand Hygiene Assessors, or by the IPC team.

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

Clinical staff who deliver care that requires asepsis must undertake ANTT eLearning (once) and be competency assessed in practice (three yearly). To ensure departments can provide the ongoing competency assessments, the IPCT deliver ANTT assessor training sessions across all sites. Two assessor training sessions were cancelled due to lack of attendance.

ESR uses all health board staff as the denominator for compliance. As not all health board staff are required to undertake ANTT e-learning or competency assessment, the compliance rate is not accurately reported for the health board.

Compliance with ANTT training to 31st December 2025 is recorded in ESR as

- 29.90% for the ANTT e-learning course
- 16.44%. three yearly competency assessment

High Consequence Infectious Disease (HCID) PPE Training

This training is not required to be undertaken by all staff, it is pertinent to those working in environments where a HCID patient may present or require ongoing

management, i.e. Emergency/unscheduled care settings, Intensive Care Units, Maternity Unit and the locations where Negative Pressure Isolation Room (NPIR) are located (i.e. ED and Ward S Morriston).

Swansea Bay UHB currently has four qualified HCID PPE Trainers who can deliver this training and perform the staff competency assessments. These individuals deliver the training in addition to undertaking their substantive clinical roles.

The details of the trainers and the training records of who has been HCID PPE competency assessed are held in the Health Board On-call Teams folder so they can be accessed in the event of a suspected HCID case presenting to hospital. Being Fit test trained to wear an FFP3 mask is an essential pre-requisite to be able to care for a suspected HCID.

Most staff who have been trained to date are nurses. A small number of Drs have been trained and assessed. The training is intense and releasing staff to attend can be challenge given the winter pressures.

- Number of staff who have attended HCID PPE training: 70.

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, consulting 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. Service Groups have also established their own programme of assurance visits; these are also supported by a senior IPCN.
- *Clostridioides difficile* (*C. difficile*) Standards: Risk Assessment and Governance Framework was introduced in August, following IPCSG member approval. Inpatient locations with a high incidence of patients that have a *C. difficile* diagnosis are visited by the IPCN to undertake a situation assessment in accordance with the framework.

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). Out-Patient and Mental Health settings are still being introduced to the system, and the IPCT have commenced their audit programme across community settings.

At the end of Quarter 3, the infection control team has undertaken 175 audits and are on track to complete the agreed annual programme. Immediate verbal feedback provided ahead of the electronic report being available in AMaT.

- 13% were rated Red (<69%)
- 27% were rated Amber (70-84%)
- 58% were rated Green (≥85%)

Service group staff are responsible for developing and monitoring improvement action plans within the system. Where audits identify concerns relating to standards of cleanliness and or infection control practice, these concerns are escalated to the Ward Manager and relevant Matron for the clinical area.

8. Infection-related Incidents and Risks in DATIX

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



Statuses

New Incident	57 Records	51 Overdue
Management review	160 Records	160 Overdue
Under Investigation	379 Records	301 Overdue
Awaiting Closure	53 Records	38 Overdue
Closed	7299 Records	
Rejected	0 Records	

8.2. Risk Register

There are currently two new and, eighteen accepted infection-related risks on the Risk Register. These 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
Morrison Hospital Service Delivery Unit	5
Neath and Singleton Service Group	7
Primary and Community Services	1
Total	20

There are two new risks on the Risk Register:

4354 relating to Water quality and standards for haemodialysis units.

4346 relating to WHC 2025 020 influenza vaccination uptake target not being achieved.

Eight risks had passed their review date, the detail of which can be found in [Table 15](#). There has been an email sent to all relevant Risk Handlers to request a review and update of overdue risks and to highlight where there may be some duplication of the same risk reported.

Table 15: Overdue review of infection-related risks, by Service Group	Overdue Review	Risk Register ID
Chief Operating Officer	1	3778
Morrison Hospital Service Delivery Unit	4	3678, 3515, 535, 3011.
Neath Singleton Service Group	3	4323, 4320, 4316

9. CHALLENGES, RISKS AND MITIGATION: HEALTHCARE ASSOCIATED INFECTIONS

- **Datix Risk 4318** – Lack of decant facility in Neath Port Talbot hospital.
- **Datix Risk 4317** - Lack of decant facilities/options at Singleton Hospital
- **Datix Risk 4180.** All Wales Cleaning Standards 2025 have been circulated. The cost of the new standards is approx. £5m. There is no funding available to implement the new standards. Current cleaning schedules remain the same, with enhanced cleaning being prioritised to areas determined to be of highest infection risk. All Health Boards have been advised to provide a breakdown of gaps and shortfalls in being able to deliver the new standards.
- **Datix Risk ID 2210** - Lack of a decant facility 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. An application is being submitted to the accommodation group, to utilise vacant office space on the Morriston Hospital site for an equipment decontamination facility.
- **Datix Risk ID 2286** Increased risk to patients for acquisition of *C. difficile* infection. Gold *C. difficile* High Incidence Management Group continues. The *C. difficile* Standards Framework was agreed at Management Board in May 2025. Implementation commenced in August 2025. Additional pre-emptive beds are being used across most of the Morriston site (including wards in PII) to facilitate ambulance offloads and decompress operational pressures in Emergency department. In January, to reduce the number of clinically optimised patients (COP's) an additional ward was reopened in Singleton. Patients meeting COP criteria were moved to this ward.
- 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 patient exposure to the risk of transmissible infections, such as MRSA and other multi-drug-resistant organisms. Additionally, the competing demands for single rooms, can delay timely isolation of patients while staff await confirmation of an infection prior to moving patients. This 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 “your next patient” on most wards throughout Morriston continues. Additional beds in existing multi-bedded rooms further reduces space between beds. An additional ward has been opened in Singleton to decompress the bed pressures in Morriston. 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. In Morriston, the bed spacing in bays where additional pre-emptive beds have been introduced as part of the UEC” Test of Change,” [this](#) has further reduced bed spacing to 1.9m (**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 £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 2025 to 31 December 2025, is as follows: *C. difficile* - £1,700,000; *Staph. aureus*

bacteraemia - £679,000; *E. coli* bacteraemia - £247,400 therefore, a total cost of **£2,626,400**

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 *Staphylococcus aureus*, and *Pseudomonas aeruginosa* bacteraemia in Wales.
- **ACKNOWLEDGE:** the decrease in numbers of cases, the numbers of PII and outbreaks of *C. difficile* cases seen in Quarter 3, and the continuation of the Gold *C. difficile* High Incidence Management Group.
- **ACKNOWLEDGE:** progress on the Infection Prevention & Control Improvement Plan to 31st December 2025.
- **ACKNOWLEDGE:** the IPC training compliance goal has been achieved (i.e. >80%). IPC Level 1 – 90.08%; Level 2 training – 84.92%.
- **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 need 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 £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 2025 to 31 December 2025, is as follows: *C. difficile* - £1,700,000; *Staph. aureus* bacteraemia - £679,000; *E. coli* bacteraemia - £247,400; therefore, a total cost of **£2,626,400**.

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 October 2025

Appendices

Appendix 1. Tier 1 Progress.
Appendix 2. All Wales comparison.
Appendix 3. HB Improvement Plan 2025_26 to end Q3, 2025/26.
Appendix 4. PII and WGS clusters for Quarter 3, 2025-26.
Appendix 5. Incidents and outbreaks of infection, Quarter 3, 2025-26.
Appendix 6. Infection Prevention & Control related education.
Appendix 7. Infection Prevention & Control Audit Programme 2025 - 2027