Foreword by the Minister for Health, Social Services and Children

This document signals a significant change. The Annual Quality Framework that sets out the NHS priorities for 2011-2012 includes the following statement:

‘It is unacceptable that the health care system should cause harm to patients’.

In the context of that statement, the NHS should adopt an explicit policy of zero tolerance to preventable healthcare associated infections (HCAIs). The change, therefore, is from controlling and reducing such infections to a requirement to eliminate those which can be prevented. One of the lessons of the 1000 Lives campaign has been a demonstration that much more can be done to deliver the highest quality healthcare services that safeguard people coming into the NHS than was thought to be the case. The key is clarity of purpose and consistent application of best practice in environmental controls, patient care and treatment.

Zero tolerance, if properly applied, would mean no more preventable HCAIs - ever. I accept that that is unrealistic at this point, but it is very definitely the aim. These infections cause so much harm and distress to patients and their relatives, and waste so much NHS time and money that we should treat them as intolerable. Local and national reductions in infection rates including Clostridium difficile, caesarean section wound infection rates and infections within critical care demonstrate what can be done. However, there is still more that can be done.

So this is a challenge to the will and competence of the NHS. This is a matter for Chairs, Boards and Directors, and for every member of staff. There must be will, organisation and impact. I expect every NHS body to bend its efforts to achieve this objective, with a very significant reduction in numbers of HCAIs this year. I will expect monthly reporting to Boards and full transparency about performance.

Zero tolerance means that this scourge should no longer blight our services and the lives of those who use them.

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1 It is recognised that at some point an ‘irreducible minimum’ will be reached and that not all HCAIs are avoidable or preventable. Arguably, the irreducible minimum is reached when local assessment and root cause analysis demonstrates that every essential element of care was in place that could have reasonably prevented such an event.
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1. **Introduction**

1.1 The new Local Health Boards (LHBs) are better equipped than ever before to tackle problems across the whole health care sector. They have a comprehensive overview of the health needs of their residents and are well placed to mobilise and integrate resources from every part of their area to tackle them. Introducing a zero tolerance approach to HCAIs is a key action in the Welsh Government's *Programme for Government* and *Together for Health* commitments to improve the lives of the people in Wales.

1.2 The Annual Quality Framework (AQF) reflects this new situation and sets out some targets to prove the ability of these bodies in this new situation. One is the zero tolerance for preventable healthcare associated infections (HCAIs).

*Healthcare-associated infection (HCAI) refers to infection that occurs as a result of contact with the healthcare system in its widest sense - from care provided in the home, to general practice, nursing home care and care in acute hospitals.*

1.3 This Framework for actions (Framework) sets out what healthcare organisations including NHS, independent contractors, voluntary bodies and others who work in healthcare settings must do.

1.4 The plan begins by emphasizing the scale of the change required. The culture has to change. A **zero tolerance** approach means that attitudes and behaviour must change across the organisation – and this means strong, effective and consistent leadership. HCAIs will be eliminated only if there is sustained interest from those - at all levels - tasked with directing the work.

1.5 Their commitment must result in safe, consistent practices across the organisation, but that is not enough. Everyday good practice will be a vital foundation, but elimination will require creative engagement with other sectors which need to support that aim. Tackling HCAIs in hospitals alone is not enough – organisations must take action in the community to find and tackle sources of infection there.

1.6 To support local efforts, WG has asked Public Health Wales (PHW) to establish an overarching advisory group on decontamination, antimicrobial resistance and HCAIs (DARHAI). This group will report directly to the WG. It is recognised that the Framework makes little reference to decontamination. A separate action plan covering this very important area will be developed under the auspices of DARHAI in collaboration with WG.

1.7 The final point in the Framework is the need for openness with the public and others. The numbers will show whether success is being achieved and whether further action is required. The only test of
success is that such infections will become increasingly rare. A slowly declining curve is not enough.

1.8 The underlying aim of the AQF is in the title. The NHS must consistently offer and evidence that it offers high quality care. The intention is to move from central control to local excellence. Action on HCAIs will be a public test of that resolve.

2. Background

2.1 Healthcare Associated Infections – A strategy for hospitals in Wales published in 2004 and subsequently Healthcare Associated Infections – A community strategy for Wales (2007) highlighted the need for:

‘all staff to understand the impact of infection and infection control practices to enable them to discharge their personal responsibilities to patients, other staff, visitors and themselves.’

The move from infection control being seen as solely the domain of the specialist infection control team to becoming everyone’s business began with the shift towards a culture of zero tolerance where one avoidable infection is considered one too many. There is still much work to be done before a position is reached where preventable HCAIs are eliminated. However, it should be recognised that considerable progress has been made and whilst there is focus on certain organisms for example:

- Clostridium difficile (C. difficile) – Table 1;
- Meticillin-resistant Staphylococcus aureus (MRSA) – Table 2; and
- meticillin-sensitive Staphylococcus aureus (MSSA) – Table 3

the approach in Wales has always been a holistic one i.e. to reduce all HCAIs.
Table 1:

Monthly rates of *Clostridium difficile* in inpatients aged over 65 per 1000 admissions for this age group in Wales, 01/01/05 - 30/09/10

![Graph showing monthly rates of *Clostridium difficile*](image1)

Start: Jan 2005
Overall U.C.L. = 85.739
Upper = 95.853
Overall L.C.L. = 12.525

Table 2:

MRSA bacteraemias per 100,000 bed days by quarter in All Wales Acute Health Boards, 01/04/01 - 30/09/10

![Graph showing MRSA bacteraemias per 100,000 bed days by quarter](image2)

Start: 1
Overall U.C.L. = 82.643
Upper = 89.954
Overall L.C.L. = 7.345
2.2 In response to the Wales Audit Office report *Minimising Healthcare Associated Infections in Trusts in Wales* published in November 2008, the WG committed to developing a refreshed national strategy.

2.3 The restructuring of the NHS in Wales has brought secondary and primary care activity under one organisation and this has provided an opportunity to tackle problems across the whole healthcare sector.

2.4 The underlying principles of effective infection prevention and control (IPC) and antimicrobial stewardship remain the same regardless of the environment of care. How the principles are translated into practice may differ between different healthcare settings and there are issues of ‘proportionality’ between different organisations but ultimately the goal is the same – to prevent and control the spread of infection.

2.5 Over the last decade there has been increasing recognition of the public health challenge posed by increasing antimicrobial resistance. The control of the spread of antimicrobial resistance requires not only attention to good hygiene and conventional infection control, but additionally an emphasis on antimicrobial stewardship.
3. **Aim of the Framework**

3.1 The aim is to ensure that healthcare organisations in Wales have suitable and sustainable IPC arrangements and antimicrobial stewardship in place for **2011-12 and beyond** to support the change in culture necessary to eliminate preventable HCAIs.

3.2 The entire healthcare workforce must unite in a common purpose to take responsibility for IPC if preventable HCAIs are to be eliminated across Wales. All staff, both clinical and non-clinical must be fully committed to this purpose if measurable change is to be sustained, unnecessary waste, harm and variation are to be avoided and lives saved.

4. **National commitments**

4.1 Actions at national and local level are set out under five core commitments:

<table>
<thead>
<tr>
<th>Changing the culture</th>
<th>To change the <strong>culture</strong> across all healthcare organisations to one in which no preventable HCAI is tolerated.</th>
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<tbody>
<tr>
<td>Leadership</td>
<td>To strengthen <strong>leadership</strong> at all levels, throughout all disciplines and within clinical and non clinical services to improve IPC and antimicrobial stewardship.</td>
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<tr>
<td>Improving Quality and Safety</td>
<td>To improve the <strong>quality and safety</strong> of care by embedding core IPC practices and antimicrobial stewardship in every day activity including more prudent and effective antimicrobial prescribing.</td>
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<tr>
<td>Measuring success</td>
<td>To measure <strong>success</strong> in eliminating preventable HCAIs.</td>
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<tr>
<td>Information sharing and transparency</td>
<td>To build and maintain the confidence and understanding of citizens and service users through a culture of <strong>information sharing and transparency</strong>.</td>
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5. The Framework

### Changing the culture

5.1 The task of changing organisational culture or collective mind-set to one in which everyone believes that HCAIs can be eliminated should not be underestimated. For many years such infections were largely overlooked and accepted as an inevitable outcome of healthcare intervention. The emergence of antibiotic resistant organisms and the realisation that antibiotics can no longer be relied upon to treat infections, coupled with the increasing awareness of the socio-economic burden such infections place on the population and the health service has brought about the need to change organisational beliefs and values. Such change takes time and the process will be hampered by new and emerging threats.

5.2 Change has started to occur in some areas and lessons need to be learnt and shared to support and sustain further change. Elimination of HCAIs is a long term goal. There is evidence that some organisations are starting to turn around. The challenge now is to sustain the pace of change and guard against complacency.

5.3 A comprehensive induction and ongoing education and training programme in IPC including antimicrobial prescribing will support the change in culture and behaviour. As will the behaviour of senior clinical and non-clinical staff – sending out clear and consistent messages and acting as role models, demonstrating to all staff the importance of IPC.

5.4 Traditionally education and training in IPC is carried out through face to face training sessions or workplace training. A national E-learning programme administered by PHW is also currently available to healthcare organisations in Wales.

5.5 Healthcare organisations need to engender a culture in which individuals recognise their personal and professional responsibility to protect themselves, their patients, their colleagues and their families. This includes their personal responsibility to keep their vaccinations and immunisations up to date including where appropriate hepatitis A, hepatitis B, tetanus, measles, mumps and rubella (MMR), varicella zoster (chicken pox), tuberculosis and influenza. Whilst some are considered essential on employment for certain groups of staff depending on the nature of their work others such as annual seasonal influenza vaccination have been recommended to staff but to date have been poorly taken up.
### Changing the Culture - Actions

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<tr>
<td>1.</td>
<td>All organisations providing healthcare must make <strong>explicit</strong> to staff, service users and citizens of Wales their commitment to eliminating preventable HCAIs.</td>
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<td>2.</td>
<td>All staff must understand their responsibility and accountability for IPC and employers must assure themselves of this on an ongoing basis.</td>
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<td>3.</td>
<td>Healthcare organisations should consider the requirement for all staff to sign a declaration to their commitment to eliminating preventable HCAIs.</td>
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<td>4.</td>
<td>IPC must be included in induction training for all new employees.</td>
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<td>5.</td>
<td>All staff both clinical and non-clinical must take part on a regular ongoing basis in training sessions, post registration education and/or online training activities. Records of attendance must be kept in line with organisational policy and persistent failure to attend dealt with through line management and escalated as necessary.</td>
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<td>6.</td>
<td>WG, PHW and healthcare organisation representatives will form a working group to review the national e-learning programme. The review will consider how best the needs of healthcare organisations across Wales can be met and make recommendations by end October 2011.</td>
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<td>7.</td>
<td>Education and training programmes must include capacity to respond to new and emerging threats.</td>
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<td>8.</td>
<td>Employers should make reference to IPC in job descriptions, individuals’ objectives and competency based assessments, including National Occupational Standards where appropriate.</td>
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<td>9.</td>
<td>Healthcare organisations must develop local plans to deliver a proactive seasonal influenza vaccination programme to maximise the number of frontline healthcare staff who are vaccinated on an annual basis. Employers are responsible for the immunisation of their staff and should put appropriate arrangements in place to facilitate high uptake.</td>
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<td>10.</td>
<td>Appropriate antimicrobial stewardship must be included in induction training for new medical staff, dental staff and others involved in prescribing and administering antimicrobials.</td>
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2 The frequency should be agreed at a local level and made explicit within the education and training programme. Training and role specific education should be linked to competences. It is not unreasonable that different groups of staff should receive different levels of training and education and at different frequencies dependent on their role and function.

3 Skills for Health (SfH) have developed a number of National Occupational Standards (NOS) for infection prevention and control. The NOS are currently under review by SfH.

4 Healthcare staff within one of the recommended clinical risk groups should go their GP practice for immunisation.
5.6 *Healthcare Associated Infections – A strategy for hospitals in Wales* published in 2004 stated that:

‘all staff should understand the impact of infection and IPC practices to enable them to discharge their personal responsibilities to patients, other staff, visitors and themselves’

and emphasised the importance of embedding IPC as a core item of the management agenda and the need to have clear lines of accountability throughout the organisational infrastructure. Similar messages were reiterated in the strategy for reducing HCAIs in community settings in 2007 and there is an ongoing need to generate interest and ownership of HCAI within healthcare settings outside of hospitals.

5.7 The major restructuring of the NHS in Wales in 2009 means that healthcare organisations have already started to address their organisational infrastructures to lead and support this agenda. At a national level, a high level steering group chaired by the Chief Nursing Officer has been established to develop national strategy and policy and to oversee its implementation. WG has identified health professional and policy leads for HCAIs (including decontamination and AMR) providing the NHS with clearly identifiable points of contact.

5.8 PHW has also established an infection control advisory group (DARHAI) that will advise the WG on matters relating to decontamination of equipment, antimicrobial resistance and IPC, engaging fully with professional networks.

5.9 The Chief Executive (CE) of each NHS body accepts on behalf of the Board ultimate responsibility for all aspects of IPC. This responsibility is usually delegated to the Director of Nursing and Midwifery who will lead on the organisational agenda for eliminating HCAIs, working closely with the Medical Director who will lead on the agenda to reduce antimicrobial resistance and improve antimicrobial stewardship. Interventions to reduce HCAIs and improve antimicrobial stewardship are key components of the national patient safety programme and the Nurse Director and Medical Director jointly lead on this programme.

5.10 It is important that **IPC is not seen solely as a nursing issue** and multi-disciplinary engagement must be evident at Board level as well as throughout the rest of the workforce. It is anticipated that all Board Members will be actively engaged in driving and supporting the organisation’s plans to eliminate preventable HCAIs with clear and consistent organisational aims and objectives being communicated to the entire workforce.
5.11 LHBs/Trusts are large complex organisations within which leadership needs to be taken not just at Board level but throughout the many clinical and non clinical directorates, divisions and localities. The 2004 strategy to reduce HCAIs in hospitals referred to in Section 5 recommended that each directorate or division identify a team at senior management level to lead on developing and implementing local plans to reduce HCAIs. This concept should be revisited and where changes have taken place following the restructuring of the NHS in Wales in October 2009. These teams will need to be reviewed and re-established to be fit for purpose in the new organisations which are now spread across large geographical areas.

5.12 In hospitals, ward sisters/charge nurses have a key role in providing leadership within their ward environment in matters relating to the patient environment, environmental cleanliness and the fundamentals of care as identified in the Ministerial Report Free to Lead, Free to Care which have a direct impact on HCAIs.

5.13 Welsh NHS bodies have a responsibility to provide an IPC service to all healthcare settings and staff within their organisation. To do this effectively they need to adequately resource the IPC team, review the skill mix within the team and ensure that staff have the knowledge and skills to competently discharge their responsibilities. The Infection Prevention Society (IPS), in collaboration with UK health departments has recently published revised outcome competences for practitioners in IPC. The competences recognise that practitioners in IPC need high level leadership and team working skills as well as good interpersonal skills if they are to effect strategic change and use science-based improvement methods to sustain behavioural change in everyone involved in the care of patients and clients.

5.14 Whilst IPC is everyone’s business and should no longer be seen solely as the domain of the IPC team, it is important that Welsh NHS bodies clearly identify their lead infection control doctor and lead infection control nurse who will work closely together and make explicit their reporting relationship to the Board.

5.15 The leadership role of specialist infection control doctors and nurses should extend into emergency preparedness related to IPC including emerging and re-emerging diseases, bioterrorism and other issues such as seasonal pressures on the health service brought about by infections such as gastrointestinal viruses and influenza.

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5 HCAI hospital strategy
6 Free to Lead, Free to Care final report
7 IPS Outcome competences for practitioners in IPC - Feb 2011
5.16 Some Health Boards already have in place link nurse or link practitioner scheme where staff actively link with the core IPC team championing IPC in their workplace. Evaluation of such schemes and their effectiveness has been variable and the decision to adopt them or not should be made at a local level.

5.17 Healthcare organisations should have clear, accessible and unambiguous policies and procedures in place to manage minor and major outbreaks of infection which are confined to the healthcare setting or extend into the wider community. They must identify who leads the outbreak management team and when the organisation will inform and/or actively engage with PHW, the Consultant in Communicable Disease Control (CCDC) and health protection team nurses. The Director of Public Health within Welsh NHS bodies will have a key leadership role in this area.

5.18 As part of PHW, the Welsh Healthcare Associated Infection Programme (WHAIP) provides structure and support for the control, prevention and management of infectious disease in Wales. The team advises on HCAIs and related prevention and control strategies. Expert scientific advice is available for the development of surveillance programmes, epidemiological advice and infection control support for the investigation of outbreaks or unexpected increases in diseases.

5.19 The WHAIP team provides independent professional advice and information to health professionals in Wales and to the WG. It also provides information to the public about HCAIs. WHAIP will continue to lead the national surveillance programme and to provide specialist epidemiological support for infection control teams in Wales.

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<th>Leadership – Actions</th>
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<tr>
<td>1. Welsh NHS bodies should review and confirm their divisional and directorate level management arrangements to ensure they are well-placed to respond to the organisational agenda to eliminate preventable HCAIs. Reporting relationships to the organisational Infection Control Committee should also be reviewed and strengthened where necessary.</td>
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<td>2. Welsh NHS bodies should support the statutory role of the independent board member appointed with responsibility for infection management and hospital cleanliness.</td>
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8 CMO Letter (2011)
9 WHAIP homepage
10 Ministerial Letter that refers to the Patient Champion
3. Welsh NHS bodies should fully recognise the health protection accountabilities of the Director of Public Health (DPH). In contributing to both the HCAI and AMR agendas, the Nurse Director, Medical Director, DPH and other board members will collaborate with external agencies - notably PHW and local authorities.

4. Welsh NHS bodies should ensure that a multi-disciplinary Antimicrobial Management Team (AMT) within which the antimicrobial pharmacist plays a key role, exists to ensure prudent antimicrobial use and to develop programmes to capture and feedback data to directorates and wards.

5. LHBs/Trusts should clearly identify the lead doctor and nurse for IPC. All other healthcare organisations should identify at a local level a key individual who will lead on interventions to improve IPC. Applying the principles of ‘proportionality’ community settings should develop an organisational infrastructure to support the development and implementation of a local IPC action plan.

6. The National Leadership and Innovation Agency for Healthcare (NLIAH) will, in conjunction with Welsh NHS bodies, review the numbers of IPC specialist staff, the skill mix of the team and competences to deliver the organisational IPC programme taking into account a number of factors including the number of acute and community inpatient beds, the acuity of patients, the number and breadth of specialist and critical care facilities within the organisation, bed occupancy rates and geographical area served.

7. PHW must review the resource available and role of the health protection team nurses in relation to IPC. This review should be done in collaboration with Welsh NHS bodies and clarity sought with regards to how teams mutually support each other ensuring that all healthcare organisations have access to appropriate IPC services.

8. Clear, accessible and unambiguous policies and procedures should be in place to manage minor and major outbreaks of infection which are confined to the hospital/healthcare setting or extend into the wider community. They must identify who leads the outbreak management team and when the organisation will inform and/or actively engage with PHW, the CCDC and health protection team nurses along with other external agencies.

9. Welsh NHS bodies should utilise the IPS competences for practitioners in IPC. Higher education institutions (HEIs) should incorporate the IPS competences into post registration training and education courses for specialist practitioners in IPC.

10. The new national leadership programme for all staff within Welsh NHS bodies will support the development of leadership skills at all levels throughout organisations which will in turn impact on this agenda.

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11. As part of their role, the DPH must ensure that the health of the local population in relation to communicable disease, IPC, environmental health and emergency planning is safeguarded.
Improving quality and safety

5.20 The health standards for Wales set out WG’s common standards to support the NHS and partner organisations in providing effective, timely and quality services across all healthcare settings.

5.21 Revised standards came into force from 1 April 2010. The updated standards Doing Well, Doing Better – Standards for Health Services in Wales sets out the requirements of all health services in all settings and is underpinned by supporting guidance including guidance on IPC and decontamination.

5.22 Standards provide a consistent structure that enables health services to look across the range of their services in an integrated way to ensure that all that they do is of the highest quality and that they are doing the right thing, at the right time, for the right patient in the right place and with the right staff.

5.23 The actions within this framework will support the delivery of these standards.

5.24 The principles for preventing and controlling infection remain the same within all healthcare organisations and the practice of IPC involves the implementation of Standard Infection Control Precautions (SICPs).

5.25 There are nine elements of SICPs:

- hand hygiene;
- personal protective equipment;
- prevention of occupational exposure to blood and body fluids;
- management of blood & body fluid spillage;
- decontamination of equipment;
- cleanliness of the environment;
- safe handling of linen;
- safe disposal of waste; and
- patient placement/isolation.

5.26 SICPs:

- must be used by all healthcare staff to prevent the spread of micro-organisms that may cause infection;
- must be used in all care settings;
- are used to protect staff and service users including carers and visitors; and

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12 Doing Well, Doing Better - Standards for health services in Wales
• are used at all times in the care setting whether an infection is known to be present or not.

5.27 Where a specific infection is suspected or confirmed it may be necessary to use additional precautions and advice may need to be sought from specialist staff/advisors. Local IPC policies must address all of the SICPs as a minimum.

5.28 Hand hygiene remains the single most important intervention to prevent and control infection. The National Patient Safety Agency (NPSA) clean your hands campaign has been a major driver in improving compliance with hand hygiene over the last five years. With the stepping down of the national campaign and the move towards greater local ownership the emphasis on continuous improvement and sustainability should not be lost. The World Health Organization’s Save Lives: Clean Your Hands campaign and website\(^{13}\) is a useful way of profiling energy and commitment to local activities and sharing best practice. NHS organisations will also be aware that the recently published All Wales NHS Dress Code\(^{14}\) contains common sense advice which supports IPC including the need for staff to roll up sleeves when providing care or undertaking clinical procedures to facilitate optimal hand hygiene.\(^{14}\)

5.29 1000 Lives Plus\(^{15}\) is a national programme that seeks to improve the quality of patient care and reduce avoidable harm across NHS Wales (Appendix A). Every LHB/Trust in Wales is involved in 1000 Lives Plus, which is introducing new ways of working to improve care by reducing harm, waste and variation. It is also committed to accelerating the pace of change to ensure good practice is spread from ward to ward, practice to practice and organisation to organisation. 1000 Lives Plus is currently implementing a number of programme areas including one to reduce HCAIs. The approach in Wales is to work on all HCAIs and not to focus solely on MRSA and C. difficile. The key outcome measure in the programme is the overall HCAI rate. The interventions have 3 main approaches:

• preventing transmission through standard infection control precautions, decontamination and isolation;
• preventing infection through better stewardship of antibiotics and rigorously applying effective techniques to prevent surgical site infection, ventilator associated pneumonia, central line infections and urinary catheter infection;
• responding rapidly to early signs of infection.

\(^{13}\) WHO website

\(^{14}\) All Wales NHS Dress Code

\(^{15}\) 1000 Lives Plus
5.30  *Free to Lead, Free to Care* set out a number of recommendations aimed at empowering ward sisters/charge nurses to improve ward cleanliness, standards of care and nutrition. The recommendation pertaining to ward environment - and specifically environmental cleaning – support the agenda to eliminate preventable HCAIs and should be implemented alongside this Framework.

5.31 Use of antibiotics may cause patients to become colonised or infected with antibiotic-resistant bacteria, such as MRSA, vancomycin-resistant *enterococci* (VRE) and highly-resistant Gram-negative bacteria. Use of antibiotics is also associated with an increased incidence of *C. difficile* infections.

5.32 The emergence, selection and spread of resistant bacteria threaten patient safety because in hospitals and the community:

- antibiotic resistance frequently leads to a delay in appropriate antibiotic therapy;
- inappropriate or delayed antibiotic therapy in patients with severe infections is associated with worse patient outcomes and sometimes death;
- the supply of new antibiotics is limited and, if antibiotic resistance continues to grow, there will be no effective antibiotics for treatment.

5.33 The NHS in Wales needs to adopt best practice with regards to antimicrobial prescribing as well as heightening public awareness of the need to use antibiotics more prudently. PHW will develop guidance to support prudent prescribing and infection management.

5.34 Additionally, healthcare organisations should develop policies and procedures to identify and prevent the transmission of multi-drug resistant organisms (MDROs) including bacteria resistant to carbapenem antibiotics. Risks from such organisms and the means of preventing transmission should be included at induction training and ongoing IPC training and education for clinicians.

5.35 Healthcare organisations must consider IPC when procuring, commissioning, planning, designing and completing new and refurbished services and facilities (and during subsequent routine maintenance). Hospitals and other healthcare estate should be built, managed and maintained in such a way as to minimise the risk of infection.

5.36 Timely diagnosis of infectious diseases ensures that the patient receives the most appropriate care including isolation if required and the correct treatment. Ensuring accurate and rapid diagnostics are available to healthcare organisations in Wales decreases the spread of infections. Welsh NHS bodies need to acknowledge the importance of timely laboratory diagnostics to support effective infection control.
## Improving Quality and Safety – Actions

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<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Healthcare improvement methodologies can be used to improve care and service delivery across all healthcare organisations. Organisations should engage with the 1000 Lives Plus programme and evaluate improvement priorities for implementation to reduce AMR and HCAI.</td>
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<td>2.</td>
<td>As the cleanyourhands campaign closed at the end of March 2011, the emphasis on continuous improvement in compliance with hand hygiene by all staff and engagement of patients and the public should not be lost. Local strategies, utilising 1000 Lives Plus improvement methodologies, should be deployed to ensure sustained focus on hand hygiene. The strategy should include reference to the availability of suitable and sufficient facilities to support staff, patient and public hand hygiene and audit of staff compliance.</td>
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<td>3.</td>
<td>Care bundles for medical devices (urinary catheters, peripheral venous catheters and central venous catheters in areas outside critical care) should be implemented with the support of the 1000 Lives Plus programme, in line with locally identified priorities and based on the latest evidence.</td>
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<td>4.</td>
<td>All healthcare organisations should adopt a single standardised approach to aseptic non touch technique and should review their policies, procedures, training and audit of practice with regards to aseptic technique. PHW will develop a model policy to support this.</td>
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<tr>
<td>5.</td>
<td>All healthcare organisations should have clear, unambiguous and easily accessible policies and procedures for IPC which are regularly reviewed and updated.</td>
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<td>6.</td>
<td>A comprehensive programme of audit should be in place to provide assurance that IPC plus antimicrobial prescribing and usage policies and procedures are being implemented.</td>
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<td>7.</td>
<td>NHS Wales Shared Services Partnership (formerly Welsh Health Estates) will review progress on the implementation of the recommendations within Free to Lead, Free to Care (F2L, F2C) with regards to hospital cleanliness to support continuing and sustained improvement in environmental cleanliness, and report progress to the Post Implementation F2L, F2C Board.</td>
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<tr>
<td>8.</td>
<td>In assessing the effectiveness of environmental cleaning Welsh NHS bodies should consider the use of new technologies which are more objective than visual inspection alone.</td>
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<td>9.</td>
<td>A care bundle for antimicrobial prescribing should be implemented with the support of the 1000 Lives Plus programme in line with locally identified priorities.</td>
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16 PHW has developed and continues to add to a number of evidence based ‘model policies’ which organisations can adopt and adapt for local usage. They can be accessed at: [National infection control policies for Wales](#).

17 The IPS supported by UK health departments has developed a set of Quality Improvement Tools (that supersede the audit tools previously developed by the ICNA) to be published in 2011. They will be freely available via the IPS website.
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<tr>
<td>10.</td>
<td>PHW will develop standards and guidance for healthcare organisations on antimicrobial usage and infection management and integrate diagnostic algorithms into the all-Wales Infection Management Guide.</td>
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<tr>
<td>11.</td>
<td>An all Wales approach to antimicrobial prescribing will be supported by the development by PHW of a restrictive antimicrobial formulary that limits availability of agents more likely to cause resistance or <em>C. difficile</em>.</td>
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<td>12.</td>
<td>Local Antimicrobial Management Teams (AMTs) within all Welsh NHS bodies will ensure stewardship measures are in place to promote optimal and safe usage of antimicrobials in order to minimise the acquisition and spread of resistance. Clinical judgement is needed to determine the balance between early recognition/treatment of infection and antimicrobial stewardship.</td>
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<td>13.</td>
<td>All organisations are required to have a policy to manage multi-drug resistant organisms (MDROs). The risks and measures for prevention of transmission need to be addressed in staff induction/ongoing IPC education and training.</td>
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<tr>
<td>14.</td>
<td>Welsh NHS bodies must prevent the spread of MDROs including bacteria resistant to carbapenem antibiotics, and support all prevention and eradication measures. They should prepare a containment action plan.</td>
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<td>15.</td>
<td>PHW will lead on the development of all-Wales laboratory standard operating procedures which will be adopted by microbiology services across Wales.</td>
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<tr>
<td>16.</td>
<td>NHS bodies should review capacity for adequate isolation facilities in the form of single rooms with en-suite facilities and appropriate cohort facilities to support effective IPC. In particular, they should review the availability of single en-suite rooms within A &amp; E departments and clinical decision making/admission units.</td>
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<tr>
<td>17.</td>
<td>NHS bodies should carry out regular audits of access to appropriate isolation facilities to monitor compliance with local isolation policy and to inform further development of such facilities.</td>
</tr>
<tr>
<td>18.</td>
<td>NHS Wales Shared Services Partnership reviewed the provision and effectiveness of hospital isolation facilities in 2005 and 2007. They will carry out a further review of compliance with national guidance (Welsh Health Circular (2006) 057 with regard to the provision of hospital isolation facilities.</td>
</tr>
<tr>
<td>19.</td>
<td>Clinical staff must communicate effectively with patients and their relatives. Every patient who is suspected of having or confirmed as having a HCAI should be told the diagnosis and if the patient agrees, appropriate close relatives or carers should also be told. This information should be given by the medical staff responsible for the treatment of the patient, and should include the facts about the infection, the treatment proposed, the likely course of the disease, the relative importance of the infection in relation to the patient’s other health problems, personal hygiene precautions, and the risk of infecting others – including the reasons for moving them to a single room or cohort ward as appropriate. This should be reinforced by a leaflet containing the same information. Regular updates of the patient’s progress should be given by doctors and nurses to the patients and relatives and recorded. If a service user needs to be cared for in a single room, is isolated or cohorted in an area with similarly affected individuals, then a full explanation should be given.</td>
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Measuring success

5.37 The elimination of preventable HCAI is one of six ‘quality deliverables’ in the 2011-12 AQF. LHBs will be expected to demonstrate measurable success in eliminating HCAIs. The AQF outlines the key evidence areas that NHS bodies will be expected to demonstrate improvement in; hand hygiene, isolation and cohort facilities, antimicrobial prescribing, 1000 Lives Plus and root cause analysis of cases of C. difficile infection.

5.38 The 2010-11 AOF included specific reference to reducing HCAIs and LHBs/Trusts were expected to demonstrate on a quarterly basis reduction in all HCAIs. For the first time, a numerical reduction target was set at national level for C. difficile cases with LHBs being asked to demonstrate a minimum of 20% reduction over the 12 months in the number of cases in patients over the age of 65, based on figures published in the July 2008 to June 2009 All-Wales report.

5.39 This target was met across Wales (see Table 1) and in most areas exceeded but it is evident that there is considerable variation across Wales and between different sites within the same organisation. Some of this variation may be attributable to the incidence of differing strains of C. difficile notably ribotype 027, in different parts of Wales and the impact this has had on length of illness, severity of symptoms and rate of relapse. In February 2011 PHW carried out a national survey of ribotypes, susceptibility testing and enhanced surveillance of severity of illness and outcome of disease. The results of the survey build on the knowledge gained from similar surveys in 2005 and 2008 and aid further understanding as to the contribution different PCR ribotypes (molecular analysis) of C. difficile are currently making to the epidemiology of infection in Wales.

5.40 Surveillance of infection involves data collection, analysis of data and very importantly feedback of results to clinicians and others involved in decision making. Surveillance is not an end in itself but a key component of every IPC programme and measure of effectiveness of that programme. In addition to local surveillance Wales currently supports a number of mandatory national surveillance schemes (Appendix B) and continued effort to increase and maintain the compliance with these schemes in respect of the quantity and quality of data collected and analysed is important if they are to provide meaningful information.

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19 [WG’s 2010-11 AoF](#)

20 C. difficile ribotype surveillance
5.41 Increasingly shorter lengths of hospital stay mean that post discharge surveillance must be developed further to identify the true impact of HCAIs.

5.42 PHW will also support the collection of HCAI and antimicrobial usage data from long term care facilities and other healthcare facilities in the community through prevalence studies such as the ECDC co-ordinated Healthcare associated infections in European long term care facilities (HALT) study.  

5.43 All HCAIs should be reported as a patient-safety incident on the local Datix system. Root cause analysis should be undertaken for all deaths due to HCAIs so mechanisms must be in place to review incidents, identify themes and share learning. As previously agreed with CEs, Medical Directors must work with their clinical teams to carry out a comprehensive review of all deaths in inpatients including those where HCAI is the primary cause of death or a contributory factor. There is evidence to support a review of all patients with *C. difficile* infection. The findings and outcome of every review must be reported to the CE and the Board in a timely manner.

<table>
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<tr>
<th>Measuring success – Actions</th>
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<tr>
<td><strong>1.</strong> LHBs/Trusts (as appropriate) will agree local targets and plans to demonstrate progress against the evidence areas highlighted within the AQF: hand hygiene, isolation and cohort facilities, antimicrobial prescribing, <em>1000 Lives Plus</em> and root cause analysis of cases of <em>C. difficile</em> infection.</td>
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<tr>
<td><strong>2.</strong> LHBs and Velindre NHS Trust will continue to report the number of cases of <em>C. difficile</em> infection and bacteraemia due to <em>S.aureus</em> on a monthly basis. PHW will provide feedback to LHBs/Trusts in the form of a report to the Board and to the WG Executive Team. LHBs/Trusts are expected to continue to sustain and build upon the percentage reduction achieved in 2010-11. Any recurring deficits must also be quickly driven down.</td>
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<tr>
<td>WG will work with LHBs and Velindre NHS Trust to develop future local reduction targets against which performance will be assessed.</td>
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21 To date ECDC have not announced if or when the HALT study will be repeated. Further information, as it becomes available can be accessed at: [HAIs in European Long term care facilities](http://www.ecdc.europa.eu/en/) and [ECDC home page](http://www.ecdc.europa.eu/en/) and from PHW: [WHAIP homepage](http://www.whaip.org.uk).

22 Datix - patient safety software for healthcare risk management, incident and adverse events reporting.

23 PHW will collate information and produce monthly reports in the same way that they have during 2010-2011. The baseline will be the 2010-11 data and the reports will include a target reduction trajectory of 20%, 40% and 60% against which organisations can measure their progress.
3. PHW will co-ordinate and support the participation of LHBs/Trusts in the ECDC HCAI and antimicrobial prevalence surveys in acute hospitals. Participation in the 2011 survey and subsequent surveys (carried out on an annual or bi-annual basis) will help to establish baseline data against which improvement can be demonstrated and local priorities for action established. Participation will also provide data comparable with the rest of the UK and European Union.

4. Healthcare organisations will need to consider the outcomes of the 2010 ECDC HCAI prevalence survey carried out in long-term care facilities by PHW to inform the development of infection control services in this sector. 18

5. Welsh NHS bodies will participate in the PHW co-ordinated annual point prevalence survey of antimicrobial use. PHW will provide education and training support.

6. Clinical engagement with national mandatory surgical surveillance programmes has continued to improve over the last three years resulting in increasingly greater compliance in reporting year on year. LHBs and Velindre NHS Trust should continue to strive towards reaching 95% compliance as outlined in the AoF 2010-2011 (Target 19). 16

7. Building on the existing ‘Top ten’ bacteraemia surveillance PHW will develop a programme of enhanced surveillance of bacteraemia caused by *Escherichia coli* to be rolled out across all LHBs/Trusts.

8. WG and PHW, in collaboration with NHS bodies, will review the current national mandatory HCAI surveillance programme and make recommendations with regard to the development of surveillance programmes for infections associated with community/outpatient healthcare interventions and those that present post hospital discharge.

9. A review of the national antimicrobial surveillance programme will also be undertaken.

10. PHW will facilitate a forum to evaluate HCAI and antimicrobial surveillance on an annual basis to feedback results and lessons learnt to healthcare organisations, to evaluate the ongoing relevance of the surveillance programmes and to determine priorities for new programmes.

11. WG will facilitate the adoption of a suitable IT solution for HBs and Trusts across Wales, which will enable more effective management and surveillance of HCAI at a local level and support enhanced data collection for national surveillance of HCAI and antimicrobial resistance.

12. It is acknowledged that adoption of improved testing methodologies for *C. difficile* will have an impact on the numbers of cases reported. This will be taken into account at a national level when considering progress in reducing numbers. PHW will advise WG when such changes occur.
5.44 Everyone who enters a healthcare environment should expect to see and be cared for in a physical environment which minimises the risk of infection. A clean, tidy, uncluttered environment engenders a feeling of confidence in those who enter it and in the people who work in that environment. National Standards for Cleaning in NHS Wales were published in 2003 and revised in 2009. Additionally recommendations on how ward sisters/charge nurses could be empowered to improve the ward environment and hospital cleanliness were published in the Ministerial report *Free to Lead, Free to Care*.  

5.45 A clean environment is important but building public confidence is about more than that and it is important that service users are engaged in activities to minimise their risk of acquiring a HCAI and that they are given meaningful information about the risks.  

5.46 Hand hygiene is a good example. Service users should be educated on when, how and why the hand hygiene of healthcare staff is so important for all aspects of their care. They should feel comfortable in asking staff if they have cleaned their hands and need to be actively encouraged to do so. Service users should be supported in cleaning their own hands if they are not able to access hand washing facilities themselves, for example inpatients at meal times. Making hand hygiene facilities available within entrance areas with clear signage for all to use is something which should by now be commonplace across hospitals in Wales. In 2004, all healthcare Trusts across Wales signed up to the NPSA *cleanyourhands* campaign and more latterly primary care providers became engaged. Emphasis has been on the use of alcohol hand rubs for staff at the point of care and patient engagement with the message that *it’s OK to ask* staff if they have cleaned their hands.  

5.47 Citizens and service users also need to understand and be reminded that antibiotics do not work on most coughs, colds and sore throats, and unnecessary use of antibiotics should be avoided as it can lead to increased bacterial resistance. Wales has over the last three years used the ECDC led European awareness day of 18 November as a focal point around which to highlight to the public and healthcare staff issues around antibiotic awareness.

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*24* Paul Williams (DG) letter and revised National Standards for Cleaning in NHS Wales  

*25* Evidence shows that the most effective hand hygiene programmes are those where the emphasis is on staff practice at the *point of care* before direct contact with a patient, between different procedures with the same patient and between patients. Organisations should not focus solely on the use of alcohol gels/rubs for visitors and the public. Staff visibly practising good hand hygiene is an effective way of raising public confidence.
5.48 WG, PHW and NHS bodies already provide a wide range of materials on infections and antibiotic awareness, aimed at patients and the public including leaflets, posters, DVDs and web based information. Citizens have access to the PHW web site which includes information on the incidence of certain HCAIs including *C. difficile* and bacteraemia due to *S. aureus* (including MRSA) across the NHS in Wales.

5.49 HCAIs have attracted a considerable amount of media attention. Communications strategies should become less reactive to media attention and more proactive in giving patients and the public more information on how they can contribute to preventing and controlling the spread of infection.

**Sharing information and transparency – Actions**

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<tr>
<td>1.</td>
<td>All service users should receive information prior to and on admission to hospital on the part they can play in helping to reduce the risk of HCAIs during their stay in hospital including advice for visitors.</td>
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<td>2.</td>
<td>The organisation’s communications strategy should include proactive information and messaging around the issues of preventing and controlling infection including seasonal pressures which can be anticipated e.g. norovirus and seasonal influenza, antibiotic awareness and the issue of restricting visiting to ‘essential visiting’ when bays or wards are closed due to infection.</td>
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<td>3.</td>
<td>Building on the success of the cleanyourhands campaign healthcare organisations will develop local communications strategies around hand hygiene to ensure that staff, service users and the public are clear about the importance of hand hygiene and that poor hand hygiene is not tolerated within the organisation.</td>
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<td>4.</td>
<td>The information currently available to the public on national mandatory infection surveillance programmes on the PHW Welsh Healthcare Associated Infection Programme web site should be reviewed. The review should consider what information would be most meaningful for the public, the level of detail to be published, the timeliness of the information posted and issues of consistency with other sources of information e.g. individual LHB web sites, so that the public are not left in any confusion. It should also consider how the outcome of the proposed annual national prevalence survey should be presented to the public on completion. Information on numbers of cases of <em>C. difficile</em> and <em>S. aureus</em> bacteraemia by NHS body will be made available on a monthly basis, by hospital, and in a timely manner.</td>
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<td>5.</td>
<td>Wards and departments should continue to display information on progress with <em>1000 Lives Plus</em> programme areas including their success in eliminating preventable HCAIs. Where numbers of infections drop to very low levels then the information can be displayed using the ‘days between’ methodology rather than as rates.</td>
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<td>6.</td>
<td>Wales will continue to proactively participate in the ECDC European antibiotic awareness day (EAAD) on an annual basis, using it as a focal point around which to educate staff, service users and citizens about the need for prudent prescribing and usage of antibiotics.</td>
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26 The aim is to increase the numbers of days that can be counted as infection free. Every time an infection occurs the count is started again. See *1000 Lives Plus* 13 ‘How to’ Guide for further information.
Appendix A

Healthcare Improvement Methodologies: *1000 Lives Plus*

**A1.** WG has acknowledged the success of the *1000 Lives* patient safety campaign in Wales by developing this further into the *1000 Lives Plus* programme, which is a key element of the NHS Wales 5 year plan. The programme aim is to improve patient safety and the quality of all NHS services including hospitals, GP surgeries and pharmacies. The intention is to accelerate the pace of change spreading new ways of working from ward to ward, practice to practice and organisation to organisation. Interventions to reduce HCAI and improve antimicrobial stewardship have been incorporated into this patient safety work.

**A2.** A mini-collaborative has been set up within the *1000 Lives Plus* programme to focus on the introduction of care bundles for medical devices. From September 2010 the focus has been firstly on a care bundle for the insertion and maintenance of urinary catheters, to be followed by care bundles for peripheral venous cannulisation and the dissemination of the care bundles for insertion and maintenance of central line care bundles beyond critical care. This work also focuses on reducing the unnecessary use of medical devices to minimise risks of infection by minimising the numbers of unnecessary interventions.

**A3.** The principles of healthcare improvement and the model for improvement can be applied broadly to AMR and HCAI issues as outlined in the *How to Guide* published on the *1000 Lives Plus* website. Patient safety and quality of care is at the heart of healthcare improvement work and is an effective method for bridging the gap between policy/guidance and implementation into practice.

**A4.** PHW will continue to support the *1000 Lives Plus* work relevant to reducing HCAIs and AMR. This includes work on hand hygiene, support for outcome measures in infection, development and implementation of care bundles for medical devices, advice and support on antimicrobial stewardship issues.

**A5.** LHBs/Trusts are engaged in ensuring healthcare improvement methodologies are used to bridge the gap between policy and practice in IPC and antimicrobial stewardship.
National surveillance of HCAIs and antimicrobial resistance

B1. To ensure appropriate interventions and actions are taken in relation to HCAIs and antimicrobial resistance as well as ensuring early awareness of new infections and resistances, appropriate information needs to be collected at a local and national level with timely feedback of data. Benchmarking of data within the UK and across Europe ensures that Wales does not act in isolation.

B2. At present Wales has a broad range of mandatory HCAI surveillance in place, developed and run by PHW’s WHAIP. Surveillance for S. aureus bacteraemia was introduced in 2001. It has since been extended to cover:

- **C. difficile surveillance:**
  - C. difficile ribotype surveillance

- **Top ten bloodstream infection surveillance**

- **Critical Care HCAI surveillance**
  - Central venous catheter (CVC) infections
  - Ventilator associated pneumonia (VAP) infections

- **Hospital outbreak surveillance**

- **Surgical Site Infection (SSI) Surveillance:**
  - Orthopaedic SSI surveillance
  - C-section SSI surveillance

B3. The WHAIP team has also supported local infection control teams to undertake surveillance of various types of HCAI and supported the measurement of outcomes related to the 1000 Lives campaign.

B4. Surveillance to support AMR issues is performed and supported by the Antimicrobial Resistance Programme (ARP), PHW. This currently comprises:

- annual report of Antimicrobial resistance across Wales in primary and secondary care including data on the ‘Top Ten’ Blood Stream Infections;
- annual report of antimicrobial use in secondary care (from pharmacy stock data);
- annual Point Prevalence survey of antimicrobial use across secondary/tertiary care in Wales; and
- periodic reports of antimicrobial use in primary care.

B5. In addition the ARP has supported local antimicrobial stewardship teams through the development of regular bespoke reports of antimicrobial usage.

B6. More information on a range of surveillance schemes can be found on the PHW website: [HCAI surveillance programmes](#)
## GLOSSARY OF TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Citizens</td>
<td>Means anyone who receives, or is affected by, public services. In the NHS, patients are the obvious citizens; but there are others whom the NHS has to consider - patients’ relatives, for example. Organisations may define this in different ways - patient, service user, service recipients, etc.</td>
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<tr>
<td>Healthcare</td>
<td>Services provided for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.</td>
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<tr>
<td>Healthcare associated infections (HCAIs)</td>
<td>Infections that arise as a result of the direct or indirect contact of people with healthcare services. HCAIs may be caused by infectious agents from endogenous or exogenous sources:</td>
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<td>- endogenous sources are body sites - such as the skin, nose, mouth, gastrointestinal (GI) trace or vagina - that are normally inhabited by micro-organisms;</td>
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<td></td>
<td>- exogenous sources are those external to the patient – such as staff, visitors, patient care equipment, medical devices or the healthcare environment.</td>
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<tr>
<td>Healthcare organisation</td>
<td>Welsh NHS bodies, independent contractors and other organisations and individuals, including the independent and voluntary sectors, which provide or commission health care for individual patients, service users and the public.</td>
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<tr>
<td>Healthcare professional</td>
<td>A person who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.</td>
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<tr>
<td>Independent Contractor</td>
<td>A person or body who provides care under arrangements with an NHS body, such as general dental services contractors, general medical services contractors, optometry and pharmacist contractors.</td>
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<tr>
<td>Medical Devices</td>
<td>All products except medicines, used in healthcare for diagnosis, prevention, monitoring or treatment.</td>
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<tr>
<td>Patient</td>
<td>A person in receipt of health care provided by or for a Welsh NHS body.</td>
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<tr>
<td>Primary Care</td>
<td>First-contact health services directly accessible to the public.</td>
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<tr>
<td>Service user</td>
<td>An individual who uses NHS services and who may also be deemed a patient.</td>
</tr>
<tr>
<td>Standards</td>
<td>Standards are a means of describing the level of quality health care organisations are expected to meet or to aspire to. The performance of organisations can be assessed against this level of quality.</td>
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<tr>
<td>Welsh NHS body</td>
<td>Local Health Boards and NHS Trusts in Wales.</td>
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