Western Health and Social Care Trust

Infection Prevention & Control Report to Trust Board

Meeting Date – 2nd July 2026

1. Target Organisms Performance

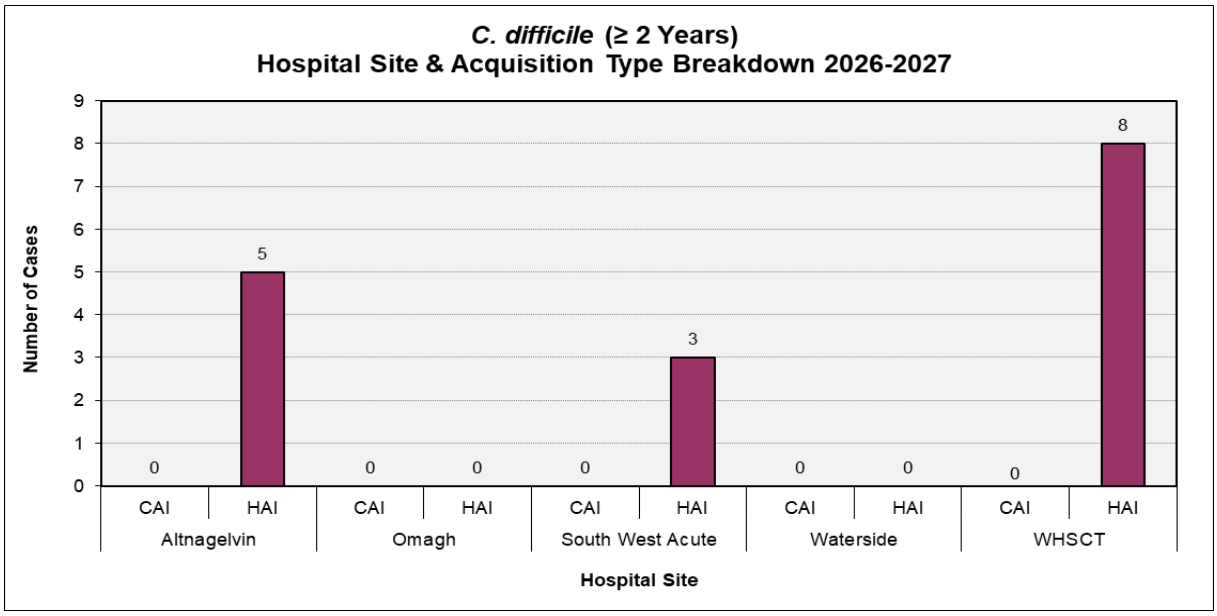
Clostridium difficile (C. difficile)

The Department of Health for Northern Ireland (DoH NI) has set a reduction target for *C. difficile* associated disease (≥ two years of age) in 2026/27. This is an incidence rate of 11.5 cases per 100,000 occupied bed days. That is a reduction of 3.4 (or 22.82%) against the baseline rate of 14.9 in 2023/24.

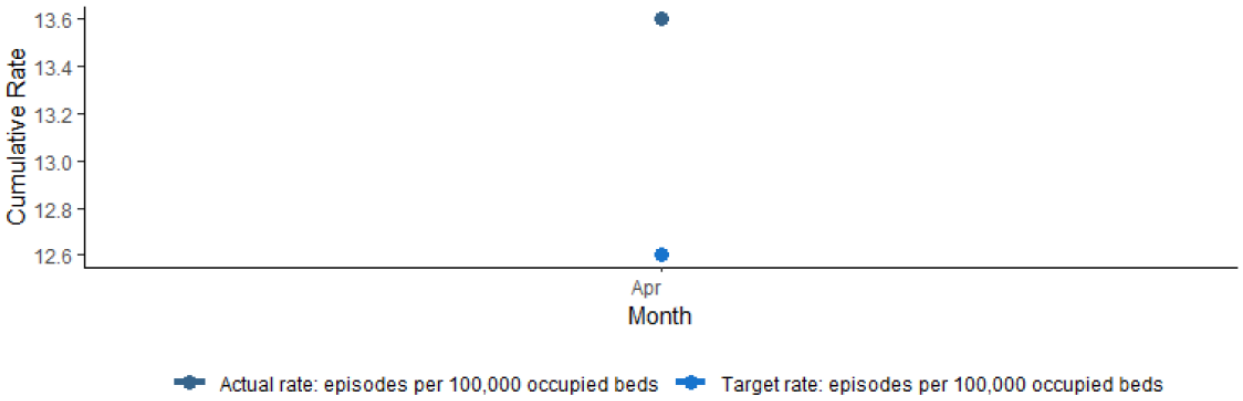
Between 1st April and 17th June 2026, eight cases have been reported. A breakdown of the cases by hospital site and acquisition type is given in the chart below.

Key:

CAI	Community-associated infection (positive test occurring less than two days after decision to admit/ admission date)
HAI	Hospital-associated infection (positive test occurring two or more days after decision to admit/ admission date)



Since occupied bed days denominator data is released several months in arrears it is not possible to provide an up-to-date incidence rate. The following graph is extracted from the Public Health Agency's (PHA) most recent Target Monitoring Report, which includes data up to the end of April 2026 only, at which point there were three cases and the rate was 13.6.



*CDI target was based on the 2023/24 baseline, a year in which the Trust observed a substantial reduction in CDI episodes in comparison to previous years.

Comparison with Other Trusts

The PHA releases regional comparator information on a quarterly basis. The most recent data available covers up to the end of December 2025. The table below summarises the number of *C. difficile* cases and the rate per 100,000 occupied bed days for each Trust, plus NI averages, for each of the last four quarters.

In October-December 2025, the Western Trust saw a slight increase in both the number of *C. difficile* cases and the corresponding rate. All but one of the other four Trusts also experienced increases. The Western Trust is currently reporting the second lowest rate in NI, and has reported either the lowest or second lowest for each of the three preceding quarters as well.

	January-March 2025		April-June 2025		July-September 2025		October-December 2025	
	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate
Western Trust	12	18.05	11	16.45	6	8.93	7	10.18
Southern Trust	18	24.13	13	17.97	12	16.80	15	20.26
South Eastern Trust	19	26.29	8	11.16	11	15.21	21	29.13
Northern Trust	6	7.94	15	20.04	14	18.48	6	8.08
Belfast Trust	24	18.55	27	19.88	38	26.54	47	33.93
Northern Ireland	79	18.89	74	17.55	81	18.84	96	22.45

Key Learning	Eight cases have been reported to date in 2026/27, with the most recent validated rate only available to April 2026 due to denominator data being released in arrears. The Western Trust continues to compare favourably regionally, reporting the second lowest rate in the most recent comparator period.

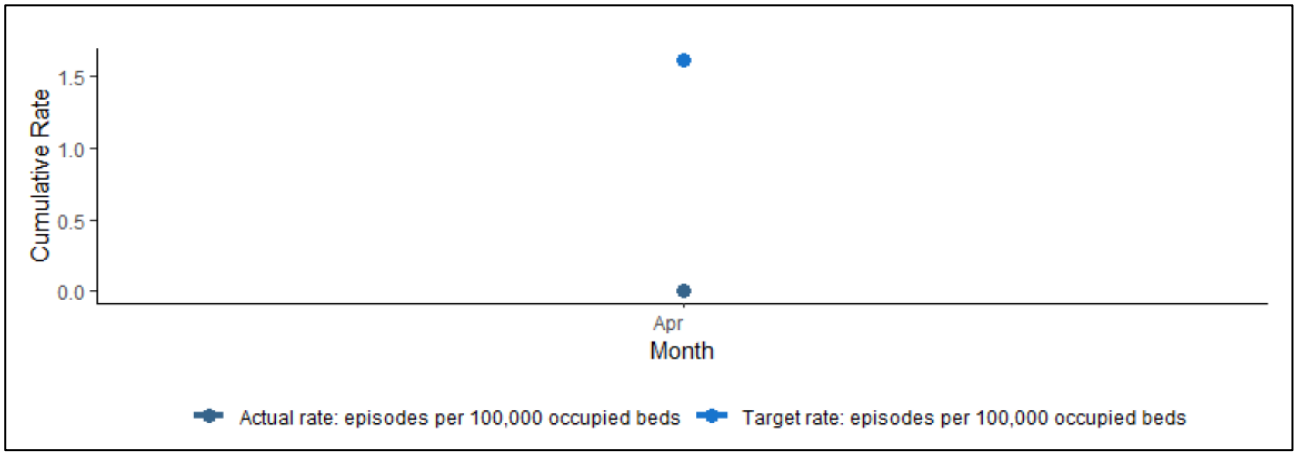
Good Practice	Ongoing surveillance, case monitoring and regional benchmarking are in place. The Trust has maintained a comparatively strong position against other Trusts over successive quarters.
Focus for Improvement	Continued focus is required on early identification, prompt isolation, antimicrobial stewardship, environmental decontamination and consistent application of the C. difficile care pathway to support sustained reduction.
Action Plan	Continue real-time review of all C. difficile cases, monitor trends by site and acquisition type, reinforce compliance with the C. difficile care pathway, and report progress through established HCAI accountability and assurance arrangements.

Meticillin-Resistant Staphylococcus aureus (MRSA) Bacteraemia

In 2026/27 the DoH NI has set a reduction target for MRSA bacteraemia. This is the same as last year, being an incidence rate of 1.613 cases per 100,000 occupied bed days. This represents no change compared to the 2019/20 baseline rate.

Since the beginning of April 2026, no cases have been reported, which equates to a rate of 0.00.

The following graph is extracted from the PHA's most recent Target Monitoring Report, which includes data up to the end of April 2026 only.



As of 17th June 2026, the total number of days since the last Trust hospital-associated MRSA bacteraemia is:

Altnagelvin Hospital – 782 days (Last recorded case was in Ward 32 ESU)
South West Acute Hospital (SWAH) – 2193 days (Last recorded case was in Ward 8)
Tyrone County Hospital/ Omagh Hospital & Primary Care Complex (OHPCC) – 4165 days (Last recorded case was in the Rehab Unit)

Comparison with Other Trusts

The PHA releases regional comparator information on a quarterly basis. The most recent data available covers up to the end of December 2025. The table below summarises the number of MRSA bacteraemia cases and the rate per 100,000 occupied bed days for each Trust, plus NI averages, for each of the last four quarters.

The Western Trust's rate saw an increase in October-December 2025, as did all other Trusts, and it currently ranks second lowest in comparison with the region. This followed a sustained period of ten months with no cases and a rate of 0.00.

	January-March 2025		April-June 2025		July-September 2025		October-December 2025	
	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate	Number of Cases	Rate
Western Trust	0	0.00	0	0.00	0	0.00	1	1.45
Southern Trust	1	1.34	1	1.38	1	1.40	2	2.70
South Eastern Trust	3	4.15	2	2.79	0	0.00	1	1.39
Northern Trust	5	6.62	1	1.34	0	0.00	3	4.04
Belfast Trust	1	0.77	5	3.68	2	1.40	3	2.17
Northern Ireland	10	2.39	9	2.13	3	0.70	10	2.34

Key Learning	No MRSA bacteraemia cases have been reported in 2026/27 to date, demonstrating sustained control. Continued vigilance remains necessary as previous regional comparator data shows variation across Trusts and a single case can materially affect the rate.
Good Practice	Sustained periods without hospital-associated MRSA bacteraemia across Trust sites provide assurance that current prevention and control measures are contributing to effective risk reduction, including surveillance, screening and decolonisation where indicated.
Focus for Improvement	Maintain focus on MRSA screening, documentation, antimicrobial stewardship, decolonisation compliance and device-related care.
Action Plan	Continue routine MRSA bacteraemia surveillance, review any new cases through established governance processes, and use independent audit findings to target support and improvement actions in relevant clinical areas.

2. Respiratory Infections

Outbreak Management

A limited number of respiratory infection outbreaks were identified across Trust services during this reporting period.
Between April and May 2026, two outbreaks were identified, associated with Influenza A and Respiratory Syncytial Virus (RSV).

IPCT led the management of both incidents. Appropriate governance arrangements were implemented, including the convening of Incident Management Teams where required. All outbreaks were managed in line with regional and local IPC guidance, with control measures implemented to minimise transmission and support patient and staff safety.

Key Learning	The limited number of respiratory outbreaks during the April–May reporting period should be interpreted in the context of seasonal respiratory virus activity. The outbreaks identified reinforced the importance of early recognition, timely escalation and prompt implementation of control measures to minimise transmission.
Good Practice	Outbreaks were managed with IPCT leadership, appropriate governance arrangements and Incident Management Team oversight where required, supporting timely decision-making and patient and staff safety.
Focus for Improvement	Maintain focus on early reporting of symptomatic patients, prompt isolation or cohorting, staff awareness of respiratory precautions, and consistent communication between wards, IPCT and operational teams.
Action Plan	Continue seasonal respiratory infection surveillance, reinforce outbreak reporting pathways, and ensure learning from incidents is shared through operational and governance forums.

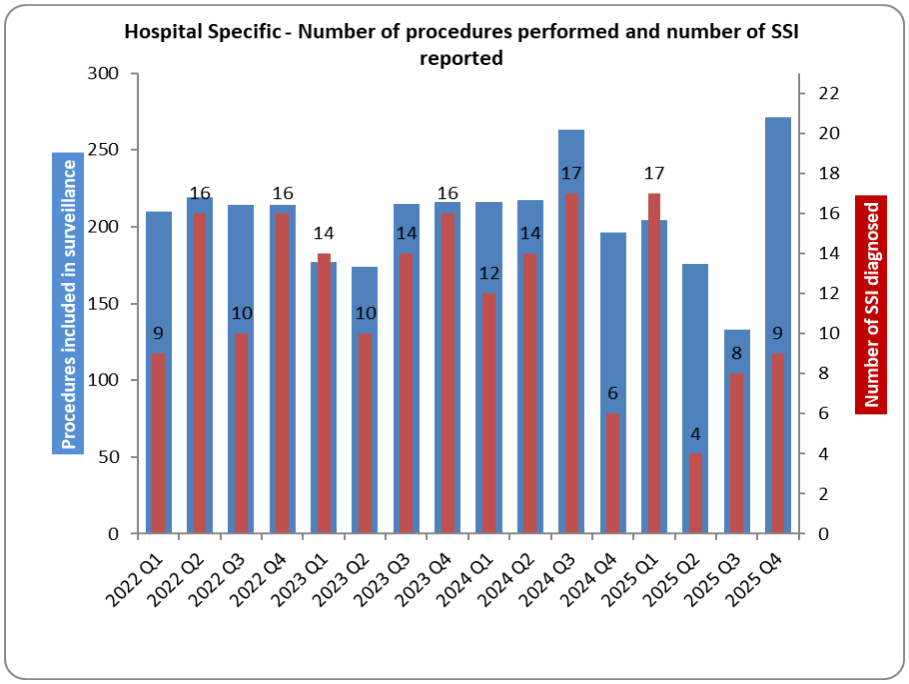
3. Caesarean Section Surgical Site Infection (SSI) Surveillance

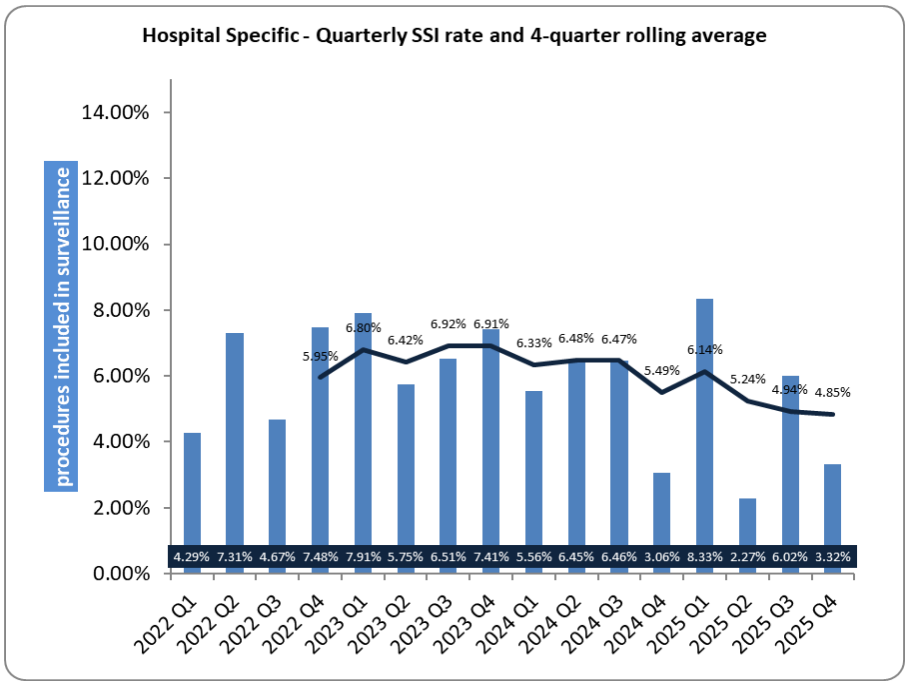
For Quarter 4 2025, the Northern Ireland average SSI rate following Caesarean Section was 3.08%, with the Western Trust reporting a lower rate of 2.30%.

South West Acute Hospital (SWAH) reported no confirmed cases during the final two quarters of 2025. A small number of cases remain subject to validation; any cases confirmed through this process will be included in revised figures and reported retrospectively in subsequent returns.

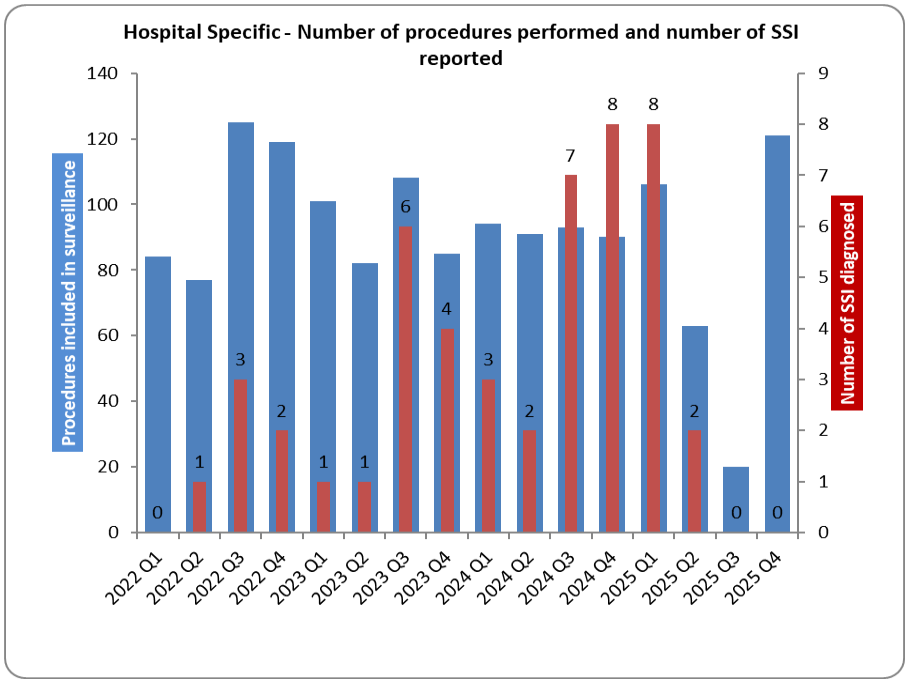
It has also been identified that three SSI cases were reported in error for Quarter 4 by the Public Health Agency (PHA). This is being rectified through the routine validation process, and amended figures will be reflected in future published data.

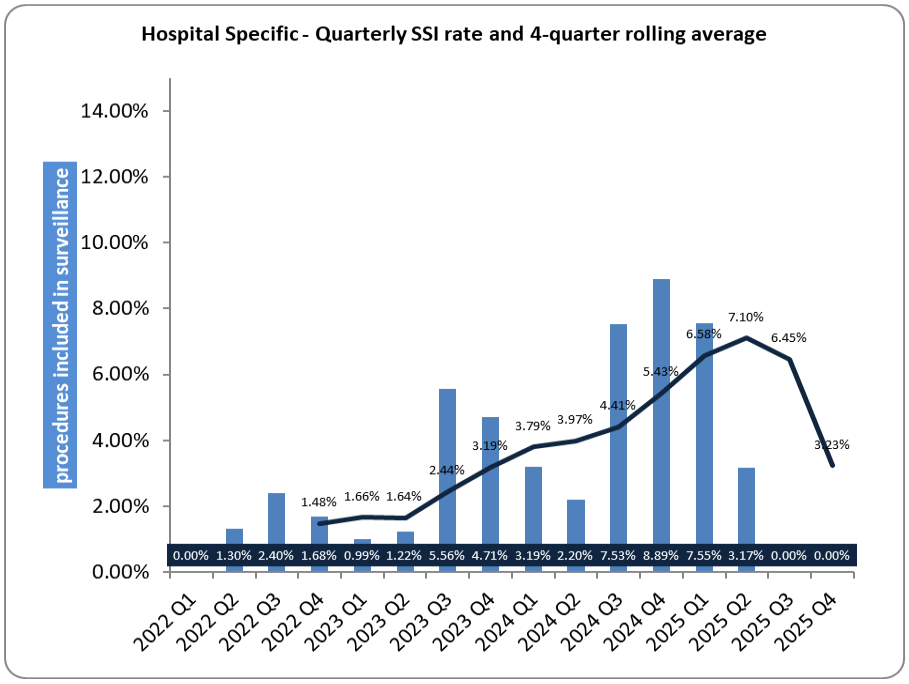
Altnagelvin Hospital





South West Acute Hospital

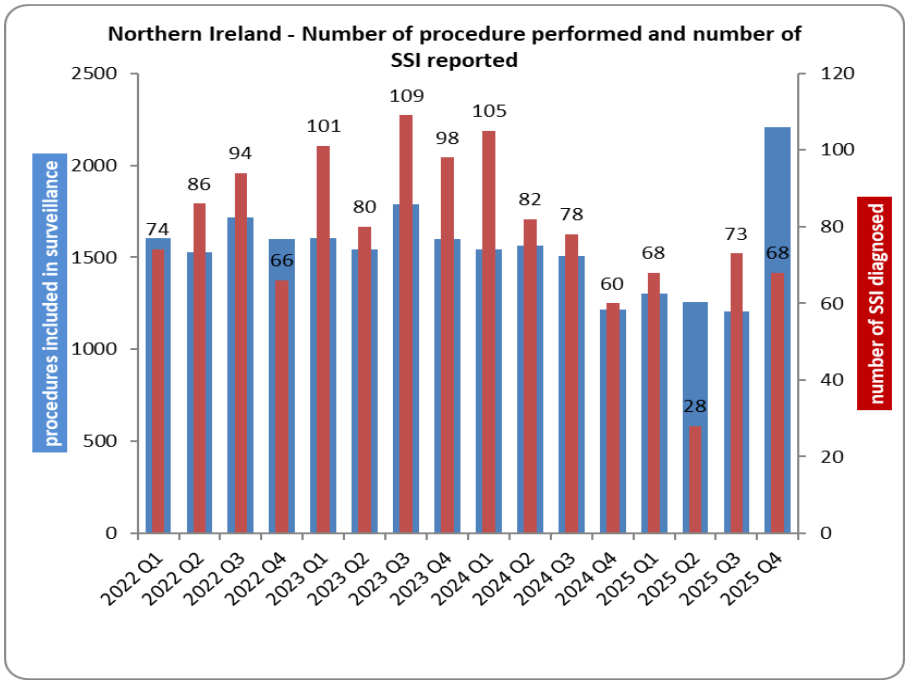


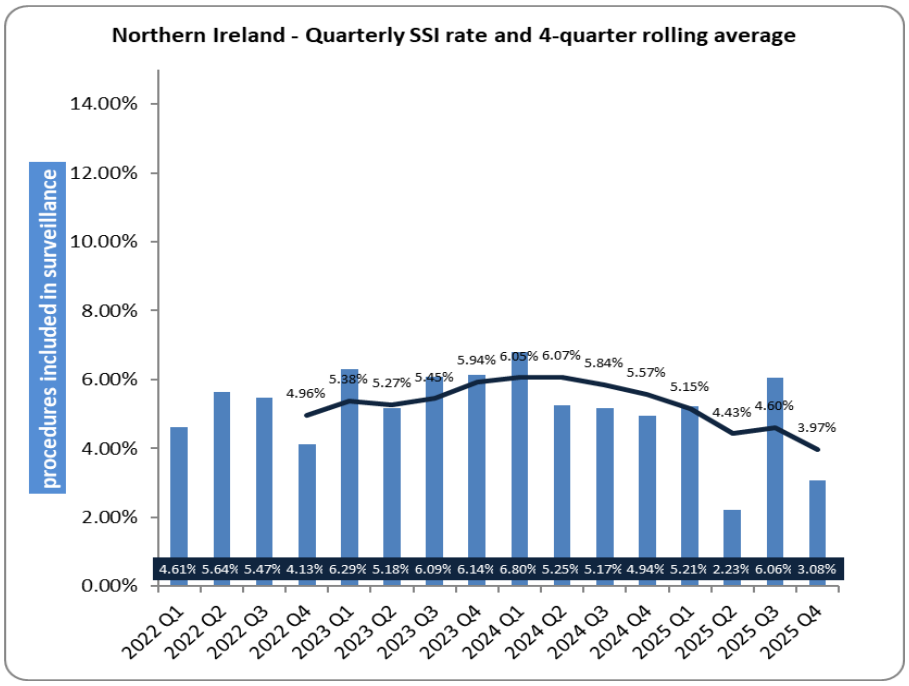


Western Trust

	Q1 22	Q2 22	Q3 22	Q4 22	Q1 23	Q2 23	Q3 23	Q4 23	Q1 24	Q2 24	Q3 24	Q4 24	Q1 25	Q2 25	Q3 25	Q4 25
No. of Procedures	294	296	339	333	278	256	323	301	310	308	356	286	310	239	153	392
No. of SSIs	9	17	13	18	15	11	20	20	15	16	24	14	25	6	8	9
Quarterly SSI Rate (%)	3.06	5.74	3.83	5.41	5.40	4.30	6.19	6.64	4.84	5.19	6.74	4.90	8.06	2.51	5.23	2.30

Northern Ireland





Key Learning	The Western Trust's Quarter 4 2025 Caesarean Section SSI rate is below the Northern Ireland average; however, validation remains important as amended figures may be required where cases are confirmed or corrected retrospectively.
Good Practice	IPCT is working collaboratively with Maternity Services and the Public Health Agency (PHA) to strengthen Caesarean Section SSI surveillance and validation arrangements. This engagement has supported identification of reporting discrepancies and is helping to improve the accuracy, reliability and governance of future SSI reporting.
Focus for Improvement	Continue to strengthen data validation, ensure timely review of potential SSI cases, and maintain focus on evidence-based peri-operative infection prevention practice across both maternity sites.
Action Plan	Complete validation of outstanding cases, liaise with PHA regarding corrected figures, and continue reporting site-level and Trust-level SSI trends through appropriate governance arrangements.

4. Critical Care Device-Associated Infection Surveillance

Critical care device-associated infection surveillance commenced in June 2011. There have been no infections in the Trust for over seven and a half years. The most recent infection recorded was a ventilator-associated pneumonia, which occurred in ICU, Altnagelvin, in October 2018.

Results, as of April 2026, are shown in the table below.

	Date of Last Recorded Case in Hospital		Hospital Rolling Average Infection Rate Per 1000 Device Utilisation Days		NI Rolling Average Infection Rate Per 1000 Device Utilisation Days
	Altnagelvin	**SWAH**	**Altnagelvin**	**SWAH**	

Ventilator-Associated Pneumonia	11/10/2018	21/09/2016	0.00	0.00	0.52
Catheter-Associated Urinary Tract Infection	Zero to date	23/07/2011	0.00	0.00	0.07
Central Line Associated Blood Stream Infection	Zero to date	11/03/2012	0.00	0.00	0.01

Key Learning	The absence of critical care device-associated infections for over seven and a half years demonstrates sustained effectiveness of prevention controls, but ongoing vigilance is essential given the high-risk nature of this patient group.
Good Practice	Rolling average infection rates remain at 0.00 for Trust sites across monitored device-associated infection categories, reflecting sustained compliance with critical care IPC bundles and device care standards.
Focus for Improvement	Maintain vigilance in device-related infection prevention practice to sustain the current zero infection position.
Action Plan	IPCT to continue routine surveillance, provide feedback to Critical Care, monitor device-care bundle compliance, and escalate any identified risks or deviations through established governance processes.

5. IPCT Independent Audits

The tables below show average compliance per quarter across a number of IPC key performance indicators where audits have been completed by IPCT. Audit results are discussed at the time with staff and used as learning opportunities. Findings are also shared with the Ward/Department Manager and Professional Lead responsible for the area. Where compliance is suboptimal, the Professional Lead and Ward Manager are responsible for developing an action plan, supported by IPCT where required. This should form part of local governance arrangements and is included in Accountability & Assurance meetings and the Corporate Management Team HCAI Accountability Forum.

As the tables show average compliance per quarter, specific improvement plans are owned by the individual clinical areas concerned.

Key:

80-100%	Green
60-79%	Amber
0-59%	Red

No audits completed – Completion of IPCT validation audits is risk assessed and audits may not be completed due to a range of factors, including no identified triggers, focus on other improvement work, and competing IPCT demands.

April – June 2025

	Northern Sector Average Compliance	Southern Sector Average Compliance	Trust Average Compliance
Hand Hygiene	73%	77%	74%
Personal Protective Equipment (PPE)	85%	91%	86%
C. difficile	77%	55%	71%
***C. difficile* Care Pathway**	Pass x 11 Fail x 2	Pass x 2 Fail x 3	Pass x 13 Fail x 5

Peripheral Line Ongoing Care	51%	73%	61%
Urinary Catheter Ongoing Care	35%	95%	63%
ANTT	93%	100%	96%
Commode	96%	80%	83%
Cleaning & Decontamination	47%	89%	71%
MRSA	54%	67%	61%

July – September 2025

	Northern Sector Average Compliance	**Southern Sector Average Compliance**	**Trust Average Compliance**
Hand Hygiene	75%	76%	75%
PPE	82%	99%	87%
C. difficile	81%	88%	83%
***C. difficile* Care Pathway**	Pass x 6 Fail x 8	Pass x 6 Fail x 2	Pass x 12 Fail x 10
Peripheral Line Ongoing Care	93%	No audits completed	93%
ANTT	52%	No audits completed	52%
Commode	58%	100%	77%
Cleaning & Decontamination	32%	80%	61%
Mattress	0%	No audits completed	0%

October – December 2025

	Northern Sector Average Compliance	**Southern Sector Average Compliance**	**Trust Average Compliance**
Hand Hygiene	82%	75%	80%
PPE	92%	78%	88%
C. difficile	70%	71%	71%
***C. difficile* Care Pathway**	Pass x 3 Fail x 2	Pass x 5 Fail x 2	Pass x 8 Fail x 4
Peripheral Line Insertion	49%	No audits completed	49%
Peripheral Line Ongoing Care	67%	No audits completed	67%
Urinary Catheter Insertion	23%	No audits completed	23%
Urinary Catheter Ongoing Care	41%	No audits completed	41%
ANTT	96%	100%	96%
Commode	50%	53%	51%
Cleaning & Decontamination	70%	52%	64%
MRSA	37%	No audits completed	37%

January – March 2026

	Northern Sector Average Compliance	**Southern Sector Average Compliance**	**Trust Average Compliance**
Hand Hygiene	84%	72%	79%
PPE	89%	86%	88%
C. difficile	43%	33%	40%
***C. difficile* Care Pathway**	Pass x 5 Fail x 2	Pass x 1 Fail x 1	Pass x 6 Fail x 3
Peripheral Line Insertion	29%	0%	22%
Peripheral Line Ongoing Care	27%	4%	19%

Urinary Catheter Insertion	76%	No audits completed	76%
Urinary Catheter Ongoing Care	71%	25%	64%
ANTT	85%	100%	89%
Commode	76%	69%	73%
Cleaning & Decontamination	59%	53%	56%
MRSA	53%	100%	59%
Mattress	81%	No audits completed	81%

Key Learning	Independent audits continue to identify variation in compliance across sectors and standards, with recurrent lower compliance in C. difficile, line care, catheter care, cleaning and MRSA processes. Findings demonstrate the importance of real-time feedback, local ownership of improvement and senior management action where non-compliance is identified.
Good Practice	IPCT provide immediate feedback and 1-to-1 education to staff at the time of audit where non-compliance is identified. Findings are discussed on the day with the Ward Manager or Nurse in Charge and shared by email with relevant clinical teams, Lead Nurses and Assistant Directors to support timely awareness and accountability. Findings are also addressed through Accountability & Assurance meetings. IPCT have commenced requesting exception reports from clinical areas for any audits scoring 79% or below.
Focus for Improvement	Focus is required on improving amber and red compliance areas through timely local review, completion of exception reports where poor compliance is identified, and strengthened senior management ownership to address non-compliance and drive sustained change.
Action Plan	IPCT to continue real-time feedback, education and offers of focused support or training following audits. Clinical teams must review findings, complete exception reports for poor compliance, implement local actions and ensure senior management oversight through Accountability & Assurance meetings and relevant governance forums.

6. Water Safety – Annual Report 2025/2026

The Trust Water Safety Group (WSG) continues to provide multi-disciplinary oversight and assurance that water systems across Trust facilities are safe, compliant, and effectively managed. The group reports through the Corporate Governance Sub-Committee and is chaired by the Head of Infection Prevention and Control.

Key Assurance Messages

The Trust has in place robust water safety governance arrangements, including independent Authorising Engineer (AE) oversight, six-monthly audits, and a risk-based Water Safety Plan.

The AE has assessed the Trust's Safe System of Work as satisfactory, providing assurance that control measures are in place to manage water safety risks. There remains no evidence of patient harm or infection linked to waterborne pathogens during the reporting period.

Significant Incident – February 2026

- A water discolouration incident at Altnagelvin Hospital was linked to a burst water main external to the Trust.

- Multi-agency investigation (including NI Water and PHA) confirmed the issue was aesthetic in nature, with no microbiological contamination.
- The Trust implemented a precautionary, risk-based response, including temporary restrictions, enhanced sampling, and use of point-of-use filters.
- The incident demonstrated effective governance, communication, and multi-agency coordination, with appropriate escalation through the WSG.

Water Quality and Surveillance

Pseudomonas:

- Strong performance Trust-wide, with minimal positive outlets and no sustained detection since April 2025.
- No positive samples identified at SWAH or Labs & Pharmacy sites.

Legionella:

- Ongoing challenge, with positive outlets identified; however, risks are actively managed through mitigation measures and monitoring regimes.
- At SWAH, a reduction in positive samples compared to the previous year has been observed.

Risk Management and Compliance

- The Trust continues to operate a risk-based compliance model, with high-risk issues prioritised and managed appropriately.
- A significant programme of Legionella risk assessment actions is underway, supported by targeted investment and prioritised risk registers.
- A previously identified corporate risk relating to Pseudomonas in water systems has now been closed, reflecting the effectiveness of controls and absence of associated infections.

Improvement Programme

Substantial works have been undertaken to improve water systems, including:

- Replacement of non-compliant storage tanks
- Upgrades to domestic hot and cold water systems
- Completion of updated Legionella risk assessments across multiple Trust sites

Improvement works are ongoing, with further targeted infrastructure upgrades and enhanced monitoring systems planned for 2026/2027.

Overall Position
The Trust maintains effective governance and control of water safety risks, supported by independent assurance, ongoing investment, and a structured improvement programme. While Legionella remains an area of continued focus, control measures are in place and risks are being actively mitigated.

Key Learning	The February 2026 water discolouration incident demonstrated the value of established water safety governance, clear escalation routes

	and multi-agency engagement in supporting a proportionate risk-based response.
Good Practice	The Trust has robust Water Safety Group oversight, independent Authorising Engineer assurance, routine surveillance and a structured Water Safety Plan. No evidence of patient harm or infection linked to waterborne pathogens was identified during the reporting period.
Focus for Improvement	Legionella remains an area of ongoing challenge and should continue to be managed through prioritised risk assessment actions, targeted infrastructure improvement, monitoring and assurance reporting.
Action Plan	Continue delivery of the 2026/27 water safety improvement programme, progress prioritised Legionella risk assessment actions, maintain enhanced monitoring where indicated, and report assurance and exceptions through the Water Safety Group and Corporate Governance Sub-Committee.

7. New and Updated Infection Prevention & Control Guidance

The following guidance was approved by the Corporate Management Team (CMT) HCAI Accountability Forum in May 2026. All four were updates of existing documents.

- Guideline on the Safe Use of Fans (Bladed and Bladeless) in the Clinical Environment
- Hand Hygiene Protocol
- Aseptic Non-Touch Technique (ANTT) Guidelines
- Policy for the Control of Transmissible Spongiform Encephalopathy (TSE), Including Creutzfeldt Jakob Disease (CJD) and variant Creutzfeldt Jakob Disease (vCJD)

The CJD Policy will now proceed to the Trust Policy Group for final ratification. The other documents will be made available to staff for implementation on the Staff IPC SharePoint site, and staff will be alerted to their presence via Trust Communications.

The CMT HCAI Accountability Forum also agreed to stand down the local Western Trust Infection Prevention & Control Standard Precautions Policy. The NI Regional IPC Manual provides more comprehensive guidance and fully meets the required standards and recommendations for standard precautions, and will therefore be used instead. Staff will be informed of this change via Trust Communications, with a clear route for accessing the Regional IPC Manual shared.

Key Learning	The review and approval of updated IPC guidance supports alignment with current regional standards and provides an opportunity to remove duplication where regional guidance is more comprehensive.
Good Practice	Updated guidance has been reviewed through the CMT HCAI Accountability Forum, with clear routes identified for ratification, publication and staff communication.
Focus for Improvement	Ensure staff are made aware of updated guidance, the standing down of the local Standard Precautions Policy, and the expectation that the NI Regional IPC Manual is used as the definitive source for standard precautions.
Action Plan	Publish approved guidance on the Staff IPC SharePoint site, issue Trust Communications to alert staff to changes, progress the CJD Policy through Trust Policy Group, and monitor implementation through existing IPC governance routes.