



Targeted intervention escalation update

June 2026

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Improvement in hospital acquired infections is not yet sustained

The tracker shows a material Quarter 4 improvement in 2025/26, but April 2026 returned to the Q3 baseline level and none of the three formal de-escalation tests has been met.

18

April 2026 cases

combined threshold is 13 per month

0 of 3

Maintenance tests met

each measure breached at least once in Feb to Apr 2026

+28

More cases in 2025/26

205 cases compared with 177 in 2024/25

+49

Above target equivalent

2025/26 annual comparator: 205 versus 156

The issue is control, not simply volume.

A quarter can look acceptable in aggregate while the monthly de-escalation rule is still failed. That is the position here: the combined Quarter 4 total was below the aggregate threshold equivalent, but individual monthly breaches remain visible.

The safest reading is targeted and cautious.

The data supports a clear conclusion that improvement has not yet become reliable. It does not, on its own, explain causation, site variation or preventability. Those questions need denominator-based and ward-level analysis.

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The formal de-escalation test has not been met

The criteria require each measure to remain at or below its monthly threshold for three consecutive months. A three-month average alone is therefore insufficient.

| Measure | Baseline | Threshold | Apr 2026 | Feb to Apr 2026 | 3-month avg | Breaches | Test result |
|-----------------------|----------|-----------|----------|-----------------|-------------|----------|-------------|
| C. difficile | 8 | ≤ 6 | 8 | 8 / 1 / 8 | 5.7 | 2 of 3 | Not met |
| S. aureus bacteraemia | 3 | ≤ 2 | 5 | 3 / 4 / 5 | 4 | 3 of 3 | Not met |
| E. coli bacteraemia | 7 | ≤ 5 | 5 | 6 / 4 / 5 | 5 | 1 of 3 | Not met |

Reading the table

C. difficile and E. coli look closer to threshold when averaged over three months, but the rule is stricter than that. Both have a breach in the latest three months. S. aureus is materially above threshold in every month from February to April 2026.

Committee Consideration

The current evidence does not support de-escalation. The correct assurance question is whether the Quarter 4 improvement can be repeated and held.

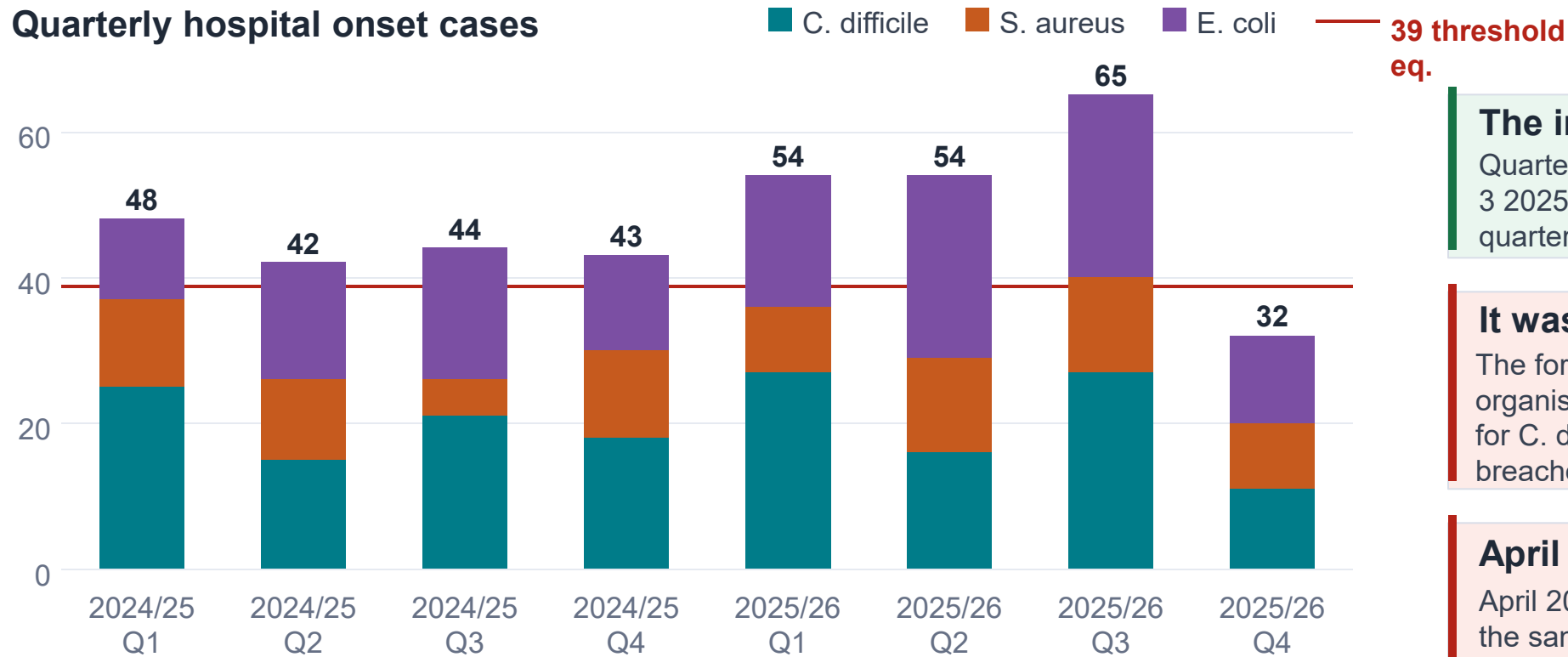
Hospital acquired infections



Quarter 4 improved sharply, but April 2026 is an early warning

The combined count fell to 32 in Quarter 4 2025/26, below the aggregate threshold equivalent. April then returned to 18 cases, which is five above the monthly threshold equivalent and equal to the tracker baseline.

Quarterly hospital onset cases



The improvement was real.

Quarter 4 fell by 33 cases from Quarter 3 2025/26. This is the strongest quarterly position in the period shown.

It was not yet reliable.

The formal test is monthly and organism-specific. February breached for C. difficile and E. coli, and S. aureus breached throughout February to April.

April matters.

April 2026 was back to 18 cases, the same as the Q3 2023/24 baseline.

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The monthly pattern is volatile rather than steadily improving

The latest 13 months show alternating improvement and deterioration. The April 2026 position is particularly important because it follows a better January to March period.

Monthly compliance view, April 2025 to April 2026

| Measure | Apr 25 | May 25 | Jun 25 | Jul 25 | Aug 25 | Sep 25 | Oct 25 | Nov 25 | Dec 25 | Jan 26 | Feb 26 | Mar 26 | Apr 26 |
|---|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| C. difficile threshold <=6 | 8 | 8 | 11 | 7 | 4 | 5 | 11 | 8 | 8 | 2 | 8 | 1 | 8 |
| S. aureus bacteraemia threshold <=2 | 3 | 3 | 3 | 4 | 5 | 4 | 3 | 4 | 6 | 2 | 3 | 4 | 5 |
| E. coli bacteraemia threshold <=5 | 6 | 5 | 7 | 10 | 6 | 9 | 10 | 7 | 8 | 2 | 6 | 4 | 5 |
| Combined total threshold <=13 | 17 | 16 | 21 | 21 | 15 | 18 | 24 | 19 | 22 | 6 | 17 | 9 | 18 |

■ At or below threshold ■ Above threshold

C. difficile

April returned to 8 cases after a low March position. Two of the latest three months were above threshold.

S. aureus

The most consistent concern. All latest three months were above threshold and April reached 5 cases.

E. coli

April was at threshold, but February was above threshold. The maintenance test is therefore not met.

Hospital acquired infections



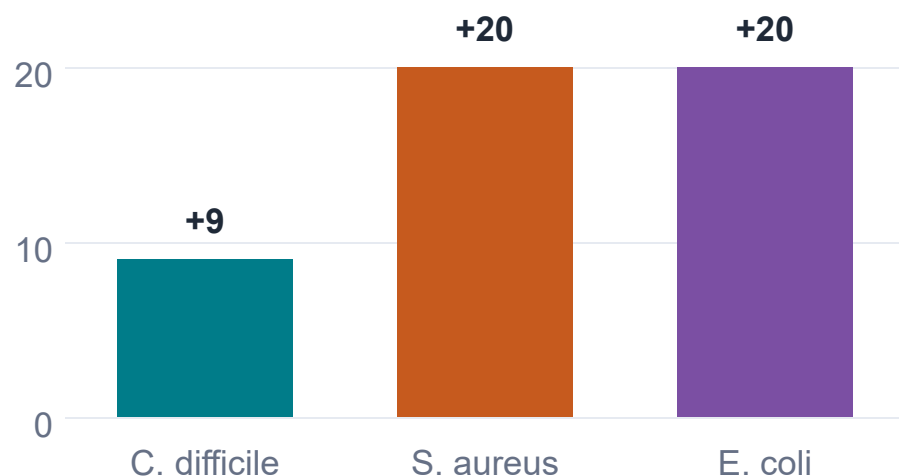
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2025/26 moved in the wrong direction, with E. coli the main driver

The full-year comparison avoids over-reading a single month. On that basis, total cases increased by 28 in 2025/26, with E. coli accounting for most of the year-on-year deterioration.

Excess cases above annual target equivalent, 2025/26



Annual target equivalent is the monthly threshold multiplied by 12. It is used here only as a comparator.

| Measure | 2024/25 | 2025/26 | Change | Target eq. | Above target |
|-----------------------|------------|------------|------------|------------|--------------|
| C. difficile | 79 | 81 | +2 | 72 | +9 |
| S. aureus bacteraemia | 40 | 44 | +4 | 24 | +20 |
| E. coli bacteraemia | 58 | 80 | +22 | 60 | +20 |
| Combined | 177 | 205 | +28 | 156 | +49 |

E. coli increased by 22 cases year on year. S. aureus remained persistently above its lower threshold. C. difficile was broadly flat, but still above the target equivalent.

The assurance response should now focus on reliability and explanation

The data is sufficient to show that the position is not yet controlled. It is not sufficient to explain the drivers. The next step is therefore a tighter evidence pack, not a broader set of assumptions based on the current IPC plans for 26/27.

What the tracker shows

The de-escalation thresholds are not being sustained. April 2026 was above the combined monthly threshold and two of the three organism measures were above threshold.

What it does not show

The TI tracker does not include occupied bed days, admissions, ward or site attribution, case-mix, source reviews or preventability assessment. It should not be read as a rate of avoidable harm.

What should happen next

Validate April, explain the February to April breaches, and add site and denominator analysis so improvement can be assessed as a rate and not only as a count.

Recommendation for the Committee

The Committee should recognise the Quarter 4 improvement but not treat it as sufficient assurance. A focused improvement response is required, with particular attention to persistent *S. aureus* breaches, the year-on-year increase in *E. coli* and the volatility in *C. difficile*. The next report should show whether the April rebound is an isolated month or the start of renewed deterioration?

Criteria 10, 11, 13, 14: Fragile services



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Fragile services arrangements are improving, but are not yet fully embedded

The Health Board has established the core framework, governance route and early oversight mechanisms, but the approach is not yet consistently applied across all services, and a consolidated Board-level view is still developing

What the current position shows

A **Fragile Services Framework** is in place, supported by **heat-map assessments**, early pilots in diabetes and ultrasound, a **Fragile Services Oversight Group**, and **Executive Improving Together Sessions** to strengthen monitoring and governance.

What remains incomplete

Not all services are completing fragility assessments to the same standard, project-management and transformation capacity remain variable, and **clinical leads are not yet formally identified for all fragile services**. A **consolidated Board-level view of fragile service scores and trajectories** is still in development and is not yet routinely reported to QSEC.

What should happen next

Embed a consistent triangulation method across all services, establish a **single central fragile services register**, confirm named clinical and operational leads for each fragile service, and implement routine QSEC / Board reporting on fragility scores, improvement trajectories and outstanding external recommendations. This aligns with the gaps identified in the existing fragile services slide.

Recommendation for the Committee

The Committee should recognise that the foundations of a more robust fragile services approach are now in place, including the framework, oversight arrangements and early improvement activity. However, the evidence also shows that the approach is not yet fully embedded across all services, and further work is required to standardise assessments, strengthen leadership and support, and provide a consolidated Board-level view. Status remains

Advise

Cross cutting risks and next steps



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The current position shows that improvement is emerging but not yet reliable across infection control and fragile services, with risks relating to consistency, leadership, and system grip.

What the current risks show

- Infection performance remains variable and not sustained, with *S. aureus* consistently above threshold and *E. coli* showing fragile improvement
- Training compliance below standard (IPC and ANTT), limiting impact of improvement actions
- Complaint timeliness below target, reducing organisational learning and responsiveness
- Fragile services approach not yet consistently embedded, with variation in assessment and oversight

What this means

- Improvement is real but not yet reliable, with risk of regression (as seen in April)
- System grip is not yet consistent, particularly in fragile services and workforce/leadership alignment
- Board visibility is improving but incomplete, with no single consolidated view of risk and trajectory

What should happen next

- Strengthen infection prevention reliability, focusing on *S. aureus* and *E. coli* driver
- Deliver and sustain training compliance (ANTT $\geq 95\%$, IPC $\geq 90\%$)
- Implement a single fragile services register with clear scores, risks and trajectories
- Confirm clinical and operational leadership for all fragile services
- Embed routine QSEC and Board reporting on fragile services and improvement delivery

Recommendation for the Committee

The Committee should recognise that improvement is emerging across both infection control and fragile services, but performance remains variable and not yet fully embedded. A continued focus on reliability, leadership, and consolidated oversight is required to ensure that recent improvements can be sustained and translated into demonstrable system control.

The Committee is asked to:

Note

- the current position that infection performance has shown periods of improvement but not sustained compliance
- fragile services arrangements are established but not yet fully embedded
- that further work is required to:
 - embed a consistent fragile services approach
 - provide a consolidated Board-level view of risk and trajectory

Discuss and scrutinise

- the ongoing variability in:
 - hospital acquired infections (criteria 22–24)
 - fragile services (criteria 10–14) recognising that system reliability and consistency have not yet been achieved

Support / consider

- strengthening infection prevention reliability
- improving training compliance