Infection Prevention & Control: Service Group Governance Arrangements

Final Internal Audit Report

May 2023

Swansea Bay University Health Board

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Auditors:	Osian Lloyd, Head of Internal Audit Felicity Quance, Deputy Head of Internal Audit Ross Hughes, Principal Auditor
Executive sign-off:	Gareth Howells, Executive Director of Nursing
Distribution:	Delyth Davies, Head of Nursing, Infection Prevention & Control Lesley Jenkins, Interim Assistant Director of Nursing Raj Krishnan, Deputy Medical Director
Committee:	Audit Committee

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Executive Summary

Purpose

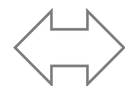
To review the effectiveness of the governance arrangements in place within the Service Groups to manage the risks relating to Infection Prevention and Control.

Overview

We have issued **reasonable** assurance on this area. The significant matters which require management attention include:

- There is no method of monitoring identified actions from the IPC audit programmes undertaken.
- A high number of actions within the Service Group work programmes have yet to achieve their set targets.
- Infection Prevention and Control (IPC) work programmes focus is limited to improving Aseptic Non-Touch Techniques compliance training, whilst IPC Level 2 is also below the Welsh Government target goal.
- Training non-compliance is not reported to the Quality & Safety Committee.

Report Classification

		Trend
Reasonable	Some matters require management attention. **Low to moderate impact** on residual risk exposure until resolved.	 2019/20

Assurance summary[1]

	Assurance objectives	Assurance
1	Policies and Procedures	Reasonable
2	Structure and responsibilities	Substantial
3	IPC Improvement Programme	Limited
4	Awareness and training	Limited
5	Mechanisms for assurance	Reasonable
6	Reporting and oversight	Reasonable

Matters arising

	Matters arising	Assurance Objectives	Control Design or Operation	Recommendation Priority
1	IPC Policies and Procedures	1	Operational	Low
2	Training compliance reporting	3,4	Operational	High
3	Work Programme implementation	3	Operational	High
4	Audit Programme	5	Design	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 Infection Prevention and Control (IPC) is fundamental in ensuring the provision of a safe environment for staff and service users. The Covid-19 pandemic has emphasised the need for healthcare organisations to have coordinated, collaborative, agile and robust IPC processes and structures in place to ensure effective and timely IPC response.

1.2 Healthcare Associated Infection (HCAI) refers to infection that occurs because of contact with the healthcare system. A consistent approach and effective leadership within the Swansea Bay University Health Board (the health board) is required to prevent HCAI within health board services.

1.3 The health board's central IPC Team provides advice and support to all health board services, particularly clinical and front facing staff. IPC is however the responsibility of all health board staff, with Service Delivery Groups responsible for ensuring effective IPC management within their operational services.

1.4 The health board has had some of the highest rates of Tier (1) infections monitored under the NHS Wales performance delivery framework, and recently developed an IPC Improvement Plan to address. In turn, the health board's Service Groups have been tasked with developing action plans and establishing governance structures to support improvement and reduce the number of infections being experienced by patients and users of health board services.

1.5 The risks considered during the review were as follows:

i. Patient or staff harm where infection, prevention and control guidance and practices are not aligned to national standards.
ii. Financial loss or reputational damage to the health board as a result of poor performance.

1.6 The review did not assess the clinical adequacy of measures to reduce HCAIs.

2. Detailed Audit Findings

2.1 The table below summarises the recommendations raised by priority rating:

	Recommendation Priority			Total
	High	Medium	Low	
Control Design	1	1	-	2
Operating Effectiveness	1	-	1	2
Total	2	1	1	4

2.2 Our detailed audit findings are set out below. All matters arising and the related recommendations and management actions are detailed in Appendix A.

Audit objective 1: The health board has an infection prevention and control policy that provides clear direction, aligns with national standards, and is supported by appropriate operational policies and procedures.

2.3 The health board's SharePoint site has a dedicated hub for Infection Prevention and Control (the hub). The hub contains a policy and protocol section where an IPC policy library is widely available to all staff. A review of the library identified that there is an overarching IPC policy that was approved by the Infection Control Committee in December 2019. The IPC policy was due for review in December 2022. It is noted, however, that approval was given at September's Infection Control Committee meeting to extend the review date by six months (June 2023).

2.4 In addition to the hub, it was noted that there is also a dedicated IPC policy library within the Clinical Online Intelligence Network (COIN) section of the health board's SharePoint site. Our review identified four additional policies to those at the hub, all of which are outside their review timescale **(see MA1):**

- Management of Seasonal Influenza Policy: review date August 2020,
- Inoculation Injury Policy: review date December 2020,
- Model Policy Aseptic Non-Touch Techniques (ANTT): review date July 2020; and
- Policy for Infection Outbreak/Incident Management in Secondary and Tertiary Care: review date July 2020, and noted that this policy references the preceding organisation's name.

2.5 There is national guidance set out by Welsh Government in the Codes of Practice for the Prevention and Control of Healthcare Associated Infections; and we reviewed the health board's policy to ensure alignment. The review identified that through the policies and available guidance contained on the hub, the points required within the national guidance are appropriately covered.

2.6 It was noted that no additional local guidance was introduced during Covid-19, on the advice of their Microbiologist the health board opted to follow National guidelines issued by Welsh Government and Public Health Wales. A Covid-19 quick reference guide was created to support the changes in guidance and is available to all staff via a link on the hub.

Conclusion:

2.7 The health board has an overarching IPC policy in place which aligns to the national guidelines. There is also a library of additional policies, procedures and guidance available to support the overarching policy. At the date of fieldwork, a number of these policies have surpassed their review date, however we recognise a decision

was made by the health board not to review/update policies during the Covid pandemic. Noting this, we assign this objective **reasonable** assurance.

Audit objective 2: The health board has a clear infection prevention and control structure and Operational and Executive responsibilities are clearly outlined.

2.8 IPC Corporate and Service Group Framework

The IPC team has created a comprehensive IPC framework document that outlines the overarching framework for the management and organisation of IPC at both a corporate and service group level. Both this framework, and the IPC policy, detail the accountabilities and responsibilities for IPC and related duties as part of the health board's governance and assurance processes.

2.9 Noting that IPC policy is to be reviewed (see para 2.3), it will make reference to the new governance structures in place at the health board i.e. an Infection Prevention Control Committee which is a sub-group of the Quality and Patient Safety Group, which in turn is a subgroup of the management board. Consideration of the new structures has been undertaken as part of a separate audit (Quality Governance Framework) which remained ongoing at the date of fieldwork.

2.10 The Framework also addresses:

- Service Groups IPC objectives;
- Service Groups operational IPC responsibilities;
- Corporate IPC accountability structure;
- Service Group IPC accountability structure;
- Decontamination structure; and
- Activities, programmes, and infrastructure in place within the health board to ensure they are complying with Health and Care Standard 2.4 (Infection Prevention & Control).

2.11 In addition, the IP&C policy also outlines the roles and responsibilities within the health board including:

- Directors and managers;
- All staff providing direct care in a health or social care setting;
- All medical and non-medical prescribers;
- Consultants and other medical staff, including health board GPs;
- Site and bed management;
- Support services and housekeeping;
- Estates and capital planning;
- Independent contractors;
- Health board IP&C staff; and
- Occupational health staff

2.12 Infection Control Committee (ICC)

The ICC is an operational group of the Quality & Safety Committee (QSC). As defined in its terms of reference, the ICC is to '*provide assurance to the QSC, that there are appropriate systems in operation for the development and monitoring of infection prevention and control work programme, policies and standards required*'.

2.13 A review of the ICC meetings for 2022 (January, March, May, June, September and December) confirmed that meetings are held on a bi-monthly basis as per the agreed terms of reference. Attendance at the meetings was quorate with the expected seniority of staff from key areas of the health board represented at each meeting, including microbiologists, estates and support services, which has enabled decisions to be taken, where required (see ***objective 6*** for reporting content).

2.14 Service Groups

Discussions with the Head / Deputy Head of Nursing for each Service Group confirmed that each has established its own IPC group which reports into the ICC. Up-to-date terms of reference are in place which clearly outline the reporting lines and responsibilities.

2.15 Review of a sample of three meetings held in 2022, for each group, noted that they were quorate with reasonable attendance at each meeting. The one exception being the Mental Health & Learning Disabilities Service Group Infection Control Governance Group, although it was noted that the group is still considered in its infancy. The IPC corporate team is well represented at all Service Group meetings, noting that the IPC Head of Nursing was present at the majority of meetings.

Conclusion:

2.16 There is a clear structure across the health board to support IPC, with documentation at corporate and service group level to outline both structure and accountability. We assign this objective **substantial** assurance.

Audit objective 3: A programme is in place to direct and deliver infection prevention and control improvements across the health board, including focus at Service Group level.

2.17 Corporate IPC Work Programme

The IPC team have established a 12-month work programme to support the improvement of IPC within the health board. The work programme is comprised of seven IPC 'goals', each with supporting actions (35 in total but noting six actions did not proceed as they were not considered viable/feasible to achieve within the available resource), baseline position, three monthly updates, expected final

outcome, responsibility for the improvement, any digital or financial implications and an IPC methodology support lead officer. The programme was issued to the ICC in March 2022 for review and approval.

2.18 The overarching goals of the 2022/23 work programme are:

- Service Groups to review IPC governance arrangements and structures; and submit to the health board's Infection Control Committee.
- Reduce incidence of the following key infections: Staph. aureus and Gram negative bacteraemia, and C. difficile infection.
- Improve safety of patient care environment.
- Review strategic and operational Corporate IPC workforce, ensuring sustainability.
- Digital Intelligence resource to support the delivery of key improvement actions
- Strengthen IPC resources within Service Groups.
- Effective communication strategy making IPC everyone's business.

These were compared to the overall IPC objectives within the IPC policy, and alignment was evident. A review of the methods to achieve the goals, and wider actions appeared reasonable with the latter reported to the QSC in April 2023 as 20 actions fully achieved, five partially achieved and four not achieving the expected outcomes. *Note: this is a significant improvement from the reported position in February where only seven were reported as fully achieved. We have not validated the health board's reported status of the improvement plan.*

2.19 It was noted that training compliance levels only focus on that for ANTT. As is noted in objective 4, at the date of fieldwork, training compliance was falling short for IPC training levels 1 & 2 and hand hygiene training, with level 1 improving by the date of reporting **(see MA2)**

2.20 It is noted that updates against the work programme progress is reported on a regular basis to the ICC and is also a standing agenda item at the QSC (see ***objective 6***). At the conclusion of the programme, a report will be issued to the ICC covering progress and success against the objectives.

2.21 Service Group Work Programmes

To support the corporate IPC work programme, there are individual work programmes in place at each Service Group. These were presented to the ICC in May 2022 for discussion and to agree a programme to be issued to Management Board, where they were subsequently approved in June 2022. The work programmes were also presented at the June QSC meeting for comment and noting.

2.22 The goals for the Service Groups are based on the corporate work programme, with the primary one being to '*reduce incidence of key infections: Staph. Aureus and Gram-negative bacteraemia, and C. difficile infection*'. It was noted that the

Service Groups all include an additional objective around improving IPC level 2 and ANTT training compliance (see *para 2.19*).

2.23 Review of the Service Group IPC reports to the ICC noted that monitoring of progress against the work programmes is a standard section of the report template. Further review also noted that the ICC report to QSC includes progress updates against each Service Group programme.

2.24 Whilst reporting mechanisms are in place, the actual progress of implementation of the programmes is not as planned:

Table 1

Service Group [1]	Total number of programmes	Complete	Evidence of progress but not completed	Off Target
Corporate	29	20 (69%)	5 (17%)	4 (14%)
Morriston	30	9 (30%)	15 (50%)	6 (20%)
Singleton / NPT	15	9 (60%)	4 (27%)	2 (13%)
MH & LD	17	6 (35%)	8 (47%)	3 (18%)

[1] At the date of fieldwork, an updated work programme for Primary Care was not provided.

With the exception of the Corporate and Singleton/NPT Service Group, there is a significant number of agreed actions yet to be implemented, or have surpassed their set target dates (see **MA3**).

2.25 To monitor the effectiveness of the work programmes in decreasing the number of HCAIs, the report to QSC contains an update on infection rates across the health board. The following details a comparison of data reported to QSC in February 2022 and February 2023

Table 2

Infection		Cumulative cases April 2021 to end of January 2022	Cumulative cases April 2022 to end of January 2023	% increase / decrease between period
1	C. difficile (CDI)	165	169	2%↑
2	Staph Aureus bacteraemia (SABSI)	117	126	6%↑
3	E.coli bacteraemia (EcBSI)	241	224	7%↓
4	Klebsiella Bacteraemia (KIBSI)	83	88	7%↑
5	Pseudomonas aeruginosa bacteraemia (PAERBSI)	19	38	100%↑

As Table 2 shows, all HCAIs with the exception of E.coli bacteraemia have seen an increase over the period reviewed. The February 2023 QSC report also highlighted that, for incidence per 100,000 population, infections (2) and (5) remain the

highest in Wales; the second highest for infections (4) and (1); and the third lowest incidence for infection (3).

2.26 Following issue of the draft report, management presented an update to the April 2023 QSC meeting in relation to the health board's position against the Welsh Government's infection reduction expectation as follows:

Table 3

Infection		SBUHB total case numbers 2022/23	2022/23 Welsh Government reduction expectation rate per 100,000 population	SBUHB 2022/23 rate per100,000 population
1	C. difficile (CDI)	201	25	51.41
2	Staph Aureus bacteraemia (SABSI)	147	20	37.60
3	E.coli bacteraemia (EcBSI)	260	67	66.50
4	Klebsiella Bacteraemia (KIBSI)	107	84	27.37
5	Pseudomonas aeruginosa bacteraemia (PAERBSI)	44	27	11.25

2.27 An end of year cumulative position,-for the Service Groups, for each of the Tier 1 infections was also issued to the April2023 QSC meeting.

Table 4

	CDI	SABSI	EcBSI	KIBSI	PAERBSI
Morriston Hospital	6%↑	36%↑	9%↑	36 (equal to)	+7 cases↑
Singleton Hospital	8%↓	8%↓	67%↑	18 ↑	+7 cases↑
Neath Port Talbot Hospital	33%↓	+ 1 case↑	87%↓	2 (equal to)	1 (equal to)
MH & LD	0 cases	0 cases	1 case	0 cases	0 cases
PCTG Gorseinon Hospital	50%↓	0 cases	50%↑	0 cases	0 cases
PCTG Community acquired	13%↑	12%↓	20%↓	31%↑	+ 6 cases↑

It was noted from the report to QSC that the rates of HCAIs in the health board's hospitals over 2022/23 has been lower than many other NHS Wales acute hospitals. Neath Port Talbot Hospital's rates of infection were consistently amongst the lowest in Wales. Rates of E.coli bacteraemia in Morriston Hospital were the fifth lowest of the eighteen hospitals, with Neath Port Talbot having the lowest incidence. It is noted also, that although the health board had the highest incidence of Pseudomonas aerugionsa bacteraemia in Wales (per 100,000 population), its hospitals did not have the highest incidence of infection per 1,000

admissions. There has also been an improvement in the number of days between infections for C.difficile and *Staph. aureus* bacteraemia.

2.28 Further, review of the Public Health Wales HCAI mandatory surveillance summary (for the period April 2022 to February 2023) for all NHS Wales organisations, confirms the increase in HCAIs across the health board, supporting what is presented in the ICC and QSC reports (recognising that the data in table 4 is per 100,000 population; and table 5 is the total number of infections in the respective health boards):

Table 5

Wales 2022/23 HCAI mandatory surveillance summary, Apr 22 - Mar 23

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Higher than same period of previous FY — Lower than same period of previous FY — Same as same period of previous FY

	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	193	32.26	12	2.01	126	21.06	138	23.07	315	52.66	118	19.73	18	3.01	451	75.39
Betsi Cadwaladr UHB	301	42.79	17	2.42	171	24.31	187	26.59	511	72.65	144	20.47	38	5.40	693	98.53
Cardiff and Vale UHB	139	27.55	12	2.38	134	26.56	144	28.54	306	60.65	134	26.56	25	4.96	465	92.17
Cwm Taf Morgannwg UHB	114	25.34	4	0.89	143	31.79	147	32.68	382	84.92	85	18.90	40	8.89	507	112.71
Hywel Dda UHB	204	52.35	14	3.59	99	25.40	113	29.00	335	85.96	117	30.02	29	7.44	481	123.42
Powys THB	12	9.02	0	0.00	0	0.00	0	0.00	1	0.75	1	0.75	1	0.75	3	2.26
Swansea Bay UHB	201	51.41	12	3.07	135	34.53	147	37.60	260	66.50	107	27.37	44	11.25	411	105.13
Velindre NHST	3		0	0.00	2		2		11		1		0		12	
Wales	1,167	34.02	71	2.07	810	23.61	878	25.60	2,121	61.83	707	20.61	195	5.68	3,023	88.13

Conclusion:

2.29 Work programmes are in place at both a corporate and Service Group level. The programmes align with the objectives set out in the IPC policy, with regular monitoring and reporting identified at ICC through to QSC. However, review of the updated Service Group work programmes identified that a high number of actions are yet to be achieved. We acknowledge that it is difficult to conclude a direct causal relationship with the status of the programmes and resulting number of HCAIs as the evidence regarding this is not clearcut e.g. seasonal factors, hospital transmissions, acuity of patients; and that it will take time for actions to embed to materialise the reductions in recorded infection rates. Whilst this has been evidenced to date for the E-coli rates, greater reduction remains required for the number of infections in the health boards areas of highest incidence. Therefore, we assign this objective **limited** assurance.

Audit objective 4: There is awareness of infection prevention and control guidance, and staff have undertaken appropriate training.

2.30 As per para 2.3, the health board has a designated IPC Hub within the SharePoint site. It was confirmed that all staff within the health board has access to the information contained within the hub.

2.31 The hub has a number of tabs specific to HCAIs, as well as other common infections including MRSA, E.coli, Ebola, Klebsiella, MMR, Pseudomonas,

Clostridium difficile, Scabies and Norovirus. Each dedicated section has a background on the infection including steps that should be taken to contain and prevent the spread of the outbreak. There is also a variety of resource available under each section including:

- Quick reference guide,
- Protocols,
- Posters to warn of the infection in the ward/area,
- Information leaflets for patients; and
- Investigation tools.

The hub also has a live spreadsheet that highlights the wards/areas that currently have an infection outbreak; as well as infection rates across the health board with a comparison to the Welsh Government targets.

2.32 In addition to information on infections, the hub also has useful links for staff to help keep themselves and patients safe in terms of IPC. These include information on outbreak management, ANTT, Personal Protective Equipment (PPE), hand hygiene, decontamination, and links to additional resource from outside the health board including World Health Organisation advice, Public Health Wales advice and NICE guidance.

2.33 In addition to the statutory and mandatory IPC training requirements, the health board has established mandatory training for all medical personnel in relation to ANTT and hand hygiene. Links to the available training courses can be found under their respective sections in the hub.

2.34 Training compliance rates are included in the Service Group reports to the ICC. The IPC report to ICC provides details of overall compliance for the health board. Training compliance levels are outlined below:

Table 6

Training Course	National Target	% Compliance to end of August 2022	% Compliance to end of October 2022	% Compliance to end of March 2023
IPC Level 1	85%	80.09%	82.72%	86.56%
IPC Level 2	85%	19.82%	21.66%	22.33%
ANTT	85%	13.95%	13.50%	8.2%

2.35 Hand Hygiene training is also reported at ICC meetings. However reporting is only on the number of staff who have completed training, percentage compliance is not included **(**see **MA2)**.

2.36 It was noted that a new training programme was approved at the December 2022 ICC meeting. The programme looks to shorten the training courses but supply a

higher frequency, which is hoped will increase the coverage of training across the health board.

2.37 Review of minutes for the QSC noted there was no reporting of the training compliance figures, even though such feature in all service group work programmes (with focus on ANTT in both Corporate and Service Group Work Programmes) and the overarching IPC work programme **(**see **MA2).**

Conclusion:

2.38 The health board provides staff with additional training and guidance to that required by the All-Wales Mandatory IPC training. However, the national compliance training target (85%) has only been achieved for IPC Level 1, with less than 25% of the required target achieved for IPC level 2 and ANTT training. Whilst the compliance figures are regularly reported at the ICC, such is not escalated within the governance framework. Noting these points, we assign the objective **limited** assurance.

Audit objective 5: Mechanisms in place to ensure compliance with health board policies and procedures are appropriate.

2.39 Discussions with the IPC Head of Nursing confirmed that the IPC team has two main audit toolkits in place: (1) Hand Hygiene / Bare Below the Elbow and (2) Standard Infection Control Precautions (SICPs), with both toolkits available via the hub. It was confirmed that no set audit programme is in place, as has been evidenced at other NHS Wales bodies, rather the team select hotspot areas for review based on infection rates, current infections, or poor training compliance. Management confirmed that any issues identified during the audits are dealt with at the time with the Ward Matrons, although no formal output is issued **(s**ee **MA4)**

2.40 In addition to the aforementioned audit toolkits (Hand Hygiene / Bare Below the Elbow and SICPs reviews), the Service Groups undertake Environmental IPC audits of the care environment – the results of which are reported in the monthly care metrics:

Indicators	Managed Unit	Target	Dec-22	Jan-23	Feb-23	Mar-23
Percentage compliance with hand hygiene (WHO 5 moments) (monthly)	Mental Health and Learning Disabilites	100	96.90%	95.39%	95.94%	95.32%
Percentage compliance with hand hygiene (WHO 5 moments) (monthly)	Morriston	100	98.42%	99.09%	91.77%	
Percentage compliance with hand hygiene (WHO 5 moments) (monthly)	Neath Port Talbot	100	96.77%	96.77%	100.00%	93.55%
Percentage compliance with hand hygiene (WHO 5 moments) (monthly)	Singleton	100	92.56%	91.24%	92.92%	92.59%
Infection Control Monthly Audit scores	Mental Health and Learning Disabilites	85	92.76%	93.39%	93.88%	94.16%
Infection Control Monthly Audit scores	Morriston	85	94.23%	91.38%	95.42%	91.84%
Infection Control Monthly Audit scores	Neath Port Talbot	85	98.45%	97.99%	98.55%	98.28%
Infection Control Monthly Audit scores	Singleton	85	96.16%	96.11%	96.63%	96.28%
Percentage compliance with appropriate infection control patient isolation	Mental Health and Learning Disabilites	100	-	-	100.00%	100.00%
Percentage compliance with appropriate infection control patient isolation	Morriston	100	100.00%	100.00%	96.12%	96.20%
Percentage compliance with appropriate infection control patient isolation	Neath Port Talbot	100	100.00%	100.00%	100.00%	100.00%
Percentage compliance with appropriate infection control patient isolation	Singleton	100	100.00%	97.30%	100.00%	95.89%
Percentage compliance with commode cleaning bundle	Mental Health and Learning Disabilites	100	98.46%	100.00%	100.00%	100.00%
Percentage compliance with commode cleaning bundle	Morriston	100	92.38%	96.12%	95.28%	94.64%
Percentage compliance with commode cleaning bundle	Neath Port Talbot	100	100.00%	100.00%	100.00%	100.00%
Percentage compliance with commode cleaning bundle	Singleton	100	100.00%	100.00%	100.00%	100.00%

2.41 A review of the Service Group IPC reports to the ICC identified that each report on any issues identified during the audits for the period, as well as compliance levels from the reviews. **(See MA4)**

Conclusion:

2.42 All Service Groups perform monthly audits of the care environment, which are reported appropriately. At Corporate level, whilst audits are being undertaken at hotspot areas, proactive assessments should be considered across all areas to prevent them becoming hotspot areas and allowing preventative measures to be implemented. Also, there is no formal output from the hotspot audits undertaken and lack of a tracking system to monitor IPC recommendations arising. Noting this, we assign the objective **reasonable** assurance.

Audit objective 6: There is regular reporting on IPC performance, with clear oversight arrangements to support escalation of risks and issues within the Service Groups as well as the Operational Clinical Directorates.

2.43 As per audit objective two, each Service Group has its own designated IPC group, with each required to issue an IPC report into the ICC on a quarterly basis. Our review confirmed that each Service Group had reported to each ICC meeting held during the period of our review (six in total).

2.44 A standard reporting template (agreed at the June 2022 ICC meeting) is used by the Service Group and includes the following:

- Summary of Tier 1 target progress;
- Outbreaks or periods of increased incidence of infection;
- Serious incidents, with the actions taken;
- Training Compliance levels;
- Decontamination of re-usable medical devices updates;
- HCAI quality priorities and Infection Control Improvement plan, with progress to date;
- Covid and influenza priorities and challenges; and
- Quality/Governance – including audits and assurance reviews.

2.45 As per para 2.20, the QSC receives regular updates from the ICC with a standing agenda item to report progress against the IPC Improvement Plan at each meeting.

2.46 QSC highlight reports are taken to Board, with the exception for one meeting (July 2022), and it was confirmed that all include an update on IPC.

Conclusion:

2.47 There is a clear reporting structure in place from Service Groups to Board, via ICC and QSC. Reasonable information is presented on performance, risks and issues to all, with the exception of training compliance (see ***audit objective 4***). As also

noted in audit objective 4, whilst progress in implementing the work programme is regularly reviewed by the Service Groups and at ICC and QSC, they are currently off track. Noting this, we assign the objective **reasonable** assurance.

Appendix A: Management Action Plan

Matter arising 1: Policies and Procedures (Operation)	Impact
All health board policies and procedures are easily accessible to all health board staff via the Infection Control Hub and COIN on the health board's SharePoint site. However, our review noted that the following policies on COIN, were overdue for review at the time of audit: • Management of Seasonal Influenza and other acute viral respiratory infection (COIN): review date August 2020; • Inoculation Injury Policy (COIN): review date December 2020; • Model Policy Aseptic Non Touch Technique (ANTT): a national, standardised approach to aseptic technique (COIN): review date July 2020; and • Policy for Infection Outbreak / Incident Management in Secondary & Tertiary Care (COIN): review date July 2020. As advised by management, we acknowledge that the health board made the decision, at the beginning of the Covid, not to update policies throughout the pandemic.	Potential risk of: • IPC policies and procedures no longer being up to date with latest practice; • An increase of infection control issues; • Poor quality care or patient harm.

Recommendations	Priority
1.1 Overdue policies should be reviewed and updated, where appropriate, as a matter or priority; and approved accordingly. 1.2 All superseded policies, and those relating to the health board's preceding name, should be removed from the SharePoint site.	Low

	Management response	Target Date	Responsible Officer
1.1	Infection Prevention and Control Policy and 11 Quick Reference Guides have been reviewed and updated and were approved by the HB Infection Control Committee on 28/03/23. These were made available on the SharePoint site on 28/03/23.	Actioned since fieldwork	Infection Prevention & Control Head of Nursing
	The Infection Control Committee approved an extension to the review of 6 other documents until 30/06/23. These will be reviewed, updated and submitted to Infection Control Committee for approval in June 2023.	30/06/23	
	All other documents remain in date. A process to monitor documents and review dates has been established and will be monitored by the IP&C Team Business Manager.		
1.2	All superseded policies, and those relating to the health board's preceding name have been removed from COIN. COIN pages provide the link to the IP&C Policies, Protocols and Quick Reference Guides page on IP&C SharePoint.	Actioned since fieldwork	Infection Prevention & Control Head of Nursing

Matter arising 2: Training compliance (Operation)	Impact
A review of training compliance within the health board identified that compliance with mandatory IPC training target (85%) has only been achieved for IPC Level 1. For IPC Level 2 and ANTT, both are significantly off target. As per para 2.34, whilst data is provided on the number of staff undertaking hand-hygiene training this is only in relation to the number of staff who have completed the training. A percentage compliance is not included. Review of the IPC work programme noted inclusion of an objective only to improve compliance for ANTT training; however, the current recorded compliance rates indicate that this objective should be extended to apply to all training requirements – IPC Level 1, Level 2 and hand-hygiene.	Potential risk of: • Patient or staff harm where infection, prevention and control practices are not applied appropriately.

Recommendations	Priority
2.1 All IPC training should be included within the work programmes going forward, to ensure all training achieves the 85% target set by Welsh Government. 2.2 For consistency, the percentage compliance for hand-hygiene training should be reported. 2.3 For improved scrutiny, training compliance should be included in the reporting to QSC.	High

Management response	Target Date	Responsible Officer
2.1 IPC training compliance is reported in reports to Infection Control Committee but was not specifically included within the Infection Improvement Programme. This has since been amended in the 2022/23 plan for Q4 reporting.	Actioned since fieldwork	Infection Prevention & Control Head of Nursing
2.2 Hand Hygiene training is included both within IPC Level 1 and Level 2 training. The Health Board has previously included supplementary training. This has since changed to training healthcare staff to undertake Hand Hygiene competence assessments going forward. As such, hand hygiene specific training data will not be provided separately in future reports.	N/A	N/A

2.3	The report for the March QSC had already been submitted prior to the receipt of the draft report. However, a verbal update was provided at QSC on 28/03/23. It will be included in all formal reports presented to QSC from 25/04/23 onwards.	Actioned since fieldwork	Infection Prevention & Control Head of Nursing

Matter arising 3: Work Programme Implementation (Design)	Impact
The health board have created work programmes to help improve Infection Prevention and Control at both Corporate and Service Group levels. As detailed in Table 1, para 2.24, review of the progress made against the implementation of the work programmes showed that a number of actions at Service Group Level are yet to be implemented or are off target.	Potential risk of: • Issues may not be identified if areas aren't reviewed regularly. • Poor quality care or patient harm.

Recommendations		Priority
3.1	The work programme target dates, and associated resource requirements, should be reviewed; with changes approved, and monitored at ICC and QSC meetings.	High

Management response		Target Date	Responsible Officer
3.1	The Infection Improvement Programme is under review for 2023/24. The key themes for the 2023/24 programme will reflect the IPC-related Outcome Measures to be approved by the Health Board. These include: 1. Achieve reduction in 5 key healthcare associated infections in line with national reduction expectations. 2. Develop a proactive schedule of IPC-related audit for Service Groups, and IPC team, using the Audit Management and Tracking (AMaT) clinical audit assurance software. 3. Achieve compliance with national training target for infection prevention DT) - all available staff. Increase compliance with staff training. Working toward IP&C Training, Level 1 and Level 2 – ≥85% (available staff). 4. Environment – Cleaning Compliance scoring matrix >95%. 5. Develop a proactive schedule of antimicrobial-related audit, using the Audit Management and Tracking (AMaT) clinical audit assurance software. 6. Develop a Quality Improvement programme to work towards compliance with the National Decontamination Agenda and relevant Welsh Health Technical Memorandum documents.	31/05/23	Infection Prevention & Control Head of Nursing, **with** Consultant Antimicrobial Pharmacist (Antimicrobial audit) Health Board Operational Decontamination Lead (Decontamination Quality Improvement Programme)

Matter arising 4: Audit Programme (Design)	Impact
Service Groups undertake Environmental IPC audits of the care environment, the results of which are reported in the monthly care metrics. At a Corporate level, however, audits are undertaken on a reactive rather than a proactive approach at hotspot areas. There was no indication in the programme that 'non' hotspot areas are included to ensure preventative measures / mitigating actions are put in place at the earliest opportunity. It was also noted that there is no formal output from audits undertaken therefore no clear action plans are in place against which achievement can be monitored and measured.	Potential risk of: • Issues may not be identified if areas aren't reviewed regularly • The health board may not fully learn from audit outcomes • Poor quality care or patient harm.

Recommendations		Priority
4.1	The health board should look to develop a prioritised schedule of audits which can be delivered by the IPC team for 2023/24.	Medium
4.2	The health board should look to develop an IPC audit tracker to detail: • The required action(s); • The individual responsible for implementation; • Deadline for implementation • Progress update, where necessary. The progress should be monitored at ICC and Service Group IPC Group, where applicable.	

Management response		Target Date	Responsible Officer
4.1	A prioritised schedule of audits for 2023/24 will be developed for approval by Infection Control Committee in June 2023. The existing programme of audits will continue in the interim. Results of existing IPC-related audits will be reported for review at Infection Control Committee.	30/06/23	Infection Prevention & Control Head of Nursing

4.2	The Health Board will review the feasibility of utilising Audit Management and Tracking (AMaT) clinical audit assurance software to provide audit tracking facilities.	30/09/23	Infection Prevention & Control Head of Nursing

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

Rating	Definition
Substantial assurance	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
Reasonable assurance	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
Limited assurance	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
No assurance	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership]