GIG CYMRU NHS WALES
Bwrdd Iechyd Hywel Dda Health Board

Infection Prevention & Control Deep Dive/Improvement Plan

Situation

To deliver the Health Board's response to the increase in escalation status to enhanced monitoring for *Clostridioides difficile* infection (CDI), the Infection Prevention & Control Strategic Steering Group (IPSSG) have undertaken a Deep Dive Exercise into the current arrangements for Infection Prevention & Control across Hywel Dda University Health Board (HDUHB) and have developed a framework of actions as detailed in the Healthcare Associated Infection Improvement plan.

NB: This Improvement Plan is applicable across Primary, Community and Secondary Care

Situation

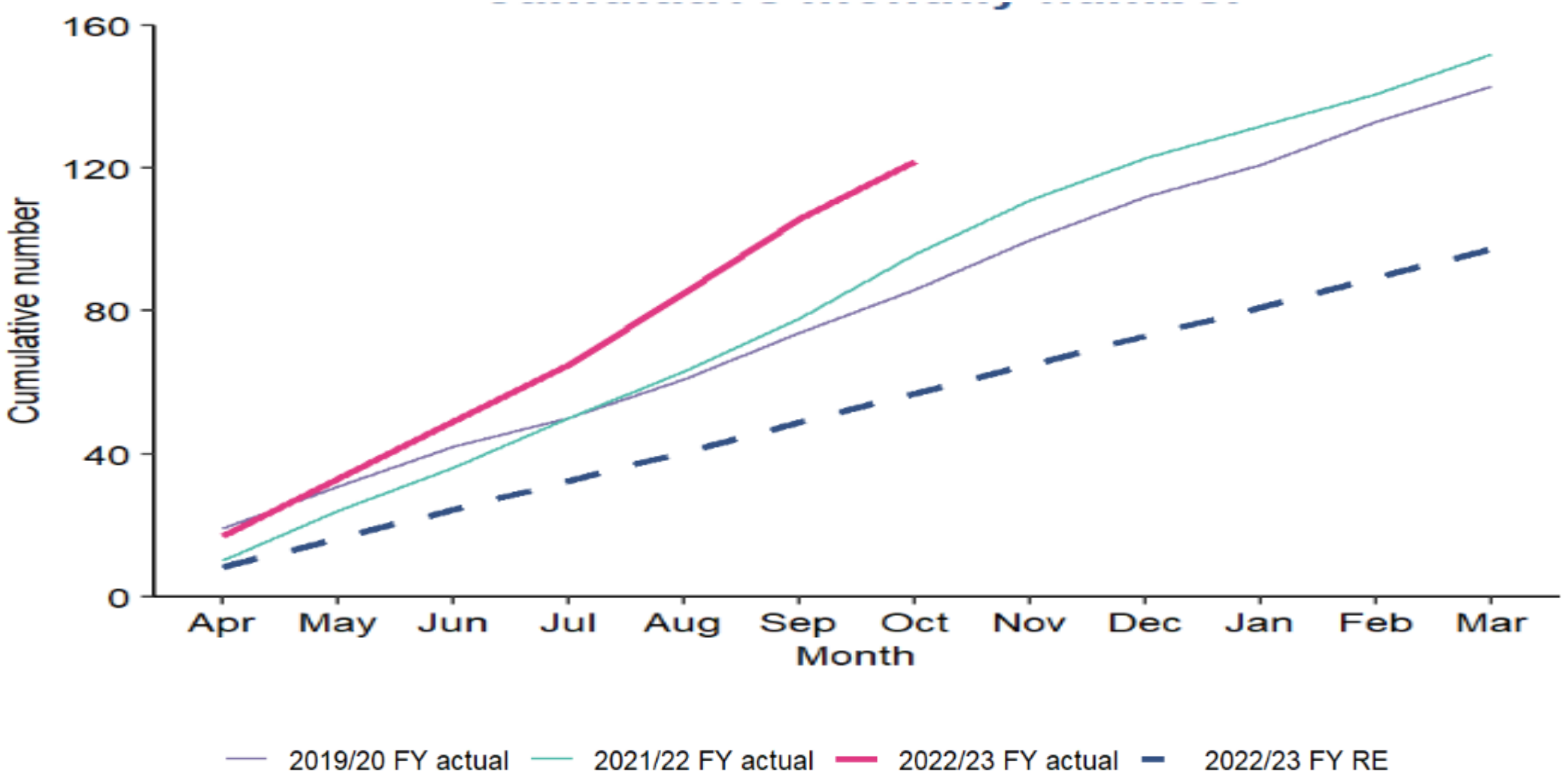
HDUHB Current Performance Against ALL HCAI Expectation Goals 1st April 2022 – 31st October 2022 (For CDI numbers presented represent samples submitted via Primary, Secondary & Community Services)

Organism	FY 2022/23	FY 2021/22	Percent difference in year	Case number difference
C. difficile	**122**	96	**+ 27%**	**+ 26**
E.coli	**200**	224	**- 11%**	- 24
S. aureus	**63**	80	**- 21%**	- 17
Klebsiella sp	**67**	44	**+ 52%**	**+ 23**
Pseudomonas aeruginosa	**20**	22	**- 13%**	- 2

amr-hcai-improvement-goals-for-2021-2023.pdf (gov.wales)

Situation

HDUHB *C. difficile* cumulative monthly numbers 1st April 2022 – 31st October 2022



Risks and Mitigation (cont'd)

The HCAI Improvement Plan aims to build on the baseline assessment undertaken against the criteria aligned to the 5 Core Commitments set out in the Strategic Framework 'Commitment To Purpose - Eliminating Preventable Health Care Associated' which are still relevant.

1. Changing the Culture
2. Leadership
3. Improving Quality & Safety
4. Measuring success
5. Public Health/Transparency

The Improvement plan recognising (in the Narrative section) some of the achievements to date and identifies areas for further action/review.

Each Theme is focused on managing and mitigating the risks presented. The Improvement Plan is a dynamic document which will be reviewed and updated monthly as a minimum.

Risks and Mitigation (cont'd)

Throughout the plan there is an overarching focus on the 4 pillars of infection prevention and control which are applicable to Hospital, Community & Primary care settings:

1. Hand Hygiene: Hand washing, not just hand sanitizing. Focus on face to face training, re invigorating the Link personnel/Champion model, reviewing efficacy of the audit process, reviewing products, signage and linking this back to the science on human factors and behaviour. Also from a service user perspective a focus on patients hand hygiene and empowerment in that 'It's ok to ask'.
2. Antimicrobial Stewardship: Start Smart Then Focus, Jabs to Tabs, UTI recognition/prevention in Care Homes, revised CDI policy.
3. Environmental Cleaning:
   - Secondary care: Paper being prepared for Executive Team (aligned to 2009 standards), HPV/UVC, symbiotics (systems and processes), review of sporicidal disinfectants products.
   - Primary care: Environmental audits undertaken and training delivered
   - Community: Environmental audits undertaken & training for care homes
4. Isolation/Patient Placement:
   - In Hospital: Bioquell Pods, Redi Rooms, Side room audits several times a week, patient Placement Policy, management of toxin negative and toxin positive patients.
   - In Community: Education delivered in care homes

Risks and Mitigation (cont'd)

The IPSSG approved the plan at the December meeting, and by exception is escalating the following actions to the Quality, Safety & Experience Committee.

- Undertake an internal review of the specific issues related to preventing CDI and how the Health Board can minimise risk of these infections.
- Establish HCAI Quality Panel chaired by Executive Director with a specific focus on CDI.
- Support the deep dive undertaken into cleaning services across the organisation
- Review the current RCA Investigation Process working with the All Wales Group
- Develop performance dashboard for clinical teams to enable targeted improvement projects to reduce CDI and other HCAIs utilising Power BI Platform (draft dashboard presented)

Health Board HCAI indepth level - Power BI

Health Board HCAI GP Clusters - Power BI

Recommendation

The Quality, Safety & Experience Committee are asked to note the actions outlined in the Improvement plan, consider the exceptions escalated and take an assurance from the presentation provided.

To receive update on progress against the Improvement plan in March 2023.

HEALTH CARE ASSOCIATED INFECTION

2022 - 2023

IMPROVEMENT PLAN

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

INTRODUCTION

ABUHB have the highest incidence of Clostridioides *difficile* infection (CDI) within Wales. Within the period April to September 2022 45% of these are attributed to non-inpatient specimens meaning that they have been either sent from a GP surgery or taken within the admission departments on the acute sites. This is not exclusive to CDI and other infections. Prevention of HCAIs and subsequent hospital admissions must be a priority across the Health Economy, inclusive of Community, Primary & Secondary care. As we continue with our zero tolerance approach; the Point Prevalence Survey in 2017 identified up-to 70% of our patients with *E.coli* bacteraemia infections are community acquired. For these reasons in order to understand this fully the Health Board has already invested in its Community IPC resource this year. Improvement work has already started. What is not clear without an in-depth deep dive is whether these cases were admitted following confirmation of the infection or indeed how many of the in-patient cases are a result of community transmission or primary care prescribing. The community infection prevention team is imperative to Commitment To Purpose - Eliminating Preventable Health Care Associated Infections as many of these strategic goals are still relevant today. In operationalising the Plan has been written with the nine standards as set out int the Code of Practice for Healthcare Associated Infections (https://gov.wales/sites/default/files/publications/2019-06/code-of-practice-for-the-outlined in the Strategic Framework that is established / ongoing. The remainder of the improvement plan is set out in the Tabs below and actions are themed under the 5 Core Commitments i.e. Changing the Culture, Leadership, Improving Quality & Safety, Measuring Progress against the Improvement Plan will be monitored monthly and reported back in line with the enhanced monitoring arrangements as applied under Targeted Interventions.

Background

Conduct Baseline Assessment against C2P:

Changing Culture Employers should make reference to IPC in job descriptions. Standard implemented for IPC must be included in induction training for all new employees. sessions, post registration education and/or online training activities. Strengthened in improvement plan (post Covid return to BAU) Education and training programmes must include capacity to respond to new and emerging and others involved in prescribing and administering antimicrobials. Strengthened in improvement plan
Leadership Reporting relationships to the organisational Infection Control Committee should also be reviewed and strengthened where necessary. Strengthened within Improvement Plan Welsh NHS bodies should support the statutory role of the independent board member appointed with responsibility for infection management and hospital cleanliness Health (DPH). In contributing to both the HCAI and AMR agendas, the Nurse Director, Medical Director, DPH and other board members collaborate with external agencies - The HB has an Antimicrobial Management Team (AMT) The HB has a lead doctor and nurse for IPC. SLA with PHW for Microbiology/IC Doctor, mix of the team and competences to deliver the organisational IPC programme, including requirement to provide a 7 day service.Community IP ANP funded 2018 team extended minor and major outbreaks of infection. Compendium of IPC Policies regularly reviewed and updated including Outbreak Management.
Quality & Safety
Healthcare improvement methodologies used to improve care and service delivery across

and audit of staff compliance. Work ongoing to strengthen / reinforce hand hygiene practice - in patients as well as staff/visitors.

Accessible policies and procedures for IPC are regularly reviewed and updated. (As Above)

antimicrobial prescribing and usage policies and procedures are being implemented. Embedded - strengthened in improvement plan.
provide a service that meets 2009 minimim environmental hospital cleanliness standards on a consistent basis curently under review by Facilities directorate.
assessment of environmental cleanliness than visual inspection alone. Strengthened in improvement plan.
measures are in place to promote optimal and safe usage of antimicrobials in order to minimise the acquisition and spread of resistance. Strengthened in improvement plan.
The HB has a policy in place to manage multi-drug resistant organisms (MDROs).
pressure isolation, single rooms with en-suite facilities and/or appropriate cohort facilities to support effective IPC. A number of semi-permanent ioslation facilities installed in ITUs during pandemic and a small number of 'pop-up' temporary facilities. Strengthened in improvement plan.
AMR
Common prescribing themes feedback at quarterly GP prescribing leads meetings by AMPs
Targeted audits in primary care for GP practices who are high 4C antibiotic prescribers with tailored feedback from Antimicrobial Pharmacists (AMP) and consultant microbiologist
HB wide prescribing management scheme audit focusing on cephalosporin prescribing
Tazocin Audit undertaken - 2022
All primary care guidelines recently reviewed to reduce the amount of 4C antibiotics
Multi-drug resistant organisms (MDROs) policy reviewed
Isolation:
Bioquell Pods installed Review impact of pods in critical care setting
Faecal Management Systems used in Critical Care settings
Update single room prioritisation list - available to all areas.
Audit
Regular side room audits undertaken
Change from C4C to Symbioitcs Scores included in RCA / PIR process
Monthly and Hygiene & Bare Below the Elbow Audit Process.
IPS Annul Audit Programme
Quarterly Quality Indicator Audit (QIA) for all in-patient areas: Continue scrutiny meetings to
Education Training
Run Back to Basics campaign during IPS Awareness Week. Focus on Hand Hygiene, Bare
Quality Improvement & Safety
RCA Tool for Acute CDI
Quality Improvement Tool for Community CDI
Identify cases that have relapsed and instigate appropriate management to reduce
Measuring Success
Continue to report the number of cases of C. difficile infection on a monthly basis.
Continue to receive AMR Reports to IPSSG
Participate in the PHW co-ordinated annual point prevalence survey of antimicrobial use.
Build on effective use of electronic surveillance. Strengthened in improvement plan - Develop
Public Health Transparency
All service users should receive information prior to and on admission to hospital
Develop local communications strategies around hand hygiene to ensure that staff, service users and the public are clear about the importance of hand hygiene. Strengthened in
Wards and departments should continue to display information on progress including their success in eliminating preventable HCAIs. Strengthened in Improvement Plan

	Changing the Culture	Key metrics
1	All staff are suitably trained and educated in IPC associated with the provision of healthcare *Standard 9*	Education and training programmes must include capacity to respond to new and emerging threats
		Increasing focus on education & training for care home and primary care staff training.
		Increasing focus on education & training and developing opportunities for Domiciliary care training.
		Provide bespoke/targeted education on CDI through development of education folders for staff and competency assessment.
		Recommence face to face training post Covid
		Review compliance against IPS/All Wales competences for practitioners in IPC.

		Make antimicrobial stewardship training and audits mandatory for all prescribers to improve engagement and drive improvement.
		Raise awareness of the Microguide Application to move to digital ways of working and increase engagement and access to evidence base
		Attendance at Clinical Microbiology and Clinical Infection Course from Infection Prevention Team (IPT) and Pharmacists
2	All staff must understand their responsibility & accountability for IPC. *Standard 5: All staff employed to provide care in all settings are fully engaged in the process of IPC.*	Work with Communication Team to reinvigorate signage to raise profile of Infection Prevention & Control across Health board premises: Digital screens, posters, hand hygiene signage.
		Re introduce GP Face to Face IPC/Antimicrobial Refresher Training

		Re introduce Medical Consultant Face to Face IPC Refresher Training
		Reignite Link Champion Role across the organisation post COVID
		Introduce Patient Stories at WHAM and QSEC Reporting

Workstream/Evide	Name	Team	Date
Folder	Mel Jenkins/Frances Howells	IPC/Operational Teams	Sept-22 Completed
Training records	Frances Howells	Community IPC Team	Commenced Oct-22 Ongoing
Training records	Frances Howells	Community IPC Team	Jan-23
Review completed records & questionnaires	Mel Jenkins	IPC Team	01/01/2023 Education completed. Questionnaires in progress
Training dates & records	Mel Jenkins	IPC Team	Sept 22 Commenced
Individual competency assessmetns	Tracey Gauci	Corporate Nursing	Jan-23

Mandate	Phil Kloer	Corporate Medical	01/08/2022 In Progress
Microguide access	Zoe Kennerley	Antimicrobial Pharmacists	Aug-22 SSTF training commenced
Study Leave records & funding	Mel Jenkins/Zoe Kennerley	IPC/Operational Teams	Oct-22 Programme ran in October completed.
Project Plan	Alwena Hughes-Moaks	Communications	Mar-23
Training records / meeting agenda	Zoe Kennerley/Nikolaos Makrygiannis	Antimicrobial Pharmacist / Consultant Microbiologist	TBC

Training records	Mel Jenkins/Microbiology Consultant	IPC Team	Jan-23
Identified champions for each ward / Dept	Mel Jenkins/Frances Howells	IPC Team	01/09/2022 Commenced
Patient story - video	Mel Jenkins / Louise O Connor /Michael Perry	Patient Experience Team & IPC Team	Jan-23

	Leadership	Key metrics	Workstream
1	Commission a review to advise on how the organisational and governance arrangements for preventing healthcare associated infections (HCAI) may be contributing to the HB being unable to achieve the Infection reduction expectations. To advise on specific issues related to preventing CDI and how the Health Board can minimise risk of these infections. Standard 1: *Appropriate organisational structures and management systems for IPC must be in place.*	1. Prepare Scope for the Review	ToR
		2. Commission Review to take place in December 2022	
		3. Prepare report for QSEC December 2022.	Deep Dive Report
2	Establish HCAI Quality Panel chaired by the Director of Nursing / Medical Director. Initial focus on CDI.	1. Develop Terms of Reference ensuring multi-disciplinary engagement from Board level through to front line.	ToR
		2. Arrange monthly meetings with clinical teams to scrutinise HCAI data (MDT Engagement)	Database to target improvement
3	Review and confirm the Locality management arrangements for IPC to ensure they are well-placed to respond to the organisational agenda to eliminate preventable HCAIs.	1. Review Terms of Reference of Locality Infection Control Meetings.	ToR

		2. Monthly Locality scrutiny (inc C.diff, QIA and other quality metrics) meetings to be held to review PIR's to determine cause and affect (IPT lead, antimicrobial pharmacist. Microbiologist, HoN to attend)	Agenda/Minutes
		3. Medical leads to attend Helath Board Wide Quality Panel meetings to be assured of policy compliance and inform colleagues of issues raised and necessary actions	Attendance records
4	Review the function of the multi-disciplinary Antimicrobial Management Group (AMT)	1. Review Terms of Reference of the Antimicrobial Management Group. Agree Purpose and membership.	Revised ToR

Name	Team	Date
Mandy Rayani/Phil Kloer	Executive Team	Nov-22
Mandy Rayani	Executive Team	Dec-22
Sharon Daniel/Tracey Gauci	Corporate Nursing	Dec-22
Mandy Rayani/ Dr Phil Kloer	Executive Team	Dec-22
Mandy Rayani/Phil Kloer	Executive Team	Jan-23
Sharon Daniel/Tracey Gauci	Corporate Nursing	Jan-23

Mel Jenkins/Frances Howells	HoN	Dec-22
Phil Kloer	Medical Directorate	Jan-23
Jenny Pugh Jones/ Dr Annette Snell	Pharmacy/Medical	Jan-23

	Improving Quality & Safety	Key metrics
1	Deliver Quality Improvement Programme and evaluate improvement priorities for implementation to reduce AMR and CDI	Start Smart then Focus Audits (SSTF) Mandated for Junior Doctors twice in each 4 month rotation
		SSTF Audits are completed and learning fed back to Locality Quality & Safety Meetings and Whole Hospital Audit meeting (WHAM)/Grand Round.
		Complete service improvement projects on reviewing/withholding PPI's when broad spectrum antibiotics prescribed. Starting BGH and PPH - other sites to follow
		Results of SSTF to be included in each RCA process.
		Report outcome of Primary care Audit Programme to Quality Panel
		GP Practices must complete 2 cycles of audit and have an action plan to receive incentivisation payment
		UTI Care Home Project: as part of this project there is an aim to reduce usage of antibiotics for Urinary Tract Infections (UTI)
Policies Procedures		

2	Review restrictive antimicrobial formulary to limits availability of agents more likely to cause resistance or CDI. *Standard 7 Policies on IPC must be in place and made readily accessible to all staff.*	C. difficile Policy revised in line with current evidence base - awaiting National Policy Publication to review content.
3	Review IPC Polices & procedure - ensure that they are clear, unambiguous and easily accessible policies .	Engage in shaping C.diff National Policy, improving reporting and RCA processes
		Continue to engage in the All Wales CDI Workstreams and implementation action plan; Epidemiology, Covid, Typing & Screening, Prevention & Intervention, Drugs & Treatment and RCA
		Review FMT Procedure and Procurement arrangements to assure sustainability
Isolation: Standard 6		
4	Review capacity for adequate isolation facilities Standard 6: *Adequate isolation facilities are provided to support effective IP*	Redirooms: - Identify areas to install Redirooms utilising Side Room Audit data - Develop Redi Room isolation criteria for ward areas (current protocol Critical Care Specific) - Liaise with supplier for updated training
		Extend use of Faecal Management System (FMS) outside of Critical Care to aid source isolation (review protocol)

5	Improve Compliance with Isolation requests	Audit compliance with isolation of patients with suspected or confirmed diarrhoea/Difficult (collate and analyse Side Room Usage data and feedback to Clinical Teams)
		Review process for management of GDH / PCR Toxin Negative Isolates
		Link with laboratory/ICNet to identify all loose stool samples sent for processing - to identify any missed opportunities for isolation.
Environmental Cleaning		
6	Conduct a deep dive into cleaning services across the organisation *Standard 2: The physical environment should be maintained and cleaned to a standard that facilitates IPC and minimises the risk of infection.*	1. Conduct baseline line assessment against 2009 Cleaning Standards.
		2. Present Paper to Executive Team December 2022
		3. Review utilisation of Ultraviolet Decontamination Technology: - Promote proactive use in addition to reactive decontamination. - Review processes for ward decant and deep clean/refurbishment
		4. Review utilisation of Hydrogen Peroxide Decontamination Technology - Update Training for all Acute Hospital Cleaning Teams - Develop programme for HPV as part of future ward decant projects.
		5. Undertake observational audit of cleaning practice.

		6. Review Cleaning Policy - to include definitions of cleaning processes to include definitions and terminology and to eliminate variation.
7	Review audit processes for environmental cleanliness.	1. Complete roll out of Symbiotics System to replace Credits for Cleaning Operational Audit System
		2. Review cleaning/disinfection/materials products in use across the Health Board.
Audit Programme		
	Hand Hygiene	3. Reinstate quarterly hand hygiene validation audits by IPC Team/Peer Audit process (to validate monthly service hand hygiene audits)
		4. Implement Improvement following review of patient hand wipes conducted in October 2022
		5. Develop process for Hand Hygiene Audits in Primary Care settings
	IPS Audits	1. Review system for auditing environment as IPS audit tool is not compatible with Symbiotics system (continue to use IPS until alternative identified)
		2. Review Bi-annual audit programme with focus on closure of audit loop
	Commode Audits	1.Link Nurses to conduct peer audits of Commode to include condition & cleaning technique
		3. Refresh commode cleaning training (clean between training)
Root Cause Analysis/Quality Improvement Tool (Community)		

12	Review of RCA Process (acute) & QI Tool (Community) potential to move to Post Infection Review	a) Work with All Wales *C.difficile* group in RCA development
	Look at development of one tool for acute and community cases	b) Review current HB RCA/Quality Improvement Tool; with a view to improving compliance and engagement & develop Post Infection Reviews document
	Review process for RCA investigation.	c) Review medical sticker, incorporate RCA questions for clinical teams to respond in notes. Trial in GGH & rollout once reviewed
		e) Feedback learning from PIR's via Scrutiny & Cluster meetings
		f) Ensure 28 day outcome data is collected and feedback to Quality Panel (including mortality data)
Period of Increased Incidence (PII) / Genotyping		
13	Ensure prompt identification of PIIs of CDI /Outbreaks and ensure that the organisation is utilising the improved testing methodologies for CDI to impact positively on the numbers of cases reported	a) Healthcare Epidemiologist to review of WGS data; identifying areas of possible cross infection, working with the Anaerobe Reference Unit (ARU)
		b) Work with All Wales *C.difficile* programme in review of WGS data in all Wales context
		c) Discuss dissemination of WGS results with ARU and Epidemiologist to avoid backlog during sickness/A/L
		e) Link with Assurance Team for Early Warning Notification to Welsh Government (PII reported via DATIX)

		f) Multi-disciplinary Incident meeting for early interventions and development of workable action plans
Relapses		
	Identify cases that have relapsed and instigate appropriate management to reduce incidence	g) Inform GP's via cluster meetings of availability and success rate of FMT

Workstream	Name	Team	Date			
Audit process	Phil Kloer	Executive	01/08/2022 In Progress			
WHAM Agenda	Zoe Kennerley/Sian Passey	Antimicrobial Pharmacists	Jan-23			
Audit Process	Zoe Kennerley/Abdulla Hamed	Antimicrobial Pharmacists	Oct-22 In Progress			
RCA process	Zoe Kennerley	Antimicrobial Pharmacists	Nov- 22 In Progress			
Audit Findings	Zoe Kennerley	Antimicrobial Pharmacists	Maarch-23			
TBC	Zoe Kennerley	Antimicrobial Pharmacists	TBC			
Outcome data	Zoe Kennerley/Frances Howells	Antimicrobial Pharmacists/IPC Team	Mar-23			

Policy	Mel Jenkins/Frances Howells	IPT Team	Oct-22 completed			
Meeting minutes	All IPT Team	IPT Team	July-22 Ongoing			
Meeting minutes	All IPT Team	IPT Team	July-22 Ongoing			
Reviewed procedure	Mel Jenkins/Frances Howells	IPT Team	Oct-22 completed			
Reviewed criteria	Tracey Gauci/HoN	IPC/Triumvirate Team	Jan-23			
Training records	Tracey Gauci/HoN	IPC/Triumvirate Team	Mar-23			

Audit results	Mel Jenkins/Kim Stevens	IPC/Corporate Nursing Team	Mar-23			
Revised Guidance	Tracey Gauci/Mel Jenkins	IPC/Corporate Nursing Team	Jan-23			
Process	Mel Jenkins/Kim Stevens / Hannah Jones	IPC/Corporate Nursing Team	Mar-23			
Cleaning paper	Leon Popham/Rob Elliott	Finance/Facilities	Dec-23			
Agenda OPD/UoR/Executive	Simon Chiffy	Facilities	Nov-22			
Action Plan (see Cleaning paper)	Simon Chiffy	Facilities	Mar-23			
Action Plan (see Cleaning paper)	Simon Chiffy/HoN	Facilities	Jan-23			
Audit Result	Tracey Gauci/Jill Richards	IPC/Facilities	Feb-23			

Revised Policy Draft	Tracey Gauci/Jill Richards	IPC/Facilities	Dec-22			
IPSSG Minutes	Simon Chiffy	Facilities	Nov-22 Completed			
Addendum to Cleaning Policy	Tracey Gauci/Jill Richards	IPC Team/Facilities	Feb-23			
Audit Process	Mel Jenkins/Frances Howe	IPC Team	Jan-22			
Project Details	Mel Jenkins/Frances Howe	IPC Team	Oct-22			
Audit process	Frances Howells/Dr Sion Ja	IPC Team	Mar-23			
Review process	Tracey Gauci/Mel Jenkins	IPC Team	Jun-23			
Review process	Tracey Gauci/Mel Jenkins	IPC Team	Mar-23			
Audit process & feedback to Locality meetings	Mel Jenkins/Frances Howells	IPC Team	Feb-23			
Training records	Mel Jenkins/Frances Howells	IPC Team	Mar-23			

New review tool	Tracey Nicholas/Frances Howells	IPC Team	Mar-23			
New review tool	Mel Jenkins/Frances Howells	IPC Team	Mar-23			
Sticker	Mel Jenkins/Frances Howells	IPC Team	Jan-23			
Agenda & Minutes	ICN/HoN	Triumvirate Team	Mar-23			
Agenda & Minutes	Mel Jenkins/Frances Howells	IPC Team	Mar-23			
Database	Hannah Jones	IPC Team	Jun-22			
Database	Michael Perry	ARU	Mar-23			
Standard Operating Procedure (SOP)	Hannah Jones/ HARP	HARP	Mar-23			
Protocol from WG & DATIX report	Mel Jenkins	IPC Team	Oct-22			

Agenda & Minutes	Mel Jenkins / HON	IPC Team & Triumvirate	Oct-22			
Agenda & Minutes	Frances Howells/Zoe Kennerley	IPC Team	Mar-23			

Measuring Success

1	Review processes Surveillance of infection with a focus on: data collection, data analysis and feedback to clinicians and others involved in decision making.
2	
3	
4	

Key metrics	Workstream
Develop performance dashboard for clinical teams to enable targeted improvement projects to reduce CDI and other HCAIS utilising Power BI Platform	Dashboard
Agree trajectories for improvement over next 18 months aligned with WHC/Infection Reduction expectations.	Dashboard
Monitor data at Locality ICTs and monthly scrutiny meetings, with exception report to IPSSG	Agenda & Minutes
Assurance / Progress report against reduction expectations to IPSSG collated from Quality Panel	Agenda & Minutes
Regular feedback from Antimicrobial Pharmacist to IPSSG on progress against prescribing targets	Agenda & Minutes

Name	Team	Date
Kim Stevens	Corporate	Nov-22
Kim Stevens / Mel Jenkins	Corporate / IPC Team	Nov-22
HoN	Nursing	Jan-23
Sharon Daniel	Corporate	Feb-23
Zoe Kennerley	Antimicrobial Pharmacist	Jan-23

	Public Health / Information Sharing
Public Health	
1	Deliver training and education to Primary care and Care Home staff on preventing UTI, RTI & antibiotic stewardship.
	Deliver public facing campaign on preventing UTI RTI and antibiotic stewardship *Standard 3: Suitable and accurate information on infections must be made available to service users, their visitors and the public.*
Patient Information - Transparency	
2	Review information inline with All Wales CDI workstream. *Standard 4: Suitable, timely and accurate information on infections must be provided to any person concerned with providing further support or nursing/medical care when a service user is moved from one organisation to another or within the same organisation.*
3	Ensure all patients with PCR/GDH toxin negative are aware of results and receive appropriate information (already in place for toxin positive patients)

Key metrics
1. Develop Project Initiation Document for UTI Identification and Prevention in Care Homes working collaboratively with Local Authority
2. Co present UTI Webinar with PHW to colleagues in Social Care
3. Work with Primary Care Clusters and Local Authorities to deliver improvements
4. Work with public groups WI/Over 50s/Communication Hubs to raise awareness
5. Public facing antimicrobial awareness session as part of European Antibiotic Awareness Week highlighting the importance of not sharing antibiotics and appropriate disposal.
Information available in varying formats
a) Identify patients that require alert card, information leaflet & cover letter via task on ICNET
b) For patients in hospital; ensure that information leaflets/CDI card is given to patient/family. Empower ward staff to undertake this with validation audits by IPN's
c) For patients in Community or discharged prior to result, IPT to inform IPT secretary via 'tasks' in ICNet for information to be sent within 72 hours (allowing for BH)

d) Identify all patients to IPT secretary for GP letter to be sent highlighting need to review antibiotics & proton pump inhibitors using task on ICNet
e) Develop patient feedback form relating to CDI information
f) Add QRS and code and web link to patient letter to enable patients to feedback on information received

Workstream	Name
PID IPC Week programme	Frances Howells / Sue Rees
	Frances Howells/Sarah Jones
Review process	Tracey Nicholas
Change in process	Mel Jenkins
Change in process	Mel Jenkins
Change in process	Mel Jenkins

Change in process	Mel Jenkins
Patient Feedback form	Hannah Jones
New Letter	Hannah Jones

Team	Date			
Community IPC Team	*From Sept 22 - Jan 23*			
	Nov-22			
	From Sept 22 - Jan 23			
	Commenced Oct 22 - ongoing			
Community IPC Team & Pharmacist	*17th Nov 22*			
IPC Team	**Dec-22**			
IPC team	Dec-22			
IPC team	Dec-22			
IPC team	Dec-22			

IPC team	Dec-22
IPC Team	Dec-22
IPC Team	Dec-22

Theme:	**Changing the Culture**
Key Outcome for Success:	
Programme:	

Overview	
Outcome	

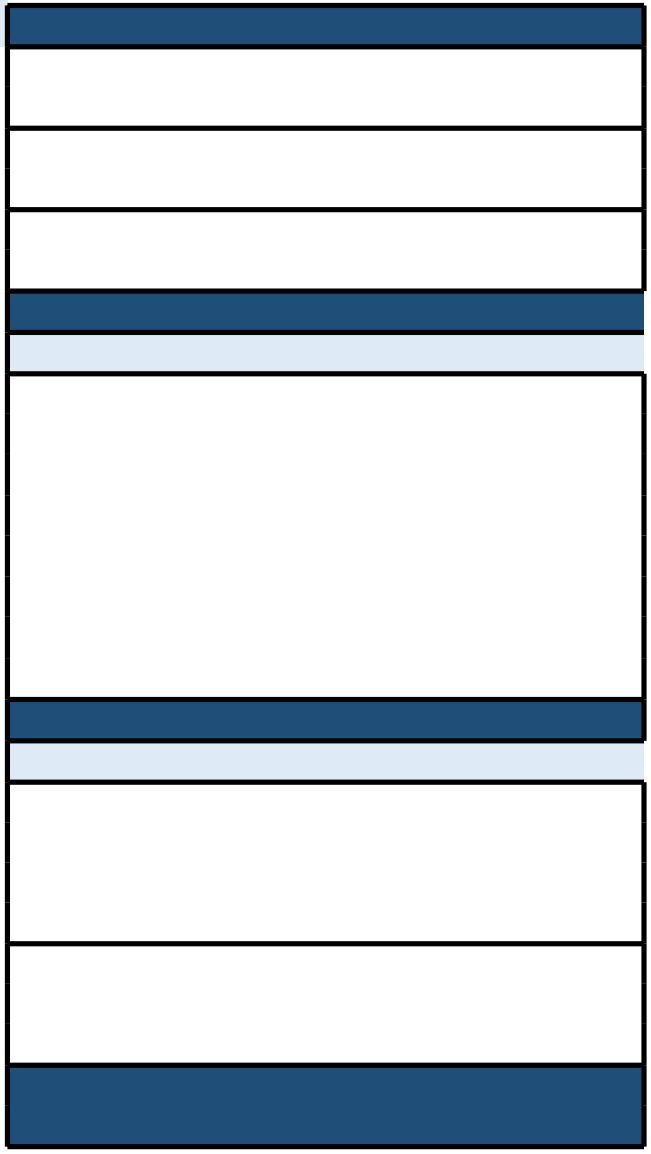
Theme:

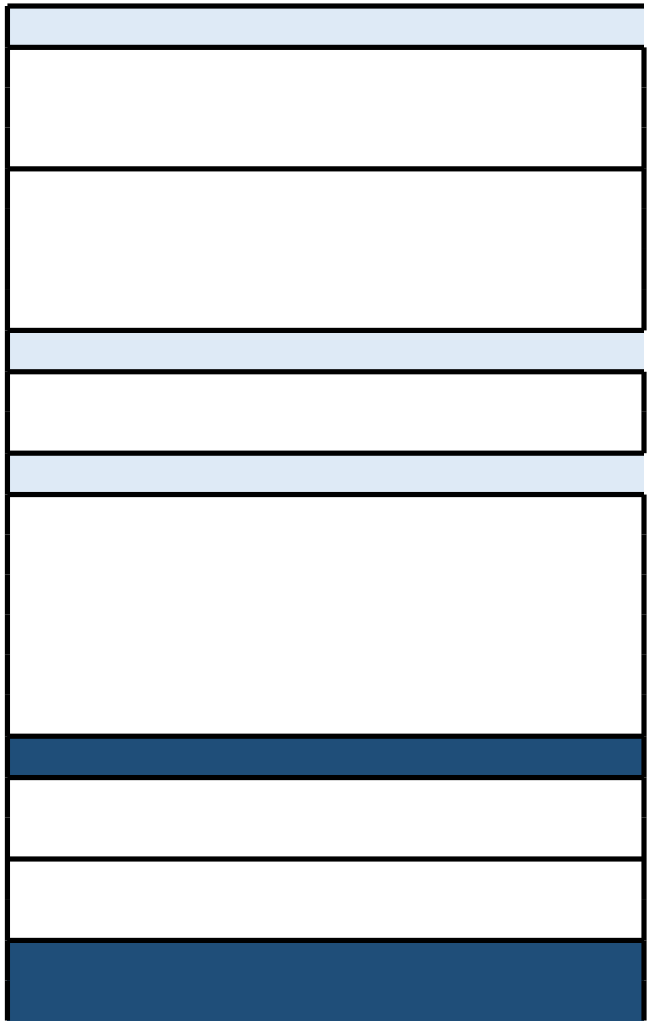
Key Outcome for Success:

Programme:

Overview
Outcome

Theme:	**Improving Q&S**
Key Outcome for Success:	
Overview:	
Outcome:	





Theme:
Key Outcome for Success:
Programme:

Measuring Success

Theme:	**Public Health**
Key Outcome for Success:	
Programme:	
Overview:	
Outcome:	